Legal Aspects Team
Health Records Department
Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN

NHS
Greater Glasgow and Clyde

MMA Legal Limited
Stok
43-59 Princes Street
Stockport
SK1 1RY

Date: 19th May 2026
Your Ref:
Our Ref: LAT/ACCESS/SB
Enquiries to: Samantha Barka
Direct Line: 0141 211 0151
Email: samantha.barka2@nhs.scot

Dear Sir/Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: ALAN FLETCHER D.O.B: 30.12.1987

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

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

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

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

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

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

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

- Complaints files
- Emails

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

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

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

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

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

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

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

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

Yours sincerely

Legal Aspects Team

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 CARE AMBULATORY HOSPITAL	☑		
WESTERN INFIRMARY RECORDS	☑		

(1) of 2

Including:

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

PRE-ASSESSMENT LIVER CLINIC

NHS Greater Glasgow and Clyde

DATE: 20/3/25

3012876456
FLETCHER
Alan
12 POLQHUAP RD
Glasgow, Lanarkshire
G53 7F

M
30/12/1987

Dr. GS Watson
Crookston Medical Practice
230 Dalmellington Road
Crookston
Glasgow
G53 7FY

Tel no: 07542465184.

Referral source: GP ref.

Reason: HFE - Compound heterozygote

P:
BP:

Weight: 81.3kg
Height: 6ft 1
BMI: 23

Past Medical History:

Asthma

New Prescriptions since referral

Nil

Non – Prescribed Medicines

Nil

Vaccinations:

HEP B:
Full partial nil don't know
HEP A:
Full partial nil don't know

Allergies:

NO

Symptoms:	Date/Details
Jaundice	☑ NO
Swelling of abdomen	☑ NO
Loss of appetite	☑ NO - not by eater
Weight loss/weight gain	☑ Weight gain - small amount.
Abdominal pain	☑ NO
Confusion	☑ NO
Bruising	☑ NO
Fever	☑ NO
Feeling generally unwell/malaise	☑ recent cold
Fatigue	☑ Yes - all the time
Itching	☑ No
Vomiting/haematemesis	☑ NO
Diarrhoea	☑ NO
What colour is your stool?	normal
Ankle swelling	☑
Joint pain	☑ Back pain, legs.
Problems with your mood	☑ NO.

Smoker Y/(N) If yes, how many per day:

3012876456
FLETCHER
Alan M
12 POLQHUAP RD 30/12/1987
Glasgow, Lanarkshire
G53 7F

Alcohol intake:

1. Current

- How many days a week do you drink____,
- Where do you drink (home, pub...) _____
- What do you drink_____, ~~one/two Beers~~ In 1 week.
- How many drinks do you have each day____
- Units_____
- How long have you drunk this amount _____

2. Past

How many days a week do you drink ____
What do you drink _____
How many drinks do have each day____/____units
How long did you drink that amount _____ Nil

Recreational Drug Use: Y (N)

Travel Abroad: (Y) N

Europe.

Social Circumstances:

live with wife (x3 children) (x1 18yr old)

Family History:

(?mum died)

Are your parents alive: Y / N.

What was the cause of their death? (adopted).

Have your parents ever had liver problems? /

Do you have siblings? (Y)/N: Details: ~~NIL~~ x 5 siblings.

Have they ever had any liver problems? (Not sure. adopted)

Patient Education:

Liver inflammation ☐ Progression of liver disease ☐ Finding Information – BSL/ Leaflets

HFE gene	✓	(Elevated ferritin/Iron studies) (HFE-compound)
ECG if Ferritin >1000		(Haemochromatosis patients only)
Sex hormones		(Haemochromatosis patients with low libido)

Investigations:

	Date of last Investigation	Investigation Organised
Ultrasound		
Endoscopy		
Fibroscan	4.4 kPa	9/10.

Checklist :

Advise on weight reduction ☐ Refer Weight management ☐

Advise on alcohol reduction ☐ Refer Addiction liaison ☐

For consultant appointment ☐ For Virtual Liver Clinic ☑

CNS performing assessment: Name: K Sensan

Sign: [signature] Date: 20/3/25

Previous Patient Notes for Endocrinology (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: 12-May-2026 15:04	**Created By:** Consultant - Endocrinology - Marie Freel1	**Role:** Doctor - GGC
Specialty: Endocrinology	**Organisation:**	Sensitive
Note: Nil to add to EDL 02/12/25		

Previous Patient Notes for Clinical Pharmacology & Therapeutics (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		**Inpatient Note**
Date/Time: 06-May-2026 19:20	**Created By:** Consultant Clinical Pharmacologist and Acute Physician - Linsay McCallum	**Role:** Doctor - GGC
Specialty: Clinical Pharmacology & Therapeutics	**Organisation:**	Sensitive
Note: FDL 30/12/25 nil to add to EDL		

Previous Patient Notes for Gastroenterology (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		**MDT Note**
Date/Time: 03-Apr-2025 12:41	**Created By:** Consultant in Gastroenterology and Hepatology - Rachael Swann	**Role:** Doctor - GGC
Specialty: Gastroenterology	**Organisation:**	Sensitive
Note:		
Liver mDT: Compound heterozygote - normal Ferritin low T Satns normal LFTs and fibroscan. Encourage to donate blood (he is keen to do this) annual virtual review for next 5 years then review at MDT.		

NEWS 2 Key | 1 | 2 | 3

3012876456
FLETCHER
Alan
12 POLQHUAP RD
Glasgow, Lanarkshire
30/12/1987 M
G53 7FL

Date	1/11	20/1[illegible]		
Time	11.00	16.05		
A + B Respirations Breaths/min			≥25	3
			21-24	2
	•	18	12-20	0
			9-11	1
			≤8	3
A + B SpO2 Scale 1 Oxygen saturation (%)	97	99	≥96	0
			94-95	1
			92-93	2
			≤91	3
SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure			≥97 on O2	3
			95-96% on O2	2
			93-94% on O2	1
			≥93 on air	0
			88-92	0
Only use scale 2 under direction of qualified clinician			86-87	1
			84-85	2
			≤83	3
Air or oxygen?	A	(A)	Air (A) or O2 device*	0
			O2 L/min 2	2
C Blood Pressure mmHg (Score uses systolic BP only)			≥220	3
			201-219	0
			181-200	0
			161-180	0
	↑		141-160	0
		118	121-140	0
			111-120	0
			101-110	1
	↓		91-100	2
			81-90	3
		95	71-80	3
			61-70	3
			51-60	3
			≤50	3
C Pulse Beats / min			≥131	3
			121-130	2
			111-120	2
			101-110	1
			91-100	1
			81-90	0
	•	8[illegible]	71-80	0
			61-70	0
			51-60	0
			41-50	1
			31-40	3
			≤30	3
D Any changes in neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.	•	•	A Alert	0
			C New Confusion	3
			V Verbal	3
			P Pressure	3
			U Unresponsive	3
E Temperature			≥39	2
			38.1-39.0	1
			37.1-38.0	0
	•	[illegible]	36.1-37.0	0
			35.1-36.0	1
			≤35.0	3
NEWS Total	0			
Blood glucose	7.0			
Pain / function score	OA			
Time Pt last passed urine	10.20			
Fluid balance chart indicated Y/N	N			
GCS indicated Y/N	N			
Time NEWS due	23.00			
Escalation of care Y/N	N			
Initials	AB			

Abbreviations for recording oxygen device

A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and % eg. V24
NIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
RM	Reservoir Mask (Emergency use only)

3012876456
FLETCHER
Alan
12 POLQHUAP RD
Glasgow, Lanarkshire
30/12/1987 M
G53 7FL

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE

A **Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.**

C **Communicate:** Inform nurse of plan. Inform senior medic if necessary. Document the discussion.

E **Escalate:** Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

NHSGGC Adult In-Patient National Early Warning Score (NEWS)

NHS Greater Glasgow and Clyde

3012876456
FLETCHER
Alan M
30/12/1987
12 POLQHUAP RD
Glasgow, Lanarkshire
G53 7FL

	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:..............................

Glasgow Coma Scale

Pupil Reaction and size: s = sluggish; + = reaction; - = no reaction; c = eyes closed

Pupil Size (mm): 1 2 3 4 5 6 7 8

Date: / Time:

EYES — Eyes closed by swelling = NT: 4 Spontaneously, 3 To sound, 2 To pressure, 1 None, NT Not testable

VERBAL — Endotracheal tube or tracheostomy = NT: 5 Orientated, 4 Confused, 3 Words, 2 Sounds, 1 None, NT Not testable

MOTOR — Always record the best response: 6 Obeys commands, 5 Localising, 4 Normal flexion, 3 Abnormal flexion, 2 Extension, 1 None, NT Not testable

TOTAL 15

PUPILS — Right size: / Right reaction: / Left size: / Left reaction:

ARMS — Record right (R) and left (L) separately if there is a difference between the two sides: Normal power, Mild weakness, Severe weakness, Spastic flexion, Extension, No response

LEGS — Record right (R) and left (L) separately if there is a difference between the two sides: Normal power, Mild weakness, Severe weakness, Spastic flexion, Extension, No response

3012876456
FLETCHER
Alan M
30/12/1987
12 POLQHUAP RD
Glasgow, Lanarkshire
G53 7FL

Pain Function Score

A — No limitations, activity unrestricted by pain or settles quickly
B — Mild limitations, mild activity restrictions
C — Moderate limitations, attempts but reluctant to continue because of pain. Seek Advice
D — Severe limitations, unable to or refuse to perform because of pain. Urgent Review Required

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

No Pain	Mild Pain			Moderate Pain			Severe Pain			
0	1	2	3	4	5	6	7	8	9	10

MI • 316654 v5.2 GGC0264

NHS GGC Hospitals, Admission Document

NHS Greater Glasgow and Clyde

CHI: 3012876456

Queen Elizabeth University Hospital

Total Att: **24**

12 Mth Att: **2**

Title: **MR**

FLETCHER **Alan**

DOB: **30/12/1987** Age: **38y** Sex: **Male**

12 POLQHUAP RD

Glasgow
Lanarkshire
G53 7FL
07542965184

Next of kin: **SMITH, Ricky**
Relationship: **Friend**
07774417777

GP: **GS Watson**
0141 883 8887

Attendance Date: **30/12/2025** Arrival Time: **15:31**

Registration Time: **15:31** Date of Incident: **30/12/2025**

Major Incident Desc:

Reason for Attendance: **LEFT SIDED CHEST PAIN**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

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

Presenting Complaint: **Chest Pain**

Observation Date: **30/12/2025 16:09** Nurse name: **Nurse Katy MacNeil**

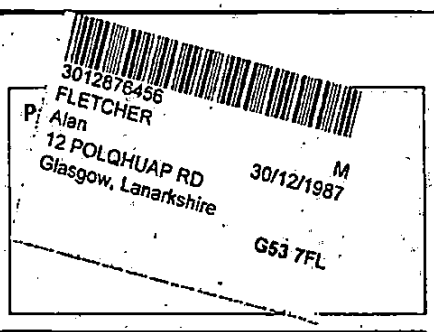
RR	**18**	bpm
Oxygen		%
Air or O2		
SpO2	**99**	%
HR	**81**	bpm
BP	**118/95**	mmHg
CRT		
MAP	**103**	mmHg
AVPU		
Temp	**35.7**	C
EWS Total		

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: **LEFT SIDED CHEST PAIN, SOB NO RADIATION FOR PAST WEEK HX ASTHMA**



Date	Emergency Department Notes	
	Ambulance Proforma reviewed Yes / No Seen by (Doctor)	Time seen

Pati 3012876456 M
FLETCHER 30/12/1987
Alan
12 POLQHUAP RD
Glasgow, Lanarkshire G53 7FL

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Differential Diagnosis/Problem List

NEWS ☐ 0-7

RED FLAG ☐ (Tick)

SEPSIS ☐

CURB 65 ☐

Done/ completed	Immediate Managment Plan

Signature: Designation: Page No:

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

Pat
3012876456
FLETCHER M
Alan 30/12/1987
12 POLQHUAP RD
Glasgow, Lanarkshire
G53 7FL

Seen By: Print: S Thomas Time Seen: 19:00 Pg. No:
PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	PC – Chest pain
History of presenting complaint	38 yr old – presented with left sided chest pain that started on Christmas Eve. Sharp in nature occasionally Feels like a pressure in the chest, worse on movement, bending over, catches on taking a deep breath in. Does not feel particularly SOB. No haemoptysis states 2 year old son sleeps next to him and doesn't know if locked in sleep. No cough, no palpitations, no fever, no leg swelling, no calf tenderness. Does not feel tender on palpation, was here yesterday & waited about 7 hours & left, today pain unbearable so came back in. Took Ibuprofen which was not helping with the pain.

Past Medical History / Review of portal
Asthma.

Systemic Enquiry

Patie

3012876455
FLETCHER M
Alan 30/12/1987

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	

Allergies	List any over-the-counter or alternative medicines
	Do medicines need further clarification? ☐ Yes ☐ No
List collected by :	Plan approved by :
Designation : Date :	Designation : Date :

Pharmacy review	Comments

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

Patie 3012876456
FLETCHER
Alan
12 POLQHUAP RD
Glasgow, Lanarkshire
G53 7FL
M
30/12/1987

Social History \ Family History

Smoking History

Ex-smoker/Smoker _____ cpd _____ yrs ☑ Never smoked

Alcohol History Occasional

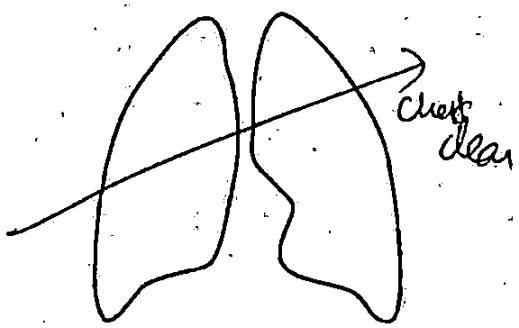
_____ Units/week FAST score if excess _____

Recreational Drugs **Driving Status**

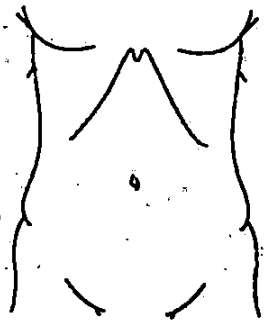
Social Circumstances (home, supports, functional status, occupation, travel) Works as a sound engineer, requires heavy lifting, independent with ADLs

General Examination		General Appearance:
Temp: 35.7°C	RR: 18	Looks comfortable at rest
Pulse: 81	CBG:	
SpO_2: 99% on air	Weight:	
BP: 118/95	Urinalysis:	

Respiratory



Gastrointestinal System



Cardiovascular

HS1+11+0.

Locomotor

Patie
3012876456
FLETCHER M
Alan 30/12/1987
12 POLQHUAP RD
Glasgow, Lanarkshire
G53 7FL

Neurological system

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

AMT 4 = age, DOB, place, year

AMT score 4/4

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

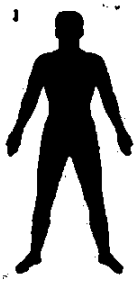
Pupils/fundoscopy: PEARL

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck: No neck stiffness / tenderness

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

No leg swelling, no calf tenderness

Pati

3012876456
FLETCHER M
Alan 30/12/1987
12 POLQHUAP RD
Glasgow, Lanarkshire
G53 7FL

Key Results

CXR ECG

(Differential) diagnosis

?MSK pain
R/O ACS / PE

NEWS ☐
Red Flag ☐
Sepsis ☐
CURB 65 ☐

Management Plan

Bloods
CXR
If troponin, d-dimer -ve patient can be discharged home with reassurance, worsening advice & some simple analgesia

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

Signature: PRINT NAME S Thomas
PRINT GRADE Locum ST0 Page:

Patie

3012876456
FLETCHER M
Alan 30/12/1987

Resuscitation Decision

Resuscitation status: FOR RESUSCITATION / DNA CPR
(please circle)

If DNA CPR → Complete appropriate form

Senior Medical review

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

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

Pa
3012876456
FLETCHER
Alan M
12 POLQHUAP RD 30/12/1987
Glasgow, Lanarkshire
G53 7FL

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 _____

3012876456
FLETCHER M
Alan 30/12/1987
12 POLQHUAP RD
Glasgow, Lanarkshire
G53 7FL

Results

Date									
Time									
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165								
WCC	4.0 - 11.0								
Plts	150 - 450								
MCV	80 - 100								
Neut	2.0 - 7.5								
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								
K+	3.5 - 5.3								
Cl-	95 - 108								
HCO3-	22 - 29								
Urea	2.5 - 7.8								
Creat	40 - 130								
eGFR									
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50								
AlkP	30 - 130								
Bil	<20								
ALT	<50								
AST	<40								
GGT	Male: <70 Female: <40								
ESR	Male: 1 -10 Female: 1 - 12								
CRP	<10								
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								

Pati
3012876456
FLETCHER
Alan
M
30/12/1987
12 POLQHUAP RD
Glasgow, Lanarkshire
G53 7FL

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO_2:

FiO2:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

3012876456 M
FLETCHER 30/12/1987
Alan
12 POLQHUAP RD
Glasgow, Lanarkshire G53 7FL

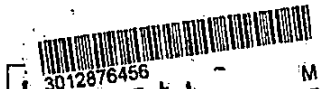
Continuation Sheet

Date: Time	

3012876456
FLETCHER M
Alan 30/12/1987
12 POLQHUAP RD
Glasgow, Lanarkshire
G53 7FL

Continuation Sheet

Date: Time	



3012876456 M
FLETCHER [redacted]
Alan 30/12/1987
12 POLQHUAP RD
Glasgow, Lanarkshire
G53 7FL

Continuation Sheet	
Date: Time	

P: 3012876456
FLETCHER
Alan M
12 POLQHUAP RD 30/12/1987
Glasgow, Lanarkshire
G53 7FL

Continuation Sheet

Date: Time	

P 3012876456 M
FLETCHER 30/12/1987
Alan
12 POLQHUAP RD
Glasgow, Lanarkshire G53 7FL

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

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

Patient Had Covid

Hospital use only	Clinic	Day / Date	Time	Hospital No.

REFERRAL LETTER

MEDICAL IN CONFIDENCE

2021 GGC General Referral Protocol

Additional Support Needs:
No known ASN requirements

REFERRAL TO

General Medicine - Hypertension
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
Date of referral 29-Dec-2025 **Date sent** 29-Dec-2025

PATIENT DETAILS

Surname	Fletcher
Forename(s)	Alan
Title	Mr
Sex	Male
Date of birth	30-Dec-1987
CHI no.	3012876456
Area of Residence	-

Patient's address

12 Polqhuap Rd
GLASGOW
G53 7FL

Contact number(s)

Voice: 07542965184

101038628346B Unique Care Pathway Number: 101038628346B

REGISTERED GP DETAILS

Name	Dr Gary Watson		
GMC code	6104661	GP code	01759
Practice name	Crookston Medical Centre (18972)		
Practice code	52344		

Practice address

Crookston Medical Centre
230 Dalmellington Road
Glasgow
G53 7FY

Contact number(s)

Voice: 0141 883 8887
Facsimile: 0141 891 4400

REFERRING GP DETAILS

Name	Dr Gary Watson		
GMC code	6104661	GP code	01759
Practice name	Crookston Medical Centre (18972)		
Practice code	52344		

Practice address

Crookston Medical Centre
230 Dalmellington Road
Glasgow
G53 7FY

Contact number(s)

Voice: 0141 883 8887
Facsimile: 0141 891 4400

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: chest pain

Comment: Dear Doctor
many thanks for seeing Alan, he awoke on Christmas eve with left sided sharp chest pains on background of asthma. it is probably worse on certain movements. He isn't sob per se but breathing is restricted. there is no chest wall tenderness. o/e bp 131/76. p68, t 36.3 sats 99%. hs normal chest clear. I suspect it is MSK but given nature of his pain feel cxr at least is needed here +/- ddimer

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]Injury of unspecified nerve at wrist and hand level	-	28-Nov-2023	28-Nov-2023
Fracture of metacarpal bone	(Right) Avulsion # base of 5th Metacarpal	25-Jan-2017	25-Jan-2017
Asthma	-	01-Feb-2003	01-Feb-2003
Asthma NOS	Disease: SPICE Asthma Opening,	01-Jan-2003	01-Jan-2003
[Q] Salter-Harris II	fracture right 1st metacarpal	16-Sep-2002	16-Sep-2002

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
Salbutamol Cfc-free Inhaler 100 micrograms/puff	1	1 inhaler	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY		09-Dec-2025	09-Dec-2025

Blood Pressure

Date Recorded	Systolic	Diastolic
23-Aug-2024	123	74
15-Jun-2012	138	72
13-Apr-2010	110	65

Body Measurements

Date Recorded	Height	Weight	BMI
18-Nov-2024	184	75	
13-Apr-2010	184	-	
19-May-2008	183	59.7	
19-Nov-2007	183	58.4	
22-Nov-2006	182	60.3	

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Never smoked tobacco:		18-Nov-2024
Never smoked tobacco:		17-Apr-2024
Never smoked tobacco:		27-Feb-2013
Never smoked tobacco:	Smoker$$ Status.dm - No Action Required	24-Feb-2010
Never smoked tobacco:	Recorded through Combined Vaccination priority=2	22-Oct-2009
Alcohol consumption, 0 units/week:		18-Nov-2024
Alcohol consumption, 0 units/week:		17-Apr-2024
Teetotaller:	Alcohol Intake$$.dm - No Action Required	09-Sep-2002

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant 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

Social circumstances
Ethnic Origin: (White) Scottish

Signature of referring doctor (or other professional) **Date**

NEWS 2 Key	1	2	3

Date	1/11	29/12
Time	11.00	19:5

A + B Respirations Breaths/min

≥25	3
21-24	2
12-20	0
9-11	1
≤8	3

97	96

A + B SpO2 Scale 1 Oxygen saturation (%)

≥96	0
94-95	1
92-93	2
≤91	3

SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure

Only use scale 2 under direction of qualified clinician

≥97 on O2	3
95-96% on O2	2
93-94% on O2	1
≥93 on air	0
88-92	0
86-87	1
84-85	2
≤83	3

Air or oxygen?		
	A	A

Air (A) or O2 device	0
O2 L/min 2	2

C Blood Pressure mmHg

(Score uses systolic BP only)

	130/63

≥220	3
201–219	0
181–200	0
161–180	0
141-160	0
121-140	0
111-120	0
101–110	1
91–100	2
81–90	3
71–80	3
61–70	3
51–60	3
≤50	3

C Pulse Beats / min

	71

≥131	3
121-130	2
111-120	2
101-110	1
91-100	1
81-90	0
71-80	0
61-70	0
51-60	0
41-50	1
31-40	3
≤30	3

D Any changes to acute response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.

	A

A Alert	0
C New Confusion	3
V Verbal	3
P Pressure	3
U Unresponsive	3

E Temperature

	36.6

≥39	2
38.1-39.0	1
37.1-38.0	0
36.1-37.0	0
35.1-36.0	1
≤35.0	3

NEWS Total		
	0	0

Blood glucose	7.0	NA
Pain / function score	0A	SA
Time Pt last passed urine	10.20	PU
Fluid balance chart indicated Y/N	N	N
GCS indicated Y/N	N	N
Time NEWS due	23.00	
Escalation of care Y/N	N	N
Initials	AB	NH

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE

A Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.

C Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.

E Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

Abbreviations for recording oxygen device

A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and % eg. V24
NIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
RM	Reservoir Mask (Emergency use only)

3012876456
FLETCHER
Alan
12 POLQHUAP RD
Glasgow, Lanarkshire
G53 7FL
30/12/1987
M

Affix Patient ID

NHSGGC Adult In-Patient National Early Warning Score (NEWS)

NHS Greater Glasgow and Clyde

3012876456
FLETCHER M
Alan 30/12/1987
12 POLQHUAP RD
Glasgow, Lanarkshire
G53 7FL

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1 Target >96%	SpO2 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

Date:
Time:
EYES
VERBAL
MOTOR
TOTAL
Right size:
Right reaction:
Left size:
Left reaction:
PUPIL
ARMS
LEGS

Affix Patient ID

Pain Function Score

A No limitations, activity unrestricted by pain or settles quickly
B Mild limitations, mild activity restrictions
C Moderate limitations, attempts but reluctant to continue because of pain. Seek Advice
D Severe limitations, unable to or refuse to perform because of pain. Urgent Review Required

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

No Pain	Mild Pain		Moderate Pain			Severe Pain				
0	1	2	3	4	5	6	7	8	9	10

MI • 316654 v5.2 GGC0264

NHS GGC Hospitals, Admission Document

NHS Greater Glasgow and Clyde

Affix Label

CHI: 3012876456

Queen Elizabeth University Hospital

Total Att: 23

12 Mth Att: 1

Title: MR

FLETCHER

Alan

DOB: 30/12/1987 Age: 37y Sex: Male

12 POLQHUAP RD

Glasgow
Lanarkshire
G53 7FL
07542965184

Next of ki[illegible] SMITH, Ricky
Relation[illegible] Friend
077744[illegible]

GP: GS [illegible]at [illegible]on
0141 883 8887

Attendance Date: 29/12/2025 Arrival Time: 18:17

Registration Time: 18:17 Date of Incident: 29/12/2025

Major Incident Desc:

Reason for Attendance: IAU - own transport. 5/7 left sided pleuritic chest pain. ?PE obs normal

Nursing Assessment

Alerts: Not Recorded Allergies: None Known Pain Score:

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

Presenting Complaint:

Observation Date: 29/12/2025 19:15

Nurse name: Nurse Ashley McIlduff

RR	18	bpm
Oxygen		%
Air or O2		
SpO2	98	%
HR	64	bpm
BP	129/83	mmHg
CRT		
MAP	98	mmHg
AVPU		
Temp	36.2	C
EWS Total		

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: 5 DAY HISTORY OF LEFT SIDED PLEURTIC CHEST PAIN

Patient ID label

Date	Emergency Department Notes	
	Ambulance Proforma reviewed Yes / No Seen by (Doctor)	Time seen

3012876456
FLETCHER M
Alan 30/12/1987

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Differential Diagnosis/Problem List

NEWS ☐ 0-7

RED FLAG ☐ (Tick)

SEPSIS ☐

CURB 65 ☐

Done/ completed	Immediate Managment Plan

Signature: Designation: Page No:

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

3012876456
FLETCHER M
Alan 30/12/1987

Seen By: Print: Time Seen: Pg. No:

PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	
History of presenting complaint	

Past Medical History / Review of portal

Systemic Enquiry

Patient ID label

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	

Allergies	List any over-the-counter or alternative medicines
	Do medicines need further clarification ? ☐ Yes ☐ No
List collected by :	**Plan approved by :**
Designation : Date :	Designation : Date :

Pharmacy review	Comments

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

Patient ID label

3012876456
FLETCHER
Alan
12 POLQHUAP RD
Glasgow, Lanarkshire
G53 7FL

M
30/12/1987

Social History \ Family History

Smoking History

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

Alcohol History

_____ Units/week FAST score if excess _____

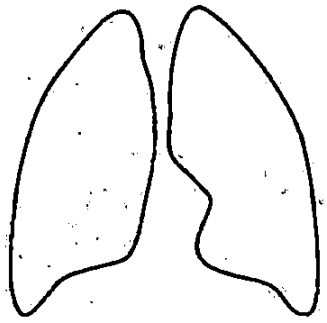
Recreational Drugs **Driving Status**

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

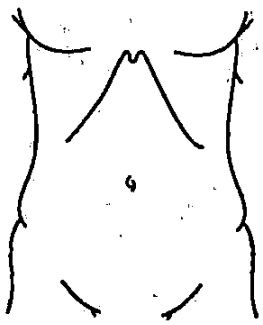
General Examination	
Temp:	RR:
Pulse:	CBG:
SpO_2:	Weight:
BP:	Urinalysis:

General Appearance:

Respiratory



Gastrointestinal System



Cardiovascular

Locomotor

Patient ID label

Neurological system

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

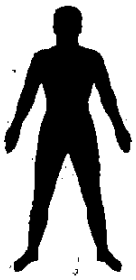
Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

3012876456
FLETCHER
Alan M
12 POLQHUAP RD 30/12/1987
Glasgow, Lanarkshire
G53 7FL

Key Results

CXR ECG

(Differential) diagnosis

NEWS ☐

Red Flag ☐

Sepsis ☐

CURB 65 ☐

Management Plan

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

Signature: PRINT NAME

PRINT GRADE 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
☐ Antimicrobial
☐ Medicine Reconciliation
☐ DNACPR
☐ 4AT/TIME
☐ AWI if appropriate

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

3012876456
FLETCHER M
Alan 30/12/1987
12 POLQHUAP RD
Glasgow, Lanarkshire
G53 7FL

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 _____

Patient ID label

Results

Date									
Time									
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165								
WCC	4.0 - 11.0								
Plts	150 - 450								
MCV	80 - 100								
Neut	2.0 - 7.5								
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								
K+	3.5 - 5.3								
Cl-	95 - 108								
HCO3-	22 - 29								
Urea	2.5 - 7.8								
Creat	40 - 130								
eGFR									
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50								
AlkP	30 - 130								
Bil	<20								
ALT	<50								
AST	<40								
GGT	Male: <70 Female: <40								
ESR	Male: 1 -10 Female: 1 - 12								
CRP	<10								
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								

3012876456
FLETCHER M
Alan 30/12/1987
12 POLQHUAP RD
Glasgow, Lanarkshire
G53 7FL

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO_2:

FiO2:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet

Date: Time	

Patient ID label

3012876456
FLETCHER
Alan
12 POLQHUAP RD
Glasgow, Lanarkshire
M
30/12/1987
G53 7FL

Continuation Sheet

Date: Time	

Patient ID label

Continuation Sheet	
Date: Time	

Patient ID label

3012876456
FLETCHER
Alan M
12 POLQHUAP RD 30/12/1987
Glasgow, Lanarkshire
G53 7FL

Continuation Sheet

Date: Time	

Patient ID label

Nursing Documentation

Done/ Time	
21.40 24/12	Patient called several times but NO answer: 20.40, 20.58 + 21.50. Currently 45 patient in dept. M. NELLANY

Once only prescriptions (inlcuding tetanus prophylaxis)

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

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)					Time Ready to Depart	
5. Died	6. Refer to O.P. Clinic (see below)	7. Irregular Discharge	8. D.O.A.					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	

IAV AGUH

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER

MEDICAL IN CONFIDENCE

2021 GGC General Referral Protocol

Additional Support Needs:
No known ASN requirements

REFERRAL TO

General Medicine - Hypertension
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
Date of referral 29-Dec-2025 **Date sent** 29-Dec-2025

PATIENT DETAILS

Surname	Fletcher
Forename(s)	Alan
Title	Mr
Sex	Male
Date of birth	30-Dec-1987
CHI no.	3012876456
Area of Residence	-

Patient's address

12 Polqhuap Rd
GLASGOW
G53 7FL

Contact number(s)

Voice: 07542965184

101038628346B Unique Care Pathway Number: 101038628346B

REGISTERED GP DETAILS

Name	Dr Gary Watson		
GMC code	6104661	GP code	01759
Practice name	Crookston Medical Centre (18972)		
Practice code	52344		

Practice address

Crookston Medical Centre
230 Dalmellington Road
Glasgow
G53 7FY

Contact number(s)

Voice: 0141 883 8887
Facsimile: 0141 891 4400

REFERRING GP DETAILS

Name	Dr Gary Watson		
GMC code	6104661	GP code	01759
Practice name	Crookston Medical Centre (18972)		
Practice code	52344		

Practice address

Crookston Medical Centre
230 Dalmellington Road
Glasgow
G53 7FY

Contact number(s)

Voice: 0141 883 8887
Facsimile: 0141 891 4400

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: chest pain

Comment: Dear Doctor
many thanks for seeing Alan, he awoke on Christmas eve with left sided sharp chest pains on background of asthma. it is probably worse on certain movements. He isn't sob per se but breathing is restricted. there is no chest wall tenderness. o/e bp 131/76. p68, t 36.3 sats 99%. hs normal chest clear. I suspect it is MSK but given nature of his pain feel cxr at least is needed here +/- ddimer

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]Injury of unspecified nerve at wrist and hand level	-	28-Nov-2023	28-Nov-2023
Fracture of metacarpal bone	(Right) Avulsion # base of 5th Metacarpal	25-Jan-2017	25-Jan-2017
Asthma	-	01-Feb-2003	01-Feb-2003
Asthma NOS	Disease: SPICE Asthma Opening,	01-Jan-2003	01-Jan-2003
[Q] Salter-Harris II	fracture right 1st metacarpal	16-Sep-2002	16-Sep-2002

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
Salbutamol Cfc-free Inhaler 100 micrograms/puff	1	1 Inhaler	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	09-Dec-2025	09-Dec-2025

Blood Pressure

Date Recorded	Systolic	Diastolic
23-Aug-2024	123	74
15-Jun-2012	138	72
13-Apr-2010	110	65

Body Measurements

Date Recorded	Height	Weight	BMI
18-Nov-2024	184	75	-
13-Apr-2010	184	-	-
19-May-2008	183	59.7	-
19-Nov-2007	183	58.4	-
22-Nov-2006	182	60.3	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Never smoked tobacco:		18-Nov-2024
Never smoked tobacco:		17-Apr-2024
Never smoked tobacco:		27-Feb-2013
Never smoked tobacco:	Smoker$$ Status.clm - No Action Required	24-Feb-2010
Never smoked tobacco:	Recorded through Combined Vaccination priority=2	22-Oct-2009
Alcohol consumption, 0 units/week:		18-Nov-2024
Alcohol consumption, 0 units/week:		17-Apr-2024
Teetotaller:	Alcohol Intake$$.clm - No Action Required	09-Sep-2002

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant 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

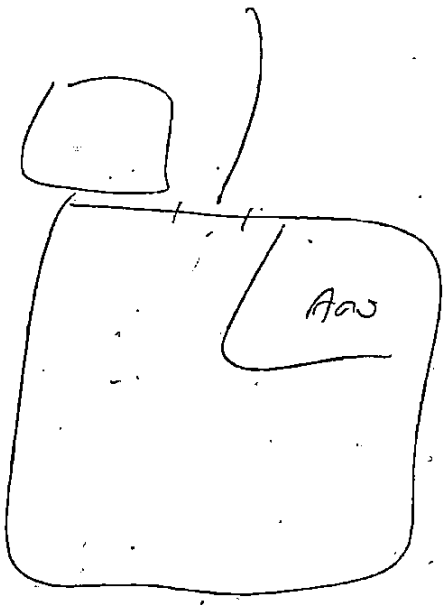
Referred By:Referring GP

Social circumstances
Ethnic Origin: (White) Scottish

Signature of referring doctor (or other professional) **Date**

3012876456
FLETCHER
Alan M
12 POLQHUAP RD 30/12/1987
Glasgow, Lanarkshire
G53 7FL

1AU



M/S

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 3012876456

Queen Elizabeth University Hospital

Total Att: 20

12 Mth Att: 1

Title: **MR**

FLETCHER **Alan**

DOB **30/12/1987** Age: **32y** Sex: **Male**

62 Innerwick Drive

Glasgow
G52 2HY

Next of kin: **SMITH, Ricky**
Relationship: **Friend**
07774417777

GP: **PA Costello**
0141 959 1196

Attendance Date: **21/06/2020** Arrival Time: **14:18**

Registration Time: **14:18** Date of Incident: **21/06/2020**

Major Incident Desc:

Reason for Attendance: **left arm injury**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

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

Presenting Complaint:

Observation Date: **21/06/2020 15:06** Nurse name: **Nurse Kirsty Allan**

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

BM		mmol/L
PF		1/min
Expected PF		1/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:

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)

FLETCHER
Alan

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) [illegible] Time seen 15:11

21/06/18

P/ L forearm inj

3012876456 30/12/1987
FLETCHER
Alan

HPI 32 year old male. RHD. Driver.
Pallet of bikes fell on forearm
1/7 ago

PMH - nil DH - nil NKDA

O/E Small bruise radial aspect forearm
Tender distal to mid shaft radius
NC pain elbow. no pain ASJ
NV intact
Full ROM wrist + elbow
IMP/ Likely contusion
PLN/ Xray L radius + ulna - No # seen
Advised RICE
regular analgesia
F/U BMP

Date	CLINICAL NOTES
	 3012876456 30/12/1987 FLETCHER Alan

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

CHI: 3012876456

New Victoria Hospital

GH

Total Att: 19

12 Mth Att: 0

Title: MR

FLETCHER

Alan

DOB: 30/12/1987 Age: 32y Sex: Male

62 Innerwick Drive

Glasgow
G52 2HY

Next of kin: SMITH, Ricky
Relationship: Friend
07774417777

GP: PA Costello
0141 959 1196

Attendance Date: 10/01/2020 Arrival Time: 18:52

Registration Time: 18:52 Date of Incident: 09/01/2020

Major Incident Desc:

Reason for Attendance: L Knee Pain

Affix Label

Nursing Assessment

Alerts: Not Recorded Allergies: None Known Pain Score:

Triage Category: Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: Nurse name:

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?		

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes:

Knee pain since November - going worse
advised to attend tomorrow - Dept. closed

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		

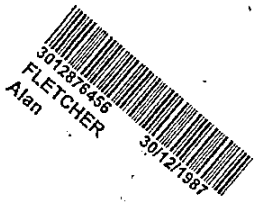
Discuss with Senior Medical Staff / Nurse on duty any factors identified

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) Time seen



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

CHI: 3012876456

Royal Alexandra Hospital

Total Att: **21**

12 Mth Att: **0**

Title: **MR**

FLETCHER **Alan**

DOB **30/12/1987** Age: **35y** Sex: **Male**

62 INNERWICK DR

Glasgow
Lanarkshire
G52 2HY
07542965184

Next of kin: **SMITH, Ricky**
Relationship: **Friend**
07774417777

GP: AP Kerr
0141 427 0191

Attendance Date: **27/11/2023** Arrival Time: **20:08**

Registration Time: **20:08** Date of Incident: **27/11/2023**

Major Incident Desc:

Reason for Attendance: **right hand injury**

Affix Label

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

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

Presenting Complaint:

Observation Date: **27/11/2023 20:34** Nurse name: **Nurse Catriona Livingston**

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?		

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **injury to R hand at work yesterday- increasing pain radiating down fingers**

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) CONNOR BOYCE FY2	Time seen 22:50

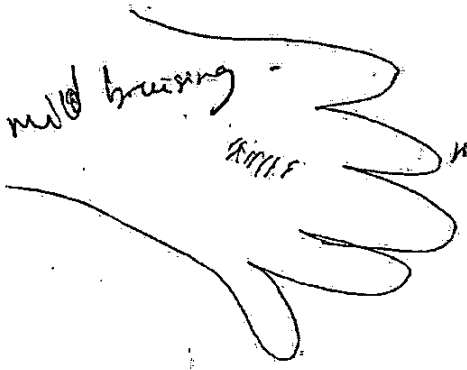
27/1

PC (R) hand injury @ work

HPC: Turning a big plug in work. Rotational injury. Yesterday 3 pm. U. tender (R) hand since. Travelling down (R) arm. Feels ~~o tingly~~ v. sore when flexing / extending wrist. Unable to grip properly.

Tried Ibuprofen → not helping.

O/E:



Able to flex + extend wrist.

Radial, medial, ulnar nerve intact.

OAF muscle intact

Imp: ? neuropraxia

? 3rd metacarpal.

? ligamentous injury.

XR then (FY) FY2

↳ No obvious #

↳ D/C ± analgesia + worsening advice

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
27/10	Co-codamol 2	8/500mg	PO	QDS		

Main w/a

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital

CHI: 3012876456

Total Att: 18

12 Mth Att: 1

Title: MR

FLETCHER **Alan**

DOB: **30/12/1987** Age: **30y** Sex: **Male**

62 Innerwick Drive

Glasgow
G52 2HY

Next of kin: **SMITH, Ricky**
Relationship: **Friend**
07774417777

GP: **PA Costello**
0141 959 1196

Attendance Date: **22/08/2018** Arrival Time: **10:50**

Registration Time: **10:50** Date of Incident: **22/08/2018**

Major Incident Desc:

Reason for Attendance: **l leg inj**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

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

Presenting Complaint: **Ankle Injury Left**

Observation Date: **22/08/2018 11:05** Nurse name: **Nurse Catherine McGillivray**

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?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **" heavy weight fell onto l ankle yesterday"**

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) MCGARRY Time seen 11.40am

22/8/18 30y ♂ →

Unloading lolly. Heavy metal door fell onto (R) ankle.

Able to WB.

Ok (R) ANKLE

Swelling / bruising / tender anterior medial malleolus.

Tender posterior aspect of medial malleolus.

Full ROM ankle.

No neurovascular deficit.

XRay (R) ANKLE - N/A acute

Date	CLINICAL NOTES
Re	D/C (4) c̄ Cocodamol 30/500 Advice. Op [illegible]

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
	Cocodamol 30/500	ii	PO	[illegible]	[illegible]	[illegible]

MWA

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 3012876456

Queen Elizabeth University Hospital

Total Att: 17

12 Mth Att: 4

Title: MR

FLETCHER **Alan**

DOB: **30/12/1987** Age: **30y** Sex: **Male**

FLAT 0-1
6 BLAWARTHILL ST
Glasgow
Lanarkshire
G14 0HG
07492566221

Next of kin: **CAMPBELL, Cartiona**
Relationship: **Partner**

GP: **PA Costello**
0141 959 1196

Attendance Date: **16/02/2018** Arrival Time: **10:24**

Registration Time: **10:24** Date of Incident: **16/02/2018**

Major Incident Desc:

Reason for Attendance: **foot pain**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

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

Presenting Complaint: **Foot Pain**

Observation Date: **16/02/2018 10:37** Nurse name: **Nurse Julie Anthoney**

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?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **foot pain for year**

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) MURPHY Time seen 11:15am.

16/2/18 30yr O→

1 year h/o (R) foot pain,
Pain over plantar aspect foot,
worse when standing on tip toes.
Tried to see GP but advised
patient to come to A+E.
Taking ibuprofen.

dl (R) foot

No external abnormality
Noted to have flat soles.
Tender ++ along plantar fascia.
No bony tenderness.
Full ROM ankle.

lvf Plantar fasciitis.

Date	CLINICAL NOTES
	(#) ↑ naproxen/Co-codamol 8/500 advised insole/footwear. GP if not settling for xrays/to orthotics. OA/ingrowing toe nail

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

CHI: 3012876456

Queen Elizabeth University Hospital

Total Att: **16**

12 Mth Att: **6**

Title: **MR**

FLETCHER **Alan**

DOB: **30/12/1987** Age: **29y** Sex: **Male**

FLAT 0-1
6 BLAWARTHILL ST
Glasgow
Lanarkshire
G14 0HG
07492566221

Next of kin: **CAMPBELL, Cartiona**
Relationship: **Partner**

GP: **PA Costello**
0141 959 1196

Attendance Date: **05/04/2017** Arrival Time: **12:48**

Registration Time: **12:48** Date of Incident: **05/04/2017**

Major Incident Desc:

Reason for Attendance: **overdose- came across from mcnair ward gartnavel royal**

Affix Label

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

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

Presenting Complaint: **Psychiatry DSH - Overdose**

Observation Date: **05/04/2017 13:07** Nurse name: **Nurse Alan Megahy**

Temp	**36.3**	C
HR	**71**	bpm
BP	**132/72**	mmHg
MAP	**92.00**	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	
Motor	
Verbal	
Total	

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

Nursing Notes: **Psych patient at Gartnaval. OD of Nytol and ? fluoxetine. Mixed OD**

Child Assessment Questionnaire

3012876456 30/12/1987
FLETCHER
Alan

	YES	NO
Previous attendance (consider any relevant trauma from		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or no		

Discuss with Senior Medical Staff / I

X-Ray and Other Reports to be filed on thi ed)

DO NOT
HERE I

SOUTHERN GENERAL
SITU

Patient Sample Report

Patient

ID:	3012876456
Last Name:	FLETCHER
First Name:	ALAN
Gender/Age:	Male, 29 years
Birth Date:	30.12.1987
Status:	ACCEPTED
Analyzed:	05.04.2017 14:42:13
Sample Type:	Venous ~~Arterial~~
Operator ID:	DONNELLY0, PAUL

Analyzer

Model:	GEM® *Premier 4000*
Area:	AH_L0ED_A
Name:	ED-POD
S/N:	06100193

Measured (37.0°C)		
cH	36.2	nmol/L
pCO_2	5.2	kPa
pO_2	⇊ 5.6	kPa
Na^+	141	mmol/L
K^+	4.0	mmol/L
Cl^-	↑ 112	mmol/L
Glu	4.9	mmol/L
Lac	1.8	mmol/L
CO-Oximetry		
tHb	↑ 176	g/L
O_2Hb	↓ 80.1	%
COHb	↑ 1.9	%
MetHb	0.8	%
HHb	↑ 17.1	%
sO_2	↓ 82.4	%
Derived		
BE(B)	2.3	mmol/L
HCO_3^-(c)	26.5	mmol/L
Operator Entered		
Temp	37.0	°C
O2 and Vent Settings		
FIO_2		%

↑↓ Outside Reference Range
⇈⇊ Outside Critical Range

ONCE ONLY PRESCRIPTIONS (

Date Given	DRUG (BLOCK CAPITALS)	Dose	ven By

UK NPIS 0344 892 0111
Ireland NPIC (01) 809 2566
mail@toxbase.org

Search
Enter word Search
Advanced Search | Unknown poisoning
Need help searching

National Poisons Information Service

A service commissioned by Public Health England (PHE) on behalf of the UK Health Departments

General Info Specialist areas Chemicals Exposure in pregnancy Poisons A-Z Dosage Calculator

Nytol Updated 6/2015 Printable version

The information on TOXBASE® requires expert clinical interpretation (ideally users should complete the TOXBASE® E-Learning modules; click here) and, therefore, should only be used by clinically trained medical/nursing professionals, who are responsible for the correct interpretation of the relevant clinical case history. **In severe or complex cases, including multiple ingestions, and people with significant co-morbidity we recommend that you discuss your case with your poisons service: in the UK NPIS 0344 892 0111, in Ireland NPIC (01) 809 2566. If your patient is pregnant please telephone the UK Teratology Information Service 0344 892 0909.**

TOXBASE® entries should not be used as patient information sheets.

Type of Product

An antihistamine for temporary sleep disturbance.

Ingredients

Diphenhydramine
Tablet - 25 mg, 50 mg

NB Do not confuse with Nytol Herbal which does not contain diphenhydramine.

Toxicity

The toxicity of diphenhydramine is due to a combination of central and peripheral anticholinergic (atropine-like) effects together with cardiotoxic and neurotoxic effects, including convulsions.

Following overdose in adults, moderate symptoms have been associated with ingestions of greater than 300-500 mg and serious symptoms associated with doses greater than 1 g diphenhydramine (Radovanovic et al, 2000). A 29-year-old male survived ingestion of 25 g of diphenhydramine (Levine and Lovecchio, 2010).

Young children may be more sensitive to the effects of overdose. Doses greater than 10 mg/kg have been reported to produce severe toxicity (Scharman et al, 2006); an infant died following ingestion of 11.6 mg/kg (Baker et al, 2003). A 13-month-old male who reportedly ingested 500 mg (estimated 50 mg/kg) diphenhydramine developed convulsions that progressed to status epilepticus and wide-complex tachycardia; the patient survived (McKeown et al, 2011).

Little absorption data is available regarding topical application of diphenhydramine; however, toxicity in children has been reported (Huston et al 1990; Turner, 2009). In the most serious case, a 17-month-old child died following use of a topical diphenhydramine cream; autopsy results showed the child's blood contained 20 times the normal therapeutic dose.

After therapeutic doses, peak plasma concentrations occur at 1-4 hours and the elimination half life ranges from 2.4-9.3 hours (Martindale, 2010). Diphenydramine is an inhibitor of CYP2D6 and interactions may occur following usage of drugs metabolised by this system (Boots Sleepeaze SPC, 2013).

ALERT BOX
All patients who have taken a deliberate overdose should be referred for assessment.
Children and adults who have ingested a toxic dose or more of a sedating antihistamine (click here for table), or those who are symptomatic, should be referred for medical assessment.
Children or adults who have accidentally ingested less than a toxic dose (click here for table) and who have no new symptoms since the time of ingestion do not need to be referred for medical assessment. Patients should be advised to seek medical attention if symptoms develop.

Antihistamines sedating - features and management Revised* 6/2015

Features

Key features include sedation and anti-cholinergic effects (delirium, cardiotoxicity, coma, and convulsions).

Common features include drowsiness, nausea, vomiting, flushing, dilated pupils, blurred vision, dry mouth and tongue, hot dry skin, fever, decreased bowel movements, urinary retention, sinus tachycardia, hypertension, ataxia, nystagmus, agitation, delirium and visual hallucinations.

Uncommon features include myoclonic jerking, muscle rigidity, hypotonia, convulsions, coma, psychosis, cardiac conduction abnormalities including both QRS and QT prolongation, ventricular dysrhythmias including torsade de pointes, cardiorespiratory instability, hyperkalaemia, metabolic acidosis and rhabdomyolysis.

Less commonly than anticholinergic toxicity, serotonin toxicity may occur; click here for features and management.

Clinical features common to cardiac/cardiotoxic agents involved in mixed overdoses may be more severe or prolonged.

Management

ALERT BOX - for hospital doctors
This agent is potentially very toxic and clinicians managing patients are encouraged to discuss **serious** cases with your poisons information service: in the UK NPIS **0344 892 0111**, in Ireland NPIC (01) 809 2566.
Click here for details you may be required to give when telephoning NPIS.

1. Maintain a clear airway and ensure adequate ventilation.
2. In the event of cardiac arrest in hospital or witnessed out of hospital cardiac arrest with bystander CPR, resuscitation should be continued for at least 1 hour and only stopped after discussion with a senior clinician. Recovery without sequelae after continuous CPR for 3 hours has been reported.

   Prolonged resuscitation for cardiac arrest is recommended following poisoning as recovery with good neurological outcome may occur.

   Discuss with your local poisons information service: in the UK NPIS **0344 892 0111**, in Ireland NPIC (01) 809 2566.

   Click here for details you may be required to give when telephoning NPIS.
3. The benefit of gastric decontamination is uncertain. Consider activated charcoal (charcoal dose: 50 g for adults; 1 g/kg for children) only if the patient presents within 1 hour of ingestion of a toxic dose or more (click here for table), provided the airway can be protected.
4. This agent is cardiotoxic and careful assessment of the ECG is required.

   Perform a 12-lead ECG in all patients who require assessment.

   Repeat 12-lead ECGs are recommended, especially in symptomatic patients or in those who have ingested sustained release preparations.

   Check cardiac rhythm, QRS duration and QT interval. Click here for further advice.
5. In symptomatic patients measure U&Es, CK activity and monitor kidney and cardiac function.
6. All patients should be observed for at least 6 hours.

   Following mixed overdoses involving cardiac/cardiotoxic agents, asymptomatic patients should be monitored for at least the longest period recommended in any of the individual TOXBASE® entries.

   Check pulse and blood pressure frequently. Monitor cardiac rhythm. Repeat ECGs should be performed. In symptomatic patients, or patients with an abnormal ECG, consider early discussion with HDU/ITU.

   Asymptomatic patients with a normal ECG can then be considered for discharge with advice to return if symptoms develop.

In seriously poisoned patients the following measures may be required:

7. Consider arterial blood gas analysis in patients who have a reduced level of consciousness (e.g. GCS less than 8; AVPU scale P or U) or have reduced oxygen saturation on pulse oximetry.
8. Assisted ventilation is indicated if hypercapnia is present.
9. Correct hypoxia.
10. **Hypotension**

    Correct hypotension by adequate fluid resuscitation with a crystalloid. Treat brady and tachyarrhythmias appropriately.

    Poisoned patients with fluid-resistant hypotension can deteriorate extremely rapidly and should be managed by experienced physicians. Patients should be referred as appropriate to the local critical care team (ICU) for adults, or paediatric intensive care unit (PICU) for children.

    While there may be evidence that certain poisons cause either reduced cardiac output or vasodilation, these mechanisms frequently co-exist in severe or mixed poisoning, making it difficult to decide whether a vasopressor or

inotrope should be used as first-line treatment. Invasive vascular monitoring and echocardiography may help identify the specific mechanisms operating in a particular patient.

There have been very occasional reports of worsening of hypotension associated with adrenaline treatment, thought to be due to beta-receptor agonist effects. This further endorses the need for careful clinical assessment by experienced clinicians.

Vasopressors and inotropes can be initiated in an emergency through peripheral venous access. **THIS SHOULD ONLY BE DONE UNDER THE DIRECTION OF AN EXPERIENCED PHYSICIAN (SpR AND ABOVE).** Click here for further advice on doses.

If severe hypotension further persists discuss with your local poisons information service: in the UK NPIS **0344 892 0111**, in Ireland NPIC (01) 809 2566.

Click here for details you may be required to give when telephoning NPIS.

11. **Convulsions**

Give oxygen, check blood glucose, U&Es and ABG. Correct acid base and metabolic disturbances as required.

Single brief convulsions do not require treatment.

Control convulsions that are frequent or prolonged with intravenous diazepam (10-20 mg in adults; 0.1-0.3 mg/kg body weight in children), lorazepam (4 mg in adults; 0.1 mg/kg in children), or midazolam (5-10 mg in adults; 0.05-0.15 mg/kg in children).

Further doses of benzodiazepines may be needed in adults; refer to intensive care. In children seek consultant paediatric input.

If unresponsive to the above measures, the patient should be referred urgently to critical care. The NPIS recommends barbiturates as second line therapy and avoidance of phenytoin, particularly in cardiotoxic agent overdose, click here for further management

12. **Agitation and delirium**

Adults: can be sedated with an initial dose of oral or IV diazepam (0.1-0.3 mg/kg body weight). Further boluses, given IV, may be administered if the patient remains severely agitated 10 to 15 minutes after the initial bolus, provided there is no impairment of respiratory function.

If agitation persists despite the above measure, consider oral (5-10 mg) or parenteral (2-10 mg) haloperidol, 0.5 -2 mg (oral or iv) initially in the elderly.

Patients with drug-induced hyperthermia, serotonin syndrome or severe agitation may need high doses, perhaps totalling more than 1 mg/kg over 30 - 60 minutes. These patients need urgent referral to critical care.

Children: it is better to manage agitation without sedation and exclude other causes (e.g. hypoxia, infection, hypoglycaemia and raised ICP). Consider nursing in a dark and quiet environment with a close relative present; seek expert paediatric advice.

Pharmacological management of agitation in children must be supervised by staff experienced in paediatric airway management and sedation.

If required, midazolam is the most appropriate drug for managing agitation in children and young people. This may be delivered buccally (dose 0.2 - 0.3 mg/kg to a maximum of 10 mg) or intravenously (dose 0.05 - 0.1 mg/kg to a maximum dose of 10 mg).

Intravenous lorazepam (0.01 mg/kg) is an alternative.

Repeat doses can be given if necessary. There is a particular risk of paradoxical increased agitation in young children.

13. **Hyperthermia**

Mild to moderate hyperthermia may respond to conventional cooling measures.

When rising body temperature exceeds 39 degrees C, core temperature monitoring should be considered (rectal probe) and urgent cooling measures (click here) should be employed according to local protocols. Sedation should be employed where it can be safely performed (diazepam 10-20 mg in adults; 0.25 mg/kg body weight in children).

Severe hyperthermia carries a high mortality rate, aggressive intervention is recommended.

Rapid sequence intubation with paralysis is usually warranted when the temperature is rising rapidly and not controlled by other measures or if the temperature exceeds 41 degrees C.

If hyperkalaemia is likely avoid succinylcholine.

On-going neuromuscular paralysis, and sedation with benzodiazepines (diazepam 10-20 mg in adults; 0.25 mg/kg body weight in children), is recommended in addition to cooling measures (see below) as per local protocols.

Cooling methods include -

- Ice-baths (may achieve rapid cooling but caution in elderly/comorbidities)

- Internal/invasive measures - cold fluid lavage (gastric, bladder, peritoneal), intravascular cooling techniques
- Ice packs to groin and axillae
- Mist and fan techniques
- External cooling devices.

Dantrolene may be considered where there is muscular hyperactivity (1 mg/kg by intravenous injection to a maximum of 10 mg/kg).

In patients with pyrexia, monitor renal function and creatine kinase activity. Ensure adequate hydration and monitor urine output carefully.

Consider other causes as hyperthermia may be caused by conditions other than poisoning.

If serotonin syndrome is present click here for management.

If neuroleptic malignant syndrome is present click here for management.

14. **Hypertension**

Adults: In agitated patients hypertension may settle once diazepam has been given. If hypertension persists, give intravenous nitrates such as glyceryl trinitrate starting at 1-2 mg/hour and gradually increase the dose (maximum 12 mg/hour) until blood pressure is controlled. Calcium antagonists such as nifedipine, verapamil or diltiazem are an alternative as second line therapy.

Sodium nitroprusside (0.5 – 1.5 microgram/kg/min to a maximum of 8 microgram/kg/min) is an option for patients with hypertension without any evidence of cardiac ischaemia, but may cause a rapid fall in blood pressure.

Alternatively give labetalol (50 mg by slow IV injection repeated to a maximum of 200 mg).

Phentolamine is an alternative therapy; however there are supply problems at present.

Children (less than 5 years): If treatment of hypertension in children is deemed necessary, discussion with paediatric services is advised.

Consider oral/sublingual nifedipine (250-500 microgram/kg body weight) or intravenous labetalol (0.5-1 mg/kg/hour increasing according to response to a maximum of 3 mg/kg/hour).

Intravenous nitrates may also be used (glyceryl trinitrate 0.2 microgram/kg/min increasing to 1-3 microgram/kg/min up to a maximum 10 microgram/kg/min).

15. **Metabolic acidosis**

If metabolic acidosis persists despite correction of hypoxia and adequate fluid resuscitation consider correction with intravenous sodium bicarbonate. Rapid correction is particularly important if there is prolongation of the QRS interval.

Adults: an initial dose of 50 mmol sodium bicarbonate may be given and repeated as necessary, guided by arterial blood gas monitoring (aim for a pH of 7.5 [Hydrogen ion concentration 32], max pH 7.55 [minimum Hydrogen ion concentration 28]). The volumes for different concentrations of sodium bicarbonate to achieve a dose of 50 mmol in adults are shown here.

Children: Give 1 - 2 mmol/kg sodium bicarbonate (1 – 2 mL/kg 8.4% (centrally) or 2 - 4 mL/kg 4.2% (peripherally)) and repeat as necessary to achieve a pH of 7.5 (max pH 7.55). For a rapid correction administer over 20 minutes otherwise administer at a rate of 1 mmol/minute.

Since 4.2% and 8.4% bicarbonate are irritant to veins and can cause local necrosis in cases of extravasation, administration by a central venous line is recommended where possible.

Adults and children: Recheck acid base status after administration of sodium bicarbonate. Monitor electrolytes since there is a risk of hypokalaemia and possibly hypernatraemia.

Click here for further information on metabolic acidosis

16. **Rhabdomyolysis**

If rhabdomyolysis is present (CK activity greater than 5 x the upper limit of the normal range), renal failure can develop particularly if the CK activity is greater than 5000 iu/L. There are theoretical and experimental reasons why early volume replacement and urine alkalinization may be helpful in preventing or reducing the severity of rhabdomyolysis-induced renal failure. There is no strong evidence base from randomized controlled trials in poisoning but there is some evidence in crush injury.

Give volume replacement as soon as possible and consider the need for urine alkalinization. In an adult give 225 mmol of 8.4% sodium bicarbonate (in a child 3 - 5 mmol/kg) **over one hour** to increase the urine pH to greater than 7.5; further doses of bicarbonate will be required to maintain pH greater than 7.5.

Since 8.4% and 4.2% bicarbonate are irritant to veins and can cause local necrosis in cases of extravasation, administration by a central venous line is recommended where possible.

Haemodiafiltration can effectively remove myoglobin from the circulation; haemodiafiltration combined with urine alkalinization is more effective than urine alkalinization alone (Peltonen et al, 2007).

Monitor fluid balance, plasma sodium and potassium and urine pH. Beware severe hyperkalaemia.

Haemodialysis / haemodiafiltration / haemofiltration may be required if acute renal failure develops or severe hyperkalaemia is present.

If initial CK is normal but there is concern about muscle damage consider repeat measurement.

Reference

17. Click here for management of serotonin syndrome.

18. Other measures as indicated by the patient's clinical condition.

Patients should be advised on discharge to seek medical attention if symptoms subsequently develop.

Adverse drug reactions from normal use can be reported to the MHRA via the Yellow Card scheme. For more information and to make a report click here.

Activated charcoal
Serotonin syndrome

Chlorphenamine in pregnancy
Promethazine use in pregnancy
Antiemetics in pregnancy

References

NHS GREATER GLASGOW & CLYDE - MENTAL HEALTH CARE PLAN

NHS Greater Glasgow and Clyde

CHRONOLOGICAL ACCOUNT OF CARE

PIMS NO/CHI NO:	3012876456	WARD:	McNAIR WARD
NAME:	ALAN FLETCHER		
ADDRESS:	0/1 6 BLANARTHILN STREET		
POST CODE:	GLASGOW G14 0HG		
DOB & GENDER:			

DATE & TIME	THE CHRONOLOGICAL ACCOUNT OF CARE IS A COMPLETE RECORD OF THE PATIENT'S JOURNEY FROM ADMISSION TO DISCHARGE. IT WILL ENCOMPASS ADMISSION STATEMENTS/DETAILS, EVALUATIONS, UPDATES, REVIEWS, MULTIDISCIPLINARY DECISIONS AND RECORDINGS OUT-WITH FORMAL MDT. EACH ENTRY MUST BE TITLED WITH A HEADING OF THE RECORDINGS. EG CARE PLAN REVIEW, EVALUATION, ONE TO ONE CONTACT. IT IS THE DUTY OF ALL REGISTERED NURSES TO REFER BACK TO THE INTERVENTIONS FOR EVALUATION PURPOSES.	SIGNATURE, PRINT NAME & DESIGNATION
5/4/17	TRANSFER LETTER	
	Dear Colleagues, Thank you for agreeing to see this 29 year old ♂ inpatient on McNair Ward. (Informal)	
RC:	Today stated "could not cope" Acutely suicidal. Left ward and went home.	
Allegedly.	Drank 8x Budweiser bottles between 10^{30} - 11^{30} estimated time 20x Nytal Tablets + 'Some others' Didn't know quantity or type "Sometimes I just blackout and can't remember" Denies illicit drugs. => Mixed OD prescription/chemist medication.	
	Now acutely anxious, facial spasms and c/o light sensitivity but thought to be behavioural.	
	Today witnessed by staff earlier to be eating + drinking, sleeping peacefully and interacting with patients in a bright and cheerful manner.	
	Diagnosis: Multiple overdose Reactive depression to pending court case / no contact with children	

CCP-CAC-220506

D805751

DATE & TIME	EACH ENTRY MUST BE TITLED WITH A HEADING OF THE RECORDINGS EG. CARE PLAN REVIEW, EVALUATION, ONE TO ONE CONTACT.	SIGNATURE, PRINT NAME & DESIGNATION
	On balance, although not diagnosed as of yet he has Antisocial / Emotionally Unstable Personality Disorder.	
	PMHx Alcohol Excess, "Blackouts" Asthma, Stress, Ligament Injury in Foot.	
	Medication: Kardex attached.	
	Observations T 36.8 100bpm Sats 95% BP 145/101	
	On balance I would have aimed to monitor Mr Fletcher here but as I cannot confirm what he has taken he may require a brief period of cardiac monitoring.	
	I would be grateful if you could maintain his consultation in A+E and refer directly back to McNair Ward. He does not require mental health assessment while in A+E. Collateral history from witnesses state he actively sought help following the overdose which he may deny.	
	Please contact Duty Doc at GRH if you have any questions.	
	Many Thanks	
	DARCY BROWN CPN	

NHS Greater Glasgow and Clyde — Mental Health Services

Prescription Sheet No. _____ of _____

NAME: ALAN FLETCHER

CHI (10 digits): 3012876456

WARD/HOSPITAL: McNAIR / GRH

CONSULTANT: Beasley

DATE REWRITTEN: 30/3/17

REGULAR PRESCRIPTIONS

PHARMACY	START DATE	MEDICINE (Block letters) - APPROVED NAME	DOSE	ROUTE	TIMES (24 hour) 0900 1300 1700 2200	OTHER TIMES	PRESCRIBER'S SIGNATURE	DISCONTINUED DATE	DISCONTINUED INITIAL
A	15/3/17	FLUOXETINE	20mg	PO	✓				
B	17/3/17	PARACETAMOL	1g	PO	✓ ✓ ✓ ✓				
C	4/4/17	ZOPICLONE	3.75mg	PO	✓				
D									
E									
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									
P									

AS REQUIRED PRESCRIPTIONS

		AS REQUIRED PRESCRIPTIONS	DOSE	ROUTE	INDICATION	DOSE INTERVAL	MAX DOSE IN 24HRS		
Q	15/3/17	DIAZEPAM	2mg	PO	Anxiety	4°	6mg		
R	15/3/17	SYMPTOMATIC RELIEF			POLICY (except paracetamol)				
S	~~16/3/17~~	~~ZOPICLONE~~	~~7.5mg~~	~~PO~~	~~insomnia~~	~~OD~~	~~7.5mg~~	4/4/17	E
T	18/3/17	CODEINE	30mg	PO	Pain	4-6°	120mg		
V	18/3/17	LAXIDO	1 sachet	PO	Constipation	PRN	TDS		
W	31/3/17	SALBUTAMOL	2TT	Inh	SOB/wheeze	PRN	PRN		

DEPOTS/LONG-ACTING INJECTIONS — DOSE — FREQUENCY

X
Y
Z

DATE	ONCE ONLY MEDICATIONS	DOSE	ROUTE	TIME	SIGNATURE	GIVEN BY	TIME GIVEN	ADDITIONAL INFORMATION

APPROPRIATE ALERT STICKERS

HIGH DOSE ANTIPSYCHOTIC THERAPY	T2/T3	RISK OF INFECTION	KNOWN ALLERGY/ADVERSE DRUG REACTION - DETAILS
			NKDA

Cedar Code - 05197

QEUH Cardiology Department

NHS Greater Glasgow and Clyde

CHI: 3012876456 **DOB:** 30/12/1987
Gender: M

ECG

Surname: FLETCHER
Forename: Alan
Address: FLAT 0-1
6 BLAWARTHILL ST
Glasgow
Lanarkshire
G14 0HG

Home Phone: 07492566221

Requestor: Dr Paul Donnelly2
Requestor's Designation: Doctor

Patient Location: QEUH ED Minors

Consultant: Dr Phil Munro
Consultant's Designation: Consultant

Investigation		TrakCare Order No
Priority	**Start Date/Time**	
12 Lead ECG		DCS000008486062
Routine	05/04/2017 14:22	

Clinical Questions & Answers

Indication for test/clinical question to be answered **Mixed OD ?QT interval**

Questions & Answers

Requestor's contact details **ED Minors**

Date	CLINICAL NOTES
	Seen by (Dr) PAUL DONNELLY (F92) Time seen 14:00

29 ♂

PC: Mixed Overdose

HPC: Currently an inpatient in McNair Ward @ Gartnavel
Informal admission → receiving Ψ support
Acutely suicidal today
Left Ward + went home
Drank 8 x Budweiser beers
Taken 20 x Nytol sleeping tablets + mixture of other tablets → quantity + type he's unsure of → although likely not more than 1 x box of pain killers.
Intended to kill himself
Wrote suicide note
Found by neighbour + taken to hospital.

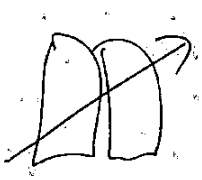
PMHx
Anxiety
Right metacarpal
Asthma

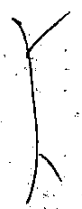
SHx
- Lives by self
- Non-smoker
- No alcohol for ~3 weeks
- Previously drank ~20 bottles/beer (normal strength) for 1 month

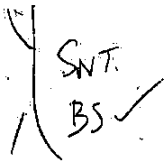
DHx
Fluoxetine 20mg OD
x ~~Zopiclone 7.5mg nocte~~
x ~~Diazepam~~
NKDA

Obs
RR 14 SpO_2 98% P71 BP 132/72 T36.3

O/E
Pulse reg
HS 1+11+0







Not c/o any pain.

Date	CLINICAL NOTES
	ECG: NSR QTc 435 ms VBG: pH 36.2 Na 141 K+ 4.0 Gl 4.9 Lac 1.8 (P) Bloods - FBC - U+E - Co-ag - Paracetamol level - Salicylate level - LFTs - CK - If bloods normal + remains well after period of observation could be discharged back to McNair Ward.
16:10	FBC (N) UtEs (N) LFTs (N) CK (N) Co-ag (N) Paracetamol <5 lactate (N) Salicylate <5 D/w Dr Smith → if obs + patient remain normal after period of observation (~6hrs = 16:30) → then can be discharged back to McNair ward.

Discharge Codes (Please CIRCLE)					Discharge date	5/4/17
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	16:40

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

7

CHI: 3012876456

Queen Elizabeth University Hospital

Total Att: **15**

12 Mth Att: **5**

Title: **MR**

FLETCHER **Alan**

DOB: **30/12/1987** Age: **29y** Sex: **Male**

FLAT 0-1
6 BLAWARTHILL ST
Glasgow
Lanarkshire
G14 0HG
07492566221

Next of kin: **CAMPBELL, Cartiona**
Relationship: **Partner**

GP: **PA Costello**
0141 959 1196

Attendance Date: **10/03/2017** Arrival Time: **10:59**

Registration Time: **10:59** Date of Incident: **10/03/2017**

Major Incident Desc:

Reason for Attendance: **bibp, threating self harm**

Registration time:	Major incident description:

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

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

Presenting Complaint: **Psychiatry DSH - Overdose**

Observation Date: **10/03/2017 11:45**

Nurse name: **Nurse Derek Turnbull**

Temp	**36.1**	C
HR	**94**	bpm
BP	**125/98**	mmHg
MAP	**107.00**	mmHg
RR	**22**	bpm
SpO2	**99**	%
Oxygen		%

BM		mmol/L
PF		1/min
Expected PF		1/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: **? OD of Nytole.**

Nursing Notes:

Emergency Department
Mental Health Triage and Risk Assessment

NHS Greater Glasgow and Clyde

Patient Name 3012876456 30/12/1987 FLETCHER Alan

DoB

Triage Observations

GCS	BM	HR	BP	RR	SaO_2	Temp
15		94	125/88	22	99	36.1

Police.

Or describe the patient's physical appearance/clothing if attending alone as they may leave before assessment

Is the patient a young person in foster care or in a residential care placement? Yes/No

Is the patient a carer for a child or for a dependent adult? Yes/No

Is there a child protection concern or concern for an adult at risk? Yes/No

Outcome of Triage Assessment

Overdose – will require medical assessment	✓
Self-Injury - will require wound management	
Other Mental Health Presentation	

Initial Presentation

Is the patient violent, aggressive or threatening?	Yes		(No)
Is the patient obviously distressed, markedly anxious or highly aroused?		Yes	(No)
Is the patient quiet and withdrawn?		Yes	(No)
Do you think the patient is behaving inappropriately to their situation?		Yes	(No)
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Yes		(No)
Do you think the patient is likely to abscond prior to assessment?	Yes		(No)
Do you think the patient's presentation suggests either delusions or hallucinations?*	Yes		(No)
Do you think the patient's presentation suggests they feel their actions are being controlled?	Yes		(No)
Are you aware of a history of mental health problems or psychiatric illness?		(Yes)	No
Are you aware of a history of violence or self harm?		(Yes)	No
Is the patient currently expressing suicidal thoughts	Yes		(No)

*Delusions: false but firmly held views and ideas. Hallucinations: false external stimuli (e.g. visual or vocal) the patient thinks are real

Triage Risk Assessment

High/Moderate/Low Risk

of self-harm/violence/absconding in department

Triage Risk		high risk – supervised *and* in the department moderate risk – supervised *or* in the department low risk – can be asked to wait if necessary

Any responses in the first column **High Risk**

Other patients can be categorized as **Moderate Risk**

If *all responses* are in the third column **Low Risk**

Initial Management Plan

Patient location, supervised by…	
Blood sample time?	Toxbase Information Printed?

Print Name Samantha Lamont

Signature S. Lamont

Date 10/3/17 Time 11.51

Patient ID label

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	

Allergies	List any over-the-counter or alternative medicines
	Do medicines need further clarification ? ☐ Yes ☐ No
List collected by :	**Plan approved by :**
Designation : Date :	Designation : Date :

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

Patient ID label

3012876456 M
FLETCHER
Alan 30/12/1987

Social History \ Family History

Smoking History

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

Alcohol History

_____ Units/week FAST score if excess _____

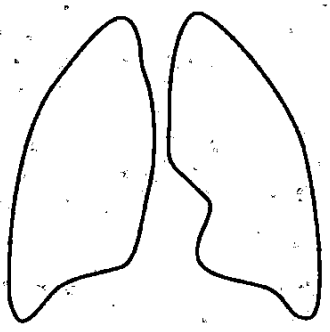
Recreational Drugs **Driving Status**

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

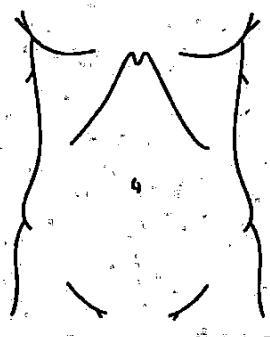
General Examination	
Temp:	RR:
Pulse:	CBG:
SpO_2:	Weight:
BP:	Urinalysis:

General Appearance:

Respiratory



Gastrointestinal System



Cardiovascular

Locomotor

Patient ID label

3012876456
FLETCHER M
Alan 30/12/1987
FLAT 0-1
6 BLAWARTHILL ST
Glasgow, Lanarkshire
G14 0HG

Key Results

CXR ECG

(Differential) diagnosis

NEWS ☐

Red Flag ☐

Sepsis ☐

CURB 65 ☐

Management Plan

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

Signature: PRINT NAME

PRINT GRADE Page:

[redacted]

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

3012876456
FLETCHER
Alan M
FLAT 0-1 30/12/1987
6 BLAWARTHILL ST
Glasgow, Lanarkshire
G14 0HG

Medical patient thromboprophylaxis decision aid – ENSURE P

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 _____

Patient ID label

Results

Date									
Time									
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165								
WCC	4.0 - 11.0								
Plts	150 - 450								
MCV	80 - 100								
Neut	2.0 - 7.5								
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								
K+	3.5 - 5.3								
Cl-	95 - 108								
HCO3-	22 - 29								
Urea	2.5 - 7.8								
Creat	40 - 130								
eGFR									
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50								
AlkP	30 - 130								
Bil	<20								
ALT	<50								
AST	<40								
GGT	Male: <70 Female: <40								
ESR	Male: 1 -10 Female: 1 - 12								
CRP	<10								
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								

Patient ID label

3012876456
FLETCHER M
Alan 30/12/1987
FLAT 0-1
6 BLAWARTHILL ST
Glasgow, Lanarkshire
G14 0HG

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO_2:

FiO2:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet	
Date: Time	

Patient ID label

3012876456
FLETCHER
Alan
FLAT 0-1
6 BLAWARTHILL ST
Glasgow, Lanarkshire
G14 0HG

M
30/12/1987

Continuation Sheet

Date: Time	

Patient ID label

Continuation Sheet	
Date: Time	

P:

3012876456
FLETCHER M
Alan 30/12/1987
FLAT 0-1
6 BLAWARTHILL ST
Glasgow, Lanarkshire
G14 0HG

Continuation Sheet

Date: Time	

Patient ID label

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

Discharge prescription packs

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

DISCHARGE CODES: Please Circle				Time Ready to Depart	
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.	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

Emergency Department
Mental Health Triage and Risk Assessment

Greater Glasgow

3 012876456 30/12/1987
FLETCHER
Alan

Patient Name _____
DoB _____ CHI _____

GCS	BM	HR	BP	RR	SaO_2	Temp
15	5.1	110	108/66	15	96	36.5

Navy TOP / Jeans Blue trainers
Tall Slim build. dark Hair

Or describe the patient's physical appearance/clothing if attending alone as they may leave before assessment

Is the patient a young person in foster care or in a residential care placement? Yes/No

Is the patient a carer for a child or for a dependent adult? Yes/No

Is there a child protection concern or concern for an adult at risk? Yes/No

	✓
Overdose – will require medical assessment	
Self-Injury – will require wound management	
Other Mental Health Presentation	

Is the patient violent, aggressive or threatening?	Yes		(No)
Is the patient obviously distressed, markedly anxious or highly aroused?		Yes	(No)
Is the patient quiet and withdrawn?		Yes	No
Do you think the patient is behaving inappropriately to their situation?		Yes	(No)
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Yes		(No)
Do you think the patient is likely to abscond prior to assessment?	Yes		(No)
Do you think the patient's presentation suggests either delusions or hallucinations?*	Yes		(No)
Do you think the patient's presentation suggests they feel their actions are being controlled?	Yes		(No)
Are you aware of a history of mental health problems or psychiatric illness?		(Yes)	No
Are you aware of a history of violence or self harm?		(Yes)	No
Is the patient currently expressing suicidal thoughts	Yes		(No)

*Delusions: false but firmly held views and ideas.Hallucinations; false external stimuli (e.g. visual or vocal) the patient thinks are real

Any responses in the first column
High Risk

Other patients can be categorized as
Moderate Risk

If *all responses* are in the third column
Low Risk

High/Moderate/Low Risk

of self-harm/violence/absconding in department

(2)

high risk – supervised *and* in the department
moderate risk – supervised *or* in the department
low risk – can be asked to wait if necessary

Patient location, supervised by…			
Blood sample time?		Toxbase Information Printed?	

Print Name J Roberts
Signature J Roberts
Date 4/2 Time 1604

Outline of current presentation and precipitating factors

TOOK AN UNKNOWN QTY OF MIRTAZAPINE + ? DIAZEPAM
? 27 x 30MG MIRTAZAPINE + ? 14 x 5MG DIAZEPAM @
~ 12:00. LEFT A SUICIDE NOTE. NOT COPING
WITH BREAKING UP WITH EX + LOOSING CHILDREN
NO OTHER COMPLAINTS. FEELING LOWED

Previous mental health problems, self harm, addictions, medication etc

- DEPRESSION - MX BY GP WITH MIRTAZAPINE
DRINKS OCCASIONALLY
- LOST TEMPER AND CHILDREN TAKEN AWAY BY WIFE. NOT COPING

Other relevant information: relationships, finances, employment, housing, physical health, childcare etc

LIVES ALONE ~ 1/12. SELF EMPLOYED "MEDIA MAN". 2 KIDS WITH MUM

Appearance	Behaviour	Speech
GOOD	NORMA	NORMAL
Mood VERY LOW	**Thought** NO DISORDER	**Insight** YES

Risk Assessment

High/Moderate/Low

Summary and Plan

Summary

ON GOING SUICIDAL IDEATION

Service Referred to	Time of Referral
Ψ GARNAVAL ROYAL HOSP	17:28

Discharge

Follow up and advice	Carer informed
MCNAIR WD GRH	NONE

Name and Designation of Consultant or Middle-Grade Involved in Reviewing Patient	ACABENIEGA SCT

male gender	(y)	n	u
age >18 and <65	(y)	n	u
depression	(y)	n	u
alcohol or drug use	y	(n)	u
separated, widowed, divorced	(y)	n	u
suicide plan/concealment	(y)	n	u
evidence of psychosis	y	(n)	u
ongoing suicial intent	(y)	n	u
lack of social support	y	(n)	u
chronic physical illness/pain	y	(n)	u
family history of suicide	y	(n)	u
family concerned about risk	y	n	(u)
disengaged/poor compliance	y	n	(u)
unemployed or retired	y	(n)	u
access to lethal means of harm	y	n	(u)
previous violent methods	y	(n)	u
history of self harm/overdose	y	(n)	u
previous psychiatric treatment	y	(n)	u
current psychiatric treatment	(y)	n	u
current use of benzodiazepines	(y)	n	u

GP

If young people in foster or residential care are assessed, their social work team should be informed, (via standby SW if out-of-hours), *and* correspondence given to carers present.

Print Name A. ACABENIEGA

Signature

Date & Time 24/2/17

Outline of current presentation and precipitating factors

TOOK AN UNKNOWN QTY OF MIRTAZIPINE + ? DIAZEPAM
? 27 x 30MG MIRTAZIPINE + ? 14 x 5MG DIAZEPAM @
~ 12:00. LEFT A SUICIDE NOTE. NOT COPING
WITH BREAKING UP WITH GF + LOOSING CHILDREN
NO OTHER COMPLAINTS. FEELING LONELY

Previous mental health problems, self harm, addictions, medication etc

- DEPRESSION - MX BY GP WITH MIRTAZIPINE
DRINKS OCCASIONALLY
- LOST TEMPER AND CHILDREN TAKEN AWAY
BY WIFE. NOT COPING

Other relevant information: relationships, finances, employment, housing, physical health, childcare etc

LIVES ALONE ~ 1/12. SELF EMPLOYED MEDIA
MAN'N. 2 KIDS WITH MUM

Appearance	Behaviour	Speech
GOOD	NORMAL	NORMAL
Mood	**Thought**	**Insight**
VERY LOW	NO DISORDER	YES

Risk Assessment

High/Moderate/Low

Summary

Summary

ON GOING SUICIDAL IDEATION

Service Referred to	Time of Referral
Ψ GARNAVAL ROYAL HOSP	17:28

Disposal

Follow up and advice	Carer informed
MCNAIR WD GRH	NONE

Name and Designation of Consultant or Middle-Grade Involved in Reviewing Patient	ACBENYEGA ST6

male gender	(y)	n	u
age >18 and <65	(y)	n	u
depression	(y)	n	u
alcohol or drug use	y	(n)	u
separated, widowed, divorced	(y)	n	u
suicide plan/concealment	(y)	n	u
evidence of psychosis	y	(n)	u
ongoing suicial intent	(y)	n	u
lack of social support	y	(n)	u
chronic physical illness/pain	y	(n)	u
family history of suicide	y	(n)	u
family concerned about risk	y	n	(u)
disengaged/poor compliance	y	n	(u)
unemployed or retired	y	(n)	u
access to lethal means of harm	y	n	(u)
previous violent methods	y	(n)	u
history of self harm/overdose	y	(n)	u
previous psychiatric treatment	y	(n)	u
current psychiatric treatment	(y)	n	u
current use of benzodiazepines	(y)	n	u

GP

If young people in foster or residential care are assessed, their social work team should be informed, (via standby SW if out-of-hours), *and* correspondence given to carers present.

Print Name A. ACBENYEGA

Signature

Date & Time 4/2/17

3012876456 M
FLETCHER
Alan
FLAT 0-1
6 BLAWARTHILL ST
Glasgow, Lanarkshire
G14 0HG
30/12/1987

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	
Address	
	3012876456
	FLETCHER M
	Alan 30/12/1987
	FLAT 0-1
CHI No.	6 BLAWARTHILL ST
	Glasgow, Lanarkshire
DoB	G14 0HG

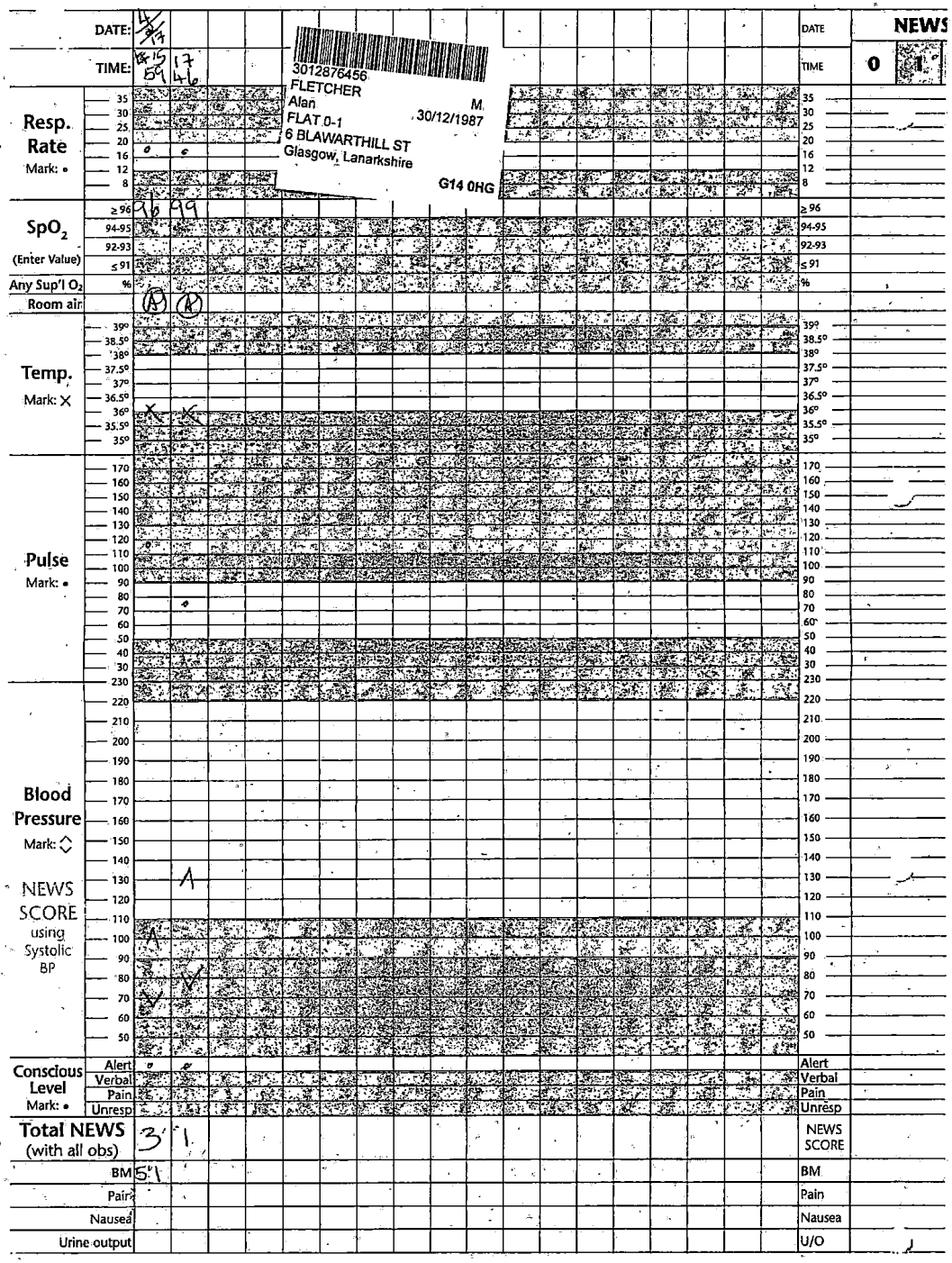
	Date	Ward
Admitted	4/2/17	AR
Transferred		
Transferred		

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


DATE
TIME
3012876456
FLETCHER
Alan
M
30/12/1987
FLAT 0-1
6 BLAWARTHILL ST
Glasgow, Lanarkshire
G14 0HG
NEWS
0
1
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
U/O

Scottish Ambulance Service Patient Report Form

Incident Number	CR003529348 on 04/02/2017 at 14:40		
Callsign		Incident Type	EMG
Crew1	E0015997	Crew3	
Crew2	E0026239	Crew4	

INCIDENT LOG

Incident Location	0/1 6 BLAWARTHILL STREET YOKER GLASGOW	Incident Postcode	G14 0HG
Call Received	14:40 - 04/02/2017	Patient at Hospital	15:21 - 04
Call Passed	14:41 - 04/02/2017	Patient Handover	
Crew Mobile	14:41 - 04/02/2017	Crew Clear	
Crew at Scene	14:48 - 04/02/2017	Clear Reason	
Crew Left Scene	15:06 - 04/02/2017		
Pre-alert Medical Standby			
Receiving Hospital	QUEEN ELIZABETH UNIVERSITY HOSPITAL		

3012876456
FLETCHER
Alan
M
30/12/1987

DIAGNOSIS

Chief Complaint Code	23
Despatch Code	23C01I : Intentional Overdosed and Not Alert
Diagnostic Code	23B01I : 23B01I - Intentional Overdose - No Priority Symptoms

PATIENT DETAILS

Surname	fletcher		
Forename	alan		
Middle Initials		Sex	Male
DoB	30/12/1987	Age	29 years 1 months 5 days
Patient Address	SAME AS LOCATION.	Patient Postcode	
Patient Telephone		Ethnicity	

PRIMARY SURVEY

AVPU Assessment	Alert
Catastrophic Haemorrhage	No
Airway Assessment	Clear
Breathing Rate	Normal
Respiratory Rate	20
Pulse	Normal
Most Peripheral Palpable Pulse Found	Radial
Skin Colour	Normal
Capillary Refill Rate	< 2 Secs
CSI Assessment	No Evidence Of C-Spine Injury

VITAL SIGNS

Time	Pulse	Rthm	AVPU	RR	SYS	DIA	PEF	BG	Temp	SpO2	PS	CRT	ECG	Sepsis	GCS	RTS	NEWS	ETCO2	Lactate
14:53	113	Reg	Alert	20	140	90		4.7	37.2	97	0	< 2 Secs	Sinus tachycardia	1	15	6.6	2		
15:00	107	Reg	Alert	18						96	0	< 2 Secs	Sinus tachycardia	1		4.9	1		

EYES AND PUPILS

Left Eye		Right Eye	
Left Pupil Size	Normal	Right Pupil Size	Normal
Left Pupil Reaction	Normal	Right Pupil Reaction	Normal
Unequal Reaction To Light			

EMERGENCY SERVICES

In Attendance	Paramedic, Police, Technician

SEPSIS

Pulse	RR	SYS	Temp	GCS	BG	Pneumonia	UTI	Other infection	Abdo Pain	Diarrhoea	Abdo distension	Meningitis	Cellulitis	Septic arthritis	Wound infection	Infected indwelling device	No signs of infection
113	20	140	37.2	15	4.7	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
107	18					NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

GCS

Time	Eye Opening	Verbal Response	Motor Response	Total
14:53	Spontaneous	Orientated	Obeys Commands	15
15:00				0

SOCIAL ASSESSMENT

Patient Age	
Situation	Patient Lives Alone
Risk Assessment	
Action Taken	Patient Conveyed To Hospital
Additional Details Of Risk Or Concern	

ADDITIONAL COMMENTS AND OBSERVATIONS

999 CALL 29 YOM PT HAS TAKEN O/D OF MIRTAZAPINE 30MG PT HAS ALSO BEEN DRINKING VODKA,BEER.PT HAS NOT VOMITED .PT CANT REMEMBER HOW MANY TABLETS TAKEN OR WHAT TIME. PT HAS NOT TAKEN ANYOTHER MEDS, PT HAD DONE THE SAME LAST WEDNESDAY.PT TAKEN O/D 14.19. PT HAS ALSO WRITTENA NOTE WHICH IS WITH EMPTY MEDS.PT HAS ASTHMA HAS INHALERS.

REPORT MANAGEMENT

Report ID	CR003529348-04022017152230		
Software Version	1.0.444	Report Type	Interim

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address
30/12/1987 3
LETCHER F
Alan A
CHI No.
DoB

	Date	Ward
Admitted	4/2/17	ARE
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:	4/7/17		DATE	NEWS
		TIME:	15:59	17:46	TIME	0 1
Resp. Rate Mark: •	35 30 25 20 16 12 8		•	•		
SpO_2 (Enter Value)	≥ 96		96	99	≥ 96	
	94-95				94-95	
	92-93				92-93	
	≤ 91				≤ 91	
Any Sup'l O_2	%				96	
Room air			(A)	(A)		
Temp. Mark: ×	39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°		×	×		
Pulse Mark: •	170 160 150 140 130 120 110 100 90 80 70 60 50 40 30		•	•		
Blood Pressure Mark: ◇	230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50			◇		
NEWS CORE using Systolic BP			1	1		
			1	✓		
			✓			
Conscious Level Mark: •	Alert		•	•	Alert	
	Verbal				Verbal	
	Pain				Pain	
	Unresp				Unresp	
Total NEWS (with all obs)			3	1	NEWS SCORE	
	BM		5.1		BM	
	Pain				Pain	
	Nausea				Nausea	
	Urine output				U/O	
	Obs due				Obs due	
	Initials		[illegible]		Initials	

KEY																										
2	3															30287.6456										DATE
																										TIME
	35																									35
	30																									30
	25																									25
	20																									20
	16																									16
	12																									12
	8																									8
	≥ 96																									≥ 96
	94-95																									94-95
	92-93																									92-93
	≤ 91																									≤ 91
	%																									%
	39°																									39°
	38.5°																									38.5°
	38°																									38°
	37.5°																									37.5°
	37°																									37°
	36.5°																									36.5°
	36°																									36°
	35.5°																									35.5°
	35°																									35°
	170																									170
	160																									160
	150																									150
	140																									140
	130																									130
	120																									120
	110																									110
	100																									100
	90																									90
	80																									80
	70																									70
	60																									60
	50																									50
	40																									40
	30																									30
	230																									230
	220																									220
	210																									210
	200																									200
	190																									190
	180																									180
	170																									170
	160																									160
	150																									150
	140																									140
	130																									130
	120																									120
	110																									110
	100																									100
	90																									90
	80																									80
	70																									70
	60																									60
	50																									50
Alert																										Alert
Verbal																										Verbal
Pain																										Pain
Unresp																										Unresp
NEWS SCORE																										NEWS SCORE
BM																										BM
Pain																										Pain
Nausea																										Nausea
Urine tput																										U/O
Obs due																										Obs due
Initials																										Initials

Resp. Rate

SpO2

Temp.

Pulse

Blood Pressure

Glasgow Coma Scale

Pupil size (mm)

1	2	3	4	5	6	7	8
•	●						

Neurological Observations

Date:																									
Time:																									
COMA SCALE	E Eyes open	Spontaneously	4																						Eyes closed by swelling = 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 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																							
		Spastic flexion																							
		Extension																							
		No response																							

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

24

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital

CHI: 3012876456

Total Att: 11

12 Mth Att: 1

Title: **MR**

FLETCHER **Alan**

DOB: **30/12/1987** Age: **29y** Sex: **Male**

FLAT 0-1
6 BLAWARTHILL ST
Glasgow
Lanarkshire
G14 0HG
07492566221

Next of kin: **FLETCHER, MARIA**
Relationship: **Parent**
0141 952 1696

GP: **PA Costello**
0141 959 1196

Attendance Date: **01/02/2017** Arrival Time: **22:27**

Registration Time: **22:27** Date of Incident: **01/02/2017**

Major Incident Desc:

Reason for Attendance: **biba od**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

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

Presenting Complaint:

Observation Date: **01/02/2017 23:32**

Temp	36.1	C
HR	76	bpm
BP	122/76	mmHg
MAP		mmHg
RR	16	bpm
SpO2	100	%
Oxygen		%

Nurse name: **Nurse Samantha Lamont1**

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: **biba - mixed overdose ?what tablets, has also had alcohol, feeling low after splitting up from girlfriend**

Child Assessment Questionnaire

3012876456 30/12/1987
FLETCHER
Alan

	YES	NO
Previous attendance (consider any r		
History variable between accounts		
Examination not compatible with h		
Delay in presentation		
Fracture/head injury or significant t		

Discuss with S

ntified

X-Ray and Other Reports

not being admitted)

Patient Sample Report

Patient

ID:	3012876456
Last Name:	**FLETCHER**
First Name:	**ALAN**
Gender/Age:	Male, 29 years
Birth Date:	30.12.1987
Status:	**ACCEPTED**
Analyzed:	02.02.2017 01:05:51
Sample Type:	**Venous**
Operator ID:	R THOMSON

Analyzer

Model:	GEM® *Premier 4000*
Area:	AH_L0ED_B
Name:	ED-MAJ-IN
S/N:	08061612

Measured (37.0°C)

cH	38.8	nmol/L
pCO_2	5.3	kPa
pO_2	7.8	kPa
Na^+	140	mmol/L
K^+	3.8	mmol/L
Cl^-	107	mmol/L
Glu	5.6	mmol/L
Lac	1.3	mmol/L

CO-Oximetry

tHb	168	g/L
O_2Hb	89.3	%
COHb	1.9	%
MetHb	0.6	%
HHb	8.2	%
sO_2	91.6	%

Derived

BE(B)	0.7	mmol/L
HCO_3^-(c)	25.4	mmol/L

Operator Entered

Temp	37.0	°C

O2 and Vent Settings

FIO_2		%

laxis)

ONCE C								
Date Given	DRUG (BLOCK C					of ration	Signature	Given By

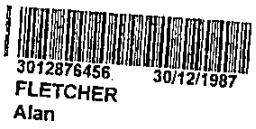
Date	CLINICAL NOTES
	Seen by (Dr) CAMF Time seen 0100

2/1/17

(29) M

PC OD

MHx SHS - ED
+ EtOH dep.



~1800

In house self
Denies other drugs
Unknown quantity

Saw CP Fluoxetine
MX Antidepressant

PMH

Argument w/ girlfriend.
↳ splitting up

DH

No HF OD
Regrets OD
Spontaneous
No plans
Left letter.
No future plans
No recreational drugs

SE

Suicidal.
Engineer.
Hx cuts
Hx OD
Effort

PAUTHSHHO
-THHB
cohx SMT
oedema

36.1
HR 76
122/76
RR 16
100% RA

SMT
BS

Date	CLINICAL NOTES
	Inj CD (1) ECG - case MC Bloods G n/c Torbest.

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

FLETCHER, Alan (Mr) Date of Birth: **30-Dec-1987 (29y)**

Flat 0/1, 6 Blawarthill Street, Glasgow, G14 0HG

CHI Number: 3012876456 Usual GP:

Consultations

Date	Consultation Text
02-Feb-2017	Face to face consultation (Queen Elizabeth University Hospital) CARR, Elizabeth (OOH)
Comment	Request for assessment Q.E.U.H. A&E Dr. Lowe. Patient taken to A&E by ambulance following overdose, unspecified amount while intoxicated. Agreed CPN assessment at A&E. Seen for assessment 02.00hrs, E Carr and M McCreadie. Patient unable to give history/timeline of events prior to attending A&E. Stated he had argument with his girlfriend yesterday (Wednesday 1/2/17.) when she told him their year long relationship had ended. He states the relationship had been difficult since Christmas when he had got angry and smashed something in house. He stated this frightened her, he denies any physical aggression towards her. Alan stated he lost his temper as he didn't get access to his two children from previous relationship at Christmas. He did not want relationship to end but girlfriend told him yesterday it was over. Alan reports other stressors, having very little work leading to financial difficulties, and being home during the day bored. He has been consulting a lawyer regards access to his children but has not seen them for six months. Alan recalled drinking beer, he was unable to recall amount but had case of 20 cans in house, he does not recall taking overdose but ambulance notes indicate he had sent picture of himself taking overdose to a neighbour who alerted police. They attended and he could be seen lying on floor. Alan was heavily intoxicated and unresponsive when ambulance crew arrived with GCS 3. Asleep on hospital trolley when assessors arrived, appeared startled and wakened very quickly sitting upright. Engaged well in assessment process, behaviour and eye contact appropriate. Casually dressed, good self care. Appeared intoxicated. Speech clear and coherent, normal rate and tone. Content appropriate to situation. No evidence of psychotic symptoms, not distracted or preoccupied. Concentration and attention span good. Mood subjectively low, objectively euthymic, reactive affect. Impulsive overdose, unknown amount of ?tablets while intoxicated. Sent photo of himself taking overdose to neighbour. No ongoing suicidal thoughts plan or intent, keen to return home to bed. No previous self harm. Future planning, has 20 jobs programmed and is seeking access to his two children. No change to appetite. Sleep pattern disturbed, long standing problem, no recent changes. Alan states this is related to his erratic work shift pattern. No drug use, rarely drinks alcohol. No evidence of cognitive deficit. Agreed to contact G.P. in am to discuss prescription. Outcome of assessment discussed and agreed with referring doctor.
Document	Risk assessment SSA MH Clinical Risk Screening and Management Tool

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address

CHI No.
DoB

	Date	Ward
Admitted		
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.

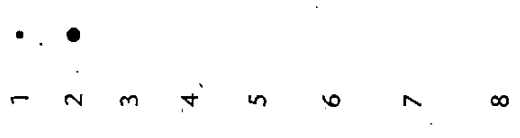
DATE:		1/2 35
TIME:		23
Resp. Rate Mark: •	35 / 30 / 25 / 20 / 16 / 12 / 8	• (16)
SpO_2 (Enter Value)	≥ 96 / 94-95 / 92-93 / ≤ 91	100
Any Sup'l O_2	%	
Room air		A
Temp. Mark: X	39° / 38.5° / 38° / 37.5° / 37° / 36.5° / 36° / 35.5° / 35°	X (36°)
Pulse Mark: •	170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50 / 40 / 30	• (90)
Blood Pressure Mark: ◇ NEWS SCORE using Systolic BP	230 / 220 / 210 / 200 / 190 / 180 / 170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50	Λ (120) V (70)
Conscious Level Mark: •	Alert / Verbal / Pain / Unresp	• (Alert)
Total NEWS (with all obs)		0
BM		
Pain		
Nausea		
Urine output		
Obs due		
Initials		[illegible]

DATE	NEWS
TIME	0 1
35 / 30 / 25 / 20 / 16 / 12 / 8	
≥ 96 / 94-95 / 92-93 / ≤ 91 / %	
39° / 38.5° / 38° / 37.5° / 37° / 36.5° / 36° / 35.5° / 35°	
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	
Alert / Verbal / Pain / Unresp	
NEWS SCORE	
BM	
Pain	
Nausea	
U/O	
Obs due	
Initials	

KEY		3012876456.	DATE
2	3		TIME
	35		35
	30		30
	25		25
	20		20
	16		16
	12		12
	8		8
Resp. Rate			Resp. Rate
	≥ 96		≥ 96
	94-95		94-95
	92-93		92-93
	≤ 91		≤ 91
SpO₂	%		%
	39°		39°
	38.5°		38.5°
	38°		38°
	37.5°		37.5°
	37°		37°
	36.5°		36.5°
	36°		36°
	35.5°		35.5°
Temp.	35°		35°
	170		170
	160		160
	150		150
	140		140
	130		130
	120		120
	110		110
	100		100
	90		90
	80		80
	70		70
	60		60
	50		50
Pulse	40		40
	30		30
	230		230
	220		220
	210		210
	200		200
	190		190
	180		180
	170		170
	160		160
	150		150
	140		140
	130		130
	120		120
	110		110
	100		100
	90		90
	80		80
	70		70
	60		60
	50		50
Blood Pressure			Blood Pressure
	Alert		Alert
	Verbal		Verbal
	Pain		Pain
	Unresp		Unresp
	NEWS SCORE		NEWS SCORE
	BM		BM
	Pain		Pain
	Nausea		Nausea
	Urine Output		U/O
	Obs due		Obs due
	Initials		Initials

Glasgow Coma Scale

Pupil size (mm)



Neurological Observations

Date:																									
Time:																									
COMA SCALE	E Eyes open	Spontaneously	4																						Eyes closed by swelling = 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 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																							
		Spastic flexion																							
		Extension																							
		No response																							

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

Scottish Ambulance Service Patient Report Form

Incident Number	CR003523017 on 01/02/2017 at 20:48		
Callsign		Incident Type	EMG
Crew1	E0005541	Crew3	
Crew2	E9888159	Crew4	

INCIDENT LOG

Incident Location	0/1 6 BLAWARTHILL STREET YOKER GLASGOW	Incident Postcode	G14 0HG
Call Received	20:48 - 01/02/2017	Patient at Hospital	22:10 - 01/02/2017
Call Passed	21:04 - 01/02/2017	Patient Handover	-
Crew Mobile	21:04 - 01/02/2017	Crew Clear	-
Crew at Scene	21:08 - 01/02/2017	Clear Reason	
Crew Left Scene	22:00 - 01/02/2017		
Pre-alert Medical Standby			
Receiving Hospital	QUEEN ELIZABETH UNIVERSITY HOSPITAL		

DIAGNOSIS

Chief Complaint Code	23
Despatch Code	23C07I : Intentional O/dose Unknown Status/Other codes N/A
Diagnostic Code	23C02I : 23C02I - Intentional Overdose with Abnormal Breathing .

PATIENT DETAILS

Surname	FLETCHER		
Forename	ALAN		
Middle Initials		Sex	Male
DoB	30/12/1987	Age	29 years 1 months 2 days
Patient Address	AS INCIDENT	Patient Postcode	
Patient Telephone		Ethnicity	A1 - White Scottish

PATIENT CONSENT

Mental Capacity Assessed	Deemed Not To Have Capacity
Level of Consent	

PRIMARY SURVEY

AVPU Assessment	Unresponsive
Catastrophic Haemorrhage	No
Airway Assessment	Clear
Breathing Rate	Slow
Respiratory Rate	10
Pulse	Normal
Most Peripheral Palpable Pulse Found	Radial
Skin Colour	Normal
Skin Texture	Dry
Capillary Refill Rate	< 2 Secs
CSI Assessment	None

3012876456 30/12/1987
FLETCHER
Alan

VITAL SIGNS

Time	Pulse	Rthm	AVPU	RR	SYS	DIA	PEF	BG	Temp	SpO2	PS	CRT	ECG	Sepsis	GCS	RTS	NEWS	ETCO2	Lactate
21:12	82	Reg	Unresponsive	10	117	62		3.9	36.7	94		< 2 Secs	Atrial Flutter		3	2.9	1		
21:49	83	Reg	Unreponsive	20	119	70				92		< 2 Secs			3	4.0	5		
22:02	83	Reg	Unreponsive	20	120	69				96		< 2 Secs			3	4.0	3		

AMPLE

Allergy Type	Unknown.
Previous Medication	FLUXITOPINE, METAZIPINE
Previous Medical History	DEPRESSION , PSYCHIATRIC
Other Disability	
Last Eaten Before Incident	More Than 5 Hours
Events Prior To Incident	PT SPLIT UP FROM GIRLFRIEND IN JANUARY HER AND KIDS LEFT THE HOME THEY WER LIVING IN TOGETHER, HE SENT A PICTURE OF HIM OVERDOSING TO HIS NEIGHBOUR AT 20:00HRS. POLICE WERE ALEERTED AND CALLED FOR THE AMBULANCE AS THEY COULD SEE HIM ON THE FLOOR THROUGH THE LETTERBOX WITH TABLETS BOXES AROUND HIM AFTER FORCING THE DOOR HE WAS FOUND TO STILL BE BREATHING ALTHOUGH UNRESPONSIVE BY THE POLICE. O/A PT WAS ON THE COUCH GCS 3 PINPOINT PUPILS RR 10 SO ADMINED NARCAN CAME UPTTO 20

EYES AND PUPILS

Left Eye		Right Eye	
Left Pupil Size	Constricted	Right Pupil Size	Constricted
Left Pupil Reaction	Abnormal	Right Pupil Reaction	Abnormal
Unequal Reaction To Light			

MEDICINES

Drug	Time	Dosage	Route	Crew No	Batch/Expiry	Pain Before	Pain After
Naloxone	21:16	400 mcg	IM		517066		
Sodium chloride 0.9%	21:20	250 ml	IV				

EMERGENCY SERVICES

In Attendance	Paramedic, Police, Technician

PATIENT HANDOVER

Patient Mobility On Arrival	Lying	On Scene Removal	Chair
Patient Transportation	Lying	Care Delivery At Hospital	Trolley
Time Of Patient Handover			

SEPSIS

Pulse	RR	SYS	Temp	GCS	BG	Pneumonia	UTI	Other infection	Abdo Pain	Diarrhoea	Abdo distension	Meningitis	Cellulitis	Septic arthritis	Wound infection	Infected indwelling device	No signs of infection
82	10	117	36.7	3	3.9	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
83	20	119		3		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
83	20	120		3		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

GCS

Time	Eye Opening	Verbal Response	Motor Response	Total
21:12	Nil	Nil	Nil	3
21:49	Nil	Nil	Nil	3
22:02	Nil	Nil	Nil	3

REPORT MANAGEMENT

Report ID	CR003523017-01022017222339		
Software Version	1.0.444	Report Type	Interim

Main WR

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 3012876456

Queen Elizabeth University Hospital

Total Att: **10**

12 Mth Att: **1**

Title: **MR**

FLETCHER **Alan**

DOB: **30/12/1987** Age: **29y** Sex: **Male**

FLAT 0-1
6 BLAWARTHILL ST
Glasgow
Lanarkshire
G14 0HG
07492566221

Next of kin: **FLETCHER, MARIA**
Relationship: **Parent**
0141 952 1696

GP: **PA Costello**
0141 959 1196

Attendance Date: **15/01/2017** Arrival Time: **23:07**

Registration Time: **23:07** Date of Incident: **01/01/2017**

Major Incident Desc:

Reason for Attendance: **upper limb pain**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

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

Presenting Complaint: **Hand Injury Right**

Observation Date: **15/01/2017 23:14** Nurse name: **Nurse Emma Campbell**

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?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **hand trapped while building a stage 2 weeks ago. someone stood on it at the time. rhd**

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) Time seen

15/11/17

PC - sore hand.

HPC injured hand (R) 2wks ago. heavy wood fell on it at work. didn't attend ED @ that time.
now - still sore + bit swollen.

O/E

(R) hand

NV in tact
full ROM.
pain on palp 5th metacarpal.
nil external to see
minimal swelling.

XR - no #.

plan (#) / splint, analgesia.
(manual worker - more for protection rather than medical need)

see - ukenlsep
ST3 ED.

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

23

Bloods including paracetamol level ☑

Affix Label

CHI: 3012876456

Queen Elizabeth University Hospital

Total Att: 9

12 Mth Att: 2

Title: **MR**

FLETCHER **Alan**

DOB: **30/12/1987** Age: **28y** Sex: **Male**

FLAT 0-1
6 BLAWARTHILL ST
Glasgow
Lanarkshire
G14 0HG
07492566221

Next of kin: **FLETCHER, MARIA**
Relationship: **Parent**
0141 952 1696

GP: **PA Costello**
0141 959 1196

Attendance Date: **21/01/2016** Arrival Time: **19:15**

Registration Time: **19:15** Date of Incident: **21/01/2016**

Major Incident Desc:

Reason for Attendance: **accidental o/d - for toothache**

Affix Label

Nursing Assessment

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

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

Presenting Complaint: **General Generally Unwell**

Observation Date: **21/01/2016 19:32** Nurse name: **Nurse Karen Bowden**

Temp	**35.4**	C
HR	**78**	bpm
BP	**137/68**	mmHg
MAP		mmHg
RR	**18**	bpm
SpO2	**97**	%
Oxygen		%

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **Pt has taken 18 paracetamol tabs in last 24hrs for toothache. Phoned NHS 24 for emergency dental appt, wont provide until he's attended for accidental OD.**

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) JNEDDON Time seen 19:55

3012876456 30/12/1987
FLETCHER
Alan

21/1/16

PC => ? PARACETAMOL OVERDOSE

HPC => PAST 24 HOURS HAS HAD TOOTHACHE (WISDOM TOOTH SEEN BOTHERING HIM PAST FEW MONTHS).

=> HAS BEEN TAKING PARACETAMOL FOR PAIN - 18 IN LAST 24 HOURS.

=> FEELS FINE

=> NOT TAKEN ANYTHING ELSE.

PMH => NIL

SOCIAL => WORKS AS SOUND ENGINEER.

~~MEDS~~ => NIL

O/E => LOOKS WELL OBS FINE

=> CVS I + II + 0 MOST

ABDO ? NAT + VE OS

PLAN - BLOODS INC. PARACETAMOL LEVEL

- IF OK - HOME

- DISCUSSED DANGERS OF PARACETAMOL OVERDOSE.

JNEDDON 741232

21/1/15 20:55

JNEDDON

=> V + E (N) LFT (N)

PARACETAMOL LEVEL 12.

PLAN - WARNED ABOUT DANGERS OF PARACETAMOL + NOT TO TAKE ~~TOO~~ TOO MANY.

- HOME.

JNEDDON 741232

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	21/1/16.
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	21:00

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

Designed by Medical Illustration Services ref 243836

NHS 24 FAX REPORT

Ale Majors

NHS 24 ID:	Call ID: 17172509	Site:	Cardonald
CHI #:	3012876456	Caller Name:	
Surname:	FLETCHER	Date/Time Call Received:	21/01/2016 18:19
Forename:	ALAN		
DOB:	30/12/1987	Date Call Completed:	
Gender:	Male	Time Call Completed:	23:54
Address:	0/1 6 Blawarthill Street	Call Priority:	CS3
	YOKER	Call Reason:	OVER SELFMEDICATE
	Glasgow	Current Location:	0/1 6 Blawarthill Street
			YOKER
	G14 0HG		Glasgow
PH NO:	01413890975 (Return)		G14 0HG
	07492566221 (Return)	Special Directions:	Intercom/Buzzer Entry
		Current PH NO:	07492566221 (Return)
Care Provider:	COSTELLO, PAUL	Care Provider Details:	1980 GREAT WESTERN ROAD
			GLASGOW
			G13 2SW
			Scotland
Temporary Resident:	No		

Referred To: Recommended Action:

CLINICAL SUMMARY

DENTAL PAIN UPPER LEFT ?WISDOM TOOTH FOR 3 DAYS AND REG CROW RD/TOOTH BROKEN/CONSTANT THROBBING PAIN/KEPT AWAKE/OOZING FROM GUM WHEN BRUSHING AND TOUCHING GUM /PEA SIZE LUMP ON GUM FEW DAYS GRADUAL INCREASE IN SIZE/PUFFY SWELLING LEFT CHEEK ALL DAY NO CHANGE IN SIZE/SELF CARE ADVICE GIVEN/ADVISED ATTEND ASAP FOR OVER SELFMEDICATION/PATIENT TO,BE SEEN WITHIN 24 HOURS/GC

PAST MEDICAL HISTORY

MEDICAL PROBLEMS

ASTHMA

MEDICATIONS

VENTOLIN INHALER

ALLERGIES

NIL

3012876456
FLETCHER M
Alan 30/12/1987
FLAT 0-1
6 BLAWARTHILL ST
Glasgow, Lanarkshire
G14 0HG

Referred Clinical Notes:

T:
P:
R:
BP: /

Print Name: Signature:

CHI: 3012876456

MR 4

Western Infirmary

Total Att: **8**

12 Mth Att: **1**

Title: **MR**

FLETCHER **Alan**

DOB: **30/12/1987** Age: **27y** Sex: **Male**

16 Blawarthill Street

Glasgow
G14 0HG
07794360657

Next of kin: **FLETCHER, MARIA**
Relationship: **Parent**
0141 952 1696

GP: **PA Costello**
0141 959 1196

Attendance Date: **01/04/2015** Arrival Time: **19:29**

Registration Time: **19:29** Date of Incident: **01/04/2015**

Major Incident Desc:

Reason for Attendance: **R Hand Injury**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **01/04/2015 19:49** Nurse name: **Nurse Catherine MacDonald**

Temp	36.1	C
HR	80	bpm
BP	156/76	mmHg
MAP	102.67	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: **self ref - pt injured right hand at work caught in door**

3012876456 30/12/1987 FLETCHER Alan
3012876456 30/12/1987 FLETCHER Alan
3012876456 30/12/1987 FLETCHER Alan
3012876456 30/12/1987 FLETCHER Alan
3012876456 30/12/1987 FLETCHER Alan

1-4-15 N. Graham CF A+E · Dr Allen ·

2250

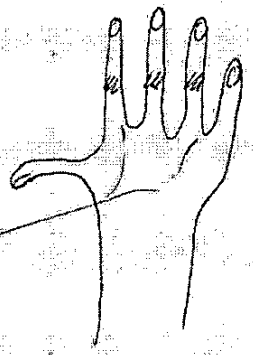
(27) PC - R hand injury

HPC - trapped hand between metal shutter & the roof at work. Pain in middle 3 fingers. Able to move them. Not used ice / taken analgesia.

PMH - nil

DHx - nil

O/E -



Couple of Superficial Scratches.

R handed..
Tender & mild swelling over 2-4 PIPJs.
Reasonable flexion
Full extension
NVI
Hand + wrist ok.

Imp - nile out #

(P) XR

Mgpl CF

XR - NBI

(P) home & advice

Mgpl CF

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

CHI: 3012876456

Victoria Infirmary Glasgow

Total Att: 7

12 Mth Att: 0

Title: **MR**

FLETCHER **Alan**

DOB: **30/12/1987** Age: **27y** Sex: **Male**

16 Blawarthill Street
Glasgow
G14 0HG
07794360657

Next of kin: **FLETCHER, MARIA**
Relationship: **Parent**
0141 952 1696

GP: **PA Costello**
0141 959 1196

Attendance Date: **10/02/2015** Arrival Time: **13:59**

Registration Time: **13:59** Date of Incident: **10/02/2015**

Major Incident Desc:

Reason for Attendance: **knee injury**

Affix Label

Nursing Assessment

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

Triage Category: Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: Nurse name:

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?		

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes:

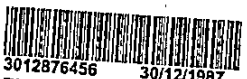
97607

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) C-STEVENSON Time seen 1410

10/2/15 PC. painful (L) leg & (R) knee sound engineer

HPC. at work today
standing on roof - collapsed
fell ~ 10ft approx
landed on feet - awkwardly
hit leg off metal bar
PMHx. nil meds nil NKDA

OE. (R) knee
slight swelling over medial aspect
no bruising or wounds
tender over fem condyle & medial soft tissues
non tender patella, fib head, tib plateau, tib tuberosity
full ROM
can SLR & flex to 90°
MCL PCL } no pain or laxity
LCL ACL }
weight bearing with slight limp
NV intact

(L) leg. superficial abrasion to knee
onset of bruising over lower calf. & slight swelling
no wounds
calf soft
tender ++ over bruised area
no bony tenderness fem condyles, patella, tib plateau & tuberosity, fib head, shaft of tib & fib, med or lat mall, mt's navicular calcaneum, phalanges

Date	CLINICAL NOTES
10/2/15	full ROM in knee, ankle & foot can SLR & flex to 90° MCL ✓ LCL ✓ PCL ✓ ACL ✓ achilles calf squeeze test ✓ nv intact weight bearing Pt has no pain in neck back or pelvis no midline tenderness in c-spine, thoracic spine, lumbar spine or coccyx Plan. X-ray (R) knee. - no # seen. Imp. soft tissue injury to (R) knee & (L) calf. Treat. tubigrip advised to rest ice & elevate (R) knee & (L) calf - A/E if any concerns wound cleaned and dressed ✓ swelling in calf

Discharge Codes (Please CIRCLE)					Discharge date	10/2/15.
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		Discharge time	1505.
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.		

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
10/2/15	IBUPROFEN	400mgs	PO	tid	CS	CS

Designed by Medical Illustration Services ref 243836

Western Infirmary

CHI: 3012876456

Total Att: **6**

12 Mth Att: **0**

Title: **MR**

FLETCHER **Alan**

DOB: **30/12/1987** Age: **26y** Sex: **Male**

FLAT 6/4
ARCHERHILL SQUARE
Glasgow
Lanarkshire
G13 4TD
07794360657

Next of kin: **FLETCHER, MARIA**
Relationship: **Parent**
0141 952 1696

GP: **PA Costello**
0141 959 1196

Attendance Date: **12/01/2014** Arrival Time: **10:02**

Registration Time: **10:02** Date of Incident: **12/01/2014**

Major Incident Desc:

Reason for Attendance: **cut right hand**

Nursing Assessment

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

Triage Category: **0** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **12/01/2014 11:03** Nurse name: **Nurse Evelyn Getty**

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?	

GCS		
Eyes		
Motor		
Verbal		
Total		

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

Nursing Notes:

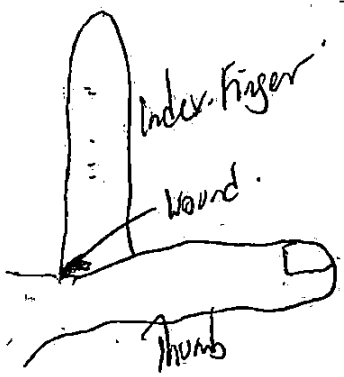
3012876456 30/12/1987 FLETCHER Alan
3012876456 30/12/1987 FLETCHER Alan
3012876456 30/12/1987 FLETCHER Alan
3012876456 30/12/1987 FLETCHER Alan
3012876456 30/12/1987 FLETCHER Alan

12/01/14
26 years old male - Sound Engineer. Tet Tox : Up-to-date.
RHD.
P/C. Laceration. ® Hand.
Hpc/ Pulling case out from Under bed.
Caught. ® Hand on sharp Edgue.
Palmer Thumb Crease. Bleeding slightly.

PmH/ Asthma. OH/ Servent. KDHA

O/E look.
lac Ragged Approx 2cms.
In Web Space between Thumb + Index finger : ○Bruising ○swelling ○evidence of Infection.

Feel. Full sensation.
Full ROM.
Active Passive Resisted.
UCL appears intact.
Can See wound. Base.



Plan clean Thoroughly.
closed Yc wound glue
+ SteRi-strips.
Inadine.
+ mepilex Border dressing applied.
Advice
Advised GP/practice Nurse for Dressings.
Discharged.

Ebdy: ENP.

NHS GREATER GLASGOW & CLYDE

3012876456
FLETCHER
Alan M
FLAT 0-1 30/12/1987
6 BLAWARTHILL ST
Glasgow, Lanarkshire
G14 0HG

CLINICAL NOTES - MEDICAL

Date & Time		Signature, Print Name & Designation
25/1/17	MOLCAT (Em CLINIC)	
	– Injury to (R) hand 3/52 ago.	
	– Cast in situ	
	– Seen at ED 15/1/17	
	⇒ xray ⇒ initially told all OK	
	⇒ report ⇒ small avulsion # at base of 5th MC.	
	– Has contact to work ⇒ manual labourer.	
	– OIC pain ⇒ use an analgesic liniment	
	OE – no deformity.	
	– mild tenderness at base of 5th MC	
	– no deformity.	
	Plan – nil antibiotics required	
	– advised that he will have pain for further 2–3/52	
	– advise re work / splint for comfort	
	– no further f/u	
	Liniment	
	(on repeat)	

83949

Date & Time		Signature, Print Name & Designation

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 2338 (82338)
Fax: Patient Attended
Email: QEUH Assessment Unit

Date Completed: 30/12/2025

Consultant: Dr Gemma McGrory

GS Watson
Crookston Medical Practice
230 Dalmellington Road
Crookston
Glasgow
Glasgow
G53 7FY

Dear GS Watson

Re: **Fletcher Alan** DOB: **30/12/1987** CHI: **3012876456**
12 POLQHUAP RD
Glasgow G53 7FL

Attended on: **30/12/2025 at 15:31 hrs.** Departed on: **30/12/2025 at 20:37 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
LEFT SIDED CHEST PAIN

Nursing Assessment:
LEFT SIDED CHEST PAIN, SOB NO RADIATION FOR PAST WEEK HX ASTHMA

Investigations in ED:

1. XR Chest	**2. Coagulation screen**	**3. Urea and Electrolytes**
4. Glucose	**5. LFT**	**6. CRP**
7. Full Blood Count	**8. Troponin I hs**	**9. Chol / Triglyceride**
10. D - Dimer		

Diagnosis:

Diagnosis	Side	Site
Chest Pain, Unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

38 year old presented with left sided sharp chest pain on background of asthma since waking up from his sleep on 24th December. It was worse on bending down, moving sideways and was also struggling to lift anything up. On examination there were no signs of chest wall tenderness, chest was clear and heart sounds were normal. His blood tests including troponin and d-dimer did not show any acute findings and CXR did not show any new changes. It was felt that his symptoms were musculoskeletal in nature. He was otherwise well and has been sent home with simple analgesia, reassurance and worsening advice. Thank you for continuing the care of the patient in the community.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Sherin Thomas
Doctor

Copies to:

1. GS Watson (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 28/11/2023

Consultant: Dr Euan McMillan

AP Kerr
The Crescent Medical Practice
12 Walmer Crescent
Glasgow
Glasgow
G51 1AT

Dear AP Kerr

Re: **Fletcher Alan** DOB: **30/12/1987** CHI: **3012876456**
62 INNERWICK DR
Glasgow G52 2HY

Attended on: **27/11/2023 at 20:08 hrs.** Departed on: **28/11/2023 at 00:01 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:
injury to R hand at work yesterday- increasing pain radiating down fingers

Investigations in ED:
1. XR Hand Rt

Diagnosis:

Diagnosis	Side	Site
Injury of Unspecified Nerve At Wrist and Hand Level		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Any medication dispensed or changed is recorded in this letter in the free text below**

Clinician Notes:

Attended following hyper-reflexive injury of right hand during work accident. Nil to find on examination. XR - nil obvious. Imp: ?neuropraxia/ strain. Home with PO analgesia and worsening advice

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Connor Boyle
Doctor

Copies to:

1. AP Kerr (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:
Fax:
Email:

Date Completed: 21/06/2020

Consultant: Dr Ronnie Mollah

PA Costello
Knightswood Medical Practice
1980 Great Western Road
Glasgow
Glasgow
G13 2SW

Dear PA Costello

Re: **Fletcher Alan** DOB: **30/12/1987** CHI: **3012876456**
62 Innerwick Drive
Glasgow G52 2HY

Attended on: **21/06/2020 at 14:18 hrs.** Departed on: **at hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
left arm injury

Nursing Assessment:

Investigations in ED:
1. XR Radius and ulna Lt

Diagnosis:

Diagnosis	Side	Site
Contusion of Other and Unspecified Parts of Forearm		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Contusion to left forearm. Dx with advice.

Followup :
Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Kirsty Allan
Nurse

Copies to:
1. PA Costello (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: 24/08/2018

Consultant: Dr Kevin Thomson

PA Costello
Knightswood Medical Practice
1980 Great Western Road
Glasgow
Glasgow
G13 2SW

Dear PA Costello

Re: **Fletcher Alan** DOB: **30/12/1987** CHI: **3012876456**
62 Innerwick Drive
Glasgow G52 2HY

Attended on: **22/08/2018 at 10:50 hrs.** Departed on: **22/08/2018 at 12:34 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
l leg inj

Nursing Assessment:
heavy weight fell onto l ankle yesterday

Investigations in ED:
1. XR Ankle Lt

Diagnosis:

Diagnosis	Side	Site
Contusion of ankle		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Contusion left ankle, no fracture on xray. Discharged with co-codamol 30/500.

Followup :
Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Claire McGroarty
Consultant

Copies to:
1. PA Costello (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: 16/02/2018

Consultant: Dr Hannah Smith

PA Costello
Knightswood Medical Practice
1980 Great Western Road
Glasgow
Glasgow
G13 2SW

Dear PA Costello

Re: **Fletcher Alan** DOB: **30/12/1987** CHI: **3012876456**
FLAT 0-1
Glasgow G14 0HG

Attended on: **16/02/2018 at 10:24 hrs.** Departed on: **16/02/2018 at 11:30 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **3**

Presenting complaint
foot pain

Nursing Assessment:
foot pain for year

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Plantar fasciitis		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

1 year history of intermittent right foot pain, worse in last month. Tender along plantar facsiia. Noted to have quite flat arches. Given naproxen and advice regarding footwear. If ongoing issue might benefit from referral to orthotics for insole.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Claire McGroarty
Consultant

Copies to:

1. PA Costello (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: 05/04/2017

Consultant: Dr Phil Munro

PA Costello
Knightswood Medical Practice
1980 Great Western Road
Glasgow
Glasgow
G13 2SW

Dear PA Costello

Re: **Fletcher Alan** DOB: **30/12/1987** CHI: **3012876456**
FLAT 0-1
Glasgow G14 0HG

Attended on: **05/04/2017 at 12:48 hrs.** Departed on: **at hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Transfer to other NHS healthcare provider**

Previous ED Attendance in last 12 months: **6**

Presenting complaint
overdose- came across from mcnair ward gartnavel royal

Nursing Assessment:
Psych patient at Gartnaval. OD of Nytol and ? fluoxetine. Mixed OD

Investigations in ED:

1. Full Blood Count	**2. CRP**	**3. Urea and Electrolytes**
4. LFT	**5. Paracetamol**	**6. Salicylate**
7. Lactate (Glasgow only)	**8. 12 Lead ECG**	**9. Coagulation screen**
10. CK		

Diagnosis:

Diagnosis	Side	Site
Deliberate self poisoning by unspecified drugs, medication and biological substances		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Presented with mixed OD with alcohol from McNair ward at GGH. Obs normal, bloods normal including paracetamol and salicylate levels, ECG normal. Remained in the department for a period of observation for 6 hours - remained well. Discharged back to McNair ward with a staff nurse from there.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Paul Donnelly2
Doctor

Copies to:

1. PA Costello (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: 10/03/2017

Consultant: Dr Ronnie Mollah

PA Costello
Knightswood Medical Practice
1980 Great Western Road
Glasgow
Glasgow
G13 2SW

Dear PA Costello

Re: **Fletcher Alan** DOB: **30/12/1987** CHI: **3012876456**
FLAT 0-1
Glasgow G14 0HG

Attended on: **10/03/2017 at 10:59 hrs.** Departed on: **10/03/2017 at 14:52 hrs.**
Discharge Type: **03 - Transferred** Destination: **Transferred to other Hospital (triaged in MIU)**

Previous ED Attendance in last 12 months: **5**

Presenting complaint
bibp, threating self harm

Nursing Assessment:
? OD of Nytole.

Investigations in ED:

1. 12 Lead ECG	**2. Amylase**	**3. Bone Profile**
4. CRP	**5. Glucose**	**6. LFT**
7. Urea and Electrolytes	**8. Full Blood Count**	

Diagnosis:

Diagnosis	Side	Site
Alcohol Dependance		
Severe depression without psychotic symptoms		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Severe situational depression with heavy alcohol intake and multiple self harm attempts, including possible unrecalled OD "Nytol" tablets last night. Dilated pupils but no other evidence toxicity, normal ECG and bloods. Reviewed by CPNs and assessed as high risk suicide, so transferred GRH for admission.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Tim Parke
Consultant

Copies to:

1. PA Costello (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: 18/02/2017

Consultant: Dr Amit Roy

PA Costello
Knightswood Medical Practice
1980 Great Western Road
Glasgow
Glasgow
G13 2SW

Dear PA Costello

Re: **Fletcher Alan** DOB: **30/12/1987** CHI: **3012876456**
FLAT 0-1
Glasgow G14 0HG

Attended on: **18/02/2017 at 03:39 hrs.** Departed on: **18/02/2017 at 05:17 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Temporary residence**
Previous ED Attendance in last 12 months: **4**

Presenting complaint
bibp, ankle and wrist pain

Nursing Assessment:
injury to r ankle yesterday seen at gri no bony injury seen ,twisted foot again this am c/o increased pain , see letter

Investigations in ED:
1. XR Foot Rt

Diagnosis:

Diagnosis	Side	Site
Sprain and strain of ankle		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

In custody. Recently seen at GRI with ankle/wrist sprain. Since then further fall and more foot pain. Normal XR. No bony injury. Discharged with co-codamol 30/500 and ibuprofen to custody

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Alan Mackay
Doctor

Copies to:

1. PA Costello (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: 04/02/2017

Consultant: Dr Jonny Gordon

PA Costello
Knightswood Medical Practice
1980 Great Western Road
Glasgow
Glasgow
G13 2SW

Dear PA Costello

Re: **Fletcher Alan** DOB: **30/12/1987** CHI: **3012876456**
FLAT 0-1
Glasgow G14 0HG

Attended on: **04/02/2017 at 15:27 hrs.** Departed on: **at hrs.**
Discharge Type: **03 - Transferred** Destination: **Transfer to other NHS healthcare provider**

Previous ED Attendance in last 12 months: **2**

Presenting complaint
BIBA - ?OD

Nursing Assessment:
999 call, took 3 strips of mitrazepine and stip of 2mg diazepam 2pm today, suicidal, not vomited

Investigations in ED:

1. Glucose	**2. CRP**	**3. Urea and Electrolytes**
4. LFT	**5. Paracetamol**	**6. Salicylate**
7. Coagulation screen	**8. Full Blood Count**	

Diagnosis:

Diagnosis	Side	Site
Deliberate self poisoning by antiepileptic, sedative, hypnotic, antiparkinsonism and psychotropic drugs		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Presented with overdose of Mirtazapine and Diazepam with normal bloods. Referred to the psychiatric team at the Gartnaval Royal Hospital for further assessment as he was suicidal and had left a suicide note on Facebook

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Akuafo Agbenyega
Doctor

Copies to:

1. PA Costello (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: 03/02/2017

Consultant: Dr Fraser Denny

PA Costello
Knightswood Medical Practice
1980 Great Western Road
Glasgow
Glasgow
G13 2SW

Dear PA Costello

Re: **Fletcher Alan** DOB: **30/12/1987** CHI: **3012876456**
FLAT 0-1
Glasgow G14 0HG

Attended on: **01/02/2017 at 22:27 hrs.** Departed on: **02/02/2017 at 02:20 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
biba od

Nursing Assessment:
biba - mixed overdose ?what tablets, has also had alcohol, feeling low after splitting up from girlfriend

Investigations in ED:

1. Amylase	**2. Bone Profile**	**3. CRP**
4. Glucose	**5. LFT**	**6. Urea and Electrolytes**
7. Full Blood Count	**8. Paracetamol**	**9. Salicylate**

Diagnosis:

Diagnosis	Side	Site
Deliberate self poisoning by and exposure to other and unspecified chemicals and noxious substances		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
overdose newly prescribed antidepressant + alcohol seen CPN and d/c pls f/u re mood

Followup :
Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
David Lowe
Doctor

Copies to:
1. PA Costello (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 2810/2811
Fax:
Email:

Date Completed: 21/01/2016

Consultant: Dr David Ritchie

PA Costello
Knightswood Medical Practice
1980 Great Western Road
Glasgow
Glasgow
G13 2SW

Dear PA Costello

Re: **Fletcher Alan** DOB: **30/12/1987** CHI: **3012876456**
FLAT 0-1
Glasgow G14 0HG

Attended on: **21/01/2016 at 19:15 hrs.** Departed on: **21/01/2016 at 21:20 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
accidental o/d - for toothache

Nursing Assessment:
Pt has taken 18 paracetamol tabs in last 24hrs for toothache. Phoned NHS 24 for emergency dental appt, wont provide until he's attended for accidental OD.

Investigations in ED:

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

Diagnosis:

Diagnosis	Side	Site
Dental caries, unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Dear Doctor, Mr. Alan Fletcher presented to A&E having phoned NHS24 re: 24 hour history of toothache. He had been self-medicating for this with paracetamol and had taken 18 paracetamol in the last 24 hours. They advised him to attend A&E prior to dentist to get his bloods checked. Bloods fine and paracetamol level only 12 therefore not requiring treatment. Advised re the dangers of taking more paracetamol than prescribed. Many thanks and kind regards, Sophie Sneddon (SHO).

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Sophie Sneddon
Doctor

Copies to:

1. PA Costello (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Western Infirmary
Dumbarton Road
Glasgow
Lanarkshire
G11 6NT

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 01/04/2015

Consultant: Dr Sonja Allen

PA Costello
Knightswood Medical Practice
1980 Great Western Road
Glasgow
Glasgow
G13 2SW

Dear PA Costello

Re: **Fletcher Alan** DOB: **30/12/1987** CHI: **3012876456**
16 Blawarthill Street
Glasgow G14 0HG

Attended on: **01/04/2015 at 19:29 hrs.** Departed on: **01/04/2015 at 23:39 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
R Hand Injury

Nursing Assessment:
self ref - pt injured right hand at work caught in door

Investigations in ED:
1. XR Hand Rt

Diagnosis:

Diagnosis	Side	Site
Contusion of wrist and hand		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Right hand got trapped between a heavy metal shutter and the roof. Some tenderness and mild swelling to 2-4 PIPJs. No fracture on XR. Ligaments intact. Home with advice.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Nathalie Graham
Doctor

Copies to:

1. PA Costello (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Victoria Infirmary Glasgow
Langside Road
Glasgow
Lanarkshire
G42 9TY

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 10/02/2015

Consultant: Dr Susan Daisley

PA Costello
Knightswood Medical Practice
1980 Great Western Road
Glasgow
Glasgow
G13 2SW

Dear PA Costello

Re: **Fletcher Alan** DOB: **30/12/1987** CHI: **3012876456**
16 Blawarthill Street
Glasgow G14 0HG

Attended on: **10/02/2015 at 13:59 hrs.** Departed on: **10/02/2015 at 15:48 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
knee injury

Nursing Assessment:

Investigations in ED:
1. XR Knee Rt

Diagnosis:

Diagnosis	Side	Site
Sprain and strain of knee, unspecified		
Superficial injury of lower leg - calf		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

fall through roof at work approx 10ft landed on feet pain in right knee and left knee and calf tender over fem condyle of right knee full rom x-ray - no # seen bruising and swelling to left lower calf - achilles intact abrasion to left knee - superficial weight bearing advice and analgesia given

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Catriona MacCrimmon
Nurse

Copies to:

1. PA Costello (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Western Infirmary
Dumbarton Road
Glasgow
Lanarkshire
G11 6NT

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 12/01/2014

Consultant: Dr Sile MacGlone

PA Costello
Knightswood Medical Practice
1980 Great Western Road
Glasgow
Glasgow
G13 2SW

Dear PA Costello

Re: **Fletcher Alan** DOB: **30/12/1987** CHI: **3012876456**
FLAT 6/4
Glasgow G13 4TD

Attended on: **12/01/2014 at 10:02 hrs.** Departed on: **12/01/2014 at 11:39 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
cut right hand

Nursing Assessment:

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Open wound of hand	**Right**	

Procedures: **1. Wound glue other**
2. Tape closure other

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Attended A/E today. Laceration to left hand. Superfical. Cleaned thoroughly , wound closed with wound glue and steri-strips. Inadine and mepilex border dressing applied. Discharge. T attende GP/Practice Nurse for dressings review. Discharged.

Followup :
Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Evelyn Getty
Nurse

Copies to:
1. PA Costello (GP)
School Address:

HOSPITAL INFORMATION MISSING

Dr GILLIAN WATSON
1980 GREAT WESTERN ROAD
GLASGOW

G13 2SW

Date : 11 Oct 2011

Dear Dr GILLIAN WATSON,

Re: ALAN FLETCHER, FLAT 6/4, ARCHERHILL SQUARE, GLASGOW, G13 4TD
Date of Birth: 30/12/1987 CHI number: 3012876456

HOSPITAL INFORMATION MISSING Patient attended on the 10 Oct 2011.

The presenting complaint was: **HEAD INJ**

Triage information:	**HEAD HIT BY STEEL TRUSS YESTERDAY, LOC FOR "UP TO A MINUTE". TODAY HAS HEADACHE ++. NO VISUAL PROBLEMS, VOMITING OR NECK PAIN. TAKEN IBUPROFEN TODAY LITTLE EFFECT. PUPILS EQUAL AND REACTING 3+.**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**** INJURY- NOT ASSAULT** - HEAD AND FACE TRAUMA - MINOR HEAD INJURY**
The following treatment was given:	**None**

At the conclusion of treatment the patient was:	**DISCHARGED**
Follow-up:	**DISCHARGED**
Additional information:	**minor HI - but also c/o midline CS tenderness - C-spine XRay normal. DC with neck and head injury advice**

Yours sincerely,

FIONA GUNN

EMERGENCY DEPARTMENT DOCTOR

HOSPITAL INFORMATION MISSING

Dr GILLIAN WATSON
1980 GREAT WESTERN ROAD
GLASGOW

G13 2SW

Date : 20 May 2011

Dear Dr GILLIAN WATSON,

Re: ALAN FLETCHER, FLAT 6/4, ARCHERHILL SQUARE, GLASGOW, G13 4TD
Date of Birth: 30/12/1987 CHI number: 3012876456

HOSPITAL INFORMATION MISSING Patient attended on the 20 May 2011.

The presenting complaint was:	**HEAD INJURY, HIT WITH FIRE EXTINGUISHER, FEELS DIZZY AND SICK**
Triage information:	**HIT HEAD ON FIRE EXTINGUISHER ? LOC WAS IN THE DARK SO IS UNSURE NOW FEELS DIZZY ALERT AND ORIENTATED PERL**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**** INJURY- NOT ASSAULT** - HEAD AND FACE TRAUMA - MINOR HEAD INJURY**
The following treatment was given:	**None**

At the conclusion of treatment the patient was: **DISCHARGED**

Follow-up: **DISCHARGED**

Additional information: **None**

Yours sincerely,

ALAN EXTON

EMERGENCY MED. MIDDLE GRADE

HOSPITAL INFORMATION MISSING

Dr GILLIAN WATSON
1980 GREAT WESTERN ROAD
GLASGOW

G13 2SW

Date : 22 Jan 2011

Dear Dr GILLIAN WATSON,

Re: ALAN FLETCHER, FLAT 6/4, ARCHERHILL SQUARE, GLASGOW, G13 4TD
Date of Birth: 30/12/1987 CHI number: 3012876456

HOSPITAL INFORMATION MISSING Patient attended on the 22 Jan 2011.

The presenting complaint was: **RIB INJURY**

Triage information:	**Not recorded**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**MUSCULO-SKELETAL (NON TRAUMA) - MUSCULO-SKELETAL PAIN OF CHEST**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**DISCHARGED**

Follow-up: **DISCHARGED**

Additional information: **Recieved left sided trunkal injury 4 months ago at work. Taking analgesia (diclofenac). exacerbated injury while pushing a trolley at work. On exam looked well. Pain triggered by movement. tenderness to palpate just below left scapula and lower ribs on mid axilliary line. Adviced to continue taking analgesia. Prescribed co-codamol as was running out. Thank you**

Yours sincerely,

SAGARA DISSANAYAKA

EMERGENCY DEPARTMENT DOCTOR

Clinical letter - GP: Discharge Letter

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100
Department: MSK Physiotherapy First Floor Barrhead Health and Social Care Centre 213 Main Street Barrhead G78 1SW
Contact Tel: 01418007107
Enquiries to:

Dr. GS Watson
Crookston Medical Practice
230 Dalmellington Road
Crookston
Glasgow
G53 7FY

Letter Date: 16/06/2025
Reference:
Dictated Date: 13/06/2025
Transcribed Date:

Dear Dr GS Watson,

Alan Fletcher; D.O.B: 30/12/1987; CHI: 3012876456
12 POLQHUAP RD, Glasgow, Lanarkshire, G53 7FL

GP Action Required: None

Presenting Condition: Chronic Lower Back Pain with intermittent right leg pain

Physiotherapy Comments:

Onset of symptoms - Gradual

Mechanism of onset - None known

Diagnosis - Unilateral Right Sided Lower Back with intermittent right leg pain to ankle

Treatment - McKenzie back extension exercises and postural awareness advice

Further Info - Alan Fletcher failed to attend their scheduled review appointment on 12/06/25 and hasn't been back in contact to reschedule. They have therefore been discharged from the service in line with our failed-to-attend/cancellation policy. Should they wish to return to the service for further and ongoing input, this would require a new referral as this episode of care has been closed. Of note, this patient has just been transferred to my caseload and this was our first appointment.

Discharge Outcome:

The patient completed a course of treatment and symptoms are now:

- Unchanged.

The patient failed to attend or cancelled review appointment(s) with no further contact.

This patient has now been discharged from our care.

Yours sincerely

Calum Goldie

Band 5 Rotational Physiotherapist

Barrhead Health and Social Care Centre, 213 Main Street, Barrhead, G78 1SW

0141 800 7107

Calum.Goldie@xggc.scot.nhs.uk

Electronically Signed: ,

cc.

Clinical letter - GP: UPDATE

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Main Switchboard: 0141 201 1100
Department: MSK PHYSIO DEPT BARRHEAD HEALTH CENTRE

Contact Tel:
Enquiries to:

Letter Date: 05/03/2025
Reference:
Dictated Date: 05/03/2025
Transcribed Date: 05/03/2025

Dr. GS Watson
Crookston Medical Practice
230 Dalmellington Road
Crookston
Glasgow
G53 7FY

Dear Dear Dr,

Alan Fletcher; D.O.B: 30/12/1987; CHI: 3012876456
12 POLQHUAP RD, Glasgow, Lanarkshire, G53 7FL

At the request of my colleague I assessed Alan Fletcher today due to lack of improvement with treatment to date.

He presented with a nine month history of severe and worsening bilateral hip pain, right-sided posterolateral thigh, calf and foot pain in a non-dermatomal distribution, with pins and needles in the lateral thigh and calf, but no numbness. On the left side, pain extends into the buttock only. Overall, symptoms are worsening with no improvement from physiotherapy exercises. They report struggling with pain severity but are avoiding medications due to concerns about addictive personality.

On examination, Mr Fletcher has a slight left lateral shift position and active range of motion is significantly restricted. Neurological examination reveals normal sensation, slight weakness of left extensor hallucis longus, intact reflexes, no clonus, and downgoing plantar responses.

Due to the severity of pain and lack of improvement to date, an MRI of the lumbar spine has been ordered. Treatment will continue whilst awaiting MRI results

Yours sincerely,

Ms Jo Chambers

Advanced Physiotherapy Practitioner (NeuroSx)

Electronically Signed: ,

cc.

Rheumatology
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

14/01/2025

Dr GS Watson
Crookston Medical Practice
230 Dalmellington Road
Crookston
Glasgow
G53 7FY

Dear Dr GS Watson
CHI Number: 3012876456
Patient Name: Alan Fletcher
Referral Date: 14/01/2025

Advice Response to recent Referral:

Thank you. I note the Ortho-Spinal referral and the letter from Mr Craig. I would agree this chap may be best referred via the low back pain pathway. Further useful information would be duration and onset of symptoms and response to NSAID. HLA B27 status can be checked and the Histocompatability lab will send the yellow form if electronic ordering is not accessible. Happy to discuss.

Yours Sincerely

Dr David Crosbie

User ID: David Crosbie

OP Advice Letter

Clinic Letter

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Dr. GS Watson
Crookston Medical Practice
230 Dalmellington Road
Crookston
Glasgow
G53 7FY

Main Switchboard:	0141 201 1100
Department:	Gastroenterology
Contact Tel:	0141 451 6080 Liver Helpline
Enquiries to:	0141 451 6152
Letter Date:	10/03/2026
Reference:	CMc/AW
Dictated Date:	10/03/2026
Transcribed Date:	25/03/2026

Dear Dr. GS Watson,

Alan Fletcher; D.O.B: 30 Dec 1987; CHI: 3012876456
12 POLQHUAP RD, Glasgow, Lanarkshire, G53 7FL

Attendance: Specialty - Gastroenterology; Clinic - SULGGA3-NURSE L GRAHAM LIVER TUESDAY AM
Date and Time of Appointment - 10/03/2026 09:30

Clinical Comments:

Diagnosis:
1. Compound heterozygote haemochromatosis.
2. Normal fibroscan - liver stiffness 4.4 KpA, IQR 9%.

I had a telephone consultation with Alan today.

He reports that he is feeling well. He has been accepted to become a blood donor but has not got round to donating yet. I have encouraged him to do so.

He attended the phlebotomy clinic last week, his ferritin is 185. Iron studies and liver function tests are normal. We will simply review him again in a years time, however if there are any issues in the meantime he can call the liver nurse helpline on 0141 451 6080.

Yours sincerely,

Christine McTaggart

Liver Nurse Specialist

Electronically Signed: Nurse Christine McTaggart, Nurse Practitioner

cc.

Hospital use only	Clinic	Day . Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Rheumatology GGC General Referral or Advice	——	**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 Urgent
Date of referral 14-Jan-2025 **Date sent** 14-Jan-2025

PATIENT DETAILS

Surname	Fletcher
Forename(s)	Alan
Title	Mr
Sex	Male
Date of birth	30-Dec-1987
CHI no.	3012876456
Area of Residence	-

Patient's address

12 Polqhuap Rd
GLASGOW
G53 7FL

Contact number(s)

Voice: 07542965184

101035284395A

Unique Care Pathway Number: 101035284395A

REGISTERED GP DETAILS

Name	Dr Gary Watson		
GMC code	6104661	GP code	01759
Practice name	Crookston Medical Centre (18972)		
Practice code	52344		

Practice address

Crookston Medical Centre
230 Dalmellington Road
Glasgow
G53 7FY

Contact number(s)

Voice: 0141 883 8887
Facsimile: 0141 891 4400

REFERRING GP DETAILS

Name	Dr. Gary Watson		
GMC code	6104661	GP code	01759
Practice name	Crookston Medical Practice (52344)		
Practice code	52344		

Practice address

230 Dalmellington Road
Crookston
Glasgow
G53 7FY

Contact number(s)

Voice: 0141 883 8887

Trauma & Orthopaedic - Spine
Dalnair Street
Glasgow
G3 8SJ

10/01/2025

Dr GS Watson
Crookston Medical Practice
230 Dalmellington Road
Crookston
Glasgow
G53 7FY

Dear Dr GS Watson

Patient Name: Alan Fletcher
CHI Number: 3012876456
Referral Date: 10/01/2025

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.

https://www.nhsggc.scot/hospitals-services/services-a-to-z/referral-guidelines/

( ) Insufficient clinical information to allow specialty to triage this referral.

Enter free text here

(x) Other

Thank you for your referral into the Orthopaedic Spinal service. We have recently standardised the pathway we are following for all patients referred for spinal care across NHSGGC to ensure consistency of approach and to optimise the management of patients. This is line with the nationally agreed back pain pathway.

The referral you have made is best placed to go through this clinical pathway. Thank you for following this approach for your patient .

For ease of reference, the following link will direct you to the patient pathway. If you feel your patient demonstrates any of the red flags, then please do not hesitate to send in an urgent referral or direct your patient to the Emergency department as per the pathway.

https://www.nhsggc.scot/downloads/back-low-back-pain-with-or-without-sciatica-pathway/

Kind regards.

Yours sincerely,

Mr Niall Craig

User ID Niall Craig

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

Trauma & Orthopaedic - Spine
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 Routine
Date of referral 10-Jan-2025 **Date sent** 10-Jan-2025

PATIENT DETAILS

Surname	Fletcher
Forename(s)	Alan
Title	Mr
Sex	Male
Date of birth	30-Dec-1987
CHI no.	3012876456
Area of Residence	-

Patient's address

12 Polqhuap Rd
GLASGOW
G53 7FL

Contact number(s)

Voice: 07542965184

101035255812J | Unique Care Pathway Number: 101035255812J

REGISTERED GP DETAILS

Name	Dr Gary Watson		
GMC code	6104661	GP code	01759
Practice name	Crookston Medical Centre (18972)		
Practice code	52344		

Practice address

Crookston Medical Centre
230 Dalmellington Road.
Glasgow
G53 7FY

Contact number(s)

Voice: 0141 883 8887
Facsimile: 0141 891 4400

REFERRING GP DETAILS

Name	Dr. Gary Watson		
GMC code	6104661	GP code	01759
Practice name	Crookston Medical Practice (52344)		
Practice code	52344		

Practice address

230 Dalmellington Road
Crookston
Glasgow
G53 7FY

Contact number(s)

Voice: 0141 883 8887

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Back pain

Comment: Dear Doctor
I would appreciate your review of the above gentleman who works as a sound engineer- his lifes work involves carrying heavy equipment. He is now struggling with right lumbar pain and some intermittent sciatic symptoms. Bloods are fine and there are no red flags. I suspect he has significant OA in his spine as well as a lot of muscle spasm. He has been finding physio quite painful. Given his occupational I feel some imaging of his lumbar spine would be useful here to best advise him.

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]Injury of unspecified nerve at wrist and hand level	-	28-Nov-2023	28-Nov-2023
Fracture of metacarpal bone	(Right) Avulsion # base of 5th Metacarpal	25-Jan-2017	25-Jan-2017
Asthma	-	01-Feb-2003	01-Feb-2003
Asthma NOS	Disease: SPICE Asthma Opening,	01-Jan-2003	01-Jan-2003
[Q] Salter-Harris II	fracture right 1st metacarpal	16-Sep-2002	16-Sep-2002

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Budesonide Dry Powder Inhaler 100 micrograms/actuation	200	200 dose	TWO PUFFS TWICE DAILY	-	19-Aug-2024	19-Aug-2024

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Cyanocobalamin Tablets 50 micrograms	100	100 tablet	2 TABS DAILY	-	02-Dec-2024	02-Dec-2024
Cyanocobalamin Tablets 50 micrograms	100	100 tablet	2 TABS DAILY	-	02-Sep-2024	02-Sep-2024
Ibuprofen Gel 5 %	50	50 GRAM (S)	APPLY TO THE AFFECTED AREA UP TO THREE TIMES A DAY	-	19-Aug-2024	19-Aug-2024
Salbutamol Cfc-free inhaler 100 micrograms/puff	1	1 inhaler	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	19-Aug-2024	19-Aug-2024

Blood Pressure

Date Recorded	Systolic	Diastolic
23-Aug-2024	123	74
15-Jun-2012	138	72
13-Apr-2010	110	65

Body Measurements

Date Recorded	Height	Weight	BMI
18-Nov-2024	184	75	-

13-Apr-2010	184	-	-
19-May-2008	183	59.7	-
19-Nov-2007	183	58.4	-
22-Nov-2006	182	60.3	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Never smoked tobacco:		18-Nov-2024
Never smoked tobacco:		17-Apr-2024
Never smoked tobacco:		27-Feb-2013
Never smoked tobacco:	Smoker$$ Status.clm - No Action Required	24-Feb-2010
Never smoked tobacco:	Recorded through Combined Vaccination priority=2	22-Oct-2009
Alcohol consumption, 0 units/week:		18-Nov-2024
Alcohol consumption, 0 units/week:		17-Apr-2024
Teetotaller:	Alcohol Intake$$.clm - No Action Required	09-Sep-2002

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
Referred By:Referring GP
Electronic Attachment Present:No

Social circumstances
Ethnic Origin: (White) Scottish

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments
Gastroenterology - 16122024 Hospital Letter 1228313

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Gastroenterology 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 09-Jan-2025 **Date sent** 09-Jan-2025

PATIENT DETAILS

Surname	Fletcher
Forename(s)	Alan
Title	Mr
Sex	Male
Date of birth	30-Dec-1987
CHI no.	3012876456
Area of Residence	-

Patient's address

12 Polqhuap Rd
GLASGOW
G53 7FL

Contact number(s)

Voice: 07542965184

1010352367398

Unique Care Pathway Number: 1010352367398

REGISTERED GP DETAILS

Name	Dr Gary Watson		
GMC code	6104661	GP code	01759
Practice name	Crookston Medical Centre (18972)		
Practice code	52344		

Practice address

Crookston Medical Centre
230 Dalmellington Road
Glasgow
G53 7FY

Contact number(s)

Voice: 0141 883 8887
Facsimile: 0141 891 4400

REFERRING GP DETAILS

Name	Dr. Gary Watson		
GMC code	6104661	GP code	01759
Practice name	Crookston Medical Practice (52344)		
Practice code	52344		

Practice address

230 Dalmellington Road
Crookston
Glasgow
G53 7FY

Contact number(s)

Voice: 0141 883 8887

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: compounf heterozygote with borderline iron indices

Comment: Dear Doctor
I woul appreciate your advice with regards the above. He was noted to have a slightly raised ferritin at 317 when investigated fro another matter. iron sats are on the high end of normal at 46%. genetic testing has revealed he is a compound heterozygote- I presume his iron indicies just need monitored?

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]Injury of unspecified nerve at wrist and hand level	-	28-Nov-2023	28-Nov-2023
Fracture of metacarpal bone	(Right) Avulsion # base of 5th Metacarpal	25-Jan-2017	25-Jan-2017
Asthma	-	01-Feb-2003	01-Feb-2003
Asthma NOS	Disease: SPICE Asthma Opening,	01-Jan-2003	01-Jan-2003
[Q] Salter-Harris II	fracture right 1st metacarpal	16-Sep-2002	16-Sep-2002

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Budesonide Dry Powder Inhaler 100 micrograms/actuation	200	200 dose	TWO PUFFS TWICE DAILY	-	19-Aug-2024	19-Aug-2024

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Cyanocobalamin Tablets 50 micrograms	100	100 tablet	2 TABS DAILY	-	02-Dec-2024	02-Dec-2024
Cyanocobalamin Tablets 50 micrograms	100	100 tablet	2 TABS DAILY	-	02-Sep-2024	02-Sep-2024
Ibuprofen Gel 5 %	50	50 GRAM (S)	APPLY TO THE AFFECTED AREA UP TO THREE TIMES A DAY	-	19-Aug-2024	19-Aug-2024
Salbutamol Cfc-free inhaler 100 micrograms/puff	1	1 inhaler	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	19-Aug-2024	19-Aug-2024

Blood Pressure

Date Recorded	Systolic	Diastolic
23-Aug-2024	123	74
15-Jun-2012	138	72
13-Apr-2010	110	65

Body Measurements

Date Recorded	Height	Weight	BMI
18-Nov-2024	184	75	-
13-Apr-2010	184	-	-
19-May-2008	183	59.7	-

19-Nov-2007	183	58.4	-
22-Nov-2006	182	60.3	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Never smoked tobacco:		18-Nov-2024
Never smoked tobacco:		17-Apr-2024
Never smoked tobacco:		27-Feb-2013
Never smoked tobacco:	Smoker$$ Status.clm - No Action Required	24-Feb-2010
Never smoked tobacco:	Recorded through Combined Vaccination priority=2	22-Oct-2009
Alcohol consumption, 0 units/week:		18-Nov-2024
Alcohol consumption, 0 units/week:		17-Apr-2024
Teetotaller:	Alcohol Intake$$.clm - No Action Required	09-Sep-2002

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
Referred By:Referring GP
Electronic Attachment Present:Yes

Social circumstances
Ethnic Origin: (White) Scottish

Gastroenterology - 16122024 Hospital Letter 1228313

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments
Ear, Nose & Throat (ENT) - 01092021 Administration Letter 634448

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Audiology 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 02-Sep-2021 **Date sent** 02-Sep-2021

PATIENT DETAILS

Surname	Fletcher
Forename(s)	Alan
Title	Mr
Sex	Male
Date of birth	30-Dec-1987
CHI no.	3012876456
Area of Residence	-

Patient's address

62 Innerwick Drive
GLASGOW
G52 2HY

Contact number(s)

Voice: 07542965184
Voice: 07542965184

1010242632003

Unique Care Pathway Number: 1010242632003

REGISTERED GP DETAILS

Name	Dr Amy Kerr		
GMC code	6026525	GP code	00868
Practice name	The Crescent Medical Practice (18955)		
Practice code	52058		

Practice address

The Crescent Medical Practice
12 Walmer Crescent
Cessnock
GLASGOW
G51 1AT

Contact number(s)

Voice: 0141 427 0191
Facsimile: 0141 427 1351
E-mail: GG-UHB.gp52058clinical@nhs.net

REFERRING GP DETAILS

Name	Dr. Victoria Thompson		
GMC code	6148107	GP code	00591
Practice name	14 Hillington Road South (52058)		

Practice address

Glasgow
G52 2AA

Contact number(s)

Voice: 0141 882 9098

Practice code	52058	

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Hearing loss

Comment: I would be grateful for your assessment of this 33 year old man with mild hearing loss. I attach his assessment done by Boots. The patient reports poor hearing for several years. He finds it particularly difficult when there is background noise and things have been exacerbated now by people wearing masks. When he attended Boots they did try a hearing aid during the assessment and the patient reported a dramatic difference. He works as a lighting and sound engineer touring with bands in big venues and festivals. He admits to not wearing ear protection due to challenges of constantly taking these in and out of his ears. He denies any pain or discharge. He has no history of recurrent ear infections as a child and did not require any grommets. On examination there was no abnormality seen in either ear. I suspect his hearing reduction is work related and I have advised him of the importance of wearing ear protection to avoid this worsening. He is keen for NHS audiology assessment and whether he requires hearing aids at this time.

Many thanks.

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
Hearing difficulty (Bilateral)	-	01-Sep-2021	01-Sep-2021
Fracture of metacarpal bone	(Right) Avulsion # base of 5th Metacarpal	25-Jan-2017	25-Jan-2017
Asthma	-	01-Feb-2003	01-Feb-2003
Asthma NOS	Disease: SPICE Asthma Opening,	01-Jan-2003	01-Jan-2003
[Q] Salter-Harris II	fracture right 1st metacarpal	16-Sep-2002	16-Sep-2002

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
Salbutamol Cfc-free inhaler 100 micrograms/puff	1	1 inhaler	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	24-Jun-2021	24-Jun-2021

Blood Pressure

Date Recorded	Systolic	Diastolic
15-Jun-2012	138	72

Body Measurements

Date Recorded	Height	Weight	BMI
13-Apr-2010	184	-	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Never smoked tobacco:		27-Feb-2013
Teetotaller:	Alcohol Intake$$.clm - No Action Required	09-Sep-2002

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
Referred By:Referring GP
Electronic Attachment Present:Yes

Social circumstances
Ethnic Origin: (White) Scottish

Ear, Nose & Throat (ENT) -
01092021 Administration Letter 634448

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

General 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-Feb-2012 **Date sent** 01-Mar-2012

PATIENT DETAILS

Surname	Fletcher
Forename(s)	Alan
Title	Mr
Sex	Male
Date of birth	30-Dec-1987
CHI no.	3012876456
Area of Residence	-

Patient's address

Fl 6-4 4 Archerhill Square
KNIGHTSWOOD
Glasgow
G13 4PH

Contact number(s)

Voice: 07896782697

101003258808C Unique Care Pathway Number: 101003258808C

REGISTERED GP DETAILS

Name	Dr Paul Costello		
GMC code	3564509	GP code	08605
Practice name	Knightswood Medical Practice (18825)		
Practice code	40332		

Practice address

1980 Great Western Rd
Knightswood
Glasgow
G13 2SW

Contact number(s)

Voice: 0141 959 1196
Facsimile: 0141 950 1811

REFERRING GP DETAILS

Name	Dr. Pamela Thorburn		
GMC code	3496774	GP code	02003
Practice name	Knightswood Medical Practice (40332)		
Practice code	40332		

Practice address

1980 Great Western Road
Glasgow
G13 2SW

Contact number(s)

Voice: 0141 959 1196

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Loose bowel motions

Comment: Thank you for seeing this young gentleman who has had loose bowel motions since October 2011. Alan can move his bowels up to five times a day and also has to get up through the night to pass a bowel motion. He has no rectal bleeding or mucus and the bowel motions are a normal brown colour. He has no nausea or vomiting and his appetite remains normal. He does complain of an increase in colicky abdominal pains prior to opening his bowels and some increased wind. He describes his diet as good, getting at least five portions of fruit and veg a day and sufficient fibre.

When Alan first presented with the symptoms of frequent loose motions I diagnosed him as having an irritable bowel and advised him to try Buscopan. He did indeed find this very helpful but once the Buscopan tablets were finished his symptoms simply recurred. As he can get caught very unaware by the need to pass a motion, he has lost a significant amount of time from his work because of these symptoms. Alan is also complaining of some minor mouth ulceration but he denies any family history of inflammatory bowel disease.

On examination Alan has a simple alphus ulcer in his mouth and although he is tender in both iliac fossa, his abdominal and rectal examination are completely unremarkable. As Alan has had these symptoms for a very long time, I wonder if you would consider a colonoscopy just to confirm that it is a simple irritable bowel that Alan is suffering from.

Thank you.

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
Asthma	Start Date: 01/02/2003	06-Feb-2003	06-Feb-2003
Asthma NOS	Disease: SPICE Asthma Opening,	01-Jan-2003	01-Jan-2003
[Q] Salter-Harris II	fracture right 1st metacarpalStart Date: 16/09/2002	23-Sep-2002	23-Sep-2002

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
Codeine Phosphate Tablets 30 mg	28	28 TABLET	1 TAB FOUR TIMES A DAY	-	15-Feb-2012	15-Feb-2012
Hyoscine Butylbromide Tablets 10 mg	56	56 tablet	2TABS QID AS REQUIRED	-	14-Feb-2012	14-Feb-2012
Codeine Phosphate Tablets 30 mg	28	28 TABLET	1 TAB FOUR TIMES A DAY	-	03-Nov-2011	03-Nov-2011
Hyoscine Butylbromide Tablets 10 mg	56	56 tablet	2TABS QID AS REQUIRED	-	03-Nov-2011	03-Nov-2011

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Never smoked tobacco:	Smoker$$ Status.clm - No Action Required	24-Feb-2010
Never smoked tobacco:	Recorded through Combined Vaccination priority=2	22-Oct-2009
Never smoked tobacco:	Recorded through E-APRS priority=2	19-May-2008

Never smoked tobacco:	Smoker$$ Status.clm - No Action Required	19-Nov-2007
Never smoked tobacco:	Recorded through E-APRS priority=2	22-Nov-2006
Teetotaller:	Alcohol Intake$$.clm - No Action Required	09-Sep-2002

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**

ELECTRONIC PATIENT RECORDS

(2) OF 2

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 CARE AMBULATORY HOSPITAL	☑		
WESTERN INFIRMARY RECORDS	☑		

Including:

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

Sigmoidoscopy report

Performed	22-Mar-2012 15:53	Received	22-Mar-2012 16:03
Reported	22-Mar-2012 16:03	Order Number	UNI163230-3012876456
Status	Final	Source System	MasterLab

UGI G1 Final

SIGMOIDOSCOPY REPORT

Name:	**Alan FLETCHER, 30/12/1987 (M)**	Address:	**4 Archerhill Square Glasgow G13 4PH**
CHI No:	**3012876456**		
Case Note No:	**51288451M**		
GP:	**COSTELLO, PAUL Knightswood Medical Practice 1980 Great Western Road Glasgow G13 2SW**	Status:	**Day patient/NHS**
		Hospital:	**GGH**
		Ward:	**(none)**
		Referring Cons:	**GP (Direct Access)**

Procedure date: 22 March 2012

Indications
Loose motions.

Report
Bowel preparation with Picolax was satisfactory.
A digital rectal examination was performed.
The sigmoidoscope was inserted via the anus to the distal transverse.
The caecum was identified positively.
The scope was retroflexed in the rectum.
Mucosa: patchy mild erythema in an area extending from the rectum to the splenic flexure.
The examination to the limit of insertion was normal.
There were no peri-operative complications.

Specimens Taken
Biopsy (random x6 from an area extending from the rectum to the splenic flexure)

Medication
Continue medication.

Follow up
Awaiting pathology results. Return to the referring Consultant and review will be in the Surgical Clinic in 3 weeks.

Consultant/Endoscopist
List consultant: Prof P O"Dwyer
Endoscopist No1: Miss Kathryn McCarthy
Nurses: SN Morven Kent
SN Marion Gahagan

Instrument
GGH 63 - CFQ260DL 2710680

Premedication
No sedation

Advice/Comments
.? microscopic colitis. Biospies taken and routine bloods to be taken by GP (including CRP please).

***** END OF REPORT *****

Transferrin / Iron View Cumulative Results

Collected	03-Mar-2026 11:02	Received	03-Mar-2026 13:16
Reported	03-Mar-2026 14:32	Order Number	B,26.0939263.B
Status	Final	Source System	Telepath
Comments	REQUESTOR**HFE		

Test	Result	Ref. Range (Units)	Abnormality
Transferrin	2.40	2.00 - 4.00 g/L (g/L)	
Iron	29	10 - 30 umol/L (umol/L)	
T'ferrin Saturation	48	25 - 55 % (%)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	03-Mar-2026 11:02	Received	03-Mar-2026 13:16
Reported	03-Mar-2026 14:32	Order Number	B,26.0939263.B
Status	Final	Source System	Telepath
Comments	REQUESTOR**HFE		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	12	<20 umol/L (umol/L)	
ALT	20	<50 U/L (U/L)	
AST	21	<40 U/L (U/L)	
Alkaline Phosphatase	62	30 - 130 U/L (U/L)	
Albumin	42	35.- 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	30-Dec-2025 18:30	Received	30-Dec-2025 18:42
Reported	30-Dec-2025 19:27	Order Number	B,25.2901700.R
Status	Final	Source System	Telepath
Comments	REQUESTOR**admission bloods		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	138	133 - 146 mmol/L (mmol/L)	
Potassium	3.8	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	108	95 - 108 mmol/L (mmol/L)	
Urea	5.3	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	70	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Troponin I hs View Cumulative Results

Collected	30-Dec-2025 18:30	Received	30-Dec-2025 18:42
Reported	30-Dec-2025 19:22	Order Number	B,25.2901702.S
Status	Final	Source System	Telepath
Comments	REQUESTOR**admission bloods		

Test	Result	Ref. Range (Units)	Abnormality
Troponin I hs	4	0 - 34 ng/L (ng/L)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	30-Dec-2025 18:30	Received	30-Dec-2025 18:42
Reported	30-Dec-2025 19:27	Order Number	B,25.2901700.R
Status	Final	Source System	Telepath
Comments	REQUESTOR**admission bloods		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	14	<20 umol/L (umol/L)	
ALT	19	<50 U/L (U/L)	
AST	29	<40 U/L (U/L)	
Alkaline Phosphatase	62	30 - 130 U/L (U/L)	
Albumin	44	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Glucose View Cumulative Results

Collected	30-Dec-2025 18:30	Received	30-Dec-2025 18:43
Reported	30-Dec-2025 19:22	Order Number	B,25.2901701.D
Status	Final	Source System	Telepath
Comments	Non-fasting sample REQUESTOR**admission bloods		

Test	Result	Ref. Range (Units)	Abnormality
Glucose	4.7	3.5 - 6.0 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	30-Dec-2025 18:30	Received	30-Dec-2025 18:42
Reported	30-Dec-2025 19:27	Order Number	B,25.2901700.R
Status	Final	Source System	Telepath
Comments	REQUESTOR**admission bloods		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	<1	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Chol/Triglyceride View Cumulative Results

Collected	30-Dec-2025 18:30	Received	30-Dec-2025 18:42
Reported	30-Dec-2025 19:27	Order Number	B,25.2901700.R
Status	Final	Source System	Telepath
Comments	REQUESTOR**admission bloods		

Test	Result	Ref. Range (Units)	Abnormality
Cholesterol	4.9	(mmol/L)	
Triglycerides	1.0	0.2 - 2.3 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	20-Mar-2025 13:39	Received	20-Mar-2025 15:48
Reported	20-Mar-2025 17:37	Order Number	B,25.1032727.Y
Status	Final	Source System	Telepath
Comments	REQUESTOR**New HFE - liver assessme....		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	141	133 - 146 mmol/L (mmol/L)	
Potassium	4.0	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	107	95 - 108 mmol/L (mmol/L)	
Urea	6.2	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	66	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Transferrin / Iron View Cumulative Results

Collected	20-Mar-2025 13:39	Received	20-Mar-2025 15:48
Reported	20-Mar-2025 17:37	Order Number	B,25.1032727.Y
Status	Final	Source System	Telepath
Comments	REQUESTOR**New HFE - liver assessme....		

Test	Result	Ref. Range (Units)	Abnormality
Transferrin	2.40	2.00 - 4.00 g/L (g/L)	
Iron	14	10 - 30 umol/L (umol/L)	
T'ferrin Saturation	***23**	25 - 55 % (%)	**Abnormal - low**

* Abnormal ** Critically Abnormal

Thyroid funct test View Cumulative Results

Collected	20-Mar-2025 13:39	Received	20-Mar-2025 15:48
Reported	20-Mar-2025 17:37	Order Number	B,25.1032727.Y
Status	Final	Source System	Telepath
Comments	REQUESTOR**New HFE - liver assessme....		

Test	Result	Ref. Range (Units)	Abnormality
TSH	0.60	0.35 - 5.00 mU/L (mU/L)	
Free T4	13.1	9.0 - 21.0 pmol/L (pmol/L)	
Total T3			

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	20-Mar-2025 13:39	Received	20-Mar-2025 15:48
Reported	20-Mar-2025 17:37	Order Number	B,25.1032727.Y
Status	Final	Source System	Telepath
Comments	REQUESTOR**New HFE - liver assessme....		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	10	<20 umol/L (umol/L)	
ALT	18	<50 U/L (U/L)	
AST	22	<40 U/L (U/L)	
Alkaline Phosphatase	70	30 - 130 U/L (U/L)	
Albumin	44	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Immunoglobulins View Cumulative Results

Collected	20-Mar-2025 13:39	Received	20-Mar-2025 15:48
Reported	20-Mar-2025 17:37	Order Number	B,25.1032727.Y
Status	Final	Source System	Telepath
Comments	These normal immunoglobulins do not exclude a paraprotein. If myeloma suspected, please request serum protein electrophoresis and send urine for electrophoresis (Bence Jones Protein). REQUESTOR**New HFE - liver assessme....		

Test	Result	Ref. Range (Units)	Abnormality
IgG	11.4	6.0 - 16.0 g/L (g/L)	
IgA	1.9	0.8 - 4.0 g/L (g/L)	
IgM	0.70	0.4 - 2.4 g/L (g/L)	

* Abnormal ** Critically Abnormal

Glucose View Cumulative Results

Collected	20-Mar-2025 13:39	Received	20-Mar-2025 15:41
Reported	20-Mar-2025 17:47	Order Number	B,25.1032765.E
Status	Final	Source System	Telepath
Comments	Non-fasting sample REQUESTOR**New HFE - liver assessme....		

Test	Result	Ref. Range (Units)	Abnormality
Glucose	4.4	3.5 - 6.0 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

GGT View Cumulative Results

Collected	20-Mar-2025 13:39	Received	20-Mar-2025 15:48
Reported	20-Mar-2025 17:37	Order Number	B,25.1032727.Y
Status	Final	Source System	Telepath
Comments	REQUESTOR**New HFE - liver assessme....		

Test	Result	Ref. Range (Units)	Abnormality
Gamma-GT	23	<70 U/L (U/L)	

* Abnormal ** Critically Abnormal

Caeruloplasmin View Cumulative Results

Collected	20-Mar-2025 13:39	Received	20-Mar-2025 17:11
Reported	21-Mar-2025 07:07	Order Number	B,25.4530387.E
Status	Final	Source System	Telepath
Comments	Note change to reference ranges from 3/12/24. REQUESTOR**New HFE - liver assessme....		

Test	Result	Ref. Range (Units)	Abnormality
Caeruloplasmin	0.21	0.16 - 0.47 g/L (g/L)	

* Abnormal ** Critically Abnormal

Alpha Feto Protein View Cumulative Results

Collected	20-Mar-2025 13:39	Received	20-Mar-2025 15:48
Reported	20-Mar-2025 17:37	Order Number	B,25.1032727.Y
Status	Final	Source System	Telepath
Comments	Within reference interval Does not exclude malignancy. REQUESTOR**New HFE - liver assessme....		

Test	Result	Ref. Range (Units)	Abnormality
Alpha Feto Protein	<3	0 - 6 kU/L (kU/L)	

* Abnormal ** Critically Abnormal

Alpha-1-Antitrypsin View Cumulative Results

Collected	20-Mar-2025 13:39	Received	20-Mar-2025 17:11
Reported	21-Mar-2025 07:07	Order Number	B,25.4530387.E
Status	Final	Source System	Telepath
Comments	Note change to reference range from 30/1/24 REQUESTOR**New HFE - liver assessme....		

Test	Result	Ref. Range (Units)	Abnormality
Alpha-1-Antitrypsin	1.31	1.00 - 2.00 g/L (g/L)	

* Abnormal ** Critically Abnormal

Transferrin / Iron View Cumulative Results

Collected	18-Nov-2024 12:20	Received	18-Nov-2024 19:52
Reported	19-Nov-2024 13:32	Order Number	B,24.2708967.T
Status	Final	Source System	Telepath
Comments	REQUESTOR**low b12. rasied iron		

Test	Result	Ref. Range (Units)	Abnormality
Transferrin	2.40	2.00 - 4.00 g/L (g/L)	
Iron	28	10 - 30 umol/L (umol/L)	
T'ferrin Saturation	46	25 - 55 % (%)	

* Abnormal ** Critically Abnormal

Vitamin D View Cumulative Results

Collected	23-Aug-2024 12:06	Received	23-Aug-2024 17:50
Reported	26-Aug-2024 12:27	Order Number	B,24.2143234.R
Status	Final	Source System	Telepath
Comments	Total 25OH Vit D: <25 deficient, 25-50 insufficient, >50 adequate. REQUESTOR**back pain		

Test	Result	Ref. Range (Units)	Abnormality
25-OH Vitamin D	66	(nmol/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	23-Aug-2024 12:06	Received	23-Aug-2024 17:50
Reported	26-Aug-2024 12:27	Order Number	B,24.2143234.R
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	139	133 - 146 mmol/L (mmol/L)	
Potassium	4.5	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	106	95 - 108 mmol/L (mmol/L)	
Urea	4.9	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	77	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Thyroid funct test View Cumulative Results

Collected	23-Aug-2024 12:06	Received	23-Aug-2024 17:50
Reported	26-Aug-2024 12:27	Order Number	B,24.2143234.R
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain		

Test	Result	Ref. Range (Units)	Abnormality
TSH	0.94	0.35 - 5.00 mU/L (mU/L)	
Free T4	13.8	9.0 - 21.0 pmol/L (pmol/L)	
Total T3			

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	23-Aug-2024 12:06	Received	23-Aug-2024 17:50
Reported	26-Aug-2024 12:27	Order Number	B,24.2143234.R
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	11	<20 umol/L (umol/L)	
ALT	45	<50 U/L (U/L)	
AST	37	<40 U/L (U/L)	
Alkaline Phosphatase	64	30 - 130 U/L (U/L)	
Albumin	44	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

HbA1C (IFCC) View Cumulative Results

Collected	23-Aug-2024 12:06	Received	23-Aug-2024 17:56
Reported	26-Aug-2024 13:12	Order Number	B,24.2144437.P
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain		

Test	Result	Ref. Range (Units)	Abnormality
HbA1c (IFCC)	32	20 - 41 mmol/mol (mmol/mol)	

* Abnormal ** Critically Abnormal

Glucose View Cumulative Results

Collected	23-Aug-2024 12:06	Received	23-Aug-2024 17:41
Reported	24-Aug-2024 14:07	Order Number	B,24.2143202.Z
Status	Final	Source System	Telepath
Comments	Non-fasting sample REQUESTOR**back pain		

Test	Result	Ref. Range (Units)	Abnormality
Glucose	3.9	3.5 - 6.0 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

Creatine Kinase View Cumulative Results

Collected	23-Aug-2024 12:06	Received	23-Aug-2024 17:50
Reported	26-Aug-2024 12:27	Order Number	B,24.2143234.R
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain		

Test	Result	Ref. Range (Units)	Abnormality
Creatine Kinase	126	40 - 320 U/L (U/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	23-Aug-2024 12:06	Received	23-Aug-2024 17:50
Reported	26-Aug-2024 12:27	Order Number	B,24.2143234.R
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	<1	.0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Bone Profile View Cumulative Results

Collected	23-Aug-2024 12:06	Received	23-Aug-2024 17:50
Reported	26-Aug-2024 12:27	Order Number	B,24.2143234.R
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain		

Test	Result	Ref. Range (Units)	Abnormality
Calcium	2.40	2.20 - 2.60 mmol/L (mmol/L)	
Calcium (adjusted)	2.39	2.20 - 2.60 mmol/L (mmol/L)	
Phosphate	1.11	0.80 - 1.50 mmol/L (mmol/L)	
Albumin	44	35 - 50 g/L (g/L)	
Alkaline Phosphatase	64	30 - 130 U/L (U/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	05-Apr-2017 14:15	Received	05-Apr-2017 14:48
Reported	05-Apr-2017 15:53	Order Number	B,17.0992097.T
Status	Final	Source System	Telepath
Comments	REQUESTOR**Mixed OD		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	144	133 - 146 mmol/L (mmol/L)	
Potassium	4.4	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	* 109	95 - 108 mmol/L (mmol/L)	**Abnormal - high**
Urea	* 2.3	2.5 - 7.8 mmol/L (mmol/L)	**Abnormal - low**
Creatinine	75	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Salicylate View Cumulative Results

Collected	05-Apr-2017 14:15	Received	05-Apr-2017 14:48
Reported	05-Apr-2017 15:53	Order Number	B,17.0992097.T
Status	Final	Source System	Telepath
Comments	REQUESTOR**Mixed OD		

Test	Result	Ref. Range (Units)	Abnormality
Salicylate	<50	(mg/L)	

* Abnormal ** Critically Abnormal

Paracetamol View Cumulative Results

Collected	05-Apr-2017 14:15	Received	05-Apr-2017 14:48
Reported	05-Apr-2017 15:53	Order Number	B,17.0992097.T
Status	Final	Source System	Telepath
Comments	Note from 04/07/16 detection limit for paracetamol is 5 mg/L. REQUESTOR**Mixed OD		

Test	Result	Ref. Range (Units)	Abnormality
Paracetamol	<5	(mg/L)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	05-Apr-2017 14:15	Received	05-Apr-2017 14:48
Reported	05-Apr-2017 15:53	Order Number	B,17.0992097.T
Status	Final	Source System	Telepath
Comments	REQUESTOR**Mixed OD		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	10	<20 umol/L (umol/L)	
ALT	16	<50 U/L (U/L)	
AST	19	<40 U/L (U/L)	
Alkaline Phosphatase	54	30 - 130 U/L (U/L)	
Albumin	45	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Lactate View Cumulative Results

Collected	05-Apr-2017 14:15	Received	05-Apr-2017 14:48
Reported	05-Apr-2017 15:23	Order Number	B,17.0992098.M
Status	Final	Source System	Telepath
Comments	REQUESTOR**Mixed OD		

Test	Result	Ref. Range (Units)	Abnormality
Lactate	1.7	0.6 - 2.2 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

Creatine Kinase View Cumulative Results

Collected	05-Apr-2017 14:15	Received	05-Apr-2017 14:48
Reported	05-Apr-2017 15:53	Order Number	B,17.0992097.T
Status	Final	Source System	Telepath
Comments	REQUESTOR**Mixed OD		

Test	Result	Ref. Range (Units)	Abnormality
Creatine Kinase	88	40 - 320 U/L (U/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	05-Apr-2017 14:15	Received	05-Apr-2017 14:48
Reported	05-Apr-2017 15:53	Order Number	B,17.0992097.T
Status	Final	Source System	Telepath
Comments	REQUESTOR**Mixed OD		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	3	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	16-Mar-2017 00:00	Received	16-Mar-2017 13:35
Reported	16-Mar-2017 15:18	Order Number	B,17.3770450.R
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Sodium	140	133 - 146 mmol/L (mmol/L)	
Potassium	4.5	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	106	95 - 108 mmol/L (mmol/L)	
Urea	3.8	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	76	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Thyroid funct test View Cumulative Results

Collected	16-Mar-2017 00:00	Received	16-Mar-2017 13:35
Reported	16-Mar-2017 15:18	Order Number	B,17.3770450.R
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
TSH	0.57	0.35 - 5.00 mU/L (mU/L)	
Free T4	14.7	9.0 - 21.0 pmol/L (pmol/L)	
Total T3			

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	16-Mar-2017 00:00	Received	16-Mar-2017 13:35
Reported	16-Mar-2017 15:18	Order Number	B,17.3770450.R
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	16	<20 umol/L (umol/L)	
ALT	10	<50 U/L (U/L)	
AST	14	<40 U/L (U/L)	
Alkaline Phosphatase	46	30 - 130 U/L (U/L)	
Albumin	43	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Bone Profile View Cumulative Results

Collected	16-Mar-2017 00:00	Received	16-Mar-2017 13:35
Reported	16-Mar-2017 15:18	Order Number	B;17.3770450.R
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Calcium	2.46	2.20 - 2.60 mmol/L (mmol/L)	
Calcium (adjusted)	2.40	2.20 - 2.60 mmol/L (mmol/L)	
Phosphate	0.95	0.80 - 1.50 mmol/L (mmol/L)	
Albumin	43	35 - 50 g/L (g/L)	
Alkaline Phosphatase	46	30 - 130 U/L (U/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	10-Mar-2017 13:13	Received	10-Mar-2017 13:39
Reported	10-Mar-2017 14:38	Order Number	B,17.0795558.S
Status	Final	Source System	Telepath
Comments	REQUESTOR**blackouts		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	138	133 - 146 mmol/L (mmol/L)	
Potassium	4.7	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	104	95 - 108 mmol/L (mmol/L)	
Urea	4.0	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	78	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	10-Mar-2017 13:13	Received	10-Mar-2017 13:39
Reported	10-Mar-2017 14:38	Order Number	B,17.0795558.S
Status	Final	Source System	Telepath
Comments	REQUESTOR**blackouts		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	16	<20 umol/L (umol/L)	
ALT	12	<50 U/L (U/L)	
AST	18	<40 U/L (U/L)	
Alkaline Phosphatase	58	30 - 130 U/L (U/L)	
Albumin	45	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Glucose View Cumulative Results

Collected	10-Mar-2017 13:13	Received	10-Mar-2017 13:38
Reported	10-Mar-2017 14:33	Order Number	B,17.0795557.D
Status	Final	Source System	Telepath
Comments	Non-fasting sample REQUESTOR**blackouts		

Test	Result	Ref. Range (Units)	Abnormality
Glucose	4.8	3.5 - 6.0 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	10-Mar-2017 13:13	Received	10-Mar-2017 13:39
Reported	10-Mar-2017 14:38	Order Number	B,17.0795558.S
Status	Final	Source System	Telepath
Comments	REQUESTOR**blackouts		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	<1	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Bone Profile View Cumulative Results

Collected	10-Mar-2017 13:13	Received	10-Mar-2017 13:39
Reported	10-Mar-2017 14:38	Order Number	B17.0795558.S
Status	Final	Source System	Telepath
Comments	REQUESTOR**blackouts		

Test	Result	Ref. Range (Units)	Abnormality
Calcium	2.51	2.20 - 2.60 mmol/L (mmol/L)	
Calcium (adjusted)	2.42	2.20 - 2.60 mmol/L (mmol/L)	
Phosphate	1.03	0.80 - 1.50 mmol/L (mmol/L)	
Albumin	45	35 - 50 g/L (g/L)	
Alkaline Phosphatase	58	30 - 130 U/L (U/L)	

* Abnormal ** Critically Abnormal

Amylase View Cumulative Results

Collected	10-Mar-2017 13:13	Received	10-Mar-2017 13:39
Reported	10-Mar-2017 14:38	Order Number	B,17.0795558.S
Status	Final	Source System	Telepath
Comments	REQUESTOR**blackouts		

Test	Result	Ref. Range (Units)	Abnormality
Amylase	61	<100 U/L (U/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	04-Feb-2017 16:11	Received	04-Feb-2017 16:44
Reported	04-Feb-2017 17:13	Order Number	B,17.0599746.H
Status	Final	Source System	Telepath
Comments	REQUESTOR**OD		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	140	133 - 146 mmol/L (mmol/L)	
Potassium	4.5	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	107	95 - 108 mmol/L (mmol/L)	
Urea	3.7	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	71	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Salicylate View Cumulative Results

Collected	04-Feb-2017 16:11	Received	04-Feb-2017 16:44
Reported	04-Feb-2017 17:13	Order Number	B,17.0599746.H
Status	Final	Source System	Telepath
Comments	REQUESTOR**OD		

Test	Result	Ref. Range (Units)	Abnormality
Salicylate	<50	(mg/L)	

* Abnormal ** Critically Abnormal

Paracetamol View Cumulative Results

Collected	04-Feb-2017 16:11	Received	04-Feb-2017 16:44
Reported	04-Feb-2017 17:13	Order Number	B,17.0599746.H
Status	Final	Source System	Telepath
Comments	Note from 04/07/16 detection limit for paracetamol is 5 mg/L. REQUESTOR**OD		

Test	Result	Ref. Range (Units)	Abnormality
Paracetamol	<5	(mg/L)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	04-Feb-2017 16:11	Received	04-Feb-2017 16:44
Reported	04-Feb-2017 17:13	Order Number	B,17.0599746.H
Status	Final	Source System	Telepath
Comments	REQUESTOR**OD		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	17	<20 umol/L (umol/L)	
ALT	11	<50 U/L (U/L)	
AST	16	<40 U/L (U/L)	
Alkaline Phosphatase	67	30 - 130 U/L (U/L)	
Albumin	43	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Glucose View Cumulative Results

Collected	04-Feb-2017 16:11	Received	04-Feb-2017 16:44
Reported	04-Feb-2017 17:13	Order Number	B,17.0599745.Q
Status	Final	Source System	Telepath
Comments	Non-fasting sample REQUESTOR**OD		

Test	Result	Ref. Range (Units)	Abnormality
Glucose	4.9	3.5 - 6.0 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	04-Feb-2017 16:11	Received	04-Feb-2017 16:44
Reported	04-Feb-2017 17:13	Order Number	B,17.0599746.H
Status	Final	Source System	Telepath
Comments	REQUESTOR**OD		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	<1	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	02-Feb-2017 00:41	Received	02-Feb-2017 01:51
Reported	02-Feb-2017 02:58	Order Number	B,17.0590570.X
Status	Final	Source System	Telepath
Comments	REQUESTOR**OD		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	141	133 - 146 mmol/L (mmol/L)	
Potassium	3.9	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	106	95 - 108 mmol/L (mmol/L)	
Urea	3.2	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	70	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Salicylate View Cumulative Results

Collected	02-Feb-2017 00:41	Received	02-Feb-2017 01:51
Reported	02-Feb-2017 02:58	Order Number	B,17.0590570.X
Status	Final	Source System	Telepath
Comments	REQUESTOR**OD		

Test	Result	Ref. Range (Units)	Abnormality
Salicylate	<50	(mg/L)	

* Abnormal ** Critically Abnormal

Paracetamol View Cumulative Results

Collected	02-Feb-2017 00:41	Received	02-Feb-2017 01:51
Reported	02-Feb-2017 02:58	Order Number	B,17.0590570.X
Status	Final	Source System	Telepath
Comments	Note from 04/07/16 detection limit for paracetamol is 5 mg/L. REQUESTOR**OD		

Test	Result	Ref. Range (Units)	Abnormality
Paracetamol	<5	(mg/L)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	02-Feb-2017 00:41	Received	02-Feb-2017 01:51
Reported	02-Feb-2017 02:58	Order Number	B,17.0590570.X
Status	Final	Source System	Telepath
Comments	REQUESTOR**OD		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	17	<20 umol/L (umol/L)	
ALT	15	<50 U/L (U/L)	
AST	19	<40 U/L (U/L)	
Alkaline Phosphatase	66	30 - 130 U/L (U/L)	
Albumin	45	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	02-Feb-2017 00:41	Received	02-Feb-2017 01:51
Reported	02-Feb-2017 02:58	Order Number	B,17.0590570.X
Status	Final	Source System	Telepath
Comments	REQUESTOR**OD		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	<1	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Bone Profile View Cumulative Results

Collected	02-Feb-2017 00:41	Received	02-Feb-2017 01:51
Reported	02-Feb-2017 02:58	Order Number	B,17.0590570.X
Status	Final	Source System	Telepath
Comments	REQUESTOR**OD		

Test	Result	Ref. Range (Units)	Abnormality
Calcium	2.42	2.20 - 2.60 mmol/L (mmol/L)	
Calcium (adjusted)	2.33	2.20 - 2.60 mmol/L (mmol/L)	
Phosphate	1.34	0.80 - 1.50 mmol/L (mmol/L)	
Albumin	45	35 - 50 g/L (g/L)	
Alkaline Phosphatase	66	30 - 130 U/L (U/L)	

* Abnormal ** Critically Abnormal

Amylase View Cumulative Results

Collected	02-Feb-2017 00:41	Received	02-Feb-2017 01:51
Reported	02-Feb-2017 02:58	Order Number	B,17.0590570.X
Status	Final	Source System	Telepath
Comments	REQUESTOR**OD		

Test	Result	Ref. Range (Units)	Abnormality
Amylase	62	<100 U/L (U/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	21-Jan-2016 19:40	Received	21-Jan-2016 20:06
Reported	21-Jan-2016 20:48	Order Number	B,16.0536581.V
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	139	133 - 146 mmol/L (mmol/L)	
Potassium	4.3	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	104	95 - 108 mmol/L (mmol/L)	
Urea	5.5	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	74	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Paracetamol View Cumulative Results

Collected	21-Jan-2016 19:40	Received	21-Jan-2016 20:06
Reported	21-Jan-2016 20:48	Order Number	B,16.0536581.V
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Paracetamol	12	(mg/L)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	21-Jan-2016 19:40	Received	21-Jan-2016 20:06
Reported	21-Jan-2016 20:48	Order Number	B,16.0536581.V
Status	Final	Source System	Telepath
Comments	Alkaline Phosphatase results IFCC aligned from 03/08/15. REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	11	<20 umol/L (umol/L)	
ALT	9	<50 U/L (U/L)	
AST	18	<40 U/L (U/L)	
Alkaline Phosphatase	69	30 - 130 U/L (U/L)	
Albumin	41	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Glucose View Cumulative Results

Collected	21-Jan-2016 19:40	Received	21-Jan-2016 20:07
Reported	21-Jan-2016 20:48	Order Number	B,16.0536582.R
Status	Final	Source System	Telepath
Comments	Non-fasting sample REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Glucose	5.0	3.5 - 6.0 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	21-Jan-2016 19:40	Received	21-Jan-2016 20:06
Reported	21-Jan-2016 20:48	Order Number	B,16.0536581.V
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	2	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	23-Mar-2012 10:06	Received	23-Mar-2012 13:04
Reported	23-Mar-2012 14:15	Order Number	N,12.7118241.E
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Sodium	140	135 - 145 mmol/L (mmol/L)	
Potassium	4.4	3.5 - 5.0 mmol/L (mmol/L)	
Chloride	106	98 - 108 mmol/L (mmol/L)	
Urea	5.0	2.5 - 7.5 mmol/L (mmol/L)	
Creatinine	68	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Thyroid Function View Cumulative Results

Collected	23-Mar-2012 10:06	Received	23-Mar-2012 13:04
Reported	23-Mar-2012 14:15	Order Number	N,12.7118241.E
Status	Final	Source System	Telepath
Comments	Euthyroid TFT results		

Test	Result	Ref. Range (Units)	Abnormality
TSH	0.69	0.35 - 5.00 mu/L (mu/L)	
Free T4	15	9 - 21 pmol/L (pmol/L)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	23-Mar-2012 10:06	Received	23-Mar-2012 13:04
Reported	23-Mar-2012 14:15	Order Number	N,12.7118241.E
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	15	<20 umol/L (umol/L)	
Aspartate Transamina	20	<40 U/L (U/L)	
Alanine Transaminase	13	<50 U/L (U/L)	
Gamma-GT	12	<70 U/L (U/L)	
Alkaline Phosphatase	55	40 - 150 U/L (U/L)	
Total Protein	71	60 - 80 g/L (g/L)	
Albumin	41	32 - 45 g/L (g/L)	
Globulins	30	23 - 38 g/L (g/L)	

* Abnormal ** Critically Abnormal

Glucose View Cumulative Results

Collected	23-Mar-2012 10:06	Received	23-Mar-2012 13:04
Reported	23-Mar-2012 14:15	Order Number	N,12.7118241.E
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Glucose	5.5	3.5 - 5.5 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

8290

West of Scotland Genetic Services
Laboratory Genetics
Level 2B, Laboratory Medicine
Queen Elizabeth University Hospital
1345 Govan Road, Glasgow G51 4TF

Email: geneticlabs@ggc.scot.nhs.uk Tel: 0141 354 9300

NHS Greater Glasgow and Clyde

Head of laboratory: Paul Westwood

Molecular Genetic Report for HFE-related Hereditary Haemochromatosis

Practice Manager [52344]
Crookston Medical Centre
230 Dalmellington Road
Glasgow
G53 7FY

Report Number: 288746

Reported: Lana Cameron

Authorised: Jacqueline Rice

Name of Patient:	Alan FLETCHER			Date of Birth:	30/12/1987
CHI/NHS Number:	3012876456	Sex:	Male	Date of Sample:	18/11/2024
Hospital Number:		Sample Type:	EDTA blood	Date Received:	19/11/2024
Pedigree Number:		Lab Number:	6240885	Date of Activation:	19/11/2024
Ref Lab Number:	IS24230844	Gestation:		Date of Report:	16/12/2024

Reason for referral: Clinical indication suggestive of Hereditary Haemochromatosis (HH). Testing for HFE-related HH has been requested.

Conclusion: The heterozygous HFE variants c.187C>G p.(His63Asp) and c.845G>A p.(Cys282Tyr) were detected.

Results and interpretation:

Analysis has detected one copy of both the c.187C>G p.(His63Asp) and the c.845G>A p.(Cys282Tyr) HFE sequence variants (compound heterozygosity).

The diagnosis of the most common HFE-related HH is excluded. This genotype may pre-dispose to mild or moderate iron overload.

In patients with iron overload other contributing factors such as fatty liver disease, metabolic syndrome and alcohol consumption should be considered. Where the patient has a severe iron overload phenotype, other rare forms of HH cannot be excluded.

Comments:

Where abnormal iron indices are detected, a referral to gastroenterology or haematology is advised.

Biochemical testing for indices of iron overload is available to first degree adult family members. Genetic testing of patients under the age of 16 is not routinely performed for this disorder.

For further information about this result or family testing, please contact Genetics.Referrals@ggc.scot.nhs.uk.

Technical Information:

Allele specific PCR amplification was performed to detect the presence of the sequence variants: c.845G>A p.(Cys282Tyr) and c.187C>G p.(His63Asp) in the HFE gene. The HGVS nomenclature for this genotype is HFE: c.[187C>G];[845G>A]; p.[(His63Asp)];[(Cys282Tyr)]. Sequence nomenclature is according to HGVS guidelines (http://www.hgvs.org/) using accession number NM_000410.4. In order to avoid error and/or misinterpretation, transcription of the content of this report is not advised; Laboratory Genetics do not take any responsibility for the accuracy of any data/text transcribed from this report.

Serum Ferritin View Cumulative Results

Collected	03-Mar-2026 11:02	Received	03-Mar-2026 13:16
Reported	03-Mar-2026 14:47	Order Number	B,26.0939263.B
Status	Final	Source System	Telepath
Comments	Males 15-300 (<15 iron deficiency) Females 15-200 (<15 iron deficiency) 15-50 intermediate result. Consider iron deficiency in anaemic patients, older patients and those with inflammatory disease. REQUESTOR**HFE		

Test	Result	Ref. Range (Units)	Abnormality
Serum Ferritin	185	15 - 300 ug/l (ug/l)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	03-Mar-2026 11:02	Received	03-Mar-2026 13:25
Reported	03-Mar-2026 13:47	Order Number	B,26.0939262.J
Status	Final	Source System	Telepath
Comments	REQUESTOR**HFE REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	5.9	4.0 - 10.0 x10^9/l (x10^9/l)	
Red Cell Count	4.80	4.50 - 6.50 x10^12/l (x10^12/l)	
Haemoglobin	158	130 - 180 g/l (g/l)	
Haematocrit	0.450	0.400 - 0.540 l/l (l/l)	
Mean Cell Volume	93.8	83.0 - 101.0 fl (fl)	
MCH	*** 32.9**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	267	150 - 410 x10^9/l (x10^9/l)	
Neutrophils	2.6	2.0 - 7.0 x10^9/l (x10^9/l)	
Lymphocytes	2.3	1.1 - 5.0 x10^9/l (x10^9/l)	
Monocytes	0.7	0.2 - 1.0 x10^9/l (x10^9/l)	
Eosinophils	0.23	0.02 - 0.50 x10^9/l (x10^9/l)	
Basophils	0	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	30-Dec-2025 18:30	Received	30-Dec-2025 18:46
Reported	30-Dec-2025 19:27	Order Number	B,25.2901706.W
Status	Final	Source System	Telepath
Comments	REQUESTOR**admission bloods REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	8.9	4.0 - 10.0 x10^9/l (x10^9/l)	
Red Cell Count	4.83	4.50 - 6.50 x10^12/l (x10^12/l)	
Haemoglobin	160	130 - 180 g/l (g/l)	
Haematocrit	0.449	0.400 - 0.540 l/l (l/l)	
Mean Cell Volume	93.0	83.0 - 101.0 fl (fl)	
MCH	* 33.1	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	262	150 - 410 x10^9/l (x10^9/l)	
Neutrophils	5.0	2.0 - 7.0 x10^9/l (x10^9/l)	
Lymphocytes	2.9	1.1 - 5.0 x10^9/l (x10^9/l)	
Monocytes	0.9	0.2 - 1.0 x10^9/l (x10^9/l)	
Eosinophils	0.18	0.02 - 0.50 x10^9/l (x10^9/l)	
Basophils	0	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

D-Dimer (IL DDHS) View Cumulative Results

Collected	30-Dec-2025 18:30	Received	30-Dec-2025 18:46
Reported	30-Dec-2025 19:47	Order Number	B,25.2901705.H
Status	Final	Source System	Telepath

Comments: The reported reference range of 0-230 ng/mL applies to patients with suspected VTE. In other populations the reference range is 0-243 ng/mL.
REQUESTOR**admission bloods
REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS)
REPORT**for scope on schedule. Please see the user handbook for clarification

Test	Result	Ref. Range (Units)	Abnormality
D-Dimer	<150	0 - 230 ng/ml (ng/ml)	

* Abnormal ** Critically Abnormal

Coagulation Screen View Cumulative Results

Collected	30-Dec-2025 18:30	Received	30-Dec-2025 18:46
Reported	30-Dec-2025 19:47	Order Number	B,25.2901705.H
Status	Final	Source System	Telepath
Comments	REQUESTOR**admission bloods REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
Prothrombin Time	11	9 - 13 s (s)	
PT Ratio	1.0		
APTT	31	27 - 36 s (s)	
APTT Ratio	1.0	0.9 - 1.1	
Thrombin time	* **16**	11 - 15 s (s)	**Abnormal - high**
TCT ratio	1.2		

* Abnormal ** Critically Abnormal

Serum Ferritin View Cumulative Results

Collected	20-Mar-2025 13:39	Received	20-Mar-2025 15:48
Reported	20-Mar-2025 17:37	Order Number	B,25.1032727.Y
Status	Final	Source System	Telepath
Comments	Males 15-300 (<15 iron deficiency) Females 15-200 (<15 iron deficiency) 15-50 intermediate result. Consider iron deficiency in anaemic patients, older patients and those with inflammatory disease. REQUESTOR**New HFE - liver assessme....		

Test	Result	Ref. Range (Units)	Abnormality
Serum Ferritin	249	15 - 300 ug/l (ug/l)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	20-Mar-2025 13:39	Received	20-Mar-2025 15:46
Reported	20-Mar-2025 16:02	Order Number	B,25.1032839.L
Status	Final	Source System	Telepath
Comments	REQUESTOR**New HFE - liver assessme...: REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	7.9	4.0 - 10.0 x10^9/l (x10^9/l)	
Red Cell Count	4.70	4.50 - 6.50 x10^12/l (x10^12/l)	
Haemoglobin	156	130 - 180 g/l (g/l)	
Haematocrit	0.435	0.400 - 0.540 l/l (l/l)	
Mean Cell Volume	92.6	83.0 - 101.0 fl (fl)	
MCH	* **33.2**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	272	150 - 410 x10^9/l (x10^9/l)	
Neutrophils	5.2	2.0 - 7.0 x10^9/l (x10^9/l)	
Lymphocytes	1.6	1.1 - 5.0 x10^9/l (x10^9/l)	
Monocytes	0.9	0.2 - 1.0 x10^9/l (x10^9/l)	
Eosinophils	0.25	0.02 - 0.50 x10^9/l (x10^9/l)	
Basophils	0	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Coagulation Screen View Cumulative Results

Collected	20-Mar-2025 13:39	Received	20-Mar-2025 15:48
Reported	20-Mar-2025 16:22	Order Number	B,25.1032724.G
Status	Final	Source System	Telepath
Comments	REQUESTOR**New HFE - liver assessme.... REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
Prothrombin Time	11	9 - 13 s (s)	
PT Ratio	0.9		
APTT	33	27 - 36 s (s)	
APTT Ratio	1.1	0.9 - 1.1	
Thrombin time	14	11 - 15 s (s)	
TCT ratio	1.1		

* Abnormal ** Critically Abnormal

Active B12 View Cumulative Results

Collected	18-Nov-2024 12:20	Received	18-Nov-2024 19:52
Reported	19-Nov-2024 16:42	Order Number	B,24.2708967.T
Status	Final	Source System	Telepath

Comments

Result in indeterminate range (25 - 70 pmol/L).
Consider treatment for B12 deficiency in following patient groups:
- Patients with a condition which may deteriorate quickly and have a severe effect on QoL (neurological, haematological cond'ns)
- Patients who are pregnant or breast feeding.
- Patients with a recognised cause of B12 deficiency (surgery or autoimmune gastritis).
Otherwise consider other causes of symptoms and if necessary repeat active B12 level at 3-6 months.
Note change in the B12 assay to an active B12 assay from 14/5/24.
REQUESTOR**low b12. rasied iron
REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS)
REPORT**for scope on schedule. Please see the user handbook for clarification

Test	Result	Ref. Range (Units)	Abnormality
Active B12	53	>25 pmol/L (pmol/L)	

* Abnormal ** Critically Abnormal

Serum Folate View Cumulative Results

Collected	23-Aug-2024 12:06	Received	23-Aug-2024 17:50
Reported	29-Aug-2024 11:02	Order Number	B,24.2143234.R
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
Serum Folate	***2.3**	3.1 - 20.0 ug/l (ug/l)	**Abnormal - low**

* Abnormal ** Critically Abnormal

Serum Ferritin View Cumulative Results

Collected	23-Aug-2024 12:06	Received	23-Aug-2024 17:50
Reported	29-Aug-2024 11:02	Order Number	B,24.2143234.R
Status	Final	Source System	Telepath

Comments: Males 15-300 (<15 iron deficiency)
Females 15-200 (<15 iron deficiency)
15-50 intermediate result. Consider iron deficiency in anaemic patients, older patients and those with inflammatory disease.
REQUESTOR**back pain
REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS)
REPORT**for scope on schedule. Please see the user handbook for clarification

Test	Result	Ref. Range (Units)	Abnormality
Serum Ferritin	*** 317**	15 - 300 ug/l (ug/l)	**Abnormal - high**

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	23-Aug-2024 12:06	Received	23-Aug-2024 18:06
Reported	23-Aug-2024 19:22	Order Number	B,24.2144460.W
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	6.6	4.0 - 10.0 x10^9/l (x10^9/l)	
Red Cell Count	5.05	4.50 - 6.50 x10^12/l (x10^12/l)	
Haemoglobin	165	130 - 180 g/l (g/l)	
Haematocrit	0.474	0.400 - 0.540 l/l (l/l)	
Mean Cell Volume	93.9	83.0 - 101.0 fl (fl)	
MCH	*** 32.7**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	259	150 - 410 x10^9/l (x10^9/l)	
Neutrophils	2.7	2.0 - 7.0 x10^9/l (x10^9/l)	
Lymphocytes	2.9	1.1 - 5.0 x10^9/l (x10^9/l)	
Monocytes	0.7	0.2 - 1.0 x10^9/l (x10^9/l)	
Eosinophils	0.25	0.02 - 0.50 x10^9/l (x10^9/l)	
Basophils	0	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

ESR View Cumulative Results

Collected	23-Aug-2024 12:06	Received	23-Aug-2024 18:06
Reported	23-Aug-2024 19:22	Order Number	B,24.2144460.W
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
ESR	2	0 - 10 mm/hr (mm/hr)	

* Abnormal ** Critically Abnormal

Active B12 View Cumulative Results

Collected	23-Aug-2024 12:06	Received	23-Aug-2024 17:50
Reported	29-Aug-2024 11:02	Order Number	B,24.2143234.R
Status	Final	Source System	Telepath

Comments

Result in indeterminate range (25 - 70 pmol/L).
Consider treatment for B12 deficiency in following patient groups:
- Patients with a condition which may deteriorate quickly and have a severe effect on QoL (neurological, haematological cond'ns)
- Patients who are pregnant or breast feeding.
- Patients with a recognised cause of B12 deficiency (surgery or autoimmune gastritis).
Otherwise consider other causes of symptoms and if necessary repeat active B12 level at 3-6 months.
Note change in the B12 assay to an active B12 assay from 14/5/24.
REQUESTOR**back pain
REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS)
REPORT**for scope on schedule. Please see the user handbook for clarification

Test	Result	Ref. Range (Units)	Abnormality
Active B12	43	>25 pmol/L (pmol/L)	

* Abnormal ** Critically Abnormal

Coagulation Screen View Cumulative Results

Collected	05-Apr-2017 14:49	Received	05-Apr-2017 15:03
Reported	05-Apr-2017 15:58	Order Number	B,17.0992141.P
Status	Final	Source System	Telepath
Comments	REQUESTOR**Mixed OD		

Test	Result	Ref. Range (Units)	Abnormality
Prothrombin Time	13	9 - 13 s (s)	
PT Ratio	1.1		
APTT	35	27 - 38 s (s)	
APTT Ratio	1.2	0.8 - 1.2	
Thrombin time	13	11 - 15 s (s)	
TCT ratio	0.9		

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	05-Apr-2017 14:15	Received	05-Apr-2017 14:48
Reported	05-Apr-2017 15:08	Order Number	B,17.0992099.V
Status	Final	Source System	Telepath
Comments	REQUESTOR**Mixed OD		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	8.8	4.0 - 11.0 x10^9/l (x10^9/l)	
Red Cell Count	5.20	4.50 - 6.50 x10^12/l (x10^12/l)	
Haemoglobin	170	130 - 180 g/l (g/l)	
Haematocrit	0.478	0.400 - 0.540 l/l (l/l)	
Mean Cell Volume	91.9	80.0 - 100.0 fl (fl)	
MCH	*** 32.7**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	347	150 - 400 x10^9/l (x10^9/l)	
Neutrophils	6.8	2.0 - 7.5 x10^9/l (x10^9/l)	
Lymphocytes	*** 1.3**	1.5 - 4.0 x10^9/l (x10^9/l)	**Abnormal - low**
Monocytes	0.5	0.2 - 0.8 x10^9/l (x10^9/l)	
Eosinophils	0.04	0.00 - 0.40 x10^9/l (x10^9/l)	
Basophils	0	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Serum Vitamin B12 View Cumulative Results

Collected	16-Mar-2017 00:00	Received	16-Mar-2017 13:35
Reported	17-Mar-2017 13:28	Order Number	B,17.3770450.R
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Serum Vitamin B12	*** 173**	200 - 900 ng/l (ng/l)	**Abnormal - low**

* Abnormal ** Critically Abnormal

Serum Folate View Cumulative Results

Collected	16-Mar-2017 00:00	Received	16-Mar-2017 13:35
Reported	17-Mar-2017 13:28	Order Number	B,17.3770450.R
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Serum Folate	3.9	3.1 - 20.0 ug/l (ug/l)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	16-Mar-2017 00:00	Received	16-Mar-2017 13:35
Reported	16-Mar-2017 13:58	Order Number	B,17.3770451.D
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	6.0	4.0 - 11.0 x10^9/l (x10^9/l)	
Red Cell Count	5.05	4.50 - 6.50 x10^12/l (x10^12/l)	
Haemoglobin	164	130 - 180 g/l (g/l)	
Haematocrit	0.487	0.400 - 0.540 l/l (l/l)	
Mean Cell Volume	96.4	80.0 - 100.0 fl (fl)	
MCH	* **32.5**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	281	150 - 400 x10^9/l (x10^9/l)	
Neutrophils	3.2	2.0 - 7.5 x10^9/l (x10^9/l)	
Lymphocytes	1.9	1.5 - 4.0 x10^9/l (x10^9/l)	
Monocytes	0.8	0.2 - 0.8 x10^9/l (x10^9/l)	
Eosinophils	0.22	0.00 - 0.40 x10^9/l (x10^9/l)	
Basophils	0	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	10-Mar-2017 13:13	Received	10-Mar-2017 13:38
Reported	10-Mar-2017 14:03	Order Number	B,17.0795556.R
Status	Final	Source System	Telepath
Comments	REQUESTOR**blackouts		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	*** 13.3**	4.0 - 11.0 x10^9/l (x10^9/l)	**Abnormal - high**
Red Cell Count	5.21	4.50 - 6.50 x10^12/l (x10^12/l)	
Haemoglobin	173	130 - 180 g/l (g/l)	
Haematocrit	0.483	0.400 - 0.540 l/l (l/l)	
Mean Cell Volume	92.7	80.0 - 100.0 fl (fl)	
MCH	*** 33.2**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	326	150 - 400 x10^9/l (x10^9/l)	
Neutrophils	*** 10.9**	2.0 - 7.5 x10^9/l (x10^9/l)	**Abnormal - high**
Lymphocytes	*** 1.4**	1.5 - 4.0 x10^9/l (x10^9/l)	**Abnormal - low**
Monocytes	*** 0.9**	0.2 - 0.8 x10^9/l (x10^9/l)	**Abnormal - high**
Eosinophils	0.09	0.00 - 0.40 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	04-Feb-2017 16:11	Received	04-Feb-2017 16:38
Reported	04-Feb-2017 17:03	Order Number	B,17.0600058.T
Status	Final	Source System	Telepath
Comments	REQUESTOR**OD		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	7.3	4.0 - 11.0 x10^9/l (x10^9/l)	
Red Cell Count	5.38	4.50 - 6.50 x10^12/l (x10^12/l)	
Haemoglobin	170	130 - 180 g/l (g/l)	
Haematocrit	0.476	0.400 - 0.540 l/l (l/l)	
Mean Cell Volume	88.5	80.0 - 100.0 fl (fl)	
MCH	31.6	27.0 - 32.0 pg (pg)	
Platelet Count	319	150 - 400 x10^9/l (x10^9/l)	
Neutrophils	4.7	2.0 - 7.5 x10^9/l (x10^9/l)	
Lymphocytes	1.8	1.5 - 4.0 x10^9/l (x10^9/l)	
Monocytes	0.7	0.2 - 0.8 x10^9/l (x10^9/l)	
Eosinophils	0.07	0.00 - 0.40 x10^9/l (x10^9/l)	
Basophils	0	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Coagulation Screen View Cumulative Results

Collected	04-Feb-2017 16:11	Received	04-Feb-2017 16:41
Reported	04-Feb-2017 17:03	Order Number	B,17.0600077.C
Status	Final	Source System	Telepath
Comments	REQUESTOR**OD		

Test	Result	Ref. Range (Units)	Abnormality
Prothrombin Time	13	9 - 13 s (s)	
PT Ratio	1.1		
APTT	34	27 - 38 s (s)	
APTT Ratio	1.1	0.8 - 1.2	
Thrombin time	14	11 - 15 s (s)	
TCT ratio	1.0		

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	02-Feb-2017 00:41	Received	02-Feb-2017 02:18
Reported	02-Feb-2017 02:33	Order Number	B,17.0589887.T
Status	Final	Source System	Telepath
Comments	REQUESTOR**OD		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	9.7	4.0 - 11.0 x10^9/l (x10^9/l)	
Red Cell Count	5.21	4.50 - 6.50 x10^12/l (x10^12/l)	
Haemoglobin	163	130 - 180 g/l (g/l)	
Haematocrit	0.463	0.400 - 0.540 l/l (l/l)	
Mean Cell Volume	88.9	80.0 - 100.0 fl (fl)	
MCH	31.3	27.0 - 32.0 pg (pg)	
Platelet Count	303	150 - 400 x10^9/l (x10^9/l)	
Neutrophils	5.9	2.0 - 7.5 x10^9/l (x10^9/l)	
Lymphocytes	2.7	1.5 - 4.0 x10^9/l (x10^9/l)	
Monocytes	0.8	0.2 - 0.8 x10^9/l (x10^9/l)	
Eosinophils	0.21	0.00 - 0.40 x10^9/l (x10^9/l)	
Basophils	0	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	21-Jan-2016 19:40	Received	21-Jan-2016 20:53
Reported	21-Jan-2016 21:18	Order Number	B,16.0535665.K
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	*** 11.5**	4.0 - 11.0 x10^9/l (x10^9/l)	**Abnormal - high**
Red Cell Count	4.67	4.50 - 6.50 x10^12/l (x10^12/l)	
Haemoglobin	156	130 - 180 g/l (g/l)	
Haematocrit	0.434	0.400 - 0.540 l/l (l/l)	
Mean Cell Volume	92.9	80.0 - 100.0 fl (fl)	
MCH	*** 33.4**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	314	150 - 400 x10^9/l (x10^9/l)	
Neutrophils	*** 8.3**	2.0 - 7.5 x10^9/l (x10^9/l)	**Abnormal - high**
Lymphocytes	2.0	1.5 - 4.0 x10^9/l (x10^9/l)	
Monocytes	*** 1.1**	0.2 - 0.8 x10^9/l (x10^9/l)	**Abnormal - high**
Eosinophils	0.2	0.0 - 0.4 x10^9/l (x10^9/l)	
Basophils	0	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

FBC View Cumulative Results

Collected	23-Mar-2012 10:06	Received	23-Mar-2012 13:04
Reported	23-Mar-2012 14:05	Order Number	H,12.6550623.J
Status	Final	Source System	Telepath
Comments	NEW PATIENT		

Test	Result	Ref. Range (Units)	Abnormality
White Cell Count	6.80	4.00 - 11.00 10^9/L (10^9/L)	
Red Cell Count	4.95	4.50 - 6.50 10^12/L (10^12/L)	
Haemoglobin	153	130 - 180 g/L (g/L)	
Haematocrit	0.452	0.400 - 0.540 L/L (L/L)	
MCV	91.3	78.0 - 99.0 fl (fl)	
MCH	30.9	27.0 - 32.0 pg (pg)	
RDW	12.2	11.5 - 14.5 % (%)	
Platelets	264	150 - 400 10^9/L (10^9/L)	
Neutrophils	3.43	2.00 - 7.50 10^9/L (10^9/L)	
Lymphocytes	2.02	1.50 - 4.00 10^9/L (10^9/L)	
Monocytes	0.60	0.20 - 0.80 10^9/L (10^9/L)	
Eosinophils	***0.74**	0.04 - 0.40 10^9/L (10^9/L)	**Abnormal - high**
Basophils	0.01	0.01 - 0.10 10^9/L (10^9/L)	

* Abnormal ** Critically Abnormal

ESR View Cumulative Results

Collected	23-Mar-2012 10:06	Received	23-Mar-2012 13:04
Reported	23-Mar-2012 14:05	Order Number	H,12.6550623.J
Status	Final	Source System	Telepath
Comments	NEW PATIENT		

Test	Result	Ref. Range (Units)	Abnormality
ESR	5	1 - 10 mm/hr (mm/hr)	

* Abnormal ** Critically Abnormal

I Coeliac Serol (Dx) View Cumulative Results

Collected	20-Mar-2025 13:39	Received	20-Mar-2025 16:05
Reported	04-Apr-2025 10:37	Order Number	B,25.3509659.G
Status	Final	Source System	Telepath

Comments: IgA TTG Ab = IgA Tissue Transglutaminase Ab.
Normal = <7.0, equivocal = 7.0-10.0, positive = >10.0.
If screening for coeliac disease, this result is only valid if the person was eating gluten at least twice a day for previous 6 weeks
IgA coeliac serology has reduced sensitivity if total IgA <0.2g/l
REQUESTOR**New HFE - liver assessme....

Test	Result	Ref. Range (Units)	Abnormality
TTG Ab (IgA)	0.5	0.0 - 7.0 U/mL (U/mL)	

*.Abnormal ** Critically Abnormal

I Autoantibodies View Cumulative Results

Collected	20-Mar-2025 13:39	Received	20-Mar-2025 16:05
Reported	27-Mar-2025 13:37	Order Number	B,25.3509658.L
Status	Final	Source System	Telepath
Comments	** Repeat Request ** Following results are from 18.11.24 and are valid for 365 days Mito Abs Negative Sm Mus Abs Negative GPC Abs Negative LKM Abs Negative LC Abs Negative ANA Rodent Negative REQUESTOR**New HFE - liver assessme....		

Test	Result	Ref. Range (Units)	Abnormality
Mitochondrial Abs			
Smooth Muscle Abs			
Gastric Parietal Abs			
LKM Abs			
Liver Cytosol Abs			
ANA (rodent) Abs			

* Abnormal ** Critically Abnormal

I ANA/Centromere Abs View Cumulative Results

Collected	20-Mar-2025 13:39	Received	20-Mar-2025 16:05
Reported	27-Mar-2025 13:37	Order Number	B,25.3509658.L
Status	Final	Source System	Telepath
Comments	ANA result is negative. REQUESTOR**New HFE - liver assessme....		

Test	Result	Ref. Range (Units)	Abnormality
ANA result	Negative		

* Abnormal ** Critically Abnormal

I Intrinsic factor Q View Cumulative Results

Collected	18-Nov-2024 12:20	Received	19-Nov-2024 09:37
Reported	27-Nov-2024 11:47	Order Number	B,24.3681298.R
Status	Final	Source System	Telepath
Comments	Ref range: 0-20=Negative, 20.1-24.9=Equivocal, >24.9=Positive REQUESTOR**low b12. rasied iron		

Test	Result	Ref. Range (Units)	Abnormality
Intrinsic Factor Ab	3.4	0.0 - 25.0 Units (Units)	

* Abnormal ** Critically Abnormal

I Autoantibodies View Cumulative Results

Collected	18-Nov-2024 12:20	Received	19-Nov-2024 09:34
Reported	21-Nov-2024 11:22	Order Number	B,24.3681296.M
Status	Final	Source System	Telepath
Comments	From 22/02/24 mouse tissue in use (previously rat). REQUESTOR**low b12. rasied iron		

Test	Result	Ref. Range (Units)	Abnormality
Mitochondrial Abs	Negative		
Smooth Muscle Abs	Negative		
Gastric Parietal Abs	Negative		
LKM Abs	Negative		
Liver Cytosol Abs	Negative		
ANA (rodent) Abs	Negative		

* Abnormal ** Critically Abnormal

I Coeliac Serology View Cumulative Results

Collected	23-Mar-2012 00:00	Received	23-Mar-2012 16:03
Reported	30-Mar-2012 09:30	Order Number	I,12.7830483.V
Status	Final	Source System	Telepath
Comments	TTG Ab = Tissue Transglutaminase Ab Normal = <7.0, equivocal = 7.0-10.0, positive = >10.0		

Test	Result	Ref. Range (Units)	Abnormality
TTG Ab (IgA)	0.7	0.0 - 7.0 U/ml (U/ml)	

* Abnormal ** Critically Abnormal

COLONIC BIOPSY

Performed	22-Mar-2012 00:00	Received	23-Mar-2012 12:49
Reported	30-Mar-2012 09:00	Order Number	P,12.0006208.S
Status	Final	Source System	Telepath

Pathology Final

NGD Pathology(WIG-211 2473 GRI-211 4738)

Nature of Specimen : COLONIC BIOPSY
Requester Location : No source details
Date Reported : 30.03.12
Auth by : Sigrid Koehler 30.03.12 08:55
T67000 M00100 P00003

RANDOM COLONIC BIOPSY

Clinical history

Loose motions.

Gross

Six pieces of tissue, the largest measuring 5 x 2 x 2mm.

Microscopy

Microscopy shows normal colonic mucosa.

JMCE A Patel
E A Mallon

Hepatitis C antibody View Cumulative Results

Collected	20-Mar-2025 13:39	Received	21-Mar-2025 09:00
Reported	21-Mar-2025 14:57	Order Number	V,25.1623463.Y
Status	Final	Source System	Telepath
Comments	This is a PLASMA sample. REQUESTOR**New HFE - liver assessme....		

Test	Result	Ref. Range (Units)	Abnormality
HCV antibody :	Not detected		

* Abnormal ** Critically Abnormal

HBSAG View Cumulative Results

Collected	20-Mar-2025 13:39	Received	21-Mar-2025 09:00
Reported	21-Mar-2025 14:57	Order Number	V,25.1623463.Y
Status	Final	Source System	Telepath
Comments	This is a PLASMA sample. REQUESTOR**New HFE - liver assessme....		

Test	Result	Ref. Range (Units)	Abnormality
HBsAg :	Not detected		

* Abnormal ** Critically Abnormal

C.trachomatis/GC PCR View Cumulative Results

Collected	06-Jan-2016 14:37	Received	07-Jan-2016 09:22
Reported	08-Jan-2016 08:03	Order Number	V,16.0300397.C
Status	Final	Source System	Telepath
Comments	This is a URINE sample.		

Test	Result	Ref. Range (Units)	Abnormality
C. trachomatis :	Not detected by PCR		
N. gonorrhoeae :	Not detected by PCR		

* Abnormal ** Critically Abnormal

Greater Glasgow & Clyde Audiology Services

NHS Greater Glasgow and Clyde

Your Audiology Management Plan

This is your Individual patient Management Plan which is referred to as your IMP. It contains information about you and a summary of the work we have done with you. It may include a copy of your most recent hearing test, information about the hearing aids that you use (if you wear any) and details of the other professionals associated with your hearing care.

As a summary, the IMP will automatically update as we add new information to your electronic audiology records. Please note that some sections of the IMP will be blank.

Current IMP date : 30/08/2022

Your details :

Name :	Fletcher, Alan	Date of Birth :	30/12/1987
Address :	62 INNERWICK DR GLASGOW G52 2HY	CHI Number :	3012876456
		Hospital Number :	ZWH1264710
		School :	
		School Address :	

Important Contacts :

GP : KERR, AMY, . 12 Walmer Crescent; -- UnDefined --, -- UnDefined -- G51 1AT 0 0

Audiologist : Audiologist, UnAssigned

ENT :

Teacher of the Deaf :

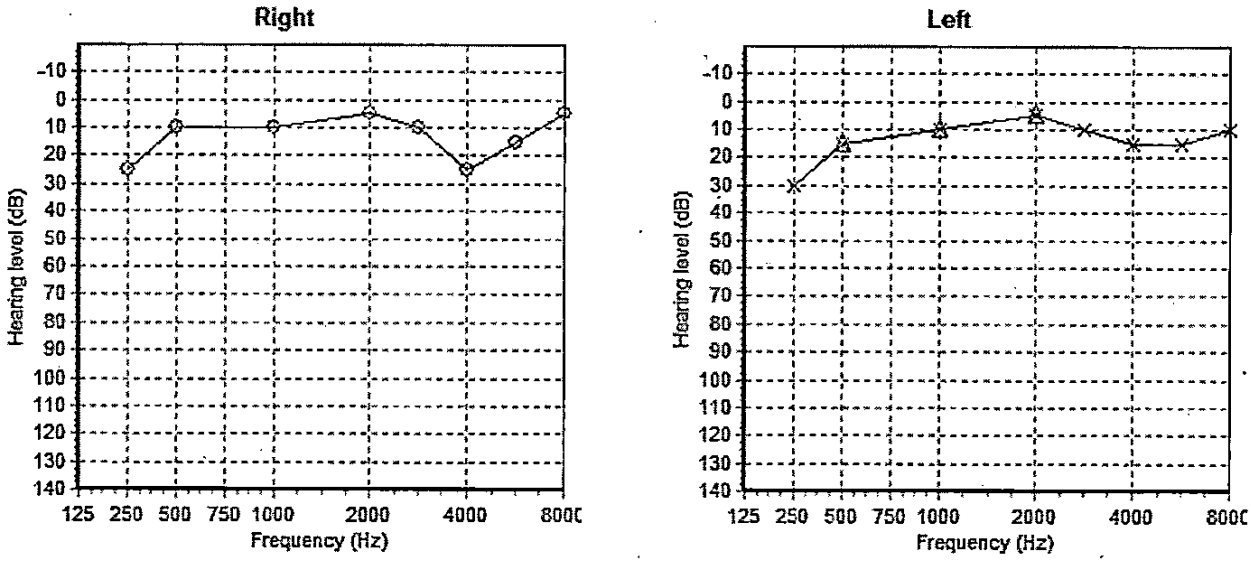
Educational Audiologist :

Paediatrician :

Speech and Language :

Other :

Your audiogram :



This is a copy of your recent hearing test. Your Audiologist will have provided you with an explanation of the type and severity of your hearing loss.

Summary of attended, scheduled and pending appointments :

Latest Medical Referral Details :	***DR/ New Assessment*** on 02/09/2021
Last attended Appointment :	Adult assessment on 30/08/2022
Next Scheduled Appointment :	

Recent Clinical Notes :

Assessment (ASS)

Date	Content of Note
30/08/2022	Presentation Patient attended for DR, GP referral. Attended alone. Pt reports he has difficulty hearing in most situations. Difficulty at work where he has to be able to hear. Ear otalgia/ear surgery/infections - no Tinnitus - sometimes at night in both ears. Balance - an episode of dizziness ~ 3 years ago, no recurrence. Medical hx/medications - Asthma - inhalers. Eyesight - fine Dexterity - fine Occupational/Recreational noise exposure - He works as a lighting and sound engineer touring with bands in big venues and festivals. He admits to not wearing ear protection Family hx HL - no 24 hr noise exposure - no. Action NP hx Q completed.

Otoscopy: clear, TMs intact.
PTA demonstrated WNL
Discussed results - pt had difficulty comprehending why I would not recommend HAs.
Explained would not be beneficial and not suitable for his working environment when he has normal range hearing.
Discussed difference between ability to hear and effective listening and how it can be challenging in complex environments.
Directed to L.A.C.E as auditory training would possibly be of benefit.
Recommended consideration of ear protection at work.
GP letter sent.

Plan
Pt discharged.

Signed (if printed)

Audiologist _____ Date: 30 August 2022

Patient _____ Date: 30 August 2022

Fibroscan Report

NHS
Greater Glasgow and Clyde

Patient Name: Alan Fletcher
CHI: 3012876456
Date: 20/03/2025

Consultant: Liver clinic

Location: QEUH O/P

Operator: H.BRYSON

Probe: M

Indication:

Fasting: Yes

Liver Stiffness: 4.4 kPa

IQR: 9%

CAP:

Spleen Stiffness: kPa

Interpretation of Liver Stiffness Measurements by Transient Elastography (Fibroscan)

Compensated Advanced Chronic Liver Disease (cACLD)

LSM <8.0-10.0 kPA Rules out cACLD

LSM >12.0-15.0 kPA Rules in cACLD

Clinically Significant Portal Hypertension (CSPH)

LSM >20.0-25.0 kPA Rules in CSPH

LSM<20.0kPa + Platelet count > 150 x 109/l excludes significant varices avoiding the need for endoscopic assessment (Baveno VI criteria)

SSM@100Hz <41.3kPa excludes high risk varices Stefanescu et al

ARLD

LSM < 8.0 kPa Rules out significant fibrosis

LSM >12 kPA Rules in significant fibrosis

NAFLD

LSM< 8.0kPa Rules out significant fibrosis

CAP	Steatosis Grade	% liver with fatty change
238-260	S1	11%-33%
260-290	S2	34%-66%
> 290	S3	67% or more

Cholestatic Liver Disease

PBC

LSM < 10.0 kPa Rules out significant fibrosis

LSM > 10.0 kPa Rules in significant fibrosis

PSC

LSM <9.5kPa Rules out significant fibrosis

References

EASL Clinical Practice Guidelines on non-invasive tests for evaluation of liver disease severity and prognosis – 2021 updated *European Association for the Study of the Liver* Journal of Hepatology 2021 vol. - j 1–31

A novel spleen-dedicated stiffness measurement by FibroScan® improves the screening of high-risk oesophageal Varices *Stefanescu et al* **Liver International.** 2020;40(1):175-185

XR Chest

Performed	30-Dec-2025 18:29	Received	08-Jan-2026 13:55
Reported	08-Jan-2026 13:53	Order Number	G405H43048241
Status	Final	Source System	MiSys

XR Chest Final
Alan Fletcher
Clinical History :

Chest pain, SOB ?LRTI

XR Chest :
The heart is not enlarged. The lungs are clear of active disease. No significant sized focal lung lesion identified.

Reported by: Dr Sean Kelly and None
Verified by: Dr Sean Kelly

XR Lumbar spine

Performed	10-Jan-2025 10:26	Received	10-Jan-2025 11:05
Reported	10-Jan-2025 11:03	Order Number	G405H41786128
Status	Final	Source System	MiSys

XR Lumbar spine Final
Alan Fletcher
Auto reported

Not performed as wrong examination or wrong side requested.

under low back pain protocol pt should be refeered to MRi discussed with duty and patient RA096412

Reported by: Auto Reporting
Verified by: Auto Reporting

XR Radius and ulna Lt

Performed	21-Jun-2020 15:28	Received	22-Jun-2020 09:36
Reported	22-Jun-2020 09:34	Order Number	G405H36309469
Status	Final	Source System	MiSys

XR Radius and ulna Lt Final
Alan Fletcher
Clinical History :
Pallet of boxes fell on forearm. Tender distal to midshaft radius. ?#

XR Radius and ulna Lt :
No acute bony injury.

Code A: Agreement: This result will be autosigned in TrakCare as there is no major discrepancy between the radiology report and the referrer's 'sticky note' interpretation.

Reported by: Dr Jennifer Curle (SpR)
Verified by: Dr Jennifer Curle (SpR)

XR Ankle Lt

Performed	22-Aug-2018 11:56	Received	22-Aug-2018 17:06
Reported	22-Aug-2018 17:04	Order Number	G405H34190529
Status	Final	Source System	MiSys

XR Ankle Lt Final
Alan Fletcher
Clinical History :

direct blow to medial aspect ankle with heavy object. Tender / swollen medial malleolus ? fracture

XR Ankle Lt :
No acute bony injury identified.

Code A: Agreement: No major discrepancy between the radiologist report and the referrer's 'sticky note' interpretation.
Images reported by Kirsteen Graham, Reporting Radiographer.

Reported by: Kirsteen Graham
Verified by: Kirsteen Graham

XR Ankle Rt

Performed	20-Mar-2017 09:53	Received	20-Mar-2017 11:17
Reported	20-Mar-2017 11:15	Order Number	G504H32459699
Status	Final	Source System	MiSys

XR Ankle Rt Final
Alan Fletcher
Clinical History :
Assaulted two weeks zero. Ongoing pain and difficult to mobilise. Tender over right lateral malleolus and base of fifth metatarsal.

XR Ankle Rt :
No bony injury seen.

Reported by: Dr Thomas Elswood (SpR) and Dr Michal Gronski
Verified by: Dr Michal Gronski

XR Foot Rt

Performed	18-Feb-2017 04:41	Received	18-Feb-2017 14:02
Reported	18-Feb-2017 14:00	Order Number	G405H32358941
Status	Final	Source System	MiSys

XR Foot Rt Final
Alan Fletcher
Clinical History :

Seen at GRI recently. Since further fall and sore 5th MT ? #

XR Foot Rt :
Comparison is made with imaging of 16/02/17.
No acute or healing fracture.
Normal alignment.

Code A: Agreement: No major discrepancy between the radiologist report and the referrer's 'sticky note' interpretation.

Report by Amanda Rutherford - reporting radiographer

Reported by: Amanda Rutherford
Verified by: Amanda Rutherford

XR Hand Rt

Performed	16-Jan-2017 01:18	Received	16-Jan-2017 16:02
Reported	16-Jan-2017 16:00	Order Number	G405H32240222
Status	Final	Source System	MiSys

XR Hand Rt Final
Alan Fletcher
Clinical History :

building stage and it collapsed trpping his hand - 2 weeks ago - however still swollen and +++ pain and decr rom - ?#

XR Hand Rt :
Comparison is made with previous right hand radiographs dated 01/04/2015.
A small bony density is noted at the ulnar aspect of the base of the little finger metacarpal. This is not present on the previous radiograph and therefore is suspicious for minimally displaced fracture.

Code D: Discrepancy: There is a significant discrepancy between the radiologist report and the referrer's 'sticky note' interpretation. Senior review advised.

Report by Graham Johnstone reporting radiographer.

Reported by: Graham Johnstone and Jonathan McConnell
Verified by: Jonathan McConnell

XR Knee Rt

Performed	10-Feb-2015 14:35	Received	10-Feb-2015 15:12
Reported	10-Feb-2015 15:10	Order Number	G306H29949310
Status	Final	Source System	MiSys

XR Knee Rt Final
Alan Fletcher
Clinical History :

fall 10 ft tender over medial aspect of knee and fem condyle

XR Knee Rt :
No acute fracture is demonstrated.

No clinician's report available yet.

Reported by: Dr Catriona Turbet (SpR)
Verified by: Dr Catriona Turbet (SpR)

XR Cervical spine

Performed	10-Oct-2011 23:33	Received	12-Oct-2011 08:45
Reported	12-Oct-2011 08:15	Order Number	G516H26278931
Status	Final	Source System	MiSys

XR Cervical spine Final
Alan Fletcher
Clinical History :
Axial load head injury yesterday. Brief loss of consciousness. Pain in C3/C4 midline.

XR Cervical spine :
Bony alignment is satisfactory, with no evidence of acute fracture. No prevertebral soft tissue swelling.

Reported by: Dr Gillian Cassels (SpR) and Dr Nigel Raby
Verified by: Dr Nigel Raby

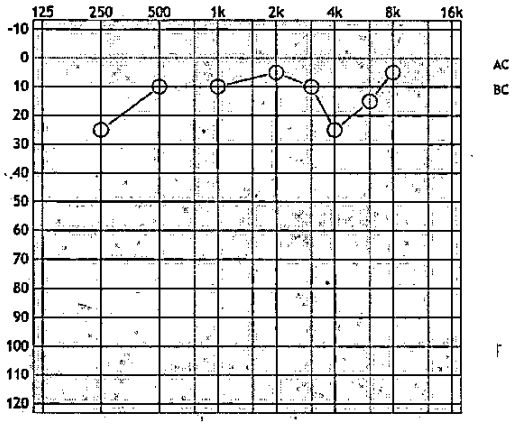
<User-defined text 1>

<User-defined text 2>

noah4

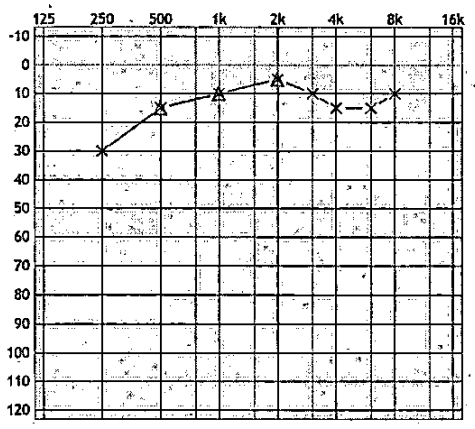
Patient Name	Fletcher, Alan	
	12 POLQHUAP RD	30/12/1987
	Glasgow	
	--.UnDefined --	

Test date: 30/08/2022



Device: AURICAL Aud **Calibrated:** 13/07/2022

Legend



Pure Tone Average

	HTL	BCL
Right (3 Freq.)	8	
Left (3 Freq.)	10	10

Report Comments

Name :
Cheryl Smith

19/05/2026