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

NHS
Greater Glasgow and Clyde

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

Date: 22nd June 2026
Your Ref: 100204
Our Ref: LAT/ACCESS/ JM
Enquiries to: JESSICA MCGHIE
Direct Line: 0141 211 3019
Email: Jessica.mcghie@nhs.scot

Dear Sir/Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: SEAN MCGUIRE **D.O.B: 01/12/1983**

Thank you for your request received **1st June 2026** in which you seek a copy of your client's personal information.

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

QUEEN ELIZABETH UNIVERSITY HOSPITAL – NEW VICTORIA INFIRMARY – WEST AMBULATORY CARE HOSPITAL
PLEASE NOTE ANY RADIOLOGY WILL FOLLOW VIA EMAIL LINK

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

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

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

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

- Emails

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

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

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

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

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

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

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

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

Yours sincerely

Legal Aspects Team

ELECTRONIC PATIENT RECORDS

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

Including:

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

NHS Greater Glasgow and Clyde

Specialty: General Medicine

Nursing Admission Documentation eForm - Version 1.0 RC 0.1

Hospital Name: Southern General Hospital

Patient Details		GP Details	
Name:	SEAN, MAGUIRE	**Name:**	KENNEDY, IAIN
Address:	1/2 321 Shieldhall Road Glasgow Lanarkshire	**Address:**	(40718) Ashton House 3 Ashton Road Glasgow G12 8SP
Postcode:	G51 4HB	**Telephone:**	
Correspondence Address 1:		**Ward:**	20
Correspondence Address 2:		**Date of Admission:**	22/02/2013
Correspondence Postcode:		**Time:**	02:20
Telephone:	NONE GIVEN	**Admitting Consultant:**	Dr Blythe
Patient Contact Number:		**Expected Date Of Discharge**	
CHI Number:	0112836097	**Admitting Nurse:**	Gillian Lillis
CRN:	51411493W, SG03153072, SG00756471, ZM0165561, ZRV1	**Consent:**	Yes
D.O.B:	01/12/1983	**Sensitivity:**	Sensitive
Age:	29		
Sex:	Male		

Next of Kin / Person to Notify

	Next of Kin	Person to Notify
Name:	MADGE MCGUIRE	
Address:		
Landline:		
Mobile:	882 0453	
Relationship:	MOTHER	
OK aware of admission:	No	**Consent for information to be given to relatives:** Yes
Nominated family contact - Day:		**Night:**
Does the patient have an appointed Welfare Guardian / Power of Attorney?		

1. Presenting Complaint / Diagnosis

INTENTIONAL OVERDOSE: 26 X 500MG PARACETAMOL
28 X 400MG IBUPROFEN
40MG CODIENE
ONGOING SUICIDAL IDEATION. FEELS WORTHLESS.

2.Patient Allergy Summary

3. Observations

Cannard:		**Pulse:**	115	**BP:**	125/58
Waterlow (if required):		**Resp:**	17	**SaO2:**	98
EWS:	0	**Temp:**	36.4	**BM:**	
Height(m):		**Weight(kg):**		**BMI:**	
Urinalysis:				**AMT4 Score:**	

4 Current Medication

NIL REGULAR

Medicines reconciled on admission?

5. Relevant Past Medical History

PREVIOUS OD

6. Risk Assessment

Patient's BMI	>20
Has the patient had unplanned weight loss?	< 5%
Will the patient have a significantly reduced diet intake over the next 5 days?	N/A
MUST Score	0
If MUST score 1 or more complete Nutrition Profile.	

Has the patient fallen in the past 6 months? No **Cannard Screening Completed?** No

7. MRSA Screening

Has the patient ever had a previous positive MRSA result?	No
Has the patient been admitted from a care home/institutional setting or another hospital?	No
Does the patient have a wound/ulcer or invasive device which was present prior to admission?	No

Has patient is to be admitted to any of the following:

Orthopaedics	No	**Vascular**	No	**Renal**	No	**Critical Care**	No

MRSA Lab Test Results

Nose	No	**Perineum**	No	**Throat**	No	**Other**	No	**Patient refused**	No

Other details:	
Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD?	No
Infection Control Team contacted?	No

8. Lifestyle

Does the patient smoke?	Yes	**How many each day?**	5
Refer to smoking cessation clinic?	No	**Referral made to Smoking Cessation Services?**	No
Does the patient use recreational drugs?	No		
How often does patient have 8 or more drinks on one occasion?			Daily or almost daily
FAST Tool completed?			Yes

9. Admission Documentation completed by

Name: Gillian Lillis **Designation:** Registered Nurse **Date:** 22/02/2013

13. Action List

Action	Yes/No	Date
Waterlow completed?	NA	
Nutrition Profile Completed?	NA	
Infection Control Team contacted?	NA	
Referral made to Smoking Cessation Service?	NA	
Alcohol Screening and Assessment Tool completed?	Yes	22/02/2013
Interpreter arranged?	NA	
al Care Bundle implemented?	NA	
Wound Assessment chart completed?	NA	
Pressure Ulcer Record completed?	NA	
Moving and handling plan completed?	NA	
Bed rail assessment completed?	NA	
Current Care / Support arrangements suspended?	NA	
Cannard screening completed?	NA	

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Southern General Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 201 1456
Fax: 0141 232 7588
Email:

Date Completed: 22/04/2013

Consultant: Dr Malcolm Gordon

IM Kennedy
Ashton Medical Practice
Ashton House
3 Ashton Road
Glasgow
Glasgow
G12 8SP

Dear IM Kennedy

Re: **Maguire Sean** DOB: **01/12/1983** CHI: **0112836097**
1/2 321 Shieldhall Road
Glasgow G51 4HB

Attended on: **22/04/2013 at 00:16 hrs.** Departed on: **22/04/2013 at 01:39 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **5**

Presenting complaint
assaulted

Nursing Assessment:
brought in by police, ? assault ? head injury ? loc intoxicated? gcs 14 (confused) pearl size 4

Investigations in ED:
1. XR Mandible

Diagnosis:

Diagnosis	Side	Site
Acute Alcohol intoxication - With injury		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Brought in by Police. Apparently has been drinking alcohol all day. Claims he was assaulted and punched on chin. o/e cooperative, GCS 15/15, perla, contusion of chin noted. no focal neurology. x-ray of madible - no obvious fracture seen. discharged home with police. Written head injury instructions provdied. Has a responsible adult at home.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Mohammed Hanif
Doctor

Copies to:

1. IM Kennedy (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Southern General Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 201 1456
Fax: 0141 232 7588
Email:

Date Completed: 22/02/2013

Consultant: Dr Jason Long

IM Kennedy
Ashton Medical Practice
Ashton House
3 Ashton Road
Glasgow
Glasgow
G12 8SP

Dear IM Kennedy

Re: **Maguire Sean** DOB: **01/12/1983** CHI: **0112836097**
1/2 321 Shieldhall Road
Glasgow G51 4HB

Attended on: **21/02/2013 at 22:26 hrs.** Departed on: **22/02/2013 at 01:58 hrs.**
Discharge Type: **02 - Admitted** Destination: **Admission to same NHS healthcare provider**

Previous ED Attendance in last 12 months: **3**

Presenting complaint
overdose

Nursing Assessment:
999 call has taken unknown amount of paracetamol, co-codomol 8/500 and ibuprofen at around 2030hrs tonight. denies alcohol.

Investigations in ED:

1. Amylase	**2. CRP**	**3. Urea and Electrolytes**
4. Bicarbonate	**5. LFT**	**6. Glucose**
7. Full Blood Count	**8. Coagulation screen**	**9. Salicylate**
10. Paracetamol		

Diagnosis:

Diagnosis	Side	Site
Deliberate self poisoning by nonopioid analgesics, antipyretics and antirheumatics		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
deliberate significant paracetamol and ibuprofen overdose in context of acute alcohol ingestion admitted for N-acetylcystiene and psych review

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

Yours sincerely,
Claire Tobin
Doctor

Copies to:
1. IM Kennedy (GP)

School Address:

VICTORIA INFIRMARY
LANGSIDE ROAD
GLASGOW G42 9TY
Accident & Emergency Dept
Phone (0141) 201 5130 Fax (0141) 636 5608

DR. GORDON GM MARTIN
MARYHILL HEALTH CENTRE
41 SHAWPARK STREET
GLASGOW

G20 9DR
0141 531 8830

Dear Dr. GORDON GM MARTIN,

Your Patient
Name : SEAN MCGUIRE
DOB : 01/12/1983
Address : 321 SHIELDHALL ROAD
FLAT 1/2
GLASGOW
LANARKSHIRE
G51 4HB

Consultant : DR JOHNATHAN GORDON

Account # : AE0091535/12 Unit # : SG03153072 CHI # : 011

Attended at : 0102 on 20/10/2012
Left A&E at : 0150 on 20/10/2012

Reason for Visit : INTOX ABDO PAINS AND HEADACHE

Diagnosis :

Investigations :

Treatments :

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given :

Additional Notes:

Follow Up :

Yours sincerely

DR.

If you require any further information please quote this attendance number: AE00

SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW G51 4TF
Accident & Emergency Dept
Phone (0141) 201 1456 Fax (0141) 201 2997

DR. GORDON GM MARTIN
MARYHILL HEALTH CENTRE
41 SHAWPARK STREET
GLASGOW

G20 9DR
0141 531 8830

Dear Dr. GORDON GM MARTIN,

Your Patient
Name : SEAN MCGUIRE
DOB : 01/12/1983
Address : 321 SHIELDHALL ROAD
FLAT 1/2
GLASGOW
LANARKSHIRE
G51 4HB

Consultant : DR PHIL MUNRO

Account # : AE0080850/12 Unit # : SG03153072 CHI # : 011

Attended at : 0151 on 15/09/2012
Left A&E at : 0340 on 15/09/2012

Reason for Visit : FOUND LYING ON STREET

Diagnosis : Renal Colic : NOT APPLICABLE : ---

Investigations :

Treatments :

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given :

Additional Notes:
admitted to urology bed with history strongly suggesting renal colic, with family history of renal colic

Follow Up :

Yours sincerely

DR. KEITH MCKILLOP

If you require any further information please quote this attendance number: AE00

SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW G51 4TF
Accident & Emergency Dept
Phone (0141) 201 1456 Fax (0141) 201 2997

DR. IAN IR STRUTHERS
ASHTON MEDICAL PRACTICE
ASHTON HOUSE
3 ASHTON ROAD
GLASGOW
GI2 8SP
0141 339 7266

Dear Dr. IAN IR STRUTHERS,

Your Patient
Name : SEAN MAGUIRE
DOB : 01/12/1983
Address : 321 SHIELDHALL ROAD
FLAT 1/2
GLASGOW
LANARKSHIRE
G51 4HB

Consultant : DR JASON LONG

Account # : AE0057262/12 Unit # : SG00756471 CHI # : 011

Attended at : 0443 on 01/07/2012
Left A&E at : 0600 on 01/07/2012

Reason for Visit : INTOXICATED

Diagnosis : See Additional Notes : NOT APPLICABLE : See Add

Investigations :

Treatments :

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given :

Additional Notes:
INTOXCIATED CAME BY AMBULANCE. WANTED TO BE ALLOWED TO SLEEP. ASKED TO LEAVE.

Follow Up : NIL

Yours sincerely

DR. MOHAMED CHEKROUD

If you require any further information please quote this attendance number: AE00

SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW G51 4TF
Accident & Emergency Dept
Phone (0141) 201 1456 Fax (0141) 201 2997

DR. IAN IR STRUTHERS
CARDONALD MEDICAL CENTRE
1831 PAISLEY ROAD WEST
GLASGOW

G52 3SS
0141 892 2551

Dear Dr. IAN IR STRUTHERS,

Your Patient	Name	: SEAN MAGUIRE
	DOB	: 01/12/1983
	Address	: 321 SHIELDHALL ROAD FLAT 1/2 GLASGOW LANARKSHIRE G51 4HB

Consultant : DR NICOLA LITTLEWOOD

Account # : AE0002146/10 Unit # : SG00756471 CHI # : 011

Attended at : 2340 on 07/01/2010
Left A&E at : 0150 on 08/01/2010

Reason for Visit : COLD SX

Diagnosis : See Additional Notes : NOT APPLICABLE : See Add

Investigations :

Treatments :

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given :

Additional Notes:
PRESENTED INTOXICATED WITH ALCOHOL CLAIMING TO BE COLD. PHONED AMBULANCE. WELL. OBS SATISFACTORY. UNABLE TO TELL ME WHY HE WAS HERE. DISCHARGED WITH ADVICE.

Follow Up : DISCHARGED HOME

Yours sincerely

DR. ROBBIE CUMMING

If you require any further information please quote this attendance number: AE00

SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW G51 4TF
Accident & Emergency Dept
Phone (0141) 201 1456 Fax (0141) 201 2997

DR. GORDON GM MARTIN
MARYHILL HEALTH CENTRE
41 SHAWPARK STREET
GLASGOW

G20 9DR
01415318830

Dear Dr. GORDON GM MARTIN,

Your Patient
Name : SEAN MCGUIRE
DOB : 01/12/1983
Address : 321 SHIELDHALL ROAD
FLAT 1/2
GLASGOW
LANARKSHIRE
G51 4HB

Consultant : DR JASON LONG

Account # : AE0088678/09 Unit # : SG03153072 CHI # : 011

Attended at : 1957 on 10/10/2009
Left A&E at : 2350 on 10/10/2009

Reason for Visit : FALL

Diagnosis : Acute Neck Sprain : NOT APPLICABLE : Neck

Investigations : Chest X-Ray
: Cervical Spine

Treatments :

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given :

Additional Notes:
PT CLAIMS TO HAVE FALLEN DOWN A FLIGHT OF STAIRS. VERY UNCOOPERATIVE AND HISTORY CHANGED CONSISTENTLY AS DID EXAMINATION FINDINGS. WAS IMMOBILISED AS POSSIBLE NEUROLOGICAL DEFICIT IN RIGHT HAND. ADMITTED UNDER ORTHO FOR FURTHER INVESTIGATION.

Follow Up :

Yours sincerely

DR. DAVID FINN

If you require any further information please quote this attendance number: AE00

SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW G51 4TF
Accident & Emergency Dept
Phone (0141) 201 1456 Fax (0141) 201 2997

DR. IAN IR STRUTHERS
CARDONALD MEDICAL CENTRE
1831 PAISLEY ROAD WEST
GLASGOW

G52 3SS
0141 892 2551

Dear Dr. IAN IR STRUTHERS,

Your Patient

Name : SEAN MAGUIRE
DOB : 01/12/1983
Address : 321 SHIELDHALL ROAD
FLAT 1/2
GLASGOW
LANARKSHIRE
G51 4HB

Consultant : DR PHIL MUNRO

Account # : AE0027926/09 Unit # : SG00756471 CHI # : 011

Attended at : 1621 on 30/03/2009
Left A&E at : 1956 on 30/03/2009

Reason for Visit : ? RIGHT MIDDLE FINGER INJURY

Diagnosis : Closed Fracture : RIGHT : Finger-

Investigations :

Treatments :

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given :

Additional Notes:
?FRACTURE RIGHT MIDDLE MC, MIDSHAFT ON XRAY. CLINICALLY CAN'T EXTEND PIPJ.
BUDDY STRAPPED AND REFERRED TO FRACTURE CLINIC.

Follow Up :

Yours sincerely

DR. RICHARD EARL

If you require any further information please quote this attendance number: AE00

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Dr. IM Kennedy
Ashton Medical Practice
Ashton House
3 Ashton Road
Glasgow
G12 8SP

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

Main Switchboard: 0141 201 1100

Date of Completion: 22/03/2013

Email Enquiries to:
Contact Tel Details: 0141 201 1401

Highly Sensitive: No
Consent for Sharing Withheld: No

Dictated: 11/03/2013
Transcribed: 21/03/2013

Dear Dr. IM Kennedy,

Patient

Name:	Maguire Sean
CHI:	0112836097
DOB:	01/12/1983
Address:	1/2 321 Shieldhall Road
	Glasgow
	G51 4HB
Long Term Conditions:	

Admission

Admitted:	22/02/2013 01:58
Discharged:	23/02/2013 15:30
Admission Type:	In Patient
Discharge to:	Private Residence - living with relatives or friends
Consultant:	Dr Dan Lassman
Specialty:	General Medicine

Reason for Admission: Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis

Clinical Comments:

ADMITTED – 21 02 13

DISCHARGED – 23 02 13

DIAGNOSIS – intentional overdose of Paracetamol, Ibuprofen, Codeine

DISCHARGE MEDS – nil

FOLLOW UP – nil

This 29 year old gentleman took an overdose as above. He has a background of low mood and alcohol excess and was treated with Parbinex and Parvolex and made an uneventful recovery.

He was reviewed by psychiatry liaison and by the addiction liaison team who advised him regarding his alcohol intake but felt he was low risk for alcohol withdrawal or suicide and he was allowed home.

Yours sincerely,
Dr Dan Lassman
Consultant

cc. 1. Dr. IM Kennedy

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

0141 201 1100

ORTHOPAEDIC DEPARTMENT

Typed: 19/09/11
CHI: 0112836097

DR IAN IR STRUTHERS
CARDONALD MEDICAL CENTRE
GLASGOW
:52 3SS

Dear Dr Struthers,

SEAN MAGUIRE DOB: 01/12/83 (SG00756471)
321 SHIELDHALL ROAD, FLAT 1/2, GLASGOW, G51 4HB

Consultant: COLIN WALKER

Admitted: 23/07/11

Discharged: 23/07/11

Diagnosis: Head injury

Procedures: Neurological observations

Follow Up: None

'ours sincerely

Simon Spencer
Orthopaedic Registrar

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

0141 201 1100

ORTHOPAEDIC DEPARTMENT

Typed: 15/10/09
CHI: 0112836097

DR GORDON GM MARTIN
MARYHILL HEALTH CENTRE
GLASGOW
;20 9DR

Dear Dr Martin

SEAN MCGUIRE DOB: 01/12/83 (SG03153072)
321 SHIELDHALL ROAD, FLAT 1/2, GLASGOW, G51 4HB

Consultant: MARC BRANSBY-ZACHARY

Admitted: 11/10/09

Discharged: 11/10/09

Diagnosis: Head Injury

Procedures: Observation

Follow Up: Not arranged routinely

Yours sincerely

Mr T Nunn
Specialist Registrar

DEPARTMENT OF UROLOGY
Direct Line: 0141 201 1511
Fax: 0141 201 2987

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

0141 201 1100

MNA/SP

Typed: 01/11/12

DR GORDON GM MARTIN
MARYHILL HEALTH CENTRE
GLASGOW
G20 9DR

Dear Dr Martin

JEAN MCGUIRE DOB: 01/12/83 (SG03153072) CHI: 0112836097
321 SHIELDHALL ROAD, FLAT 1/2, GLASGOW, G51 4HB

Admitted: 15/09/12
Discharged: 15/09/12
Inpatient
Diagnosis: abdominal pain
Follow up: nil

This gentleman was admitted with right flank pain. His bloods were normal as was his urinalysis. His abdomen was soft and non-tender. His CT/KUB showed no evidence of any renal tract calculi but an incidental finding of bilateral duplex kidneys. It also mentioned that he had quite a lot of faecal loading but otherwise was fine. His pain settled and he was discharged home. He requires no urology follow-up.

Kind regards

Yours sincerely

Sarah Reid
ST6 in Urology to Mr Gren Oades, Consultant Urological Surgeon

MAGUIRE, SEAN ID:0112836097 23-JUL-2011 04:32:36 GREATER GLASGOW SITE-SGAE ROUTINE RECORD

01-DEC-1983 (27 yr)
Male Caucasian

Room:
Loc:301

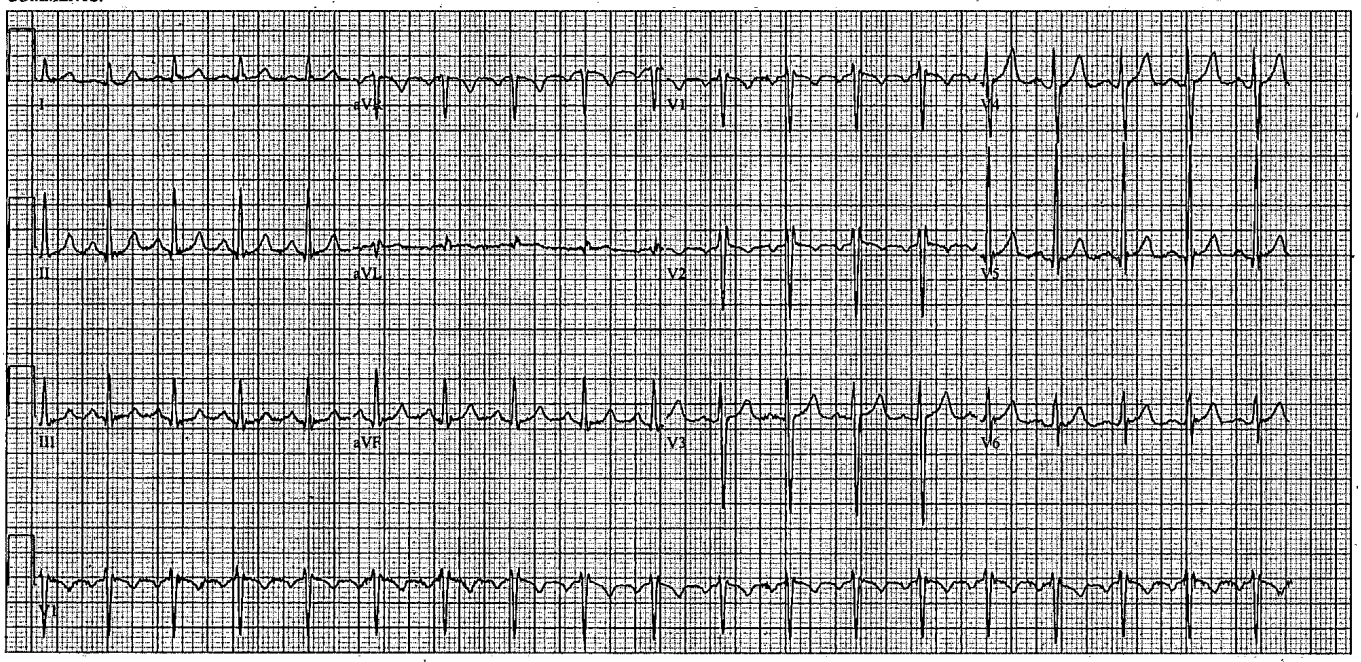
Vent. rate	112	BPM
PR interval	148	ms
QRS duration	88	ms
QT/QTc	312/425	ms
P-R-T axes	70 66	61

Sinus tachycardia
Possible Left atrial enlargement

History:Unknown
Technician:SGH A/E STAFF SGH A/E STAFF
Test ind:

Referred by: UNCONFIRMED ECG REPORT Sys Admin 3

COMMENTS:



25mm/s 10mm/mV 150Hz 7.1.1 12SL 237 CID: 255

SID: 2270133 EID:2003 EDT: 18:37 27-JUL-2011 ORDER:

XR Orthopantomogram full

Performed	22-Apr-2013 00:59	Received	22-Apr-2013 16:18
Reported	22-Apr-2013 15:56	Order Number	G405H27886260
Status	Final	Source System	MiSys

XR Mandible Final
Sean Maguire
Clinical History :
Punched and face. Tender. Exclude fracture.

XR Mandible :
No fracture demonstrated.

XR Orthopantomogram full :
No fracture demonstrated.

Reported by: Kirsteen Graham
Verified by: Kirsteen Graham

XR Mandible

Performed	22-Apr-2013 00:59	Received	22-Apr-2013 16:18
Reported	22-Apr-2013 15:56	Order Number	G405H27886259
Status	Final	Source System	MiSys

XR Mandible Final
Sean Maguire
Clinical History :
Punched and face. Tender. Exclude fracture.

XR Mandible :
No fracture demonstrated.

XR Orthopantomogram full :
No fracture demonstrated.

Reported by: Kirsteen Graham
Verified by: Kirsteen Graham

CT Urinary tract

Performed	15-Sep-2012 11:59	Received	15-Sep-2012 14:13
Reported	15-Sep-2012 13:51	Order Number	G405H27258098
Status	Final	Source System	MiSys

CT Urinary tract Final
Sean Maguire
Clinical History :
Severe right flank pain with trace of blood in urine. Strong family history of renal stones. Colicky pain for 2-3 days. Renal stones?

CT Urinary tract :
Unenhanced volume acquisition through the abdomen and pelvis.

Both kidneys are of duplex morphology but are uncomplicated. No calculi seen in the kidneys, ureters or bladder. Several tiny calcific foci in the pelvis lie outwith the ureters. No abnormality of the remaining visualised unenhanced solid organs. There is faecal loading of the whole colon. No abdominal or pelvic adenopathy. No free fluid.

Extreme lung bases are clear. No bony abnormality.

Conclusion: No evidence of renal tract calculi. Incidental uncomplicated bilateral duplex kidneys. Only potentially relevant positive finding is faecal loading throughout the colon.Appendix is outlined and normal.

Reported by: Dr Claire McArthur (SpR) and Dr Robert Shaw
Verified by: Dr Robert Shaw

XR Chest

Performed	15-Sep-2012 02:43	Received	19-Sep-2012 11:45
Reported	19-Sep-2012 11:23	Order Number	G405H27258011
Status	Final	Source System	MiSys

XR Chest Final
Sean Maguire
Clinical History : Severe right sided chest pain.

XR Chest : The heart size is not enlarged. No focal active lung lesion seen.

Reported by: Dr John Morrison
Verified by: Dr John Morrison

US Testes

Performed	05-Mar-2010 15:41	Received	11-Mar-2010 16:11
Reported	11-Mar-2010 15:51	Order Number	G405H13591082
Status	Final	Source System	MiSys

US Testes Final
Sean Maguire
Clinical History : ? Lump right testis.

US Testes :

Sonographer scan.

Both testes normal. There is slight enlargement of the right epididymis, particularly the tail and this maybe inflammatory in nature. No other scrotal lesion identified.

Reported by: DR GDK URQUHART and BLANK CLINICIAN
Verified by: DR GDK URQUHART

XR Pelvis

Performed	10-Oct-2009 20:23	Received	14-Oct-2009 15:46
Reported	14-Oct-2009 15:25	Order Number	G405H13258267
Status	Final	Source System	MiSys

XR Chest Final
Sean Maguire
Clinical History : Fell downstairs. Tender cervical spine, lower thoracic and upper lumbar spine. Tender abdomen and pelvis. Pelvic fracture? Tachycardia.

XR Chest : AP supine.

The lungs appear clear. Normal cardiac and mediastinal contour. No abnormality is seen in the bony thorax.

XR Cervical spine : No evidence of fracture or dislocation.

XR Lumbar spine : The examination includes the lower thoracic spine to the level of T8/9. No evidence of fracture or dislocation.

XR Pelvis : No fracture demonstrated.

Reported by: DR C CAMPBELL and BLANK CLINICIAN
Verified by: DR C CAMPBELL

XR Lumbar spine

Performed	10-Oct-2009 20:23	Received	14-Oct-2009 15:46
Reported	14-Oct-2009 15:25	Order Number	G405H13258266
Status	Final	Source System	MiSys

XR Chest Final
Sean Maguire
Clinical History : Fell downstairs. Tender cervical spine, lower thoracic and upper lumbar spine. Tender abdomen and pelvis. Pelvic fracture? Tachycardia.

XR Chest : AP supine.

The lungs appear clear. Normal cardiac and mediastinal contour. No abnormality is seen in the bony thorax.

XR Cervical spine : No evidence of fracture or dislocation.

XR Lumbar spine : The examination includes the lower thoracic spine to the level of T8/9. No evidence of fracture or dislocation.

XR Pelvis : No fracture demonstrated.

Reported by: DR C CAMPBELL and BLANK CLINICIAN
Verified by: DR C CAMPBELL

XR Chest

Performed	10-Oct-2009 20:23	Received	14-Oct-2009 15:46
Reported	14-Oct-2009 15:25	Order Number	G405H13258264
Status	Final	Source System	MiSys

XR Chest Final
Sean Maguire
Clinical History : Fell downstairs. Tender cervical spine, lower thoracic and upper lumbar spine. Tender abdomen and pelvis. Pelvic fracture? Tachycardia.

XR Chest : AP supine.

The lungs appear clear. Normal cardiac and mediastinal contour. No abnormality is seen in the bony thorax.

XR Cervical spine : No evidence of fracture or dislocation.

XR Lumbar spine : The examination includes the lower thoracic spine to the level of T8/9. No evidence of fracture or dislocation.

XR Pelvis : No fracture demonstrated.

Reported by: DR C CAMPBELL and BLANK CLINICIAN
Verified by: DR C CAMPBELL

XR Cervical spine

Performed	10-Oct-2009 20:23	Received	14-Oct-2009 15:46
Reported	14-Oct-2009 15:25	Order Number	G405H13258265
Status	Final	Source System	MiSys

XR Chest Final
Sean Maguire
Clinical History : Fell downstairs. Tender cervical spine, lower thoracic and upper lumbar spine. Tender abdomen and pelvis. Pelvic fracture? Tachycardia.

XR Chest : AP supine.

The lungs appear clear. Normal cardiac and mediastinal contour. No abnormality is seen in the bony thorax.

XR Cervical spine : No evidence of fracture or dislocation.

XR Lumbar spine : The examination includes the lower thoracic spine to the level of T8/9. No evidence of fracture or dislocation.

XR Pelvis : No fracture demonstrated.

Reported by: DR C CAMPBELL and BLANK CLINICIAN
Verified by: DR C CAMPBELL

XR Fingers Rt

Performed	30-Mar-2009 18:54	Received	31-Mar-2009 17:26
Reported	31-Mar-2009 17:06	Order Number	G405H12863730
Status	Final	Source System	MiSys

XR Fingers Rt Final
Sean Maguire
Clinical History : Staved right middle finger 3 days ago. Cannot extend PIPJ. Query fracture.

XR Fingers Rt : There is a bony fragment seen volarly adjacent to the base of the middle phalanx of the right middle finger. This is in keeping with a volar plate injury.

Reported by: DR GO CLARKE
Verified by: DR GO CLARKE

MANUAL PATIENT RECORDS

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

Including:

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

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS TRUS
SOUTHERN GENERAL HOSPITAL

RTHO

IAL

NOT TO BE HANDLED BY PATIENTS OR
UNAUTHORISED PERSONS

SOUTHERN GENERAL HOSPITAL NHS TRUST 1

SURNAME (Block Letters)	FIRST NAME	UNIT No.
MAGUIRE	SEAN	756471

ADDRESS	OCCUPATION	SEX	DATE OF BIRTH
197 GLENDOCH RD GLASGOW G52 4RF.		M	01/2/83

PHONE No. 882 0253

NEXT OF KIN (Name and Address)

CHANGE OF ADDRESS
321 SHIELDHALL ROAD
FLAT 1/2
GLASGOW G51 4HB

PHONE No.

NAME AND ADDRESS OF OWN DOCTOR
DR BARNES
DALMELLINGTON RD.
GLASGOW G53 7FY 883-8887.

CHANGE OF ADDRESS

PHONE No.

NAME AND ADDRESS OF OWN DOCTOR G52 2551
STRUTHERS
1831 PAISLEY RD WEST
GLASGOW G52 3SS

BLOOD GROUP

SENSITIVITY

UNIT CASE RECORDS

GENERAL		ORTHOPAEDIC	✓
INSTITUTE		PODIATRY	
MATERNITY		PSYCHIATRIC	
SPINAL			

INDEX OF ATTENDANCES

Every NEW out-patient attendance, and EACH in-patient admission must be noted below

DATE	CLINIC / WARD	DOCTOR	DIAGNOSIS / OPERATION	CODED	DISCH. DATE
19/12/00	HAND INJ	MBZ			
11/12/02	Ward 2	CRLD.	CRUSH INJURY (R) HAND. HIGH ELEVATION		12/12/02
28-1-03	#	WALKER	DNA.		
27.8.07	Urol op	Momsen			
30/9/07	W02	PATIL	? C SPINE INJURY. OBSERVATION.		30/9/07
31/3/09	PLASTER	Walker.			
23.7.11	WARD 1	WALKER	HEAD INJURY OBSERVATION		23/7/11

USE RED INK FOR NOTIFICATION OF DEATH. ALL OTHER ENTRIES IN BLACK

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

0141 201 1100

ORTHOPAEDIC DEPARTMENT

Typed: 19/09/11
CHI: 0112836097

DR IAN IR STRUTHERS
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr Struthers,

SEAN MAGUIRE DOB: 01/12/83 (SG00756471)
321 SHIELDHALL ROAD, FLAT 1/2, GLASGOW, G51 4HB

Consultant: COLIN WALKER

Admitted: 23/07/11

Discharged: 23/07/11

Diagnosis: Head injury

Procedures: Neurological observations

Follow Up: None

Yours sincerely

Simon Spencer
Orthopaedic Registrar

L 2718 01/56 756471

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

Monica

REFERRAL TO

Urology CB
G General Referral

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

Southern General Hospital

— **Hospital** and **hospital address**

Hospital location code. G405H

Email address -

Urgency of referral **Urgent** Lump in scrotum

PATIENT DETAILS

Surname	Maguire
Forename(s)	Sean
Title	Mr
Sex	Male
Date of birth	01-Dec-1983
CHI no.	0112836097

Patient's address

1/2 321 Sheildhall Rd
GLASGOW
G51 4HB

Contact number(s) -

SEEN BY GP DETAILS

Name	Dr IR Struthers		
GMC code	1352935	GP code	G09253
Practice name	Dr Struthers		
Practice code	52378		

Practice address

Cardonald Medical Centre
1831 Paisley Road West
Glasgow G52 3SS

Contact number(s)

Voice: 0141 892 2551
Facsimile: 0141 892 2553

REFERRING PRACTITIONER DETAILS

Name	Dr. Ian Struthers		
GMC code	1352935	GP code	09253
Practice name	CARDONALD MEDICAL CENTRE (52378)		
Practice code	52378		

Practice address

1831 PAISLEY ROAD WEST
GLASGOW

Contact number(s)

Voice: 0141 892 2551
Facsimile: 0141 892 2553

1/8

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Lump in scrotum

Date of onset: 15-Aug-2007

Comment: Dear Doctor,

This 23 year-old man is new to my medical practice and I do not have his previous medical records. He presents with a lump in the right side of his scrotum which he says has been present for three months. He tells me this was investigated at the Western Infirmary and he was reassured but he was increasingly concerned because the lump did not appear to be disappearing. Certainly there was a palpable lump in the scrotum which appeared to be a thickened right epididymus and possible epididymal cyst but I would be grateful for your reassurance that no serious pathology is being overlooked.

As yet I have no details of his past medical history but currently he is taking no current drug therapy.

Thank you for seeing him.

Yours sincerely,

Dr. Ian Struthers

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Moderate drinker - 3-6u/day:		25-Jun-2007

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history - please ensure inappropriate and irrelevant codes are deleted

Family conditions (High and medium priority - all)

Description	Modifier	Extension	Date Recorded
Family history	-	no family history	25-Jun-2007

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

No current medications recorded

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

No recent medications recorded

Clinical warnings Smoking status Alcohol consumption

Additional relevant information - please ensure inappropriate and irrelevant codes are deleted

Administrative information

Referred By:Seen by GP

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

urgent

NHS Greater Glasgow & Clyde
Acute Services Division

NHS
Greater Glasgow and Clyde

URGENT REFERRAL TRACKING – Outpatient Clinic Outcome Form

Section A – to be completed by Medical Records staff.
Please complete section below with date of referral, outpatient appointment and patient

SG00756471
SEAN MAGUIRE
321 SHIELDHALL ROAD
FLAT 1/2
GLASGOW 01/12/1983
G51 4HB CHI 0112836097

Date of Urgent Referral: 15/8/07

Date of Outpatient Appointment: _____

Clinic: _____

Section B – to be completed by Clinician

Please indicate status of referral following today's appointment by ticking the appropriate box:

OPCAT1	☐	Not cancer
OPCAT2	☐	Cancer not suspected - for routine review/investigation/treatment
OPCAT3	☐	Cancer not likely but further *urgent* investigations required to exclude it
OPCAT4	☐	Cancer suspected, for urgent investigations/follow-up appointment
OPCAT5	☐	Cancer diagnosed (clinical/imaging/cytological/histological diagnosis)
OPCAT6	☐	Cancer diagnosed and treatment commenced (eg hormones prescribed)

Please add any additional comments below:

Clinician - Please return the completed form to the nominated clinic nurse.
Clinic Nurse/Co-ordinator - Please collate these forms and fax them to the Referral Tracking Office, GRI on Ext 29399. If you have any queries, please call the office on Ext 20762.

MR M BRANSBY -ZACHARY FRCS
Orthopaedic Hand & Upper Limb Service

DOCTOR'S LETTER SHEET

UNIT NUMBER

Our ref: MB-Z/CC
Enquiries: Mrs Cant
Telephone: DIRECT LINE 0141 201 1473

30 November 1999

Dr Graham
14 Hillington Road South
GLASGOW
G52 2AA

Dear Dr Graham

SEAN MAGUIRE DOB 1.12.83
97 GLEDDOCH ROAD, GLASGOW (UNIT NUMBER: 756471)

Diagnosis: Undisplaced fracture waist right scaphoid

This 16 year old boy was playing football on 21 November 1999 when he fell saving a ball as the goalkeeper. He sustained an hyperextension injury to his right wrist and attended Accident & Emergency Department the next day. On examination he is extremely tender over the scaphoid and all movements of the wrist are painful. On x-ray the clinical suspicion is confirmed by an undisplaced fracture at the waist of the scaphoid. I have placed him a scaphoid cast and will review him in 6 weeks time with cast off on arrival.

Yours sincerely

ANDREW SHAW FRCS
Orthopaedic Registrar

SOUTHERN GENERAL HOSPITAL
NHS TRUST

3Y

MR M BRANSBY -ZACHARY FRCS
Orthopaedic Hand & Upper Limb Service

DOCTOR'S LETTER SHEET

UNIT NUMBER

Our ref: MB-Z/CC
Enquiries: Mrs Cant
Telephone: DIRECT LINE 0141 201 1473

11 January 2000

Dr Graham
14 Hillington Road South
GLASGOW.
G52 2AA

Dear Dr Graham

SEAN MAGUIRE. DOB 1.12.83
97 GLEDDOCH ROAD, GLASGOW (UNIT NUMBER: 756471)

This young lad is now 6 weeks post scaphoid fracture. On examination out of plaster he is non tender at the wrist and has a surprisingly excellent range of movement here. I have simply reassured him and discharged him from the clinic.

Yours sincerely

JASON ROBERTS FRCS
Orthopaedic Registrar

21/12/00 No dictation

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST
DEPARTMENT OF ORTHOPAEDIC SURGERY
SOUTHERN GENERAL HOSPITAL

3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

MR MARC BRANSBY-ZACHARY FRCS
ORTHOPAEDIC, HAND & UPPER LIMB SERVICE
Seen/dictated: 19 December 2000
Typed: 22 December 2000

Our Ref MTS/MM
Enquiries to Myra McKellar
DIRECT LINE 0141 201 1189

Dr Barnes
230 Dalmellington Road
Crookston
GLASGOW G53 7FY

Dear Dr Barnes

RE: SEAN MAGUIRE 97 GLEDDOCH ROAD GLASGOW
DOB: 01 12 83 UNIT NO: 756471

I reviewed this young boy at the Hand Clinic today. I understand that he injured his left little finger while playing football about eight days ago. His hand was hit by the ball and he thinks it was probably a hyperextension injury that he sustained. He was apparently seen in the A&E Dept at the time and an x-ray was carried out. He was reassured that there was no evidence of any fracture and he was simply treated with buddy strapping. He re-attended the A&E Dept yesterday complaining that the finger was still sore and he was therefore referred to the Hand Clinic.

On review of the hand today he certainly has a little bit of swelling around the PIP joint. He has full extension of the joint. He is tender around all aspects of the joint but most markedly on the medial aspect and over the dorsal area. There is no evidence of any instability. Review of his x-rays did not show any bony injury.

I think he has a simple soft tissue injury. He should be treated with buddy strapping for perhaps another 10 to 14 days. I have advised him on simple exercises for mobility. I would expect his symptoms to gradually settle and I have not made a routine review appointment but he does have an open appointment to attend should he have ongoing problems.

Kind regards.

Yours sincerely

M T Smith FRCS
Staff Grade in Orthopaedics and Rehabilitation Medicine

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR COLIN R C WALKER FRCS
FRACTURE CLINIC

Our Ref: CRW/LM
Enquiries To: Lillian McInnes
DIRECT LINE: 0141 201 1465

Seen & Dict: 17th December 2002
Typed: 19th December 2002

Dr. Barnes
The Surgery
230 Dalmellington Road
Glasgow
G53 7FY

Dear Dr. Barnes

RE: SEAN MAGUIRE, 97 GLEDDOCH ROAD, GLASGOW
DOB: 1/12/83 UNIT NO: 756471

Sean was reviewed a week after having his right arm rolled over by a heavy tyre. He seems to have an ulnar nerve neuropraxia. He has 3/5 power on abduction of the small finger but adduction of the thumb appears normal. He has difficulty flexing any of the fingers of the hand although it doesn't appear weak. He has altered sensation over the volar and dorsal aspects of the small, ring and long fingers but the index and thumb have been spared. He has full passive extension of all the fingers of the left hand. I have asked the Physio to show him some passive and active mobilisation exercise and will review him again in 6 weeks time.

Yours sincerely

Mr C. Walker, FRCS,
Consultant Orthopaedic Surgeon.

28/1/3
DNA
DFA
11/2/03
DNA
Letter GP

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF UROLOGY

DIRECT LINE: 0141 201 1517
UROLOGY FAX: 0141 201 2987

LM/CP

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

0141 201 1100

Clinic Date: 27/08/07
Typed: 28/08/07
CHI: 0112836097

Dr Barnes
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr Barnes

SEAN MAGUIRE DOB: 01/12/83 (SG00756471)
321 SHIELDHALL ROAD, FLAT 1/2, GLASGOW, G51 4HB

This twenty three year old man was seen recently at the clinic. He had noticed some swelling associated with the right testes some three months ago. He has had no particular pain associated with this nor has it changed in size since he was first aware of it.

On examination there is some thickening of the epididymis. Both testes feel normal.

As a precaution I have arranged a scan to exclude any under lying pathology. I will be in contact again when the results of this is available.

Yours sincerely

L Morrison
Associate Specialist in Urology

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF UROLOGY
1345 Govan Road
GLASGOW
G51 4TF

Direct line: 0141-201-1517
Fax: 0141-201-2987
carol.patterson@sgh.scot.nhs.uk

LM/CP/756471
CHI: 0112836097

(Dict) 18th September 2007
(Typed) 19th September 2007

Mr Sean Maguire
97 Gleddoch Road
GLASGOW
G52 4RF

Dear Mr Maguire

Your recent scan has shown no significant abnormality. I have not arranged to see you back at the clinic.

Yours sincerely

L Morrison FRCS
Associate Specialist in Urology

S.G.H./3Y

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

Direct line: 0141-201-1517
Fax: 0141-201-2987
carol.patterson@sgh.scot.nhs.uk

DEPARTMENT OF UROLOGY
1345 Govan Road
GLASGOW
G51 4TF

LM/CP/756471
CHI: 0112836097

(Dict) 18th September 2007
(Typed) 19th September 2007

Dr Barnes
Crookston Medical Centre
230 Dalmellington Road
GLASGOW
G53 7FY

Dear Dr Barnes

SEAN MAGUIRE, DOB: 01/12/1983
97 GLEDDOCH ROAD, GLASGOW G52 4RF

This patient's recent ultrasound shows both testes are normal. The right epididymis is a little prominent but this is not significant. I have not arranged to see him again.

Yours sincerely

L Morrison FRCS
Associate Specialist in Urology

S.G.H./3Y

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MICHAEL HULLIN MA MD FRCS
FRACTURE CLINIC

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Direct Tel: 0141 201 1357

Our Ref: MGH/MJ
Enquiries To: Margaret Nicol

Seen & Dict: 31/03/09
Typed: 02/04/09
CHI: 0112836097

DR IAN IR STRUTHERS
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr

SEAN MAGUIRE DOB: 01/12/83 (SG00756471)
321 SHIELDHALL ROAD, FLAT 1/2, GLASGOW, G51 4HB

This patient attended the fracture clinic today. He sustained a hyperextension injury to his right middle finger playing football in goals.

On examination he has swelling and bruising around the PIP joint and is tender around the volar aspect. He is able to achieve approximately 60 degs. of flexion of the PIP joint and has function of both extensor and flexor tendons.

X rays reveal a volar plate evulsion fracture affecting the base of the middle phalanx.

No intervention is required. Neighbour strapping has been applied and he has been encouraged to mobilise as symptoms allow. General advice has been given as regards to this injury.

Yours sincerely

Michael Mullen
Orthopaedic Registrar

DR. JAMES J. BARNES
DR. WILLIAM M. GRAHAM

DR GRAHAM & DR BARNES
14 Hillington Road South
Glasgow G52 2AA
Telephone: 0141 883 8887
Fax: 0141 892 0629

To: A+E SGH

22/11/99

Re: Sean Maguire 1/12/83
97 Gleddoch Rd
G52

The above 16 yr old injured his wrist (right - dominant hand) at football yesterday (goalkeeper
Initial injury was hyperextension
& he had strained his flexor carpi radialis
& he then fell on outstretched (R) hand -
scaphoid injury possible.
Can you arrange scaphoid wrist views &
follow up?

Many thanks

James Barnes

VT 756471

ACCIDENT / EMERGENCY FORM **TREATMENT CARD**

ACCIDENT & EMERGENCY DEPT.
SOUTHERN GENERAL HOSPITAL NHS TRUST
GLASGOW G51 4TF
TEL: DIRECT: 0141 201 1456/8
SWITCHBOARD: 0141 201 1100
FAX: 0141 201 2997

AE No.

SURNAME	FORENAMES
Maguire	Sean

ADDRESS

POST CODE	TELEPHONE No.	DATE OF BIRTH	SEX	MARITAL STATUS	RELIGION
			M		RC

NEXT OF KIN NAME	RELATIONSHIP	FAMILY DOCTOR SURNAME	INITIALS

ADDRESS	ADDRESS
	HKG

POST CODE	TELEPHONE No.	POST CODE	TELEPHONE No.

ACCIDENT/EMERGENCY DATE OF ATTENDANCE	PREVIOUS ATTENDANCE AT THIS HOSPITAL YES/NO	IN/OUT PATIENT	YEAR

TIME OF ATTENDANCE

MODE OF TRANSPORT
AMBULANCE ______ PUBLIC ______ OWN ______ NONE ______

DATE OF INJURY OR ILLNESS	TIME OF INJURY	TYPE (CODE)	SOURCE OF REFERRAL
			GP A&E ____ GP SPEC. ____ 999 ____ SELF ____ POLICE ____ OTHER (CODE) ____

ROAD TRAFFIC ACCIDENT PLACE

DETAILS
FSP ______ DRIVER ______ M/C DRIVER ______ OTHER ______
BSP ______ PED. ______ M/C PASSENGER ______

REASON FOR ATTENDANCE

	TIME
TRIAGE	1839
DOCTOR	
NURSE	
LEFT DEPT.	

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

Dear Doctor,

The above-named patient attended the Accident & Emergency Department today.

Diagnosis ______

X-Ray film / ECG shows ______

Treatment given ______

Drugs ______ days supply of ______ has been given.

Tetanus Prophylaxis has/has not been administered. TT Course ______ TT Booster ______ HATI ______ (Please Tick)

Would you please arrange ______

DISCHARGE CODES: Please Circle

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

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

Follow Up	Not arranged ______	Arranged ______	To be arranged ______

Clinic Referred to	AE	Hand Injury	Fracture	Pop Check	Ortho	Medical	Surgical	ENT	Others Specify

Medical Officers Name (In Block Letters)	Signature of Medical Officer
Cons SR Reg SHO JHO Clin Assist Staff Grade (please circle)	

SGH 458 0431551

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

SOUTHERN GENERAL HOSPITAL NHS TRU
DEPARTMENT OF RADIOLOGY

99061606 M 22/11/99 XR 0133709 **X-RAY REPORT**

MAGUIRE, Sean 15Y M M, GORDON CAS

97 GLEDDOCH RD, GLASGOW

#30/11

WRIST SCAPHOID
(RIGHT)

NO FRACTURE IS DEMONSTRATED. REPEAT VIEWS IN TEN DAYS ADVISED TO EXCLUDE A SCAPHOID FRACTURE.

*DR J HOWELLS/Dr. L STEWART/CM 23/11/99

23/11/99 - WRIST SCAPHOID

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

DISCHARGE PRESCRIPTION PACKS

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	FREQUENCY	SIGNATURE	GIVEN BY

TRIAGE NOTES

R _____ BP _____ P _____ T _____ BM _____ SpO_2 _____ Expected PEF _____ PEF _____

Urine: Leuco _____ Prot. _____ ph _____ Blood _____ SG _____ Ket. _____ Gluc _____ Nitrites _____

Attended GP today (see attached letter).
Tender over (R) wrist.

SR.

CONSULTANT MUNRO. **SEEN BY** MCINTYRE. **AT (TIME)** 20.10

DATE	CLINICAL NOTES
22.11.99	(16) Playing football yesterday - hyperextension injury right wrist when caught ball, then fell on outstretched (R) hand Attended GP today with wrist pain - ? scaphoid fracture. No analgesia taken. PMH - nil of note. DH - nil. °allergies. O/E - right wrist non swollen tender over distal radius tender over anatomical snuffbox ↓ ROM in wrist.

OPEN BEFORE WRITING

DATE	CLINICAL NOTES
	scaphoid series – no fracture visible – note epiphyses open. Plan – scaphoid cast declined analgesia review 10/7 On discharge, scaphoid POP applied given instruction leaflet Plaster sling and POP check for a.m. SIN A DAVIDSON.
11/11/99.	SCAPHOID POP REMOVED & REPLACED WITH L.W. CAST.

DOCTOR'S LETTER SHEET

UNIT NUMBER

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

0141 201 1100

ORTHOPAEDIC DEPARTMENT

Typed: 10/10/07
CHI: 0112836097

DR IAN IR STRUTHERS
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr Struthers

SEAN MAGUIRE DOB: 01/12/83 (SG00756471)
321 SHIELDHALL ROAD, FLAT 1/2, GLASGOW, G51 4HB

Consultant: SANJEEV PATIL

Admitted: 30/09/07

Discharged: 30/09/07

Diagnosis: Fall - ? C-spine injury

Procedures: CT C-spine - no fracture
Pt took irregular discharge

Follow Up:

Yours sincerely

MS A AUGUSTINE
ORTHOPAEDIC REGISTRAR

Run: 10/10/07-10:42 by DOCHERTY,MARY

S.G.H./3B

ACCIDENT / EMERGENCY FORM — TREATMENT CARD

ACCIDENT & EMERGENCY DEPT.
SOUTHERN GENERAL HOSPITAL NHS TRUST
GLASGOW G51 4TF
TEL. DIRECT: 0141 201 1456/8
SWITCHBOARD: 0141 201 1100
FAX: 0141 201 2997

756421 0

AE No. 00 41137

SURNAME	FORENAMES
~~M~~ Maguire	Dean

ADDRESS: 11 [illegible]

POST CODE	TELEPHONE No.	DATE OF BIRTH	SEX	MARITAL STATUS	RELIGION
[illegible]	5[illegible]	[illegible]	M	S	[illegible]

NEXT OF KIN NAME	RELATIONSHIP	FAMILY DOCTOR SURNAME	INITIALS
	Mother	[illegible]	

ADDRESS	ADDRESS
	[illegible] Drumlarion Road

POST CODE	TELEPHONE No.	POST CODE	TELEPHONE No.

ACCIDENT/EMERGENCY DATE OF ATTENDANCE	PREVIOUS ATTENDANCE AT THIS HOSPITAL YES/NO	IN/OUT PATIENT	YEAR
13/2/05			

TIME OF ATTENDANCE: 09.13

MODE OF TRANSPORT: AMBULANCE _____ PUBLIC _____ OWN _____ NONE _____

DATE OF INJURY OR ILLNESS	TIME OF INJURY	TYPE (CODE)	SOURCE OF REFERRAL
			GP A&E _____ GP SPEC. _____ 999 _____ SELF _____ POLICE _____ OTHER (CODE) _____

ROAD TRAFFIC ACCIDENT PLACE

DETAILS: FSP _____ DRIVER _____ M/C DRIVER _____ OTHER _____ BSP _____ PED. _____ M/C PASSENGER _____

REASON FOR ATTENDANCE: [illegible]

	TIME
TRIAGE	09.13
DOCTOR	
NURSE	
LEFT DEPT.	

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

Dear Doctor,

The above-named patient attended the Accident & Emergency Department today.

Diagnosis

X-Ray film / ECG shows _____

Treatment given Returned to Monitoring Unit.

Drugs _____ days supply of _____ has been given.

Tetanus Prophylaxis has/has not been administered. TT Course _____ TT Booster _____ HATI _____ (Please Tick)

Would you please arrange _____

DISCHARGE CODES: Please Circle

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

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

Follow Up	Not arranged	Arranged	To be arranged
		[illegible]	

Clinic Referred to	AE	Hand Injury	Fracture	Pop Check	Ortho	Medical	Surgical	ENT	Others Specify

Medical Officers Name (In Block Letters) SQUIRES

Cons SR Reg (SHO) JHO Clin Assist Staff Grade (please circle)

Signature of Medical Officer [signature]

SGH 458 0431551

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

DO NOT WRITE OR LEAN HERE PLEASE !

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

DISCHARGE PRESCRIPTION PACKS

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	FREQUENCY	SIGNATURE	GIVEN BY

TRIAGE NOTES

R _____ BP _____ P _____ T _____ BM _____ SpO_2 _____ Expected PEF _____ PEF _____

Urine: Leuco _____ Prot. _____ ph _____ Blood _____ SG _____ Ket. _____ Gluc _____ Nitrites _____

see previous card - still c/o pain + ↓ movement, has been taken analgesia as prescribed. AM.

CONSULTANT MUNRO SEEN BY SMICOS AT (TIME) _____

DATE	CLINICAL NOTES
18/12/00.	17→ hyp ? while playing football ? hyperextension (L) 5th finger Seen Mt - no # on xR report not available yet... Still c/o pain + ↓ movement (R) handed school kid.

OPEN BEFORE WRITING

DATE	CLINICAL NOTES

O/E - swollen (L) 5th P.I.P joint
unable to fully extend at P.I.P
neurovascular intact
ligaments intact

O/W ortho Reg
Xrays r/v. no # seen
? ligament damage

→ Hand Injury Clinic

Becky
SHICOS
Locum

2. 9. 8

ORTHO

Southern General Hospital, Accident & Emergency Department, Glasgow G51 4TF

Tel Direct: 0141 201 1456/8 Switchboard: 0141 201 1100 Fax: 0141 201 2997

Affix Label

NAME: SEAN MAGUIRE AGE: 19 DOB: 01/12/83 CONSULTANT: MALCOLM W G GORDON

UNIT No: SG00756471 Account No: AE0041653/02 DATE: 11/12/02 TIME: 1857

GP Name:	WILLIAM WM GRAHAM GP Phone No: 0141 883 8887
REASON FOR VISIT:	R HAND INJURY
ALERTS:	(1) (2)
ALLERGIES:	(1) PARAMAX (2)
RELEVENT HISTORY:	
MEDICATIONS:	

TRIAGE CATEGORY: STANDARD TRIAGE NURSE: ANDY LETHAM TRIAGE TIME 1904

TRANSCRIBED ANALGESIA :

OBSERVATION TEXT:

FELL AT WORK ONTO R HAND AND HEAVY TYRE ROLLED OVER ON IT.
C/O PAIN OVER ULNAR BORDER OF R HAND AND PAIN OVER DORSUM OF WRIST.

Enter/Edit Vital Signs						Visual Acuity	
DATE	TIME	COMPLETED BY	DATE	TIME	COMPLETED BY	Left-6m	Right-6m

T	36.3		T			Correction Y/N	
HR	89		HR			Weight (kg)	
R	18		R			Breath Alcohol	
BP	105/58		BP			Pain Score	
Sa02	100	ON %	Sa02		ON %		
BG			BG				
PF			PF				
EPF							
E			E				
V			V				
M			M				

DISCHARGE

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

Discharge Date 11/12/02

Discharge Time 2225

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

Follow Up	Not arranged	Arranged	To be arranged

Clinic Referred to	AE	Hand Injury	Fracture	Pop Check	Medical	Surgical	ENT	Others Specify

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

DO NOT WRITE HERE PLEASE !

DATE 11/12/02 CLINICAL NOTES

SEEN BY (DR) [illegible] TIME SEEN 1935

PC R hand + wrist pain

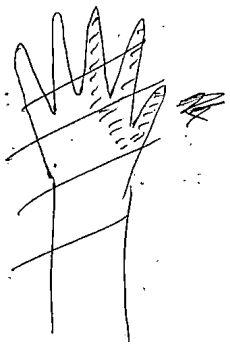
HPC At work 2/7 ago
Fell onto dc Burn R hand
Tyre then rolled over hand (lorry)
Since then has had ↓ ROM wrist
Hand feels numb.

RH dentist -

PMHx Nil

DHx Nil

O/E



palmar aspect

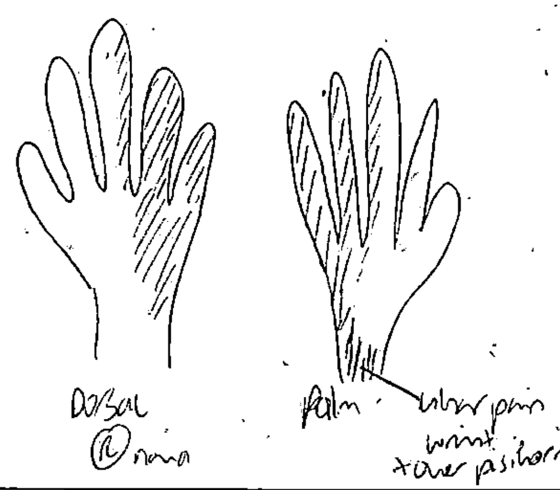
R wrist - able to move in all directions but ROM limited

Tender dorsal radius + ulna
A.B ven - tender

R hand - full ROM all fingers
- Tenderness
- CRT < 2sec

sensation absent over ring + little fingers with some loss on palmar & dorsal aspects as indicated including to sharp sensation with green needle (? C8 dermatome)

DATE	CLINICAL NOTES
	X rays wrist hand - no bony injury
	Imp ? Ulnar nerve crush injury
	Man O/W ortho SHO Dr Leij - will r/v - Thanks
	[signature] SHO
1 2/12	OAB referral - Thanks
	(19) had a tyre roll over his (R) hand 5/7 ago. Carried on c̄ work since then but pain + tingling worsened in his hand.
	∴ Seen today.
	O/E
	C ✓
	S ↓ pins+needles, numbness every few minutes over lateral (ulnar) 2½ fingers + dorsum ulnar aspect of hand
	M - achieving ↓ flex ? (wrist) + ext ? of fingers
	passively ↓ slightly better than active m/m
	XR: Nil bony injury



ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

DISCHARGE PRESCRIPTION PACKS

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	FREQUENCY	SIGNATURE	GIVEN BY

SOUTHERN GENERAL HOSPITAL

7U

MALE

SG00756471
SEAN MAGUIRE
321 SHIELDHALL ROAD
FLAT 1/2
GLASGOW 01/12/1983
G51 4HB CHI 0112836097

UROLOGY DEPARTMENT

Date 27/8/13

MALE

COMPLAINT: Right ureter stent [illegible] when [illegible] Duration

HISTORY: second opinion

Appetite | Weight | Bowels: PMH –

PREVIOUS HISTORY:

Examination by

Tongue | Build | Pulse

Abdomen | B.P.

Genitalia: Hair pubic [illegible]

Prostate: N/S

URINE

Reaction acid/alkaline | R.B.C. | Crystals | Casts

Albumen present/absent: NAD | W.B.C. | Organisms

X-Ray Findings (Summary)

Cystoscopic Findings (Summary)

ANAESTHETIC RECORD

Diagnosis | Disposal

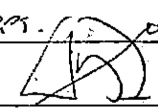
SOUTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST
SOUTHERN GENERAL HOSPITAL

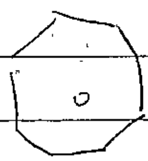
7

Sean Maguire

CLINICAL NOTES

DATE	
11/12/12 Cont'd	Tinel's Test = +ve
	Phalen's Test = +ve
	Palp^n = tender at ulnar position + triquetrum region
	tender over carpal tunnel region + proximally to it
	PMH prev # of (R) ulnar styloid?
	DH nil — Allergic to Paramax.
	SH 0 cig, 21+ units/wk
	Lives c mother, works in garage, (R) handed
	FH nil.
	SE: CVS, RS, GI, GU — nil
	PE 0 JACCOL 0 PERLA
	CVS HR 80bpm
	HS I+II no added
	RS chest clear 0 creps.
	central
	GI — SNT, BS ✓, 0 org/meg
	Imp ? carpal tunnel compression 2° trauma
	?? internal derangement
	?? compartment syndrome





DATE | CLINICAL NOTES (Continued)

Plan Admit
Consent + Mane
Bloods – FBC/UE/CK.
Myoglobinuria – urine sample now
Elevate arm in lanseate splint
Urinalysis
Fasting for MR. Clerk SHO 2353

1/12/08 OLIVER On call reg for Mr Walker
22:5 19y RHD ♂ warehouse worker
5/7 ago lorry tyre 'went over' volar aspect (R) wrist.
No medical attention sought until now
Gradual ↑ discomfort (R) wrist + hand
C/O pain ⊕ middle, ring + small fingers
unable to fully extend them
Altered sens^n ulnar border middle + all of ring + wee fingers
No other injuries, otherwise well.

O/E unclistressed at rest T 36.3°C
No deglaving of skin
Bruising volar aspect wrist. Possible slight wasting in intrinsic muscles of hand.
Strong palpable radial pulse. Unable to palpate ulnar pulse but also difficult on (L). CRT RIGHT hand 3-4SECS. CRT LEFT < 2 secs
Holding ulnar fingers slightly flexed MCP + PIP joints
Active movements: From thumb + index fingers
Almost full flexion middle ring + wee fingers
unable to fully extend these fingers + causes more pain
Unable to passively extend much more due to pain in palm
Has noticed ↑ discomfort on high elevation.

Cont —

SEAN MAGUIRE
1/12/83.

CLINICAL NOTES

DATE	
11/12/02	cont. Good urine O/P, normal colour urine. U&E 4.9, Cr 78; CK (total) 184 XR → No bony injury. Imp ? Establishing ischaemic contracture ? Ulnar nerve neuropraxia. Plan D/W Mr Hallin - Probable neuropraxia - no urgent intervention indicated - elevate on pillow / whichever comfortable - R/V in am.

DATE	CLINICAL NOTES (Continued)

Southern General Hospital, Accident & Emergency Department, Glasgow G51 4TF
Tel Direct: 0141 201 1456/8 Switchboard: 0141 201 1100 Fax: 0141 201 2997

AE0086904/07

NAME: SEAN MAGUIRE
AGE:23 DOB:01/12/83
UNIT No: SG00756471

CONSULTANT: JASON LONG
Account No: AE0086904/07

DATE:28/09/07
TIME: 2251
CHI#:0112836097

GP Name:	IAN IR STRUTHERS GP Phone No: 0141 892 2551 | 12
REASON FOR VISIT:	SEIZURES
ALERTS:	(1) (2)
ALLERGIES:	(1) PARAMAX (2)
RELEVENT HISTORY:	
MEDICATIONS:	

TRIAGE CATEGORY: URGENT TRIAGE NURSE: BARRY BLYTH TRIAGE TIME 2255

TRANSCRIBED ANALGESIA :

OBSERVATION TEXT:

BEEN DRINKING TONIGHT AND FELL DOWN 12 STAIRS HAVING ?SEIZURES WITH LUCID MOMENTS

SOUTHERN GENERAL HOSPITAL
28/09/2007 E-2835398
MAGUIRE, Sean
SGCAS 01/12/1983
CRIS No:423112

Enter/Edit Vital Signs

DATE	TIME	COMPLETED BY	DATE	TIME	COMPLETED BY	Left-6m	Right-6m
28/09/07	2255	NU.BLYBA.					

T	36.5		T				Correction Y/N	
HR	100		HR				Weight (kg)	
R	15		R				Breath Alcohol	
BP	143/51		BP				Pain Score	
Sa02	98	ON 21 %	Sa02		ON %		BM, U, C mmol URINE, NAD.	D
BG			BG					
PF			PF					
EPP								
E			E					
V			V					
M			M					

DISCHARGE CODES: Please Circle
1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other hospital (see below)
5. Died 6. Refer to O.P. Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Discharge Date: 29/9/07
Discharge Time: 02.40

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

Follow Up	Not arranged	Arranged	To be arranged

Clinic Referred to	AE	Hand Injury	Fracture	Pop Check	Medical	Surgical	ENT	Others Specify

SGH 439

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

DO

SEAN MAGUIRE
SG00756471
01/12/83
Date_____ Time_____
Spec./Sig._____

SEAN MAGUIRE
SG00756471
01/12/83 M
Date_____ Time_____
Spec./Sig._____

SEAN MAGUIRE
SG00756471 / 01/12/8
321 SHIELDHALL ROAD
GLASGOW
G51 4HB SEX: M

DIRECTION
FEED THROU
PRINTER

SE!

E-Paced PATIENT REPORT

Time 22:21 Date 28/09/2007

PATIENT AND INCIDENT DETAILS

Incident number	PA0022622307 001
Name	SHAUN MAGUIRE
Age	26
Gender	Male
Incident location	321 SHIELDHALL ROAD SHIELDHALL GLASGOW
Incident post code	G51 4HB
Incident type	EMG
Crew at scene	28/09/2007 21:54
Crew left scene	28/09/2007 22:15
Patient at hospital	28/09/2007 22:19
Receiving hospital and ID	2008H Southern General Hospital

PRIMARY SURVEY

RESPONSE
AVPU: Alert

NOK Mag (Mother)

BREATHING
Respiratory rate: 18

VITAL SIGNS

Time hr:min	Pulse bpm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol/l	Temp °C	SpO2 %	GCS Total	EtCO2 k Pa RTS
22:06		18	-/-						15	

DRUGS, GASES AND PAIN RELIEF

Pain before	Drug / gas given	Time given	Dose given	Route	Rate II No	Pain after
	Oxygen	22:10	15	OR		

PATIENT HANDOVER

On arrival at scene	
Scene	
Transp[illegible]	
Care delivery at hospital	Trolley
Time of handover	22:20

FINAL OBSERVATION AND COMMENTS

PT FELL SINGLE FLIGHT OF STAIRS AND LANDED BACK INTO THE FLAT. UNCONTROLLABLE SHAKING AND SEVERE PAIN AT MID NECK. LIMITED RESPONSE TO PAIN STIMULAS

Report ID	1ea02e76-2ac4-4fd1-c0f6-b091bd9ff48a

Pt collared and boarded on scene

98 36.5

120

14

145/91

DATE	28/9/07	CLINICAL NOTES
	SEEN BY (DR) COLQUHOUN	TIME SEEN 11.15 pm

PC: Fall

HPC: Drinking tonight. Fell down ~ 12 stairs. Denies LOC. Retrograde amnesia + time period? States he has vertigo & diplopia. Mild frontal headache. No vomiting.
C/O C-spine tenderness & lumbar spine tenderness
C/O weakness - lower limbs & numbness left side.
Not C/O anything else.

PMH: "Funny turns" awaiting seizure clinic appointment.

DH: Nil
Allergic to Paramax.

SH: Uses drinking tonight - amount?
Smoker - occasional.

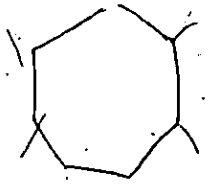
O/E: Temp 36.5, HR 100 reg, RR 15, BP 143/51, O_2 98% on 3L.
GCS 14/15. Is unable to answer where he is or when it is but is orientated in person.
Pupils reactive - left slightly bigger than (N).
No signs of head injury - no blood behind tympanic membrane.

CN - c/o diplopia - no nystagmus.

	RUL	LUL	LLL	RLL
Tone	(N)	(N)	(N)	(N)
Power	5/5	5/5	4/5	4/5
Reflexes	not tested →			
Sensation	(N)	↓	↓	(N)
Plantars			↓	↓

Trachea ↔
Good AE (N) = (CT) nil added.

CV: HS I+II +0



Voluntary guarding & tender throughout but when distracted abdomen completely soft & non-tender BS ✓ (N)

DATE	CLINICAL NOTES

MS : Log roll - tender C-spine / lumbar spine
Tender pelvis.
No other bony tenderness
Having "episodes" in dept - seizures? Looks like pseudoseizures.
Not post-ictal, last a few seconds. Twitching all 4 limbs but stops when shouted at / sternal rub.
Reviewed & examined by Dr. Milne.
For lumbar spine XR, CXR, pelvis XR.
For CT head & neck.
IV access & bloods incl GBS.
ECG - (N) SR
Patient is immobilised.
Patient passed onto Dr. Milne at end of my shift.

N ~ (FY2 ASE)

29/09/07 - Radiology - Provisional Report -
CT Brain - unenhanced scan - No significant abnormality
CT C-Spine. Images partially degraded by motion artefact + streak artefact from dental fillings.
(N) alignment. Incert line seen on sagittal view at top of axis (C2). This may simply be artefact from metalwork however needs should be kept immobilised until can be clinically assessed.
No soft tissue swelling
NAD Full report to follow.

SPR

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

DISCHARGE PRESCRIPTION PACKS

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	FREQUENCY	SIGNATURE	GIVEN BY

Southern General Hospital, Accident & Emergency Department, Glasgow G51 4TF
Tel Direct: 0141 201 1456/8 Switchboard: 0141 201 1100 Fax: 0141 201 2997

6

NAME: SEAN MAGUIRE DATE:30/09/07
AGE:23 DOB:01/12/83 CONSULTANT: JASON LONG TIME: 0154
UNIT No: SG00756471 Account No: AE0087248/07 CHI#:0112836097

GP Name:	IAN IR STRUTHERS GP Phone No: 0141 892 2551	13
REASON FOR VISIT:	NECK PAIN	
ALERTS:	(1) (2)	
ALLERGIES:	(1) PARAMAX (2)	
RELEVENT HISTORY:		
MEDICATIONS:		

TRIAGE CATEGORY: STANDARD TRIAGE NURSE: ELAINE FRASER TRIAGE TIME 0157

TRANSCRIBED ANALGESIA :

OBSERVATION TEXT:

999 CALL PT C/O NECK PAIN
ATTENDED DEPT LAST NIGHT TOOK IRREGULAR DISCHARGE ?# NECK
LIFTING HEAVY OBJECTS AT WORK TODAY
PT HAS HAD ALCOHOL TONIGHT
COLLAR INSITU

Enter/Edit Vital Signs						Visual Acuity	
DATE	TIME	COMPLETED BY	DATE	TIME	COMPLETED BY	Left-6m	Right-6m

T			T			Correction Y/N	
HR			HR			Weight (kg)	
R			R			Breath Alcohol	
BP			BP			Pain Score	
Sa02		ON 21 %	Sa02		ON %		
BG			BG				
PF			PF				
EPF							

E		E	
V		V	
M		M	

SOUTHERN GENERAL HOSPITAL
30/09/2007 E-2835694 CRIS No:423112
MAGUIRE, Sean
SG02 01/12/1983

DISCHARGE CODES: Please Circle
1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other hospital (see below)
5. Died 6. Refer to O.P. Clinic (see below) 7. Irregular Discharge 8. D.O.A. Discharge Time

Ward No. (If admitted) 2	Transfer to Hospital	Consultant (if admitted)

Follow Up	Not arranged		Arranged	To be arranged

Clinic Referred to	AE	Hand Injury	Fracture	Pop Check	Medical	Surgical	ENT	Others Specify

Stat 456

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

DO

SEAN MAGUIRE
SG00756471
01/12/83 M
Date_____ Time_____
Spec./Sig._____

SEAN MAGUIRE
SG00756471
01/12/83 M
Date_____ Time_____
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SG00756471
01/12/83 M
Date_____ Time_____
Spec./Sig._____

SEAN MAGUIRE
SG00756471 / 01/12/83
321 SHIELDHALL ROAD
GLASGOW
G51 4HB SEX: M

ASE!

E-Pacer PATIENT REPORT

01:46 | Date | 30/09/2007

PATIENT AND INCIDENT DETAILS

[redacted] number	PA002263685 001
[redacted]	JOHN MCGUIRE,
Address	AS ABOVE
Age	23
Date of birth	01/12/1983
Gender	Male
Incident location	FLAT 1/2, 321 - 1 2 SHIELDHALL ROAD SHIELDHALL, GLASGOW
Incident post code	G51 4HB
Incident type	EMG
Crew at scene	30/09/2007 01 29

PRIMARY SURVEY

RESPONSE	
AVPU	Alert
AIRWAY	
Airway [redacted]ment	Clear
BREATHING	
Breathing rate	Normal
Respiratory rate	18
CIRCULATION	
Pulse rate	Normal
Most peripheral pulse found	Radial
Cap refill rate	<2 secs
Skin colour	Normal
Skin texture	Dry

INJURIES

?
FRACTURE

#1 Pain
Immobilised
#2
#3
#4

AMPDS

Infection | Falls, Dangerous Body Part

VITAL SIGNS

Time hr:m:n	Pulse bpm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow l/min	Blood sugar mmol/l	Temp °C	SpO2 %	GCS Total	RTS	EtCO2 k Pa

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	Normal

SAMPLE

Medication	[redacted]ATE'S FRIEND
Events p[redacted]	[redacted] JOURNEY LET [redacted] DOWN STAIRS EARLY HOURS OF SAT MORNING PATIENT SAT STOOD QUERYING FRACTURED NECK PATIENT SIGNED HIMSELF OUT OF HOSPITAL YESTERDAY

FINAL OBSERVATION AND COMMENTS

PATIENT STATES HE WENT TO A CONCERT ON SAT NIGHT IN GLASGOW AND HAS WALKED HOME. HAS ALSO BEEN TO WORK TODAY AND LIFTING HEAVY OBJECTS.

DATE	30/9/07	CLINICAL NOTES
	SEEN BY (DR) if MICVE	TIME SEEN 0400

RC/ Neck Injury

Attended last night. Intoxicated fallen down flight of stairs. Pseudoseizures, neck + lumbar back pain

Normal cervical/L-spine

CT Brain normal.

CT neck: $\#C_2$? artefact

Pt got up (GCS 15) + took irregular discharge. Good movement neck.

Pt now body & pain c/o neck + back.

Intoxicated tonight

? who called ambulance.

No new injury

O/E GCS 15 Intoxicated

CVS - P. 90 Hs I+II

Resp - chest clear

Abdo -  soft non-tender BS(+) no rebs

Normal tone/power throughout all 4 limbs

CN II → XII intact

Reflex

No new #.

C/O lumbar pain + neck → good ROM → new pain nodal image → C8/9

DATE	CLINICAL NOTES

XRays removed – No # seen.
Await final report of CT neck from radiology – will be available 0500.

0530 – Final report same as provisional report
Scan left right
Lucency lip C_2 – ? will clinically different to
area – collar in situ
→ ortho review

HMO

OW SHO
→ Admit ward 2.
Keep collar in situ
Allow to sit up.
Reassess clinically when alert + awake.
Analgesia as required.

HMO

20/9/17 SHO review
Needs C-spine views.
Consultant happy for collar to be removed while getting C-spine viewed.
Reviewed

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

DISCHARGE PRESCRIPTION PACKS

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	FREQUENCY	SIGNATURE	GIVEN BY

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

7

SEAN MAGUIRE
SG00756471
01/12/83 M
Date_____ Time_____
Spec./Sig._____

CLINICAL NOTES

DATE	
29/9/07	Hx as above. Fell down 12 steps. Having jerking of limbs since admission → fully orientated x4 reads + obeying commands Last 10 secs + no post ictal period CT brain – normal. ? C2 # ? subject O/E – No abnormality NAD / lung fields clear. Pelvis – unable to see due crest NV # seen. C-spine – no #
	Keep collar on / until clinical review possible Remain alone Yours H Murray
29/9/07	FRANCES 8th ORTHO NIGHTS Fell down 12 steps. C spine views cannot exclude # Advised to remain in collar overnight + be re xrayed tomorrow. Pt unwilling to stay. Lengthy negotiations. Informed of risks of further seizures, spinal cord injury or paralysis.

JMcC/71599

DATE | CLINICAL NOTES (Continued)

Pt signed irregular discharge.
Will be staying with girlfriend + her mother.

7682

SOUTHERN GENERAL HOSPITAL — **Against Advice**

SURNAME (Block Letters)	FIRST NAMES (Block Letters)	UNIT NUMBER
MAGUIRE-	SEAN-	7 5 6 4 7 (

This is to cerify that I go out/~~take out~~ .....

on my own responsibility, having been warned by the medical staff of the risk involved.

Witnessed ..... Signature .....

Designation SHO Address .....

.....

Date .....

AGAINST ADVICE

SGH 283

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

7

SEAN MAGUIRE M
SG00756471
01/12/83 Time
Date
Spec./Sig.

CLINICAL NOTES

DATE

20/9/17 SHO Nurses

C-spine XR normal as is lumbar spine.

Pt tender over dist C spine - no specific point.

lumbar spine clear clinically.

Full ROM C-spine

No other problems, no focal neurology.

Struggled to pass urine earlier - no problem now, passing fine.

Discuss SpR -> Happy to discharge pt

-> no follow-up.

Dr Nurses

DATE	CLINICAL NOTES (Continued)

X-R WR

Southern General Hospital, Accident & Emergency Department, Glasgow G51 4TF

Tel Direct: 0141 201 1456/8 Switchboard: 0141 201 1100 Fax: 0141 201 2997

09/27926

NAME: SEAN MAGUIRE
AGE 25 DOB 01/12/83
UNIT No: SG00756471

CONSULTANT: PHIL MUNRO
Account No: AE0027926/09

DATE:30/03/09
TIME: 1621
CHI#:0112836097

GP Name:	IAN IR STRUTHERS GP Phone No: 0141 892 2551	14
REASON FOR VISIT:	? RIGHT MIDDLE FINGER INJURY	
ALERTS:	(1), (2)	
ALLERGIES:	(1) PARAMAX (2)	
RELEVENT HISTORY:		
MEDICATIONS:		

TRIAGE CATEGORY: STANDARD TRIAGE NURSE: GILLIAN CURRAN TRIAGE TIME 1647

TRANSCRIBED ANALGESIA :

OBSERVATION TEXT:

INJURED RIGHT MIDDLE FINGER ON THURSDAY NIGHT WHILE PLAYING FOOTBALL

Enter/Edit Vital Signs						Visual Acuity	
DATE	TIME	COMPLETED BY	DATE	TIME	COMPLETED BY	Left-6m	Right-6m
30/03/09	1647	NU.CURGI	30/03/09	1647	NU.CURGI		

T			T			Correction Y/N	
HR			HR			Weight (kg)	
R			R			Breath Alcohol	
BP			BP			Pain Score	
Sa02		ON 21 %	Sa02				
BG			BG				
PF			PF				
EPF							
E			E				
V			V				
M			M				

MAGUIRE, Sean.
Attend: 30/03/09 1854 DOB: 01/12/1983 Sex: M
Ref: DR PT MUNRO - SGH CASUALTY DEPARTMENT
XR Fingers Rt

CRIS: 423112 E-11624632 ChiNo: 0112836097

DISCHARGE CODES: Please Circle

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

Discharge Date	J	
Discharge Time	20.00	

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

Follow Up	Not arranged	Arranged	To be arranged

Clinic Referred to	AE	Hand Injury	Fracture	Pop Check	Medical	Surgical	ENT	Others Specify

SGH 458

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

For: PSAETRIAGE01 From: CHEYNE,DREW
Mon Mar 30, 2009 4:21 pm Taken by: MEDITECH ()
Subject: ********** THIS PATIENT REQUIRES TRIAGE **********

********** THIS PATIENT REQUIRES TRIAGE **********

ne: MAGUIRE,SEAN A&E Number: AE0027926/09 Unit Number: SG00756471

ents Address: 321 SHIELDHALL ROAD GLASGOW G51 4HB Tel:

ATION.....SAEO.....

********** THIS PATIENTS REQUIRES TRIAGE **********

DIRECTION
FEED THROU
PRINTER

ents GP: STRUTHERS, IAN IR Practice: CARDONALD MEDICAL CENTRE Address:
RDONALD MEDICAL CENTRE Tel: 0141 892 2551

xt of Kin: MAGUIRE,MADGE

ationship: MOT

ress: 97 GLEDDOCH RD GLASGOW

882 0453

DATE	CLINICAL NOTES
	SEEN BY (DR) C GARR TIME SEEN 18:45

30/3/9

(25)[M] finger injury

Steel middle finger 3/7

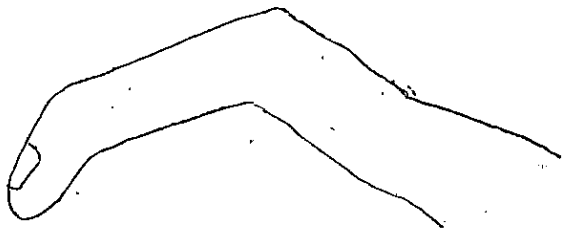
Can't fully straighten finger at PIPJ

O/E

Swollen (R) middle finger

Sensation intact

No bony tenderness



Full flexion/extension @ DIPJ + MCPJ

Can flex PIPJ, but not fully extend, painful

No rotational deformity

x-Ray: ? Undisplaced # of 3rd MC, midshaft.

(P) Buddy strap finger

Clinic r/v

RE ST2

DATE	CLINICAL NOTES

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

DISCHARGE PRESCRIPTION PACKS

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	FREQUENCY	SIGNATURE	GIVEN BY

Southern General Hospital, Accident & Emergency Department, Glasgow G51 4TF
Tel Direct: 0141 201 1456/8 Switchboard: 0141 201 1100 Fax: 0141 201 2997

14

NAME: MAGUIRE, SEAN DATE: 23/07/11
AGE: 27 DOB: 01/12/83 CONSULTANT: NICOLA LITTLEWOOD TIME: 0143
UNIT No: SG00756471 Account No: AE0052477/11 CHI#: 0112836097

GP Name:	IAN IR STRUTHERS GP Phone No: 0141 892 2551	16
REASON FOR VISIT:	FACIAL INJURY	
ALERTS:	(1) (2)	
ALLERGIES:	(1) PARAMAX (2)	
RELEVENT HISTORY:	HX AS PRF-999, HAS BEEN DRINKING	
MEDICATIONS:		

TRIAGE CATEGORY: URGENT TRIAGE NURSE: ELAINE O'DONNELL TRIAGE TIME: 0149

TRANSCRIBED ANALGESIA :

OBSERVATION TEXT:

HAS LACERATION TO BRIDGE OF NOSE DEEP WITH ? BONY CREPITUS FELT. INTOXICATED O/A. CONFUSED TO DATE, UNABLE TO GIVE ADDRESS, OBEYING COMMANDS. GCS AS CHARTED. VOMITED O/A NFI

MAGUIRE, SEAN
SG00756471 01/12/83
CHI: 0112836097.

Enter/Edit Vital Signs						Visual Acuity	
DATE	TIME	COMPLETED BY	DATE	TIME	COMPLETED BY	Left-6m	Right-6m
23/07/11	0149	NU.DONEL					

T	35.8°C		T				Correction Y/N	
HR	118		HR				Weight (kg)	
R	16		R				Breath Alcohol	
BP	133/69		BP				Pain Score	
Sa02	99	ON 21 %	Sa02		ON %			
BG	5-8mmols		BG					
PF			PF					
EPF								
E	SPONTANEOUSLY >4		E					
V	CONFUSED		V					
M	OBEYS COMMANDS		M					

DISCHARGE CODES: Please Circle
1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other hospital (see below)
5. Died 6. Refer to O.P. Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Discharge Date: 23/07/11
Discharge Time:

Ward No. (If admitted): PNC (ORTHO)
Transfer to Hospital:
Consultant (if admitted):

Follow Up	Not arranged	Arranged	To be arranged

Clinic Referred to	AE	Hand Injury	Fracture	Pop Check	Medical	Surgical	ENT	Others Specify

For SAETRIAGE01 From: DEEGAN,CAROL
Sat Jul 23, 2011 1:43 am Taken by: MEDITECH ()
Subject: ********** THIS PATIENT REQUIRES TRIAGE **********

********** THIS PATIENT REQUIRES TRIAGE **********

Name: MAGUIRE,SEAN A&E Number: AE0062477/11 Unit Number: SG00756471

Patients Address: 321 SHIELDHALL ROAD GLASGOW G51 4HB Tel:

LOCATION.....SAEOC.....

********** THIS PATIENTS REQUIRES TRIAGE **********

Patients GP: STRUTHERS, IAN IR Practice: CARDONALD MEDICAL CENTRE Address: CARDONALD MEDICAL CENTRE Tel: 0141 892 2551

Next of Kin: MAGUIRE,MADGE

Relationship: MOT

Address: 97 GLEDDOCH RD GLASGOW

Tel: 882 0453

'SE!

it is not being admitted)

Siemens Diagnostics
Clinitek Status®

Patient:

Multistix® 8 SG
Test date 07-23-2011
Time 1:00AM
Operator
Test number 5703
Color Not Entered
Clarity Not Entered

GLU Negative
KET Negative
SG <=1.005
BLO Trace-lysed
pH 5.0
PRO Negative
NIT Negative
LEU Negative

Siemens Diagnostics
Clinitek Status®

Patient:

Multistix® 8 SG
Test date 07-23-2011
Time 3:18AM
Operator
Test number 5706
Color Not Entered
Clarity Not Entered

GLU Negative
KET Negative
SG <=1.005
BLO Negative
pH 6.0
PRO Negative
NIT Negative
LEU Negative

E-Pace PATIENT REPORT

Time	01:27	Date	23/07/2011

PATIENT AND INCIDENT DETAILS

Incident number	PA003834137.001
Name	SEAN MAGUIRE
Age	27
Date of birth	01/12/1983
Gender	Male
Incident location	ASIDE ARGOSY BAR, 2202 PAISLEY ROAD WEST CARDONALD GLASGOW
Incident post code	G52 3SJ
Incident type	EMG
Call received	23/07/2011, 01:00
Call passed	23/07/2011, 01:01
Crew mobile	23/07/2011, 01:01
Crew at scene	23/07/2011, 01:07
Crew left scene	23/07/2011, 01:25
Receiving hospital and department	SOGH Southern General Hospital

TREATMENT REFUSAL FORM

PRIMARY SURVEY

62977/V

RESPONSE

AVPU	Alert

AIRWAY

Airway assessment	Clear

BREATHING

Breathing rate	Normal
Respiratory rate	

CIRCULATION

Pulse rate	Fast
Most peripheral pulse found	Radial
Cap refill rate	
Skin colour	Normal
Skin texture	Dry

C-SPINE INJURY

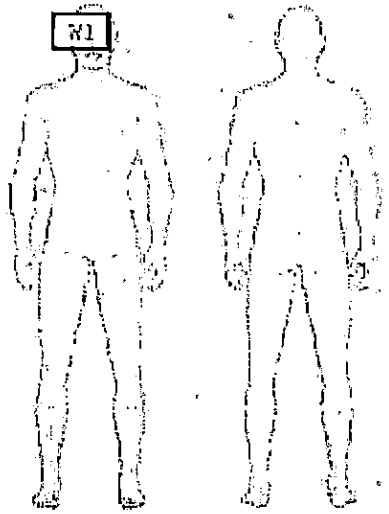
Suspicion of CSI	No evidence of C-spine injury

PATIENT CONSENT

Patient consent	Treatment benefits explained, Risks of condition explained, Capacity to understand risks and treatment

INJURIES

WOUND	W1. Pain, Laceration, None W2. W3. W4.



AMPDS

Dispatch code	17B01	Fallen with Possibly Dangerous Area Injuries
Final code	17B01	Falls, Possibly Dangerous Area

GCS

Final GCS eye opening	Spontaneous
Final GCS verbal response	Confused
Final GCS motor response	Obeys commands

VITAL SIGNS

Time hr : min	Pulse bpm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Temp °C	SpO2 %	GCS Total	RTS	SEWS	ECG	Pain score
01:10	131	18	149 / 100	<2 secs	-	6.3	-	98	14	7.550	-	-	

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	Normal

AMPLE

Allergies	None
Other allergies	
Medication	NONE
Past history	NONE
Last eaten	>5 hrs
Events prior	PT WAS SAW TO FALL ON FACE.. PT CLAIMS HE WAS UNCONSCIOUS..

EMERGENCY SERVICES ON SCENE

Paramedic	Technician

PATIENT HANDOVER

On arrival at scene	Seated
Scene removal	Walking
Transportation	Seated
Care delivery at hospital	Chair

FINAL OBSERVATION AND COMMENTS

PT HAS VOMITD X2	
Report ID	82045ced-a4be-49ca-933b-99077442c8ce

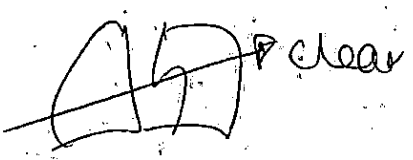
DATE	CLINICAL NOTES
	SEEN BY (DR) PAULA FALCONER. TIME SEEN

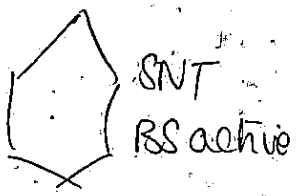
23.7.11 (27) PC. Facial injury.

HPC No history from patient - not speaking.
Eventually admits to having two beers. Denies other drugs.
No idea what happened to him, where he is - remembers for a few seconds then asking 'where am I.'
Ambulance report - found on street - seen falling onto face.

O/E Smells very strongly of alcohol +++ slurring
Not responding initially to voice - responded well to Trapezius squeeze
Obeying commands.
GCS 14/15 - now confused → does not know where he is and forgets shortly after being told.
PEARL Tone, power, reflexes normal. Plantars dl.
Patient not co-operative ∴ Cranial nerve exam

HS 1+11+0
CRT < 2 sec
Calves SNT





T 35.8 P 118 BP 133/69 RR 16 Sats 99% (air)
BM 5.8

Passed urine in A+E, negative.

→

DATE	CLINICAL NOTES

Large full thickness laceration above nose
V shaped

Lignocaine instilled.
Uneventful. 5 sutures put in + steristrips.

Girlfriend came into department - patient does not recognise his girlfriend.

Impression: Head injury, laceration, likely concussion under influence of alcohol +/- other substances.

Plan
IV access
IV fluids
Routine bloods
Neuro observations
Ortho bed overnight for neuro obs.

23/7/11 WR MR WALKER
9:30

- Fall onto face: facial swelling bruising & laceration
New obs stable overnight
- R/V by MR Walker happy to be discharged (F42) home if stable in late afternoon.

FALCONER

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

DISCHARGE PRESCRIPTION PACKS

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	FREQUENCY	SIGNATURE	GIVEN BY

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES

Sean Maguire

Date & Time		Signature, Print Name & Designation
23/7/4 05:30	Received an admission from A&E with intoxicated head injury. Fall onto face. Laceration to Nose — sutured. pt is alert but drowsy. Cannot assess him. pink venflon on (R) hand. IV fluid started. Neuroobservations checked & charted. c+ - morning.	J. Walker (S)
15/20 W/R	Independent with care, S/B Mr Walker for neuro observations, no C.T. Vital signs stable, SEWS 0 GCS 15/15. No complaints offered For discharge late afternoon patient discharged to attend practice nurse in 7 days for suture removal IV cannula removed	J Dick (S) J DICK
		Me (S)

193443

Date & Time		Signature, Print Name & Designation

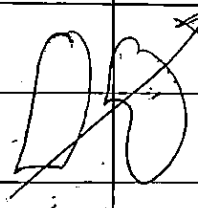
NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES

MAGUIRE, SEAN
SG00756471 01/12/83
321 SHIELDHALL ROAD
GLASGOW G51 4HB
CHI: 0112836097 M

Date	F42 SMITH ORTHO.	Signature	Print
23/7/11	(27) Facial Injury BIBA. ?LOC.		
0445.	HPC Patient unable to remember what happened. Remembers being at work yesterday + going for drinks after. Unsure if in a fight / fell. Knows he is in hospital but unsure which one.		
	PMH } unknown +DH } unknown Clinical Portal - Previous admission Oct 09 for neuro obs 2° HI.		
	o/e. Smells of alcohol.		
	E_5 M_6 V_3 = 14/15 confused		
	Patient uneo-operative; difficult examination.		
	CNS PEARL (N) eye movements.		
	Neuro Grossly intact.		
	Tone / Power / Reflexes (N).		
	c/o (R) shoulder pain — full ROM.		

193443

Date		Signature	Print
	HS 1+11+0.  Abdo SNT  Good AE b/lat		
	HR 100, reg Chest clear.		
	Facial laceration sutured in A+E. Not co-operative.		
	for ~~XR~~ XR facial bones.		
	Imp - Head Injury ? LOC.		
	↳ retrograde amnesia but under the		
	influence of alcohol. Consider CT within 8hrs		
	as per SIGN guidelines.		
	Plan - IV access		
	- Bld s		
	- IV Fluids		
	- Admit to ward for neuro obs.		
	- ? CT mane.		
	- ? Facial & views mane.		
	- If deteriorates overnight	CUth	SMITH
	↳ urgent CT.	PM2	7555.

South Glasgow University Hospitals NHS Trust

TEMPERATURE / CVP/ RESP / PULSE / BP CHART

NHS Greater Glasgow

Name: Sean Maguire | Age: | Unit No:

DATE 11/12

DAY

TIME 0-24 0/A 10/16

PAIN 1 0

SEDATION 0 0

NAUSEA 0 0

TEMPERATURE

BLOOD PRESSURE

PULSE

CVP/RESPNS

INCIDENTS DRUGS ETC 98 96 97

PAIN SCORE:
S= Sleeping
0= No pain
1= Mild pain
2= Moderate pain
3= Severe pain

SEDATION SCORE:
S= Sleep normal
0= None, Patient alert
1= Mildly sedated, awakes to verbal stimuli.
2= Moderately drowsy, awakes to verbal stimuli
3= Severe, Somnolent, difficult to awake to verbal stimuli

NAUSEA SCORE:
0= None
1= Mild, No treatment required
2= Nausea and vomiting, helped by treatment
3= Nausea, persistant despite treatment

SGH 8A

South Glasgow Hospitals

NHS Greater Glasgow and Clyde

STANDARDISED EARLY WARNING SCORING SYSTEM (SEWS)

Patient Observation Chart

Name	AFFIX PATIENT ID
Address	
Hospital No.	
DOB	

	Date	Ward	Consultant
Admitted			
Transferred			
Transferred			
Transferred			

This is Chart Number_____during this admission

All seven parameters must be assessed with each set of observations to obtain an accurate SEWS score. If a patient has abnormal vital signs please pay particular attention to scoring for urine output.

How to calculate SEWS Score

- Note whether observation falls in shaded "At Risk Zone". Score as per SEWS Key.
- Add points scored and record total "Sews Score" in bottom row of chart.
- Respiratory rate — Write numerical value in appropriate box
- Saturation Sp02 — Write numerical value in appropriate box
- Inspired Oxygen — If the patient's saturation is recorded on air please write A in appropriate box. If patient is on oxygen therapy, please document the amount in appropriate box.
- Temperature — Write numerical value in appropriate box
- Blood pressure — Write numerical values for systolic and diastolic pressure in appropriate box. Remember only the systolic value is considered for the SEWS Score.
- Heart rate — Write numerical value in appropriate box
- Neuro Response — Record patient's best response. If the patient is asleep or demonstrates new confusion, award the same score as verbal response.
- Urine Output — Check that patient has voided urine recently. If yes write PU in box provided. If no write NPU in box provided.
- Urine Output — Check if the patient has passed the equivalent of or more than 30mls/hour for the last three consecutive hours. If yes score 0 in box provided. If no score 3 in box provided and add to total SEWS score.
- SEWS Score — Add up scores for all 7 parameters and write in box provided. If the patient merits an aggregate score of 0 please write 0 in the SEWS score box. Action as per guidelines below.

SEWS KEY

0	1	2	3

SEWS 0-1: Routine observations
SEWS 2-3: Hourly observations and inform nurse in charge
SEWS 4+: Contact PRHO immediately. SHO or more senior doctor must be informed by Junior Doctor. Please record action taken in Nursing Notes

FURTHER SEWS SCORE SHOULD BE CHECKED

- In the event of a sudden worrying ***Change***
- If there is a worsening ***Trend***
- If concerned the patient looks ***Unwell***

The frequency of SEWS scoring is determined by the previous SEWS Score. If the patient continually scores 0-1, the nurse caring for the patient should determine frequency of observations.

A full set of observations and SEWS score should still be carried out.

If SEWS continually 0-1 frequency of observations:

Date												
Frequency												

For extra information such as wound, CSM etc. use slanted columns at bottom of page.

SEWS KEY			
0	1	2	3

NAME _____ DOB _____

Date:		30/9																
Time:					1340													
RESP. RATE	36+																	
	31-35																	
	21-30																	
	9-20																	
	≤8																	
SpO2 Numerical Value	93+	99																
	90-92																	
	85-89																	
	<85																	
Inspired O2%	%	A																
TEMP.	39°																	
	38°																	
	37°																	
	36°																	
	35°																	
	34°																	
BLOOD PRESSURE SEWS SCORE uses Systolic BP	210																	
	200																	
	190																	
	180																	
	170																	
	160																	
	150																	
	140	131																
	130	A																
	120																	
	110																	
	100																	
	90																	
	80																	
	70	V																
	60	46																
	50																	
	40																	
	150																	
HEART RATE	140																	
	130																	
	120																	
	110																	
	100																	
	90																	
	80																	
	70																	
	60																	
	50																	
	40																	
	30																	
	20																	
NEURO RESPONSE	Alert	A																
	Verbal																	
	Pain																	
	Unresponsive																	
URINE OUTPUT	PU/NPU:				666													
	UO<30mls/hr (3 hrs +)																	
SEWS SCORE:	with all observations																	
PAIN refer to guideline p4	Severe	7-10																
	Moderate	4-6																
	Mild	1-3																
	None	0																
		N/V																

UNIT No. _____

SEWS KEY

0	1	2	3

Date:	
Time:	
36+	
31-35	
21-30	
9-20	
≤8	
93+	
90-92	
85-89	
<85	
%	
39°	
38°	
37°	
36°	
35°	
34°	
210	
200	
190	
180	
170	
160	
150	
140	
130	
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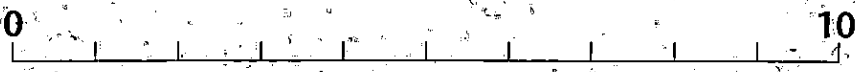
70	
60	
50	
40	
30	
20	
Alert	
Verbal	
Pain	
Unresponsive	
PU/NPU:	
UO<30mls/hr	
7-10	
4-6	
1-3	
0	
N/V	

Pain Assessment & Management Guidelines

How to score pain:



No Pain — Worst Pain Imagineable

Pain Score:		Action:
0	NONE	Continue to assess pain with every set of observations (**must be** at least daily).
1-3	MILD	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
4-6	MODERATE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
7-10	SEVERE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.

Guidelines

Cancer-related pain:

Always score the worst pain in the last 24hours or since last assessment.

FOR PERSISTANT MODERATE PAIN (4 OR ABOVE) WHICH DISTRESSES THE PATIENT:

Use Cancer Pain Management Algorithm in Palliative Care Resource File. This is distributed to all wards and is also accessible on the intranet. If no improvement in pain score contact Hospital palliative care team on **page 1266** at SGH and **page 5742** at VI.

Out of hours advice can be obtained from the Prince and Princess of Wales Hospice on **0141 420 6785.**

Acute pain:

Score current pain on movement e.g. deep breathing

PERSISTENT SEVERE PAIN (7 OR ABOVE), WHICH DISTRESSES THE PATIENT:

Use Acute Pain Manual - distributed to all Operating Theatres areas and Surgical wards throughout Division. Also accessible on Intranet (via anaesthetic department homepage)

If no improvement in pain score contact CNS Pain Management on **page 1186/1157** at SGH and **page 3404/3101** at VI. On Call anaesthetist **page 1658** at SGH and **3004** at VI.

Measuring Sedation

The SEWS system uses the AVPU scoring system for conscious level. AVPU is an acronym for Alert, Verbal Pain, Unresponsive. The AVPU system relates to the previous sedation scale as follows:

Sedation	Descriptor	AVPU
0	Awake	A
1	Asleep, roused by speech	V
2	Physical stimulation (eg shaking) required to waken	P
3	Not roused by speech or shaking	U

Measuring Nausea

Is now recorded as 0 for no nausea or vomiting, N for nausea and V for vomiting
For persistent nausea and/or vomiting see clinical handbook or acute pain manual.

NB: Review Treatment Plan

If Temp>38
blood cultures ☐ other cultures ☐ Start antibiotic therapy if indicated

If Systolic BP<100
Review monitoring (cardiac/oximetry/urine output/invasive BP etc)
IV Access
Review patient/drug kardex. Consider fluid challenge → Definitive Therapy

Consider:

Hypovolaemia	Cardiac	Obstructive	Distributive
Dehydration	*Arryhthmia*	*PE*	*Sepsis*
Blood loss	*Pump failure*	*Tamponade*	*Anaphylaxis*

If Pulse>130
Review monitoring
IV Access
Review patient/ECG/electrolytes → Definitive Therapy

If O_2 sats <93%
Review probe ? accurate
Review patient → prescribe oxygen on kardex if indicated.

If RR>24
Review patient/CXR +/- gases/PEF etc → Definitive Therapy

If responds to pain only or unresponsive
Assess airway, BM GCS, consider neuro obs chart, review patient/kardex.

If BM<4
Check urgent blood glucose/IV dextrose or oral carbohydrate

MACGUIRE, SEAN ID: 0000000000 28-Sep-2007 23:04:47 SOUTHERN GENERAL HOSPITAL

Vent. rate	94 bpm
PR interval	146 ms
QRS duration	92 ms
QT/QTc	338/422 ms
P-R-T axes	60 50 50

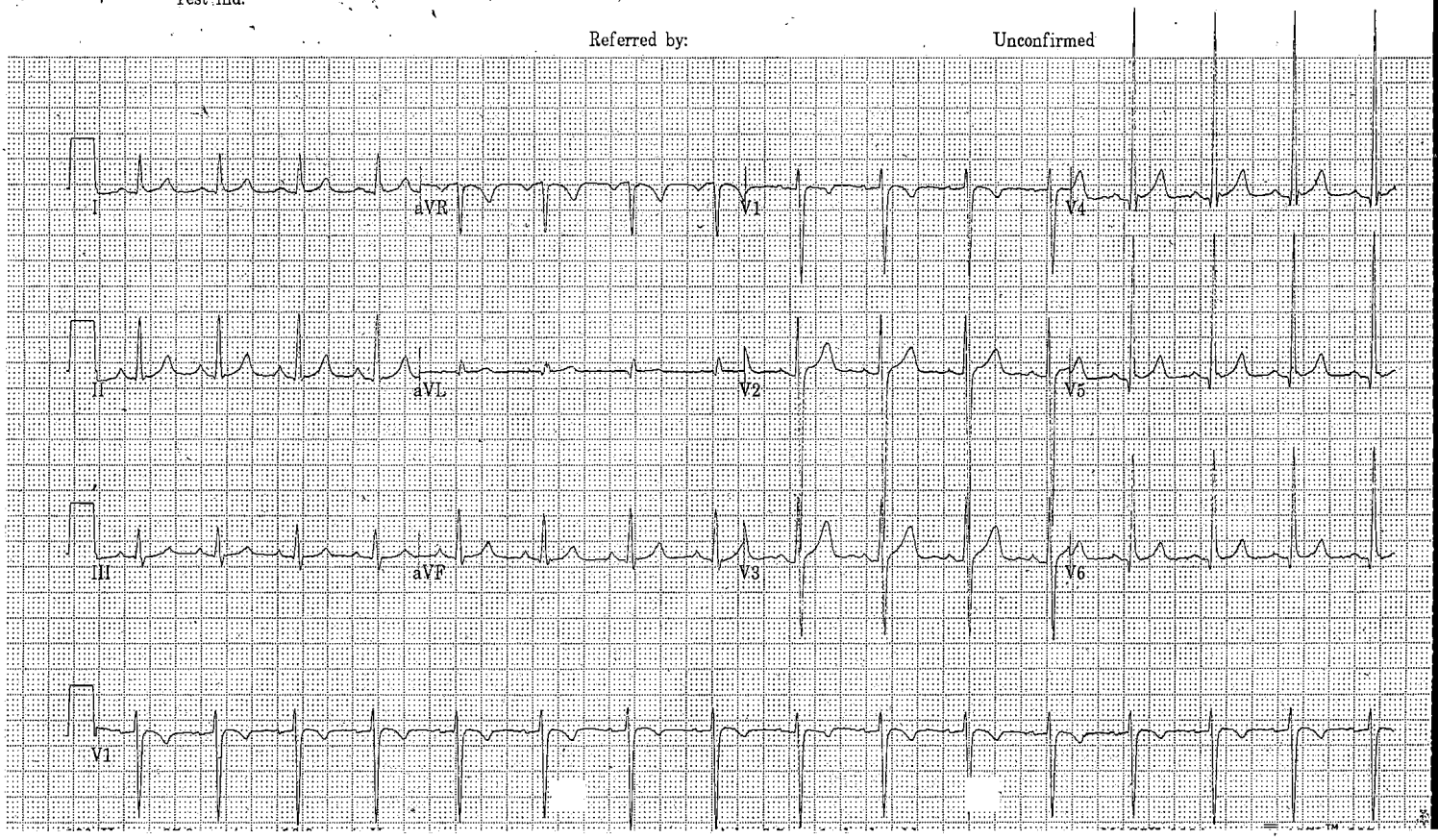
Normal sinus rhythm
Voltage criteria for left ventricular hyper hy

[redacted]

Technician:
Test ind:

Referred by:

Unconfirmed



MAGUIRE, SEAN ID: 0112836097 23-Jul-2011 4:32:36 SOUTHERN GENERAL HOSPITAL

1-Dec-1983
Male Caucasian

Loc: 301

Vent. rate 112 bpm
PR interval 148 ms
QRS duration 88 ms
QT/QTc 312/425 ms
P-R-T axes 70 66 61

Sinus tachycardia
Possible Left atrial enlargement

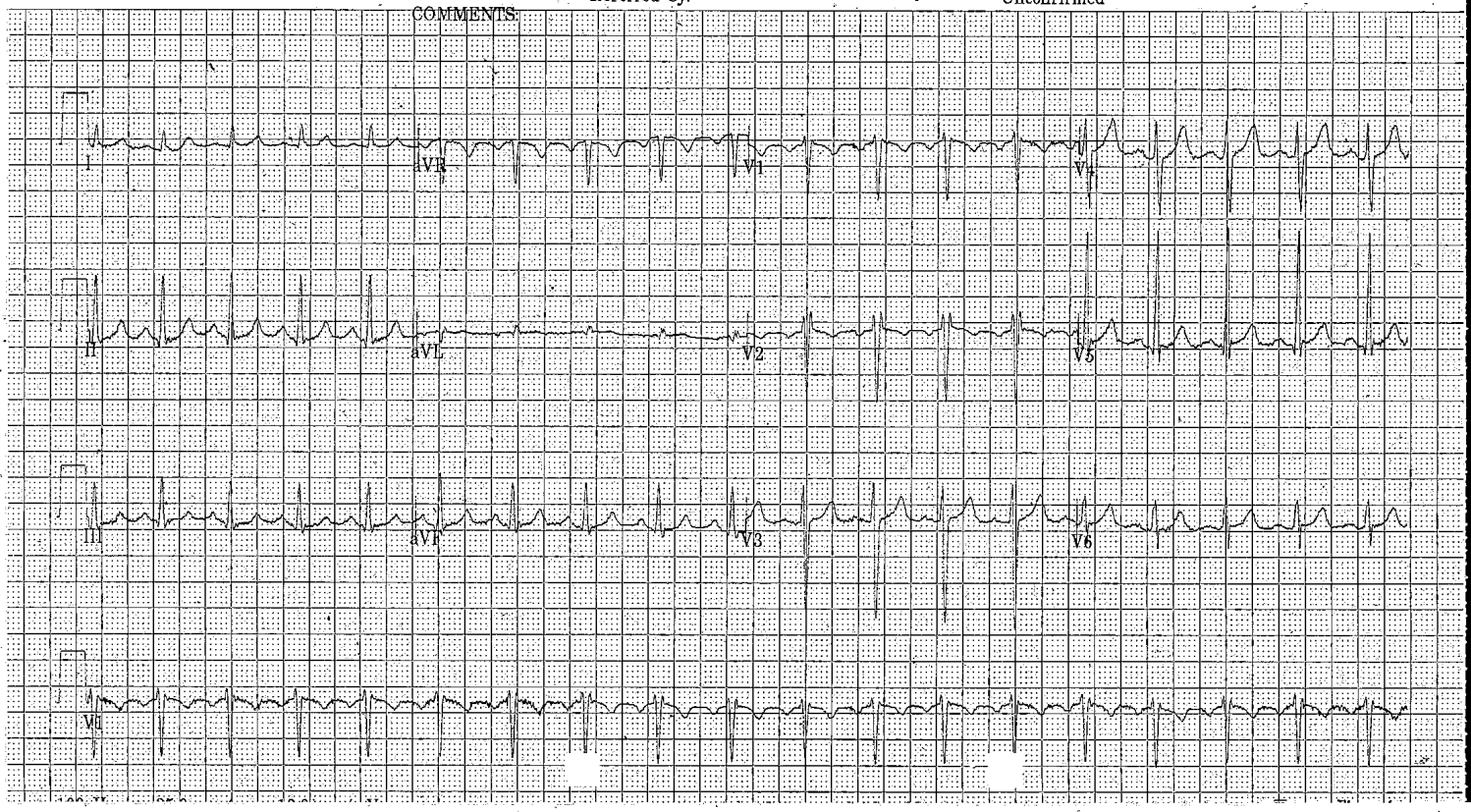
MAGUIRE,SEAN
SG00756471 01/12/83
CHI: 0112836097 M
Date____ Time____
Spec./Sig.____

[redacted]
History: Unknown
Technician: 333
Test ind:

Referred by:

Unconfirmed

COMMENTS:



X-RAY REPORTS

NHS Greater Glasgow and Clyde

Southern General Hospital — Diagnostic Imaging Report

MACGUIRE, Sean **01/12/1983** **CHI: 0112836097**

Flat 1/2, 321 Shieldhall Road, Renfrewshire, G51 4HB Hosp: SG03153072

Source: SGH UROLOGY DEPARTME **Age: 23yr Sex: M** **CRIS: 739709**

Ref: MR L MORRISON (UROLOGY) UROLOGY **Event: E-2814992**

US TESTES/SCROTUM

Reported by: Dr B MUCCI (Cons). Verified

Clinical History : Thickened right scrotum.

US TESTES/SCROTUM :

Ultrasound shows normal testes. The epididymis on the right is a little prominent but no discrete cysts or masses are seen. The appearances are essentially normal. They are certainly entirely benign with no significant mass or cysts.

Exam: 05/09/2007 MR L MORRISON (UROLO (UROLOGY)

Reported: 05/09/2007 SGH UROLOGY DEPARTMENT

Typed: 10/09/2007 HEWLY

08964
JMcC/71591

NHS Greater Glasgow & Clyde
SGH 401 Cat 5290802

Stick Slips on in order received commencing at the Bottom

South Glasgow University Hospitals Division
NEUROLOGICAL OBSERVATION CHART

NHS Greater Glasgow

Name Joan McGuire

Record no.

Date 28/4/8 — 19/9/8 — 30/09

Time 1115 1125 1135 1145 1208 1300 1400 0900 0906 1040

Coma Scale

		1115	1125	1135	1145	1208	1300	1400	0900	0906	1040
Eyes open	Spontaneously	0	1	0	0	0	0	0		1	0
	To speech										
	To pain										
	None										
Best motor response	Obeys commands	1	0	0	0	0	0	0		0	0
	Localise pain										
	Normal flexion to pain										
	Abnormal flexion to pain										
	Extension to pain										
	None										
Verbal response	Orientated		0	0	0	0				0	0
	Confused	0					0	0			
	Inappropriate words										
	Incomprehensible sounds										
	None										

Eyes closed by swelling = C

Usually record the best arm response.

Endotracheal tube or tracheostomy = T

Pupil Scale (mm)

1 2 3 4 5 6 7 8

Blood pressure and Pulse rate / Respiration

240 230 220 210 200 190 180 170 160 140 130 120 110 90 80 70 60 40 30 20 or 10

Temperature °C

40 39 38 37 36 35 34 33 32 31 30

Pupils			1115	1125	1135	1145	1208	1300	1400	0900	0906	1040
	Right	Size	3	3	3	4	4	4			5	4
		Reaction	+	+	+	+	+	+			+	+
	Left	Size	3	3	3	4	4	4			5	4
		Reaction	+	+	+	+	+	+			+	+

+ reacts
- no reaction
c. eye close

Limb Movement			1115	1125	1135	1145	1208	1300	1400	0900	0906	1040
Arms		Normal power	1	1	0							0
		Mild weakness				0	0	0			0	
		Severe weakness										
		Spastic flexion										
		Extension										
		No response										
Legs		Normal power	1	1	0							0
		Mild weakness				0	0	0			0	
		Severe weakness										
		Spastic flexion										
		Extension										
		No response										

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

Basic Guide for Performing Neurological Observations

1. Frequency of performing observations: **This is the minimum recommended.**

   More frequent observations should be carried out if the clinical condition requires it.

- On arrival i.e. following transfer from another area. Should be compared to previous recording and any deterioration discussed with medical staff.
- At half hourly intervals for 2 hours.
- At hourly intervals for 4 hours.
- At 2 hourly intervals for 6 hours.
- At 4 hourly intervals until fit for discharge.

2. Examples of neurological deterioration that should be reported immediately to medical staff:

- Development of agitation or abnormal behaviour. (Do not automatically attribute to effects of alcohol or drug abuse.)
- Sustained decrease in conscious level of at least one point in the motor or verbal response, or two points in the eye opening response.
- Development of severe or increasing headache.
- Persisting vomiting.
- New or evolving neurological signs i.e. pupil inequality, asymmetry of limb or facial movement.

Eyes Open

- Conscious patients sense your approach and open their eyes spontaneously.
- Verbal stimulus may be normal, repeated or loud, recognisably use their name (beware not to touch at this time- use only verbal).
- Painful stimulus is applied by trapezius squeeze (use thumb and two fingers to hold and squeeze 2 inches of trapezius muscle where the head/neck meets the shoulder). If eyes do not open in response, squeeze the side of the patient's finger (3rd or 4th) between your thumb and a pen.

Best Motor Response

- **Obey commands.** The patient understands and carries out instructions e.g. lift up arms; hold up thumb, squeeze hands - always ask patient to release grip in order to eliminate primitive reflex. Be aware of possible hearing/speech disorders.
- **Localise pain.** The patient must bring hand up beyond level of the clavicle in response to central painful stimulus (trapezius, finger squeeze).

  Patients may localise to irritants such as O_2 masks or N/G tubes. Best arm response is used as leg response may be a spinal reflex only.
- **Flexion to pain.** The patient may flex or bend their arm towards source of pain but do not actually localise or try to remove the source. Response is variable with each stimulus.
- **Abnormal flexion.** The patient may flex or bend the arm at elbow and rotate wrist (spastic posture) whilst drawing arm across chest. Response is slower than in normal flexion to pain.
- **Extension to pain.** The patient may extend or straighten arm at elbow or may rotate arm towards.
- **No response to pain.** Beware absence of response may be due to high spinal injury or muscle paralysing drugs.

Best Verbal Response

- **Orientation.** The patient knows who they are, where they are, month and year and why they are where they are.
- **Confusion.** The patient holds a conversation but cannot answer accurately, talks in sentences, unaware of self or environment.
- **Inappropriate words.** The patient replies in words said at random, often shouts or swears.
- **Incomprehensible sounds.** You may have to use both verbal and painful stimulus to get a response. Patient may moan or groan (beware of English language ability).
- **No response.** Beware of possible hearing/speech disorders.

Pupils

- **Size.** Look at pupil before shining light into the eye. Both should be equal in size (beware drugs affecting size). Beware pre-existing irregularities e.g. cataracts, blindness etc. Shape is normally round.
- **Reaction.** Should be 'consensual' reaction i.e. where both eyes constrict as light shone into one (bring light in from side of eye).

Vital Signs

- **Temperature.** Alterations may be due to damage to hypothalamus. Raised temperature also increases demand for O_2 by brain cells so regulation is important.
- **Blood pressure and pulse.** Haemorrhage from an extra-cranial site may lead to falling blood pressure and rising pulse and if under treated, shock may cause neurological deterioration. Rising blood pressure and slowing of pulse can be a sign of increasing intra-cranial pressure.
- **Respirations.** Reduced conciousness may cause hypoxia through inadequate respiration or an obstructed airway. Hypoxia may cause neurological deterioration. Changes in rate and pattern may indicate a rise in intra-cranial pressure.

Limb movement

- **Normal power.** The patient matches resistance applied to any joint movement (pulls you towards them or pushes you away).
- **Mild weakness.** The patient moves against resistance but is easily overcome.
- **Severe weakness.** The patient able to move limb but not against resistance.
- **Spastic flexion.** The patient may flex or bend the arm at elbow and rotate wrist (spastic posture) whilst drawing arm across chest. Response is slower than in normal flexion to pain.
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References

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Compiled by Mrs. B. Wellington, Clinical Nurse Specialist (Orthopaedics) on behalf of SGUH SIGN No 46 Local Guideline Development Group, March 2002

Lead Clinician Mr. T. Parke, Clinical Director for A&E.

Next review date: March. 2003

South Glasgow Hospitals
NEUROLOGICAL OBSERVATION CHART

NHS Greater Glasgow and Clyde

MAGUIRE, SEAN
SG00756471 01/12/83
CHI: 0112836097 M
Date_____ Time_____
Spec./Sig._____

Date 23/7/11

Time 01 45 | 03 30 | 05 40 | 07 45 | 11 45 | 15 00 | 16 00

Coma Scale

Eyes open	Spontaneously	4 4 1 4 4 4 4
	To speech	3 3 2 3 3 3 3
	To pain	2 2 1 2 2 2 2
	None	1 1 1 1 1 1 1
Best motor response	Obeys commands	6 6 1 6 6 6 6
	Localise pain	5 5 2 5 5 5 5
	Normal flexion to pain	4 4 3 4 4 4 4
	Abnormal flexion to pain	3 3 4 3 3 3 3
	Extension to pain	2 2 5 2 2 2 2
	None	1 1 6 1 1 1 1
Best verbal response	Orientated	5 5 3 5 5 5 5
	Confused	4 4 2 4 4 4 4
	Inappropriate words	3 3 1 3 3 3 3
	Incomprehensible sounds	2 2 T 2 2 2 2
	None	1 1 1 1 1 1 1

Eyes closed by swelling = C

Usually record the best arm response.

Endotracheal tube or tracheostomy = T

Pupil Scale (mm)

1 2 3 4 5 6 7 8

Blood pressure and Pulse rate 240 230 220 210 200 190 180 170 160 140 130 120 110 90 80 70 60 40 30 20 10

Respiration

Temperature °C 40 39 38 37 36 35 34 33 32 31 30

Pupils	Right	Size	5	4	4	5	4	4	4
		Reaction	+	+	+	+	+	+	+
	Left	Size	5	4	4	5	4	4	4
		Reaction	+	+	+	+	+	+	+

+ reacts
- no reaction
c. eye close

Limb Movement

Arms		Normal power	6	6	R				
		Mild weakness			L				
		Severe weakness							
		Spastic flexion							
		Extension							
		No response							
Legs		Normal power			R				
		Mild weakness			L				
		Severe weakness							
		Spastic flexion							
		Extension							
		No response							

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- **No response.** Beware absence of response may be due to high spinal injury or muscle paralysing drugs.

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Lead Clinician Mr. T. Parke, Clinical Director for A&E.

Next review date: March. 2003

NHS
Greater Glasgow and Clyde

South Glasgow Hospitals

STANDARDISED EARLY WARNING SCORING SYSTEM (SEWS)

Patient Observation Chart

Name Sean Maguire AFIX PATIENT ID

Address

Hospital No.

DOB 01/12/83

	Date	Ward	Consultant
Admitted			
Transferred			
Transferred			
Transferred			

This is Chart Number_____during this admission

All seven parameters must be assessed with each set of observations to obtain an accurate SEWS score. If a patient has abnormal vital signs please pay particular attention to scoring for urine output.

How to calculate SEWS Score

- Note whether observation falls in shaded "At Risk Zone". Score as per SEWS Key.
- Add points scored and record total "Sews Score" in bottom row of chart.
- Respiratory rate — Write numerical value in appropriate box
- Saturation Sp02 — Write numerical value in appropriate box
- Inspired Oxygen — If the patient's saturation is recorded on air please write A in appropriate box. If patient is on oxygen therapy, please document the amount in appropriate box.
- Temperature — Write numerical value in appropriate box
- Blood pressure — Write numerical values for systolic and diastolic pressure in appropriate box. Remember only the systolic value is considered for the SEWS Score.
- Heart rate — Write numerical value in appropriate box
- Neuro Response — Record patient's best response. If the patient is asleep or demonstrates new confusion, award the same score as verbal response.
- Urine Output — Check that patient has voided urine recently. If yes write PU in box provided. If no write NPU in box provided.
- Urine Output — Check if the patient has passed the equivalent of or more than 30mls/hour for the last three consecutive hours. If yes score 0 in box provided. If no score 3 in box provided and add to total SEWS score.
- SEWS Score — Add up scores for all 7 parameters and write in box provided. If the patient merits an aggregate score of 0 please write 0 in the SEWS score box. Action as per guidelines below.

SEWS KEY

0	1	2	3

SEWS 0-1: Routine observations
SEWS 2-3: Hourly observations and inform nurse in charge
SEWS 4+: Contact PRHO immediately. SHO or more senior doctor must be informed by Junior Doctor. Please record action taken in Nursing Notes

FURTHER SEWS SCORE SHOULD BE CHECKED

- In the event of a sudden worrying ***Change***
- If there is a worsening ***Trend***
- If concerned the patient looks ***Unwell***

The frequency of SEWS scoring is determined by the previous SEWS Score. If the patient continually scores 0-1, the nurse caring for the patient should determine frequency of observations.

A full set of observations and SEWS score should still be carried out.

If SEWS continually 0-1 frequency of observations:

Date												
Frequency												

For extra information such as wound, CSM etc. use slanted columns at bottom of page.

SEWS KEY			
0	1	2	3

NAME Sean maguire DOB 01/12/83

Date:		23/07															
Time:		0530															
RESP. RATE	36+																
	31-35																
	21-30																
	9-20	14															
	≤8																
SpO2	93+	97															
Numerical Value	90-92																
	85-89																
	<85																
Inspired O2%	%	A															
TEMP.	39∞																
	38∞																
	37∞																
	36∞																
	35∞	?															
	34∞																
BLOOD PRESSURE	210																
	200																
	190																
	180																
	170																
	160																
	150																
	140																
	130																
	120																
	110																
SEWS SCORE uses Systolic BP	100	91															
	90	A															
	80																
	70																
	60																
	50	40															
	40																
HEART RATE	150																
	140																
	130																
	120																
	110																
	100																
	90																
	80																
	70	82															
	60																
	50																
	40																
	30																
	20																
NEURO RESPONSE	Alert																
	Verbal																
	Pain	✓															
	Unresponsive																
URINE OUTPUT	PU/NPU:	NPU															
	UO<30mls/hr (3 hrs +)																
SEWS SCORE:	with all observations	2															
PAIN refer to guideline p4	Severe	7-10															
	Moderate	4-6															
	Mild	1-3															
	None	0	0														
		N/V	0														

UNIT No. _____

SEWS KEY

0	1	2	3

Date:

Time:

36+

31-35

21-30

9-20

≤8

93+

90-92

85-89

<85

%

39∞

38∞

37∞

36∞

35∞

34∞

210

200

190

180

170

160

150

140

130

120

110

100

90

80

70

60

50

40

150

140

130

120

110

100

90

80

70

60

50

40

30

20

Alert

Verbal

Pain

Unresponsive

PU/NPU:

UO<30mls/hr

7-10

4-6

1-3

0

N/V

Pain Assessment & Management Guidelines

How to score pain: 0 — 10

No Pain — Worst Pain Imagineable

Pain Score:		Action:
0	NONE	Continue to assess pain with every set of observations (**must be** at least daily).
1-3	MILD	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
4-6	MODERATE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
7-10	SEVERE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.

Guidelines

Cancer-related pain:

Always score the worst pain in the last 24hours or since last assessment.

FOR PERSISTANT MODERATE PAIN (4 OR ABOVE) WHICH DISTRESSES THE PATIENT:

Use Cancer Pain Management Algorithm in Palliative Care Resource File. This is distributed to all wards and is also accessible on the intranet. If no improvement in pain score contact hospital palliative care team on **page 1266** at SGH and **page 5742** at VI.

Out of hours advice can be obtained from the Prince and Princess of Wales Hospice on **0141 420 6785.**

Acute pain:

Score current pain on movement e.g. deep breathing

PERSISTENT SEVERE PAIN (7 OR ABOVE), WHICH DISTRESSES THE PATIENT:

Use Acute Pain Manual - distributed to all Operating Theatres areas and Surgical wards throughout Division. Also accessible on Intranet (via anaesthetic department homepage)

If no improvement in pain score contact CNS Pain Management on **page 1186/1157** at SGH and **page 3404/3101** at VI. On Call anaesthetist **page 1658** at SGH and **3004** at VI.

Measuring Sedation

The SEWS system uses the AVPU scoring system for conscious level. AVPU is an acronym for Alert, Verbal Pain, Unresponsive. The AVPU system relates to the previous sedation scale as follows:

Sedation	Descriptor	AVPU
0	Awake	A
1	Asleep, roused by speech	V
2	Physical stimulation (eg shaking) required to waken	P
3	Not roused by speech or shaking	U

Measuring Nausea

Is now recorded as 0 for no nausea or vomiting, N for nausea and V for vomiting

For persistent nausea and/or vomiting see clinical handbook or acute pain manual.

NB: Review Treatment Plan

If Temp>38 — blood cultures ☐ other cultures ☐ Start antibiotic therapy if indicated

If Systolic BP<100 — Review monitoring (cardiac/oximetry/urine output/invasive BP etc)
IV Access
Review patient/drug kardex. Consider fluid challenge ⟶ Definitive Therapy

Consider:

Hypovolaemia	Cardiac	Obstructive	Distributive
Dehydration	*Arryhthmia*	*PE*	*Sepsis*
Blood loss	*Pump failure*	*Tamponade*	*Anaphylaxis*

If Pulse>130 — Review monitoring
IV Access
Review patient/ECG/electrolytes ⟶ Definitive Therapy

If O_2 sats <93% — Review probe ? accurate
Review patient ⟶ prescribe oxygen on kardex if indicated.

If RR>24 — Review patient/CXR +/- gases/PEF etc ⟶ Definitive Therapy

If responds to pain only or unresponsive — Assess airway, BM GCS, consider neuro obs chart, review patient/kardex.

If BM<4 — Check urgent blood glucose/IV dextrose or oral carbohydrate

Patient's Name: Sean Maguire

D.o.B.: 01/12/83

Unit number:

Ward: 1

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

Date: 23/7/14

Previous 24 hour fluid balance - Intake: Output:

	Intake					Output		
Time	IV infusions	Volume	Enteral / Oral	Volume	Running Total	Urine	Drains (D), Vomit (V), Aspirate (A) etc	Running To
01								
02								
03								
04								
06	(N) saline	500			500			
07	(N) saline	500			1000			
08								
09								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
	Individual Totals:							
				Total Intake:			**Total Output:**	

Final Fluid Balance +/-

itient's Name: _____

.o.B.: _____

nit number: _____

'ard: _____

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

Date: | Previous 24 hour fluid balance - | Intake: | Output:

	Intake					Output		
Time	IV infusions	Volume	Enteral / Oral	Volume	Running Total	Urine	Drains (D), Vomit (V) Aspirate (A) etc	Running Tota
01								
02								
03								
04								
05								
06								
07								
08								
09								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
	Individual Totals:							
				Total Intake:			**Total Output:**	
ıal Fluid Balance	+/-							

SOUTHERN GENERAL HOSPITAL — **I.V. THERAPY PRESCRIPTION SHEET**

NAME: SEAN MAGUIRE. WARD: A+E UNIT No.: SG 00756471 D.O.B.: 01/12/83.

DATE	TIME		FLUID / BLOOD	ADDITIVE	VOLUME OR DOSE	TIMING	DOCTORS SIGNATURE		BATCH No.	NURSES SIGNATURE			
							ORDERED BY	CANCELLED BY		DATE	TIME	GIVEN BY	CHECKED BY
23.7.11		A	NaCl 0.9%		1000ml	Stat			11E 03TUC	23/7/11	05:45		
23/7/11		B	(N) Saline		500ml	4°	Cltl		11E 05TUC	23/7/11	06:45		
23/7/11		C	5% dextrose		500ml	4°	Cltl						
		D											
		E											
		F											
		G											
		H											
		I											
		J											
		K											
		L											
		M											
		N											
		O											
		P											
		Q											
		R											

DATE	ADVERSE REACTION	STOP FLUID/BLOOD/ADDITIVE	RECORD BATCH No. BELOW

0368104-SGH 27C

SOUTHERN GENERAL HOSPITAL — **I.V. THERAPY PRESCRIPTION SHEET**

NAME: WARD: UNIT No.: D.O.B.:

DATE	TIME		FLUID / BLOOD	ADDITIVE	VOLUME OR DOSE	TIMING	DOCTORS SIGNATURE		BATCH No.	NURSES SIGNATURE			
							ORDERED BY	CANCELLED BY		DATE	TIME	GIVEN BY	CHECKED BY
		A											
		B											
		C											
		D											
		E											
		F											
		G											
		H											
		I											
		J											
		K											
		L											
		M											
		N											
		O											
		P											
		Q											
		R											

DATE	ADVERSE REACTION	STOP FLUID/BLOOD/ADDITIVE	RECORD BATCH No. BELOW

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW UNIVERSITY HOSPITALS

A

Name MAGUIRE SEAN Sex M D.O.B. 01.12.83 Location Acc / Emergency SGH

CHI Number 0112836097 Consultant Dr.Jason.Long Hosp. Number SG00756471

Received 29.09.07 00:25

Prov. Diagnosis Lab. Number R,07.1201597.R

Withdrawal		Na 135-145	K 3.5-5.0	Cl 97-107	HCO_3 23-30	Urea 2.5-7.0	Creat. 40-130	Glucose 3.5 - 6.0 mmol/L Fasting	Amylase <100	Magnesium 0.70-1.00	Urate F: 0.15-0.36 M: 0.21-0.44	Ser. Osm. 275-295	Ur. Osm.
Date	Time	mmol/L					µmol/L		U/L	mmol/L		mmol/kg	
27.05.07	00:39	146	4.3	107	28	4.3	102	5.5					
06.07.07	11:00	141	4.8	104	28	4.5	89						
29.09.07	00:14	145	3.8	111	23	3.5	88	4.8	38				

Withdrawal		T.Protein 62-82	Albumin 35-49	Globulins 20-35	Bilirubin <20	Alk. Phos. 60-260	AST <40	ALT <40	γ-GT F<30, M<50	CK F<170, M<210	Calcium	Adj. Ca 2.15-2.60	Phosphate 0.70-1.40
Date	Time	g/L			µmol/L	U/L					mmol/L		
27.05.07	00:39	80	42	38	5	107	33	21	26				
06.07.07	11:00	77	44	33	14	103	19	20					
29.09.07	00:14	77	43	34	9	95	26	23					

29.09.07 eGFR >60 mL/min Refer to CKD guidelines

Revised Albumin Ref Range 32-45g/L and Globulins 23-38g/L.

ALP Age & sex Ref Ranges (Male 25-110 Female 25-110) ***

Report authorised by Computer validation

Run No: 327 Issued 29.09.07 at 08:00

SGH 365

BIOCHEMISTRY DEPARTMENT

EDGE TO LINE ABOVE

SOUTHERN GENERAL HOSPITAL GLASGOW

A

Name MAGUIRE SEAN Sex M D.O.B. 01.12.83 Hospital SGH Ward 2

Address 97 GLEDDOCH RD GLASGOW Consultant Mr.M.W.G.Gordon Reg. Number SG00756471

Received 11.12.02 21:50

Prov. Diagnosis ? Compression hand Lab. Number R,02.0183105.D

Withdrawal		Sod. 135-145	Pot. 3.5 - 5.0	Chlor. 101 - 111	Tot. CO_2 23 - 30	Urea 2.5 - 7.5	Creat. 40 - 130 µmol/l	H+ 36 - 43 nmol/l	Pco_2 4.6 - 6.0	Po_2 10.5 - 13.5	Bicarb. 23 - 30 mmol/l	Glucose 3.3 - 5.6 mmol/l Fasting	Pl. Osm. 275 - 295	Urine Osmol.	Bili (Paed.) µmol/l
Date	Time	mmol/l							kPa				mmol/kg		
11.12.02	21:00	140	3.7	103	29	4.9	78								

Withdrawal		Calc. 2.12 - 2.62	Phos. 0.70 - 1.40	T. Prot. 62 - 82	Alb. 35 - 50	Glob. 20 - 35	Bili. 5 - 20 (µmol/l)	Alk. Phos. 70 - 350	AsT. <40	AlT <40	LDH 240 - 525	CK <170	GGT. M<50 F<35
Date	Time	mmol/l		g/l				IU/l					
11.12.02	21:00											184	

COMMENT

Reference ranges may vary with age and sex. Quoted ranges are for guidance only.

Run No: 124 Issued: 12.12.02 08:48

HAEMATOLOGY

MOUNT SHEET

	11)
	10)
	9)
	8)
	7)
	6)
	5)
	4)
	3)
	2)

REPORTS ARE NO FURTHER TO THE RIGHT THAN THIS LINE

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
MAGUIRE	SEAN	M	01.12.83	SG00756471
DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS			
Mr.M.W.G.Gordon	Ward 2 SGH			Run : 4458

REPORT

RR

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
12-DEC-02	X10⁹/L	3.2	1.79	0.68	0.19	0.04	Fiona Baillie		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
11-Dec-02	174091	5.9	188	4.81	146	0.432	90	30.3	

FORM 0164158

JB-24336/2

SOUTHERN GENERAL HOSPITAL NHS TRUST
PATIENTS PROFILE

WARD / DEPT: Wd 2		NAMED NURSE:	
CONSULTANT: Mr ~~McGreath~~ WACKER		REFERRAL: A+E	
DATE: 11-12-02		TIME: ~~2115~~ 2140	
PATIENTS NAME: Sean Maguire			
UNIT NUMBER: 00756471			
PREFERS TO BE CALLED:			
ADDRESS: 97 Gleddoch Road			
TELEPHONE NUMBER: 882 0453			
AGE: 19	D.O.B.: 01/12/83	SEX: M	MARITAL STATUS: S
OCCUPATION: Warehouse			
RELIGION: RC	CLERGY / OTHER:	CONTACT REQUIRED:	CONTACTED:

REASON FOR ADMISSION:

Reduced sensation to middle (R) finger, sensation absent (R) little finger and (R) Ring finger.

Accident 5 days ago involving a crushing injury to (R) hand when tyre fell on top of hand.

PREVIOUS HEALTH HISTORY:

Nil stated

KNOWN ALLERGIES:

Paramax

SGH 308

PATIENTS PROFILE (cont'd)

MEDICATION ON ADMISSION:

Nare

PATIENTS PRECEPTION OF CURRENT HEALTH STATUS:

Awaiting

RELATIVES PRECEPTIONS OF PATIENTS HEALTH STATUS:

EMERGENCY CONTACT NAME:

NEXT OF KIN: Madge Maguire

RELATIONSHIP: Mother

ADDRESS: S/A

TELEPHONE NUMBER (DAY): 0141 8820453 | TELEPHONE NUMBER (NIGHT):

OTHER RELEVANT CONTACT:

G.P.'s NAME: Dr Barn's

G.P.'s ADDRESS: Crookston Road

G.P.'s TELEPHONE NUMBER:

Patient / Relative spoken to by	DATE	TIME	DOCTOR	NURSE

VALUABLES: DISPOSAL HOME WARD CASHIER'S OFFICE

CLOTHING: DISPOSAL HOME WARD CASHIER'S OFFICE

NURSES SIGNATURE: M Mackenna

SOUTHERN GENERAL HOSPITAL
NURSING ASSESSMENT

PATIENTS NAME: Sean Maguire	UNIT No.:	WARD: 2

GENERAL ASSESSMENT ON ADMISSION:

Well kempt on admission

Pain beginning to increase down (R) arm since admission

(R) hand cold to touch
capillary return appears slow.

SOCIAL / HOME BACKGROUND (INCLUDING PROBLEMS RELATED TO ADMISSION):

Lives with mum and brother

No social services

Smoke - None

Alcohol - Weekends only

BLOOD PRESSURE:	147/66 98%	WEIGHT:	10st
PULSE:	84	HEIGHT:	5ft 11"
RESPIRATIONS:	18	URINALYSIS:	NAD
TEMPERATURE:	36.8	WATERLOW SCORE:	

SGH 310

NURSING ASSESSMENT (ASSESSMENT OF ACTIVITIES OF DAILY LIVING)

MAINTAINING A SAFE ENVIRONMENT, COMMUNICATING, BREATHING, EATING AND DRINKING, ELIMINATING, PERSONAL CLEANSING AND DRESSING, CONTROLLING BODY TEMPERATURE, MOBILISING, WORKING AND PLAYING, EXPRESSING SEXUALITY, SLEEPING, DYING.

Independant normally with activities of daily living.

NURSES SIGNATURE:

SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: Sean Maguire UNIT NO. WARD: 2

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
11.12.02 2210		Admitted to Ward 2 via A+E, (R) arm elevated high in bradford sling Observations stable BP 147/66 to fast from midnight as requested by Dr Loij, Range of movement limited, will wrist flexion of (R) hand. sensation remains unchanged since admission little finger and ring finger remain absent of sensation, pain increasing, Dr Loij aware Urinalysis - NAD	MMacLean
		(R) hand cold to touch, capillary return appears slow, Brufen given for pain settled thereafter.	MMacLean
	06[10]	Slept well overnight, fasted from midnight, (R) Hand warm to touch	MMacLean
		S/B Reg A. Oliver last night, no longer requires to have arm in high elevation, has had discussion with Mr Walker.	MMacLean
		Has slight return of sensation now to (R) little finger and ring finger.	MMacLean
		Seen by Mr Walker. No surgery at present. To be discharged home OPA Tues. To ~~keep~~ keep arm in high elevation. Sling given.	SMcGuire

GH 306A

Waterlow Pressure Sore Risk Assessment

Southern General Hospital NHS Trust

Ward..... 2 .....

Weight on admission..... 10st .....

Name Sean Maguire

Waterlow score on admission..... 5 .....

Unit No. .....

Assessment should be carried out on all patients within 2-4 hours of admission and repeated within 24hrs. Reassess if condition changes or at least weekly thereafter.

Select scores from table, add to get total. Several scores per category can be used.

A: BUILD/WEIGHT FOR HEIGHT			C: SKIN TYPE, VISUAL RISK AREAS		E: SEX,AGE		SPECIAL RISKS	
BMI			Healthy	0	Male	1	G:TISSUE MALNUTRITION	
20 - 24.9	Average	0	Tissue Paper	1	Female	2	eg: Terminal Cachexia	8
25 - 29.9	Above Average	1	Dry	1	14 - 49	1	Cardiac Failure	5
> 30	Obese	2	Oedematous	1	50 - 64	2	Peripheral Vascular disease	5
< 20	Below Average	3	Clammy (temp+)	1	65 - 74	3	Anaemia	2
CONTINENCE			Discoloured	2	75 - 80	4	Smoking	1
Complete/Catheterised		0	Broken/Spot	3	80+	5		
Occasional Incontinence		1	D: MOBILITY		F: APPETITE		H: NEUROLOGICAL DEFICIT	
Cath/Incontinent of Faeces		2	Fully	0	Average	0	eg: Diabetes, M.S., C.V.A.,	
Doubly Incontinent		3	Restless/Fidgety	1	Poor	1	Motor/Sensory Paraplegia	4-6
			Apathetic	2	N.G. Tube		I: MAJOR SURGERY/TRAUMA	
			Restricted	3	Fluids only	2	Orthopaedic-	
			Inert/Traction	4	NBM/Anorexic	3	Below Waist, Spinal	5
			Chairbound	5			On table > 2 hours	5
							J: MEDICATIONS	
							Cytotoxics, High Dose Sterioids Anti-Inflammatory	4

SCORE	10 + AT RISK	15 + HIGH RISK	20 + VERY HIGH RISK

If Waterlow score >10 or BMI <20 or >25 refer the patient to the Dietitian. Date of referal to Dietitian.....

DATE	A	B	C	D	E	F	G	H	I	J	TOTAL	WEIGHT	SIGNATURE	REVIEW DATE
1/12/00	0	0	0	0	1	0	-	4	-	-	5		MMK.	

NB DOCUMENT "ACTION TAKEN" IN NURSING CARE PLAN

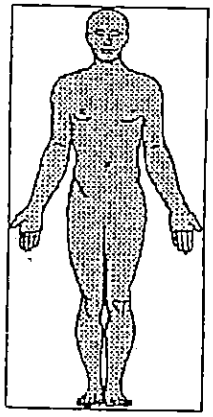
WRAC.DOC

DATE	A	B	C	D	E	F	G	H	I	J	TOTAL	WEIGHT	SIGNATURE	REVIEW DATE

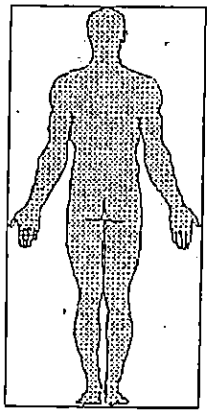
DETAILS OF PRESSURE SORES PRESENT ON ADMISSION

Site of sore.

Front



Back



Grade of sore.

1 Blanching hyperaemia.

2 Non-blanching hyperaemia.

3 Ulcer progresses through to subcutaneous tissue.

4 Lesion extends into subcutaneous fat.

5 Infective necrosis/necrotic tissue.

(Torrance 1983)

On admission, number site of sore on the above diagram and enter grade on table below. Commence on wound assessment chart where appropriate, i.e. stage 3 and above and stage 2 if there is a break in the skin.

Number	Date	Grade	Treatment

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

PATIENT MOVING AND HANDLING RISK ASSESSMENT

Patient's Name: Sean Maguire	If patient is totally independent, tick here and go to date box ✓
Named Nurse:	

BODY BUILD

Obese		Tall	
Above average		Medium	
Average		Short	
Below Average		Weight:	

RISK OF FALLS — High | Low

Problems with comprehension, behaviour, co-operation (specify)

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

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE | SUPERVISION | INDEPENDENT ✓

Staff required:

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE | SUPERVISION | INDEPENDENT

Additional Information

TOILETING

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE | SUPERVISION | INDEPENDENT

Additional Information

WALKING

NO WALKING		ASSISTANCE	
Staff required:			
Walking Aid			

SUPERVISION | INDEPENDENT

Distance walked / additional information

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT	
Which hoist?		Sliding aid	
Sling type?		Rope ladder	
Sling size?		Hand blocks	
		Monkey poles	

ASSISTANCE | SUPERVISION | INDEPENDENT

Additional information (include details of any therapy beds used)

Staff required:

SIT UP OVER SIDE OF BED

Rope ladder | Sliding aid | ASSISTANCE | SUPERVISION | INDEPENDENT

MOVE ON/OFF BED PAN

Hoist | Roll Patient | Patient bridges | Monkey pole | Not used

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid) | Sliding aid (fabric) | Transfer aid (specify) | Staff required (specify) | INDEPENDENT

Date assessed: 11.12.02 | Assessors signature:

Date reviewed									
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:					

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information					

TOILETING

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information					

WALKING

NO WALKING		ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:				Distance walked / additional information			
king Aid							

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT	
Which hoist?		Sliding aid	
Sling type?		Rope ladder	
Sling size?		Hand blocks	
		Monkey poles	

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information (include details of any therapy beds used)					
Staff required:					

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges		Monkey pole		Not used	

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid)		Sliding aid (fabric)		Transfer aid (specify)	Staff required (specify)		INDEPENDENT	

Date assessed:	Assessors signature:

e reviewed									
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

SOUTHERN GENERAL HOSPITAL NHS TRUST

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

NURSING CARE PLAN

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

DATE AND TIME	PROB NO	PROBLEM	NURSING ACTION	AIMS OF CARE	INTL	REVIEW DATE	DISC
11-12-02 2145		Loss of sensation (R) little and ring finger	(R) hand on high elevation in bradford sling + observe				
11-12-02 2145		Altered sensation (R) middle finger	same				

PATIENTS NAME: Sean Maguire

UNIT NO. [redacted]

WARD NO. 2

SGH 309

SOUTH N GENERAL AND ASSOCIATED HOSPITALS

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17
18 19 20 21 22 23 24 25 26 27 28 29 30 31

NURSING CARE PLAN

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17
18 19 20 21 22 23 24 25 26 27 28 29 30 31

DATE AND TIME	PROB NO	PROBLEM	NURSING ACTION	AIMS OF CARE	INTL	REVIEW DATE	DISC
11.12.87	1	Anxiety due to admission.	Orientation to ward – introduction to patients and staff on / / .	To minimise patient's anxiety.			
			Explain ward routine / / .	To ensure patient has adequate understanding of planned procedures and management in order to promote a good post-operative recovery.			
			Explain – a) Pre-op. management b) Operational procedure c) Post op. management to patient on / / .				
			Provide opportunity for patient to ask questions.				
	2	Prepare for Theatre	Prepare as specified on Theatre Check List evening of / / . morning of / / .	To ensure adequate preparation of patient for Theatre.			
			Fast from am pm / / .	To prevent post operative complications.			
	3	Transfer of Patient to Theatre	Patient escorted to Theatre by a trained nurse.	To ensure safe transfer of patient to Theatre.			
			Nurse escort introduces patient to Theatre Nurse and hands over documentation to Theatre Nurse.				

GD/PM 4/91.

PATIENTS NAME: Sean Maguire

UNIT NO.

WARD NO. 2

SGH 309

NHS Greater Glasgow

South Glasgow University Hospitals NHS Trust

DISCHARGE CHECKLIST

Patient's name: Sean Maguire
Unit number: 00756471
Discharge destination: H

Ward: 2
Date of discharge: 12/12/02

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		J. McM	
Relative / Carer informed	✓			
Others informed: Res. / Nursing Home		—		
Transport arranged		✓		
Ambulance - 1 man / 2 man am / pm		✓		
Hospital ~~car~~ TAXI	✓		J. McM	
Own transport		✓		
Other - Please specify:		—		
Discharge medication	✓			
Discharge prescription completed	✓		J. McM	
Compliance aids requested				
Medication received	✓			
Medication explained to patient	✓			
Own medication returned to patient		✓		
Dressings / Continence aids (7 days supply)		✓		
Other discharge items		✓		
Keys		✓	J. McM	
Patients clothing available		✓		
Valuables		✓		
Intravenous canula removed		✓		
Part 2 Discharge Letter - Required		✓		
Completed		✓		
OP clinic appointment	✓		J. McM	
Arranged	✓			
To follow		✓		
Not known		✓		
Informed of discharge		✓		
Physiotherapist		✓	J. McM	
Occupational Therapist		✓		
Dietitian		✓		
Speech and Language Therapist		✓		
Clinical Nurse Specialist		✓		
Liaison / District Nurse		✓		
Social Work / Other agencies / Home help		✓		

Additional Information / Leaflets / Factsheets

Nurse's signature: J. McM Designation: SN Date: / /

SGH 488
0005752

PRESCRIPTION FORM

Hospital Name: .....

PATIENT DETAILS

Name: Sean Maguire	Height:
Hospital Number: 756471	Weight:
DOB: 1/12/83	Surface area:
Date of Admission: 11/12/12	Date of writing discharge prescription: __/__/__
Consultant Name: McCrea M	Ward:

Date and time this form prepared:	Sheet No	2nd Prescription in use
__/__/__ Time:_____	.....	Yes or NO

DRUG SENSITIVITIES

Paramax

DVT Risk on Admission (SIGN Guideline)

High ☐ Moderate ☐ Low ☐

Assessed by: Date: __/__/__

OTHER CHARTS IN USE

Insulin	☐	TPN:	☐
PCA and other infusions	☐	Enteral Nutrition:	☐
Anticoagulants: Heparin	☐	Oxygen Therapy:	☐
Oral	☐	Other:	
Topical:	☐		

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF DOCTOR	GIVEN BY	TIME GIVEN

PATIENT'S NAME:

ADMINISTRATION

Parenteral Drugs: Regular Prescription

DATE →

MONTH →

A DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

B DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

C DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

E DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

F DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

G DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

H DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE

MONTH

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

J DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF DOCTOR

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

K DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF DOCTOR

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

L DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF DOCTOR

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

M DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF DOCTOR

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescriptions

DATE
MONTH

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

T DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

V DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

W DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

X DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

LL DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

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

PATIENT'S NAME:

All Routes: As Required Prescriptions

ADMINISTRATION

MM	DRUG: ~~Eqpake~~		STOPPED DATE: 11/12
DOSE: 2tabs	ROUTE: po	INDICATION: pain	INITIALS: [illegible]
SIGNATURE OF DOCTOR: [illegible]		MAX.FREQUENCY: 4-6°	DATE: 11/12/2
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE																										
TIME																										
DOSE																										
GIVEN BY																										

NN	DRUG: Brufen		STOPPED DATE:
DOSE: 400mg	ROUTE: po	INDICATION: pain	INITIALS:
SIGNATURE OF DOCTOR: [illegible]		MAX.FREQUENCY: 4-6°	DATE: 11/12/2
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE	12/12	12/12																								
TIME	0200	1010																								
DOSE	400mg	400mg																								
GIVEN BY	[illegible]	[illegible]																								

PP	DRUG		STOPPED DATE:
DOSE	ROUTE	INDICATION	INITIALS:
SIGNATURE OF DOCTOR		MAX.FREQUENCY	DATE:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE																										
TIME																										
DOSE																										
GIVEN BY																										

RR	DRUG		STOPPED DATE:
DOSE	ROUTE	INDICATION	INITIALS:
SIGNATURE OF DOCTOR		MAX.FREQUENCY	DATE:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE																										
TIME																										
DOSE																										
GIVEN BY																										

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

SS	DRUG			STOPPED DATE: INITIALS:	DATE	
DOSE	ROUTE	INDICATION			TIME	
SIGNATURE OF DOCTOR		MAX.FREQUENCY		DATE:	DOSE	
					GIVEN BY	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						

TT	DRUG			STOPPED DATE: INITIALS:	DATE	
DOSE	ROUTE	INDICATION			TIME	
SIGNATURE OF DOCTOR		MAX.FREQUENCY		DATE:	DOSE	
					GIVEN BY	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						

VV	DRUG			STOPPED DATE: INITIALS:	DATE	
DOSE	ROUTE	INDICATION			TIME	
SIGNATURE OF DOCTOR		MAX.FREQUENCY		DATE:	DOSE	
					GIVEN BY	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						

WW	DRUG			STOPPED DATE: INITIALS:	DATE	
DOSE	ROUTE	INDICATION			TIME	
SIGNATURE OF DOCTOR		MAX.FREQUENCY		DATE:	DOSE	
					GIVEN BY	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						

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

Nurse/Midwife Administration by Proto(- Authorised Nurses/Midwives (

(Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the nurse/midwife administration protocol No.(s) ..... with the following exceptions: _____

Signature: _____ Date: _____

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF NURSE	GIVEN BY	TIME GIVEN

Notes for Users

FOR DOCTORS:

1. Sign your name clearly against each prescription.
2. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date appropriate boxes.
3. If an existing prescription is to be modified, delete existing prescription as described and re-write new instructions in a new section.
4. Use approved names in BLOCK LETTERS and use metric doses as follows:

   Milligram = **mg** Gram = **g**

   Millilitre = **ml** Microgram: **to be written in full.**

   Fractions of a milligram should be written in micro grams. A zero should be written in front of a decimal point where there is no other figure, e.g. 0.5ml **not** .5ml.
5. Method of administration should be abbreviated as follows:

Intravenous	= **IV**	Oral	= **O**
Subcutaneous	= **SC**	Per rectum	= **PR**
Inhalations	= **INH**	Topical	= **TOP**
Sublingual	= **SL**	Nasogastric	= **NG**
Intramuscular	= **IM**	Vaginal	= **PV**
Intradermal	= **ID**		

FOR NURSES:

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

Codes for Non-Administration of Drugs

(3) Patient refused	(7) Patient asleep	(11) Unable to swallow	(14) Other - Record in nursing notes
(4) Drug not available	(8) Time varied on doctor's instructions	(12) No intravenous access	(15) Prescription clarification required
(5) Nil by mouth/fasting	(9) Dose withheld on doctor's instructions	(13) Patient Self-Administration of Medicine	
(6) Patient unavailable	(10) Nausea/vomiting		

Ver 6, 01/2002

South Glasgow University Hospitals NHS Trust
Southern General Hospital, Glasgow G51 4TF Tel. 0141-201-110[illegible]

Part I Discharge Letter and Medicine Prescription Form - Confidential Ref No: 033672

Dear Doctor .....
Surgery .....

Patient: SEAN MAGUIRE
Address: 97 GLENDOCH RD
.....
.....
DOB: 1/1283 Unit no: 756471
Weight ..... *Fix ID label to all 4 copies.*

Ward: 21
Ward telephone number: .....
Consultant: Mr WALKER
Named Nurse: .....
Admission date: 11/12/02
Discharge date: 12/12/02

Follow-up arrangements
Clinic appointment made:
Yes ☐ No ☐ To follow ☐
Clinic name .....
Date ...../...../.....
Non-childproof containers required: Yes ☐ No ☐
Medicine compliance aids required: Yes ☐ No ☐
Specify: .....

Reason for admission, treatment, diagnosis
crush injury right arm

Other information

MEDICINE	Dosage form	Dose	Times for administration: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 8	pm 10	Other times	Recommended duration of treatment after discharge	New Drug ✔	New Dose ✔	Number of days supply	Dispensing Details (Pharmacy only)
CODAMOL 30/500	2	2 tabs		✓		✓		✓					PRN				100 Sa/dh

Medicines discontinued	Reason (if known) e.g. side effects

Clinical Pharmacy check:
Drug sensitivity

Dispensed by: LA Date: 12/12/02
Checked by: [signature]

WARD USE ONLY
Med. rec. on ward by: .....
Issued by: [signature] Date: 12/12/02
Signature of recipient: [signature]

Doctor's name: RACECOURSE Signature: [signature] Date: 12/12/02
Doctor's grade: SHO Pager number: 2557

Number of prescription sheets at discharge:

White copy - G.P.; Pink copy - Case Notes; Blue copy - Pharmacy; White copy - Patient.

If you have any problems after discharge, please contact the Ward or your G.P.

SOUTHERN GENERAL HOSPITAL
PATIENTS PROFILE

WARD / DEPT: 2. Ortho	NAMED NURSE: ~~H~~ K. L Blair
CONSULTANT: MR Patel	REFERRAL: A+E
DATE: 30-9-07	TIME: 06.30
PATIENTS NAME: Sean McGuire	
UNIT NUMBER: 5900764711	
PREFERS TO BE CALLED: Sean	
ADDRESS:	
TELEPHONE NUMBER:	

AGE:	D.O.B.:	SEX:	MARITAL STATUS:
23.	1-12-83	M	S.

OCCUPATION:			
RELIGION:	CLERGY / OTHER:	CONTACT REQUIRED:	CONTACTED:

REASON FOR ADMISSION: ? CSpine injury ? #C2
attended A+E last pm after falling
down 12 stairs. ? having seizures
with lucid moments
CT - Brain - Normal
CT - Brain - ? C2 ~~fx~~
Took an irregular discharge from A+E
Presented again to A+E 999 call this am
with Neck pain
For Neuro observations GCS 15/15

PREVIOUS HEALTH HISTORY: awaiting seizure clinic
appointment

KNOWN ALLERGIES: Paramax

SGH 308

PATIENTS PROFILE (cont'd)

MEDICATION ON ADMISSION: N. I to Note

PATIENTS PRECEPTION OF CURRENT HEALTH STATUS:

Patient aware

RELATIVES PRECEPTIONS OF PATIENTS HEALTH STATUS:

EMERGENCY CONTACT NAME:

NEXT OF KIN:

RELATIONSHIP:

RESS:

TELEPHONE NUMBER (DAY):

TELEPHONE NUMBER (NIGHT):

OTHER RELEVANT CONTACT:

G.P.'s NAME:

G.P.'s ADDRESS:

G.P.'s TELEPHONE NUMBER:

Patient / Relative spoken to by	DATE	TIME	DOCTOR	NURSE

VALUABLES: DISPOSAL HOME WARD CASHIER'S OFFICE

CLOTHING: DISPOSAL HOME WARD CASHIER'S OFFICE

NURSES SIGNATURE: [signature]

SOUTHERN GENERAL HOSPITAL
NURSING ASSESSMENT

PATIENTS NAME: Sean McGuire	UNIT No. 875471.	WARD: 2

GENERAL ASSESSMENT ON ADMISSION:

Smelling of alcohol.
Complaining of painful neck
GCS 15/15
Hard collar in situ

SOCIAL / HOME BACKGROUND (INCLUDING PROBLEMS RELATED TO ADMISSION):

~~Lives with family~~ Lives with girlfriend.
Smokes occasionally
alcohol weekends.

BLOOD PRESSURE: 131 / 76	WEIGHT:
PULSE: 86	HEIGHT:
RESPIRATIONS: SATS 97%	URINALYSIS:
TEMPERATURE: 35.6	WATERLOW SCORE: 8

SGH 310

NURSING ASSESSMENT (ASSESSMENT OF ACTIVITIES OF DAILY LIVING)

MAINTAINING A SAFE ENVIRONMENT, COMMUNICATING, BREATHING, EATING AND DRINKING, ELIMINATING, PERSONAL CLEANSING AND DRESSING, CONTROLLING BODY TEMPERATURE, MOBILISING, WORKING AND PLAYING, EXPRESSING SEXUALITY, SLEEPING, DYING.

Normally independent with ADLs

NURSES SIGNATURE: [signature]

SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: Seán McGUIRE UNIT NO. 0756471 WARD: 2

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
30/9/08	0645	Admitted to ward via A+E with ? C. Spine injury. Hard collar in situ. CSM to all 4 Ltbs intact. For neuro observations: GCS 15/15. For review thro' am. Observations stable. Patient states he is single/friend knows he has been admitted to ward	[illegible]
	1500	Stable GCS 15/15. 9/3. MV Portil for C-Spine trans. Unable to PV Contacted PHO - PT called to attend CT Side of bed. Pulse OCCMS. Awaiting r/v of Xrays. Hard collar remains in situ.	[illegible]
		PHO reviewed Xrays. Hard collar off. Diet + fluids taken.	[illegible]
	1945	Patient requested to be discharged home. Seen by SHO Registrar aware Patient discharged as per profile next of kin follow up. Part I discharge letter to be posted. Discharged as per profile	[illegible]

SGH 306A

SOUTH GLASGOW HOSPITALS
PATIENT MOVING AND HANDLING RISK ASSESSMENT

NHS Greater Glasgow and Clyde

Patient's Name: Sean Mc Guire	If patient is totally independent, tick here and go to date box
Named Nurse:	

BODY BUILD

Obese		Tall	
Above average		Medium	
Average	✓	Short	
Below Average		Weight:	

RISK OF FALLS — High | | Low | ✓

Problems with comprehension, behaviour, co-operation (specify)

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

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:					

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information					

TOILETING

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information					

WALKING

NO WALKING		ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:				Distance walked / additional information			
Walking Aid							

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT	
Which hoist?		Sliding aid	✓
Sling type?		Rope ladder	
Sling size?		Hand blocks	
		Monkey poles	

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information (include details of any therapy beds used)					
Staff required:					

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges	✓	Monkey pole		Not used	

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid)		Sliding aid (fabric)	✓	Transfer aid (specify)	Staff required (specify)		INDEPENDENT	

Date assessed: 30-9-07	Assessors signature: LCS

Date reviewed									
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH		ASSISTANCE		SUPERVISION		INDEPENDENT	
Hoist (Specify)		Parker		Staff required:					
Shower chair.		Variable height							
		Standard							
		Any							

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT	ASSISTANCE		SUPERVISION		INDEPENDENT	
Which hoist?		Staff required:	Additional Information					
Sling type?		Specify support given						
Sling size?								

TOILETING

HOIST		MANUAL SUPPORT	ASSISTANCE		SUPERVISION		INDEPENDENT	
Which hoist?		Staff required:	Additional Information					
Sling type?		Specify support given						
Sling size?								

WALKING

NO WALKING		ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:				Distance walked / additional information			
Walking Aid							

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT		ASSISTANCE		SUPERVISION		INDEPENDENT	
Which hoist?		Sliding aid		Additional information (include details of any therapy beds used)					
Sling type?		Rope ladder		Staff required:					
Sling size?		Hand blocks							
		Monkey poles							

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges		Monkey pole		Not used	

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid)		Sliding aid (fabric)		Transfer aid (specify)	Staff required (specify)		INDEPENDENT	

Date assessed:	Assessors signature:

Date reviewed									
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

Patient's name Sean McGuire

Unit number 300 0756471

Ward 2

Use addressograph label.

South Glasgow Hospitals

Pressure Ulcer Risk Assessment Record

NHS Greater Glasgow and Clyde

Modified Waterlow Risk Assessment

Initials	LG														
Date	3/5														
Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Body weight for height:															
Average 0 Above average 1															
Obese 2 Below 3	0														
Continence:															
Completely / Catheterised 0 Occasionally incontinent 1															
Catheterised / Incontinent of faeces 2 Doubly incontinent 3	0														
Skin type - Visual risk areas:															
Healthy 0															
Tissue paper/Dry 1															
Oedematous/Clammy (temp. raised) 1															
Discoloured 2															
Broken spot 3	0														
Mobility:															
Fully 0 Restless/Fidgety 1															
Apathetic 2 Restricted 3															
Inert/Traction 4 Chairbound 5	5														
Sex/Age:															
Male/Female 1/2 14-49 1	1														
50-64 2 65-74 3															
75-80 4 80+ 5	1														
Appetite:															
Average 0 Poor 1															
N.G. tubes/fluids only 2 NBM / Anorexic 3	0														
Special risks - Tissue malunitrition:															
e.g. Terminal cachexia 8															
Cardiac failure 5															
Peripheral vascular disease 5															
Anaemia 2															
Smoking 1	1														
Neurological deficit:															
e.g. Diabetes, MS, CVA, Motor-sensory paraplegia 4-6	0														
Major surgery /trauma:															
Orthopaedic; Below waist; Spinal 5															
On table > 2 hours 5	0														
Medication:															
Cytotoxics; Highdose steroids; Anti-inflamatory 4	0														
TOTAL SCORE:	8														

Score as follows: <10 = Low risk; 10-14 = At risk; 15-19 = High risk; 20+ = Very high risk.

Refer to Pressure Ulcer Prevention Guidelines (GGHB) for action.

Action Plan

Date	Preventative action to be taken (e.g. turning time; position; support surface/cushion; other)	Signature

Further action

	Date	Signature
Referred to dietitian		
Referred to TVNS		
'Wound and Pressure Area Care Assessment Chart' commenced		

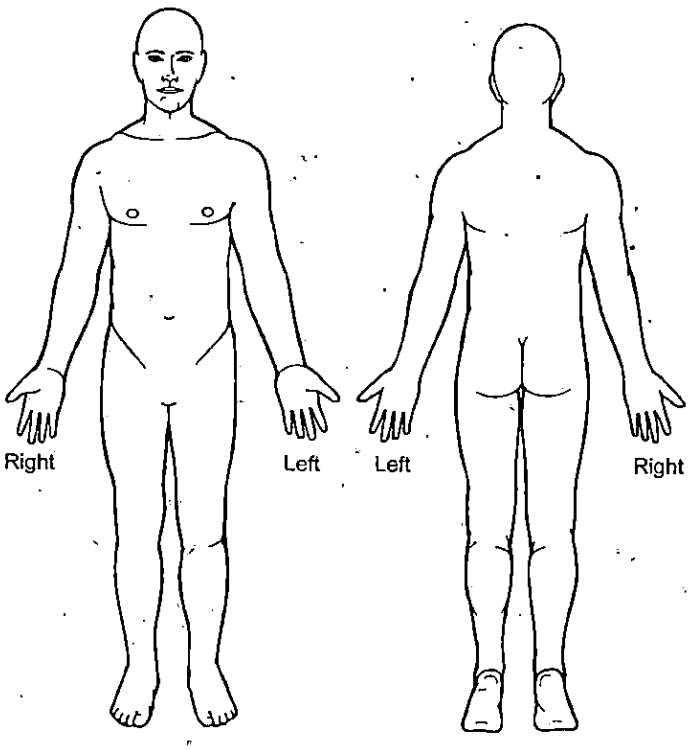
GRADE OF ULCER (Torrance)

GRADE	*DEFINITION*
1.	Blanching hyperaemia.
2.	Non-blanching hyperaemia.
3.	Ulceration progresses through to dermis.
4.	Lesion extends through to subcutaneous fat.
5.	Infective necrosis / necrotic tissue.

RECORDING THE GRADE OF ULCER

On admission, **number site of ulcer** on the diagram opposite and **enter the ulcer number and the grade** in the action plan.

Assessment should be carried out on all patients within 2 - 4 hours of admission and repeated 24 - 48 hours afterwards. Repeat assessment as condition changes or at weekly intervals.



SURGICAL DIRECTORATES: PATIENT CARE PLAN

NAME: Seán McGuire UNIT NO: 076471

D.O.B: 1-12-83 WARD: 7 DATE OF ADMISSION: 30-9-07

Date Commenced & Signature	PERSONAL HYGIENE/DRESSING	Tick	Date Discontinued & Signature
	Independent		
	Bedbath		
	Shower		
	Immersion Bath		
	Basin		
	Assistance Required:		
	No of Staff:		
[redacted]	Oral Hygiene:		
	Independent		
	Assistance Required:		
	MOBILISATION		
	Independent		
	Assistance Required:		
	No of Staff:		
	Aids Used: Walking Stick:		
	Zimmer:		
	Elbow Crutches:		
	Wheelchair:		
30-9-07 LR	Other: Bed rest due to ? Cspine injury	✓	
	EATING & DRINKING		
LR 30-9-07	Normal Diet:		
	Special Diet:	✓	
	Light Diet:		
[redacted]	Assistance to Eat & Drink:		
	Fluids Only:		
	Dietary Supplements:		
	Parental/Entral Nutrition:		
	Nasogastric Tube:		
	Fasting: From:		
	To:		
	Light Early Breakfast: Time:		
	ELIMINATIONS		
LR 30-9-07	Independent:		
	Assistance to Toilet:	✓	
	No of Staff:		
	Urinary Catheter:		
	Suprapubic Catheter:		
	Ileal Conduit:		
	Colostomy:		

ıte Commenced Signature	SPECIAL NEEDS/MAINTAIN PERSONAL SAFETY	Tick	Date Discontinued & Signature
	Cotsides:		
	Visually Impaired: Removal Hazards		
	TECHNICAL CARE		
	Venflon Insitu:		
	IV Infusion:		
	Check Site:		
	Subcutaneous Cannula Insitu:		
	Oxygen: Mask:		
	Rate:		
	Length of Time:		
	OBSERVATIONS		
	BP:		
	Pulse:		
	Temperature:		
	Saturations:		
	Fluid Balance:		
	Glucose Monitoring:		
	C.S.M. (Fingers: R L) (Toes R L)		
	Vascular Observations:		
	Stool Chart:		
	PAR Scoring:		
KD 3.9.02	Head Injury Observations:	✓	
	WOUND CARE/OTHER CARE		
	Pressure Area Care:		
	Check: Hourly		
	Pressure Cushion:		
	Therapy Mattress:		
	Avant Guard Bed:		
	Wound Assessment Chart:		
	PAIN ASSESSMENT CHART		
NB 3.9.02	Patient Moving & Handling Risk Assessment	✓	
	MISCELLANEOUS		
	Ted Stockings: Size:		

NHS
Greater Glasgow and Clyde

South Glasgow Hospitals

DISCHARGE CHECKLIST

Patient's name: Sean Maguire

Ward: 2

Unit number:

Date of discharge: 30/9/07

Discharge destination: Home

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓			
Relative / Carer informed		✓		✓
Others informed: Res. / Nursing Home				
Transport arranged				
Ambulance - 1 man / 2 man am / pm				
Hospital car				
Own transport	✓			
Other - Please specify:				
Discharge medication				
Discharge prescription completed		✓		
Compliance aids requested				
Medication received				
Medication explained to patient				
Own medication returned to patient		✓		
Dressings / Continence aids (7 days supply)				
Other discharge items				
Keys				
Patients clothing available				
Valuables				
Intravenous canula removed		✓		
Part 2 Discharge Letter - Required		✓		
Completed				
OP clinic appointment				
Arranged		✓		
To follow				
Not known				
Informed of discharge				
Physiotherapist		✓		
Occupational Therapist				
Dietitian				
Speech and Laguage Therapist				
Clinical Nurse Specialist				
Liaison / District Nurse				
Social Work / Other agencies / Home help				

Additional Information / Leaflets / Factsheets

Nurse's signature: [signature] Designation: [signature] Date: 30/9/07

SGH 488
0005752

PRESCRIPTION FORM

Hospital Name: ....

PATIENT DETAILS

Name: SEAN MAGUIRE	Height:
Hospital Number: SG 00756471	Weight:
DOB: 01/12/83	Surface area:
Date of Admission: 30/09/07	Date of writing discharge prescription: ___/___/___
Consultant Name:	Ward: 2

Date and time this form prepared:	Sheet No	2nd Prescription in use
30/09/07 Time: 0540	....	Yes or NO

DRUG SENSITIVITIES

DVT Risk on Admission (SIGN Guideline)

High ☐ Moderate ☐ Low ☐

Assessed by: Date: ___/___/___

OTHER CHARTS IN USE

Insulin ☐	TPN: ☐
PCA and other infusions ☐	Enteral Nutrition: ☐
Anticoagulants: Heparin ☐	Oxygen Therapy: ☐
Oral ☐	Other:
Topical: ☐	

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF DOCTOR	GIVEN BY	TIME GIVEN

PATIENT'S NAME:

ADMINISTRATION

Parenteral Drugs: Regular Prescription

DATE →

MONTH →

A DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

B DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

C DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

D DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

H DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE

MONTH

J DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF DOCTOR — INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

K DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF DOCTOR — INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

L DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF DOCTOR — INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

M DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF DOCTOR — INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Oral and Other Drugs: Regular Prescriptions

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE

MONTH

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

T DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

V DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

W DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

X DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

DD DRUG

DOSE | ROUTE | DATE

STOPPED DATE:
INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

EE DRUG

DOSE | ROUTE | DATE

STOPPED DATE:
INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

FF DRUG

DOSE | ROUTE | DATE

STOPPED DATE:
INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

GG DRUG

DOSE | ROUTE | DATE

STOPPED DATE:
INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

LL DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

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

PATIENT'S NAME: JEAN MARVIER

All Routes: As Required Prescriptions

ADMINISTRATION

MM DRUG: COCODAMOL 8/500

DOSE	ROUTE	INDICATION	STOPPED DATE: / INITIALS:
2 tabs	O	PAIN	

SIGNATURE OF DOCTOR	MAX.FREQUENCY	DATE:
	4-6 hourly	30/9

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: MAX 8 TABS 24 hrs

DATE	30/9																										
TIME	1800																										
DOSE	2																										
GIVEN BY	LO																										

NN DRUG:

DOSE	ROUTE	INDICATION	STOPPED DATE: / INITIALS:

SIGNATURE OF DOCTOR	MAX.FREQUENCY	DATE:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE																											
TIME																											
DOSE																											
GIVEN BY																											

PP DRUG:

DOSE	ROUTE	INDICATION	STOPPED DATE: / INITIALS:

SIGNATURE OF DOCTOR	MAX.FREQUENCY	DATE:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE																											
TIME																											
DOSE																											
GIVEN BY																											

RR DRUG:

DOSE	ROUTE	INDICATION	STOPPED DATE: / INITIALS:

SIGNATURE OF DOCTOR	MAX.FREQUENCY	DATE:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE																											
TIME																											
DOSE																											
GIVEN BY																											

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

SS	DRUG			STOPPED DATE: INITIALS:	DATE																											
DOSE	ROUTE	INDICATION			TIME																											
SIGNATURE OF DOCTOR		MAX.FREQUENCY		DATE:	DOSE																											
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					GIVEN BY																											
TT	DRUG			STOPPED DATE: INITIALS:	DATE																											
DOSE	ROUTE	INDICATION			TIME																											
SIGNATURE OF DOCTOR		MAX.FREQUENCY		DATE:	DOSE																											
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					GIVEN BY																											
VV	DRUG			STOPPED DATE: INITIALS:	DATE																											
DOSE	ROUTE	INDICATION			TIME																											
SIGNATURE OF DOCTOR		MAX.FREQUENCY		DATE:	DOSE																											
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					GIVEN BY																											
WW	DRUG			STOPPED DATE: INITIALS:	DATE																											
DOSE	ROUTE	INDICATION			TIME																											
SIGNATURE OF DOCTOR		MAX.FREQUENCY		DATE:	DOSE																											
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					GIVEN BY																											

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

Nurse/Midwife Administration by Proto - Authorised Nurses/Midwives Only

(Maximum number of d es as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the nurse/midwife administration protocol No.(s) ..... with the following exceptions: _____

Signature: _____ Date: _____

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF NURSE	GIVEN BY	TIME GIVEN

Notes for Users

FOR DOCTORS:

1. Sign your name clearly against each prescription.
2. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date appropriate boxes.
3. If an existing prescription is to be modified, delete existing prescription as described and re-write new instructions in a new section.
4. Use approved names in BLOCK LETTERS and use metric doses as follows:

Milligram =	**mg**	Gram =	**g**
Millilitre =	**ml**	Microgram:	**to be written in full.**
		Units:	**to be written in full.**

Fractions of a milligram should be written in micro grams. A zero should be written in front of a decimal point where there is no other figure, e.g. 0.5ml **not** .5ml.

5. Method of administration should be abbreviated as follows:

Intravenous =	**IV**	Oral =	**O**
Subcutaneous =	**SC**	Per rectum =	**PR**
Inhalations =	**INH**	Topical =	**TOP**
Sublingual =	**SL**	Nasogastric =	**NG**
Intramuscular =	**IM**	Vaginal =	**PV**
Intradermal =	**ID**		

FOR NURSES:

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

Codes for Non-Administration of Drugs

(3) Patient refused	(7) Patient asleep	(11) Unable to swallow	(14) Other - Record in nursing notes
(4) Drug not available	(8) Time varied on doctor's instructions	(12) No intravenous access	(15) Prescription clarification required
(5) Nil by mouth/fasting	(9) Dose withheld on doctor's instructions	(13) Patient Self-Administration of Medicine	
(6) Patient unavailable	(10) Nausea/vomiting		

Ver 7, 07/2005

SOUTHERN GENERAL HOSPITAL
PATIENTS PROFILE

WARD / DEPT: 1 Ortho	NAMED NURSE: ~~Sam~~ K. Johnston
CONSULTANT: Mr. Walkes	REFERRAL: A&E
DATE: 23/7/11	TIME: 05:30
PATIENTS NAME: Sean Maguire	
UNIT NUMBER: SG0075647[illegible]1	
PREFERS TO BE CALLED:	
ADDRESS: 321 Shieldhall Road, Glasgow, G51 4HB	
TELEPHONE NUMBER:	

AGE: 27	D.O.B.: 01/12/83	SEX: M	MARITAL STATUS:
OCCUPATION:			
RELIGION:	CLERGY / OTHER:	CONTACT REQUIRED:	CONTACTED:

REASON FOR ADMISSION:

Intoxicated H1
Ambulance report - found in street
Falling on to face
GCS 14/15
- haematoma to ~~face~~ Nose — sutured.

PREVIOUS HEALTH HISTORY:

- unknown

KNOWN ALLERGIES:

unknown.

SGH 308

PATIENTS PROFILE (cont'd)

MEDICATION ON ADMISSION:

PATIENTS PRECEPTION OF CURRENT HEALTH STATUS:

RELATIVES PRECEPTIONS OF PATIENTS HEALTH STATUS:

EMERGENCY CONTACT NAME:

NEXT OF KIN: Madge Maguire

RELATIONSHIP: Mother

ADDRESS: 97 Glendotch Road, Glasgow

TELEPHONE NUMBER (DAY): 0141-882-6453 | TELEPHONE NUMBER (NIGHT):

OTHER RELEVANT CONTACT:

G.P.'s NAME: Dr. Iain Struthers

G.P.'s ADDRESS: Cadonald medical centre

G.P.'s TELEPHONE NUMBER: 0141-892-2551

Patient / Relative spoken to by	DATE	TIME	DOCTOR	NURSE

VALUABLES:	DISPOSAL	HOME	WARD	CASHIER'S OFFICE
CLOTHING:	DISPOSAL	HOME	WARD	CASHIER'S OFFICE

NURSES SIGNATURE: J. Matthew

SOUTHERN GENERAL HOSPITAL
NURSING ASSESSMENT

PATIENTS NAME: Sean Mc guire	UNIT No.:	WARD: C

GENERAL ASSESSMENT ON ADMISSION:

Laceration to Nose sutured.
GCS 14/15.
D. Hault to assess.
due to intoxicated state

SOCIAL / HOME BACKGROUND (INCLUDING PROBLEMS RELATED TO ADMISSION):

Unable to ascertain.

BLOOD PRESSURE: 91/40 mmHg	WEIGHT: Unable to ascertain
PULSE: 82	HEIGHT: Unable to ascertain
RESPIRATIONS: 14	URINALYSIS:
TEMPERATURE: 35.5°C	WATERLOW SCORE:

NURSING ASSESSMENT (ASSESSMENT OF ACTIVITIES OF DAILY LIVING)

MAINTAINING A SAFE ENVIRONMENT, COMMUNICATING, BREATHING, EATING AND DRINKING, ELIMINATING, PERSONAL CLEANSING AND DRESSING, CONTROLLING BODY TEMPERATURE, MOBILISING, WORKING AND PLAYING, EXPRESSING SEXUALITY, SLEEPING, DYING.

Independent with ADL's

NURSES SIGNATURE: J. Mellett

MEDICINE **PRESCRIPTION FORM** Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐
Date _____ Name (Print) _____
Discharge Prescription Prepared & Reconciled YES ☐
Date _____ Name (Print) _____

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

_____

with the following exceptions: _____

Print & Sign: Clt Date: 23/7/11

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____
Address _____
Compliance Aid Details _____
Patient consent to share discharge information Y/N
Print & Sign _____

PATIENT DETAILS

Hospital Number: SG 00136471.	Height:
DOB: 01/12/83.	Weight:
Date of Admission: __/__/__	Surface area:
Consultant Name:	Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

	DATE →																								
	MONTH →																								
	RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)																								
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N																									
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N																									
SIGNATURE OF ASSESSOR																									
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N																									

Parenteral Drugs : Regular Prescription

																										Patient's Own Medicine
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**A** DRUG DOSE / ROUTE / DATE PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	STOPPED DATE: INITIALS:	Other time																							For Use Y/N
			0700-0900																							Qty:
			1200-1400																							Date:
			1600-1800																							Assessed by:
			2200-2400																							Ordered from Pharm.
			Other time																							
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**B** DRUG DOSE / ROUTE / DATE PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	STOPPED DATE: INITIALS:	Other time																							For Use Y/N
			0700-0900																							Qty:
			1200-1400																							Date:
			1600-1800																							Assessed by:
			2200-2400																							Ordered from Pharm.
			Other time																							
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**C** DRUG DOSE / ROUTE / DATE PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	STOPPED DATE: INITIALS:	Other time																							For Use Y/N
			0700-0900																							Qty:
			1200-1400																							Date:
			1600-1800																							Assessed by:
			2200-2400																							Ordered from Pharm.
			Other time																							

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine: For Use Y/N; Qty:; Date:; Assessed by:; Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

H DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

J DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

K DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

L DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Patient's Own Medicine
For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

T DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

V DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

W DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

[redacted]

All Routes: As Required Prescriptions

BEFORE ADMISSION ☐	LL	DRUG: Paracetamol			STOPPED DATE:
NEW DOSE ☐	DOSE: 1g	ROUTE: PO	INDICATION: Pain/Pyrexia		INITIALS:
	PRESCRIBER (PRINT & SIGN): [illegible]			MAX.FREQ.: 4-6°	DATE: 23/7/11
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				

DATE	[illegible]																					
TIME	[illegible]																					
DOSE	1g																					
GIVEN BY	[illegible]																					

Patient's Own Medicine: For Use Y/N; Qty:; Date:; Assessed by:; Ordered from Pharm.

BEFORE ADMISSION ☐	MM	DRUG: Ondansetron			STOPPED DATE:
NEW DOSE ☐	DOSE: 4mg	ROUTE: PO/IV	INDICATION: N+V		INITIALS:
	PRESCRIBER (PRINT & SIGN): [illegible]			MAX.FREQ.: 8°	DATE: 23/7/11.
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				

DATE	
TIME	
DOSE	
GIVEN BY	

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

BEFORE ADMISSION ☐	NN	DRUG			STOPPED DATE:
NEW DOSE ☐	DOSE	ROUTE	INDICATION		INITIALS:
	PRESCRIBER (PRINT & SIGN)			MAX.FREQ.	DATE:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				

DATE	
TIME	
DOSE	
GIVEN BY	

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

BEFORE ADMISSION ☐	PP	DRUG			STOPPED DATE:
NEW DOSE ☐	DOSE	ROUTE	INDICATION		INITIALS:
	PRESCRIBER (PRINT & SIGN)			MAX.FREQ.	DATE:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				

DATE	
TIME	
DOSE	
GIVEN BY	

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

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

BEFORE ADMISSION																														Patient's Own Medicine
☐	RR	DRUG																												For Use Y/N
NEW DOSE		DOSE	ROUTE	INDICATION	STOPPED DATE: INITIALS:	DATE																								Qty:
☐		PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:		TIME																								Date:
NEW MEDICATION		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				DOSE																								Assessed by:
☐						GIVEN BY																								Ordered from Pharm.
BEFORE ADMISSION																														For Use Y/N
☐	SS	DRUG																												Qty:
NEW DOSE		DOSE	ROUTE	INDICATION	STOPPED DATE: INITIALS:	DATE																								Date:
☐		PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:		TIME																								Assessed by:
NEW MEDICATION		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				DOSE																								Ordered from Pharm.
☐						GIVEN BY																								
BEFORE ADMISSION																														For Use Y/N
☐	TT	DRUG																												Qty:
NEW DOSE		DOSE	ROUTE	INDICATION	STOPPED DATE: INITIALS:	DATE																								Date:
☐		PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:		TIME																								Assessed by:
NEW MEDICATION		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				DOSE																								Ordered from Pharm.
☐						GIVEN BY																								
BEFORE ADMISSION																														For Use Y/N
☐	VV	DRUG																												Qty:
NEW DOSE		DOSE	ROUTE	INDICATION	STOPPED DATE: INITIALS:	DATE																								Date:
☐		PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:		TIME																								Assessed by:
NEW MEDICATION		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				DOSE																								Ordered from Pharm.
☐						GIVEN BY																								

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Name JEAN MAGUIRE

CHI No 0112836097

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

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Print & Sign your full name clearly against each prescription entry.
4. Time should be recorded in 24hr format e.g. 0600, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

Milligram = mg Gram = g
Millilitre = ml Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused
(4) Drug not available
(5) Nil by mouth/fasting
(6) Patient unavailable
(7) Patient asleep
(8) Time varied on doctor's instructions
(9) Dose withheld on doctor's instructions
(10) Nausea/vomiting
(11) Unable to swallow
(12) No intravenous access
(13) Patient Self-Administration of Medicine
(14) Other - Record in nursing notes
(15) Prescription clarification required

Cat. No. 40995 Ver 4, 09/2010

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name: Jean Maguire	Ward: 1
Unit number: 5000756471	Discharge destination: Home address
CHI number:	Estimated Discharge Date (1) 23/7/11
Apply addressograph label	Estimated Discharge Date (2) / /
	Final date of discharge : 23/7/11

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓			✓
Relative/carer informed	✓			
Others informed: Care Home		✓		
Transport arranged				
Own transport (preferred option)	✓			
Ambulance-1 man/ 2 man am/pm		✓		
Other: Flight, Air ambulance etc.		✓		
Discharge medication				
Discharge prescription completed	✓			
Compliance aids e.g. Dossette Box (involve pharmacist)		✓		
Medication received		✓		
Medication explained to patient and/or relative/carer		✓		
Own medication returned to patient		✓		
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓		
Informed of discharge				
Social work/ Other agencies/Home help		✓		
Physiotherapist		✓		
Occupational Therapist		✓		
Dietician		✓		
Speech and Language Therapist		✓		
Clinical Nurse specialist e.g. Care Home Liaison		✓		
Liaison/ District Nurse/Practice Nurse		✓		
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓			
Patients clothing available for day of discharge	✓			
Valuables e.g. cashier		✓		
Intravenous cannula removed	✓			
Equipment ordered (inc. walking aids) in place for discharge		✓		
Part 2 Discharge letter - Required		✓		
- Completed		✓		
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow		✓		
If unknown at time of discharge state reason		✓		
Additional information / leaflets / factsheets		✓		
Time of Discharge:	1600			
Nurse's signature:	[signature]	Designation: SN		Date: 23/7/11

South Glasgow Hospitals
Southern General Hospital, Glasgow G51 4TF. Tel. 0141 201 1100

Part I Discharge Letter and Medicine Prescript Form - Confidential

Ref No: 173962

NHS Greater Glasgow and Clyde

VIMI - DISCHARGE - 2725 SGH

Dear Doctor .....
Surgery .....

Copies .....

Patien [barcode]
Addre SG00756471
.....MAGUIRE, SEAN
.....321 SHIELDHALL ROAD
.....FLAT 1/2
DOB: GLASGOW 01/12/1983
Weigh G51 4HB CHI 0112836097

64.71
097

Ward: 1 Tel: .....
Consultant: MR WALKER
Specialty ORTHOPAEDICS
Named Nurse: .....
Admission date: ..... / ..... / .....
Mode of admission .....
Source of admission .....
Discharge date: ..... / ..... / .....

Follow-up arrangements
Clinic appointment made: GP.
Yes ☐ No ☐ To follow ☑
Clinic name .....
Date ..... / ..... / .....
Non-childproof containers required: Yes ☐ No ☐
Medicine compliance aids required: Yes ☐ No ☐
Specify: .....

Reason for admission, treatment, diagnosis, investigations, operations, complications:

Alcohol XS. BIBA, fell onto face ? fx.
Swelling & bruising. Laceration behind.
Neurol — stable overnight. Dr C per Mr Walker

Other information

Tetanus ? Update.

MEDICINE	Dosage form	Dose	Times for administration: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 8	pm 10	Other times	Recommended duration of treatment after discharge	New Drug	New Dose	Number of days supply	Dispensing Details (Pharmacy only)

Medicines discontinued	Reason (if known) e.g. side effects

Clinical Pharmacy check:
All known drug sensitivity / adverse reactions:

Dispensed by: ..... Date: ..... / ..... / .....
Checked by:

WARD USE ONLY
Med. rec. on ward by: .....
Issued by: ..... Date: 23 / 7 / 11
Signature of recipient:

Doctor s name: Dr W Walker Signature: [signature] Date 23 / 7 / 11
Doctor s grade: GP Retd Pager number: 75553

Number of prescription sheets at discharge:

White copy - G.P; Pink copy - Case Notes; Blue copy - Pharmacy; White copy - Patient

If you have any problems after discharge, please contact the Ward or your G.P.

Orthopaedic Codes Emergency ☑ Elective ☐ MGH ☐ MBZ ☐ SMcC ☐ DBA ☐ DAS ☐ CRW ☐

PATIENT DETAILS

0756471
MAGUIRE SEAN
97 GLEDDOCH RD
GLASGOW
01/12/1983 M
G52 4RF CHI

GP NAME / ADDRESS: DR BARNES, 230 DALMELLINGTON RD

Admission DATE 11/12/02 FROM Home A&E OP Other ward Other Hospital
Surgery RIGHT LEFT BILATERAL
Discharge 12/12/02 TO Home Other Ward Other Hosp Irreg Died
FOLLOW-UP 1/52 10/7 2/52 4/52 6/52 None C'town

RTA Injured Pedestrian Cyclist M/cycle Driver Passenger in Car HGV/PSV Van Hit Stationary object Cyclist M/cycle Car HGV/PSV Van
Fall Ice/snow Level surface Bed Chair Stair Ladder Scaffold Building Hole in ground Assault Sharp Blunt Fight Bite Human Animal
Accident Hit by object Crush Glass Knife Hand tool Powered tool Hit by another Site Home Sport Public building Street Industrial

FRACTURE Open ☐ Closed ☐

HEAD

Contusion	Scalp S00.0	Orbit S00.1	Nose S00.3	Ear S00.4	Lip/Mouth S00.5	Multiple S00.7
Open Wound	S01.0	S01.1	S01.2	S01.3	S01.5	S01.7

cture	Skull Vault S02.0	Base S02.1	Nose S02.2	Orbit S02.3	Malar S02.4	Jaw S02.6	Multiple S42.4

i-Cranial Concussion S06.0
ain Injury Diffuse S06.3 Focal S06.2
naemorrhage Epidural S06.4 Subdural S06.5 Subarachnoid S076.6

NECK

Nerve Injury	Cord S14.0	Nerve root S14.2	Brachial Plexus S14.3	
Fracture	C1 S12.0	C2 S12.1	C3-C7 S12.3	Multiple S12.7
Dislocation Sprain	Facet Jt S13.1	Multiple S13.3	Whiplash S13.4	

CHEST, THORAX

Fracture	Vertebra S22.0	Sternum S22.1	Rib S22.2	Multiple ribs S22.4	Flail Chest S22.5
Nerve Injury	Spinal Cord S24.0	Nerve Root S23.2			

SHOULDER, UPPER ARM

Primary OA	M19.01	Post trauma OA	M19.11
R.A. Sero +ve	M05.81	Sero -ve	M06.01
Adhesive capsulitis	M75.0	Rotator cuff tear	M75.1
Impingement syndrome	M75.4	Biceps tendinitis	M75.2
Calcific tendinitis	M75.3	Bursitis	M75.5
Recurrent dislocation	M24.41		

Contusion	S40.0					
n Wound	Shoulder S41.0	Upper arm S41.1				
acture	Clavicle S42.0	Scapula S42.1	Humerus	Proximal S42.2	Shaft S42.3	Distal S42.4
ocation	Shoulder S43.0	A-C Joint S43.1	S-C Joint S43.2			
prain	Shoulder S43.4	A-C Joint S43.5	S-C Joint S43.6			
Nerve Injury	Ulnar S44.0	Median S44.1	Radial S44.2	Axillary S44.3	Musc.Cut S44.4	Multiple S44.7
Blood Vessel	Axillary S45.0	Brachial S45.1	Vein S45.3			
Muscle Tendon	Rotator Cuff S46.0	Biceps	Long head S46.1	Other S46.2	Triceps S46.3	Multiple S46.7
Traumatic Amputation	Shoulder S48.0	Upper arm S48.1	Crush S47.0			

ELBOW, FOREARM

Primary OA	M19.02	Post trauma OA	M19.12
R.A. Sero +ve	M05.82	Sero -ve	M06.02
Medial epicondylitis	M77.0	Lateral epicondylitis	M77.1

Nerve Lesions Ulnar G56.2 Median G56.1 Radial G56.3

Contusion	Elbow S50.0	Forearm S50.1				
Open Wound	Elbow S51.0	Forearm S51.8				
Fracture	Ulna	Upper S52.0	Shaft S52.2	Radius	Proximal S52.1	Shaft S52.3	Distal S52.5
	Radius & Ulna Shaft S52.4 Distal S52.6						
Dislocation Sprain	Radial Head S53.0	Elbow S53.1	Radial Collateral S53.2	Ulnar Collateral S53.3			
Nerve Injury	Ulnar S54.0	Median S54.1	Radial S54.2	Cutaneous S54.3	Multiple S54.7		
Blood Vessel	Ulnar Artery S55.0	Radial Artery S55.1					
Muscle Tendon	Flexor Thumb S56.0	Finger S56.1	Wrist S56.2	Extensor Thumb S56.3	Finger S56.4	Wrist S56.5	
Traumatic Amputation	Elbow S58.0	Forearm S58.1	Crush S57.8				

WRIST, HAND

Primary OA	M19.03	Post trauma OA	M19.13
R.A. Sero +ve	M05.83	Sero -ve	M06.03
Crepitant synovitis of wrist	M70.0	Wrist pain	M25.53
Triangular cartilage tear	M24.13	Wrist instability	M24.23
Chronic UCL thumb	M24.24	Carpal tunnel	G56.0
Other Nerve Lesions	Ulnar G56.2	Median G56.1	Radial G56.3
Trigger finger	M65.3	de Quervain	M65.4
Dupuytrens	M72.0		
Finger deformity	*Acquired* M20.0	*Congenital* Q68.1	

Contusion	Finger S60.0	Finger + Nail S60.1	Wrist & Hand S60.2			
Open Wound	Finger S61.0	Finger + Nail S61.1	Wrist & Hand S61.8			
Fracture	Scaphoid S62.0	Other Carpal S62.1	1st MC S62.2	Other MC S62.3	Thumb S62.5	Finger S62.6
Dislocation	Wrist Carpus S63.0	Finger thumb MCP/IPS63.1				
Ligament	Wrist S63.3	MCP/IP S63.4				
Nerve Injury	Ulnar S64.0	Median S64.1	Radial S64.2	Digital Thumb S64.3	Finger S64.4	Multiple S64.7
Blood Vessel	Ulnar S65.0	Radial S65.1	Palm Deep S65.3	Sup S65.2		
Muscle Tendon	Flexor Thumb S66.0	Finger S66.1	Extensor	Thumb S66.2	Finger S66.3	Intrinsic S66.5
Crush	Fingers S67.0	Wrist/Hand S67.8				
Traumatic Amputation	Thumb S68.0	One Finger S68.1	>1Finger S68.2	Hand S68.3	Wrist S68.4	

PREVIOUS SURGERY / INJURY

Infection	Prosthesis T84.5	ORIF T84.6	Surgical Wound T81.4
Mechanical Failure	Fusion M96.0	Prosthesis T84.0	ORIF T84.1
Fracture	Around implant M96.6	Malunion M84.0	Non-union M84.1

INFECTION

Abscess L02.4 Cellulitis Toe or Finger L03.0 Limb L03.1
Lymphadenitis L04.3 Infected bursa M71.0

AMPUTATION

Diabetic IDDM E10.5 Non IDDM E11.5 P.V.D I73.8
Stump Neuroma T87.3 Infection T87.4 Necrosis T87.5

OTHER ADMISSION CODE

Limb fitting Z44.1 Investigation Z13.9
Physio Z50.1 Social Z63.2 Fracture rehab Z54.4 Fracture follow-up Z09.4

Surgery cancelled

Contra-indicated Z53.0 Patient decision Z53.2 Other reason Z53.8

DIAGNOSIS

PROCEDURE

COMMENTS

HIP, PELVIS, BACK, LEG

Primary OA	M16.1	Post-trauma OA	M16.5
R.A. Sero +ve	M05.85	Sero -ve	M06.05
Dysplastic	M16.3	Post Perthes	M91.2
Protrusio	M24.7	S.U.F.E	M93.0
Post-traumatic AVN	M87.25	Idiopathic A.V.N.	M87.05
Mechanical Back Pain	M54.5	True sciatica	M51.1

Contusion	Hip S70.0	Thigh S70.1			
Open Wound	Hip S71.0	Thigh S71.1	Multiple S71.7		
Fracture	Femur	Shaft S72.3	Distal S72.4	Segmental S72.7	
N.O.F.	Subcapital S72.0	Pertrochanteric S72.1	SubtrochantericS72.2		
L Spine S32.0	Sacrum S42.1	Ilium S32.3	Acetab S32.4	Pubis S32.5	
Dislocation	Hip S73.0	Hip Prosthesis S73.0 & T84.0			
Nerve	Cord S34.0	Nerve root S34. 2	Cauda equina S34.3	Sciatic S74.0	Femoral S74.1
Blood Vessel	Femoral	Artery S75.0	Vein S75.1		
Muscle	Hip S76.0	Quads S76.1	Adductor S76.2	Hamstrings S76.3	
Crush	Hip S77.1	Thigh S77.2			

ANKLE, FOOT

Primary OA	M19.07	Post trauma OA	M19.17
R.A. Sero +ve	M05.87	Sero -ve	M06.07
Hallux valgus	M20.1	Hallux rigidus	M20.2
Hammer toe	M20.4	Other toe deformity	M20.5
Acquired deformity	M21.6	Acquired flat foot	M21.4
Morton's neuroma	G57.6	Peroneal drop foot	G57.3
Ingrowing toenail	L60.0	Onychogryphosis	L60.2

Contusion	Ankle S90.0	Foot S90.3	Toe S90.1	Toe + Nail S90.2		
Open Wound	Ankle S91.0	Foot S91.3	Toe S91.1	Toe + Nail S91.2		
Fracture	Calcaneus S92.0	Talus S92.1	Tarsal S92.2	Metatarsal S92.3	1st Toe S92.4	Toe S92.5	Multiple S92.7
Dislocation Sprain	Ankle S93.0	Toe S93.1	Foot S93.3			
Nerve	Plantar Lateral S94.0	Medial S94.1	Deep peroneal S94.2			
Blood Vessel	Dorsal artery S95.0	Plantar artery S95.1				
Muscle/Tendon	Long flexor S96.0	Long extensor S96.1	Intrinsic S96.2			
Crush	Ankle S97.0	Toes S97.1				
Amputation	Ankle S98.0	One Toe S98.1	>2 Toes S98.2	Foot S98.3		

KNEE, LOWER LEG

Primary OA	M17.1	Post trauma OA	M17.3
R.A. Sero +ve	M05.86	Sero -ve	M06.06
Patella	Recurrent dislocation M22.0	Recurrent subluxation	M22.1
	Anterior Knee pain M22.2	Chondromalacia	M22.4
Loose body	M23.4	Osteochondritis	M93.26

Meniscus	Bucket handle	Anterior	Posterior	Discoid	Cyst
Medial	M23.23	M23.31	M23.32	M23.13	M23.03
Lateral	M23.26	M23.34	M23.35	M23.16	M23.06

Instability	ACL	PCL	MCL	LCL	Multiple
Acute	S83.5		S83.4		S83.7
Chronic	M23.51	M23.52	M25.53	M23.54	M23.50

Contusion	Knee S80.0	Leg S80.1			
Open Wound	Knee S81.0	Leg S81.8	Multiple S81.7		
Fracture	Patella S82.0	Tibia Upper S82.1	Shaft S82.2	Distal S82.3	Fibula S82.4
Medial malleolus S82.5	Lateral malleolus S82.6	Bi/Tri malleolar S82.8			
Dislocation	Patella S83.0	Knee S83.1	Acute Meniscus S83.2		
Nerve Injury	Tibial S84.0	Peroneal S84.1			
Blood Vessel	Popliteal Artery S85.0	Vein S85.5	Tibial S85.1		
Muscle Tendon	Achilles tendon S86.0	Posterior S86.1	Anterior S86.2	Perone S86.3	
Crush	Knee S87.0	Leg S87.8			
Traumatic Amputation	Knee S88.0	Below knee S88.8			

PROCEDURES

ELECTIVE

Arthroplasty	Primary	Revision	Convert To	Excision
Hip	W37.1	W37.3	W37.2	W57.4 Z84.3
Knee (Cemented)	W41.1 W40.1	W41.3 W40.3	W41.2 W40.2	W57.4 Z84.6
Shoulder				
Hemi	W50.1	W50.3	W50.2	
Hemi Cement	W49.1	W49.3	W49.2	W57.4 Z81..3
Total	W43.1 Z81..3	Revision W43.3 Z81.3		
Elbow	W43.1 Z81.5	Revision W43.3 Z81.5	W57.4 Z81.5	
Wrist	W44.1 Z82.1	Revision W44.3 Z82.1	W57.4 Z82.1	
MCP	W44.1 Z83.2	No.		

Arthrodesis	Hip	Knee	Ankle	Subtalar	Triple	1st MTP	PIP toe
W62.1	Z84.3	Z84.6	Z85.6	W04.3	W04.2	W59.3	W59.5
1st MCP Z83.1	Finger PIP Z83.4 DIP Z83.5	Thumb IP Z83.3					
Wrist Pin W62.1 Z82.1	Plate & graft W61.1 Z82.1						

Arthroscopy	Diagnostic	Menisectomy	Loose body	Biopsy	Lavage
Knee	W87.9	W82.2	W85.1	W87.1	W85.2
Diagnostic W88.8	Loose body W86.1	Drilling W83.1	Shaving W83.3		
Triangular cartilage W86.8	Plica W84.3	Fixation W83.2	Biopsy W88.1		
SAD W84.8	Shoulder Z81.3	Elbow Z81.5	Wrist Z82.1	Knee Z84.6	

SHOULDER	Stabilisation	W77.1 Z81.3	A.C Jt W74.3 Z81.2		
Acromioplasty W08.5 Z68.2	Rotator Cuff T79.1	Distal clavicle W57.2Z81.2			
ELBOW	Ulna nerve A67.1	Radial head excision W57.2 Z81.6			
Tennis elbow T83.2 Z55.2	Epicondylectomy W08.1 Z69.6				
WRIST	Ganglion T59.1	Anchovy W56.2 Z82.3	Synovectomy W69.1 Z82.1		
Herbert screw W19.4 Z72.2	Ulnar head excision W08.5 Z71.6				
HAND	Trigger finger T72.3 Z55.3	de Quervain T72.3 Z55.8			
Ganglion T59.2	Carpal tunnel A65.1	Fasciectomy T52.1 (Re-do T52.2)			
	Soft tissue correction W02.4 Z89.6				
FOOT	Morton's Neuroma A61.1 Z12.4	Ganglion T59.4			
1st MT otomy W15.1	Kellers W57.1	Fowlers W03.1	Stainsby W57.2 Z86.5		

ACL Reconstruction W74.2 Z84.6

Metalwork removal	Diagnosis Z47.0	Procedure W28.3

TRAUMA

POP X48.1	MUA + POP W26.2	Closed reduction W66.9	IV Antibiotics X3
N.O.F	Screws W24.1	DHS W19.1	Hemi W47.1 (Cement W46.1)

IM Nail W19.2	Ex Fix W25.1	Plate	Shaft W20.1	Complex W20.4	Intra-articula W21.4
Percutaneous wires W24.8	ORIF + Screws W19.4	ORIF + Wires 19.6			
Ankle Fracture W20.5	Chondral # W21.3				

Humerus	Proximal Z69.3	Shaft Z69.4	Distal Z69.7	
Radius	Head Z70.1	Shaft Z70.3	Distal Z70.5	Ulna Z71.2 Olecranon Z7
Scaphoid Z72.2	MC1 Z73.3	2-5 Z 73.2	Phalanx Finger Z73.4	Thumb Z7
Pelvis Z75.3	Acetabulum Z75.6			
Femur	Shaft Z76.4	Supracondylar Z76.5	Patella	
Tibia	Condyle Z77.1	Shaft Z77.2	Distal Z77.	
Talus Z79.1	Os calcis Z79.2	Navicular Z79.3	MT 1 Z80.1	2-5 Z80

Skin	Suture S42.1	I + D S47.2	Debride S57.1	Graft S35.8
Amputation	Finger X08.3	Toe X11.2	Above knee X09.3	Below knee X09
Foreign body	Glass S44.4	Metal S44.2	Other S44.6	

Tendon/Muscle	Repair T67.6	Graft T68.5	Lysis T69. 1	Silastic T68
Quads Z57.3	Patella Z58.7			
Flexor Wrist Z55.1	FDS Z56.3	FDP Z56.4	FPL Z56.1	Thenar Z56.2
Extensor Hand Z56.7	Wrist Z55. 2	Hypothenar Z56.5	Intrinsic Z56.	

Nerve	A64.2	Fem Z10.1	Sciatic Z11.1	Popliteal Z12.1	Tib P Z12.7
Ulna Z09.4	Radial Z09.3	Median Z09.2	Digital Z09.		

Joint Primary Non arthroscopic

Aspiration	W90.1
EUA	W92.4
EUA + II	W92.3
Open biopsy Joint	W92.1
Open biopsy Synovium	W69.4
Loose body removal	W81.2
Incision Drainage	W81.3
Arthrotomy	W81.4
Synovectomy Total	W69.1
Sub-total	W69.2
Debridement	W71.3
Drilling of cartilage	W71.1

Shoulder Z81.4	A-C Jt Z81.2			
Elbow Z81.5	Radio/ulna Prox Z81.6	Distal Z81.7		
Wrist Z82.1	Intercarpal Z82.2			
Thumb CMC Z823	MCP Z83.1	IP Z83		
Finger	CMC Z82.4	MCP Z83.2	PIP Z83.4	DIP Z83.
Knee Z84.6	Ankle Z85.6			
Subtalar Z85. 3	Midtarsal Z86.1	Tarso-metatarsa Z86.3		
1st MTP Z86.4	MTP 2-5 Z86.5	IP Jt Z86		