NHS Forth Valley

Carseview House
Castle Business Park
Stirling
FK9 4SW

Telephone: 01324 566292
Fax:

NHS Forth Valley

Private and Confidential

MMA Legal
43-59 Princes Street
Stockport
SK1 1RY

Date: 13 May 2026
Your Ref: 100116
Our Ref: GDP/0021299

Enquiries to: Legal Admin Team
Extension:
Direct Line: 01324 566292

Dear Sir/Madam

Re: George Baltzell 24/10/1976

With reference to your recent access request please find enclosed copy health records as requested.

Please note that records held by Forth Valley Royal Hospital will include records for Falkirk Community Hospital and Stirling Health & Care Village.

If we can be of any further assistance then please do not hesitate to contact us.

Yours Sincerely

Legal Admin Team
E-mail: fv.healthrecs-legal@nhs.scot

Clinical Notes

Seen by: M. Greenaway FY2 **Time:** 0545 29/3/22

RC: burn to (R) hand

HPC: works as chef. 2/7 (Sat day evening) spilt hot oil over (R) hand.
hand cold water over, ↓ for ~1hr immediately.
went home, hand submerged in water for further 5hrs.
reports prev. large blister to dorsum, burst.
pain ++
4 pints alcohol yesterday
describes pin & needle in tip of ring finger.

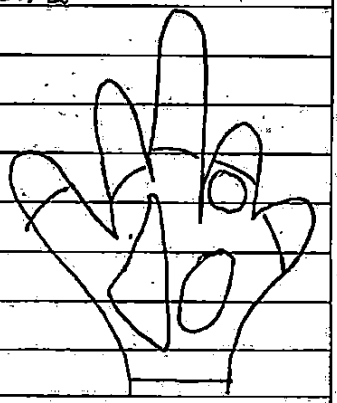
(R) hand dominant.

PMH: Nil DH: Nil.
NKDA

SH: lives with wife.
moderate alcohol use.
smoker 10/day.
full time employed.

O/E: patient appears well propped up bed.

(R) hand: partial thickness burns to majority of dorsum
. reduced sensation over blisters closest to 5th finger.
full ROM.
absent at tips of index/middle/ring finger



Plan (1) will likely require plastics input
↳ for senior r/v (or Blackburn)
photo sent to plastics team

Guidelines Used: de-rogged & dressed. 7758657

01C ē dihydrocodeine TTO.

George Balkwill
24/07/1954/6

Attach here onto face of pocket

Attach continuation sheets here

FVRH Emergency Department Forth Valley Royal Hospital

03

Date of attendance: 07/03/2025 23:56

Presenting complaint: Blood in stools and vomit

Surname: Baltzell	**Forename:** George	**Title:** Mr
Address 9 GRANGE VIEW STENHOUSEMUIR Larbert Stirlingshire	**Postcode:** FK5 3DF	**CHI:** 2410765416
Telephone: 07716414856		
Date of Birth: 24/10/1976	**Sex:** Male	**Age:** 48 Years

GP Name: G Moffat	
Address: 25648/1 Tryst Medical Centre 431 King Street Stenhousemuir Larbert Larbert FK5 4HT	**Telephone:** 01324 551555

Next of Kin	
Name:	
Relationship:	**Postcode:**
Address:	**Telephone:**

Triage Information

GI BLEEDING / D&V - Black or redcurrant stools

"Abdo pain, umbilical to pelvic region. For the past few days states has had blood in urine, stool and vomit. States this is fresh red/dark blood. States has lost a large amount of weight recently. "

BM 6.4

Obersvations

P= 90 **PB=** 122 / 79 **RR=** 17 **Sat=** 96 **BM=** **Temp=** 36.9

Peak Flow= **GCS=** **News=** 0

Emergency Department / Pre-Hospital Drugs **Allergies**

Date	Drug	Dose	Route		Signature	Given by	Time

DNW SK

Clinical Notes

Seen by:		Time:	

Attach continuation sheets here

Attach here onto face of pocket

Guidelines Used:	

NEWS key	0	1	2	3

FULL NAME: George Baltzell
DATE OF BIRTH: 2410765916
DATE OF ADMISSION:

Parameter	Range	Entry	Score
	DATE	8/3	
	TIME	25 40	
Respirations (Breathing rate)	≥25		
	21-24		2
	18-20	19	
	15-17		
	12-14		
	9-11		1
	≤8		
SpO_2 Scale 1 (Oxygen saturation (%))	≥96	96	
	94-95		1
	92-93		2
	≤91		
SpO_2 Scale 2	≥97 on O_2		
	95-96 on O_2		2
	93-94 on O_2		1
	≥93 on air		
	88-92		
Tick if using Scale 2 ☐	86-87		1
Signed	84-85		2
	≤83%		
Air or oxygen?	A=Air	A	
	O_2 L/min		2
	Device		
Blood Pressure mmHg Score uses systolic BP only	≥220		
	201-219		
	181-200		
	161-180		
	141-160		
	121-140	125	
	111-120	^	
	101-110	|	1
	91-100	|	2
	81-90		
	71-80		
	61-70		
	51-60		
	≤50		
Pulse Beats/min	≥131		
	121-130		2
	111-120		
	101-110		1
	91-100		
	81-90		
	71-80	73	
	61-70		
	51-60		
	41-50		1
	31-40		
	≤30		
Consciousness (Score for NEW onset of confusion (no score if chronic))	Alert	✓	
	Confusion		
	V		
	P		
	U		
Temperature °C	≥39.1°		2
	38.1-39.0°		1
	37.1-38.0°		
	36.1-37.0°	36.2	
	35.1-36.0°		1
	≤35.0°		
NEWS TOTAL		0	
Monitoring frequency			
Escalation of care Y/N		N	
Blood Sugar			
Pain Score 0-3		0	
Initials		[illegible]	

National Early Warning Score (NEWS2)

NHS Forth Valley

Name:
DOB:
CHI No:
Address:

*** Regardless of NEWS always escalate if concerned about a patient's condition**

Total NEWS	Frequency of Monitoring	Clinical Response
0 *	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations
1-4 *	Minimum 4 - 6 hourly	• Inform registered nurse who must assess the patient • Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5-6 * or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	• Registered nurse to urgently inform the medical team caring for the patient • Urgent assessment by a clinician with core competencies to assess acutely ill patients • Ensure structured Response Stickers A & B are completed *(Not Applicable in Emergency Dept)*
	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	• Registered nurse to immediately inform the medical team caring for the patient • Emergency assessment by clinical team with core competencies to assess acutely unwell patients • Ensure structured Response Stickers A & B are completed *(Not Applicable in Emergency Dept)* • Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.
Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30–60 min to check for rising CO2 or H^+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency
Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)
Acute Hypercapnia (pCO2 >6 and H^+ >45)
Urgent ST3 (or equivalent) review is required to optimise management.
Duty or on call consultant should be contacted if advice required.
Critical care referral and ventilatory support may be needed.

Pain Score
0 = no pain
1 = mild pain
2 = moderate pain
3 = severe pain

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)
N = Nasal Canulae
SM = Simple Mask
V24 = Venturi 24% V28 = Venturi 28% V35 = Venturi 35% V40 = Venturi 40% V60 = Venturi 60%
H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)
RM = Reservoir Mask
TM = Tracheostomy Mask
CP = Patient on CPAP System
NIV = Patient on NIV System
OTH = Other Device: (specify which)

Sepsis Screening Tool

NHS Forth Valley

Patient triggering NEWS ≥ 5 OR Clinical Concern
Neutropenia suspected OR MEWS triggering for obstetric patients

Is this likely to be due to infection?

Cough/sputum
Abdominal pain/distension/diarrhoea
Line infection
Endocarditis
Dysuria
Cellulitis
Headache with neck stiffness
Wound infection

Obstetric patients (Refer to FV protocol: Sepsis in Maternity Patients)
Perineal trauma Vaginal discharge Prolonged SRM Sore Throat

YES

Escalate to Doctor/ANP with suspected sepsis
Place Sepsis 6 Sticker in notes
Prepare giving set/IV fluids

NO

Escalate to Doctor/ANP
Repeat NEWS/MEWS in max 60 mins

ASSESS FOR OTHER CAUSES OF TRIGGERING

Two people work together to deliver the Sepsis 6 within 60 mins of patient first triggering

- Correct Hypoxia
- Take Blood Cultures
- Give IV antibiotics according to NHS FV Protocol
- Measure whole blood Lactate
- Assess urine output (catheter if obstetric patient)
- Start IV fluids ~20ml/kg, minimum 500mls in the first hour

ASSESS FOR SEVERE SEPSIS

SEVERE SEPSIS

Sepsis with ≥ organ dysfunction:
- Hypotension
- Renal
- Respiratory
- Hepatic
- Haematologic
- CNS
- Metabolic acidosis

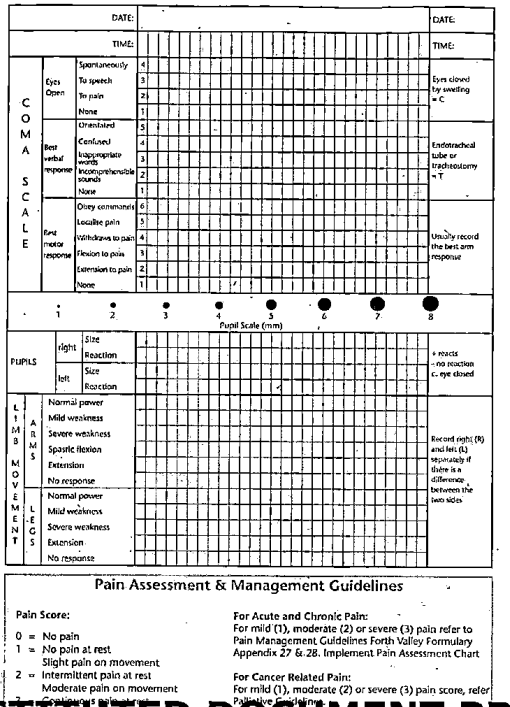
IF SEVERE SEPSIS
Contact middle grade Doctor (Consultant if obstetric patient)
Catheter mandatory if evidence of AKI
NO EVIDENCE OF SEVERE SEPSIS
Assess response to sepsis 6
Continue regular NEWS

SEPTIC SHOCK

- Hypotension despite fluid resuscitation
- Organ dysfunction

HIGH RISK FACTORS
- Hypotension
- Lactate > 4
- Unexplained INR > 1.5
- APTT > 60 secs
- Bilirubin > 34 (70 if obstetric)
- Platelets < 100

Conscious Level Chart (only as required for head injury observation)



Pain Assessment & Management Guidelines

Pain Score:

0 = No pain
1 = No pain at rest
Slight pain on movement
2 = Intermittent pain at rest
Moderate pain on movement
3 = Continuous pain at rest
Severe pain on movement

For Acute and Chronic Pain:
For mild (1), moderate (2) or severe (3) pain refer to Pain Management Guidelines Forth Valley Formulary Appendix 27 & 28. Implement Pain Assessment Chart

For Cancer Related Pain:
For mild (1), moderate (2) or severe (3) pain score, refer Palliative Guidelines

Supportive and Palliative Care Indicators Tool (SPICT™)

Review Date: 2025

The SPICT™ is a guide to identifying people at risk of deteriorating and dying. Assessment of unmet supportive and palliative care needs may be appropriate.

Look for two or more general indicators of deteriorating health.

- Performance status poor or deteriorating, with limited reversibility: (needs help with personal care, in bed or chair for 50% or more of the day).
- Two or more unplanned hospital admissions in the past 6 months.
- Weight loss (5 – 10%) over the past 3 – 6 months and/or body mass index < 20.
- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
- Lives in a nursing care home or NHS continuing care unit, or needs care to remain at home.
- Patient requests supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of advanced conditions

Cancer

Functional ability deteriorating, due to progressive metastatic cancer.

Too frail for oncology treatment or treatment is for symptom control.

Dementia / frailty

Unable to dress, walk or eat without help.

Choosing to eat and drink less; difficulty maintaining nutrition.

Urinary and faecal incontinence.

No longer able to communicate using verbal language; little social interaction.

Fractured femur; multiple falls.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive dysphagia.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart / vascular disease

NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:
- breathlessness or chest pain at rest or on minimal exertion.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe chronic lung disease with:
- breathlessness at rest or on minimal exertion between exacerbations.

Needs long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping dialysis.

Liver disease

Advanced cirrhosis with one or more complications in past year:
- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is contraindicated.

Assess and plan supportive & palliative care

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals/plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Handover: care plan, agreed levels of intervention, CPR status.
- Coordinate care (eg. with a primary care register).

Re-order Ref: FF7013155

NEWS2

FVRH Emergency Department Forth Valley Royal Hospital

03

Date of attendance: 19/06/2025 03:33

Presenting complaint: l shoulder ?dis

KPD

Surname: Baltzell		**Forename:** George	**Title:** Mr
Address	9 Grange View Stenhousemuir Larbert Stirlingshire	**Postcode:** FK5 3DF	**CHI:** 2410765416
Telephone: 07716 414856			
Date of Birth: 24/10/1976		**Sex:** Male	**Age:** 48 Years

GP Name: G Moffat		
Address: 25648/1 Tryst Medical Centre 431 King Street Stenhousemuir Larbert Larbert FK5 4HT	**Telephone:** 01324 551555	EDL

Next of Kin

Name: Emma Baltzell		
Relationship: Wife	**Postcode:** FK1 4SQ	
Address: 9 Grange View Larbert Stirlingshire	**Telephone:** 07716 414856	

Triage Information

limb chart- gross deformity

"Fall down 14 stairs 2200 last night - No LOC - feels left shoulder may be dislocated. deformity to left shoulder. No other injuries. Denies c-spine pain." GCS 15.

Obersvations

P= 76	**PB=** 106 / 71	**RR=** 16	**Sat=** 96	**BM=**	**Temp=** 36.9
Peak Flow=		**GCS=**		**News=** 1	

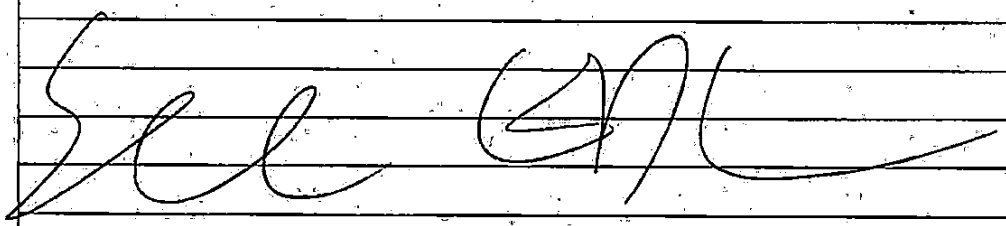
Emergency Department / Pre-Hospital Drugs	Allergies	

Date	Drug	Dose	Route	Signature	Given by	Time

1045 Called in WR N/A.

Clinical Notes

Seen by:		Time:	



Attach continuation sheets here

Attach here onto face of pocket

Guidelines Used:	

FVRH Emergency Department Forth Valley Royal Hospital

04

Date of attendance: 23/08/2025 01:50

Presenting complaint: assault sas wr

Surname: Baltzell		**Forename:** George	**Title:** Mr
Address	9 Grange View Stenhousemuir Larbert Stirlingshire	**Postcode:** FK5 3DF	**CHI:** 2410765416
Telephone: 07716 414856			
Date of Birth: 24/10/1976		**Sex:** Male	**Age:** 48 Years

GP Name: G Moffat

Address: 25648/1
Tryst Medical Centre
431 King Street
Stenhousemuir
Larbert
Larbert
FK5 4HT

Telephone: 01324 551555

Next of Kin

Name: Emma Baltzell

Relationship: Wife

Address: 9 Grange View
Larbert
Stirlingshire

Postcode: FK1 4SQ

Telephone: 07716 414856

Triage Information

"WOUNDS, ABSCESSES & LOCAL INFECTION-r recent problem "
"assaulted earlier by wife used Stanley blade full thickness laceration to left elbow "
"wound to rt elbow full thickness "

Obersvations

P= 82	**PB=** 106 / 72	**RR=** 18	**Sat=** 98	**BM=**	**Temp=** 36.6
Peak Flow=		**GCS=**		**News=** 1	

Emergency Department / Pre-Hospital Drugs

Allergies NKDA

Date	Drug	Dose	Route	Signature	Given by	Time
23/8/25	Paracetamol	1g	PO	PRO (unreadable)		02:58
23/08/25	ORAMORPH	10mg	PO			7:21
23/8/25	CO-AMOXICLAV	625mg	PO			08:35
23/8/25	REVAXIS	0.5ml	IM			08:35

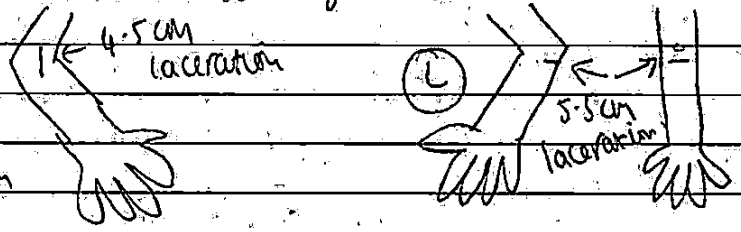
Co-Amoxiclav 625mg
Tablets (21)
One tablet 3 times a day
Presc: [illegible] KGRAHAM FEVD.
Disp: [illegible]

Dihydrocodeine 30mg
28 Tablets
One tablet every 4 or 6 hours as required
Presc: [illegible] KGRAHAM FEVD
Disp: [illegible]

Clinical Notes

Seen by:	FY2 K BRADFIELD	Time:	28/8/25 08:40.

48 y/o male - PC: Laceration on both elbows.
~~Interpreter~~ Reports wife/partner attacked him with a Stanely knife.
Reports no loss of sensation or reduced feeling.



Radial, ulnar, medial nerve all intact. Musculocutaneous nerve also intact.

	(R) arm	(L) arm
Tone	normal	normal
Power	4/5	4/5 - due to pain.

Sensation - C5 C6, C7 C8 + T1 - No deficits reported by pt on either side.

	(R) arm	(L) arm
Elbow flexion	intact.	intact
Elbow extension	intact.	intact
Wrist extension	intact	intact.
Wrist flexion	intact.	intact
Finger extension	intact	intact
Finger Abduction	intact	intact.
thumb abduction	intact	intact.

Only restricted due to pain - reports he feels he could do it with normal power if it wasn't sore.
R/L pulses present (radial + ulnar).
Both wounds thoroughly irrigated, closed with sutures. (5 to (R) arm, 6 to (L) arm).
Review given. Also given co-amoxiclav + analgesia.
Worsening advice given RE signs of infection/ change in sensation/motor of a/ms.
Suture + tetanus advice leaflet given.
Advised for suture removal in 10-14 days at GP.

Guidelines Used:

Attach continuation sheets here

Attach here onto face of pocket

Immediate Discharge Letter

NHS Forth Valley

COPY

Hospital: Forth Valley Royal Hospital, Larbert
Consultant: Maka, Dr Noorahmed
Specialty: General Medicine

Tel: 01324 566000
Discharging Ward: FVRH - Ward B32

GP Details		Patient Details		Admission Details	
Practice Code:	25652	Patient CHI No:	2410765416	Admission Date:	03/05/2014
		Patient Hospital No:	S667905		
GP Name:	Dr Gordon Muircroft	Surname:	Baltzell	Admission Type:	Emergency - Non-Injury (e.g. Stroke, MI, Ruptured Appendix)
Address:	Carron Medical Centre, Ronades Road, Bainsford, alkirk, FK2 7TA	Forename:	George	Presenting Complaint:	Confusion
		Date of Birth:	24/10/1976		
		Address:	124 Haugh Street, Bainsford, Falkirk, FK2 7QT	Discharge Date:	05/05/2014
				Discharge To:	Private Residence - Living with Relatives or Friends

Diagnosis/Problem List

2841. - Confusion

Additional comment (Progress, Investigations, Procedures, Complications etc)

Dear Doctor,

This 37 year old gentleman was admitted with acute confusion. He was brought in by his mother who described him as being very confused and different to normal self. He had no focal neurology to find on examination.
He had been hit over the head with a break twice in the recent past. On presentation he was thought to be intoxicated and have a history of alcohol problems.

However, the 24 hrs after admission he settled and became completely back to normal. He denied alcohol excess and a CT scan was preformed which was entirely normal.

He was discharged home.
He has no other significant medical past.

I trust this is satisfactory.
Yours sincerely,

Dr. C.Pirret
GP ST1 to Dr. Maka

Results Outstanding (Y/N) If yes, give details:	No

Information to patient/carer (Y/N):	Patient: Yes Carer (if applicable):

Follow up arrangements

There are no Reviews planned

Dr called 6/5/14 I have not seen this pt.

File

Authorisor's name:	Dr C Pirret	**Authorisor's Signature:**
Authorisor's grade:	GPST1	
Read/Approved by:		
Date:	05/05/2014	**COPY**
Discharge Ward Nurse:	Howlin, Martina	

Validation/Contact Name: Maka, Dr Noorahmed

THIS IS THE FINAL DOCUMENT

Name: George Baltzell

CHI: 2410765416

File

Forth Valley Acute Hospitals Acute Division
Medications Discharge Summary

Name:	George Baltzell	Patient's Tel No:	
Address:	124 Haugh Street, Bainsford, Falkirk, FK2 7QT	Patient's Tel Eve:	
Admission Date:	03/05/2014	Discharge Date:	05/05/2014

COPY

PATIENT ALERTS

Alert Group	Alert	Alert Comment	When Added	Added By

PATIENT DRUG REACTIONS

CURRENT PRESCRIPTION (all medicines currently prescribed) *e.g. clinical indication for prescription monitoring

** Prescription Not Requested For Discharge **

	Drug	Route	Dose	Frequency	Duration (days)	New Drug / Altered Dose	POD
1	THIAMINE 100mg TABLETS	Oral	100 mg	THREE times daily		ND	

*

MEDICINES DISCONTINUED

Nurse check on discharge:

Signature 1:

Signature 2:

Name: George Baltzell

CHI: 2410765416

File

COPY

Accident and Emergency Department
Forth Valley Royal Hospital

2410760511

A&E No. 13000049215

COPY

Surname	BALTZELL	**Forename**	GEORGE	**Title:**	
Address:	124 HAUGH STREET BAINSFORD FALKIRK	**Postcode** **Telephone:**	FK2 7QT 01324 820792	**CHI No:**	2410760511
Date of Birth:	24.10.76 ✓	**Sex:**	M	**Age:**	37 yrs

CHI Number: 2410760511

GP Name:	MUIRCROFT GORDON			
Address:	CARRON MEDICAL CENTRE RONADES ROAD BAINSFORD FALKIRK	**Postcode** **Telephone:**	FK2 7TA 01324 619940	

Next of Kin.	LISA MARIE		TJ - 6. Piper - 2
Relationship:	MOTHER		
Address:		**Postcode**	
		Telephone:	01324 820792

Manual CHI Entry:

Date of Attendance: 03.05.14 04:55

Date of Incident:

Presenting Complaint: NHS 24 REF - HEAD INJURY 2/7 - CONFUSED

Ti

Tetanus Cover:

Allergies:

P= **BP=** / **RR=** **Sat=** **BM=**

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

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

CHI: 2410760511 24/10/1976 M
BALTZELL
GEORGE
124 HAUGH STREET
FALKIRK
FK2 7QT

COPY

Attach here onto face of pocket

Attach continuation sheets here

Clinical Notes

Seen by: [illegible] **Time:** 05-45

(37) ♂ - PC - Confusion.
- ↑ in severity for a week according to family.
- ? head injury 2/7 ago
→ called police who 'did not believe him'
- Thinks he is going to Rangers vs Celtic tomorrow c̄ Grandad (who is dead)
- Family think confusion related to alcohol as no ETOH yesterday and was 'fine'.
- Drinking to excess today, all day.
- Mild headache.

PMHx — Nil
Meds — Nil

O/E → TPRBP (N) CNS (N)
PERLA GCS 15
No sign basal skull #
Small bruise to (R) forehead ? old
Chest clear HS (N)

inconsistent story

Imp → ? confusion unclear why
No indication acute
(P) medics for ? neuro obs
Bloods EEG

Guidelines Used:

CHI: 2410760511 24/10/1976 M
BALTZELL
GEORGE
124 HAUGH STREET
FALKIRK
FK2 7QT

COPY

PVC INSERTION BUNDLE AND REMOVAL RECORD — PLEASE COMPLETE ALL BOXES

The patients skin is decontaminated and allowed to dry — YES / NO
Hand hygiene & gloves donned prior to insertion — YES / NO
Aseptic Non Touch Technique is used to insert PVC — YES / NO
If not possible, use either **STERILE GLOVES** or **MINI CHLORAPREP**
Sterile dressing & sticker (date & time) applied after insertion — YES / NO

Why is PVC clinically indicated for patient?: (please tick)

IV Fluids		Blood Transfusion	
IV Drugs		Diagnostics	✓
Predicted clinical need	✓		

Colour: PINK Insertion Site: (R) lower arm

Ward/Department ED

Inserted by: A Cindbak Date & Time: 3/5/14 - 06[illegible]

INVESTIGATIONS

BLOODS TAKEN? YES / NO

FBC	GLU	CLOTTING	TROP	URINALYSIS	XRAY	CXR
U&E	CRP	G&S	D DIMER	HCG	ECG	AXR
LFT	AMY	ESR	ABG	CATHETER	CULTURES	
PARACETAMOL		SALICYLATE		ETHANOL		

Others: [illegible]

Troponin 0hr result: ..... Troponin 12hr due: .....

Preliminary Pressure Ulcer Risk Assessment (PPURA):

Mobility: Person is fully mobile without equipment/assistance
Continence: Person is fully continent
Nutrition: Person appears well nourished and able to eat and drink

Points to Consider
* People who are overweight may not be well nourished
* please sign after each check

Record your answer in the grid below Y = Yes or N = No
If the answer is **NO** to any assessments undertake a PPURA and consider any other relevant assessment

DATE	TIME	MOBILITY	CONTINENCE	NUTRITION	SKIN INSPECTED	BRADEN	SIGNATURE
3/5/14	06:00	Y	Y	Y	Y	N	[illegible]

Over 65s

AMT 4

1. How old are you? 2. What is your date of birth? /4
3. What is this place? 4. What year is it?

If score is 3 or less proceed to Delirium screen/cam Initial.....

	Confusion Assessment Method (CAM) Inouye, SK et al.	Box 1	
1	**Acute Onset or fluctuating course** a) Acute change in **mental state from** patient's baselines? **OR** b) Did the (abnormal) behaviour fluctuate in severity or tend to come and go?	☐ Yes	☐ No
2	**Inattention** Difficulty focusing attention or keeping track of conversation, easily distractible	☐ Yes	☐ No
	If there is a '**yes**' answer for questions 1 **AND** 2 then continue to questions 3 and 4.	**Box 2**	
3	**Disorganised Thinking** e.g. disorganised thinking or incoherant speech such as rambling or irrevelant conversation, unclear or illogical flow of ideas	☐ Yes	☐ No
4	**Altered Level of Consciousness** NB Alert = normal Score 'yes' if vigilant, lethargic, in a stupor or un-arousable	☐ Yes	☐ No
	Add total '**Yes**' answers for section 1,2,3 and 4		
Initial.....	**Consider diagnosis of delirium if score is 3 or more**		

Date: 3-5-14

Time: 0510

Named nurse: Sr Binnie
Sr Lindsay

Patients preferred name: George

CHI: 2410760511
BALTZELL
GEORGE
124 HAUGH STREET
FALKIRK
FK2 7QT

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S — Situation

Presenting complaint: Confusion
head inj.

History of presenting complaint:
Hit are head with bread on weeds
night continuous vomiting & confusion
last night, asking for dad who was died-
? if any loc

B — Background - Relevant medical history

no prob
Smokes 20 cpd
occcasional alcohol

Relative / Carer informed? YES / NO Present YES / NO

A — Assessment - Clinical condition and likely diagnosis include EWS on arrival and prior to admission.

EWS 0 GCS 15 Conc.
BBS ☑
ECG ☑

Mobility: Independent Pain Score: /10

R — Recommendations - Direction for ward staff, include outstanding treatments and obs required.

ED MU ☑
~~CT Brain ☐~~
1° neuro obs
Urinalysis ☐

Admit
Medical MU ☐
await blood results

EWS SCORE : 0

Signature:

EMERGENCY CARE ASSESSMENT RECORD - VERSION 4

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PART A - PATIENT DOCUMENT

PATIENT DETAILS

Surname: [illegible]
Forename: [illegible] M
Address: [illegible]
Postcode: [illegible]

Title: Mr | Mrs | Miss | Ms | Dr

DOB: 24/10/76
Age: 37
CHI No/ 2410760511
Patient ID:
Tel No: 01324 820792.

NEXT OF KIN DETAILS

Next of Kin: [illegible]
Relationship: Mother
Address:

No: 01324 820792

Alt. Next of Kin
Relationship:
Address:

Tel No:

Other Family Member Details

Name of Relative/ Carer

Present on Admission? Y/N
Contacted? Y/N
Tel No:

GP

Name: Dr Munteanu
Practice:
Address:

Postcode:

Tel No:

Date of Attendance:

Date of Incident/Onset

PRESENTING COMPLAINT

1 Confusion
2

Allergies:

- ☐ Drugs
- ☐ Latex
- ☐ Metal
- ☐ Food
- ☐ Nil known

Alert High Risk Factors:

Named Consultant:

Named Nurse:

SPECIAL REQUIREMENTS	Yes	No	Action
Translation Service			
Visual Impairment			
Hearing Impairment			
Learning Disability			
Neck Breather			
Requires assistance with ADLs			
Other relevant information:			

Date	Time	Signature

P: CHI: 2410765416 M
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Practitioners name: MacKenzie

Specialty: Med Grade: ST3

Patient age: ____ Date: 3 / 5 / 14 Time: 07 : 10 Location: AAU

PRESENTING COMPLAINT	3707 Collision.
BACKGROUND Including HISTORY OF PRESENTING COMPLAINT	BG: Alcohol xs. Recent head injury. odd history — family brought to A+Es as they were concerned he was confused; thought he was going to the football with his dad — he could see him + was talking to him (he has been dead for 5y) He is currently telling me the wrong date, his incorrect DOB + wrong location (but all close to correct). Hx from Mum + partner. - Recent stressors. Lost job in Dec. Separated from partner with whom he has 2 children + is not being allowed visiting rights. - ↑ Alcohol consumption over this time. ~1 bottle of vodka/day
Previous Medical History	☐ IHD ☐ TIA ☐ Stroke ☐ Diabetes Mellitus ☐ MI ☐ COPD ☐ Hypertension ☐ Asthma Other:

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Drug History	Compliance Device: Y / N	Filled by: patient / relative/ carer / community pharmacy .....
	Self medicates at home ☐	Supervised by carers ☐
	History obtained by:	Grade: ..... Date: .....
	ECS Permission obtained by:	Date:..... On Eward ☐ E Careplan ☐
Allergies:	NKDA ✓	

Pt	POD	GP	ECS	Comm.Pharm	Other	**Drug Name and route /dose / frequency** (please include all of these)	Continue	Date Withheld	Date Stopped	Comments / Reason for change	Kardex
✓						MI Reg.					

Any Herbal / OTC Meds: NIL

Medicines Reconciliation carried out

By: ..... Date: .....

CHI: 2410765416
24/10/1976 M
Pt BALTZELL George
124 HAUGH STREET
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Can All Practitioners adding to document please sign /date / time each entry

Family History

☐ IHD / MI ☐ Asthma ☐ Diabetes Mellitus
☐ Cancer ☐ Hypertension ☐ Stroke / TIA
Other:

Social History

Occupation:
Lives with: denies recreational drugs support/carers
☑ Smoker (Amount per day 20 roll-ups) ☐ Ex Smoker (Since.....) ☐ Never Smoked
☐ Alcohol (Units per week)..1..bottle normal day ale to family
Normal Exercise Capacity: ADLs:

Systems Review

CVS
RESP
GI
GU
CNS

Mi except over.
Family state recently ill.
They spoke to him yesterday
° prev ↓ Hx

Examination

Weight : ..... kg Height: ..... m BMI: .....

General

Obs

Temp: Heart Rate: Resp Rate: BP_{supine}: BP_{erect}:
SpO_2 (FiO_2:) Anaemia Y/N Clubbing Y/N
Cyanosis Y/N Jaundice Y/N Cervical Lymphadenopathy Y/N
Blood Sugar: **MEWS SCORE :**

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CVS

JVP flat

Apex

Heart Sounds I — II — 0

Oedema none

Neck Bruit Y / N

Peripheral Pulses

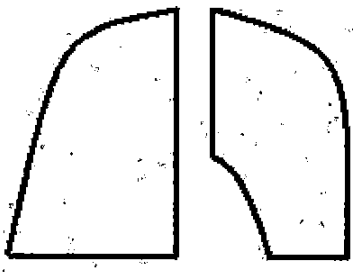
Respiratory

Trachea:

Expansion:

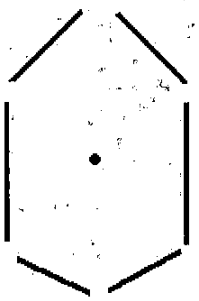
Percussion: Clear

Breath Sounds:



R L

Abdomen



SNT

BS +

Bowel sounds:

Rectal examination:

Liver:

Kidneys:

Spleen:

OTHER (eg. face, limbs, trunk, skin)

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Pt 24/10/1976 M
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NEURO

Cranial nerves: 2–12 intact. Can follow 2-point commands

Cerebellar: intact

Reflexes	B	T	S	K	A	Plantars	Clonus
L	(N) hypogmt					↓	
R						↓	

CNS Exam

Limb	R arm	L arm	R leg	L leg
Tone	(N)	(N)	(N)	(N)
Power	5	5	5	5
Sensation	(N)	(N)	(N)	(N)
Co-ordination	N	N	N	N

Abbreviated Mental Test Score (AMTS)

How old are you (exact age only)? X
What is your date of birth? X 0/4
What place is this? X
What year is it? X

A score of 3 or less warrants further investigation

Glasgow Coma Scale

Best Eye Opening 4
Best Motor Response 6
Best Verbal Response 5 15

Score

X-ray / ECG Interpretation

CXR

NAD.

AXR

ECG Interpretation

SR.
Biphasic ST V_2 + V_3

Urinalysis

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IMPRESSION/ DIFFERENTIAL DIAGNOSIS	Acute confusion ? 2° alcohol intoxication + recent HI ? Ψ → Nil to suggest CNS infection/ ICH.
INITIAL MANAGEMENT PLAN	Pabrinex IV fluids Neuro obs. HAT Consider CT (B) if fails to improve

Investigations

PLEASE TICK BOX IF REQUESTED

☐ FBC	☐ CRP
☐ ESR	☐ ABG
☐ Clotting Factors	☐ Blood Cultures
☐ U&Es	☐ CXR
☐ LFTs	☐ ECG
☐ Glucose	☐ HCG ☐ Positive ☐ Negative
☐ Calcium	☐ Urinalysis
☐ Ohr Troponin Date/Time.....	☐ .....
☐ 12 hr Troponin Date/Time.....	☐ .....

IV Cannula Insertion/ Removal Record

Ward .... Date .....

Inserted By .... Size / Colour .....

Batch No .....Insertion Site .....

Removed By .... Date .....

DVT Prophylaxis

DVT Prophylaxis Indicated ☐ Yes ☐ No
Any Contraindications to this? ☐ Yes ☐ No
Prescribed? ☐ Yes ☐ No

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24/10/1976 M
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Resuscitation Status	Following discussion with patient/family please indicate **PLEASE COMPLETE & ATTACH NHS FV DNAR FORM**
Practitioner Signature Date/Time	PRINT NAME: ..... SIGNATURE: ..... BLEEP NO: ..... DATE / TIME: .....
Family Dialogue	

Date/Time	Clinical Notes – MEDICAL/SURGICAL MIDDLE GRADE REVIEW

CHI: 2410765416
24/10/1976 M ...h
BALTZELL George
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Date/Time	Clinical Notes – CONSULTANT REVIEW (Please finish each note with Practitioner Name/Job Title)
	MM
	(37) Alcohol Excess & Nil regular
	Brought in by family – Confused & Intoxicated ↑ MTJ Q/4
	Recent Stress – Lost job in 12/13
3/5/14	Separated from Partner
	Bottle of vodka / Day
10:25	O/E Cachectic Dry +
	RR 16 T 36, BP 125/75 Bloods
	Sat 98% on AMTS 4/4 WBC/N
	Chest Bruising FBC/
	CS (R) forehead LFT Rend
	Abds
	ECG Tall 'T' waves
	SR 80/M; QTc 399
	(1) - Alcohol excess
	Ac Intoxication
	- Alcohol withdrawal Rx
	- MAT
	- IV fluid
	- Rehab
	MMA

Pt

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24/10/1976 M
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Sc Management Plan

EDD:
<48 hrs ☐ >48 hrs ☐

Consultant

Please sign and date at end of each entry

Date Time	Problem No	Clinical Problem List / Background	Recommendations/ Desired Outcomes and Actions	Complete Sign & date

Pt Na

CHI: 2410765416
24/10/1976 M
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Senior Clinician Patient Management Plan

EDD:
<48 hrs ☐ >48 hrs ☐

Consultant

Please sign and date at end of each entry

Date Time	Problem No	Clinical Problem List / Background	Recommendations/ Desired Outcomes and Actions	Complete Sign & date

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Date / Time	Clinical Notes (Please finish each note with Practitioner Name / Job Title)
3/5/14	Settled morning Observation as charted IV fluids to commenced for alcohol withdrawal regime HAT when available. Care as planned. Lilli Miller SN
3/5/14	patient settled into room 7 in AAU IV pabrinex given, librium given as per alcohol withdrawel Schedyal IV fluids commenced 4 hourly eating and drinking well observations stable - slightly tachycardic, 105bpm for HAT review when able neuro obs continue patient very sleepy no complaints CS
17.30	no new issues IV fluids continue with K+ replacement EWS = 0 small diet managed librium continues CS

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24/10/1976 M
BALTZELL George
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Clinical Notes

(Please finish each note with Practitioner Name / Job Title)

Date / Time	Clinical Notes
	for transfer to B32
	verbal handover given
4/5/14 Nightshift	Patient arrived to ward B32 around 1900. Orientated to new surroundings. Observations stable on arrival. IV fluids running - venflon insitu to right arm - appears free from infection. Medication given as per kardex. Passing urine. No new issues. F Cook, F Cook, S/N
4/5/14 1500	Vital signs charted. New venflon insitu as prev one dislodged. IV pabrinex given. IV fluids running behind time. Eating and drinking. Leaving ward for cigarette breaks with mother. Independant with ADLs. No prn librium required as yet. Campbell SN
	WR A/W AC Confusion & intoxication
	Says drinks 6-7 Pints x T / week
4/5/14 15:30	Hit by ex partner by brick on two occasions last time x3/7 ago had sever head ache c is better
	(I) Mr Baltzell's Alcohol intake does not seem to be very heavy. In view of HI & HA Needs CT Scan

(P) - CT brain tomorrow
- No Need for [13] Neuro obs

[signature] MCNAB

CHI: 2410765416
24/10/1976 M
Pt Nam BALTZELL George
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Date / Time	Clinical Notes (Please finish each note with Practitioner Name / Job Title)
4/5/14 1900	FOV CT brain tommorrow. Not happy about librium regime as feels he is only a social drinker. R/V today, see prev note and ↓ librium Nil new issues Kipbell SN
5/5/14 Nightshift	settled night tonight so far. Observations stable Medication given as per kardex - IV pabrinex continues. independant with personal care. No issue voiced. [illegible], FCOOK, SN
5/5/14 1000	WR- PINNED
	37o→ Convulsion
	- Initially thought to be related to alcohol excess.
	- Now realise just drinks at weekend.
	- Ben hit on head twice recently.
	- Neurologically in tact.
	① For CT Brain - ? Chronic Subdural.
	② If (N) → (H).
5/5/14 1400	CT Brain
	- (N)
	- Can go (H)

Pt Name / CHI / Addressograph

COPY

Date / Time	Clinical Notes (Please finish each note with Practitioner Name / Job Title)
5/5/14 1430	Patient settled. Independant with personal care, Eating and drinking. Medications as per kardex. Observations stable as charted. Ven flon removed. Attended CT head ALL well. No new issues. No complaints given. Patient discharged from ward. ALL well.
	SND Ei SC
	SN RIN S CLARK

CHI: 2410765416
24/10/1976
Pt 1 BALTZELL George M
124 HAUGH STREET
BAINSFORD
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Nursing Intervention

Pressure Area Assessment

Pressure Areas Intact Yes ☐ No ☐

Absolute Risk (Score 2	Relative Risk (Score 1)
Unconsciousness	Age >70yrs
Dehydration	Restricted mobility
Paralysis	Incontinence
	Pronounced Emaciation
	Redness over bony prominences

Score (Circle) Low 0 Medium 1 High 2

Intervention .....

Pain Score	0	1	2	3	4	5	6	7	8	9	10

Analgesia Given Yes ☐ No ☐

Effect of analgesia	0	1	2	3	4	5	6	7	8	9	10

Belongings ☐ With patient ☐ Family ☐ Safe ☐ Bagged ☐ Labeled

Own Medication ☐ Yes ☐ No

Name band ☐ Yes ☐ No

Patient Fasted Food ☐ Yes ☐ No

Food Time ..... **Drink** Time .....

Relatives with Patient ☐ Yes ☐ No ☐ Informed

Named Nurse:
..... Time/Date: .....

Signature: .....

Baltzell, George
ID:
DOB: 24-Oct-1976
37yr, Male

3-May-2019 [illegible]

Vent rate:	80 BPM
PR int:	147 ms
QRS dur:	97 ms
QT/QTc:	362/399 ms
P-R-T axes:	76 82 67

SINUS RHYTHM
NORMAL ECG

UNCONFIRMED REPORT

(N) SR
Tall T-Wave $V_2 \rightarrow V_3$
$\rightarrow$?, Potassium

Dr. [illegible]
CT

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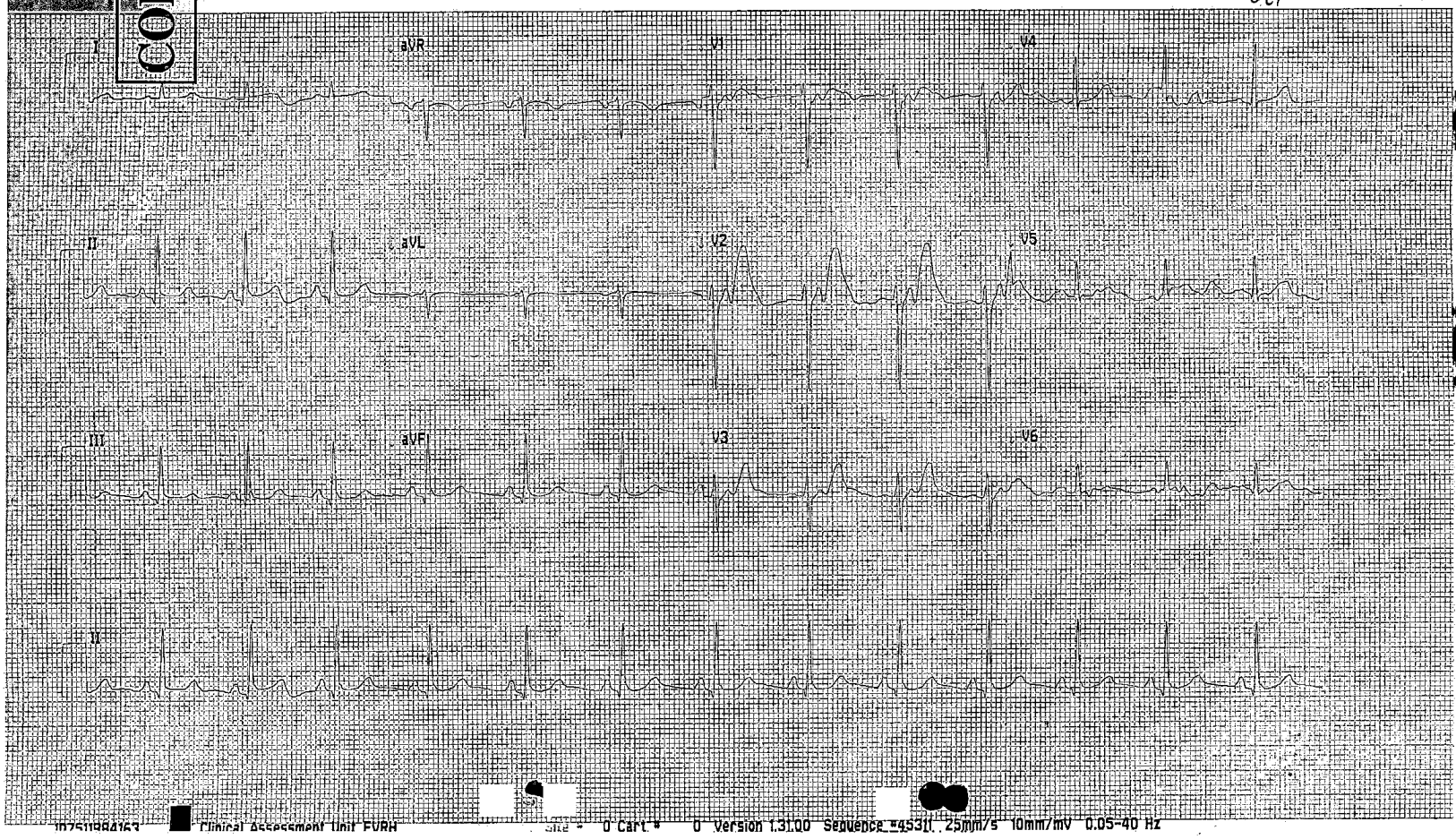

[illegible] Clinical Assessment Unit FVRH Site # 0 Cart # 0 Version 1.31.00 Sequence #4531 25mm/s 10mm/mV 0.05-40 Hz

EWS KEY	0	1	2	3	EWS 0-1: Routine Observation, state frequency 2-3: Inform Nurse in Charge 4 or above h

DATE:	3.5.14							3/5/14	4/5/14	4/5/14	4/5/14	5/5/14	5/5/14	5/5/14				
TIME:	0510	0615	0850	1055	1400	1730		2100	0630	1100	1630	2100	0623	1235				
Is Patient ≥70?	X	X		X														
RESP. RATE >30																		
26-29																		
21-25																		
9-20	16	16	16	18	17	18		15	15	16	16	15	15	16				
≤8																		
SpO_2 ≥94	98	96/98	96	97	96			98	98	99	98	98	99	99				
92-93																		
86-91																		
<86																		
O_2 Device or Air refer to key	N	A	AIR	A	A	A		A	A	A	A	A	A	A				
O_2 Flow or Rate																		
pt on O_2 with SpO_2 <95																		
TEMP 39°																		
38°																		
37°																		
36°																		
35°																		
34°																		
VS SCORE es Systolic BP 210																		
≥200																		
BLOOD PRESSURE 190																		
180																		
170																		
160																		
150																		
140																		
130																		
120																		
110																		
100																		
90																		
80																		
70																		
60																		
50																		
>170																		
HEART RATE 160																		
150																		
140																		
130																		
120																		
110																		
100																		
90																		
80		90																
70																		
60																		
50																		
40																		
30																		
NEURO RESPONSE Alert	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓				
Verbal																		
Pain																		
Unresponsive																		
EWS SCORE (with all obs)	0	0	0	0	1	0		0	0	0	0	0	0	0				
Blood Glucose		4.5																
PAIN (guidance for scoring and management overleaf) No pain	✓			✓	✓	✓		✓	✓	✓	✓	✓	✓	✓				
Mild		✓	✓															
Moderate																		
Severe																		
Nausea Score 0-3	0	0	0	0	0	0		0	0	0	0	0	0	0				
Initial		AM																

2410760511
BALTZELL
GEORGE
24/10/1976 M
DATE: TIME:
SIGNATURE:

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CODES FOR RECORDING OXYGEN DELIVERY ON OBSERVATION CHART

A	Air (not requiring oxygen, or weaning or on "PRN" oxygen)			H28	Humidified oxygen at 28%
N	Nasal cannulae				(also H35, H40, H60 for humidified oxygen at 35%, 4
SM	Simple mask			RM	Reservoir mask
V24	Venturi 24%	V28	Venturi 28%	V35	Venturi 35%
V40	Venturi 40%	V60	Venturi 60%	TM	Tracheostomy mask
				CP	Patient on CPAP system

B2

Early Warning Score (EWS) Trigger Protocol

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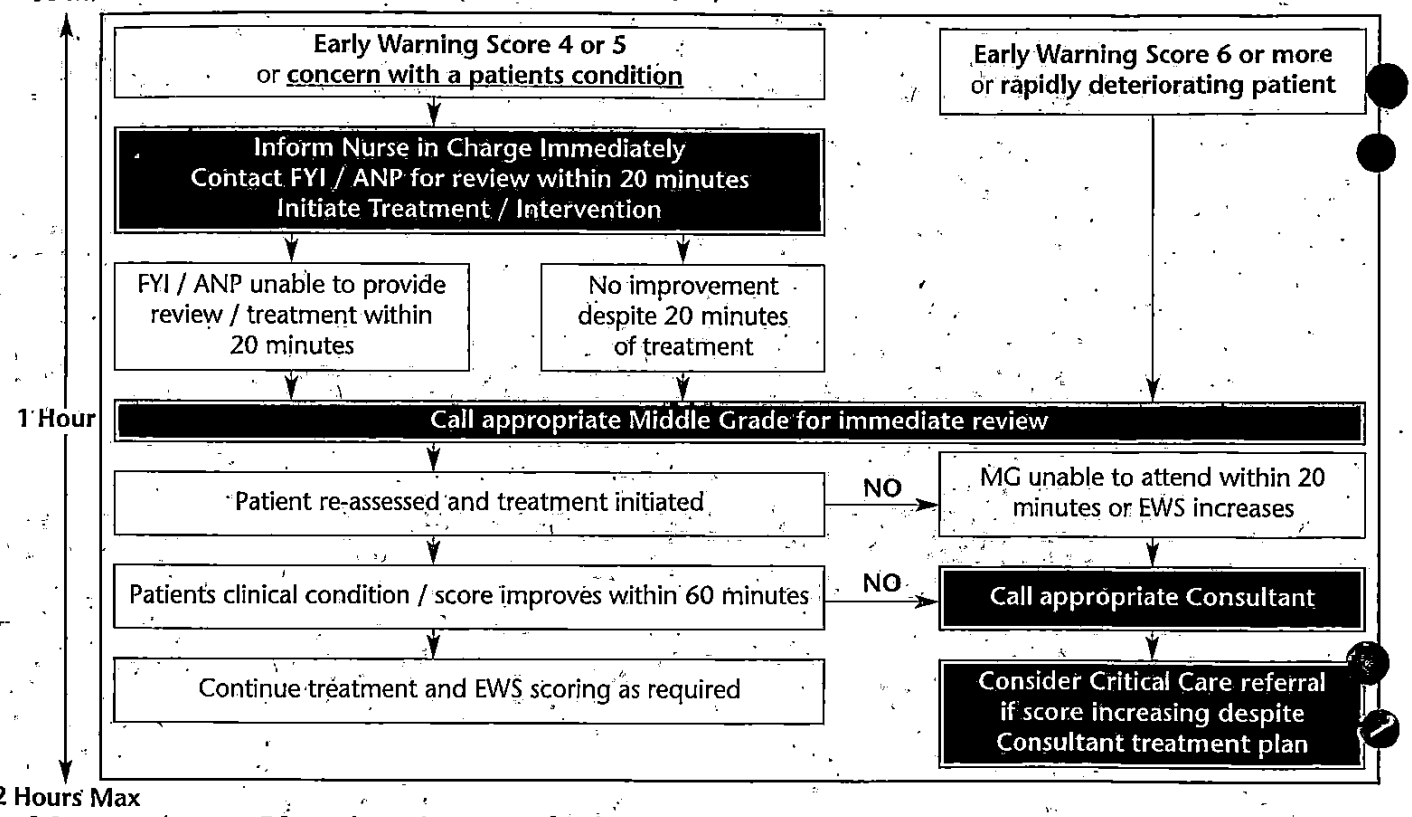
Name:
DOB:
Chi No:
Address:

CHI: 2410760511 24/10/1976 M
BALTZELL
GEORGE
124 HAUGH STREET
FALKIRK
FK2 7QT

Consultant:_____ Ward:_____ Admission Date:_____

Score 0-1 Routine observation - state frequency
2-3 Inform nurse in charge and initiate appropriate treatment

Staff should use SBAR in all communications
Definition
- S ituation
- B ackground
- A ssessment
- R ecommendations



Management Plan / Patient Exclusions

Date	Management of EWS Observations	Signed

Conscious Level Chart (only as required for head injury observation)

2410760511
BALTZELL
GEORGE
24/10/1976 M
DATE:
TIME:
SIGNATURE:

DATE: 3.5.14

		TIME:		05 10	06 15	[illegible]	[illegible]	22 00	02 30	01 00
COMA SCALE	**Eyes Open**	Spontaneously	4	✓	✓	✓	✓	✓	✓	✓
		To speech	3							
		To pain	2							
		None	1							
	Best verbal response	Orientated	5	✓	✓	✓	✓	✓	✓	✓
		Confused	4							
		Inappropriate words	3							
		Incomprehensible sounds	2							
		None	1							
	Best motor response	Obey commands	6	✓	✓	✓	✓	✓	✓	✓
		Localise pain	5							
		Withdraws to pain	4							
		Flexion to pain	3							
		Extension to pain	2							
		None	1							

Eyes closed by swelling = C

Endotracheal tube or tracheostomy = T

Usually record the best arm response

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

PUPILS									
right	Size	4	4	4	3	4	3	3
	Reaction	+	+	+	+	+	+	+
left	Size	4	4	4	3	4	3	3
	Reaction	+	+	+	+	+	+	+

+ reacts
- no reaction
c. eye closed

LIMB MOVEMENT									
ARMS	Normal power	✓	✓	R/L	R/L	✓	✓	✓
	Mild weakness							
	Severe weakness							
	Spastic flexion							
	Extension							
	No response	[illegible]						
LEGS	Normal power			R/L	R/L	✓	✓	✓
	Mild weakness							
	Severe weakness							
	Extension							
	No response							

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

Pain Assessment and Management Guidelines

Pain Score:
No pain
Mild = No Pain at Rest
Slight Pain on Movement
Moderate = Intermittent Pain at Rest
Moderate Pain on Movement
Severe = Continuous Pain at Rest

Nausea Score (0-3):
0 = No nausea or vomiting
1 = Nausea only
2 = Vomiting once
3 = Vomiting more than once

For Acute and Chronic Pain:
For mild, moderate or severe pain refer to Pain Management Guidelines *Forth Valley Formulary Appendix 27 & 28*
Implement Pain Assessment Chart

For Cancer Related Pain:
For a mild, moderate or severe pain score, refer to Palliative Guidelines.

Re-order Ref: TF/1013/SS Issue Date: 2010 Review Date: 2014

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NHS Forth Valley

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NHS Forth Valley Tobacco Policy

PATIENTS LEAVING CLINICAL AREA TO SMOKE

As smoking is biggest single cause of ill health in Scotland NHS Forth Valley does not permit smoking in any of premises including the grounds and car parks. It is also against the law in Scotland to smoke in any enclosed public place.

Assistance is available from NHS Forth Valley with helping you stop smoking, including Nicotine Replacement Therapy which is a free service. We also can offer you one to one help from nurses whose role is to help / aid / offer advice to people to stop smoking. These nurses will be informed that you are in the ward / department, if you do not wish this support please indicate below.

However should you wish to smoke, you will have to leave NHS Forth Valley premises to do so this includes the grounds of the hospital. Please use the bins provided at the gates to the hospital to extinguish your cigarettes to keep our entrances clear of tobacco.

I have read the above and understand that I must leave NHS Forth Valley premises if I wish to smoke. I understand **if I choose to do so that this will be at my own risk to my health, safety and well-being and that of others.** I understand that it is illegal to smoke in any enclosed public space.

Name: _____

CHI Number: _____

Ward or Department: _____

Hospital: _____

Signature: (*patient*) _____

Date: 3/5/14.

CHI: 2410765416 M
24/10/1976
BALTZELL George
124 HAUGH STREET
BAINSFORD
FALKIRK FK2 7QT

☑ Please tick this box if you **do not** wish to speak to a smoking cessation nurse.

TOP COPY - FOR PATIENTS NOTES

SECOND COPY - PATIENT

THIRD COPY - SMOKING CESSATION NURSE, HUT 5, FALKIRK ROYAL INFIRMARY

Produced: July 2008

ING1641

NHS

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PATIENT ASSESSMENT, CARE PLAN AND REVIEW

ere

CHI: 2410765416
24/10/1976 M
BALTZELL George
124 HAUGH STREET
BAINSFORD
FALKIRK FK2 7QT

Start date of document 3/5/14

End date of document.....

Number of document.....

Frequency of Completion

This should be completed daily in every acute area or in-patients with longer term needs this can be less often. If patient care requirements change, document time, date and change in care in the actual nursing action box.

In community hospitals, this should be reviewed according to patient's condition but no less frequent than weekly.

This care plan is a legal document. Your signature indicates you have reviewed and updated it and it is a true reflection of the care given by you or delegated by you.

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Staff identification – must be completed by all staff prior to recording in this document

Date	Designation	Print name	Signature	Initials
3/5/14	SN	PPACKER	QPQ	QP
4/5/14	SN	FCOOK	FCook	B
5/5/14	SN	EBROSCHARK	E-J C	CC

Guidelines for use

- Good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care.
- All entries to records must be signed. In the case of written records, the persons name and job title should be printed alongside the first entry (NMC Guidance on Record Keeping)
- All registered staff must sign the staff identification sheet before using this care plan.
- Assess each care requirement using the criteria within the assessment section
- Place a tick in the coloured column of the identified level of care requirement
- Document appropriate letters from the potential nursing actions in the actual nursing actions section. If further instructions are required there is room to write these in the box
- Rationale for care changes should be documented in the unified notes

Colour coding for assessment

Green = Patient requires minimal assistance/intervention

= Patient requires moderate assistance/intervention

Red = Patient requires full assistance/interventions

	Potential Care Requirement	Goal	Date Assessment		Potential Nursing Actions	Date 3/5/14 Actual Nursing Actions
1	Patient Involvement in Planning Care	Enable patient to be included in planning their care	Patient/carer is involved in planning care	✓	*Please discuss and document patient's goals*	
			Patient/carer requires prompting/assistance to participate in planning care			
			Patient/carer requires in-depth assistance in planning care			
2	Cognitive Function		No significant impairment	✓	**A.** Complete using Cognitive Assessment checklist and butterfly documentation **B.** Use REACH response **C.** Encourage involvement of relatives or carers **D.** Refer to Learning Disability or Liaison Psychiatry team according to protocols	
			Cognitive impairment has no significant impact on treatment			
			Delirium suspected/identified			
			Newly identified			
			Significant impact			
3	Behaviour that Challenges	To minimise the risk of distress or harm to patient; other patients and staff	No risk identified		**A.** Reduce stress/distress - specify **B.** Use of ABC chart **C.** Complete patient risk assessment **D.** Implement safe working procedures **E.** Contact Risk Management for advice	
			Behaviour or psychological symptoms that are easily managed	✓		
			Behaviours or psychological symptoms that need additional assistance or supervision			
			Verbal aggression towards self/other			
			Physical aggression towards self/others			
			Risk of absconding			
						Sign

Date 4/5/14 Actual Nursing Actions	Date 5/5/14 Actual Nursing Actions	Date Actual Nursing Actions	Date Actual Nursing Actions	Date Actual Nursing Actions
✓	✓			
✓ Confused at times.	✓			
✓	✓			
Sign RB	Sign EC	Sign	Sign	Sign

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	Potential Care Requirement	Goal	Date: Assessment		Potential Nursing Actions	Date 3/5/14 Actual Nursing Actions
4	Vital signs monitoring – including TPR, respiration, Sp02, blood glucose, Glasgow coma scale	Early recognition of change and early escalation to most appropriate health professional	Within normal parameters	✓	**A.** T, P, BP, Resp, Sp02, - state frequency **B.** Blood transfusion observation **C.** Blood glucose – state frequency **D.** Neurological observation – state frequency **E.** Other – e.g. daily weight – please specify	A D
			Out with normal parameters for patient			
5	Nutrition	Ensure the patient is monitored and given nutrition	Every patient will have a nutritional screening and a MUST care plan		**A.** Complete MUST care plan **B.** Review MUST care plan **C.** Complete patient board **D.** Enteral feeding **E.** TPN	A
6	Fluid Hydration	Prevention of dehydration	Independent		**A.** Prompt to drink **B.** Assist to drink **C.** Requires specialist equipment – specify **D.** Monitor fluid balance **E.** Administer fluid replacement therapy – specify (IV, S/C, enteral **F.** Document equipment required (e.g. volumetric pump) **G.** Complete patient board	A
			Requires assistance/supervision/ Encouragement/fluid balance monitoring			
			Dependent			
7	Pressure Area Care	Prevent the acquisition of pressure ulcers	Braden = 15-16 – Low risk		**A.** Re-assess Braden Score **B.** Use of SSKINS bundle **C.** Document type of pressure relieving equipment in use **D.** Inspect skin – specify how often	A
			Braden = 13-14 – Moderate risk			
			Braden = 12 or less High risk			
8	Mobility	Promote and maintain maximum mobility	Independent		**A.** Complete mobility chart **B.** Complete patient bed board	A
			Requires assistance/ supervision/ walking aid			
			Dependent			
9	Falls	Prevent falls	No history of falls and < 65 years		**A.** Falls Care Plan **B.** Ensure patient bed board is up to date **C.** Complete/update bed rails risk assessment	
			No history of falls and > 65 years or history of falls – any age			
			Bed rails in use			
						Sign

Date 4/5/14 Actual Nursing Actions	Date 5/5/14 Actual Nursing Actions	Date Actual Nursing Actions	Date Actual Nursing Actions	Date Actual Nursing Actions
✓ A-4-6° D-6°	✓ A-4-6° D-6°			
✓ B	✓ B			
✓ A E-IV	✓ A			
✓ A	✓ A			
✓ A IND	✓ A			
✓	✓			
Sign RB	Sign EC	Sign	Sign	Sign

	Potential Care Requirement	Goal	Date Assessment	Potential Nursing Actions	Date 3/5/14 Actual Nursing Actions
10	Personal Hygiene	Enable patient to maintain appropriate level of personal hygiene	Independent Requires assistance/supervision/ encouragement Dependent	**A.** Self care **B.** Basin/shower/bed bath **C.** Hair washed **D.** Shave **E.** Nail Care **F.** Other **G.** Document changes **Specify level of assistance required**	COPY
11	Oral Hygiene	Enable patient to maintain appropriate level of oral hygiene	Independent Requires assistance/supervision/ encouragement Dependent	**A.** Self care **B.** Assistance to brush **C.** Mouthwash **D.** Denture care **E.** Full oral hygiene – state frequency	
12	Elimination	Promote effective elimination function. Prevent Infection	Independent Requires assistance/supervision/ catheter/stoma Dependent	**A.** Provide commode **B.** Walk/wheel to toilet – specify **C.** Catheter care – specify how often **D.** Hourly urine volumes **E.** Continence assessment **F.** Provide and change continence aids – specify **G.** Stool chart **H.** Review need for catheter **I.** Stoma care	
13	Pain	Provide appropriate pain management	No pain/mild pain Moderate pain/breakthrough medication required Severe pain PCA/PCEA continuous sub cut infusion	**A.** Document pain an nausea score on EWS – state frequency **B.** Administer analgesia as prescribed **C.** Document additional pain assessment charts in use e.g. Abbey pain scale **D.** Complete infusion device chart	A B C
14	Infection Control	To prevent/reduce risk of infection	Not at risk of infection Infection risks present: Previous infection identified Invasive device in situ On antibiotics Has diarrhoea or vomiting Produce cough Exfoliating skin conditions Large leaking wounds Suspected/confirmed infection	**A.** Ensure MRSA risk assessment has been completed **B.** Ensure all invasive devices are documented **C.** Ensure patient is appropriately placed in ward **D.** Control measures in place	
15	Wound Care	Promote optimum wound healing	No wound/healed surgical wound Clean, closed surgical wound Open wound/skin integrity broken	**A.** Complete wound assessment chart **B.** Refer to Wound Formulary for appropriate dressing choice **C.** Refer to Tissue Viability team for further advice	sign

Date 4/5/14 Actual Nursing Actions	Date 5/5/14 Actual Nursing Actions	Date Actual Nursing Actions	Date Actual Nursing Actions	Date Actual Nursing Actions
✓ A - IND	✓ A - IND			
✓ A - IND	✓ A - IND			
✓ IND	✓ A - IND			
✓ A B	✓ AB			
✓ venflon	✓ venflon.			
✓	✓			
Sign: RB	Sign: EC	Sign:	Sign:	Sign:

COPY

Date 3/5/16

	Potential Care Requirement	Goal	Assessment		Potential Nursing Actions	Actual Nursing Actions
16	Communication	Enable effective communication	No communication difficulties identified	✓	**A.** Ensure environment private to enable conversation **B.** Give eye contact, speak clearly and ensure understanding **C.** Patient has glasses **D.** Patient has a working hearing aid **E.** Refer to Speech & Language **F.** Interpreter service **G.** Use written communication **H.** Contact sensory impairment centre	**COPY**
			Existing communication difficulty identified			
			New communication difficulty identified			
17	Emotional wellbeing (including spiritual and expressing sexuality)		No concerns identified	✓	**A.** Communicate about condition **B.** Ensure record is kept in family dialogue sheet **C.** Encourage use of personal clothes and belongings **D.** Consider referral to chaplaincy service	
			Difficulty expressing concerns			
			Inability to manage			
18	Sleep	Promote and enable effective sleep	No difficulty with sleep identified	✓	**Specify actions required** **A.** Consider sleep assessment chart	
			Existing difficulty with sleep identified			
			New difficulty with sleep identified			
19	Discharge Plan	Facilitate a timely, safe and effective discharge	Simple discharge	✓	**A.** Ensure patient has PDD on e-ward **B.** Communicate PDD to patient **C.** Communicate PDD to relatives **D.** Commence discharge plan and dialogue	
			Complex discharge			
						Sign:

Date 4/5/14	Date 5/5/14	Date	Date	Date
Actual Nursing Actions	Actual Nursing Actions	Actual Nursing Actions	Actual Nursing Actions.	Actual Nursing Actions
✓ A B	✓ B			
✓ A B C	✓ A B C			
✓	✓			
✓ A	✓ A			
Sign: [illegible]	Sign: EC	Sign:	Sign:	Sign:

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CARE BUNDLE AND ASSESSMENT BOOKLET

CHI: 2410765416
24/10/1976 M
BALTZELL George
124 HAUGH STREET
BAINSFORD
FALKIRK FK2 7QT

Date of admission 3/5/14
Ward admitted to OAU
Consultant Minhas
Ward transferred to .....
Date of transfer .....
Consultant .....
Ward transferred to .....
Date of transfer .....
Consultant .....
Booklet number .....

Timescales for completion of initial assessments	
MRSA - on admission	□ .....
Braden - within 6 hours of admission	□ .....
MUST - within 24 hours of admission	□ .....
Mobility - within 24 hours of admission	□ .....
Falls - within 24 hours of admission	□ .....
Stool chart - within 24 hours of admission	□ .....

The information within this document is confidential and may only be viewed and shared with the permission of the named patient

This care bundle and assessment booklet is a legal document. Your signature indicates you have reviewed and updated it and it is a true reflection of the care given by you or delegated by you.

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Staff identification – must be completed by all staff prior to recording in this document

Date	Designation	Print name	Signature	Initials
3/5/14	S/N	APARKER	[illegible]	AP

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Patient CHI: 2410765416 24/10/1976 M Name: BALTZELL George 124 HAUGH STREET Unit/CH BAINSFORD FALKIRK FK2 7QT	Ward: ..... Date of Admission: ..... Usual/pre-illness weight:..... .....

STEP 1 (BMI)	STEP 2 (Weight Loss)	STEP 3 (Acute Disease Effect)	*If weight/ height not measured please indicate how this was obtained
Weight (kg) = 58.7 Height (m) = 1.78 **BMI(kg/m²)= 18** See BMI charts Greater than 20 score 0 18.5 – 20 score 1 Less than 18.5 score (2) (greater than 30=obese)	Total unplanned weight loss over 3-6 months Weight loss (kg) = 6kg **% weight loss =** See Weight Loss Chart Less than 5% score 0 5-10% (score 1) Greater than 10% score 2	Acute illness **AND** there has been or is likely to be no nutritional intake for **5 days** No (score 0) Yes score 2	Reported Estimated Based solely on clinical impression (See **"Ward information pack"** for alternative measures)

STEP 4 (Overall Risk Score)	STEP 5 (Care Plan)
Add scores from steps 1+2+3 to calculate overall risk score SCORE 0 = LOW RISK SCORE 1 = MEDIUM RISK SCORE 2+ = (HIGH) *(Please record all details in the table below)* If risk category arrived at by clinical impression alone, circle risk category LOW/MEDIUM/HIGH and document rationale in care plan	Implement appropriate Nutritional Care Plan **0 = LOW RISK** **1 = MEDIUM RISK** **2 = (HIGH RISK)** **Treat as High Risk - immediate Dietetic Referral** ▪ Dysphagia ▪ Decompensated Liver Disease ▪ Enteral Tube Feeding ▪ Multiple Fractures ▪ Pressure Ulcers Grade 3 or more

'MUST' SCREENING

Date	Weight (kg)	Weight ↑↔↓	BMI (kg/m²)	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	'MUST' Risk	Sign/Print Name
5/5/14	58.7	↓	18	2	1	0	3	High	T. Tennyson

Report 'MUST' screening results to nursing staff and housekeeper if appropriate

BAPEN

The 'Malnutrition Universal Screening Tool '('MUST') is adapted here with the kind permission of BAPEN (British Association for Parenteral and Enteral Nutrition). ***See 'MUST' ward folder for further information.***

Step 1 – BMI score (& BMI)

BAPEN
www.bapen.org.uk

Height (feet and inches)

Weight (kg)	4'9¾	4'10¼	4'11	5'0	5'0¾	5'1¼	5'2	5'3	5'4	5'4½	5'5¼	5'6	5'7	5'7¾	5'8½	5'9¼	5'10	5'11	5'11¾	6'0½	6'1	6'2	6'3	6'3¾	6'4¼	Weight (stones and pounds)
100	47	46	44	43	42	41	40	39	38	37	36	35	35	34	33	32	32	31	30	30	29	28	28	27	27	15 10
99	46	45	44	43	42	41	40	39	38	37	36	35	34	33	33	32	31	31	30	29	29	28	27	27	26	15 8
98	46	45	44	42	41	40	39	38	37	36	36	35	34	33	32	32	31	30	30	29	28	28	27	27	26	15 6
97	46	44	43	42	41	40	39	38	37	36	35	34	34	33	32	31	31	30	29	29	[illegible]	27	[illegible]	[illegible]	26	15 4
96	45	44	43	42	40	39	38	38	37	36	35	34	33	32	32	31	30	30	29	28	[illegible]	27	[illegible]	[illegible]	26	15 2
95	45	43	42	41	40	39	38	37	36	35	34	34	33	32	31	31	30	29	29	28	[illegible]	[illegible]	[illegible]	26	25	14 13
94	44	43	42	41	40	39	38	37	36	35	34	33	33	32	31	30	30	29	28	28	27	[illegible]	26	25	25	14 11
93	44	42	41	40	39	38	37	36	35	35	34	33	32	31	31	30	29	29	28	27	27	[illegible]	[illegible]	[illegible]	25	14 9
92	43	42	41	40	39	38	37	36	35	34	33	33	32	31	30	30	29	28	28	27	27	26	25	25	24	14 7
91	43	42	40	39	38	[illegible]	36	36	35	34	33	32	31	31	30	29	29	28	27	27	26	26	25	25	24	14 5
90	42	41	40	39	38	37	36	35	34	33	33	32	31	30	30	29	28	28	27	27	26	25	25	24	24	14 2
89	42	41	40	39	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	25	24	24	14 0
88	41	40	39	38	37	36	35	34	34	33	32	31	30	30	29	28	28	27	27	26	25	25	24	24	23	13 12
87	41	40	39	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	25	24	24	23	13 10
86	40	39	38	37	36	35	34	34	33	32	31	30	30	29	28	28	27	27	26	25	25	24	24	23	23	13 8
85	40	39	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	25	24	24	23	23	13 5
84	39	38	37	36	35	35	34	33	32	31	30	30	29	28	28	27	27	26	25	25	24	24	23	23	22	13 3
83	39	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	25	24	23	23	23	22	13 1
82	38	37	36	35	35	34	33	32	31	30	30	29	28	28	27	26	26	25	25	24	24	23	23	22	22	12 13
81	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	24	24	23	23	22	22	22	12 11
80	38	37	36	35	34	33	32	31	30	30	29	28	28	27	26	26	25	25	24	24	23	23	22	22	21	12 8
79	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	24	24	23	23	22	22	21	21	12 6
78	37	36	35	34	33	32	31	30	30	29	28	28	27	26	26	25	25	24	24	23	23	22	22	21	21	12 4
77	36	35	34	33	32	32	31	30	29	29	28	27	27	26	25	25	24	24	23	23	22	22	21	21	20	12 2
76	36	35	34	33	32	31	30	30	29	28	28	27	26	26	25	25	24	23	23	22	22	22	21	21	20	12 0
75	35	34	33	32	32	31	30	29	29	28	27	27	26	25	25	24	24	23	23	22	22	21	21	20	20	11 11
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72	34	33	32	31	30	30	29	28	27	27	26	26	25	24	24	23	23	22	22	21	21	20	20	20	19	11 5
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68	32	31	30	29	29	28	27	27	26	25	25	24	24	23	22	22	21	21	21	20	20	19	19	18	18	10 10
67	31	31	30	29	28	28	27	26	26	25	24	24	23	23	22	22	21	21	20	20	19	19	19	18	18	10 8
66	31	30	29	29	28	27	26	26	25	25	24	23	23	22	22	21	21	20	20	19	19	19	18	18	18	10 6
65	30	30	29	28	27	27	26	25	25	24	24	23	22	22	21	21	21	20	20	19	19	18	18	18	17	10 3
64	30	29	28	28	27	26	26	25	24	24	23	23	22	22	21	21	20	20	19	19	18	18	18	17	17	10 1
63	30	29	28	27	27	26	25	25	24	23	23	22	22	21	21	20	20	19	19	19	18	18	17	17	17	9 13
62	29	28	28	27	26	25	25	24	24	23	22	22	21	21	20	20	20	19	19	18	18	18	17	17	16	9 11
61	29	28	27	26	26	25	24	24	23	23	22	22	21	21	20	20	19	19	18	18	18	17	17	17	16	9 8
60	28	27	27	26	25	25	24	23	23	22	22	21	21	20	20	19	19	19	18	18	17	17	17	16	16	9 6
59	28	27	26	26	25	24	24	23	22	22	21	21	20	20	19	19	19	18	18	17	17	17	16	16	16	9 4
58	27	26	26	25	24	24	23	23	22	22	21	21	20	20	19	19	18	18	18	17	17	16	16	16	15	9 2
57	27	26	25	25	24	23	23	22	22	21	21	20	20	19	19	18	18	18	17	17	16	16	16	15	15	9 0
56	26	26	25	24	24	23	22	22	21	21	20	20	19	19	18	18	18	17	17	17	16	16	16	15	15	8 11
55	26	25	24	24	23	23	22	21	21	20	20	19	19	19	18	18	17	17	17	16	16	16	15	15	15	8 9
54	25	25	24	23	23	22	22	21	21	20	20	19	19	18	18	17	17	17	16	16	16	15	15	15	14	8 7
53	25	24	24	23	22	22	21	21	20	20	19	19	18	18	18	17	17	16	16	16	15	15	15	14	14	8 5
52	24	24	23	23	22	21	21	20	20	19	19	18	18	18	17	17	16	16	16	15	15	15	14	14	14	8 3
51	24	23	23	22	22	21	20	20	19	19	19	18	18	17	17	16	16	16	15	15	15	14	14	14	14	8 0
50	23	23	22	22	21	21	20	20	19	19	18	18	17	17	17	16	16	15	15	15	14	14	14	14	13	7 12
49	23	22	22	21	21	20	20	19	19	18	18	17	17	17	16	16	15	15	15	14	14	14	14	13	13	7 10
48	23	22	21	21	20	20	19	19	18	18	17	17	17	16	16	15	15	15	14	14	14	14	13	13	13	7 8
47	22	21	21	20	20	19	19	18	18	17	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	7 6
46	22	21	20	20	19	19	18	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	7 3
45	21	21	20	19	19	18	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	7 1
44	21	20	20	19	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	12	6 13
43	20	20	19	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	12	11	6 11
42	20	19	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	12	11	11	6 9
41	19	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	12	11	11	11	6 6
40	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	12	11	11	11	11	6 4
39	18	18	17	17	16	16	16	15	15	15	14	14	13	13	13	13	12	12	12	12	11	11	11	11	10	6 2
38	18	17	17	16	16	16	15	15	14	14	14	13	13	13	13	12	12	12	11	11	11	11	11	10	10	6 0
37	17	17	16	16	16	15	15	14	14	14	13	13	13	13	12	12	12	11	11	11	11	10	10	10	10	5 12
36	17	16	16	16	15	15	14	14	14	13	13	13	12	12	12	12	11	11	11	11	10	10	10	10	10	5 9
35	16	16	16	15	15	14	14	14	13	13	13	12	12	12	12	11	11	11	11	10	10	10	10	9	9	5 7
34	16	16	15	15	14	14	14	13	13	13	12	12	12	11	11	11	11	10	10	10	10	10	9	9	9	5 5
33	15	15	15	14	14	14	13	13	13	12	12	12	11	11	11	11	10	10	10	10	10	9	9	9	9	5 3
32	15	15	14	14	13	13	13	13	12	12	12	11	11	11	11	10	10	10	10	9	9	9	9	9	9	5 1
31	15	14	14	13	13	13	12	12	12	12	11	11	11	10	10	10	10	10	9	9	9	9	9	8	8	4 12
30	14	14	13	13	13	12	12	12	11	11	11	11	10	10	10	10	9	9	9	9	9	8	8	8	8	4 10
Height (m)	1.46	1.48	1.50	1.52	1.54	1.56	1.58	1.60	1.62	1.64	1.66	1.68	1.70	1.72	1.74	1.76	1.78	1.80	1.82	1.84	1.86	1.88	1.90	1.92	1.94	

Height (m)

© BAPEN

Note : The black lines denote the exact cut off points (30,20 and 18.5 kg/m²), figures on the chart have been rounded to the nearest whole number.

Step 2 – Weight loss score

BAPEN
www.bapen.org.uk

Current weight

KILOGRAMS	Score 0 Wt loss < 5%	Score 1 Wt loss 5-10%	Score 2 Wt loss > 10%	STONES AND POUNDS	Score 0 Wt loss < 5%	Score 1 Wt loss 5-10%	Score 2 Wt loss > 10%
	Weight loss in last 3 to 6 months				Weight loss in last 3 to 6 months		
kg	Less than (kg)	Between (kg)	More than (kg)	st lb	Less than (st lb)	Between (st lb)	More than (st lb)
30	1.6	1.6-3.3	3.3	4 10	0 3	0 3-0 7	0 7
31	1.6	1.6-3.4	3.4	4 12	0 4	0 4-0 8	0 8
32	1.7	1.7-3.6	3.6	5 1	0 4	0 4-0 8	0 8
33	1.7	1.7-3.7	3.7	5 3	0 4	0 4-0 8	0 8
34	1.8	1.8-3.8	3.8	5 5	0 4	0 4-0 8	0 8
35	1.8	1.8-3.9	3.9	5 7	0 4	0 4-0 9	0 9
36	1.9	1.9-4.0	4.0	5 9	0 4	0 4-0 9	0 9
37	1.9	1.9-4.1	4.1	5 12	0 4	0 4-0 9	0 9
38	2.0	2.0-4.2	4.2	6 0	0 4	0 4-0 9	0 9
39	2.1	2.1-4.3	4.3	6 2	0 5	0 5-0 10	0 10
40	2.1	2.1-4.4	4.4	6 4	0 5	0 5-0 10	0 10
41	2.2	2.2-4.6	4.6	6 6	0 5	0 5-0 10	0 10
42	2.2	2.2-4.7	4.7	6 9	0 5	0 5-0 10	0 10
43	2.3	2.3-4.8	4.8	6 11	0 5	0 5-0 11	0 11
44	2.3	2.3-4.9	4.9	6 13	0 5	0 5-0 11	0 11
45	2.4	2.4-5.0	5.0	7 1	0 5	0 5-0 11	0 11
46	2.4	2.4-5.1	5.1	7 3	0 5	0 5-0 11	0 11
47	2.5	2.5-5.2	5.2	7 6	0 5	0 5-0 12	0 12
48	2.5	2.5-5.3	5.3	7 8	0 6	0 6-0 12	0 12
49	2.6	2.6-5.4	5.4	7 10	0 6	0 6-0 12	0 12
50	2.6	2.6-5.6	5.6	7 12	0 6	0 6-0 12	0 12
51	2.7	2.7-5.5	5.7	8 0	0 6	0 6-0 12	0 12
52	2.7	2.7-5.8	5.8	8 3	0 6	0 6-0 13	0 13
53	2.8	2.8-5.9	5.9	8 5	0 6	0 6-0 13	0 13
54	2.8	2.8-6.9	6.0	8 7	0 6	0 6-0 13	0 13
55	2.9	2.9-6.1	6.1	8 9	0 6	0 6-0 13	0 13
56	2.9	2.9-6.2	6.2	8 11	0 6	0 6-1 0	1 0
57	3.0	3.0-6.3	6.3	9 0	0 7	0 7-1 0	1 0
58	3.1	3.1-6.4	6.4	9 2	0 7	0 7-1 0	1 0
59	3.1	3.1-6.6	6.6	9 4	0 7	0 7-1 0	1 0
60	3.2	3.2-6.7	6.7	9 6	0 7	0 7-1 1	1 1
61	3.2	3.2-6.8	6.8	9 8	0 7	0 7-1 1	1 1
62	3.3	3.3-6.9	6.9	9 11	0 7	0 7-1 1	1 1
63	3.3	3.3-7.0	7.0	9 13	0 7	0 7-1 1	1 1
64	3.4	3.4-7.1	7.1	10 1	0 7	0 7-1 2	1 2

Current weight

KILOGRAMS	Score 0 Wt loss < 5%	Score 1 Wt loss 5-10%	Score 2 Wt loss > 10%	STONES AND POUNDS	Score 0 Wt loss < 5%	Score 1 Wt loss 5-10%	Score 2 Wt loss > 10%
	Weight loss in last 3 to 6 months				Weight loss in last 3 to 6 months		
kg	Less than (kg)	Between (kg)	More than (kg)	st lb	Less than (st lb)	Between (st lb)	More than (st lb)
65	3.4	3.4-7.2	7.2	10 3	0 8	0 8-1 2	1 2
66	3.5	3.5-7.3	7.3	10 6	0 8	0 8-1 2	1 2
67	3.5	3.5-7.4	7.4	10 8	0 8	0 8-1 2	1 2
68	3.6	3.6-7.7	7.6	10 10	0 8	0 8-1 3	1 3
69	3.6	3.6-7.7	7.7	10 12	0 8	0 8-1 3	1 3
70	3.7	3.7-7.8	7.8	11 0	0 8	0 8-1 3	1 3
71	3.7	3.7-7.9	7.9	11 3	0 8	0 8-1 3	1 3
72	3.8	3.8-8.0	8.0	11 5	0 8	0 8-1 4	1 4
73	3.8	3.8-8.1	8.1	11 7	0 8	0 8-1 4	1 4
74	3.9	3.9-8.2	8.2	11 9	0 9	0 9-1 4	1 4
75	3.9	3.9-8.3	8.3	11 11	0 9	0 9-1 4	1 4
76	4.0	4.0-8.4	8.4	12 0	0 9	0 9-1 5	1 5
77	4.1	4.1-8.6	8.6	12 2	0 9	0 9-1 5	1 5
78	4.1	4.1-8.6	8.7	12 4	0 9	0 9-1 5	1 5
79	4.2	4.2-8.7	8.8	12 6	0 9	0 9-1 5	1 5
80	4.2	4.2-8.9	8.9	12 8	0 9	0 9-1 6	1 6
81	4.3	4.3-9.0	9.0	12 11	0 9	0 9-1 6	1 6
82	4.3	4.3-9.1	9.1	12 13	0 10	0 10-1 6	1 6
83	4.4	4.4-9.2	9.2	13 1	0 10	0 10-1 6	1 6
84	4.4	4.4-9.3	9.3	13 3	0 10	0 10-1 7	1 7
85	4.5	4.5-9.4	9.4	13 5	0 10	0 10-1 7	1 7
86	4.5	4.5-9.6	9.6	13 8	0 10	0 10-1 7	1 7
87	4.6	4.6-9.7	9.7	13 10	0 10	0 10-1 7	1 7
88	4.6	4.6-9.8	9.8	13 12	0 10	0 10-1 8	1 8
89	4.7	4.7-9.9	9.9	[illegible]	[illegible]	0 10-1 8	1 8
90	4.7	4.7-10.0	10.0	14 2	[illegible]	0 10-1 8	1 8
91	4.8	4.8-10.1	10.1	[illegible]	0 11	0 11-1 8	1 8
92	4.8	4.8-10.2	10.2	[illegible]	0 11	0 11-1 9	1 9
93	4.9	4.9-10.3	10.3	14 9	[illegible]	0 11-1 9	1 9
94	4.9	4.9-10.4	10.4	[illegible]	0 11	0 11-1 9	1 9
95	5.0	5.0-10.6	10.6	14 13	0 11	0 11-1 9	1 9
96	5.1	5.1-10.7	10.7	15 2	0 11	0 11-1 10	1 10
97	5.1	5.1-10.8	10.8	15 4	0 11	0 11-1 10	1 10
98	5.2	5.2-10.9	10.9	15 6	0 11	0 11-1 10	1 10
99	5.2	5.2-11.0	11.0	15 8	0 11	0 11-1 10	1 10

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FORTH VALLEY ACUTE HOSPITALS

Infusion Fluids / Blood Products Page

NHS Forth Valley

WARD	CONSULTANT
ALLERGIES - Please use RED INK	

HEIGHT (m)	WEIGHT (kg)	DATE	SURFACE AREA (m^2)

PATIENT DETAILS OVERLEAF

CHI: 2410765416
24/10/1976
BALTZELL George
124 HAUGH STREET
BAINSFORD
FALKIRK FK2 7QT

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HOSPIT... E:

DATE OF ... AGE:

- enter dosage times as 24hour clock
- please write in block capitals in black pen
- IV site MUST be checked prior to and after IV administration

	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
A			IV	1300	
INFUSION FLUID			TOTAL VOLUME	TIME STARTED	
0.9% NaCl			500ml		CR
DOCTORS SIGNATURE	DATE		RATE	PUMP NO.	BATCH NO.
	3/5/14		40		14B14T23 1/16
B	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	KCl	20mmol	IV	17.30	
INFUSION FLUID			TOTAL VOLUME	TIME STARTED	
0.9% NaCl			500ml		CR/
DOCTORS SIGNATURE	DATE		RATE	PUMP NO.	BATCH NO.
	3/5/14		40		14A10E5G 12/15
C	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
			IV		
INFUSION FLUID			TOTAL VOLUME	4/5/14 TIME STARTED 0000	
5% Dextrose			500ml		PB
DOCTORS SIGNATURE	DATE		RATE	PUMP NO.	BATCH NO.
	3/5/14		40		14B10T40 01/16
D	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID			TOTAL VOLUME	TIME STARTED	
0.9% Saline			500		
DOCTORS SIGNATURE	DATE		RATE	PUMP NO.	BATCH NO.
	3/5/14		40		
E	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID			TOTAL VOLUME	TIME STARTED	
DOCTORS SIGNATURE	DATE		RATE	PUMP NO.	BATCH NO.
F	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID			TOTAL VOLUME	TIME STARTED	
DOCTORS SIGNATURE	DATE		RATE	PUMP NO.	BATCH NO.
G	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID			TOTAL VOLUME	TIME STARTED	
DOCTORS SIGNATURE	DATE		RATE	PUMP NO.	BATCH NO.
H	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID			TOTAL VOLUME	TIME STARTED	
DOCTORS SIGNATURE	DATE		RATE	PUMP NO.	BATCH NO.

In-Patient Management of Alcohol Withdrawal: Care Plan

NHS Forth Valley

CHI: 2410765416
24/10/1976 M
BALTZELL George
124 HAUGH STREET
BAINSFORD
FALKIRK FK2 7QT

Standard Alcohol Withdrawal Schedule

	Weight (kg)	Consultant	Hospital & Ward
		MINHNS	

- To be used for detoxification from alcohol and clinical review is essential. Prescribe on regular section of the prescription sheet: 'Standard Alcohol Withdrawal Schedule'.
- *** Prescriber must complete starting dose of chlordiazepoxide on 'day 0' for morning, lunch, evening & night as appropriate.**
- Administering nurse will record and initial the time when dose is administered in the 'Time/Given by' box. Omit prescribed dose if patient is drowsy.
- Give PRN for symptoms of alcohol withdrawal ONLY: review chart with doctor if more than two PRN doses are needed daily.

			Regular Medication								PRN Medication				
Day	Date	Drug	Morning Dose	Time/ Given By	Lunch Time Dose	Time/ Given By	Evening Dose	Time/ Given By	Night Time Dose	Time/ Given By	PRN Dose	Time/ Given By	Time/ Given By	Time/ Given By	Time/ Given By
0	3/5/14	Chlordiazepoxide oral	*		*20mg	12-30	20mg	17:00	20mg	20mg	20mg				
1	4/5/14	Chlordiazepoxide oral	20mg	07:30	20mg	12:30	20mg	17:00	20mg	20mg	20mg				
2		Chlordiazepoxide oral	15mg		15mg		15mg		15mg		20mg				
3		Chlordiazepoxide oral	15mg				15mg		15mg		15mg				
4		Chlordiazepoxide oral	10mg				10mg		10mg		10mg				
5		Chlordiazepoxide oral	5mg				5mg		5mg		5mg				
6		Chlordiazepoxide oral	5mg						5mg		5mg				
7		Chlordiazepoxide oral							5mg		5mg				
*** Please complete below: prophylactic dose, Pabrinex IV/IM 1 pair daily for three days must be prescribed for all patients, unless: neurological signs or cognitive problems are evident, prescribe Pabrinex IV 2 pairs of amps three times daily for 3 DAYS then review**															
1	3/5/14	Pabrinex IV/IM**			2 pairs		2 pairs								
2		Pabrinex IV/IM**	2 pairs		2 pairs		2 pairs								
3		Pabrinex IV/IM**													
Please complete start date on admission:															
		Diazepam rectal									10mg				
			Prescriber Signature:								Date: 3/5/14				

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PRESCRIPTION AND ADMINISTRATION RECORD

Hospital Name: .....

NHS Forth Valley

Date and time this form prepared: / / Time:	Sheet No	2nd Prescription in use
	.....	YES ☐ NO ☐

COPY

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date ____ Name (Print) ____

Discharge Prescription Prepared & Reconciled YES ☐

Date ____ Name (Print) ____

SYMPTOMATIC RELIEF POLICY DECLARATION

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy:

____

with the following exceptions: ____

Print & Sign: ____ Date: ____

COMMUNITY PHARMACY INFORMATION

Name ____ Tel No. ____

Address ____

Compliance Aid Details ____

Patient consent to share discharge information Y/N

Print & Sign ____

PATIENT DETAILS

CHI: 2410760511 24/10/1976 M
BALTZELL
GEORGE
124 HAUGH STREET
FALKIRK
FK2 7QT

Height:

Weight:

Surface Area:

Consultant Name:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
3/5	Paracetamol	1g	PO		O Henderson		06-17

DRUGS ADMINISTERED PRIOR TO HOSPITAL ARRIVAL

DATE	DRUG	DOSE	ROUTE	GIVEN BY (e.g. SAS, GP)	Time given

ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000	MENTAL HEALTH (CARE & TREATMENT) (SCOTLAND) ACT 2003	HIGH DOSE ANTIPSYCHOTIC MONITORING APPLICABLE	
YES / NO	FORM T2 YES / NO	YES / NO	AFFIX PHOTOGRAPH
EXPIRY DATE	FORM T3 YES / NO	DATE	
	If yes check treatment plan details before prescribing		

Name 24/10/1976 BALTZELL George 124 HAUGH STREET BAINSFORD FALKIRK FK2 7QT

CHI No ____

Ward ____

Drug Allergies / Sensitivities None Known ☐ Yes ☐ (provide details below)

Penicillin

DATE → 3/5

RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST DAILY)

IS DRUG THROMBOPROPHYLAXIS CONTRAINDICATED? Y / N

ARE ANTIEMBOLIC STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N

Parenteral Drugs : Regular Prescription

TIME ↓

Patient's Own Medicine

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

A DRUG: ENOXAPARIN (Adults only)

DOSE Delete as appropriate: 20 / 40mg | ROUTE: S/C | DATE:

STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N: Qty: Date: Assessed by: Ordered from Pharm.

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

B DRUG: PABRINEX

DOSE: As per chart | ROUTE: IV | DATE: 3/5/14

STOPPED DATE: 5/5 INITIALS:

PRESCRIBER (PRINT & SIGN): [signature] MCCARTHY

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

0800 [signature] 4/3/14

1400 [signature]

2200 [signature]

For Use Y/N: Qty: Date: Assessed by: Ordered from Pharm.

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

C DRUG

DOSE | ROUTE | DATE

STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N: Qty: Date: Assessed by: Ordered from Pharm.

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REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE

Drug OXYGEN

Circle target oxygen saturation

88-92% 94-98% Other _____

Starting device/flow rate _____

PRN/continuous (refer to O_2 guideline)

Tick here if saturation not indicated* ☐

Date and signature

Print name

Is oxygen on patient, if so record twice daily at 0800 and 2200 drug round

DATE → / TIME ↓

0800

2200

Oral and Other Drugs: Regular Prescription

DATE → 3/5/14 / TIME ↓

Patient's Own Medicine

BEFORE ADMISSION ☐ **NEW DOSE** ☐ **NEW MEDICATION** ☐

H **DRUG** CHLORDIAZEPOXIDE

DOSE: As per chart | ROUTE: O | DATE: 3/5/14 | STOPPED DATE: | INITIALS: SS

PRESCRIBER (PRINT & SIGN): [signature] MCDARTELL.

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ **NEW DOSE** ☐ **NEW MEDICATION** ☐

J **DRUG**

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

COPY

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

NHS Forth Valley
Endoscopy Department

NHS
Forth Valley

Consent Form
Upper Gastrointestinal Endoscopy

CHI NO: 2410765416 24/10/1976
CRN: M
George BALTZELL
9 GRANGE VIEW
STENHOUSEMUIR
LARBERT
FK5 3DF

I, ...

of .....

.....

.....

hereby consent
(or hereby consent to the submission of my child/ward .....)

to the procedure of: **Upper Gastrointestinal Endoscopy +/- Oesophageal Dilatation**
the purpose of which has been explained to me in the document entitled:
"Upper Gastrointestinal Endoscopy - Information for Patients".

I confirm that:

- I have read the document
- I have understood the information that has been given to me
- I understand that I will be given the opportunity to ask questions about the procedure.

I also give consent for any necessary biopsies and for photographs or x-rays to be taken.

Signed (Patient/Parent) ..... Date 8/4/25

Name of Patient/Parent.....(block capitals)

Please ensure that you bring this form with you.

You do not have to sign this before you attend if you have further questions you would like answered.

Even if you have signed the form you are under no obligation to proceed with the test.

To be completed by the Endoscopist

I confirm that the patient received written information about the procedure, including the risks, and has been given the opportunity to ask any further questions.

Signed ..... **Date** 8/4/25

Endoscopist/Medical Practitioner

Re-Order Ref: PIL/1058/SS

Review Date: 2025

FORTH VALLEY ACUTE HOSPITALS NHS TRUST
Endoscopy Unit

NHS Forth Valley

Date 8/4/25 Ward/Dept Endoscopy Name _____

Presenting Complaint Weight loss/ vomiting Address _____

Procedure Gastroscopy _____

Is this a repeat procedure? Yes / No CHI No. _____

Contact Number Wife waiting - 07746728081

GP Trust M/C 07746728081

CHI NO: 2410765416 24/10/1976
CRN: M
George BALTZELL
9 GRANGE VIEW
STENHOUSEMUIR
LARBERT
FK5 3DF

Endoscopy Preparation

Please confirm each check by ticking box or circling item as required, Wards please complete before endoscopy, if not applicable, write N/A in box.

	Ward	Endo
Procedure explained		✓
Written consent		✓
I.D. band checked		✓
Recordings obtained		✓
Premedication given		✓
Correct casenotes		✓
Correct nursing notes		✓
Referral letter		✓
Relevant X-Rays		✓
Blood results obtained		Sat
On warfarin		X
INR obtained (If required)		X
Date LMPO (X-Ray only)		X
Antibiotics given		✓
I.V. cannula sited		✓
I.V. cannula flushed		✓
I.V. cannula sited b whom		

Dentures — Retained / Removed / N/A
Crowns — Loose Teeth / N/A
Hearing aid — Retained / Removed (None) / N/A
Contact lenses/ spectacles — Retained / Removed / N/A

Prosthesis — Yes / No
Type _____

Orthopaedic implants — Yes / No
Type _____

Cardiac Pacemaker — Yes / No

Heart valve replacement — Yes / No

Jewellery & Valuables — Retained In locker / Removed Documented

Time last ate or drank Last night (food) fluids 8:30 am

Pre scope stool (please circle) loose / bloody / solid	Enteric precautions required Yes / No
Bowel preparation (if required) type -	
Result	
Any side effects / problems	N/A

History & Medication

Have you ever been notified that you are at risk of CJD or vCJD? Yes / No

Allergies Yes / No (specify) _____

Heart disease Yes / No (specify) _____

Chest problems Yes / No (specify) _____

Rheumatoid Arthritis Yes / No

Glaucoma Yes / No

Epilepsy Yes / No

Diabetes Yes / No

Other problems None

Previous surgery None

Present medication None

Mobility Assessment Complete mobility chart below

Actual or Potential Problems	nil at present		
Task	Pre Scope	Post Scope	Discharge
If independently mobile please tick			✓
	Asst Equipment	Asst Equipment	Asst Equipment
Chair to Chair Chair to Couch Couch to Chair Other Specify		while on trolley	
Signature	[illegible]	[illegible]	[illegible]

Nursing Assessment Is Sedation Requested (Yes) No Undecided

Admitted for OGD & Sedation
Observations on chart,
Reance given.
Op — DCN.

Venflon (Yes) / No Size 22g Lot No. 4317918 Expires 2027

Sodium Chloride (Yes) / No Batch No. 5.023115 Expires 2027

re Room: Time in 16 10hrs Time out 16 29hrs

	AS PLETED rculating Nurse)	COMMENTS: Please document any comments/concerns below (To be completed below by Named Nurse prior to safety brief)
PATIENT DEMOGRAPHICS Name, Address, DOB, GP	✓	correct.
PROCEDURE/INDICATIONS CONSENT completed/checked	✓	Yes.
ANTICOAGULANTS Warfarin, Clopidogrel etc	✓	NO.
ALLERGIES To what and effect on patient	✓	NO.
MOBILITY STATUS Hoist, glide sheets etc	✓	NO.
INFECTION CONTROL MRSA, C-Diff, TB etc	✓	NO
PATIENT ISSUES Same name, confused, fall risk, Pacemakers, Diabetic, Artificial joints etc.	✓	none.

Sign below on completion of safety brief

Circulating Nurse K Stanley Endoscopist Mr Robertson

Procedure Performed OGD - only

Endoscope decontaminated, prepared & checked prior to use (Yes) / No

Throat spray (Yes) / No Time 16 10hrs

Abdominal Pressure Applied Yes / (No) Where?

Diathermy plate Yes / (No) Pad site Skin intact Yes / No

APC Applied: Yes / (No) Effect: Watts:

Present in Procedure Room (Witnessing Safety Brief)

Name Nurse Circulating Nurse K Stanley

Theatre Nurse E Scott Endoscopist Mr Robertson

Trainess Endoscopist Others H Everingham

Patient Comfort Score: 0 - None 1 - Mild 2 - Moderate 3 - Severe

Comments Tolerated procedure

Reassurance given

Endoscopy prescriptions

Date	Medicines	Route	Dose	Time	Dr's Signature	Given By
	Midazolam	I.V.	2mg	16[19]		MR ROBERTSON
	Fentanyl	I.V.				
	Pethidine	I.V.				
	Buscopan	I.V.				
	Voltarol	PR				
	Anexate	I.V.				
	Adrenaline	INJ				
	Botox	INJ				
	Lignocaine	NEB				
	Sodium Chloride	IV				
	Oxygen Therapy	NC	2L	during procedure		

Comments

Handover to Recovery

Post procedure safety brief carried out ✓ Signed KS

Endoscope & Equipment decontamination record Valve No. _____

Please attach all decontamination reports / certificates securely to this page _____

Recovery Needs

Fast until K 17-10-14 K B.P. Pulse & Resps ¼ hourly until sedation score 1 and stable

Lie in recovery position (circle as required) Left side Right side ~~Either~~

Observe for any of the following - Haemorrhage, Perforation, Abdominal pain, Pulse, BP, Change of colour, Change of temperature, Respirations

Oxygen must be administered at 2litres a minute until sedation score 1 or less and oxygen saturation level maintained at pre endoscopy saturation level

Reversal of sedation Yes / (No) (specify) _____

Type of recovery (Uneventful) / Eventful (specify) _____

Have passed urine Yes / No I.V. cannula removed (Yes) / No / None

I.V. cannula site (Satisfactory) / Unsatisfactory (specify) _____

	Time	Admission			Theatre and Recovery																
		15			10		16	16	16												
BP & Pulse	190	65			110		20	35	50												
	180																				
	170																				
	160																				
	150																				
	140																				
	130																				
	120	120					114	110													
	110																				
	100																				
	90																				
	80																				
	70	59							78												
	60							75													
	50						67														
	40																				
O2 saturation		96			97		97	100	98												
O2 therapy		SV			2L		A	N	AA												
Respirations		17			16				17												
Temperature		37.1					37	37.1	T												
BM		—						—	T												
Sedation score		0			0		0	0	0												
Nausea score		0			0		0	0	0												
Comfort score		0			0		0	0	0												
Staff Initials		CM			LD		ET	JL	MS												

Sedation score

0. Fully aware of self & surroundings
1. Mostly aware of self & surroundings, but sedate
2. Slightly aware of self & surroundings, usually somnolent, arouses easily with stimuli
3. Not aware of self or surroundings, little arousal with stimuli
4. Unconscious, no arousal with painful stimuli

Nausea score

0. None
1. Mild, no treatment required
2. Moderate, helped by treatment
3. Severe, despite treatment

COMFORT SCORE

0. None / minimal
1. Mild
2. Moderate
3. Severe

Discharge

Sedation score, pain score and nausea score must all be 1 or less for safe discharge. Discharge criteria must be met.

Sedation score = 0 Pain score= 0 Nausea Score= 0

Has patient had a drink	Yes / (No)
Has patient had food	Yes / (No)
Has patient been seen by doctor / N.E.	Yes / (No)
Has patient been seen by nurse	(Yes) / No
Advice on discharge sheet given	(Yes) / No
Discharge criteria met	(Yes) / No

If no specify fasting

Discharged home (circle as required)

Alone / (Accompanied)

By ambulance Yes / (No)

Transfer to ward Yes (No)

Which ward _____

Back to ward _____

Personal effects transferred

Teeth	Yes (No)
Clothes	(Yes) / No
Glasses	(Yes) / No
Valuables	(Yes) / No

Response to endoscopy (Satisfactory) / Unsatisfactory (specify)

Patient education (None required) / Yes (specify)

After care leaflet given (Yes) Signature K Stanley

Condition on leaving endoscopy unit Drowsy / Slightly Drowsy / (Awake)

Clinic appointment:- Has one for _____ To be made for _____

To be rescoped :- Yes _____ Referral sent:- Yes _____

Other follow up GP

Additional comments patient has responded well in the recovery nil complaints of nausea or discomfort.
unable to offer food and drink due to fasting
observations stable and drowsy
After care advice discussed and understood.

CHI NO: 2410765416 24/10/1976 M
CRN:
George BALTZELL
9 GRANGE VIEW
STENHOUSEMUIR
LARBERT
FK5 3DF

Time left department 1655 Signature Meyer Sproule

Endoscopy Tracking Sheet

Pati
CHI NO: 2410765416 24/10/1976
CRN: M
George BALTZELL
9 GRANGE VIEW
STENHOUSEMUIR
LARBERT
FK5 3DF

8/4/25

eprocessor ID: 1
Cycle: 23455
GASTROSCOPE
Washed
08-04-2025 - 15:08
Processed
08-04-2025 - 16:01
Scope Code: 3000137
User Code: KEY50186942
Lot: 02856
Serial No: 2857230
Use By:
DO NOT USE IF PACKING IS DAMAGED OR OPEN
STORE IN A CLEAN DUST FREE ENVIRONMENT
RE-ORDER CODE KIT/TUPADP8948/1000
Tel. +44 01454 321456

NHS Forth Valley

Forth Valley Royal Hospital

GASTROSCOPY REPORT

Name:	**George BALTZELL (M)**	Address:	**9 Grange View**
Date of birth:	**24/10/1976**		**Stenhousemuir**
CHI No:	**2410765416**		**Larbert**
Case note no.:	**2410765416**		**Stirlingshire**
			FK5 3DF

GP: **Dr G Moffat**
Tryst Medical Centre
431 King Street
Stenhousemuir
Larbert
FK5 4HT

Procedure date: **8th April 2025 (16:18)**
Priority: **Urgent**
Status: **Outpatient/NHS**
Hospital: **FVRH**
Referring Cons: **Dr Francis Robertson (Referring Consultants)**

Indications
Weight loss.

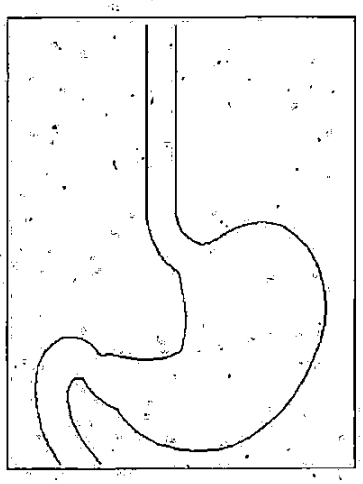
Consultant/Endoscopist
Mr Francis Robertson
Nurses: Practioner Assistant Eilidh Scott, Endoscopy Practioner assistant Katie Stanley

Report
The scope was retroflexed in the stomach.
The procedure was completed successfully to D2.
Apparent mucosal junction at 38cm from the incisors.
The whole upper gastro-intestinal tract was normal.

Instrument
GIF HQ290 2857230

Premedication
Midazolam (IV) 2 mg
Xylocaine (Spray) 100 mg

Advice/comments
Normal gastroscopy. No cause for symptoms encountered. Note recent normal CT CAP. No further investigations under general surgery. Return to GP care.



Follow up
Return to the referring GP.

Mr Francis Robertson
Consultant
c.c. Baltzell, George

Urgent Outpatient Clinic Note

NHS Forth Valley

Name: **George Baltzell**
CHI: **2410765416**

Registered GP Name: MOFFAT, GREG
Registered GP Practice: Tryst Medical Centre

Clinic attended: Dietetics

Clinic (From PAS): Ms Ruth Ramsay - FCH Clinic
Date/Time of clinic: Mon 19 May 2025 14:15
Lead clinician for clinic: Ms Ruth Ramsay

Presenting Complaint, Investigations, Results, Diagnosis:

This man had an initial appointment with me on the 21st April following your referral for unexplained weight loss and very low BMI. He failed to answer his phone after me trying several times. He was sent a DNA letter and he must have contacted the department for a further appointment. I tried calling today and when I rang his number initially rang but then his line was switched to "line busy". I was not planning to offer a third appointments at this time.

0 Medication Recommendation(s):

No (new, stop or alter) medication recommendation(s) entered/recorded

0 Follow Up action(s):

No 'follow up' info recorded/entered

Further Info:

No 'further info' recorded/entered

Form completed by: Ruth Ramsay on Mon 19 May 2025 at 14:31
Form sent to: Primary and secondary care document management system(s), eg. Docman and EDMS

Urgent Outpatient Clinic Note: George Baltzell / 2410765416

Emergency Discharge Letter (Authorised)

G Moffat
Tryst Medical Centre
431 King Street
Stenhousemuir
Larbert
Larbert
FK5 4HT

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode: 2410765416

Date of Completion: 23-Mar-2026

GP Practice

GP Name:	G Moffat	**GP GMC:**	7134031
GP Practice Address:		**GP Practice Code:**	7134031/25648
		GP Clinic Code:	25648
		GP Telephone:	

Patient Demographics

Patient Name:	BALTZELL, George	**Date Of Birth:**	24-Oct-1976
Patient Address:	9 Grange View Stenhousemuir Larbert Stirlingshire FK5 3DF	**Gender:**	Male
		CHI No:	2410765416
Telephone No:	07716 414856		

Admission Details

Patient Location:	FVRH Emergency Department	**Admission Date:**	23-Mar-2026
Admission Care Provider:	Dr John David Brown	**Admission Time:**	02:39
Source Of Admission:	Self referral		

Presenting Complaint

head inj

Diagnosis

Diagnosis	Site	Laterality
ED diagnosis - Left before clinical assessment		

Discharge Details

Discharge Type:	Patient left before assessment completed	**Discharge Date:**	23-Mar-2026
		Discharge Time:	02:57
Discharge Destination:	Private Residence - Usual place of residence		
Referred To:			

Notes for GP

Person completing record

Authorised by	Clinically completed by
Name:	**Name:**

Authorised by		Clinically completed by	
Designation or role:		Designation or role:	
Specialty:		Specialty:	
Date completed:	23-Mar-2026		

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
G Moffat	GP	Tryst Medical Centre

Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

G Moffat
Tryst Medical Centre
431 King Street
Stenhousemuir
Larbert
Larbert
FK5 4HT

CHI Barcode: 2410765416

Date of Completion: 24-Aug-2025

GP Practice

GP Name:	G Moffat	**GP GMC:**	7134031
GP Practice Address:		**GP Practice Code:**	7134031/25648
		GP Clinic Code:	25648
		GP Telephone:	

Patient Demographics

Patient Name:	BALTZELL, George	**Date Of Birth:**	24-Oct-1976
Patient Address:	9 Grange View Stenhousemuir Larbert Stirlingshire FK5 3DF	**Gender:**	Male
		CHI No:	2410765416
Telephone No:	07716 414856		

Admission Details

Patient Location:	FVRH Emergency Department	**Admission Date:**	23-Aug-2025
Admission Care Provider:	Dr Stefano Corrieri	**Admission Time:**	01:50
Source Of Admission:	999 Emergency Services		

Presenting Complaint

assault sas wr

Diagnosis

Diagnosis	Site	Laterality
ED injury - wound - Laceration		
ED injury - wound - Laceration		

Discharge Details

Discharge Type:	With no follow up	**Discharge Date:**	23-Aug-2025
Discharge Destination:	Private Residence - Usual place of residence	**Discharge Time:**	08:57
Referred To:			

Notes for GP

PC: Lacerations to both elbows with stanley knife at home by wife/partner.
4.5cm on Right arm, lateral to elbow in a vertical incision - irrigated and closed with 5 non-absorbable sutures.
5.5cm on Left arm, inferior to elbow in a horizontal incision - irrigated and closed with 6 non-absorbable sutures.

On examination his radial, ulnar and median nerves appear intact bilaterally. He had no indication of tendon/ligament injury, and was given safety netting advice regarding changes in symptoms.

He was also given a tetanus vaccine and a course of oral anti-biotics to cover him for infection due to the knife used.

George was given worsening advice re signs of infection in either wound.

GP actions: for suture removal in 10-14 days

Person completing record

Authorised by		Clinically completed by	
Name:	Dr Katherine Bradfield	Name:	
Designation or role:	Doctor	Designation or role:	
Specialty:		Specialty:	
Date completed:	24-Aug-2025		

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
G Moffat	GP	Tryst Medical Centre

Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

G Moffat
Tryst Medical Centre
431 King Street
Stenhousemuir
Larbert
Larbert
FK5 4HT

CHI Barcode: 2410765416

Date of Completion: 19-Jun-2025

GP Practice

GP Name:	G Moffat	**GP GMC:**	7134031
GP Practice Address:		**GP Practice Code:**	7134031/25648
		GP Clinic Code:	25648
		GP Telephone:	

Patient Demographics

Patient Name:	BALTZELL, George	**Date Of Birth:**	24-Oct-1976
Patient Address:	9 Grange View Stenhousemuir Larbert Stirlingshire FK5 3DF	**Gender:**	Male
		CHI No:	2410765416
Telephone No:	07716 414856		

Admission Details

Patient Location:	FVRH Emergency Department	**Admission Date:**	19-Jun-2025
Admission Care Provider:	Dr Elizabeth Nimmo	**Admission Time:**	03:33
Source Of Admission:	Self referral		

Presenting Complaint

l shoulder ?dis

Diagnosis

Diagnosis	Site	Laterality
ED injury - soft tissue - Muscle strain		

Discharge Details

Discharge Type:	Discharged	**Discharge Date:**	19-Jun-2025
Discharge Destination:	Private Residence - Usual place of residence	**Discharge Time:**	11:08
Referred To:			

Notes for GP

48 yo male

Slipped at top of stairs last night, landed on left shoulder and slip down the rest. C/o pain left shoulder only. No HI; no neck/back pain; no CP; no AP; fully mobile since

PMH: nil

DH: nil
NKDA
SH: smokes 20cpd; 16-20u alcohol/week; no drugs

OE: A - patent; no neck/back tenderness
B - RR 16; sats 96; chest clear; no tenderness
C - HR 76; BP 106/71; abdo soft
D - GCS 15; moving all 4 limbs
E - Left shoulder: mild anterior swelling and tenderness over prox bicep/lateral pectoral; good passive RoM; pain ++ on flexion and abduction; NV intact

XR: no bony injury

Imp: muscle/soft tissue strain left shoulder

Plan: discharge with shoulder injury advice sheet; regular analgesia; ice; mobilise shoulder as able

Person completing record

Authorised by		Clinically completed by	
Name:	Dr Gerrard O'Neill	**Name:**	
Designation or role:	Doctor	**Designation or role:**	
Specialty:		**Specialty:**	
Date completed:	19-Jun-2025		

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
G Moffat	GP	Tryst Medical Centre

NHS Forth Valley

Department of Nutrition and Dietetics
Stirling Community Hospital
Livilands Gate
Stirling
FK8 2AU

NHS Forth Valley

Mr George Baltzell
9 Grange View
Stenhousemuir
Larbert
Stirlingshire
FK5 3DF

Direct dial:	01786 434046 (24 hour Answerphone)
Date:	28/04/2025
Our Ref:	RR/CG
CHI:	2410765416

Please confirm attendance at this appointment by telephoning 01786 434046 a.s.a.p.

Dear Mr Baltzell

The Dietitian has arranged a telephone appointment for you as follows:-

Date: 19/5/2025
Time: 14:15 p.m.

We will phone you on this number: 07716 414856

If this appointment does not suit you or you no longer wish to speak to a Dietitian, please call us on:

Tel: 01786 434046 (24 hour answer phone available)

If you miss this telephone appointment and then do not contact us within one month, you may be discharged from the service.

Please note if you are prescribed Nutritional Supplements by your GP, these will be stopped unless you are being reviewed by a Dietitian.

Checking your weight

It would be useful if you could check your weight before your telephone appointment but do not worry if you do not have scales or feel it is not safe for you to do this.

We look forward to speaking with you.

Yours sincerely

Ruth Ramsay
Community Dietitian

NHS Forth Valley

Department of Nutrition and Dietetics
Stirling Community Hospital
Livilands Gate
Stirling
FK8 2AU

NHS Forth Valley

Mr George Baltzell
9 Grange View
Stenhousemuir
Larbert
Stirlingshire
FK5 3DF

Direct dial:	01786 434046 (24 hour Answerphone)
Date:	23/04/2025
Our Ref:	RR/CG
CHI:	2410765416

Dear Mr Baltzell

I was expecting to speak to you at the Dietetic clinic for your telephone appointment on 21/4/2025 at 14:15 p.m. but you failed to attend.

In accordance with NHS Forth Valley's Access Policy you have been removed from our waiting list.

However, if you contact the department within 21 days from the date of your appointment we will reinstate you on our waiting list. After this period you will require a new referral to see the Dietitian.

If you cancel another confirmed appointment or do not attend you will be discharged and referred back to your referrer/General Practitioner.

Yours sincerely

Dictated and electronically checked by:

Ruth Ramsay
Community Dietitian

CC:
Dr G Moffat
Tryst Medical Centre
431 King Street
Stenhousemuir
Larbert
FK5 4HT

NHS Forth Valley

Department of Nutrition and Dietetics
Stirling Community Hospital
Livilands Gate
Stirling
FK8 2AU

NHS Forth Valley

Mr George Baltzell
9 Grange View
Stenhousemuir
Larbert
Stirlingshire
FK5 3DF

Direct dial:	01786 434046 (24 hour Answerphone)
Date:	27/03/2025
Our Ref:	RR/CG
CHI:	2410765416

Please confirm attendance at this appointment by telephoning 01786 434046 a.s.a.p.

Dear Mr Baltzell

The Dietitian has arranged a telephone appointment for you as follows:-

Date: 21/4/2025
Time: 14:15 p.m.

We will phone you on this number: 07716 414856

If this appointment does not suit you or you no longer wish to speak to a Dietitian, please call us on:

Tel: 01786 434046 (24 hour answer phone available)

If you miss this telephone appointment and then do not contact us within one month, you may be discharged from the service.

Please note if you are prescribed Nutritional Supplements by your GP, these will be stopped unless you are being reviewed by a Dietitian.

Checking your weight

It would be useful if you could check your weight before your telephone appointment but do not worry if you do not have scales or feel it is not safe for you to do this.

We look forward to speaking with you.

Yours sincerely

Ruth Ramsay
Community Dietitian

Hospital use only	Clinic	Day Date	Time	Hospital No.

Date Referral Submitted
(This date is fixed at hospital end):
26-Mar-2025

REFERRAL LETTER

MEDICAL IN CONFIDENCE

?

2410765416 CHI No: 2410765416 *101036006451Y*

Unique Care Pathway Number: 101036006451Y

REFERRAL TO

General SurgeryC1 FV Suspected OG Cancer	? **Consultant / receiving practitioner** and/or **specialty clinic**
Forth Valley Cancer Services NHS Forth Valley	? **Hospital** and hospital **address** Hospital location code. V001G

Urgency of Referral **Urgent - Suspected Cancer (Upper GI - OG) Referral??** ?

Administrative Information

Please indicate suitability for Near Me or Telephone consult (preference Near Me):Unknown
Age in Years:48
Patient has special requirements:No
Ethnic Origin: (White) Scottish
?

PATIENT DETAILS

Surname	Baltzell
Forename(s)	George
Title	- Sex Male
Previous Surname	-
Date of birth	24-Oct-1976
CHI no.	2410765416

Patient's address

9 Grange View
STENHOUSEMUIR
LARBERT
FK5 3DF

Contact number(s)

Voice: 07716414856
E-mail: georgebaltzell32@gmail.com

REFERRING HCP DETAILS

Name:	MichaelOverend
Organisation name:	Tryst Medical Centre (25648) (25648)
Specialty:	- (-)

Organisation address

431 King Street
Stenhousemuir
Larbert
FK5 4HT
Voice: 01324 551555

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: Weight loss, unexplained vomiting

Examinations and Investigations

Is this person fit for day case endoscopy?:	Yes
Symptom details:	48 y/o gentleman, 6/12 Hx of unexplained weight loss (14kg in last 5 months). Daily coughing, vomiting at least 3 x per day after most meals. Some diarrhoea. Smoker. Looks very cachectic in appearance. Abdomen - nil masses. Bloods reassuring. Had recent CT CAP which was reassuring however given ongoing weight loss and predominantly upper GI Sx, kindly request urgent OGD to fully exclude OG malignancy as underlying aetiology.
Patient understanding::	Patient has been told that referring clinician thinks cancer could be a possibility and they are being referred to explore this
Performance Status:	0 - Fully active, able to carry on all pre-disease performance without restriction
FBC sent:	Not Recorded
Ferritin sent:	Not Recorded
U and E's sent:	Not Recorded
LFTs sent:	Not Recorded
Previous Endoscopy done:	Not Recorded

Patient Measurements

Diastolic	Systolic	Height	Weight	BMI	Date Recorded
117	69				21-Apr-2015
118	70				19-Apr-2013
		180	59	19.6	17-Oct-2024
		175.5	58	18.83	21-Apr-2015
			64		20-May-2013

Reason for referral

Care type requested: Out Patient

Expected outcome: Investigate

Medical history

Pre-existing Conditions (High Priority)

Description	??	Laterality	??	Modifier	??	Extension	??	Date Started	??
Cough	??	-	??	-	??	-	??	17-Oct-2024	
Vomiting	??	-	??	-	??	- weight loss	??	17-Oct-2024	
Burn of wrist or hand NOS	??	-	??	-	??	- 2nd degree	??	29-Mar-2022	
Overdose of drug	??	-	??	-	??	Low mood - psychiatric depressive episode	??	28-Nov-2015	
Weight decreasing	??	-	??	-	??	-	??	21-Apr-2015	
Confusion	??	-	??	-	??	/agitation- following head injury	??	03-May-2014	
Headache	??	-	??	-	??	-	??	19-Apr-2013	

Past Procedures (High priority)

Description	??	Laterality	??	Extension	??	Date Recorded
Computerised tomograph scan	??	-	??	-	??	05-May-2014
Computerised tomograph scan	??	-	??	-	??	09-May-2013
ECG normal	??	-	??	-	??	22-Apr-2013

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

No current medications recorded

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

Drug name	??	Drug code	??	Formulation	??	Dosage	??	Frequency	??
Complan Shake Starter pack sachets	??	-	??	30 sachet	??	ONE TO BE TAKEN DAILY	??	-	?? - ?? 45?Days

Clinical warnings

Description	Comment	Date Recorded
Cigarette smoker, 10 Cigarettes/day	-	17-Oct-2024
Current smoker	-	21-Apr-2015
Light smoker - 1-9 cigs/day	reduced from 20cpd to 2cpd using e cigarettes	19-Nov-2013
Cigarette smoker, 20 Cigarettes/day	-	19-Apr-2013
Current smoker	-	11-Feb-2013
Description	**Comment**	**Date Recorded**
Alcohol consumption, 14 units/week	-	21-Apr-2015
Alcohol consumption, 20 units/week	-	19-Apr-2013
Current non drinker	-	11-Feb-2013

Description	Comment	Date Recorded
Aerobic exercise 2 times/week	-	21-Apr-2015

Additional relevant information
?

Signature of referring doctor (or other professional)	**Date**	26-Mar-2025

Hospital use only	Clinic	Day Date	Time	Hospital No.

Date Referral Submitted
(This date is fixed at hospital end):
26-Mar-2025

REFERRAL LETTER

MEDICAL IN CONFIDENCE

?

2410765416 CHI No: 2410765416

101036006580V
Unique Care Pathway Number: 101036006580V

REFERRAL TO

DieteticsR3
FV Dietetics

? **Consultant / receiving practitioner** and/or **specialty clinic**

Falkirk Community Hospital
Majors Loan
Falkirk
FK1 5QE

? **Hospital** and **hospital address**

Hospital location code.
V102H

Urgency of Referral **Urgent Dietetic Referral??** ?

Administrative Information

Please indicate suitability for Near Me or Telephone consult (preference Near Me):Unknown
Age in Years:48
Patient has special requirements:No
Ethnic Origin: (White) Scottish
?

PATIENT DETAILS

Surname	Baltzell
Forename(s)	George
Title	- Sex Male
Previous Surname	-
Date of birth	24-Oct-1976
CHI no.	2410765416

Patient's address

9 Grange View
STENHOUSEMUIR
LARBERT
FK5 3DF

Contact number(s)

Voice: 07716414856
E-mail: georgebaltzell32@gmail.com

REFERRING HCP DETAILS

Name: MichaelOverend
Organisation name: Tryst Medical Centre (25648) (25648)
Specialty: - (-)

Organisation address

431 King Street
Stenhousemuir
Larbert
FK5 4HT
Voice: 01324 551555

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: Unexplained significant weight loss

Comment: Dear colleague,
This 48 year old gentleman presents with significant unexplained weight loss over the last 6 months. In October 2024 he was 180cm height and 59kg (BMI 19). Last week he weighed himself at home and is now 45kg (BMI 14.2). He has had a recent CT CAP which did not show any malignancy. I have referred him today for an urgent OGD to fully exclude oesophagi-gastric malignancy. He vomits frequently (> 3 x daily), states he brings up most meals. We gave him some Complan starter shakes last months which he does find slightly easier to keep down. Given his significant weight loss, I would kindly appreciate urgent review with regards to need for ongoing nutritional supplements.

Examinations and Investigations

Is this a nutritionally compromised/ONS referral?: No -

Patient Measurements

Diastolic	Systolic	Height	Weight	BMI	Date Recorded
117	69				21-Apr-2015
118	70				19-Apr-2013
		180	59	19.6	17-Oct-2024
		175.5	58	18.83	21-Apr-2015
			64		20-May-2013

Reason for referral

Care type requested: Out Patient

Expected outcome: Investigate.

Medical history

Pre-existing Conditions (High Priority)

Description	?? Laterality	?? Modifier	?? Extension	?? Date Started ??
Cough	?? -	?? -	?? -	?? 17-Oct-2024
Vomiting	?? -	?? -	?? - weight loss	?? 17-Oct-2024
Burn of wrist or hand NOS	?? -	?? -	?? - 2nd degree	?? 29-Mar-2022
Overdose of drug	?? -	?? -	?? Low mood - psychiatric depressive episode	?? 28-Nov-2015
Weight decreasing	?? -	?? -	?? -	?? 21-Apr-2015
Confusion	?? -	?? -	?? /agitation- following head injury	?? 03-May-2014
Headache	?? -	?? -	?? -	?? 19-Apr-2013

Past Procedures (High priority)

Description	?? Laterality	?? Extension	?? Date Recorded
Computerised tomograph scan	?? -	?? -	?? 05-May-2014
Computerised tomograph scan	?? -	?? -	?? 09-May-2013
ECG normal	?? -	?? -	?? 22-Apr-2013

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

No current medications recorded

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

Drug name	?? Drug code	?? Formulation	?? Dosage	?? Frequency ??
Complan Shake Starter pack sachets	?? -	?? 30 sachet	?? ONE TO BE TAKEN DAILY	?? - ?? 45?Days

Clinical warnings

Description	Comment	Date Recorded
Cigarette smoker, 10 Cigarettes/day	-	17-Oct-2024
Current smoker	-	21-Apr-2015
Light smoker - 1-9 cigs/day	reduced from 20cpd to 2cpd using e cigarettes	19-Nov-2013
Cigarette smoker, 20 Cigarettes/day	-	19-Apr-2013
Current smoker	-	11-Feb-2013
Description	**Comment**	**Date Recorded**
Alcohol consumption, 14 units/week	-	21-Apr-2015
Alcohol consumption, 20 units/week	-	19-Apr-2013
Current non drinker	-	11-Feb-2013
Description	**Comment**	**Date Recorded**
Aerobic exercise 2 times/week	-	21-Apr-2015

Additional relevant information

?

Signature of referring doctor (or other professional)	Date	26-Mar-2025

Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

G Moffat
Tryst Medical Centre
431 King Street
Stenhousemuir
Larbert
Larbert
FK5 4HT

CHI Barcode: 2410765416

Date of Completion: 08-Mar-2025

GP Practice

GP Name:	G Moffat	**GP GMC:**	7134031
GP Practice Address:		**GP Practice Code:**	7134031/25648
		GP Clinic Code:	25648
		GP Telephone:	

Patient Demographics

Patient Name:	BALTZELL, George	**Date Of Birth:**	24-Oct-1976
Patient Address:	9 GRANGE VIEW STENHOUSEMUIR Larbert Stirlingshire FK5 3DF	**Gender:**	Male
		CHI No:	2410765416
Telephone No:	07716414856		

Admission Details

Patient Location:	FVRH Emergency Department	**Admission Date:**	07-Mar-2025
Admission Care Provider:	Dr Emma Elliott	**Admission Time:**	23:56
Source Of Admission:	Self referral		

Presenting Complaint

Blood in stools and vomit

Diagnosis

Diagnosis	Site	Laterality
ED diagnosis - Left before clinical assessment		

Discharge Details

Discharge Type:	Patient left before assessment completed	**Discharge Date:**	08-Mar-2025
		Discharge Time:	12:13
Discharge Destination:	Not Known		
Referred To:			

Notes for GP

Person completing record

Authorised by		**Clinically completed by**	
Name:	Dr Mohammed Altelbani	**Name:**	
Designation or role:	Doctor	**Designation or role:**	

Authorised by		Clinically completed by
Specialty:		Specialty:
Date completed:	08-Mar-2025	

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
G Moffat	GP	Tryst Medical Centre

Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

G Muircroft
Carron Medical Centre
Ronades Road
Bainsford
Falkirk
Falkirk
FK2 7TA

CHI Barcode: 2410765416

Date of Completion: 29-Mar-2022

GP Practice

GP Name:	G Muircroft	**GP GMC:**	2750596
GP Practice Address:	Carron Medical Centre Ronades Road Bainsford Falkirk Falkirk FK2 7TA	**GP Practice Code:** **GP Clinic Code:** **GP Telephone:**	2750596/25652 25652/1 01324 619940

Patient Demographics

Patient Name:	BALTZELL, George	**Date Of Birth:**	24-Oct-1976
Patient Address:	103 Kilbrennan Drive Falkirk FK1 4SQ	**Gender:** **CHI No:**	Male 2410765416
Telephone No:	07759 650881		

Admission Details

Patient Location:	FVRH Emergency Department	**Admission Date:**	29-Mar-2022
Admission Care Provider:	Dr Joanne Mitchell	**Admission Time:**	04:22
Source Of Admission:	Self referral		

Presenting Complaint

R hand burn

Diagnosis

Diagnosis	Site	Laterality
Burn of Second Degree of Wrist and Hand		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	With follow up	**Discharge Date:**	29-Mar-2022
Discharge Destination:	Private Residence - Usual place of residence	**Discharge Time:**	07:12

Referred To:

Notes for GP

Presented with burn to R hand

Dropped hot oil on R hand at work 2/7 ago
Immediate first aid measures taken
Attempted to manage at home

Partial thickness burn to dorsum of R hand
3 large areas where blisters have burst
Full ROM
Some reduced sensation throughout

De-roofed and dressed

Referred to O/P plastic surgery at GRIfor onward management

Person completing record

Name:	Dr Molly Greenaway	**Specialty:**	
Designation or role:	Doctor	**Date completed:**	29-Mar-2022

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
G Muircroft	GP	Carron Medical Centre

Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

G Muircroft
Carron Medical Centre
Ronades Road
Bainsford
Falkirk
Falkirk
FK2 7TA

CHI Barcode: 2410765416

Date of Completion: 25-Apr-2020

GP Practice

GP Name:	G Muircroft	**GP GMC:**	2750596
GP Practice Address:	Carron Medical Centre Ronades Road Bainsford Falkirk Falkirk FK2 7TA	**GP Practice Code:**	2750596/25652
		GP Clinic Code:	25652/1
		GP Telephone:	01324 619940

Patient Demographics

Patient Name:	BALTZELL, George	**Date Of Birth:**	24-Oct-1976
Patient Address:	103 Kilbrennan Drive Falkirk FK1 4SQ	**Gender:**	Male
		CHI No:	2410765416
Telephone No:	07759 650881		

Admission Details

Patient Location:	FVRH Emergency Department	**Admission Date:**	25-Apr-2020
Admission Care Provider:	Dr Elizabeth Nimmo	**Admission Time:**	09:53
Source Of Admission:	999 Emergency Services		

Presenting Complaint

chest pain

Diagnosis

Diagnosis	Site	Laterality
ED diagnosis - Gastrointestinal - Gastro-oesophageal reflux		
ED diagnosis - Left before clinical assessment		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	Patient left before assessment completed	**Discharge Date:**	25-Apr-2020
		Discharge Time:	12:14

Discharge Destination:	Private Residence - Usual place of residence
Referred To:	

Notes for GP

1) left department before assessment complete

Presented with central chest pain, worse on lying down for last 3-4 months.
Patient was seen, but left departmentbefore bloods results available. Bloods inc FBC, U+Es, LFTs, amylase, CRP and trop reassuring.

Advised patient to see GP as has a range of longer term health concerns, and a family history of MS.

Person completing record

Name:	Dr Alexander Fullbrook	**Specialty:**	
Designation or role:	Doctor	**Date completed:**	25-Apr-2020

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
G Muircroft	GP	Carron Medical Centre

Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

G Muircroft
Carron Medical Centre
Ronades Road
Bainsford
Falkirk
Falkirk
FK2 7TA

CHI Barcode: 2410765416

Date of Completion: 16-Sep-2019

GP Practice

GP Name:	G Muircroft	**GP GMC:**	2750596
GP Practice Address:	Carron Medical Centre Ronades Road Bainsford Falkirk Falkirk FK2 7TA	**GP Practice Code:** **GP Clinic Code:** **GP Telephone:**	2750596/25652 25652/1 01324 619940

Patient Demographics

Patient Name:	BALTZELL, George	**Date Of Birth:**	24-Oct-1976
Patient Address:	103 Kilbrennan Drive Falkirk FK1 4SQ	**Gender:** **CHI No:**	Male 2410765416
Telephone No:	07759 650881		

Admission Details

Patient Location:	FVRH Emergency Department	**Admission Date:**	14-Sep-2019
Admission Care Provider:	Dr Stephen Feltbower	**Admission Time:**	03:45
Source Of Admission:	999 Emergency Services		

Presenting Complaint

CHEST PAIN

Diagnosis

Diagnosis	Site	Laterality
ED diagnosis - Left before clinical assessment		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	Patient left before being treated	**Discharge Date:**	14-Sep-2019
Discharge Destination:	Private Residence - Usual place of residence	**Discharge Time:**	05:15

Referred To:

Notes for GP

Person completing record

Name:	Dr Ainsley Heyworth	**Specialty:**	
Designation or role:	Doctor	**Date completed:**	16-Sep-2019

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
G Muircroft	GP	Carron Medical Centre

NHS Forth Valley

NHS Forth Valley Radiology Report

Patient Name:	Baltzell, George	Exam Date:	19/06/2025
Patient ID:	2410765416	Consultant:	NIMMO E ED CONS
Patient Date of Birth:	24/10/1976	Report Date and Time:	19/06/2025 13:21:12
Patient Address	9 GRANGE VIEW STENHOUSEMUIR LARBERT FK5 3DF	Referring Dept/Location:	FV EMERGENCY DEPT

Accession: V214035954301, Examination Date: 19/06/2025, Examination: XR Shoulder Lt:

Indication:
Clinical Details :
Fall this evening down flight of 14 stairs. Now has left shoulder pain and appears deformed.
Provisional Diagnosis :
?Shoulder dislocation / #

Findings:
Left shoulder.

-
No previous imaging for comparison.

-
No convincing acute bony injury demonstrated on current radiographs.

-
No glenohumeral joint dislocation or AC joint disruption.

-
No rib fractures or pneumothorax identified on the imaged portion of the thorax.

-
The humeral head appears high-riding in relation to the glenoid. This appearance may simply be positional in nature however given the context of trauma, a rotator cuff injury should also be considered. Please correlate clinically.

-
Agreement with sticky note.

Final Report By: Dawn Culbert Reporting Radiographer HCPC RA66996 at 19/06/2025 13:21:12
Email Address: **dawn.culbert@nhs.scot.**

NHS Forth Valley

NHS Forth Valley Radiology Report

Patient Name:	Baltzell, George	Exam Date:	24/03/2025
Patient ID:	2410765416	Consultant:	GP REQUESTOR
Patient Date of Birth:	24/10/1976	Report Date and Time:	25/03/2025 08:21:50
Patient Address	9 GRANGE VIEW STENHOUSEMUIR LARBERT FK5 3DF	Referring Dept/Location:	OVEREND, DR M, GPST3 TRYST MEDICAL PRACTICE

Accession: V214009297201, Examination Date: 24/03/2025, Examination: CT Chest/Abdo/Pelvis:

Indication:
Clinical Details :
48 y/o, 6/12 Hx of unexplained weight loss (10kg in 3 months), daily coughing, intermittent vomiting, change in bowel habit. Smoker. Nil significant on bloods or CXR. Cachectic in appearance. Concern re malignancy - given several Sx, kindly request CT CAP to assess for solid organ malignancy
Provisional Diagnosis :
?malignancy

Findings:
Portal venous phase study. No previous for comparison. The abdominal images are degraded by breathing motion artefact.

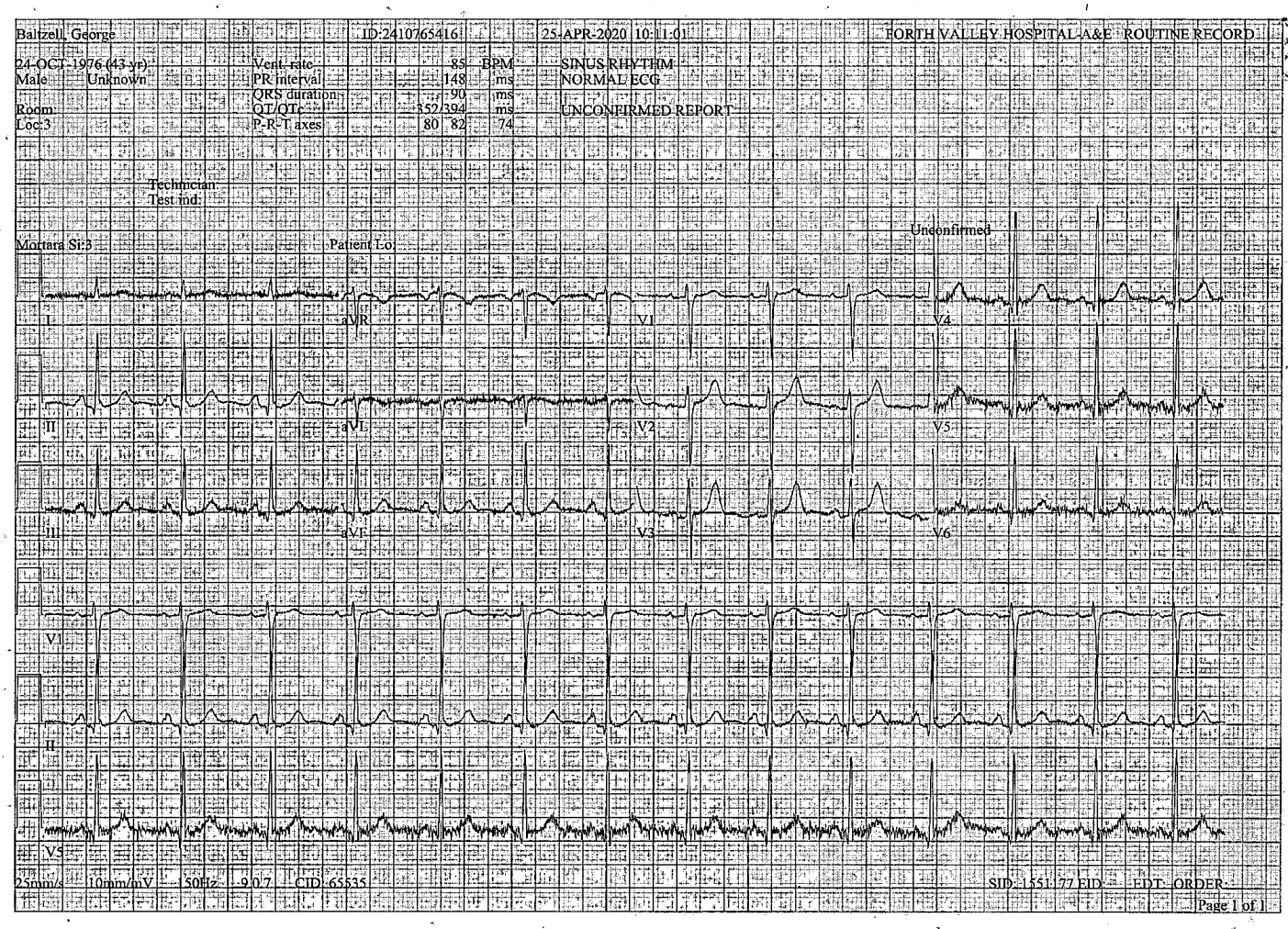
No concerning pulmonary nodule or mass. Minor biapical paraseptal emphysema and scarring. No thoracic lymphadenopathy.

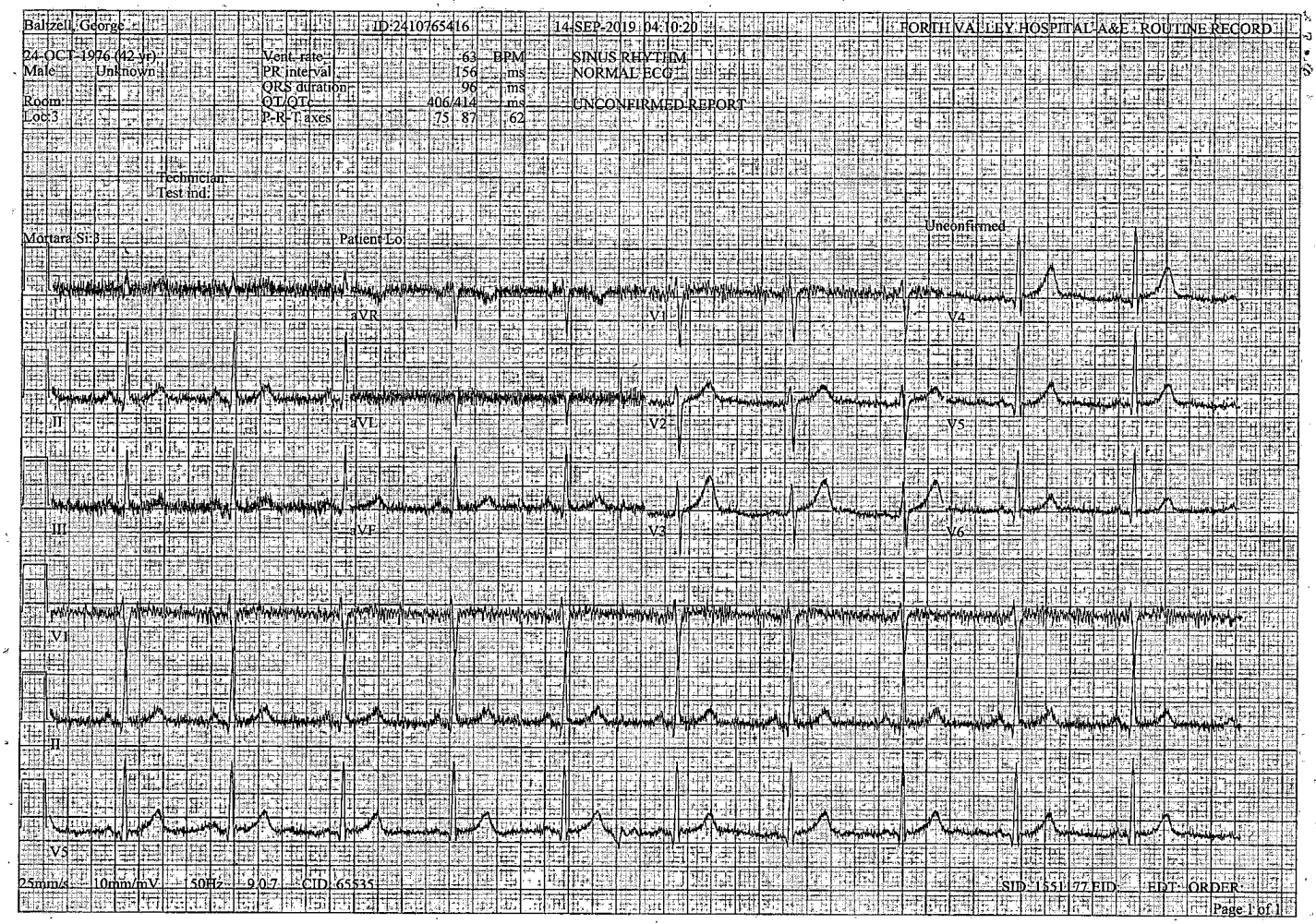
Unremarkable solid upper abdominal organs. Fluid within the distal and mid oesophagus may reflect reflux. No gross colonic mass. No abdominal or pelvic lymphadenopathy. Patent major abdominal vessels. No free fluid.

No concerning bone lesion.

Conclusion
No evidence of malignancy. An endoluminal GI tract lesion is not excluded.
No cause for the patient's presentation demonstrated.

Final Report By: Thomas Eriksen Consultant Radiologist GMC 7411094 at 25/03/2025 08:21:50
Email Address: **thomas.eriksen3@nhs.scot.**





FVRH Emergency Department Forth Valley Royal Hospital 04

D/C
LC

Date of attendance: 29/03/2022 04:22
Presenting complaint: R hand burn

Surname: Baltzell	**Forename:** George	**Title:** Mr
Address: 103 Kilbrennan Drive Falkirk	**Postcode:** FK1 4SQ	**CHI:** 2410765416
Telephone: 07759 650881	01324 670697	
Date of Birth: 24/10/1976	**Sex:** Male	**Age:** 45 Years

GP Name: G Muircroft
Address: 25652/1
Carron Medical Centre
Ronades Road
Bainsford
Falkirk
Falkirk
FK2 7TA
Telephone: 01324 619940

Next of Kin
Name:
Relationship: **Postcode:**
Address: **Telephone:**

Triage Information
"burn to dorsum of (R) hand 2 days ago - works as chef and spilt hot oil over hand - first aid at time/had dressing on since - attends this am due to blister bursting exposing raw skin increasing pain. saline soak applied at triage. "

Observations

P=	**BP=/**	**RR=**	**Sat=**	**BM=**	**Temp=**
Peak Flow=		**GCS=**		**News=**	

Emergency Department / Pre-Hospital Drugs **Allergies** NKDA

Date	Drug	Dose	Route	Signature	Given by	Time
29/3	Oramorph	10mg	PO			0620
29/3	DIHYDROCODEINE	60mg	PO			0700

Dihydrocodeine 30mg
30 Tablets
One tablet every 4 or 6 hours as required
Presc: [signature] GIVEN AWAY
Disp: Signature Print Name [signature]