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

NHS
Greater Glasgow and Clyde

MMA Legal Ltd
23 Goodlass road
Building B
Speke Liverpool
L24 9HJ

Date: 17th June 2026
Your Ref: 100292
Our Ref: SAR/ACCESS/ ZK
Enquiries to: Zaneta
Direct Line: 0141 211 1644
Email: zaneta.kolodiejczyk@nhs.scot

Dear Sir/Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: DIANE DONALD **D.O.B: 16/12/1983**

Thank you for your request received 28th May 2026 in which you seek a copy of your client's personal information.

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

QUEEN ELIZABETH UNIVERSITY HOSPITAL, YORKHILL HOSPITAL, NEW VICTORIA HOSPITAL, GARTNAVEL GENERAL HOSPITAL, WESTERN INFIRMARY RECORDS

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

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

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

- Patient health records, photographs or radiology images
- Video/telephone recordings, including CCTV images
- Witness statements
- Incident reports
- Complaints files
- Emails



ELECTRONIC PATIENT RECORDS

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

Including:

BADGERNET	☐
AREVUE	☐
MEDICAL ILLUSTRATION	☐
METAVISION	☐
PHYSIOTHERAPY	☐
RADIOLOGY	☑
WEST MARC	☐
LABS	☐

Patient name ....

Patient CHI ....

1612836909
DONALD F
Diane 16/12/1983
27 ST ANDREWS WAY.
Clydebank, Dunbartonshire
G81 1BP

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
22/01/22 2025	Headache, photophobia	

Nursing notes - on admission

Date and Time		Name/Signature
22:25	pt moved to majors cubicle, given ondansetron & aspirin. Awaiting medical r/v	T Hudson SN
0040.	Not for CT head overnight, Admit GM r/v in am.	

Triage

Patient prepared for exam - clothing bagged				Y	N
NEWS Chart	(Y)	N	X-rays	Y	N
ID band	Y	N			
Peak Flow	Y	N	Please specify		
12-lead ECG	(Y)	N	Urinalysis	Y	N
IV access	(Y)	N			
Blood samples	(Y)	N	Positive findings		
Blood Gas	Y	N	B-HCG	Y	N

Communication

GGC Red Bag with Patient (nursing home resident)	Y	N
Language or hearing difficulty	Y	N
Interpreter required	Y	N
what arrangements have been made?		
Relatives / Carer / Next of Kin present	Y	N
name,relationship,location,particular concerns		

Risk Assessments and Screening Tools

SEPSIS	Y	N	GMAWS	Y	N
FAST	Y	N	Adult Support and Protection	Y	N
Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
Falls Risk (clinical judgeument)	Y	N	Child Protection Concerns	Y	N

Signature:

Patient name .....

Patient CHI .....

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Care Rounds Checklist

I have evaluated and deemed that the frequency of care delivery over the next work shift,
based on the patient's most critical need, should be every (please circle) **1hr** **2hr** **3hr** **4hr**

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:
Y = Yes **N** = No **NA** = Not Applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** - Independent

			Times										
	1	**THINK DELIRIUM** Is the patient more confused/drowsy than normal?If yes inform registered nurse.											
	2	**PAIN: ASSESS AND ADDRESS.** Is the patient distressed or in pain?If yes inform registered nurse.											
S	3	**SKIN INSPECTION** Pressure areas checked?											
		R = RED **D** = Discloured **PU** - Pressure Ulcer **INT** = Intact **M**= Moisture											
K	4	**KEEP MOVING** Has the patient moved or walked?											
		Bed **R** =Right side (30°) tilt **L** =Left side (30°) tilt **B** =Back Chair **W/ST** = Assist to walk / stand											
		ELIMINATION. Does the patient need the toilet?											
I	5	**I** = Independent **A** - Assistance given **IC** = Incontinent (urine/faeces)											
N	6	**FOOD FLUIDS AND NUTRITIO.** Is the patient nil by mouth?											
		Drink taken?											
		Food, snack, or supplements taken?											
		Has oral hygiene been carried out as per care plan?											
	7	**ENVIRONMENT CHECK** Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?											
	8	**INFORMATION** Is there anything else I can help you with? Inform the patient of the time of return											
	9	**ESCALATION** Is there anything else I can help you with? Inform the patient of the time of return											
		Care provider											
		Role											

Ask the patient if there is anything they specifically want done today:

Patient name .....

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Nursing notes - discharge plannning

Date and Time		Name/Signature

Outcomes and outstanding issues

Date and Time		Name/Signature

Pause for Discharge or Transfer

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band	Y	N
Nursing Screening Tools Complete	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart NEWS completed within 1 hour of transfer/discharge	Y	N
Prescriptions and fluid charts signed	Y	N
Cannula	Y	N
Notes Complete	Y	N
Analgesia	Y	N
Belongings	Y	N
Transport	Y	N
Signature:		

Contact with relatives

Signature:

Patient name .....

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Hospital:	Points to consider:
Ward:	• Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

NHS Greater Glasgow and Clyde

PUDRA

1	Pressure Damage	Does the person have redness and/or existing pressure damage? **IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care** to avoid further damage occurring and complete the pressure ulcer interventional plan.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	Mobility	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	Continence	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							_____hrly	
/ /	:							_____hrly	
/ /	:							_____hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S Skin Inspection	S Surface	K Keep Moving	I Incontinence/ Moisture	N Nutrition	S Self Management/ Shared Care
Check: • Pressure areas _____ hourly • Skin under medical devices _____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition ____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning _____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out _____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer **YES / NO** 2. Prevent Pressure Ulcers" leaflet given to patient/family/ carer **YES / NO**

Patient name .....

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4AT assessment - for delirium and cognitive impairment

		Circle Score
(1) ALERTNESS This includes patients who may be markedly drowsy (eg. dificult to rouse and/or obviously sleepy during assessment) or agitated/ hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.	Normal (alert, but not agitated, through assessment) Mild sleepiness (<10 secs) after waking, then normal Clearly abnormal	0 0 4
(2) AMT4 Age, date of birth, place (name of the hospital/building), current year.	No mistakes 1 mistake 2 or more mistakes/untestable	0 1 2
(3) ATTENTION Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.	wAchieves 7 months or more correctly Starts but scores <7 months / refuses to start Untestable (cannot start, unwell, drowsy, inattentive	0 1 2
(4) ACUTE CHANGE OR FLUCTUATING COURSE Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs.	No Yes	0 4

4 or more possible delirium + /- cognitive impairment
1-3 possible cognitive impairment
0 delirium or severe cognitive impairment unlikey (but delirium still possibe if (4) information incomplete

TOTAL

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)? circle Y or N

F	**Functional Impairment**	(new or worsening) eg difficulty with self care	**Y**	**N**
R	**Resident**	in a care home	**Y**	**N**
A	**Altered mental state**	such as delirium or dementia (**4AT Assessment**)	**Y**	**N**
I	**Immobility/Instability**	decline in mobility, difficulty mobilising without help, fall leading to presentation	**Y**	**N**
L	**Living at home with support**	on a daily basis (homecare, one visit or more per day)	**Y**	**N**

If YES to any of the criteria in Step 1 move to Step 2

Step 2 Would this person be better managed by another speciality team at present? circle Y or N

Clear need for other specialty input eg exacerbation of known long-term condition such as COPD	**Y**	**N**
Need for HDU/ITU (including non-invasive ventilation)	**Y**	**N**
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit	**Y**	**N**
Head injury with loss of consciousness	**Y**	**N**
Acute abdominal pain/ surgical presentation	**Y**	**N**
Upper GI Bleed	**Y**	**N**
Chest pain with suspected acute coronary syndrome	**Y**	**N**
Trauma with suspected fracture	**Y**	**N**

Are any of the criteria met?

If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

Patient name .....

Patient CHI .....

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Nursing notes - ongoing care

Date and Time		Name/Signature

My Admission Record

NHS Greater Glasgow and Clyde

N 1612836909
DONALD F
A Diane 16/12/1983
27 ST ANDREWS WAY
Clydebank, Dunbartonshire
G81 1BP
C
Affix patient ID label

Hospital: QEUH Ward: AAU1
Date of Admission: 23/1/22 Time: 0130
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 38 Telephone Number:
Consultant: DR. V HEPHERD

C-19 ☑

Communication

What is your first language? English
Do you require an interpreter? Yes ☐ No ☑
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☑
Do you need someone to help you to communicate? Yes ☐ No ☑ If yes, who _____

Preferred first contact	**Preferred second contact**
Name: ALLAN	Name:
Relationship: PARTNER	Relationship:
Address:	Address:
Telephone: 07981 942 866	Telephone:
Is this person aware of your admission? Yes ☑ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☑ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Bilateral Eye Pain / Vomiting

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☐ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☑ Flagyl

Relevant past medical history

migraines SB optha last Nov. ? Glaucoma

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☑ If yes, Who asked for a copy? _____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

Name:
1612838909
DONALD F
Diane 16/12/1983
27 ST ANDREWS WAY
Clydebank, Dunbartonshire
G81 1BP
CI

Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy?_____ Date they asked for a copy __/__/__ Date Obtained __/__/__

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

If the answer is yes to **ANY** of the questions in this section, you must

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☑	☐	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☑	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☑	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☑	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES inform the IPCT** ☐

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Lifestyle

Smoking

Are you a: smoker ☐ ex- smoker ☑ when did you stop? _____

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☐

If a smoker, the NHSGGC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ___/___/___

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☑

If yes, please specify and refer to the NHSGGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

_____

_____

Alcohol

Do you drink alcohol? Yes ☐ No ☑

How often do you have more than 6 units of alcohol on one occasion:

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

Name (Please PRINT): M. Plentie Signature:

Designation: (T Date: 23 / 1 / 2e

My Assessment Record

1612836909 F
DONALD 16/12/1983
Diane
27 ST ANDREWS WAY
Clydebank, Dunbartonshire
G81 1BP

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1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?		✓	
Do you have a Learning Disability?		✓	
Do you have support from a Learning Disability Team? Contact details: _____			

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Diane 16/12/1983
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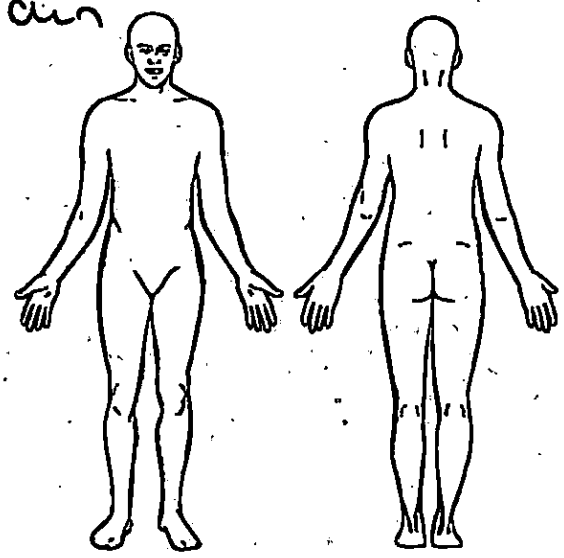
3. Senses

Vision	**Yes** ✓	**No** ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓	✓	
Do you wear glasses?		✓	Distance ☐ Reading ☐ Both ☐
Do you have your glasses with you?		✓	
Do you wear contact lenses?		✓	
Do you have your lenses with you?			
Do you wear a prosthesis?			
Hearing	**Yes** ✓	**No** ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?		✓	
Do you use a hearing aid?		✓	
Do you have your hearing aid(s) with you?			
Pain	**Yes** ✓	**No** ✓	Assessment of the patient's pain
Do you have pain?	✓		

Can you describe where and what the pain is like?

Bilateral Eye pain

Mark current pain on body chart



Have you had treatment / intervention for the pain?

Await KY

N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale.

Can you describe any chronic pain that you have?

nil

What makes the pain better?

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Diane 16/12/1983
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4. Cognitive Status THINK DELIRIUM

	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

nil

What do you like to eat and drink?

varied diet

What do you not like to eat and drink?

nil

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

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Assessment of the patient's hydration and nutrition needs

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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DONALD
Diane
F
16/12/1983
Created on 23 Jan 2022 00:17 by M
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N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☑ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ___/___/____

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGGC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move?

How often in a day/week do you have a bowel movement? Per day ☐ Per week ☐

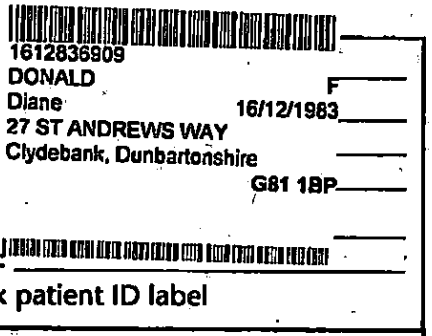
Do you use any medication e.g. laxative to help your bowels move? Yes ☐ No ☑

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular	✓	✓	
Constipated			
Diarrhoea / loose stools			
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. if concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?		✓	
Do you require assistance with your stoma care?			
Have you brought any of your stoma products with you?			



7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			
Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			
Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☐ ✓

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ **Adult wound assessment and management chart required**

N.B If Grade 2 pressure damage on ankle or below refer to Podiarty via TrakCare

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		✓

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8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent	✓	✓	
Unsteady when walking			
Do you use a mobility aid	Yes ☐	No ☑	
Do you have your mobility aid with you?	Yes ☐	No ☑	

N.B. If not fully mobile and independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?		✓	

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?		✓	
Do you do or use anything to help you sleep?		✓	

1612836909
Name DONALD
Diane F
Address 27 ST ANDREWS WAY 16/12/1983
Clydebank, Dunbartonshire
G81 1BP
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CHI:
Affix patient ID label

11. Social Circumstances

Do you:

Live alone	☐	Live with family/ friend/ other	☑
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐
Other please specify_____	☐		

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants? 2 CHILDREN	✓	✗
Do you support anyone (e.g. partner, children, relatives, animals)?	✓	
Do they need support from someone else whilst you are in hospital?	✓	
Would someone else be able to provide this support when you are in hospital? If yes, who?	✓	

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

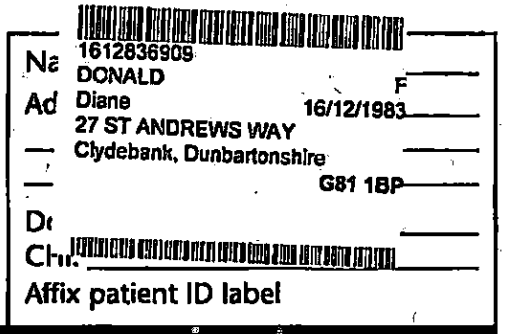
12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☐

Healthcare Chaplain informed Yes ☐ N/A ☑



13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name: .....

Contact Details: .....

.....

.....

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☐ No ☐

If yes, has the help or support listed above been confirmed with the patient's family/ friends? (please tick) Yes ☐ No ☐

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Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?
Yes ☐ No ☐
Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?
Yes ☐ No ☐ Not appropriate at this time ☐
Carers Information Line: 0141 353 6584
Carers Information Leaflet provided?
Yes ☐ No ☐

Are you:
Employed ☐ Unemployed ☐
Self-employed ☐ Retired ☐
Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?
Yes ☐ No ☐ Not appropriate to ask at this time ☐
If yes would you like referred to a money advice service that can offer confidential advice/ support?
Yes ☐ No ☐ If yes when was patient referred ___/___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?
Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☐
If yes when was patient referred ___/___/___

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Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)					
Generic Pain Scale Assessment Chart					
Abbey Pain Scale (if unable to self report pain)					
4AT and TIME for Detection, Management and Prevention of Delirium					
Getting to Know Me – Relatives to complete					
What Matters to Me					
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)					
Malnutrition Universal Screening Tool (MUST)	✓				
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan					
Bristol Stool Chart					
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		23/1/22
Adult Wound Assessment and Management Chart					
Moving and Handling Assessment	✓		✓		
Falls Risk Assessment	✓		✓		
Bedrail Risk Assessment		✓			

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
23/1/22	Admitted from A/E	
0147	c/o sudden onset	
	of Bilateral Eye	
	Pain.	
	Hx of Eye Lasers	
	?? of AH	
	Given Ondansetron IV	

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	Aspirin 300 mg in ED.	
	NEWS 1 / BP 110/70	
	Pt alert / oriented.	
	Awaiting medical	
	RV.	
0400	Nil to RV /	
	Eye pain ? related	
	to Glaucoma	
	? thyroid	
	Plan	
	Optha RV	
	d/w ED ; felt unlikely	
	to be opth cause as	
	Bilateral)	
	Analgesia	
	? CT Head	
	Check TFTs	
0600	Paracetamol given for	
	eye pain. Mobile to	
	toilet. Spt for	
	short spell. NEWS	
	2 BP 100/40 temp	
	35.1	
	covid swabbed ✓	
23.1.22	Patient family settled, independent	
10.10	with zoom. Pain coming in	
	eyes, analgesia given with	

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	good effect. Observations charted, NEWS 1, RR 89/54. Encouraged patient to take more fluids.	
	No other complaints offered.	S Deacon
23.122	Wife Dr Sheerer: Mr. Sall, migraine	
10.40	: Lm Diclofenac • CT Brain • If negative for News	
		S Deacon
1840	Patient family settled, small diet + fluids tolerated orally. Observations charted. Given Paracetamol given as headache remains. Lm diclofenac was given earlier with little effect. slept for a few hours after. No other complaints, await CT head	
	No other complaints offered	S Deacon
2100	Attach CT Head ✓	
	no SOL/ICH	
	MH monitor	
	To: o/w Neurology	
	Re: MH bradycardia.	
24/1/22	Paracetamol given by	
0300	Lyspath. BP 100/60	
	Mobile to toilet.	
	Slept for short spells.	
0700	c/o vomiting. Anti-emetic given + pain. Paracetamol given as well	

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CLINICAL NOTES - MEDICAL ☐ NURSING ☑

Please tick ✔ appropriate directorate

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Date & Time		Signature, Print Name & Designation
	NEWS 1.	
0730	Pt with D/C. Wants to go Home. Advised to stay for 1hr but keen to go. NIC made aware. Triggered from D/C risk by pt. Ventilon removed.	

83949 CCC0072

NHSGGC Bedrail Risk Assessment

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NHS Greater Glasgow and Clyde

This Risk Assessment Tool is an aide memoire for staff. It should be used in conjunction with the Bedrail Guidance (see reverse) and Guidelines for Falls Prevention and Management (Adults).

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Patient Name:

CHI Number:

	Use guidance on the reverse of this document when completing this Risk Assessment								
		DATE	23/12						
		TIME	0830						
		WARD	A-MU1						
		HOSPITAL	QEUH						
	SECTION ONE – GENERAL		Y	N	Y	N	Y	N	Y	N
1	Is the patient likely to fall, roll, slip or slide from the bed?			✓						
2	Has the patient requested the use of bedrails?			✓						
	IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
	SECTION TWO – COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?									
4	Is the patient stressed, delirious or restless?									
5	Is the patient small in stature?									
6	Does the patient have an unusually large or small head that might present an entrapment issue?									
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?									
	IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
	SECTION THREE – COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?									
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition									
10	Has the use of bedrails been discussed with relatives/carers?									
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?									
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?									
	IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
	SECTION FOUR – DECISION MAKING		Y	N	Y	N	Y	N	Y	N
13	Will bedrails be used for this patient at the present time?			✓						
14	Rationale for use of bedrails: (Please insert code in the box on the right)									
	A – Risk of falling from the bed									
	B – Risk of rolling from the bed									
	C – Risk of slipping from the bed									
	D – Risk of sliding from the bed									
	E – Patient request									
15	Bedrail risk assessment completed by:									
16	Bedrails checked by:									
17	Date		23/12							

Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here

A. Alternatives to bed rails:-

- Move the patient to a more observable area
- Increase patient observation
- Ensure the bed is returned to the lowest height appropriate to the patient needs, after care delivery
- Ensure patient needs are anticipated e.g. drinks are accessible, regular toileting, call bell to hand
- Nursing patient on mattress on the floor should be the last resort, and safety checks should be made for hot pipes, trailing wires, electrical sockets etc
- A generic moving and handling assessment must be carried out for staff caring for patients nursed on mattress on the floor.
- Contact Hospital Falls team for advice where appropriate

B. If bedrails are to be used, please consider the following:-

Is patient:-

- Stressed, delirious or restless
- At risk of entrapment
- At risk of climbing over the top of the bed rail
- At risk of being psychologically affected by the use of the bed rail

C. Safe use and application of bedrails:-

- If bedrail is fitted and there is a gap between the lower rail and the mattress then a bedrail should not be used.
- If the gap between the bars on the bedrail is greater than 12cm then a bedrail should not be used
- If the bedrail moves away from the side of the mattress then a bedrail should not be used
- If the gap between the bedrail and the headboard is between 6cm and 25cm then a bedrail should not be used
- If the gap between the bedrail and the footboard is between 6cm and 25cm then a bedrail should not be used
- If the bedrail has not been fitted correctly then the bedrail should not be used
- If the bedrail is not secure then the bedrail should not be used
- If the bedrail is not compatible with the frame it will be fitted to then a bedrail should not be used
- If the bedrail is not in good working order then the bedrail should not be used

D. Record keeping:-

All of the following should be recorded:-

- Date and time of assessment
- Bedrail information leaflet given to patient and-or next of kin
- Rationale for decision in care plan or in AWI treatment plan
- Where bedrails are considered appropriate and patient has declined their use
- Any other actions implemented
- Care planning should be reviewed and updated as per record keeping standards.

Bedrail risk assessments should be made as follows:-

- On admission
- If patient's condition changes or fall / suspected fall from bed
- Daily/weekly depending on the patient's status

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Care Plan

NHS Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
23/1/22 †	Independent APC by		23/1/22 †	Risk assessment	
			23/1/22 †	10. Sleep and Rest	
				Promote	
23/1/22 †	8. Mobility				
	Independent		23/1/22 †	12. Privacy, dignity and sexuality	
				Promote	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

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Care Plan

NHS Greater Glasgow and Clyde

Care discussed with patient Unable	☐ Yes	☐ No	☐	If unable, give reason:			
Care discussed with family Unable	☐ Yes	☐ No	☐	If unable, give reason:			
Date commenced & signature	1. Breathing and circulation			Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
23/1/22	RLG e obs				23/1/22	Family	
					23/1/22	5. Hydration and Nutrition	
						NOF	
23/1/22	~~2.3.~~ Communication and senses						
	NIL						
					23/1/22	6. Elimination	
23/1/22	4. Cognitive status					continent	
	Alert/oriented						

Care Rounds Checklist

Date: 23/1/22

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr 4hr

1. Signed _____ Name mop Designation F
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach 1612836909 F
DONALD 16/12/1983
Diane
27 ST ANDREWS WAY
Clydebank, Dunbartonshire G81 1BP
Ward: Amy

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:
nil

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	0810	0905			2030															
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	Y	N			N															
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	Y	Y			Y															
S	3	**SKIN INSPECTION** Pressure areas checked:	I	I			I															
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	I	I			I															
K	4	**KEEP MOVING** Has the patient moved or walked?	I	I			I															
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	I	I			I															
		Chair Assist to walk or stand (W/ST)	/	/			/															
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I			I															
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	Y	N			N															
		Drink taken?	Y	Y			Y															
		Food, snack, or supplement taken?	Y	Y			Y															
		Has oral hygiene been carried out as per care plan?	I	I			I															
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y			Y															
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	Y	N/A			N/A															
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N	N/A			N/A															
		Care provider / role	A	B			D															

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 24/1/22

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed mcy Name MIAMI Designation AWP/N
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach A
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Clydebank, Dunbartonshire
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Ward: ARU1

NHS Greater Glasgow and Clyde

'Must dos' for n... patient if there is anything they want specific... today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

			Times	08:30	04																	
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N																	
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N	N																	
S	3	**SKIN INSPECTION** Pressure areas checked:		N	N																	
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		-	-																	
K	4	**KEEP MOVING** Has the patient moved or walked?		I	I																	
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B	B																	
		Chair Assist to walk or stand (W/ST)		I	I																	
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		I	I																	
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N																	
		Drink taken?		I	S																	
		Food, snack, or supplement taken?		I	S																	
		Has oral hygiene been carried out as per care plan?		I	S																	
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y																	
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		M	NA										—							
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA	NA																	
		Care provider / role		AW	AW																	

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward. Update weekly or on change of condition.

	Ward: [illegible] Date: 23/12 Time: 0130	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	tick				
2. Check walking aid (if required) is in reach and in use.	tick				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓				
5. If glasses are worn, check they are available and in use.	n/a				
6. If hearing aid/s are worn, check they are working and in use.	n/a				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?		✓								
2. Does the patient have cognitive impairment or a possible delirium?		✓								
3. Does the patient attempt to walk alone although unsteady or unsafe?		✓								
4. Does the patient or their relative have a fear or anxiety of the patient falling?		✓								
5. Based on your clinical judgement, is this patient at high risk of falling?		✓								
Signature of nurse completing assessment / update	[signature]									

Highlight risk of fall at the ward safety brief.

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FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

nplete for all patients identified at risk of falling.

	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)	/				
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

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Created on 23 Jan 2022 00:17 by M

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date_____ Time_____ of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	_____cm	☐	☐	
Admission Weight	_____Kg	☐	☐	

*Obtain accurate height/weight and rescreen as soon as possible

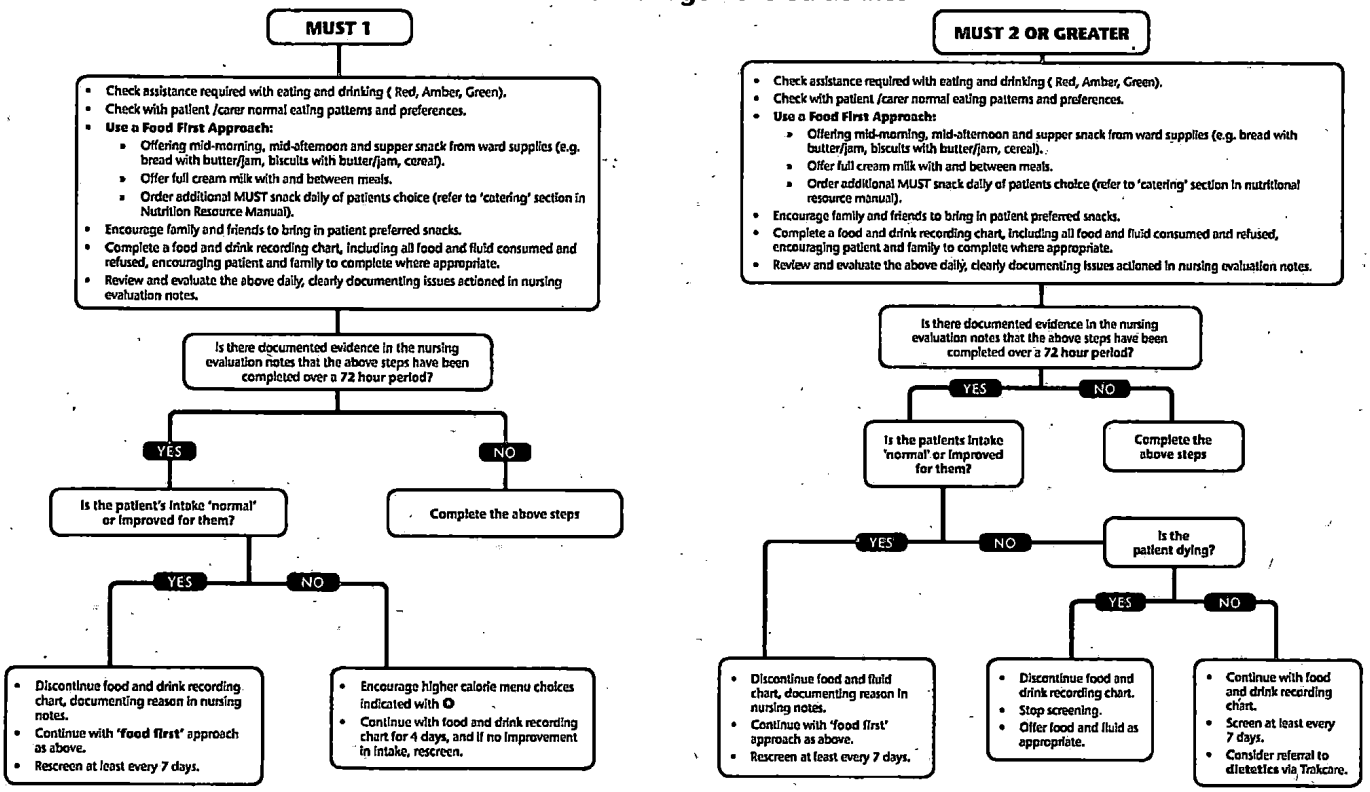
Patients reported normal weight _____ Unable to Recall ☐

Any unplanned weight loss in the last 6 months Yes ☐ how much_____ No ☐ Don't Know ☐

Date								
Time								
Ward								
Oedema/ Ascities present Y/N								
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes								
Weight (kgs)								
BMI								
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2								
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2								
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0								
Step 4 Overall Risk of Malnutrition TOTAL								
Rescreen on								
Signature								

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)	
Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	**LOW RISK** - Repeat screening every 7 days
1	**MEDIUM RISK** - Follow the flowchart for MUST 1 overleaf
2 or greater	**HIGH RISK** - Follow the flowchart for MUST 2 or greater overleaf

N ST STEP 5 Management Guidelin_



DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "*Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

mil • 285984 v3.0 • GGC0250

NEWS 2 Key | 1 | 2 | 3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

1612836909 F
DONALD 16/12/1983
Diane
27 ST ANDREWS WAY
Clydebank, Dunbartonshire G81 1BP

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed .....

Medical: .....

Date: .....

Pupil Reaction and Size
s = sluggish
+ = reaction
- = no reaction
c = eyes closed
Pupil Size (mm) 1 2 3 4 5 6 7 8

Glasgow Coma Scale

| | 1st | | |

Pers[illegible]it) Moving and Handling Assessment Form

Person's Name:	[illegible]1612836909 DONALD Diane 27 ST ANDREWS WAY Clydebank, Dunbartonshire G81 1BP	16/12/1983	F [illegible]med [illegible]rse:		Person is totally independent (tick here and go to date box)	

1. Gener[illegible]

[illegible]s with comprehension, behaviour, co-operation (specify):

Weight [illegible]

Kg

cm

BMI

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Risk of Falls: Yes | No

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 / 2 / ≥3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 / 2 / ≥3	Additional Information:	
	Monkey pole			
	Independent bridging			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 / 2 / ≥3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 / 2 / ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sling tilting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Ateas)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walker)	

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	17/1/2[illegible]		
Assessor's signature:	[illegible]		
Proposed Review date:	[illegible]		

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes	No	

2. Sit to Stand to Sit Transfers (including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 ≥3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 2 ≥3	Additional Information:	
	Monkey pole			
	Person bridges			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 2 ≥3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 2 ≥3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 2 ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 2 ≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Ateno)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

1612836909 F DONALD 16/12/1983 Diane 27 ST ANDREWS WAY Clydebank, Dunbartonshire G81 1BP	Hospital: QEUH Ward: Ward 1	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

1 Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise?
3 Continence	Does the person have continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
22/12/16	0130	N	N	N	N	N	N	4 hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Intervei ›nal Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____

Adult Peripheral Vascular Cannu

Insertion and Maintenance Care Plan

1612836809
DONALD
Diane
F
16/12/1983
CHI: _____
Address: _____
Hospital: _____

NHS Greater Glasgow and Clyde

Insertion cri[arion Plantilla] ction at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ Resuscitation/Chest Pain ☐ IV Drugs ☑ Fluids ☐ Transfusion ☐

PVC Inserted: Day 0	Date: 23/1/22 Hospital: QEUH Area: ED ☑ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☑ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☑ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: Inserted in AD

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: 24/1/22

*Reason For Removal: No Ac

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula Seek further advice
As above including: palpable venous cord	4	
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → **Can I switch my patient from IV to oral antibiotics?**

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

Previous Patient Notes for Ophthalmology (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		**Outpatient Note**
Date/Time: 31-Aug-2022 13:06	**Created By:** Consultant Ophthalmologist, Stobhill ACH, SGH, Victoria ACH - Maria Gregory	**Role:** Doctor - GGC
Specialty: Ophthalmology	**Organisation:** Queen Elizabeth University Hospital	Sensitive
Note:		
carotid Doppler normal, lipid profile not done - letter to patient to ask if she could liaise with GP to have this done. No follow up required		

Previous Patient Notes for Acute Specialties GGC (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		**Other**
Date/Time: 01-Mar-2022 16:37	**Created By:** IMT3 - Kirsty Bisset	**Role:**
Specialty: Acute Specialties GGC	**Organisation:**	Sensitive
Note: IDL 23/1/22- no FDL required		

Previous Patient Notes for (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		**Historical Note**
Date/Time: 11-Feb-2014 11:54	**Created By:** Midwife - OPD 43 - SGH. - Lorna McCarron	**Role:**
Specialty:	**Organisation:**	Sensitive
Note:		
IOL 27/02/2014.Admot ward 50 26/02/2014 @ 8pm. omplaining of possible SRM daycare for speculum examination		

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

RHSC | GRI | WIC | VI | VIMIU | Stob | VOL | SGH

Queen Elizabeth University Hospital

CHI: 1612836909

Total Att: 6

12 Mth Att: 0

Title: **MISS**

DONALD **Diane**

DOB **16/12/1983** Age: **36y** Sex: **Female**

43 LONGDEN STREET
WHITECROOK
Clydebank
Dunbartonshire
G81 1AG
07393645082

Next of kin: **NEIL, Allan**
Relationship: **Partner**
07982 942 866

GP: **F Irvine**
0141 531 6425

Attendance Date: **10/10/2020** Arrival Time: **13:41**

Registration Time: **13:41** Date of Incident: **10/10/2020**

Major Incident Desc:

Reason for Attendance: **swollen finger**

Affix Label

Nursing Assessment

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

Triage Category: **4** Tetanus up to date/fully immunised:

Presenting Complaint: **Finger: Index**

Observation Date: **10/10/2020 13:58** Nurse name: **Nurse Brian Barnes**

Temp	36.4	C
HR	88	bpm
BP	/	mmHg
MAP		mmHg
RR	16	bpm
SpO2	99	%
Oxygen		%

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **SWELLING TO LEFT INDEX FINGER IS BEING TREATED FOR INFECTION TO FINGER WITH FLUCLOX, SWELLING HAS BECAME WORSE**

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES
	Seen by (Dr) P. Moffatt — Time seen 14:40

(36) ♀ Swollen (L) index finger

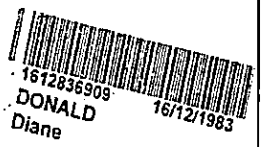
PMHx: Migraine

Hx

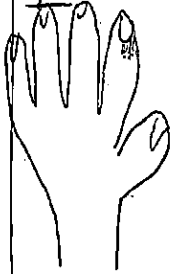
- 2 weeks swollen (L) index finger. No injury or instrumentation
  - Erythema initially up finger and dorsum of hand
- Started Flucloxacillin by GP 6 days ago
  - Has been improving erythema nearly gone, swelling reduced + pain reduced
  - °Fevers. No systemic feelings
- Today states swelling worse. No erythema. No pain
  - ROM restricted by swelling
  - °Pus draining
  - Normall sensation
- Has 4 more days of abx left

Dx: Flucloxacillin + Naproxen. NKDA

Sx: (R) handed. Student



O/E: Looks well



- Small area around nail bed red + slight swelling
- Good ROM in each joint
- No fluctuating cellulitis. °Heat
- No fluctuant area or pus draining
- (N) sensation. Good CRT <2secs

Impression: Resolving cellulitis. No area amenable to drain

PLAN

(1) Continue abx + RICE (2) Worsening advice given

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

Hospital (circle)	IRH	RAH	RHSC	GRI	WIG	VI	VIMIU	Stob	VOL	SGH

Queen Elizabeth University Hospital

CHI: 1612836909

Total Att: **5**

12 Mth Att: **1**

Title: **MISS**

DONALD **Diane**

DOB: **16/12/1983** Age: **35y** Sex: **Female**

43 LONGDEN STREET
WHITECROOK
Clydebank
Dunbartonshire
G81 1AG
07833226267

Next of kin: **NEIL, Allan**
Relationship: **Partner**

GP: **F Irvine**
0141 531 6425

Attendance Date: **22/05/2019** Arrival Time: **21:44**

Registration Time: **21:44** Date of Incident: **22/05/2019**

Major Incident Desc:

Reason for Attendance: **rib and back pain, painful when breatning**

Affix Label

Nursing Assessment

Alerts: **Not Recorded**

Allergies: **Not Recorded** Pain Score:

Triage Category: **4**

Tetanus up to date/fully immunised:

Presenting Complaint: **General**

Observation Date: **22/05/2019 22:26**

Nurse name: **Nurse Jennifer Smith4**

Temp	36.4	C
HR	37	bpm
BP	131/80	mmHg
MAP	97.00	mmHg
RR	15	bpm
SpO2	99	%
Oxygen		%

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **pain to R truncal region radiaitng to back, worse on inpiration. treated for muscular back pain by gp**

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date 28/05/19 **CLINICAL NOTES**

Seen by (Dr) RMCCARTHY

1612836909 16/12/1983
DONALD
Diane

35 yrs F

C/O Rt shoulder pain -

NB Lac injury / NB infective Sx

Now C/O Lt back pain

Works as house cleaner

NB Lac resp problems

SOB SP yesterday - refused analgesia

Provisionally on Naproxen for Rt frozen shoulder

O/E - T 36.4°C / HR 87 / BP 131/80

RR 16 / Spo2 99% on RA / PEFR

CVS/RS/Abd + N + D

MSK/Neuro exam

NAD good tablet.

Tender Rt ICS 6th / 7th

Rash ?Bruising -

Spine no midline tenderness -

no neuro deficit.

Imp / Musculoskeletal CP ?

Rx Analgesia / PSH IDs / Leaflet

RMC

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant if admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By
22/05	CODEDAMOL	2	ORAL	PRN	RMC	RMC
22/05	NAPROXEN	500mg	PO	PRN	RMC	RMC

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital

CHI: 1612836909

Total Att: 4

12 Mth Att: 0

Title: MISS

DONALD **Diane**

DOB: **16/12/1983** Age: **34y** Sex: **Female**

43 LONGDEN STREET
WHITECROOK
Clydebank
Dunbartonshire
G81 1AG
07833226267

Next of kin: **UNKNOWN**
Relationship: **Unknown**

GP: **F Irvine**
0141 531 6425

Attendance Date: **06/12/2018** Arrival Time: **12:31**

Registration Time: **12:31** Date of Incident: **2/12/2018**

Major Incident Desc:

Reason for Attendance: **right hand injury**

Nursing Assessment

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

Triage Category: **4** Tetanus up to date/fully immunised:

Presenting Complaint: **Hand Injury**

Observation Date: **06/12/2018 12:47** Nurse Name: **Nurse Gillian Currar**

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

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

Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"fell 2/52 injuring right hand c/o still painful was intoxicated so cannot remember how she landed "**

Child Assessment Questionnaire

1612836909 16/12/1983
DONALD
Diane

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

1612836909 16/12/1983
DONALD

6/12/18 CLINICAL NOTES

Seen by ~~DR~~ CAP KIM MCNEIL Time seen 13.30

PC Right Hand

HPC Injury to hand 2/52 ago RHD when intoxicated - Been able to go to work.

OCC Housekeeper

PMHx Nil Dx Nil NKDA

O/E Nil of note to see.

PT 5th MC + proximal phalanx small finger.

OBS Rt of hand wrist

NVI CRFC3 Good range

all moves

oExtensor lag

oRotation oSassory.

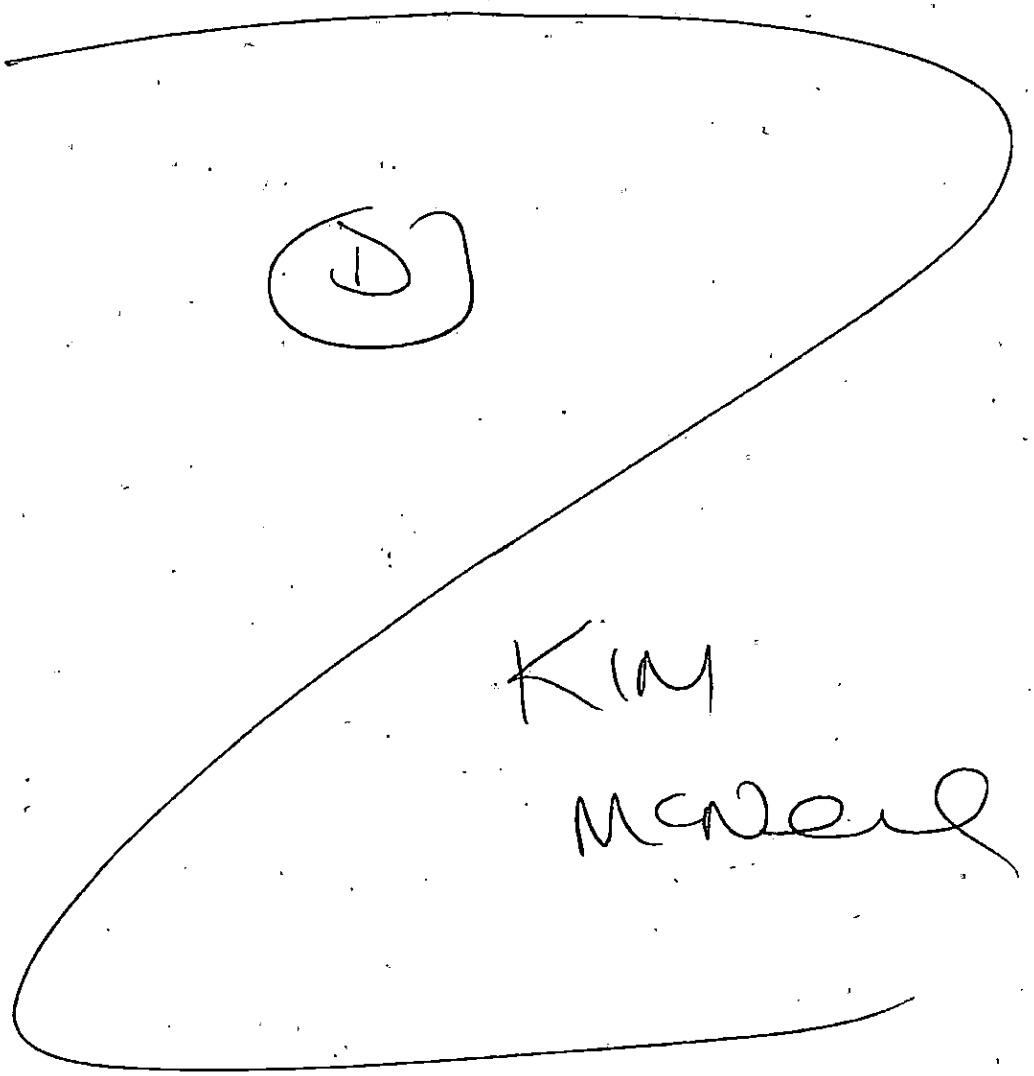
Xray Right Hand - NO #

Rx Reassurance - (D)

KIM MCNEIL

Date	CLINICAL NOTES

1612836909 16/12/1983
DONALD
Diane



Discharge Codes (Please CIRCLE)					Discharge date	6/12/18.
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A..	Discharge time	14:06

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

NHS GGC Hospitals, Admission Document

NHS Greater Glasgow and Clyde

& MAU 11

Affix Label

Queen Elizabeth University Hospital

CHI: 1612836909

Total Att: 7

12 Mth Att: 0

Title: MISS

DONALD

Diane

DOB 16/12/1983 Age: 38y Sex: Female

27 ST ANDREWS WAY

Clydebank
Dunbartonshire
G81 1BP
07393645082

Next of kin: NEIL, Allan
Relationship: Partner
07982 942 866

GP: F Irvine
0141 531 6425

Attendance Date: 22/01/2022 Arrival Time: 19:26

Registration Time: 19:26 Date of Incident: 22/01/2022

Major Incident Desc:

Reason for Attendance: PAIN IN BOTH EYES- SUDEN ONSET 2 HRS- NO COVID-19 SYMPTOMS

Nursing Assessment

Alerts: Not Recorded Allergies: None Known Pain Score:

Triage Category: 2 Tetanus up to date/fully immunised:

Presenting Complaint: Eye Pain Bilateral

Observation Date: 22/01/2022 20:10 Nurse name: Nurse Shona McCarthy

Temp	36.9	C
HR	106	bpm
BP	119/85	mmHg
MAP	96.33	mmHg
RR	14	bpm
SpO2	98	%
Oxygen		%

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

Nursing Notes: NHS 24 ref - suffers from migrane, Sudden onset bilateral eye pain at 1600hrs followed by vomiting at 1700hrs. Doesn't feel like normal migrane pain. Prev ophthalmology review ?glaucoma. Has taken analgesia at home with no effect.

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DONALD
Diane
27 ST ANDREWS WAY
Clydebank, Dunbartonshire
G81 1BP
F
16/12/1983

Date	Emergency Department Notes
	Ambulance Proforma reviewed Yes / (No) Seen by (Doctor) Thorburn CF Time seen 22:55
22/1/22	(38) PC: Bilateral eye pain. + HPC: Seen by ophthalmology in Nov. with floaters in both eyes. Diagnosed as normal ~~pressure~~ tension glaucoma. Floaters no worse than usual. Today at ~16:00 had sudden onset of bilateral eye pain focussed on eye balls. No other headache. Vomited 3x pre-hospital and 4x since arrival. Not noticed any visual blurring but photophobic. 8/10 pain at worst. 'Never had pain like it'. Known to suffer migraines but these are normally one-sided, throbbing temporal headaches. No other PMHx. No regular meds. No hx of injury to eyes. Onset when lying on sofa. OE GCS 15. No temporal artery tenderness. PEARL. Photophobic Full range of eye movements. c/o generalised diplopia. No nystagmus. CNII-~~XII~~ intact. Power 5/5 all 4 limbs. (N) tone. (N) sensation. VAR 6/9 unassisted. VAL 6/9 unassisted. C/O tenderness on palpation (L) eye.

NHS24 CONTACT REPORT

PCM ID:	74159952		
CHI:	1612836909	**Caller : Self**	
Surname:	DONALD	**Date/Time Call Received:**	22.01.2022 17:57:00
Forename:	DIANE	**Date/Time Call Completed:**	22.01.2022 18:25:49
DOB:	16.12.1983		
Gender:	F		
Address:	27 St. Andrews Way CLYDEBANK G81 1BP	**Current Location:**	27 St. Andrews Way CLYDEBANK G81 1BP
Phone Number: 07393645082		**GP:**	CRAIG LENNOX THE GREEN MEDICAL PTCE THE GREEN MEDICAL PTCE
Phone Ext.:			CLYDEBANK HEALTH CENTRE
Special Directions:			CLYDEBANK G 811BS
Temporary Resident: NO			

Call Classification:

CALL SUMMARY:
FINAL ENDPOINT:
Accident & Emergency (ASAP)
REASON FOR CALL / RELEVANT INFORMATION:
PAIN IN BOTH EYES- SUDEN ONSET 2 HRS- NO COVID- 19 SYMPTOMS
OUTCOME:
Patient advised to go to A&E

Confirmed Symptom(s):
#Confirmed eye problem
#Eyes light sensitive - noother symptoms
#Endpoint Management Selected(CCT)

Symptom(s) not found:
#No fever

Call Detail(s):
#Clinical supervisor (FirstTriage): SCN N QUINN

PAST MEDICAL HISTORY:

NOTES:

22:01:2022 17:59:38 TIERNEYF PT SUFFERS FROM MIGRAINE BUT THIS IS NOT A MIGRAINE- MAKING HER FEEL SICK
VOMITED X3 IN LAST 30 MINS-
SUDDEN ONSET PAIN BEHIND EYES-PAIN SCORE 8/10-ONGOING FOR 2 HRS-NO CHANGE-VOMITING STATED 30 MINS AGO- CAN MOBLISE- SHOOTING PAIN FROM SITTING TO STANDING- VOMITED BACK PARAMOL -NO ONE-SIDED WEAKNESS-LIGHT SENSITIVE-
SUFFERS FROM MIGRAINE ONE PER WEEK & NORMALLY AFFECTS ONE EYE- CURRENTLY UNDER INVESTIGATION FOR GLAUCOMA- ADVISED TO TAKE NORMAL MIGRAINE MEDICATION 40 MINS AFTER LAST VOMIT- WS GIVEN- A&E ASAP TO QEUH

Support Line Notes:

1612836909
DONALD F
Diane 16/12/1983
27 ST ANDREWS WAY
Clydebank, Dunbartonshire
G81 1BP

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen
23:40	D/w ophthalmology → In light of fairly normal eye examination, and unchanged visual acuity, unlikely to be an eye problem affecting both eyes. More likely to be neurological problem to be investigated.	

Differential Diagnosis/Problem List

- ? eye cause
- ?? SAH.

NEWS ☐ 0-7
RED FLAG ☐ (Tick)
SEPSIS ☐
CURB 65 ☐

Done/ completed	Immediate Managment Plan
	D/w Dr Ledinek → Speak to ophthalmology.
23:50	D/w Dr Traiforos:
	- Sounds more like migraine, very unlikely
	- SAH
	- Not for CT at present
	- Admit to medicine

Signature: JF Designation: CF Page No:

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

F1612836909
DONALD
Diane F
16/12/1983
27 ST ANDREWS WAY
Clydebank, Dunbartonshire
G81 1BP

Seen By: Print: J-LATTER Time Seen: 23/01/22 Pg. No: 0350.
PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	Bilateral Eye Pain
History of presenting complaint	Sudden onset severe bilateral eye pain while watching TV last night. Different to usual migraine – affects (R) side of face. Reports severe boring pain across nasal bridge on standing since onset. Assoc vomiting + nausea. Some relief since arriving at hospital – although no clear relieving factor.

Past Medical History / Review of portal

Migraine
S/B ophthalmology in Nov 2021 ⇒ suspected normal tension glaucoma.

Systemic Enquiry

E + D (N). BO (N). Passing urine (N). No fevers.
No SOB/cough/chest pain.
Upper abdo pain recently – resolved for ~1/52.

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G81 1BP

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history (>1 source preferred)
☒ Patient/Relative/carer ☐ GP Phone call ☒ ECS
☐ Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary
☐ Repeat Prescription

Other (please specify)

Admission Medicines			Plan for Medicines (Dr complete)				Comments Reason for alteration
Name	Dose	Freq	Continue	Amend	Withhold	Stop	
Nil regular.							
			✓				
Sumatriptan.	50mg	PRN					

Allergies	List any over-the-counter or alternative medicines
Metronidazole → sleepy	
	Do medicines need further clarification ? ☐ Yes ☐ No
List collected by : J WATTER	Plan approved by :
Designation : PMT2 Date : 23/01/12	Designation : Date :

Pharmacy review	Comments

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

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G81 1BP

Social History \ Family History

Smoking History

(Ex-smoker)/Smoker _____ cpd _____ yrs ☐ Never smoked

Alcohol History

0 Units/week FAST score if excess _____

Recreational Drugs **Driving Status**

nil.

Social Circumstances (home, supports, functional status, occupation, travel)

lives with partner + children. (N)Independent
attending college - hairdressing.

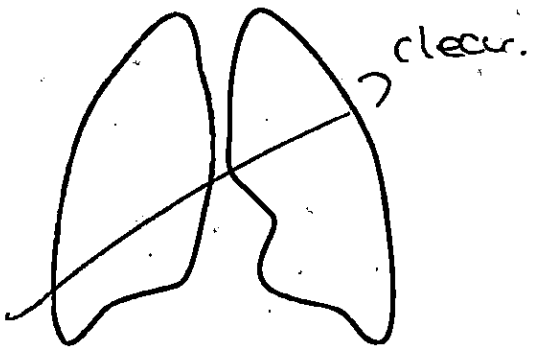
General Examination

Temp: 36.3	RR: 14.
Pulse: 78	CBG:
SpO_2: 97 (A).	Weight:
BP: 110/60.	Urinalysis:

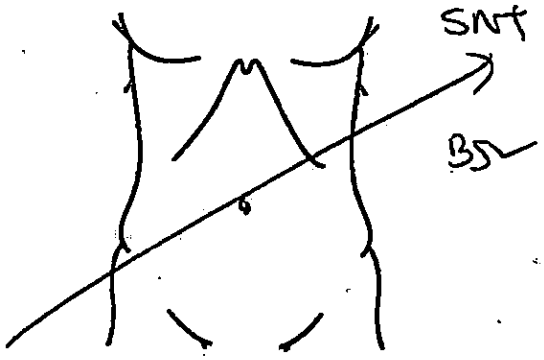
General Appearance:

~~drowsy~~
photophobia.

Respiratory



Gastrointestinal System



Cardiovascular

HS I + II +0
WWP
Calves SNT
°oedema.

Locomotor

moving all 4 limbs.

Patier 1612836909
DONALD F
Diane 16/12/1983
27 ST ANDREWS WAY
Clydebank, Dunbartonshire
G81 1BP

Neurological system

GCS: 15/15 E: 4/4 M: 6/6 V: 5/5

AMT 4 = age, DOB, place, year

AMT score ____ /4

Is the patient more confused/drowsy than normal: Y / N
If yes complete 4AT / TIME

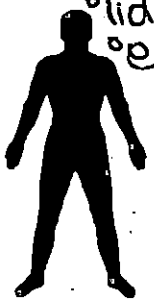
Pupils/fundoscopy: (N) eye movements c/o diplopia in all planes.

Cerebellar and extrapyramidal:

Cranial Nerves: °nystagmus. photophobic. °lid lag °exophthalmos

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone	N	→	→	→
Power	5/5	→	→	→
Co-ordination				
Sensation	N	→	→	→

Plantars: R L

Skin/Other

psoriatic skin patches

thyroid scar.

P: 1612836909
DONALD F
Diane 16/12/1983
27 ST ANDREWS WAY
Clydebank, Dunbartonshire
G81 1BP

Key Results

CXR

ECG SR67bpm.

(Differential) diagnosis

1) eye pain - ? related to glaucoma.
? thyroid.

NEWS ☐
Red Flag ☐
Sepsis ☐
CURB 65 ☐

Management Plan

1) Ophth r/v (note d/w ED + ophth; felt unlikely to be ophth cause as bilateral).
2) Analgesia.
3) ? CT head
4) Check TFTs.

☐ Thromboprophylaxis assessed ☐ Medicine Reconciliation ☐ 4AT/TIME
☐ Antimicrobial

Signature:

PRINT NAME J. LATTER
PRINT GRADE IMT2.

Page:

Patient ID label

Resuscitation Decision
Resuscitation status: FOR RESUSCITATION / DNA CPR (please circle)
If DNA CPR → Complete appropriate form

Senior Medical review

☐ Thromboprophylaxis assessed ☐ Medicine Reconciliation ☐ 4AT/TIME
☐ Antimicrobial ☐ DNACPR ☐ AWI if appropriate

Sepsis Six
- ☐ Antibiotics within 1 hour
- ☐ Appropriate Cultures
- ☐ Fluids
- ☐ Oxygen
- ☐ Lactate
- ☐ Fluid balance, consider catheter

Patient ID label

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED

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

☐ Yes

☐ No

Does the patient have any of the following risk factors? Tick if apply

Active cancer or cancer treatment		Use of oestrogen containing contraceptive	
Age> 60		Hormone replacement therapy	
Dehydration		Pregnancy or <6 weeks post partum (seek specialist advice)	
Known thrombophillia		Critical care admission	
BMI >30		Varicose veins with phlebitis	
Personal/1st degree relative history of VTE		Current significant medical condition e.g. infection, inflammation, cardio resp disease	
Hip fracture			

- No thromboprophylaxis
- Reassess (every 72 hours minimum)and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

☐ Yes

☐ No

Does the patient have any of the following contraindications? Tick if apply

Active bleeding		Untreated inherited bleeding disorder	
Acquired bleeding disorder		Thrombocytopaenia <75 x109/l	
Thyroid, spinal, posterior eye or neurosurgery		Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR>2		Uncontrolled hypertension (>230/120)	
Acute stroke		Varicose veins	
Recent (<4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic			
Other - Document			

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum)and document

☐ No

☐ Yes

Enoxaparin 40mg (reduce to 20mg if weighs < 50kg or eGFR <30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A
(only n/a if due to cognitive impairment or similar)
If N/A why? _____
Assessed by _____
Date _____

1612836909
DONALD [illegible] F
Diane 16/12/1983
27 ST ANDREWS WAY
Clydebank, Dunbartonshire
G81 1BP

Results

Date		241							
Time									
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165	144							
WCC	4.0 - 11.0	9.5							
Plts	150 - 450	278							
MCV	80 - 100	95							
Neut	2.0 - 7.5	5.6							
PT	9.0 - 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	( )								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146	140							
K+	3.5 - 5.3	4.5							
Cl-	95 - 108	109							
HCO3-	22 - 29	24							
Urea	2.5 - 7.8	3.4							
Creat	40 - 130	53							
eGFR		>60							
Glucose	3.5 - 6.0	4.5							
Protein	60 - 80								
Albumin	35 - 50	40							
AlkP	30 - 130	79							
Bil	<20	8							
ALT	<50	23							
AST	<40	17							
GGT	Male: <70 Female: <40								
ESR	Male: 1 -10 Female: 1 - 12								
CRP	<10	<1							
Troponin hs I	Male: 0 - 34 Female 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 – 2.0								

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Diane 16/12/1983
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Clydebank, Dunbartonshire
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Post Take Ward Round IAU/ARU

Consultant: Shepherd. Date: 23/1/22. Time: _____

Summary

38
Severe frontal headache Coursed on eyes - bilateral.
Sudden onset - Vomiting
Now resolving.

2/12 - FROGM.
- No Strabismus.
- No Local neurology

Temp:
Pulse:
BP:
SpO_2:
FiO2:
RR:

Diagnosis: Mod Reducity Left Subtentorial - Possible Migrain

Plan:
IM - Metoclopramide
CT - Draw.
Ref - c/w Neurology - as advised by ophthalmology
⇒ GenMed bed.

Recommended Destination: _____
Suitable to board if required ☐ Yes ☐ No
Expected Date of Discharge: _____

Signature: _____
Designation: Orthy
Bleep Number: _____

Patient ID label

1612836909
DONALD
Diane
16/12/1983

Continuation Sheet

Date: Time	
23/1/22	CT Head reported 20:40 - Lt pons - impression of small focal low density lesion lying anteriorly to the left of the midline, ↳ ? artefact. - hazy mucosal polyps in (L) maxillary antrum. -No herniation, SOL, ICH or hydrocephalus. -MR Recommended. - For d/w neurology tomorrow re: benefit of MRI. - Headache persisting - worsened by light.

1612836909
DONALD F
Diane 16/12/1983
27 ST ANDREWS WAY
Clydebank, Dunbartonshire
G81 1BP

Continu

1612836909
Date: Tir DONALD F
Diane 16/12/1983
27 ST ANDREWS WAY
Clydebank, Dunbartonshire
G81 1BP

1612836909
DONALD F
Diane 16/12/1983
27 ST ANDREWS WAY
Clydebank, Dunbartonshire
G81 1BP

NHS
tor Glasgow
and Clyde

Hospital Queen

I hereby certify that I am being discharged from this hospital on my own responsibility.

Signed .....

Witness .....

I hereby agree to relieve the Health Board of all responsibility in connection with the discharge of ..... from hospital.

Signed .....

Relationship .....

Address .....

Witness .....

Note: A permanent form of writing instrument should be used in completing this form.

STY5017N

Patient ID label

Continuation Sheet	
Date: Time	

Patient ID label

Continuation Sheet	
Date: Time	

1612836909
DONALD F
Diane 16/12/1983
27 ST ANDREWS WAY
Clydebank, Dunbartonshire
G81 1BP

Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

Date Given	Drug (Block Capitals)	Dose	Method of administration	Time of administration	Signature	Given by
22/1	ASPIRIN	300mg	O	22:20		ITA
22/1	ONDANSETRON	4mg	IV	2135		EL

Discharge prescription packs

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by

DISCHARGE CODES: Please Circle

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

Time Ready to Depart	
Discharge Time	

Ward No. (if admitted)	Transfer to Hospital	Consultant (if admitted)

Outpatient clinic specialty						Admission or specialty clinic consultant		
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

Diane
DONALD
16/2836909

Date & Time		Signature, Print Name & Designation
15/02	42/F Phone	
	Core	
	Driver.	
19/1/26	12/5/25:	
		Amb. FCC (N)
	toilet. — breathing team.	MRI-H 2022
	bathroom; felt strange	— (N).
	sec — minute.	
Witnessed	body convulsing — felt	
	abnormal	
	fell on the floor.	
	No tongue bite/ incontinence	
	No FH/further/ funny turn.	
	Adv: MRI-H	
	— safety	
	E	

83949 GGC0072

Cardiac Outpatients Department
West Glasgow ACH

Tel: 0141 201 0179

NHS
Greater Glasgow and Clyde

PATIENT EVENT DIARY

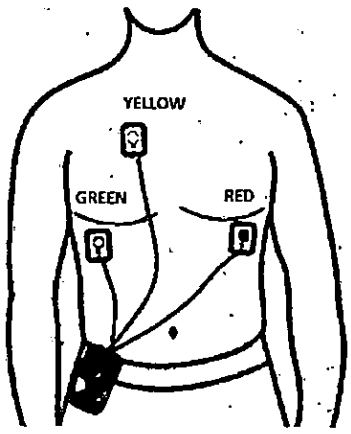
PATIENTS NAME	Diane Donald
CHI NO	1612836909
MONITORING DURATION	24Hr Monitoring
RECORDER DETAILS	L541673 093
DATE STARTED	19/02/2025
DATE STOPPED	20/02/2025

It is important that you record any relevant symptoms while the monitor is on.

To record a symptomatic event press the **YELLOW** or **GREEN** button on the front of the recorder and then document your symptoms and activity on the **DIARY overleaf**. Please insure you write the **date and time** of symptoms in this diary.
If you are asked to wear the monitor for more than 24 hours then you have the option to change the electrodes. When you disconnect the monitor it will alarm for a few cycles. To reattach new electrodes the skin should prepared as instructed and then place them in positions slightly away from the original site to prevent skin irritation.

The colour code for the monitor leads is:

Right shoulder = **YELLOW**
Lower right chest = **GREEN**
Lower left chest = **RED**



The time the monitor is due to be returned will be written overleaf under the diary.

Please note: All stickers should be disconnected from the monitor leads and disposed of before the monitor is returned. Do not return any stickers to the hospital.

It is **your responsibility** to ensure that the monitor is returned on time to the department specified. If you have any problems at all please contact us on the number stated above.

FAILURE TO RETURN HOSPITAL EQUIPMENT WILL BE TREATED AS THEFT

Thank you for your co-operation

DATE	MONITOR TIME (24 hour clock)	SYMPTOMS	ACTIVITY
19/2/25	10:23	breathing fast, feeling weak	driving
"	12:48	" " "	watching tv.
	14:21	breathing fast, can feel beating	watching tv.
	16:24	out of breath feeling.	sitting in barbers.
	22:43	fast breathing, feeling weak	in bed.

RETURN EQUIPMENT TO CARDIOLOGY CLINIC RECPTION

RETURN MONITOR DATE AND TIME	20/02/2025 between 9 – 12pm

Cardiac Outpatients Department
West Glasgow ACH

Tel: 0141 201 0179

NHS
Greater Glasgow and Clyde

PATIENT EVENT DIARY

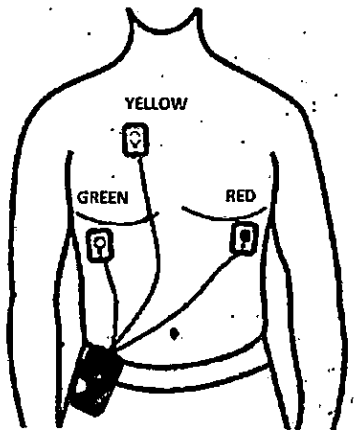
PATIENTS NAME	Diane Donald
CHI NO	1612836909
MONITORING DURATION	24Hr Monitoring
RECORDER DETAILS	L541673 093
DATE STARTED	19/02/2025
DATE STOPPED	20/02/2025

It is important that you record any relevant symptoms while the monitor is on.

To record a symptomatic event press the **YELLOW** or **GREEN** button on the front of the recorder and then document your symptoms and activity on the **DIARY overleaf**. Please insure you write the **date and time** of symptoms in this diary.
If you are asked to wear the monitor for more than 24 hours then you have the option to change the electrodes. When you disconnect the monitor it will alarm for a few cycles. To reattach new electrodes the skin should prepared as instructed and then place them in positions slightly away from the original site to prevent skin irritation.

The colour code for the monitor leads is:

Right shoulder = **YELLOW**
Lower right chest = **GREEN**
Lower left chest = **RED**



The time the monitor is due to be returned will be written overleaf under the diary.

Please note: All stickers should be disconnected from the monitor leads and disposed of before the monitor is returned. Do not return any stickers to the hospital.

It is **your responsibility** to ensure that the monitor is returned on time to the department specified. If you have any problems at all please contact us on the number stated above.

FAILURE TO RETURN HOSPITAL EQUIPMENT WILL BE TREATED AS THEFT

Thank you for your co-operation

DATE	MONITOR TIME (24 hour clock)	SYMPTOMS	ACTIVITY
19/2/25	10:23	breathing fast, feeling weak	driving
"	12:48	" " "	watching tv.
	14:21	breathing fast, can feel beating	watching tv.
	16:24.	out of breath feeling.	sitting in barbers.
	22:43	fast breathing, feeling weak	in bed.

RETURN EQUIPMENT TO CARDIOLOGY CLINIC RECPTION

RETURN MONITOR DATE AND TIME	20/02/2025 between 9 – 12pm

DONALD, Diane
BORN 16-Dec-1983 (42y) GENDER Female
CHI 1612836909

Request to GP to prescribe medication

Last updated by Katie MURPHY (Katie Murphy) 16 months ago (v. 1) Show History

Content Restricted	No	Sensitivity	Sensitive
If the information on this form merits further restriction than that of Highly Sensitive, please select **Yes** to apply a Privacy Seal		The information on this form **will** be viewable by health and care providers with the appropriate access permissions	

Date	14-Feb-2025		
Hospital	Queen Elizabeth University Hospital	Other	—
Specialty / Service	Obstetrics		
Clinic	No	Please Specify	—

Dear Doctor

Your Patient Was Reviewed

Please Prescribe

Urgent / Routine Urgent - within 48 hours

Phone practice prior to completing form.

indication Increased blood sugars

Additions and Replacements

Product	Dose	Frequency	Current Regime Status	Comments
Metformin SR	500mg	BD, to be slowly increased to 1gBD, patient given instructions	Addition	—

Replacements

This medication replaces which should now be stopped —

Patient advised to collect prescription Yes

Please Note: A Detailed Letter Will Follow..

Additional Notes / Summary

Additional Notes / Summary —

When you click to 'Complete' a summary of the the form will be sent electronically to the registered GP practice.

DONALD, Diane

BORN 16-Dec-1983 (42y) GENDER Female

CHI 1612836969

Clinician Details

Name	Katie Murphy
ClinicianDetailsRole	Other
Specify Other Role	Diabetes Specialist Midwife
Professional Registration Number	17I0303s
Contact Details	ggc.dsm-qeuh2@nhs.scot

Amend

DONALD, Diane
BORN 16-Dec-1983 (42y) GENDER Female
CHI 1612836909

Request to GP to prescribe medication

Last updated by Jillian SMITH (Jillian Smith) 16 months ago (v. 1) Show History

Content Restricted	No	Sensitivity	Sensitive
If the information on this form merits further restriction than that of Highly Sensitive, please select **Yes** to apply a Privacy Seal		The information on this form **will** be viewable by health and care providers with the appropriate access permissions	

Date	04-Feb-2025		
Hospital	Queen Elizabeth University Hospital	Other	—
Specialty / Service	Obstetrics		
Clinic	No	Please Specify	—

Dear Doctor

Your Patient Was Reviewed

Please Prescribe

Urgent / Routine: Routine - prescription available 48 hours following request

indication: —

Additions and Replacements

Product	Dose	Frequency	Current Regime Status	Comments
Freestyle Libre Sensor	1 sensor	every 2 weeks	Addition	Please ensure 4 sensors are given at one time

Replacements

This medication replaces which should now be stopped

The above lady has met the NHS GGC eligibility for FreeStyle Libre as they have recently been diagnosed with Gestational Diabetes Mellitus.

FreeStyle Libre is a flash glucose monitoring technology which provides glucose results without requiring a finger prick. The system comprises of an adhesive sensor (worn for 2 weeks at a time).

I would be grateful if you would add the FreeStyle Libre Sensor to your patient's prescription. We recommend that the patient be given 4 sensors at a time, which would require a repeat prescription every couple of months. Faulty sensor should be replaced by the manufacture.

If you have any queries please email ggc.dsm-qeuh2@nhs.scot

Patient advised to collect prescription: Yes

Please Note: A Detailed Letter Will Follow.

Additional Notes / Summary

DONALD, Diane

Additional Notes Summary

Addtnl Notes 1983 (42y) GENDER Female

CHI 1612836909

When you click to 'Complete' a summary of the the form will be sent electronically to the registered GP practice.

Clinician Details

Name	Jillian Smith
ClinicianDetailsRole	Other
Specify Other Role	Diabetes Specialist MW
Professional Registration Number	08I2083s
Contact Details	Jillian.smith@nhs.scot

Amend

DONALD, Diane
BORN 16-Dec-1983 (42y) GENDER Female
CHI 1612836909

Request to GP to prescribe medication

Last updated by Jillian SMITH (Jillian Smith) 17 months ago (v. 1) Show History

Content Restricted	No	Sensitivity	Sensitive
If the information on this form merits further restriction than that of Highly Sensitive, please select **Yes** to apply a Privacy Seal		The information on this form **will** be viewable by health and care providers with the appropriate access permissions	
Date	29-Jan-2025		
Hospital	Queen Elizabeth University Hospital	Other	—
Specialty / Service	Obstetrics		
Clinic	No	Please Specify	—

Dear Doctor

Your Patient Was Reviewed

Please Prescribe

Urgent / Routine Routine - prescription available 48 hours following request

indication —

Additions and Replacements

Product	Dose	Frequency	Current Regime Status	Comments
WaveSense Jazz Blood Glucose testing Strips	4 vials of 50	—	Addition	- PIP Code 340-1619
Agamatrix Ultra-Thin lancets 33G	– 1 box of 200	—	—	– PIP Code 342-0601

Replacements

This medication replaces which should now be stopped —

Patient advised to collect prescription Yes

Please Note: A Detailed Letter Will Follow.

Additional Notes / Summary

Additional Notes / Summary: This woman has been diagnosed with gestational diabetes. We would be grateful if you would perform fasting blood glucose/HbA1c 6-12 weeks postnatally to exclude diabetes after pregnancy and arrange a yearly Hba1c.

When you click to 'Complete' a summary of the the form will be sent electronically to the registered GP practice

DONALD, Diane
BORN 16-Dec-1983 (42y) GENDER Female
CHI 1612836909

Clinician Details

Name	Jillian Smith
ClinicianDetailsRole	Other
Specify Other Role	Diabetes Specialist MW
Professional Registration Number	08I2083S
Contact Details	jillian.smith@nhs.scot

Amend

DONALD, Diane
BORN 16-Dec-1983 (42y) GENDER Female
CHI 1612836909

Request to GP to prescribe medication

Last updated by David RUTHERFORD (David Rutherford) 21 months ago (v. 1) Show History

Content Restricted	No	Sensitivity	Sensitive
If the information on this form merits further restriction than that of Highly Sensitive, please select **Yes** to apply a Privacy Seal		The information on this form **will** be viewable by health and care providers with the appropriate access permissions	

Date	24-Sep-2024		
Hospital	Queen Elizabeth University Hospital	Other	—
Specialty / Service	Obstetrics		
Clinic	Yes	Please Specify	—

Dear Doctor

Your Patient Was Seen

Please Prescribe

Urgent / Routine: Routine - prescription available 48 hours following request

indication: Migraine prophylaxis in pregnancy and to reduce risk of pre-eclampsia.

Additions and Replacements

Product	Dose	Frequency	Current Regime Status	Comments
aspirin	150mg	once daily at night time	—	Stop at 36 weeks gestation

Replacements

This medication replaces which should now be stopped: —

Patient advised to collect prescription: Yes

Please Note: A Detailed Letter Will Follow.

Additional Notes / Summary

Additional Notes / Summary: —

When you click to 'Complete' a summary of the the form will be sent electronically to the registered GP practice.

Clinician Details

Name	David Rutherford
ClinicianDetailsRole	Consultant
Professional Registration Number	7411218
Contact Details	david.rutherford@ggc.scot.nhs.uk

Amend

DONALD, Diane
BORN 16-Dec-1983 (42y) GENDER Female
CHI 1612836909

DONALD, Diane
BORN 16-Dec-1983 (42y) GENDER Female
CHI 1612836909

Request to GP to prescribe medication

Last updated by Holly DOCHERTY (Holly Docherty) 21 months ago (v. 1) Show History

Content Restricted	No	Sensitivity	Sensitive
If the information on this form merits further restriction than that of Highly Sensitive, please select **Yes** to apply a Privacy Seal		The information on this form **will** be viewable by health and care providers with the appropriate access permissions	
Date	19-Sep-2024		
Hospital	Queen Elizabeth University Hospital	Other	—
Specialty / Service	Obstetrics		
Clinic	Yes	Please Specify	—

Dear Doctor

Your Patient Was Reviewed

Please Prescribe

Urgent / Routine: Routine - prescription available 48 hours following request

indication: Low Ferritin for pregnancy 22

Additions and Replacements

Product	Dose	Frequency	Current Regime Status	Comments
Ferrous sulfate	200mg	1x daily	Addition	Pregnancy and 3 months postnatally

Replacements

This medication replaces which should now be stopped: —

Patient advised to collect prescription: Yes

Please Note: A Detailed Letter Will Follow.

Additional Notes / Summary

Additional Notes / Summary: —

When you click to 'Complete' a summary of the the form will be sent electronically to the registered GP practice.

Clinician Details

Name	Holly Docherty
ClinicianDetailsRole	Other
Specify Other Role	Midwife
Professional Registration Number	19i1890S
Contact Details	01412012226

Amend

DONALD, Diane
BORN 16 Dec 1983 (42y) GENDER Female
CHI 1612836909

DONALD, Diane
BORN 16-Dec-1983 (42y) GENDER Female
CHI 1612836909

Request to GP to prescribe medication

Last updated by Lisa DOHERTY (Lisa Doherty3) 3.5 years ago (v. 1) Show History

Content Restricted	No	Sensitivity	Sensitive
If the information on this form merits further restriction than that of Highly Sensitive, please select **Yes** to apply a Privacy Seal		The information on this form **will** be viewable by health and care providers with the appropriate access permissions	

Date	29-Dec-2022		
Hospital	West Glasgow ACH - Yorkhill	Other	—
Specialty / Service	Obstetrics		
Clinic	Yes	Please Specify	—

Clinician Details

Name	Lisa Doherty3
ClinicianDetailsRole	Other
Specify Other Role	midwife
Professional Registration Number	10i0362s
Contact Details	0141 201 0141

Dear Doctor

Your Patient Was Seen

Please Prescribe

Urgent / Routine: Routine - prescription available 48 hours following request

indication: 28/40 ferritin 6

Additions and Replacements

Product	Dose	Frequency	Current Regime Status	Comments
ferrous fumerate	210mg	od	—	—

Replacements

This medication replaces which should now be stopped: —

Patient advised to collect prescription: Yes

Please Note: A Detailed Letter Will Follow.

Additional Notes / Summary

DONALD, Diane
Additional Notes /
Summary
BORN 16-Dec-1983 (42y) GENDER Female
CHI 1612836909

When you click to 'Complete' a summary of the the form will be sent electronically to the registered GP practice.

Amend

DONALD, Diane
BORN 16-Dec-1983 (42y) GENDER Female
CHI 1612836909

Request to GP to prescribe medication

Last updated by Christine CREE (Christine Cree) 3.5 years ago (v. 1) Show History

Content Restricted	No	Sensitivity	Sensitive
If the information on this form merits further restriction than that of Highly Sensitive, please select **Yes** to apply a Privacy Seal		The information on this form **will** be viewable by health and care providers with the appropriate access permissions	

Date	09-Nov-2022		
Hospital	Queen Elizabeth University Hospital	Other	—
Specialty / Service	Obstetrics & Gynaecology		
Clinic	Yes	Please Specify	—

Clinician Details

Name	Christine Cree
ClinicianDetailsRole	Other
Specify Other Role	midwife
Professional Registration Number	0710700s
Contact Details	01412324363

Dear Doctor

Your Patient Was Reviewed

Please Prescribe

Urgent / Routine: Routine - prescription available 48 hours following request

indication: —

Additions and Replacements

Product	Dose	Frequency	Current Regime Status	Comments
piriton	4mg	one daily	Addition	—
dermacool	1x 500g bottle	as required	—	—

Replacements

This medication replaces which should now be stopped: —

Patient advised to collect prescription: Yes

Please Note: A Detailed Letter Will Follow.

DONALD, Diane

Additional Notes / Summary

BORN 16-Dec-1983 (42y) GENDER Female

Additional Notes / Summary patient has ongoing itch all over body

When you click to 'Complete' a summary of the the form will be sent electronically to the registered GP practice.

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☐

Please tick ✔ appropriate directorate

Dianne Donald.
1612836509.

Date & Time		Signature, Print Name & Designation
5/4/21	Heard both tonsils enlarged / with Thubby clean exudate / Throat / tender to palpation.	Fu 22 Feb.
	No rash / No lymphadenopathy /	- Stopped handwriting
	Rashes on. No loc. /	(R) Duke (upper) (A) Alcock (left).
		Sarah Pollock Nurse Practitioner

83949 GCC0072

17.00

Gartnavel General Hospital Breast Clinic

New Patient Assessment

1612836909
P DONALD F
Diane 16/12/1983
43 Longden Street
Clydebank, Dunbartonshire
G81 1AG

Date of Clinic: 20/04/2018

Doctor: MISS J DOUGHTY EXTRA

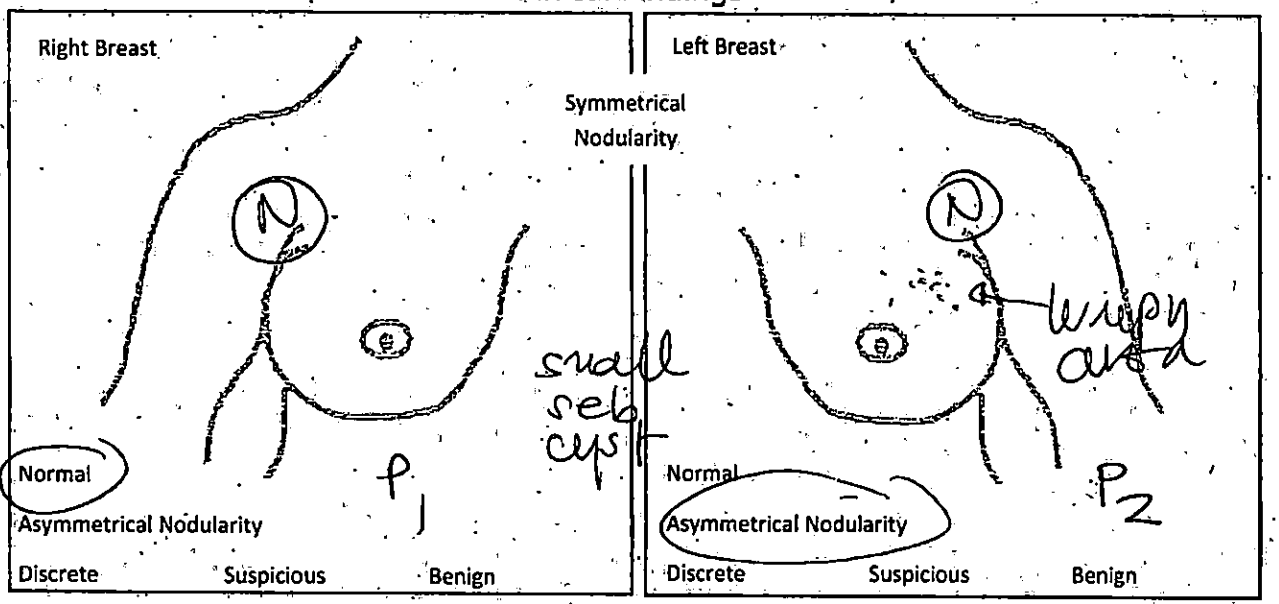
Age 34

History: Tender wispy area (L) laterally + wisp skin of flank.

Family History: No BC or OC

HRT implant – no cycles

Clinical Findings



Investigations

Right Breast		Left Breast	
Mammogram	Ultrasound	Mammogram	Ultrasound
			Normal RT only (L)
Cytology ☐	Core Biopsy ☐	Cytology ☐	Core Biopsy ☐

Overall Impression and Action Plan

Reassure & Discharge.

1612836909
DONALD
Diane
F
16/12/1983

Glasgow

B28

Greater Glasgow and Clyde

GYNAECOLOGY SHEET

Date	Reason for attendance	Diagnosis · Irregular menstrual bleeding
17/10/16		Treatment
	Para2 (SVD).	
	32 ♀ Nexplanon since march 2014.	
	Irregular bleeding since Febuaiy 2016	
	(Amenorrhoeic prior to this) · Last bleed 1mouth ago	
	- "old blood" + clots. Associated cramps.	
	Last smear test -ve.	
	USS Febuaiy (N) Golden Jubilee.	
	Last episode of PCB 1mouth ago - mixture of old + new.	
	No Dyspareunia. No abnormd discharge.	
	Previous illness · Prev LLETZ 2009 CINIII	
	Operations —	
	Parity 2	
	Menarche 12 yrs · Cycle Prev reg · Menopause —	
	L.M.P. — · Contraception Nexplanon.	
	Urinary Symptoms Nil · ~~DF~~ SI	
	~~NF~~ ~~Dysuria~~	
	Examination by: A SINGH	Speculum c+c.
		(N) V+V } HVSV.
	SNT	Healthy Cervix.
	No masses palpable	
		Bimanual - no tender
		- no masses
	DIW Dr Pringle: Nil concern	
	∴ continue with Nexplanon. or try Mirena / Copper Coil ✓	
	Info leaflets given ✓	
	No furthr gyn appt needed.	
		A SINGH.

Alan Lyell Centre for Dermatology

Dermatological Surgery

Pre-operative Risk Assessment & Biopsy Request

GRI ☐ VIG ☐
STB ☐ RAH ☐
WIG/GGH ☐ IRH ☐
SGH ☐

NHS Greater Glasgow and Clyde

Date: 4/12/13
Doctor: S MacAlpine
Biopsy date: 12/12/13

Patie 1612836909
DONALD
Diane F
43 Longden Street 16/12/1983
Clydebank, Dunbartonshire
Tel N G81 1AG

1. Bleeding Risk

YES / NO

☐ aspirin continuing/stopped _____
☐ NSAID continuing/stopped _____
☐ warfarin continuing/stopped _____
☐ for pre-op INR
☐ bleeding disorder _____

2. Anaphylaxis Risk

YES / NO

☐ previous anaphylaxis ☐ latex allergy
☐ rubber allergy ☐ other _____
☐ previous local anaesthetic reaction

3. CV/Respiratory Risk

YES / NO

☐ pacemaker ☐ defibrillator
☐ valve defect/prosthetic valve ☐ CV/respiratory impairment
☐ drugs
◆ **Antibiotic prophylaxis required YES / NO**

4. Infection Risk

YES / NO

☐ immunocompromised ☐ diabetes mellitus
☐ HIV ☐ Hepatitis B ☐ Hepatitis C ☐ MRSA
☐ other _____

5. Risk of poor wound healing

YES / NO

☐ systemic steroids ☐ immunosuppressants
☐ peripheral vascular dis. ☐ conn. tiss/collagen dis.
☐ diabetes mellitus
◆ **Smoker** YES / NO 10 cpd

6. Operative risks discussed with patient

YES / NO

☐ infection ☑ bleeding
☑ nerve damage ☑ wound dehiscence
☑ scarring

7. Biopsy request

a. ☐ incisional ☐ excisional
b. ☐ curettage ☐ shave ☐ elliptical
☐ punch _____ mm ☐ flap ☐ other _____

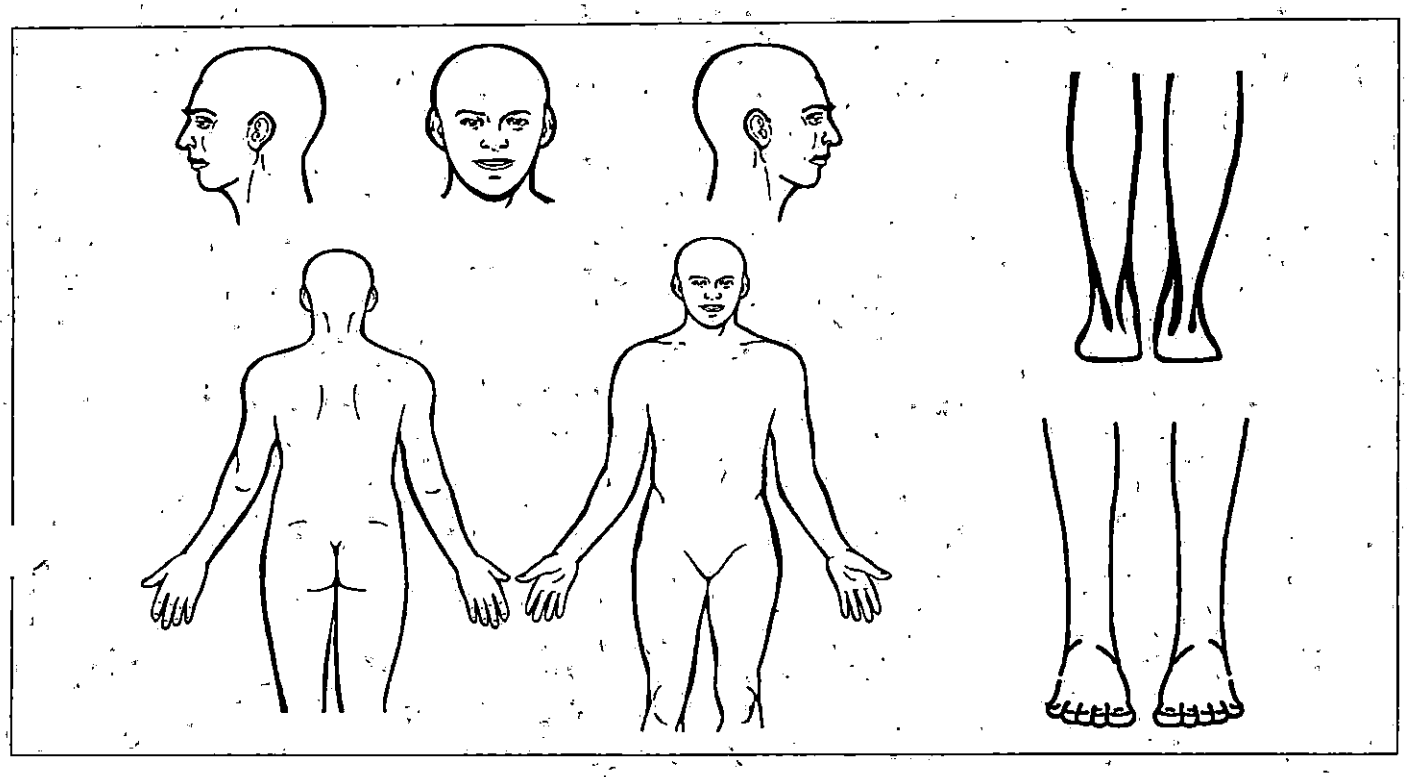
GRI 238141

Operation note

Date ___/___/___

1. Consent ☐ written ☐ verbal ☐ other _____

2. Site(s) of biopsy(ies)



3. Biopsy type
   a. ☐ incision ☐ excision
   b. ☐ curettage ☐ shave ☐ elliptical ☐ margin taken _____mm
   ☐ punch [☐ 2mm ☐ 3mm ☐ 4mm ☐ 5mm ☐ 6mm]
   ☐ other _____

4. Local anaesthetic ☐ 0.5% lignocaine ☐ 1% lignocaine ☐ 2% lignocaine
   ☐ other _____ ☐ with adrenaline ☐ no adrenaline
   Quantity used _____ ml

5. Haemostasis ☐ chemical ☐ hyfrecator _____ high/low ☐ sutures

6. Sutures ☐ subcuticular number _____ size _____ type _____
   ☐ cuticular number _____ size _____ type _____
   Removal of sutures _____ days - GP/Dermatology unit/DNurse

7. Additional notes

8. Investigations ☐ H&E ☐ IMF ☐ culture ☐ EM
   ☐ special stains _____

9. Follow-up ☐ appointment _____ weeks ☐ discharge to GP

10. Doctor (Print) _____ Nurse _____

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 23/01/2022

Consultant: Dr Kevin Thomson

F Irvine
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
Clydebank
G81 2TQ

Dear F Irvine

Re: **Donald Diane** DOB: **16/12/1983** CHI: **1612836909**
27 ST ANDREWS WAY
Clydebank G81 1BP

Attended on: **22/01/2022 at 19:26 hrs.** Departed on: **23/01/2022 at 00:54 hrs.**
Discharge Type: **02 - Admitted** Destination: **Admission to this Hospital**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
PAIN IN BOTH EYES- SUDEN ONSET 2 HRS- NO COVID- 19 SYMPTOMS

Nursing Assessment:
NHS 24 ref - suffers from migrane, Sudden onset bilateral eye pain at 1600hrs followed by vomiting at 1700hrs. Doesn't feel like normal migrane pain. Prev ophthalmology review ?glaucoma. Has taken analgesia at home with no effect.

Investigations in ED:

1. Full Blood Count	**2. CRP**	**3. Urea and Electrolytes**
4. Bicarbonate	**5. LFT**	**6. Glucose**

Diagnosis:

Diagnosis	Side	Site
Other Migraine		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Presented with bilateral eye pain. No focal neurological deficit in ED. Known to suffer from migraines. Admitted to medicine.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Kevin Ka Shing Bee
Doctor

Copies to:

1. F Irvine (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 10/10/2020

Consultant: Dr Hannah Smith

F Irvine
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
Clydebank
G81 2TQ

Dear F Irvine

Re: **Donald Diane** DOB: **16/12/1983** CHI: **1612836909**
43 LONGDEN STREET
Clydebank G81 1AG

Attended on: **10/10/2020 at 13:41 hrs.** Departed on: **10/10/2020 at 14:50 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
swollen finger

Nursing Assessment:
SWELLING TO LEFT INDEX FINGER IS BEING TREATED FOR INFECTION TO FINGER WITH FLUCLOX, SWELLING HAS BECAME WORSE

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Cellulitis of Finger and Toe		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

2 weeks finger cellulitis. Day 6 flucloxacillin. Improving, minimal erythema. No heat . No systemic features. Concerned regards swelling. Home with worsening advice, no fluctuant area to drain.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Peter Moffitt
Doctor

Copies to:

1. F Irvine (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 09/07/2019

Consultant: Dr Alan Whitelaw

F Irvine
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
Clydebank
G81 2TQ

Dear F Irvine

Re: **Donald Diane** DOB: **16/12/1983** CHI: **1612836909**
43 LONGDEN STREET
Clydebank G81 1AG

Attended on: **22/05/2019 at 21:44 hrs.** Departed on: **23/05/2019 at 00:20 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
rib and back pain, painful when breathing

Nursing Assessment:
pain to R truncal region radiaitng to back, worse on inpiration. treated for muscular back pain by gp

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Musculoskeletal chest pain (non - traumatic)		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Katy McCarthy
Consultant

Copies to:

1. F Irvine (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 06/12/2018

Consultant: Dr Nicola Littlewood

F Irvine
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
Clydebank
G81 2TQ

Dear F Irvine

Re: **Donald Diane** DOB: **16/12/1983** CHI: **1612836909**
43 LONGDEN STREET
Clydebank G81 1AG

Attended on: **06/12/2018 at 12:31 hrs.** Departed on: **at hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
right hand injury

Nursing Assessment:
fell 2/52 injuring right hand c/o still painful was intoxicated so cannot remember how she landed

Investigations in ED:
1. XR Hand Rt

Diagnosis:

Diagnosis	Side	Site
Sprain and strain of hand - unspecified	**Right**	**Hand**

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Fell 2 weeks ago when intoxicated and had right hand pain since. X-ray of hand today shows no signs of fracture. Advice ice and gently mobilise. Simple analgesia. Worsens return. Discharged.

Followup : **none**

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Kim McNeill
Nurse

Copies to:

1. F Irvine (GP)

School Address:

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100
Department:
Contact Tel:
Enquiries to:

Dr. CA Lennox
The Green Medical Practice
Clydebank Health & Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Letter Date: 01/05/2025
Reference:
Dictated Date:
Transcribed Date: 01/05/2025

Dear ,

Diane Donald; D.O.B: 16/12/1983; CHI: 1612836909
27 St. Andrews Way, Clydebank, Dunbartonshire, G81 1BP

DNA QEUH ED, discharged from our service.

Electronically Signed: ,

cc.

Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
1345 Govan Rd, Govan, Glasgow, G51 4TF.

NHS Greater Glasgow and Clyde

Transfer of Care from Community to Health Visitor

Donald, Diane (CHI: 1612836909 | PMS Number: 1612836909)
16 Dec 83 (Age at Birth: 41) | 27 St. Andrews Way, Clydebank, Dunbartonshire, G81 1BP | 07393645082 (mobile)
G5 P4+1 | Baby 1 DOB: 07 Mar 25 at 09:55 (39+2) | No. of Babies: 1 | Booking BMI: 26.22 | Current BMI: 27.82 | Blood Group: O+
| Hb at 35+6/40: 122g/L | PN 1wk, 3d | Current Care: HV

Postnatal Key Details

Date/time gave birth	07 Mar 25 at 09:55
Baby 1 Outcome	Livebirth
Baby 1 Birthweight	3965
Baby 1 Sex	Male
Location of birth	Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Primary Language Spoken	English
Interpreter/Communication Professional Required	No
Number of Adopted/Stepchildren	2
Hb (g/dL)	12.2 (11 Feb 25 at 10:28)
FGM	None
Smoking Status	No (07 Mar 25 at 07:35)
Mental Health (recorded 07 Mar 25 at 07:35)	
Past month - Have you felt down, depressed or hopeless?	Unknown
Past month - Have you had little interest or pleasure in doing things?	(Not Recorded)
Is this something you feel you need or want help with?	(Not Recorded)
Past month - Have you been feeling nervous, anxious or on edge?	(Not Recorded)
Past month - Have you not been able to stop or control worrying?	(Not Recorded)

Circle of Care

Delivery plan	Consultant Unit	**Intended Location of Birth**	Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Lead Professional	(Not Recorded)	**Lead Professional's telephone**	(Not Recorded)
Named Midwife	Katie Murphy	**Named Consultant**	David Rutherford
Team	(Not Recorded)	**Hospital Contacts**	Maternity Unit Contact numbers can be found in the main menu of the app or website.
GP Name	LENNOX, CRAIG	**GP Practice**	The Green Medical Practice
GP Address	Clydebank Health & Care Centre,, Queens Quay Main Avenue, Clydebank, G81 1BS	**GP Practice Code**	40224

Transfer of Care Details

Date of Discharge	17 Mar 25	**Transferred By**	Caitlin McFadyen
How was Transfer done	Face to face	**Discharged From**	(Not Recorded)
Discharge Destination	Home (usual residence)	**Telephone**	07393645082
Mobile Telephone	07393645082	**Baby 1 transferred with mother**	Yes
Baby 1 Details	DONALD, Baby (0703250876)		

Risk Assessment

Recorded: 17 Mar 25 at 10:00

Risk	High	**Current Postnatal**	Grand Multiparity, Caesarean Section, PPH, Epidural/Spinal in Labour and Birth
Current Pregnancy	Gestational Diabetes, Intermediate risk of preterm birth, Fetal macrosomia (90th centile)	**Previous Obstetric**	Previous Antepartum haemorrhage, Previous Caesarean Section, Previous Massive PPH >2000ml
Medical	Diabetes - Previous Gestational, Neurology, Age greater than or equal to 40 at booking, BMI 25-29.9	**Gynaecological**	Previous Uterine Surgery, Previous Cervical Surgery

Secondary PPH

No blood loss has been recorded

Labour and Birth Summary

Number of Babies	1	**Date and Time of Birth**	07 Mar 25 at 09:55
Gestation at Birth	39+2/40	**Onset of Labour**	Caesarean Section Before Labour (including failed induction)

Reason for Elective Caesarean	Previous C-Section	**Final Type of Birth**	Caesarean Section Before labour
Reason for Caesarean Section	Previous C-Section	**Baby 1 Mode of Birth**	Elective (planned) caesarean section
Baby 1 Birth Assisted By	Jane Richmond	**Complications**	None
Place of Birth	NHS hospital - Shared (Consultant/GP/Midwife)	**Locations of Birth**	Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Date and Time Placenta Birthed	07 Mar 25 at 09:57	**Placental Birth Method**	Removed at CS
Placenta Complete	Apparently Complete	**Placenta Appearance**	Normal
Cord Problems	Cord round body - slipped over	**Membranes Complete**	Appears Complete
Episiotomy	No	**Tear**	No
Other Trauma to Vaginal Tract	No	**Sutures to be removed**	No
Dressing removal on day	7	**Wound Sutures Removed**	No
Estimated Blood Loss (mls)	500	**Analgesia/Anaesthetic**	Spinal
RoM Duration	0 Hours + 1 Mins	**Duration of third stage**	0 hrs 2 mins
Other Operations Performed	Other: Bilateral tubal ligation		

Medical History

Diabetes	Previous Gestational Diabetes, Current Gestational Diabetes	**Neurological**	Migraine with aura
Gynaecological	LLETZ/LEEP Biopsy		

Surgical History

Previous Anaesthetic(s) (excluding Childbirth) GA

Non-obstetric Operations Other: HALF THYROID REMOVAL

Latest Postnatal Observations

Recorded: 17 Mar 25 at 10:00

Blood pressure	110/76	**Temperature (°C)**	36.6
Pulse (bpm)	74	**Breasts**	Lactating
Nipples	No problems	**Lochia Amount**	Scanty
Lochia Description	Brown	**Uterus**	not palpated
Wound Sutures Removed	No	**Perineum**	Intact

Latest Postnatal Meows Observations

Recorded: 07 Mar 25 at 16:30

Blood pressure	109/59	**Temperature (°C)**	36.3
Pulse (bpm)	92	**Respirations**	16
O2 Saturations	97		

Contraception Discussed

Chosen method of contraception Irreversible method (tubal ligation)

Additional Information

Administrative Additional Notes Diane well on discharge. Advised to see GP for ongoing nerve type pain in hips from ELUSCS and BTL procedures. Felt birth was traumatic due to reduced analgesia from spinal and seen part of surgery in reflection in light. Declines PN debrief today but aware can request in future if would feel beneficial. Mood good on discharge. Aware to see GP at 12+ weeks for FBC and HBA1c as GDM this pregnancy.

Postnatal MMR required No

Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
1345 Govan Rd, Govan, Glasgow, G51 4TF.

NHS Greater Glasgow and Clyde

Labour and Birth Summary Report

Donald, Diane (CHI: 1612836909 | PMS Number: 1612836909)
16 Dec 83 (Age at Birth: 41) | 27 St. Andrews Way, Clydebank, Dunbartonshire, G81 1BP | 07393645082 (mobile)
G5 P4+1 | Baby 1 DOB: 07 Mar 25 at 09:55 (39+2) | No. of Babies: 1 | Booking BMI: 26.22 | Current BMI: 27.82 | Blood Group: O+
| Hb at 35+6/40: 122g/L | PN 0hrs | Current Care: Hospital

Critical Incidents (Woman)

No Relevant Information Recorded

Induction Details

No Relevant Information Recorded

Rupture of Membranes

RoM Duration 0 Hours + 1 Mins
Baby 1 Date/Time Membranes Ruptured 07 Mar 25 at 09:53
Baby 1 Method of Membrane Rupture At Caesarean Section

Spontaneous Onset of Labour

No Relevant Information Recorded

Error loading block

Labour and Birth Details

Onset	Caesarean Section Before Labour (including failed induction)	**CS Reason**	Previous C-Section
		Mode of Birth	Elective (planned) caesarean section
CS Category	Category 4 (Delivery timed to suit the woman and staff)	**Placental Birth Method**	Removed at CS
Place of Birth	NHS hospital - Shared (Consultant/GP/Midwife)	**1st Stage Duration**	(Not Recorded)
		3rd Stage Duration	0 Hours + 2 Mins
Summary of Analgesia and Anaesthesia	Spinal	**Maternal Problems**	First Stage : (Not Recorded) Second Stage : (Not Recorded)
2nd Stage Duration	(Not Recorded)		
Labour Total Duration	(Not Recorded)		
Date of last admission prior to birth	07 Mar 25 at 07:19		

Transfer of Midwifery Led Care to Obstetric Led Care in Labour

No Relevant Information Recorded

Third Stage of Labour

Date and Time Placenta Birthed	07 Mar 25 at 09:57	**Main Placental Birth Method**	Removed at CS
Placenta	Apparently Complete	**Placenta Appearance**	Normal
Membranes	Appears Complete		

Perineum

No Relevant Information Recorded

Risk Assessment

Recorded: 07 Mar 25 at 07:35

Risk	High	**Current Pregnancy**	Gestational Diabetes, Intermediate risk of preterm birth
Previous Obstetric	Previous Antepartum haemorrhage, Previous Caesarean Section, Previous Massive PPH >2000ml	**Medical**	Diabetes - Previous Gestational, Neurology, Age greater than or equal to 40 at booking, BMI 25-29.9
Gynaecological	Previous Uterine Surgery, Previous Cervical Surgery		

Blood Loss

Operative blood loss within 24hr of birth 0mls
Cumulative blood loss within 24hr of birth 500mls

Circle of Care

Delivery plan	Consultant Unit	**Intended Location of Birth**	Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Lead Professional	(Not Recorded)	**Lead Professional's telephone**	(Not Recorded)
Named Midwife	Katie Murphy	**Named Consultant**	David Rutherford
Team	(Not Recorded)	**Hospital Contacts**	Maternity Unit Contact numbers can be found in the main menu of the app or website.
GP Name	LENNOX, CRAIG	**GP Practice**	The Green Medical Practice
GP Address	Clydebank Health & Care Centre,, Queens Quay Main Avenue, Clydebank, G81 1BS		

Intended Location of Birth

Queen Elizabeth University Hospital Glasgow (Prev. Southern General)

Donald, Baby (CHI: 0703250876 | PMS Number: ?)
DOB: 07 Mar 25 at 09:55 | M | Baby 1 of 1 | 27 St. Andrews Way, Clydebank, Dunbartonshire, G81 1BP | 07393645082
Type of Birth: CS | Gestation at Birth: 39+2 | Birthweight: 3965 | Apgar: 1min: 9 5mins: 9

Critical Incidents (Baby)

No Relevant Information Recorded

Baby 1 Key Details

Date of Birth	07 Mar 25 at 09:55
Gestation at Birth	39+2
CHI Number	0703250876
Outcome	Livebirth
Final Outcome	Livebirth
Sex of Baby	Male
Birthweight	3965g
Birthweight Centile	94.05
Type of Birth	CS
Place of Birth	Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Mode of Birth	Elective (planned) caesarean section
Most Influential Baby Reason for CS	No Baby Reason
Liquor State at Birth or Caesarean Section	Clear
Liquor Volume at Birth or Caesarean Section	Excessive
Fetal Problems in Labour	None
Shoulder Dystocia	No
Resuscitation	Not required
Vitamin K Date / Time Recorded	07 Mar 25 at 10:10
Vitamin K Offered and Consented by Parent/Guardian	Accepted
Vitamin K Dose	0.1ml / 1 mg IM
Birthweight Centile	94.05

Baby 1 Apgar Scores

Assessed at 1/60 Yes **Assessed at 5/60** Yes

	1 minute	5 minutes	10 minutes	20 minutes
Heart rate	2 100bpm or more	2 100bpm or more		
Respiratory Effort	2 Good or crying.	2 Good or crying		
Muscle tone	2 Active	2 Active		
Reflex irritability	2 Cry, active	2 Cry, active		
Colour	1 Body pink, extremities blue	1 Body pink, extremities blue		
Total	9	9		

Baby 1 Present at Birth

Personnel

Status of Person Assisting Birth	Hospital Doctor
Person assisting birth is a BadgerNet user	Yes
Birth Assisted By	Jane Richmond
Additional Surgeon(s)	Sarah Chitson
Anaesthetist Present	Yes
Anaesthetist Present	Fiona Breckenridge
Neonatologist Present	No
Scrub Nurse(s)	Maryanne Connolly
Circulating Nurse	Brenda Donaldson
Other Staff Present	Yes
Other (Personnel) Present at Birth	Sarah Chitson
Baby Received By	Brenda Donaldson
Receiver's Team	No team assigned
Rank of Most Senior Person Present (Obstetrician or Midwife)	Consultant
Non Personnel Present At Birth	Husband
Clinical Non-BadgerNet Users Present	Fiona campbell Julie moffat
Additional CS Personnel	
Anaesthetist Assistant Present	Yes

Baby 1 Vaccinations

No Relevant Information Recorded

Baby 1 Skin to Skin

Skin to skin established Yes

Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
1345 Govan Rd, Govan, Glasgow, G51 4TF.

Antenatal Booking Summary - CLINICAL COPY

Donald, Diane (CHI: 1612836909 | PMS Number: 1612836909)
16 Dec 83 (Current Age: 40) | 27 St. Andrews Way, Clydebank, Dunbartonshire, G81 1BP | 07393645082 (mobile)
G5 P3+1 | LMP: 06 Jun 24 | Booked: 03 Sep 24 at 15:01 | EDD (Dates): 12 Mar 25 | Current Gest: 12+6 | Babies on scan: ? |
Booking BMI: 26.22 | Current BMI: 26.22 | Blood Group: ?

Key Booking Information

Registered GP Name:	LENNOX, CRAIG	**Registered GP Practice:**	The Green Medical Practice
Registered GP Address:	Clydebank Health & Care Centre,, Queens Quay Main Avenue, Clydebank, G81 1BS	**Named Midwife:**	Holly Docherty
		Intended Location of Birth (Booking):	Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Named Midwife's telephone:	Not Recorded		

Risk Assessment

Recorded: 03 Sep 24 at 14:51

Risk	High	**Current Pregnancy**	Intermediate risk of preterm birth
Previous Obstetric	Previous Antepartum haemorrhage, Previous Caesarean Section, Previous Massive PPH >2000ml	**Medical**	Diabetes - Previous Gestational, Neurology, Age greater than or equal to 40 at booking, BMI 25-29.9
Gynaecological	Previous Cervical Surgery		

General Health History

Allergies and adverse reactions	None
Diet Type	Conventional
Would Accept Blood Transfusion	Yes
Would Accept Blood Products	Yes
Previous Infections and Childhood Illnesses	Chickenpox

Medical History

Diabetes	Previous Gestational Diabetes	**Neurological**	Migraine with aura
Gynaecological	LLETZ/LEEP Biopsy		

Surgical History

Previous Anaesthetic(s) (excluding Childbirth)	GA
Non-obstetric Operations	Other: HALF THYROID REMOVAL

Cervical Smear History

Last Smear	More than 3 years ago	**Result**	Normal
Ever Referred for Colposcopy	Yes	**Details**	1X COLPOSCOPY AROUND 12 YEARS AGO
Ever Had A LLETZ/LEEP Biopsy	Yes		

Family Health History

Baby's Parents Blood Relatives	No	**Any Family Health Issues**	Yes
Diabetes	Biological father's extended family: UNCLE	**Allergies**	Mother's blood family: son has food allergies
Hypertension (High Blood Pressure)	Baby's father	**Severe Jaundice at Birth**	Mother's blood family: son was admitted for 4 days for phototherapy

TB Risk Assessment

Has a Family Member had TB within the last 5 years	No
Is your (the baby's) family likely to live for more than one month in a High Prevalence Area	No
Has either parent moved from a high prevalence area and not been immunised	No
Either parent of the baby or any grandparent born in high prevalence area	No

Mental Health

No Relevant Information Recorded

Recreational Drugs and Substances

Ever Used Drugs	No
Ever Overdosed	Yes
Overdose Details	AS A TEENAGER
Overdose Drug Known	No
Ever Self Harmed	Yes
Self Harm Details	AS A TEENAGER
Current Partner Using Drugs	No
Partner Currently/Has Attended an Addiction Service	No

Alcohol

Average Units Per Week Before Conception	0
Average Units Per Week Since Conception	0
Average Units Per Week (Current Partner)	0

Smoking

Latest CO	1	Latest CO Gestation	Gestation 12Weeks, 6Days
Smoker at Booking	No	Number a day at Booking	(Not Recorded)
CO at Booking	1	Gestation CO Recorded	Gestation 12Weeks, 6Days
Number of Smokers in Household	0		

Medication

Recorded: 03 Sep 24 at 15:09
Drugs Given Healthy start - Vitamins

Children

JOHN DONALD

Sex	Boy	Date of Birth	30 Dec 12
Age	11		

LIA DONALD

Sex	Girl	Date of Birth	27 Feb 14
Age	10		

AJ DONALD

Sex	Boy	Date of Birth	01 Mar 23
Age	1		

Additional Children

Number of Additional Children 2

Confidential Social Issues

Date and time completed	03 Sep 24 at 14:51
Gestation	12+6/40
Completed by	Holly Docherty
Anyone else that lives in the household	Yes
Details of anyone else that lives in the household	LIVES WITH PARTNER AND 3 CHILDREN
Any Previous Children	Yes
Previous Child(ren) Details	3 PREVIOUS CHILDREN AND 2 STEP CHILDREN
Number of Adopted/Stepchildren	2

Confidential Domestic Issues

Asked - 03 Sep 24 at 14:51

Current domestic abuse	No	Previous domestic abuse	No

Confidential Medical Issues

Female Genital Mutilation None

FGM

Have you been cut	No	**Female Genital Mutilation**	None

Communication and Mobility

No Relevant Information Recorded

Other Registration Details

Marital Status (at Booking)	Never married nor registered civil partnership	**Support Status (at Booking)**	Lives with husband/partner/family
Feels Supported (at Booking)	Yes	**Accommodation**	Council rental
Religion	00R121 - None	**Woman's Country of Birth**	United Kingdom of Great Britain and Northern Ireland
Woman's Ethnic Group (SMR02)	1A. Scottish	**Woman's Citizenship**	British Citizen
Woman's Employment Status	Unemployed - with benefits	**Biological Father's Employment Status**	Employed
Email Address	dianedonald83@gmail.com		

Other Contacts

Next of Kin:	alan neil	**Next of Kin Address:**	27 St. Andrews Way, Clydebank, Dunbartonshire, G81 1BP
Next of Kin Mobile Number:	07982942866	**Next of Kin Relationship:**	PARTNER

Biological Father's Details

Biological Father is Current Partner	Yes	**Details Known**	Known
Forename	alan	**Surname**	neil
Address	27 St. Andrews Way, Clydebank, Dunbartonshire, G81 1BP	**Contact Number**	07982942866
		Age at Booking	38
		Employment Status	Employed
		Citizenship	British Citizen
Date of Birth	05 Dec 85 at 00:00		
Ethnic Category	1A. Scottish		
Occupation	groundworker		

Circle of Care

Delivery plan	Consultant Unit	**Intended Location of Birth**	Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Named Midwife	Holly Docherty	**Named Consultant**	David Rutherford
Team	(Not Recorded)	**Hospital Contacts**	Maternity Unit Contact numbers can be found in the main menu of the app or website.
GP Name	LENNOX, CRAIG	**GP Practice**	The Green Medical Practice
GP Address	Clydebank Health & Care Centre,, Queens Quay Main Avenue, Clydebank, G81 1BS	**GP Practice Code**	40224

Care Plan at Booking

Delivery plan Consultant Unit
KCND Pathway Red
Hospital Community Midwife Is Attached To Queen Elizabeth University Hospital Glasgow (Prev. Southern General)

Obstetric History

2012 Ges: 40+0 | Type of Birth: Ventouse (1) | Outcome: Livebirth (1) | JOHN DONALD | Current Status: Alive (1) | 3090g | [INTERGROWTH Centile, 22.62]
Place of Birth: UK Hospital
Hospital of Birth: Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Maternal Problems in Pregnancy: APH

Onset of Labour:	Induced
Reason for IoL:	Social reasons
Maternal Problems in Labour:	None
Maternal Problems Post Birth:	None
Perineum	Episiotomy
Anaesthetic	None
JOHN DONALD : 30 Dec 12	
Gestation at Birth	40 weeks, 0 days
Outcome	Livebirth
Sex	Boy
Current Status	Alive
Any Problems	None
Problems in Pregnancy	None
Problems in Labour	None
Type of Birth	Ventouse
Birthweight	3090
Where is the Child Now?	Living with Mother
Reason for Ventouse	Failure to Progress
Abnormalities	None

2014 Ges: 40+0 | Type of Birth: Vaginal (1) | Outcome: Livebirth (1) | LIA DONALD | Current Status: Alive (1) | 3544g | [INTERGROWTH Centile, 75.64]

Place of Birth:	UK Hospital
Hospital of Birth:	Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Maternal Problems in Pregnancy:	None
Onset of Labour:	Induced
Reason for IoL:	Social reasons
Maternal Problems in Labour:	None
Maternal Problems Post Birth:	None
Perineum	1st Degree Tear - Injury to perineal skin only, 2nd Degree Tear - Perineal muscles but not involving the anal sphincter.
Anaesthetic	None
LIA DONALD : 27 Feb 14	
Gestation at Birth	40 weeks, 0 days
Outcome	Livebirth
Sex	Girl
Current Status	Alive
Any Problems	None
Problems in Pregnancy	None
Problems in Labour	None
Type of Birth	Normal
Birthweight	3544
Where is the Child Now?	Living with Mother
Abnormalities	None

2023 Ges: 37+4 | Type of Birth: CS (1) Elective | Outcome: Livebirth (1) | AJ DONALD | Maternal Problems (Post Birth): Massive PPH >2000ml | Current Status: Alive (1) | 2954g | [INTERGROWTH Centile, 45.5]

Place of Birth:	UK Hospital
Hospital of Birth:	Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Maternal Problems in Pregnancy:	Gestational Diabetes, Polyhydramnios
Onset of Labour:	CS before labour
Reason for No Labour Caesarean Section:	Diabetes
Maternal Problems Post Birth:	Massive PPH >2000ml
Anaesthetic	Spinal
Additional Notes	2.2L EBL
AJ DONALD : 01 Mar 23	
Gestation at Birth	37 weeks, 4 days
Outcome	Livebirth
Sex	Boy
Current Status	Alive
Any Problems	None
Problems in Pregnancy	None
Problems in Labour	
Type of Birth	Caesarean Section

Birthweight 2954
Where is the Child Now? Living with Parents
Reason for CS Maternal request
Anaesthetic for CS Spinal
Abnormalities None

2024 (?) Ges: 4+0 Miscarriage
Gestation of the miscarriage 4+0

Obstetric History Summary

Gravida/Parity: G5 P3+1
Livebirths 3
Total registerable babies 3
Total registerable pregnancies 3
Miscarriages 1
Total Non-Registerable Births 1
Caesarean Sections 1
Neonatal, Infant and child deaths 0
Unknown Current Status 0

Current Pregnancy Details

Certainty of LMP No
LMP 06 Jun 24 at 00:00
EDD by Dates 12 Mar 25
Agreed EDD 01 Jan 01
Date of Antenatal Booking Appointment or Express Booking 03 Sep 24
Gestation at Booking Gestation 12Weeks, 6Days
Age at Booking 40
Any Vaginal Bleeding Since LMP Similar to usual

Menstruation, Conception and Contraception

Menstruation Length Min:28 Max:30
Planned Pregnancy No
Previous Contraception None

Scans Offered

03 Sep 24 at 14:51

Offered	Viability scans, Dating, Nuchal Translucency, Invasive, Anomaly/Detailed, Fetal Growth/Doppler, Cervical Length, Placental site scan, Other	**Accepted**	Viability scans, Dating, Nuchal Translucency, Invasive, Anomaly/Detailed, Fetal Growth/Doppler, Cervical Length, Placental site scan, Other
Declined	None		

Booking Bloods

Bloods	Offered / Explained	Accepted / Declined	Date Taken	Results	Reviewed by
Blood Group	Yes	Accepted	03 Sep 24 at 15:14		
Antibodies	Yes	Accepted	03 Sep 24 at 15:14		
Other Antibodies	Yes	Accepted	03 Sep 24 at 15:14		
Hb	Yes	Accepted	03 Sep 24 at 15:14		
Platelets	Yes	Accepted	03 Sep 24 at 15:14		
Hep B	Yes	Accepted	03 Sep 24 at 15:14		
HIV	Yes	Accepted	03 Sep 24 at 15:14		
Syphilis	Yes	Accepted	03 Sep 24 at 15:14		
Rubella	No				
Haemoglobin - Mother	Yes	Accepted	03 Sep 24 at 15:14		
Haemoglobin - Father	No				

Bloods	Offered / Explained	Accepted / Declined	Date Taken	Results	Reviewed by
Ferritin	Yes	Accepted	03 Sep 24 at 15:14		
Thyroid TSH	No				
Thyroid Total T4	No				
Thyroid Free T3	No				
Thyroid Free T4	No				

1st Trimester Screening

Bloods	Offered / Explained	Accepted / Declined	Date Taken	Baby Risk	Reviewed by
Down's Syndrome	Yes	Accepted			
Edwards and Patau	Yes	Accepted			

Urinalysis

Date of Urinalyis 03 Sep 24 at 14:51

Observations

Recorded: 03 Sep 24 at 14:51

Height (m) 1.62 **Weight (kg)** 68.80
BMI 26.22

Contact Us

- PRM 01412115400- GENERAL ENQUIRES ONLY
- QEUH 0141 2011100- GENERAL ENQUIRIES
- West Maternity Care 01412010140
- RAH 01418879111- GENERAL ENQUIRIES
- VOL 01389754121

Maternity Unit

- PRM 0141347352-TRIAGE/EMERGENCY
- QEUH 01412324377 or 01412324363- TRIAGE/EMERGENCY
- New Victoria ACH 01413478585
- RAH 0141 3146067- TRIAGE/EMERGENCY
- IRH 01475633777

Clinical letter - GP: SCI Gateway Obstetrics Request

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100
Department: Maternity Centralised Booking
Contact Tel: 0141 347 8422
Enquiries to:

Dr. CA Lennox
The Green Medical Practice
Clydebank Health & Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Letter Date: 29/08/2024
Reference:
Dictated Date: 29/08/2024
Transcribed Date:

Dear CA Lennox,

Diane Donald; D.O.B: 16/12/1983; CHI: 1612836909
27 St. Andrews Way, Clydebank, Dunbartonshire, G81 1BP

The above patient has self-referred (or been referred by the midwife) to the Centralised Maternity Booking Service and has been given the following appointments;

Generic QEUH Midwife Booker

Date: 03/09/2024 Time: 14:30 Location:Queen Elizabeth University Hospital, Maternity Outpatient Dept

Ultrasound Scan

Date: 06/09/2024 Time:14:35 Location:Queen Elizabeth Hospital, Maternity Ultrasound Dept

Your patient has given consent to contact you and in line with the agreed protocol, I would be grateful if the practice could complete the "SCI Gateway Obstetrics Request for Info" template. It is essential to have this provided in time for the booking appointment.

All Obstetric SCI Gateway referrals are directed back to the Centralised Maternity Booking Service to be processed.

Yours faithfully,

Maternity Centralised Booking Service.

Electronically Signed: ,

cc.

Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
1345 Govan Rd, Govan, Glasgow, G51 4TF.

NHS Greater Glasgow and Clyde

Transfer of Care from Community to Health Visitor

Donald, Diane (CHI: 1612836909 | PMS Number: 1612836909)
16 Dec 83 (Age at Birth: 39) | 27 St. Andrews Way, Clydebank, West Dunbartonshire, G81 1BP | 07393645082 (mobile)
G3 P3+0 | Baby 1 DOB: 01 Mar 23 at 09:43 (37+4/40) | No. of Babies: 1 | Booking BMI: 26.03 | Current BMI: 28.48 | Blood Group: O+ | Hb at 37+2: 11.5g/dL | PN 1wk, 2d | Current Care: HV

Postnatal Key Details

Date/time gave birth	01 Mar 23 at 09:43
Baby 1 Outcome	Livebirth
Baby 1 Birthweight	2954
Baby 1 Sex	Male
Location of birth	Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Primary Language Spoken	English
Interpreter/Communication Professional Required	No
Hb (g/dL)	11.5 (27 Feb 23 at 09:30)
FGM	None
Smoking Status	No (01 Mar 23 at 07:47)
Mental Health (recorded 01 Mar 23 at 07:47)	
Past month - Have you felt down, depressed or hopeless?	Unknown
Past month - Have you had little interest or pleasure in doing things?	(Not Recorded)
Is this something you feel you need or want help with?	(Not Recorded)
Past month - Have you been feeling nervous, anxious or on edge?	(Not Recorded)
Past month - Have you not been able to stop or control worrying?	(Not Recorded)

Circle of Care

Delivery plan	Consultant Unit	**Intended Location of Birth**	Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Lead Professional	Fisher, Anne	**Lead Professional's telephone**	(Not Recorded)
Named Midwife	Anne Fisher	**Named Consultant**	Carla Summerhill
Team	(Not Recorded)	**Hospital Contacts**	Maternity Unit Contact numbers can be found in the main menu of the app or website.
GP Name	LENNOX, CRAIG	**GP Practice**	The Green Medical Practice
GP Address	Clydebank Health & Care Centre,, Queens Quay Main Avenue, Clydebank, G81 1BS	**GP Practice Code**	40224

Transfer of Care Details

Date of Discharge	10 Mar 23	**Transferred By**	Karen Bruce
How was Transfer done	Face to face	**Discharged From**	(Not Recorded)
Discharge Destination	Home (usual residence)	**Telephone**	0
Mobile Telephone	07393645082	**Baby 1 transferred with mother**	Yes
Baby 1 Details	DONALD, (0103235590)		

Risk Assessment

Recorded: 09 Mar 23 at 14:00

Risk	Normal Low	**Current Postnatal**	Caesarean Section, PPH, Epidural/Spinal in Labour and Birth
Current Pregnancy	Gestational Diabetes, Diminished Fetal Movements (2 or more episodes)	**Previous Obstetric**	Previous Antepartum haemorrhage
Medical	Endocrine Disorder, Central nervous system, Neurology, BMI 25-29.9 , Sensory and physical disabilities	**Anaesthetic**	Currently prescribed low molecular weight heparin

Secondary PPH

No blood loss has been recorded

Labour and Birth Summary

Number of Babies	1	**Date and Time of Birth**	01 Mar 23 at 09:43
Gestation at Birth	37+4/40	**Onset of Labour**	Caesarean Section Before Labour (including failed induction)
Reason for Elective Caesarean	Maternal Request - (no medical indication)	**Final Type of Birth**	Caesarean Section Before labour

Reason for Caesarean Section	Maternal Request - (no medical indication)	**Baby 1 Mode of Birth**	Elective (planned) caesarean section
Baby 1 Birth Assisted By	Claire Higgins	**Complications**	Haemorrhage
Place of Birth	NHS hospital - Shared (Consultant/GP/Midwife)	**Locations of Birth**	Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Date and Time Placenta Birthed	01 Mar 23 at 09:57	**Placental Birth Method**	Removed at CS
Placenta Complete	Apparently Complete	**Placenta Appearance**	Normal
Membranes Complete	Appears Complete	**Episiotomy**	No
Tear	No	**Other Trauma to Vaginal Tract**	No
Sutures to be removed	No	**Dressing removal on day**	10
Wound Sutures Removed	N/A	**Estimated Blood Loss (mls)**	2200
Analgesia/Anaesthetic	Spinal	**RoM Duration**	0 Hours + 1 Mins
Duration of third stage	0 hrs 14 mins	**Other Operations Performed**	None

Medical History

Diabetes	Current Gestational Diabetes	**Endocrine**	Other endocrine problem: partial thyroidectomy not on thyroxine
Neurological	Migraine without aura, Other cns problem: investigated for head and eye pain recently NAD found	**Other Medical Problems**	Other medical problem: Reynaulds

Surgical History

Non-obstetric Operations Other: partiel thyroidectomy

Latest Postnatal Observations

Recorded: 09 Mar 23 at 14:00

Breasts	No problems	**Nipples**	No problems
Lochia Amount	Scanty	**Lochia Description**	Brown
Uterus	not palpated	**Wound Sutures Removed**	N/A
Perineum	Intact		

Latest Postnatal Meows Observations

Recorded: 02 Mar 23 at 06:30

Blood pressure	97/56	**Temperature (°C)**	36.4
Pulse (bpm)	79	**Respirations**	14
O2 Saturations	99	**Conscious Level**	Alert
Lochia	Normal	**Pain Assessment**	No pain
MEOWS Score	1		

Contraception Discussed

Chosen method of contraception Progesterone only implant, Vasectomy for partner
Implant inserted No
Reason implant not inserted just decided

Follow Up Appointments

No Relevant Information Recorded

Recorded Appointment Notes

No Relevant Information Recorded

Additional Information

Does the CMW or HW need to make contact to discuss any causes of concern? No

Postnatal Diabetes Management Plan

No Relevant Information Recorded

Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
1345 Govan Rd, Govan, Glasgow, G51 4TF.

NHS Greater Glasgow and Clyde

Transferred to Postnatal Community Care - CLINICAL COPY

Donald, Diane (CHI: 1612836909 | PMS Number: 1612836909)
16 Dec 83 (Age at Birth: 39) | 27 St. Andrews Way, Clydebank, West Dunbartonshire, G81 1BP | 07393645082 (mobile)
G3 P3+0 | Baby 1 DOB: 01 Mar 23 at 09:43 (37+4/40) | No. of Babies: 1 | Booking BMI: 26.03 | Current BMI: 28.48 | Blood Group: O+ | Hb at 37+2: 11.5g/dL | PN 1wk, 0d | Current Care: Hospital

Postnatal Key Details

Date/time gave birth	01 Mar 23 at 09:43
Baby 1 Outcome	Livebirth
Baby 1 Birthweight	2954
Baby 1 Sex	Male
Location of birth	Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Primary Language Spoken	English
Interpreter/Communication Professional Required	No
Hb (g/dL)	11.5 (27 Feb 23 at 09:30)
FGM	None
Smoking Status	No (01 Mar 23 at 07:47)
Mental Health (recorded 01 Mar 23 at 07:47)	
Past month - Have you felt down, depressed or hopeless?	Unknown
Past month - Have you had little interest or pleasure in doing things?	(Not Recorded)
Is this something you feel you need or want help with?	(Not Recorded)
Past month - Have you been feeling nervous, anxious or on edge?	(Not Recorded)
Past month - Have you not been able to stop or control worrying?	(Not Recorded)

Circle of Care

Delivery plan	Consultant Unit	**Intended Location of Birth**	Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Lead Professional	Fisher, Anne	**Lead Professional's telephone**	(Not Recorded)
Named Midwife	Anne Fisher	**Named Consultant**	Carla Summerhill
Team	(Not Recorded)	**Hospital Contacts**	Maternity Unit Contact numbers can be found in the main menu of the app or website.
GP Name	LENNOX, CRAIG	**GP Practice**	The Green Medical Practice
GP Address	Clydebank Health & Care Centre,, Queens Quay Main Avenue, Clydebank, G81 1BS	**GP Practice Code**	40224

Transfer of Care Details

Date of Discharge	08 Mar 23	**Transferred By**	Jill Irvine
How was Transfer done	Face to face	**Discharged From**	Postnatal Ward
Discharge Destination	Home (usual residence)	**Telephone**	(Not Recorded)
Mobile Telephone	07393645082	**Baby 1 transferred with mother**	Yes
Baby 1 Details	DONALD, (0103235590)		

Readmission

Date and Time Admitted	06 Mar 23

Risk Assessment

Recorded: 06 Mar 23 at 10:00

Risk	Normal Low
Current Postnatal	Caesarean Section, PPH, Epidural/Spinal in Labour and Birth
Current Pregnancy	Gestational Diabetes, Diminished Fetal Movements (2 or more episodes)
Previous Obstetric	Previous Antepartum haemorrhage
Medical	Endocrine Disorder, Central nervous system, Neurology, BMI 25-29.9 , Sensory and physical disabilities

Secondary PPH

No blood loss has been recorded

Labour and Birth Summary

Number of Babies	1	**Date and Time of Birth**	01 Mar 23 at 09:43
Gestation at Birth	37+4/40	**Onset of Labour**	Caesarean Section Before Labour (including failed induction)
Reason for Elective Caesarean	Maternal Request - (no medical indication)	**Final Type of Birth**	Caesarean Section Before labour
Reason for Caesarean Section	Maternal Request - (no medical indication)	**Baby 1 Mode of Birth**	Elective (planned) caesarean section
Baby 1 Birth Assisted By	Claire Higgins	**Complications**	Haemorrhage
Place of Birth	NHS hospital - Shared (Consultant/GP/Midwife)	**Locations of Birth**	Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Date and Time Placenta Birthed	01 Mar 23 at 09:57	**Placental Birth Method**	Removed at CS
Placenta Complete	Apparently Complete	**Placenta Appearance**	Normal
Membranes Complete	Appears Complete	**Episiotomy**	No
Tear	No	**Other Trauma to Vaginal Tract**	No
Sutures to be removed	No	**Dressing removal on day**	10
Estimated Blood Loss (mls)	2200	**Analgesia/Anaesthetic**	Spinal
RoM Duration	0 Hours + 1 Mins	**Duration of third stage**	0 hrs 14 mins
Other Operations Performed	None		

Medical History

Diabetes	Current Gestational Diabetes	**Endocrine**	Other endocrine problem: partial thyroidectomy not on thyroxine
Neurological	Migraine without aura, Other cns problem: investigated for head and eye pain recently NAD found	**Other Medical Problems**	Other medical problem: Reynaulds

Surgical History

Non-obstetric Operations Other: partiel thyroidectomy

Latest Postnatal Observations

Recorded: 08 Mar 23 at 08:15

Blood pressure	110/64	**Temperature (°C)**	36.1
Pulse (bpm)	86	**Breasts**	No problems
Nipples	No problems	**Lochia Amount**	Scanty
Lochia Description	Pink	**Uterus**	not palpated
Perineum	Intact		

Latest Postnatal Meows Observations

Recorded: 02 Mar 23 at 06:30

Blood pressure	97/56	**Temperature (°C)**	36.4
Pulse (bpm)	79	**Respirations**	14
O2 Saturations	99	**Conscious Level**	Alert
Lochia	Normal	**Pain Assessment**	No pain
MEOWS Score	1		

Contraception Discussed

No Relevant Information Recorded

Follow Up Appointments

No Relevant Information Recorded

Recorded Appointment Notes

No Relevant Information Recorded

Additional Information

Additional Notes Readmission for baby to have second cycle phx. Mum and baby well on discharge.

Does the CMW or HW need to make contact to discuss any causes of concern? No

Postnatal Management Plan

Recorded 06 Mar 23 at 10:00
Revised Management Plan Administer Anticoagulation Therapy.
Provide Analgesia.
Insert Urinary Catheter.
Timing for catheter removal - When Mobile
plesae take FBC 2/3/23 in view of blood loss - if significant fall and sys of anaemia may need to consider blood transfusion
hba1c 3 months with GP
Saved By Lisa Doherty

Postnatal Diabetes Management Plan

No Relevant Information Recorded

Blood Tests and Results

Blood Tests and Results: 17 Aug 22 at 15:46

Location:	Antenatal Clinic	**Offered:**	Antibodies, Blood Group and Rhesus Factor, FBC, Ferritin, Haemoglobinopathy - Mother, Hepatitis B, HIV, Syphilis
Accepted:	Antibodies, Blood Group and Rhesus Factor, FBC, Ferritin, Haemoglobinopathy - Mother, Hepatitis B, HIV, Syphilis	**Antibodies:**	No antibodies present
Blood Group and Rhesus Factor:	O+	**Ferritin:**	67
		Hep B:	Negative
Mother's Haemoglobinopathy:	Normal	**Syphilis:**	Negative
		WCC:	9.60
HIV:	Negative		
Hb (g/dL):	14.0		
Platelets:	244.00		

Blood Tests and Results: 17 Aug 22 at 15:47

Offered:	Down's Syndrome (T21), Edwards (T18) and Patau's (T13) Syndromes	**Declined (Woman's Choice):**	Down's Syndrome (T21), Edwards (T18) and Patau's (T13) Syndromes
Date/Time Declined:	17 Aug 22 at 15:47		

Blood Tests and Results: 04 Oct 22 at 11:19

Location:	Antenatal Clinic	**Offered:**	Blood Glucose (Random), FBC, Thyroid Function, Urea and Electrolytes
Accepted:	Blood Glucose (Random), FBC, Thyroid Function, Urea and Electrolytes	**Hb (g/dL):**	11.9
WCC:	9.90	**Platelets:**	239.00
Sodium:	137	**Potassium:**	3.30
Urea:	1.80	**Serum Creatinine:**	39
Haematocrit:	0.36	**MCV:**	91.3
Thyroid TSH:	0.5	**Thyroid Free T4:**	9.5
Blood Glucose:	5.8		

Blood Tests and Results: 28 Dec 22 at 14:28

Location:	Antenatal Clinic	**Offered:**	Antibodies, Blood Group and Rhesus Factor, FBC, Ferritin
Accepted:	Antibodies, Blood Group and Rhesus Factor, FBC, Ferritin	**Antibodies:**	No antibodies present
Blood Group and Rhesus Factor:	O+	**Ferritin:**	6
		WCC:	10.50
Hb (g/dL):	11.7		
Platelets:	267.00		

Blood Tests and Results: 19 Jan 23 at 06:40

Offered:	Glucose Tolerance Test	**Accepted:**	Glucose Tolerance Test
Results Outstanding:	Glucose Tolerance		

Blood Tests and Results: 19 Jan 23 at 08:45

Location:	Antenatal Ward	**Offered:**	FBC, Glucose Tolerance Test, Group and Save
Accepted:	FBC, Glucose Tolerance Test, Group and Save	**Results Outstanding:**	Glucose Tolerance, Haemoglobin

Blood Tests and Results: 26 Jan 23 at 09:01

Location:	Ward	**Offered:**	CRP, FBC
Accepted:	CRP, FBC	**CRP:**	9.0
Hb (g/dL):	10.4	**Platelets:**	170.00

Blood Tests and Results: 15 Feb 23 at 15:24

Location:	Antenatal Clinic	**Offered:**	FBC, Ferritin, Thyroid Function
Accepted:	FBC, Ferritin, Thyroid Function	**Ferritin:**	7
Hb (g/dL):	11.5	**WCC:**	8.10
Platelets:	210.00	**Haematocrit:**	0.36
MCV:	91.9	**Thyroid TSH:**	1.2
Thyroid Free T4:	10.9		

Blood Tests and Results: 27 Feb 23 at 09:30

Location:	Other: pre op	**Offered:**	FBC, Group and Save
Accepted:	FBC, Group and Save	**Blood Group and Rhesus Factor:**	O+
Hb (g/dL):	11.5		
Platelets:	207.00	**WCC:**	7.00

Blood Tests and Results: 01 Mar 23 at 11:30

Location:	Delivery Suite	**Offered:**	Clotting Screen, FBC, Urea and Electrolytes
Accepted:	Clotting Screen, FBC, Urea and Electrolytes	**Results Outstanding:**	APPT, PT, Creatinine, Platelets, WCC, Haematocrit, Haemoglobin, INR, MCV, Potassium, Sodium, Urea, Uric Acid, Urine Alb Creatinine Ratio (AC

Blood Tests and Results: 01 Mar 23 at 17:15

Location:	Other: PN ward	**Offered:**	FBC, Urea and Electrolytes
Accepted:	FBC, Urea and Electrolytes	**Results Outstanding:**	Creatinine, Haemoglobin, Potassium, Sodium, Urea, Uric Acid, Urine Alb Creatinine Ratio (AC

Blood Tests and Results: 02 Mar 23 at 06:00

Offered:	FBC	**Accepted:**	FBC
Results Outstanding:	Haemoglobin		

Blood Tests and Results: 03 Mar 23 at 10:01

Location:	Ward	**Offered:**	FBC
Accepted:	FBC	**Results Outstanding:**	Haemoglobin

Medication TTOs

TTOs Given Not required

Surgical Interventions

No Relevant Information Recorded

Labour and Birth Summary Report

Donald, Diane (CHI: 1612836909 | PMS Number: 1612836909)
16 Dec 83 (Age at Birth: 39) | 27 St. Andrews Way, Clydebank, West Dunbartonshire, G81 1BP | 07393645082 (mobile)
G3 P3+0 | Baby 1 DOB: 01 Mar 23 at 09:43 (37+4/40) | No. of Babies: 1 | Booking BMI: 26.03 | Current BMI: 28.48 | Blood Group: O+ | Hb at 37+2: 11.5g/dL | PN 0hrs | Current Care: Hospital

Critical Incidents (Woman)

No Relevant Information Recorded

Induction Details

No Relevant Information Recorded

Rupture of Membranes

RoM Duration 0 Hours + 1 Mins
Baby 1 Date/Time Membranes Ruptured 01 Mar 23 at 09:41
Baby 1 Method of Membrane Rupture At Caesarean Section

Spontaneous Onset of Labour

No Relevant Information Recorded

Surgical Interventions

No Relevant Information Recorded

Labour and Birth Details

Onset	Caesarean Section Before Labour (including failed induction)	**CS Reason**	Maternal Request - (no medical indication)
		CS Notes	Gdm
CS Grade	Grade 4 (Delivery timed to suit the woman and staff)	**Place of Birth**	NHS hospital - Shared (Consultant/GP/Midwife)
Mode of Birth	Elective (planned) caesarean section	**Summary of Analgesia and Anaesthesia**	Spinal
Placental Birth Method	Removed at CS		
1st Stage Duration	(Not Recorded)	**2nd Stage Duration**	(Not Recorded)
3rd Stage Duration	0 Hours + 14 Mins	**Labour Total Duration**	(Not Recorded)
Maternal Problems	First Stage: (Not Recorded) Second Stage: (Not Recorded)	**Date of last admission prior to birth**	01 Mar 23 at 06:47

Third Stage of Labour

Date and Time Placenta Birthed	01 Mar 23 at 09:57	**Main Placental Birth Method**	Removed at CS
Placenta	Apparently Complete	**Placenta Appearance**	Normal
Membranes	Appears Complete		

Perineum

No Relevant Information Recorded

Risk Assessment

Recorded: 01 Mar 23 at 07:46
Risk High
Current Pregnancy Gestational Diabetes, Diminished Fetal Movements (2 or more episodes)
Previous Obstetric Previous Antepartum haemorrhage
Medical Endocrine Disorder, Central nervous system, Neurology, BMI 25-29.9 , Sensory and physical disabilities

Blood Loss

Operative blood loss within 24hr of birth 0mls
Cumulative blood loss within 24hr of birth 2200mls

Circle of Care

Delivery plan	Consultant Unit	**Intended Location of Birth**	Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Lead Professional	Fisher, Anne		

Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
1345 Govan Rd, Govan, Glasgow, G51 4TF.

Named Midwife	Anne Fisher	**Lead Professional's telephone**	(Not Recorded)
Team	(Not Recorded)	**Named Consultant**	Carla Summerhill
GP Name	LENNOX, CRAIG	**Hospital Contacts**	Maternity Unit Contact numbers can be found in the main menu of the app or website.
GP Address	Clydebank Health & Care Centre,, Queens Quay Main Avenue, Clydebank, G81 1BS	**GP Practice**	The Green Medical Practice

Intended Location of Birth

Queen Elizabeth University Hospital Glasgow (Prev. Southern General)

Donald, Baby (CHI: 0103235590 | PMS Number: ?)
DOB: 01 Mar 23 at 09:43 | M | Baby 1 of 1 | 27 St. Andrews Way, Clydebank, West Dunbartonshire, G81 1BP | 07393645082
Type of Birth: CS | Gestation at Birth: 37+4 | Birthweight: 2954 | Apgar: 1min: 9 5mins: 9

Critical Incidents (Baby)

No Relevant Information Recorded

Baby 1 Key Details

Date of Birth 01 Mar 23 at 09:43
Gestation at Birth 37+4
CHI Number 0103235590
Outcome Livebirth
Final Outcome Livebirth
Sex of Baby Male
Birthweight 2954g
Birthweight Centile 45.5
Type of Birth CS
Place of Birth Queen Elizabeth University Hospital Glasgow (Prev. Southern General)
Mode of Birth Elective (planned) caesarean section
Most Influential Baby Reason for CS No Baby Reason
Liquor State at Birth or Caesarean Section Clear
Liquor Volume at Birth or Caesarean Section Normal
Fetal Problems in Labour None
Shoulder Dystocia No
Resuscitation Not required
Vitamin K Date / Time Recorded 01 Mar 23 at 10:00
Vitamin K Date / Time Given 01 Mar 23 at 10:04
Vitamin K Dose 0.1ml / 1 mg IM
Birthweight Centile 45.5

Baby 1 Apgar Scores

Assessed at 1/60 Yes **Assessed at 5/60** Yes

	1 minute	5 minutes	10 minutes	20 minutes
Heart rate	2 100bpm or more	2 100bpm or more		
Respiratory Effort	2 Good or crying	2 Good or crying		
Muscle tone	2 Active	2 Active		
Reflex irritability	2 Cry, active	2 Cry, active		
Colour	1 Body pink, extremities blue	1 Body pink, extremities blue		
Total	9	9		

Baby 1 Present at Birth

Personnel
Status of Person Assisting Birth Hospital Doctor
Person assisting birth is a BadgerNet user Yes
Birth Assisted By Claire Higgins
Anaesthetist Present Yes

Neonatologist Present	No
Scrub Nurse(s)	KAREN TAYLOR
Circulating Nurse	Brenda Donaldson
Other Staff Present	Yes
Other (Personnel) Present at Birth	Isla Cruickshank
Baby Received By	Brenda Donaldson
Receiver's Team	No team assigned
Non Personnel Present At Birth	Husband
Clinical Non-BadgerNet Users Present	George simm Mary stewart

Baby 1 Vaccinations

No Relevant Information Recorded

Baby 1 Skin to Skin

Skin to skin established Yes

Clinical letter - GP: SCI Gateway Obstetrics Request

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100
Department: Maternity Centralised Booking
Contact Tel: 0141 347 8422
Enquiries to:

Dr. CA Lennox
The Green Medical Practice
Clydebank Health & Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Letter Date: 19/07/2022
Reference:
Dictated Date: 19/07/2022
Transcribed Date:

Dear CA Lennox ,

Diane Donald; D.O.B: 16/12/1983; CHI: 1612836909
27 St. Andrews Way, Clydebank, Dunbartonshire, G81 1BP

The above patient has self-referred (or been referred by the midwife) to the Centralised Maternity Booking Service and has been given the following appointments:-

Midwife Anne Margaret Fisher

Date: 17/08/2022 Time: 15.00 Location: West Maternity Care Centre, Antenatal Clinic

Ultrasound Scan

Date: 07/09/2022 Time: 10.35 Location: Queen Elizabeth University Hospital, Ultrasound Dept

Your patient has given consent to contact you and in line with the agreed protocol, I would be grateful if the practice could complete the "SCI Gateway Obstetrics Request for Info" template. It is essential to have this provided in time for the booking appointment.

All Obstetric SCI Gateway referrals are directed back to the Centralised Maternity Booking Service to be processed.

Yours faithfully,

Maternity Centralised Booking Service

Electronically Signed: ,

cc.

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN

Main Switchboard: 0141 211 3000
Department: Ophthalmology
Contact Tel: 0141 355 1850
Enquiries to: alice.breslin@ggc.scot.nhs.uk
Letter Date: 13/07/2022
Reference:
Dictated Date: 06/07/2022
Transcribed Date: 11/07/2022

Dr. CA Lennox
The Green Medical Practice
Clydebank Health & Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Dear Dr Ng,

Diane Donald; D.O.B: 16/12/1983; CHI: 1612836909
27 ST ANDREWS WAY, Clydebank, Dunbartonshire, G81 1BP

Thank you for your letter dated 10/6/22

Unfortunately I was away on leave and your letter was only brought to my attention on 5/7/2022 when i returned to work.

I note your concern regarding her visual symptoms. I agree that this may represent a neurological phenomenon, given normal findings by her optometrist, but I am reassured by her normal MRI. She has a follow up with me in August 2022 at which point I will reasssess her eye and decide if any further investigations are indicated.

In the meantime i would be grateful if you could run some baseline checks looking for any vascular risk factors, such as BP check, ruling out any arryhthmias, baseline bloods to include lipid profile, ESR, CRP, full blood count and random blood glucose.

thankyou

Electronically Signed: Dr Maria Gregory , Consultant

cc.

THE GREEN MEDICAL PRACTICE

Clydebank Health Centre & Care Centre

Queens Quay Main Avenue

Dr. Alan McDevitt CBE M.B., Ch.B, D.R.C.O.G., M.R.C.G.P **Clydebank G81 1BS**
Dr. Craig Lennox M.B., Ch.B., M.R.C.G.P.
Dr. Neil Murray M.B., Ch.B., D.R.C.O.G, M.R.C.G.P.
Dr. Francesca Irvine M.B., Ch.B., M.R.C.G.P
DrMai MacSorley M.B., Ch.B., M.R.C.G.P.
Dr. Ben Esson M.B., ChB., M.R.C.G.P.
Dr. Lucienne Donaldson M.B., ChB., B.S.C hons. M.R.C.G.P.

Phone 0141-531-6425
Fax 0141-531-6433

27 06 2022

Dictated: 23 06 2022
Typed: 27 06 2022
Ref: CALLET27JUN/CN

Mr Allan Hall
Consultant Neurosurgeon
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

ACTION REQUIRED SPECIALIST TO SPECIALIST REFERRAL

Dear Mr Hall

RE: Diane Donald **27 St Andrews Way, CLYDEBANK, G81 1BP**
D.O.B: 16/12/1983 **C.H.I: 1612836909**

Many thanks for your letter dated 21st June regarding Diane Donald.

In your letter you asked "I would be very grateful if the GP could refer Miss Donald onto Neurology just so that they can review her and exclude any underlying causing such as MS".

You may not be aware but the Health Board directs that for good communication reasons such referrals should be made specialist to specialist.

This makes absolute sense as you have the expertise and the desire to make the referral and having that done 3rd party would make for a less clear communiation and less clear referral.

I will not be referring as you suggested and if you feel it is required I would direct you to make the referral directly from your neurosurgery team to the neurology team.

Many thanks for your attention to this matter.

Yours sincerely,

Dr Craig Lennox GP

CC.. Mr Grivas, Neurosurgeon, QEUH, 1345 Govan Rd, G51 4TF

Clinical letter - GP: Discharge from Physiotherapy

NHS
Greater Glasgow and Clyde

Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN
Main Switchboard: 0141 211 3000
Department: Clydebank Health Centre
MSK Physiotherapy
Contact Tel: 01415316324
Enquiries to:
Letter Date: 19/03/2019
Reference:
Dictated Date:
Transcribed Date:

Dr. F Irvine
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Dear Dr. Irvine,

Diane Donald; D.O.B: 16/12/1983; CHI: 1612836909
43 LONGDEN STREET, WHITECROOK, Clydebank, Dunbartonshire, G81 1AG

This patient did not keep their first appointment with us on 19/03/19 at 13:00, and did not notify us that they would not be attending.

No further appointment will be offered and they will be removed from our waiting list, unless they contact us within 24 hours.

Yours sincerely

Tory Prentice

B6 Locum Physiotherapist

Electronically Signed: ,

cc.

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN
0141 211 3000

Dr. F Irvine
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Main Switchboard: 0141 211 3000
Department: Vascular
Contact Tel: 0141 451 5945
Enquiries to: Lynn.Graham@ggc.scot.nhs.uk
Letter Date: 03/02/2016
Reference: PT/LPG
Dictated Date: 29/01/2016
Transcribed Date: 29/01/2016

Dear Dr Lennox,

Diane Donald; D.O.B: 16/12/1983; CHI: 1612836909
43 Longden Street, Clydebank, Dunbartonshire, G81 1AG

This lady was referred by one of your Locum's. She seems to be describing vasospasm affecting this lady's toes in cold weather. Examination seems to confirm that her foot pulses are present, and as such I do not think as a vascular surgery unit we have anything to offer.

If this lady did find her symptoms particularly troublesome then I would suggest Nifedipine might be helpful.

Yours sincerely

Paul Teenan
Consultant Vascular Surgeon

Electronically Signed: Mr Paul Teenan, Consultant

cc.

Clinical letter - GP: Physiotherapy discharge

NHS
Greater Glasgow and Clyde

Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN
Main Switchboard: 0141 211 3000
Department: Clydebank physiotherapy
Contact Tel: 0141 531 6324
Enquiries to:

Dr. F Irvine
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Letter Date: 15/04/2015
Reference:
Dictated Date: 15/04/2015
Transcribed Date:

Dear Dr McDevitt,

Diane Donald; D.O.B: 16/12/1983; CHI: 1612836909
43 Longden Street, Clydebank, Dunbartonshire, G81 1AG

This patient was referred to Physiotherapy on: 02/3/15

Via: Self Referral

Presenting Condition: acute non-specific mechanical low back pain

she received treatment(s) from 16/3/15

GP Action Required: please ask patient to be refer should you feel this is appropriate.

Discharge Outcome:

- Cancalled her first review appointment(s) on 23/3/15

Additional Physiotherapy Comments: nil specific

This patient has now been discharged from our care.

Yours sincerely

Graeme Watson

Specialist Physiotherapist

Electronically Signed: Physiotherapist Graeme Watson1, Physiotherapist

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Dr. F Irvine
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Western Infirmary
Dumbarton Road
Glasgow
G11 6NT

Main Switchboard: 0141 211 2000
Email Inquiries to:
Contact Tel Details: Tele: 0141 211 6259

Dictated Date: 04/12/2013
By: Dr Shona MacAlpine
Transcribed Date: 06/12/2013
By: Linda Hope

Dear Dr. F Irvine,

Patient

Name:	Donald Diane
CHI:	1612836909
DOB:	16 Dec 1983
Address:	43 Longden Street Clydebank G81 1AG

Attendance

Attended:	04/12/2013 14:10
New/Return:	G N URG SCS
Referral Source:	General Practitioner
Consultant:	Dr Martin Porter
Specialty:	Dermatology
Clinic:	WIMPDE6-DR PORTER SCS WED PM

Clinical Comments:
DIAGNOSES:
Atypical naevus - upper back
Fleshy mole - left side of chest

MANAGEMENT: For removal 12th December

FOLLOW UP: Pending pathology

Thank you for referring this lady to dermatology. The mole on her back in much darker than her her others, and looks slightly atypical although not paticularly sinister. I have arranged for her to attend for excision of the naevus and shave excision of the fleshy mole on her chest.

We will be in touch with the pathology when available.

Yours sincerely
Dr Shona MacAlpine
GPST2

Electronically Signed: Dr Shona MacAlpine, Doctor

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
0141 201 1100

Dr. GA Robertson
Yellow Medical Practice
Clydebank Health & Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Main Switchboard:	
Department:	Neurology
Contact Tel:	0141 201 2374
Enquiries to:	Melanie Birnie
Letter Date:	19/01/2026
Reference:	RN/EP
Dictated Date:	19/01/2026
Transcribed Date:	11/02/2026

Dear Dr. GA Robertson,

Diane Donald; D.O.B: 16 Dec 1983; CHI: 1612836909
27 St. Andrews Way, Clydebank, Dunbartonshire, G81 1BP

Attendance: Specialty - Neurology; Clinic - SURKNNE2-DR NEKKARE FIRST SEIZURE MONDAY PM
Date and Time of Appointment - 19/01/2026 15:00

Requested Out-patient Investigations:
MRI head.

Clinical Comments:
I spoke with this 42 year old lady over the phone today. She is a carer for her children. She is a driver.

On the 12th May 2025 she had an unwitnessed episode in the bathroom. She did not develop any tongue biting, incontinence or vomiting. She had a minor operation because of the fall. When she realised she was on the floor. There was no prior warning except that she felt a bit strange while brushing her teeth after going to the toilet. This happened in the bathroom. She thinks that she might have lost consciousness for seconds to minutes. She has not had any further similar episode, blackout. She does not have an ongoing headache other than migraine.

She never had any similar episode in the past.

Her ambulatory ECG in 2025 was satisfactory.

The nature of the unwitnessed episode occured in the bathroom on the 12th of May 2025 is not clear. I have requested MRI of head. I have explained to her regarding the safety measures and to meet with you if at all she develops any further episodes. She does not have any myoclonic jerks or absent seizure.

Many thanks

Yours sincerely

Dr Ramesha Nekkare

Consultant Neurologist

Electronically Signed: Dr Ramesha Nekkare, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
0141 201 1100

Dr. CA Lennox
The Green Medical Practice
Clydebank Health & Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Main Switchboard:	0141 201 1100
Department:	Neurology
Contact Tel:	0141 232 7542
Enquiries to:	
Letter Date:	24/01/2023
Reference:	SM/LD
Dictated Date:	24/01/2023
Transcribed Date:	27/01/2023

Dear Dr. CA Lennox,

Diane Donald; D.O.B: 16 Dec 1983; CHI: 1612836909
27 St. Andrews Way, Clydebank, Dunbartonshire, G81 1BP

Attendance: Specialty - Neurology; Clinic - SUSMNE3-DR MILLER NEURO TUES AM
Date and Time of Appointment - 24/01/2023 11:00

Clinical Comments:
This lady failed to attend a headache patient review today. Due to pressures on our system she has been discharged.

Yours sincerely

Dr Sarah Miller

Consultant Neurologist

Electronically Signed: Dr Sarah Miller, Consultant

cc. Mr A Grivas
Consultant Neurosurgeon
INS
QEUH

THE GREEN MEDICAL PRACTICE

Clydebank Health Centre & Care Centre

Queens Quay Main Avenue

22 JUN 2022

Dr. Alan McDevitt CBE M.B., Ch.B, D.R.C.O.G., M.R.C.G.P
Dr. Craig Lennox M.B., Ch.B., M.R.C.G.P.
Dr. Neil Murray M.B., Ch.B., D.R.C.O.G, M.R.C.G.P.
Dr. Francesca Irvine M.B., Ch.B., M.R.C.G.P
Dr Mai MacSorley M.B., Ch.B., M.R.C.G.P.
Dr. Ben Esson M.B., ChB., M.R.C.G.P.
Dr. Lucienne Donaldson M.B., ChB., B.S.C hons. M.R.C.G.P.

Clydebank G81 1BS

Phone 0141-531-6425
Fax 0141-531-6433

13 06 2022

Dictated: 10 06 2022
Typed: 13 06 2022
Ref: CNLET13JUN/CN

Mr Grivas
Consultant Neurosurgeon
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Dear Mr Grivas,

RE: Diane Donald **27 St Andrews Way, CLYDEBANK, G81 1BP**
D.O.B: 16/12/1983 **C.H.I: 1612836909**

This lady has a follow up appointment with yourself on the 25th of June to discuss her MRI results. She presented today as she had 2 episodes of visual disturbance in her right eye. The first episode occurred 2 weeks ago where she had a sudden onset of blurry and double vision at about 8pm, just in her right eye. She fell asleep at 1am and when she woke the next morning, her vision was still blurry but better than it was the night before.

She attended her optician who couldn't find any abnormalities. She was advised that this could be neurological. Her right eye returned to normal a couple of days later. This happened again last night at about 9pm. The vision in her right eye became blurry and double vision. She fell asleep at around 10.30pm. She woke up this morning and noted that her vision was almost back to normal. There was no associated headache. She reports that other than the visual problems in her right eye, she has felt fine.

Examination today revealed full range of eye movement. There was no blurring or double vision. She complained of a pain behind her right eye with movement - she reports that this isn't new and she has mentioned this to various specialists in the past. I would be grateful for your opinion with regards to these episodes. Thank you.

Yours sincerely,

Dr Cheryl Ng GP Locum

Clinic Letter

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Dr. CA Lennox
The Green Medical Practice
Clydebank Health & Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Main Switchboard:	0141 201 1100
Department:	Neurosurgery
Contact Tel:	0141 201 2020
Enquiries to:	
Letter Date:	21/06/2022
Reference:	AH/JL
Dictated Date:	21/06/2022
Transcribed Date:	21/06/2022

Dear Dr. CA Lennox,

Diane Donald; D.O.B: 16 Dec 1983; CHI: 1612836909
27 ST ANDREWS WAY, Clydebank, Dunbartonshire, G81 1BP

Attendance: Specialty - Neurosurgery; Clinic - SUCCNS4-GENERIC GLIOMA TUES PM
Date and Time of Appointment - 21/06/2022 14:30

Follow Up: Discharged

Clinical Comments:
I reviewed this 38 year old lady on behalf of Mr Grivas this afternoon in clinic. Miss Donald was initially referred to neurosurgery following a CT which she had in January of 2022 following a very severe episode of headache. At that time it was thought the CT showed an abnormality in the left side of PONS and therefore warranted further investigation with an MRI. This MRI has now taken place the results of which state that the area is normal in appearance and it is likely that the finding on the preceding CT head was artefactual. I relayed this good news to Miss Donald today. She states that she still has ongoing headaches and specifically she has developed new eye pain with associated intermittent loss of vision on the right side. From what she tells me today this sounds similar to an optic neuritis type of pain. Therefore I would be very grateful if the GP could refer Miss Donald onto neurology just so they can review her and exclude any underlying causes such as MS.
However I explained to Miss Donald given the reassuring MRI that she can be discharged from our clinic, however if she experiences any related problems in the future we would be very happy to see her again. She was very happy with this outcome.

Kind regards

Yours sincerely

Mr Allan Hall

Neurosurgical Registrar to

Mr Grivas

Consultant Neurosurgeon

Electronically Signed: Dr Allan Hall1, Doctor

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Dr. CA Lennox
The Green Medical Practice
Clydebank Health & Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Main Switchboard: 0141 201 1100
Department: Neurosurgery
Contact Tel: 0141 201 2020
Enquiries to: Janice.Lafferty@ggc.scot.nhs.uk
Letter Date: 05/04/2022
Reference: AG/JL
Dictated Date: 05/04/2022
Transcribed Date: 06/04/2022

Dear Dr. CA Lennox,

Diane Donald; D.O.B: 16 Dec 1983; CHI: 1612836909
27 ST ANDREWS WAY, Clydebank, Dunbartonshire, G81 1BP

Attendance: Specialty - Neurosurgery; Clinic - SUCCNS4-GENERIC GLIOMA TUES PM
Date and Time of Appointment - 05/04/2022 16:30

Requested Out-patient Investigations:
Scan within the next few weeks

Follow Up: Telephone consultation with results

Clinical Comments:
Thank you for referring Miss Donald to neurosurgical out patient clinic. Miss Donald is a migraine sufferer who has been reviewed under the ophthalmology clinic for intermittent floaters in the right eye greater on the left and who had recently presented to A & E department with throbbing headache with a bifrontal distribution which after a period 15 minutes became exacerbated to high intensity headache. Following this episode her symptoms had resolved spontaneously but they have returned back approximately a week ago with the same features. Today in clinic we have reviewed Miss Donald who is a healthy 38 year old lady who trains as a hairdresser . She denies any neurological complaints, her balance is not impaired and she does not have double vision, loss of consciousness or seizures. The clinical neurological examination today was unremarkable indicating intact pyramidal tracks, normal sensation, normal facial sensation and cranial nerves, no double vision and healthy disc on papilledema. The Hoffman's were non indicative of any pathologies. The CT scan of the head from January 2022 shows possible abnormality on the left side of the pons which is most likely incidental and there is no other intracranial pathology. This is quite challenging to characterise this lesion on the CT scan brain and on this occasion we are planning to offer an MRI scan with IV contrast within the next few weeks. I have reassured Miss Donald that it is unlikely that the suspected lesion is related to the episodes of headaches. I will arrange a telephone consultation when the scan is completed.

Plan:

1. Telephone consultation with the results of the scan.

Yours sincerely

Mr Grivas

Consultant Neurosurgeon

Electronically Signed: Mr Athanasios Grivas, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN
0141 211 3000

Department of Surgery
0141 301 9857
Lorna.Macrae@ggc.scot.nhs.uk

Dr. F Irvine
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Main Switchboard:	
Department:	Department of Surgery
Contact Tel:	0141 301 9857
Enquiries to:	Lorna.Macrae@ggc.scot.nhs.uk
Letter Date:	20/04/2018
Reference:	SS/AM
Dictated Date:	20/04/2018
Transcribed Date:	25/04/2018

Dear Dr. F Irvine,

Diane Donald; D.O.B: 16 Dec 1983; CHI: 1612836909
43 LONGDEN STREET, WHITECROOK, Clydebank, Dunbartonshire, G81 1AG

Attendance: Specialty - General Surgery; Clinic - GGJDGSI-MISS DOUGHTY BREAST EXTRA CLINIC
Date and Time of Appointment - 20/04/2018 17:00

Follow Up: Patient discharged from Breast Clinic.

Clinical Comments:
Thanks for referring this 34 year old patient who noticed a painful lumpy area in the axillary tail of her left breast and also a small lump on her skin between her breasts over her sternum and she also felt a lump in her left inframammary fold near her flank. She's not had any family history of breast or ovarian cancer and has no periods as she has contraceptive implant in situ.

On clinical examination today the left breast was a bit bigger than the right one and was more lumpy in the axillary tail of the breast compared with the right side and was quite tender over the nodular area. Her axillas both felt normal, the small area between her breasts is a small sebaceous cyst and is of no concern and the other area in the inframammary fold neither of us could find today.

We did an ultrasound scan of her left breast and everything looked fine (U1) it just looked like normal breast tissue. I have therefore reassured her today and have discharged her.

All the best.

Yours Sincerely

Miss Sheila Stallard

Consultant Breast Surgeon

Electronically Signed: Miss Sheila Stallard, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Dr. F Irvine
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Main Switchboard:	0141 201 1100
Department:	Gynaecology
Contact Tel:	
Enquiries to:	june.reid@ggc.scot.nhs.uk
Letter Date:	17/10/2016
Reference:	AS/JR
Dictated Date:	17/10/2016
Transcribed Date:	19/10/2016

Dear Dr. F Irvine,

Diane Donald; D.O.B: 16 Dec 1983; CHI: 1612836909
43 Longden Street, Clydebank, Dunbartonshire, G81 1AG

Attendance: Specialty - Gynaecology; Clinic - SGSPGY2-DR PRINGLE GYN MONDAY PM
Date and Time of Appointment - 17/10/2016 13:30

Clinical Comments:
I was happy to review Diane on behalf of Dr Pringle in the gynaecology clinic today. She is a 30 year old para x 2 (SVDs) who presented with history of irregular bleeding since February of this year. Diane had a Nexplanon inserted in March 2014 and had been amenorrhoeic following this up until her bleeding re-commenced in February. She last had a bleed a month ago which she described as the appearance of old blood, passing some clots with associated abdominal cramps. She denies any dyspareunia or abnormal discharge however had an episode of postcoital bleeding one month ago but nothing since. Diane's smear tests are normal and up to date and I note she had a previous LETZ procedure to the cervix in 2009 for CIN 3.

Diane had an ultrasound at the Golden Jubilee in February of this year which was reported as normal however we are unable to access the result on our computer system.

On examination in the clinic Diane's abdomen was soft and non tender with no palpable masses. Speculum and bi-manual examination was entirely normal I have discussed her case with Dr Pringle in the clinic today and we agreed that there were no concerning features in Diane's history nor examination. We gave her the options to continue with the Nexplanon and see if the bleeding settles or try the Mirena or the copper coil. I have given Diane some information leaflets regarding this and she is aware that she can have the Mirena coil or copper coil fitted at her GP practice or at Sandyford.

We will not routine see Diane back in the clinic however if there are further concerns then please do not hesitate to get back in contact.

Yours sincerely

Dr Amy Sinclair

ST2, Obstetrics & Gynaecology

Electronically Signed: Dr Stewart Pringle, Consultant

cc.

SURGICAL ENDOCRINE UNIT

Mr C R Wilson (Tel: 0141-211-6248)
Miss J Doughty (Tel: 0141-211-2122)

Western Infirmary
Dumbarton Road
GLASGOW
G11 6NT

SURGICAL ENDOCRINE CLINIC – 19/03/2013

Ref: CRW/LJH
Dictated: *19/03/2013*
Typed : *10/04/2013*

Dr Joyce McDevitt
The Green Medical Practice
Clydebank Health Centre, Kilbowie Road
Clydebank
G81 2TQ

Dear Dr McDevitt

Diane Donald – 16/12/1983 – CHI: 1612836909 – CRN: 10631776W
Flat 2, 18 Onslow Road, Clydebank, G81 2NE

I would be grateful if you could arrange to take Diane's thyroid function at approximately 6 to 8 weeks time. She has recovered well from her recent thyroid lobectomy and I am very pleased to say that the results of that show that the lump in her thyroid was a benign follicular adenoma.

She has some difficulty in projecting her voice and pitch problems at the moment following her surgery but this is something that we would expect to completely resolve in the next few weeks. If is doesn't however, we could arrange for Diane to have some speech therapy to see if we can improve her vocal range. If this is the case please don't hesitate to contact me and I would be happy to arrange that.

Yours sincerely

Mr C R Wilson
Consultant Surgeon

SURGICAL ENDOCRINE UNIT

Mr C R Wilson (Tel: 0141-211-6248)
Miss J Doughty (Tel: 0141-211-2122)

Western Infirmary
Dumbarton Road
GLASGOW
G11 6NT

SURGICAL ENDOCRINE CLINIC – 19/03/2013

Ref: CRW/LJH
Dictated: *19/03/2013*
Typed: *10/04/2013*

Dr Robert Lindsay
Consultant Endocrinologist
Endocrine Unit
Western Infirmary
Glasgow

Dear Robbie

Diane Donald - 16/12/1983 - CHI: 1612836909 - CRN: 10631776W
Flat 2, 18 Onslow Road, Clydebank, G81 2NE

Diane came back to the clinic today where I am pleased to see following her pregnancy her follicular cytology had shown us that she had a Thy3F. Her result of her thyroid lobectomy has shown this to be a benign follicular adenoma and she has recovered well from this surgery. I am going to ask her GP to check her thyroid function test in 6 to 8 weeks time but today at the clinic all is well.

Kind regards.

Yours sincerely

Mr C R Wilson
Consultant Surgeon

SURGICAL ENDOCRINE UNIT

Mr C R Wilson (Tel: 0141-211-6248)
Miss J Doughty (Tel: 0141-211-2122)

Western Infirmary
Dumbarton Road
GLASGOW
G11 6NT

Ref: CRW/KC
CHI: 1612836909
Dictated: *12/02/2013*
Typed : *14/02/2013*

Mrs Diane Donald
Flat 2, 18 Onslow Road
Clydebank
G81 2NE

Dear Mrs Donald

Patient No: 10631776W
Patient Type: Inpatient

Arrangements have been made for your admission to ward Level 10 of the Western Infirmary under the care of Mr C R Wilson.

I would be grateful if you could report to the Admissions Desk, Level 3, at **8.00am on Thursday, 21 February 2013.**

As you are having a general anaesthetic I would be grateful if you would **fast** from midnight the night before your admission.

Please bring with you any medicines, in their original containers, which have been prescribed by your General Practitioner, who will be informed of your Admission.

Should this date be unsuitable, it would be very much appreciated if you would contact me immediately on 0141 211 6248 so that arrangements may be made to offer the bed to another patient.

Yours sincerely

K Cruickshank
Secretary to Mr C R Wilson

SURGICAL ENDOCRINE UNIT

Mr C R Wilson (Tel: 0141-211-6248)
Miss J Doughty (Tel: 0141-211-2122)

Western Infirmary
Dumbarton Road
GLASGOW
G11 6NT

SURGICAL ENDOCRINE CLINIC – 05/02/2013

Ref: CRW/KC
Dictated: *05/02/2013*
Typed : *13/02/2013*

Dr Neil Murray
The Green Medical Practice
Clydebank Health Centre, Kilbowie Road, Clydebank
G81 2TQ

Dr Robert Lindsay
Consultant Endocrinologist
Endocrine Unit
Western Infirmary

Dear Dr Murray

Diane Donald - 16/12/1983 - CHI: 1612836909 - CRN: 10631776W
Flat 2, 18 Onslow Road, Clydebank, G81 2NE

Diane came back to see me after her recent successful pregnancy. As you remember she had about a 2-3cm left solitary thyroid nodule which has really been difficult to prove benign as her cytology has always been C1.

When we spoke before her pregnancy she was keen to have this removed but we delayed that until after her pregnancy had finished. She is now there, the lesion is still palpable and we have talked today about a left thyroid lobectomy and we have placed her on the list to have this done in the very near future.

Yours sincerely

Mr C R Wilson
Consultant Surgeon

Southern General Hospital
1345 Govan Road
Glasgow G51 4TF
Switchboard 0141 201 1100

Secretary: Leanne
Direct Line: 0141 232 7955

DEPARTMENT OF GYNAECOLOGY

DR T DOW, LOCUM	DR K SPOWART
DR K HANRETTY	DR C TAGGART
DR E HADOURA, LOCUM	DR R PANIGRAHY, LOCUM
DR J RICHMOND	DR J ROBERTS
DR S PRINGLE	DR V McKAY
DR C HARDWICK	DR R HAWTHORN
DR A KHAUND, LOCUM	DR K GUERRERO
DR H ALI	DR S BJORNSSON

SB/LR/10631776W SG 3295684

DEPARTMENT OF OBSETRICS

Date: 09/01/2013

Dr Robertson
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Dear Dr Robertson

Diane Donald - 16/12/1983 - CHI: 1612836909
Flat 2, 18 Onslow Road, Clydebank, G81 2NE

Diane was admitted to the Southern General Hospital on the 29th December 2012 for induction of labour at term. Diane is a para 0+1 and has remained well antenatally. She had some investigations for cervical lengths due to previous cervical surgery but she is otherwise fit and well.

Following one doze of vaginal Prostaglandin she had spontaneous rupture of membranes and went on to labour very quickly. She was delivered by kiwi Ventouse for fetal distress in the second stage. Her son was born on the 30th December 2012 in good condition with a birth weight of 3.0kg.

Postnatally she made a good recovery and was discharged on the 31st December 2012. Discharge medications include oral analgesia.

Yours sincerely

Sarah Barr
Registrar to Dr Roberts

SURGICAL ENDOCRINE UNIT

Mr C R Wilson (Tel: 0141-211-6248)
Miss J Doughty (Tel: 0141-211-2122)

Western Infirmary
Dumbarton Road
GLASGOW
G11 6NT

SURGICAL ENDOCRINE CLINIC – 14/08/2012

Ref: CRW/KC
Dictated: *14/08/2012*
Typed : *27/08/2012*

Dr Robert Lindsay
Consultant Endocrinologist
Endocrine Unit
Western Infirmary

Dr Neil Murray
The Green Medical Practice
Clydebank Health Centre, Kilbowie Road,
Clydebank
G81 2TQ

Dear Dr Lindsay

Diane Donald - 16/12/1983 - CHI: 1612836909 - CRN: 10631776W
17/7 Ashtree Court, Old Kilpatrick, Glasgow, G60 5JD

Thank you for referring Diane for consideration of thyroid lobectomy in view of her presentation with a thyroid nodule that it has been difficult to prove on cytology it is benign.

Diane is going to complete her pregnancy and we will arrange to see her at the end of her pregnancy and discuss further management at that stage.

Yours sincerely

Mr C R Wilson
Consultant Surgeon

Western Infirmary – Dumbarton Road – Glasgow G11 6NT

Endocrine Unit
Professor A F Dominiczak
Dr A R McLellan /Dr M Freel
Dr G C Jones /Dr C Sainsbury
Dr C Perry / Dr R Lindsay

Karen.Campbell3@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]
Donna.Grant@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]

Gill.Mitan@ggc.scot.nhs.uk
Emma.Nairne@ggc.scot.nhs.uk [Secretaries] ☎ : *0141-211-2737*

DR ROBERT LINDSAY'S THYROID CLINIC - 29/03/2012

RL/CD 26/04/2012

Dr Neil Murray
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Dear Dr Murray

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
17/7 Ashtree Court, Old Kilpatrick, Glasgow, G60 5JD

Diagnosis: 1. 27x22mm nodule left lobe of thyroid stable on ultrasound from June 2010

I saw Diane Donald back in clinic. She has a partially cystic nodule in the thyroid that was ultrasounded in June of 2010 and again in January 2012. There has been no significant change over that time in size. The appearances are benign. She has had two FNA's which both unfortunately are non-contributory showing blood (Thy 1). I had a long discussion with her. I have been very reassuring that given the length of time that we have shown this to be stable I think it highly unlikely there is any major disease going on and I would be content discharging her today and not having any further imaging or fine needle aspiration. She remains somewhat concerned by the appearance of the nodule. I would like to discuss with one of the surgeons as to the possibility of having it removed. For that reason I will refer her on to Mr Wilson.

Yours sincerely

DR ROBERT LINDSAY
Consultant in Diabetes & Endocrinology

Copy to:-

Mr C Wilson
Consultant Surgeon
Western Infirmary
Glasgow
G11 6NT

Western Infirmary – Dumbarton Road – Glasgow G11 6NT

Endocrine Unit
Professor A F Dominiczak
Dr A R McLellan /Dr M Freel
Dr G C Jones /Dr C Sainsbury
Dr C Perry / Dr R Lindsay

Karen.Campbell3@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]
Donna.Grant@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]

Gill.Mitan@ggc.scot.nhs.uk
Emma.Nairne@ggc.scot.nhs.uk [Secretaries] ☎ : *0141-211-2737*

DR ROBERT LINDSAY'S THYROID CLINIC

RL/CD

26th April 2012

Mr C Wilson
Consultant Surgeon
Western Infirmary
Glasgow
G11 6NT

Dear Mr Wilson

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
17/7 Ashtree Court, Old Kilpatrick, Glasgow, G60 5JD

I would be grateful if this lady with a 27mm nodule left lobe of thyroid might be seen. As detailed it is stable, not causing particular concern but she is wishing to pursue whether it might be removed.

Yours sincerely

DR ROBERT LINDSAY
Consultant in Diabetes & Endocrinology

NHS
Greater Glasgow and Clyde

Western Infirmary – Dumbarton Road – Glasgow G11 6NT

Endocrine Unit
Professor A F Dominiczak
Dr A R McLellan /Dr M Freel
Dr G C Jones /Dr C Sainsbury
Dr C Perry / Dr R Lindsay

Karen.Campbell3@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]
Donna.Grant@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]

Gill.Mitan@ggc.scot.nhs.uk
Emma.Nairne@ggc.scot.nhs.uk [Secretaries] ☎ : *0141-211-2737*

DR ROBERT LINDSAY'S THYROID CLINIC - 05/01/2012

CS/CD 19/01/2012

Dr Neil Murray
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Dear Dr Murray

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
17/7 Ashtree Court, Old Kilpatrick, Glasgow, G60 5JD

Diagnosis: 1. 27x22mm nodule in left lobe of thyroid – FNA June THY 1

Thank you for re-referring Diane to Dr Lindsay's Clinic where I met her on the 5th of January. I note she had previously DNA'd from an appointment on the 5th of August 2010. She still has the left-sided nodule which she feels has increased in size since her last review. She has no dysphagia or shortness of breath. She feels the nodule becomes more prominent when she has a throat infection. I note the previous plan was to try and repeat ultrasound and FNA to get a more definitive tissue sample.

On examination today she is clinically euthyroid which is in keeping with her normal thyroid function tests from November 2011. The nodule on the left is approximately 2½cm and moves on swallowing and feels cystic. I have tired to reassure her today that I suspect this will be a benign lesion and we will arrange a repeat ultrasound and FNA with the radiology department. I have booked her back for review in two months time.

Yours sincerely

Dr Chris Smith
ST6 in Endocrinology

Western Infirmary – Dumbarton Road – Glasgow - G11 6NT

Endocrine Unit
Professor A F Dominiczak
Dr A R McLellan /Dr M Freel
Dr G Jones/ Dr C Sainsbury
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Emma.Nairne@ggc.scot.nhs.uk *Secretaries ☎ : 0141-211-2737*

DR ROBERT LINDSAY'S ENDOCRINE CLINIC - 24/06/2010

NG/GM Date: 05/07/2010

Dr Neil Murray
Clydebank Health Centre
Kilbowie Road
CLYDEBANK
G81 2TQ

Dear Dr Murray

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
Flat 3/1, 804 Dumbarton Road – Clydebank - Dunbartonshire, G81 4BA

Diagnoses: 1. 27 x 22mm nodule in left lobe of thyroid

I reviewed Diane in clinic today. She had her FNA done on 9.6.10 however the tissue sample was blood stained and therefore was not suitable for full analysis. The ultrasound reports stated that there was some internal hypervascularity with some peripheral calcification.

On examination today her nodule was normal consistency and moving with swallowing – I did not appear to have changed in size. Diane mentioned at times her nodule is more noticeable and that she has lost her voice on a couple of occasions. I have told her it is unlikely that it could be due to her thyroid nodule and that if she was keen for surgery then this is an obvious complication of thyroid surgery, we have therefore agreed that the plan of action should be to repeat the FNA and for her to come back to the clinic in six weeks time. Depending on the results of the FNA any appropriate steps will be followed.

Yours sincerely

DR N GHOURI
CLINICAL RESEARCH FELLOW

NHS
Greater Glasgow and Clyde

Western Infirmary – Dumbarton Road – Glasgow - G11 6NT

Endocrine Unit
Professor A F Dominiczak
Dr A R McLellan /Dr M Freel
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Karen.Campbell3@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]
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Gill.Mitan@ggc.scot.nhs.uk
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DR ROBERT LINDSAY'S ENDOCRINE CLINIC - 24/06/2010

NG/GM Date: 05/07/2010

Dr Neil Murray
Clydebank Health Centre
Kilbowie Road
CLYDEBANK
G81 2TQ

Dear Dr Murray

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
Flat 3/1, 804 Dumbarton Road – Clydebank - Dunbartonshire, G81 4BA

Diagnoses: 1. 27 x 22mm nodule in left lobe of thyroid

I reviewed Diane in clinic today. She had her FNA done on 9.6.10 however the tissue sample was blood stained and therefore was not suitable for full analysis. The ultrasound reports stated that there was some internal hypervascularity with some peripheral calcification.

On examination today her nodule was normal consistency and moving with swallowing – I did not appear to have changed in size. Diane mentioned at times her nodule is more noticeable and that she has lost her voice on a couple of occasions. I have told her it is unlikely that it could be due to her thyroid nodule and that if she was keen for surgery then this is an obvious complication of thyroid surgery, we have therefore agreed that the plan of action should be to repeat the FNA and for her to come back to the clinic in six weeks time. Depending on the results of the FNA any appropriate steps will be followed.

Yours sincerely

DR N GHOURI
CLINICAL RESEARCH FELLOW

Western Infirmary – Dumbarton Road – Glasgow - G11 6NT

Endocrine Unit
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Karen.Campbell3@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]
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Gill.Mitan@ggc.scot.nhs.uk
Emma.Nairne@ggc.scot.nhs.uk *Secretaries ☎ : 0141-211-2737*

DR ROBERT LINDSAY'S ENDOCRINE CLINIC - 13/05/2010

RL/GM Date: 01/06/2010

Dr Neil Murray
Clydebank Health Centre
Kilbowie Road
CLYDEBANK
G81 2TQ

Dear Dr Murray

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
Flat 3/1, 804 Dumbarton Road - Clydebank, G81 4BA

Diagnoses: 1. 3 x 2 x 1.5cm nodule in left lobe of thyroid

I saw Diane in Clinic today. She is previously well but noted a lump in her neck in mid March. She feels there might have been a small increase in size since then. She has also had some hoarseness of her voice but symptomatically does seem to have had an upper respiratory tract infection as the cause of this. There is no history of neck irradiation or thyroid disease in the family.

On examination she has a 3cm nodule in the left lobe of normal consistency on moving and swallowing. There was no lymphadenopathy in the neck. I have arranged for her to have an FNA. I have explained that this is likely to be a benign lump but that we need to do some further testing to clarify this. She will come back to clinic in six weeks for the results of the FNA.

Yours sincerely

DR ROBERT LINDSAY
Consultant in Diabetes & Endocrinology

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

CRAIG LENNOXThe Green Medical Practice,Clydebank Health & Care Centre,,Queens Quay Main Avenue, Clydebank, G81 1BS

Main Switchboard:
Date of Completion: 04-Mar-2023

Dear CRAIG LENNOX,

Name	CHI	DoB	Address
Diane Donald	**1612836909**	**16-Dec-1983**	**27 St. Andrews Way, Clydebank, Dunbartonshire, G81 1BP**

Admitted	Type	Discharged	Destination
01-Mar-2023 06:47	IP	03-Mar-2023	Private Residence - living with relatives or friends

Specialty	Consultant	Ward	Telephone
Obstetrics	Summerhill	QEUH Ward 50 - Obstetrics	

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
There is no data to display.

Last Discharge Review: Amanda Holmes (Amanda Holmes - Paediatric Clinical Fellow) on 02 Mar 2023 10:42

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Clexane 40mg/0.4ml solution for injection pre-filled syringes (DE Pharmaceuticals)	subcutaneous	40 mg once daily , Fixed Period 10 Day(s) from 01 Mar 2023	Yes				Added
Diclofenac sodium 50mg gastro-resistant tablets	oral	1 tablet three times daily when required , Fixed Period 1 Week(s) from 02 Mar 2023	Yes				Added
Ferrous sulfate 200mg tablets	oral	1 tablet once daily , Fixed Period 3 Month(s) from 02 Mar 2023	Yes				Added
Lactulose 3.1-3.7g/5ml oral solution	oral	10 mL twice daily when required	Yes				Added
Paracetamol 500mg tablets	oral	1 tablet four times daily when required	Yes				Added

"Added" means this medicine was added to the Clinical Portal record after admission. It does not necessarily mean this medicine was started by the hospital.

Dispensing Comments
There is no data to display.

Withheld Medication:

Date	Withheld Drug Name	Route	Dose	Note	Withheld Reason
There is no data to display.					

Stopped Medication:

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
2023-03-02	Trimethoprim 200mg tablets	oral	1 tablet twice daily , Fixed Period 7 Day(s) from 26 Jan 2023		Course completed

Reason for Admission and Presenting Complaints	Admission Category
No data available	No data available

Clinical Comments:	GP actions: Please check HbA1C and TFTs at 3 months. Please check FBC at 6 week check due to blood loss. Diane has not had a smear in over 5 years, we have encouraged her to make an appointment for this in a few months time. Dear Doctor, Please see details below regarding Diane Donald's recent delivery at QEUH. Date and time of delivery: 01/03/2023 09:43 Gestation at delivery: 37+4 Onset of labour: Elective CS Mode of delivery: CS Estimated blood loss: 2.2L Discharge Hb: 94 Number of babies: 1 Sex of baby: Male Birth weight: 2954 kg Feeding: Formula VTE risk assessment: Risk score 5, for 10 days of LMWH post partum Antenatal events: Gestation diabetes on metformin and insulin. Both stopped post-delivery, BMs satisfactory. Reduced fetal movements towards end of pregnancy. Delivery events: Elective C-section, vascular uterus and PPH. Postnatal complications: To continue oral iron for 3 months. Contraception: Patient expressed wish for Nexplanon, but subsequently decided to hold off with a plan to discuss vasectomy with her partner.
Discharge Comments:	
Follow Up:	Yes CMW
Results Awaited:	No
Pharmacist Comments:	

Final Discharge Letter to Follow:	Yes

Yours sincerely,

Allyson CULLEN

Prescription Review
Checked by: Allyson CULLEN (Midwife)
Discharged by: Allyson CULLEN (Midwife)

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

CRAIG LENNOXThe Green Medical Practice,Clydebank Health & Care Centre,,Queens Quay Main Avenue, Clydebank, G81 1BS

Main Switchboard:
Date of Completion: 26-Jan-2023

Dear CRAIG LENNOX,

Name	CHI	DoB	Address
Diane Donald	**1612836909**	**16-Dec-1983**	**27 St. Andrews Way, Clydebank, Dunbartonshire, G81 1BP**

Admitted	Type	Discharged	Destination
25-Jan-2023 03:00	IP	26-Jan-2023	

Specialty	Consultant	Ward	Telephone
Obstetrics	Roberts	QEUH Ward 47 - Obstetrics	

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
There is no data to display.

Last Discharge Review: Julia Manini (7844251 - FY2) on 26 Jan 2023 15:22

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Trimethoprim 200mg tablets	oral	1 tablet twice daily , Fixed Period 7 Day(s) from 26 Jan 2023	Yes				Added

"Added" means this medicine was added to the Clinical Portal record after admission. It does not necessarily mean this medicine was started by the hospital.

Dispensing Comments
There is no data to display.

Withheld Medication:

Date	Withheld Drug Name	Route	Dose	Note	Withheld Reason
There is no data to display.					

Stopped Medication:

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
There is no data to display.					

Reason for Admission and Presenting Complaints	Admission Category
No data available	No data available

Clinical Comments:	
	Dear Colleague Diane Donald, 39F, was admitted to QEUH with abdo pain, palpitations and presumed uterine activity. Diagnosis- UTI BG- P2+0 currently 32+5 weeks. Prev SVD x2 New diagnosis of GDM- diet controlled. Admitted last week with reduced FM. Polyhydramnios on most recent scan. Issues-

[redacted]	CTG normal. Commenced on treatment for UTI Hb 104 Wcc 7.5 CRP 9 Meds- discharged with trimethoprim Follow up- C section booked for 37 weeks. For OP 24 hour tape to investigation 3 weeks history of palpitations, and tachycardia with ectopic beats on the ward. CTG on Monday and clinic next week. Thank you for your ongoing care Obstetrics team QEUH
Discharge Comments:	
Follow Up:	Yes OP 24 hour tape CTG on Monday and clinic next week. C section booked for 37 weeks
Results Awaited:	Yes OP 24 hour tape requested
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Julia MANINI

Prescription Review
Checked by: Heather OHARA (Staff Nurse)
Discharged by: Heather OHARA (Staff Nurse)

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

CRAIG LENNOXThe Green Medical Practice,Clydebank Health & Care Centre,,Queens Quay Main Avenue, Clydebank, G81 1BS

Main Switchboard:
Date of Completion: 20-Jan-2023

Dear CRAIG LENNOX,

Name	CHI	DoB	Address
Diane Donald	**1612836909**	**16-Dec-1983**	**27 St. Andrews Way, Clydebank, Dunbartonshire, G81 1BP**

Admitted	Type	Discharged	Destination
17-Jan-2023 14:04	IP	20-Jan-2023	

Specialty	Consultant	Ward	Telephone
Obstetrics	Roberts	QEUH Ward 48 - Obstetrics	

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
There is no data to display.

Last Discharge Review: Holly MacLean (Holly MacLean - FY1 Aug 18) on 20 Jan 2023 12:16

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
There is no data to display.							

"Added" means this medicine was added to the Clinical Portal record after admission. It does not necessarily mean this medicine was started by the hospital.

Dispensing Comments
There is no data to display.

Withheld Medication:

Date	Withheld Drug Name	Route	Dose	Note	Withheld Reason
There is no data to display.					

Stopped Medication:

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
There is no data to display.					

Reason for Admission and Presenting Complaints	Admission Category
No data available	No data available

Clinical Comments:	Dear Doctor, Diane was admitted to the antenatal ward on 17/01/2023 at 31 weeks pregnant. Diane has had multiple episodes of reduced fetal movements and on this admission was not reassured by CTGs. On admission a scan has shown a baby with a weight over the 90th centile and mild polyhdramnios. A GTT confirmed a diagnosis of GDM. Following her scan Diane was discharged home. She will be seen in daycare for repeat CTG on Monday and then Diabetes ANC on Wednesday. Kind regards Ward 48 QEUH
Discharge Comments:	

Follow Up:	Yes DCU ANC
Results Awaited:	Yes MSSU
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Holly MACLEAN

Prescription Review
Discharged by: Holly MACLEAN (FY1 Aug 18)

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

FRANCESCA IRVINEThe Green Medical Practice,Clydebank Health & Care Centre,,Queens Quay Main Avenue, Clydebank, G81 1BS

Main Switchboard:
Date of Completion: 01-Mar-2022

Dear FRANCESCA IRVINE,

Name	CHI	DoB	Address
Diane Donald	**1612836909**	**16-Dec-1983**	**27 ST ANDREWS WAY, Clydebank, Dunbartonshire, G81 1BP**

Admitted	Type	Discharged	Destination
23-Jan-2022 00:54	IP	23-Jan-2022	

Specialty	Consultant	Ward	Telephone
Respiratory Medicine	Shepherd	QEUH ARU1 Respiratory	

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
There is no data to display.

Last Discharge Review: Kirsty Bisset (Kirsty Bisset - FY2) on 01 Mar 2022 16:31

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
There is no data to display.							

"Added" means this medicine was added to the Clinical Portal record after admission. It does not necessarily mean this medicine was started by the hospital.

Dispensing Comments
There is no data to display.

Withheld Medication:

Date	Withheld Drug Name	Route	Dose	Note	Withheld Reason
There is no data to display.					

Stopped Medication:

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
There is no data to display.					

Reason for Admission and Presenting Complaints	Admission Category
No data available	No data available

Clinical Comments:	This patient is not known to me: I have been asked to write this IDL as I was on shift the day following the patient's discharge. Diagnosis: Undetermined- differential migraine, SAH Background: Normal tension glaucoma Migraine Investigations: CTB: small focal low density lesion lying anteriorly to the left of midline of the pons- unlikely to explain the patient's presenting symptoms, but clarification with MR is recommended in due course; large mucosal polyps in left maxillary antrum.

	This 38 year old female was admitted to ARU1 on 22/1/22 with sudden onset retro-orbital pain with associated vomiting and photophobia. Neurological examination is documented as normal. Visual acuity was unchanged. Ophthalmology did not feel that this was an eye problem. CT brain showed the above. Unfortunately Diane is documented as taking irregular discharge against medical advice on the 23/1/22, prior to neurology discussion. Kind regards, Dr K Bisset IMT1
Discharge Comments:	
Follow Up:	No n/a
Results Awaited:	No
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Kirsty BISSET

Prescription Review
Discharged by: Kirsty BISSET (FY2)

Immediate Discharge Letter

NHS
Greater Glasgow and Clyde

First Issued: 23/02/2013 09:31
Printed: 23/02/2013 09:31
Author: Michael Gillespie

Western Infirmary
Dumbarton Road
Glasgow
G11 6NT

Admitted: 21/02/2013 **Discharged:** 22/02/2013
Discharged To: Home
Ward: L10E
Consultant: MR CHRISTOPHER WILSON, General SurgeryC1
Hospital No: 10631776W **Date Of Birth:** 16/12/1983
CHI: 1612836909

REGISTERED GP

Dr NEIL MURRAY
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

PATIENT

DIANE DONALD
FLAT 2
18 ONSLOW ROAD
CLYDEBANK
G81 2NE

DIAGNOSES	ICD10	PROCEDURES	OPCS4
No diagnoses have been made for this patient		Thyroid lobectomy, N/A, 22/02/2013	B084

MEDICATION

Drug Name	Format	Route	Dose	Admin Times 8	12	14	18	22	PRN/Comment	Course Length	Quantity Dispensed

No medication has been prescribed for this patient.

Pharmacy Comments

FOLLOW UP ARRANGEMENTS

Outpatient Clinic	Consultant	Date
Surgical	MR C -	4 weeks

Outpatient Investigations	Date
No arrangements made	

Community Care	Date	Reason
No arrangements made		

GENERAL COMMENTS
Final discharge letter to follow:

Dear Colleague,

Diane Donald was admitted for elective left thyroid lobectomy on 21/02/13 under Mr Chris Wilson. This went succesfully and post op period was unremarkable. Clinic follow up in 4 weeks.

Yours Sincerely,

Michael Gillespie
FY1 General Surgery

Contact: Michael Gillespie **Designation:** Doctor

This letter has been produced by the NHS Greater Glasgow Incremental Discharge Letter System

Letter to Patient:

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Diane Donald
27 St. Andrews Way
Clydebank
Dunbartonshire
G81 1BP

Main Switchboard: 0141 201 1100
Department: Neurology
Contact Tel: 0141 201 2374
Enquiries to: melanie.birnie@nhs.scot
Letter Date: 20/04/2026
Reference: RKN/CC
Dictated Date: 05/03/2026
Transcribed Date: 18/04/2026

Dear Miss Donald ,

I am pleased to inform you that your recent MRI brain was normal.

Yours sincerely

Dr Ramesha Nekkare

Consultant Neurologist

Electronically Signed: Dr Ramesha Nekkare, Consultant

cc.

Electronically to GP.

Letter to Patient:

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Diane Donald
27 St. Andrews Way
Clydebank
Dunbartonshire
G81 1BP

Main Switchboard:	0141 201 1100
Department:	Obstetrics
Contact Tel:	0141 201 1959
Enquiries to:	Nicola Stewart
Letter Date:	08/04/2025
Reference:	DR/NS
Dictated Date:	18/03/2025
Transcribed Date:	26/03/2025

Dear Diane ,

I am writing to let you know about the results of the 24 hour ECG that you had done in February. This did not show any abnormal heart rhythm. This is a very reassuring test and you do not need to have any further follow up tests regarding this.

Yours sincerely

Dr David Rutherford

Consultant Obstetrician

Electronically Signed: Dr David Rutherford, Consultant

cc. Dr Lennox
The Green Medical Practice Clydebank Health & Care Centre
Queens Quay Main Avenue Clydebank
G81 1BS

Letter to Patient: covid19

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Diane Donald
27 ST ANDREWS WAY
Clydebank
Dunbartonshire
G81 1BP

Main Switchboard:	0141 201 1100
Department:	NEUROSCIENCES & OMFS
Contact Tel:	0141 201 2203
Enquiries to:	WAITING LIST TEAM
Letter Date:	18/03/2022
Reference:	WLT/COVID
Dictated Date:	18/03/2022
Transcribed Date:	18/03/2022

Dear Diane Donald,

UPDATE ON NHS GGC HOSPITAL SERVICES

We are writing to you because you are currently on our outpatient waiting list. We wish to give you an update on our current position.

During the COVID-19 pandemic, hospitals across Scotland had to cancel a large number of appointments. We are sorry this has caused your wait to be extended.

We wish to share with you the current situation for our hospitals and our plans for restarting our services.

Services were stopped during the COVID-19 pandemic for a number of reasons including patient and staff safety, but also to allow many staff to be redeployed to help manage the pandemic. As the spread of COVID-19 slows down, we are beginning to restart services in line with the Scottish Government guidance. However, this will be a very gradual process and it could be some months before we are back at full capacity.

The safety and wellbeing of patients and staff remains our top priority. To ensure the most clinically urgent patients are being seen first, all referrals into services and entries on waiting lists are being carefully reviewed by a consultant or senior nurse.

We are also making changes to the way we provide services. You may be offered a telephone or a video appointment or we may write to you and your GP with advice you can follow. Face-to-face appointments at a hospital will only be offered when the clinician has considered it essential. At this time services may be offered in a limited number of hospitals. This means that you may be asked to attend any hospital in the NHS Greater Glasgow and Clyde area.

We thank you for your patience whilst we work through the recovery from the COVID-19 pandemic.

Kind regards

Neurosciences & Oral and Maxillofacial Department

You can contact us between the hours of 08:45 – 17:00 Monday – Friday, excluding public holidays.

Electronically Signed: ,

cc.

Letter to Patient:

NHS
Greater Glasgow and Clyde

Diane Donald
43 Longden Street
Clydebank
Dunbartonshire
G81 1AG

Western Infirmary
Dumbarton Road
Glasgow
G11 6NT
Main Switchboard: 0141 211 2000

Department: Dermatology
Tel: 0141 211 6259
Enquiries to:

Letter Date: 13/01/2014
Reference: MP/SE
Dictated Date: 07/01/2014
Transcribed Date: 08/01/2014

Dear Diane,

The mole removed from your back showed some atypical features under the microscope but importantly there was no evidence of any skin cancer here and it has been completely removed in any case. The mole which was also removed from your chest area has shown an entirely benign mole as expected.

No further treatment here is necessary on either area and I hope the areas are healing reasonably well and that you are reassured by this.

Kind regards.

Yours sincerely,
Dr Martin Porter
Consultant Dermatologist

Electronically Signed: Dr Martin Porter, Consultant

cc. Dr. F. Irvine
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Case No 7618331 **Case Active** 30/04/2025 07:24 **Case Type** MIU Telephone / Remote Consultation

Patient Diane Donald **Sex** F **D.O.B** 16/12/1983 **Age** 41 years

Current Address
27 St. Andrews Way Clydebank

G81 1BP

Home Address (if currently not at home)

Current Phone: 07393 645082 **Home Phone:** **CHI:** 1612836909

Case Origin **Callers Name** Diane **Callers Tel:**

Own Doctor Lennox,Craig
Surgery The Green Medical Practice Clydebank HC

NHS24 Received By Lauren Wilson (Call Taker Si) () **NHS24 Triage Start** 07:26
NHS24 Triage By Lauren Wilson (Call Taker Si) () **NHS24 Triage End** 07:39
NHS24 Reported Condition **NHS24 Outcome** MIU4
FOOT INJURY 1 DAY

NHS24 Recorded Allergies **NHS24 Recorded Medications** **NHS24 Recorded Medical History**

NHS24 Clinical Summary
Clinical summary created by: Lauren Wilson (Call Taker Si) () [30/04/2025 08:39:44]
Reason for call: FOOT INJURY 1 DAYConfirmed Symptom(s):
Foot injury

Additional details of problem(s):
No heavy bleeding or bleeding currently controlled
Inability to move injured area
Clinical Supervisor: Injuries up to 5 - 7 days can be referred to MIU if required

Symptom(s) not found:
Injury not ???bent??? or ???misshaped???
No complaints of numbness or tingling in affected area
No current fever

Risk Factor(s):
No travel outside Europe in last 21 days or to an affected country

Call Detail(s):

30:04:2025 07:28:13 WILSONL1.. STRUGGLING TO WEIGHTBEAR.. LUMP TO THE SIDE OF THE FOOT GESTATIONAL DIABETES DUE CHECK UP.. A&R CALLER MIU 4 FNC TO ARRANGE..
Outcome: Patient suitable for MIU 4Hr - Flow Hub to arrange

NHS24 Disposition
Accident & Emergency / MIU within 4 Hours

NHS24 NUrse Comments

Reported Condition **Received By** **Received**

TAS Assessment **Assessed By** **TAS Assess Start**
TAS Assess End

Consultation **Consult By** **Consult Start**

Case No 7618331 **Case Active** 30/04/2025 07:24 **Case Type** MIU Telephone / Remote Consultation

Consult End

Examination Details

Clinical Codes

Diagnosis

Treatment

Prescriptions

Follow-up(s)

Case No 6581010 **Case Active** 22/01/2022 17:59 **Case Type** Direct Referral ED

Patient Diane Donald **Sex** F **D.O.B** 16/12/1983 **Age** 38 years
Current Address
27 St. Andrews Way Clydebank

G81 1BP
Current Phone: 07393 645082 **Home Phone:** **CHI:** 1612836909

Case Origin **Callers Name** Diane **Callers Tel:**

Own Doctor Lennox,Craig(023)
Surgery The Green Medical Practice

NHS24 Received By Frances. Tierney (Call Taker SI) ()
NHS24 Triage By Frances. Tierney (Call Taker SI) ()
NHS24 Triage Start 18:00
NHS24 Triage End 18:24
NHS24 Outcome AEP

NHS24 Reported Condition
PAIN IN BOTH EYES- SUDEN ONSET 2 HRS- NO COVID- 19 SYMPTOMS

NHS24 Recorded Allergies **NHS24 Recorded Medications** **NHS24 Recorded Medical History**

NHS24 Clinical Summary
Clinical summary created by: Frances. Tierney (Call Taker SI) () [22/01/2022 18:24:46]
Reason for call: PAIN IN BOTH EYES- SUDEN ONSET 2 HRS- NO COVID- 19 SYMPTOMSConfirmed Symptom(s):
Confirmed eye problem
Eyes light sensitive - no other symptoms
Endpoint Management Selected (CCT)

Symptom(s) not found:
No fever

Call Detail(s):

Clinical supervisor (First Triage): SCN N QUINN
22:01:2022 17:59:38 TIERNEYF.. PT SUFFERS FROM MIGRAINE BUT THIS IS NOT A MIGRAINE- MAKING HER FEEL SICK.. VOMITED X3 IN LAST 30 MINS-.. SUDDEN ONSET PAIN BEHIND EYES-PAIN SCORE 8/10-ONGOING FOR 2 HRS-NO CHANGE-VOMITING STATED 30 MINS AGO- CAN MOBLISE- SHOOTING PAIN FROM SITTING TO STANDING- VOMITED BACK PARAMOL -NO ONE-SIDED WEAKNESS-LIGHT SENSITIVE-.. SUFFERS FROM MIGRAINE ONE PER WEEK & NORMALLY AFFECTS ONE EYE- CURRENTLY UNDER INVESTIGATION FOR GLAUCOMA- ADVISED TO TAKE NORMAL MIGRAINE MEDICATION 40 MINS AFTER LAST VOMIT- WS GIVEN- A&E ASAP TO QEUH..
Outcome: Patient advised to go to A&E

NHS24 Disposition
Accident & Emergency (ASAP)

NHS24 NUrse Comments

Reported Condition **Received By** **Received**

TAS Assessment **Assessed By** **TAS Assess Start** **TAS Assess End**

Consultation **Consult By** **Consult Start** **Consult End**

Examination Details **Clinical Codes**

Case No 6581010 **Case Active** 22/01/2022 17:59 **Case Type**Direct Referral ED

Diagnosis

Treatment

Prescriptions

Follow-up(s)

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Neurology - First Seizure GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral Routine
Date of referral 13-May-2025 **Date sent** 13-May-2025

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address

27 St Andrews Way
CLYDEBANK
G81 1BP

Contact number(s)

Voice: 07393645082
Voice: 07393645082

101036448610M Unique Care Pathway Number: 101036448610M

REGISTERED GP DETAILS

Name	Dr Craig A Lennox		
GMC code	3317044	GP code	05517
Practice name	The Green Medical Practice		
Practice code	40224		

Practice address

Clydebank Health and Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Contact number(s)

Voice: 0141 531 6425
Facsimile: 0141 531 6433
E-mail: ggc.gp40224clinical@nhs.scot

REFERRING GP DETAILS

Name	Dr. Selali Fiamanya		
GMC code	7556728	GP code	99999
Practice name	The Green Medical Practice (40224)		
Practice code	40224		

Practice address

Clydebank Health & Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Contact number(s)

Voice: 0141 531 6425

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: *FIRST SEIZURE*

Comment: Dear Doctor,

Thanks for your review of this patient who had an unwitnessed seizure last night. She described brushing her teeth and feeling not right and then falling to the floor and having convulsions. She did not retain full consciousness however she does remember the sensation of shaking. She then describes 15 minutes of confusion afterwards and remained a big foggy today. She slept on and off all day yesterday. There were no limb or visual neurological symptoms, no tongue biting, no incontinence, she is not on any medications including over the counter medications and does not consume drugs and drinks less than 14 units of alcohol a week. There is also no chest pain or breathing issues before hand. I have booked her in for an ECG and some blood test and explained to him that she must contact the DVLA. Given this likely seizure I would be grateful for your review. Many thanks.

Yours sincerely

Dr Selali Fiamanya GP ST 3

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Gestational diabetes mellitus	-	17-Jan-2023	17-Jan-2023
Headache	possible migraine	09-Aug-2022	09-Aug-2022
Blurred vision NOS	right eye	09-Aug-2022	09-Aug-2022
Coronavirus infection	positive Covid-19	07-Mar-2022	07-Mar-2022
Normal pressure glaucoma	-	30-Nov-2021	30-Nov-2021
Mechanical low back pain	-	08-Sep-2021	08-Sep-2021
Vulnerable child in family	-	31-Aug-2017	31-Aug-2017
Migraine	-	25-Jul-2017	25-Jul-2017
[X]Depressive episode	-	24-Apr-2015	24-Apr-2015
Mechanical low back pain	-	02-Mar-2015	02-Mar-2015
Spontaneous vertex delivery	-	27-Feb-2014	27-Feb-2014
[V]Single live birth	Male 3090	30-Dec-2012	30-Dec-2012
Thyroid nodule	27x22mm left lobe	09-Jun-2010	09-Jun-2010
Psoriasis NOS	-	02-Oct-2008	02-Oct-2008
Overdose of drug	-	06-Jan-2003	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002	19-Sep-2002
Congenital nasal septum deviation	-	04-Sep-2001	04-Sep-2001
Vasomotor rhinitis	-	04-Sep-2001	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Elective caesarean delivery	-	07-Mar-2025	07-Mar-2025
Livebirth	baby boy - 3965g	07-Mar-2025	07-Mar-2025
Patient pregnant	-	29-Aug-2024	29-Aug-2024
Elective caesarean delivery	-	01-Mar-2023	01-Mar-2023

Livebirth	baby boy - 2954kg	01-Mar-2023	01-Mar-2023
Patient pregnant	-	19-Jul-2022	19-Jul-2022
Livebirth	baby girl 3542 grams	27-Feb-2014	27-Feb-2014
Removal of mole of skin by excision	Mole removed from back showed some atypical features - completely excised. Mole from chest area - benign mole	07-Jan-2014	07-Jan-2014
Lobectomy of thyroid gland NEC	-	22-Feb-2013	22-Feb-2013
Patient pregnant NOS	-	15-Oct-2012	15-Oct-2012
Fine needle aspiration NOC	the tissue sample was blood stained and therefore not suitable for full analysis	09-Jun-2010	09-Jun-2010
Ultrasound scan	report stated that there was some internal hypervascularity with some peripheral calcification	09-Jun-2010	09-Jun-2010
Ultrasound scan NEC	there is a 3x2x1.25 cm lesion in the left lobe of thyroid. This contains some peripheral calcification with some areas of cystic degeneration but is largely sol;id	17-Mar-2010	17-Mar-2010
Termination of pregnancy NEC	at 22 weeks	20-Feb-2010	20-Feb-2010
Patient pregnant NOS	-	30-Dec-2009	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009	18-May-2009
Meningitis vaccination	C	16-Nov-1999	16-Nov-1999

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Metformin Hydrochloride M/R tablets 500 mg	112	112 TABLET	ONE TO BE TAKEN DAILY FOR 1 WEEK AND THEN TWICE DAILY SLOWLY INCREASING TO 1G BD AS DIRECTED BY OBSTETRIC TEAM	-	17-Feb-2025	17-Feb-2025
Freestyle Libre 2 Plus Sensor	2	2*1 KIT	TO BE REPLACED EVERY 2-WEEKS. ANY FAULTY SENSORS TO BE REPORTED DIRECTLY TO ABBOT. MAX 26 PER YEAR	-	06-Feb-2025	06-Feb-2025
Wavesense Jazz Test strips	200	4*50 strip	AS DIRECTED	-	30-Jan-2025	30-Jan-2025
Agamatrix Ultra-Thin Lancets 0.2 mm/33 gauge	200	1*200 lancet	AS DIRECTED	-	30-Jan-2025	30-Jan-2025
Aspirin Dispersible tablets 75 mg	112	112 tablet	TWO TABS TO BE TAKEN AT NIGHT UNTIL 36 WEEKS GESTATION - AS PER OBSTETRICS	-	25-Sep-2024	25-Sep-2024
Paracetamol Tablets 500 mg	100	100 tablet	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)	-	09-Sep-2020	10-Sep-2024

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Flucloxacillin Capsules 500 mg	20	20 CAPSULE	ONE TO BE TAKEN FOUR TIMES A DAY FOR 5 DAYS	-	21-Mar-2025	21-Mar-2025
	112	112 tablet		-	14-Feb-2025	

Metformin Hydrochloride Tablets 500 mg			TO BE INCREASED AS PER PLAN GIVEN BY DIABETIC NURSE TEAM TO TWO TABS BD			14-Feb-2025
Clotrimazole Pessary 500 mg	5	5 pessary	ONE TO BE INSERTED AT NIGHT FOR A 5 DAY COURSE	-	16-Jan-2025	16-Jan-2025
Clotrimazole Cream 1 %	20	20 GRAM	APPLY TWO TO THREE TIMES DAILY	-	08-Jan-2025	08-Jan-2025

Blood Pressure

Date Recorded	Systolic	Diastolic
27-Jul-2022	107	72
17-Jun-2021	106	77
19-Jan-2015	113	74
04-Sep-2013	101	67
25-Jul-2013	92	66

Body Measurements

Date Recorded	Height	Weight	BMI
17-Jun-2021	160	68	26.56
22-Mar-2021	-	70.7	27.62
03-Jul-2013	-	58	-
07-Jan-2009	160	58	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		17-Jun-2021
Current smoker :		21-Jan-2016
Current smoker :	- 12/day	26-Jan-2015
Moderate smoker - 10-19 cigs/d :		04-Sep-2013
Current smoker:		27-Feb-2013
Alcohol consumption, 0 units/week:		17-Jun-2021

Clinical warnings

Allergies

Description	Comment	Date recorded
Adverse reaction to Metronidazole	felt sleepy	01-Aug-2016

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Obstetrics - Request for Information GGC Obs Request for Info	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral Not applicable
Date of referral 29-Aug-2024 **Date sent** 29-Aug-2024

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address

27 St Andrews Way
CLYDEBANK
G81 1BP

Contact number(s)

Voice: 07393645082
Voice: 07393645082

101034053163W Unique Care Pathway Number: 101034053163W

REGISTERED GP DETAILS

Name	Dr. Ben Esson		
GMC code	7277405	GP code	00965
Practice name	The Green Medical Practice		
Practice code	40224		

Practice address

Clydebank Health and Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Contact number(s)

Voice: 0141 531 6425
Facsimile: 0141 531 6433
E-mail: ggc.gp40224clinical@nhs.scot

REFERRING GP DETAILS

Name	Dr. Ben Esson		
GMC code	7277405	GP code	00965
Practice name	The Green Medical Practice (40224)		
Practice code	40224		

Practice address

Clydebank Health & Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Contact number(s)

Voice: 0141 531 6425

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint
Description: Pregnancy – Information Request

Reason for referral
Care type requested: Out Patient
Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Gestational diabetes mellitus	-	17-Jan-2023	17-Jan-2023
Headache	possible migraine	09-Aug-2022	09-Aug-2022
Blurred vision NOS	right eye	09-Aug-2022	09-Aug-2022
Coronavirus infection	positive Covid-19	07-Mar-2022	07-Mar-2022
Normal pressure glaucoma	-	30-Nov-2021	30-Nov-2021
Mechanical low back pain	-	08-Sep-2021	08-Sep-2021
Vulnerable child in family	-	31-Aug-2017	31-Aug-2017
Migraine	-	25-Jul-2017	25-Jul-2017
[X]Depressive episode	-	24-Apr-2015	24-Apr-2015
Mechanical low back pain	-	02-Mar-2015	02-Mar-2015
Spontaneous vertex delivery	-	27-Feb-2014	27-Feb-2014
Thyroid nodule	27x22mm left lobe	09-Jun-2010	09-Jun-2010
Psoriasis NOS	-	02-Oct-2008	02-Oct-2008
Overdose of drug	-	06-Jan-2003	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002	19-Sep-2002
Congenital nasal septum deviation	-	04-Sep-2001	04-Sep-2001
Vasomotor rhinitis	-	04-Sep-2001	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Patient pregnant	-	29-Aug-2024	29-Aug-2024
Elective caesarean delivery	-	01-Mar-2023	01-Mar-2023
Livebirth	baby boy - 2954kg	01-Mar-2023	01-Mar-2023
Patient pregnant	-	19-Jul-2022	19-Jul-2022
Livebirth	baby girl 3542 grams	27-Feb-2014	27-Feb-2014
Removal of mole of skin by excision	Mole removed from back showed some atypical features - completely excised. Mole from chest area - benign mole	07-Jan-2014	07-Jan-2014
Lobectomy of thyroid gland NEC	-	22-Feb-2013	22-Feb-2013
Patient pregnant NOS	-	15-Oct-2012	15-Oct-2012
Fine needle aspiration NOC	the tissue sample was blood stained and therefore not suitable for full analysis	09-Jun-2010	09-Jun-2010
Ultrasound scan	report stated that there was some internal hypervascularity with some peripheral calcification	09-Jun-2010	09-Jun-2010
Ultrasound scan NEC	there is a 3x2x1.25 cm lesion in the left lobe of thyroid. This contains some peripheral calcification with some areas of cystic degeneration but is largely sol;id	17-Mar-2010	17-Mar-2010

Termination of pregnancy NEC	at 22 weeks	20-Feb-2010	20-Feb-2010
Patient pregnant NOS	-	30-Dec-2009	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009	18-May-2009
Meningitis vaccination	C	16-Nov-1999	16-Nov-1999

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

No recent medications recorded

Blood Pressure

Date Recorded	Systolic	Diastolic
27-Jul-2022	107	72
17-Jun-2021	106	77
19-Jan-2015	113	74
04-Sep-2013	101	67
25-Jul-2013	92	66

Body Measurements

Date Recorded	Height	Weight	BMI
17-Jun-2021	160	68	26.56
22-Mar-2021	-	70.7	27.62
03-Jul-2013	-	58	-
07-Jan-2009	160	58	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		17-Jun-2021
Current smoker :		21-Jan-2016
Current smoker :	- 12/day	26-Jan-2015
Moderate smoker - 10-19 cigs/d :		04-Sep-2013
Current smoker:		27-Feb-2013
Alcohol consumption, 0 units/week:		17-Jun-2021

Investigations

Description/Question	Result/Comment	Date
Chosen place for Delivery:	Please select	-
Risk Assessment on booking identified in this pregnancy:	Please select	-
Are you aware of any Vulnerability or Child Protection issues in relation to this pregnancy?:	Please select	-

Clinical warnings

Allergies

Description	Comment	Date recorded
Adverse reaction to Metronidazole	felt sleepy	01-Aug-2016

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Referred By:Referring GP
Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

GGC ELECTIVE CSECTION BOOKING FORM (QEUH)

Email completed form to:	CSectionBooking@ggc.scot.nhs.uk		
Patient Name:	diane donald		CHI: 1612836909
Contact Number:	07393645082		
Today's Date: 3/2/23	Consultant:	Summerhill	Referring Clinician: Summerhill
Date range for delivery (Advised date with maximum range for booking)	EARLIEST CS DATE:	28/2/23	To a maximum of: + 3 Days
Obstetric Consultant to do:	Yes ☐ No ☒	Consent form Completed:	Yes ☒ No ☐
If specific consultant to perform CS or specific date required please state date /consultant:			
BMI: 26	Weight: 65 Kg	EDD by scan:	18/03/2023
Additional procedures:	☐ Sterilisation ☐ Intra-uterine device ☐ Other (please name)		
Theatre slot required:	☒ 1 slot ☐ 1.5 slot ☐ 2 slots		
Base Hospital (Please note patient may not always be delivered at 1st choice)	☐ PRM ☒ QEUH ☐ RAH		Hospital delivery (2nd option) ☐ PRM ☐ QEUH ☐ RAH
Clinical History (Risk factors)	Parity: 2		Previous deliveries: No. Previous Sections:
	☐ Diabetic (on insulin) ☐ Steroid Treatment required ☐ Cell Salvage required		
Indication for Section:	maternal request, LGA/poly		Interpreter Required: Yes ☐ No ☐
Additional Information:	GDM MF polyhydramnios 10cm		Language:
Anaesthetic Concerns	no		
Neonatal Concerns	no		
Additional Staff required:	no		
Additional Equipment required:	no		

C Section Referral Form

Women who will require a specific date:

- Women with diabetes (on insulin or metformin) requiring steroids prior to section
- Women with abnormally invasive placenta
- Women with coagulation disorders requiring specific blood products
- Women with fetus with anomaly which requires specific timing of delivery to facilitate neonatal care
- Women who require another surgeon/specialty present at the delivery
- Women with complex issues who have required a MDT

The expectation is that there are 5 slots per day

Table 1: Specific issues requiring additional operating time

1.5 Slot	☐	2 Slots	☐
BMI 45-50	☐	BMI >50	☐
Placenta praevia	☐	>4 previous Caesarean sections	☐
>3 previous Caesarean sections	☐	Abnormally invasive placenta not requiring delivery in main theatres	☐
Previous extensive abdominal surgery	☐	2 items from the 1.5 slot list	☐
Large fibroids >8cm	☐	Laser (Fetal Medicine)	☐
Preterm ≤ 28 weeks	☐	Patient requiring invasive monitoring	☐
Previous difficult section	☐	Cardiac	☐
Cell salvage required	☐	PD case: MDT involvement at birth, fetal airway abnormalities or high multiple triplets and up	☐
Difficult venous access	☐		
Previous difficult regional anaesthesia	☐		
Previous difficult airway	☐		
Severe anxiety or needle phobia requiring gas induction	☐		
Sterilisation/Oopherectomy	☐		

This list is not exhaustive and the clinician must use their judgement to assign slot required

Please remember to review any anaesthetic letters in Portal/Critical Alerts on BadgerNet as extra time may be required for specific anaesthetic issues.

Official use only:	Official use only:
Date received:	Date Section booked:
Date letter to be sent :	Date phone call was made:
Consultant who agreed date change of C/Section:	Consultant who agreed transfer to Other Site:

Please send document as E-mail with PDF attachment to the following email address: CSectionBooking@ggc.scot.nhs.uk

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Obstetrics - Request for Information GGC Obs Request for Info	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral Not applicable
Date of referral 20-Jul-2022 **Date sent** 20-Jul-2022

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address

27 St Andrews Way
CLYDEBANK
G81 1BP

Contact number(s)

Voice: 07393645082
Voice: 07910848712

101026910363R Unique Care Pathway Number: 101026910363R

REGISTERED GP DETAILS

Name	Dr Craig A Lennox		
GMC code	3317044	GP code	05517
Practice name	The Green Medical Practice		
Practice code	40224		

Practice address

Clydebank Health and Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Contact number(s)

Voice: 0141 531 6425
Facsimile: 0141 531 6433
E-mail: ggc.gp40224clinical@nhs.scot

REFERRING GP DETAILS

Name	Dr. Mai MacSorley		
GMC code	7134160	GP code	04791
Practice name	The Green Medical Practice (40224)		
Practice code	40224		

Practice address

Clydebank Health & Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Contact number(s)

Voice: 0141 531 6425

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint
Description: Pregnancy – Information Request

Reason for referral
Care type requested: Out Patient
Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Coronavirus infection	positive Covid-19	07-Mar-2022	07-Mar-2022
Normal pressure glaucoma	-	30-Nov-2021	30-Nov-2021
Mechanical low back pain	-	08-Sep-2021	08-Sep-2021
Vulnerable child in family	-	31-Aug-2017	31-Aug-2017
Migraine	-	25-Jul-2017	25-Jul-2017
[X]Depressive episode	-	24-Apr-2015	24-Apr-2015
Mechanical low back pain	-	02-Mar-2015	02-Mar-2015
Spontaneous vertex delivery	-	27-Feb-2014	27-Feb-2014
Thyroid nodule	27x22mm left lobe	09-Jun-2010	09-Jun-2010
Psoriasis NOS	-	02-Oct-2008	02-Oct-2008
Overdose of drug	-	06-Jan-2003	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002	19-Sep-2002
Vasomotor rhinitis	-	04-Sep-2001	04-Sep-2001
Congenital nasal septum deviation	-	04-Sep-2001	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Patient pregnant	-	19-Jul-2022	19-Jul-2022
Livebirth	baby girl 3542 grams	27-Feb-2014	27-Feb-2014
Removal of mole of skin by excision	Mole removed from back showed some atypical features - completely excised. Mole from chest area - benign mole	07-Jan-2014	07-Jan-2014
Lobectomy of thyroid gland NEC		22-Feb-2013	22-Feb-2013
Patient pregnant NOS	-	15-Oct-2012	15-Oct-2012
Fine needle aspiration NOC	the tissue sample was blood stained and therefore not suitable for full analysis	09-Jun-2010	09-Jun-2010
Ultrasound scan	report stated that there was some internal hypervascularity with some peripheral calcification	09-Jun-2010	09-Jun-2010
Ultrasound scan NEC	there is a 3x2x1.25 cm lesion in the left lobe of thyroid. This contains some peripheral calcification with some areas of cystic degeneration but is largely sol;id	17-Mar-2010	17-Mar-2010
Termination of pregnancy NEC	at 22 weeks	20-Feb-2010	20-Feb-2010
Patient pregnant NOS	-	30-Dec-2009	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009	18-May-2009
Meningitis vaccination	C	16-Nov-1999	16-Nov-1999

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Paracetamol Tablets 500 mg	100	100 tablet	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS).	-	09-Sep-2020	09-Jun-2022
Sumatriptan Succinate Tablets 50 mg	12	12 tablet	ONE TO BE TAKEN AT ONSET OF MIGRAINE; DOSE MAY BE REPEATED AT LEAST TWO HOURS LATER IF ATTACK RECURS	-	09-Sep-2020	09-Jun-2022
Naproxen Tablets 500 mg	56	56 TABLET	ONE TO BE TAKEN TWICE A DAY IF NEEDED FOR MIGRAINE	-	09-Sep-2020	09-Jun-2022

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Co-Dydramol 10/500 Tablets	50	50 tablet	2 TABS UP TO 4 X DAILY FOR SEVERE	-	17-Jun-2022	17-Jun-2022

Blood Pressure

Date Recorded	Systolic	Diastolic
17-Jun-2021	106	77
19-Jan-2015	113	74
04-Sep-2013	101	67
25-Jul-2013	92	66
03-Jul-2013	92	65

Body Measurements

Date Recorded	Height	Weight	BMI
17-Jun-2021	160	68	26.56
22-Mar-2021	-	70.7	27.62
03-Jul-2013	-	58	-
07-Jan-2009	160	58	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		17-Jun-2021
Current smoker :		21-Jan-2016
Current smoker :	- 12/day	26-Jan-2015
Moderate smoker - 10-19 cigs/d :		04-Sep-2013
Current smoker:		27-Feb-2013
Alcohol consumption, 0 units/week:		17-Jun-2021

Investigations

Description/Question	Result/Comment	Date
Are you aware of any Vulnerability or Child Protection issues in relation to this pregnancy?:	Not Known	-

Clinical warnings

Allergies

Description	Comment	Date recorded
Adverse reaction to Metronidazole	felt sleepy	01-Aug-2016

Additional Support Needs

No known ASN requirements

Additional relevant information
Administrative information
OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Referred By:Referring GP
Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Referral letter: Referral

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Neurology Services:
Institute of Neurological Sciences:
Queen Elizabeth University Hospital:
1345 Govan Road:
G51 4TF:
Glasgow:

Main Switchboard: 0141 201 1100
Department: Neurosurgery
Contact Tel: 0141 201 2021
Enquiries to: jo.sinclair@ggc.scot.nhs.uk
Letter Date: 06/07/2022
Reference: AG/RM
Dictated Date: 01/07/2022
Transcribed Date: 05/07/2022

Dear Consultant Neurologist,

Diane Donald; D.O.B: 16/12/1983; CHI: 1612836909
27 ST ANDREWS WAY, Clydebank, Dunbartonshire, G81 1BP

I am wondering if you could kindly agree to review this 38 year old lady who presents with bifrontal headaches with features of throbbing headache since January and most recently she has complained of intermittent lose of vision of the right side associated with new eye orbital pain. I am wondering if she could be seen for these headaches and visual symptoms. It is interesting that the original CT brain scan showed a vague abnormality on the left side of the pons but on a recent MR head from 12th of February 2022 there were normal intracranial appearances and normal appearance of the pons with the comments of the findings of the proceeding CT were artefactual.

Yours sincerely,

Mr Athanasios Grivas

Consultant Neurosurgeon

Electronically Signed: Mr Athanasios Grivas, Consultant

cc. Dr CA Lennox
The Green Medical Practice
Clydebank Health & Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Referral letter: Referral

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Neurology Services:
Institute of Neurological Sciences:
Queen Elizabeth University Hospital:
1345 Govan Road:
G51 4TF:
Glasgow:

Main Switchboard:	0141 201 1100
Department:	Neurosurgery
Contact Tel:	0141 201 2021
Enquiries to:	jo.sinclair@ggc.scot.nhs.uk
Letter Date:	06/07/2022
Reference:	AG/RM
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Dear Consultant Neurologist,

Diane Donald; D.O.B: 16/12/1983; CHI: 1612836909
27 ST ANDREWS WAY, Clydebank, Dunbartonshire, G81 1BP

I am wondering if you could kindly agree to review this 38 year old lady who presents with bifrontal headaches with features of throbbing headache since January and most recently she has complained of intermittent lose of vision of the right side associated with new eye orbital pain. I am wondering if she could be seen for these headaches and visual symptoms. It is interesting that the original CT brain scan showed a vague abnormality on the left side of the pons but on a recent MR head from 12th of February 2022 there were normal intracranial appearances and normal appearance of the pons with the comments of the findings of the proceeding CT were artefactual.

Yours sincerely,

Mr Athanasios Grivas

Consultant Neurosurgeon

Electronically Signed: Mr Athanasios Grivas, Consultant

cc. Dr CA Lennox
The Green Medical Practice
Clydebank Health & Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Neurosurgery GGC General Referral	—	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	—	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral Routine
Date of referral 17-Mar-2022 **Date sent** 17-Mar-2022

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address

27 St Andrews Way
CLYDEBANK
G81 1BP

Contact number(s)

Voice: 07393645082
Voice: 07910848712

101025838929Y Unique Care Pathway Number: 101025838929Y

REGISTERED GP DETAILS

Name	Dr Craig A Lennox		
GMC code	3317044	GP code	05517
Practice name	The Green Medical Practice		
Practice code	40224		

Practice address

Clydebank Health and Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Contact number(s)

Voice: 0141 531 6425
Facsimile: 0141 531 6433
E-mail: ggc.gp40224clinical@nhs.scot

REFERRING GP DETAILS

Name	Dr. Craig Lennox		
GMC code	3317044	GP code	05517
Practice name	The Green Medical Practice (40224)		
Practice code	40224		

Practice address

Clydebank Health & Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Contact number(s)

Voice: 0141 531 6425

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: *

Comment: Dear Doctor,

I would be grateful if you could review this 38 year old woman who if you please refer to the immediate discharge letter from 23rd January 2022 when she was admitted because of sudden onset with bilateral eye pain with a previous background of normal tensive glaucoma and migraine.

CT brain showed a small focal low density lesion lying anteriorly to the left mid-line of the pawns and clarification of MRI was recommended. Unfortunately she took her own discharge before that seemingly was arranged with neurosurgery so I would be grateful if you could follow this brain abnormality and consider with her MRI as suggested as recommended.

Many thanks indeed.

Yours sincerely

Dr Craig Lennox GP

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Coronavirus infection	positive Covid-19	07-Mar-2022	07-Mar-2022
Normal pressure glaucoma	-	30-Nov-2021	30-Nov-2021
Mechanical low back pain	-	08-Sep-2021	08-Sep-2021
Vulnerable child in family	-	31-Aug-2017	31-Aug-2017
Migraine	-	25-Jul-2017	25-Jul-2017
[X]Depressive episode	-	24-Apr-2015	24-Apr-2015
Mechanical low back pain	-	02-Mar-2015	02-Mar-2015
Spontaneous vertex delivery	-	27-Feb-2014	27-Feb-2014
Thyroid nodule	27x22mm left lobe	09-Jun-2010	09-Jun-2010
Psoriasis NOS	-	02-Oct-2008	02-Oct-2008
Overdose of drug	-	06-Jan-2003	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002	19-Sep-2002
Vasomotor rhinitis	-	04-Sep-2001	04-Sep-2001
Congenital nasal septum deviation	-	04-Sep-2001	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Livebirth	baby girl 3542 grams	27-Feb-2014	27-Feb-2014
Removal of mole of skin by excision	Mole removed from back showed some atypical features - completely excised. Mole from chest area - benign mole	07-Jan-2014	07-Jan-2014
Lobectomy of thyroid gland NEC	-	22-Feb-2013	22-Feb-2013
Patient pregnant NOS	-	15-Oct-2012	15-Oct-2012
Ultrasound scan	report stated that there was some internal hypervascularity with some peripheral calcification	09-Jun-2010	09-Jun-2010
Fine needle aspiration NOC	the tissue sample was blood stained and therefore not suitable for full analysis	09-Jun-2010	09-Jun-2010

Ultrasound scan NEC	there is a 3x2x1.25 cm lesion in the left lobe of thyroid. This contains some peripheral calcification with some areas of cystic degeneration but is largely sol;id	17-Mar-2010	17-Mar-2010
Termination of pregnancy NEC	at 22 weeks	20-Feb-2010	20-Feb-2010
Patient pregnant NOS	-	30-Dec-2009	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009	18-May-2009
Meningitis vaccination	C	16-Nov-1999	16-Nov-1999

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Sumatriptan Succinate Tablets 50 mg	12	12 tablet	ONE TO BE TAKEN AT ONSET OF MIGRAINE; DOSE MAY BE REPEATED AT LEAST TWO HOURS LATER IF ATTACK RECURS	-	09-Sep-2020	20-Jul-2021
Naproxen Tablets 500 mg	56	56 TABLET	ONE TO BE TAKEN TWICE A DAY IF NEEDED FOR MIGRAINE	-	09-Sep-2020	20-Jul-2021

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Hydrocortisone Cream 0.5 %	15	15 gram	AAPLY ONCE DAILY	-	06-Oct-2021	06-Oct-2021

Blood Pressure

Date Recorded	Systolic	Diastolic
17-Jun-2021	106	77
19-Jan-2015	113	74
04-Sep-2013	101	67
25-Jul-2013	92	66
03-Jul-2013	92	65

Body Measurements

Date Recorded	Height	Weight	BMI
17-Jun-2021	160	68	26.56
22-Mar-2021	-	70.7	27.62
03-Jul-2013	-	58	-
07-Jan-2009	160	58	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		17-Jun-2021
Current smoker :		21-Jan-2016
Current smoker :	- 12/day	26-Jan-2015
Moderate smoker - 10-19 cigs/d :		04-Sep-2013
Current smoker:		27-Feb-2013
Alcohol consumption, 0 units/week:		17-Jun-2021

Clinical warnings

Allergies

Description	Comment	Date recorded
Adverse reaction to Metronidazole	felt sleepy	01-Aug-2016

Additional Support Needs
No known ASN requirements

Additional relevant information
Administrative information
OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Referred By:Referring GP
Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments
Ophthalmology - DD OCT LE
Ophthalmology - C_HENSON9000_DATA_FLD8images_donald_135405_20-10-2021_09-11-07
Ophthalmology - DD OCT RE
Ophthalmology - C_HENSON9000_DATA_FLD8images_donald_135405_27-10-2021_09-19-01

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Ophthalmology - General Ophthalmology GGC General (optom use only)	——	**Consultant / receiving practitioner** and/or **specialty clinic**
West Glasgow 1053 Great Western Road Glasgow G12 0YN	——	**Hospital** and **hospital address** Hospital location code. G516H Email address -

Urgency of referral Urgent
Date of referral 03-Nov-2021 **Date sent** 03-Nov-2021

PATIENT DETAILS

Surname	DONALD
Forename(s)	DIANE
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-
Reference:	-

Patient's address
27 ST ANDREWS WAY
CLYDEBANK
G81 1BP

Contact number(s)
Voice: 07393645082

**** Patient does consent to send past medical history and drug history via SCI Gateway to the Hospital indicated **.**

101024759000Y
Unique Care Pathway Number: 101024759000Y

REFERRING HCP DETAILS

HCP Name	SamanthaMcNeil
HCP code	01-29426
HCP Position	-
Organisation name	Specsavers Opticians (21468)
Location code	-

Organisation address
1 - 3 BRITANNIA WAY
CLYDEBANK
GLASGOW
G81 2RZ

Contact number(s)
Voice: 0141 951 8822

OPTOMETRY INFORMATION

Diagnosis	-	**Treatment Instigated**	-	**Treatment**	-

Right	Ocular Examination - External/Internal	Left
Please find comments below under **Administrative information.**		Please find comments below under **Administrative information.**

Applanation Tonometry **R** 18 mmhg **L** 19 mmhg **RAPD** No **Fields Attached** Yes

Time 09: 05 **Applanation** Yes

Vision	Sph	Cyl	Axis	Prism	VA	PH VA	Add	NVA	Test Date
R	-0.00	+0.25	110	----	6/6-2	-	-	N5	03-Nov-2021
L	-0.00	--	-	----	6/6-1	-	-	N5	
								Images Attached	Yes

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Optometrist Direct Referral

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

No recent medications recorded

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information
Administrative information

Comment Right:mild MGD
otherwise ext eye healthy
lens clear
floaters in vitreous
Macula clear
Fundus clear and intact
ONH healthy

Comment Left:mild MGD
otherwise ext eye healthy
lens clear
floaters in vitreous
Macula clear
Fundus clear and intact
ONH healthy

Patient History and Details:Diane attended for an EE after being triaged r.e. floaters , on first visit all tests were normal and retinal detachement etc ruled out, px then called back saying getting "visual disturbances" and still seeing floaters so seen again. Again all tests were normal but px reporting pain on motility in RE and new photophobia. Px also missed a few random points on her full threshold fields (which I attached), we assumed migraine but she returned 1 week later still with same problems e.g. pain on motility in RE and photophobia and on repeat full threshold fields missed points again (attached).

Can you investigate further for 2nd opinion as no indication of any ocular problems to us but px has symptoms coupled with random VF loss.

Previous Attendance at Hospital Eye Service?:No

If Yes, Location:(Not Known)

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient consent:Yes

Ophthalmology - DD OCT LE
Ophthalmology -

Signature of referring doctor (or other professional) **Date**

C:\HENSON9000\DATA\FLD8images\donald_135405_20-10-2021_09-11-07
Ophthalmology - DD OCT RE
Ophthalmology - C:\HENSON9000\DATA\FLD8images\donald_135405_27-10-2021_09-19-01

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

General Surgery - Breast GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
West Glasgow 1053 Great Western Road Glasgow G12 0YN	——	**Hospital** and **hospital address** Hospital location code. G516H Email address -

Urgency of referral Urgent
Date of referral 10-Apr-2018 **Date sent** 10-Apr-2018

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address

43 Longden St
Whitecrook
CLYDEBANK
G81 1AG

Contact number(s)

Voice: 07910848712
Voice: 07910848712

101015853033T Unique Care Pathway Number: 101015853033T

REGISTERED GP DETAILS

Name	Dr. Francesca Irvine		
GMC code	7020160	GP code	09687
Practice name	The Green Medical Practice		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425
Facsimile: 0141 531 6433

REFERRING GP DETAILS

Name	Dr. Francesca Irvine		
GMC code	7020160	GP code	09687
Practice name	The Green Medical Practice (40224)		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: ** HARD AREA OF TISSUE LEFT BREAST **

Comment: Dear colleagues,

I would be grateful for your review of this 34 year old lady who over the last month to 6 weeks has noticed a firm area within the left breast. When she lies on her right side her partner can just about see the area protruding slightly. This is non tender and she has not noticed any other abnormalities.

On examination I could palpate a soft swelling arising from the lateral aspect of her left breast which to me did feel like prominence of the normal breast tissue and I could not palpate any enlarged lymph nodes.

I explained my findings to the patient however she remained concerned and was keen to see yourselves for more specialist review. I have therefore agreed to do this on this occasion but hoped there would be nothing on towards here.

Many thanks in advance.

Kind regards,

Dr F Irvine GP

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Vulnerable child in family	-	31-Aug-2017	31-Aug-2017
[X]Depressive episode	-	24-Apr-2015	24-Apr-2015
Mechanical low back pain	-	02-Mar-2015	02-Mar-2015
Spontaneous vertex delivery	-	27-Feb-2014	27-Feb-2014
Thyroid nodule	27x22mm left lobe	09-Jun-2010	09-Jun-2010
Psoriasis NOS	-	02-Oct-2008	02-Oct-2008
Overdose of drug	-	06-Jan-2003	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002	19-Sep-2002
Vasomotor rhinitis	-	04-Sep-2001	04-Sep-2001
Congenital nasal septum deviation	-	04-Sep-2001	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Livebirth	baby girl 3542 grams	27-Feb-2014	27-Feb-2014
Removal of mole of skin by excision	Mole removed from back showed some atypical features - completely excised. Mole from chest area - benign mole	07-Jan-2014	07-Jan-2014
Lobectomy of thyroid gland NEC	-	22-Feb-2013	22-Feb-2013
Patient pregnant NOS	-	15-Oct-2012	15-Oct-2012
Ultrasound scan	report stated that there was some internal hypervascularity with some peripheral calcification	09-Jun-2010	09-Jun-2010
Fine needle aspiration NOC	the tissue sample was blood stained and therefore not suitable for full analysis	09-Jun-2010	09-Jun-2010
Ultrasound scan NEC	there is a 3x2x1.25 cm lesion in the left lobe of thyroid. This contains some peripheral calcification with some areas of cystic degeneration but is largely sol;id	17-Mar-2010	17-Mar-2010

Termination of pregnancy NEC	at 22 weeks	20-Feb-2010	20-Feb-2010
Patient pregnant NOS	-	30-Dec-2009	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3.	18-May-2009	18-May-2009
Meningitis vaccination	C	16-Nov-1999	16-Nov-1999

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

No recent medications recorded

Blood Pressure

Date Recorded	Systolic	Diastolic
19-Jan-2015	113	74
04-Sep-2013	101	67
25-Jul-2013	92	66
03-Jul-2013	92	65
25-Jun-2012	107	71

Body Measurements

Date Recorded	Height	Weight	BMI
03-Jul-2013	-	58	-
07-Jan-2009	160	58	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker :		21-Jan-2016
Current smoker :	- 12/day	26-Jan-2015
Moderate smoker - 10-19 cigs/d :		04-Sep-2013
Current smoker:		27-Feb-2013
Current smoker :	Attended for flu vaccine and repevax. Repevax BN H0353-2 Exp 04/14 given IM (L) deltoid. Imuvac BN A03 Exp 05/13 given IM (R) deltoid. Consent forms completed for both vaccines.	15-Oct-2012

Clinical warnings

Allergies

Description	Comment	Date recorded
Adverse reaction to Metronidazole	felt sleepy	01-Aug-2016

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Gynaecology - General GGC Gynae Gen Ref	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral Routine
Date of referral 01-Aug-2016 **Date sent** 03-Aug-2016

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address

43 Longden St
CLYDEBANK
G81 1AG

Contact number(s)

Voice: 07833226267
Voice: 07833226267

101011864892E | Unique Care Pathway Number: 101011864892E

REGISTERED GP DETAILS

Name	Dr. Francesca Irvine		
GMC code	7020160	GP code	09687
Practice name	The Green Medical Practice		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425
Facsimile: 0141 531 6433

REFERRING GP DETAILS

Name	Dr. Francesca Irvine		
GMC code	7020160	GP code	09687
Practice name	The Green Medical Practice (40224)		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: ** ABNORMAL BLEEDING **

Comment: Dear Colleagues,

I would be most grateful for your review of this 32 year old lady who was referred to yourselves back in February due to abnormal vaginal bleeding which had really just started around this time despite having had the implant in place for 2 years with amenorrhoea during this time. Prior to insertion of the implant her periods were normal. I believe however, that Diane did not make the appointment that was sent to her and she now returns to the surgery describing ongoing irregular bleeding essentially since February of this year and is now experiencing postcoital bleeding in addition. She had an ultrasound performed in February at the Golden Jubilee which was normal. Diane also describes bad cramps associated with the bleeding which is unusual for her although no abnormal discharge. Her last smear was in February of this year and was negative although it is to be repeated in 12 months.

Examination revealed no areas of tenderness or masses on bimanual examination and speculum examination revealed a healthy vulva, vagina and cervix.

Swabs were obtained which were negative for chlamydia and gonorrhoea but did show a mixed anaerobe infection sensitive to Metronidazole.

Diane is keen to consider the coil and although her bleeding may well be due to her implant because it is a clear change for her I felt she warranted further investigation particularly before we entertained the possibility of inserting a coil instead. I would therefore be most grateful for your further review.

Kind regards

Dr F Irvine GP

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
[X]Depressive episode	-	24-Apr-2015	24-Apr-2015
Mechanical low back pain	-	02-Mar-2015	02-Mar-2015
Spontaneous vertex delivery	-	27-Feb-2014	27-Feb-2014
Thyroid nodule	27x22mm left lobe	09-Jun-2010	09-Jun-2010
Psoriasis NOS	-	02-Oct-2008	02-Oct-2008
Overdose of drug	-	06-Jan-2003	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002	19-Sep-2002
Congenital nasal septum deviation	-	04-Sep-2001	04-Sep-2001
Vasomotor rhinitis	-	04-Sep-2001	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Livebirth	baby girl 3542 grams	27-Feb-2014	27-Feb-2014
Removal of mole of skin by excision	Mole removed from back showed some atypical features - completely excised. Mole from chest area - benign mole	07-Jan-2014	07-Jan-2014
Lobectomy of thyroid gland NEC	-	22-Feb-2013	22-Feb-2013
Patient pregnant NOS	-	15-Oct-2012	15-Oct-2012
Ultrasound scan	report stated that there was some internal hypervascularity with some peripheral calcification	09-Jun-2010	09-Jun-2010

Fine needle aspiration NOC	the tissue sample was blood stained and therefore not suitable for full analysis	09-Jun-2010	09-Jun-2010
Ultrasound scan NEC	there is a 3x2x1.25 cm lesion in the left lobe of thyroid. This contains some peripheral calcification with some areas of cystic degeneration but is largely sol;id	17-Mar-2010	17-Mar-2010
Termination of pregnancy NEC	at 22 weeks	20-Feb-2010	20-Feb-2010
Patient pregnant NOS	-	30-Dec-2009	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009	18-May-2009
Meningitis vaccination	C	16-Nov-1999	16-Nov-1999

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Metronidazole Tablets 400 mg	21	21 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	27-Jul-2016	27-Jul-2016
Trimethoprim Tablets 200 mg	6	6 TABLET	ONE TO BE TAKEN TWICE A DAY	-	21-Jul-2016	21-Jul-2016
Norethisterone Tablets 5 mg	30	30 TABLET	TAKE ONE THREE TIMES A DAY	-	13-Jul-2016	13-Jul-2016
Mefenamic Acid Tablets 500 mg	28	28 tablet	TAKE ONE THREE TIMES A DAY	-	12-Jul-2016	12-Jul-2016
Citalopram Hydrobromide Tablets 10 mg	28	28 tablet	ONE TO BE TAKEN EACH DAY	-	13-Jun-2016	13-Jun-2016
Citalopram Hydrobromide Tablets 20 mg	28	28 tablet	ONE TO BE TAKEN DAILY	-	13-Jun-2016	13-Jun-2016
Citalopram Hydrobromide Tablets 10 mg	28	28 tablet	ONE TO BE TAKEN EACH DAY	-	25-Apr-2016	25-Apr-2016
Citalopram Hydrobromide Tablets 20 mg	28	28 tablet	ONE TO BE TAKEN DAILY	-	25-Apr-2016	25-Apr-2016
Citalopram Hydrobromide Tablets 10 mg	28	28 tablet	ONE TO BE TAKEN EACH DAY	-	17-Mar-2016	17-Mar-2016
Citalopram Hydrobromide Tablets 20 mg	28	28 tablet	ONE TO BE TAKEN DAILY	-	17-Mar-2016	17-Mar-2016

Blood Pressure

Date Recorded	Systolic	Diastolic
19-Jan-2015	113	74
04-Sep-2013	101	67
25-Jul-2013	92	66
03-Jul-2013	92	65
25-Jun-2012	107	71

Body Measurements

Date Recorded	Height	Weight	BMI
03-Jul-2013	-	58	-
07-Jan-2009	160	58	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker :		21-Jan-2016
Current smoker :	- 12/day	26-Jan-2015
Moderate smoker - 10-19 cigs/d :		04-Sep-2013
Current smoker:		27-Feb-2013
Current smoker :	Attended for flu vaccine and repevax. Repevax BN H0353-2 Exp 04/14 given IM (L) deltoid. Imuvac BN A03 Exp 05/13 given IM (R) deltoid. Consent forms completed for both vaccines.	15-Oct-2012

Clinical warnings

Allergies

Description	Comment	Date recorded
Adverse reaction to Metronidazole	felt sleepy	01-Aug-2016

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Gynaecology - General GGC Gynae Gen Ref	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address

Urgency of referral Routine
Date of referral 22-Feb-2016 **Date sent** 24-Feb-2016

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address

43 Longden St
CLYDEBANK
G81 1AG

Contact number(s)

Voice: 07833226267
Voice: 07833226267

101010877170V Unique Care Pathway Number: 101010877170V

REGISTERED GP DETAILS

Name	Dr. Aileen Stenhouse		
GMC code	4706393	GP code	95702
Practice name	The Green Medical Practice		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425
Facsimile: 0141 531 6433

REFERRING GP DETAILS

Name	Dr. Aileen Stenhouse		
GMC code	4706393	GP code	95702
Practice name	The Green Medical Practice (40224)		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: ** 3 WEEK HISTORY OF PV BLEEDING **

Comment: Dear Doctor,

This 32 year old lady has a contraceptive implant in place and has had for past 2 years. She has never had any problems with bleeding as her periods stopped when she had the implant fitted and prior to this her periods were normal. However for the past 3 weeks she has had daily PV bleeding and a feeling of her stomach being bloated. She does not describe any PV discharge and has not been sexually active for the past couple of years and there is no history of post-coital bleeding. She has had 1 previous smear dyskaryosis smear result in 2009 but it was normal in 2011.

On examination she was very tender over at the left adnexa and her cervix looked normal and i checked a smear and chlamydia swab (chlamydia swab has returned as normal). After being examined she found that her bleeding became significantly heavier with flooding and clots and a significant increase in her abdominal pain although this settled after a couple of days with some Mefenamic Acid.

I suspect her bleeding may well be a simple side effect of her contraceptive implant however trying her on the combined pill is not an option as she has a history of Migraine and i wondered if you would review her with her inter-menstrual bleeding with pain and tenderness on examination.

I would be grateful for your opinion.

Yours sincerely,

Dr Aileen Stenhouse.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
[X]Depressive episode	-	24-Apr-2015	24-Apr-2015
Mechanical low back pain	-	02-Mar-2015	02-Mar-2015
Spontaneous vertex delivery	-	27-Feb-2014	27-Feb-2014
Thyroid nodule	27x22mm left lobe	09-Jun-2010	09-Jun-2010
Psoriasis NOS	-	02-Oct-2008	02-Oct-2008
Overdose of drug	-	06-Jan-2003	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002	19-Sep-2002
Congenital nasal septum deviation	-	04-Sep-2001	04-Sep-2001
Vasomotor rhinitis	-	04-Sep-2001	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Livebirth	baby girl 3542 grams	27-Feb-2014	27-Feb-2014
Removal of mole of skin by excision	Mole removed from back showed some atypical features - completely excised. Mole from chest area - benign mole	07-Jan-2014	07-Jan-2014
Lobectomy of thyroid gland NEC	-	22-Feb-2013	22-Feb-2013
Patient pregnant NOS	-	15-Oct-2012	15-Oct-2012
Ultrasound scan	report stated that there was some internal hypervascularity with some peripheral calcification	09-Jun-2010	09-Jun-2010
Fine needle aspiration NOC	the tissue sample was blood stained and therefore not suitable for full analysis	09-Jun-2010	09-Jun-2010

Ultrasound scan NEC	there is a 3x2x1.25 cm lesion in the left lobe of thyroid. This contains some peripheral calcification with some areas of cystic degeneration but is largely sol;id	17-Mar-2010	17-Mar-2010
Termination of pregnancy NEC	at 22 weeks	20-Feb-2010	20-Feb-2010
Patient pregnant NOS	-	30-Dec-2009	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009	18-May-2009
Meningitis vaccination	C	16-Nov-1999	16-Nov-1999

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Mefenamic Acid Tablets 500 mg	28	28 tablet	TAKE ONE THREE TIMES A DAY	-	11-Feb-2016	11-Feb-2016
Nifedipine Capsules 5 mg	84	84 capsule	ONE TO BE TAKEN THREE TIMES A DAY	-	08-Feb-2016	08-Feb-2016
Citalopram Hydrobromide Tablets 20 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	08-Feb-2016	08-Feb-2016
Norethisterone Tablets 5 mg	30	30 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	01-Feb-2016	02-Feb-2016
Citalopram Hydrobromide Tablets 20 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	19-Nov-2015	14-Dec-2015

Blood Pressure

Date Recorded	Systolic	Diastolic
19-Jan-2015	113	74
04-Sep-2013	101	67
25-Jul-2013	92	66
03-Jul-2013	92	65
25-Jun-2012	107	71

Body Measurements

Date Recorded	Height	Weight	BMI
03-Jul-2013	-	58	-
07-Jan-2009	160	58	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker :		21-Jan-2016
Current smoker :	- 12/day	26-Jan-2015
Moderate smoker - 10-19 cigs/d :		04-Sep-2013
Current smoker:		27-Feb-2013
Current smoker :	Attended for flu vaccine and repevax. Repevax BN H0353-2 Exp 04/14 given IM (L) deltoid. Imuvac BN A03 Exp 05/13 given IM (R) deltoid. Consent forms completed for both vaccines.	15-Oct-2012

Clinical warnings

Additional Support Needs
No known ASN requirements

Additional relevant information
Administrative information
OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Vascular Surgery
Gartnavel General Hospital
1053 Great Western Road
Glasgow G12 0YN

29/01/2016

DR F Irvine
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Dear Dr F Irvine

Patient Name: Miss Diane Donald
CHI Number: 1612836909
Referral Date: 29/01/2016

Thank you for your referral. On this occasion I am unable to offer a consultation to your patient.

Please see the following reasons.

( ) Please refer to the referral guidance directory for referral criteria for this service.

http://www.staffnet.ggc.scot.nhs.uk/Info%20Centre/PoliciesProcedures/GGC%20Referral%20Guidance/Pages/GGCReferralGuidance.aspx

( ) Insufficient clinical information to allow specialty to triage referral.

Enter free text here
Full letter to follow
( ) Other

Enter free text here

Yours sincerely

Mr Paul Teenan

User ID Paul Teenan

SCGC Opwl Rem Ref Hosp Req V1

Vascular Surgery
Gartnavel General Hospital
1053 Great Western Road
Glasgow G12 0YN

29/01/2016

DR F Irvine
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Dear Dr F Irvine

Patient Name: Miss Diane Donald
CHI Number: 1612836909
Referral Date: 29/01/2016

Thank you for your referral. On this occasion I am unable to offer a consultation to your patient.

Please see the following reasons.

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( ) Insufficient clinical information to allow specialty to triage referral.

Enter free text here
Full letter to follow
( ) Other

Enter free text here

Yours sincerely

Mr Paul Teenan

User ID Paul Teenan

SCGC Opwl Rem Ref Hosp Req V1

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Vascular Surgery GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Western Infirmary/Gartnavel General Dumbarton Road Glasgow G11 6NT	——	**Hospital** and **hospital address** Hospital location code. G516H Email address -

Urgency of referral Routine
Date of referral 28-Jan-2016 **Date sent** 28-Jan-2016

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address

43 Longden St
CLYDEBANK
G81 1AG

Contact number(s)

Voice: 07833226267
Voice: 07833226267

101010732177V

Unique Care Pathway Number: 101010732177V

REGISTERED GP DETAILS

Name	Dr Craig A Lennox		
GMC code	3317044	GP code	05517
Practice name	The Green Medical Practice		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425
Facsimile: 0141 531 6433

REFERRING GP DETAILS

Name	Dr Julia Park GP Locum		
GMC code	7036987	GP code	G87018
Practice name	-		
Practice code	40224		

Practice address

Contact number(s)

-

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: ** COLD TOES **

Comment: Many thanks for reviewing this lady in the clinic. She had been discussing with her friends regarding her cold toes that she has had on and off for well over a year and they advised she may need some investigations. She is a lady who doesn't complain of any hand coldness nor change of colour but has always had problems with her toes turning white particularly in the cold. She has tried heated socks and various things like this with no benefit.

On examination her feet are warm with good dorsalis pedis pulses on both sides although I struggled to feel the posterior tibial pulse on both sides. However, her toes are certainly a little paler and quite a bit colder compared to the rest of her foot. We did bloods to look in to this and her ESR was only 2. She continues to have problems and is now getting quite distressed with the pain that she gets in her feet. I wonder if you would be kind enough to see just to see whether any further investigations of treatment is required.

Many thanks.

Yours sincerely

Dr J Park GP Locum

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
[X]Depressive episode	-	24-Apr-2015	24-Apr-2015
Mechanical low back pain	-	02-Mar-2015	02-Mar-2015
Spontaneous vertex delivery	-	27-Feb-2014	27-Feb-2014
Thyroid nodule	27x22mm left lobe	09-Jun-2010	09-Jun-2010
Psoriasis NOS	-	02-Oct-2008	02-Oct-2008
Overdose of drug	-	06-Jan-2003	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002	19-Sep-2002
Congenital nasal septum deviation	-	04-Sep-2001	04-Sep-2001
Vasomotor rhinitis	-	04-Sep-2001	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Livebirth	baby girl 3542 grams	27-Feb-2014	27-Feb-2014
Removal of mole of skin by excision	Mole removed from back showed some atypical features - completely excised. Mole from chest area - benign mole	07-Jan-2014	07-Jan-2014
Lobectomy of thyroid gland NEC	-	22-Feb-2013	22-Feb-2013
Patient pregnant NOS	-	15-Oct-2012	15-Oct-2012
Ultrasound scan	report stated that there was some internal hypervascularity with some peripheral calcification	09-Jun-2010	09-Jun-2010
Fine needle aspiration NOC	the tissue sample was blood stained and therefore not suitable for full analysis	09-Jun-2010	09-Jun-2010
Ultrasound scan NEC	there is a 3x2x1.25 cm lesion in the left lobe of thyroid. This contains some peripheral calcification with some areas of cystic degeneration but is largely sol;id	17-Mar-2010	17-Mar-2010
Termination of pregnancy NEC	at 22 weeks	20-Feb-2010	20-Feb-2010

Patient pregnant NOS	-	30-Dec-2009	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009	18-May-2009
Meningitis vaccination	C	16-Nov-1999	16-Nov-1999

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Citalopram Hydrobromide Tablets 20 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	19-Nov-2015	14-Dec-2015
Salicylic Acid Solution 26 %	10	10 ML	APPLY TO THE WART/VERRUCA DAILY	-	04-Sep-2015	04-Sep-2015
Citalopram Hydrobromide Tablets 40 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	24-Aug-2015	24-Aug-2015

Blood Pressure

Date Recorded	Systolic	Diastolic
19-Jan-2015	113	74
04-Sep-2013	101	67
25-Jul-2013	92	66
03-Jul-2013	92	65
25-Jun-2012	107	71

Body Measurements

Date Recorded	Height	Weight	BMI
03-Jul-2013	-	58	-
07-Jan-2009	160	58	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker :		21-Jan-2016
Current smoker :	- 12/day	26-Jan-2015
Moderate smoker - 10-19 cigs/d :		04-Sep-2013
Current smoker:		27-Feb-2013
Current smoker :	Attended for flu vaccine and repevax. Repevax BN H0353-2 Exp 04/14 given IM (L) deltoid. Imuvac BN A03 Exp 05/13 given IM (R) deltoid. Consent forms completed for both vaccines.	15-Oct-2012

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Urology GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Western Infirmary/Gartnavel General Dumbarton Road Glasgow G11 6NT	——	**Hospital** and **hospital address** Hospital location code. G516H Email address -

Urgency of referral Routine
Date of referral 28-Jan-2016 **Date sent** 28-Jan-2016

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address

43 Longden St
CLYDEBANK
G81 1AG

Contact number(s)

Voice: 07833226267
Voice: 07833226267

101010729424V Unique Care Pathway Number: 101010729424V

REGISTERED GP DETAILS

Name	Dr Craig A Lennox		
GMC code	3317044	GP code	05517
Practice name	The Green Medical Practice		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425
Facsimile: 0141 531 6433

REFERRING GP DETAILS

Name	Dr Julia Park GP Locum		
GMC code	7036987	GP code	G87018
Practice name	-		
Practice code	40224		

Practice address

Contact number(s)

-

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: ** COLD TOES **

Comment: Many thanks for reviewing this lady in the clinic. She had been discussing with her friends regarding her cold toes that she has had on and off for well over a year and they advised she may need some investigations. She is a lady who doesn't complain of any hand coldness nor change of colour but has always had problems with her toes turning white particularly in the cold. She has tried heated socks and various things like this with no benefit.

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Many thanks.

Yours sincerely

Dr J Park GP Locum

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
[X]Depressive episode	-	24-Apr-2015	24-Apr-2015
Mechanical low back pain	-	02-Mar-2015	02-Mar-2015
Spontaneous vertex delivery	-	27-Feb-2014	27-Feb-2014
Thyroid nodule	27x22mm left lobe	09-Jun-2010	09-Jun-2010
Psoriasis NOS	-	02-Oct-2008	02-Oct-2008
Overdose of drug	-	06-Jan-2003	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002	19-Sep-2002
Congenital nasal septum deviation	-	04-Sep-2001	04-Sep-2001
Vasomotor rhinitis	-	04-Sep-2001	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Livebirth	baby girl 3542 grams	27-Feb-2014	27-Feb-2014
Removal of mole of skin by excision	Mole removed from back showed some atypical features - completely excised. Mole from chest area - benign mole	07-Jan-2014	07-Jan-2014
Lobectomy of thyroid gland NEC	-	22-Feb-2013	22-Feb-2013
Patient pregnant NOS	-	15-Oct-2012	15-Oct-2012
Ultrasound scan	report stated that there was some internal hypervascularity with some peripheral calcification	09-Jun-2010	09-Jun-2010
Fine needle aspiration NOC	the tissue sample was blood stained and therefore not suitable for full analysis	09-Jun-2010	09-Jun-2010
Ultrasound scan NEC	there is a 3x2x1.25 cm lesion in the left lobe of thyroid. This contains some peripheral calcification with some areas of cystic degeneration but is largely sol;id	17-Mar-2010	17-Mar-2010
Termination of pregnancy NEC	at 22 weeks	20-Feb-2010	20-Feb-2010

Patient pregnant NOS	-	30-Dec-2009	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009	18-May-2009
Meningitis vaccination	C	16-Nov-1999	16-Nov-1999

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Citalopram Hydrobromide Tablets 20 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	19-Nov-2015	14-Dec-2015
Salicylic Acid Solution 26 %	10	10 ML	APPLY TO THE WART/VERRUCA DAILY	-	04-Sep-2015	04-Sep-2015
Citalopram Hydrobromide Tablets 40 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	24-Aug-2015	24-Aug-2015

Blood Pressure

Date Recorded	Systolic	Diastolic
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25-Jun-2012	107	71

Body Measurements

Date Recorded	Height	Weight	BMI
03-Jul-2013	-	58	-
07-Jan-2009	160	58	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker :		21-Jan-2016
Current smoker :	- 12/day	26-Jan-2015
Moderate smoker - 10-19 cigs/d :		04-Sep-2013
Current smoker:		27-Feb-2013
Current smoker :	Attended for flu vaccine and repevax. Repevax BN H0353-2 Exp 04/14 given IM (L) deltoid. Imuvac BN A03 Exp 05/13 given IM (R) deltoid. Consent forms completed for both vaccines.	15-Oct-2012

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Dermatology GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Western Infirmary/Gartnavel General Dumbarton Road Glasgow G11 6NT	——	**Hospital** and **hospital address** Hospital location code. G516H Email address -

Urgency of referral URGENT
Date of referral 28-Oct-2013 **Date sent** 28-Oct-2013

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address

43 Longden St
CLYDEBANK
G81 1AG

Contact number(s)

Voice: 07833226267
Voice: 07833226267

101006176493E Unique Care Pathway Number: 101006176493E

REGISTERED GP DETAILS

Name	Dr. Francesca Irvine		
GMC code	7020160	GP code	99999
Practice name	The Green Medical Practice (18818)		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425
Facsimile: 0141 531 6433

REFERRING GP DETAILS

Name	Dr. Francesca Irvine		
GMC code	7020160	GP code	99999
Practice name	The Green Medical Practice (40224)		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: ** CHANGES TO 2 PIGMENTED LESIONS AT CHEST AREA **

Comment: Dear Doctor,

I would be grateful if you could arrange to see this 29 year old lady who is currently 22 weeks pregnant. She came with 2 moles that she was concerned about. One is at the upper portion of her left breast which was always present as a papillomatous pigmented lesion and in the last few weeks has developed a brown speck of pigment at the edge of the lesion as well as on the surface and in addition to this has started bleeding without any trauma being inflicted to it. In addition to this it has become more painful. The one on her back has been noted by others and is very dark and has quite an irregular border. She is unsure whether this has changed or whether it has always been like this.

Diane has no previous history of melanoma or skin cancers but has used sunbeds for many years in the past and also burnt on multiple occasions as a youngster.

I would therefore be most grateful for your review.

Kind regards,

Dr F Irvine GP ST3.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Thyroid nodule	27x22mm left lobe	09-Jun-2010	09-Jun-2010
Psoriasis NOS	-	02-Oct-2008	02-Oct-2008
Overdose of drug	-	06-Jan-2003	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002	19-Sep-2002
Vasomotor rhinitis	-	04-Sep-2001	04-Sep-2001
Congenital nasal septum deviation	-	04-Sep-2001	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Lobectomy of thyroid gland NEC	-	22-Feb-2013	22-Feb-2013
Patient pregnant NOS	-	15-Oct-2012	15-Oct-2012
Ultrasound scan	report stated that there was some internal hypervascularity with some peripheral calcification	09-Jun-2010	09-Jun-2010
Fine needle aspiration NOC	the tissue sample was blood stained and therefore not suitable for full analysis	09-Jun-2010	09-Jun-2010
Ultrasound scan NEC	there is a 3x2x1.25 cm lesion in the left lobe of thyroid. This contains some peripheral calcification with some areas of cystic degeneration but is largely sol;id	17-Mar-2010	17-Mar-2010
Blood grouping	Rh(D) positive	20-Feb-2010	20-Feb-2010
Termination of pregnancy NEC	at 22 weeks	20-Feb-2010	20-Feb-2010
Patient pregnant NOS	-	30-Dec-2009	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009	18-May-2009

Meningitis vaccination	C	16-Nov-1999	16-Nov-1999

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Amoxicillin Capsules 500 mg	21	21 capsule	ONE TO BE TAKEN THREE TIMES A DAY	-	04-Sep-2013	04-Sep-2013
Ferrous Fumarate Tablets 210 mg	168	168 TABLET	ONE TO BE TAKEN TWO OR THREE TIMES DAILY (OR ONE TO BE TAKEN ONCE OR TWICE DAILY FOR PROPHYLAXIS)	-	30-Jul-2013	30-Jul-2013
Folic Acid Tablets 400 micrograms	90	90 tablet	ONE TO BE TAKEN EACH DAY	-	03-Jul-2013	03-Jul-2013

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Moderate smoker - 10-19 cigs/d:		04-Sep-2013
Current smoker:		27-Feb-2013
Current smoker:	Attended for flu vaccine and repevax. Repevax BN H0353-2 Exp 04/14 given IM (L) deltoid. Imuvac BN A03 Exp 05/13 given IM (R) deltoid. Consent forms completed for both vaccines.	15-Oct-2012
Current smoker, 0 per day:		15-Oct-2012
Current smoker:		20-Apr-2012

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Obstetrics GGC Obstetrics	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Southern General Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral ROUTINE
Date of referral 09-Jul-2013 **Date sent** 10-Jul-2013

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address

43 Longden St
CLYDEBANK
G81 1AG

Contact number(s)

Voice: 07833226267

101005626780M Unique Care Pathway Number: 101005626780M

REGISTERED GP DETAILS

Name	Dr Craig A Lennox		
GMC code	3317044	GP code	05517
Practice name	The Green Medical Practice (18818)		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank

Contact number(s)

Voice: 0141 531 6425
Facsimile: 0141 531 6433

REFERRING GP DETAILS

Name	Dr R Dhillon GP Locum.		
GMC code	6115441	GP code	G87018
Practice name	-		
Practice code	40224		

Practice address

Contact number(s)

-

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Pregnant

Comment: Dear Doctor,

I would be grateful if you could share the care of this 29 year old lady who is approx 6 weeks gestation with her LMP unknown. However she had intercourse on the 1st June 2013 since the birth of her child 6 months ago. She denied any PV bleeding or any abdominal pain. No nausea, vomiting or any mastalgia. A pregnancy test was carried out twice which was positive. She is 6 months post natal and is pregnant. She was initially quite concerned about the pregnancy but has decided to carry on with the pregnancy ultimately.

On examination her weight was 58kg, blood pressure was 92/65, abdomen was soft and non-tender.

I have given her the usual pregnancy care advice and I have started her on Folic Acid.

Yours sincerely,

Dr R Dhillon GP Locum.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Thyroid nodule	27x22mm left lobe	09-Jun-2010	09-Jun-2010
Psoriasis NOS	-	02-Oct-2008	02-Oct-2008
Overdose of drug	-	06-Jan-2003	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002	19-Sep-2002
Congenital nasal septum deviation	-	04-Sep-2001	04-Sep-2001
Vasomotor rhinitis	-	04-Sep-2001	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Lobectomy of thyroid gland NEC	-	22-Feb-2013	22-Feb-2013
Patient pregnant NOS	-	15-Oct-2012	15-Oct-2012
Ultrasound scan	report stated that there was some internal hypervascularity with some peripheral calcification	09-Jun-2010	09-Jun-2010
Fine needle aspiration NOC	the tissue sample was blood stained and therefore not suitable for full analysis	09-Jun-2010	09-Jun-2010
Ultrasound scan NEC	there is a 3x2x1.25 cm lesion in the left lobe of thyroid. This contains some peripheral calcification with some areas of cystic degeneration but is largely sol;id	17-Mar-2010	17-Mar-2010
Blood grouping	Rh(D) positive	20-Feb-2010	20-Feb-2010
Termination of pregnancy NEC	at 22 weeks	20-Feb-2010	20-Feb-2010
Patient pregnant NOS	-	30-Dec-2009	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009	18-May-2009
Meningitis vaccination	C	16-Nov-1999	16-Nov-1999

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Folic Acid Tablets 400 micrograms	90	90 tablet	ONE TO BE TAKEN EACH DAY	-	03-Jul-2013	03-Jul-2013

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		27-Feb-2013
Current smoker:	Attended for flu vaccine and repevax. Repevax BN H0353-2 Exp 04/14 given IM (L) deltoid. Imuvac BN A03 Exp 05/13 given IM (R) deltoid. Consent forms completed for both vaccines.	15-Oct-2012
Current smoker, 0 per day:		15-Oct-2012
Current smoker:		20-Apr-2012
Ex smoker:	Recorded through Combined Vaccination priority=2	07-Jan-2010

Investigations

Description/Question	Result/Comment	Date
Are you aware of any Vulnerability or Child Protection issues in relation to this pregnancy?:	Not Known	-

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Obstetrics GGC Obstetrics	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Southern General Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral ROUTINE
Date of referral 30-Apr-2012 **Date sent** 02-May-2012

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address

17-7 Ashtree Court
Old Kilpatrick
GLASGOW
G60 5JD

Contact number(s)

Voice: 07791041354

101003556733K Unique Care Pathway Number: 101003556733K

REGISTERED GP DETAILS

Name	Dr G Robertson		
GMC code	4188977	GP code	G87018
Practice name	The Green Medical Practice (18818)		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425
Facsimile: 0141 531 6433

REFERRING GP DETAILS

Name	Dr G Robertson		
GMC code	4188977	GP code	G87018
Practice name	-		
Practice code	40224		

Practice address

Contact number(s)

-

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Pregnant

Comment: Dear Doctor

Diane finds herself pregnant. Her LMP was almost exactly four weeks ago. She is para 0+1 having had a T.O.P at 22 weeks in 2010. Her past medical history includes a benign thyroid nodule, psoriasis but more importantly she had CIN III at colposcopy in 2009 treated with LLETZ. She was supposed to get six monthly smears but has never attended for this. She is a current smoker but plans to quite today. I have given her folic acid, advised her about flu vaccinations when they are back in the practice this autumn and would be very grateful if she could get an appointment for her booking scan.

Many thanks

Dr G Robertson

Reason for referral

Care type requested: Out Patient

Expected outcome: Investigate

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Thyroid nodule	27x22mm left lobe	09-Jun-2010	09-Jun-2010
Psoriasis NOS	-	02-Oct-2008	02-Oct-2008
Overdose of drug	-	06-Jan-2003	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002	19-Sep-2002
Congenital nasal septum deviation	-	04-Sep-2001	04-Sep-2001
Vasomotor rhinitis	-	04-Sep-2001	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Patient pregnant	-	20-Apr-2012	20-Apr-2012
Ultrasound scan	report stated that there was some internal hypervascularity with some peripheral calcification	09-Jun-2010	09-Jun-2010
Fine needle aspiration NOC	the tissue sample was blood stained and therefore not suitable for full analysis	09-Jun-2010	09-Jun-2010
Ultrasound scan NEC	there is a 3x2x1.25 cm lesion in the left lobe of thyroid. This contains some peripheral calcification with some areas of cystic degeneration but is largely sol;id	17-Mar-2010	17-Mar-2010
Blood grouping	Rh(D) positive	20-Feb-2010	20-Feb-2010
Termination of pregnancy NEC	at 22 weeks	20-Feb-2010	20-Feb-2010
Patient pregnant NOS	-	30-Dec-2009	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009	18-May-2009
Meningitis vaccination	C	16-Nov-1999	16-Nov-1999

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Folic Acid Tablets 400 micrograms	90	90 tablet	ONE TO BE TAKEN EACH DAY	-	20-Apr-2012	20-Apr-2012

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		20-Apr-2012
Ex smoker:	Recorded through Combined Vaccination priority=2	07-Jan-2010
Ex smoker:	Disease: SPICE Basic Health Values, priority=2	01-Jan-2009
Current smoker:	Disease: SPICE Basic Health Values, priority=2	22-Oct-2008
Current smoker:	priority=2	22-Oct-2008

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

NHS
Greater Glasgow and Clyde

Western Infirmary – Dumbarton Road – Glasgow G11 6NT

Endocrine Unit
Professor A F Dominiczak
Dr A R McLellan /Dr M Freel
Dr G C Jones /Dr C Sainsbury
Dr C Perry / Dr R Lindsay

Karen.Campbell3@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]
Donna.Grant@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]

Gill.Mitan@ggc.scot.nhs.uk
Emma.Nairne@ggc.scot.nhs.uk [Secretaries] ☎ : *0141-211-2737*

DR ROBERT LINDSAY'S THYROID CLINIC

RL/CD

26th April 2012

SURGERY
SVR COMEND

Mr C Wilson
Consultant Surgeon
Western Infirmary
Glasgow
G11 6NT

Dear Mr Wilson

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
17/7 Ashtree Court, Old Kilpatrick, Glasgow, G60 5JD

I would be grateful if this lady with a 27mm nodule left lobe of thyroid might be seen. As detailed it is stable, not causing particular concern but she is wishing to pursue whether it might be removed.

Yours sincerely

DR ROBERT LINDSAY
Consultant in Diabetes & Endocrinology

Western Infirmary – Dumbarton Road – Glasgow G11 6NT

Endocrine Unit
Professor A F Dominiczak
Dr A R McLellan /Dr M Freel
Dr G C Jones /Dr C Sainsbury
Dr C Perry / Dr R Lindsay

Karen.Campbell3@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]
Donna.Grant@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]

Gill.Mitan@ggc.scot.nhs.uk
Emma.Nairne@ggc.scot.nhs.uk [Secretaries] ☎ : *0141-211-2737*

DR ROBERT LINDSAY'S THYROID CLINIC – 29/03/2012

RL/CD 26/04/2012

Dr Neil Murray
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Dear Dr Murray

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
17/7 Ashtree Court, Old Kilpatrick, Glasgow, G60 5JD

Diagnosis: 1. 27x22mm nodule left lobe of thyroid stable on ultrasound from June 2010

I saw Diane Donald back in clinic. She has a partially cystic nodule in the thyroid that was ultrasounded in June of 2010 and again in January 2012. There has been no significant change over that time in size. The appearances are benign. She has had two FNA's which both unfortunately are non-contributory showing blood (Thy 1). I had a long discussion with her. I have been very reassuring that given the length of time that we have shown this to be stable I think it highly unlikely there is any major disease going on and I would be content discharging her today and not having any further imaging or fine needle aspiration. She remains somewhat concerned by the appearance of the nodule & would like to discuss with one of the surgeons as to the possibility of having it removed. For that reason I will refer her on to Mr Wilson.

Yours sincerely

DR ROBERT LINDSAY
Consultant in Diabetes & Endocrinology

Copy to:-

Mr C Wilson
Consultant Surgeon
Western Infirmary
Glasgow
G11 6NT

NHS
Greater Glasgow and Clyde

Western Infirmary – Dumbarton Road – Glasgow G11 6NT

Endocrine Unit
Professor A F Dominiczak
Dr A R McLellan /Dr M Freel
Dr G C Jones /Dr C Sainsbury
Dr C Perry / Dr R Lindsay

Karen.Campbell3@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]
Donna.Grant@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]

Gill.Mitan@ggc.scot.nhs.uk
Emma.Nairne@ggc.scot.nhs.uk [Secretaries] ☎ : *0141-211-2737*

DR ROBERT LINDSAY'S THYROID CLINIC

RL/CD

26th April 2012

SURGEON
SVR COMEND

Mr C Wilson
Consultant Surgeon
Western Infirmary
Glasgow
G11 6NT

Dear Mr Wilson

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
17/7 Ashtree Court, Old Kilpatrick, Glasgow, G60 5JD

I would be grateful if this lady with a 27mm nodule left lobe of thyroid might be seen. As detailed it is stable, not causing particular concern but she is wishing to pursue whether it might be removed.

Yours sincerely

DR ROBERT LINDSAY
Consultant in Diabetes & Endocrinology

NHS
Greater Glasgow and Clyde

Western Infirmary – Dumbarton Road – Glasgow G11 6NT

Endocrine Unit
Professor A F Dominiczak
Dr A R McLellan /Dr M Freel
Dr G C Jones /Dr C Sainsbury
Dr C Perry / Dr R Lindsay

Karen.Campbell3@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]
Donna.Grant@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]

Gill.Mitan@ggc.scot.nhs.uk
Emma.Nairne@ggc.scot.nhs.uk [Secretaries] ☎ : *0141-211-2737*

DR ROBERT LINDSAY'S THYROID CLINIC - 29/03/2012

RL/CD 26/04/2012

Dr Neil Murray
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Dear Dr Murray

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
17/7 Ashtree Court, Old Kilpatrick, Glasgow, G60 5JD

Diagnosis: 1. 27x22mm nodule left lobe of thyroid stable on ultrasound from June 2010

I saw Diane Donald back in clinic. She has a partially cystic nodule in the thyroid that was ultrasounded in June of 2010 and again in January 2012. There has been no significant change over that time in size. The appearances are benign. She has had two FNA's which both unfortunately are non-contributory showing blood (Thy 1). I had a long discussion with her. I have been very reassuring that given the length of time that we have shown this to be stable I think it highly unlikely there is any major disease going on and I would be content discharging her today and not having any further imaging or fine needle aspiration. She remains somewhat concerned by the appearance of the nodule & would like to discuss with one of the surgeons as to the possibility of having it removed. For that reason I will refer her on to Mr Wilson.

Yours sincerely

DR ROBERT LINDSAY
Consultant in Diabetes & Endocrinology

Copy to:-

Mr C Wilson
Consultant Surgeon
Western Infirmary
Glasgow
G11 6NT

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Endocrinology GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Western Infirmary/Gartnavel General Dumbarton Road Glasgow G11 6NT	——	**Hospital** and **hospital address** Hospital location code. G516H Email address -

Urgency of referral ROUTINE
Date of referral 15-Nov-2011 **Date sent** 17-Nov-2011

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address

17-7 Ashtree Court
Old Kilpatrick
GLASGOW
G60 5JD

Contact number(s)

Voice: 07791041354

101002806988A

Unique Care Pathway Number: 101002806988A

REGISTERED GP DETAILS

Name	Dr. Alan McDevitt		
GMC code	3069987	GP code	02992
Practice name	The Green Medical Practice (18818)		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425
Facsimile: 0141 531 6433

REFERRING GP DETAILS

Name	Dr. Alan McDevitt		
GMC code	3069987	GP code	02992
Practice name	The Green Medical Practice (40224)		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: LOST TO FOLLOW UP ~ THYROID CYST

Comment: Dear Doctor

This lady is known to have a left thyroid cyst which has previously been investigated. She appears to have been lost to follow up and now reports an enlargement in the neck cyst. I would be grateful if you could review to assess whether further investigation is worthwhile.

Many thanks

Dr A McDevitt

Reason for referral

Care type requested: Out Patient

Expected outcome: Investigate

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Thyroid nodule	1.27x22mm left lobe	09-Jun-2010	09-Jun-2010
Psoriasis NOS	-	02-Oct-2008	02-Oct-2008
Overdose of drug	-	06-Jan-2003	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002	19-Sep-2002
Vasomotor rhinitis	-	04-Sep-2001	04-Sep-2001
Congenital nasal septum deviation	-	04-Sep-2001	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Fine needle aspiration NOC	the tissue sample was blood stained and therefore not suitable for full analysis	09-Jun-2010	09-Jun-2010
Ultrasound scan	report stated that there was some internal hypervascularity with some peripheral calcification	09-Jun-2010	09-Jun-2010
Ultrasound scan NEC	there is a 3x2x1.25 cm lesion in the left lobe of thyroid. This contains some peripheral calcification with some areas of cystic degeneration but is largely sol;id	17-Mar-2010	17-Mar-2010
Termination of pregnancy NEC	at 22 weeks	20-Feb-2010	20-Feb-2010
Blood grouping	Rh(D) positive	20-Feb-2010	20-Feb-2010
Patient pregnant NOS	-	30-Dec-2009	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009	18-May-2009
Meningitis vaccination	C	16-Nov-1999	16-Nov-1999

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

No recent medications recorded

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex smoker:	Recorded through Combined Vaccination priority=2	07-Jan-2010
Ex smoker:	Disease: SPICE Basic Health Values, priority=2	01-Jan-2009
Current smoker:	Disease: SPICE Basic Health Values, priority=2	22-Oct-2008
Current smoker:	priority=2	22-Oct-2008
Current smoker:	Disease: SPICE Basic Health Values, priority=2	23-Mar-2006

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments
Endocrinology - 15032010_Result_101275
Endocrinology - 15032010_Result_101276
Endocrinology - 17032010_Results_102192

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Endocrinology GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Western Infirmary/Gartnavel General Dumbarton Road Glasgow G11 6NT	——	**Hospital** and **hospital address** Hospital location code. G516H Email address -

Urgency of referral URGENT
Date of referral 24-Mar-2010 **Date sent** 25-Mar-2010

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address
3-1 804 Dumbarton Rd
DALMUIR
CLYDEBANK
G81 4BA

Contact number(s)
Voice: 07791041354

101000327752X

Unique Care Pathway Number: 101000327752X

REGISTERED GP DETAILS

Name	Dr. Neil Murray		
GMC code	4253981	GP code	04073
Practice name	The Green Medical Practice		
Practice code	40224		

Practice address
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)
Voice: 0141 531 6425
Facsimile: 0141 531 6433

REFERRING GP DETAILS

Name	Dr. Neil Murray		
GMC code	4253981	GP code	04073
Practice name	CLYDEBANK HEALTH CENTRE (40224)		

Practice address
KILBOWIE ROAD
CLYDEBANK

Contact number(s)

Practice code	40224	Voice: 0141-531-6425

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: AS PER ENCLOSED ULTRASOUND LEFT THYROID LUMP FOR CONSIDERATION OF FNA BIPOSY

Comment: Dear Doctor

I would be grateful if you could see this lady in your clinic. She had noted a lump on the left side of her neck which felt as if it was related to her thyroid. I checked her FBC which was normal, her ESR was 6 and her thyroid function was normal and I enclose all the results of these together with an ultrasound which confirms a 3.0 cm x 2.0 cm x 1.5 cm lesion on the left lobe of the thyroid with some areas of cystic degeneration but largely solid. As you can see from the enclosed report they recommended referral to your clinic for FNA biopsy of this.

Many thanks for your urgent attention with this

Dr N Murray

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset
Psoriasis NOS	-	02-Oct-2008
Overdose of drug	-	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002
Congenital nasal septum deviation	-	04-Sep-2001
Vasomotor rhinitis	-	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed
Blood grouping	Rh(D) positive	20-Feb-2010
Termination of pregnancy NEC	at 22 weeks	20-Feb-2010
Patient pregnant NOS	-	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009
1st hepatitis A vaccination	ATYAB02OAJ exp 10-2009	14-Nov-2008
Meningitis vaccination	C	16-Nov-1999
Tuberculosis (BCG) vaccination	-	20-Sep-1996

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Micronor	84 x 2	TABS	1 Tab	Daily	15-Mar-2010	-
Amoxicillin	21	CAPS 250MG	1 Cap	3 times daily	05-Feb-2010	-
Epaderm Emollient	1	500g Pump	use often	-	20-Jan-2010	-
Folic Acid	90	TABS 400MICROGRAMS	1 Tab	Daily	09-Dec-2009	-

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex smoker:	Recorded through Combined Vaccination	07-Jan-2010
Ex smoker:		01-Jan-2009
Current smoker:		22-Oct-2008
Current smoker:		22-Oct-2008
Current smoker:		23-Mar-2006

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:Yes

Endocrinology - 15032010 Result 101275

Endocrinology - 15032010 Result 101276

Endocrinology - 17032010 Results 102192

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Obstetrics GGC Obstetrics	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Mother's Hospital Yorkhill Dalnair Street Glasgow G3 8SJ	——	**Hospital** and **hospital address** Hospital location code. G515H Email address -

Urgency of referral ROUTINE
Date of referral 15-Dec-2009 **Date sent** 22-Dec-2009

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address

804 Dumbarton Road
Flat 3/1
Dalmuir
CLYDEBANK
G81 4BA

Contact number(s)

Voice: 07791041354

1010000630265 | Unique Care Pathway Number: 1010000630265

REGISTERED GP DETAILS

Name	Dr CA Lennox		
GMC code	3317044	GP code	G05517
Practice name	The Green Medical Practice		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425
Facsimile: 0141 531 6433

REFERRING GP DETAILS

Name	Dr D Morrison GP Locum		
GMC code	6128586	GP code	G87018
Practice name	-		
Practice code	40224		

Practice address

Contact number(s)

-

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Pregnant

Comment: Dear Doctor

This 25 year old saw me yesterday having four positive pregnancy tests. She is on the oral contraceptive pill and last had a bleed in September the 18th but really wasn't sure when her LMP was. She was unsure about whether to proceed with the pregnancy or not but has had a scan somewhere and has been told that she is 12 weeks pregnant. It seems she is now keen to proceed with the pregnancy. She has had no previous pregnancies. She is an ex-smoker. I have started her on folic acid.

We are happy to share her care.

Reason for referral

Care type requested: Out Patient

Expected outcome: Investigate

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset
Psoriasis NOS	-	02-Oct-2008
Overdose of drug	-	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002
Congenital nasal septum deviation	-	04-Sep-2001
Vasomotor rhinitis	-	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009
1st hepatitis A vaccination	ATYAB02OAJ exp 10-2009	14-Nov-2008
Meningitis vaccination	C	16-Nov-1999
Tuberculosis (BCG) vaccination	-	20-Sep-1996

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Calcipotriol	120	OINT 50MCG/G	Apply sparingly	Twice daily	01-May-2009	-

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Folic Acid	90	TABS 400MICROGRAMS	1 Tab	Daily	09-Dec-2009	-
Diclofenac Sodium	84	Ec TABS 50MG	1 Tab	3 times daily	24-Aug-2009	-
Co-Codamol	100	30mg/500mg TABS	1 or 2 Tabs	4 times daily	24-Aug-2009	-

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question Result/Comment Date

Ex smoker:	01-Jan-2009
Current smoker:	22-Oct-2008
Current smoker:	22-Oct-2008
Current smoker:	23-Mar-2006
Current smoker:	20-Mar-2003

Clinical warnings

Additional Support Needs
No known ASN requirements

Additional relevant information
Administrative information
OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

South Glasgow Hospitals

Department of Anaesthesia

Obstetric Anaesthesia/Analgesia

NHS Greater Glasgow and Clyde

SURNAME

FORENAME

UNIT NO.

AGE 41

WARD

1612836909
DONALD
Diane
16/12/198
27 St. Andrews Way
Clydebank, Dunbartonshire
G81 1BJ

DATE 07/03/25

PRE-OP INSTRUCTIONS

SIA

Pre-operative notes

1x vent
1x SVD
1 x CJ - PPH > 2L - spinal ok.
GDM
Bladder retention
24hr tape - ST/SUES.
P+V CA - Thyroidectomy

CONSENT / RISKS DISCUSSED Seen with

Technique Spinal USIA	☑	Info card read	☐
Failure / Inadequate	☑	↓ BP	☑
Motor block	☑	Headache	☑
Nerve Injury	☑	Infection	☑
Total Spinal	☐	All the above	☐
Epidural Haematoma/Paralysis	☑		

AIRWAY
MP2 Moine
Jaw R

CURRENT MEDICATION
Metformin Aspirin.
NSAIDS: OK

ASA GRADE 1 (2) 3 4 5 E

C. SECTION CATEGORY 1 2 3 (4)

ALLERGIES
NKDA

PARA
3+1

WEEKS
39+2

Hb 127
WBC 9·7
PLATELETS 196.
DATE 6/3/25

OTHER RESULTS
MASL 2520
OPOS

HEIGHT (M) 1.62
WEIGHT (KG) 73
BMI 28
PRE-OP BP

POST-OPERATIVE INSTRUCTIONS AND NOTES

Time of first post-operative dose of LMWH: 1500

Time of first post-operative dose of long acting opiate: 1800/0600

BM in recovery please

PROCEDURE PERFORMED

PCB + BTL - Spinal anaesthetic

PROBLEMS FOR FUTURE REFERENCE

ANAESTHETIST

Sign: Aed Print: BALLANTYNE

If Trainee: Consultant Present ☐ Informed ☐ Not Informed ☐

SURGEON

Dr Richmond

Continuous epidural analgesia record

Technique details

Asepsis ☐ Sitting Lateral 16G/18G Level ☐

LOR to Air/Saline at ☐ cm. Catheter ☐ cm at skin

Aspiration:

Comments:

ANAESTHETIST

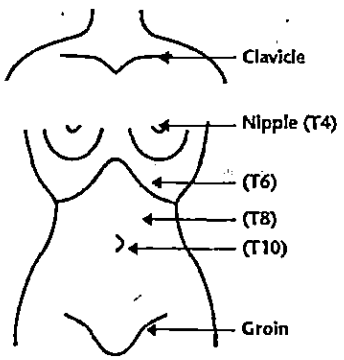
Sign: _____

Print: _____

	Cumulative Dose (ml) from syringe / bag
	Volume Remaining (ml)
	Infusion (mls/hr)
	Top up no
	Time

200
180
160
140
120
100
80
60
40

	Motor block
0	Normal movement
1	Slight weakness
2	Marked weakness
3	No movement



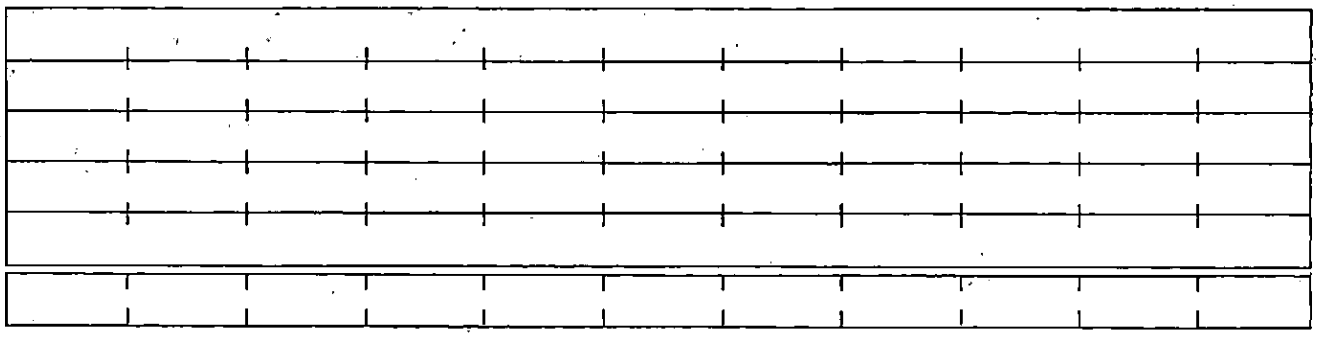
R L R L R L R L R L R L R L R L

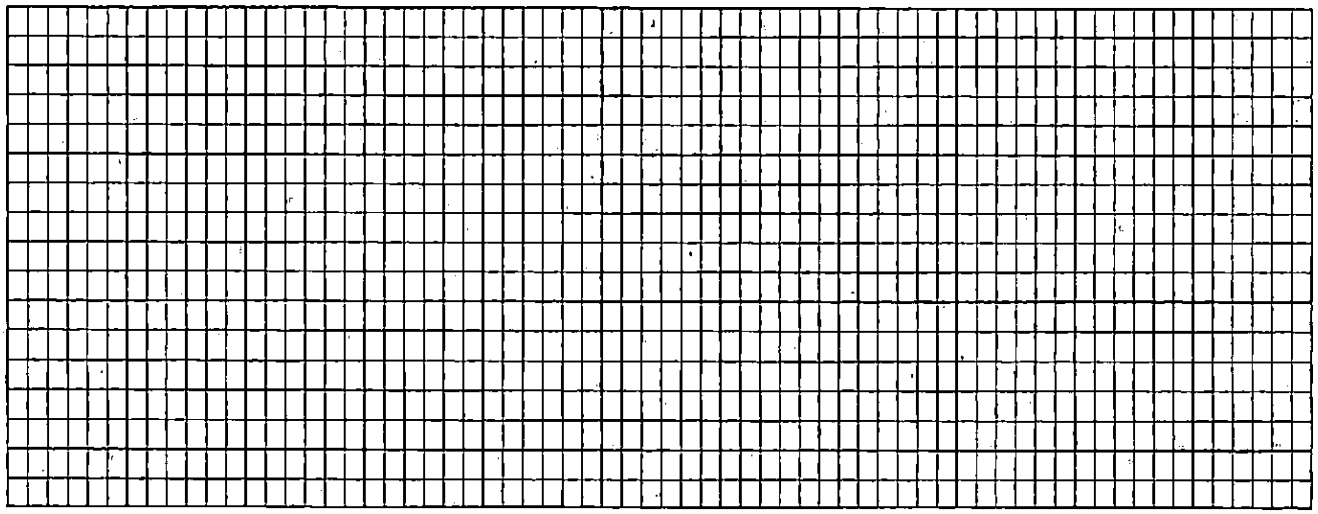
	Motor block R/L

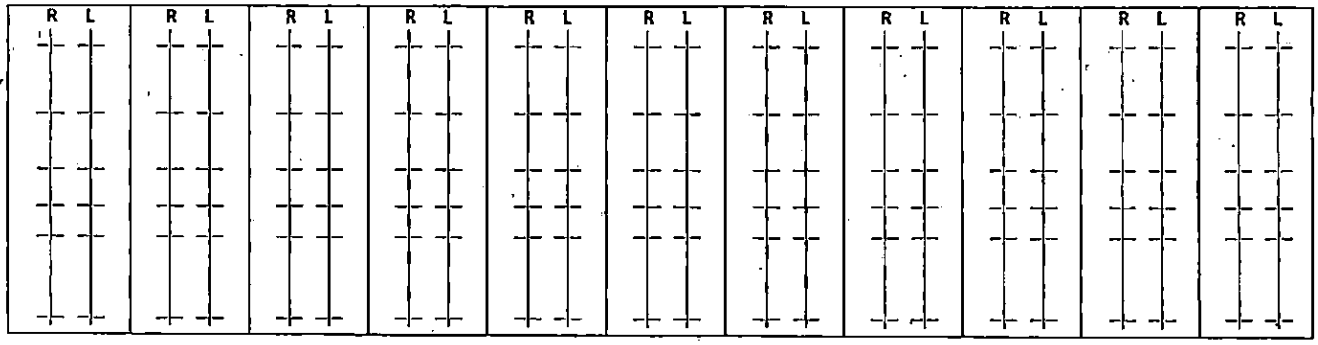
	Time	Top-up	Sign.
1			
2			
3			
4			
5			
6			
7			
8			
9			

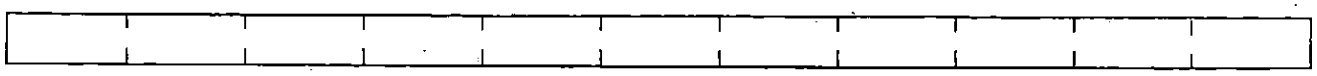
IV SITES

EPIDURAL INFUSION









Time	IV Fluids

Time	Events

Machine Check ☑	Airway	Ventilation	IV Sites
GA ☐	☐ Oral/Nasal ☐ Mask	☐ Spontaneous Vt	Hand 16G (L)(R) 16G
RSI ☐	☐ Cuff ☐ Pack Phar. Airway	☐ I P P V f	Forearm L R
Pre Ox ☐	Tube/LMA size:	Circuit PAW	Internal jugular L R
	Laryngoscopy Grade: 1 2 3 4	Ventilator	Other L R
			Blood warmer ☐

Asepsis ☑ (Chl/Alc/Aq) Sitting/Lateral Level: L3/4

Spinal ☑ Epidural ☐ CSE ☐ LOR to air/saline at cm

LA to skin: 0.5% chlorhex spray + 1ml 1% lidocaine

Catheter cm at skin

Needle: 25G sprotte white

Spinal Drugs: 2.5ml 0.5% heavy marcaine + 300mcg diamorphine

Comments: 1st pass. Clear CSF. No paresthesia/blood.

Comfortable throughout surgery ☐ Nausea intermittent throughout. R sided pain during sheath - afferent? given. N2O declined. Aware of GA going on.

ECG ☑
SpO_2 ☑
NIBP ☑
$ETCO_2$ ☐
ETAA ☐
ABP ☐
PNS ☐

Arterial line:

Block height to cold (c) to sharp (s) Motor block R/L Does not bilat

Upper R/L	T3|T3 bilateral
Lower R/L	S1|S1 @ 9 min

Time	0930		1000		1030		
CEFTRIAXONE	2g						
TRANEXAMIC ACID			1g — 1				
OXYTOCIN			5				
SYNTOMETRINE IM			500				
DEXAMETHASONE / ONDANSETRON			6/4				
KETAMINE 20%					50ml		
ATTENTION						300mcg	
Phenylephrine mIU	30	— 35 — 40 — 30 — 20 —				5 — 0	
DICLOFENAC PR							100mg
SpO_2	97	97	99	97	100	100	99
FiO_2	RA → 2						
$EtCO_2$							
EtAA							
Temp							
Fluid	①		②	③			

Fluids:
① CSL 1000ml
② 0.9% NaCl 500ml + 15units Oxytocin @ 125ml/hr.
③ CSL 1000ml

210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0

CVP

Blood Loss 500ml

Urine Output

SO.MAZ 0927
READY 0936
KB 0946.
DELIVERY 0955

ANAESTHETIST
Sign: [signature]
Print: BRECKENRIDGE

BM

3.8 4.1 (senior - spinal machine not working)

Patient name:.....

Date of birth:..... 1612836909 16/12/1983

CHI No:..... DONALD Diane

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
22/1	2135	Haemaccel	1000	IV	start		MOCAH		22/1/22	2135	SL		

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid Name of additive	Volume (ml) Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

Inpatient prescription & administration record for Diane Donald (1612836909)

Admission: 07/03/2025 => 08/03/2025

05:00
11/03/25

Patient Demographics

DONALD Diane (1612836909)
DOB: 16/12/1983
27 St. Andrews Way, Clydebank,
Dunbarto,
G81 1BP

Admitted: 07/03/2025 07:19
Discharged: 08/03/2025 22:45

Transfer history

Admission	2025-03-07 07:19:00	Q44 QEUH 44
Transfer	2025-03-07 13:01:00	Q47 QEUH 47

Responsible Consultant history

David Rutherford 07/03/25 07:19

Allergy

Admission Allergy Check performed by:
Current recorded allergy (reaction): No Known Drug Allergies

Co-amoxiclav 1000/200 Intravenous Injection

07/03/25 09:40 1,200 mg (Intravenous Slow Bolus Injection) Fiona Breckenridge

07/03/25	09:40	07/03/2025	09:40	Fiona Breckenridge	

Diclofenac 50 mg Enteric Coated Tablets

07/03/25 22:00 50 mg THREE TIMES DAILY 7am:12pm:10pm (Oral) Fiona Breckenridge

07/03/25	22:00	07/03/2025	22:09	Michaela Whiteside	
08/03/25	07:00	08/03/2025	06:06	Yvonne Breslin	
08/03/25	12:00	08/03/2025	11:47	Aileen Gray	
08/03/25	22:00			SYSTEM	Not Charted prior to Discharge

Diclofenac 100 mg Suppositories

07/03/25 10:49 100 mg (Rectal) Fiona Breckenridge

07/03/25	10:49	07/03/2025	10:49	Fiona Breckenridge	

Enoxaparin (Inhixa) 40 mg in 0.4mL Pre-Filled Syringe

07/03/25 17:00 40 mg ONCE daily at 5pm (Subcutaneous Bolus Injection) Fiona Breckenridge

07/03/25	17:00	Suspended			
08/03/25	17:00	08/03/2025	18:38	Aileen Gray	

07/03/25 15:00 40 mg (Subcutaneous Bolus Injection) Fiona Breckenridge

07/03/25	15:00	07/03/2025	15:16	Heather Neilson	

Paracetamol 500 mg Tablets

07/03/25 12:00 1,000 mg FOUR TIMES DAILY 7am:12pm:5pm:10pm (Oral) Fiona Breckenridge

07/03/25	12:00	07/03/2025	12:00	Brenda Donaldson	
07/03/25	17:00	07/03/2025	17:07	Heather Neilson	
07/03/25	22:00	07/03/2025	22:09	Michaela Whiteside	
08/03/25	07:00	08/03/2025	06:06	Yvonne Breslin	
08/03/25	12:00	08/03/2025	11:47	Aileen Gray	
08/03/25	17:00	08/03/2025	18:38	Aileen Gray	
08/03/25	22:00			SYSTEM	Not Charted prior to Discharge

CHLORPHENAMINE 4 mg Tablets as required

07/03/25 10:06 4 mg every 12 hours (Oral) Itch Fiona Breckenridge

4.00	08/03/2025	04:05	Yvonne Breslin	

Cyclizine 50 mg in 1 mL Injection as required

07/03/25 10:06 50 mg every 8 HOURS (Intramuscular) FOR NAUSEA *prescribed as part of either/or protocol:Mat Qeuh Post Cs (No C/I To Nsaids)* Fiona Breckenridge

07/03/25 10:06 50 mg every 8 HOURS (Intravenous Slow Bolus Injection) FOR NAUSEA *prescribed as part of either/or protocol:Mat Qeuh Post Cs (No C/I To Nsaids)* Fiona Breckenridge

Cyclizine 50 mg Tablets as required

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

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Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

HEPMA MAP v1.0

Cyclizine 50 mg Tablets as required *(Continued)*

☒ 07/03/25 10:06 50 mg every 8 HOURS (Oral) FOR NAUSEA *prescribed as part of either/or protocol:Mat Qeuh Post Cs (No C/I To Nsaids)* Fiona Breckenridge

Lactulose Oral Solution as required

☒ 07/03/25 10:06 15 mL TWICE DAILY 7am:10pm (Oral) DOSE ONCE OR TWICE A DAY Fiona Breckenridge

15:00	08/03/2025	06:06	Yvonne Breslin

Morphine sulfate (Sevredol) 10 mg Tablets as required

☒ 07/03/25 10:06 10 mg every HOUR (Oral) FOR PAIN WAIT 2H AFTER ZOMORPH Fiona Breckenridge

10.00	07/03/2025	11:57	Brenda Donaldson/ Lucy Mcguinness
10.00	07/03/2025	13:03	Heather Neilson/ Laura Durkin
10.00	07/03/2025	20:25	Michaela Whiteside/ Erin Porter

NALOXONE 400 micrograms in 1mL Injection as required

☒ 07/03/25 10:06 40 microgram every HOUR (Subcutaneous Bolus Injection) FOR ITCH MAXIMUM UP TO 120MCG Fiona Breckenridge

Ondansetron 4 mg Tablets as required

☒ 07/03/25 10:06 4 mg every 8 HOURS (Oral) For Nausea *prescribed as part of either/or protocol:Mat Qeuh Post Cs (No C/I To Nsaids)* Fiona Breckenridge

Ondansetron 4 mg in 2mL Injection as required

07/03/25 10:06 4 mg every 8 HOURS (Intravenous Slow Bolus Injection) FOR NAUSEA *prescribed as part of either/or protocol:Mat Qeuh Post Cs (No C/I To Nsaids)* Fiona Breckenridge

☒ 07/03/25 10:06 4 mg every 8 HOURS (Intramuscular) FOR NAUSEA *prescribed as part of either/or protocol:Mat Qeuh Post Cs (No C/I To Nsaids)* Fiona Breckenridge

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Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

Patient level notes

added by **Francis Quinn** on 07/03/2025 at 10:08

Title: MAT Post CS

First Post CS, no contraindication to NSAIDs

Zomorph 20mg oral stat dose (10mg if weight <50kg)

Administer at least 4 hours post delivery timed to fit with drug round, suggested timings below **(Adjust start time in 'Order Entry' tab)**

Delivery 0900-1300 - administer at 1800

Delivery 1300-1700 - administer at 2200

Delivery 1700-0200 - administer at 0600

Delivery 0200-0900 - administer at 1000

Zomorph 10mg oral stat

Administer approx. 12 hours from last dose timed to fit with drug round **(Adjust start time in 'Order Entry' tab)**

Delivery 0900-1300 - administer at 0600

Delivery 1300-1700 - administer at 0600

Delivery 1700-0200 - administer at 1800

Delivery 0200-0900 - administer at 2200

Sevredol 10mg oral prn hourly 1st dose at least 2 hours after Zomorph **(Adjust start time in 'Order Entry' tab)**

Paracetamol - Reduce dose to 500mg if maternal weight <50kg. Check when last dose of paracetamol was given in labour for timing of 1st dose & **'amend start date/time if necessary on Order Entry'** tab

DVT Prophylaxis - Enoxaparin

<50kg = 20mg daily

50-90.9kg = 40mg daily

91-130.9kg = 60mg daily

131-170kg = 80mg daily

>170kg = 0.6mg/kg daily

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Inpatient prescription & administration record for Diane Donald (1612836909)

Admission: 01/03/2023 => 04/03/2023

05:00
06/03/23

Patient Demographics

DONALD Diane (1612836909)
DOB: 16/12/1983
27 St. Andrews Way, Clydebank,
Dunbarto,
G81 1BP

Admitted: 01/03/2023 06:47
Discharged: 04/03/2023 03:47

Transfer history

Admission	2023-03-01 06:47:00	Q44 QEUH 44
Transfer	2023-03-01 14:44:00	Q50 QEUH 50

Responsible Consultant history

Assigned No Consultant 01/03/23 06:47

Allergy

Admission Allergy Check performed by:
Current recorded allergy (reaction): No Known Drug Allergies

CO-AMOXICLAV 1000/200 Intravenous Injection

01/03/23 09:15 1,200 mg (Intravenous Slow Bolus Injection) Ramesh Sai

01/03/23	09:15	01/03/2023	09:15	Ramesh Sai

☒ 01/03/23 10:05 1,200 mg (Intravenous Slow Bolus Injection) Kathryn Harper

01/03/23	10:05	01/03/2023	10:05	Kathryn Harper

DICLOFENAC 50 mg Enteric Coated Tablets

Note to Nurse added by **Kathryn Harper** on 01/03/2023 at 10:40

Title: do not give if further bleeding

2.2 l ebl. Withold if further bleeding/ coagulopathy. Bloods being taken post op in recovery.

☒ 01/03/23 12:00 50 mg THREE TIMES DAILY 7am:12pm:10pm (Oral) Ramesh Sai

01/03/23	12:00	Suspended		
01/03/23	22:00	Suspended		
02/03/23	07:00	02/03/2023	06:18	Jenna Maley/ Aimee Grant
02/03/23	12:00	02/03/2023	12:51	Della JONES
02/03/23	22:00	02/03/2023	22:33	Jenna Maley
03/03/23	07:00	03/03/2023	06:36	Jenna Maley
03/03/23	12:00	03/03/2023	13:00	Della JONES
03/03/23	22:00	03/03/2023	22:35	Allyson Cullen

DICLOFENAC 100 mg Suppositories

☒ 01/03/23 10:15 100 mg (Rectal) Ramesh Sai

01/03/23	10:15	Kathryn Harper	Drug discontinued

Discontinued on: 01/03/2023 10:35 by: Kathryn Harper . Reason: Contra-Indicated

ENOXAPARIN 40 mg in 0.4mL Pre-Filled Syringe

☒ 02/03/23 17:00 40 mg ONCE daily at 5pm (Subcutaneous Bolus Injection) Ramesh Sai

02/03/23	17:00	02/03/2023	18:27	Della JONES
03/03/23	17:00	03/03/2023	18:16	Della JONES

☒ 01/03/23 14:00 40 mg (Subcutaneous Bolus Injection) Ramesh Sai

01/03/23	14:00	01/03/2023	22:12	Jenna Maley

FERROUS FUMARATE 210 mg Tablets

☒ 02/03/23 07:00 210 mg ONCE DAILY MORNING 7am (Oral) Isla Cruickshank

02/03/23	07:00	02/03/2023	06:18	Jenna Maley/ Aimee Grant
03/03/23	07:00	03/03/2023	06:36	Jenna Maley

LACTULOSE Oral Solution

☒ 01/03/23 22:00 15 mL TWICE DAILY 7am:10pm (Oral) Ramesh Sai

01/03/23	22:00	01/03/2023	22:12	Jenna Maley
02/03/23	07:00	02/03/2023	06:18	Jenna Maley/ Aimee Grant
02/03/23	22:00	02/03/2023	22:33	Jenna Maley
03/03/23	07:00	03/03/2023	06:36	Jenna Maley

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

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LACTULOSE Oral Solution *(Continued)*

03/03/23 22:00 03/03/2023 22:35 Allyson Cullen

MORPHINE SULFATE 10 mg (Zomorph) Modified Release Capsules

☒ 01/03/23 18:00 20 mg (Oral) Ramesh Sai

01/03/23 18:00 01/03/2023 18:06 Sharon Hannah/ Lorna Caldwell

☒ 02/03/23 06:00 10 mg (Oral) Ramesh Sai

02/03/23 06:00 02/03/2023 06:18 Jenna Maley/ Aimee Grant

MW PARACETAMOL 500 mg Tablets

☒ 02/03/23 04:35 1,000 mg (Oral) Jenna Maley

02/03/23 04:35 02/03/2023 04:35 Jenna Maley

NEXPLANON (ETONOGESTREL) 68 mg Implant

☒ 02/03/23 12:00 1 Implant ONCE daily at midday (Subdermal) for 1 dose(s) Isla Cruickshank

02/03/23 12:00 Suspended

PARACETAMOL 500 mg Tablets

☒ 01/03/23 12:00 1,000 mg FOUR TIMES DAILY 7am:12pm:5pm:10pm (Oral) Ramesh Sai

01/03/23	12:00	Suspended		
01/03/23	17:00	01/03/2023	18:05	Sharon Hannah/ Lorna Caldwell
01/03/23	22:00	01/03/2023	22:12	Jenna Maley
02/03/23	07:00	02/03/2023	06:18	Jenna Maley/ Aimee Grant
02/03/23	12:00	02/03/2023	12:51	Della JONES
02/03/23	17:00	02/03/2023	18:27	Della JONES
02/03/23	22:00	02/03/2023	22:33	Jenna Maley
03/03/23	07:00	03/03/2023	06:36	Jenna Maley
03/03/23	12:00	03/03/2023	13:00	Della JONES
03/03/23	17:00	03/03/2023	18:18	Della JONES
03/03/23	22:00	03/03/2023	22:35	Allyson Cullen

PARACETAMOL_1000 mg in 100mL Intravenous Infusion

☒ 01/03/23 10:20 1,000 mg (Intravenous Intermittent Infusion) Kathryn Harper

01/03/23 10:20 01/03/2023 10:20 Kathryn Harper

CHLORPHENAMINE 4 mg Tablets (CHLORPHENIRAMINE) as required

☒ 01/03/23 09:20 4 mg every 6 HOURS (Oral) Itch Ramesh Sai

CYCLIZINE 50 mg Tablets as required

☒ 01/03/23 09:19 50 mg every 8 HOURS (Oral) FOR NAUSEA *prescribed as part of either/or protocol:Mat Qeuh Post Cs (No C/I To Nsaids)* Ramesh Sai

mg Kathryn Harper Alternative administered

CYCLIZINE 50 mg in 1 mL Injection as required

☒ 01/03/23 09:19 50 mg every 8 HOURS (Intramuscular) FOR NAUSEA *prescribed as part of either/or protocol:Mat Qeuh Post Cs (No C/I To Nsaids)* Ramesh Sai

mg Kathryn Harper Alternative administered

01/03/23 09:19 50 mg every 8 HOURS (Intravenous Slow Bolus Injection) FOR NAUSEA *prescribed as part of either/or protocol:Mat Qeuh Post Cs (No C/I To Nsaids)* Ramesh Sai

50.00 mg 01/03/2023 10:00 Kathryn Harper

MORPHINE SULFATE 10 mg (Sevredol) Tablets as required

☒ 01/03/23 09:19 10 mg every HOUR (Oral) FOR PAIN WAIT 2H AFTER ZOMORPH Ramesh Sai

10.00 mg 01/03/2023 12:08 Jane Clement/ Fiona Connaghan

10.00 mg 01/03/2023 14:59 Lorna Caldwell/ Pamela Yuill

NALOXONE 400 micrograms in 1mL Injection as required

☒ 01/03/23 09:19 40 microgram every HOUR (Subcutaneous Bolus Injection) FOR ITCH MAXIMUM UP TO 120MCG Ramesh Sai

Discontinued on: 02/03/2023 08:54 by: Amanda Holmes . Reason: Rationalising Medication

ONDANSETRON 4 mg Tablets as required

☒ 01/03/23 09:19 4 mg every 8 HOURS (Oral) For Nausea *prescribed as part of either/or protocol:Mat Qeuh Post Cs (No C/I To Nsaids)* Ramesh Sai

ONDANSETRON 4 mg in 2mL Injection as required

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

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ONDANSETRON 4 mg in 2mL Injection as required *(Continued)*

☒ 01/03/23 09:19 4 mg every 8 HOURS (Intravenous Slow Bolus Injection) FOR NAUSEA *prescribed as part of either/or protocol:Mat Qeuh Post Cs (No C/I To Nsaids)* Ramesh Sai

☒ 01/03/23 09:19 4 mg every 8 HOURS (Intramuscular) FOR NAUSEA *prescribed as part of either/or protocol:Mat Qeuh Post Cs (No C/I To Nsaids)* Ramesh Sai

Patient level notes

Protocol Information Unseen added by **Francis Quinn** on 01/03/2023 at 09:20

Title: MAT Post CS

First Post CS, no contraindication to NSAIDs

Zomorph 20mg oral stat dose (10mg if weight <50kg)

Administer at least 4 hours post delivery timed to fit with drug round, suggested timings below **(Adjust start time in 'Order Entry' tab)**

Delivery 0900-1300 - administer at 1800

Delivery 1300-1700 - administer at 2200

Delivery 1700-0200 - administer at 0600

Delivery 0200-0900 - administer at 1000

Zomorph 10mg oral stat

Administer approx. 12 hours from last dose timed to fit with drug round **(Adjust start time in 'Order Entry' tab)**

Delivery 0900-1300 - administer at 0600

Delivery 1300-1700 - administer at 0600

Delivery 1700-0200 - administer at 1800

Delivery 0200-0900 - administer at 2200

Sevredol 10mg oral prn hourly 1st dose at least 2 hours after Zomorph **(Adjust start time in 'Order Entry' tab)**

Paracetamol - Reduce dose to 500mg if maternal weight <50kg. Check when last dose of paracetamol was given in labour for timing of 1st dose & **'amend start date/time if necessary on Order Entry'** tab

DVT Prophylaxis - Enoxaparin

<50kg = 20mg daily

50-90.9kg = 40mg daily

91-130.9kg = 60mg daily

131-170kg = 80mg daily

>170kg = 0.6mg/kg daily

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Inpatient prescription & administration record for Diane Donald (1612836909)

Admission: 25/01/2023 => 26/01/2023

05:00
28/01/23

Patient Demographics

DONALD Diane (1612836909)
DOB: 16/12/1983
27 St. Andrews Way, Clydebank,
Dunbarto,
G81 1BP

Admitted: 25/01/2023 03:00
Discharged: 26/01/2023 16:04

Transfer history

Admission 2023-01-25 03:00:00 Q47 QEUH 47

Responsible Consultant history

Judith Roberts 25/01/23 03:00

Allergy

Admission Allergy Check performed by:
Current recorded allergy (reaction): No Known Drug Allergies

OMEPRAZOLE 20 mg Capsules

☐ 26/01/23 07:00 20 mg ONCE DAILY MORNING 7am (Oral) — Isabella Burdess

26/01/23	07:00	26/01/2023	06:38	Nicole Amzaleg

TRIMETHOPRIM 200 mg Tablets

☒ 25/01/23 22:00 200 mg TWICE DAILY 7am:10pm (Oral) — Shams Mustafa

25/01/23	22:00	25/01/2023	22:37	Nicole Amzaleg
26/01/23	07:00	26/01/2023	06:38	Nicole Amzaleg

PARACETAMOL 500 mg Tablets as required

☒ 25/01/23 22:40 1,000 mg FOUR times daily - 7am;12pm;5pm;10pm (Oral) FOR PAIN — Isabella Burdess

1,000.00 mg	25/01/2023	23:00	Nicole Amzaleg
1,000.00 mg	26/01/2023	06:38	Nicole Amzaleg

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

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Inpatient prescription & administration record for Diane Donald (1612836909)
Admission: 17/01/2023 => 20/01/2023

05:00
22/01/23

Patient Demographics

DONALD Diane (1612836909)
DOB: 16/12/1983
27 St. Andrews Way, Clydebank,
Dunbarto,
G81 1BP

Admitted: 17/01/2023 14:04
Discharged: 20/01/2023 11:42

Transfer history		Responsible Consultant history	
Admission 2023-01-17 14:04:00	Q48 QEUH 48	Judith Roberts	17/01/23 14:04

Allergy

Admission Allergy Check performed by:
Current recorded allergy (reaction): No Known Drug Allergies

FERROUS FUMARATE 210 mg Tablets

18/01/23 07:00 210 mg ONCE DAILY MORNING 7am (Oral) — Lauren Quinn

18/01/23	07:00	18/01/2023	08:05	Rachel Coleman
19/01/23	07:00	19/01/2023	08:02	Rachel Coleman
20/01/23	07:00	20/01/2023	08:02	Katie Murphy

MW OMEPRAZOLE 20 mg Capsules

☒ 17/01/23 22:52 20 mg (Oral) — Elisabeth Blackley

17/01/23	22:52	17/01/2023	23:10	Elisabeth Blackley

OMEPRAZOLE 20 mg Capsules

☒ 18/01/23 07:00 20 mg ONCE DAILY MORNING 7am (Oral) — Lauren Quinn

18/01/23	07:00		Rachel Coleman	Prescription Clarification Required

☒ 19/01/23 22:00 20 mg ONCE DAILY NIGHT 10pm (Oral) — Robin Macintosh

19/01/23	22:00	19/01/2023	22:11	Emma McCrudden

☒ 18/01/23 22:00 20 mg (Oral) — Robin Macintosh

18/01/23	22:00	18/01/2023	22:09	Niamh Dickson

CYCLIZINE 50 mg Tablets as required

☒ 17/01/23 19:46 50 mg THREE times daily - 7am;12pm;10pm (Oral) FOR NAUSEA — Lauren Quinn

PARACETAMOL 500 mg Tablets as required

☒ 17/01/23 19:46 1,000 mg FOUR times daily - 7am;12pm;5pm;10pm (Oral) FOR PAIN — Lauren Quinn

	1,000.00 mg	18/01/2023	21:54	Niamh Dickson

PEPTAC Oral Sugar Free Suspension as required

☒ 17/01/23 19:46 10 mL (Oral) FOR INDIGESTION — Lauren Quinn

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

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Patient Agreement to Investigation or Treatment

NHS
er Glasgow
d Clyde

CONSENT FORM

s2384–037 3132281
Skin Biopsy Set

PATIENT DETAILS (OR PRE-PRINTED)

1612836909
DONALD
Diane
43 Longden Street
Clydebank, Dunbartonshire
G81 1AG
F
16/12/1983

Hospital/Clinic/GP Practice .....

Patient's surname/family name :.....

Patient's first name(s): .....

Date of Birth___/___/_____ Gender: Male ☐ Female ☐

NHS/ CHI Number _____

Special requirements (e.g. other language/communication method) .....

.....

Responsible practitioner: S MACALPINE

Job title: .....

STATEMENT FOR PRACTITIONER

(to be filled in by practitioner with appropriate knowledge of proposed procedure- see guidance notes)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side: (WRITTEN IN FULL)

Excision of mole on back
Shave excision of fleshy mole left breast

I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedures above).

Signature of practitioner: SMacAlpine

Name/Designation (Print) S. MACALPINE

Date 4/12/13

00526

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*

(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

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

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- to the emergency administration of blood or blood products

Additionally you have to agree or disagree the following:-	**Agree**	**Disagree**
that information and/or images kept in records may be used anonymously for education, audit, and research with appropriate ethical approval, to improve the quality of patient care.	☐	☐
that surplus tissue or other biological material not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☐

PATIENT REFUSAL FOR BLOOD PRODUCTS

Please sign here if you refuse to consent to the emergency administration of blood or blood products. Even if this results in death.

Signature: ..... Date ...../...../.....

Practitioner Signature: ..... Date ...../...../.....

PATIENT/PARENT* AGREEMENT FOR TREATMENT

Signature: Donald ..... Date 4/12/13

Name (Print): Diane Donald

Pathfinder SL — Donald, Diane

West Glasgow ACH — Confirmed — 2 Lead Holter Report

Patient ID: 1612836909 Date of Birth: Fri 16 Dec 1983 (41 years) Gender: Female

National ID: Case: Recorded: Wed 19/02/2025 10:07:00
Hospital / Practice: West Glasgow ACH Order: Analyzed Length: 23 hr 4 min 39 sec, 0.0% artifact
Referring Doctor: Dr D Rutherford Ward: maternity o/p dept Analyzed by: , Thu 20 Feb 2025

Indications (reason for test) :

?arrythmia

Beats

Beats	Total	Normal		Ventricular		Supraventricular		Paced	
Count	148,248	148,229	>99%	0	0%	19	<1%	0	0%
Max/Hour		7,410	Wed 19, 21:00	0		3	Wed 19, 21:00	0	

Intervals:					
RR Interval	Longest	1.32 s	(Thu 20, 04:23:12)	Shortest	315 ms (Wed 19, 20:13:34)
NN Interval	Longest	1.32 s	(Thu 20, 04:23:12)	Shortest	320 ms (Wed 19, 17:11:16)

Heart Rates

Heart Rates (1 min avg)	Rate (bpm)	Time
Max	144	Thu 20, 08:27
Min	75	Thu 20, 04:23
Mean	107	
Mean HR (Day)	114	07:00:00 - 23:00:00
Mean HR (Night)	93	23:00:00 - 07:00:00

Rate Dependent Events

Rate Dependent Events	Count	Most Severe Rate (bpm)	Longest (beats / secs)
Pause	0	-	
Dropped Beat		-	-
Bradycardia	0		
Tachycardia	766	158 : Thu 20, 08:20	3585 beats : Wed 19, 13:37

Ventricular Arrhythmias

Ventricular Beats : 0 (0%) Max/Hour : 0 Max/Minute: 0 Average/Hour : 0

Event	Event Count	V Beat Count	% V Beats	% Total Beats	Per 1000	Max Rate (bpm)	Longest (beats / cycles)
VT	0	0	0%	0%	0		
V-Run/AIVR	0	0	0%	0%	0		
IVR	0	0	0%	0%	0		
Triplet	0	0	0%	0%	0	-	-
Couplet	0	0	0%	0%	0	-	-
Bigeminy	0	0	0%	0%	-	-	-
Trigeminy	0	0	0%	0%	-	-	
Single VE Events	0	0	0%	0%	0	-	-

Supraventricular Arrhythmias

Supraventricular Beats : 19 (<1%) Max/Hour : 3 (Wed 19, 21:00) Max/Minute: 2 (Wed 19, 21:40) Average/Hour : 1

Event	Event Count	SV Beat Count	% SV Beats	% Total Beats	Per 1000	Max Rate (bpm)	Longest (beats)
SVT	0	0	0%	0%	0		
SVE Run	0	0	0%	0%	0		
SVE Couplet	0	0	0%	0%	0	-	-
Single SVE Events	19	19	100%	<1%	0	-	-

Findings :

3 day ambulatory ECG report: good quality recording.

Sinus tachycardia / arrhythmia, mean HR 107 bpm.

No VE's.
19 x SVE's.

Min HR 75 bpm @ 04:23.
Max HR 144 bpm @ 08:27.

Patient reported symptoms of " breathing fast, feel weak" at 5 x occasions, correlate with sinus tachycardia.

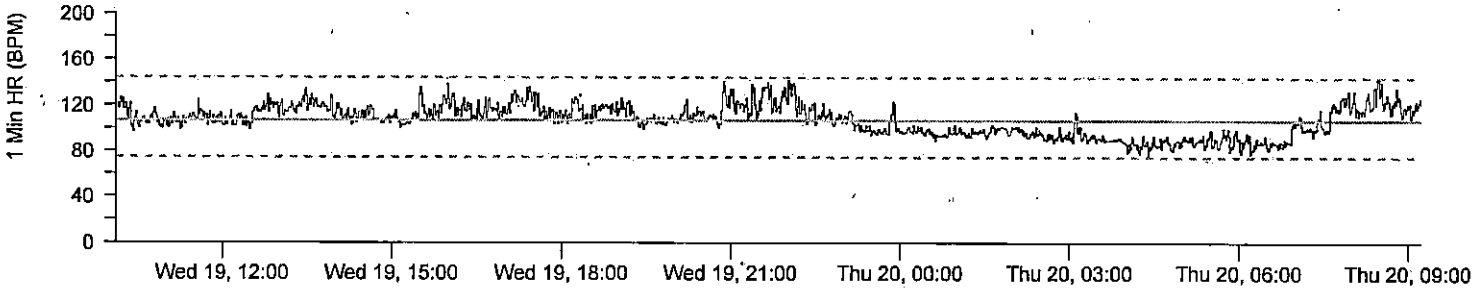
Locum CP MH.

Operator Signature ..... Doctor Signature .....

Signed By: Mingwang (Michael) Ho (WGACH) on 20/02/2025 10:11:10

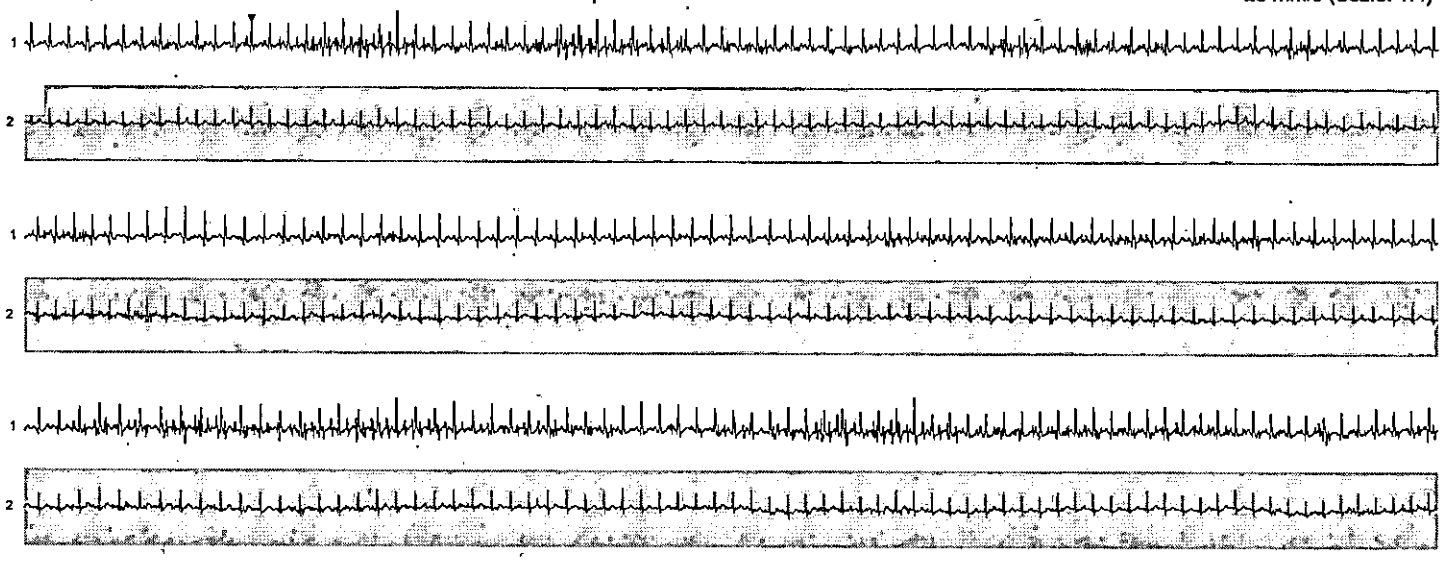
Patient ID: 1612836909 Date of Birth: Fri 16 Dec 1983 (41 years) Gender: Female

Overall Heart Rate



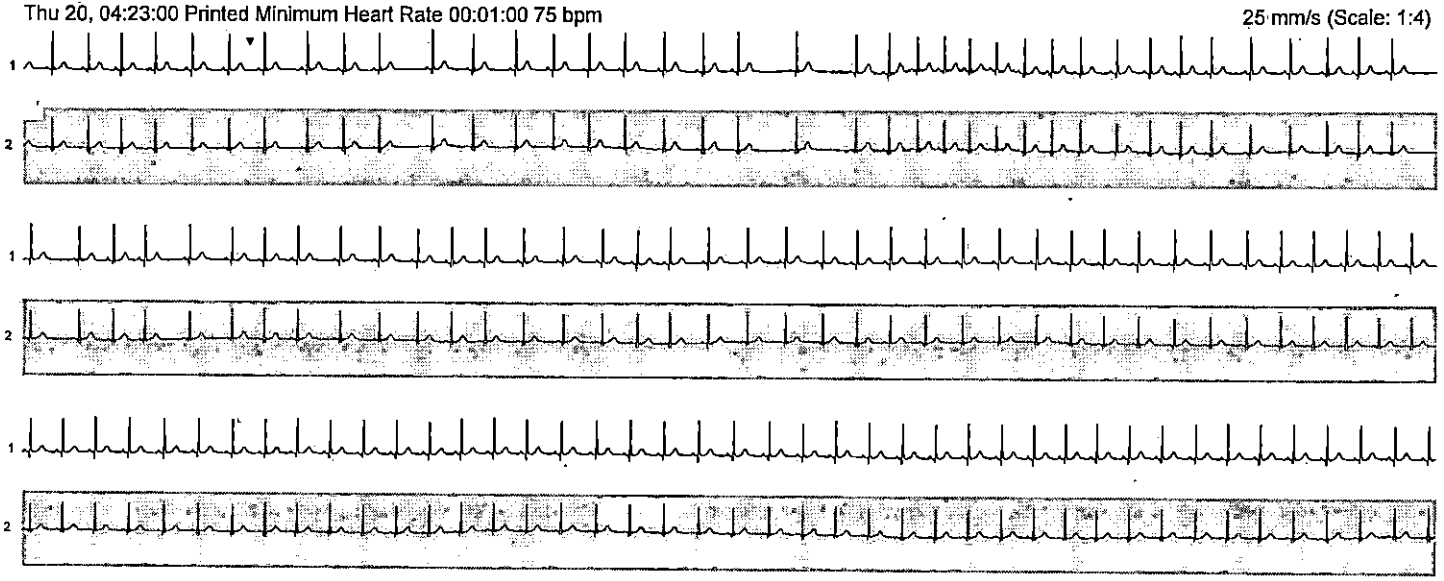
Maximum Heart Rate Event (1 Minute Avg)

Thu 20, 08:27:00 Printed Maximum Heart Rate 00:01:00 144 bpm 25 mm/s (Scale: 1:4)



Minimum Heart Rate Event (1 Minute Avg)

Thu 20, 04:23:00 Printed Minimum Heart Rate 00:01:00 75 bpm 25 mm/s (Scale: 1:4)

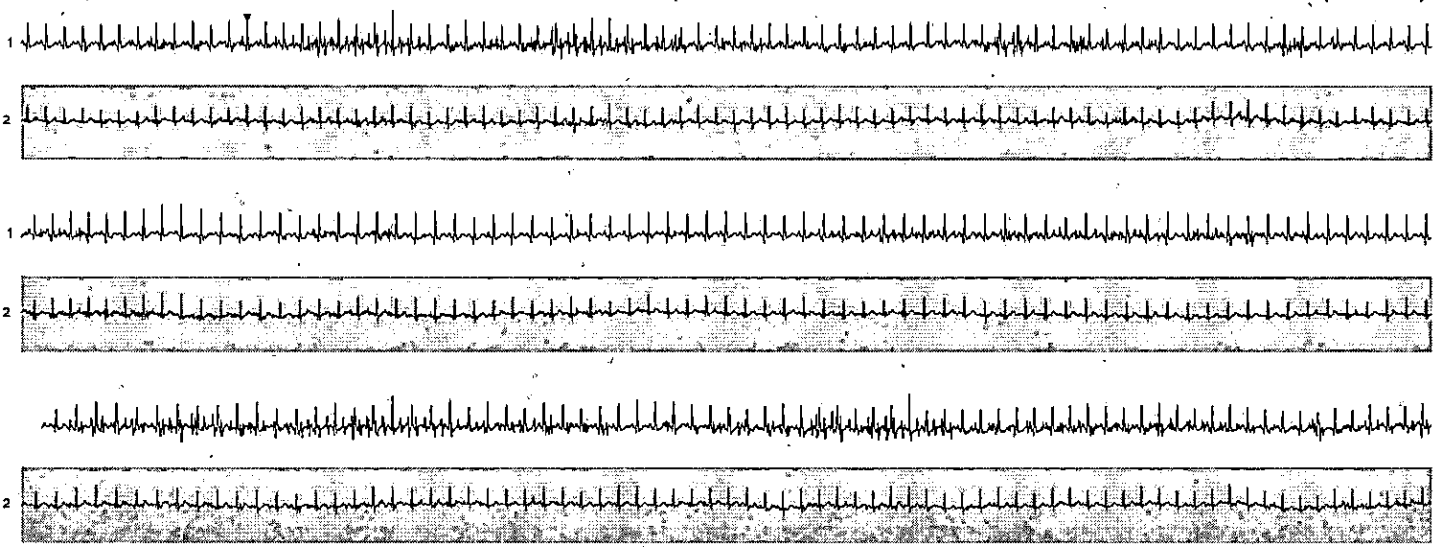


Patient ID: 1612836909 | Date of Birth: Fri 16 Dec 1983 (41 years) | Gender: Female

Sinus Heart Rate

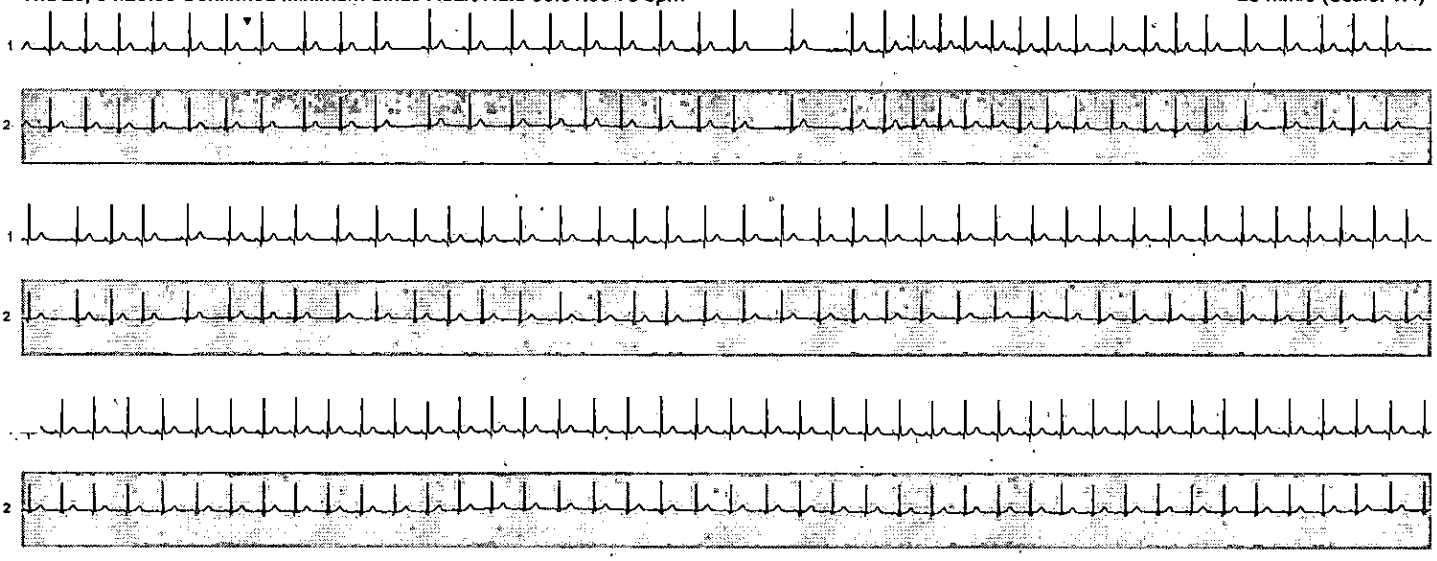
Maximum Sinus Heart Rate Event (1 Minute Avg)

Thu 20, 08:27:00 Confirmed Maximum Sinus Heart Rate 00:01:00 144 bpm — 25 mm/s (Scale: 1:4)



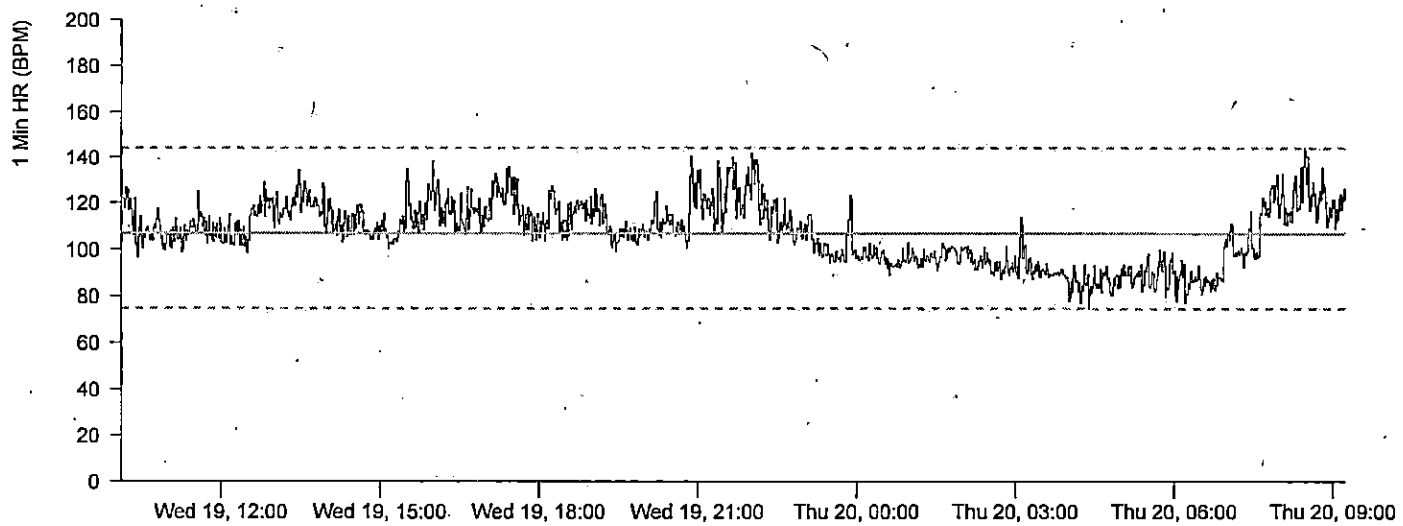
Minimum Sinus Heart Rate Event (1 Minute Avg)

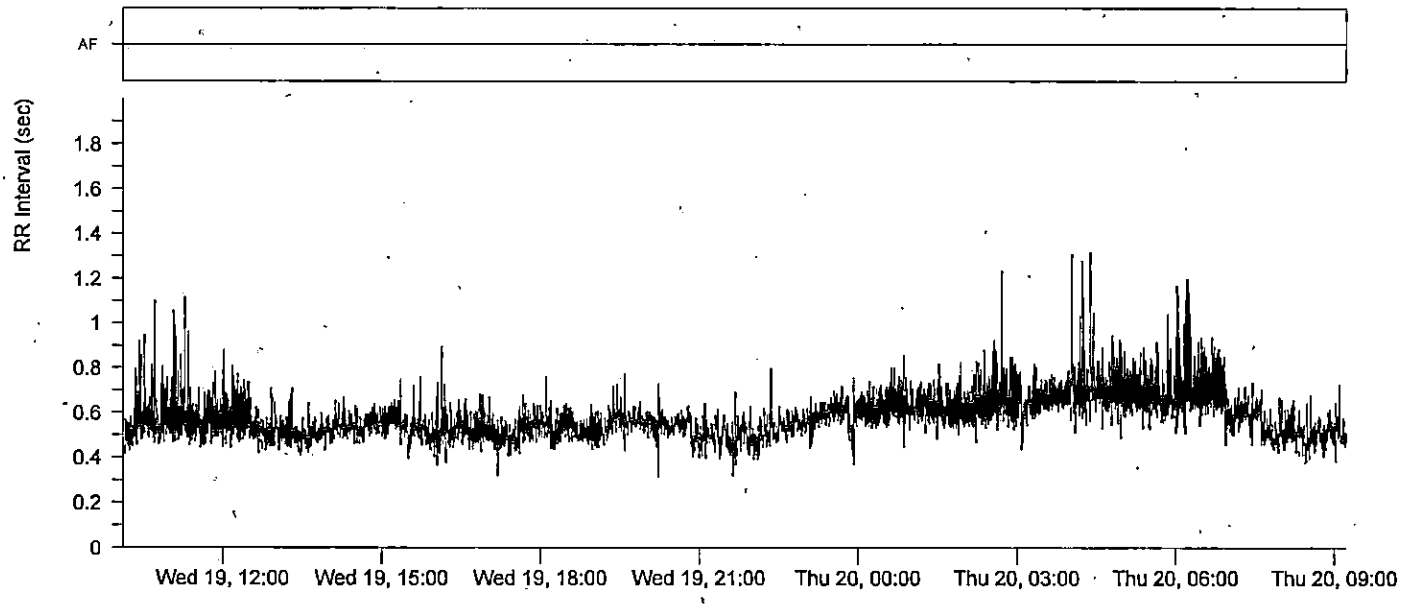
Thu 20, 04:23:00 Confirmed Minimum Sinus Heart Rate 00:01:00 75 bpm — 25 mm/s (Scale: 1:4)

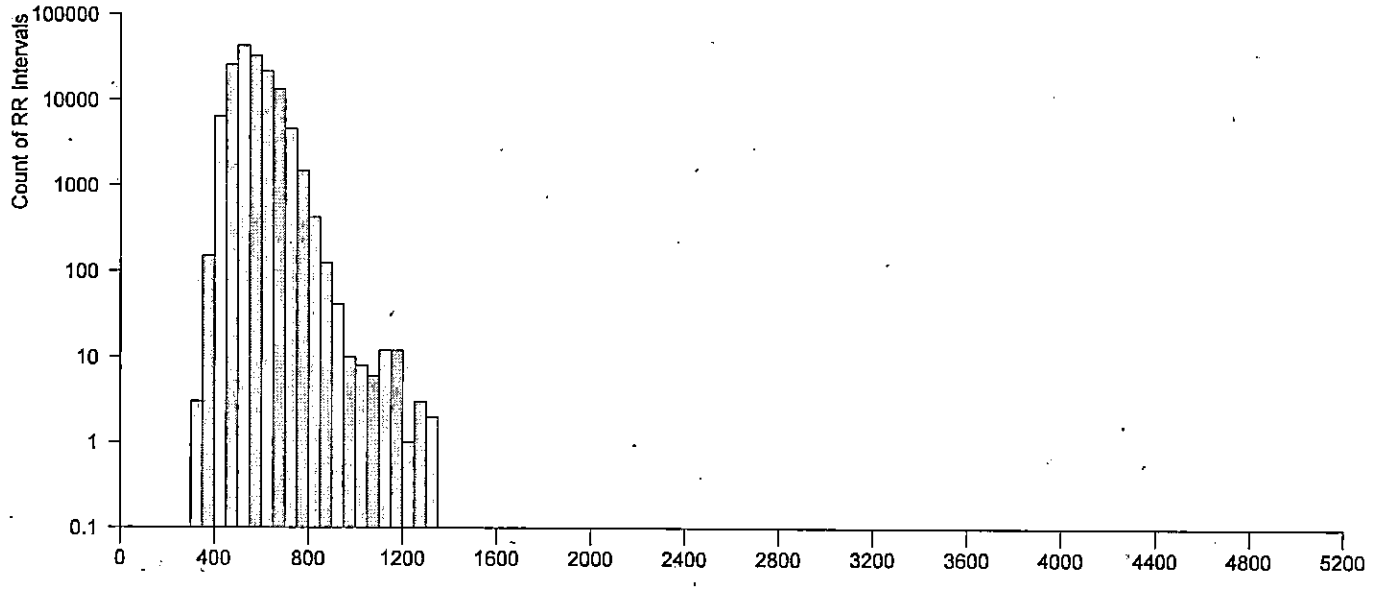


Patient ID: 1612836909 Date of Birth: Fri 16 Dec 1983 (41 years) Gender: Female

Graphs

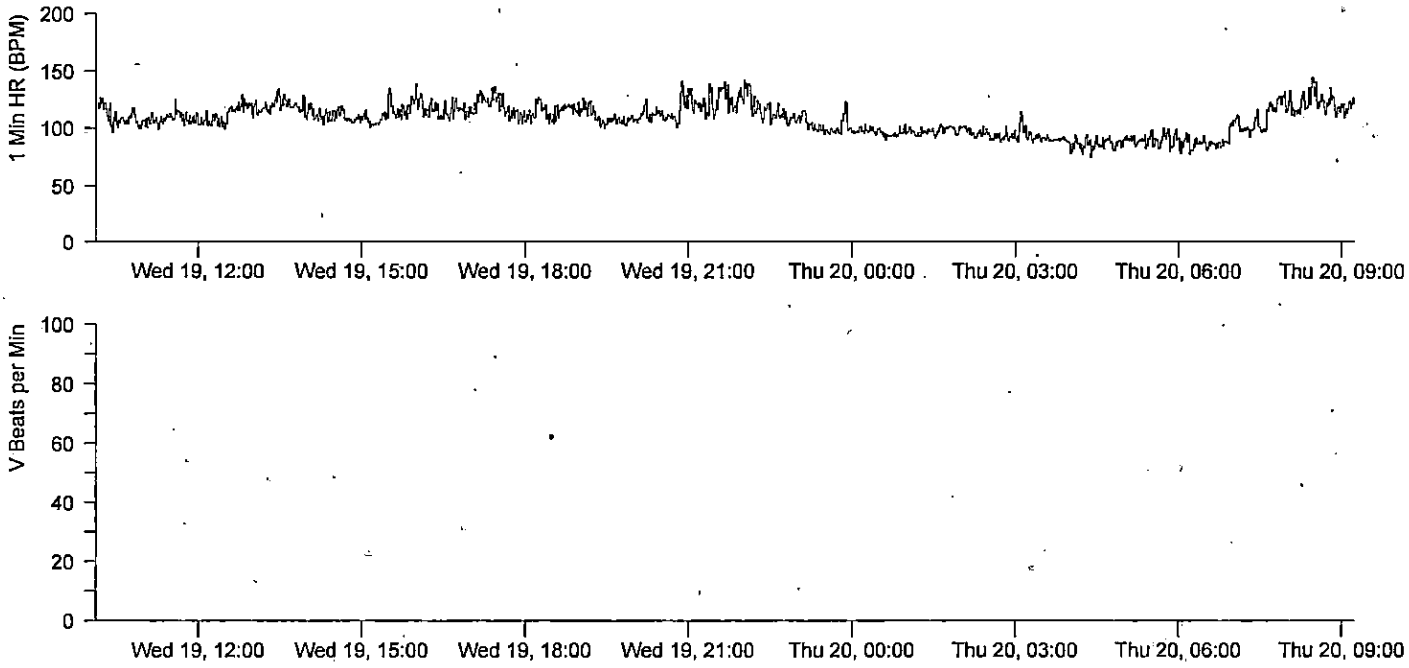






Signed By: Mingwang (Michael) Ho (WGACH) on 20/02/2025 10:11:10

Patient ID: 1612836909 Date of Birth: Fri 16 Dec 1983 (41 years) Gender: Female

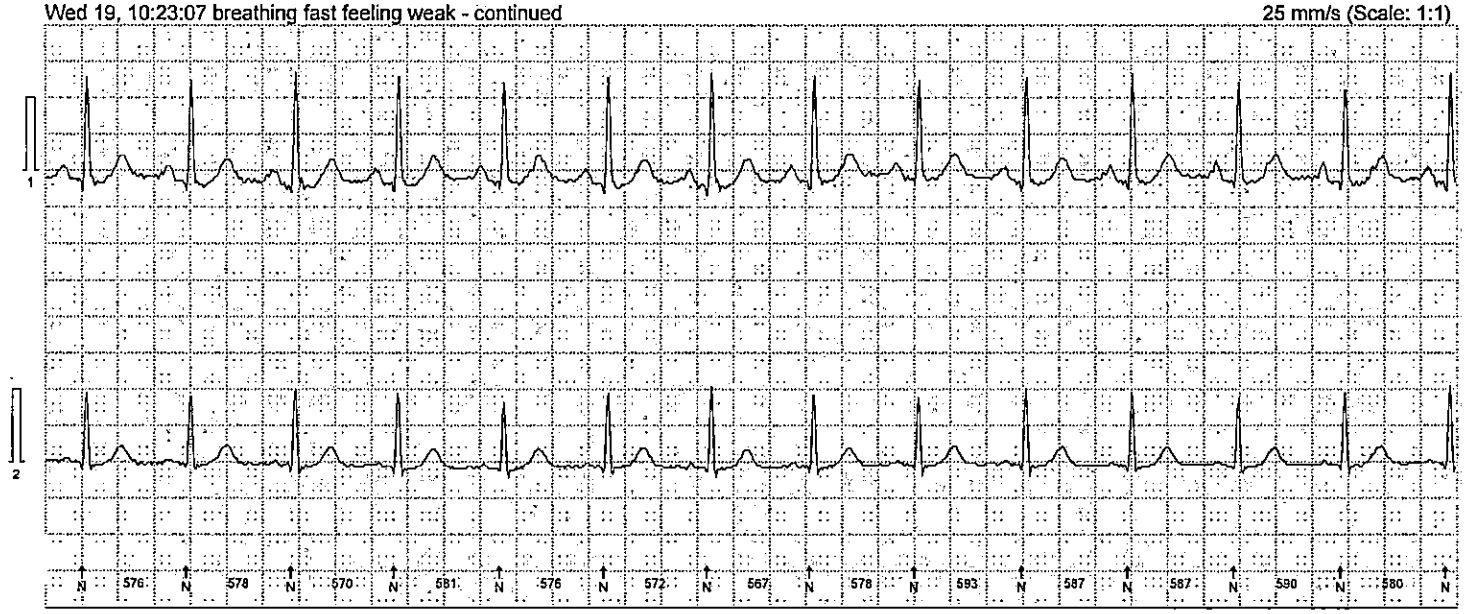


Patient ID: 1612836909 Date of Birth: Fri 16 Dec 1983 (41 years) Gender: Female

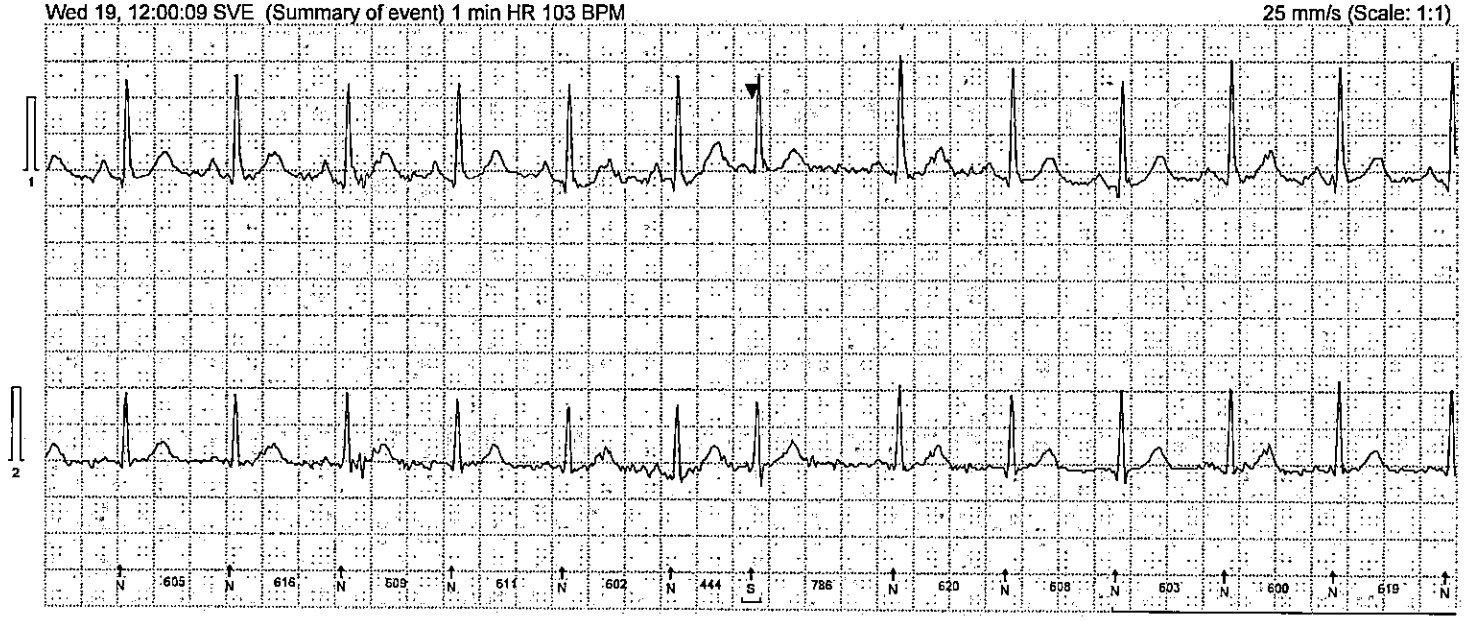
Wed 19, 10:23:04 breathing fast feeling weak 563ms (Entire event) 1 min HR 103 BPM 25 mm/s (Scale: 1:1)



Wed 19, 10:23:07 breathing fast feeling weak - continued 25 mm/s (Scale: 1:1)

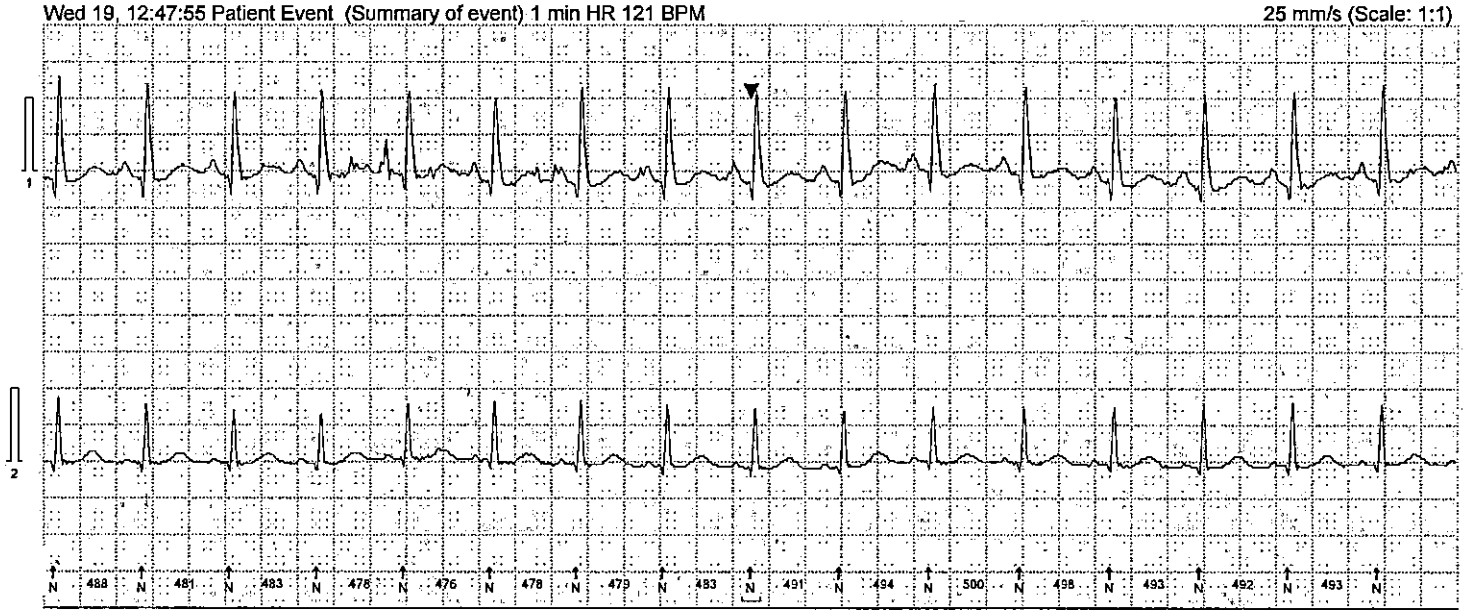


Wed 19, 12:00:09 SVE (Summary of event) 1 min HR 103 BPM 25 mm/s (Scale: 1:1)

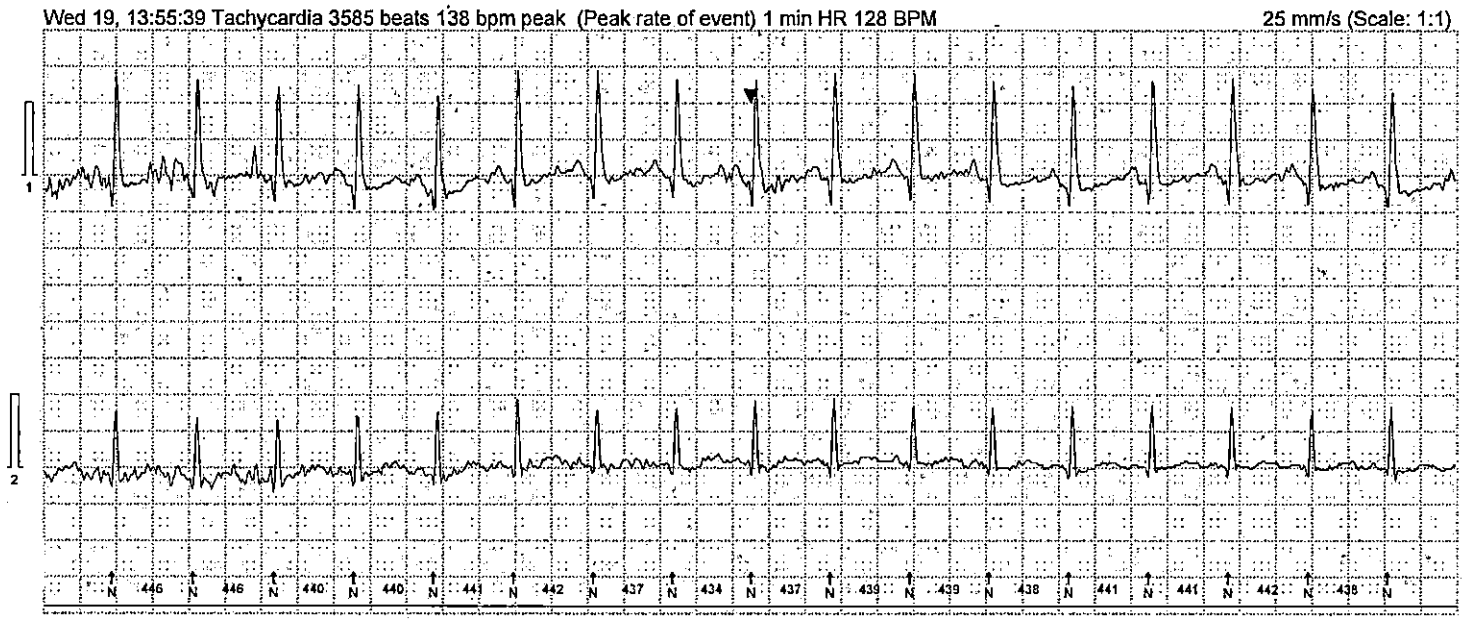


Patient ID: 1612836909 Date of Birth: Fri 16 Dec 1983 (41 years) Gender: Female

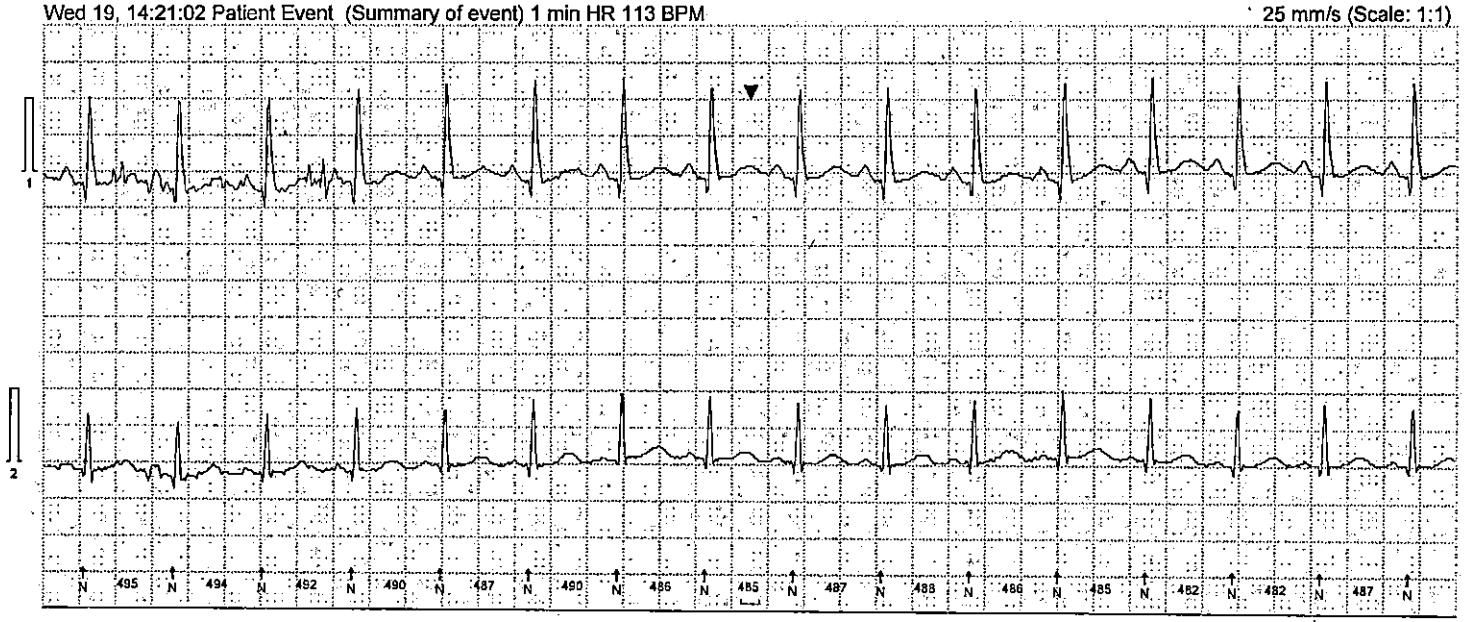
Wed 19, 12:47:55 Patient Event (Summary of event) 1 min HR 121 BPM 25 mm/s (Scale: 1:1)



Wed 19, 13:55:39 Tachycardia 3585 beats 138 bpm peak (Peak rate of event) 1 min HR 128 BPM 25 mm/s (Scale: 1:1)

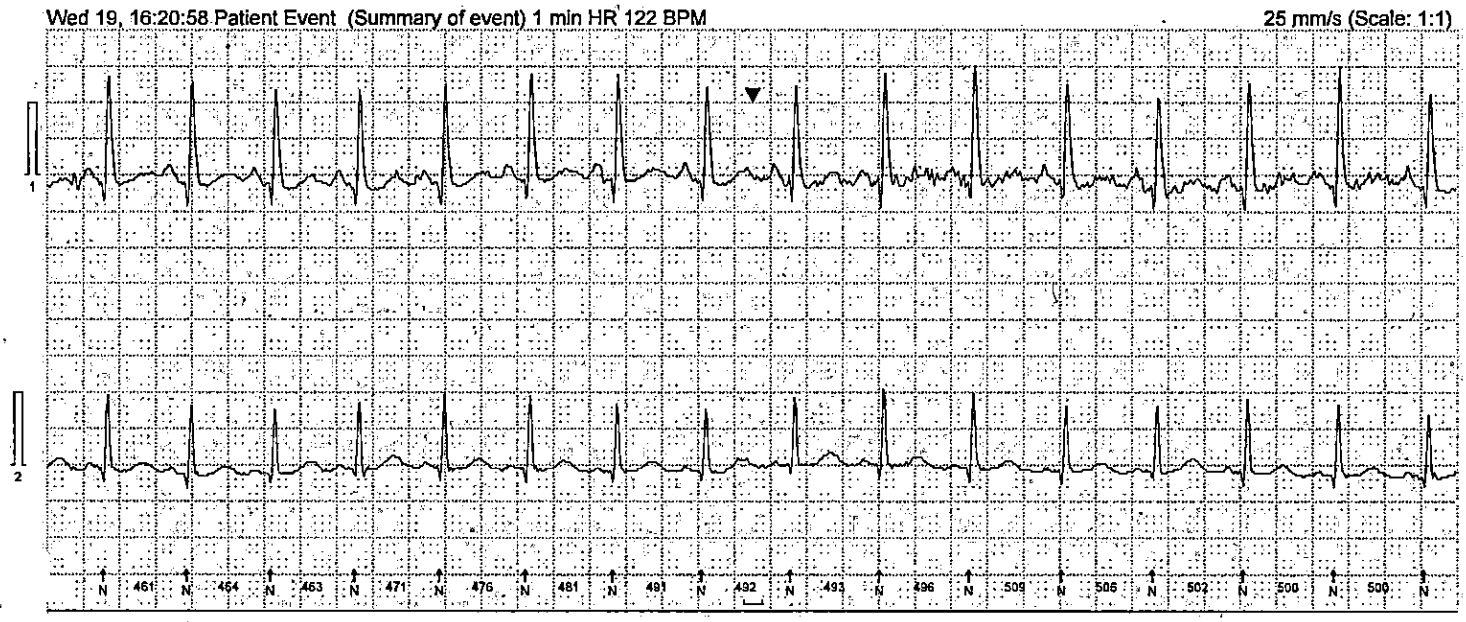


Wed 19, 14:21:02 Patient Event (Summary of event) 1 min HR 113 BPM 25 mm/s (Scale: 1:1)

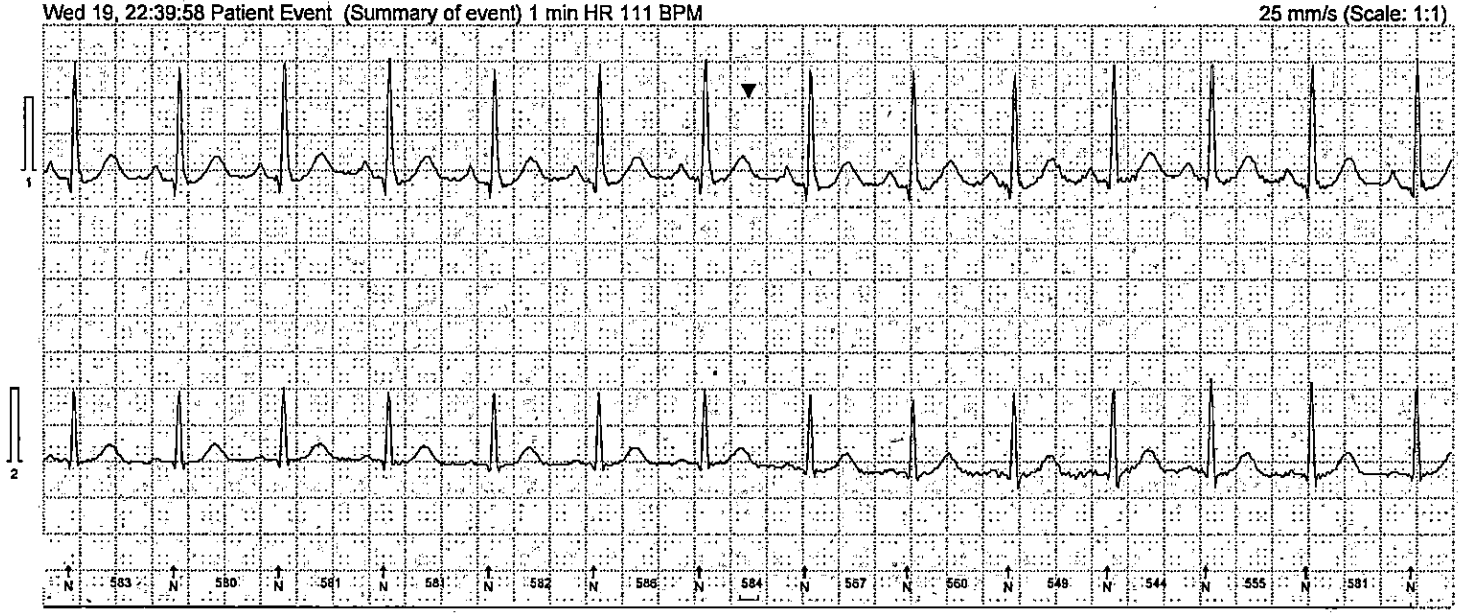


Patient ID: 1612836909 Date of Birth: Fri 16 Dec 1983 (41 years) Gender: Female

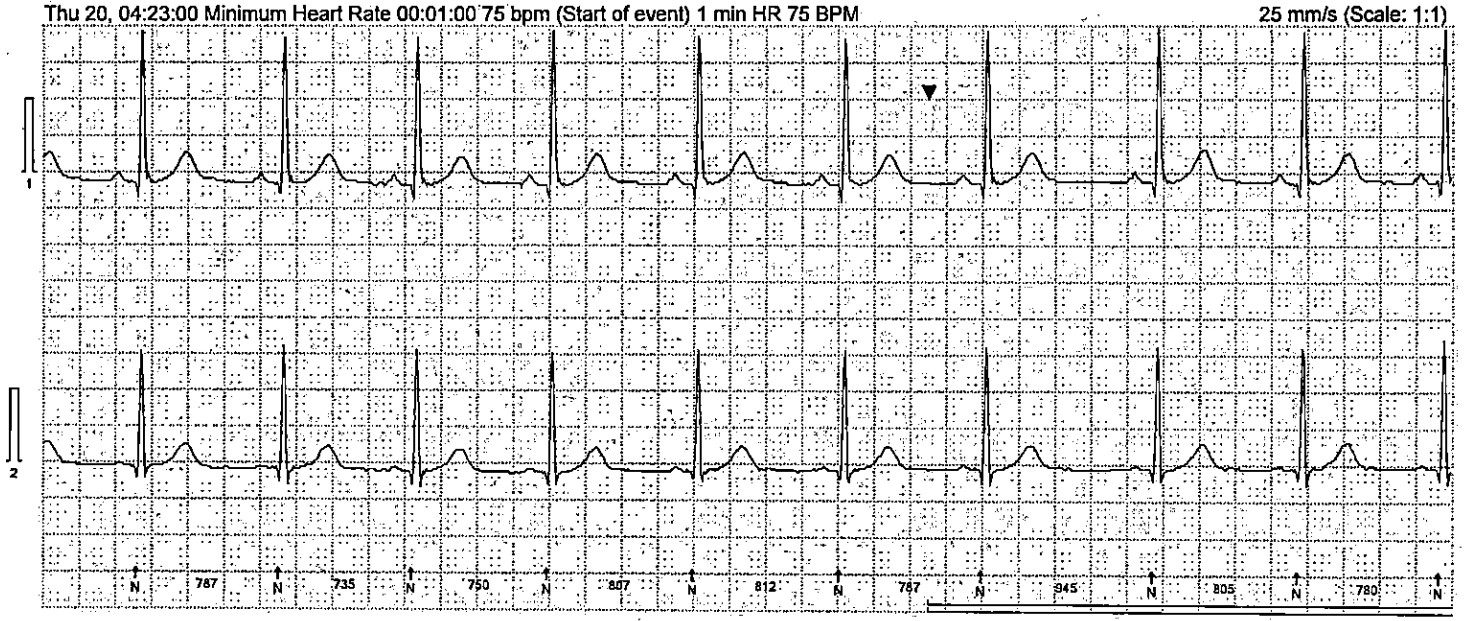
Wed 19, 16:20:58 Patient Event (Summary of event) 1 min HR 122 BPM 25 mm/s (Scale: 1:1)



Wed 19, 22:39:58 Patient Event (Summary of event) 1 min HR 111 BPM 25 mm/s (Scale: 1:1)



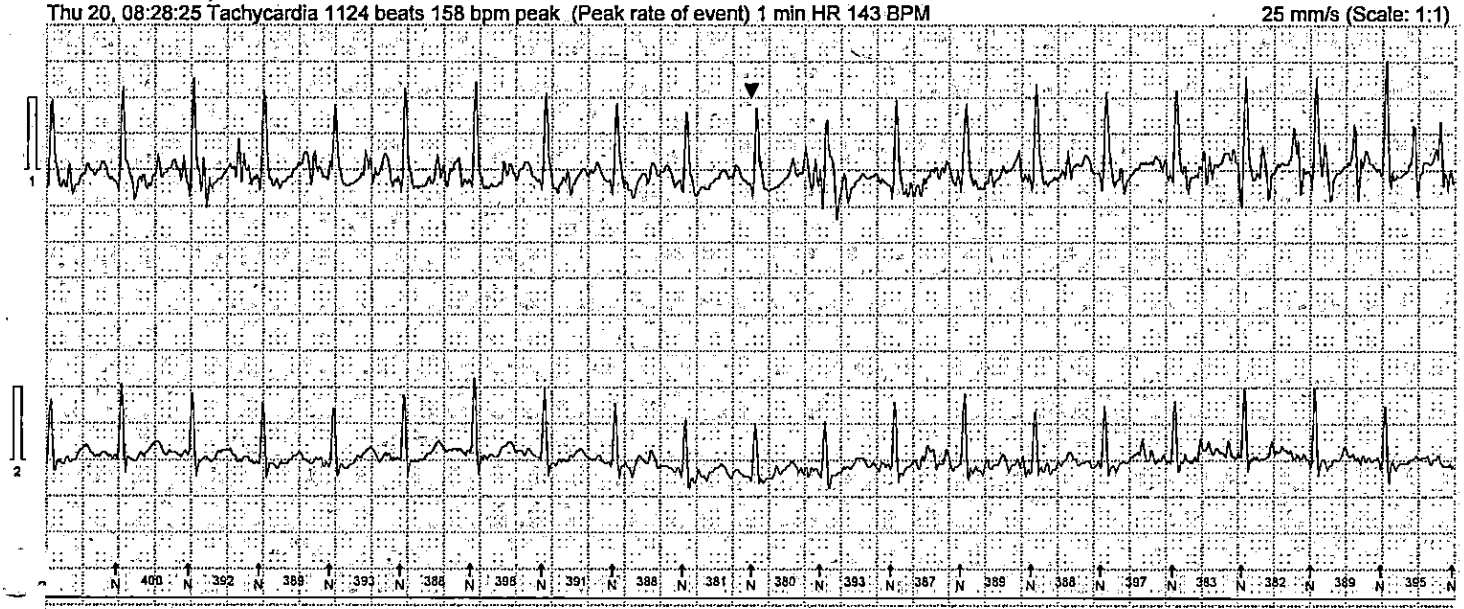
Thu 20, 04:23:00 Minimum Heart Rate 00:01:00 75 bpm (Start of event) 1 min HR 75 BPM 25 mm/s (Scale: 1:1)



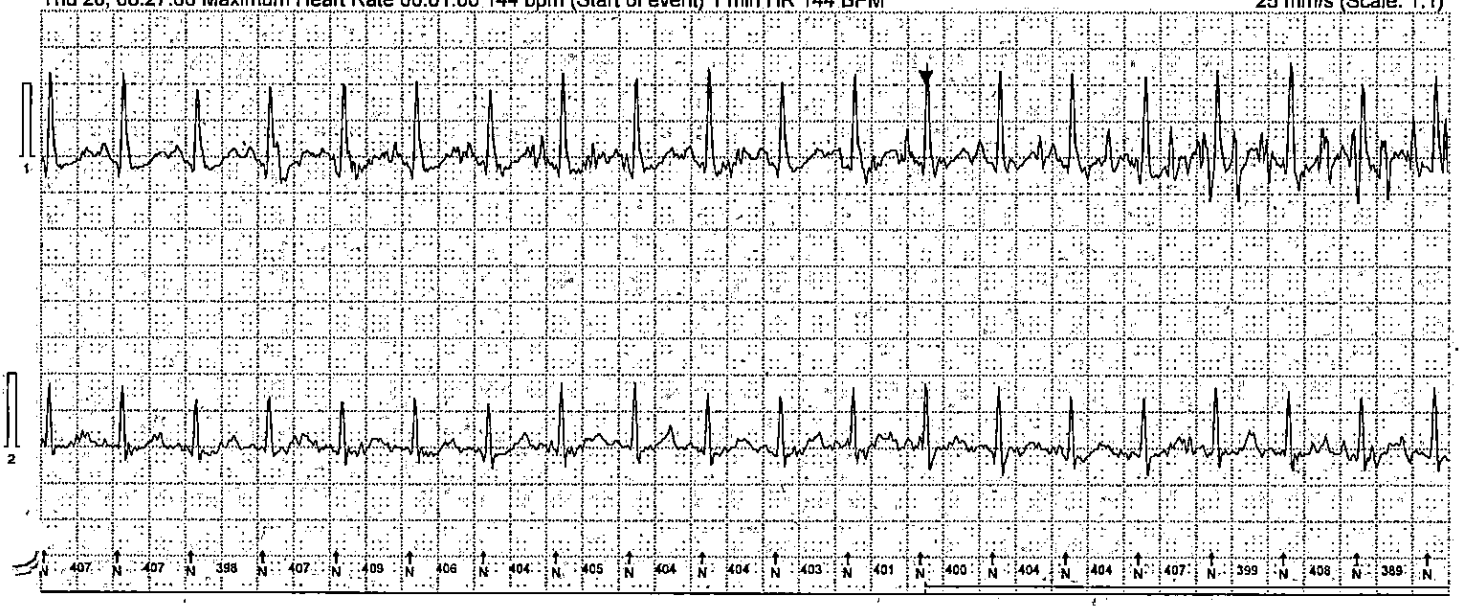
Signed By: Mingwang (Michael) Ho (WGACH) on 20/02/2025 10:11:10

Patient ID: 1612836909 Date of Birth: Fri 16 Dec 1983 (41 years) Gender: Female

Thu 20, 08:28:25 Tachycardia 1124 beats 158 bpm peak (Peak rate of event) 1 min HR 143 BPM 25 mm/s (Scale: 1:1)



Thu 20, 08:27:00 Maximum Heart Rate 00:01:00 144 bpm (Start of event) 1 min HR 144 BPM 25 mm/s (Scale: 1:1)



Donald, Diane ID:1612836909 22-JAN-2022 21:27:40 GREATER GLASGOW SITE-QEED ROUTINE RECORD

16-DEC-1983 (38 yr)
Female

Room:
Loc:1301

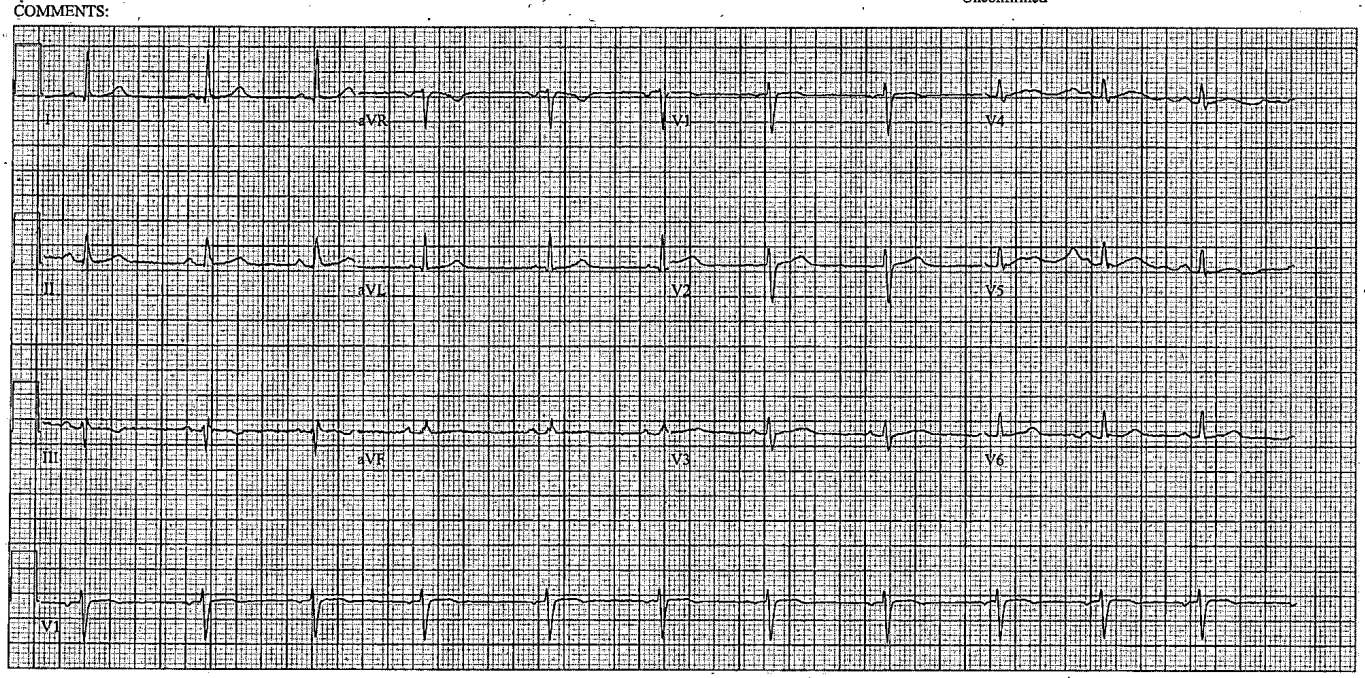
Vent. rate	67	BPM
PR interval	144	ms
QRS duration	80	ms
QT/QTc	390/412	ms
P-R-T axes	49 15	18

Normal sinus rhythm with sinus arrhythmia
Normal ECG

Technician:
Test ind:

Unconfirmed

COMMENTS:



25mm/s 10mm/mV 100Hz 9.0.10 12SL 241 HD CID: 29

SID: 1458757 EID: EDT: ORDER:

DONALD, DIANE ID: 1612836909 22-Jan-2022 21:27:40 QUEEN ELIZABETH UNIVERSITY HOSPITAL

16-Dec-1983
Female

Loc: 1301

Vent. rate 67 bpm
PR interval 144 ms
QRS duration 80 ms
QT/QTc 390/412 ms
P-R-T axes 49 15 18

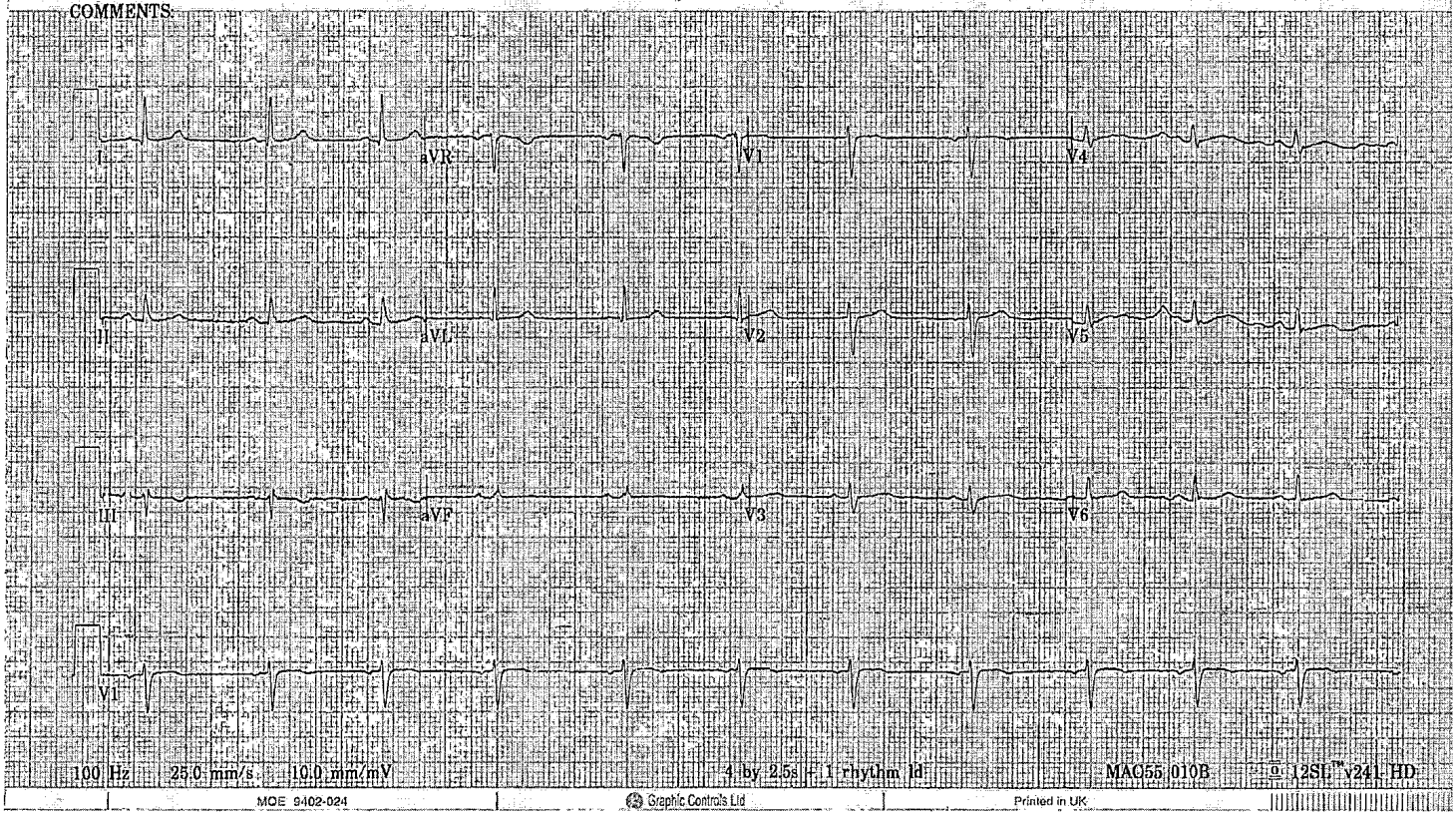
Normal sinus rhythm with sinus arrhythm
Normal ECG

Technician:
Test ind:

1612836909
DONALD F
Diane 16/12/1983
27 ST ANDREWS WAY
Clydebank, Dunbartonshire
G81 1BP

Referred by: Unconfirmed

COMMENTS:



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC55 010B 12SL™ v241 HD

MRI Head

Performed	28-Feb-2026 11:55	Received	04-Mar-2026 12:12
Reported	04-Mar-2026 12:10	Order Number	G405H43115311
Status	Final	Source System	MiSys

MRI Head Final
Diane Donald
Clinical History :
unwitnessed blackout with some seizure marker. Any epileptogenic lesion

MRI Head :
Standard sequences. Comparison with MRI head dated 12/04/2022 and CT head dated 23/01/2022.

Slight prominence of the right temporal horn however allowing for lack of dedicated sequences the mesial temporal lobe structures appear unremarkable.
No cortical or migration abnormality. No space occupying lesion or evidence of prior insult.

No blood products/vascular malformation on susceptibility sequences.
No other significant finding.

Summary: No definite epileptogenic focus demonstrated.

Reported by: Dr Catherine Cobburn (SpR) and Dr Saif Khan
Verified by: Dr Saif Khan

MRI Head with contrast

Performed	12-Apr-2022 15:29	Received	14-Apr-2022 09:07
Reported	14-Apr-2022 09:05	Order Number	G405H38249211
Status	Final	Source System	MiSys

MRI Head with contrast Final
Diane Donald
Clinical History :
Headaches, retro-orbital pain ??? Pontine anterior lesion

MRI Head with contrast :
Sagittal T1, axial T2/T2 FLAIR, DWI, SWI, volume T2 FLAIR and pre and post contrast volume T1 sequences performed. Reference made with preceding CT head 23/01/2022.

Normal intracranial appearances. Specifically, normal appearance of the pons - finding on preceding CT was artifactual.
Mucosal thickening within several of the paranasal sinuses.

Reported by: Dr Katy MacDonald
Verified by: Dr Katy MacDonald

CT Head

Performed	23-Jan-2022 19:27	Received	23-Jan-2022 20:19
Reported	23-Jan-2022 20:17	Order Number	G405H38065314
Status	Final	Source System	MiSys

CT Head Final
Diane Donald
Clinical History :

38 year old year lady presents with severe frontal headache focused on eyes. Sudden onset vomiting, now resolving. No focal neurology on examination. B/G normal tension glaucoma. D/W'd ophthalmology who advised unlikely related to glaucoma and advised exclude other pathologies. CT H to exclude evidence of ICH or SOL. Many thanks.

CT Head :

aln pons, the impression of a small focal low density lesion lying anteriorly to the left of midline. This is at the site of very marked streak from the skull base and the appearance could be artifactual.

Otherwise, the intracranial appearances are satisfactory. No hydrocephalus, space-occupying pathology or acute intracranial haematoma. No brain herniation or hydrocephalus.

Large mucosal polyps in left maxillary antrum. Skull base and calvarium are intact.

OPINION: The possible a finding related to the left side of pons is unlikely to explain the patient's presenting symptoms, but clarification with MR is recommended in due course.

Reported by: Dr Peter Garmany
Verified by: Dr Peter Garmany

XR Hand Rt

Performed	06-Dec-2018 13:44	Received	06-Dec-2018 14:20
Reported	06-Dec-2018 14:18	Order Number	G405H34549240
Status	Final	Source System	MiSys

XR Hand Rt Final
Diane Donald
Clinical History :

Fell when intoxicated bony tender 5th MC and small finger exclude #

XR Hand Rt :
No acute bone or joint abnormality identified.

Code A: Agreement: No major discrepancy between the radiologist report and the referrer's 'sticky note' interpretation.

Reported by: Dr Killian Mac A' BhÃ¡ird (ST2)
Verified by: Dr Killian Mac A' BhÃ¡ird (ST2)

US Breast Lt

Performed	20-Apr-2018 17:06	Received	20-Apr-2018 17:19
Reported	20-Apr-2018 17:10	Order Number	G504H33780382
Status	Final	Source System	MiSys

US Breast Lt Final
Diane Donald
Clinical History :
Palpable area left breast.

US Breast Lt :
Ultrasound of the area of clinical concern demonstrates prominent glandular tissue only.

U one.

Reported by: Dr Janet Litherland
Verified by: Dr Janet Litherland

US Thyroid

Performed	25-Jan-2012 09:56	Received	26-Jan-2012 12:04
Reported	26-Jan-2012 11:42	Order Number	G516H26521380
Status	Final	Source System	MiSys

US Thyroid Final
Diane Donald
Clinical History : Left-sided 2 cm thyroid nodule. Previous Thy 1.

US Thyroid :

The right lobe of thyroid and isthmus are essentially normal. When compared to the previous examination of 9/6/10, there has been no significant change in the size of the nodule within the left lobe of thyroid. This currently measures approximately 2.5 x 2.3 x 1.8 cm. Internal hypervascularity is again demonstrated. The lesion remains partly cystic, although the cystic component has reduced in extent.

There is no significant lymphadenopathy in the neck.

US Guided aspiration thyroid :

Fine needle aspiration of the left-sided nodule was performed.

Reported by: Dr Wilma Kincaid
Verified by: Dr Wilma Kincaid

US Guided aspiration thyroid

Performed	25-Jan-2012 09:56	Received	26-Jan-2012 12:04
Reported	26-Jan-2012 11:42	Order Number	G516H26521381
Status	Final	Source System	MiSys

US Thyroid Final
Diane Donald
Clinical History : Left-sided 2 cm thyroid nodule. Previous Thy 1.

US Thyroid :

The right lobe of thyroid and isthmus are essentially normal. When compared to the previous examination of 9/6/10, there has been no significant change in the size of the nodule within the left lobe of thyroid. This currently measures approximately 2.5 x 2.3 x 1.8 cm. Internal hypervascularity is again demonstrated. The lesion remains partly cystic, although the cystic component has reduced in extent.

There is no significant lymphadenopathy in the neck.

US Guided aspiration thyroid :

Fine needle aspiration of the left-sided nodule was performed.

Reported by: Dr Wilma Kincaid
Verified by: Dr Wilma Kincaid

US Guided aspiration thyroid

Performed	09-Jun-2010 10:15	Received	10-Jun-2010 13:45
Reported	10-Jun-2010 13:24	Order Number	G516H13801847
Status	Final	Source System	MiSys

US Guided aspiration thyroid Final
Diane Donald
Clinical History : 3 cms nodule left lobe of thyroid. For FNA.

US Guided aspiration thyroid :

A solitary slightly hypervascular, partly cystic, partly solid, 27 x 22mms nodule is seen in the upper pole of the left lobe of thyroid. Some internal hypervascularity is demonstrated with peripheral calcification. An FNA was performed of the more solid looking component of this nodule. Sample sent to cytology. No immediate post procedural complications.

Unremarkable appearances of the isthmus and right lobe of thyroid. No significant cervical lymphadenopathy. The salivary glands are unremarkable.

Reported by: DR P DEONARINE and DR W KINCAID
Verified by: DR P DEONARINE

WEST GLASGOW HOSPITALS

MANUAL PATIENT RECORDS

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

Including:

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

SURGICAL ENDOCRINE UNIT

Mr C R Wilson (Tel: 0141-211-6248)
Miss J Doughty (Tel: 0141-211-2122)

Western Infirmary
Dumbarton Road
GLASGOW
G11 6NT

SURGICAL ENDOCRINE CLINIC – 19/03/2013

Ref: CRW/LJH
Dictated: *19/03/2013*
Typed : *10/04/2013*

Dr Joyce McDevitt
The Green Medical Practice
Clydebank Health Centre, Kilbowie Road
Clydebank
G81 2TQ

Dear Dr McDevitt

Diane Donald – 16/12/1983 – CHI: 1612836909 – CRN: 10631776W
Flat 2, 18 Onslow Road, Clydebank, G81 2NE

I would be grateful if you could arrange to take Diane's thyroid function at approximately 6 to 8 weeks time. She has recovered well from her recent thyroid lobectomy and I am very pleased to say that the results of that show that the lump in her thyroid was a benign follicular adenoma.

She has some difficulty in projecting her voice and pitch problems at the moment following her surgery but this is something that we would expect to completely resolve in the next few weeks. If is doesn't however, we could arrange for Diane to have some speech therapy to see if we can improve her vocal range. If this is the case please don't hesitate to contact me and I would be happy to arrange that.

Yours sincerely

Mr C R Wilson
Consultant Surgeon

SURGICAL ENDOCRINE UNIT

Mr C R Wilson (Tel: 0141-211-6248)
Miss J Doughty (Tel: 0141-211-2122)

Western Infirmary
Dumbarton Road
GLASGOW
G11 6NT

SURGICAL ENDOCRINE CLINIC – 19/03/2013

Ref: CRW/LJH
Dictated: *19/03/2013*
Typed : *10/04/2013*

Dr Robert Lindsay
Consultant Endocrinologist
Endocrine Unit
Western Infirmary
Glasgow

Dear Robbie

Diane Donald - 16/12/1983 - CHI: 1612836909 - CRN: 10631776W
Flat 2, 18 Onslow Road, Clydebank, G81 2NE

Diane came back to the clinic today where I am pleased to see following her pregnancy her follicular cytology had shown us that she had a Thy3F. Her result of her thyroid lobectomy has shown this to be a benign follicular adenoma and she has recovered well from this surgery. I am going to ask her GP to check her thyroid function test in 6 to 8 weeks time but today at the clinic all is well.

Kind regards.

Yours sincerely

Mr C R Wilson
Consultant Surgeon

IMMEDIATE DISCHARGE LETTER

NHS
Greater Glasgow

GP COPY

First Issued: 23/02/2013 09:31
Printed: 23/02/2013 09:32

Western Infirmary
Dumbarton Road
Glasgow
G11 6NT
Telephone : 0141 - 211 - 2000

Admitted: 21/02/2013 **Discharged:** 22/02/2013
Discharged to: Home
Ward: L10E
Consultant: MR C WILSON, General Surgery
Hospital No: 10631776W **Date of birth:** 16/12/1983
CHI: 1612836909

REGISTERED GP

Dr NEIL MURRAY
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

PATIENT

DIANE DONALD
FLAT 2
18 ONSLOW ROAD
CLYDEBANK
G81 2NE

DIAGNOSES	ICD10	PROCEDURES	OPCS4
No diagnoses have been made for this patient		1. Thyroid lobectomy, N/A, 22/02/2013	B084

MEDICATION

No medication has been prescribed for this patient

Pharmacy Comments

FOLLOW UP ARRANGEMENTS

Outpatient Clinic	Consultant	Date
Surgical	MR C WILSON	4 weeks

Outpatient Investigations	Date
No arrangements made	

Community Care	Date	Reason
No arrangements made		

GENERAL COMMENTS

Final discharge letter to follow

Dear Colleague,

Diane Donald was admitted for elective left thyroid lobectomy on 21/02/13 under Mr Chris Wilson. This went succesfully and post op period was unremarkable. Clinic follow up in 4 weeks.

Yours Sincerely,

Michael Gillespie
FY1 General Surgery

Signed: _____ **Designation:** _____

Contact: Michael Gillespie **Pager Number:**

Western Infirmary Surg___ ___it

Mr C R Wilson

OPERATION NOTE

Name	10631776W DONALD DIANE F FLAT 2 18 ONSLOW ROAD CLYDEBANK G81 2NE CHI-1612836909	**Unit Number**	
Date of Birth	16/12/1983	**Date of Admission**	21/2/13
		Date of Operation	21/2/13

Principal Surgeon Cuthbert

Assistant Surgeon(s) Cuthbert / T Usman

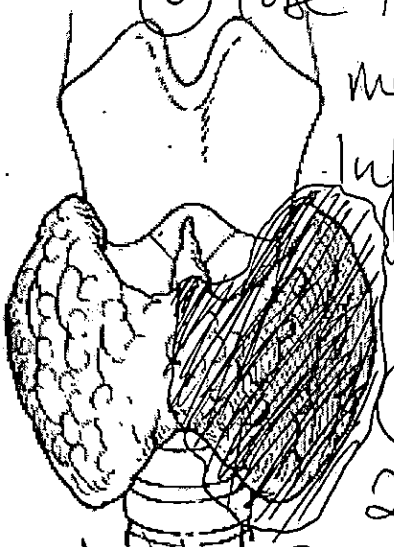
Anaesthetist S Ghosh

Diagnosis Dominant nodule left thyroid

Procedure left thyroid lobectomy

Indications

Operation Details GA. collar incision. Strap divided.



(1) lobe thyroid mobilized medially. Superior/inferior + medial vessels identified + ligated.

(2) RLN ✓

2x parathyroids preserved.

(3) Isthmus divided @ isthmus + sutured c 3/0 PDS for haemostasis 2/0 vicryl + 3/0 biosyn skin. (Only 0.5% chlorhex). 10G drain secured c silk. Steristrip + dsite

Post operative Instructions

F+D.

Master drain

(1) paracetamol

A — Kelly F42

well post op
No swelling
Some pain in neck. Obs stable.

(1) observe
hopefully drain out am

Miller FY1

22/2/13 0840 S/B mr Wilson
Drain out
(11) today
F/up arranged

(D) T comm'd

Intraoperative Accountable Record

Date 21-2-13

ADDRESSOGRAPH

10631776W
DONALD F
DIANE 16/12/1983
FLAT 2
18 ONSLOW ROAD
CLYDEBANK G81 2NE
CHI-1612836909

WARD 210

HOSP - Lo i9

THEATRE - 4

COUNTS	Scrub Nurse(s) Print Name	Circulating Nurse(s) - Signature & Print name
PRE - OP SWAB COUNT CORRECT	L. Wilkie	M McKenzie
PRE - OP INSTRUMENT COUNT CORRECT	L. Wilkie	T Russell
FINAL SWAB COUNT CORRECT	L. Wilkie	T Russell
FINAL INSTRUMENT COUNT CORRECT	L. Wilkie	T Russell
FINAL SWAB DISPATCH COUNT CORRECT	L. Wilkie	T Russell

SCRUB NURSE VERIFICATION - PLEASE SIGN ON PAGE UNDERNEATH.

I have reviewed this count sheet and can verify my count(s) correct
SCRUB NURSE 1- SIGNATURE - L Wilkie
SCRUB NURSE 2 SIGNATURE - NONE
To be signed by replacement scrub nurse if applicable

HANDOVER COUNT IN EVENT OF REPLACEMENT OF SCRUB NURSE DURING PROCEDURE

	Outgoing Scrub Nurse - Print Name	Incoming Scrub Nurse - Print Name	Circulating Nurse(s) - Signature & Print name
OUTGOING COUNT *To be completed for permanent and temporary replacement*			
INCOMING COUNT *To be completed for temporary replacement*			

OPERATION LEFT THYROIDECTOMY

TALLY OF EACH ITEM USED - ADD ANY ITEMS SPECIFIC TO YOUR SPECIALITY

						ITEMS REMAINING IN SITU (Type & Number)
Swabs (2x2)	✓	Tapes	✓			
Swabs (10x10)	20	Sloops/Slings	✓			
Abdominal packs	✓	Bulldogs	✓			
Sutures	5	Shods	✓			
Blades	1	Tibbs Cannula	✓			
IV needles	1	Ports	✓			
Syringes	1	Staple Gun Inserts	✓			
Discard-a-pad	1	Spears	✓			
Diathermy pencil	1	Throat packs - Anae	✓			
Diathermy tips	1	Throat packs - Scrub	✓			
Scratch pad	1	Retrieval Bag (Bert)	✓			
Reels	✓	Digital Tourniquets	✓			
Patties	✓					
Pledgelets	15					

DISCREPANCY IN COUNT - ACTIONS AND OUTCOME NONE

COUNT IN WHICH DISCREPANCY OCCURRED

DETAILS

ACTIONS TAKEN AND OUTCOME (I.E. SWABS ISOLATED, SEARCH UNDERTAKEN, WOUND EXPLORED, X - RAY TAKEN) -

SCRUB NURSES SIGNATURE IF COUNT STILL INCORRECT FOLLOWING ALL POSSIBLE ACTIONS

SURGEONS SIGNATURE IF COUNT INCORRECT FOLLOWING ALL POSSIBLE ACTIONS

PLEASE INSERT TRACEABILITY STICKERS ON BACK OF COPY- TO STAY IN THEATRE.

NORTH[illegible] HOSPITALS

Greater Glasgow and Clyde

CLINICAL DIRECTORATE OF ANAESTHESIA THEATRES, ITU AND PAIN RELIEF SERVICES

MULTI DISCIPLINARY CARE PLAN

U 10631776W F
Na DONALD DIANE 16/12/1983
Ad FLAT 2 18 ONSLOW ROAD CLYDEBANK G81 2NE
Do CHI-1612836909

Ward: 10 EAST Date: 21/2/13

Consultant WILSON

Theatre: TH 4 LS

Proposed Operation:

LEFT THYROID lobectomy

PRE-OPERATIVE VISITS
Any Relevant Visits:

CHECK LIST
Please check the following before pre-med is given:-

	WARD YES	RECEPTION YES	COMMENT / N.A.
When did the patient last eat or drink	TIME FAST 12MN BMN		
BM Stix?	TIME N/A VALUE N/A		Clexane Given at 9.20am
Consent signed?	YES	✓	
Identity band correct (Name, DoB hospital no., ward no.)	YES	✓	
Case notes (including current ECG N/A biochemistry, haematology), nursing notes, drug Kardex, recording sheet)? TAKEN THIS MORNING	YES	✓ NO ECG	- Clexane this am 40mg
X-Rays available?	N/A	N/A	- No metalwork
Operation site prepared - marked?	N/A	N/A	
Dentures removed?	OWN TEETH	own teeth	- No allergies
Prothesis/Hearing aids, contact lenses removed?		N/A	- No betadocres
Make-up, nail varnish, jewellery (taped/removed)?	HAS EXTENSIONS IN SITU	hair extensions	
Wearing black tied cotton gown, disposable pants?	YES	✓	
Pacemaker?	N	NO	
Allergies?	NKDA	None Known	
Have you passed urine this morning?	YES	✓	
Waterlow score noted	YES	5	
Pre-med given?	N/A	NA	Clexane - 40mg

Signature [signature] Ward 10 EAST

Reception:

Correct patient received and documentation complete? ☐

Time into Reception .....

Signature [signature]

	YES	N/A	
Patient identified in anaesthetic room?	☑	☐	NAMED NURSE

Time: 0955 Signature: M Jackson SK McKenzie

MONITORING

ECG	☑	IBP	☐	PULSE	☐
NIBP	☑	CVP			
SaO_2	☑	Core Temp.			
CO_2	☑	Peripheral Temp.			

Laryngeal Mask ☐ Size:.....

ET tube ☑ Size: 7.5 Reinforced

Throat Pack ☐ Removed? Yes ☐ No ☐

TOURNIQUET ☐ Time applied ..... Pressure .....

Time released ..... Site .....

DIATHERMY ☑ Site .....

BI-POLAR ☐

Patient position on table Supine

	Yes	Comment
Positioned as per policy?	☑	.....
Prevention of pressure sores?	☐	.....
Prevention of heat loss	☑	Bair Hugger
F e mattress?	☐	.....
Padding?	☑	.....
Warmed fluids?	☐	.....

IV Cannulation ☑ Site .....

Arterial Cannulation ☐ Site .....

CVP Line ☐ Site .....

METHOD OF ANAESTHESIA

General	☑	Regional	☐	Site .....
Local	☐	Spinal	☐	
Epidural	☐	Sedation	☐	Site .....

OPERATION (L) THYROID : La Bx Chony

ANAESTHETIC POST-OP INSTRUCTIONS

O_2 Therapy 4 L/M 4 Hours Hudson Mask

Post-operative IV Fluid Regimen:

CSL - 60 ml/h TIL Bx Rec'd

Routine Observations: Yes ☑

Special Instructions: CVP ☐ Urine volumes ☐

Analgesia Prescribed Yes ☐ N/A ☐

Does Anaesthetist wish to see patient before return to ward? Yes ☐ N/A ☐

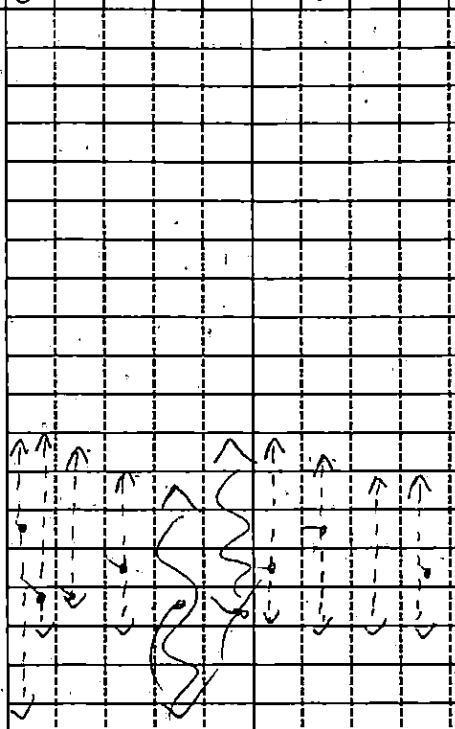
BLOOD LOSS IN THEATRE ..... mls

Anaesthetist's Signature .....

WOUND CARE **Specify:**

Skin Preparation	☑	Transept
Drain	☑	Lowac 10ch exit Sutured
Catheter	☐	
Staples	☐	
Sutures	☑	3 @ Bx Site
Packing	☐	
Dressing	☑	Steri-Strip
Wound toilet	☑	Transept

PAIN SCORE 2. SEDATION SCORE

Time	11 50	12 05	12 20	12 35	12 [illegible]	13 [illegible]	13 15	13 30	13 45
Pain Score	0	4/10	4/10			4/10	5/10	3/10	5/10
Sedation Score	1	0	0			0	0	0	0
Nausea Score	0	0	0			0	0	0	0
BP / PULSE									
RESPS	18/16	16/16	16	16	16	16	16	16	
SaO_2	99%/100%	97	95	97%	97%	98%	96%		
Temp.	37.1							37.9	
ECG	SIR/SIR	SIR/SR	SR			SIR	SIR	SIR	
DRAIN	nil/nil	nil/NIL	NIL			nil	nil	nil	
Wound	dry/dry	dry/DRY	DRY			dry	dry	dry	
FACIAL SYMMETRY		tve	tve			✓	✓	✓	
SMILE		tve	tve.			✓	✓	✓	

00583

SURGICAL POST-OP INSTRUCTIONS

Surgeon's Signature .....

Time into Recovery: 11:50

RECOVERY

NAMED NURSE .....

	Yes	N/A	
ET tube?	☐	☑	removed: .....
Laryngeal mask?	☐	☑	removed: .....
Airway?	☐	☑	removed: .....

MONITORING

ECG	☑	IVP	☐	RESPIRATION	☑
NIBP	☑	CVP	☐		
SaO_2	☑	PULSE	☑		

	Yes	N/A
X-rays Requested	☐	☑

Prevention of Pressure Sores

			Comments
Waterlow score	☐	☐	Nursed shoal bum on
Equipment?	☐	☐	trolley. PL encouraged to
Nursing action	☐	☐	make own positional change

CRITERIA TO BE MET BEFORE DISCHARGE FROM RECOVERY

Is the patient conscious and orientated to time and place?	☑	☐
Is patient cardiovascularly stable?	☑	☐
Is patient comfortable?	☑	☐
Are drains patent and is drainage within expected limits? Are wounds free from excessive staining?	☐	☐

NEWS SCORE

1g (IV) PARACETOMOL.
100 mcg (IV) FENTANYL.
10 mg morphine

Signature: .....

EVENTS

11⁵⁰ Patient received into recovery breathing spontaneously and maintaining own airway. Observations as charted

12⁰⁵ 1g IV paracetamol given as prescribed

Pt c/o blurry vision in left eye.

12²⁰ Pt has passed urine 300mls

12³⁵ PT COMPLAINING TOOTHACHE CHECKED WITH ANAESTHETIST PT WAS'NT BITING ON ETTUBE ON EXTUBATION - REVIEWED BY ANAESTHETIST AND TOOTHACHE PROBABLY RELATED TO WOUND —

i-044493-010 2774347
Rusch Lary Blade Size 3

REF DYJPEUNPSM3
www.medline.com
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Thyroidectomy Set

S6696-008 2790757
General Basic

i-045283-102 27820

Anaesthetic Record

NHS Greater Glasgow and Clyde

10631776W
DONALD F
DIANE 16/12/1983
FLAT 2
18 ONSLOW ROAD
CLYDEBANK G81 2NE
CHI-1612836909

Premedication

Procedure(s) (2) Thyroid Lobectomy

Anaesthetist(s) A. S. Ghanaj / D. M. Chandran ☒ iC ☐ SAS ☒ StR

Surgeon(s) MR Watson & A ☐ ☐ ☐

Date 21/2/17

Supervising consultant Discussed ☐

Airway ✓

RS

NAD

CVS

Fitted / Lungs: Clear

Current therapy

Nil

Weight (kg) 59 kg HL - 158

Haematology

Biochemistry

ECG

BP ___ / ___

Other significant illnesses

- 10-20 cpd

Allergies NKDA

Previous anaesthesia Yes
NAD

ASA (1) 2 3 4 5 E

Technique & associated risks discussed with patient ☒

Supine ☑ Prone ☐ Lateral H Head down ☐

GA ☑ Spinal ☐ Epidural ☐ Other LA _____

ETT RI 7.5 LMA _____ F Mask ☐ Laryngoscopy grade I

IV site(s) (R) HA 20G

Art line

CVP

Ventilator A/S

Breathing system ⊙

Start 10:0-

Finish :

Equipment check ☑

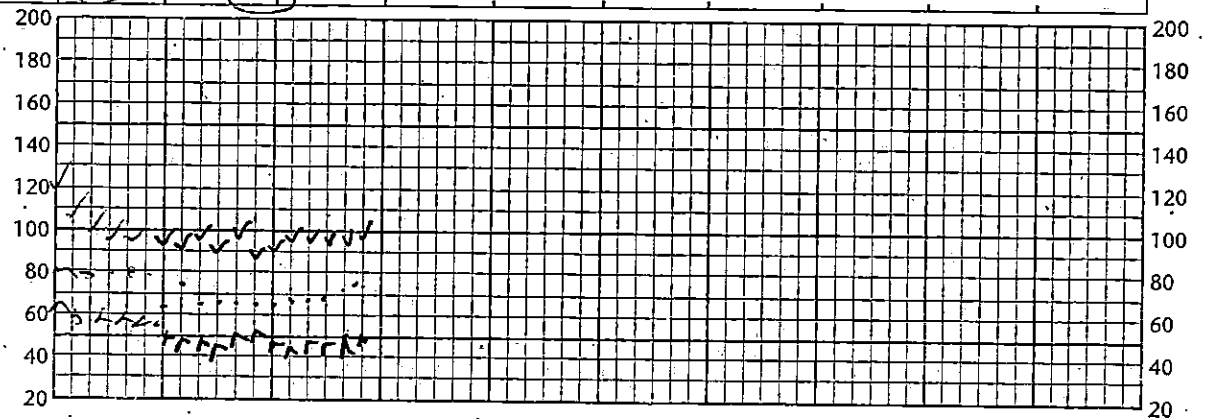
Technique details

- PPP
- ET

REMIFENTANIL TCI	2.-
PROPOFOL	200
ROCURONIUM	40
ONDANSETRON	4
DEXAMETHASONE	4
IV fluids	(1) (2)

Pre-ox ☑
RSI ☐

ECG ☐
SpO_2 ☐
NIBP ☐
$ETCO_2$ ☐
ETAA ☐
All of the above ☑
PNS ☐



Time	10:0	10:30	11:	11:30	12:
Events					
FiO_2	1.0 .5	.5	0.5L	0.5L	
SpO_2	98		99	99	
$ETCO_2$	4.9 4.6		4.1	4.1	
ETAA	2.0 2.1		2.0	1.9.	

Events
① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

IV fluids
① CSA - 1 U
② CSA - 1
③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

B Warmer ☑

Signature _____
Name _____ (S. Chopra)

MIS 155180

Patient Agreement to Investigation or Treatment

NHS Greater Glasgow and Clyde

CONSENT FORM

PATIENT DETAILS (OR PRE-PRINTED LABEL)

Ho

10631776W
DONALD F
DIANE 16/12/1983
FLAT 2
18 ONSLOW ROAD
CLYDEBANK G81 2NE
CHI-1612836909

Pat ne :.....

Pat .....

Da ____ ____ _____ Gender: Male ☐ Female ☐

NHS/ CHI Number _____

Special requirements (e.g. other language/communication method) .....

.....

Responsible practitioner: .....WILSON.....

Job title: .....Cons Surgeon.....

STATEMENT FOR PRACTITIONER

(to be filled in by practitioner with appropriate knowledge of proposed procedure- see guidance notes)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side: (WRITTEN IN FULL)

left thyroid (dectomy

I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedures above).

Signature of practitioner: .....

Name/Designation (Print) .....ST.....

Date 21/2/13

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*

(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

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

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- to the emergency administration of blood or blood products

Additionally you have to agree or disagree the following:-	**Agree**	**Disagree**
that information and/or images kept in records may be used anonymously for education, audit, and research with appropriate ethical approval, to improve the quality of patient care.	☐	☐
that surplus tissue or other biological material not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☐

PATIENT REFUSAL FOR BLOOD PRODUCTS

Please sign here if you refuse to consent to the emergency administration of blood or blood products. Even if this results in death.

Signature: ..... Date ...../...../.....

Practitioner Signature: ..... Date ...../...../.....

PATIENT/PARENT* AGREEMENT FOR TREATMENT

Signature: ..... Date 21/2/13

Name (Print): .....

SURGICAL ENDOCRINE UNIT

Mr C R Wilson (Tel: 0141-211-6248)
Miss J Doughty (Tel: 0141-211-2122)

Western Infirmary
Dumbarton Road
GLASGOW
G11 6NT

Ref: CRW/KC
CHI: 1612836909
Dictated: *12/02/2013*
Typed : *14/02/2013*

Mrs Diane Donald
Flat 2, 18 Onslow Road
Clydebank
G81 2NE

Dear Mrs Donald

Patient No: 10631776W
Patient Type: Inpatient

Arrangements have been made for your admission to ward Level 10 of the Western Infirmary under the care of Mr C R Wilson.

I would be grateful if you could report to the Admissions Desk, Level 3, at **8.00am on Thursday, 21 February 2013.**

As you are having a general anaesthetic I would be grateful if you would **fast** from midnight the night before your admission.

Please bring with you any medicines, in their original containers, which have been prescribed by your General Practitioner, who will be informed of your Admission.

Should this date be unsuitable, it would be very much appreciated if you would contact me immediately on 0141 211 6248 so that arrangements may be made to offer the bed to another patient.

Yours sincerely

K Cruickshank
Secretary to Mr C R Wilson

General Surgery
Surgery & Anaesthetics
Western Infirmary/gartnavel General
Dumbarton Road
Glasgow
G11 6NT

NHS
Greater Glasgow and Clyde

Switchboard: 1000 **Contact:** 0141-211-6248

Date: 13/02/2013
CHI number: 1612836909

Name: DIANE DONALD
Address: FLAT 2
18 Onslow Road
Clydebank
G81 2NE

Dear DIANE DONALD,

I am writing to confirm that you have been added to the General Surgery Waiting List to have a procedure carried out. Under the Patient's Rights (Scotland) Act 2011 you have a Guarantee to be admitted for treatment within 12 weeks. This means that we will offer you an appointment on or before 30/04/2013. This is the maximum that you should wait; we will of course endeavour to see you sooner.

You may have already been contacted, or you will be contacted, to arrange a time for the procedure to be carried out and a separate appointment for pre-assessment clinic if this is required. If there are any periods when you will not be able to have the procedure carried out please contact us on the above telephone number.

Please note that we are unable to accept requests for treatment to be deferred for longer than three months.

If you have any queries relating to your appointment or procedure, please do not hesitate to contact me.

Yours sincerely

Krysia Cruickshank
Medical Secretary

SURGICAL ENDOCRINE UNIT

Mr C R Wilson (Tel: 0141-211-6248)
Miss J Doughty (Tel: 0141-211-2122)

Western Infirmary
Dumbarton Road
GLASGOW
G11 6NT

SURGICAL ENDOCRINE CLINIC – 05/02/2013

Ref: CRW/KC
Dictated: *05/02/2013*
Typed : *13/02/2013*

Dr Neil Murray
The Green Medical Practice
Clydebank Health Centre, Kilbowie Road, Clydebank
G81 2TQ

Dr Robert Lindsay
Consultant Endocrinologist
Endocrine Unit
Western Infirmary

Dear Dr Murray

Diane Donald - 16/12/1983 - CHI: 1612836909 - CRN: 10631776W
Flat 2, 18 Onslow Road, Clydebank, G81 2NE

Diane came back to see me after her recent successful pregnancy. As you remember she had about a 2-3cm left solitary thyroid nodule which has really been difficult to prove benign as her cytology has always been C1.

When we spoke before her pregnancy she was keen to have this removed but we delayed that until after her pregnancy had finished. She is now there, the lesion is still palpable and we have talked today about a left thyroid lobectomy and we have placed her on the list to have this done in the very near future.

Yours sincerely

Mr C R Wilson
Consultant Surgeon

SURGICAL ENDOCRINE UNIT

Mr C R Wilson (Tel: 0141-211-6248)
Miss J Doughty (Tel: 0141-211-2122)

Western Infirmary
Dumbarton Road
GLASGOW
G11 6NT

SURGICAL ENDOCRINE CLINIC – 14/08/2012

Ref: CRW/KC
Dictated: *14/08/2012*
Typed : *27/08/2012*

Dr Robert Lindsay
Consultant Endocrinologist
Endocrine Unit
Western Infirmary

Dr Neil Murray
The Green Medical Practice
Clydebank Health Centre, Kilbowie Road,
Clydebank
G81 2TQ

Dear Dr Lindsay

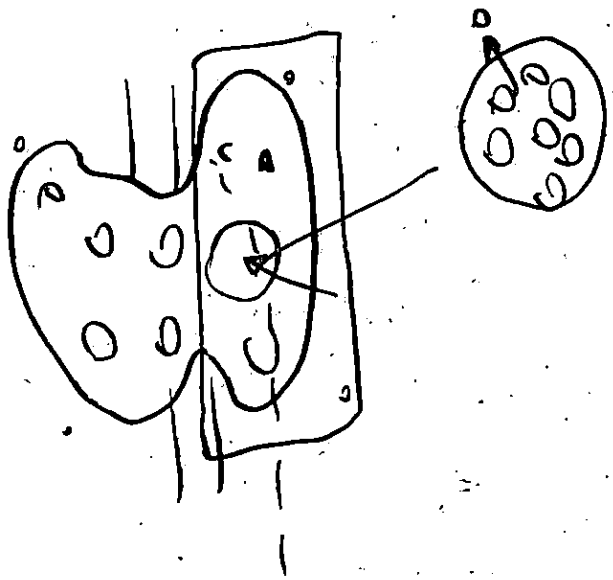
Diane Donald - 16/12/1983 - CHI: 1612836909 - CRN: 10631776W
17/7 Ashtree Court, Old Kilpatrick, Glasgow, G60 5JD

Thank you for referring Diane for consideration of thyroid lobectomy in view of her presentation with a thyroid nodule that it has been difficult to prove on cytology it is benign.

Diane is going to complete her pregnancy and we will arrange to see her at the end of her pregnancy and discuss further management at that stage.

Yours sincerely

Mr C R Wilson
Consultant Surgeon



1063176W

OBSTETRICS DEPARTMENT

Secretary to Dr Roberts- Cheryl
Tel: 0141 201 2236
Fax: 0141 201 2994
E-mail: cheryl.gaughan@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

JR/LR
Clinic: 10/07/12
Dictated:
Typed: 17/07/12
CHI: 1612836909

DR LENNOX
CLYDEBANK HEALTH CENTRE
CLYDEBANK
G81 2TQ

Dear Dr Lennox

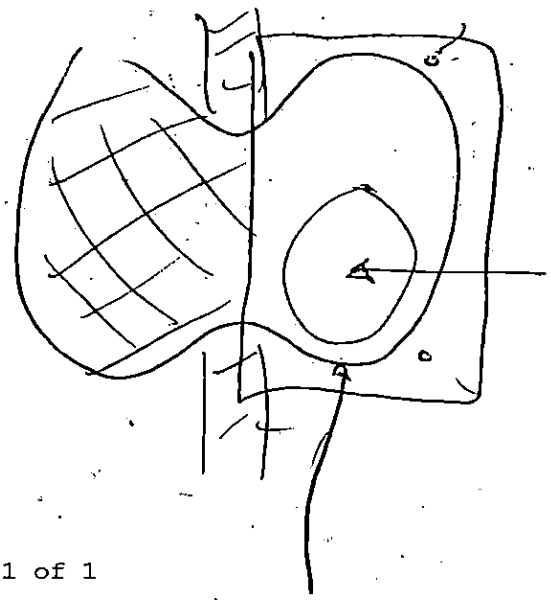
DIANE DONALD DOB: 16/12/83 (SG03295684)
17-7 ASHTREE COURT, OLD KILPATRICK, GLASGOW, G60 5JD

I am writing to let you know that Diane is currently pregnant and has just attended my antenatal clinic at 15 weeks gestation with an estimated date of delivery of the 29th December 2012. I understand that she has been under your care over the last couple of years because of thyroid nodule which has been biopsied on a couple of occasions. You have recently referred her to Mr Wilson for consideration of surgical management and she has an appointment for him in August. I have suggested to Diane that is probably unlikely that she would have any surgery carried out during her pregnancy. She wonders if her nodule is increasing in size but is otherwise very well.

Kind regards
Yours sincerely

JUDITH ROBERTS
CONSULTANT GYNAECOLOGIST

cc Dr Chris Wilson
Consultant Surgeon
Western Infirmary
Dumbarton Road
GLASGOW
G11 6NT



OPA
14/8

NHS
Greater Glasgow and Clyde

Western Infirmary – Dumbarton Road – Glasgow G11 6NT

Endocrine Unit
Professor A F Dominiczak
Dr A R McLellan /Dr M Freel
Dr G C Jones /Dr C Sainsbury
Dr C Perry / Dr R Lindsay

Karen.Campbell3@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]
Donna.Grant@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]

Gill.Mitan@ggc.scot.nhs.uk
Emma.Nairne@ggc.scot.nhs.uk [Secretaries] ☎ : *0141-211-2737*

DR ROBERT LINDSAY'S THYROID CLINIC

RL/CD

SURGERY
SVR COMEND

26th April 2012

Mr C Wilson
Consultant Surgeon
Western Infirmary
Glasgow
G11 6NT

Dear Mr Wilson

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
17/7 Ashtree Court, Old Kilpatrick, Glasgow, G60 5JD

I would be grateful if this lady with a 27mm nodule left lobe of thyroid might be seen. As detailed it is stable, not causing particular concern but she is wishing to pursue whether it might be removed.

Yours sincerely

DR ROBERT LINDSAY
Consultant in Diabetes & Endocrinology

NHS
Greater Glasgow and Clyde

Western Infirmary – Dumbarton Road – Glasgow G11 6NT

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DR ROBERT LINDSAY'S THYROID CLINIC – 29/03/2012

RL/CD 26/04/2012

Dr Neil Murray
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Dear Dr Murray

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 1063176W
17/7 Ashtree Court, Old Kilpatrick, Glasgow, G60 5JD

Diagnosis: 1. 27x22mm nodule left lobe of thyroid stable on ultrasound from June 2010

I saw Diane Donald back in clinic. She has a partially cystic nodule in the thyroid that was ultrasounded in June of 2010 and again in January 2012. There has been no significant change over that time in size. The appearances are benign. She has had two FNA's which both unfortunately are non-contributory showing blood (Thy 1). I had a long discussion with her. I have been very reassuring that given the length of time that we have shown this to be stable I think it highly unlikely there is any major disease going on and I would be content discharging her today and not having any further imaging or fine needle aspiration. She remains somewhat concerned by the appearance of the nodule & would like to discuss with one of the surgeons as to the possibility of having it removed. For that reason I will refer her on to Mr Wilson.

Yours sincerely

DR ROBERT LINDSAY
Consultant in Diabetes & Endocrinology

Copy to:-

Mr C Wilson
Consultant Surgeon
Western Infirmary
Glasgow
G11 6NT

NHS
Greater Glasgow and Clyde

Western Infirmary – Dumbarton Road – Glasgow G11 6NT

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DR ROBERT LINDSAY'S THYROID CLINIC - 29/03/2012

RL/CD 26/04/2012

Dr Neil Murray
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
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G81 2TQ

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Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
17/7 Ashtree Court, Old Kilpatrick, Glasgow, G60 5JD

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Yours sincerely

DR ROBERT LINDSAY
Consultant in Diabetes & Endocrinology

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Mr C Wilson
Consultant Surgeon
Western Infirmary
Glasgow
G11 6NT

NHS
Greater Glasgow and Clyde

Western Infirmary – Dumbarton Road – Glasgow G11 6NT

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Emma.Nairne@ggc.scot.nhs.uk [Secretaries] ☎ : *0141-211-2737*

DR ROBERT LINDSAY'S THYROID CLINIC

RL/CD

26th April 2012

Mr C Wilson
Consultant Surgeon
Western Infirmary
Glasgow
G11 6NT

Dear Mr Wilson

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
17/7 Ashtree Court, Old Kilpatrick, Glasgow, G60 5JD

I would be grateful if this lady with a 27mm nodule left lobe of thyroid might be seen. As detailed it is stable, not causing particular concern but she is wishing to pursue whether it might be removed.

Yours sincerely

DR ROBERT LINDSAY
Consultant in Diabetes & Endocrinology

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Greater Glasgow and Clyde

Western Infirmary – Dumbarton Road – Glasgow G11 6NT

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DR ROBERT LINDSAY'S THYROID CLINIC – 29/03/2012

RL/CD 26/04/2012

Dr Neil Murray
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Dear Dr Murray

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
17/7 Ashtree Court, Old Kilpatrick, Glasgow, G60 5JD

Diagnosis: 1. 27x22mm nodule left lobe of thyroid stable on ultrasound from June 2010

I saw Diane Donald back in clinic. She has a partially cystic nodule in the thyroid that was ultrasounded in June of 2010 and again in January 2012. There has been no significant change over that time in size. The appearances are benign. She has had two FNA's which both unfortunately are non-contributory showing blood (Thy 1). I had a long discussion with her. I have been very reassuring that given the length of time that we have shown this to be stable I think it highly unlikely there is any major disease going on and I would be content discharging her today and not having any further imaging or fine needle aspiration. She remains somewhat concerned by the appearance of the nodule. I would like to discuss with one of the surgeons as to the possibility of having it removed. For that reason I will refer her on to Mr Wilson.

Yours sincerely

DR ROBERT LINDSAY
Consultant in Diabetes & Endocrinology

Copy to:-

Mr C Wilson
Consultant Surgeon
Western Infirmary
Glasgow
G11 6NT

NHS
Greater Glasgow and Clyde

Western Infirmary – Dumbarton Road – Glasgow G11 6NT

Endocrine Unit
Professor A F Dominiczak
Dr A R McLellan /Dr M Freel
Dr G C Jones /Dr C Sainsbury
Dr C Perry / Dr R Lindsay

Karen.Campbell3@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]
Donna.Grant@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]
Gill.Mitan@ggc.scot.nhs.uk
Emma.Nairne@ggc.scot.nhs.uk [Secretaries] ☎ : *0141-211-2737*

DR ROBERT LINDSAY'S THYROID CLINIC

RL/CD

26th April 2012

Mr C Wilson
Consultant Surgeon
Western Infirmary
Glasgow
G11 6NT

Dear Mr Wilson

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
17/7 Ashtree Court, Old Kilpatrick, Glasgow, G60 5JD

I would be grateful if this lady with a 27mm nodule left lobe of thyroid might be seen. As detailed it is stable, not causing particular concern but she is wishing to pursue whether it might be removed.

Yours sincerely

DR ROBERT LINDSAY
Consultant in Diabetes & Endocrinology

NHS
Greater Glasgow and Clyde

Western Infirmary – Dumbarton Road – Glasgow G11 6NT

Endocrine Unit
Professor A F Dominiczak
Dr A R McLellan /Dr M Freel
Dr G C Jones /Dr C Sainsbury
Dr C Perry / Dr R Lindsay

Karen.Campbell3@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]
Donna.Grant@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]

Gill.Mitan@ggc.scot.nhs.uk
Emma.Nairne@ggc.scot.nhs.uk [Secretaries] ☎ : *0141-211-2737*

DR ROBERT LINDSAY'S THYROID CLINIC - 05/01/2012

CS/CD 19/01/2012

Dr Neil Murray
The Green Medical Practice
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Dear Dr Murray

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
17/7 Ashtree Court, Old Kilpatrick, Glasgow, G60 5JD

Diagnosis: 1. 27x22mm nodule in left lobe of thyroid – FNA June THY 1

Thank you for re-referring Diane to Dr Lindsay's Clinic where I met her on the 5th of January. I note she had previously DNA'd from an appointment on the 5th of August 2010. She still has the left-sided nodule which she feels has increased in size since her last review. She has no dysphagia or shortness of breath. She feels the nodule becomes more prominent when she has a throat infection. I note the previous plan was to try and repeat ultrasound and FNA to get a more definitive tissue sample.

On examination today she is clinically euthyroid which is in keeping with her normal thyroid function tests from November 2011. The nodule on the left is approximately 2½cm and moves on swallowing and feels cystic. I have tired to reassure her today that I suspect this will be a benign lesion and we will arrange a repeat ultrasound and FNA with the radiology department. I have booked her back for review in two months time.

Yours sincerely

Dr Chris Smith
ST6 in Endocrinology

Hospital use only	Clinic	Day Date	Time	Hospital No.
	Dr. Lindsay Thy	5-1-12	10.10	10631776

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

GGC Single Stylesheet - [standard|dental|diagnostic imaging]

GGC General Referral Protocol (Glasgow, vR13.0)

Goitre of thyroid. cervical LN. Thyroid. thyroid. palpitations. pain areas NKDA. GD — open.

REFERRAL TO

Endocrinology
GGC General Referral

— **Consultant / receiving practitioner** and/or **specialty clinic**

Western Infirmary/Garthavel General
Dumbarton Road
Glasgow
G11 6NT

— **Hospital** and **hospital address**

Hospital location code: G516H

Email address: -

Urgency of referral ROUTINE
Date of referral 15-Nov-2011 **Date sent** 17-Nov-2011

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address

17-7 Ashtree Court
Old Kilpatrick
GLASGOW
G60 5JD

Contact number(s)

Voice: 07791041354

101002806988A Unique Care Pathway Number: 101002806988A

REGISTERED GP DETAILS

Name	Dr. Alan McDevitt		
GMC code	3069987	GP code	02992
Practice name	The Green Medical Practice (18818)		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425
Facsimile: 0141 531 6433

REFERRING GP DETAILS

Name	Dr. Alan McDevitt		
GMC code	3069987	GP code	02992
Practice name	The Green Medical Practice (40224)		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: LOST TO FOLLOW UP ~ THYROID CYST

Comment: Dear Doctor

This lady is known to have a left thyroid cyst which has previously been investigated. She appears to have been lost to follow up and now reports an enlargement in the neck cyst. I would be grateful if you could review to assess whether further investigation is worthwhile.

Many thanks

Dr A McDevitt

Reason for referral

Care type requested: Out Patient

Expected outcome: Investigate

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Thyroid nodule	1.27x22mm left lobe	09-Jun-2010	09-Jun-2010
Psoriasis NOS	-	02-Oct-2008	02-Oct-2008
Overdose of drug	-	06-Jan-2003	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002	19-Sep-2002
Vasomotor rhinitis	-	04-Sep-2001	04-Sep-2001
Congenital nasal septum deviation	-	04-Sep-2001	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Fine needle aspiration NOC	the tissue sample was blood stained and therefore not suitable for full analysis	09-Jun-2010	09-Jun-2010
Ultrasound scan	report stated that there was some internal hypervascularity with some peripheral calcification	09-Jun-2010	09-Jun-2010
Ultrasound scan NEC	there is a 3x2x1.25 cm lesion in the left lobe of thyroid. This contains some peripheral calcification with some areas of cystic degeneration but is largely sol;id	17-Mar-2010	17-Mar-2010
Termination of pregnancy NEC	at 22 weeks	20-Feb-2010	20-Feb-2010
Blood grouping	Rh(D) positive	20-Feb-2010	20-Feb-2010
Patient pregnant NOS	-	30-Dec-2009	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009	18-May-2009
Meningitis vaccination	C	16-Nov-1999	16-Nov-1999

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

No recent medications recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex smoker:	Recorded through Combined Vaccination priority=2	07-Jan-2010
Ex smoker:	Disease: SPICE Basic Health Values, priority=2	01-Jan-2009
Current smoker:	Disease: SPICE Basic Health Values, priority=2	22-Oct-2008
Current smoker:	priority=2	22-Oct-2008
Current smoker:	Disease: SPICE Basic Health Values, priority=2	23-Mar-2006

Clinical warnings

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

10631776

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

Attachments

REFERRAL TO

Endocrinology
GGC General Referral

— **Consultant / receiving practitioner** and/or **specialty clinic**

Western Infirmary/Gartnavel General
Dumbarton Road
Glasgow
G11 6NT

— **Hospital** and **hospital address**

Hospital location code.
G516H

Email address

Urgency of referral ROUTINE
Date of referral 15-Nov-2011 **Date sent** 17-Nov-2011

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909
Area of Residence	-

Patient's address

17-7 Ashtree Court
Old Kilpatrick
GLASGOW
G60 5JD

Contact number(s)

Voice: 07791041354

101002806988A Unique Care Pathway Number: 101002806988A

REGISTERED GP DETAILS

Name	Dr. Alan McDevitt		
GMC code	3069987	GP code	02992
Practice name	The Green Medical Practice (18818)		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425
Facsimile: 0141 531 6433

REFERRING GP DETAILS

Name	Dr. Alan McDevitt		
GMC code	3069987	GP code	02992
Practice name	The Green Medical Practice (40224)		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)

Voice: 0141 531 6425

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: LOST TO FOLLOW UP ~ THYROID CYST

Comment: Dear Doctor

This lady is known to have a left thyroid cyst which has previously been investigated. She appears to have been lost to follow up and now reports an enlargement in the neck cyst. I would be grateful if you could review to assess whether further investigation is worthwhile.

Many thanks

Dr A McDevitt

Reason for referral

Care type requested: Out Patient

Expected outcome: Investigate

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Thyroid nodule	1.27x22mm left lobe	09-Jun-2010	09-Jun-2010
Psoriasis NOS	-	02-Oct-2008	02-Oct-2008
Overdose of drug	-	06-Jan-2003	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002	19-Sep-2002
Vasomotor rhinitis	-	04-Sep-2001	04-Sep-2001
Congenital nasal septum deviation	-	04-Sep-2001	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Fine needle aspiration NOC	the tissue sample was blood stained and therefore not suitable for full analysis	09-Jun-2010	09-Jun-2010
Ultrasound scan	report stated that there was some internal hypervascularity with some peripheral calcification	09-Jun-2010	09-Jun-2010
Ultrasound scan NEC	there is a 3x2x1.25 cm lesion in the left lobe of thyroid. This contains some peripheral calcification with some areas of cystic degeneration but is largely sol;id	17-Mar-2010	17-Mar-2010
Termination of pregnancy NEC	at 22 weeks	20-Feb-2010	20-Feb-2010
Blood grouping	Rh(D) positive	20-Feb-2010	20-Feb-2010
Patient pregnant NOS	-	30-Dec-2009	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009	18-May-2009
Meningitis vaccination	C	16-Nov-1999	16-Nov-1999

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

No recent medications recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex smoker:	Recorded through Combined Vaccination priority=2	07-Jan-2010
Ex smoker:	Disease: SPICE Basic Health Values, priority=2	01-Jan-2009
Current smoker:	Disease: SPICE Basic Health Values, priority=2	22-Oct-2008
Current smoker:	priority=2	22-Oct-2008
Current smoker:	Disease: SPICE Basic Health Values, priority=2	23-Mar-2006

Clinical warnings

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

6/8/10 FNA
Appt 8/12 R

NHS
Greater Glasgow and Clyde

24/12/10 FNA Letter to R

Western Infirmary – Dumbarton Road – Glasgow - G11 6NT

Endocrine Unit
Professor A F Dominiczak
Dr A R McLellan /Dr M Freel
Dr G Jones/ Dr C Sainsbury
Dr C Perry/Dr R Lindsay

Karen.Campbell3@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]
Donna.Grant@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]

Gill.Mitan@ggc.scot.nhs.uk
Emma.Nairne@ggc.scot.nhs.uk *Secretaries ☎ : 0141-211-2737*

DR ROBERT LINDSAY'S ENDOCRINE CLINIC - - 24/06/2010

NG/GM Date: 05/07/2010

Dr Neil Murray
Clydebank Health Centre
Kilbowie Road
CLYDEBANK
G81 2TQ

Dear Dr Murray

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
Flat 3/1, 804 Dumbarton Road – Clydebank - Dunbartonshire, G81 4BA

Diagnoses: 1. 27 x 22mm nodule in left lobe of thyroid

I reviewed Diane in clinic today. She had her FNA done on 9.6.10 however the tissue sample was blood stained and therefore was not suitable for full analysis. The ultrasound reports stated that there was some internal hypervascularity with some peripheral calcification.

On examination today her nodule was normal consistency and moving with swallowing – I did not appear to have changed in size. Diane mentioned at times her nodule is more noticeable and that she has lost her voice on a couple of occasions. I have told her it is unlikely that it could be due to her thyroid nodule and that if she was keen for surgery then this is an obvious complication of thyroid surgery, we have therefore agreed that the plan of action should be to repeat the FNA and for her to come back to the clinic in six weeks time. Depending on the results of the FNA any appropriate steps will be followed.

Yours sincerely

DR N GHOURI
CLINICAL RESEARCH FELLOW

Western Infirmary – Dumbarton Road – Glasgow - G11 6NT

Endocrine Unit
Professor A F Dominiczak
Dr A R McLellan / Dr M Freel
Dr G Jones/ Dr C Sainsbury
Dr C Perry/Dr R Lindsay

Karen.Campbell3@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]
Donna.Grant@ggc.scot.nhs.uk [*Endocrine Specialist Nurse*]

Gill.Mitan@ggc.scot.nhs.uk
Emma.Nairne@ggc.scot.nhs.uk *Secretaries ☎ : 0141-211-2737*

DR ROBERT LINDSAY'S ENDOCRINE CLINIC - 13/05/2010

RL/GM Date: 01/06/2010

Dr Neil Murray
Clydebank Health Centre
Kilbowie Road
CLYDEBANK
G81 2TQ

Dear Dr Murray

Diane Donald - 16/12/1983 - CHI: 1612836909 Hospital Number: 10631776W
Flat 3/1, 804 Dumbarton Road - Clydebank, G81 4BA

Diagnoses: 1. 3 x 2 x 1.5cm nodule in left lobe of thyroid

I saw Diane in Clinic today. She is previously well but noted a lump in her neck in mid March. She feels there might have been a small increase in size since then. She has also had some hoarseness of her voice but symptomatically does seem to have had an upper respiratory tract infection as the cause of this. There is no history of neck irradiation or thyroid disease in the family.

On examination she has a 3cm nodule in the left lobe of normal consistency on moving and swallowing. There was no lymphadenopathy in the neck. I have arranged for her to have an FNA. I have explained that this is likely to be a benign lump but that we need to do some further testing to clarify this. She will come back to clinic in six weeks for the results of the FNA.

Yours sincerely

DR ROBERT LINDSAY
Consultant in Diabetes & Endocrinology

C0/L 1/4/10 Gp Appt Rec 10631764

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Endocrinology
GGC General Referral

— **Consultant / receiving practitioner** and/or **specialty clinic**

Western Infirmary/Gartnavel General
Dumbarton Road
Glasgow
G11 6NT

— **Hospital** and **hospital address**

Hospital location code.
G516H

Email address
-

Urgency of referral URGENT
Date of referral 24-Mar-2010 **Date sent** 25-Mar-2010

PATIENT DETAILS

Surname	Donald
Forename(s)	Diane
Title	Miss
Sex	Female
Date of birth	16-Dec-1983
CHI no.	1612836909

Patient's address

3-1 804 Dumbarton Rd
DALMUIR
CLYDEBANK
G81 4BA

Contact number(s)
Voice: 07791041354

101000327752X Unique Care Pathway Number: 101000327752X

REGISTERED GP DETAILS

Name	Dr. Neil Murray		
GMC code	4253981	GP code	04073
Practice name	The Green Medical Practice		
Practice code	40224		

Practice address

Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Contact number(s)
Voice: 0141 531 6425
Facsimile: 0141 531 6433

REFERRING GP DETAILS

Name	Dr. Neil Murray		
GMC code	4253981	GP code	04073
Practice name	CLYDEBANK HEALTH CENTRE (40224)		
Practice code	40224		

Practice address

KILBOWIE ROAD
CLYDEBANK

Contact number(s)
Voice: 0141-531-6425

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: AS PER ENCLOSED ULTRASOUND LEFT THYROID LUMP FOR CONSIDERATION OF FNA BIPOSY

Comment: Dear Doctor

I would be grateful if you could see this lady in your clinic. She had noted a lump on the left side of her neck which felt as if it was related to her thyroid. I checked her FBC which was normal, her ESR was 6 and her thyroid function was normal and I enclose all the results of these together with an ultrasound which confirms a 3.0 cm x 2.0 cm x 1.5 cm lesion on the left lobe of the thyroid with some areas of cystic degeneration but largely solid. As you can see from the enclosed report they recommended referral to your clinic for FNA biopsy of this.

Many thanks for your urgent attention with this

Dr N Murray

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset
Psoriasis NOS	-	02-Oct-2008
Overdose of drug	-	06-Jan-2003
Chlamydial infection, unspecified	trachomatis	19-Sep-2002
Congenital nasal septum deviation	-	04-Sep-2001
Vasomotor rhinitis	-	04-Sep-2001
[X]Overdose - paracetamol	-	26-Dec-1998
[X]Overdose - ibuprofen	-	20-Feb-1998
Closed fracture of bones, unspecified	minimally displaced	22-Jun-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed
Blood grouping	Rh(D) positive	20-Feb-2010
Termination of pregnancy NEC	at 22 weeks	20-Feb-2010
Patient pregnant NOS	-	30-Dec-2009
LLETZ - Large loop excision of transformation zone	CIN3	18-May-2009
1st hepatitis A vaccination	ATYAB02OAJ exp 10-2009	14-Nov-2008
Meningitis vaccination	C	16-Nov-1999
Tuberculosis (BCG) vaccination	-	20-Sep-1996

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Duration
Micronor	84 x 2	TABS	1 Tab	Daily	15-Mar-2010	0 Days
Amoxicillin	21	CAPS 250MG	1 Cap	3 times daily	05-Feb-2010	0 Days
Epaderm Emollient	1	500g Pump	use often	-	20-Jan-2010	0 Days
Folic Acid	90	TABS 400MICROGRAMS	1 Tab	Daily	09-Dec-2009	0 Days

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex smoker:	Recorded through Combined Vaccination	07-Jan-2010
Ex smoker:		01-Jan-2009
Current smoker:		22-Oct-2008
Current smoker:		22-Oct-2008
Current smoker:		23-Mar-2006

Clinical warnings

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:Yes

Signature of referring doctor (or other professional) **Date**

Golden Jubilee National Hospital
National Waiting Times Centre Special Health Board

Beardmore St
Clydebank G81 4HX
Telephone 0141 951 5000
Fax 0141 951 5006

DEPARTMENT OF RADIOLOGY
Phone: 0141 951 5862/5870
Fax: 0141 951 5869
(OFFICE HOURS 9.00-5PM MON-THUR, 9.00-4.30PM FRI)

NHS SCOTLAND

RADIOLOGY REPORT

Name: Diane Mary Donald **DOB:** 16/12/1983
CHI NUMBER: 1612836909 **Examination Number:** 40362997
Examination Date: 17/03/2010 **Examination Time:** 14:35
Examination: US Neck
Dictating Radiologist: Baxter, Grant (Dr) **Date Reported:** 17/03/2010
Typed by: Murphy, Elizabeth
Referring Consultant: MURRAY, DR NEIL S
Referring Department / Location: CLYDEBANK HEALTH CENTRE (GG) KILBOWIE ROAD CLYDEBANK G81 2TQ
Clinical history: Lump left side of neck anteriorly - ?related to thyroid.

Report:

There is a 3 x 2 x 1.5cm lesion in the left lobe of thyroid. This contains some peripheral calcification with some areas of cystic degeneration but is largely solid.

The right lobe of thyroid is normal.

I would strongly recommend referral to a thyroid clinic where almost certainly an FNA will be performed.

Dictated By Baxter, Grant (Dr)

Verified by Baxter, Grant (Dr)

Total number of pages for this report = 1
Name: Diane Mary Donald ID: 1612836909 DOB: 16/12/1983
Examination date: 17/03/2010

Page 1 of 1
https://www.scigw.scot.nhs.uk/web/Worklist/DownloadImage.aspx?key=CHI:1612836909;24-Mar-2
25/03/2010

VALE OF LEVEN HOSPITAL BIOCHEMISTRY DEPARTMENT 01389 817568

VC01H 20

CHI Number	1612836909	Patient Address	28 GLENDEVON PLACE DALMUIR CLYDEBANK DUNBARTONSHIRE G81 4SG
CRN	VOL243511		
Surname	DONALD	Sex	Female
Forename	DIANE	Date of Birth	16/12/1983
Clinician	DR N MURRAY		
Address	CLYDEBANK HC NO 1 CLYDEBANK HEALTH CENTRE KILBOWIE ROAD CLYDEBANK GLASGOW, G81 2TQ		

Clinical Details: LUMP (L) SIDE NECK ? THYROID

Laboratory Ref: BC569250N

Page: 1 of 1

TSH	0.66	mU/L	(0.35 - 4.0) (a)
Free T4	12.5	pmol/L	(9.0 - 21.0)

(a) Euthyroid levels.

Normal Adult Reference Ranges are for Guidance Only. They do not take into account age difference.

Date / Time Received: 16/03/2010 11:08
Date / Time Reported: 16/03/2010 15:41

[redacted] BIOCHEMISTRY

TFT

Date / Time Collected: 15/03/2010 14:42

Page 1 of 1

Page: Diane, CHI 1612836909, 24-Mar
25/03/2010
https://www.scigw.scot.nhs.uk/web/Worklist/DownloadImage.aspx

VALE OF LEVEN HOSPITAL **HAEMATOLOGY DEPARTMENT** **01389 817265**

VH(FRC 47

CHI Number **1612836909**
CRN VOL243511
Surname **DONALD**
Forename **DIANE**
Sex **Female**
Date of Birth **16/12/1983**

Patient Address: 28 GLENDEVON PLACE, DALMUIR, CLYDEBANK, DUNBARTONSHIRE, G81 4SG

Clinician **DR N MURRAY**
Address **CLYDEBANK HC NO 1**, CLYDEBANK HEALTH CENTRE, KILBOWIE ROAD, CLYDEBANK, GLASGOW, G81 2TQ

Clinical Details: LUMP (L) SIDE NECK ? THYROID

Laboratory Ref. **BL569250T**

Normal Adult reference Ranges are for Guidance Only. They do not take into account age difference.

Date / Time Received / Date / Time Reported	Neut 10^9/L (2.0 - 7.5)	Lymph 10^9/L (1.5 - 4.0)	Mono 10^9/L (0.2 - 0.8)	Eos 10^9/L (0.0 - 0.4)	Baso 10^9/L (0.01 - 0.10)	Meta	Myelo	Blast	Others	Atypical Lymph	NRBC
16/03/2010 11:08 / 16/03/2010 11:51	4.1	2.1	0.5	0.1	0.0						

Date / Time Collected	WCC 10^9/L (4.0 - 11.0)	Hb g/L (115 - 165)	RCC 10^12/L (3.60 - 5.60)	Hct L/L (0.370 - 0.470)	MCV fL (78 - 99)	MCH pg (27.0 - 32.0)	RDW % (11.5 - 14.5)	Retic	Platelets 10^9/L (150 - 400)	Infectious Mono Screen	ESR mm/hr (1 - 12)
15/03/2010 14:42	6.9	146	4.83	0.450	93	30.2	13.7		261		6

Western Infirmary, Glasgow, G11 6NT
Level 8 Medical Unit
Direct ☎ Secretary : 0141 211 2850

CONSULTANT IN CHARGE *DR A MCLELLAN*

PATIENT	DIANE DONALD	HOSPITAL NO.	1124600
ADDRESS	28 GLENAVON ROAD CLYDEBANK, G81 4SG	DATE OF BIRTH	16.12.83
ADMITTED	6.1.03	DISCHARGED	7.1.03

RP/GM

Dictated: 15.01.03
Typed: 16.02.03

Dr G Rogerson
Clydebank Health Centre
Kilbowie Road
CLYDEBANK
G81 2TQ

Dear Dr Rogerson

This 19 year old girl was admitted to the AMAU on 6.1.03. She presented having taken 16 Paracetamol tablets with a sizeable amount of alcohol. She did not claim to have any suicidal intent.

On examination she was alert and well. Cardiovascular, respiratory and abdominal examinations were unremarkable. Four hours after taking the overdose Miss Donald was found to be a candidate for Parvolex treatment and she was commenced and continued for 24 hours.

She was reviewed by the Psychiatrists who felt that Miss Donald did not have any ongoing suicidal intent and allowed home. They recommend that she commence an anti-depressant.

Yours sincerely

DR RAJAN PATEL
MEDICAL SHO

GLASGOW UNIVERSITY HOSPITALS NHS TRUST

Inpatient Day Case Record

NHS Greater Glasgow

Patient Identification

Patient CRN	1124660	Provider SGC04	Hosp WIG
Surname	DONALD	Patient's Address	
First Forename	DIANE	28 Glendevon Place	
Second Forename			
Previous Surname		CLYDEBANK	
Date of Birth	16 Dec 1983	Postcode G81 4SG	
Sex Female	Marital Status Single / Ne	Tel No: NONE	
CHI No 1612836909		Ethnic Group	
NHS No		GP Practice CLYDEBANK HEALTH CENTRE5 31-6425	
Alt CRN		GMC No: 0548269 ROGERSON	

Episode Management

Spell/Care Package ID	Ward L8M*WIG	Admission Date 06/01/03
Speciality/Discipline (Code + Text National) GM GENERAL MEDICINE		Admission Type 31
Significant Facility OTH OTHER HOSP WARD		Admission Reason TREAT
Consultant Code MCLE		Admission/Transfer From 1 0
Consultant Name MCLELLAN		Admission/Transfer From – Location
Management of Patient INPATIENT	Patient Category NATIONAL HEA	GP Referral Letter No.
Waiting List Guarantee Exception Code	Waiting List Date	Waiting List Type

General Clinical

Main Diagnosis – ICD 10

Other Condition – ICD 10 – 2

4

5

6

Main Operation/Procedure

Other 2

Other 3

Other 4

Date Main Operation

Clinician Responsible

Date (OPP2)

Clinician Responsible (2)

Date (OPP3)

Clinician Responsible (3)

Date (OPP4)

Clinician Responsible (4)

Development data

Chronic Sick/Disabled ☐

Clinical Problem of Spell/Care Package

Lifestyle Risk Factors 1 2

Outcome Measures 1 2

Dependency/Severity Measures 1 2

Consultants
Mr. Brian F. O'Reilly
Mr. B.W.H. Irvine
Mr. D.C. Simpson

Department of Otolaryngology
Head and Neck Surgery
Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Direct Line:- 0141 201 3161

AI/AMS
Clinic 27.11.01
Dictated 27.11.01
Typed 2.12.01

Dr. G. Rogerson
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Dear Dr. Rogerson

DIANE DONALD DOB 16.12.83 UNIT NO. 631776
62 STEWART DRIVE, CLYDEBANK, G81 6AG

I reviewed this patient who was referred to Stobhill as part of an initiative to cut down waiting times for operations. She has had a two year history of nasal obstruction, right being worse than the left, exacerbated by colds and also cold weather. She also suffers from posterior nasal drip however denies rhinorrhoea or facial pain. I note that she has had epistaxis before on both sides. She has had a trial of Nasonex and another steroid spray which exacerbated her epistaxis and did not help her symptoms. I note she smokes 5-10 cigarettes a day.

On examination her mouth and oropharynx were normal. Her septum was midline and her mucosa was noted to be erythematous with a hypertrophied right inferior turbinate. Both her airways were patent with only a slight decreased on the right side. These findings were confirmed by Mr. Simpson. Skin testing to cat, flowers, grass and house dust-mite today were negative.

Contd./..

Consultants
Mr. Brian F. O'Reilly
Mr. B.W.H. Irvine
Mr. D.C. Simpson

Department of Otolaryngology
Head and Neck Surgery
Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Direct Line:- 0141 201 3161

Contd./...

In view of the findings we feel that this patient is possibly suffering from vasomotor rhinitis and as the septum is midline we do not feel that she would benefit from a septoplasty. We have therefore given her a hand written note for nasal steroids and have discharged her from the clinic. Should she have any further problems we would be pleased to see her back again.

Yours sincerely

A. ISA
S.H.O. to Mr. D.C. Simpson

cc: Ms. S. Railton
Surgical Services
Floor 4
Gartnavel General Hospital
1053 Great Western Road
GLASGOW
G12 0YN

Gartnavel General Hospital, 1053 Great Western Road, Glasgow, G12 OYN

DIVISION OF SURGERY

Reply to: D G CARRICK
Ref No: Hospital No 1124660

Direct Line: 0141 211 3212
Direct FAX: 0141 357 4725

4 September 2001

DR ROGERSON
CLYDEBANK HEALTH CENTRE
KILBOWIE ROAD
CLYDEBANK
G81 2TQ

Dear Dr Rogerson,

Re: DIANE DONALD, D.O.B. 16/12/1983
62 STEWART DRIVE, CLYDEBANK
G81 6AG

Thank you for referring this patient for a surgical opinion. She was put on the non-urgent waiting list on 30/08/2001 under my care for admission to Gartnavel General Hospital as an in-patient.

PROVISIONAL DIAGNOSIS:

CONGENITAL NASAL SEPTUM DEVIATION
VASOMOTOR RHINITIS

PROPOSED TREATMENT:

SEPTOPLASTY
BILATERAL SUBMUCOUS DIATHERMY TO TURBINATE

Yours sincerely,

D G CARRICK
CONSULTANT OTOLARYNGOLOGIST

DIRECTORATE OF GENERAL AND ENT SURGERY

MR D G CARRICK'S ENT CLINIC

Our Ref : SB/KC

Gartnavel General Hospital
1053 Great Western Road
GLASGOW G12 0YN

Direct Line : 0141 211 3212
Fax No : 0141 357 4725

DICTATED : 31 05 01
TYPED : 25.06 01

Dr A Walker
The Green Practice
Clydebank Health Centre
Kilbowie Road
CLYDEBANK
G81 2TQ

Dear Dr Walker,

RE: **Diane Donald, d.o.b 16.12.83, Hospital No 1124660**
Hillpark, 62 Stewart Drive, CLYDEBANK G81 6AG

I saw this young patient on behalf of Mr Carrick. She complains that her nose has been blocked for almost a year. The symptoms are mainly right sided and she doesn't complain of any discharge, sinus pain nor post nasal drip. She has had two mild episodes of self limiting epistaxis on the right side. She has never injured her nose nor had any surgery to the nose. She tells me she took a spray applied topically for one month but wasn't sure that this helped much.

I note she is otherwise well. She is not asthmatic, she has no allergies nor hayfever. She smokes five cigarettes per day.

On examination she has very mild septal deviation to the left and the inferior turbinate on the right side is indeed congested. However both nostrils are patent. Diane has agreed to try Nasonex spray taken once a day for three months in the hope that this will improve her symptoms. We will review her at the end of this period and consider whether surgical treatment may help her symptoms.

Yours sincerely

S BOYCE
SENIOR HOUSE OFFICER IN ENT SURGERY

WEST GLASGOW HOSPITALS

DEPARTMENT

DATE

1124660
DONALD DIANE
62 Stewart Drive F

CLYDEBANK 16/12/83
G81 6AG
G.P.Prac. 40224

DIAGNOSIS NASAL OBSTRUCTION.

Dear Dr,

I saw this patient at my outpatient clinic today. A full report will/will not follow.

PLEASE TRY NASONEX 2D FOR 3/12.

Consultant CARNICK.

Hospital use only	Clinic	Day Date	Time	No.
	NHNO	12/7/01	2pm	

Ambulance transport required ?

Yes ☐ No ☑

Sitting ☐ Stretcher ☐

GP REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Consultant	Any Doctor	Hospital Address	Dumbarton Road Glasgow
Speciality Clinic	Ear, Nose & Throat (ENT)		
Hospital	Western Infirmary/Gartnavel General		
E-Mail No.	Glasgow	Postcode	G11 6NT
Urgency of Referral	Routine		

PATIENT DETAILS

Surname	DONALD	Patient's Address	
Forename(s)	DIANE		HILLPARK 62 STEWART DRIVE CLYDEBANK
Previous Surname			
Title	Miss	Postcode	G816AG
Date of Birth	16/12/1983 Sex Female		
CHI No.	1612836909		
Phone No.	01389-872200		

REGISTERED GP DETAILS

Name	Dr A Walker (Retainee)	Practice Address	The Green Practice, Clydebank Health Centre, Kilbowie Road, Clydebank, Glasgow
Practice Code	40224		
GP Identifier	X99996		
Phone No.	0141-531-6425	Postcode	G81 2TQ
Fax No.	0141-531-6433		
E-Mail No.			

REFERRING DETAILS

Name of agency referring		Address of agency referring	as above
Name of referring practitioner	Dr A Walker (Retainee)		
Phone No.			
Fax No.		Postcode	

Rheumatology
Routine

10 NOV 2000

CLINICAL INFORMATION

History of presenting complaint/examination findings/investigation results

Thank you for seeing this 16 year old girl who presents with a 5 month history of blocked nose and some nose bleeds. She has tried a 2 month course of Flixonase with no improvement, there is no obvious allergy or precipitating factor and I would be most grateful for your further advice.

Reason for Referral (including expectation of referral outcome)

Past medical history (computer generated from problem lists, where possible)

Nil

Current and recent medication (computer generated and free text)

Clinical Warnings e.g. allergies, blood-borne viruses

Nil

Smoking Status

No. per day

Alcohol Consumption

Units per week

Additional relevant information (including patient's issues, social circumstances, and special needs)

D Arvalle

Signature of referring doctor

9 November 2000

Date

DIRECTORATE OF GENERAL AND ENT SURGERY

MR D S BYRNE'S SURGICAL CLINIC
10.01.01

Our ref: DSB/LG

Gartnavel General Hospital
1053 Great Western Road
GLASGOW G12 0YN

Direct Line: 0141 211 0154
Fax No: 0141 357 4725

28.01.01

Dr Walker
The Green Practice
Clydebank Health Centre
Kilbowie Road
Clydebank G81 2TQ

Dear Dr Walker

DIANE DONALD 1124660 DOB 16.12.83
62 STEWART DRIVE CLYDEBANK G81 6AG

This young girl failed to return to my clinic this afternoon. As you know she had sustained a laceration of her forehead in a road traffic accident last year and was thought to have a piece of glass embedded in the wound. However clinically this does not appear to be the case and she has now undergone X ray views of the area. There is no evidence of a foreign body in the wound. As such I think that there is no indication for exploration of the wound. I have therefore not arranged for her to receive another appointment.

Kind regards.

Yours sincerely

D S BYRNE
CONSULTANT SURGEON

DIRECTORATE OF GENERAL AND ENT SURGERY

MR D S BYRNE'S SURGICAL CLINIC

27.11.00

Our ref: DSB/LG

Gartnavel General Hospital
1053 Great Western Road
GLASGOW G12 0YN

Direct Line: 0141 211 0154
Fax No: 0141 357 4725

29.12.00

Dr Thomson
Clydebank Health Centre
Kilbowie Road
Clydebank G81 2TQ

Dear Dr Thomson

DIANE DONALD 1124660 DOB 16.12.83
62 STEWART DRIVE CLYDEBANK G81 6AG

Thank you for referring this young lady to the clinic today. She feels she has a small piece of glass underneath the scar on her forehead and is very keen to have this removed in the hope that the appearance of the scar will improve following this.

On examination I could not feel any foreign body underneath the scar. Mr Byrne also examined Diane and he has advised a soft tissue X-ray of her forehead to see if there is a piece of glass there in the first instance and we will see her again in the clinic for review.

Yours sincerely

J ABDUL-RAHMAN
SENIOR HOUSE OFFICER IN SURGERY

THE GREEN MEDICAL PRACTICE

Clydebank Health Centre

Kilbowie Road
Clydebank
G81 2TQ

Phone 0141-531-6425
Fax 0141-531-6433

Dr. Grace Rogerson M.B., Ch.B.
Dr. Jan Thomson M.B., Ch.B.
Dr. Alan McDevitt M.B., Ch.B., D.R.C.O.G, M.R.C.G.P.
Dr. Craig Lennox M.B., Ch.B., M.R.C.G.P.
Dr. Joyce McDevitt M.B., Ch.B.

9th. November 2000

Dictated : 6/11/00
Typed : 9/11/00
Ref. : AW/09NLETDV

Gartnavel General Hospital,
1053 Great Western Road,
Glasgow,
G12 OYN.

For the attention of Dr. Byrne
Surgical Outpatient

Dear Dr. Byrne,

Diane Donald – D.O.B. 16/12/83 – Hosp.No.1124660
Hillpark, 62 Stewart Drive, Clydebank, G81 6AG

This 16 year old girl was seen in Mr. Byrne's clinic on 16th. May following a road traffic accident. She had hit her forehead against the window screen, the glass had smashed and she had a little bit of glass buried in the scar on her forehead. This was to be removed on a minor op. list under local anaesthetic. Apparently she went to the Day Unit but could not cope with the needles and they were unable to do it. She was told she would be sent for in a couple of months to have the glass removed under general anaesthetic but had not heard anything as yet. I just wanted to make sure that she was on the waiting list for this to be done under general anaesthetic. The scar has grown slightly larger and it is quite tender to palpation.

Many thanks.

Yours sincerely,

Dr A Walker

Gartnavel General Hospital, 1053 Great Western Road, Glasgow, G12 0YN

DIRECTORATE OF GENERAL AND E.N.T. SURGERY

Reply to: GRANT FULLARTON
Our Ref : Hospital No 1124660

Direct Line: 0141 211 3193
FAX Line : 0141 357 4725

9 June 2000

Dr J K Thomson
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Dear Dr Thomson,

Re: DIANE DONALD, D.O.B. 16/12/1983
62 STEWART STREET, , CLYDEBANK G81 6AG

Your patient was admitted as a day case to Gartnavel General Hospital on 5 June 2000.

MAIN DIAGNOSIS FOR EPISODE
RESIDUAL FOREIGN BODY IN SOFT TISSUE OF FACE (729.6)

PAST MEDICAL HISTORY
HEAD INJURY - ROAD TRAFFIC ACCIDENT (854.0+E819.9) Aug 00

PROCEDURES PERFORMED
NO PROCEDURE

COMPLICATIONS
NONE (V65.8)

OUTCOME
SATISFACTORY AT DISCHARGE

ADDITIONAL COMMENTS
Patient refused excision under LA and oral sedation. Suggest referral for excision under GA once scar matured after 6 months if foreign body has not spontaneously surfaced.

Your patient was discharged home on 5 June 2000. No further appointment has been arranged in this unit, but I would be pleased to see this patient again if required.

Yours sincerely

GRANT FULLARTON
Consultant Surgeon

WEST G

Medical In Confi
Inpatient/Day Case Recor

I/A/D/C

Patient Identification

Patient CRN	1124660	Provider SGC04 Hosp	GGH
Surname	DONALD	Patient's Address	62 Stewart Drive
First Forename	DIANE		
Second Forename			CLYDEBANK
Previous Surname			Dunbartonshire
Date of Birth	16 Dec 1983	Postcode	G81 6AG
Sex	Female	Marital Status	Single / Ne
CHI No	1612836909	Tel No:	
NHS No		Ethnic Group	
Alt CRN		GP Practice	CLYDEBANK HEALTH CENTRE531-6425
		GMC No:	0833709 THOMSON

Episode Management

Spell/Care Package ID	Ward DUG*GGH	Admission Date 05/06/00
Specialty/Discipline (Code + Text National) GS GENERAL SURGERY		Admission Type 10
Significant Facility OTH OTHER HOSP WARD		Admission Reason TREAT
Consultant Code FULL		Admission/Transfer From 1 0
Consultant Name FULLARTON		Admission/Transfer From - Location
Management of Patient DC IN DBU (NO OVE	Patient Category NATIONAL HEA	GP Referral Letter No.
Waiting List Guarantee Exception Code	Waiting List Date	Waiting List Type

General Clinical

Main Diagnosis - ICD 10	
Other Condition - ICD 10 - 2	
3	
4	
5	
6	

Main Operation/Procedure

			Date Main Operation	
			Clinician Responsible	
Other 2			Date (OPP2)	
			Clinician Responsible (2)	
Other 3			Date (OPP3)	
			Clinician Responsible (3)	
Other 4			Date (OPP4)	
			Clinician Responsible (4)	

Development data

Chronic Sick/Disabled ☐

Clinical Problem of Spell/Care Package

Lifestyle Risk Factors 1		2
Outcome Measures 1		2
Dependency/Severity Measures 1		2

DIRECTORATE OF GENERAL AND ENT SURGERY
MR D S BYRNE'S SURGICAL CLINIC

Gartnavel General Hospital
1053 Great Western Road
Glasgow G12 0YN

Direct Line: 0141 211 0154
Fax: 0141 357 4725

BP/LG

Dictated 16.05.00
Typed 29.06.00

Dr J K Thomson
Clydebank Health Centre
Kilbowie Road
CLYDEBANK
G81 2TQ

Dear Dr Thomson

DIANE DONALD 1124660 DOB 16.12.83
62 STEWART DRIVE CLYDEBANK G81 6AG

I saw this lady in Mr Byrne's clinic today. She hit her forehead against the windscreen. The glass smashed and she has a little bit of glass buried in the scar on her forehead. I have arranged for this to be removed on our Minor Op's list.

Yours sincerely

BLAITHIN PAGE
SENIOR HOUSE OFFICER IN SURGERY

use only | MR BYRNE | Day TUE Date 16/5/00 | 1400 | Hospital No. 1124660

Ambulance transport required ?

Yes ☐ No ☑

Sitting ☐ Stretcher ☐

GP REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Consultant	Any Doctor	Hospital Address	Dumbarton Road Glasgow
Speciality Clinic	Day Surgery Unit		
Hospital	Western Infirmary/Gartnavel General		
E-Mail No.	Glasgow	Postcode	G11 6NT
Urgency of Referral	Urgent		

PATIENT DETAILS

Surname	DONALD	Patient's Address	Hillpark 62 Stewart Drive Clydebank
Forename(s)	DIANE		
Previous Surname			
Title	Miss	Postcode	G816AG
Date of Birth	16/12/1983 Sex Female		
CHI No.	1612836909		
Phone No.	01389-872200		

REGISTERED GP DETAILS

Name	Dr J.K. Thomson	Practice Address	The Green Practice, Clydebank Health Centre, Kilbowie Road, Clydebank, Glasgow
Practice Code	40224		
GP Identifier	G05304		
Phone No.	0141-531-6425	Postcode	G81 2TQ
Fax No.	0141-531-6433		
E-Mail No.	administrator@G40224.glasgow.hb.scot.nhs.uk		

REFERRING DETAILS

Name of agency referring	
Name of referring practitioner	Dr J.K. Thomson
Phone No.	
Fax No.	

MINOR SURGERY
Address of agency referring as above
SURGICAL CLINIC
Postcode
MINOR PROCEDURE THEATRE

16 APR 2000

CLINICAL INFORMATION

History of presenting complaint/examination findings/investigation results

This 16 year old girl was involved in a car crash 5 weeks ago when she received a head wound above the left eye. This wound has healed but is still very painful and I think there is a foreign body possibly a bit of glass beneath the wound.

I would be grateful if she could be seen for exploration of this small wound.

Reason for Referral (including expectation of referral outcome)

Past medical history (computer generated from problem lists, where possible)

Current and recent medication (computer generated and free text)

Clinical Warnings e.g. allergies, blood-borne viruses

Smoking Status
No. per day

Alcohol Consumption
Units per week

Additional relevant information (including patient's issues, social circumstances, and special needs)

M Thomas.

Signature of referring doctor

25 April 2000

Date

Western Infirmary, Dumbarton Road, Glasgow, G11 6NT

DIRECTORATE OF GENERAL AND E.N.T. SURGERY

Reply to: P O'DWYER
Our Ref : Hospital No 1124660

Direct Line: 0141 211 2804
FAX Line : 0141 211 8562

24 March 2000

Dr J K Thomson
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Dear Dr Thomson,

Re: DIANE DONALD, D.O.B. 16/12/1983
62 STEWART STREET, , CLYDEBANK G81 6AG

Your patient was admitted as an emergency to the Western Infirmary on 15 March 2000.

MAIN DIAGNOSIS FOR EPISODE
HEAD INJURY - ROAD TRAFFIC ACCIDENT (854.0+E819.9)

PROCEDURES PERFORMED
NO PROCEDURE

COMPLICATIONS
NONE (V65.8)

OUTCOME
SATISFACTORY AT DISCHARGE

ADDITIONAL COMMENTS
Skull, pelvis and spine X Rays- NAD
Admitted for neuro observation- NAD.

Your patient was discharged home on 15 March 2000. No further appointment has been arranged in this unit, but I would be pleased to see this patient again if required.

Yours sincerely

P O'DWYER
Professor Of Surgery

You must use a ballpoint pen and fully complete this form or the prescription will not be dispensed

195006

CONFIDENTIAL



IMMEDIATE DISCHARGE AND MEDICINE PRESCRIPTION FORM

Name of G.P.: _____

WEST GLASGOW HOSPITALS UNIVERSITY NHS TRUST
WESTERN INFIRMARY, Glasgow G11 6NT
Telephone 0141-211-2000

Your Patient :

Name: DIANE DONALD

Address: _____

D.O.B. 16/12/83 Unit No. 1124660

Consultant C OWNER

Admitted to Ward 10W On 14/3/00

Discharged on 15/3/00 From Ward 10W

Or seen at _____ *Clinic, on* __/__/__

Diagnosis

1 R.T.A.

2 _____

3 _____

4 _____ 4/4 plan

Operation/Procedures

1 _____

2 _____

3 _____

Follow Up Arrangements

Clinic _____ Date __/__/__

Home Help Yes No

District Nurse Yes No

Meals/Wheels Yes No

Paramedical (please state) _____

Other _____

Please TICK box if childproof containers are UNSUITABLE ☐

Medicine	Form	Dose	TIMES FOR ADMINISTRATION										Recommended duration of treatment from date of discharge
			am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 8	pm 10	Other Times	
[illegible]	CAPS	2 tabs				pm	4-6hrly		max 8/24				7 days

PHARMACY USE ONLY

No. of Days Supply	Quantity, Name, Strength and Manufacturer supplied by Pharmacy.
	50 Stemetil

Dispensed by _____ Checked by _____

Date 15/3/00 CP Check _____

Medication Collected by (Messenger)

_____

WARD USE ONLY

Medication Rec. on Ward by _____

Issued by _____

Date Issued _____

Signature of Recipient _____

OTHER TREATMENT and COMMENTS (Including details of drug sensitivities, appliances, etc.)

DR.s NAME IN BLOCK CAPITALS GRAHAM MACKAY **SIGNATURE** G.C.M.K **DATE** 15/3/00

White - GP Copy, Pink - Medical Records Copy, Blue - Pharmacy Copy

Pager No. _____

You must use a ballpoint pen and fully complete this form or the prescription will not be dispensed

195005

CONFIDENTIAL

WEST GLASGOW HOSPITALS UNIVERSITY NHS TRUST

WESTERN INFIRMARY, Glasgow G11 6NT
Telephone 0141-211-2000

IMMEDIATE DISCHARGE AND MEDICINE PRESCRIPTION FORM

Name of G.P.: _____

Your Patient :

Name: DANIELLE WILSON
Address: _____
D.O.B. 17/2/84 Unit No. 1265830

Consultant PROF O DWYER
Admitted to Ward 10 W On 14/3/10
Discharged on 15/3/10 From Ward 10 W
Or seen at _____ *Clinic,on* __/__/__

Diagnosis
1 R.T.A.
2
3
4

Operation/Procedures
1
2
3

Follow Up Arrangements

Clinic _____ Date __/__/__
Home Help Yes No
District Nurse Yes No
Meals/Wheels Yes No
Paramedical (please state) _____
Other _____

Please TICK box if childproof containers are UNSUITABLE ☐

Medicine	Form	Dose	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 8	pm 10	Other Times	Recommended duration of treatment from date of discharge
CODEINE	ORA	2 tabs						pm 4-6 hrly		max 8			7 days

PHARMACY USE ONLY

No. of Days Supply	Quantity, Name, Strength and Manufacturer supplied by Pharmacy.
	60 Sinemet

Dispensed by _____ Checked by _____
Date 15/3/10 CP Check _____

Medication Collected by (Messenger)

_____

WARD USE ONLY

Medication Rec. on Ward by _____
Issued by _____
Date Issued _____
Signature of Recipient _____

OTHER TREATMENT and COMMENTS (Including details of drug sensitivities, appliances, etc.)

DR.s NAME IN BLOCK CAPITALS GRAHAM MACKAY SIGNATURE _____ DATE 15/3/10.

White - GP Copy, Pink - Medical Records Copy, Blue - Pharmacy Copy

Pager No. _____

GLASGOW HOSPITALS

Inpatient/Day Case Record

Patient Identification

Patient CRN	1124660	Provider	SGC04WIG Hosp
Surname	DONALD	Patient's Address	62 Stewart Drive
First Forename	DIANE		HILLPARK CHILDREN'S HOME
Second Forename			CLYDEBANK
Previous Surname			DUNBARTONSHIRE
Date of Birth	16 Dec 1983	Postcode	G81 6AG
Sex	Female	Marital Status	Single / Ne
CHI No	1612836909	Tel No:	
NHS No		Ethnic Group	
Alt CRN		GP Practice	CLYDEBANK HEALTH CENTRE531-6425
		GMC No:	0833709 THOMSON

Episode Management

Spell/Care Package ID	Ward: L10S*WI	Admission Date: 15/03/00
Specialty/Discipline (Code + Text National)	GS GENERAL SURGERY	Admission Type: 32
Significant Facility	OTH OTHER HOSP WARD	Admission Reason: TREAT
Consultant Code	BJAQ	Admission/Transfer From: 2 2
Consultant Name	JAQUES	Admission/Transfer From - Location
Management of Patient: INPATIENT	Patient Category: NATIONAL HEA	GP Referral Letter No.
Waiting List Guarantee Exception Code	Waiting List Date	Waiting List Type

General Clinical

Main Diagnosis - ICD 10	
Other Condition - ICD 10 - 2	
3	
4	
5	
6	

Main Operation/Procedure

		Date Main Operation	
		Clinician Responsible	
Other 2		Date (OPP2)	
		Clinician Responsible (2)	
Other 3		Date (OPP3)	
		Clinician Responsible (3)	
Other 4		Date (OPP4)	
		Clinician Responsible (4)	

Development data

Chronic Sick/Disabled ☐ Clinical Problem of Spell/Care Package

Lifestyle Risk Factors 1		2
Outcome Measures 1		2
Dependency/Severity Measures 1		2

(2)

...TISH AMBULANCE SERVICE ... FORM

INCIDENT No. | | / | |

PATIENT NAME: DIANE MARY ELIZABETH DOWNS — SEX: M ☐ F ☒

PATIENT ADDRESS: 62 STEWART DRIVE, HANDSACRE — D.O.B.: 16/12/85

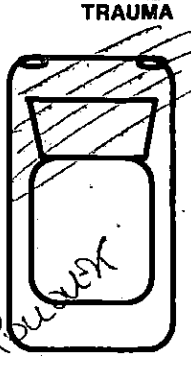
TYPE OF INCIDENT

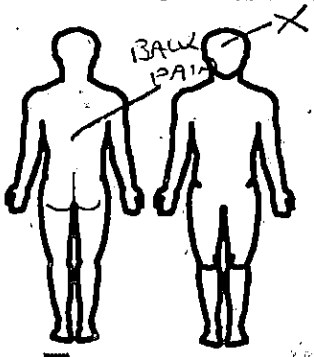
Trauma	☒
Assault	
Cardiac Arrest	
Other Collapse	
DSH	
IHT	
Obstetric	
Other	

TRAUMA INCIDENTS

RTA	
Cyclist	
M/Cyclist	
Pedestrian	
Ejected	
Trapped	
>20 mins. Extricate	
Helmet Worn	
Seat Belt Worn	

Home	
Work	
Leisure	
Burns	
Drowning	
Fall < 2 mtr.	
Fall > 2 mtr.	
Head Injury	
Poisoning	
Other	





■ Damaged Area ▶ Point of Impact X Position of Patient ■ Damaged Area/ Burns % # ? Fracture X Laceration

INJURY / ILLNESS

Acute Abdo.	
Breathlessness	
Chest Pain	
Other Cardiac	
Convulsions	
C.V.A.	
DSH O/dose	
Haemorrhage	
Hypoglycaemia	
Other	

PRIMARY SURVEY

Treatment prior to arrival	Y	☒	N	
By whom	BY BYSTANDER			
Duration of treatment / CPR				
Airway	Clear ☐		Obstructed	
Breathing	Y		N	
Circulation - Pulse	Y		N	
Responsibility - Alert	Y	☒	N	
Vocal Stimuli	Y		N	
Pain Stimuli	Y		N	
Unresponsive	Y		N	
Vomited	Y		N	☒
Fitting	Y		N	☒
Knocked Out	Y		N	☒

INITIAL ACTIONS

Airway				
Pharyngeal Airway	Y		N	
Tracheal Tube	Y		N	
Laryngeal Mask	Y		N	
Size			•	
Successful ?	Y		N	
Breathing				
O_2 Flow rate	10 %		85	
Mask Type	HUDSON			
IPPV	NOT CANNULATED FRIGHTENED OF NEEDLES.			
Circulation				Success
Cannulation	Size	Side	Site	full
1				Y N
2				Y N

A.M.P.L.E.

Allergies (See reverse for coding) NIL

1	2	3	4	5	6	7	8	9

Medication: NIL

Past Medical History: NIL

Last Eaten: LAST EATEN

Events Preceding Incident: R.T.A. ROLLOVER.

OBSERVATIONS

Time	Breathing R.R.	Breathing SpO2 %	Circulation Pulse	Circulation Blood Pressure	Capillary Refill Norm	Capillary Refill Delay	Pupils Left Size (C N D)	Pupils Left React Y/N	Pupils Right Size (C N D)	Pupils Right React Y/N	GCS E	GCS M	GCS V	GCS Total
0021	16	99	116	NOT OBT	X		N	Y	N	Y	4	6	5	15
0040	16	100	116	"	X		N	Y	N	Y	4	6	5	15
0058	16	100	106	"	X		N	Y	N	Y	4	6	5	15
0115	16	100		"	X		N	Y	N	Y	4	6	5	15

TREATMENTS

Time	Presenting Condition	Defib. (Joules)	Fluid / Drug	Batch / Box No.	Dose	Route	Result e.g. Pulse, Asys, VF, Other
	S. I/C LEFT						

COMMENTS / ADDITIONAL INFORMATION R.T.A. ROLLOVER, SEVERE DAMAGE TO CAR & FAMILY. O/A PATIENT HAD MANAGED TO LEAVE SCENE IN ANOTHER CAR AND TAKEN TO PUBLIC HOUSE & A MILE AWAY. O/E PATIENT WAS VERY PALE OBVIOUS WOUND TO FOREHEAD C/O ACUTE BACK PAIN LOW THORACIC SPINAL ALIGN. NO NEURO DEFICIT FOUND (NO SEAT BELT WORN) TRANSPORTED FULLY IMMOBILISED.

(Affix Rhythm Strip Here)

CREW 1	
CREW 2	
MEDICAL STAFF	
INCIDENT LOCATION	STIRLING MUIR ROAD CROFTAMIE BUCCLEUCH
DATE OF CALL	15/08/03
TIME OF CALL	2345
TREATMENT COMMENCED	0020
TIME LEFT SCENE	0115
TIME ARRIVED HOSPITAL	0145

SIGNATURE (Crew 1 or 2) R. Moore

CONDITION ON ARRIVAL AT HOSPITAL: Conscious ☒ Pulse ☐ Breathing ☐ No Vital Signs ☐

DESTINATION HOSPITAL: WESTERN GENERAL

HOSPITAL USE ONLY

GG/DMcB/1124660

Western Infirmary
Dumbarton Road
GLASGOW
G11 6NT

Tel: 0141 211 6259
Fax: 0141 211 2400

Department of Dermatology – Dr Burden's Clinic

Typed: 22 June 1999
Dictated: 21 June 1999

Dr Thomson
Clydebank Health Centre
Kilbowie Road
CLYDEBANK
G81 2TQ

Dear Dr Thomson

DIANE DONALD – DOB 16.12.1983
62 STEWART DRIVE, CLYDEBANK G81 6AG

Your patient failed to attend her appointment at the Dermatology Clinic today. As our clinics are very busy a further appointment has not been sent.

Many thanks.

Yours sincerely

GIRISH GUPTA
Specialist Registrar in Dermatology

Western Infirmary
Dumbarton Road
Glasgow
G11 6NT

☎Tel: 0141 211 6259
Fax: 0141 211 2400

DEPARTMENT OF DERMATOLOGY

DB/VJD

Dictated: 11.05.99
Typed: 12.05.99

Dr Thomson
Clydebank Health Centre
Kilbowie Road
Clydebank
G81 2TQ

Dear Dr Thomson

Diane Donald DoB 16.12.83
c/o Ramsay house Risk Street Clydebank G81 - HOSP NO: 1124660

Diagnosis: Generalised pruritus

Thank you for referring this 15 year-old girl to the dermatology clinic. Over the past year she has had a generalised itch. Initially a rash was present and was treated variably as scabies or eczema. Although the rash has cleared she has persistent itch. She is generally in good health and lives in a children's home.

On examination there were not any cutaneous abnormalities that I could find.

There were no features of scabies today and I think the itch has persisted too long to be post-scabetic. I have therefore arranged a series of blood investigations to see if I can find an underlying cause. I will see her again in the clinic with the results in four weeks' time. In the meantime I have suggested Atarax 25mg at night time.

Yours sincerely

David Burden
CONSULTANT DERMATOLOGIST

GREATER GLASGOW COMMUNITY AND MENTAL HEALTH SERVICES NHS TRUST
Working in Harmony with
West Dunbartonshire Council

Our Ref. EH/KB

Your Ref.

If Phoning
Ask for: Dr Bouch's Secretary

Goldenhill Resource Centre
2 Stewart Drive
Clydebank
G81 6AQ

Telephone : 01389 874120
Fax: As Above

CONFIDENTIAL

12 January 1999
(Dict 07 01 99)

Dr J K Thomson
Clydebank Health Centre
Kilbowie Road
Clydebank

Please file (Medical patient)

Dear Dr Thomson

DIANE DONALD DOB 16 12 83
Ramsay House, Risk Street, Clydebank

I assessed Diane on 28 December 1998 in my duty as on-call psychiatrist when she was referred to me by the physicians at Level 8 Medical, Western Infirmary, Glasgow. She was admitted on 26 December having taken an overdose of 32 paracetamol 500 mg tablets. Diane took the tablets while she was out with her friends but didn't tell them initially, but after a couple of hours she told them and then they phoned for an ambulance as she was feeling unwell. She did not take any alcohol with the tablets. Diane stated that she was suicidal at the time of the overdose and this was due to a multitude of problems.

She is currently living in Ramsay House which is a child unit, where she has been staying since November 1998, due to a break-up with her family. She was previously staying with her ex-boyfriend's mother. She said that she had felt upset because she did not get any presents at Christmas and that she had recently failed her school exams and was not wishing to stay on at school. She describes problems since the beginning of November and although she described her mood as low, this appeared to be situational and she was able to go out and enjoy being with her friends. She had recently started a new relationship with her boyfriend. She described her appetite as being satisfactory and thought that she had a slight increase in weight. She describes sleep disturbance in that she only got approximately four hours per night as she felt restless.

Drug History

Ponstan prn for abdominal pain
Antibiotics for a foot infection

Past Medical History - Nil.

Social History

Diane has a Social Worker called She is living at Ramsay House but describes herself as not being very happy there. She says that she smokes normally but had given up two weeks ago. She takes alcohol approximately on one occasion per week and described this as binge drinking. She denied any illicit drug use.

CARER MARK
Awarded for excellence
to Goldenhill Resource Centre

Mental State Examination

Diane was a young, slim girl dressed in a pink satin dressing gown. She was pleasant and smiling on occasion. Her mood was subjectively low but objectively euthymic with a reactive affect. Her thoughts were not of any active plans currently, but she was slightly regretful that the overdose was unsuccessful. I could not identify any perceptual abnormalities.

My impression was that Diane was a young 15 year old girl who took an overdose with suicidal intent at the time. I felt that this was situational and there was no evidence of a preceding depressive illness. She was due to be discharged to Ramsay House of 28 December 1998, having been certified medically fit by the physicians. I discussed Diane's case with the on-call senior psychiatrist, Dr Gray, Specialist Registrar, as Diane falls into the adolescent age catchment group. I understand that Diane had previously been referred to the Adolescent Services; however, she said she never received an appointment. She was keen on discharge to be seen by the Adolescent Unit and I will therefore send them a copy of this letter. I have not arranged any follow up by myself.

Yours sincerely

Enida

ELLEN HOIDA
SHO to Dr Bouch

cc
Dr Fox, Consultant Physician, Level 8 Medical, Western Infirmary.

ADMISSION No.

WEST GLASGOW HOSPITALS UNIVERSITY NHS TRUST

Acute Medical Receiving Unit Level 8, Western Infirmary, Glasgow, G11 6NT – 0141 211 2850

CONSULTANT IN CHARGE Dr Fox

PATIENT	Diane Donald	AGE	HOSP. No. 1124660
ADDRESS	C/o Ramsey House Risk Street Clydebank G81	DATE OF BIRTH	16.12.83
ADMITTED	26.12.98	DISCHARGED	28.12.98
DIAGNOSIS 1st		OPERATION 1st	
DIAGNOSIS 2nd		OPERATION 2nd	
DIAGNOSIS 3rd		OPERATION 3rd	
DIAGNOSIS 4th		OPERATION 4th	

MH/JS

CASE SUMMARY

Date Dictated: 29.12.98
Date Typed: 16.01.99

Dr Thomson
Clydebank Health Centre
Kilbowie Road
CLYDEBANK
G81 2TQ

Dear Dr Thomson

This 15 year old girl was admitted as an emergency having taken a serious Paracetamol overdose. She admitted to having taken 32 500mg Paracetamol tablets, claimed to be depressed and wanted to die. Since the overdose she had been vomiting.

Examination was unremarkable although she had a slightly tender iliac fossa. As this was a significant Paracetamol overdose she was commenced on intravenous Parvolex.

Her INR was 1.2 and this stayed stable until discharge.

Psychiatric review found no evidence of preceding depressive illness, and although she still insisted that she wished she had been successful, her mood was objectively normal, with a reactive affect.

As her INR had remained at 1.2 I would be grateful if you could re-check this in 2 days time, as discussed with your receptionist.

Diane will be followed up the adolescent psychiatry unit.

Yours sincerely

Marian McKinnon
Senior House Officer

D062573/

HOSPI NHS TRUST

Medical In Con
Inpatient/Day Case Reco.d

I/A/D/C ☐

Patient Identification

Patient CRN		Provider SGC04	Hosp.
Surname	DONALD	Patient's Address	HOUSE
First Forename			RISK STREET
Second Forename			
Previous Surname			
Date of Birth		Postcode	
Sex		Marital Status	
CHI No		Tel No:	
NHS No		Ethnic Group	
Alt CRN		GP Practice	
		GMC No:	

Episode Management

Spell/Care Package ID	Ward	Admission Date
Specialty/Discipline (Code + Text National)		Admission Type
Significant Facility		Admission Reason
Consultant Code		Admission/Transfer From
Consultant Name		Admission/Transfer From - Location
Management of Patient	Patient Category	GP Referral Letter No.
Waiting List Guarantee Exception Code	Waiting List Date	Waiting List Type

General Clinical

Main Diagnosis - ICD 10	
Other Condition - ICD 10 - 2	
3	
4	
5	
6	

Main Operation/Procedure

		Date Main Operation	
		Clinician Responsible	
Other 2		Date (OPP2)	
		Clinician Responsible (2)	
Other 3		Date (OPP3)	
		Clinician Responsible (3)	
Other 4		Date (OPP4)	
		Clinician Responsible (4)	

Development data

Chronic Sick/Disabled ☐

Clinical Problem of Spell/Care Package

Lifestyle Risk Factors 1		2
Outcome Measures 1		2
Dependency/Severity Measures 1		2

Hospital use Only | Clinic Dr Burden | Day Date 8/2/99 | Time 2.25 | Hospital No. 1124660. | GP112

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category: Routine ☐ Soon ☐ Urgent ☐

Hospital WESTERN INFIRMARY Date 29/9/98

CHI No. 1 6 1 2 8 3 6 9 0 9

Please arrange for this patient to attend the SKIN CLINIC clinic of Dr/Mr

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Patient's Surname DONALD — Maiden Surname

First Names DIANE — Single/Married/Widowed/Other

Address 70 WOOD QUADRANT — Date of Birth 16/12/83

CLYDEBANK

G81 1AP — Patient's Occupation

Postal Code — Contact telephone number

Has the patient attended hospital before? YES / NO If "YES" please state:

Name of Hospital WESTERN INFIRMARY

Year of attendance 1998 Hospital No. 1124660

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

40224
DR. J K THOMSON
CLYDEBANK HEALTH CENTRE
KILBOWIE ROAD
CLYDEBANK
FEATURENET 720 6425

Please use rubber stamp

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 14 year old girl has been complaining of a rash for 1 year. She has been treated with Quellada, Eurax, Lyclear, antihistamines, Eumovate with little or no improvement in her condition. Her mother confirms that she has stuck totally to the scabetic advice but despite this she is still having problems.

I would be grateful if you could see and advise on further management and also to confirm that this itch and rash is due to scabies.

Thank you for your help and management of this troublesome rash.

Dictated : 23/9/98
Typed : 29/9/98
Ref. : JKT/29SREFDV

Diagnosis / provisional diagnosis:

Present drug treatment and potential special hazards:

X-ray (women of childbearing age). Date of first day of L.M.P.

30 SEP 1998

Relevant X-rays available from: No. (if known)

Signature

355-2104

Printed for The Stationery Office , Dd8457208,08/97, R.P.(53791)

GREATER GLASGOW COMMUNITY AND MENTAL HEALTH SERVICES NHS TRUST

Our Ref. MK/MM

Your Ref.

West House Offices
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH

If Phoning
Ask for EXT. 3695

Telephone: 0141 211 3888
Fax: 0141 211 2408

CONFIDENTIAL

Dict : 25 February 1998
Type:26 February 1998

Dr. Rogerson
Clydebank Health Centre
Kilbowie Road
CLYDEBANK
GLASGOW
G81 2TQ

Dear Dr. Rogerson,

RE : DIANE DONALD. D.O.B. 16.12.83
70 WOOD QUADRANT, CLYDEBANK, GLASGOW G81 1AP

I reviewed this girl on Level 8 of the Western Infirmary on the 21st. February, 1998. Diane had taken an overdose of 76 Brufen 600 mg tablets over two days - the 19th and 20th February, 1998. She had attended Dr. Ballantyne at the Health Centre on Wednesday, 18th February and was prescribed Brufen for abdominal pain. She initially took the tablets to take the pain away, but then continued to take an excess of tablets. Diane had had an argument with her mother four weeks ago and since then has been staying with her paternal uncle. Her mother was arranging for her to return home and she told me that she took the excess of tablets so that she would have to go to hospital and would not have to return to her mother's house. The argument was regarding Diane's boyfriend whom her mother did not wish her to see any more, feeling that he was a bad influence on her.

She took the majority of tablets on the 20th February whilst at school and on the way home from school stopped at Clydebank Mega Bowl to 'phone for an ambulance which brought her to Accident and Emergency.

She told me at interview that she felt what she did was "a bit daft". She told me that she was trying to send a message to her mother.

There is no past psychiatric history.

Past Medical History : She was admitted to hospital in September of 1997 for investigation of her abdominal pain and she told me no diagnosis was made.

Apart from the Brufen tablets she is currently on no medication.

Family History : Her mother is 33 and works as a Dinner Lady. They have not been getting on for the past couple of months. Her father lives in Kent. She has not seen him since she was aged 8. Her parents divorced when she was aged 1. She has a half-brother who is aged 6. His father lives in Dumbarton. Her mother has a boyfriend of 4 years duration. Diane does not get on with him and feels that he chooses his natural daughter over her.

There is no family history of psychiatric illness.

Personal History : She was born in England but raised in Clydebank. She enjoyed Primary School and made friends readily. She is currently in Third Year at St. Andrew's High School, Clydebank and enjoys it. She is doing well with her school-work.

Social Situation : She lives with her mother, her mother's boyfriend and her half-brother. She has been living with her paternal uncle for the past 4 weeks. She is in third year of High School, does not smoke, denies the use of alcohol or drugs. Her boyfriend is 15 and they have been going out for a year. Her mother does not like him. Diane and her boyfriend get on well.

On Mental State Examination she was dressed in a dressing gown. She looked her age. She appeared rather petulant. She was not smiling initially but later on in the interview smiled. Her speech was normal. She described her mood as tired. Her affect was euthymic. She denied any further thoughts of self-harm.

The impression was of an impulsive overdose in an adolescent who is having difficulties in her relationship with her mother. There were no further thoughts of self-harm.

I recommended that she be discharged when medically fit and explained to Diane and her mother that I would refer them to the Adolescent Psychiatry Services with a view to looking at their relationship difficulties.

Yours sincerely,

monica keenan

DR. MONICA KEENAN
S.H.O. TO DR. DAVID BROWN

Copy to :- Dr. Hunter, Consultant Physician, W.I.

WESTERN INFIRMARY
GLASGOW G11 6NT

ACUTE MEDICAL UNIT
DR HUNTER

Patient's Name	**Diane Donald**	**Hosp No**	**1124660**
Address	**70 Wood Quadrant CLYDEBANK G81 1AP**	**DOB**	**16.12.83**
Admission date	**21.02.98**	**Discharge date**	**22.02.98**
1st Diagnosis	**Overdose**		
2nd Diagnosis			
3rd Diagnosis			
4th Diagnosis			
Ref:	**JG/CL**	**Direct dial:**	
Dictated:	**23.02.98**		
Typed:	**08.03.98**		

Dr G Rogerson
Clydebank Health Centre
Kilbowie Road
CLYDEBANK
G81 2TQ

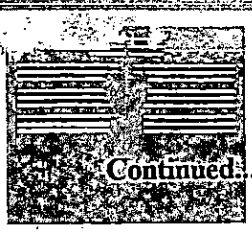
Dear Dr Rogerson

ADMISSION SUMMARY

This 14 year old girl, who had ran away from home 4 weeks ago and had been living with her uncle, was admitted after having taking 76 tablets of Ibuprofen 600mg. She claims to have taken the overdose in order to send a message to her mother that she doesn't want to stay with her. There are multiple family difficulties.

On presentation, she was light headed with abdominal pain and vomiting, although she denies any haematemesis. She denied taking any other medications. She has no past medical history of note.

On examination, she was fully alert and orientated with a heart rate of 120 and BP of 123/81. Respiratory and cardiovascular examinations were normal. She had mild tenderness in her left upper quadrant and flank.



She was admitted for observation after having charcoal in casualty. Initial U+E's and full blood count were normal. Paracetamol and salicylate were not detected. However, the next day her U+E's showed that her urea and creatine had mildly increased, with a urea of 12.2 and creatine of 161. Previously it had been 5.2 and 65 respectively. Coagulation was normal. There was also a trace of protein in her urine. It was monitored over the next day.

She was kept in for a further night and given IV fluids overnight. The next days U+E's were normal. She still complains of intermittent left and right loin pain. It appears to be of chronic nature and has been investigated at Yorkhill without a positive diagnosis. I advised her that if she still continues to have these pains, she should see her GP and ask for an out patient Clinic appointment.

Yours sincerely

JOE GUADAGNO
MEDICAL SENIOR HOUSE OFFICER

You must use a ballpoint pen and fully complete this form or the prescription will not be dispensed

131369

CONFIDENTIAL

WEST GLASGOW HOSPITALS UNIVERSITY NHS TRUST

WESTERN INFIRMARY, Glasgow G11 6NT
Telephone 0141-211-2000



IMMEDIATE DISCHARGE AND MEDICINE PRESCRIPTION FORM

Name of G.P.: _____

Your Patient :

Name: DONALD

Address: _____

D.O.B. __/__/__ Unit No. _____

Consultant Hutton

Admitted to Ward LB On 20/2/98

Discharged on 22/2/98 From Ward LB1

Or seen at _____ *Clinic,on* __/__/__

Diagnosis

1 o/d. 60 tablets Bruffen

2 _____

3 _____

4 _____

Operation/Procedures

1 - Rehydrated overnight.

2 _____

3 _____

Follow Up Arrangements

Clinic _____ Date __/__/__

Home Help Yes No

District Nurse Yes No

Meals/Wheels Yes No

Paramedical (please state) _____

Other _____

Please TICK box if childproof containers are UNSUITABLE ☐

Medicine	Form	Dose	TIMES FOR ADMINISTRATION										Recommended duration of treatment from date of discharge
			am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 8	pm 10	Other Times	

PHARMACY USE ONLY

No. of Days Supply	Quantity, Name, Strength and Manufacturer supplied by Pharmacy.

Dispensed by _____ Checked by _____

Date _____ CP Check _____

Medication Collected by (Messenger)

_____

WARD USE ONLY

Medication Rec. on Ward by _____

Issued by _____

Date Issued _____

Signature of Recipient _____

OTHER TREATMENT and COMMENTS (Including details of drug sensitivities, appliances, etc.)

- please arrange an O.P appointment if rapid Gi investigation of abdo. pain. (of chronic nature).

→ (N) ulcers on discharge.

DR.s NAME IN BLOCK CAPITALS J Cuadrado **SIGNATURE** CUADRADO **DATE** 22/2/98.

White - GP Copy, Pink - Medical Records Copy, Blue - Pharmacy Copy

Pager No. 4044

You must use a ballpoint pen and fully complete this form or the prescription will not be dispensed

131369

CONFIDENTIAL

WEST GLASGOW HOSPITALS UNIVERSITY NHS TRUST
WESTERN INFIRMARY, Glasgow G11 6NT
Telephone 0141-211-2000



IMMEDIATE DISCHARGE AND MEDICINE PRESCRIPTION FORM

Name of G.P.: _____

Your Patient:

Name: Mary Ward

Address: _____

D.O.B. __/__/__ Unit No. _____

Consultant Hunter

Admitted to Ward U6 On 20/2/98

Discharged on 21/2/98 From Ward U6M

Or seen at _____ *Clinic, on* __/__/__

Diagnosis

1 o/p. GO Lasser Bruffin

2 _____

3 _____

4 _____

Operation/Procedures

1 - Rehydrated overnight.

2 _____

3 _____

Follow Up Arrangements

Clinic _____ Date __/__/__

Home Help Yes No

District Nurse Yes No

Meals/Wheels Yes No

Paramedical (please state) _____

Other _____

Please TICK box if childproof containers are UNSUITABLE ☐

Medicine	Form	Dose	TIMES FOR ADMINISTRATION										Recommended duration of treatment from date of discharge
			am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 8	pm 10	Other Times	

PHARMACY USE ONLY

No. of Days Supply	Quantity, Name, Strength and Manufacturer supplied by Pharmacy.

Dispensed by _____ Checked by _____

Date _____ CP Check _____

Medication Collected by (Messenger)

WARD USE ONLY

Medication Rec. on Ward by _____

Issued by _____

Date Issued _____

Signature of Recipient _____

OTHER TREATMENT and COMMENTS (Including details of drug sensitivities, appliances, etc.)

- please arrange an O/P appointment if req'd for investigation of abd. pain (of chronic nature).

→ (N) Urine on discharge.

DR.s NAME IN BLOCK CAPITALS J Cuadrado **SIGNATURE** Cuadrado **DATE** 21/2/98.

White - GP Copy, Pink - Medical Records Copy, Blue - Pharmacy Copy

Pager No. 4064

WEST GLASGOW
HOSPITALS UNIVERSITY
NHS TRUST

Confidence

Inpatient/Day Case Record

Patient Identification

Patient CRN: *roF 1124660	Provider: SGC04 Hosp.: WIG
Surname: DONALD	Patient's Address: 70 Wood Quadrant
First Forename: DIANE	
Second Forename:	CLYDEBANK
Previous Surname:	DUNBARTONSHIRE
Date of Birth: 16 Dec 1983	Postcode: G81 1AP
Sex: Female / Marital Status: Single / Ne	Tel No: 0141 941 0232
CHI No:	Ethnic Group:
NHS No:	GP Practice: CLYDEBANK HEALTH CENTRE9522080
It CRN:	GMC No: 0548269 ROGERSON

Episode Management

Spell/Care Package ID	Ward: L8M*WIG	Admission Date: 21/02/98
Specialty/Discipline (Code + Text National): GM GENERAL MEDICINE		Admission Type: 36
Significant Facility: OTH OTHER HOSP WARD		Admission Reason: TREAT
Consultant Code: HUNT		Admission/Transfer From: 1 1
Consultant Name: HUNTER		Admission/Transfer From - Location
Management of Patient: INPATIENT	Patient Category: NATIONAL HEA	GP Referral Letter No.
Waiting List Guarantee Exception Code	Waiting List Date	Waiting List Type

General Clinical

Main Diagnosis - ICD 10	
Other Condition - ICD 10 - 2	
3	
4	
5	
6	

Main Operation/Procedure

		Date Main Operation
		Clinician Responsible
Other 2		Date (OPP2)
		Clinician Responsible (2)
Other 3		Date (OPP3)
		Clinician Responsible (3)
Other 4		Date (OPP4)
		Clinician Responsible (4)

Development data

Chronic Sick/Disabled ☐

Clinical Problem of Spell/Care Package

Lifestyle Risk Factors 1		2
Outcome Measures 1		2
Dependency/Severity Measures 1		2

Patient Agreement to Investigation or Treatment

NHS
ter Glasgow
d Clyde

CONSENT FORM

s2384 – 037 3132281
Skin Biopsy Set

PATIENT DETAILS (OR PRE-PRINTED)

1612836909
DONALD F
Diane 16/12/1983
43 Longden Street
Clydebank, Dunbartonshire
G81 1AG

Hospital/Clinic/GP Practice .....

Patient's surname/family name :.....

Patient's first name(s): .....

Date of Birth____/____/_____ Gender: Male ☐ Female ☐

NHS/ CHI Number _____

Special requirements (e.g. other language/communication method) .....

.....

Responsible practitioner: S MACALPINE

Job title: .....

STATEMENT FOR PRACTITIONER

(to be filled in by practitioner with appropriate knowledge of proposed procedure- see guidance notes)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side: (WRITTEN IN FULL)

Excision of mole on back
Shave excision of fleshy mole left breast

I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedures above).

Signature of practitioner: SMacAlpine

Name/Designation (Print) S. MACALPINE

Date 4/12/13

00526

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*

(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

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

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- to the emergency administration of blood or blood products

Additionally you have to agree or disagree the following:-	**Agree**	**Disagree**
that information and/or images kept in records may be used anonymously for education, audit, and research with appropriate ethical approval, to improve the quality of patient care.	☐	☐
that surplus tissue or other biological material not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☐

PATIENT REFUSAL FOR BLOOD PRODUCTS

Please sign here if you refuse to consent to the emergency administration of blood or blood products. Even if this results in death.

Signature: ..... Date ...../...../.....

Practitioner Signature: ..... Date ...../...../.....

PATIENT/PARENT* AGREEMENT FOR TREATMENT

Signature: Donald ..... Date 4/12/13

Name (Print): Diane Donald

1063177

NHS GREATER GLASGOW AND CLYDE
PATHOLOGY DEPARTMENT CPA Accredited

Name	: DONALD DIANE	CHI No.:	1612836909
Address	: FLAT 2 18 ONSLOW ROAD G81 2NE	DoB :	16.12.1983
Location:	Level 10 Surgical WIG	Sender :	Dr Christoph. Wilson

LEFT THYROID

CLINICAL HISTORY:
Dominant nodule left thyroid - cytology C1. ?Benign.

MACRO:
A thyroid lobe 55x33x32mm with attached isthmus 14x22x17mm (20g). Sections show a fairly well circumscribed nodule 20x18x15mm at one end of the lobe.

MICROSCOPY:
Sections show an encapsulated follicular adenoma of the thyroid with degenerate features. Excision is complete. There is no evidence of malignancy. The thyroid parenchyma apart from the tumour is unremarkable. No parathyroid glands are present. There are no lymph nodes.

Dr D McLellan (Consultant)
Dictated 07/03/13 Typed 08/03/13 LMCL

Electronically authorised by Dr Douglas McLellan.

19/3

Reporting Pathologist : Douglas McLellan
Consultant Pathologist: Douglas McLellan

Date received: 22.02.13
Date authorised: 08.03.13

Lab No: D,13.0013616.L

Western Infirmary

Preoperative Assessment Document

Nam	Telephone numbers:
Addr	Home
	Mobile
	N.O.K.
DOB:	Name
Age:	Relationship
	Telephone

10631776W
DONALD F
DIANE 16/12/1983
FLAT 2
18 ONSLOW ROAD
CLYDEBANK G81 2NE
CHI-1612836909

Assessment

Consultant: WILSON	Assessment Date: 21/2/13

Admission

Admission Hospital : WIG	Admission Ward: L10 G
Admission Date : 21/2/13	Admission Time : 08:55
	Procedure: (2) thyroid lobectomy

Discharge

Estimated date of discharge/length of stay:

Supervising adult for discharge: Y ☐ N ☐	Own transport for discharge: Y ☐ N ☐

Pre-operat... ...ent

Assessor: L LAM	Grade: FY1	Date: 21/2/13

Anaesthetic		**Details/Problems:**
Previous GA	N ☐ Y ☑	termination of pregnancy
Previous LA	N ☐ Y ☐	
Dentition risk	N ☑ Y ☐	
Reduced neck movement	N ☑ Y ☐	
Other risk	N ☑ Y ☐	
Heartburn	N ☑ Y ☐	
Sickle cell disease	N ☑ Y ☐	
Surgical		
Any serious surgical or anaesthetic complication	N ☑ Y ☐	

Cardiovascular		**Details/Problems:**
Hypertension	N ☑ Y ☐	
Palpitations	N ☑ Y ☐	
Angina	N ☑ Y ☐	
Heart Attack	N ☑ Y ☐	
Murmur	N ☑ Y ☐	
Blackouts	N ☑ Y ☐	
Heart failure	N ☑ Y ☐	
Respiratory		
Asthma\bronchitis	N ☑ Y ☐	
URTI	N ☑ Y ☐	
Neurological		
Stroke	N ☑ Y ☐	
Epilepsy	N ☑ Y ☐	
Neurological disease	N ☑ Y ☐	
Physical disability	N ☑ Y ☐	
Haematological		
Bleeding disorder	N ☑ Y ☐	
Previous DVT	N ☑ Y ☐	
Anaemia	N ☑ Y ☐	
Others		
Kidney disease	N ☑ Y ☐	
Liver disease/jaundice	N ☑ Y ☐	

Diabetes	N ☐ Y ☒	
Arthritis	N ☒ Y ☐	

Any serious illness not already mentioned?	N ☒ Y ☐	

Exercise Tolerance

Climbs stairs without stopping:	N ☐ Y ☒	Climbs stairs with stopping:	N ☐ Y ☐	Cannot climb stairs:	N ☐ Y ☐

Social

Alcohol >30U	N ☒ Y ☐	Units/Wk	Duration ..... years		
Smokes	N ☐ Y ☒	Cigs/Day 10-20			
drug abuser	N ☒ Y ☐	Methadone req.	N ☐ Y ☐	Self-admin	N ☐ Y ☐
Pregnant	N ☒ Y ☐	Gestation 40/weeks	LMP		

Drug History

Nil regular.

Allergies:	N ☒ Y ☐	Details

Prosthesis/implants

Pacemaker	N ☐ Y ☒	Date of last check	Settings
Prosthesis/others			

Examination

Weight ..... kg	Height ..... M	BMI	Temp ..... °C
HR ..... 65 ../min	Regular N ☐ Y ☑	BP 1) ..113/76.. /	BP 2) ..... /
SaO_2 ..... 99 ..... %	Resps ..... 19 ...../min		

Investigations

FBC	Y ☑	COAG	Y ☑	ECG	Y ☐
BONE	Y ☑	U+Es	Y ☑	CXR	Y ☐ N ☐
LFTs	Y ☐	Group & save	Y ☑ N ☐	Other	

DVT Risk Factors:

Pre-operative Assessment Summary

Assessor L Lam	Grade Fy1

fit for op.

Anaesthetic Assessment

Anaesthetist	Grade

Recommended Admission Pathway

Review by	Anaesthetist	Y ☐ N ☐	Other	Y ☐ N ☐
	DSU criteria met Reason if no	Y ☐ N ☐	SDA criteria met Reason if no	Y ☐ N ☐

Presenting Complaint

Physical examination

CARDIOVASCULAR

Heart Rate JVP

Heart Sounds

Ankle oedema N ☐ Y ☐

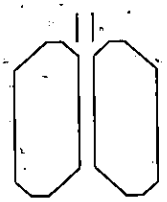
RESPIRATORY:

Trachea

Air entry

Added sounds

Percussion

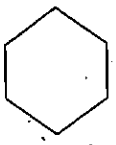


ABDOMEN:

Tenderness/guarding

Palpable masses

Bowel Sounds



PATHOLOGY DEPT - GLASGOW ROYAL INFIRMARY

Lab No.:N,12.0000271 CHI No. 1612836909

Name:DONALD DIANE DOB/Age:16.12.83
Post code:

Hosp.No(orPath.Comp.Ref.ZP): 1612836909

Consultant:Dr R Lindsay Location:WIG Endocrine Clinic

Clinical history:

Solid/cystic nodule left thyroid.

FNA Thyroid

Macro: Three air dried slides, three wet fixed slides and saline received.

Micro: Microscopy shows a bloodstained hypocellular smear with insufficient material for assessment, Thy1.

CH

Dr C van der Horst

This report has been authorised electronically by CYNTHIA VAN DER HORST.

To ask
when
appt

Rep .Path.CYNTHIA VAN DER HORST Date collected 25.01.12
Cons.Path. Date received 25.01.12
Date reported 09.02.12

DEPT OF CYTOLOGY-GLASGOW ROYAL INFIRMARY

Lab No.:N,10.0001733 CHI No. 1612836909

Name:DONALD DIANE DOB/Age:16.12.83
Post code:G81 1AP

Hosp.No(orPath.Comp.Ref.ZP): 10631776W

Consultant:DR RS LINDSAY Location:Outpatients G3 & G4

CLINICAL HISTORY
Solitary nodule left lobe of thyroid with peripheral calcification and some cystic degeneration but predominantly solid.

FNA THYROID

Macro: 2 air dried slides, 2 wet fixed slides and needle washings received.

Micro: A hypocellular blood stained sample containing insufficient cellular material for assessement, Thy 1.

amc Dr C van der Horst

Date collected 09.06.10
Date received 09.06.10 Next appt 24/6
Date reported 11.06.10

WESTERN INF./GARTNAVE [illegible]OLOGY LABORATORY
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
1124660	DONALD DIANE	16.12.83	F	8W

Specimen H,80221.4040.N Type Blood
Collected 21.02.98 08:00 A.Diag

.....CSE.....

PT	13
PTT	28
INR	1.1
PFIB	3.06

CSE PT NORMAL RANGE 10-13 SECS

Quit \ Earlier req \ Later req
Back \ Nxt Comm <Q> ..

WESTERN INF./GARTNA\ T)LOGY LABORATORY
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
1124660	DONALD DIANE	16.12.83	F	AE

Specimen H,80220.4149.G Type Blood
Collected 20.02.98 18:07 A.Diag

.....CSE.....

PT	12
PTT	28
INR	1.1
PFIB	3.06

CSE PT NORMAL RANGE 10-13 SECS

Quit \ Earlier req \ Later req
Back \ Nxt Comm <Q> ..

WESTERN INF./GARTNA ATOLOGY LABORATORY
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
1124660	DONALD DIANE	16.12.83	F	8W

Specimen H,81228.4071.J Type Blood
Collected 28.12.98 12:34 A.Diag

.....CSE.....

PT	14
PTT	32
INR	1.2
PFIB	2.34

Quit \ Earlier req \ Later req
Back <Q> ..

83y. Many wife (R) LL pneumonia acidotic ↓O2
AFib Digoxin
Af + erythr.

GARTNAVEL GEN. HAEMATOLG

Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
1124660	DONALD DIANE	16.12.83	F	8W

Specimen H,81227.4034.G. Type Blood

Collected 27.12.98 09:00 A.Diag

.....CSE.....

PT	14
PTT	29
INR	1.2
PFIB	2.55

Quit \ Earlier req \ Later req

Back <Q> ..

GARTNAVEL GEN. HAEMATO Y

Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
1124660	DONALD DIANE	16.12.83	F	8W

Specimen H,81227.0086.H Type Blood

Collected 27.12.98 03:10 A.Diag

.....FBC.....		Eosins	0.01
WBC	10.10	Basos	0.02
RBC	4.87	.....ESR.....	
Hb	14.3	ESR	5
Hct	0.417		
MCV	85.6		
MCH	29.4		
MCHC	34.3		
RDW	12.4		
Plts	257		
Neuts	8.28		
Lymphs	1.34		
Monos	0.45		

Quit \ Earlier req \ Later req

Back <Q> ..

8th

7th

6th

5th

4th

3rd

2nd

AFFIX 1st REPORT HERE

WEST GLASGOW HOSPITALS UNIVERSITY NHS TRUST

RADIOLOGY DEPARTMENT

00021933 M 15/03/00 XR 0382048

DONALD, Diane 16Y F 1124660

62 STEWART DRIVE, CLYDEBANK, G81 PJ, ODWYER

X-RAY W.I.G.

WL10S

SKULL
No evidence of any fracture.

CERVICAL SPINE
No evidence of any recent injury.

DORSAL SPINE
No fracture.

PELVIS
No fracture.

CHEST MOBILE
Reduced radiolucency in both lung fields. No other significant abnormality.

*DR N MCMILLAN/RT 15/03/00

15/03/00 - SKULL 3 VIEWS, C/SPINE, CHEST MOB, D/SPINE, PELVIS

NHS Greater Glasgow and Clyde

Western Infirmary

DONALD, Diane

F17/7 Ashtree Court, Old Kilpatrick, Glasgow, Dunbartonshire, G60 5JD
Referrer: Dr Robert Lindsay - WIG ENDOCRINE CLINIC

Diagnostic Imaging Report

DoB: **16/12/1983**
Chi No: **1612836909**
CRIS No: **6055109**
Hosp No: **10631776W**

~~**VERIFIED** Verified By: Dr Wilma Kincaid 26/01/12 1142.~~

Clinical History : Left-sided 2 cm thyroid nodule. Previous Thy 1.

US Thyroid :

The right lobe of thyroid and isthmus are essentially normal. When compared to the previous examination of 9/6/10, there has been no significant change in the size of the nodule within the left lobe of thyroid. This currently measures approximately 2.5 x 2.3 x 1.8 cm. Internal hypervascularity is again demonstrated. The lesion remains partly cystic, although the cystic component has reduced in extent.

There is no significant lymphadenopathy in the neck.

US Guided aspiration thyroid :

Fine needle aspiration of the left-sided nodule was performed.

FNA THY 1
Hos appt 29/3/12

~~Ref. Src: Western Infirmary, Dumbarton Road, Glasgow, G11 6NT~~
Exams: US Thyroid,US Guided aspiration thyroid
Exam Date: 25/01/12 Event: E-26295987

08966

North Glasgow Hospitals

NHS Greater Glasgow and Clyde

North Glasgow Hospitals

Western Infirmary

DONALD, Diane
F3/1 804 Dumbarton Road, , Clydebank, Dunbartonshire, G81 4BA
Referrer: DR RS LINDSAY - WIG G3/4 OP CLINIC

Diagnostic Imaging Report

DoB: **16/12/1983**
Chi No: **1612836909**
CRIS No: **6055109**
Hosp No: **10631776W**

24/6 p.m.

VERIFIED Verified By: DR P DEONARINE 10/06/10 1324 and: DR W KINCAID Last Verified By: DR W KINCAID 10/06/10 1324.
Clinical History : 3 cms nodule left lobe of thyroid. For FNA.

US Guided aspiration thyroid :

A solitary slightly hypervascular, partly cystic, partly solid, 27 x 22mms nodule is seen in the upper pole of the left lobe of thyroid. Some internal hypervascularity is demonstrated with peripheral calcification. An FNA was performed of the more solid looking component of this nodule. Sample sent to cytology. No immediate post procedural complications.

Unremarkable appearances of the isthmus and right lobe of thyroid. No significant cervical lymphadenopathy. The salivary glands are unremarkable.

Ref. Src: Western Infirmary, Dumbarton Road, Glasgow, G11 6NT
Exams: US Guided aspiration thyroid
Exam Date: 09/06/10 Event: E-12436382

08966

00837364 M 27/11/00 XR 0382048
1124660

DONALD, Diane 16Y F D.S, BYRNE

X-RAY G.G.H.
DSB 13/12
GOPGS

62 STEWART DRIVE, HILLPARK CHILDREN'S HOME, CLYDEBANK, G81 6AG

SKULL

No vault fracture demonstrated. Views show no evidence of radio opaque foreign bodies.

*DR N RABY/RKP 30/11/00

PORT LEI...
...N -01 DEC ...

30/11/00 - SKULL 3 VIEWS

8th

7th

6th

5th

4th

3rd

MICROBIOLOGY DEPARTMENT **WEST GLASGOW HOSPITALS UNIVERSITY NHS TRUST**

Name: DIANE DONALD
Address: 70 Wood Quadrant

Sex: F Age: 16.12.83
Cons: Dr. J.Hunter

Hosp: Western Infirmary
Practice Number: 6016
Ward: Level 8 West - Medicine
L8 MEDICAL

Hosp No.: 1124660

Specimen: Mid-strean specimen of urine

Investigation: Urine C & S

Taken: 21.02.98
Reported: 23.02.98

Home
22/2

Numerous organisms seen
Numerous pus cells seen.
No red cells seen

pma

1. Heavy growth of Lactose fermenting coliform
2.
3.
4.

Antibiotic	Organism 1. 2. 3. 4.
Amoxycillin	S
Trimethoprim	S
Cephalexin	S

pma

Microbiologists: Dr G.D. Corcoran

Mid-stream specimen of urine

Lab No.: B.98.0020516.R

KALAMAZOO S-10361785 - 114x89A V

BIOCHEMISTRY REPORT

L105

A

DONALD DIANE
WGT A/E
WGT1124660 16/12/1983
BURDEN
145163H Reported: 15/03/2000
15/03/00 03:41
02:53 Authorised By: Auto

RESULTS	CONSTITUENT
141	Sodium 135-144 mmol/l
3.7	Potassium 3.5-5.1 mmol/l
106	Chloride 97-108 mmol/l
23	Total CO_2 22-32 mmol/l
4.5	Urea 2.5-7.5 mmol/l *
62	Creatinine 60-110 µmol/l *
	Serum Osmolality 275-295 mmol/kg
	Urine Osmolality mmol/kg
	Calcium 2.20-2.65 mmol/l
	'Corrected' Calcium 2.16-2.53 mmol/l
	Phosphate 0.8-1.45 mmol/l
	Total Protein 60-77 g/l
	Albumin 36-50 g/l
	Bilirubin 3-18 µmol/l
	Alkaline Phosphatase 70-260 U/l *
	Gamma G.T. 5-50 U/l
	AST 10-35 U/l
	ALT 10-50 U/l
	Total CK 10-171 U/l
	CK-MB Ratio
5.2	Glucose 2.80-6.0 mmol/l
	Urate 0.10-0.42 mmol/l *
43	Amylase 0-100 U/l

* Reference ranges for these assays have significant age and sex dependence.
Further information may be obtained from the Duty Biochemist (211 - 3355/3341)

MI 01/00

BIOCHEMISTR

DONALD DIANE F/1
WGT G2
WGT1124660 16/12/83
BURDEN
421365Q Reported: 11/05/99
10/05/99 12:20
: Authorised By: Auto

RESULTS		CONSTITUENT
144		Sodium 135-144 mmol/l
4.1		Potassium 3.5-5.1 mmol/l
108		Chloride 97-108 mmol/l
25		Total CO_2 22-32 mmol/l
5.8		Urea 2.5-7.5 mmol/l *
84		Creatinine 60-110 µmol/l *
		Serum Osmolality 275-295 mmol/kg
		Urine Osmolality mmol/kg
2.45		Calcium 2.20-2.65 mmol/l
2.39		'Corrected' Calcium 2.16-2.53 mmol/l
1.25		Phosphate 0.8-1.45 mmol/l
67		Total Protein 60-77 g/l
43		Albumin 36-50 g/l
15		Bilirubin 3-18 µmol/l
162		Alkaline Phosphatase 70-260 U/l *
23		Gamma G.T. 5-50 U/l
15		AST 10-35 U/l
		ALT 10-50 U/l
		Total CK 10-171 U/l
		CK-MB Ratio
4.3		Glucose 2.80-6.0 mmol/l
		Urate 0.10-0.42 mmol/l *
		Amylase 0-100 U/l

Stick 2nd Report Here >	Stick 3rd Report Here >	Stick 4th Report Here >	Stick 5th Report Here >

*Reference ranges for these assays have significant age and sex dependence.
Further information may be obtained from the Duty Biochemist (211 - 3355/3341) MP 12/98

CK BELOW THIS LINE

[redacted]

BIOCHEMISTRY REPORT

GARTNAVEL GENERAL HOSPITAL

CONSULTANT BURDEN		SURNAME DONALD	HOSPITAL NUMBER WGT112466(
HOSPITAL WGT	WARD G2	FORENAME DIANE	DATE OF BIRTH 16/12/83
DATE	TIME WITHDRAWN	LABORATORY NUMBER 421365Q	SEX Female

S E R U M

Date	Time	T4 nmol/L	T3 nmol/L	Free T4 pmol/L	TSH mU/L
10/05/99					0.56

Comment: EUTHYROID BIOCHEMISTRY
Authorised By: Auto
Reported Time: 13:15 Reported Date: 11/05/99
Profiles requested on this patient: SMS GLU TFT

RESULT CODE, ABBREVIATIONS AND REFERENCE VALUES ARE GIVEN ON THE REVERSE OF THIS REPORT

OCHEMISTRY REPORT **GARTNAVEL GENERAL HOSPITAL F2**

ONSULTANT NOT STATED	SURNAME DONALD	HOSPITAL NUMBER WGT 1124660
OSPITAL WGT WARD A/E	FORENAME DIANE	DATE OF BIRTH 16/12/83
ATE 26/12/98 TIME WITHDRAWN 23:45	LABORATORY NUMBER 166977G	SEX Female 18M

S E R U M

Paracetamol	1.16	mmol/L
Salicylate	N.D.	mmol/L

Comment:
Authorised By: Auto
Reported at 00:52 on 27/12/98
Profiles requested: KGLU KELU !DRUG



RESULT CODE, ABBREVIATIONS AND REFERENCE VALUES ARE GIVEN ON THE REVERSE OF THIS REPORT

8th

7th

6th

5th

4th

3rd

BIOCHEMISTRY REPORT

GARTNAVEL GENERAL HOSPITAL F2

CONSULTANT	SURNAME DONALD	HOSPITAL NUMBER WGT112466
HOSPITAL WGT WARD A/E	FORENAME DIANE	DATE OF BIRTH 16/12/83
DATE 20/02/98 TIME WITHDRAWN 19:08	LABORATORY NUMBER 895611H	SEX Female

7993/98

S E R U M

Paracetamol	N.D.	umol/L
Salicylate	N.D.	mmol/L

L8M

Comment:
Authorised By: Auto
Reported at 19:51 on 20/02/98
Profiles requested: KELU GLU DRUG

0061841

RESULT CODE, ABBREVIATIONS AND REFERENCE VALUES ARE GIVEN ON THE REVERSE OF THIS REPORT

WEST GLASGOW HOSPITALS UNIVERSITY NHS TRUST

BLOOD TRANSFUSION

SURNAME	FORENAMES	HOSP No.	D.O.B.
DONALD L105		1124660	16-Dec-83

MEDICAL OFFICER	WARD	SEX	HOSPITAL
DUS 1513	WARD 13 MAT	F	Western Infirmary

BLOOD GROUP	RHESUS	ADDRESS
O	POS	62 STEWART DR.

LABORATORY NUMBER	ANTIBODY SCREEN
0.4532.2	Negative

EXPIRY DATE	PRODUCT CODE	DONOR GROUP	COMPATIBLE PACK NOS.
10/04	LDRA	O POS	156 106 X5
10/04	LDRA	O POS	156 200 X2
10/04	LDRA	O POS	167 225 X8

TO BE COMPLETED BY NURSE/MEDICAL OFFICER

USED TIME	USED DATE	PACK PUT UP BY	CHECKED BY	REACT

"THIS BLOOD WILL BE DERESERVED" AT 9.00 AM ON 17-Mar-00

LAB COMMENT

SPECIMEN RECEIVED DATE 15-Mar-00 DATE OF TEST 15-Mar-00 AUTHORISED BY

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST — DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC. BURDEN
OR GP NAME & ADDRESS Accident and Emergency

SURNAME	FORENAME	SEX	D.O.B. AGE	HOSPITAL	LABORATORY No.
DONALD	DIANE	F	16.12.83	1124660	H.00315.0009.F

REPORT

Cumulative FBC's

	20.02.98	26.12.98	27.12.98	10.05.99	15.03.00	
WBC	11.70	7.51	10.10	6.65	11.67	(4.00–11.00)
RBC	5.10	4.58	4.87	4.72	4.57	(3.80–5.80)
Hb.	14.8	13.6	14.3	14.2	13.5	(11.5–16.5)
Hct	0.445	0.397	0.417	0.419	0.403	(0.370–0.470)
MCV	87.3	86.7	85.6	88.8	88.2	(80.0–100.0)
MCH	29.0	29.7	29.4	30.1	29.5	(27.0–32.0)
Plts	194	237	257	209	198	(150–400)
Neuts	8.18	4.52	8.28	4.12	9.37	(2.00–7.50)
Lymphs	1.54	2.10	1.34	1.56	1.24	(1.50–4.00)
Monos	0.45	0.59	0.45	0.53	0.85	(0.20–0.80)
Eos	1.50	0.23	0.01	0.41	0.16	(0.04–0.40)
ESR			5	6.		(2–10)
GFST						
Retics						(25.0–85.0)

DATE OF REPORT	TIME
15.03.00	10:40
RUN	
864	DT
DATE OF SAMPLE	TIME
15.03.00	02:39

FULL BLOOD COUNT

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST — DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC. OR NAME ADDRESS	SURNAME	FORENAME			
BURDEN Accident and Emergency	DONALD	DIANE			
	SEX	D.O.B. AGE	HOSPITAL	LABORATORY No.	
	F	16.12.83	1124660	H/00315.4004.K	

REPORT

LOS

COAGULATION SCREEN			
PROTHROMBIN	12	SECONDS	(10–13)
PARTIAL THROM TIME	23	SECONDS	(26–36)
INT. RATIO	1.0		
DER FIBRINOGEN	2.29	g/l	(1.50–4.50)

Authorised by: MAUREEN SIMMS

DATE OF REPORT	TIME
15.03.00	11:36
RUN 386	
DATE OF SAMPLE	TIME
15.03.00	02:39

WEST GLASGOW HOSPITALS UNIVERSITY NHS TRUST

WEIGHT				
Date	Kgm.	St.	Lbs.	Own Clothes/O.C. Hospital Clothes/ H.C.
	:			
	:			
	:			
	:			
	:			
	:			
	:			
	:			
	:			
	:			
	:			
	:			
	:			
	:			

1124660
DONALD DIANE
28 Glendevon Place F
CLYDEBANK 16/12/83
G81 4SG
G.P.Prac. 40224

TEL. NO. 941 0232

PATIENT'S OCCUPATION SCHOOLGIRL

NEXT OF KIN ANGELA O'NEILL MOTHER

ADDRESS 70 Kilbreck Ahead

TEL. NO.

FAMILY DOCTOR ~~Rogerson~~ THOMPSON ~~Logerson~~ G81 2TQ

ADDRESS G/B Mc Kilbowie Rd

TEL NO. 531 6425

CHANGE OF FAMILY DOCTOR

ADDRESS

TEL NO.

PRIMARY

SUMMARY OF ATTENDANCES (OUT-PATIENTS AND IN-PATIENTS)

DATE	HOSPITAL	CLINIC/ WARD	AGE	DIAGNOSIS	OPERATION	DATE OF DISCHARGE
20/12/98	WGH	L8M	14			22/12/98
26/12/98	WGH	L8M	15			28/12/98
1/2/99	WGH	SR	Skins			
10/5/99	WGH	Dr Burden				
15.3.00	WGH	L10S	16			15.3.00
16/5/00	GGH	Mr Byrne				
27.11	"	"	"			
13.12	"	"	"			
10/1/01	"	"	"			
31/5/01	"	Mr Carnick				
30/8/01	"	"	"			

0061761MI

Name	Hospital No.
	CHI Number
	Age
	Sex
PHYS/ SURG	Dept.
	Ward

NHS Greater Glasgow and Clyde

DATE	OUT-PATIENT HISTORY
5/1/12	WT: 63·6kg
9/3/12	WT- 64·0kg
	2·5cm thyroid nodule (L)
	Stable June '10 ⇒ Jan 12
	2° THY FNA
	Thyroid nodule enlarged
	Ref to Mr Wilson - surgery
4/8/12	WT- 65·7kg

NHS
Greater Glasgow and Clyde

Name	Hospital No. Age
	Sex
PHYS/ SURG	Dept. Ward

OUT-PATIENT HISTORY

DATE	
13/5/10	Dr Lindsay WT 61.7kg HT 1M 58cm. Late teenage P=0.1 – Nodule lump ~ mid Neck ?? goes w swallow Posterior of right of larynx but has cold + sometimes Pain over – 3cm solid (L) lobe thyroid own small isthmus Imp – likely benign adenoma ↳ FNA c USS Lang
24/6/10	STA/CNC Pt well change in size clearly Rec FNA → TFT 2 → phased sleeve P/ Agreed RTV 6/52 (note pt been fr retired as lab observer at Ninewells) N. GHORAI

DATE	HISTORY (Use other side first)
4/6/10	WT: 63.1kg
5/8/10	D Lindsay Endo

NAME

HOSPITAL No

AGE

PHYS/ SURG.

DEPT WARD

IN-PAT FORM

IN PATIENT CONTINUATION HISTORY

DATE	
14/12/04	GYN TOG

NORTH GLA ... NHS TRUST

NA
1124660
DONALD DIANE
62 Stewart Drive F
HILLPARK CHILDREN'S
CLYDEBANK 16/12/83
PH G81 6AG
SU G.P.Prac. 40224

OUT-PATIENT HISTORY

MR D CARRICK

DATE 31/5/01

DEPARTMENT OF OTOLARYNGOLOGY

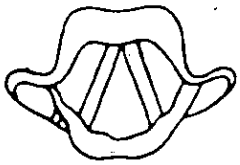
HISTORY

BOYCE

- NOSE BLOCKED 1 YEAR Hx
- MAINLY (R) SIDE
- NO DISCHARGE
- NO SINUS PAIN
- NO POST NASAL DRIP
- 2 - 3 EARLIER SELF LIMITING EPISTAXIS (R) SIDE
- NO (NOTHING) TO NOSE
- THINK A SPRAY ? what - did it help

Right EARS	NOSES AND SINUSES	MOUTH, PHARYNX, TONSILS, NECK
		
Left 	NASOPHARYNX	

LARYNX



X-RAY EXAMINATIONS

SINUSES
CHEST
OESOPHAGUS
MASTOID
DENTAL
OTHERS

TREATMENT

GRH JMcC/10774

HISTOR

(Use other side first)

Date

PMH °HTN/Epil/Arth

Well

PSH nil.

DH nil

17 F

° allergies stall giving

° hayfever

smokes 5 cpd.

VDU operator

°/e - see previous

30/8/01 to enhancement GP Rooms

- for refit/Hosp + SMO to IT

WEST GLASG



ıspital No.

10631776W
DONALD F
DIANE 16/12/1983
FLAT 2
18 ONSLOW ROAD
CLYDEBANK G81 2NE
CHI-1612836909

je
ıx
ept.
ard

OUT PATIENT HISTORY

DATE	
19.3.13	Mr L Wilson

0061588MI

WEST GLA S

NAME

1124660
DONALD DIANE
62 Stewart Drive F

CLYDEBANK 16/12/83
G81 6AG
G.P.Prac. 40224

PHYS/ SURG.

OUT PATIENT
HISTORY

DATE

27.11.00 ? Carotid glom. ~~Foan~~ [illegible] RS art +
better looking scan (1
seen by mr DS B ⇒
[illegible] of forehead
R
[illegible]

0061588MI

WEST GL ... AL

NA
PHY
SUR

1124660 DIANE
DONALD F
62 Stewart Drive
CLYDEBANK 16/12/83
G81 6AG
G.P.Prac. 40224

OUT PATIENT
HISTORY

DATE

16/5/00

16/7

forehead → windscreen

RTA — Mar 14th.

acc bic pain

forehead wound small
piece of glass 1cm
scar
wounds excised &
explored — sup glass
just below skin
CA (c midg cover)

Emma

0061588MI

P1AES

ACCIDENT & EMERGENCY DEPT.
WESTERN INFIRMARY
GLASGOW
G11 6NT
TEL: 0141-211-2304/2409

...CY FORM

CRN: 1124660

Surname	Forename	Age	Date of Birth	Arr Date	Time	AE Number
DONALD	DIANE	16	16/12/83	15/03/00	01:45	011281/00

Address	Sex	Religion	Date of Inc	Time
62 Stewart Drive CLYDEBANK	Female		15/03/00	

Marital Status	Occupation/School	Type of Inc	Mode of Arrival
Single /	SCHOOL	RTA	By Ambul

PC G81 6AG | Tel

Name: Dr THOMSON
Address: CLYDEBANK HEALTH CEN
KILBOWIE ROAD
CLYDEBANK
G81 2TQ

Referred by: OTHER

Name: ANGELA O NEILL
Relat: MOTHER
Tel. No.: 0141 941 0232
Address: 70 Wood Quadrant
CLYDEBANK
G81 1AP

Complaint: PAS
FRONT SEAT PASSENGER

ROAD TRAFFIC ACCIDENT PLACE: STOCKIEMUIR RD NR GOLF COURSE

DETAILS: 1 CAR INVOLVED

HOME ACCIDENT PROBABLE CAUSE

TRIAGE

TRIAGE TIME TRIAGE CATEGORY

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

Dear Doctor,

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

Diagnosis: RTA - head injury + laceration

INITIAL COMPLAINT

INITIAL TREATMENT

X-Ray film/ECG shows

Treatment given: Admitted for neuro obs.

FILED BY MRJMCG

Drugs_____days supply of _____has been given.

Tetanus Prophylaxis has/has not been administered. TT Course_____ TT Booster_____ HATI_____ (Please Tick)

Would you please arrange_____

DISCHARGE CODES: Please Circle

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

Ward No. (if admitted)	Transfer to Hospital	Consultant (if admitted)
L10W		

Follow up	Not arranged	Arranged	To be arranged

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

Medical Officers Name (In Block Letters): ARTHUR

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

Signature of Medical Officer: Arthur

TRIAGE DATE: TIME:

CHIEF COMPLAINT: RELEVANT HISTORY: PHYSICAL SIGNS:

VITAL SIGNS: TREATMENT AT TRIAGE: DISPOSITION:

HR:
BP:
RR:
GCS:
TEMP:

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

TRIAGE NURSE..... SIGN
..... PRINT

1813
Hb 13-5
wce 11.67
pl 198

PT 12
PTT 23
INR 1.0
Plts 202

Glu 5-2
Na 141
K 3.7
Cl 106
HCO3 23
Urea 4.5
Creat 62
Amy 43

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

TO BE RECORDED O

T_____ P_____ R_____ BP_____

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

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

CONSULTANT_____ REG/SHO_____ JHO_____

SEEN BY Clapham AT (TIME)_____

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

CLINICAL NOTES

DATE

Involved in RTA
Rear seat passenger behind driver
One fatality at the scene.
left car to get help
PMH prev ODS
UTI's
DH No meds °allergies

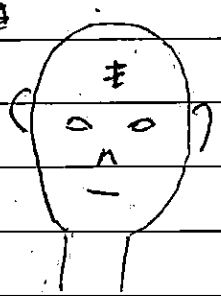
on Arrival A+E
GCS 15/15 pupils equal reactive
orientated x3
A maintaining airway
speaking
SpO2 98% on Air
B Resp rate 16
Bilateral AE good.
BS vesicular nil added
C HR 88 BP 128/70
peripheries warm not shocked.
IV access 16G cannulae
500 ml NaCl.

OPEN BEFORE W

DATE | CLINICAL NOTES

D c/o pain thoracic vertebrae.
and back of skull.

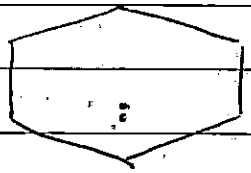
E log roll
No obvious trauma to spine.



small incised wound
1cm
No other facial injuries

	RUL	LUL	LLL	RLL
T	N	N	N	N
P	5	5	5	5
R	+	+	+	+

No sensory loss lower extremities



Soft
BSV
Non tender

Bloods sent FBC coag UTE glucose.
Xrays Cspine NAD
CxR NAD
pelvis NAD

Needs AP spine PEG
Intercostal chest

NAME DIANE DONALD. AL No

AGE 16

PHYS/SURG. O'DWYER DEPT WARD

N-PAT FORM 3

IN PATIENT CONTINUATION HISTORY

DATE	
15/3/00	16yr ♀: unrestrained offside rear seat passenger in
04:40	RTA - car roll over - 1 fatality ~ 23:45.
	• not ejected from vehicle
	• climbed out from seat, walking after, hailed lift
	to local pub.
	A - no allergies.
	M - OCP LMP - menstruating.
	P - 2 x OD ATT 1yr ago.
	UTI
	L - last ate - cup of tea ~0000hrs.
	- Meal 18:30
	E -
	Hit head off ? what
	- °LOC °vomit °diplopia.
	- c/o frontal headache + laceration
	- recalls all events.
	- denies any drug/alcohol ingestion
	c/o pain in back & scapulae
	O/E:
	A) Speaking maintaining airway
	B) Resps 14/min Sa O_2
	C P 80 reg good vol.
	BP 128/70
	HS 1-1,1-0 °murmur.
	IV access (R) ACF 500ml (N) saline runn

0061619MI

HISTORY
(Use other side first)

Date

Skull: 10mm laceration as marked.
surrounding tenderness
no facial bone
no haemotympanum / nasal discharge



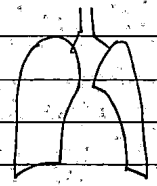
XR: No skull # or fluid

– needs wound cleared

C-spine: no process tenderness, tender @ trapezius. steri-strip peel
full independant ROM

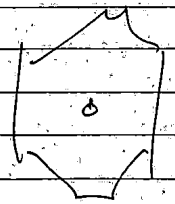
XR: lateral – extended – no bony or soft tissue injury
AP + Peg – no bony injury
→ C-collar removed

Chest:
trachea |
no chest wall bruising or flail seg.
no chest wall tenderness



percussion resonant (R) = (L)
GOOD AE all areas.
CXR: no pneumothorax
no rib #.

Abdo: Soft. non-tender
moving w resp.
BS active



Pelvis: non-tender on springing
no PV / urethral blood.

Upper limbs: nil

Lower limbs: superficial abrasion (R) patella.
Full ROM minimal bony tenderness.
needs reassessed

NAME DIANE DONACD HOSPITAL No 1124660

AGE

PHYS/SURG. O'DWYER DEPT/WARD RESUS.

IN-PAT FORM 3

IN PATIENT CONTINUATION HISTORY

DATE	
	Neuro
15/3/00	Alert, orientated GCS E 4
	CRANIAC nerves intact M 6
	PERL 3mm V 5
	FROEM ° diplopia
	RUE LUE RLE LLE
	sensation —— (N) ——
	tone —— (N) ——
	power —— 5/5 ——
	reflex: B ++ ++ K ++ ++
	T +++ ++ A ++ ++
	S ++ ++ P ↓ ↓
	PR: normal anal tone + perianal sensation
	log roll: - no bruising / skin wounds.
	- tender mid dorsal spine.
	XR: dark Hlm normal aligment, ?? stable wedge # mid dorsal spine
	Imp: 16 yr ♀ unrestrained rear seat passenger in RTA car rollover ∴ 1 fatality. • Head injury ∴ frontal laceration + no neurological symptoms/signs.
	Dorsal spine tenderness.
	STI (L) knee.
	Plan: Admit - neuro-obs
	- observe on ward.
	- IV fluids + allow oral fluids.
	- Radiologist report of spine Hlms.
	2° survey outstanding:
	- reassess (R) knee
	- BUCG from urine
	A+E: Needs Head wound steri-stripped
	Angus MacKenzie (ACEMR/SHO)

0061619MI

HISTORY
(Use other side first)

ate

1573 LHR PCN

- Tender on dorsal spine
- Request Filum Dorsal spine today, a repeat film.
- If clear → D/C today

[signature]
Consultant

5/3 DIW Radiologist - Dorsal spine looks fine, no need to repeat. (H) today

GM.Kg. (DHo 3161)

1124660
DONALD DIANE
62 Stewart Drive F

CLYDEBANK 16/12/83
G81 6AG
G.P.Prac. 40224

OUT PATIENT HISTORY

DATE 10/5/99

DEPARTMENT OF DERMATOLOGY

Dr Burden

Duration 15 F Site of Initial Lesion

History 1yr generalised itch
initially a rash + healed excoriations
+ eczema
now no rash but itch persists.

Rx Feb 98 overdose ? NSAID

Previous History generally well.

Family History living in a childrens home
no contact with scabies

Occupational Details (when relevant)

Exam

nil. except mild dermographism

Investigations

1 FBC ESR ferritin

2 ?thyroid glucose TFT

3 lg r SEP

4. ↓ atarax 25mg/5ml

Steroids

Photographs

Biopsy

M.N.I. 4/52

Drugs and Medicaments used prior to attendance

Treatment (Initial)

1124660
DONALD DIANE
70 Wood Quadrant F

CLYDEBANK 16/12/83
G81 1AP
G.P.Prac. 40224

OUT PATIENT
HISTORY

DATE	
1/2/99	SR SKins
10/5/99	Dr Burden
21/6/99	Dr Burden

GRII

NORTH GLA HOSPITALS NHS TRUST

ACCIDENT & EI
WESTERN INFI
GLASGOW
G11 6NT
Tel: 0141-211-2304/2409
Fax: 0141-339-3046

CONSULTA

Dr S Perry
NURSE MANAGER: Mr G D Wright

B 0415

CRN: 1124660

NHS Greater Glasgow

MEDICAL RECORDS COPY

PATIENT

Surname	Forename	Age	Date of Birth	Arr Date	Time	AE Number
DONALD	DIANE	19	16/12/83	06/01/03	03:20	000738/03

Address	Sex	Religion	Date of Inc	Time
28 Glendevon Place CLYDEBANK	Female		06/01/03	

Marital Status	Occupation/School	Type of Inc	Mode of Arrival
Single /	DATA INPUT	O/D	By Ambul

PC	Tel
G81 4SG	NONE

GP

Name	Address	Referred by
Dr ROGERSON	CLYDEBANK HEALTH CE KILBOWIE ROAD CLYDEBANK G81 2TQ 531-6425	Selfref

NEXT OF KIN

Name ANGELA O NEILL

Relat. MOTHER

[redacted] No. 952 1389

Address
22 Montrose Street
CLYDEBANK
G81 2PZ

Complaint

ROAD TRAFFIC ACCIDENT PLACE

DETAILS

HOME ACCIDENT PROBABLE CAUSE

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

Triage Time	Triage Category
03:20	Category 2

Initial Complaint: Overdose 2

Dear Doctor,

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

Diagnosis OD

X-ray film/ECG shows

Treatment given

[redacted]

Drugs _____ days supply of _____ has been given.

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

Would you please arrange

DISCHARGE CODES: *Please circle*

(1.) Admission 3. Refer to G.P. 5. Died 7. Irregular Discharge

2. Discharge 4. Transfer to other hospital *(see below)* 6. Refer to O.P. Clinic *(see below)* 8. D.O.A.

Ward No. *(if admitted)*	Transfer to Hospital	Consultant *(if admitted)*
L8M		MCLELLAN

Follow-up	Not Arranged	Arranged	To be arranged	IRIS

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

Medical Officer's Name *(in BLOCK LETTERS)* W FREEL

Signature of Medical Officer Freel

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

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST — CONSUL

ACCIDENT & EMERGENCY
WESTERN INFIRMARY
GLASGOW
G11 6NT
Tel: 0141-211-2304/2409
Fax: 0141-339-3046

B

Dr S Perry
NURSE MANAGER: Mr G D Wright

NHS Greater Glasgow

CRN: 1124660

TREATMENT COPY

PATIENT GP EXT OF IN

Surname	Forename	Age	Date of Birth	Arr Date	Time	AE Number
DONALD	DIANE	19	16/12/83	06/01/03	03:20	000738/03

Address	Sex	Religion	Date of Inc	Time
28 Glendevon Place CLYDEBANK	Female		06/01/03	

Marital Status	Occupation/School	Type of Inc	Mode of Arrival
Single /	DATA INPUT	O/D	By Ambul

PC G81 4SG Tel NONE 01389 380264

Name Dr ROGERSON
Address CLYDEBANK HEALTH CE
KILBOWIE ROAD
CLYDEBANK
G81 2TQ
531-6425

Referred by Selfref

Complaint

Name ANGELA O NEILL
Relat. MOTHER
No. 952 1389
Address 22 Montrose Street
CLYDEBANK
G81 2PZ

ROAD TRAFFIC ACCIDENT PLACE

DETAILS

HOME ACCIDENT PROBABLE CAUSE

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

Triage Time	Triage Category
03:20	Category 3

Initial Complaint: Overdose

Dear Doctor,

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

Diagnosis OD

X-ray film/ECG shows

Treatment given

Drugs _____ days supply of _____ has been given.

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

Would you please arrange _____

DISCHARGE CODES: *Please circle*

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

Ward No. *(if admitted)*	Transfer to Hospital	Consultant *(if admitted)*
L8MM		MCLELLAN

Follow-up: Not Arranged _____ Arranged _____ To be arranged _____ IRIS _____

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

Medical Officer's Name *(in BLOCK LETTERS)* M FREEL

Signature of Medical Officer M Freel

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

R: ING NOTES

TRIAGE DATE: TIME:

CHIEF COMPLAINT: RELEVANT HISTORY: PHYSICAL SIGNS

VITAL SIGNS: TREATMENT AT TRIAGE: DISPOSITION:

HR:
BP:
RR:
GCS:
TEMP:

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

TRIAGE NURSE ..... SIGN

..... PRINT

X-ray and other reports to be filed on this side *(if the patient is not being admitted)*

SCOTTIS[illegible]E SERVICE - PATIENT RE[illegible]

CCS INCIDENT No. A A / N N N N N N N / N N N

Last Name: Donald
First Name: Diane
Location: 28 Lendown Pl Dalmuir
Age: 19
Sex: M F
D of B: 4 6 M 2 8 3

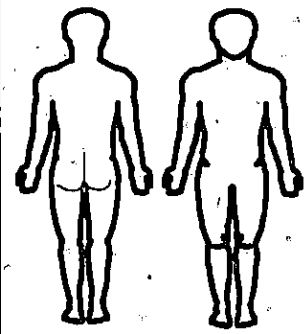
Date: 06 01 03
Time of Call:
Time at Patient: 0252
Time Left: 0300
Incident Code:
Revised Code:

Airway Clear [X] Suction [ ] N/OPA [ ] ET [ ] LMA [ ] Successful ? [Y]
Breathing [X] Rate F N S BVM [ ] Ventilation [ ] Successful ? [Y]
Pulse [X] Rate F N S CPR [ ] IV/IO [ ] Fluids [ ] Successful ? [Y]

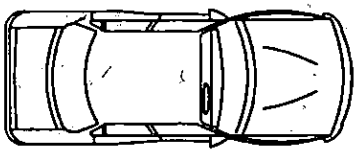
C-spine Injury [Y] Paralysis [Y] Fitting [Y] ECG

Despite the above unable to
Clear airway [ ] Detect breathing [ ] Detect pulse [ ] A V P U

Injury Site	Wound	#	Pain	Splint	Dressed
Head					
Neck					
Chest					
Abdomen					
Back					
R/Arm					
R/Leg					
L/Arm					
L/Leg					



RTA [ ]
Trapped [ ]
Ejected [ ]
M / cyclist [ ]
Cyclist [ ]
Pedestrian [ ]
>20 min. Extricate [ ]



Allergies: 1 2 3 4 5 6 7 8 9
Medication: NONE
Assisted by and Name -
Doctor [Y] Nurse [Y] Other [Y]

Temp. [ ] °C
PEFR [ ] % B. Sugar [ ] mmol

Time	Pulse	Resp	BP	C / Refill	SpO2 %	GCS	Lpupil	Rpupil
0251	096	16	S Y S / D I A	F S N		E M V	S R	S R
			S Y S / D I A	F S N		E M V	S R	S R
			S Y S / D I A	F S N		E M V	S R	S R
			S Y S / D I A	F S N		E M V	S R	S R

Time	Fluid/Drug/Gas	Dose	Unit	Route	Effect	Rhythm	No. Joules	Repeat	Result Rhythm
					+ 0 -				
					+ 0 -				
					+ 0 -				
					+ 0 -				

Condition at: WIG hospital Pulse [Y] Breathing [Y] Conscious [Y] Time at Hospital:

History and Additional Information: "999" to has taken 16 paracetamol at sometime tonight along with small amount of alcohol Strength of tablet 500mg

Working assessment: OD Paracetamol

Incident Code:

Crew Name 1: Lvall 1014 Grade: L P T C
Crew Name 2: CHurd Grade: L P T C

SASPATIENT (10/2001)

SCOTTISH AMBULANCE SERVICE NHS TRUST - PATIENT REPORT FORM

INCIDENT No. A A / 2 3 0 2 4 0 / N N N

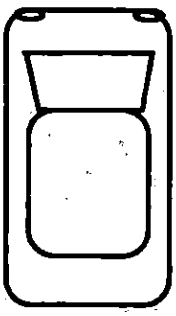
PATIENT NAME	DIANE DONALD	SEX	M / F X
PATIENT ADDRESS	C/O RAMSAY HOUSE RISK STREET DALMUIR	D.O.B.	15 12 83

TYPE OF INCIDENT

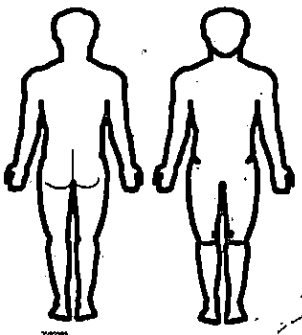
Trauma	
Assault	
Cardiac Arrest	
Other Collapse	
DSH	X
IHT	
Obstetric	
Other	X

TRAUMA INCIDENTS

RTA	
Cyclist	
M/Cyclist	
Pedestrian	
Ejected	
Trapped	
>20 mins. Extricate	
Helmet Worn	
Seat Belt Worn	



Home	
Work	
Leisure	
Burns	
Drowning	
Fall < 2 mtr.	
Fall > 2 mtr.	
Head Injury	
Poisoning	
Other	



▒ Damaged Area ▶ Point of Impact X Position of Patient ▒ Damaged Area/ Burns % # ? Fracture X Laceration

INJURY / ILLNESS

Acute Abdo.	
Breathlessness	
Chest Pain	
Other Cardiac	
Convulsions	
C.V.A.	
DSH O/dose	X
Haemorrhage	
Hypoglycaemia	
Other	

PRIMARY SURVEY

Treatment prior to arrival	Y	N
E om		
[on of treatment / CPR		
Airway Clear		Obstructed
thing.	Y	N
ulation - Pulse	Y	N
Disability- Alert	Y	N
Vocal Stimuli	Y	N
Pain Stimuli	Y	N
Unresponsive	Y	N
Vomited	Y	N
Fitting	Y	N
Knocked Out	Y	N

INITIAL ACTIONS

Airway		
Pharyngeal Airway	Y	N
Tracheal Tube	Y	N
Laryngeal Mask	Y	N
Size		•
Successful ?	Y	N
Breathing		
O_2 Flow rate	%	
Mask Type		
IPPV		
Circulation		Success

Cannulation	Size	Side	Site	-full	
1				Y	N
2				Y	N

A.M.P.L.E. ?

Allergies (See reverse for coding)

1	2	3	4	5	6	7	8	9

Medication: TOO PANICKY / TO

Past Medical History: GIVE

Last Eaten: DETAILS

Events Preceding Incident

OBSERVATIONS

Time	Breathing R.R.	Breathing SpO2 %	Circulation Pulse	Circulation Blood Pressure	Capillary Refill Norm	Capillary Refill Delay	Pupils Left Size (C N D)	Pupils Left React Y/N	Pupils Right Size (C N D)	Pupils Right React Y/N	Glasgow Coma Score E	M	V	Total
2005	50										4	6	5	15

TREATMENTS

Time	Presenting Condition	Defib. (Joules)	Fluid / Drug	Batch / Box No.	Dose	Route	Result e.g. Pulse, Asys, VF, Other

COMMENTS / ADDITIONAL INFORMATION 999 TO FEMALE DIFF. IN BREATHING

THIS GIRL CLAIMS TO HAVE TAKEN 2 BOXES (12) PARACETAMOL OVER THE LAST 2 HOURS. SHE PRESENTS IN A PANICK ATTACK, REFUSES TO BREATH INTO BAG. (HIST. PANICK ATTACKS) (1 PREV. O/DOSE CLAIMED)

(Affix Rhythm Strip Here)

CREW 1	H. L.	SIGNATURE (Crew 1 or 2)
CREW 2	B. F.	
MEDICAL STAFF		
INCIDENT LOCATION	CALL BOX AT 161 BARNS ST	DESTINATION HOSPITAL WIG

CONDITION ON ARRIVAL AT HOSPITAL

Conscious	X	Pulse	X
Breathing	X	No Vital Signs	

DATE OF CALL	26/12/98
TIME OF CALL	0945
TREATMENT COMMENCED	0955
TIME LEFT SCENE	2008
(m/a) ARRIVED HOSPITAL	2030

HOSPITAL USE ONLY

Patient's name _____ Age 19

NURSING DOCUMENTATION - ACCIDENT & EMERGENCY DEPARTMENT

Date _____ Time _____ Triage Nurse _____ PC _____

C/O OD x 10 Paracetamol 7 Time

Triage category 1 (2) 3 4 5

Relatives present: Relatives informed:

INITIAL VITAL SIGNS

at:(Time) _____
HR: 109
BP: 104/59
RR: _____
SaO_2: 97/0
Temp: _____
G.C.S: _____
Signed _____

INITIAL MANAGEMENT

Nurse _____

Oxygen started _____ %: Signed _____ ECG: Signed _____

Bloods: AE1 AE2 AE3 Trama OD Signed _____

Other _____

Treatment _____

NEUROLOGICAL OBSERVATIONS

	TIME	hrs									1
RESPONSIVENESS	EYES OPEN	spontaneously 4 to speech 3 to pain 2 none 1									eye closed by swelling =C
	BEST VERBAL RESPONSE	orientated 5 confused 4 inappropriate words 3 incomprehensible sounds 2 none 1									Endotracheal tube or Tracheostomy = E Dysphalsa=D
	BEST MOTOR RESPONSE	obey commands 6 localises pain 5 normal flexion to pain 4 abnormal flexion to pain 3 extention to pain 2 none 1									Record the best arm response Paralysed =P
		COMA SCORE 15									
	PUPILS	RIGHT size (mm) Reaction									2 += Reacts -=No Recaction C= Eye closed SL= sluggish pupil
		LEFT size (mm) Reaction									
LIMB M	ARMS	Normal power Mild weakness Severe weakness Extention No response									3 Record right (R) and left (L) seperatly if there is a difference between the two sides Fractured limb = #
MENT	LEGS	Normal power Mild weakness Severe weakness Extention No response									
	1 2 3 4 5 6 7 PUPIL SCALE (mm)	BLOOD PRESSURE mm Hg: 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 PULSE RATE: 80 70 60 50 40 30									4 40 39 38 37 Temp C° 36 35 34 33 32 31 30
		RESPIRATORY RATE									5
		SaO_2									
		NURSE INITIALS									6

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

Signed: _____

URINALYSIS

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

Signed: _____

MEDICAL NOTES ... NATION

Consultant Mc LELLAN Seen by Mheel

Grade: SpR SHO (SHO3) JHO Clin Assist ENP *(Please circle)* At (time) 0350.

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

Date

6/1 19 ♀

Background: Depression
Previous OD

- took 16 paracetamol tablets @ midnight
- had been drinking in pub earlier (5-10 vodkas)
- motivation unclear
- phoned friend who then phoned police
- no ongoing suicidal intent
- no physical symptoms

DMH Chlamydia. DH nil NKDA

SH Lives alone

O/E Looks well
BP 104/59

Physical exam NAD

Impr: Impulsive OD

Plan Bloods and levels (4h post OD ✓)
Admit for Y evaluation

nb In view of alcohol intake, use high risk Rx line for levels

Mheel
FREG

6/6/03
Self poisoning paracetamol
superficial - wished to die.
For written psychiatry review.

CT pordex for INR, LFT.
Data until cause completed.

Mlk

MEDICAL NOTE ... MINATION (cont)

Date

Psychiatry review

7/1/03 (PC) paracetamol OD

(HPC)

- Drinking at local pub with freind - had 5-10 vodkas. Went home from pub on her own, felt "really down" thinking "about everything that's gone wrong" - relationships within family and recent end of sexual relationship. Had paracetamol already in house - took all 16 tablets available, wanted to die. Can't remember much, apparently phoned former childrens home who then phoned police who came to house.

→ Ambulance to Victoria

- Mood: low mood for ~2 months.
  - reduced appetite
  - sleep reasonable.
  - suicidal ~~###~~ thoughts over last 2 months.
  - one episode when had tablets in hand but threw them away, beginning 2002.
  - no ongoing suicidal intent at present.
- 2 previous ODs at age 14yr - required activated charcoal (ibuprofen)
  15yr -

(PMH)

nil.

(PSH)

only liason assessment after OD - no follow up.

(DH)

Contraceptive implant

nil else

(FH)

- father, Alan, lives England } no contact with either
- mother, Angela, lives Ireland } "never had rel. with Dad"
  "mum and I don't get on"
- brother, Sean, lives in Ireland = mother, 11yr, mother preventing contact.
- aunt, Elizabeth, lives Bristol, is only person with whom she has regular phone contact.

(SH)

- lives in council flat in Clydebank, there for 1 year. prev. childrens homes.
- solvs directory enquiries

MEDICAL NO. EXAMINATION (cont)

Date

(personal hx)

childhood – parents split & when she was 2 yr.
– little contact with dad after this, didn't like him, denies abuse
– lived with mother until 14yr. "she chose father over me" moved into childrens homes.
– lived in childrens homes for 3 yrs → own flat
no happy memories of time with mother

educ. – enjoyed primary school
– school "fell apart" when she sent into care half way through secondary, truanting, passed exams but not with expected grades – regretful.

occup – working in phone sales / operator since 15yr.

alcohol – binge drinking 4 times per over last 2 mont since splitting with partner.

drug – tried other coke + ecstasy but not regular use.

rel – still sees ex partner, lives round corner.
gets abusive text messages from ex-girlfriend.

forensic – nil.

(MSE)

[appearance behaviour] – polite, friendly, good eye contact, good rapport.

[mood] subjectively + objectively low.
no ongoing ongoing suicidal intent but little regret.

[speech] (N) rate, vol.

[thought] form (N)
content – ruminations social situation/relationship problems
nil psychotic..

[cognitive] (3)

(Impies)

19 yr old woman with low mood 2° to social situation took impulsive paracetamol OD following alcohol consumption. No ongoing suicidal intent but low mood

(Plan)

Allow home – going to stay with friends mother for a couple of days
Follow up – antidepressant
provision of sources of support.

MACRAE (SHO)

WEST GLASGOW HO[illegible] TRUST — ACCIDENT[illegible] — TREATMI

ACCIDENT & EMERGENCY DEPT.
WESTERN INFIRMARY
GLASGOW
G11 6NT
TEL: 0141-211-2304/2409

CRN: T12[illegible]60

Surname	Forename	Age	Date of Birth	Arr Date	Time	AE Number
DONALD	DIANE	15	16/12/83	26/12/98	20:55	055716/98

Address	Sex	Religion	Date of Inc	Time
C/O RAMSAY HOUSE RISK STREET CLYDEBANK	Female		26/12/98	

PC	Tel	Marital Status	Occupation/School	Type of Inc	Mode of Arrival
		Single	SCHOOL	Other	By Ambul

Name	Address	Referred by
Dr THOMSON	CLYDEBANK HEALTH CEN KILBOWIE ROAD CLYDEBANK 0141 531 6400	Self ref

Name	Address	Complaint
ANGELA O NEILL	G81 2TQ 70 Wood Quadrant	
Relat. MOTHER		
Tel. No. 0141 941 0232	CLYDEBANK G81 1AP	

ROAD TRAFFIC ACCIDENT PLACE

DETAILS

HOME ACCIDENT PROBABLE CAUSE

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

Dear Doctor,

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

Diagnosis [illegible]

X-Ray film/ECG shows

Treatment given

TRIAGE

TRIAGE TIME 20:55

TRIAGE CATEGORY Category 3

INITIAL COMPLAINT
Overdose

INITIAL TREATMENT

FILED BY MRRDYBALL

Drugs _____ days supply of _____ has been given.

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

Would you please arrange _____

DISCHARGE CODES: Please Circle

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

Ward No. (if admitted)	Transfer to Hospital	Consultant (if admitted)
[illegible]		FOX

Follow up	Not arranged	Arranged	To be arranged

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

Medical Officers Name (In Block Letters)
A. NEWTON

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

Signature of Medical Officer

TRIAGE DATE: TIME:

CHIEF COMPLAINT: RELEVANT HISTORY: PHYSICAL SIGNS:

999 - See PAF
not breathless on arrival
- Taken 2 tubs / boxes paracetamol (>2hours)
4x attempted suicide - (brufen)

VITAL SIGNS: TREATMENT AT TRIAGE: DISPOSITION:

HR:
BP:
RR:
GCS:
TEMP:

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

TRIAGE NURSE ..... SIGN
..... PRINT

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

TO BE RECORDED ON ARRIVAL

T. 36 P 78 R 16 BP 107 SO_2 98%

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

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

CONSULTANT _____ REG/SHO _____ JHO _____

SEEN BY NEWTON AT (TIME) 2110

CLINICAL NOTES

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

DATE

26/12 Overdose. ~32 x 500mg paracetamol.
Half at 1830, half at 1900.
Wanted to die.
Not remorseful.
Previous OD (ibuprofen) — no psychiatric follow-up.

PMH — Chronic abdominal pain — no cause found

Rx — on antibiotics currently for in-growing toenail
NSAID. ? pontax for period pain.

°/E. Looks well.
Underweight

CVS — Pulse 78 bpm reg
BP 88/57
HS I + II + 0

RS — Chest clear

Abdo — tender RIF. ° mass ° guarding BS ✓

CLINICAL NOTES

lung — paracetamol OD.

Refuses activated charcoal.
Dr — to refer physicians.
paracetamol levels at 23:00 approx.

1298 15 YEAROLD F

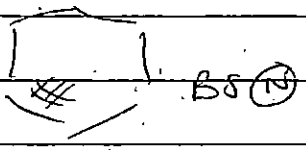
0·20 BACKGROUND Hx • Prev OD overdose Jan 1998
— did not attend for psych. f/u.

PC OVERDOSE

Took 32×500mg Paracetamol at ~ 6pm.
wanted to die. depressed
vomiting since.

No other relevant PMH

OE Nauseated abdo
Pulse 80 SR
BP 90/50.
JVP ↓
THYROID
Chest clear



IMP SIGNIFICANT PARACETAMOL OD.

— Biochem; G&C; FBC; paracetamol level.
? for Parcolex
Psych review

SUSANNE IRVINE SHO

NAME Donald. No AGE PHYS/ SURG. DEPT WARD

FORM C

IN PATIENT CONTINUATION HISTORY

DATE	
27/12/98	Consultant review. Admitted ↳ serious Paracetamol OD. Now on Parilax. Pt needs to stay until reviewed by psychiatrist.
28/12/98	psychiatric review Young 15 ♀. overdose of premeditated ↳ suicidal intent. Situational difficulties - fallen out ↳ family & living in children unit. failed exams at school - didn't get any x mas presents. No evidence of preceding depressive illness. Mood - although subjectively low objectively euthymic ↳ reactive affect. Thoughts - not regretful. though no plans at present d/w Dr Greg SpR allow home if Pt happy refer to adolescent unit for FU. by ♀. Emerda. duty ♀ SHO.

0061619M1

HISTORY
(Use other side first)

te

12-98 Note above INR 1·2 PT 14

needs PT result prior to discharge

5/12/98 – Called to see c/o SOB & abdo pain

Has been complaining of epigastric pain extending to CER UQ for ~2hours.

Very sore + sharp!

Tender to palpation

No assoc with position/respiration

Reluctant to take any tablet for pain

Onset of SOB with expiratory wheeze 30mins ago

Has been attending GP due to wheeze but not on inhalers.

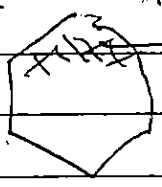
Also tingling in fingers extending to forearms

O/E – pulse 110bpm sats 99% on a.i.r

– HS I+II+nil

– BP

– chest few exp wheezes

– abdo  – tender to palpation esp RUQ

No rebound, guarding

BS+ve

PR not done

Imp – upper abdo pain (? esp RUQ) causing hyperventilation with some wheeze.

Plan – salbutamol 5mg nebs

– await PT result

– inform SHO

DSCN

NAME Dianne Driscoll. HOSPITAL No

AGE

PHYS/ SURG. DEPT WARD

IN-PAT FORM 3

IN PATIENT CONTINUATION HISTORY

DATE	
23-12-98	PT 14 c/o upper calvde pain R+L non specific
	PTT 32 °BM today
	INR 1·2 pulse 100 reg BP stable 118/76 soft
	Fib 2·34. 2KKS
	not growing
	Dr For contacted - satisfied that could go °reboused.
	home with the proviso that she has her INR
	checked on wednesday by GP.
	- GP contacted ✓

IM619100

TTISH AMBULANCE SERVICE NHS TRUST - PATIENT REPORT FORM

INCIDENT No. [illegible]

PATIENT NAME: DIANE DONALD — SEX: M / F ✗

PATIENT ADDRESS: 70 WOOD QUAD, CLYDEBANK — D.O.B. 16/5/83

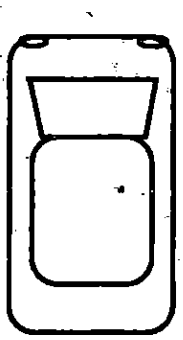
TYPE OF INCIDENT

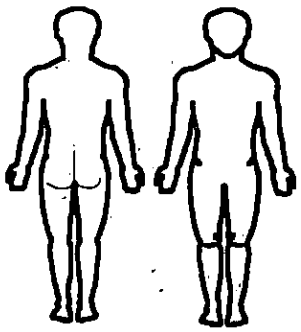
Trauma	
Assault	
Cardiac Arrest	
Other Collapse	✗
DSH	
IHT	
Obstetric	
Other	

TRAUMA INCIDENTS

RTA	
Cyclist	
M/Cyclist	
Pedestrian	
Ejected	
Trapped	
>20 mins. Extricate	
Helmet Worn	
Seat Belt Worn	

Home	
Work	
Leisure	
Burns	
Drowning	
Fall < 2 mtr.	
Fall > 2 mtr.	
Head Injury	
Poisoning	
Other	





Damaged Area ▶ Point of Impact X Position of Patient — Damaged Area/Burns % # ? Fracture X Laceration

INJURY / ILLNESS

Acute Abdo.	✗
Breathlessness	
Chest Pain	
Other Cardiac	
Convulsions	
C.V.A.	?
DSH O/dose	✗
Haemorrhage	
Hypoglycaemia	
Other	

PRIMARY SURVEY

Treatment prior to arrival	Y		N	✗
By whom				
Duration of treatment / CPR				
Airway	Clear ✗	Obstructed		
Breathing	Y	✗	N	
Circulation - Pulse	Y	✗	N	
Disability- Alert	Y	✗	N	
Vocal Stimuli	Y		N	
Pain Stimuli	Y		N	
Unresponsive	Y		N	
Vomited	Y		N	✗
Fitting	Y		N	✗
Knocked Out	Y		N	✗

INITIAL ACTIONS

Airway			
Pharyngeal Airway	Y		N ✗
Tracheal Tube	Y		N ✗
Laryngeal Mask	Y		N ✗
Size		●	
Successful ?	Y		N
Breathing			
O2 Flow rate		%	
Mask Type			
IPPV			
Circulation			Success

Cannulation	Size	Side	Site	Success	
1				Y	N
2				Y	N

A.M.P.L.E.

Allergies (See reverse for coding) NONE

1	2	3	4	5	6	7	8	9

Medication: Ibuprofen 600mg

Past Medical History: Panic attacks. Abdo pain (seen at VRH)

Last Eaten: 1300

Events Preceding Incident: Taken O.D. of above meds as abdo pain increased.

OBSERVATIONS

Time	Breathing R.R.	Breathing SpO2 %	Circulation Pulse	Circulation Blood Pressure	Capillary Refill Norm	Capillary Refill Delay	Pupils Left Size (C N D)	Pupils Left React Y/N	Pupils Right Size (C N D)	Pupils Right React Y/N	GCS E	GCS M	GCS V	GCS Total
1644	30		140	NT.	✗		D	Y	D	Y	4	6	5	15
1700	16		130		✗						4	6	5	15

TREATMENTS

Time	Presenting Condition	Defib. (Joules)	Fluid / Drug	Batch / Box No.	Dose	Route	Result e.g. Pulse, Asys, VF, Other

COMMENTS / ADDITIONAL INFORMATION

Pt complaining of abdo pain, headache. Prescribed above meds 2 days ago, ? taken 76 tablets since. Pt very anxious on our arrival, Calmed down en route.

(Affix Rhythm Strip Here)

CREW 1: KILPATRICK

CREW 2: DORAN

MEDICAL STAFF:

INCIDENT LOCATION: Inside Meadowhead - Clydebank

SIGNATURE (Crew 1 or 2): G. Kilpatrick

CONDITION ON ARRIVAL AT HOSPITAL: Conscious ✗ Pulse ; Breathing ✗ No Vital Signs

DESTINATION HOSPITAL: A/E

DATE OF CALL: 2 0 0 2 9 6

TIME OF CALL: 1 6 3 7

TREATMENT COMMENCED: 1 6 4 4

TIME LEFT SCENE: 1 6 5 5

TIME ARRIVED HOSPITAL: 1 7 [illegible]

HOSPITAL USE ONLY

GOW HOSPITALS UNIVERSITY NHS TRU — TREATMENT CARD

ACCIDENT/EMERGENCY FORM

ACCIDENT & EMERGENCY DEPT.
WESTERN INFIRMARY
GLASGOW
G11 6NT
TEL: 0141-211-2304/2409

CRN: 1124660

Surname	Forename	Age	Date of Birth	Arr Date	Time	AE Number
DONALD	DIANE	14	16/12/83	20/02/98	17:17	007993/98

Address	Sex	Religion	Date of Inc	Time
70 Wood Quadrant CLYDEBANK	Female		20/02/98	

PC G81 1AP	Tel 0141 941 0232	Marital Status	Occupation/School	Type of Inc	Mode of Arrival
		Single	SCHOOL	Other	By Ambul

Name	Address	Referred by
Dr ROGERSON	CLYDEBANK HEALTH CEN KILBOWIE ROAD CLYDEBANK	Selfref

Name	Address	Complaint
ANGELA O NEILL Relat MOTHER Tel. No. 0141 941 0232	1ST FLR 70 Wood Quadrant CLYDEBANK G81 1AP	

ROAD TRAFFIC ACCIDENT PLACE

DETAILS

HOME ACCIDENT PROBABLE CAUSE

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

TRIAGI
TRIAGE TIME 17:17
TRIAGE CATEGORY Category 2

Dear Doctor,

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

Diagnosis Overdose of Ibuprofen,

INITIAL COMPLAINT
Overdose

X-Ray film/ECG shows

INITIAL TREATMENT

Treatment given Charcoal
IV Drip,
Observ.,

FILED BY MRADTI

Drugs _____ days supply of _____ has been given.

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

Would you please arrange _____

DISCHARGE CODES: Please Circle

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

Ward No. (if admitted)	Transfer to Hospital	Consultant (if admitted)
Level 8 (Med).		

Follow up	Not arranged	Arranged	To be arranged

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

Medical Officers Name (In Block Letters) BIGGART

Signature of Medical Officer

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

NURSING NOTES

TRIAGE DATE: TIME:

CHIEF COMPLAINT: RELEVANT HISTORY: PHYSICAL SIGNS:

VITAL SIGNS: TREATMENT AT TRIAGE: DISPOSITION:

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

TRIAGE NURSE ..... SIGN
..... PRINT

DIANE DONALD
ON AIR

BLOODGAS

20 Feb 98 18:30
INST ID 3172
SEQ NO 196
ID 200298

SYRINGE SAMPLE

ACID/BASE		37°C
H+	43.3	nmol/L
PCO2	4.65+	kPa
PO2	12.71	kPa
HCO3a	19.8	mmol/L
tCO2	20.9	mmol/L
BE(vv)	-4.6	mmol/L

OXYGEN STATUS		37°C
PO2	12.71	kPa
O2SAT	97.1	%

+,+=beyond ref limit

Na 148
K+ 4·3
HCO_3 23
Urea 5·2
Creat 83

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

ARRIVAL

T 36.6 P 138 R ____ BP 123/81 on Sat 96%.

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY
20/2/98	Carbimix	1 bottle	orally (50g)	1800	[signature]	

CONSULTANT ____ REG/SHO Beckett JHO ____

SEEN BY ____ AT (TIME) 1730

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

CLINICAL NOTES

DATE

Seen c mother + uncle.

20/2/98 c/o Overdose.

Took ?76 600mg Ibuprofen tablet today.
Initially took 1-3 tablets for abdo pain (prescribed by GP ~~[illegible]~~ 90 tablets) — at lunch took 10-15 tablets (unsure) then ~1.30-2pm took the rest of tablets
c/o light headed, abdo pain, vomited x2.
Nausea, headache
" drowsy
denies other tablets.
No previous Hx of OD, self harm
No psychiatric Hx in past
At says she took the tablets so she didn't have to go + stay with the mother + mum's boyfriend. Apparently normally stay c uncle. She says her mum doesn't like her friends/boyfriend + doesn't want to stay.

EXAMINATION

CVS — P 120 bpm BP 123/81.
HS I + II +0.

Resp — chest clear
" hyperventilating

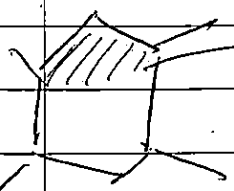
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OF ING

DATE	CLINICAL NOTES

GCS 15.

Mobo



Mildly tender upper abdo.
°Rebound / Guarding
°LLCCS, nausea
BS Active

Mann / Carbimix 50g orally.
IV line - FBC, UTS, Glu, clothing, para, ~~tetty~~ gallaplate lect
Refer medics

[illegible]
[illegible]

HOSPITAL No

DONALD DIANE AGE

PHYS/ SURG. DOB 16.12.83 DEPT WARD

IN-PAT FORM 3

IN PATIENT CONTINUATION HISTORY

DATE

20/2/98 14 yr old girl

Overdose of Ibuprofen.

HPI This girl took about ≈ 76 tablets of Ibuprofen (600mg) today, ~~bec~~.

She ran away from home 4wk back (& has been living with her uncle) because her mother did not approve her boyfriend

Initially took 1-3 tab for abd pain then around 1.30 - 2 pm took the rest of the tablets

Present c/o - lightheadedness
abdom pain
vomiting
nausea.
tiredness
'tinitus'

Denies that she has taken other tablets

No previous overdoses

PMHx

Nil of Note.

Med

Nil of Note

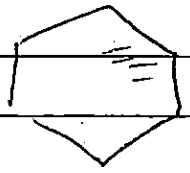
0001619MI

HISTORY
(Use other side first)

ite

O/E Fully alert/oriented
°Anaemia, °Jaundice.
HR - 120/m R
BP 123/81 mm Hg
RR - 16/m.

JVP →
HS ⊢⊣
Chest clear.

Abd  Mild tender.

CNS - Fully oriented

Impr= 14 yr Female
OD of Ibuprofen.

Plan
- Admit.
- Had channula in A/E → For IV Drip in the ward.
- Blood Na 148/K 4.3/HCO3 23/Ur=5.2
Cr = 83
Glu = 4.1
salicylate/PCM Not Detected.
- For U/E Mane
- For Psychiatry Referral tomorrow

HOSPITAL

IN-PAT FORM 3

Diane DONALD

No

AGE 16/12/83

PHYS/ SURG.

DEPT. WARD

IN PATIENT CONTINUATION HISTORY

DATE	
21/2/98	OD substantial ingestion of ibuprofen - provoking manipulative - needs psychiatric assessment 8 ↓ Pneumomediastinum - check urinalysis with every SOU + not to go home till clearing + LFTs thus AM confirmed OK No lumbar pain lower unspecified pain - except epigastric pain ? due to ibuprofen Plan Psych to see urinalysis + LFTs. If OK → home Dr Hunter Gms
21-2-98	Y - thankyou. Benzo overdose. No evidence of depression. OD taken to send message to mother, that she does not want to stay c her. Family difficulties.

IM619100

HISTORY

(Use other side first)

Date

Ref discharge over medically fit
Ref adolescent Ψ ✓
Letter to GP ✓

pre-recess ✓

1124660
DONALD DIANE
70 Wood Quadrant F

CLYDEBANK 16/12/83
G81 1AP
G.P.Prac. 40224

IN PATIENT
CONTINUATION HISTORY

DATE	
21/2/98	Na+ 139. (20/2) Na 148
	K+ 4.1 K 4.3
	HCO 17 HCO 23
	Urea 12.2 Urea 5.2
	Cr. 161 Cr 85
	Glu. 6. Glu 4.1
	Ca(adj) 2.25
	protein 68
	Alb 44
	Bilirubin 6
	Alk P. 259.
	↑GT 14
	PT. 13
	PTT 28
	WR 1.1
	Fib 3.06
22/2/98	
2pm	Trace Protein + Ketones in blood + urine
	→ needed U+E's now
	→ For IV fluids overnight
22/2/98	Complaining still of subcostal / epigastric pain (claims to have occurred before Brufen 0/0)
	→ IV Fluids overnight 6°.
	→ not passing a good deal of water. & anuric.
	→ Check the morning U+E's.

HISTORY

(Use other side first)

Date	
2/2/68	Va 140
	K 4·1
	Rc 24
	Ur 4·2
	Cr 69
	→ Hom.

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

10631776W F DONALD 16/12/1983 DIANE FLAT 2 18 ONSLOW ROAD G81 2NE CLYDEBANK CHI-1612836909 *Apply addressograph label*	Ward: 10 EAST Discharge destination: **Estimated Discharge Date** (1) 22/2/13 **Estimated Discharge Date** (2) / / Final date of discharge : / /

Checklist	Yes	N/A	Initials	Comments
Patient informed				✓
Relative/carer informed				
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)	✓			Friend will check
Ambulance-1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Discharge prescription completed				
Compliance aids e.g. Dossette Box (involve pharmacist)				
Medication received				
Medication explained to patient and/or relative/carer				
Own medication returned to patient				
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)				
Informed of discharge				
Social work/ Other agencies/Home help				
Physiotherapist				
Occupational Therapist				
Dietician				
Speech and Language Therapist				
Clinical Nurse specialist e.g. Care Home Liaison				
Liaison/ District Nurse/Practice Nurse				
Other discharge items				
Access arrangements (e.g. keys, door entry)				
Patients clothing available for day of discharge				
Valuables e.g. cashier				✓
Intravenous cannula removed				
Equipment ordered (inc. walking aids) in place for discharge				
Part 2 Discharge letter - Required				
- Completed				
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow				
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge:				
Nurse's signature:	Designation:			Date: / /

...ices Division

Nursing Admission & Assessment

Greater Glasgow and Clyde

Name	[redacted]	
Addre	10631776W	
	DONALD	F
	DIANE	16/12/1983
DoB:	FLAT 2	
	18 ONSLOW ROAD	
CHI n	CLYDEBANK	G81 2NE
	CHI-1612836909	

1. Admission

Hospital: WIG	Ward: 10 EAST
Date of admission: 21/2/13	Time: 09.10
Admitting Consultant: Wilson	Admitting Nurse: Ustenko

1. Patient Details

Preferred name:	Next of Kin (NoK): Pamela Pritchard
Age: 29	Relationship: Friend
Religion: None	NoK Address: Dumbarton Road
Telephone: 0141 570 8120	
GP:	NoK Telephone: 07568527632
GP address: Dr. N MURRAY, The Green Medical Practice, Clydebank Health Centre, Kilbowie Road, Clydebank, G81 2TQ	NoK Aware of admission: ☑ Yes ☐ No
GP telephone	Consent for information to be given to relatives: ☐ Yes ☐ No
	Nominated family contact:
	Telephone - Day:
	Telephone - Evening:

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☑ No ☐ N/A

a. If 'Yes' please provide – Name: ..... Relationship: .....

Contact telephone number: .....

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☐ No ☐

If 'No' to 'b' please inform medical staff. Name of doctor informed: .....

2. Presenting Complaint / Diagnosis

LEFT THYROID lobectomy (R) (L)
TSDG - ANGLE 21cm 21cm
CARE 34½cm 34½cm
BELOW KNEE 43cm 43cm

3. Allergies (including food allergies)

No known allergies: ☑

4. Observations

Cannard (if required)	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
N/A	5	0	65	113/76	14	99	36.1°C
Urinalysis:		AMT4 Score	BM	EWS Score	Weight	Height	BMI
		N/A	N/A	0	59.85	156	24

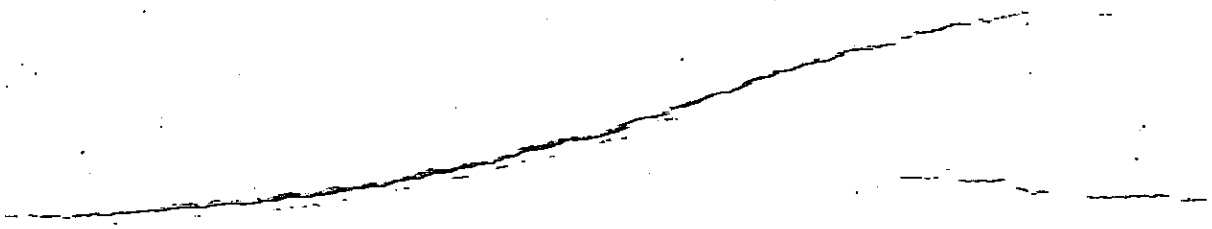
5. Current Medication

Nil

Medicines reconciled on admission? ☐ Yes ☐ No

6. Relevant Past Medical History

Termination of pregnancy



Risk Assessment

MUST

1. Is the patient's BMI: > 20 ..... Score 0
   18.5-20 ..... Score 1
   <18.5 ..... Score 2
2. Has the patient had unplanned weight loss in the past 3-6 months?
   < 5% ..... Score 0
   5-10% ..... Score 1
   >10% ..... Score 2
3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
   Score = 2

   Not applicable: Score = 0

MUST Score: ..... If score 1 or more, complete full Nutrition Profile

Cannard

Has the patient fallen in the last 6 months?

☐ Yes ☑ No

If 'Yes' complete a full Cannard Screening Tool.

8. Cognitive Impairment

For all patients ≥ 65 years, ask the following 4 AMT questions:

1. How old are you? ..... years
2. What is your date of birth? ../../.....
3. What is this place? .....
4. What year is it? .....

If the patient does not answer all questions correctly then refer to medical staff.

AMT Score: ..... out of 4

Name of Doctor informed (if required)

..... Grade.....

MRSA Screening / CJD

Will the patient be an inpatient >23 hours? ☐ Yes ☑ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☐ No ☐ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☐ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☐ No ☐ Not known

If **'Yes'** to any of the above questions **OR** if the patient is admitted to a 'high impact speciality' e.g. **Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:**

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CJD: **Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:**

☐ Yes ☑ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

0 Lifestyle

Smoking:

Does the patient smoke?

☑ Yes ☐ No

If 'Yes' how many per day: 10 - 20 cigs/day

Does the patient use nicotine replacement therapy?

☐ Yes ☑ No

Does the patient wish referral to Smoking Cessation Service?

☐ Yes ☑ No If 'Yes', date of referral: / /

Drugs:

Does the patient use recreational drugs?

☐ Yes ☑ No

If 'Yes' please specify:

Alcohol (Men):

How often do you have **8** or more drinks on one occasion:

☐ Never ☐ Less than monthly
☐ Monthly ☐ Weekly
☐ Daily or almost daily

If 'Monthly' or more then complete GMAWS Tool.

Alcohol (Women):

How often do you have **6** or more drinks on one occasion:

☑ Never ☐ Less than monthly
☐ Monthly ☐ Weekly
☐ Daily or almost daily

If 'Monthly' or more then complete GMAWS Tool.

1. Admission Documentation Completed By

Name (Please PRINT): Hazel Stanford	Signature: Hazel Stanford
Designation: Clinical Admissions Sr	Date: 21/2/13

Services Division

Nursing Admission & Assessment

2. Assessment

Hospital:	Ward:
Date of Assessment: / /	Time:

Name: .....
Address: .....
.....
DoB: .....
Chi number



10631776W
DONALD F
DIANE 16/12/1983
FLAT 2
18 ONSLOW ROAD
CLYDEBANK G81 2NE
CHI-1612836909

Affix patient data label

1. Breathing and Circulation

Breathing:

- [x] No symptoms or history of respiratory problems
- [ ] Dyspnoeic at rest
- [ ] Dyspnoeic on minimal exertion
- [ ] Dyspnoeic on maximum exertion
- [ ] Productive / non-productive cough evident
- [ ] Normally receives oxygen therapy

If 'Yes' provide details:

Circulation:

- [x] No symptoms
- [ ] Known cardiac or circulatory problems

Immediate Action Taken

	Initial

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

..... English .....

Interpreter: Required ☐ Not required ☑

If required, provide details and arrangement made:

.....

.....

Does the patient have:

a. Speech difficulties? ☐ Yes ☑ No

b. A learning disability e.g. Down's Syndrome?

☐ Yes ☑ No

If 'Yes' please specify:

.....

If 'Yes' contact Liaison Learning Disability Team.

Liaison Learning Disability Team contacted:

☐ Yes ☑ No

c. A learning difficulty e.g. dyslexia, dyspraxia?

☐ Yes ☑ No

If 'Yes' please specify:

.....

3. Senses

Senses:

Eyesight

- [x] Normal vision
- [ ] Glasses – ☐ Distance ☐ Reading
- [ ] Prosthesis – ☐ Left ☐ Right
- [ ] Contact lenses
- [ ] Registered blind

Hearing

- [x] Normal
- [ ] Hearing impaired
- [ ] Hearing aid – ☐ Left ☐ Right

4. Mental Status

Mental Status:

- [x] Orientated
- [ ] Confused
- [ ] Distressed
- [ ] Aggressive /Abusive
- [ ] Unconcious

Immediate Action Taken

	Initial

5. Hydration and Nutrition

MUST Score: 0 **If score is 1 or more, complete a Nutrition Profile.**

Nutition Profile completed ☐ Yes ☐ No

Do not complete sections 5a to 5d.

If score is 0, reassess / screen patient in 7 days. Complete sections 5a to 5d. | Date of reassessment:

5a1. Food likes / dislikes:

as MUST

5a2. Fluid likes / dislikes

as MUST

5c. Help needed with eating and drinking:

☐ Yes ☑ No

If 'Yes' provide details:

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):

☐ Yes ☑ No

f 'Yes' specify diet needed:

5d. Texture Modified Diet needed?

☐ Yes ☑ No

If 'Yes' specify texture: A☐ B☐ C☐ D☐ E☐

Thickened Fluids required? ☐ Yes ☐ No

If 'Yes' specify stage required: 1☐ 2☐ 3☐

Immediate Action Taken

	Initial

6. Elimination

Continent:	Incontinent:	NHS GGC Stool Chart commenced:
☑ Bladder	☐ Bladder	☐ Required ☐ Not required
☑ Bowel	☐ Bowel	

Long-term urinary catheter in situ? ☐ Yes ☑ No If 'Yes' – Size: .....fg Make: .....

Continence assessment commenced:

☐ Yes ☐ No ☑ Not applicable

Containment products in use? Please specify:

☑ Bowels regular

☑ Constipated

☐ Diarrhoea / loose stools

Stoma: ☐ Yes ☐ No

If 'Yes' please specify and list appliances used:

Immediate Action Taken

	Initial

7. Personal Hygiene, Oral [illegible] and Skin Assessment

Personal hygiene:
- [x] Self-caring and independent
- [ ] Requires assistance

Specify assistance if required:

Oral health:

Self-caring and independent	[x] Yes	[ ] No
Evidence or oral ulceration, infection, dry mouth	[ ] Yes	[ ] No
Requires assistance	[ ] Yes	[ ] No

If assistance required or evidence of ulceration etc, implement Oral Care Bundle.

Oral Hygiene Care Bundle:
- [ ] Required
- [ ] Not required

Dentures:
- [ ] Not worn
- [ ] Upper set
- [ ] Lower set
- [ ] Full set
- [x] Dentures with patient on admission

Skin assessment:
- [x] Skin healthy with no evidence of damage
- [ ] Skin broken
- [ ] Skin oedematous
- [ ] Skin discoloured
- [ ] Skin clammy

If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: [ ] Yes [ ] No [x] Not applicable

Pressure ulcer evident: [ ] Yes [ ] No

If 'Yes' please identify Grade and record on Pressure Ulcer record sheet – Grade: .....

Immediate Action Taken

	Initial

8. Mobility

Patient fully mobile / independent? [x] Yes [ ] No If 'No' complete Moving and Handling Assessment.

- [ ] Limited mobility
- [ ] Mobile with aid – Specify:
- [ ] Prosthesis – Specify:

Moving and Handling Plan commenced:
- [ ] Yes
- [ ] No

Immediate Action Taken

	Initial

9. Maintaining a Safe Environment

Pain status:

Does the patient have pain? [ ] Yes [x] No

If 'Yes' record Pain Score on EWS chart.

What makes their pain better? Please provide brief details:

Bed rail assessment completed: [ ] Yes [x] No

Bed rails required:
- [ ] Required
- [x] Not required

Immediate Action Taken

	Initial

10. Sleep and Rest

Sleep habits:
- [x] Less than 8 hours
- [ ] Afternoon nap
- [ ] Morning nap

Sleep difficulties:
- [ ] None
- [ ] Disturbed e.g. nocturia, insomnia
- [ ] Early wakening

Medication required: [ ] Yes [ ] No

Immediate Action Taken

Initial

11. Social Circumstances

- [x] Employed [ ] Unemployed [ ] Retired
- [ ] Lives alone
- [ ] Lives with Family
- [ ] Friend
- [ ] Dependants
- [ ] Other: [ ] Nursing Home [ ] Residential

Current Care / Support Service arrangement:
- [ ] Social Services
- [ ] Private Carers
- [ ] None

If support services in place, please provide details:

Current Care / Support arrangements suspended:
[ ] Yes [ ] No [ ] Not applicable

Immediate Action Taken

Initial

12. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission?
[ ] Yes [x] No

If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?
[ ] Yes [x] No

If 'Yes' please provide brief details:

Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?
[ ] Yes [x] No

If 'Yes' please provide brief details:

Ask the patient:
"Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?"
[ ] Yes [ ] No [x] Not at this time

If 'Yes' please specify faith group:

14. Anticipatory Care (when appropriate and relevant)

■ Appropriate ■ Not appropriate

Is the **patient** aware of their:	Is the **patient's family** aware of their:
Diagnosis? ☐ Yes ☐ No	Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No	Prognosis? ☐ Yes ☐ No
Preferred place of care: Home: ☐ Hospital ☐ Hospice ☐	Preferred place of death: Home: ☐ Hospital ☐ Hospice ☐
Current treatment – please identify (e.g. chemotherapy/ radiotherapy):	Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☐ Yes ☐ No

If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

15. Admission Assessment Completed By

Name (Please PRINT):	
Signature:	
Designation:	Date:

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
21.2.13	rtw past (L) thyroid lobectomy	
14[00].	wound drain in situ	
	obs fine	
	fluids + diet taken	LL Ross/SE
2000 2030	Analgesia given as charted for pain. Still complaining of pain and requesting morphine. FYI contacted to review as morphine only prescribed in theatre. FYI prescribed tramadol, dose given to patient.	
2330	Still complaining of discomfort not pacified by oral drug route. FYI contacted to review	
0030	FYI come do to review, but patient down for a cigarette. Increased tramadol to 50 100mgs, no further doses given.	
22/2/13 am	Appears settled now, reg neurological assessment WNL but FYI busy in A&E at present.	
3am	Appears settled. Wound clean dry & intact. Obs stable. Drain — removed 30mls	

Clinical Notes continue on next page

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
12^{00}	3/5 Mr Wilson –	
	drain out ∴ for discharge	
	home	
	IOS + meds requested	
	OPA 3/52 requested.	Lie Ross/SR

MEDICINE **PRESCRIPTION FORM** Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date _____ Name (Print) _____

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

Date and time this form prepared:	Sheet No	2nd Prescription in use
__/__/__ Time: _____	.....	YES ☐ NO ☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

Print & Sign _____

DETAILS

Ho

DOI 10631776W F
DONALD 16/12/1983
DIANE
FLAT 2
Date 18 ONSLOW ROAD
Cons CLYDEBANK G81 2NE
CHI-1612836909

Height:

Weight:

Surface area:

Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIV. (24hr)
21/2/12	CLEXANE	40mg	SC	0700			
	PARACETAMOL	1g	IV				1205

	DATE →																								
	MONTH →																								
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N	RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)																								
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N																									
SIGNATURE OF ASSESSOR																									
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N																									

Parenteral Drugs : Regular Prescription

																										Patient's Own Medicine
BEFORE ADMISSION ☐	**A** DRUG CLEXANE	Other time																								For Use Y/N
NEW DOSE ☐	DOSE 40 mg | ROUTE SC | DATE 21/2/13 | STOPPED DATE:	0700-0900																								Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) [signature] | STOPPED INITIALS:	1200-1400																								Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	1600-1800	✓																							Assessed by:
		2200-2400	X																							Ordered from Pharm.
		Other time																								
BEFORE ADMISSION ☐	**B** DRUG	Other time																								For Use Y/N
NEW DOSE ☐	DOSE | ROUTE | DATE | STOPPED DATE:	0700-0900																								Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:	1200-1400																								Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	1600-1800																								Assessed by:
		2200-2400																								Ordered from Pharm.
		Other time																								
BEFORE ADMISSION ☐	**C** DRUG	Other time																								For Use Y/N
NEW DOSE ☐	DOSE | ROUTE | DATE | STOPPED DATE:	0700-0900																								Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:	1200-1400																								Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	1600-1800																								Assessed by:
		2200-2400																								Ordered from Pharm.
		Other time																								

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

| | | |

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Print & Sign your full name clearly against each prescription entry.

4. Time should be recorded in 24hr format e.g. 0600, 1800.

5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.

6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

7. The following metric unit abbreviations must be used –

Milligram = mg Gram = g
Millilitre = ml Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused
(4) Drug not available
(5) Nil by mouth/fasting
(6) Patient unavailable
(7) Patient asleep
(8) Time varied on doctor's instructions
(9) Dose withheld on doctor's instructions
(10) Nausea/vomiting
(11) Unable to swallow
(12) No intravenous access
(13) Patient Self-Administration of Medicine
(14) Other - Record in nursing notes
(15) Prescription clarification required

Cat. No. 40995 Ver. 4, 09/2010

Adult Periphe[illegible]ulation (PVC) Chart

Please use 1 chart per PVC

NI Greater Glasgow and Clyde

Affix patient lab

Name: DONALD DIANE F 16/12/1983

Address: FLAT 2, 18 ONSLOW ROAD, CLYDEBANK, G81 2NE

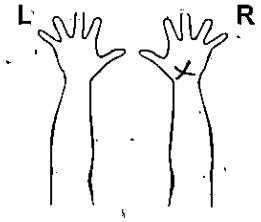
D.O.B: 10631776W

CHI number: CHI-1612836909

Hospital: NIG Ward: L10E

PVC Insertion Information

*Ensure the PVC dressing has **date** and **time** of insertion written on it. This implies that appropriate technique has been used for insertion.*



Date: 21.2.13

Time: 12[00]

(See IV Dressing)

Reason for Insertion: TH

Flushed on insertion ☐ (if known)

Other Site: _____

PVC Maintenance Information

Modified V.I.P (Visual Infusion Phlebitis) Score

IV site appears healthy	0	No Phlebitis — **Observe Cannula**
ONE of the following is evident: - slight pain or redness near site	1	Possible first signs — **Observe Cannula**
TWO of the following are evident: - pain -redness - swelling	2	Early stage of phlebitis — **Re-site Cannula**
ALL of the following are evident: - pain - redness - hardening of the surrounding tissue	3	Phlebitis / Thrombophlebitis **Re-site Cannula & Seek Further Advice**
As above including: - palpable venous cord	4	
As above including: - pyrexia	5	

Day 1 (24 hours after insertion)

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

1. Continuing clinical indication for PVC? Yes / No
2. VIP Score? ☐
3. PVC Dressing dry & intact? Yes / No
4. Was PVC dressing renewed? Yes / No / NA
5. Was PVC Removed? Yes / No

Removal Reason: MOF req'd

Comments/Actions Taken:

Date: 22.2.13 Initials:

Day 2

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

1. Continuing clinical indication for PVC? Yes / No
2. VIP Score? ☐
3. PVC Dressing dry & intact? Yes / No
4. Was PVC dressing renewed? Yes / No / NA
5. Was PVC Removed? Yes / No

Removal Reason: _____

Comments/Actions Taken:

Date: Initials:

After Day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain insitu:

Date: Initials:

Day 3

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

1. Continuing clinical indication for PVC? Yes / No
2. VIP Score? ☐
3. PVC Dressing dry & intact? Yes / No
4. Was PVC dressing renewed? Yes / No / NA
5. Was PVC Removed? Yes / No

Removal Reason: _____

Comments/Actions Taken:

Date: Initials:

Day 4

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

1. Continuing clinical indication for PVC? Yes / No
2. VIP Score? ☐
3. PVC Dressing dry & intact? Yes / No
4. Was PVC dressing renewed? Yes / No / NA
5. Was PVC Removed? Yes / No

Removal Reason: _____

Comments/Actions Taken:

Date: Initials:

MEDICINES RECONCILIATION

10631776W
DIANE
DONALD
DOB 16/12/1983

Source Of Medication History (2 Sources)

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

Other (please specify) .....

Admission Medicines			Plan for Medicines (Dr Complete)				Comments
Name	Dose	Freq	Continue	Amend	Withhold	Stop	Reason for Alteration
No regular							

Allergies

None known ☑

List any Over The Counter or Alternative Medicines

Do medicines need further clarification **Yes** ☐ **No** ☐

List collected by: [signature]

Designation: Com. Ph. Date: 21/2/19

Plan initiated by:

Designation: Date:

Compliance aid : Yes ☐ No ☐

Community pharmacist Phone

Reviewed by: Designation: Date:

NHS
Greater Glasgow and Clyde

North Glasgow Hospitals

IN.PAT FORM 6A

24 Hour Fluid Balance Chart

Name: DIANE DONALD Case Record No: 1063177GW Ward: L10E Date: 21/2/13

		INPUT (mls)								IN	OUTPUT (mls)						OUT
TIME HRS (Please delete 1 column)		ORAL	NASO GASTRIC TPN	BLOOD COLLOID PLASMA	IV (1) /	TYPE	IV (2)	IV (3) Drugs	Hourly Total	Cumulative Total	URINE	URINE Cumulative Total	Gastric Aspirate / Vomit	Drain 1		Hourly Total	Cumulative Total
08	24																
09	01																
10	02																
11	03																
12	04				1000	R/L	THEATRE			1000	350	300					
13	05																
14	06																
15	06																
16	07																
17	08																
18	09																
19	10																
20	11																
21	12																
22	13																
23	14																
24	15																
01	16																
02	17																
03	18																
04	19																
05	20																
06	22																
07	23																
TOTALS								TOTAL IN MLS			BALANCE			TOTAL OUT MLS			

00561

NHS
Greater Glasgow and Clyde

NAT
SCOTLAND

WRITE
Surnar 10631776W .....
DONALD F
Forena DIANE 16/12/1983 .....
FLAT 2
DoB .. 18 ONSLOW ROAD
CLYDEBANK G81 2NE
Locatic CHI-1612836909 .....

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

More than one score/category can be used: **10+= 'At Risk': 15+= 'High Risk': 20+= 'Very High Risk'**

Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

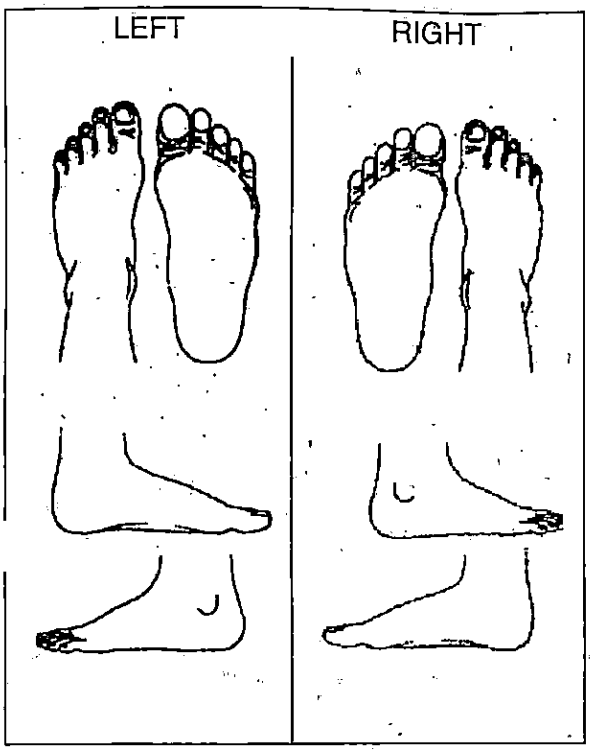
Sex		HOS							
Male	1								
Female	2	2							
Age									
14 -49	1	1							
50 -64	2								
65 - 74	3								
75 - 80	4								
81+	5								
Build/Weight for Height (BMI=weight in Kg/height in m²)									
Average - BMI 20-24.9	0	0							
Above average - BMI 25-29.9	1								
Obese - BMI > 30	2								
Below average - BMI < 20	3								
Continence									
Complete/catheterised	0	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	1							
Oedematous (puffy)	1								
Clammy (moist to touch)/pyrexia	1								
Discoloured (bruising/mottled)	2								
Broken (established ulcer)	3								
Mobility									
Fully mobile	0	0							
Restless/fidgety	1								
Apathetic (sedated/depressed/reluctant to move)	2								
Restricted (restricted by sever pain or disease)	3								
Bedbound (unconscious/unable to change position/traction)	4								
Chairbound (unable to leave chair without assistance)	5								
Nutritional Element									
Unplanned weight loss in past 3-6 months		0							
<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	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		5							
Date		21/2/13							
initials		[illegible]							
Time		09.30							

83826

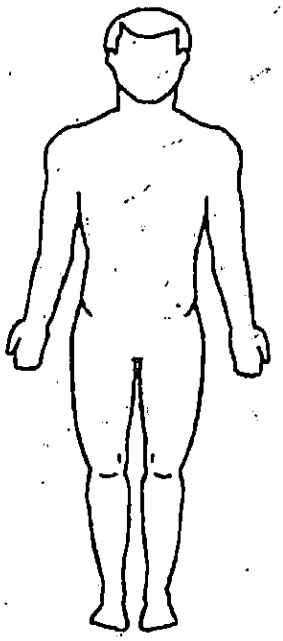
Ensure plan of care is implemented / reviewed for all identified areas of concern.

CER RECORD

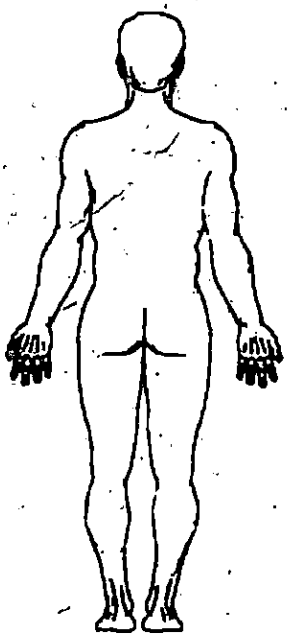
Indicate by circling and numbering all pressure damage on diagrams, then complete box below. Indicate care plan/wound assessment chart.



Anterior view



Posterior view



SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

GRADE 1 Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.

GRADE 2 Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.

GRADE 3 Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.

GRADE 4 Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

DATE	NUMBER OF ULCER(S)	LOCATION OF ULCER(S)	GRADE OF ULCER(S)	LOCATION OF ULCER(S)

Pressure Ulcers may deteriorate from Grade 1 to Grade 4, but can not be reversed and should be documented as a healing grade of pressure ulcer, eg healing grade 4.

Acute Services Division

Hospital / Department W19

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: .....
10631776W
DONALD F
DIANE 16/12/1983
FLAT 2
18 ONSLOW ROAD
CLYDEBANK G81 2NE
CHI-1612836909

Ward: L10E .....

CHI number: ....Unit/Hospital number .....

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission to each ward.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Risk assessment and care plan reviewed monthly.

Referral Criteria for Hospital Falls Prevention Co-ordinator

1. Cannard score of 18+.
2. Second or subsequent fall
3. Significant Injury caused by a fall. (Significant Injury defined as any fracture, significant bruising or laceration to head or body.)

The patient should be referred with any of the above criteria.

General Safety Precautions

- Ensure patient has buzzer to hand
- Check patient has the manual dexterity and cognitive ability to operate buzzer
- Place personal items within easy reach
- Keep the bed in lowest position possible (use low bed if available)
- DO NOT leave patients with cognitive impairment unattended on commodes, in toilets, baths and showers.
- Patients with poor mobility, who are known not to ask for assistance, should not be left unattended on commodes, toilets, baths and showers.
- If noted that mobility / transfers are unsafe refer to physio / OT for assessment
- If patient wears glasses, ensure they are clean
- Ensure patient's footwear is adequate
- Lock wheels on all wheelchairs, beds, commodes and trolleys when in use
- Provide adequate lighting at night
- Request medication review if appropriate
- Clean up spills immediately
- Orientate patient to the ward environment

Cannard Falls Risk Assessment

(Must be completed within 24 hours of admission to each ward)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 2.12.13	Date:	Date:	Date:	Date:	Date:	Date:
						Ward: L10	Ward:	Ward:	Ward:	Ward:	Ward:	Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				2						
Age	13-59 0	60-70 1	71-80 2	81+ 1		0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type**	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		0						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound/ wheel-chair 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE:		4						
				ACTION(S) TAKEN: Enter action code(s) from Care Plan below		1, 23						
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves				NURSE SIGNATURE		✓						

Please see back page for glossary of terms relating to the assessment above.

Falls Assessment Care Plan

Please tick all applicable nursing interventions

Action code	NURSING INTERVENTIONS	Date: 2.2.13 Ward: UCE	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
1	Falls prevention and general safety precautions discussed with patient and family.	✓						
2	Move to more observable area of ward to optimise supervision.							
3	Advise patient they may experience dizziness when they mobilise initially.							
4	Requires assistance with mobilisation.							
5	Observe trip hazard due to invasive lines, drains and catheters.							
6	Do not leave the patient unattended when using commode, toilet, in shower or the bathroom area.							
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
8	Monitor lying and standing / sitting BP and pulse.							
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.							
10	Commence continence assessment, follow Local Guidelines.							
11	Refer to Occupational Therapist.							
12	Select suitable seating (refer to policy).							
13	Non slip mat on chair /floor following advice from therapists.							
14	Refer to Physiotherapist.							
15	Review Transfer techniques.							
16	Request medication review.							
17	Bed/chair monitor in use.							
18	Falls map in use for seven days for patient who has second or subsequent falls.							
19	Bed rails/bumpers to be used (refer to policy).							
20	Patient requires low bed / mattress on the floor (refer to policy.)							
21	Patient requires one to one nursing care.							
22	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).	✓						
23	Other interventions. Buzzer	✓						
		✓						

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment page above.

Nutrition Profile

NHS Greater Glasgow and Clyde

Name:	Date of admission: 21/2/13
Address:  10631776W F DONALD DIANE 16/12/1983 FLAT 2 18 ONSLOW ROAD CLYDEBANK G81 2NE CHI-1612836909	Time: 14^00
DoB:	HOSPITAL: W19
CHI number:	Ward: L10E.
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 1.5 metres Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Weight: 59.8 kg Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☑ Loose clothing ☐ History of reduced food-intake/appetite ☐ Swallowing problem ☐

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☑

Please state:

Food Allergies: Yes ☐ No ☑ If 'Yes' please state:

Eating likes and dislikes (including appetite):	Drinking likes and dislikes:	Patient NBM Yes ☐ No ☑ If 'Yes' why?:
nil particular	nil particular	

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties, loose teeth), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental**? Yes ☐ No ☑

Please specify all factors:

Is the patient on oral nutritional supplements? Yes ☐ No ☑

If 'Yes' please state:

Is the patient experiencing oropharyngeal swallowing problems (excluding oesophageal issues e.g. GORD, Stricture)? Yes ☐ No ☑

If 'Yes' please complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS). If oesophageal problem present please discuss with medical staff.

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

If 'Yes' please state:

Has this patient received written information about inpatient food (e.g. "Food in Hospitals" leaflet)?

Yes ☐ No ☑ Not applicable (received on previous admission) ☐ not available

Profile completed by: Name (PRINT): Liz Ross Signature: Liz Ross Date: 21.2.13

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Is your patient on the Liverpool Care Pathway (LCP)? Yes ☐ No ☐

If 'Yes' please follow LCP advice as screening for malnutrition may not be appropriate.

Malnutrition Universal Screening Tool ('MUST')

Date	21/2											
Initials	VR SS											
Height (see page 1) 1.5 Weight	59.8											
Oedema or ascites present Y/N	N											
BMI (refer to chart on page 4)	24											

'MUST'

Step 1: BMI Score (refer to chart on page 4) :0 (>30 = Obese) .....0 18.5 - 20 .....1 <18.5.....2	0											
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: <5% ..... 0 5-10% ..... 1 >10% 2	0											
Step 3: Acute Disease Effect Score If patient is acutely ill **and** there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0											
Step 4: Overall Risk of Malnutrition Total:	0											

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	LOW RISK – ***Routine Clinical Care*** • Repeat screening. Hospital Acute .....:.....Weekly Hospital Rehabilitation .....Monthly
1	MEDIUM RISK – ***Observe*** • Document dietary intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	HIGH RISK – ***Treat**** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).
- REMEMBER TO CONSIDER YOUR PATIENT'S HYDRATION REQUIREMENTS.
- Ensure Discharge Plan includes most recent 'MUST' Score and any necessary follow-up requirements.

Referral Services		Referred by	Method of referral	Reason for referral
Nutritional Support Team	Date Referred / /			
Dietitian	Date Referred: / /			
Speech and Language Therapy	Date Referred: / /			
Occupational Therapy	Date Referred / /			
Dental Service	Date Referred / /			

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Action discussed with patient / carer	Review date	Name (PRINT) Signature/ Designation
21/12	0	BMI + MUST noted	✓	28/12	LezRoss

National Early Warn

NHS
Greater Glasgow and Clyde

10631776W
DONALD F
DIANE 16/12/1983
FLAT 2
18 ONSLOW ROAD
CLYDEBANK G81 2NE
CHI-1612836909

DoB

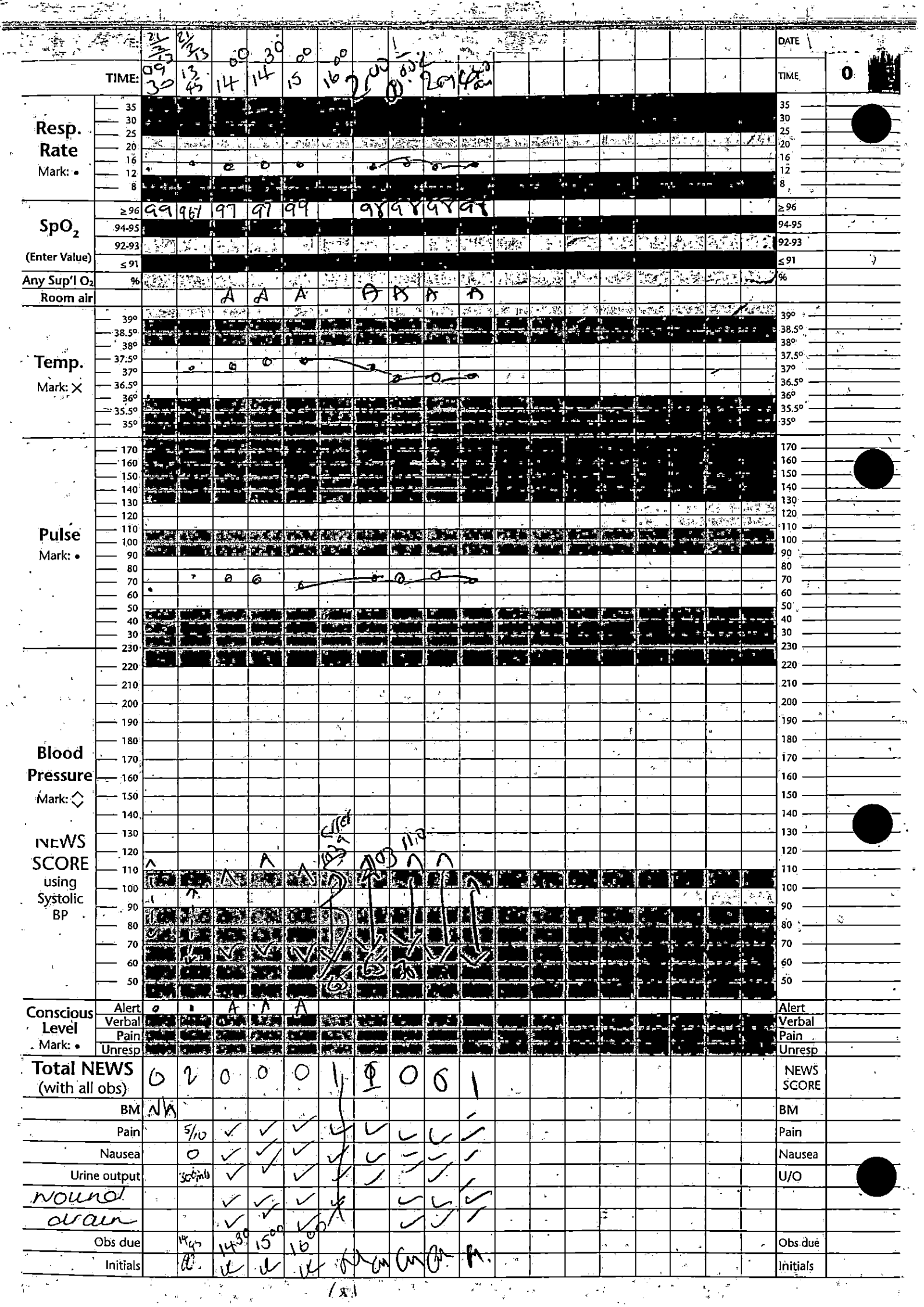
	Date	Ward
Admitted	2/12/13	10 East
Transferred		
Transferred		

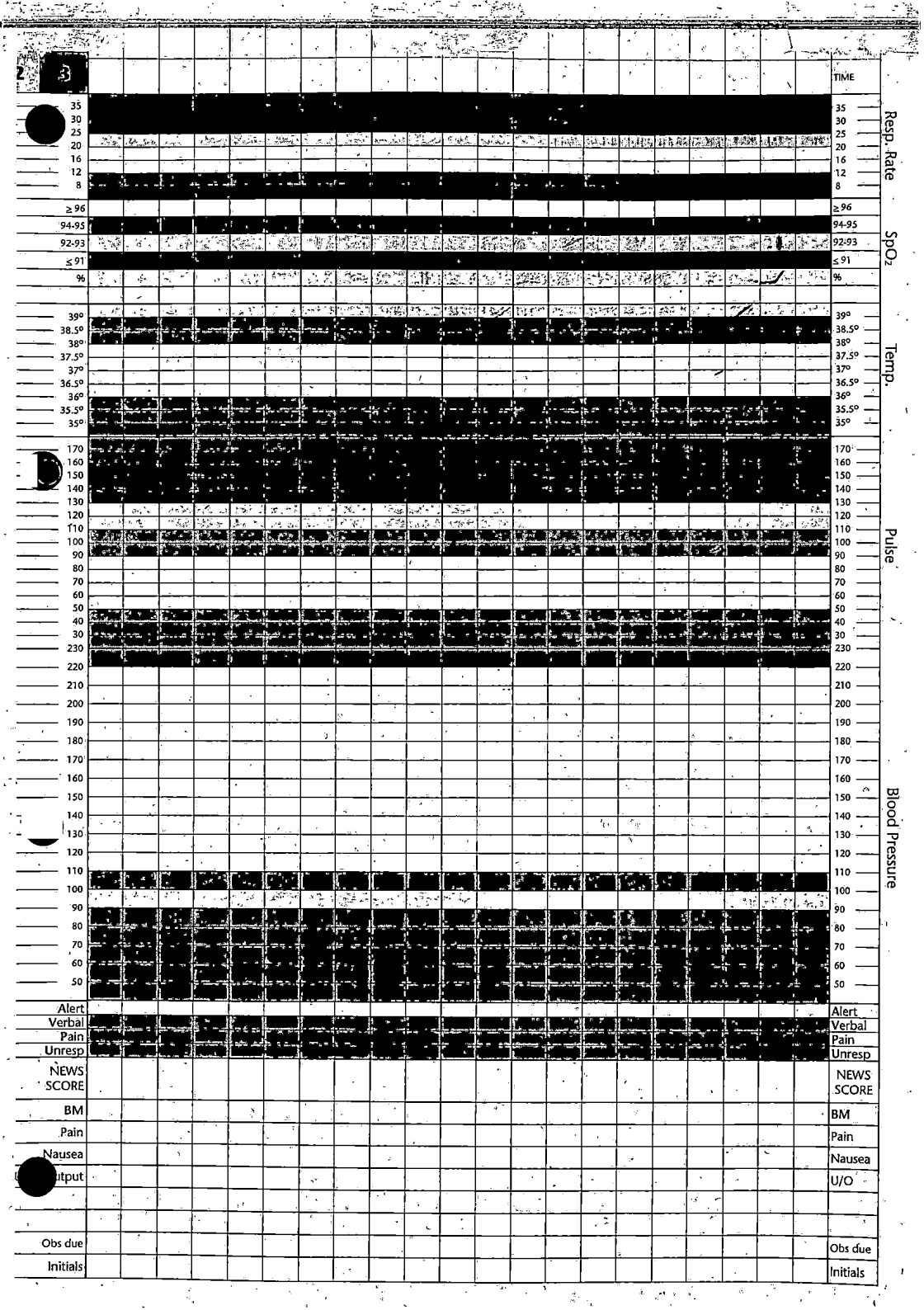
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1-4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE
TIME
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: ×
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
NEWS SCORE
BM
Pain
Nausea
Urine output
Obs due
Initials

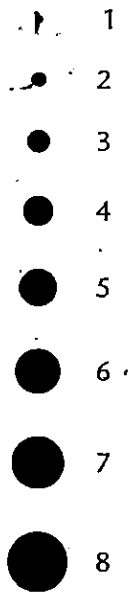

TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

...ological Observations

Date:																									
Time:																									
COMA SCALE	E Eyes open	Spontaneously	4																						Eyes closed by dwelling = C
		To speech	3																						
		To pain	2																						
		None	1																						
	V Best Verbal response	Orientated	5																						Endotracheal tube or tracheostomy = T
		Confused	4																						
		Inappropriate words	3																						
		Incomprehensible sounds	2																						
		None	1																						
	M Best motor response	Obeys	6																						Usually record the best arm response
		Localises	5																						
		Flexion - withdrawal	4																						
		Flexion - abnormal	3																						
		Extension to pain	2																						
		None	1																						
TOTAL SCORE																									
PUPILS	R	Size																							+ reacts – no reaction c. eyes closed
		Reaction																							
	L	Size																							
		Reaction																							
LIMB MOVEM...	ARMS	Normal power																							Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																							
		Severe weakness																							
		Spastic flexion																							
		Extension																							
		No response																							
	LEGS	Normal power																							
		Mild weakness																							
		Severe weakness																							
		Spastic flexion																							
		Extension																							
		No response																							

Glasgow Coma Scale

Pupil size (mm)



Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

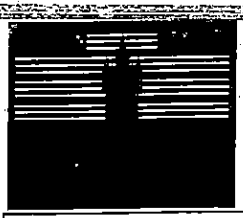
0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

Nausea and Vomiting	
0	= None
1	= Mild (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Redesigned by Medical Illustration Services • 231261



Patient

Ward: L8 Med **Date:** 05/10/03 **Time:** 05[30] (24hr clock)

Please print clearly in BLOCK CAPITALS

Title: Miss
Name: Diane Donald.
Preferred name:
Address: 28. Glendevon Place
Clydebank.
Post Code: G81 4SG
☎:
DOB: 16.12.83 Age: 19
Hosp. No: 1124660.
Occupation:
Religion:
S.O.S. ☐ date: ☐☐/☐☐/☐☐
Interpreter required: ☐
(specify:)
Lives alone ☑

Consultant: Dr McClelland
Named Nurse ①: S/N [illegible] F Cameron.
Admitting Nurse: S/N Fowler
Named Nurse ②:
Relatives seen by Doctor ☐

1 NOK/Friend/Contact: Angela O'Neill
Address: 22 Montrose St.
Clydebank.
☎Day: 952 1389
☎Night:
Relationship: Mother
2 NOK/Friend/Contact: Irene Kelly
Address:
mobile:
☎Day: 07719956147
☎Night:
Relationship: Keyworker
NOK informed of admission ☐ no at pt's request.
NOK informed by:
GP: Dr Roberson.
Address: Clydebank Health Centre,
Kilbowie Road
☎: 531 6625.

REASON FOR ADMISSION

O.D. 16 paracetamol at midnight. Had been drinking earlier. Motivation unclear.

Patient's perception of illness:
Aware.

Diagnosis: overdose

Operation/Treatment: Psychatric review
Levels
IV Parvolex.

Relevant PMH:
Depression
Previous Self Poisonings.
Chlamydia

OBSERVATIONS ON ADMISSION

Temperature	36. °C
Pulse	84 bpm
BP	102/60
Resp	16 97% on air
Pain Score	0
Urinalysis	Requested.
Waterlow Score	3.
Height	m
Weight	kg
Body Mass Index	
Blood sugar(if appropriate)	mmols
Allergies	Yes ☐ No ☑
details:	NKDA.

MEDICATION

With patient	☐
Stored & receipt given	☐
No medication required	☐
Taken home	☐
details:	

PERSONAL BELONGINGS

Clothing listed	☐
Valuables listed	☐
Valuables in ward	☐
Valuables in hospital safe	☐

0568763/MI

D ANNING

Boarding 1st 2nd 3rd	Signature	Time	Comments/Information
Informed: ward ☐ ☐ ☐ patient ☐ ☐ ☐ relatives ☐ ☐ ☐			
Date patient boarded: 1st: ☐☐/☐☐/☐☐ 2nd: ☐☐/☐☐/☐☐ 3rd: ☐☐/☐☐/☐☐			
Internal Transfers			
Transfer destination:			
Planned transfer date: ☐☐/☐☐/☐☐			
Medical consent ☐			
Arranged with receiving area ☐			
Patient informed ☐			
NOK/Contact informed ☐			
Transport: stretcher ☐ 2 hand seat ☐ chair ☐			
Escort ☐			
Case notes ☐			
X-rays ☐			
Nursing notes & Drug Form ☐			
Property/Valuables listed ☐			
Catering ☐			
Dietitian ☐			
Physiotherapy ☐			
Occupational Therapist ☐			
Speech and Language Therapist ☐			
Discharge Checklist			
Planned discharge date: 07/01/03			
Medical consent ☑			
Date discussed with patient: 07/01/03			
Date discussed with NOK/Contact: 07/01/03			
Transport: own ☑ ambulance ☐			
Ambulance ordered on: ☐☐/☐☐/☐☐ • type: _____ • order no.: _____			
District nurse ☐ /Liaison nurse ☐			
Home help: ☐			
Social work dept. ☐			
Discharge prescription ☐			
Discharge dressings ☐			
Patient information ☐			
Valuables/Cashier ☐			
Physiotherapy ☐			
Speech and Language Therapist ☐			
Out patient appointment ☐☐/☐☐/☐☐	KJ	4.00	Bloods letaken, patient to be telephoned for results.
Other:			

Name: Dro Ward: 6B Med Date: 06/01/10 No.: 1126660

ACTIVITIES OF DAILY LIVING

HOME CIRCUMSTANCES/ SOCIAL SUPPORT

Lives with family ☐
Lives alone ☑
Nursing home ☐
Residential care ☐
Elderly/disabled partner ☐
Family support (specify below) ☐

District Nurse (_____days/week) ☐
(cancelled ☐)
Home help(_____days/week) ☐
(cancelled ☐)
Other services (specify below) ☐

Stairs: Internal ☐ External ☐
Comments:

SMOKING

Non-smoker ☐
Smoker:_____per day ☐
Ex-smoker ☐
Aware of hospital policy ☐

HYGIENE

Bath ☐ Shower ☐
Requires assistance ☐ Stand up wash ☐
Skin assessment:

Other:

ELIMINATION

Bowels regular ☐
Constipated ☐
Diarrhoea/Loose stools ☐
Uses aperient ☐
Has stoma:
- Colostomy ☐
- Urostomy ☐
- Ileostomy ☐

appliances used:

Frequency of micturition ☐
Incontinent: urine/faeces ☐
day/night ☐
stress ☐
No urinary symptoms ☐
Comments:

NUTRITION

Normal menu (includes vegetarian) ☐
Vegan ☐ Child's menu ☐
Halal ☐ Kosher ☐
Refer to Dietician if any below ticked:
Inability to eat/swallow ☐
(refer to speech and language therapist)
Any recent weight changes ☐
Medically related nutrition problems (e.g. diabetes) ☐
Other (specify):

SLEEP

Hours/night ☐
Medication ☐
details:

BREATHING

1. No symptoms ☐
2. Breathless with moderate exercise ☐
3. Breathless with minimal exertion ☐
4. Breathless at rest ☐
5. Uses inhalers ☐

Comments:

MENTAL STATE

Alert/Orientated ☐
Confused: day/night ☐
Anxious/Distressed ☐
Unconscious ☐
Other (specify):

0568751

Name: [redacted] Ward: LS Med Date: 06/01/03 Record No.: 1124660

CARE PLAN

Date Comm.	Signature	1.BASIC CARE AND PERSONAL HYGIENE	Date Disc.	Signature
06/01/03	+ fowler	Independent - AS able		
		Bed bath		
		Assisted wash		
06/01/03	+ fowler	Oral hygiene offer mouth care		
06/01/03	+ fowler	Pressure care independant		
		2.NUTRITION		
		Fasting		
06/01/03	+ fowler	Normal Diet + oral fluids		
		Special Diet / Modified Diet		
		3.ELIMINATION		
		Independent		
06/01/03	+ fowler	Commode		
		Bedpan/urinal		
		Urinary Catheter Size: Batch No:		
		Type of Material: H_2O in Balloon:		
		Type of Stoma Appliance:		
		4.MOBILITY		
6.1.03	FULL	Fully Independent/fully mobile. AS Able.		
		Minimal assistance (give details)		
		Dependent (See movement and handling sheet - keep with patient)		
		5.OBSERVATIONS		
6.1.03	FULL	Waterlow daily (if score is over 10+)		
06/01/03	+ fowler	TPR 4°		
06/01/03	+ fowler	BP 4°		
6.1.03	FULL	Pain Score ongoing		
6.1.03	FULL	Fluid Balance - cumulative		
6.1.03	FULL	SaO_2 4 Hourly		
6.1.03	FULL	BM stix pre meal + lopm		

0568738

CARE PLAN

Date Comm.	Signature	6.TECHNICAL CARE	Date Disc.	Signature
6.1.03	FUlte	IV Infusion c/o IV Parvolex		
		Monitor		
		Catheter		
		Oxygen Therapy		
		Nebulisers		
06/01/03	J Fowler	IV access: • IV cannulae observe for patency • others		
		7.WOUND CARE		
		8.SPECIMENS/INVESTIGATIONS		
06/01/03	J Fowler	WSU		
		9.SLEEP		
		10.SPECIAL NEEDS		
		Assess for dysphagia (refer to speech and language therapist)		
		Source/protective isolation (refer to infection Control)		
		Blind/visually impaired		
		Deaf/hard of hearing		
		Anti-embolic stockings		
		Nurse escort when out of ward		
		11.OTHER RELEVANT INFORMATION		
		12.FAMILY/SIGNIFICANT OTHER		

Initial Care Plan seen and agreed by patient: Yes ☐ N/A ☐

Signature of nurse: Fiona Ulte **Date:** 06/01/03

Name: Diane Dould. Ward: L8 Med. Date: 06/01/03 Case Record No.: 1124660.

CARE PLAN EVALUATION		
1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No	EVALUATION AND PROGRESS OF CARE	SIGNATURE
6.1.03	0/A		Emergency admission to L8M via A+E with history as over. On admission to ward patient settled undistressed unwilling to talk about reasons why she took the tablets. Does not wish anybody to be contacted or informed of her admission. Vital signs stable. Fluid balance and Routine BM's commenced. IV Parvolex commenced.	
			settled and uncomplaining at present	FURb.
	1230		as plan	
			quite bright.	
			On IV parvolex 1st 8 hrly.	
			for psychiatry review	
			tomorrow.	jcm
	730 pm		settled.	
			on 1 ear bag parvolex	
			for LFT & Coag &	
			psych. review. mane.	
			To board in G9 over	
			night.	jcm
	2041		IV cannula to G9	
			venous haemaccess given	
			NOW CEASE.	
			for routine renew tomorrow	
			IV patency controls.	
6.1.03	21.30.		Admitted to G9 to board overnight. Orientated to ward.	
7.1.03	7a.		Settled & slept soundly.	
			Parvolex infusion completed.	
	1400		Independent with personal hygiene observations satisfactory reviewed by medical staff discharged home. SHO will telephone patient with blood results	

Please refer to "MEDICINES GIVEN BY SYRINGE PUMP/ INFUSION PUMP.- GUIDELINES ON USE"before completion

Prescription sheet number _____

Patients Name Diane Donald Case Record Number _____

Hospital WIG Weight 60 kg

Ward L8M D.O.B. _____

This document must be retained

Prescriptions and Administration sheet for **Acetylcysteine**
Each Prescription must be completed fully and unambiguously.
FULL SIGNATURE TO BE USED

1 ACETYLCYSTEINE 150mg/kg = 9 grams (50 mls) in 200ml glucose 5% over 15 mins. *Prescribers Signature:* [signature]

Prepared by	Checked by	Date	Time	Date	Start time	Drug dose per hour	Required flow rate setting	Set by	Checked by
FULL	[signature]	6.1.03	0515	6.1.03	0545			FULL	

2 ACETYLCYSTEINE 50mg/kg = 3 grams (15 mls) in 500ml glucose 5% over 4 hrs. *Prescribers Signature:* [signature]

Prepared by	Checked by	Date	Time	Date	Start time	Drug dose per hour	Required flow rate setting	Set by	Checked by
FULL	[signature]	6.1.03	0515	6.1.03	0605		125mls	FULL	[signature]

Administration check to be completed hourly by nursing staff

Date	Time	Vol Remaining	Total Volume Infused	Rate Setting	Checked By	Comments	Date	Time	Vol Remaining	Total Volume Infused	Rate Setting	Checked By	Comm
6/1/03	0605	500mls	—	125/hr	FULL	Commenced							
6/1	0810	240mls	260ml	125ml/hr	[signature]								

For infusions 3 & 4 please see overleaf

Please ensure that infusions 1 & 2 have been completed on page 1 before infusion 3 is commence

Patients Name Diane Donald

3 **ACETYLCYSTEINE** 50mg/kg = 3 grams (15 mls) in 500ml glucose 5% over 8hrs. *Prescribers Signature:* [signature]

Prepared by	Checked by	Date	Time	Date	Start time	Drug dose per hour	Required flow rate setting	Set by	Checked by
Rameron	V Simonis	06/01/03	1025	6/1/13	1030		63mls	Rameron	

Administration check to be completed hourly by nursing staff

Date	Time	Vol Remaining	Total Volume Infused	Rate Setting	Checked By	Comments	Date	Time	Vol Remaining	Total Volume Infused	Rate Setting	Checked By	Comments
6/1	1030	500ml	0ml	63mls	Rameron	Commenced							
6/1	1330	301	199	63ml	[signature]								

4 **ACETYLCYSTEINE** 50mg/kg = 3 grams (15 mls) in 500ml glucose 5% over 8 hrs. *Prescribers Signature:* [signature]

Prepared by	Checked by	Date	Time	Date	Start time	Drug dose per hour	Required flow rate setting	Set by	Checked by
Rameron	M Rankine	06/01/03	1850	6/1/03	1855		63mls	Rameron	

Administration check to be completed hourly by nursing staff

Date	Time	Vol Remaining	Total Volume Infused	Rate Setting	Checked By	Comments	Date	Time	Vol Remaining	Total Volume Infused	Rate Setting	Checked By	Comments
6/1/3	1855	500	0	63ml/hr	Rameron	Commenced							
	2005	373	127	63mls	[signature]								

IN.PAT FORM 6A

West Glasgow Hospitals University NHS Trust

24 Hour Fluid Balance Chart

Name: Diane Donald. Case Record No: 1124660 Ward: GRM. Date: 6.1.05

TIME HRS (Please delete 1 column)		INPUT (mls) ORAL	NASO GASTRIC TPN	BLOOD COLLOID PLASMA	IV (1) /	TYPE	IV (2)	IV (3) Drugs	Hourly Total	IN Cumulative Total	OUTPUT (mls) URINE	URINE Cumulative Total	Gastric Aspirate / Vomit	Drain 1		Hourly Total	OU Cumulative Total
08	24																
09	01																
10	02																
11	03																
12	04																
13	05	—						commenced									
14	06				250	Parolex.											
15	07																
16	08																
17	09																
18	10				500	Parolex			500	750							
19	11	200							200	950	Pu	in to wee					
20	12	—								950			Vomit x 1				
21	13	100							100	1050							
22	14																
23	15																
24	16																
01	17	100							100	1150							
02	18																
03	19																
04	20																
05	21																
06	22																
07	23																
TOTALS								TOTAL IN MLS			BALANCE			TOTAL OUT MLS			

006244

GREATER GLASGOW HEALTH BOARD

DIABETIC CHART and INSULIN PRESCRIPTION SHEET

NAME: Diane Donald

HOSPITAL No. 1124660

AGE 19

PHY/SURG. Dr McClellan

DEPT./WARD CSW

Date		6-1-02																											
Time/Hours		~~07~~	12	17	22	07	12	17	22	07	12	17	22	07	12	17	22	07	12	17	22	07	12	17	22	07	12	17	22
Urine Sugar	2%	O/A																											
	1%																												
	½%																												
	¼%																												
	0																												
Ketones																													
Blood Glucose																													
Strip/Meter Glucose		12.8		6.1																									
Insulin Dose Type/Units	A																												
	M																												
Doctor's Signature																													
Administered by																													
Checked by																													
Insulin Dose Type/Units	P																												
	M																												
Doctor's Signature																													
Administered by																													
Checked by																													

NO DRUGS OTHER THAN INSULIN TO BE PRESCRIBED ON THIS CHART.

ON DISCHARGE, FILE WITH PRESCRIPTION SHEET.

WEST GLASGOW HOSPITALS

BP, TPR and Pain Assessment Chart

Name: Diane Donald.

Case Record No.: 1124660.

DOB: 16.12.83

Ward: L8 med Consultant: Dr McKelland

1. Pain Score 2. Sedation Score 3. Nausea Score See reverse for scoring details

Date	06/01/03	07.01.03			
Time	9A	30 11			
Pain Score	0	0			
Sedation Score	0	0			
Nausea Score	0	0			
Nurse Initials	FW	K			
Temperature C° 40					
39					
38					
37					
36					
35					
BP 210					
200					
190					
180					
170					
160					
150					
140					
130					
120					
110	102 A				
100					
90					
80					
Pulse 70					
60	60				
50					
40					
30					
RESPS	16				
SaO2	97%	94			
Bowels	↓				
	air.				



- Part of **North Glasgow University Hospitals NHS Trust**

Pressure Sore Risk Assessment Documentation Form

Patient Name: Diane Donald.

Case Record Number: 1124660 Ward: L8 Med

Waterlow Risk Assessment		Initials	FW													
		Date	6/1													
		No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Body weight for height:	Average 0 Above average 1 Obese 2 Below average 3		0													
Continence:	Completely catheterised 0 Occasionally incontinent 1 Cath. Incontinence of faeces 2 Doubly incontinent 3		0													
Skin type-visual risk areas:	Healthy 0 Tissue paper/dry 1 Oedematous clammy (temp↑) 1 Discoloured 2 Broken spot 3		1													
Mobility:	Fully 0 Restless/fidgety 1 Apathetic 2 Restricted 3 Inert/traction 4 Chairbound 5		0													
Age/Sex:	Male/Female ½ 14-49 1 50-64 2 65-74 3 75-80 4 80+ 5		2 1													
Appetite:	Average 0 Poor 1 NG Tube/fluids only 2 nbm – Anorexic 3		0													
Special risks – tissue malnutrition:	eg Terminal cachexia 8 Cardiac failure 5 Peripheral vascular disease 5 Anaemia 2 Smoking 1		1													
Neurological deficit:	Motor-sensory paraplegia 4-6 eg diabetes, MS, CVA		/													
Major surgery/trauma:	Orthopaedic Below waist, Spinal 5 On table > 2 hours 5		/													
Medication:	Cytotoxics, High dose steroids 4 Anti-inflammatory		/													
TOTAL SCORE			5													

Score: <10 = low risk; 10-14 = at risk; 15 – 19 = high risk 20+ = very high risk

WEST GLASGOW HOSPITALS

In Pat. Form 66

NAME Diane Donald,

HOSPITAL No 1124660.

AGE 19

SEX F.

PHYS.

SURG Dr McLellan.

DEPT.

WARD C8W

CUMULATIVE FLUID BALANCE SHEET

"Balance" = Intake minus measured losses

i.e. excludes insensible loss.

Date	Total Intake	Total Output	Daily "Balance"		Cumul. "Balance"		Wt.
/ / / /	ml.	ml.	Pos. ml.	Neg. ml.	Pos. ml.	Neg. ml.	Kg.

Patient Observation Chart

NHS Greater Glasgow

Name Diane Donald
Address
AFFIX PATIENT ID
Hospital No. 112 4660
DOB 16/12/83

Admitted Date 6/11/03 Ward L8 Med
Transferred Date _____ Ward _____
Transferred Date _____ Ward _____

Reference Scoring Chart

Modified Early Warning System Observation Score (MEWS)

Score	3	2	1	0	1	2	3
Pulse		<40	41-50	51-100	101-110	111-130	>131
Resp. Rate		<8		9-14	15-20	21-29	>30
Temp. (°C)		<35.0	35.1-36.0	36.1-38.0	38.1-38.5	>38.6	
AVPU/GCS	Unresponsive	Pain	Voice	Alert / 15	14	13-9	<8
Urine	<10mls/hr for 2 hrs	30mls/hr for 2 hrs				<300mls in 24hrs	<100mls in 24 hrs
Systolic BP	<70	71-80	81-100	101-199		>200	

If your patient scores 4 or more
If your patient score increases by 2 or more
If your patient's GCS drops by 2 points or more regardless of any other information
Or any patient causing concern to any healthcare professional
Immediately inform your relevant medical staff and contact the Critical Care Outreach Service

Glasgow Coma Scale

Eye opening
4 – spontaneous
3 – voice
2 – pain
1 – none

Verbal
5 – orientated
4 – confuse
3 – inappropriate word
2 – incomprehensible sound

Motor
6 – obeys commands
5 – localises to pain
4 – normal flexion
3 – abnormal flexion
2 – extension1 – nil
1 – nil

Pain Score

Remember to check scores after pain relief.
Patient asked to report pain at rest and on movement.

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

Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

Sedation Score

0 = Awake, alert, orientated
1 = Mild, aroused by verbal stimulus
2 = Moderate, aroused by physical stimulus
3 = Severe, no response
S = Normal sleep, easy to rouse

Score 2 or 3 requires immediate intervention

Nausea Score

0 = No nausea
1 = Mild (No treatment wanted)
2 = Moderate (Treatment required)
3 = Severe (Clinical problem persists despite treatment)

Review 1 hour after treatment. Inform doctor if additional treatment required.

NAME: HOSPITAL NO:

DATE	6/10/23	11	20																			TEMP
Time	0/a																					
BP and Pulse (1 • 2 •• 3 ••• 4 •••• 5 ••••• 6 ••••• 7 ••••• 8 •••••) 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40																						40°C 39°C 38°C 37°C 36°C 35°C
Pupil size (mm)																						
Resp. Rate	16	12	14																			
Inspiration O_2%	A.a	Air	A																			
SpO_2%	97	96	97																			
Pain Score	0	0	0																			
Sedation Score	0	0	0																			
Nausea Score	0	1	0																			

MEWS Scores

Pulse	0	1	0																			Pulse
Resp. Rate	0	0	0																			Resp. Rate
Temp.	0	0	0																			Temp.
GCS / AVPU	0	0	0																			CNS
Urine Output	0	0	0																			Urine
stolic BP	0	0	0																			BP
TOTAL	0	1	0																			TOTAL

COMA SCALE — E Eyes open: Spontaneously 4; To speech 3; To pain 2; None 1																						Eyes closed by dwelling = C
V Best verbal response: Orientated 5; Confused 4; Inappropriate words 3; Incomprehensible sounds 2; None 1																						Endotracheal tube or tracheostomy = T
M Best motor response: Obeys 6; Localises 5; Flexion - withdrawal 4; Flexion - abnormal 3; Extension to pain 2; None 1																						Usually record the best arm response
TOTAL SCORE																						
PUPILS — R Size / Reaction; L Size / Reaction																						= reacts – no reaction c. eyes closed
LIMB MOVEMENT — ARMS: Normal power; Mild weakness; Severe weakness; Spastic flexion; Extension; No response																						Record right (R) and left (L) separately if there is a difference between the two sides
LEGS: Normal power; Mild weakness; Severe weakness; Extension; No response																						

NAME: HOSPITAL NO:

DATE																							TEMP
Time																							
BP and Pulse	1	240																					40°C
	2	230																					
		220																					39°C
		210																					
	3	200																					38°C
		190																					
		180																					37°C
	4	170																					
		160																					36°C
		150																					
	5	140																					35°C
		130																					
		120																					
	6	110																					
		100																					
	7	90																					
		80																					
	8	70																					
		60																					
Pupil size (mm)		50																					
		40																					
Resp. Rate																							
Inspiration O_2%																							
SpO_2%																							
Pain Score																							
Sedation Score																							
Nausea Score																							

MEWS Scores

Pulse																						Pulse
Resp. Rate																						Resp. Rate
Temp.																						Temp.
GCS / AVPU																						CNS
Urine Output																						Urine
Systolic BP																						BP
TOTAL																						TOTAL

COMA SCALE	E Eyes open	Spontaneously	4																				Eyes closed by dwelling = C
		To speech	3																				
		To pain	2																				
		None	1																				
	V Best verbal response	Orientated	5																				Endotracheal tube or tracheostomy = T
		Confused	4																				
		Inappropropriate words	3																				
		Incomprehensible sounds	2																				
		None	1																				
	M Best motor response	Obeys	6																				Usually record the best arm response
		Localises	5																				
		Flexion - withdrawal	4																				
		Flexion - abnormal	3																				
		Extension to pain	2																				
		None	1																				
		TOTAL SCORE																					
PUPILS	R	Size																					= reacts – no reaction c. eyes closed
		Reaction																					
	L	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																					
		Spastic flexion																					
		Extension																					
		No response																					
	LEGS	Normal power																					
		Mild weakness																					
		Severe weakness																					
		Extension																					
		No response																					

Oxygen Devices and Flow Related Percentages

Nasal Cannula

O_2 Flow Rate (L/min)	1	2	3	4	5	6
Approximate O_2 concentration (%)	24	28	32	36	40	44

Hudson Face Mask

O_2 Flow Rate (L/min)	4	6	8	12-15
Approximate O_2 concentration (%)	40	50	55	65

Venturi Mask

Colour of Venturi Device	Blue	White	Yellow	Red	Green
O_2 Flow Rate (L/min)	2	4	8	10	15
Approximate O_2 concentration (%)	24	28	35	40	60

Non-rebreathe masks

An oxygen flow rate of 12-15 litres/minute will provide an oxygen percentage of approximately 95%.

These figures are intended for guidance only. Slight variations may exist between products manufactured by different companies.

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02-1909

West Gl[illegible]ia[illegible]s University NHS Tr

DAY CARE

Date 5·6·00 Consultant FULLARTON

Name [redacted] Surgeon ARTHUR

Address 1124660 DONALD DIANE F
62 Stewart Drive
CLYDEBANK 16/12/83
G81 6AG
Hospita G.P.Prac. 40224

Proposed Procedure REMOVAL OF GLASS FROM WOUND - FOREHEAD

Next of Kin ANGELA RILEY (MUM)

Telephone No 562 8458

Escort FRIEND WILL WAIT

Pre Procedure Check Case Sheet Yes/No Name Band Yes/No

Past Medical History

Heart Condition	Yes/No	Breathing Problems	Yes/No
Diabetes	Yes/No	Epilepsy	Yes/No
Allergies	Yes/No		
Medication	Yes/No		

Comments Emla Cream applied to forehead at 15[35].
10mg TEMAZEPAM GIVEN 16[00] - FEAR OF NEEDLES

Signature Admitting Nurse [signature]

Consent Yes/No By

PROCEDURE PERFORMED No treatment.

Post-Operative Instructions ½ hour rest; B.P. & pulse x 2.

Time	BP	Pulse
PRE OP 1445	124/70	94
1715	97/63	77

O_2Sa 98%

Post-Operative Progress

Discharged at 1735 Accompanied by

Discharge Information Given Yes/No Out-Patient Appointment Yes/No

Signature of Discharge Nurse [signature]

North Glasgow University Hospitals NHS Trust

Gartnavel Day Surgery Unit

BOOKLET FOR DAY PROCEDURES

CONFIDENTIAL PATIENT INFORMATION

Patient Label

Na

Ad 1124660
DONALD DIANE
62 Stewart Drive F

CLYDEBANK 16/12/83
G81 6AG
G.P.Prac. 40224

Ho

Procedure Appointment Date 5/6/00

Consultant FULLARTON

General Practitioner

Phone No.

MED ILLWIG 2000/624

Date of Outpatient Appointment _____

Seen by Dr. _____

Diagnosis _____

Proposed Procedure EXCISION OF GLASS FROM "FOREHEAD

Proposed Anaesthesia: General ☐ Local ☑

Investigations Required (please tick)

Haemoglobin ☐ Blood Glucose ☐

ECG ☐ Blood Group ☐

"s and E's ☐

Others _____

Pre-Anaesthetic Assessment

Date _____ Assessed by _____

Social

Do you live alone? Yes ☐ No ☐

Can you arrange an escort? Yes ☐ No ☐

Will someone be with you overnight? Yes ☐ No ☐

Patient tel. no. _____

Height _____ cms. Weight _____ Kilos BMI _____

B.P. _____ Pulse _____

Understanding of English Good ☐ Poor ☐ None ☐

ADMISSION

Named Nurse

Admitted by _____ Date _____

Case Sheet Yes ☐ No ☐

Name Band Yes ☐ No ☐

Next of Kin _____ Relationship _____ Phone No. _____

Discharge Escort _____ Relationship _____ Phone No. _____

Overnight Escort _____

Anaesthetic Questionnaire Complete Yes ☐ No ☐

Fasted since _____

Current Medication _____

_____

_____ Pulse _____ O2 Saturation _____

LMP _____ BM Stix _____

Pre-Operative Medication (if required)

Drug	Dose	Route	Doctor's Signature	Time Given	Nurse's Signature	Witness
[illegible]						
Temazepam	10mg	PO	A.	1605	[signature]	D Mordaunt

Before the patient proceeds into theatre, Nursing Staff please check and tick that:

	YES	NO	N/A
Consent form is signed	☐	☐	
They are wearing an identification bracelet	☐	☐	
Make-up has been removed	☐	☐	☐
Jewellery has been removed or taped	☐	☐	☐
Have contact lenses/prosthesis been removed?	☐	☐	☐
Have dentures been removed?	☐	☐	☐
Operation site is clearly marked	☐	☐	☐

CONSENT TO ANAESTHESIA, OPERATION, INVESTIGATION OR TREATMENT

(Notes for Guidance of Doctors and Patients overleaf)

Patient Name (BLOCK CAPITALS) DIANE DONALD Date 5/6/00.

UNIT No _____ Proposed Procedure (BLOCK CAPITALS) _____

Excision of glass FB + scar on forehead.

TO BE COMPLETED BY MEDICAL OR DENTAL PRACTITIONER

I HAVE FULLY EXPLAINED: **To the patient/~~parent/guardian/next of kin~~*** (* DELETE AS APPROPRIATE)

1. **The procedure named on this form**
2. **Appropriate alternatives which are available**
3. **Side-effects which may result from the procedure**

Name (BLOCK CAPITALS) ANGUS ARGYLE

SIGNATURE Angus Arg

TO BE COMPLETED BY THE PATIENT

You should read this form and the notes overleaf carefully. If there is anything you do not understand ask the doctor or dentist for an explanation. If the information is correct and you understand the procedure, you should sign the form.

I AM **The Patient/Parent/Guardian/Next of Kin.** (DELETE AS APPROPRIATE)

I UNDERSTAND

The procedure which has been explained to me by the Doctor or Dentist named on this form.

That the procedure may not be carried out by the Doctor/Dentist who has been treating me so far.

That any procedure in addition to that named on this form will ony be carried out if it is necessary and in my best interests and can be justified for medical reasons.

I AGREE

To the administration of an anaesthetic or to sedation if required.

To the procedure named on this form.

That examination for the purposes of teaching will not be undertaken without my consent. (SEE OVERLEAF)

Signature Donald

Patient/Parent/Guardian/ Next of Kin*

(* DELETE AS APPROPRIATE)

Name (BLOCK CAPITALS)

Address

1124660
DONALD DIANE
62 Stewart Drive F

CLYDEBANK 16/12/83
G81 6AG
G.P.Prac. 40224

REF/CTA1
JMcC/930795

NOTES OF GUIDANCE

1. DOCTORS

A patient has the right to grant or withhold consent prior to examination, investigation, treatment or operation. The Doctor/Dentist must give the patient sufficient information, in a way he/she can understand, about the proprosed procedure, any side effects and the possible alternatives. The Doctor/Dentist must give the patient enough time to read this form and ask any questions relating to it or their treatment. The patient must be allowed to decide whether he or she will agree to the procedure and they may refuse or withdraw consent to a procedure at any time. The patient's consent to a procedure should be recorded on this form.

1.1 The patient must give written consent to be examined by students during any procedure for which written consent if required. (See Below).

PATIENTS

2.1 The doctor is here to help you. He or she will explain the procedure, which you are entitled to refuse. You can ask any questions and ask for more information.

2.2 You may ask for a relative or a friend or a nurse to be present while the Doctor/Dentist explains the procedure and asks you to sign this form.

2.3 Students need to learn how to examine patients and to see how procedures are done. This is important for the future of health services. You may be asked to give consent to be examined by students during the procedure. It is up to you to decide whether you give your consent or not but whatever you decide, it will not affect your treatment.

---

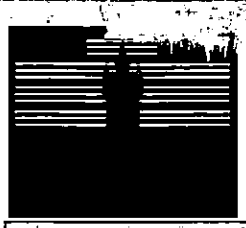
1. **I agree/do not agree*** to the involvement of a student at the procedure named on this form.

2. **I agree/do not agree*** to examination by a student during the procedure named on this form under the supervision of the senior medical/dental officer undertaking the procedure.

Name _____ Date _____
(BLOCK CAPITALS)

Signature _____

* DELETE AS APPROPRIATE



Patient Profile

Ward: Lilw **Date:** 15/3/00 **Time:** 06°° **(24hr clock)**

Please print clearly in BLOCK CAPITALS

Title: Miss
Name: Dosie Donald
Preferred name:
Address: 62 Stewart Drive
Clydebank.

Post Code: G81 6AG
☎: 01389 872200
DOB: 16.12.83 Age: 16yr
Hosp. No: 1124660
Occupation: Office Junior
Religion: None.
S.O.S. ☐ date: ☐☐/☐☐/☐☐
Interpreter required: ☐
(specify:)
Lives alone Independant Unit ☐

1 NOK/Friend/Contact: Angela O'Neil
Address: 70 Wood Quadrant
Clydebank.
☎Day: 0141-562-9458
☎Night:
Relationship: mother
2 NOK/Friend/Contact: raymond walsh
Address: N/A

☎Day: N/A
☎Night:
Relationship: Career
NOK informed of admission ☑
NOK informed by: Independant unit
GP: Dr Rogerson
Address: Clydebank Health Centre
Kilbowie Road
☎:

Consultant: Prof O Dwyer
Named Nurse ①: S/N or Ready
Admitting Nurse: S/N O Hara
Named Nurse ②:
Relatives seen by Doctor ☑ ☐

REASON FOR ADMISSION

RTA- Head injury NOH
Laceration ① side head 2x
Steristrips.

Patient's perception of illness:

Diagnosis:

Operation/Treatment:

Relevant PMH: previous UTI's

MEDICATION

With patient	☐
Stored & receipt given	☐
No medication required	☑
Taken home	☐

details:

PERSONAL BELONGINGS

Clothing listed	☐
Valuables listed	☐
Valuables in ward	☐
Valuables in hospital safe	☐

OBSERVATIONS ON ADMISSION

Temperature	37.3	°C
Pulse	80	bpm
BP	120/70	
Resp	14	
Pain Score	1	
Urinalysis	Neg	
Waterlow Score		
Height	5ft 1	m
Weight	8½	kg
Body Mass Index		
Blood sugar(if appropriate)	N/A	mmols
Allergies	Yes ☐	No ☑

details:

Nam Ward: WOW Date: 15 Record No.:

ACTIVITIES OF DAILY LIVING

HOME CIRCUMSTANCES/ SOCIAL SUPPORT

- Lives with family ☐
- Lives alone Independant Unit ☑
- Nursing home ☐
- Residential care ☐
- Elderly/disabled partner ☐
- Family support (specify below) ☐

_____

- District Nurse (_____days/week) ☐
- (cancelled ☐)
- Home help(_____days/week) ☐
- (cancelled ☐)
- Other services (specify below) ☐

_____

_____

Stairs: Internal ☐ External ☐

Comments:_____

_____

NUTRITION

- Normal menu (includes vegetarian) ☑
- Vegan ☐ Child's menu ☐
- Halal ☐ Kosher ☐

Refer to Dietitian if any below ticked:

- Inability to eat/swallow ☐
- Any recent weight changes ☐
- Medically related nutrition problems (e.g. diabetes) ☐

Other (specify):_____

_____

_____

BREATHING

- 1. No symptoms ☑
- 2. Breathless with moderate exercise ☐
- 3. Breathless with minimal exertion ☐
- 4. Breathless at rest ☐
- 5. Uses inhalers ☐

Comments:_____

_____

SMOKING

- Non-smoker ☐
- Smoker:__5__per day ☑
- Ex-smoker ☐
- Aware of hospital policy ☑

HYGIENE

Bath ☐ Shower ☑

Requires assistance ☐ Stand up wash ☐

Skin assessment: Intact

_____

Other:_____

ELIMINATION

- Bowels regular ☑
- Constipated ☐
- Diarrhoea/Loose stools ☐
- Uses aperient ☐

Has stoma:

- Colostomy ☐
- Urostomy ☐
- Ileostomy ☐

appliances used:_____

_____

- Frequency of micturition ☐
- Incontinent: urine/faeces ☐
- day/night ☐
- stress ☐
- No urinary symptoms ☑

Comments:_____

_____

SLEEP

Hours/night ☑

Medication ☐

details:_____

MENTAL STATE

- Alert/Orientated ☑
- Confused: day/night ☐
- Anxious/Distressed ☐
- Unconscious ☐

Other (specify):

SENSES

Glasses:	distance	☐
	reading	☑
Hearing impaired:	left/right	☐
Hearing aid:	left/right	☐
Dentures:	upper	☐
	lower	☐

Other:

MOBILITY (Pre admission)

- Mobile without aid ☑
- Mobile with aid ☐
- (Specify type/side held:)
- Furniture walking ☐
- Chair Bound ☐
- Housebound ☐

RELATIVE PARTICIPATION

Mum aware & carer

ALCOHOL INTAKE

Units/week:	nil	☐
	less than 14	☑
	14 - 21	☐
	over 21	☐

(1 unit = 1 measure spirits/half pint beer/ lager/1 glass wine)

PROFILE COMPLETED BY

(Please print name in block capitals)

Louise O' Hara

Signature: [signature]

Designation: SIN

Countersigned (if applicable):

OTHER RELEVANT INFORMATION

Name: Diane Donald Ward: LIOW Date: 15/3/00 Case Record No.:

CARE PLAN EVALUATION		
1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

1. DATE	1. TIME	1. No.	2. EVALUATION AND PROGRESS OF CARE	3. SIGNATURE
15/3/00	0610		patient admitted via A&E with Head injury & Laceration	
		2	can have Diet & Fluids	
		6	IVI continue at present.	
		5	10 Neuro obs stable. T37.3.	
			Uncomplicated c/A.	LoHare
	11am		SIB Prof O'Dwyer - For Spinal xRays - if stable then for discharge home today	
			No follow up.	Memorandum
		(5)	Neuro obs satisfactory.	Xmokendl
		(2)	Fluids + Diet.	

0568726

Ward: L10W Dati Case Record No.:

CARE PLAN

Date Comm.	Signature	1.BASIC CARE AND PERSONAL HYGIENE	Date Disc.	Signature
15/3/00	L Otara	Independent		
		Bed bath		
		Assisted wash		
		Oral hygiene		
		Pressure care		
		2.NUTRITION		
		Fasting		
15/3/00	L Otara	Normal Diet		
		Special Diet		
		3.ELIMINATION		
15/3/00	L Otara	Independent		
		Commode		
		Bedpan/urinal		
		Urinary Catheter | Size: | Batch No:		
		Type of Material: | H_2O in Balloon:		
		Type of Stoma Appliance:		
		4.MOBILITY		
15/3/00	L Otara	Fully Independent/fully mobile		
		Minimal assistance (give details)		
		Dependent (See movement and handling sheet - keep with patient)		
		5.OBSERVATIONS		
		Waterlow daily (if score is over 10+)		
		TPR 1° Review dos		
15/3/00	L Otara	BP		
		Pain Score Ongoing		
		Fluid Balance		

0568738

CARE PLAN

Date Comm.	Signature	6.TECHNICAL CARE	Date Disc.	Signature
15/3/00	[illegible]	IV Infusion as ordered	15/3	[illegible]
		Monitor		
		Catheter		
		Oxygen Therapy		
		Nebulisers		
15/3/00	[illegible]	IV access: • IV cannulae (R) Arm • others	15/3	[illegible]
		7.WOUND CARE		
		8.SPECIMENS/INVESTIGATIONS		
15/3/00	[illegible]	U&E		
		9.SLEEP		
		10.SPECIAL NEEDS		
		Assess for dysphagia		
		Source/protective isolation (refer to infection Control)		
		Blind/visually impaired		
		Deaf/hard of hearing		
		Anti-embolic stockings		
		Nurse escort when out of ward		
		11.OTHER RELEVANT INFORMATION		
		12.FAMILY/SIGNIFICANT OTHER		

Initial Care Plan seen and agreed by patient: Yes ☐ N/A ☐

Signature of nurse: [illegible] **Date:** ☐☐/☐☐/☐☐

Hospital Name: .....

PRESCRIPTION FORM

PATIENT DETAILS	DRUG SENSITIVITIES	OTHER CHARTS IN USE
Name: Diane Donald		Insulin ☐
Hospital Number: 1124660		PCA and other infusions ☐
DOB: 16/12/83		Anticoagulants: Heparin ☐ Oral ☐
Date of Admission: __/__/__	Consultant Name:	Topical: ☐
Ward: / Height:	DVT Risk on Admission (SIGN Guideline) High ☐ Moderate ☐ Low ☐	TPN: ☐ Enteral Nutrition: ☐
Weight: / Surface area:	Assessed by: Date: __/__/__	Other:
Date of writing discharge prescription: __/__/__	Prescription sheet number:	Date and time form re-written: __/__/__ Time:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF DOCTOR	GIVEN BY	TIME GIVEN
15/3	PARACETAMOL	1g	O	11am	[signature]	[signature]	10[illegible]

Parenteral Drugs: Regular Prescription

ADMINISTRATION

DATE →
MONTH →

Other time															
0700-0900															
1200-1400															
1600-1800															
2200-2400															
Other time															

A DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

B DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

C DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

WEST GLASGOW UNIVERSITY NHS TRUST

OBSERVATION CHART

NAME DIANE DONALD

HOSP No.:— 1124660

AGE:—

CONSULTANT:— MR O'DWYER

DATE:— 15/3/00

TIME 0500 | 0700 | 0900 | 1030 | 1610

COMA SCALE

Eyes open
- Spontaneously
- To speech
- To pain
- None

Best verbal response
- Orientated
- Confused
- Inappropriate Words
- Incomprehensible Sounds
- None

Best motor response
- Obey commands
- Localise pain
- Flexion to pain
- Extension to pain
- None

Eyes closed by swelling = C

Endotracheal tube or tracheostomy = T

Usually record the best arm response

Pupil scale (m.m.): 1 2 3 4 5 6 7 8

Blood pressure and Pulse rate: 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30

Respiration: 20 10

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

PUPILS

		0500	0700	0900	1030	1610
right	Size	6	6	5	6	
	Reaction	+	+	+	+	
left	Size	6	6	5	6	
	Reaction	+	+	+	+	

+ reacts
– no reaction
c. eye closed

LIMB MOVEMENT

ARMS
- Normal power
- Mild weakness
- Severe weakness
- Spastic flexion
- Extension
- No response

LEGS
- Normal power
- Mild weakness
- Severe weakness
- Extension
- No response

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

WEST GLAS S UNIVERSITY NHS TRUST

OBSERVATION CHART

NAME Diana Dodd

HOSP No.:-

AGE:-

CONSULTANT:-

DATE:-

TIME 02 03 02 02 03 04 / 05 15 30 45 30 05

COMA SCALE

Eyes open	Spontaneously	4
	To speech	3
	To pain	2
	None	1
Best verbal response	Orientated	5
	Confused	4
	Inappropriate Words	3
	Incomprehensible Sounds	2
	None	1
Best motor response	Obey commands	6
	Localise pain	5
	flexion to pain	4
	Extension to pain	3
	None	2

Eyes closed by swelling = C

Endotracheal tube or tracheostomy = T

Usually record the best arm response

Pupil scale (m.m.) 1 2 3 4 5 6 7 8

Blood pressure and Pulse rate 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

Respiration

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

PUPILS

right-	Size	4 4 4 4 4
	Reaction	+ + - - +
left	Size	4 4 4 4 4
	Reaction	+ + - + +

+ reacts
- no reaction
c. eye closed

LIMB MOVEMENT

ARMS	Normal power
	Mild weakness
	Severe weakness
	Spastic flexion
	Extension
	No response
LEGS	Normal power
	Mild weakness
	Severe weakness
	Extension
	No response

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

WEST GLASGOW HOSPITALS UNIVERSITY NHS TRUST

PATIENT PROFILE

Ward: L8 Date: 27/12/98 Time: 0030 (24hr clock)

PLEASE PRINT CLEARLY IN BLOCK CAPITALS

Title:
Name: Diane Donald
Preferred name:
Address: c/o Romsay House
Risk st
Clydebank
☎: 952 6121 Post Code:
DOB: 16-12-83 Age: 15
Hosp. No: 1124660
Occupation: School
Religion: None
S.O.S. ☐ date: ☐☐/☐☐/☐☐
Interpreter required: ☐
(specify language)
Date arranged ☐☐/☐☐/☐☐
Lives alone ☐

1 NOK/Friend/Contact: Angela O'Neil
Address: 70 Lood Quadrant
☎Day: 941-0232 Night:
Relationship: mother
2 NOK/Friend/Contact:
Address:
☎Day: Night:
Relationship:

NOK informed of admission ☑
NOK informed by: Pt
GP: Dr Thomson
Address: Clydebank Health Centre
☎:

MEDICATION None
With patient ☐
Stored & receipt given ☐
No medication required ☐
Taken home ☐

PERSONAL BELONGINGS
Clothing listed ☐
Valuables listed ☐
Valuables in ward ☐
Valuables in hospital safe ☐
House keys held by :
(If req'd)

Consultant: Dr Fox
Named Nurse: L McGowan
Admitting Nurse: K McInnes
Countersigned:
Relatives seen by Doctor ☐

REASON FOR ADMISSION
Overdose of 32 paracetamol tablets

Patient's perception of illness:
Clear

Diagnosis:
Paracetamol overdose (32 x 500mgs at 1830)

Operation/Treatment:
Panadex

Relevant PMH:
Chronic abdominal pain
No Rx found or cause
Previous overdose Jan 1998

OBSERVATIONS ON ADMISSION

Temperature	36° °C
Pulse	92 bpm
BP	120/70
Resp	18
Pain Score	0
Urinalysis	
Waterlow Score	5
Height	m
Body Mass Index	
Blood sugar(if appropriate)	mmols

ALLERGIES Yes ☐ No ☑
details:

0568763MI

Name: Ward: Case Record No:

DISCHARGE PLANNING

Boarding 1st 2nd 3rd	Signature	Time	Comments/Information
Informed: ward ☐ ☐ ☐ patient ☐ ☐ ☐ relatives ☐ ☐ ☐			
Date patient boarded: 1st: ☐☐/☐☐/☐☐ 2nd: ☐☐/☐☐/☐☐ 3rd: ☐☐/☐☐/☐☐			
EXTERNAL/INTERNAL TRANSFERS			
Transfer destination:			
Planned transfer date: ☐☐/☐☐/☐☐			
Medical consent ☐			
Arranged with receiving area ☐			
Patient informed ☐			
NOK/Contact informed ☐			
Transport:stretcher ☐ 2 hand seat ☐ chair ☐			
Escort ☐			
Case notes ☐			
X-rays ☐			
Nursing notes & Drug Form ☐			
Property/Valuables listed ☐			
Catering ☐			
Dietitian ☐			
Physiotherapist ☐			
Occupational therapist ☐			
DISCHARGE CHECKLIST			
Actual discharge date: 28/12/90			
Medical consent ☑			
Date discussed with patient: 28/12/98			
Date discussed with NOK/Contact: 28/12/98			
Transport: own ☑ ambulance ☐			
Ambulance ordered on: ☐☐/☐☐/☐☐ type:_____			
District nurse ☐/Liaison nurse ☐			
Home help: ☐☐☐☐☐☐☐			
Social work dept. ☐			
Discharge prescription ☐			
Discharge dressings ☐			
Patient information ☐			
Valuables/Cashier ☐			
Physiotherapy ☐			
Out patient appointment: ☐☐/☐☐/☐☐	re-aquilation Screen on wed @ own GP.		
Other:			

Name: D. [redacted] Date: 27/12/98

ACTIVITIES OF DAILY LIVING

HOME CIRCUMSTANCES/ SOCIAL SUPPORT

- Lives with family ☐
- Lives alone ☐
- Nursing home ☐
- Residential care ☑
- Elderly/disabled partner ☐
- Family support (specify below) ☐

District Nurse (_____days/week) ☐
(cancelled ☐)
Home help(_____days/week) ☐
(cancelled ☐)
Other services (specify below) ☐

Stairs: Internal ☐ External ☐
Comments:

NUTRITION

- Normal menu (includes vegetarian) ☑
- Vegan ☐ Child's menu ☐
- Halal ☐ Kosher ☐

Refer to Dietitian if any below ticked:
- Inability to eat/swallow ☐
- Any recent weight changes ☐
- Medically related nutrition problems (e.g. diabetes) ☐

Other (specify):

BREATHING

- 1. No symptoms ☑
- 2. Breathless with moderate exercise ☐
- 3. Breathless with minimal exertion ☐
- 4. Breathless at rest ☐
- 5. Uses inhalers ☐

Comments:

SMOKING

- Non-smoker ☐
- Smoker:_____per day ☑
- Ex-smoker ☐
- Aware of hospital policy ☐

HYGIENE

Bath ☑ Shower ☐
Requires assistance ☐ Stand up wash ☐
Skin assessment:

Other:

ELIMINATION

- Bowels regular ☑
- Constipated ☐
- Diarrhoea/Loose stools ☐
- Uses aperient ☐

Has stoma:
- Colostomy ☐
- Urostomy ☐
- Ileostomy ☐

appliances used:

Frequency of micturition ☐
Incontinent: urine/faeces ☐
day/night ☐
stress ☐
No urinary symptoms ☑
Comments:

SLEEP

Hours/night Good Sleeper ☐
Medication ☐
details:

MENTAL STATE

- Alert/Orientated ☑
- Confused: day/night ☐
- Anxious/Distressed ☐
- Unconscious ☐

Other (specify):

SENSES

Glasses:	distance	☐
	reading	☐
Hearing impaired:	left/right	☐
Hearing aid:	left/right	☐
Dentures:	upper	☐
	lower	☐

Other:

MOBILITY (Pre admission)

- Mobile without aid ☑
- Mobile with aid ☐
- (Specify type/side held: _____)
- Furniture walking ☐
- Chair Bound ☐
- Housebound ☐

RELATIVE PARTICIPATION

Lives in childrens home

ALCOHOL INTAKE

Units/week:	nil	☐
	less than 14	☑
	14 - 21	☐
	over 21	☐

(1 unit = 1 measure spirits/half pint beer/ lager/1 glass wine)

PROFILE COMPLETED BY:

(Please print name in block capitals)

K mclmos

Signature: Kerri Holmes

Designation: Sister

Countersigned (if applicable):

OTHER RELEVANT INFORMATION

Name: D. Donald Ward: L8 Date: 27/12/98 Case Record No.: 1124660

CARE PLAN EVALUATION		
1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
27/12			Emergency via A/E	
			On enquiry pt stable	
			General colour good	
			Vomited x 2 bile stained	
			no tablets	
			Paracetamol levels high	
			Pt commenced on parodex	
			Pt not expressing any	
			suicide intent at present	
		*	Please refer to social	
			worker in am in view of	
			pts age	
			Vomited x 4 post admission -	Karen Hines
			HNPU as yet	
	1400		Settled morning.	
			NO further vomiting noted.	
			3rd bag of parodex in	
			progress.	
			for SW referral name	
			for psychiatric review on	
			Tuesday.	L Hargreaves
	2115		Settled evening	
		5	Observations Stable	
		6	2nd 8hourly bag of parodex in	
			progress @ 32mls/hr.	
			BM's Stable. 5.2mmols @ 1515.	J Mills
28/12	6am		Slept for long spells	
			iv parodex complete	
			Observations	
			No complaints	Karen Hines
	1200		Independent with personal hygiene.	
			SB Psychiatrist and may be discharged	
			if medically fit. Await Blood results.	
			Has an Social Worker.	
			Discharge letter to be completed.	
	1300		Complains of pain in abdomin. Patient	
			then felt dizzy and unwell. Patient	
			returned to bed. Hyperventilating +++.	
			O2 saturation 100% on air. BP and Pulse	
			stable. SB JMO - observe. Await Blood	
			results.	

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EVALUATION OF CARE

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
23/12/98	1620		LFT & Co-agulation screen within normal limits - Medically f.t for discharge. Dr McGuinness contacted GP for further Co-agulation screen on Wednesday	A Lumpe

[redacted] HOSPITAL

PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS			DOSE	ROUTE	TIMES FOR ADMINISTRATION										Prescribers Signature (Full)	DISCONTINUED	
Pharmacy Use	Date Started	MEDICINE (Block Capitals)			am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times		Date	Signed
	A																
	B																
	C																
	D																
	E																
	F																
	G																
REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED																	
	H																
	J																
	K																
	L																
	M																
	N																
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS — **DIET**

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
28/12/21		SALBUTAMOL NEBULE	5mg	NEB	[redacted]		

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE SENSITIVITIES	1.

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
L8	DIANE DONALD	15			112466D	Dr Fox

HOSPITAL

MEDICINE RECORDING SHEET No.

DATE	REGULAR PRESCRIPTIONS: 6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
27/12/98	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	
28/12/98											

DO NOT ENTER APPROPRIATE CODE FOR

NAME	UNIT NUMBER	WARD
Diane Donald		L8 Amo.

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. X = PATIENT ABSENT

FORM MR1.1090

(3)

PRESCRIPTION SHEET NUMBER ..... THIS DOCUMENT MUST BE RETAINED REFER OVERLEAF FOR INSTRUCTIONS

PATIENT'S NAME DIANE DONALD

HOSPITAL W.I.G UNIT NUMBER .....

WARD L8med D.O.B. .....

Prescriptions and Administration sheet for medicines given by Syringe / Infusion Pump
Each prescription must be completed fully and unambiguously. FULL SIGNATURE TO BE USED

1 PRESCRIPTION DETAILS (to be completed by DOCTOR before start of therapy)

MEDICINE(S)	TOTAL AMOUNT OF DRUG(S) in syringe / bag	DILUENT	TOTAL VOLUME in syringe / bag	DRUG CONC'N(S) (mg/ml)	ROUTE	TYPE SYRINGE PUMP OR INFUSION PUMP MODEL:	PRESCRIBERS SIGNATURE
PARVOLEX.	12.5ml	5% Dex.	250 ml	0-05	IV		mok.

2 FLOW RATE DETAILS (to be completed by DOCTOR and NURSING STAFF)

	Date	Start Time	Drug Dose per Hour	Required Flow Rate Setting	Prescribed by	Set by	Checked by
Initial rate	26/12	5.45	32ml	32ml	mok		
Change 1							
Change 2							
Change 3							
Change 4							

3 PREPARATION DETAILS (to be completed by DOCTOR or NURSING STAFF)

	Date	Time	Prepared by	Checked by	Set by	Checked by
Initial Prep.	26/12	12pm	[illegible]	[illegible]	[illegible]	
Rpt. 1	27/12	5pm	V McKune	[illegible]	[illegible]	[illegible]
Rpt. 2						
Rpt. 3						
Rpt. 4						

4 ADMINISTRATION CHECK (to be completed HOURLY by NURSING STAFF)

Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments	Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments
27/12	0700	250ml	ml	32ml	[illegible]	Commenced							
27/12	1450	110ml's	139	32ml	[illegible]								
27/12	1710	250	—	32MS	[illegible]								
27/12	2115	176	124	32MS	[illegible]								

5 DISCONTINUATION (Sign): ..... DATE: ..... TIME: .....

NOTE: IF THE 'BOOST' FACILITY OF A SYRINGE DRIVER IS USED, RECORD THIS IN THE 'COMMENTS' SECTION.

REF: PAS.1

(2)

4) 12.5 / 8 / 4.5

12.5 / 250 5

25g 12.5 / 25

PRESCRIPTION SHEET NUMBER ..... THIS DOCUMENT MUST BE RETAINED REFER OVERLEAF FOR INSTRUCTION

PATIENT'S NAME DIANE DONALD

HOSPITAL ..... UNIT NUMBER .....

WARD ..... D.O.B. .....

Prescriptions and Administration sheet for medicines given by Syringe / Infusion Pump
Each prescription must be completed fully and unambiguously. FULL SIGNATURE TO BE USE

1 PRESCRIPTION DETAILS (to be completed by DOCTOR before start of therapy)

MEDICINE(S)	TOTAL AMOUNT OF DRUG(S) in syringe / bag	DILUENT	TOTAL VOLUME in syringe / bag	DRUG CONC'N(S) (mg/ml)	ROUTE	TYPE SYRINGE PUMP OR INFUSION PUMP MODEL:	PRESCRIBERS SIGNATURE
PARUOLEX.	12.5 ml	5% DEX.	250ml	0.05	IV		MOK.

2 FLOW RATE DETAILS (to be completed by DOCTOR and NURSING STAFF)

	Date	Start Time	Drug Dose per Hour	Required Flow Rate Setting	Prescribed by	Set by	Checked by
Initial rate	26/12	1145	65ml	65ml	mok		
Change 1							
Change 2							
Change 3							
Change 4							

3 PREPARATION DETAILS (to be completed by DOCTOR or NURSING STAFF)

	Date	Time	Prepared by	Checked by	Set by	Checked by
Initial Prep.			MOK			
Rpt. 1						
Rpt. 2						
Rpt. 3						
Rpt. 4						

4 ADMINISTRATION CHECK (to be completed HOURLY by NURSING STAFF)

Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments	Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments
27/12	0250	250	0	65		Infusion commenced							
	0450	175	75	65									
	0540	64	186.	65									
	0700	0ml	250ml	65ml		Completed.							

5 DISCONTINUATION

(Sign): ..... DATE: ..... TIME: .....

NOTE: IF THE 'BOOST' FACILITY OF A SYRINGE DRIVER IS USED, RECORD THIS IN THE 'COMMENTS' SECTION.

REF: PAS

(1)

37.5
3.4
150

PRESCRIPTION SHEET NUMBER ..... THIS DOCUMENT MUST BE RETAINED REFER OVERLEAF FOR INSTRUCTION

PATIENT'S NAME DUNE DONALD

HOSPITAL ..... UNIT NUMBER .....

WARD ..... D.O.B. .....

Prescriptions and Administration sheet for medicines given by Syringe / Infusion Pump
Each prescription must be completed fully and unambiguously. FULL SIGNATURE TO BE USED

1 PRESCRIPTION DETAILS (to be completed by DOCTOR before start of therapy)

MEDICINE(S)	TOTAL AMOUNT OF DRUG(S) in syringe / bag	DILUENT	TOTAL VOLUME in syringe / bag	DRUG CONC'N(S) (mg/ml)	ROUTE	TYPE SYRINGE PUMP OR INFUSION PUMP MODEL:	PRESCRIBERS SIGNATURE
~~DRUG~~ PAROLEX	37.5ml	Dex. 5%	100ml	0.375 ~~mg/ml~~	IV		MOK.

2 FLOW RATE DETAILS (to be completed by DOCTOR and NURSING STAFF)

	Date	Start Time	Drug Dose per Hour	Required Flow Rate Setting	Prescribed by	Set by	Checked by
Initial rate	26/12	1.30pm	150ml	150ml	MOK		
Change 1							
Change 2							
Change 3							
Change 4							

3 PREPARATION DETAILS (to be completed by DOCTOR or NURSING STAFF)

	Date	Time	Prepared by	Checked by	Set by	Checked by
Initial Prep.						
Rpt. 1						
Rpt. 2						
Rpt. 3						
Rpt. 4						

4 ADMINISTRATION CHECK (to be completed HOURLY by NURSING STAFF)

Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments	Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments
27/12	0130	150	0	150									

5 DISCONTINUATION (Sign): ..... DATE: ..... TIME: .....

NOTE: IF THE 'BOOST' FACILITY OF A SYRINGE DRIVER IS USED, RECORD THIS IN THE 'COMMENTS' SECTION.

REF: PAS

Name: O. Donald Ward: L8 Date: 27-12-98 Case Record No.: 1124660

CARE PLAN

Date Goal Set	Time	1. BASIC CARE AND PERSONAL HYGIENE	Date Met	Signature
		Independent		
		Bed bath		
27/12	If	Assisted wash x one nurse		
27/12	If	Oral hygiene Maxthuroles post meals		
27/12	If	Pressure care - encourage change of position while in bed		
		2. NUTRITION		
		Fasting		
27/12	If	Normal Diet & free fluids		
		Special Diet		
		3. ELIMINATION		
		Independent		
		Commode		
27/12	If	Bedpan/~~urinal~~		
		4. MOBILITY		
		Fully independent/fully mobile		
		Minimal assistance (give details)		
27/12	If	Bed rest at present		
		Dependent (See movement and handling sheet - keep with patient)		
		5. OBSERVATIONS		
		Waterlow daily (if score is over 10+)		
27/12	If	TPR 4 only		
29/12	If	BP 4 only		
		Pain Score 4 only		
		Fluid Balance 24 only		
27/12	If	BM's 6 only		

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CARE PLAN

		[illegible]		
27/12	o/a	IV infusion: ½ Ponudex		
		Monitor		
		Catheter		
		Oxygen Therapy		
		Nebulisers		
27/12	o/a	IV access: • IV cannulae obsve 4hly • others		
		[illegible]		
		[illegible]		
27/12	✓	W.S.U.		
		[illegible]		
		[illegible]		
		Assess for dysphagia		
		Source/protective isolation (refer to Infection Control)		
		Blind/visually impaired		
		Deaf/hard of hearing		
		Anti-embolic stockings		
		Nurse escort when out of ward		
		[illegible]		

Initial Care Plan seen and agreed by patient: Yes ☐ N/A ☐

Signature of nurse: **Date:** ☐☐/☐☐/☐☐

BP, TPR and Pain Assessment Chart

Name: Diane Donald

Hospital No: 1124660

DOB: 16.12.83

Ward: 8 Consultant: DR Fox

1. PAIN SCORE 2. SEDATION SCORE 3. NAUSEA SCORE See reverse for scoring details.

DATE	27.12.98					28.12.98				
Time	6a	6	3PM	6	10	6	10	2	6	10
Pain Score	0	0	0	0	0					
Sedation Score	0	0	0	0	0					
Nausea Score	1	1	0	0	0					
TEMPERATURE C°										
BP										
PULSE										
RESPS	18	18	20		20					
SaO_2							100%			
Bowels										
Bm	6	1	5	4	6	2				

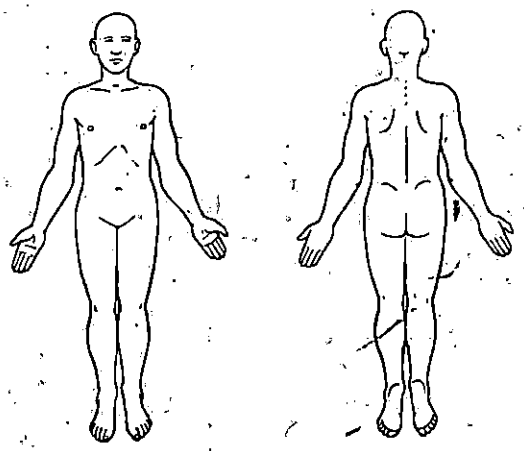
WEST GLASGOW HOSPITALS UNIVERSITY NHS TRUST

Name : D . Donald 5 Hospital Number : 1124

PRESSURE SORE RISK ASSESSMENT

TORRANCE GRADE OF PRESSURE SORE

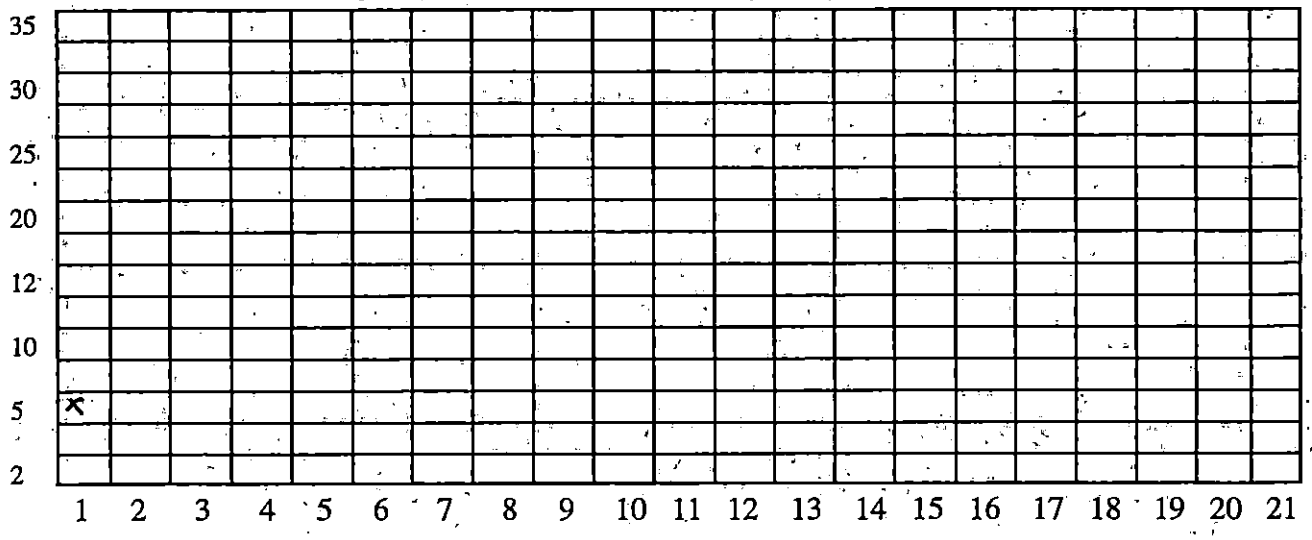
0 = no damage
1 = blanching hyperaemia (red area)
2 = non-blanching hyperaemia and/or superficial break
3 = ulceration progress through to meet subcutaneous tissue
4 = ulcer extends through fat to meet underlying muscle
5 = damage through muscle and/or necrotic tissue



DOCUMENT SEVERITY AND SITE OF PRESSURE DAMAGE ON ABOVE DIAGRAM

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

▲ Risk Assessment Scoring Graph



Waterlow Assessment

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

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

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

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

0568695MI

WEST GLASGOW HOSPITALS
UNIVERSITY NHS TRUST

PATIENT PROFILE

Ward: L8 MED Date: 20/12/98 Time: 12 30 mid/an (24hr clock)

PLEASE PRINT CLEARLY IN BLOCK CAPITALS

Title: MISS
Name: Dave Donald
Preferred name: Dave
Address: 70 wood avenue
Cadzebank

☎: 941 0232 Post Code: G81 4AP
DOB: 16/12/83 Age: 14.
Hosp. No: 1124660
Occupation: School
Religion: —
S.O.S. ☐ date: ☐☐/☐☐/☐☐
Interpreter required: ☐
(specify language _____)
Date arranged ☐☐/☐☐/☐☐
Lives alone ☐

1 NOK/Friend/Contact: Angela O'Neill
Address: SIA

☎Day: SIA Night: _____
Relationship: mother.
2 NOK/Friend/Contact: _____
Address: _____

☎Day: _____ Night: _____
Relationship: _____
NOK informed of admission ☑
NOK informed by: Patient
GP: Dr Rogerson
Address: Cadzebank H/C.
Kilbowie Road.
☎: _____

MEDICATION
With patient ☐
Stored & receipt given ☐
No medication required ☐
Taken home ☐
PERSONAL BELONGINGS
Clothing listed ☑
Valuables listed ☐
Valuables in ward ☐
Valuables in hospital safe ☐
House keys held by : _____
_____ (If req'd)

Consultant: Dr Hunter.
Named Nurse: SN Quinn
Admitting Nurse: SN Mahadar
Countersigned: _____
Relatives seen by Doctor ☐

REASON FOR ADMISSION Was taken in by mother for abdo. pain, felt depressed as she ran away from home 4 wks ago, so decided to take the whole bottle.
Patient's perception of illness:
aware.

Diagnosis:
Overdose of Ibuprofen.
(76 tablets approx.).

Operation/Treatment: Referred Enacol in A+E.
N/gastric.
U+Es. Psych. referral.
Salicylate/Paracetamol levels.
Relevant PMH: Nil of note.

OBSERVATIONS ON ADMISSION

Temperature	36.6 °C
Pulse	130 bpm
BP	124/80.
Resp	not counted.
Pain Score	
Urinalysis	large Protein, large ketones
Waterlow Score	4.
Height	m
Body Mass Index	
Blood sugar (if appropriate)	mmols

ALLERGIES Yes ☐ No ☑
details: _____

0568763MI

Name: Diane Donald Ward: [illegible] Case Record No: 1126660

ACTIVITIES OF DAILY LIVING

COMPLETE FOR PATIENTS WHOSE DURATION OF STAY IS IN EXCESS OF 48 HOURS (OR IF RELEVANT)

HOME CIRCUMSTANCES/ SOCIAL SUPPORT

- Lives with family ☑
- Lives alone ☐
- Elderly/disabled partner ☐
- Able/safe to cook/use appliances y ☐ n ☐
- Type of accommodation: _____

- Stairs: Internal ☐ External ☐
- Comments: _____

- Nursing home ☐
- Residential care ☐
- Family support (specify below)

- District Nurse ☐☐☐☐☐☐☐
- (cancelled ☐)
- Home help ☐☐☐☐☐☐☐
- (cancelled ☐)
- Other services (specify below) ☐

NUTRITION

- Normal menu (includes vegetarian) ☑
- Vegan ☐ Child's menu ☐
- Halal ☐ Kosher ☐
- Refer to Dietitian if any below ticked:
- Difficulty with eating/swallowing ☐
- Any recent weight changes ☐
- Medically related nutrition problems (e.g. diabetes) ☐
- Other (specify): _____

BREATHING

- 1. No symptoms ☑
- 2. Breathless with moderate exercise ☐
- 3. Breathless with minimal exertion ☐
- 4. Breathless at rest ☐
- 5. Uses inhalers ☐
- Comments: _____

SMOKING

- Non-smoker ☑
- Smoker: _____ per day ☐
- Ex-smoker ☐ Stopped: ☐☐/☐☐/☐☐
- Aware of hospital policy ☐

MOBILITY (Pre admission)

- Mobile without aid ☑
- Mobile with aid ☐
- (Specify type/side held: _____)

- Furniture walking ☐
- Chair Bound ☐
- Housebound ☐

ELIMINATION

- Bowels regular ☑
- (specify) _____
- Constipated ☐
- Diarrhoea/Loose stools ☐
- Uses aperient ☐
- Has stoma ☐
- Colostomy ☐ Urostomy ☐
- Ileostomy ☐ Ileal Conduit ☐
- Appliances used: _____

- Frequency of micturition ☐
- Incontinent: urine/faeces/both ☐
- day/night ☐
- stress ☐
- Uses incontinence aids ☐
- Type used: _____

- No urinary symptoms ☑
- Comments: _____

SLEEP

- Hours/night ☐
- Medication ☐
- details: _____

MENTAL STATE

- Alert/Orientated ☑
- Confused: day/night ☐
- Anxious/Distressed ☐
- Unconscious ☐
- Aggressive/Abusive ☐
- Other _____

SENSES

Registered blind		☐
Visually impaired:	left/right/both	☐
Glasses:	distance	☐
	reading	☐
Hearing impaired:	left/right/both	☐
Hearing aid:	left/right/both	☐
Dentures:	upper	☐
	lower	☐

Other:

HYGIENE

Bath	☐ Shower	☐
Stand up wash		☐
Independent		☑
Requires assistance		☐

Skin assessment:

Other:

RELATIVE PARTICIPATION ☐

ALCOHOL INTAKE

Inappropriate/relevant on admission		☐
Units/week:	nil	☑
	less than 14	☐
	14 - 21	☐
	over 21	☐

(1 unit = 1 measure spirits/half pint beer/lager/1 glass wine)

PROFILE COMPLETED BY:

(Please print name in block capitals)

ROSA MACFARLANE

Signature:

Designation: SN

Countersigned (if applicable):

Designation:

OTHER RELEVANT INFORMATION

Name: Byrne · Donald ·

Ward: 28 Med Date: 21/2/98 Case Record No: 1126660

EVALUATION OF CARE (each shift)		
1. Basic Care and Hygiene	5. Movement and Handling	9. Wound Care
2. Nutrition	6. Special Needs	10. Specimens/Investigations
3. Elimination	7. Observations	11. Sleep
4. Mobility	8. Technical Care	

DATE	TIME	No	EVALUATION AND PROGRESS OF CARE	SIGNATURE
21/2/98	1 Am		Settled on admission	/
			c/o IV fluids & hungry.	dno
			tachycardic.	dnoland
	530 am		fairly settled.	
			c/o pain in lower	
			back & abdomen.	
			urine foul smelling &	
			cloudy. ? UTI. MSSU	
			obtained.	
			IV fluids 4 hourly.	dnoland
		AM	Care ap plan	
		3.	NPU'd this am	
			All urine to be	
			tested please.	
		7	Observations stable	
			IVs to be discontinued	
			Encourage fluid intake	K Cobain
	9PM		Care as plan	
			Urine supervised -	
			trace protein +	
			keytones - no blood	
			SIB Dr Guadango.	
			U/E's df - to IV fluids	
			4 hourly	
22/2/98	6am		Slept well.	
			IV fluids 4 hourly.	dnoland
	11a		Care as plan.	
			Up + about -	
			IV fluids discontinued	
			venflon out.	
			c/k. Awaiting U/E's	
			if ok to leave pending	
			renal review.	
		-	To D/C home	

HOSPITAL

PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	mid 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Sign
	A																
	B																
	C																
	D																
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H	Trimethoprim	200mg	PO		✓					✓						
	J																
	K																
	L																
	M																
	N																
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
	4						

DIET

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION		
INSULIN		FLUID/ADDITIVE
ORAL ANTICOAGULANT		ANAESTHETIC
TOPICAL APPLICATION		VARIABLE DOSE

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
L8M.	Diane Donald	1445			1124669	Hunter.

KNOWN MEDICINE SENSITIVITIES 1.

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

DATE	REGULAR PRESCRIPTIONS																								COMMENTS ON DISCREPANCIES
	6 a.m.			8 a.m.			10 a.m.			12 m.d.			2 p.m.			4 p.m.			6 p.m.			10 p.m.			12 m.n.			OTHER TIMES			
			Initial			Initial			Initial			Initial			Initial			Initial			Initial			Initial			Initial	

NAME	UNIT NUMBER	WARD
Diane Donald	1124660	L8med

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. ✗ = PATIENT ABSENT

FORM MR1

Name: Donald Ward: L&med Date: 21/2/98 Case Record No:

CARE PLAN

DATE COMM.	SIGNATURE	1. BASIC CARE AND PERSONAL HYGIENE	DATE DISC.	SIGNATURE
20/2/98	dm	Independent ✓		
		Bed bath		
		Assisted wash		
20/2/98	dm	Oral hygiene ✓ offe to oral/denture/teeth		
		Pressure care		
		2. NUTRITION		
		Fasting		
20/2/98	dm	Normal Diet ✓		
		Special Diet		
20/2/98	dm	3. ELIMINATION		
		Uprotoner.		
		4. MOBILITY (If requires assessment more than once use Individual Movement & Handling Care Plan)		
		Fully independent		
		Independent with supervision		
		Independent with aids: details		
		Partially dependent: see 5 below		
		Fully dependent: see 5 below		
		Other:		
		5.MOVEMENT AND HANDLING		
		Toiletting:		
		Bathing:		
		Moving in Bed:		
		Chair transfers:		
		Other:		
		IF A HOIST OR SLING IS USED, PLEASE INDICATE THE TYPE AND SIZE		
		6. SPECIAL NEEDS		
		Assess for dysphagia		

CARE PLAN

DATE COMM.	SIGNATURE	7. OBSERVATIONS	DATE DISC.	SIGNATURE
		Waterlow daily (if score is over 10+)		
21/2/98	dr	TPR		
"	dr	BP		
		Pain Score		
		Fluid Balance		
		8. TECHNICAL CARE		
2012-	dr	IV infusion: Chymodactics vaffed at	22/2	
		Monitor		
		Catheter		
		Oxygen Therapy		
		Nebulisers		
	dr	IV access: • IV cannulae ✓ R hand, • others		
		9. WOUND CARE		
		10. SPECIMENS/INVESTIGATIONS		
21/2/98	dr	Urine ✓ large Protein large Ketones		
		MSU - 4pm 21/2/98 protein + keytones trace		
		11. SLEEP		

Initial Care Plan seen and agreed by patient: Yes ☐ N/A ☐

Signature of nurse: _____ Date: ☐☐/☐☐/☐☐

TIME	INTAKE				OUTPUT					
	PARENTERAL		Oral/ Nasogastric	Oral/NG Running Total	URINE	Urine Running Total	SECRETIONS			
	TYPE	AMOUNT					Vomit/ NG ASP	Wound Drain		
08-09										
09-10										
10-										
11-										
12-										
1 p.m.										
2-										
3-										
4-										
5-										
6-										
7-										
8-										
9-										
10-										
11-										
12-										
1 a.m.										
2-										
3-										
4-										
5-										
6-										
07-08										
TOTALS										
	TOTAL INTAKE ml				TOTAL OUTPUT ml					

NAME Diane Donald

HOSPITAL NO. 22/2/98.

	NEG	POS
BALANCE		

ml

WEST GLASGOW HOSPITALS UNIVERSITY NHS TRUST

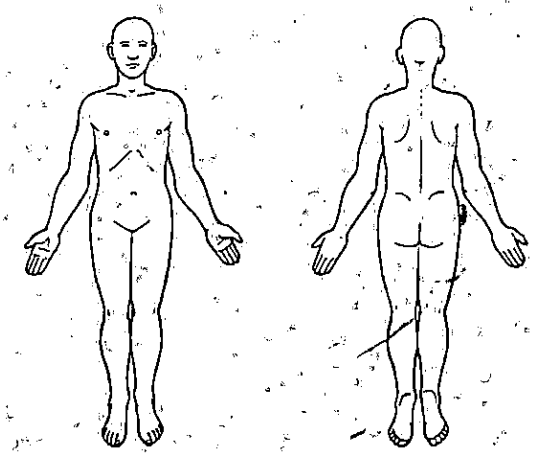
Name : Dane Donald Howard

Hospital Number : N246660

PRESSURE SORE RISK ASSESSMENT

TORRANCE GRADE OF PRESSURE SORE

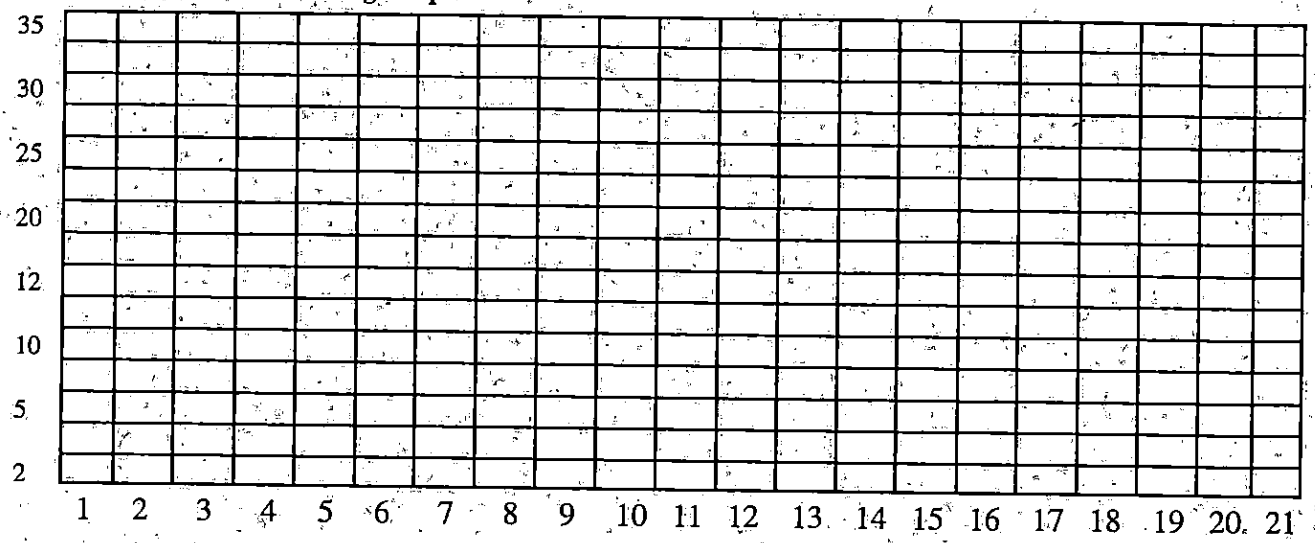
0 = no damage
1 = blanching hyperaemia (red area)
2 = non-blanching hyperaemia and/or superficial break
3 = ulceration progress through to meet subcutaneous tissue
4 = ulcer extends through fat to meet underlying muscle
5 = damage through muscle and/or necrotic tissue



DOCUMENT SEVERITY AND SITE OF PRESSURE DAMAGE ON ABOVE DIAGRAM

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

▲ Risk Assessment Scoring Graph



Waterlow Assessment

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

Build/ Weight for Height	
Average	0
Above Average	1
Obese	2
Below Average	3

Appetite	
Average	0
Poor	1
NG Tube/ Fluids Only	2
Nil by mouth	3
Anorexic	3

Skin Type (Visual Risk)	
Healthy	0
Tissue Paper	1
Dry	1
Oedematous	1
Clammy (Temp ↑)	1
Discoloured	2
Broken Spot	3

Continence	
Complete/catheterised	0
Occasional incontinence	1
Cath/faecal incontinence	2
Doubly Incontinent	3

Mobility	
Fully	0
Restless	1
Apathetic	2
Restrictive	3
Inert/Traction	4
Chairbound	5

Sex	
Male	1
Female	2
14 - 49	1
50 - 64	2
65 - 74	3
75 - 80	4
81+	5

Major Surgery/Trauma	
Orthopaedic	5
Below waist/spinal	5
On operating table > 2hours	5

Special Risks	
Tissue Malnutrition e.g.	
Terminal Cachexia	8
Cardiac Failure	5
Peripheral Vascular Disease	5
Anaemia	2
Smoking	1

Medication	
Cytotoxics	4
High dose steroids	4
Anti-inflammatory drugs	4

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

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

BP, TPR and Pain Assessment Chart

Name: Diane Donald

Hospital No: 1124660

DOB: 16/12/83.

Ward: L8 medicine Consultant: Dr. Hunter

1. PAIN SCORE 2. SEDATION SCORE 3. NAUSEA SCORE See reverse for scoring details.

DATE	21/2/98				22/2/98																			
Time	9a	1a	11	10 pm	12				10															
Pain Score	2	0	1	0																				
Sedation Score	0	0	0	0																				
Nausea Score	0	0	0	0																				

TEMPERATURE C°: 40, 39, 38, 37, 36, 35

BP: 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30

PULSE

RESPS

SaO_2

Bowels

0062303MI

WEST GLASGOW HOSPITALS UNIVERSITY NHS TRUST

In Pat. Form 6b

NAME

HOSPITAL No.

AGE

SEX

PHYS.

DEPT.

SURG.

WARD

CUMULATIVE FLUID BALANCE SHEET

"Balance" = Intake minus measured losses
i.e. excludes insensible loss.

Date	Total Intake	Total Output	Daily "Balance"		Cumulative "Balance"		Weight
/ / / /	ml.	ml.	Pos. ml.	Neg. ml.	Pos. ml.	Neg. ml.	Kg.
20/2/98							
21/2/98	2650	600					

West Glasgow Hospitals University NHS Trust

IN.PAT. FORM 6 A

FIRST SIDE

NAME HOSPITAL No.

AGE

SEX

PHYS. DEPT.

SURG. WARD

24HR FLUID BALANCE AND PRESCRIPTION SHEET

DATE FROM

FLUID	Amount	Time to run	ADDED DRUGS	Doctor's Signature	Added by	Time began	Put up by	Serial or Batch No.
(N) Saline	500	4°	—	J Sinclair		17⁰⁰	R	98A 16BY
5% Dextrose	500	4°	—	J Sinclair		21⁰⁰	R	99L 23BY
5% Dextrose	500	4°	—	J Sinclair		1030 pm	dr	
(N) Saline	500	4°	—	J Sinclair		330 am	dr	

21/2/98

22/2/98

OTHER ORDERS

60 drops per min = 500 ml in 2 hours

0062444MI

GRH

TIME	INTAKE				OUTPUT					
	PARENTERAL		Oral/ Nasogastric	Oral/NG Running Total	URINE	Urine Running Total	SECRETIONS			
	TYPE	AMOUNT					Vomit/ NG ASP	Wound Drain		
08-09			150							
09-10			100	250	NPU					
10-										
11-			NIL	250	NPU					
12-										
1 p.m.										
2-					250	protein + trace ketones no blood				
3-										
4-										
5-			150.	400						
6-										
7-										
8-			250	650.	0					
9-	NaCl	500.								
10-					0.					
11-	nacl	500	.200	850	NPU	250				
12-										
1 a.m.										
2-			100	950.	NPU	250				
3-	IV 5% Dex	500			350	600				
4-										
5-										
6-	Ivrace	200								
07-08	ven can	our.								
		1700		950						
TOTALS		1900								
		TOTAL INTAKE 2650 ml			TOTAL OUTPUT 600 ml					

NAME Dane Donald

HOSPITAL NO. 21/2/98

	NEG	POS
BALANCE		

ml

WL CARD - ENT, FLOOR 5, GGH 27/11 1030 GGH I/P

SURNAME	Donald	HOSPITAL No	1124660
FORENAME	Diane	D.O.B	16/12/1983
ADDRESS	62 Stewart Drive	CONSULTANT	DGC
	Clydebank	G.P.	Rogerson
	G81 6AG	GP PRACTICE	40224
TEL No	077529 30651	SHORT NOTICE	Yes
		AMBULANCE	No

DIAGNOSIS

754.0 Congenital Nasal Septum Deviation

477.9 Vasomotor Rhinitis

PROCEDURES

E03.6 Septoplasty

E04.1 Bilateral Submucous Diathermy To Turbinate

COMMENTS

DATE ON WAITING LIST 30/08/2001 | STATUS NON-URGENT