NHS Lothian

Immediate Outpatient Letter

Serial number 677522

IN CONFIDENCE

Hospital : L C H   Department : [illegible]   Consultant : [illegible]

Name and address of General Practitioner	Mr/Mrs/Miss Surname: First Name: Address: Weight (where applicable)
	700793490X /E4490056 M DAY Colin 27-Apr-61 CHI: 270 461 0150 70268 SG Watt 27s Findhorn Place EH9 2NY

Your patient attended the clinic on: ______

Recommendations/comments:

Gout

Follow-up advice: To attend hospital for further review in ______

To attend GP surgery Y / N

Follow-up required Y / N

Medication: The following medicines are recommended. Only those items that must be initiated immediately have been provided from the hospital pharmacy, as indicated under the 'Quantity to be provided' section.

Pharmacy use:

Medicine and Form	Dose	Administration Times				Additional Instructions (including length of treatment course)	Quantity to be provided *	LJF **	Dispensed/ Issued by:	Checked by:
			✓	✓	✓					
1. COLCHICINE 500						[illegible]	15		[illegible]	[illegible]
2.										
3.										
4.										
5.										
6.										

N.B. * A 14 day supply should be provided from the hospital if required unless a shorter or longer course is appropriate.

** Tick the box if the medicine is not on the Lothian Joint Formulary, and include an explanatory note for non-Formulary medicines under Recommendations/comments.

Prescribed by : ______ (sign) Date : 11/1/[illegible]

______ (print)

Contact for advice : ______ Tel/bleep no. : ______

WHITE COPY - TO PHARMACY *PINK COPY - G.P.* *BLUE COPY - CASENOTES*

RIE 334

700793490X /E4490056 M
DAY Colin
27-Apr-61 CHI: 270 461 0150
70268 SG Watt
27s Findhorn Place
EH9 2NY

WGH MAU Triage

Nurse: Sara-ann
Initials: SR
Date: 14/7/20

Presenting Complaint:
Sore left toe, Red-Swelling

PMH: Angina,

Allergies: None known.

Allergy band applied : Yes / (No)

NEWS (Y)/N Frequency 4°
Bloods (Y)/N
BM Y/(N)
PVC (Y)/N *Complete Trak PVC Bundle *
ECG (Y)/N
GCS Y/(N)
Analgesia Y/(N)
Swallow Y/N/(NA)

Mobility Ind with stick
Falls Risk (Y)/N
Weight ____
Height ____
NOK ____

TRIAGE UP Y / N

Plan for admission:

PRESCRIPTION AND ADMINISTRATION RECORD

Standard Chart

NHS Lothian

Hospital/Ward:	Consultant:
Weight:	Height:
If re-written, date:	
DISCHARGE PRESCRIPTION	
Date completed:	Completed by:

Name of Pa 700793490X /E4490056 M
DAY Colin
CHI Numbe 27-Apr-61 CHI: 270 461 0150
70268 SG Watt
D.O.B. 27s Findhorn Place
EH9 2NY

OTHER MEDICINE CHARTS IN USE		PREVIOUS ADVERSE REACTIONS This section must be completed before any medicine is given		Completed by (sign & print)	Date
Date	Type of Chart	None known ☐			
		Medicine / Agent	Description of reaction		

- **Write clearly in block capitals, using a black ballpoint pen**
- **Use approved names for medicines**
- **Never alter a prescription**
- **Route of administration**
  The only acceptable abbreviations are:
  IV - intravenous SL - sublingual NG - nasogastric
  IM - intramuscular PR - per rectum ID - intradermal
  SC - subcutaneous PV - per vagina TOP - topical
  INHAL - inhaled NEB - nebulised
  Never abbreviate ORAL or INTRATHECAL
  Specify RIGHT or LEFT for eye and ear preparations

- **Write the medicine dose clearly**
  - The only acceptable abbreviations are:
  g - gram mg - milligram ml - millilitre
  all other doses must be written out in full eg. micrograms
  - Avoid decimal points eg. 100 micrograms (not 0.1mg). If unavoidable, write zero in front of the decimal point
  - Prescribe liquids by writing the dose in mg
  - For 'as required' medicines, state the symptoms to be relieved, the minimum time interval between doses and the maximum daily dose
  - Write units as 'units' not 'iu'

ONCE ONLY

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber - Sign + Print	Time Given	Given By
		~~[illegible]~~					
14/7/20	1855	COLCHICINE	0.5mg	oral	[signature]	1905	SS

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINE

If a dose is not administered as prescribed, initial and enter a code in the column with a circle drawn round the code according to the reason as shown below. **Inform the responsible doctor in the appropriate timescale.**

1. Patient refuses
2. Patient not present
3. Medicines not available - CHECK ORDERED
4. Asleep / drowsy
5. Administration route not available - CHECK FOR ALTERNATIVE
6. Vomiting / nausea
7. Time varied on doctor's instructions
8. Once only / as required medicine given
9. Dose withheld on doctor's instructions
10. Possible adverse reaction / side effect

Oxygen Prescribing for Acute Admissions

PRESCRIBER: Circle appropriate target range, date and sign.

NURSE: Sign at drug rounds four times daily. This indicates administration has been reviewed and either patient is within target range **OR** adjustments are being made.

For patients outside target range **Nurse** should adjust oxygen and recheck Saturations within 10 minutes. Document all changes to oxygen administration on **NEWS chart.**

PRESCRIPTION			Patient's Own Medicine	Date→ / Time↓														
Oxygen				6														
To maintain O2 saturations				(8)														
94-98% 88-92%				(12)														
Please WEAN if able				14														
Start Date:				(18)														
Sign and print				(22)														
Medicine (Approved Name)			For Use / Date	6														
				8														
Dose		Route	Quantity	12														
Notes/Indication for antibiotic		Start Date	Stop Date	14														
Prescriber - sign + print			Pharmacy	18														
				22														
Medicine (Approved Name)			For Use / Date	6														
				8														
Dose		Route	Quantity	12														
Notes/Indication for antibiotic		Start Date	Stop Date	14														
Prescriber - sign + print			Pharmacy	18														
				22														
Medicine (Approved Name)			For Use / Date	6														
				8														
Dose		Route	Quantity	12														
Notes/Indication for antibiotic		Start Date	Stop Date	14														
Prescriber - sign + print			Pharmacy	18														
				22														

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															

AS REQUIRED THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine													
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓																
Medicine (Approved Name)		For Use / Date	6																
Dose	Route	Quantity	8																
			12																
Notes/Indication for antibiotic	Start Date	Stop Date	14																
Prescriber - sign + print		Pharmacy	18																
			22																
Medicine (Approved Name)		For Use / Date	6																
Dose	Route	Quantity	8																
			12																
Notes/Indication for antibiotic	Start Date	Stop Date	14																
Prescriber - sign + print		Pharmacy	18																
			22																
Medicine (Approved Name)		For Use / Date	6																
Dose	Route	Quantity	8																
			12																
Notes/Indication for antibiotic	Start Date	Stop Date	14																
Prescriber - sign + print		Pharmacy	18																
			22																
Medicine (Approved Name)		For Use / Date	6																
Dose	Route	Quantity	8																
			12																
Notes/Indication for antibiotic	Start Date	Stop Date	14																
Prescriber - sign + print		Pharmacy	18																
			22																
Medicine (Approved Name)		For Use / Date	6																
Dose	Route	Quantity	8																
			12																
Notes/Indication for antibiotic	Start Date	Stop Date	14																
Prescriber - sign + print		Pharmacy	18																
			22																
Medicine (Approved Name)		For Use / Date	6																
Dose	Route	Quantity	8																
			12																
Notes/Indication for antibiotic	Start Date	Stop Date	14																
Prescriber - sign + print		Pharmacy	18																
			22																

TURN OVER →

AS REQUIRED THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine													
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												

National Early Warning Score 2 (NEWS2) Chart

NHS Lothian

700793490X /E4490056 M
DAY Colin
27-Apr-61 **CHI:** 270 461 0150
70268 SG Watt
27s Findhorn Place
EH9 2NY

Date chart commenced: 14/7/20

This is chart number 1 of this admission

Conscious Level Chart to be completed when clinically indicated

	Date			
	Time			
GLASGOW COMA SCALE – Eyes Open	Spontaneously	4		Eyes closed by swelling = C
	To speech	3		
	To pain	2		
	None	1		
Best Verbal Response	Orientated	5		Endotracheal tube or tracheostomy = T
	Confused	4		
	Inappropriate words	3		
	Incomprehensible sounds	2		
	None	1		
Best Motor Response	Obey commands	6		Always record the best arm response
	Localise to pain	5		
	Flexion to pain	4		
	Abnormal flexion	3		
	Extension to pain	2		
	None	1		
	Total GCS Score			
Right Pupil	Size			+ reacts - no reaction c. eye closed
	Reaction			
Left Pupil	Size			
	Reaction			
LIMB MOVEMENT – ARMS	Normal power			Record right (R) and left (L) separately if there is a difference between the two sides
	Mild weakness			
	Severe weakness			
	Extension			
	No response			
LEGS	Normal power			
	Mild weakness			
	Severe weakness			
	Extension			
	No response			
	Initials			

Pupil Scale mm 1 • 2 ● 3 4 5 6 7 8

REMEMBER
- **Record all observations** on NEWS2 chart
- **Document concerns/decisions in clinical notes**
- **Escalate** your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

	Assess	Possible Actions
AIRWAY	Is the airway - • patent • at risk • obstructed	• suction if indicated • head tilt, chin lift / jaw thrust • airway adjuncts • administer oxygen • call 2222 if at risk
BREATHING	• respiratory rate • SpO_2 • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	• administer prescribed oxygen to maintain saturations 94-98% (NB COPD 88-92%) • monitor SpO_2 / ABGs • consider chest x-ray • treat underlying cause • call 2222 if not breathing
CIRCULATION	• pulse • blood pressure • capillary refill time • core temperature / colour • urine output • consider 4 body cavities for fluid & blood loss (4 + on the floor) • monitor drain losses	• obtain IV access • obtain blood samples • prepare fluid challenge • initiate fluid balance chart • call 2222 if no circulation • consider initiating major haemorrhage protocol • monitor response to actions
DISABILITY A = Alert V = Voice / Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	• re-assess GCS • check blood glucose if less than 4mmols/litre activate hypoglycaemia protocol • check drug chart • remember accurate documentation
EXPOSURE	• top to toe examination • look for evidence of blood loss / rashes / drains / wounds etc	• control bleeding • treat any underlying conditions identified • reassess • maintain patient's dignity • evaluate actions

Pain and Symptom Assessment and Management

Supportive care - pain: Always score worst pain in the last 24 hours or since last assessment. If the patient has deteriorating health with limited reversibility, refer to **Scottish Palliative Care Guidelines**

Acute Pain: Score current pain on movement, e.g. deep breathing. Refer to **Acute Pain Guidelines**

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

↓

Call Medical Staff / Senior Nurse / Nurse Practitioner

↓

For further advice contact:

ACUTE	SPECIALIST PALLIATIVE CARE
Mon-Fri: bleep Acute Pain Team Out of Hours: on-call Anaesthetist	Mon-Fri: bleep Palliative Care Team Out of Hours: via Switchboard

Pain Score	Nausea Score	Epidural Motor Block Score please do not (✓) motor block column
0 - None Continue to assess pain at least daily	**0 - No Nausea**	**0 - Full Power**
1 - 3 Mild Continue to assess pain with routine observations, must be at least daily	**1 - Nausea** Consider anti-emetic	**1 - Weak but able to raise legs**
		2 - Able to bend knees
4 - 5 Moderate Assess, administer and review analgesia as appropriate for patient	**2 - Nausea / Vomiting** Administer anti-emetic	**3 - Minimal movement**
6 - 10 Severe Assess, administer and review analgesia as appropriate for patient	**3 - Persistent Nausea &/or Vomiting** Contact Doctor	**4 - Paralysis**
Using appropriate Lothian Guidelines	Using guidelines prescribe / give anti-emetics and review	If score 2 or above please immediately contact the Acute Pain Team or on-call Anaesthetist if out of hours

Addressograph
700793490X /E4490056 M
DAY Colin
27-Apr-61 CHI: 270 461 0150
70268 SG Watt
27s Findhorn Place
EH9 2NY

NEWS of 5 or more?

Think Sepsis!

In a patient with a **NEWS** of **5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Special Instructions:
Only to be completed under the direction of a senior member of the medical team

A total NEWS of ______ or individual parameter of ______
is acceptable for this patient because ______

Please escalate if ______

Print ______ Sign ______ Designation ______
Date ______ Time ______ *(only valid if signed and dated)*

***Regardless of NEWS always Escalate if concerned about a patient's condition. Escalate immediately if clinical observations cannot be obtained**

NEWS TOTAL	Monitoring Frequency	Clinical Response Document concerns/decisions in patients clinical notes
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 Urgent response threshold	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart

Codes for recording oxygen delivery on the NEWS2 observations chart

A	breathing air	RM	reservoir mask
N	nasal cannula (document in litres)	TM	tracheostomy mask
SM	simple mask	CP	CPAP mask
V	venturi mask and percentage (e.g device = V, % = 40)	H	humidified oxygen and percentage (e.g device = H, L/min or % = 40)
NIV	patient on NIV system	OTH	Other specify

Date / Time															
Circulation															
Sensation															
Movement															

NEWS Key 0 1 2 3

Parameter	Range	14/7 18:10	Score
	Date:	14/7	
	Time:	18:10	
A+B Respirations Breaths/min	≥25		3
	21-24		2
	18-20	18	
	15-17		
	12-14		
	9-11		1
	≤8		3
A+B SpO$_2$ Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%	≥96	96	
	94-95		1
	92-93		2
	≤91		3
SpO$_2$ Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure	≥97 on O$_2$		3
	95-96 on O$_2$		2
	93-94 on O$_2$		1
	≥93 on air		
* ONLY use Scale 2 under the direction of a qualified clinician	88-92		
	86-87		1
Tick box if using SpO$_2$ Scale 2	84-85		2
Sign:	≤83		3
Air or Oxygen? Oxygen is a drug and prescribed by target range	A = Air	A	
	O² L/min or %		2
	Device		
C Blood Pressure mmHg Score uses Systolic BP only	≥220		3
	201-219		
	181-200	161	
	161-180		
	141-160		
If manual BP mark as M	121-140		
	111-120		
	101-110		1
	91-100	104	2
	81-90		
	71-80		
	61-70		3
	51-60		
	≤50		
C Pulse Beats/min	≥131		3
	121-130		2
	111-120	101	
	101-110		1
	91-100		
Manual pulse	81-90		
	71-80		
	61-70		
	51-60		
	41-50		1
	31-40		3
	≤30		
D Consciousness Score for new onset of confusion (no score if chronic)	Alert	A	
	New Confusion		
	V		3
	P		
	U		
E Temperature °C	≥39.1°		2
	38.1-39.0°	37.3	1
	37.1-38.0°		
	36.1-37.0°		
	35.1-36.0°		1
	≤35.0°		3
NEWS TOTAL		1	
Monitoring frequency		6	
Escalation of care Y/N		N	
Initials		[illegible]	
Urine output recorded Y/N		Y	
Blood Glucose level or N/A		n/a	
Pain score (0-10)		3-4	
Nausea score (0-3)		0	
Motor Block score (0-4) or N/A		n/a	

Date: 21/12/23 Hospital: NGH .
Edinburgh.

DISCHARGE AGAINST ADVICE

I COLIN DAM, hereby declare that I am taking my OWN discharge at my own request an**against medical advice.** I take full responsibility for anything that may occu as a result of my action.

Signed: .....

Witnessed by Sister or Nurse-in-Charge: .....

LHB 1698

700793490X /E5558159 M
DAY Colin
27-Apr-61 CHI: 270 461 0150
70470 FJ Wright
27s Findhorn Place
EH9 2NY

NHS Lothian

Nursing Assessment Triage Form

Hospital no/CHI:

Date: 21/12/23	Time of Triage: 1600
Name of nurse completing triage (print name):	

Subjective/Objective/Assessment/Plan (SOAP):	**PAST MEDICAL HISTORY:**
S: Had sudden onset of dizziness. finds it worse when bending her head down. no headache, no vomiting, no fever.	→ prev CVA (3 yrs ago).
O: was comfortable and well spoken in full sentences mobilising independently with w/s stick in hand	**ALLERGIES:** NKDA.
A: NEWS → 1, GCS 15 Alert + orientated to time and place. no current c/o pain or discomfort	Pain Score: 0/10 Analgesia?: YES ☐ NO ☑
	BP: 166/90
	SPO₂ 95% on RA
P: obs bloods ECG	**RR** 19
	PULSE 85
	TEMP 36.1
	NEWS Score 1
	BM —
	Ketones —

TRIAGE CATOGORY (please circle) 1 2 (3) 4 5

FALLS RISK? YES ☐ NO ☐ ✓ If YES, please affix a sticker and add a TRACK alert, and complete the 4AT in the Patient-centred Care Plan.
Yellow Falls Kit issued? YES ☐ NO ☑ If NO, provide rationale:

Enhanced Obs required: YES ☐ NO ☐ N/A ☐	WEIGHT (kg):

IV Cannula YES ☐ NO ☑ N/A ☐ If YES, date: ___/___/___

Nurse's signature: [signature] Print name: J. Carter	Date: 21/12/23

Approved: Sep 2023
Review: Sep 2026

NHS Lothian

Medical Assessment Unit Admission Care Plan and Checklist	Addressograph, or Name: DOB: Hospital no/CHI:

Date/time	Progress Notes	Signature/print name

NURSING ADMISSION CHECKLIST

Standard Admission Procedures	**Initials**
Vital signs recorded YES ☐ NO ☐ N/A ☐	
NEWS2 score recorded YES ☐ NO ☐ N/A ☐	
Name band attached YES ☐ NO ☐	
Relatives: In ED ☐ At home ☐ Not aware ☐	
Clothing and valuables: labelled: YES ☐ NO ☐ Documented YES ☐ NO ☐	
Procedures	
ECG completed: YES ☐ NO ☐	
Falls Risk assessment completed: YES ☐ NO ☐	

NHS Lothian

Medical Assessment Unit **Care Rounding**	Addressograph, or Name: DOB: Hospital no/CHI:

CARE ROUNDING FREQUENCY: 1 ☐ 2 ☐ 3 ☐ 4 ☐ hourly

Review frequency every 12 hours or if the patient's clinical condition requires

Print name of nurse reviewing:					Date: ___/___/___
Time of Round					
Clinical Area					
Care Round Leader's Initials					
Review Frequency of Vital Signs & Cardiac Monitoring					
Vital Signs Frequency					
Cardiac Monitoring required?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
Pain Management (refer to doctor if analgesia is required)					
Pain score (0 – 10)					
Analgesia provided	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
Medication					
Is the person due any routine medication?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
Mobility – tick one option per care rounding					
Fully weight bearing	☐	☐	☐	☐	☐
Requires some assistance/uses walking aid	☐	☐	☐	☐	☐
Non weight bearing – needs full assistance	☐	☐	☐	☐	☐
Identified as at risk of falls	☐	☐	☐	☐	☐
Elimination					
Ask patient if they require the toilet	☐	☐	☐	☐	☐
Patient is self caring and can walk to toilet	☐	☐	☐	☐	☐
Patient is incontinent and needs to be checked	☐	☐	☐	☐	☐
Patient has catheter in situ - needs to be checked	☐	☐	☐	☐	☐
Nutrition and Hydration (tick one option per care rounding)					
Patient is self caring	☐	☐	☐	☐	☐
Patient needs assistance with feeding/drinks	☐	☐	☐	☐	☐
Patient is only allowed fluids	☐	☐	☐	☐	☐
Patient is **NBM**	☐	☐	☐	☐	☐
Patient has **IVI** in situ	☐	☐	☐	☐	☐
Fluid balance chart updated?	Y☐ N☐ N/A☐	Y☐ N☐ N/A☐	Y☐ N☐ N/A☐	Y☐ N☐ N/A☐	Y☐ N☐ N/A☐
Refreshments – Provided (P) Refused (R)					
Drink	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐
Snack	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐
Catered meal	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐	P☐ R☐

NHS Lothian

Medical Assessment Unit Care Rounding Cont'd	Addressograph, or Name: DOB: Hospital no/CHI:

Visual Skin Inspection – tick one option per care rounding					
Patient is healthy – no concerns	☐	☐	☐	☐	☐
Visible areas of redness	☐	☐	☐	☐	☐
Broken skin and evidence of pressure ulcers	☐	☐	☐	☐	☐
Is a Waterlow assessment required?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
Is pressure relieving equipment/mattress required?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
Invasive Devices – please circle device used and tick if device in situ					
PVC /PVC insertion bundle completed	☐	☐	☐	☐	☐
Urinary catheter /catheter insertion bundle completed	☐	☐	☐	☐	☐
Infusion device	☐	☐	☐	☐	☐
NG tube / PEG tube / Tracheotomy	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐
Vulnerable person/cognitive impairment	**Is a 4AT required?** Y☐ N☐				
Family Communication					
Patient and relatives present, and have been made aware of any changes	☐	☐	☐	☐	☐
Cubicle Tidy					
Ensure area is tidy and free of obstructions	☐	☐	☐	☐	☐

Receiving Ward Nurse's signature		MAU Escort's signature:		Date: ___/___/___

MAU TROLLEYS TO WARD HANDOVER	
NEWS	
Outstanding jobs	
HEPMA administered?	YES ☐ NO ☐
Diagnosis	

National Early Warning Score 2 (NEWS2) Chart

NHS Lothian

95 kg

70079490X /E5558159 M
DAY Colin
27-Apr-61 **CHI:** 270 461 0150
70470 FJ Wright
27s Findhorn Place
EH9 2NY

Date chart commenced:

This is chart number _____ of this admission

Conscious Level Chart to be completed when clinically indicated

		Date		
		Time		
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4	Eyes closed by swelling = C
		To speech	3	
		To pain	2	
		None	1	
	Best Verbal Response	Orientated	5	Endotracheal tube or tracheostomy = T
		Confused	4	
		Inappropriate words	3	
		Incomprehensible sounds	2	
		None	1	
	Best Motor Response	Obey commands	6	Always record the best arm response
		Localise to pain	5	
		Flexion to pain	4	
		Abnormal flexion	3	
		Extension to pain	2	
		None	1	
		Total GCS Score		
	Right Pupil	Size		+ reacts - no reaction c. eye closed
		Reaction		
	Left Pupil	Size		
		Reaction		
LIMB MOVEMENT	ARMS	Normal power		Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
	LEGS	Normal power		
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
		Initials		

Pupil Scale mm 1 2 3 4 5 6 7 8

REMEMBER
- **Record all observations** on NEWS2 chart
- **Document concerns/decisions in clinical notes**
- **Escalate** your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

	Assess	Possible Actions
AIRWAY	Is the airway - • patent • at risk • obstructed	• suction if indicated • head tilt, chin lift / jaw thrust • airway adjuncts • administer oxygen • call 2222 if at risk
BREATHING	• respiratory rate • SpO_2 • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	• administer prescribed oxygen to maintain saturations 94-98% (NB COPD 88-92%) • monitor SpO_2 / ABGs • consider chest x-ray • treat underlying cause • call 2222 if not breathing
CIRCULATION	• pulse • blood pressure • capillary refill time • core temperature / colour • urine output • consider 4 body cavities for fluid & blood loss (4 + on the floor) • monitor drain losses	• obtain IV access • obtain blood samples • prepare fluid challenge • initiate fluid balance chart • call 2222 if no circulation • consider initiating major haemorrhage protocol • monitor response to actions
DISABILITY A = Alert V = Voice / Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	• re-assess GCS • check blood glucose if less than 4mmols/litre activate hypoglycaemia protocol • check drug chart • remember accurate documentation
EXPOSURE	• top to toe examination • look for evidence of blood loss / rashes / drains / wounds etc	• control bleeding • treat any underlying conditions identified • reassess • maintain patient's dignity • evaluate actions

Pain and Symptom Assessment and Management

Supportive care - pain: Always score worst pain in the last 24 hours or since last assessment. If the patient has deteriorating health with limited reversibility, refer to **Scottish Palliative Care Guidelines**

Acute Pain: Score current pain on movement, e.g. deep breathing. Refer to **Acute Pain Guidelines**

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

↓

Call Medical Staff / Senior Nurse / Nurse Practitioner

↓

For further advice contact:

ACUTE	SPECIALIST PALLIATIVE CARE
Mon-Fri: bleep Acute Pain Team Out of Hours: on-call Anaesthetist	Mon-Fri: bleep Palliative Care Team Out of Hours: via Switchboard

Pain Score	Nausea Score	Epidural Motor Block Score please do not (✓) motor block column
0 - None Continue to assess pain at least daily	**0 - No Nausea**	**0 - Full Power**
1 - 3 Mild Continue to assess pain with routine observations, must be at least daily	**1 - Nausea** Consider anti-emetic	**1 - Weak but able to raise legs**
4 - 5 Moderate Assess, administer and review analgesia as appropriate for patient	**2 - Nausea / Vomiting** Administer anti-emetic	**2 - Able to bend knees**
6 - 10 Severe Assess, administer and review analgesia as appropriate for patient	**3 - Persistent Nausea &/or Vomiting** Contact Doctor	**3 - Minimal movement** **4 - Paralysis**
Using appropriate Lothian Guidelines	**Using guidelines prescribe / give anti-emetics and review**	If score 2 or above please immediately contact the Acute Pain Team or on-call Anaesthetist if out of hours

Ref: MPS NHS Lothian 2018 Printed January 2019 V1.1 Review December 2021 LOT 1651

700793490X /E5558159 M
DAY Colin
N: 27-Apr-61 CHI: 270 461 0150
70470 FJ Wright
D(27s Findhorn Place
EH9 2NY
Cł

NEWS of 5 or more?

Think Sepsis!

In a patient with a **NEWS** of **5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Special Instructions:

Only to be completed under the direction of a senior member of the medical team

A total NEWS of ______ or individual parameter of ______
is acceptable for this patient because ______

Please escalate if ______

Print ______ Sign ______ Designation ______
Date ______ Time ______ (only valid if signed and dated)

***Regardless of NEWS always Escalate if concerned about a patient's condition. Escalate immediately if clinical observations cannot be obtained**

NEWS TOTAL	Monitoring Frequency	Clinical Response (Document concerns/decisions in patients clinical notes)
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 **Urgent response threshold**	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more **Emergency response threshold**	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart

Codes for recording oxygen delivery on the NEWS2 observations chart

Code	Delivery	Code	Delivery
A	breathing air	RM	reservoir mask
N	nasal cannula (document in litres)	TM	tracheostomy mask
SM	simple mask	CP	CPAP mask
V	venturi mask and percentage (e.g device = V, % = 40)	H	humidified oxygen and percentage (e.g device = H, L/min or % = 40)
NIV	patient on NIV system	OTH	Other specify

Date / Time	
Circulation	
Sensation	
Movement	

NEWS Key: 0 1 2 3

Parameter	Range	Score	Obs 1	Obs 2	Obs 3	Obs 4
	Date		21/12	21/12	21/12	22/12
	Time		18°	23°	23°	10:16
A+B Respirations Breaths/min	≥25	3				
	21-24	2				
	18-20		17	20	20	18
	15-17					
	12-14					
	9-11	1				
	≤8	3				
A+B SpO₂ Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%	≥96			97	97	
	94-95	1	95			95
	92-93	2				
	≤91	3				
SpO₂ Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure. *ONLY use Scale 2 under the direction of a qualified clinician. Tick box if using SpO₂ Scale 2. Sign	≥97 on O₂	3				
	95-96 on O₂	2				
	93-94 on O₂	1				
	≥93 on air					
	88-92					
	86-87	1				
	84-85	2				
	≤83	3				
Air or Oxygen? Oxygen is a drug and prescribed by target range	A = Air		A	A	A	A
	O² L/min or %	2				
	Device					
C Blood Pressure mmHg Score uses Systolic BP only. If manual BP mark as M	≥220	3				
	201-219					
	181-200		166	(S)	(S)	
	161-180			154	154	
	141-160					
	121-140					132
	111-120					
	101-110	1		102		
	91-100	2	98		96	
	81-90	3				
	71-80					
	61-70					80
	51-60					
	≤50					
C Pulse Beats/min. Manual pulse	≥131	3				
	121-130	2				
	111-120					
	101-110	1				
	91-100		95			
	81-90			89	89	
	71-80					80
	61-70					
	51-60					
	41-50	1				
	31-40	3				
	≤30					
D Consciousness Score for new onset of confusion (no score if chronic)	Alert		A	A	A	A
	New Confusion	3				
	V					
	P					
	U					
E Temperature °c	≥39.1°	2				
	38.1-39.0°	1				
	37.1-38.0°					
	36.1-37.0°		36.1	36.1	36.1	36.5
	35.1-36.0°	1				
	≤35.0°	3				
NEWS TOTAL			1	0	0	1
Monitoring frequency			12°	4	4	
Escalation of care Y/N			N	N	N	
Initials				NK	NK	
Urine output recorded Y/N						
Blood Glucose level or N/A			N/A			
Pain score (0-10)			0			0
Nausea score (0-3)			0			0
Motor Block score (0-4) or N/A			N/A			

NHS Lothian

OPD FLEXIBLE CYSTOSCOPY CHECKLIST

700793490X M 27/04/1961
Day, Colin
27s Findhorn Place,
Edinburgh,
EH9 2NY

CHI 2704610150
70470 H Cockburn

700793490X M 27/04/1961
Day, Colin
27s Fi...
F...

Date 11/02/26

One Stop Clinic ☑ Diagnostic Cysto ☐ Surveillance Cysto ☐

Stent removal ☐ Botox Injection ☐

Urine dipstick ☑

Anticoagulant therapy YES ☐ NO ☐
Drug: Date stopped:

BP: 136/71 Pulse: 78 Temp: 36.8

Allergies NKDA

DIAGNOSTIC ROOM

Instillagel YES ☐ NO ☐

Completed by Mr Blachmore Assistant Mr J Kilah

Comments &F/up instructions.....

.....

.....

.....

POST PROCEDURE

Affix Scope label

Flow study/Bladder scan/Ultrasound same day (please circle)

Prescription ☐

DISCHARGE CRITERIA

Voiding urine Yes ☐ No ☐

Post-op advice Yes ☑ No ☐

700793490X M 27/04/1961
Day, Colin
27s Findhorn Place,
Edinburgh,
EH9 2NY

CHI 2704610150
70470 H Cockburn

[ ]
[-- WASH CYCLE PASSED --]
[ ]
[-]
[-]
[Cantel RapidAER]
[Serial No RA1143]
[-]
[Start 09h 59m]
[End 10h 21m]
[Date 11-02-2026]
[-]
[Cycle No 2477]
[-]
[Load Operator 19]
[Name Paul Hart]
[-]
[Unload Operator 13]
[Name Santosh Raviyar]
[-]
[-- Hookup --]
[Hookup No 202]
[Serial No 202/001]
[Barcode]
[-]
[-- Endoscope --]
[OLYM CYF-VH]
[Serial No 2928343]
[Barcode]
[Revision a]
[-]
[IMS Verify Enabled]
[-]
[Control Pass]
[IMS Verify Pass]
[-]
[Contact Time 5 Minutes]
[-]
[Last SD 11-02-2026 at 02h 36m]
[-]
[Suction Not tested]
[Biopsy Av Flow 1520 ml]
[Water Not tested]
[Air Not tested]
[Aux 1 Not tested]
[Aux 2 Not tested]
[RB Not tested]
[Leak Test Av Pres 178 mb]
[-]
[-- Conductivity --]
[Detergent 1573 uS]
[Disinfectant 1078 uS]
[Final Rinse 0 uS]
[-]
[-- Temperature --]
[Detergent 25.5 deg]
[Disinfectant 27.4 deg]
[Final Rinse 16.7 deg]
[-]
[-- Chemical Batch/Lot & Serial No --]
[Detergent 25000801/D000000728]
[Part B 25000978/B000000758]
[Part A 25000975/A000003460]

·indhorn Place,
·dinburgh,
EH9 2NY

CHI 2704610150
70470 H Cockburn
Serial Number:
287480

Patient:

Multistix® 10 SG
Test date 02-11-2026
Time 2:59PM
Operator
Test number 3312
Color Not Entered
Clarity Not Entered

GLU Negative
BIL Negative
KET Negative
SG 1.025
BLO Trace-Intact
pH 6.0
PRO Negative
URO 0.2 E.U./dL
NIT Negative
LEU Negative

This sheet should only be used for essential patient information not currently captured electronically (e.g. diagrams).

NHS Lothian

Essential Scanning Sheet

Anything documented on this sheet will be scanned and made available to view electronically via SCI Store

PATIENT PROGRESS NOTES /COMMUNICATION SHEET

700793490X M 27/04/1961
Day, Colin
27s Findhorn Place,
Edinburgh,
EH9 2NY

CHI 2704610150
70470 H Cockburn

Hospital ☐ **OPD** ☐ **Ward**

State Action/s taken After Exception Reporting
Each entry should be dated and timed

Date and Time	Progress notes / Problems Action Taken and Investigations Required	Signature (Print name & designation)
	Sore throat pain (R)	
	No more VH.	
	Own shopping → uses wheeler	
	Walks with sticks	
	No breathlessness	
	Manages stairs	
	Travelling back + forth to London visit family	
	Drove.	
		eGFR>60
	Clopidogrel → stopped → CVA 2021	

Authorised: Nov 2022
Review: Nov 2025

Essential Scanning Sheet

This sheet should only be used for essential patient information not currently captured electronically (e.g. diagrams).

NHS Lothian

Anything documented on this sheet will be scanned and made available to view electronically via SCI Store

PATIENT PROGRESS NOTES /COMMUNICATION SHEET	Addressograph, or Name DOB Unit No./CHI

Hospital	☐ OPD	☐ Ward	☐ Clinical area

State Action/s taken After Exception Reporting
Each entry should be dated and timed

Date and Time	Progress notes / Problems Action Taken and Investigations Required	Signature (Print name designation)

Authorised: Nov 2022
Review: Nov 2025

NHS Lothian

Pre-operative Nursing Checklist

700793490X M 27/04/1961
Name: Day, Colin
27s Findhorn Place,
Edinburgh,
Dob: EH9 2NY

Unit: CHI 2704610150
70470 H Cockburn

Date: _____

Weight: 94.3 Kg Height: 166 cm

CHECKLIST	WARD STAFF	THEATRE STAFF	NOTES
Correct Patient and Procedure:			
3 Name Bands Applied	Y N	Y N	
Consent Form Signed	Y N AWI	Y N	
Site Marked	Y N NA	Y N NA	
ALLERGIES RE-CHECKED	Y N	Y N	NKDA
Anti-embolic stockings	Y N NA	Y N NA	
Paracetamol PGD Given	Y N NA		Date: Time:
Patient received any Antibiotics during last 24 hours	Y N		If given, details are on: ☐ HEPMA ☐ Paper prescription form
Last dose of Anticoagulant/Antithrombotic medication(s) OR ☐ NA	Date: Time:		
Last Food Intake (solids and non clear liquids)	Date: Time:	Date: Time:	
Sip Till Send	Y N NA		
Last Passed Urine OR ☐ NA	Ask	Time:	

Pregnancy Test	Y N NA	Y N NA	Result:
Blood Glucose (BM)	Y N NA		Result: Time:
Group and save	Y N NA		
Any other investigations requested by Surgeon/ Anaesthetist done	Y N NA		Details:

Pacemaker	Y N	Y N	
Metal work / Prosthesis	Y N	Y N	Where:
Jewellery Taped	Y NA	Y NA	☐ In-situ ☐ removed
Hearing aids	Y N	Y N	☐ In-situ ☐ removed
Dentures	Y N	Y N	☐ In-situ ☐ removed
☐ Glasses ☐ Contact lenses	Y N	Y N	☐ In-situ ☐ removed

PRINT NAME & SIGNATURE			
DATE & TIME			

COMMENTS:

INTERVENTIONAL RADIOLOGY
SURGICAL PAUSE

700793490X M
DAY Colin
27-Apr-61 CHI: 270 461 0150
70470 H Cockburn
27s Findhorn Place
EH9 2NY.

Name:
CHI:
Procedure:
Date: 29/04/2026
Ward: 53

	YES	NO	N/A	COMMENTS
Introduction of staff	✓			
Consent signed	✓			
Correct side identified	✓			Right
Allergies documented		✓	None	
Medical Notes	✓			
Nursing notes	✓			
Drug kardex			✓	
Blood results seen by Radiologist	✓			
IV access		✓		
Prophylactic antibiotics given			✓	
Patient fasted			✓	
Infection control status		✓		
Red form in notes (DNAR)		✓		
Relevant medical history (renal disease/diabetes)	✓			Stroke
Relevant previous radiology intervention		✓		
All equipment available	✓			
Drugs checked by Radiologist			✓	
Appropriate dosimeters worn by Radiologist			✓	
Arm Support	✓			
Safety Straps			✓	
Any potential problems		✓		
Radiographer to confirm 1. Pregnancy status 2. IRMER compliant			✓	

Completed by (sign and print): Rachel King Designation: SN

POST PROCEDURE DEBRIEF

	YES	NO	N/A	COMMENTS
Procedure performed as planned				
Procedure and side documented				
Drug kardex/CD book signed				
Post procedure instructions documented				
Specimens taken				
All equipment accounted for by scrub nurse				

Completed by (sign and print): Designation:

Author: Carol Manning, Radiology Dept, WGH
Written: 17/6/10 Review date: 17/06/13
Reviewed: 29/4/13 Review date: 29/4/15
Approved by: Dr S Glancy, Lead Radiologist

WGH Main X-Ray
Radiology Department

Liver / Renal / Splenic Guided Biopsy

CT Guided ☐ Ultrasound Guided ☐
(delete as appropriate)

700793490X M
DAY Colin
27-Apr-61 CHI: 270 461 0150
70470 H Cockburn
27s Findhorn Place
EH9 2NY

Name:
CHI No:

Date of procedure: 29/04/2026

Procedure performed: Renal biopsy

	Telephone	Yes	No	Comment
Blood results requested • FBC • Clotting screen • U&E's		✓		
Patient notes		✓		
Drug prescription & Administration record			✓	
Anticoagulation therapy				Stopped 3 weeks ago
Venflon			✓	
Fasted (only if patient requires sedation) • 6Hrs food • 2 hrs fluid			✓	
Infection control issues			✓	
Communication difficulties			✓	
Ability/ capacity to consent		✓		
Transport status • ~~Bed~~ • Chair • Oxygen		✓		

Name bands		✓		
Allergies			✓	
Relevant Medical history • Asthma • Angina • Diabetes • Any other		✓		Stroke R sided weakness angina
Emergency contact details		✓		
DNAR status documented			✓	
Drains and lines in situ			✓	
Consent		✓		

Comments: daughter NOK 07533 367927

Signature (admitting nurse): [signature] Print name: Rachel King Designation: SN

WGH Main X-Ray
Radiology Department

Liver / Renal / Splenic Guided Biopsy
CT Guided ☐ Ultrasound Guided ☑
(delete as appropriate)

Name: Colin Day Date: 29/04/2026 CHI: 2704610150

	O/A	1420	1455
O_2 Ltrs/Min		RA	RA
O_2 Sats		97	97
Respirations	18	18	17
Conscious Level		2	2
Wound Check		—	OK
Pain Score		4	4
240			
230			
220			
210			
200			
190			
180		166	
170		A	
160			148
150			A
140			
130			
120			
110			
100		V	V
90		90	86
80			
70			
60			
50			
40			
Heart Rate		100	89
Temp		37.0	37.1
Comments			

Conscious Level: 0 = Unconscious 1: Asleep/Rousable 2: Awake/Orientated
Pain Score 6-10 = Severe 4-5 Moderate 1-3= Mild 0= None

PROCEDURE PERFORMED: R renal biopsy
SURGICAL PAUSE DOCUMENTATION COMPLETED ☑
TYPE OF DRESSING APPLIED: Mepore
DRUG KARDEX SIGNED: ☑

PROCEDURE SUMMARY

1445 2x biopsies taken

REF K52462/P1
LOT 25L0338
KIMAL

Post-Procedure Instructions:
Observations:
Every 15 minutes for first two hours. Every 30 minutes for next two hours and then hourly for remaining two hours.

Bed rest for 6 hours post-procedure. Patient to lie flat for first two hours, and thereafter can gradually sit upright and mobilise as normal thereafter.
Fluids only for first two hours.
ALL SPLENIC BIOPSY PATIENTS REQUIRE AN OVERNIGHT STAY

Signature (monitoring nurse) RG Print Name: Rachel King Designation: SN

Ward: 53 Site: D 6 H Date: 29/04/16

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly 3 hrly _____hrly (please circle/complete)

Print name and sign

Addressograph, or

700793490X M
DAY Colin
27-Apr-61 CHI: 270 461 0150
70470 H Cockburn
27s Findhorn Place
EH9 2NY

NHS Lothian

Codes (Y) Yes, (N) No, (N/A) not applicable, (O) Oedined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Time of Care Rounding Document the exact time care rounding took place e.g. 0830	15 39	21 51	25 50										
	08.00 am ← 24 hour period → 07.00 am												
Pressure Area Care — Waterlow score less than 10 low risk requires only a daily skin review: Use codes for outcome of skin review													
Waterlow 10+ - Visual Skin Check (tick)	✓	✓	✓										
Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	H	H	H										
Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....												
If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan													
Have you changed position since last CR?	Y	Y	Y										
Positioning (R) or (L) side (B) Back (C) Chair	B	B	B										
Mattress type / Cushion type	*please state type:*												
Elimination — Do you need the toilet?	I	I	I										
Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y										
Continence product changed/offered?	N	N	N										
Catheter care performed?	N	N	N										
Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact													
Is patient continent of faeces? (at time of Care Rounding)	Y	Y	Y										
Bowel function monitored	Observe bowel function and update daily												
Food, Fluid & Nutrition — Would you like a drink? Ensure fluids are within easy reach	W	W	W										
Fluid Balance Chart (if clinically indicated)	N	N	Y										
When did you last eat?	L	D	—										
(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required													
Oral Hygiene Performed (ref to risk assessment)	I	I	Y										
Falls — Appropriate Footwear?	Y	Y	Y										
Walking aid available(and within reach)	I	I	I										
Area de-cluttered?	Y	Y	Y										
Chair and bed height assessed?	Y	Y	Y										
Falls alarm in use and attached?	/	—	Y										
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	/	/	Y										
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐													
Pain — Are you in pain?	N	N	Y										
Analgesia Given?	N	N	Y										
General — Peripheral Venous Cannula observed?	Y	Y	Y										
Observe for signs of inflammation/swelling at every CR session. Bundle/VIP score to be updated daily													
Are you comfortable? Y/N	Y	Y	Y										
Anything else I can do for you?	N	N	Y										
Buzzer within easy reach	Y	Y	Y										

Personal Care *Type* _____ *(specify)* Time Given _____

Initials – document at time of care delivery													

Ward: Site: Date:	Addressograph, or
This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency. **1hrly 2 hrly 3 hrly _____hrly** (please circle/complete) **Print name and sign** ________	**NHS Lothian** Name DOB Unit no. / CHI

Codes (Y) Yes, (N) No, (N/A) not applicable,(D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Section	**Time of Care Rounding** Document the exact time care rounding took place e.g. 0830												
		08.00 am		←	24 hour period			→				07.00 am	
Pressure Area Care	**Waterlow score less than 10 low risk requires only a daily skin review** Use codes for outcome of skin review												
Pressure Area Care	**Waterlow 10+** - Visual Skin Check (tick)												
Pressure Area Care	**Outcome of skin review:** (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister												
Pressure Area Care	Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.................											
Pressure Area Care	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan												
Pressure Area Care	Have you changed position since last CR?												
Pressure Area Care	Positioning (R) or (L) side (B) Back (C) Chair												
Pressure Area Care	Mattress type / Cushion type	*please state type:*											
Elimination	Do you need the toilet?												
Elimination	Is the patient continent of urine? (at time of Care Rounding)												
Elimination	Continence product changed/offered?												
Elimination	Catheter care performed?												
Elimination	Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact												
Elimination	Is patient continent of faeces? (at time of Care Rounding)												
Elimination	Bowel function monitored	Observe bowel function and update daily											
Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach												
Food, Fluid & Nutrition	Fluid Balance Chart (if clinically indicated)												
Food, Fluid & Nutrition	When did you last eat?												
Food, Fluid & Nutrition	(B) Breakfast (L) Lunch (D) Dinner (S)Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required												
Food, Fluid & Nutrition	Oral Hygiene Performed (ref to risk assessment)												
Falls	Appropriate Footwear?												
Falls	Walking aid available(and within reach)												
Falls	Area de-cluttered?												
Falls	Chair and bed height assessed?												
Falls	Falls alarm in use and attached?												
Falls	Glasses available for use? (if worn) Hearing aid available for use? (if worn)												
Falls	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain	Are you in pain?												
Pain	Analgesia Given?												
General	Peripheral Venous Cannula observed?												
General	Observe for signs of inflammation/swelling at every CR session. Bundle/VIP score to be updated daily												
General	Are you comfortable? Y/N												
General	Anything else I can do for you?												
General	Buzzer within easy reach												

Personal Care *Type* ________ *(specify)* **Time Given** ________

Initials – document at time of care delivery												

Patient Name	CHI	Date of Birth	Age	GP	GP Practice	GP Practice Code
OAY COLIN	2704610150	27/04/1961	64	Craig, Julie	Dalkeith Road Medical Practice	70470

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Source 1*	Source 2*	Source 3*	Action NC	Action W	Action SE	Comments
GP practice	Bisoprolol 3.75mg tablets	56 tablet	1 TABLET ONCE DAILY		12/08/2020	22/01/2026		1						
GP practice	Allopurinol 300mg tablets	56 tablet	1 TABLET ONCE A DAY		12/08/2020	22/01/2026		1						
GP practice	Isosorbide mononitrate 20mg tablets	112 tablet	1 TABLET 8AM AND 2PM		12/08/2020	22/01/2026		1						
GP practice	Fluoxetine 20mg capsules	56 capsule	1 EVERY DAY		12/08/2020	22/01/2026		1						
GP practice	Atorvastatin 80mg tablets	56 tablet	1 TABLET ONCE A DAY		27/12/2023	21/01/2026		1						
GP practice	Clopidogrel 75mg tablets	56 tablet	1 TABLET ONCE A DAY		15/01/2021	22/01/2026		1						
GP practice	Co-codamol 30mg/500mg capsules	100 capsule	1-2 CAPSULES UP TO FOUR TIMES DAILY		14/08/2024	21/01/2026		1						

Compliance Device	Name and telephone number for community pharmacy

Completed by	Designation	Grade	Date	Time	Contact Number
Reviewed by	**Designation**	**Grade**	**Date**	**Time**	**Contact Number**

Key Information Summary

(Extract of selected information - additional information may be available in the full KIS report)

Upload Decision: No

Patient Consent: No

Patient Aware: No

Patient Not Aware Reasons:

Checked + Correct

Patient Name	CHI	Date of Birth	Age	GP	GP Practice	GP Practice Code
DAY COLIN	2704610150	27/04/1961	64	Craig, Julie	Oalkeith Road Medical Practice	70470

Reason for Access: Provide information necessary for the care and treatment of the patient

Allergies

Description	Date Recorded	Comments
	No ECS data exists	

Sources: [1] ECS [ ] Patient's Drugs [ ] Referrer Kardex [ ] GP Practice [ ] TRAK
[ ] Patient [ ] Relative / Carer [ ] Referrer Letter [ ] Comm Pharmacy [ ] Other - Specify .....

Actions: C: Continue W: Withhold S: Stop

Acute Medication (including those greater than 30 days)

Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Source 1*	Source 2*	Source 3*	Action C	Action W	Action S	Comments
Tamsulosin 400microgram modified-release capsules	30 capsule	TAKE ONE CAPSULE ONCE DAILY		22/01/2026	22/01/2026	1						
Tamsulosin 400microgram modified-release capsules	30 capsule	TAKE ONE CAPSULE ONCE DAILY		18/12/2025	18/12/2025	1						
Quinine sulfate 200mg tablets	28 tablet	1 TABLET AT BEDTIME TRY TO MINIMISE USE, REGULAR STRETCHING MAY BE AS EFFECTIVE		21/11/2025	21/11/2025	1						
Colecalciferol 400unit tablets	60 tablet	TAKE ONE TABLET ONCE DAILY		24/10/2025	24/10/2025	1						
Quinine sulfate 200mg tablets	28 tablet	1 TABLET AT BEDTIME TRY TO MINIMISE USE, REGULAR STRETCHING MAY BE AS EFFECTIVE		18/09/2025	18/09/2025	1						

Patient Name	CHI	Date of Birth	Age	GP	GP Practice	GP Practice Code
OAY COLIN	2704610150	27/04/1961	64	Craig, Julie	Dalkeith Road Medical Practice	70470

Carer Details:

Next of Kin Details:

Is there a DNACPR Form in Place? No

Resuscitation Status

Item	Date Recorded	Description	Comments
Actual Resuscitation Status	24/10/2025	Not for attempted CPR (cardiopulmonary resuscitation)	

Is there a CYPADM Form in Place? No

Medical History

	Date Recorded	Comments
Pain in lumbar spine	01/01/1998	
Nose operations NOS	01/01/1999	
Septorhinoplasty NEC	01/11/2003	
Ischaemic heart disease	16/06/2014	
Neck sprain, unspecified	07/11/2014	
Pain in lumbar spine	19/01/2015	
Obesity	19/01/2015	
Alcohol dependence syndrome	23/02/2015	
Stress at home	20/04/2015	
[X]Depressive episode, unspecified	14/05/2015	
Upper respiratory infection NOS	16/11/2017	
Leg cramps	04/10/2018	
Cellulitis and abscess of digit NOS	05/11/2018	
Other malignant neoplasm of skin	15/10/2019	scalp
Gout	25/02/2020	
[SO]Toe NEC	17/03/2020	
Stroke and cerebrovascular accident unspecified	15/01/2021	R lacunar
Fit to drive	25/04/2023	following driving assessment.
Not for attempted CPR (cardiopulmonary resuscitation)	24/10/2025	

Special Note

Date: Expiry Date:

Patient Name	CHI	Date of Birth	Age	GP	GP Practice	GP Practice Code
DAY COLIN	2704610150	27/04/1961	64	Craig, Julie	Dalkeith Road Medical Practice	70470

Anticipatory Care Plan
No data recorded

PRESCRIPTION AND ADMINISTRATION RECORD

Standard Chart

NHS Lothian

Hospital/Ward:	Consultant:
Weight:	Height:
If re-written, date:	
DISCHARGE PRESCRIPTION	
Date completed:	Completed by:

Nam 700793490X M
DAY Colin
CHI 27-Apr-61 CHI: 270 461 0150
70470 H Cockburn
D.D. 27a Findhorn Place
EH8 2NY

OTHER MEDICINE CHARTS IN USE		PREVIOUS ADVERSE REACTIONS This section must be completed before any medicine is given		Completed by (sign & print)	Date
Date	Type of Chart	None known ☑			
		Medicine / Agent	Description of reaction		

- Write clearly in block capitals, using a black ballpoint pen
- Use approved names for medicines
- Never alter a prescription
- Route of administration
  The only acceptable abbreviations are:

IV	- intravenous	SL	- sublingual	NG	- nasogastric
IM	- intramuscular	PR	- per rectum	ID	- intradermal
SC	- subcutaneous	PV	- per vagina	TOP	- topical
INHAL	- inhaled	NEB	- nebulised		

  Never abbreviate ORAL or INTRATHECAL
  Specify RIGHT or LEFT for eye and ear preparations

- Write the medicine dose clearly
  - The only acceptable abbreviations are:
    g - gram mg - milligram ml - millilitre
    all other doses must be written out in full eg. micrograms
  - Avoid decimal points eg. 100 micrograms (not 0.1mg). If unavoidable, write zero in front of the decimal point
  - Prescribe liquids by writing the dose in mg
  - For 'as required' medicines, state the symptoms to be relieved, the minimum time interval between doses and the maximum daily dose
  - Write units as 'units' not 'iu'

ONCE ONLY

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber - Sign + Print	Time Given	Given By
27/4/x	1500	LIDOCAINE	15ml	SC	[signature]	1500	[signature]

REGULAR THERAPY

Name of Patient:

CHI Number:

O.O.B.:

(Attach printed label here)

CODES FOR NDN-ADMINISTRATION OF PRESCRIBED MEDICINE

If a dose is not administered as prescribed, initial and enter a code in the column with a circle drawn round the code according to the reason as shown below. Inform the responsible doctor in the appropriate timescale.

1. Patient refuses
2. Patient not present
3. Medicines not available - CHECK ORDERED
4. Asleep / drowsy
5. Administration route not available - CHECK FOR ALTERNATIVE
6. Vomiting / nausea
7. Time varied on doctor's instructions
8. Dnce only / as required medicine given
9. Dose withheld on doctor's instructions
10. Possible adverse reaction / side effect

OXYGEN	Start Date	Start Time	Route Mask (%)	Route Prongs (l/min)	Prescriber - Sign + Print	Administered by	Stop Date	Stop Time

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														
Medicine (Approved Name)		For Use / Date	6														
Dose	Route	Quantity	8														
			12														
Notes/Indication for antibiotic	Start Date	Stop Date	14														
Prescriber - sign + print		Pharmacy	18														
			22														

TURN OVER →

AS REQUIRED THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine													
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															

AS REQUIRED THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine													
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												

Date 29/4/24 WGH Hospital/
Edinburgh.

DISCHARGE AGAINST ADVICE

I Colin Day hereby declare that I am taking my discharge discharge at my own request and against medical advice. I take full responsibility for anything that may occur as a result of my action.

Signed .....

Witnessed by Sister or Nurse-in-Charge L. KNIGHT

LHE 98

NHS Lothian Consent Form

NHS Lothian

Patient Name | DOB | CHI

700793490X M
DAY Colin
27-Apr-61 CHI: 270 461 0150
70470 H Cockburn
27s Findhorn Place
EH9 2NY

Attach Label

Consultant or health professional responsible for your care

Name and job title: DR Jean Brown

Any special needs of the patient? (e.g. help with communication?)

A Name of proposed procedure or course of treatment

(include brief explanation if medical term not clear)
Please circle: Patient's **LEFT / RIGHT** side or **N/A**

US guided (R) renal biopsy

B Statement of health professional (details of treatment, risks and benefits)

1 With **appropriate knowledge of the proposed procedure**, I have explained the procedure to the patient. In particular, I have explained:

a) the intended benefits of the procedure. (please state)

b) the possible risks involved. I have discussed and listed below significant, unavoidable or frequently occuring risks including any risks that may be of specific concern to the patient:

c) what the benefits and risks of alternative treatments that might be offered for this patient (including option of no treatment):

d) any extra procedures that might become necessary during the procedure such as:
Blood transfusion ☐ or Other procedure (please state):

2 The following patient information leaflet has been provided:

Version No.:

or I have offered the patient information about the procedure but this has been declined ☐
or no further written information ☐

3 This procedure will involve:
General and/or regional anaesthesia ☐ Local anaesthesia ☒ Sedation ☐ None ☐

Signed (Health professional): Date: 29/4/26

Name (PRINT): JOHN BRUCE Time (24hr):

Designation: Contact/bleep no:

C Consent of patient/person with parental responsibility

Photography, Audio or Visual Recording

a) **I agree** to the use of any of the above type of recordings for the purpose of diagnosis and treatment. **YES / NO**

b) **I agree** to unidentified versions of any of the above recordings being used for audit and medical teaching in a healthcare setting. **YES / NO**

Medical Training
I agree to the involvement of medical and other students as part of their formal training.
YES / NO

Use of Tissue

a) I agree that tissue (including blood) removed as part of my routine care but not needed for my own diagnosis or treatment can be used and stored for BioResource which may include genetic analysis **YES / NO**
I have received the patient information sheet about the BioResource **YES / NO**

b) Where additional clinical information is needed for the purpose of ethically approved research, I agree that relevant sections of my medical record may be looked at and anonymised prior to release to researchers **YES / NO**

I have listed below any procedures that I do **not wish to be carried out without further discussion.**

_____

_____

_____

_____

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.

I have read and understood information given to me about the planned procedure.

I wish to proceed with the planned procedure.

I therefore give my consent to the procedure as described

Signed (Patient): X_____ Date: _____

Name of patient (PRINT): _____

If signing for a child or young person; delete if not applicable.

I confirm I am a person with **parental responsibility** for the patient named on this form.

Signed: _____ Date: _____

Relationship to patient: _____

If signing for a patient who does not have capacity, I confirm I am the person with legal welfare power of attorney or the welfare guardian acting in the best interest for the patient named in this form.

Signed:_____ Date:_____

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.

Signed (Witness):_____ Date:_____

Name of witness (PRINT):_____

Address:_____

D Confirmation of consent

Confirmation of consent (where the procedure/treatment has been discussed in advance)
On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional):_____ Date:_____

Name (PRINT):_____ Job title:_____

Please initial to confirm all sections have been **completed**:_____

E Interpreter's statement (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

Signed (Interpreter):_____ Date:_____

Name(PRINT):_____

Or, please note the telephone interpreter ID number: _____

F Withdrawal of patient consent

The patient has withdrawn consent and does not wish to proceed with the treatment.
(ask patient to sign and date here)

Signed (Patient):_____ Date:_____

Signed (Health professional):_____ Date:_____

Name (PRINT): _____

Job title:_____

Version 3.0 Approved: Mar 2023 Review: Mar 2026