NWML – R44 – C02 – S07

COLDSIDE
MEDICAL PRACTICE
Supporting Your Health

Dr G.W. Macmillan
Dr A. Taylor
Dr A. Oswald
Dr F. Bullions
Dr J. Boileau
Dr T. Ansar

129 Strathmartine Road
Dundee
DD3 8DB

Tel: 01382 880900
Fax: 01382 884129

FB/TMc/11166

10 January 2022

Dr Benjamin Jaa Ming New
Specialty Registrar
Medicine Directorate
Ninewells Hospital
DUNDEE
DD1 9SY

Dear Dr New

**Re: David Standish DOB 05.03.70 0053**
**6 Dargarvel Gardens Ormiston Crescent DUNDEE DD4 0UQ**

Thank you for your recent correspondence.

Please note if you require bloods to be available to look at you need to request these on ICE then contact the patient prior and give them the contact number for hospital bloods. We do not organise hospital bloods in primary care.

Yours sincerely

**DR F BULLIONS**

We pay the Living Wage Employer

(4)

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Tayside

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Dr F Bullions
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 01/07/2019 |
| Clinic Date | 18/06/2019 |
| Your Ref | |
| Our Ref | JJ/SG/ **0503700053** |
| Enquiries to | Ward 4 Outpatient Office |
| Extension | 40471 |
| Direct Line | 01382 740471 |
| Email | samantha.garvock@nhs.net |

Dear Dr Bullions

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

**Diagnosis:**
1. Coronary artery disease
2. Heterozygous FH
3. Peripheral vascular disease
4. Hypertension
5. Statin and Ezetimibe intolerance
6. Asthma
7. Currently on Alirocumab

**Medication:** Ramipril 2.5 mg once daily, Bisoprolol 2.5 mg once daily, Folic Acid 5 mg once daily, Aspirin 75 mg, Lansoprazole 30 mg twice daily, Alirocumab 150 mg every 2 weeks, GTN and asthma inhalers.

I reviewed this gentleman in the cardiovascular risk clinic this morning. He is well and has had no side effects from Alirocumab, which he has now been on for around 18 months. His children have undergone cascade testing since his previous clinic appointment and he tells me that they do not have FH.

Last cholesterol when checked in April last year showed a total cholesterol of 4.49 mmol/L with an HDL of 1.29mmol/L, an LDL of 2.64 mmol/L, giving him a ratio of 3.4.

Blood pressure was also well controlled today and best blood pressure obtained was 114/72. I have not made any changes to his medication but I have checked his cholesterol today and will review him again in a year's time.

Many thanks

Yours sincerely

Authorised on 05/07/2019 17:00:47 by Clin Pharm Jennifer Johnstone.

**Dr J Johnstone**
**Specialty Registrar**

| | | | |
|---|---|---|---|
| **TOTAL CHOLESTEROL** | 4.00 | mmol/L | 0.00 - 5.00 |
| **HDL-CHOLESTEROL** | 1.19 | mmol/L | 0.60 - 2.50 |
| **TOTAL CHOL/HDL-CHOL** | 3.30 | . | |
| **LDL-CHOL. (CALCULATED)** | 2.15 | mmoL/L | 0 - 2.60 |
| **TRIGLYCERIDES** | 1.46 | mmol/L | 0.00 - 2.30 |

Clinical Genetics
Surgical Directorate
Ninewells Hospital
Dundee
DD1 9SY

Telephone 01382 632035

www.nhstayside.scot.nhs.uk

NHS Tayside

**PRIVATE & CONFIDENTIAL**
David Standish
6 Dargarvel Gardens
Ormiston Crescent
Dundee
DD4 0UQ

| | |
|---|---|
| Date Typed: | 21/08/2018 |
| Date Dictated | 16/07/2018 |
| Clinic Date: | 13/07/2018 |
| Your Ref: | |
| Our Ref: | EG/jr/ **0503700053** |
| Pedigree No: | **10953** |
| Enquiries to: | Clinical Genetics |
| Extension: | 32035 |
| Direct Line: | 01382 632035 |
| Email: | Tay-UHB.clinicalgenetics@nhs.net |

Dear Mr Standish

It was lovely to meet you at the cholesterol clinic at Ninewells Hospital, Dundee on 13th July 2018. As discussed at clinic you have been identified as having a change in the ApoB gene for Familial Hypercholesterolaemia (FH). For your own information and should you or any members of your family be asked what the specific gene change is in order for them to be tested, we call it the **'heterozygous c.10580G>A: p.(Arg3527Gln) ApoB gene change'**. A copy of your laboratory report and this letter are filed in your medical records. I also gave you a copy of this at clinic for your information.

**Personal Information**
I started our appointment discussing your genetic test result. As I explained, this is helpful because it confirms the clinical diagnosis of FH and reinforces the need for you to maintain a healthy lifestyle and to continue with your cholesterol lowering treatment. As you are aware, there is strong evidence to support the effectiveness of these treatments in reducing your future risk of further heart and vascular disease. I was sorry to hear that you are having mobility problems at present, believed to be associated with the circulation in your legs. I gave you some further information about FH at clinic which included some useful links to further websites to include the British Heart Foundation and Heart UK.

You are currently under review at the cholesterol consultant clinic with regards to your cholesterol lipid-lowering therapy.

**Family History**
Your father had a heart attack in his 40s. Your mother had a stroke in her 60s. Your maternal grandfather had a heart attack in her 50s. You have limited contact with your extended family.

**Familial Hypercholesterolaemia**
I explained what FH is in detail. As you remember, I explained that if FH is appropriately treated with cholesterol lowering medication and a healthy lifestyle, the LDL 'bad' cholesterol and the risk of developing coronary heart disease (CHD) can be reduced. It is therefore important to be diagnosed and appropriately treated. In addition to this, informing other family members of their risk is also very important.

**FH Genes and their Inheritance**
We talked about the genes that are affected by FH and how these are inherited using your own family tree and visual illustrations to demonstrate this. You will remember that we all have two copies of every gene, one of which we inherit from our mother and the other from our father.

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Someone affected with FH has one normal copy of the gene and one faulty copy. There is therefore a 50% chance or a 1 in 2 chance that they may pass on the faulty copy to any child that they may have. It is the same risk for each pregnancy.

**Cascade Screening**

We discussed, now we have found this gene change in you many members of your family will be eligible for testing. After discussion you requested your two daughters be offered screening for familial hypercholesterolaemia. Early identification of this condition and treatment significantly reduces their risk of developing cardiovascular disease. I have met with Savannah in clinic and should have her results shortly. Charlotte has been sent an appointment to be seen in clinic in due course.

With this letter I have included some information for any other relatives that wish to undergo screening. I explained that if they feel that they do not want to go ahead with genetic testing it is very important that they have their cholesterol levels measured. This, however, does not determine their genetic risk.

Please do not hesitate to contact me on the telephone number on this letter should you have any questions.

Yours sincerely

Authorised on 24/08/2018 10:39:42 by Emma Gellatly.

**Emma Gellatly**
**Familial Hypercholesterolaemia Nurse Specialist**

Enc: Letter for relatives

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB (copy genetics report sent under separate cover)
(P) Professor Jacob George, Honorary Consultant Physician, Cardiovascular Risk Clinic, Wards 3/4 Corridor, Ninewells Hospital, Dundee, DD1 9SY
Invu
Casenotes

NHS Tayside

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Dr F Bullions
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 23/08/2018 |
| Clinic Date | 14/08/2018 |
| Your Ref | |
| Our Ref | JG/SG/ **0503700053** |
| Enquiries to | Miss Sam Garvock |
| Extension | 40157 |
| Direct Line | 01382 740157 |
| Email | samantha.garvock@nhs.net |

Dear Dr Bullions

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

Diagnosis:
1. Coronary artery disease
2. Peripheral vascular disease
3. Familial hypercholesterolaemia
4. Hypertension
5. Statin and Ezetimibe intolerance
6. Asthma
7. Currently on Alirocumab

Medication: Ramipril 2.5 mg once daily, Bisoprolol 2.5 mg once daily, Folic Acid 5 mg once daily, Aspirin 75 mg once daily, Lansoprazole 30 mg once daily, Alirocumab 150 mg every 2 weeks, GTN and asthma inhalers

I reviewed this pleasant gentleman at the Cardiovascular Risk Clinic this morning. He is keeping well and tolerating his medications. He has responded well to 150 mg of Alirocumab. His total cholesterol is 4.49 mmol/L, with an LDL of 2.64 mmol/L. Reassuringly, his HDL is 1.29 mmol/L. His blood pressure was well controlled in clinic today. It was 120/86 mmHg. I have given him one further review appointment in 6 months. If he remains well, he can be considered for discharge from this clinic. In the meanwhile, I have copied in his pharmacist, Bruce Ramsay at 87 Fintry Road in Dundee, so that he is aware that Mr Standish will require Alirocumab from the end of this month onwards.

Yours sincerely
Authorised on 28/08/2018 07:45:38 by Jacob George.

**Professor Jacob George**
**Honorary Consultant Physician**

(P) Pharmacist Bruce Ramsay Chemist, 87 Fintry Road, DD4 9JB

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Dr F Bullions
Coldside Medical Practice
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DD3 8DB

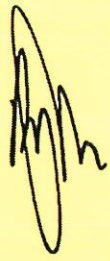
| | |
|---|---|
| Date | 22/05/2018 |
| Clinic Date | 08/05/2018 |
| Your Ref | |
| Our Ref | MJM/SG/ **0503700053** |
| Enquiries to | Miss Sam Garvock |
| Extension | 40157 |
| Direct Line | 01382 740157 |
| Email | samantha.garvock@nhs.net |

Dear Dr Bullions

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

I saw this man and his wife at the Risk Clinic. Since his last visit, molecular genetic testing for FH has come back. He has a mutation in the ApoB gene – in layman's terms he has heterozygous FH. They have two children, age 23 and 14, and an appointment has been made with our FH nurse, Emma Gellatly, who will talk them through the implications and what we would advise. David himself, I am happy to say, tolerates alirocumab 150 mg every two weeks. Many thanks for checking his lipids recently: total cholesterol 4.49 mmol/L, calculated LDL 2.64 mmol/L, HDL 1.29 mmol/L, total/HDL 3.4 and triglycerides 1.25 mmol/L. These are the best results we have had on him for a long time, and he should persist on alirocumab for the moment. **Please note that the prescription of alirocumab reverts to primary care after six months, which will be in about three months from now.** I'm flagging this up now so there is plenty of time to source this.

Yours sincerely



**Authorised on 25/05/2018 10:01:47 by Clin Pharm Michael Murphy.Dr Michael Murphy**
**Honorary Consultant**
**Biochemical Medicine**

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Mr David Standish
6 Dargarvel Gardens
Ormiston Crescent
Dundee
Angus
DD4 0UQ

| | |
|---|---|
| Date | 01/05/2018 |
| Your Ref | |
| Our Ref | RH/SG/ **0503700053** |
| Enquiries to | Miss Sam Garvock |
| Extension | 40157 |
| Direct Line | 01382 740157 |
| Email | samantha.garvock@nhs.net |

Dear Mr Standish

We look forward to seeing you at your clinic appointment at the Cardiovascular Risk Clinic next week (Tuesday 8 May at 10.25 am). I just wanted to let you know that I have also asked one of our specialist nurses, Emma Gellatly, to offer you a follow up appointment in her Friday afternoon clinic. You should hear from her in due course. We can discuss more about this at your appointment next week.

Yours sincerely

Authorised on 01/05/2018 14:06:58 by Typist/Secretary Clin Pharm Sam Garvock, on behalf of Clin Pharm Rosalind Harpur.

**Dr Rosalind Harpur**
**Specialty Doctor**

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

**David Standish, 050370 0053**

I appears that this man has not been tested for familial hypercholesterolaemia, but given his high pre-treatment, personal and strong family history for heart disease it would be prudent to do so. The patient is aware that the blood test is sent to Aberdeen and the result can take some time to return to us, but I hope it will be available by his next Cardiovascular Risk Clinic appointment to allow discussion.

If you, or the patient, have any questions regarding his Alirocumab treatment, please do not hesitate to get in touch in the meantime.

Yours sincerely

Authorised on 09/03/2018 16:47:12 by Clin Pharm Rosalind Harpur.

**Dr Rosalind Harpur**
**Specialty Doctor**

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Dr F Bullions
Coldside Medical Practice
129 Strathmartine Road
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DD3 8DB

| | |
|---|---|
| Date | 07/12/2017 |
| Clinic Date | 17/11/2017 |
| Your Ref | |
| Our Ref | IM/SG/ **0503700053** |
| Enquiries to | Miss Sam Garvock |
| Extension | 40157 |
| Direct Line | 01382 740157 |
| Email | samantha.garvock@nhs.net |

Dear Dr Bullions

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

Diagnosis:
1. NSTEMI, November 2016, VF arrest during angiogram
2. Peripheral vascular disease
3. Coronary stents
4. Statin intolerance
5. Ezetimibe intolerance
6. Hypercholesterolaemia
7. Asthma

I reviewed this gentleman in the Cardiovascular Risk Clinic today, accompanied by his partner. He has a history of hyperlipidaemia. He previously took statins for several years when he was also on Diazepam, but when the Diazepam was later stopped, he developed aches and pains, felt generally unwell and had cold symptoms. He tried several different statins over time under the care of Dr Baines, including Rosuvastatin, with similar reactions. His main side effects were insomnia, myalgia and abdominal pains. He also tried Ezetimibe which caused abdominal pains.His blood pressure has been relatively well controlled on treatment. He still experiences some atypical chest pains. These sometimes respond to GTN treatment. He has no major breathlessness, but occasionally has some chest tightness relieved by Salbutamol. He has no ankle swelling and no orthopnoea. His exercise tolerance is limited due to pain occurring in both legs on walking 10 to 15 metres. He has previously had a vascular bypass in his right leg and it was felt not beneficial to intervene in his left leg at that time.

His current treatment is Ramipril 2.5 mg, Bisoprolol 1.25 mg to 2.5 mg depending on leg symptoms, Aspirin 75 mg, Folic Acid 5 mg, Lansoprazole 30 mg, Zopiclone 7.5 mg at night, GTN spray prn and Salbutamol inhaler prn. He has no actual drug allergies. He stopped smoking in November 2016, drinks very little alcohol. He previously worked as a boat builder, but is not currently working. He lives with his partner and daughter.

His father had several MIs from his early 40s onwards and is now in his 70s. His sister died age 48 of a brain tumour.

On examination,/ **cont./**

**David Standish, 050370 0053**

On examination his weight was 105 kg, height 1.78 m. Blood pressure initially measured 152/94, pulse 63, but settled to 138/84, pulse 55.

Examination was normal except peripheral pulses were difficult to feel. His feet were warm. He had no xanthelasmata, or corneal arcus or vascular bruits.

I have discussed the treatment options for his hyperlipidaemia. I think he may be eligible for Alirocumab on the grounds of his polyvascular disease, his intolerance of statins and Ezetimibe, however we do not have a recent lipid profile. The most recent one in November 2016 showed cholesterol 6.64, HDL 1.67 and a previous one September 2015 showed cholesterol 7.13, HDL 1.34. I have repeated bloods today, including a full lipid profile and will advise further based on these results. If he is eligible for PCSK9 inhibition, we will start him on Alirocumab 75 mg subcutaneous injection, given 2 weekly. He feels that his partner may need to administer this for him, so they can both attend for training, if this is appropriate. If he does not meet the Scottish Medicines Consortium criteria for Alirocumab therapy based on his LDL result, alternatives include trying a very low dose statin, given very infrequently, or retrying Ezetimibe and he is open to these options, if required. I will contact the patient by telephone next week with his lipid results, and our treatment plan. I will review him in this clinic in 3 months.

Yours sincerely

Authorised on 11/12/2017 14:06:53 by Clin Pharm Isla Mackenzie.

**Dr I Mackenzie**
**Honorary Consultant Physician**

**PS added 11.12.17- After reviewing his recent lipid results, I discussed them with Mr Standish by telephone and prescribed alirocumab and arranged with our clinic nurses to train him to start on alirocumab therapy as above in early December. His partner will administer the injections. We will review him in clinic in 3 months. Please could you check a fasting lipid profile on him in late February so that we have these results to review his dose when he next attends. Many thanks.**

**Results cont./**

## David Standish, 050370 0053

| | | | | |
|---|---|---|---|---|
| Hb | | 138 | g/L | 130 - 180 |
| WBC | | 7.9 | $x10^9$/L | 4.0 - 11.0 |
| PLT | | 380 | $x10^9$/L | 150 - 400 |
| RBC | | 4.66 | $x10^{12}$/L | 4.5 - 6.0 |
| HCT | | 0.439 | | 0.40 - 0.52 |
| MCV | | 94.1 | fl | 85 - 105 |
| MCH | | 29.6 | pg | 27 - 32 |
| MCHC | *[LO] | 314 | g/L | 320 - 360 |
| NE# | | 4.2 | $x10^9$/L | 2.0 - 7.5 |
| LY# | | 2.9 | $x10^9$/L | 1.5 - 4.0 |
| MO# | | 0.4 | $x10^9$/L | 0.2 - 0.8 |
| EO# | | 0.26 | $x10^9$/L | 0.0 - 0.4 |
| BA# | | 0.1 | $x10^9$/L | 0.0 - 0.1 |

| | | | | |
|---|---|---|---|---|
| TOTAL CHOLESTEROL | *[HI] | 7.36 | mmol/L | 0.00 - 5.00 |
| TRIGLYCERIDES | | 1.85 | mmol/L | 0.00 - 2.30 |
| SODIUM | | 137 | mmol/L | 133 - 146 |
| POTASSIUM | | 4.7 | mmol/L | 3.5 - 5.3 |
| UREA | | 4.3 | mmol/L | 2.5 - 7.8 |
| CREATININE | | 74 | umol/L | 62 - 106 |
| AKI | | Not detected: but may not exclude AKI in all cases | . | |
| ALT | | 40 | U/L | 5 - 55 |
| BILIRUBINS | | 7 | umol/L | 0 - 21 |
| ALKALINE PHOSPHATASE | | 83 | U/L | 30 - 130 |
| ALBUMIN | | 36 | g/L | 35 - 50 |
| CALCIUM | | 2.39 | mmol/L | 2.10 - 2.55 |
| CALCIUM (CORRECTED) | | 2.43 | mmol/L | 2.10 - 2.55 |
| ESTIMATED GFR | | GT60 | mL/min | |
| CKD Stage | | IF HIGH RISK, EXCLUDE CKD1/2.<br>CHECK FOR HAEMATURIA AND PROTEINURIA | . | |
| HDL-CHOLESTEROL | | 1.47 | mmol/L | 0.60 - 2.50 |
| TOTAL CHOL/HDL-CHOL | | 5.00 | . | |
| GLUCOSE (preserved tube) | | 5.3 | mmol/L | 3.3 - 5.8 |
| TSH | | 1.61 | mU/L | 0.4 - 4.0 |

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Department of Cardiology
Medicine Directorate
Acute Services Division
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Dr Vivien Smith
Clinical Psychologist
Clinical Neuropsychology Department
Level 6, South Block
Ninewells Hospital
Dundee
DD1 9SY

| | |
|---|---|
| Date | 11/09/2017 |
| Dictated | 07/09/2017 |
| Our Ref | TM/IR/ **0503700053** |
| Enquiries to | Mrs I Robertson |
| Extension | 32263 |
| Direct Line | 01382 632263 |
| Email | |

Dear Dr Smith

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, DD4 0UQ DOB: 05/03/1970**

Thank you for copying me into your letter of the 4th of September 2017. I would like to clarify some of the points in your text.

The patient had to be defibrillated whilst he was having a heart attack. This is a not uncommon complication and merely indicates the seriousness of having a heart attack rather than any long-term problem.

Mr Standish was discharged from our Cardiac Rehab Service as he was doing well.

He awaits an appointment with the Cardiovascular Risk Management Team, which is not part of the Cardiology Department. Cardiovascular risk management is regarding his cholesterol, which is not particularly high. I wrote to Dr Jacob George and received a reply in February 2017, which the General Practitioner will also have received, stating that the patient was not suitable for consideration of Alirocumab. Dr George did state that he would arrange for the patient to be seen in the Cardiovascular Risk Clinic (Lipid Clinic) and it is this clinic Mr Standish is awaiting an appointment, not Cardiology.

Yours sincerely

Authorised on 14/09/2017 10:11:22 by Cardio Tom Martin.
**Dr Thomas Martin**
**Consultant Cardiologist**
(P) Dr Jacob George, Clinical Pharmacology, Ward 4 Corridor, Ninewells Hospital, Dundee, DD1 9SY
(P) David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ
(D) Dr Fiona Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

- on w/l for CVR
- pls get notes

R17-C25-506
Not there

NHS
Tayside

Department of Cardiology
Medicine Directorate
Acute Services Division
NHS Tayside
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Dr Vivien Smith
Clinical Psychologist
Clinical Neuropsychology Department
Level 6, South Block
Ninewells Hospital
Dundee
DD1 9SY

| | |
|---|---|
| Date | 11/09/2017 |
| Dictated | 07/09/2017 |
| Our Ref | TM/IR/ **0503700053** |
| Enquiries to | Mrs I Robertson |
| Extension | 32263 |
| Direct Line | 01382 632263 |
| Email | |

Dear Dr Smith

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, DD4 0UQ DOB: 05/03/1970**

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Yours sincerely

Authorised on 14/09/2017 10:11:22 by Cardio Tom Martin.
**Dr Thomas Martin**
**Consultant Cardiologist**
(P) Dr Jacob George, Clinical Pharmacology, Ward 4 Corridor, Ninewells Hospital, Dundee, DD1 9SY
(P) David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ
(D) Dr Fiona Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

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Dr WA Oswald
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 29/06/2017 |
| Your Ref | |
| Our Ref | CB/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Oswald

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

Many thanks for your letter regarding this gentleman and his previous Escitalopram. I have had a chance to look back through his medical notes and I see he was on Escitalopram back in 2010. He was on this up to 2013. At that stage Dr Dick had suggested switching to Mirtazipine because of sleep disturbances and the prospect of Mirtazipine being more titratable in this regard. From what I can see thereafter he didn't start the Mirtazipine but his Escitalopram did stop and it then co-incided with the fact that his sleeping improved after changes in his lipid therapy.

He had an OGD in 2015 at which stage he was off the Escitalopram and therefore I can't see any evidence of this being implicated in his GI symptoms.

Hopefully this clarification on the timeline will provide him reassurance and give you the opportunity to try the necessary drugs.

Kind regards.

Yours sincerely

Authorised on 30/06/2017 12:17:34 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

# COLDSIDE MEDICAL PRACTICE

Dr G W Macmillan
Dr A Taylor
Dr A Oswald
Dr F Bullions
Dr J Boileau

129 Strathmartine Road
DUNDEE
DD3 8DB
Tel: 01382 880900
Fax: 01382 884129
Appointments only: 826724

on Escitalopram in 2010 → stopped in 2012
Hx of PAD
↓
switched to Mirtazapine in 2013
? tryptophol. – ? stopped Escitalopram
NbOGD Oct 2015

AO/7069/TMc/11166

8 June 2017

Dr Colin Baines
Staff Grade Physician
Department of Medicine
Ninewells Hospital
DUNDEE
DD1 9SY

Dear Dr Baines

**Re: David Standish DOB 05.03.70 0053**
**6 Dargarvel Gardens Ormiston Crescent DUNDEE DD4 0UQ**

I wonder whether I could ask your advice regarding David Standish who I think is a well known patient to yourself.

Mr Standish attends the surgery today following a recent psychology appointment. The Psychologist has suggested medication for anxiety and we had a discussion regarding this today in the surgery.

My question to yourself is that Mr Standish tells me he previously had "Escitalopram" stopped due to GI issues he tells me following a scope.

My inclination would be to use an SSRI in his case but he is somewhat anxious about this and his stomach and I wondered what your thoughts on the matter are. He is currently on Zopiclone, Lansoprazole, GTN, Ramipril, Aspirin, Brilique, Bisoprolol, Salbutamol and Folic acid.

Thank you for your advice here.

Yours sincerely

V

**DR A OSWALD**

Notes please.

MBE 13/6/17

Cardiac Rehabilitation
Cardiology
Acute Services Division
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Dr F Bullions
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 28/02/2017 |
| Clinic Date | 20/02/2017 |
| Your Ref | |
| Our Ref | HM/SH/ **0503700053** |
| Enquiries to | Mrs Sharon Hepburn |
| Extension | |
| Direct Line | 01738 473326 |
| Email | |

Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

This patient attended the nurse led cardiac clinic on 20/02/2017.

Consultant Cardiologist: Dr T Martin

Diagnosis: Non ST Elevation MI on 16/11/2016.

**Investigations and Results:**

- Echocardiogram
  Demonstrated normal LV size and function. Normal RV size and function. Mildly dilated LA. Normal RA size.
- Inpatient Coronary Angiogram/Intervention
  Demonstrated 75-94% stenosis in the proximal right coronary artery. >95% stenosis in the mid right coronary artery. The team proceeded to angioplasty with the insertion of a drug eluting stent to the mid right coronary artery and a drug eluting stent to the right ostial.

**Cardiac symptoms:**
Mr Standish reports some left sided chest discomfort, left sub-axillary discomfort, and intermittent localised discomfort in the antecubital fossa area. On closer questioning this did not sound typically cardiac in nature as Mr Standish informs me that these areas were painful to touch and affected by movement. He advises me that this discomfort has become less problematic over the last few weeks however I noted today that Mr Standish is using a stick to assist his walking. On further discussion he informs me that this stick belongs to a relative. He has therefore not been assessed regarding whether the stick is appropriate for him and as the stick has not been measured specifically for him it may be at the wrong height. As Mr Standish is using this stick in his left hand I was concerned that this may be contributing to the discomfort he is feeling. I will liaise with my cardiac rehabilitation Physiotherapist colleagues regarding getting Mr Standish properly assessed and he has agreed to this. He reports no obvious anginal sounding symptoms and has not used his GTN spray. He reports no palpitations, no ankle swelling and no undue breathlessness.

**Continued/**

**RE: David Standish 0503700053**

**Progress since MI:**
Mr Standish's progress is somewhat limited due to his PVD however he is managing his activities of living and is trying to undertake the home exercise DVD he was prescribed by the cardiac rehabilitation Physiotherapist.

**Relevant Modifiable CHD Risk Factors:**

| | | | |
|---|---|---|---|
| Diabetes | Random glucose 5.7mmol/L on admission to hospital | | |
| Smoking | Mr Standish has reduced his smoking to approximately 6 cigarettes per day | | |
| Blood Pressure | 148/87mmHg | Pulse | 57bpm and regular |
| Weight | 95kgs | BMI | 31 |
| Cholesterol | Admission cholesterol 6.64mmol/L | | |

| Current Medication/Dose: | Current Dose | Comments |
|---|---|---|
| Aspirin | 75mg once daily | |
| Bisoprolol | 2.5mg once daily | **Reduction to be considered** |
| GTN spray | 2 puffs as required | |
| Ticagrelor | 90mg twice daily | **For six months post angioplasty** |
| Ramipril | 2.5mg once daily | **Up titration to be considered** |
| Folic acid | 5mg once daily | |
| Lansoprazole | 60mg once daily | |
| Salbutamol inhaler | As required | |

***The author of this letter is not a non medical prescriber, however recommendations or changes to medications have been undertaken using an agreed protocol or in consultation with medical staff.***

**Comments/Recommendations:**
I would appreciate if you could arrange for Mr Standish to have bloods taken to recheck his renal function. If this is satisfactory and his blood pressure is maintained we would recommend up titration of his Ramipril towards the target dose of 10mg as tolerated. Mr Standish informed me today that he feels his intermittent claudication has been worse since being commenced on Bisoprolol 2.5mg and in an effort to manage this he has been removing a portion of the tablet each day and feels things have improved. I informed him that this is not advisable and following discussion with his Consultant Cardiologist Dr T Martin we have agreed to reduce his dose to 1.25mg and monitor the effect of this.

Given his progress and lack of symptoms there have been no formal plans to follow Mr Standish up however Dr Martin would be happy to review him at any time in the future should you feel it necessary. I believe Mr Standish is awaiting review at the Cardiovascular Risk Clinic and an appointment for that will be sent in due course.

Yours sincerely

**Helen Miller**
**Cardiac Rehab Specialist Nurse**

**Dr T Martin**
**Consultant Cardiologist**

NHS
Tayside

Department of Cardiology
Medicine Directorate
Acute Services Division
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Wards 3/4 Corridor
Level 7
Ninewells Hospital
Dundee
DD1 9SY

| | |
|---|---|
| Date | 16/01/2017 |
| Dictated | 12/01/2017 |
| Our Ref | TM/IR/ **0503700053** |
| Enquiries to | Mrs I Robertson |
| Extension | 32263 |
| Direct Line | 01382 632263 |
| Email | |

Dear Colleagues

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I would be grateful if this patient could be seen at your clinic with a view to consideration of Alirocumab.

He was admitted under Cardiology in November 2016 with a non-ST elevation myocardial infarction and had percutaneous coronary intervention to the right coronary artery. He has a background of peripheral vascular disease. His total cholesterol was 6.64 mmol/L.

The patient is intolerant of statins and his peripheral vascular disease is that he had previous right common femoral artery end-arterectomy with vein patch and a right superficial femoral artery angioplasty.

I wonder if you would be able to see this patient for consideration of alternative therapies to statins, given his significant atherosclerosis.

Yours sincerely

Authorised on 17/01/2017 07:17:30 by Cardio Tom Martin.

**Dr Thomas Martin**
**Consultant Cardiologist**

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

NHS
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Clinical Psychology Department
South Block
Level 6
Ninewells Hospital
Dundee
DD1 9SY

| | |
|---|---|
| Date | 09/12/2016 |
| Clinic Date | 08/12/2016 |
| Your Ref | |
| Our Ref | CB/CH/ **0503700053** |
| Enquiries to | Cheryl Hayes |
| Extension | 32407 |
| Direct Line | 01382 32407 |
| Email | chayes4@nhs.net |

Dear Colleague

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I would be very grateful for your input on this gentleman's care. He is a young gentleman who has early atherosclerotic disease. He was known to have peripheral arterial disease and required an operation for this. More recently in November he suffered a non-ST elevation MI and underwent percutaneous therapy with angioplasty and stenting.

He has made a good physical recovery following his myocardial infarction but unfortunately for him during the percutaneous procedure he required to be defibrillated on two occasions and he is having great difficulty in coming to terms with both the diagnosis of myocardial infarction and also the requirement for his defibrillation. He is more anxious and struggles to leave the house and although he is managing to take great reassurance in the physical performance of his heart, his psychological recovery is lagging some way behind.

I have discussed this with his cardiac rehab team as well and they are in complete agreement and think your input would be of great value to him in his ongoing recovery. I am aware that your service is in great demand but if there was to be a way that this gentleman could be seen soon I think it would be of great benefit to him. Many thanks in advance.

Kind regards

Yours sincerely

Authorised on 12/12/2016 13:37:09 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

**Communication To Primary Care**

Dear Dr,

This gentleman came into hospital with chest pain and was worked up for an ACS. He returned positive troponins and no ST elevation on ECG and therefore was diagnosed as an NSTEMI.
He went to the cath lab and unfortunately went into VF and received 2 successful shocks and made a full recovery. Mr Standish has now received stents to the causative lesions and is otherwise well for discharge. We have started him on dual antiplateltes for 6 months and aspirin lifelong as well as cardioprotective drugs if you could optimise these as appropriate.

He is also due to be started on Alirocumab for cholesterol as he is intolerant to other cholesterol reducing drugs. This is to be arranged through the cardiovascular risk clinic.

If you have any questions please do not hesiatate to contact the ward,
Many thanks,

**Consultant Comments**

RCA stented with drug eluting stents. VF arrest as a procedural complication - no action required.

Dr Thomas Martin (Position: Doctor. Pager: _____)

**Date/Time Signed Off: 23/11/2016 15:18:36**

**Discharge Consultant: THOMAS NICHOLAS MARTIN**

CC: cardiac rehab ✓ (copy sent)

**Letter History**

| Version | Letter Type | Date | Amended Sections |
|---|---|---|---|
| 1.0 | Immediate | 23/11/2016 | N/A |
| 2.0 | Final | 23/11/2016 | Consultant's Comments |

**Appendix**

No items have been appended to this letter.

RJJ-C10-501

NHS Tayside

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David Standish
20 Canning Place
Dundee
DD3 7RT

| | |
|---|---|
| Date | 03/10/2016 |
| Your Ref | |
| Our Ref | CB/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear David Standish

Further to seeing you in clinic we have been in discussion with your GP and Pharmacist regarding the prescription of the Cilostazol tablet we discussed. As remembered this was hopefully to work as an antiplatelet. You may also have a symptomatic benefit for your walking distance.

As you remember from our discussion I did say that this was an off licence use of the drug and it might be that the practice would feel this is not appropriate to prescribe initially in primary care and indeed this is the case. I think this is entirely understandable and appropriate. I am happy to take on the responsibility for prescribing in the first instance at least. As you can see I have enclosed the prescription for the drug which you should be able to take to any pharmacy. We have also discussed the dosing of this. As you may remember I said that some of the acid suppressing tablets can interact with this drug and, although it is not definitely proven with the Lansoprazole that you are taking, there is a concern that it is a class effect of these group of drugs and for that reason we thought it was more sensible to reduce the dose. I have therefore arranged the prescription for Cilostazol 50 mg twice daily and I will assess how your are getting on with this when you come back to see me in clinic. I have copied this to your practice for their files, to let them know that you are starting on the drug.

Kind regards

Yours sincerely

Authorised on 03/10/2016 12:03:50 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

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129 Strathmartine Road
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| | |
|---|---|
| Date | 21/09/2016 |
| Clinic Date | 08/09/2016 |
| Your Ref | |
| Our Ref | CB/SG/ **0503700053** |
| Enquiries to | Shannen Gray |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | shannengray@nhs.net |

Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I reviewed David back in clinic where being in possession of a very helpful letter from Dr George in the cardiovascular risk clinic. I explained the discussion regarding the cholesterol treatment to David and he is happy to try the Rosuvastatin 5mg weekly for 3 months. If he is tolerating this there would be rationale to then trying to increase the frequency of this dosing to twice weekly and then perhaps every second day depending on how well he is tolerating it. If he fails to tolerate this then I could action an IPTR for the PCSK9 inhibitor as per Dr George's letter.

He is on his antihypertensive and he feels better off the Clopidogrel and he also wonders whether stress has played a part in his ulcer related disease. This may well be the case, particularly as he has had a very tough time with family illness and his sister sadly died recently. He himself is feeling more positive in general and hopefully this will allow him to tolerate his medications better. From an antiplatelet side I would think Aspirin would be even worse than the Clopidogrel for his gastric mucosa and as such I wonder whether we could try Cilostazol 100mg twice daily. This does have an antiplatelet effect and also has the additional benefit that it might improve his walking distance from his peripheral arterial disease. I would be grateful if you could try this at 100mg twice daily for 3 months to see what happens with his walking distance. If it does improve then we can perhaps consider continuing this drug but if hasn't improved then I would be inclined to stop the Cilostazol and perhaps consider Ticagrelor at that stage although again we would have to be cautious about his stomach. I therefore would be very grateful if you could prescribe the Rosuvastatin 5mg weekly currently and also the Cilostazol 100mg twice daily as a 3 month trial. I will be seeing him back in clinic in around 3 month's time to assess the effect of the Cilostazol.

Kind regards

Yours sincerely

Authorised on 21/09/2016 10:43:52 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

R24 C22 502

NHS Tayside

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Dr Colin Baines
Associate Specialist
Vascular Ward 4
Ninewells Hospital
DUNDEE
DD1 9SY

| | |
|---|---|
| Date | 25/08/2016 |
| Your Ref | |
| Our Ref | JG/WB/ **0503700053** |
| Enquiries to | Samantha Garvock |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Baines

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Thank you for your letter regarding this gentleman and the possibility of using PCSK9 inhibitors in him. Unfortunately the SMC have not approved the use of PCSK9 inhibitors in patients who are intolerant to statins. The only current licensed and approved PCSK9 inhibitor is Alirocumab (Praluent) but the SMC restrictions and local guidelines mean that we are only using for patients with heterozygous familial hypercholesterolaemia. There are two options here. Firstly that he was previously on a statin fibrate combination, it is unsurprising that he had issues with myalgia. What we do try in patients like him is Rosuvastatin 5 mg once weekly for approximately three months and if he is tolerating that it can be increased to twice weekly. We find that quite a lot of patients who are previously "intolerant" to statins tolerate this regime better. If he is genuinely not able to tolerate this, then an independent patient treatment request (IPTR) could be put in and I would be supportive of this.

Thank you.

Yours sincerely

Authorised on 26/08/2016 15:56:57 by Jacob George.

**Dr Jacob George**
**Clinical Senior Lecturer/Honorary Consultant Physician**

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

NHS
Tayside

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Dr Colin Baines
Associate Specialist
Vascular Ward 4
Ninewells Hospital
DUNDEE
DD1 9SY

| | |
|---|---|
| Date | 25/08/2016 |
| Your Ref | |
| Our Ref | JG/WB/ **0503700053** |
| Enquiries to | Samantha Garvock |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Baines

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Thank you for your letter regarding this gentleman and the possibility of using PCSK9 inhibitors in him. Unfortunately the SMC have not approved the use of PCSK9 inhibitors in patients who are intolerant to statins. The only current licensed and approved PCSK9 inhibitor is Alirocumab (Praluent) but the SMC restrictions and local guidelines mean that we are only using for patients with heterozygous familial hypercholesterolaemia. There are two options here. Firstly that he was previously on a statin fibrate combination, it is unsurprising that he had issues with myalgia. What we do try in patients like him is Rosuvastatin 5 mg once weekly for approximately three months and if he is tolerating that it can be increased to twice weekly. We find that quite a lot of patients who are previously "intolerant" to statins tolerate this regime better. If he is genuinely not able to tolerate this, then an independent patient treatment request (IPTR) could be put in and I would be supportive of this.

Thank you.

Yours sincerely

File please
Review at Clinic

Authorised on 26/08/2016 15:56:57 by Jacob George.

**Dr Jacob George**
**Clinical Senior Lecturer/Honorary Consultant Physician**

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

R24 - C22 - 502

NHS Tayside

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Dr F Bullions
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| | |
|---|---|
| Date | 24/08/2016 |
| Your Ref | |
| Our Ref | CB/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I have the results of David's repeat OGD available. This has demonstrated a significant improvement in the endoscopy findings with only mild distal gastritis with a normal duodenum and oesophagus. The biopsies from the distal stomach demonstrated chemical gastritis with no evidence of H pylori organisms and CLO test was negative. It is obviously hard to know whether the withdrawal of Clopidogrel alone is sufficient in resulting in these improvements or whether the H pylori eradication that he did undergo has benefited him, but regardless I don't think Clopidogrel is going to be an option for him going forward. I will bring him back to clinic to discuss his antiplatelet further in light of this result, and it maybe we have to consider using Cilostazol which at least may have additional benefit of improving some of his peripheral arterial disease symptoms although with his history of drug intolerance this may also be a drug that is difficult for him to tolerate. Hopefully the cardiovascular risk clinic will be able to advise further regarding his lipid management and hopefully soon we will manage to get him on to a manageable long term secondary prevention strategy here.

Kind regards

Yours sincerely

Authorised on 24/08/2016 15:36:12 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

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Dr J George
Consultant Physician/Honorary Senior Lecturer
Clinical Pharmacology
Medicine Directorate
Ninewells Hospital
DD1 9SY

| | |
|---|---|
| Date | 05/08/2016 |
| Your Ref | |
| Our Ref | CB/WB/ **0503700053** |
| Enquiries to | Wendy burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr George

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

My apologies for not having written to you before. I thought I had written with a referral previously, but it appears that this has gone missing. I would be very grateful for your help with this gentleman who has complicated secondary prevention requirements. He presented with early atherosclerotic disease for which he had right common femoral endartectomy and SFA angioplasty and stenting. His SFA stent has unsurprisingly gone down and he continues to suffer from claudication, but actually his left leg is worse than his right and on that side he requires bypass surgery which is not clinically indicated.

He struggles with tolerating his second prevention medication and has had significant gastric upset with Clopidogrel. I am endeavouring to find an antiplatelet agent which will be of benefit to him. I will probably try Cilostazol next, both from a claudication perspective but also for trying to improve his stomach symptoms as he appears to be genuinely intolerant of Clopidogrel.

The reason for asking your advice is relating to his lipid profile. This is significantly sub optimal and having inherited this gentleman from Dr Dick's clinic you will be aware that John has tried every avenue possible in order to maintain him on statin therapy. Previously he was on statin, fibrate and Ezetemibe combination. He has multiple side effects including myalgia, abdominal pain and insomnia with these drugs. Interestingly he also developed significant abdominal pain on the Ezetemibe alone but I don't think the temporal relationship between the insomnia and medication is something that the patient is prepared to ignore.

Dr Dick had also previously spoken to him about PCSK-9 inhibitors and this is an avenue that he is very keen to explore further. I would therefore be very grateful if you could see him with a view to optimising his lipid management for which currently he is not regularly taking any therapy. I will be seeing him in clinic to look at the rest of his secondary prevention, in particular his anti platelet therapy following his most recent OGD.

Many thanks in advance.

Kind regards

Yours sincerely

Authorised on 05/08/2016 10:11:20 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

NHS
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(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

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Dr F Bullions
Coldside Medical Practice
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| | |
|---|---|
| Date | 04/07/2016 |
| Clinic Date | 16/06/2016 |
| Your Ref | |
| Our Ref | CB/SG/ **0503700053** |
| Enquiries to | Shannen Gray |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | shannengray@nhs.net |

Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I reviewed Mr Standish back in clinic on the 16th June. It is fair to say he is rather unhappy with his symptoms currently and he describes himself as feeling terrible. As you know he had the endoscopy back in November which showed significant oesophagitis, gastritis and duodenitis with one gastric erosion. He has subsequently been shown to have H-pylori and has undergone H-pylori eradication. Attempts to restart his secondary prevention medication initially showed some promise following the H-pylori eradication, but now he getting worsening dyspeptic symptoms and indeed presented himself to A&E with these relatively recently.

I tried to explain that Clopidogrel rarely causes true gastric symptoms but it can do this. I think it is worth him staying off the Clopidogrel at this stage until we further assess his gastric mucosa and his dyspeptic symptoms. I have explained that the benefits from antiplatelets in secondary prevention are there, but are relatively small compared to the benefits of other drugs and they are a lifetime benefit rather than any short term benefit. Therefore it should not be causing him any undue problems by being off these currently. Indeed his recent vascular lab reassessment demonstrated his endarterectomy was widely patent but there is a short occlusion in his SFA which I presume is where was previously stented (or angioplastied). It doesn't surprise me that this SFA intervention area has re-occluded as this is a natural history of intervention into SFA and the fact collaterals are forming is an encouraging sign. There does not seem to be significant progression of atherosclerotic disease in the rest of the leg arteries which is reassuring.

The other atherosclerotic secondary prevention measure has been a statin. He feels that he gets significant side effects with all of these now. Previously he had managed to tolerate a low dose of Atorvastatin at 10mg but that started causing insomnia at that has been a major feature of a lot of his statin intolerances. Most recently Fluvastatin caused a lot of abdominal pain, sweating and insomnia.

Certainly Simvastatin has been known to cause vivid dreams and sleep disturbance due to its ability to cross the blood brain barrier, the mechanism of this effect with other statins is perhaps harder to understand in this case, but regardless there seems no way that Mr Standish will continue to take a statin in any case. We therefore have two problems, one is his secondary prevention medication and I think these certainly are beneficial for our colleagues in the cardiovascular risk clinic to advise regarding his lipid management in particular.

One does wonder whether PCSK9 inhibitors may be an option if not now then at some stage in the future for this gentleman (it is perhaps notable that Dr Dick had discussed this with him in the past and the patient himself was really very keen for these drugs)

The other issue is his ongoing dyspepsia. I had a chance to speak to the Gastroenterologists about the next best test here. I did wonder his H-pylori has been needing retreated rather than this all being down to his Clopidogrel and I wondered whether a urea breath test or OGD was a best next test. Overall, after consideration of his case with the gastroenterologists, they feel it is probably best just to repeat his OGD and I will go ahead and make these arrangements. He should certainly stay off the Clopidogrel until after this has been done and I will arrange to review him in clinic thereafter.

It is perhaps worth noting that this gentleman is rather frustrated and claims that he is unable to be seen when he is complaining his symptoms of dyspepsia. I suspect his understanding of this is probably incorrect but he does feel that he is told that he has to be seen by the specialist rather than at the surgery. As I say I suspect that he has picked this up wrongly but certainly it would not be possible for me to be able to respond in this manner and I am certainly not a specialist in gastroenterology in any case. I have explained it is not possible for me to operate a drop in service given the changes to our workforce and work pattern. I will let him know that we are arranging an OGD.

Kind regards

Yours sincerely

Authorised on 06/07/2016 08:47:54 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

NHS Tayside

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David Standish
20 Canning Place
Dundee
DD3 7RT

| | |
|---|---|
| Date | 30/06/2016 |
| Clinic Date | 16/06/2016 |
| Your Ref | |
| Our Ref | CB/SG/ **0503700053** |
| Enquiries to | Shannen Gray |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | shannengray@nhs.net |

Dear David Standish

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Just to keep you updated I have had a chance to discuss with the Gastroenterologists and they feel that a repeat endoscopy would be the most useful next test and I have gone ahead to arrange this. It would be best to stay off your Clopidogrel currently at least until this test has been completed.

Kind regards

Yours sincerely

Authorised on 01/07/2016 09:13:15 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

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| | |
|---|---|
| Date | 13/05/2016 |
| Clinic Date | 12/05/2016 |
| Your Ref | |
| Our Ref | CB/DO/ **0503700053** |
| Enquiries to | Debbie Orr |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | d.orr@nhs.net |

Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I reviewed Mr Standish back in clinic today. Overall things have been slightly improved particularly from his stomach symptoms and he is now established on his Clopidogrel, Felodipine, Folic Acid and Lansoprazole. Since his H.pylori eradication therapy there certainly has been a gradual improvement in his dyspeptic symptoms although there is still persistence of some of these. He is much more comfortable with this however.

He has not restarted back on his statins as he continues to get bad side effects from these, predominantly related to poor sleep and nightmares. This has been present with Simvastatin, Atorvastatin and Rosuvastatin and he also finds he has problems with Ezetimibe. There is some difficulty with the direct causative relationships with these, particularly with Ezetimibe and the statins that do note cross the blood brain barrier, however there does seem to be a persistent and consistent temporal relationship to these drugs with his symptomatology and he is not at all keen to retry these.

Apparently Dr Dick had previously discussed with him that he may be eligible for consideration for an injection type therapy which I suspect is one of the new PCSK-9 directed therapies. This may well be worth investigating and I will ask my colleagues in the cardiovascular risk clinic for their opinion on this. In the intervening time however, before abandoning statins altogether, I do think it would be worth a trial on Fluvastatin at the lowest dose to see if we can provide a statin he can tolerate. If he is unable to tolerate this, I would try and commence him back on his Fibrate but I will ask my colleagues in the cardiovascular risk clinic for their opinion regarding treating him with a PCSK9 directed therapy.

With regards to his peripheral arterial disease, he finds his claudication distance has reduced particularly noticeable in his right leg where previously he had a common femoral artery endarterectomy and distal SFA stent insertion. It may well be that the stent is thrombosed but we have discussed again the rationale for conservative therapy instead of bypass surgery. He completely understands this and is happy to continue with conservative therapy. We will arrange a duplex of his right leg to assess whether or not his stent is thrombosed, but it may well be that we don't choose to do anything with this even if this were to be the case. We will review him again with the results of this.

Kind regards

Yours sincerely

Authorised on 13/05/2016 12:07:37 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

(P) Dr J George, Consultant Physician/Honorary Senior Lecturer, Clinical Pharmacology , Medicine Directorate, Ninewells Hospital, DD1 9SY

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| | |
|---|---|
| Date | 08/03/2016 |
| Your Ref | |
| Our Ref | CB/DO/ **0503700053** |
| Enquiries to | Debbie Orr |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | d.orr@nhs.net |

Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I have the results of your patient's urea breath test. This has demonstrated a positive test implying current infection with H.pylori. I think it therefore does support the suggestion of giving him H.pylori eradication therapy.

Kind regards

Yours sincerely

Authorised on 09/03/2016 14:54:21 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

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| | |
|---|---|
| Date | 18/02/2016 |
| Your Ref | |
| Our Ref | CB/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Many thanks for your letter regarding this gentleman and his Esomeprazole and Clopidogrel use. The data on PPIs and Clopidogrel is far from conclusive and it is also based on laboratory tests in relation to platelet aggregation index. The only clinical situation when there has been any potential proven impact for PPI and Clopidogrel is in the 30 days post acute coronary syndrome. My own personal belief, and that of many others, is in people on long term Clopidogrel there is no difficulty in co-prescribing Esomeprazole. However Lansoprazole is a perfectly reasonable alternative and 30 mg twice daily would be fine as would high dose Pantoprazole.

It is one of the vagaries of our medicine licensing authorities that they are unwilling to accept surrogate end points as indications for drug licence, however they seem very happy to accept surrogate markers of potential problems in order to issue statements suggesting a drug shouldn't used.

Regardless of my views however, I suspect we will continue to be hamstrung by these recommendations and as such any appropriate PPI would obviously be suitable at a high dose.

Kind regards

Yours sincerely

Authorised on 22/02/2016 09:48:33 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

# COLDSIDE MEDICAL PRACTICE

Dr G W Macmillan
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Dr A Oswald
Dr F Bullions
Dr J Boileau

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FB/7093/TMc/11166

4 February 2016

Dr Colin Baines
Staff Grade Physician
Department of General Medicine
Ninewells Hospital
DUNDEE
DD1 9SY

Dear Dr Baines

**Re: David Standish DOB 05.03.70 0053**
**20 Canning Place DUNDEE DD3 7RT**

Many thanks for your letter regarding the above patient. Unfortunately, Esomeprazole is not recommended with Clopidogrel as it can reduce the antiplatelet effect. I have requested advice from our Pharmacist regarding this, however I am aware due to having consulted her recently regarding a patient with a similar medication clash that Lansoprazole is usually recommended instead of Omeprazole or Esomeprazole.

I am waiting for an update on other PPI's as one of those may be more suitable.

I thought I should just let you know.

Kind regards.

Yours sincerely

MISC
11/2/16

pp **DR F BULLIONS**

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| | |
|---|---|
| Date | 26/01/2016 |
| Clinic Date | 07/01/2016 |
| Your Ref | |
| Our Ref | CB/SG/ **0503700053** |
| Enquiries to | Shannen Gray |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | shannengray@nhs.net |

Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I reviewed Mr Standish back in clinic with the results of his OGD. As you know this has demonstrated quite dramatic gastritis and duodenitis, and the question will be whether this is a chemical gastritis or as suggested by the biopsy could this be H.pylori (despite the fact that no H.pylori organisms were identified on the biopsy itself). He is off all medication including his PPI and there does seem to be a temporal relationship to his symptoms improving and being off the medication. This may however relate to initial rebounding of high acid reduction once the Lansoprazole has stopped rather than it being due to avoiding all other medication. Regardless I think we need to prove one way or another whether he does have H.pylori and I have arranged for a urea breath test in the nuclear medicine department, and I have encouraged him to stay off his Lansoprazole until this is available.

After that is available it may be that we need increase his acid suppression, and given that his Lansoprazole has not been particularly effective perhaps changing him on to Esomeprazole 40mg twice daily for a period of time before reducing to 40mg daily would be a reasonable approach. Once we have had the breath test we will be able to know whether H.pylori eradication in addition is needed, but if not we could start to slowly re introduce his medication alongside the high dose of his PPI and it would seem sensible to do this one tablet at a time with Clopidogrel being the last tablet to restart.

I have asked him to contact the surgery once he has had his breath test performed so that he can commence on his Esomeprazole and I will be in touch with the breath test results when I have them.

Kind regards

Yours sincerely

Authorised on 26/01/2016 12:29:28 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

(P) David Standish, 20 Canning Place, Dundee, DD3 7RT

7/1/16
AIMFTN

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Dr F Bullions
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| | |
|---|---|
| Date | 22/12/2015 |
| Your Ref | |
| Our Ref | CB/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I have the results of your patient's OGD which has been rather helpful. This has demonstrated gastritis and duodenitis with one erosion in the gastric fundus. He certainly needs to continue his Lansoprazole. Currently I would be inclined to leave him off his Clopidogrel. He may need a double dose of Lansoprazole for a period of time before we slowly restart his other secondary prevention medication to co-exist with this. Perhaps at a later date we will be able to get his anti platelet agent restarted.

Biopsy demonstrated there was no clear evidence of helicobacter pylori but with the mixed features of chronic active gastritis and chemical type gastritis I did wonder whether other attempts at excluding H pylori are worthwhile.

I also have the result of his breath test for bacterial overgrowth which has demonstrated no evidence of bacterial overgrowth.

This therefore has come as a possible plausible explanation for his severe stomach pains and certainly would suggest that we would hope to be able to treat these with acid suppression, perhaps considering empirical H pylori eradication is something we should also do. I would hope that with adequate treatment of his gastritis we would be able to restart his other medication. I will arrange to bring him back to clinic.

Kind regards

Yours sincerely

Authorised on 29/12/2015 14:11:14 by Vascular Colin Baines.

**Colin Baines**
**Grade Physician**

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| | |
|---|---|
| Date | 18/11/2015 |
| Clinic Date | 29/10/2015 |
| Your Ref | |
| Our Ref | CB/SG/ **0503700053** |
| Enquiries to | shannengray@nhs.net |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | chayes4@nhs.net |

Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I reviewed Mr Standish back in clinic today following a phone call from him asking to discuss again with me at clinic. Further to my most recent letter, again I again went over with the patient that I'd misinterpreted what has been happening with his Diazepam when I thought he had been recommenced back on this. If he had been recommenced back on this I would have been happy for it to continue so it was causing him the additional benefits of being able to take his medication but I certainly wouldn't have been suggesting re-prescribing it purely for the indication to take other medications. Further to my previous letter I apologised to the patient for the confusion I had caused and explained that I had apologised to yourself regarding this also.

Regardless, he's still suffering significant central abdominal pain and although CT scanning has been performed in the past we never actually had an OGD performed. I think this is worthwhile and given the number of medications he's taking, and all the over counter remedies he's tried, I think it's also worth while doing a glycolic breath test to ensure there's no small intestinal bacterial overgrowth here. In the mean time I've suggested he simply stays off his medication currently but restarts these a couple of weeks before his OGD so they can re-assess what is happening to his mucosa if his medication or if indeed anything at all is indeed irritating this.

I will write back with the results of these tests and I plan also to speak to the gastroenterologists about possible measures of treatment here. As he's not found the Buscopan helpful, perhaps Mebeverine could be tried although further treatment for an IBS type picture will be limited by the fact that the gentleman is not keen on the thought of trying Amitriptyline or any other antidepressant type medication. I'll be in touch again with the results of the above tests in due course.

Kind regards

Yours sincerely

Authorised on 18/11/2015 14:29:48 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

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| | |
|---|---|
| Date | 29/10/2015 |
| Your Ref | |
| Our Ref | CB/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr MacMillan

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I wish to write to apologise for any confusion related to my clinic letter which this gentleman came brandishing in front of you. It was my understanding when I spoke to the gentleman in clinic that he had been prescribed Diazepam for another reason and this was having a knock on effect of allowing him to tolerate the secondary prevention medication. I felt that this was a bonus and the intention from my letter had been that, although I thought it was unusual that this was allowing him to tolerate his medication, if there had been a reason for him being on Diazepam then perhaps this additional advantage gave a reason to consider continuing the drug. Certainly I didn't intend the letter to read, or to give the patient the impression, that I was suggesting that long term Diazepam being only prescribed to allow him to tolerate other medication was something that I would be advocating.

I certainly wasn't aware of the other issues relating to his Diazepam prescription from previous GP practices and having met this gentleman only once or twice myself I don't think I would be in a position to suggest long term Diazepam prescription.

I just wanted to take the time to clarify my position on this matter and apologise for any confusion or difficulty that this may have caused you from my previous letter, which on reading back perhaps was not the most clear and was open to interpretation by the patient. For clarity sake I wanted to confirm that I was not advising long term Diazepam use to enable him to tolerate his medication and I fully support your stance in this matter.

Kind regards

Yours sincerely

Authorised on 02/11/2015 08:50:55 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

**p.s. I have also seen the gentleman back at clinic to explain the above.**

# COLDSIDE MEDICAL PRACTICE

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GWM/7162/TMc/11166

23 October 2015

Dr Colin Baines
Staff Grade Physician
Medicine Directorate
Ninewells Hospital
DUNDEE
DD1 9SY

Misc
28/10/15

Dear Dr Baines

**Re: David Standish DOB 05.03.70 0053**
**20 Canning Place DUNDEE DD3 7RT**

You may remember this patient from your clinic in September. He presented today with his copy of your recent letter. He was keen to start a prescription for Diazepam, less keen to consider increasing his dose of Atorvastatin or adding in Ezetimibe.

Mr Standish is relatively new to this Practice but on perusal of his previous GP notes it is apparent that he had been on previous long term prescriptions of Diazepam for no obvious clinical reason that is indicated in the BNF nor indeed licensed. When he was put off the list of the prescribing doctor his next GP has weaned him off of this long term prescription.

It is with some surprise that I see a recommendation for this medication in this instance with no obvious clinical indication and Mr Cavendish's past medicinal history.

Mr Standish tells me that the abdominal pain that he experiences with medication is presumed to be "intestinal muscle spasm" as advised by Dr Dick. With this in mind I have prescribed Buscopan to see if this helps with his symptoms.

I hope this meets with your approval. If you have any other suggestions then I would be happy to consider them.

Kind regards.

Yours sincerely

**DR G W MACMILLAN**

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| | |
|---|---|
| Date | 14/10/2015 |
| Clinic Date | 24/09/2015 |
| Your Ref | |
| Our Ref | CB/DO/ **0503700053** |
| Enquiries to | Debbie Orr |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | d.orr@nhs.net |

Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Many apologies for the delay in this clinic letter relating to this gentleman's clinic appointment on 24th September. I had been waiting on the results before doing a letter.

As you know this gentleman has significant atherosclerosis and has had multiple problems maintaining on his medication regime. He had been trying his medication at different times in an attempt to tolerate these with all his severe abdominal pains, but even despite initial improvements with this things deteriorated and he had to come off all of his medication again. He has however noticed that since he has tried Diazepam again he has been able to take all of his medication without difficulty. This is a small dose of 5mg Diazepam and, looking back, all of his problems with his medications that he had previously been tolerating well did seem to start when the Diazepam was initially withdrawn.

I know that long term Diazepam use is not something we are keen to encourage but I would have thought on the balance of risks and benefits for this gentleman and his significant atherosclerotic disease at an early age, the use of Diazepam to allow him to maintain his medication would be reasonable.

With regards to his medication I have suggested he stops his Fibrate and continues on Atorvastatin 10mg. His total cholesterol I checked demonstrated a total cholesterol at 7.13 with an HDL of 1.34. We could titrate up the Atorvastatin towards 40mg daily or alternatively add back in Ezetimibe 10mg once daily to see if this gets his cholesterol more to target. He gets the most benefit from being on a statin.

I have arranged further review to see how he is getting on with his medications and once again apologies for the delay in this letter.

David Standish 0503700053

Kind regards

Yours sincerely

Authorised on 14/10/2015 11:29:35 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

(P) David Standish, 20 Canning Place, Dundee, DD3 7RT

| | | | | | |
|---|---|---|---|---|---|
| **FBC** | | | | | |
| | **Hb** | | 133 | g/L | 130 - 180 |
| - | **WBC** | *[HI] | **15.2** | **x10$^9$/L** | **4.0 - 11.0** |
| - | **PLT** | *[HI] | **406** | **x10$^9$/L** | **150 - 400** |
| | **RBC** | *[LO] | 4.48 | x10$^{12}$/L | 4.5 - 6.0 |
| | **HCT** | | 0.417 | | 0.40 - 0.52 |
| | **MCV** | | 92.9 | fl | 85 - 105 |
| | **MCH** | | 29.7 | pg | 27 - 32 |
| | **MCHC** | | 320 | g/L | 320 - 360 |
| - | **NE#** | *[HI] | **10.9** | **x10$^9$/L** | **2.0 - 7.5** |
| | **LY#** | | 3.0 | x10$^9$/L | 1.5 - 4.0 |
| - | **MO#** | *[HI] | **1.0** | **x10$^9$/L** | **0.2 - 0.8** |
| | **EO#** | | 0.32 | x10$^9$/L | 0.0 - 0.4 |
| | **BA#** | | 0.1 | x10$^9$/L | 0.0 - 0.1 |

| | | | | | |
|---|---|---|---|---|---|
| - | **TOTAL CHOLESTEROL** | *[HI] | **7.13** | **mmol/L** | **0.00 - 5.00** |
| | **CREATINE KINASE** | | 280 | U/L | 40 - 320 |
| | **GGT** | | 63 | U/L | 3 - 73 |
| | **Urea & Electrolytes** | | | | |
| | **SODIUM** | | 141 | mmol/L | 133 - 146 |
| | **POTASSIUM** | | 5.1 | mmol/L | 3.5 - 5.3 |
| | **UREA** | | 5.0 | mmol/L | 2.5 - 7.8 |
| | **CREATININE** | | 83 | umol/L | 62 - 106 |
| | **AKI** | | Not detected: but may not exclude AKI in all cases | . | |
| | **Liver Function Tests (LFT)** | | | | |
| | **ALT** | | 43 | U/L | 5 - 55 |
| | **BILIRUBINS** | | 13 | umol/L | 0 - 21 |
| | **ALKALINE PHOSPHATASE** | | 115 | U/L | 30 - 130 |
| | **ALBUMIN** | | 37 | g/L | 35 - 50 |
| | **ESTIMATED GFR** | | GT60 | mL/min | |
| | **CKD Stage** | | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | . | |
| | **TOTAL CHOL/HDL-CHOL** | | | | |
| | **HDL-CHOLESTEROL** | | 1.34 | mmol/L | 0.60 - 2.50 |
| | **TOTAL CHOL/HDL-CHOL** | | 5.30 | . | |

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Dr N Smeaton
Mill Practice
Arthurstone Medical Practice
DD4 6QY

| | |
|---|---|
| Date | 17/06/2015 |
| Clinic Date | 05/06/2015 |
| Your Ref | |
| Our Ref | JD/AH/ **0503700053** |
| Enquiries to | Abi Hamon |
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| Direct Line | 01382 632407 |
| Email | ahamon@nhs.net |

Dear Dr Smeaton

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

This 45 year old man has peripheral arterial disease, dyslipidemia and medication intolerance. I reviewed him in the clinic on 5/6/15. He has been keeping reasonably well. He has now phased in his tablets, and is taking them at half hourly intervals after lunch. This is suiting him, and he is no longer getting abdominal pain or odd visceral reactions. He has managed to add back Felodipine as well, at the 2.5 mg dose.

In the clinic he was well, and looked a lot more comfortable with himself and with life. His weight was stable at 100 kg and his blood pressure was satisfactory at 124/74.

This unorthodox resume is clearly suiting him, and I have made no further changes. I have arranged his clinic review for 3 months, but I have explained to him that if all is well at this next appointment we will extend the frequency of his review. He is happy with this. He is also aware that this future review will no longer be with me.

Kind regards

Yours sincerely

Authorised on 25/07/2015 18:14:51 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

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| | |
|---|---|
| Date | 19/05/2015 |
| Clinic Date | 08/05/2015 |
| Your Ref | |
| Our Ref | JD/CH/ **0503700053** |
| Enquiries to | Cheryl Hayes |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | chayes4@nhs.net |

Dear Dr Smeaton

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

This 45 year old man has peripheral arterial disease, dyslipidaemia, and medication intolerance. I reviewed him in the clinic on 08/05/15. He attended with his wife, and explained that he is feeling reasonably well. He is still sleeping satisfactorily. He has had no stomach pains. He managed to reintroduce both Clopidogrel and then Folic Acid without any real difficulty. However once he started Ezetimibe, he feels that his sleep deteriorated dramatically once more and he has discontinued this.

I didn't examine him on this occasion. We spent some time discussing our next approach. He is happy to keep trying adding tablets back gradually and is still taking these at lunchtime. He wondered about his calcium channel blocker, but my main concern is that he's not on any lipid prophylaxis. I have therefore suggested that he start Atorvastatin 10mg once daily again taking these at lunchtime and further to my hand note I am grateful to you for prescribing. If he can tolerate this and all is going well, we could then consider a calcium channel blocker and I would suggest Felodipine 2.5mg once daily as the smallest of a dihydropyridine. If however he has any concerns about this or matters aren't exactly straight forward I would be happy that he leave this until his next review. I think there is a certain momentum to be gained here from frequent review and reassurance, and so I have given him an appointment for four weeks.

Kind regards

Yours sincerely

Authorised on 25/05/2015 12:56:30 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

8/5/15
AIDVN

NHS Tayside

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| | |
|---|---|
| Date | 24/04/2015 |
| Your Ref | |
| Our Ref | KW/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Smeaton

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I have the results of this gentleman's bloods coeliac IgA tissue transglutaminase test which is within normal limits.

Yours sincerely

Authorised on 04/05/2015 08:22:51 by Vascular Jill Belch.

**Dr Katherine Walesby**
**Speciality Registrar**

David Standish 0503700053

NHS Tayside

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| | |
|---|---|
| Date | 03/04/2015 |
| Clinic Date | 03/04/2015 |
| Your Ref | |
| Our Ref | KW/CH/ **0503700053** |
| Enquiries to | Cheryl Hayes |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | chayes4@nhs.net |

Dear Dr Smeaton

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Diagnosis:

1. Premature Peripheral Arterial Disease
2. Abdominal pain following medication/CT abdomen normal
3. Anxiety regarding abdominal pain related to medication

Medications: Amlodipine, Clopidogrel, Atorvastatin, Azetimibe, Fenobibrate, Lansoprazole, and Folic Acid.
***Please restart Clopidogrel, Atorvastatin, Folic acid and Lansoprazole (Fast tab)***

I reviewed this 45 year old gentleman in Dr Dick's vascular clinic, he attended with his partner. His CT abdomen was very reassuring which I informed him, but this unfortunately did not make him happy as he had hoped it would explain his symptoms of severe abdominal pain after taking his medication. He is very worried there is an underlying diagnosis for this. He doesn't feel there is one medication causing this, but all of them. He took Ibruprofen last week , I've advised him to take paracetamol instead. He is equally anxious he hasn't had his anti-platelets for many months now.

His pain occurs 20minutes after taking his medication, and he describes it as very severe over the epigastric, supra-pubic regions and radiating to the sides and back. He has had no change in his bowel habits.

I spent some time discussing the situation with him. Dr Dick was concerned about a psychological cause for his intolerance to medication. I did not go into this today as he did not appear amenable for this discussion today. Instead we discussed a way forward that may be a "trial and error" for him to see if small changes may help and stressed the positives of a normal CT abdomen in the first instance is reassuring. However, given he is folate deficient previously I have arranged a coeliac blood test along with his routine bloods to ensure a possible cause for atypical abdominal pain is not overlooked.

Following discussion we have agreed to try:
1. Restarting Clopidogrel, Lansoprazole and Atorvastatin, but to take this after his lunchtime medications in case this improves his symptoms
2. Please could you prescribe a fast tab Lansoprazole as this may overcome some of the symptoms he experiences with the capsules or tablets.
3. If he experiences pain I have advised him to persist for the first few days but instead try taking Paracetamol thirty minutes before taking his tablets at lunchtime
4. If the problem appears to be the tablet/capsule form we can review if some medication may be available in liquid form (he seemed amenable to this)
5. I have checked his bloods including a coeliac screen.
6. We can consider an OGD should all above fail and he remains focussed on a gastric abnormality

It may be in the future we need to look to other therapies to help him including CBT but I think currently he is not amenable for discussion about this and I hope that a step by step approach we might be able to manage his intolerance of tablets.

I have arranged for him to come back in one month to see Dr Dick.

Yours sincerely

Authorised on 08/04/2015 22:43:01 by Vascular Katherine Walesby.

**Dr Katherine Walesby**
**Speciality Registrar**

| | | | |
|---|---|---|---|
| **FBC** | | | |
| **Hb** | 140 | g/L | 130 - 180 |
| **WBC** | 8.0 | $x10^9/L$ | 4.0 - 11.0 |
| **PLT** | 396 | $x10^9/L$ | 150 - 400 |
| **RBC** | 4.75 | $x10^{12}/L$ | 4.5 - 6.0 |
| **HCT** | 0.429 | | 0.40 - 0.52 |
| **MCV** | 90.3 | fl | 85 - 105 |
| **MCH** | 29.4 | pg | 27 - 32 |
| **MCHC** | 326 | g/L | 320 - 360 |
| **NE#** | 4.6 | $x10^9/L$ | 2.0 - 7.5 |
| **LY#** | 2.6 | $x10^9/L$ | 1.5 - 4.0 |
| **MO#** | 0.5 | $x10^9/L$ | 0.2 - 0.8 |
| **EO#** | 0.18 | $x10^9/L$ | 0.0 - 0.4 |
| **BA#** | 0.1 | $x10^9/L$ | 0.0 - 0.1 |

| | | | |
|---|---|---|---|
| **MAGNESIUM** | | | |
| **MAGNESIUM** | 0.83 | mmoL/L | 0.70 - 1.00 |
| **PHOSPHATE** | | | |
| **PHOSPHATE** | 1.07 | mmoL/L | 0.8 - 1.5 |
| **Urea & Electrolytes** | | | |
| **SODIUM** | 139 | mmol/L | 133 - 146 |
| **POTASSIUM** | 4.9 | mmol/L | 3.5 - 5.3 |
| **UREA** | 5.4 | mmol/L | 2.5 - 7.8 |
| **CREATININE** | 74 | umol/L | 62 - 106 |
| **Liver Function Tests (LFT)** | | | |
| **ALT** | 46 | U/L | 5 - 55 |
| **BILIRUBINS** | 7 | umol/L | 0 - 21 |
| **ALKALINE PHOSPHATASE** | 100 | U/L | 30 - 130 |
| **ALBUMIN** | 38 | g/L | 35 - 50 |
| **Bone Group** | | | |
| **CALCIUM** | 2.38 | mmol/L | 2.10 - 2.55 |
| **CALCIUM (CORRECTED)** | 2.40 | mmol/L | 2.10 - 2.55 |
| **ESTIMATED GFR** | | | |
| **ESTIMATED GFR** | GT60 | mL/min | |
| **CKD Stage** | | | |
| **CKD Stage** | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | . | |
| **GLUCOSE** | | | |
| **GLUCOSE (preserved tube)** | 5.8 | mmol/L | 3.3 - 5.8 |
| **TSH** | | | |

NHS
Tayside

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

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Dr Alistair Emslie-Smith
Mill Practice
Arthurstone Medical Practice
39 Arthurstone Terrace
Dundee
DD4 6QY

| | |
|---|---|
| Date | 30/03/2015 |
| Your Ref | |
| Our Ref | JD/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Emslie-Smith *Alistair*

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Further to my clinic letter I now have the results of this man's CT scan. There is a small perfusion defect in the liver, but this is otherwise normal with a normal gallbladder, pancreas, biliary tree and also normal spleen, kidneys and adrenal glands. In view of the rather vague symptoms, a full abdominal surveillance was undertaken and was reported by Dr Duncan as being normal. I have written to the patient with this reassuring result and he will be reviewed as planned.

Kind regards

Yours sincerely

*John*
Authorised on 31/03/2015 18:33:04 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

NHS
Tayside

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Acute Services Division
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Dundee
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David Standish
20 Canning Place
Dundee
DD3 7RT

| | |
|---|---|
| Date | 30/03/2015 |
| Your Ref | |
| Our Ref | JD/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Mr Standish

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Further to your clinic visit I now have your CT scan result and reassuringly this is entirely normal. I will see you in the clinic as planned.

Yours sincerely

Authorised on 31/03/2015 18:33:16 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

Medicine and Cardiovascular Group
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Dr AM Emslie-Smith
Mill Practice
Arthurstone Medical Practice
39 Arthurstone Terrace
Dundee
DD4 6QY

| | |
|---|---|
| Date | 09/02/2015 |
| Clinic Date | 30/01/2015 |
| Your Ref | |
| Our Ref | JD/AH/ **0503700053** |
| Enquiries to | Abi Hamon |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | ahamon@nhs.net |

Dear Dr Emslie-Smith *Alistair*

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

This 44 year old man has premature peripheral arterial disease, and is now suffering side effects from various medications. I reviewed him in the clinic on 30/01/15. He volunteered a rather nervous and anxious feeling in his stomach when he was taking folic acid, but was tolerating this. However when he started taking Ezetimibe, he got severe abdominal pain and cramp radiating down his right side and right flank. He tried on and off the drug several times over the past few weeks, and replicated this symptom every time. He himself wondered if it might be an ulcer, but it is more likely that this is gallstone related. David is as you know rather difficult to assess, but I think it would be worthwhile getting an upper abdominal CT scan to make sure that we are not missing any occult pathology. The outcome of this will dictate our approach to his multiple intolerances. I have given him a review appointment for 6 weeks and asked him to stay on folic acid meantime.

Kind regards

Yours sincerely

*John*
Authorised on 25/02/2015 19:56:34 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
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Dr AM Emslie-Smith
Mill Practice
Arthurstone Medical Practice
39 Arthurstone Terrace
Dundee
DD4 6QY

| | |
|---|---|
| Date | 07/01/2015 |
| Clinic Date | 12/12/2014 |
| Your Ref | |
| Our Ref | JD/CH/ **0503700053** |
| Enquiries to | Cheryl Hayes |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | chayes4@nhs.net |

Dear Dr Emslie-Smith *Alastair*

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

This 44 year old man has premature peripheral arterial disease. I reviewed him in the clinic on 12/12/2014. This was an expedited appointment created by him telephoning the appointments secretary. He is once again struggling with various aspects of his medication, and is now convinced that Amlodipine keeps him awake, and that Clopidogrel is contributing to his right iliac fossa pain. He has therefore stopped all his medication.

In the clinic he was very anxious but otherwise much the same. His blood pressure was reasonable at 135/80. His weight was up 1.5kg at 100kg.

He is still off the cigarettes by using his E- cigarette device. He reported a classical side effect of Rosuvastatin, mainly myalgia. He only managed this tablet for about ten days before having to discontinue it. I have suggested that he re-start his folic acid and his Ezetimibe 10mg od. The former should do no harm, and indeed if he gets side effects with folic supplementation this would place him on a different track regarding his symptoms. The Ezetimibe is not systemically absorbed, and its side effect profile is extremely low. I was slightly concerned leaving him off anti-platelet drugs, but we will do this for now to see how he gets on. I have given him a review appointment for six weeks.

Kind regards

Yours sincerely

*John*
Authorised on 14/01/2015 17:51:47 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

POSITIVE ABOUT DISABLED PEOPLE

*Working with you for better health and better care*
Headquarters: Ninewells Hospital & Medical School,
Dundee, DD1 9SY (for mail) DD2 1UB (for Sat Nav)

Chairman, Mr Sandy Watson OBE DL
Chief Executive, Ms Lesley McLay

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Acute Services Division
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Dr AM Emslie-Smith
Mill Practice
Arthurstone Medical Practice
39 Arthurstone Terrace
Dundee
DD4 6QY

| | |
|---|---|
| Date | 07/11/2014 |
| Clinic Date | 10/10/2014 |
| Your Ref | |
| Our Ref | JD/CH/ **0503700053** |
| Enquiries to | Cheryl Hayes |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | chayes4@nhs.net |

Dear Dr Emslie-Smith *Alasdair*

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

This 44 year old man has premature peripheral arterial disease. I reviewed him in the clinic on 10/10/14. He has been having a really difficult time with his medication of late, in particular with insomnia. He was quite open that he had switched to your practice from his previous GP because of disagreements about this. On his own behalf he did various internet searches, and eventually came to the conclusion that his insomnia might be related to his lipid lowering therapy. Ten days before I saw him, he stopped his Atorvastatin, Fenofibrate and Ezetimibe, and also his Amlodipine as he was thinking that the latter was causing some GI upset. He has had a dramatic response to this, with prompt return to very nearly full sleep.

I didn't examine him on this occasion, but spent quite a lot of time going over his medications and how to take things forward. I have suggested he take a one month holiday, until everything is back on a more even keel. He could then re-introduce the Ezetimibe, which isn't systemically absorbed and is unlikely to be giving him the insomnia. After a further month of this, he could then attend you and see if he can manage Rosuvastatin 5mg once daily. I have explained to him that this is water soluble rather than lipid soluble, and produces fewer in the way of central side effects. He is happy to give this a try. In terms of his GI problems, this might be the Fibrate rather than the Amlopdipine. It's up to him whether or not he retries the Amlodipine in the interim. This was quite a full discussion, and we agreed that we would park his leg symptoms for now until this was all resolved. He continues on his folic acid and Clopidogrel as before, and I have given him a review appointment for three months.

Kind regards

Yours sincerely

*John*
Authorised on 12/11/2014 17:51:11 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

POSITIVE ABOUT DISABLED PEOPLE

*Working with you for better health and better care*
Headquarters: Ninewells Hospital & Medical School,
Dundee, DD1 9SY (for mail) DD2 1UB (for Sat Nav)

Chairman, Mr Sandy Watson OBE DL
Chief Executive, Ms Lesley McLay

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Dr MC Duffy
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

| | |
|---|---|
| Date | 26/06/2014 |
| Clinic Date | 06/06/2014 |
| Your Ref | |
| Our Ref | CB/AH/ **0503700053** |
| Enquiries to | Abigail Hamon |
| Extension | 33480 |
| Direct Line | 01382 660111 |
| Email | ahamon@nhs.net |

Dear Dr Duffy

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I reviewed your patient in clinic with peripheral arterial disease. As you know he has a right common femoral artery endarterectomy and his left leg demonstrated unreconstructable disease. This left leg claudication is static. What is new is pain in his right leg in particular his right groin. I note ultrasound demonstrated no sign of a hernia and this is a different quality of pain to his previous claudication pain and radiates from his groin down to into his inner thigh where there has been some chronic swelling. He walks with an unusual gait following his peripheral arterial disease, in any case certainly there has been some increased pain in his back and his right hip recently. I want to make sure it is not musculoskeletal in origin first and I have arranged an x-ray of his hip and lumbar spine. On receipt of results, we may proceed to an MRI scan of his groin but I certainly do not think this is vascular in origin.

We discussed again the electronic cigarette as he stopped using this due to scare stories in the press. We have reiterated our advice from a vascular perspective that this is a preferable form of nicotine delivery rather than cigarettes and he is going to reinvestigate this.

Once we get to the bottom of his right groin pain it may be worth reconsidering Cilostazol as an option for this gentleman's ongoing treatment. I will do this when we see him back in clinic in due course.

Kind regards

Yours sincerely

Authorised on 26/06/2014 14:58:41 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

Radiology Examination 5358775: 06 Jun 2014 11:14

**XR Pelvis**

**XR Pelvis**

Clinical History :

Severe pain right hip and groin
Radiates down front of thigh
Recent back pain
Abnormal gait pattern due to peripheral arterial disease
Recently developed antalgic gait
?evidence of significant OA
ENTERED BY: Colin Baines (medical)
BLEEP: 01382 633883

x-ray pelvis.
. Mild bilateral symmetrical osteoarthritis noted
No other significant feature

. X-ray lumbar spine.
lumbar spine demonstrates normal appearances

DR RUSSELL DAVIES (MEDICA) / RDAVIES

Medicine & Cardiovascular Group
Ward 4
Ninewells Hospital
DUNDEE
DD1 9SY
Telephone Number: 01382 633883
Fax Number: 01382 632682
www.nhstayside.scot.nhs.uk

Mr David Standish
9 Mansion Drive
DUNDEE
DD4 9DD

| | |
|---|---|
| Date | 11 October 2010 |
| Dictated | 4 October 2010 |
| Your Ref | |
| Our Ref | JD/SG 050370 0053 |
| Enquiries to | Mrs Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Mr Standish

Further to your clinic visit I now have your blood results. Unfortunately, these show that your cholesterol is still not low enough for someone with early arterial disease. Rather than increase your statin, I think it is worthwhile adding another tablet to your regime. I have now written to Dr Davage, who is expecting you to contact the surgery to arrange this. You will need a repeat blood test 6-8 weeks after making this change. I will write again once we have your MRI result and take matters on from there.

Yours sincerely

Dr John Dick
Consultant Physician

Medicine & Cardiovascular Group
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Ninewells Hospital
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Dr M Davage
Park Avenue Medical Centre
Park Avenue
DUNDEE
DD4 6PP

| | |
|---|---|
| Date | 11 October 2010 |
| Dictated | 4 October 2010 |
| Your Ref | |
| Our Ref | **JD/SG 050370 0053** |
| Enquiries to | Mrs Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Davage

**David Standish, 9 Mansion Drive, Dundee, DD4 9DD**

I enclose a copy of my results letter on this man. I would be grateful if you could add Ezetimibe 10 mg to his regime. He will need repeat TG, routine CK along with his check lipid profile about 8 weeks after making this change. I have written to the patient who will contact the surgery. Thank you for your help.

Yours sincerely

Dr John Dick
Consultant Physician

Enc.

Medicine & Cardiovascular Group
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Ninewells Hospital
DUNDEE
DD1 9SY
Telephone Number: 01382 633883
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Ms Gill Crowe
Vascular Specialist Nurse
Ward 12
Ninewells Hospital

| | |
|---|---|
| Date | 11 October 2010 |
| Dictated | 4 October 2010 |
| Your Ref | |
| Our Ref | JD/SG 050370 0053 |
| Enquiries to | Mrs Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Ms Crowe

**David Standish, 9 Mansion Drive, Dundee, DD4 9DD**

Further to my clinic letter, this man's blood results are now to hand. His routine chemistry, liver group and GGT are normal, and his CK is acceptable at 294. His lipid profile shows a cholesterol of 6.4, HDL 1.6 (ratio 4.0 and triglycerides 1.1).

This man's lipids are therefore not at target and we will need to escalate his therapy. He already has a raised CK and I have suggested adding Ezetimibe rather than increasing his statin dose and have written separately to Dr Davage and the patient. We await his MRI scan with interest.

Kind regards.

Yours sincerely

Dr John Dick
Consultant Physician

Cc Dr M Davage, Park Avenue Medical Centre, Park Avenue, DUNDEE, DD4 6PP

## Delivery Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

27 September 2010
Clinic Date: 22/09/2010
Dictation Date: 22/09/2010
Your Ref: (CHI:0503700053)
Our Ref: GC/WJ/0503700053
Enquiries To: Ward 12 OP Office
Telephone: 01382 660111
Extension: 33889

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

I reviewed this patient with bilateral calf claudication at clinic today with his arterial duplex scan result. I also note that Dr Dick has assessed and addressed his risk factors. The arterial duplex shows normal aorto iliac segments. In the right leg a significant stenosis involving the distal common femoral extending to the origin of the profunda femoris artery. There appears to be a 6cm occlusion of the SFA at the adductor. In the left leg the superficial femoral artery is occluded with reconstitution at the adductor. As stated in Mr Nagy's last letter, this gentleman's pattern of arterial disease would require mainly surgery to correct with some components amenable to angioplasty. I have explained this to Mr Standish today along with the risks involved. He is keen for further investigation and intervention if possible, therefore I have requested an MRA and he will be reviewed in clinic with these results.

Yours sincerely

**Gill Crowe**
**Vascular Specialist Nurse**
**NHS Tayside**

Copy to:

Dr J Dick, Consultant Physician, Ward 4, Ninewells

Medicine & Cardiovascular Group
Ninewells Hospital
DUNDEE
DD1 9SY
Telephone Number: 01382 633883
Fax Number: 01382 632682
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Ms G Crowe
Vascular Specialist Nurse
Ward 12
Ninewells Hospital

| | |
|---|---|
| Date | 22 September 2010 |
| Date clinic | 10 September 2010 |
| Our Ref | JD/DO 05 03 70 0053 |
| Your Ref | |
| Enquires to | Miss D Orr |
| Extension | 33480 |
| Direct Line | 01382 660111 |

Dear Dr Davage

**David Standish, 9 Mansion Drive, Dundee**

Thank you for referring this 40-year old man with premature arteriopathy. I saw him in the clinic on 10/09/10. This 40-year old man gives a history of progressive claudication symptoms in both legs, with his current effort tolerance of around 50 metres. He has also developed more variable buttock pain, but this is often after exercise rather than during. Lastly, and more recently, he has developed chest discomfort which he describes is a tired feeling in his chest radiating down his left arm. This tends to happen when her relaxes, and lasts for 15-20 minutes at a time. He just sits quietly until it passes. This again has been getting more frequent, and he now gets if 4 or 5 times a week.

Currently he is taking Atorvastatin 40mg once daily, Escitalopram, Diazepam and Paracetamol with Dihydrocodeine. He also has Salbutamol and Qvar inhalers, but has not needed these since he stopped smoking 10 weeks ago. He used to smoke 10-15 cigarettes per day. He has no known allergies. He eats a normal diet, and normally drinks no alcohol at all. His only previous history is of asthma at the age of 20. In his family his father aged 66 is a patient of the cardiovascular risk clinic having had his first MI at the age of 43. His mother aged 63 is well. He has a sister who is well as are his two daughters. He is a boat builder to trade, but is currently off work with his illness. His wife is also well; she is a smoker but is trying to stop. They have no history of endemic travel for more than 10 years.

Systems review added some palpitations to this history, and dyspepsia and nausea. He has also noted cramps in his arms when he is working above his head, something he does when working on boat holes. He has noted some difficulties with intercourse, but on more detailed questioning this was pain on ejaculation which has now resolved. He has no urinary symptoms, and no erectile dysfunction. He has noted some headaches, some blurred vision, and his wife comments that his legs jerk a lot at night. He has parasthesia in his feet and toes, usually with exercise but now just on standing.

On examination he was a pleasant anxious man with no chronic stigmata. He was not particularly overweight at 89kg (height 1.78 metres, BMI 28.1). His pulse was 70 regular and blood pressure 130/74. His heart sounds were pure, his chest was clear and he had no oedema. Peripheral pulses were synchronous and intact in his upper limbs and at his groins with no bruits. His abdomen was soft with no organomegaly. He had no palpable thyroid nor lymphadenopathy. Fundoscopy showed mild background changes only.

I share your concern for this man. I have arranged an ECG from the clinic, and will proceed to arrange a cardiac isotope scan in case this is true angina. I have rechecked his lipid profile now that he is on Atorvastatin. Unfortunately Dr Davage interpreted his normal folic acid level as a reason no to give folic acid supplementation, but I have written separately with regard to this. The folate is purely to treat his homocysteine, and although it is lifelong, a normal folic acid level does not alleviate this treatment. He is also not on anti-platelet drugs, and I have suggested that he take Clopidogrel because of his dyspepsia and that if necessary he add Pantoprazole into this. Lastly I have suggested Amlodipine to try and help his circulation a little further and this also may help his chest pain if it is truly angina. In terms of his peripheral disease, we discussed MR angiogram and he is happy to proceed to this.

This was quite a long consultation, in conjunction with his wife, where we went over all of the various aspects of his arteriopathy and he seemed more comfortable at the end of this. He is aware of the importance of risk factor magnification, and that he must not go back on to cigarettes. I have arranged his clinic review for 6 months, but I know that you will be seeing him in the interim and I will contact you when I have his MR result.

Kind regards

Yours sincerely

Dr J Dick
Consultant Physician

c.c. Dr M Davage, Park Avenue Medical Centre, Park Avenue, Dundee

Medicine & Cardiovascular Group
Ninewells Hospital
DUNDEE
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Telephone Number: 01382 633883
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Dr M Davage
Park Avenue Medical Centre
Park Avenue
Dundee

| | |
|---|---|
| Date | 22 September 2010 |
| Date clinic | 10 September 2010 |
| Our Ref | JD/DO 05 03 70 0053 |
| Your Ref | |
| Enquires to | Miss D Orr |
| Extension | 33480 |
| Direct Line | 01382 660111 |

Dear Dr Davage

**David Standish, 9 Mansion Drive, Dundee**

I enclose a copy of my clinic letter on this man. Further to my hand note, I am grateful to you for starting him on folic acid 5mg once daily, Clopidogrel 75mg once daily and Amlodipine 5mg once daily. If the Clopidogrel produces dyspepsia, I would add Pantoprazole to enable him to continue with this drug. The patient in formed me that after his normal folic acid blood levels you had declined to prescribe the folic acid. This is not to treat folic acid deficiency as such, but to overdrive the MTHFR in order to drop his homocysteine. He should commence this and stay on it lifelong.

I will write again with his scan results and take matters on from there.

Yours sincerely

Dr J Dick
Consultant Physician

Medicine & Cardiovascular Group
Ninewells Hospital
DUNDEE
DD1 9SY
Telephone Number: 01382 633883
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Dr Davage
Park Avenue Medical Centre
Park Avenue
DUNDEE
DD4 6PP

| | |
|---|---|
| Date | 20 August 2010 |
| Date dict | 16 August 2010 |
| Our Ref | JD/WB 050370 0053 |
| Your Ref | |
| Enquires to | Mrs Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Davage

**David Standish, 9 Mansion Drive, Dundee**

Further to correspondence I now have the result of this man's vascular duplex scanning. On the right leg there is significant stenosis of the common femoral artery extending to involve the origin of the profunda artery. In the superficial femoral artery, there is a 6 cm occlusion at the level of the adductor canal. On the left side the superficial femoral artery is also occluded with reconstitution to the level of the adductor.

This highlights the aggressive nature of this man's disease aged only 40. Anatomically, these lesions don't sound particularly attractive for angioplasty though this will depend on his symptom level. He may well need an MR angiogram in due course. We will discuss this with him when he is reviewed in the clinic, whether this is by Ms Crowe and her team or in the vascular medicine clinic ( whichever is first).

Yours sincerely

Dr J Dick
Consultant Physician

c.c. Ms G Crowe, Vascular Specialist Nurse, vascular Surgery, Ninewells Hospital

## Delivery Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

16 August 2010
Misc Date: 30/07/2010
Dictation Date: 30/07/2010
Your Ref: (CHI:0503700053)
Our Ref: JN/WJ/0503700053
Enquiries To: Ward 12 OP Office
Telephone: 01382 660111
Extension: 33889

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

This patient with bilateral calf claudication at 50 metres has now had an arterial duplex. This shows normal aorto iliac segments. In the right leg a significant stenosis involving the distal common femoral extends into the origin of the profunda femoris artery. There appears to be a 6cm occlusion of the SFa at the adductor. In the left leg the superficial femoral artery is occluded with reconstitution at the adductor. This gentleman's pattern of arterial disease would require mainly surgery to correct with some components amenable to angioplasty. At this point in time I think it is important to get his risk factors under control and Charge Nurse Crowe has referred the gentleman on to Dr Dick. To investigate his arterial disease in more detail would require an MR angiogram and would require a significant series of interventions to resolve. We will review this patient at clinic in due course.

Yours sincerely

✓ 22/9 PAS

**John Nagy**
**Consultant Vascular Surgeon**

Medicine & Cardiovascular Group
Ninewells Hospital
DUNDEE
DD1 9SY
Telephone Number: 01382 633883
Fax Number: 01382 632682
www.nhstayside.scot.nhs.uk

NHS Tayside

Dr Davage
Park Avenue Medical Centre
Park Avenue
DUNDEE
DD4 6PP

| | |
|---|---|
| Date | 16 July 2010 |
| Date dict | 12 July 2010 |
| Our Ref | JD/WB 050370 0053 |
| Your Ref | |
| Enquires to | Mrs Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Davage Gill

**David Standish, 9 Mansion Drive, Dundee**

Further to correspondence this man's blood results are now to hand. His anticardiolipin Ab are normal as are his full blood count and plasma viscosity. His background clotting was normal with normal INR, APTT ratio and fibrinogen of only 2.9. There is no evidence of lupus anticoagulant. His anti thrombin is borderline low at 82, but his protein C and protein S values are normal. His routine chemistry, liver group, GGT, TSH and glucose are normal with a CK of 207 in keeping with exercise profile. His cholesterol is 7.3 with an hdl of 1.6 ( ratio 4.5) and triglycerides 1.0. Lastly his homocysteine is elevated at 20 ( adult ref 0 – 14).

I would therefore recommend starting this man on a statin, with a target total cholesterol of 4.0 or less. I would also suggest checking his baseline serum B12 and folate values and then commencing him on folic acid 5 mg once daily. I have written to the patient who will contact your surgery to arrange all this. His further vascular studies are awaited, but in the meantime I have arranged a clinic appointment for him. Thank you for your help.

Yours sincerely

Dr J Dick
Consultant Physician

c.c. Ms G Crowe, Vascular Specialist Nurse, Vascular Surgery, Ninewells Hospital

✓ Five

Medicine & Cardiovascular Group
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NHS Tayside

Dr Davage
Park Avenue Medical Centre
Park Avenue
DUNDEE
DD4 6PP

| | |
|---|---|
| Date | 21 July 2010 |
| Date dict | 19 July 2010 |
| Our Ref | JD/WB 050370 0053 |
| Your Ref | |
| Enquires to | Mrs Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Davage BüU

**David Standish, 9 Mansion Drive, Dundee**

Further to correspondence this man's blood tests are negative for both factor V leiden and the common pro thrombin mutations. We await his further vascular study but I have arranged his review as per my previous letter.

Kind regards

Yours sincerely

4

Dr J Dick
Consultant Physician

c.c. Ms G Crowe, Vascular Specialist Nurse, Vascular Surgery, Ninewells Hospital

✓ File

POSITIVE ABOUT DISABLED PEOPLE

Medicine & Cardiovascular Group
Ninewells Hospital
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Fax Number: 01382 632682
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Dr Davage
Park Avenue Medical Centre
Park Avenue
DUNDEE
DD4 6PP

| | |
|---|---|
| Date | 21 July 2010 |
| Date dict | 19 July 2010 |
| Our Ref | JD/WB 050370 0053 |
| Your Ref | |
| Enquires to | Mrs Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Davage

**David Standish, 9 Mansion Drive, Dundee**

Further to correspondence this man's blood tests are negative for both factor V leiden and the common pro thrombin mutations. We await his further vascular study but I have arranged his review as per my previous letter.

Kind regards

Yours sincerely

Dr J Dick
Consultant Physician

c.c. Ms G Crowe, Vascular Specialist Nurse, Vascular Surgery, Ninewells Hospital

Medicine & Cardiovascular Group
Ninewells Hospital
DUNDEE
DD1 9SY
Telephone Number: 01382 633883
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Dr Davage
Park Avenue Medical Centre
Park Avenue
DUNDEE
DD4 6PP

| | |
|---|---|
| Date | 16 July 2010 |
| Date dict | 12 July 2010 |
| Our Ref | JD/WB 050370 0053 |
| Your Ref | |
| Enquires to | Mrs Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Davage

**David Standish, 9 Mansion Drive, Dundee**

Further to correspondence this man's blood results are now to hand. His anticardiolipin Ab are normal as are his full blood count and plasma viscosity. His background clotting was normal with normal INR, APTT ratio and fibrinogen of only 2.9. There is no evidence of lupus anticoagulant. His anti thrombin is borderline low at 82, but his protein C and protein S values are normal. His routine chemistry, liver group, GGT, TSH and glucose are normal with a CK of 207 in keeping with exercise profile. His cholesterol is 7.3 with an hdl of 1.6 ( ratio 4.5) and triglycerides 1.0. Lastly his homocysteine is elevated at 20 ( adult ref 0 – 14).

I would therefore recommend starting this man on a statin, with a target total cholesterol of 4.0 or less. I would also suggest checking his baseline serum B12 and folate values and then commencing him on folic acid 5 mg once daily. I have written to the patient who will contact your surgery to arrange all this. His further vascular studies are awaited, but in the meantime I have arranged a clinic appointment for him. Thank you for your help.

Yours sincerely

Dr J Dick
Consultant Physician

c.c. Ms G Crowe, Vascular Specialist Nurse, Vascular Surgery, Ninewells Hospital

Medicine & Cardiovascular Group
Ninewells Hospital
DUNDEE
DD1 9SY
Telephone Number: 01382 633883
Fax Number: 01382 632682
www.nhstayside.scot.nhs.uk

Mr D Standish
9 Mansion Drive
Dundee

| | |
|---|---|
| Date | 16 July 2010 |
| Date dict | 12 July 2010 |
| Our Ref | JD/WB 050370 0053 |
| Your Ref | |
| Enquires to | Mrs Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Mr Standish

Further to your clinic visit I now have your results. There are two main positives. Firstly your cholesterol is too high for someone with arterial disease, and indeed it of a level where it is probably genetic in origin, with your liver making too much cholesterol. You therefore need a statin type tablet to bring this down. The other positive is of a high level of homocysteine in your blood. This is an amino acid, present in everyone. However high levels cause the blood to be more sticky, and make arterial narrowings. This is also genetic, usually related to the liver enzyme not metabolising the homocysteine properly. This enzyme uses folic acid, the vitamin, as a co factor. Taking extra folic acid overdrives the enzymes and drops the homocysteine value once more. You therefore need blood tests as a baseline for your vitamin levels, and then to start folic acid regularly. I have now written to Dr Davage who is expecting you to contact the surgery with regard to both of these. We will write again with imaging results but in the meantime I have arranged a vascular medicine clinic appointment for you and you will receive this directly through the post.

Yours sincerely

Dr J Dick
Consultant Physician

## Delivery Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

28 June 2010
Clinic Date: 25/06/2010
Dictation Date: 25/06/2010
Your Ref: (CHI:0503700053)
Our Ref: GC/WJ/0503700053
Enquiries To: Ward 12 OP Office
Telephone: 01382 660111
Extension: 33889

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

Thank you for referring this gentleman who complains of bilateral calf claudication at around 50 yards which is alleviated after stopping walking for approximately 10 minutes. He denies any rest pain. There is some toe numbness on the right foot but this can happen occasionally just on standing. He has had no previous arterial treatment and has no history of ischaemic heart disease. He does have asthma which he uses his inhalers for as required. There is no history of cerebro vascular disease, diabetes or hypertension. He currently smokes 10-15 cigarettes per day and is currently on a statin but not an anti-platelet agent.

On examination his upper limb pulses were normal. His blood pressure was 117/72, his random sugar 6.4 and his BMI 26. With the exception of both popliteals I was able to palpate all remaining leg pulses bilaterally. There is no sign of ischaemia in his feet. His ankle brachial indices are 0.56 on the right and 0.51 on the left, falling to 0.31 and 0.20 respectively after exercise.

I believe his symptoms are that of intermittent claudication and have requested an arterial duplex scan and we will review him with these results.

As Dave is only 40 years of age I have discussed his case with Dr Dick, Vascular Physician today at clinic and we have taken bloods for thrombophillia screening and Dr Dick will arrange to see him with these results.

Yours sincerely

**Gill Crowe, Vascular Specialist Nurse to**
**John Nagy, Consultant Vascular Surgeon**

Copy to:

Dr J Dick, Consultant Physician, Ward 4, Ninewells

Department of Neurology
Acute Services Division
NHS Tayside
South Block, Level 6
Ninewells Hospital
DUNDEE
DD1 9SY
Telephone Number: 01382 425720
Fax Number: 01382 425739
www.nhstayside.scot.nhs.uk

Dr C Affleck
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

| | |
|---|---|
| Date Typed | 23rd June 2005 |
| Clinic Date | 21st June 2005 |
| Your Ref | |
| Our Ref | DS/FB 05.03.70 0053 |
| Enquiries to | Anne Crosby, Secretary to Dr Roberts |
| Direct Line | (01382 ) 632134 |
| E-mail | anne.crosby@tuht.scot.nhs.uk |

Dear Dr Affleck,

**David Standish, 4E Balcarres Terrace, Dundee, DD4 8QX**

Many thanks for referring Mr Standish who attended Dr Roberts epilepsy clinic on the morning of the 21st June 2005.

He is a 35 year old left handed man who has no significant background medical history. He has no early life risk factors for epilepsy. His current symptoms date back approximately one year. "Attacks" always occur in bed before going to sleep, when he is trying to relax. He develops a diffuse aching discomfort throughout both lower limbs which gradually builds in intensity. He feels the urge to move the legs and rub the muscles, but notably the discomfort is not relieved on getting up and walking about. He finds the only way to relieve his symptoms is to take a bath. If he does not do this his legs become increasingly uncomfortable and stiff and eventually he develops marked tremulous movements of both lower legs, which may persist for up to 40 minutes. Both he and his partner are quite clear in their account of these episodes, and both are adamant that he remains fully aware throughout with no impairment or loss of consciousness. During this time he has developed no persistent or progressive neurological symptoms affecting his lower limbs or elsewhere. He is prone to cramp in the gastrosolei bilaterally which can be relieved by "stretching off". His exercise tolerance remains normal and he does not described exercise related myalgia. Systemic enquiry is otherwise negative.

Past medical history includes only mild bronchial asthma. I note the family history of a first cousin who has recently been diagnosed with epilepsy at the age of 35. He is a smoker of 6 cigarettes per day and takes moderate alcohol on a recreational basis.

On examination today, he was orientated and comfortable. Fundoscopy revealed normal optic discs bilaterally and the remainder of cranial nerve examination was entirely unremarkable. Tone, power and reflexes were normal and symmetrical in upper and lower limbs with negative Hoffman and flexor plantar responses bilaterally. Upper and lower limb co-ordination was normal and symmetrical and there was no sensory deficit. Cardiovascular examination revealed the heart rate at 70 bpm regular, heart sounds were dual and pure with no audible murmur or bruit. The remainder of systemic examination was normal.

In summary there is no suggestion in the given history of an epileptic aetiology for his current symptoms. His symptoms are not suggestive of restless leg syndrome. They are reminiscent of a "muscle over use syndrome" but do not fit comfortably with any specific syndrome. A further possibility would be paroxysmal nocturnal myoglobinuria, but there is no history of altered urine or weakness, making this less likely. It might be worth dipping a nocturnal urine during an attack.

I understand that he has tried Quinine with some improvement, and if this is not already at 300 mg this could be increased. In addition it might be worth giving him 0.5 mg Clonazepam at night empirically. We will see him back in clinic in due course.

Headquarters
King's Cross, Clepington Road, Dundee DD3 8EA

Chairperson, Mr Peter Bates
Chief Executive, Professor Tony Wells

Yours sincerely,

***Dr D Simpson***
***Signed electronically on the 1st July 2005***

Dr D Simpson
Specialist Registrar in Neurology

P.S. FBC, PV, U+E, LFT, Ca2+, Glu, Mg2+, CRP all normal. Unfortunately CK was omitted, and I would be grateful if you could send a sample.

**FJ/MB.M.P.I.** **05 03 70 0053**
**Dr. F. Jenkinson**
**Ward 15.**

**MEDICAL ADMISSIONS**

18th February, 2002

Dr. C. Affleck,
Park Avenue Medical Centre,
Park Avenue,
DUNDEE.

Dear Dr. Affleck,

**DAVID STANDISH, 10 BALLINDEAN TERRACE, DUNDEE.**

I now have available the results of this gentleman's upper GI motility studies. These studies showed normal oesophageal motility however they did show evidence of both postprandial and supine acid reflux with delayed clearance. This is likely to be causing this gentleman's retrosternal chest pain and therefore I recommend that you should commence him on a proton pump inhibitor such as Omeprazole or Lansoprazole when you next see him to try and reduce his symptomatology.

Yours sincerely,

Dr. Fiona Jenkinson
Senior House Officer.

POSITIVE ABOUT DISABLED PEOPLE

Headquarters
Ninewells Hospital & Medical School, Dundee, DD1 9SY

Chairperson, Professor Jim McGoldrick
Chief Executive, Mr Gerry Marr
*Tayside NHS Board is the common name of Tayside Health Board*

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

01382 633883
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www.nhstayside.scot.nhs.uk

Dr MD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

| | |
|---|---|
| Date | 14/06/2013 |
| Your Ref | |
| Our Ref | JD/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Davage

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Further to my clinic letter this man's blood results are now to hand and show a normal routine chemistry, liver group, GGT and CK. His lipid profile shows a cholesterol of 4.3, hdl 1.3 (ratio 3.4) and non fasting triglycerides 1.2.

This man's target cholesterol is less than 4. However he is already on Atorvastatin, Ezetemibe and Fenofibrate. The next step would be to consider replacing the Atorvastatin with Rosuvastatin, but we will discuss the pros and cons of this move when he is next reviewed. As before, his outstanding risk factor remains his smoking habit. I have written to him with these results and he will be reviewed in the clinic as planned.

Kind regards

Yours sincerely

Authorised on 15/06/2013 15:34:18 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

01382 633883
01382 632682
www.nhstayside.scot.nhs.uk

David Standish
20 Canning Place
Dundee
DD3 7RT

| | |
|---|---|
| Date | 14/06/2013 |
| Your Ref | |
| Our Ref | JD/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Mr Standish

Further to your clinic visit I now have your blood results. These show your cholesterol is just above 4, with your target actually being 4. We could consider swapping your statin round in due course, but there is no urgency for this. As before, your outstanding residual risk is related to cigarettes and I wish you well with this. We will see you in the clinic as planned.

Yours sincerely

Authorised on 15/06/2013 15:34:51 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
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Dr MD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

| | |
|---|---|
| Date | 14/05/2013 |
| Clinic Date | 26/04/2013 |
| Your Ref | |
| Our Ref | JD/KH/ **0503700053** |
| Enquiries to | Kirsty Hannan |
| Extension | 33480 |
| Direct Line | 01382 660111 |
| Email | k.hannan@nhs.net |

Dear Dr Davage

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

This 43 year old man has peripheral arterial disease. I reviewed him in the clinic on 26/04/2013. His main problem is that he continues to smoke. He has not attended any of the no smoking services, and he is still struggling with this. He did manage off for about 3 weeks under his own steam, and noted his walking distance improving when he did so. However he relapsed reasonably quickly. I pointed out to him that he has 4 times the chance of staying off cigarettes if we help him rather than him simply going "cold turkey". I have given him a smoke free card, there is also currently a booth manned in the hospital and I hope that he will go and attend this. I have rechecked his lipid profile and will write again with this result; we may well need to increase the potency of his statin therapy. I have given him a review appointment for 6 months.

Yours sincerely

Authorised on 17/05/2013 19:18:19 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

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Dr MD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

| | |
|---|---|
| Date | 14/01/2013 |
| Clinic Date | 21/12/2012 |
| Your Ref | |
| Our Ref | CB/DO/ **0503700053** |
| Enquiries to | Debbie Orr |
| Extension | 33480 |
| Direct Line | 01382 660111 |
| Email | d.orr@nhs.net |

Dear Dr Davage

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I reviewed your patient with his peripheral arterial disease. He is aware that there is no interventional option at this stage and he continues to get pain at around 10-15 metres which causes him to stop after about 10-15 minutes although he has only covered around 200 yards in this time. He has noticed some modest improvement in his right leg following intervention but his left leg would not be suitable for femoral bypass at this stage.

Please note his cholesterol is 4.94 with the target for peripheral arterial disease being 3.5 he could increase his Atorvastatin.

Unfortunately he is still smoking and I have given him the Tayside Smoke Free Service's contact details today and hopefully he will manage to stop.

If he does manage to stop there may be some rationale in trying Cilostazol to see if this has an effect on improving his walking distance and for that reason I have arranged follow up at clinic.

Kind regards

Yours sincerely

Authorised on 14/01/2013 16:12:32 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

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Dr MD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

| | |
|---|---|
| Date | 11/07/2012 |
| Clinic Date | 22/06/2012 |
| Your Ref | |
| Our Ref | JD/DO/ **0503700053** |
| Enquiries to | Debbie Orr |
| Extension | 33480 |
| Direct Line | 01382 660111 |
| Email | d.orr@nhs.net |

Dear Dr Davage

**David Standish, 16 Hillbank Place, Dundee, DD3 7BE DOB: 05/03/1970**

This 42 year old man has premature aretiopathy and has had surgical intervention on the right leg. He still has claudication in his left leg. I reviewed him in the clinic on 22/06/12. Matters are much the same today, with no real change in his symptoms. He is still smoking five cigarettes per day.

In the clinic he was well. His weight was stable at 93kg and blood pressure satisfactory at 113/70. Unfortunately there was a fire alarm at the time of his clinic visit, and so we didn't check his bloods. There aren't any in the ICE system; his last cholesterol in September '11 was 5.6 though with the rest of the profile satisfactory.

David therefore continues on his folic acid supplements, Amlodipine, Clopidogrel and Lansoprazole, together with Ezetimibe, Atorvastatin, and Fenofibrate for his lipids. He is also still taking a small dose of Escitalopram. Smoking is really the outstanding risk factor for him and he is well aware of this but finds it very difficult. His wife attended with him, and she is supportive and frustrated in equal measures. I have therefore referred him to Audrey Mackenzie in the hospital no smoking service to see if she can help him any further. He will be reviewed in the clinic in 6 months time.

Yours sincerely

Authorised on 11/07/2012 16:39:20 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

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Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

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Mrs A MacKenzie
No Smoking Service
Health Shop
Ninewells Hospital

| | |
|---|---|
| Date | 11/07/2012 |
| Your Ref | |
| Our Ref | JD/DO/ **0503700053** |
| Enquiries to | Debbie Orr : |
| Extension | 33480 |
| Direct Line | 01382 660111 |
| Email | d.orr@nhs.net |

Dear Mrs MacKenzie *Audrey*

**David Standish, 16 Hillbank Place, Dundee, DD3 7BE DOB: 05/03/1970**

I would be grateful if you could see this 42 year old premature arteriopath in your no smoking clinic.

This man presented in 2010 with bilateral claudication at around 50 metres. From the anatomical point of view, the right leg was treatable with a right common femoral endarterectomy and a vein patch, with a right superficial femoral artery angioplasty. The left side would require a femoral popliteal bypass, and is being managed conservatively at present. In terms of his blood work, he has a significant hyperlipidaemia in which he is being treated with triple therapy, and a modestly elevated homocysteine for which he is being treated with folic acid.

David's outstanding risk factor is his inability to get off cigarettes. He would be very grateful for any support that you are able to give him as he hasn't had much success with a community based programme thus far. Of note, he is on Escitalopram, with his other medication being Clopidogrel, Amlodipine, Lansoprazole, Folic acid, Ezetimibe, Atorvastatin and Fenofibrate. Thank you for your help.

Kind regards.

Yours sincerely

*John*
Authorised on 11/07/2012 16:40:21 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
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Dr MD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

| | |
|---|---|
| Date | 07/11/2011 |
| Your Ref | |
| Our Ref | JD/WB/ **0503700053** |
| Enquiries to | Wendy Burns : |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Davage

**David Standish, 4 Keats Place, Dundee, DD3 6QH DOB: 05/03/1970**

Further to my clinic letter this man's blood results are now to hand. His routine chemistry, liver group, GGT and CK are normal. His cholesterol is 5.6 with an hdl of 2.0 ( ratio 2.7) and triglycerides 1.0.

Although his total cholesterol isn't that much better, his hdl has risen a little which will be of benefit in terms of the overall profile. In addition he is now on triple lipid lowering therapy. I think we have to accept this for just now though I would hope that matters will improve if he tightens up on lifestyle issues as well. I haven't therefore suggested any changes to his medication at this stage and he will be reviewed in the clinic as planned.

Yours sincerely

Authorised on 09/11/2011 15:32:44 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

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www.nhstayside.scot.nhs.uk

David Standish
4 Keats Place
Dundee
DD3 6QH

| | |
|---|---|
| Date | 07/11/2011 |
| Your Ref | |
| Our Ref | JD/WB/ **0503700053** |
| Enquiries to | Wendy Burns : |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Mr Standish

Further to your clinic visit I now have your blood results. The background bloods are satisfactory. Your cholesterol is much the same. However, hidden within this, you now have slightly more of the hdl ('good' cholesterol) and less of the ldl ('bad' cholesterol). These are therefore satisfactory for the present. With luck your cholesterol levels will go down a little further with time. We will see you in the clinic as planned.

Yours sincerely

Authorised on 09/11/2011 15:33:21 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
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Tel Number: 33480
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Dr MD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

| | |
|---|---|
| Date | 07/10/2011 |
| Clinic Date | 22/09/2011 |
| Your Ref | |
| Our Ref | JD/DO/ **0503700053** |
| Enquiries to | Debbie Orr |
| Extension | 33480 |
| Direct Line | 01382 660111 |
| Email | d.orr@nhs.net |

Dear Dr Davage

**David Standish, 4 Keats Place, Dundee, DD3 6QH DOB: 05/03/1970**

This 41 year old man has premature arteriopathy and has had surgical intervention on the right leg. He is left with claudication of his left leg. I reviewed him in the clinic on 22/09/11. He has been keeping reasonably well apart from his claudication. Unfortunately he has gone back to cigarette smoking, with two recent bereavements in the family plus the death of his dog. He currently has a pain threshold of around 20 metres on the left, variable walk through pain, and no obvious conditioning. He is aware that being back on cigarettes is spectacularly bad for this and plans to tackle this shortly.

In the clinic he was otherwise well. His weight was up a little at 96kg. His blood pressure was 144/85 on arrival, settling to 124/66. He is now on Atorvastatin, Ezetimbe and Fenofibrate for his lipid profile, and continues on Clopidogrel, Citalopram and inhalers as before. I have rechecked his lipid profile and will write again with these results. Assuming they are satisfactory, I would just leave him for the next 6 months and see if he collateralises further once he manages to get off the cigarettes again. I have therefore given him a review appointment for 6 months.

Yours sincerely

Authorised on 12/10/2011 18:12:58 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

## Operational Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

22 August 2011
Clinic Date: 11/08/2011
Dictation Date: 11/08/2011
Your Ref: (CHI:0503700053)
Our Ref: PAS/WJ/0503700053
Enquiries To: Ward 12 OP Office
Telephone: 01382 660111
Extension: 33889

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

Dear Dr Davage,

**David Standish, 050370-0053**
**4 Keats Place, Dundee, DD3 6QH**

I reviewed this gentleman in clinic today. Following Mr Griffith's recent letter I have had a discussion with him about the pro's and con's of intervention. My personal biased is that when we are using other than single segment good quality long saphenous vein we have to think very carefully about this. I think if he had that then it would not be unreasonable at this stage to consider a femoro popliteal bypass graft. Unfortunately he would require at least 2 segments of vein, one of them not from the long saphenous vein, in which the patency rates are significantly worse. Given his relatively young age and his expectations, I do not think an operation is not going to have a reasonable expectation of lasting many years is a good idea. He accepts this. Clearly it does leave him with a degree of disability. Hopefully his risk factors are all adequately dealt with, I have noticed he has been seeing Dr Dick and has stopped smoking. I would be more than happy to review him again should he request it, but otherwise I have discharged him from clinic.

Yours sincerely

**Peter A Stonebridge, ChM FRCS Edin, FRCP Edin**
**Professor of Vascular Surgery**

## Delivery Unit

Surgical Directorate
Vascular Surgery Unit
Ward 12
Ninewells Hospital
Dundee
www.nhstayside.scot.nhs.uk

31 May 2011
Date: 31/05/2011
Dictation Date: 30/05/2011
Your Ref: (CHI:0503700053)
Our Ref: GDG/GS/0503700053
Enquiries To: Ward 12 Office
Extension: 33889
Telephone: 01382 633889

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

Further to Professor Stonebridge's recent letter this patient's right long saphenous vein is of reasonable size from the groin to the mid lower thigh but reduces in size distal to that. The left long saphenous vein is small proximally but becomes reasonable calibre from the mid thigh to the knee. Both short saphenous veins are reasonable. We will see him in clinic.

Yours sincerely

**Gareth Griffiths**
**Consultant Vascular Surgeon**

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

01382 633883
01382 632682
www.nhstayside.scot.nhs.uk

Dr MD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

| | |
|---|---|
| Date | 25/04/2011 |
| Your Ref | |
| Our Ref | JD/WB/ **0503700053** |
| Enquiries to | Wendy Burns : |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Davage

**David Standish, 9 Mansion Drive, Dundee, DD4 9DD DOB: 05/03/1970**

Further to my clinic letter this man's baseline bloods are now to hand and show an ALT of 69 and GGT of 82 but otherwise normal routine chemistry, liver group, CK and TSH. This is all acceptable for now. Once he has been on the fibrate, statin and Ezetemibe combination for 6 weeks or so he should have repeat blood tests comprising LFT, GGT, CK and cholesterol hdl and triglycerides. I would be grateful if I could leave this for your practice nurse. He will be reviewed as planned.

Yours sincerely

Authorised on 25/04/2011 17:39:36 by John Dick.

**Dr John Dick**
**Consultant Physician**

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

Tel Number: 33480
Fax Number: 01382 632682
www.nhstayside.scot.nhs.uk

Dr MD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

| | |
|---|---|
| Date | 29/03/2011 |
| Clinic Date | 16/03/2011 |
| Your Ref | |
| Our Ref | JD/DO/ **0503700053** |
| Enquiries to | Debbie Orr |
| Extension | 33480 |
| Direct Line | 01382 660111 |
| Email | d.orr@nhs.net |

Dear Dr Davage

**David Standish, 9 Mansion Drive, Dundee, DD4 9DD DOB: 05/03/1970**

This 41 year old man has premature arteriopathy and has had surgical intervention on the right leg. I reviewed him in the clinic on 16/03/11. He has been keeping well. He has had a good result from his intervention. He does have some reactive oedema early on, but this is settling with rest and his right leg is now asymptomatic. It is still a little early to gauge how the left leg is responding, but there are good collaterals and he may not need intervention on this side.

In the clinic he was well. His weight was up a little at 92.5kg and blood pressure satisfactory at 117/65. His right foot was warm and well perfused with hirsute toes in and intact skin.

Thank you for checking this man's lipid profile prior to the clinic. Unfortunately his cholesterol was still not at target (4). Although there are some dietary indiscretions, mostly around chocolate, I explained to him that this is largely due to his liver making too much cholesterol. As he is already on a statin and Ezetimibe combination, the next thing to do is to add a fibrate. I have checked his baseline bloods (CK and TSH etc) but would recommend adding Fenofibrate 200mg od to his Atorvastatin 40mg and Ezetimibe 10mg od. Further to my hand note I am grateful to you for prescribing.

The only other problem is that he has gone back to having the occasional cigarette. He is aware that this represents a slippery slope and his wife in particular is clearly very distressed that he has done this. He is aware of the lack of the durability of the intervention if he does keep smoking, and also that he will not collateralise his left leg satisfactorily. I will leave this with him.

He is due surgical review at the end of May, and so I will see him myself in 6 months.

Kind regards

Yours sincerely

Authorised on 30/03/2011 18:22:30 by John Dick.

**Dr John Dick**
**Consultant Physician**

(P) Mr J Nagy, Consultant Vascular Surgeon , Dept of Vascular Surgery , Ninewells Hospital

## Delivery Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

22 April 2011
Clinic Date: 20/04/2011
Dictation Date: 20/04/2011
Your Ref: (CHI:0503700053)
Our Ref: PAS/WJ/0503700053
Enquiries To: Ward 12 OP Office
Telephone: 01382 660111
Extension: 40444

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

I reviewed this gentleman following his recent right common femoral endarterectomy, vein patch and right superficial femoral artery angioplasty. Unfortunately this has now uncovered claudication affecting his left leg which he tells me is stopping him getting back to his work. His recent angiogram showed he had a long superficial femoral artery occlusion on the left hand side which necessitates a fem above knee popliteal bypass graft. I also note he continues to smoke. We have had a conversation about this. He is very keen to consider even further surgery but one of the difficulties with one operation going well, the patient's expect every operation to go well, this is not always the case. I have organised a vein scan to see if there is a suitable long saphenous vein for the above operation. Should he have a good one, given his thoughts on the subject, I suspect we will be proceeding to intervention. Should he not have a good vein then all that would be left with a prosthetic graft with it's intendant increased risks. I am not sure this is a good idea, but clearly its an eye for a debate with the patient. Clearly none of this is a particularly good idea if he continues to smoke. I will see him once his scan has been performed.

Yours sincerely

**Peter A Stonebridge, ChM FRCS Edin, FRCP Edin**
**Professor of Vascular Surgery**

## Delivery Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

04 March 2011
Date: 21/02/2011
Dictation Date: 21/02/2011
Your Ref: (CHI:0503700053)
Our Ref: JN/WJ/0503700053
Enquiries To: Ward 12 OP Office
Telephone: 01382 660111
Extension: 33889

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

Date of Admission: 13 02 11

Date of Discharge: 16 02 11

Operation: Right common femoral endarterectomy and vein patch and right SFa angioplasty

Follow Up: Vascular Clinic 6 weeks

LSA Code: 35 02 06

This patient was admitted electively for a right common femoral endarterectomy and vein patch and a further right SFa angioplasty. The above procedures were carried out on the 14th of February, 2011. He made an uneventful post-operative recovery. We will review him at clinic in approximately 6 weeks time.

Yours sincerely

**John Nagy**
**Consultant Vascular Surgeon**

## Delivery Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

10 March 2011
Clinic Date: 09/03/2011
Dictation Date: 09/03/2011
Your Ref: (CHI:0503700053)
Our Ref: JN/WJ/0503700053
Enquiries To: Ward 12 OP Office
Telephone: 01382 660111
Extension: 33889

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

I reviewed this gentleman at clinic today. In February 2011 he underwent a right common femoral endarterectomy from which he made a good recovery. Unfortunately he presented at clinic today having noticed for the past week that at the end of the day his leg was swollen on the right requiring elevation. He has been exercising quite vigorously according to himself and his partner.

On examination he had normal lower limb pulses on the right. His wounds have healed. There were no clinical signs of infection, no calf tenderness. Duplex scan excluded a deep vein thrombosis with normal femoral and popliteal veins and calf veins all clear of thrombus. The common femoral artery was widely patent with triphasic flow. Nothing untoward was discovered on these investigations. It is possible that with vigorous exercise he has induced some swelling in the leg that was previously under-perfused. We will review this gentleman in 4-6 weeks time.

Yours sincerely

**John Nagy**
**Consultant Vascular Surgeon**

310286.

**Delivery Unit**

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

04 March 2011
Date: 21/02/2011
Dictation Date: 21/02/2011
Your Ref: (CHI:0503700053)
Our Ref: JN/WJ/0503700053
Enquiries To: Ward 12 OP Office
Telephone: 01382 660111
Extension: 33889

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

Date of Admission: 13 02 11

Date of Discharge: 16 02 11

Operation: Right common femoral endarterectomy and vein patch and right SFa angioplasty

Follow Up: Vascular Clinic 6 weeks ✓

LSA Code: 35 02 06 ?

This patient was admitted electively for a right common femoral endarterectomy and vein patch and a further right SFa angioplasty. The above procedures were carried out on the 14th of February, 2011. He made an uneventful post-operative recovery. We will review him at clinic in approximately 6 weeks time.

Yours sincerely

**John Nagy**
**Consultant Vascular Surgeon**

2/3 - patient placed, was told he could have if having problems
Has leg swelling. He rested in bed for a week after discharge
but has had swelling since.
- as I couldn't get hold of anyone and there was a space at 9.30
I decided to give him that appt - better to be safe than sorry!
Regs

| 01 03 [illegible] Jan [illegible] | 18 [illegible] | Ward 10 AH |
|---|---|---|
| Diagnosis: Left [illegible] pseud[illegible]monas in [illegible] | for | months, known ESB in her urine, |
| Progress: Mrs [illegible] peripheral arte[illegible]isc disease with an ABPI been started on antib[illegible] and we are cons[illegible]in angiop[illegible]sty. | is a[illegible] ABPI [illegible] e has [illegible] Mero [illegible] ogran[illegible] | for further assessment of her eft leg suggest peripheral arterial fection in her leg ulcer and has . Duplex scan has been arranged ld there be anything suitable for |

| 01 03 [illegible] Kei[illegible] | 13 1[illegible] | 419 | Ward 10 AH |
|---|---|---|---|
| Diagnosis: [illegible] and se[illegible]ond [illegible] | emia | ainful and necrotic tips of the first |
| Past history: [illegible]y hyper[illegible]sion, [illegible] | farcti[illegible] moke | rebrovascular accident |
| Progress: [illegible] 3 wee[illegible] histe[illegible] first a[illegible] third [illegible] of criti[illegible] limb [illegible] He is [illegible] a dupl[illegible] | was audic mall [illegible] mora[illegible] angio. | ergency admission yesterday with nd severe pain in the tips of his left s of necrosis there with evidence is palpable, but no distal pulses. |

| 01 03 [illegible] Eve[illegible] A[illegible] | 05 36 [illegible] | Ward 9 AH |
|---|---|---|
| Diagnosis: [illegible] | schac | |
| Plan: [illegible] Palliative Care [illegible] is plan[illegible]d for [illegible] | care. [illegible] re or[illegible] her N[illegible] | llan has been seen by the ng a return to her Nursing Home. It Home at 1400 this afternoon. |

| 01 03 [illegible] Ro[illegible] 38 | 1 04 [illegible] | 0140 | Ward 7 AH |
|---|---|---|---|
| Diagnosis/ Ope[illegible] | ove kn[illegible] | nputation | |
| Other problem[illegible] | | | |
| Plan: [illegible] Home [illegible] is afte[illegible]n. | n is b[illegible] l posit[illegible] | ischarged back to her Nursing t asymptomatic for C.diff. | |

| 01 03 [illegible] Th[illegible] | ALL [illegible] | 33 0350 | Ward 7 AH |
|---|---|---|---|
| Diagnosis: [illegible] | emia [illegible] | t | |
| Progress: [illegible] angio[illegible]sty fo[illegible]ar[illegible] Magg[illegible] AS[illegible]. | all ha[illegible] t thir[illegible] | a successful anterior tibial oday. Convalescence in Queen | |

Hospital/Clinic

**IMMEDIATE OUT-PATIENT COMMUNICATION**

Clinic

Ward/Clinic/

**05 03 70**

0503700053

DAVID STANDISH

Cons.

D D M M Y Y

C.H.I. No.

M. State

Sex

USE BLOCK LETTERS OR PATIENT LABEL

Fold Back

Date .....

Dear Doctor,

The above patient attended my clinic today, please accept this as the only / interim* communication in respect of this visit.

Provisional/Diagnosis is .....

Comment/Recommendations .....

Next appointment (if any) ..... weeks/months

| MEDICINE TREATMENT RECOMMENDED NAME—State Date when Medicines should be stopped | DOSE | STOP DATE | Times of Administration (Mark ✓) 8 10 12 14 16 18 20 22 24 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Prescription given / Medicines supplied / Medicines not supplied *

Signed by..... for .....

Consultant

Do not write below this line

*Delete as appropriate

Dr. .....

.....

.....

.....

THB(MR)159 (2-part set General — 3 part set Psychiatry Dundee)

Hospital/Clinic

**IMMEDIATE OUT-PATIENT COMMUNICATION**

Clinic

Ward/Clinic/

Hosp.

Cons.

D D M M Y Y

0 5 0 3 7 0 0 9 0 5 3

C.H.I. No.

Surname STANDISH

First Name DAVID

Address 16 FLOBALLINDEANTCE DUNDEE

M. State

Sex

G.P. & Address (G.P. Requests only)

USE BLOCK LETTERS OR PATIENT LABEL

Fold Back

Date .....

Dear Doctor,

The above patient attended my clinic today, please accept this as the only / interim* communication in respect of this visit.

Provisional/Diagnosis is high cholesterol

Comment/Recommendations .....

commence simvastatin

Next appointment (if any) ..... weeks/months

| MEDICINE TREATMENT RECOMMENDED NAME—State Date when Medicines should be stopped | DOSE | STOP DATE | Times of Administration (Mark ✓) 8 10 12 14 16 18 20 22 24 |
|---|---|---|---|
| SIMVASTATIN | 10mg | | ✓ |
| | | | |
| | | | |
| | | | |

Prescription given / Medicines supplied / Medicines not supplied *

Signed by A Cleland for DR PULLAR

Consultant

Do not write below this line

*Delete as appropriate

Dr. .....

.....

.....

.....

THB(MR)159 (2-part set General — 3 part set Psychiatry Dundee)

Hospital/Clinic

**IMMEDIATE OUT-PATIENT COMMUNICATION**

Clinic

Ward/Clini
Hosp. ..... Cons.

**05 03 70**

**0503700053**

DAVID STANDISH

C.H.I. No.

Surname
First Name ..... M. State
Address ..... Sex

G.P. & Adc

USE BLOCK LETTERS OR PATIENT LABEL

Fold Back

Date .....

Dear Doctor,

The above patient attended my clinic today, please accept this as the only / interim* communication in respect of this visit.

Provisional/Diagnosis is .....

Comment/Recommendations .....

Next appointment (if any) ..... weeks/months

| MEDICINE TREATMENT RECOMMENDED NAME—State Date when Medicines should be stopped | DOSE | STOP DATE | Times of Administration (Mark ✓) 8 10 12 14 16 18 20 22 24 | | | | | | | | | | | |
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| | | | | | | | | | | | | | | |

Prescription given / Medicines supplied / Medicines not supplied *

Signed by..... for .....
Consultant

**Do not write below this line**

*Delete as appropriate

Dr. .....

.....

.....

.....

THB(MR)159 (2-part set General – 3 part set Psychiatry Dundee)

Hospital/Clinic

**IMMEDIATE OUT-PATIENT COMMUNICATION**

Clinic

Ward/Clinic/
Hosp. ..... Cons.

D D M M Y Y
05 03 70

C.H.I. No.

Surname
First Name ..... M. State
Address ..... Sex

G.P. & Address (G.P. Requests only)

USE BLOCK LETTERS OR PATIENT LABEL

Fold Back

Date .....

Dear Doctor,

The above patient attended my clinic today, please accept this as the only / interim* communication in respect of this visit.

Provisional/Diagnosis is .....

Comment/Recommendations .....

Next appointment (if any) ..... weeks/months

| MEDICINE TREATMENT RECOMMENDED NAME—State Date when Medicines should be stopped | DOSE | STOP DATE | Times of Administration (Mark ✓) 8 10 12 14 16 18 20 22 24 | | | | | | | | | | | |
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| | | | | | | | | | | | | | | |

Prescription given / Medicines supplied / Medicines not supplied *

Signed by..... for .....
Consultant

**Do not write below this line**

*Delete as appropriate

Dr. .....

.....

.....

.....

THB(MR)159 (2-part set General – 3 part set Psychiatry Dundee)

AC/KC

**RHEUMATIC DISEASES UNIT**
Dr Alison Clarke
☎ Secretary ext 33039
Fax: 01382 425509

20 September 2001
Clinic: 22 08 01

Dr C Affleck
Park Avenue Medical Centre
Park Avenue
Dundee

Dear Dr Affleck

Re: ***David Standish, 050370 0053, 10 Ballindean Terrace, Dundee***

31 year old David was reviewed in clinic today. Since his last clinic attendance in April David has been well having only one episode of chest pain two nights ago. He was lying in his bed at the time. He describes it as sharp, localised to the left pericardium and subsided spontaneously within 20 minutes. He did mention that he has had a few home problems, separating from his partner and having to bring up his 6 year old daughter by himself. He has also had to give up work due to this.

On examination today he looked well. I did note that he had lost 4½ kg in weight since April. He did admit he had not been eating quite as much, probably due to stresses of home life. Pulse was 70 beats and regular, two heart sounds were audible with nil added and his chest was clear. The exercise tolerance test performed in July showed no evidence of inducible ischaemia and he achieved an exercise time of 12 minutes. Happily an echocardiogram carried out on the 29th of June was also normal. Although we have not yet found a cause for this intermittent chest pain all cardiac tests have been normal. He continues to smoke approximately 10 cigarettes a day and I note that he had a high cholesterol level at 7.15 in January of this year. As yet he has not been on any treatment and therefore I have commenced Simvastatin 10 mg at night. I have also advised him to follow a low fat diet.

In view of the fact that all of our tests have been normal I am discharging David from our clinic today. If the chest pain does become more frequent or troublesome I think it would be appropriate to refer David to our cardiology colleagues.

Yours sincerely

Dr Alison Clarke
Senior House Officer in Rheumatology

Date signed.....

NB Probably 20mg Simvastatin at night is more appropriate.

AC

PK/LW/MPI 05 03 70 0053

Dr P Kumar, Wards 1 and 2
☎ **Ext** 33015 **Fax** 425509

**Medicine and Cardiovascular Group**

22 April 2001
Clinic 18 04 2001

Dr C Affleck
Park Avenue Medical Centre
Park Avenue
DUNDEE
DD4 6PP

Dear Dr Affleck

**David Standish, 16 Fintryside, Dundee, DD4 9JW**

I reviewed this gentleman in the Clinic today.

He says that his chest pain has got much better and he has had only two episodes since his last visit three months ago. He tells me that his chest pain is always sharp, localised to the left pericardium and subsides within 20 minutes spontaneously. He also says that the pain always occurs while he is relaxing rather than exerting.

On examining him today he looks well at rest. Pulse rate is 70 per minute regular. Heart sounds were normal without any murmur.

I have re-booked for an Exercise Tolerance Test as I understand that it has been missed during his last visit.

We will see him again in the Clinic in four months time when hopefully the treadmill test will have been done.

Yours sincerely

Dr P Kumar
Specialist Registrar

Date signed ……..

AA/MJ/MPI 05 03 70 0053

Dr Anwar Arshad, Wards 1 & 2
☎ Ext 33015 **Fax** 01382 425509

**Medicine & Cardiovascular Group**

1 February 2001
Dictated: 24.01.01
Clinic: 24.01.01

Dr C Affleck
Park Avenue Medical Centre
Park Avenue
DUNDEE
DD4 6PP

Dear Dr Affleck

**David Standish, 18 Fintryside, Dundee, DD4 9LW**

Thank you for referring the above patient whom I saw in the General Medical Clinic today. He is a 31 year old gentleman who presented with intermittent chest pain over the last 6 months. He described the chest pain as dull aching, mostly localised to the left precordium without any radiation. The chest pain was constant and occurred mostly when he is relaxed. There was no evidence of nausea or vomiting. There was no pain on exertion. There was no history to suggest thromboembolic disease. Risk factors include smoker, high cholesterol as well as some history. He is asthmatic on prn Ventolin inhaler. He lives with his girlfriend and occasionally consumes alcohol.

Blood pressure was 110/70. Pulse rate was 70 and regular. Cardiovascular, lung, abdomen and other system examinations were unremarkable.

From the nature of his pain I do not think it is cardiac in origin however the strong risk factors we ought to investigate further. In the first instance I have repeated all the blood investigations, organised an ECG as well as an exercise tolerance test and given him a further follow up in 2 months' time. I have also organised a chest x-ray today.

Yours sincerely

Anwar Arshad
Specialist Registrar

Date signed .....

continued

David Standish, 05 03 70 0053

Results: Haemoglobin 14.8, WBC 8.4, platelets 330

Sodium 136, potassium 4.6, urea 4.7, creatinine 94, ALT 36, bilirubins 6, alkaline phosphatase 83, albumin 43, calcium 2.26, calcium (corrected) 2.31, glucose 5.7, cholesterol 7.15, HDL-cholesterol 1.57, Total chol/HDl-chol 4.55.

Chest – Male: Possible small peripheral opacity in the right mid-zone is unlikely to be significant. Remainder of lung fields clear. It may be worthwhile having a review chest film at a later stage for fuller assessment.

CLVH - R24 - C03 - 507

**CARDIORISK**

**DR GEORGE**

Ward/Clinic/ Hosp. 10.40

Surname STANDISH D D M M Y Y 05 03 37 C0 05 3 C.H

First Name DAVID

Address ..... M.

G.P. & Address (G.P. Requests only)

USE BLOCK LET OR PATIENT L

DATE 22/6/23

Page

91 kg 178 cm.

122/43 P69

Meds: Lansoprazole 30mg

Rivaroxaban 2.5mg

Folic Acid 5mg

Escitalopram 20mg

Zopiclone 7.5mg

Atorvastatin 150mg ISC

~~Atom~~ Bisoprolol 10mg

T-C 4.7 mol/L

HDL 1.35 mol/L

P A

Sick day rules

GEORGE

## Risks

This procedure is recommended because it means we can offer you the best treatment for your condition and reduce the risk of further problems with your heart in the future. The benefits of the procedure significantly outweigh the small risk of complications. However you should be aware that these could occur and include:

| | | |
|---|---|---|
| Heart Attack | Chest Pain | Reaction to X-Ray dye |
| Stroke | Bleeding | |
| Death | Damage to blood vessels | |

Exceptionally rarely, due to a complication, you may require emergency Heart Surgery and this would mena urgent tranfer to a different hospital, either Edinburgh of Glasgow.

Following PCI there is a small risk of Stent Restenosis (renarrowing) or Stent Thrombosis (blood clot in the stent).

## Recording data

It can be helpful for your doctors to use x-ray images obtained during the procedure for education or publication. Use of images in these ways would not allow you to be identified.

Every patient who has this procedure is recorded in the national database. This information is used for audit and research to help ensure high standards of treatment are maintained. If you object to your information being collected in this way, please inform the doctor performing the test.

## Consent

Further information is available in the form of booklets produced by the British Heart Foundation. These are kept on the wards. The nurses will be able to get them for you.

Before you sign the form, you should take the opportunity to ask your doctors any questions you may have. You may also wish to discuss the information we have given you, with y family.

## Emergency Cases

Occasionally another patient may need an emergency procedure and result in a delay to your procedure or may even cause your procedure to be cancelled. If this is the case, you will be kept informed and your procedure re-arranged as soon as possible.

**Please note:**

The figures quoted in this document are average figures for all cases. Your Cardiologist will discuss with you any specific additional aspects of your case before the procedure. The department where your procedure will take place regularly has professional observers. The majority of these observers are health care professionals, qualified or in training, and on occasions, specialist company representatives. If you do not wish observers to be present during your procedure please tell a doctor or nurse.



NHS Tayside

**CONSENT FOR INVESTIGATIONS, TREATMENT OR OPERATION FORM**
**(Please complete using block capitals & no abbreviations)**

NHS Tayside

| | | | |
|---|---|---|---|
| **Patient's Surname** | ~~DA~~ Standish | **Hospital/Ward** | NW1 |
| **Other Names** | DAVID | **Speciality** | CARDIO |
| **CHI Number** | 050770 0053 | **Consultant** | MARTIN |

*Patient Label can be used*

**Name of proposed procedure or course of treatment**

# CORONARY ANGIOGRAPHY ± PERCUTANEOUS CORONARY INTERVENTION

I have explained the procedure to the patient. In particular I have explained:

**Intended Benefits:** **INVESTIGATION AND TREATMENT OF HEART ARTERY DISEASE.**

**Significant Risks:**

| | |
|---|---|
| **HEART ATTACK** | **BLEEDING** |
| **STROKE** | **REACTION TO X-RAY DYE** |
| **DEATH** | **VASCULAR COMPLICATION** |

Any extra procedures which may become necessary during the procedure:

**Blood Transfusion** ☐ **Other** (specify)

(The need and alternatives have been discussed with the patient)

I have also discussed what the procedure is likely to involve, the benefits and the significant risks of any available alternative (including no treatment), and any particular concerns of this patient. I have done this in terms that, in my judgement have been understood.

The following information leaflet(s) has been given

Has the patient ever been notified that they are at increased risk of CJD or vCJD for public health purposes?

| | | |
|---|---|---|
| No | ☐ | Proceed as normal |
| Unable to Respond | ☐ | Proceed as normal unless high risk tissue, e.g. Brain, Spinal Cord Posterior Eye and Quarantine instruments pending contact with infection control for further advice. |
| Yes | ☐ | Ask for further explanation. Quarantine instruments pending contact with infection control for further advice. |

| | | | |
|---|---|---|---|
| **Clinicians Signature:** | | **Date** | 21/4/16 |
| **Name Printed:** | W. SALOH | **Grade** | ST7 |
| **Contact Details** | | | |

NHS Tayside

## Consent for Investigations, Treatment or Operation Form

**This page is to be completed by the patient/representative.**

Please read this form carefully. If you have any further questions, do ask; we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

**I agree:** To the procedure or course of treatment described on this form.

To the administration of a general, local or other anaesthetic as appropriate, following informed discussion including the benefits and significant risks with the anaesthetist.

**I understand:**

- That any procedure in addition to those described above will only be carried out if it is necessary to save my life or to prevent serious harm to my health.
- That you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.
- Information including digital information (radiological e.g. x-rays, CT and MRI scans, video and/or photographic material) may be stored as part of the patients medical records and may be stored on computer databases.
- Body tissue e.g. fluids, organs or parts of them may be removed during the procedure and used for diagnosis, my future treatment and then discarded or stored as considered appropriate.

The University of Dundee is very active in medical research: donations of excess body tissues and agreement to the use of images are a valuable resource for researchers.

Please tick ✓appropriate box if you agree to

☐ Excess body tissue not required for diagnosis or future treatment being used for medical research.

☐ To photographs and other digital images being used for research, education and teaching, in presentations at conferences or available on websites and in publications Images will be anonymised to protect patient privacy.

(If consent is withdrawn at a later date it may not be possible to withdraw images that are already in the public domain) NB Medical staff you must complete the appropriate clinical photography forms.

**I have been told** about additional procedures as specified which may become necessary during my treatment. I have listed below any procedures which **I do not wish to be carried out** without further discussion.

Specified Additional Procedures | Additional Procedures I do not want carried out

**Patient's Signature:** D. Stansfield **Date:** 21/11/16

**Print Name:**

**Witness Signature** **Date:**

**(if patient unable to sign)**

**Print Name**

**Statement of Interpreter** (if applicable): I have interpreted the information above to the patient to the best of my ability and in a way in which I believe the patient can understand.

**Interpreters Signature:** **Date**:

**Name Printed:**

**Day of Operation**

**I have marked** the skin at the operation site and / or confirmed consent ☐

**Signature** **Date**

NHS Tayside

# Cardiac Catheterisation with possible Coronary Intervention

### Why should I have this procedure?

We are concerned about the blood flow to the heart muscle. This test allows us to take detailed X-ray pictures of the arteries that take blood to the heart, and recommend the best treatment for you.

### What is involved in the procedure?

A small soft, narrow tube (sheath) is inserted under local anaesthetic into the artery at your wrist or your groin. The injection stings for a moment then goes numb. Most patients find that this is the only uncomfortable part of the test. Then a thin plastic tube (catheter) is fed through the sheath, along the arteries to your heart. Contrast dye is injected down the catheter to outline the coronary arteries on X-ray pictures.

### Decision making

Diseased and narrowed coronary arteries can be treated by medicines alone, or by procedures which directly improve the blood flow. Improved blood flow means a lower chance of chest pains or a heart attack in the future. There is also a small benefit on life expectancy. These procedures do not cure the problem. It is also important to take medicines and change lifestyle to reduce the future risk.

### Medical Treatment

- Aspirin and clopidogrel to prevent blood clots
- Beta Blockers and Ace Inhibitors to reduce the workload on the heart
- Statins to reduce cholesterol

### Percutaneous coronary intervention (PCI)

This procedure is recommended when the arteries have tight narrowings in short sections. The narrowings are stretched with a balloon, and a metal mesh scaffold (stent) is embedded in the vessel wall. We use the same sheath in the artery and can often do PCI immediately after the diagnostic angiogram.

If we treat you with stents then it is extremely important to continue to take the Aspirin and Clopidogrel tablets until you are told to stop. Stopping these tablets early can be fatal.

### Coronary artery bypass graft surgery (CABG)

This procedure is not performed in Ninewells Hospital. It is recommended when severe disease has developed in every vessel, or in critical locations in the coronary vessels, in which PCI would not be as effective.

Often it is straightforward to decide which is the best treatment. However, it is not unusual to require discussion between the doctor performing the angiogram and colleagues. In this case we would not proceed to PCI during the same procedure.

| Consultant | Patient Name | CHI |
|---|---|---|
| | DAVID STANDISH | 0503780053 |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DATE | 17/11 | 18/11 | | | | | | | | | | | | | |
| Hb | 128 | 137 | | | | | | | | | | | | | |
| MCV | | | | | | | | | | | | | | | |
| WCC | 7.2 | 6.5 | | | | | | | | | | | | | |
| Platelet | 348 | 300 | | | | | | | | | | | | | |
| Na | 141 | 142 | | | | | | | | | | | | | |
| K | 4.2 | 4.5 | | | | | | | | | | | | | |
| Urea | 4.1 | 4.6 | | | | | | | | | | | | | |
| Creat | 74 | 82 | | | | | | | | | | | | | |
| eGFR | >60 | >60 | | | | | | | | | | | | | |
| ALT | 49 | 58 | | | | | | | | | | | | | |
| Bilir | 5 | 7 | | | | | | | | | | | | | |
| ALP | 96 | 89 | | | | | | | | | | | | | |
| Album | 36 | 33 | | | | | | | | | | | | | |
| GGT | | | | | | | | | | | | | | | |
| Amyl | | | | | | | | | | | | | | | |
| Glucose | | | | | | | | | | | | | | | |
| HbA1c | | | | | | | | | | | | | | | |
| INR | | | | | | | | | | | | | | | |
| APTT | | | | | | | | | | | | | | | |
| APTTr | | | | | | | | | | | | | | | |
| Ca | | 2.26 | | | | | | | | | | | | | |
| Corr Ca | | 2.36 | | | | | | | | | | | | | |
| Mg | 0.84 | 0.86 | | | | | | | | | | | | | |
| PO4 | 1.20 | 1.13 | | | | | | | | | | | | | |
| Iron | | | | | | | | | | | | | | | |
| Transf | | | | | | | | | | | | | | | |
| %sat Tranf | | | | | | | | | | | | | | | |
| TSH | | | | | | | | | | | | | | | |
| FT4 | | | | | | | | | | | | | | | |
| Total Cholesterol | | | | | | | | | | | | | | | |
| Triglycer | | | | | | | | | | | | | | | |
| HDL | | | | | | | | | | | | | | | |
| CRP | | | | | | | | | | | | | | | |

THB 024SS

# TAYSIDE PRESCRIPTION AND ADMINISTRATION RECORD
## (3 WEEK RECORD)

NHS Tayside

DATE OF ADMISSION 16/11/16 RECORD START DATE 16/11/16

| | |
|---|---|
| **Hospital /Ward:** NIW ~~2~~ (1) | **Patient Name:** DAVID STANDISH. |
| **Consultant:** HUTCHESON | **CHI number:** 0503700053 |
| **On admission:** **Weight:** 95kg. **Height:** 1.76. | **Date of Birth:** |
| | (Attach printed label here) |

**CONFIRMATION OF PRESCRIPTION REVIEW ON TRANSFER OF MEDICAL CARE**

| Receiving Unit | Date | Authorised Prescriber (Signature) |
|---|---|---|
| | | |
| | | |

**MEDICINE ALLERGIES/ SENSITIVITIES**

IF NIL KNOWN TICK HERE THEN DATE & SIGN ☐ .....

1. Intolerant of clopidogrel; No Allergies on ECS. 2. 3. 4.

## ONCE ONLY PRESCRIPTIONS

| Date | Time | Medicine | Dose | Route | Prescribed By | Time Given | Given By |
|---|---|---|---|---|---|---|---|
| 16/11/16 | 2310 | BISOPROLOL | 2.5mg | oral | EBS. | 2320 | EBS |
| 16/11/16 | 2310 | Nicotine Patch | 14mg/24hours-transdermal | | EBS | 2320 | EBS |
| 16/11/16 | 2310 | fondaparinux | 2.5mg | s/cut | EBS. | 2320 | EBS |
| 17/11/16 | 0830 | Ticagrelor | 180mg | O | | 0930 | EB |
| 17/11/16. | 1930 | CETIRIZINE | 10mg | ORAL | [illegible] | 1940 | EB |
| 17.11.16 | 2030 | fondaparinux | 2.5mg | s/cut | [illegible] | 2045 | EBS |
| 21/11/16 | 00:50 | ZOPICLONE | 3.75 | oral | [illegible] | 0050 | [illegible] (1) |
| 21/11/16 | 02:20 | TEMAZEPAM | 10mg | oral | [illegible] | 0225 | [illegible] |
| 22/11/16 | 22:20 | TEMAZEPAM | 20mg | ORAL | [illegible] | 2305 | [illegible] |
| 22/11/16 | 1322 | Lidocaine 1% | 5mls | S/C | | 1322 | |
| 22/11/16 | 1325 | Heparin | 5000IU | IA | | 1325 | |
| 22/11/16 | 1325 | GTN | 200mcg | IA | | 1325 | |
| 22/11/16 | 1332 | Fentanyl | 25mcg | IV | | 1332 | SV |
| 22/11/16 | 1327 | Diazemuls | 2.5mg | IV | | 1327 | SV |
| 22/11/16 | 1340 | Heparin | 4000 IU | IV | | 1340 | |
| 22/11/16 | 1350 | GTN | 200mcg | IA | | 1350 | |
| 22/11/16 | 1357 | GTN | 200mcg | IA | | 1357 | |
| 22/11/16 | 16:30 | DIAZEPAM | 2 mg | oral | [illegible] | 1630 | |
| 22/11/16 | 22:00 | Diazepam | 2mg | PO | [illegible] | 2200 | PA |

**OTHER MEDICINE CHARTS IN USE**

| Chart Type | Signed | | Signed |
|---|---|---|---|
| 1. Insulin | | 4. Anticoagulant | |
| 2. Epidural/Pain relief | | 5. Mental Health Act | |
| 3. Fluid | | 6. Other | |

## CONTINUOUS INFUSIONS

| Date | Drugs | 12/24 Hourly Dose | Route | Prescribed By | Date Stopped | Comments |
|---|---|---|---|---|---|---|
| | | | | | | |
| Date | | | | | | |
| Time | | | | | | |
| Initials | | | | | | |
| Initials | | | | | | |

| Date | Drugs | 12/24 Hourly Dose | Route | Prescribed By | Date Stopped | Comments |
|---|---|---|---|---|---|---|
| | | | | | | |
| Date | | | | | | |
| Time | | | | | | |
| Initials | | | | | | |
| Initials | | | | | | |

| Date | Drugs | 12/24 Hourly Dose | Route | Prescribed By | Date Stopped | Comments |
|---|---|---|---|---|---|---|
| | | | | | | |
| Date | | | | | | |
| Time | | | | | | |
| Initials | | | | | | |
| Initials | | | | | | |

| Date | Drugs | 12/24 Hourly Dose | Route | Prescribed By | Date Stopped | Comments |
|---|---|---|---|---|---|---|
| | | | | | | |
| Date | | | | | | |
| Time | | | | | | |
| Initials | | | | | | |
| Initials | | | | | | |

| Date | Drugs | 12/24 Hourly Dose | Route | Prescribed By | Date Stopped | Comments |
|---|---|---|---|---|---|---|
| | | | | | | |
| Date | | | | | | |
| Time | | | | | | |
| Initials | | | | | | |
| Initials | | | | | | |

## CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINES

**If a dose is not administered, initial and enter the appropriate code in the box with a circle drawn round it:**

1. Patient refused
2. Patient unavailable
3. Medicine out of stock
4. Instructions not clear / legal
5. Nil by mouth.
6. Once only / prn given
7. Dose withheld – Prescriber's instructions
8. Self administered by patient
9. Nausea/vomiting
10. Unable to swallow
11. No intravenous access
12. "On Pass"
14. Other .....
15. Other .....
16. Other .....

General Comments

## AS REQUIRED THERAPY

| Medicine / Form | | Date | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Salbutamol 100 micrograms | | Time | | | | | | | | | | |
| Dose & Frequency | Route | Dose | | | | | | | | | | |
| 2 puff PRN | inh | | | | | | | | | | | |
| Signature | Start Date | Route | | | | | | | | | | |
| EW | 16/11/16 | | | | | | | | | | | |
| Indication / Notes | Pharmacy | Initials | | | | | | | | | | |
| SOB/wheeze | (S) 21/11 | | | | | | | | | | | |

| Medicine / Form | | Date | 21/11/16 | 21/11/16 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GTN | | Time | 1130 | 2120 | | | | | | | | |
| Dose & Frequency | Route | Dose | 2puffs | 2puffs | | | | | | | | |
| 2 puffs | S/ling | | | | | | | | | | | |
| Signature | Start Date | Route | S/L | S/L | | | | | | | | |
| EW | 16/11/16 | | | | | | | | | | | |
| Indication / Notes | Pharmacy | Initials | BS | | | | | | | | | |
| chest pain | (S) 21/11 | | | | | | | | | | | |

| Medicine / Form | | Date | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metoclopramide | | Time | | | | | | | | | | |
| Dose & Frequency | Route | Dose | | | | | | | | | | |
| 10mg 8hrly | IV | | | | | | | | | | | |
| Signature | Start Date | Route | | | | | | | | | | |
| EW | 16/11/16 | | | | | | | | | | | |
| Indication / Notes | Pharmacy | Initials | | | | | | | | | | |
| N&V | (S) 21/11 | | | | | | | | | | | |

| Medicine / Form | | Date | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Morphine Sulphate | | Time | | | | | | | | | | |
| Dose & Frequency | Route | Dose | | | | | | | | | | |
| @ 1-10mg | IV | | | | | | | | | | | |
| Signature | Start Date | Route | | | | | | | | | | |
| EW | 16/11/16 | | | | | | | | | | | |
| Indication / Notes | Pharmacy | Initials | | | | | | | | | | |
| Titrate to pain | (S) CD | | | | | | | | | | | |

## NOTES FOR USERS

**For Prescribers:**

1. Sign your name clearly against each prescription.
2. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date appropriate boxes.
3. If an existing prescription is to be modified, delete existing prescription as described and re-write new instructions in a new section.
4. Use approved names in BLOCK LETTERS and use metric doses as follows:
   **Milligram = mg** **Gram = g** **Millilitre = ml** **Microgram: to be written in full**
   Fractions of a milligram should be written in micro grams. A zero should be written in front of a decimal point where there is no other figure, e.g. 0.5ml **not** .5ml
5. Method of administration should be abbreviated as follows:
   **Intravenous = IV** **Inhalations = INH** **Intramuscular = IM** **Oral = Oral** **Topical = TOP** **Vaginal = PV**
   **Subcutaneous = S Cut** **Sublingual = S Ling** **Intradermal = ID** **Per rectum = PR** **Nasogastric = NG**

**For Nurses:**

1. The 'Regular' and 'As Required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.
2. Ensure entry is made on administration record each time drug is given. Initial in relevant date column and time row.
3. Check that all drugs prescribed at a certain time are administered.
4. If drug is not administered, enter reason in appropriate box using the coding system.

## AS REQUIRED THERAPY

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicine / Form: Zopiclone | | Date | | | | | | | | | | |
| | | Time | | | | | | | | | | |
| Dose & Frequency: 7.5mg nocte PO | Route | Dose | | | | | | | | | | |
| Signature | Start Date: 21/11/16 | Route | | | | | | | | | | |
| Indication / Notes | Pharmacy | Initials | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicine / Form: ZOPICLONE | | Date | 22/11/16 | | | | | | | | | |
| | | Time | 23:15 | | | | | | | | | |
| Dose & Frequency: 3.75mg | Route: PO | Dose | 3.75 mg | | | | | | | | | |
| Signature | Start Date: 22/11/16 | Route | PO | | | | | | | | | |
| Indication / Notes: INSOMNIA | Pharmacy | Initials | PD | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicine / Form | | Date | | | | | | | | | | |
| | | Time | | | | | | | | | | |
| Dose & Frequency | Route | Dose | | | | | | | | | | |
| Signature | Start Date | Route | | | | | | | | | | |
| Indication / Notes | Pharmacy | Initials | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicine / Form | | Date | | | | | | | | | | |
| | | Time | | | | | | | | | | |
| Dose & Frequency | Route | Dose | | | | | | | | | | |
| Signature | Start Date | Route | | | | | | | | | | |
| Indication / Notes | Pharmacy | Initials | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicine / Form | | Date | | | | | | | | | | |
| | | Time | | | | | | | | | | |
| Dose & Frequency | Route | Dose | | | | | | | | | | |
| Signature | Start Date | Route | | | | | | | | | | |
| Indication / Notes | Pharmacy | Initials | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicine / Form | | Date | | | | | | | | | | |
| | | Time | | | | | | | | | | |
| Dose & Frequency | Route | Dose | | | | | | | | | | |
| Signature | Start Date | Route | | | | | | | | | | |
| Indication / Notes | Pharmacy | Initials | | | | | | | | | | |

# REGULAR THERAPY

Date

Time

Medicine / Form

Dose | Route

Signature | Start Date

Further Information

6 | 8 | 12 | 14 | 18 | 22

Medicine / Form

Dose | Route

Signature | Start Date

Further Information

6 | 8 | 12 | 14 | 18 | 22

Medicine / Form

Dose | Route

Signature | Start Date

Further Information

6 | 8 | 12 | 14 | 18 | 22

Medicine / Form

Dose | Route

Signature | Start Date

Further Information

6 | 8 | 12 | 14 | 18 | 22

Medicine / Form

Dose | Route

Signature | Start Date

Further Information

6 | 8 | 12 | 14 | 18 | 22

Medicine / Form

Dose | Route

Signature | Start Date

Further Information

6 | 8 | 12 | 14 | 18 | 22

# REGULAR THERAPY

Date

Time

| | | |
|---|---|---|
| Medicine / Form | | 6 |
| Dose | Route | 8 |
| | | 12 |
| Signature | Start Date | 14 |
| | | 18 |
| Further Information | | 22 |

| | | |
|---|---|---|
| Medicine / Form | | 6 |
| Dose | Route | 8 |
| | | 12 |
| Signature | Start Date | 14 |
| | | 18 |
| Further Information | | 22 |

| | | |
|---|---|---|
| Medicine / Form | | 6 |
| Dose | Route | 8 |
| | | 12 |
| Signature | Start Date | 14 |
| | | 18 |
| Further Information | | 22 |

| | | |
|---|---|---|
| Medicine / Form | | 6 |
| Dose | Route | 8 |
| | | 12 |
| Signature | Start Date | 14 |
| | | 18 |
| Further Information | | 22 |

| | | |
|---|---|---|
| Medicine / Form | | 6 |
| Dose | Route | 8 |
| | | 12 |
| Signature | Start Date | 14 |
| | | 18 |
| Further Information | | 22 |

| | | |
|---|---|---|
| Medicine / Form | | 6 |
| Dose | Route | 8 |
| | | 12 |
| Signature | Start Date | 14 |
| | | 18 |
| Further Information | | 22 |

## REGULAR THERAPY

Date: 17/11/16 | 18/11/16 | 19/11/16 | 20/11/16 | 21/11/16 | 22/11/16 | 23/11/16

Time: 6 | 8 | 12 | 14 | 18 | 22

**Medicine / Form:** Felodipine MR
**Dose:** 2.5mg
**Route:** oral
**Signature:** EW.
**Start Date:** 16/11/16
**Further Information:**
8: EB KW KW
RW

**Medicine / Form:** Folic Acid
**Dose:** 5mg
**Route:** oral
**Signature:** EW.
**Start Date:** 16/11/16
**Further Information:**
8: EB KW KW DN P K K

**Medicine / Form:** Lansoprazole
**Dose:** 30mg
**Route:** oral
**Signature:** EW
**Start Date:** 16/11/16
**Further Information:**
8: EB KW KW DN P K K
18: EB KW KW K K

**Medicine / Form:** Ticagrelor
**Dose:** 90mg
**Route:** o
**Signature:**
**Start Date:** 17/11/16
**Further Information:** *DECISION TO BE MADE
8: (6) KW KW DN P K K
22: M

**Medicine / Form:** Aspirin
**Dose:** 75mg
**Route:** —
**Signature:**
**Start Date:** 17/11/16
**Further Information:** *DECISION TO BE MADE
8: EB KW KW DN P K K

**Medicine / Form:** Ramipril
**Dose:** 2.5mg
**Route:** ORAL
**Signature:** RW
**Start Date:** 19/11
**Further Information:**
8: — X DN P K K

# REGULAR THERAPY

| Date | 16/11 | 17/11 | 18/11 | 19/11 | 20/11 | 21/11 | 22/11 | 23/11 |
|---|---|---|---|---|---|---|---|---|
| Time | | | 16 | 16 | 16 | 16 | 16 | 16 |

## OXYGEN

Target $O_2$ Saturation

88 – 92%  94 – 98%

Signature | Start Date

Continuous/ PRN

6 | 8 | 12 | 14 | 18 | 22

## THROMBOPROPHYLAXIS

Dalteparin S Cut injection | TEDS | None

Dose: 2500units | 5000units

Signature | Start Date

Fondaparinux

6 | 8 | 12 | 14 | 18 | 22

## Medicine / Form: Bisoprolol

Dose: 2.5mg | Route: oral

Signature | Start Date: 16/11/16

Further Information

8: X 88 kmw DN

## Medicine / Form: Nicotine Patch

Dose: 14mg/24hours | Route: transdermal

Signature | Start Date: 16/11/16

Further Information

22: 6

## Medicine / Form: Fondaparinux

Dose: 2.5mg | Route: S/cut

Signature | Start Date: 16/11/16

Further Information

18: 6 6

## DRUG DOSAGE CALCULATIONS

Usually: Roshvastatin twice weekly
Cilostazol 50mg BD

} Discuss c team.

Tel # 114 (1)

Ward One Telemetry

Name: David Standish Bed: B4B6

CHI: 050370 0053 Reason for admission: NSTEMI

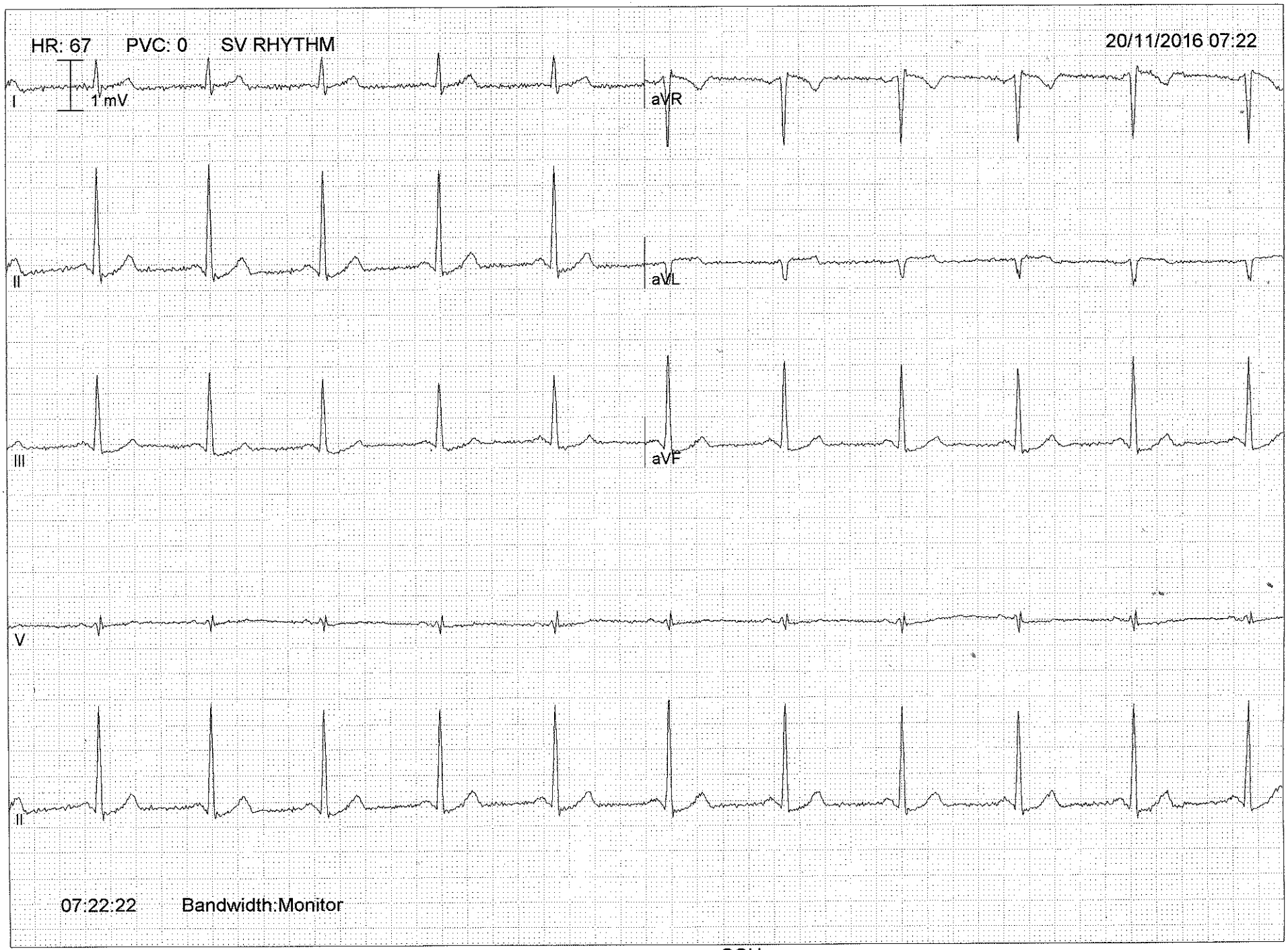
Consultant: AW Angus 22/11/16 ☑

Time on Telemetry: 24 hours
48 hours
Unknown

2x VF arrest

| Date/Time | Rhythm | Rate | Action | Init |
|---|---|---|---|---|
| 20/11/16 0722 | SR | 67 | | me |
| 1210 | S.A. | 66 | HR ↓43. | ON/R |
| 1720 | SR | 65 | | R |
| 2400 | SR | 68 | STV. | me |
| 21/11/16 0600 | SB | 56 | | me |
| 1157 | SR | 68 | | LS |
| 1800 | SR | 73 | | LP |
| 2400 | SR | 73 | | me |
| 22/11/16 0530 | SB | 52 | | me. |
| 1153 | SR | 63 | | LP |
| | VF x2 PCT | | | |
| 1500 | SR | ~~SR~~ 66 | | LP |
| 1800 | SR | 77 | | LP |
| 23/11/16 0015 | SR | 64 | | SL |
| 0545 | SR | 76 | | SL |

Patient Window Report



MARK AS SHOWN

120

60

150 140 130 120 110 100 90 80 70 60 50

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CONSCIOUS LEVEL<br>ANY CHANGE IN RESPONSE - COMMENCE NEURO OBS - IMMEDIATE MEDICAL REVIEW | Alert | A | | | | | | | | | | | | | | | | | | | | | | | | |
| | Verbal | V | | | | | | | | | | | | | | | | | | | | | | | | |
| | Pain | P | | | | | | | | | | | | | | | | | | | | | | | | |
| | Unresponsive | U | | | | | | | | | | | | | | | | | | | | | | | | |
| **NEWS SCORE (with all obs)** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Frequency of observations<br>H = Hourly, M = minutes, D = Daily | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Escalation to medical team/HAN/ANP<br>Y / N / E (exclusion) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INITIAL | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Check patient's Urine Output | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Consider DELIRIUM - 4AT score | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Blood Glucose | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pain Score | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nausea Score | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sedation | | | | | | | | | | | | | | | | | | | | | | | | | | |

If observations are expected for patient's clinical condition, please note expected parameters below

| | Pulse Rate | Respiratory Rate | SpO2 | BP | Temp | |
|---|---|---|---|---|---|---|
| Acceptable Parameters | | | | | | Doctors/NP/ANP<br>Sign<br>Date and time |
| Discontinue Date and Sign | | | | | | |

**DOCUMENT ALL ACTIONS, INTERVENTIONS, EXCLUSIONS AND CLINICAL RESPONSES IN THE NURSING RECORDS**

**CLINICAL CONCERN SHOULD ALWAYS OVERRIDE NEWS SCORE**

| NEWS 0 | NEWS 1-4 | NEWS ≥ 5 OR 3 IN ONE PARAMETER | NEWS ≥ 7 |
|---|---|---|---|
| REFER TO LOCAL ACTION AND ESCALATION POLICY<br><br>MIN 12 HOURLY OBSERVATIONS | MIN 4 HOURLY OBSERVATIONS<br>INFORM REGISTERED NURSE<br>AGREE FREQUENCY OF OBSERVATION REQUIRED<br>RESPONSE WITHIN 60 MINUTES<br>LOW CLINICAL RISK | MIN HOURLY OBSERVATIONS<br>URGENT ASSESSMENT BY MEDICAL TEAM<br>STRUCTURED RESPONSE<br>THINK SEPSIS<br>RESPONSE WITHIN 30 MINUTES<br>MEDIUM CLINICAL RISK | CONTINUOUS MONITORING<br>URGENT ASSESSMENT BY SENIOR MEDICAL TEAM<br>STRUCTURED RESPONSE<br>CONSIDER 2222<br>RESPONSE WITHIN 15 MINUTES<br>HIGH CLINICAL RISK |

## RECOGNISE PAIN

PAINGO **at least** once per shift

Assessment

**0** No pain at rest or on movement
**1** No pain at rest, slight on movement
**2** Intermittent pain at rest, moderate on movement
**3** Continuous pain at rest, severe on movement

If 2 or 3 repeat PAINGO to guide intervention

use ABBEY tool if patient unable to report pain

If 8 or above repeat PAINGO to guide intervention

## NAUSEA AND VOMITING SCORE

(see post op nausea and vomiting guidelines)

**0** No nausea and vomiting
**1** Nausea only
**2** Vomiting once
**3** Vomiting more than once

Intervene at score 1, 2 or 3

## SEDATION SCORE

**0** None (patient alert)
**1** Mild (occasionally drowsy, easy to rouse)
**2** Moderate (frequently drowsy, easy to rouse)
**3** Severe (somnolent, difficult to rouse)

Intervene at score 3

**THINK - UNCONTROLLED PAIN?**

**REFER TO LOCAL ACTION AND ESCALATION POLICY**

# Ninewells Hospital

CORONARY INTERVENTION RECORD

0503700053
307785620
22/11/2016

| | | | |
|---|---|---|---|
| **Name:** | David Standish | **Date:** | 22 November 2016 |
| **Hosp.No.:** | 0503700053 | **Consultant:** | Dr Neil Anglim |
| **CHI No.:** | | **Operators:** | Dr Neil Anglim |
| **Address:** | | **Procedure:** | Multi-Lesion Coronary Intervention<br>K63.4; K49.2; |

Urgent case. Catheterisation via the Right Radial artery, under local anaesthetic.
Artery closure method: Pressure - Helix.

**Guide Catheters:** Judkins R 4.0 (right)
**Guide Wires:** BMW (left)

**Complications:** None (in lab)

❍ **Mid RCA**

**Treatment:** Preliminary: Sprinter NC 15 x 3mm Balloon to 16atm.
Primary: BMX 3 x 18mm DE stent to 16atm.
Further: Trek NC 15 x 3mm Balloon to 18atm.

**Outcome:** Complete success:- stenosis from 99% to 0%

❍ **Right Ostial**

Lesion >10 mm long. Ostial location.

**Treatment:** Preliminary: Sprinter NC 15 x 3mm Balloon to 14atm.
Primary: BMX 3.5 x 14mm DE stent to 14atm.
Further: Trek NC 12 x 3.5mm Balloon to 18atm.

**Outcome:** Complete success:- stenosis from 80% to 0%

**Overall Outcome:** Complete success

**Case Comment:** NSTEMI.Peripheral vascular disease

**Report:** For PCI to RCA mid and proximal lesions.
JR4 guide. Heparin. BMW.
Predilated lesions with 3.0 balloon.
Stented mid vessel lesion with 3.0x18 Biomatrix DES. Stented proximal lesion to ostium with 3.5x14 Biomatrix DES. Postdilated with 3.0NC and 3.5NC respectively.
Good final result.

Plan:
ASPIRIN LIFELONG. TICAGRELOR FOR 6 MONTHS.

Dr N Anglim
Consultant

**signed:**

# Ninewells Hospital

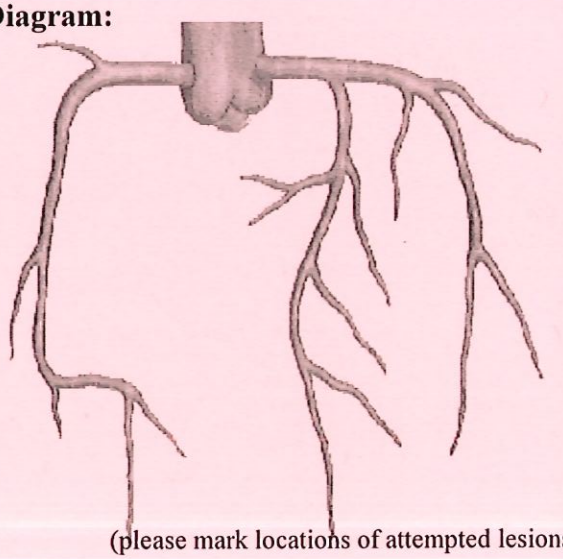
## CORONARY INTERVENTION RECORD

**0503700053 David Standish 22 November 2016**

**Clinical Presentation / Risk Factors:**

Unstable angina (ECG pos, Tn pos)
CCS Class: 0
NYHA Class: I
BMI = 31.9 kg/m2

**Diagram:**



(please mark locations of attempted lesions)

# Ninewells Hospital

Cardiac Catheterisation
Dundee
DD1 9SY

## Patient Information

| | |
|---|---|
| **Patient Name** | Standish, David |
| **Study Date** | 22/11/2016 |
| **MRN** | 0503700053 |
| **Study Number** | 1773 |
| **Account Number** | Dr Hutcheon Elective PCI |
| **Date of Birth** | 05/03/1970 |
| **Age** | 46 Years |
| **Gender** | Male |
| **Race** | Caucasian |
| **Height** | 175 cm (5'9") |
| **Weight** | 95 kg (209 lbs) |
| **BSA** | 2.10 $m^2$ |

## Procedures

| Time | Procedure | Code 1 | Code 2 | Code 3 | Code 4 | Comment |
|---|---|---|---|---|---|---|
| 1:22PM | Right Radial Artery Access | | | | | |
| 1:36PM | Left Coronary Angiography | | | | | |
| 1:36PM | Right Coronary Angiography | | | | | |
| 1:39PM | PCI to single vessel | | | | | RCA |

## Staff

| Duty | Name | IN | OUT |
|---|---|---|---|
| Referring Consultant | Stuart Hutcheon, MD | 1:20PM | |
| Session Consultant | Neil Anglim, MD | 1:20PM | |
| Cardiac Physiologist | Ross Finlayson, CVT | 1:21PM | |
| Cardiac Physiologist | Lynsey Dailly, CVT | 1:21PM | |
| Scrub Nurse | Elaine Bruce, RN | 1:21PM | |
| Circulating Nurse | Susan Purves, RN | 1:21PM | |
| Radiographers | Lyndsey Heaton, RT | 1:21PM | |

## Pressure Summary (mmHg)

| Time | Site | Sys | Dias | End | Mean | A Wave | V Wave | Max dp/dt | HR (BPM) |
|---|---|---|---|---|---|---|---|---|---|
| 1:39PM | AO | 110 | 61 | 0 | 83 | 0 | 0 | 0 | 71 |

# Ninewells Hospital

Cardiac Catheterisation
Dundee
DD1 9SY

## Intervention Summary

CORONARY TYPE OF INTERVENTION

| | | | |
|---|---|---|---|
| **Lesion number:** | 1 | **Intervention type:** | 1 |
| **Coronary segment:** | mRCA | | |
| **Acute closure:** | | **Guidewire crossing:** | Successful |
| **Reopening:** | | | |

| | | | |
|---|---|---|---|
| **Treatment:** | 1 | **Treatment type:** | Balloon |
| **Primary indication:** | | **Success indication:** | |

| | | | |
|---|---|---|---|
| **Max ATM:** | 14 | **Max sec:** | 8 |

| **Supply Name** | **Usage** |
|---|---|
| Emerge Monorail | |
| Sprinter Legend | |

| | | | |
|---|---|---|---|
| **Treatment:** | 2 | **Treatment type:** | Drug Eluting Stent |
| **Primary indication:** | | **Success indication:** | |

| | | | |
|---|---|---|---|
| **Max ATM:** | 16 | **Max sec:** | 20 |

| **Supply Name** | **Usage** |
|---|---|
| Biomatrix Flex | |

| | | | |
|---|---|---|---|
| **Treatment:** | 3 | **Treatment type:** | Balloon |
| **Primary indication:** | | **Success indication:** | |

| | | | |
|---|---|---|---|
| **Max ATM:** | 18 | **Max sec:** | 10 |

| **Supply Name** | **Usage** |
|---|---|
| NC TREK | |

CORONARY TYPE OF INTERVENTION

| | | | |
|---|---|---|---|
| **Lesion number:** | 2 | **Intervention type:** | 1 |
| **Coronary segment:** | pRCA | | |
| **Acute closure:** | | **Guidewire crossing:** | |
| **Reopening:** | | | |

| | | | |
|---|---|---|---|
| **Treatment:** | 1 | **Treatment type:** | Drug Eluting Stent |
| **Primary indication:** | | **Success indication:** | |

| | | | |
|---|---|---|---|
| **Max ATM:** | 12 | **Max sec:** | 20 |

| **Supply Name** | **Usage** |
|---|---|
| Biomatrix Flex | |

| | | | |
|---|---|---|---|
| **Treatment:** | 2 | **Treatment type:** | Balloon |

# Ninewells Hospital

Cardiac Catheterisation
Dundee
DD1 9SY

| Primary indication: | | Success indication: | |
|---|---|---|---|

| Max ATM: | | Max sec: | |
|---|---|---|---|

| Supply Name | Usage |
|---|---|
| NC TREK | |

| Treatment: | 3 | Treatment type: | Balloon |
|---|---|---|---|
| Primary indication: | | Success indication: | |

| Max ATM: | 18 | Max sec: | 8 |
|---|---|---|---|

| Supply Name | Usage |
|---|---|
| NC Trek | |

## Supplies Summary

| Time | Size | Manufacturer | Item Name (Model) | Serial Number | Lot Number | Part Number | Billing Code | Comment |
|---|---|---|---|---|---|---|---|---|
| 1:22PM | 5F | | JL 3.5 | | | | | |
| 1:39PM | 190cm | Abbott | Balance Middleweight Universal 2 | | | 1009664 | | |
| 1:39PM | 6F | BSC | JR 4 | | | 34356-686 | | |
| 1:42PM | 3.0 x 15mm | Boston Scientific | Emerge Monorail | | | 3913-1530 | | |
| 1:45PM | 3.0 X 15MM | MED | Sprinter Legend | | | SPL30015X | | |
| 1:48PM | 3.0MM X 18MM | BIOSENSORS | Biomatrix Flex | | | BMX-3018 | | |
| 1:53PM | 3.5mm x 14mm | Biosensors | Biomatrix Flex | | | BMX-3514 | | |
| 1:57PM | 3.0mm x 15mm | Abbot | NC TREK | | | 1012449-15 | | |
| 1:59PM | 3.5mm x 12mm | Abbot | NC Trek | | | 1012451-12 | | |
| 2:07PM | | | Helix | | | 1306200 | | |

# Ninewells Hospital

Cardiac Catheterisation
Dundee
DD1 9SY

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Tourniquet | | | 1 | | |

## Event Log

| Time | Summary | Comment |
|---|---|---|
| | Phase: | |
| 1:22:15 PM | Procedure: Right Radial Artery Access | |
| 1:22:33 PM | 5F JL 3.5 | |
| 1:22:40 PM | 12-Lead Print | |
| 1:36:08 PM | Procedure: Left Coronary Angiography | |
| 1:36:09 PM | Procedure: Right Coronary Angiography | |
| 1:36:24 PM | Lignocaine Subcut 5 ml | |
| 1:36:49 PM | Nitrocene IA 200 mcg | |
| 1:37:21 PM | Heparin IV 5,000 units | |
| 1:38:21 PM | Diazemuls IV 2.5 mg | |
| 1:38:44 PM | Heparin IV 4,000 units | |
| 1:39:02 PM | Procedure: PCI to single vessel | |
| 1:39:15 PM | 190cm Balance Middleweight Universal 2 | |
| 1:39:27 PM | 6F JR 4 | |
| 1:39:43 PM | AO : 110/61/83, HR = 71, V1 | |
| 1:39:43 PM | Snapshot: AO : 110/61/83 | |
| 1:40:12 PM | Fentanyl IV 25 mcg | |
| 1:42:17 PM | 3.0 x 15mm Emerge Monorail | |
| 1:44:12 PM | Balloon inflated for 8 sec @ 14 atm in the mRCA. | |
| 1:45:27 PM | 3.0 X 15MM Sprinter Legend | |
| 1:47:41 PM | Balloon inflated for 6 sec @ 14 atm in the mRCA. | |
| 1:48:36 PM | 3.0MM X 18MM Biomatrix Flex | |
| 1:49:21 PM | Stent deployed for 20 sec @ 16 atm in the mRCA. | |
| 1:53:05 PM | 3.5mm x 14mm Biomatrix Flex | |
| 1:53:59 PM | Stent deployed for 20 sec @ 12 atm in the pRCA. | |
| 1:57:41 PM | 3.0mm x 15mm NC TREK | |
| 1:58:23 PM | Balloon inflated for 10 sec @ 18 atm in the mRCA. | |
| 1:59:19 PM | 3.5mm x 12mm NC Trek | |
| 1:59:28 PM | Balloon inflated for 5 sec @ 18 atm in the pRCA. | |
| 2:00:25 PM | HEPARIN IC 4,000 units | |
| 2:00:37 PM | Nitrocene IC 200 mcg | |
| 2:00:49 PM | Balloon inflated for 6 sec @ 18 atm in the pRCA. | |
| 2:01:06 PM | Balloon inflated for 8 sec @ 18 atm in the pRCA. | |
| 2:06:08 PM | 12-Lead Print | |
| 2:07:09 PM | Helix Tourniquet | |

## Contrast

| Time | Contrast | Amount (ml) | Comment |
|---|---|---|---|
| 2:06PM | Omnipaque 300mgI/ml | 265 | |

# Ninewells Hospital

Cardiac Catheterisation
Dundee
DD1 9SY

## Complications

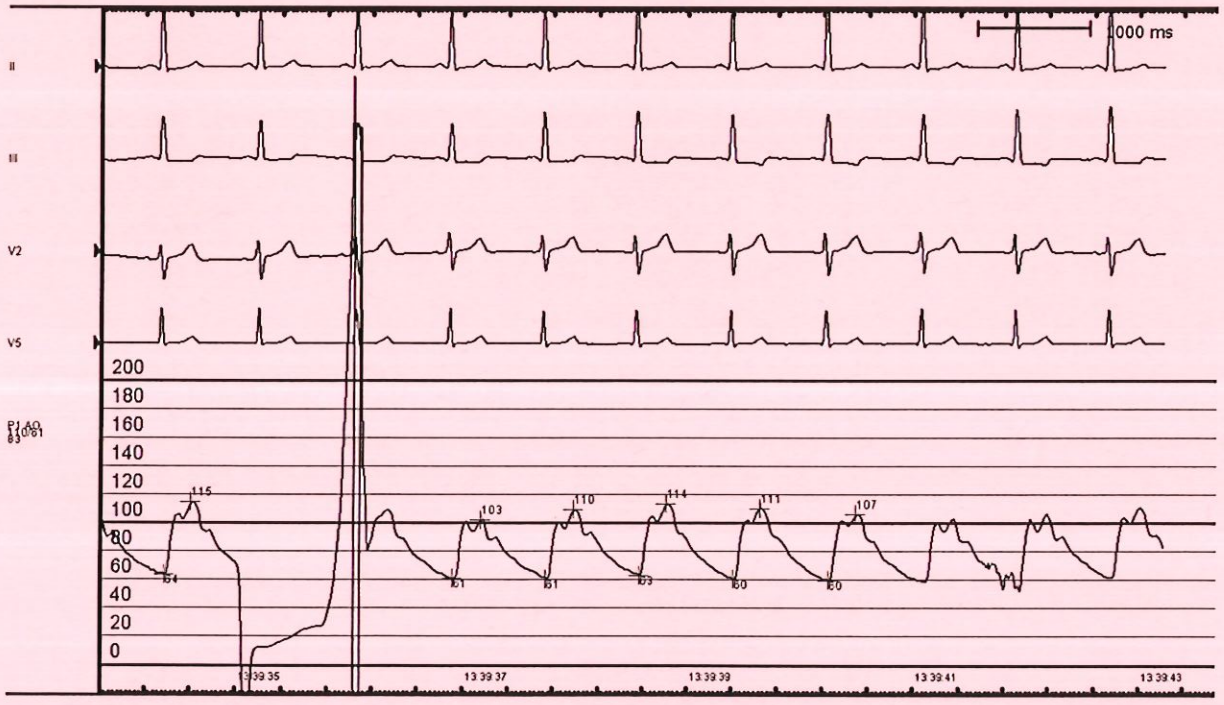
| Time | Complication | Comment |
|---|---|---|
| 2:06PM | VF Arrest | |

## Medication Summary

| Medication | Route | Unit | Total | Billing Code | Type |
|---|---|---|---|---|---|
| Diazemuls | IV | mg | 2.5 | | Other |
| Fentanyl | IV | mcg | 25 | | Opiate Antagonist |
| Heparin | IV | units | 9000 | | Other |
| HEPARIN | IC | units | 4000 | | Other |
| Lignocaine | Subcut | ml | 5 | | Other |
| Nitrocene | IC | mcg | 200 | | Other |
| Nitrocene | IA | mcg | 200 | | Other |

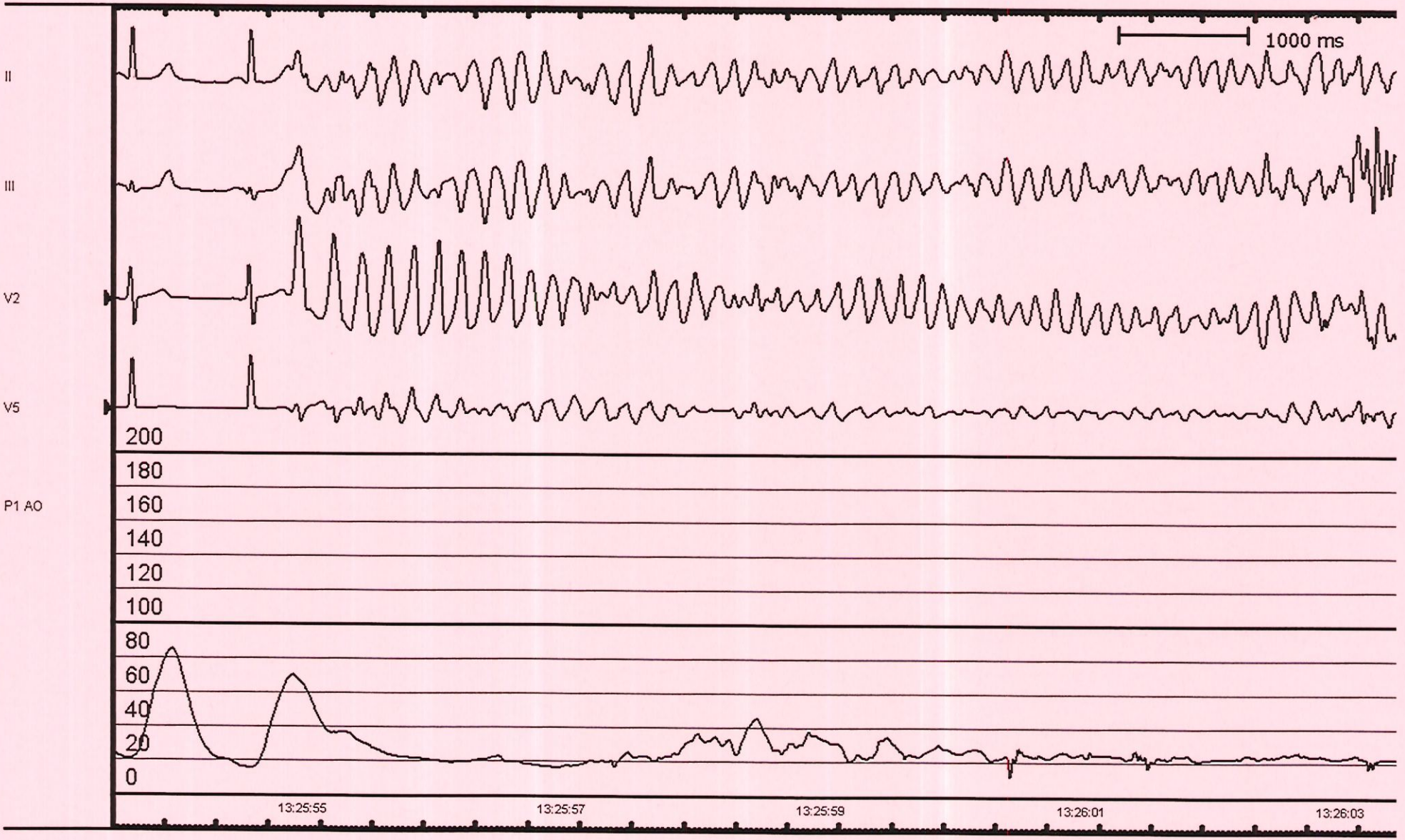
## Snapshots

Snapshot: AO : 110/61/83



Standish, David
22/11/2016 13:25:54
0503700053
Snapshot: Review: Page 1

Ninewells Hospital




Mac-Lab v6.5
GE Medical Systems

Standish, David
22/11/2016 14:06:08
0503700053

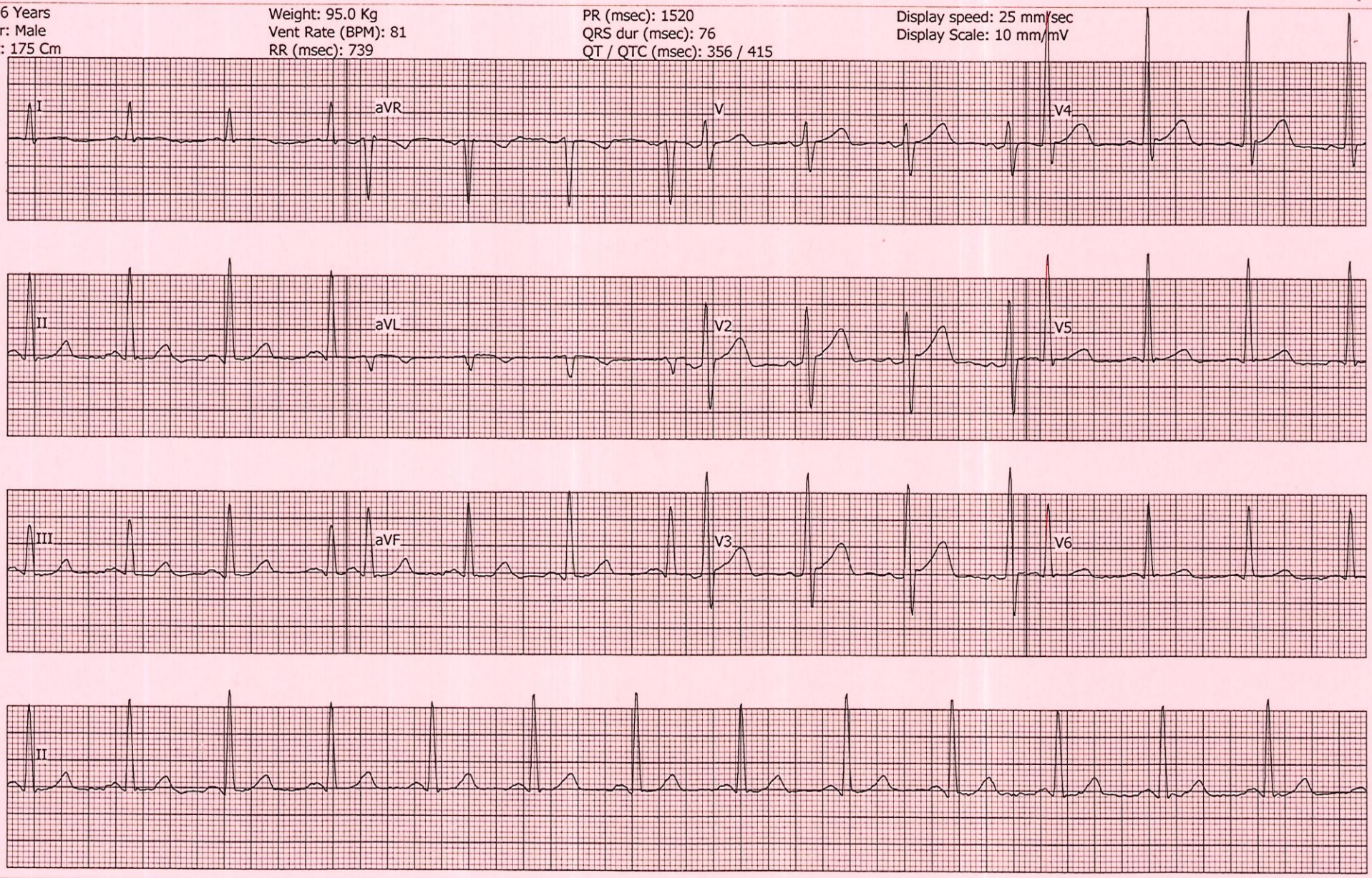
Ninewells Hospital

Age: 46 Years
Gender: Male
Height: 175 Cm

Weight: 95.0 Kg
Vent Rate (BPM): 81
RR (msec): 739

PR (msec): 1520
QRS dur (msec): 76
QT / QTC (msec): 356 / 415

Display speed: 25 mm/sec
Display Scale: 10 mm/mV




Mac-Lab v6.5
GE Medical Systems

Standish, David
22/11/2016 13:22:40
0503700053

SpO2 97%

HR65

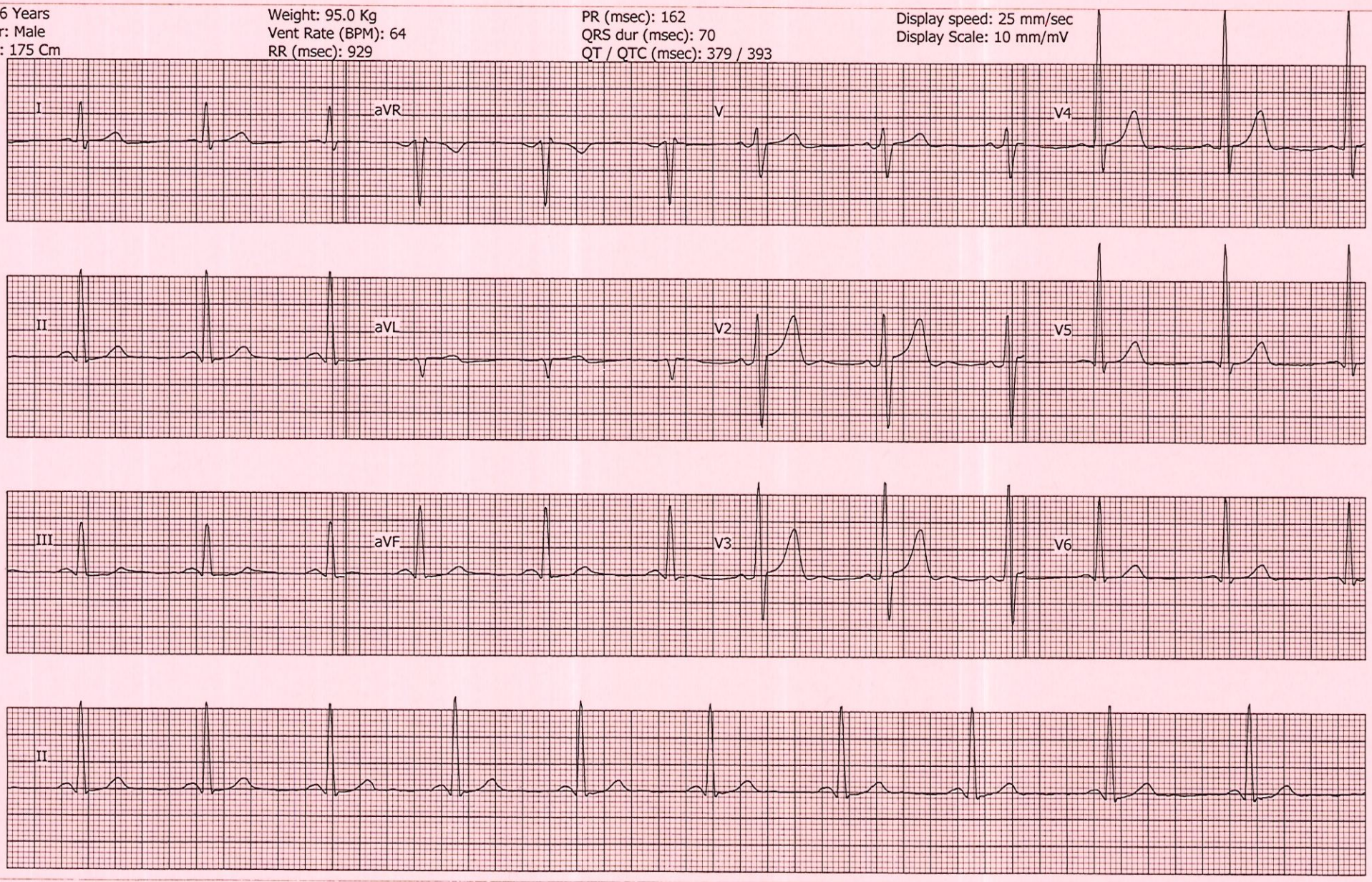
Ninewells Hospital

Age: 46 Years
Gender: Male
Height: 175 Cm

Weight: 95.0 Kg
Vent Rate (BPM): 64
RR (msec): 929

PR (msec): 162
QRS dur (msec): 70
QT / QTC (msec): 379 / 393

Display speed: 25 mm/sec
Display Scale: 10 mm/mV




Mac-Lab v6.5
GE Medical Systems

# Ninewells Hospital

CARDIAC CATHETERISATION DIAGNOSTIC REPORT

0503700053
307785620
22/11/2016

| | | | |
|---|---|---|---|
| **Name:** | David Standish | **Date:** | 22 November 2016 |
| **Hosp.No.:** | 0503700053 | **Consultant:** | Dr Neil Anglim |
| **CHI No.:** | | **Operators:** | Dr Neil Anglim |
| **Address:** | | **Procedures:** | Coronary Angiography - Native vessels<br>K63.4; K49.2; |

Urgent case. Catheterisation via the Right Radial artery, under local anaesthetic.
Artery closure method: Pressure - Helix.

**Catheters:**

**Complications:** None (in lab)

**LV angiogram:** Not performed

**Coronary Arteries:** Right-dominant.

- 75-94% stenosis in the proximal RCA.
- >95% stenosis in the mid RCA.

**Case Comment:** NSTEMI.Peripheral vascular disease

**Report:** Coronary angiogram:
JL3.5 engaged RCA - patient went into VF, sucessfully cardioverted to SR. Once LCA engaged, again, patient went into VF - sucessfully cardioverted.

Right dominant.
LMS, LAD and Cx normal.
RCA had severe Proximal lesion and severe med vessel lesion.

For PCI to RCA mid and proximal lesions

**Recommendation:** Definite PTCA **signed:**

photocopy for medical notes.

NHS
Tayside

# PATIENT INFORMATION SHEET AND CONSENT FORM

| | |
|---|---|
| Study Title: | **A drug utilization study (DUS) of alirocumab in Europe to assess the effectiveness of the dosing recommendation to avoid very low LDL-C levels** |
| Protocol Number: | **OBS14697** |
| Sponsor of the study: | **Sanofi-Aventis Recherche & Développement ("SAR&D")**<br>**1, Avenue Pierre Brossolette**<br>**91385 Chilly Mazarin Cedex, France** |
| Clinical Research Organistation (CRO): | **IQVIA Ltd. (formerly known as Quintiles Limited) 500 Brook Park, Green Park, Reading, Berkshire, RG2 6UU,**<br>**United Kingdom** |
| Name of Investigator (Study Doctor): | Professor Isla Mackenzie |
| Address of Research site: | **Ninewells Hospital and Medical School, Dundee, DD1 9SY, United Kingdom.** |
| Phone number of Research site: | **+44 1382 383 119** |
| Patient ID: | 826001200001 |

**Introduction**
You are invited to take part in an observational research study.

To help you decide, you should understand the study and what it will involve for you. This process is called 'informed consent'. Please take the time to read the following information carefully and feel free to share and discuss it with others. Please ask your doctor if there is anything that is not clear or if you would like more information.

If you decide that you want to take part, you will be asked to sign the attached consent form. If you are unable to read or to sign the form, a witness can sign on your behalf to document that you understand the study and what you have to do. You will be given a copy of the signed and dated Informed Consent Form to keep, and an original will stay at your doctor's office.

**What is the purpose of the study?**
Statins are a group of medicines used to regulate lipid (fat) levels, lowering the bad cholesterol, called low-density lipoprotein cholesterol (LDL-C), that can lead to diseases. Sometimes, to significantly lower the bad cholesterol, statins are prescribed in combination with other medicines that work differently, but have the same effect. One such medicine is PRALUENT® (alirocumab). PRALUENT is an approved and marketed medicine used in the lowering of LDL-C. High levels of LDL-C in the blood can cause conditions such as coronary heart disease,

hypercholesterolaemia and dyslipidaemia. However, the long-term effects of very low levels of LDL-C are not fully understood and are therefore best avoided.

This study will assess how effective the current 3 dosing recommendations of PRALUENT are in avoiding very low LDL-C levels while lowering LDL-C levels. In addition, this study will investigate how the 3 recommended doses of PRALUENT are prescribed in real life and in certain clinical situations.

This study is sponsored by Sanofi Aventis Recherche & Développement (SAR&D), who will be referred to as the 'Sponsor' in this form.

An observational study aims to collect data over time on how a certain treatment is used and its effects, without any change to your normal care. This study is a retrospective study, data are collected from a specific time period that is in the past. This means you will not need to have any additional doctor visits or tests. You are only giving permission to use your medical information already collected for the purpose of this study. This study will not alter or interfere with the normal care you receive in any way.

**Why have you been invited?**
You have been invited to participate in this study because you were prescribed PRALUENT on its own or in combination with other lipid lowering therapies to regulate bad cholesterol.

**How many people will take part in this study?**
Approximately 900 patients will participate in this study, at approximately 210 sites in at least 4 countries in Europe.

**What treatment will you receive?**
Because this is an observational, retrospective study, no medications or other treatments are provided to you by the Sponsor as part of this study. Your doctor prescribed you PRALUENT as part of your regular medical care, and it was not being given to you as part of this study.

**What will happen if you take part in this study?**
We will collect historic data from the time when you started receiving PRALUENT until 6 months later. Overall data collection for all patients will be done over a period of 3 years

If you choose to take part in this study, you will review and sign the Patient Information Sheet and Informed Consent Form (ICF). If you meet all of the study requirements, you will be entered into the study.

You can either sign the consent form at the study site with your doctor or you can sign it at home, this is called remote consenting.

In the latter case, your doctor or a member of his/her study team will contact you over the phone to explain the purpose of the study to you and ask if you want to participate.

You will have as much time as needed to review this document and to think about your participation.

You can ask any question you may have to your doctor at any time; either when he/she calls you or you can also call him/her at the number listed on the first page of this form, before sending back the form.

Once you have decided you want to participate, you will have to sign two copies of this document and provide them back to the study doctor, using the return envelope provided or at your next visit to your doctor.

Upon receipt, your doctor will also sign the forms and you will receive one fully signed form to keep, and the other signed form will stay at the doctor's site.

During the study, the following information will be collected from your medical records, if available:

1. Information about you, which includes:
   - Demographics: age, sex;
   - Height, weight, and body mass index;
   - Smoking status
   - Medical history: data on past conditions you may have had that required a prescription of PRALUENT on its own or in combination with other lipid lowering therapies to regulate bad cholesterol

2. Information about PRALUENT prescription; date of prescription, dosage and how often you took the medicine, number of doses prescribed, number of dose renewals, and reasons for dose modification, if applicable

3. Information about discontinuation of PRALUENT, if applicable, date of discontinuation and reason for discontinuation

4. Information about other lipid lowering therapies you used just before or after PRALUENT prescription but only within the 6-month period of data collection

5. The results of the lipid tests performed as part of your routine care just before initiating PRALUENT and during the 6-month period of data collection

6. Information about adverse events (side effects) that happened during the 6 months of data collection

7. Date you are no longer managed by treating physician, if applicable

**What are your responsibilities if you take part in this study?**
Since this study will look at data that has already been recorded in your medical record, nothing further is expected from you to participate in this study. You will attend your usual doctor's appointments with your doctor and continue to take your regular medication as prescribed by your doctor.

**Will you have to pay to take part in the study?**
You do not have to pay to take part in this study.

**Will you be paid to take part in the study?**
You will not be paid to take part in this study.

**Do you have to take part in the study?**
Your participation in this study is voluntary. Your decision to participate or not participate will not impact the care you receive from your doctor. This research study does not involve treatment for your disease. Your alternative option is to not take part in this research study.

**What are the possible risks of taking part in this study?**

Since the study is observational, it will not change how your treatment is managed by your doctor. There are no physical risks of taking part in this study.

There is a low risk of loss of confidentiality of your personal information; however, steps have been taken to help ensure this will not happen. You will read more about the protection of your information later in this form.

The study may be changed once it has started. If this happens, your doctor will tell you about the new information, and he/she will talk to you about whether you want to remain in the study. If you decide to withdraw from the study, we will stop collecting your data for the study.

**What are the possible benefits of taking part in this study?**
There are no direct benefits for your participation in this study. However, the information collected in this study may lead to an improved understanding of your illness and your treatment management. The findings from this study may provide healthcare providers with important information for treating diseases caused by increased LDL-C in the future.

**What will happen if you are injured as a result of taking part in this study?**
Since the study is observational, and data will be collected only retrospectively, the study will not influence or change how your treatment is managed by your doctor. There are no physical risks associated with taking part in this study. You do not give up any of your legal rights by signing this consent form.

**What if you have a question or problem?**
If you have any questions about this study, you can call your doctor at the number listed on the first page of this document.

If you have any questions about your rights as a research subject, questions about the study, or any concerns or complaints about the research that you do not want to discuss with your doctor or research team, you may contact someone independent from the study at **Patient Advice and Support Service (PASS): Dundee Citizens Advice Bureau, Dundee Central Library, Level 4, Wellgate Centre, Dundee, DD1 1DB. Telephone number: +44 1382 307 494.**

**Complaints contact: NHS Tayside Complaints & Feedback Team, Ninewells Hospital, Dundee, DD1 9SY. Email: Feedback.tayside@nhs.net . Telephone number: +44 800 027 5507.**

**What will happen if you don't want to carry on with the study?**
You can stop taking part in the study and ask for your data not to be used in this study at any time without giving any reason by telling your doctor. This will not affect your future care or your relationship with your doctor.

Your doctor or Sponsor may decide to withdraw you from the study at any time. You may also be withdrawn for any of the following reasons:

- If the study is discontinued by the Sponsor or the regulatory authorities
- If the study doctor or the study site can no longer participate in the study

The study may be stopped at any time, prior to being completed. Your doctor will inform you if the study is stopped for any reason and your normal care will not be affected.

**Will taking part in this study be kept confidential and how will your personal information be used?**

Sanofi-Aventis Recherche & Développement (SAR&D) is the Sponsor for this study based in FRANCE. We will be using information from your medical records in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. SAR&D will keep link-anonymised information about you for 25 years after the study has finished.
Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information by contacting the study doctor or research team. They will then be able to direct your questions to the Sponsor's Data Protection Officer or the Sponsor's Data Representative as needed.

SAR&D will collect information about you for this research study from source. The NHS will keep identifiable information about you from this study for 5 years after the study has finished.

The doctor and research team will collect, record and use personal information about you for the study purposes. Your personal information collected and used during the study may include sensitive information about your physical or mental health or condition, and health information about you in medical records. Your data will be link anonymised using a patient study number and will not contain any identifiable information such as your name or address. Your privacy and your personal information will be protected using measures which follow the requirements applicable in your country for the protection of your personal information. Any information about you that is collected and used during this study will remain confidential.

If you withdraw, no new information about you will be collected, but information that was already collected will continue to be used for the study if it has already been processed and no longer identifiable which patient it came from. You can object to any further processing of your personal information by telling your doctor. Information collected for and used in the study that does not identify you will not be affected by these conditions.

During the study, your collected personal information including your medical files may be disclosed to the Sponsor, its representatives assisting with the study research, study monitors, and to auditors, government or regulatory health authorities. Your medical files will be reviewed only at the hospital (or your doctor's office) in order to check the information and verify the study procedures, without breaking your confidentiality.

All information which is collected about you in records that leave your doctor's office for the purposes of medical, statistical or regulatory activities related to the study research will be identified only by your study patient number. Identifiable information such as your full name or any address details and telephone number will not be included in these link anonymised records but your age and gender will be included.

The information from the study may be published or sent to regulatory authorities or health insurers in your country or other countries where regulatory approval or payment for the medication is required. By signing this consent form, you are giving permission for the processing and use of your personal information for this study. You are also giving permission for your information which has been link anonymised and is only identified by a patient study

number to be transferred to people and organisations (mentioned above) outside the United Kingdom and the European Economic Area (EEA), where personal data protection laws may be different to those in your own country. If your personal information is accessed or processed outside of your country, the Sponsor will ensure that the privacy and confidentiality of your information is protected according to the data protection laws and regulations applicable in your country. You may use your rights under your local data protection laws to access and correct your personal information or ask for it to be deleted.

A description of this clinical study will be available on ENCePP, you can search for it using this number: EUPAS21314. This website will not include information that can identify you. At most, the website will include a summary of the results. You can search this website at any time.

*Help with Data Collection*

Collection of data from the medical files is called data abstraction. In case patient's data from medical records cannot be transferred to the Study Database by study doctor or delegated site staff, a Clinical Data Abstractor/Collector can enter the data on their behalf. The Data Abstractor is an employee of the Clinical Research Organisation (CRO) or the sponsor, delegated to enter medical data into the Study Database in accordance to the patient's data available in the medical files. As the employee of the CRO or the sponsor company, the Data Abstractor will be granted access to the patient's medical records to be able to enter the data to the Study Database and verify the accuracy of these data. As mentioned above your privacy will be kept according to European and national data protection regulations.

**What will happen to the results of this study?**
The overall results of the study may be published in aggregate form; this means that data collected from your medical records will be combined with the data from other patients participating in the study. Your personal information that could identify you will not be used or made available.

**Who has reviewed the study?**
All research studies are reviewed by an independent group of people, called a Research Ethics Committee to protect your safety, rights, well-being and dignity. This study has been reviewed and has been given a favourable opinion by **London-Queen Square Research Ethics Committee.**

**Who should you contact for more information?**
If you have any questions about your participation in the study, please contact your study doctor or research team.

If you have any questions about your personal data protection rights as a participant in this study, or a complaint about the use of your personal information, please liaise with the study doctor or research team. They will then be able to direct your questions to the Sponsor's Data Protection Officer or the Sponsor's Data Representative as needed.

You also have the right to complain about the collection, processing, use, and disclosure of your personal information to your national data protection authority, the Information Commissioner's Office (ICO). The ICO's contact details are: Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF, United Kingdom.
Telephone: +0303 123 1113 (or +44 1625 545745 if calling from overseas)

Fax: 01625 524510
Website: www.ico.org.uk

**Thank you for reading this and considering if you will take part in this study.**

NHS
Tayside

## INFORMED CONSENT FORM

| | |
|---|---|
| Study Title: | **A drug utilization study (DUS) of alirocumab in Europe to assess the effectiveness of the dosing recommendation to avoid very low LDL-C levels** |
| Protocol Number: | **OBS14697** |
| Sponsor of the study: | **Sanofi-Aventis Recherche & Développement ("SAR&D")**<br>**1, Avenue Pierre Brossolette**<br>**91385 Chilly Mazarin Cedex, France** |
| Clinical Research Organisation (CRO): | **IQVIA Ltd. (formerly known as Quintiles Limited) 500 Brook Park, Green Park, Reading, Berkshire, RG2 6UU,**<br>**United Kingdom** |
| Name of Investigator (Study Doctor): | Professor Isla Mackenzie |
| Address of Research site: | **Ninewells Hospital and Medical School, Dundee, DD1 9SY, United Kingdom.** |
| Phone number of Research site: | **+44 1382 383 119** |
| Patient ID: | S26001200001 |

Patient ID added to form here 3/9/2019 SM.

I confirm the following:

| | |
|---|---|
| • I have read and understand the Patient Information Sheet for the above study, and have had enough time to think about taking part. | DS |
| • I am satisfied with the answers given to all of my questions. | DS |
| • I voluntarily agree to be part of this research study and to provide the information the doctor, nurses or other staff members ask from me. | DS |
| • I understand that I am free to withdraw from this study at any time without giving a reason and without my medical care or rights being affected. | DS |
| • I agree that if I decide to withdraw and leave the study, the information and data collected about me up to the point when I withdraw may continue to be used. | DS |
| • I have been informed that I will receive a copy of this information sheet and signed consent form to keep for myself. | DS |
| • I give permission for my personal information to be collected and used as part of this study. I will be identified by a patient number and in this way my data will be:<br>- reviewed, processed and disclosed by and to the Sponsor and its authorised representatives and study monitors for the purposes described in the study protocol;<br>- reviewed or audited by the appropriately authorised organisations; | DS |

| | |
|---|---|
| - published and sent to regulatory authorities or health insurers in my country or other countries; and<br>- transferred, if required, to any country, where laws protecting my personal information may be different to my own. | |
| • I understand I may also be contacted at a later date(s) for my permission in connection with this study or any related sub study. | Patient Initials DAS |

By signing this document, I agree to take part in this study, as set out in the Patient Information Sheet and this Informed Consent Form. Make sure you receive a copy of this form that is signed and dated by both you (or your representative) and the investigator (or their designee). There is no expiration date for this consent form.

DAVID ANDREW STANDISH
Patient (or representative) print your full name

David Standish — 24/7/19
Patient (or representative) sign your name — Patient (or representative) print today's date

**Investigator/Authorised Designee:**

- ✓ I have fully and carefully explained the study to the person named above and confirm that, to the best of my knowledge, they clearly understand the nature this study.
- ✓ I confirm that I gave them all opportunities to ask questions about the study, and that I answered all the questions they asked correctly and to the best of my ability.
- ✓ I confirm that they have not been forced into giving consent, and that they have given their consent freely and voluntarily.
- ✓ I confirm that I will provide a copy of this information sheet and signed consent form to the patient.

ISLA MACKENZIE
Investigator (or authorized designee) print your full name

Investigator (or authorized designee) sign your name — 24 JULY 2019
Investigator (or authorized designee) print today's date

photocopy for medical notes.

NHS
Tayside

## PATIENT INFORMATION SHEET AND CONSENT FORM

| | |
|---|---|
| Study Title: | **A drug utilization study (DUS) of alirocumab in Europe to assess the effectiveness of the dosing recommendation to avoid very low LDL-C levels** |
| Protocol Number: | **OBS14697** |
| Sponsor of the study: | **Sanofi-Aventis Recherche & Développement ("SAR&D")**<br>**1, Avenue Pierre Brossolette**<br>**91385 Chilly Mazarin Cedex, France** |
| Clinical Research Organistation (CRO): | **IQVIA Ltd. (formerly known as Quintiles Limited) 500 Brook Park, Green Park, Reading, Berkshire, RG2 6UU,**<br>**United Kingdom** |
| Name of Investigator (Study Doctor): | Professor Isla Mackenzie |
| Address of Research site: | **Ninewells Hospital and Medical School, Dundee, DD1 9SY, United Kingdom.** |
| Phone number of Research site: | **+44 1382 383 119** |
| Patient ID: | 826001200001 |

**Introduction**
You are invited to take part in an observational research study.

To help you decide, you should understand the study and what it will involve for you. This process is called 'informed consent'. Please take the time to read the following information carefully and feel free to share and discuss it with others. Please ask your doctor if there is anything that is not clear or if you would like more information.

If you decide that you want to take part, you will be asked to sign the attached consent form. If you are unable to read or to sign the form, a witness can sign on your behalf to document that you understand the study and what you have to do. You will be given a copy of the signed and dated Informed Consent Form to keep, and an original will stay at your doctor's office.

**What is the purpose of the study?**
Statins are a group of medicines used to regulate lipid (fat) levels, lowering the bad cholesterol, called low-density lipoprotein cholesterol (LDL-C), that can lead to diseases. Sometimes, to significantly lower the bad cholesterol, statins are prescribed in combination with other medicines that work differently, but have the same effect. One such medicine is PRALUENT® (alirocumab). PRALUENT is an approved and marketed medicine used in the lowering of LDL-C. High levels of LDL-C in the blood can cause conditions such as coronary heart disease,

hypercholesterolaemia and dyslipidaemia. However, the long-term effects of very low levels of LDL-C are not fully understood and are therefore best avoided.

This study will assess how effective the current 3 dosing recommendations of PRALUENT are in avoiding very low LDL-C levels while lowering LDL-C levels. In addition, this study will investigate how the 3 recommended doses of PRALUENT are prescribed in real life and in certain clinical situations.

This study is sponsored by Sanofi Aventis Recherche & Développement (SAR&D), who will be referred to as the 'Sponsor' in this form.

An observational study aims to collect data over time on how a certain treatment is used and its effects, without any change to your normal care. This study is a retrospective study, data are collected from a specific time period that is in the past. This means you will not need to have any additional doctor visits or tests. You are only giving permission to use your medical information already collected for the purpose of this study. This study will not alter or interfere with the normal care you receive in any way.

**Why have you been invited?**
You have been invited to participate in this study because you were prescribed PRALUENT on its own or in combination with other lipid lowering therapies to regulate bad cholesterol.

**How many people will take part in this study?**
Approximately 900 patients will participate in this study, at approximately 210 sites in at least 4 countries in Europe.

**What treatment will you receive?**
Because this is an observational, retrospective study, no medications or other treatments are provided to you by the Sponsor as part of this study. Your doctor prescribed you PRALUENT as part of your regular medical care, and it was not being given to you as part of this study.

**What will happen if you take part in this study?**
We will collect historic data from the time when you started receiving PRALUENT until 6 months later. Overall data collection for all patients will be done over a period of 3 years

If you choose to take part in this study, you will review and sign the Patient Information Sheet and Informed Consent Form (ICF). If you meet all of the study requirements, you will be entered into the study.

You can either sign the consent form at the study site with your doctor or you can sign it at home, this is called remote consenting.

In the latter case, your doctor or a member of his/her study team will contact you over the phone to explain the purpose of the study to you and ask if you want to participate.

You will have as much time as needed to review this document and to think about your participation.

You can ask any question you may have to your doctor at any time; either when he/she calls you or you can also call him/her at the number listed on the first page of this form, before sending back the form.

Once you have decided you want to participate, you will have to sign two copies of this document and provide them back to the study doctor, using the return envelope provided or at your next visit to your doctor.

Upon receipt, your doctor will also sign the forms and you will receive one fully signed form to keep, and the other signed form will stay at the doctor's site.

During the study, the following information will be collected from your medical records, if available:

1. Information about you, which includes:
   - Demographics: age, sex;
   - Height, weight, and body mass index;
   - Smoking status
   - Medical history: data on past conditions you may have had that required a prescription of PRALUENT on its own or in combination with other lipid lowering therapies to regulate bad cholesterol

2. Information about PRALUENT prescription; date of prescription, dosage and how often you took the medicine, number of doses prescribed, number of dose renewals, and reasons for dose modification, if applicable

3. Information about discontinuation of PRALUENT, if applicable, date of discontinuation and reason for discontinuation

4. Information about other lipid lowering therapies you used just before or after PRALUENT prescription but only within the 6-month period of data collection

5. The results of the lipid tests performed as part of your routine care just before initiating PRALUENT and during the 6-month period of data collection

6. Information about adverse events (side effects) that happened during the 6 months of data collection

7. Date you are no longer managed by treating physician, if applicable

**What are your responsibilities if you take part in this study?**
Since this study will look at data that has already been recorded in your medical record, nothing further is expected from you to participate in this study. You will attend your usual doctor's appointments with your doctor and continue to take your regular medication as prescribed by your doctor.

**Will you have to pay to take part in the study?**
You do not have to pay to take part in this study.

**Will you be paid to take part in the study?**
You will not be paid to take part in this study.

**Do you have to take part in the study?**
Your participation in this study is voluntary. Your decision to participate or not participate will not impact the care you receive from your doctor. This research study does not involve treatment for your disease. Your alternative option is to not take part in this research study.

**What are the possible risks of taking part in this study?**

Since the study is observational, it will not change how your treatment is managed by your doctor. There are no physical risks of taking part in this study.

There is a low risk of loss of confidentiality of your personal information; however, steps have been taken to help ensure this will not happen. You will read more about the protection of your information later in this form.

The study may be changed once it has started. If this happens, your doctor will tell you about the new information, and he/she will talk to you about whether you want to remain in the study. If you decide to withdraw from the study, we will stop collecting your data for the study.

**What are the possible benefits of taking part in this study?**
There are no direct benefits for your participation in this study. However, the information collected in this study may lead to an improved understanding of your illness and your treatment management. The findings from this study may provide healthcare providers with important information for treating diseases caused by increased LDL-C in the future.

**What will happen if you are injured as a result of taking part in this study?**
Since the study is observational, and data will be collected only retrospectively, the study will not influence or change how your treatment is managed by your doctor. There are no physical risks associated with taking part in this study. You do not give up any of your legal rights by signing this consent form.

**What if you have a question or problem?**
If you have any questions about this study, you can call your doctor at the number listed on the first page of this document.

If you have any questions about your rights as a research subject, questions about the study, or any concerns or complaints about the research that you do not want to discuss with your doctor or research team, you may contact someone independent from the study at **Patient Advice and Support Service (PASS): Dundee Citizens Advice Bureau, Dundee Central Library, Level 4, Wellgate Centre, Dundee, DD1 1DB. Telephone number: +44 1382 307 494.**

**Complaints contact: NHS Tayside Complaints & Feedback Team, Ninewells Hospital, Dundee, DD1 9SY. Email: Feedback.tayside@nhs.net . Telephone number: +44 800 027 5507.**

**What will happen if you don't want to carry on with the study?**
You can stop taking part in the study and ask for your data not to be used in this study at any time without giving any reason by telling your doctor. This will not affect your future care or your relationship with your doctor.

Your doctor or Sponsor may decide to withdraw you from the study at any time. You may also be withdrawn for any of the following reasons:

- If the study is discontinued by the Sponsor or the regulatory authorities
- If the study doctor or the study site can no longer participate in the study

The study may be stopped at any time, prior to being completed. Your doctor will inform you if the study is stopped for any reason and your normal care will not be affected.

**Will taking part in this study be kept confidential and how will your personal information be used?**

Sanofi-Aventis Recherche & Développement (SAR&D) is the Sponsor for this study based in FRANCE. We will be using information from your medical records in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. SAR&D will keep link-anonymised information about you for 25 years after the study has finished.
Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information by contacting the study doctor or research team. They will then be able to direct your questions to the Sponsor's Data Protection Officer or the Sponsor's Data Representative as needed.

SAR&D will collect information about you for this research study from source. The NHS will keep identifiable information about you from this study for 5 years after the study has finished.

The doctor and research team will collect, record and use personal information about you for the study purposes. Your personal information collected and used during the study may include sensitive information about your physical or mental health or condition, and health information about you in medical records. Your data will be link anonymised using a patient study number and will not contain any identifiable information such as your name or address. Your privacy and your personal information will be protected using measures which follow the requirements applicable in your country for the protection of your personal information. Any information about you that is collected and used during this study will remain confidential.

If you withdraw, no new information about you will be collected, but information that was already collected will continue to be used for the study if it has already been processed and no longer identifiable which patient it came from. You can object to any further processing of your personal information by telling your doctor. Information collected for and used in the study that does not identify you will not be affected by these conditions.

During the study, your collected personal information including your medical files may be disclosed to the Sponsor, its representatives assisting with the study research, study monitors, and to auditors, government or regulatory health authorities. Your medical files will be reviewed only at the hospital (or your doctor's office) in order to check the information and verify the study procedures, without breaking your confidentiality.

All information which is collected about you in records that leave your doctor's office for the purposes of medical, statistical or regulatory activities related to the study research will be identified only by your study patient number. Identifiable information such as your full name or any address details and telephone number will not be included in these link anonymised records but your age and gender will be included.

The information from the study may be published or sent to regulatory authorities or health insurers in your country or other countries where regulatory approval or payment for the medication is required. By signing this consent form, you are giving permission for the processing and use of your personal information for this study. You are also giving permission for your information which has been link anonymised and is only identified by a patient study

number to be transferred to people and organisations (mentioned above) outside the United Kingdom and the European Economic Area (EEA), where personal data protection laws may be different to those in your own country. If your personal information is accessed or processed outside of your country, the Sponsor will ensure that the privacy and confidentiality of your information is protected according to the data protection laws and regulations applicable in your country. You may use your rights under your local data protection laws to access and correct your personal information or ask for it to be deleted.

A description of this clinical study will be available on ENCePP, you can search for it using this number: EUPAS21314. This website will not include information that can identify you. At most, the website will include a summary of the results. You can search this website at any time.

*Help with Data Collection*

Collection of data from the medical files is called data abstraction. In case patient's data from medical records cannot be transferred to the Study Database by study doctor or delegated site staff, a Clinical Data Abstractor/Collector can enter the data on their behalf. The Data Abstractor is an employee of the Clinical Research Organisation (CRO) or the sponsor, delegated to enter medical data into the Study Database in accordance to the patient's data available in the medical files. As the employee of the CRO or the sponsor company, the Data Abstractor will be granted access to the patient's medical records to be able to enter the data to the Study Database and verify the accuracy of these data. As mentioned above your privacy will be kept according to European and national data protection regulations.

**What will happen to the results of this study?**
The overall results of the study may be published in aggregate form; this means that data collected from your medical records will be combined with the data from other patients participating in the study. Your personal information that could identify you will not be used or made available.

**Who has reviewed the study?**
All research studies are reviewed by an independent group of people, called a Research Ethics Committee to protect your safety, rights, well-being and dignity. This study has been reviewed and has been given a favourable opinion by **London-Queen Square Research Ethics Committee.**

**Who should you contact for more information?**
If you have any questions about your participation in the study, please contact your study doctor or research team.

If you have any questions about your personal data protection rights as a participant in this study, or a complaint about the use of your personal information, please liaise with the study doctor or research team. They will then be able to direct your questions to the Sponsor's Data Protection Officer or the Sponsor's Data Representative as needed.

You also have the right to complain about the collection, processing, use, and disclosure of your personal information to your national data protection authority, the Information Commissioner's Office (ICO). The ICO's contact details are: Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF, United Kingdom.
Telephone: +0303 123 1113 (or +44 1625 545745 if calling from overseas)

Fax: 01625 524510
Website: www.ico.org.uk

**Thank you for reading this and considering if you will take part in this study.**

NHS
Tayside

## INFORMED CONSENT FORM

| | |
|---|---|
| Study Title: | **A drug utilization study (DUS) of alirocumab in Europe to assess the effectiveness of the dosing recommendation to avoid very low LDL-C levels** |
| Protocol Number: | **OBS14697** |
| Sponsor of the study: | **Sanofi-Aventis Recherche & Développement ("SAR&D")**<br>**1, Avenue Pierre Brossolette**<br>**91385 Chilly Mazarin Cedex, France** |
| Clinical Research Organisation (CRO): | **IQVIA Ltd. (formerly known as Quintiles Limited) 500 Brook Park, Green Park, Reading, Berkshire, RG2 6UU,**<br>**United Kingdom** |
| Name of Investigator (Study Doctor): | Professor Isla Mackenzie |
| Address of Research site: | **Ninewells Hospital and Medical School, Dundee, DD1 9SY, United Kingdom.** |
| Phone number of Research site: | **+44 1382 383 119** |
| Patient ID: | ..... |

I confirm the following:

| | |
|---|---|
| • I have read and understand the Patient Information Sheet for the above study, and have had enough time to think about taking part. | DS |
| • I am satisfied with the answers given to all of my questions. | DS |
| • I voluntarily agree to be part of this research study and to provide the information the doctor, nurses or other staff members ask from me. | DS |
| • I understand that I am free to withdraw from this study at any time without giving a reason and without my medical care or rights being affected. | DS |
| • I agree that if I decide to withdraw and leave the study, the information and data collected about me up to the point when I withdraw may continue to be used. | DS |
| • I have been informed that I will receive a copy of this information sheet and signed consent form to keep for myself. | DS |
| • I give permission for my personal information to be collected and used as part of this study. I will be identified by a patient number and in this way my data will be:<br>- reviewed, processed and disclosed by and to the Sponsor and its authorised representatives and study monitors for the purposes described in the study protocol;<br>- reviewed or audited by the appropriately authorised organisations; | DS |

| | |
|---|---|
| - published and sent to regulatory authorities or health insurers in my country or other countries; and<br>- transferred, if required, to any country, where laws protecting my personal information may be different to my own. | |
| • I understand I may also be contacted at a later date(s) for my permission in connection with this study or any related sub study. | Patient Initials DS |

By signing this document, I agree to take part in this study, as set out in the Patient Information Sheet and this Informed Consent Form. Make sure you receive a copy of this form that is signed and dated by both you (or your representative) and the investigator (or their designee). There is no expiration date for this consent form.

DAVID ANDREW STANDISH
Patient (or representative) print your full name

David Standish — 24/7/19
Patient (or representative) sign your name — Patient (or representative) print today's date

**Investigator/Authorised Designee:**

- ✓ I have fully and carefully explained the study to the person named above and confirm that, to the best of my knowledge, they clearly understand the nature this study.
- ✓ I confirm that I gave them all opportunities to ask questions about the study, and that I answered all the questions they asked correctly and to the best of my ability.
- ✓ I confirm that they have not been forced into giving consent, and that they have given their consent freely and voluntarily.
- ✓ I confirm that I will provide a copy of this information sheet and signed consent form to the patient.

ISLA MACKENZIE
Investigator (or authorized designee) print your full name

Investigator (or authorized designee) sign your name — 24 JULY 2019
Investigator (or authorized designee) print today's date

HISTORY/CONTINUATION SHEET

UNIT/WARD/DEPT.

Ward/Clinic/
Hosp. .....

STANDISH
DAVID
Surname .... 20 CANNING PLACE
First Name .. DUNDEE
Address .... DD3 7RT
Mill Practice, Arthurstone Medical Pract
G.P. & Address

D D M M Y Y
0503700053
M

C.H.I. No
M. Stat
Se
USE BLOCK LETTERS OR PATIENT LABEL

| DATE | Page ..... |
|---|---|
| 23/7/2019 | A drug utilization study of alirocumab in Europe to assess the effectiveness of the dosing recommendation to avoid very low LDL-C levels Protocol Number ODS14697<br>Sponsor: Sanofi-Aventis Recherche - Développement<br>PI: Prof Isla Mackenzie<br><br>Patient contacted by telephone to ask whether willing to consider taking part in this study. Patient was about to arrive at Ninewells to visit a relative so suggested meeting in person to receive the information sheet and consent form. Study explained to patient. Information sheet + consent form Version 1.0 (08 Mar 2019) provided to patient and arranged to meet in person at 2:30pm on 24/7/19 when he plans to be in Ninewells again to visit relative to complete the informed consent process<br>I MACKENZIE |
| 24/7/2019. 1430 | CONS.<br>Consent taken in person at Ninewells Hospital by PI Prof Isla Mackenzie<br>PIS + ICF Version 1.0 (08 Mar 2019)<br>Patient understood information sheet. Explained study + right to withdraw. Asked questions about GDPR / data - reiterated that a study ID is used but he is identifiable as his name + study ID are held here. Happy with that.<br>Asked questions about different dosing frequencies mentioned in PIS. Explained that dosing practice varies from what is done here. Happy with explanation. Wants to participate<br>Patient signed ICF x 2 copies. Signed by me.<br>Explained a copy will be posted to him once study ID available.<br>Thanked patient for his participation.<br>Copy of ICF to be filed in medical notes<br>I MACKENZIE |
| 24/7/2019 1530 | Investigator CONS.<br>Assigned patient study ID: 826001200001. Confirmed by Site Manager C McCarthy |

| DATE | |
|---|---|
| 06/09/19 | Patient ID added to Informed Consent Form by Prof Mackenzie on 03/09/19. Further copy sent to patient<br>L Hall |
| 04/09/19 | Contacted Nuewells Pharmacy regarding alirocumab prescription Dates for Sanofi DUS Study (28 Nov 17 - 30 May 18)<br>01 Dec 2017 - 75mg<br>27 Feb 2018 - 150mg<br>14 Mar 2018 - 150mg<br>08 May 2018 - 150mg.<br>L Hall. |

NHS Tayside
Ninewells Hospital

NHS Tayside

# Gastroscopy Report

| | | | | | |
|---|---|---|---|---|---|
| Name | **STANDISH, David**<br>**05-Mar-1970 (46y) (M)** | Address | **20 CANNING PLACE**<br>**DUNDEE**<br>**DD3 7RT** | Hospital No.<br>CHI No. | **0503700053**<br>**0503700053** |

Procedure Date
**Thursday 21st July 2016 15:59**

**Case Notes Copy**

### *Referral Details*

| | |
|---|---|
| Patient Category | **NHS/Outpatient/Urgent** |
| Referral Date | **19-Jul-2016** |
| Referral Source | **Out Patients** |
| GP | **FIONA BULLIONS** |

### *Procedure Summary*

| | |
|---|---|
| Endoscopist(s) | **Mr Afshin Alijani** |
| Instrument(s) | |
| Medication | **Throat Spray** |
| Extent of Exam | **Duodenum - Second part** |
| Limitations | **None** |
| Complications | **None** |

### *Referral Reasons*

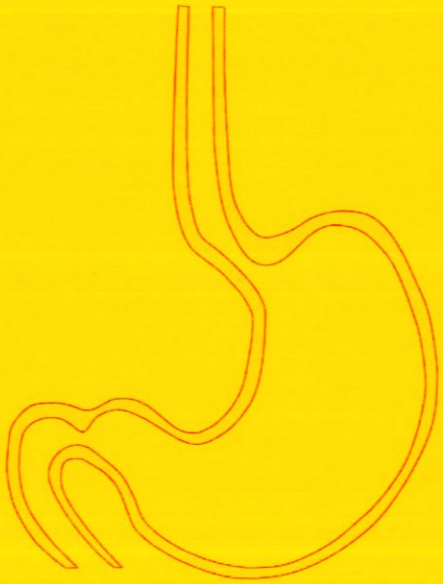
| | |
|---|---|
| Reasons | **Dyspepsia** |
| Co-Morbidities | **None** |
| Current Medication | **None** |
| ASA Status | **Not assessed** |

### *Abnormalities & Procedures*

### *Diagnosis*

### *Report Comments*

**Off Clopidogrel for 2 months. Has had H Pylori eradication therapy. There is now only mild distal gastritis. Normal duodenum and oesophagus. Biopsies from distal stomach sent for histology. CLO test negative.**



### *Follow Up and Recommendations*

Follow Up **Return to Referring Consultant**

Mr Afshin Alijani
CONSULTANT SURGEON

MDC
2/8/16

Case Notes

Printed By Medilogik EMS on 21-Jul-2016 16:02

NHS Tayside
Perth Royal Infirmary

# Gastroscopy Report

| | | | | | |
|---|---|---|---|---|---|
| Name | **STANDISH, David**<br>**05-Mar-1970 (45y) (M)** | Address | **20 CANNING PLACE**<br>**DUNDEE**<br>**DD3 7RT** | Hospital No.<br>CHI No. | **0503700053**<br>**0503700053** |

Procedure Date
**Tuesday 24th November 2015 14:18**

**Ref. Consultant Copy**

## Referral Details

| | |
|---|---|
| Patient Category | **NHS/Outpatient/Routine** |
| Referral Date | **02-Nov-2015** |
| Referral Source | **Gastroscopy Outpatient** |
| GP | **FIONA BULLIONS** |

## Procedure Summary

| | |
|---|---|
| Endoscopist(s) | **Ms Beverly Lim** |
| Instrument(s) | |
| Medication | **Throat Spray** |
| Extent of Exam | **Duodenum - Second part** |
| Limitations | **None** |
| Complications | **None** |

## Referral Reasons

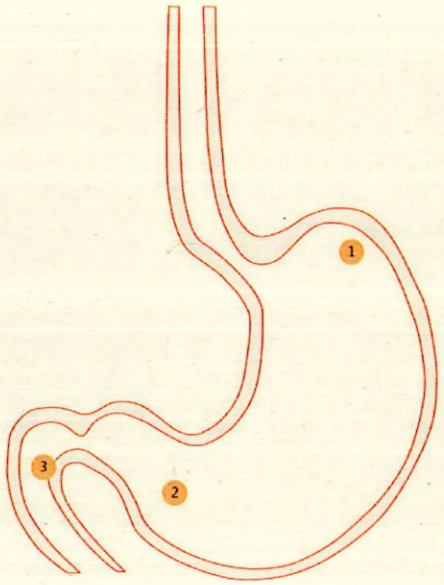
| | |
|---|---|
| Reasons | **Abdominal distress/pain** |
| Co-Morbidities | **Arterial disease** |
| Current Medication | **Lansoprazole** |
| ASA Status | **II** |

## Abnormalities & Procedures

Region: Stomach
**1 - Fundus**
- **Patchy Erythematous mucosa**

**2 - Antrum**
- **Generalised Erythematous mucosa**
- **4 x Biopsy taken and placed in 1 container**

Region: Duodenum
**3 - First part**
- **Patchy Erythematous mucosa**




## Diagnosis (recorded at procedure)

**Oesophagus - Normal**
**Stomach - Gastritis (Hyperemic)**
**Duodenum - Duodenitis (Hyperemic)**

## Report Comments

**On clopidogrel for peripheral vascular disease. Small single erosion in fundus. Severe gastritis mainly in antrum and mild duodenitis in D1. Biopsies taken. Needs to continue lansoprazole.**

## Follow Up and Post Pathology Recommendations

| | |
|---|---|
| Diagnosis (Post Pathology) | **Awaiting Results** |
| Follow Up | **Return to Referring Consultant** |

Ms Beverly Lim
Consultant

CB 15/12

**Tayside Pathology Laboratories**
**Ninewells Hospital, Dundee**

**BIOPSY REPORT**

| | | |
|---|---|---|
| STANDISH, David | 05 Mar 1970 | TS15028053 |
| PRI Endoscopy | | CHI No. 0503700053 |
| Clinician Mr Christopher PAYNE | | |
| Date Recvd 26 Nov 2015 | Date Issued 04 Dec 2015 | |

Nature of Specimen(s)

Antrum

Clinical Information Supplied

Gastritis on Clopidogrel

09 DEC 2015

Macro Report

Two fragments up to 3mm

Micro Report

Sections show multiple fragments of gastric antral type mucosa with marked regeneration and marked chronic active inflammation. No evidence of Helicobacter pylori on special stains. No evidence of dysplasia or malignancy.

**Conclusion**

Mixed features of chronic active gastritis and chemical type gastritis. Clinical correlation and exclusion of Helicobacter pylori infection by other methods is strongly recommended.

Signature of Pathologist(s)

Dr SV Walsh
PFT



PENDOS PAYC1H

ACKNOWLEDGEMENT OF RECEIPT

| WARD SECRETARY | DOCTOR |
|---|---|
| 08 DEC 2015 | |

THB(MR)309

NHS Tayside
Perth Royal Infirmary

# Gastroscopy Report

| | | | | | |
|---|---|---|---|---|---|
| Name | **STANDISH, David**<br>**05-Mar-1970 (45y) (M)** | Address | **20 CANNING PLACE**<br>**DUNDEE**<br>**DD3 7RT** | Hospital No.<br>CHI No. | **0503700053**<br>**0503700053** |

Procedure Date
**Tuesday 24th November 2015 14:18**

**Case Notes Copy**

## Referral Details

| | |
|---|---|
| Patient Category | **NHS/Outpatient/Routine** |
| Referral Date | **02-Nov-2015** |
| Referral Source | **Gastroscopy Outpatient** |
| GP | **FIONA BULLIONS** |

## Procedure Summary

| | |
|---|---|
| Endoscopist(s) | **Ms Beverly Lim** |
| Instrument(s) | |
| Medication | **Throat Spray** |
| Extent of Exam | **Duodenum - Second part** |
| Limitations | **None** |
| Complications | **None** |

## Referral Reasons

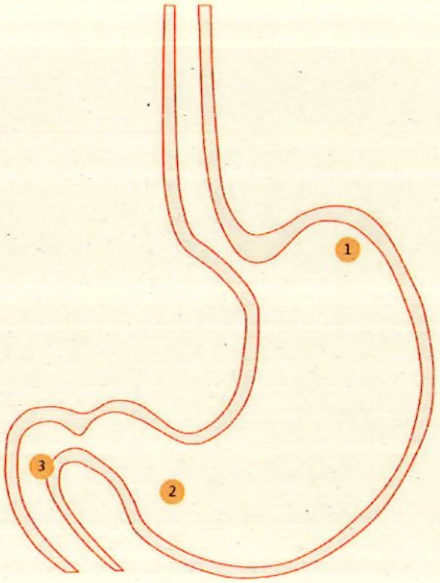
| | |
|---|---|
| Reasons | **Abdominal distress/pain** |
| Co-Morbidities | **Arterial disease** |
| Current Medication | **Lansoprazole** |
| ASA Status | **II** |

## Abnormalities & Procedures

Region: Stomach
**1 - Fundus**
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**2 - Antrum**
- **Generalised Erythematous mucosa**
- **4 x Biopsy taken and placed in 1 container**

Region: Duodenum
**3 - First part**
- **Patchy Erythematous mucosa**




## Diagnosis (recorded at procedure)

**Oesophagus - Normal**
**Stomach - Gastritis (Hyperemic)**
**Duodenum - Duodenitis (Hyperemic)**

## Report Comments

**On clopidogrel for peripheral vascular disease. Small single erosion in fundus. Severe gastritis mainly in antrum and mild duodenitis in D1. Biopsies taken. Needs to continue lansoprazole.**

## Follow Up and Post Pathology Recommendations

| | |
|---|---|
| Diagnosis (Post Pathology) | **Awaiting Results** |
| Follow Up | **Return to Referring Consultant** |

Ms Beverly Lim
Consultant

# ENDOSCOPY CARE PATHWAY

NHS Tayside

STANDISH
DAVID
20 CANNING PLACE
DUNDEE

DD3 7RT

0503700053

Affix patient label here

Fiona Bullions

**Patients telephone number** 07402 993659.

**Next of Kin**
Name..... Mrs A Glen Standish.
Address ..4 Leat Place..... DD3 6QH.
Tel No.....01382 819469.
Relationship...Mother.....

**Planned Procedure**
Gastroscopy EUS Flexible Sigmoidoscopy Colonoscopy

**Date:** 24/11/15 **Time:** 1350

**Referring Consultant**
No referral - see letter in notes

**Patient Escort Details**
Self - discharge.

| PRINT NAME | DESIGNATION | SIGNATURE | INITIALS |
|---|---|---|---|
| Rachel Chandler | SN | RC | RC |
| ARLENE PHILLIPS | SIN | [illegible] | [illegible] |
| LINDA FINNIE | SN | L Finnie | LF |
| MARIE ANDERSON | SN | [illegible] | [illegible] |
| | | | |

**PRE-PROCEDURE**

| | |
|---|---|
| Patient likes to be known as: | David. |
| Case notes available | RC |
| Pre-admission assessment completed and with patient | RC joint replacement NO. pace maker /icd NO. |
| Name band/~~Drug Allergy~~ band in situ | RC. |
| If patient is on medication what has been taken today: | Clopidogrel, felodipine, Folic acid atorvastatin 11:00. |
| Patient last ate at date: 23/11/15. time: PM. | |
| Patient last had fluids at date: 24/11/15. time: 2 hours ago H2O. | |
| Bowel preparation tolerated yes/no describe: Phosphate enema picolax x klean prep x moviprep x | |
| Blood sample obtained if indicated | INR NA. Blood Glucose NA. |
| Procedure and plan of care explained | RC. |
| Is consent form signed RC. | check CJD No risk |
| Sedation options discussed | RC. |
| Patient preference: With sedation Without sedation | (Throat Spray) Entonox |
| Patient advised not to drink alcohol, sign legal documents, drive or operate machinery for 24 hours post sedation | NA |
| Patient understands discharge advice | RC. |
| Patient consent obtained to inform escort of procedure outcome | NA. |
| Any mobility issues ~~NO~~ Mobile x1. pressure sore assessment | NA. |
| Venous access site | NA |
| Communication barriers NO | interpreter required NO |

**I have received written and verbal discharge advice**
**I give /~~do not give~~ (delete as necessary) consent to you to inform escorting adult of procedure outcome**

NA.

Patient signature..D. Standish..... Nurses initials: RC.

Lansoprazole stopped for a few months on clopidogrel

## MEDICINE RECORDING SHEET

| Date | Medicines (once only prescriptions) | Dose &Form | Time of Admin | Method or Site | Signature | Given By Signature |
|---|---|---|---|---|---|---|
| | Oxygen | 2litres/min | | | | |
| | Symptomatic Relief Policy as per MCGD | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| **Known Allergies :** | | | | | | |

## INTRA-PROCEDURE

| | |
|---|---|
| Patient identity confirmed ✓ | safety pause undertaken ✓ |
| Consent form correctly and accurately/completed and signed ✓ | |
| Artificial aids present? (please circle) Spectacles Contact Lenses Hearing aid Dentures Other (Specify) | |
| IV Sedation given NO | |
| Xylocaine spray administered at (record time) 1415 | |
| Oxygen therapy at 2 litres/min administered during procedure ✓ | |

Start time: 1415 Finish time: 1420

Biopsies Performed Yes ☑ No ☐

Urease Test YES/NO RESULT: POSITIVE/NEGATIVE

| | |
|---|---|
| 1 Antral | 2 |
| 3 | 4 |
| 5 | 6 |
| 7 | 8 |

**Single Use Items Label**

Boston Scientific
Radial Jaw™ 4
2.8mm
GTIN 08714729745549
REF M00513330
LOT 18295573

Reprocessor ID: 1
Cycle: 4376

Manual Wash:
17-11-2015 - 15:22
Processed Time:
17-11-2015 - 16:08

EDGE
RE-ORDER CODE FPLB 378
Tel. +44 1454 322777

Perth Royal Infirmary
GASTROSCOPE

Scope Code 3000043
User Code 987093
Lot No 00179
Serial No 2846379

DO NOT USE IF PACKING IS DAMAGED OR OPEN
STORE IN A CLEAN DUST FREE ENVIRONMENT

| SBAR Handover to Endoscopy Recovery Nurse | |
|---|---|
| 1. Situation | 2. Background |
| State patient details: | Summary of relevant history, procedure performed, medication given and care given intra-procedure. |
| 3. Assessment | 4. Recommendations |
| Provide details of current observations, sedation, pain and nausea scores | Inform the nurse of any further monitoring and any specific discharge information |

Nurses initials:



AP

## OBSERVATION CHART

| Date | 24/11/15 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Time | o/a | | | 2 1630 | | | | | | |
| 240 | | 1415 | 14 | | | | | | | |
| 230 | | | | | | | | | | |
| 220 | | | | | | | | | | |
| 210 | | | | | | | | | | |
| 200 | | | | | | | | | | |
| 190 | | | | | | | | | | |
| 180 | | | | | | | | | | |
| 170 | | | | | | | | | | |
| 160 | | | | | | | | | | |
| 150 | | | | | | | | | | |
| 140 | | | | 134 | | | | | | |
| 130 | 122 | | | | | | | | | |
| 120 | | | | | | | | | | |
| 110 | | | | | | | | | | |
| 100 | | | | | | | | | | |
| 90 | | | | | | | | | | |
| 80 | 85 | | | | | | | | | |
| 70 | 75 | 70 | | 79 | | | | | | |
| 60 | | | | (72) | | | | | | |
| 50 | | | | | | | | | | |
| 40 | | | | | | | | | | |
| 30 | | | | | | | | | | |
| Temperature | 36 | | | – | | | | | | |
| Respiratory Rate | 14 | | | – | | | | | | |
| O2 Rate | A | air | 2 | (A) | | | | | | |
| SpO2 | 97 | 96 | 98 | 96 | | | | | | |
| Sedation Score | – | 0 | 0 | – | | | | | | |
| Pain Score | 0 | 0 | 0 | – | | | | | | |
| Nausea Score | 0 | 0 | | – | | | | | | |
| | | | | | | | | | | |
| Blood glucose levels (mmols) | NA | | | – | | | | | | |
| SEWS SCORE | 0 | | | ✓ | | | | | | |

**Sedation Scale**
0=Alert
1= Drowsy, easy to rouse
2= Drowsy, difficult to rouse
3 = Somnolent, unable to rouse

**Pain Scale**
0 = No pain
1= Mild pain
2= Moderate pain
3 = Severe pain

**Nausea Scale**
0 = No nausea
1 = Mild nausea
2 = Nausea and/or vomiting
3 = Persistent nausea and/or vomiting

**SEWS SCORE**
0 = Fit for discharge, if able
1-2 = Continue to monitor every 15 minutes
3 in one parameter or > 3 = Inform Nurse in Charge/Endoscopists and continue to monitor

| SEWS | Score: | | | | |
|---|---|---|---|---|---|
| | Respiration Rate | SpO2 | Temperature | Pulse | Systolic BP |
| 3 | 36+ | | | 130+ | |
| 2 | 31-35 | | 38.5+ | 110-130 | 200+ |
| 1 | 21-30 | | 38.0 – 38.5 | 100-110 | |
| 0 | 9-20 | 94+ | 36.0 – 37.9 | 50-100 | 100-200 |
| 1 | | 90-93 | 35.5 – 35.9 | 40-50 | 80-100 |
| 2 | | 85-89 | 35.0 – 35.4 | 30-40 | |
| 3 | <=8 | ↓85 | ↓35.0 | ↓30 | ↓80 |

## POST PROCEDURE

| **Intervention for patients who have received IV Sedation** |
|---|
| Patient nursed in recovery position |
| Oxygen therapy continued at 2 litres/minute until patient awake and orientated |
| Oxygen saturation, Sedation, Pain & Nausea levels monitored until patient awake and orientated |
| Vital signs monitored until patient awake and orientated |
| Nurses initials: |
| **Interventions for patients who have received Throat Spray** |
| Vital signs stable in room yes/no |
| Pain & Nausea levels monitored |
| Patient can restart fluids/diet 30 – 60 minutes post procedure |
| Nurses initials |
| **Interventions for patients who have not received IV sedation and/or throat spray** |
| Vital signs stable in room yes/no |
| Pain levels monitored |
| Nausea levels monitored |
| Nurses initials: |

## DISCHARGE

| |
|---|
| Patient alert and orientated |
| Tolerating oral fluids |
| Venflon removed |
| **If patient has received IV sedation** Responsible adult to accompany patient home |
| Property returned to patient/carer |
| Report, advice sheet and verbal explanation given to: Patient ☑ Carer ☐<br>Private discussion offered to patient and carer |
| Educational Leaflets given to patient as applicable |
| Patient fit for discharge time: 1435<br><br>Nurses initials: |

| SBAR Handover to Ward Nurse | |
|---|---|
| 1. Situation | 2. Background |
| State patient details: | Summary of relevant history, procedure performed and care given intra-procedure and in recovery. Provide instructions from endoscopist |
| 3. Assessment | 4. Recommendations |
| Provide details of intravenous infusions, current monitoring, SEWS, sedation, pain and nausea scores | Confirm patient's condition is suitable for return to ward. Ask if ward nurse requires any additional information. |

**Variance to care pathway**

| Date | Time | Multi-disciplinary progress notes | initials |
|---|---|---|---|
| 24/11/15 | 1420 | Procedure tolerated well | [illegible] |
| | | | |
| | | | |
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STANDISH
DAVID
20 CANNING PLACE
DUNDEE

DD3 7RT

0503700053 IS
ide

Fiona Bullions

# NHS Tayside Consent Form

Name of procedure(s): **Gastroscopy**

Inspection of the upper gastrointestinal tract with a flexible e
and photography/video).

Biopsy specimens will be retained.

---

**Statement of patient**

You have the right to change your mind at any time, including after you have signed this form.

**I have read** and understood the information in the attached booklet including the benefits and any risks.

**I agree** to the procedure described in this booklet and on the form.

**I understand:**

- That any procedure in addition to those described above will only be carried out if it is necessary to save my life or to prevent serious harm to my health.
- That you cannot give me a guarantee that a particular person will perform the procedure. The person will however, have appropriate experience.
- Information, including digital information (video and/or photographic material) may be stored as part of the patients medical records and may be stored on computer databases.

The University of Dundee is very active in medical research: donations of excess body tissues and agreement to the use of images are a valuable resource for researchers and clinical scientists.

Please tick (✓) the appropriate box if you agree to:

☐ Excess body tissue not required for diagnosis or future treatment being used for medical research

☐ Digital images (for example – such as described above) being used for research, education and teaching in presentations (for example – conferences or websites) and in publications. Whenever relevant, such images will be anonymised to protect patient privacy.

(If consent is withdrawn at a later date, it may not be possible to withdraw images that are already in the public domain.)
NB: Medical staff – you must complete the appropriate clinical photography forms.

**Have you ever** been notified that you are at increased risk of CJD or vCJD for public health purposes?
(Please tick) Yes ☐ No ☑

**Patient Signature:** D. Standish **Date:** 24/11/17

**Name (print in capitals):** DAVID STANDISH

If you would like to ask further questions please do not sign the form now. Bring it with you and you can sign it after you have talked to the healthcare professional.

**Please remember to bring this booklet and form with you when attending for your appointment.**

## Confirmation of consent

(To be completed by a health professional when the patient is admitted for the procedure).

I have confirmed that the patient/parent understands what the procedure involves including the benefits and any risks.

I have confirmed that the patient/parent has no further questions and wishes the procedure to go ahead.

**Signed:** ..... **Date:** 22/11/15 24/11/15

**Name (print in capitals):** DAVID STANDISH RACHEL CHANDLER

**Job title:** SN

**Additional discussions with patient**

**Endoscopist signature:** ..... **Date:** .....

This questionnaire is designed to help the doctors and nurses looking after you when you have your endoscopy. If you find any question difficult to answer, please contact your GP or telephone the Endoscopy Unit.

Name...DAVID STANDISH.....

Date of Birth...05/03/70.....

Please tick appropriate box

1. Do you currently have, or have you ever had any of these problems?

| | Yes | No | Comments |
|---|---|---|---|
| Lung problems (asthma – pneumonia – bronchitis – emphysema - breathlessness | ✓ | | ASTHMA |
| Heart attack, heart failure, angina or any other heart or valve problems | | ✓ | |
| Rheumatic fever | | ✓ | |
| High Blood pressure | ✓ | | |
| Stroke | | ✓ | |
| Fainting, dizzy spells or blackouts | | ✓ | |
| Seizures or epilepsy | | ✓ | |
| Anaemia or blood problems | ✓ | | |
| Bruising or bleeding problems | | ✓ | |
| Liver problems or hepatitis | ~~✓~~ | ~~✓~~ | |
| Diabetes | | ✓ | |
| Addisons Disease | | ✓ | |
| Arthritis | ✓ | | |
| Joint replacement, orthopaedic implants | | ✓ | |
| Abdominal surgery | | ✓ | |
| Glaucoma or any other eye problems | | ✓ | |

Any other illness (please specify)

PERIPHERAL ARTERIAL DISEASE

2. Please list any medicines you are taking, the amount and the number of times per day (including any herbal / homeopathic remedies).

| Medicine | Amount taken | Times per day |
|---|---|---|
| CLOPIDOGREL | 75mg | 1 a day |
| FELODIPINE | 2.5mg | 1 a day |
| FOLIC ACID | 5mg | 1 a day |
| LANSOPRAZOLE | 30mg | 1 a day |
| ATORVASTATIN | 10mg | 1 a day |
| EZETIMIBE | 10mg | 1 a day |
| FENOFIBRATE | 200mg | 1 a day |

3. Do you take Warfarin, Heparin, Aspirin or Clopidogrel?

Yes ☑ No ☐

4. Are you **allergic or sensitive** to anything (medicines or adhesive tape)?

Yes ☐ No ☑

If Yes, please list below and describe what happened in each case

5. Do you smoke?

Yes ☑ No ☐

6. How many units of alcohol do you drink in one week?
(1 unit is half a pint of beer, a small glass of wine or 1 measure of spirit)

0

7. Do you have any cultural or religious needs?

Yes ☐ No ☑

If Yes, please give details

8. Do you have any special needs that we may need to be aware of?

Yes ☐ No ☑

If Yes, please give details

9. Please make a note of anything that you particularly wish to ask staff or discuss with them.

10. If you are having a **gastroscopy or colonoscopy with sedation**, someone **must** accompany you home and stay with you for 12 hours.

**Escorts Name:**.....

**Telephone Number:**.....

Reviewed by Endoscopy Patient Information Group
Reviewed: 09/2013 Review: 09/2015 LN0469

NHS Tayside

# Pre-Endoscopy Questionnaire

Please bring this form with you when attending for your endoscopy

**Ninewells Hospital**
Telephone: 01382 632750
**Perth Royal Infirmary**
Telephone: 01738 473825
**Stracathro Hospital**
Telephone: 01356 665012

Version 2

Ninewells Hospital

# Echocardiography Report

NHS Tayside

| | | |
|---|---|---|
| **Name:** STANDISH, DAVID | **Study Date:** 17/11/2016 11:49 | |
| **MRN:** 0503700053 | **Patient Location:** NW ward 21 | **Patient Class:** Inpatient |
| **DOB:** 05/03/1970 (dd/MM/yyyy) | **Gender:** Male | |
| **Age:** 46 yrs | | |
| **Reason For Study:** LV function post MI | | |
| **Image Quality:** Adequate image quality. | | |
| **Performed By:** GMY | **Referring Physician:** DR SD HUTCHEON | |
| **Echo Machine:** IE33 4 | | |

**Aortic Valve**
The aortic valve is normal in structure and function. No aortic stenosis. No aortic regurgitation.

**Mitral Valve**
Mildly thickened leaflets, seen to open well. No mitral stenosis. Trace mitral regurgitation.

**Tricuspid Valve**
Normal in structure and function. No tricuspid stenosis. Physiological tricuspid regurgitation.

**Pulmonary Valve**
Normal in structure and function. No pulmonary stenosis. Physiological pulmonary regurgitation.

**Left Ventricle**
Normal LV systolic function. Normal LV size. No LV hypertrophy.

**Regional Wall Motion Abnormalities**
No obvious regional wall motion abnormality noted.

**Right Ventricle**
Normal right heart size and function.

**Atria**
The LA is mildly dilated. Normal RA size. The interatrial septum appears intact with no evidence of a defect.

**Great Vessels**
Undilated aortic root.

**Pericardium/Pleural**
No pericardial effusion.

**Inferior Vena Cava**
Normal IVC with complete inspiratory collapse.

**ECG**

Sinus Rhythm 74 BPM.

**CONCLUSION**

**Normal LV size and systolic function.**
**Normal RV size and systolic function**
**The LA is mildly dilated. Normal RA size.**
**No significant valvular pathologies.**
**No significant pericardial effusion.**

---

**LV - 2D and M Mode**

LVIDd: 5.2 cm
LVIDs: 4 cm
IVSd: 1.1 cm
LVPWd: 0.9 cm
LVOT diam: 2.0 cm

**RV - 2D and M Mode**

TAPSE: 1.7 cm

**Atrial Dimensions**

LA dimension: 3.6 cm
LA 4ch area: 29 $cm^2$
RA area: 14.7 $cm^2$

**AO - 2D and M Mode**

Ao root diam: 3.5 cm

**AV - 2D and M Mode**

DVI: 0.96

**AV - Doppler**

Ao V2 max: 1.7 m/sec
Ao max PG: 12 mmHg
Ao mean PG: 6 mmHg
Ao V2 VTI: 32.8 cm
AVA(I,D): 2.8 $cm^2$
AVA(V,D): 2.9 $cm^2$
LV V1 max PG: 10.9 mmHg
LV V1 max: 1.6 m/sec
LV V1 VTI: 29.7 cm

**MV - Doppler**

MV E max vel: 0.8 m/sec
MV A max vel: 0.7 m/sec
MV E/A: 1.2
MV dec time: 180 msec

**TV - Doppler**

TR Max PG: mmHg

**TDI Doppler**

Med Peak E' Vel: 8 cm/sec
Med Peak S Vel: 9 cm/sec
E/E' tdi Med: 10.4
Lat Peak E' Vel: 11 cm/sec
Lat Peak S Vel: 12 cm/sec
E/E' tdi Lat: 8.0

---

**Reported by:**

**Greg Mysak, Locum Cardiac Physiologist 17/11/2016 13:05**

**Reviewer:**

NHS Grampian

North East Scotland Genetics Service
A Scottish Genetic Consortium Laboratory Member
Aberdeen Royal Hospitals NHS Grampian
Polwarth Building, Foresterhill, Aberdeen, AB25 2ZD
Tel. 01224 553893 or 553820; Email grampian.molgen@nhs.net
http://www.nhsgrampian.org/medicalgenetics

# Molecular Genetic Report for Familial Hypercholesterolaemia (FH) Screen

| | | | | | |
|---|---|---|---|---|---|
| Patient name: | David | Standish | | Date of birth: | 5 3 1970 |
| CHI number: | 0503700053 | Sex: | Male | Sample type: | DNA |
| Hospital number: | | DNA number: | 201801779 | Date received: | 12/3/2018 |
| Patient ID: | PAT-20181179 | Referring lab ref: | 1801317-1-1 | Activation date: | 12/3/2018 |
| Pedigree number: | MG102838 | | | | |

**Reason for referral**

Pre alirocumab total cholesterol 7.36 on 17/11/17. LDL 5.0 calculated 28/11/17. Patient had an MI at 46 and required defibrillation during stent insertion. Father MI in his 40s. Mother stroke aged 65.

**Results summary** ***APOB*** **heterozygous c.10580G>A: p.(Arg3527Gln) pathogenic variant detected**

**Analyses performed, results and interpretation**

This sample was analysed by next generation sequencing of the coding regions and immediate flanking regions of *LDLR*, APOE, *PCSK9 genes.* A region of APOB (exon 26 c.10200 to c.11000) was also sequenced. Copy number variation (CNV) analysis of the sequenced areas of the genes was also performed to detect any large scale rearrangements.

Direct sequence analysis of a fragment of the *ApoB* gene confirmed the presence of the heterozygous sequence change c.10580G>A; p.(Arg3527Gln). This sequence change has been found in ~5-7% of all definite familial hypercholesterolaemia patients in the UK and is well documented as being responsible for the FH phenotype.

No sequence changes of known clinical significance were detected in the *LDLR, PCSK9* or *APOE* genes. Furthermore, no large scale deletions or duplications were detected.

**This result confirms a diagnosis of familial hypercholesterolaemia in this individual.**

Any children of David are at 50% risk of inheriting the *ApoB* c.10580G>A; p.(Arg3527Gln) pathogenic variant. These, and other at risk family members can be offered testing for this pathogenic variant following referral to Clinical Genetics. Genetic counselling is advised.

Comments

This interpretation represents the best analysis of the data at the time of reporting but it should be noted that this may change as additional information becomes available.

Additonal test information

Mutations in the *LDLR, APOB* and *PCSK9* genes account for a proportion of families with Familial Hypercholesterolaemia (FH). Mutation screening of the promoter, coding and flanking regions of *LDLR, APOE* and *PCSK9* as well as exon 26 of *APOB* (c.10200 to c.11000) is performed by next generation sequencing. DNA is amplified using Multiplicom ADH MASTR v2 kit and sequenced using MiSeq Control software v2.5.0.5 and v3 chemistry kit on the Illumina MiSeq platform. Sequence data analysis is performed on the Sophia Genetics Data Driven Medicine platform and CE-IVD marked ADH pipeline. This method has demonstrated >95% sensitivity in detecting variants. Any regions not covered at >50X read depth, and any variants of uncertain clinical significance or pathogenic (or likely) variants are repeated/confirmed by Sanger sequencing. Other variants (likely/non pathogenic) are not confirmed or reported in this screen. Details of these variants are available on request. Please note NGS is not included in our current UKAS scope.

Mutation nomenclature is according to HGVS guidelines and is based on Genbank sequences NM_000527.4 (*LDLR*), NM_000041.3 (*APOE*), NM_174936.3 (*PCSK9*) and NM_000384.2 (*APOB*), with +1 being A of the ATG start codon. Large duplications or deletions of the genes may be detected by the CNV caller built into the Sophia Genetics CE-IVD marked ADH pipeline. Any samples that do not provide a result of suitable quality on CNV caller and any *LDLR* positive results are confirmed using MLPA (multiplex ligation-dependent probe amplification) dosage assay (described at http://www.mrc-holland.com). *LDLR* MLPA is performed using the MRC Holland kit P062-D2 which employ probes across relevant *LDLR* coding regions and appropriate controls probes. Familial Hypercholesterolaemia resulting from other causes may not be detected in this screen. Please note that any remaining DNA will be stored in the laboratory.

**Dr J George**

**Cardiology, Ninewells Hosptial, Dundee, DD1 9SY**

Reported

Christine Armstrong, Research Scientist

Checked

Dawn O'Sullivan, Clinical Scientist

CC East of Scotland Regional Genetics Lab, Ninewells Hospital, Dundee

**Report date** 12/04/2018

walked2 12/04/2018 15:49

**In order to avoid error and/or misinterpretation, transcription of all or part of this report is inadvisable.**

Please order quoting MLS C155

Name:DAVID STANDISH
ID:0503700053
Sex:Male Birth date: 5- 3-1970 46 Yea
0.0 cm 0.0 kg 0/0 mmHg
Medication:

19-11-2016 8:23

RS

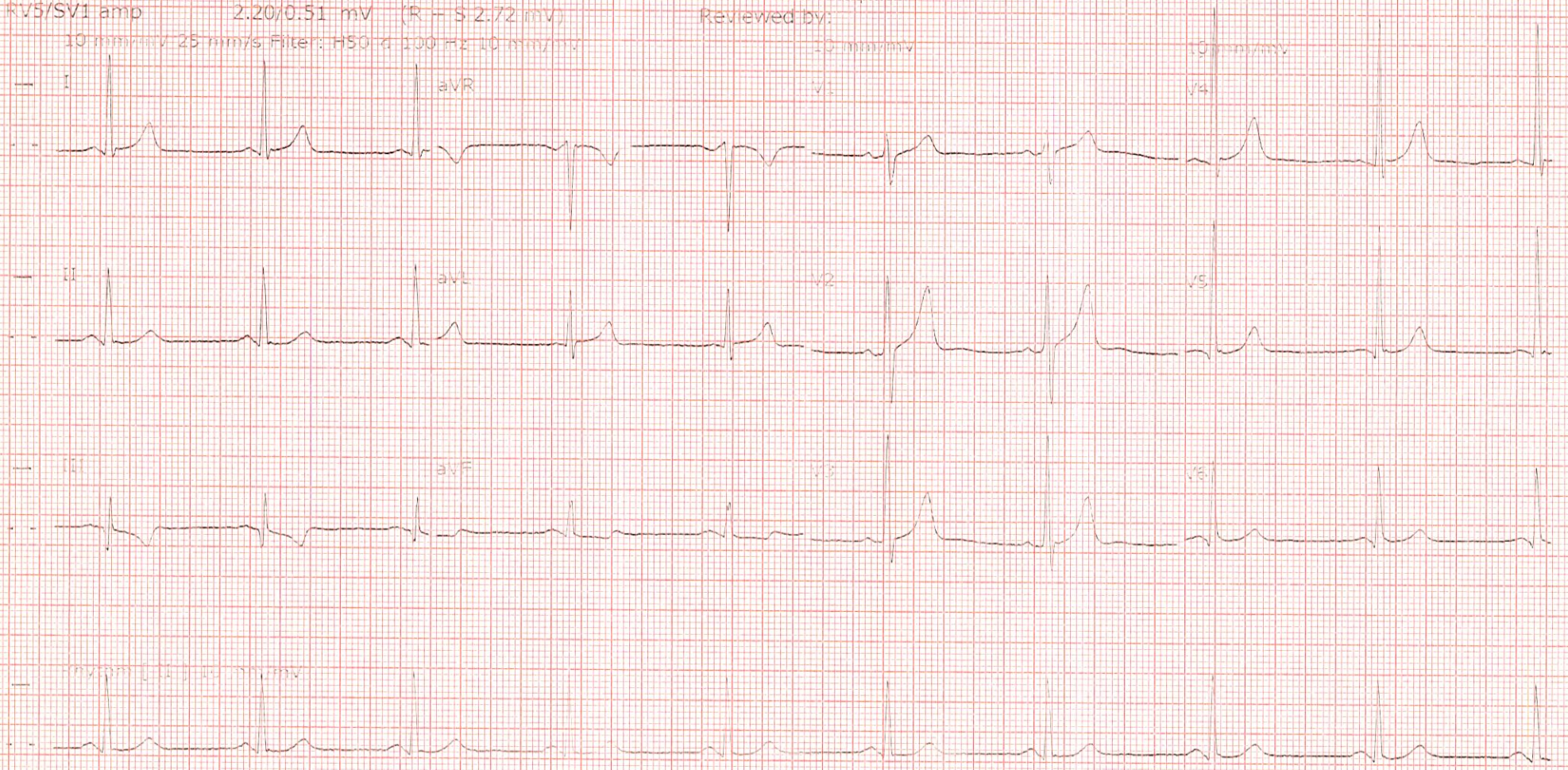
Symptoms:
History:

| | | |
|---|---|---|
| HR | 56 | bpm |
| PR int. | 136 | ms |
| QRS dur. | 88 | ms |
| QT/QTc(E) int. | 410/402 | ms |
| P/QRS/T axis | 45/23/-5 | ° |
| RV5/SV1 amp | 2.20/0.51 | mV |

(R + S 2.72 mV)

Unconfirmed Report
Reviewed by:

10 mm/mV 25 mm/s Filter: HSO a 100 Hz 10 mm/mV






Neurotechnics Ltd www.neuro-technics.com t: +44 (0) 845 450 0590 f: +44 (0) 845 450 0592

Please order quoting MLS C155

Name:DAVID STANDISH
ID:0503700053
Sex:Male Birth date: 5- 3-1970 46 Years
0.0 cm 0.0 kg 0/0 mmHg
Medication:

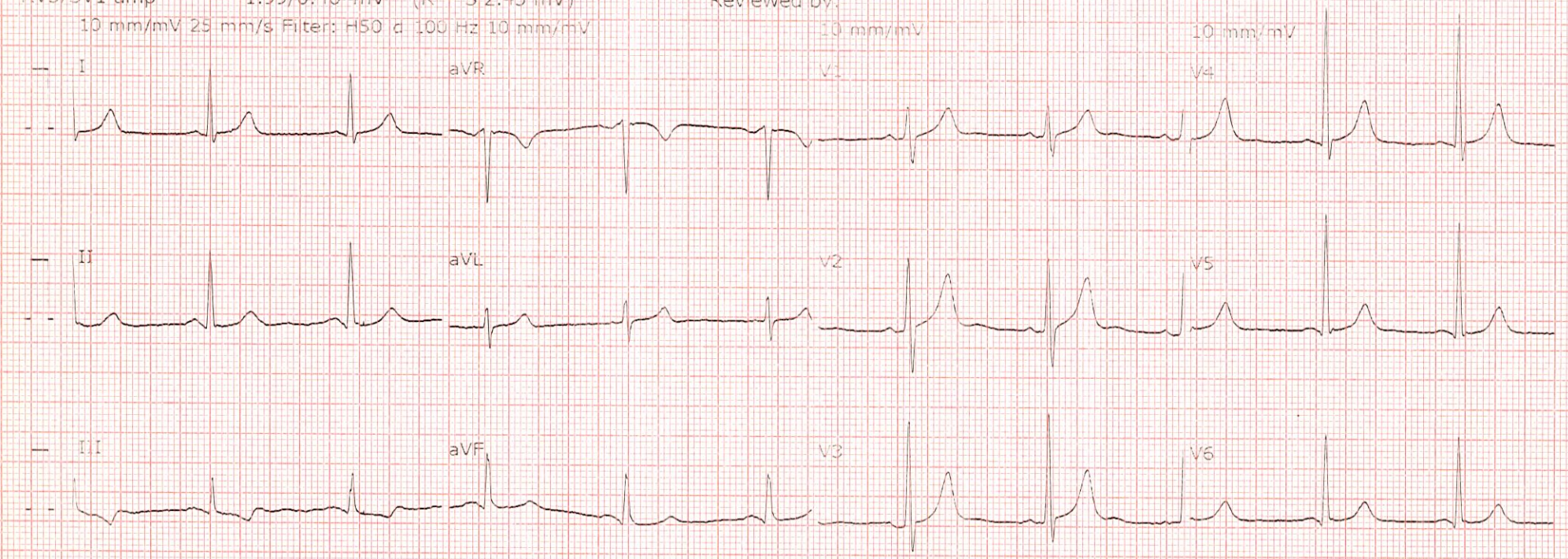
Symptoms:
History:

13-11-2016 8:20

| | |
|---|---|
| HR | 64 bpm |
| PR int. | 128 ms |
| QRS dur. | 88 ms |
| QT/QTc(E) int. | 412/421 ms |
| P/QRS/T axis | 40/38/7 ° |
| RV5/SV1 amp | 1.99/0.46 mV (R + S 2.45 mV) |

Unconfirmed Report
Reviewed by:

10 mm/mV 25 mm/s Filter: H50 d 100 Hz 10 mm/mV




SBF 17-01 03-06 Exam: NINE WEEK CARDIOLOGY

Neurotechnics Ltd www.neuro-technics.com t: +44 (0) 845 450 0590 f: +44 (0) 845 450 0592

Please order quoting MLS C155

Name:DAVID STANDISH
ID:0503700053
Sex:Male Birth date: 5- 3-1970 46 Yea
0.0 cm 0.0 kg 0/0 mmHg
Medication:

Symptoms:
History:

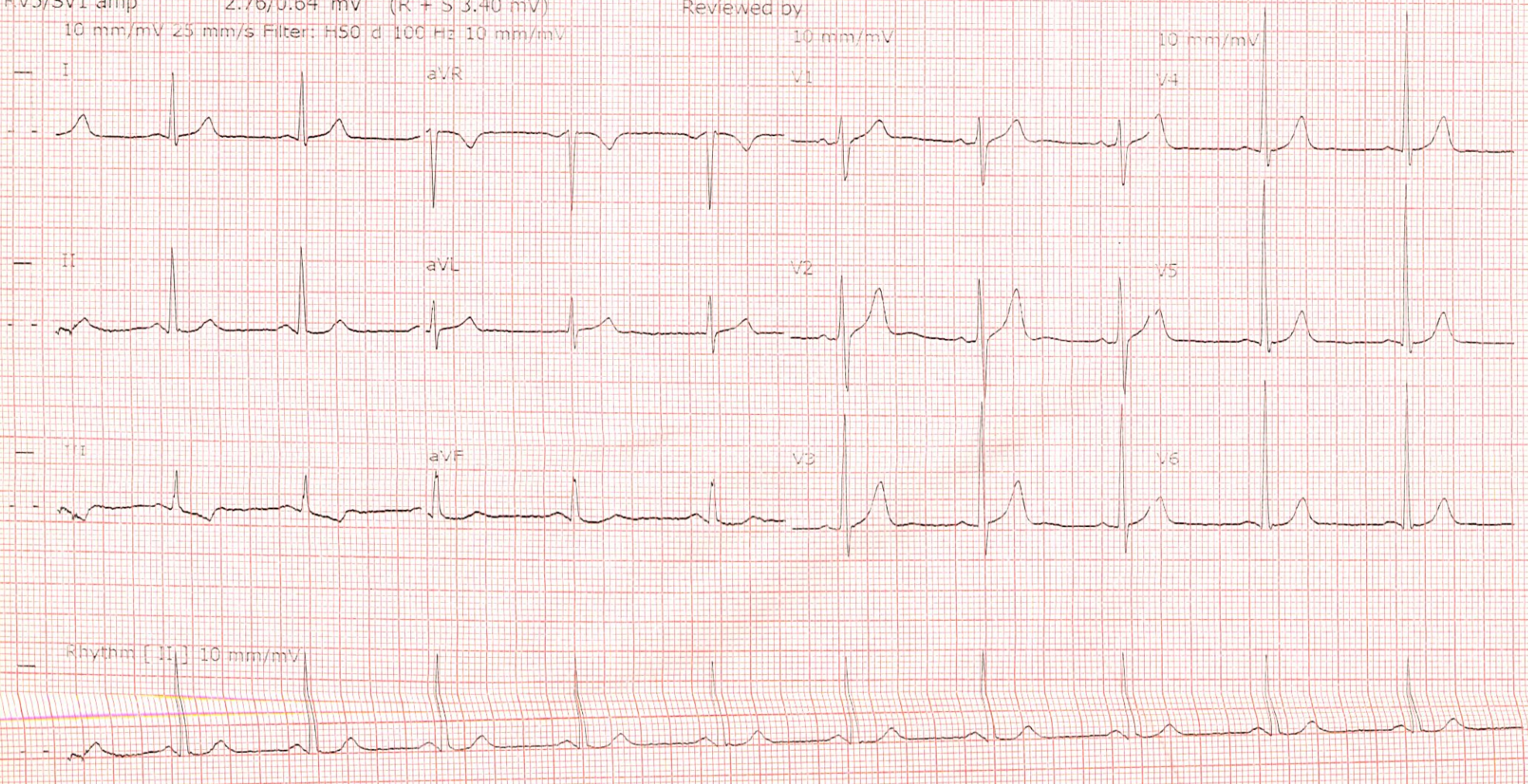
17-11-2016 8:14

5

| | | |
|---|---|---|
| HR | 63 | bpm |
| PR int. | 134 | ms |
| QRS dur. | 92 | ms |
| QT/QTc(E) int. | 394/402 | ms |
| P/QRS/T axis | 60/39/4 | ° |
| RV5/SV1 amp | 2.76/0.64 | mV (R + S 3.40 mV) |

Unconfirmed Report
Reviewed by

10 mm/mV 25 mm/s Filter: H50 d 100 Hz 10 mm/mV




158F 17-01 03-06 Exam:NINEWELLS CARD

Neurotechnics Ltd. www.neuro-technics.com t: +44 (0) 845 450 0590 f: +44 (0) 845 450 0592

Nwells 21/7/16

Ninewells Hospital And Medical School

# REQUEST FOR UPPER G.I. ENDOSCOPY

STANDISH DAVID 0503700053 M
20 CANNING PLACE
DUNDEE DD3 7RT

Coldside Medical Practice, 129 Strathm

Ward..... 3/4 OP
Consultant..... Rowan
Date..... 1.7.16.....
~~Inpatient~~
Outpatient

Requesting Dr..... RADWAN
Pager..... 4542.....

Diabetes (please tick) — insulin / tablets / diet
Warfarin *(see reverse)* INR.....
Antibiotic prophylaxis required
Allergies.....
Infection Risk (Detail below)
MRSA

## ROUTINE

1. Reflux symptoms *(see over)*
Dyspepsia *(see over)*
3.PEG insertion *(see over)*

4. Follow-up procedures .....weeks
ulcer healing
varices
Barrett's *(G.I. clinic only)*

5. Other *(use 'Further Information')*

## URGENT

1. Dysphagia (duration.....) solids only / total / intermittent
2. Iron Deficiency Anaemia
3. Weight loss
4. Persistent vomiting
5. Epigastric mass

20 JUN 2016

## EMERGENCY

***N.B.* please refer to Ninewells upper G.I. bleeding protocol**

1. Upper G.I. bleed — haematemesis / melaena

Co-morbidity:
1. None
2. IHD/CCF/other
3. Renal/liver impairment or malignancy

pulse.....
BP.....
Hb.....
Urea.....

**N.B.** 2 large bore iv cannulae are mandatory *(see over for out of hours/weekend requests)*

Further Information/Other Significant Medical Problems:
Significant dyspepsia. OGD Nov 2015 = Gastritis, Duodenitis + Gastric erosion x1
H.Pylori suggested on U.rea Breath test.
Also seen on Clyndyl (currently off of this)
Symptoms deteriorated again. No anaemia but significant dyspepsia
D/W Dr Monat => Repeat Endoscopy advised ? Ulcerative ? evidence H.Pylori

*For further advice please contact the GI Page (4482) 09:00-17:00 Monday to Friday*

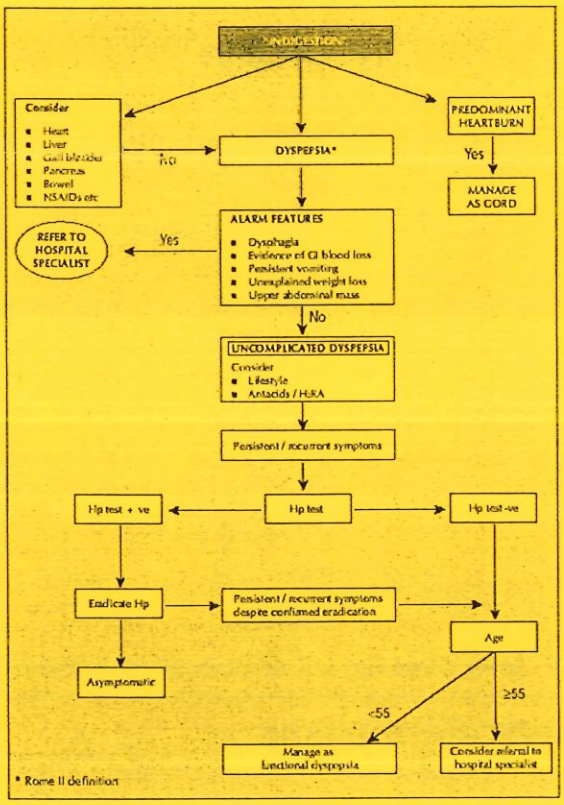
## REFLUX

***In the absence of alarm features***, a reasonable therapeutic trial of anti-reflux strategies should be undergone before requesting endoscopy:

1. Lifestyle modification
2. Simple antacids
3. $H_2$-receptor antagonist
4. Proton pump inhibitor

## DYSPEPSIA

***In the absence of alarm features***, a 'test and treat' strategy is appropriate before requesting endoscopy.




Please refer to SIGN Guideline 68
www.sign.ac.uk

## REQUESTS FOR ENDOSCOPIC PEG INSERTION

Please contact G.I. Specialist Nurse Jan Tait (bleep 4470) who will assess the patient and make the necessary arrangements.

## GUIDELINES FOR PATIENTS ON WARFARIN

In cases where therapeutic intervention or biopsies are anticipated, patients must stop warfarin. If the patient is anti-coagulated for a 'low risk' indication e.g. AF, warfarin should be stopped 3 days prior to the procedure. The patient should have their INR checked, and the result available in the notes, when they attend the endoscopy suite. If they are an outpatient this will be performed by endoscopy staff on the day of th procedure. In the case of a 'high risk' indication e.g. metal prosthetic heart valve, the patient will require admission for warfarin cessation and heparinisation. If in doubt contact the clinician responsible for initiation of anticoagulation.

## OUT OF HOURS & WEEKEND REQUESTS

Emergency endoscopy lists occur on Saturday and Sunday mornings from 09:00 to 12:00. Requests must be delivered to the endoscopy suite nursing station by 09:00 that morning. Outwith these times emergency endoscopy service will be provided by the on-call surgical team, as occurs after 17:00 on weekdays.

# ENDOSCOPY CARE PATHWAY

NHS Tayside

| | |
|---|---|
| STANDISH DAVID 0503700053 M<br>20 CANNING PLACE<br>DUNDEE DD3 7RT<br>Mill Practice, Arthurstone Medical Pract<br>P: | **Next of Kin**<br>Name... Denise McLaughlin<br>Address 9 Monsion Drive, Dundee<br>Tel No.... 0744 9022684<br>Relationship... Partner |

**Planned Procedure**

Gastroscopy EUS Flexible Sigmoidoscopy Colonoscopy

| | |
|---|---|
| **Date:** 21/07/16 **Time:** 15.02<br>**Referring Consultant** | **Patient Escort Details** |

| PRINT NAME | DESIGNATION | SIGNATURE | INITIALS |
|---|---|---|---|
| Aine McShea | ST/N | AMcShea | AMCS |
| Lisa Law | SN | | |
| Jean Collier | SN | | JC |
| | | | |
| | | | |

**PRE-PROCEDURE**

| | |
|---|---|
| Patient likes to be known as: David | |
| Case notes available | ✓ |
| Pre-admission assessment completed and with patient | joint replacement X pace maker /icd X |
| Name band/Drug Allergy band in situ | ✓ |
| If patient is on medication what has been taken today: | Nill |
| Patient last ate at date: 21st July | time: 3am |
| Patient last had fluids at date: 21st July | time: 1345 – water |
| Bowel preparation tolerated yes/no describe: | N/A |
| Phosphate enema picolax x | klean prep x moviprep x |
| Blood sample obtained if indicated | ~~INR~~ clopidogrel discontinued (few months ago) Blood Glucose X |
| Procedure and plan of care explained | ✓ |
| Is consent form signed ✓ | check CJD X |
| Sedation options discussed | ✓ |
| Patient preference: With sedation | Without sedation Throat Spray Entonox |
| Patient advised not to drink alcohol, sign legal documents, drive or operate machinery for 24 hours post sedation | N/A |
| Patient understands discharge advice | ✓ |
| Patient consent obtained to inform escort of procedure outcome | ✓ |
| Any mobility issues | can walk but poorly (walking stick) pressure sore assessment N/A |
| Venous access site | |
| Communication barriers N/A | interpreter required N/A |

**I have received written and verbal discharge advice**

**I give / do not give (delete as necessary) consent to you to inform escorting adult of procedure outcome**

Patient signature..... Nurses initials: AMCS

* Copidogril discontinued a few months ago.

Lanzoprazole stopped a month ago

## MEDICINE RECORDING SHEET

| Date | Medicines (once only prescriptions) | Dose &Form | Time of Admin | Method or Site | Signature | Given By Signature |
|---|---|---|---|---|---|---|
| | Oxygen | 2litres/min | | | | |
| | Symptomatic Relief Policy as per MCGD | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| **Known Allergies :** NKDA | | | | | | |

## INTRA-PROCEDURE

| | |
|---|---|
| Patient identity confirmed ✓ | safety pause undertaken ✓ |
| Consent form correctly and accurately/completed and signed ✓ | |
| Artificial aids present? (please circle) Hearing aid Y (Specify) | Spectacles Y Dentures Contact Lenses Y Other |
| IV Sedation given N/A | |
| Xylocaine spray administered at (record time) 15:50 | |
| Oxygen therapy at 2 litres/min administered during procedure N/A | |

Start time: 15:50 Finish time: 15:51

Biopsies Performed Yes ☑ No ☐

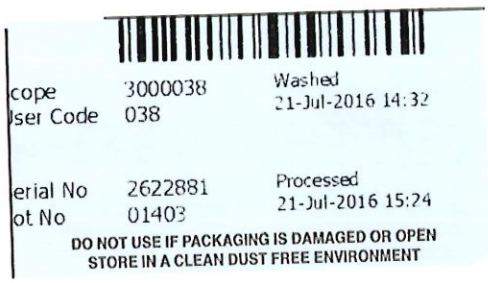
Urease Test YES/NO RESULT: POSITIVE/NEGATIVE

| | |
|---|---|
| **1** distal stomach bx | **2** |
| **3** | **4** |
| **5** | **6** |
| **7** | **8** |

**Single Use Items Label**

Ninewells Endo. Dept.

GASTROSCOPE VIDEO




Boston Scientific
Radial Jaw™ 4
2.8mm
GTIN 08714729745549
REF M00513330
LOT 18916191

| SBAR Handover to Endoscopy Recovery Nurse | |
|---|---|
| 1. Situation | 2. Background |
| State patient details: | Summary of relevant history, procedure performed, medication given and care given intra-procedure. |
| 3. Assessment | 4. Recommendations |
| Provide details of current observations, sedation, pain and nausea scores | Inform the nurse of any further monitoring and any specific discharge information |

Nurses initials: SV

## OBSERVATION CHART

| Date | Pulse and BP chart | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Time | o/a | 1550 | | | | | | | | |
| 240 | | | | | | | | | | |
| 230 | | | | | | | | | | |
| 220 | | | | | | | | | | |
| 210 | | | | | | | | | | |
| 200 | | | | | | | | | | |
| 190 | | | | | | | | | | |
| 180 | | | | | | | | | | |
| 170 | | | | | | | | | | |
| 160 | | | | | | | | | | |
| 150 | | | | | | | | | | |
| 140 | | | | | | | | | | |
| 130 | 133 | | | | | | | | | |
| 120 | | | | | | | | | | |
| 110 | | | | | | | | | | |
| 100 | | | | | | | | | | |
| 90 | | (81) | | | | | | | | |
| 80 | 81 | | | | | | | | | |
| 70 | | | | | | | | | | |
| 60 | (63) | | | | | | | | | |
| 50 | | | | | | | | | | |
| 40 | | | | | | | | | | |
| 30 | | | | | | | | | | |
| Temperature | 36.3 | | | | | | | | | |
| Respiratory Rate | 16 | 16 | | | | | | | | |
| O2 Rate | Air | AIR | | | | | | | | |
| SpO2 | 97 | 97 | | | | | | | | |
| Sedation Score | — | 0 | | | | | | | | |
| Pain Score | — | 0 | | | | | | | | |
| Nausea Score | — | 0 | | | | | | | | |
| | | | | | | | | | | |
| Blood glucose levels (mmols) | — | — | | | | | | | | |
| SEWS SCORE | 0 | | | | | | | | | |

**Sedation Scale**
0=Alert
1= Drowsy, easy to rouse
2= Drowsy, difficult to rouse
3 = Somnolent, unable to rouse

**Pain Scale**
0 = No pain
1= Mild pain
2= Moderate pain
3 = Severe pain

**Nausea Scale**
0 = No nausea
1 = Mild nausea
2 = Nausea and/or vomiting
3 = Persistent nausea and/or vomiting

**SEWS SCORE**
0 = Fit for discharge, if able
1-2 = Continue to monitor every 15 minutes
3 in one parameter or > 3 = Inform Nurse in Charge/Endoscopists and continue to monitor

| SEWS | Score: Respiration Rate | SpO2 | Temperature | Pulse | Systolic BP |
|---|---|---|---|---|---|
| 3 | 36+ | | | 130+ | |
| 2 | 31-35 | | 38.5+ | 110-130 | 200+ |
| 1 | 21-30 | | 38.0 – 38.5 | 100-110 | |
| 0 | 9-20 | 94+ | 36.0 – 37.9 | 50-100 | 100-200 |
| 1 | | 90-93 | 35.5 – 35.9 | 40-50 | 80-100 |
| 2 | | 85-89 | 35.0 – 35.4 | 30-40 | |
| 3 | <=8 | ↓85 | ↓35.0 | ↓30 | ↓80 |

## POST PROCEDURE

| **Intervention for patients who have received IV Sedation** |
|---|
| Patient nursed in recovery position |
| Oxygen therapy continued at 2 litres/minute until patient awake and orientated |
| Oxygen saturation, Sedation, Pain & Nausea levels monitored until patient awake and orientated |
| Vital signs monitored until patient awake and orientated |
| Nurses initials: |
| **Interventions for patients who have received Throat Spray** |
| Vital signs stable in room yes/no |
| Pain & Nausea levels monitored |
| Patient can restart fluids/diet 30 – 60 minutes post procedure |
| Nurses initials |
| **Interventions for patients who have not received IV sedation and/or throat spray** |
| Vital signs stable in room yes/no |
| Pain levels monitored |
| Nausea levels monitored |
| Nurses initials: |

## DISCHARGE

| |
|---|
| Patient alert and orientated |
| Tolerating oral fluids advise sore on when can take oral fluids and diet |
| Venflon removed N/A |
| **If patient has received IV sedation** Responsible adult to accompany patient home N/A |
| Property returned to patient/carer |
| Report, advice sheet and verbal explanation given to: Patient ☐ Carer ☐<br>Private discussion offered to patient and carer Report letter given |
| Educational Leaflets given to patient as applicable |
| Patient fit for discharge time: 16 15<br><br>Nurses initials: |

| SBAR Handover to Ward Nurse | |
|---|---|
| 1. Situation | 2. Background |
| State patient details: | Summary of relevant history, procedure performed and care given intra-procedure and in recovery. Provide instructions from endoscopist |
| 3. Assessment | 4. Recommendations |
| Provide details of intravenous infusions, current monitoring, SEWS, sedation, pain and nausea scores | Confirm patient's condition is suitable for return to ward. Ask if ward nurse requires any additional information. |

**Variance to care pathway**

| Date | Time | Multi-disciplinary progress notes | initials |
|---|---|---|---|
| | | | |
| | | | |
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| | | | |

STANDISH DAVID 0503700053 M
20 CANNING PLACE
DUNDEE DD3 7RT
Mill Practice, Arthurstone Medical Pract

NHS Tayside

# NHS Tayside Consent Form

Name of procedure(s): **Gastroscopy**

Inspection of the upper gastrointestinal tract with a flexib biopsy and photography/video).

Biopsy specimens will be retained.

---

**Statement of patient**

You have the right to change your mind at any time, including after you have signed this form.

**I have read** and understood the information in the attached booklet including the benefits and any risks.

**I agree** to the procedure described in this booklet and on the form.

**I understand:**

- That any procedure in addition to those described above will only be carried out if it is necessary to save my life or to prevent serious harm to my health.
- That you cannot give me a guarantee that a particular person will perform the procedure. The person will however, have appropriate experience.
- Information, including digital information (video and/or photographic material) may be stored as part of the patients medical records and may be stored on computer databases.

The University of Dundee is very active in medical research: donations of excess body tissues and agreement to the use of images are a valuable resource for researchers and clinical scientists.

Please tick (✓) the appropriate box if you agree to:

☐ Excess body tissue not required for diagnosis or future treatment being used for medical research

☐ Digital images (for example – such as described above) being used for research, education and teaching in presentations (for example – conferences or websites) and in publications. Whenever relevant, such images will be anonymised to protect patient privacy.

(If consent is withdrawn at a later date, it may not be possible to withdraw images that are already in the public domain.)
NB: Medical staff – you must complete the appropriate clinical photography forms.

**Have you ever** been notified that you are at increased risk of CJD or vCJD for public health purposes?
(Please tick) Yes ☐ No ☐

**Patient Signature:** D. Standish **Date:** 20/7/16

**Name (print in capitals):** DAVID STANDISH

If you would like to ask further questions please do not sign the form now. Bring it with you and you can sign it after you have talked to the healthcare professional.

**Please remember to bring this booklet and form with you when attending for your appointment.**

## Confirmation of consent

(To be completed by a health professional when the patient is admitted for the procedure).

I have confirmed that the patient/parent understands what the procedure involves including the benefits and any risks.

I have confirmed that the patient/parent has no further questions and wishes the procedure to go ahead.

**Signed:** ..... **Date:** 21/7/16

**Name (print in capitals):** LISA LOW

**Job title:** SN

**Additional discussions with patient**

**Endoscopist signature:** ..... **Date:** .....

This questionnaire is designed to help the doctors and nurses looking after you when you have your endoscopy. If you find any question difficult to answer, please contact your GP or telephone the Endoscopy Unit.

Name..... DAVID STANDISH .....

Date of Birth..... 05/03/70 .....

Please tick appropriate box

1. Do you currently have, or have you ever had any of these problems?

| | Yes | No | Comments |
|---|---|---|---|
| Lung problems (asthma – pneumonia – bronchitis – emphysema - breathlessness | ✓ | | |
| Heart attack, heart failure, angina or any other heart or valve problems | ? | | |
| Rheumatic fever | | ✓ | |
| High Blood pressure | ? | | |
| Stroke | | ✓ | |
| Fainting, dizzy spells or blackouts | | ✓ | |
| Seizures or epilepsy | | ✓ | |
| Anaemia or blood problems | | ✓ | |
| Bruising or bleeding problems | | ✓ | |
| Liver problems or hepatitis | | ✓ | |
| Diabetes | | ✓ | |
| Addisons Disease | | ✓ | |
| Arthritis | | ✓ | |
| Joint replacement, orthopaedic implants | | ✓ | |
| Abdominal surgery | | ✓ | |
| Glaucoma or any other eye problems | | ✓ | |

Any other illness (please specify)

PERIPHERAL ARTERIAL DISEASE

2. Please list any medicines you are taking, the amount and the number of times per day (including any herbal / homeopathic remedies).

| Medicine | Amount taken | Times per day |
|---|---|---|
| LANSOPRAZOLE 30mg | 1 | 2 |
| FOLIC ACID 5mg | 1 | 1 |
| FELODIPINE 2.5mg | 1 | 1 |
| CLOPIDOGREL | 1 | 1 |
| SALBUTAMOL | | |
| EZETIMIBE | RECENTLY | STOPPED TAKING |
| STATINS | RECENTLY | STOPPED TAKING |

3. Do you take any blood thinning medication? This includes: Warfarin, Heparin, Aspirin, Clopidogrel, Rivaroxabin or Apixiban?

Yes ✓ No

4. Are you **allergic or sensitive** to anything (medicines or adhesive tape)?

Yes No ? NOT SURE

If Yes, please list below and describe what happened in each case

5. Do you smoke?

Yes ✓ No

6. How many units of alcohol do you drink in one week? [0]
   (1 unit is half a pint of beer, a small glass of wine or 1 measure of spirit)

7. Do you have any cultural or religious needs?

Yes [ ] No [✓]

If Yes, please give details

8. Do you have any special needs that we may need to be aware of?

Yes [ ] No [✓]

If Yes, please give details

9. Please make a note of anything that you particularly wish to ask staff or discuss with them.

10. If you are having a **gastroscopy or colonoscopy with sedation**, someone **must** accompany you home and stay with you for 12 hours.

**Escorts Name:**.....

**Telephone Number:**.....

Reviewed by Endoscopy Patient Information Group
Reviewed: 07/2015 Review: 07/2017 LN0469

NHS Tayside

# Pre-Endoscopy Questionnaire

Please bring this form with you when attending for your endoscopy

**Ninewells Hospital**
Telephone: 01382 632750
**Perth Royal Infirmary**
Telephone: 01738 473825
**Stracathro Hospital**
Telephone: 01356 665012

C11/4/88 N/W.

NF

| Hospital use Only | Clinic | Day Date | Time | Hospital No. | GP112 |
|---|---|---|---|---|---|
| | | 09 JAN 2001 | | JKS, Dalkeith. | |

**REQUEST FOR OUT-PATIENT CONSULTATION**
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category: Routine [X] Soon [ ] Urgent [ ]

CHI No. 0 5 0 3 7 0 0 0 5 3

Hospital NINEWELLS Date 05 01 01

Please arrange for this patient to attend the GENERAL MEDICAL clinic of Dr/Mr

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Patient's Surname STANDISH Maiden Surname

First Names DAVID Single/Married/Widowed/Other

Address 18 FINTRYSIDE Date of Birth 05 03 70

DUNDEE Patient's Occupation

Postal Code DD4 9JW Contact telephone number

Has the patient attended hospital before? YES / NO If "YES" please state:

Name of Hospital

Year of attendance Hospital No.

If the patient's name and/or address has/have changed since then please give details:

Can patient attend at short notice? YES / NO

If YES, minimum notice required days

Name, Address and Telephone number of MEDICAL / DENTAL PRACTITIONER

Dr COLIN C AFFLECK
Park Avenue Medical Centre
Dundee
DD4 6PP
Tel.: 01382 462222

Please use rubber stamp

11005

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

This 30 year old man has been experiencing chest pains recently. The pain does not sound particularly cardiac in nature but there is a fairly strong family history of heart disease. His fasting serum cholesterol and triglycerides were somewhat raised.

6·81 3.07
HDL 1·39.

Diagnosis / provisional diagnosis: **Chest pains**

Present drug treatment and potential special hazards:

X-ray (women of childbearing age). Date of first day of L.M.P.

Relevant X-rays available from: No. (if known)

Signature

DR C C AFFLECK

355-2104

Wd 12 OP

Q

**Delivery Unit**

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

NHS Tayside

19 JUL 2010

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

28 June 2010
Clinic Date: 25/06/2010
Dictation Date: 25/06/2010
Your Ref: (CHI:0503700053)
Our Ref: GC/WJ/0503700053
Enquiries To: Ward 12 OP Office
Telephone: 01382 660111
Extension: 33889

Appt 10/09/10 Dr Dick Vasc Med.

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

Thank you for referring this gentleman who complains of bilateral calf claudication at around 50 yards which is alleviated after stopping walking for approximately 10 minutes. He denies any rest pain. There is some toe numbness on the right foot but this can happen occasionally just on standing. He has had no previous arterial treatment and has no history of ischaemic heart disease. He does have asthma which he uses his inhalers for as required. There is no history of cerebro vascular disease, diabetes or hypertension. He currently smokes 10-15 cigarettes per day and is currently on a statin but not an anti-platelet agent.

On examination his upper limb pulses were normal. His blood pressure was 117/72, his random sugar 6.4 and his BMI 26. With the exception of both popliteals I was able to palpate all remaining leg pulses bilaterally. There is no sign of ischaemia in his feet. His ankle brachial indices are 0.56 on the right and 0.51 on the left, falling to 0.31 and 0.20 respectively after exercise.

I believe his symptoms are that of intermittent claudication and have requested an arterial duplex scan and we will review him with these results.

As Dave is only 40 years of age I have discussed his case with Dr Dick, Vascular Physician today at clinic and we have taken bloods for thrombophillia screening and Dr Dick will arrange to see him with these results.

Yours sincerely

G Crowe

**Gill Crowe, Vascular Specialist Nurse to**
**John Nagy, Consultant Vascular Surgeon**

Copy to:

✓ Dr J Dick, Consultant Physician, Ward 4, Ninewells

Vasc Med
New, routine
Banner/Dick
4 Dick

POSITIVE ABOUT DISABLED PEOPLE

Clinical Pharmacology
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

Tel:01382 740157
01382 632682
www.nhstayside.scot.nhs.uk

Dr Thomas Martin
Consultant Cardiologist
Department of Cardiology
Ninewells Hospital
Dundee
DD1 9SY

| | |
|---|---|
| Date | 16/02/2017 |
| Clinic Date | 06/02/2017 |
| Your Ref | |
| Our Ref | JG/SG/ **0503700053** |
| Enquiries to | Miss Sam Garvock |
| Extension | 40157 |
| Direct Line | 01382 740157 |
| Email | samantha.garvock@nhs.net |

Dear Dr Martin

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Thank you for your referral of this patient for consideration of Alirocumab. As he is intolerant of statins, he does not qualify for Alirocumab as per current SMC guidelines. However, I have appointed him to the lipid clinic and he can be seen there. If it is felt that this is an appropriate treatment for him, the doctor will need to fill in an individual patient treatment request (IPTR).

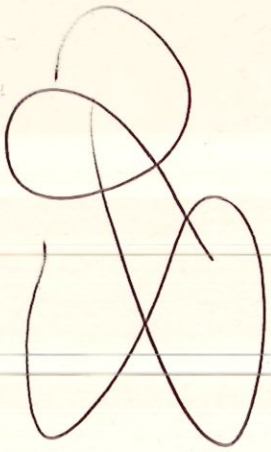
Thank you.

Yours sincerely

Authorised on 17/02/2017 08:15:03 by Jacob George.

**Dr Jacob George**
**Clinical Senior Lecturer/Honorary Consultant Physician**

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB



E55-C10-503 23 FEB 2017

NHS Tayside

Department of Cardiology
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Cardiovascular Risk Clinic
Wards 3/4 Corridor
Level 7
Ninewells Hospital
Dundee
DD1 9SY

| | |
|---|---|
| Date | 16/01/2017 |
| Dictated | 12/01/2017 |
| Our Ref | TM/IR/ **0503700053** |
| Enquiries to | Mrs I Robertson |
| Extension | 32263 |
| Direct Line | 01382 632263 |
| Email | |

Dear Colleagues

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I would be grateful if this patient could be seen at your clinic with a view to consideration of Alirocumab.

He was admitted under Cardiology in November 2016 with a non-ST elevation myocardial infarction and had percutaneous coronary intervention to the right coronary artery. He has a background of peripheral vascular disease. His total cholesterol was 6.64 mmol/L.

The patient is intolerant of statins and his peripheral vascular disease is that he had previous right common femoral artery end-arterectomy with vein patch and a right superficial femoral artery angioplasty.

I wonder if you would be able to see this patient for consideration of alternative therapies to statins, given his significant atherosclerosis.

Yours sincerely

Authorised on 17/01/2017 07:17:30 by Cardio Tom Martin.

**Dr Thomas Martin**
**Consultant Cardiologist**

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

OSC Lipid clinic

Does NOT qualify for Alirocumab as per SMC

→ If needed → IPTR request to be filled

NITMH lipid Slot Please

HISTORY/CONTINUATION SHEET

UNIT/WARD/DEPT.

Ward/Clinic/
Hosp. .....

Surname ..... STANDISH
First Name ..... DAVID G
Address ..... 18 FINTRYSIDE
DUNDEE DD4 9JW

G.P. & Address (G.P. Requests ) DR. C AFFLECK
PARK AVE M/C
DUNDEE

05 03 70 0053
M

Cons.
C.H.I. No.
M. State
Sex
USE BLOCK LETTERS OR PATIENT LABEL

DATE

Page .....

DATE 24-1-01
WEIGHT 84.
HEIGHT 180.
URINE NEG

31 yo ♂

Chest pain x 6/12
- dull aching ± ↓ pressure.
↑ radiation.
constant
- 'tube' relief
on ↑.
↑ pain on exertion.
↑ calf tenderness.

Risk factors - smoker.
↑ cholesterol.
↑ cholesterol.
family hx.

Asthma.

Ventolin inhaler. PRN.

Lives in Dundee.

O/E
BP 110/70
PR 70 regular.

CVS - JVP ↔
S1 — S2
murmur

THB.(MR)3A

DATE

Lung- clear

Abdo- soft
Lscleo
BS+

CVS- ns

Δ+ Probably non cardiac

PR
Bloods
ETT
ECGs
CXR
Plan F/U
Add echo
ABPM
[illegible]

Conc

DATE 28.3.01
18.4.01
WEIGHT 81.5kg
HEIGHT
URINE

Lt sided chest pain
(sharp)
atypical
2x since last visit
(lasted 20 mts)
while relaxing

Nil

O/E well
RR - 10/mt, regular
Heart Sounds - (N), no murmur

Plan:
ETT
F-up P/C

[illegible]
4/58

HISTORY/CONTINUATION SHEET

Ward/Clinic/Hosp. .....

Surname . STANDISH

First Name DAVID G

Address . ~~14 FINTRYSIDE~~ 10 BALLINDEAN TCE DUNDEE DD4 9JW

G.P. & Ad. DR. C AFFLECK PARK AVE M/C DUNDEE

05 03 70 0053 M

Cons. .....

Y Y C.H.I. No. .....

M. Stat. .....

Sex .....

USE BLOCK LETTERS OR PATIENT LABEL

.....UNIT/WARD/DEPT.

DATE

Page .....

DATE 22-8-01
WEIGHT 77kg
HEIGHT
URINE

Well, no pain up til 2 nights ago
- woken, trying to sleep
- sudden onset
- same place ⓛ praecordium
- not as painful as usual
- subsided in 20mins.
- no pain since. no N/V, ° radiating
- felt relaxed.

Stressed re: family probs.
not working.
Note Wt loss 4.5kg since April '01

— Exercise TT - normal.
ECHO - normal
CXR - normal

Cholesterol - high 7.15 in Jan '01.
(no Rx yet)
smoking - 8-10/day
exercising
occasional alcohol.

Asthma well controlled

O/E P=70 reg
NS I+II+O
Chest clear

Plan ① Simvastatin 10mg OD nocte, low fat diet
② D/W Dr Kumar - happy to discharge as above tests neg
③ If pain becomes more frequent → GP to refer to cardiologists

Alvin Clarke 5035

DATE

DATE 26/4/13
WEIGHT 92kg
HEIGHT
URINE

bp 110/63
p 66

Still struggling i making
long chat, + partner
Given info
Bloods, urine

6/12 4 Jab

DATE 12.12.14
WEIGHT 100.kg
HEIGHT
URINE

BP 135/81 (P) 83

Meds nil

Meds keeps him awake
- tried on + off
R IR pain
- thinks this is clopidogrel
- stopped this
Nausea → myalgia, etc.
- 6/7, then stopped
Runs on e-cigs.
Chest.
Just take plavix + exer for now.
Rev. 2mm.

4 Jab

DATE 30/1/15
WEIGHT 97kg
HEIGHT
URINE

BP 134/78
P 69

Getting nervous, sick feeling in abdo
with plavix.
But exer → severe abdo pain, cramp,
→ @ side + flatus.
Chest.
Ca abdo.

8/52 4 Jab

**PATIENT SPECIFIC REMINDER**

**DVT PROPHYLAXIS**

Ward/Clinic/
Hosp. .....Cons.
D D M M Y Y
C.H.I.No.
Surname.....
First Name..... M. State
Address..... Sex
.....
G.P. & Address (G.P. Requests only) USE BLOCK LETTERS

Hospital Patients in any of the following categories are at risk of venous thromboembolism and should be considered for prophylaxis.

| | | (Proformas) Tick if present |
|---|---|---|
| **HIGH RISK** | | |
| **Orthopaedic surgery** | Elective hip or knee replacement. | _____ |
| | Hip fracture or major lower limb fracture. | _____ |
| | Spinal cord injury causing lower limb paralysis. | _____ |
| **General Surgery** | Major pelvic or abdominal surgery for cancer. | _____ |
| **Vascular Surgery** | Critical lower limb ischaemia or major amputation. | _____ |
| **Medical** | Acute stroke or other illness causing lower limb paralysis. | _____ |
| **All** | Major trauma, surgery or medical illness in patients with: | |
| | • previous deep vein thrombosis or pulmonary embolism | _____ |
| | • known thrombophilia (e.g. antithrombin deficiency. | _____ |
| **MODERATE RISK** | | |
| **Trauma** | Major trauma. | _____ |
| **Surgery** | Major surgery (over 30 minutes duration) **and** any of the following: | |
| | • age 40 years or more | _____ |
| | • markedly obese | _____ |
| | • immobility (4 days or more) | _____ |
| | • pregnancy/puerperium | _____ |
| | • high dose oestrogens | _____ |
| | • medical illness | _____ |
| **Medical** | Myocardial infarction/heart failure/ chest infection. | _____ |
| | Malignancy/inflammatory bowel disease/ nephrotic syndrome. | _____ |
| **All** | Minor trauma, surgery or medical illness in patients with: | |
| | • previous deep vein thrombosis or pulmonary embolism | _____ |
| | • known thrombophilia (e.g. antithrombin deficiency). | _____ |

DVT prophylaxis employed Yes/No

If no, why not:-

HISTORY/CONTINUATION SHEET

Ward/Clinic/Hosp. .....

Surname ..... STANDISH

First Name ..... DAVID

Address ..... 9 MANSION DR
DUNDEE

DD4 9DD

0503700053

M

PARK AVENUE MEDICAL CENTRE, PARK AVE

G.P. & Address (G.P. Requests only)

..... Cons.

C.H.I. No. .....

..... M. Stafe

..... Sex

USE BLOCK LETTERS OR PATIENT LABEL

..... UNIT/WARD/DEPT.

DATE

Page .....

DATE 3-4-15
WEIGHT 96kg
HEIGHT
URINE

Amlodipine
Clopidogrel
Atorvastatin
Betrinse
Fenofibrate
Lansoprazole
Folic acid

} Seen c partner

not taking

Ibuprofen. last week

Pt upset at normal CT report
feels something is not right

worried here

AM drop ceased cyclo for
hyperkin / symptoms + all are / reduced
20 mins after tablets.

Sh no diarrhoea change c foods
sometimes worse with fatty foods.

Bowels Sh.

Related

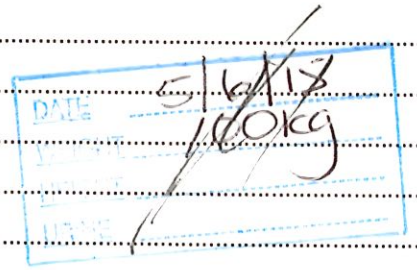
Discussed.
- Risks + coeliac
- trial of taking Clopidogrel, Atorvastatin, Lansoprazole at lunch

- trial Lansoprazole last help.
- Consider triple not analgesia

Consider OGD

THB.(MR)3A

DATE



# REQUEST FOR ADMISSION* / URGENT CONSULTATION*

**DETAILS OF PATIENT**

Full Name ..... DAVID STANDISH .....

Address ..... 10 Ballindean Tce .....

..... Dundee .....

.....

Date of Birth (CHI) 0 5 0 3 7 0 ( 0 0 5 3 )

Previous Attendance (Hospital) .....

Unit No. (if available) .....

Occupation .....

Dr MC Duffy
Park Avenue Medical Centre
Park Avenue
DUNDEE, Angus
DD4 6PP
462222

TO THE ADMITTING ..... Medical ..... UNIT ..... N/K ..... HOSPITAL

Dear Doctor,

I should be grateful if you would admit* / examine and admit* if necessary the above patient.

HISTORY OF PRESENT COMPLAINT:

Chest pain light → Stomach & Back Pain all
relieved by GTN

RELEVANT SOCIAL DETAILS:

smoke 30/day FH IHD.

FINDINGS ON EXAMINATION:

not C.V. compromised.

SIGNIFICANT PAST ILLNESSES:

dyslipidaemia. Previous Asthma

PRESENT DRUG THERAPY:

Symbicort 400/12 2 puffs bd

PROVISIONAL DIAGNOSIS:

?? unstable angina ? Dyspepsia

Yours faithfully,

.....

Date ..... 22.10.01

Time .....

*Delete as appropriate

THB(MR)9

# TAYSIDE UNIVERSITY HOSPITALS NHS TRUST
## MEDICAL ADMISSIONS UNIT

**NAME:** DAVID STANDISH

**DOB / CHI** 0503700053

Place patient label here

**DATE AND TIME OF ADMISSION:** 22/10/01 1900

**CONSULTANT :** MORLEY

31yr old ♂

## PRESENTING COMPLAINT:

C/P - since 1pm yesterday (L) parasternal sharp pain °rad:
- Sudden onset
- Constant since
- took paracetamol + 1xGTN - relieved pain
- also abdo. pain across upper abdo + round flanks to back
- °pain in chest @ present - still abdo.
- took dog for walk this pm → C/P really bad
- Sweating ++ °N/V °diarrhoea
- SOBOE 2° to asthma no ↑ in SOB past 24°
- occ. wakes up SOB °orthopnoea
- °Cough °sputum
- smokes 10/day for 15 yrs
- father - angina, MI 55yo mother - angina

Prev episodes of C/P past yr.
→ never admitted
→ had ETT -ve
Echo Cx -ve

## PAST MEDICAL HISTORY

4x @ 38 post M.I.

| | | |
|---|---|---|
| ANGINA | Y / (N) | |
| MI | Y / (N) | |
| HYPERTENSION | Y / (N) | |
| COAD | Y / (N) | |
| ASTHMA | (Y) / N | 10y |
| CVA / TIA | Y / (N) | |
| DIABETES | Y / (N) | |
| EPILEPSY | Y / (N) | |
| RHEUMATIC FEVER | Y / (N) | |
| JAUNDICE / HEPATITIS | Y / (N) | |
| PEPTIC ULCER DISEASE | Y / (N) | |

**OTHER SIGNIFICANT Hx**

Several A+E attendances for ↓↑
°GPs
°Hospital admissions
Never had anaesthetics
Hyperlipidaemia - 4x 3/12 ago

## MEDICATIONS:

Simvastatin 10mg nocte

## KNOWN ALLERGIES:

NKOA

## SYSTEMIC ENQUIRY

**CVS** HPC

**RESP** SOB

**GI** Bowels regular
-Blood/mucus
Occ heartburn - less frequently
*Prev. abdo. pain
-Dysphagia
App OK Wt loss 6/12 lost 1st.

**GU** NAD

**CNS** NAD

**LOCO** NAD

↓ - *Anx/Dep

## LIFE STYLE

EMPLOYMENT: Unemployed single parent - prev. worked as a wind turbine manufacturer

SMOKING: YES / EX / NEVER
No. per day 10+ or stopped when? 15+ y

ALCOHOL: YES / NO Units per week >28U one night/wk Friday

HOME CIRCUMSTANCES:
Lives ± daughter - 6y.o. → good health

## FAMILY HISTORY

| | | | |
|---|---|---|---|
| DIABETES | YES / NO | TB | YES / NO |
| HYPERTENSION | YES / NO Father | ASTHMA | YES / NO |
| IHD | YES / NO Father Mother Grandad | Rh ARTHRITIS | YES / NO |

OTHER CONDITIONS / INFORMATION:

Nil

## Summary & Differential Diagnosis

- NSTEMI – lateral
- complex aimant regime for RVD.

## Initial Cardiac Diagnosis

- ☐ ST ELEVATION MI
- ☐ ACS NO ST ELEVATION
- ☐ ACS EXCLUDED

## Initial Management

- Usual CCU Rules re therapy, ~~diet~~
- Bisoprolol now
- Fondaparinux
- Nicotinepatch.
- Nurse not prescribed; aspirin or ticagrelor; Decide tomorrow.
- TROP 2 @ 0100. PCI +/- } ANGIO. ECHO }

## Risk Scoring

GRACE

| | Death | Death / MI |
|---|---|---|
| In-hospital | | |
| 6 months | | |

http://www.outcomes-umassmed.org/grace

**TIMI Score** Total Score

## ECG Interpretation (include date & time)

SR
TWI III L avh
(2) ST↓ avF, V
(1) ST↓ V3 – V6
↓.

## CXR Interpretation

~~Bilateral~~ Bilateral lingular
- no focal consolidation
- both angles seen.

## Baseline Blood Results

| | | | | | |
|---|---|---|---|---|---|
| Hb | 134 | Na | 139 | Ca | |
| MCV | 11.6 | K | 4.1 | Corr Ca | |
| WCC | 358 | Urea | 4.6 | Glucose | 5.7 |
| Plt | | Creat | 74 | Total Chol | 6.64 |
| PT | | Est GFR | >60 | HDL | 1.67 |
| APTT | | ALT | 44 | TRIGS | |
| Mg | | Bili | 6 | HDL:LDL | 3.90 |
| $PO_4$ | | ALP | 101 | TSH | |
| | | ALB | 35 | | |
| $CK_1$ | 26 | $CK_2$ | | Trop T | (1) 0.067 (2) 2-5 2000 |

bic

### Arterial Blood Gases

| Time | | | |
|---|---|---|---|
| $FiO_2$ | | | |
| pH | | | |
| $pCO_2$ | | | |
| $pO_2$ | | | |
| Bicarb | | | |
| BE | | | |
| $O_2$ sats | | | |

### Urinalysis

Leuko
Nitrite
Protein
Blood
Ketone
Glucose
pH

## Emergency Echo Findings / Other Investigations

Signed _____ Date _____

**Admitting Nurse** NAME _____

Signed _____ Date 16/11/16

**Admitting Doctor** NAME _____ PAGER 4226

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# NHS Tayside Cardiology Services

Ninewells ☐ PRI ☐ Ward CCU.

Consultant -

Ethnic Group
- ☑ White Scottish
- ☐ White Irish
- ☐ White British
- ☐ White Other
- ☐ Mixed Origin
- ☐ Other Black
- ☐ Black African
- ☐ Black Caribbean
- ☐ Other
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Other Asian

CHI No. 050370 0058
Surname STANDISH
Forename(s) DAVID
Address

## Admission Source

Ambulance No. (from amb form)

☐ 999 Direct ☐ Outpatients ☐ self presentation (didn't call GP/999) ☐ already in hospital (specify source ward)

☐ Called GP, told make own way to hospital ☐ GP saw patient, then dialled 999 ☐ GP dialled 999 then saw patient ☐ Other (specify)

## Timings

| | Date | Time | | Date | Time | | Date | Time |
|---|---|---|---|---|---|---|---|---|
| Symptom onset | | | Arrival at hospital *from ambulance form* | 16/11/16 | 1830 | Seen by Nurse | | |
| Call for help | | | Arrival at CCU | 16/11/16 | 2000 | Seen by Doctor | | |
| Arrival of help | | | First ECG | | | | | |

## History

16/11/16 CN shift

- Increase in anginal chest pain at rest for 6 m', gets at rest about 1 per month, not actioned
- Today ~2pm', (c) chest pain radiating to (L) arm-heavy, dizzy. Not clammy/nauseas/no jaw pain. Pain high enough to call 999. +1700
- Same position but worse than 'angina' pain.

- Hx of palpitations over last 6 m also', uncertain that related to angina, thinks occur seperately.

- Pain had resolved by the time in to ED.
  → Had Aspirin & GTN.

- NVD', can't take clopidogrel

reduced over years

## Cardiac Risk Factors

- ☑ Smoking — Ex ☐ Current ☐ 6 /day 30 /yrs
- ☐ Diabetes — Type 1 ☐ Type 2 ☐ Diet Control ☐ Oral Rx ☐ Insulin ☐
- ☐ Family History — Male <55 yr, Female < 60 yr — Details: Father 40 MI
- ☑ Hypertension
- ☑ Cholesterol
- ☐ Obesity

## ECG

*If ECG is not diagnostic in a patient who gives a typical history of MI then repeat ECG in 15 mins.*

- ☐ ACS WITH NO ST ELEVATION (Utilise ACS with NO ST-Elevation ICP)
- ☐ ST ELEVATION MI
  - ☐ ST Elevation >1mm in 2 contiguous limb leads (II,III,avF / I,avL)
  - ☐ ST Elevation >2mm in 2 contiguous chest leads (V2 - V6)
  - ☐ Posterior MI (ST depression V1-V3 &/or ST elevation >1mm in V7-V9
  - ☐ New / apparently new Left Bundle Branch Block

**EARLY THROMBOLYSIS** if no Contra-Indications - see STEMI ICP
Aim for within 30 mins - this is National Standard

- ☐ ACUTE CORONARY SYNDROME EXCLUDED

## Drug History

Source of history: ☐ Patient ☐ Relative ☐ GP Letter ☐ GP Practice ☐ Database printout ☐ Drug Boxes ☐ Nursing Kardex ☐ Community Pharmacy

| Name | Dose | Frequency | Hold | Stop | Comments (if medication held or stopped) |
|---|---|---|---|---|---|
| ✓Rosuvastatin | 5mg | Twice a week; Wed + Sat | | | – not tolerating |
| ~~Fluvastatin~~ | | | | | |
| ✓Cilostazol | 50mg | BD | | | Being used as antiplatelet for PVD – Hospital prescribes usually – antiplatelet therapy. |
| Salbutamol | 100mcg | 2puffs | PRN | | |
| ✓Lansoprazole | 30mg | ~~daily~~ BD | | | |
| ✓Felodipine MR | 2.5mg | daily | | | |
| ✓Folic Acid | 5mg | daily | | | |

Amlodipine, clopidogrel, fluvastatin, atorvastatin, all stopped – problems with abdominal pain, currently awaiting injectable therapy.
Dr Bains is his consultant for PVD therapy.

Are you satisfied that this drug history is accurate and complete ☑ Y ☐ N 4276 — If no then what action is required e.g. call GP

Reviewed by Pharmacist ? Name: Signature

## Allergy & Hypersensitivity

Please record name of substance in addition to type of reaction e.g rash

- Various changes to therapy.

## Past Medical History

| | | Details |
|---|---|---|
| Previous MI | ☐ | |
| Angina | ☑ | Gen perpetuations |
| CABG | ☐ | |
| PCI | ☐ | |
| Heart Failure | ☐ | |
| Arrythmia | ☐ | |
| Rheumatic fever | ☐ | |
| Valvular disease | ☐ | |
| Renal Disease | ☐ | |
| PVD | ☑ | ~~fem~~ CFA endarterectomy, vein patch @ SFA Angioplasty. Bypass Sx. |
| CVA / TIA | ☐ | |
| Jaundice | ☐ | |
| Epilepsy | ☐ | |
| COAD | ☐ | |
| Asthma | ☑ | Ulcer disease; Anti platelet related. |

If Previous CABG or PCI, include dates and vessels if known

Father & mother; CVAs.

## Social History & Functional Status

- live alone
- Father in Dundee – Demise.
- unemployed due to medical reasons.
- Nil regular alcohol; v. occasional.

Smoking Status is recorded in the risk factor section on front page

## Systemic Enquiry

- cold – 2 days
- °UTI °DVT

## Clinical Examination

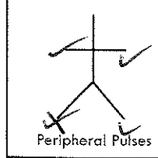
**General**

well, pain free
clearly.

BM
S.E.W.S
MSQ

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| BP Left | 171/88. | Heart Rate | 97 | Heart Rhythm | SR. | | |
| BP Right | 157/89 | Temp | 37° C | $O_2$ Sats | RA on Air | Resp. Rate | 18. |

**Cardiovascular**

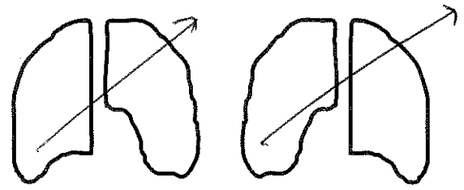



Dorsalis pedis ✓ (L) Absent (R)

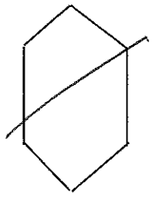
Both feet warm.

HS 1+II+0 JVP ~2cm
No pedal oedema
Calves SNT.

**Respiratory**



**Abdominal**



SNT
BS ✓

**Neurological**

Moving appropriately.

**Other**

VRI
Hospital/Clinic

**IMMEDIATE OUT-PATIENT COMMUNICATION**

WASE (MED)
Clinic

Ward/Clinic/
Hosp. ..... Cons.

D D M M Y Y
2 5 0 3 0 4 C.H.I. No. 3

Surname STANTISH
First Name DAVID M. State
Address 41 MADISON AVE DUNDEE Sex

G.P. & Address (G.P. Requests only)

USE BLOCK LETTERS OR PATIENT LABEL

**Fold Back**

Date 16/3/04

Dear Doctor,

The above patient attended my clinic today, please accept this as the only / interim* communication in respect of this visit.

Provisional/Diagnosis is PAD

Comment/Recommendations

Has stop smoking
Already on ATENOLOL 50 and BENZHEXOL 2.
Please add BENOFIBRATE 200 od
(2 vs usual in March August etc)
Insulin
4 Jabs

Next appointment (if any) 6 weeks/months

**Fold Back**

| MEDICINE TREATMENT RECOMMENDED NAME—State Date when Medicines should be stopped | DOSE | STOP DATE | Times of Administration (Mark ✓) 8 10 12 14 16 18 20 22 24 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Prescription given / Medicines supplied / Medicines not supplied *

Signed by JOHN MCCLL for ..... Consultant

**Do not write below this line**

*Delete as appropriate

Dr. .....

.....

.....

.....

THB(MR)159 (2-part set General – 3 part set Psychiatry Dundee)

Agreed to take for now. On lansoprazole bd.
He asked if Dr Baines from vascular medicine could speak with him - I have sent him an e-mail.

G Feltham
5431

17/11/16 Pharmacist note.
See clinic letter 21/9/16 from Dr Baines - aspirin hadn't been given because of GI potential effects, and if clopidogrel treatment hadn't worked, ticagrelor was to be considered cautiously.
Dr Baines should definitely be involved in the antiplatelet treatment of this gentleman.

Thanks
JM McGeoghegan
#4276

Also - it could be considered now to ↑ rosuvastatin to every alternate

HISTORY/CONTINUATION SHEET

UNIT/WARD/DEPT.

Ward/Clinic/
Hosp. ..... Cons.

D D M M Y Y
01 03 70 00 51 3 C.H.I. No.

Surname STANDISH
First Name DAVID M. State
Address Sex

G.P. & Address (G.P. Requests only)

USE BLOCK LETTERS OR PATIENT LABEL

Page .....

| DATE | |
|---|---|
| | CT2 Ferguson |
| 17/11/16 | |
| 15.40 | Call back from pharmacist re: above - ALIROCUMAB, PCSK9 inhibitor has actually passed SMC approval. It is available through the cardiovascular risk clinic. |
| | G FERGUSON 5431 |
| | ECHO - normal LV size/function<br>- normal RV size/function<br>- no significant valve disease.<br>- LA mildly dilated. |
| 18/11/16 | WR Hutchison |
| 08.55 | 120/67, 60. |
| | Remains well, pain free. Waiting for angio - ? today, ? Monday. Managed fallots so far. |
| | G FERGUSON 5431 |
| | Plan: Angiogram |
| 19/11/16 | WR D. Ben |
| | NSTEMI await angio (PVD) Bypass graft, Exercise (intolerant to clopidogrel) |
| | SpO2 100% |
| | O/E BP 136/77 |
| | P 65 |
| | clear |
| | (P) smack to ramp |
| | Angio ? Monday |
| | 3rd |

THB.(MR)3A

DATE

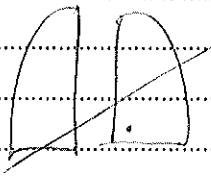
21/11/16
1100

WR @ SAUH

Patient not sleeping well.
Reports from nurses he was upset overnight about this.
Tried Temazepam, refused Zopiclone overnight
- neither helped with sleep.

Patient requesting side room to improve sleep
Advised unlikely due to demand.

O/E
HS I+II+0



→ Chest clear
° Peripheral oedema

P/ for Angio - on list for today.

Anne Petersen
FY-5 MBChB

22/11/16 WR Dr Martin

- Awaiting angio
- Discussed angio and options depending on findings
- NEWS 0

Plan : Angio

K McNeil
Medical Student.

23.11.16
1100

CARDIAC REHABILITATION

Discussed hospital admission, diagnosis, procedure and recovery.
Feeling shocked by events, but keen for home. All questions answered
and BHF booklets given, also directed to BHF website for information.
We will arrange for phase 2 contact to provide ongoing support
once home.
We would be happy to see at NVBC led clinic when there are any
medical objections.

L Byrne cardiac rehab nurse ext 22114

HISTORY/CONTINUATION SHEET

WI ..... UNIT/WARD/DEPT.

Ward/Clinic/ Hosp. NWH ..... Cons.

D D M M Y Y C.H.I. No.

Surname STANNISH

First Name DAVID 05 03 ..... M. State

Address 70 ..... Sex

0053

G.P. & Address (G.P. Requests only)

USE BLOCK LETTERS OR PATIENT LABEL

Page .....

DATE

23/4/16 DR SHERAR

Feeling better today

O/E

RS1+11 70

? regarding cholesterol injection.

Plan

(A) → LFT bloods tomorrow.

FH
#5034

THB.(MR)3A

DATE

8/12/16
46kg / BP unable

⇒ Chest pains
⇒ recent trauma

NSTEMI
⇒ Generally not very happy

Clinical Health Psychology re: Patient phone
Referral x 2.

New thyroid nodule

HISTORY/CONTINUATION SHEET

.....UNIT/WARD/DEPT.

Ward/Clinic/
Hosp. ..... Cons.

Surname ...
First Name .
Address ....
.....
G.P. & Address


0503700053

DAVID STANDISH

Y Y
C.H.I. No.
M. State
Sex

USE BLOCK LETTERS
OR PATIENT LABEL

DATE

22/11/16

Page 1

Dr N. Anglem / Dr Graham

NSTEMI

PCI RCA

6F RRA
JL 3.5 JR 4.0 ® guide BMW
GTN · bgm

LMS
LAD
Lex
} Clear

RCA proximal severe
distal severe
mid severe disease

2 DES previously
deployed

had NSVT during the
procedure : Torsades de Pointes

on DAPT

24° cardiac monitor.

Dr Ong

THB.(MR) 3

HISTORY CONTINUATION SHEET

Ward/Clinic/Hosp ..... 0503700053 Cons

D D M M Y Y C.H.I. No.

Surname ..... Standish

First Name ..... David

Address ..... Sex .....

UNIT/WARD/DEPT. G.P. & ADDRESS

USE BLOCK LETTERS OR PATIENT LABEL

DATE

Page

DATE 17.11.17
WEIGHT 105 Kg
HEIGHT 178 cm
URINE NO Spec

NSTEMI Nov 2016 VF during angio.
PVD Cor stents.
Statin intolerance. Ezetimibe intolerance abdo pain.
Chol 7.13 Sep 2015 HDL 1.34
6.64 Nov 2016 HDL 1.67

Took statins for several years. Aches + pains, felt unwell, cold symptoms. Tried several different statins. including rosuvastatin. Only noticed side effects after stopping diazepam. Ezetimibe - abdo pains. Insomnia, myalgia on statins.

No chol Rx for >1 yr

BP been controlled on Rx

Still some chest pains - atypical. Sometimes responds to GTN.

No breathlessness. Sometimes uses salbutamol.

No ankle swelling. No orthopnoea

PMH NSTEMI
VF arrest
PVD
Iliofemoral bypass (R) leg.
- pain 10-15m. both legs.
Asthma
Hs

FH Father MIs from early 40s. Age 72 of
Sister † 48 brain tumour

Rx
Ramipril 2.5mg
Bisoprolol 2.5mg
Aspirin 75mg
Folic acid 5mg
Lansoprazole 30mg
Zopiclone 7.5mg nocte
GTN spray
Salbutamol inhaler prn.

Allergies
Statin intolerance
Ezetimibe intolerance

Social
Stopped smoking Nov 2016.
Alcohol - v. little
Boat builder - not working
Lives i father + daughter

(MR)3A

BP 152/94 P63. HS I+II+0 JVP → °Oedema
144/89 PS7 °Bruits Perpheral pulses difficult to feel. Feet warm.
146/82 PS7 Chest clear
138/84 PSS Abdo soft non-tender °LKKS °Masses
BS (N)
Neuro grossly intact
°Xanthelasmata °Corneal arcus.

Plan FBC, U+E, full lipid profile including LDL + TG, TSH, LFTs, glucose.

Assess for eligibility for alirocumab
- Polyvascular disease
- Intolerant statins + ezetimibe
- Need to review lipid profile

Probably will be eligible for → alirocumab 75mg SC injection 2 weekly.
Discussed treatment + side effects
If not, try v. low dose statin mixed or retry ezetimibe

Ring pt next week ~ results + plan.

3/12 ~ fasting full lipid profile prior to review

I MACKENZIE CONS.

28/11/17 Total chol >7
Calculated LDL 5.0mmol/l.
Phoned patient. Agreed to start alirocumab 75mg sc injection 2 weekly. Discussed side effects again.
Prescription written
Nurses in Area 5/6 to contact pt to start Rx.
Wife will administer injections → to be trained

I MACKENZIE CONS.

See 3/12 as planned

HISTORY/CONTINUATION SHEET

Ward/Clinic/Hosp. .....

Surname .....
First Name .....
Address .....
.....
G.P. & Address (G.P. R

STANDISH
DAVID
20 CANNING
DUNDEE

DD3 7RT

Fiona

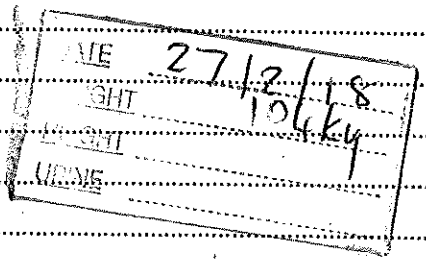
DATE

BLOCK LETTERS
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.....UNIT/WARD/DEPT.

Page .....

DATE




(47)

Current medication unchanged from last visit.

BP 132/85 pulse reg 57 bpm.

3/12 Review after starting Alirocumab 75mg s/c in Dec 2017. No problems. Good compliance

Most recent Lipids 05/02/18: TC 5.05 (7.36 on 17/11/17)
Trig 2.12
HDL 1.27 no LDL result.

? need to ↑ Alirocumab to 150mg s/c.
Discuss with Consultant Prof George.
Yes ↑ to 150mg s/c – prescription
f/u 3/12 to get lipids incl. LDL/trigs @ GP 1 week before CVA Risk clinic.
Refer for bloods to check for FH

DR HARPER
Spec Doctor

8/5/18 } on the 24 April I referred patient to E. Gellatly FH nurse.
on the 1st May I ~~referred~~ verified a letter to the patient to let him know that I had referred him to our specialist clinic nurse Emma Gellatly. To be discussed further ~~in next~~ in clinic today.

DATE 8/5/18
WEIGHT 101 kg
HEIGHT
URINE

DATE 13/7/18
WEIGHT 101 K
HEIGHT
URINE

DATE 14/8/18
WEIGHT 100kg
HEIGHT
URINE

BP 127/76
P62
Sleeping well, tolerating meds

Chronic:
Ramipril 2.5mg od
Bisoprolol 2.5mg od
Folic Acid 5mg od
Aspirin 75mg od
Canagrazole 30g od
Atorvastatin 150g on Q2W
GTN
inhaler

T.C 4.49
HDL 1.29
Trigs 1.25
LDL 2.64

Bp ⓞ 120/76 mmHg

ⓟ - Remain bl/c & op appt

HISTORY/CONTINUATION SHEET

.....UNIT/WARD/DEPT.

Ward/Clinic/
Hosp. ..... Cons.

Surname ..
First Name
Address ...
.....
G.P. & Addr

STANDISH 05 03 70 0053
DAVID G M
10 BALLINDEAN TCE
DUNDEE
DD4 8PB

DR. C AFFLECK
PARK AVE M/C
DUNDEE

D D M M Y Y
C.H.I. No.
M. State
Sex
USE BLOCK LETTERS OR PATIENT LABEL

DATE

Page .....

23/10/01 – Oesophageal motility test organised as OP
10:30 – This will be done sometime in November.

TRSP THTO:01
GLAXMACM
NP CB/452

DATE 10.9.70
WEIGHT 89 Kgs
HEIGHT 178 M.
URINE ✓

BPT 28:1

Lhm.
Pares L leg > bottom
Leg - claudic-, 50 m, bilat.
Buttocks - more variable
- often after ex.
See my chr.
GP decimal points: level ok.

Meds chorus 40
excit 20
dalte 5
salb. inh } was needed much since stopped smoking
QVAR inh.
f'sol / chlorphen cod.
Allergies nk
Ex. smoker 40/52 (10-15/day)
Diet normal
Etoh v. little, (usually none)

Past Childhood nil
Admit nil
chest - asthma 20

Fam F (66) - Dementia, Dr, HT cvd 43
M (63) well
Sibs 4 blood fam.: HT
Children 2 (6, 15) well
Bone brittles - off @ present

DATE

Wife ill, vomiting, trying to stop
- H/W
Moodle, will underwrite W + y

82 tried feeling + pain ↓ chest
→ @ arm
- happens when relaxes
- lasts 15-20 mins ; more freq.
clamps ↓ arm when working above head
pain:
appt ✓ it →
dyspepsia
nausea
had wine ER - park on afore:
- for this, settled now
- no other alarm features
legs pink @ night
headaches
blurred vision
paroxysmal hot

Gen pleasant, anx.
no sig.
URS ↓ for 3/7 no/24
Hb & RF wo
other uri, groin
↓ foot
Chest clear
Abdo soft
No edema, ? uri
Fundi hyd only

Chest (+ xray)
R carotid, endo ?, folate
- for Hr
ECG, cardiac echo
UR cyto

GM 4-jab

HISTORY/CONTINUATION SHEET

.....UNIT/WARD/DEPT.

Ward/Clinic/
Hosp. ..... Cons.

D D M M Y Y
C.H.I. No.

Surname .....
First Name ..... M. State
Address ..... Sex
.....
G.P. & Address (G.P. Requests only)

USE BLOCK LETTERS OR PATIENT LABEL

DATE

Page .....

DATE 16-3-11.
WEIGHT 52.5 kg
HEIGHT
URINE

117/65
62

Rec Hx
Fine. Fingers and Hay.
Poor con + still perfumed.
Bloods not quite as hoped
- Rx fibrate, for Hx.
(Bone line bloods today)
Smoking - chest again (+ N),
6/12 4 Jith

Needs
Above 40
over 10
Not much.
Clopid 75

DATE 22/9/11
96 kg

BP 144/85
P 124/66 78

Has had
- still some pain i & leg
Ex tol 20 m
variable walk. then
no conditioning
Back on ezet
- 2 breakthroughs (plus dog)
Chest, knee,
Bloods, urine
(? clopidogrel next time)

Needs
Above 40
over 10
Less 200
Clopid 75

over 20
ish.

6/12 4 Jith

DATE 23/3/12
WEIGHT
HEIGHT
URINE

THB.(MR)3A

DATE

DATE 22.6.12
WEIGHT 92kg
HEIGHT
URINE

113/70
70

Much the same
Still on cigs.
- 5/day.
Clearance ok.
Chest
Refer Audrey
(tried puffer for ex).

Meds
Advise
Asmo
Clopixol
Lansop

Ear
Arms
Face
Eyelid.

6/12 4-Jul

DATE 21.12.12
WEIGHT 94kg
HEIGHT
URINE

111/66
68

PPP

⇒ Claudius
- Pain 10-15 metres
stops after 10-15 minutes
<200 yds

Meds
Unchgd.

⇒ Sleep, mostly upright.

⇒ Smoking still
Keen to stop

⇒ N.S Chest ↳ 9/4
cough ↑ Sputum

4/12

DATE 18/10/12
WEIGHT 96kg
HEIGHT
URINE

112/66 P 63.
BP Meds unch.

- Cough Chest wall

Not bad.
Walking much the same.
Still struggling ↓ cigs
- 6/day at present
Tried chantix - felt terrible
Paralysed, unobserved
- ch. excited to existence
(the Un)
e.g. eg:

6/12 4 Jul

BP 2.5.12 8/11

**HISTORY CONTINUATION SHEET**

Ward/Clinic/Hosp ..... STANDISH

Surname ..... DAVID

First Name ..... 20 CANNING PLACE

Address ..... DUNDEE DD3 7RT

0503700053 M

..... Cons

C.H.I. No. .....

Park Avenue Medical Centre, Park Ave

Sex .....

..... UNIT/WARD/DEPT.

G.P. & ADDRESS

USE BLOCK LETTERS OR PATIENT LABEL

DATE

Page

DATE 6-6-14
WEIGHT 96.6kg
HEIGHT
URINE

112/64 P 55

PMH
Hernia (P) CVA epilepsy

(P) leg painful
⇒ (P) groin injection

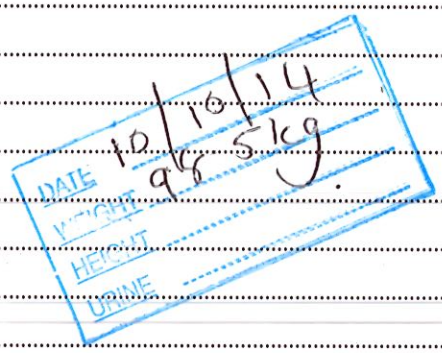
DH ⇒ Pin over CVA extra scan
Clinical Rheumatology review (P) groin injection now up
Examination No clinical signs (P) leg.
Investigations
Treatment (P) leg venous problem
Progress
Comments ⇒ Mirtazapine caused significant side effects mood related.
Problems

⇒ X-Ray hip + lumbar spine
⇒ ? some mild right OA

⇒ Cipralex few a day
likely MRI will be needed to assess
Does not want knee injection.
Await results of X-Rays before any

[illegible]
6/6/14
8[illegible]

THB.(MR)3A




149
77
95 y.

Stopped anti depressants last Oct
(mood swings & mirtaz)
Changed practice :: argumentative over
Meds, meds, etc.
Stopped ezet + statin + fenofibrate
- Meds better already
Stopped amlo → stomach issues
- better off them
Stopped all this w/ statin
- sleeping better now
Ch e-copy for us
- good

Meds folate
clopid

Leg ulcer.
½ off.
Has leg ulcer
Has ? varicose (hand note)
Gout ; probably fibrate rather than ACEI
- ok to inc.

3/12 4- fits

# HISTORY CONTINUATION SHEET

Ward/Clinic/
Hosp ..... Cons

D D M M Y Y
C.H.I. No.

Surname .....

First Name .....

Address ..... Sex .....

..... UNIT/WARD/DEPT.

G.P. & ADDRESS

USE BLOCK LETTERS
OR PATIENT LABEL

DATE

Page

DATE 08/05/15
WEIGHT 100kg
HEIGHT .....
URINE .....

BP - 139/74

P - 70

Ulcer too head.
No stomach pains
- bowling much & 1/time
Clopid ✓
Pariet ✓
Endoscopy → problem, reflux
Chest.
1g stone W & 1/time
Hb (?) falsed 8.5

4/52 4-/dh

5/6/15 124/74
100kg

Ulcer too head.
Stones after the lunch.
Pulsed 8.5 - managing Urin too.
Excel.
Chest happy.
Leave as Gen.

3/12 (Next on)
- Ulcer b/n, etc.
4-/dh

B.(MR)3A

DATE 24/9/15
WEIGHT 100kg
HEIGHT
URINE

Mba

Ezekiel
1

- Alcoholic
- Urgent metabolic regime due to intubation.
- So. So again no
- Now off meds again
- Tried Diazepam again
  Now back with metabolic
  ⇒ Dr MacMillan Carlisle (is GP)
  → 5mg Diazepam.

Alc problems seemed to hit the Diazepam was withdrawn.

Stop Fluids
Continue Thiamine 40mg 10mg
either IV Pabrin or oral tabs
Ezekiel if needed.

Write to Results of Bloods.
GP + patient
(Urgent).

THI

HISTORY/CONTINUATION SHEET

Ward/Clinic/
Hosp. ..... Cons.

D D M M Y Y
05 03 70 08 53 C.H.I. No.

Surname Standish
First Name David M. Stafe
Address ..... Sex

UNIT/WARD/DEPT.

G.P. & Address (G.P. Requests only)

USE BLOCK LETTERS OR PATIENT LABEL

DATE

Page .....

DATE 29/10/15
WEIGHT 98.1kg
HEIGHT
URINE

146 p82
177

Not actually posted Diazepam.
Thope I fully agree that we should let that it for the reason that he can that his pills against If he was on it anyway, that would be a different matter.
N.B. Chatted T.

Needs OGD
+ Breath test

⇒ Atherosclerotic burden is high.
2° Prevention is crucial
Investigate alcohol, pins, cramps + some thinning
Intolerant of Antidepressants + not keen on any antidepressant
Consult to Medicine
DNW U.T. re optics

B (MB)3A

DATE

DATE 07.01.16
WEIGHT 95 kg
HEIGHT
URINE

1) Fasted
2) Off all pills
3) ⇒ Urea breath test

⇒ One breath test ± separate high dose
+/− H. Pylori eradication

↓
Pellet meds are by me

↓
Clinical test

Copy letter to patient

TH

HISTORY/CONTINUATION SHEET

UNIT/WARD/DEPT.

Ward/Clinic/
Hosp. .....

**05 03 70**

Surname .....
First Name ...
Address .....

0503700053
DAVID STANDISH

G.P. & Address (Dr ... Request ...)

..... Cons.
Y C.H.I. No.
..... M. State
..... Sex
USE BLOCK LETTERS OR PATIENT LABEL

DATE

Page .....

DATE 12/5/16
WEIGHT 94kg
HEIGHT
URIN

MB
Examined
Pelvic Anal
Digital
Retroflexion

1) Symptoms
⇒ ~50-yd Hx
⇒ Bleeding & Constipation Hx
⇒ Prev (P) Femal endometriosis
⇒ (L) needs Hem-Par bypass & ablation
⇒ (P) Long mst symptomatic
likely Ant Pathology
⇒ Scan ☑ (P) Long re. slide.

2) Colorectal Hx.
⇒ Continue rectal agent
? PCSK-9 Hx.
⇒ Assay Pharm + refer Fibrate f/ups
in Nursing Home

Re Nemon.

DATE

DATE 16/06/16
WEIGHT 93.7
HEIGHT
URINE NIL

144/79
74

Tenable

⇒ Clopidogrel = stopped
= Smooth pms input

H. Pylori +ve too.

DATE
WEIGHT
HEIGHT
URINE

⇒ Pleurisy ⇒ Bleed due to risk of intracranially.

⇒ Avoid Antiplatelet

⇒ Seek CVR clinic advice re: PCSK-9 inhibitors

N.B. Multiple unmet risk effects ⇒ statins

Multiple issues + concerns.

⇒ Ask Gastro re: Re-Scope

CVR re. PCSK-9

HISTORY/CONTINUATION SHEET

.....UNIT/WARD/DEPT.

Ward/Clinic/
Hosp. ..... Cons.

D D M M Y Y

Surname ..... 05 03 70
First Name .....
Address ..... 0503700053
..... DAVID STANDISH
G.P. & Address (G.F

C.H.I. No. .....
..... M. State
..... Sex
.....
USE BLOCK LETTERS OR PATIENT LABEL

DATE

Page .....

DATE 8/9/16
WEIGHT 94kg
[illegible] 178
[illegible] NAD

157/83
p93

Tramadol life ever
↳ little diet

Clotting

⇒ Symptomatically a bit better

Clotted ✓ – Pneumo
– Referral to gyne urology Plymouth
– if fits at 3 mths.
Persona ✓

Platelets ✓ Hep
Aspirin

⇒ Try Clotted (Club discuss Laryngeal)

If fits, exit Tramadol
3-6 mths

GSF
8/16

Folic acid
Selenium
Lansoprazole

N.B. thrombocytopenia
GM Dynamics

THB.(MR)3A

DATE

DATE 18.6.19
WEIGHT 100kg

Last seen April 18

NS SC from rheumatology
still taking every 2 weeks
children have been tested for RA - not carriers

| | |
|---|---|
| Ramipril | 2.5mg |
| Lansoprazole | 60mg |
| Bisoprolol | 2.5mg |
| Folic Acid | 5mg |
| Aspirin | 75mg |
| Nicoumalone | 1.5mg |

Last checked April 18
TC 4.49
HDL 1.29
Rat 3.4
Trig 1.25
LDL-C 2.64

BP today 114/72

(P) 1. No A to rx
2. Cholesterol bloods today
3. R/V 12/12

Dr Smythe
NSH ext 33075

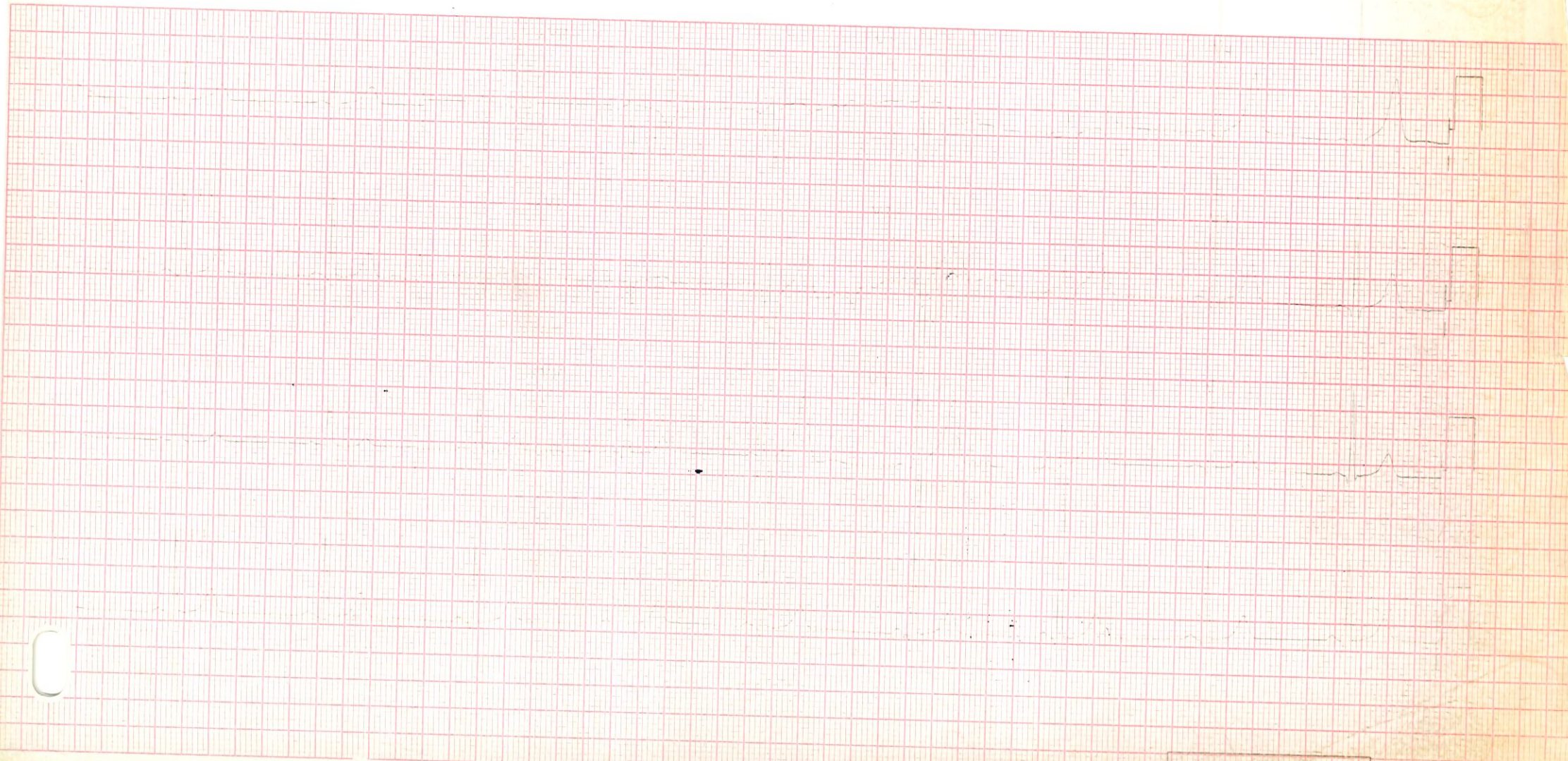
05 03 70 0053

DAVID STANDISH

MIZ

23/10/07

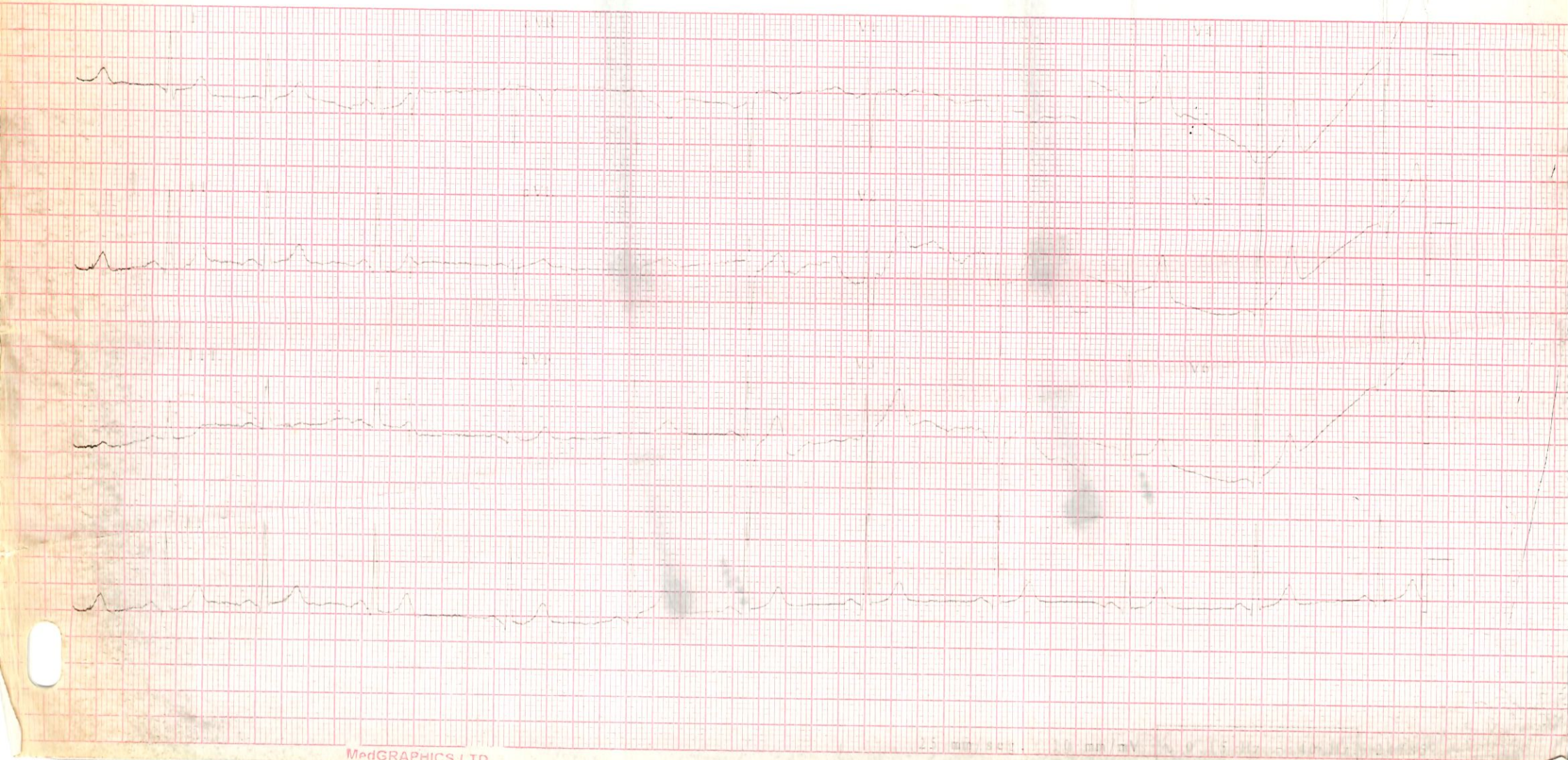
03[40]



MedGRAPHICS LTD

25 mm/sec 10 mm/mV ∿ 0.15 Hz - 40 Hz 24807

DAVID STANDISH 22/10/01 20[00]




MedGRAPHICS LTD

David Standish

22/10/01




25 mm/seg. 10 mm/mV ∿ 0.15 Hz - 40 Hz 24786

MedGRAPHICS LTD

DAVID STANDISH 5.3.70 M/W WIS 23.10.01 9AM



Ninewells Hospital

A&E No. **NW-16-042402-1**

# TAYSIDE UNIVERSITY HOSPITALS
# ACCIDENT & EMERGENCY SERVICES

CONSULTANTS:
**N.M. Nichol**

NHS Tayside

REGISTERED BY: **lorraine fyall**

| | | | | |
|---|---|---|---|---|
| SURNAME<br>**Standish** | DOB<br>**05 Mar 1970** | CHI<br>**0503700053** | DATE<br>**16 Nov 2016** | TIME OF ARRIVAL<br>**18:29** |
| FORENAME<br>**David** | AGE<br>**46 Years** | | COMPLAINT<br>**CHEST PAIN** | |
| ADDRESS<br>**20 CANNING PLACE**<br>**DUNDEE** | SEX<br>**Male** | STATUS<br>**Single** | LOCATION OF INCIDENT<br>**Home or other house and garden** | |
| | RELIGION<br>**None** | | MODE OF ARRIVAL<br>**Ambulance (road)** | |
| POSTCODE **DD3 7RT**<br>TEL. **07402993659**<br>MOBILE | 1st LANGUAGE<br><br>ETHNIC ORIGIN<br>**White** | | TIME SINCE EVENT<br>**4-6 Hours**<br>OCCUPATION/SCHOOL<br>**unemployed** | |
| TEMPORARY ADDRESS<br><br>POSTCODE:<br>TEL. | ALLERGIES<br>**None known**<br>REFERRED BY<br>**999 emergency services** | | GP NAME **BULLIONS**<br>ADDRESS<br>**COLDSIDE MEDICAL PRACTICE**<br>**129 STRATHMARTINE ROAD**<br>**DUNDEE**<br><br>POSTCODE: **DD3 8DB**<br>TEL. **01382880900** | |
| 1st CONTACT<br>**Miss Denise Mclaughlin**<br>ADDRESS<br>**9 MANSION DRIVE**<br>**DUNDEE**<br><br>POSTCODE<br>TEL. **07449 022684**<br>RELATIONSHIP **Partner** | 2nd CONTACT<br><br>ADDRESS<br><br>TEL.<br>1st CONTACT NOTIFIED<br>**Yes / No** | | ACCOMPANIED BY<br>**Partner** | |
| TRIAGE TIME<br>**18:39** | TRIAGE NURSE<br>**karen ferguson** | | IMMUNISATIONS | |
| FLOW CHART / DISCRIMINATOR / PAIN SCORE<br>**Chest Pain, Cardiac pain,8** | | | TRIAGE CATEGORY<br>**2** | |

TRIAGE INTERVENTIONS
**SEWS chart commenced, Temperature, Respiratory rate, BP, Sp02, Heart rate, 12L ECG, Cardiac monitoring**

NURSING ASSESSMENT
**Left shoulder and arm pain today x 2 episodes. PMH peripheral artery disease.**

## NURSING NOTES

Surname **Standish** Forename **David** A-CHI **0503700053**

ASSESSMENT: A - Patent, pv talking
B - Self ventilating
C - Pale
D - GCS 15/15.

RE-TRIAGE to: ..... *(Using Man. Triage)*
Time: ..... Transferred to: .....

Nurse Name: K. FERGUSON
Signature: KF
Time:

INTERVENTIONS:

T: 36.6 P: 104 BP: 146/79 R: 18 SpO2: 99% on BM:

TRIAGE DATE & TIME: **16/11/2016 18:39**

**Assisted onto trolley, Pressure relieving mattress in situ, Brakes on and cot side up., White patient ID band on, SEWS commenced, Clothes off and examination gown on, Procedure explained and reassurance given**

Continuous cardiac monitoring. Senior Dr. called for. KF
NEWS 1 ↑HR
Was signed for own belongings KF
GTN administered as prescribed KF.
Aspirin administered as prescribed KF.
Repeat NEWS. & 12 lead ECG. NEWS 1 ↑HR KF.
Wife into see David
Awaiting CCU review (Dr. currently in CT scan
Prepared for transfer to.

EVALUATION:

Now pain free KF

PAIN SCORE:
WATERLOW SCORE:

David & partner aware of need for admission & understand plan of care

Prepared for admission to CCU, patient and partner aware of reason for admission and appear happy with this transfered on trolley with cot sides in situ, appears comfortable, NEWS = 0, escorted to ward

Nurse Name: LYNATHER
Signature: Lmather
Time: 2040

Patients Name DAVID STENHOUSE A-CHI 0503700053

00053

1st CLINICIAN Baird DATE 16/11/16 TIME

46 → PC Chest pain

HPC ~~No previous chest pains~~ Has had CP 1-2/month prior 6/12; in bed, last ~10 mins

Today @ 1400 onset (L) sided CP at rest.
- Constant ache, radiating to (L) arm
- Felt a bit clammy, ? vomit.
- Here on moving, not pleuritic.
- Eased after ~ 1 hr.

Further episode @ 1700. - as above
- Hyperventilated → SAS → pain resolved by arrival → ED.

In ED short episode in (L) arm only

Heavily stressed obsessional ? 6 years ulcer.

PMH
PVD - CFA endarterectomy + SFA angioplasty
- Ongoing claudication. ~/20 yrs
Gastric ulcer - not on antiplatelets
Asthma

DH
Clopidogrel
Salbutamol
Lansoprazole
Ferrodimol
Folic acid
Fluoxetine

SH
Smokes 10/day.
Occ alcohol.
Unemployed.

SENIOR CMORNACH TIME ____ SPECIALITY ED. TIME REFERRED
(if involved)

TREATMENT DYNAMIC ECG CHANGES WITH NEW CHEST PAIN
1x @ 1400 LASTING 60 MINS + ACMI @ 1710.
NO ECG TO COMPARE, NO ANTICHOLINE Rx.

(P) CARDIOLOGY REVIEW, ASP/CLOP.

Patients Name David Standish A-CHI 0503700053

## ONCE ONLY PRESCRIPTION

| DATE | DRUG | DOSE | METHOD OF ADMIN | SIGNATURE | GIVEN BY | TIME GIVEN |
|---|---|---|---|---|---|---|
| 16/11/16. | GTN | 2 sprays | S/L ing | | | 1850 |
| 16/11/16. | Adrain | 300mg | Oral | | | 1854. |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

A - pain

B - $SpO_2$ 99%. RR 18.
A/E equal
Few scattered crepe.



C - HR 104 BP 146/79.
Oedema
ECG - SR, ST↓ $V_3$-$V_6$.
HS 1+11+0.

D - RUQ
Mowing all 4 limbs

E - T36.6°C.
Abd soft.



Unstable angina ?NSTEMI.

GTN -> pain resolved.
Aspirin
ACS bloods
Repeat ECG -> improvement in ST↓, now TWI III + aVF
CXR.
?/v CCU

PAMS
ST3.

## Scottish Ambulance Service Patient Report Form

| | | | |
|---|---|---|---|
| Incident Number | CR003344242 on 16/11/2016 at 17:49 | | |
| Callsign | | Incident Type | EMG |
| Crew1 | E1014919 | Crew3 | |
| Crew2 | E0027650 | Crew4 | |

### INCIDENT LOG

| | | | |
|---|---|---|---|
| Incident Location | 20 CANNING PLACE DUNDEE | Incident Postcode | DD3 7RT |
| Call Received | 17:49 - 16/11/2016 | Patient at Hospital | 18:27 - 16/11/2016 |
| Call Passed | 17:49 - 16/11/2016 | Patient Handover | - |
| Crew Mobile | 17:49 - 16/11/2016 | Crew Clear | - |
| Crew at Scene | 17:53 - 16/11/2016 | Clear Reason | |
| Crew Left Scene | 18:15 - 16/11/2016 | | |
| Pre-alert Medical Standby | | | |
| Receiving Hospital | NINEWELLS HOSPITAL | | |

### DIAGNOSIS

| | |
|---|---|
| Chief Complaint Code | 10 |
| Despatch Code | 10D05 : Nausea or Vomiting with Chest Pains |
| Diagnostic Code | 10C04 : 10C04 - Chest Pain over 35 Breathing Normally |

### PATIENT DETAILS

| | | | |
|---|---|---|---|
| Surname | STANDISH | | |
| Forename | DAVID | | |
| Middle Initials | | Sex | Male |
| DoB | 05/03/1970 | Age | 46 years 8 months 11 days |
| Patient Address | AS LOCUS | Patient Postcode | |
| Patient Telephone | | Ethnicity | |

### PATIENT CONSENT

| | |
|---|---|
| Mental Capacity Assessed | Deemed To Have Capacity |
| Level of Consent | Risk Of Refusal Explained, Risks Of Condition Explained, Treatment Benefits Explained |

### PRIMARY SURVEY

| | |
|---|---|
| AVPU Assessment | Alert |
| Catastrophic Haemorrhage | No |
| Airway Assessment | Clear |
| Breathing Rate | Normal |
| Respiratory Rate | 15 |
| Pulse | Fast |
| Most Peripheral Palpable Pulse Found | Radial |
| Skin Colour | Normal |
| Skin Texture | Dry |
| Capillary Refill Rate | < 2 Secs |
| CSI Assessment | None |

### VITAL SIGNS

| *Time* | *Pulse* | *Rthm* | *AVPU* | *RR* | *SYS* | *DIA* | *PEF* | *BG* | *Temp* | *SpO2* | *PS* | *CRT* | *ECG* | *Sepsis* | *GCS* | *RTS* | *NEWS* | *ETCO2* | *Lactate* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 17:54 | 112 | Reg | Alert | 15 | 134 | 96 | | 8.0 | 36.6 | 99 | | < 2 Secs | Atrial Flutter | 2 | 15 | 6.6 | 2 | | |
| 18:19 | 100 | | | | | | | | | 98 | | < 2 Secs | | 1 | 15 | 6.6 | 1 | | |

### AMPLE

| | |
|---|---|
| Allergy Type | None |
| Previous Medication | LIST WITH PT CILOSTAZOL |
| Previous Medical History | PERIPHERAL ARTERIAL DISEASE AFFECTING BOTH LEGS |
| Disability | Long Standing Illness |
| Last Eaten Before Incident | More Than 5 Hours |
| Events Prior To Incident | PAST 6 MONTHS OCCAISIONAL L SIDED UPPER CHEST PAIN AND DOWN L ARM 4/10 AT WORST. LASTING 10-20 MINS ALWAYS WHEN PT IN BED |

### CHEST PAIN

| | | | |
|---|---|---|---|
| Patient History | Patient Over 35 Yrs old, Family history of MI | | |
| Symptoms | Chest Pain | | |
| Time Of Onset | 16:50 | Physical Activity | |
| Activity at time | JUST OUT OF SHOWER | | |
| Pain Location | Radiates to arms | | |
| Pain Character | Constant pain | | |
| Other ECG Details | ATRIAL FLUTTER | | |

### SEPSIS

| *Pulse* | *RR* | *SYS* | *Temp* | *GCS* | *BG* | *Pneumonia* | *UTI* | *Other infection* | *Abdo Pain* | *Diarrhoea* | *Abdo distension* | *Meningitis* | *Cellulitis* | *Septic arthritis* | *Wound infection* | *Infected indwelling device* | *No signs of infection* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 112 | 15 | 134 | 36.6 | 15 | 8.0 | NO | NO | NO | NO | NO | NO | NO | NO | NO | NO | NO | NO |
| 100 | | | | 15 | | NO | NO | NO | NO | NO | NO | NO | NO | NO | NO | NO | NO |

### GCS

| *Time* | *Eye Opening* | *Verbal Response* | *Motor Response* | *Total* |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| 17:54 | Spontaneous | Orientated | Obeys Commands | 15 |
| 18:19 | Spontaneous | Orientated | Obeys Commands | 15 |

## PATIENT SUPPORT

| | | | |
|---|---|---|---|
| GP Name | DR BULLION | GP Practice | COLDSIDE MEDICAL PRACTICE |
| Surgery Address | DUNDEE | Surgery Postcode | |
| Next of Kin | DENISE MCGLAUCHLIN | Next of Kin Telephone | |
| Next of Kin Address | AS LOCUS | | |

## ADDITIONAL COMMENTS AND OBSERVATIONS

999 CALL FOR 46 YOM WITH LSIDED UPPER CHEST PAIN INTO SHOULDER AND L ARM. PT DESCRIBES AS ACHE AND FEELS LIKE MUSCLE PAIN. PT HX PERIPHERAL ARTERIAL DISEASE AND FAMILY HX MI. PT NOW VIRTUALLY PAN FREE IN CHEST SLIGHT ACHE REMAINING IN ARM PT HAS HAD SAME OCCAISIONALLY (1-2 TIMES PER MONTH) OVER LAST 6 MNTHS ALWAYS IN BED, LESS SEVERE AND LASTING ONLY 10-20MINS. PT HAS NOT MENTIONED TO DRS. PAIN NOT ALTERED ON DEEP INSPIRATION OR MOVEMENT, FEELS IT IS EASED BY LYING ON HIS BACK. PT VERY ANXIOUS ALL OBS WITHIN ACCEPTABLE LIMITS, PT TACHYCADIC AND ECG SHOWS ATRIAL FLUTTER WHICH PT IS NOT AWARE OF PT TRANSPORTED TO NWHO A/E

## REPORT MANAGEMENT

| | | | |
|---|---|---|---|
| Report ID | CR003344242-16112016184404 | | |
| Software Version | 1.0.444 | Report Type | Interim |

Patients Name _____ A-CHI _____

CTI HART (+CCU review).

- hx noted.
- ECG shows ischaemic changes.
- Twave inversion III/aVF
- 2 episodes of (L) sided CP

→ 1st trop 0.067

(P) Admit CCU
Tx as NSTEMI.

#4326.

16·11·16. **DISCHARGE PROFILE**

Patients Name DAVID STANDISH A-CHI 0503700053

| | | | | | |
|---|---|---|---|---|---|
| Drugs: | Brought in by Patient | (Y) / N | Removed from Patient | Y / N |
| | Returned to Patient | Y / N | Transferred to ward | Y / N |
| | Other ..... | | | |

## Valuables / Belongings

Patient accepts responsibility for own belongings / Valuables: *Signature* X D Standish

Book No. ..... Page No. ..... Where stored ..... Receipt No. .....

Taken by ..... Taken by Police: *Signature* .....

## Discharge against Medical Advice

I, .....of.....

- wish to take my discharge from the hospital
- wish to remove .....aged.....

from the hospital. *(state name & relationship)*

I appreciate that this is against the advice and wishes of the Consultant in charge or his Deputy.
I acknowledge that I have been informed of the dangers of doing so and I accept full responsibility for my action and consequences arising therefrom.

Signed .....(patient / parent or guardian) Date.....

Signed .....Witness Date.....

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

Signed .....Medical Practitioner Date.....

| | |
|---|---|
| Out Patients: Date..... | Paed. Liaison HV: Y / N |
| ..... Time..... | |
| ..... Area..... | |

## Discharge Drugs

Prescribed by ..... Given by.....

| | |
|---|---|
| Left AED at: 2045 | Discharged by: doctor |
| Discharged to: CW | Accompanied by: doctor/nurse |

heck 22 Nov 2016 8:03:29 Qty/Check List: M4735A Serial Number:US00454960 ▷Delayed

em Test: Problems:

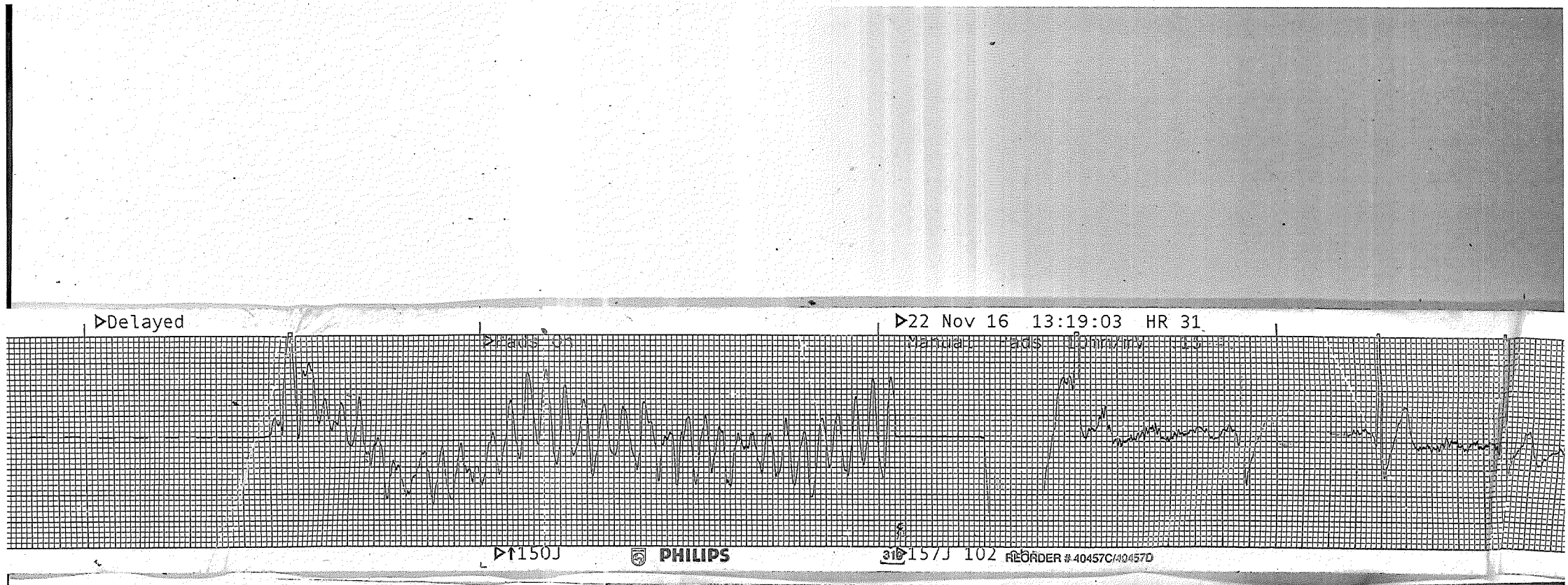
Test:

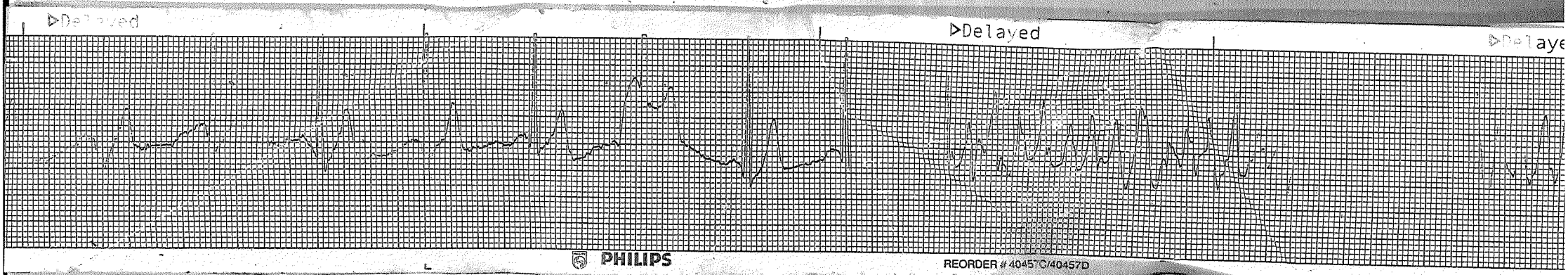
Visual Inspection
Patient Connectors
Cables / Leads
Monitoring Electrodes
Charged Battery
AC Power Cord
Paper
Supplies



PHILIPS

REORDER # 40457C/40457D

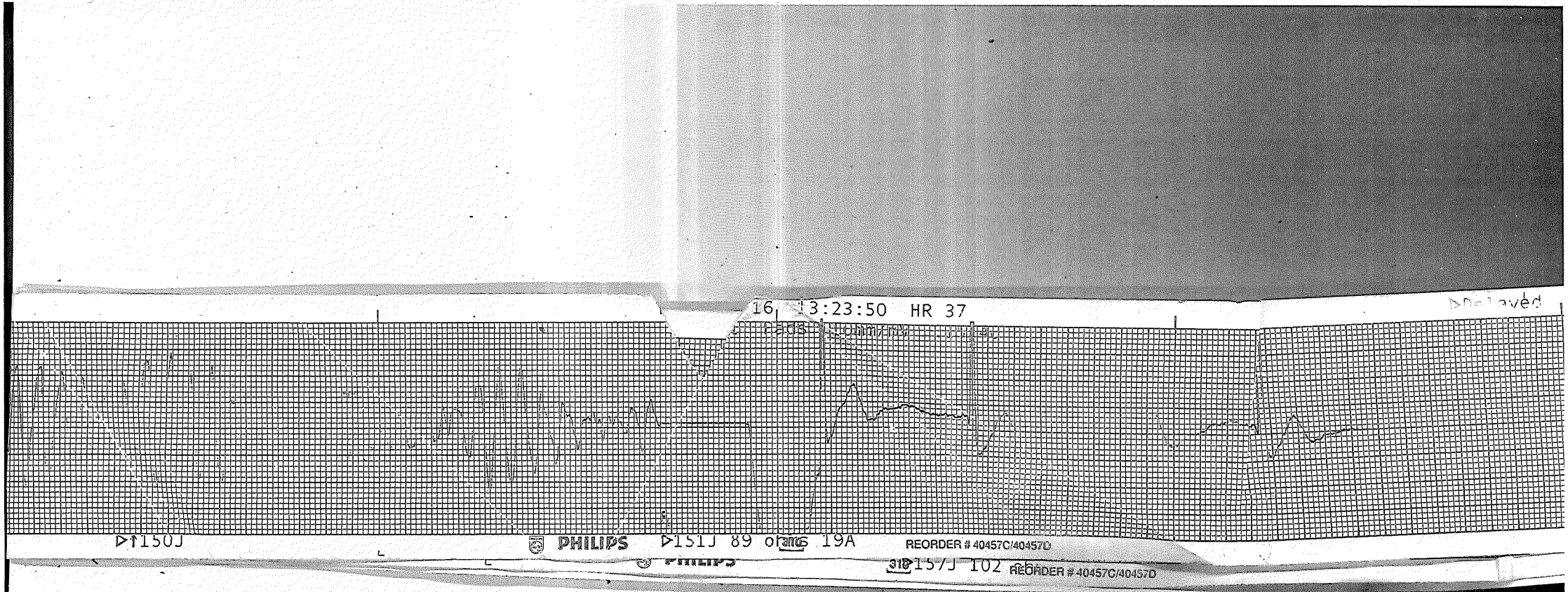

▷Delayed
▷22 Nov 16 13:19:03 HR 31
Manual Leads I 1mV/mV
▷Lead: I
▷↑150J
PHILIPS
316 157J 102
RECORDER # 40457C/40457D




PHILIPS

REORDER # 40457C/40457D

REORDER # 40457C/40457D


16 13:23:50 HR 37
Delayed
150J
PHILIPS
151J 89 of 316 19A
REORDER # 40457C/40457D
315 157J 102
REORDER # 40457C/40457D

# REFERRAL LETTER

MEDICAL IN CONFIDENCE

NHS Tayside

## REFERRAL TO

| | | | |
|---|---|---|---|
| CLINIC: | NEUROLOGY EPILEPSY | | |
| LOCATION: | NINEWELLS HOSPITAL | | |
| CONSULTANT: | ANY CONSULTANT | HOSPITAL CODE: | T101H |
| ADDRESS: | DUNDEE | CONSULTANT EMAIL: | |
| POSTCODE: | DD1 9SY | | |
| REFERRAL URGENCY: | SOON | AMBULANCE: | NO |
| REASON (If not routine) | REFERRAL TO FIRST FIT CLINIC | | |

## PATIENT DETAILS

| | | | |
|---|---|---|---|
| SURNAME: | STANDISH | ADDRESS: | 4E BALCARRES TERRACE |
| FORENAME(s): | DAVID | | DUNDEE |
| TITLE: | MR | POSTCODE: | DD4 8QX |
| SEX: | M | | |
| DATE OF BIRTH: | 05/03/1970 | TELEPHONE: | 07984910066 |
| CHI no: | 0503700053 | | |

## REGISTERED GP DETAILS

| | | | |
|---|---|---|---|
| NAME: | COLIN AFFLECK | PRACTICE ADDRESS: | PARK AVENUE MEDICAL CENTRE |
| PRACTICE CODE: | 11005 | | PARK AVENUE |
| GP IDENTIFIER: | T7130 | | DUNDEE |
| EMAIL ADDRESS: | caffleck@parkavenue.tayside.scot.nhs.uk | | |
| TELEPHONE: | 01382 462222 | POSTCODE: | DD4 6PP |
| FAX: | 01382 452866 | | |

## REFERRAL SOURCE (If different from above)

| | | | |
|---|---|---|---|
| DOCTOR: | | PRACTICE ADDRESS: | |
| PRACTICE CODE: | | | |
| TELEPHONE: | | | |
| FAX: | | POSTCODE: | |

SPECIALTY: Neurology Epilepsy | CLINICIAN: ANY CONSULTANT | SOURCE: COLIN AFFLECK

15 MAR 2005

## CLINICAL INFORMATION

**Reason for Referral** (including expectation of referral outcome)

REFERRAL TO FIRST FIT CLINIC ?fits.

**History of presenting complaint/examination findings/Investigation results**

This patient was seen on 14/02/05 when he gave a history of a possible fit while on holiday recently. It was witnessed by his girlfriend who I was unable to speak to today. Apparently it was characterised by shaking, a feeling of not being quite with it and 'feeling sleepy afterwards'. He has had these attacks really infrequently, though it appears that the first one may have been one and a half years ago. At present he is taking Diazepam as he is under severe stress.

**Past medical History**

**Current and recent medication**

Ventolin, Seretide, Simvastatin.

**Clinical Warnings** (e.g allergies, blood-borne, viruses)

**Additional relevant information** (including patients issues, social circumstances and special needs)

**Smoking status / Alcohol consumption**

Smoking Status: NOT APPLICABLE Alcohol Consumption: NOT APPLICABLE

**Electronic Signature**

SIGNATURE: Colin Affleck:Clinician DATE: 16/02/2005

**Referral Attachment Summary**

PDF DOCUMENTS: 0 IMAGES: 0 TOTAL ATTACHMENTS: 0

Urgent Up Clinic
New
Add 11.30/12.00
Slot

| | |
|---|---|
| Urgent | |
| Soon | |
| Routine | |

HISTORY/CONTINUATION SHEET

Ward/Clinic/
Hosp. ..... Cons

Surname ..... STANDISH 05 03 70 0053
First Name ..... DAVID G M
Address ..... 4E BALCARRES TERR
DUNDEE
DD4 8QX
G.P. & Address (G.P. Requ DR. C AFFLECK
PARK AVE M/C
DUNDEE

C.H.I. No.
M. State
Sex
USE BLOCK LETTERS OR PATIENT LABEL

.....UNIT/WARD/DEPT.

DATE

Page .....

N/L.

21/6/05 W -> 77kg
H -> 1.78.
B.P -> 122/72.
Pulse -> 78
Urine sample unobtainable.

(SS) -> LH.

-> No ELRFs: also if sitting for any length of time.

- Hx history:

Hx attacks: Always in bed trying to relax:
- Legs aching: ++.
- Takes bath to relieve pain.

-> Has to move legs, rub them.

If not relieved, legs shift
pseudo-clonus. Upto 40 min.

-> No LOC:

-> No weakness, sensory Δ
Prone to cramps:

- No other symptoms. No Chemotherapy.

PMH: Asthma. FH: Cancer (Aunt on mat. SS.

SH: Smoker 6/pd.
Alcohol:

THB.(MR)3A

DATE

- Exercise tolerance (N)

- OE: CN (N)

ULTN PS RH

CTN PS RR - 1L

No pallor.

(P) Tiq quinine - Improved cramps: now nocturnal symptoms

#

OSTEOPOROSIS SVL SOL4.

- Fell at sup 16 from roof. Unable to walk 3/12.

- S. T. MRI

ISJIA DNA Letter GP

R

**ONGOING PLAN OF PATIENT CARE & EVALUATION**
(Record plan of care all **Amber/Red** problems from Traffic Light Assessment.
**Document interventions/treatment, evaluation & changes to patient condition**

| Code | | | | | |
|---|---|---|---|---|---|
| N | Nutrition | FB | Fluid Balance | LD | Learning Disabilities |
| PUP | Pressure Ulcer Prevention | P | Pain | PS | Personal Safety |
| M | Manual Handling & Mobility | W | Wound/Skin Integrity | PC | Psychological Care |
| F | Falls | PH | Personal Hygiene | S | Sleep |
| A | Airway/Breathing | OH | Oral Hygiene | CF | Cognitive Function |
| O | Observation & Monitoring | I | Infection Control | ACN | Additional Care Needs |
| E | Elimination | C | Communication | | |

| Date/Time | Code | | Initials |
|---|---|---|---|
| | (PS) | Current smoker on NRT. | |
| | (PC) | Patient been for sideroom, due to noise levels in ward. Side rooms currently full | GJ |
| 21/11/16 | (C) | NEWS 0 | |
| | (ACN) | No changes from previous evaluations. | |
| | | Awaiting Angiogram - Cancelled for today | IL |
| 21116 0400 | | CADD 21116 N, FB, PUP, M, PVC, I, PS | |
| | S | 2mg Temazepam given tonight. Good effect | |
| | P | c/o arm tightness that was relieved with x2 puffs GTN. Did not tell nursing staff until hours late. Reminded of the importance of alerting staff of any pains. | |
| 22/11/16 | (PuP) | Pressure areas intact - no redness | |
| 1615 | (M) | Mobilising independently | |
| | (O) | NEWS 0 | |
| | (PH) | Washed independently | |
| | (ACN) | Had angiogram and stented :- Awaiting Minerva | |
| | | Had VT in Cathlab and shocked x 2 | |
| | | - Currently on telemetry | |



# CONFIDENTIAL

## Multidisciplinary Record of Care Core Data Set

**PLEASE DO NOT VIEW THESE RECORDS UNLESS YOU HAVE THE PATIENT'S CONSENT**

**PATIENTS/ CARERS ARE ASKED TO COMPLETE ALL SECTIONS HIGHLIGHTED IN BLUE IF ABLE TO DO SO**

**MANDATORY COMPLETION**

**Core Data Set completed by** Patient ☐ Carer ☐ Nurse ☑

**Partially completed** Initials of Nurse: - Date: - Time:-

**If Section/s not completed then specify section number and communicate this on handover**

**Fully completed** ✓ Initials of Nurse: - GS Date: - 16.11.16 Time:- 2100

**Affix sticker if patient/carer opted in to the "Butterfly Scheme"**

## Admission History

| Admission/Transfer/Boarding | Destination 1 | Destination 2 | Destination 3 | Destination 4 |
|---|---|---|---|---|
| Hospital | NW | | | |
| Ward | 21 | | | |
| Transfer date & time | 16/11/16 2045 | | | |
| Patient & relatives informed? | YES | | | |
| Completed by - Initials | MB | | | |

| Readmission History | Date | Date | Date | Date |
|---|---|---|---|---|
| Hospital | | | | |
| Ward | | | | |
| Consultant | | | | |

## Multidisciplinary Record of Care
## Register of all personnel writing in Core Data Set

All members of staff who are using this Core Data Set should complete this section once.

| Name | Job title | Ward | Hospital | Signature | Initial | Date |
|---|---|---|---|---|---|---|
| Danielle Burgess | SN | 21 | NW | DBurgess | DB | 16/11/16 |
| Liz Baird | SN | 21 | NWH | LBaird | LB | 17/11/16 |
| SARA BLAIR | SN | 21 | NW | SB | SB | 20-11-16 |
| Kevin Docherty | SN | 1 | N/W | KDocherty | KD | 20/11/16 |
| Jenna Smart | SN | 1 | N/W | JS | JS | 21/11/16 |
| Emma Ferguson | SN | 1 | NW | EF | EF | 21/11/16 |
| INES HERADIA | SN | 6 | N/W | IH | IH | 22/11/16 |
| PAULINE DUNBAR | SN | 1 | NW | PD | PD | 22/11/16 |
| | | | | | | |
| | | | | | | |
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## Multidisciplinary Record of Care
## Register of all personnel writing in Core Data Set

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| Name | Job title | Ward | Hospital | Signature | Initials | Date |
|---|---|---|---|---|---|---|
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## Abbreviations

This abbreviation list has been approved by NHS Tayside and is supported by NHS Tayside policy for Records and Record Keeping for Registered Nurses, Midwives and Specialist Community Public Health Nurses.

| | | | |
|---|---|---|---|
| **A & E** | Accident and Emergency | **IM** | Intramuscular |
| **ABX** | Antibiotics | **INR** | International Ratio |
| **BM** | Blood Glucose Monitoring | **ICU** | Intensive Care Unit |
| **BMI** | Body Mass Index | **IV** | Intravenous |
| **BP** | Blood Pressure | **LA** | Local Anaesthetic |
| **CAD** | Care given as described on.....Date.....(the date and planned care must be stated on the ongoing record) | **MUST** | Malnutrition Universal Screening Tool |
| **CCU** | Coronary Care Unit | **MRSA** | Methicillin Resistant Staphylococcus Aureus |
| **C DIFF** | Clostridium Difficile | **MSSU** | Mid Stream Specimen of Urine |
| **CHI** | Community Health Index | **NIR** | No Intervention Required |
| **CPE** | Carbapenemase Producing Enterobacteriaceae | **NRT** | Nicotine Replacement Therapy |
| **CPR** | Cardio Pulmonary Resuscitation | **O2** | Oxygen |
| **CSU** | Catheter Specimen of Urine | **PAC** | Pre Assessment Clinic |
| **CVA** | Cerebral Vascular Accident (Stroke) | **PEG** | Percutaneous Endoscopic Gastronomy |
| **CVC** | Central Venous Catheter | **PICC** | Peripherally Inserted Central Catheter |
| **DNA CPR** | Do Not Attempt Cardio Pulmonary Resuscitation | **PMH** | Past Medical History |
| **DOB** | Date of Birth | **PVC** | Peripheral Vascular Catheter |
| **DOSA** | Day of Surgery Admission Unit | **SBAR** | Situation Background Assessment Recommendations |
| **DVT** | Deep Vein Thrombosis | **SEWS** | Scottish Early Warning Score |
| **ECG** | Electrocardiogram | **SPO2** | Saturation of Peripheral Oxygen |
| **GA** | General Anaesthetic | **TPAR** | Tayside Prescription Administration Record |
| **HAN** | Hospital At Night | **TTO's** | Tablets to Take Out |
| **HDU** | High Dependency Unit | **UTI** | Urinary Tract Infection |
| **ICT** | Infection Control Team | | |
| | | | |
| | | | |
| | | | |



## 1. GENERIC PATIENT DETAILS

Hospital NW Ward 21 Consultant HUTCHEON

Date of Admission 16/11/16 Time 2045 Expected Date of Discharge >24°

**"Coming in to and Leaving Hospital Explained" patient information leaflet given** ☐

**Patient details (affix label)**
Surname STANDISH
Forename DAVID
DOB and CHI 050370 00553
Address 20 CANNING PLACE
DUNDEE
Postcode DD3 7RT
Sex M

**GP Details (affix label)**
GP Name DR BULLIONS
Address COLDSIDE MEDICAL PRACTICE, 129 STRATHMARTINE ROAD, DUNDEE
Postcode DD3 8DB
Telephone Number 01382 850900

Allergies (Record on TPAR)
NKDA.

Possibility of pregnancy? Y (N)
LMP (If applicable) _____

If address different on admission, please state:

Home Telephone Number —
Mobile Telephone Number 07402993659

Preferred Name David. Title MR Age 46 Marital Status Single

Ethnic Origin White. First Language English Other: _____ Interpreter Required Y (N)

Do you/the patient use other methods of communication? Y (N)

Sign Language ☐ Braille ☐ Makaton ☐ Talking Mat ☐ Other: _____

Date/Time Interpreter Contacted _____ Staff Initials _____

Religion None.

Do you have any religious/spiritual needs whilst in hospital? Y (N)

Please specify _____

You/the patient may have worries/concerns whilst in hospital. Would you like the opportunity to talk through these worries/concerns with a member of the Spiritual Care Team? Y (N)

Date/Time Spiritual Care Team Contacted _____ Staff Initials _____

Emergency / First Contact/s

1st. Contact Denise McLaughlin
Relationship partner
Address 9 MANSION DRIVE
DUNDEE
Telephone Number 07449 022684

2nd Contact NIL GIVEN
Relationship _____
Address _____
Telephone Number _____

Is Emergency / First contact aware of admission: (Y) N

**If No** Date & time notified of admission _____

## 2. CONSENT/CAPACITY: To be completed for all patients within **6 hours** of admission

### 2a. CAPACITY

Do you have any concerns regarding the patient's capacity or ability to make healthcare decisions (including Cognitive Impairment/ Delirium/ Confusion/ Diagnosed Mental Health Condition / Learning Disability)? Y (N)

**IF YES SPECIFY** _____

**IF NO** review using the Traffic Light Risk Assessment per shift/as required and complete assessment below if any changes

**IF YES** Please complete the **"Assessment and Intervention" section below** and review using the Traffic Light Risk Assessment per shift

### 2b. FORMAL CONSENT TO TREATMENT

Check Consent to Treatment Form completed for Surgery/Medical Procedure/Test **(if applicable)**, signed and in medical records ☐

| Assessment and Intervention | | | | Date/Time | Initial |
|---|---|---|---|---|---|
| "Butterfly Scheme" discussed? | Y | N | Consent to opt in to "Butterfly Scheme" given | | |
| "Getting to Know Me" offered? | Y | N | "Getting to Know Me" completed | | |
| Has medical staff been informed? | Y | N | **Inform** Consultant / medical Staff to undertake appropriate Cognitive Testing | | |
| Has Certificate of Incapacity (Section 47) form been completed? | Y | N | **Notify** medical staff of the need to undertake a **capacity assessment with regard to the treatment needed** | | |

**If the emergency / first contact has Power of Attorney (Welfare only) or Legal Guardianship they are legally entitled to full disclosure of all confidential information**

## 3. DISCLOSURE OF INFORMATION

I/ the patient give consent for full disclosure of confidential information to first contact only i.e. diagnosis, test results etc? (Y) N

I/ the patient give consent to disclosure of general information to general enquiries from all other relative/carers/friends i.e had a good day; doing well etc? (Y) N

**Is there anyone you do NOT wish us to disclose any information to?** Y (N)

Full name/s & relationship _____

### Power of Attorney/Legal Guardianship (complete for ALL patients)

| | | | |
|---|---|---|---|
| a) Welfare? | Y | N | If Yes is this activated: Y N<br>Name & Contact details: |
| b) Financial affairs? | Y | N | If Yes is this activated: Y N<br>Name & Contact details: |
| c) Anticipatory/ Advanced Care Plan? | Y | N | If Yes have you seen verification Y N |

## 4. SELF CARE

Is there any care you/ the patient **(and/or relative/friend)** would like to be involved in whilst in hospital: for example, washing and dressing, help at mealtimes? (Y) N

**IF YES, SPECIFY** all as able.



## 5. SOCIAL CIRCUMSTANCES

### Dependants

Do you/ the patient provide care or support for someone, or have concerns regarding care of pets? Y (N)

**IF YES,** what arrangements been made for their care whilst you / the patient are in hospital?

_____

### Significant other (s) Involved in Care

Do you / the patient have someone who provides unpaid care or support for you on a **daily/ weekly** basis? (Y) N

**IF YES, SPECIFY** Name of main Carer denise Relationship partner.

Briefly describe care given anything required

Key Holder **Y N** Name _____

### Home Environment

Is the patient planning to return to their usual home after they leave hospital? (Y) N

**IF NO, SPECIFY** _____

**IF YES**, are there any concerns regarding discharge i.e. poor mobility around the home , personal care, cooking, housework, shopping , laundry etc Y (N)

**IF YES,** and aged over 75 years AND/ OR admitted with falls, deterioration in mental state or poor mobility please complete **Functional Assessment Screening Tool** (where applicable).

**OR** Use **'Referral to Social Work/District Nurse Form' THB (MR)565** and document in the discharge plan

**If any community service in place please table complete below**

| Community Services | Please circle | Specify Care | Contact Details | Days provided | Number of visits per day | Date phoned to be restarted | Initial |
|---|---|---|---|---|---|---|---|
| Home Care | Y (N) | | | | | | |
| Nurse Specialist | Y (N) | | | | | | |
| District Nurse | Y (N) | | | | | | |
| Care Manager/ Social worker | Y (N) | | | | | | |
| Meals Delivered | Y (N) | | | | | | |
| Day care | Y (N) | | | | | | |
| Other | Y (N) | | | | | | |

Phone to restart services if the patient is able to go home on existing package of care. **Complete the grey section.** Please note; services may be stopped following admission and therefore a re-referral or a new referral will be required.

# 'MUST' RISK ASSESSMENT

To be completed for all patients within **24 hours** of admission

| If patient **NOT** appropriate for 'MUST' Assessment specify reason:- | If patient **NOT** appropriate for Dietary Assessment specify reason:- |
|---|---|
| **Review Date** | **Review Date** |
| **Review Date** | **Review Date** |

**STEP 1**

| | | |
|---|---|---|
| **Height (m)** | 1.76 | Stadiometer ☐ Self reported height (if reliable) ☑ Reported by carer ☐ |
| **Ulna Length (cm)** | | (not appropriate for Learning Disability) |
| **Tape Measure (m)** | | (Learning Disability only) |
| **Weight (kg)** | 95 | Actual ☑ Self- reported ☐ Reported by carer ☐ |

**STEP 2** **(If none, write 'nil')**

| | | | |
|---|---|---|---|
| **Any unplanned weight loss over the last 3–6 months)** | NIL (kg) | **Any unplanned weight gain over the last 3–6 months.** | NIL (kg) |

**Are there any factors affecting weight?** Yes ☐ No ☑

| | | | | | |
|---|---|---|---|---|---|
| Amputation | Weight | (kg) | Corrected Weight | | (kg) |
| Oedema | Wet Weight | (kg) | Corrected Weight | | (kg) |
| Ascites | Wet Weight | (kg) | Corrected Weight | | (kg) |
| Plaster Cast | Weight | (kg) | Corrected Weight | | (kg) |

**BMI (kg/m²)** from Ready Reckoner: 31

**STEP 3**

Is the patient acutely ill **and** there has been or is likely to be little or no nutritional intake for more than **5** days (Y) N

## 'MUST' CALCULATOR

| STEP 1 BMI score (from Ready Reckoner) | | STEP 2 Weight loss score (from Ready Reckoner) | | STEP 3 Acute disease |
|---|---|---|---|---|
| **BMI kg/m²** | **Score** | Unplanned weight loss in past 3-6 months (this includes obese patients) | | If patient is acutely ill and there has been or is likely to be little or no nutritional intake for more than 5 days |
| greater than 20 (>30 obese) | = 0 | **%** | **Score** | **Score 2** |
| 18.5 – 20 | = 1 | less than 5 | = 0 | **Score 0** if not applicable |
| Less than 18.5 | = 2 | 5-10% | = 1 | |
| | | greater than 10 | = 2 | |
| 0 | | 0 | | 0 |

**STEP 4 (add step 1, 2 and 3 together to give overall risk of malnutrition 'MUST' score)**

0

| Score 0 Low Risk | | Score 1 Medium Risk | | Score 2 or more High Risk |
|---|---|---|---|---|

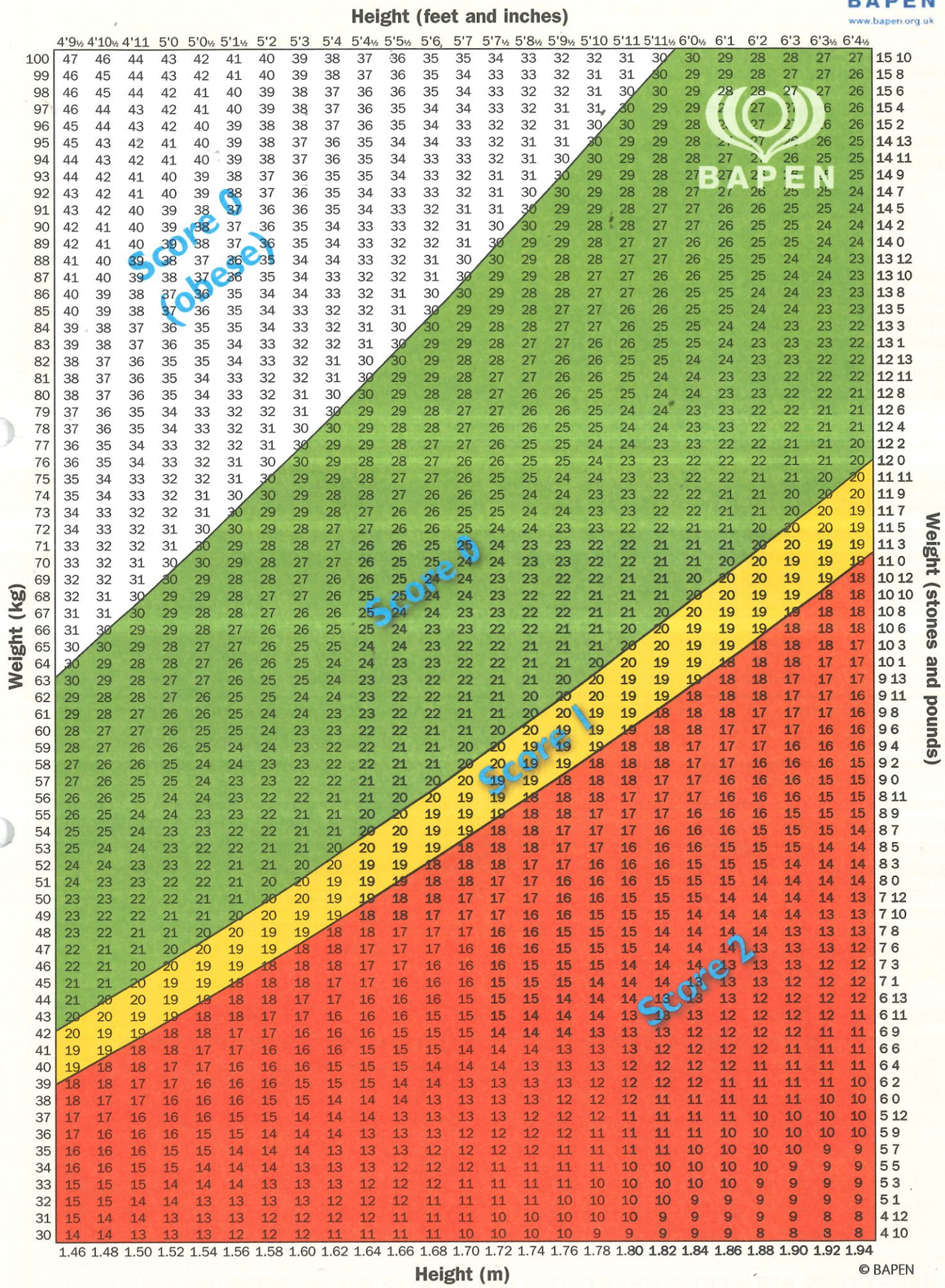
**Follow STEP 5 Management Guidelines**

'MUST' is adapted and reproduced with kind permission of BAPEN (British Association for Parenteral and Enteral Nutrition).

THB 600

## Step 1 – BMI score (& BMI)

BAPEN
www.bapen.org.uk




© BAPEN

Note : The black lines denote the exact cut off points (30,20 and 18.5 kg/m²), figures on the chart have been rounded to the nearest whole number.

THB 600

## DIETARY ASSESSMENT

To be completed for all patients within **24 hours** of admission

| Criterion | Y | N | If YES specify below | Intervention/Considerations | |
|---|---|---|---|---|---|
| Patient has a Learning Disability | | ✓ | | **Refer / contact Learning Disability Liaison on 07740 937309 Date.....** | |
| Patient has a Food Allergy **(Complete within 6 hours of admission)** | | ✓ | | **Kitchen informed**<br>**Relevant staff informed/included in safety brief**<br>**Wrist allergy band in situ**<br>**Allergies recorded in Nursing Notes and Drug Kardex**<br>**Other, specify .....** | ☐<br>☐<br>☐<br>☐<br>☐ |
| Patient has Specific Cultural/Ethnic/Religious dietary requirements e.g. Halal/Vegetarian | | ✓ | | **Kitchen informed**<br>**Halal/Vegetarian menu offered (if appropriate)**<br>**Other, specify .....** | ☐<br>☐ |
| Patient has specific therapeutic dietary requirements e.g. Gluten Free/Renal/Diabetic | | ✓ | | **Kitchen informed**<br>**Other, specify .....** | ☐ |
| Patient **unable** to make menu choices independently | | ✓ | | **Give assistance if necessary to make menu choices, taking into account likes/dislikes**<br>**Other, specify .....** | ☐ |
| Patient has **Specific** eating and drinking likes/dislikes | | ✓ | | | |
| Patient **unable** to maintain their own hydration needs | | ✓ | **If> 60 years of age** 30 mls/kg x body weight per day<br>**If 18-60 years of age** 35 mls/kg x body weight per day | **Calculate daily fluid goal**<br>**.....mls/kg per day**<br>**Offer regular fluids (8-10 drinks per day)** ***(or if applicable fluid restriction)*** | ☐ |

| Criterion | Y | N | If YES specify below | Intervention/Considerations |
|---|---|---|---|---|
| Patient has cognitive impairement/Dementia/medical or psychological factors affecting nitrition | | | | **If YES, please specify and follow Specific Nutritional Requirements Guidance**<br>**Record level of risk on the traffic lights and document plan of care in the nursing record.**<br>**If NO to any question reassess each shift and record level of risk on traffic lights** |
| Patient unable to take 'adequate' food and /or fluid orally/swallowing problems/poor oral health | | | | |
| Patient requires physical assistance with eating and drinking/adapted equipment or requires nutrition/supplements | | | | |

**Completed - Initials of nurse** OS **Date** 16.11.16 **Time** 21⁰⁰

| Review Date | Oedema /Ascites Yes/No | Weight | Corrected Weight | B.M.I. | Step 1 Score | Step 2 Score | Step 3 Score | Total Score | Dietetic Referral Yes/No | DATIX Yes/No | Initial |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 23.11 | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

**PLEASE COMPLETE WEIGHT CHART FOR LONGER STAY PATIENTS(THB(MR)566)**



## PRELIMINARY PRESSURE ULCER RISK ASSESSMENT (PPURA)

To be completed for all patients within **6 hours** of admission

| | | | |
|---|---|---|---|
| 1 | Requires assistance and or aids to **regularly** relieve **any** pressure area (including heels/head etc) **OR** cannot / will not move independently **OR** will be on an operating table for > 2hrs? | Y | (N) |
| 2 | Incontinent? - Urine or faeces in contact with the skin? | Y | (N) |
| 3 | BMI < 18.5 or > 40 or patient appears undernourished? | Y | (N) |
| 4 | Pressure ulcer grade 1-4? | Y | (N) |

**If Yes** to any question; complete the Pressure Ulcer Prevention Treatment Plan and carry out the full Waterlow Risk Assessment. **If No** to ALL question follow treatment plan A which is:- encourage patient to check own skin condition regularly, re-assess PPURA each shift, and record on the traffic lights

**Treatment Plan A commenced on** 16.11.16

**Initials of nurse** OS **Date** 16.11.16 **Time** 21⁰⁰ **Pressure ulcer treatment plan commenced** Y (N)

## FALLS RISK ASSESSMENT

To be completed for all patients within **24 hours** of admission

| | | | |
|---|---|---|---|
| 1 | History of falls prior to admission, or reason for admission | Y | (N) |
| 2 | Additional falls risk factors for this patient at time of admission?<br>e.g. patient tries to walk alone but unsteady/unsafe, significant learning disabilities, Neurovascular injury / disease, delirium, continence issues, visual impairment, etc. | Y | (N) |

**If Yes** to any of the above, and considered to have significant risk factors or has a fall following admission, then complete falls prevention action plan and use the bedrails assessment tool on the falls risk plan
**If No** to any question re-assess each shift or if a change in clinical condition then record on traffic lights and complete full assessment.

**Initials of nurse** OS **Date** 16.11.16 **Time** 21⁰⁰ **Falls treatment plan commenced** Y (N)

**BEDRAILS - Please note:-** Following a falls risk assessment some patients might not be assessed as at risk of falling but require bedrails:-

- In transit between areas - in which case no recording of the use of bedrails is required as this is standard practice
- If the patient is unconscious, or patient uses bedrails to help move in bed, and again is not assessed as a falls risk, the decision support tool must be used to guide the patient's care and the traffic light colour to be recorded; the reason for use must be recorded in the nursing record - a falls care plan does not require to be raised in this circumstance.

## MANUAL HANDLING & MOBILITY ASSESSMENT

To be completed for all patients within **24 hours** of admission

| | | | |
|---|---|---|---|
| 1 | Is the patient fully mobile and walking without assistance on admission? | Y | (N) |

**If No** to the above question, please complete a full manual handling and mobility action plan.
**If Yes** to the above question re-asses each shift, or if a change in the patients clinical condition, then record on traffic lights and complete a full assessment

**Initials of nurse** OS **Date** 16.11.16 **Time** 21⁰⁰ **Mobility action plan raised?** (Y) N

**If all the above were completed at PAC please re-assess on admission**

| | | | | | |
|---|---|---|---|---|---|
| Changes to pressure ulcer risk? | Y | N | Pressure ulcer treatment plan commenced? | Y | N |
| Changes to falls risk? | Y | N | Falls treatment plans commenced? | Y | N |
| Changes to Manual Handling and mobility | Y | N | Mobility action plan raised? | Y | N |

**Initials of nurse** **Date** **Time**

**Does the patient have Diabetes?** Y (N)

**Undertake CPR for Feet Assessment**

## 6. INFECTION RISK STATUS (Please complete ALL sections for all patients within **6 hours** of admission)

**If deemed "at risk" document AMBER (suspected) or RED (confirmed) on Traffic Light each shift**

**If there is any suspicion of, or confirmed transmissible infection please ensure appropriate patient placement, (side room where possible, practical and safe) and document in the nursing record.**
**Additional Infection Control Precautions (contact, droplet, airborne) as per NHS Tayside Policy.**

**Date and time of completion** 16.11.16 21⁰⁰ **Initials** JB

**CARBAPENEMASE PRODUCING ENTEROBACTERIACEAE (CPE) RISK ASSESSMENT**

- **Hospitalised (as in patient including holiday dialysis) outside Scotland within the last 12 months?** Y (N)
- Transferred in from any high risk unit (ICU/HDU, Renal, Hematology, Oncology, and Infectious Diseases outside Tayside? Y (N)
- Previous known CPE colonisation / infection? Y (N)

If **YES** to any of the above questions, obtain verbal consent prior to taking swabs Consent Y N

Please tick: Stool Specimen ☐ or Rectal Swab (preferred) ☐

**MRSA SCREENING RISK ASSESSMENT (NOT DAY CASE)**

1. Admitted from Care Home, Sheltered Housing, Prison, Homeless Hostel or from another hospital? Y (N)
2. Admitted/transferred to:- HDU ICU Renal Vascular Orthopaedics **Please circle** Y (N)
3. Previous history of MRSA colonisation/infection? **(Check on ICE)** Y (N)
4. Any open wound/ulcer or invasive medical device present **before** admission to hospital? Y (N)

If **YES** to any of the above questions, obtain verbal consent prior to taking swabs Consent Y N

**Swabs - please tick** Nose & Perineum ☐ **(preferred option)** Nose & Throat ☐
Wound ☐ CSU ☐ Invasive Device Site ☐

If rescreened, please tick which swabs **AND** include Wound, CSU and Invasive Device Site if present

Date/Time
Nose & Perineum ☐ **(preferred option)** Nose & Throat ☐ Invasive Device Site ☐ Wound ☐ CSU ☐

Date/Time
Nose & Perineum ☐ **(preferred option)** Nose & Throat ☐ Invasive Device Site ☐ Wound ☐ CSU ☐

## 7. LIFESTYLE, WELLBEING AND HEALTH PROMOTION: (refer to flow charts)

**Smoking**
Are you a smoker / use tobacco products? (Y) N
**IF YES:**
**Smoking policy discussed/smoking information leaflet given** (Y) N
**Opt into NRT In-patient Pathway?** (Y) N

**If No, Sign Disclaimer (THB 610 Personal Safety Risk Assessment)**

**Substance Use** anti histimine
Are you taking any 'over the counter' medications e.g. Pain killers, herbal remedies? (Y) N
Are you taking any "recreational drugs" or inhalants? Y (N)
**IF YES:**
Would like help and support with addiction? Y N

**Alcohol**
Do you 'regularly' drink alcohol? Y (N)
('Regularly' means drinking every day or most days of the week)

**IF YES:**
Would like to reduce/stop drinking? ~~Y N~~

**Weight / Activity Levels - BMI of >25 only**
Do you undertake 30 minutes per day of physical activity? Y N
Are you comfortable with your current weight? Y N
**IF NO TO BOTH:**
Are you interested in receiving support to reduce your weight? Y N
Would you like help/support to increase your activity levels? Y N



## 8. COMPLETE ON ADMISSION TO EACH WARD/AREA

| PATIENT MEDICATION | DATE/ WARD | 21 16/11/16 | | | |
|---|---|---|---|---|---|
| Is the patient taking prescribed medications? | | (Y) N | Y N | Y N | Y N |
| Patient has brought in own medicines? | | (Y) N | Y N | Y N | Y N |
| Patient has brought in controlled drugs stored in the controlled drugs cupboard? | | Y (N) | Y N | Y N | Y N |
| Does the patient understand what their medications are for? | | (Y) N | Y N | Y N | Y N |

Is the patient registered with a pharmacy? **Please state name of pharmacy & telephone number:-**

How does the patient usually obtain/order their medications: - include compliance aid details?
(specify) Repeat prescription. Collects.

**ORIENTATION**

| | | | | |
|---|---|---|---|---|
| Familiarised to ward environment? | (Y) N | Y N | Y N | Y N |
| Identity band in situ? | (Y) N | Y N | Y N | Y N |
| Nurse call system explained? | (Y) N | Y N | Y N | Y N |
| Explained where toilet/wash facilities are? | (Y) N | Y N | Y N | Y N |
| Explain Bed Controls to patient | (Y) N | Y N | Y N | Y N |
| Explained visiting/protected mealtimes/rest times? | (Y) N | Y N | Y N | Y N |
| Explain confidentiality of notes – does the patient wish to have access to their nursing record of care during their stay? | Y N | Y N | Y N | Y N |

**GIVE "Your Food and Drinks in Hospital"** patient information leaflet ☐

**If NO to any of the above , please give reason why and document in the On-going Nursing Record of Care**

**VALUABLES** **Please circle below if applicable:-**

Dentures Top / Bottom / Full partial. Glasses / Contact lenses Hearing aid/s Own clothing

Other (specify)

Walking aids (specify)

| | | | | |
|---|---|---|---|---|
| Patient's funds and property procedure explained and **PF1 completed**? | (Y) N | Y N | Y N | Y N |
| Money/property to be handed over on behalf of patient for safekeeping? **(Please refer and follow section 2.2.3 of Patient's Funds and Property procedure)** | Y (N) | Y N | Y N | Y N |

## NHS TAYSIDE – PATIENT FUNDS AND PROPERTY PROCEDURE
## PERSONAL DISCLAIMER FORM - LOSS OF PERSONAL EFFECTS

**NHS TAYSIDE STATEMENT:**

*****NHS Tayside will not accept any responsibility for loss or damage to any article/personal belongings unless such article/personal belongings (including cash) have been handed over and accepted by NHS Tayside, for safe keeping and an official receipt issued****

*[* delete as appropriate]*

**Section A TO BE COMPLETED BY NURSING STAFF**

**If the patient or patient's representative at the time of admission is unable or refusing to complete and sign section B below, for whatever reason, inform the patient / representative verbally that they are responsible for their own belongings and valuables and state below the reason for non completion of Section B. Sign and date this, and enter a review date in Section C:**

Reason: _____

Signature of Staff Recording _____ Date _____

Signature of Staff Witness: _____ Date: _____

**Section B TO BE COMPLETED BY PATIENT**

**I have been given the opportunity to read the above statement and *~~do~~ / do not wish to take advantage of the facilities provided for safe keeping of my personal belongings.**

Patient Signature*** D. Standish Date: 16.11.16

Print Name: DAVID STANDISH

Hospital: NW. Ward: 21

*****If signing on behalf of a patient, please enter your relationship with the patient, and your address:**

Relationship: _____

Address: _____

_____

Witness to above signature: _____

Print Name: _____

Date: _____

**Section C**

**If section A has been completed and a review is required, please enter review date (should be held every 4 weeks) noting two staff signatures required at each review :**

(1)_____

Sign: _____

Sign: _____

(2)_____

Sign: _____

Sign: _____

(3)_____

Sign: _____

Sign: _____

(4)_____

Sign: _____

Sign: _____

**Note: Please note that when a patient is absent from the ward for treatment (e.g. x-ray, an operation etc), the safe custody of their property which has not been handed over to NHS Tayside for safe keeping, remains the patient's responsibility. Arrangements may be available whereby property can be handed over to Nursing Staff for safe keeping during such periods. However, please note that due to storage restrictions, it is not possible to store larger items.**



## Discharge Plan - To be commenced on admission

**(Not to be used for transfer information - use Transfer Checklist)**

| | |
|---|---|
| Planned patient discharge date: 23/11/16. | Actual patient discharge date: 23/11/16. *If delay please specify reason:* |
| Patient informed of date (Y) N N/A<br>Date Initials of nurse 23/11/16 W | Relative/carer informed of date (Y) N N/A<br>Who was informed Relative<br>Date 23/11/16 Initials of nurse W |

Patient Discharge Destination home

Complete referral/s to Early Supported Discharge / Enablement Team / District Nurse / AHP/NRT pharmacy referral or similar (if applicable) Please Specify:-

_____

Date Initials of nurse

Transport plan agreed and arrangements made to date and progress (if applicable) **Y N N/A**

Adult available to escort home if using own/public transport? **Y N N/A**

Date Initials of nurse

| | |
|---|---|
| Does the patient have any ongoing nutritional care needs? **Y N N/A**<br><br>Does patient currently have an infection / colonisation / history of positive culture e.g. MRSA, VRE, CDI, CPE, Norovirus, etc **Y N N/A**<br><br>Specify.....<br><br>Has this information been communicated to carers/relevant agencies? **Y N N/A** | Does the patient / carer understand the treatment they received? **Y N N/A**<br><br>Healthcare / self-care / advice and information given to patient and / or carer **Y N N/A**<br>**state what type(s):**<br><br>Carer support referral postcard given? **Y N N/A**<br><br>Date Initials of nurse |

| | | | |
|---|---|---|---|
| Medications ordered and sent to pharmacy | Date | | Initials of nurse |
| Delivered to ward | Date | | Initials of nurse |

Dressings / catheter / equipment ordered **Y N N/A**

Specify: _____

Supply ordered **Y N** Date Initials of nurse

| | |
|---|---|
| **Patient's home is suitable for them to return to?** | (Y) N N/A |
| **Does patient require a relative / carer to be present at home on discharge?** | (N) N N/A |
| **Patient has key / access to inside of their home?** | (Y) N N/A |
| **Patient has clothing and footwear to go home in that is appropriate for the weather conditions?** | (Y) N N/A |

**If any issues highlighted from any of the information obtained during the admission or as part of the discharge plan, including if the patient has triggered RED or AMBER on any of the traffic lights: -**

- Please describe plan and interventions required for effective and safe discharge including any conversations you have with the patient/carer on Discharge Plan Continuation sheet
- If a referral to Social Work, Enablement Team, or District Nurse are required, please complete the Social **work/District Nurse Referral Form THB(MR)565**
- For patients with a Learning Disability/Dementia consider holding a pre-discharge multidisciplinary meeting

**NOTE: IF THE PATIENT DISCHARGES THEMSELVES AGAINST MEDICAL ADVICE**

**Complete the Discharge Plan as far as possible. Ensure the GP / relevant agencies are informed.**

## DAY OF DISCHARGE FINAL CHECK

| | |
|---|---|
| Equipment/dressings etc. given to patient / carer? | Y N (N/A) |
| PVC removed? | (Y) N N/A |
| Discharge documentation completed and sent to GP / copy given to patient? | (Y) N N/A |
| Patient / carer given medication? | (Y) N N/A |
| Patient / carer given any leaflets / cards associated with medications detailing side effects and cautions? | Y N (N/A) |
| Valuables returned to patient? E.g. glasses / hearing aids / walking aids | (Y) N N/A |
| Out Patient Appointment/s Please state..... | (Y) N N/A |
| Pharmacy Smoking Support request given | |

**Initials of Nurse** [signature] **Date** ~~23/11/16~~ 24/11/16 **Time** 1700

| Date/Time | DISCHARGE PLAN CONTINUATION SHEET | Initial |
|---|---|---|
| | (Not to be used for transfer information - Complete a Transfer SBAR in Ongoing Record of Care) | |
| 16.11.16 | No discharge date. | [initials] |
| 23/11/16. | patient Discharged Home Belongings returned and medication given. | [initials] |
| | | |
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| Date/ Time | DISCHARGE PLAN CONTINUATION SHEET | Initials |
|---|---|---|
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## ONGOING PLAN OF PATIENT CARE & EVALUATION

(Record plan of care for all **Amber/Red** problems from Traffic Light Assessment.
**Document interventions/treatment, evaluation & changes to patient condition**

| | | | | | |
|---|---|---|---|---|---|
| **N** | Nutrition | **FB** | Fluid Balance | LD | Learning Disabilities |
| **PUP** | Pressure Ulcer Prevention | **P** | Pain | PS | Personal Safety |
| **M** | Manual Handling & Mobility | **W** | Wound/Skin Integrity | PC | Psychological Care |
| **F** | Falls | **PH** | Personal Hygiene | S | Sleep |
| **A** | Airway/Breathing | **OH** | Oral Hygiene | CF | Cognitive Function |
| **O** | Observation & Monitoring | **I** | Infection Control | ACN | Additional Care Needs |
| **E** | Elimination | **C** | Communication | | |

| Date/Time | Code | ADMISSION SBAR | Initials |
|---|---|---|---|
| 16.11.16 | | **Situation** (Short summary of reason for Admission) | |
| 2140 | | 46 year old gentleman admitted | |
| | | via A+E due to chest pain. 1st | |
| | | troponin 0.067 | |
| | | | |
| | | | |
| | | **Background** (Recent events , circumstances, relevant medical history) | |
| | | 1-2 months chest pain. has recently | |
| | | stopped clopidogrel due to stomach | |
| | | problems. | |
| | | hx of PVD - 2x fem pop bypass | |
| | | **Assessment** (Observations, risk factors, injuries) | |
| | | Cardiac monitoring insitu. Sinus | |
| | | rhythm 89 BP 121/88 (L) 157/89 (R) | |
| | | $SpO_2$ 99%. RR 17 | |
| | | Pain free and comfortable. | |
| | | | |
| | | | |
| | | **Recommendation/s** (Nursing plan for all Amber /Red needs) (*continue on next page if needed)* | |
| | | Aspirin given in A+E | |
| | | ?? further antiplatelets | |
| | | await medical clerk in | |
| | | more than likely for angiogram | gs |
| | | | |



## ONGOING PLAN OF PATIENT CARE & EVALUATION

(Record plan of care for all **Amber/Red** problems from Traffic Light Assessment.
**Document interventions/treatment, evaluation & changes to patient condition**

| *Code* | | | | | |
|---|---|---|---|---|---|
| **N** | Nutrition | **FB** | Fluid Balance | LD | Learning Disabilities |
| **PUP** | Pressure Ulcer Prevention | **P** | Pain | PS | Personal Safety |
| **M** | Manual Handling & Mobility | **W** | Wound/Skin Integrity | PC | Psychological Care |
| **F** | Falls | **PH** | Personal Hygiene | S | Sleep |
| **A** | Airway/Breathing | **OH** | Oral Hygiene | CF | Cognitive Function |
| **O** | Observation & Monitoring | **I** | Infection Control | ACN | Additional Care Needs |
| **E** | Elimination | **C** | Communication | | |

| Date/Time | Code | | Initials |
|---|---|---|---|
| 17/11/16 | N/FB | MUST 0. Normal diet + fluids. Coffee + | |
| 0300 | | toast on arrival. fluid balance chart | |
| | | commenced | |
| | PuP | Plan A changing position independently | |
| | | no pressure damaged. | |
| | M | Restricted due to cardiac monitoring. | |
| | | Uses 1x walking stick for distance | |
| | F | No falls risks identified. | |
| | A | $SpO^2$ + RR satisfactory on room air | |
| | O | Sinus rhythm. Continuous monitoring | |
| | E | Aware of continence needs. Use of commode | |
| | | or urine bottles | |
| | P | No further pain | |
| | W | No wounds | |
| | 1/PVC | Pink PVC (L) arm, inserted 16.11.16. dressing | |
| | | dry + intact. Left insitu for any emergency | |
| | | medicines VIP score 0. | |
| | C | Communicates needs. NOK updated and | |
| | | aware of admission | |
| | PS | Current smoker. Would like NRT | |
| | ACN | Await rlv. | gs |
| 0600 | ACN | 2nd trop 2S. unable to load & DAPT | |
| | | due to complex stomach problems in the | |
| | | passed | |

**ONGOING PLAN OF PATIENT CARE & EVALUATION**
(Record plan of care all **Amber/Red** problems from Traffic Light Assessment.
**Document interventions/treatment, evaluation & changes to patient condition**

| Code | | | | | |
|---|---|---|---|---|---|
| N | Nutrition | FB | Fluid Balance | LD | Learning Disabilities |
| PUP | Pressure Ulcer Prevention | P | Pain | PS | Personal Safety |
| M | Manual Handling & Mobility | W | Wound/Skin Integrity | PC | Psychological Care |
| F | Falls | PH | Personal Hygiene | S | Sleep |
| A | Airway/Breathing | OH | Oral Hygiene | CF | Cognitive Function |
| O | Observation & Monitoring | I | Infection Control | ACN | Additional Care Needs |
| E | Elimination | C | Communication | | |

| Date/Time | Code | | Initials |
|---|---|---|---|
| 17/11/16 | ACN | to be discussed with cardiology consultant | |
| 06⁰⁰ | | and vascular consultant regarding | |
| | | optimum therapy. | |
| | P | No further pain | |
| | S | does not sleep well normally Usually | |
| | | get about 2 hours sleep. | |
| | ACN | Given s/c fondaparinux and 2.5mg oral | |
| | | bisoprolol. | JR |
| 17-11-16 | (C) | Shift change. Bed checks completed. | |
| 12²⁰ | (A) | Airway patent. Saturating adequately on room | |
| | | air. Breathing unlabaured. | |
| | (O) | Peripherally warm. | |
| | | BP = 134/73 mmHg. | |
| | | HR = 72 bpm, Sinus rhythm. | |
| | | Apyrexial. | |
| | | GCS = 15/15. | |
| | (E) | Diuresis adequate. Indepent c toileting. | |
| | (PVC) | PVC x1 (pink) in (R) hand. VIP = 0. | |
| | (FB) | Free oral fluids. Drinking well. | |
| | (N) | Aptite reasonable. MUST = 0. | |
| | (PuP) | Plan A. Independently altering pressure areas. | |
| | (M) | Independently mobile c walking stick. | |
| | (PH) | Does not want a wash at present. Independent | |
| | | c self care. | ES |

THB 600

**ONGOING PLAN OF PATIENT CARE & EVALUATION**
(Record plan of care for all **Amber/Red** problems from Traffic Light Assessment.
**Document interventions/treatment, evaluation & changes to patient condition**

| Code | | | | | |
|---|---|---|---|---|---|
| N | Nutrition | FB | Fluid Balance | LD | Learning Disabilities |
| PUP | Pressure Ulcer Prevention | P | Pain | PS | Personal Safety |
| M | Manual Handling & Mobility | W | Wound/Skin Integrity | PC | Psychological Care |
| F | Falls | PH | Personal Hygiene | S | Sleep |
| A | Airway/Breathing | OH | Oral Hygiene | CF | Cognitive Function |
| O | Observation & Monitoring | I | Infection Control | ACN | Additional Care Needs |
| E | Elimination | C | Communication | | |

| Date/Time | Code | | Initials |
|---|---|---|---|
| 17.11.16 | (ACN) | W/R c Dr Hutcheon this morning. | |
| 12³⁰ | | (Plan) Angio +/- as inpatient | |
| | | ACS Rx. | |
| | | DAPT check - Ticagrelor started | |
| | (PS) | Pt reluctant to take loading dose of Ticagrelor | |
| | | given stomach issues while on Clopidogrel. | |
| | | Reassured by medical staff and all meds taken | ES |
| 1430 | (ACN) | Pharmacist has r/v meds. Advise for Dr | |
| | | Baines to be cancelled re:- antiplatelet | |
| | | therapy. Email sent to Dr Baines requesting | |
| | | this. | |
| | | Pt has attended for ECHO. Report awaited | ES |
| 1930 | (ACN) | Pt requested Antihistamine for irritated | |
| | | eyes. 10mg Cetirizine given as per Kardex | ES |
| | (O) | Awaiting spare telemetry from ward | |
| 18/11/16 | N/FB | MUST 0. normal diet. Coffee + toast for | |
| 0130 | | supper. Inaccurate fluid balance as | |
| | | drinking own juice therefore discontinued. | |
| | PuP | Plan A. No pressure damage. Changing | |
| | | position independently. | |
| | M | Mobile with 1x WS. able to mobilise | |
| | | independently | JS |

THB 600

## ONGOING PLAN OF PATIENT CARE & EVALUATION

(Record plan of care all **Amber/Red** problems from Traffic Light Assessment.
**Document interventions/treatment, evaluation & changes to patient condition**

| Code | | | | | |
|---|---|---|---|---|---|
| N | Nutrition | FB | Fluid Balance | LD | Learning Disabilities |
| PUP | Pressure Ulcer Prevention | P | Pain | PS | Personal Safety |
| M | Manual Handling & Mobility | W | Wound/Skin Integrity | PC | Psychological Care |
| F | Falls | PH | Personal Hygiene | S | Sleep |
| A | Airway/Breathing | OH | Oral Hygiene | CF | Cognitive Function |
| O | Observation & Monitoring | I | Infection Control | ACN | Additional Care Needs |
| E | Elimination | C | Communication | | |

| Date/Time | Code | | Initials |
|---|---|---|---|
| 18.11.16. | F | No falls | |
| 0130 | A/O | Vitals Stable. Commenced on telemetry | |
| | | Sinus rhythm. Normotensive | |
| | E | Using urine bottles @ bedside. | |
| | P | No c/o pain | |
| | N | No issues | |
| | I | Pink PVC (L) hand inserted 16.11.16 | |
| | | VIP score 0. Left insitu for IV medications | |
| | | and angiogram. | |
| | C | Communicates needs. Has spoken to | |
| | | partner on telephone tonight. | |
| | PS | NRT insitu. States he has not had | |
| | | any cravings for cigarettes. | |
| | S | Sleeping @ present. | |
| | ACN | for angiogram. | |
| | | antiplatelet therapy to be discussed/ | |
| | | confirmed with Dr Bains. | JGS |
| | N. | MUST 0. No new dietary issues. | |
| | PUP | Treatment plan A insitu. | |
| | M. | Independent around the ward. | |
| | F. | Safety maintained. | |
| | O. | BP Stable, monitoring in sinus rhythm. Apyrexial. | |
| | P | Pain free. | |
| | ACN | Awaiting review by vascular team. Awaiting PCI. | |



## ONGOING PLAN OF PATIENT CARE & EVALUATION

(Record plan of care for all **Amber/Red** problems from Traffic Light Assessment.
**Document interventions/treatment, evaluation & changes to patient condition**

| Code | | | | | |
|---|---|---|---|---|---|
| N | Nutrition | FB | Fluid Balance | LD | Learning Disabilities |
| PUP | Pressure Ulcer Prevention | P | Pain | PS | Personal Safety |
| M | Manual Handling & Mobility | W | Wound/Skin Integrity | PC | Psychological Care |
| F | Falls | PH | Personal Hygiene | S | Sleep |
| A | Airway/Breathing | OH | Oral Hygiene | CF | Cognitive Function |
| O | Observation & Monitoring | I | Infection Control | ACN | Additional Care Needs |
| E | Elimination | C | Communication | | |

| Date/Time | Code | | Initials |
|---|---|---|---|
| 18.11.16. | CONT | List on today's list. | KMc |
| | I | Pink Cannula in (L) hand. VIP Score. 0. | KMc |
| 19/11/16 | N/FB | toast + tea for supper. Fluid balance | |
| 0430 | | discontinued. | |
| | PuP | Plan A. Independent : pressure area care | |
| | M | Mobilising independently | |
| | F | No falls | |
| | A/O | Vitals Stable. Sinus rhythm. apyrexial | |
| | E | Using toilet facilities | |
| | P | No c/o pain | |
| | I | Pink PVC (L) hand. Required for angiogram | |
| | | VIP Score 0. | |
| | C | Communicates needs. | |
| | PS | Nicotine patch insitu | |
| | S | Not sleeping well. | |
| | ACN | Await angiogram. | JS |
| 1200 | N | MUST 0. No new dietary issues. | |
| | PUP | Treatment plan A insitu. | |
| | m. | Independent around the ward. | |
| | F. | Safety maintained | |
| | O. | BP Stable, apyrexial. Monitoring in SE/SB. | |
| | PVC. | Pink cannula in (R) hand VIP score 0. | |
| | ACN | Awaiting angiogram. ? Monday Last on list. | KMc |

**ONGOING PLAN OF PATIENT CARE & EVALUATION**
(Record plan of care all **Amber/Red** problems from Traffic Light Assessment.
**Document interventions/treatment, evaluation & changes to patient condition**

| Code | | | | | |
|---|---|---|---|---|---|
| N | Nutrition | FB | Fluid Balance | LD | Learning Disabilities |
| PUP | Pressure Ulcer Prevention | P | Pain | PS | Personal Safety |
| M | Manual Handling & Mobility | W | Wound/Skin Integrity | PC | Psychological Care |
| F | Falls | PH | Personal Hygiene | S | Sleep |
| A | Airway/Breathing | OH | Oral Hygiene | CF | Cognitive Function |
| O | Observation & Monitoring | I | Infection Control | ACN | Additional Care Needs |
| E | Elimination | C | Communication | | |

| Date/Time | Code | | Initials |
|---|---|---|---|
| 20.11.16 0500 | S | Late to settle. | |
| | N | must = 0. No issues identified. | |
| | PUP 3M | Up on telemetry. Mobilising out to the toilet / relieving own pressure areas. | |
| | F | No falls noted. | |
| | O | Normotensive. Afebrile. In SR. | |
| | P | No c/o pain. | |
| | I | Pink venflon to back of (R) hand. Dated 16-11-16. VIP = 0. | SB |
| 0730 | | ~~transferred~~ to Ward 1 via CCU. Alert/Orientated. ~~telemetry~~ insitu. | |
| 20/11/16 R30. | (PUP) | ABLE TO RELIEVE OWN PRESSURE AREAS. NO REPORTS OF BREAKDOWN AREAS. | |
| | (M) | INDEPENDENTLY MOBILE | |
| | (P) | NO C/O PAIN | |
| | (O) | NEWS STABLE. TELEMETRY CONTINUES - S.R. | |
| 0845 | (PVC) | PVC TO (L) HAND VIP = 0 IN SITU FOR ANGIO | |
| | (PI) | INDEPENDENT WITH PERSONAL HYGIENE NEEDS | |
| | (ACN) | AWAITING ANGIO. TO BE CONSENTED ☐ | RN. |
| 20/11/16 1600 | (O) | NEWS 0 | |
| | (ACN) | Awaiting Angiogram. On list 21/11/16 - 9th on list | K |



**ONGOING PLAN OF PATIENT CARE & EVALUATION**
(Record plan of care for all **Amber/Red** problems from Traffic Light Assessment.
**Document interventions/treatment, evaluation & changes to patient condition**

| Code | | | | | |
|---|---|---|---|---|---|
| N | Nutrition | FB | Fluid Balance | LD | Learning Disabilities |
| PUP | Pressure Ulcer Prevention | P | Pain | PS | Personal Safety |
| M | Manual Handling & Mobility | W | Wound/Skin Integrity | PC | Psychological Care |
| F | Falls | PH | Personal Hygiene | S | Sleep |
| A | Airway/Breathing | OH | Oral Hygiene | CF | Cognitive Function |
| O | Observation & Monitoring | I | Infection Control | ACN | Additional Care Needs |
| E | Elimination | C | Communication | | |

| Date/Time | Code | | Initials |
|---|---|---|---|
| 21/11/16 0200 | N/FB | Independent | |
| | PUP/M | Independent | |
| | F | No risk | |
| | P | No c/o pain. | |
| | PVC/I | venflon insitu (L) hand, VIP=0. | |
| | PS | Current smoker on NRT | |
| | PC/S | very distressed as unable to sleep. Medical staff prescribed Zopiclone, however patient refused this as states cannot take it. Was very stressed out & aggitated. Doctor & nursing staff agreed was not good for patient to be so distressed. Temazepam 10mg prescribed & administered | |
| 21/11/16 1215 | (O) | Telemetry monitor insitu - SR. News 0 | |
| | (P) | C/o chest discomfort - 1/10 pain. 2 puffs GTN spray. No further reports of pain. | |
| | (I/PVC) | PVC insitu. (L) hand. Vip score 0. Dsg (S). To remove post Ayio. Awaits Ayio. 9th on list today. | KS |

NHS Tayside

| NEWS KEY | 0 | 1 | 2 | 3 |
|---|---|---|---|---|

NAME: DAVID STANDISH
DOB/CHI: 050370 0053
WARD: 1 W
ADMISSION DATE:

| | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DATE | 23/4/16 | | | | | | | | | | | | | | | | | | | | | | | | |
| TIME | 0710 | | | | | | | | | | | | | | | | | | | | | | | | |

**RESP RATE**
Write Respirations

| | |
|---|---|
| >25 | |
| 21-24 | |
| 12-20 | 18 |
| 9-11 | |
| <8 | |

Complete only **ONE SpO2** section based on target saturations. Ensure oxygen is prescribed on TPAR.

**SpO2 - Target Saturations 94-98%** ☐

| | |
|---|---|
| >96 | 96 |
| 94-95 | |
| 92-93 | |
| <91 | |

**SpO2 - Target Saturations 88-92%** ☐

| | |
|---|---|
| >88 | |
| 84-87 | |
| 80-83 | |
| <80 | |
| AIR OXYGEN CODE | e.g. V |
| % inspired 02 and L/M | eg 60% / 8L |

AL

**TEMPERATURE**
record with a . (dot) and join with a — (line)

| | |
|---|---|
| 39 | |
| 38 | |
| 37 | |
| 36 | • |
| 35 | |
| Write Actual Temperature | 36.2 |

**PULSE RATE**
record with a . (dot) and join with a — (line)

| | |
|---|---|
| 150 | |
| 140 | |
| 130 | |
| 120 | |
| 110 | |
| 100 | |
| 90 | |
| 80 | |
| 70 | |
| 60 | 67 |
| 50 | |
| 40 | |

**NEWS SCORE** use Systolic BP mark as shown

**BLOOD PRESSURE**

MARK AS SHOWN

120 ↕ 60

| | |
|---|---|
| 230 | |
| 220 | |
| 210 | |
| 200 | |
| 190 | |
| 180 | |
| 170 | |
| 160 | |
| 150 | |
| 140 | |
| 130 | |
| 120 | 110 |
| 110 | |
| 100 | |
| 90 | |
| 80 | |
| 70 | |
| 60 | 76 |
| 50 | |

**CONSCIOUS LEVEL**
ANY CHANGE IN RESPONSE - COMMENCE NEURO OBS - IMMEDIATE MEDICAL REVIEW

| | | |
|---|---|---|
| Alert | A | A |
| Verbal | V | |
| Pain | P | |
| Unresponsive | U | |

| | |
|---|---|
| **NEWS SCORE (with all obs)** | 0 |
| Frequency of observations H = Hourly, M = minutes, D = Daily | 4 |
| Escalation to medical team/HAN/ANP Y / N / E (exclusion) | N |
| INITIAL | AD |
| Check patient's Urine Output | ✓ |
| Consider DELIRIUM - 4AT score | — |
| Blood Glucose | — |
| Pain Score | 0 |
| Nausea Score | 0 |
| Sedation | 0 |

**OXYGEN CODES**

| | |
|---|---|
| A | Room Air |
| NC | Nasal Cannulae 1-6 L/min |
| SM | Simple Mask 5-10 L/min |
| V | Venturi 24% blue 28% white 35% yellow 40% red 60% green |
| RM | Reservoir Mask 15L/min |
| NB | Nebuliser |
| H | Humidified Oxygen |

**RECOGNISE PAIN**

PAINGO **at least** once per shift

Assessment

- **0** No pain at rest or on movement
- **1** No pain at rest, slight on movement
- **2** Intermittent pain at rest, moderate on movement
- **3** Continuous pain at rest, severe on movement

If 2 or 3 repeat PAINGO to guide intervention

use ABBEY tool if patient unable to report pain

If 8 or above repeat PAINGO to guide intervention

**NAUSEA AND VOMITING SCORE**
(see post op nausea and vomiting guidelines)

- **0** No nausea and vomiting
- **1** Nausea only
- **2** Vomiting once
- **3** Vomiting more than once

Intervene at score 1, 2 or 3

**SEDATION SCORE**

- **0** None (patient alert)
- **1** Mild (occasionally drowsy, easy to rouse)
- **2** Moderate (frequently drowsy, easy to rouse)
- **3** Severe (somnolent, difficult to rouse)

Intervene at score 3

**THINK - UNCONTROLLED PAIN?**

If observations are expected for patient's clinical condition, please note expected parameters below

| | Pulse Rate | Respiratory Rate | SpO2 | BP | Temp | |
|---|---|---|---|---|---|---|
| Acceptable Parameters | | | | | | Doctors/NP/ANP Sign Date and time |
| Discontinue Date and Sign | | | | | | |

**DOCUMENT ALL ACTIONS, INTERVENTIONS, EXCLUSIONS AND CLINICAL RESPONSES IN THE NURSING RECORDS**

**CLINICAL CONCERN SHOULD ALWAYS OVERRIDE NEWS SCORE**

| NEWS 0 | NEWS 1-4 | NEWS ≥ 5 OR 3 IN ONE PARAMETER | NEWS ≥ 7 |
|---|---|---|---|
| REFER TO LOCAL ACTION AND ESCALATION POLICY<br>MIN 12 HOURLY OBSERVATIONS | MIN 4 HOURLY OBSERVATIONS<br>INFORM REGISTERED NURSE<br>AGREE FREQUENCY OF OBSERVATION REQUIRED<br>RESPONSE WITHIN 60 MINUTES<br>LOW CLINICAL RISK | MIN HOURLY OBSERVATIONS<br>URGENT ASSESSMENT BY MEDICAL TEAM<br>STRUCTURED RESPONSE<br>THINK SEPSIS<br>RESPONSE WITHIN 30 MINUTES<br>MEDIUM CLINICAL RISK | CONTINUOUS MONITORING<br>URGENT ASSESSMENT BY SENIOR MEDICAL TEAM<br>STRUCTURED RESPONSE<br>CONSIDER 2222<br>RESPONSE WITHIN 15 MINUTES<br>HIGH CLINICAL RISK |

**REFER TO LOCAL ACTION AND ESCALATION POLICY**

| NAME: | WARD: |
|---|---|
| DOB/CHI: | ADMISSION DATE: |

# 24 Hour Management Document

## FLUID CHART

| Bottle No. | FLUID SITE | FLUID TYPE | FLUID AMOUNT ml | RATE OF FLOW (ml/hr) | BATCH No. | ADDITIONS (sign here if drugs added subsequently) | BATCH NO. | USE 24hr CLOCK START | USE 24hr CLOCK FINISH | Prescribed by (Doctor signature) | Administered by (Signature) 1 | Administered by (Signature) 2 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |
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| | | | | | | | | | | | | |

| 24hr clock | INTAKE in ml IV | INTAKE in ml ORAL | OUTPUT in ml Running Total | urine | vomit | aspirate | drain | stool | COMMENTS |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | Intake (ml) | | Output (ml) | | | | Total (ml) |

## Preliminary Pressure Ulcer Risk Assessment (PPURA)

**The following 4 questions must be completed with ALL patients within 6 hours of admission or for community staff, on the day of admission to the service.**
**Re-assessment required if the patient condition changes including the day of major surgery**

(please write Yes/No below)

| | | |
|---|---|---|
| 1 | Requires assistance and or aids to **regularly** relieve **any** pressure area (includes heels/head etc.) Cannot or will not move independently. OR on an operating table for > 2hrs? | no |
| 2 | Incontinent - urine or faeces in contact with the skin? | no |
| 3 | BMI <18.5 or >40 / patient appears malnourished? | no |
| 4 | Pressure Ulcer Grade 1 - 4 | no |
| **Date** | | 16.11.16 |
| **Time** | | 1850 |
| **Initial** | | |

## SEE EPUAP PRESSURE ULCER CLASSIFICATION 2009

If **Yes** to any question raise the PUP treatment plan and carry out a full asssment within **6 hours** of admission (or day of admission to the DN service). **Theatre staff to complete Plan D**
If **No** to any question re-assess each shift, or a change in clinical condition then record on traffic lightd and implement **Treatment plan A**

| DATE & TIME | Pressure ulcer on admission Y N Source of Ulcer _____ (home other ward/hospital) | Initiate PUP Treatment plan B or C and raise a wound care plan for grade 2 and above pressure ulcers Treatment plan _____ (**A B C**) Date _____ |
|---|---|---|

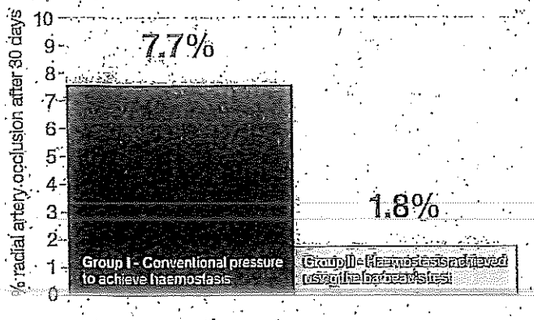
### PRESSURE ULCER RECORD

| DATE/TIME | Ulcer Location | EPUAP Grade | Record on AIM any stage 2 if developed in your area, also if the pressure ulcer was present on admission from another area and no record in the notes **state incident reference** number(s) and date | Initials |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## WHY?

HELIX™
For easier patent haemostasis

### Findings from the Prophet Study



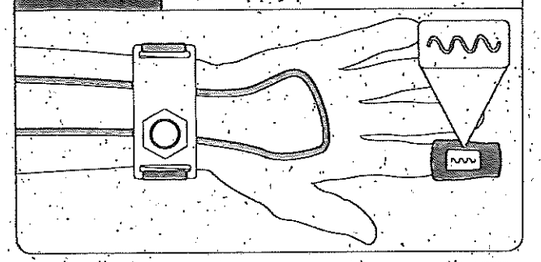

Catheterization and Cardiovascular Interventions
DOI 10.1002/ccd.

Published on behalf of The Society for Cardiovascular Angiography and Interventions (SCAI).

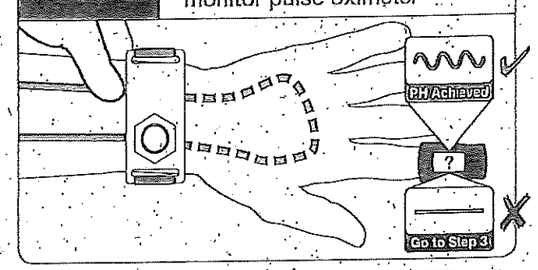
**Conclusion:** Patent haemostasis is highly effective in reducing radial artery occlusion after radial access and guided compression should be performed to maintain radial artery patency at the time of haemostasis, to prevent future radial artery occlusion.

## HOW?

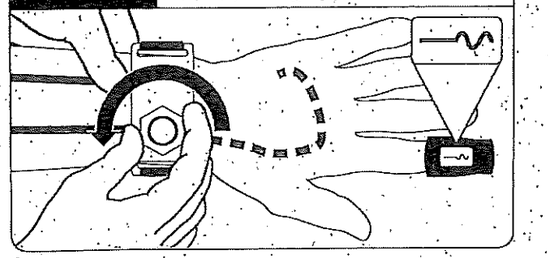
**STEP 1** Achieve Haemostasis and apply pulse oximeter



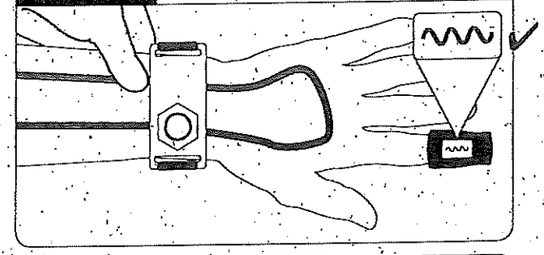
**STEP 2** Occlude ulnar and monitor pulse oximeter




**STEP 3** Gradually reduce pressure until reading appears



**STEP 4** Occluded ulnar + pulse oximeter reading = Patent Haemostasis



HELIX applied at 14 : 05
(leave approx. 10 mins)

PH Achieved at 14 : 20
(leave 1 hour)

Begin releasing remaining pressure at: _____ : _____ (1 or 2 turns per 15/20 mins)
Pressure released (Should bleeding occur, re-apply ½ turns clockwise, till bleeding stops, leave 15 mins and then re-confirm PH):

_____ : _____ _____ : _____ _____ : _____ _____ : _____

☐ Helix removed at: _____ : _____ ☐ Site dressed at: _____ : _____

**Important Notes:**

- The timings illustrated should only be used as a guide
- If PH cannot be achieved, revert to existing Hospital protocol
- If other factors such as GPIIb/IIIa inhibitors are used or if INR >2 - add 1 hour to above timings.
- If Bivalirudin is used – achieve and maintain patent haemostasis throughout infusion and allow one hour after infusion is complete.
- If patients have clotting disorders or are taking other forms of anti-coagulants or anti-platelets then Doctor's should advise the timings.
- If there is a significant drop in systolic blood pressure while the device is applied, it is advisable to re-check for patent haemostasis and adjust pressure if required.

www.vascularperspectives.com

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Vasculaperspectives
Innovations for the interventionalist

## DUNDEE TEACHING HOSPITALS TAYSIDE NHS

## CAREPLAN : PATIENT UNDERGOING CORONARY ANGIOGRAM / PCI

**Date :** 22/11/16 **Patient**

05 03 70
0503700053
DAVID STANDISH

**Problems.**

1. Patient requires to be adequately prepared for coronary angio
2. Patient is at risk of occlusion / haemorrhage.

**Goals.**

1. Patient is prepared for procedure.
2. Early detection and treatment of occlusion / haemorrhage.

**Interventions.**
**Ward/Cathlab**

| | |
|---|---|
| Assess patient's knowledge of coronary angiogram and reinforce as necessary. | ✓ |
| Check patient has ID band containing name, DOB and CHI on **left wrist** | ✓ 22/11/16 083419 ✓ |
| Check patient has had no diet 2 hours prior to angio. Encourage all fluids. | ✓ |
| Ensure consent form is signed and available.(inform lab if not ) | ✓ |
| Site pink venflon or larger in left arm and ensure patent | ✓ |
| Record baseline TPR,Bp,Spo2 | |
| ----------Document any allergies _____ NIL KNOWN | |
| Document if patient is asthmatic or has hayfever. | N/A |
| Medication. STOP.....Warfarin (INR------) | N/A |
| LMWH | N/A |
| Metformin | |
| NSAIDs . | |
| Ensure patient has been started/loaded with Aspirin | NOT KNOWN. ASPIRIN |
| Ensure patient has been started/loaded with Clopidogrel | CLOPIDOGREL. |
| Record patient height & weight. (H) 5 ft 9" (W) 95 Kg | |

*MAXIMUM WEIGHT FOR LAB TABLE – 32st/202Kg*

**Sign on completion** ✓

If femoral approach, follow cath lab report for mobility instructions
If radial approach, follow instructions on reverse side of procedure report
Check wound and pulses every 15 minutes for 1 hour then hourly for 4 hours.
Record vital signs hourly for 4 hours.
Fluids and diet allowed on return to ward.
Ensure nurse call system is within reach.

**Sign on completion**

**Observations Table**

**R = Right L = Left**
**Colour – WH = White PK = Pink PA = Pale BL = Blue**
**Temp – WM = Warm CO = Cold CI = Cool**

| Time | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Wound (F or R) | | | | | | | | | | | | | | | | | | |
| Pulse R | | | | | | | | | | | | | | | | | | |
| Pulse L | | | | | | | | | | | | | | | | | | |
| Colour R | | | | | | | | | | | | | | | | | | |
| Colour L | | | | | | | | | | | | | | | | | | |
| Temp R | | | | | | | | | | | | | | | | | | |
| Temp L | | | | | | | | | | | | | | | | | | |
| Checked by: | | | | | | | | | | | | | | | | | | |

## DUNDEE TEACHING HOSPITALS TAYSIDE NHS

## CAREPLAN : PATIENT UNDERGOING CORONARY ANGIOGRAM / PCI

**Date :** 21/11/16 **Patient**

**05 03 70**
**0503700053**
DAVID STANDISH

**Problems.**

1. Patient requires to be adequately prepared for coronary angio
2. Patient is at risk of occlusion / haemorrhage.

**Goals.**

1. Patient is prepared for procedure.
2. Early detection and treatment of occlusion / haemorrhage.

**Interventions.**
**Ward/Cathlab**

Assess patient's knowledge of coronary angiogram and reinforce as necessary. ✓
Check patient has ID band containing name, DOB and CHI on **left wrist** ✓
Check patient has had no diet 2 hours prior to angio. Encourage all fluids. ✓
Ensure consent form is signed and available.(inform lab if not ) ☐ ✓
Site pink venflon or larger in left arm and ensure patent ✓
Record baseline TPR,Bp,Spo2 ✓
----------Document any allergies See kardex
---
Document if patient is asthmatic or has hayfever. ✓ Asthma. ✓
Medication. STOP.....Warfarin (INR------) 3 N/A. ✓
LMWH ✓
Metformin ✓
NSAIDs ✓

Ensure patient has been started/loaded with Aspirin ✓
Ensure patient has been started/loaded with Clopidogrel ticagrelor ✓

Record patient height & weight. (H) 5 ft 9" (W) 95 Kg ✓

*MAXIMUM WEIGHT FOR LAB TABLE – 32st/202Kg*

**Sign on completion** JLA

If femoral approach, follow cath lab report for mobility instructions
If radial approach, follow instructions on reverse side of procedure report
Check wound and pulses every 15 minutes for 1 hour then hourly for 4 hours.
Record vital signs hourly for 4 hours.
Fluids and diet allowed on return to ward.
Ensure nurse call system is within reach.

**Sign on completion**

**Observations Table**

**R = Right L = Left**
**Colour – WH = White PK = Pink PA = Pale BL = Blue**
**Temp – WM = Warm CO = Cold CI = Cool**

| Time | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Wound (F or R) | | | | | | | | | | | | | | | | | | |
| Pulse R | | | | | | | | | | | | | | | | | | |
| Pulse L | | | | | | | | | | | | | | | | | | |
| Colour R | | | | | | | | | | | | | | | | | | |
| Colour L | | | | | | | | | | | | | | | | | | |
| Temp R | | | | | | | | | | | | | | | | | | |
| Temp L | | | | | | | | | | | | | | | | | | |
| Checked by: | | | | | | | | | | | | | | | | | | |

WRITE OR ATTACH LABEL

Surname Stanclish Sex M

Forename David

DOB and CHI 05/03/70 0053

Hospital N/Wells

Ward One

NHS Tayside

## ONGOING PLAN OF PATIENT CARE & EVALUATION

(Record plan of care for all **Amber/Red** problems from Traffic Light Assessment.
**Document interventions/treatment, evaluation & changes to patient condition**

| Code | | | | | |
|---|---|---|---|---|---|
| N/FB | Nutrition & Fluid balance | E | Elimination | C | Communication |
| PUP | Pressure Ulcer Prevention | P | Pain | LD | Learning Disabilities |
| M | Manual Handling & Mobility | W | Wound/Skin Integrity | PS | Personal Safety |
| F | Falls | PH | Personal Hygiene | PC | Psychological Care/Wellbeing |
| BR | Bedrails | OH | Oral Hygiene | S | Sleep |
| A | Airway/Breathing | I | Infection Control | CF | Cognitive Function |
| O | Observation & Monitoring | PVC | PVC/CVC | ACN | Additional Care Needs |

| Date/Time | Code | | |
|---|---|---|---|
| 22/11/16 | ACN | Helix now off. RN Rowan taken it off | |
| | | Kept @ arm elevated on rolled towel | |
| | | No sign of bleeding. | |
| | N/FB | Normal diet and fluid tolerated well. | |
| | PVC | on @ arm | |
| | | Had one of diazepam | |
| | O | NEWS 0. | |
| | CP | Alert and orientated. | m |
| 2100. | | Walked with partner to T junction. | |
| | | felt dizzy slightly clammy color pale. | |
| | | News 0. lying on bed feeling better | |
| | | but not right. | PR. |
| | | Advised not to leave ward | |
| 23/11/16 0400. | PUP | Indep in relieving own pressure areas skin no red/broken areas. | |
| | M | Indep. | |
| | W. | Angio - Radial site - satisfactory. | |
| | | minimal bleeding + pressure. | |
| | O | News 0. | |
| | S | Finding difficult to sleep despite diazepam + night sedation. | |
| | O. | Telemetry in SSU overnight. | |
| | ACN | For review in am. | PR |
| | | | |
| | | | |

**WRITE OR ATTACH LABEL**

Surname.....Sex.....

Forename.....

DOB and CHI.....

Hospital.....

Ward .....

NHS Tayside

## ONGOING PLAN OF PATIENT CARE & EVALUATION

(Record plan of care for all **Amber/Red** problems from Traffic Light Assessment.
**Document interventions/treatment, evaluation & changes to patient condition**

| Code | | | | | |
|---|---|---|---|---|---|
| **N/FB** | Nutrition & Fluid balance | **E** | Elimination | **C** | Communication |
| **PUP** | Pressure Ulcer Prevention | **P** | Pain | **LD** | Learning Disabilities |
| **M** | Manual Handling & Mobility | **W** | Wound/Skin Integrity | **PS** | Personal Safety |
| **F** | Falls | **PH** | Personal Hygiene | **PC** | Psychological Care/Wellbeing |
| **BR** | Bedrails | **OH** | Oral Hygiene | **S** | Sleep |
| **A** | Airway/Breathing | **I** | Infection Control | **CF** | Cognitive Function |
| **O** | Observation & Monitoring | **PVC** | PVC/CVC | **ACN** | Additional Care Needs |

| Date/Time | Code | | |
|---|---|---|---|
| 23/11/16 | (PuP) | Pressure areas intact - no redness | |
| 1500 | (M) | Mobilising independently | |
| | (O) | News 0 | |
| | (PH) | Washed independently | |
| | (Act) | Medical Review :- Home today | ✓ |
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**WRITE OR ATTACH LABEL**

Surname STANDISH Sex M

Forename DAVID

DOB and CHI 050370 0053

Hospital NW

Ward 21

NHS Tayside

# MANUAL HANDLING AND MOBILITY ASSESSMENT CHART

**(To be completed within 24 hours of admission)**

Patient Fully Independant without Aids/Assistance Y (N) **(If yes - no further action required)**

Relevant Medical History/Underlying Condition e.g. Confusion/Surgery .....

Weight: .....kg Consider safe working load of equipment

Comprehension: (sight, hearing, speech) ..... Attachments (infusions, catheter, drains) .....

| | CODES | CODES | CODES | CODES | CODES | CODES | CODES |
|---|---|---|---|---|---|---|---|
| Sit>>Lie | I | | | | | | |
| Lying>>Sitting | I | | | | | | |
| Sit>>Stand | I | | | | | | |
| Stand>>Sit | I | | | | | | |
| Walking | 1xWS | | | | | | |
| Bathing | I /A1 | | | | | | |
| Moving up the bed | I | | | | | | |
| Turning/proning | I | | | | | | |
| Lateral Transfers | PAT A4 / I | | | | | | |
| Floor to Bed | H A2 / I | | | | | | |
| **Comments** | | | | | | | |
| **Date** | 16.11.16 | | | | | | |
| **Time** | 2130 | | | | | | |
| **Initials** | OS | | | | | | |

**A Risk Assessment should be carried out prior to any Manual Handling Manoeuvre. All changes or comments should be clearly documented in the Nursing Record of On-Going Care & Multidisciplinary Notes. Please indicate 'YES' if (any) in the Comments box.**

**Enter Mobility and Equipment Codes**

**Mobility Codes**

| | |
|---|---|
| I = Independent | A1 = Assistance x 1 staff |
| VP = Verbal prompting | A2 = Assistance x 2 staff |
| S = Supervision | A3 = Assistance x 3 staff |
| D = Dependant | A4 = Assistance x 4 staff |
| BR = Bedrest | |
| NWB = Non weight bearing | |
| PWB = Partial weight bearing | |
| FWB = Full weight bearing | |

**Aids/Equipment Codes**

| | |
|---|---|
| H = Full Body Hoist | GC = Gutter Crutch |
| ST= Stand Aid | WZF = Wheeled Zimmer Frame |
| GS= 1/2 Glide Sheet | ZF = Zimmer Frame |
| WS= Walking Stick | TWW = Three Wheeled Walker |
| WS1=One Stick | 4WW = Four Wheeled Walker |
| WS2=Two Sticks | RZ = Rollator Wheeled Zimmer |
| EC = Elbow Crutch | WC = Wheelchair |
| AC = Axillary Crutch | PAT = Patslide |

# MANUAL HANDLING AND MOBILITY ASSESSMENT CHART

Patient Fully Independant without Aids/Assistance Y N **(If yes - no further action required)**

Relevant Medical History/Underlying Condition e.g. Confusion/Surgery .....

Weight: .....kg Consider safe working load of equipment

Comprehension: (sight, hearing, speech) ..... Attachments (infusions, catheter, drains) .....

| | CODES | CODES | CODES | CODES | CODES | CODES | CODES |
|---|---|---|---|---|---|---|---|
| Sit>>Lie | | | | | | | |
| Lying>>Sitting | | | | | | | |
| Sit>>Stand | | | | | | | |
| Stand>>Sit | | | | | | | |
| Walking | | | | | | | |
| Bathing | | | | | | | |
| Moving up the bed | | | | | | | |
| Turning/proning | | | | | | | |
| Lateral Transfers | | | | | | | |
| Floor to Bed | | | | | | | |
| **Comments** | | | | | | | |
| **Date** | | | | | | | |
| **Time** | | | | | | | |
| **Initials** | | | | | | | |

**A Risk Assessment should be carried out prior to any Manual Handling Manoeuvre. All changes or comments should be clearly documented in the Nursing Record of On-Going Care & Multidisciplinary Notes. Please indicate 'YES' if (any) in the Comments box.**

## Enter Mobility and Equipment Codes

**Mobility Codes**

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S = Supervision
D = Dependant
BR = Bedrest
NWB = Non weight bearing
PWB = Partial weight bearing
FWB = Full weight bearing
A1 = Assistance x 1 staff
A2 = Assistance x 2 staff
A3 = Assistance x 3 staff
A4 = Assistance x 4 staff

**Aids/Equipment Codes**

H = Full Body Hoist
ST= Stand Aid
GS= 1/2 Glide Sheet
WS= Walking Stick
WS1=One Stick
WS2=Two Sticks
EC = Elbow Crutch
AC = Axillary Crutch
GC = Gutter Crutch
WZF = Wheeled Zimmer Frame
ZF = Zimmer Frame
TWW = Three Wheeled Walker
4WW = Four Wheeled Walker
RZ = Rollator Wheeled Zimmer
WC = Wheelchair
PAT = Patslide

**NINEWELLS HOSPITAL**
**CORONARY CARE UNIT**

DATE: 18.11.16 Day No: 23

SURNAME: STANDISH D.O.B.: 050370

FIRST NAME: DAVID UNIT NO: 0053

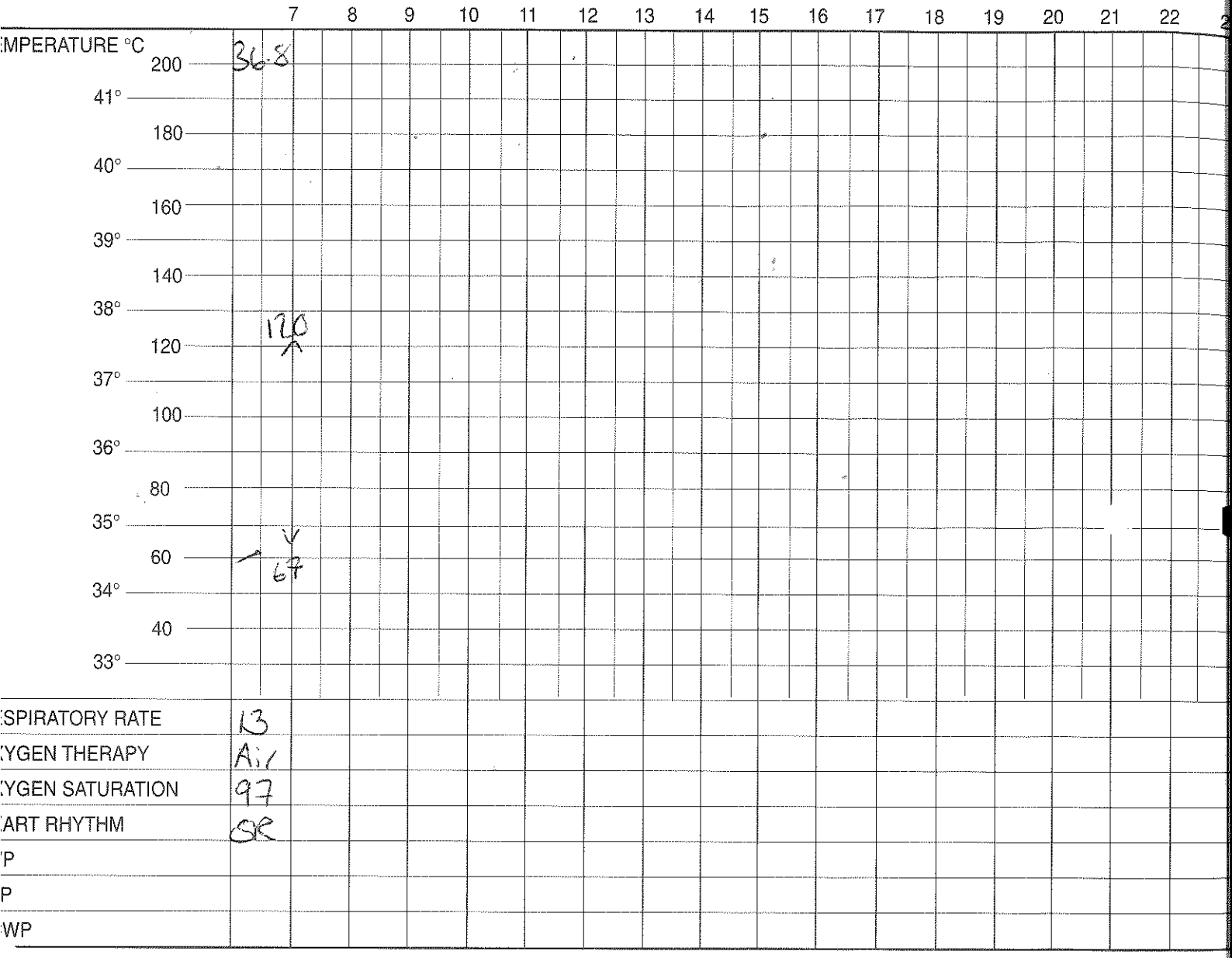
ADDRESS:

DATE/TIME OF ADMISSION 16.11.16

DIAGNOSIS: NSTEMI

CONSULTANT: SH

| TIME | PRESCRIBED TREATMENT | SIGNATURE |
|---|---|---|
| | | |




TIMATED WEIGHT
RUG INFUSIONS

URLY INFUSION CHECK
XTROSTIX

| 23 | Mn | 1 | 2 | 3 | 4 | 5 | 6 | TEMPERATURE °C |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | 200 |
| | | | | | | | | 41° |
| | | | | | | | | 180 |
| | | | | | | | | 40° |
| | | | | | | | | 160 |
| | | | | | | | | 39° |
| | | | | | | | | 140 |
| | | | | | | | | 38° |
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| | | | | | | | | 37° |
| | | | | | | | | 100 |
| | | | | | | | | 36° |
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| | | | | | | | | 35° |
| | | | | | | | | 60 |
| | | | | | | | | 34° |
| | | | | | | | | 40 |
| | | | | | | | | 33° |
| | | | | | | | | RESPIRATORY RATE |
| | | | | | | | | OXYGEN THERAPY |
| | | | | | | | | OXYGEN SATURATION |
| | | | | | | | | HEART RHYTHM |
| | | | | | | | | CVP |
| | | | | | | | | PAP |
| | | | | | | | | PCWP |

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| | | | | | | | | HOURLY INFUSION CHECK |
| | | | | | | | | DEXTROSTIX |

## URINALYSIS

SG :

PH :

PROTEIN :

BLOOD :

SUGAR :

KETONES :

BILIRUBIN :

UROBILINOGEN :

NITRATES :

## OVERALL FLUID BALANCE

IV TOTAL :

ORAL TOTAL :

TOTAL INTAKE :

TOTAL OUTPUT :

BALANCE :

# IV - INTAKE

| Time | Fluid Type | Batch No. | Volume Comm. | Volume Infused | Additions | Estab. | Witness |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
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## ORAL INTAKE

## OUTPUT

| Time | Oral | Time | Urine | Urine Total | Vomit | N/Gastric | Stool |
|---|---|---|---|---|---|---|---|
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# PAIN ASSESSMENT CHART

**WHEN YOU ASSESS PATIENTS PAINPLEASE CONSIDER THE FOLLOWING ONSET AND PRECIPITATING FACTORS**

- *LOCATION (WITH RADIATION) - DEFINE THE SITE OF THE PAIN*
- *DURATION - HOW LONG IT LASTED, IS THERE A PATTERN TO ITS OCCURENCE*
- *EFFECTS OF PREVIOUSPAIN RELIEF*
- *QUALITY - WHAT THE PATIENT SAYS IT FEELS LIKE*
- *INTENSITY (USE SCALE 0 - 10)*
- *AGGRAVATING/RELIEVING FACTORS - WHAT MAKES THE PAIN BETTER OR WORSE*

| Date and Time | Pain Assessment | Pain Site | Patients Score | Patients Activity | Analgesia given Name, Route, Amount | Evaluation of Action |
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**NINEWELLS HOSPITAL**
**CORONARY CARE UNIT**

DATE: 16·11·16 Day No: 1

SURNAME: STANDISH D.O.B 030370

FIRST NAME: DAVID UNIT NO: 0053

ADDRESS:

DATE/TIME OF ADMISSION 16·11·16 2100

DIAGNOSIS: NSTEMI

CONSULTANT: S.H.

| TIME | PRESCRIBED TREATMENT | SIGNATURE |
|---|---|---|
| | | |
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| | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 |
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| TEMPERATURE °C | | | | | | | | | | | | | | | | |
| 200 / 41° | | | | | | | | | | | | | | | | |
| 180 / 40° | | | | | | | | | | | | | | | | |
| 160 / 39° | | | | | | | | | | | | | | | | |
| 140 / 38° | | | | | | | | | | | | | | | | |
| 120 / 37° | | | | | | | | | | | | | | | | |
| 100 / 36° | | | | | | | | | | | | | | | | |
| 80 / 35° | | | | | | | | | | | | | | | | |
| 60 / 34° | | | | | | | | | | | | | | | | |
| 40 / 33° | | | | | | | | | | | | | | | | |
| RESPIRATORY RATE | | | | | | | | | | | | | | | | |
| OXYGEN THERAPY | | | | | | | | | | | | | | | | |
| OXYGEN SATURATION | | | | | | | | | | | | | | | | |
| HEART RHYTHM | | | | | | | | | | | | | | | | |
| CVP | | | | | | | | | | | | | | | | |
| PAP | | | | | | | | | | | | | | | | |
| PCWP | | | | | | | | | | | | | | | | |

ESTIMATED WEIGHT
DRUG INFUSIONS

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| HOURLY INFUSION CHECK | | | | | | | | | | | | | | | | |
| DEXTROSTIX | | | | | | | | | | | | | | | | |

37.0C

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(R) 1157

V88 0497 V89

| 23 | Mn | 1 | 2 | 3 | 4 | 5 | 6 | TEMPERATURE °C |
|---|---|---|---|---|---|---|---|---|
| 37 | | | | | | | | 200 / 41° |
| | | | | | | | | 180 / 40° |
| 37 | | | | | | | | 160 / 39° |
| | | | | | | | | 140 / 38° |
| | | | | | | | | 120 / 37° |
| | | | | | | | | 100 / 36° |
| 89 | | | | | | | | 80 / 35° |
| | | | | | | | | 60 / 34° |
| | | | | | | | | 40 / 33° |
| 14 | | | | | | | | RESPIRATORY RATE |
| Air | | | | | | | | OXYGEN THERAPY |
| 100 | | | | | | | | OXYGEN SATURATION |
| SR. | | | | | | | | HEART RHYTHM |
| | | | | | | | | CVP |
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| | | | | | | | | PCWP |

## URINALYSIS

SG :

PH :

PROTEIN :

BLOOD :

SUGAR :

KETONES :

BILIRUBIN :

UROBILINOGEN :

NITRATES :

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| | | | | | | | | HOURLY INFUSION CHECK |
| | | | | | | | | DEXTROSTIX |

## OVERALL FLUID BALANCE

IV TOTAL : —

ORAL TOTAL : 800

TOTAL INTAKE : 800

TOTAL OUTPUT : 396

BALANCE : 404

# IV - INTAKE

| Time | Fluid Type | Batch No. | Volume Comm. | Volume Infused | Additions | Estab. | Witness |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
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**ORAL INTAKE** **OUTPUT**

| Time | Oral | TOTAL | Time | Urine | Urine Total | Vomit | N/Gastric | Stool |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| 2100 | 200 | 200 | | | | | | |
| | | | 2340 | 396 | 396 | | | |
| | | | | | | | | |
| 100 | 300 | 500 | | | | | | |
| 200 | 200 | 700 | | | | | | |
| | | | | | | | | |
| 0540 | 100 | 800 | | | | | | |
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| | TOTAL | 800 | | TOTAL | 396 | | | |

+404

# PAIN ASSESSMENT CHART

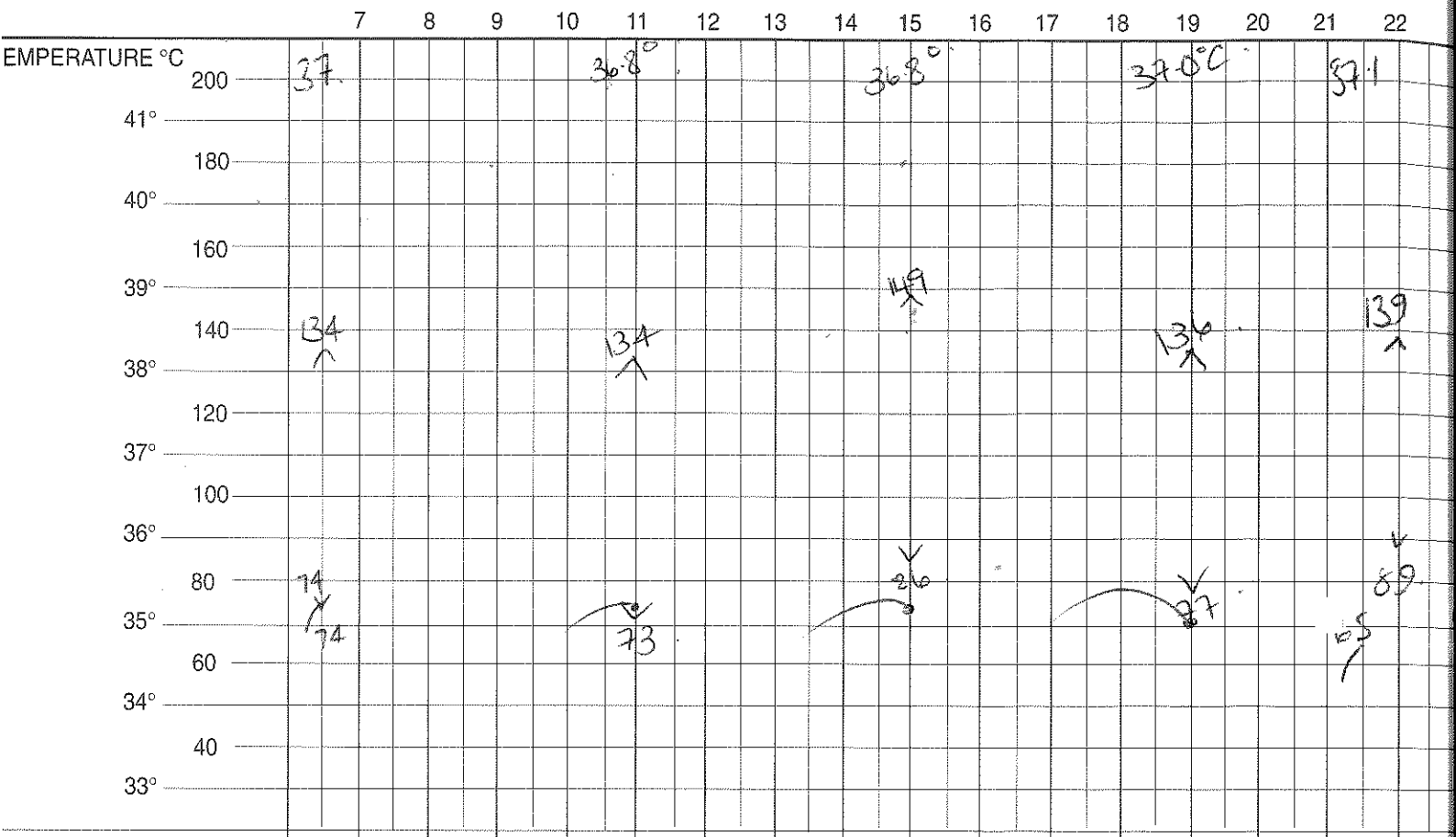
**WHEN YOU ASSESS PATIENTS PAINPLEASE CONSIDER THE FOLLOWING ONSET AND PRECIPITATING FACTORS**

- *LOCATION (WITH RADIATION) - DEFINE THE SITE OF THE PAIN*
- *DURATION - HOW LONG IT LASTED, IS THERE A PATTERN TO ITS OCCURENCE*
- *EFFECTS OF PREVIOUSPAIN RELIEF*
- *QUALITY - WHAT THE PATIENT SAYS IT FEELS LIKE*
- *INTENSITY (USE SCALE 0 - 10)*
- *AGGRAVATING/RELIEVING FACTORS - WHAT MAKES THE PAIN BETTER OR WORSE*

| Date and Time | Pain Assessment | Pain Site | Patients Score | Patients Activity | Analgesia given Name, Route, Amount | Evaluation of Action |
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| NINEWELLS HOSPITAL<br>CORONARY CARE UNIT<br><br>DATE: 17.11.16 Day No: 2 | SURNAME: Standish D.O.B.: 050370<br>FIRST NAME: David UNIT NO: 0053<br>ADDRESS: |
|---|---|
| DATE/TIME OF ADMISSION<br>DIAGNOSIS:<br>NSTEMI<br>Trop 0.067 → 2.5 | CONSULTANT: |

| TIME | PRESCRIBED TREATMENT | SIGNATURE |
|---|---|---|
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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ESPIRATORY RATE | 14 | | | | | 12 | | | | | | 16 | | | | | 15 | | | | | 16 | |
| )XYGEN THERAPY | Air | | | | | AIR | | | | | | AIR | | | | | AIR | | | | | Air | |
| )XYGEN SATURATION | 99 | | | | | 96% | | | | | | 98% | | | | | 97% | | | | | 97 | |
| EART RHYTHM | SR. | | | | | SR | | | | | | SR | | | | | SR | | | | | SR | |
| VP | | | | | | | | | | | | | | | | | | | | | | | |
| AP | | | | | | | | | | | | | | | | | | | | | | | |
| CWP | | | | | | | | | | | | | | | | | | | | | | | |

STIMATED WEIGHT
RUG INFUSIONS

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| OURLY INFUSION CHECK | | | | | | | | | | | | | | | | | | | | | | | |
| EXTROSTIX | | | | | | | | | | | | | | | | | | | | | | | |

| 23 | Mn | 1 | 2 | 3 | 4 | 5 | 6 | TEMPERATURE °C |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | 200 — 41° |
| | | | | | | | | 180 — 40° |
| | | | | | | | | 160 — 39° |
| | | | | | | | | 140 — 38° |
| | | | | | | | | 120 — 37° |
| | | | | | | | | 100 — 36° |
| | | | | | | | | 80 — 35° |
| | | | | | | | | 60 — 34° |
| | | | | | | | | 40 — 33° |
| | | 18 | | | | | | RESPIRATORY RATE |
| | | ~ | | | | | | OXYGEN THERAPY |
| | | aa | | | | | | OXYGEN SATURATION |
| | | SR | | | | | | HEART RHYTHM |
| | | | | | | | | CVP |
| | | | | | | | | PAP |
| | | | | | | | | PCWP |

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## URINALYSIS

SG :

PH :

PROTEIN :

BLOOD :

SUGAR :

KETONES :

BILIRUBIN :

UROBILINOGEN :

NITRATES :

## OVERALL FLUID BALANCE

IV TOTAL :

ORAL TOTAL :

TOTAL INTAKE :

TOTAL OUTPUT :

BALANCE :

# IV - INTAKE

| Time | Fluid Type | Batch No. | Volume Comm. | Volume Infused | Additions | Estab. | Witness |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
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+404

## ORAL INTAKE

## OUTPUT

| Time | Oral | TOTAL | Time | Urine | Urine Total | Vomit | N/Gastric | Stool |
|---|---|---|---|---|---|---|---|---|
| 09[00] | 150 (TEA) | | 10[00] | 370 | | | | |
| | | | 11[00] | p'u'd | | | | |
| 13[00] | 150 (coffee) | 300 | | | | | | |
| 15[00] | 200 | 500 | | | | | | |
| 16[00] | 150 (TEA) | 650 | | | | | | |
| 19[00] | 300 | 950 | | | | | | |
| | | | 2230 | 240 | | | | |
| | TOTAL | | | TOTAL | | | | |

# PAIN ASSESSMENT CHART

**WHEN YOU ASSESS PATIENTS PAINPLEASE CONSIDER THE FOLLOWING ONSET AND PRECIPITATING FACTORS**

- *LOCATION (WITH RADIATION) - DEFINE THE SITE OF THE PAIN*
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- *QUALITY - WHAT THE PATIENT SAYS IT FEELS LIKE*
- *INTENSITY (USE SCALE 0 - 10)*
- *AGGRAVATING/RELIEVING FACTORS - WHAT MAKES THE PAIN BETTER OR WORSE*

| Date and Time | Pain Assessment | Pain Site | Patients Score | Patients Activity | Analgesia given Name, Route, Amount | Evaluation of Action |
|---|---|---|---|---|---|---|
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## SHIFT ASSESSMENT

| DATE | 22/11/16 | | | 23/11/16 | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N |
| **(PVC) PVC / CVC / PICC** | | | | | | | | | | | | | | | | | | |
| No PVC/CVC/PICC | | | | 14 | | | | | | | | | | | | | | |
| CVC /PICC line in situ | | | | | | | | | | | | | | | | | | |
| PVC (1) - write day of insertion (i.e. 1,2 or 3) in box | | 20 | 4 | | | | | | | | | | | | | | | |
| PVC (2) - write day of insertion (i.e. 1,2 or 3) in box | | | | | | | | | | | | | | | | | | |
| PVC in situ>3 days - Consider removal and/or write day since insertion (i.e. 4,5,6) in box | | | | | | | | | | | | | | | | | | |
| VIP Score >1 | | | | | | | | | | | | | | | | | | |
| **(C) COMMUNICATION** | | | | | | | | | | | | | | | | | | |
| No Communication barriers identified/self manages own communication needs | | 20 | 4 | 14 | | | | | | | | | | | | | | |
| Existing communication barriers that require support or intervention | | | | | | | | | | | | | | | | | | |
| New communication barrier e.g. stroke/or patient requires Language/British Sign Language Interpreter/Blind/Deafblind | | | | | | | | | | | | | | | | | | |
| **(LD) LEARNING DISABILITY** | | | | | | | | | | | | | | | | | | |
| No learning disability | | 20 | 4 | 14 | | | | | | | | | | | | | | |
| Learning disability identified (Contact Learning Disability Liaison Team) | | | | | | | | | | | | | | | | | | |
| **(PS) PERSONAL SAFETY** | | | | | | | | | | | | | | | | | | |
| Not ambulant/ambulant but clinically stable Mentally capable of making sound judgements Identity Bracelet in place - Legible/complete and correct patient details | | 20 | 4 | 14 | | | | | | | | | | | | | | |
| Ambulant, but clinically unstable Current smoker/Alcohol or Substance misuse (complete disclaimer on Patient Safety Risk assessment THB 610) | | | | | | | | | | | | | | | | | | |
| Risk of absconding/Concerns for patient safety/impaired judgment/Sedation (complete Patient Safety Risk Assessment THB610) | | | | | | | | | | | | | | | | | | |
| **(PC) WELL BEING** | | | | | | | | | | | | | | | | | | |
| Patient reports psychological/spiritual care needs are being met | | 20 | 4 | 14 | | | | | | | | | | | | | | |
| Distress or stress identified and being managed | | | | | | | | | | | | | | | | | | |
| Requires active psychological/spiritual care | | | | | | | | | | | | | | | | | | |
| Has a longstanding mental health condition that is managed | | | | | | | | | | | | | | | | | | |
| Patient experiencing intense emotions/distress/or behavioural issues Requiring immediate professional input | | | | | | | | | | | | | | | | | | |
| **(S) SLEEP** | | | | | | | | | | | | | | | | | | |
| No sleep problem identified/usual sleep pattern | | 20 | 0 | | | | | | | | | | | | | | | |
| Altered sleep pattern/difficulty sleeping/insomnia | | | 4 | 14 | | | | | | | | | | | | | | |
| **(CF) COGNITIVE FUNCTION (Think Delirium)** | | | | | | | | | | | | | | | | | | |
| No problems identified | | 20 | 0 | 14 | | | | | | | | | | | | | | |
| Cognitive Impairement with controlled symptoms | | | | | | | | | | | | | | | | | | |
| Delirium/Acute change in cognitive function/deteriorating Dementia with significant symptoms | | | | | | | | | | | | | | | | | | |
| Relative/carer/friend has Welfare Power of Attorney/Legal Guardianship | | | | | | | | | | | | | | | | | | |
| Active Adults with Incapacity (section 47) - review dates weekly | | | | | | | | | | | | | | | | | | |
| **(ACN) ADDITIONAL CARE NEEDS** | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| **Initials of Nurse** | | [illegible] | [illegible] | [illegible] | | | | | | | | | | | | | | |

## SHIFT ASSESSMENT

| DATE | 22/11/16 | | | 23/11/16 | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N |
| **(E) ELIMINATION - Urine** | | | | | | | | | | | | | | | | | | |
| Independent and continent | | 20 | ✓ | 15 | | | | | | | | | | | | | | |
| Long term catheter / stoma in situ and self caring | | | | | | | | | | | | | | | | | | |
| Short term catheter in situ (Review need daily) | | | | | | | | | | | | | | | | | | |
| Managed incontinence/requires prompting | | | | | | | | | | | | | | | | | | |
| Incontinent / new stoma | | | | | | | | | | | | | | | | | | |
| Moisture lesions to skin | | | | | | | | | | | | | | | | | | |
| Has not passed urine > 30 mls per hour | | | | | | | | | | | | | | | | | | |
| **(E) ELIMINATION - Bowels** | | | | | | | | | | | | | | | | | | |
| Continent - Normal bowel habit/bowels opened | | | | | | | | | | | | | | | | | | |
| Stoma in situ and self caring | | | | | | | | | | | | | | | | | | |
| Constipated/bowels not opened | | 20 | ✓ | 15 | | | | | | | | | | | | | | |
| Managed incontinence | | | | | | | | | | | | | | | | | | |
| Loose stools | | | | | | | | | | | | | | | | | | |
| Incontinent/loose stools/new stoma | | | | | | | | | | | | | | | | | | |
| **(P) PAIN - Complete PAINGO** | | | | | | | | | | | | | | | | | | |
| No pain reported. Not requiring analgesia | | 20 | ✓ | 15 | | | | | | | | | | | | | | |
| Regular or as required analgesia prescribed. Pain management plan evaluated with patient and reported to be effective | | | | | | | | | | | | | | | | | | |
| Problems identified with pain control or analgesia related side-effects. *Patient unable to communicate - ABBEY tool (delete if not applicable) | | | | | | | | | | | | | | | | | | |
| **(W) WOUND/SKIN INTEGRITY** | | | | | | | | | | | | | | | | | | |
| Skin healthy - no concerns | | 20 | | 15 | | | | | | | | | | | | | | |
| Dry or delicate skin/Dermatological condition | | | | | | | | | | | | | | | | | | |
| Clean surgical wound - Wound Care Plan active | | | ✓ | | | | | | | | | | | | | | | |
| Open wound - Wound Care Plan active | | | | | | | | | | | | | | | | | | |
| **(PH) PERSONAL HYGIENE** | | | | | | | | | | | | | | | | | | |
| Independent | | 20 | ✓ | 15 | | | | | | | | | | | | | | |
| Requires encouragement/minimal support | | | | | | | | | | | | | | | | | | |
| Requires active assistance to wash/bathe | | | | | | | | | | | | | | | | | | |
| Dependent requires full assistance | | | | | | | | | | | | | | | | | | |
| **(OH) ORAL HYGIENE** | | | | | | | | | | | | | | | | | | |
| Brushes teeth/dentures independently | | 20 | ✓ | 15 | | | | | | | | | | | | | | |
| Requires assistance/observation to brush teeth/dentures (12 hourly oral care) | | | | | | | | | | | | | | | | | | |
| Dependent/active assistance with oral care required. (Oral assessment undertaken and 4 hourly oral care) | | | | | | | | | | | | | | | | | | |
| Oral trauma/acute oral complaint | | | | | | | | | | | | | | | | | | |
| **(I) INFECTION CONTROL** | | | | | | | | | | | | | | | | | | |
| No known risk (follow SICPS) | | | | | | | | | | | | | | | | | | |
| Infection risk identified | | 20 | ✓ | 15 | | | | | | | | | | | | | | |
| Confirmed infection/colonization - (follow Transmission Based Precautions/Consider patient placement | | | | | | | | | | | | | | | | | | |

| SHIFT ASSESSMENT<br>Patient Name | CHI/DOB | | | | | Ward | | | | | Hospital | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DATE | 22/11/16 | | | 23/11/16 | | | | | | | | | | | | | | | |
| COMPLETE ASSESSMENT AND RECORD CARE REQUIRED AND GIVEN FOR ANY AMBER & RED RISKS ONLY | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N |
| **(N/FB) NUTRITION AND FLUID BALANCE** | | | | | | | | | | | | | | | | | | | |
| Independent with eating and drinking needs | | 20 | 4 | 15 | | | | | | | | | | | | | | | |
| Requires therapeutic diet / special diet | | | | | | | | | | | | | | | | | | | |
| Requires IV / SC fluids/On Fluid Balance Chart | | | | | | | | | | | | | | | | | | | |
| Requires assistance or aids to eat and drink/ oral nutritional supplements | | | | | | | | | | | | | | | | | | | |
| Swallowing problem/On texture modified diet/thickened fluids | | | | | | | | | | | | | | | | | | | |
| Hydration Card or 3 Day Food Record Chart | | | | | | | | | | | | | | | | | | | |
| Nausea and/or vomiting | | | | | | | | | | | | | | | | | | | |
| Requires Enteral/Parenteral Nutrition | | | | | | | | | | | | | | | | | | | |
| Nil by Mouth/Fasting for procedure/weight loss >than 10% | | | | | | | | | | | | | | | | | | | |
| **(PUP) PRESSURE ULCER PREVENTION** | | | | | | | | | | | | | | | | | | | |
| No risk on PPURA Treatment plan A active | | 20 | 4 | 15 | | | | | | | | | | | | | | | |
| At risk on PPURA Treatment plan B and SKIN chart | | | | | | | | | | | | | | | | | | | |
| Grade 1 or 2 pressure ulcer | | | | | | | | | | | | | | | | | | | |
| At high risk Treatment plan C and SKIN chart | | | | | | | | | | | | | | | | | | | |
| Grade 3 or 4 pressure ulcer or Unstageable or/Suspected deep tissue injury | | | | | | | | | | | | | | | | | | | |
| **(M) MANUAL HANDLING & MOBILITY** | | | | | | | | | | | | | | | | | | | |
| Independent. No risk identified | | 20 | 4 | 15 | | | | | | | | | | | | | | | |
| Independent with own mobility aids | | | | | | | | | | | | | | | | | | | |
| Requires assistance/supervision of 1 or 2 to mobilise/new mobility aids | | | | | | | | | | | | | | | | | | | |
| Fully Dependent<br>Hoist required and / or assistance of > 2 to mobilise | | | | | | | | | | | | | | | | | | | |
| **(F) FALLS / BEDRAILS** | | | | | | | | | | | | | | | | | | | |
| No history of falls/No risk identified | | 20 | 4 | 15 | | | | | | | | | | | | | | | |
| History of falls,<br>At risk Falls Care Plan active | | | | | | | | | | | | | | | | | | | |
| High risk of falls/New fall since admission<br>Falls Care Plan active | | | | | | | | | | | | | | | | | | | |
| Bedrail assessment carried out<br>Bedrails can be used | | | | | | | | | | | | | | | | | | | |
| Bedrail assessment carried out. Bedrails can be used with caution with other interventions | | | | | | | | | | | | | | | | | | | |
| Bedrails assessment carried out<br>**DO NOT USE BEDRAILS** | | | | | | | | | | | | | | | | | | | |
| **(A) AIRWAY / BREATHING** | | | | | | | | | | | | | | | | | | | |
| No airway/breathing problem | | 20 | 4 | 15 | | | | | | | | | | | | | | | |
| Existing airway/breathing problem identified- condition optimal | | | | | | | | | | | | | | | | | | | |
| Requires oxygen therapy | | | | | | | | | | | | | | | | | | | |
| New problem identified/exacerbation of existing problem | | | | | | | | | | | | | | | | | | | |
| Requires external support to assist breathing | | | | | | | | | | | | | | | | | | | |
| DNACPR activated | | | | | | | | | | | | | | | | | | | |
| **(O) OBSERVATION & MONITORING** | | | | | | | | | | | | | | | | | | | |
| Routine monitoring<br>Minimum 12 hourly/or as per local protocol | | | | 15 | | | | | | | | | | | | | | | |
| Monitoring minimum 4 hourly | | 20 | 4 | | | | | | | | | | | | | | | | |
| Monitoring increased to minimum 1 hourly<br>Urgent escalation to medical team/Nurse in charge informed | | | | | | | | | | | | | | | | | | | |
| Continuous cardiac and vital sign monitoring<br>Emergency escalation - think SEPSIS | | | 4 | | | | | | | | | | | | | | | | |

**SHIFT ASSESSMENT**

**Patient Name** DAVID STANDISH **CHI/DOB** 050370 0053 **Ward** 21 **Hospital** NW

| DATE | 16.11.16 | | | 17.11.16 | | | 18.11.16 | | | 19.11.16 | | | 20/11/16 | | | 21/11/16 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **COMPLETE ASSESSMENT AND RECORD CARE REQUIRED AND GIVEN FOR ANY AMBER & RED RISKS ONLY** | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N |
| **(N/FB) NUTRITION AND FLUID BALANCE** | | | | | | | | | | | | | | | | | | |
| Independent with eating and drinking needs | | | 23 | 13[00] | 19[30] | 01 | 09 | 13.5 | | 09 | 12.5 | | 12[30] | 16 | 2 | 12 | 16 | 4 |
| Requires therapeutic diet / special diet | | | | | | | | | | | | | | | | | | |
| Requires IV / SC fluids/On Fluid Balance Chart | | | | | | | | | | | | | | | | | | |
| Requires assistance or aids to eat and drink/ oral nutritional supplements | | | | | | | | | | | | | | | | | | |
| Swallowing problem/On texture modified diet/thickened fluids | | | | | | | | | | | | | | | | | | |
| Hydration Card or 3 Day Food Record Chart | | | | | | | | | | | | | | | | | | |
| Nausea and/or vomiting | | | | | | | | | | | | | | | | | | |
| Requires Enteral/Parenteral Nutrition | | | | | | | | | | | | | | | | | | |
| Nil by Mouth/Fasting for procedure/weight loss >than 10% | | | | | | | | | | | | | | | | | | |
| **(PUP) PRESSURE ULCER PREVENTION** | | | | | | | | | | | | | | | | | | |
| No risk on PPURA Treatment plan A active | | | 23 | 13[00] | 19[30] | 01 | 09 | 13.5 | | 09 | 12.5 | | 12[30] | 16 | 2 | 12 | 16 | 4 |
| At risk on PPURA Treatment plan B and SKIN chart | | | | | | | | | | | | | | | | | | |
| Grade 1 or 2 pressure ulcer | | | | | | | | | | | | | | | | | | |
| At high risk Treatment plan C and SKIN chart | | | | | | | | | | | | | | | | | | |
| Grade 3 or 4 pressure ulcer or Unstageable or/Suspected deep tissue injury | | | | | | | | | | | | | | | | | | |
| **(M) MANUAL HANDLING & MOBILITY** | | | | | | | | | | | | | | | | | | |
| Independent. No risk identified | | | | | | | | | | | | | 12[30] | 16 | 2 | 12 | 16 | 4 |
| Independent with own mobility aids | | | 23 | 13[00] | 19[30] | 01 | 09 | 13.5 | | 09 | 12.5 | | 12 | | | | | |
| Requires assistance/supervision of 1 or 2 to mobilise/new mobility aids | | | | | | | | | | | | | | | | | | |
| Fully Dependent Hoist required and / or assistance of > 2 to mobilise | | | | | | | | | | | | | | | | | | |
| **(F) FALLS / BEDRAILS** | | | | | | | | | | | | | | | | | | |
| No history of falls/No risk identified | | | 23 | 13[00] | 19[30] | 01 | 09 | 13.5 | | 09 | 12.5 | | 12[30] | 16 | 2 | 12 | | 4 |
| History of falls, At risk Falls Care Plan active | | | | | | | | | | | | | | | | | | |
| High risk of falls/New fall since admission Falls Care Plan active | | | | | | | | | | | | | | | | | | |
| Bedrail assessment carried out Bedrails can be used | | | 23 | | | 01 | 09 | 13 | 5 | 09 | 12 | 5 | 1 | | 2 | | | |
| Bedrail assessment carried out. Bedrails can be used with caution with other interventions | | | | | | | | | | | | | | | | | | |
| Bedrails assessment carried out **DO NOT USE BEDRAILS** | | | | | | | | | | | | | | | | | | |
| **(A) AIRWAY / BREATHING** | | | | | | | | | | | | | | | | | | |
| No airway/breathing problem | | | 23 | 13[00] | 19[30] | 01 | 09 | 13 | 5 | 09 | 12 | 5 | 12[30] | 16 | 2 | 12 | | 4 |
| Existing airway/breathing problem identified- condition optimal | | | | | | | | | | | | | | | | | | |
| Requires oxygen therapy | | | | | | | | | | | | | | | | | | |
| New problem identified/exacerbation of existing problem | | | | | | | | | | | | | | | | | | |
| Requires external support to assist breathing | | | | | | | | | | | | | | | | | | |
| DNACPR activated | | | | | | | | | | | | | | | | | | |
| **(O) OBSERVATION & MONITORING** | | | | | | | | | | | | | | | | | | |
| Routine monitoring Minimum 12 hourly/or as per local protocol | | | | | | | | | | | | | | | 2 | 12 | | 4 |
| Monitoring minimum 4 hourly | | | | | | | | | | | | | | | | | | |
| Monitoring increased to minimum 1 hourly Urgent escalation to medical team/Nurse in charge informed | | | | | | | | | | | | | | | | | | |
| Continuous cardiac and vital sign monitoring Emergency escalation - think SEPSIS | | | 23 | 13[00] | 19[30] | 01 | 09 | 13.5 | | 09 | 12.5 | | 12[30] | 16 | 2 | 12 | | 4 |

DAVID STANDISH 050370 0053

## SHIFT ASSESSMENT

| DATE | 16·11·16 | | | 17·11·16 | | | 18·11·16 | | | 19·11·16 | | | 20/11/16 | | | 21/11/16 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N |
| **(E) ELIMINATION - Urine** | | | | | | | | | | | | | | | | | | |
| Independent and continent | | | 23 | 13[00] | 19[30] | ✓ | 09 | 13 | 5 | 09 | 12 | 5 | 1230 | 16 | 2 | 12 | 16 | 4 |
| Long term catheter / stoma in situ and self caring | | | | | | | | | | | | | | | | | | |
| Short term catheter in situ (Review need daily) | | | | | | | | | | | | | | | | | | |
| Managed incontinence/requires prompting | | | | | | | | | | | | | | | | | | |
| Incontinent / new stoma | | | | | | | | | | | | | | | | | | |
| Moisture lesions to skin | | | | | | | | | | | | | | | | | | |
| Has not passed urine > 30 mls per hour | | | | | | | | | | | | | | | | | | |
| **(E) ELIMINATION - Bowels** | | | | | | | | | | | | | | | | | | |
| Continent - Normal bowel habit/bowels opened | | | | | 19[30] | ✓ | 09 | 13 | | 09 | 12 | 5 | 1230 | 16 | 2 | 12 | 16 | 4 |
| Stoma in situ and self caring | | | | | | | | | | | | | | | | | | |
| Constipated/bowels not opened | | | 23 | 13[00] | | | | | 5 | | | | | | | | | |
| Managed incontinence | | | | | | | | | | | | | | | | | | |
| Loose stools | | | | | | | | | | | | | | | | | | |
| Incontinent/loose stools/new stoma | | | | | | | | | | | | | | | | | | |
| **(P) PAIN - Complete PAINGO** | | | | | | | | | | | | | | | | | | |
| No pain reported. Not requiring analgesia | | | 23 | 13[00] | 19[30] | ✓ | 09 | 13 | 5 | 09 | 12 | 5 | 1230 | 16 | 2 | | | |
| Regular or as required analgesia prescribed. Pain management plan evaluated with patient and reported to be effective | | | | | | | | | | | | | | | | 12 | 16 | 4 |
| Problems identified with pain control or analgesia related side-effects. *Patient unable to communicate - ABBEY tool (delete if not applicable) | | | | | | | | | | | | | | | | | | |
| **(W) WOUND/SKIN INTEGRITY** | | | | | | | | | | | | | | | | | | |
| Skin healthy - no concerns | | | 23 | 13[00] | 19[30] | ✓ | 09 | 13 | 5 | 09 | 12 | 5 | 1230 | 16 | 2 | 12 | 16 | 4 |
| Dry or delicate skin/Dermatological condition | | | | | | | | | | | | | | | | | | |
| Clean surgical wound - Wound Care Plan active | | | | | | | | | | | | | | | | | | |
| Open wound - Wound Care Plan active | | | | | | | | | | | | | | | | | | |
| **(PH) PERSONAL HYGIENE** | | | | | | | | | | | | | | | | | | |
| Independent | | | | | | | 09 | 13 | 5 | 09 | 12 | 5 | 1230 | 16 | 2 | 12 | 16 | 4 |
| Requires encouragement/minimal support | | | 23 | 13[00] | 19[30] | ✓ | | | | | | | | | | | | |
| Requires active assistance to wash/bathe | | | | | | | | | | | | | | | | | | |
| Dependent requires full assistance | | | | | | | | | | | | | | | | | | |
| **(OH) ORAL HYGIENE** | | | | | | | | | | | | | | | | | | |
| Brushes teeth/dentures independently | | | 23 | 13[00] | 19[30] | ✓ | 09 | 13 | 5 | 09 | 12 | 5 | 1230 | 16 | 2 | 12 | 16 | 4 |
| Requires assistance/observation to brush teeth/dentures (12 hourly oral care) | | | | | | | | | | | | | | | | | | |
| Dependent/active assistance with oral care required. (Oral assessment undertaken and 4 hourly oral care) | | | | | | | | | | | | | | | | | | |
| Oral trauma/acute oral complaint | | | | | | | | | | | | | | | | | | |
| **(I) INFECTION CONTROL** | | | | | | | | | | | | | | | | | | |
| No known risk (follow SICPS) | | | 23 | | | | | | | | | | | | | | | |
| Infection risk identified PVC IN SITU. | | | | 13[00] | 19[30] | ✓ | 09 | 13 | 5 | 09 | 12 | 5 | 1230 | 16 | 2 | 12 | 16 | 4 |
| Confirmed infection/colonization - (follow Transmission Based Precautions/Consider patient placement | | | | | | | | | | | | | | | | | | |

DAVID STANDISH 050370 0053

## SHIFT ASSESSMENT

| DATE | 16.11.16 | | | 17.11.16 | | | 18.11.16 | | | 19.11.16 | | | 20/11/16 | | | 21/11/16 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N |
| **(PVC) PVC / CVC / PICC** | | | | | | | | | | | | | | | | | | |
| No PVC/CVC/PICC | | | | | | | | | | | | | | | | | | |
| CVC /PICC line in situ | | | 0 | 1 | 1 | 2 | 2 | 3 | 0 | | | | | | | | | |
| PVC (1) - write day of insertion (i.e. 1,2 or 3) in box | | | 23 | 13 | 19 | 01 | 09 | 13 | 5 | 09 | 12 | 5 | 1 | | | | | |
| PVC (2) - write day of insertion (i.e. 1,2 or 3) in box | | | | | | | | | | | | | | | | | | |
| PVC in situ>3 days - Consider removal and/or write day since insertion (i.e. 4,5,6) in box | | | | | | | | | | | | | 1230 | 16 | 2 | 12 | 16 | 4 |
| VIP Score >1 | | | | | | | | | | | | | | | | | | |
| **(C) COMMUNICATION** | | | | | | | | | | | | | | | | | | |
| No Communication barriers identified/self manages own communication needs | | | 23 | 13 | 19 | 01 | 09 | 13 | 5 | 09 | 12 | 5 | 1230 | 16 | 2 | 12 | 16 | 4 |
| Existing communication barriers that require support or intervention | | | | | | | | | | | | | | | | | | |
| New communication barrier e.g. stroke/or patient requires Language/British Sign Language Interpreter/Blind/Deafblind | | | | | | | | | | | | | | | | | | |
| **(LD) LEARNING DISABILITY** | | | | | | | | | | | | | | | | | | |
| No learning disability | | | | 13 | 19 | 01 | 09 | 13 | 5 | 09 | 12 | 5 | 1230 | 16 | 2 | 12 | 16 | 4 |
| Learning disability identified (Contact Learning Disability Liaison Team) | | | | | | | | | | | | | | | | | | |
| **(PS) PERSONAL SAFETY** | | | | | | | | | | | | | | | | | | |
| Not ambulant/ambulant but clinically stable Mentally capable of making sound judgements Identity Bracelet in place - Legible/complete and correct patient details | | | | | | | | | | | | | | | | | | |
| Ambulant, but clinically unstable Current smoker/Alcohol or Substance misuse (complete disclaimer on Patient Safety Risk assessment THB 610) | | | 23 | 13 | 19 | 01 | 09 | 13 | 5 | 09 | 12 | 5 | 1230 | 16 | 2 | 12 | 16 | 4 |
| Risk of absconding/Concerns for patient safety/impaired judgment/Sedation (complete Patient Safety Risk Assessment THB610) | | | | | | | | | | | | | | | | | | |
| **(PC) WELL BEING** | | | | | | | | | | | | | | | | | | |
| Patient reports psychological/spiritual care needs are being met | | | 23 | 13 | 19 | 01 | 09 | 13 | 5 | 09 | 12 | 5 | 1230 | 16 | | | 16 | 4 |
| Distress or stress identified and being managed | | | | | | | | | | | | | | | 2 | 12 | | |
| Requires active psychological/spiritual care | | | | | | | | | | | | | | | | | | |
| Has a longstanding mental health condition that is managed | | | | | | | | | | | | | | | | | | |
| Patient experiencing intense emotions/distress/or behavioural issues Requiring immediate professional input | | | | | | | | | | | | | | | | | | |
| **(S) SLEEP** | | | | | | | | | | | | | | | | | | |
| No sleep problem identified/usual sleep pattern | | | ✓ | | | | | | | | | | | | | | | |
| Altered sleep pattern/difficulty sleeping/insomnia | | | 23 | 13 | 19 | 01 | 09 | 13 | 5 | 09 | 12 | 5 | 1230 | 16 | 2 | 12 | 16 | 4 |
| **(CF) COGNITIVE FUNCTION (Think Delirium)** | | | | | | | | | | | | | | | | | | |
| No problems identified | | | 23 | 13 | 19 | 01 | 09 | 13 | 5 | 09 | 12 | 5 | 1230 | 16 | 2 | 12 | 16 | 4 |
| Cognitive Impairement with controlled symptoms | | | | | | | | | | | | | | | | | | |
| Delirium/Acute change in cognitive function/deteriorating Dementia with significant symptoms | | | | | | | | | | | | | | | | | | |
| Relative/carer/friend has Welfare Power of Attorney/Legal Guardianship | | | | | | | | | | | | | | | | | | |
| Active Adults with Incapacity (section 47) - review dates weekly | | | | | | | | | | | | | | | | | | |
| **(ACN) ADDITIONAL CARE NEEDS** | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| **Initials of Nurse** | | | DS | GH | LD | JH | KMC | KMC | JH | KMC | KMC | SP | DW | KH | KH | KH | KH | KH |

# IMMUNOPATHOLOG

DMR 375

Tayside Clinical Laboratory Services | Telephone 01382 632539 | Internal Ext.32539

Name: STANDISH David | Sex: M | PID: 0503700053 | DoB: 05 Mar 1970

Lab No: I153757755

N/W Wards 5 & 6 Outpatients | Clinician: Dr J.B.C. DICK | N5/60P DICJ1H

| | | | | |
|---|---|---|---|---|
| IgA Tissue Transglutaminase | 0.8 | u/ml | ( | 0-3 ) |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
03 Apr 2015 12:50

Clin.Details: On T4?: No
abdominal pain folate deficiency

22/4/15

Request Entered: 03 Apr 2015 14:02

Report Printed: 14 Apr 2015 15:52

REPORT RECEIVED

DOCTOR'S INITIALS

# East of Scotland Vascular Network (NHS Tayside)

## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Segmental Pressures
**Date of study :** 01/06/2016

**Consultant:** Dr C Baines
Ward 4
Out-patient Dept
Ninewells Hospital

**Referral details:** Out-patient referral. Increased right leg claudication symptoms. Previous right CFA endarterectomy with vein patch and right SFA angioplasty.

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 130 | 134 |
| Posterior Tibial | 110 | 92 |
| Dorsalis Pedis | 80 | 84 |
| Ankle/Brachial Pressure Index | 0.82 | 0.68 |

**Report:** Patient states bilateral claudication - increase in right leg symptoms. Known left SFA occlusion. However, patient wouldn't walk for exercise test
Scan report attached.

LS/MMcC

**Previous results:**

| Date | Right Ankle | Left Ankle | Right ABPI | Left ABPI |
|---|---|---|---|---|
| 06/03/2013 | 128 | 84 | 0.98 | 0.76 |
| 16/03/2012 | 118 | 74 | 1.07 | 0.67 |
| 11/08/2011 | 140 | 90 | 1.04 | 0.67 |
| 24/06/2011 | 112 | 70 | 0.86 | 0.61 |
| [illegible]/05/2011 | 120 | 70 | 0.95 | 0.55 |
| [illegible]/2011 | 136 | 90 | 1.17 | 0.77 |

[illegible]rt

# HAEMATOLOGY

DMR292

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970
Lab No: H175888571
N/W Wards 3 & 4 Outpatients — Clinician: Dr Isla MACKENZIE — N3/4OP KENI1H

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| HGB | 138 | g/L | ( 130-180 ) | WBC | 7.9 | x10^9/L | ( 4.0-11.0 ) |
| RBC | 4.66 | x10^12/L | ( 4.5-6.0 ) | NE# | 4.2 | x10^9/L | ( 2.0-7.5 ) |
| HCT | 0.439 | | ( 0.40-0.52 ) | LY# | 2.9 | x10^9/L | ( 1.5-4.0 ) |
| MCV | 94.1 | fl | ( 85-105 ) | MO# | 0.4 | x10^9/L | ( 0.2-0.8 ) |
| MCH | 29.6 | pg | ( 27-32 ) | EO# | 0.26 | x10^9/L | ( 0.0-0.4 ) |
| MCC | 314 L | g/L | ( 320-360 ) | BA# | 0.1 | x10^9/L | ( 0.0-0.1 ) |
| | | | | PLT | 380 | x10^9/L | ( 150-400 ) |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
17 Nov 2017 14:18

Clin.Details: On T4?: No
Hypercholesterolaemia, NSTEMI, peripheral vascular disease.

Request Entered: 17 Nov 2017 14:47 — Report Printed: 17 Nov 2017 15:11

REPORT RECEIVED

DOCTOR'S INITIALS


# HAEMATOLOGY

DMR292


Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970
Lab No: H154143250
N/W Wards 3 & 4 Outpatients — Clinician: Prof J. BELCH — N3/4OP BELJ1H

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| HGB | 133 | g/L | ( 130-180 ) | WBC | 15.2 H | x10^9/L | ( 4.0-11.0 ) |
| RBC | 4.48 L | x10^12/L | ( 4.5-6.0 ) | NE# | 10.9 H | x10^9/L | ( 2.0-7.5 ) |
| HCT | 0.417 | | ( 0.40-0.52 ) | LY# | 3.0 | x10^9/L | ( 1.5-4.0 ) |
| MCV | 92.9 | fl | ( 85-105 ) | MO# | 1.0 H | x10^9/L | ( 0.2-0.8 ) |
| MCH | 29.7 | pg | ( 27-32 ) | EO# | 0.32 | x10^9/L | ( 0.0-0.4 ) |
| MCC | 320 | g/L | ( 320-360 ) | BA# | 0.1 | x10^9/L | ( 0.0-0.1 ) |
| | | | | PLT | 406 H | x10^9/L | ( 150-400 ) |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
24 Sep 2015 11:15

Clin.Details: Dyslipidaemia Atherosclerosis

Request Entered: 24 Sep 2015 12:33 — Report Printed: 24 Sep 2015 13:09

REPORT RECEIVED

DOCTOR'S INITIALS

Note: Remove strip to reveal gummed area.
Attach reports from bottom to top.
Please set them accurately

HAEMATOLOGY

14 13 12 11 10 9 8 7 6 5 4 3 2

LIFT TAB AND PEEL OFF STRIP FROM THIS SIDE

MOUNT

22188

DMR292

# HAEMATOLOGY

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

Lab No: H153757755

N/W Wards 5 & 6 Outpatients — Clinician: Dr J.B.C. DICK — N5/60P DICJ1H

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| HGB | 140 | g/L | ( 130-180 ) | WBC | 8.0 | x10^9/L | ( 4.0-11.0 ) |
| RBC | 4.75 | x10^12/L | ( 4.5-6.0 ) | NE# | 4.6 | x10^9/L | ( 2.0-7.5 ) |
| HCT | 0.429 | | ( 0.40-0.52 ) | LY# | 2.6 | x10^9/L | ( 1.5-4.0 ) |
| MCV | 90.3 | fl | ( 85-105 ) | MO# | 0.5 | x10^9/L | ( 0.2-0.8 ) |
| MCH | 29.4 | pg | ( 27-32 ) | EO# | 0.18 | x10^9/L | ( 0.0-0.4 ) |
| MCC | 326 | g/L | ( 320-360 ) | BA# | 0.1 | x10^9/L | ( 0.0-0.1 ) |
| | | | | PLT | 396 | x10^9/L | ( 150-400 ) |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
03 Apr 2015 12:50

Clin.Details: On T4?: No
abdominal pain folate deficiency

Request Entered: 03 Apr 2015 14:02

Report Printed: 03 Apr 2015 14:53

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DOCTOR'S INITIALS

# BIOCHEMICAL MEDICINE

DMR 374

results on clinic letter.

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

Lab No: C175888571

N/W Wards 3 & 4 Outpatients — Clinician: Dr Isla MACKENZIE — N3/4OP KENI1H

| | | | | | |
|---|---|---|---|---|---|
| SODIUM | 137 | | mmol/L | ( | 133-146 ) |
| POTASSIUM | 4.7 | | mmol/L | ( | 3.5-5.3 ) |
| UREA | 4.3 | | mmol/L | ( | 2.5-7.8 ) |
| CREATININE | 74 | | umol/L | ( | 62-106 ) |
| ESTIMATED GFR | GT60 | | mL/min | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | | | | |
| ALT | 40 | | U/L | ( | 5-55 ) |
| BILIRUBINS | 7 | | umol/L | ( | 0-21 ) |
| ALKALINE PHOSPHATASE | 83 | | U/L | ( | 30-130 ) |
| ALBUMIN | 36 | | g/L | ( | 35-50 ) |
| CALCIUM | 2.39 | | mmol/L | ( | 2.10-2.55 ) |
| CALCIUM (CORRECTED) | 2.43 | | mmol/L | ( | 2.10-2.55 ) |
| GLUCOSE (preserved tube) | 5.3 | | mmol/L | ( | 3.3-5.8 ) |
| TSH | 1.61 | | mU/L | ( | 0.4-4.0 ) |
| TOTAL CHOLESTEROL | 7.36 | > | mmol/L | ( | 0.00-5.00 ) |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
17 Nov 2017 14:18

Clin.Details: On T4?: No
Hypercholesterolaemia, NSTEMI, peripheral vascular disease.
Being considered for PCSK9 inhibitor therapy. PLEASE SUPPLY FULL LIPID PROFILE including TG and calculated LDL.
Non-fasted.

Page 1 of 2

REPORT RECEIVED

Request Entered: 17 Nov 2017 14:47 — Amended Report Printed: 19 Jul 2019 10:03

DOCTOR'S INITIALS


# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

Lab No: C175888571

N/W Wards 3 & 4 Outpatients — Clinician: Dr Isla MACKENZIE — N3/4OP KENI1H


| | | | | | |
|---|---|---|---|---|---|
| TRIGLYCERIDES | 1.85 | | mmol/L | ( | 0.00-2.30 ) |
| HDL-CHOLESTEROL | 1.47 | | mmol/L | ( | 0.60-2.50 ) |
| TOTAL CHOL/HDL-CHOL | 5.00 | | . | | |
| AKI | Not detected: May not exclude AKI in all cases | | | | |
| LDL-CHOL. (CALCULATED) | 5.06 | >> | mmoL/L | ( | 0-2.60 ) |


Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
17 Nov 2017 14:18

Clin.Details: On T4?: No
Hypercholesterolaemia, NSTEMI, peripheral vascular disease.
Being considered for PCSK9 inhibitor therapy. PLEASE SUPPLY FULL LIPID PROFILE including TG and calculated LDL.
Non-fasted.


Page 2 of 2


REPORT RECEIVED

Request Entered: 17 Nov 2017 14:47 — Amended Report Printed: 19 Jul 2019 10:03

# BIOCHEMICAL MEDICINE

JJ.

DMR 374

NWmL-R55-C04-503

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

Lab No: C197158864

N/W Rheumatology Outpatients CALOO — Clinician: Dr M.J. MURPHY — NRHEU MURM2H

| | | | | |
|---|---|---|---|---|
| TOTAL CHOLESTEROL | 4.00 | mmol/L | ( | 0.00-5.00 ) |
| TRIGLYCERIDES | 1.46 | mmol/L | ( | 0.00-2.30 ) |
| HDL-CHOLESTEROL | 1.19 | mmol/L | ( | 0.60-2.50 ) |
| TOTAL CHOL/HDL-CHOL | 3.30 | . | | |
| LDL-CHOL. (CALCULATED) | 2.15 | mmoL/L | ( | 0-2.60 ) |

Lab.Comments: SLIGHTLY HAEMOLYSED

Sample is blood unless otherwise stated

Sample Date/Time
18 Jun 2019 11:00

Clin.Details: fh on alirocumab

REPORT RECEIVED

Request Entered: 18 Jun 2019 11:14 — Report Printed: 18 Jun 2019 11:47

DOCTOR'S INITIALS


# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)


Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

Lab No: C175888571

N/W Wards 3 & 4 Outpatients — Clinician: Dr Isla MACKENZIE — N3/4OP KENI1H

| | | | | |
|---|---|---|---|---|
| SODIUM | 137 | mmol/L | ( | 133-146 ) |
| POTASSIUM | 4.7 | mmol/L | ( | 3.5-5.3 ) |
| UREA | 4.3 | mmol/L | ( | 2.5-7.8 ) |
| CREATININE | 74 | umol/L | ( | 62-106 ) |
| ESTIMATED GFR | GT60 | mL/min | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | | | |
| ALT | 40 | U/L | ( | 5-55 ) |
| BILIRUBINS | 7 | umol/L | ( | 0-21 ) |
| ALKALINE PHOSPHATASE | 83 | U/L | ( | 30-130 ) |
| ALBUMIN | 36 | g/L | ( | 35-50 ) |
| CALCIUM | 2.39 | mmol/L | ( | 2.10-2.55 ) |
| CALCIUM (CORRECTED) | 2.43 | mmol/L | ( | 2.10-2.55 ) |
| GLUCOSE (preserved tube) | 5.3 | mmol/L | ( | 3.3-5.8 ) |
| TSH | 1.61 | mU/L | ( | 0.4-4.0 ) |
| TOTAL CHOLESTEROL | 7.36 > | mmol/L | ( | 0.00-5.00 ) |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
17 Nov 2017 14:18

Clin.Details: On T4?: No
Hypercholesterolaemia, NSTEMI, peripheral vascular disease.



Request Entered: 17 Nov 2017 14:47 — Report Printed: 17 Nov 2017 15:42

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DOCTOR'S INITIALS

# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services  Telephone 01738 473223 (PRI)  01382 632602 (NW)

Name: STANDISH  David  Sex: M  PID: 0503700053  DoB: 05 Mar 1970
Lab No: C175888571
N/W Wards 3 & 4 Outpatients  Clinician: Dr Isla MACKENZIE  N3/4OP  KENI1H

| | | | | | |
|---|---|---|---|---|---|
| TRIGLYCERIDES | 1.85 | mmol/L | ( | 0.00-2.30 | ) |
| HDL-CHOLESTEROL | 1.47 | mmol/L | ( | 0.60-2.50 | ) |
| TOTAL CHOL/HDL-CHOL | 5.00 | . | | | |
| AKI | Not detected: but may not exclude AKI in all cases | | | | |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
17 Nov 2017  14:18

Clin.Details: On T4?: No
Hypercholesterolaemia, NSTEMI, peripheral vascular disease.

Page 2 of 2

Request Entered: 17 Nov 2017 14:47  Report Printed: 17 Nov 2017 15:42

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DOCTOR'S INITIALS


# BIOCHEMICAL MEDICINE

DMR 374


Tayside Clinical Laboratory Services  Telephone 01738 473223 (PRI)  01382 632602 (NW)

Name: STANDISH  David  Sex: M  PID: 0503700053  DoB: 05 Mar 1970
Lab No: C154143250
N/W Wards 3 & 4 Outpatients  Clinician: Prof J. BELCH  N3/4OP  BELJ1H

| | | | | | |
|---|---|---|---|---|---|
| SODIUM | 141 | mmol/L | ( | 133-146 | ) |
| POTASSIUM | 5.1 | mmol/L | ( | 3.5-5.3 | ) |
| UREA | 5.0 | mmol/L | ( | 2.5-7.8 | ) |
| CREATININE | 83 | umol/L | ( | 62-106 | ) |
| ESTIMATED GFR | GT60 | mL/min | | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | | | | |
| ALT | 43 | U/L | ( | 5-55 | ) |
| BILIRUBINS | 13 | umol/L | ( | 0-21 | ) |
| ALKALINE PHOSPHATASE | 115 | U/L | ( | 30-130 | ) |
| ALBUMIN | 37 | g/L | ( | 35-50 | ) |
| CREATINE KINASE | 280 | U/L | ( | 40-320 | ) |
| GGT | 63 | U/L | ( | 3-73 | ) |
| TOTAL CHOLESTEROL | 7.13 > | mmol/L | ( | 0.00-5.00 | ) |
| HDL-CHOLESTEROL | 1.34 | mmol/L | ( | 0.60-2.50 | ) |
| TOTAL CHOL/HDL-CHOL | 5.30 | . | | | |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
24 Sep 2015  11:15

Clin.Details: Dyslipidaemia Atherosclerosis

Page 1 of 2

Request Entered: 24 Sep 2015 12:33  Report Printed: 24 Sep 2015 13:37

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# OCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

N/W Wards 3 & 4 Outpatients — Clinician: Prof J. BELCH — Lab No: C154143250 — N3/4OP BELJ1H

AKI — Not detected: but may not exclude AKI in all cases

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
24 Sep 2015 11:15

Clin.Details: Dyslipidaemia Atherosclerosis

Page 2 of 2

Request Entered: 24 Sep 2015 12:33

Report Printed: 24 Sep 2015 13:37

REPORT RECEIVED

DOCTOR'S INITIALS

# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

N/W Wards 5 & 6 Outpatients — Clinician: Dr J.B.C. DICK — Lab No: C153757755 — N5/6OP DICJ1H

| | | | | |
|---|---|---|---|---|
| SODIUM | 139 | mmol/L | ( 133-146 ) | |
| POTASSIUM | 4.9 | mmol/L | ( 3.5-5.3 ) | |
| UREA | 5.4 | mmol/L | ( 2.5-7.8 ) | |
| CREATININE | 74 | umol/L | ( 62-106 ) | |
| ESTIMATED GFR | GT60 | mL/min | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | | | |
| ALT | 46 | U/L | ( 5-55 ) | |
| BILIRUBINS | 7 | umol/L | ( 0-21 ) | |
| ALKALINE PHOSPHATASE | 100 | U/L | ( 30-130 ) | |
| ALBUMIN | 38 | g/L | ( 35-50 ) | |
| CALCIUM | 2.38 | mmol/L | ( 2.10-2.55 ) | |
| CALCIUM (CORRECTED) | 2.40 | mmol/L | ( 2.10-2.55 ) | |
| GLUCOSE (preserved tube) | 5.8 | mmol/L | ( 3.3-5.8 ) | |
| TSH | 1.16 | mU/L | ( 0.4-4.0 ) | |
| MAGNESIUM | 0.83 | mmol/L | ( 0.70-1.00 ) | |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
03 Apr 2015 12:50

Clin.Details: On T4?: No
abdominal pain folate deficiency

Page 1 of 2

Request Entered: 03 Apr 2015 14:02

Report Printed: 03 Apr 2015 15:04

REPORT RECEIVED

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Please set them accurately

BIOCHEMISTRY

14 13 12 11 10 9 8 7 6 5 4 3 2

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MOUNTS

22190

# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David Sex: M PID: 0503700053 DoB: 05 Mar 1970
Lab No: C153757755
N/W Wards 5 & 6 Outpatients Clinician: Dr J.B.C. DICK N5/60P DICJ1H

| | | | | |
|---|---|---|---|---|
| PHOSPHATE | 1.07 | mmoL/L | ( | 0.8-1.5 ) |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
03 Apr 2015 12:50

Clin.Details: On T4?: No
abdominal pain folate deficiency



Request Entered: 03 Apr 2015 14:02 Report Printed: 03 Apr 2015 15:04

REPORT RECEIVED

DOCTOR'S INITIALS

**STANDISH, DAVID**
20 CANNING PLACE, DUNDEE, DD3 7RT
Ref. Locn. : **NW 3/4 OUT PATIENTS**
Referrer : **DR JJ BELCH**

DoB : **05-Mar-1970**
Hosp. No. :
CRIS No. : **298013**
CHI No. : **0503700053**

**VERIFIED** Verified By : DR GILLIAN DUNCAN 12-Feb-2016
Typed By : GMVCC 12-Feb-2016

**Clinical History :**

?evidence of H.Pylori
Severe Gastritis and Duodenitis
Biopsy from OGD inconclusive
Advised H.Pylori Exclusion
?evidence of H.Pylori
ENTERED BY: Colin Baines (medical)

BLEEP: 01382 633883

MISC 22/2/16

Event Number : E-4962328
Copy To : ,
Examinations : **NM C14 urea breath test**

Examination Date : **08-Feb-2016**
Attendance Number : 15

NHS Tayside: Clinical Report - Ninewells Hospital


**STANDISH, DAVID**
20 CANNING PLACE, DUNDEE, DD3 7RT
Ref. Locn. : **NW 3/4 OUT PATIENTS**
Referrer : **DR JJ BELCH**

DoB : **05-Mar-1970**
Hosp. No. :
CRIS No. : **298013**
CHI No. : **0503700053**

**NM C14 urea breath test :**
This test is positive. This implies current infection with H pylori.

Event Number : E-4962328
Copy To : ,
Examinations : **NM C14 urea breath test**

Examination Date : **08-Feb-2016**
Attendance Number : 15

## NHS Tayside: Clinical Report - Ninewells Hospital



**STANDISH, DAVID**
20 CANNING PLACE, DUNDEE, DD3 7RT
Ref. Locn. : **NW 3/4 OUT PATIENTS**
Referrer : **DR JJ BELCH**

DoB : **05-Mar-1970**
Hosp. No. :
CRIS No. : **298013**
CHI No. : **0503700053**

**VERIFIED** Verified By : Dr J DAVIDSON 24-Nov-2015
Typed By : DAVJ 24-Nov-2015

**Clinical History :**

?evidence of bacterial overgrowth
Episodic abdominal pain and bloating with signifcant heartburn and diarrhoea.
Multiple medications for Atherosclerosis
Reguilar over the counter stomach remedies taken
?evidence of SIBO
ENTERED BY: Colin Baines (medical)
BLEEP: 01382 633883

**NM C14 glychocholic breath test :**
This test is negative. There is no evidence of active bacterial overgrowth of the small bowel on this study

Event Number : E-4903124
Copy To : ,
Examinations : **NM C14 glychocholic breath test**

Examination Date : **19-Nov-2015**
Attendance Number : 14

M1R

## NHS Tayside: Clinical Report - Stracathro Hospital



**STANDISH, DAVID**
20 CANNING PLACE, DUNDEE, DD3 7RT
Ref. Locn. : **NW 3/4 OUT PATIENTS**
Referrer : **DR JB DICK**

DoB : **05/03/1970**
Hosp. No. :
CRIS No. : **298013**
CHI No. : **0503700053**

**VERIFIED** Verified By : DR GILLIAN DUNCAN 20/03/15
Typed By : SMIF 20/03/15

**Clinical History :**

colicky right upper quadrant pain with ezetemibe; ?GB/pancreatic; arteriopath, currently on no Rx pending this
ENTERED BY: John Dick (Medical)
BLEEP: 33883

**CT Abdomen & pelvis with contrast :** 100mls. Omnipaque 300 injected iv. No immediate complications.

The lung bases are clear.

Event Number : E-4665377
Copy To : ,
Examinations : **CT Abdomen & pelvis with contrast**

Examination Date : **13/03/15**
Attendance Number : 3

**STANDISH, DAVID**
20 CANNING PLACE, DUNDEE, DD3 7RT
Ref. Locn. : **NW 3/4 OUT PATIENTS**
Referrer : **DR JB DICK**

DoB : **05/03/1970**
Hosp. No. :
CRIS No. : **298013**
CHI No. : **0503700053**

Focus of hypoattenuation in the right lobe of liver adjacent to the falciform ligament is in keeping with a perfusion defect. The liver is otherwise unremarkable. No pertinent findings in relation to the spleen, pancreas, gall bladder, biliary tree, kidneys or adrenal glands.

The aorta is of normal calibre, major visceral branches opacify normally and centrally. There is no significant inguinal, iliac, retroperitoneal or intra abdominal lymphadenopathy.

Minor soft tissue stranding in the right groin is similar to the previous investigation and likely relates to previous vascular intervention involving the right common femoral artery.

The large bowel is unremarkable within the limitations of this unprepared study, no dilatation of the small bowel. No ascites.

Small scattered lymph nodes in the root of the mesentery show no interval change when compared to the previous study of 16th April, 2014.

Event Number : E-4665377
Copy To : ,
Examinations : **CT Abdomen & pelvis with contrast**

Examination Date : **13/03/15**
Attendance Number : 3



**STANDISH, DAVID**
20 CANNING PLACE, DUNDEE, DD3 7RT
Ref. Locn. : **NW 3/4 OUT PATIENTS**
Referrer : **DR JB DICK**

DoB : **05/03/1970**
Hosp. No. :
CRIS No. : **298013**
CHI No. : **0503700053**

No destructive bony lesions are apparent.

Event Number : E-4665377
Copy To : ,
Examinations : **CT Abdomen & pelvis with contrast**

Examination Date : **13/03/15**
Attendance Number : 3

25 MAY 2010

**PARK AVENUE MEDICAL CENTRE**
**DRS DUFFY, DEUBEL & DAVAGE**
*Park Avenue, Dundee, DD4 6PP*
*Telephone: 01382 462222*
*Fax: 01382 443859*

MD/JB

22 March 2010

WD12

Vascular lab
Ninewells Hospital
Dundee

Dear Colleague,

**RE: Mr David Standish, CHI: 0503700053, 9 Mansion Drive, Dundee, DD4 9DD.**

I would be grateful if you would carry out vascular studies on this patients legs. He gives a strong history of intermittent claudication – about 100 yds – both legs and some numbness in his right big toe. He is a long term smoker and has hyperlipidaemia.

**Significant Medical History**
08/05/1996 Asthma NOS
08/07/2004 Asthma prevention
07/11/2005 Asthma symptoms
20/12/2001 hi chol rheumatology clinic 01
Referral for further care

**Current Medication**
04/11/2009 QVAR cfc free inh 50micrograms/actuation INHALE ONE TO BE TAKEN DOSE TWICE DAILY 2
08/01/2010 SIMVASTATIN tabs 40mg TAKE ONE AT NIGHT 56
08/01/2010 VENTOLIN EVOHALER 100micrograms/inhalation 2 Puffs 4 times daily 2

Yours Sincerely,

12 APR 2010

Dr Morgan Davage
General Practitioner

180510
9.00
IC clinic

HISTORY/CONTINUATION SHEET

Ward/Clinic/
Hosp. ..... Cons.

Surname ..... STANDISH
First Name ..... DAVID
Address ..... 9 MANSION DR DUNDEE

D D M M Y Y
0503700053 C.H.I. No.
M M. State
DD4 9DD Sex

G.P. & Address (G.P. Rec PARK AVENUE MEDICAL CENTR, PARK AVEN

USE BLOCK LETTERS OR PATIENT LABEL

..... UNIT/WARD/DEPT.

Page .....

| DATE | |
|---|---|
| 25/6/10 | N/L |
| 22.9.10 | Has stopped smoking<br>Risk Factors addressed by Dr Dick ✓<br>Nuclear Medicine Scan arranged for Monday to review possible angina Symptoms by Dr Dick. Bilateral calf Claudication continues at 25–50 metres and is keen for further investigation and intervention if possible<br>MRA – requested.<br>G Crae<br>GILL CRANE<br>VASCULAR NURSE SPECIALIST |
| 15/11/10 | CANC |
| 1.12.10 | |

BP
Pulse
RM

DATE

15/12/10

Lidat off R→L jc 25-50m.
some numbers R tes
no right foot pain

No Glu HD / aD / CKD / DM
some doe
arthrm - knees

HT } on R
HC }
on asp
* on dap *
smokes 2 d

Angio - MDM explained

R's + B's of R (R lg fmt) fully explained
and knee less 1t info' morbidity + mortality

Pt would like to proceed
- agrees on R lg fmt then consider L level lg.

W/L R CFA EFA R SFA PTA.

14/2/11 Theatre

Mr Murray + El Saman
Dr Chamberlain
Dr Loftus

(R) CFA endarterectomy
vein patch.
(R) SFA angioplasty
stenting

# Surgical Admission Document

NHS Tayside

(Patient label if available)

First Name: .....

Family Name: STANDISH

CHI: 0503700053

Address: DAVID M
9 MANSION DR
DUNDEE
DD4 9DD

PARK AVENUE MEDICAL CENTRE, PARK AVE

WARD: 12 Consultant: GRIFFITHS

Pre-assessment.

Date: 3 / 2 / 2011

Day: Mon ☐ Tue ☐ Wed ☐ Thu ☑ Fri ☐ Sat ☐ Sun ☐

Time of arrival:

| | | |
|---|---|---|
| Resps | 14 | bpm |
| $O_2$ Sats | 98% | % |
| Fi $O_2$ | AIR | % |
| Temp | 36·2 | °C |
| BP | 119/70 | lying |
| (BP | | Standing) |
| Pulse | 67 | bpm |

Pre-assessment.

A ☑ V ☐ P ☐ U ☐

SEWS Total: 0 (SEWS: A, inform SpR)

Surgical Clerking F1 ☑ F2 ☐ SpR ☐

Name of doctor (please print): A HAGGOR

Bleep 4474

Time of assessment: 1045.

(40) PC: Elective (R) common femoral endarterectomy & Superficial femoral angioplasty.

HPC: Bilateral calf claudication at 25-50 metres,
- Right leg more
Seen clinic by Dr Griffiths 16/12/10.
No changes since clinic appt.
Except
Slight pain top (L) leg now last few weeks.

PMH

| | Yes | No | Details: |
|---|---|---|---|
| MI | ☐ | ☑ | |
| Angina | ☐ | ☑ | |
| ↑BP | ☑ | ☐ | |
| ↑Lipids | ☑ | ☐ | |
| COPD / Asthma | ☑ | ☐ | Mild - No regular inhaler Uses 1-2 times per week. |
| Stroke/TIA | ☐ | ☑ | |
| Diabetes | ☐ | ☑ | |
| Epilepsy | ☐ | ☑ | |
| Cardiac Failure | ☐ | ☑ | |
| Jaundice / Hepatitis | ☐ | ☑ | |
| Peptic Ulcer Disease | ☐ | ☑ | |
| PE / DVT | ☐ | ☑ | |

Previous Operations:

Anaesthetic History:

Family History:

Other PMH:

Date & Time

# Surgical Admission Document

NHS Tayside

(Patient label if available)

First Name: .....

Family Name: STANDISH

CHI: 0503700053

DAVID M

9 MANSION DR

DUNDEE DD4 9DD

Addr

PARK AVENUE MEDICAL CENTRE, PARK AVE

WARD: 12 Consultant: GRIFFITHS

Pre-assessment.

Date 3 / 2 / 20 11

Day: Mon ☐ Tue ☐ Wed ☐ Thu ☑ Fri ☐ Sat ☐ Sun ☐

Time of arrival:

| | | |
|---|---|---|
| Resps | 14 | bpm |
| $O_2$ Sats | 98% | % |
| Fi $O_2$ | AIR. | % |
| Temp | 36.2 | °C |
| BP | 119/70 | lying |
| (BP | | Standing) |
| Pulse | 67 | bpm |

Pre-assessment

A ☑ V ☐ P ☐ U ☐

SEWS Total: 0 (SEWS: A, Inform SpR)

Surgical Clerking F1 ☑ F2 ☐ SpR ☐

Name of doctor (please print): A. HAGGER

Bleep 4474

Time of assessment 1045.

(40) PC: Elective (R) common femoral endarterectomy & Superficial femoral angioplasty.

HPC: Bilateral calf claudication at 25-50 metres,
- Right leg worse

Seen clinic by Dr Griffiths 16/12/10.

No changes since clinic appt.

Except

Slight pain top ① leg now last few weeks.

| PMH | Yes | No | Details: |
|---|---|---|---|
| MI | ☐ | ☑ | |
| Angina | ☐ | ☑ | |
| ↑BP | ☑ | ☐ | |
| ↑Lipids | ☑ | ☐ | |
| COPD / Asthma | ☑ | ☐ | Mild - No regular inhaler Uses 1-2 times per week. |
| Stroke/TIA | ☐ | ☑ | |
| Diabetes | ☐ | ☑ | |
| Epilepsy | ☐ | ☑ | |
| Cardiac Failure | ☐ | ☑ | |
| Jaundice / Hepatitis | ☐ | ☑ | |
| Peptic Ulcer Disease | ☐ | ☑ | |
| PE / DVT | ☐ | ☑ | |

Previous Operations:

Anaesthetic History:

Family History:

Other PMH:

## Drug History

**Source(s) of history:** Patient ☑ | GP referral letter ☐ | Prescribing database ☐
GP practice ☐ | Patient's Own Drugs ☐ | Community pharmacy ☐
Relative ☐ | Nursing home prescription ☐ | Other:

If the patient is taking
**Aspirin, Clopidogrel(*Plavix*®), Dipyridamole (*Persantin*®) or Warfarin**
then contact senior medical staff for advice regarding continuation of therapy.
If unavailable then **WITHOLD** therapy until senior review

| ADMISSION MEDICATION | | | ACTION | | Note: Unless indicated to stop / hold, medication should be continued on TPAR / discharge. |
|---|---|---|---|---|---|
| Name (Generic) | Dose | Frequency | Hold | Stop | Comments (if medication held or stopped) |
| ~~ASPIRIN~~ | ~~75mg~~ | ~~OD~~ | | | |
| CLOPIDOGREL | 75mg | OD | | | |
| LANSOPRAZOLE | 30mg | OD. | | | |
| FOLIC ACID | 5mg | OD. | | | |
| CO-DYDRAMOL 30/500 | 1-2 TABS | 4-6° | | | |
| AMLODIPINE | 5mg | OD. | | | |
| EZETIMIBE | 10mg | OD. | | | |
| ATORVASTATIN | 40mg | OD. | | | |
| SALBUTAMOL | 2 puffs | PRN | | | |
| DIAZEPAM | 5mg | BD. | | | |
| ESCITALOPRAM | 20mg | OD. | | | |

**Adverse reactions / Allergies**

No Known Drug Allergies ☑ OR

| Drug / Substance: | Reaction: | Drug / Substance: | Reaction: |
|---|---|---|---|
| | | | |
| | | | |

**Are you satisfied this medication history is complete and accurate? Yes ☐ No ☐**

If "no", what further action is necessary (contact GP, etc)?

Reviewed by pharmacist? Name: Signature:

**Social History** Occupation.....

**Housing**: Lives alone? Yes ☐ No ☐ Own ☐ Shelt. ☐ RH ☐ NH ☐
**Smoking**: Never ☐ Ex ☐ (stopped..... years) Current 2 /day
**Alcohol** 10. units/week

**Social Care:** Home Help ☐ District Nurse ☐ Meals on wheels ☐

Other social issues:

## Systemic Enquiry

**CARDIOVASCULAR**
Chest Pain / Dyspnoea / PND / Cough / Ankle Swelling / Intermittent Claudication
Details:

**RESPIRATORY**
Cough / Sputum / Haemoptysis / Wheeze / Weight Loss / Sweats
Details:

**GASTROINTESTINAL**
Appetite: Bowel Habit:
Weight Loss:
Jaundice:
Abdominal pain / Dysphagia / Heartburn / Indigestion / Haematemesis / Nausea . Vomiting / Diarrhoea / Constipation / PR bleed / PR mucous / Tenesmus
Details:

**GENITO-URINARY**
Loin pain / Suprapubic pain / Dysuria / Haematuria / Frequency / Urgency / Hesitancy / Incontinence / Dripping
Details:

**CENTRAL NERVOUS SYSTEM**
Dizziness / Headaches / Blackouts / Seizures / Numbness / Weakness / Visual Disturbances
Details:

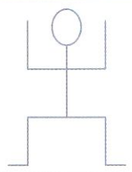
## Examination

General: Comfortable sat chair

MSQ ...../10

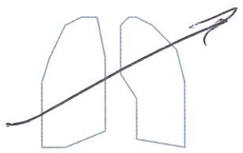
GCS: M.....E.....V.....=...../15

C.V.S
Pulses



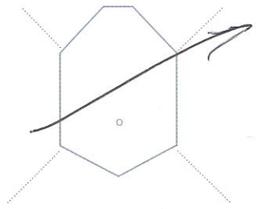
Heart Sounds 1+11
Murmurs 0
JVP ↔
Ankle Oedema 0
Peripheral Circulation

Respiratory



Trachea
Breath sounds Clear
Added Sounds
Percussion note Good air entry.

Abdomen



Soft : (Yes) / No
Masses: Yes / (No)
BS ✓
PR

(if PR not performed,specify WHY) _

**Clinical Impression**

fit for surgery

**Plan**

Bloods ✓
G&S ✓
Kardex ✓

STOP CLOPIDOGREL 1 week before Surgery
pt. aware.

G&S + ? X match on admission ☐

**Clerking complete. Signed:** _____ (Note: name and bleep number must appear at the front of the clerking)

**Results** (Note: It is important to document times when results are recorded and to initial in the box provided)

| | Initials: | Time: |
|---|---|---|
| ECG1 WNL acute | | |
| AXR | | |
| CXR | | |
| Ultrasound | | |
| CT | | |
| Other Investigations | | |

**Biochemistry** Initials: Time:
Initial results received

| | Date | 3/2/11 | |
|---|---|---|---|
| | Time | | |
| PREVIOUS SAMPLES | Na | 141 | |
| | K | 4.6 | |
| | Urea | 5.1 | |
| | Creat | 72 | |
| | ALT | 43 | |
| | Bil | 12 | |
| | Alk Ph | 107 | |
| | Alb | 45 | |
| | C. Ca | 2.25 | |
| | Mg | | |
| | PO4 | | |
| | Amylase | | |
| | CRP | | |
| | CK | | |
| | Gluc | 5.6 | |

**Haematology** Initials: Time:
Initial results received

| | Date | 3/2/11 | |
|---|---|---|---|
| | Time | | |
| PREVIOUS SAMPLES | Hb | 13.5 | |
| | MCV | | |
| | WCC | 10.1 | |
| | Neut | | |
| | Lymph | | |
| | Plat | 374 | |
| | INR | | |
| | APTTr | 0.9 | |

**ABG**

| Initials | | | | |
|---|---|---|---|---|
| Time | | | | |
| $FiO_2$ | | | | |
| pH | | | | |
| $PCO_2$ | | | | |
| $PO_2$ | | | | |
| Bicarb | | | | |
| BE | | | | |
| Sats | | | | |
| Hb | | | | |

Other Bloods: Time:

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Urinalysis

**Senior Review ☐ / Consultant Ward Round ☐** **Name:** Consultant ☐ SpR ☐ FY2 ☐

Date / / 20 Time

Advice regarding the continuation and / or restarting of **Anti-platelet / Anti-coagulation** therapy fully documented in the **DRUG HISTORY section** when appropriate ☐ (Tick Box)

AXR

CXR

Other

Resus. Status: Normal ☐ **Not for 2222** ☐
(If not for 2222, document fully and complete form).

DVT prophylaxis: None at present ☐ TEDS ☐ LMWH ☐

Signature

Name Bleep

| 14 02 11 David STANDISH 05 03 70 0053 | Ward 12 GDG |
|---|---|
| This patient is on the list today for a right common femoral endarterectomy and angioplasty for claudication. He also has claudication in his left leg but would require a bypass on that side. We will review that situation after his right leg surgery. | |

11.8.11

| 16 02 11 David STANDISH 05 03 70 0053 | Ward 12 GDG |
|---|---|
| Diagnosis/operation:right common femoral endarterectomy and vein patch angioplasty for claudication | |
| Progress: he has done very well post operatively. The wounds are fine. He has a good posterior tibial pulse. He has been seen in the Vascular Lab and there are no issues | |
| Plan: he can go home today; for review in about six weeks | |

9.3.11.

**SUMMARY:**

Start Time:

Finish Time:

Operation Performed:

Operating Surgeon:

Anaesthesia Summary:

**ANAESTHETIC DIFFICULTIES & DRUG REACTIONS**

**POSTOPERATIVE INSTRUCTIONS:**

Maintain airway. Observe colour, airway, respiration and pulse continuously until fully awake.

Oxygen 2 L/min via nasal for 24 hours

Observations: Pulse, Respiratory Rate, Blood Pressure and Pulse Oximetry

Frequency: 1/4hly Duration: 1 hour then hly.

Other observations/comments:

Invasive Monitoring and Lines: Bruflex a clotted. Spinal opioids

Fluid Therapy: Hartmans 80ml/hr => oral intake.

Proposed Analgesia:

Discharge: Ward ☐ HDU ☐ ICU ☐

**FLUID BALANCE:**

Urine Output:

Blood Loss: 600ml

Fluids Given:

Overall:

**RECOVERY ROOM: ANALGESIA & OTHER DRUGS:** Dosage, route and frequency:

Paracetamol 1g IV 6 hrly prn

Ondansetron 4mg IV 8 hrly prn

Signature: ..... Name: Carey

**RECOVERY ACTIONS:**

1. .....
2. .....
3. .....
4. .....
5. .....
6. .....

**RECOVERY TO WARD HANDOVER:**

# FILE IN NOTES

THB MR 135

## ANAESTHETIC RECORD
## NHS TAYSIDE

Date: 14-2-11 Ward: 12

Theatre: 3

Operation Proposed: Rt fem Gallbladder + cryptorchidism SG

Ward / Clinic / Hospital ..... Cons.

D D M M Y Y C.H.I. No.

STANDISH 0503700053
DAVID M
9 MANSION DR M. State
DUNDEE Sex
DD4 9DD

PARK AVENUE MEDICAL CENTRE, PARK AVE

USE BLOCK LETTERS OR PATIENT LABEL

**PRE OP ASSESSMENT**

By: Carey Site: 12 Date: 14-2-11

Elective ☐ Scheduled ☐ Urgent ☐ Emergency ☐

Weight/BMI: ..... Pulse: ..... Blood Pressure: .....

**CVS/RS:** Heavy smoker Mild COPD Hypertensive

**Other:** PVD

**Airway Assessment:** ✓

**FBC** Hb 13.5g/dl **U&E** ✓ **Other**

**G&S / XMATCH Y / N**

**Units** .....

**ECG / ~~CXR~~**

**ASA Grade:** III **PONV Score:**

**Consent for Operation** ☑.....

**Drugs:** Lopressor Ezetimibe Esomeprazole
Cozaar Statin
Amlodipine Sertraline
Doxazosin

**Allergies:** NKA

DVT Prophylaxis? YES / NO Method: .....

**Anaesthetic Plan / Techniques discussed:**

Spinal + Sedation

**PREMEDICATION AND INSTRUCTIONS:**

| Date | Drug and Dose | Form | Route | Time | Signature | Given By | Time |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Give routine medications EXCEPT: ..... Premed Effect: .....

Fast as per protocol ☐ **OR** fast solids from ..... fluids from .....

**PERSONNEL**

Anaesthetist and Grade

1. Carey Cass

2.

Assistant:

Consultant: .....

Informed Y / N

**ANAESTHETIC TECHNIQUE:** Spinal

**INJECTION SITE:** 16/5 D (2) L

**DRUGS & DOSES:**
Midalum 3mg + 2mg + 2mg + 3mg + 2mg
O2
Cyclizine 50mg
Cefotaxime 2400mg
Chlorhexidine 1%
Atropine 0.3mg
Ondansetron 4mg

**EQUIPMENT CHECKS: Circuit, Machine & Monitor**

Anaesthetic Room ☑ Theatre ☑

**AIRWAY AND BREATHING SYSTEM:**

| | | | | | |
|---|---|---|---|---|---|
| Facemask | ☐ | SV | ☑ | Circuit | ——— |
| Airway - Oral/Nasal | ☐ | IPPV | ☐ | Ventilator | ——— |
| LMA/OETT/NETT/Trache | | Ventilation Mode: VC/PCV | | | |
| Type | ——— | $V_T$ | ——— | PEEP | ——— |
| Size | ——— | frequency | ——— | $P_{AW}$ | ——— |
| Laryngoscopy Grade: | ——— | Throat Pack | ☐ | HME | ☐ |

**REGIONAL:** Sterile prep

BLOCK: Spinal

POSITION: Left lateral

SITE: L3/5

NEEDLE/CATH: 25g whitacre

TECHNIQUE: Midline

DRUGS: 3.4ml bupivacaine 0.5%

B.1 block – T9.

**MONITORING:**

| | | | |
|---|---|---|---|
| ECG | ☑ | PNS | ☐ |
| NIBP | ☑ | TEMP | ☐ |
| $SpO_2$ | ☑ | URINE | ☐ |
| $ETCO_2$ | ☐ | IABP | ——— |
| $F_IO_2$ | ☐ | CVP | ——— |
| ET Agent | ☐ | PAWP | ——— |
| VENT ALARM | ☐ | ODM | ——— |
| PAW | ☐ | Other | ——— |
| MIN VOL | ☐ | Other | ——— |

**EVENTS:**

1 KGS
2 Heparin 5000 units.
3
4
5
6
7
8
9
10

Patient Position & Protection: Supine

Fluid Warmer:

Warming Blanket:

**I.V. FLUIDS**

(1) RL 500 ml
(2) RL 500 ml
(3) RL 500 ml

| | 30 | 45 | 10[00] | 15 | 30 | 45 | 11[00] | 15 | 30 | 45 | 12[00] | 15 | 30 | 45 | 13[00] | 15 | 30 | 45 | 14[00] | 15 | 30 | 45 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TIME | | | | | | | | | | | | | | | | | | | | | | |
| Events | | | (1) | | (2) 2g | | | | | | | | | | POSS 36.4 | | | 36.9 | | | | |
| Mod | | | | | | | | | | | | | | | | | | | | | | |
| TEMP °C | | | | | | | | | | | | | | | | | | | | | | |
| $SpO_2$ | | | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 99 | | |
| $F_IO_2$ | | | 5l/min hood | | | | | | | | | | | | | | | | | | | |
| $E_TCO_2$ | | | | | | | | | | | | | | | 0 | 0 | 0 | 0-5 | 0-5 | 0-5 | | |
| Agent | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | 0 | | |
| CVP | | | | | | | | | | | | | | | 11 | 10 | 9 | 13 | 14 | 15 | | |
| Urine | | | | | | | | | | | | | | | P | P | P | P | P | P | | |
| | | | | | | | | | | | | | | | N | N | N | N | N | N | | |
| | | | | | | | | | | | | | | | N | N | N | N | N | N | | |
| FLUIDS | | | | | | | | | | | | | | | DRY | DRY | DRY | DRY | DRY | DRY | | |

$SpO_2$ Pain Sedation Nausea Resps

Wounds (x2)

S = Sleep

NHS Tayside

# CONSENT FOR INVESTIGATIONS, TREATMENT OR OPERATION FORM

**(Please complete using block capitals & no abbreviations)**

NHS Tayside

| | | | |
|---|---|---|---|
| **Patient's Surname** | STANDISH | **Hospital/Ward** | N W |
| **Other Names** | DAVID | **Speciality** | Vascular Surg. |
| **CHI Number** *Patient Label can be used* | 0503700053 | **Consultant** | N.J.N |

**Name of proposed procedure or course of treatment**

(R) Femoral Endarterectomy + Angiography

**The site / side of surgery**

I have explained the procedure to the patient. In particular I have explained:

**Intended Benefits:**

clearing the vessels

**Significant Risks:**

Bleeding - infection.

Any extra procedures which may become necessary during the procedure:

**Blood Transfusion** ☐ **Other** (specify)

(The need and alternatives have been discussed with the patient)

I have also discussed what the procedure is likely to involve, the benefits and the significant risks of any available alternative (including no treatment), and any particular concerns of this patient. I have done this in terms that, in my judgement have been understood.

The following information leaflet(s) has been given

Has the patient ever been notified that they are at increased risk of CJD or vCJD for public health purposes?

| | | |
|---|---|---|
| No | ☐ | Proceed as normal |
| Unable to Respond | ☐ | Proceed as normal unless high risk tissue, e.g. Brain, Spinal Cord Posterior Eye and Quarantine instruments pending contact with infection control for further advice. |
| Yes | ☐ | Ask for further explanation. Quarantine instruments pending contact with infection control for further advice. |

| | | | |
|---|---|---|---|
| **Clinicians Signature:** | | **Date** | 14.7.11 |
| **Name Printed:** | A. Ellam | **Grade** | SPR |
| **Contact Details** | 4980 | | |



Please Turn over for Patient Section

NHS Tayside

# CONSENT FOR INVESTIGATIONS, TREATMENT OR OPERATION FORM

**This page is to be completed by the patient/representative.**

Please read this form carefully. If you have any further questions, do ask; we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

**I agree:** To the procedure or course of treatment described on this form.

To the administration of a general, local or other anaesthetic as appropriate, following informed discussion including the benefits and significant risks with the anaesthetist.

**I understand:**

- That any procedure in addition to those described above will only be carried out if it is necessary to save my life or to prevent serious harm to my health.
- That you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.
- Information including digital information (radiological e.g. x-rays, CT and MRI scans, video and/or photographic material) may be stored as part of the patients medical records and may be stored on computer databases.
- Body tissue e.g. fluids, organs or parts of them may be removed during the procedure and used for diagnosis, my future treatment and then discarded or stored as considered appropriate.

Please tick ✓appropriate box if you agree to

☐ Excess body tissue not required for diagnosis or future treatment being used for medical research (the University of Dundee is very active in medical research and donations of excess body tissues are a valuable resource for research)

☐ To photographs and other digital images being used for teaching, in presentations at conferences or available on websites and in publications

(If consent is withdrawn at a later date it may not be possible to withdraw images that are already in the public domain) NB Medical staff you must complete the appropriate medical photography forms.

**I have been told** about additional procedures as specified which may become necessary during my treatment. I have listed below any procedures which **I do not wish to be carried out** without further discussion.

Specified Additional Procedures

Additional Procedures I do not want carried out

**Patient's Signature:** D. Stansfield **Date:**

**Print Name:** _____ _____

**Witness Signature** **Date:**

**(if patient unable to sign)**

**Print Name** _____

**Statement of Interpreter** (if applicable): I have interpreted the information above to the patient to the best of my ability and in a way in which I believe the patient can understand.

**Interpreters Signature:** **Date:**

**Name Printed:**

**Day of Operation**

**I have marked** the skin at the operation site and / or confirmed consent ☐

**Signature** **Date**

STANDISH 05 03 70 0053
David

12

Date: 14 02 11

Surgeon: Mr J Nagy
Mr A El Sawi
Radiologist: Dr S Chakraverty
Anaes: Dr D Coventry

RIGHT COMMON FEMORAL ENDARTERECTOMY AND RIGHT SUPERFICIAL FEMORAL ANGIOPLASTY

Skin was prepped and draped in the routine fashion. Right groin incision. The common femoral artery, superficial femoral artery and profunda femoris arteries were clearly identified and dissected. These were all slung. Long saphenous vein from the right ankle was harvested. 5000 units of Heparin were given, arteries clamped, longitudinal arterioty. This revealed an atheromatous plaque about 2.5 cm central to the common femoral bifurcation. Endarterectomy was performed, distal intimal flap was sutured down using multiple 6/0 Prolene sutures. All vessels were backbled and flushed with HepSaline. The arteriotomy was closed using a long saphenous vein patch using a continuous 6/0 Prolene suture. Again prior to completion of anastomosis all vessels were backbled and flushed. Arteries opened, flow in both superficial femoral arteries and profunda femoris arteries was confirmed using hand-held doppler. The right superficial femoral artery was then angioplastied by Dr Chakraverty – details in Radiology report. At the end of the procedure haemostasis was confirmed, wound closed in layers, PDS to fat, Monocryl to skin.

JOHN NAGY
Consultant Vascular Surgeon

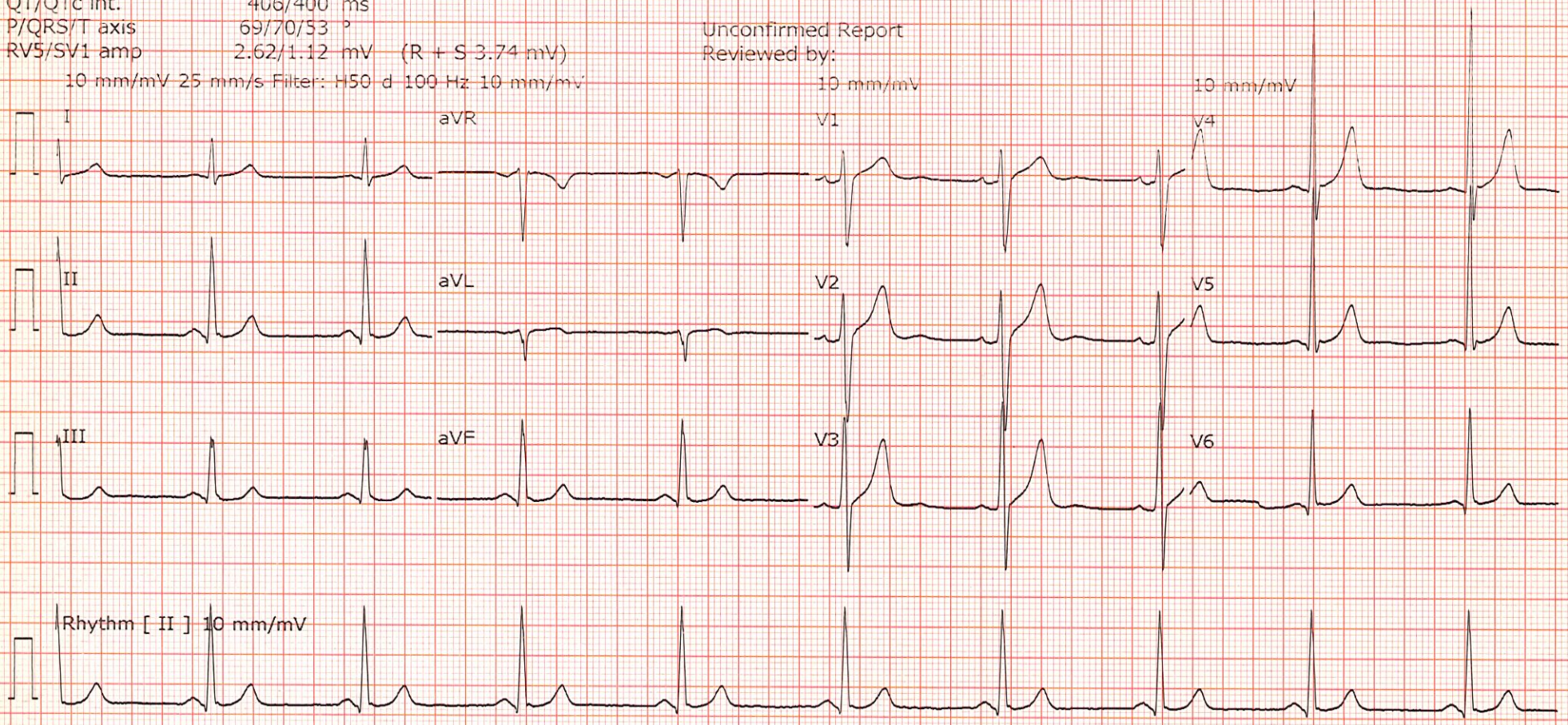
Name:STANDISH DAVID
ID:0503700053
Sex:Male Birth date. Years
cm kg mmHg
Medication:

Symptoms:
History:

3/ 2/2011 9:13

| | | |
|---|---|---|
| HR | 57 | bpm |
| PR int. | 134 | ms |
| QRS dur. | 96 | ms |
| QT/QTc int. | 406/400 | ms |
| P/QRS/T axis | 69/70/53 | ° |
| RV5/SV1 amp | 2.62/1.12 | mV (R + S 3.74 mV) |

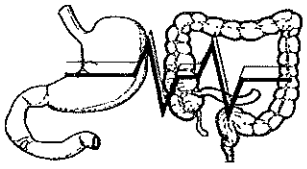
Unconfirmed Report
Reviewed by:




158E 04-01 02-10 Dept.:AREA 5 Exam:B DEAN,NINEWELLS HOSPITAL

TAYSIDE
University Hospitals
NHS Trust

**GI MOTILITY LABORATORY**
Department of Clinical Measurement
Level 4
Ninewells Hospital and Medical School
Dundee DD1 9SY
Telephone (01382) 632972



**RESULTS : (Dated :** 21/01/02 **)** **CONSULTANT :** Dr Morley

**PATIENT :** David Standish

**D.O.B. :** 050370 00 53

***OESOPHAGEAL MANOMETRY***

**Lower oesoph. high pressure zone :**
- **length (cms)**
- **dist from the nares (cms)**
- **respiratory inversion point (cms)**
- **pressure (mm Hg)** 18·3

***COMMENT :*** Normal

**Oesoph. Motility :**
- **Propagation (velocity cm/sec)**
- **Wave amplitude (mm Hg)** 51
- **Wave duration (secs)** 3
- **Propulsive contractions %**
- **Simultaneous contractions %**
- **Segmental contractions %**
- **Retrograde contractions %**

***COMMENT :*** A few high amplitude, long duration contractions in distal oesophagus.

**24HR AMBULATORY OESOPHAGEAL pH.**
**Cumulative acid exposure :**

| | | |
|---|---|---|
| **i. Significant exposure in erect posture** | **(yes)** | **no** |
| **ii. Significant exposure in supine posture** | **(yes)** | **no** |

**Reflux pattern :**
- **Normal**
- **HPZ incompetence**
- **Impaired oesoph. clearing mechanism**

***COMMENT :*** Post-prandial and supine acid reflux with delayed clearance.

***OESOPHAGEAL ECG TRANSIT TEST.***

**Motility pattern (type)**

**Transit times (secs) :**
- **Total**
- **Prox. Third**
- **Mid. Third**
- **Dist. Third**

DNA.

***COMMENT :***

**OVERALL COMMENT :** Combined (erect & supine) acid reflux & impaired motility.

**Reviewed June 2000**

**SAMI M. SHIMI FRCS**

# G I  R E P O R T

Summary report
Multigram Ver. 6.31, GI Edition

Copyright 1987-1994
Gastrosoft Inc.

**Patient** : STANDISH, David **Date** : 14/11/01

**GENERAL ANALYSIS CONSTANTS :**

| | |
|---|---|
| Analysis Date | : 11-15-2001 (10:46:24) |
| Auto Baseline Period | : 60.0 |
| Max. allowed change | : 0.0 |
| Pages Analyzed | : 1 to 1107 |
| Version used | : 6301 |

**Motility Analysis**

| | |
|---|---|
| Pressure Unit mmHg | : |
| Pressure threshold for contractions | : 6.0 |
| Minimum duration of a contraction | : 1.0 |
| Maximum duration of a contraction | : 30.0 |
| Minimum contraction interval | : 1.0 |
| Removed repetitive contractions? | : Yes |
| Time Interval (t) Between Contractions | : |
| on Adjacent Channels for | : |
| Retrograde | : -0.60 < t <=-0.60 |
| Simultaneous | : -0.60 < t <= 0.30 |
| Peristaltic | : 0.30 < t <= 5.00 |
| Calculate Peristalsis Based on | : Peak |

TRIAGE

Synectics Medical Ltd March95

# G I R E P O R T

Summary report
Multigram Ver. 6.31, GI Edition

Copyright 1987-1994
Gastrosoft Inc.

**Patient** : STANDISH, David **Date** : 14/11/01

## SUMMARY TABLE

| Period | Chan | %Ampl.>140mmH | %Dur. > 2sec | %Dur. > 7sec | Mean Ampl. | Mean Dur. | Mean Slope | Mean Area |
|---|---|---|---|---|---|---|---|---|
| | 3 | 0.0 | 49.6 | 5.2 | 26.3 | 2.7 | 14.2 | 34.5 |
| TOTAL | 4 | 0.0 | 47.3 | 2.8 | 22.8 | 2.5 | 14.6 | 25.7 |
| | 5 | 0.2 | 25.8 | 3.5 | 14.5 | 1.9 | 5.4 | 20.8 |
| | 6 | 0.0 | 9.3 | 1.1 | 18.8 | 1.5 | 18.0 | 10.5 |
| | 3 | 0.0 | 73.8 | 14.3 | 47.0 | 4.2 | 22.0 | 76.1 |
| MEAL | 4 | 0.0 | 69.4 | 16.3 | 53.7 | 4.0 | 23.3 | 83.0 |
| | 5 | 0.0 | 72.7 | 25.0 | 56.8 | 5.2 | 24.0 | 119.9 |
| | 6 | 0.0 | 2.1 | 0.0 | 17.4 | 1.1 | 16.5 | 7.3 |
| | 3 | 0.0 | 43.9 | 1.5 | 19.0 | 2.2 | 11.8 | 20.0 |
| UPRIGHT | 4 | 0.0 | 45.2 | 1.0 | 18.8 | 2.3 | 13.7 | 18.4 |
| | 5 | 0.4 | 33.8 | 2.6 | 13.3 | 2.2 | 5.3 | 19.3 |
| | 6 | 0.0 | 9.2 | 1.2 | 23.1 | 1.5 | 23.9 | 13.3 |
| | 3 | 0.0 | 25.9 | 0.0 | 11.7 | 1.7 | 7.9 | 5.2 |
| SUPINE | 4 | 0.0 | 34.4 | 0.0 | 14.6 | 1.7 | 9.7 | 8.8 |
| | 5 | 0.0 | 7.5 | 0.0 | 6.9 | 0.9 | 1.7 | 1.9 |
| | 6 | 0.0 | 10.1 | 1.0 | 15.3 | 1.6 | 13.1 | 8.4 |
| | 3 | 0.0 | 69.2 | 0.0 | 22.1 | 2.9 | 12.1 | 24.8 |
| CIGARETTE | 4 | 0.0 | 50.0 | 5.6 | 20.1 | 2.8 | 10.4 | 25.2 |
| | 5 | 0.0 | 47.6 | 4.8 | 21.0 | 3.9 | 8.8 | 38.3 |
| | 6 | 0.0 | 20.8 | 0.0 | 13.9 | 1.6 | 11.8 | 5.3 |

# G I  R E P O R T

Summary report
Multigram Ver. 6.31, GI Edition

Copyright 1987-1994
Gastrosoft Inc.

**Patient** : STANDISH, David **Date** : 14/11/01

## SUMMARY TABLE

| Period | Chan | Mean | D.P. |
|---|---|---|---|
| TOTAL | 3 | 29.5 | |
| | 4 | 30.2 | |
| | 5 | 13.5 | |
| | 6 | 28.5 | |
| MEAL | 3 | 58.3 | |
| | 4 | 73.9 | |
| | 5 | 75.1 | |
| | 6 | 30.3 | |
| UPRIGHT | 3 | 18.8 | |
| | 4 | 25.0 | |
| | 5 | 11.5 | |
| | 6 | 36.8 | |
| SUPINE | 3 | 10.8 | |
| | 4 | 13.9 | |
| | 5 | 2.8 | |
| | 6 | 21.4 | |
| CIGARETTE | 3 | 25.2 | |
| | 4 | 17.3 | |
| | 5 | 20.1 | |
| | 6 | 19.6 | |

**G I  R E P O R T**

Summary report
Multigram Ver. 6.31, GI Edition

Copyright 1987-1994
Gastrosoft Inc.

**Patient** : STANDISH, David **Date** : 14/11/01

**GENERAL ANALYSIS CONSTANTS :**

| | |
|---|---|
| Analysis Date | : 11-15-2001 (10:44:44) |
| Auto Baseline Period | : 60.0 |
| Max. allowed change | : 0.0 |
| Pages Analyzed | : 1 to 1107 |
| Version used | : 6301 |

**Motility Analysis**

| | |
|---|---|
| Pressure Unit mmHg | : |
| Pressure threshold for contractions | : 15.0 |
| Minimum duration of a contraction | : 1.0 |
| Maximum duration of a contraction | : 30.0 |
| Minimum contraction interval | : 1.0 |
| Removed repetitive contractions? | : Yes |
| Time Interval (t) Between Contractions | : |
| on Adjacent Channels for | : |
| Retrograde | : -0.60 < t <=-0.60 |
| Simultaneous | : -0.60 < t <= 0.30 |
| Peristaltic | : 0.30 < t <= 5.00 |
| Calculate Peristalsis Based on | : Peak |

**Esophageal pH Analysis**

| | |
|---|---|
| pH CHANNEL 1 | |
| Acid reflux begins at pH | : 4.0 |
| Acid reflux ends at pH | : 4.0 |
| Alkaline shift begins at pH | : 7.0 |
| Alkaline shift ends at pH | : 7.0 |

Synectics Medical Ltd March95

# G I R E P O R T

Summary report
Multigram Ver. 6.31, GI Edition

Copyright 1987-1994
Gastrosoft Inc.

**Patient** : STANDISH, David **Date** : 14/11/01

## SUMMARY TABLE

| Period | Chan | # Contr. | Contr/Min | % Perist. | % Simult. | % Retrog. | % Isolated | %Ampl.> 20mmH |
|---|---|---|---|---|---|---|---|---|
| | 3 | 1738 | 1.28 | 79.2 | 13.1 | 0.0 | 7.7 | 89.8 |
| TOTAL | 4 | 1776 | 1.31 | 79.5 | 15.3 | 0.0 | 5.2 | 87.6 |
| | 5 | 1709 | 1.26 | 74.0 | 22.5 | 0.0 | 3.6 | 91.7 |
| | 3 | 218 | 2.79 | 90.4 | 8.7 | 0.0 | 0.9 | 92.7 |
| MEAL | 4 | 228 | 2.92 | 90.4 | 8.8 | 0.0 | 0.9 | 91.2 |
| | 5 | 227 | 2.91 | 83.7 | 11.9 | 0.0 | 4.4 | 96.0 |
| | 3 | 1299 | 1.76 | 79.8 | 11.4 | 0.0 | 8.8 | 89.1 |
| UPRIGHT | 4 | 1306 | 1.77 | 80.9 | 13.4 | 0.0 | 5.7 | 87.4 |
| | 5 | 1260 | 1.71 | 74.2 | 24.0 | 0.0 | 1.8 | 91.4 |
| | 3 | 221 | 0.41 | 64.3 | 27.6 | 0.0 | 8.1 | 90.5 |
| SUPINE | 4 | 242 | 0.45 | 61.6 | 31.8 | 0.0 | 6.6 | 85.5 |
| | 5 | 222 | 0.41 | 62.6 | 24.8 | 0.0 | 12.6 | 88.7 |
| | 3 | 99 | 2.47 | 67.7 | 8.1 | 0.0 | 24.2 | 86.9 |
| OTHER | 4 | 72 | 1.80 | 84.7 | 15.3 | 0.0 | 0.0 | 76.4 |
| | 5 | 76 | 1.90 | 85.5 | 14.5 | 0.0 | 0.0 | 84.2 |
| | 3 | 203 | 1.84 | 78.3 | 12.3 | 0.0 | 9.4 | 90.1 |
| CIGARETTE | 4 | 185 | 1.68 | 84.3 | 14.1 | 0.0 | 1.6 | 89.7 |
| | 5 | 181 | 1.64 | 86.7 | 12.7 | 0.0 | 0.6 | 94.5 |

Synectics Medical Ltd March95

# G I R E P O R T

Summary report
Multigram Ver. 6.31, GI Edition

Copyright 1987-1994
Gastrosoft Inc.

**Patient** : STANDISH, David **Date** : 14/11/01

## SUMMARY TABLE

| Period | Chan | %Ampl.>140mmH | %Dur. > 2sec | %Dur. > 7sec | Mean Ampl. | Mean Dur. | Mean Slope | Mean Area |
|---|---|---|---|---|---|---|---|---|
| | 3 | 0.2 | 57.9 | 0.3 | 46.4 | 2.5 | 29.6 | 49.1 |
| TOTAL | 4 | 0.2 | 58.5 | 2.8 | 44.7 | 2.8 | 26.7 | 51.7 |
| | 5 | 3.8 | 72.4 | 6.7 | 62.2 | 3.7 | 34.6 | 117.6 |
| | 3 | 0.5 | 59.6 | 0.5 | 50.4 | 2.6 | 33.1 | 54.3 |
| MEAL | 4 | 0.4 | 57.0 | 0.9 | 52.0 | 2.6 | 33.1 | 54.0 |
| | 5 | 2.2 | 70.0 | 6.2 | 71.1 | 3.3 | 46.8 | 93.2 |
| | 3 | 0.2 | 56.7 | 0.2 | 43.8 | 2.4 | 28.8 | 42.6 |
| UPRIGHT | 4 | 0.2 | 57.6 | 0.8 | 41.7 | 2.6 | 25.2 | 41.2 |
| | 5 | 2.5 | 73.7 | 2.3 | 57.7 | 3.3 | 32.1 | 87.6 |
| | 3 | 0.0 | 63.3 | 1.4 | 57.5 | 3.0 | 31.5 | 82.3 |
| SUPINE | 4 | 0.4 | 64.9 | 15.3 | 53.4 | 4.2 | 28.4 | 106.2 |
| | 5 | 13.1 | 68.0 | 32.0 | 78.6 | 6.1 | 35.8 | 313.2 |
| | 3 | 0.0 | 41.4 | 0.0 | 38.7 | 2.0 | 28.7 | 27.8 |
| OTHER | 4 | 0.0 | 45.8 | 0.0 | 36.3 | 2.1 | 24.7 | 26.7 |
| | 5 | 1.3 | 59.2 | 0.0 | 52.1 | 2.7 | 31.2 | 64.0 |
| | 3 | 0.0 | 56.2 | 0.0 | 44.2 | 2.4 | 29.2 | 41.8 |
| CIGARETTE | 4 | 0.0 | 62.7 | 0.5 | 43.8 | 2.6 | 27.6 | 44.8 |
| | 5 | 1.7 | 79.0 | 1.1 | 60.2 | 3.3 | 35.9 | 86.6 |

# G I  R E P O R T

Summary report
Multigram Ver. 6.31, GI Edition

Copyright 1987-1994
Gastrosoft Inc.

**Patient** : STANDISH, David **Date** : 14/11/01

## SUMMARY TABLE

| Period | Chan | Mean | D.P. |
|---|---|---|---|
| TOTAL | 3 | 47.6 | |
| | 4 | 46.6 | |
| | 5 | 69.3 | |
| MEAL | 3 | 52.5 | |
| | 4 | 59.9 | |
| | 5 | 97.0 | |
| UPRIGHT | 3 | 45.7 | |
| | 4 | 43.6 | |
| | 5 | 63.0 | |
| SUPINE | 3 | 53.7 | |
| | 4 | 50.4 | |
| | 5 | 76.7 | |
| OTHER | 3 | 43.6 | |
| | 4 | 39.4 | |
| | 5 | 57.9 | |
| CIGARETTE | 3 | 46.3 | |
| | 4 | 47.4 | |
| | 5 | 68.5 | |

# G I  R E P O R T

Summary report
Multigram Ver. 6.31, GI Edition

Copyright 1987-1994
Gastrosoft Inc.

**Patient** : STANDISH, David **Date** : 14/11/01

## Numerical Analysis Tables

| CHANNEL 1 | | TOTAL | MEAL | UPRIGHT | SUPINE | OTHER | CIGARETTE |
|---|---|---|---|---|---|---|---|
| Duration (hh:mm:ss) | | 22:36:08 | 01:18:00 | 13:36:08 | 09:00:00 | 00:40:00 | 01:50:00 |
| Acid Reflux Episodes | | | | | | | |
| Total Number | | 79 | 1 | 28 | 51 | 1 | 4 |
| Duration of Longest (min.) | | 24.3 | 0.1 | 12.1 | 24.3 | 0.1 | 0.1 |
| # longer than | 5.0 min. | 7 | 0 | 1 | 6 | 0 | 0 |
| Percent Time pH below | 4.0 | 10.3 | 0.1 | 3.6 | 20.5 | 0.2 | 0.4 |
| Symptom Index | | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

## Acid Score Table

| DeMeester Score for Acid Episodes | | | | Normal (95th%) | Patient Score | |
|---|---|---|---|---|---|---|
| Total Number | | (ref/24 h) | | 46.90 | 79 | 6.09 |
| # longer than | 5.0 min. | (ref/24 h) | | 3.45 | 7 | 6.59 |
| Duration of Longest (min.) | | | | 19.80 | 24.33 | 3.24 |
| Time pH below | 4.0 | TOTAL | (%) | 4.45 | 10.32 | 7.48 |
| Time pH below | 4.0 | UPRIGHT | (%) | 8.42 | 3.62 | 1.55 |
| Time pH below | 4.0 | SUPINE | (%) | 3.45 | 20.46 | 20.83 |
| Total DeMeester Score | | | | 14.72 | | 45.77 |

# Graded Exercise Summary Report

NINE [illegible] DEPT OF CARDIOLOGY

Name: STANDISH, DAVID
ID: 0503700053
Age: 31yrs
Ht:
Wt:
Sex: Male
Race: Cauc

Date: 29-JUN-2001
Time: 13:59:41
Referred by: DR T PRINGLE
Medications: NIL
Test Indication: ? CHEST PAIN
Test Type: BRUCE
Technician: MF + CD

MUSE Loc: 0

6826

| Phase | Stage | Time in Phase | Duration of Stage | Speed (mph) | Grade (%) | W.L. (METS) | H.R. (bpm) | B.P. | R.P.P. (x100) | P.E. | V.E. (/min) | ST (aVF) | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PRE-TEST | | 00:00 | 00:00 | 0.0 | 0.0 | 1 | 49 | 110/70 | 54 | | 0 | -0.3? | |
| SUPINE | | 00:23 | 00:23 | 0.0 | 0.0 | 1 | 51 | | | | 0 | -0.1? | |
| STANDING | | 00:16 | 00:16 | 0.0 | 0.0 | 1 | 67 | | | | 0 | 0.5 | |
| HYPERV | | 00:24 | 00:24 | 1.0 | 0.0 | 1 | 65 | | | | 0 | 0.2 | |
| EXERCISE | 1 | 03:00 | 03:00 | 1.7 | 10.0 | 4 | 104 | 140/70 | 146 | | 0 | 0.1 | |
| | 2 | 06:00 | 03:00 | 2.5 | 12.0 | 7 | 122 | 140/70 | 171 | | 0 | 0.0 | |
| | 3 | 09:00 | 03:00 | 3.4 | 14.0 | 10 | 147 | 150/70 | 221 | | 0 | -0.9 | |
| | 4 | 12:00 | 03:00 | 4.2 | 16.0 | 13 | 169 | 150/70 | 254 | | 0 | -1.2 | |
| | 5 | 12:13 | 00:13 | 5.0 | 18.0 | 13 | 170 | | | | 0 | -0.9 | |
| PEAK EX | | 00:00 | 00:00 | 5.0 | 18.0 | 13 | 170 | | | | 0 | -0.9 | |
| RECOVERY | | 05:19 | 05:19 | 0.0 | 0.0 | 1 | 87 | 130/70 | 113 | | 0 | 0.0 | |

Results:

Procedure: BRUCE
Exercise Time: 12:13
Maximum Heart Rate Attained: 174bpm 92% Max Predicted 189bpm
Maximum BP: 170/70
Maximum Workload Attained: 13METS
Reason for Termination:
CLAUDICATION
SL. SOB + TIRED
NO CHEST DISCOMFORT

Seen
P-C Wmow

Impressions:

Resting ECG - SR normal axis
Average exercise time for age. Achieved target HR
No chest symptoms No evidence of inducible ischaemia
Negative Test

A58 D06G [illegible] Signed By: YFogarty Date: 02/07/01

DOLBY REGULAR

29-JUN-2001 STANDISH, DAVID
13:59:48
ID: 0503700053

25mm/s
10mm/mV
100Hz

12 Lead Report

Clock 1: 00:07
Clock 2: 00:07

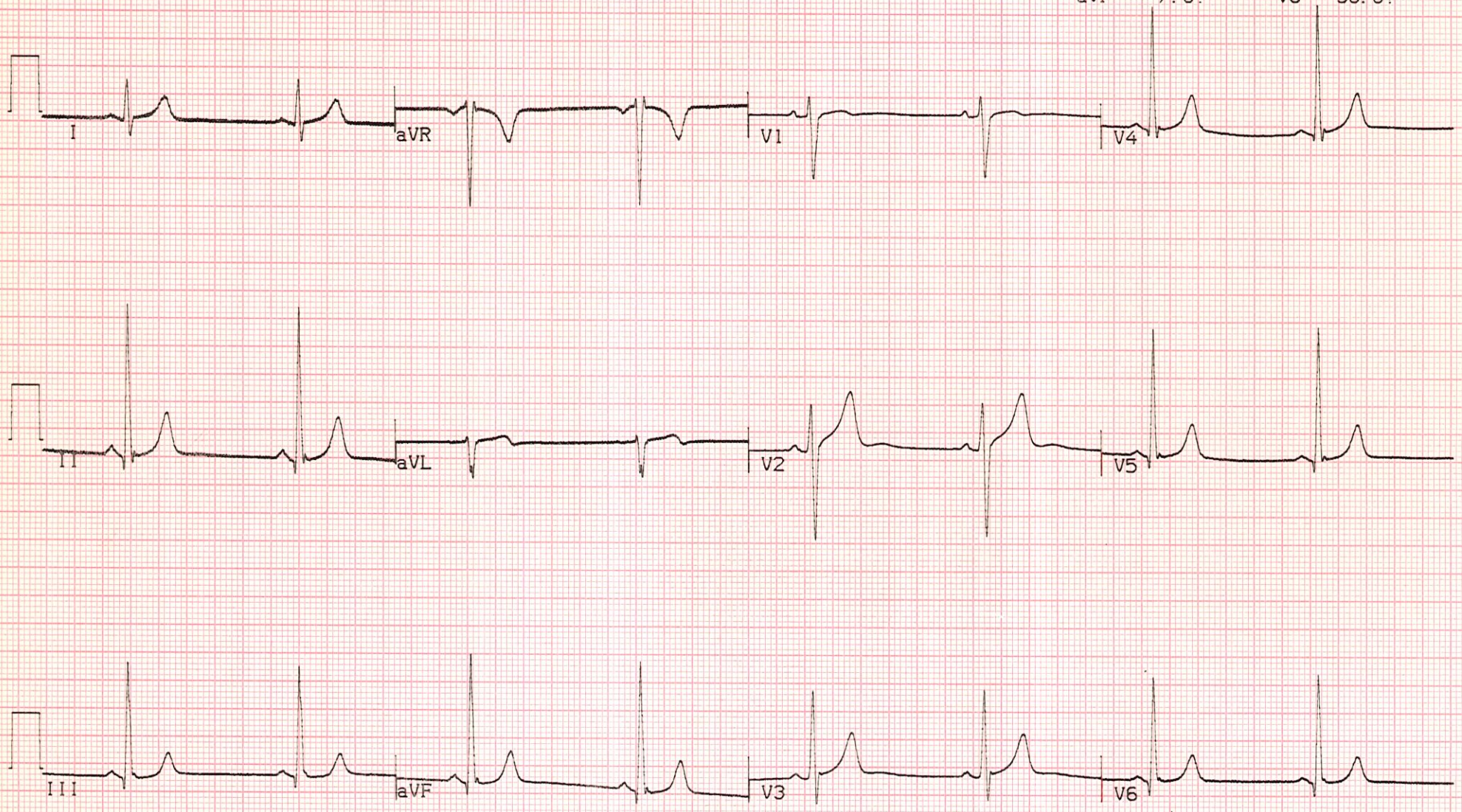
HR: 49bpm

Speed: 0.0mph
Grade: 0.0%

NINEWELLS DEPT OF CARDIOLOGY

Measured At 80ms post J ( 10mm/mV)
Auto Points

| Lead | ST(mm) | Lead | ST(mm) |
|---|---|---|---|
| I | -4.9? | V1 | -15.6? |
| II | -9.6? | V2 | -0.9? |
| III | -7.5? | V3 | -1.9? |
| aVR | -8.1? | V4 | -4.8? |
| aVL | -8.6? | V5 | -1.0? |
| aVF | -7.8? | V6 | -38.8? |




2 A- H- S+ F+ 50 Sf23 H442 #4798 CASE 1066

DOLBY REGULAR

29-JUN-2001 STANDISH, DAVID
14:00:34
ID: 0503700053

25mm/s
10mm/mV
100Hz

STAND

HR: 66bpm

12 Lead Report

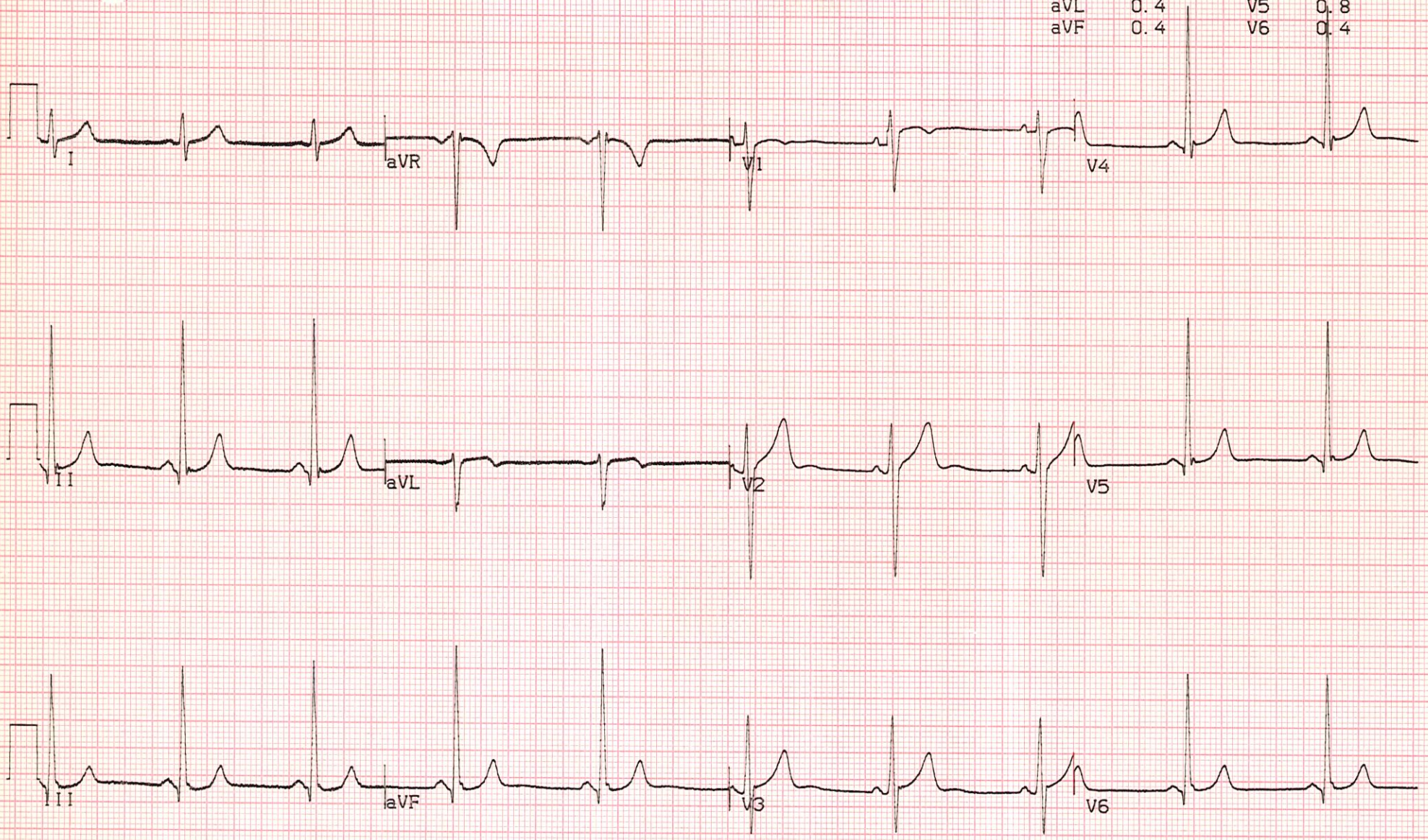
Clock 1: 00:52
Clock 2: 00:11

Speed: 0.0mph
Grade: 0.0%

NINEWELLS DEPT OF CARDIOLOGY

Measured At 80ms post J ( 10mm/mV)
Auto Points

| Lead | ST(mm) | Lead | ST(mm) |
|---|---|---|---|
| I | 1.0 | V1 | 0.6 |
| II | 0.8 | V2 | 3.3 |
| III | 0.0 | V3 | 2.5 |
| aVR | -0.6 | V4 | 1.2 |
| aVL | 0.4 | V5 | 0.8 |
| aVF | 0.4 | V6 | 0.4 |




2 A- H- S+ F+ 50 Sf23 H442 #4798 CASE 106G

DOLBY REGULAR

29-JUN-2001 14:03:36

STANDISH, DAVID

ID: 0503700053

25mm/s
10mm/mV
100Hz

EXERCISE 1

HR: 106bpm
BP: 140/70

12 Lead Report

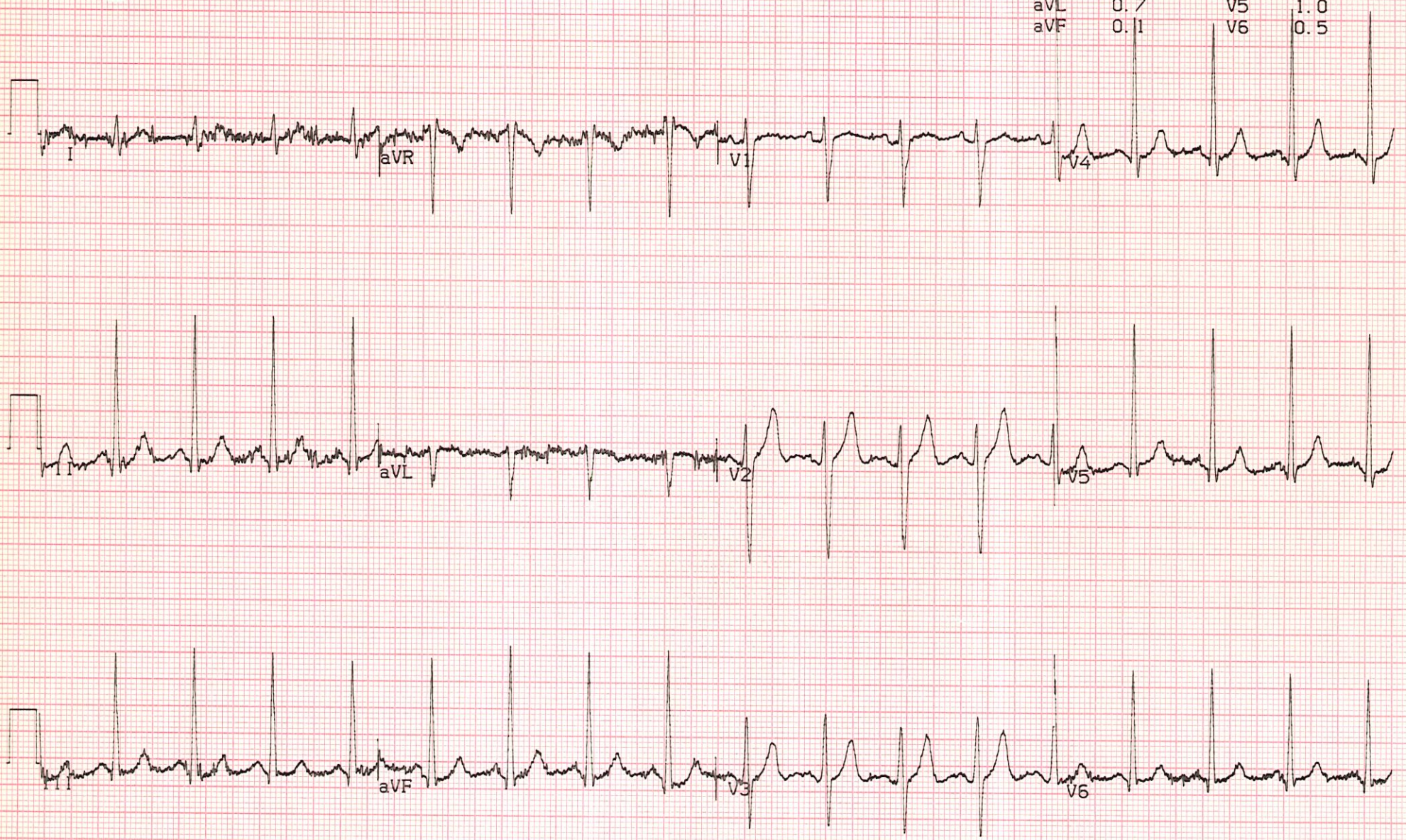
Clock 1: 02:50
Clock 2: 02:50

Speed: 1.7mph
Grade: 10.0%

NINEWELLS DEPT OF CARDIOLOGY

Measured At 80ms post J ( 10mm/mV)
Auto Points

| Lead | ST(mm) | Lead | ST(mm) |
|---|---|---|---|
| I | 1.0 | V1 | 1.0 |
| II | 0.4 | V2 | 5.0 |
| III | -0.2 | V3 | 3.5 |
| aVR | -0.3 | V4 | 1.6 |
| aVL | 0.7 | V5 | 1.0 |
| aVF | 0.1 | V6 | 0.5 |




82 A- H- S+ F+ 50 Sf23 H442 #4798 CASE 106G

DOLBY REGULAR

29-JUN-2001 STANDISH, DAVID
14:06:36 ID: 0503700053

25mm/s
10mm/mV
100Hz

12 Lead Report

EXERCISE 2

HR: 123bpm
BP: 140/70

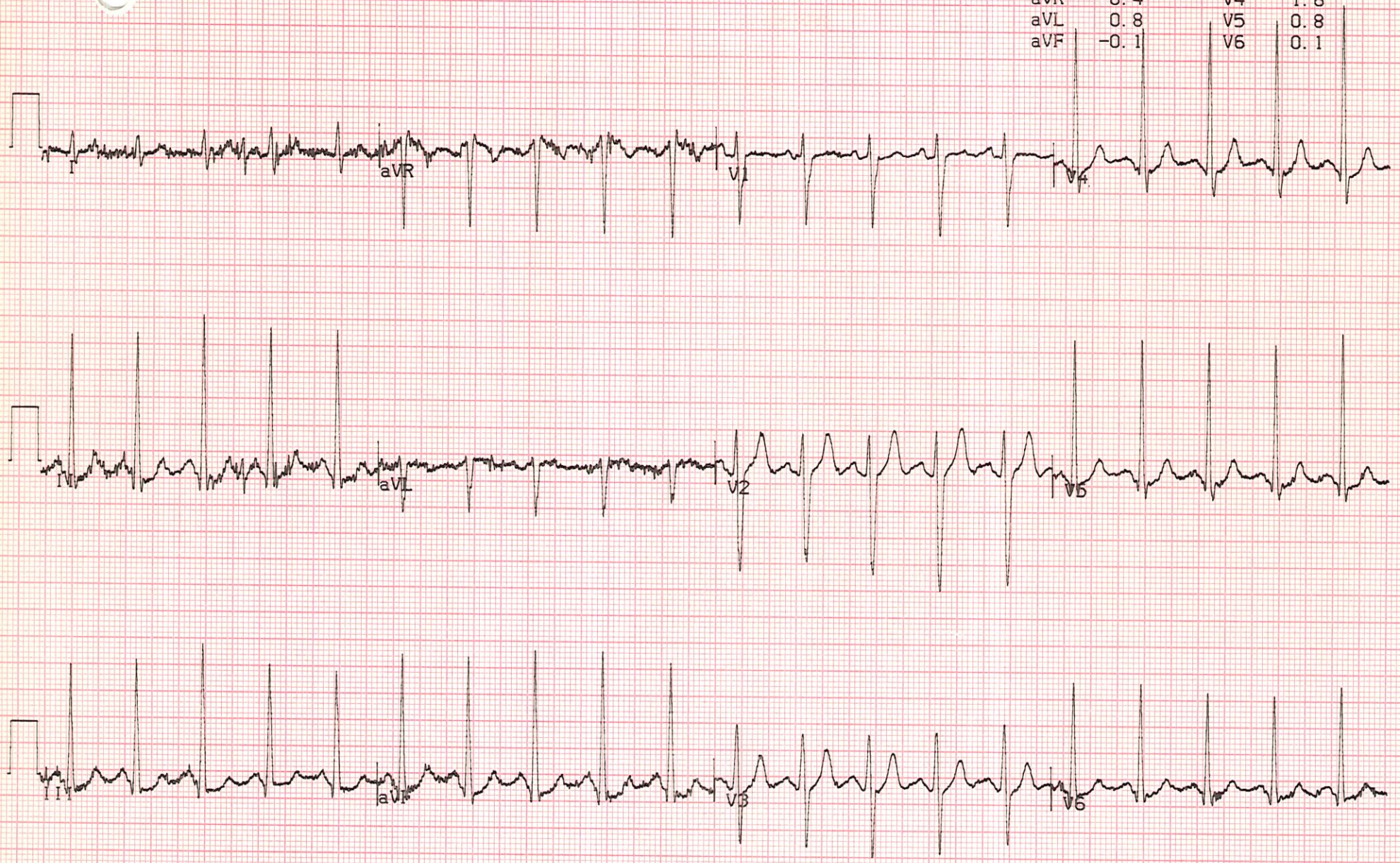
Clock 1: 05:50
Clock 2: 02:50

Speed: 2.5mph
Grade: 12.0%

NINEWELLS DEPT OF CARDIOLOGY

Measured At 80ms post J ( 10mm/mV)
Auto Points

| Lead | ST(mm) | Lead | ST(mm) |
|---|---|---|---|
| I | 0.9 | V1 | 0.8 |
| II | 0.1 | V2 | 5.2 |
| III | -0.6 | V3 | 3.3 |
| aVR | -0.4 | V4 | 1.6 |
| aVL | 0.8 | V5 | 0.8 |
| aVF | -0.1 | V6 | 0.1 |




82 A- H- S+ F+ 50 Sf23 H442 #4798 CASE 106G

DOLBY REGULAR

29-JUN-2001 STANDISH, DAVID
14:09:37
ID: 0503700053

25mm/s
10mm/mV
100Hz

EXERCISE 3

HR: 147bpm
BP: 150/70

12 Lead Report

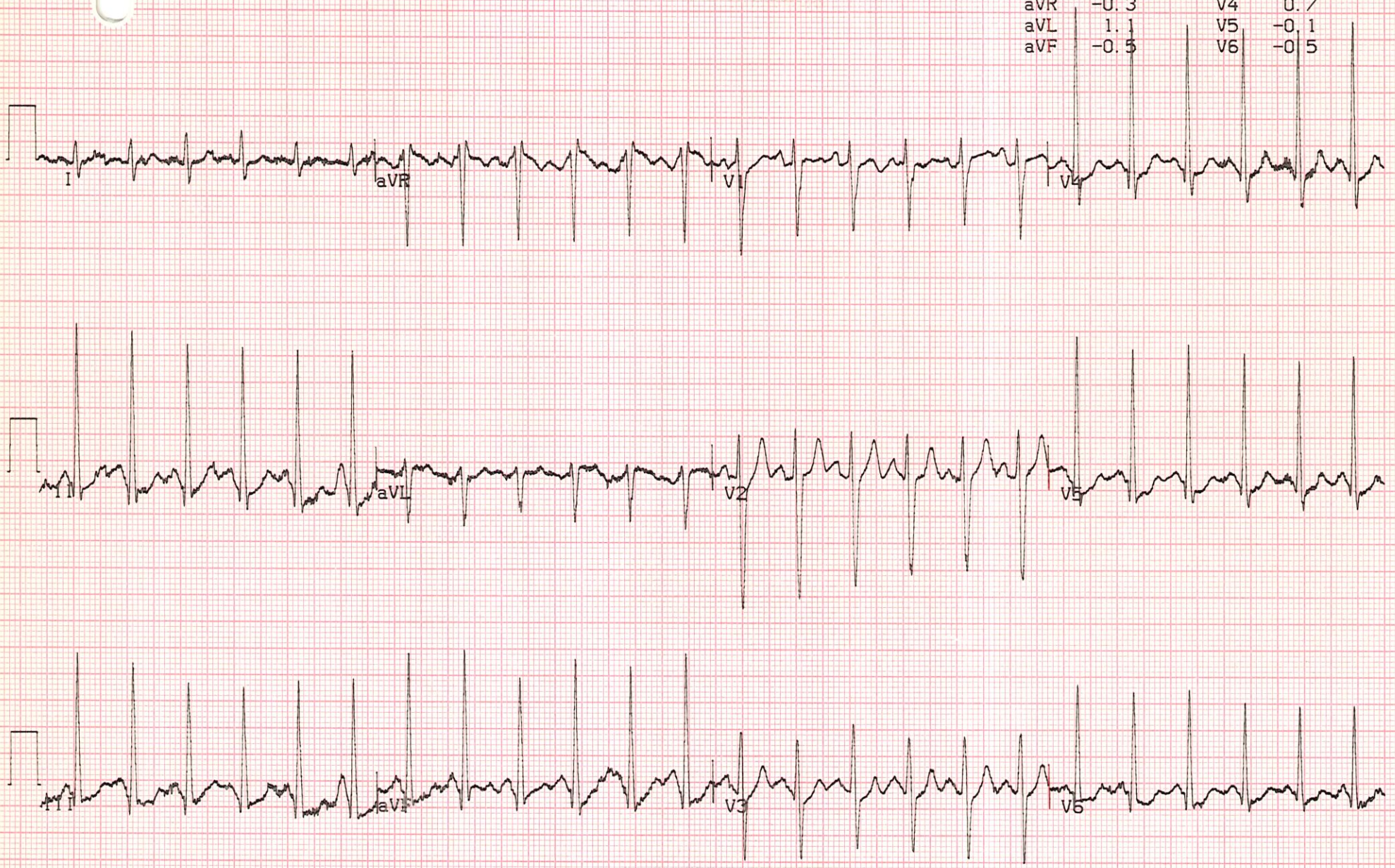
Clock 1: 08:50
Clock 2: 02:50

Speed: 3.4mph
Grade: 14.0%

NINEWELLS DEPT OF CARDIOLOGY

Measured At 80ms post J ( 10mm/mV)
Auto Points

| Lead | ST(mm) | Lead | ST(mm) |
|---|---|---|---|
| I | 1.1 | V1 | 0.7 |
| II | -0.1 | V2 | 5.8 |
| III | -1.1 | V3 | 3.0 |
| aVR | -0.3 | V4 | 0.7 |
| aVL | 1.1 | V5 | -0.1 |
| aVF | -0.5 | V6 | -0.5 |




82 A- H- S+ F+ 50 Sf23 H442 #4798 CASE 106G

DOLBY REGULAR

29-JUN-2001 STANDISH, DAVID
14:10:43
ID: 0503700053

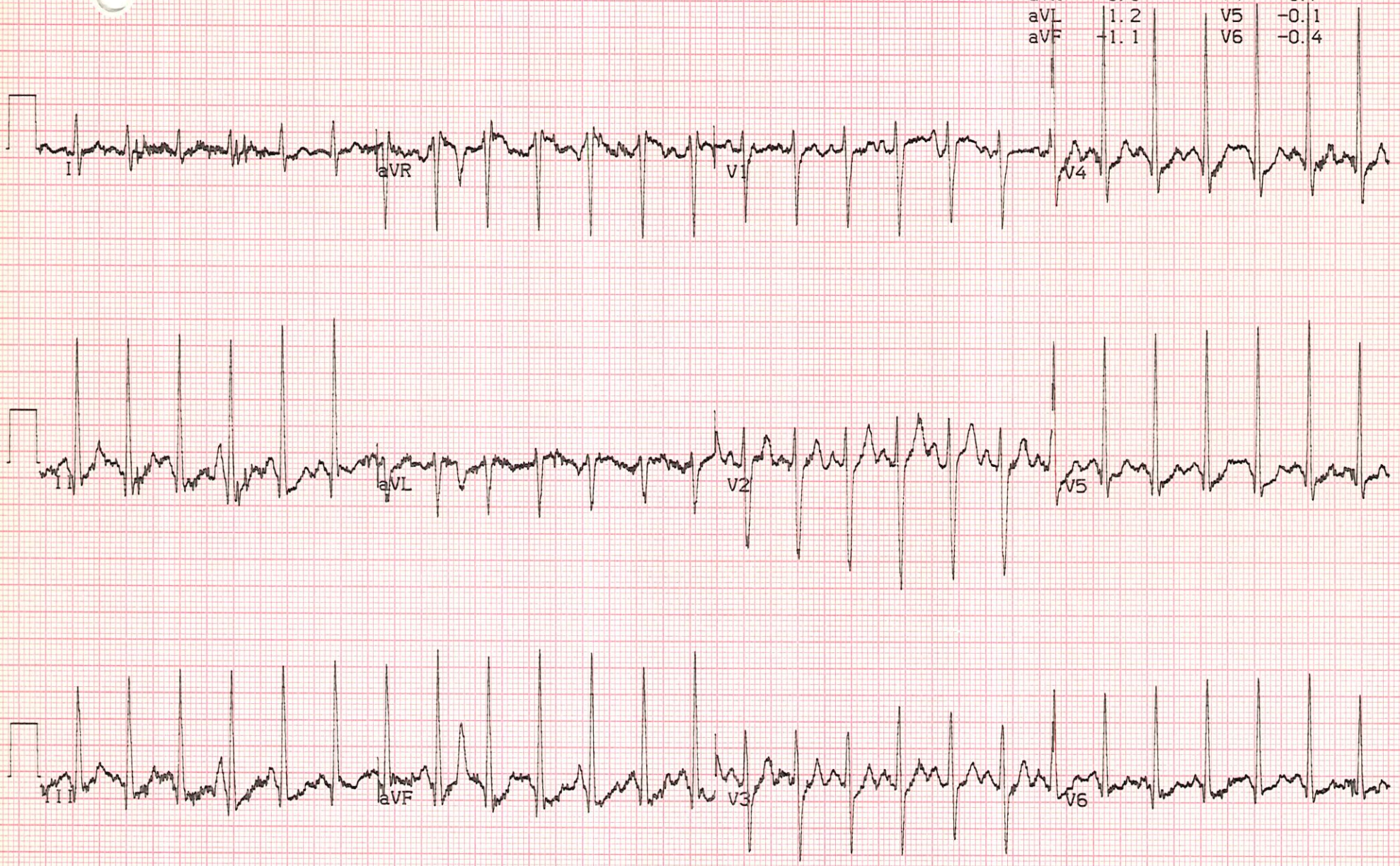
25mm/s
10mm/mV
100Hz

EASI-6 SE 4
HR: 159bpm

12 Lead Report
Clock 1: 09:56
Clock 2: 00:56
Speed: 4.2mph
Grade: 16.0%

NINEWELLS DEPT OF CARDIOLOGY
Measured At 80ms post J ( 10mm/mV)
Auto Points

| Lead | ST(mm) | Lead | ST(mm) |
|---|---|---|---|
| I | 1.0 | V1 | 0.7 |
| II | -0.7 | V2 | 5.5 |
| III | -1.6 | V3 | 3.1 |
| aVR | 0.0 | V4 | 0.7 |
| aVL | 1.2 | V5 | -0.1 |
| aVF | +1.1 | V6 | -0.4 |




2 A- H- S+ F+ 50 Sf23 H442 #4798 CASE 106G

DOLBY REGULAR

Echo No: 54370
Tape: 514
From: 2957

**Tayside University Hospitals NHS Trust**
**Ninewells Hospital**
**Cardiology Department**
**Echocardiography Report**

Ward/Clinic: 1/2 OP, Ninewells Hospital
Consultant: Pullar, Dr T
Surname: **Standish** IDNo: **0503700053**
First Name: **David**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| LVIDD: | cms (N=3.5-5.7cms) | IVS: | cms (N=0.6-1.1cms) | RV: | cms (N=0.9-2.6cms) |
| LVIDS: | cms | LVPW: | cms (N=0.6-1.1cms) | LA: | 3.76 cms (N=1.9-4.0cms) |
| FS: | % (N=25-42%) | E/A: | 1.4 | Ao: | 3.17 cms (N=2.0-3.7cms) |

***AORTIC VALVE:***
Normal
No stenosis **Max Inst Grad: 6.67 mmHg**
No regurgitation seen

***MITRAL VALVE:***
Normal

No regurgitation seen
***No stenosis***

***TRICUSPID VALVE:***
Normal
No regurgitation seen
***No stenosis***

***PULMONARY VALVE:***
Normal

No regurgitation seen
***No stenosis***

***LEFT VENTRICLE:*** Normal diastolic size
Normal systolic function
Normal diastolic function

***OTHER:***

Left atrium normal
Right atrium normal
Right ventricle normal

Seen
To file please
P. Ilmmar

***COMMENTS/ CONCLUSIONS:*** ***Normal study.***

Signature..... Y Fogarty ..... Y Fogarty Date: 29/06/2001

Ward/Clinic/Hosp. CP 142. TP Cons.

DEPARTMENT OF CARDIOLOGY

ECHOCARDIOGRAPHY REPORT

10.30 FRI 29th

STANDISH 05 03 70 0053
DAVID G M
18 FINTRYSIDE
DUNDEE
DD4 9JW

DR. C AFFLECK
PARK AVE M/C
DUNDEE

D M M Y Y C.H.I. No.

M. State

Sex

USE BLOCK LETTERS OR PATIENT LABEL

514 2957-3243

PAST HISTORY:

☐ HYPERTENSION TRT June ☐ MYOCARDIAL INFARCT ☐ PROSTHETIC VALVE

☐ CONGENITAL HEART DISEASE ☐ PULMONARY DISEASE ☐ ENDOCARDITIS

OTHER RELEVANT DETAILS: chest pain. ECG- LVH.

MURMURS:

PROVISIONAL DIAGNOSIS: ? ~~SOA~~ investigation of CP

REASON FOR REQUEST: ? septal hypertrophy ?? LVOT

DATE 24/1/11 BLEEP No. 4068 SIGNATURE

54370

REPORT: PLEASE DO NOT FOLD

AoRoot 3.17 Ao Grad 6.67

LA 3.76 EIA 1.43

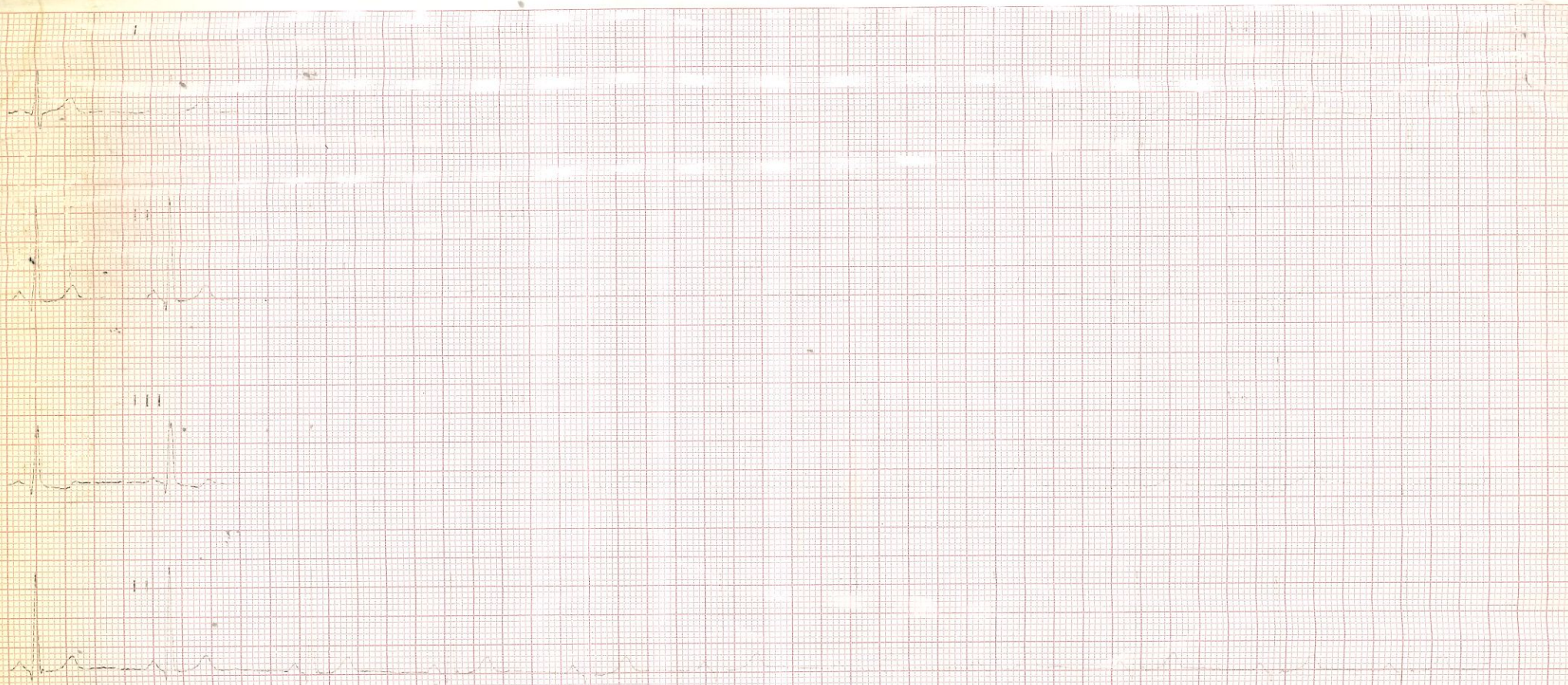
Signature .....

Date .....

DMR. 277 (Rev. '86)

STAUDISH DAVID 05·03·70 DR ARSHAD N/WELLS 24/01/2001 9.45am




I
II
III

**Report Details:** Authorised | **View:** Original

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053
Patient Name : STANDISH, David
Investigation: Artery Scan
Date of study: 19/07/2010

Consultant: Mr J Nagy
Vascular OUT-patients
Ward 12
Ninewells Hospital

---

Referral details:
Out-patient referral - bilateral claudication
reduced ABPI

| | Right | Left |
|---|---|---|
| Aorto/Iliac Segment | See report text | See report text |
| Femoro/Popliteal Segment | See report text | See report text |
| Runoff | See report text | See report text |

Report:
Normal calibre aorta. No significant aorto iliac disease.
Right leg. significant stenosis of the distal CFA extending to involve the origin of the PFA. The proximal SFA is patent there is however a 6 cm occlusion at the level of the adductor. The popliteal is patent and there is continuity to cross the ankle.
Left leg: CFA and PFA are patent. The SFA is occluded with reconstitution at the level of the adductor. The popliteal is patent and there is continuity to cross the ankle. Patient is only complaining of claudication therefore the LSVs were not assessed for possible bypass.

RAR (ET)

end of report

---

Authorised: 21/07/2010 08:06 RAL Date of study: 19/07/2010
86196R0 220 377


Printed by liblair\ldap.tuht.scot.nhs.uk on 12/08/2010 12:02:59

29-JUN-2001 STANDISH, DAVID
14:14:00 ID: 0503700053

25mm/s
10mm/mV
100Hz

12 Lead Report

Clock 1: 12:13
Clock 2: 01:00

HR: 138bpm

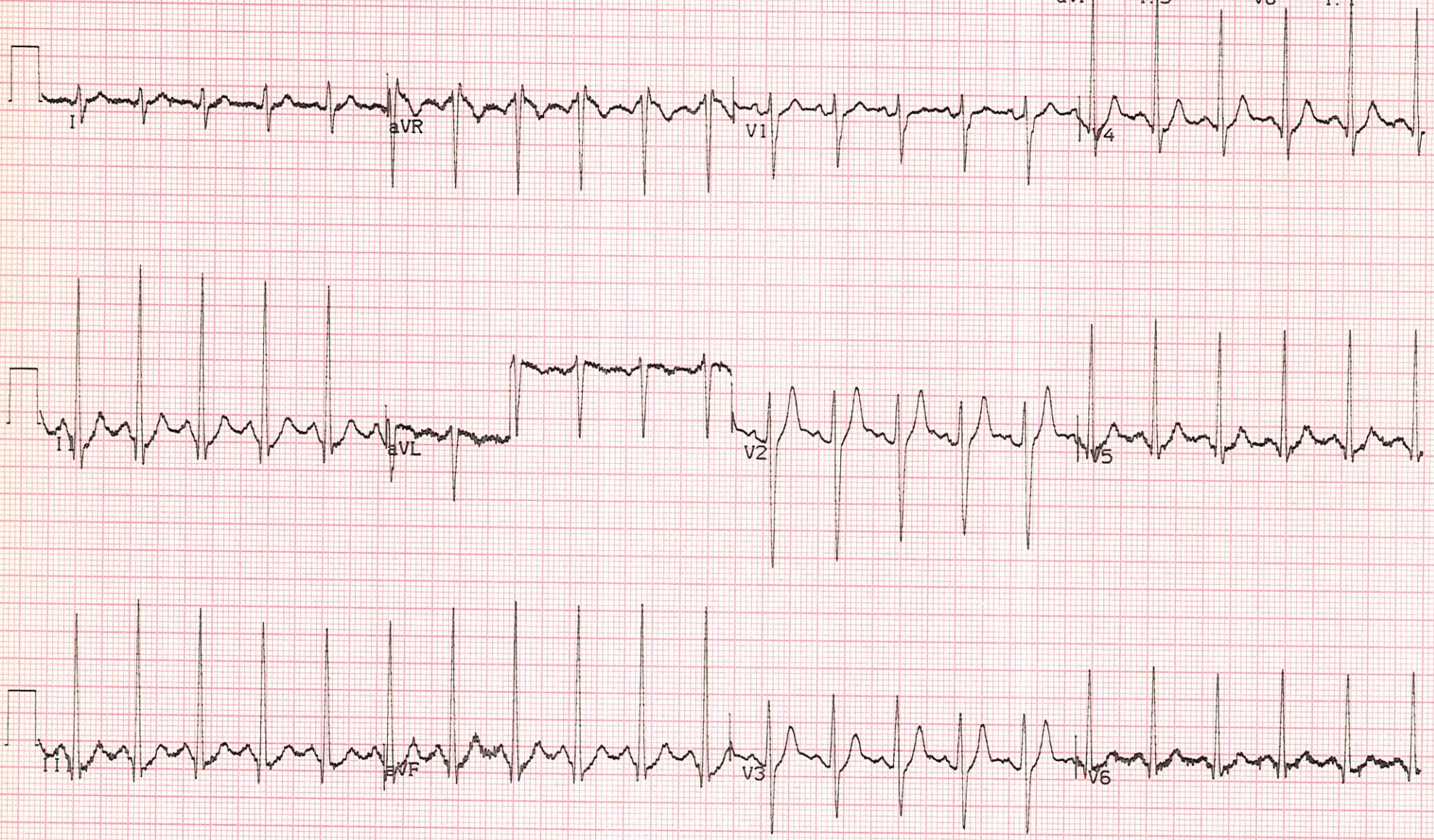
Speed: 0.0mph
Grade: 0.0%

NINEWELLS DEPT OF CARDIOLOGY

Measured At 80ms post J ( 10mm/mV)
Auto Points

| Lead | ST(mm) | Lead | ST(mm) |
|---|---|---|---|
| I | 2.0 | V1 | 1.7 |
| II | 2.5 | V2 | 9.1 |
| III | 0.6 | V3 | 6.3 |
| aVR | -2.1 | V4 | 3.8 |
| aVL | 0.5 | V5 | 2.1 |
| aVF | 1.5 | V6 | 1.1 |

BP 170/70.




82 A- H- S+ F+ 50 Sf23 H442 #4798 CASE 106G

29-JUN-2001 STANDISH, DAVID 12 Lead Report NINEWELLS DEPT OF CARDIOLOGY

14:16:01 ID: 0503700053 Clock 1: 12:13

25mm/s Clock 2: 03:00

10mm/mV

100Hz

HR: 92bpm Speed: 0.0mph

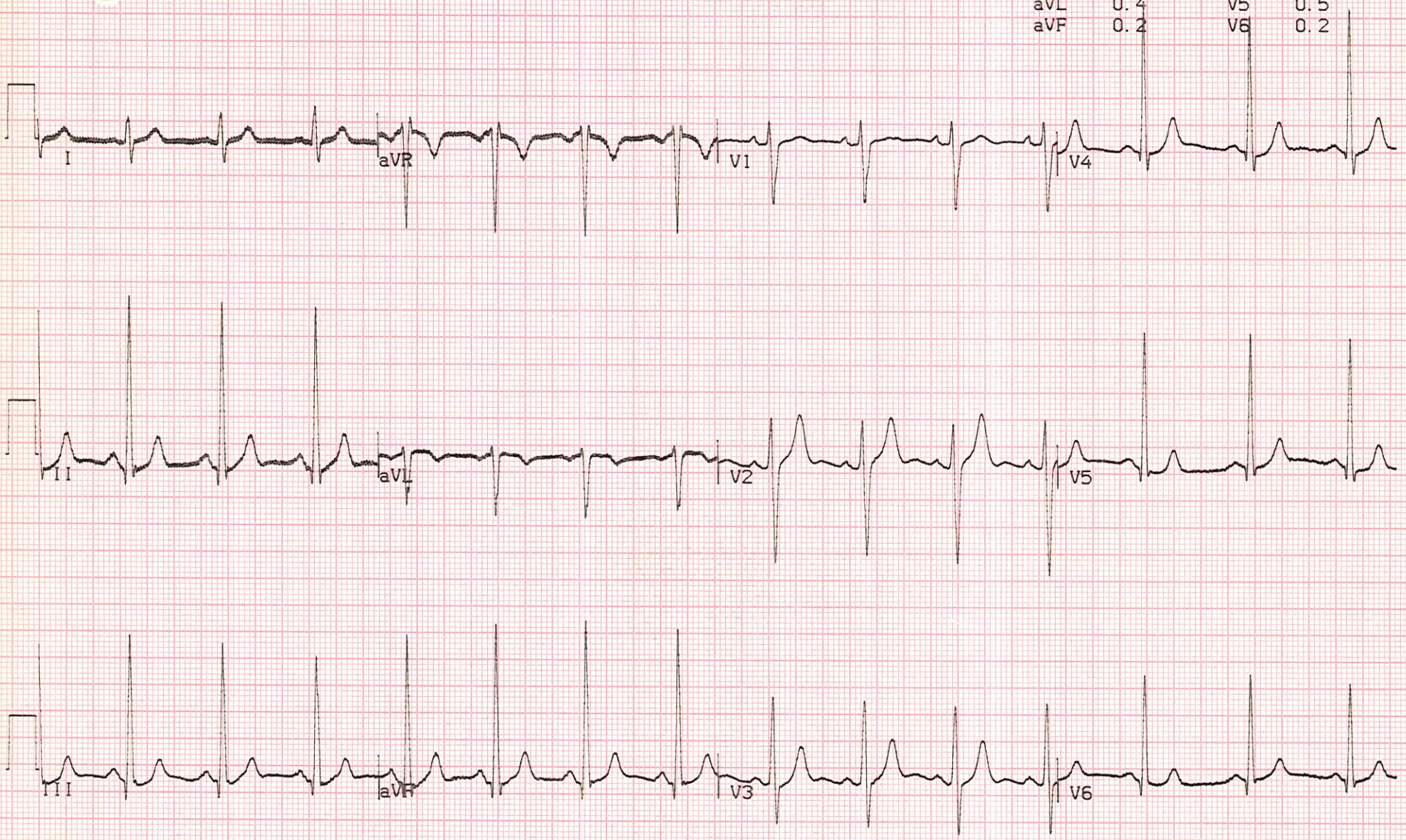
BP: [illegible]/70 Grade: 0.0%

130

Measured At 80ms post J ( 10mm/mV)

Auto Points

| Lead | ST(mm) | Lead | ST(mm) |
|---|---|---|---|
| I | 1.0 | V1 | 0.9 |
| II | 0.6 | V2 | 4.4 |
| III | -0.2 | V3 | 2.7 |
| aVR | -0.7 | V4 | 1.2 |
| aVL | 0.4 | V5 | 0.5 |
| aVF | 0.2 | V6 | 0.2 |




82 A- H- S+ F+ 50 Sf23 H442 #4798 CASE 106G

DOLBY REGULAR

29-JUN-2001 14:18:00

STANDISH, DAVID

ID: 0503700053

25mm/s
10mm/mV
100Hz

12 Lead Report

Clock 1: 12:13
Clock 2: 05:00

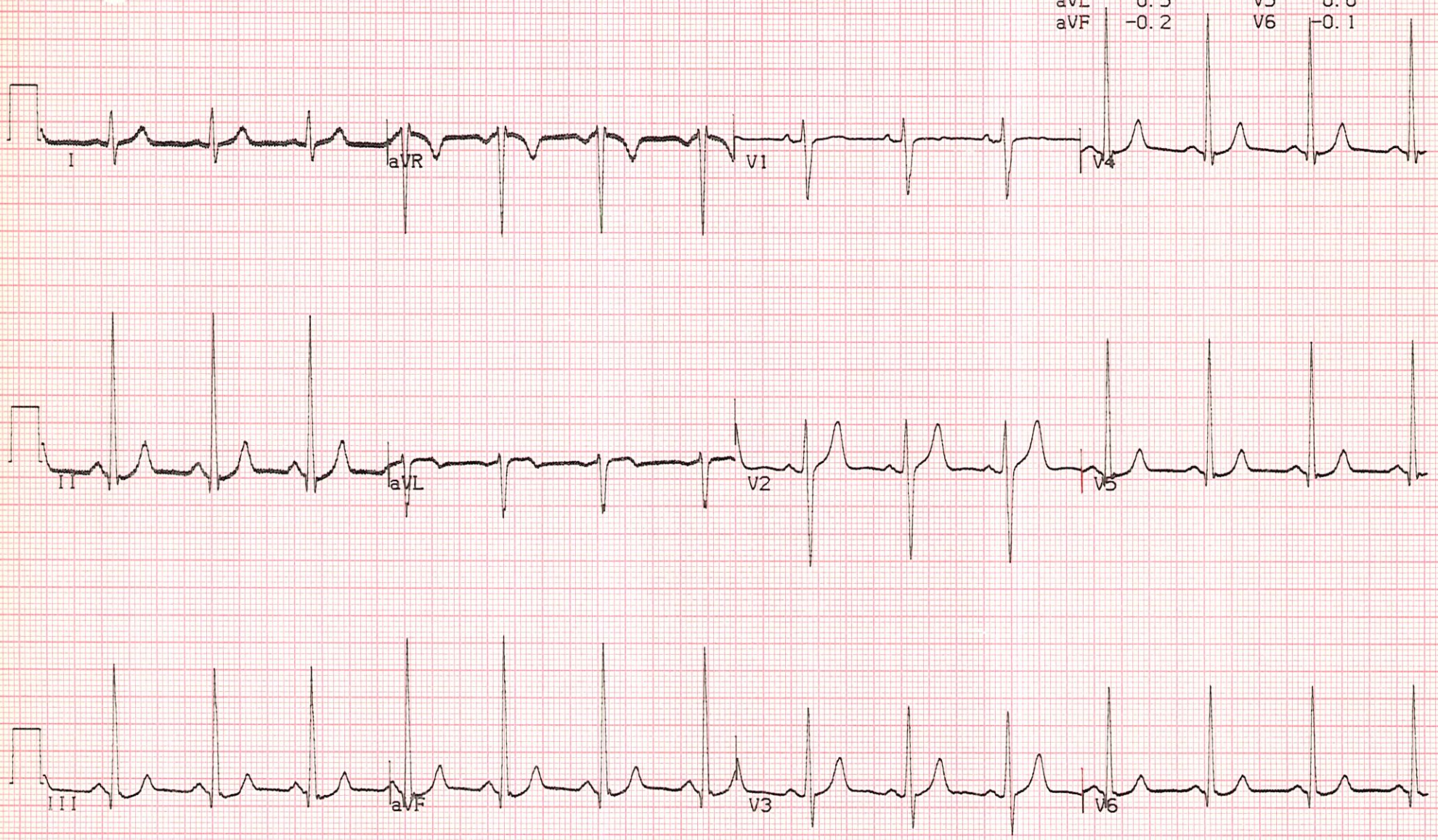
HR: 85bpm
BP: 130/70

Speed: 0.0mph
Grade: 0.0%

NINEWELLS DEPT OF CARDIOLOGY

Measured At 80ms post J ( 10mm/mV)
Auto Points

| Lead | ST(mm) | Lead | ST(mm) |
|---|---|---|---|
| I | 0.8 | V1 | 0.7 |
| II | 0.0 | V2 | 3.1 |
| III | -0.6 | V3 | 2.2 |
| aVR | -0.3 | V4 | 1.1 |
| aVL | 0.5 | V5 | 0.0 |
| aVF | -0.2 | V6 | -0.1 |




82 A- H- S+ F+ 50 Sf23 H442 #4798 CASE 106G

DOLBY REGULAR

Graded Exercise Summary Report

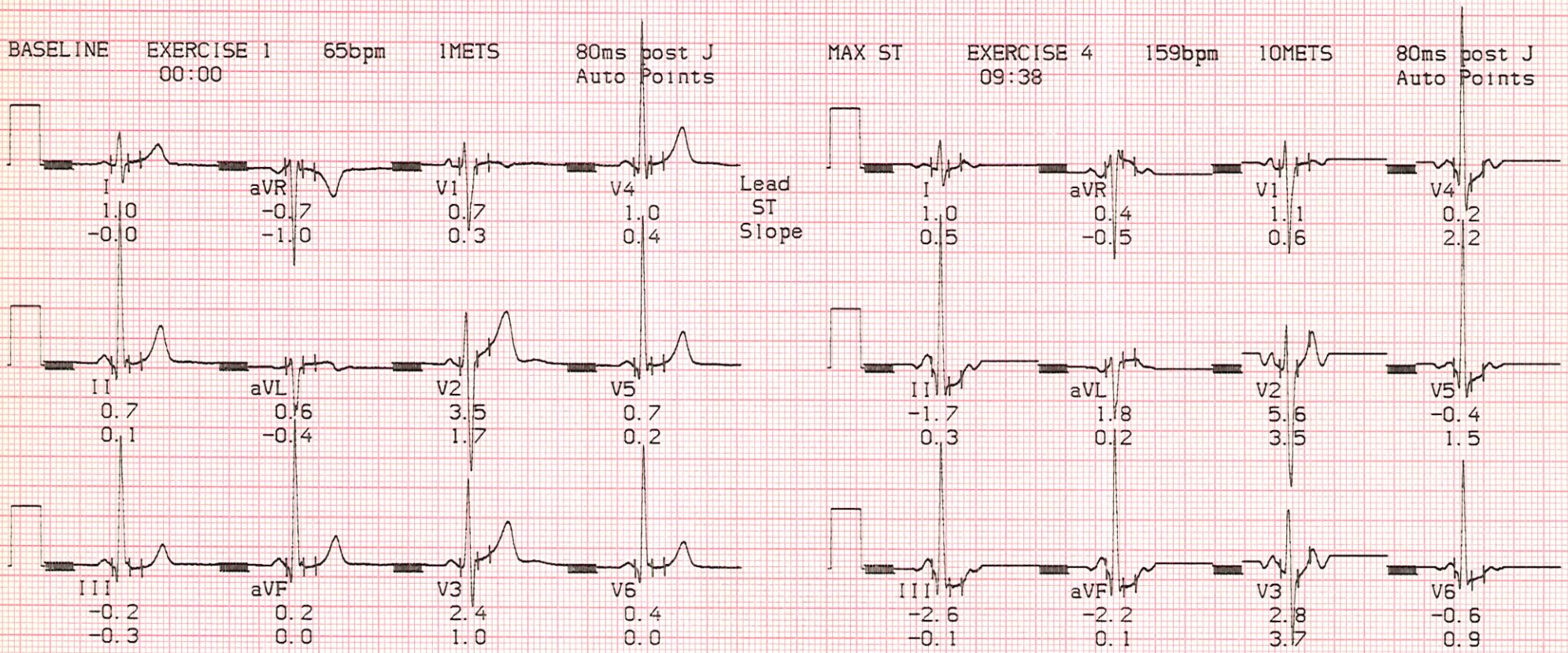
NINEWELLS DEPT OF CARDIOLOGY

STANDISH, DAVID
ID: 0503700053
31yrs Ht: Wt:
Male Cauc
29-JUN-2001
13:59:41

25mm/s
10mm/mV
100Hz

Procedure: BRUCE
DR T PRINGLE
NIL

Exercise Time 12:13
Maximum Heart Rate Attained: 174bpm 92% Maximum Predicted 189bpm
Maximum BP: 170/70
Maximum Workload Attained: 13METS
Reason for Termination:
CLAUDICATION
SL. SOB + TIRED
NO CHEST DISCOMFORT

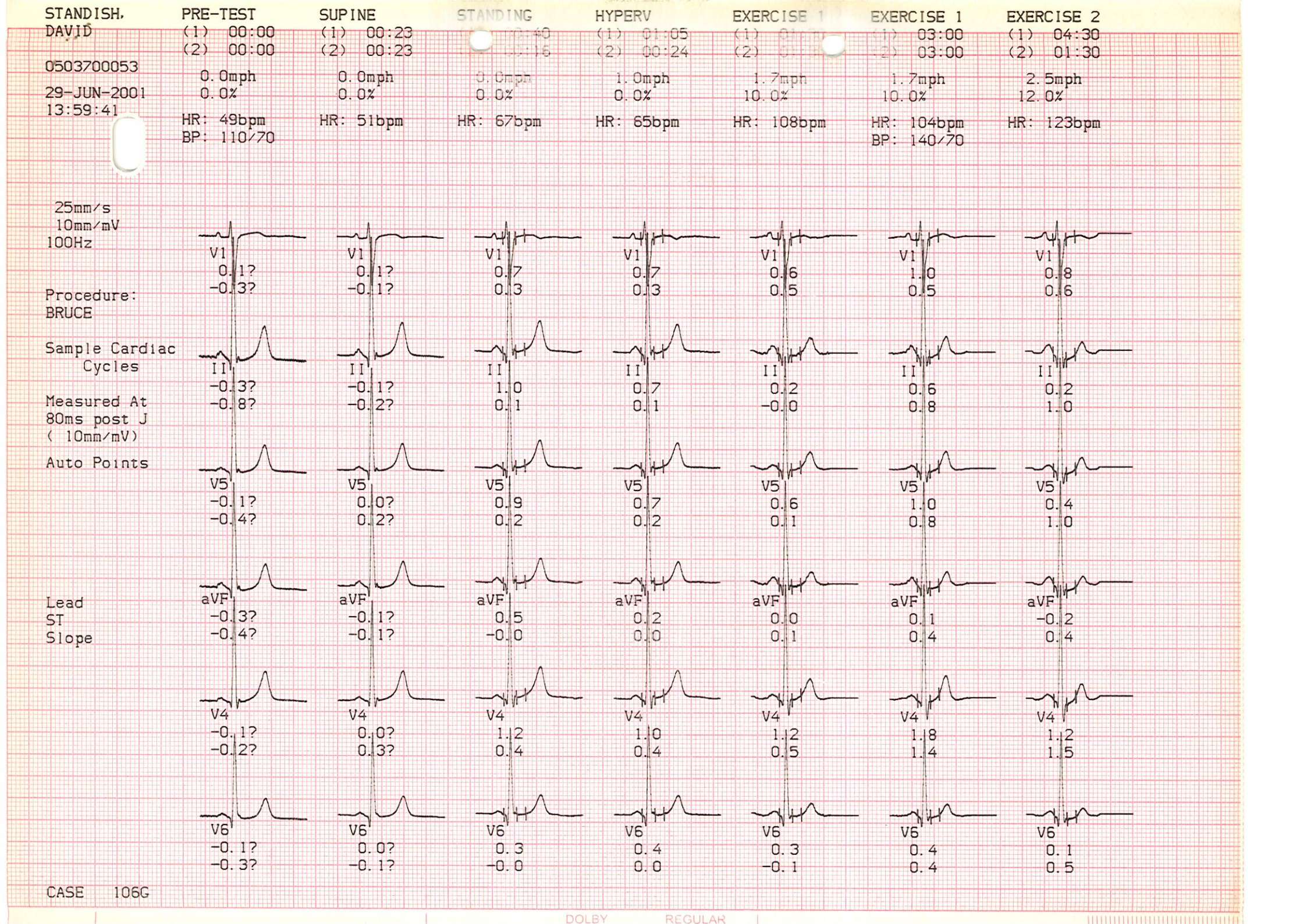



Impressions:

Confirmed By: Date:

CASE 106G

DOLBY REGULAR

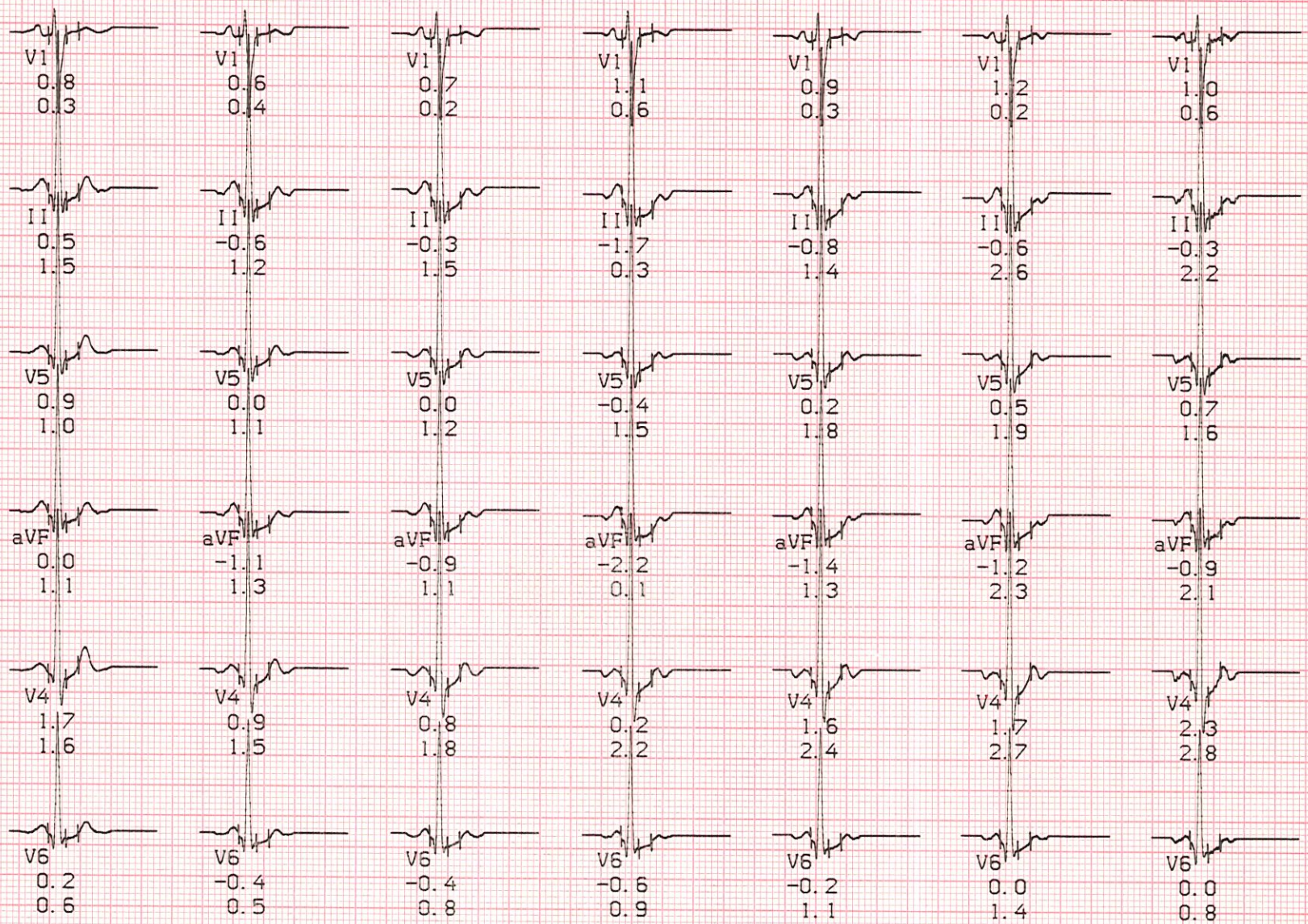

STANDISH, DAVID
0503700053
29-JUN-2001
13:59:41
PRE-TEST (1) 00:00 (2) 00:00
0.0mph 0.0%
HR: 49bpm
BP: 110/70
SUPINE (1) 00:23 (2) 00:23
0.0mph 0.0%
HR: 51bpm
STANDING
0.0mph 0.0%
HR: 67bpm
HYPERV (1) 01:05 (2) 00:24
1.0mph 0.0%
HR: 65bpm
EXERCISE 1
1.7mph 10.0%
HR: 108bpm
EXERCISE 1 (1) 03:00 (2) 03:00
1.7mph 10.0%
HR: 104bpm
BP: 140/70
EXERCISE 2 (1) 04:30 (2) 01:30
2.5mph 12.0%
HR: 123bpm
25mm/s
10mm/mV
100Hz
Procedure:
BRUCE
Sample Cardiac Cycles
Measured At
80ms post J
( 10mm/mV)
Auto Points
Lead
ST
Slope
V1 0.1? -0.3? | V1 0.1? -0.1? | V1 0.7 0.3 | V1 0.7 0.3 | V1 0.6 0.5 | V1 1.0 0.5 | V1 0.8 0.6
II -0.3? -0.8? | II -0.1? -0.2? | II 1.0 0.1 | II 0.7 0.1 | II 0.2 -0.0 | II 0.6 0.8 | II 0.2 1.0
V5 -0.1? -0.4? | V5 0.0? 0.2? | V5 0.9 0.2 | V5 0.7 0.2 | V5 0.6 0.1 | V5 1.0 0.8 | V5 0.4 1.0
aVF -0.3? -0.4? | aVF -0.1? -0.1? | aVF 0.5 -0.0 | aVF 0.2 0.0 | aVF 0.0 0.1 | aVF 0.1 0.4 | aVF -0.2 0.4
V4 -0.1? -0.2? | V4 0.0? 0.3? | V4 1.2 0.4 | V4 1.0 0.4 | V4 1.2 0.5 | V4 1.8 1.4 | V4 1.2 1.5
V6 -0.1? -0.3? | V6 0.0? -0.1? | V6 0.3 -0.0 | V6 0.4 0.0 | V6 0.3 -0.1 | V6 0.4 0.4 | V6 0.1 0.5
CASE 106G
DOLBY REGULAR

STANDISH,
DAVID

0503700053

29-JUN-2001
13:59:41

| EXERCISE 2 | EXERCISE 3 | EXERCISE 3 | EXERCISE 4 | EXERCISE 4 | EXERCISE 4 | EXERCISE 5 |
|---|---|---|---|---|---|---|
| (1) 06:00 | (1) 07:30 | (1) [illegible]:00 | (1) 09:38 | (1) 10:38 | (1) 12:00 | (1) 12:13 |
| (2) 03:00 | (2) 01:30 | [illegible]:00 | (2) 00:38 | (2) 0[illegible] | (2) 03:00 | (2) 00:13 |
| 2.5mph | 3.4mph | 3.4mph | 4.2mph | 4.2mph | 4.2mph | 5.0mph |
| 12.0% | 14.0% | 14.0% | 16.0% | 16.0% | 16.0% | 18.0% |
| HR: 122bpm | HR: 141bpm | HR: 147bpm | HR: 159bpm | HR: 163bpm | HR: 169bpm | HR: 170bpm |
| BP: 140/70 | | BP: 150/70 | | | BP: 150/70 | |




MAX ST

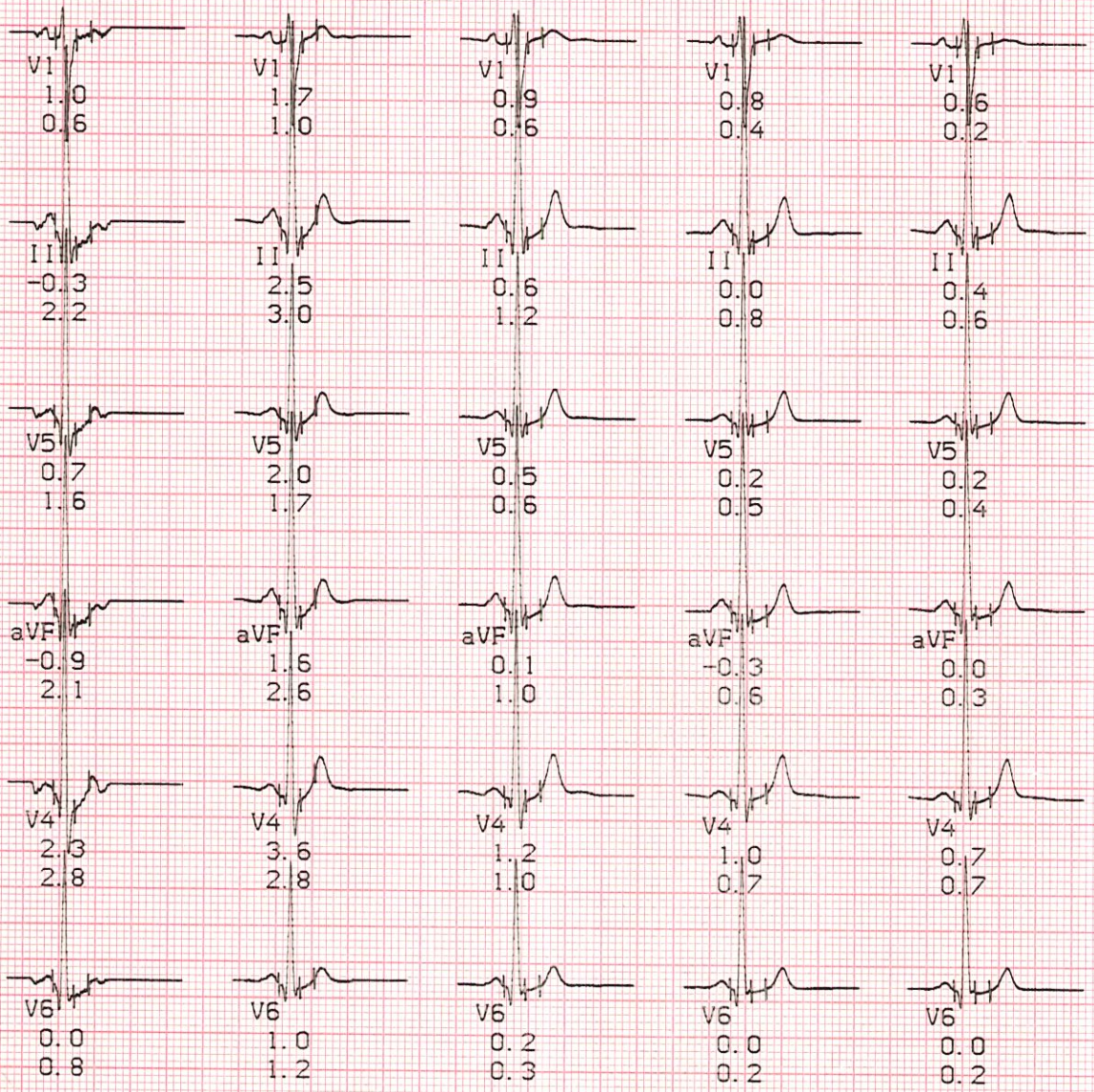
DOLBY REGULAR

STANDISH, DAVID

0503700053

29-JUN-2001
13:59:41

| PEAK EX | RECOVERY | RECOVERY | RECOVERY | RECOVERY |
|---|---|---|---|---|
| (1) 12:13 | (1) 12:13 | (1) 12:13 | (1) 12:13 | (1) 12:13 |
| (2) 00:00 | (2) 01:30 | (2) 03:00 | (2) 04:30 | (2) 05:00 |
| 5.0mph | 0.0mph | 0.0mph | 0.0mph | 0.0mph |
| 18.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| HR: 170bpm | HR: 120bpm | HR: 92bpm | HR: 84bpm | HR: 87bpm |
| | BP: 170/70 | BP: 170/70 | BP: 130/70 | BP: 130/70 |




DOLBY REGULAR

## NHS Tayside: Clinical Report - Ninewells Hospital



**STANDISH, DAVID**
20 CANNING PLACE, DUNDEE, DD3 7RT
Ref. Locn. : **NW UROLOGY OP**
Referrer : **MR A MARTINDALE**

DoB : **05/03/1970**
Hosp. No. :
CRIS No. : **298013**
CHI No. : **0503700053**

**VERIFIED** Verified By : Dr R BHAT 24/04/14
Typed By : MAUS 20/04/14

29 APR 2014

**Clinical History :**

URGENT. Severe left loin pain. In keeping with renal colic. Urgent OP referral from GP as intermittent. May present as emergency if worsens. ?stone ? hydronephrosis
ENTERED BY: Andrew Martindale (Medical)
BLEEP: 4603

4603
21/04/14

**CT Renal Both :**

No evidence of urinary tract calculi on either side. No hydronephrosis or hydroureter.

Event Number E 4394181
Copy To
Examinations : **CT Renal Both**

Examination Date : 16/04/14
Attendance Number : 11

## NHS Tayside: Clinical Report - Ninewells Hospital



**STANDISH, DAVID**
20 CANNING PLACE, DUNDEE, DD3 7RT
Ref. Locn. : **NW 3/4 OUT PATIENTS**
Referrer : **DR JB DICK**

DoB : **05/03/1970**
Hosp. No. :
CRIS No. : **298013**
CHI No. : **0503700053**

**VERIFIED** Verified By : DR RUSSELL DAVIES (MEDICA) 11/06/14
Typed By : RDAVIES 11/06/14

**Clinical History :**

Severe pain right hip and groin
Radiates down front of thigh
Recent back pain
Abnormal gait pattern due to peripheral arterial disease
Recently developed antalgic gait
?evidence of significant OA
ENTERED BY: Colin Baines (medical)
BLEEP: 01382 633883

Severe pain right hip and groin
Radiates down front of thigh

Event Number E-4445440
Copy To
Examinations : **XR Pelvis,XR Lumbar spine**

Examination Date 06/06/14
Attendance Number 13

**STANDISH, DAVID**
20 CANNING PLACE, DUNDEE, DD3 7RT
Ref. Locn. : **NW 3/4 OUT PATIENTS**
Referrer : **DR JB DICK**

DoB : **05/03/1970**
Hosp. No. :
CRIS No. : **298013**
CHI No. : **0503700053**

Recent back pain
Abnormal gait pattern due to peripheral arterial disease
Recently developed antalgic gait
?evidence of significant OA
ENTERED BY: Colin Baines (medical)
BLEEP: 01382 633883

x-ray pelvis.
. Mild bilateral symmetrical osteoarthritis noted
No other significant feature

. X-ray lumbar spine.

Event Number E-4445440
Copy To
Examinations : **XR Pelvis,XR Lumbar spine**

Examination Date 06/06/14
Attendance Number 13



**STANDISH, DAVID**
20 CANNING PLACE, DUNDEE, DD3 7RT
Ref. Locn. : **NW 3/4 OUT PATIENTS**
Referrer : **DR JB DICK**

DoB : **05/03/1970**
Hosp. No. :
CRIS No. : **298013**
CHI No. : **0503700053**

lumbar spine demonstrates normal appearances

Event Number E-4445440
Copy To
Examinations : **XR Pelvis,XR Lumbar spine**

Examination Date 06/06/14
Attendance Number 13

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Surveillance Scan
**Date of study :** 16/03/2012

**Consultant:** Mr G Griffiths
Vascular OUT-patients
Ward 12
Ninewells Hospital

**Referral details:** Routine surveillance - 1 yr post right CFA endarterectomy with vein patch and right SFA angioplasty

**Report:** The endarterectomy site is widely patent, good runoff with triphasic flow in the proximal SFA. Next review March 2013

RAL

**end of report**


Authorised: 21/03/2012 11:51 RAR

Date of study : 16/03/2012

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Segmental Pressures
**Date of study :** 16/03/2012

**Consultant:** Mr G Griffiths
Vascular OUT-patients
Ward 12
Ninewells Hospital

**Referral details:** Routine surveillance - 1 yr post right CFA endarterectomy with vein patch and right SFA angioplasty

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 110 | 102 |
| Posterior Tibial | 118 | 74 |
| Dorsalis Pedis | 104 | 56 |
| Ankle/Brachial Pressure Index | 1.07 | 0.67 |

| Post-Exercise Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 132 | |
| Ankle | 52 | 32 |
| Ankle/Brachial Pressure Index | 0.39 | 0.24 |

**Exercise Test**
Treadmill speed: 4 Kph Inclination: 10.0 %
Treadmill time: 01:00

**Report:** Scan report attached.
Follow up appointment to be made for March 2013.

SMc/ MMcC

**Previous results:**

| Date | Right Ankle | Left Ankle | Right ABPI | Left ABPI |
|---|---|---|---|---|
| 11/08/2011 | 140 | 90 | 1.04 | 0.67 |
| 24/06/2011 | 112 | 70 | 0.86 | 0.61 |
| 10/05/2011 | 120 | 70 | 0.95 | 0.55 |
| 09/03/2011 | 136 | 90 | 1.17 | 0.77 |
| 18/05/2010 | 70 | 64 | 0.56 | 0.51 |


Authorised: 21/03/2012 11:51 RAR

Date of study : 16/03/2012

STANDISH, DAVID
9 MANSION DRIVE, DUNDEE, DD4 9DD
Ref. Locn. : NW 3/4 OUT PATIENTS
Referrer : DR JB DICK

DoB : 05/03/1970
Hosp. No. :
CRIS No. : 298013
CHI No. : 0503700053

**VERIFIED** Verified By : Dr J DAVIDSON 08/11/10
Typed By : 08/11/10

**NM MPS MIBI/Tf stress gated :**

CLINICAL INDICATION:
Premature arteriopath. Atypical chest pain. PVD precludes ETT.

CARDIAC STRESS DATA:
Dipyridamole was infused at 0.56 mg/kg over 4 minutes followed by 2 minutes isometric arm exercise
Pulse 57 bpm - 90 bpm
BP 112/65 - 132/70

MAGING DESCRIPTION:
Tracer uptake in the myocardium of the left ventricle is within normal limits on both the stress

Event Number : E-3334716
Copy To : ,
Examinations : NM MPS MIBI/Tf stress gated

Examination Date : 27/10/10
Attendance Number : 6



STANDISH, DAVID
9 MANSION DRIVE, DUNDEE, DD4 9DD
Ref. Locn. : NW 3/4 OUT PATIENTS
Referrer : DR JB DICK

DoB : 05/03/1970
Hosp. No. :
CRIS No. : 298013
CHI No. : 0503700053

and resting images.

CONCLUSION:
No evidence of fixed or inducible ischaemia of the myocardium of the left ventricle.

Event Number : E-3334716
Copy To : ,
Examinations : NM MPS MIBI/Tf stress gated

Examination Date : 27/10/10
Attendance Number : 6

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Surveillance Scan
**Date of study :** 24/06/2011

**Consultant:** Mr G Griffiths
Vascular OUT-patients
Ward 12
Ninewells Hospital

**Referral details:** Routine surveillance - patient asked for early review, some groin swelling

**Report:** The endarterectomy site is widely patent with triphasic flow. Spontaneous phasic flow in the femoral veins right groin. The site of swelling was examined, no abnormality seen.

RAL

**end of report**


Authorised: 27/06/2011 13:24 RAL

Date of study : 24/06/2011

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Segmental Pressures
**Date of study :** 24/06/2011

**Consultant:** Mr G Griffiths
Vascular OUT-patients
Ward 12
Ninewells Hospital

**Referral details:** Routine surveillance - patient asked for early review, some groin swelling

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 130 | 122 |
| Posterior Tibial | 112 | 080 |
| Dorsalis Pedis | 112 | 70 |
| Ankle/Brachial Pressure Index | 0.86 | 0.61 |

| Post-Exercise Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 136 | |
| Ankle | 114 | 38 |
| Ankle/Brachial Pressure Index | 0.83 | 0.27 |

**Exercise Test**
Treadmill speed: 4 Kph Inclination: 10.0 %
Treadmill time: 01:00

**Report:** Strong pedal signals.
Scan report attached.
Follow up appointment to be made for 3/12.

SMc

**Previous results:**

| Date | Right Ankle | Left Ankle | Right ABPI | Left ABPI |
|---|---|---|---|---|
| 10/05/2011 | 120 | 70 | 0.95 | 0.55 |
| 09/03/2011 | 136 | 90 | 1.17 | 0.77 |
| 18/05/2010 | 70 | 64 | 0.56 | 0.51 |

**end of report**


Authorised: 27/06/2011 13:24 RAL

Date of study : 24/06/2011

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Surveillance Scan
**Date of study :** 11/08/2011

**Consultant:** Mr G Griffiths
Vascular OUT-patients
Ward 12
Ninewells Hospital

**Referral details:** Routine surveillance- 5/12 post right CFA endarterectomy and vein patch and right SFA angioplasty

**Report:** The right CFA is widely patent with triphasic flow demonstrated.
Patient continues to c/o groin swelling, no obvious abnormalitiy detected.

DM

**end of report**


Authorised: 11/08/2011 13:47 RAL

Date of study : 11/08/2011

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Segmental Pressures
**Date of study :** 11/08/2011

**Consultant:** Mr G Griffiths
Vascular OUT-patients
Ward 12
Ninewells Hospital

**Referral details:** Routine surveillance- 5/12 post right CFA endarterectomy and vein patch and right SFA angioplasty

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 134 | 128 |
| Posterior Tibial | 140 | 90 |
| Dorsalis Pedis | 128 | 82 |
| Ankle/Brachial Pressure Index | 1.04 | 0.67 |

| Post-Exercise Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 150 | |
| Ankle | 92 | 52 |
| Ankle/Brachial Pressure Index | 0.61 | 0.34 |

**Exercise Test**
Treadmill speed: 4 Kph Inclination: 10.0 %
Treadmill time: 01:00

**Report:** Right groin swelling still evident. Patient describing left leg claudication.
Follow up appointment to be made for February 2012

MMcC / SMc

**Previous results:**

| Date | Right Ankle | Left Ankle | Right ABPI | Left ABPI |
|---|---|---|---|---|
| 24/06/2011 | 112 | 70 | 0.86 | 0.61 |
| 10/05/2011 | 120 | 70 | 0.95 | 0.55 |
| 09/03/2011 | 136 | 90 | 1.17 | 0.77 |
| 18/05/2010 | 70 | 64 | 0.56 | 0.51 |

**end of report**


Authorised: 11/08/2011 13:47 RAL

Date of study : 11/08/2011

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**HI No.:** 050370/0053
**tient Name:** STANDISH, David
**vestigation :** Surveillance Scan
**te of study :** 10/05/2011

**Consultant:** Mr G Griffiths
Vascular OUT-patients
Ward 12
Ninewells Hospital

**ferral details:** Routine surveillance -2/12 post right CFA endarterectomy + Vein scan for possible bypass.

**port:** Right side: the CFA is widely patent with strong triphasic flow, no significant disease seen. Minimally vated velocities in the SFA at previous angioplasty site (distal thigh).

patient reports no problems regarding his right leg. Next follow up in 3/12.

**of report**


ised: 10/05/2011 16:45 RAL

Date of study : 10/05/2011


## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)


**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Vein Scan
**Date of study :** 10/05/2011

**Consultant:** Mr G Griffiths
Vascular OUT-patients
Ward 12
Ninewells Hospital

**Referral details:** Routine surveillance -2/12 post right CFA endarterectomy + Vein scan for possible bypass.

| | Right | Left |
|---|---|---|
| **Scan site:** | Lower limb | Lower limb |

**Report:** The right LSV is >3mm in calibre from the groin to the mid / lower thigh but reduces in size distally. The left LSV is small calibre proximally but becomes reasonable calibre (>3mm) from the mid thigh to knee level. Both SSVs are reasonable calibre if composite considered.

SS.

**end of report**


ıthorised: 10/05/2011 16:45 RAL

Date of study : 10/05/2011

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Segmental Pressures
**Date of study :** 10/05/2011

**Consultant:** Mr G Griffiths
Vascular OUT-patients
Ward 12
Ninewells Hospital

**Referral details:** Routine surveillance -2/12 post right CFA endarterectomy + Vein scan for possible bypass.

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 124 | 126 |
| Posterior Tibial | 120 | 70 |
| Dorsalis Pedis | 112 | 60 |
| Ankle/Brachial Pressure Index | 0.95 | 0.55 |

| Post-Exercise Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 126 | |
| Ankle | 60 | 34 |
| Ankle/Brachial Pressure Index | 0.47 | 0.26 |

**Exercise Test**
Treadmill speed: 4 Kph Inclination: 10.0 %
Treadmill time: 01:00

**Report:** Scan report attached.
Follow up appointment to be made for 6/52.

SMc/ MMcC

**Previous results:**

| Date | Right Ankle | Left Ankle | Right ABPI | Left ABPI |
|---|---|---|---|---|
| 09/03/2011 | 136 | 90 | 1.17 | 0.77 |
| 18/05/2010 | 70 | 64 | 0.56 | 0.51 |

**end of report**


Authorised: 10/05/2011 16:45 RAL

Date of study : 10/05/2011

Hopper
20/4/11

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Vein Scan
**Date of study :** 09/03/2011

**Consultant:** Mr J Nagy
Vascular OUT-patients
Ward 12
Ninewells Hospital

**Referral details:** Out - patient referral, seen from SOPD. On routine surveillance post right CFA endarterectomy. Swollen and painful right leg, ?DVT.

| | Right | Left |
|---|---|---|
| **Scan site:** | Lower limb | Not examined |

**Report:** The right femoro popliteal segment is widely patent with spontaneous phasic flow, no evidence of DVT seen.

PF

**end of report**


Authorised: 11/03/2011 15:01 RAL

Date of study : 09/03/2011

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Surveillance Scan
**Date of study :** 09/03/2011

**Consultant:** Mr J Nagy
Vascular OUT-patients
Ward 12
Ninewells Hospital

**Referral details:** Out - patient referral, seen from SOPD. On routine surveillance post right CFA endarterectomy. Swollen and painful right leg, ?DVT.

**Report:** The right CFA is widely patent with triphasic flow.
Next follow up to be arranged for May'11.

PF

**end of report**


Authorised: 11/03/2011 15:01 RAL

Date of study : 09/03/2011

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Segmental Pressures
**Date of study :** 09/03/2011

**Consultant:** Mr J Nagy
Vascular OUT-patients
Ward 12
Ninewells Hospital

**Referral details:** Out - patient referral, seen from SOPD. On routine surveillance post right CFA endarterectomy. Swollen and painful right leg, ?DVT.

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 116 | 116 |
| Posterior Tibial | 136 | 90 |
| Dorsalis Pedis | 130 | 88 |
| Ankle/Brachial Pressure Index | 1.17 | 0.77 |

| Post-Exercise Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 134 | |
| Ankle | 128 | 88 |
| Ankle/Brachial Pressure Index | 0.95 | 0.65 |

**Exercise Test**
Treadmill speed: 2 Kph Inclination: 10.0 %
Treadmill time: 02:00

**Report:** Scan reports attached
Reduced exercise at patient request - finds it difficult to walk faster due to right ankle pain
Follow up appointment to be made for May 2011

MMcC / SMc / PF

**Previous results:**

| Date | Right Ankle | Left Ankle | Right ABPI | Left ABPI |
|---|---|---|---|---|
| 18/05/2010 | 70 | 64 | 0.56 | 0.51 |

**end of report**


Authorised: 11/03/2011 15:01 RAL

Date of study : 09/03/2011

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Segmental Pressures
**Date of study :** 09/03/2011

**Consultant:** Mr J Nagy
Vascular OUT-patients
Ward 12
Ninewells Hospital

**Referral details:** Out - patient referral, seen from SOPD. On routine surveillance post right CFA endarterectomy. Swollen and painful right leg, ?DVT.

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 116 | 116 |
| Posterior Tibial | 136 | 90 |
| Dorsalis Pedis | 130 | 88 |
| Ankle/Brachial Pressure Index | 1.17 | 0.77 |

| Post-Exercise Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 134 | |
| Ankle | 128 | 88 |
| Ankle/Brachial Pressure Index | 0.95 | 0.65 |

**Exercise Test**
Treadmill speed: 2 Kph Inclination: 10.0 %
Treadmill time: 02:00

**Report:** Scan reports attached
Reduced exercsie at patinet request - finds it difficult to walk faster due to right ankle pain
Follow up appointment to be made for May 2011

MMcC / SMc / PF

**Previous results:**

| Date | Right Ankle | Left Ankle | Right ABPI | Left ABPI |
|---|---|---|---|---|
| 18/05/2010 | 70 | 64 | 0.56 | 0.51 |

**end of report**

UN



## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Surveillance Scan
**Date of study :** 09/03/2011

**Consultant:** Mr J Nagy
Vascular OUT-patients
Ward 12
Ninewells Hospital

**Referral details:** Out - patient referral, seen from SOPD. On routine surveillance post right CFA endarterectomy. Swollen and painful right leg, ?DVT.

**Report:** The right CFA is widely patent with triphasic flow.
Next follow up to be arranged for May'11.

PF

**end of report**

VN —

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Vein Scan
**Date of study :** 09/03/2011

**Consultant:** Mr J Nagy
Vascular OUT-patients
Ward 12
Ninewells Hospital

**Referral details:** Out - patient referral, seen from SOPD. On routine surveillance post right CFA endarterectomy. Swollen and painful right leg, ?DVT.

| | Right | Left |
|---|---|---|
| **Scan site:** | Lower limb | Not examined |

**Report:** The right femoro popliteal segment is widely patent with spontaneous phasic flow, no evidence of DVT seen.

PF

**end of report**

02



## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Surveillance Scan
**Date of study :** 15/02/2011

**Consultant:** Mr G Griffiths
Vascular IN patient
Ward 12
Ninewells Hospital

**Referral details:** Inpatient on ward 12 - post right CFA endarterectomy with vein patch and angioplasty of distal SFA stenosis

**Report:** The femoral endarterectomy site is widely patent. Triphasic flow in the SFA, mild disease at the plasty site in the lower thigh, no significant residual stenosis seen.
ABPIs were not performed - vein harvesting site lower calf.
Next review in 6 weeks.

RAL

**end of report**

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Surveillance Scan
**Date of study :** 15/02/2011

**Consultant:** Mr G Griffiths
Vascular IN patient
Ward 12
Ninewells Hospital

**Referral details:** Inpatient on ward 12 - post right CFA endarterectomy with vein patch and angioplasty of distal SFA stenosis

**Report:** The femoral endarterectomy site is widely patent. Triphasic flow in the SFA, mild disease at the plasty site in the lower thigh, no significant residual stenosis seen.
ABPIs were not performed - vein harvesting site lower calf.
Next review in 6 weeks.

RAL

**end of report**


Authorised: 15/02/2011 17:19 RAL

Date of study : 15/02/2011

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Artery Scan
**Date of study :** 19/07/2010

**Consultant:** Mr J Nagy
Vascular OUT-patients
Ward 12
Ninewells Hospital

**Referral details:** Out-patient referral - bilateral claudication reduced ABPI

| | Right | Left |
|---|---|---|
| Aorto/Iliac Segment | See report text | See report text |
| Femoro/Popliteal Segment | See report text | See report text |
| Runoff | See report text | See report text |

**Report:** Normal calibre aorta. No significant aorto iliac disease.
Right leg. significant stenosis of the distal CFA extending to involve the origin of the PFA. The proximal SFA is patent there is however a 6 cm occlusion at the level of the adductor. The popliteal is patent and there is continuity to cross the ankle.
Left leg: CFA and PFA are patent. The SFA is occluded with reconstitution at the level of the adductor. The popliteal is patent and there is continuity to cross the ankle. Patient is only complaining of claudication therefore the LSVs were not assessed for possible bypass.

RAR (ET)

**end of report**


Authorised: 21/07/2010 08:06 RAL

Date of study : 19/07/2010

NP

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053
**Patient Name:** STANDISH, David
**Investigation :** Segmental Pressures
**Date of study :** 18/05/2010

**Consultant:** Consultant Vascular Surgeon
Ward 12
Ninewells Hospital

**Referral details:** Out-patient referral - RTM - Bilateral claudication right > left

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 124 | 120 |
| Posterior Tibial | 70 | 64 |
| Dorsalis Pedis | 56 | 64 |
| Ankle/Brachial Pressure Index | 0.56 | 0.51 |

| Post-Exercise Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 128 | |
| Ankle | 40 | 26 |
| Ankle/Brachial Pressure Index | 0.31 | 0.20 |

**Exercise Test**
Treadmill speed: 4 Kph Inclination: 10.0 %
Treadmill time: 01:00

**Report:** Monophasic pedal waveforms bilaterally
Patient clearly describing right > left IC with right great toe becoming numb - this is not supported by the ABPIs.

MMcC*

**Previous results:**
No previous results held
**end of report**

Page 1 of 1
Authorised: 19/05/2010 09:40 RAL

Date of study : 18/05/2010

TC1 13/2

## NHS Tayside: Clinical Report - Ninewells Hospital

Page 1 of 1

**STANDISH, DAVID**
9 MANSION DRIVE, DUNDEE, DD4 9DD
Ref. Locn. : **NW AREA 5, SURGICAL**
Referrer : **MR GD GRIFFITHS**

DoB : **05/03/1970**
Hosp. No. :
CRIS No. : **298013**
CHI No. : **0503700053**

**VERIFIED** Verified By : DR KATRIN BRAUER 07/02/11
Typed By : MCAS 07/02/11

**XR Chest**

No previous chest radiographs for comparison. Cardiac and mediastinal outlines are normal. Background changes compatible with COPD, the lungs are otherwise clear.

KB

Event Number : E-3432176
Copy To : ,
Examinations : **XR Chest**

Examination Date : **03/02/11**
Attendance Number : 8

**STANDISH, DAVID**
9 MANSION DRIVE, DUNDEE, DD4 9DD
Ref. Locn. : **NW WARD 12**
Referrer : **DR J NAGY**

DoB : **05/03/1970**
Hosp. No. :
CRIS No. : **298013**
CHI No. : **0503700053**

**VERIFIED** Verified By : DR I ZEALLEY 15/10/10
Typed By : MCAS 15/10/10

**MRA Lower limb Both**

Distal aorta normal calibre.

In the RIGHT, iliacs are good but there is an eccentric plaque in the CFA (corresponding to the stenosis identified at duplex). PFA good but there is a short (1cm) stenosis/occlusion in the distal SFA. Below this the popliteal and calf run-off is good.

On the LEFT, iliacs, CFA and PFA all good. the SFA is occluded at its origin, reforming in the adductor canal via collaterals. Below this the POPA and calf run-off is good.

On the right the dominant (treatable) lesions are the SFA stenosis and short CFA stenosis/occlusion. These should be amenable to combine surgical/endovascular procedure.

Event Number : E-3342861
Copy To : ,
Examinations : **MRA Lower limb Both**

Examination Date : **14/10/10**
Attendance Number : 4



**STANDISH, DAVID**
9 MANSION DRIVE, DUNDEE, DD4 9DD
Ref. Locn. : **NW WARD 12**
Referrer : **DR J NAGY**

DoB : **05/03/1970**
Hosp. No. :
CRIS No. : **298013**
CHI No. : **0503700053**

On the left the dominant lesion is the long SFA occlusion.

IZ

Event Number : E-3342861
Copy To : ,
Examinations : **MRA Lower limb Both**

Examination Date : **14/10/10**
Attendance Number : 4

**STANDISH, DAVID**
9 MANSION DRIVE, DUNDEE, DD4 9DD
Ref. Locn. : **NW VAS SURG SEC (WD12)**
Referrer : **UNKNOWN CONSULTANT**

DoB : **05/03/1970**
Hosp. No. :
CRIS No. : **298013**
CHI No. : **0503700053**

**VERIFIED** Verified By : Dr R BHAT 21/10/10
Typed By : DAWS 20/10/10

**MDM MEETING :**

Referring Clinician: Mr Nagy

Date of Procedure: 14th October

Procedure/Indication: MR angiogram for claudication.

Clinical Background: Bilateral calf claudication.

Management Plan/Results of Intervention: Requires vascular medical referral. Could have a right common femoral endarterectomy and superficial femoral angioplasty at the same time in theatre. The left would require a femoro-popliteal bypass if appropriate.

Event Number : E-3360484
Copy To : ,
Examinations : **MDM MEETING**

Examination Date : **20/10/10**
Attendance Number : 5



**STANDISH, DAVID**
9 MANSION DRIVE, DUNDEE, DD4 9DD
Ref. Locn. : **NW VAS SURG SEC (WD12)**
Referrer : **UNKNOWN CONSULTANT**

DoB : **05/03/1970**
Hosp. No. :
CRIS No. : **298013**
CHI No. : **0503700053**

Follow-up: Angio review clinic.

GDG

Event Number : E-3360484
Copy To : ,
Examinations : **MDM MEETING**

Examination Date : **20/10/10**
Attendance Number : 5

## Scottish Molecular Genetics Consortium

**Human Genetics, Dept of Pathology, Ninewells Hospital, Dundee**

**Telephone: 01382 632035, Fax: 01382 496382**


**Pedigree no:** MG102838 **Report no:** 35972 

**Report to:** Dr Griffiths
Coagulation Clinic
Ninewells Hospital
Dundee
Tayside DD1 9SY

**Your ref:** H100481007

**Date printed** 12/07/2010

**Name:** **David Standish** **D.O.B.** **05/03/1970** **MPI** 0053

**Investigations relating to:** Thrombophilia

**Reason for request:** None given.

***Negative for the p.Arg506Gln and g.20210G->A mutations***

| Name | DOB | Sample | Tissue | Test | Result |
|---|---|---|---|---|---|
| David Standish | 05/03/1970 | 102838A | Blood / Citrate | Thromb/ARMS | p.Arg506Gln/g.20210G>A not detected |

**Last sample received on:** 29/06/2010

**Comment:**

A DNA sample from this patient has been screened for the p.Arg506Gln mutation (previously referred to as p.R506Q) in the factor V gene, in addition to the g.20210G->A mutation in the prothrombin gene. Both mutations are associated with an increased risk of venous thrombosis.

David Standish does not carry either of these mutations.

Dorothy Mechan
**Clinical Scientist**

**Nicola Joy PhD**
**MTO2**

Gel/batch nos. 101008 Worksheet nos. 10/2467

Copies to: MG Lab

MOUNT SHEET

Note: Remove strip to reveal gummed area.
Attach reports from bottom to top.
Please set them accurately.

JB-8267

HAEMATOLOGY

12

11

# HAEMATOLOGY

DMR292

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

N/W Ward 12 — Clinician: Mr G.D. GRIFFITHS — Lab No: H116335999 N12 GRIG1H

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| HGB | 12.1 | L g/dL | ( 13.0-18.0 ) | WBC | 11.6 | H x10^9/L | ( 4.0-11.0 ) |
| RBC | 3.90 | L x10^12/l | ( 4.5-6.0 ) | NE# | 7.6 | H x10^9/l | ( 2.0-7.5 ) |
| HCT | 0.362 | L | ( 0.40-0.52 ) | LY# | 2.7 | x10^9/l | ( 1.5-4.0 ) |
| MCV | 92.8 | fl | ( 80-96 ) | MO# | 1.1 | H x10^9/l | ( 0.2-0.8 ) |
| MCH | 31.0 | pg | ( 27-32 ) | EO# | 0.16 | x10^9/l | ( 0.0-0.4 ) |
| MCC | 33.4 | g/dl | ( 32-36 ) | BA# | 0.0 | x10^9/l | ( 0.0-0.1 ) |
| | | | | PLT | 292 | x10^9/L | ( 150-400 ) |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
15 Feb 2011 07:47

Clin.Details: right fem endarterectomy

Request Entered: 15 Feb 2011 13:00 — Report Printed: 15 Feb 2011 13:23

REPORT RECEIVED
DOCTOR'S INITIALS
REPORT RECEIVED
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REPORT RECEIVED
DOCTOR'S INITIALS

# HAEMATOLOGY

DMR292

TCI

Tayside Clinical Laboratory Services

Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David

Sex: M PID: 0503700053

DoB: 05 Mar 1970

N/W Ward 12 Outpatients

Clinician: Mr G.D. GRIFFITHS

Lab No: H110418592

N12OP GRIG1H

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| HGB | 13.5 | g/dL | ( 13.0-18.0 ) | WBC | 10.1 | x10^9/L | ( 4.0-11.0 ) |
| RBC | 4.29 | L x10^12/l | ( 4.5-6.0 ) | NE# | 6.2 | x10^9/l | ( 2.0-7.5 ) |
| HCT | 0.403 | | ( 0.40-0.52 ) | LY# | 2.9 | x10^9/l | ( 1.5-4.0 ) |
| MCV | 93.9 | fl | ( 80-96 ) | MO# | 0.7 | x10^9/l | ( 0.2-0.8 ) |
| MCH | 31.5 | pg | ( 27-32 ) | EO# | 0.29 | x10^9/l | ( 0.0-0.4 ) |
| MCC | 33.5 | g/dl | ( 32-36 ) | BA# | 0.1 | x10^9/l | ( 0.0-0.1 ) |
| | | | | PLT | 374 | x10^9/L | ( 150-400 ) |

| | | | |
|---|---|---|---|
| APTT | 22.7 | secs. | ( 22-30 ) |
| APTT Ratio | 0.9 | | |
| Prothrombin Time | 11.3 | secs. | ( 9-12 ) |
| PT Ratio: | 1.1 | | |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
03 Feb 2011 11:30

Clin.Details: PRE OP

Request Entered: 03 Feb 2011 12:57

Report Printed: 03 Feb 2011 14:18

REPORT RECEIVED

DOCTOR'S INITIALS

DOCTOR'S INITIALS

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REPORT RECEIVED

DOCTOR'S INITIALS

# HAEMATOLOGY

DMR292

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

N/W Wards ~~3 & 4~~ Outpatients — Clinician: - NOT GIVEN — Lab No: H100481007 N3/4OP NG

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| HGB | 14.6 | g/dL | ( 13.0-18.0 ) | WBC | 9.8 | x10^9/L | ( 4.0-11.0 ) |
| RBC | 4.58 | x10^12/l | ( 4.5-6.0 ) | NE# | 6.5 | x10^9/l | ( 2.0-7.5 ) |
| HCT | 0.429 | | ( 0.40-0.52 ) | LY# | 2.3 | x10^9/l | ( 1.5-4.0 ) |
| MCV | 93.7 | fl | ( 80-96 ) | MO# | 0.7 | x10^9/l | ( 0.2-0.8 ) |
| MCH | 31.9 | pg | ( 27-32 ) | EO# | 0.28 | x10^9/l | ( 0.0-0.4 ) |
| MCC | 34.0 | g/dl | ( 32-36 ) | BA# | 0.0 | x10^9/l | ( 0.0-0.1 ) |
| | | | | PLT | 341 | x10^9/L | ( 150-400 ) |

| | | | |
|---|---|---|---|
| APTT | 24.1 | secs. | ( 22-30 ) |
| APTT Ratio | 0.9 | | |
| Fibrinogen (Clauss) | 2.9 | g/l | ( 1.5-4.0 ) |
| Prothrombin Time | 11.4 | secs. | ( 9-12 ) |
| PT Ratio: | 1.1 | | |

Lab.Comments:

Sample Date/Time
25 Jun 2010 AM

Clin.Details: UNREADABLE

Request Entered: 25 Jun 2010 11:19 — Report Printed: 25 Jun 2010 12:12

REPORT RECEIVED
DOCTOR'S INITIALS
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DOCTOR'S INITIALS
REPORT RECEIVED
DOCTOR'S INITIALS

# HAEMATOLOGY

DMR292

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

Lab No: H100481007

N/W Wards ~~3 & 4~~ Outpatients — Clinician: - NOT GIVEN — N3/4OP NG

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| HGB | 14.6 | g/dL | ( 13.0-18.0 ) | WBC | 9.8 | x10^9/L | ( 4.0-11.0 ) |
| RBC | 4.58 | x10^12/l | ( 4.5-6.0 ) | NE# | 6.5 | x10^9/l | ( 2.0-7.5 ) |
| HCT | 0.429 | | ( 0.40-0.52 ) | LY# | 2.3 | x10^9/l | ( 1.5-4.0 ) |
| MCV | 93.7 | fl | ( 80-96 ) | MO# | 0.7 | x10^9/l | ( 0.2-0.8 ) |
| MCH | 31.9 | pg | ( 27-32 ) | EO# | 0.28 | x10^9/l | ( 0.0-0.4 ) |
| MCC | 34.0 | g/dl | ( 32-36 ) | BA# | 0.0 | x10^9/l | ( 0.0-0.1 ) |
| | | | | PLT | 341 | x10^9/L | ( 150-400 ) |

| | | | |
|---|---|---|---|
| PV | 1.65 | mPa.s. | ( 1.5-1.72 ) |
| APTT | 24.1 | secs. | ( 22-30 ) |
| APTT Ratio | 0.9 | | |
| Fibrinogen (Clauss) | 2.9 | g/l | ( 1.5-4.0 ) |
| Prothrombin Time | 11.4 | secs. | ( 9-12 ) |
| PT Ratio: | 1.1 | | |

Lab.Comments:

Sample Date/Time
25 Jun 2010 AM

Clin.Details: UNREADABLE

Request Entered: 25 Jun 2010 11:19 — Report Printed: 25 Jun 2010 12:43

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# HAEMATOLOGY

DMR292

Tayside Clinical Laboratory Services

Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David

Sex: M PID: 0503700053

DoB: 05 Mar 1970

Lab No: H100481007

N3/4OP NG

N/W Wards 3 & 4 Outpatients

Clinician: - NOT GIVEN

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| HGB | 14.6 | g/dL | ( 13.0-18.0 ) | WBC | 9.8 | x10^9/L | ( 4.0-11.0 ) |
| RBC | 4.58 | x10^12/l | ( 4.5-6.0 ) | NE# | 6.5 | x10^9/l | ( 2.0-7.5 ) |
| HCT | 0.429 | | ( 0.40-0.52 ) | LY# | 2.3 | x10^9/l | ( 1.5-4.0 ) |
| MCV | 93.7 | fl | ( 80-96 ) | MO# | 0.7 | x10^9/l | ( 0.2-0.8 ) |
| MCH | 31.9 | pg | ( 27-32 ) | EO# | 0.28 | x10^9/l | ( 0.0-0.4 ) |
| MCC | 34.0 | g/dl | ( 32-36 ) | BA# | 0.0 | x10^9/l | ( 0.0-0.1 ) |
| | | | | PLT | 341 | x10^9/L | ( 150-400 ) |

KCT Ratio 0.80 ( up to 1.10)

Lab.Comments:

Sample Date/Time
25 Jun 2010 AM

Clin.Details: UNREADABLE



Request Entered: 25 Jun 2010 11:19

Report Printed: 06 Jul 2010 14:11

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# HAEMATOLOGY

DMR292

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

Lab No: H100481007

N/W Wards 3 & 4 Outpatients — Clinician: - NOT GIVEN — N3/4OP NG

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| HGB | 14.6 | g/dL | ( 13.0-18.0 ) | WBC | 9.8 | x10^9/L | ( 4.0-11.0 ) |
| RBC | 4.58 | x10^12/l | ( 4.5-6.0 ) | NE# | 6.5 | x10^9/l | ( 2.0-7.5 ) |
| HCT | 0.429 | | ( 0.40-0.52 ) | LY# | 2.3 | x10^9/l | ( 1.5-4.0 ) |
| MCV | 93.7 | fl | ( 80-96 ) | MO# | 0.7 | x10^9/l | ( 0.2-0.8 ) |
| MCH | 31.9 | pg | ( 27-32 ) | EO# | 0.28 | x10^9/l | ( 0.0-0.4 ) |
| MCC | 34.0 | g/dl | ( 32-36 ) | BA# | 0.0 | x10^9/l | ( 0.0-0.1 ) |
| | | | | PLT | 341 | x10^9/L | ( 150-400 ) |

| | | | |
|---|---|---|---|
| PT Ratio: | 1.1 | | |
| DVVT rat.:DVVC ratio | - | | |
| Antithrombin | 81.6 | u/dl | ( 80-120 ) |
| Protein C | 88.4 | u/dl | ( 70-140 ) |
| Total Protein S | - | | |
| Free Protein S | 95.9 | u/dl | ( 85-130 ) |

Lab.Comments: this new method.

Sample Date/Time
25 Jun 2010 AM

Clin.Details: UNREADABLE



Request Entered: 25 Jun 2010 11:19 — Report Printed: 06 Jul 2010 14:11

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# HAEMATOLOGY

DMR292

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

Lab No: H100481007

N/W Wards 3 & 4 Outpatients — Clinician: - NOT GIVEN — N3/4OP NG

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| HGB | 14.6 | g/dL | ( 13.0-18.0 ) | WBC | 9.8 | x10^9/L | ( 4.0-11.0 ) |
| RBC | 4.58 | x10^12/l | ( 4.5-6.0 ) | NE# | 6.5 | x10^9/l | ( 2.0-7.5 ) |
| HCT | 0.429 | | ( 0.40-0.52 ) | LY# | 2.3 | x10^9/l | ( 1.5-4.0 ) |
| MCV | 93.7 | fl | ( 80-96 ) | MO# | 0.7 | x10^9/l | ( 0.2-0.8 ) |
| MCH | 31.9 | pg | ( 27-32 ) | EO# | 0.28 | x10^9/l | ( 0.0-0.4 ) |
| MCC | 34.0 | g/dl | ( 32-36 ) | BA# | 0.0 | x10^9/l | ( 0.0-0.1 ) |
| | | | | PLT | 341 | x10^9/L | ( 150-400 ) |

| | | | |
|---|---|---|---|
| PV | 1.65 | mPa.s. | ( 1.5-1.72 ) |
| INR | 1.1 | | |
| APTT | 24.1 | secs. | ( 22-30 ) |
| APTT Ratio | 0.9 | | |
| Fibrinogen (Clauss) | 2.9 | g/l | ( 1.5-4.0 ) |
| Prothrombin Time | 11.4 | secs. | ( 9-12 ) |

Lab.Comments: Sample passed to Molecular Genetics for Factor V Leiden analysis.
NO EVIDENCE OF LUPUS ANTICOAGULANT
This is a new method for the assay of free Protein S.
Please note the slight change in reference range for

Sample Date/Time
25 Jun 2010 AM

Clin.Details: UNREADABLE



Request Entered: 25 Jun 2010 11:19 — Report Printed: 06 Jul 2010 14:11

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# HAEMATOLOGY

DMR292

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

NAME: STANDISH David — Sex: M — CHI Number: 0503700053 — DoB: 05 Mar 1970

Lab No: H05519708

N/W Neurology Outpatients — Clinician: - NOT GIVEN — NNEUR NG

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| HGB | 14.3 | | g/dl | ( 13-18 ) | WBC | 10.6 | | x10^9/l | ( 4-11 ) |
| RBC | 4.48 | L | x10^12/l | ( 4.5-6.0 ) | NE# | 6.4 | | x10^9/l | ( 2.0-7.5 ) |
| HCT | 0.430 | | | ( 0.4-0.52 ) | LY# | 3.0 | | x10^9/l | ( 1.5-4.0 ) |
| MCV | 96.0 | | fl | ( 80-96 ) | MO# | 0.7 | | x10^9/l | ( 0.2-0.8 ) |
| MCH | 31.9 | | pg | ( 27-32 ) | EO# | 0.41 | H | x10^9/l | ( 0-0.4 ) |
| MCC | 33.3 | | g/dl | ( 31.5-36.0 ) | BA# | 0.1 | | x10^9/l | ( 0-0.1 ) |
| | | | | | PLT | 350 | | x10^9/l | ( 150-400 ) |

PV 1.59 mPa.s. ( 1.5-1.72 )

Lab.Comments:

Received 21 Jun 2005 13:05 — Date of FBC Request 21 Jun 2005 — Report Issued 21 Jun 2005

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# HAEMATOLOGY

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Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

NAME: STANDISH David — Sex: M — CHI Number: 0503700053 — DoB: 05 Mar 1970

Lab No: H05519708

N/W Neurology Outpatients — Clinician: - NOT GIVEN — NNEUR NG

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| HGB | 14.3 | | g/dl | ( 13-18 ) | WBC | 10.6 | | x10^9/l | ( 4-11 ) |
| RBC | 4.48 | L | x10^12/l | ( 4.5-6.0 ) | NE# | 6.4 | | x10^9/l | ( 2.0-7.5 ) |
| HCT | 0.430 | | | ( 0.4-0.52 ) | LY# | 3.0 | | x10^9/l | ( 1.5-4.0 ) |
| MCV | 96.0 | | fl | ( 80-96 ) | MO# | 0.7 | | x10^9/l | ( 0.2-0.8 ) |
| MCH | 31.9 | | pg | ( 27-32 ) | EO# | 0.41 | H | x10^9/l | ( 0-0.4 ) |
| MCC | 33.3 | | g/dl | ( 31.5-36.0 ) | BA# | 0.1 | | x10^9/l | ( 0-0.1 ) |
| | | | | | PLT | 350 | | x10^9/l | ( 150-400 ) |

Lab.Comments:

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# HAEMATOLOGY

DMR292

Tayside Clinical Laboratory Services

Telephone 660111 Ext 32602

NAME: STANDISH David Sex: M CHI Number: 0503700053 DoB: 05 Mar 1970

N/W Ward 15 Clinician: - NOT GIVEN Lab No: H01148847

N15 NG

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Hb | 14.1 | g/dl | WBC | 10.5 | x10^9/l | PLT | 320 | x10^9/l |
| RBC | 4.47 | x10^12/l | NE# | 6.5 | x10^9/l | MPV | 9.5 | fl |
| HCT | 0.425 | 1/1 | LY# | 2.9 | x10^9/l | | | |
| MCV | 95.1 | fl | MO# | 0.8 | x10^9/l | | | |
| MCH | 31.5 | pg | EO# | 0.3 | x10^9/l | | | |
| MCC | 33.2 | g/dl | BA# | 0.0 | x10^9/l | | | |

| | | | |
|---|---|---|---|
| Prothrombin Time | 12.5 H | secs. | ( 9-12 ) |
| INR | 1.2 | | |
| APTT | 23.8 | secs. | ( 22-30 ) |
| APTT Ratio | 0.9 | | |

Received 22 Oct 2001 19:56 Date of FBC Request 22 Oct 2001 Report Issued 22 Oct 2001

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# HAEMATOLOGY

DMR292

DEPARTMENT OF HAEMATOLOGY - NINEWELLS HOSPITAL

NAME: STANDISH David Sex: M CHI Number: 0503700053 DoB: 05 Mar 1970
Lab No: H01221695

N/W Wards 1 & 2 Outpatients Clinician: Dr T. PULLAR N1/2OP PULT1H

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Hb | 14.8 | g/dl | WBC | 8.4 | | x10^9/l | PLT | 330 | x10^9/l |
| RBC | 4.82 | x10^12/l | NE# | 4.7 | | x10^9/l | MPV | 10.0 | fl |
| HCT | 0.447 | 1/1 | LY# | 2.3 | | x10^9/l | | | |
| MCV | 92.7 | fl | MO# | 0.8 | | x10^9/l | | | |
| MCH | 30.7 | pg | EO# | 0.5 | H | x10^9/l | | | |
| MCC | 33.1 | g/dl | BA# | 0.1 | | x10^9/l | | | |

Received 24 Jan 2001 11:00 Date of FBC Request 24 Jan 2001 Report Issued 24 Jan 2001

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Please set them accurately.

JB-8267

BIOCHEMISTRY

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# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David Sex: M PID: 0503700053 DoB: 05 Mar 1970
Lab No: C132151251
N/W Wards 3 & 4 Outpatients Clinician: Dr J.B.C. DICK N3/4OP DICJ1H

| | | | | |
|---|---|---|---|---|
| SODIUM | 139 | mmol/L | ( | 133-146 ) |
| POTASSIUM | 5.0 | mmol/L | ( | 3.5-5.3 ) |
| UREA | 4.6 | mmol/L | ( | 2.5-7.8 ) |
| CREATININE | 87 | umol/L | ( | 62-106 ) |
| ESTIMATED GFR | GT60 | mL/min | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | | | |
| ALT | 24 | U/L | ( | 5-55 ) |
| BILIRUBINS | 6 | umol/L | ( | 0-21 ) |
| ALKALINE PHOSPHATASE | 63 | U/L | ( | 30-130 ) |
| ALBUMIN | 37 | g/L | ( | 35-50 ) |
| CREATINE KINASE | 115 | U/L | ( | 40-320 ) |
| GGT | 25 | U/L | ( | 3-73 ) |
| TOTAL CHOLESTEROL | 4.33 | mmol/L | ( | 0.00-5.00 ) |
| TRIGLYCERIDES | 1.22 | mmol/L | ( | 0.00-2.30 ) |
| HDL-CHOLESTEROL | 1.25 | mmol/L | ( | 0.60-2.50 ) |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
26 Apr 2013 13:35

Clin.Details: pad, statin



Request Entered: 26 Apr 2013 14:54 Report Printed: 26 Apr 2013 15:36

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# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

Lab No: C132151251

N/W Wards 3 & 4 Outpatients — Clinician: Dr J.B.C. DICK — N3/4OP DICJ1H

| | | |
|---|---|---|
| TOTAL CHOL/HDL-CHOL | 3.40 | . |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
26 Apr 2013 13:35

Clin.Details: pad, statin



Request Entered: 26 Apr 2013 14:54 — Report Printed: 26 Apr 2013 15:36

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# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970
Lab No: C116638870

N/W Vascular Clinic (Wd 3/4OP) — Clinician: Dr J.B.C. DICK — NVASC DICJ1H

| | | | | |
|---|---|---|---|---|
| SODIUM | 141 | mmol/L | ( | 135-147 ) |
| POTASSIUM | 4.5 | mmol/L | ( | 3.5-5.0 ) |
| UREA | 5.9 | mmol/L | ( | 3.3-6.6 ) |
| CREATININE | 88 | umol/L | ( | 62-106 ) |
| ESTIMATED GFR | GT60 | mL/min | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | | | |
| ALT | 24 | U/L | ( | 15-55 ) |
| BILIRUBINS | 6 | umol/L | ( | 0-17 ) |
| ALKALINE PHOSPHATASE | 62 | U/L | ( | 30-105 ) |
| ALBUMIN | 45 | g/L | ( | 36-50 ) |
| CREATINE KINASE | 180 | U/L | ( | 45-180 ) |
| GGT | 39 | U/L | ( | 11-75 ) |
| TOTAL CHOLESTEROL | 5.55 > | mmol/L | ( | 0.00-5.00 ) |
| TRIGLYCERIDES | 0.95 | mmol/L | ( | 0.00-2.30 ) |
| HDL-CHOLESTEROL | 2.02 | mmol/L | ( | 0.60-2.50 ) |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
22 Sep 2011

Clin.Details: pad, lipids
Drugs:statin, fibrate, ezet



Request Entered: 22 Sep 2011 13:02 — Report Printed: 22 Sep 2011 14:20

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# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

N/W Vascular Clinic (Wd 3/4OP) — Clinician: Dr J.B.C. DICK — Lab No: C116638870 NVASC DICJ1H

| | | | | | |
|---|---|---|---|---|---|
| TOTAL CHOL/HDL-CHOL | 2.70 | . | | | |
| LDL-CHOL. (CALCULATED) | 3.10 | > | mmoL/L | ( 0-2.60 ) | |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
22 Sep 2011

Clin.Details: pad, lipids
Drugs:statin, fibrate, ezet



Request Entered: 22 Sep 2011 13:02

Report Printed: 22 Sep 2011 14:20

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# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970
Lab No: C116381850

N/W Vascular Clinic (Wd 3/4OP) — Clinician: Dr J.B.C. DICK — NVASC DICJ1H

| | | | | |
|---|---|---|---|---|
| SODIUM | 143 | mmol/L | ( 135-147 ) | |
| POTASSIUM | 4.8 | mmol/L | ( 3.5-5.0 ) | |
| UREA | 4.3 | mmol/L | ( 3.3-6.6 ) | |
| CREATININE | 75 | umol/L | ( 62-106 ) | |
| ESTIMATED GFR | GT60 | mL/min | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | | | |
| ALT | 69 > | U/L | ( 15-55 ) | |
| BILIRUBINS | LT5 | umol/L | ( 0-17 ) | |
| ALKALINE PHOSPHATASE | 87 | U/L | ( 30-105 ) | |
| ALBUMIN | 44 | g/L | ( 36-50 ) | |
| CREATINE KINASE | 142 | U/L | ( 45-180 ) | |
| TSH | 1.73 | mU/L | ( 0.4-4.0 ) | |
| GGT | 82 > | U/L | ( 11-75 ) | |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
16 Mar 2011

Clin.Details: pad, lipids, for fibrate
Drugs:statin, ezet

Request Entered: 16 Mar 2011 12:44 — Report Printed: 16 Mar 2011 14:46

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# BIOCHEMISTRY

DMR 374

# BIOCHEMICAL MEDICINE

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970
Lab No: C116335999
N12 GRIG1H

N/W Ward 12 — Clinician: Mr G.D. GRIFFITHS

| | | | | |
|---|---|---|---|---|
| SODIUM | 139 | mmol/L | ( 135-147 ) | |
| POTASSIUM | 3.9 | mmol/L | ( 3.5-5.0 ) | |
| UREA | 4.8 | mmol/L | ( 3.3-6.6 ) | |
| CREATININE | 80 | umol/L | ( 62-106 ) | |
| ESTIMATED GFR | GT60 | mL/min | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | | | |
| ALT | 38 | U/L | ( 15-55 ) | |
| BILIRUBINS | 14 | umol/L | ( 0-17 ) | |
| ALKALINE PHOSPHATASE | 88 | U/L | ( 30-105 ) | |
| ALBUMIN | 41 | g/L | ( 36-50 ) | |
| CALCIUM | 2.22 | mmol/L | ( 2.10-2.55 ) | |
| CALCIUM (CORRECTED) | 2.31 | mmol/L | ( 2.10-2.55 ) | |
| MAGNESIUM | 0.79 | mmoL/L | ( 0.70-1.15 ) | |
| PHOSPHATE | 0.93 | mmoL/L | ( 0.80-1.50 ) | |
| C-REACTIVE PROTEIN | 23 > | mg/L | ( up to 5 ) | |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
15 Feb 2011 07:47

Clin.Details: right fem endarterectomy

Request Entered: 15 Feb 2011 13:00 — Report Printed: 15 Feb 2011 14:25

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# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

Lab No: C110418592

N/W Ward 12 Outpatients — Clinician: Mr G.D. GRIFFITHS — N12OP GRIG1H

| | | | | |
|---|---|---|---|---|
| SODIUM | 141 | mmol/L | ( | 135-147 ) |
| POTASSIUM | 4.6 | mmol/L | ( | 3.5-5.0 ) |
| UREA | 5.1 | mmol/L | ( | 3.3-6.6 ) |
| CREATININE | 72 | umol/L | ( | 62-106 ) |
| ESTIMATED GFR | GT60 | mL/min | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | | | |
| ALT | 43 | U/L | ( | 15-55 ) |
| BILIRUBINS | 12 | umol/L | ( | 0-17 ) |
| ALKALINE PHOSPHATASE | 107 > | U/L | ( | 30-105 ) |
| ALBUMIN | 45 | g/L | ( | 36-50 ) |
| CALCIUM | 2.25 | mmol/L | ( | 2.10-2.55 ) |
| CALCIUM (CORRECTED) | 2.26 | mmol/L | ( | 2.10-2.55 ) |
| GLUCOSE (preserved tube) | 5.5 | mmol/L | ( | 3.3-5.8 ) |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
03 Feb 2011 11:30

Clin.Details: PRE OP

Request Entered: 03 Feb 2011 12:57 — Report Printed: 03 Feb 2011 14:35

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# CHEMICAL MEDICINE

DMR 374

al Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970
Lab No: C106122364

linic (Wd 3/4OP) — Clinician: Dr J.B.C. DICK — NVASC DICJ1H

| | | | | |
|---|---|---|---|---|
| | 141 | mmol/L | ( 135-147 ) | |
| | 4.5 | mmol/L | ( 3.5-5.0 ) | |
| | 5.5 | mmol/L | ( 3.3-6.6 ) | |
| | 83 | umol/L | ( 62-106 ) | |
| | GT60 | mL/min | | |
| IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | | | | |
| | 47 | U/L | ( 15-55 ) | |
| | 17 | umol/L | ( 0-17 ) | |
| SPHATASE | 82 | U/L | ( 30-105 ) | |
| | 45 | g/L | ( 36-50 ) | |
| IASE | 294 >> | U/L | ( 45-180 ) | |
| | 52 | U/L | ( 11-75 ) | |
| STEROL | 6.36 > | mmol/L | ( up to 5.00 ) | |
| ES | 1.14 | mmol/L | ( up to 2.30 ) | |
| TEROL | 1.58 | mmol/L | ( 0.60-2.50 ) | |

ts:

Sample is blood unless otherwise stated

Sample Date/Time
10 Sep 2010

ails: pad
Drugs:atorva



Entered: 10 Sep 2010 10:33 — Report Printed: 10 Sep 2010 12:03

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Request

11

# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

N/W Vascular Clinic (Wd 3/4OP) — Clinician: Dr J.B.C. DICK — Lab No: C106122364 NVASC DICJ1H

| | | | | |
|---|---|---|---|---|
| TOTAL CHOL/HDL-CHOL | 4.00 | . | | |
| LDL-CHOL. (CALCULATED) | 4.27 >> | mmoL/L | ( up to 2.60 ) | |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
10 Sep 2010

Clin.Details: pad
Drugs:atorva



Request Entered: 10 Sep 2010 10:33 — Report Printed: 10 Sep 2010 12:03

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Request

# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services

Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David

Sex: M PID: 0503700053

DoB: 05 Mar 1970

N/W Wards ~~3 & 4~~ Outpatients

Clinician: - NOT GIVEN

Lab No: C100481007
N3/4OP NG

| | | | | |
|---|---|---|---|---|
| TRIGLYCERIDES | 0.95 | mmol/L | ( up to 2.30 ) | |
| HDL-CHOLESTEROL | 1.59 | mmol/L | ( 0.60-2.50 ) | |
| TOTAL CHOL/HDL-CHOL | 4.50 | | | |

HOMOCYSTEINE TO FOLLOW

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
25 Jun 2010 AM

Clin.Details: UNREADABLE



Request Entered: 25 Jun 2010 11:19

Report Printed: 25 Jun 2010 12:03

REPORT RECEIVED

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# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

N/W Wards ~~3 & 4~~ Outpatients — Clinician: - NOT GIVEN — Lab No: C100481007 N3/4OP NG

| | | | | |
|---|---|---|---|---|
| SODIUM | 140 | mmol/L | ( 135-147 ) | |
| POTASSIUM | 4.7 | mmol/L | ( 3.5-5.0 ) | |
| UREA | 4.0 | mmol/L | ( 3.3-6.6 ) | |
| CREATININE | 76 | umol/L | ( 62-106 ) | |
| ESTIMATED GFR | GT60 | mL/min | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | | | |
| ALT | 38 | U/L | ( 15-55 ) | |
| BILIRUBINS | 6 | umol/L | ( 0-17 ) | |
| ALKALINE PHOSPHATASE | 83 | U/L | ( 30-105 ) | |
| ALBUMIN | 45 | g/L | ( 36-50 ) | |
| GLUCOSE (preserved tube) | 5.2 | mmol/L | ( 3.3-5.8 ) | |
| CREATINE KINASE | 207 > | U/L | ( 45-180 ) | |
| TSH | 1.39 | mU/L | ( 0.4-4.0 ) | |
| GGT | 44 | U/L | ( 11-75 ) | |
| TOTAL CHOLESTEROL | 7.28 > | mmol/L | ( up to 5.00 ) | |

Lab.Comments: HOMOCYSTEINE Analysed by RHSC, Edinburgh.

Sample is blood unless otherwise stated

Sample Date/Time
25 Jun 2010 AM

Clin.Details: UNREADABLE



Request Entered: 25 Jun 2010 11:19 — Report Printed: 25 Jun 2010 12:03

Request

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# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

Lab No: C100481007

N/W Wards 3 & 4 Outpatients — Clinician: - NOT GIVEN — N3/4OP NG

| | | | | |
|---|---|---|---|---|
| TRIGLYCERIDES | 0.95 | mmol/L | ( | up to 2.30 ) |
| HDL-CHOLESTEROL | 1.59 | mmol/L | ( | 0.60-2.50 ) |
| TOTAL CHOL/HDL-CHOL | 4.50 | . | | |
| HOMOCYSTEINE | 20.00 | umol/L | ( | 0-20 ) |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
25 Jun 2010 AM

Clin.Details: UNREADABLE



Request Entered: 25 Jun 2010 11:19 — Report Printed: 06 Jul 2010 11:22

REPORT RECEIVED

DOCTOR'S INITIALS

Request

# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

N/W Wards 3 & 4 Outpatients — Clinician: - NOT GIVEN — Lab No: C100481007 N3/4OP NG

| | | | | |
|---|---|---|---|---|
| SODIUM | 140 | mmol/L | ( | 135-147 ) |
| POTASSIUM | 4.7 | mmol/L | ( | 3.5-5.0 ) |
| UREA | 4.0 | mmol/L | ( | 3.3-6.6 ) |
| CREATININE | 76 | umol/L | ( | 62-106 ) |
| ESTIMATED GFR | GT60 | mL/min | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | | | |
| ALT | 38 | U/L | ( | 15-55 ) |
| BILIRUBINS | 6 | umol/L | ( | 0-17 ) |
| ALKALINE PHOSPHATASE | 83 | U/L | ( | 30-105 ) |
| ALBUMIN | 45 | g/L | ( | 36-50 ) |
| GLUCOSE (preserved tube) | 5.2 | mmol/L | ( | 3.3-5.8 ) |
| CREATINE KINASE | 207 > | U/L | ( | 45-180 ) |
| TSH | 1.39 | mU/L | ( | 0.4-4.0 ) |
| GGT | 44 | U/L | ( | 11-75 ) |
| TOTAL CHOLESTEROL | 7.28 > | mmol/L | ( | up to 5.00 ) |

Lab.Comments: HOMOCYSTEINE Analysed by RHSC, Edinburgh.

Sample is blood unless otherwise stated

Sample Date/Time
25 Jun 2010 AM

Clin.Details: UNREADABLE



Request Entered: 25 Jun 2010 11:19 — Report Printed: 06 Jul 2010 11:22

Request

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# BIOCHEMICAL MEDICINE

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

Lab No: C05519708

N/W Neurology Outpatients — Clinician: - NOT GIVEN — NNEUR NG

| | | | | |
|---|---|---|---|---|
| SODIUM | 138 | mmol/L | ( | 135-147 ) |
| POTASSIUM | 4.8 | mmol/L | ( | 3.5-5.0 ) |
| UREA | 4.5 | mmol/L | ( | 3.3-6.6 ) |
| CREATININE | 92 | umol/L | ( | 64-120 ) |
| ALT | 36 | U/L | ( | 15-55 ) |
| BILIRUBINS | 8 | umol/L | ( | 0-17 ) |
| ALKALINE PHOSPHATASE | 77 | U/L | ( | 30-105 ) |
| ALBUMIN | 44 | g/L | ( | 36-50 ) |
| CALCIUM | 2.40 | mmol/L | ( | 2.10-2.55 ) |
| CALCIUM (CORRECTED) | 2.43 | mmol/L | ( | 2.10-2.55 ) |
| GLUCOSE | 4.8 | mmol/L | ( | 3.3-5.8 ) |
| MAGNESIUM | 0.80 | mmoL/L | ( | 0.70-1.15 ) |
| C-REACTIVE PROTEIN | LT3 | mg/L | ( | up to 5 ) |

Lab.Comments:

Sample Date/Time
21 Jun 2005 AM

Request Entered: 21 Jun 2005 13:05 — Report Printed: 21 Jun 2005

REPORT RECEIVED
DOCTOR'S INITIALS

# OCHEMICAL MEDICINE

DMR 374

e Clinical Laboratory Services — Telephone 660111 Ext 32601

STANDISH David Sex: M PID: 0503700053 DoB: 05 Mar 1970
Lab No: C01501017
Ward 15 Clinician: Dr K.D. MORLEY N15 MORK1H

| | | | | |
|---|---|---|---|---|
| PONIN T | LTO.01 | ug/L | ( less than 0.1 ) | |

Lab.Comments:

Sample Date/Time
23 Oct 2001 AM

Request Entered: 23 Oct 2001 09:22

Report Printed: 23 Oct 2001

REPORT RECEIVED

DOCTOR'S INITIALS

# BIOCHEMICAL MEDICINE

DMR 374

(4)

Tayside Clinical Laboratory Services

Telephone 660111 Ext 32601

Name: STANDISH David Sex: M PID: 0503700053

DoB: 05 Mar 1970
Lab No: C01148902
N15 MORK1H

N/W Ward 15 Clinician: Dr K.D. MORLEY

| | | | | |
|---|---|---|---|---|
| CREATINE KINASE | 368 * | U/L | ( | 45-180 ) |

Lab.Comments:

Sample Date/Time
23 Oct 2001 03:25

Request Entered: 23 Oct 2001 03:35

Report Printed: 23 Oct 2001

REPORT RECEIVED

DOCTOR'S INITIALS

DOCTOR'S INITIALS

# BIOCHEMICAL MEDICINE

DMR 374

Tayside Clinical Laboratory Services — Telephone 660111 Ext 32601

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970
Lab No: C01148847

N/W Ward 15 — Clinician: - NOT GIVEN — N15 NG

| | | | | |
|---|---|---|---|---|
| SODIUM | 141 | mmol/L | ( | 135-147 ) |
| POTASSIUM | 3.8 | mmol/L | ( | 3.5-5.0 ) |
| UREA | 4.8 | mmol/L | ( | 3.3-6.6 ) |
| CREATININE | 83 | umol/L | ( | 64-120 ) |
| ALT | 21 | U/L | ( | 15-55 ) |
| BILIRUBINS | 9 | umol/L | ( | 0-17 ) |
| ALKALINE PHOSPHATASE | 70 | U/L | ( | 30-105 ) |
| ALBUMIN | 43 | g/L | ( | 36-50 ) |
| CALCIUM | 2.25 | mmol/L | ( | 2.10-2.55 ) |
| CALCIUM (CORRECTED) | 2.30 | mmol/L | ( | 2.10-2.55 ) |
| GLUCOSE | 5.1 | mmol/L | ( | 3.3-5.8 ) |
| CREATINE KINASE | 479 >> | U/L | ( | 45-180 ) |
| AMYLASE | 38 | U/L | ( | 0-100 ) |
| GGT | 21 | U/L | ( | 9-70 ) |
| C-REACTIVE PROTEIN | LT3 | mg/L | ( | up to 5 ) |

Lab.Comments:

Sample Date/Time
22 Oct 2001

Request Entered: 22 Oct 2001 19:56

Report Printed: 22 Oct 2001

REPORT RECEIVED

# BIOCHEMICAL MEDICINE

DMR 374

NINEWELLS HOSPITAL AND MEDICAL SCHOOL — Telephone 660111 Ext 32601/2

Name: STANDISH David — Sex: M — PID: 0503700053 — DoB: 05 Mar 1970

Lab No: C01221695

N/W Wards 1 & 2 Outpatients — Clinician: Dr T. PULLAR — N1/2OP PULT1H

| | | | | |
|---|---|---|---|---|
| SODIUM | 136 | | mmol/L | ( 135-147 ) |
| POTASSIUM | 4.6 | | mmol/L | ( 3.5-5.0 ) |
| UREA | 4.7 | | mmol/L | ( 3.3-6.6 ) |
| CREATININE | 94 | | umol/L | ( 64-120 ) |
| ALT | 36 | | U/L | ( 15-55 ) |
| BILIRUBINS | 6 | | umol/L | ( 0-17 ) |
| ALKALINE PHOSPHATASE | 83 | | U/L | ( 30-105 ) |
| ALBUMIN | 43 | | g/L | ( 36-50 ) |
| CALCIUM | 2.26 | | mmol/L | ( 2.10-2.55 ) |
| CALCIUM (CORRECTED) | 2.31 | | mmol/L | ( 2.10-2.55 ) |
| GLUCOSE | 5.7 | | mmol/L | ( 3.3-5.8 ) |
| CREATINE KINASE | 180 | | U/L | ( 45-180 ) |
| CHOLESTEROL | 7.15 | > | mmol/L | ( up to 5.00 ) |
| HDL-CHOLESTEROL | 1.57 | | mmol/L | |
| TOTAL CHOL/HDL-CHOL | 4.55 | | | (see SIGN Guideline 40) |

Lab.Comments:

Sample Date/Time
24 Jan 2001 AM

Request Entered: 24 Jan 2001 11:00

Report Printed: 24 Jan 2001

REPORT RECEIVED

MOUNT SHEET

Note: Remove strip to reveal gummed area.
Attach reports from bottom to top.
Please set them accurately.

JB-8267

PATHOLOGY

12 11 10 9 8 7 6 5 4 3

MOUNT

# IMMUNOPATHOLOGY

DMR 375

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Tayside Clinical Laboratory Services Telephone 01382 632539 Internal Ext.32539

---

Name: STANDISH David Sex: M PID: 0503700053 DoB: 05 Mar 1970
Lab No: I100481007

N/W Wards ~~3 & 4~~ Outpatients Clinician: - NOT GIVEN N3/4OP NG

---

| | | | | | |
|---|---|---|---|---|---|
| IgM Anti Cardiolipin Antibody | 1 | MPL U/ml | ( | 0-7 | ) |
| IgG Anti Cardiolipin Antibody | 1 | GPL U/ml | ( | 0-10 | ) |

Lab.Comments:

Sample is blood unless otherwise stated

Sample Date/Time
25 Jun 2010 AM

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Clin.Details: UNREADABLE

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Request Entered: 25 Jun 2010 11:19 Report Printed: 29 Jun 2010 16:50

REPORT RECEIVED

DOCTOR'S INITIALS

**Ongoing Nursing Record of Care & Multidisciplinary Notes** (Record all Amber/Red problems from Traffic Light Assessment. Document interventions/treatment, evaluation & changes to patient condition)

| Code | | | | | |
|---|---|---|---|---|---|
| N | Nutrition | FB | Fluid Balance | LD | Learning Disability |
| PUP | Pressure Ulcer Prevention | P | Pain | PS | Personal Safety |
| M | Manual Handling & Mobility | W | Wound/Skin Integrity | PC | Psychological/ Spiritual Care |
| F | Falls | PH | Personal Hygiene | | |
| A | Airway/Breathing | OH | Oral Hygiene | PCG | Patient Centred Goal |
| O | Observation & Monitoring | I | Infection Control | ACN | Additional Care Needs |
| E | Elimination | C | Communication | | |

| Date/Time | Code | | Initial |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Multidisciplinary Record of Care

### Register of all personnel writing in Core Data Set

All members of staff who are using this Core Data Set should complete this section.

| Name | Job Title | Ward | Hospital | Signature | Initials |
|---|---|---|---|---|---|
| NICOLA STEPHEN | SN | SCPD | N/WELLS | N/Stephen | NJ |
| | | | | | |
| | | | | | |
| | | | | |

## Abbreviations

This abbreviation list has been approved by NHS Tayside and is supported by NHS Tayside policy for Records and Record Keeping for Registered Nurses, Midwives and Specialist Community Public Health Nurses.
There are blank spaces incorporated and each clinical speciality can utilise their own relevant abbreviations in full below, and therefore can be included within the record.

| | | | |
|---|---|---|---|
| **A&E** | Accident and Emergency | **HDU** | High Dependency Unit |
| **BG** | Blood Glucose | **ICT** | Infection Control Team |
| **BMI** | Body Mass Index | **IM** | Intramuscular |
| **BP** | Blood Pressure | **INR** | International Ratio |
| **CCU** | Coronary Care Unit | **ICU** | Intensive Care Unit |
| **C DIFF** | Clostridium Difficile | **IV** | Intravenous |
| **CHI** | Community Health Index | **MUST** | Malnutrition Universal Screening Tool |
| **CPR** | Cardio Pulmonary Resuscitation | **MRSA** | Methicillin Resistant Staphylococcus Aureus |
| **CVA** | Cerebral Vascular Accident | **O2** | Oxygen |
| **CVC** | Central Venous Catheter | **PEG** | Percutaneous Endoscopic Gastrostomy |
| **DOB** | Date of Birth | **PMH** | Past Medical History |
| **ECG** | Electrocardiogram | **PVC** | Peripheral Vascular Catheter |
| **GP** | General Practitioner | **SBAR** | Situation Background Assessment Recommendations |
| **HAI** | Healthcare Associated Infection | **SEWS** | Scottish Early Warning Score |
| **HAN** | Hospital At Night | **SPO2** | Saturation of Peripheral Oxygen |



(To be completed on admission or within 24 hours)

## 1. BIOGRAPHICAL DETAILS

Hospital Nuwell Ward 12 Consultant GDC

Date of Admission 13/2/11 Time 14⁰⁰ Estimated Discharge Date

STANDISH
DAVID
9 MANSION DR
DUNDEE
DD4 9DD

0503700053
M

PARK AVENUE MEDICAL CENTRE, PARK AVE

If different address, please state:

Day/Evening Telephone Number:
(Alternative if call bar present)
01382-519023

Own home ☐ Rented ☐ Homeless Unit ☐ Other: ☐

Preferred Name Dave Title mr Age Marital Status ENGAGED

Ethnic Origin BRITISH First Language ENGLISH Other: Interpreter Required Y (N)

Prefered method of communication: Verbal ☑ Sign ☐ Language ☐ Braille ☐ Makaton ☐ Other:

Religion none Do you have any religious/spiritual needs whilst in hospital? Y (N)

Request a visit from hospital chaplain? Y (N) Date contacted: Give spiritual care leaflet

PARK AVENUE MEDICAL CENTR
PARK AVENUE
DUNDEE
11005

**ALLERGIES**
none

Reason for Admission
(R) common femoral endarterectomy + superfical femoral angioplasty.

Past Medical History
ASTHMA

1st Contact **(To whom information can be disclosed to)**
Can they be contacted overnight? (Y) N
Name Denise McGlaughan
Relationship Partner
Address As patient

Postcode
Telephone Number **(Check Call Bar)** 519023
Mobile Number:

2nd Contact
Name Aileen Standish
Relationship mum
Address

Postcode
Telephone Number **(Check Call Bar)** 01382 - 819449
Mobile Number:

1st Contact aware of admission: (Y) N (If No), Date of time notified of admission
Data collected from: Patient ☑ Other:

| Transfer/Boarding | Destination 1 | Destination 2 | Destination 3 | Destination 4 |
|---|---|---|---|---|
| Ward number | | | | |
| Hospital | | | | |
| Transfer date & time | | | | |
| Patient & relatives informed? | | | | |

**(please delete as appropriate)**
Complete/Incomplete. Initials of Nurse: N Date/Time: 3/2/11

If Incomplete, date of when nurse to complete: Initials of Nurse Date/Time

## 2. CONSENT/CAPACITY ISSUES:

Patient has capacity to understand and consent to treatment/care/ disclosure of information: (Y) N

**(If no). please state reason:**

Please complete below if applicable:

| | Y | N | N/A | |
|---|---|---|---|---|
| Medical staff informed | | | | |
| Medical Incapacity form completed and in medical case note | | | | |
| Patient unconscious | | | | |
| Appointed welfare guardian | | | | Contact details & Verification: (please state) |
| Living will/Advance directives | | | | Verification: (please state) |
| Legal Authority for finance affairs | | | | Verification: (please state) |
| Independent advocate | | | | Contact details: (please state) |

## 3. DISCLOSURE OF INFORMATION:

Is there anyone else the patient wishes to receive information with regards to their healthcare: (Y) **(If yes, please complete below)** N **(go to Q.4)**

| Individuals | | | Level of information sharing | | Mode of Information sharing | | | |
|---|---|---|---|---|---|---|---|---|
| Significant others name & Contact number | Y | N | General Eg. stable | Specific Eg. test results | Face to Face | Telephone | Appointment | Other |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| Other healthcare/social/housing providers | | | | | | | | |
| Police | | | | | | | | |
| Press Office | | | | | | | | |

## 4. ASPECTS OF SELF CARE:

Is there any aspects of self care the patient would like to be involved in whilst in hospital: (Y) **(If yes, please state below)** N **(Go to next page)**

Independent

**(please delete as appropriate)**

Complete/Incomplete. Initials of Nurse: NJ Date/Time: 3/2/11

If Incomplete, date of when nurse to complete: _____ Initials of Nurse _____ Date/Time _____



## 5. PATIENT MEDICATIONS:

Is the patient on any medications? (Y) N

Patient manages own medicines at home? (Y) N

**(If No, please state reason below)**

Patient uses compliance aids at home?

**(If Yes, please state, name of pharmacy & telephone Number:**

Patient has brought in own medicines? Y N

Patient medicines have been assessed by pharmacist for suitability in hospital? Y N

Patient brought in controlled drugs and stored in controlled drug cupboard? Y N

Pharmacist/Technician has assessed patient medicines? Y N

Date assessed: _____

## 6. INFECTION CONTROL:

Was the patient admitted via another hospital? Y (N)

Was the patient admitted via a Nursing Home? Y (N)

Previously positive for MRSA? Y (N)

Hospitalised in the last year? Y (N)

Patient requires admission screening? (Y) N (e.g. MRSA policy or local speciality policies)

History of diarrhoea/loose stool outwith normal bowel pattern? Y (N)

## 7. VALUABLES:

Dentures Top/Bottom/Full Y N

Glasses /Contant Lenses Y N

Hearing Aid Y N

Other _____

Explanation of Patient's Funds and Property Procedure explained? Y N

Personal Disclaimer Form (PF1) completed? Y N

**(If yes, complete form) (If no, please state reason below)**

Money/property to be handed over on behalf of patient for safekeeping? Y N

**(If yes, please refer and follow section 2.2.3 of Patients Funds and Property Procedure)**

## 8. ORIENTATION TO WARD:

Orientation of ward and explanation of buzzer and nurse call system? Y N

Explanation of confidentiality given, and does the patient want there nursing records stored at the foot of their bed? Y N

**(If No, records to be stored at nursing desk)**

Visiting, meal and rest period times explained? Y N

## 9. LIFESTYLE AND HEALTH PROMOTION:

| Smoking | | Alcohol | | Substance Misuse | |
|---|---|---|---|---|---|
| Non-smoker | Y (N) | Does the patient drink alcohol? | (Y) N | Are you taking any 'over the counter' medications ? | Y (N) |
| Ex smoker | Y (N) | Women: Do you ever drink 6 or more units of alcohol on 1 occasion? | Y N | Are you taking any street drugs? | Y (N) |
| Current smoker | (Y) N | | | | |
| No smoking policy discussed | (Y) N | Men: Do you ever drink 8 or more units of alcohol on 1 occasion? | Y (N) | Are you worried about this use? | Y (N) |
| Patient interested in stopping smoking? | (Y) N | **(If yes, refer to flow chart)** | | **(If yes, refer to flow chart)** | |
| **(If yes, refer to flow chart)** | | | | | |

**Additional Information:**

**(please delete as appropriate)**

Complete/Incomplete. Initials of Nurse: NJ Date/Time: 3/2/11

If Incomplete, date of when nurse to complete: 13/2/11 Initials of Nurse _____ Date/Time _____

## 10. DEPENDANTS:

Is the patient a main carer or have any dependants? Y (N)

**(If yes, please state below)**

Name _____

Address _____

_____

Relationship _____

Arrangements made for dependant:

**(Please state details below)**

_____

_____

_____

Arrangements made for care of pets

**(If any, please state below)**

_____

_____

_____

_____

## 11. SIGNIFICANT OTHER INVOLVEMENT IN THE PATIENT'S CARE AND TREATMENT:

Has the patient a main carer Y (N)

**(If yes, please state below)**

Name _____

Address _____

_____

Relationship _____

Male Female Key holder: Y N

Has the patient other carers Y N

**(Please describe below)**

Name _____

Address _____

_____

Relationship _____

Male Female Key holder: Y N

Describe care provided by main carer

**(Please describe below)**

_____

_____

_____

_____

Describe care provided by other carer

**(Please describe below)**

_____

_____

_____

_____

Would the patient like anyone to provide any aspects of their care whilst in hospital? Y N

**(Please describe details of who, and what aspects of care to be provided below)**

_____

_____

_____

Individual agrees to take part: Y N

Please complete below if patient has any of the following:

| Current Community Care Provision | Name | Contact Details | Days provided | Date | Initial |
|---|---|---|---|---|---|
| Home Care | | | | | |
| Meals | | | | | |
| District Nurse | | | | | |
| Care Manager | | | | | |
| Day Hospital | | | | | |
| Crossroads | | | | | |
| Day Care | | | | | |
| Relative/Friend | | | | | |
| Other | | | | | |
| Other | | | | | |

**(please delete as appropriate)**

Complete/Incomplete. Initials of Nurse: NJ Date/Time: 3/2/11

If Incomplete, date of when nurse to complete: _____ Initials of Nurse _____ Date/Time _____



## Please complete if the patient requires new or review of community services.

**(Complete fields below and photocopy all pages of core data and send to relevant agency)**

If needs regarding any of the following are identified **(Please tick if applicable)**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Lives alone | | | Personal care | | |
| Stairs inside | | | Finances | | |
| Stairs outside | | | Feeding | | |
| Lack of support network | | | Household tasks | | |
| Accommodation unsuitable | | | Communication | | |
| Cooking | | | Social function/contacts | | |
| Continence | | | Medication | | |
| Mental health | | | Physical health | | |
| Diet | | | Mobility | | |
| Vulnerability/risk (e.g. domestic abuse) | | | Is the person being referred aware of the referral | | |
| Is the main carer aware of the referral | | | Does the main carer have separate needs | | |

Description of current problem:
**(Please describe)**

Person's expectation of referral:
**(Please describe)**

Carer's expectation of referral:
**(Please describe)**

Description of carer needs:
**(Please describe)**

**HEALTH CARE WORKER'S SIGNATURE:** N/Stephen **DATE/TIME:** 3/2/11

## Information Sharing Consent

**The purpose of this consent has been explained to me, including the need to share information recorded in the assessment between health care, social care and housing department professionals.**

**I consent / do ~~not consent to this~~ information being shared. (Delete as appropriate)**

**PATIENT'S SIGNATURE:** x D. Stansfield **DATE:** 3/2/11

### Additional Information

Please provide any reasons/discussions around consent to share information here **(if any)**
**(Please describe)**

**HEALTH CARE WORKER'S SIGNATURE:** N/Stephen **DATE/TIME:** 3/2/11

To be completed by individuals receiving referral e.g. (Initial assessment and screening – definition of problem and associated risks and proposed actions)

| Please Describe |
|---|
| |

**LOCAL AUTHORITY SIGNATURE:** _____ **DATE/TIME:** _____



| Investigations/Tests/Procedures/Surgery | Date | Result/insert labels (E.g. catheter label, urinalysis label) |
|---|---|---|
| ECG | | |
| Bloods | 3/2/11 | |
| Urinalysis | | |
| MRSA screen | | |
| | | |
| | | |
|

**Ongoing Nursing Record of Care & Multidisciplinary Notes** (Record all Amber/Red problems from Traffic Light Assessment. Document interventions/treatment, evaluation & changes to patient condition)

| Code | | | | | |
|---|---|---|---|---|---|
| N | Nutrition | FB | Fluid Balance | LD | Learning Disability |
| PUP | Pressure Ulcer Prevention | P | Pain | PS | Personal Safety |
| M | Manual Handling & Mobility | W | Wound/Skin Integrity | PC | Psychological/ Spiritual Care |
| F | Falls | PH | Personal Hygiene | | |
| A | Airway/Breathing | OH | Oral Hygiene | PCG | Patient Centred Goal |
| O | Observation & Monitoring | I | Infection Control | ACN | Additional Care Needs |
| E | Elimination | C | Communication | | |

| Date/Time | Code | | Initial |
|---|---|---|---|
| 13/2/11 | | | |
| 1400. | | Elective admission for th am Acute m/n | CRD |
| 14/2/11 | N | fasting for theatre. | |
| 0300 | ACN | fast on test Q/ | |
| 1900/ | O | $O^2$ 2L via nasal cannula. | |
| | | Eating and drinking. | |
| | FB | IVI in sit until finished. | |
| | | Observations stable. | CRD |
| | 2300 | Vomited 450 ml foodstuffs | CRD |
| 15/2/11 | | | |
| 0600. | A | $O_2$ 21 not tolerated Sews 0 | |
| | D | Sews 0 | |
| | E | PU post op. | |
| | P | Analgesia appears effective | |
| | W | Intact no staining | |
| | IC | PUC post op PUC Bundle. | CRD |
| 0700. | | c/o dysuria - advised provide spec for MSU/pH's | CRD |
| 15/2/11 | A | On Air | |
| | C | Sews 0. | |
| | E | Is Dx' Eliminating but not full Stream yet | |
| | P | Analgesia not required this shift | |
| | W | dry and intact | |
| | | Nursing no complaints this shift | RN |
| 1900/ | M | Independent. | |
| | W | Duoderm in situ. | |
| | C | Sews = 0- | |
| | | Attended Vasc lab this afternoon | CRD |



# CONFIDENTIAL

# PATIENT RECORD

**Please do not view these records unless you have the patient's consent**

## Multidisciplinary Record of Care

### Register of all personnel writing in Core Data Set

All members of staff who are using this Core Data Set should complete this section.

| Name | Job Title | Ward | Hospital | Signature | Initials |
|---|---|---|---|---|---|
| FIONA FRASER | SSN | 12 | N/W | | |
| | | | | | |
| | | | | | |
| | | |

## Abbreviations

This abbreviation list has been approved by NHS Tayside and is supported by NHS Tayside policy for Records and Record Keeping for Registered Nurses, Midwives and Specialist Community Public Health Nurses.
There are blank spaces incorporated and each clinical speciality can utilise their own relevant abbreviations in full below, and therefore can be included within the record.

| | | | |
|---|---|---|---|
| **A&E** | Accident and Emergency | **HDU** | High Dependency Unit |
| **BG** | Blood Glucose | **ICT** | Infection Control Team |
| **BMI** | Body Mass Index | **IM** | Intramuscular |
| **BP** | Blood Pressure | **INR** | International Ratio |
| **CCU** | Coronary Care Unit | **ICU** | Intensive Care Unit |
| **C DIFF** | Clostridium Difficile | **IV** | Intravenous |
| **CHI** | Community Health Index | **MUST** | Malnutrition Universal Screening Tool |
| **CPR** | Cardio Pulmonary Resuscitation | **MRSA** | Methicillin Resistant Staphylococcus Aureus |
| **CVA** | Cerebral Vascular Accident | **O2** | Oxygen |
| **CVC** | Central Venous Catheter | **PEG** | Percutaneous Endoscopic Gastrostomy |
| **DOB** | Date of Birth | **PMH** | Past Medical History |
| **ECG** | Electrocardiogram | **PVC** | Peripheral Vascular Catheter |
| **GP** | General Practitioner | **SBAR** | Situation Background Assessment Recommendations |
| **HAI** | Healthcare Associated Infection | **SEWS** | Scottish Early Warning Score |
| **HAN** | Hospital At Night | **SPO2** | Saturation of Peripheral Oxygen |
| | | | |
| | | | |
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| | | | |



(To be completed on admission or within 24 hours)

### 1. BIOGRAPHICAL DETAILS

Hospital N/W. Ward 12 Consultant GG.

Date of Admission 13/2/11. Time 1400. Estimated Discharge Date 21/2/11.

**WRITE OR ATTACH LABEL**
Surname STANDISH
Forename DAVID
DOB and CHI 250370
Address 9 MANSION DRIVE
DUNDEE
Postcode DD4 9DD.
Sex

If different address, please state:

Day/Evening Telephone Number: (Alternative if call bar present)

Own home ☐ Rented ☐ Homeless Unit ☐ Other:

Preferred Name DAVID. Title MR Age 40 Marital Status ENGAGED.

Ethnic Origin _____ First Language ENGLISH Other: _____ Interpreter Required Y (N)

Prefered method of communication: Verbal ☑ Sign ☐ Language ☐ Braille ☐ Makaton ☐ Other: _____

Religion N/A Do you have any religious/spiritual needs whilst in hospital? Y (N)

Request a visit from hospital chaplain? Y (N) Date contacted: _____ Give spiritual care leaflet

**WRITE OR ATTACH LABEL**
GP Name DAVACE
Address PARK AVE MED CENTRE
DUNDEE.
Postcode
Telephone Number

Reason for Admission: BIL ISC LEGS

Past Medical History:

**ALLERGIES**
NIL KNOWN.

1st Contact (To whom information can be disclosed to)

Name DENISE MCLAUGHLIN.
Relationship _____
Address SIA.
_____
Postcode _____
Telephone Number (Check Call Bar) 01382 519023
Mobile Number: _____

2nd Contact

Name _____
Relationship _____
Address _____
_____
Postcode _____
Telephone Number (Check Call Bar) _____
Mobile Number: _____

1st Contact aware of admission: (Y) N (If No), Date of time notified of admission _____
Data collected from: Patient ☑ Other:

| Transfer/Boarding | Destination 1 | Destination 2 | Destination 3 | Destination 4 |
|---|---|---|---|---|
| Ward number | | | | |
| Hospital | | | | |
| Transfer date & time | | | | |
| Patient & relatives informed? | | | | |

(please delete as appropriate)

Page 5. Complete/Incomplete. Initials of Nurse: _____ Date/Time: 13/2/11 - 1400.

If Incomplete, date of when nurse to complete: _____ Initials of Nurse _____ Date/Time _____

## 2. CONSENT/CAPACITY ISSUES:

Patient has capacity to understand and consent to treatment/care/ disclosure of information: (Y) N

**(If no). please state reason:**

Please complete below if applicable:

| | Y | N | N/A | |
|---|---|---|---|---|
| Medical staff informed | | | | |
| Medical Incapacity form completed and in medical case note | | | | |
| Patient unconscious | | | | |
| Appointed welfare guardian | | | | Contact details & Verification: (please state) |
| Living will/Advance directives | | | | Verification: (please state) |
| Legal Authority for finance affairs | | | | Verification: (please state) |
| Independent advocate | | | | Contact details: (please state) |

## 3. DISCLOSURE OF INFORMATION:

Is there anyone else the patient wishes to receive information with regards to their healthcare: Y **(If yes, please complete below)** (N) **(go to Q.4)**

| Individuals | | | Level of information sharing | | Mode of Information sharing | | | |
|---|---|---|---|---|---|---|---|---|
| Significant others name & Contact number | Y | N | General Eg. stable | Specific Eg. test results | Face to Face | Telephone | Appointment | Other |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| Other healthcare/social/housing providers | | | | | | | | |
| Police | | | | | | | | |
| Press Office | | | | | | | | |

## 4. ASPECTS OF SELF CARE:

Is there any aspects of self care the patient would like to be involved in whilst in hospital: Y **(If yes, please state below)** (N) **(Go to next page)**

_____

_____

_____



## 5. PATIENT MEDICATIONS:

Is the patient on any medications? (Y) N

Patient consents to using own medicines in hospital, once been assessed by Pharmacist/ Technician? (Y) N

Patient medicines have been assessed by pharmacist for suitability in hospital? Y (N)

Patient brought in controlled drugs and stored in controlled drug cupboard? Y (N)

Patient manages own medicines at home? (Y) N

**(If No, please state reason below)**

_____

_____

Patient uses compliance aids at home?

**(If Yes, please state, name of pharmacy & telephone Number:**

_____

_____

Pharmacist/Technician has assessed patient medicines? Y (N)

Date assessed: _____

## 6. INFECTION CONTROL:

Was the patient admitted via another hospital? Y (N)

Was the patient admitted via a Nursing Home? Y (N)

Previously positive for MRSA? Y (N)

Hospitalised in the last year? Y (N)

Patient requires admission screening? (Y) N

(e.g. MRSA policy or local speciality policies) Y N

History of diarrhoea/loose stool outwith normal bowel pattern? Y (N)

## 7. VALUABLES:

Explanation of Patient's Funds and Property Procedure explained? (Y) N

Personal Disclaimer Form (PF1) completed? (Y) N

**(If yes, complete form) (If no, please state reason below)**

_____

_____

Money/property to be handed over on behalf of patient for safekeeping? Y (N)

**(If yes, please refer and follow section 2.2.3 of Patients Funds and Property Procedure)**

## 8. ORIENTATION TO WARD:

Orientation of ward and explanation of buzzer and nurse call system? (Y) N

Explanation of confidentiality given, and does the patient want there nursing records stored at the foot of their bed? (Y) N

**(If No, records to be stored at nursing desk)**

Visiting, meal and rest period times explained? (Y) N

## 9. LIFESTYLE AND HEALTH PROMOTION:

| Smoking | | Alcohol | | Substance Misuse | |
|---|---|---|---|---|---|
| Non-smoker | Y N | Does the patient drink alcohol? | Y N | Are you taking any 'over the counter' Medications ? | Y N |
| Ex smoker | Y N | Women: Do you ever drink 6 or more units of alcohol on 1 occasion? | Y N | | |
| Current smoker | Y N | | | Are you taking any street drugs? | Y N |
| No smoking policy discussed | Y N | Men: Do you ever drink 8 or more units of alcohol on 1 occasion? | Y N | | |
| Patient interested in stopping smoking? | Y N | | | | |
| **(If yes, refer to flow chart)** | | **(If yes, refer to flow chart)** | | **(If yes, refer to flow chart)** | |

**Additional Information:**

## 10. DEPENDANTS:

Is the patient a main carer or have any dependants? Y (N)

**(If yes, please state below)**

Name _____

Address _____

_____

Relationship _____

Arrangements made for dependant:

**(Please state details below)**

_____

_____

_____

Arrangements made for care of pets

**(If any, please state below)**

_____

_____

_____

_____

## 11. SIGNIFICANT OTHER INVOLVEMENT IN THE PATIENT'S CARE AND TREATMENT:

Has the patient a main carer Y (N)

**(If yes, please state below)**

Name _____

Address _____

_____

Relationship _____

Male Female Key holder: Y N

Describe care provided by main carer

**(Please describe below)**

_____

_____

_____

_____

Has the patient other carers Y N

**(Please describe below)**

Name _____

Address _____

_____

Relationship _____

Male Female Key holder: Y N

Describe care provided by other carer

**(Please describe below)**

_____

_____

_____

_____

Would the patient like anyone to provide any aspects of their care whilst in hospital? Y N

**(Please describe details of who, and what aspects of care to be provided below)**

_____

_____

_____

Individual agrees to take part: Y N

Please complete below if patient has any of the following:

| Current Community Care Provision | Name | Contact Details | Days provided | Date | Initial |
|---|---|---|---|---|---|
| Home Care | | | | | |
| Meals | | | | | |
| District Nurse | | | | | |
| Care Manager | | | | | |
| Day Hospital | | | | | |
| Crossroads | | | | | |
| Day Care | | | | | |
| Relative/Friend | | | | | |
| Other | | | | | |
| Other | | | | | |

**(please delete as appropriate)**

Page 8. Complete/Incomplete. Initials of Nurse: _____ Date/Time: 13/2/11 1400.

If Incomplete, date of when nurse to complete: _____ Initials of Nurse _____ Date/Time _____



## Please complete if the patient requires new or review of community services.

**(Complete fields below and photocopy all pages of core data and send to relevant agency)**

If needs regarding any of the following are identified **(Please tick if applicable)**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Lives alone | | | Personal care | | |
| Stairs inside | | | Finances | | |
| Stairs outside | | | Feeding | | |
| Lack of support network | | | Household tasks | | |
| Accommodation unsuitable | | | Communication | | |
| Cooking | | | Social function/contacts | | |
| Continence | | | Medication | | |
| Mental health | | | Physical health | | |
| Diet | | | Mobility | | |
| Vulnerability/risk (e.g. domestic abuse) | | | Is the person being referred aware of the referral | | |
| Is the main carer aware of the referral | | | Does the main carer have separate needs | | |

Description of current problem:
**(Please describe)**

Person's expectation of referral:
**(Please describe)**

Carer's expectation of referral:
**(Please describe)**

Description of carer needs:
**(Please describe)**

**HEALTH CARE WORKER'S SIGNATURE:** _____ **DATE/TIME:** _____

## Information Sharing Consent

**The purpose of this consent has been explained to me, including the need to share information recorded in the assessment between health care, social care and housing department professionals.**

**I consent / do not consent to this information being shared. (Delete as appropriate)**

**PATIENT'S SIGNATURE:** **DATE:**

### Additional Information

Please provide any reasons/discussions around consent to share information here **(if any)**
**(Please describe)**

_____

_____

_____

**HEALTH CARE WORKER'S SIGNATURE:** _____ **DATE/TIME:** _____

To be completed by individuals receiving referral e.g. (Initial assessment and screening – definition of problem and associated risks and proposed actions)

| Please Describe |
|---|
| |

**LOCAL AUTHORITY SIGNATURE:** _____ **DATE/TIME:** _____



| Investigations/Tests/Procedures/Surgery | Date | Result/insert labels (E.g. catheter label, urinalysis label) |
|---|---|---|
| MRSA SCREEN | 13/2/11 | |
| URINALYSIS | 13/2/11 | |
| | | |
| | | |
| |

NHS TAYSIDE

NINEWELLS HOSPITAL

PERI-OPERATIVE CARE RECORD



0503700053
0503700053
DAVID STANDISH

| | |
|---|---|
| **Problem** | Potential risk of wrong procedure being performed |
| **Goal** | Correct procedure performed on correct patient |
| **Intervention** | Check identity of patient with name band, theatre list and consent form<br>Check operation site is correctly marked |

✓ SM

| | |
|---|---|
| **Problem** | Potential risk of injury during transfer from trolley to operating table |
| **Goal** | Safe transfer as per theatre policy |
| **Intervention** | Ensure trolley is in working order<br>Ensure brakes are on trolley and operating table<br>Ensure adequate number of staff carry out safe transfer |

✓ SM

| | |
|---|---|
| **Problem** | Potential risk of injury or pressure sore related to position on operating table |
| **Goal** | Minimise risk of injury/pressure sores during surgery |
| **Intervention** | Ensure patient is secure in following positions throughout their surgery |

(Supine) Prone Lithotomy Loyd Davis Left Lateral Right Lateral

Position of patient's arms

Right Arm: On arm board At side (Over Chest) Other (specify)

Left Arm: On arm board At side (Over Chest) Other (specify)

SM

Is the patient positioned on - Trolley Bed (Theatre Table)

Protect patient and patient's limbs using aids as per theatre policy

Propad Heel pads Head ring Gel pads Pillows

Towels Angled arm boards

| | |
|---|---|
| **Problem** | Patient is unable to maintain dignity intraoperatively |
| **Goal** | Maintain patient's dignity throughout surgery |
| **Intervention** | Ensure patient is covered appropriately<br>Do not expose patient until surgeon is ready to commence operation |

✓ SM

| | |
|---|---|
| **Problem** | Potential risk of infection |
| **Goal** | Minimise risk of infection ✓ |
| **Intervention** | Establish and record skin preparation used<br>Ensure asepsis is maintained throughout surgery<br>Skin prep used: hydrex pint/scrub A Livingston |
| **Problem** | Potential for burns/skin irritation related to use of diathermy |
| **Goal** | Prevent burns/skin irritation ✓ |
| **Intervention** | Use of diathermy and application of pads as per theatre policy<br>Make: Valleylab ERBE (Other (specify))<br>Placement of pad: (Left Thigh) Right Thigh Other (specify)<br>Mode: (Monopolar) Bi-polar<br>Used: (Yes) No<br>Generator used: (Valleylab) ERBE Other (specify)<br>Check skin under plate site pre and postoperatively and record observations<br>Preoperative skin condition: Intact<br>Postoperative skin condition: INTACT |
| **Problem** | Potential for shock/haemorrhage |
| **Goal** | Patient's haemodynamic state is monitored ✓ |
| **Intervention** | Maintain accurate record of blood loss from swabs and suction jars and record on nursing care summary<br>Assist surgeon should patient be in danger of excessive blood loss<br>Assist anaesthetist with fluid/blood replacement therapy<br>Monitor/record urine output<br>Assist with invasive monitoring equipment |
| **Problem** | Potential risk of foreign body retention |
| **Goal** | No foreign body retention ✓ A Livingston |
| **Intervention** | All equipment used during surgery is accounted for as per NHS Tayside policy |
| **Problem** | Potential for altered urinary output |
| **Goal** | Identify patients need for a urinary catheter |
| **Intervention** | Liaise with medical staff to identify whether a urinary catheter is required<br>Type of catheter used:<br>Size:<br>Amount of water in balloon: N/A |

# ANAESTHETIC CARE

Patient Name:

0503700053
0503700053
DAVID STANDISH

sh

Ward: 12

Theatre: 3

Allergies: none known

| Anaesthetist: Dr Courtney | | Anaesthetic Assistant: SN SM Greer | |
|---|---|---|---|
| ECG | Blood Pressure Cuff | Pulse oximeter Probe | Arterial Line |
| Central Venous Pressure | Capnograph | Temperature Probe | Intravenous Cannula |
| Intravenous Infusion | Blood Warmer | Cell Saver | Naso-gastric Tube |
| Bair Hugger<br>Temperature Setting<br>Low / Medium / High | Eye Care<br>Eyes Taped / Padded<br>Ointment (Specify) | Throat Pack<br>Inserted: Yes / No<br>Removed: Yes / No<br>Throat Sprayed<br>Yes / No | Urinary Catheter<br>Yes<br>Size Type<br>No<br>In Situ |
| Sequential Compression Boots | Oesophageal Doppler Monitor | | |

## TYPE OF ANAESTHESIA

General Anaesthetic
Endotracheal Tube (Specify size)
Laryngeal Mask (Specify size)
Intubating Laryngeal Mask Airway (Specify size)
Proseal (Specify size)
Ventilation Spontaneous / Intermittent positive pressure ventilation

Sedation
Propofol Target Controlled Infusion
Guedel Airway
Nasopharyngeal airway (Specify size)
Face Mask
Hudson Mask
Ventimask
Nasal Cannula / Prongs

Spinal Anaesthetic
Thoracic Epidural
Lumbar Epidural
Combined Spinal/Epidural
Regional Block (Specify)
Local Infiltration
Other (specify)

## ADDITIONAL INFORMATION

Size 16g cannula sited dorsum right hand. Secured patent. Comfortable & dated
uneventful spinal anaesthetic
into theatre limbs + pressure areas
Padded + protected

SIGNATURE SM Greer DATE 14/

# Intraoperative Summary Sheet

**Theatre:** 3

**Procedure Performed:** RIGHT COMMON FEMORAL ENDARTERECTOMY + ANGIOPLASTY

**Surgeon:** Mr Nagy

Specimens: NONE

Drains: NONE

Dressings: Aquacell + Duoderm

Pack in situ Yes (No)

Local Infiltration Yes (No)

Type:

Amount:

## Additional Information

MINOR VASCULAR
ID - 003146 2011/01/25 NMTS478
NHS Tayside

FORCEP TISSUE DEBAKEY 15CM.X1

ID-060496 2011/01/18 N037189
NHS Tayside

HOLDER NEEDLE CASTROVIEJO 18CM WITH CATCH (GU4340)
ID-061918 2011/02/11 N038568
NHS Tayside

CLAMP CAROTID 35-7195

ID-027073 2011/02/12 N010738
NHS Tayside

CANNULA TIBBS OLIVE ANGLED SMALL 11.10

ID-065626 2011/02/08 N042046
NHS Tayside

PROBE DOPPLER INTRA-OP

ID-059521 2011/02/08 N036257
NHS Tayside

Scrub Nurse Signature: A Livingston

Flooring Nurse Signature: CMcCabe

# WHO Surgical Safety Checklist (Adapted for NHS Tayside – v6)

**This checklist is the minimum standard for NHS Tayside**

NHS Tayside

**Patient Details or Addressograph**

| | |
|---|---|
| Last Name: | Sandish |
| First Name: | David |
| DOB: | 03/03/70 |
| NHS/CHI#: | 0013 |
| Procedure: | |
| Date: | 14.2.11 |

**THEATRE:** 3 **DATE:** 14/2/11

## Theatre: SIGN IN (To be read out loud)

**Before Induction of anaesthesia**

- Has the patient confirmed his her identity, site, procedure ☑
- Is the surgical site/side marked? ☑
- Drug prescription chart checked ☑
- Is all equipment and medication needed for this case checked and available ☑

**Are there any specific anaesthesia concerns? (e.g. difficult airway / blood loss etc.)**

Yes ☐ No ☑

If yes, is equipment available? ☑

**Does the patient have a known allergy?**

Yes ☐ No ☑

**ASA Score** 3

**Name:** SM·GREGOR

**Anaesthetist:** Dr Coventry

**To be signed by member of staff who read out checklist**

SM·Greg

## SURGICAL PAUSE (To be read out loud)

**Before start of surgical intervention e.g. skin incision**

- Confirm all team members are aware of roles and responsibilities and are familiar with each other ☑

**Surgeon, Anaesthetist & Registered Nurse/ODP verbally confirm:**

- What is the patient's name ☑
- What procedure, site and position are planned ☑
- Patient allergy status confirmed? Yes ☑ No ☐
- **Any metal implants in patient?** Yes ☐ N/A ☑
- Anticipated blood loss discussed ☑
- Are there any specific equipment requirements or special investigations? ☑
- Confirm all elements of SSI bundle have been undertaken ☑
- **Has DVT/VTE prophylaxis been agreed and applied?** Yes ☑ N/A ☐
- **Essential imaging displayed?** Yes ☐ N/A ☑
- **Diathermy settings confirmed?** Yes ☑ N/A ☐

**Name:** L McCABE

**To be signed by member of staff who read out checklist**

Lorna McCabe

**Please complete SSI bundle overleaf**

## SIGN OUT (To be read out loud)

**Before any member of the team leaves the operating room**

Registered practitioner verbally confirms with the team:

- The name of the procedure been recorded? ☑
- Confirmed that instruments, swabs and sharps counts are complete (including throat pack) ☑
- Specimens been labelled (including patient name) N/A ☐
- Blood loss confirmed to anaesthetist ☑

**Have any equipment problems been identified?**

Yes ☐ No ☑

**Name:** Livingston

**To be signed by member of staff who read out checklist**

## Anaesthetic assistant to recovery nurse handover

- Surgical instructions available ☑
- Anaesthetic instructions available (including fluids / analgesia) ☑
- Anaesthetic complications documented? Yes ☐ N/A ☑
- Any additional information:

**Name:** N Fairfield

**Signature of Registered Nurse/ODP**

N Fairfield

# WHO Surgical Safety Checklist (Adapted for NHS Tayside – v6)

**This checklist is the minimum standard for NHS Tayside**

## SSI Bundle

| | Yes | No | | | | |
|---|---|---|---|---|---|---|
| **ANTIBIOTIC PROPHYLAXIS** | | | | | | |
| Antibiotics indicated for this procedure? | ☐ | ☐ | | | | |
| Is administration recorded in the once only section of the TPAR? | ☐ | ☐ | | | | |
| Drugs given and finished within 30 mins KTS? | ☐ | ☐ | | | | |
| Only apparent after KTS | ☐ | | **Forgotten** | ☐ | **Local protocol** | ☐ |
| Started before KTS but not finished on time | ☐ | | | | | |
| **NORMOTHERMIA** | | | | | | |
| Temperature control - Temp ≥ 36° on ward | ☐ | ☐ | | | | |
| Intra op of procedure > 1 hour | ☐ | ☐ | | | | |
| Recovery if > 1 hour since last temp | ☐ | ☐ | | | | |
| **SKIN PREPARATION SHAVING** | | | | | | |
| Hair removal required? | ✓ | ☐ | | | | |
| If yes, were clippers used? | ✓ | ☐ | | | | |
| **GLYCAEMIC CONTROL** | | | | | | |
| Is the patient Diabetic? | ☐ | ☐ | | | **N/A** | ☐ |
| Glucose level before KTS ☐ Glycaemic control< 11 | ☐ | ☐ | | | | ☐ |
| Hourly Glucose levels measured? | ☐ | ☐ | | | | ☐ |
| Glucose level on discharge from recovery | ☐ | | **mmols** | | | |

✓ RoC 36.7

in 36.4
out 36.8

**Name:**

**Signature of Registered Nurse/ODP**

NHS Tayside

# IN-PATIENT PRE-OPERATIVE CHECK LIST (ADULT)
# GENERAL AND REGIONAL ANAESTHESIA

Ward ~~[illegible]~~ 12 Date 14/2/14.

Admitting Consultant MR G.D. GRIFFITHS

Planned Procedure RIGHT COMMON FEMORAL ENDARTERECTOMY
RIGHT. SFA. Angioplasty.

DAVID STANDISH.
Patient Label
050370 0053.

BASELINE RECORDINGS - TEMP. 36.0° PULSE 67. RESPS 18 BP 149/73

ADMISSION WEIGHT Kgs SpO2 – 97% on AIR

WATERLOW SCALE RATING ..... PRE-OP BM-STIX 4.6mM MRSA STATUS – VE'

**Column W = Ward Staff** **Column T = Theatre Staff**

| CHECK/CONFIRM FOLLOWING | YES | NO | NA | W | T | COMMENTS |
|---|---|---|---|---|---|---|
| **IDENTIFY** patient with appropriate band WHITE : RED : BLUE | ✓ | | | R. | | |
| ~~**CONSENT**~~ obtained - form accurately completed & signed | | | | | | |
| **ALLERGIES** noted and recorded (see over) | | ✓ | | | | NKOA. |
| Preoperative bath/shower | ✓ | | | R. | | |
| Patient suitably attired | ✓ | | | R. | | |
| Underwear in place | | ✓ | | R. | | |
| Note menstrual protection (tampon to be removed) | | | ✓ | R | | |
| Has patient emptied bladder within past 2 hours? | ✓ | | | R | | Voided time 0600 hrs |
| Urinary catheter patent | | | ✓ | R | | |
| Denture: removed (see over) | ✓ | | | R | | |
| Capped teeth : crowns : bridges noted | | ✓ | | R. | | |
| Jewellery : Hair adornments removed | | | ✓ | R. | | |
| Body piercings removed : taped Oral jewellery must be removed | ✓ | | | R | | |
| Make up, nail varnish removed | | | ✓ | R. | | |
| Contact lenses removed | | | ✓ | R. | | |
| Hearing aid in situ? (see over) | | | ✓ | R. | | |
| Spectacles (see over) | | | ✓ | R | | |
| Eye drops instilled | | | ✓ | R | | Time hrs |
| Anti-embolus stocking applied | | | ✓ | R. | | |
| **FASTED** appropriately | ✓ | | | R | | Last clear fluid 0000 hrs<br>Last food 0000 hrs |
| **OPERATION SITE CHECKED AND MARKED** (Medical staff) | | ✓ | | R. | | Right side Left side |
| **PRE-MEDICATION** administered : recorded | | | ✓ | | | Time hrs |
| **ROUTINE DRUGS** administered : recorded | ✓ | | | | | Time hrs |
| **IDENTIFY PATIENT** against Theatre request slip? | ✓ | | | | | |
| **CONFIRM PATIENT IDENTITY AND PLANNED PROCEDURE** against Theatre list | ✓ | | | | | |

CONTINUE OVER

NHS Tayside

| ADDITIONAL INFORMATION | YES | NO | NA | W | T | COMMENTS |
|---|---|---|---|---|---|---|
| Prosthesis present ORBITAL : JOINT | | ✓ | | SR | | |
| Pacemaker | | ✓ | | SR | | |
| Other | | | | | | |
| Has patient had previous surgery/NOTE | | ✓ | | SR | | |
| Medication to accompany patient GTN INHALER OXYGEN | ✓ | | | SR | | |
| Intravenous infusion patent and administered as prescribed | | | | | | |
| **ITEMS TO BE REMOVED PRIOR TO ANAESTHESIA – label and retain in recovery** | | | | | | |
| Dentures | | | | | | |
| Plate | | | | | | |
| Bridge | | | | | | |
| Spectacles | | | | | | |
| Hearing aid | | | | | | |
| **DOCUMENTS TO ACCOMPANY PATIENT** | | | | | | |
| Consent form | | | | | | |
| Case notes | ✓ | | | | | |
| Nursing record | ✓ | | | | | |
| Fluid chart | | | | | | |
| Prescription chart | ✓ | | | | | |
| X-rays | | | | | | |
| ECG | ✓ | | | | | |
| Blood results | | | | | | |

| ALLERGIES NOTE | INFUSION PUMP STATUS – WARD STAFF |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

IDENTIFY ANY MOVEMENT RESTRICTION
NONE.

FURTHER RELEVANT INFORMATION eg skin condition, presence of pressure sores, any dressing in place etc
SKIN INTACT.

WARD BED IS IT CAPABLE OF BEING TIPPED HEAD DOWN RAPIDLY? (YES/NO)

SIGNATURES

WARD STAFF ..... DESIGNATION SSA

THEATRE RECEPTION STAFF ..... DESIGNATION .....

ANAESTHETIC ASSISTANT ..... DESIGNATION .....

# SPINAL OPIOIDS

STANDISH 0503700053
DAVID M
9 MANSION DR
DUNDEE DD4 9DD

PARK AVENUE MEDICAL CENTRE, PARK AVE

THIS PATIENT HAD INTRATHECAL Morphine 0.1 mg at 09.00 hours

~~EPIDURAL~~
(Delete as appropriate)

***He/she may exhibit respiratory depression within the next 24 hours***

1. Maintain intravenous access for 24 hours
   Maintain oxygen by nasal cannula or mask for 24 hours
   Naloxone to be readily available

2. Record respiratory rate hourly for 24 hours

3. Record pain and sedation scores 4 hourly (sedation usually precedes respiratory depression)

4. NO other opioids given until 15.00 hours

5. At 15.00 hours oramorph may be started as charted if required

6. If respiratory rate is below 8/minute or if patient is unrousable, give Naloxone 0.1 mg increments intravenously until respiratory rate is above 10/minute and patient is fully conscious again. More Naloxone may be needed later. If in doubt consult Anaesthetic Senior Registrar or on call Pain Consultant

7. For respiratory arrest call 2222

8. Urinary retention may require catheterisation

9. Inadequate analgesia, excessive sedation or other problems relating to intrathecal opioid
   Duty anesthetist p 4017

NHS
Tayside

# IN-PATIENT PRE-OPERATIVE CHECK LIST (ADULT)
# GENERAL AND REGIONAL ANAESTHESIA

STANDISH 0503700053
DAVID M
9 MANSION DR
DUNDEE DD4 9DD

PARK AVENUE MEDICAL CENTRE, PARK AVE

Ward ..... Date .....

Admitting Consultant .....

Planned Procedure .....

BASELINE RECORDINGS - TEMP. ° PULSE RESPS BP \

ADMISSION WEIGHT Kgs

WATERLOW SCALE RATING ..... PRE-OP BM-STIX MRSA STATUS

**Column W = Ward Staff** **Column T = Theatre Staff**

| CHECK/CONFIRM FOLLOWING | YES | NO | NA | W | T | COMMENTS |
|---|---|---|---|---|---|---|
| **IDENTIFY** patient with appropriate band WHITE : RED : BLUE | | | | | | |
| **CONSENT** obtained - form accurately completed & signed | | | | | | |
| **ALLERGIES** noted and recorded (see over) | | | | | | |
| Preoperative bath/shower | | | | | | |
| Patient suitably attired | | | | | | |
| Underwear in place | | | | | | |
| Note menstrual protection (tampon to be removed) | | | | | | |
| Has patient emptied bladder within past 2 hours? | | | | | | Voided time hrs |
| Urinary catheter patent | | | | | | |
| Denture: removed (see over) | | | | | | |
| Capped teeth : crowns : bridges noted | | | | | | |
| Jewellery : Hair adornments removed | | | | | | |
| Body piercings removed : taped Oral jewellery must be removed | | | | | | |
| Make up, nail varnish removed | | | | | | |
| Contact lenses removed | | | | | | |
| Hearing aid in situ? (see over) | | | | | | |
| Spectacles (see over) | | | | | | |
| Eye drops instilled | | | | | | Time hrs |
| Anti-embolus stocking applied | | | | | | |
| **FASTED** appropriately | | | | | | Last clear fluid hrs<br>Last food hrs |
| **OPERATION SITE CHECKED AND MARKED** (Medical staff) | | | | | | Right side Left side |
| **PRE-MEDICATION** administered : recorded | | | | | | Time hrs |
| **ROUTINE DRUGS** administered : recorded | | | | | | Time hrs |
| **IDENTIFY PATIENT** against Theatre request slip? | | | | | | |
| **CONFIRM PATIENT IDENTITY AND PLANNED PROCEDURE** against Theatre list | | | | | | |

CONTINUE OVER

NHS
Tayside

| ADDITIONAL INFORMATION | YES | NO | NA | W | T | COMMENTS |
|---|---|---|---|---|---|---|
| Prosthesis present ORBITAL : JOINT | | | | | | |
| Pacemaker | | | | | | |
| Other | | | | | | |
| Has patient had previous surgery/NOTE | | | | | | |
| Medication to accompany patient GTN INHALER OXYGEN | | | | | | |
| Intravenous infusion patent and administered as prescribed | | | | | | |
| ITEMS TO BE REMOVED PRIOR TO ANAESTHESIA – label and retain in recovery | | | | | | |
| Dentures | | | | | | |
| Plate | | | | | | |
| Bridge | | | | | | |
| Spectacles | | | | | | |
| Hearing aid | | | | | | |
| DOCUMENTS TO ACCOMPANY PATIENT | | | | | | |
| Consent form | | | | | | |
| Case notes | | | | | | |
| Nursing record | | | | | | |
| Fluid chart | | | | | | |
| Prescription chart | | | | | | |
| X-rays | | | | | | |
| ECG | | | | | | |
| Blood results | | | | | | |

| ALLERGIES NOTE | INFUSION PUMP STATUS – WARD STAFF |
|---|---|
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| | |
| | |

IDENTIFY ANY MOVEMENT RESTRICTION

FURTHER RELEVANT INFORMATION eg skin condition, presence of pressure sores, any dressing in place etc

WARD BED IS IT CAPABLE OF BEING TIPPED HEAD DOWN RAPIDLY? YES/NO

SIGNATURES

WARD STAFF .....DESIGNATION .....

THEATRE RECEPTION STAFF ..... DESIGNATION .....

ANAESTHETIC ASSISTANT ..... DESIGNATION .....

STANDISH 0503700053
DAVID M
9 MANSION DR
DUNDEE DD4 9DD

PARK AVENUE MEDICAL CENTRE, PARK AVE

Hospital.....

Ward .....

NHS Tayside

# MANUAL HANDLING AND MOBILITY ASSESSMENT CHART

**(To be completed within 24 hours of admission)**

Relevant Medical History/Underlying Condition/Surgery & Date:.....Behaviour: (confused).....

Weight:.....kg Consider safe working load of equipment History of Falls: Y N (if yes, complete Falls Risk Assessment)

Comprehension:(sight, hearing, speech).....Attachments: (infusions, catheter, drains).....

| | CODES | CODES | CODES | CODES | CODES | CODES | CODES |
|---|---|---|---|---|---|---|---|
| Sit>>Lie | | | | | | | |
| Lying>>Sitting | | | | | | | |
| Sit>>Stand | | | | | | | |
| Stand>>Sit | | | | | | | |
| Walking | | | | | | | |
| Bathing | | | | | | | |
| Moving up the bed | | | | | | | |
| Turning/proning | | | | | | | |
| Lateral Transfers | | | | | | | |
| Floor to Bed | | | | | | | |
| Comments | | | | | | | |
| **Date** | | | | | | | |
| **Time** | | | | | | | |
| **Initials** | | | | | | | |

**A Risk Assessment should be carried out prior to any Manual Handling Manoeuvre. All changes or comments should be clearly documented in the Nursing Record of On-Going Care & Multidisciplinary Notes. Please indicate 'YES' if (any) in the Comments box.**

**Enter Mobility and Equipment Codes**

**Mobility Codes**

I = Independent
VP = Verbal prompting
S = Supervision
D = Dependant
BR = Bedrest
NWB = Non weight bearing
PWB = Partial weight bearing
FWB = Full weight bearing
A1 = Assistance x 1 staff
A2 = Assistance x 2 staff
A3 = Assistance x 3 staff
A4 = Assistance x 4 staff

**Aids/Equipment Codes**

H = Full Body Hoist
ST= Stand Aid
GS= 1/2 Glide Sheet
WS= Walking Stick
WS1=One Stick
WS2=Two Sticks
EC = Elbow Crutch
AC = Axillary Crutch
GC = Gutter Crutch
WZF = Wheeled Zimmer Frame
ZF = Zimmer Frame
TWW = Three Wheeled Walker
4WW = Four Wheeled Walker
RZ = Rollator Wheeled Zimmer
WC = Wheelchair
PAT = Patslide

# MANUAL HANDLING AND MOBILITY ASSESSMENT CHART

Relevant Medical History/Underlying Condition/Surgery & Date:.....Behaviour: (confused).....

Weight:.....kg Consider safe working load of equipment History of Falls: Y N (if yes, complete Falls Risk Assessment)

Comprehension:(sight, hearing, speech).....Attachments: (infusions, catheter, drains).....

| | CODES | CODES | CODES | CODES | CODES | CODES | CODES |
|---|---|---|---|---|---|---|---|
| Sit>>Lie | | | | | | | |
| Lying>>Sitting | | | | | | | |
| Sit>>Stand | | | | | | | |
| Stand>>Sit | | | | | | | |
| Walking | | | | | | | |
| Bathing | | | | | | | |
| Moving up the bed | | | | | | | |
| Turning/proning | | | | | | | |
| Lateral Transfers | | | | | | | |
| Floor to Bed | | | | | | | |
| Comments | | | | | | | |
| **Date** | | | | | | | |
| **Time** | | | | | | | |
| **Initials** | | | | | | | |

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RZ = Rollator Wheeled Zimmer
WC = Wheelchair
PAT = Patslide

# Pre- Admission Assessment

Nt STANDISH 0503700053
DAVID M
9 MANSION DR
DUNDEE
DD4 9DD

PARK AVENUE MEDICAL CENTRE, PARK AVE

**RESULTS CHECKED and ACTIONED**
Completed by: NICOLA STEPHEN
Signed N Stephen
date 3/2/11

**Core Data Set** ✓
**Simple/Complex Discharge Plan Completed and attached** ✓

**MRSA Screening** ✓
**Wound site (if appropriate)** N/A
***Infection Control Bookmark issued***

**Blood Glucose Monitoring (BM) Result** 4.6 ✓

**Nicotine Replacement Advice** ✓
***Smoking Cessation Leaflet issued*** ✓

| | | | |
|---|---|---|---|
| **Temp** | 36.2 | °C | |
| **B.P.** *left* | 119/70 | *right* | 120/70 |
| **Pulse** | 67 | *b.p.m.* | |
| **Resp. Rate** | 14 | | |
| **$SPO_2$** | 98 | | |
| **Height** | 176.5 | *cms* | |
| **Weight** | 88.4 | *kgs* | |
| **BMI** | 28 | | |

% weight loss (if appropriate)

**Comments**

**Urinalysis Tests**
*Please tick appropriate box for each test*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Nitrite (60 seconds) | Negative ✓ | Positive (any degree of pink colour) | | | | | |
| Urobilinogen (60 seconds) | normal 3 ✓ 16 | mmol/l 33 | 84 | 131 | | | |
| Protein (60 seconds) | g/l Neg ✓ | Trace | 0.30 + | 1 ++ | 3 +++ | ≥ 20 ++++ | |
| Blood (60 seconds) | Neg ✓ | Trace | Trace | + | ++ | +++ | |
| Specific Gravity (45 seconds) | 1.000 | 1.005 ✓ | 1.010 | 1.015 | 1.020 | 1.025 | 1.030 |
| Ketone (40 seconds) | Neg ✓ mmol/l | Trace 0.5 | Small 1.5 | Moderate 4 | 8 | Large 16 | |
| Bilirubin (30 seconds) | Neg ✓ | Small + | Moderate ++ | Large +++ | | | |
| Glucose (30 seconds) | g/l Neg ✓ | 5.5 Trace | 14 + | 28 ++ | 55 +++ | ≥ 111 ++++ | |

## Medical Check-list

**Admission Sheet**
**BM result actioned if required**

**Patient normally on Warfarin** - yes/no
date stopped (if applicable)

**Patient normally on Clopidogrel** - yes/no
If yes, discuss with Senior Medical Team
date stopped (if applicable)

**ECG**
**Bloods** U+E
FBC
G&S

**Chest x-ray (if required)**

**Other Investigations: specify**

Vascular Lab Investigations undertaken and noted

**RESULTS CHECKED and ACTIONED**
Completed by:
Signed
date

**Comments**

## Anaesthetic Assessment - *to be completed by Anaesthetist*

## OPERATION NOTES

..... UNIT/WARD/DEPT

Ward/Clinic/
Hosp. ..... Cons.

STANDISH 0503700053
DAVID M
9 MANSION DR
DUNDEE
DD4 9DD

PARK AVENUE MEDICAL CENTRE, PARK AVE

D M M Y Y C.H.I. No.

..... M. State

..... Sex

USE BLOCK LETTERS OR PATIENT LABEL

| DATE OF OPERATION | Operation Proposed | TIME BEGAN ..... AM PM |
|---|---|---|
| | | TIME FINISHED ..... AM PM |

SURGEON'S NOTES

DMR9

# CONSENT FOR OPERATION INVESTIGATION

I, .....

of, .....

hereby consent to * (undergo (the submission of my * (child (ward .....

.....to undergo (the operation/investigation of).....

.....the nature and purpose of which have been explained to me by * Dr/Mr/Mrs/Ms .....

I also consent to such further 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

NOTE: **Age of Consent**
The Tayside Health Board have been advised by the Central Legal Office that anyone who has attained 16 years of age can give or withhold valid consent to operation/investigation on himself/herself. Ordinarily the parent or guardian should be informed in the case of a patient who has not reached the age of 18.

* DELETE AS APPROPRIATE
** THE CLAUSE SHOULD BE DELETED WHERE THE INITIAL CONSENT IS FOR AN INVESTIGATION AND NOT AN OPERATION

ANY DELETIONS, INSERTIONS OR AMENDMENTS TO THE FORM ARE TO BE MADE BEFORE THE EXPLANATION IS GIVEN AND THE FORM SUBMITTED FOR SIGNATURE.

STANDISH 0503700053
DAVID M
9 MANSION DR
DUNDEE
Surname: ..... DD4 9DD .....
First Name: ..... ..... C.H.I. No.
Address: ..... PARK AVENUE MEDICAL CENTRE, PARK AVE .....
.....

## Drug History:

**Source(s) of history:**

Patient ☐ GP Referral Letter ☐ Prescribing Database ☐
GP Practice ☐ Patient's Own Drugs ☐ Community Pharmacy ☐
Relative ☐ Nursing Home Kardex ☐ Other:

| **ADMISSION MEDICATION** | | | **ACTION** | | Note: Unless indicated to stop/hold, medication should be continued on TPAR/discharge. |
|---|---|---|---|---|---|
| Name | Dose | Frequency | Hold | Stop | Comments (if medication held or stopped) |
| | | | | | |
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| | | | | | |

Non-prescription medications, herbal medications and illicit drugs:

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Adverse reactions/Allergies**

| Drug / Substance: | Reaction: | Drug / Substance: | Reaction: | Or **No Known Drug Allergies** ☐ |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Are you satisfied this medication history is complete and accurate? Yes** ☐ **No** ☐

If "no", what further action is necessary (contact GP, etc)?

Doctor's name: ..... Signature: ..... Bleep no: .....

Reviewed by pharmacist? Name: Signature:

# DAILY IV FLUID PRESCRIPTION AND FLUID BALANCE CHART

Date 14-2-11

For Incompatibilities and Rate of Flow – See Overleaf

Ward/Clinic/Hosp. 13 NW Nagy Cons.

0503700053

LABORATORY REQUEST LABEL

STANDISH, DAVID

Surname

First Nam

Address

G.P. & Ac

M Y Y 3 7 0 C.H.I. No.

M. State

Sex

USE BLOCK LETTERS OR PATIENT LABEL

| Bottle No. | FLUID TYPE | FLUID Amount ml. | Rate of Flow per hour ml/hr | Batch No. | ADDITIONS (Sign here if Drugs added subsequently) | Use 24hr Clock Start | Use 24hr Clock Finish | Prescribed by (Doctors Signature) / Administered by (Signature) |
|---|---|---|---|---|---|---|---|---|
| 1 | Hartmans | 500 | th | | | 0920 | 0940 | Th3SMc |
| 2 | Hartmans | 500 | th | | | 0940 | 1110 | Th3SMc |
| 3 | Hartmans | 500 | th | | | 1110 | 1400 | Th3SMc |
| 4 | Hartmanns | 500 | 80 | 1011STAD | | 1400 | | |

THIS CHART MAY BE DESTROYED ON DISCHARGE OF PATIENT PROVIDED NO RECORDINGS ARE MADE ABOVE THIS LINE

| 24hr clock Time | INTAKE in ml. I.V. | INTAKE in ml. ORAL | OUTPUT in ml. Urine | Vomit | Aspirate | Fistulae | Drain | Stool | COMMENTS |
|---|---|---|---|---|---|---|---|---|---|
| 0940 | 500 | | | | | | | | |
| 1400 | (2+3) 1000 | | | | | | | | |
| TOTALS | | | | | | | | | |

SPECIAL INSTRUCTIONS:

I.V. Total ..... Oral Total ..... Balance .....

Total Intake .....

Total Output .....

Known Drug Sensitivity – or Adverse Reaction

1. 2.

THB (MR) 29 Rev.8/92

# INCOMPATIBILITIES OF DRUGS

*Precautions –*

*Do* NOT *add Drugs to the following*

AMINO ACID SOLUTIONS
LIPID EMULSIONS
MANNITOL SOLUTIONS – *check solution has not crystallised*
WHOLE BLOOD OR BLOOD PRODUCTS

| RATE OF FLOW (for 500ml) |
|---|
| PLEASE CONSULT OUTER COVER OF THE IV SET |

POTASSIUM CHLORIDE

*A standard solution of 0.3% Potassium Chloride in 5% Dextrose solution or 0.9% Sodium Chloride solution containing 40 millimoles of $K^+$ per litre is available. Normally not more than* 80 millimoles $K^+$ (6 grams Potassium Chloride) *should be infused in 24 hours.*

CONSULT THE PHARMACY DEPARTMENT *about the addition of drugs to infusion solution. Remember to* ensure good mixing *after adding drugs to an infusion solution. Following the addition of a drug to an infusion fluid remember to affix a* "Drug Additive" Label *to the container.*
Infuse solution as soon as possible after the addition of drug(s).

ANTIBIOTICS – PREFERABLY AVOID ADMINISTRATION BY INTRAVENOUS INFUSION
*To achieve Therapeutic Levels* – ADMINISTER BY BOLUS INJECTION

ON OCCASIONS OF NECESSITY REFER TO TABLE BELOW OR SEEK ADDITIONAL INFORMATION

| | |
|---|---|
| CEPHALORIDINE | TETRACYCLINES, ERYTHROMYCIN *incompatible* |
| ERYTHROMYCIN LACTOBIONATE | *Should only be added to IV Fluids after reconstitution with water for injection* (See package insert for full details)<br>NO *other drugs to be added to infusion* |
| GENTAMICIN | Do not add to Infusion Fluids. *Give as a bolus injection* |
| HEPARIN | *Add* preferably *to* SODIUM CHLORIDE 0.9% *Solution*<br>ANTIBIOTICS, HYDROCORTISONE *incompatible* |
| HYDROCORTISONES<br>*e.g. Sodium Phosphate*<br>*Sodium Succinate preparations* | ANTIBIOTICS, HEPARIN *incompatible* |
| PENICILLINS<br>*e.g. Ampicillin*<br>*Benzylpenicillin* | *Add* only *to* Sodium Chloride 0.9%<br>*Prepare immediately before administration.*<br>Infuse within 4 hours. Do not mix with other drugs. |
| TETRACYCLINES | NO *other drugs to be added to infusion.*<br>*Do* NOT *add to solutions containing* Calcium. |

FOR PHARMACY USE
Checked by:
.....
Clinical Pharmacist
Patient Counselled:
.....(Initials)

Medicines Required On Ward

Date.....

Time.....

.....2nd Fold.....

# DISCHARGE NOTIFICATION AND PRESCRIPTION FORM

.....Hosp./Inf.

To Dr. .....
PARK AVENUE MEDICAL CENTRE
PARK AVENUE, DUNDEE

HOSPITAL: NW WARD/CLINIC: 12

*1 of 2*

D D M M Y Y
0 5 0 3 7 0 0 0 5 3 C.H.I. No.

Surname: STANDISH
First Name: DAVID M. State
Address: 9 MANSION DR, DUNDEE

**ALWAYS USE BALLPOINT PEN**

THIS IS THE *ONLY / *INTERIM DISCHARGE LETTER (to be completed by Discharging Doctor)

Date Placed on Waiting List: ..... (if appropriate) Date of Admission: 13/2/11

*Delete as appropriate

Type of Admission: Elective /Emergency / Urgent / Transfer

| DISCHARGE DETAILS | DATE | SPECIALITY | CONSULTANT | DISCHARGED TO | TRANSFERRED TO: HOSPITAL | SPECIALITY | CONSULTANT |
|---|---|---|---|---|---|---|---|
| | | VASCULAR | GRIFFITHS | HOME | | | |

DIAGNOSIS AND OPERATIONS

PRINCIPAL DIAGNOSIS: CLAUDICATION

PRINCIPAL OPERATION / PROCEDURES: RIGHT COMMON FEMORAL ENDARTERECTOMY AND ANGIOPLASTY

OTHER CONDITIONS:
1, .....
2. .....
3. .....

OTHER OPERATIONS / PROCEDURES:

When Medicines are to be dispensed All copies to be sent to Pharmacy

| Days | MEDICINE TREATMENT ON DISCHARGE NAME OF MEDICINE | DOSE | Times of Administration (Mark √) 8 10 12 14 16 18 20 22 24 | DURATION OF TREATMENT | DISPENSED BY PHARMACY Number | Brand Names (for information only) |
|---|---|---|---|---|---|---|
| ✓ | LANSOPRAZOLE | 30mg | X | | ✓ | @home |
| ✓ | FOLIC ACID | 5mg | X | | ✓ | |
| ✓ | AMLODIPINE | 5mg | X | | ✓ | |
| ✓ | EZETIMIBE | 10mg | X | | ✓ | |
| ✓ | ATORVASTATIN | 40mg | X | | ✓ | |
| ✓ | DIAZEPAM | 5mg | X X | | ✓ | |
| ✓ | ESCITALOPRAM | 20mg | X | | ✓ | |
| ✓ | CLOPIDOGREL | 75mg | X | | ✓ | |

.....1st Fold.....

7 days supply will be dispensed unless stated otherwise in box provided

| DISCONTINUED MEDICINE | REASON DISCONTINUED |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

Discharge Prescriptions should normally be sent to pharmacy at least 24 hours before discharge

INFORMATION / ADVICE TO PATIENT ☐ YES ☐ NO IF YES, SPECIFY

KNOWN ALLERGIES: NKDA

CARE ARRANGEMENTS ON DISCHARGE (TICK BOX) NONE ☐ DISTRICT NURSE ☐ SOCIAL WORK ☐ HOME HELP/ RELATIVES ☐

| FOLLOW-UP APPOINTMENT | DATE | TIME | CLINIC | DELETE AS APPROPRIATE GIVEN / TO BE SENT |
|---|---|---|---|---|
| | | | | |

RESULTS AWAITED: YES ☐ NO ☐
IF YES, SPECIFY:.....

FOR FURTHER INFORMATION CONTACT ..... (NAME) ..... (STATUS) .....(TEL NO)

Signature: ..... Status: FYI

..... GRIFFITHS Consultant Date: 16/2/11

Dispensed By: .....
Checked By: .....
Date: .....

Final Distribution:
WHITE - GP
PINK - Pharmacy
YELLOW - Case Records
BLUE - Audit/Coding

THB(MR)26
4 Part Set

FOR PHARMACY USE

Checked by:

.....

Clinical Pharmacist

Patient Counselled:

.....(Initials)

Medicines Required On Ward

Date.....

Time.....

.....2nd Fold.....

# DISCHARGE NOTIFICATION AND PRESCRIPTION FORM

.....Hosp./Inf.

To Dr. .....

PARK AVENUE MEDICAL CENTRE,

PARK AVENUE, DUNDEE

**ALWAYS USE BALLPOINT PEN**

HOSPITAL: NW WARD/CLINIC: 12

*2 of 2*

D D M M Y Y: 0 5 0 3 7 0 0 0 5 3 C.H.I. No.

Surname: STANDISH

First Name: DAVID M. State

Address: 9 MANSION DR, DUNDEE

THIS IS THE *ONLY / *INTERIM DISCHARGE LETTER (to be completed by Discharging Doctor)

Date Placed on Waiting List: ..... (if appropriate) Date of Admission: 13/2/11

*Delete as appropriate

Type of Admission: Elective /Emergency / Urgent / Transfer

| DISCHARGE DETAILS | DATE | SPECIALITY | CONSULTANT | DISCHARGED TO | TRANSFERRED TO: HOSPITAL | SPECIALITY | CONSULTANT |
|---|---|---|---|---|---|---|---|
| | | VASCULAR | GRIFFITHS | HOME | | | |

DIAGNOSIS AND OPERATIONS

PRINCIPAL DIAGNOSIS: CLAUDICATION

PRINCIPAL OPERATION / PROCEDURES: RIGHT COMMON FEMORAL ENDARTERECTOMY AND ANGIOPLASTY

OTHER CONDITIONS:

1, .....
2. .....
3. .....

OTHER OPERATIONS / PROCEDURES:

When Medicines are to be dispensed All copies to be sent to Pharmacy

| Days | MEDICINE TREATMENT ON DISCHARGE: NAME OF MEDICINE | DOSE | Times of Administration (Mark √): 8 10 12 14 16 18 20 22 24 | DURATION OF TREATMENT | DISPENSED BY PHARMACY: Number | Brand Names (for information only) |
|---|---|---|---|---|---|---|
| ✓ | CO-DYDRAMOL 30/500 | 1-2tabs | AS REQUIRED 4-6° | | ✓ | @home |
| ✓ | SALBUTAMOL | 2 PUFFS | AS REQUIRED | | ✓ | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

....1st Fold....

7 days supply will be dispensed unless stated otherwise in box provided

| DISCONTINUED MEDICINE | REASON DISCONTINUED |
|---|---|
| 1. Also has a QVAR 50mcg MDI @home, which is rarely used. | |
| 2. | |
| 3. | |
| 4. | |

Discharge Prescriptions should normally be sent to pharmacy at least 24 hours before discharge

INFORMATION / ADVICE TO PATIENT ☐ YES ☐ NO IF YES, SPECIFY

KNOWN ALLERGIES:

CARE ARRANGEMENTS ON DISCHARGE (TICK BOX) NONE ☐ DISTRICT NURSE ☐ SOCIAL WORK ☐ HOME HELP/ RELATIVES ☐

| FOLLOW-UP APPOINTMENT | DATE | TIME | CLINIC | DELETE AS APPROPRIATE: GIVEN / TO BE SENT |
|---|---|---|---|---|
| | | | | |

RESULTS AWAITED: YES ☐ NO ☐ IF YES, SPECIFY:.....

FOR FURTHER INFORMATION CONTACT ..... (NAME) ..... (STATUS) .....(TEL NO)

Signature: ..... Status: FYI

GRIFFITHS ..... Consultant Date: 16/2/11

Dispensed By: .....

Checked By: .....

Date: .....

Final Distribution:

WHITE - GP
PINK - Pharmacy
YELLOW - Case Records
BLUE - Audit/Coding

THB(MR)26
4 Part Set

THB(MR) 024SS

NHS Tayside

DATE OF ADMISSION / RECORD START DATE 13/2/11

# TAYSIDE PRESCRIPTION AND ADMINISTRATION RECORD (SHORT STAY)

**Hospital /Ward:** NW 12

**Consultant:** GRIFFITH

**On admission:**

**Weight:** **Height:**

STANDISH 0503700053
DAVID M
9 MANSION DR
DUNDEE
DD4 9DD

PARK AVENUE MEDICAL CENTRE, PARK AVE

## CONFIRMATION OF PRESCRIPTION REVIEW ON TRANSFER OF MEDICAL CARE

| Receiving Unit | Date | Authorised Prescriber (Signature) |
|---|---|---|
| | | |
| | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Date | | | | | | | | | |
| Weight | | | | | | | | | |
| Signature | | | | | | | | | |

## ONCE ONLY PRESCRIPTIONS

| Date | Time | Medicine | Dose | Route | Prescribed By | Time Given | Given By |
|---|---|---|---|---|---|---|---|
| 14.2.11 | 10.00 | Gentamycin | 240mg | IV | DLe | 10.00 | DC |
| 14.2.11 | 10.00 | Flucloxacillin | 1g | IV | DLe | 10.00 | DC |
| | | | | | | | |
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## KNOWN MEDICINE ALLERGIES/ SENSITIVITIES (if NONE confirmed write NKA in Box 1)

| 1. | 2. | 3. | 4. |
|---|---|---|---|
| NKDA | | | |

## OTHER MEDICINE CHARTS IN USE

| Chart Type | Signed | Chart Type | Signed |
|---|---|---|---|
| 1. Insulin | | 5. Anticoagulant | |
| 2. Epidural / Pain relief | | 6. Mental Health Act | |
| 3. Fluid | | 7. Symptomatic Relief Administration Record | |
| 4. Anaesthetic Chart | | 8. Other | |

## AS REQUIRED THERAPY

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicine / Form | | Date | | | | | | | | | | |
| | | Time | | | | | | | | | | |
| Dose & Frequency | Route | Dose | | | | | | | | | | |
| | | Initials | | | | | | | | | | |
| Signature | Start Date | Date | | | | | | | | | | |
| | | Time | | | | | | | | | | |
| Indication / Notes | Pharmacy | Dose | | | | | | | | | | |
| | | Initials | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicine / Form | | Date | | | | | | | | | | |
| | | Time | | | | | | | | | | |
| Dose & Frequency | Route | Dose | | | | | | | | | | |
| | | Initials | | | | | | | | | | |
| Signature | Start Date | Date | | | | | | | | | | |
| | | Time | | | | | | | | | | |
| Indication / Notes | Pharmacy | Dose | | | | | | | | | | |
| | | Initials | | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicine / Form | | Date | | | | | | | | | | |
| | | Time | | | | | | | | | | |
| Dose & Frequency | Route | Dose | | | | | | | | | | |
| | | Initials | | | | | | | | | | |
| Signature | Start Date | Date | | | | | | | | | | |
| | | Time | | | | | | | | | | |
| Indication / Notes | Pharmacy | Dose | | | | | | | | | | |
| | | Initials | | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicine / Form | | Date | | | | | | | | | | |
| | | Time | | | | | | | | | | |
| Dose & Frequency | Route | Dose | | | | | | | | | | |
| | | Initials | | | | | | | | | | |
| Signature | Start Date | Date | | | | | | | | | | |
| | | Time | | | | | | | | | | |
| Indication / Notes | Pharmacy | Dose | | | | | | | | | | |
| | | Initials | | | | | | | | | | |

### NOTES FOR USERS

**For Prescribers:**

1. Sign your name clearly against each prescription.
2. When medicines are discontinued, draw a single diagonal line through the medicine prescribed section, a single vertical line through the rest of that day's administration boxes and a double diagonal line through the remaining boxes on the administration section for that medicine. The authorised prescriber must then sign and date under this double line.
3. If an existing prescription is to be modified, delete existing prescription as described and re-write new instructions in a new section.
4. Use approved names in BLOCK LETTERS and use metric doses as follows:
   **Milligram = mg** **Gram = g** **Millilitre = mL** **Microgram: to be written in full**
   Fractions of a milligram should be written in micrograms. A zero should be written in front of a decimal point where there is no other figure, e.g. 0.5mL **not** .5mL
5. Method of administration should be abbreviated as follows:
   **Intravenous = IV** **Inhalations = INHALE** **Intramuscular = IM** **Oral = ORAL**
   **Topical = TOP** **Vaginal = PV** **Subcutaneous = SC** **Sublingual = SL**
   **Intradermal = ID** **Per rectum = PR** **Nasogastric = NG**

**For Nurses:**

1. The 'Regular' and 'As Required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.
2. Ensure entry is made on administration record each time medicine is given. Initial in relevant date column and time row.
3. Check that all medicines prescribed at a certain time are administered.
4. If medicine is not administered, enter reason in appropriate box using the coding system.

## CONTINUOUS INFUSIONS/ SYRINGE DRIVER

| Date | Medicines | Dose Hourly/ 12/24 | Route | Prescribed By | Date Stopped | Comments |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Date | | | | | | |
| Time | | | | | | |
| Signature | | | | | | |
| Signature | | | | | | |

| Date | Medicines | Dose Hourly/ 12/24 | Route | Prescribed By | Date Stopped | Comments |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Date | | | | | | |
| Time | | | | | | |
| Signature | | | | | | |
| Signature | | | | | | |

| Date | Medicines | Dose Hourly/ 12/24 | Route | Prescribed By | Date Stopped | Comments |
|---|---|---|---|---|---|---|
| | | | | | | |
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| | | | | | | |
| Date | | | | | | |
| Time | | | | | | |
| Signature | | | | | | |
| Signature | | | | | | |

| Date | Medicines | Dose Hourly/ 12/24 | Route | Prescribed By | Date Stopped | Comments |
|---|---|---|---|---|---|---|
| | | | | | | |
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| | | | | | | |
| Date | | | | | | |
| Time | | | | | | |
| Signature | | | | | | |
| Signature | | | | | | |

| Date | Medicines | Dose Hourly/ 12/24 | Route | Prescribed By | Date Stopped | Comments |
|---|---|---|---|---|---|---|
| | | | | | | |
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| | | | | | | |
| Date | | | | | | |
| Time | | | | | | |
| Signature | | | | | | |
| Signature | | | | | | |

| Date | Medicines | Dose Hourly/ 12/24 | Route | Prescribed By | Date Stopped | Comments |
|---|---|---|---|---|---|---|
| | | | | | | |
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| | | | | | | |
| Date | | | | | | |
| Time | | | | | | |
| Signature | | | | | | |
| Signature | | | | | | |

## AS REQUIRED THERAPY

| Medicine / Form | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ORAMORPH | | Date | 14/2/11 | | | | | | | | | | |
| | | Time | 1655 | | | | | | | | | | |
| Dose & Frequency | Route | Dose | 10mg | | | | | | | | | | |
| 10mg 1-2hly | PO | Initials | AMC/SP | | | | | | | | | | |
| Signature | Start Date | Date | | | | | | | | | | | |
| | 14/2/11 | Time | | | | | | | | | | | |
| Indication / Notes | Pharmacy | Dose | | | | | | | | | | | |
| Pain | | Initials | | | | | | | | | | | |

| Medicine / Form | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PROCHLORPERAZINE | | Date | | | | | | | | | | | |
| | | Time | | | | | | | | | | | |
| Dose & Frequency | Route | Dose | | | | | | | | | | | |
| 12.5mg 6-8hly | IM | Initials | | | | | | | | | | | |
| Signature | Start Date | Date | | | | | | | | | | | |
| | 14/2/11 | Time | | | | | | | | | | | |
| Indication / Notes | Pharmacy | Dose | | | | | | | | | | | |
| Nausea | S/P | Initials | | | | | | | | | | | |

| Medicine / Form | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Date | | | | | | | | | | | |
| | | Time | | | | | | | | | | | |
| Dose & Frequency | Route | Dose | | | | | | | | | | | |
| | | Initials | | | | | | | | | | | |
| Signature | Start Date | Date | | | | | | | | | | | |
| | | Time | | | | | | | | | | | |
| Indication / Notes | Pharmacy | Dose | | | | | | | | | | | |
| | | Initials | | | | | | | | | | | |

| Medicine / Form | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Date | | | | | | | | | | | |
| | | Time | | | | | | | | | | | |
| Dose & Frequency | Route | Dose | | | | | | | | | | | |
| | | Initials | | | | | | | | | | | |
| Signature | Start Date | Date | | | | | | | | | | | |
| | | Time | | | | | | | | | | | |
| Indication/ Notes | Pharmacy | Dose | | | | | | | | | | | |
| | | Initials | | | | | | | | | | | |

| Medicine / Form | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Date | | | | | | | | | | | |
| | | Time | | | | | | | | | | | |
| Dose & Frequency | Route | Dose | | | | | | | | | | | |
| | | Initials | | | | | | | | | | | |
| Signature | Start date | Date | | | | | | | | | | | |
| | | Time | | | | | | | | | | | |
| Indication / Notes | Pharmacy | Dose | | | | | | | | | | | |
| | | Initials | | | | | | | | | | | |

| Medicine / Form | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Date | | | | | | | | | | | |
| | | Time | | | | | | | | | | | |
| Dose & Frequency | Route | Dose | | | | | | | | | | | |
| | | Initials | | | | | | | | | | | |
| Signature | Start Date | Date | | | | | | | | | | | |
| | | Time | | | | | | | | | | | |
| Indication / Notes | Pharmacy | Dose | | | | | | | | | | | |
| | | Initials | | | | | | | | | | | |

# REGULAR THERAPY

Date →
Time ↓

| Medicine / Form | | Pharmacy |
|---|---|---|
| Dose | Route | |
| Signature | Start Date | |

Time: 6, 8, 12, 14, 18, 22

| Medicine / Form | | Pharmacy |
|---|---|---|
| Dose | Route | |
| Signature | Start Date | |

Time: 6, 8, 12, 14, 18, 22

| Medicine / Form | | Pharmacy |
|---|---|---|
| Dose | Route | |
| Signature | Start Date | |

Time: 6, 8, 12, 14, 18, 22

| Medicine / Form | | Pharmacy |
|---|---|---|
| Dose | Route | |
| Signature | Start Date | |

Time: 6, 8, 12, 14, 18, 22

| Medicine / Form | | Pharmacy |
|---|---|---|
| Dose | Route | |
| Signature | Start Date | |

Time: 6, 8, 12, 14, 18, 22

## CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINES

If a dose is not administered, initial and enter the appropriate code in the box with a circle drawn round it:

1. Patient refused
2. Patient unavailable
3. Medicine out of stock
4. Instructions not clear / legal
5. Nil by mouth.
6. Once only / prn given
7. Dose withheld – Prescriber's instructions
8. Self administered by patient
9. Nausea/vomiting
10. Unable to swallow
11. No intravenous access
12. Anaesthetist requested omission
13. Other .....
14. Other .....
15. Other .....

General Comments

# REGULAR THERAPY

Date → 15/2 16/2 1.

Time ↓

| Medicine / Form | Dose | Route | Signature | Start Date | Pharmacy | Time | 15/2 | 16/2 | 1. |
|---|---|---|---|---|---|---|---|---|---|
| CLOPIDOGREL | 75mg | PO | | 15/2/11 | | 6 | | | |
| | | | | | | 8 | MN | | |
| | | | | | | 12 | | | |
| | | | | | | 14 | | | |
| | | | | | | 18 | | | |
| | | | | | OSD 15/2 | 22 | | | |
| | | | | | | 6 | | | |
| | | | | | | 8 | | | |
| | | | | | | 12 | | | |
| | | | | | | 14 | | | |
| | | | | | | 18 | | | |
| | | | | | | 22 | | | |
| | | | | | | 6 | | | |
| | | | | | | 8 | | | |
| | | | | | | 12 | | | |
| | | | | | | 14 | | | |
| | | | | | | 18 | | | |
| | | | | | | 22 | | | |
| | | | | | | 6 | | | |
| | | | | | | 8 | | | |
| | | | | | | 12 | | | |
| | | | | | | 14 | | | |
| | | | | | | 18 | | | |
| | | | | | | 22 | | | |
| | | | | | | 6 | | | |
| | | | | | | 8 | | | |
| | | | | | | 12 | | | |
| | | | | | | 14 | | | |
| | | | | | | 18 | | | |
| | | | | | | 22 | | | |

## CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINES

If a dose is not administered, initial and enter the appropriate code in the box with a circle drawn round it:

1. Patient refused
2. Patient unavailable
3. Medicine out of stock
4. Instructions not clear / legal
5. Nil by mouth.
6. Once only / prn given
7. Dose withheld – Prescriber's instructions
8. Self administered by patient
9. Nausea/vomiting
10. Unable to swallow
11. No intravenous access
12. Anaesthetist requested omission
13. Other .....
14. Other .....
15. Other .....

General Comments

# REGULAR THERAPY

Date ▶ / Time ▼

**Medicine / Form:** FRAGMIN
**Dose:** 5000 UNITS
**Route:** S/C
**Signature:** AA
**Start Date:** 13/2/11
**Pharmacy:** S.

| Time | Date 13/2/11 | 14/2/11 | 15/2/11 | 16/2/11 | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 | | AA | | | | | | | | | | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 | | | | | | | | | | | | | | | | | | | | | | | | |
| (18) | | AA | | | | | | | | | | | | | | | | | | | | | | |
| 22 | | | | | | | | | | | | | | | | | | | | | | | | |

~~**Medicine / Form:** ASPIRIN~~
~~**Dose:** 75mg~~
~~**Route:**~~
~~**Signature:** AA~~
~~**Start Date:**~~
~~**Pharmacy:**~~

| Time | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 | | | | | | | | | | | | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 | | | | | | | | | | | | | | | | | | | | | | | | |
| 18 | | | | | | | | | | | | | | | | | | | | | | | | |
| 22 | | | | | | | | | | | | | | | | | | | | | | | | |

**Medicine / Form:** LANSOPRAZOLE
**Dose:** 30mg
**Route:** ORAL
**Signature:** AA
**Start Date:** 13/2/11
**Pharmacy:** OD SR

| Time | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 | | | | | | | | | | | | | | | | | | | | | | | | |
| (8) | | M | M | M | | | | | | | | | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 | | | | | | | | | | | | | | | | | | | | | | | | |
| 18 | | | | | | | | | | | | | | | | | | | | | | | | |
| 22 | | | | | | | | | | | | | | | | | | | | | | | | |

**Medicine / Form:** FOLIC ACID
**Dose:** 5mg
**Route:** ORAL
**Signature:** AA
**Start Date:** 13/2/11
**Pharmacy:** OD SR

| Time | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 | | | | | | | | | | | | | | | | | | | | | | | | |
| (8) | | M | M | M | | | | | | | | | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 | | | | | | | | | | | | | | | | | | | | | | | | |
| 18 | | | | | | | | | | | | | | | | | | | | | | | | |
| 22 | | | | | | | | | | | | | | | | | | | | | | | | |

**Medicine / Form:** AMLODIPINE
**Dose:** 5mg
**Route:** ORAL
**Signature:** AA
**Start Date:** 13/2/11
**Pharmacy:** OD SR

| Time | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 | | | | | | | | | | | | | | | | | | | | | | | | |
| (8) | | M | M | M | | | | | | | | | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 | | | | | | | | | | | | | | | | | | | | | | | | |
| 18 | | | | | | | | | | | | | | | | | | | | | | | | |
| 22 | | | | | | | | | | | | | | | | | | | | | | | | |

## CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINES

If a dose is not administered, initial and enter the appropriate code in the box with a circle drawn round it:

1. Patient refused
2. Patient unavailable
3. Medicine out of stock
4. Instructions not clear / legal
5. Nil by mouth.
6. Once only / prn given
7. Dose withheld – Prescriber's instructions
8. Self administered by patient
9. Nausea/vomiting
10. Unable to swallow
11. No intravenous access
12. Anaesthetist requested omission
13. Other .....
14. Other .....
15. Other .....

General Comments

# REGULAR THERAPY

Date → / Time ↓ — 13/2/11 | 14/2/11 | 15/2/11 | 16/2/11

**Medicine / Form:** EZETIMIBE
Dose: 10mg | Route: ORAL
Signature: [signature] | Start Date: 13/2/11
Pharmacy: RD/OD/ISR

| Time | | | | |
|---|---|---|---|---|
| 6 | | | | |
| 8 | | M | M | M |
| 12 | | | | |
| 14 | | | | |
| 18 | | | | |
| 22 | | TAKES AT NIGHT | | |

**Medicine / Form:** ATORVASTATIN
Dose: 40mg | Route: ORAL
Signature: [signature] | Start Date: 13/2/11
Pharmacy: RD/OD/ISR

| Time | | | | |
|---|---|---|---|---|
| 6 | | | | |
| 8 | | | | |
| 12 | | | | |
| 14 | | | | |
| 18 | | | | |
| 22 | | [signature] | | |

**Medicine / Form:** DIAZEPAM
Dose: 5mg | Route: ORAL
Signature: [signature] | Start Date: 13/2/11
Pharmacy: RD/OD/ISR

| Time | | | | |
|---|---|---|---|---|
| 6 | | | | |
| 8 | | | | |
| 12 | | | | |
| 14 | | | | |
| 18 | | OD | OD | |
| 22 | | [signature] | [signature] | |

**Medicine / Form:** ESCITALOPRAM
Dose: 20mg | Route: ORAL
Signature: [signature] | Start Date: 13/2/11
Pharmacy: OD/ISR/RD

| Time | | | | |
|---|---|---|---|---|
| 6 | | | | |
| 8 | | M | M | M |
| 12 | | | | |
| 14 | | | | |
| 18 | | | | |
| 22 | | | | |

**Medicine / Form:** PARACETAMOL
Dose: 1g | Route: PO/IV
Signature: [signature] | Start Date: 14/2/11
Pharmacy: S

| Time | | | | |
|---|---|---|---|---|
| 6 | | | | USES CO-CODAMOL 30/500 @ HOME |
| 8 | | | M | M |
| 12 | | | PRN | M |
| 14 | | | | |
| 18 | | RD | OD | |
| 22 | | [signature] | [signature] | |

## CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINES

If a dose is not administered, initial and enter the appropriate code in the box with a circle drawn round it:

1. Patient refused
2. Patient unavailable
3. Medicine out of stock
4. Instructions not clear / legal
5. Nil by mouth.
6. Once only / prn given
7. Dose withheld – Prescriber's instructions
8. Self administered by patient
9. Nausea/vomiting
10. Unable to swallow
11. No intravenous access
12. Anaesthetist requested omission
13. Other .....
14. Other .....
15. Other .....

General Comments

# ECS - Live - Patient Report

## Patient

| Patient Name | CHI | Date Of Birth | Age | GP | GP Practice | GP Practice Code |
|---|---|---|---|---|---|---|
| DAVID STANDISH Name Changed | 0503700053 | 05/03/1970 | 40 | (70271) | PARK AVENUE MEDICAL CENTRE | 11005 |

## Clinical Data

**Last Emergency Care Summary received 25 January 2011**

Allergy

| Description | Date Recorded | Comments |
|---|---|---|

Acute Medication (within 30 days)

| Drug ID | Formulation | Dose | Frequency | Medication Start Date | Presc Da |
|---|---|---|---|---|---|
| ESCITALOPRAM tabs 20mg | 28 tablet(s) | 1 Tab Daily | 1 Tab Daily | | 24 Jan |
| DIAZEPAM tabs 5mg | 56 tablet(s) | TAKE ONE TABLET(S) TWICE DAILY | TAKE ONE TABLET (S) TWICE DAILY | | 24 Jan |

Repeat Medication

| Originator | Drug ID | Formulation | Dose | Frequency | Medication Start Date | Prescription Date | Disper Dat |
|---|---|---|---|---|---|---|---|
| | EZETIMIBE tabs 10mg | 56 tablet(s) | TAKE ONE DAILY | TAKE ONE DAILY | 19 Oct 2010 | 17 Dec 2010 | |
| | CLOPIDOGREL FC tab 75mg | 56 tablet(s) | TAKE ONE ONCE DAILY | TAKE ONE ONCE DAILY | 13 Sep 2010 | 17 Dec 2010 | |
| | FOLIC ACID tabs 5mg | 56 tablet(s) | TAKE ONE DAILY | TAKE ONE DAILY | 13 Sep 2010 | 17 Dec 2010 | |
| | LANSOPRAZOLE caps(ec grans) 30mg | 56 capsule (s) | TAKE ONE ONCE DAILY | TAKE ONE ONCE DAILY | 13 Sep 2010 | 17 Dec 2010 | |
| | AMLODIPINE tabs 5mg | 56 tablet(s) | TAKE ONE DAILY | TAKE ONE DAILY | 13 Sep 2010 | 17 Dec 2010 | |
| | ATORVASTATIN tabs 40mg | 56 tablet(s) | TAKE ONE DAILY | TAKE ONE DAILY | 09 Aug 2010 | 17 Dec 2010 | |
| | SALBUTAMOL cfc free inh 100micrograms/inhalation | 2 200 dose inhaler | INHALE 2 DOSES AS NEEDED | INHALE 2 DOSES AS NEEDED | 09 Aug 2010 | 17 Dec 2010 | |
| | ATORVASTATIN tabs 40mg | 56 tablet(s) | TAKE ONE DAILY | TAKE ONE DAILY | 02 Aug 2010 | 02 Aug 2010 | |
| | SALBUTAMOL cfc free inh 100micrograms/inhalation | 2 200 dose inhaler | INHALE 2 DOSES AS NEEDED | INHALE 2 DOSES AS NEEDED | 17 Jun 2010 | 17 Jun 2010 | |
| | NIQUITIN CLEAR patch 14mg | 14 patch(es) clear | APPLY DAILY | APPLY DAILY | 14 Jun 2010 | 14 Jun 2010 | |
| | SIMVASTATIN tabs 40mg | 56 tablet(s) | TAKE ONE AT NIGHT | TAKE ONE AT NIGHT | 14 Jun 2010 | 14 Jun 2010 | |
| | QVAR cfc free inh 50micrograms/actuation | 2 200 dose inhaler | INHALE ONE TO BE TAKEN DOSE | AILY | 14 Jun 2010 | 14 Jun 2010 | |

NHS TAYSIDE

## PATIENTS' FUNDS AND PROPERTY PROCEDURE

### PERSONAL DISCLAIMER NOTICE
### LOSS OF PERSONAL EFFECTS

NHS TAYSIDE will not accept any responsibility for loss or damage to any article/personal belongings unless such articles/personal belongings (including cash) have been handed over to and accepted by NHS TAYSIDE for safe keeping and an official receipt given.

I have been given the opportunity to read the above and I do not wish to take advantage of the facilities provided.

**Section A**

Signed:_____ Date: _____

Hospital:_____ Ward No/Name: _____

Print Name: _____

**Section B**

**If this form is being signed on behalf of a patient please state your relationship to the patient:**

Signed:_____ Date: _____

Print Name:_____ Relationship: _____

**Section C**

**Witness**

Signature:_____

Address:_____

_____

Note for guidance to patients:

It should be understood that when a patient is absent from the ward for treatment (e.g. : x-ray, an operation etc) the safe custody of their property which has not been handed over to NHS TAYSIDE for safe keeping remains their responsibility.

Arrangements are available, whereby, such property (i.e. watches, rings etc) may be handed over to the Nursing staff for safe keeping and appropriate envelopes are available for this purpose.

**HISTORY CONTINUATION SHEET**

Ward/Clinic/Hosp: 12 N/W

Cons

D D M M Y Y: 09 03 1952

C.H.I. No.

Surname: STALDISH

First Name: DAVID

Address

Sex

G.P. & Address

USE BLOCK LETTERS OR PATIENT LABEL

UNIT/WARD/DEPT.

Page

| DATE | |
|---|---|
| 16/2/11 | (O) Maintained BP sats O<br>(W) Intact no staining<br>(N) Indep. |
| 16/2/11 | (O) On air<br>(S) Sats satisfactory.<br>(P) No complaints of pain<br>(N) Dry and exposed now exposed O<br>c/c can will not require DN<br>(RPN) after home - today. Has been<br>Swabbed. has Sceptic just awaiting<br>transport. |

THB.(MR)3A

**SHIFT ASSESSMENT**

NAME: DAVID STANDISH HOSPITAL: RIW
DOB & CHI: 050370 0053 WARD: 7

| Date & Time each shift | 14/2/11 | | | 15/2/11 | | | 16/2/11 | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Mandatory Risk Assessments & Treatment Plans** | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N |
| **(N) NUTRITION** | | | | | | | | | | | | | | | | | | | | | |
| MUST 0 & Independent Low risk identified | | 19 | [illegible] | 12 | 19 | [illegible] | 12 | | | | | | | | | | | | | | |
| MUST 0-1 or >1 and or requires assistance/encouragement/oral supplements | | | | | | | | | | | | | | | | | | | | | |
| Dependant/NBM/Enteral/Parenteral nutrition/swallowing problems | | | | | | | | | | | | | | | | | | | | | |
| **(PUP) PRESSURE ULCER PREVENTION** | | | | | | | | | | | | | | | | | | | | | |
| No risk using PPURA or Waterlow, <10 and/or No ulcer | | 19 | [illegible] | 12 | 19 | [illegible] | 12 | | | | | | | | | | | | | | |
| Waterlow >10 and at risk or Grade 1 or 2 pressure ulcer | | | | | | | | | | | | | | | | | | | | | |
| Waterlow >10 at risk, and Grade 3 or 4 pressure ulcer and or cannot be repositioned | | | | | | | | | | | | | | | | | | | | | |
| **(M) MANUAL HANDLING & MOBILITY** | | | | | | | | | | | | | | | | | | | | | |
| Independent No risk identified | | 19 | [illegible] | 12 | 19 | [illegible] | 12 | | | | | | | | | | | | | | |
| Requires supervision or assistance walking aids/additional equipment | | | | | | | | | | | | | | | | | | | | | |
| Dependant New problem | | | | | | | | | | | | | | | | | | | | | |
| **(F) FALLS** | | | | | | | | | | | | | | | | | | | | | |
| No history of falls No risk identified | | 19 | [illegible] | 12 | 19 | [illegible] | 12 | | | | | | | | | | | | | | |
| History of falls Risk factor identified New fall since admission | | | | | | | | | | | | | | | | | | | | | |
| **Record care required and given For any AMBER & RED risks** | | | | | | | | | | | | | | | | | | | | | |
| **(A) AIRWAY/BREATHING** | | | | | | | | | | | | | | | | | | | | | |
| No airway/breathing problem No risk identified | | | | | | [illegible] | 12 | | | | | | | | | | | | | | |
| Existing airway/breathing problem identified | | 19 | [illegible] | 12 | 19 | | | | | | | | | | | | | | | | |
| New problem identified | | | | | | | | | | | | | | | | | | | | | |
| **(O) OBSERVATION & MONITORING** | | | | | | | | | | | | | | | | | | | | | |
| SEWS 0 -1 | | 19 | | | | [illegible] | 12 | | | | | | | | | | | | | | |
| | | | [illegible] | 12 | 19 | | | | | | | | | | | | | | | | |
| SEWS 4 or more New risk/Nurse Concern | | | | | | | | | | | | | | | | | | | | | |
| **(E) ELIMINATION** | | | | | | | | | | | | | | | | | | | | | |
| Independent No risk identified | | 19 | [illegible] | 12 | 19 | [illegible] | 12 | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| Dependent / incontinent Urine/faeces | | | | | | | | | | | | | | | | | | | | | |
| **(FB) FLUID BALANCE/HYDRATION** | | | | | | | | | | | | | | | | | | | | | |
| Independent No risk identified | | | [illegible] | 12 | 19 | [illegible] | 12 | | | | | | | | | | | | | | |
| Fluid balance Monitoring / assistance to drink | | 19 | | | | | | | | | | | | | | | | | | | |
| Active Fluid Management New problem identified | | | | | | | | | | | | | | | | | | | | | |
| **(P) PAIN** | | | | | | | | | | | | | | | | | | | | | |
| No pain or score 0 - 1 | | 19 | [illegible] | 12 | 19 | [illegible] | 12 | | | | | | | | | | | | | | |
| Pain score 2 - 3 | | | | | | | | | | | | | | | | | | | | | |
| Pain Score 3 continuous at rest | | | | | | | | | | | | | | | | | | | | | |
| **(W) WOUND/SKIN INTEGRITY** | | | | | | | | | | | | | | | | | | | | | |
| Skin healthy No risk identified | | 19 | [illegible] | 12 | 19 | [illegible] | | | | | | | | | | | | | | | |
| Skin fragile, and at risk Clean surgical wound | | | [illegible] | | | [illegible] | 12 | | | | | | | | | | | | | | |
| Open wound/skin damage/ excoriation, and requiring active management | | | | | | | | | | | | | | | | | | | | | |

| Date & Time each shift | | | | 14/2/11 | | | 15/2/11 | | | 16/2/11 | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Record care required and given For any AMBER & RED risks** | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N |
| **(PH) PERSONAL HYGIENE** | | | | | | | | | | | | | | | | | | | | | | | | |
| | Independent | | | 19 | 22 | 12 | 19 | 22 | 12 | | | | | | | | | | | | | | | |
| | Requires supervision/assistance & encouragement | | | | | | | | | | | | | | | | | | | | | | | |
| | Dependant | | | | | | | | | | | | | | | | | | | | | | | |
| **(OH) ORAL HYGIENE** | | | | | | | | | | | | | | | | | | | | | | | | |
| | Independent | | | 19 | 22 | 12 | 19 | 22 | 12 | | | | | | | | | | | | | | | |
| | Requires assistance/observation | | | | | | | | | | | | | | | | | | | | | | | |
| | Dependant/oral care required | | | | | | | | | | | | | | | | | | | | | | | |
| **(I) INFECTION CONTROL** | | | | | | | | | | | | | | | | | | | | | | | | |
| | No known risk (follow HAI) | | | | | | | 22 | 12 | | | | | | | | | | | | | | | |
| | Previous infection identified Patient has invasive PVC/CVC | | | 19 | 22 | 12 | 19 | | | | | | | | | | | | | | | | | |
| | Confirmed risk | | | | | | | | | | | | | | | | | | | | | | | |
| **(C) COMMUNICATION** | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | 19 | 22 | 12 | 19 | 22 | 12 | | | | | | | | | | | | | | | |
| | Update given to patient/ relatives/significant others | | | | | | | | | | | | | | | | | | | | | | | |
| | New or existing Communication Barriers | | | | | | | | | | | | | | | | | | | | | | | |
| **(LD) LEARNING DISABILITY** | | | | | | | | | | | | | | | | | | | | | | | | |
| | No learning disability | | | 19 | 22 | 12 | 19 | 22 | 12 | | | | | | | | | | | | | | | |
| | Learning disability identified | | | | | | | | | | | | | | | | | | | | | | | |
| **(PS) PERSONAL SAFETY** | | | | | | | | | | | | | | | | | | | | | | | | |
| | Not amubulant Ambulant but clinically stable Mentally capable of making sound judgements Legible ID bracelet in place | | | 19 | 22 | 12 | 19 | 22 | 12 | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| **(PC) PSYCHOLOGICAL /SPIRITUAL CARE** | | | | | | | | | | | | | | | | | | | | | | | | |
| | No psychological care need identified | | | 19 | 22 | 12 | 19 | 22 | 12 | | | | | | | | | | | | | | | |
| | Patient has concerns/underlying condition. Requiring psychological/spiritual care input | | | | | | | | | | | | | | | | | | | | | | | |
| | Patient experiencing intense emotions. Requiring immediate professional input | | | | | | | | | | | | | | | | | | | | | | | |
| **(CB) CHALLENGING BEHAVIOUR** | | | | | | | | | | | | | | | | | | | | | | | | |
| | No behaviour risks | | | 19 | 22 | 12 | 19 | 22 | 12 | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | Physical/self injurious behaviour Aggressive towards others | | | | | | | | | | | | | | | | | | | | | | | |
| **(PCG) PATIENT CENTRED GOAL** | | | | | | | | | | | | | | | | | | | | | | | | |
| | Patient has been given opportunity to identify a personal goal | | | 19 | | 12 | 19 | | 12 | | | | | | | | | | | | | | | |
| **(ACN) ADDITIONAL CARE NEEDS** | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| **Initial** | | | | | | | | | | | | | | | | | | | | | | | | |

Last review: January 10
Review date: January 11

| SHIFT ASSESSMENT | NAME: DAVID STANDISH HOSPITAL: 12 NLW. DOB & CHI: 050370 WARD: | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Date & Time each shift** | 13/2/11 | | | 14/2/11 | | | | | | | | | | | | | | | | | |
| **Mandatory Risk Assessments & Treatment Plans** | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N | E | L | N |
| (N) **NUTRITION** | | | | | | | | | | | | | | | | | | | | | |
| MUST 0 & Independent Low risk identified | | | | 12 | | | | | | | | | | | | | | | | | |
| MUST 0-1 or >1 and or requires assistance/encouragement/oral supplements | | | | | | | | | | | | | | | | | | | | | |
| Dependant/NBM/Enteral/Parenteral nutrition/swallowing problems | | | 03 | | | | | | | | | | | | | | | | | | |
| (PUP) **PRESSURE ULCER PREVENTION** | | | | | | | | | | | | | | | | | | | | | |
| No risk using PPURA or Waterlow, <10 and/or No ulcer | | | 03 | 12 | | | | | | | | | | | | | | | | | |
| Waterlow >10 and at risk or Grade 1 or 2 pressure ulcer | | | | | | | | | | | | | | | | | | | | | |
| Waterlow >10 at risk, and Grade 3 or 4 pressure ulcer and or cannot be repositioned | | | | | | | | | | | | | | | | | | | | | |
| (M) **MANUAL HANDLING & MOBILITY** | | | | | | | | | | | | | | | | | | | | | |
| Independent No risk identified | | | 03 | 12 | | | | | | | | | | | | | | | | | |
| Requires supervision or assistance walking aids/additional equipment | | | | | | | | | | | | | | | | | | | | | |
| Dependant New problem | | | | | | | | | | | | | | | | | | | | | |
| (F) **FALLS** | | | | | | | | | | | | | | | | | | | | | |
| No history of falls No risk identified | | | 03 | 12 | | | | | | | | | | | | | | | | | |
| History of falls Risk factor identified New fall since admission | | | | | | | | | | | | | | | | | | | | | |
| **Record care required and given For any AMBER & RED risks** | | | | | | | | | | | | | | | | | | | | | |
| (A) **AIRWAY/BREATHING** | | | | | | | | | | | | | | | | | | | | | |
| No airway/breathing problem No risk identified | | | 03 | 12 | | | | | | | | | | | | | | | | | |
| Existing airway/breathing problem identified | | | | | | | | | | | | | | | | | | | | | |
| New problem identified | | | | | | | | | | | | | | | | | | | | | |
| (O) **OBSERVATION & MONITORING** | | | | | | | | | | | | | | | | | | | | | |
| SEWS 0 -1 | | | 03 | 12 | | | | | | | | | | | | | | | | | |
| SEWS 2 - 3 | | | | | | | | | | | | | | | | | | | | | |
| SEWS 4 or more New risk/Nurse Concern | | | | | | | | | | | | | | | | | | | | | |
| (E) **ELIMINATION** | | | | | | | | | | | | | | | | | | | | | |
| Independent No risk identified | | | 03 | 12 | | | | | | | | | | | | | | | | | |
| Requires supervision/assistance Problems with input/output, frequency or catheter insitu | | | | | | | | | | | | | | | | | | | | | |
| Dependent / incontinent Urine/faeces | | | | | | | | | | | | | | | | | | | | | |
| (FB) **FLUID BALANCE/HYDRATION** | | | | | | | | | | | | | | | | | | | | | |
| Independent No risk identified | | | 03 | 12 | | | | | | | | | | | | | | | | | |
| Fluid balance Monitoring / assistance to drink | | | | | | | | | | | | | | | | | | | | | |
| Active Fluid Management New problem identified | | | | | | | | | | | | | | | | | | | | | |
| (P) **PAIN** | | | | | | | | | | | | | | | | | | | | | |
| No pain or score 0 - 1 | | | 03 | 12 | | | | | | | | | | | | | | | | | |
| Pain score 2 - 3 | | | | | | | | | | | | | | | | | | | | | |
| Pain Score 3 continuous at rest | | | | | | | | | | | | | | | | | | | | | |
| (W) **WOUND/SKIN INTEGRITY** | | | | | | | | | | | | | | | | | | | | | |
| Skin healthy No risk identified | | | 03 | 12 | | | | | | | | | | | | | | | | | |
| Skin fragile, and at risk Clean surgical wound | | | | | | | | | | | | | | | | | | | | | |
| Open wound/skin damage/ excoriation, and requiring active management | | | | | | | | | | | | | | | | | | | | | |

## Multi-Disciplinary Notes

| Date | Time | | Initial |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| | | | | | |
|---|---|---|---|---|---|
| Hospital medical certificate provided | ❑ | ❑ | | | |
| Valuables returned if applicable | ❑ | ❑ | | | |
| Venflon/lines removed if applicable | ❑ | ❑ | | | |
| Appropriate persons informed of infection control status (please state) | ❑ | ❑ | | | |
| **Discharge Medicines** | **Y** | **N** | **Comments/Variance** | **Date** | **Initial** |
| Own medicines destroyed | ❑ | ❑ | | | |
| Own medicines returned to patient | ❑ | ❑ | | | |
| Discharge medication ordered | ❑ | ❑ | | | |
| Discharge medication provided | ❑ | ❑ | | | |
| Refer to community Pharmacist for compliance needs assessment | ❑ | ❑ | | | |
| Refer to community Pharmacist for restart of compliance aid | ❑ | ❑ | | | |
| Refer to community Pharmacist for medication review | | | | | |
| Patient demonstrates ability to manage own medicines | ❑ | ❑ | | | |
| Carer demonstrates ability to manage patients medicines if appropriate | ❑ | ❑ | | | |
| **Multidisciplinary Referrals** | | | | | |
| Physiotherapist | ❑ | ❑ | | | |
| Occupation therapist | ❑ | ❑ | | | |
| Specialist Nurse (please state) | ❑ | ❑ | | | |
| Other (please state) | ❑ | ❑ | | | |
| **Referrals/discharge summaries provided to:** | **Y** | **N** | **Comments/Variance** | **Date** | **Initial** |
| GP | ❑ | ❑ | | | |
| Practice nurse | ❑ | ❑ | | | |
| Patient and/or carer | ❑ | ❑ | | | |
| Other (please state) include nursing homes etc. | ❑ | ❑ | | | |
| **Follow-up arrangements** | **Y** | **N** | **Comments/Variance** | **Date** | **Initial** |
| OPD | ❑ | ❑ | | | |
| Other (please state) | ❑ | ❑ | | | |
| Discharge Completed | ❑ | ❑ | | | |



**Multi-Disciplinary Notes**

| Date | Time | | Initial |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Hospital Falls History

To be completed for all patients who have had a fall during current admission. This is in addition to completion of an IR1 within the Adverse Incident Management system.

| **Date/Time (of Fall)** | | | |
|---|---|---|---|
| AIM reference number | | | |
| Circumstances surrounding patients fall? | | | |
| Location: | | | |
| Activity preceding fall: | | | |
| Type of fall: (slip, trip, fall on same level, slip, trip, fall from height) | | | |
| Any neck/spinal injury? Y/N (If yes, please describe) | | | |
| Loss of consciousness /seizure/head injury? Y/N (If yes, please state) | | | |
| Injury sustained? Y/N (If yes, please describe) | | | |
| Immediate Action Taken: (Including First Aid) | | | |
| Medical staff informed and reviewed patient: Y/N | | | |
| Complete/update and review Falls Prevention Action Plan | | | |
| Relatives informed? Y/N (please include date, time, who contacted & details of conversation) | | | |
| **Date/Time** | | | |
| **Initial** | | | |



WRITE OR ATTACH LABEL

Surname STANDISH Sex.....

Forename DAVID.....

DOB and CHI 050370.....

Hospital N/W

Ward 12

NHS Tayside

## Falls Risk Assessment

**The following 3 questions must be completed with ALL patients, within 24 hours of admission. Re-assessment required if patient condition changes.**

(Please document Yes/No below)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1 | History of falls prior to admission (if yes, complete falls history & falls prevention action plan) | N | | | | | | |
| 2 | Falls(s) since admission? (if yes, complete hospital falls history & falls prevention action plan) | N | | | | | | |
| 3 | Additional falls risk factors for this patient? E.g. Patient tries to walk alone but unsteady/unsafe, learning disabilities, parkinson's, CVA, cognitive impairment, acute confusional state, continence issues, visual impairment, medication, surgery etc. (if yes, complete falls prevention action plan) Please state: | N | | | | | | |
| **Date** | | 13/2/11 | | | | | | |
| **Time** | | 1600 | | | | | | |
| **Initial** | | CNA | | | | | | |

### Falls History: (within 48 hours of admission)

**Falls history assessment:** (Date & Time of last fall prior to admission)

Has the patient been admitted following a fall? Yes ☐ No ☐ Date ..... Time of day.....

First fall? Yes ☐ No ☐ Recurrent falls? Yes ☐ No ☐ Number of falls within the last year?.....

Any warning immediately prior to any falls? Yes ☐ No ☐

Palpitation ☐ Dizziness ☐ Alcohol ☐ Loss of Consciousness ☐
Slip/Trip ☐ Environmental hazards ☐ Associated movement ☐

Explanation about fall/previous falls:(where, when, why) Activity at time of fall? (Please describe)

.....

.....

.....

Any injury sustained or previous fracture? Yes ☐ No ☐ (if yes, please describe)

.....

Any pain related to fall? Yes ☐ No ☐ (if yes, please describe)

.....

Any anxiety regarding further falls/confidence affected? Yes ☐ No ☐ (If yes please describe)

.....

Comments/other information/highlight areas of concern: -

.....

.....

Data collected from: Patient ☐ Relative ☐ Carer ☐ Other:.....

**(please delete as appropriate)**

Complete/Incomplete. Initials of Nurse:_____Date/Time:_____

If Incomplete, date of when nurse to complete:_____Initials of Nurse:_____Date/Time:_____

## Initial Falls Prevention Action Plan

Professional judgment is required when considering the nursing care patients need to minimise their risk of falling. The following nursing interventions may address some of the falls risk factors. They are however NOT exhaustive and staff should use their clinical reasoning/professional judgment when determining falls risk interventions.

**Please state all actions taken from the list of interventions below.**

| Interventions: | State Actions |
|---|---|
| **Environmental:**<br>• Nurse in most appropriate place on ward for their needs e.g. easily observable area, near toilet etc.<br>• Area hazard free, personal belongings within easy reach.<br>• Nurse call system working and within arm reach at all times.<br>• Adequate lighting at all times particularly overnight.<br>• Check infusion stands facilitate mobility. | |
| **Vision:**<br>• Ensure correct glasses worn/within easy reach and clean.<br>• Consider a visual acuity assessment by medical staff. | |
| **Lying and Standing Blood Pressure:**<br>• Check and record. If deficit exists, inform medical staff and continue to check twice daily for at least 72 hours.<br>• Advice patient on slow movement from sitting/lying to standing. | |
| **Mobility:**<br>• Follow mobility risk assessment/care plan.<br>• Refer to Physiotherapy and/or Occupational Therapy.<br>• If patient is independent, is walking aid within easy reach? | |
| **Medication:**<br>• Request Medical staff or Pharmaceutical review. | |
| **Delirium (Acute Confusional State)**<br>• Treat causes of delirium, refer to delirium guidelines | |
| **Incontinence:**<br>• Assess continence. If urine frequency, ward test urine.<br>• Consider routine/frequent toileting.<br>• Consider a commode for night time toileting.<br>• Consider full continence assessment and refer to continence service if indicated. | |
| **Bed and bedrails:**<br>• Bed at optimum height and brakes applied.<br>• Assess the need for bedrails (refer to NHS Tayside bedrail policy and complete bedrail risk assessment tool).<br>• Consider bed exit alarm (if available). | |
| **Multidisciplinary Team:**<br>• Ensure Medical staff, Physiotherapist, OT, Social Worker etc, are aware of patients falls risk, frequency and nature | |
| **Footwear:**<br>• Encourage patient to wear shoes not slippers.<br>• Check footwear for secure fit, non-slip sole. Ask relatives to supply safer replacements.<br>• Podiatry referral (as necessary). | |
| **Inform:**<br>• Involve/educate patient/relatives in safe practice.<br>• Discuss with patient/relative re. specific interventions.<br>• Issue leaflet "How to reduce falls in hospital". | |
| **Additional Falls Risk Management Interventions for Patient:** | |

Initials of Nurse:_____ Date & Time:_____

## Hospital Falls History

To be completed for all patients who have had a fall during current admission. This is in addition to completion of an IR1 within the Adverse Incident Management system.

| **Date/Time (of Fall)** | | | |
|---|---|---|---|
| AIM reference number | | | |
| Circumstances surrounding patients fall? | | | |
| Location: | | | |
| Activity preceding fall: | | | |
| Type of fall:<br>(slip, trip, fall on same level, slip, trip, fall from height) | | | |
| Any neck/spinal injury? Y/N<br>(If yes, please describe) | | | |
| Loss of consciousness /seizure/head injury? Y/N<br>(If yes, please state) | | | |
| Injury sustained? Y/N<br>(If yes, please describe) | | | |
| Immediate Action Taken:<br>(Including First Aid) | | | |
| Medical staff informed and reviewed patient: Y/N | | | |
| Complete/update and review Falls Prevention Action Plan | | | |
| Relatives informed? Y/N<br>(please include date, time, who contacted & details of conversation) | | | |
| **Date/Time** | | | |
| **Initial** | | | |

## THEATRE TREATMENT PLAN D

**At risk Waterlow above 10**

Refine risk assessment of individuals undergoing surgery by examining other factors that are likely to occur and will increase risk of pressure ulcer developing

- Length of the operation
- Increased hypotensive episodes intraoperatively
- Low core temperature during surgery
- Reduced mobility on post operative day one

All at risk patients receiving surgery will have a pressure-relieving device on the operating table and transfer trolleys

All nursing staff in reception theatre and recovery will ensure that they know the patient's risk status at all points of the patient's journey through theatre

All patients identified as at risk will have their pressure areas inspected prior to theatre and in the recovery area and where possible during the operation

In collaboration with the anaesthetist, move the head position to prevent continued pressure on the occipital area (if patient condition allows)

All patients at risk will have measures in place to alleviate factors that cause pressure ulcers in reception, theatre and throughout the recovery phase

Elevate heels completely in such a way as to distribute weight of the leg along the calf without putting all the pressure on the Achilles tendon. If possible the knee should be in slight flexion. (hyperextension of the knee may cause obstruction of the popliteal vein predisposing to deep vein thrombosis)

Position the individual in a different posture preoperatively and post operatively than the posture adopted during surgery and record this on the **SKIN** bundle
If a pressure ulcer develops this will be recorded on the treatment plan

The recovery nurse will discuss the patients' skin integrity with the nurse receiving the patient for return to the ward

Theatre staff must continue the **SKIN** bundle throughout the patients' theatre journey

| | Date/Time | Signature |
|---|---|---|
| **Position of patient pre operatively – state:** | | |
| **Position of patient when on the theatre table – state:** | | |
| **Position of patient in recovery area – state:** | | |
| **Condition of skin on return to ward – state:** | | |
| **Treatment plan D active Y/N/N/A** | | |

**WRITE OR ATTACH LABEL**

Surname STANDISH Sex M

Forename DAVID.

DOB and CHI.....

Hospital N/W

Ward 12

NHS Tayside

## Preliminary Pressure Ulcer Risk Assessment (PPURA)

**The following 3 questions must be completed with ALL patients within 6 hours of admission.**
**Re-assessment required if patient condition changes including day of theatre.**

(please write Yes/No below)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **1** | Requires assistance and or aids to move or cannot move including day of theatre? | N | | | | | | |
| **2** | Incontinent? | N | | | | | | |
| **3** | MUST score 1 or above? | N | | | | | | |
| **Date** | | 13/2/11 | | | | | | |
| **Time** | | 1600 | | | | | | |
| **Initial** | | CD | | | | | | |

If **Yes** to any question a full **Waterlow** risk assessment must be carried out within **6 hours** of admission
If **No** to any question **re-assess PPURA each shift** and implement Treatment plan A.
Treatment plan to go to theatre with the patient and theatre staff follow treatment plan D

| DATE & TIME | Pressure ulcer on admission Y N Source of admission_____ | Initiate PUP Treatment plan B or C and raise a wound care plan for grade 2 and above pressure ulcers |
|---|---|---|

**EPUAP PRESSURE ULCER CLASSIFICATION (2009)**

| GRADE | VISUAL DESCRIPTION |
|---|---|
| 1 | Intact skin with non-blanchable redness of a localised area over a bony prominence. Apply light finger pressure to the site, remove finger, and score 1 if: Non-blanchable erythema of intact skin. Discoloration of the skin, pain, firm, soft, warmer, cooler, oedema, hardness as compared to the adjacent skin may also be used as indicators, particularly in individuals with darker skin. |
| 2 | Partial thickness loss of the Dermis presenting as a shallow open ulcer with red pink wound bed, without slough or bruising. May also present as an intact or open/ruptured serum-filled blister. The ulcer is superficial and presents clinically as an abrasion or blister. It is not to be confused with skin tears, burns, incontinence dermatitis, moisture and excoriation. |
| 3 | Full thickness tissue loss subcutaneous fat may be visible but not bone muscle or tendon Slough may be present but does not obscure the depth of tissue loss. May include tunnelling and undermining |
| 4 | Full thickness tissue loss with exposed muscle, bone and tendon. Slough or Eschar may be present and may completely obscure the wound bed. |

**Sub categorise**

- Unstageable/unclassified full thickness unknown- Full thickness tissue loss but until the slough or Eschar are removed the full extent cannot be determined
- Suspected deep tissue Injury-depth unknown – Purple or maroon area intact skin or blood filled blister – might be painful 'boggy' to touch. Evolution may expose deeper layers, or a thin Eschar may form over the surface

**PRESSURE ULCER RECORD**

| Date/Time | Ulcer Location | EPUAP Grade | Record on AIM if developed in this area, also if the pressure ulcer was present on admission from another area and no record in the notes **state incident reference** number(S) and date | Initials |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

NHS Quality Improvement Scotland

## Adapted Waterlow Pressure Area Risk Assessment Chart

**10+= 'At Risk': 15+ = 'High Risk': 20+ = 'Very High Risk'**

Complete assessment on admission if PPURA shows at Risk. Repeat Waterlow weekly or if there is a change in individual's condition.

More than one score/category can be used:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Male** | 1 | | | | | | | |
| **Female** | 2 | | | | | | | |
| Age | | | | | | | | |
| 14 – 49 | 1 | | | | | | | |
| 50 – 64 | 2 | | | | | | | |
| 65 – 74 | 3 | | | | | | | |
| 75 – 80 | 4 | | | | | | | |
| 81+ | 5 | | | | | | | |
| **Build/Weight for Height (BMI=weight in Kg/height in m2)** | | | | | | | | |
| Average – BMI 20-24.9 | 0 | | | | | | | |
| Above average – BMI 25-29.9 | 1 | | | | | | | |
| Obese – BMI > 30 | 2 | | | | | | | |
| Below average – BMI < 20 | 3 | | | | | | | |
| **Continence** | | | | | | | | |
| Complete/catheterised | 0 | | | | | | | |
| Incontinent urine | 1 | | | | | | | |
| Incontinent faeces | 2 | | | | | | | |
| Doubly incontinent (urine & faeces) | 3 | | | | | | | |
| Skin Type – Visual Risks Area | | | | | | | | |
| **Healthy** | 0 | | | | | | | |
| Tissue paper (thin/fragile) | 1 | | | | | | | |
| Dry (appears flaky) | 1 | | | | | | | |
| Oedematous (puffy) | 1 | | | | | | | |
| Clammy (moist to touch)/pyrexia | 1 | | | | | | | |
| Discoloured (bruising/mottled) | 2 | | | | | | | |
| Broken (established ulcer) | 3 | | | | | | | |
| **Mobility** | | | | | | | | |
| Fully mobile | 0 | | | | | | | |
| Restless/fidgety | 1 | | | | | | | |
| Apathetic (sedated/depressed/reluctant to move) | 2 | | | | | | | |
| Restricted (restricted by severe pain or disease) | 3 | | | | | | | |
| Bedbound (unconscious/unable to change position/traction) | 4 | | | | | | | |
| Chair bound (unable to leave chair without assistance) | 5 | | | | | | | |
| **Nutritional Element** | | | | | | | | |
| **Unplanned weight loss in past 3-6 months** | | | | | | | | |
| < 5% Score **0**, 5-10% Score **1**, >10% Score **2** | 0-2 | | | | | | | |
| BMI >20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2** | 0-2 | | | | | | | |
| Patient acutely ill or no nutritional intake > 5 days | 2 | | | | | | | |
| **Special Risks – Tissue Malnutrition** | | | | | | | | |
| Multiple organ failure/terminal cachexia | 8 | | | | | | | |
| Single organ failure e.g. cardiac, renal, respiratory | 5 | | | | | | | |
| Peripheral vascular disease | 5 | | | | | | | |
| Anaemia = Hb < 8 | 2 | | | | | | | |
| Smoking | 1 | | | | | | | |
| **Special Risks – Neurological Deficit** | | | | | | | | |
| Diabetes/ MS/ CVA/ motor/ sensory/ paraplegia Max 6 | 4-6 | | | | | | | |
| Special Risks – Surgery/Trauma | | | | | | | | |
| On table > 6 hours | 8 | | | | | | | |
| Orthopaedic/ below waist/spinal (up to 48 hours post op) | 5 | | | | | | | |
| On table > 2 hours (up to 48 hours post op) | 5 | | | | | | | |
| **Special Risks – Medication** | | | | | | | | |
| Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4* | 4 | | | | | | | |
| **Total Score** | | | | | | | | |
| **Date** | | | | | | | | |
| **Time** | | | | | | | | |
| **Initials** | | | | | | | | |

Ensure plan of care is implemented / reviewed for all identified areas of concern.

## Pressure Ulcer Prevention Treatment Plan Guide

**The use of clinical judgement is paramount when deciding on pressure ulcer prevention.**
**Ensure each planned intervention is recorded on the record of ongoing care**

Pressure ulcer risk assessment performed using recognised tool (Waterlow NATVNS) and skin assessment performed using EPUAP pressure ulcer classification system or PPURA within 6 hours from the beginning of the episode of care

**No risk** (PPURA) and / or Waterlow <10
No evidence of current pressure damage
No history of pressure ulcers
Patient mobile

**At Risk** Waterlow >10 and or
No pressure ulcer/ Grade 1 or 2 pressure ulcer and or
Patient able to be re-positioned

**High Risk** - Waterlow >10 and or
Grade 3 or 4 pressure ulcer and or
Patient unable to be re-positioned

### TREATMENT PLAN A

- No special mattress intervention required
- Patient encouraged to check their own skin, if appropriate and with education from registered nurse
- Patient will independently change position, if appropriate and with education from registered nurse
- Re-assess PPURA risk factors on each shift, if Yes to the PPURA carry out a Waterlow and continue weekly or if there are changes in the patient's general condition, skin condition or treatment
- Re-assess skin if there are changes in the patient's general condition, skin condition, theatre, medication or recovery

### TREATMENT PLAN B

- Profiling bed with high specification foam mattress such as softform premier. Do not elevate the bed head more than 30 degrees for long periods
- Show patients how to relieve their own pressure areas and actively mobilise where possible.
- The re-positioning interval, either 2/3/4 hrly will be determined by the condition of the skin on inspection. If applicable, re position with alternating 30 degree lateral tilt. Bony prominences are kept from direct contact with one another
- Skin inspection particularly heels and sacral areas are carried out at specified times or with each repositioning. Chart and document condition of skin/ulcer on re-positioning and the interval times using the SKIN bundle
- Keep bed linen loose

**Heels**

Friction and shear damage is minimised
Consider elevating heels off the bed with pillows or heel elevators, use film dressing or moisturisers to prevent friction

**Seating**:

- Limit the time seated to no more than 2 hours at any one time. Patients with pressure ulcers and at high risk should be actively mobilised.
- Ensure maximum contact with the chair and the patient's back and head are fully supported. The buttocks, knees and feet are supported fully at angles of 90 degrees.
- Pressure relieving foam cushion will be used for grade 1 and 2 ulcers and ensure the patients are sitting at the correct angle and fully supported at the feet, thighs, buttocks back and head
- Complete the **SKIN** Bundle

### TREATMENT PLAN C

- Profiling bed with a dynamic mattress document type of mattress on the intervention sheet. Do not elevate the bed head more than 30 degrees for long periods
- Show patients how to relieve their own pressure areas where possible. Actively mobilse when possible
- The re-positioning interval, either 2/3/4 hrly will be determined by the condition of the skin on inspection. If applicable, re position with alternating 30 degree lateral tilt. Bony prominences are kept from direct contact with one another
- Skin inspection particularly heels and sacral areas are carried out at specified times or with each repositioning. Chart and document condition of skin/ulcer on re-positioning and the interval times using the SKIN bundle
- keep bed linen loose

**Heels**

- Elevate heels off the bed and protect from pressure shear and friction, consider moisturisers or film dressings to prevent friction

**Seating:**

- Patients with grade 3 / 4 ulcer on the sacral area will be discouraged from sitting in a chair and the profiling chair function of the bed utilised when possible. The body should have maximum contact with the chair and the patient's back and head are fully supported. The buttocks, knees and feet are supported fully at angles of 90 degrees.
- Seek advise on specialist seating if sitting unavoidable

Complete the **SKIN** Bundle

### For all at risk patients consider the following:-

**Nutrition and hydration**
Strive to ensure adequate nutrition and hydration compatible with the patient's condition.
Nutritional protein supplements to be given when ulcer healing is the goal

**Skin.** Wetness on the skin is a key factor in pressure ulcer development particularly from incontinence, this must be cleaned immediately with a skin cleanser **not** soap and water and the cause addressed. Where the source of wetness cannot be controlled the use of moisture absorbing continence aids must be used. Document excoriation using NHSQIS Excoriation Tool and NHS Tayside continence skin guidelines
For dry skin a non-perfumed moisturiser may be applied sparingly at least twice daily. Avoid rubbing and massaging

**Pain**
Pain control is important to enable patients to move themselves or to be moved more easily thus increasing compliance with pressure relieving turning regimes. Pain from area known to be at risk of pressure ulcer development must be inspected immediately and re-assessed.

| WRITE OR ATTACH LABEL | Hospital N/W |
|---|---|
| Surname STADDISH Sex | Ward 12 |
| Forename DAVID | |
| DOB and CHI 250370 | |

NHS Tayside

## MUST and Nutritional Assessment (To be completed within 24 hours of admission)

Data gathered from: Patient ☐ Other (please specify):

| Malnutrition Universal Screening Tool (MUST) adapted from BAPEN | Measures and Scores | Date/Time | Initial |
|---|---|---|---|
| **Height:** Method height recorded (Please tick)<br>• stadiometer<br>• self-reported height (if reliable and realistic)<br>• reported by carer<br>• ulna length (not applicable for learning disability patients, estimate or measure using tape measure) | 1 m 76 cm<br>☐<br>☐<br>☐<br>☐ | | |
| **Weight** Actual ☒ Estimated ☐ Unable to weigh ☐<br>if unable to weigh state reason .....<br>Patients usual weight (liaise with carer)<br>Are there any factors affecting weight e.g. ascites, oedema or an amputation. **Please specify plus the impact on weight:** | 87.4kg<br>kg | | |
| **BMI** score recorded | 28 kg/m² | | |

| | | | | |
|---|---|---|---|---|
| STEP 1 | BMI >20 (>30 obese) Score = 0<br>BMI 18.5-20 Score = 1<br>BMI < 18.5 Score = 2 | STEP 3 | 0 | Patient is acutely ill and there has been or is likely to be no nutritional intake for >5 days<br>Yes = Score 2 No = Score 0 |
| STEP 2 | Unplanned weight loss in past 3-6 months<br>Patient has < 5% weight loss Score = 0<br>Patient has 5-10% weight loss Score = 1<br>Patient has >10% weight loss Score = 2 | STEP 4 | 0 | **TOTAL SCORE:**<br>**(Add scores together)** |

| STEP 5 | **Management Guidelines**<br>These guidelines may not be appropriate for medium/high risk patients e.g food allergy/dysphagia | Date/Time | Initial |
|---|---|---|---|
| Total MUST score = 0<br>Patient is at **low** risk | **Repeat screening:**<br>Monthly for Continuing Care /Weekly for all other wards<br>*For overweight or obese patients refer to MUST folder for information that can be given to the patient* | 13/2/11 | CL |
| Total MUST score 1or >1<br>Patient is at **medium/ high** risk | • Complete a care plan<br>• Encourage with meals and snacks (little and often)<br>• Complete and review food record charts for 3 days<br>• Encourage to drink full cream milk<br>• Commence a supplement drink e.g. Build Up or 1.5Kcal/ml supplement as per local guidelines<br>If after 3 days, less than ½ meals, supplements drinks and snacks are taken refer to the dietitian<br>**Repeat screening:**<br>Monthly for Continuing Care/Weekly for all other wards | | |
| **All Learning Disabilities Clients**<br>Date referred:<br>Date seen: | If patient has a Learning Disability refer to the Nurse Consultant for Learning Disabilities<br>Available Mon – Fri<br>Ext 27803 or 07740937309<br>(Answerphone out with these times) | | |
| **Immediate dietetic referral**<br>Date Referred:<br>Date Seen: | Enteral Tube Feeding (Ward dietitian can provide regimen for patients who are on an established feed)<br>Parenteral Nutrition<br>Swallowing problems<br>Newly diagnosed Coeliac Disease/Crohns/Ulcerative Colitis<br>Therapeutic diets that affect nutritional status<br>Newly diagnosed Type 1 diabetes<br>**See MUST folder for further guidance** | | |

# Malnutrition Universal Screening Tool ('MUST') and Dietetic Referral Guidelines for In-Patients

**STEP 1**
**BMI score**

| BMI kg/m² | Score |
|---|---|
| >20 (>30 Obese) | = 0 |
| 18.5 – 20 | = 1 |
| < 18.5 | = 2 |

+

**STEP 2**
**Weight loss score**

**Unplanned weight loss in past 3-6 months (this includes obese patients)**

| % | Score |
|---|---|
| <5 | = 0 |
| 5 – 10 | = 1 |
| >10 | = 2 |

+

**STEP 3**
**Acute disease effect score**

If patient is acutely ill and there has been or is likely to be no nutritional intake for > 5 days
**Score 2**

*If unable to obtain height and weight, refer to MUST folder for alternative measures and use of subjective criteria*

## STEP 4
## Overall risk of malnutrition

Add Scores together to calculate overall risk of malnutrition
Score 0: Low risk
Score 1: Medium Risk
Score 2 or more: High Risk

If patient has a **Learning Disability** refer to Nurse Consultant for Learning Disabilities

Available Mon – Fri
Ext 27803 or
07740937309
(Answerphone out with these times)

**Immediate Referral**

- Enteral Tube Feeding
- Parenteral Nutrition
- Swallowing problems
- Newly Diagnosed Coeliac Disease/ Crohns/Ulcerative Colitis
- Therapeutic diets that affect nutritional status
- Newly diagnosed Type 1 Diabetes

See MUST folder for further guidance

## STEP 5 Management Guidelines

**Low Risk**
**Repeat screening:**
Monthly for Continuing Care
Weekly for all other wards
*For overweight/obese patients refer to MUST folder for information that can be given to the patient*

**Medium / High Risk Score***

- Complete a care plan
- Encourage with meals and snacks (little and often)
- Complete and review food record charts for 3 days
- Encourage to drink full cream milk
- Commence a supplement drink e.g. Build up or 1.5Kcal/ml supplement as per local guidelines

**If after 3 days ½ or more of meals and snacks taken:**

- Encourage with meals
- Offer snacks
- Stop food record charts
- Review need for supplement drinks

**If after 3 days < ½ meals, supplement drinks and snacks taken**

*Please note that the Step 5 management guidelines for medium/high risk may not be appropriate e.g. food allergy/dysphagia

**Repeat Screening:**
Monthly for Continuing Care
(If concerned increase to weekly)
Weekly for all other wards

If weight loss continues refer to the dietitian

Refer to Dietitian for further assessment
**Completed referrals to be sent to:**

***The local Dietetic department***

**Repeat Screening**:
Monthly for Continuing Care
Weekly for all other wards

Adapted from guidelines originally produced by Dietitians working in Oxfordshire 2004
NHST Hospitals 8th September 2009

## Initial Nursing Assessment
## (To be completed within 24 hours of admission)

| (Please tick) | Y | N | Comments/Variance |
|---|---|---|---|
| Able to make menu choices independently? | X | | If no, please provide further information: |
| Any specific religious/cultural/ethnic dietary requirements | | X | If yes, please provide further information: |
| Any food allergies? | | X | If yes, please provide further information: |
| Any specific eating and drinking dislikes? | | X | If yes, please provide further information: |
| Does the patient take a therapeutic diet? | | X | If yes, please provide further information: |
| Able to take diet and fluid orally and independently? | X | | If no, please state:<br>☐ New problem<br>☐ Old problem<br>☐ Patient nauseated<br>☐ Physical e.g. dexterity difficulties<br>☐ Difficulties in chewing & swallowing<br>☐ Coughing, choking or spluttering during or after intake<br>☐ Other reason, please specify: |
| Patient able to achieve adequate fluid intake<br>• Over 60 yrs age – 30mls/ Kg body weight<br>• 18 – 60 yrs age - 35mls/ Kg body weight<br><br>Fluid requirements_____<br><br>Unless otherwise advised by medical staff | X | | If no, please state:<br>☐ Ongoing difficulties with constipation/diarrhoea<br>☐ Problems with tongue thrush, poor lip closure/drooling<br>☐ Problems with vomiting/regurgitation<br>☐ Other reason, please specify: |
| Patient needs/uses specific equipment to help them with eating or drinking? | | X | If yes, please state equipment used<br><br>Own equipment brought in:<br>Y ☐ N ☐ |
| Patient has specific social/environmental mealtime requirements | | X | If yes, please provide further information: |
| Patient has a dental problem influencing dietary intake | | X | If yes, please provide further information: |
| Patient is currently receiving nutritional support at home/care setting | | X | Enteral: NG ☐ PEG ☐ Gastrostomy/Jejunostomy ☐<br>Parenteral: Central ☐ Peripheral ☐<br>Please state regimen |
| Patient is currently receiving supplement drinks | | X | If yes, please state type and frequency: |

**INITIALS OF NURSE:** CQA **DATE/TIME:** 13/2/11

## Initial Nursing Interventions
## (To be completed within 24 hours of admission)

| (Please tick) | Y | N | N/A | Comments/Variance |
|---|---|---|---|---|
| Give assistance to make menu choices, taking into account particular likes/dislikes | | | | ☐ Verbal prompting<br>☐ Assistance<br>☐ Involve carers/family<br>☐ Other, please state |
| Kitchen informed of religious/cultural/ethnic or therapeutic diet | | | | ☐ Kitchen informed<br>☐ Halal menu offered if appropriate<br>☐ Other, please state |
| Arrangements made to ensure patient does not receive foods which they are allergic to | | | | ☐ All relevant staff informed<br>☐ Patient wrist allergy band insitu<br><br>**Allergies recorded in;**<br>☐ Nursing assessment documents<br>☐ Medical notes<br>☐ Drug kardex<br><br>☐ Other, please state |
| Arrangements made to ensure patient does not receive foods they dislike | | | | Please state: |
| Give support to eat and drink | | | | ☐ Needs food cutting up<br>☐ Needs assistance with feeding<br>☐ Needs help to sit in chair/sit up in bed<br>☐ Needs fed in moulded chair/wheelchair<br>☐ Provided with equipment<br>☐ Initiate nausea treatment plan<br>☐ Other: please state<br><br>Refer to Speech & Language Therapy Y ☐ N ☐<br>Date referred: Date seen:<br><br>Refer to Occupational Therapist Y ☐ N ☐<br>Date referred: Date seen: |
| Ensure that fluid requirements are met | | | | ☐ Fluid chart<br>☐ Additional fluids are given IV or subcutaneously<br>☐ Other: please state |
| Arrangements have been made to meet the specific social/environmental mealtime requirements | | | | Please state: |
| Provide appropriate dental care to improve oral health | | | | Please state<br><br>Refer to Dentist Y ☐ N ☐<br>Date referred: Date seen: |

| **Nutritional Support** | | | | **Type of feed** | **Volume/rate/frequency (where appropriate)** |
|---|---|---|---|---|---|
| Supplement drinks | | | | | |
| NG feeds | | | | | |
| PEG /Gastrostomy feeds | | | | | |
| Jejunostomy feeds | | | | | |
| Parenteral Nutrition | | | | | |

**INITIALS OF NURSE:** _____ **DATE/TIME:** _____

# Malnutrition Universal Screening Tool (MUST) Screening Scores

Following completion of the MUST and assessment all patients must have their MUST reviewed a minimum of **weekly** and a regular review of the nursing intervention. Any changes should be recorded in the ongoing nursing intervention. It is recommended that when a patient has been screened the date for the next screening is set.

| DATE FOR REVIEW | WEIGHT | B.M.I | STEP 1 SCORE | STEP 2 SCORE | STEP 3 SCORE | STEP 4 TOTAL SCORE | DIETETIC REFERRAL YES/NO | Date/Time | Initial |
|---|---|---|---|---|---|---|---|---|---|
| 20/2/11. | | | | | | | | | |
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| WRITE OR ATTACH LABEL |
|---|
| Surname STANDISH Sex |
| Forename DAVID |
| DOB and CHI 050370 |

Hospital NLW

Ward 12

# Peripheral Vascular Catheter (PVC) Bundle

1. Check the PVCs in situ are **still required**
2. Removing PVCs where there is **extravasation or inflammation**
3. Check PVC **dressings are intact**
4. Consider removal of PVCs in situ **longer than 72 hours**
5. Perform hand hygiene **before and after** PVC procedures (ask the patient to confirm this)

*NB ensure there are no contraindications for insertion i.e. renal fistula, post breast surgery*

| CATHETER No: | | State reason for PVC insertion: | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| INSERTION DATE: | | **Date:** | | | | | | | | | |
| | | PVC still in use | ☐ Y Continue | ☐ N Remove | ☐ Y Continue | ☐ N Remove | ☐ Y Continue | ☐ N Remove | ☐ Y Continue | ☐ N Remove |
| DATE DUE FOR REMOVAL: | | PVC dressing intact | ☐ Y Continue | ☐ N Renew dressing | ☐ Y Continue | ☐ N Renew dressing | ☐ Y Continue | ☐ N Renew dressing | ☐ Y Continue | ☐ N Renew dressing |
| INSERTION SITE: | | Absence of inflammation and or extra-vasation | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter |
| DRESSING DATED: | | PVC been inserted for <72 hours | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter |
| SIZE/COLOUR: | | Hand hygiene before & after all PVC procedures | ☐ Y Continue | ☐ N Request removal | ☐ Y Continue | ☐ N Request removal | ☐ Y Continue | ☐ N Request removal | ☐ Y Continue | ☐ N Request removal |
| DATE REMOVED | | What was done (circle) | PVC left insitu | PVC removed | PVC left insitu | PVC removed | PVC left insitu | PVC removed | PVC left insitu | PVC removed |
| **INITIAL** | | **Initial & Time** | | | | | | | | |

**IF CATHETER IN PLACE FOR MORE THAN 72 HOURS, STATE REASON WHY:**

| CATHETER No: | | State reason for PVC insertion: | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| INSERTION DATE: | | **Date:** | | | | | | | | | |
| | | PVC still in use | ☐ Y Continue | ☐ N Remove | ☐ Y Continue | ☐ N Remove | ☐ Y Continue | ☐ N Remove | ☐ Y Continue | ☐ N Remove |
| DATE DUE FOR REMOVAL: | | PVC dressing intact | ☐ Y Continue | ☐ N Renew dressing | ☐ Y Continue | ☐ N Renew dressing | ☐ Y Continue | ☐ N Renew dressing | ☐ Y Continue | ☐ N Renew dressing |
| INSERTION SITE: | | Absence of inflammation and or extra-vasation | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter |
| DRESSING DATED: | | PVC been inserted for <72 hours | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter |
| SIZE/COLOUR: | | Hand hygiene before & after all PVC procedures | ☐ Y Continue | ☐ N Request removal | ☐ Y Continue | ☐ N Request removal | ☐ Y Continue | ☐ N Request removal | ☐ Y Continue | ☐ N Request removal |
| DATE REMOVED | | What was done (circle) | PVC left insitu | PVC removed | PVC left insitu | PVC removed | PVC left insitu | PVC removed | PVC left insitu | PVC removed |
| **INITIAL** | | **Initial & Time** | | | | | | | | |

**IF CATHETER IN PLACE FOR MORE THAN 72 HOURS, STATE REASON WHY:**

| CATHETER No: | | State reason for PVC insertion: | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| INSERTION DATE: | | **Date:** | | | | | | | | | |
| | | PVC still in use | ☐ Y Continue | ☐ N Remove | ☐ Y Continue | ☐ N Remove | ☐ Y Continue | ☐ N Remove | ☐ Y Continue | ☐ N Remove |
| DATE DUE FOR REMOVAL: | | PVC dressing intact | ☐ Y Continue | ☐ N Renew dressing | ☐ Y Continue | ☐ N Renew dressing | ☐ Y Continue | ☐ N Renew dressing | ☐ Y Continue | ☐ N Renew dressing |
| INSERTION SITE: | | Absence of inflammation and or extra-vasation | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter |
| DRESSING DATED: | | PVC been inserted for <72 hours | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter |
| SIZE/COLOUR: | | Hand hygiene before & after all PVC procedures | ☐ Y Continue | ☐ N Request removal | ☐ Y Continue | ☐ N Request removal | ☐ Y Continue | ☐ N Request removal | ☐ Y Continue | ☐ N Request removal |
| DATE REMOVED | | What was done (circle) | PVC left insitu | PVC removed | PVC left insitu | PVC removed | PVC left insitu | PVC removed | PVC left insitu | PVC removed |
| **INITIAL** | | **Initial & Time** | | | | | | | | |
| **IF CATHETER IN PLACE FOR MORE THAN 72 HOURS, STATE REASON WHY:** | | | | | | | | | | |

| CATHETER No: | | State reason for PVC insertion: | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| INSERTION DATE: | | **Date:** | | | | | | | | | |
| | | PVC still in use | ☐ Y Continue | ☐ N Remove | ☐ Y Continue | ☐ N Remove | ☐ Y Continue | ☐ N Remove | ☐ Y Continue | ☐ N Remove |
| DATE DUE FOR REMOVAL: | | PVC dressing intact | ☐ Y Continue | ☐ N Renew dressing | ☐ Y Continue | ☐ N Renew dressing | ☐ Y Continue | ☐ N Renew dressing | ☐ Y Continue | ☐ N Renew dressing |
| INSERTION SITE: | | Absence of inflammation and or extra-vasation | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter |
| DRESSING DATED: | | PVC been inserted for <72 hours | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter | ☐ Y Continue | ☐ N Remove catheter |
| SIZE/COLOUR: | | Hand hygiene before & after all PVC procedures | ☐ Y Continue | ☐ N Request removal | ☐ Y Continue | ☐ N Request removal | ☐ Y Continue | ☐ N Request removal | ☐ Y Continue | ☐ N Request removal |
| DATE REMOVED | | What was done (circle) | PVC left insitu | PVC removed | PVC left insitu | PVC removed | PVC left insitu | PVC removed | PVC left insitu | PVC removed |
| **INITIAL** | | **Initial & Time** | | | | | | | | |
| **IF CATHETER IN PLACE FOR MORE THAN 72 HOURS, STATE REASON WHY:** | | | | | | | | | | |

**WRITE OR ATTACH LABEL**

Surname STANDISH Sex

Forename DAVID

DOB and CHI 050370

Hospital N/W

Ward 12

NHS Tayside

# MANUAL HANDLING AND MOBILITY ASSESSMENT CHART

**(To be completed within 24 hours of admission)**

Relevant Medical History/Underlying Condition/Surgery & Date:.....Behaviour: (confused).....

Weight:.....kg Consider safe working load of equipment History of Falls: Y N (if yes, complete Falls Risk Assessment)

Comprehension:(sight, hearing, speech).....Attachments: (infusions, catheter, drains).....

| | CODES | CODES | CODES | CODES | CODES | CODES | CODES |
|---|---|---|---|---|---|---|---|
| Sit>>Lie | I | | | | | | |
| Lying>>Sitting | I | | | | | | |
| Sit>>Stand | I | | | | | | |
| Stand>>Sit | I | | | | | | |
| Walking | I | | | | | | |
| Bathing | I | | | | | | |
| Moving up the bed | I | | | | | | |
| Turning/proning | I | | | | | | |
| Lateral Transfers | I | | | | | | |
| Floor to Bed | I | | | | | | |
| Comments | | | | | | | |
| **Date** | 13/2/11 | | | | | | |
| **Time** | 1500 | | | | | | |
| **Initials** | CM | | | | | | |

**A Risk Assessment should be carried out prior to any Manual Handling Manoeuvre. All changes or comments should be clearly documented in the Nursing Record of On-Going Care & Multidisciplinary Notes. Please indicate 'YES' if (any) in the Comments box.**

**Enter Mobility and Equipment Codes**

**Mobility Codes**

| | |
|---|---|
| I = Independent | A1 = Assistance x 1 staff |
| VP = Verbal prompting | A2 = Assistance x 2 staff |
| S = Supervision | A3 = Assistance x 3 staff |
| D = Dependant | A4 = Assistance x 4 staff |
| BR = Bedrest | |
| NWB = Non weight bearing | |
| PWB = Partial weight bearing | |
| FWB = Full weight bearing | |

**Aids/Equipment Codes**

| | |
|---|---|
| H = Full Body Hoist | GC = Gutter Crutch |
| ST= Stand Aid | WZF = Wheeled Zimmer Frame |
| GS= 1/2 Glide Sheet | ZF = Zimmer Frame |
| WS= Walking Stick | TWW = Three Wheeled Walker |
| WS1=One Stick | 4WW = Four Wheeled Walker |
| WS2=Two Sticks | RZ = Rollator Wheeled Zimmer |
| EC = Elbow Crutch | WC = Wheelchair |
| AC = Axillary Crutch | PAT = Patslide |

# MANUAL HANDLING AND MOBILITY ASSESSMENT CHART

Relevant Medical History/Underlying Condition/Surgery & Date:.....Behaviour: (confused).....

Weight:.....kg Consider safe working load of equipment History of Falls: Y N (if yes, complete Falls Risk Assessment)

Comprehension:(sight, hearing, speech).....Attachments: (infusions, catheter, drains).....

| | CODES | CODES | CODES | CODES | CODES | CODES | CODES |
|---|---|---|---|---|---|---|---|
| Sit>>Lie | | | | | | | |
| Lying>>Sitting | | | | | | | |
| Sit>>Stand | | | | | | | |
| Stand>>Sit | | | | | | | |
| Walking | | | | | | | |
| Bathing | | | | | | | |
| Moving up the bed | | | | | | | |
| Turning/proning | | | | | | | |
| Lateral Transfers | | | | | | | |
| Floor to Bed | | | | | | | |
| Comments | | | | | | | |
| **Date** | | | | | | | |
| **Time** | | | | | | | |
| **Initials** | | | | | | | |

**A Risk Assessment should be carried out prior to any Manual Handling Manoeuvre. All changes or comments should be clearly documented in the Nursing Record of On-Going Care & Multidisciplinary Notes. Please indicate 'YES' if (any) in the Comments box.**

**Enter Mobility and Equipment Codes**

**Mobility Codes**

| | |
|---|---|
| I = Independent | A1 = Assistance x 1 staff |
| VP = Verbal prompting | A2 = Assistance x 2 staff |
| S = Supervision | A3 = Assistance x 3 staff |
| D = Dependant | A4 = Assistance x 4 staff |
| BR = Bedrest | |
| NWB = Non weight bearing | |
| PWB = Partial weight bearing | |
| FWB = Full weight bearing | |

**Aids/Equipment Codes**

| | |
|---|---|
| H = Full Body Hoist | GC = Gutter Crutch |
| ST= Stand Aid | WZF = Wheeled Zimmer Frame |
| GS= 1/2 Glide Sheet | ZF = Zimmer Frame |
| WS= Walking Stick | TWW = Three Wheeled Walker |
| WS1=One Stick | 4WW = Four Wheeled Walker |
| WS2=Two Sticks | RZ = Rollator Wheeled Zimmer |
| EC = Elbow Crutch | WC = Wheelchair |
| AC = Axillary Crutch | PAT = Patslide |

WARD 12 CHECKLIST FOR DISCHARGE/TRANSFER

| ITEM | TICK WHEN COMPLETE OR N/A | INITIAL |
|---|---|---|
| *MEDICATION (POD & SCRIPT) | | |
| FRIDGE ITEMS | | |
| CONTROLLED DRUGS | | |
| TRANSFER LETTER | | |
| DRESSINGS | | |
| NURSING NOTES | | |
| DRUG KARDEX | | |
| CASE NOTES | | |
| PATIENTS BELONGINGS TAKEN | | |
| MRSA SCREEN | | |
| NEXT OF KIN AWARE OF DISCHARGE/TRANSFER | | |
| NECESSARY PIECES OF EQUIPMENT e.g. slings, splints, basins, wheelchairs etc | | |
| D/N,S/W,S/N CONTACTED AND HANDOVER GIVEN | | |

***N.B. IF VENALINK/NOMAD IN USE FOR DISCHARGE DO NOT GIVE SEPARATE BOXES FROM POD LOCKER.**

**AT WEEKEND PLEASE CHECK DISCHARGE SCRIPT IS ACCURATELY TRANSCRIBED AGAINST DRUG KARDEX.**

**BEFORE PATIENTS ARE ASKED TO WAIT IN DAYROOM PLEASE ENSURE ALL OF THE ABOVE IS COMPLETED AND THEY HAVE ALL OF THE ABOVE.**

Date 14/02/11 Time into Recovery 1250

Operation – RIGHT COMMON FEMORAL ENDARTERECTOMY + ANGIOPLASTY

Surgeon – MR NAGY

Anaesthetist – DR COVENTRY.

Anaesthetic - GA ☐ LA ☐ Spinal ☑ Epidural ☐ Regional ☐ Sedation ☑ Intrathecal opiate ☑

**Patient Name & CHI**

**05 03 70**

0503700053

DAVID STANDISH

**Status on Arrival in Recovery**

Airway - ETT ☐ LMA ☐ Oral Airway ☐ Nasal Airway ☐ Chin Support ☐ Independent ☑
Time Airway removed .....

Sedation Level A ☑ V ☐ P ☐ U ☐ Comments.....

Oxygen Therapy - 2 L/min for 24 hours SpO2 100%
Mask ☐ Nasal Cannulae ☑ Non Re-breather Mask ☐

Monitoring in situ - Invasive BP ☐ NIBP ☑ ECG ☑ Oximeter ☑ CVP ☐ Temperature 36.4

Diabetic - Yes ☐ No ☑ BM ..... mmols GKI ☐ Sliding Scale ☐

Cannulae in situ - X1 Peripheral ☑ Sites RDH
Arterial ☐ Sites_____ Time Removed ..... In Situ ☐
Central Line ☐ Chest X-Ray Required ☐ Reviewed ☐ NAD ☐

Neuro Obs Yes ☐ No ☑ (see chart)

Dressings - X2 Dry ☑ Slight Ooze ☐ Mod. Ooze ☐ Reinforced ☐ Replaced ☐

Waterlow Scale – pressure areas intact.

Blood Loss Intra Operatively - ~600 mls

Packs in situ - Yes ☐ No ☑

Drains x..... in situ Yes ☐ No ☑ Position..... Open ☐ To Be Opened At .....

Nasogastric Tube Yes ☐ No ☑

Catheter - Yes ☐ No ☑ Hourly Volumes ☐ Free drainage ☐ Irrigation ☐

Pain Score - (0) 1 2 3 Analgesia Given ☐ Nausea Score - (0) 1 2 3 Antiemetic Given ☐

PCA in situ - Yes ☐ No ☑ (See PCA Chart)

Epidural in situ - Yes ☐ No ☑ (See Epidural Chart)

Elastomeric Infusion Device in situ - Yes ☐ No ☑ Rate .....mls/hr

IV Infusion in situ - Yes ☑ No ☐ Type Hartmanns Rate th:...mls/hr

CSM - R ☐ L ☐ Colour Pink Sensation NAD Movement NAD

Additional Information

## PRIOR TO DISCHARGE FROM RECOVERY

Maintaining own Airway - Yes ☑

Conscious Level - A ☑ V ☐ P ☐ U ☐ Comments –

Patient Stable - Yes ☑

Dressings – X 2 dry + intact.

Drains - NIL Patent ☐ Amount ..... Nature .....

Drugs Given in Recovery (See Anaesthetic Sheet for details)

NIL

Pain Score – 0 ☑ 1 ☐ 2 ☐ 3 ☐

CSM - R ☑ L ☑ C Pink S NIL M NIL

SEWS SCORE ..... 0 .....

Time Ready for Discharge ..... 1400 .....

Additional Information (prior to discharge)

Discharge Checklist

Post-op instructions Anesthetist ☑ Surgeon ☑

DVT Prophylaxis Prescribed Yes ☑ No ☐

Post-op Antibiotics Prescribed Yes ☐ No ☑

Post-op Analgesia Prescribed Yes ☑ No ☐

Epidural / PCA Programme TPAR prescription checked & recorded on chart. Yes ☑ N/A ☐

SEWS Score on Discharge - .....

Time out of Recovery.....

| | |
|---|---|
| Recovery Nurse Name N Pairpuid | Ward Nurse Name |
| Signature | Signature |

05 03 70

0503700053

DAVID STANDISH

Hospital.....

Ward .....

NHS Tayside

## MUST and Nutritional Assessment (To be completed within 24 hours of admission)

Data gathered from: Patient ☑ Other (please specify):

| Malnutrition Universal Screening Tool (MUST) adapted from BAPEN | Measures and Scores | Date/Time | Initial |
|---|---|---|---|
| **Height:**<br>Method height recorded **(Please tick)**<br>• stadiometer<br>• self-reported height (if reliable and realistic)<br>• reported by carer<br>• ulna length (not applicable for learning disability patients, estimate or measure using tape measure) | 1 m 76 cm<br>☑<br>☐<br>☐<br>☐ | 3/2/11 | NS |
| **Weight** Actual ☐ Estimated ☐ | 88.4 kg | | |
| Patients usual weight (liaise with carer)<br>Are there any factors affecting weight e.g. ascites, oedema or an amputation. **Please specify plus the impact on weight:** | 88.4 kg | | |
| **BMI** score recorded | 29 kg/m² | | |

| | | | | |
|---|---|---|---|---|
| STEP 1 | BMI >20 (>30 obese)<br>BMI 18.5-20<br>BMI < 18.5 | Score = 0<br>Score = 1<br>Score = 2 | STEP 3 | Patient is acutely ill and there has been or is likely to be no nutritional intake for >5 days<br>Yes = Score 2 No = Score 0 |
| STEP 2 | Unplanned weight loss in past 3-6 months<br>Patient has < 5% weight loss<br>Patient has 5-10% weight loss<br>Patient has >10% weight loss | <br>Score = 0<br>Score = 1<br>Score = 2 | STEP 4 | **TOTAL SCORE:**<br>**(Add scores together)** 0 |

| STEP 5 | **Management Guidelines**<br>These guidelines may not be appropriate for medium/high risk patients e.g food allergy/dysphagia | Date/Time | Initial |
|---|---|---|---|
| Total MUST score = 0<br>Patient is at **low** risk | **Repeat screening:**<br>Monthly for Continuing Care /Weekly for all other wards<br>*For overweight or obese patients refer to MUST folder for information that can be given to the patient* | 3/2/11 | NS |
| Total MUST score 1or >1<br>Patient is at **medium/ high** risk | • Complete a care plan<br>• Encourage with meals and snacks (little and often)<br>• Complete and review food record charts for 3 days<br>• Encourage to drink full cream milk<br>• Commence a supplement drink e.g. Build Up or 1.5Kcal/ml supplement as per local guidelines<br>If after 3 days, less than ½ meals, supplements drinks and snacks are taken refer to the dietitian<br>**Repeat screening:**<br>Monthly for Continuing Care/Weekly for all other wards | | |
| **All Learning Disabilities Clients**<br><br>Date referred:<br>Date seen: | If patient has a Learning Disability refer to the Nurse Consultant for Learning Disabilities<br>Available Mon – Fri<br>Ext 27803 or 07740937309<br>(Answerphone out with these times) | | |
| **Immediate dietetic referral**<br><br>Date Referred:<br>Date Seen: | Enteral Tube Feeding (Ward dietitian can provide regimen for patients who are on an established feed)<br>Parenteral Nutrition<br>Swallowing problems<br>Newly diagnosed Coeliac Disease/Crohns/Ulcerative Colitis<br>Therapeutic diets that affect nutritional status<br>Newly diagnosed Type 1 diabetes<br>**See MUST folder for further guidance** | | |

# Malnutrition Universal Screening Tool ('MUST') and Dietetic Referral Guidelines for In-Patients

## STEP 1 BMI score

| BMI kg/m² | Score |
|---|---|
| >20 (>30 Obese) | = 0 |
| 18.5 – 20 | = 1 |
| < 18.5 | = 2 |

+

## STEP 2 Weight loss score

**Unplanned weight loss in past 3-6 months (this includes obese patients)**

| % | Score |
|---|---|
| <5 | = 0 |
| 5 – 10 | = 1 |
| >10 | = 2 |

+

## STEP 3 Acute disease effect score

If patient is acutely ill and there has been or is likely to be no nutritional intake for > 5 days
**Score 2**

*If unable to obtain height and weight, refer to MUST folder for alternative measures and use of subjective criteria*

## STEP 4 Overall risk of malnutrition

Add Scores together to calculate overall risk of malnutrition
Score 0: Low risk
Score 1: Medium Risk
Score 2 or more: High Risk

If patient has a **Learning Disability** refer to Nurse Consultant for Learning Disabilities

Available Mon – Fri
Ext 27803 or
07740937309
(Answerphone out with these times)

**Immediate Referral**

- Enteral Tube Feeding
- Parenteral Nutrition
- Swallowing problems
- Newly Diagnosed Coeliac Disease/ Crohns/Ulcerative Colitis
- Therapeutic diets that affect nutritional status
- Newly diagnosed Type 1 Diabetes

See MUST folder for further guidance

## STEP 5 Management Guidelines

**Low Risk**
**Repeat screening:**
Monthly for Continuing Care
Weekly for all other wards
*For overweight/obese patients refer to MUST folder for information that can be given to the patient*

**Medium / High Risk Score***

- Complete a care plan
- Encourage with meals and snacks (little and often)
- Complete and review food record charts for 3 days
- Encourage to drink full cream milk
- Commence a supplement drink e.g. Build up or 1.5Kcal/ml supplement as per local guidelines

**If after 3 days ½ or more of meals and snacks taken:**

- Encourage with meals
- Offer snacks
- Stop food record charts
- Review need for supplement drinks

**If after 3 days < ½ meals, supplement drinks and snacks taken**

*Please note that the Step 5 management guidelines for medium/high risk may not be appropriate e.g. food allergy/dysphagia

**Repeat Screening:**
Monthly for Continuing Care
(If concerned increase to weekly)
Weekly for all other wards

If weight loss continues refer to the dietitian

Refer to Dietitian for further assessment
**Completed referrals to be sent to:**

***The local Dietetic department***

**Repeat Screening**:
Monthly for Continuing Care
Weekly for all other wards

Adapted from guidelines originally produced by Dietitians working in Oxfordshire 2004
NHST Hospitals 8th September 2009

## Initial Nursing Assessment
## (To be completed within 24 hours of admission)

| (Please tick) | Y | N | Comments/Variance |
|---|---|---|---|
| Able to make menu choices independently? | | | If no, please provide further information: |
| Any specific religious/cultural/ethnic dietary requirements | | | If yes, please provide further information: |
| Any food allergies? | | | If yes, please provide further information: |
| Any specific eating and drinking dislikes? | | | If yes, please provide further information: |
| Does the patient take a therapeutic diet? | | | If yes, please provide further information: |
| Able to take diet and fluid orally and independently? | | | If no, please state:<br>☐ New problem<br>☐ Old problem<br>☐ Patient nauseated<br>☐ Physical e.g. dexterity difficulties<br>☐ Difficulties in chewing & swallowing<br>☐ Coughing, choking or spluttering during or after intake<br>☐ Other reason, please specify: |
| Patient able to achieve adequate fluid intake<br>• Over 60 yrs age – 30mls/ Kg body weight<br>• 18 – 60 yrs age - 35mls/ Kg body weight<br><br>Fluid requirements_____<br><br>Unless otherwise advised by medical staff | | | If no, please state:<br>☐ Ongoing difficulties with constipation/diarrhoea<br>☐ Problems with tongue thrush, poor lip closure/drooling<br>☐ Problems with vomiting/regurgitation<br>☐ Other reason, please specify: |
| Patient needs/uses specific equipment to help them with eating or drinking? | | | If yes, please state equipment used<br><br>Own equipment brought in:<br>Y ☐ N ☐ |
| Patient has specific social/environmental mealtime requirements | | | If yes, please provide further information: |
| Patient has a dental problem influencing dietary intake | | | If yes, please provide further information: |
| Patient is currently receiving nutritional support at home/care setting | | | Enteral: NG ☐ PEG ☐ Gastrostomy/Jejunostomy ☐<br>Parenteral: Central ☐ Peripheral ☐<br>Please state regimen |
| Patient is currently receiving supplement drinks | | | If yes, please state type and frequency: |

**INITIALS OF NURSE:** _____ **DATE/TIME:** _____

## Initial Nursing Interventions
## (To be completed within 24 hours of admission)

| (Please tick) | Y | N | N/A | Comments/Variance |
|---|---|---|---|---|
| Give assistance to make menu choices, taking into account particular likes/dislikes | | | | ☐ Verbal prompting<br>☐ Assistance<br>☐ Involve carers/family<br>☐ Other, please state |
| Kitchen informed of religious/cultural/ethnic or therapeutic diet | | | | ☐ Kitchen informed<br>☐ Halal menu offered if appropriate<br>☐ Other, please state |
| Arrangements made to ensure patient does not receive foods which they are allergic to | | | | ☐ All relevant staff informed<br>☐ Patient wrist allergy band insitu<br><br>**Allergies recorded in;**<br>☐ Nursing assessment documents<br>☐ Medical notes<br>☐ Drug kardex<br><br>☐ Other, please state |
| Arrangements made to ensure patient does not receive foods they dislike | | | | Please state: |
| Give support to eat and drink | | | | ☐ Needs food cutting up<br>☐ Needs assistance with feeding<br>☐ Needs help to sit in chair/sit up in bed<br>☐ Needs fed in moulded chair/wheelchair<br>☐ Provided with equipment<br>☐ Initiate nausea treatment plan<br>☐ Other: please state<br><br>Refer to Speech & Language Therapy Y ☐ N ☐<br>Date referred: Date seen:<br><br>Refer to Occupational Therapist Y ☐ N ☐<br>Date referred: Date seen: |
| Ensure that fluid requirements are met | | | | ☐ Fluid chart<br>☐ Additional fluids are given IV or subcutaneously<br>☐ Other: please state |
| Arrangements have been made to meet the specific social/environmental mealtime requirements | | | | Please state: |
| Provide appropriate dental care to improve oral health | | | | Please state<br><br>Refer to Dentist Y ☐ N ☐<br>Date referred: Date seen: |

| **Nutritional Support** | | | | **Type of feed** | **Volume/rate/frequency (where appropriate)** |
|---|---|---|---|---|---|
| Supplement drinks | | | | | |
| NG feeds | | | | | |
| PEG /Gastrostomy feeds | | | | | |
| Jejunostomy feeds | | | | | |
| Parenteral Nutrition | | | | | |

**INITIALS OF NURSE:** _____ **DATE/TIME:** _____

# Malnutrition Universal Screening Tool (MUST) Screening Scores

Following completion of the MUST and assessment all patients must have their MUST reviewed a minimum of **weekly** and a regular review of the nursing intervention. Any changes should be recorded in the ongoing nursing intervention. It is recommended that when a patient has been screened the date for the next screening is set.

| DATE FOR REVIEW | WEIGHT | B.M.I | STEP 1 SCORE | STEP 2 SCORE | STEP 3 SCORE | STEP 4 TOTAL SCORE | DIETETIC REFERRAL YES/NO | Date/Time | Initial |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
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## Hospital Falls History

To be completed for all patients who have had a fall during current admission. This is in addition to completion of an IR1 within the Adverse Incident Management system.

| **Date/Time (of Fall)** | | | |
|---|---|---|---|
| AIM reference number | | | |
| Circumstances surrounding patients fall? | | | |
| Location: | | | |
| Activity preceding fall: | | | |
| Type of fall: (slip, trip, fall on same level, slip, trip, fall from height) | | | |
| Any neck/spinal injury? Y/N (If yes, please describe) | | | |
| Loss of consciousness /seizure/head injury? Y/N (If yes, please state) | | | |
| Injury sustained? Y/N (If yes, please describe) | | | |
| Immediate Action Taken: (Including First Aid) | | | |
| Medical staff informed and reviewed patient: Y/N | | | |
| Complete/update and review Falls Prevention Action Plan | | | |
| Relatives informed? Y/N (please include date, time, who contacted & details of conversation) | | | |
| **Date/Time** | | | |
| **Initial** | | | |



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## Falls Risk Assessment

**The following 3 questions must be completed with ALL patients, within 24 hours of admission. Re-assessment required if patient condition changes.**

(Please document Yes/No below)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1 | History of falls prior to admission **(if yes, complete falls history & falls prevention action plan)** | | | | | | | |
| 2 | Falls(s) since admission? **(if yes, complete hospital falls history & falls prevention action plan)** | | | | | | | |
| 3 | Additional falls risk factors for this patient? E.g. Patient tries to walk alone but unsteady/unsafe, learning disabilities, parkinson's, CVA, cognitive impairment, acute confusional state, continence issues, visual impairment, medication, surgery etc. **(if yes, complete falls prevention action plan)** Please state: | | | | | | | |
| **Date** | | | | | | | | |
| **Time** | | | | | | | | |
| **Initial** | | | | | | | | |

### Falls History: (within 48 hours of admission)

**Falls history assessment:** (Date & Time of last fall prior to admission)

Has the patient been admitted following a fall? Yes ☐ No ☐ Date ..... Time of day.....

First fall? Yes ☐ No ☐ Recurrent falls? Yes ☐ No ☐ Number of falls within the last year?.....

Any warning immediately prior to any falls? Yes ☐ No ☐

Palpitation ☐ Dizziness ☐ Alcohol ☐ Loss of Consciousness ☐
Slip/Trip ☐ Environmental hazards ☐ Associated movement ☐

Explanation about fall/previous falls:(where, when, why) Activity at time of fall? (Please describe)

.....

.....

.....

Any injury sustained or previous fracture? Yes ☐ No ☐ (if yes, please describe)

.....

Any pain related to fall? Yes ☐ No ☐ (if yes, please describe)

.....

Any anxiety regarding further falls/confidence affected? Yes ☐ No ☐ (If yes please describe)

.....

Comments/other information/highlight areas of concern: -

.....

.....

Data collected from: Patient ☐ Relative ☐ Carer ☐ Other:.....

**(please delete as appropriate)**

Complete/Incomplete. Initials of Nurse:_____Date/Time:_____

If Incomplete, date of when nurse to complete:_____Initials of Nurse:_____Date/Time:_____

## Initial Falls Prevention Action Plan

Professional judgment is required when considering the nursing care patients need to minimise their risk of falling. The following nursing interventions may address some of the falls risk factors. They are however NOT exhaustive and staff should use their clinical reasoning/professional judgment when determining falls risk interventions.

**Please state all actions taken from the list of interventions below.**

| Interventions: | State Actions |
|---|---|
| **Environmental:**<br>• Nurse in most appropriate place on ward for their needs e.g. easily observable area, near toilet etc.<br>• Area hazard free, personal belongings within easy reach.<br>• Nurse call system working and within arm reach at all times.<br>• Adequate lighting at all times particularly overnight.<br>• Check infusion stands facilitate mobility. | |
| **Vision:**<br>• Ensure correct glasses worn/within easy reach and clean.<br>• Consider a visual acuity assessment by medical staff. | |
| **Lying and Standing Blood Pressure:**<br>• Check and record. If deficit exists, inform medical staff and continue to check twice daily for at least 72 hours.<br>• Advice patient on slow movement from sitting/lying to standing. | |
| **Mobility:**<br>• Follow mobility risk assessment/care plan.<br>• Refer to Physiotherapy and/or Occupational Therapy.<br>• If patient is independent, is walking aid within easy reach? | |
| **Medication:**<br>• Request Medical staff or Pharmaceutical review. | |
| **Delirium (Acute Confusional State)**<br>• Treat causes of delirium, refer to delirium guidelines | |
| **Incontinence:**<br>• Assess continence. If urine frequency, ward test urine.<br>• Consider routine/frequent toileting.<br>• Consider a commode for night time toileting.<br>• Consider full continence assessment and refer to continence service if indicated. | |
| **Bed and bedrails:**<br>• Bed at optimum height and brakes applied.<br>• Assess the need for bedrails (refer to NHS Tayside bedrail policy and complete bedrail risk assessment tool).<br>• Consider bed exit alarm (if available). | |
| **Multidisciplinary Team:**<br>• Ensure Medical staff, Physiotherapist, OT, Social Worker etc, are aware of patients falls risk, frequency and nature | |
| **Footwear:**<br>• Encourage patient to wear shoes not slippers.<br>• Check footwear for secure fit, non-slip sole. Ask relatives to supply safer replacements.<br>• Podiatry referral (as necessary). | |
| **Inform:**<br>• Involve/educate patient/relatives in safe practice.<br>• Discuss with patient/relative re. specific interventions.<br>• Issue leaflet "How to reduce falls in hospital". | |
| **Additional Falls Risk Management Interventions for Patient:** | |

Initials of Nurse:_____ Date & Time:_____

## Hospital Falls History

To be completed for all patients who have had a fall during current admission. This is in addition to completion of an IR1 within the Adverse Incident Management system.

| **Date/Time (of Fall)** | | | |
|---|---|---|---|
| AIM reference number | | | |
| Circumstances surrounding patients fall? | | | |
| Location: | | | |
| Activity preceding fall: | | | |
| Type of fall:<br>(slip, trip, fall on same level, slip, trip, fall from height) | | | |
| Any neck/spinal injury? Y/N<br>(If yes, please describe) | | | |
| Loss of consciousness /seizure/head injury? Y/N<br>(If yes, please state) | | | |
| Injury sustained? Y/N<br>(If yes, please describe) | | | |
| Immediate Action Taken:<br>(Including First Aid) | | | |
| Medical staff informed and reviewed patient: Y/N | | | |
| Complete/update and review Falls Prevention Action Plan | | | |
| Relatives informed? Y/N<br>(please include date, time, who contacted & details of conversation) | | | |
| **Date/Time** | | | |
| **Initial** | | | |

## THEATRE TREATMENT PLAN D

**At risk Waterlow above 10**

Refine risk assessment of individuals undergoing surgery by examining other factors that are likely to occur and will increase risk of pressure ulcer developing

- Length of the operation
- Increased hypotensive episodes intraoperatively
- Low core temperature during surgery
- Reduced mobility on post operative day one

- All at risk patients receiving surgery will have a pressure-relieving device on the operating table and transfer trolleys
- All nursing staff in reception, theatre and recovery will ensure that they know the patient's risk status at all points of the patient's journey through theatre
- All patients identified as at risk will have their pressure areas inspected prior to theatre and in the recovery area and where possible during the operation
- In collaboration with the anaesthetist, move the head position to prevent continued pressure on the occipital area (if patient condition allows)
- All patients at risk will have measures in place to alleviate factors that cause pressure ulcers in reception, theatre and throughout the recovery phase
- Elevate heels completely in such a way as to distribute weight of the leg along the calf without putting all the pressure on the Achilles tendon. If possible the knee should be in slight flexion. (hyperextension of the knee may cause obstruction of the popliteal vein predisposing to deep vein thrombosis)
- Position the individual in a different posture preoperatively and post operatively than the posture adopted during surgery and record this on the **SKIN** bundle
  If a pressure ulcer develops this will be recorded on the treatment plan
- The recovery nurse will discuss the patients' skin integrity with the nurse receiving the patient for return to the ward
- Theatre staff must continue the **SKIN** bundle throughout the patients' theatre journey

| | Date/Time | Signature |
|---|---|---|
| **Position of patient pre operatively – state:** | | |
| **Position of patient when on the theatre table – state:** | | |
| **Position of patient in recovery area – state:** | | |
| **Condition of skin on return to ward – state:** | | |
| **Treatment plan D active Y/N/N/A** | | |

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## Preliminary Pressure Ulcer Risk Assessment (PPURA)

**The following 3 questions must be completed with ALL patients within 6 hours of admission.**
**Re-assessment required if patient condition changes including day of theatre.**

(please write Yes/No below)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **1** | Requires assistance and or aids to move or cannot move including day of theatre? | | | | | | | |
| **2** | Incontinent? | | | | | | | |
| **3** | MUST score 1 or above? | | | | | | | |
| **Date** | | | | | | | | |
| **Time** | | | | | | | | |
| **Initial** | | | | | | | | |

If **Yes** to any question a full **Waterlow** risk assessment must be carried out within **6 hours** of admission
If **No** to any question **re-assess PPURA each shift** and implement Treatment plan A.
Treatment plan to go to theatre with the patient and theatre staff follow treatment plan D

| DATE & TIME | Pressure ulcer on admission<br>Y N<br>Source of admission_____ | Initiate PUP Treatment plan B or C and raise a wound care plan for grade 2 and above pressure ulcers |
|---|---|---|

**EPUAP PRESSURE ULCER CLASSIFICATION (2009)**

| GRADE | VISUAL DESCRIPTION |
|---|---|
| 1 | Intact skin with non-blanchable redness of a localised area over a bony prominence. Apply light finger pressure to the site, remove finger, and score 1 if: Non-blanchable erythema of intact skin. Discoloration of the skin, pain, firm, soft, warmer, cooler, oedema, hardness as compared to the adjacent skin may also be used as indicators, particularly in individuals with darker skin. |
| 2 | Partial thickness loss of the Dermis presenting as a shallow open ulcer with red pink wound bed, without slough or bruising. May also present as an intact or open/ruptured serum-filled blister. The ulcer is superficial and presents clinically as an abrasion or blister. It is not to be confused with skin tears, burns, incontinence dermatitis, moisture and excoriation. |
| 3 | Full thickness tissue loss. Subcutaneous fat may be visible but not bone muscle or tendon. Slough may be present but does not obscure the depth of tissue loss. May include tunnelling and undermining. |
| 4 | Full thickness tissue loss with exposed muscle, bone and tendon. Slough or Eschar may be present and may completely obscure the wound bed. |

**Sub categorise**

- Unstageable/unclassified full thickness unknown- Full thickness tissue loss but until the slough or Eschar are removed the full extent cannot be determined
- Suspected deep tissue Injury-depth unknown – Purple or maroon area intact skin or blood filled blister – might be painful 'boggy' to touch. Evolution may expose deeper layers, or a thin Eschar may form over the surface

**PRESSURE ULCER RECORD**

| Date/Time | Ulcer Location | EPUAP Grade | Record on AIM if developed in this area, also if the pressure ulcer was present on admission from another area and no record in the notes **state incident reference** number(S) and date | Initials |
|---|---|---|---|---|
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NHS Quality Improvement Scotland

## Adapted Waterlow Pressure Area Risk Assessment Chart

**10+= 'At Risk': 15+ = 'High Risk': 20+ = 'Very High Risk'**

Complete assessment on admission if PPURA shows at Risk. Repeat Waterlow weekly or if there is a change in individual's condition.

More than one score/category can be used:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Male** | 1 | | | | | | | |
| **Female** | 2 | | | | | | | |
| Age | | | | | | | | |
| 14 – 49 | 1 | | | | | | | |
| 50 – 64 | 2 | | | | | | | |
| 65 – 74 | 3 | | | | | | | |
| 75 – 80 | 4 | | | | | | | |
| 81+ | 5 | | | | | | | |
| **Build/Weight for Height (BMI=weight in Kg/height in m2)** | | | | | | | | |
| Average – BMI 20-24.9 | 0 | | | | | | | |
| Above average – BMI 25-29.9 | 1 | | | | | | | |
| Obese – BMI > 30 | 2 | | | | | | | |
| Below average – BMI < 20 | 3 | | | | | | | |
| **Continence** | | | | | | | | |
| Complete/catheterised | 0 | | | | | | | |
| Incontinent urine | 1 | | | | | | | |
| Incontinent faeces | 2 | | | | | | | |
| Doubly incontinent (urine & faeces) | 3 | | | | | | | |
| **Skin Type – Visual Risks Area** | | | | | | | | |
| Healthy | 0 | | | | | | | |
| Tissue paper (thin/fragile) | 1 | | | | | | | |
| Dry (appears flaky) | 1 | | | | | | | |
| Oedematous (puffy) | 1 | | | | | | | |
| Clammy (moist to touch)/pyrexia | 1 | | | | | | | |
| Discoloured (bruising/mottled) | 2 | | | | | | | |
| Broken (established ulcer) | 3 | | | | | | | |
| **Mobility** | | | | | | | | |
| Fully mobile | 0 | | | | | | | |
| Restless/fidgety | 1 | | | | | | | |
| Apathetic (sedated/depressed/reluctant to move) | 2 | | | | | | | |
| Restricted (restricted by severe pain or disease) | 3 | | | | | | | |
| Bedbound (unconscious/unable to change position/traction) | 4 | | | | | | | |
| Chair bound (unable to leave chair without assistance) | 5 | | | | | | | |
| **Nutritional Element** | | | | | | | | |
| **Unplanned weight loss in past 3-6 months** | | | | | | | | |
| < 5% Score **0**, 5-10% Score **1**, >10% Score **2** | 0-2 | | | | | | | |
| BMI >20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2** | 0-2 | | | | | | | |
| Patient acutely ill or no nutritional intake > 5 days | 2 | | | | | | | |
| **Special Risks – Tissue Malnutrition** | | | | | | | | |
| Multiple organ failure/terminal cachexia | 8 | | | | | | | |
| Single organ failure e.g. cardiac, renal, respiratory | 5 | | | | | | | |
| Peripheral vascular disease | 5 | | | | | | | |
| Anaemia = Hb < 8 | 2 | | | | | | | |
| Smoking | 1 | | | | | | | |
| **Special Risks – Neurological Deficit** | | | | | | | | |
| Diabetes/ MS/ CVA/ motor/ sensory/ paraplegia Max 6 | 4-6 | | | | | | | |
| **Special Risks – Surgery/Trauma** | | | | | | | | |
| On table > 6 hours | 8 | | | | | | | |
| Orthopaedic/ below waist/spinal (up to 48 hours post op) | 5 | | | | | | | |
| On table > 2 hours (up to 48 hours post op) | 5 | | | | | | | |
| **Special Risks – Medication** | | | | | | | | |
| Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4* | 4 | | | | | | | |
| **Total Score** | | | | | | | | |
| **Date** | | | | | | | | |
| **Time** | | | | | | | | |
| **Initials** | | | | | | | | |

Ensure plan of care is implemented / reviewed for all identified areas of concern.

## Pressure Ulcer Prevention Treatment Plan Guide

**The use of clinical judgement is paramount when deciding on pressure ulcer prevention.**
**Ensure each planned intervention is recorded on the record of ongoing care**

Pressure ulcer risk assessment performed using recognised tool (Waterlow NATVNS) and skin assessment performed using EPUAP pressure ulcer classification system or PPURA within 6 hours from the beginning of the episode of care

**No risk** (PPURA) and / or Waterlow <10
No evidence of current pressure damage
No history of pressure ulcers
Patient mobile

**At Risk** Waterlow >10 and or
No pressure ulcer/ Grade 1 or 2 pressure ulcer and or
Patient able to be re-positioned

**High Risk** - Waterlow >10 and
Grade 3 or 4 pressure ulcer and/or
Patient unable to be re-positioned

### TREATMENT PLAN A

- No special mattress intervention required
- Patient encouraged to check their own skin, if appropriate and with education from registered nurse
- Patient will independently change position, if appropriate and with education from registered nurse
- Re-assess PPURA risk factors on each shift, if Yes to the PPURA carry out a Waterlow and continue weekly or if there are changes in the patient's general condition, skin condition or treatment
- Re-assess skin if there are changes in the patient's general condition, skin condition, theatre, medication or recovery

### TREATMENT PLAN B

- Profiling bed with high specification foam mattress such as softform premier. Do not elevate the bed head more than 30 degrees for long periods
- Show patients how to relieve their own pressure areas and actively mobilise where possible.
- The re-positioning interval, either 2/3/4 hrly will be determined by the condition of the skin on inspection. If applicable, re position with alternating 30 degree lateral tilt. Bony prominences are kept from direct contact with one another
- Skin inspection particularly heels and sacral areas are carried out at specified times or with each repositioning. Chart and document condition of skin/ulcer on re-positioning and the interval times using the SKIN bundle
- Keep bed linen loose

**Heels**

Friction and shear damage is minimised
Consider elevating heels off the bed with pillows or heel elevators, use film dressing or moisturisers to prevent friction

**Seating**:

- Limit the time seated to no more than 2 hours at any one time. Patients with pressure ulcers and at high risk should be actively mobilised.
- Ensure maximum contact with the chair and the patient's back and head are fully supported. The buttocks, knees and feet are supported fully at angles of 90 degrees.
- Pressure relieving foam cushion will be used for grade 1 and 2 ulcers and ensure the patients are sitting at the correct angle and fully supported at the feet, thighs, buttocks, back and head
- Complete the **SKIN** Bundle

### TREATMENT PLAN C

- Profiling bed with a dynamic mattress; document type of mattress on the intervention sheet. Do not elevate the bed head more than 30 degrees for long periods
- Show patients how to relieve their own pressure areas where possible. Actively mobilise when possible
- The re-positioning interval, either 2/3/4 hrly will be determined by the condition of the skin on inspection. If applicable, re position with alternating 30 degree lateral tilt. Bony prominences are kept from direct contact with one another
- Skin inspection particularly heels and sacral areas are carried out at specified times or with each repositioning. Chart and document condition of skin/ulcer on re-positioning and the interval times using the SKIN bundle
- Keep bed linen loose

**Heels**

- Elevate heels off the bed and protect from pressure shear and friction, consider moisturisers or film dressings to prevent friction

**Seating:**

- Patients with grade 3 / 4 ulcer on the sacral area will be discouraged from sitting in a chair and the profiling chair function of the bed utilised when possible. The body should have maximum contact with the chair and the patient's back and head are fully supported. The buttocks, knees and feet are supported fully at angles of 90 degrees.
- Seek advise on specialist seating if sitting unavoidable

Complete the **SKIN** Bundle

### For all at risk patients consider the following:-

**Nutrition and hydration**
Strive to ensure adequate nutrition and hydration compatible with the patient's condition.
Nutritional protein supplements to be given when ulcer healing is the goal

**Skin.** Wetness on the skin is a key factor in pressure ulcer development particularly from incontinence, this must be cleaned immediately with a skin cleanser **not** soap and water and the cause addressed. Where the source of wetness cannot be controlled the use of moisture absorbing continence aids must be used. Document excoriation using NHSQIS Excoriation Tool and NHS Tayside continence skin guidelines
For dry skin a non-perfumed moisturiser may be applied sparingly at least twice daily. Avoid rubbing and massaging

**Pain**
Pain control is important to enable patients to move themselves or to be moved more easily thus increasing compliance with pressure relieving turning regimes. Pain from area known to be at risk of pressure ulcer development must be inspected immediately and re-assessed.

## Multi-Disciplinary Notes

| Date | Time | | Initial |
|---|---|---|---|
| | | | |
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| | | | | | |
|---|---|---|---|---|---|
| Hospital medical certificate provided | ❑ | ❑ | | | |
| Valuables returned if applicable | ❑ | ❑ | | | |
| Venflon/lines removed if applicable | ❑ | ❑ | | | |
| Appropriate persons informed of infection control status (please state) | ❑ | ❑ | | | |
| **Discharge Medicines** | **Y** | **N** | **Comments/Variance** | **Date** | **Initial** |
| Own medicines destroyed | ❑ | ❑ | | | |
| Own medicines returned to patient | ❑ | ❑ | | | |
| Discharge medication ordered | ❑ | ❑ | | | |
| Discharge medication provided | ❑ | ❑ | | | |
| Refer to community Pharmacist for compliance needs assessment | ❑ | ❑ | | | |
| Refer to community Pharmacist for restart of compliance aid | ❑ | ❑ | | | |
| Refer to community Pharmacist for medication review | | | | | |
| Patient demonstrates ability to manage own medicines | ❑ | ❑ | | | |
| Carer demonstrates ability to manage patients medicines if appropriate | ❑ | ❑ | | | |
| **Multidisciplinary Referrals** | | | | | |
| Physiotherapist | ❑ | ❑ | | | |
| Occupation therapist | ❑ | ❑ | | | |
| Specialist Nurse (please state) | ❑ | ❑ | | | |
| Other (please state) | ❑ | ❑ | | | |
| **Referrals/discharge summaries provided to:** | **Y** | **N** | **Comments/Variance** | **Date** | **Initial** |
| GP | ❑ | ❑ | | | |
| Practice nurse | ❑ | ❑ | | | |
| Patient and/or carer | ❑ | ❑ | | | |
| Other (please state) include nursing homes etc. | ❑ | ❑ | | | |
| **Follow-up arrangements** | **Y** | **N** | **Comments/Variance** | **Date** | **Initial** |
| OPD | ❑ | ❑ | | | |
| Other (please state) | ❑ | ❑ | | | |
| Discharge Completed | ❑ | ❑ | | | |



## Multi-Disciplinary Notes

| Date | Time | | Initial |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

WRITE OR ATTACH LABEL

Surname STANDISH Sex.....

Forename DAVID.

DOB and CHI 050370

Hospital NIW

Ward 12

NHS Quality Improvement Scotland

NHS Tayside

NATVNS SCOTLAND

# Assessment Chart for Wound Management

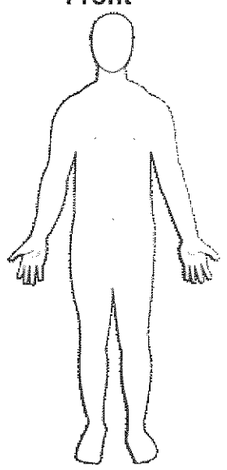
For multiple wounds complete formal wound assessment for each wound. Add Inserts as needed.

**Factors which could delay healing:**
*(Please tick relevant box)*

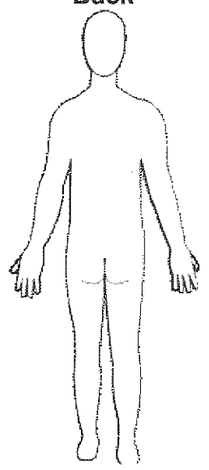
| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Immobility | ☐ | Poor Nutrition | ☐ | Diabetes | ☐ | Incontinence | ☐ |
| Respiratory/Circulatory Disease | ☐ | Anaemia | ☐ | Medication | ☐ | Wound Infection | ☐ |
| Inotropes | ☐ | Anti-Coagulants | ☐ | Oedema | ☐ | Steroids | ☐ |
| Chemotherapy | ☐ | Other..... | | Allergies & Sensitivities..... | | | |

**Body Diagram**

Front



Back



Mark location with 'X' and number each wound

**Type of Wound** **Total number & duration of each type of wound**

Leg Ulcer .....

Problem Surgical Wound .....

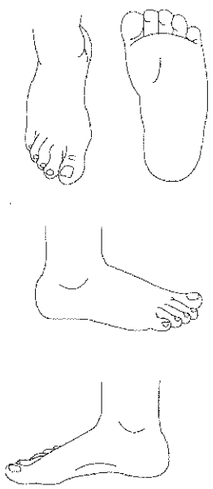
Diabetic Ulcer .....

Pressure Ulcer .....

Other, specify .....

**Feet Diagram**

Right



Left



Mark location with 'X' and number each wound

**Date referred to:**

Leg Ulcer specialist .....
Dermatology Specialist.....
Plastics.....
Physiotherapist.....
Podiatrist.....
Dietician.....

Other (please specify).....

**Assessors signature:** .....

**Date:** .....

## Formal Wound Assessment

**Complete on initial assessment and thereafter complete at every dressing change**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Date of Assessment | | | | | | | | |
| Number of wound | | | | | | | | |
| **Analgesia required** *(Refer to local pain assessment tool)* | Y /N | Y /N | Y /N | Y /N | Y /N | Y /N | Y /N | Y /N |
| Regular/ongoing analgesia | | | | | | | | |
| Pre-dressing only | | | | | | | | |
| **Wound Dimensions (enter size)** | | | | | | | | |
| Length (cm/mm) | | | | | | | | |
| Width (cm/mm) | | | | | | | | |
| Depth (cm/mm) | | | | | | | | |
| Or trace wound circumference | | | | | | | | |
| Is wound tracking/undermining | | | | | | | | |
| Photography | | | | | | | | |
| **Tissue type on wound bed ( enter percentages)** | | | | | | | | |
| Necrotic (Black) | | | | | | | | |
| Sloughy (Yellow/Green) | | | | | | | | |
| Granulating (Red) | | | | | | | | |
| Epithelialising (Pink) | | | | | | | | |
| Hypergranulating (Red) | | | | | | | | |
| Haematoma | | | | | | | | |
| Bone/tendon | | | | | | | | |
| **Wound exudate levels/ type (tick all relevant boxes)** | | | | | | | | |
| Low | | | | | | | | |
| Moderate | | | | | | | | |
| High * | | | | | | | | |
| Serous (Straw) | | | | | | | | |
| Haemoserous (Red/Straw) | | | | | | | | |
| Purulent (Green/Brown/Yellow)* | | | | | | | | |
| **Peri-wound skin (tick relevant boxes)** | | | | | | | | |
| Macerated (White) | | | | | | | | |
| Oedematous * | | | | | | | | |
| Erythema (Red)* | | | | | | | | |
| Excoriated (Red) | | | | | | | | |
| Fragile | | | | | | | | |
| Dry/scaly | | | | | | | | |
| Healthy/intact | | | | | | | | |
| **Signs of Infection * 1 or more of these signs may indicate possible infection** | | | | | | | | |
| Heat * | | | | | | | | |
| New slough/necrosis(deteriorating wound bed)* | | | | | | | | |
| Increasing pain* | | | | | | | | |
| Increasing exudate* | | | | | | | | |
| Increasing odour* | | | | | | | | |
| Friable granulation tissue* | | | | | | | | |
| Swab obtained for culture (not routine) | | | | | | | | |
| **Treatment objectives (tick relevant box)** | | | | | | | | |
| Debridement | | | | | | | | |
| Absorption | | | | | | | | |
| Hydration | | | | | | | | |
| Protection | | | | | | | | |
| Palliative / conservative | | | | | | | | |
| Reduce bacterial load | | | | | | | | |
| **Assessors Print Initials** | | | | | | | | |
| **Dressing Renewed (planned or unplanned dressing change)** | | | | | | | | |
| **Re-assessment date** | | | | | | | | |
| **Initial** | | | | | | | | |

## Wound Treatment Plan and Evaluation of Care

To be completed when treatment or dressing type / regime altered
**NB print information (write clearly)**

| Date | Wound Number | Cleansing Method, Dressing Choice & Rationale (state if antibiotics have been prescribed) | Frequency | Evaluation & Rationale for changing dressing type (please state rationale for any deviance from the NHST Wound management formulary) | Initial |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**SEWS KEY** 0 | 1 | 2 | 3

SEWS 0 - 1 : Routine Observation:- state frequency:
2 - 3 : Inform Nurse in Charge and hourly observation
4 or new red risk : See flowchart overleaf and monitor patient

NAME: DAVID STANDISH. D.O.B.: 250370

WARD: 12 N/W
ADMISSION DATE: 13/2/11.

| | | |

## Staff should use SBAR in all communications relating to clinical matters.

**Definition**
- **S ituation**
- **B ackground**
- **A ssessment**
- **R ecommendations**

**Early Warning Score 4 or more or new red risk**
or **concern with a patients condition**

▼

**Inform Nurse in Charge Immediately**
**Establish Urgency of Clinical Situation**
**Initiate Treatment/Intervention**

▼

Nurse in Charge unable to initiate Treatment/Intervention

▼

Determine level of clinician required
Contact Clinician/ HAN Practitioner
State the appropriate response time
based on urgency of clinical situation

▼

Clinician/HAN Practitioner unable to provide
Review/Treatment within required response time
or Patient Deteriorating

▼

**Early Warning Score 6 or more**
or **rapidly deteriorating patient**

▼

**Call appropriate Registrar for immediate review**

▼

Patient re-assessed and
treatment initiated

**NO** →

Registrar unable to
attend immediately
or SEWS increases by 2 or more

▼

Patients clinical condition/score improves

**NO** →

**Call appropriate Consultant.**
**Consider ICU**
**referral/review of treatment plan**

▼

Continue treatment and
SEWS scoring as required

## Pain Assessment & Management Guidelines

**Pain Score:**

score 0 = No Pain at Rest
No Pain on Movement
score 1 = No Pain at Rest
Slight Pain on Movement
score 2 = Intermittent Pain at Rest
Moderate Pain on Movement
score 3 = Continuous Pain at Rest

**Nausea Score (0-3):**

0 = No nausea or vomiting
1 = Nausea only
2 = Vomiting once
3 = Vomiting more than once

**For Acute and Chronic Pain**
For pain score of 2 or more, implement pain assessment chart and complete Assessment Information 5: Pain Management. Refer to Pain Management Guideline/Mini-guidelines.

**For Cancer Related Pain**
For pain score of 2 or more, refer to Palliative Guidelines



NHS Tayside

## SBAR Record

| Date | Time | Situation / Background | Recommendation / Action | Initials |
|---|---|---|---|---|
| | | | | |
| | | | | |

## Management Plan / Local Exclusions

| Date | Management of SEWS Observations | Signed |
|---|---|---|
| | | |

NHS TAYSIDE

## PATIENTS' FUNDS AND PROPERTY PROCEDURE

### PERSONAL DISCLAIMER NOTICE
### LOSS OF PERSONAL EFFECTS

NHS TAYSIDE will not accept any responsibility for loss or damage to any article/personal belongings unless such articles/personal belongings (including cash) have been handed over to and accepted by NHS TAYSIDE for safe keeping and an official receipt given.

I have been given the opportunity to read the above and I do not wish to take advantage of the facilities provided.

**Section A**

Signed: × D. Standish Date: _____

Hospital: N/W Ward No/Name: 12

Print Name: D. STANDISH

**Section B**

**If this form is being signed on behalf of a patient please state your relationship to the patient:**

Signed: _____ Date: _____

Print Name: _____ Relationship: _____

**Section C**

**Witness**

Signature: _____

Address: _____

_____

Note for guidance to patients:

It should be understood that when a patient is absent from the ward for treatment (e.g. : x-ray, an operation etc) the safe custody of their property which has not been handed over to NHS TAYSIDE for safe keeping remains their responsibility.

Arrangements are available, whereby, such property (i.e. watches, rings etc) may be handed over to the Nursing staff for safe keeping and appropriate envelopes are available for this purpose.

**Report Details:** Unauthorised | **View:** Original

Tayside University Hospitals N.H.S. Trust - RADIOLOGY REPORT PAGE 1
PAS No: 0503700053 Comp No. 298013 E-3342861 Hospital: T101H
Name: STANDISH, DAVID Referring Clinician: DR J NAGY
Address: 9 MANSION DRIVE Ward: T101HN12
DUNDEE In/Out:

DD4 9DD REQUEST DATE 23/09/2010 ATTEND DATE 14/10/20

---

MRA Lower limb Both

Distal aorta normal calibre.

In the RIGHT, iliacs are good but there is an eccentric plaque in the CFA (corresponding to the stenosis identified at duplex). PFA good but there is a short (1cm) stenosis/occlusion in the distal SFA. Below this the popliteal and calf run-off is good.

On the LEFT, iliacs, CFA and PFA all good. the SFA is occluded at its origin, reforming in the adductor canal via collaterals. Below this the POPA and calf run-off is good.

On the right the dominant (treatable) lesions are the SFA stenosis and short CFA stenosis/occlusion. These should be amenable to combine surgical/endovascular procedure. On the left the dominant lesion is the long SFA occlusion.

IZ

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This report is only valid when verified

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Exam date 14/10/2010 Date reported
Exam: MALLB Reported by:DR I ZEALLEY/ZEAI VERIFIED



Printed by GC[illegible]e\ldap.tuht.scot.nhs.uk on 15/1[illegible] 12:41:21

**Report Details:** Unauthorised | **View:** Original

Tayside University Hospitals N.H.S. Trust - RADIOLOGY REPORT PAGE 1
PAS No: 0503700053 Comp No. 298013 E-3360484 Hospital: T101H
Name: STANDISH, DAVID Referring Clinician: UNKNOWN CONSULTANT
Address: 9 MANSION DRIVE Ward: T101HNVSS
DUNDEE In/Out: Inpatient

DD4 9DD REQUEST DATE 20/10/2010 ATTEND DATE 20/10/20

---

MDM MEETING :

Referring Clinician: Mr Nagy

Date of Procedure: 14th October

Procedure/Indication: MR angiogram for claudication.

Clinical Background: Bilateral calf claudication.

Management Plan/Results of Intervention: Requires vascular medical referral. Could have a right common femoral endarterectomy and superficial femoral angioplasty at the same time in theatre. The left would require a femoro-popliteal bypass if appropriate.

Follow-up: Angio review clinic.

GDG

---

This report is only valid when verified

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Exam date 20/10/2010 Date reported
Exam: MDM Reported by:Dr R BHAT/BHATR VERIFIED



Printed by GCrowe\ldap.tuht.scot.nhs.uk on 15/11/2010 12:41:27

Please order quoting MLS C155

Name:DAVID STANDISH
ID:0503700053
Sex:Male Birth date: Years
cm kg mmHg
Medication:

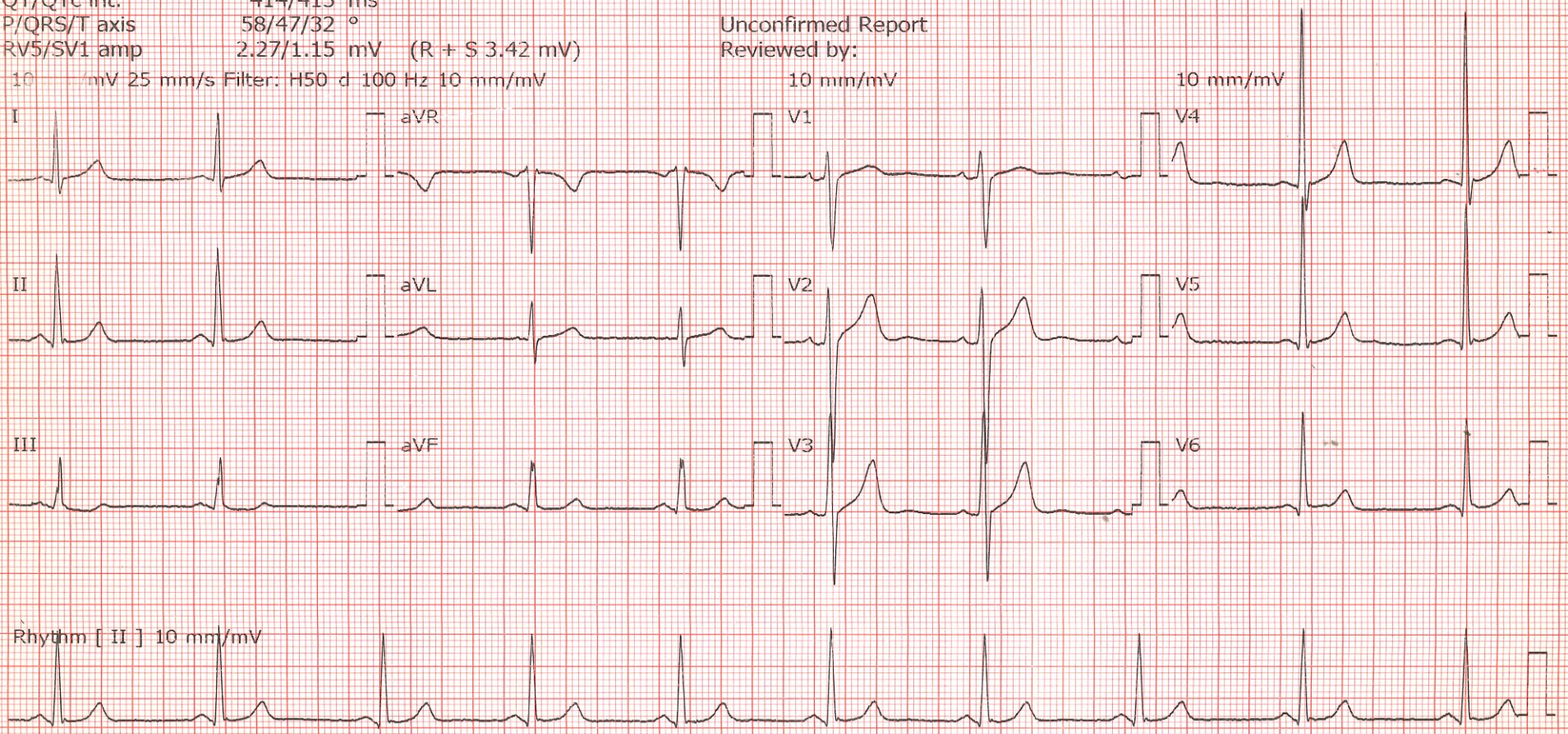
10- 9-2010 9:59

Symptoms:
History:

| | | |
|---|---|---|
| HR | 59 | bpm |
| PR int. | 132 | ms |
| QRS dur. | 96 | ms |
| QT/QTc int. | 414/413 | ms |
| P/QRS/T axis | 58/47/32 | ° |
| RV5/SV1 amp | 2.27/1.15 | mV (R + S 3.42 mV) |

Unconfirmed Report
Reviewed by:

10 mV 25 mm/s Filter: H50 d 100 Hz 10 mm/mV




158E 04-01 02-10 Dept.:Area 6 Exam:S. Cummings,CARDIOLOGY DEPT NINEWELLS

Medilink Services Belfast: Tel. 028 9058 2999 Dublin: Tel. 01 283 9999 Kilmarnock: Tel. 01563 559 159

AREAS (SOPD). 25/6/10

**East of Scotland Vascular Network**
**Nurse led Intermittent**
**Claudication Clinic**

| | |
|---|---|
| STANDISH | 0503700053 |
| DAVID | M |
| 9 MANSION DR | |
| DUNDEE | |
| | DD4 9DD |
| PARK AVENUE MEDICAL CENTR, PARK AVEN | |

## History

Side right / left / bilateral RIGHT WORSE ONLY BECAUSE I BIC TOE NUMBNESS.

Site calf / thigh / buttock

Walking Distance/Time 50 YARDS Pain starts at Has to stop at

Is pain relieved on rest - Y/N (If yes, how long does it take)

Rest pain : in calf - Y/N

in foot - Y/N

50 YARDS
10 MINS stopping
No rest pain but
Toe numbness occassionally
even on standing

**Previous vascular treatment**

none

Previous Vascular team input Y/N

Outcome :

Intervention carried out :

Risk factor modification ☐

ABPI ☐

Duplex ☐

Angio or MRA ☐

angioplasty
site.....

bypass
type.....

Amputation
Site.....

## Other medical conditions

### Ischaemic heart disease

CHD Risk factor modification by GP ☐
(attach recent results from Central vision)

MI number..... date of most recent.....

angina at rest / dressing / walking.....yards / more strenuous activity / none

from GP or case notes

no history

### Respiratory disease

INHALERS when needed.

non specific / asthma / chronic bronchitis / emphysema / from GP / none

### Dyspnoea on exertion

speaking / dressing / less than one flight of stairs and more / none

### Cerebro-vascular disease

no / yes / from GP .....

TIA
Stroke
Carotid Endarterectomy

### Diabetes

none / diet / tablet / insulin metformin yes / no

### Hypertension

patient not aware / no / yes / from GP

### Hypercholesterolaemia

patient not aware / no / yes / from GP

| | | | |
|---|---|---|---|
| **Weight** | 84.1 | **BP** | 117/72 |
| **Height** | 175 | **Pulse** | 56 |
| **BMI** | 26 | **BM** | 6.4 |
| **Cholesterol** | | **Waist size** | |

**Smoking**

never / current / stopped.....10-15.....per day.....ago

How many cigarettes per day. :

Smoking Cessation advice given Y/N
Info Leaflet given Y/N

**Current Medication**

| | |
|---|---|
| Aspirin | ☐ — NO. |
| Clopidogrel | ☐ |
| Cilostazol | ☐ |
| Naftidrofuryl | ☐ |
| Statin | ☑ |
| Ace inhibitor | ☐ |
| Beta Blocker | ☐ |

INHALERS.

ESCITALOPRAM

**Known allergies**.....NIL V. KNOWN

**Upper limb pulses**

| | axillary | brachial | radial | ulnar |
|---|---|---|---|---|
| right | | | ✓ | |
| left | | | ✓ | |

**Aorta**

not palpable / palpable size.....cm

**Lower limb pulses**

| | femoral | popliteal | dorsalis pedis | posterior tibial |
|---|---|---|---|---|
| right | ✓ | 0 | ✓ | ✓ |
| left | ✓ | 0 | ✓ | ✓ |

**Appearance of Feet**

normal no tissue threat

Buerger's -ve +ve tissue loss threatened

tissue loss.....

**Ankle:brachial Indices**

| | resting | post-exercise |
|---|---|---|
| right | 0.56 | 0.37 |
| left | 0.51 | 0.20. |

Monophasic bilaterally

**Impression**

Bil IC.

**Plan**

Duplex requested.

Refer Dr Dick.

- Discussed with Dr Dick at clinic today
- thrombophilia screening bloods taken → SD will see pt @ clinic with results.

Alan
Will create
VNSP.

HISTORY/CONTINUATION SHEET

Ward/Clinic/Hosp. 15 N/4 ..... Cons.

D D M M Y Y
05 03 00 05 3 C.H.I. No.

Surname ... Standish

First Name ... David ... M. State

Address ... Sex

G.P. & Address (G.P. Requests only)

USE BLOCK LETTERS OR PATIENT LABEL

UNIT/WARD/DEPT.

Page .....

| DATE | 1850 |
|---|---|
| 22/10/01 | Admitted via GP with 24 hr history of O sided chest pain radiating to back. Took 2 puffs of his partners GTN spray & effect o/A pain still present but eased. Recordings stable. For cardiac monitor. Previous chest pain investigations -ve. DrHopkins. |
| 2120 | Given once only Prochlorperazine, for MI screen. No further c/o pain. KJR Cassell |
| 2340 | C/O chest pain, given 2 puffs GTN Spray given. Rae Hunter |
| 0030 | Pain still present, given 2 further puffs of GTN Spray. Rae Hunter |
| 0625 | Pain free Rae Hunter |
| 23/10/01 | |
| 0625 | Slept for short spells at latter part of night, SHO does not want him weaned to do BP. CK 479 CK2 368. Very unsettled overnight. No further chest pain. Rae Hunter |
| | W/R Dr Jones refer CPS, complete MI screen. May require gastric investigations. DrHopkins. |
| | Reviewed by CPS for input non cardiac pain if trop -ve not for CPS. Keenan SPCPS |
| 1330. | Venflon removed. trip min negative, due for discharge home. KJR Cassell |

NAME

UNIT NUMBER

# MEDICINE RECORDING SHEET

## REGULAR PRESCRIPTIONS

| DATE | OTHER TIMES Time | Code | Intls | Intls | Time | Code | Intls | Intls | 0600 Intls Intls | 0800 Intls Intls | 1000 Intls Intls | 1200 Intls Intls | 1400 Intls Intls | 1600 Intls Intls | 1800 Intls Intls | 2000 Intls Intls | 2200 Intls Intls | 2400 Intls Intls | Comments on Discrepancies |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | |
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PLEASE ENTER APPROPRIATE LINE KEY FROM PRESCRIPTION SHEET: If a drug is unavailable, advise presc

If a drug is refused, encircle the line key letter e.g. (H)

If the patient is absent at the time of the medicine round, encircle the line key letter and cancel e.g. (E)

NAME David Stradwick UNIT NUMBER 050370 MEDICINE RECORDING SHEET

## REGULAR PRESCRIPTIONS

| DATE | OTHER TIMES Time | Code | Intls | Intls | Time | Code | Intls | Intls | 0600 Intls | Intls | 0800 Intls | Intls | 1000 Intls | Intls | 1200 Intls | Intls | 1400 Intls | Intls | 1600 Intls | Intls | 1800 Intls | Intls | 2000 Intls | Intls | 2200 Intls | Intls | 2400 Intls | Intls | Comments on Discrepancies |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 22.10.03 | 2200 | D | 10 | | | | | | | | | | | | | | | | | | | | | | A | N | B | R | |
| 23.10.03 | | | | | | | | | | | P | KL CG | N/J | KL | N/J | KL | | | | | | | | | | | | | |

PLEASE ENTER APPROPRIATE LINE KEY FROM PRESCRIPTION SHEET: If a drug is unavailable, advise prescriber
If a drug is refused, encircle the line key letter e.g. (H)
If the patient is absent at the time of the medicine round, encircle the line key letter and cancel e.g. (E)

**TAYSIDE UNIVERSITY HOSPITALS/**
**TAYSIDE PRIMARY CARE**

# GENERAL ACUTE/LONG STAY

**PATIENT ADMISSION, ORIENTATION, ASSESSMENT, DISCHARGE AND DISCLAIMER DOCUMENTATION**

Ward/Clinic/Hosp. 15 N/W Cons.

Surname: Standish D D M M Y Y 0 5 0 3 7 0 6 0 5 3 C.H.I. No.

First Name: David M. State

Address:

G.P. & Address (G.P. Requests Only)

USE BLOCK LETTERS OR PATIENT LABEL

AGE: 31

PROVISIONAL DIAGNOSIS: L sided chest/ abdo pain radiating to back

DATE AND TIME OF ADMISSION: 22/10/01 1840

PATIENT'S TEL NO:

SOURCE OF REFERRAL: GP

DIAGNOSIS:

PATIENT UNDERSTANDING OF REASON FOR ADMISSION:

RELIGION:

NEXT OF KIN:

Name:

Address: 41 Balgowrie Ave Dundee

Relationship: Dad

Tel No: (Home): 451294

(Work):

OTHER CONTACT:

Name:

Address:

Relationship:

Tel No: (Home):

(Work):

ARE RELATIVES AWARE OF ADMISSION: (YES) / NO

RELATIVES WISH CONTACT AT NIGHT: YES / NO

KNOWN ALLERGIES: Nil known

ALLERGY BAND INSITU: YES / (NO)

IDENTITY BAND INSITU: (YES) / NO

DRUGS BROUGHT IN WITH PATIENT: YES / (NO)

RETURNED TO PATIENT / RELATIVES: YES / NO

PAST MEDICAL HISTORY: previous c/p - results -ve

SMOKING: (YES) / NO — 8-10 daily

ALCOHOL: (YES) / NO — binge drinker

ROUTINE URINALYSIS: Will not use bottles for specimen.

| TEMP | PULSE | B/P | RESP |
|---|---|---|---|
| 36.9° | 69 | 156/85 | 96% on air |

HEIGHT (M)

WEIGHT (metric): 73kg.

## PERSONAL PROPERTY AND EFFECTS

CASH VALUABLES RETAINED: Nil.

VALUABLES RECEIPT No:

VALUABLES TAKEN HOME BY RELATIVES:

D.S.S. ALLOWANCE / PENSION BOOK HELD BY:

Name: .....

Address: .....

.....

.....

Relationship: ..(a) non.....

DENTURES: UPPER YES / (NO) SPECTACLES: YES / NO APPLIANCES: .....

LOWER YES / (NO) CONTACT LENSES: YES / NO PROSTHESIS: .....

PARTIAL YES / (NO) HEARING AID: YES / NO

CROWNS YES / (NO) OTHERS (Specify):

## COMMUNITY CARE RECEIVED PRIOR TO ADMISSION

DISTRICT NURSE: YES / NO

HEALTH VISITOR: YES / NO

COMMUNITY PSYCHIATRIC NURSE: YES / NO

HOME HELP: YES / NO

MEALS ON WHEELS: YES / NO

PHYSIOTHERAPY: YES / NO

OTHERS:

Nil.

## SOCIAL ASPECTS

OCCUPATION: ..housewife (a present.....

TYPE OF ACCOMMODATION: .....

TYPE OF HEATING: .....

WARDEN: YES / NO

STAIRS: YES / NO

LIFT: YES / NO

LIVES ALONE (If no, with whom?): ...daughter.....

6yrs NU.

KEYS OF PROPERTY HELD BY:

Name: .....

Address: .....

.....

Relationship: none.....

D. daughter will be grandfather.

ARRANGEMENTS FOR PETS, CHILDREN OR OTHER DEPENDANTS (If applicable):

NAME OF COMMUNITY CARE MANAGER (If applicable): NA

TELEPHONE NUMBER:

SIGNATURE AND DATE OF NURSE ADMITTING PATIENT: [signature] SN TIME: 2000.

NAMED NURSE: ASSOCIATE NURSES:

DATE AND TIME IDENTIFIED:

# PATIENT NURSING ASSESSMENT

NUTRITION: No special diet. Usually good appetite

COMMUNICATION / EYE SIGHT / HEARING / PAIN: Communicates needs effectively.

DRESSING ABILITY:

PERSONAL HYGIENE: Independent.

MOBILITY:

ELIMINATION (Bowel): continent regular

ELIMINATION (Bladder): Continent Regular

EMOTIONAL ASPECTS: Copes maintain independantly.

SLEEP PATTERN: # Normally sleeps well.

BREATHING: Smokes 8-10 per day. ~~Has~~ has Asthmatic. Takes salbutamol inhalers

PRESSURE AREA ASSESSMENT / SKIN CONDITION (Waterlow Score on Admission):

Intact.

HAS A WATERLOW ASSESSMENT CHART BEEN COMMENCED? YES / NO

IF NO, STATE WHY:

SIGNATURE OF NURSE CARRYING OUT ASSESSMENT: [signature] SN

DATE: 22/10/01 TIME: 2000

## PATIENT / RELATIVE WARD ORIENTATION AND CARE PLANNING CHECKLIST
(ON ADMISSION ONLY)

WARD NO:

| DATE | | YES | NO | COMMENT | SIGNATURE |
|---|---|---|---|---|---|
| | Orientate patient to the ward environment eg, toilets | | | | |
| | Has patient been made aware as to who their Named and Associate Nurses are? | | | | |
| | Has patient been given the opportunity to be involved with the planning of their care? | | | | |
| | Has relative / carer been given information regarding the Named Nurse concept? | | | | |
| | Were relatives / carers given the opportunity to be involved in planning of patient's care? | | | | |

## (CHECKLIST FOR TRANSFERS ONLY)

WARD NO:

DATE AND TIME OF TRANSFER:

| | | | | | |
|---|---|---|---|---|---|
| | Was relative / carer informed prior to patient transfer? | | | | |
| | Orientate patient to ward environment eg, toilets | | | | |
| | Has patient been made aware as to who their Named and Associate Nurses are? | | | | |
| | Has patient and their relatives / carers been given Patient Information Leaflets? | | | | |
| | Has all documentation been checked for omissions? | | | | |
| | Does patient's identity band have correct details on it? | | | | |
| | Has patient's own medication been transferred and any relevant non-stock drugs? | | | | |
| | Has the condition of patient's pressure areas been checked and documented? | | | | |
| | Has a patient's Care Plan been adopted or commenced following transfer? | | | | |

## RE-ASSESSMENT, IF REQUIRED

## PATIENT DISCHARGE ARRANGEMENTS

| | ACTION | COMMENTS | DATE | SIGNATURE |
|---|---|---|---|---|
| 1 | PHARMACIST<br>(a) Explanation / teaching re-medication<br>(b) Medication explained to support person | | | |
| 2 | CARE MANAGERS | | | |
| 3 | OCCUPATIONAL THERAPIST INVOLVEMENT | | | |
| 4 | PHYSIOTHERAPY INVOLVEMENT | | | |
| 5 | DIETETIC INVOLVEMENT | | | |
| 6 | SPEECH THERAPIST INVOLVEMENT | | | |
| 7 | COMMUNITY NURSING SERVICES<br>(a) Liaison Nurse contacted<br>(b) Community Nurse referral completed | | | |

## PATIENT DISCHARGE PREPARATION ARRANGEMENTS

| | ACTION | COMMENTS | DATE | SIGNATURE |
|---|---|---|---|---|
| 1 | Date and time of discharge arranged / discussed with relatives | | | |
| 2 | TRANSPORT<br>Own transport: YES / NO<br>Ambulance required: YES / NO<br>Ambulance arranged: YES / NO | | | |
| 3 | Does patient have adequate clothing for discharge? | | | |
| 4 | MEDICATION<br>(a) Medication explained to patient<br>(b) Explained to Support Person<br>(c) Patient own medication returned if applicable | | | |
| 5 | PATIENT PROPERTY<br>(a) Valuables<br>(b) Personal clothing<br>(c) Laundry | | | |
| 6 | G.P. INFORMED OF DISCHARGE | | | |
| 7 | FOLLOW-UP ARRANGEMENT<br>State: | | | |

SIGNATURE OF PATIENT: .....

SIGNATURE OF NURSE DISCHARGING PATIENT: .....

DATE: ..... TIME: .....

## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053 **Consultant:** Mr G Griffiths
**Patient Name:** STANDISH, David Vascular OUT-patients
**Investigation :** Segmental Pressures Ward 12
**Date of study :** 11/08/2011 Ninewells Hospital

**Referral details:** Routine surveillance- 5/12 post right CFA endarterectomy and vein patch and right SFA angioplasty

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 134 | 128 |
| Posterior Tibial | 140 | 90 |
| Dorsalis Pedis | 128 | 82 |
| Ankle/Brachial Pressure Index | 1.04 | 0.67 |

| Post-Exercise Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 150 | |
| Ankle | 92 | 52 |
| Ankle/Brachial Pressure Index | 0.61 | 0.34 |

**Exercise Test**
Treadmill speed: 4 Kph Inclination: 10.0 %
Treadmill time: 01:00

**Report:** Right groin swelling still evident. Patient describing left leg claudication.
Follow up appointment to be made for February 2012

MMcC / SMc

**Previous results:**

| Date | Right Ankle | Left Ankle | Right ABPI | Left ABPI |
|---|---|---|---|---|
| 24/06/2011 | 112 | 70 | 0.86 | 0.61 |
| 10/05/2011 | 120 | 70 | 0.95 | 0.55 |
| 09/03/2011 | 136 | 90 | 1.17 | 0.77 |
| 18/05/2010 | 70 | 64 | 0.56 | 0.51 |

**end of report**



## East of Scotland Vascular Network (NHS Tayside)
## Vascular Laboratory (Ext: 33869)

**CHI No.:** 050370/0053 **Consultant:** Mr G Griffiths
**Patient Name:** STANDISH, David Vascular OUT-patients
**Investigation :** Surveillance Scan Ward 12
**Date of study :** 11/08/2011 Ninewells Hospital

**Referral details:** Routine surveillance- 5/12 post right CFA endarterectomy and vein patch and right SFA angioplasty

**Report:** The right CFA is widley patent with triphasic flow demonstrated.
Patient continues to c/o groin swelling, no obvious abnormalitiy detected.

DM

**end of report**

NW
Hospital/Clinic

**IMMEDIATE OUT-PATIENT COMMUNICATION**

VRH MED
Clinic

Ward/Clinic/
Hosp. ..... Con

D D M M Y Y
C.H.I. No

Surname .....
First Name ..... M. State
Address ..... Sex
.....

G.P. & Address (G.P. Requests only)

USE BLOCK LETTERS OR PATIENT LABEL

Fold Back

Date 10/9/15

Dear Doctor,

The above patient attended my clinic today, please accept this as the only / interim* communication in respect of this visit.

Provisional/Diagnosis is PAD

Comment/Recommendations .....
Peripheral hypercholesterolaemia - please start PRAVASTATIN 5mg od
(Maternal folate level doesn't obviate this treatment)
Dyspepsia - please prescribe OMEPRAZOLE 20 mg od (review
in 4 weeks and add PANTOPRAZOLE if needed)
Gently titrate AMLODIPINE 5mg od (to 10 mg od)
Pravastatin
Amlodipine

Next appointment (if any) 6 weeks/months

Fold Back

| MEDICINE TREATMENT RECOMMENDED NAME—State Date when Medicines should be stopped | DOSE | STOP DATE | Times of Administration (Mark ✓) 8 | 10 | 12 | 14 | 16 | 18 | 20 | 22 | 24 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |

Prescription given / Medicines supplied / Medicines not supplied *

Signed by JOHN SMITH for .....
Consultant

**Do not write below this line**

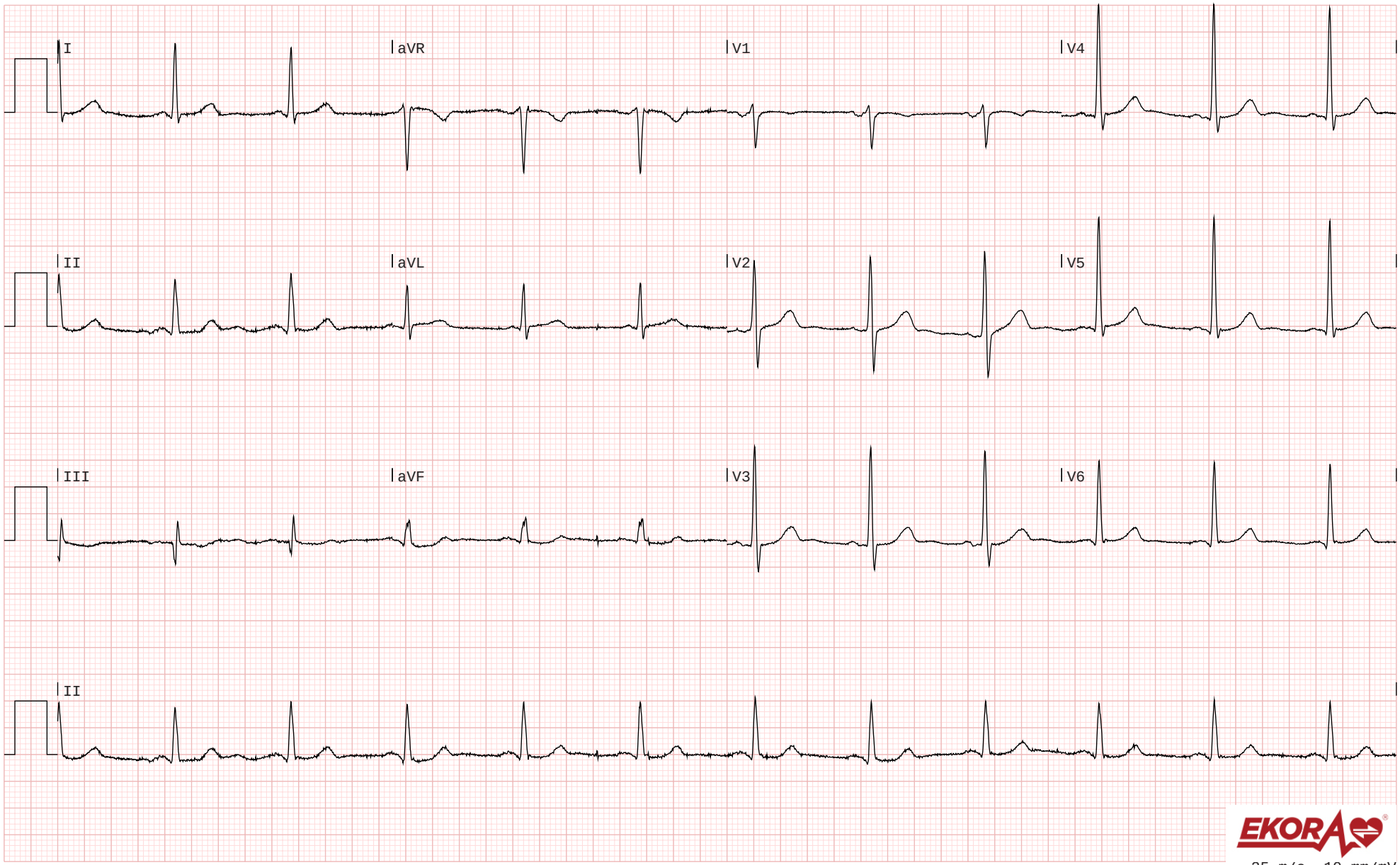
*Delete as appropriate

Dr. .....
.....
.....
.....

THB(MR)159 (2-part set General – 3 part set Psychiatry Dundee)

***** UNCONFIRMED AUTOMATED ANALYSIS *****

| | | | | | |
|---|---|---|---|---|---|
| **Name** | : Standish David | **Heart Rate** | : 69 bpm | **Summary** | : No Automated Analysis Available |
| **CHI** | : 0503700053 | **PR int** | : 134 ms | **Rhythm** | : No Automated Analysis Available |
| **Date** | : 04/07/2024 | **QRS dur** | : 90 ms | **Analysis** | : - |
| **Time** | : 10:07:22 | **QT/QTc** | : 398/417 ms | | |
| **Site** | : Coldside_Medical_Practice | **P-R-T axis** | : 30 21 23 | | |




This ECG was processed by ECGManager © 2017 Clinical IT Ltd.

Department of Cardiology
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Dr Vivien Smith
Clinical Psychologist
Clinical Neuropsychology Department
Level 6, South Block
Ninewells Hospital
Dundee
DD1 9SY

| | |
|---|---|
| Date | 11/09/2017 |
| Dictated | 07/09/2017 |
| Our Ref | TM/IR/ **0503700053** |
| Enquiries to | Mrs I Robertson |
| Extension | 32263 |
| Direct Line | 01382 632263 |
| Email | |

Dear Dr Smith

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, DD4 0UQ DOB: 05/03/1970**

Thank you for copying me into your letter of the 4th of September 2017. I would like to clarify some of the points in your text.

The patient had to be defibrillated whilst he was having a heart attack. This is a not uncommon complication and merely indicates the seriousness of having a heart attack rather than any long-term problem.

Mr Standish was discharged from our Cardiac Rehab Service as he was doing well.

He awaits an appointment with the Cardiovascular Risk Management Team, which is not part of the Cardiology Department. Cardiovascular risk management is regarding his cholesterol, which is not particularly high. I wrote to Dr Jacob George and received a reply in February 2017, which the General Practitioner will also have received, stating that the patient was not suitable for consideration of Alirocumab. Dr George did state that he would arrange for the patient to be seen in the Cardiovascular Risk Clinic (Lipid Clinic) and it is this clinic Mr Standish is awaiting an appointment, not Cardiology.

Yours sincerely

Authorised on 14/09/2017 10:11:22 by Cardio Tom Martin.
**Dr Thomas Martin**
**Consultant Cardiologist**
(P) Dr Jacob George, Clinical Pharmacology, Ward 4 Corridor, Ninewells Hospital, Dundee, DD1 9SY
(P) David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ
(D) Dr Fiona Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

Cardiac Rehabilitation
Cardiology
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Dr F Bullions
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 28/02/2017 |
| Clinic Date | 20/02/2017 |
| Your Ref | |
| Our Ref | HM/SH/ **0503700053** |
| Enquiries to | Mrs Sharon Hepburn |
| Extension | |
| Direct Line | 01738 473326 |
| Email | |

Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

This patient attended the nurse led cardiac clinic on 20/02/2017.

Consultant Cardiologist: Dr T Martin

Diagnosis: Non ST Elevation MI on 16/11/2016.

**Investigations and Results:**

- Echocardiogram
  Demonstrated normal LV size and function. Normal RV size and function. Mildly dilated LA. Normal RA size.
- Inpatient Coronary Angiogram/Intervention
  Demonstrated 75-94% stenosis in the proximal right coronary artery. >95% stenosis in the mid right coronary artery. The team proceeded to angioplasty with the insertion of a drug eluting stent to the mid right coronary artery and a drug eluting stent to the right ostial.

**Cardiac symptoms:**
Mr Standish reports some left sided chest discomfort, left sub-axillary discomfort, and intermittent localised discomfort in the antecubital fossa area. On closer questioning this did not sound typically cardiac in nature as Mr Standish informs me that these areas were painful to touch and affected by movement. He advises me that this discomfort has become less problematic over the last few weeks however I noted today that Mr Standish is using a stick to assist his walking. On further discussion he informs me that this stick belongs to a relative. He has therefore not been assessed regarding whether the stick is appropriate for him and as the stick has not been measured specifically for him it may be at the wrong height. As Mr Standish is using this stick in his left hand I was concerned that this may be contributing to the discomfort he is feeling. I will liaise with my cardiac rehabilitation Physiotherapist colleagues regarding getting Mr Standish properly assessed and he has agreed to this. He reports no obvious anginal sounding symptoms and has not used his GTN spray. He reports no palpitations, no ankle swelling and no undue breathlessness.

**Continued/**
**Continued/2**

**RE: David Standish 0503700053**

**Progress since MI:**
Mr Standish's progress is somewhat limited due to his PVD however he is managing his activities of living and is trying to undertake the home exercise DVD he was prescribed by the cardiac rehabilitation Physiotherapist.

**Relevant Modifiable CHD Risk Factors:**

| | | | |
|---|---|---|---|
| Diabetes | Random glucose 5.7mmol/L on admission to hospital | | |
| Smoking | Mr Standish has reduced his smoking to approximately 6 cigarettes per day | | |
| Blood Pressure | 148/87mmHg | Pulse | 57bpm and regular |
| Weight | 95kgs | BMI | 31 |
| Cholesterol | Admission cholesterol 6.64mmol/L | | |

| **Current Medication/Dose:** | **Current Dose** | **Comments** |
|---|---|---|
| Aspirin | 75mg once daily | |
| Bisoprolol | 2.5mg once daily | **Reduction to be considered** |
| GTN spray | 2 puffs as required | |
| Ticagrelor | 90mg twice daily | **For six months post angioplasty** |
| Ramipril | 2.5mg once daily | **Up titration to be considered** |
| Folic acid | 5mg once daily | |
| Lansoprazole | 60mg once daily | |
| Salbutamol inhaler | As required | |

***The author of this letter is not a non medical prescriber, however recommendations or changes to medications have been undertaken using an agreed protocol or in consultation with medical staff.***

**Comments/Recommendations:**
I would appreciate if you could arrange for Mr Standish to have bloods taken to recheck his renal function. If this is satisfactory and his blood pressure is maintained we would recommend up titration of his Ramipril towards the target dose of 10mg as tolerated. Mr Standish informed me today that he feels his intermittent claudication has been worse since being commenced on Bisoprolol 2.5mg and in an effort to manage this he has been removing a portion of the tablet each day and feels things have improved. I informed him that this is not advisable and following discussion with his Consultant Cardiologist Dr T Martin we have agreed to reduce his dose to 1.25mg and monitor the effect of this.

Given his progress and lack of symptoms there have been no formal plans to follow Mr Standish up however Dr Martin would be happy to review him at any time in the future should you feel it necessary. I believe Mr Standish is awaiting review at the Cardiovascular Risk Clinic and an appointment for that will be sent in due course.

Yours sincerely

**Helen Miller**
**Cardiac Rehab Specialist Nurse**

**Dr T Martin**
**Consultant Cardiologist**

Department of Cardiology
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Cardiovascular Risk Clinic
Wards 3/4 Corridor
Level 7
Ninewells Hospital
Dundee
DD1 9SY

| | |
|---|---|
| Date | 16/01/2017 |
| Dictated | 12/01/2017 |
| Our Ref | TM/IR/ **0503700053** |
| Enquiries to | Mrs I Robertson |
| Extension | 32263 |
| Direct Line | 01382 632263 |
| Email | |

Dear Colleagues

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I would be grateful if this patient could be seen at your clinic with a view to consideration of Alirocumab.

He was admitted under Cardiology in November 2016 with a non-ST elevation myocardial infarction and had percutaneous coronary intervention to the right coronary artery. He has a background of peripheral vascular disease. His total cholesterol was 6.64 mmol/L.

The patient is intolerant of statins and his peripheral vascular disease is that he had previous right common femoral artery end-arterectomy with vein patch and a right superficial femoral artery angioplasty.

I wonder if you would be able to see this patient for consideration of alternative therapies to statins, given his significant atherosclerosis.

Yours sincerely

Authorised on 17/01/2017 07:17:30 by Cardio Tom Martin.

**Dr Thomas Martin**
**Consultant Cardiologist**

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

This letter replaces all previous discharge letters that have been received relating to this patient's episode of care.

NHS Tayside

Ninewells Hospital, Dundee
Discharging Ward: 1 (Cardiology)

**FINAL DISCHARGE LETTER**

Dr. FIONA BULLIONS
COLDSIDE MEDICAL PRACTICE
129 STRATHMARTINE ROAD
DUNDEE
DD3 8DB

Date: 23/11/2016
Letter Version: 2.0
Enquiries to:
Telephone:
Email:

## DAVID ANDREW STANDISH, CHI: 0503700053, DOB: 05/03/1970, 20 CANNING PLACE, DUNDEE, DD3 7RT

| Read Code | Diagnosis | Date | Laterality | Principal / Other |
|---|---|---|---|---|
| | **NSTEMI** | | | **Principal** |

Date of Admission: **16/11/2016**
Mode of Admission: **Emergency**
Source of Admission: **A & E**
Admission Reason: **Chest Pain**
Admission Ward: **21**
Admission Speciality: **Cardiology**
Discharge Type: **Discharge from NHS inpatient/day case care**
Date Of Discharge: **23/11/2016**
Discharge Destination: **Private Residence - lives alone**

| Read Code | Operations, Procedures, Investigations and Complications | Date | Laterality | Principal / Other |
|---|---|---|---|---|
| | **Angio + PCI** | | | **Principal** |
| | **TTE** | | | **Principal** |

**Operations, Procedures, Investigations and Complications Comments**

Angio
NSTEMI.Peripheral vascular disease
For PCI to RCA mid and proximal lesions.
JR4 guide. Heparin. BMW.
Predilated lesions with 3.0 balloon.
Stented mid vessel lesion with 3.0x18 Biomatrix DES. Stented proximal lesion to ostium with 3.5x14 Biomatrix DES. Postdilated with 3.0NC and 3.5NC respectively.
Good final result.
Plan:
ASPIRIN LIFELONG. TICAGRELOR FOR 6 MONTHS.

TTE
Normal LV size and systolic function.
Normal RV size and systolic function
The LA is mildly dilated. Normal RA size.
No significant valvular pathologies.
No significant pericardial effusion.

**Medications**

| Drug | Dose | Frequency | Duration | Quantity | Supply | Additional Information |
|---|---|---|---|---|---|---|
| Folic acid 5mg tablets 56 tablet | 1 TABLET ONCE A DAY | | | | Own At Home | CHOLESTEROL INJECTION TO BE ADDED, PLEASE DISPENSE OTHER ITEMS AND SEND TO WARD, THANK YOU. RB |
| Lansoprazole 30mg gastro-resistant capsules 112 capsule | 1 CAPSULE TWICE DAILY | | | | Own At Home | |
| Salbutamol 100micrograms/dose inhaler CFC free 200 dose | 1 TO 2 PUFFS UP TO FOUR TIMES DAILY AS REQUIRED | | | | Hospital Pharmacy | |
| Glyceryl trinitrate 400micrograms/dose sublingual spray | 2 doses | As required - chest pain | | | TTO | |
| Bisoprolol 2.5mg tablets | 2.5mg | In the morning | Long term | | TTO | |
| Nicotine 14mg/24hours transdermal patches | 14mg | Not Applicable - 24hourly patch | | | Hospital Pharmacy | |
| Ticagrelor 90mg tablets | 90mg | Morning and Night | 6 months | | TTO | |
| Aspirin 75mg tablets | 75mg | In the morning | Long term | | TTO | |
| Ramipril 2.5mg tablets | 2.5mg | In the morning | Long term | | TTO | |

Medicines checked by pharmacist: Miss Rachel Byars, 23/11/2016 14:47:20

**Medication Comments / Other Information**

Please titrate ACE-I and beta blocker up to 10mg or maximum tolerated dose and review renal function and blood pressure.

RB: 14:40 To hear back about how we source alirocumab. it can be given under supervision of the cardiovascular risk clinic. Unable to reach Gordon D Thomson. Trying to contact senior pharmacists. Dispensary please dispense the two meds needed.

**Care Arrangements**

None

**Follow Up Details**

| Follow Up | Date | Date To Be Arranged |
|---|---|---|
| Cardiac rehab | | |

**Communication To Primary Care**

Dear Dr,

This gentleman came into hospital with chest pain and was worked up for an ACS. He returned positive troponins and no ST elevation on ECG and therefore was diagnosed as an NSTEMI.
He went to the cath lab and unfortunately went into VF and received 2 successful shocks and made a full recovery. Mr Standish has now received stents to the causative lesions and is otherwise well for discharge. We have started him on dual antiplateltes for 6 months and aspirin lifelong as well as cardioprotective drugs if you could optimise these as appropriate.

He is also due to be started on Alirocumab for cholesterol as he is intolerant to other cholesterol reducing drugs. This is to be arranged through the cardiovascular risk clinic.

If you have any questions please do not hesiatate to contact the ward,
Many thanks,



**Consultant Comments**

RCA stented with drug eluting stents. VF arrest as a procedural complication - no action required.

Dr Thomas Martin (Position: Doctor. Pager: _____)

**Date/Time Signed Off: 23/11/2016 15:18:36**

**Discharge Consultant: THOMAS NICHOLAS MARTIN**

CC: cardiac rehab

**Letter History**

| Version | Letter Type | Date | Amended Sections |
|---|---|---|---|
| 1.0 | Immediate | 23/11/2016 | N/A |
| 2.0 | Final | 23/11/2016 | Consultant's Comments |

**Appendix**

No items have been appended to this letter.

This letter replaces all previous discharge letters that have been received relating to this patient's episode of care.

NHS Tayside

Ninewells Hospital, Dundee
Discharging Ward: 1 (Cardiology)

**IMMEDIATE DISCHARGE LETTER**

Dr. FIONA BULLIONS
COLDSIDE MEDICAL PRACTICE
129 STRATHMARTINE ROAD
DUNDEE
DD3 8DB

Date: 23/11/2016
Letter Version: 1.0
Enquiries to:
Telephone:
Email:

## DAVID ANDREW STANDISH, CHI: 0503700053, DOB: 05/03/1970, 20 CANNING PLACE, DUNDEE, DD3 7RT

| Read Code | Diagnosis | Date | Laterality | Principal / Other |
|---|---|---|---|---|
| | **NSTEMI** | | | **Principal** |

Date of Admission: **16/11/2016**
Mode of Admission: **Emergency**
Source of Admission: **A & E**
Admission Reason: **Chest Pain**
Admission Ward: **21**
Admission Speciality: **Cardiology**
Discharge Type: **Discharge from NHS inpatient/day case care**
Date Of Discharge: **23/11/2016**
Discharge Destination: **Private Residence - lives alone**

| Read Code | Operations, Procedures, Investigations and Complications | Date | Laterality | Principal / Other |
|---|---|---|---|---|
| | **Angio + PCI** | | | **Principal** |
| | **TTE** | | | **Principal** |

**Operations, Procedures, Investigations and Complications Comments**

Angio
NSTEMI.Peripheral vascular disease
For PCI to RCA mid and proximal lesions.
JR4 guide. Heparin. BMW.
Predilated lesions with 3.0 balloon.
Stented mid vessel lesion with 3.0x18 Biomatrix DES. Stented proximal lesion to ostium with 3.5x14 Biomatrix DES. Postdilated with 3.0NC and 3.5NC respectively.
Good final result.
Plan:
ASPIRIN LIFELONG. TICAGRELOR FOR 6 MONTHS.

TTE
Normal LV size and systolic function.
Normal RV size and systolic function
The LA is mildly dilated. Normal RA size.
No significant valvular pathologies.
No significant pericardial effusion.

**Medications**

| Drug | Dose | Frequency | Duration | Quantity | Supply | Additional Information |
|---|---|---|---|---|---|---|
| Folic acid 5mg tablets 56 tablet | 1 TABLET ONCE A DAY | | | | Own At Home | CHOLESTEROL INJECTION TO BE ADDED, PLEASE DISPENSE OTHER ITEMS AND SEND TO WARD, THANK YOU. RB |
| Lansoprazole 30mg gastro-resistant capsules 112 capsule | 1 CAPSULE TWICE DAILY | | | | Own At Home | |
| Salbutamol 100micrograms/dose inhaler CFC free 200 dose | 1 TO 2 PUFFS UP TO FOUR TIMES DAILY AS REQUIRED | | | | Hospital Pharmacy | |
| Glyceryl trinitrate 400micrograms/dose sublingual spray | 2 doses | As required - chest pain | | | TTO | |
| Bisoprolol 2.5mg tablets | 2.5mg | In the morning | Long term | | TTO | |
| Nicotine 14mg/24hours transdermal patches | 14mg | Not Applicable - 24hourly patch | | | Hospital Pharmacy | |
| Ticagrelor 90mg tablets | 90mg | Morning and Night | 6 months | | TTO | |
| Aspirin 75mg tablets | 75mg | In the morning | Long term | | TTO | |
| Ramipril 2.5mg tablets | 2.5mg | In the morning | Long term | | TTO | |

Medicines checked by pharmacist: Miss Rachel Byars, 23/11/2016 14:47:20

**Medication Comments / Other Information**

Please titrate ACE-I and beta blocker up to 10mg or maximum tolerated dose and review renal function and blood pressure.

RB: 14:40 To hear back about how we source alirocumab. it can be given under supervision of the cardiovascular risk clinic. Unable to reach Gordon D Thomson. Trying to contact senior pharmacists. Dispensary please dispense the two meds needed.

**Care Arrangements**

None

**Follow Up Details**

| Follow Up | Date | Date To Be Arranged |
|---|---|---|
| Cardiac rehab | | |

**Communication To Primary Care**

Dear Dr,

This gentleman came into hospital with chest pain and was worked up for an ACS. He returned positive troponins and no ST elevation on ECG and therefore was diagnosed as an NSTEMI.
He went to the cath lab and unfortunately went into VF and received 2 successful shocks and made a full recovery. Mr Standish has now received stents to the causative lesions and is otherwise well for discharge. We have started him on dual antiplateltes for 6 months and aspirin lifelong as well as cardioprotective drugs if you could optimise these as appropriate.

He is also due to be started on Alirocumab for cholesterol as he is intolerant to other cholesterol reducing drugs. This is to be arranged through the cardiovascular risk clinic.

If you have any questions please do not hesiatate to contact the ward,
Many thanks,

Dr John Prentice (Position: Doctor. Pager: _____)

**Date/Time Signed Off: 23/11/2016 14:27:55**

**Discharge Consultant: THOMAS NICHOLAS MARTIN**

**Appendix**

No items have been appended to this letter.

# Department of Cardiology

CORONARY INTERVENTION RECORD

0503700053
307785620
22/11/2016

| | | | |
|---|---|---|---|
| **Name:** | David Standish | **Date:** | 22 November 2016 |
| **Hosp.No.:** | 0503700053 | **Consultant:** | Dr Neil Anglim |
| **CHI No.:** | | **Operators:** | Dr Neil Anglim |
| **Address:** | | **Procedure:** | Multi-Lesion Coronary Intervention<br>K63.4; K49.2; |

Urgent case. Catheterisation via the Right Radial artery, under local anaesthetic.
Artery closure method: Pressure - Helix.

None (in lab)

❍ **Mid RCA**

**Treatment:** Preliminary: Sprinter NC 15 x 3mm Balloon to 16atm.
Primary: BMX 3 x 18mm DE stent to 16atm.
Further: Trek NC 15 x 3mm Balloon to 18atm.

**Outcome:** Complete success:- stenosis from 99% to 0%

❍ **Right Ostial**

Lesion >10 mm long. Ostial location.

**Treatment:** Preliminary: Sprinter NC 15 x 3mm Balloon to 14atm.
Primary: BMX 3.5 x 14mm DE stent to 14atm.
Further: Trek NC 12 x 3.5mm Balloon to 18atm.

**Outcome:** Complete success:- stenosis from 80% to 0%

**Overall Outcome:** Complete success

NSTEMI.Peripheral vascular disease

For PCI to RCA mid and proximal lesions.
JR4 guide. Heparin. BMW.
Predilated lesions with 3.0 balloon.
Stented mid vessel lesion with 3.0x18 Biomatrix DES. Stented proximal lesion to ostium with 3.5x14 Biomatrix DES. Postdilated with 3.0NC and 3.5NC respectively.
Good final result.

Plan:
ASPIRIN LIFELONG. TICAGRELOR FOR 6 MONTHS.

Dr N Anglim
Consultant

**signed:**



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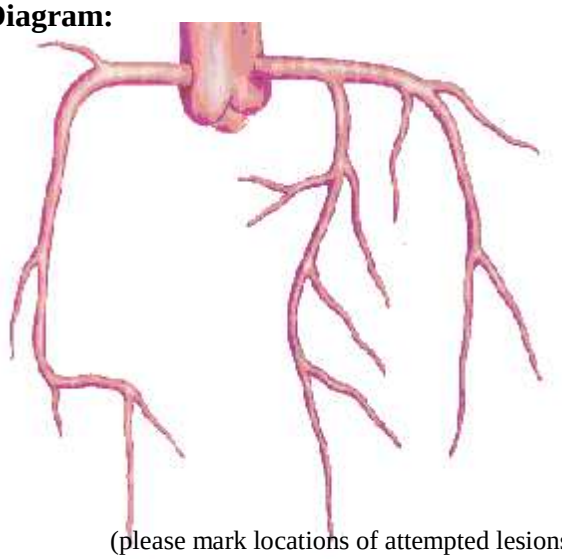
# Department of Cardiology

CORONARY INTERVENTION RECORD

**0503700053 David Standish 22 November 2016**

## Clinical Presentation / Risk Factors:

## Diagram:



(please mark locations of attempted lesions)



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# Department of Cardiology

## CARDIAC CATHETERISATION DIAGNOSTIC REPORT

| | | | |
|---|---|---|---|
| **Name:** | David Standish | **Date:** | 22 November 2016 |
| **Hosp.No.:** | 0503700053 | **Consultant:** | Dr Neil Anglim |
| **CHI No.:** | 0503700053 | **Operators:** | Dr Neil Anglim |
| **Address:** | | **Procedures:** | Coronary Angiography - Native vessels<br>K63.4; K49.2; |

Urgent case. Catheterisation via the Right Radial artery, under local anaesthetic.
Artery closure method: Pressure - Helix.

**Catheters:**

None (in lab)

**LV angiogram:**

**Coronary Arteries:**

- 75-94% stenosis in the proximal RCA.
- >95% stenosis in the mid RCA.

NSTEMI.Peripheral vascular disease

Coronary angiogram:
JL3.5 engaged RCA - patient went into VF, sucessfully cardioverted to SR. Once LCA engaged, again, patient went into VF - sucessfully cardioverted.

Right dominant.
LMS, LAD and Cx normal.
RCA had severe Proximal lesion and severe med vessel lesion.

For PCI to RCA mid and proximal lesions

**Recommendation:** Definite PTCA **signed:**



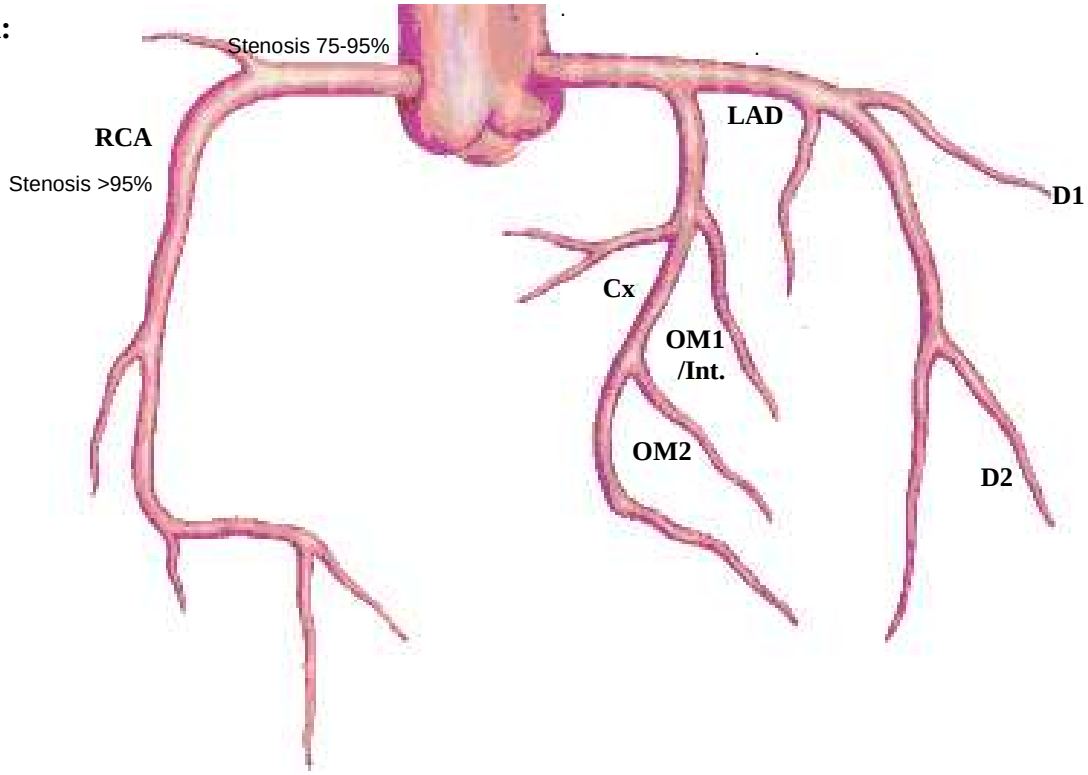
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# Department of Cardiology

## CARDIAC CATHETERISATION DIAGNOSTIC REPORT

**0503700053 David Standish 22 November 2016**

**Diagram:**






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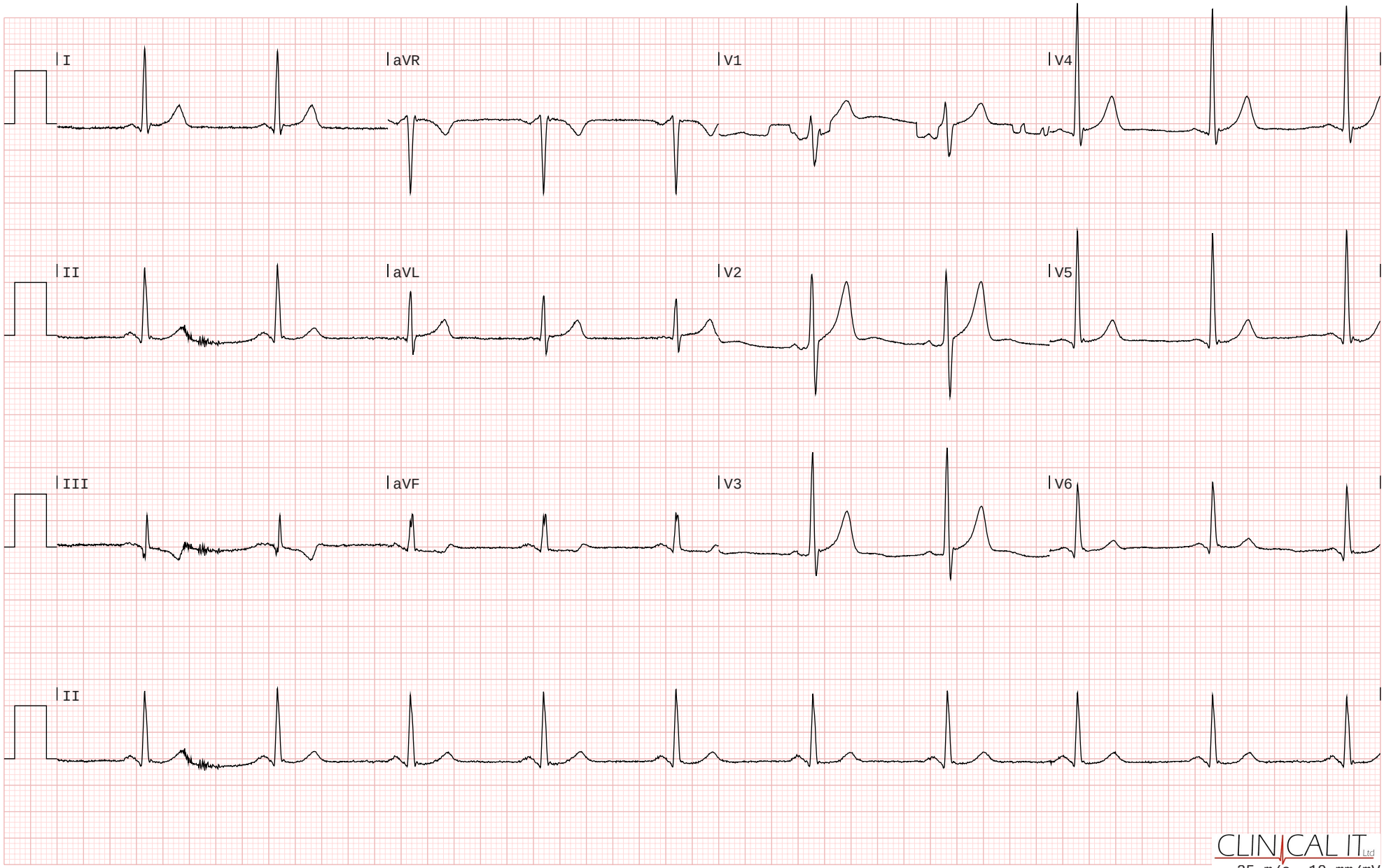
*** UNCONFIRMED AUTOMATED ANALYSIS ***

NHS Tayside

**Name** : Standish David
**CHI** : 0503700053
**Date** : 19/11/2016
**Time** : 08:22:29
**Site** : Ninewells_Cardiology

**Heart Rate** : 59 bpm
**PR int** : 132 ms
**QRS dur** : 90 ms
**QT/QTc** : 402/401 ms
**P-R-T axis** : 47 23 -5

**Summary** : ** normal ECG **
**Rhythm** : Sinus rhythm
**Analysis** : -




CLINICAL IT Ltd
25 m/s, 10 mm/mV

This ECG was processed by ECGManager © 2015 Clinical IT Ltd.

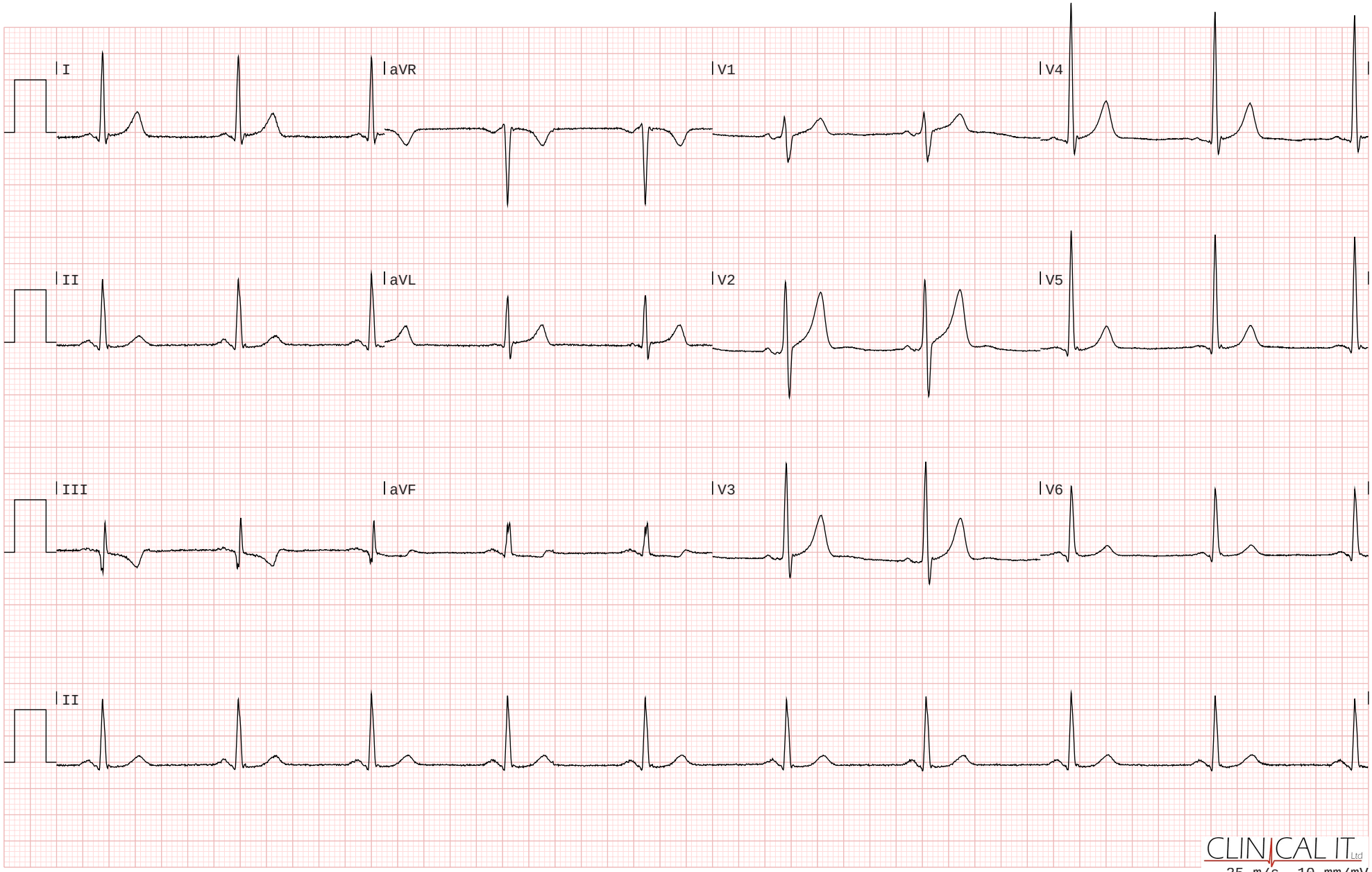
*** UNCONFIRMED AUTOMATED ANALYSIS ***

**Name** : Standish David
**CHI** : 0503700053
**Date** : 19/11/2016
**Time** : 08:23:14
**Site** : Ninewells_Cardiology

**Heart Rate** : 56 bpm
**PR int** : 136 ms
**QRS dur** : 88 ms
**QT/QTc** : 410/402 ms
**P-R-T axis** : 45 23 -5

**Summary** : No Automated Analysis Available
**Rhythm** : No Automated Analysis Available
**Analysis** : -

NHS Tayside




CLINICAL IT Ltd
25 m/s, 10 mm/mV

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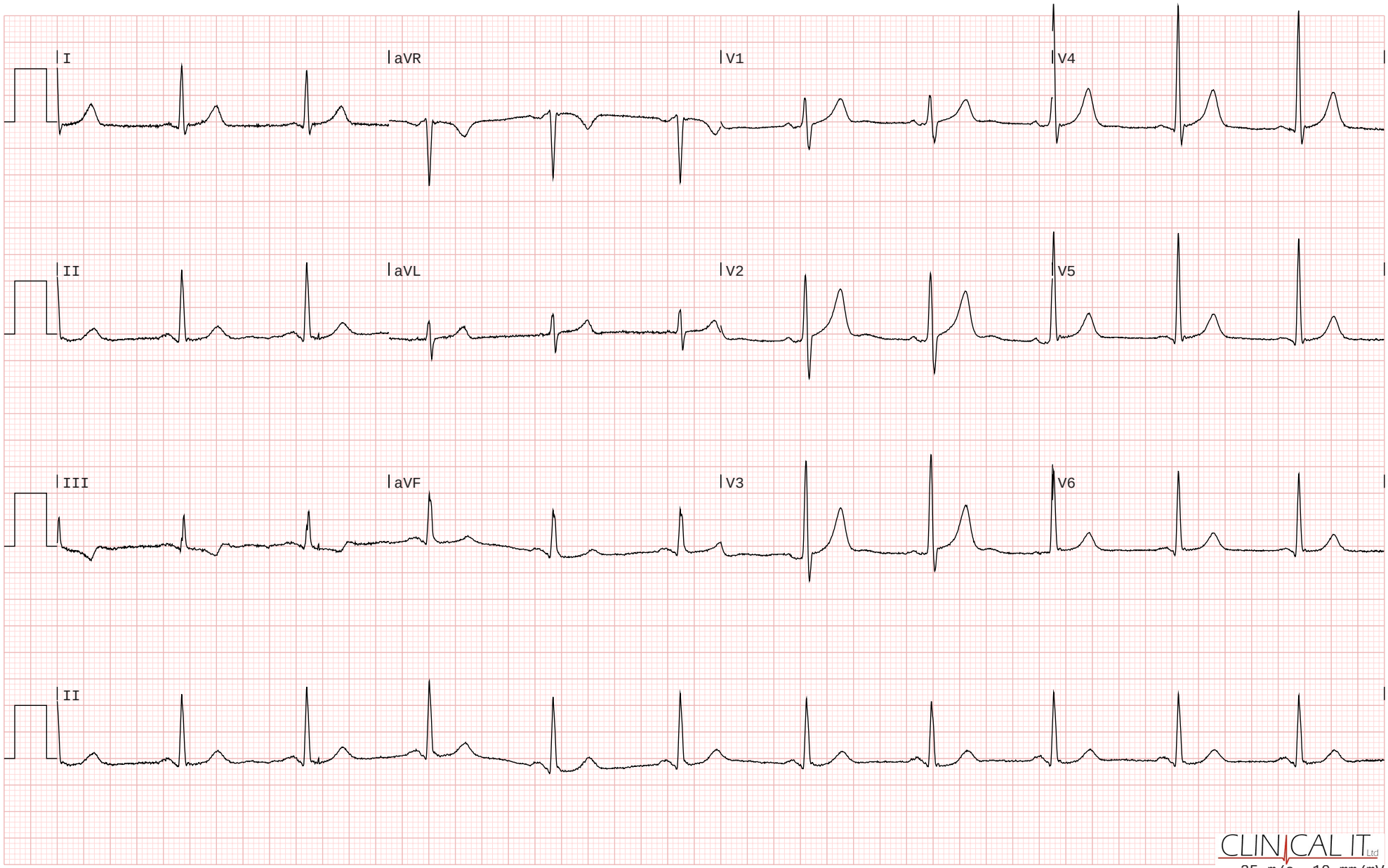
*** UNCONFIRMED AUTOMATED ANALYSIS ***

**Name** : Standish David
**CHI** : 0503700053
**Date** : 18/11/2016
**Time** : 08:20:06
**Site** : Ninewells_Cardiology

**Heart Rate** : 64 bpm
**PR int** : 128 ms
**QRS dur** : 88 ms
**QT/QTc** : 412/421 ms
**P-R-T axis** : 40 38 7

**Summary** : ** normal ECG **
**Rhythm** : Sinus rhythm
**Analysis** : -

NHS Tayside




CLINICAL IT Ltd
25 m/s, 10 mm/mV

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Version 2

**Ninewells Hospital**

# Echocardiography Report

NHS Tayside

| | | |
|---|---|---|
| **Name:** STANDISH, DAVID | **Study Date:** 17/11/2016 11:49 | |
| **MRN:** 0503700053 | **Patient Location:** NW ward 21 | **Patient Class:** Inpatient |
| **DOB:** 05/03/1970 (dd/MM/yyyy) | **Gender:** Male | |
| **Age:** 46 yrs | | |
| **Reason For Study:** LV function post MI | | |
| **Image Quality**: Adequate image quality. | | |
| **Performed By:** GMY | **Referring Physician:** DR SD HUTCHEON | |
| **Echo Machine:** IE33 4 | | |

## Aortic Valve
The aortic valve is normal in structure and function. No aortic stenosis. No aortic regurgitation.

## Mitral Valve
Mildly thickened leaflets, seen to open well. No mitral stenosis. Trace mitral regurgitation.

## Tricuspid Valve
Normal in structure and function. No tricuspid stenosis. Physiological tricuspid regurgitation.

## Pulmonary Valve
Normal in structure and function. No pulmonary stenosis. Physiological pulmonary regurgitation.

## Left Ventricle
Normal LV systolic function. Normal LV size. No LV hypertrophy.

## Regional Wall Motion Abnormalities
No obvious regional wall motion abnormality noted.

## Right Ventricle
Normal right heart size and function.

## Atria
The LA is mildly dilated. Normal RA size. The interatrial septum appears intact with no evidence of a defect.

## Great Vessels
Undilated aortic root.

## Pericardium / Pleural
No pericardial effusion.

## Inferior Vena Cava
Normal IVC with complete inspiratory collapse.

## ECG

Sinus Rhythm 74 BPM.

**CONCLUSION**

**Normal LV size and systolic function.**
**Normal RV size and systolic function**
**The LA is mildly dilated. Normal RA size.**
**No significant valvular pathologies.**
**No significant pericardial effusion.**

---

**LV - 2D and M Mode**

**LVIDd: 5.2 cm**
**LVIDs: 4 cm**
**IVSd: 1.1 cm**
**LVPWd: 0.9 cm**
**LVOT diam: 2.0 cm**

**RV - 2D and M Mode**

**TAPSE: 1.7 cm**

**Atrial Dimensions**

**LA dimension: 3.6 cm**
**LA 4ch area: 29 $cm^2$**
**RA area: 14.7 $cm^2$**

**AO - 2D and M Mode**

**Ao root diam: 3.5 cm**

**AV - 2D and M Mode**

**DVI: 0.96**

**AV - Doppler**

**Ao V2 max: 1.7 m/sec**
**Ao max PG: 12 mmHg**
**Ao mean PG: 6 mmHg**
**Ao V2 VTI: 32.8 cm**
**AVA(I,D): 2.8 $cm^2$**
**AVA(V,D): 2.9 $cm^2$**
**LV V1 max PG: 10.9 mmHg**
**LV V1 max: 1.6 m/sec**
**LV V1 VTI: 29.7 cm**

**MV - Doppler**

**MV E max vel: 0.8 m/sec**
**MV A max vel: 0.7 m/sec**
**MV E/A: 1.2**
**MV dec time: 180 msec**

**TV - Doppler**

**TR Max PG: mmHg**

**TDI Doppler**

**Med Peak E' Vel: 8 cm/sec**
**Med Peak S Vel: 9 cm/sec**
**E/E' tdi Med: 10.4**
**Lat Peak E' Vel: 11 cm/sec**
**Lat Peak S Vel: 12 cm/sec**
**E/E' tdi Lat: 8.0**

---

**Reported by:**

**Greg Mysak, Locum Cardiac Physiologist 17/11/2016 13:05**

**Reviewer:**

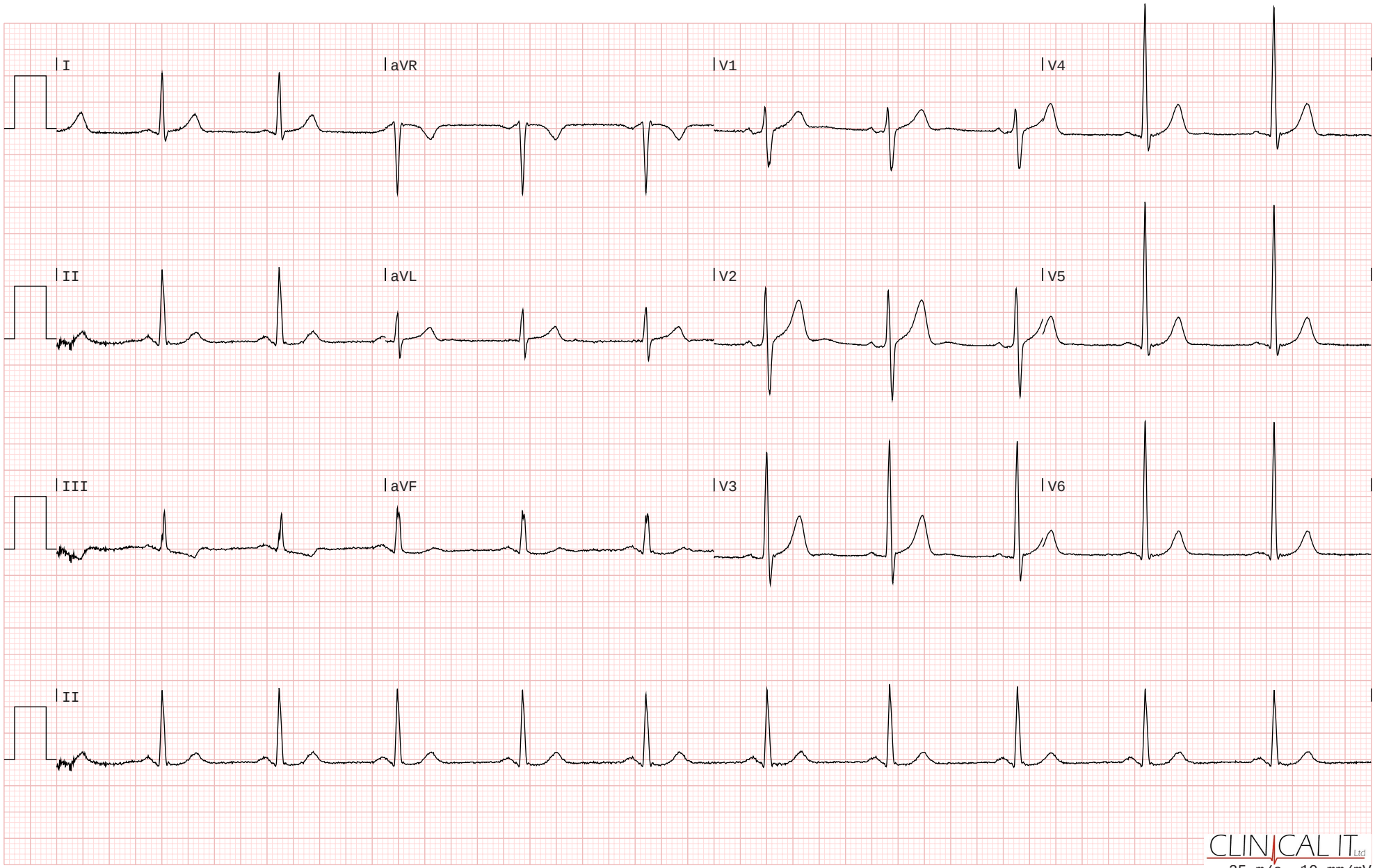
*** UNCONFIRMED AUTOMATED ANALYSIS ***

**Name** : Standish David
**CHI** : 0503700053
**Date** : 17/11/2016
**Time** : 08:14:56
**Site** : Ninewells_Cardiology

**Heart Rate** : 63 bpm
**PR int** : 134 ms
**QRS dur** : 92 ms
**QT/QTc** : 394/402 ms
**P-R-T axis** : 60 39 4

**Summary** : ** normal ECG **
**Rhythm** : Sinus rhythm
**Analysis** : -

NHS Tayside




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25 m/s, 10 mm/mV

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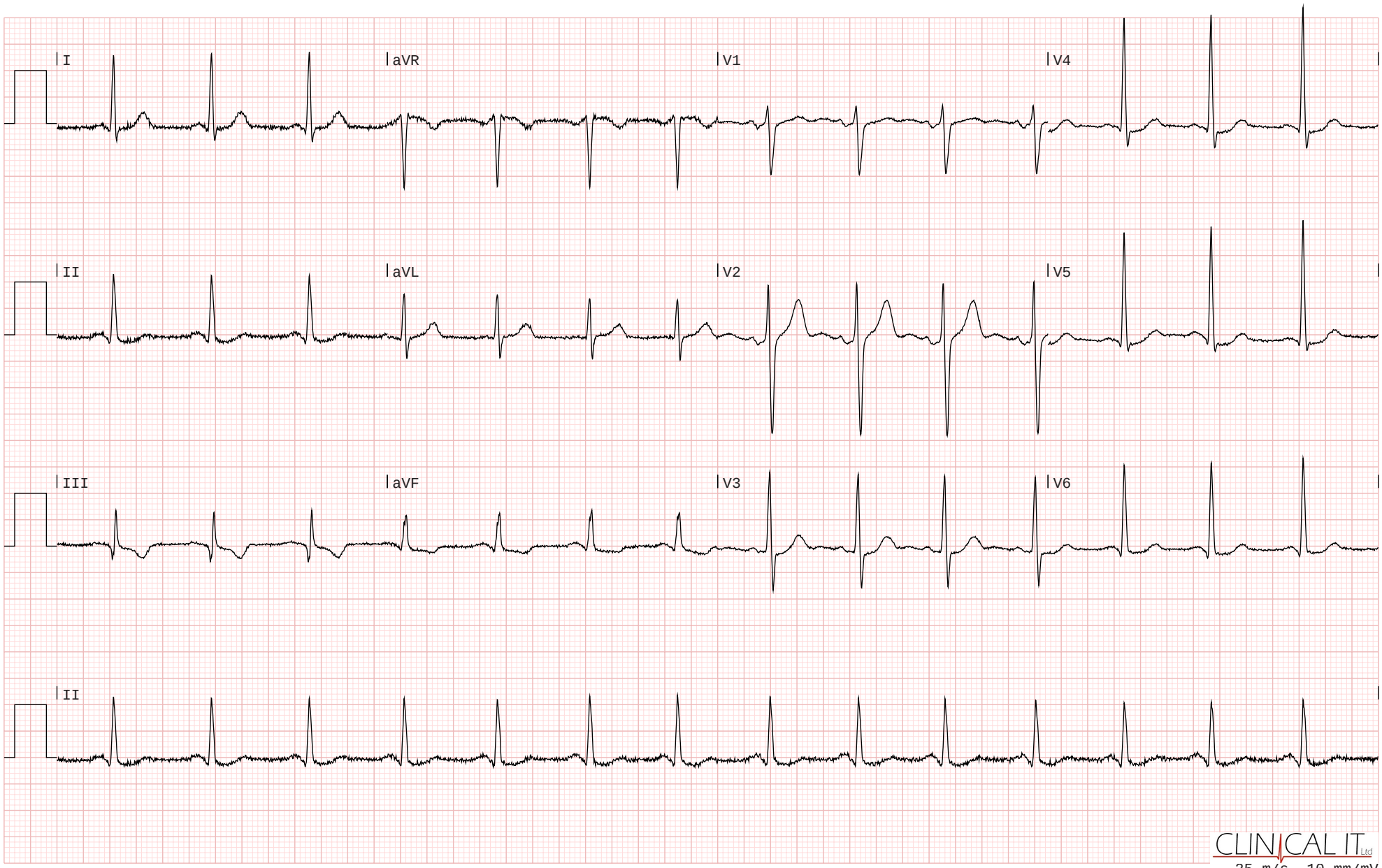
*** UNCONFIRMED AUTOMATED ANALYSIS ***

**Name** : Standish David
**CHI** : 0503700053
**Date** : 16/11/2016
**Time** : 19:23:09
**Site** : Ninewells_Ae_Resuscitation

**Heart Rate** : 86 bpm
**PR int** : 126 ms
**QRS dur** : 94 ms
**QT/QTc** : 352/396 ms
**P-R-T axis** : 43 25 -33

**Summary** : ** abnormal ECG **
**Rhythm** : Sinus rhythm
**Analysis** : -

NHS Tayside




CLINICAL IT Ltd

25 m/s, 10 mm/mV

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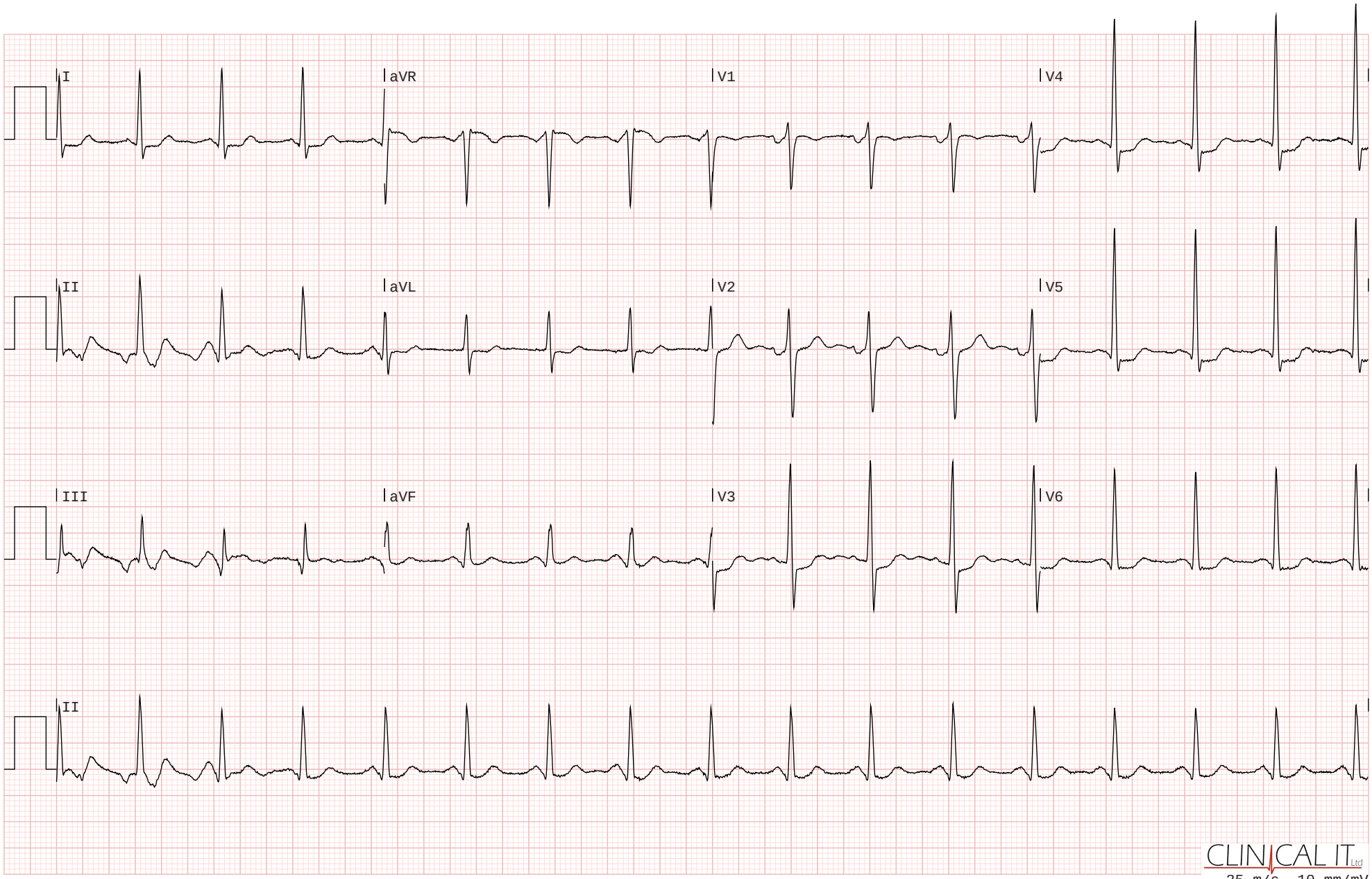
*** UNCONFIRMED AUTOMATED ANALYSIS ***

**Name** : Standish David
**CHI** : 0503700053
**Date** : 16/11/2016
**Time** : 18:36:34
**Site** : Ninewells_Ae_Resuscitation

**Heart Rate** : 97 bpm
**PR int** : 120 ms
**QRS dur** : 94 ms
**QT/QTc** : 334/388 ms
**P-R-T axis** : 56 31 27

**Summary** : ** abnormal ECG **
**Rhythm** : Sinus rhythm
**Analysis** : -

NHS Tayside




CLINICAL IT Ltd

25 m/s, 10 mm/mV

This ECG was processed by ECGManager © 2015 Clinical IT Ltd.

Test Date: 29/06/2001

Operator 1: MF + CD

NHS Tayside

Ninewells
Cardiology Department
Exercise Tolerance Test Report

Name: STANDISH, DAVID

CHI Number: 0503700053

Health Record ID:

Date of Birth: 05/03/1970

| | | | |
|---|---|---|---|
| Patient Type: | Outpatient | | |
| Hospital: | Imported Data | Clinic: | 1/2 OP |
| GP: | | Consultant: | Pringle, Dr TH |
| Practice Address: | | | |

| | | | |
|---|---|---|---|
| Test Indication: | Diagnosis of chest pain | | |
| Medication Comments: | | Test Type: | Full Bruce |
| Reported By: | Dr Y Fogarty | | |

## Results:

| | | | |
|---|---|---|---|
| Resting HR: | 49 | Resting BP: | 110 / 70 |
| Max HR: | 174 | Max BP: | 170 / 70 |
| Predicted Max HR: | 179 | % Pred Max HR Achieved: | 97 |
| Exercise Time: | 12 mins, 13 secs | METS: | 13 |

## Comments:

Resting ECG:

Exercise Capacity:

Reason for Stopping:

Response to Exercise:

Symptoms:

ST Segment Change:

Arrhythmia:

Other:

## Conclusion:

Resting ECG- sinus rhythm, normal axis. Average exercise time for age. Achieved target HR. No chest symptoms. No evidence of inducible ischaemia. NEGATIVE ETT.

Echo Number: 54370
Date Performed: 29/06/2001
Operator:
Machine: 514

NHS Tayside
Ninewells Hospital, Dundee
Cardiology Department
Echocardiography Report

Name: STANDISH, DAVID
CHI Number: 0503700053
Consultant: Pullar, Dr T
Ward/Clinic: 1/2 OP
Hospital: Ninewells Hospital
Requesting GP: MORGAN D DAVAGE

Reason For Request:

| | | | | |
|---|---|---|---|---|
| LVIDD | IVS | | LA | 3.76cm |
| LVIDS | LVPW | | RA | |
| FS | Ao | 3.17cm | RV | |
| EF | LVOT | | IVC | |

**Aortic Valve**
Normal
No stenosis
No regurgitation seen
Peak Gradient 6mmHg

**Mitral Valve**
Normal
No regurgitation seen
No stenosis
E/A 1

**Tricuspid Valve**
Normal
No regurgitation seen
No stenosis

**Pulmonary Valve**
Normal
No regurgitation seen
No stenosis

**Left Ventricle**
Normal diastolic size
Normal systolic function
Normal diastolic function

**Other**
Left atrium normal
Right atrium normal
Right ventricle normal

**CONCLUSION:** *Normal study.*

**Reported By:** Imported Data

Clinical Genetics
Surgical Directorate
Ninewells Hospital
Dundee
DD1 9SY

Telephone 01382 632035

www.nhstayside.scot.nhs.uk

**PRIVATE & CONFIDENTIAL**
David Standish
6 Dargarvel Gardens
Ormiston Crescent
Dundee
DD4 0UQ

| | |
|---|---|
| Date Typed: | 21/08/2018 |
| Date Dictated | 16/07/2018 |
| Clinic Date: | 13/07/2018 |
| Your Ref: | |
| Our Ref: | EG/jr/ **0503700053** |
| Pedigree No: | **10953** |
| Enquiries to: | Clinical Genetics |
| Extension: | 32035 |
| Direct Line: | 01382 632035 |
| Email: | Tay-UHB.clinicalgenetics@nhs.net |

Dear Mr Standish

It was lovely to meet you at the cholesterol clinic at Ninewells Hospital, Dundee on 13th July 2018. As discussed at clinic you have been identified as having a change in the ApoB gene for Familial Hypercholesterolaemia (FH). For your own information and should you or any members of your family be asked what the specific gene change is in order for them to be tested, we call it the **'heterozygous c.10580G>A: p.(Arg3527Gln) ApoB gene change'**. A copy of your laboratory report and this letter are filed in your medical records. I also gave you a copy of this at clinic for your information.

**Personal Information**
I started our appointment discussing your genetic test result. As I explained, this is helpful because it confirms the clinical diagnosis of FH and reinforces the need for you to maintain a healthy lifestyle and to continue with your cholesterol lowering treatment. As you are aware, there is strong evidence to support the effectiveness of these treatments in reducing your future risk of further heart and vascular disease. I was sorry to hear that you are having mobility problems at present, believed to be associated with the circulation in your legs. I gave you some further information about FH at clinic which included some useful links to further websites to include the British Heart Foundation and Heart UK.

You are currently under review at the cholesterol consultant clinic with regards to your cholesterol lipid-lowering therapy.

**Family History**
Your father had a heart attack in his 40s. Your mother had a stroke in her 60s. Your maternal grandfather had a heart attack in her 50s. You have limited contact with your extended family.

**Familial Hypercholesterolaemia**
I explained what FH is in detail. As you remember, I explained that if FH is appropriately treated with cholesterol lowering medication and a healthy lifestyle, the LDL 'bad' cholesterol and the risk of developing coronary heart disease (CHD) can be reduced. It is therefore important to be diagnosed and appropriately treated. In addition to this, informing other family members of their risk is also very important.

**FH Genes and their Inheritance**
We talked about the genes that are affected by FH and how these are inherited using your own

family tree and visual illustrations to demonstrate this. You will remember that we all have two copies of every gene, one of which we inherit from our mother and the other from our father. Someone affected with FH has one normal copy of the gene and one faulty copy. There is therefore a 50% chance or a 1 in 2 chance that they may pass on the faulty copy to any child that they may have. It is the same risk for each pregnancy.

**Cascade Screening**
We discussed, now we have found this gene change in you many members of your family will be eligible for testing. After discussion you requested your two daughters be offered screening for familial hypercholesterolaemia. Early identification of this condition and treatment significantly reduces their risk of developing cardiovascular disease. I have met with Savannah in clinic and should have her results shortly. Charlotte has been sent an appointment to be seen in clinic in due course.
With this letter I have included some information for any other relatives that wish to undergo screening. I explained that if they feel that they do not want to go ahead with genetic testing it is very important that they have their cholesterol levels measured. This, however, does not determine their genetic risk.

Please do not hesitate to contact me on the telephone number on this letter should you have any questions.

Yours sincerely

Authorised on 24/08/2018 10:39:42 by Emma Gellatly.

**Emma Gellatly**
**Familial Hypercholesterolaemia Nurse Specialist**

Enc: Letter for relatives

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB (copy genetics report sent under separate cover)
(P) Professor Jacob George, Honorary Consultant Physician, Cardiovascular Risk Clinic, Wards 3/4 Corridor, Ninewells Hospital, Dundee, DD1 9SY
Invu
Casenotes

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

01382660111

www.nhstayside.scot.nhs.uk

Dr A Taylor
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 23/08/2023 |
| Clinic Date | 22/08/2023 |
| Your Ref | |
| Our Ref | JG/DH/ **0503700053** |
| Enquiries to | Ward 4 Office |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | |

Dear Dr Taylor

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

Diagnosis:
1. Heterozygous FH2
2. Previous MI
3. Asthma
4. Peripheral vascular disease

I reviewed this gentleman at the cardiovascular risk clinic. He remains well. He was last reviewed here a year ago when his blood pressure and lipids were well controlled. This continues to be the case, with a blood pressure of 122/43mmHg this morning. His total cholesterol is 4.7mmol/L with a HDL of 1.35mmol/L.

For the record he is currently on ramipril 2.5mg once daily and evolocumab 150mg subcut Q2W for cardiovascular disease. I have therefore discharged him from routine follow up at this clinic but I have reminded him with regards to sick day rules.

Thank you

Yours sincerely

Authorised on 23/08/2023 14:57:52 by Jacob George.

**Professor Jacob George**
**Professor of Cardiovascular Medicine and Therapeutics &**
**Honorary Consultant Physician**

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

01382 660111

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Dr A Taylor
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 13/07/2022 |
| Clinic Date | 12/07/2022 |
| Your Ref | |
| Our Ref | IM/AM/ **0503700053** |
| Enquiries to | Ward 4 Office |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | |

Dear Dr Taylor

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

Diagnoses:
1. Heterozygous familial hypercholesterolaemia
2. Previous MI
3. Asthma
4. Peripheral vascular disease – currently under assessment by the Vascular Surgeons

I reviewed David by telephone from the Cardiovascular Risk Clinic today. He tells me that his blood pressure when checked 2 months ago at your surgery was described as 'perfect', although he was not sure of the actual numbers. He is continuing to take his Alirocumab and is tolerating this well. Although he was prescribed Atorvastatin again recently, he is not taking this as he failed to tolerate it in the past and he is going to speak to you about having this removed from his repeat prescription. He has been having some issues with leg pain and is under review by the Vascular Surgeons. He has an appointment for a CT on the 22nd July and the plan is for them to review him again with this result. He feels that his leg issues are very related to the dose of beta blockers so he has not been taking his Bisoprolol every day. He was prescribed Naftidrofuryl and again he has not been taking this regularly, but more as required. I have encouraged him to discuss both of these medications further with his Vascular Surgeon at his next appointment, but at present he prefers to manage them this way.

His current medications are Ramipril 2.5 mg, Zopiclone 7.5 mg at night, Salbutamol inhaler, Folic acid 5 mg, Bisoprolol 2.5 mg daily (not taking every day), Escitalopram 20 mg, Alirocumab 150 mg injection every 2 weeks, Lansoprazole GR 30 mg bd, Aspirin 75 mg, GTN spray prn and Naftidrofuryl 200 mg tds (not taking every dose). From the point of view of his cholesterol management and blood pressure management, he is stable at present and I have given him a one year review appointment in this clinic.

Thank you

Yours sincerely

Authorised on 18/07/2022 12:33:04 by Isla Mackenzie.

**Professor Isla Mackenzie**
**Honorary Consultant Physician**

COLDSIDE
MEDICAL PRACTICE
Supporting Your Health

Dr G.W. Macmillan
Dr A. Taylor
Dr A. Oswald
Dr F. Bullions
Dr J. Boileau
Dr T. Ansar

129 Strathmartine Road
Dundee
DD3 8DB

Tel: 01382 880900
Fax: 01382 884129

FB/TMc/11166

10 January 2022

Dr Benjamin Jaa Ming New
Specialty Registrar
Medicine Directorate
Ninewells Hospital
DUNDEE
DD1 9SY

Dear Dr New

**Re: David Standish DOB 05.03.70 0053**
**6 Dargarvel Gardens Ormiston Crescent DUNDEE DD4 0UQ**

Thank you for your recent correspondence.

Please note if you require bloods to be available to look at you need to request these on ICE then contact the patient prior and give them the contact number for hospital bloods. We do not organise hospital bloods in primary care.

Yours sincerely

**DR F BULLIONS**

We are a Living Wage

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

01382660111

www.nhstayside.scot.nhs.uk

Dr F Bullions
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 15/12/2021 |
| Clinic Date | 07/12/2021 |
| Your Ref | |
| Our Ref | BN/AM/ **0503700053** |
| Enquiries to | Ward 4 office |
| Extension | 33883 |
| Direct Line | 01382633883 |
| Email | |

Dear Dr Bullions

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

Diagnoses:
1. Heterozygous familial hypercholesterolaemia
2. Coronary heart disease
3. Peripheral vascular disease

Medications:
1. Ramipril 2.5 mg
2. Bisoprolol 2.5 mg twice a day (new)
3. Aspirin
4. Alirocumab
5. No changes to other medications

I reviewed Mr Standish in the Cardiovascular Risk Clinic with Professor MacDonald on the 7th December 2021. Unfortunately, there were no blood results available for our clinic review, and Mr Standish does not have the habit of monitoring his own blood pressure as well. He otherwise reports that he is tolerating Alirocumab with no issues, with no pain or injection site trouble. He reports that now and again he still gets angina and uses his GTN spray, as well as pain in his lower limbs. We recognise that there is a need to improve his angina control, as well as monitor his BP.

After reviewing his medications, we recommended that Mr Standish start taking Bisoprolol 2.5 mg twice a day, and get a blood pressure monitor machine to do regular blood pressure checks. We would also appreciate your help if Primary Care can organise a set of blood tests including a full lipid profile to ensure that he is responding well to Alirocumab. We will review Mr Standish again in the Cardiovascular Risk Telephone Clinic in 6 months' time

Yours sincerely

Authorised on 23/12/2021 12:09:19 by ST3 Benjamin Jaa Ming New.

**Benjamin Jaa Ming New**
**Specialty Registrar**

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Dr F Bullions
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 11/05/2021 |
| Clinic Date | 20/04/2021 |
| Your Ref | |
| Our Ref | JG/SG/ **0503700053** |
| Enquiries to | Ward 4 Office |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | |

Dear Dr Bullions

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

I reviewed this pleasant gentleman over the phone for his Cardiovascular Risk Clinic appointment this morning. He is keeping well and tolerating the Alirocumab without any difficulty. His medications have not changed and his blood pressure was very well controlled when last seen in clinic. His weight is also stable. I would be grateful if you could arrange for him to have a fasted lipid profile, including LDL and triglycerides before we review him one last time in 6 months.

Yours sincerely

Authorised on 11/05/2021 10:29:41 by Jacob George.

**Professor Jacob George**
**Professor of Cardiovascular Medicine and Therapeutics &**
**Honorary Consultant Physician**

Clinical Pharmacology
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Acute Services Division
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Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

David Standish
6 Dargarvel Gardens
Ormiston Crescent
Dundee
Angus
DD4 0UQ

| | |
|---|---|
| Date | 02/06/2020 |
| Your Ref | |
| Our Ref | /SG/ **0503700053** |
| Enquiries to | Clinical Pharmacology Secretary |
| Extension | 40157 |
| Direct Line | 01382 740157 |
| Email | |

Dear David Standish

**Cardiovascular Risk Clinic Appointment**

All hospitals across Scotland are now developing plans to manage the expected increase in demand due to a rise in the number of positive cases of Coronavirus. As part of NHS Tayside's preparations, we have to postpone a number of outpatient appointments.

Unfortunately, your appointment on Tuesday 16/06/20 has been affected and has been postponed at this time.

We hope you can understand why we have had to take this difficult decision and we are sorry that this may cause you some upset.

You will receive a letter with your new appointment date in due course

If you organised ambulance transport to attend this appointment please contact the Scottish Ambulance Service on **0300 123 1236** to cancel the ambulance request.

Many thanks

Claire Jane Hoose.

Capacity Manager
Medicine Directorate

Medicine and Cardiovascular Group
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Dr F Bullions
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 01/07/2019 |
| Clinic Date | 18/06/2019 |
| Your Ref | |
| Our Ref | JJ/SG/ **0503700053** |
| Enquiries to | Ward 4 Outpatient Office |
| Extension | 40471 |
| Direct Line | 01382 740471 |
| Email | samantha.garvock@nhs.net |

Dear Dr Bullions

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

**Diagnosis:**
1. Coronary artery disease
2. Heterozygous FH
3. Peripheral vascular disease
4. Hypertension
5. Statin and Ezetimibe intolerance
6. Asthma
7. Currently on Alirocumab

**Medication:** Ramipril 2.5 mg once daily, Bisoprolol 2.5 mg once daily, Folic Acid 5 mg once daily, Aspirin 75 mg, Lansoprazole 30 mg twice daily, Alirocumab 150 mg every 2 weeks, GTN and asthma inhalers.

I reviewed this gentleman in the cardiovascular risk clinic this morning. He is well and has had no side effects from Alirocumab, which he has now been on for around 18 months. His children have undergone cascade testing since his previous clinic appointment and he tells me that they do not have FH.

Last cholesterol when checked in April last year showed a total cholesterol of 4.49 mmol/L with an HDL of 1.29mmol/L, an LDL of 2.64 mmol/L, giving him a ratio of 3.4.

Blood pressure was also well controlled today and best blood pressure obtained was 114/72. I have not made any changes to his medication but I have checked his cholesterol today and will review him again in a year's time.

Many thanks

Yours sincerely

Authorised on 05/07/2019 17:00:47 by Clin Pharm Jennifer Johnstone.
**Dr J Johnstone**

**Specialty Registrar**

| | | | |
|---|---|---|---|
| **TOTAL CHOLESTEROL** | 4.00 | mmol/L | 0.00 - 5.00 |
| **HDL-CHOLESTEROL** | 1.19 | mmol/L | 0.60 - 2.50 |
| **TOTAL CHOL/HDL-CHOL** | 3.30 | . | |
| **LDL-CHOL. (CALCULATED)** | 2.15 | mmoL/L | 0 - 2.60 |
| **TRIGLYCERIDES** | 1.46 | mmol/L | 0.00 - 2.30 |

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Dr F Bullions
Coldside Medical Practice
129 Strathmartine Road
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DD3 8DB

| | |
|---|---|
| Date | 23/08/2018 |
| Clinic Date | 14/08/2018 |
| Your Ref | |
| Our Ref | JG/SG/ **0503700053** |
| Enquiries to | Miss Sam Garvock |
| Extension | 40157 |
| Direct Line | 01382 740157 |
| Email | samantha.garvock@nhs.net |

Dear Dr Bullions

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

Diagnosis:
1. Coronary artery disease
2. Peripheral vascular disease
3. Familial hypercholesterolaemia
4. Hypertension
5. Statin and Ezetimibe intolerance
6. Asthma
7. Currently on Alirocumab

Medication: Ramipril 2.5 mg once daily, Bisoprolol 2.5 mg once daily, Folic Acid 5 mg once daily, Aspirin 75 mg once daily, Lansoprazole 30 mg once daily, Alirocumab 150 mg every 2 weeks, GTN and asthma inhalers

I reviewed this pleasant gentleman at the Cardiovascular Risk Clinic this morning. He is keeping well and tolerating his medications. He has responded well to 150 mg of Alirocumab. His total cholesterol is 4.49 mmol/L, with an LDL of 2.64 mmol/L. Reassuringly, his HDL is 1.29 mmol/L. His blood pressure was well controlled in clinic today. It was 120/86 mmHg. I have given him one further review appointment in 6 months. If he remains well, he can be considered for discharge from this clinic. In the meanwhile, I have copied in his pharmacist, Bruce Ramsay at 87 Fintry Road in Dundee, so that he is aware that Mr Standish will require Alirocumab from the end of this month onwards.

Yours sincerely
Authorised on 28/08/2018 07:45:38 by Jacob George.

**Professor Jacob George**
**Honorary Consultant Physician**

(P) Pharmacist Bruce Ramsay Chemist, 87 Fintry Road, DD4 9JB

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Dr F Bullions
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 22/05/2018 |
| Clinic Date | 08/05/2018 |
| Your Ref | |
| Our Ref | MJM/SG/ **0503700053** |
| Enquiries to | Miss Sam Garvock |
| Extension | 40157 |
| Direct Line | 01382 740157 |
| Email | samantha.garvock@nhs.net |

Dear Dr Bullions

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

I saw this man and his wife at the Risk Clinic. Since his last visit, molecular genetic testing for FH has come back. He has a mutation in the ApoB gene – in layman's terms he has heterozygous FH. They have two children, age 23 and 14, and an appointment has been made with our FH nurse, Emma Gellatly, who will talk them through the implications and what we would advise. David himself, I am happy to say, tolerates alirocumab 150 mg every two weeks. Many thanks for checking his lipids recently: total cholesterol 4.49 mmol/L, calculated LDL 2.64 mmol/L, HDL 1.29 mmol/L, total/HDL 3.4 and triglycerides 1.25 mmol/L. These are the best results we have had on him for a long time, and he should persist on alirocumab for the moment. **Please note that the prescription of alirocumab reverts to primary care after six months, which will be in about three months from now.** I'm flagging this up now so there is plenty of time to source this.

Yours sincerely



**Authorised on 25/05/2018 10:01:47 by Clin Pharm Michael Murphy.Dr Michael Murphy**
**Honorary Consultant**
**Biochemical Medicine**

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Mr David Standish
6 Dargarvel Gardens
Ormiston Crescent
Dundee
Angus
DD4 0UQ

| | |
|---|---|
| Date | 01/05/2018 |
| Your Ref | |
| Our Ref | RH/SG/ **0503700053** |
| Enquiries to | Miss Sam Garvock |
| Extension | 40157 |
| Direct Line | 01382 740157 |
| Email | samantha.garvock@nhs.net |

Dear Mr Standish

We look forward to seeing you at your clinic appointment at the Cardiovascular Risk Clinic next week (Tuesday 8 May at 10.25 am). I just wanted to let you know that I have also asked one of our specialist nurses, Emma Gellatly, to offer you a follow up appointment in her Friday afternoon clinic. You should hear from her in due course. We can discuss more about this at your appointment next week.

Yours sincerely

Authorised on 01/05/2018 14:06:58 by Typist/Secretary Clin Pharm Sam Garvock, on behalf of Clin Pharm Rosalind Harpur.

**Dr Rosalind Harpur**
**Specialty Doctor**

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

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Dr F Bullions
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DUNDEE
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| | |
|---|---|
| Date | 09/03/2018 |
| Clinic Date | 27/02/2018 |
| Your Ref | |
| Our Ref | RH/SG/ **0503700053** |
| Enquiries to | Miss Sam Garvock |
| Extension | 40157 |
| Direct Line | 01382 740157 |
| Email | samantha.garvock@nhs.net |

Dear Dr Bullions

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

Past medical history: NSTEMI November 2016
VF arrest during angiogram
Peripheral vascular disease
Coronary stents
Statin intolerance
Ezetimibe intolerance
Hypercholesterolaemia
Asthma

Current medication: Alirocumab 75 mg per 1 ml solution for injection fortnightly (dose to be increased to 150 mg fortnightly from today – prescription issued for 3/12), Folic Acid 5 mg once daily, Aspirin 75 mg once daily, Bisoprolol 2.5 mg once daily, Ramipril 2.5 mg once daily, Lansoprazole 30 mg once daily, Salbutamol inhaler PRN, GTN spray PRN

I reviewed this 47-year-old man in the Cardiovascular Risk Clinic today. His medication has been unchanged since his last visit and he has tolerated well, 3 months of Alirocumab 75 mg, two weekly injections. He reports no problems or symptoms from the medication or with the injection site and has had good compliance. He self administers the injections.

There has been a significant improvement in his lipid profile. On 5 February 2018, his total cholesterol was 5.05 mmol/L (previously having been 7.36 mmol/L on 17 November 2017). His triglycerides were 2.12 mmol/L, and HDL 1.27 mmol/L. No LDL result was available.

I discussed this gentleman's Alirocumab prescription and recent cholesterol results with Professor George, who has advised that we increase his Alirocumab to 150 mg subcutaneous injection fortnightly and he has provided a 3 month prescription from our clinic for the patient today. We will follow him up within the 3 months before the next prescription is required. I have asked the patient to attend his general practice to get a full lipid profile, including LDL and triglycerides one week before his next cardiovascular risk clinic appointment.

**David Standish, 050370 0053**

I appears that this man has not been tested for familial hypercholesterolaemia, but given his high pre-treatment, personal and strong family history for heart disease it would be prudent to do so. The patient is aware that the blood test is sent to Aberdeen and the result can take some time to return to us, but I hope it will be available by his next Cardiovascular Risk Clinic appointment to allow discussion.

If you, or the patient, have any questions regarding his Alirocumab treatment, please do not hesitate to get in touch in the meantime.

Yours sincerely

Authorised on 09/03/2018 16:47:12 by Clin Pharm Rosalind Harpur.

**Dr Rosalind Harpur**
**Specialty Doctor**

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Dr F Bullions
Coldside Medical Practice
129 Strathmartine Road
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DD3 8DB

| | |
|---|---|
| Date | 07/12/2017 |
| Clinic Date | 17/11/2017 |
| Your Ref | |
| Our Ref | IM/SG/ **0503700053** |
| Enquiries to | Miss Sam Garvock |
| Extension | 40157 |
| Direct Line | 01382 740157 |
| Email | samantha.garvock@nhs.net |

Dear Dr Bullions

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

Diagnosis:
1. NSTEMI, November 2016, VF arrest during angiogram
2. Peripheral vascular disease
3. Coronary stents
4. Statin intolerance
5. Ezetimibe intolerance
6. Hypercholesterolaemia
7. Asthma

I reviewed this gentleman in the Cardiovascular Risk Clinic today, accompanied by his partner. He has a history of hyperlipidaemia. He previously took statins for several years when he was also on Diazepam, but when the Diazepam was later stopped, he developed aches and pains, felt generally unwell and had cold symptoms. He tried several different statins over time under the care of Dr Baines, including Rosuvastatin, with similar reactions. His main side effects were insomnia, myalgia and abdominal pains. He also tried Ezetimibe which caused abdominal pains.His blood pressure has been relatively well controlled on treatment. He still experiences some atypical chest pains. These sometimes respond to GTN treatment. He has no major breathlessness, but occasionally has some chest tightness relieved by Salbutamol. He has no ankle swelling and no orthopnoea. His exercise tolerance is limited due to pain occurring in both legs on walking 10 to 15 metres. He has previously had a vascular bypass in his right leg and it was felt not beneficial to intervene in his left leg at that time.

His current treatment is Ramipril 2.5 mg, Bisoprolol 1.25 mg to 2.5 mg depending on leg symptoms, Aspirin 75 mg, Folic Acid 5 mg, Lansoprazole 30 mg, Zopiclone 7.5 mg at night, GTN spray prn and Salbutamol inhaler prn. He has no actual drug allergies. He stopped smoking in November 2016, drinks very little alcohol. He previously worked as a boat builder, but is not currently working. He lives with his partner and daughter.

His father had several MIs from his early 40s onwards and is now in his 70s. His sister died age 48 of a brain tumour.

On examination,/ **cont./**

**David Standish, 050370 0053**

On examination his weight was 105 kg, height 1.78 m. Blood pressure initially measured 152/94, pulse 63, but settled to 138/84, pulse 55.

Examination was normal except peripheral pulses were difficult to feel. His feet were warm. He had no xanthelasmata, or corneal arcus or vascular bruits.

I have discussed the treatment options for his hyperlipidaemia. I think he may be eligible for Alirocumab on the grounds of his polyvascular disease, his intolerance of statins and Ezetimibe, however we do not have a recent lipid profile. The most recent one in November 2016 showed cholesterol 6.64, HDL 1.67 and a previous one September 2015 showed cholesterol 7.13, HDL 1.34. I have repeated bloods today, including a full lipid profile and will advise further based on these results. If he is eligible for PCSK9 inhibition, we will start him on Alirocumab 75 mg subcutaneous injection, given 2 weekly. He feels that his partner may need to administer this for him, so they can both attend for training, if this is appropriate. If he does not meet the Scottish Medicines Consortium criteria for Alirocumab therapy based on his LDL result, alternatives include trying a very low dose statin, given very infrequently, or retrying Ezetimibe and he is open to these options, if required. I will contact the patient by telephone next week with his lipid results, and our treatment plan. I will review him in this clinic in 3 months.

Yours sincerely

Authorised on 11/12/2017 14:06:53 by Clin Pharm Isla Mackenzie.

**Dr I Mackenzie**
**Honorary Consultant Physician**

**PS added 11.12.17- After reviewing his recent lipid results, I discussed them with Mr Standish by telephone and prescribed alirocumab and arranged with our clinic nurses to train him to start on alirocumab therapy as above in early December. His partner will administer the injections. We will review him in clinic in 3 months. Please could you check a fasting lipid profile on him in late February so that we have these results to review his dose when he next attends. Many thanks.**

**Results cont./**

## David Standish, 050370 0053

| | | | | |
|---|---|---|---|---|
| **Hb** | | 138 | g/L | 130 - 180 |
| **WBC** | | 7.9 | $x10^9$/L | 4.0 - 11.0 |
| **PLT** | | 380 | $x10^9$/L | 150 - 400 |
| **RBC** | | 4.66 | $x10^{12}$/L | 4.5 - 6.0 |
| **HCT** | | 0.439 | | 0.40 - 0.52 |
| **MCV** | | 94.1 | fl | 85 - 105 |
| **MCH** | | 29.6 | pg | 27 - 32 |
| **MCHC** | ***[LO]** | **314** | **g/L** | **320 - 360** |
| **NE#** | | 4.2 | $x10^9$/L | 2.0 - 7.5 |
| **LY#** | | 2.9 | $x10^9$/L | 1.5 - 4.0 |
| **MO#** | | 0.4 | $x10^9$/L | 0.2 - 0.8 |
| **EO#** | | 0.26 | $x10^9$/L | 0.0 - 0.4 |
| **BA#** | | 0.1 | $x10^9$/L | 0.0 - 0.1 |

| | | | | |
|---|---|---|---|---|
| **TOTAL CHOLESTEROL** | ***[HI]** | **7.36** | **mmol/L** | **0.00 - 5.00** |
| **TRIGLYCERIDES** | | 1.85 | mmol/L | 0.00 - 2.30 |
| **SODIUM** | | 137 | mmol/L | 133 - 146 |
| **POTASSIUM** | | 4.7 | mmol/L | 3.5 - 5.3 |
| **UREA** | | 4.3 | mmol/L | 2.5 - 7.8 |
| **CREATININE** | | 74 | umol/L | 62 - 106 |
| **AKI** | | Not detected: but may not exclude AKI in all cases | . | |
| **ALT** | | 40 | U/L | 5 - 55 |
| **BILIRUBINS** | | 7 | umol/L | 0 - 21 |
| **ALKALINE PHOSPHATASE** | | 83 | U/L | 30 - 130 |
| **ALBUMIN** | | 36 | g/L | 35 - 50 |
| **CALCIUM** | | 2.39 | mmol/L | 2.10 - 2.55 |
| **CALCIUM (CORRECTED)** | | 2.43 | mmol/L | 2.10 - 2.55 |
| **ESTIMATED GFR** | | GT60 | mL/min | |
| **CKD Stage** | | IF HIGH RISK, EXCLUDE CKD1/2.<br>CHECK FOR HAEMATURIA AND PROTEINURIA | . | |
| **HDL-CHOLESTEROL** | | 1.47 | mmol/L | 0.60 - 2.50 |
| **TOTAL CHOL/HDL-CHOL** | | 5.00 | . | |
| **GLUCOSE (preserved tube)** | | 5.3 | mmol/L | 3.3 - 5.8 |
| **TSH** | | 1.61 | mU/L | 0.4 - 4.0 |

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Dr WA Oswald
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 29/06/2017 |
| Your Ref | |
| Our Ref | CB/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Oswald

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

Many thanks for your letter regarding this gentleman and his previous Escitalopram. I have had a chance to look back through his medical notes and I see he was on Escitalopram back in 2010. He was on this up to 2013. At that stage Dr Dick had suggested switching to Mirtazipine because of sleep disturbances and the prospect of Mirtazipine being more titratable in this regard. From what I can see thereafter he didn't start the Mirtazipine but his Escitalopram did stop and it then co-incided with the fact that his sleeping improved after changes in his lipid therapy.

He had an OGD in 2015 at which stage he was off the Escitalopram and therefore I can't see any evidence of this being implicated in his GI symptoms.

Hopefully this clarification on the timeline will provide him reassurance and give you the opportunity to try the necessary drugs.

Kind regards.

Yours sincerely

Authorised on 30/06/2017 12:17:34 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

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Dr Thomas Martin
Consultant Cardiologist
Department of Cardiology
Ninewells Hospital
Dundee
DD1 9SY

| | |
|---|---|
| Date | 16/02/2017 |
| Clinic Date | 06/02/2017 |
| Your Ref | |
| Our Ref | JG/SG/ **0503700053** |
| Enquiries to | Miss Sam Garvock |
| Extension | 40157 |
| Direct Line | 01382 740157 |
| Email | samantha.garvock@nhs.net |

Dear Dr Martin

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Thank you for your referral of this patient for consideration of Alirocumab. As he is intolerant of statins, he does not qualify for Alirocumab as per current SMC guidelines. However, I have appointed him to the lipid clinic and he can be seen there. If it is felt that this is an appropriate treatment for him, the doctor will need to fill in an individual patient treatment request (IPTR).

Thank you.

Yours sincerely

Authorised on 17/02/2017 08:15:03 by Jacob George.

**Dr Jacob George**
**Clinical Senior Lecturer/Honorary Consultant Physician**

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

Medicine and Cardiovascular Group
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Clinical Psychology Department
South Block
Level 6
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Dundee
DD1 9SY

| | |
|---|---|
| Date | 09/12/2016 |
| Clinic Date | 08/12/2016 |
| Your Ref | |
| Our Ref | CB/CH/ **0503700053** |
| Enquiries to | Cheryl Hayes |
| Extension | 32407 |
| Direct Line | 01382 32407 |
| Email | chayes4@nhs.net |

Dear Colleague

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I would be very grateful for your input on this gentleman's care. He is a young gentleman who has early atherosclerotic disease. He was known to have peripheral arterial disease and required an operation for this. More recently in November he suffered a non-ST elevation MI and underwent percutaneous therapy with angioplasty and stenting.

He has made a good physical recovery following his myocardial infarction but unfortunately for him during the percutaneous procedure he required to be defibrillated on two occasions and he is having great difficulty in coming to terms with both the diagnosis of myocardial infarction and also the requirement for his defibrillation. He is more anxious and struggles to leave the house and although he is managing to take great reassurance in the physical performance of his heart, his psychological recovery is lagging some way behind.

I have discussed this with his cardiac rehab team as well and they are in complete agreement and think your input would be of great value to him in his ongoing recovery. I am aware that your service is in great demand but if there was to be a way that this gentleman could be seen soon I think it would be of great benefit to him. Many thanks in advance.

Kind regards

Yours sincerely

Authorised on 12/12/2016 13:37:09 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

Medicine and Cardiovascular Group
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Acute Services Division
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Dr F Bullions
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 09/12/2016 |
| Clinic Date | 08/12/2016 |
| Your Ref | |
| Our Ref | CB/CH/ **0503700053** |
| Enquiries to | Cheryl Hayes |
| Extension | 32407 |
| Direct Line | 01382 32407 |
| Email | chayes4@nhs.net |

Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I reviewed Mr Standish back in clinic where I was saddened to hear of his recent non-ST elevation MI. In general he was rather frustrated about the processes leading up to this and felt that there should have been an attempt to perform coronary angiography before some of the changes were made to his medication. I did explain that with the absence of symptoms coronary angiography would not have been a test that would have been undertaken and our aim would have been purely with the secondary prevention of stable arterial disease, hence why we were trying to use the medication that was best tolerated in order to manage both his adverse effects along with his atherosclerotic disease.

He is aware of course that the largest trigger for his ongoing atherosclerotic disease and his non-ST elevation MI was his ongoing smoking.

Overall he is doing well after his MI; he has used his GTN spray on one occasion but is not really bothered by significant chest pain. He has now completely stopped smoking and this is encouraging.

Unfortunately during the interventional procedures he did require to be defibrillated on two occasions and he is finding this a very difficult psychological boundary to cross. Although he is very reassured that his echocardiogram demonstrates good cardiac function he is definitely struggling with the psychological aspects of both his myocardial infarction and also the requirement to be defibrillated.

I discussed with him, and subsequently with one of his cardiac rehab team, regarding the potential benefit for clinical psychology input here. He was entirely accepting of this and I will duly make a referral on. He is aware of the long waiting list however. It may be that with ongoing support from the cardiac rehab team he gets to the stage where he doesn't require this clinical psychology input and of course he could also cancel the appointment at that stage.

As he is now being followed up by cardiology services I have not arranged further review back in my vascular clinic.

Kind regards

Yours sincerely
Authorised on 12/12/2016 13:36:06 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

Medicine and Cardiovascular Group
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David Standish
20 Canning Place
Dundee
DD3 7RT

| | |
|---|---|
| Date | 03/10/2016 |
| Your Ref | |
| Our Ref | CB/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear David Standish

Further to seeing you in clinic we have been in discussion with your GP and Pharmacist regarding the prescription of the Cilostazol tablet we discussed. As remembered this was hopefully to work as an antiplatelet. You may also have a symptomatic benefit for your walking distance.

As you remember from our discussion I did say that this was an off licence use of the drug and it might be that the practice would feel this is not appropriate to prescribe initially in primary care and indeed this is the case. I think this is entirely understandable and appropriate. I am happy to take on the responsibility for prescribing in the first instance at least. As you can see I have enclosed the prescription for the drug which you should be able to take to any pharmacy. We have also discussed the dosing of this. As you may remember I said that some of the acid suppressing tablets can interact with this drug and, although it is not definitely proven with the Lansoprazole that you are taking, there is a concern that it is a class effect of these group of drugs and for that reason we thought it was more sensible to reduce the dose. I have therefore arranged the prescription for Cilostazol 50 mg twice daily and I will assess how your are getting on with this when you come back to see me in clinic. I have copied this to your practice for their files, to let them know that you are starting on the drug.

Kind regards

Yours sincerely

Authorised on 03/10/2016 12:03:50 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

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| | |
|---|---|
| Date | 21/09/2016 |
| Clinic Date | 08/09/2016 |
| Your Ref | |
| Our Ref | CB/SG/ **0503700053** |
| Enquiries to | Shannen Gray |
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| Email | shannengray@nhs.net |

Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I reviewed David back in clinic where being in possession of a very helpful letter from Dr George in the cardiovascular risk clinic. I explained the discussion regarding the cholesterol treatment to David and he is happy to try the Rosuvastatin 5mg weekly for 3 months. If he is tolerating this there would be rationale to then trying to increase the frequency of this dosing to twice weekly and then perhaps every second day depending on how well he is tolerating it. If he fails to tolerate this then I could action an IPTR for the PCSK9 inhibitor as per Dr George's letter.

He is on his antihypertensive and he feels better off the Clopidogrel and he also wonders whether stress has played a part in his ulcer related disease. This may well be the case, particularly as he has had a very tough time with family illness and his sister sadly died recently. He himself is feeling more positive in general and hopefully this will allow him to tolerate his medications better. From an antiplatelet side I would think Aspirin would be even worse than the Clopidogrel for his gastric mucosa and as such I wonder whether we could try Cilostazol 100mg twice daily. This does have an antiplatelet effect and also has the additional benefit that it might improve his walking distance from his peripheral arterial disease. I would be grateful if you could try this at 100mg twice daily for 3 months to see what happens with his walking distance. If it does improve then we can perhaps consider continuing this drug but if hasn't improved then I would be inclined to stop the Cilostazol and perhaps consider Ticagrelor at that stage although again we would have to be cautious about his stomach. I therefore would be very grateful if you could prescribe the Rosuvastatin 5mg weekly currently and also the Cilostazol 100mg twice daily as a 3 month trial. I will be seeing him back in clinic in around 3 month's time to assess the effect of the Cilostazol.

Kind regards

Yours sincerely

Authorised on 21/09/2016 10:43:52 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

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| Date | 25/08/2016 |
| Your Ref | |
| Our Ref | JG/WB/ **0503700053** |
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| Email | w.burns@nhs.net |

Dear Dr Baines

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Thank you for your letter regarding this gentleman and the possibility of using PCSK9 inhibitors in him. Unfortunately the SMC have not approved the use of PCSK9 inhibitors in patients who are intolerant to statins. The only current licensed and approved PCSK9 inhibitor is Alirocumab (Praluent) but the SMC restrictions and local guidelines mean that we are only using for patients with heterozygous familial hypercholesterolaemia. There are two options here. Firstly that he was previously on a statin fibrate combination, it is unsurprising that he had issues with myalgia. What we do try in patients like him is Rosuvastatin 5 mg once weekly for approximately three months and if he is tolerating that it can be increased to twice weekly. We find that quite a lot of patients who are previously “intolerant” to statins tolerate this regime better. If he is genuinely not able to tolerate this, then an independent patient treatment request (IPTR) could be put in and I would be supportive of this.

Thank you.

Yours sincerely

Authorised on 26/08/2016 15:56:57 by Jacob George.

**Dr Jacob George**
**Clinical Senior Lecturer/Honorary Consultant Physician**

(D) Dr F Bullions, Coldside Medical Practice, 129 Strathmartine Road, Dundee, DD3 8DB

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|---|---|
| Date | 24/08/2016 |
| Your Ref | |
| Our Ref | CB/WB/ **0503700053** |
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Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I have the results of David's repeat OGD available. This has demonstrated a significant improvement in the endoscopy findings with only mild distal gastritis with a normal duodenum and oesophagus. The biopsies from the distal stomach demonstrated chemical gastritis with no evidence of H pylori organisms and CLO test was negative. It is obviously hard to know whether the withdrawal of Clopidogrel alone is sufficient in resulting in these improvements or whether the H pylori eradication that he did undergo has benefited him, but regardless I don't think Clopidogrel is going to be an option for him going forward. I will bring him back to clinic to discuss his antiplatelet further in light of this result, and it maybe we have to consider using Cilostazol which at least may have additional benefit of improving some of his peripheral arterial disease symptoms although with his history of drug intolerance this may also be a drug that is difficult for him to tolerate. Hopefully the cardiovascular risk clinic will be able to advise further regarding his lipid management and hopefully soon we will manage to get him on to a manageable long term secondary prevention strategy here.

Kind regards

Yours sincerely

Authorised on 24/08/2016 15:36:12 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

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Dr J George
Consultant Physician/Honorary Senior Lecturer
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Dear Dr George

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

My apologies for not having written to you before. I thought I had written with a referral previously, but it appears that this has gone missing. I would be very grateful for your help with this gentleman who has complicated secondary prevention requirements. He presented with early atherosclerotic disease for which he had right common femoral endartectomy and SFA angioplasty and stenting. His SFA stent has unsurprisingly gone down and he continues to suffer from claudication, but actually his left leg is worse than his right and on that side he requires bypass surgery which is not clinically indicated.

He struggles with tolerating his second prevention medication and has had significant gastric upset with Clopidogrel. I am endeavouring to find an antiplatelet agent which will be of benefit to him. I will probably try Cilostazol next, both from a claudication perspective but also for trying to improve his stomach symptoms as he appears to be genuinely intolerant of Clopidogrel.

The reason for asking your advice is relating to his lipid profile. This is significantly sub optimal and having inherited this gentleman from Dr Dick's clinic you will be aware that John has tried every avenue possible in order to maintain him on statin therapy. Previously he was on statin, fibrate and Ezetemibe combination. He has multiple side effects including myalgia, abdominal pain and insomnia with these drugs. Interestingly he also developed significant abdominal pain on the Ezetemibe alone but I don't think the temporal relationship between the insomnia and medication is something that the patient is prepared to ignore.

Dr Dick had also previously spoken to him about PCSK-9 inhibitors and this is an avenue that he is very keen to explore further. I would therefore be very grateful if you could see him with a view to optimising his lipid management for which currently he is not regularly taking any therapy. I will be seeing him in clinic to look at the rest of his secondary prevention, in particular his anti platelet therapy following his most recent OGD.

Many thanks in advance.

Kind regards

Yours sincerely

Authorised on 05/08/2016 10:11:20 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

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| Clinic Date | 16/06/2016 |
| Your Ref | |
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Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I reviewed Mr Standish back in clinic on the 16th June. It is fair to say he is rather unhappy with his symptoms currently and he describes himself as feeling terrible. As you know he had the endoscopy back in November which showed significant oesophagitis, gastritis and duodenitis with one gastric erosion. He has subsequently been shown to have H-pylori and has undergone H-pylori eradication. Attempts to restart his secondary prevention medication initially showed some promise following the H-pylori eradication, but now he getting worsening dyspeptic symptoms and indeed presented himself to A&E with these relatively recently.

I tried to explain that Clopidogrel rarely causes true gastric symptoms but it can do this. I think it is worth him staying off the Clopidogrel at this stage until we further assess his gastric mucosa and his dyspeptic symptoms. I have explained that the benefits from antiplatelets in secondary prevention are there, but are relatively small compared to the benefits of other drugs and they are a lifetime benefit rather than any short term benefit. Therefore it should not be causing him any undue problems by being off these currently. Indeed his recent vascular lab reassessment demonstrated his endarterectomy was widely patent but there is a short occlusion in his SFA which I presume is where was previously stented (or angioplastied). It doesn't surprise me that this SFA intervention area has re-occluded as this is a natural history of intervention into SFA and the fact collaterals are forming is an encouraging sign. There does not seem to be significant progression of atherosclerotic disease in the rest of the leg arteries which is reassuring.

The other atherosclerotic secondary prevention measure has been a statin. He feels that he gets significant side effects with all of these now. Previously he had managed to tolerate a low dose of Atorvastatin at 10mg but that started causing insomnia at that has been a major feature of a lot of his statin intolerances. Most recently Fluvastatin caused a lot of abdominal pain, sweating and insomnia.

Certainly Simvastatin has been known to cause vivid dreams and sleep disturbance due to its ability to cross the blood brain barrier, the mechanism of this affect with other statins is perhaps harder to understand in this case, but regardless there seems no way that Mr Standish will continue to take a statin in any case. We therefore have two problems, one is his secondary prevention medication and I think these certainly are beneficial for our colleagues in the cardiovascular risk clinic to advise regarding his lipid management in particular.

One does wonder whether PCSK9 inhibitors may be an option if not now then at some stage in the future for this gentleman (it is perhaps notable that Dr Dick had discussed this with him in the past and the patient himself was really very keen for these drugs)

The other issue is his ongoing dyspepsia. I had a chance to speak to the Gastroenterologists about the next best test here. I did wonder his H-pylori has been needing retreated rather than this all being down to his Clopidogrel and I wondered whether a urea breath test or OGD was a best next test. Overall, after consideration of his case with the gastroenterologists, they feel it is probably best just to repeat his OGD and I will go ahead and make these arrangements. He should certainly stay off the Clopidogrel until after this has been done and I will arrange to review him in clinic thereafter.

It is perhaps worth noting that this gentleman is rather frustrated and claims that he is unable to be seen when he is complaining his symptoms of dyspepsia. I suspect his understanding of this is probably incorrect but he does feel that he is told that he has to be seen by the specialist rather than at the surgery. As I say I suspect that he has picked this up wrongly but certainly it would not be possible for me to be able to respond in this manner and I am certainly not a specialist in gastroenterology in any case. I have explained it is not possible for me to operate a drop in service given the changes to our workforce and work pattern. I will let him know that we are arranging an OGD.

Kind regards

Yours sincerely

Authorised on 06/07/2016 08:47:54 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

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David Standish
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| Clinic Date | 16/06/2016 |
| Your Ref | |
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Dear David Standish

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Just to keep you updated I have had a chance to discuss with the Gastroenterologists and they feel that a repeat endoscopy would be the most useful next test and I have gone ahead to arrange this. It would be best to stay off your Clopidogrel currently at least until this test has been completed.

Kind regards

Yours sincerely

Authorised on 01/07/2016 09:13:15 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

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| Date | 13/05/2016 |
| Clinic Date | 12/05/2016 |
| Your Ref | |
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Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I reviewed Mr Standish back in clinic today. Overall things have been slightly improved particularly from his stomach symptoms and he is now established on his Clopidogrel, Felodipine, Folic Acid and Lansoprazole. Since his H.pylori eradication therapy there certainly has been a gradual improvement in his dyspeptic symptoms although there is still persistence of some of these. He is much more comfortable with this however.

He has not restarted back on his statins as he continues to get bad side effects from these, predominantly related to poor sleep and nightmares. This has been present with Simvastatin, Atorvastatin and Rosuvastatin and he also finds he has problems with Ezetimibe. There is some difficulty with the direct causative relationships with these, particularly with Ezetimibe and the statins that do note cross the blood brain barrier, however there does seem to be a persistent and consistent temporal relationship to these drugs with his symptomatology and he is not at all keen to retry these.

Apparently Dr Dick had previously discussed with him that he may be eligible for consideration for an injection type therapy which I suspect is one of the new PCSK-9 directed therapies. This may well be worth investigating and I will ask my colleagues in the cardiovascular risk clinic for their opinion on this. In the intervening time however, before abandoning statins altogether, I do think it would be worth a trial on Fluvastatin at the lowest dose to see if we can provide a statin he can tolerate. If he is unable to tolerate this, I would try and commence him back on his Fibrate but I will ask my colleagues in the cardiovascular risk clinic for their opinion regarding treating him with a PCSK9 directed therapy.

With regards to his peripheral arterial disease, he finds his claudication distance has reduced particularly noticeable in his right leg where previously he had a common femoral artery endarterectomy and distal SFA stent insertion. It may well be that the stent is thrombosed but we have discussed again the rationale for conservative therapy instead of bypass surgery. He completely understands this and is happy to continue with conservative therapy. We will arrange a duplex of his right leg to assess whether or not his stent is thrombosed, but it may well be that we don't choose to do anything with this even if this were to be the case. We will review him again with the results of this.

Kind regards

Yours sincerely

Authorised on 13/05/2016 12:07:37 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

(P) Dr J George, Consultant Physician/Honorary Senior Lecturer, Clinical Pharmacology , Medicine Directorate, Ninewells Hospital, DD1 9SY

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Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I have the results of your patient's urea breath test. This has demonstrated a positive test implying current infection with H.pylori. I think it therefore does support the suggestion of giving him H.pylori eradication therapy.

Kind regards

Yours sincerely

Authorised on 09/03/2016 14:54:21 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

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| Date | 18/02/2016 |
| Your Ref | |
| Our Ref | CB/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
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Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Many thanks for your letter regarding this gentleman and his Esomeprazole and Clopidogrel use. The data on PPIs and Clopidogrel is far from conclusive and it is also based on laboratory tests in relation to platelet aggregation index. The only clinical situation when there has been any potential proven impact for PPI and Clopidogrel is in the 30 days post acute coronary syndrome. My own personal belief, and that of many others, is in people on long term Clopidogrel there is no difficulty in co-prescribing Esomeprazole. However Lansoprazole is a perfectly reasonable alternative and 30 mg twice daily would be fine as would high dose Pantoprazole.

It is one of the vagaries of our medicine licensing authorities that they are unwilling to accept surrogate end points as indications for drug licence, however they seem very happy to accept surrogate markers of potential problems in order to issue statements suggesting a drug shouldn't used.

Regardless of my views however, I suspect we will continue to be hamstrung by these recommendations and as such any appropriate PPI would obviously be suitable at a high dose.

Kind regards

Yours sincerely

Authorised on 22/02/2016 09:48:33 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

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|---|---|
| Date | 26/01/2016 |
| Clinic Date | 07/01/2016 |
| Your Ref | |
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Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I reviewed Mr Standish back in clinic with the results of his OGD. As you know this has demonstrated quite dramatic gastritis and duodenitis, and the question will be whether this is a chemical gastritis or as suggested by the biopsy could this be H.pylori (despite the fact that no H.pylori organisms were identified on the biopsy itself). He is off all medication including his PPI and there does seem to be a temporal relationship to his symptoms improving and being off the medication. This may however relate to initial rebounding of high acid reduction once the Lansoprazole has stopped rather than it being due to avoiding all other medication. Regardless I think we need to prove one way or another whether he does have H.pylori and I have arranged for a urea breath test in the nuclear medicine department, and I have encouraged him to stay off his Lansoprazole until this is available.

After that is available it may be that we need increase his acid suppression, and given that his Lansoprazole has not been particularly effective perhaps changing him on to Esomeprazole 40mg twice daily for a period of time before reducing to 40mg daily would be a reasonable approach. Once we have had the breath test we will be able to know whether H.pylori eradication in addition is needed, but if not we could start to slowly re introduce his medication alongside the high dose of his PPI and it would seem sensible to do this one tablet at a time with Clopidogrel being the last tablet to restart.

I have asked him to contact the surgery once he has had his breath test performed so that he can commence on his Esomeprazole and I will be in touch with the breath test results when I have them.

Kind regards

Yours sincerely

Authorised on 26/01/2016 12:29:28 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

(P) David Standish, 20 Canning Place, Dundee, DD3 7RT

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Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I have the results of your patient's OGD which has been rather helpful. This has demonstrated gastritis and duodenitis with one erosion in the gastric fundus. He certainly needs to continue his Lansoprazole. Currently I would be inclined to leave him off his Clopidogrel. He may need a double dose of Lansoprazole for a period of time before we slowly restart his other secondary prevention medication to co-exist with this. Perhaps at a later date we will be able to get his anti platelet agent restarted.

Biopsy demonstrated there was no clear evidence of helicobacter pylori but with the mixed features of chronic active gastritis and chemical type gastritis I did wonder whether other attempts at excluding H pylori are worthwhile.

I also have the result of his breath test for bacterial overgrowth which has demonstrated no evidence of bacterial overgrowth.

This therefore has come as a possible plausible explanation for his severe stomach pains and certainly would suggest that we would hope to be able to treat these with acid suppression, perhaps considering empirical H pylori eradication is something we should also do. I would hope that with adequate treatment of his gastritis we would be able to restart his other medication. I will arrange to bring him back to clinic.

Kind regards

Yours sincerely

Authorised on 29/12/2015 14:11:14 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

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Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I reviewed Mr Standish back in clinic today following a phone call from him asking to discuss again with me at clinic. Further to my most recent letter, again I again went over with the patient that I'd misinterpreted what has been happening with his Diazepam when I thought he had been recommenced back on this. If he had been recommenced back on this I would have been happy for it to continue so it was causing him the additional benefits of being able to take his medication but I certainly wouldn't have been suggesting re-prescribing it purely for the indication to take other medications. Further to my previous letter I apologised to the patient for the confusion I had caused and explained that I had apologised to yourself regarding this also.

Regardless, he's still suffering significant central abdominal pain and although CT scanning has been performed in the past we never actually had an OGD performed. I think this is worthwhile and given the number of medications he's taking, and all the over counter remedies he's tried, I think it's also worth while doing a glycolic breath test to ensure there's no small intestinal bacterial overgrowth here. In the mean time I've suggested he simply stays off his medication currently but restarts these a couple of weeks before his OGD so they can re-assess what is happening to his mucosa if his medication or if indeed anything at all is indeed irritating this.

I will write back with the results of these tests and I plan also to speak to the gastroenterologists about possible measures of treatment here. As he's not found the Buscopan helpful, perhaps Mebeverine could be tried although further treatment for an IBS type picture will be limited by the fact that the gentleman is not keen on the thought of trying Amitriptyline or any other antidepressant type medication. I'll be in touch again with the results of the above tests in due course.

Kind regards

Yours sincerely

Authorised on 18/11/2015 14:29:48 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

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Dear Dr MacMillan

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I wish to write to apologise for any confusion related to my clinic letter which this gentleman came brandishing in front of you. It was my understanding when I spoke to the gentleman in clinic that he had been prescribed Diazepam for another reason and this was having a knock on effect of allowing him to tolerate the secondary prevention medication. I felt that this was a bonus and the intention from my letter had been that, although I thought it was unusual that this was allowing him to tolerate his medication, if there had been a reason for him being on Diazepam then perhaps this additional advantage gave a reason to consider continuing the drug. Certainly I didn't intend the letter to read, or to give the patient the impression, that I was suggesting that long term Diazepam being only prescribed to allow him to tolerate other medication was something that I would be advocating.

I certainly wasn't aware of the other issues relating to his Diazepam prescription from previous GP practices and having met this gentleman only once or twice myself I don't think I would be in a position to suggest long term Diazepam prescription.

I just wanted to take the time to clarify my position on this matter and apologise for any confusion or difficulty that this may have caused you from my previous letter, which on reading back perhaps was not the most clear and was open to interpretation by the patient. For clarity sake I wanted to confirm that I was not advising long term Diazepam use to enable him to tolerate his medication and I fully support your stance in this matter.

Kind regards

Yours sincerely

Authorised on 02/11/2015 08:50:55 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

**p.s. I have also seen the gentleman back at clinic to explain the above.**

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Dr F Bullions
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 14/10/2015 |
| Clinic Date | 24/09/2015 |
| Your Ref | |
| Our Ref | CB/DO/ **0503700053** |
| Enquiries to | Debbie Orr |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | d.orr@nhs.net |

Dear Dr Bullions

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Many apologies for the delay in this clinic letter relating to this gentleman's clinic appointment on 24th September. I had been waiting on the results before doing a letter.

As you know this gentleman has significant atherosclerosis and has had multiple problems maintaining on his medication regime. He had been trying his medication at different times in an attempt to tolerate these with all his severe abdominal pains, but even despite initial improvements with this things deteriorated and he had to come off all of his medication again. He has however noticed that since he has tried Diazepam again he has been able to take all of his medication without difficulty. This is a small dose of 5mg Diazepam and, looking back, all of his problems with his medications that he had previously been tolerating well did seem to start when the Diazepam was initially withdrawn.

I know that long term Diazepam use is not something we are keen to encourage but I would have though on the balance of risks and benefits for this gentleman and his significant atherosclerotic disease at an early age, the use of Diazepam to allow him to maintain his medication would be reasonable.

With regards to his medication I have suggested he stops his Fibrate and continues on Atorvastatin 10mg. His total cholesterol I checked demonstrated a total cholesterol at 7.13 with an HDL of 1.34. We could titrate up the Atorvastatin towards 40mg daily or alternatively add back in Ezetimibe 10mg once daily to see if this gets his cholesterol more to target. He gets the most benefit from being on a statin.

I have arranged further review to see how he is getting on with his medications and once again apologies for the delay in this letter.

Kind regards

Yours sincerely

Authorised on 14/10/2015 11:29:35 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

(P) David Standish, 20 Canning Place, Dundee, DD3 7RT

**FBC**

| | | | | |
|---|---|---|---|---|
| **Hb** | | 133 | g/L | 130 - 180 |
| **WBC** | ***[HI]** | **15.2** | **$x10^9$/L** | **4.0 - 11.0** |
| **PLT** | ***[HI]** | **406** | **$x10^9$/L** | **150 - 400** |
| **RBC** | *[LO] | 4.48 | $x10^{12}$/L | 4.5 - 6.0 |
| **HCT** | | 0.417 | | 0.40 - 0.52 |
| **MCV** | | 92.9 | fl | 85 - 105 |
| **MCH** | | 29.7 | pg | 27 - 32 |
| **MCHC** | | 320 | g/L | 320 - 360 |
| **NE#** | ***[HI]** | **10.9** | **$x10^9$/L** | **2.0 - 7.5** |
| **LY#** | | 3.0 | $x10^9$/L | 1.5 - 4.0 |
| **MO#** | ***[HI]** | **1.0** | **$x10^9$/L** | **0.2 - 0.8** |
| **EO#** | | 0.32 | $x10^9$/L | 0.0 - 0.4 |
| **BA#** | | 0.1 | $x10^9$/L | 0.0 - 0.1 |

| | | | | |
|---|---|---|---|---|
| **TOTAL CHOLESTEROL** | ***[HI]** | **7.13** | **mmol/L** | **0.00 - 5.00** |
| **CREATINE KINASE** | | 280 | U/L | 40 - 320 |
| **GGT** | | 63 | U/L | 3 - 73 |
| **Urea & Electrolytes** | | | | |
| **SODIUM** | | 141 | mmol/L | 133 - 146 |
| **POTASSIUM** | | 5.1 | mmol/L | 3.5 - 5.3 |
| **UREA** | | 5.0 | mmol/L | 2.5 - 7.8 |
| **CREATININE** | | 83 | umol/L | 62 - 106 |
| **AKI** | | Not detected: but may not exclude AKI in all cases | . | |
| **Liver Function Tests (LFT)** | | | | |
| **ALT** | | 43 | U/L | 5 - 55 |
| **BILIRUBINS** | | 13 | umol/L | 0 - 21 |
| **ALKALINE PHOSPHATASE** | | 115 | U/L | 30 - 130 |
| **ALBUMIN** | | 37 | g/L | 35 - 50 |
| **ESTIMATED GFR** | | GT60 | mL/min | |
| **CKD Stage** | | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | . | |
| **TOTAL CHOL/HDL-CHOL** | | | | |
| **HDL-CHOLESTEROL** | | 1.34 | mmol/L | 0.60 - 2.50 |
| **TOTAL CHOL/HDL-CHOL** | | 5.30 | . | |

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Dr N Smeaton
Mill Practice
Arthurstone Medical Practice
DD4 6QY

| | |
|---|---|
| Date | 17/06/2015 |
| Clinic Date | 05/06/2015 |
| Your Ref | |
| Our Ref | JD/AH/ **0503700053** |
| Enquiries to | Abi Hamon |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | ahamon@nhs.net |

Dear Dr Smeaton

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

This 45 year old man has peripheral arterial disease, dyslipidemia and medication intolerance. I reviewed him in the clinic on 5/6/15. He has been keeping reasonably well. He has now phased in his tablets, and is taking them at half hourly intervals after lunch. This is suiting him, and he is no longer getting abdominal pain or odd visceral reactions. He has managed to add back Felodipine as well, at the 2.5 mg dose.

In the clinic he was well, and looked a lot more comfortable with himself and with life. His weight was stable at 100 kg and his blood pressure was satisfactory at 124/74.

This unorthodox resume is clearly suiting him, and I have made no further changes. I have arranged his clinic review for 3 months, but I have explained to him that if all is well at this next appointment we will extend the frequency of his review. He is happy with this. He is also aware that this future review will no longer be with me.

Kind regards

Yours sincerely

Authorised on 25/07/2015 18:14:51 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

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39 Arthurstone Terrace
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DD4 6QY

| | |
|---|---|
| Date | 19/05/2015 |
| Clinic Date | 08/05/2015 |
| Your Ref | |
| Our Ref | JD/CH/ **0503700053** |
| Enquiries to | Cheryl Hayes |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | chayes4@nhs.net |

Dear Dr Smeaton

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

This 45 year old man has peripheral arterial disease, dyslipidaemia, and medication intolerance. I reviewed him in the clinic on 08/05/15. He attended with his wife, and explained that he is feeling reasonably well. He is still sleeping satisfactorily. He has had no stomach pains. He managed to reintroduce both Clopidogrel and then Folic Acid without any real difficulty. However once he started Ezetimibe, he feels that his sleep deteriorated dramatically once more and he has discontinued this.

I didn't examine him on this occasion. We spent some time discussing our next approach. He is happy to keep trying adding tablets back gradually and is still taking these at lunchtime. He wondered about his calcium channel blocker, but my main concern is that he's not on any lipid prophylaxis. I have therefore suggested that he start Atorvastatin 10mg once daily again taking these at lunchtime and further to my hand note I am grateful to you for prescribing. If he can tolerate this and all is going well, we could then consider a calcium channel blocker and I would suggest Felodipine 2.5mg once daily as the smallest of a dihydropyridine. If however he has any concerns about this or matters aren't exactly straight forward I would be happy that he leave this until his next review. I think there is a certain momentum to be gained here from frequent review and reassurance, and so I have given him an appointment for four weeks.

Kind regards

Yours sincerely

Authorised on 25/05/2015 12:56:30 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

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Dr Nicola Smeaton
Mill Practice
Arthurstone Medical Practice
39 Arthurstone Terrace
Dundee
DD4 6QY

| | |
|---|---|
| Date | 24/04/2015 |
| Your Ref | |
| Our Ref | KW/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Smeaton

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I have the results of this gentleman's bloods coeliac IgA tissue transglutaminase test which is within normal limits.

Yours sincerely

Authorised on 04/05/2015 08:22:51 by Vascular Jill Belch.

**Dr Katherine Walesby**
**Speciality Registrar**

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Dr Nicola Smeaton
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DD4 6QY

| | |
|---|---|
| Date | 03/04/2015 |
| Clinic Date | 03/04/2015 |
| Your Ref | |
| Our Ref | KW/CH/ **0503700053** |
| Enquiries to | Cheryl Hayes |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | chayes4@nhs.net |

Dear Dr Smeaton

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Diagnosis:
1. Premature Peripheral Arterial Disease
2. Abdominal pain following medication/CT abdomen normal
3. Anxiety regarding abdominal pain related to medication

Medications: Amlodipine, Clopidogrel, Atorvastatin, Azetimibe, Fenobibrate, Lansoprazole, and Folic Acid.
***Please restart Clopidogrel, Atorvastatin, Folic acid and Lansoprazole (Fast tab)***

I reviewed this 45 year old gentleman in Dr Dick's vascular clinic, he attended with his partner. His CT abdomen was very reassuring which I informed him, but this unfortunately did not make him happy as he had hoped it would explain his symptoms of severe abdominal pain after taking his medication. He is very worried there is an underlying diagnosis for this. He doesn't feel there is one medication causing this, but all of them. He took Ibruprofen last week , I've advised him to take paracetamol instead. He is equally anxious he hasn't had his anti-platelets for many months now.

His pain occurs 20minutes after taking his medication, and he describes it as very severe over the epigastric, supra-pubic regions and radiating to the sides and back. He has had no change in his bowel habits.

I spent some time discussing the situation with him. Dr Dick was concerned about a psychological cause for his intolerance to medication. I did not go into this today as he did not appear amenable for this discussion today. Instead we discussed a way forward that may be a "trial and error" for him to see if small changes may help and stressed the positives of a normal CT abdomen in the first instance is reassuring. However, given he is folate deficient previously I have arranged a coeliac blood test along with his routine bloods to ensure a possible cause for atypical abdominal pain is not overlooked.

Following discussion we have agreed to try:
1. Restarting Clopidogrel, Lansoprazole and Atorvastatin, but to take this after his lunchtime medications in case this improves his symptoms
2. Please could you prescribe a fast tab Lansoprazole as this may overcome some of the symptoms he experiences with the capsules or tablets.
3. If he experiences pain I have advised him to persist for the first few days but instead try taking Paracetamol thirty minutes before taking his tablets at lunchtime
4. If the problem appears to be the tablet/capsule form we can review if some medication may be available in liquid form (he seemed amenable to this)
5. I have checked his bloods including a coeliac screen.
6. We can consider an OGD should all above fail and he remains focussed on a gastric abnormality

It may be in the future we need to look to other therapies to help him including CBT but I think currently he is not amenable for discussion about this and I hope that a step by step approach we might be able to manage his intolerance of tablets.

I have arranged for him to come back in one month to see Dr Dick.

Yours sincerely

Authorised on 08/04/2015 22:43:01 by Vascular Katherine Walesby.

**Dr Katherine Walesby**
**Speciality Registrar**

| | | | |
|---|---|---|---|
| **FBC** | | | |
| **Hb** | 140 | g/L | 130 - 180 |
| **WBC** | 8.0 | $x10^9$/L | 4.0 - 11.0 |
| **PLT** | 396 | $x10^9$/L | 150 - 400 |
| **RBC** | 4.75 | $x10^{12}$/L | 4.5 - 6.0 |
| **HCT** | 0.429 | | 0.40 - 0.52 |
| **MCV** | 90.3 | fl | 85 - 105 |
| **MCH** | 29.4 | pg | 27 - 32 |
| **MCHC** | 326 | g/L | 320 - 360 |
| **NE#** | 4.6 | $x10^9$/L | 2.0 - 7.5 |
| **LY#** | 2.6 | $x10^9$/L | 1.5 - 4.0 |
| **MO#** | 0.5 | $x10^9$/L | 0.2 - 0.8 |
| **EO#** | 0.18 | $x10^9$/L | 0.0 - 0.4 |
| **BA#** | 0.1 | $x10^9$/L | 0.0 - 0.1 |

| | | | |
|---|---|---|---|
| **MAGNESIUM** | | | |
| **MAGNESIUM** | 0.83 | mmoL/L | 0.70 - 1.00 |
| **PHOSPHATE** | | | |
| **PHOSPHATE** | 1.07 | mmoL/L | 0.8 - 1.5 |
| **Urea & Electrolytes** | | | |
| **SODIUM** | 139 | mmol/L | 133 - 146 |
| **POTASSIUM** | 4.9 | mmol/L | 3.5 - 5.3 |
| **UREA** | 5.4 | mmol/L | 2.5 - 7.8 |
| **CREATININE** | 74 | umol/L | 62 - 106 |
| **Liver Function Tests (LFT)** | | | |
| **ALT** | 46 | U/L | 5 - 55 |
| **BILIRUBINS** | 7 | umol/L | 0 - 21 |
| **ALKALINE PHOSPHATASE** | 100 | U/L | 30 - 130 |
| **ALBUMIN** | 38 | g/L | 35 - 50 |
| **Bone Group** | | | |
| **CALCIUM** | 2.38 | mmol/L | 2.10 - 2.55 |
| **CALCIUM (CORRECTED)** | 2.40 | mmol/L | 2.10 - 2.55 |
| **ESTIMATED GFR** | | | |
| **ESTIMATED GFR** | GT60 | mL/min | |
| **CKD Stage** | | | |
| **CKD Stage** | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | . | |
| **GLUCOSE** | | | |
| **GLUCOSE (preserved tube)** | 5.8 | mmol/L | 3.3 - 5.8 |
| **TSH** | | | |

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David Standish
20 Canning Place
Dundee
DD3 7RT

| | |
|---|---|
| Date | 30/03/2015 |
| Your Ref | |
| Our Ref | JD/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Mr Standish

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Further to your clinic visit I now have your CT scan result and reassuringly this is entirely normal. I will see you in the clinic as planned.

Yours sincerely

Authorised on 31/03/2015 18:33:16 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

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Dr Alistair Emslie-Smith
Mill Practice
Arthurstone Medical Practice
39 Arthurstone Terrace
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DD4 6QY

| | |
|---|---|
| Date | 30/03/2015 |
| Your Ref | |
| Our Ref | JD/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Emslie-Smith *Alistair*

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Further to my clinic letter I now have the results of this man's CT scan. There is a small perfusion defect in the liver, but this is otherwise normal with a normal gallbladder, pancreas, biliary tree and also normal spleen, kidneys and adrenal glands. In view of the rather vague symptoms, a full abdominal surveillance was undertaken and was reported by Dr Duncan as being normal. I have written to the patient with this reassuring result and he will be reviewed as planned.

Kind regards

Yours sincerely

*John*
Authorised on 31/03/2015 18:33:04 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

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Dr AM Emslie-Smith
Mill Practice
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39 Arthurstone Terrace
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| | |
|---|---|
| Date | 09/02/2015 |
| Clinic Date | 30/01/2015 |
| Your Ref | |
| Our Ref | JD/AH/ **0503700053** |
| Enquiries to | Abi Hamon |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | ahamon@nhs.net |

Dear Dr Emslie-Smith *Alistair*

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

This 44 year old man has premature peripheral arterial disease, and is now suffering side effects from various medications. I reviewed him in the clinic on 30/01/15. He volunteered a rather nervous and anxious feeling in his stomach when he was taking folic acid, but was tolerating this. However when he started taking Ezetimibe, he got severe abdominal pain and cramp radiating down his right side and right flank. He tried on and off the drug several times over the past few weeks, and replicated this symptom every time. He himself wondered if it might be an ulcer, but it is more likely that this is gallstone related. David is as you know rather difficult to assess, but I think it would be worthwhile getting an upper abdominal CT scan to make sure that we are not missing any occult pathology. The outcome of this will dictate our approach to his multiple intolerances. I have given him a review appointment for 6 weeks and asked him to stay on folic acid meantime.

Kind regards

Yours sincerely

*John*
Authorised on 25/02/2015 19:56:34 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

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Dr AM Emslie-Smith
Mill Practice
Arthurstone Medical Practice
39 Arthurstone Terrace
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DD4 6QY

| | |
|---|---|
| Date | 07/01/2015 |
| Clinic Date | 12/12/2014 |
| Your Ref | |
| Our Ref | JD/CH/ **0503700053** |
| Enquiries to | Cheryl Hayes |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | chayes4@nhs.net |

Dear Dr Emslie-Smith *Alastair*

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

This 44 year old man has premature peripheral arterial disease. I reviewed him in the clinic on 12/12/2014. This was an expedited appointment created by him telephoning the appointments secretary. He is once again struggling with various aspects of his medication, and is now convinced that Amlodipine keeps him awake, and that Clopidogrel is contributing to his right iliac fossa pain. He has therefore stopped all his medication.

In the clinic he was very anxious but otherwise much the same. His blood pressure was reasonable at 135/80. His weight was up 1.5kg at 100kg.

He is still off the cigarettes by using his E- cigarette device. He reported a classical side effect of Rosuvastatin, mainly myalgia. He only managed this tablet for about ten days before having to discontinue it. I have suggested that he re-start his folic acid and his Ezetimibe 10mg od. The former should do no harm, and indeed if he gets side effects with folic supplementation this would place him on a different track regarding his symptoms. The Ezetimibe is not systemically absorbed, and its side effect profile is extremely low. I was slightly concerned leaving him off anti-platelet drugs, but we will do this for now to see how he gets on. I have given him a review appointment for six weeks.

Kind regards

Yours sincerely

*John*
Authorised on 14/01/2015 17:51:47 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

Medicine and Cardiovascular Group
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Dr AM Emslie-Smith
Mill Practice
Arthurstone Medical Practice
39 Arthurstone Terrace
Dundee
DD4 6QY

| | |
|---|---|
| Date | 07/11/2014 |
| Clinic Date | 10/10/2014 |
| Your Ref | |
| Our Ref | JD/CH/ **0503700053** |
| Enquiries to | Cheryl Hayes |
| Extension | 32407 |
| Direct Line | 01382 632407 |
| Email | chayes4@nhs.net |

Dear Dr Emslie-Smith *Alasdair*

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

This 44 year old man has premature peripheral arterial disease. I reviewed him in the clinic on 10/10/14. He has been having a really difficult time with his medication of late, in particular with insomnia. He was quite open that he had switched to your practice from his previous GP because of disagreements about this. On his own behalf he did various internet searches, and eventually came to the conclusion that his insomnia might be related to his lipid lowering therapy. Ten days before I saw him, he stopped his Atorvastatin, Fenofibrate and Ezetimibe, and also his Amlodipine as he was thinking that the latter was causing some GI upset. He has had a dramatic response to this, with prompt return to very nearly full sleep.

I didn't examine him on this occasion, but spent quite a lot of time going over his medications and how to take things forward. I have suggested he take a one month holiday, until everything is back on a more even keel. He could then re-introduce the Ezetimibe, which isn't systemically absorbed and is unlikely to be giving him the insomnia. After a further month of this, he could then attend you and see if he can manage Rosuvastatin 5mg once daily. I have explained to him that this is water soluble rather than lipid soluble, and produces fewer in the way of central side effects. He is happy to give this a try. In terms of his GI problems, this might be the Fibrate rather than the Amlopdipine. It's up to him whether or not he retries the Amlodipine in the interim. This was quite a full discussion, and we agreed that we would park his leg symptoms for now until this was all resolved. He continues on his folic acid and Clopidogrel as before, and I have given him a review appointment for three months.

Kind regards

Yours sincerely

*John*
Authorised on 12/11/2014 17:51:11 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

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Dr MC Duffy
Park Avenue Medical Centre
Park Avenue
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DD4 6PP

| | |
|---|---|
| Date | 26/06/2014 |
| Clinic Date | 06/06/2014 |
| Your Ref | |
| Our Ref | CB/AH/ **0503700053** |
| Enquiries to | Abigail Hamon |
| Extension | 33480 |
| Direct Line | 01382 660111 |
| Email | ahamon@nhs.net |

Dear Dr Duffy

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I reviewed your patient in clinic with peripheral arterial disease. As you know he has a right common femoral artery endarterectomy and his left leg demonstrated unreconstructable disease. This left leg claudication is static. What is new is pain in his right leg in particular his right groin. I note ultrasound demonstrated no sign of a hernia and this is a different quality of pain to his previous claudication pain and radiates from his groin down to into his inner thigh where there has been some chronic swelling. He walks with an unusual gait following his peripheral arterial disease, in any case certainly there has been some increased pain in his back and his right hip recently. I want to make sure it is not musculoskeletal in origin first and I have arranged an x-ray of his hip and lumbar spine. On receipt of results, we may proceed to an MRI scan of his groin but I certainly do not think this is vascular in origin.

We discussed again the electronic cigarette as he stopped using this due to scare stories in the press. We have reiterated our advice from a vascular perspective that this is a preferable form of nicotine delivery rather than cigarettes and he is going to reinvestigate this.

Once we get to the bottom of his right groin pain it may be worth reconsidering Cilostazol as an option for this gentleman's ongoing treatment. I will do this when we see him back in clinic in due course.

Kind regards

Yours sincerely

Authorised on 26/06/2014 14:58:41 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

Radiology Examination 5358775: 06 Jun 2014 11:14

**XR Pelvis**

**XR Pelvis**

Clinical History :

Severe pain right hip and groin
Radiates down front of thigh
Recent back pain
Abnormal gait pattern due to peripheral arterial disease
Recently developed antalgic gait
?evidence of significant OA
ENTERED BY: Colin Baines (medical)
BLEEP: 01382 633883

x-ray pelvis.
. Mild bilateral symmetrical osteoarthritis noted
No other significant feature

. X-ray lumbar spine.
lumbar spine demonstrates normal appearances

DR RUSSELL DAVIES (MEDICA) / RDAVIES

Medicine and Cardiovascular Group
Medicine Directorate
Acute Services Division
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Dr MD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

| | |
|---|---|
| Date | 07/11/2013 |
| Clinic Date | 18/10/2013 |
| Your Ref | |
| Our Ref | JD/DO/ **0503700053** |
| Enquiries to | Debbie Orr |
| Extension | 33480 |
| Direct Line | 01382 660111 |
| Email | d.orr@nhs.net |

Dear Dr Davage

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

This 43 year old man has peripheral arterial disease. I reviewed him in the clinic on 18/10/13. His walking is much the same. He is still struggling with cigarettes, and can't seem to get below six per day. He tried Champix, but this made him feel terrible. His other complaint in the clinic was of feeling fatigued and enervated. He has attended you with this, and routine screening has proved unrewarding.

In the clinic he was much the same. His weight was up 2kg at 96kg. His blood pressure was 112/66.

I note his recent blood tests, and that his cholesterol has risen a little. On direct questioning, he revealed that he had relaxed his diet and I have advised him to tighten up on this once more, and haven't altered his lipid lowering medication. We did discuss E-cigarettes, and although the nicotine still has an action on platelets, this would be better for him than a conventional smoking habit. He will therefore investigate this further. In terms of his other symptoms, I did wonder about his mental state and his sleep pattern. I would suggest switching his Escitalopram to Mirtazapine, initially 30mg at night. This can be titrated upwards or downwards as required. The main advantage of this is to get a better nights sleep, but also the titratability. Further to my hand note I am grateful to you for taking this forward. I have left the rest of his medications unchanged, and have given him a review appointment for 6 months.

Kind regards

Yours sincerely

Authorised on 07/11/2013 19:13:24 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

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David Standish
20 Canning Place
Dundee
DD3 7RT

| | |
|---|---|
| Date | 14/06/2013 |
| Your Ref | |
| Our Ref | JD/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Mr Standish

Further to your clinic visit I now have your blood results. These show your cholesterol is just above 4, with your target actually being 4. We could consider swapping your statin round in due course, but there is no urgency for this. As before, your outstanding residual risk is related to cigarettes and I wish you well with this. We will see you in the clinic as planned.

Yours sincerely

Authorised on 15/06/2013 15:34:51 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

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|---|---|
| Date | 14/06/2013 |
| Your Ref | |
| Our Ref | JD/WB/ **0503700053** |
| Enquiries to | Wendy Burns |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Davage

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

Further to my clinic letter this man's blood results are now to hand and show a normal routine chemistry, liver group, GGT and CK. His lipid profile shows a cholesterol of 4.3, hdl 1.3 (ratio 3.4) and non fasting triglycerides 1.2.

This man's target cholesterol is less than 4. However he is already on Atorvastatin, Ezetemibe and Fenofibrate. The next step would be to consider replacing the Atorvastatin with Rosuvastatin, but we will discuss the pros and cons of this move when he is next reviewed. As before, his outstanding risk factor remains his smoking habit. I have written to him with these results and he will be reviewed in the clinic as planned.

Kind regards

Yours sincerely

Authorised on 15/06/2013 15:34:18 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

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| | |
|---|---|
| Date | 14/05/2013 |
| Clinic Date | 26/04/2013 |
| Your Ref | |
| Our Ref | JD/KH/ **0503700053** |
| Enquiries to | Kirsty Hannan |
| Extension | 33480 |
| Direct Line | 01382 660111 |
| Email | k.hannan@nhs.net |

Dear Dr Davage

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

This 43 year old man has peripheral arterial disease. I reviewed him in the clinic on 26/04/2013. His main problem is that he continues to smoke. He has not attended any of the no smoking services, and he is still struggling with this. He did manage off for about 3 weeks under his own steam, and noted his walking distance improving when he did so. However he relapsed reasonably quickly. I pointed out to him that he has 4 times the chance of staying off cigarettes if we help him rather than him simply going ”cold turkey”. I have given him a smoke free card, there is also currently a booth manned in the hospital and I hope that he will go and attend this. I have rechecked his lipid profile and will write again with this result; we may well need to increase the potency of his statin therapy. I have given him a review appointment for 6 months.

Yours sincerely

Authorised on 17/05/2013 19:18:19 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

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Dr MD Davage
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| | |
|---|---|
| Date | 14/01/2013 |
| Clinic Date | 21/12/2012 |
| Your Ref | |
| Our Ref | CB/DO/ **0503700053** |
| Enquiries to | Debbie Orr |
| Extension | 33480 |
| Direct Line | 01382 660111 |
| Email | d.orr@nhs.net |

Dear Dr Davage

**David Standish, 20 Canning Place, Dundee, DD3 7RT DOB: 05/03/1970**

I reviewed your patient with his peripheral arterial disease. He is aware that there is no interventional option at this stage and he continues to get pain at around 10-15 metres which causes him to stop after about 10-15 minutes although he has only covered around 200 yards in this time. He has noticed some modest improvement in his right leg following intervention but his left leg would not be suitable for femoral bypass at this stage.

Please note his cholesterol is 4.94 with the target for peripheral arterial disease being 3.5 he could increase his Atorvastatin.

Unfortunately he is still smoking and I have given him the Tayside Smoke Free Service's contact details today and hopefully he will manage to stop.

If he does manage to stop there may be some rationale in trying Cilostazol to see if this has an effect on improving his walking distance and for that reason I have arranged follow up at clinic.

Kind regards

Yours sincerely

Authorised on 14/01/2013 16:12:32 by Vascular Colin Baines.

**Dr Colin Baines**
**Staff Grade Physician**

Medicine and Cardiovascular Group
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Mrs A MacKenzie
No Smoking Service
Health Shop
Ninewells Hospital

| | |
|---|---|
| Date | 11/07/2012 |
| Your Ref | |
| Our Ref | JD/DO/ **0503700053** |
| Enquiries to | Debbie Orr : |
| Extension | 33480 |
| Direct Line | 01382 660111 |
| Email | d.orr@nhs.net |

Dear Mrs MacKenzie *Audrey*

**David Standish, 16 Hillbank Place, Dundee, DD3 7BE DOB: 05/03/1970**

I would be grateful if you could see this 42 year old premature arteriopath in your no smoking clinic.

This man presented in 2010 with bilateral claudication at around 50 metres. From the anatomical point of view, the right leg was treatable with a right common femoral endarterectomy and a vein patch, with a right superficial femoral artery angioplasty. The left side would require a femoral popliteal bypass, and is being managed conservatively at present. In terms of his blood work, he has a significant hyperlipidaemia in which he is being treated with triple therapy, and a modestly elevated homocysteine for which he is being treated with folic acid.

David's outstanding risk factor is his inability to get off cigarettes. He would be very grateful for any support that you are able to give him as he hasn't had much success with a community based programme thus far. Of note, he is on Escitalopram, with his other medication being Clopidogrel, Amlodipine, Lansoprazole, Folic acid, Ezetimibe, Atorvastatin and Fenofibrate. Thank you for your help.

Kind regards.

Yours sincerely

*John*
Authorised on 11/07/2012 16:40:21 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

Medicine and Cardiovascular Group
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Dr MD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

| | |
|---|---|
| Date | 11/07/2012 |
| Clinic Date | 22/06/2012 |
| Your Ref | |
| Our Ref | JD/DO/ **0503700053** |
| Enquiries to | Debbie Orr |
| Extension | 33480 |
| Direct Line | 01382 660111 |
| Email | d.orr@nhs.net |

Dear Dr Davage

**David Standish, 16 Hillbank Place, Dundee, DD3 7BE DOB: 05/03/1970**

This 42 year old man has premature aretiopathy and has had surgical intervention on the right leg. He still has claudication in his left leg. I reviewed him in the clinic on 22/06/12. Matters are much the same today, with no real change in his symptoms. He is still smoking five cigarettes per day.

In the clinic he was well. His weight was stable at 93kg and blood pressure satisfactory at 113/70. Unfortunately there was a fire alarm at the time of his clinic visit, and so we didn't check his bloods. There aren't any in the ICE system; his last cholesterol in September '11 was 5.6 though with the rest of the profile satisfactory.

David therefore continues on his folic acid supplements, Amlodipine, Clopidogrel and Lansoprazole, together with Ezetimibe, Atorvastatin, and Fenofibrate for his lipids. He is also still taking a small dose of Escitalopram. Smoking is really the outstanding risk factor for him and he is well aware of this but finds it very difficult. His wife attended with him, and she is supportive and frustrated in equal measures. I have therefore referred him to Audrey Mackenzie in the hospital no smoking service to see if she can help him any further. He will be reviewed in the clinic in 6 months time.

Yours sincerely

Authorised on 11/07/2012 16:39:20 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

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| | |
|---|---|
| Date | 29/03/2011 |
| Clinic Date | 16/03/2011 |
| Your Ref | |
| Our Ref | JD/DO/ **0503700053** |
| Enquiries to | Debbie Orr |
| Extension | 33480 |
| Direct Line | 01382 660111 |
| Email | d.orr@nhs.net |

Dear Dr Davage

**David Standish, 9 Mansion Drive, Dundee, DD4 9DD DOB: 05/03/1970**

This 41 year old man has premature arteriopathy and has had surgical intervention on the right leg. I reviewed him in the clinic on 16/03/11. He has been keeping well. He has had a good result from his intervention. He does have some reactive oedema early on, but this is settling with rest and his right leg is now asymptomatic. It is still a little early to gauge how the left leg is responding, but there are good collaterals and he may not need intervention on this side.

In the clinic he was well. His weight was up a little at 92.5kg and blood pressure satisfactory at 117/65. His right foot was warm and well perfused with hirsute toes in and intact skin.

Thank you for checking this man's lipid profile prior to the clinic. Unfortunately his cholesterol was still not at target (4). Although there are some dietary indiscretions, mostly around chocolate, I explained to him that this is largely due to his liver making too much cholesterol. As he is already on a statin and Ezetimibe combination, the next thing to do is to add a fibrate. I have checked his baseline bloods (CK and TSH etc) but would recommend adding Fenofibrate 200mg od to his Atorvastatin 40mg and Ezetimibe 10mg od. Further to my hand note I am grateful to you for prescribing.

The only other problem is that he has gone back to having the occasional cigarette. He is aware that this represents a slippery slope and his wife in particular is clearly very distressed that he has done this. He is aware of the lack of the durability of the intervention if he does keep smoking, and also that he will not collateralise his left leg satisfactorily. I will leave this with him.

He is due surgical review at the end of May, and so I will see him myself in 6 months.

Kind regards

Yours sincerely

Authorised on 30/03/2011 18:22:30 by John Dick.

**Dr John Dick**

**Consultant Physician**

(P) Mr J Nagy, Consultant Vascular Surgeon , Dept of Vascular Surgery , Ninewells Hospital

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| | |
|---|---|
| Date | 25/04/2011 |
| Your Ref | |
| Our Ref | JD/WB/ **0503700053** |
| Enquiries to | Wendy Burns : |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Davage

**David Standish, 9 Mansion Drive, Dundee, DD4 9DD DOB: 05/03/1970**

Further to my clinic letter this man's baseline bloods are now to hand and show an ALT of 69 and GGT of 82 but otherwise normal routine chemistry, liver group, CK and TSH. This is all acceptable for now. Once he has been on the fibrate, statin and Ezetemibe combination for 6 weeks or so he should have repeat blood tests comprising LFT, GGT, CK and cholesterol hdl and triglycerides. I would be grateful if I could leave this for your practice nurse. He will be reviewed as planned.

Yours sincerely

Authorised on 25/04/2011 17:39:36 by John Dick.

**Dr John Dick**
**Consultant Physician**

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Bruce Short Solicitors
3 Rattray Street
Dundee DD1 1NA

| | |
|---|---|
| Date | 24/06/2011 |
| Your Ref | |
| Our Ref | JD/WB/ **0503700053** |
| Enquiries to | Wendy Burns : |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Sirs

**David Standish, 9 Mansion Drive, Dundee, DD4 9DD DOB: 05/03/1970**

I have been asked to prepare a report on the current medical status of this 41 year old man.

This man is an arteriopath, an unusual condition in someone of his age, despite a previous smoking habit. He presented to the vascular service with bilateral progressive claudication, and given his age had extensive work up of his cardiovascular risk factors. Apart from his smoking habit, he had an elevated cholesterol, and an elevated homocysteine. The former is treated by statin therapy and the latter by a vitamin supplement. He also has a significant family history in that his father had his first heart attack at the age of 43.

In view of the potential for generalised arteriopathy, an isotope heart scan was arranged but this was reassuringly normal. This man therefore proceeded to intervention, and in February 2011 had a right common femoral endarterectomy and vein patch, with a right superficial femoral artery angioplasty. This was technically a very successful procedure, and at subsequent clinic review he had normal lower limb pulses on the right. He did get some reactive oedema after the procedure, but this has settled. Unfortunately being able to walk long distances has revealed worsening symptoms on the left leg. Intervention on this side will require a bypass procedure. This is currently under review.

From a cardiovascular risk point of view, he was last reviewed in March. His cholesterol was not quite at target, and he will require triple therapy (statin, ezetemibe, fibrate) to bring this down. His blood pressure was satisfactory and he continues on inhaler therapy for background airways disease.

This man's current activities of daily living are limited by his left leg claudication. He is opening up collaterals on this side and may not require intervention. This will be decided at his next clinic review. It is more difficult to estimate this man's long term prognosis. Risk calculator engines do not work well in individuals with cardiovascular disease at this young age, particularly where there is a strong family history. Although we are treating this man's homocysteine, it is not particularly elevated and I suspect that it is not a major inherited issue for premature cardiovascular risk. In part this may well be due to his cholesterol (which was 7.3 prior to any treatment) though I suspect also may be related to some as yet undetected but inherited factor from his father. It is however somewhat reassuring that he had no problems with surgery, and that his myocardial perfusion scan is normal.

He remains under active review by the vascular team in Ninewells.

Dr John Dick, FRCP Ed
Consultant Physician Vascular Team

Authorised on 24/06/2011 11:23:03 by Vascular John Dick.

Medicine and Cardiovascular Group
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David Standish
4 Keats Place
Dundee
DD3 6QH

| | |
|---|---|
| Date | 07/11/2011 |
| Your Ref | |
| Our Ref | JD/WB/ **0503700053** |
| Enquiries to | Wendy Burns : |
| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Mr Standish

Further to your clinic visit I now have your blood results. The background bloods are satisfactory. Your cholesterol is much the same. However, hidden within this, you now have slightly more of the hdl ('good' cholesterol) and less of the ldl ('bad' cholesterol). These are therefore satisfactory for the present. With luck your cholesterol levels will go down a little further with time. We will see you in the clinic as planned.

Yours sincerely

Authorised on 09/11/2011 15:33:21 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

Medicine and Cardiovascular Group
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| Date | 07/11/2011 |
| Your Ref | |
| Our Ref | JD/WB/ **0503700053** |
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| Extension | 33883 |
| Direct Line | 01382 633883 |
| Email | w.burns@nhs.net |

Dear Dr Davage

**David Standish, 4 Keats Place, Dundee, DD3 6QH DOB: 05/03/1970**

Further to my clinic letter this man's blood results are now to hand. His routine chemistry, liver group, GGT and CK are normal. His cholesterol is 5.6 with an hdl of 2.0 ( ratio 2.7) and triglycerides 1.0.

Although his total cholesterol isn't that much better, his hdl has risen a little which will be of benefit in terms of the overall profile. In addition he is now on triple lipid lowering therapy. I think we have to accept this for just now though I would hope that matters will improve if he tightens up on lifestyle issues as well. I haven't therefore suggested any changes to his medication at this stage and he will be reviewed in the clinic as planned.

Yours sincerely

Authorised on 09/11/2011 15:32:44 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

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Dr MD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
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| | |
|---|---|
| Date | 07/10/2011 |
| Clinic Date | 22/09/2011 |
| Your Ref | |
| Our Ref | JD/DO/ **0503700053** |
| Enquiries to | Debbie Orr |
| Extension | 33480 |
| Direct Line | 01382 660111 |
| Email | d.orr@nhs.net |

Dear Dr Davage

**David Standish, 4 Keats Place, Dundee, DD3 6QH DOB: 05/03/1970**

This 41 year old man has premature arteriopathy and has had surgical intervention on the right leg. He is left with claudication of his left leg. I reviewed him in the clinic on 22/09/11. He has been keeping reasonably well apart from his claudication. Unfortunately he has gone back to cigarette smoking, with two recent bereavements in the family plus the death of his dog. He currently has a pain threshold of around 20 metres on the left, variable walk through pain, and no obvious conditioning. He is aware that being back on cigarettes is spectacularly bad for this and plans to tackle this shortly.

In the clinic he was otherwise well. His weight was up a little at 96kg. His blood pressure was 144/85 on arrival, settling to 124/66. He is now on Atorvastatin, Ezetimbe and Fenofibrate for his lipid profile, and continues on Clopidogrel, Citalopram and inhalers as before. I have rechecked his lipid profile and will write again with these results. Assuming they are satisfactory, I would just leave him for the next 6 months and see if he collateralises further once he manages to get off the cigarettes again. I have therefore given him a review appointment for 6 months.

Yours sincerely

Authorised on 12/10/2011 18:12:58 by Vascular John Dick.

**Dr John Dick**
**Consultant Physician**

# Operational Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

22 august 2011
clinic Date: 11/08/2011
Dictation Date: 11/08/2011
Your Ref: (CHI:0503700053)
Our Ref: PAS/WJ/0503700053
Enquiries to: Ward 12 OP Office
Telephone: 01382 660111
Extension: 33889

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

Dear Dr Davage,

**David Standish, 050370-0053**
**4 Keats Place, Dundee, DD3 6QH**

I reviewed this gentleman in clinic today. Following Mr Griffith's recent letter I have had a discussion with him about the pro's and con's of intervention. My personal biased is that when we are using other than single segment good quality long saphenous vein we have to think very carefully about this. I think if he had that then it would not be unreasonable at this stage to consider a femoro popliteal bypass graft. Unfortunately he would require at least 2 segments of vein, one of them not from the long saphenous vein, in which the patency rates are significantly worse. Given his relatively young age and his expectations, I do not think an operation is not going to have a reasonable expectation of lasting many years is a good idea. He accepts this. Clearly it does leave him with a degree of disability. Hopefully his risk factors are all adequately dealt with, I have noticed he has been seeing Dr Dick and has stopped smoking. I would be more than happy to review him again should he request it, but otherwise I have discharged him from clinic.

Yours sincerely

**Peter A Stonebridge, ChM FRCS Edin, FRCP Edin**
**Professor of Vascular Surgery**

# Operational Unit

Surgical Directorate
Vascular Surgery Unit
Ward 12
Ninewells Hospital
Dundee
www.nhstayside.scot.nhs.uk

31 may 2011
Date: 31/05/2011
Dictation Date: 30/05/2011
Your Ref:
(CHI:0503700053)
Our Ref:
GDG/GS/0503700053
Enquiries to: Ward 12 Office
Extension: 33889
Telephone: 01382 633889

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

Further to Professor Stonebridge's recent letter this patient's right long saphenous vein is of reasonable size from the groin to the mid lower thigh but reduces in size distal to that. The left long saphenous vein is small proximally but becomes reasonable calibre from the mid thigh to the knee. Both short saphenous veins are reasonable. We will see him in clinic.

Yours sincerely

**Gareth Griffiths**
**Consultant Vascular Surgeon**

# Operational Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
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22 april 2011
clinic Date: 20/04/2011
Dictation Date: 20/04/2011
Your Ref: (CHI:0503700053)
Our Ref: PAS/WJ/0503700053
Enquiries to: Ward 12 OP Office
Telephone: 01382 660111
Extension: 40444

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

I reviewed this gentleman following his recent right common femoral endarterectomy, vein patch and right superficial femoral artery angioplasty. Unfortunately this has now uncovered claudication affecting his left leg which he tells me is stopping him getting back to his work. His recent angiogram showed he had a long superficial femoral artery occlusion on the left hand side which necessitates a fem above knee popliteal bypass graft. I also note he continues to smoke. We have had a conversation about this. He is very keen to consider even further surgery but one of the difficulties with one operation going well, the patient's expect every operation to go well, this is not always the case. I have organised a vein scan to see if there is a suitable long saphenous vein for the above operation. Should he have a good one, given his thoughts on the subject, I suspect we will be proceeding to intervention. Should he not have a good vein then all that would be left with a prosthetic graft with it's intendant increased risks. I am not sure this is a good idea, but clearly its an eye for a debate with the patient. Clearly none of this is a particularly good idea if he continues to smoke. I will see him once his scan has been performed.

Yours sincerely

**Peter A Stonebridge, ChM FRCS Edin, FRCP Edin**
**Professor of Vascular Surgery**

# Operational Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

10 march 2011
Clinic Date: 09/03/2011
Dictation Date: 09/03/2011
Your Ref: (CHI:0503700053)
Our Ref: JN/WJ/0503700053
Enquiries to: Ward 12 OP Office
Telephone: 01382 660111
Extension: 33889

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

I reviewed this gentleman at clinic today. In February 2011 he underwent a right common femoral endarterectomy from which he made a good recovery. Unfortunately he presented at clinic today having noticed for the past week that at the end of the day his leg was swollen on the right requiring elevation. He has been exercising quite vigorously according to himself and his partner.

On examination he had normal lower limb pulses on the right. His wounds have healed. There were no clinical signs of infection, no calf tenderness. Duplex scan excluded a deep vein thrombosis with normal femoral and popliteal veins and calf veins all clear of thrombus. The common femoral artery was widely patent with triphasic flow. Nothing untoward was discovered on these investigations. It is possible that with vigorous exercise he has induced some swelling in the leg that was previously under-perfused. We will review this gentleman in 4-6 weeks time.

Yours sincerely

**John Nagy**
**Consultant Vascular Surgeon**

# Operational Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

04 march 2011
Date: 21/02/2011
Dictation Date: 21/02/2011
Your Ref: (CHI:0503700053)
Our Ref: JN/WJ/0503700053
Enquiries to: Ward 12 OP Office
Telephone: 01382 660111
Extension: 33889

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

Date of Admission: 13 02 11

Date of Discharge: 16 02 11

Operation: Right common femoral endarterectomy and vein patch and right SFa angioplasty

Follow Up: Vascular Clinic 6 weeks

LSA Code: 35 02 06

This patient was admitted electively for a right common femoral endarterectomy and vein patch and a further right SFa angioplasty. The above procedures were carried out on the 14th of February, 2011. He made an uneventful post-operative recovery. We will review him at clinic in approximately 6 weeks time.

Yours sincerely

**John Nagy**
**Consultant Vascular Surgeon**

# Operational Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

16 december 2010
Clinic Date: 15/12/2010
Dictation Date: 15/12/2010
Your Ref: (CHI:0503700053)
Our Ref:
GDG/WJ/0503700053
Enquiries to: Ward 12 OP Office
Telephone: 01382 660111
Extension: 33889

Private and Confidential
Mr David Standish
9 Mansion Drive
Dundee
DD4 9DD

Dear Mr Standish,

You will need to stop your Clopidogrel tablets for a full week before the operation. You will get notification of this through the post, but I just wanted to let you know ahead of time. You should continue on the Aspirin throughout.

Yours sincerely

**Gareth Griffiths**
**Consultant Vascular Surgeon**

# Operational Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

16 december 2010
Clinic Date: 15/12/2010
Dictation Date: 15/12/2010
Your Ref: (CHI:0503700053)
Our Ref:
GDG/WJ/0503700053
Enquiries to: Ward 12 OP Office
Telephone: 01382 660111
Extension: 33889

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

I saw this patient for review today. He continues to complain of bilateral calf claudication at 25-50 metres, if anything his right leg is worse and he does notice some numbness in his right toes when he has his claudication pain but there is no night or rest pain. He is however significantly limited by his symptoms. There is no history of ischaemic heart disease and I note a recent Tetrofosmin scan which was normal. He does get some dyspnoea on exertion probably due to his asthma. There is no history of cerebro vascular disease, chronic kidney disease or diabetes. He is treated for hypertension and hypocholesterolaemia. He is on Aspirin and Clopidogrel and smokes 2 cigarettes a day. His MR angiogram shows a right common femoral stenosis and a short right superficial femoral occlusion amenable to common femoral endarterectomy and SFa angioplasty. The left side would require a femoro popliteal bypass. I have had a long discussion with him and his partner today about the risks of treatment, including those of limb loss, morbidity and mortality and he has decided to go ahead after due consideration. We have agreed that his right leg is worse and in particular as this is the lesser intervention we should start on this leg and I have told him that we would reconsider the whole situation before doing anything to the left leg. I have therefore listed him for a right common femoral endarterectomy and superficial femoral angioplasty. He will need to stop his Clopidogrel for a full week pre-operatively.

Yours sincerely

**Gareth Griffiths**
**Consultant Vascular Surgeon**

Copy to:

w/l

# Operational Unit

Surgical Directorate
Vascular Surgery Unit
Ward 12
Ninewells Hospital
Dundee
www.nhstayside.scot.nhs.uk

27 october 2010
Date: 27/10/2010
Your Ref:
(CHI:0503700053)
Our Ref: GS/GS/0503700053
Enquiries to: Ward 12 Office
Extension: 33889
Telephone: 01382 633889

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

Date of procedure: 14 10 10

Procedure: MR angiogram

Date of MDM: 20 10 10

Follow up plans: Mr Nagy's clinic 15 11 10

This patient attended for MR angiography for claudication. His films were discussed at our multi disciplinary meeting (full report available on Central Vision) and he will be reviewed in clinic with the results in due course.

Yours sincerely

**Gaynor Scott**
**Vascular Unit Secretary**

# Operational Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

27 september 2010
Clinic Date: 22/09/2010
Dictation Date: 22/09/2010
Your Ref: (CHI:0503700053)
Our Ref: GC/WJ/0503700053
Enquiries to: Ward 12 OP Office
Telephone: 01382 660111
Extension: 33889

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

I reviewed this patient with bilateral calf claudication at clinic today with his arterial duplex scan result. I also note that Dr Dick has assessed and addressed his risk factors. The arterial duplex shows normal aorto iliac segments. In the right leg a significant stenosis involving the distal common femoral extending to the origin of the profunda femoris artery. There appears to be a 6cm occlusion of the SFA at the adductor. In the left leg the superficial femoral artery is occluded with reconstitution at the adductor. As stated in Mr Nagy's last letter, this gentleman's pattern of arterial disease would require mainly surgery to correct with some components amenable to angioplasty. I have explained this to Mr Standish today along with the risks involved. He is keen for further investigation and intervention if possible, therefore I have requested an MRA and he will be reviewed in clinic with these results.

Yours sincerely

**Gill Crowe**
**Vascular Specialist Nurse**
**NHS Tayside**

Copy to:

Dr J Dick, Consultant Physician, Ward 4, Ninewells

# Operational Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

16 august 2010
Misc Date: 30/07/2010
Dictation Date: 30/07/2010
Your Ref: (CHI:0503700053)
Our Ref: JN/WJ/0503700053
Enquiries to: Ward 12 OP Office
Telephone: 01382 660111
Extension: 33889

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

This patient with bilateral calf claudication at 50 metres has now had an arterial duplex. This shows normal aorto iliac segments. In the right leg a significant stenosis involving the distal common femoral extends into the origin of the profunda femoris artery. There appears to be a 6cm occlusion of the SFa at the adductor. In the left leg the superficial femoral artery is occluded with reconstitution at the adductor. This gentleman's pattern of arterial disease would require mainly surgery to correct with some components amenable to angioplasty. At this point in time I think it is important to get his risk factors under control and Charge Nurse Crowe has referred the gentleman on to Dr Dick. To investigate his arterial disease in more detail would require an MR angiogram and would require a significant series of interventions to resolve. We will review this patient at clinic in due course.

Yours sincerely

**John Nagy**
**Consultant Vascular Surgeon**

# Operational Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
DUNDEE DD1 9SY
www.nhstayside.scot.nhs.uk

28 june 2010
Clinic Date: 25/06/2010
Dictation Date: 25/06/2010
Your Ref: (CHI:0503700053)
Our Ref: GC/WJ/0503700053
Enquiries to: Ward 12 OP Office
Telephone: 01382 660111
Extension: 33889

Dr MorganD Davage
Park Avenue Medical Centre
Park Avenue
Dundee
DD4 6PP

Dear Dr Davage,

**David Standish, 050370-0053**
**9 Mansion Drive, Dundee, DD4 9DD**

Thank you for referring this gentleman who complains of bilateral calf claudication at around 50 yards which is alleviated after stopping walking for approximately 10 minutes. He denies any rest pain. There is some toe numbness on the right foot but this can happen occasionally just on standing. He has had no previous arterial treatment and has no history of ischaemic heart disease. He does have asthma which he uses his inhalers for as required. There is no history of cerebro vascular disease, diabetes or hypertension. He currently smokes 10-15 cigarettes per day and is currently on a statin but not an anti-platelet agent.

On examination his upper limb pulses were normal. His blood pressure was 117/72, his random sugar 6.4 and his BMI 26. With the exception of both popliteals I was able to palpate all remaining leg pulses bilaterally. There is no sign of ischaemia in his feet. His ankle brachial indices are 0.56 on the right and 0.51 on the left, falling to 0.31 and 0.20 respectively after exercise.

I believe his symptoms are that of intermittent claudication and have requested an arterial duplex scan and we will review him with these results.

As Dave is only 40 years of age I have discussed his case with Dr Dick, Vascular Physician today at clinic and we have taken bloods for thrombophillia screening and Dr Dick will arrange to see him with these results.

Yours sincerely

**Gill Crowe, Vascular Specialist Nurse to**
**John Nagy, Consultant Vascular Surgeon**

Copy to:

Dr J Dick, Consultant Physician, Ward 4, Ninewells

# Tayside Out of Hours Service OOH Call Incident Report

| | | | |
|---|---|---|---|
| Call number: | **11251** | Receive Date: | **2-Apr-2018 10:03** |
| Patient's Name: | **David Standish** | | |
| Date of birth: | **5-Mar-1970 ( 48 years )** | Gender: | **M** |
| Address: | **6 Dargarvel Gardens Ormiston Crescent Dundee DD4 0UQ** | Current Address: | **6 Dargarvel Gardens Ormiston Crescent Dundee DD4 0UQ** |
| Return Contact No: | | | |
| Tel No: | **07402 993659** | | **07402 993659** |
| Mobile No: | | | |
| Priority: | **NHS24 Advised (Info Only)** | Call Origin: | **NHS24** |
| Received: | **2-Apr-2018 10:03** | Calltype: | **NHS24 Advised (Info Only)** |
| Advised: | **10:05** | Arrived PCC: | |
| Cons start: | | Cons End: | |
| Consulting Doctor: | | Own doctor: | |

Reported Condition:

**DENTAL PAIN**

Followups:

**None**

NHS24 details:

Disposition - **Accident & Emergency (ASAP)**

| | | | |
|---|---|---|---|
| Ward/Clinic | 3/4 | CHI | 0503700053 |
| Hospital | Ninewells Hospital | Surname | STANDISH |
| Clinician | Thomas MacDonald | First Name | DAVID |
| Specialty | CLINICAL PHARMACOLOGY & THERAPEUTICS | Address | 6 DARGARVEL GARDENS<br>ORMISTON CRESCENT<br>DD4 0UQ |
| Date | 07/12/2021 | GP/Address | Coldside Medical Practice<br>129 Strathmartine Road<br>Dundee<br>DD3 8DB |

Dear Doctor,

The above patient was reviewed today; please accept this brief communication.

Provisional/Diagnosis is: FH & IHD

Comment/Recommendations: Angina still an issue. increaseisoprolol to 2.5 mg bd. If does not tolerate try isosorbide (he has PVD)

Follow up by clinic required: Yes

Follow up by clinic required: 6/12

Specific Monitoring Required: No
The following treatment is recommended:

| | Medication | Dose | Frequency | Indication | Duration |
|---|---|---|---|---|---|
| 1. | bisoprolol 2.5mg | 2.5mg | BD | Angina | cont |

Is any Medication to be discontinued: No

Surgical Directorate
Urology Department
NHS Tayside

Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Mr David Standish
20 Canning Place
Dundee
DD3 7RT

| | |
|---|---|
| Date | 22/05/2014 |
| Your Ref | |
| Our Ref | AM/CO/ **0503700053** |
| Enquiries to | Urology : 12/05/2014 |
| Extension | 35119 |
| Direct Line | |
| Email | |

Dear Mr Standish

Further to your doctors referral with potential kidney stones I have now seen the results of the CT scan that we organised and you will be pleased to know this does not show any sign of any blockage to the kidneys or any sign of kidney stones. It may well be that if your symptoms have completely settled that a small stone has been passed. However if you do have ongoing symptoms I would ask you in the first instance to visit your GP. As there are no stones on the current scan I won't be planning to see you in the Urology Clinic.

Yours sincerely

Authorised on 29/05/2014 21:56:04 by Andrew Martindale.

**Mr Andrew Martindale**
**Consultant Urological Surgeon**

(D) Dr MD Davage, Park Avenue Medical Centre, Park Avenue, Dundee, DD4 6PP

## BOOKING DETAILS

| | | | |
|---|---|---|---|
| CLINIC: | Ix Only-CTSS | | |
| DATE: | 11/04/2014 | SCREENED BY: | Andrew Martindale:Sc |
| SPECIALTY: | T101H_CB | BOOKED IN TOPAS: | Yes |
| ORIGINAL URGENCY: | Routine | LATEST URGENCY: | Urgent |
| URGENCY CHANGE REASON: | renal colic | | |
| INSTRUCTIONS: | Discussed with Dr Davage; happy not to send him up as emergency at present but will if symptoms increase. | | |
| SUGGESTED CLINICIAN: | None selected | | |
| CLINICAL INSTRUCTIONS: | None entered | | |

REFERRAL LETTER

MEDICAL IN CONFIDENCE

NHS Tayside

| Hospital use only | Clinic | Day Date | Time | Hospital No. |
|---|---|---|---|---|
| | | | | |

**Transport required?**

# REFERRAL LETTER

MEDICAL IN CONFIDENCE

**REFERRAL TO**

UrologyCB
TAY General Referral

— **Consultant / receiving practitioner** and/or **specialty clinic**

Ninewells Hospital
Dundee
DD1 9SY

— **Hospital** and **hospital address**

Hospital unit no.: T101H

Email address: -

**Date of Referral (set by referrer)** 10-Apr-2014

**Date referral was submitted** 10-Apr-2014

**Urgency of referral** Routine

**Armed Forces Personnel, Immediate Families & Veterans**

- ☐ On active service
- ☐ Condition related to service
- ☐ Immediate family member

**Impairment(s)**

- ☐ Learning
- ☐ Visual
- ☐ Hearing

**Miscellaneous**

- ☐ Requires support of a translator

**PATIENT DETAILS**

| | |
|---|---|
| **Surname** | STANDISH |
| **Forename(s)** | DAVID |
| Title | MR |
| Sex | Male |
| **Date of birth** | 05-Mar-1970 |
| CHI no. | 0503700053 |

**Patient's address**

20 CANNING PLACE
DUNDEE
DD3 7RT

Contact number(s)

Voice: 07551494079

**REGISTERED GP DETAILS**

| | | | |
|---|---|---|---|
| **Name** | Dr Morgan Davage | | |
| GMC code | 6031035 | GP code | 70271 |
| Practice name | Park Avenue Medical Centre | | |
| Practice code | 11005 | | |

**Practice address**

PARK AVENUE
DUNDEE

Cor

Voice: 01382462222

**REFERRING PRACTITIONER DETAILS**

| | | | |
|---|---|---|---|
| **Name** | Dr Morgan Davage | | |
| GMC code | 6031035 | GP code | 70271 |
| Practice name | Park Avenue Medical Centre | | |
| Practice code | 11005 | | |

**Practice address**

PARK AVENUE
DUNDEE

Cor

Voice: 01382462222

| | |
|---|---|
| **Periods of Future Unavailability** | None provided. |

## CLINICAL INFORMATION

### History of presenting complaint / examination findings / investigation results

**Presenting complaint**

Description: likely left renal colic

Comment: I would be grateful for your opinion on this gentleman who has been having intermittent problems over the last 2 weeks with excruciating left flank pain. His description is very suggestive of renal colic. I saw him this week in surgery in distress, he had been 'on all fours' crawling around at home. This episodic pain tends to settle for a few days then suddenly recur. I gave him an IM voltarol injection and his pain subsided over 24 hours. Urinalysis was clear. I would be grateful for your further investigation and management as appropriate

**Examinations and Investigations**

Cigarette smoker: Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 6. 07-Nov-2013

Alcohol consumption: Drinking status on eventdate: Current drinker, Units of alcohol drank per week: 1. 16-May-2008

### Most recent height, weight, BMI and Blood Pressure

| | | | | |
|---|---|---|---|---|
| Height: | 1.81 | m | Recorded Date: | None provided |
| Weight: | 95 | Kg | Recorded Date: | None provided |
| BMI: | 28.9 | $Kg/m^2$ | Recorded Date: | None provided |
| Blood Pressure: | 140/80 | mmHg | Recorded Date: | None provided |

### Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

### Past medical history

**Pre-existing conditions**

| Description | Laterality | Modifier | Extension | Date of onset |
|---|---|---|---|---|
| Ischaemic heart disease | - | - | - | 13-Feb-2011 |
| Peripheral vascular disease NOS | - | - | - | 13-Sep-2010 |
| Acid reflux | - | - | post prandial and supine with delayed clearance | 18-Feb-2002 |
| Asthma NOS | - | - | - | 08-May-1996 |

**Past procedures**

| Description | Laterality | Modifier | Date performed |
|---|---|---|---|
| Medication requested | - | - | 07-Mar-2014 |
| Medication requested | - | - | 06-Feb-2014 |
| Medication requested | - | - | 07-Jan-2014 |
| Medication requested | - | - | 03-Dec-2013 |
| Smoking cessation advice | - | - | 07-Nov-2013 |
| Had a chat to patient | - | - | 11-Oct-2013 |
| Medication requested | - | - | 03-Sep-2013 |
| Medication requested | - | - | 02-Aug-2013 |
| Medication requested | - | - | 01-Jul-2013 |
| Medication requested | - | - | 07-Jun-2013 |
| Referral to smoking cessation advisor | - | - | 13-May-2013 |
| Medication requested | - | - | 10-May-2013 |
| Lipid lowering therapy | - | - | 02-Aug-2010 |

### Current and recent medication

**Current repeat medication**

| Drug name | BNF code | Formulation | Dosage | Frequency | Course started | Duration |
|---|---|---|---|---|---|---|
| Fenofibrate micronised 200mg capsules | 86192020 | capsule | TAKE ONE DAILY | - | 21-Mar-2011 | - |
| Salbutamol 100micrograms/dose inhaler CFC free | 59554020 | dose | INHALE 2 DOSES AS NEEDED | - | 17-Jun-2010 | - |
| Ezetimibe 10mg tablets | 76979020 | tablet | TAKE ONE DAILY | - | 19-Oct-2010 | - |
| Atorvastatin 40mg tablets | 83945020 | tablet | TAKE ONE DAILY | - | 02-Aug-2010 | - |
| Folic acid 5mg tablets | 59305020 | tablet | TAKE ONE DAILY | - | 13-Sep-2010 | - |
| Clopidogrel 75mg tablets | 83784020 | tablet | TAKE ONE ONCE DAILY | - | 13-Sep-2010 | - |
| Amlodipine 5mg tablets | 88863020 | tablet | TAKE ONE DAILY | - | 13-Sep-2010 | - |
| Lansoprazole 30mg gastro-resistant capsules | 75584020 | capsule | TAKE ONE ONCE DAILY | - | 13-Sep-2010 | - |

**Recent acute medication (last 30 days)**

| Drug name | BNF code | Formulation | Dosage | Frequency | Course started | Duration |
|---|---|---|---|---|---|---|
| Tramadol 50mg capsules | 75786020 | capsule | 1 CAPSULE 4 HOURLY WHEN REQUIRED. | - | 08-Apr-2014 | - |
| Diazepam 2mg tablets | 58980020 | tablet | 2 TABS UP TO BD (MAX FOUR DAI[more] | - | 08-Apr-2014 | - |

**Clinical warnings**

**Additional relevant information**

**Administrative information**

Referred By:Registered GP

**Signature** of referring doctor (or other professional)

**Date**

| Hospital use only | Clinic | Day Date | Time | Hospital No. |
|---|---|---|---|---|
| | | | | |

| Transport required? | **REFERRAL LETTER**<br>MEDICAL IN CONFIDENCE | **Unique Care Pathway Number**<br>101025660509C |
|---|---|---|

**REFERRAL TO**

| | | |
|---|---|---|
| Vascular SurgeryC12<br>TAY General Referral v6.2 | ——— | **Consultant / receiving practitioner** and/or **specialty clinic** |
| Ninewells Hospital<br>Dundee<br>DD1 9SY | ——— | **Hospital** and **hospital address**<br>Hospital unit no.<br>T101H<br>Email address<br>- |

| | | | |
|---|---|---|---|
| **Date of Referral (set by referrer)** | 24-Feb-2022 | **Armed Forces Personnel, Immediate Families & Veterans** | **Remote Consulting** Patient can manage: |
| **Date referral was submitted** | 24-Feb-2022 | ☐ On active service<br>☐ Condition related to service<br>☐ Immediate family member | Video consultation: Not Known<br>Telephone consultation: Not Known |
| **Urgency of referral** | Routine | | |

| **PATIENT DETAILS** | | **Patient's address** |
|---|---|---|
| **Surname** | STANDISH | 6 DARGARVEL GARDENS<br>ORMISTON CRESCENT<br>DUNDEE<br>DD4 0UQ |
| **Forename (s)** | DAVID | |
| Title | MR | |
| Sex | Male | |
| **Date of birth** | 05-Mar-1970 | Contact number(s) |
| CHI no. | 0503700053 | Voice: 07402 993659 |

| **REGISTERED GP DETAILS** | | | | **Practice address** |
|---|---|---|---|---|
| **Name** | Dr Fiona Bullions | | | 129 STRATHMARTINE ROAD<br>DUNDEE |
| GMC code | 4738066 | GP code | 70939 | |
| Practice name | Coldside Medical Practice | | | |

| | | | |
|---|---|---|---|
| Practice code | 11166 | | Contact number(s) |
| | | | Voice: 01382880900 |

| REFERRING PRACTITIONER DETAILS | | | | | Practice address |
|---|---|---|---|---|---|
| **Name** | Dr. Fiona Bullions | | | | 129 Strathmartine Road<br>Dundee |
| GMC code | 4738066 | GP code | 70939 | | |
| Practice name | Coldside Medical Practice (11166) | | | | |
| Practice code | 11166 | | | | Contact number(s) |
| | | | | | Voice: 01382 880900 |

| | |
|---|---|
| **Periods of Future Unavailability** | None provided. |

| | |
|---|---|
| **Additional Support Needs** | No known ASN requirements. |

CLINICAL INFORMATION

## History of presenting complaint / examination findings / investigation results

### Presenting complaint

Description: Ongoing claudication and leg pain.

Comment: This 50 year old chap with severe arterial disease would be grateful for an appointment for review in the vascular clinic. He was being seen until he had an MI in 2016 and feels that 'nobody was interested' in his leg pain after he had the heart attack. I assured him this was not the case. He has ongoing claudication and leg pain, and reports that when his beta blockers were recently increased this made things considerably worse. In fact, he is unable to continue on the advised increased dose. Also, he reports that every few months when his leg pain gets bad, he stops his beta blockers altogether and this resolves the leg pain, albeit temporarily, and he generally restarts them in a month or so. Many thanks for seeing him - in the interim I would be grateful for any advice regarding medication that may benefit him.

### Examinations and Investigations

| | | |
|---|---|---|
| Ex smoker: | Smoking status on date of event: Ex-smoker. | 23-Feb-2022 |
| Stopped drinking alcohol: | Drinking status on eventdate: Ex-drinker. | 23-Feb-2022 |
| Avoids even trivial exercise: | due to pain in both legs with peripheral vascular disease | 23-Feb-2022 |

## Most recent height, weight, BMI and Blood Pressure

| | | | | |
|---|---|---|---|---|
| Height: | 1.76 | m | Recorded Date: | None provided |
| Weight: | 99.6 | Kg | Recorded Date: | None provided |
| BMI: | 31.4 | $Kg/m^2$ | Recorded Date: | None provided |
| Blood Pressure: | 118/68 | mmHg | Recorded Date: | None provided |

## Reason for referral

Care type requested: Out Patient

Expected outcome: Investigate

## Past medical history

### Pre-existing conditions

| Description | Laterality | Modifier | Extension | Date of onset |
|---|---|---|---|---|
| Familial hypercholesterolaemia | - | - | - | 13-Jul-2018 |
| Acute non-ST segment elevation myocardial infarction | - | First ever | /VF arrest - stents to RCA/Ostial | 16-Nov-2016 |
| Gastritis and duodenitis | - | - | with small single erosion in stomach, needs to continue PPI (gastroscopy) | 01-Dec-2015 |
| Head injury | - | - | - | 28-Sep-2015 |
| Aggressive behaviour | - | - | - removed from prev doc | 20-Jun-2014 |
| Low mood | - | - | - | 10-May-2013 |
| Peripheral vascular disease NOS | - | Continuing | - | 16-Mar-2011 |
| Intermittent claudication | - | - | - | 25-Jun-2010 |
| Nondependent cannabis abuse | - | - | - | 01-Jan-2005 |

| | | | | |
|---|---|---|---|---|
| Asthma | - | - | - | 03-Mar-2004 |
| Acid reflux | - | - | - post prandial & supine with delayed clearance | 18-Feb-2002 |
| Chest pain | - | - | - probably abdominal | 20-Nov-2001 |
| Chest pain | - | - | - echo normal | 05-Jan-2001 |
| Measles | - | - | - | 04-Feb-1985 |
| Cocaine type drug dependence | - | - | - | 01-Jan-1985 |
| Behavioural problem | - | - | at school | 10-Dec-1984 |
| Greenstick fracture | - | - | left | 18-May-1983 |

**Past procedures**

| Description | Laterality | Modifier | Date performed |
|---|---|---|---|
| Gene studies | - | - | 08-May-2018 |

## Current and recent medication

### Current repeat medication

| Drug name | BNF code | Formulation | Dosage | Frequency | Course started | Duration |
|---|---|---|---|---|---|---|
| Zopiclone 7.5mg tablets | 72416020 | tablet | 1 TABLET AT NIGHT | - | 06-Jan-2017 | - |
| Salbutamol 100micrograms/dose inhaler CFC free | 59554020 | dose | 1 TO 2 PUFFS UP TO FOUR TIMES [more] | - | 03-Jun-2015 | - |
| Folic acid 5mg tablets | 59305020 | tablet | 1 TABLET ONCE A DAY | - | 03-Jun-2015 | - |
| Bisoprolol 2.5mg tablets | 83178020 | tablet | 1 TABLET (S) TWICE A DAY | - | 09-Dec-2021 | - |
| Escitalopram 20mg tablets | 53823020 | tablet | ONE TABLET ONCE A DAY | - | 15-Mar-2019 | - |
| Alirocumab 150mg/1ml solution for injection pre-filled disposable devices | 60215021 | pre-filled disposable injection | ONE EVERY TWO WEEKS BEING TOL [more] | - | 07-Jun-2018 | - |
| Lansoprazole 30mg gastro-resistant capsules | 75584020 | capsule | 1 CAPSULE TWICE DAILY | - | 19-Apr-2016 | - |
| Aspirin 75mg tablets | 72648020 | tablet | ONE TO BE TAKEN EVERY MORNING | - | 01-Dec-2016 | - |
| Ramipril 2.5mg capsules | 72675020 | capsule | 1 CAPSULE | - | 01-Dec-2016 | - |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | IN THE MORNING | | | |
| Glyceryl trinitrate 400micrograms/dose pump sublingual spray | 62987020 | dose | ONE OR TWO SPRAYS UNDER THE T [more] | - | 01-Dec-2016 | - |

**Recent acute medication (last 30 days)**

| Drug name | BNF code | Formulation | Dosage | Frequency | Course started | Duration |
|---|---|---|---|---|---|---|
| Zopiclone 7.5mg tablets | 72416020 | tablet | 1 TABLET AT NIGHT | - | 06-Jan-2017 | - |
| Salbutamol 100micrograms/dose inhaler CFC free | 59554020 | dose | 1 TO 2 PUFFS UP TO FOUR TIMES [more] | - | 03-Jun-2015 | - |

**Clinical warnings**

**Additional relevant information**

**Administrative information**

Referred By:Registered GP

**Signature** of referring doctor (or other professional) **Date**

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053 Consultant: Dr C Baines
Patient Name : STANDISH, David Ward 4
Investigation: Segmental Pressures Out-patient Dept
Date of study: 01/06/2016 Ninewells Hospital

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Referral details:
Out-patient referral. Increased right leg claudication symptoms. Previous right CFA endarterectomy with vein patch and right SFA angioplasty.

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 130 | 134 |
| Posterior Tibial | 110 | 92 |
| Dorsalis Pedis | 80 | 84 |
| Ankle/Brachial Pressure Index | 0.82 | 0.68 |

Report:
Patient states bilateral claudication - increase in right leg symptoms. Known left SFA occlusion. However, patient wouldn't walk for exercise test
Scan report attached.

LS/MMcC

Previous results:

| Date | Right Ankle | Left Ankle | Right ABPI | Left ABPI |
|---|---|---|---|---|
| 06/03/2013 | 128 | 84 | 0.98 | 0.76 |
| 16/03/2012 | 118 | 74 | 1.07 | 0.67 |
| 11/08/2011 | 140 | 90 | 1.04 | 0.67 |
| 24/06/2011 | 112 | 70 | 0.86 | 0.61 |
| 10/05/2011 | 120 | 70 | 0.95 | 0.55 |
| 09/03/2011 | 136 | 90 | 1.17 | 0.77 |

end of report

---

Authorised: 09/06/2016 18:38 RAR Date of study: 01/06/2016

| | | |
|---|---|---|
| 140670R3 | 278 | 487 |

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053 Consultant: Dr C Baines
Patient Name : STANDISH, David Ward 4
Investigation: Artery Scan Out-patient Dept
Date of study: 01/06/2016 Ninewells Hospital

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Referral details:
Out-patient referral. Increased right leg claudication symptoms. Previous right CFA endarterectomy with vein patch and right SFA angioplasty.

| | Right | Left |
|---|---|---|
| Aorto/Iliac Segment | <Not assessed> | <Not assessed> |
| Femoro/Popliteal Segment | See report text | <Not assessed> |
| Runoff | <Not assessed> | <Not assessed> |

Report:
The CFA, including endarterectomy site, and proximal PFA are widely patent with strong biphasic flow. Approximately 10cm occlusion of the SFA in the upper thigh, large collateral noted. The distal SFA and popliteal are patent with monophasic flow.

LS*

end of report

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Authorised: 09/06/2016 18:38 RAR Date of study: 01/06/2016
140670R0 278 487

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053
Patient Name : STANDISH, David
Investigation: Segmental Pressures
Date of study: 06/03/2013

Consultant: Mr G Griffiths
Vascular OUT-patients
Ward 12
Ninewells Hospital

---

Referral details:
Routine surveillance - 2yr post right CFA endarterectomy with vein patch and right SFA angioplasty

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 130 | 130 |
| Posterior Tibial | 128 | 100 |
| Dorsalis Pedis | 120 | 84 |
| Ankle/Brachial Pressure Index | 0.98 | 0.76 |

| Post-Exercise Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 164 | |
| Ankle | 60 | 54 |
| Ankle/Brachial Pressure Index | 0.36 | 0.32 |

Exercise Test
Treadmill Speed: 4Kph Inclination: 10.0%
Treadmill time: 01:00

Report:
Patient describing increasing left leg claudication and discomfort at in right leg, however does not wish referral back to clinic.
Scan report attached
Follow up discontinued

MMcC / SMc

Previous results:

| Date | Right Ankle | Left Ankle | Right ABPI | Left ABPI |
|---|---|---|---|---|
| 16/03/2012 | 118 | 74 | 1.07 | 0.67 |
| 11/08/2011 | 140 | 90 | 1.04 | 0.67 |
| 24/06/2011 | 112 | 70 | 0.86 | 0.61 |
| 10/05/2011 | 120 | 70 | 0.95 | 0.55 |
| 09/03/2011 | 136 | 90 | 1.17 | 0.77 |
| 18/05/2010 | 70 | 64 | 0.56 | 0.51 |

end of report

---

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053 Consultant: Mr G Griffiths
Patient Name : STANDISH, David Vascular OUT-patients
Investigation: Surveillance Scan Ward 12
Date of study: 06/03/2013 Ninewells Hospital

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Referral details:
Routine surveillance - 2yr post right CFA endarterectomy with vein patch and right SFA angioplasty

Report:
Minimal hyperpalsia persists at the CFA endarterectomy site. Strong triphasic flow in the proximal SFA. Stenosis in the distal SFA persists.
Patient c/o discomfort in the right leg however does not require referral to clinic at this point. Is due to see Dr Dick on 26/3/13 and will discuss symptoms then.#
Minimal reduction in resting ABPI.
Follow up discontinued.

SMc/ RAR

end of report

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Authorised: 08/03/2013 18:04 RAR Date of study: 06/03/2013
102952R13 114 404

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053 Consultant: Mr G Griffiths
Patient Name : STANDISH, David Vascular OUT-patients
Investigation: Segmental Pressures Ward 12
Date of study: 16/03/2012 Ninewells Hospital

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Referral details:
Routine surveillance - 1 yr post right CFA endarterectomy with vein patch and right SFA angioplasty

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 110 | 102 |
| Posterior Tibial | 118 | 74 |
| Dorsalis Pedis | 104 | 56 |
| Ankle/Brachial Pressure Index | 1.07 | 0.67 |

| Post-Exercise Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 132 | |
| Ankle | 52 | 32 |
| Ankle/Brachial Pressure Index | 0.39 | 0.24 |

Exercise Test
Treadmill Speed: 4Kph Inclination: 10.0%
Treadmill time: 01:00

Report:
Scan report attached.
Follow up appointment to be made for March 2013.

SMc/ MMcC

Previous results:

| Date | Right Ankle | Left Ankle | Right ABPI | Left ABPI |
|---|---|---|---|---|
| 11/08/2011 | 140 | 90 | 1.04 | 0.67 |
| 24/06/2011 | 112 | 70 | 0.86 | 0.61 |
| 10/05/2011 | 120 | 70 | 0.95 | 0.55 |
| 09/03/2011 | 136 | 90 | 1.17 | 0.77 |
| 18/05/2010 | 70 | 64 | 0.56 | 0.51 |

end of report

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Authorised: 21/03/2012 11:51 RAR Date of study: 16/03/2012
101591R3 114 404

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053 Consultant: Mr G Griffiths
Patient Name : STANDISH, David Vascular OUT-patients
Investigation: Surveillance Scan Ward 12
Date of study: 16/03/2012 Ninewells Hospital

---

Referral details:
Routine surveillance - 1 yr post right CFA endarterectomy with vein patch and right SFA angioplasty

Report:
The endarterectomy site is widely patent, good runoff with triphasic flow in the proximal SFA.
Next review March 2013

RAL

end of report

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Authorised: 21/03/2012 11:51 RAR Date of study: 16/03/2012
101591R13 114 404

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053 Consultant: Mr G Griffiths
Patient Name : STANDISH, David Vascular OUT-patients
Investigation: Surveillance Scan Ward 12
Date of study: 11/08/2011 Ninewells Hospital

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Referral details:
Routine surveillance- 5/12 post right CFA endarterectomy and vein patch and right SFA angioplasty

Report:
The right CFA is widely patent with triphasic flow demonstrated.
Patient continues to c/o groin swelling, no obvious abnormalitiy detected.

DM

end of report

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Authorised: 11/08/2011 13:47 RAL Date of study: 11/08/2011
94783R13 114 404

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053
Patient Name : STANDISH, David
Investigation: Segmental Pressures
Date of study: 11/08/2011

Consultant: Mr G Griffiths
Vascular OUT-patients
Ward 12
Ninewells Hospital

---

Referral details:
Routine surveillance- 5/12 post right CFA endarterectomy and vein patch and right SFA angioplasty

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 134 | 128 |
| Posterior Tibial | 140 | 90 |
| Dorsalis Pedis | 128 | 82 |
| Ankle/Brachial Pressure Index | 1.04 | 0.67 |

| Post-Exercise Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 150 | |
| Ankle | 92 | 52 |
| Ankle/Brachial Pressure Index | 0.61 | 0.34 |

Exercise Test
Treadmill Speed: 4Kph Inclination: 10.0%
Treadmill time: 01:00

Report:
Right groin swelling still evident. Patient describing left leg claudication.
Follow up appointment to be made for February 2012

MMcC / SMc

Previous results:

| Date | Right Ankle | Left Ankle | Right ABPI | Left ABPI |
|---|---|---|---|---|
| 24/06/2011 | 112 | 70 | 0.86 | 0.61 |
| 10/05/2011 | 120 | 70 | 0.95 | 0.55 |
| 09/03/2011 | 136 | 90 | 1.17 | 0.77 |
| 18/05/2010 | 70 | 64 | 0.56 | 0.51 |

end of report

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Authorised: 11/08/2011 13:47 RAL Date of study: 11/08/2011
94783R3 114 404

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053 Consultant: Mr G Griffiths
Patient Name : STANDISH, David Vascular OUT-patients
Investigation: Surveillance Scan Ward 12
Date of study: 24/06/2011 Ninewells Hospital

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Referral details:
Routine surveillance - patient asked for early review, some groin swelling

Report:
The endarterectomy site is widely patent with triphasic flow. Spontaneous phasic flow in the femoral veins right groin. The site of swelling was examined, no abnormality seen.

RAL

end of report

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Authorised: 27/06/2011 13:24 RAL Date of study: 24/06/2011
95455R13 114 404

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053
Patient Name : STANDISH, David
Investigation: Segmental Pressures
Date of study: 24/06/2011

Consultant: Mr G Griffiths
Vascular OUT-patients
Ward 12
Ninewells Hospital

---

Referral details:
Routine surveillance - patient asked for early review, some groin swelling

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 130 | 122 |
| Posterior Tibial | 112 | 080 |
| Dorsalis Pedis | 112 | 70 |
| Ankle/Brachial Pressure Index | 0.86 | 0.61 |

| Post-Exercise Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 136 | |
| Ankle | 114 | 38 |
| Ankle/Brachial Pressure Index | 0.83 | 0.27 |

Exercise Test
Treadmill Speed: 4Kph Inclination: 10.0%
Treadmill time: 01:00

Report:
Strong pedal signals.
Scan report attached.
Follow up appointment to be made for 3/12.

SMc

Previous results:

| Date | Right Ankle | Left Ankle | Right ABPI | Left ABPI |
|---|---|---|---|---|
| 10/05/2011 | 120 | 70 | 0.95 | 0.55 |
| 09/03/2011 | 136 | 90 | 1.17 | 0.77 |
| 18/05/2010 | 70 | 64 | 0.56 | 0.51 |

end of report

---

Authorised: 27/06/2011 13:24 RAL Date of study: 24/06/2011
95455R3 114 404

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053 Consultant: Mr G Griffiths
Patient Name : STANDISH, David Vascular OUT-patients
Investigation: Vein Scan Ward 12
Date of study: 10/05/2011 Ninewells Hospital

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Referral details:
Routine surveillance -2/12 post right CFA endarterectomy + Vein scan for possible bypass.

| | Right | Left |
|---|---|---|
| Scan Site | Lower limb | Lower limb |

Report:
The right LSV is >3mm in calibre from the groin to the mid / lower thigh but reduces in size distally. The left LSV is small calibre proximally but becomes reasonable calibre (>3mm) from the mid thigh to knee level. Both SSVs are reasonable calibre if composite considered.

SS.

end of report

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Authorised: 10/05/2011 16:45 RAL Date of study: 10/05/2011
92902R4 114 404

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053
Patient Name : STANDISH, David
Investigation: Segmental Pressures
Date of study: 10/05/2011

Consultant: Mr G Griffiths
Vascular OUT-patients
Ward 12
Ninewells Hospital

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Referral details:
Routine surveillance -2/12 post right CFA endarterectomy + Vein scan for possible bypass.

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 124 | 126 |
| Posterior Tibial | 120 | 70 |
| Dorsalis Pedis | 112 | 60 |
| Ankle/Brachial Pressure Index | 0.95 | 0.55 |

| Post-Exercise Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 126 | |
| Ankle | 60 | 34 |
| Ankle/Brachial Pressure Index | 0.47 | 0.26 |

Exercise Test
Treadmill Speed: 4Kph Inclination: 10.0%
Treadmill time: 01:00

Report:
Scan report attached.
Follow up appointment to be made for 6/52.

SMc/ MMcC

Previous results:

| Date | Right Ankle | Left Ankle | Right ABPI | Left ABPI |
|---|---|---|---|---|
| 09/03/2011 | 136 | 90 | 1.17 | 0.77 |
| 18/05/2010 | 70 | 64 | 0.56 | 0.51 |

end of report

---

Authorised: 10/05/2011 16:45 RAL Date of study: 10/05/2011
92902R3 114 404

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053 Consultant: Mr G Griffiths
Patient Name : STANDISH, David Vascular OUT-patients
Investigation: Surveillance Scan Ward 12
Date of study: 10/05/2011 Ninewells Hospital

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Referral details:
Routine surveillance -2/12 post right CFA endarterectomy + Vein scan for possible bypass.

Report:
Right side: the CFA is widely patent with strong triphasic flow, no significant disease seen. Minimally elevated velocities in the SFA at previous angioplasty site (distal thigh).

The patient reports no problems regarding his right leg. Next follow up in 3/12.

SS.

end of report

---

Authorised: 10/05/2011 16:45 RAL Date of study: 10/05/2011
92902R13 114 404

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053 Consultant: Mr J Nagy
Patient Name : STANDISH, David Vascular OUT-patients
Investigation: Vein Scan Ward 12
Date of study: 09/03/2011 Ninewells Hospital

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Referral details:
Out - patient referral, seen from SOPD. On routine surveillance post right CFA endarterectomy. Swollen and painful right leg, ?DVT.

| | Right | Left |
|---|---|---|
| Scan Site | Lower limb | Not examined |

Report:
The right femoro popliteal segment is widely patent with spontaneous phasic flow, no evidence of DVT seen.

PF

end of report

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Authorised: 11/03/2011 15:01 RAL Date of study: 09/03/2011
92714R4 220 377

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053 Consultant: Mr J Nagy
Patient Name : STANDISH, David Vascular OUT-patients
Investigation: Segmental Pressures Ward 12
Date of study: 09/03/2011 Ninewells Hospital

---

Referral details:
Out - patient referral, seen from SOPD. On routine surveillance post right CFA endarterectomy. Swollen and painful right leg, ?DVT.

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 116 | 116 |
| Posterior Tibial | 136 | 90 |
| Dorsalis Pedis | 130 | 88 |
| Ankle/Brachial Pressure Index | 1.17 | 0.77 |

| Post-Exercise Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 134 | |
| Ankle | 128 | 88 |
| Ankle/Brachial Pressure Index | 0.95 | 0.65 |

Exercise Test
Treadmill Speed: 2Kph Inclination: 10.0%
Treadmill time: 02:00

Report:
Scan reports attached
Reduced exercise at patient request - finds it difficult to walk faster due to right ankle pain
Follow up appointment to be made for May 2011

MMcC / SMc / PF

Previous results:

| Date | Right Ankle | Left Ankle | Right ABPI | Left ABPI |
|---|---|---|---|---|
| 18/05/2010 | 70 | 64 | 0.56 | 0.51 |

end of report

---

Authorised: 11/03/2011 15:01 RAL Date of study: 09/03/2011
92714R3 220 377

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053 Consultant: Mr J Nagy
Patient Name : STANDISH, David Vascular OUT-patients
Investigation: Surveillance Scan Ward 12
Date of study: 09/03/2011 Ninewells Hospital

---

Referral details:
Out - patient referral, seen from SOPD. On routine surveillance post right CFA endarterectomy. Swollen and painful right leg, ?DVT.

Report:
The right CFA is widely patent with triphasic flow.
Next follow up to be arranged for May'11.

PF

end of report

---

Authorised: 11/03/2011 15:01 RAL Date of study: 09/03/2011
92714R13 220 377

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053 Consultant: Mr G Griffiths
Patient Name : STANDISH, David Vascular IN patient
Investigation: Surveillance Scan Ward 12
Date of study: 15/02/2011 Ninewells Hospital

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Referral details:
Inpatient on ward 12 - post right CFA endarterectomy with vein patch and angioplasty of distal SFA stenosis

Report:
The femoral endarterectomy site is widely patent. Triphasic flow in the SFA, mild disease at the plasty site in the lower thigh, no significant residual stenosis seen.
ABPIs were not performed - vein harvesting site lower calf.
Next review in 6 weeks.

RAL

end of report

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Authorised: 15/02/2011 17:19 RAL Date of study: 15/02/2011
92136R13 114 27

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053 Consultant: Mr J Nagy
Patient Name : STANDISH, David Vascular OUT-patients
Investigation: Artery Scan Ward 12
Date of study: 19/07/2010 Ninewells Hospital

---

Referral details:
Out-patient referral - bilateral claudication
reduced ABPI

| | Right | Left |
|---|---|---|
| Aorto/Iliac Segment | See report text | See report text |
| Femoro/Popliteal Segment | See report text | See report text |
| Runoff | See report text | See report text |

Report:
Normal calibre aorta. No significant aorto iliac disease.
Right leg. significant stenosis of the distal CFA extending to involve the origin of the PFA. The proximal SFA is patent there is however a 6 cm occlusion at the level of the adductor. The popliteal is patent and there is continuity to cross the ankle.
Left leg: CFA and PFA are patent. The SFA is occluded with reconstitution at the level of the adductor. The popliteal is patent and there is continuity to cross the ankle. Patient is only complaining of claudication therefore the LSVs were not assessed for possible bypass.

RAR (ET)

end of report

---

Authorised: 21/07/2010 08:06 RAL Date of study: 19/07/2010
86196R0 220 377

East of Scotland Vascular Network (NHS Tayside)
Vascular Laboratory (Ext: 33869)

CHI No : 0503700053
Patient Name : STANDISH, David
Investigation: Segmental Pressures
Date of study: 18/05/2010

Consultant: Consultant Vascular Surgeon
Ward 12
Ninewells Hospital

---

Referral details:
Out-patient referral - RTM - Bilateral claudication right > left

| Resting Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 124 | 120 |
| Posterior Tibial | 70 | 64 |
| Dorsalis Pedis | 56 | 64 |
| Ankle/Brachial Pressure Index | 0.56 | 0.51 |

| Post-Exercise Pressures (mmHg) | Right | Left |
|---|---|---|
| Brachial | 128 | |
| Ankle | 40 | 26 |
| Ankle/Brachial Pressure Index | 0.31 | 0.20 |

Exercise Test
Treadmill Speed: 4Kph Inclination: 10.0%
Treadmill time: 01:00

Report:
Monophasic pedal waveforms bilaterally
Patient clearly describing right > left IC with right great toe becoming numb -
this is not supported by the ABPIs.

MMcC*

Previous results:
No previous results held

end of report

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Authorised: 19/05/2010 09:40 RAL Date of study: 18/05/2010
83951R3 232 393

General Surgery
Surgical Directorate
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

01382 660111

www.nhstayside.scot.nhs.uk

Dr A Taylor
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 23/09/2022 |
| Clinic Date | 14/09/2022 |
| Your Ref | |
| Our Ref | DS/ag/ **0503700053** |
| Enquiries to | Ward 12 office |
| Extension | 58300 |

Dear Dr Taylor

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

Diagnosis: Bilateral lower limb claudication.
Extensive peripheral vascular disease.
Previous right sided fem distal bypass.
Previous cardiac arrest and coronary interventions.

Management Plan: Discharge from clinic at present.

It was a pleasure to speak to Mr Standish today at the Vascular clinic.

He informs me that he gets symptoms in keeping with claudication when he walks approximately 100m on the flat. He denies any rest pain and any tissue loss. He informs me that he has recently restarted his smoking habit and currently is not taking his Beta Blockers as he feels these worsen his leg pain symptoms. I understand that he is currently unable to take a Statin, however, continues on a low dose Aspirin.

We had a discussion today about the nature of peripheral vascular disease and the natural history of the disease, particulary in view of his ongoing smoking.

We also explored his previous history including his cardiac arrest following percutaneous coronary interventions approximately 6 years ago. At present, based on his ability to manage his symptoms and his long distance claudication, I do not feel that intervention would be warranted and Mr Standish is, in any case, not keen for any intervention at this time.

I will therefore discharge him back to your care, with the proviso that should his symptoms deteriorate or he develops rest pain or tissue loss, would be happy to see him again and discuss his options at that point. I have impressed upon him the importance of smoking cessation or switching to a Vape which would be a preferable vice from a Vascular point of view. Your support with this would be appreciated.

Yours aye

Authorised on 23/09/2022 23:51:05 by  David Strachan.

**David Strachan**
**Surgical Trainee**

General Surgery
Surgical Directorate
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY
Tel. 01382 660111

www.nhstayside.scot.nhs.uk

Dr A Taylor
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 04/05/2022 |
| Clinic Date | 28/04/2022 |
| Your Ref | |
| Our Ref | GG/pa/ **0503700053** |
| Enquiries to | Ward 12 office |
| Extension | 33889 |
| Direct Line | 01382 633889 |

Dear Dr Taylor

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

I saw Mr Standish in the Vascular clinic today.

As you know he has a significant history of arterial disease having suffered a myocardial infarction in 2016 and a VF arrest at that time. He has had stents applied to his right coronary artery for this. He also suffers from asthma and has in the past been known to use recreational drugs. He is on appropriate secondary prevention and I note that he is on Alirocumab injections to control his cholesterol as he does not tolerate statins.

In clinic today he tells me that his walking is severely limited by what he describes as calf pain. He said that this is exacerbated whenever his beta-blockers are increased so he is avoiding this. He gives a history of restless legs at night and possibly some night pain although I am not clear whether or not this is true ischaemic night pain. He certainly gives no history of tissue loss and there is none currently.

On examination today both feet look relatively well perfused. There is no evidence of tissue loss. He has satisfactory inflow with femoral pulses palpable. It was difficult to feel any pulses beyond this.

He has had a duplex this morning which shows bilateral SFa occlusions roughly to the adductor on both sides. He has patent popliteal and 2 vessel run-off bilaterally below these.

I have explained to Mr Standish that aggressive secondary prevention is very important in his case. Given his cardiac history we need to be very clear that we should intervene for critical limb ischaemia only. At the moment it is difficult to discern whether or not he truly has this but the suggestion of night pain should not be ignored. I have arranged a CT angiogram to fully assess the circulation and following this we will review him at our MDT. We will see him back in clinic once we have reviewed his CT. In the meantime I have advised him to walk as much as possible and advised him of warning signs to look out for. We will see him back in due course.

With kind regards.

Yours sincerely

Authorised on 13/05/2022 15:26:00 by  Graeme Guthrie.

**Graeme Guthrie**
**Consultant Vascular Surgeon**

General Surgery
Surgical Directorate
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY
Tel. 01382 660111

www.nhstayside.scot.nhs.uk

Dr F Bullions
Coldside Medical Practice
129 Strathmartine Road
Dundee
DD3 8DB

| | |
|---|---|
| Date | 18/03/2022 |
| Dictation Date | 17/03/2022 |
| Your Ref | |
| Our Ref | DJM/pa/ **0503700053** |
| Enquiries to | Ward 12 office |
| Extension | 33889 |
| Direct Line | 01382 633889 |

Dear Dr Bullions

**David Standish, 6 Dargarvel Gardens, Ormiston Crescent, Dundee, Angus, DD4 0UQ DOB: 05/03/1970**

Thank you for your letter regarding this patient.

We will arrange an urgent review in the outpatient clinic. He will have an appointment in the Vascular lab for ABPI's and an arterial duplex.

In the interim he would benefit from the addition of Atorvastatin (40-80mg) and as he has a history of documented peripheral arterial disease and intermittent claudication it would be reasonable to trial him with Naftidrofuryl Oxalate 200mg tds which does occasionally provide symptomatic benefit for patients in this cohort. Nonetheless, we will of course see him and assess things.

Yours sincerely

Authorised on 09/04/2022 21:26:54 by Douglas Mackenzie.

**Mr Douglas MacKenzie**
**Consultant Vascular Surgeon**

(P) Dr Rose Ross, Clinical Specialist, Vascular Laboratory, East Block, Level 4, Ninewells Hospital, DD1 9SY

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

# Tayside Diagnostic Services

Printed by algill (Arrianne Gill (non referrer)) at 23 Jun 2026 14:00

| | | | | | |
|---|---|---|---|---|---|
| Patient name: | **DAVID STANDISH** | CHI Number: | **0503700053** | Sex: | **Male** |
| Date of birth: | **05 Mar 1970** | : | | | |
| Address: | **6 DARGARVEL GARDENS, ORMISTON CRESCENT, DUNDEE DD4 0UQ** | | | | |

**Report 1/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 01 Aug 2016 15:58 | Histopathology | NW WARD 3 | Dr Paul S BAINES (Opthamology) (Opthalmology) |

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:25

CLINICAL DETAILS :

Sample TS16017612 (Stomach Biopsy) Collected 21 Jul 2016 00:00 Received 22 Jul 2016 09:35

**Report**

```
Nature of Specimen(s)
Distal stomach biopsy
Clinical Information Supplied
Mild distal gastritis. CLO test negative.
Macro Report
Three fragments up to 4mm.
Micro Report
Sections show gastric antral type mucosa showing regenerative
features, consistent with a diagnosis of chemical gastritis.
Helicobacter pylori-type organisms are not identified.
Signature of Pathologist(s)
Dr S Lang
MM
```

**Report 2/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 28 Apr 2016 15:41 | Radiology | GENERAL PRACTIONER | Dr FIONA BULLIONS (General Practice) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:30

Sample 6060301 (TYPE UNSPECIFIED) Collected 22 Apr 2016 13:11 Received 22 Apr 2016 13:11

**XR Lumbar spine**

```
Clinical History :
?worsening OA
ENTERED BY: Fiona Bullions (Medical)
BLEEP: 01382 880900
XR Pelvis :
There is minimal OA change involving both hip joints with superolateral joint space
narrowing and also early buttressing of the femoral neck.  The bony pelvis and sacroiliac
joints are normal.
XR Lumbar spine :
Vertebral alignment preserved.  Disc spaces preserved.  No bony abnormality.  Calcified
atheroma is noted in a non aneurysmal abdominal aorta.
 DR JOHN BRUNTON / MOND
```

**Report 3/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 28 Apr 2016 15:41 | Radiology | GENERAL PRACTIONER | Dr FIONA BULLIONS (General Practice) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:30

Sample 6060300 (TYPE UNSPECIFIED) Collected 22 Apr 2016 13:11 Received 22 Apr 2016 13:11

**XR Pelvis**

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

```
Clinical History :
?worsening OA
ENTERED BY: Fiona Bullions (Medical)
BLEEP: 01382 880900
XR Pelvis :
There is minimal OA change involving both hip joints with superolateral joint space
narrowing and also early buttressing of the femoral neck.  The bony pelvis and sacroiliac
joints are normal.
XR Lumbar spine :
Vertebral alignment preserved.  Disc spaces preserved.  No bony abnormality.  Calcified
atheroma is noted in a non aneurysmal abdominal aorta.
 DR JOHN BRUNTON / MOND
```

**Report 4/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 12 Feb 2016 16:56 | Radiology | NW OP 3/4 | Prof Jill J BELCH (Cardiovascular/Geriatric M (Geriatric Medicine) |

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 05:05

Sample 5952235 (TYPE UNSPECIFIED) Collected 08 Feb 2016 10:11 Received 08 Feb 2016 10:11
**NM C14 urea breath test**

```
Clinical History :
?evidence of H.Pylori
Severe Gastritis and Duodenitis
Biopsy from OGD inconclusive
Advised H.Pylori Exclusion
?evidence of H.Pylori
ENTERED BY: Colin Baines (medical)
BLEEP: 01382 633883
NM C14 urea breath test :
This test is positive.  This implies current infection with H pylori.
 DR GILLIAN DUNCAN / GMVCC
```

**Report 5/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 04 Dec 2015 16:35 | Histopathology | PRI OP ENDOSCOPY | Mr Christopher PAYNE (General Surgery) (General Surgery) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:50

```
CLINICAL DETAILS :
```

Sample TS15028053 (Stomach Biopsy) Collected 24 Nov 2015 00:00 Received 26 Nov 2015 14:11
**Report**

```
Nature of Specimen(s)
Antrum
Clinical Information Supplied
Gastritis on Clopidogrel
Macro Report
Two fragments up to 3mm
Micro Report
Sections show multiple fragments of gastric antral type mucosa
with marked regeneration and marked chronic active inflammation.
No evidence of Helicobacter pylori on special stains. No evidence
of dysplasia or malignancy.
Conclusion
Mixed features of chronic active gastritis and chemical type
gastritis. Clinical correlation and exclusion of Helicobacter
pylori infection by other methods is strongly recommended.
Signature of Pathologist(s)
Dr SV Walsh
PFT
```

**Report 6/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 24 Nov 2015 15:38 | Radiology | NW OP 3/4 | Prof Jill J BELCH (Cardiovascular/Geriatric M (Geriatric Medicine) |

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 05:05

Sample 5883443 (TYPE UNSPECIFIED) Collected 19 Nov 2015 09:21 Received 19 Nov 2015 09:21

**NM C14 glychocholic breath test**

```
Clinical History :
?evidence of bacterial overgrowth
Episodic abdominal pain and bloating with signifcant heartburn and diarrhoea.
Multiple medications for Atherosclerosis
Regular over the counter stomach remedies taken
?evidence of SIBO
ENTERED BY: Colin Baines (medical)
BLEEP: 01382 633883
NM C14 glychocholic breath test :
This test is negative. There is no evidence of active bacterial overgrowth of the small
bowel on this study
 Dr J DAVIDSON / DAVJ
```

**Report 7/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 24 Sep 2015 13:37 | Blood Sciences | NW OP 3/4 | Prof Jill J BELCH (Cardiovascular/Geriatric M (Geriatric Medicine) |

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 05:05

```
CLINICAL DETAILS :
  Dyslipidaemia Atherosclerosis
```

Sample C154143250 (Blood) Collected 24 Sep 2015 11:15 Received 24 Sep 2015 12:33

| | | | |
|---|---|---|---|
| **CHOLESTEROL** | | | |
| TOTAL CHOLESTEROL | * **7.13** | mmol/L | 0.00 - 5.00 |
| **CREATINE KINASE** | | | |
| CREATINE KINASE | 280 | U/L | 40 - 320 |
| **GGT** | | | |
| GGT | 63 | U/L | 3 - 73 |
| **Urea & Electrolytes** | | | |
| SODIUM | 141 | mmol/L | 133 - 146 |
| POTASSIUM | 5.1 | mmol/L | 3.5 - 5.3 |
| UREA | 5.0 | mmol/L | 2.5 - 7.8 |
| CREATININE | 83 | umol/L | 62 - 106 |
| **AKI** | | | |
| AKI | Not detected: but may not exclude AKI in all cases | . | |
| **Liver Function Tests (LFT)** | | | |
| ALT | 43 | U/L | 5 - 55 |
| BILIRUBINS | 13 | umol/L | 0 - 21 |
| ALKALINE PHOSPHATASE | 115 | U/L | 30 - 130 |
| ALBUMIN | 37 | g/L | 35 - 50 |
| **ESTIMATED GFR** | | | |
| ESTIMATED GFR | GT60 | mL/min | |
| **CKD Stage** | | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | . | |
| **TOTAL CHOL/HDL-CHOL** | | | |
| HDL-CHOLESTEROL | 1.34 | mmol/L | 0.60 - 2.50 |
| TOTAL CHOL/HDL-CHOL | 5.30 | . | |

**Report 8/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 24 Sep 2015 13:09 | Blood Sciences | NW OP 3/4 | Prof Jill J BELCH (Cardiovascular/Geriatric M (Geriatric Medicine) |

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 05:05

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

CLINICAL DETAILS :
Dyslipidaemia Atherosclerosis

Sample H154143250 (EDTA) Collected 24 Sep 2015 11:15 Received 24 Sep 2015 12:33

**FBC**

| | | | | |
|---|---|---|---|---|
| Hb | | 133 | g/L | 130 - 180 |
| WBC | * | **15.2** | x10^9/L | 4.0 - 11.0 |
| PLT | * | **406** | x10^9/L | 150 - 400 |
| RBC | * | **4.48** | x10^12/L | 4.5 - 6.0 |
| HCT | | 0.417 | | 0.40 - 0.52 |
| MCV | | 92.9 | fl | 85 - 105 |
| MCH | | 29.7 | pg | 27 - 32 |
| MCHC | | 320 | g/L | 320 - 360 |
| NE# | * | **10.9** | x10^9/L | 2.0 - 7.5 |
| LY# | | 3.0 | x10^9/L | 1.5 - 4.0 |
| MO# | * | **1.0** | x10^9/L | 0.2 - 0.8 |
| EO# | | 0.32 | x10^9/L | 0.0 - 0.4 |
| BA# | | 0.1 | x10^9/L | 0.0 - 0.1 |

**Report 9/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 14 Apr 2015 15:52 | Blood Sciences | NW OP 5/6 | Dr JOHN B DICK (General Medicine) (General Medicine) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:25

CLINICAL DETAILS :
On T4?: No
abdominal pain folate deficiency

Sample I153757755 (SERUM) Collected 03 Apr 2015 12:50 Received 03 Apr 2015 14:02

**IgA Tissue Transglutaminase Ab**

| | | | |
|---|---|---|---|
| IgA Tissue Transglutaminase | 0.8 | u/ml | 0 - 3 |

**Report 10/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 03 Apr 2015 15:04 | Blood Sciences | NW OP 5/6 | Dr JOHN B DICK (General Medicine) (General Medicine) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:25

CLINICAL DETAILS :
On T4?: No
abdominal pain folate deficiency

Sample C153757755 (Blood) Collected 03 Apr 2015 12:50 Received 03 Apr 2015 14:02

| | | | |
|---|---|---|---|
| **MAGNESIUM** | | | |
| MAGNESIUM | 0.83 | mmoL/L | 0.70 - 1.00 |
| **PHOSPHATE** | | | |
| PHOSPHATE | 1.07 | mmoL/L | 0.8 - 1.5 |
| **Urea & Electrolytes** | | | |
| SODIUM | 139 | mmol/L | 133 - 146 |
| POTASSIUM | 4.9 | mmol/L | 3.5 - 5.3 |
| UREA | 5.4 | mmol/L | 2.5 - 7.8 |
| CREATININE | 74 | umol/L | 62 - 106 |
| **Liver Function Tests (LFT)** | | | |
| ALT | 46 | U/L | 5 - 55 |
| BILIRUBINS | 7 | umol/L | 0 - 21 |
| ALKALINE PHOSPHATASE | 100 | U/L | 30 - 130 |
| ALBUMIN | 38 | g/L | 35 - 50 |
| **Bone Group** | | | |
| CALCIUM | 2.38 | mmol/L | 2.10 - 2.55 |

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

| | | | |
|---|---|---|---|
| CALCIUM (CORRECTED) | 2.40 | mmol/L | 2.10 - 2.55 |
| **ESTIMATED GFR** | | | |
| ESTIMATED GFR | GT60 | mL/min | |
| **CKD Stage** | | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA . | | |
| **GLUCOSE** | | | |
| GLUCOSE (preserved tube) | 5.8 | mmol/L | 3.3 - 5.8 |
| **TSH** | | | |
| TSH | 1.16 | mU/L | 0.4 - 4.0 |

**Report 11/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 03 Apr 2015 14:53 | Blood Sciences | NW OP 5/6 | Dr JOHN B DICK (General Medicine) (General Medicine) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:25

```
CLINICAL DETAILS :
On T4?: No
abdominal pain folate deficiency
```

Sample H153757755 (EDTA) Collected 03 Apr 2015 12:50 Received 03 Apr 2015 14:02

**FBC**

| | | | |
|---|---|---|---|
| Hb | 140 | g/L | 130 - 180 |
| WBC | 8.0 | x10^9/L | 4.0 - 11.0 |
| PLT | 396 | x10^9/L | 150 - 400 |
| RBC | 4.75 | x10^12/L | 4.5 - 6.0 |
| HCT | 0.429 | | 0.40 - 0.52 |
| MCV | 90.3 | fl | 85 - 105 |
| MCH | 29.4 | pg | 27 - 32 |
| MCHC | 326 | g/L | 320 - 360 |
| NE# | 4.6 | x10^9/L | 2.0 - 7.5 |
| LY# | 2.6 | x10^9/L | 1.5 - 4.0 |
| MO# | 0.5 | x10^9/L | 0.2 - 0.8 |
| EO# | 0.18 | x10^9/L | 0.0 - 0.4 |
| BA# | 0.1 | x10^9/L | 0.0 - 0.1 |

**Report 12/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 20 Mar 2015 12:24 | Radiology | NW OP 3/4 | Dr JOHN B DICK (General Medicine) (General Medicine) |

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 05:05

Sample 5607984 (TYPE UNSPECIFIED) Collected 13 Mar 2015 14:25 Received 13 Mar 2015 14:25

**CT Abdomen & pelvis with contrast**

```
Clinical History :
colicky right upper quadrant pain with ezetemibe; ?GB/pancreatic; arteriopath, currently
on no Rx pending this
ENTERED BY: John Dick (Medical)
BLEEP: 33883
CT Abdomen & pelvis with contrast : 100mls. Omnipaque 300 injected iv.  No immediate
complications.
The lung bases are clear.
Focus of hypoattenuation in the right lobe of liver adjacent to the falciform ligament is
in keeping with a perfusion defect. The liver is otherwise unremarkable.  No pertinent
findings in relation to the spleen, pancreas, gall bladder, biliary tree, kidneys or
adrenal glands.
The aorta is of normal calibre, major visceral branches opacify normally and centrally.
There is no significant inguinal, iliac, retroperitoneal or intra abdominal
lymphadenopathy.
Minor soft tissue stranding in the right groin is similar to the previous investigation
and likely relates to previous vascular intervention involving the right common femoral
artery.
The large bowel is unremarkable within the limitations of this unprepared study, no
dilatation of the small bowel.  No ascites.
Small scattered lymph nodes in the root of the mesentery show no interval change when
```

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

```
compared to the previous study of 16th April, 2014.
No destructive bony lesions are apparent.
 DR GILLIAN DUNCAN / SMIF
```

**Report 13/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 11 Jun 2014 10:24 | Radiology | NW OP 3/4 | Dr JOHN B DICK (General Medicine) (General Medicine) |

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 05:05

Sample 5358776 (TYPE UNSPECIFIED) Collected 06 Jun 2014 11:14 Received 06 Jun 2014 11:14
**XR Lumbar spine**

```
Clinical History :
Severe pain right hip and groin
Radiates down front of thigh
Recent back pain
Abnormal gait pattern due to peripheral arterial disease
Recently developed antalgic gait
?evidence of significant OA
ENTERED BY: Colin Baines (medical)
BLEEP: 01382 633883
Severe pain right hip and groin
Radiates down front of thigh
Recent back pain
Abnormal gait pattern due to peripheral arterial disease
Recently developed antalgic gait
?evidence of significant OA
ENTERED BY: Colin Baines (medical)
BLEEP: 01382 633883
x-ray pelvis.
. Mild bilateral symmetrical osteoarthritis noted
No other significant feature
. X-ray lumbar spine.
lumbar spine demonstrates normal appearances
 DR RUSSELL DAVIES (MEDICA) / RDAVIES
```

**Report 14/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 11 Jun 2014 10:24 | Radiology | NW OP 3/4 | Dr JOHN B DICK (General Medicine) (General Medicine) |

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 05:05

Sample 5358775 (TYPE UNSPECIFIED) Collected 06 Jun 2014 11:14 Received 06 Jun 2014 11:14
**XR Pelvis**

```
Clinical History :
Severe pain right hip and groin
Radiates down front of thigh
Recent back pain
Abnormal gait pattern due to peripheral arterial disease
Recently developed antalgic gait
?evidence of significant OA
ENTERED BY: Colin Baines (medical)
BLEEP: 01382 633883
Severe pain right hip and groin
Radiates down front of thigh
Recent back pain
Abnormal gait pattern due to peripheral arterial disease
Recently developed antalgic gait
?evidence of significant OA
ENTERED BY: Colin Baines (medical)
BLEEP: 01382 633883
x-ray pelvis.
. Mild bilateral symmetrical osteoarthritis noted
No other significant feature
. X-ray lumbar spine.
lumbar spine demonstrates normal appearances
 DR RUSSELL DAVIES (MEDICA) / RDAVIES
```

**Report 15/20**

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 03 Jun 2014 15:44 | Radiology | GENERAL PRACTIONER | Dr MORGAN D DAVAGE (General Practice) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:20

Sample 5326138 (TYPE UNSPECIFIED) Collected 02 Jun 2014 14:20 Received 02 Jun 2014 14:20

**US Groin & inguinal region**

```
Clinical History :
discomfort and swelling right groin - prev femoral endarterectomy. but I suspect this is a
hernia-  please assess
ENTERED BY: Morgan Davage (Medical)
BLEEP: 01382 462222
US Groin & inguinal region :
The right groin was examined.  No significant abnormality has been demonstrated.  In
particular, there is no evidence of a hernia and there is no evidence of a mass lesion.
 Dr A S McCULLOCH / DAWS
```

**Report 16/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 24 Apr 2014 15:38 | Radiology | NW OP UROLOGY | Mr Andrew MARTINDALE (Urology) (Urology) |

Filed by **amartindale** (Andrew Martindale (Medical)) at 18 May 2014 14:41

Sample 5300372 (TYPE UNSPECIFIED) Collected 16 Apr 2014 17:23 Received 16 Apr 2014 17:23

**CT Renal Both**

```
Clinical History :
URGENT. Severe left loin pain. In keeping with renal colic. Urgent OP referral from GP as
intermittent. May present as emergency if worsens. ?stone ? hydronephrosis
ENTERED BY: Andrew Martindale (Medical)
BLEEP: 4603
CT Renal Both :
No evidence of urinary tract calculi on either side.  No hydronephrosis or hydroureter.
 Dr R BHAT / MAUS
```

**Report 17/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 08 Oct 2013 18:09 | Blood Sciences | T11005-PARK AVENUE MED CENTRE | Dr MORGAN D DAVAGE (General Practice) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 06:33

```
CLINICAL DETAILS :
  routine.

LAB COMMENTS :
Note the change in units for HGB and MCHC from 01/10/13
```

Sample H132518261 (EDTA) Collected 08 Oct 2013 14:46 Received 08 Oct 2013 16:57

**FBC**

| | | | | |
|---|---|---|---|---|
| Hb | | 140 | g/L | 130 - 180 |
| WBC | | 6.3 | x10^9/L | 4.0 - 11.0 |
| PLT | | 373 | x10^9/L | 150 - 400 |
| RBC | * | **4.41** | x10^12/L | 4.5 - 6.0 |
| HCT | | 0.408 | | 0.40 - 0.52 |
| MCV | | 92.3 | fl | 85 - 105 |
| MCH | | 31.7 | pg | 27 - 32 |
| MCHC | | 343 | g/L | 320 - 360 |
| NE# | | 3.4 | x10^9/L | 2.0 - 7.5 |
| LY# | | 2.2 | x10^9/L | 1.5 - 4.0 |
| MO# | | 0.4 | x10^9/L | 0.2 - 0.8 |
| EO# | | 0.21 | x10^9/L | 0.0 - 0.4 |

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

| | | | |
|---|---|---|---|
| BA# | 0.0 | x10^9/L | 0.0 - 0.1 |

**Report 18/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 08 Oct 2013 18:09 | Blood Sciences | T11005-PARK AVENUE MED CENTRE | Dr MORGAN D DAVAGE (General Practice) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 06:33

CLINICAL DETAILS :
routine.

Sample C132518261 (Fluoride Oxalate) Collected 08 Oct 2013 14:46 Received 08 Oct 2013 16:57

| | | | |
|---|---|---|---|
| **GLUCOSE** | | | |
| GLUCOSE (preserved tube) | 5.4 | mmol/L | 3.3 - 5.8 |
| **ALKALINE PHOSPHATASE** | | | |
| ALKALINE PHOSPHATASE | 68 | U/L | 30 - 130 |
| **ALBUMIN** | | | |
| ALBUMIN | 40 | g/L | 35 - 50 |
| **CALCIUM** | | | |
| CALCIUM | 2.37 | mmol/L | 2.10 - 2.55 |
| **CORRECTED CALCIUM** | | | |
| CALCIUM (CORRECTED) | 2.36 | mmol/L | 2.10 - 2.55 |
| **CHOLESTEROL** | | | |
| TOTAL CHOLESTEROL | * **5.67** | mmol/L | 0.00 - 5.00 |
| **ALT** | | | |
| ALT | 26 | U/L | 5 - 55 |
| **BILIRUBINS** | | | |
| BILIRUBINS | 10 | umol/L | 0 - 21 |
| **SODIUM** | | | |
| SODIUM | 140 | mmol/L | 133 - 146 |
| **POTASSIUM** | | | |
| POTASSIUM | 4.9 | mmol/L | 3.5 - 5.3 |
| **UREA** | | | |
| UREA | 4.0 | mmol/L | 2.5 - 7.8 |
| **CREATININE** | | | |
| CREATININE | 81 | umol/L | 62 - 106 |
| **ESTIMATED GFR** | | | |
| ESTIMATED GFR | GT60 | mL/min | |
| **CKD Stage** | | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA . | | |
| **TOTAL CHOL/HDL-CHOL** | | | |
| HDL-CHOLESTEROL | 1.50 | mmol/L | 0.60 - 2.50 |
| TOTAL CHOL/HDL-CHOL | 3.70 | . | |
| **TSH** | | | |
| TSH | 1.05 | mU/L | 0.4 - 4.0 |

**Report 19/20**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 26 Apr 2013 15:36 | Blood Sciences | NW OP 3/4 | Dr JOHN B DICK (General Medicine) (General Medicine) |

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 05:05

CLINICAL DETAILS :
pad, statin.

Sample C132151251 (Blood) Collected 26 Apr 2013 13:35 Received 26 Apr 2013 14:54

| | | | |
|---|---|---|---|
| **CHOLESTEROL** | | | |
| TOTAL CHOLESTEROL | 4.33 | mmol/L | 0.00 - 5.00 |

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

| | | | |
|---|---|---|---|
| **CREATINE KINASE** | | | |
| CREATINE KINASE | 115 | U/L | 40 - 320 |
| **GGT** | | | |
| GGT | 25 | U/L | 3 - 73 |
| **ALT** | | | |
| ALT | 24 | U/L | 5 - 55 |
| **BILIRUBINS** | | | |
| BILIRUBINS | 6 | umol/L | 0 - 21 |
| **ALKALINE PHOSPHATASE** | | | |
| ALKALINE PHOSPHATASE | 63 | U/L | 30 - 130 |
| **ALBUMIN** | | | |
| ALBUMIN | 37 | g/L | 35 - 50 |
| **TRIGLYCERIDES** | | | |
| TRIGLYCERIDES | 1.22 | mmol/L | 0.00 - 2.30 |
| **SODIUM** | | | |
| SODIUM | 139 | mmol/L | 133 - 146 |
| **POTASSIUM** | | | |
| POTASSIUM | 5.0 | mmol/L | 3.5 - 5.3 |
| **UREA** | | | |
| UREA | 4.6 | mmol/L | 2.5 - 7.8 |
| **CREATININE** | | | |
| CREATININE | 87 | umol/L | 62 - 106 |
| **ESTIMATED GFR** | | | |
| ESTIMATED GFR | GT60 | mL/min | |
| **CKD Stage** | | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA . | | |
| **TOTAL CHOL/HDL-CHOL** | | | |
| HDL-CHOLESTEROL | 1.25 | mmol/L | 0.60 - 2.50 |
| TOTAL CHOL/HDL-CHOL | 3.40 | . | |

**Report 20/20**

| **Reported** | **Specialty** | **Location** | **Clinician** |
|---|---|---|---|
| 09 Jul 2012 16:45 | Blood Sciences | T11005-PARK AVENUE MED CENTRE | Dr MICHAEL C DUFFY (General Practice) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 06:13

CLINICAL DETAILS :
routine check.

Sample C121507564 (Blood) Collected 09 Jul 2012 11:53 Received 09 Jul 2012 15:46

| | | | | |
|---|---|---|---|---|
| **CHOLESTEROL** | | | | |
| | TOTAL CHOLESTEROL | 4.94 | mmol/L | 0.00 - 5.00 |
| **TOTAL CHOL/HDL-CHOL** | | | | |
| | HDL-CHOLESTEROL | 1.44 | mmol/L | 0.60 - 2.50 |
| | TOTAL CHOL/HDL-CHOL | 3.40 | . | |

**End of reports**

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

# Tayside Diagnostic Services

Printed by algill (Arrianne Gill (non referrer)) at 23 Jun 2026 14:01

| | | | | | |
|---|---|---|---|---|---|
| Patient name: | **DAVID STANDISH** | CHI Number: | **0503700053** | Sex: | **Male** |
| Date of birth: | **05 Mar 1970** | : | | | |
| Address: | **6 DARGARVEL GARDENS, ORMISTON CRESCENT, DUNDEE DD4 0UQ** | | | | |

**Report 1/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 21 May 2025 17:27 | Blood Sciences | T11166-COLDSIDE MEDICAL PRACTI | Dr ANDREW TAYLOR (General Practice) |

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 06:34

CLINICAL DETAILS :
CHD Review

Sample C252740989 (Blood) Collected 21 May 2025 14:58 Received 21 May 2025 16:33

| | | | |
|---|---|---|---|
| **CHOLESTEROL** | | | |
| TOTAL CHOLESTEROL | * **5.44** | mmol/L | 0.00 - 5.00 |
| **TOTAL CHOL/HDL-CHOL** | | | |
| HDL-CHOLESTEROL | 1.42 | mmol/L | 0.60 - 2.50 |
| TOTAL CHOL/HDL-CHOL | 3.80 | . | |
| **FASTING GLUCOSE** | | | |
| FASTING GLUCOSE | 4.6 | mmol/L | 3.3 - 5.8 |
| **Creatinine and Electrolytes** | | | |
| SODIUM | 137 | mmol/L | 133 - 146 |
| POTASSIUM | 4.5 | mmol/L | 3.5 - 5.3 |
| CREATININE | 80 | umol/L | 62 - 106 |
| **AKI** | | | |
| AKI | NOT AVAILABLE | . | |
| **ESTIMATED GFR** | | | |
| ESTIMATED GFR | GT60 | mL/min | |

eGFR should not be used to assess renal function
for any drug dosing in over 75s or extremes of BMI
and for DOAC dosing in those with an eGFR less
than 60ml/min.

| | | | |
|---|---|---|---|
| **CKD Stage** | | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA . | | |

**Report 2/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 10 Mar 2023 17:11 | Blood Sciences | T11166-COLDSIDE MEDICAL PRACTI | Dr ANDREW TAYLOR (General Practice) |

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 06:36

CLINICAL DETAILS :
chd review

LAB COMMENTS :
SLIGHTLY HAEMOLYSED

Sample C239889578 (Fluoride Oxalate) Collected 10 Mar 2023 13:26 Received 10 Mar 2023 16:25

| | | | |
|---|---|---|---|
| **GLUCOSE** | | | |
| GLUCOSE (preserved tube) | * **6.6** | mmol/L | 3.3 - 5.8 |
| **CHOLESTEROL** | | | |
| TOTAL CHOLESTEROL | 4.70 | mmol/L | 0.00 - 5.00 |
| **TOTAL CHOL/HDL-CHOL** | | | |
| HDL-CHOLESTEROL | 1.35 | mmol/L | 0.60 - 2.50 |
| TOTAL CHOL/HDL-CHOL | 3.40 | . | |
| **Creatinine and Electrolytes** | | | |
| SODIUM | 139 | mmol/L | 133 - 146 |

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

| | | | |
|---|---|---|---|
| POTASSIUM | 4.7 | mmol/L | 3.5 - 5.3 |
| CREATININE | 76 | umol/L | 62 - 106 |

**AKI**

| | | |
|---|---|---|
| AKI | NOT AVAILABLE | . |

**ESTIMATED GFR**

| | | |
|---|---|---|
| ESTIMATED GFR | GT60 | mL/min |

eGFR should not be used to assess renal function
for any drug dosing in over 75s or extremes of BMI
and for DOAC dosing in those with an eGFR less
than 60ml/min.

**CKD Stage**

| | |
|---|---|
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA . |

**Report 3/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 23 Nov 2022 13:41 | Radiology | NW WARD 12 | DR Olivia MCBRIDE (Vascular) (Vascular Surgery) |

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:16

Sample 8437740 (TYPE UNSPECIFIED) Collected 14 Sep 2022 13:27 Received 14 Sep 2022 13:27
**Vein Scan Leg Both**

Clinical History :
Vein look
OPC 14/9/22 AT 0930 - NEEDS vein look. For ?bilateral fem - BK POP
ENTERED BY: Olivia McBride (medical)
BLEEP: 4260
Vein Scan Leg Both :
NOT PREFORMED
ROSE ROSS / RROSS

**Report 4/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 15 Aug 2022 18:40 | Radiology | NW OP VASCULAR SURGERY (OP 12) | Unknown Unknown (Dental Medicine Specialties) |

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:05

Sample 8379682 (TYPE UNSPECIFIED) Collected 27 Jul 2022 12:20 Received 27 Jul 2022 12:20
**MDM OP Meeting**

MDM 10.08.22
Diagnosis : short distance disabling bilateral calf claudication. No critical limb ischaemia.
Background : Coronary artery stents. Previous myocardial infarction and cardiac arrest 2016.
Investigation Findings : Duplex shows SFa occlusions.
CT Findings : aorta satisfactory. Tight right internal iliac stenosis. He has a dilated right common femoral which could either be consistent with a prior endarterectomy or femoral aneurysm. The proximal SFa is patent, occluded SFa from mid SFa to adductor, the popliteal is patent and 3 vessel run-off on the right. On the left inflow is satisfactory, SFa occluded with a good profunda. SFa occluded from its origin reconstituting at the above knee popliteal. The popliteal is patent with 3 vessel run-off.
Outcome of MDM : Needs reassessed at clinic face-to-face to clarify his symptoms and clarify priory surgery in the right groin. On the right leg, if this is an endarterectomy, he could potentially have an antegrade angiogram with a view to SFa intervention. For the left leg he would require a femoropopliteal bypass, could also have a fem pop on the right.
Plan : assess and clarify symptoms in clinic. Assess the prior surgery in the right groin. Vein look.
SS/pa
VASCULAR MDM MEETING / ANDP

**Report 5/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 01 Aug 2022 12:13 | Radiology | NW WARD 12 | Mr Graeme GUTHRIE (Vascular) (Vascular Surgery) |

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:16

Sample 8307284 (TYPE UNSPECIFIED) Collected 22 Jul 2022 11:02 Received 22 Jul 2022 11:02
**CT Angiogram lower limb Both**

```
Clinical History :
Arteriopath - previous MI and cardiac arrest 2016. Right coronary artery stents placed.
Severely limited by bilateral calf pain. Pain worsened by beta-blockers. No features of
CLTI. Duplex shows SFA occlusions bilaterally with 2 vessel runoff. CTA please.
CT Angiogram lower limb Both :
No previous for comparison.
Normal calibre abdominal aorta with the distal aorta measuring a maximum diameter of 26
mm. Unremarkable coeliac axis, SMA, IMA and both renal arteries.
RIGHT: Normal calibre CIA, IIA and EIA. Dilation of the CFA to a maximum diameter of 20
mm. Thready SFA which occludes in its mid section. There is reconstitution at the
adductor. Normal popliteal artery with high take off of AT. Three-vessel run-off at the
ankle.
LEFT: Normal calibre CIA, IIA. Mild stenosis proximal EIA. Normal CFA. The SFA is occluded
from its origin reconstituting at the adductor canal. Normal popliteal artery with 3
vessel run-off at the ankle.
Unremarkable appearances of the solid organ upper abdominal viscera. The unprepared
small/large bowel is unremarkable. No free fluid or gas. No abdominal/pelvic
lymphadenopathy - Small scattered lymph nodes in the small bowel mesentery ae stable. No
destructive bone lesions.
Impression: Bilateral occlusions of SFA, worse on the left.
 DR DOMINIC MCGOWAN / DMCGOWAN
```

**Report 6/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 29 Apr 2022 16:42 | Radiology | NW OP VASCULAR CLINIC | Rose Ross (NMR186) (Vascular Surgery) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:45

Sample 8278148 (TYPE UNSPECIFIED) Collected 28 Apr 2022 09:53 Received 28 Apr 2022 09:53
**Arterial Scan Leg Lt**

```
Clinical History :
See scanned letter
Worsening claudication symptoms bilaterally - scanned at SOPD.
Arterial Scan Leg Rt :
The abdominal aorta is ectatic measuring 25 mm. The iliac segment, CFA and PFA are widely
patent with triphasic flow. The SFA is occluded from the proximal thigh reconstituting at
the adductor canal. The popliteal artery, ATA and PTA are widely patent with monophasic
flow that can be traced into the foot.
The patient describes worsening claudication symptoms. No history of ischemic rest pain.
On examination both feet were warm and the skin was intact.
Mr Guthrie was notified and discussed results with the patient at clinic.
KP
Arterial Scan Leg Lt :
The abdominal aorta is ectatic measuring 25 mm. The iliac segment, CFA and PFA are widely
patent with triphasic flow. The SFA is occluded from its origin reconstituting at the
adductor canal.  The popliteal artery, ATA and PTA are widely patent with monophasic flow
that can be traced into the foot.
The patient describes worsening claudication symptoms. No history of ischemic rest pain.
On examination both feet were warm and the skin was intact.
Mr Guthrie was notified and discussed results with the patient at clinic.
KP
 KERR PATERSON / PKERR
```

**Report 7/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 29 Apr 2022 16:42 | Radiology | NW OP VASCULAR CLINIC | Rose Ross (NMR186) (Vascular Surgery) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:45

Sample 8266219 (TYPE UNSPECIFIED) Collected 28 Apr 2022 09:53 Received 28 Apr 2022 09:53
**Arterial Scan Leg Rt**

```
Clinical History :
See scanned letter
Worsening claudication symptoms bilaterally - scanned at SOPD.
Arterial Scan Leg Rt :
The abdominal aorta is ectatic measuring 25 mm. The iliac segment, CFA and PFA are widely
patent with triphasic flow. The SFA is occluded from the proximal thigh reconstituting at
```

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

the adductor canal. The popliteal artery, ATA and PTA are widely patent with monophasic flow that can be traced into the foot.
The patient describes worsening claudication symptoms. No history of ischemic rest pain.
On examination both feet were warm and the skin was intact.
Mr Guthrie was notified and discussed results with the patient at clinic.
KP
Arterial Scan Leg Lt :
The abdominal aorta is ectatic measuring 25 mm. The iliac segment, CFA and PFA are widely patent with triphasic flow. The SFA is occluded from its origin reconstituting at the adductor canal. The popliteal artery, ATA and PTA are widely patent with monophasic flow that can be traced into the foot.
The patient describes worsening claudication symptoms. No history of ischemic rest pain.
On examination both feet were warm and the skin was intact.
Mr Guthrie was notified and discussed results with the patient at clinic.
KP
KERR PATERSON / PKERR

**Report 8/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 17 Feb 2022 16:43 | Blood Sciences | T11166-COLDSIDE MEDICAL PRACTI | Dr FIONA BULLIONS (General Practice) |

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 06:13

CLINICAL DETAILS :
CHD review

Sample C229062372 (Fluoride Oxalate) Collected 17 Feb 2022 13:30 Received 17 Feb 2022 15:45

| | | | |
|---|---|---|---|
| **GLUCOSE** | | | |
| GLUCOSE (preserved tube) | 5.6 | mmol/L | 3.3 - 5.8 |
| **CHOLESTEROL** | | | |
| TOTAL CHOLESTEROL | 4.60 | mmol/L | 0.00 - 5.00 |
| **TOTAL CHOL/HDL-CHOL** | | | |
| HDL-CHOLESTEROL | 1.57 | mmol/L | 0.60 - 2.50 |
| TOTAL CHOL/HDL-CHOL | 2.90 | . | |
| **Creatinine and Electrolytes** | | | |
| SODIUM | 140 | mmol/L | 133 - 146 |
| POTASSIUM | 4.7 | mmol/L | 3.5 - 5.3 |
| CREATININE | 80 | umol/L | 62 - 106 |
| **AKI** | | | |
| AKI | NOT AVAILABLE | . | |
| **Liver Function Tests (LFT)** | | | |
| ALT | 27 | U/L | 5 - 55 |
| BILIRUBINS | 5 | umol/L | 0 - 21 |
| ALKALINE PHOSPHATASE | 95 | U/L | 30 - 130 |
| ALBUMIN | 35 | g/L | 35 - 50 |
| **ESTIMATED GFR** | | | |
| ESTIMATED GFR | GT60 | mL/min | |

eGFR should not be used to assess renal function for any drug dosing in over 75s or extremes of BMI and for DOAC dosing in those with an eGFR less than 60ml/min.

| | |
|---|---|
| **CKD Stage** | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA . |

**Report 9/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 17 Feb 2022 16:08 | Blood Sciences | T11166-COLDSIDE MEDICAL PRACTI | Dr FIONA BULLIONS (General Practice) |

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 06:13

CLINICAL DETAILS :
CHD review

Sample H229062372 (EDTA) Collected 17 Feb 2022 13:30 Received 17 Feb 2022 15:45

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

**FBC**

| | | | | |
|---|---|---|---|---|
| Hb | | 138 | g/L | 130 - 180 |
| WBC | | 8.0 | x10^9/L | 4.0 - 11.0 |
| PLT | | 398 | x10^9/L | 150 - 400 |
| RBC | * | **4.45** | x10^12/L | 4.5 - 6.0 |
| HCT | | 0.419 | | 0.40 - 0.52 |
| MCV | | 94.1 | fl | 85 - 105 |
| MCH | | 31.0 | pg | 27 - 32 |
| MCHC | | 329 | g/L | 320 - 360 |
| NE# | | 3.9 | x10^9/L | 2.0 - 7.5 |
| LY# | | 3.1 | x10^9/L | 1.5 - 4.0 |
| MO# | | 0.5 | x10^9/L | 0.2 - 0.8 |
| EO# | | 0.29 | x10^9/L | 0.0 - 0.4 |
| BA# | | 0.1 | x10^9/L | 0.0 - 0.1 |

**Report 10/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 31 Jul 2019 15:39 | Blood Sciences | T11166-COLDSIDE MEDICAL PRACTI | Dr FIONA BULLIONS (General Practice) |

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:23

CLINICAL DETAILS :
CHD Bloods

Sample C197252605 (Blood) Collected 31 Jul 2019 13:06 Received 31 Jul 2019 14:54

| | | | |
|---|---|---|---|
| **CHOLESTEROL** | | | |
| TOTAL CHOLESTEROL | FREQUENCY OF TEST NOT JUSTIFIED. | mmol/L | |
| **GLUCOSE** | | | |
| GLUCOSE (preserved tube) | 5.3 | mmol/L | 3.3 - 5.8 |
| **Creatinine and Electrolytes** | | | |
| SODIUM | 141 | mmol/L | 133 - 146 |
| POTASSIUM | 4.8 | mmol/L | 3.5 - 5.3 |
| CREATININE | 74 | umol/L | 62 - 106 |
| **AKI** | | | |
| AKI | NOT AVAILABLE | . | |
| **Liver Function Tests (LFT)** | | | |
| ALT | 29 | U/L | 5 - 55 |
| BILIRUBINS | 10 | umol/L | 0 - 21 |
| ALKALINE PHOSPHATASE | 86 | U/L | 30 - 130 |
| ALBUMIN | 35 | g/L | 35 - 50 |
| **ESTIMATED GFR** | | | |
| ESTIMATED GFR | GT60 | mL/min | |
| **CKD Stage** | | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA . | | |

**Report 11/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 31 Jul 2019 15:18 | Blood Sciences | T11166-COLDSIDE MEDICAL PRACTI | Dr FIONA BULLIONS (General Practice) |

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:23

CLINICAL DETAILS :
CHD Bloods

Sample H197252605 (EDTA) Collected 31 Jul 2019 13:06 Received 31 Jul 2019 14:54

**FBC**

| | | | | |
|---|---|---|---|---|
| Hb | | 134 | g/L | 130 - 180 |
| WBC | | 8.9 | x10^9/L | 4.0 - 11.0 |
| PLT | | 396 | x10^9/L | 150 - 400 |
| RBC | * | **4.30** | x10^12/L | 4.5 - 6.0 |

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

| | | | |
|---|---|---|---|
| HCT | 0.405 | | 0.40 - 0.52 |
| MCV | 94.1 | fl | 85 - 105 |
| MCH | 31.2 | pg | 27 - 32 |
| MCHC | 332 | g/L | 320 - 360 |
| NE# | 5.7 | x10^9/L | 2.0 - 7.5 |
| LY# | 2.3 | x10^9/L | 1.5 - 4.0 |
| MO# | 0.5 | x10^9/L | 0.2 - 0.8 |
| EO# | 0.32 | x10^9/L | 0.0 - 0.4 |
| BA# | 0.1 | x10^9/L | 0.0 - 0.1 |

**Report 12/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 24 Jul 2019 12:08 | Blood Sciences | T11166-COLDSIDE MEDICAL PRACTI | Dr FIONA BULLIONS (General Practice) |

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:22

CLINICAL DETAILS :
On T4?: No
pt on alirocumab for 3 months, due f/u at CV risk clinic
??dose change - to be prescribed via secondary care

LAB COMMENTS :
Amended Report Text : Amended

Sample C186056411 (Blood) Collected 05 Feb 2018 09:44 Received 05 Feb 2018 16:13

| | | | |
|---|---|---|---|
| **CHOLESTEROL** | | | |
| TOTAL CHOLESTEROL | *** 5.05** | mmol/L | 0.00 - 5.00 |
| **TRIGLYCERIDES** | | | |
| TRIGLYCERIDES | 2.12 | mmol/L | 0.00 - 2.30 |
| **Creatinine and Electrolytes** | | | |
| SODIUM | 140 | mmol/L | 133 - 146 |
| POTASSIUM | 4.9 | mmol/L | 3.5 - 5.3 |
| CREATININE | 77 | umol/L | 62 - 106 |
| **AKI** | | | |
| AKI | Not detected: May not exclude AKI in all cases | . | |
| **Liver Function Tests (LFT)** | | | |
| ALT | 39 | U/L | 5 - 55 |
| BILIRUBINS | 7 | umol/L | 0 - 21 |
| ALKALINE PHOSPHATASE | 88 | U/L | 30 - 130 |
| ALBUMIN | 35 | g/L | 35 - 50 |
| **Bone Group** | | | |
| CALCIUM | 2.27 | mmol/L | 2.10 - 2.55 |
| CALCIUM (CORRECTED) | 2.32 | mmol/L | 2.10 - 2.55 |
| **ESTIMATED GFR** | | | |
| ESTIMATED GFR | GT60 | mL/min | |
| **CKD Stage** | | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | . | |
| **TOTAL CHOL/HDL-CHOL** | | | |
| HDL-CHOLESTEROL | 1.27 | mmol/L | 0.60 - 2.50 |
| TOTAL CHOL/HDL-CHOL | 3.90 | . | |
| **TSH** | | | |
| TSH | 1.36 | mU/L | 0.4 - 4.0 |
| **LDL-CHOLESTEROL (CALCULATED)** | | | |
| LDL-CHOL. (CALCULATED) | *** 2.83** | mmoL/L | 0 - 2.60 |

**Report 13/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 19 Jul 2019 10:03 | Blood Sciences | NW OP 3/4 | Dr Isla S MACKENZIE (Clinical Pharmacology) (Clinical Pharmacology) |

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 05:06

CLINICAL DETAILS :

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

On T4?: No
Hypercholesterolaemia, NSTEMI, peripheral vascular disease.
Being considered for PCSK9 inhibitor therapy. PLEASE SUPPLY
FULL LIPID PROFILE including TG and calculated LDL.
Non-fasted.

LAB COMMENTS :
Amended Report Text : Amended

Sample C175888571 (Blood) Collected 17 Nov 2017 14:18 Received 17 Nov 2017 14:47

| | | | |
|---|---|---|---|
| **CHOLESTEROL** | | | |
| TOTAL CHOLESTEROL | * **7.36** | mmol/L | 0.00 - 5.00 |
| **TRIGLYCERIDES** | | | |
| TRIGLYCERIDES | 1.85 | mmol/L | 0.00 - 2.30 |
| **Urea & Electrolytes** | | | |
| SODIUM | 137 | mmol/L | 133 - 146 |
| POTASSIUM | 4.7 | mmol/L | 3.5 - 5.3 |
| UREA | 4.3 | mmol/L | 2.5 - 7.8 |
| CREATININE | 74 | umol/L | 62 - 106 |
| **AKI** | | | |
| AKI | Not detected: May not exclude AKI in all cases | . | |
| **Liver Function Tests (LFT)** | | | |
| ALT | 40 | U/L | 5 - 55 |
| BILIRUBINS | 7 | umol/L | 0 - 21 |
| ALKALINE PHOSPHATASE | 83 | U/L | 30 - 130 |
| ALBUMIN | 36 | g/L | 35 - 50 |
| **Bone Group** | | | |
| CALCIUM | 2.39 | mmol/L | 2.10 - 2.55 |
| CALCIUM (CORRECTED) | 2.43 | mmol/L | 2.10 - 2.55 |
| **ESTIMATED GFR** | | | |
| ESTIMATED GFR | GT60 | mL/min | |
| **CKD Stage** | | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | . | |
| **TOTAL CHOL/HDL-CHOL** | | | |
| HDL-CHOLESTEROL | 1.47 | mmol/L | 0.60 - 2.50 |
| TOTAL CHOL/HDL-CHOL | 5.00 | . | |
| **GLUCOSE** | | | |
| GLUCOSE (preserved tube) | 5.3 | mmol/L | 3.3 - 5.8 |
| **TSH** | | | |
| TSH | 1.61 | mU/L | 0.4 - 4.0 |
| **LDL-CHOLESTEROL (CALCULATED)** | | | |
| LDL-CHOL. (CALCULATED) | * **5.06** | mmoL/L | 0 - 2.60 |

**Report 14/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 18 Jun 2019 11:47 | Blood Sciences | NW OP RHEUMATOLOGY | Dr Michael J MURPHY (medical) (Chemical Pathology) |

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:05

CLINICAL DETAILS :
fh on alirocumab

LAB COMMENTS :
SLIGHTLY HAEMOLYSED

Sample C197158864 (Blood) Collected 18 Jun 2019 11:00 Received 18 Jun 2019 11:14

| | | | |
|---|---|---|---|
| **CHOLESTEROL** | | | |
| TOTAL CHOLESTEROL | 4.00 | mmol/L | 0.00 - 5.00 |
| **TOTAL CHOL/HDL-CHOL** | | | |
| HDL-CHOLESTEROL | 1.19 | mmol/L | 0.60 - 2.50 |
| TOTAL CHOL/HDL-CHOL | 3.30 | . | |
| **LDL-CHOLESTEROL (CALCULATED)** | | | |
| LDL-CHOL. (CALCULATED) | 2.15 | mmoL/L | 0 - 2.60 |
| **TRIGLYCERIDES** | | | |
| TRIGLYCERIDES | 1.46 | mmol/L | 0.00 - 2.30 |

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

**Report 15/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 26 Apr 2018 15:59 | Blood Sciences | T11166-COLDSIDE MEDICAL PRACTI | Dr FIONA BULLIONS (General Practice) |

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:57

CLINICAL DETAILS :
request by NW

Sample C186241655 (Blood) Collected 26 Apr 2018 12:06 Received 26 Apr 2018 15:02

| | | | | |
|---|---|---|---|---|
| **SAMPLE IS** | | | | |
| | SAMPLE IS | (FASTING) | . | |
| **CHOLESTEROL** | | | | |
| | TOTAL CHOLESTEROL | 4.49 | mmol/L | 0.00 - 5.00 |
| **LDL-CHOLESTEROL (CALCULATED)** | | | | |
| | TOTAL CHOL/HDL-CHOL | 3.40 | . | |
| | TRIGLYCERIDES | 1.25 | mmol/L | 0.00 - 2.30 |
| | LDL-CHOL. (CALCULATED) * | **2.64** | mmoL/L | 0 - 2.60 |
| **TOTAL CHOL/HDL-CHOL** | | | | |
| | HDL-CHOLESTEROL | 1.29 | mmol/L | 0.60 - 2.50 |

**Report 16/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 05 Feb 2018 17:02 | Blood Sciences | T11166-COLDSIDE MEDICAL PRACTI | Dr FIONA BULLIONS (General Practice) |

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:52

CLINICAL DETAILS :
On T4?: No
pt on alirocumab for 3 months, due f/u at CV risk clinic
??dose change - to be prescribed via secondary care

Sample H186056411 (EDTA) Collected 05 Feb 2018 09:44 Received 05 Feb 2018 16:13

| | | | | |
|---|---|---|---|---|
| **FBC** | | | | |
| | Hb | 139 | g/L | 130 - 180 |
| | WBC | 9.4 | x10^9/L | 4.0 - 11.0 |
| | PLT | 365 | x10^9/L | 150 - 400 |
| | RBC * | **4.43** | x10^12/L | 4.5 - 6.0 |
| | HCT | 0.419 | | 0.40 - 0.52 |
| | MCV | 94.7 | fl | 85 - 105 |
| | MCH | 31.5 | pg | 27 - 32 |
| | MCHC | 333 | g/L | 320 - 360 |
| | NE# | 5.3 | x10^9/L | 2.0 - 7.5 |
| | LY# | 3.0 | x10^9/L | 1.5 - 4.0 |
| | MO# | 0.6 | x10^9/L | 0.2 - 0.8 |
| | EO# | 0.34 | x10^9/L | 0.0 - 0.4 |
| | BA# | 0.1 | x10^9/L | 0.0 - 0.1 |

**Report 17/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 17 Nov 2017 15:11 | Blood Sciences | NW OP 3/4 | Dr Isla S MACKENZIE (Clinical Pharmacology) (Clinical Pharmacology) |

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 05:06

CLINICAL DETAILS :
On T4?: No
Hypercholesterolaemia, NSTEMI, peripheral vascular disease.
Being considered for PCSK9 inhibitor therapy. PLEASE SUPPLY
FULL LIPID PROFILE including TG and calculated LDL.
Non-fasted.

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

Sample H175888571 (EDTA) Collected 17 Nov 2017 14:18 Received 17 Nov 2017 14:47

**FBC**

| | | | | |
|---|---|---|---|---|
| Hb | | 138 | g/L | 130 - 180 |
| WBC | | 7.9 | x10^9/L | 4.0 - 11.0 |
| PLT | | 380 | x10^9/L | 150 - 400 |
| RBC | | 4.66 | x10^12/L | 4.5 - 6.0 |
| HCT | | 0.439 | | 0.40 - 0.52 |
| MCV | | 94.1 | fl | 85 - 105 |
| MCH | | 29.6 | pg | 27 - 32 |
| MCHC | * | **314** | g/L | 320 - 360 |
| NE# | | 4.2 | x10^9/L | 2.0 - 7.5 |
| LY# | | 2.9 | x10^9/L | 1.5 - 4.0 |
| MO# | | 0.4 | x10^9/L | 0.2 - 0.8 |
| EO# | | 0.26 | x10^9/L | 0.0 - 0.4 |
| BA# | | 0.1 | x10^9/L | 0.0 - 0.1 |

**Report 18/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 23 Nov 2016 12:20 | Blood Sciences | NW WARD 1 | Dr Thomas N MARTIN (Cardiology) (Cardiology) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:50

CLINICAL DETAILS :
Post angio

Sample C165089813 (Blood) Collected 23 Nov 2016 07:30 Received 23 Nov 2016 11:36

**Urea & Electrolytes**

| | | | |
|---|---|---|---|
| SODIUM | 139 | mmol/L | 133 - 146 |
| POTASSIUM | 4.4 | mmol/L | 3.5 - 5.3 |
| UREA | 5.5 | mmol/L | 2.5 - 7.8 |
| CREATININE | 84 | umol/L | 62 - 106 |

**AKI**

| | | |
|---|---|---|
| AKI | Not detected: but may not exclude AKI in all cases | . |

**ESTIMATED GFR**

| | | |
|---|---|---|
| ESTIMATED GFR | GT60 | mL/min |

**CKD Stage**

| | |
|---|---|
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA . |

**Report 19/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 23 Nov 2016 12:03 | Blood Sciences | NW WARD 1 | Dr Thomas N MARTIN (Cardiology) (Cardiology) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:50

CLINICAL DETAILS :
Post angio

Sample H165089813 (EDTA) Collected 23 Nov 2016 07:30 Received 23 Nov 2016 11:36

**FBC**

| | | | | |
|---|---|---|---|---|
| Hb | | 136 | g/L | 130 - 180 |
| WBC | * | **11.2** | x10^9/L | 4.0 - 11.0 |
| PLT | | 379 | x10^9/L | 150 - 400 |
| RBC | * | **4.44** | x10^12/L | 4.5 - 6.0 |
| HCT | | 0.413 | | 0.40 - 0.52 |
| MCV | | 93.1 | fl | 85 - 105 |
| MCH | | 30.6 | pg | 27 - 32 |
| MCHC | | 329 | g/L | 320 - 360 |
| NE# | | 7.4 | x10^9/L | 2.0 - 7.5 |
| LY# | | 2.8 | x10^9/L | 1.5 - 4.0 |
| MO# | | 0.7 | x10^9/L | 0.2 - 0.8 |

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

| | | | |
|---|---|---|---|
| EO# | 0.18 | x10^9/L | 0.0 - 0.4 |
| BA# | 0.1 | x10^9/L | 0.0 - 0.1 |

**Report 20/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 19 Nov 2016 10:06 | Blood Sciences | NW WARD 21 | Dr Stuart D HUTCHEON (Cardiology) (Cardiology) |

Filed by **rwilkie1** (Rachel Wilkie (medical)) at 19 Nov 2016 12:17

CLINICAL DETAILS :
monitor bloods pre angio

Sample C165082875 (Blood) Collected 19 Nov 2016 07:30 Received 19 Nov 2016 09:23

| | | | |
|---|---|---|---|
| **MAGNESIUM** | | | |
| MAGNESIUM | 0.79 | mmoL/L | 0.70 - 1.00 |
| **PHOSPHATE** | | | |
| PHOSPHATE | 1.03 | mmoL/L | 0.8 - 1.5 |
| **BICARBONATE** | | | |
| BICARBONATE | 24 | mmol/L | 22 - 29 |
| **Urea & Electrolytes** | | | |
| SODIUM | 141 | mmol/L | 133 - 146 |
| POTASSIUM | 4.1 | mmol/L | 3.5 - 5.3 |
| UREA | 6.0 | mmol/L | 2.5 - 7.8 |
| CREATININE | 77 | umol/L | 62 - 106 |
| **AKI** | | | |
| AKI | Not detected: but may not exclude AKI in all cases | . | |
| **Liver Function Tests (LFT)** | | | |
| ALT | 49 | U/L | 5 - 55 |
| BILIRUBINS | 10 | umol/L | 0 - 21 |
| ALKALINE PHOSPHATASE | 86 | U/L | 30 - 130 |
| ALBUMIN | * **33** | g/L | 35 - 50 |
| **Bone Group** | | | |
| CALCIUM | 2.21 | mmol/L | 2.10 - 2.55 |
| CALCIUM (CORRECTED) | 2.29 | mmol/L | 2.10 - 2.55 |
| **ESTIMATED GFR** | | | |
| ESTIMATED GFR | GT60 | mL/min | |
| **CKD Stage** | | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA . | | |

**Report 21/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 19 Nov 2016 09:34 | Blood Sciences | NW WARD 21 | Dr Stuart D HUTCHEON (Cardiology) (Cardiology) |

Filed by **rwilkie1** (Rachel Wilkie (medical)) at 19 Nov 2016 12:17

CLINICAL DETAILS :
monitor bloods pre angio

Sample H165082875 (EDTA) Collected 19 Nov 2016 07:30 Received 19 Nov 2016 09:23

**FBC**

| | | | |
|---|---|---|---|
| Hb | 137 | g/L | 130 - 180 |
| WBC | 8.0 | x10^9/L | 4.0 - 11.0 |
| PLT | 339 | x10^9/L | 150 - 400 |
| RBC | 4.61 | x10^12/L | 4.5 - 6.0 |
| HCT | 0.428 | | 0.40 - 0.52 |
| MCV | 92.9 | fl | 85 - 105 |
| MCH | 29.7 | pg | 27 - 32 |
| MCHC | 320 | g/L | 320 - 360 |
| NE# | 4.7 | x10^9/L | 2.0 - 7.5 |
| LY# | 2.5 | x10^9/L | 1.5 - 4.0 |

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

| | | | |
|---|---|---|---|
| MO# | 0.5 | x10^9/L | 0.2 - 0.8 |
| EO# | 0.32 | x10^9/L | 0.0 - 0.4 |
| BA# | 0.1 | x10^9/L | 0.0 - 0.1 |

**Report 22/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 18 Nov 2016 15:20 | Radiology | NW ACCIDENT & EMERGENCY | Mr Neil M NICHOL (A&E) (Accident & Emergency) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:51

Sample 6277805 (TYPE UNSPECIFIED) Collected 16 Nov 2016 19:13 Received 16 Nov 2016 19:13
**XR Chest**

```
Clinical History :
Left sided chest pain to arm. SOB recently, cough. Scattered creps. ?consolidation
ENTERED BY: Alastair Baird (medical)
BLEEP: 32170
XR Chest :
AP erect image in resus.  Comparison with the previous chest x-ray dated 03/02/2011.
The heart and mediastinal contours are normal.  There is background coarsening of the lung
markings as seen previously with some superadded patchy bibasal opacification in keeping
with inflammatory or infective change.
CM/SD
 DR CHRISTOPHER MURRILLS / CMURR
```

**Report 23/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 18 Nov 2016 10:12 | Blood Sciences | NW WARD 21 | Dr Stuart D HUTCHEON (Cardiology) (Cardiology) |

Filed by **gferguson** (Graeme Ferguson (Medical)) at 18 Nov 2016 11:31

```
CLINICAL DETAILS :
  monitor bloods
```

Sample H165080115 (EDTA) Collected 18 Nov 2016 08:15 Received 18 Nov 2016 08:35
**FBC**

| | | | |
|---|---|---|---|
| Hb | 137 | g/L | 130 - 180 |
| WBC | 6.5 | x10^9/L | 4.0 - 11.0 |
| PLT | 300 | x10^9/L | 150 - 400 |
| RBC | 4.51 | x10^12/L | 4.5 - 6.0 |
| HCT | 0.420 | | 0.40 - 0.52 |
| MCV | 93.0 | fl | 85 - 105 |
| MCH | 30.3 | pg | 27 - 32 |
| MCHC | 326 | g/L | 320 - 360 |
| NE# | 3.2 | x10^9/L | 2.0 - 7.5 |
| LY# | 2.2 | x10^9/L | 1.5 - 4.0 |
| MO# | 0.7 | x10^9/L | 0.2 - 0.8 |
| EO# | 0.26 | x10^9/L | 0.0 - 0.4 |
| BA# | 0.1 | x10^9/L | 0.0 - 0.1 |

**Report 24/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 18 Nov 2016 09:30 | Blood Sciences | NW WARD 21 | Dr Stuart D HUTCHEON (Cardiology) (Cardiology) |

Filed by **gferguson** (Graeme Ferguson (Medical)) at 18 Nov 2016 11:32

```
CLINICAL DETAILS :
  monitor bloods
```

Sample C165080115 (Blood) Collected 18 Nov 2016 08:15 Received 18 Nov 2016 08:35
**MAGNESIUM**

| | | | |
|---|---|---|---|
| MAGNESIUM | 0.86 | mmoL/L | 0.70 - 1.00 |

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

| | | | |
|---|---|---|---|
| **PHOSPHATE** | | | |
| PHOSPHATE | 1.13 | mmoL/L | 0.8 - 1.5 |
| **BICARBONATE** | | | |
| BICARBONATE | 27 | mmol/L | 22 - 29 |
| **Urea & Electrolytes** | | | |
| SODIUM | 142 | mmol/L | 133 - 146 |
| POTASSIUM | 4.5 | mmol/L | 3.5 - 5.3 |
| UREA | 4.6 | mmol/L | 2.5 - 7.8 |
| CREATININE | 82 | umol/L | 62 - 106 |
| **AKI** | | | |
| AKI | Not detected: but may not exclude AKI in all cases | . | |
| **Liver Function Tests (LFT)** | | | |
| ALT | * **58** | U/L | 5 - 55 |
| BILIRUBINS | 7 | umol/L | 0 - 21 |
| ALKALINE PHOSPHATASE | 89 | U/L | 30 - 130 |
| ALBUMIN | * **33** | g/L | 35 - 50 |
| **Bone Group** | | | |
| CALCIUM | 2.26 | mmol/L | 2.10 - 2.55 |
| CALCIUM (CORRECTED) | 2.34 | mmol/L | 2.10 - 2.55 |
| **ESTIMATED GFR** | | | |
| ESTIMATED GFR | GT60 | mL/min | |
| **CKD Stage** | | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA . | | |

**Report 25/30**

| **Reported** | **Specialty** | **Location** | **Clinician** |
|---|---|---|---|
| 17 Nov 2016 13:18 | Radiology | NW WARD 21 | Dr Stuart D HUTCHEON (Cardiology) (Cardiology) |

Filed by **gferguson** (Graeme Ferguson (Medical)) at 18 Nov 2016 11:32

Sample 6277995 (TYPE UNSPECIFIED) Collected 17 Nov 2016 11:42 Received 17 Nov 2016 11:42

**Transthoracic Echocardiogram**

```
THIS REPORT HAS BEEN CHANGED
This is a summary report only, the full report is available within the Cardiology Results
Service and should be reviewed prior to making a clinical decision.
THIS REPORT HAS BEEN CHANGED
Reason for study : LV function post MI
Image Quality    :  Adequate image quality  Fair
AORTIC VALVE   :  The aortic valve is normal in structure and function. No aortic
stenosis. No aortic regurgitation.
MITRAL VALVE   :  Mildly thickened leaflets, seen to open well. No mitral stenosis.  Trace
mitral regurgitation.
TRICUSPID VALVE:  Normal in structure and function. No tricuspid stenosis.  Physiological
tricuspid regurgitation.
PULMONARY VALVE :  Normal in structure and function. No pulmonary stenosis. Physiological
pulmonary regurgitation.
RIGHT VENTRICLE:  Normal right heart size and function.
LEFT VENTRICLE :  Normal LV size. No LV hypertrophy. Normal LV systolic function.
WALL MOTION    :  No obvious regional wall motion abnormality noted
GREAT VESSELS  :  Undilated aortic root.
IVC            :  Normal IVC with complete inspiratory collapse
ATRIA          :  The LA is mildly dilated. Normal RA size. The interatrial septum appears
intact with no evidence of a defect.
ECG            :  Sinus Rhythm 74 BPM
CONCLUSIONS
Normal LV size and systolic function.
Normal RV size and systolic function
The LA is mildly dilated. Normal RA size.
No significant valvular pathologies.
No significant pericardial effusion.
InterpretingPhysician:  Greg  Mysak, Locum Cardiac Physiologist electronically signed on
2016-11-17 13:16:15.117
Report generated by Cardiology Results Service
 CARDIOLOGY RESULTS SERVICE / EXTERNAL
```

**Report 26/30**

| **Reported** | **Specialty** | **Location** | **Clinician** |
|---|---|---|---|
| 17 Nov 2016 09:25 | Blood Sciences | NW WARD 21 | Dr Stuart D HUTCHEON (Cardiology) (Cardiology) |

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

Filed by **gferguson** (Graeme Ferguson (Medical)) at 17 Nov 2016 12:26

CLINICAL DETAILS :
Monitoring, post NSTEMI

Sample C165077345 (Blood) Collected 17 Nov 2016 08:35 Received 17 Nov 2016 08:52

| | | | | |
|---|---|---|---|---|
| **MAGNESIUM** | | | | |
| MAGNESIUM | 0.84 | | mmoL/L | 0.70 - 1.00 |
| **PHOSPHATE** | | | | |
| PHOSPHATE | 1.20 | | mmoL/L | 0.8 - 1.5 |
| **Urea & Electrolytes** | | | | |
| SODIUM | 141 | | mmol/L | 133 - 146 |
| POTASSIUM | 4.2 | | mmol/L | 3.5 - 5.3 |
| UREA | 4.1 | | mmol/L | 2.5 - 7.8 |
| CREATININE | 74 | | umol/L | 62 - 106 |
| **AKI** | | | | |
| AKI | Not detected: but may not exclude AKI in all cases | | . | |
| **Liver Function Tests (LFT)** | | | | |
| ALT | 49 | | U/L | 5 - 55 |
| BILIRUBINS | 5 | | umol/L | 0 - 21 |
| ALKALINE PHOSPHATASE | 96 | | U/L | 30 - 130 |
| ALBUMIN | * **34** | | g/L | 35 - 50 |
| **ESTIMATED GFR** | | | | |
| ESTIMATED GFR | GT60 | | mL/min | |
| **CKD Stage** | | | | |
| CKD Stage | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA . | | | |

**Report 27/30**

| **Reported** | **Specialty** | **Location** | **Clinician** |
|---|---|---|---|
| 17 Nov 2016 09:11 | Blood Sciences | NW WARD 21 | Dr Stuart D HUTCHEON (Cardiology) (Cardiology) |

Filed by **gferguson** (Graeme Ferguson (Medical)) at 17 Nov 2016 12:26

CLINICAL DETAILS :
Monitoring, post NSTEMI

Sample H165077345 (EDTA) Collected 17 Nov 2016 08:35 Received 17 Nov 2016 08:52

**FBC**

| | | | | |
|---|---|---|---|---|
| Hb | * | **128** | g/L | 130 - 180 |
| WBC | | 7.2 | x10^9/L | 4.0 - 11.0 |
| PLT | | 348 | x10^9/L | 150 - 400 |
| RBC | * | **4.40** | x10^12/L | 4.5 - 6.0 |
| HCT | | 0.408 | | 0.40 - 0.52 |
| MCV | | 92.8 | fl | 85 - 105 |
| MCH | | 29.0 | pg | 27 - 32 |
| MCHC | * | **312** | g/L | 320 - 360 |
| NE# | | 3.9 | x10^9/L | 2.0 - 7.5 |
| LY# | | 2.2 | x10^9/L | 1.5 - 4.0 |
| MO# | * | **0.9** | x10^9/L | 0.2 - 0.8 |
| EO# | | 0.20 | x10^9/L | 0.0 - 0.4 |
| BA# | | 0.1 | x10^9/L | 0.0 - 0.1 |

**Report 28/30**

| **Reported** | **Specialty** | **Location** | **Clinician** |
|---|---|---|---|
| 17 Nov 2016 02:03 | Blood Sciences | NW WARD 21 | Dr Stuart D HUTCHEON (Cardiology) (Cardiology) |

Filed by **gferguson** (Graeme Ferguson (Medical)) at 17 Nov 2016 12:27

CLINICAL DETAILS :
: 2nd or subsequent sample

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

Hours since last: 6
2nd trop - NSTEMI

LAB COMMENTS :
A Cardiac Troponin I value greater than 0.45ug/L highly
suggestive of ACS.
SIGNIFICANT CHANGE. Interpret in conjunction with
history and ECG changes.

Sample C165077266 (Blood) Collected 16 Nov 2016 23:42 Received 17 Nov 2016 01:17

| | | | | |
|---|---|---|---|---|
| **TROPONIN I** | | | | |
| TROPONIN I | * | **2.510** | ug/L | 0.015 - 0.045 |

**Report 29/30**

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 16 Nov 2016 23:55 | Blood Sciences | NW ACCIDENT & EMERGENCY | Mr Neil M NICHOL (A&E) (Accident & Emergency) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:51

CLINICAL DETAILS :
: 1st sample
: Chest Pain
Symptom onset: 16 Nov 2016 17:00
: ST Depression
ECG done: 16 Nov 2016 19:00
Left sided chest pain to arm. SOB recently, cough. Scattered
creps. ?consolidation

LAB COMMENTS :
Cardiac Troponin I above 99th centile. If this is a
baseline sample it suggests evolving ACS; repeat in 6
hours. If this is a second or subsequent sample, a
significant change suggests ACS.

Sample C165077171 (Blood) Collected 16 Nov 2016 19:03 Received 16 Nov 2016 19:37

| | | | | |
|---|---|---|---|---|
| **BICARBONATE** | | | | |
| BICARBONATE | | 26 | mmol/L | 22 - 29 |
| **CHOLESTEROL** | | | | |
| TOTAL CHOLESTEROL | * | **6.64** | mmol/L | 0.00 - 5.00 |
| **Urea & Electrolytes** | | | | |
| SODIUM | | 139 | mmol/L | 133 - 146 |
| POTASSIUM | | 4.1 | mmol/L | 3.5 - 5.3 |
| UREA | | 4.6 | mmol/L | 2.5 - 7.8 |
| CREATININE | | 74 | umol/L | 62 - 106 |
| **AKI** | | | | |
| AKI | | Not detected: but may not exclude AKI in all cases | . | |
| **Liver Function Tests (LFT)** | | | | |
| ALT | | 44 | U/L | 5 - 55 |
| BILIRUBINS | | 6 | umol/L | 0 - 21 |
| ALKALINE PHOSPHATASE | | 101 | U/L | 30 - 130 |
| ALBUMIN | | 35 | g/L | 35 - 50 |
| **ESTIMATED GFR** | | | | |
| ESTIMATED GFR | | GT60 | mL/min | |
| **CKD Stage** | | | | |
| CKD Stage | | IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA | . | |
| **TOTAL CHOL/HDL-CHOL** | | | | |
| HDL-CHOLESTEROL | | 1.67 | mmol/L | 0.60 - 2.50 |
| TOTAL CHOL/HDL-CHOL | | 3.90 | . | |
| **GLUCOSE** | | | | |
| GLUCOSE (preserved tube) | | 5.7 | mmol/L | 3.3 - 5.8 |
| **TROPONIN I** | | | | |
| TROPONIN I | * | **0.067** | ug/L | 0.015 - 0.045 |
| **MAGNESIUM** | | | | |
| MAGNESIUM | | 0.77 | mmoL/L | 0.70 - 1.00 |
| **PHOSPHATE** | | | | |
| PHOSPHATE | | 0.92 | mmoL/L | 0.8 - 1.5 |

**Report 30/30**

Patient name: **DAVID STANDISH**
Hospital number: **0503700053**
:

| Reported | Specialty | Location | Clinician |
|---|---|---|---|
| 16 Nov 2016 19:55 | Blood Sciences | NW ACCIDENT & EMERGENCY | Mr Neil M NICHOL (A&E) (Accident & Emergency) |

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:51

```
CLINICAL DETAILS :
: 1st sample
: Chest Pain
Symptom onset: 16 Nov 2016 17:00
: ST Depression
ECG done: 16 Nov 2016 19:00
Left sided chest pain to arm. SOB recently, cough. Scattered
creps. ?consolidation
```

Sample H165077171 (EDTA) Collected 16 Nov 2016 19:03 Received 16 Nov 2016 19:37

**FBC**

| | | | | |
|---|---|---|---|---|
| Hb | | 134 | g/L | 130 - 180 |
| WBC | * | **11.6** | x10^9/L | 4.0 - 11.0 |
| PLT | | 358 | x10^9/L | 150 - 400 |
| RBC | * | **4.40** | x10^12/L | 4.5 - 6.0 |
| HCT | | 0.412 | | 0.40 - 0.52 |
| MCV | | 93.8 | fl | 85 - 105 |
| MCH | | 30.4 | pg | 27 - 32 |
| MCHC | | 325 | g/L | 320 - 360 |
| NE# | * | **9.0** | x10^9/L | 2.0 - 7.5 |
| LY# | * | **1.4** | x10^9/L | 1.5 - 4.0 |
| MO# | * | **1.0** | x10^9/L | 0.2 - 0.8 |
| EO# | | 0.19 | x10^9/L | 0.0 - 0.4 |
| BA# | | 0.1 | x10^9/L | 0.0 - 0.1 |

**End of reports**