

# A&E Records

# Patient & GP Information

<b>UHPI Number</b>	610094959B
<b>CHI Number</b>	1805580019
<b>Episode Number</b>	E2035998
<b>Surname/Forename</b>	Macmillan, Donald
<b>Date of Birth</b>	5/18/58
<b>Sex</b>	Male
<b>Patient Address.</b>	75/2 Calder Gardens Edinburgh EH11 4JX
<b>Registered GP</b>	J Burns
<b>GP Address.</b>	Sighthill Red Medical Practice, Sighthill Health Centre, Calder Road, Edinburgh EH11 4AU

## Report Contents

The report bundle provides information on the following:

\* IP/OP Clinical Notes

<b>Surname/Forename</b>	Macmillan, Donald
<b>UHPI Number</b>	610094959B

<b>Episode Number</b>	E2035998
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## Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
<p>A&amp;E Notes Episode/Ref: E2035998 David Flucker</p> <p>8/27/11 15:05 Cathy Galanopoulos</p>	<p>CHI: 1805580019, This 53 yr old man was referred for review following his overdose of 20-30 x 50mg Tramadol at 1000hrs. He states that he had taken overdose due to lots of social and some physical issues. His wife had called him on Tuesday and stated that she was pregnant to the gentleman that she had been seeing whilst living with Donald. He found this to be difficult to take and has been dwelling on this since Tuesday. He is also requiring bloods to be taken on Tuesday coming (these were done today in A&amp;E) for further investigations into him losing 1.5 stones over the past 2 months. He also states that he has some skin cancer on the side of his nose of which he is awaiting the removal. He states that he has an appointment coming up in the next two weeks for an endoscopy to check for ? bowel cancer. ,PPH: Previous contact with Psychiatric Services and previous in-patient stay following low mood, suicidal ideas in the context of alcohol misuse. Has current contact with Andy Mclevey, CPN from Homeless Outreach Project. He has a meeting with him on Tuesday coming and he was last seen Tuesday past. ,SH: Had ongoing marital issues for many months. Wife left recently then phoned stating she was pregnant to another man. Currently living alone and has a dog which is five years old. He states that he needs to go home and look after his dog as there is no one else to take care of him. ,MSE: Mood - subjectively low, objectively reactive and euthymic., Sleep - ruminating about his current problems prior to sleeping but once sleeping no problems., Appetite - slightly reduced but states is able to eat okay. Had a pizza last night. Has lost weight approximately 1.5 stone in 2 months but is unsure why as he has never been able to lose weight previously, even when exercising., Concentration - normal., Energy levels - unchanged. , Speech - normal rate, rhythm and tone, a good rapport established with reasonable eye contact., No formal thought disorder or perceptual abnormalities. , Denies any ongoing thoughts of suicide or self harm and states that he is going to attend his appointments regarding possible cancer for the investigation of his rapid weight loss. ,IMP: Impulsive OD in the context of physical and social issues which Donald now regrets., PLAN: Bloods were taken and results can be found on TRAK. , Discharged from a psychiatric point of view., Contact CPN on Monday and ask him to make contact with Donald. Donald was happy with outcome. , Any queries please contact A&amp;E Reception on 0131 242 1300</p>

<b>Surname/Forename</b>	Macmillan, Donald
<b>UHPI Number</b>	610094959B

<b>Episode Number</b>	E2035998
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<b>Note Details</b>	<b>Clinical Notes</b>
<p>A&amp;E Notes Episode/Ref: E2035998 Dr Angela Dickinson</p> <p>9/3/11 20:51 Elma K Laing</p>	<p>CHI: 1805580019,,53 year old male took 35 x 50 mls of Tramadol.,HPC: He took the above OD at 10 a.m this morning. His intention was to kill himself. After he took the tablets he vomited x 1. ,no other symptoms. He says that he wanted to kill himself because he was worried about tests for bowel cancer and also a recent conversation with his wife who said she was pregnant with another man's child sparked this OD. He phoned family member soon after the OD and they phoned an emergency amb.,,PH: Harmful alcohol use 4-5 previous ODs. Skin CA. OA. ,SH: Lives alone. Drinks 8 cans of lager every other day. He lives on disability living allowance.,DH: Amitriptyline. Mirtazepine.,,EXAM: Temp 35.2 P. 79 RR 16 BP 149/93. BM 6.3 Sats 98% RA.,Cardiovascular examination. HS I + II + 0. Nil peripheral oedema.,Respiratory - chest clear.,GI Abdo. SNT. BS present. ,Neuro GCS 15. Pupils pinpoint otherwise neurological examination was normal.,,IMP: Intentional Tramadol OD as a response to a situational crisis.,,PLAN: Psych review,Discharged home after 6 hours of observation,,Any queries please contact A&amp;E Reception on 0131 242 1300 ,</p>

Dr J Burns  
Drs Sharpe putta & burns practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date:** 03/09/2011

## Emergency Discharge Summary

<b>Patient</b>	Donald McMillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>CHI</b>	<b>1805580019</b>
<b>Attendance Date</b>	27/08/2011	<b>Date of Birth / Age</b>	18/05/1958 (53 years)
<b>Attendance Time</b>	12:31	<b>UHPI</b>	610094959B
<b>Mode of Arrival</b>	Emergency Ambulance	<b>A&amp;E Attendance Number</b>	E2035998
<b>Source of Referral</b>	999 Emergency	<b>Contact</b>	[REDACTED]
<b>Discharge Date</b>	27/08/2011		
<b>Discharge To</b>			

Dear Dr J Burns

**Presentation:** o/d

CHI: 1805580019

53 year old male took 35 x 50 mls of Tramadol.

HPC: He took the above OD at 10 a.m this morning. His intention was to kill himself. After he took the tablets he vomited x 1. no other symptoms. He says that he wanted to kill himself because he was worried about tests for bowel cancer and also a recent conversation with his wife who said she was pregnant with another man's child sparked this OD. He phoned family member soon after the OD and they phoned an emergency amb.

PH: Harmful alcohol use 4-5 previous ODs. Skin CA. OA.

SH: Lives alone. Drinks 8 cans of lager every other day. He lives on disability living allowance.

DH: Amitriptyline. Mirtazepine.

EXAM: Temp 35.2 P. 79 RR 16 BP 149/93. BM 6.3 Sats 98% RA.

Cardiovascular examination. HS I + II + 0. Nil peripheral oedema.

Respiratory - chest clear.

GI Abdo. SNT. BS present.

Neuro GCS 15. Pupils pinpoint otherwise neurological examination was normal.

IMP: Intentional Tramadol OD as a response to a situational crisis.

PLAN: Psych review

Discharged home after 6 hours of observation

Any queries please contact A&E Reception on 0131 242 1300


Yours Sincerely,

Dr Angela Dickinson, Doctor

Dr DP Putta  
Drs Sharpe putta & burns practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date:** 29/08/2011

## Emergency Discharge Summary

<b>Patient</b>	Donald McMillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>CHI</b>	<b>1805580019</b>
		<b>Date of Birth / Age</b>	18/05/1958 (53 years)
		<b>UHPI</b>	610094959B
		<b>A&amp;E Attendance Number</b>	E2035998
		<b>Contact</b>	
<b>Attendance Date</b>	27/08/2011		
<b>Attendance Time</b>	12:31		
<b>Mode of Arrival</b>	Emergency Ambulance		
<b>Source of Referral</b>	999 Emergency		
<b>Discharge Date</b>	27/08/2011		
<b>Discharge To</b>			

Dear Dr DP Putta

**Presentation:** o/d

CHI: 1805580019

This 53 yr old man was referred for review following his overdose of 20-30 x 50mg Tramadol at 1000hrs. He states that he had taken overdose due to lots of social and some physical issues. His wife had called him on Tuesday and stated that she was pregnant to the gentleman that she had been seeing whilst living with Donald. He found this to be difficult to take and has been dwelling on this since Tuesday. He is also requiring bloods to be taken on Tuesday coming (these were done today in A&E) for further investigations into him losing 1.5 stones over the past 2 months. He also states that he has some skin cancer on the side of his nose of which he is awaiting the removal. He states that he has an appointment coming up in the next two weeks for an endoscopy to check for ? bowel cancer.

PPH: Previous contact with Psychiatric Services and previous in-patient stay following low mood, suicidal ideas in the context of alcohol misuse. Has current contact with Andy McIlvey, CPN from Homeless Outreach Project. He has a meeting with him on Tuesday coming and he was last seen Tuesday past.

SH: Had ongoing marital issues for many months. Wife left recently then phoned stating she was pregnant to another man. Currently living alone and has a dog which is five years old. He states that he needs to go home and look after his dog as there is no-one else to take care of him.

MSE: Mood - subjectively low, objectively reactive and euthymic.

Sleep - ruminating about his current problems prior to sleeping but once sleeping no problems.

Appetite - slightly reduced but states is able to eat okay. Had a pizza last night. Has lost weight approximately 1.5 stone in 2 months but is unsure why as he has never been able to lose weight previously, even when exercising.

Concentration - normal.

Energy levels - unchanged.

Speech - normal rate, rhythm and tone, a good rapport established with reasonable eye contact.

No formal thought disorder or perceptual abnormalities.

Denies any ongoing thoughts of suicide or self harm and states that he is going to attend his appointments regarding possible cancer for the investigation of his rapid weight loss.

IMP: Impulsive OD in the context of physical and social issues which Donald now regrets.

PLAN: Bloods were taken and results can be found on TRAK.  
Discharged from a psychiatric point of view.  
Contact CPN on Monday and ask him to make contact with Donald. Donald was happy with outcome.

Any queries please contact A&E Reception on 0131 242 1300

Yours Sincerely,

David Flucker, Nurse



Clinical Lead Dr. A. Gray  
Clinical Nurse Manager Mr. Nell Boyle  
THE ROYAL INFIRMARY OF EDINBURGH  
51 Little France Crescent, Edinburgh EH16 4SU  
Tel: 0131 242 1300 • Fax: 0131 242 1344



A/E no. E2035998

Previous no. E1960149

UHPI no. 610094959B

CHI no. 1805580019

PATIENT INFORMATION

Surname McMillan Date of Birth 18/05/1958  
Forenames Donald Gordon Age Yrs Sex M  
Address 75/2 Calder Gardens Edinburgh  
Postcode EH11 4JX Telephone 0131 622 0695

Contact Address [Redacted]

Complaint/s Allergies

Attendances in last 12 months: 3 School: ON RA

General Practitioner

Name  
Dr P Putta  
Address  
Drs Sharpe putta & burns practice  
Sighthill Heat  
EH11 4AU  
Telephone 0131 537 7040

Date and Time of Attendance  
27/08/2011 12:31  
Incident Date & Time:  
Mode of Arrival  
Emergency Ambulance  
Source of Referral  
999 Emergency

T 35.2	P 79	RR 16	BP 149/93	BM 6.3	SpO2 98%	Penkflow	Urinalysis	Alcometer
Nursing Assessment faint averaged 20 of 20-30 x 50mg tramadol episodes of 10-20mg, vomit x 4. C/P 15. Sore throat infectious Pleur dx, am, ECG, MRI								
Pain Assessment Score					Waterlow Score			
Pain Score Review					Time		Triage Score	
Signature [Signature]					Time 12:40		Print Name NFF	

Clinical Notes

(S3) →

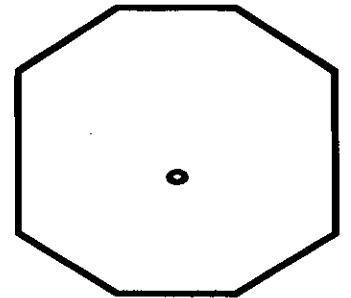
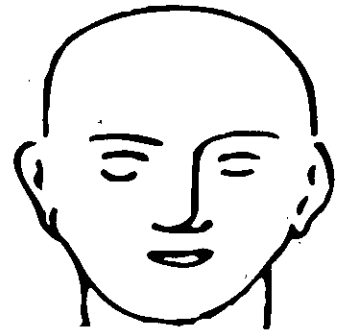
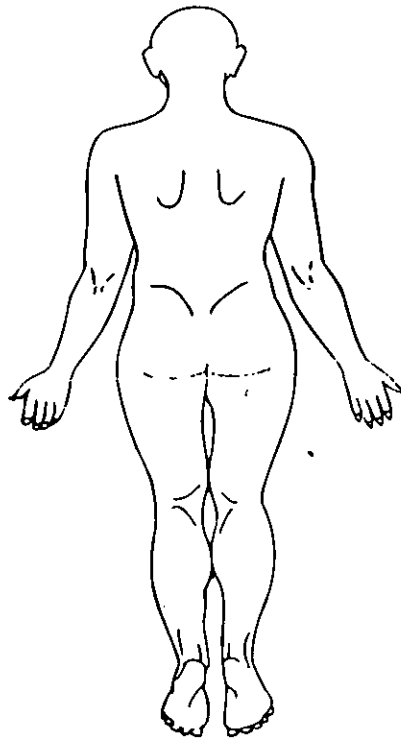
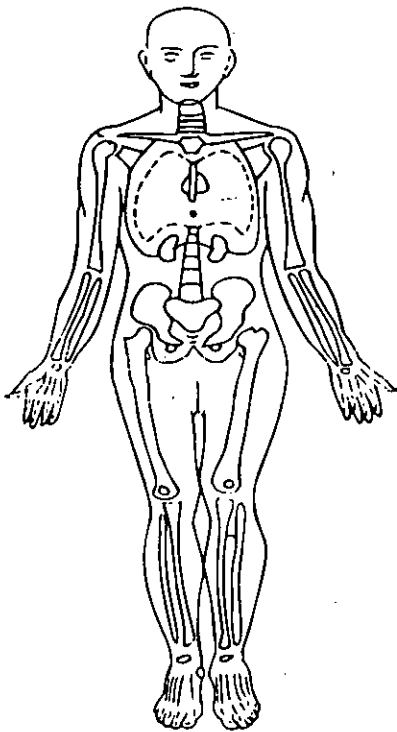
OD 35 x 50mg tramadol, 1 x vomit  
- worried because epix for tests for bone cancer,  
separated from wife. Moved house  
- Still feels like wants to kill self

PMH - takes 4-5 aa in the past, skin ca, osteoarthritis  
SH lives alone, DLA  
DH - amitriptyline, mirtazapine, has CPN Andy McLeary  
8 cans every other day  
begs branched off friend

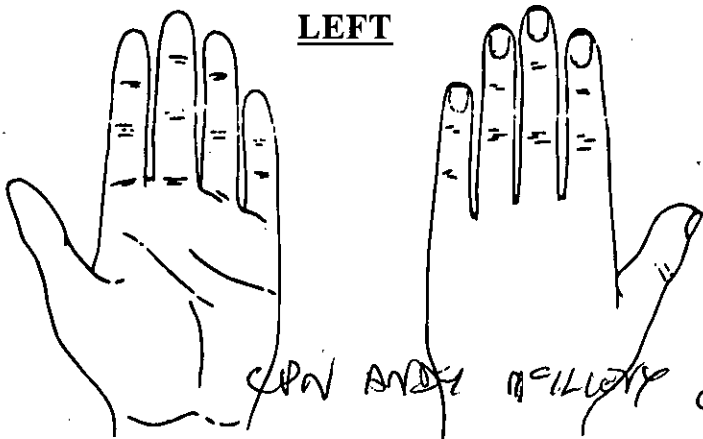
Diagnosis

Doctor's Name (print) A Dickinson Signature [Signature]

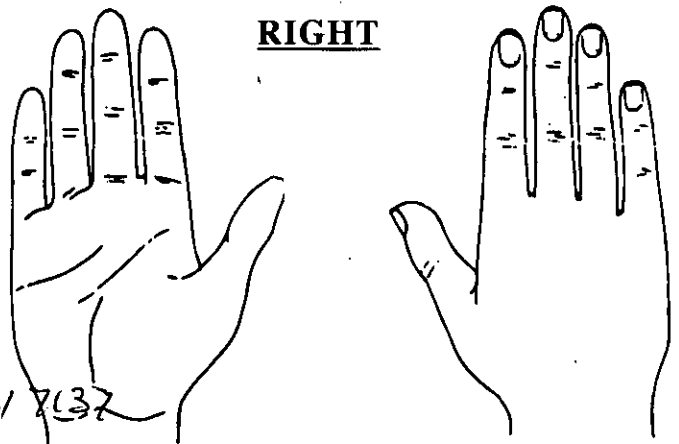
Nursing Release				Clinical Notes Continued
Instruction/Health Education	Y	N	N/A	Plan 12 lead ECG & review! D/C
Medication	Y	N	N/A	
Review				
X-rays	Y	N	N/A	D/C from PSYCH POINT OF VIEW SEE STATE FOR ASSESS
Clinic Notes/X-rays	Y	N	N/A	
Walking Aids	Y	N	N/A	
Transport				
Self	Y	N	N/A	
Other	Y	N	N/A	
Amb ref no.....	Y	N	N/A	
Primary Care Ref.				
Safe Home	Y	N	N/A	
Crisis Care	Y	N	N/A	
District Nurse	Y	N	N/A	
GP	Y	N	N/A	
NoK/carer aware				
Documentation Complete	Y	N		
CSW signature				
RN signature				



**LEFT**



**RIGHT**




CPN ANDY MILLER 0131 661 7137





**Accident and Emergency Unit  
Nursing Care Plan**

610094959B/E2035998 M 18/05/1958 <b>McMillan, Donald G</b> 75/2 Calder Gardens, Edinburgh, EH11 4JX
CHI 1805580019  70906 DP Putta

Admission Nurse Signature

.....

**Admission Care Guide**

Mandatory Admission Tasks	Tick	Optional Admission Tasks	Tick
Undress patient	✓	Connected to acuity	
Nurse on Sheet	✓	12 Lead ECG	
Clothing bagged and labelled	✓	Nurse X-Ray	
Vital Signs recorded (including pain score)	✓	Analgesia	
Relatives informed		Valuables listed	

**Pressure Care Guide**

<b>Build/Weight for Height</b>		<b>Appetite</b>		<b>Mobility</b>		<b>SCORE 1-10</b>
Average	0	Average	0	Fully	0	<b>LOW RISK</b> LIKELY TO BE SELF CARING AND INDEPENDENT IN ALL OR MOST ASPECTS OF SCALE
Above average	1	Poor	1	Restless/fidgety	1	
Obese	2	NG tube/fluids only	2	Apathetic	2	
Below	3	NDM/anorexic	3	Restricted/inert	3	
				Traction	4	
				Chairbound	5	
<b>Continence</b>		<b>Tissue Malnutrition</b>		<b>Major Surgery/Trauma</b>		<b>SCORE 10-15</b>
Completely catheterised	0	Terminal cachexia	8	Orthopaedic - below waist	5	<b>MODERATE RISK</b> NEEDS 2 HRLY PRESSURE CARE AND PRESSURE AREAS OBSERVED
Occasional incontinence	1	Cardiac failure	5	Spinal - on table over 2 hrs	5	
Cath / incont of faeces	2	Peripheral disease	2			
Doubly incontinent	3	Anaemia	2			
		Smoking	1			
<b>Skin Type: Visual Risk Area</b>		<b>Neurological Deficit</b>		<b>Sex/Age</b>		<b>SCORE 15-20</b>
Healthy	0	Diabetes	4-6	Male	1	<b>HIGH RISK</b> NEEDS 2 HRLY PRESSURE CARE AND POSITIONED ONTO A PRESSURE MATTRESS CHART ANY VULNERABLE AREAS AND OBSERVE
Tissue paper	1	MS	4-6	Female	2	
Dry	1	CVA	4-6	14-49	1	
Oedematous	1	Motor sensory	4-6	50-64	2	
Clammy	1	Paraplegia	4-6	65-74	3	
Discoloured	2			75-80	4	
Broken/spot	3			81+	5	
<b>Medication</b>		<b>TOTAL SCORE</b>				<b>SCORE 20+</b>
Cytotoxics	4					<b>VERY HIGH RISK</b> NEEDS 2 HRLY PRESSURE CARE AND POSITIONED ONTO A PRESSURE MATTRESS. INFORM BED MANAGER IF ADMISSION IS REQUIRED AND CONTACT TISSUE VIABILITY SERVICE FOR FURTHER ADVICE. CONSIDER AIR MATTRESS
High doses of steroids	4					
Anti-inflammatory	4					

**Continuous Nursing Care Record**

*Please note time and sign for any care delivered*

NUTRITION	CONTINENCE	PRESSURE CARE





Rate 75 . Age not entered, assumed to be 50 years old for purpose of ECG interpretation  
 PR 163 . Sinus rhythm.....normal P axis, V-rate 60- 99  
 QRSD 97 . Abnormal R-wave progression, early transition.....QRS area>0 in V2  
 QT 405  
 QTc 453

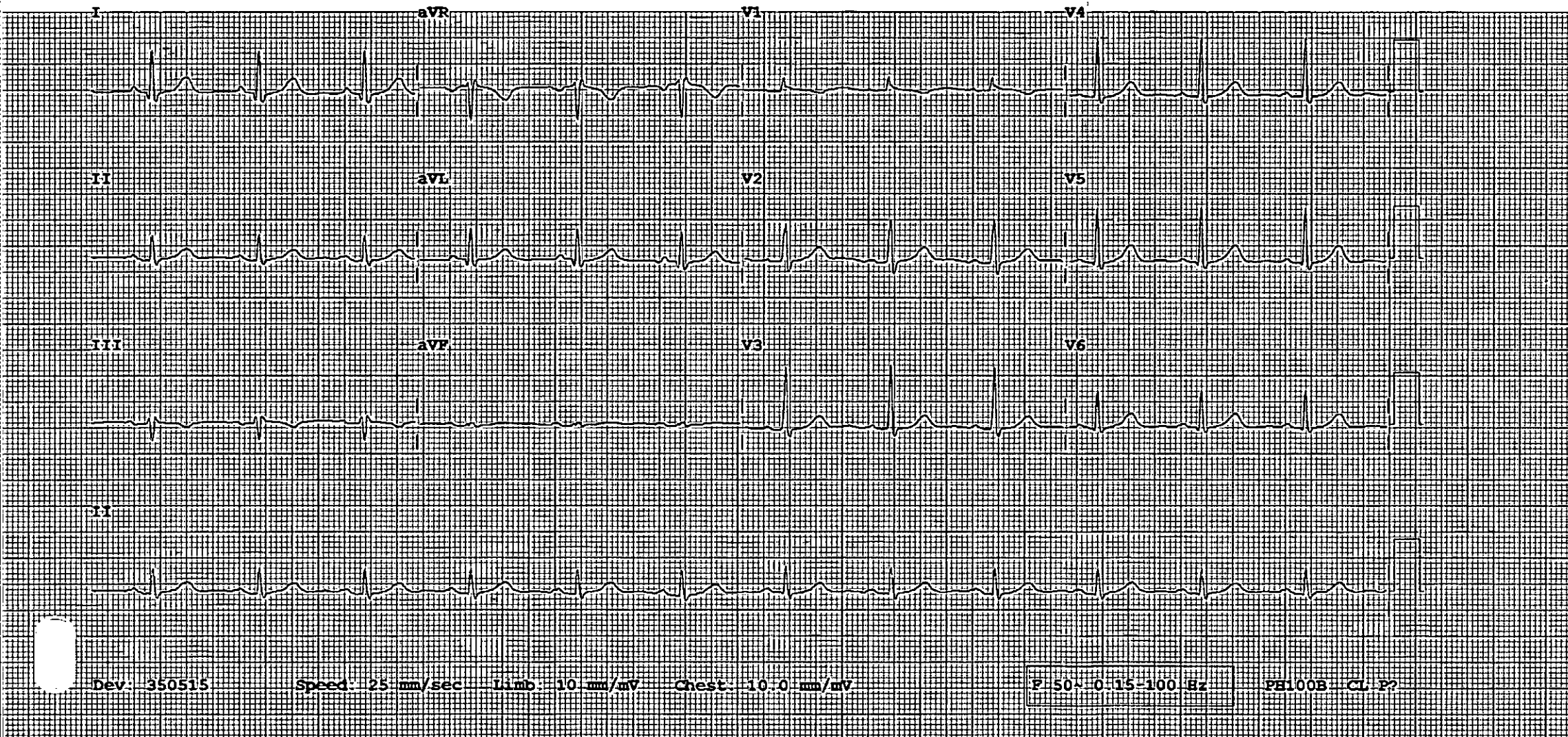
Donald Macmillan  
 18/05/58

sinus,  
 w abnormalities, normal  
 QTC

--AXIS--  
 P 24  
 QRS 15  
 T 16

- OTHERWISE NORMAL ECG -

Unconfirmed Diagnosis



# E-Pacer PATIENT REPORT

Time 12:25 Date 27/08/2011

## PATIENT AND INCIDENT DETAILS

Incident number	ED003125027.001
Name	DONALD MACMILLAN
Age	53
Date of birth	18/05/1958
Gender	Male
Incident location	FLAT 2, 75 2 CALDER GARDENS
Incident post code	SIGHTHILL EDINBURGH
Incident type	EH11 4JX
Call received	EMG
Call passed	27/08/2011, 11:37
Crew mobile	27/08/2011, 11:37
Crew at scene	27/08/2011, 11:39
	27/08/2011, 11:58

## PRIMARY SURVEY

<b>RESPONSE</b>			
AVPU	Alert	CHI 1805580019	610094959B/E2035998 M 18/05/1958
<b>AIRWAY</b>		70906	McMillan, Donald G
Airway assessment	Clear	DP Puta	75/2 Calder Gardens,
<b>BREATHING</b>			Edinburgh,
Breathing rate	Normal		EH11 4JX
Respiratory rate			
<b>CIRCULATION</b>			
Pulse rate	Normal		
Most peripheral pulse found	Radial		
Cap refill rate			
Skin colour	Normal		
Skin texture	Dry		

## AMPDS

Dispatch code	23C011	Intentional Overdosed and Not Alert
Final code	23B01	Overdose/Poisoning, Overdose (Without Priority Symptoms)

## GCS

Final GCS eye opening	Spontaneous
Final GCS verbal response	Orientated
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	EKG	Pain score
12:00	98	16	-/-	<2 secs	-	-	-	-	15	-	-	-	-
12:08	96	16	144 / 110	<2 secs	-	-	-	100	15	7.550	-	-	-
12:25	95	16	-/-	-	-	-	-	99	15	-	-	-	-

## AMPLE

Allergies	
Other allergies	
Medication	IBUPROFEN, ASPIRIN
Past history	AMITRIPTYLINE, MIRTAZAPINE
Last eaten	DEPRESSION, SKIN CA
Events prior	999. 53YOM. SUICIDAL. INTENTIONAL OVERDOSE. ? 35X 50MG TRAMADOL @ 1000HRS TODAY. NO ALCOHOL. VOMITED 1HR AFTERWARDS. STILL FEELING SUICIDAL. HAS NOT TAKEN HIS AMATRIPTILYNE OR MIRTAZAPINE TODAY.

## FINAL OBSERVATION AND COMMENTS

GP: SIGHTHILL MC. NOK: NIL

Report ID ad0c2806-79d5-4bbe-8f3e-20d5db8d0b9b

# Patient & GP Information

<b>UHPI Number</b>	610094959B
<b>CHI Number</b>	1805580019
<b>Episode Number</b>	E1960149
<b>Surname/Forename</b>	Macmillan, Donald
<b>Date of Birth</b>	5/18/58
<b>Sex</b>	Male
<b>Patient Address.</b>	75/2 Calder Gardens Edinburgh EH11 4JX
<b>Registered GP</b>	J Burns
<b>GP Address.</b>	Sighthill Red Medical Practice, Sighthill Health Centre, Calder Road, Edinburgh EH11 4AU

## Report Contents

The report bundle provides information on the following:

\* IP/OP Clinical Notes

<b>Surname/Forename</b>	Macmillan, Donald
<b>UHPI Number</b>	610094959B

<b>Episode Number</b>	E1960149
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## Inpatient/Outpatient Clinical Notes

<b>Note Details</b>	<b>Clinical Notes</b>
<p>A&amp;E Notes            Episode/Ref: E1960149            Dr Zoe HH Sallon</p> <p>5/9/11            21:17            Zoe HH Sallon</p>	<p>CHI: 1805580019,Overdose at 14.00 with intention to 'get a sleep', was definitely not trying to harm himself in any way. Took 10x 50mg tramadol, 1x 25mg mirtazepine, 1x 25mg amitryptaline, and 4x blue diazepam. Has been well since, feeling slightly thirsty and a bit groggy, but no other symptoms. Attended A+E with his wife.,O.E T36.8, HR 68, RR 17, BP 100/65, Sats 96 air.,HS normal, chest clear. pupils 2mm bilaterally.,Dry mucous membranes,Abdo SNT.,,ECG normal.,,Impression-,Toxbase states if &lt;13mg/kg tramadol and well 6 hrs post ingestion does not need hospital assessment. Diazepam has relatively short half life and should be wearing off by now. Other drugs are his usual prescribed medications taken at appropriate does.,I feel confident that there was no suicidal intention there fore does not need see psych.,,Plan,DC home with advise to return if any worries overnight. Drink plenty of water.</p>

Dr AG Stevenson  
Bangholm Medical Centre  
Bangholm Loan  
Edinburgh  
EH5 3AH

**Date:** 09/05/2011

## Emergency Discharge Summary

<b>Patient</b>	Donald McMillan 20/6 Crewe Road Gardens Edinburgh EH5 2NJ	<b>CHI</b>	<b>1805580019</b>
		<b>Date of Birth / Age</b>	18/05/1958 (52 years)
		<b>UHPI</b>	610094959B
		<b>A&amp;E Attendance Number</b>	E1960149
		<b>Contact</b>	
<b>Attendance Date</b>	09/05/2011		
<b>Attendance Time</b>	17:55		
<b>Mode of Arrival</b>	Emergency Ambulance		
<b>Source of Referral</b>	999 Emergency		
<b>Discharge Date</b>	09/05/2011		
<b>Discharge To</b>			

Dear Dr AG Stevenson

**Presentation:** od

CHI: 1805580019

Overdose at 14.00 with intention to 'get a sleep', was definitely not trying to harm himself in any way. Took 10x 50mg tramadol, 1x 25mg mirtazepine, 1x 25mg amitryptaline, and 4x blue diazepam. Has been well since, feeling slightly thirsty and a bit groggy, but no other symptoms. Attended A+E with his wife.

O.E T36.8, HR 68, RR 17, BP 100/65, Sats 96 air.  
HS normal, chest clear. pupils 2mm bilaterally.  
Dry mucous membranes  
Abdo SNT.

ECG normal.

Impression-

Toxbase states if <13mg/kg tramadol and well 6 hrs post ingestion does not need hospital assessment. Diazepam has relatively short half life and should be wearing off by now. Other drugs are his usual prescribed medications taken at appropriate doses. I feel confident that there was no suicidal intention there fore does not need see psych.

Plan

DC home with advise to return if any worries overnight. Drink plenty of water.

Yours Sincerely,

Dr Zoe HH Sallon, Doctor

Directorate of  
Accident and Emergency Medicine  
LOTHIAN UNIVERSITY HOSPITALS NHS TRUST



Clinical Lead Dr. A. Gray  
Clinical Nurse Manager Mr. Neil Boyle  
THE ROYAL INFIRMARY OF EDINBURGH  
51 Little France Crescent, Edinburgh EH16 4SU  
Tel: 0131 242 1300 • Fax: 0131 242 1344



A/E no. E1960149

Previous no. E1867010

UHPI no. 10094959B

CHI no. 1805580019

PATIENT INFORMATION

Surname McMillan Date of Birth 8/05/1958  
Forename Donald Gordon Age 52 Yrs Sex M

Address 20/6 Crewe Road Gardens  
Edinburgh

Postcode EH5 2NJ

Telephone

Contact Address [Redacted]

Complaint

Allergies

Attendances in last 12 months: 5

School:

General Practitioner

Name AG Stevenson  
Address Bingham Medical Centre  
Bingham Loan  
EH5 3AH  
Telephone 0131 552 7676

Date and Time of Attendance 09/05/2011 17:55  
Incident Date & Time:  
Mode of Arrival Emergency Ambulance  
Source of Referral 999 Emergency

T 36.8 P 68 RR 17 BP 100/65 BM SpO2 96% Peakflow Urinalysis Alcometer

Nursing Assessment  
 10 of 3 Tramadol ~~18~~ 10 / 1 nitrazepine 25mg  
 1 Amitriptyline at 14.00 25mg  
 Looks well. 4x blue dig 70mg  
 Pain Assessment Score Waterlow Score  
 Pain Score Review P-obs then refer ED Triage Score  
 Signature [Signature] Time 18:20 Print Name

Clinical Notes  
 See typed.

Diagnosis  
 Doctor's Name (print) ZOE JAMES Signature [Signature]





Dept: Emergency Dept.

610094959B/E1960149 M 18/05/1958

McMillan, Donald G  
20/6 Crewe Road Gardens,  
Edinburgh,  
EH5 2NJ

CHI 1805580019  
70272 AG Stevenson

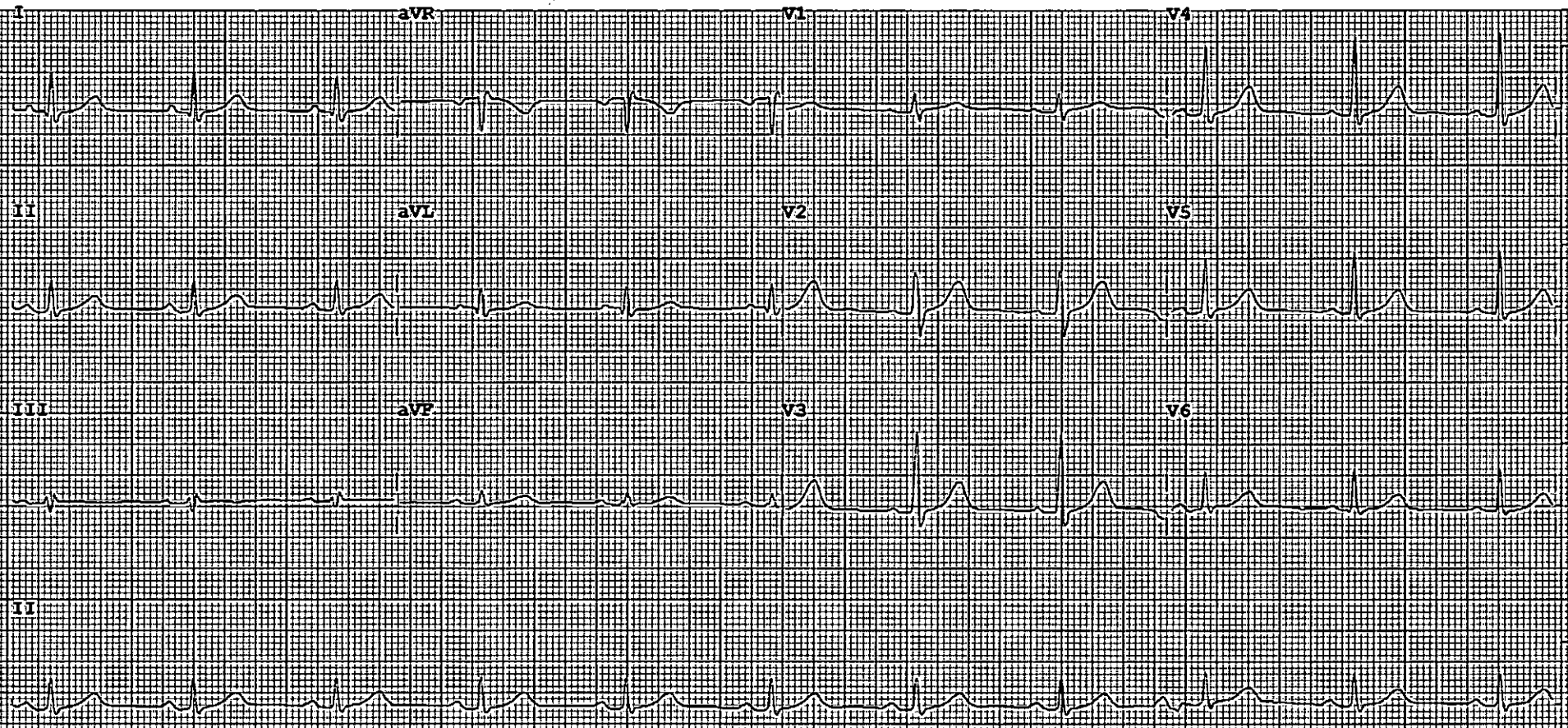
Rate 64 . Age not entered, assumed to be 50 years old for purpose of ECG interpretation  
 PR 171 . Sinus rhythm.....normal P axis, V-rate 60- 99  
 QRSD 101 . Abnormal R-wave progression, early transition.....QRS area>0 in V2  
 QT 444  
 QTc 458

*SR. nil acute.  
Z fallen.*

--AXIS--  
 P 19  
 QRS 40  
 T 34

- OTHERWISE NORMAL ECG -

Unconfirmed Diagnosis



**E-Pacer PATIENT REPORT**

Time 17:31 Date 09/05/2011

**PATIENT AND INCIDENT DETAILS**

Incident number ED003037157.001  
 Name DONALD MACMILLAN  
 Address AS INCIDENT  
 Age 52  
 Date of birth 18/05/1958  
 Gender Male  
 Incident location 20 HOMELESS UNIT, CREWE ROAD GARDENS PILTON EDINBURGH  
 Incident post code EH5 2NH  
 Incident type EMG  
 Call received 09/05/2011, 16:46  
 Call passed 09/05/2011, 16:50  
 Crew mobile 09/05/2011, 16:50  
 Crew at scene 09/05/2011, 16:52  
 Crew left scene 09/05/2011, 17:09  
 Receiving hospital and department NERI New Edinburgh Royal Infirmary

**PRIMARY SURVEY**

**RESPONSE**

AVPU Alert

**AIRWAY**

Airway assessment Clear

**BREATHING**

Breathing rate Normal

Respiratory rate

**CIRCULATION**

Pulse rate Normal

Most peripheral pulse Radial

Cap refill rate

Skin colour Normal

Skin texture Dry

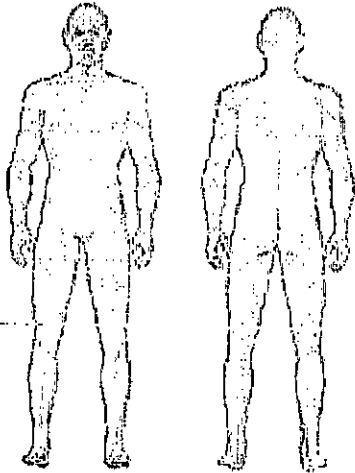
**C-SPINE INJURY**

Suspicion of CSI No evidence of C-spine injury

**PATIENT CONSENT**

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

**INJURIES**



PAIN P1. No pain relief provided  
 P2.  
 P3.  
 P4.

Other identified DENIES ANY PAIN

**AMPDS**

Dispatch code 23C011 Intentional Overdosed and Not Alert  
 Triage code 23B01 Overdose/Poisoning, Overdose (Without Priority Symptoms)

**GCS**

Final GCS eye opening Spontaneous  
 Final GCS verbal response Orientated  
 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	SEMS	EKG	Pain score
16:55	88	20	103 / 76	<2 secs	-	6.7	0.0	96	15	7.550	0	NSR	0/10
17:23	73	16	108 / 73	<2 secs	-	-	0.0	95	15	7.550	0	NSR	0/10

**EYES AND PUPIL SIZE AND REACTION**

Pupil size Left Normal Right Normal  
 Pupil reaction Left Normal Right Normal

**AMPLE**

Allergies Aspirin  
 Other allergies IBUPROFEN  
 Medication MIRTAZIPINE, TRAMADOL, AMITRIPTYLINE, ANTIHISTAMINES, OVERDOSES, OSTEO ARTHRITIS OF R KNEE, SEVERED TENDON ON R THUMB, HYATUS HERNIA, DUODENAL ULCER, RECENT BIOPSY OF R NOSTRILL, ALCOHOL ISSUES, (7ALCOHOLIC),  
 Past history  
 Last eaten >5 hrs  
 Events prior TOOK AN OVERDOSE CONSISTING OF 1X30mg MIRTAZIPINE, 10X50mg TRAMADOL, ALONG WITH HIS PRESCRIBED DOSE OF AMITRIPTYLINE, (25mg), AT APPROX 1500HRS. PT STATES THIS IS DUE TO HIS FRIEND BEING EVICTED FROM HOMELESS ACCOMMODATION

**PATIENT HANDOVER**

On arrival at scene Standing  
 Scene removal Walking  
 Transportation Seated  
 Care delivery at hospital Chair  
 Time of handover 17:48

**FINAL OBSERVATION AND COMMENTS**

GP. BALMORE H/C, LEITH, DR STEVENSON. NOK WIFE KATHLEEN TAIT MACMILLAN, TEL: 07981 916541, WOMENS HOSTEL, 15 LEITH STREET, EDINBURGH.  
 Report ID 9a9f4df7-3143-4687-a89b-dd6f99cc0385

# Patient & GP Information

<b>UHPI Number</b>	610094959B
<b>CHI Number</b>	1805580019
<b>Episode Number</b>	E1867010
<b>Surname/Forename</b>	Macmillan, Donald
<b>Date of Birth</b>	5/18/58
<b>Sex</b>	Male
<b>Patient Address.</b>	75/2 Calder Gardens Edinburgh EH11 4JX
<b>Registered GP</b>	J Burns
<b>GP Address.</b>	Sighthill Red Medical Practice, Sighthill Health Centre, Calder Road, Edinburgh EH11 4AU

## Report Contents

The report bundle provides information on the following:

\* IP/OP Clinical Notes


<b>Surname/Forename</b>	Macmillan, Donald
<b>UHPI Number</b>	610094959B

<b>Episode Number</b>	E1867010
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## Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
<p>A&amp;E Notes Episode/Ref: E1867010 Dr Morven Mackay</p> <p>12/24/10 02:44 Morven MacKay</p>	<p>PC: Tramadol overdose,HPC: Says he has taken 50 x 50mg tramadol tablets at 10pm tonight after drinking 8 pints. Received new supply of tramadol today. Has been planning to end his life - was considering going out into the snow to let nature take its course. Lots of things going through his mind. Upset re recent break up with wife and having to put his dog in kennels - cannot keep him in the hostel where he is currently staying. Struggling to get to sleep until 7am, poor appetite. Regretful that OD has not worked, says he wants to go to sleep and never wake up. Says he would have taken paracetamol instead if he'd known that tramadol wouldn't work. Drinking heavily over the last few weeks - daily drinking. Phoned NHS 24 to ask what to expect from tramadol OD. Attended A&amp;E 10/7 ago after tramadol OD - seen by psych -impulsive OD, referred to APS and GP - pt was too tired to go to APS,unsure if he wants to give up drinking. ,PMH: OA, repeated overdoses,Drugs: mirtazapine, fexofenadine, tramadol,Allergies: ibuprofen, aspirin,SH: living in a hostel, smoker, separated,,O/E T35.5, HR71, RR15, BP 105/73, BM5.1, Sats 96% air, alcometer 1.16,Lying with eyes closed. E4, V5, M6,warm peripheries, HR 60 reg, HS pure,RS:clear vesicular, nil added, A/E R=L,GIS: soft, non tender, BS+Ve,NS - constricted pupils, reactive. CN intact. normal tone, power, co-ordination, sensation, reflexes throughout,ECG: sinus rhythm nil acute,,Imp: significant tramadol OD - mild symptoms only. depressed,Plan:bloods inc paracetamol and salicylate levels, needs to be observed for 6 hrs post OD, refer to psychiatry,bloods: paracetamol and salicylate levels undetectable, bloods unremarkable,,Psych - Donald is too intoxicated to assess properly from a mental health piont of view, due to his on going thoughts of suicide admit for further assessment mane, BrAC 1.16 on an insufficient sample.,,D Flucker / B Hamilton MHAS,</p>

Dr A Morrison  
65 Liberton Gardens  
Edinburgh  
EH16 6JT**Date:** 24/12/2010**Emergency Discharge Summary**

<b>Patient</b>	Donald McMillan 143 Gilmerton Dykes Drive Edinburgh Midlothian EH17 8LP	<b>CHI</b>	<b>1805580019</b>
		<b>Date of Birth / Age</b>	18/05/1958 (52 years)
		<b>UHPI</b>	610094959B
		<b>A&amp;E Attendance Number</b>	E1867010
<b>Attendance Date</b>	24/12/2010	<b>Contact</b>	
<b>Attendance Time</b>	00:41		
<b>Mode of Arrival</b>	Emergency Ambulance		
<b>Source of Referral</b>	Self Referral to A&E		
<b>Discharge Date</b>			
<b>Discharge To</b>			

Dear Dr A Morrison

**Presentation:** OD

PC: Tramadol overdose

HPC: Says he has taken 50 x 50mg tramadol tablets at 10pm tonight after drinking 8 pints. Received new supply of tramadol today. Has been planning to end his life - was considering going out into the snow to "let nature take its course". Lots of things going through his mind. Upset re recent break up with wife and having to put his dog in kennels - cannot keep him in the hostel where he is currently staying. Struggling to get to sleep until 7am, poor appetite. Regretful that OD has not worked, says he wants to go to sleep and never wake up. Says he would have taken paracetamol instead if he'd known that tramadol wouldn't work. Drinking heavily over the last few weeks - daily drinking. Phoned NHS 24 to ask what to expect from tramadol OD. Attended A&E 10/7 ago after tramadol OD - seen by psych -impulsive OD, referred to APS and GP - pt was too tired to go to APS, unsure if he wants to give up drinking.

PMH: OA, repeated overdoses

Drugs: mirtazapine, fexofenadine, tramadol

Allergies: ibuprofen, aspirin

SH: living in a hostel, smoker, separated

O/E T35.5, HR71, RR15, BP 105/73, BM5.1, Sats 96% air, alcometer 1.16

Lying with eyes closed. E4, V5, M6

warm peripheries, HR 60 reg, HS pure

RS: clear vesicular, nil added, A/E R=L

GIS: soft, non tender, BS+Ve

NS - constricted pupils, reactive. CN intact. normal tone, power, co-ordination, sensation, reflexes throughout

ECG: sinus rhythm nil acute

Imp: significant tramadol OD - mild symptoms only. depressed

Plan: bloods inc paracetamol and salicylate levels, needs to be observed for 6 hrs post OD, refer to psychiatry

bloods: paracetamol and salicylate levels undetectable, bloods unremarkable

Psych - Donald is too intoxicated to assess properly from a mental health point of view, due to his on going thoughts of suicide admit for further assessment mane, BrAC 1.16 on an insufficient sample.

D Flucker / B Hamilton MHAS

Yours Sincerely,

Dr Morven Mackay, Doctor

Directorate of  
Accident and Emergency Medicine  
LOTHIAN UNIVERSITY HOSPITALS NHS TRUST



Clinical Lead Dr. A. Gray  
Clinical Nurse Manager Mr. Neil Boyle  
THE ROYAL INFIRMARY OF EDINBURGH  
51 Little France Crescent, Edinburgh EH16 4SU  
Tel: 0131 242 1300 • Fax: 0131 242 1344



A/E no. E1867010

E1861436

Previous no.

UHPI no. 610094959B

CHI no. 1805580019

PATIENT INFORMATION

Surname **McMillan** Date of Birth **18/05/1958**  
Forenames **Donald Gordon** Age **52** Yrs Sex **M**  
Address **143 Gilmerton Dykes Drive**  
**Edinburgh**  
**Midlothian**  
Postcode **EH17 8LP** Telephone

Contact Address [Redacted]

Complain **OD** Allergies

Attendances in last 12 months: **4** School:

General Practitioner

Name **Morrison**  
Address **65 Liberton Gardens**  
**Edinburgh**  
**EH16 6JT**  
Telephone **0131 664 3050**

Date and Time of Attendance **24/12/2010 00:41**

Incident Date & Time:

Mode of Arrival **Emergency Ambulance**

Source of Referral **Self Referral to A&E**

*zero effort*

T **355** P **71** RR **15** BP **105/73** BM **5.1** SpO2 **96%** Peakflow Urinalysis Alcometer **1.16**

Nursing Assessment **OD of ? 52 x 50mg Tramadol between 23:00 & 00:00**  
**alcohol Hx similar**

Pain Assessment Score Waterlow Score  
Pain Score Review Time Triage Score  
Signature **L. Brown** Time **0045** Print Name

Clinical Notes

- **Mirtazapine** • **Zonipfen + aspirin** **Pmt**
- **Antihistamine** **OA - R line**
- **Tramadol**

*See EPR*

Diagnosis

Doctor's Name (print) **Dr M MacC...** Signature *[Signature]*



**Accident and Emergency Unit  
Nursing Care Plan**

610094959B/E1867010 M 18/05/1958

**McMillan, Donald G**  
143 Gilmerton Dykes Drive,  
Edinburgh,  
Midlothian,  
EH17 8LP

CHI 1805580019   
70376 A Morrison



Admission Nurse Signature

*L Brown*  
24/12/10

**Admission Care Guide**

Mandatory Admission Tasks	Tick	Optional Admission Tasks	Tick
Undress patient	✓	Connected to acuity	✓
Nurse on Sheet	✓	12 Lead ECG	✓
Clothing bagged and labelled	✓	Nurse X-Ray	
Vital Signs recorded (including pain score)	✓	Analgesia	
Relatives informed	✓	Valuables listed	

**Pressure Care Guide**

Build/Weight for Height	Appetite	Mobility	SCORE 1-10
Average 0	Average 0	Fully 0	LOW RISK LIKELY TO BE SELF CARING AND INDEPENDENT IN ALL OR MOST ASPECTS OF SCALE
Above average 1	Poor 1	Restless/fidgety 1	
Obese 2	NG tube/fluids only 2	Apathetic 2	
Below 3	NDM/anorexic 3	Restricted/inert 3	
		Traction 4 Chairbound 5	
Continence	Tissue Malnutrition	Major Surgery/Trauma	SCORE 10-15
Completely catheterised 0	Terminal cachexia 8	Orthopaedic - below waist 5	MODERATE RISK NEEDS 2 HRLY PRESSURE CARE AND PRESSURE AREAS OBSERVED
Occasional incontinence 1	Cardiac failure 5	Spinal - on table over 2 hrs 5	
Cath / incont of faeces 2	Peripheral disease 5		
Doubly incontinent 3	Anaemia 2 Smoking 1		
Skin Type: Visual Risk Area	Neurological Deficit	Sex/Age	SCORE 15-20
Healthy 0	Diabetes 4-6	Male 1	HIGH RISK NEEDS 2 HRLY PRESSURE CARE AND POSITIONED ONTO A PRESSURE MATTRESS AND CONTACT TISSUE VIABILITY SERVICE FOR FURTHER ADVICE AND OBSERVE
Tissue paper 1	MS 4-6	Female 2	
Dry 1	CVA 4-6	14-49 1	
Oedematous 1	Motor sensory 4-6	50-64 2	
Clammy 1	Paraplegia 4-6	65-74 3	
Discoloured 2		75-80 4	
Broken/spot 3		81+ 5	
Medication	<b>TOTAL SCORE</b>		SCORE 20+
Cytotoxics 4			VERY HIGH RISK NEEDS 2 HRLY PRESSURE CARE AND POSITIONED ONTO A PRESSURE MATTRESS. INFORM BED MANAGER IF ADMISSION IS REQUIRED AND CONTACT TISSUE VIABILITY SERVICE FOR FURTHER ADVICE. CONSIDER AIR MATTRESS
High doses of steroids 4			
Anti-inflammatory 4			

**Continuous Nursing Care Record**

*Please note time and sign for any care delivered*

NUTRITION	CONTINENCE	PRESSURE CARE



## Patient & GP Information

<b>UHPI Number</b>	610094959B
<b>CHI Number</b>	1805580019
<b>Episode Number</b>	E1861436
<b>Surname/Forename</b>	Macmillan, Donald
<b>Date of Birth</b>	5/18/58
<b>Sex</b>	Male
<b>Patient Address.</b>	75/2 Calder Gardens Edinburgh EH11 4JX
<b>Registered GP</b>	J Burns
<b>GP Address.</b>	Sighthill Red Medical Practice, Sighthill Health Centre, Calder Road, Edinburgh EH11 4AU

## Report Contents

The report bundle provides information on the following:

\* IP/OP Clinical Notes

Surname/Forename	Macmillan, Donald
UHPI Number	610094959B

Episode Number	E1861436
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## Inpatient/Outpatient Clinical Notes


Note Details	Clinical Notes
<p>A&amp;E Notes            Episode/Ref: E1861436            Dr Rachel MacAlister            Hall</p> <p>12/14/10            23:41            Karen Darroch</p>	<p>psych review.,Donald informed us recently he has had relationship difficulties with his wife, reports over 1/52 ago going to the bank to put money in to pay bills, and after this they decided to go to there local pub for a drink, after having 4-5 drinks he reports his wife going back to the bank withdrawing the money and voicing that she planned to stay out. Donald reports going home. Since then he voiced that his wife has decided to end there relationship and has met someone else [REDACTED]. Donald voiced this has happend before but they managed to sort things out however voiced that she has apparently given up the home they have been sharing and because he has no rights to the tenancy he is having to move out. Reports for the last 4 days dinking heavily approx 12-15 cans per day, denies planned overdose today though had spoken with his wife and feels that there is not much point anymore and took the tablets impulsivly with the view to going to sleep and not waking up.,MSE,A&amp;B,Cassualy dressed gentelman who was appropraite throught, formed good rapport.,mood- reports has been feeling down due to recent social events also aware alcohol will be effecting his mood. no evidence of altered mood.,sleep- reports having better sleep when he has been drinking, finds difficult to get to sleep when not.,appetite- no concers,thoughts- currently upset about his situation with his wife though not sure how things are going to turn out with her and also worried about his dog as he may have to go into a bed and breakfast. describes self as an anxious person dosnt like being around alot of people. no evidance of FTD/abnormal perceptions.,social- recent social stressor re relationship with wife, awaiting temp accomadation, currently unemployed, denies any family contact.,meds- mirtazipine 45 mg no benefit though agrees due to his alcohol use may be having impact on this.,alcohol- periods of abstaining from alcohol use, though recently has been drinking for 4 days due to his current situation with his wife. keen to get help with this.,risk- impulsive overdose in context of socila crisis complicated by alcohol. previous presentation in july 10 though denied this was an overdose. Currently feels there is no much point and initialy voiced would like to go to sleep and never wake up however also voiced would like help with his alcohol use and have his medication reviewed as feels no benefit from his mirtazepine.Denies any further active intent though Donald maybe at future risk of impulsive acts of DSH/overdosing due to his chronic alcohol use and current social stressors.,Imp- Impulsive overdose in context of social crisis complicated by alcohol.,plan- discharge home when medically fit, Agreed to attend GP in the morning for review of current medication and presentation., aqnd please could GP discuss again with Donald re referral to alcohol problem service and if he still keen and motivated to address this can you please make referral to Alcohol problem service.,Advised Donald regarding his use of alcohol use effects on his health and mood and possible risk, appeared to demonstrate insight into this.,karen milligan,Dr Talbot,MHAS</p>

<b>Surname/Forename</b>	Macmillan, Donald
<b>UHPI Number</b>	610094959B

<b>Episode Number</b>	E1861436
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<b>Note Details</b>	<b>Clinical Notes</b>
<p>A&amp;E Notes Episode/Ref: E1861436 Dr Rachel MacAlister Hall</p> <p>12/15/10 11:50 Valerie Hardie</p>	<p>CHI: 1805580019,52 year old male,PC: Tramadol, overdose,HPC: Took 30 x 50 mgs tramadol tablets around 5.30 pm. Took a further 10 50 mgs tramadol tablets after ambulance had arrived.,Recent split from wife. Decided to take overdose earlier in afternoon. Has been drinking heavily over the last 3 days. Texted wife to say goodbye after taking the overdose. Wife phoned an ambulance. ,PMH: Recurrent overdoses, OA. ,Drugs: Fexofenadine, tramadol, mirtazepine,ALLERGIC TO ASPIRIN AND IBUPROFEN.,SH; Lives with dog. Smokes 15 cpd. Binge drinks once weekly usually, on disability living allowance.,,On exam: Temp. 36.4. BP 104/67. Pulse 78. Sats 93% improving to 96% on air.,RR 16/min. BM 4.2. Sleepy but easily rousable,CVS: Peripheries warm and well perfused. Pulse regular. Heart sounds normal.,RS: chest clear.,GI - abdomen soft, mildly tender RUQ. Bowel sounds active.,Neuro - GCS 15. PERL. Brisk reflexes globally.,,IMP: Tramadol overdose, alcohol misuse.,ECG sinus rhythm 71, nil acute.,Observed in department.,Reviewed by the Psychiatric Team who were happy for discharge.,,Any queries please contact A&amp;E Reception on 0131 242 1300 ,</p>

Dr A Morrison  
Blackridge Health Centre  
Fleming Place  
Blackridge  
EH48 3SS**Date:** 15/12/2010**Emergency Discharge Summary**

<b>Patient</b>	Donald McMillan 143 Gilmerton Dykes Drive Edinburgh Midlothian EH17 8LP	<b>CHI</b>	<b>1805580019</b>
		<b>Date of Birth / Age</b>	18/05/1958 (52 years)
		<b>UHPI</b>	610094959B
		<b>A&amp;E Attendance Number</b>	E1861436
		<b>Contact</b>	
<b>Attendance Date</b>	14/12/2010		
<b>Attendance Time</b>	21:02		
<b>Mode of Arrival</b>	Emergency Ambulance		
<b>Source of Referral</b>	Self Referral to A&E		
<b>Discharge Date</b>	15/12/2010		
<b>Discharge To</b>			

Dear Dr A Morrison

**Presentation:** overdose

CHI: 1805580019

52 year old male

PC: Tramadol, overdose

HPC: Took 30 x 50 mgs tramadol tablets around 5.30 pm. Took a further 10 50 mgs tramadol tablets after ambulance had arrived. Recent split from wife. Decided to take overdose earlier in afternoon. Has been drinking heavily over the last 3 days. Texted wife to say goodbye after taking the overdose. Wife phoned an ambulance.

PMH: Recurrent overdoses, OA.

Drugs: Fexofenadine, tramadol, mirtazepine

ALLERGIC TO ASPIRIN AND IBUPROFEN.

SH; Lives with dog. Smokes 15 cpd. Binge drinks once weekly usually, on disability living allowance.

On exam: Temp. 36.4. BP 104/67. Pulse 78. Sats 93% improving to 96% on air.

RR 16/min. BM 4.2. Sleepy but easily rousable

CVS: Peripheries warm and well perfused. Pulse regular. Heart sounds normal.

RS: chest clear.

GI - abdomen soft, mildly tender RUQ. Bowel sounds active.

Neuro - GCS 15. PERL. Brisk reflexes globally.

IMP: Tramadol overdose, alcohol misuse.

ECG sinus rhythm 71, nil acute.

Observed in department.

Reviewed by the Psychiatric Team who were happy for discharge.

Any queries please contact A&amp;E Reception on 0131 242 1300

Yours Sincerely,

Dr Rachel MacAlister Hall, Doctor

Dr A Morrison  
Blackridge Health Centre  
Fleming Place  
Blackridge  
EH48 3SS

**Date:** 15/12/2010

## Emergency Discharge Summary

<b>Patient</b>	Donald McMillan 143 Gilmerton Dykes Drive Edinburgh Midlothian EH17 8LP	<b>CHI</b>	<b>1805580019</b>
<b>Attendance Date</b>	14/12/2010	<b>Date of Birth / Age</b>	18/05/1958 (52 years)
<b>Attendance Time</b>	21:02	<b>UHPI</b>	610094959B
<b>Mode of Arrival</b>	Emergency Ambulance	<b>A&amp;E Attendance Number</b>	E1861436
<b>Source of Referral</b>	Self Referral to A&E	<b>Contact</b>	[REDACTED]
<b>Discharge Date</b>	15/12/2010		
<b>Discharge To</b>			

Dear Dr A Morrison

**Presentation:** overdose

psych review

Donald informed us recently he has had relationship difficulties with his wife, reports over 1/52 ago going to the bank to put money in to pay bills, and after this they decided to go to their local pub for a drink, after having 4-5 drinks he reports his wife going back to the bank withdrawing the money and voicing that she planned to stay out. Donald reports going home. Since then he voiced that his wife has decided to end their relationship and has met someone else [REDACTED]. Donald voiced this has happened before but they managed to sort things out however voiced that she has apparently given up the home they have been sharing and because he has no rights to the tenancy he is having to move out. Reports for the last 4 days drinking heavily approx 12-15 cans per day, denies planned overdose today though had spoken with his wife and feels that there is not much point anymore and took the tablets impulsively with the view to going to sleep and not waking up.

MSE

A&B

Casualty dressed gentleman who was appropriate thought, formed good rapport.

mood- reports has been feeling down due to recent social events also aware alcohol will be affecting his mood. no evidence of altered mood.

sleep- reports having better sleep when he has been drinking, finds difficult to get to sleep when not.

appetite- no concerns

thoughts- currently upset about his situation with his wife though not sure how things are going to turn out with her and also worried about his dog as he may have to go into a bed and breakfast. describes self as an anxious person doesn't like being around a lot of people. no evidence of FTD/abnormal perceptions.

social- recent social stressor re relationship with wife, awaiting temporary accommodation, currently unemployed, denies any family contact.

meds- mirtazapine 45 mg no benefit though agrees due to his alcohol use may be having impact on this.

alcohol- periods of abstaining from alcohol use, though recently has been drinking for 4 days due to his current situation with his wife. keen to get help with this.

risk- impulsive overdose in context of social crisis complicated by alcohol. previous presentation in July 10 though denied this was an overdose. Currently feels there is no much point and initially voiced would like to go to sleep and never wake up however also voiced would like help with his alcohol use and have his medication reviewed as feels no benefit from his mirtazapine. Denies any further active intent though Donald maybe at future risk of impulsive acts of DSH/overdosing due to his chronic alcohol use and

current social stressors.

Imp- Impulsive overdose in context of social crisis complicated by alcohol.

plan- discharge home when medically fit

Agreed to attend GP in the morning for review of current medication and presentation., and please could GP discuss again with Donald re referral to alcohol problem service and if he still keen and motivated to address this can you please make referral to Alcohol problem service.

Advised Donald regarding his use of alcohol use effects on his health and mood and possible risk, appeared to demonstrate insight into this.

karen milligan

Dr Talbot

MHAS

Yours Sincerely,

Dr Rachel MacAlister Hall, Doctor



Clinical Lead Dr. A. Gmy  
Clinical Nurse Manager Mr. Neil Boyle  
THE ROYAL INFIRMARY OF EDINBURGH  
51 Little France Crescent, Edinburgh EH16 4SU  
Tel: 0131 242 1300 • Fax: 0131 242 1344



A/E no. E1861436

Previous no. E1769085

UHPI no. 610094959B  
CHI no. 1805580019

PATIENT INFORMATION

Surname **McMillan** Date of Birth **18/05/1958**  
Forenames **Donald Gordon** Age **52 Yrs** Sex **M**  
Address **143 Gilmerton Dykes Drive**  
**Edinburgh**  
**Midlothian**  
Postcode **EH17 8LP** Telephone

Contact Address

Complain **overdose** Allergies

Attendances in last 12 months: **3** School:

General Practitioner

Name **Morrison**  
Address **Blackridge Health Centre**  
**Fleming Place**  
**EH48 3SS**  
Telephone **01501 751238**

Date and Time of Attendance  
**4/12/2010 21:02**

Incident Date & Time:  
Mode of Arrival  
**Emergency Ambulance**

Source of Referral  
**Self Referral to A&E**

T	36.4	P	78	RR	16	BP	104/67	BM	4.2	SpO2	93	Peakflow	Urinalysis	Alcometer	0.08
---	------	---	----	----	----	----	--------	----	-----	------	----	----------	------------	-----------	------

Nursing Assessment **30x 50mg tramadol at approx 1930.**

Pain Assessment Score	Waterlow Score	
Pain Score Review	Time	Triage Score
Signature	Time <b>2100</b>	Print Name <b>Hume</b>

Clinical Notes

**seen typed up.** **MC Obs**  
**SA C7** **CA**

**PC Tramadol overdose.** **SA Fexofenadine**  
**Tramadol**

**WPC** **Mirtazapine.**

**Took 30x 50mg tramadol tablets** **Allergic to aspirin/**  
**at ~1730. Took a further** **ibuprofen**

**10x 50mg tramadol tablets**

**after SAS arrived.** **SA lives with dog.**

**Recent split from wife -** **Smokes 1.5 cpd**  
**she is drinking heavily.** **binge drinks x1/week**

**Decided to take od this** **On DUA**  
**afternoon.**

**has been drinking heavily - so cans of beer over**  
**last 3 days.**

**Texted wife to say good bye after od.**

Diagnosis **Tramadol overdose.**

Doctor's Name (print) **Rachna Hume GPR1** Signature **RHume**

Nursing Release				Clinical Notes Continued
Instruction/Health Education	Y	N	N/A	Wife phoned ambulance.
Medication	Y	N	N/A	Wants to go to sleep and not wake up. Sees 'no future'.
Review				Mood v. low.
X-rays	Y	N	N/A	
Clinic	Y	N	N/A	
Notes/X-rays	Y	N	N/A	o/e sleepy but easily rousable.
Walking Aids	Y	N	N/A	CVS - peripheral hwp, pulse regular, legs normal.
Transport				
Self	Y	N	N/A	RS - chest clear.
Other	Y	N	N/A	GI - abd soft. Mildly tender
Amb ref no.....	Y	N	N/A	BS ✓ ROQ.
Primary Care Ref.				
Safe Home	Y	N	N/A	newsc - GCS 15. PELL.
Crisis Care	Y	N	N/A	Brisk reflexes globally
District Nurse	Y	N	N/A	
GP	Y	N	N/A	
NoK/carer aware				Imp Tramadol overdose
Documentation Complete	Y	N		Alcohol misuse.
CSW signature				
RN signature				Man observe for 4h in dept.

review.

ECC - 8271, with acute  
QTc 450ms.

psych review.  
full assess on EPR.  
- Plan - discharge & agreed plan should will contact GP in the morning for review.  
- Plan for referral to APS

**LEFT** - ~~Review~~ review re medication  
as feels no benefit from mirtazapine  
thought aware could be due to alcohol use.

**RIGHT** - medication

~~Review~~





VITAL SIGNS	
Cap refill (secs)	< 2
Peak flow %	-
Blood sugar mmol / l	-
Temp °C	36
SpO2 %	98
GCS Total	15
ECG	-
SEMS	-
RTS	-
Pain score	-

EYES AND PUPIL SIZE AND REACTION	
Left	Normal
Right	Normal

**AMPLE**

Allergies  
Other allergies  
Medication  
Past history  
Last eaten  
Events prior

MIRTAZEPINE, TRAMADOL  
DEPRESSION, OSTEOARTHRITIS  
> 5 hrs

**SUBSTANCES AFFECTING CONDITION**

Alcohol

**PATIENT HANDOVER**

On arrival at scene  
Scene removal  
Transportation  
Care delivery at hospital  
Time of handover

Standing  
Walking  
Seated  
Walking  
21:06

**FINAL OBSERVATION AND COMMENTS**

52 YO MALE WHO HAS TAKEN AN INTENTIONAL OD OF 30 X 50MG TRAMADOL TONIGHT AT ABOUT 1930. INITIALLY REFUSED TO TRAVEL BUT EVENTUALLY CONVINCED BY THE POLICE. ALL OBS NORMAL EN ROUTE. VOMIED X1 AT 20:45.

Report ID

dc322286-dfd1-4c0e-84e3-d5b9cf7ddf2

**E-Pacer PATIENT REPORT**

Time 21:08 Date 14/12/2010

**PATIENT AND INCIDENT DETAILS**

Incident number ED002917608.001  
Name DONALD MACMILLAN  
Age 52  
Gender Male  
Incident location 143 GILMERTON DYKES DRIVE GILMERTON EDINBURGH  
Incident post code EH17 8LP  
Incident type EMG  
Call received 14/12/2010, 19:55  
Call passed 14/12/2010, 19:56  
Crew mobile 14/12/2010, 19:56  
Crew at scene 14/12/2010, 20:01

**TREATMENT REFUSAL FORM**

**PRIMARY SURVEY**

**RESPONSE** AVPU Alert  
**AIRWAY** Airway assessment Clear  
**BREATHING** Breathing rate Normal  
Respiratory rate 16  
**CIRCULATION** Pulse rate Normal  
Most peripheral pulse found Radial  
Cap refill rate <2 secs  
Skin colour Normal  
Skin texture Dry  
**C-SPINE INJURY** No evidence of C-spine injury

**PATIENT CONSENT**

Suspicion of CSI  
Patient consent Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment, Lack of patient consent  
Duty of care delegated to CREW / POLICE

**AMPDS**

Dispatch code 23C071 Intentional O/dose Unknown  
Status/Other codes N/A  
Final code 23B01 Overdose/Poisoning, Overdose (Without Priority Symptoms)

**GCS**

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

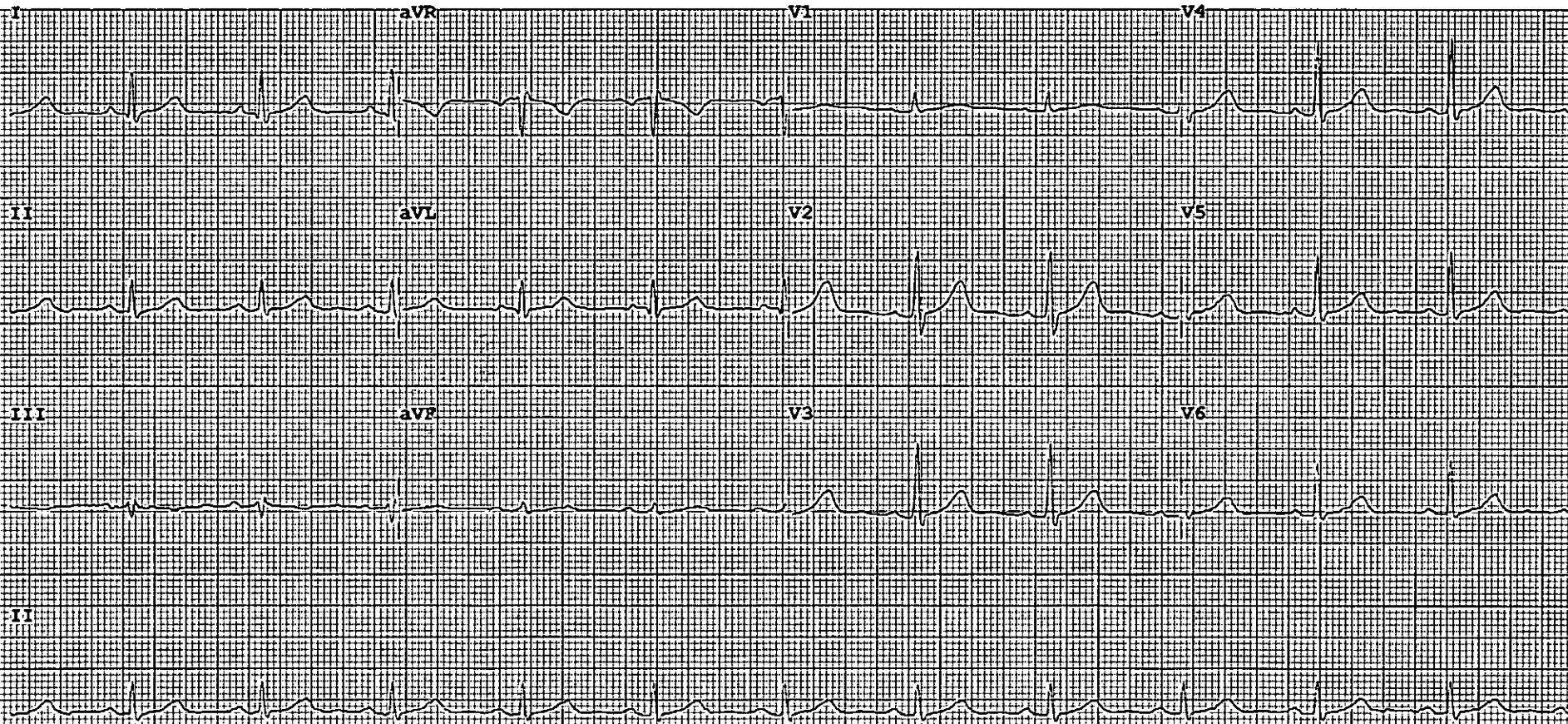
Rate 71 . Age not entered, assumed to be 50 years old for purpose of ECG interpretation  
 PR 164 . Sinus rhythm.....normal P axis, V-rate 60-99  
 QRSD 98 . Abnormal R-wave progression, early transition.....QRS area>0 in V2  
 QT 414  
 QTc 450

610094959B/E1861436 M 18/05/1958  
 McMillan, Donald G  
 143 Gilmerton Dykes Drive,  
 Edinburgh,  
 Midlothian,  
 EH17 8LP  
 CHI 1805580019  
 78096 A Morrison

--AXIS--  
 P 36  
 QRS 25  
 T 21

- OTHERWISE NORMAL ECG -

Unconfirmed Diagnosis



Dev: 350515

Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 50 0.15 100 Hz PH100B CL P?

## Patient & GP Information

<b>UHPI Number</b>	610094959B
<b>CHI Number</b>	1805580019
<b>Episode Number</b>	E1769085
<b>Surname/Forename</b>	Macmillan, Donald
<b>Date of Birth</b>	5/18/58
<b>Sex</b>	Male
<b>Patient Address.</b>	75/2 Calder Gardens Edinburgh EH11 4JX
<b>Registered GP</b>	J Burns
<b>GP Address.</b>	Sighthill Red Medical Practice, Sighthill Health Centre, Calder Road, Edinburgh EH11 4AU

## Report Contents

The report bundle provides information on the following:

\* IP/OP Clinical Notes

<b>Surname/Forename</b>	Macmillan, Donald
<b>UHPI Number</b>	610094959B

<b>Episode Number</b>	E1769085
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## Inpatient/Outpatient Clinical Notes

<b>Note Details</b>	<b>Clinical Notes</b>
<p>A&amp;E Notes            Episode/Ref: E1769085            Dr Ian Coulter</p> <p>7/27/10            05:21            Ian Coulter</p>	<p>PC: OD,,Patient admits to taking an OD of 14 x 500mg Paracetamol tablets, 1 x venlafaxine tablet and 1 x fixofenadine at 02.30am in attempt 'to get some sleep'. He was unclear as to whether this was an attempt to end his life. He also admits to drinking 8 cans of larger prior to the OD. Since then he has vomited several times (no tablets seen), but otherwise feels physically well.,,PMH: Previous ODs, OA,,DH: Antidepressant, Tramadol, Antihistamine,NKDA,,SH: Lives with wife, Admits to consuming 40+ cans of larger per week, smokes 15cpd,,O/E OBS: Temp 36.5, Pulse 67, RR 16, bp 113/65, BM 6.4, Sats 96%,,Looks well, PEARL, no nystagmus,Cardiorespiratory examination unremarkable,Abdomen soft and NT, BS Present,,Imp: Impulsive OD, likely non-toxic,,Plan: IV access, paracetamol levels at 06.30, Psych Ax,,Paracetamol level taken at 4hrs - not detected, for discharge following psych Ax</p>

<b>Surname/Forename</b>	Macmillan, Donald
<b>UHPI Number</b>	610094959B

<b>Episode Number</b>	E1769085
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<b>Note Details</b>	<b>Clinical Notes</b>
<p>A&amp;E Notes            Episode/Ref: E1769085            Kevin Darge Old</p> <p>7/27/10            07:21            Kevin Darge</p>	<p>Psych Review 0700,Asked to review Pt in A&amp;E after he presents with OD. Mr McMillan clearly states his main problem is sleep and he took the tablets this evening to help with sleep. Denies suicide intent. Admits to occasional suicidal ideation but cites his wife and dogs as protective factors..Admits to forgetting to take his antidepressant for the past week, states has felt a little lower but also slightly agitated. Doesn't feel antidepressants are doing much for him. We discussed briefly alternatives and spoke about there being options available which help with sleep and anxiety e.g. Mirtazipine. We asked Mr McMillan to attend his GP to discuss this.,Mr McMillan reports that he has consumed slightly more alcohol than normal over the last week due to having house guests. He has a Hx of xs alcohol. He has been referred in the past to for assessment of PTSD which he tells us he doesn't have.,We took the oppertunity to discuss above with Mr McMillans wife who agrred that the OD wasn't likely taken with suicide intent but to reduce agitation and help sleep. Therefore formal Psych assessment not carried out. We advised him to make contact with GP to discuss ongoing treatment options.,,DC from MHAS. DC from A&amp;e when medically fit.,Kevin Darge RMN,Rhona McLeod RMN,MHAS</p>

## Patient & GP Information

<b>UHPI Number</b>	610094959B
<b>CHI Number</b>	1805580019
<b>Episode Number</b>	E1723573
<b>Surname/Forename</b>	Macmillan, Donald
<b>Date of Birth</b>	5/18/58
<b>Sex</b>	Male
<b>Patient Address.</b>	75/2 Calder Gardens Edinburgh EH11 4JX
<b>Registered GP</b>	J Burns
<b>GP Address.</b>	Sighthill Red Medical Practice, Sighthill Health Centre, Calder Road, Edinburgh EH11 4AU

## Report Contents

The report bundle provides information on the following:

\* IP/OP Clinical Notes

<b>Surname/Forename</b>	Macmillan, Donald
<b>UHPI Number</b>	610094959B

<b>Episode Number</b>	E1723573
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## Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
<p>A&amp;E Notes Episode/Ref: E1723573 Dr Wasim Haider</p> <p>5/20/10 05:39 Wasim Haider</p>	<p>CHI 1805580019,,52 Yr male,alcohol excess/smokes 20/day,,recent admisison with RUQ/Rt Flank pains, USS/LFTs NAD, discharged home on PPI along with OPC UGIE,4 pints of brandy, as misse dhis friends, birthday (in-patient), same pain recurred, no vomiting, bowel opened today but usually sluggish ? constipation.taken tramdol along with paracetamol, nil effect.,nil haeamtemsis/malaena.no jaundice/dark urine or clay coloured stool,PMH:as above,Meds omeprazole,Social;as above,,OE:Alert GCS 15/15 ,temp 36 P 80/min BP 117/70 BM 6.5 sats 100% A,RUQ tedrness along with volunatry guarding BS sluggish,no radioradial/radiofemoral delay,nil focla neurology,,Plan:IV Access/ codeine/ PRN anti emetics/Fluids, Routine Blodos inc amylase (LFT/Amylase NR), much releif with codeine/IV fluids, patient was advised to quit smoking/alcohol and oral fluids and fibers,,UGIE as scheduled already,,GP F/U if persistent Sx.</p>

Directorate of  
Accident and Emergency Medicine  
LOTHIAN UNIVERSITY HOSPITALS NHS TRUST



THE ROYAL INFIRMARY OF EDINBURGH  
51 Little France Crescent  
Edinburgh EH16 4SU  
Telephone: 0131 242 1300  
Fax: 0131 242 1344



A/E no. E1723573

Previous no. E1720998

UHPI no. 610094959B  
CHI no. 1805580019

PATIENT INFORMATION

Surname: McMillan  
Forenames: Donald  
Date of Birth: 18/05/1958  
Age: 52 Yrs Sex: M  
Address: 143 Gilmerton Dykes Drive  
Edinburgh  
Midlothian  
Postcode: EH17 8LP  
Telephone: 343 1086  
Contact Address: Telephone H  
W  
Complaint: bdo pain  
Allergies  
Attendances in last 12 months: 1 School:

General Practitioner

Name: Morrison  
Address: 65 Liberton Gardens  
Edinburgh  
EH16 6JT  
Telephone: 0131 664 3050

Date and Time of Attendance: 20/05/2010 03:36  
Incident Date & Time:  
Mode of Arrival: Emergency Ambulance  
Source of Referral: 999 Emergency

T 36° P 80 RR BP 117/70 BM 68 SpO2 100% Peakflow Urinalysis Alcometer

Nursing Assessment: Discharged from A&E following gastritis 18/5/10  
awaiting U&E. No abdo pain.

Plan: obs, BM, A+E

Pain Assessment Score Waterlow Score

Pain Score Review Time Triage Score

Signature: [Signature] Time: 0400 Print Name: MAIBR

Clinical Notes

Diagnosis

Doctor's Name (print)

Signature

ROYAL INFIRMARY OF EDINBURGH  
EMERGENCY DEPARTMENT

610094959B/E1723573 M 18/05/1958  
McMillan, Donald  
143 Gilmerton Dykes Drive,  
Edinburgh,  
Midlothian,  
EH17 8LP  
CHI 1805580019  
70376 A Morrison

ALLERGIES *Ibuprofen - Asthma*

DRUG AND PRESCRIPTION RECORD  
ONCE ONLY PRESCRIPTION

Date *20/5/10*

Date	Time	Drug (Approved Name)	Dose	Route	Prescriber's Signature	Time Given	Given By (Initials)	Checked By (Initials)
<i>21/5/10</i>	<i>0530</i>	<i>Codeine Phosphate</i>	<i>3mg oral</i>		<i>[Signature]</i>	<i>0530</i>	<i>MB</i>	<i>[Signature]</i>

Insulin Sliding Scale Prescription Chart

BM	Insulin u/hr	Dextrose 10% ml/hr	Other Action	BM	Insulin u/hr	Dextrose 10% ml/hr	Other Action
				INSULIN		SIGNATURE	



**CHECK:** Does this patient have a Drug Kardex?  
If YES, discontinue this prescription record

DRUG INFUSION	DRUG NAME	STARTING AMOUNT	TIME	TIME	TIME	TIME	TIME	TIME	TIME	TIME	TIME	TIME
			MLS	MLS	MLS	MLS	MLS	MLS	MLS	MLS	MLS	MLS

**E-Pacer PATIENT REPORT**

Time 03:43 Date 20/05/2010  
**PATIENT AND INCIDENT DETAILS**  
 Incident number ED002747366 001  
 Name DONALD MCMILLIAN  
 Address AS INCIDENT, G.P. LIBERTON  
 M.C. N.O.K. WIFE [REDACTED]  
 52  
 Age 18/05/1958  
 Date of birth Male  
 Gender 143 GILMERTON DYKES DRIVE  
 Incident location GILMERTON EDINBURGH  
 EH17 8LP  
 Incident post code EMG  
 Incident type 20/05/2010, 02:54  
 Call received 20/05/2010, 02:54  
 Call passed 20/05/2010, 02:54  
 Crew mobile 20/05/2010, 02:59  
 Crew at scene 20/05/2010, 03:20  
 Crew left scene 20/05/2010, 03:30  
 Patient at hospital NERI New Edinburgh Royal  
 Receiving hospital and department Infirmiry

**TREATMENT REFUSAL FORM  
 PRIMARY SURVEY**

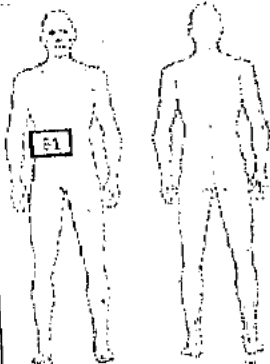
**RESPONSE**  
 AVPU Alert  
**AIRWAY**  
 Airway assessment Clear  
**BREATHING**  
 Breathing rate Fast  
 Respiratory rate

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

**C-SPINE INJURY**  
 No evidence of C-spine injury

**PATIENT CONSENT**  
 Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment

**INJURIES**



**AMPDS**  
 Abdominal Pain, Patient Alert

Final code: 01A01

**GCS**  
 Final GCS eye opening Spontaneous  
 Final GCS verbal response Orientated  
 Final GCS motor response Obeys commands

**VITAL SIGNS**  
 BP mm Hg  
 Cap refill (secs)  
 Peak flow %  
 Blood sugar mmol/l  
 Temp °C  
 SpO2 %  
 GCS Total  
 RTs  
 ECG  
 SEWS  
 Pain score

Time hr : min  
 Pulse bpm  
 Resp. rpm  
 BP mm Hg

03:15 88 24 121 / 76 <2 secs 15 7.550 - 8/10

**EYES AND PUPIL SIZE AND REACTION**

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	Normal

**AMPLE**

**Allergies** Aspirin  
**Other allergies** VARIOUS OTHERS  
**Medication** SEE D/C LETTER  
**Previous medication** Paracetamol  
**Past history** RECENT DIAGNOSED WITH GASTRITIS, DEPRESSION.  
**Last eaten** >5 hrs  
**Events prior** GRADUAL ONSET OF RUQ PAIN RADIATING TO R FLANK.

**DRUGS, GASES AND PAIN RELIEF**

Pain before	Drug / gas given	Time given	Dose given	Route	Batch No.	Pain after
10/10	Entonox	03:05	S/A	Inh	-	8/10
	TRAMADOL	02:45	50mg	OR	-	

**EMERGENCY SERVICES ON SCENE**

Technician

**PATIENT HANDOVER**

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

**FINAL OBSERVATION AND COMMENTS**

999 FOR 52 YOM ABDO PAIN. O/A PT ALERT LOOKS WELL OBVIOUS DISTRESS. PT WAS DIC YESTERDAY FROM ERI WD 105 WITH GASTRITIS. TONIGHT HAS HAD PAIN RETURN GRADUALLY. WAS GIVEN TRAMADOL TO TAKE 4 TIMES A DAY BUT HAS ONLY HAD IT ONCE BEFORE PAIN RETURNED. PAIN IS DESCRIBED AS A GRIPPING PAIN SAME AS PREVIOUS ADICTION. O/E GCS 15. TACHYPNOEIC INITIALY NOW SETTLED. GOOD REGULAR RADIAL PULSE. COLOUR NORMAL. PAIN IN RUQ AND R FLANK. ABDO SOFT AND TENDER OVER R SIDE. URINE AND BOWEL HABITS NORMAL. NO NEUSEA OR VOMITING. GIVEN ENTONOX WITH LITTLE EFFECT. OBS AS RECORDED.

610094959DE1723573 M 18/05/1958  
 McMillian, Donald  
 143 Gilmerton Dykes Drive,  
 Edinburgh,  
 Midlothian,  
 EH17 8LP  
 CHI 1805580019  
 70376 A Merrison

347e5683-eb44-40f5-a51c-42cfe7cabd28

Report ID



TIME OF RECORDING																								
BLOOD PRESSURE	200																					200		
	190																						190	
	180																						180	
	170																						170	
	160																						160	
	150																						150	
	140																						140	
	130																						130	
	120																						120	
	110																						110	
	100																						100	
	90																						90	1
	80																						80	2
	70																						70	2
	60																						60	3
	50																						50	3
	40																						40	3
30																						30	3	
ENTER VALUE IF SYSTOLIC BELOW 30 →																							Enter value if Systolic below 30	

0510

Score if Systolic falls within parameters

117 122  
A  
70 68

PULSE RATE	180																							180	3	
	160																							160	3	
	140																							140	2	
	120																							120	2	
	100																							100	1	
	90																							90	1	
	80																							80	2	
	70																							70	1	
	60																							60	1	
	50																							50	2	
	40																							40	2	
	30																							30	3	
	ENTER VALUE BELOW 30 BPM →																								Enter value below 30 BPM	

80

RESPIRATORY RATE	40																								40	3	
	35																								35	2	
	30																								30	1	
	25																								25	1	
	20																								20	1	
	15																								15	1	
	10																								10	1	
	5																								5	1	
	ENTER VALUE BELOW 8 RPM →																									Enter value below 8 RPM	

16

TEMPERATURE	39°																								39°	2	
	38°																								38°	1	
	37°																							37°	1		
	36°																							36°	1		
	35°																							35°	2		
	34°																							34°	2		
	ENTER VALUE BELOW 8 RPM →																									Enter value below 8 RPM	

36

SAO2	>93	100	100																							1
	90-92																									2
	85-89																									2
	<85																									3
Inspired O2%	%																									3

NA

**I.V. LINE 1**

Fluid	volume	start	finish	PRESCRIBER'S SIGNATURE	given by
Added Drugs	dose	start	finish	PRESCRIBER'S SIGNATURE	added by
2/10/10 0530 0.9% NSaline	500ml	0540		[Signature]	[Signature]
2/10/10 0530 0.9% NSaline	500ml	0610		[Signature]	[Signature]

**I.V. LINE 2**

Fluid	volume	start	finish	PRESCRIBER'S SIGNATURE	given by
Added Drugs	dose	start	finish	PRESCRIBER'S SIGNATURE	added by

**PATIENT MANAGEMENT PLAN**

PRIMARY ASSESSMENT				EQUIPMENT REQUIRED		PROCEDURES REQUIRED		
AIRWAY	TICK	TIME	SIZE	TYPE	TICK	TYPE	TICK	TIME
PATENT				BAIR HUGGER		12 LEAD ECG		
GUEDEL				NIV		A LINE		
NASO PHARYNGEAL				DEFIB		CATHERISATION		
ETT				INTERNAL DEFIB		CORE TEMP MONITORING		
TRACHEOSTOMY				LEVEL ONE		CVP LINE		
				PROPAQ		INTUBATION		
BREATHING	TICK	TIME	SIZE	THUMPER		NG TUBE		
SELF VENTILATION				VENTILATOR		OTHER SCAN		
ASSISTED VENTILATION				OTHER-		PERITONEAL LAVAGE		
ASPIRATION						ULTRASOUND		
CHEST DRAIN L <input type="checkbox"/> R <input type="checkbox"/>				REFERRAL TO		OTHER -		
THORACOTOMY				ANAESTHETICS				
CIRCULATION	TICK	TIME	SIZE	CARDIO THORACIC				
CARDIAC OUTPUT				CARDIOLOGY				
CPR				GASTRO-INTESTINAL				
CANNULATION				MEDICINE				
VENEPUNCTURE				NEUROLOGY				
IV FLUIDS				ORTHOPAEDICS				
DEFIBRILLATION / CARIOVERSION				SURGERY				
SHOCK NO.				VASCULAR				
JOULES				OTHER -				

E1720998 M 16  
Donald  
nerton Dykes Drive,  
burgh,  
Midlothian,  
EH17 8LP  
CHI 1805580019  
70376 A Morrison  
Clinic

Patient: \_\_\_\_\_

Multistix® 10 SG  
Test date 16-05-20  
Time 13:00  
Operator \_\_\_\_\_  
Test number .153  
Color Not Entered  
Clarity Not Entered

GLU Negative  
BIL Small  
KET Trace  
SG 1.015  
BLO Trace-intact  
pH 7.0  
PRO 100 mg/dL  
URO 2.0 E.U./dL  
NIT Negative  
LEU Small

-----

## Patient & GP Information

<b>UHPI Number</b>	610094959B
<b>CHI Number</b>	1805580019
<b>Episode Number</b>	E1720998
<b>Surname/Forename</b>	Macmillan, Donald
<b>Date of Birth</b>	5/18/58
<b>Sex</b>	Male
<b>Patient Address.</b>	75/2 Calder Gardens Edinburgh EH11 4JX
<b>Registered GP</b>	J Burns
<b>GP Address.</b>	Sighthill Red Medical Practice, Sighthill Health Centre, Calder Road, Edinburgh EH11 4AU

## Report Contents

The report bundle provides information on the following:

\* IP/OP Clinical Notes

<b>Surname/Forename</b>	Macmillan, Donald
<b>UHPI Number</b>	610094959B

<b>Episode Number</b>	E1720998
-----------------------	----------

## Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
<p>A&amp;E Notes            Episode/Ref: E1720998            Debra Cullerton</p> <p>5/16/10            14:28            Sara Osburn</p>	<p>CHI: 1805580019,,51 yo male attends today with right sided upper abdominal pain which started 3-4 days ago. Pain increased in intensity over night and is sharp and spasm like in nature, radiating around to his back and to his right shoulder. Patient took brufen x 1 this AM and developed body rash. Has previously taken a reaction to ibuprofen. Patient states his rash is decreasing and he has had no tongue swelling or throat tightness. ,PMH: Previous OD years ago. OA of knee. ,DH: Venlafaxine, tramadol, anti-histamine ?which one. ,ALLERGIES TO BRUFEN AND ASPIRIN.,,OE: Generalised body rash. Temp 37.1; BP 118/74; pulse 107; BM 6.0; bilateral equar air entry; O2 sats 96% on room air. RR 16.,Abdo soft, tender to right upper quadrant. Bowel sounds present. Last bowel movement this AM - normal in nature. No urinary symptoms. ,Imp: Abdominal pain - ?related to gallbladder. ,Plan: IV access and bloods awaited. ,ECG sinus rhythm.,,CXR awaited. ,Urinalysis non-haemolysed trace of blood. Protient ++. Leukocytes small. Bilirubin small. ,Patient reviewed by Dr McCarthy, ED reg, for surgical opinion. ,</p>

Department of General Surgery

Dr Morrison  
65 Liberton Gardens  
Edinburgh  
EH16 6JT

Print Date 18/05/2010  
Print Time 20:22  
Our Ref 610094959B  
CHI 1805580019

<b>Patient:</b> Donald McMillan 143 Gilmerton Dykes Drive Edinburgh EH17 8LP	<b>UHPI:</b> 610094959B <b>Date of Birth:</b> 18/05/1958
<b>Ward:</b> Ward 105 RIE	<b>Admission Date:</b> 16/05/2010
<b>Consultant:</b> Mr A De Beaux	<b>Discharge Date:</b> 18/05/2010

General Surgery  
Prof OJ Garden  
Prof KCH Fearon  
Ms TE Gillies  
Mr TE Madiba  
Mr TJ Crofts  
Mr SJ Wigmore  
Mr SJ Nixon  
Mr SCA Fraser  
Mr S Paterson-Brown  
Mr RW Parks  
Mr M Akyol  
Mr KK Singh  
Mr KK Madhavan  
Mr JLR Forsythe  
Mr JJC Casey  
Mr JJ Powell  
Mr J Santhianathan  
Mr IM Pope  
Mr H Pleass  
Mr GW Couper  
Mr GGP Browning  
Mr EL Hidalgo  
Mr D Lee  
Mr C De Jong  
Mr BNJT Thomson  
Mr B Tulloh  
Mr A De Beaux  
Dr LP Marson  
Dr JJ Neary  
Dr D Kitts  
Dr CS Blair

Discharge Medication	Dose	Frequency	Duration	Additional Info
Adult prepack Paracetamol 500mg Tbs (TTO 32 tbs)	2 TABLETS	Every SIX to EIGHT hours	4 Days	32 capsules
Tramadol Capsules	50 MG	FOUR times daily	Short Term	for pain pre pack 30 capsules
Venlafaxine Tablets	150 MG	ONCE DAILY	Long Term	own supply
Omeprazole Capsules	20 MG	ONCE DAILY	Short Term	pre pack 28 capsules

Prescribed By *J. Davidson* Date ..... Print Name.....  
 Dispensed By *J. Davidson* Date 18/5/10: Print Name: DONALDSON  
 Pharmacist Check ..... Date ..... Print Name.....  
 Final Check *M. G. Grant* Date 18/5/10 Print Name *M. G. Grant*

For enquiries: 0131 242 1000  
Hepatobiliary Team: 0131 242 3661/2

PRINCIPAL DIAGNOSIS/OPERATION  
Gastritis.

Upper GI:  
0131 242 3620  
0131 242 3667

TREATMENT  
Admitted with RUQ/R flank pain. Normal AUSS and LFTs. Discharged with omeprazole and for OP UGIE.

Thyroid:  
0131 242 3663

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL  
UGIE as outpatient

Oncology Consultant WGH:  
Dr Lucy Wall  
0131 537 3916

CHANGES TO DRUGS SINCE ADMISSION (eg Warfarin changed)

Inpatient Discharge Summary

Cont'd... Ref: 610094959B

Patient Name: Donald McMillan

Started omeprazole 20mg

PREVIOUS ADVERSE DRUG REACTIONS

ibuprofen and aspirin cause rash.

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS

nil

GP to please consider the following...

Should you need further information please contact...  
ward 105 RIE 0131 2421057

Information contained in this letter has been discussed with the patient/carer.

Staff Signature: J. Donaldson Print Name: J. DONALDSON

Designation: Staff Nurse Date: 18/5/10 Time: 2030

Patient/Carer Signature: [Signature]

Inpatient Discharge Summary



THE ROYAL INFIRMARY OF EDINBURGH  
51 Little France Crescent  
Edinburgh EH16 4SU  
Telephone: 0131 242 1300  
Fax: 0131 242 1344



A/E no: E1720998

Previous no.

UHPI no: 610094959B  
CHI no: 1805580019

PATIENT INFORMATION

General Practitioner

Surname McMillan Date of Birth 8/05/1958  
Forename Donald Age Yrs Sex M  
Address 143 Gilmerton Dykes Drive  
Edinburgh  
Midlothian  
Postcode EH17 8LP Telephone 0131 664 1086  
Contact Telephone H  
Address W  
Complain lower back/left side pain Allergies  
Attendances in last 12 months: 0 School:

Name Morrison  
Address 65 Liberton Gardens  
Edinburgh  
EH16 6JT  
Telephone 0131 664 3050  
Date and Time of Attendance 6/05/2010 12:16  
Incident Date & Time:  
Mode of Arrival Private Transport  
Source of Referral Self Referral to A&E

T 17.1	P 107	RR 16	BP 118/74	BM 6.6	SpO2 96%	Peakflow	Urinalysis	Alcometer
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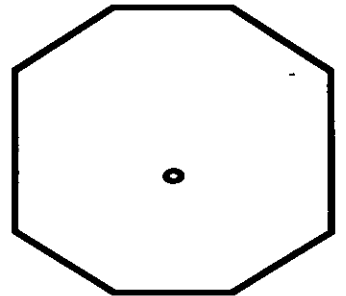
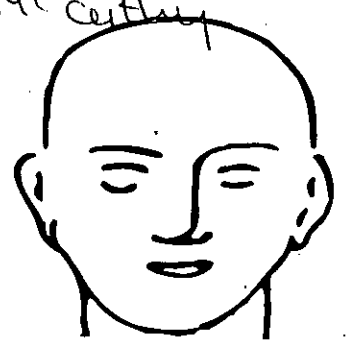
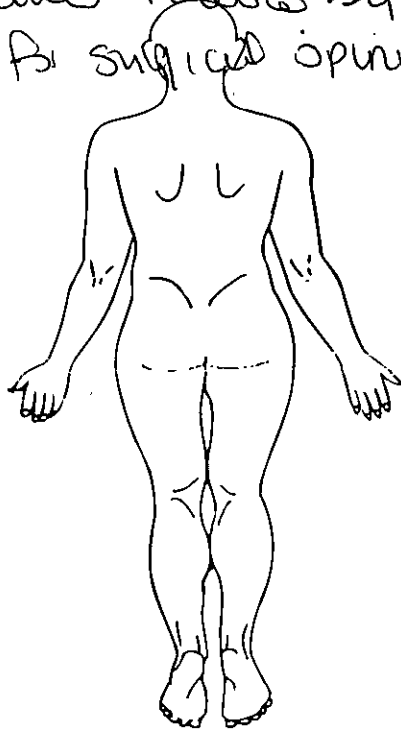
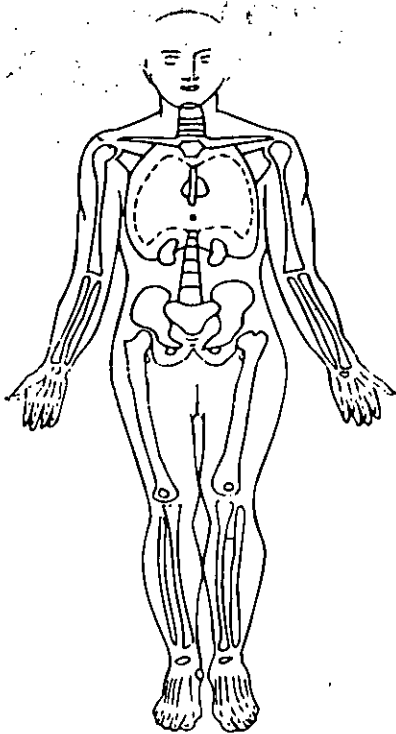
Nursing Assessment RIF pain over last 3x day now 10/10  
Back pain continued whole pain.

P: 05 BM  
Pain Assessment Score Waterlow Score  
Pain Score Review Time Triage Score  
Signature Time 12:50 Print Name

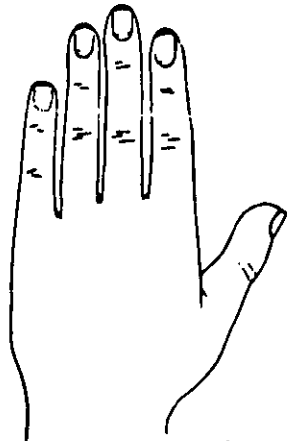
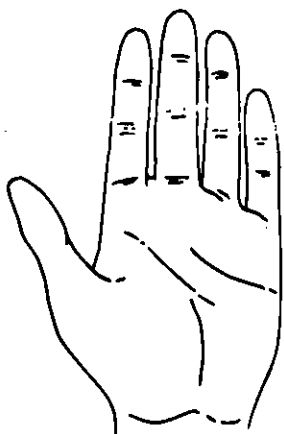
Clinical Notes 1350  
51 year old male attends today with (L) sided abdominal pain B: 1st 3+7 pain increased overnight and patient unable to get comfortable therefore come to the emergency department  
According to patient pain (1) situated in (L) flank area radiating to (L) back and up to (R) shoulder and (1) sharp + spasm like in nature.  
Patient taken Ibuprofen x1 today and developed rash over the body has previous taken reaction to the according to patient rash improving no tongue swelling or throat tightness  
PMH - previous OP o/a  
Drugs - antihistamine? Temadol?  
Venlafoxine  
Allegy - Ibuprofen Aspirin  
Diagnosis  
Doctor's Name (print) [Signature] Signature [Signature]

Nursing Release				Clinical Notes Continued
Instruction/Health Education	Y	N	N/A	G1c generalised body rash Temp 37.1 BP 118/74 pulse 107 RR 60 bilateral equal air entry S2 96 rom air resp rate 16 abdomen soft tender (RU) upper quadrant no urinary or bowel symptoms. bowel sounds present.
Medication	Y	N	N/A	
Review				
X-rays	Y	N	N/A	
Clinic	Y	N	N/A	
Notes/X-rays	Y	N	N/A	
Walking Aids	Y	N	N/A	
Transport				
Self	Y	N	N/A	
Other	Y	N	N/A	
Amb ref no.....	Y	N	N/A	
Primary Care Ref.				
Safe Home	Y	N	N/A	Impression - abdominal pain ? related to gall bladder
Crisis Care	Y	N	N/A	
District Nurse	Y	N	N/A	
GP	Y	N	N/A	
NoK/carer aware				plan - IV cross bloods awaited.
Documentation Complete	Y			ECU - OK.
CSW signature				OK awaited
RN signature				bilirubin small, plate # ure - non haem trace blood. Leucocytes small.

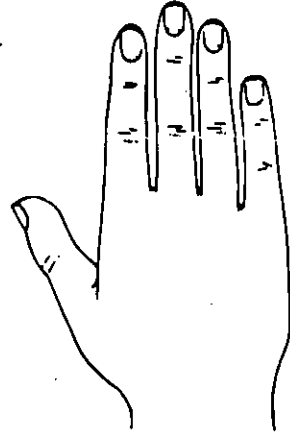
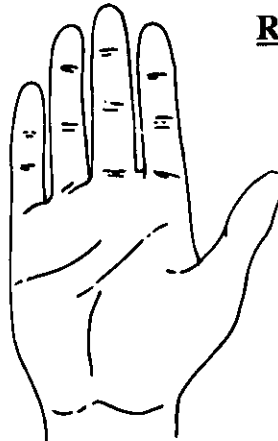
Patient reviewed by Dr Mc Carthy  
 As surgical opinion



**LEFT**



**RIGHT**



# Patient & GP Information

<b>UHPI Number</b>	610094959B
<b>CHI Number</b>	1805580019
<b>Episode Number</b>	05206715
<b>Surname/Forename</b>	Macmillan, Donald
<b>Date of Birth</b>	5/18/58
<b>Sex</b>	Male
<b>Patient Address.</b>	75/2 Calder Gardens Edinburgh EH11 4JX
<b>Registered GP</b>	J Burns
<b>GP Address.</b>	Sighthill Red Medical Practice, Sighthill Health Centre, Calder Road, Edinburgh EH11 4AU

## Report Contents

The report bundle provides information on the following:

\* IP/OP Clinical Notes

<b>Surname/Forename</b>	Macmillan, Donald
<b>UHPI Number</b>	610094959B

<b>Episode Number</b>	05206715
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## Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
<p>A&amp;E Notes            Episode/Ref: 05206715            Dr J Musgrave              7/28/05</p>	<p>HISTORY: 47 year old male presents with HI,Background - chronic alcoholism. Depression and anxiety/panic attacks.,Denies cardiac history, DM, asthma.,Drugs: antabuse, telfast, thiamine and Vitamin B. ,allergies: NSAIDs/Ibuprofen - SOB.,SH: Lives alone in Dundee. Chronic alcoholic, 15-20 cpd. ,HPC: brought in by ambulance. Called because apparent head injury.,Alcoholic binge last 24 hours with female friend. Was wrestling and fell backwards. Hit occiput on concrete - apparent LOC 30 seconds.,On SAS arrival GCS 15 and haemodynamically stable.,In A/E the patient gives a history c/o lower back pain which is chronic - slightly worse than normal. Has pain at occiput, but denies sig. headache. Denies N&amp;V, neck stiffness or photophobia. Denies focal neurological symptoms. Denies abdo pain.,Admits to taking alcohol - no antabuse for 2 weeks.,,O/E: Lying on side c/o back pain. Pulse 89. BP 130/90. Sats 97%. Afebrile. Alcometer 1.24. ,Heart sounds dual, nil added. No AO. ,Chest equal and adequate air entry, sounds clear. ,abdo soft and non tender. ,Face symmetrical. Pupils fine 2mm and equally reactive.,Tongue midline, palate symmetrical. ,UL normal T/P.,LL normal T/P/R with decreased use of right knee secondary to chronic pain. ,No visible HI on occipital,ENT normal.,No neck stiffness and no apparent photophobia.,Lower back, no visible redness or swelling. Tender L4/5 - not new.,IMP: Minor HI, no focal neurology, alcoholic on antabuse. Has been drinking alcohol but apparently has not had antabuse for 2/52. ,Plan: Monitor, IV and basic bloods. ,SXR, neuro obs. IV fluids, watch BP. May require Benzodiazepines. Dip urine and pabrinex.,Hb 147. WCC 7.7. Platelets 278. Urea 3.2. Creat 84. LFTs normal. Amylase 23.,,Plan: as above, keep for 6 hours then home.,vh</p>

## Patient & GP Information

<b>UHPI Number</b>	610094959B
<b>CHI Number</b>	1805580019
<b>Episode Number</b>	E991411
<b>Surname/Forename</b>	Macmillan, Donald
<b>Date of Birth</b>	5/18/58
<b>Sex</b>	Male
<b>Patient Address.</b>	75/2 Calder Gardens Edinburgh EH11 4JX
<b>Registered GP</b>	J Burns
<b>GP Address.</b>	Sighthill Red Medical Practice, Sighthill Health Centre, Calder Road, Edinburgh EH11 4AU

## Report Contents

The report bundle provides information on the following:

\* IP/OP Clinical Notes

<b>Surname/Forename</b>	Macmillan, Donald
<b>UHPI Number</b>	610094959B

<b>Episode Number</b>	E991411
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## Inpatient/Outpatient Clinical Notes

<b>Note Details</b>	<b>Clinical Notes</b>
Historic SJH A&E Conversion Data Episode/Ref: E991411 Dr P Freeland  2/29/08 17:45	A&E Doctor 1: DR A WHITE,Time Seen: 21:55,Alcohol: 0,Provisonal Diagnosis: 11CR,Drug 1: Nil ,Investigation 1: Plain X-Ray ,Destination: ,Examination: L BIG TOE INJ,Primary Diagnosis: SOFT TISSUE INJURY RIGHT GREAT TOE

# Progress Notes

# Patient & GP Information

<b>UHPI Number</b>	610094959B
<b>CHI Number</b>	1805580019
<b>Episode Number</b>	I0002657753
<b>Surname/Forename</b>	Macmillan, Donald
<b>Date of Birth</b>	5/18/58
<b>Sex</b>	Male
<b>Patient Address.</b>	75/2 Calder Gardens Edinburgh EH11 4JX
<b>Registered GP</b>	J Burns
<b>GP Address.</b>	Sighthill Red Medical Practice, Sighthill Health Centre, Calder Road, Edinburgh EH11 4AU

## Report Contents

The report bundle provides information on the following:

\* IP/OP Clinical Notes

<b>Surname/Forename</b>	Macmillan, Donald
<b>UHPI Number</b>	610094959B

<b>Episode Number</b>	I0002657753
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## Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0002657753 Dr Arvindan Veiraiah  1/20/11 14:08 Susan Glass	DATE DICTATED: 18.01.11 DATE TYPED: 20.01.11 ,DIAGNOSIS: OVERDOSE OF TRAMADOL.,Specific treatment required: NONE.,Patient detained under the Mental Health Act: NO.,,PSYCHIATRIC ASSESSMENT:,I saw this patient in CAA6 on the 24th of December 2010. He had been admitted the night previously after taking 50 x 50mg of Tramadol. He had taken another overdose 2 weeks previously. This overdose was on the background of a situational crisis, after his wife of 15 years had left him. He has both depression and harmful alcohol use. At the time of interview he had on-going suicidal ideation and was thought to be at high risk of repeated deliberate self harm. There did not appear to be any protective factors and it was thought most appropriate to transfer this patient to Mechiston Ward at the Royal Edinburgh Hospital.,,A full discharge summary will be forwarded from them in due course.,Yours sincerely,,,,,Angela Dickinson,FY1,,SG,

## Patient & GP Information

<b>UHPI Number</b>	610094959B
<b>CHI Number</b>	1805580019
<b>Episode Number</b>	I0002523861
<b>Surname/Forename</b>	Macmillan, Donald
<b>Date of Birth</b>	5/18/58
<b>Sex</b>	Male
<b>Patient Address.</b>	75/2 Calder Gardens Edinburgh EH11 4JX
<b>Registered GP</b>	J Burns
<b>GP Address.</b>	Sighthill Red Medical Practice, Sighthill Health Centre, Calder Road, Edinburgh EH11 4AU

## Report Contents

The report bundle provides information on the following:

\* IP/OP Clinical Notes

<b>Surname/Forename</b>	Macmillan, Donald
<b>UHPI Number</b>	610094959B

<b>Episode Number</b>	I0002523861
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## Inpatient/Outpatient Clinical Notes

<b>Note Details</b>	<b>Clinical Notes</b>
Inpatient Discharge Summary Episode/Ref: I0002523861 Mr Andrew C De Beaux  5/18/10 19:58 Christy Lamont	PRINCIPAL DIAGNOSIS/OPERATION,Gastritis. ,,TREATMENT,Admitted with RUQ/R flank pain. Normal AUSS and LFTs. Discharged with omeprazole and for OP UGIE. ,,FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL,UGIE as outpatient ,,CHANGES TO DRUGS SINCE ADMISSION (eg Warfarin changed), Started omeprazole 20mg,,PREVIOUS ADVERSE DRUG REACTIONS,ibuprofen and aspirin cause rash. ,,SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS,nil ,,GP to please consider the following...,Should you need further information please contact...,ward 105 RIE 0131 2421057,,Information contained in this letter has been discussed with the patient/carer.,,Staff Signature..... Print Name.....,Designation..... Date.....Time.....,Patient/Carer Signature.....,

<b>Surname/Forename</b>	Macmillan, Donald
<b>UHPI Number</b>	610094959B

<b>Episode Number</b>	I0002523861
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<b>Note Details</b>	<b>Clinical Notes</b>
Inpatient Discharge Summary Episode/Ref: I0002523861 Mr Gavin GP Browning  5/24/10 14:14 Karen Ann Bell	Clinical Summary:., This gentleman was admitted as an emergency with a 4 day history of upper abdominal pain associated with vomiting. He was afebrile with a soft abdomen tender in the right upper quadrant and flank. Routine blood tests showed normal inflammatory markers and liver function tests. A chest x-ray was clear and a CT KUB was performed which showed no evidence of renal or ureteric stones. An ultrasound scan of the abdomen showed no stones in the gallbladder and a normal liver. His symptoms settled so he was discharged with plans for an outpatient OGD., Follow Up: Outpatient OGD.,, Yours sincerely,,,,, Mr STEVE BENNETT, Specialist Registrar to Mr GAVIN BROWNING,

## Patient & GP Information

<b>UHPI Number</b>	610094959B
<b>CHI Number</b>	1805580019
<b>Episode Number</b>	I0000308557
<b>Surname/Forename</b>	Macmillan, Donald
<b>Date of Birth</b>	5/18/58
<b>Sex</b>	Male
<b>Patient Address.</b>	75/2 Calder Gardens Edinburgh EH11 4JX
<b>Registered GP</b>	J Burns
<b>GP Address.</b>	Sighthill Red Medical Practice, Sighthill Health Centre, Calder Road, Edinburgh EH11 4AU

## Report Contents

The report bundle provides information on the following:

\* IP/OP Clinical Notes

Surname/Forename	Macmillan, Donald
UHPI Number	610094959B

Episode Number	I0000308557
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## Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0000308557 Prof Neal G Uren  9/19/00	<p>DIAGNOSIS: OVERDOSE. This patient was admitted following an overdose. Specific treatment was given: N Acetylcysteine. Patient was detained under the Mental Health Act. / NO. PSYCHIATRIC DIAGNOSIS: ALCOHOL HARMFUL USE. I reviewed this 41 year old man on Ward 1A, RIE, on 20th September, 2000. He had been admitted there the evening before following an overdose of 40 Cocodamol tablets and 2 litres of cider. His partner was present at the time of the overdose and had telephoned an ambulance. His breath alcohol was 0.63 at the time of admission and he required treatment with N Acetylcysteine. He reported that the precipitant for the overdose was his 4 month old son has been in social work care since his birth. This is due to concerns about his partner's parenting skills and his own parenting skills. He and his partner had had gradually increasing access to their son and had had unsupervised access at times. The Social Work Department had come round to the house the night before and they were told they could no longer have unsupervised access. He was feeling very angry about this and took the tablets. He has been with his partner, [REDACTED], for about 15 months. She has three children from previous relationships, 12 year old son who is in foster care, two daughters 4 and 2 who have been adopted. There are also concerns about his own parenting skills. He has a 19 year old son from a relationship with whom he has some contact with. He then has two daughters who are aged 13 and 2, whom he has no access to because of allegations of sexual abuse. He reported that no charges had been brought against him. He also reported that he and his wife had two sons (non twins) who both died from cerebral palsy at different times. On review the next day he reported that he regretted taking the overdose and very much denied any ongoing thoughts of self-harm. He said that thinking about his son had made him realise that he wanted to live. Previous Psychiatric History: He took an overdose several years ago in the context of situational difficulties when his marriage was breaking down. He has no significant past medical history. Social history: He lives with his fiancée and works a security guard. He has been in this job for 3-4 months. They live in a council flat and have some debts, many credit card and car loan. He was in the Army between 1974 and 1978. He reported that he left of his own accord and found it difficult to adjust to civilian life afterwards. He was married to his first wife for 15 years. Alcohol intake: He reports that he drinks approximately every 2 weeks and will drink around 12 units of alcohol at a time. He denies any features of alcohol dependence. Forensic History: He said he had a drink/driving offence 10 years ago but had had no other charges against him. On mental state examination he was cooperative and formed a reasonable rapport and eye contact. He reported that his mood had otherwise been OK and there seemed to be no evidence of a depressive illness. He was objectively euthymic. His speech was normal in rate and volume. Thought content: He had no ongoing thoughts of self-harm and his thoughts were centred around wanting to try to gain access to his son and eventually for his son to come to live with him and his partner. He had limited insight into his previous difficulties, there was concern about his parenting skills. In summary: This is a 42 year old man who has taken an impulsive overdose. The psychiatric diagnosis is an acute stress reaction and acute alcohol intoxication. He also seems to drink alcohol to a harmful level. He had no ongoing thoughts of self-harm and the situation is very complicated family and social situation regarding access to his son and serious allegations against him and his partner for the care of their previous children. He was discharged with social work follow-up. His social worker is: Lorette Tansy at the West Pilton Gardens. Dr Dinah Bennett, Senior House Officer in Psychiatry.</p>

# Clinic Letters

## Orthopaedics

Dr Burns  
Sighthill Red Medical Practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date First Created:** 07/07/2015  
**Date/Time Printed:** 27/04/2026 15:55  
**Our Ref:** 610094959B  
**CHI:** 1805580019

<b>Patient:</b> Mr Donald Macmillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>UHPI:</b> 610094959B <b>Date of Birth:</b> 18/05/1958
<b>Specialty:</b> Orthopaedics	<b>Consultant:</b> Mr Anish K Amin

## Diagnoses

- 1: Left knee medial and lateral joint pain query meniscal pathology.
- 2: Skin cancer - right nostril excision 2011.
- 3: Current smoker.

Plan: MRI scan to left knee to exclude a meniscal pathology. If pathology amenable to surgery patient to be listed for a left knee arthroscopy plus partial meniscectomy and review in Preadmission. If no pathology identified to write to Mr MacMillan with the results.

History: I reviewed this 57 year old right hand dominant gentleman who is currently unemployed due to disability in clinic today. He tells me has bilateral knee pain worse on the left than the right that commenced in January this year. He said that the pain was so bad for at least 4 months that he could hardly walk. Then the pain improved but over the last 2 weeks he has experienced more pain in the left knee than expected. He walks with a stick in his right hand due to pain in the left knee. He has increasing pain on going up the stairs rather than down. The knee occasionally gives way but he has not fallen to the ground with it and it does swell. He does not notice any clicking but does describe the knee locking occasionally. The pain at night time is not so much that he stays awake but his walking distance has reduced he says over the last few months.

Examination: On examination he stood with varus deformity of the knees bilaterally, worse on the left than the right and with the left knee in slight flexion on standing. There is no limb length discrepancy and he had an antalgic gait. His left hip movements were normal and painfree. There was an effusion to the knee and tenderness on palpation around the medial and lateral patella, both the medial and lateral joint line. ACL, PCL and collaterals were intact. McMurray's test was positive. Range of movement of the left knee 5-90 degrees compared to 0-100 degrees on the right.

Investigations: Radiographs taken at the Western General on 12/02/15 shows some generalised joint space narrowing but nothing significant.

## Orthopaedics

Dr Burns  
Sighthill Red Medical Practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date First Created:** 07/07/2015  
**Date/Time Printed:** 27/04/2026 15:55  
**Our Ref:** 610094959B  
**CHI:** 1805580019

I explained to Mr MacMillan today that we will organise for him to have an MRI scan to exclude a meniscal pathology. I have explained that if we find a pathology that is amenable to surgery we will list him for a day case arthroscopy +/- partial meniscectomy. I explained to him the risks of the procedure including infection, neurovascular damage, ongoing pain and swelling and he is happy to be listed for the procedure and discuss the details with Mr Amin in Preadmission Clinic. He also understands if we find no pathology we will write to him with the results. He understands this and is happy with the plan.

Yours sincerely,

Miss Sally-Anne Phillips/JC  
ST in Orthopaedics to Mr AK Amin  
Secretary 0131 242 3563  
(Not checked or signed for expediency)

Dr Burns  
Drs Sharpe putta & burns practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date:** 16/03/2016

## Outpatient Clinic Letter

<b>Patient</b>	Donald MacMillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>CHI</b>	<b>1805580019</b>
		<b>Date of Birth / Age</b>	18/05/1958 (57 years)
		<b>UHPI</b>	610094959B
<b>Specialty</b>	Orthopaedics	<b>Attendance Date</b>	15/03/2016
<b>Consultant</b>	Mr Anish K Amin		

Dear Dr Burns

### Diagnosis:

- 1.Suspected spontaneous osteonecrosis left knee.
- 2.Previous smoker and alcohol excess (teetotal now for two years).

Donald is managing reasonably with only intermittent symptoms around his left knee, which are not causing any significant functional limitation. He is keen to leave matters alone and I entirely agree. I have explained to him that if he develops any persistent pain in the future I would be very happy to review him but otherwise I have discharged him back to your care.

Kind regards

Yours sincerely

Mr Anish K Amin  
MBChB PhD FRCSEd (Tr&Orth)  
Consultant Trauma & Orthopaedic Surgeon  
AKA/KB  
Secretary 0131 242 3427

Not checked or signed for expediency.

## Orthopaedics

Dr Burns  
Sighthill Red Medical Practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date First Created:** 15/09/2015  
**Date/Time Printed:** 27/04/2026 15:55  
**Our Ref:** 610094959B  
**CHI:** 1805580019

<b>Patient:</b> Mr Donald Macmillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>UHPI:</b> 610094959B <b>Date of Birth:</b> 18/05/1958
<b>Specialty:</b> Orthopaedics	<b>Consultant:</b> Mr Anish K Amin

## Diagnoses:

1. Left knee medial and lateral joint pain query meniscal pathology or spontaneous osteonecrosis of the knee.
2. Skin cancer - right nostril excision.
3. Previous smoker until November 2014 and alcohol use until 2 years ago.

Plan: Review back in 6 months in clinic. Query MRI scan requests at that time. No x-rays necessary.

I reviewed this 57 year old gentleman. He has previously been seen by my colleague Sally-Anne Phillips. He is still suffering from left knee pain. An MRI scan was requested. Things have settled a bit in the meantime since last presentation in July this year. Every day it is still sore but today is a good day. On examination there is no effusion. The knee is stable but painful over the medial joint line and the medial joint. Stable collaterally in AP. MRI scan on examination does show an undisplaced subchondral fracture within the medial femoral condyle with extensive bone marrow oedema and less marked undisplaced subchondral fracture in the lateral femoral condyle. There is an absence of trauma so spontaneous osteonecrosis of the knee is considered. There are normal menisci.

Plan/discussion: I discussed the case with Mr Amin. We think at the moment there are no surgical options and the pain medications are already used by this gentleman. Spontaneous osteonecrosis of the knee can settle in months with conservative treatment. We would like to review him back in clinic in 6 months and will think about re-requesting an MRI scan on that date if things have not settled at that moment. In the back of our minds there is a surgical option in the form of an HTO to realign his weightbearing line of his left leg so there is less weightbearing at the medial most affected side of his left knee. Mr MacMillan is not keen to proceed with any surgery. He is happy to continue his conservative treatment. He has an appointment in 6 months for review clinically.

Yours sincerely,

## Orthopaedics

Dr Burns  
Sighthill Red Medical Practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date First Created:** 15/09/2015  
**Date/Time Printed:** 27/04/2026 15:55  
**Our Ref:** 610094959B  
**CHI:** 1805580019

Mr Maurik van Haagen/JC  
Fellow in Orthopaedics to Mr AK Amin  
Secretary 0131 242 3563  
(Not checked or signed for expediency)

Dr Burns  
Drs Sharpe putta & burns practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date:** 15/09/2015

## Outpatient Clinic Letter

<b>Patient</b>	Donald MacMillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>CHI</b>	<b>1805580019</b>
		<b>Date of Birth / Age</b>	18/05/1958 (57 years)
		<b>UHPI</b>	610094959B
<b>Specialty</b>	Orthopaedics	<b>Attendance Date</b>	15/09/2015
<b>Consultant</b>	Mr Anish K Amin		

Dear Dr Burns

### Diagnoses:

1. Left knee medial and lateral joint pain query meniscal pathology or spontaneous osteonecrosis of the knee.
2. Skin cancer - right nostril excision.
3. Previous smoker until November 2014 and alcohol use until 2 years ago.

Plan: Review back in 6 months in clinic. Query MRI scan requests at that time. No x-rays necessary.

I reviewed this 57 year old gentleman. He has previously been seen by my colleague Sally-Anne Phillips. He is still suffering from left knee pain. An MRI scan was requested. Things have settled a bit in the meantime since last presentation in July this year. Every day it is still sore but today is a good day. On examination there is no effusion. The knee is stable but painful over the medial joint line and the medial joint. Stable collaterally in AP. MRI scan on examination does show an undisplaced subchondral fracture within the medial femoral condyle with extensive bone marrow oedema and less marked undisplaced subchondral fracture in the lateral femoral condyle. There is an absence of trauma so spontaneous osteonecrosis of the knee is considered. There are normal menisci.

Plan/discussion: I discussed the case with Mr Amin. We think at the moment there are no surgical options and the pain medications are already used by this gentleman. Spontaneous osteonecrosis of the knee can settle in months with conservative treatment. We would like to review him back in clinic in 6 months and will think about re-requesting an MRI scan on that date if things have not settled at that moment. In the back of our minds there is a surgical option in the form of an HTO to realign his weightbearing line of his left leg so there is less weightbearing at the medial most affected side of his left knee. Mr MacMillan is not keen to proceed with any surgery. He is happy to continue his conservative treatment. He has an appointment in 6 months for review clinically.

Yours sincerely,

Mr Maurik van Haagen/JC  
Fellow in Orthopaedics to Mr AK Amin  
Secretary 0131 242 3563  
(Not checked or signed for expediency)

## Orthopaedics

Dr Burns  
Sighthill Red Medical Practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date First Created:** 16/03/2016  
**Date/Time Printed:** 27/04/2026 15:55  
**Our Ref:** 610094959B  
**CHI:** 1805580019

<b>Patient:</b> Mr Donald Macmillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>UHPI:</b> 610094959B <b>Date of Birth:</b> 18/05/1958
<b>Specialty:</b> Orthopaedics	<b>Consultant:</b> Mr Anish K Amin

## Diagnosis:

1. Suspected spontaneous osteonecrosis left knee.
2. Previous smoker and alcohol excess (teetotal now for two years).

Donald is managing reasonably with only intermittent symptoms around his left knee, which are not causing any significant functional limitation. He is keen to leave matters alone and I entirely agree. I have explained to him that if he develops any persistent pain in the future I would be very happy to review him but otherwise I have discharged him back to your care.

Kind regards

Yours sincerely

Mr Anish K Amin  
MBChB PhD FRCSEd (Tr&Orth)  
Consultant Trauma & Orthopaedic Surgeon  
AKA/KB  
Secretary 0131 242 3427

Not checked or signed for expediency.

Dr Burns  
Drs Sharpe putta & burns practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date:** 07/07/2015

## Outpatient Clinic Letter

<b>Patient</b>	Donald MacMillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>CHI</b>	<b>1805580019</b>
		<b>Date of Birth / Age</b>	18/05/1958 (57 years)
		<b>UHPI</b>	610094959B
<b>Specialty</b>	Orthopaedics	<b>Attendance Date</b>	07/07/2015
<b>Consultant</b>	Mr Anish K Amin		

Dear Dr Burns

### Diagnoses

- 1: Left knee medial and lateral joint pain query meniscal pathology.
- 2: Skin cancer - right nostril excision 2011.
- 3: Current smoker.

Plan: MRI scan to left knee to exclude a meniscal pathology. If pathology amenable to surgery patient to be listed for a left knee arthroscopy plus partial meniscectomy and review in Preadmission. If no pathology identified to write to Mr MacMillan with the results.

History: I reviewed this 57 year old right hand dominant gentleman who is currently unemployed due to disability in clinic today. He tells me has bilateral knee pain worse on the left than the right that commenced in January this year. He said that the pain was so bad for at least 4 months that he could hardly walk. Then the pain improved but over the last 2 weeks he has experienced more pain in the left knee than expected. He walks with a stick in his right hand due to pain in the left knee. He has increasing pain on going up the stairs rather than down. The knee occasionally gives way but he has not fallen to the ground with it and it does swell. He does not notice any clicking but does describe the knee locking occasionally. The pain at night time is not so much that he stays awake but his walking distance has reduced he says over the last few months.

Examination: On examination he stood with varus deformity of the knees bilaterally, worse on the left than the right and with the left knee in slight flexion on standing. There is no limb length discrepancy and he had an antalgic gait. His left hip movements were normal and painfree. There was an effusion to the knee and tenderness on palpation around the medial and lateral patella, both the medial and lateral joint line. ACL, PCL and collaterals were intact. McMurray's test was positive. Range of movement of the left knee 5-90 degrees compared to 0-100 degrees on the right.

Investigations: Radiographs taken at the Western General on 12/02/15 shows some generalised joint space narrowing but nothing significant.

I explained to Mr MacMillan today that we will organise for him to have an MRI scan to exclude a meniscal pathology. I have explained that if we find a pathology that is amenable to surgery we will list him for a day case arthroscopy +/- partial meniscectomy. I explained to him the risks of the procedure including infection, neurovascular damage, ongoing pain and swelling and he is happy to be listed for the procedure and discuss the details with Mr Amin in Preadmission Clinic. He also understands if we find no pathology we will write to him with the results. He understands this and is happy with the plan.

Yours sincerely,

Miss Sally-Anne Phillips/JC

ST in Orthopaedics to Mr AK Amin  
Secretary 0131 242 3563  
(Not checked or signed for expediency)

## Dermatology

Dr Burns  
Sighthill Red Medical Practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date First Created:** 24/02/2012  
**Date/Time Printed:** 27/04/2026 15:56  
**Our Ref:** 610094959B  
**CHI:** 1805580019

<b>Patient:</b> Mr Donald Macmillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>UHPI:</b> 610094959B <b>Date of Birth:</b> 18/05/1958
<b>Specialty:</b> Dermatology	<b>Consultant:</b> Prof JL Rees Registrar 4

## DIAGNOSIS:

Infiltrative micronodular BCC - right naso ala rim - treated with Mohs micrographic surgery 21st November 2011

## REVIEW:

3 months

## COMMENT:

Unfortunately the para median forehead flap, used to reconstruct the surgical defect following Mohs surgery, failed and the defect was therefore left to heal by secondary intention.

I discussed with Mr MacMillan the option of scar revision would entail a further interpolation flap (either a left sided para median flap or a naso labial cheek interpolation flap) with the associated risks of further flap failure. As he currently feels the aesthetic appearance does not trouble him particularly he would rather not proceed down the surgical route at present. He will be kept under regular review.

Yours sincerely

Dr Lisa Naysmith  
Consultant Dermatological Surgeon & Dermatologist

LN/AMB/ 22.02.12 - Dictated

For queries concerning the above, please contact Anne McBride on 0131-536-2442

## Dermatology

Dr Burns  
Sighthill Red Medical Practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date First Created:** 24/02/2012  
**Date/Time Printed:** 27/04/2026 15:56  
**Our Ref:** 610094959B  
**CHI:** 1805580019

Advice on Dermatology management and referral pathways are available on <http://www.18weeks.scot.nhs.uk/patient-pathways/dermatology/>

Dr Putta  
Drs Sharpe putta & burns practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date:** 29/02/2012

## Outpatient Clinic Letter

<b>Patient</b>	Donald MacMillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>CHI</b>	<b>1805580019</b>
		<b>Date of Birth / Age</b>	18/05/1958 (53 years)
		<b>UHPI</b>	610094959B
<b>Specialty Consultant</b>	Dermatology Dr Lisa Naysmith	<b>Attendance Date</b>	21/02/2012

Dear Dr Putta

### DIAGNOSIS:

Infiltrative micronodular BCC - right naso ala rim - treated with Mohs micrographic surgery 21st November 2011

### REVIEW:

3 months

### COMMENT:

Unfortunately the para median forehead flap, used to reconstruct the surgical defect following Mohs surgery, failed and the defect was therefore left to heal by secondary intention.

I discussed with Mr MacMillan the option of scar revision would entail a further interpolation flap (either a left sided para median flap or a naso labial cheek interpolation flap) with the associated risks of further flap failure. As he currently feels the aesthetic appearance does not trouble him particularly he would rather not proceed down the surgical route at present. He will be kept under regular review.

Yours sincerely

Dr Lisa Naysmith  
Consultant Dermatological Surgeon & Dermatologist

LN/AMB/ 22.02.12 - Dictated

For queries concerning the above, please contact Anne McBride on 0131-536-2442

## General Surgery

Dr Burns  
Sighthill Red Medical Practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date First Created:** 19/06/2012  
**Date/Time Printed:** 27/04/2026 15:56  
**Our Ref:** 610094959B  
**CHI:** 1805580019

<b>Patient:</b> Mr Donald Macmillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>UHPI:</b> 610094959B <b>Date of Birth:</b> 18/05/1958
<b>Specialty:</b> General Surgery	<b>Consultant:</b> Prof Malcolm G Dunlop

r Donald McMillan, 75-2 Calder Gardens, Edinburgh, EH11 4JX  
UHPI:610094959B, DoB: 18/5/1958, CHI: 1805580019

I met with this patient in the Outpatient clinic today. His previous symptoms of altered bowel habit, rectal bleeding and weight loss have resolved and he is beginning to put on his lost weight. Currently his bowel habit is regular and he has no rectal bleeding.

I note his family history of bowel cancer affecting his Brother at age 40. Some of his parents generation have had cancer but not obviously colorectal.

General examination today, including rigid sigmoidoscopy, was unremarkable.

Obviously the resolution of his symptoms is reassuring, but his family history does put him in a slightly higher risk group and the current recommendation is that he should have a one off colonoscopy at 55 years of age and since he is 54, I have requested this today. If this is unremarkable then no further investigation is required and I will let you know in due course.

Yours sincerely

Mr HUGH PATERSON Clinical Senior Lecturer in Coloproctology

Dr Burns  
Drs Sharpe putta & burns practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date:** 24/11/2011

**Outpatient Clinic Letter**

<b>Patient</b>	Donald McMillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>CHI</b>	<b>1805580019</b>
		<b>Date of Birth / Age</b>	18/05/1958 (53 years)
		<b>UHPI</b>	610094959B
<b>Specialty Consultant</b>	Dermatology Dr Lisa Naysmith	<b>Attendance Date</b>	21/11/2011

Dear Dr Burns

The original letter was sent to Professor Rees - copy for GP

**DIAGNOSIS:**  
Infiltrative micro nodular BCC - right naso ala rim

**TREATMENT:**  
Mohs micrographic surgery - 21st of November 2011

**REVIEW:**  
2 days for wound check  
2 weeks for division of pedical  
Out-patient 3 to 4 months

**COMMENT:**  
Many thanks for referring this gentleman with the above. Tumour free margins were obtained in 3 stages and 6 blocks. The defect was repaired with para medium forehead flap and cartilage baton harvested from his right ear.

Yours sincerely

Dr Lisa Naysmith  
Consultant Dermatological Surgeon & Dermatologist

cc: GP

LN/AMB/ 22.11.11 - Dictated

For queries concerning the above, please contact Anne McBride on 0131-536-2442

Advice on Dermatology management and referral pathways are available on <http://www.18weeks.scot.nhs.uk/patient-pathways/dermatology/>

## General Surgery

Dr Burns  
Sighthill Red Medical Practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date First Created:** 29/01/2013  
**Date/Time Printed:** 27/04/2026 15:56  
**Our Ref:** 610094959B  
**CHI:** 1805580019

<b>Patient:</b> Mr Donald Macmillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>UHPI:</b> 610094959B <b>Date of Birth:</b> 18/05/1958
<b>Specialty:</b> General Surgery	<b>Consultant:</b> Prof Malcolm G Dunlop

Mr Donald McMillan, 75-2 Calder Gardens, Edinburgh, EH11 4JX  
UHPI:610094959B, DoB: 18/5/1958, CHI: 1805580019

As you are probably aware, Mr MacMillan has now had a colonoscopy which has shown no untoward finding. Hyperplastic polyps are not significant.

Yours sincerely

Mr HUGH PATERSON Clinical Senior Lecturer in Coloproctology

## Dermatology

Dr Burns  
Sighthill Red Medical Practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date First Created:** 18/04/2011  
**Date/Time Printed:** 27/04/2026 16:00  
**Our Ref:** 610094959B  
**CHI:** 1805580019

<b>Patient:</b> Mr Donald Macmillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>UHPI:</b> 610094959B <b>Date of Birth:</b> 18/05/1958
<b>Specialty:</b> Dermatology	<b>Consultant:</b> Prof JL Rees Registrar 4

DIAGNOSIS:  
?BCC, right nostril

Thank you for referring this 52 year old man to the Dermatology Outpatient Clinic. I reviewed him together with Professor Rees today. He presents with a 6 month history of a lesion on the right nostril which is gradually enlarging but is otherwise asymptomatic. He does not normally get much sun exposure and has no significant past or family history of note.

On examination today there was a 1.0 cm pearly nodule on his right nostril with a central deep crater, which is deforming his nostril rim. Clinically this is a BCC. We have taken a punch biopsy of this lesion today to confirm the histology. When we have the results of this, we will arrange for him to have this formally excised and I will write to Mr McMillan and yourself when I have these results.

Kind regards

Yours sincerely

DR EE TING OOI  
ST3 - Dermatology

ET/kmd/Dictated 15/4/11

## Dermatology

Dr Burns  
Sighthill Red Medical Practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date First Created:** 09/05/2011  
**Date/Time Printed:** 27/04/2026 16:00  
**Our Ref:** 610094959B  
**CHI:** 1805580019

<b>Patient:</b> Mr Donald Macmillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>UHPI:</b> 610094959B <b>Date of Birth:</b> 18/05/1958
<b>Specialty:</b> Dermatology	<b>Consultant:</b> Prof JL Rees Registrar 4

I am writing to inform you of the results of the biopsy that we took from your right nostril. The results show that the lesion was a rodent ulcer or a basal cell carcinoma. As we explained to you in clinic this is a form of skin tumour which grows very slowly and tends to only stay in the skin and not spread elsewhere in the body. I hope your wound is healing well. I would like to see you back in my clinic in 6 weeks time at which time we can arrange for complete removal of the lesion on your nose. Please find included with this letter a further appointment as well as an information leaflet about basal cell carcinoma. I look forward to seeing you then.

Yours sincerely

Dr Ee Ting Ooi  
ST3 in Dermatology

Cc: Dr Stevenson  
Bangholm Medical Centre  
Bangholm Loan  
EDINBURGH  
EH5 3AH

## Dermatology

Dr Burns  
Sighthill Red Medical Practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date First Created:** 27/06/2011  
**Date/Time Printed:** 27/04/2026 16:00  
**Our Ref:** 610094959B  
**CHI:** 1805580019

<b>Patient:</b> Mr Donald Macmillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>UHPI:</b> 610094959B <b>Date of Birth:</b> 18/05/1958
<b>Specialty:</b> Dermatology	<b>Consultant:</b> Prof JL Rees Registrar 4

## DIAGNOSIS:

Histologically confirmed nodular and micronodular BCC - right ala rim

## TREATMENT:

Waiting list for Mohs Micrographic surgery

## COMMENT:

This gentleman was reviewed in the clinic today. He has a 17 x 12 mm ill-defined histologically confirmed BCC involving the right ala rim with erosion through the ala rim centrally. This would be best managed by Mohs Micrographic surgery and may require a cartilage batten to recreate the ala rim with a flap for reconstruction. He knows that there is a waiting list for this and it may be the end of August/September before surgery will be carried out. We will let you know his progress.

Yours sincerely,

DR LISA NAYSMITH  
Consultant Dermatological Surgeon & Dermatologist

LN/AMB - 24.06.11 - Dictated

## Dermatology

Dr Burns  
Sighthill Red Medical Practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date First Created:** 23/11/2011  
**Date/Time Printed:** 27/04/2026 16:00  
**Our Ref:** 610094959B  
**CHI:** 1805580019

<b>Patient:</b> Mr Donald Macmillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>UHPI:</b> 610094959B <b>Date of Birth:</b> 18/05/1958
<b>Specialty:</b> Dermatology	<b>Consultant:</b> Prof JL Rees Registrar 4

## DIAGNOSIS:

Infiltrative micro nodular BCC - right naso ala rim

## TREATMENT:

Mohs micrographic surgery - 21st of November 2011

## REVIEW:

2 days for wound check  
2 weeks for division of pedicle  
Out-patient 3 to 4 months

## COMMENT:

Many thanks for referring this gentleman with the above. Tumour free margins were obtained in 3 stages and 6 blocks. The defect was repaired with para medium forehead flap and cartilage baton harvested from his right ear.

Yours sincerely

Dr Lisa Naysmith  
Consultant Dermatological Surgeon & Dermatologist

cc: GP

LN/AMB/ 22.11.11 - Dictated

For queries concerning the above, please contact Anne McBride on 0131-536-2442

## Dermatology

Dr Burns  
Sighthill Red Medical Practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date First Created:** 23/11/2011  
**Date/Time Printed:** 27/04/2026 16:00  
**Our Ref:** 610094959B  
**CHI:** 1805580019

Advice on Dermatology management and referral pathways are available on <http://www.18weeks.scot.nhs.uk/patient-pathways/dermatology/>

## Dermatology

Dr Burns  
Sighthill Red Medical Practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date First Created:** 23/11/2011  
**Date/Time Printed:** 27/04/2026 16:00  
**Our Ref:** 610094959B  
**CHI:** 1805580019

<b>Patient:</b> Mr Donald Macmillan 75/2 Calder Gardens Edinburgh EH11 4JX	<b>UHPI:</b> 610094959B <b>Date of Birth:</b> 18/05/1958
<b>Specialty:</b> Dermatology	<b>Consultant:</b> Prof JL Rees Registrar 4

The original letter was sent to Professor Rees - copy for GP

## DIAGNOSIS:

Infiltrative micro nodular BCC - right naso ala rim

## TREATMENT:

Mohs micrographic surgery - 21st of November 2011

## REVIEW:

2 days for wound check  
2 weeks for division of pedicle  
Out-patient 3 to 4 months

## COMMENT:

Many thanks for referring this gentleman with the above. Tumour free margins were obtained in 3 stages and 6 blocks. The defect was repaired with para medium forehead flap and cartilage baton harvested from his right ear.

Yours sincerely

Dr Lisa Naysmith  
Consultant Dermatological Surgeon & Dermatologist

cc: GP

LN/AMB/ 22.11.11 - Dictated

## Dermatology

Dr Burns  
Sighthill Red Medical Practice  
Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

**Date First Created:** 23/11/2011  
**Date/Time Printed:** 27/04/2026 16:00  
**Our Ref:** 610094959B  
**CHI:** 1805580019

For queries concerning the above, please contact Anne McBride on 0131-536-2442

Advice on Dermatology management and referral pathways are available on <http://www.18weeks.scot.nhs.uk/patient-pathways/dermatology/>

# Referrals

# NHS Lothian - Imaging Request

<b>Referral To</b>	Royal Infirmary of Edinburgh at Little France Clinical Radiology LI Radiology Plain X-ray
<b>Urgency of referral</b>	Routine
<b>Date of referral</b>	17/11/2023
<b>Date submitted</b>	17/11/2023
<b>UCPN</b>	101031382973D

## PATIENT DETAILS

**CHI number:** 1805580019

**Name:** MR DONALD MACMILLAN

**Date of birth:** 18/05/1958

**Sex:** Male

## **Contact Details**

75 2 CALDER GARDENS  
EDINBURGH  
EH11 4JX

Voice (Mobile) : 07769 179 383  
E-mail :  
donaldmacmillan872@gmail.com

## REFERRING PRACTITIONER DETAILS

**Name:** Dr. John Burns (GMC: 6054583)  
**Practice:** Sighthill Red Medical Practice (70906)  
**Phone:** Voice : 0131 322 6559

## **Practice address**

Sighthill Health Centre  
Calder Road  
Edinburgh  
EH11 4AU

## INVESTIGATION REQUESTED

**Test Requested:** Hands both

Reason for Request: 65 year old c/o pain both hands small joints stiffness and localising 1st carpo-metacarpal joints ?OA

## **CLINICAL INFORMATION**

### **Investigations**

<u>Description</u>	<u>Result</u>	<u>Date</u>
--------------------	---------------	-------------

Suspected : Arthritis

Could the patient be pregnant? : Blank

<b>Signature</b> of requesting doctor	<b>Designation</b>	<b>Date</b>
---------------------------------------	--------------------	-------------

**PATIENT INFO - Call Monday to Friday  
only  
Radiology Departments – to arrange**

### **appointments:**

East Lothian Community Hospital (Roodlands)	8:30am - 4:00pm	0131 536 6400
Lauriston Building	8:30am - 4:00pm	0131 536 6400
Leith Community Treatment Centre	8:30am - 4:00pm	0131 536 6400
Midlothian Community Hospital	9:15am - 4:00pm	0131 536 6400
Royal Hospital for Sick Children - <b>U16s Only</b>	8:30am - 4:00pm	0131 536 6400
Royal Infirmary of Edinburgh	9:00am - 5:00pm	0131 536 6400
St John's Hospital	8:30am - 5:00pm	0131 536 6400
Western General Hospital	8:30am - 5:00pm	0131 536 6400

# NHS Lothian - Imaging Request

<b>Referral To</b>	Royal Infirmary of Edinburgh at Little France Clinical Radiology L Radiology Walk In
<b>Urgency of referral</b>	Routine
<b>Date of referral</b>	09/09/2019
<b>Date submitted</b>	09/09/2019

## PATIENT DETAILS

**CHI number:** 1805580019  
**Name:** MR DONALD MACMILLAN  
**Date of birth:** 18/05/1958  
**Sex:** Male

## Contact Details

75 2 CALDER GARDENS  
EDINBURGH  
EH11 4JX  
Voice (Home) : 07775841953

## REFERRING PRACTITIONER DETAILS

**Name:** Dr John Burns (GMC: 6054583)  
**Practice:** Drs Sharpe, Putta & Burns  
**Phone:** Voice : 01315377040

## Practice address

SIGHTHILL HEALTH CENTRE  
380 CALDER ROAD  
EDINBURGH  
LOTHIAN  
EH11 4AU

## INVESTIGATION REQUESTED

**Test Requested:** Pelvis/Hips

Reason for Request: c/o progressive left groin and buttock discomfort ?OA hip prev hx of osteonecrosis left knee

## **CLINICAL INFORMATION**

### **Investigations**

**Description**                      **Result Date**

Could the patient be pregnant? : Blank

# NHS Lothian - Referral Letter

<b>Referral To</b>	Lauriston Buildings Orthopaedic - Knee L Basic SIGN Referral
<b>Urgency of referral</b>	Routine
<b>Date of referral</b>	13/03/2015
<b>Date submitted</b>	13/03/2015
<b>UCPN</b>	101008882016F

<b>PATIENT DETAILS</b>		<b>Contact Details</b>	
<b>CHI number:</b>	1805580019	75 2 CALDER GARDENS	Voice (Home) : 07775841953
<b>Name:</b>	MR DONALD MACMILLAN	EDINBURGH	
<b>Date of birth:</b>	18/05/1958	EH11 4JX	
<b>Sex:</b>	Male		

<b>REFERRING PRACTITIONER DETAILS</b>		<b>Practice address</b>
<b>Name:</b>	Dr. John Burns (GMC: 6054583)	Sighthill Health Centre
<b>Practice:</b>	Drs Sharpe, Putta & Burns Practice (70906)	Calder Road
<b>Phone:</b>	Voice : 0131 537 7040	Edinburgh
		EH11 4AU

## CLINICAL INFORMATION

Reason for Referral: KNEE PAIN ...

Main Referral: Dear Doctor

Text: Thank you for seeing this pleasant 56 year old gentleman who presented initially at the start of March, 2015, with an 8 week history of persistent left lateral knee pain which he describes as being worse following periods of inactivity. At the time of his presentation the symptoms seemed to be in keeping with degenerative OA. X rays have subsequently normal. However, despite maximal analgesic in the form of Tramadol, Amitriptyline and topical anti inflammatories (the patient is not suitable for oral NSAID'S) he complains of quite limiting symptoms of pain and poor mobility.

On examination he has anterior lateral knee tenderness with no marked effusion, erythema or heat.

With his ongoing symptoms and poor response for conventional treatment I would be grateful for your specialist review.

Many thanks in advance.

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

<b>Drug name</b>	<b>Formulation</b>	<b>Dosage</b>	<b>Frequency</b>	<b>Course started</b>	<b>Duration</b>	<b>Last Prescribed Date</b>
Amitriptyline 50mg tablets	tablet	1 TAB NOCTE		02/03/2015		02/03/2015
Lansoprazole 30mg gastro-resistant capsules	capsule	TAKE ONE AT NIGHT		02/03/2015		02/03/2015
Tramadol 50mg capsules	capsule	2 CAPS 4 TIMES DAILY		02/03/2015		02/03/2015
Paracetamol 500mg tablets	tablet	2 TABLETS UP TO FOUR TIMES DAILY		02/03/2015		02/03/2015
Mirtazapine 45mg tablets	tablet	1 TABLET ONCE A DAY AT NIGHT		02/03/2015		02/03/2015
Ibuprofen 10% gel	gram	APPLY THREE TIMES DAILY TO TH[more]		02/03/2015		02/03/2015
Ibuprofen 10% gel	gram	APPLY THREE TIMES DAILY TO TH[more]		10/02/2015		10/02/2015
Movelat gel (Thornton & Ross Ltd)	gram	APPLY UP TO FOUR TIMES DAILY		13/01/2015		13/01/2015

Amitriptyline 50mg tablets	tablet	1 TAB NOCTE	13/01/2015	13/01/2015
Lansoprazole 30mg gastro resistant capsules	capsule	TAKE ONE AT NIGHT	13/01/2015	13/01/2015
Tramadol 50mg capsules	capsule	2 CAPS 4 TIMES DAILY	13/01/2015	13/01/2015
Paracetamol 500mg tablets	tablet	2 TABLETS UP TO FOUR TIMES DAILY	13/01/2015	13/01/2015
Mirtazapine 45mg tablets	tablet	1 TABLET ONCE A DAY AT NIGHT	13/01/2015	13/01/2015

### Clinical warnings

#### Allergies

<u>Description</u>	<u>Comment</u>	<u>Modifier</u>	<u>Start Date</u>	<u>Recorded Date</u>
H/O: drug allergy	Drug code for allergy: Ibuprofen 200mg modified-release capsules, Reaction type: Allergy, Certainty of allergy: Likely, Severity of allergy: Moderate.		27/04/2010	27/04/2010
H/O: drug allergy	Drug code for allergy: Aspirin powder, Reaction type: Allergy, Certainty of allergy: Likely, Severity of allergy: Moderate.		27/04/2010	27/04/2010

#### Additional information

Smoking history (Encounters):Current smoker Date recorded:11-Mar-2014

Patient Weight in Kilograms:71

Patient Height in Metres:1.67

# NHS Lothian - Imaging Request

<b>Referral To</b>	Western General Hospital Clinical Radiology L Radiology Walk In
<b>Urgency of referral</b>	Routine
<b>Date of referral</b>	10/02/2015
<b>Date submitted</b>	10/02/2015

<b><u>PATIENT DETAILS</u></b>		<b>Contact Details</b>	
<b>CHI number:</b>	1805580019	75 2 CALDER GARDENS	Voice (Home) : 07775841953
<b>Name:</b>	MR DONALD MACMILLAN	EDINBURGH	
<b>Date of birth:</b>	18/05/1958	EH11 4JX	
<b>Sex:</b>	Male		

<b><u>REFERRING PRACTITIONER DETAILS</u></b>		<b>Practice address</b>
<b>Name:</b>	Dr. John Burns (GMC: 6054583)	Sighthill Health Centre
<b>Practice:</b>	Drs Sharpe, Putta & Burns Practice (70906)	Calder Road
<b>Phone:</b>	Voice : 0131 537 7040	Edinburgh
		EH11 4AU

## **INVESTIGATION REQUESTED**

**Test Requested: Knee left**

Reason for Request: 56 year old gentleman c/o worsening anterior knee pain. Symptomatically in keeping with degenerative OA.

## **CLINICAL INFORMATION**

### **Investigations**

**Description**                      **Result Date**

Could the patient be pregnant? : Blank

# NHS Lothian - Referral Letter

<b>Referral To</b>	Western General Hospital General Surgery - Colorectal L GI - Colorectal
<b>Urgency of referral</b>	Routine
<b>Date of referral</b>	28/08/2012
<b>Date submitted</b>	28/08/2012
<b>UCPN</b>	101004112899E

<b>PATIENT DETAILS</b>		<b>Contact Details</b>	
<b>CHI number:</b>	1805580019	75 2 CALDER GARDENS	Voice (Home) : 07775841953
<b>Name:</b>	MR DONALD MACMILLAN	EDINBURGH	
<b>Date of birth:</b>	18/05/1958	EH11 4JX	
<b>Sex:</b>	Male		

<b>REFERRING PRACTITIONER DETAILS</b>		<b>Practice address</b>
<b>Name:</b>	Dr. John Burns (GMC: 6054583)	Sighthill Health Centre
<b>Practice:</b>	Drs Sharpe, Putta & Burns Practice (70906)	Calder Road
<b>Phone:</b>	Voice : 0131 537 7040	Edinburgh
		EH11 4AU

## CLINICAL INFORMATION

Reason for Referral: REQUEST FOR FURTHER APPOINTMENT

Main Referral Text: Dear Doctor

This gentleman was seen in your clinic recently and was to return for colonoscopy, which, unfortunately, he failed to do. I would, therefore, be most grateful if you would send him a further appointment.

We have had a frank conversation today and he assures me he will attend any future appointments.

I attach a copy of his original referral for your information.

With best wishes.

### Investigations

<u>Description</u>	<u>Result</u>	<u>Date</u>
Age :	40-55 years	
Duration of symptoms :	3 to 4 months	
Bleeding PR :	None	
Obstructive Symptoms :	None	
Hb result :	Not Done	
eGFR >30 :	Unknown	

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

<u>Drug name</u>	<u>Formulation</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Course started</u>	<u>Duration</u>	<u>Last Prescribed Date</u>
Mirtazapine 30mg tablets	tablet	1 TAB AT NIGHT		27/08/2012		27/08/2012
Amitriptyline 50mg tablets	tablet	1 TAB NOCTE		27/08/2012		27/08/2012
Lansoprazole 30mg gastro-resistant capsules	capsule	TAKE ONE AT NIGHT		27/08/2012		27/08/2012
Tramadol 50mg capsules	capsule	2 CAPS 4 TIMES DAILY		27/08/2012		27/08/2012

TRAMADOL caps 50mg	capsule	2 CAPS 4 TIMES DAILY	02/07/2012	02/07/2012
LANSOPRAZOLE caps(ec grans) 30mg	capsule	TAKE ONE AT NIGHT	02/07/2012	02/07/2012
AMITRIPTYLINE HCl tabs 50mg	tablet	1 TAB NOCTE	02/07/2012	02/07/2012
MIRTAZAPINE tabs 30mg	tablet	1 TAB AT NIGHT	02/07/2012	02/07/2012
LANSOPRAZOLE caps(ec grans) 30mg	capsule	TAKE ONE AT NIGHT	04/06/2012	04/06/2012
AMITRIPTYLINE HCl tabs 50mg	tablet	1 TAB NOCTE	04/06/2012	04/06/2012
MIRTAZAPINE tabs 30mg	tablet	1 TAB AT NIGHT	04/06/2012	04/06/2012
TRAMADOL caps 50mg	capsule	2 CAPS 4 TIMES DAILY	04/06/2012	04/06/2012

### Clinical warnings

#### Allergies

<u>Description</u>	<u>Comment</u>	<u>Modifier</u>	<u>Start Date</u>	<u>Recorded Date</u>
H/O: drug allergy	Drug code for allergy: Ibuprofen 200mg modified-release capsules, Reaction type: Allergy, Certainty of allergy: Likely, Severity of allergy: Moderate.			27/04/2010
H/O: drug allergy	Drug code for allergy: Aspirin powder, Reaction type: Allergy, Certainty of allergy: Likely, Severity of allergy: Moderate.			27/04/2010

#### Additional information

Smoking history (Encounters):Light smoker - 1-9 cigs/day Date recorded:7-Feb-2012

Patient Weight in Kilograms:71

Patient Height in Metres:1.67

# NHS Lothian - Referral Letter

<b>Referral To</b>	Western General Hospital General Surgery - Colorectal L GI - Colorectal
<b>Urgency of referral</b>	Urgent
<b>Date of referral</b>	06/06/2012
<b>Date submitted</b>	06/06/2012
<b>UCPN</b>	101003729172V

<b><u>PATIENT DETAILS</u></b>		<b>Contact Details</b>	
<b>CHI number:</b>	1805580019	75 2 CALDER GARDENS	Voice (Home) : 07775841953
<b>Name:</b>	MR DONALD MACMILLAN	EDINBURGH	
<b>Date of birth:</b>	18/05/1958	EH11 4JX	
<b>Sex:</b>	Male		

<b><u>REFERRING PRACTITIONER DETAILS</u></b>		<b>Practice address</b>
<b>Name:</b>	DR PATRICIA YOUNG (GMC: LOCUM TO DR JOHN BURNS)	SIGHTHILL HEALTH CENTRE 380 CALDER ROAD EDINBURGH EH11 4AU
<b>Practice:</b>	DRS SHARPE, PUTTA & BURNS	
<b>Phone:</b>	Voice : 0131 537 7040	

## CLINICAL INFORMATION

Reason for Referral: SOON APPOINTMENT PLEASE

Main Referral Text: Dear Doctor

This gentleman has been in surgery a couple of times since 13th April, 2012. According to your records he is recorded as having failed to attend his 2nd Out Patient Clinic appointment.

Mr MacMillan is adamant that on this day he did attend but was given the option to either wait several hours or to go home and await a further appointment, due to an emergency which was occurring in the hospital.

Mr MacMillan is continuing to lose weight and attach again a copy of his original referral letter. I would be grateful if you could prioritise Mr MacMillan as he has a strong family history of cancer, and due to the fact he is currently losing weight.

As he has had over the last month or two a recurrence of his upper GI symptoms I have, however, started him on Lansoprazole. You will not, however, that the original concerns are regarding colorectal side of things.

### Investigations

<b><u>Description</u></b>	<b><u>Result</u></b>	<b><u>Date</u></b>
Age :	40-55 years	
Duration of symptoms :	More than 6 months	
Bleeding PR :	None	
Obstructive Symptoms :	None	
Hb result :	Not Done	
eGFR >30 :	Unknown	

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

<b><u>Drug name</u></b>	<b><u>Formulation</u></b>	<b><u>Dosage</u></b>	<b><u>Frequency</u></b>	<b><u>Course started</u></b>	<b><u>Duration</u></b>	<b><u>Last Prescribed Date</u></b>
LANSOPRAZOLE caps(ec grans) 30mg	capsule	TAKE ONE AT NIGHT		04/06/2012		04/06/2012
AMITRIPTYLINE HCl tabs 50mg	tablet	1 TAB NOCTE		04/06/2012		04/06/2012
MIRTAZAPINE tabs 30mg	tablet	1 TAB AT NIGHT		04/06/2012		04/06/2012

TRAMADOL caps 50mg	capsule	2 CAPS 4 TIMES DAILY	04/06/2012	04/06/2012
TRAMADOL caps 50mg	capsule	2 CAPS 4 TIMES DAILY	08/05/2012	08/05/2012
MIRTAZAPINE tabs 30mg	tablet	1 TAB AT NIGHT	08/05/2012	08/05/2012
AMITRIPTYLINE HCl tabs 50mg	tablet	1 TAB NOCTE	08/05/2012	08/05/2012
TRAMADOL caps 50mg	capsule	2 CAPS 4 TIMES DAILY	27/04/2012	27/04/2012
MIRTAZAPINE tabs 30mg	tablet	1 TAB AT NIGHT	27/04/2012	27/04/2012
AMITRIPTYLINE HCl tabs 25mg	tablet	2 TAB AT NIGHT	27/04/2012	27/04/2012
TRAMADOL caps 50mg	capsule	2 CAPS 4 TIMES DAILY	30/03/2012	30/03/2012
MIRTAZAPINE tabs 30mg	tablet	1 TAB AT NIGHT	30/03/2012	30/03/2012
AMITRIPTYLINE HCl tabs 25mg	tablet	2 TAB AT NIGHT	30/03/2012	30/03/2012

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### Clinical warnings

#### Allergies

<u>Description</u>	<u>Comment</u>	<u>Modifier</u>	<u>Start Date</u>	<u>Recorded Date</u>
H/O: drug allergy	Drug code for allergy: IBUPROFEN mr cap 200mg, Reaction type: Allergy, Certainty of allergy: Likely, Severity of allergy: Moderate.			27/04/2010
H/O: drug allergy	Drug code for allergy: ASPIRIN pwr, Reaction type: Allergy, Certainty of allergy: Likely, Severity of allergy: Moderate.			27/04/2010

#### Additional information

Smoking history (Encounters):Light smoker - 1-9 cigs/day Date recorded:7-Feb-2012

Patient Weight in Kilograms:71

Patient Height in Metres:1.67

# NHS Lothian - Referral Letter

<b>Referral To</b>	Western General Hospital General Surgery - Colorectal L GI - Colorectal
<b>Urgency of referral</b>	Urgent
<b>Date of referral</b>	09/01/2012
<b>Date submitted</b>	09/01/2012
<b>UCPN</b>	1010030105270

<b>PATIENT DETAILS</b>		<b>Contact Details</b>	
<b>CHI number:</b>	1805580019	75 2 CALDER GARDENS	Voice (Home) : 07775841953
<b>Name:</b>	MR DONALD MACMILLAN	EDINBURGH	
<b>Date of birth:</b>	18/05/1958	EH11 4JX	
<b>Sex:</b>	Male		

<b>REFERRING PRACTITIONER DETAILS</b>		<b>Practice address</b>
<b>Name:</b>	Dr. John Burns (GMC: 6054583)	Sighthill Health Centre
<b>Practice:</b>	Drs Sharpe, Putta & Burns Practice (70906)	Calder Road
<b>Phone:</b>	Voice : 0131 537 7040	Edinburgh
		EH11 4AU

## CLINICAL INFORMATION

Reason for Referral: PR BLEEDING

Main Referral Text: Dear Doctor

This gentleman apologises for not keeping his previous appointment with your department. I have stressed to him today the necessity for him to keep his appointment and he assures me that he will definitely attend any future appointments.

I attach a copy of his original referral for your information and I would be most grateful if you would send him a further appointment.

### Investigations

<u>Description</u>	<u>Result</u>	<u>Date</u>
Age :	40-55 years	
Duration of symptoms :	More than 6 months	
Bleeding PR :	None	
Obstructive Symptoms :	None	
Hb result :	Not Done	
eGFR >30 :	Unknown	

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

<u>Drug name</u>	<u>Formulation</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Course started</u>	<u>Duration</u>	<u>Last Prescribed Date</u>
TRAMADOL caps 50mg	capsule	2 CAPS 4 TIMES DAILY		09/01/2012		09/01/2012
MIRTAZAPINE tabs 30mg	tablet	1 TAB AT NIGHT		09/01/2012		09/01/2012
AMITRIPTYLINE HCl tabs 25mg	tablet	2 TAB AT NIGHT		09/01/2012		09/01/2012
NIQUITIN loz 4mg	lozenge	USE AS NEEDED		09/01/2012		09/01/2012
NIQUITIN patch 21mg	patch	APPLY DAILY		09/01/2012		09/01/2012
NICORETTE chewing gum 4mg	piece(s) original	CHEW AS NEEDED		13/12/2011		13/12/2011
NIQUITIN patch 21mg	patch	APPLY DAILY		13/12/2011		13/12/2011

AMITRIPTYLINE HCl tabs 25mg	tablet	1 TAB AT NIGHT	13/12/2011	13/12/2011
MIRTAZAPINE tabs 30mg	tablet	1 TAB AT NIGHT	13/12/2011	13/12/2011
TRAMADOL caps 50mg	capsule	2 CAPS 4 TIMES DAILY	13/12/2011	13/12/2011
TEMAZEPAM tabs 10mg	tablet	TAKE ONE AT NIGHT	25/11/2011	25/11/2011
MIRTAZAPINE tabs 30mg	tablet	1 TAB AT NIGHT	25/11/2011	25/11/2011
TRAMADOL caps 50mg	capsule	2 CAPS 4 TIMES DAILY	25/11/2011	25/11/2011
AMITRIPTYLINE HCl tabs 25mg	tablet	1 TAB AT NIGHT	25/11/2011	25/11/2011
TRAMADOL caps 50mg	capsule	2 CAPS 4 TIMES DAILY	01/11/2011	01/11/2011
AMITRIPTYLINE HCl tabs 25mg	tablet	1 TAB AT NIGHT	01/11/2011	01/11/2011
MIRTAZAPINE tabs 30mg	tablet	1 TAB AT NIGHT	01/11/2011	01/11/2011

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### Clinical warnings

#### Allergies

<u>Description</u>	<u>Comment</u>	<u>Modifier</u>	<u>Start Date</u>	<u>Recorded Date</u>
H/O: drug allergy	Drug code for allergy: IBUPROFEN mr cap 200mg, Reaction type: Allergy, Certainty of allergy: Likely, Severity of allergy: Moderate.			27/04/2010
H/O: drug allergy	Drug code for allergy: ASPIRIN pwr, Reaction type: Allergy, Certainty of allergy: Likely, Severity of allergy: Moderate.			27/04/2010

#### Additional information

Smoking history (Encounters):Cigarette smoker Date recorded:29-Sep-2011

Patient Weight in Kilograms:71

Patient Height in Metres:1.67

# NHS Lothian - Referral Letter

<b>Referral To</b>	Western General Hospital General Surgery - Colorectal L GI - Colorectal
<b>Urgency of referral</b>	Urgent
<b>Date of referral</b>	30/08/2011
<b>Date submitted</b>	30/08/2011
<b>UCPN</b>	101002469708B

<b>PATIENT DETAILS</b>		<b>Contact Details</b>	
<b>CHI number:</b>	1805580019	75 2 CALDER GARDENS	Voice (Home) : 07775841953
<b>Name:</b>	MR DONALD MACMILLAN	EDINBURGH	
<b>Date of birth:</b>	18/05/1958	EH11 4JX	
<b>Sex:</b>	Male		

<b>REFERRING PRACTITIONER DETAILS</b>		<b>Practice address</b>
<b>Name:</b>	Dr. John Burns (GMC: 6054583)	Sighthill Health Centre
<b>Practice:</b>	Drs Sharpe, Putta & Burns Practice (70906)	Calder Road
<b>Phone:</b>	Voice : 0131 537 7040	Edinburgh EH11 4AU

## CLINICAL INFORMATION

Reason for Referral: PR BLEEDING

Main Referral: Dear Doctor

Text: Thank you for seeing this 53 year old gentleman who is relatively new to our practice having moved here from Broughty Ferry in Dundee.

He complains of a six week history of fresh PR blood loss on toilet paper and mixed with bowel motion. This is on a background of approximately 3 month history of loss of roughly 1 1/2 stone in weight, with clothes feeling looser etc. Mr MacMillan has a family history of carcinoma. His brother - who is younger than him - had been diagnosed with bowel CA and his mother had a mastectomy for breast CA and both maternal grandparents died of cancer, although he is unsure which type.

Of note - Mr MacMillan also has a history of a BCC on his right nostril and is currently awaiting nose micrographic surgery to remove this. Mr MacMillan has long standing problem with constipation which are probably secondary to his use of Tramadol for knee and back pain. With his weight loss and recent PR bleeding I would be grateful if he could be considered for urgent colonoscopy.

Many thanks in advance.

### Investigations

<u>Description</u>	<u>Result</u>	<u>Date</u>
Age :	40-55 years	
Duration of symptoms :	1 to 2 months	
Suspicion of Bowel Cancer :	Yes	
Bleeding PR :	Altered blood in stool	
Obstructive Symptoms :	None	
Hb result :	Not Done	
eGFR >30 :	Unknown	

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

<u>Drug name</u>	<u>Formulation</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Course started</u>	<u>Duration</u>	<u>Last Prescribed Date</u>
MIRTAZAPINE tabs 30mg	tablet	1 TAB AT NIGHT		26/08/2011		26/08/2011

AMITRIPTYLINE HCl tabs 25mg	tablet	1 TAB AT NIGHT	26/08/2011	26/08/2011
TRAMADOL caps 50mg	capsule	2 CAPS 4 TIMES DAILY	26/08/2011	26/08/2011
Tramadol Hydrochloride CAPS 50MG		2 Caps 4 Times daily	01/08/2011	01/08/2011
Amitriptyline Hydrochloride TABS 25MG		1 Tab At night	01/08/2011	01/08/2011
Mirtazapine TABS 30MG		1 Tab At night	01/08/2011	01/08/2011

**Additional information**

Smoking history (Encounters):Current smoker Date recorded:1-Aug-2011

Patient Weight in Kilograms:71

Patient Height in Metres:1.67

# REFERRAL LETTER

MEDICAL IN CONFIDENCE

<b>REFERRAL TO</b>	
Ophthalmology C7 L Basic SIGN Referral	
Princess Alexandra Eye Pavillion (S316H) 45 Chalmers Street Edinburgh EH3 9HA	
<b>Urgency of referral</b>	Routine
<b>Date of referral</b>	13/04/2011
<b>Date submitted</b>	13/04/2011
<b>UCPN</b>	101001864860M

<b>PATIENT DETAILS</b>		<b>Address</b>
Surname	MacMillan	20-6 Crewe Road Gardens EDINBURGH EH5 2NS
Forename(s)	Donald	
Title	Mr                      Sex    Male	
Date of birth	18/05/1958	
CHI no.	1805580019	
Previous Surname		<b>Contact number(s)</b>
		Voice : 07786 708225

<b>REFERRING PRACTITIONER DETAILS</b>		<b>Practice address</b>
<b>Name</b>	Dr. Anne Stevenson	BANGHOLM LOAN EDINBURGH EH5 3AH
GMC code	2546465                      GP code    48836	
Practice name	BANGHOLM MEDICAL CENTRE (70272)	
Practice code	70272	
		<b>Contact number(s)</b>
		Voice : 0131 552 7676 Facsimile : 0131 552 8145

**CLINICAL INFORMATION****History of presenting complaint / examination findings / investigation results****Presenting complaint**

Description: See attached optometrist's report

Comment: This 52 year-old man has only recently joined our practice. He describes his occupation as 'disabled' secondary to depression, anxiety, stress and osteoarthritis. He is ex forces. Blood pressure is 130/90 and urinalysis is negative. Thank you for seeing him.

**Reason for referral**

Care type requested: Out Patient - New

Expected outcome: Not Specified

**Past medical history****Pre-existing conditions** (High & Medium Priority)

<u>Description</u>	<u>Modifier</u>	<u>Extension</u>	<u>Start Date</u>	<u>Date Recorded</u>
[D]Alcohol blood level excessive				14/02/2011

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

<u>Drug name</u>	<u>BNF code</u>	<u>Formulation</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Course started</u>	<u>Duration</u>	<u>Last Prescribed Date</u>
Tramadol Hydrochloride	04.07.02.0	CAPS 50MG	2 Caps	4 Times daily	13/01/2011		28/03/2011
Fexofenadine Hydrochloride	03.04.01.0	TABS 120MG	1 Tab	Daily	13/01/2011		28/03/2011
Mirtazapine	04.03.04.0	TABS 45MG	1 Tab	At night	13/01/2011		13/01/2011

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

<u>Drug name</u>	<u>BNF code</u>	<u>Formulation</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Course started</u>	<u>Duration</u>	<u>Last Prescribed Date</u>
Mirtazapine	04.03.04.0	TABS 30MG	1 Tab	At night	28/03/2011		28/03/2011
Amitriptyline Hydrochloride	04.03.01.0	TABS 25MG	1 Tab	At night	28/03/2011		28/03/2011
Nicorette	04.10.00.0	15mg/16 Hours PATCH	Apply	As directed	31/01/2011		31/01/2011
Nicorette	04.10.00.0	Sf Chewing Gum Freshfruit 2MG			31/01/2011		31/01/2011

**Clinical warnings****Allergies**

<u>Description</u>	<u>Comment</u>	<u>Modifier</u>	<u>Start Date</u>	<u>Recorded Date</u>
H/O: aspirin allergy	and ibuprofen			01/02/2011
Food allergy	Some foods			01/02/2011
-				



# REFERRAL LETTER

MEDICAL IN CONFIDENCE

<b>REFERRAL TO</b>	
Dermatology A7 L Other Urgent Referral	
Lauriston Buildings (S374C) Lauriston Place Edinburgh EH3 9EN	
<b>Urgency of referral</b>	Urgent
<b>Date of referral</b>	28/03/2011
<b>Date submitted</b>	28/03/2011
<b>UCPN</b>	101001788127J

<b>PATIENT DETAILS</b>		<b>Address</b>
Surname	MacMillan	20-6 Crewe Road Gardens EDINBURGH EH5 2NS
Forename(s)	Donald	
Title	Mr                      Sex    Male	
Date of birth	18/05/1958	
CHI no.	1805580019	<b>Contact number(s)</b>
Previous Surname		Voice : 07786 708225

<b>REFERRING PRACTITIONER DETAILS</b>		<b>Practice address</b>
<b>Name</b>	Dr. Anne Stevenson	BANGHOLM LOAN EDINBURGH EH5 3AH
GMC code	2546465      GP code    48836	
Practice name	BANGHOLM MEDICAL CENTRE (70272)	
Practice code	70272	
		<b>Contact number(s)</b>
		Voice : 0131 552 7676

**CLINICAL INFORMATION****History of presenting complaint / examination findings / investigation results****Presenting complaint**

Description: ? BCC right nostril

Comment: This 52 yo man has recently joined our practice. He is registered disabled and has had an alcohol problem in the past. He has an ulcerated lesion on the edge of his right nostril which has been getting bigger over the period of a few months. It is now 1cm diameter. I suspect it is a BCC or possibly SCC. Thank you for seeing him.

**Reason for referral**

Care type requested: Out Patient - New

Expected outcome: Not Specified

**Past medical history****Pre-existing conditions** (High & Medium Priority)

<u>Description</u>	<u>Modifier</u>	<u>Extension</u>	<u>Start Date</u>	<u>Date Recorded</u>
[D]Alcohol blood level excessive				14/02/2011

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

<u>Drug name</u>	<u>BNF code</u>	<u>Formulation</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Course started</u>	<u>Duration</u>	<u>Last Prescribed Date</u>
Tramadol Hydrochloride	04.07.02.0	CAPS 50MG	2 Caps	4 Times daily	13/01/2011		28/03/2011
Fexofenadine Hydrochloride	03.04.01.0	TABS 120MG	1 Tab	Daily	13/01/2011		28/03/2011
Mirtazapine	04.03.04.0	TABS 45MG	1 Tab	At night	13/01/2011		13/01/2011

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

<u>Drug name</u>	<u>BNF code</u>	<u>Formulation</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Course started</u>	<u>Duration</u>	<u>Last Prescribed Date</u>
Amitriptyline Hydrochloride	04.03.01.0	TABS 25MG	1 Tab	At night	28/03/2011		28/03/2011
Mirtazapine	04.03.04.0	TABS 30MG	1 Tab	At night	28/03/2011		28/03/2011
Nicorette	04.10.00.0	Sf Chewing Gum Freshfruit 2MG			31/01/2011		31/01/2011
Nicorette	04.10.00.0	15mg/16 Hours PATCH	Apply	As directed	31/01/2011		31/01/2011

**Clinical warnings****Allergies**

<u>Description</u>	<u>Comment</u>	<u>Modifier</u>	<u>Start Date</u>	<u>Recorded Date</u>
Food allergy	Some foods - unspecified			01/02/2011

H/O: aspirin and 01/02/2011  
allergy ibuprofen

H/O: non- 01/02/2011  
drug allergy detergent

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**Additional relevant information**

Smoking history (Encounters): Current smoker , Date recorded: 13-Jan-2011

Alcohol history (Encounters): Alcohol intake above recommended sensible limits , Date recorded: 13-Jan-2011

Exercise history (Encounters): Avoids even trivial exercise , Date recorded: 13-Jan-2011

Patient Weight in Kilograms:80

Patient Height in Metres:1.66

Patient BMI:29.03

Patient Blood Pressure (Systolic):130

Patient Blood Pressure (Diastolic):90

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

# Lab and Radiology Reports

**ESC Sendaway Tests**

Immunoglobulins	Send away test	WGH Biochemistry
Protein E'phoresis	Send away test	WGH Biochemistry

**Requestor Comments**

Query Hypothyroid  
back pain.

**Blood haematinic levels**

Description	Value	Range	Unit	Normalcy Notes
Ferritin	33	20 - 300	ug/L	
Vitamin B12	222	180 - 2000	ng/L	
Serum Folate	5.0	2.8 - 20	ug/L	

**Requestor Comments**

Query Hypothyroid  
back pain.

**Thyroid function tests**

Description	Value	Range	Unit	Normalcy Notes
TSH	2.1	0.23 5.6	mU/L	
Free T4	17	9 28	pmol/L	

**Requestor Comments**

Query Hypothyroid  
back pain.

**Bone Group**

Description	Value	Range	Unit	Normalcy Notes
Calcium	2.47	2.2 - 2.6	mmol/L	
Adjustd Calcium	2.48	2.2 - 2.6	mmol/L	
Phosphate	1.21	0.8 - 1.4	mmol/L	
Albumin	41	36 - 47	g/L	
Alk.Phos	69	40 - 125	U/L	

**Requestor Comments**

Query Hypothyroid  
back pain.

**Liver function tests**

Description	Value	Range	Unit	Normalcy Notes
Bilirubin	6	3 21	umol/L	
ALT	18	10 50	U/L	
GGT	30	10 55	U/L	

**Requestor Comments**

Query Hypothyroid  
back pain.

**Serum lipids**

Description	Value	Range	Unit	Normalcy Notes
Cholesterol	5.0		mmol/L	
HDL Chol.	1.4	0.9 - 1.4	mmol/L	
Chol:HDLC Ratio	3.6			
LDL Chol.	<b>3.1</b>		<b>mmol/L</b>	<b>A</b>
Triglyceride	1.2	0.8 - 2.1	mmol/L	

**Requestor Comments**

Query Hypothyroid  
back pain.

**Urea and electrolytes**

Description	Value	Range	Unit	Normalcy Notes
Urea	6.1	2.5 - 6.6	mmol/L	
Creatinine	101	64 - 111	umol/L	
Sodium	138	135 - 145	mmol/L	
Potassium	4.7	3.6 - 5	mmol/L	
eGFR (/1.73m2)	>60		ml/min	

**Requestor Comments**

Query Hypothyroid  
back pain.

Serum C reactive protein level				
Description	Value	Range	Unit	Normalcy Notes
C-Reactive Prot	1.0	0 - 5	mg/L	

**Requestor Comments**

Query Hypothyroid  
back pain.

Serum urate level				
Description	Value	Range	Unit	Normalcy Notes
Urate	0.32	0.12 - 0.42	mmol/L	(BUA)
<b>Test Comments</b>				
(BUA)	In clinically confirmed gout the goal of urate lowering			
(BUA)	therapy is to achieve target urate of 0.36mmol/L (or			
(BUA)	below)in all patients. In newly diagnosed patients, and			
(BUA)	in patients with tophi, guidelines recommend aiming for			
(BUA)	target urate of 0.3 mmol/L (or below).			

**Requestor Comments**

Query Hypothyroid  
back pain.

Tumour marker levels				
Description	Value	Range	Unit	Normalcy Notes
PSA	0.4	0 - 4	ug/L	

**Requestor Comments**

Query Hypothyroid  
back pain.

**Report Information**

Requestor Burns, Dr John R  
 Requesting Location (GSSIGB) Sighthill Red Medical Practice  
 Report Identifier HB888266J  
 Sample Date 30/07/2025 12:13:00

Full blood count - FBC				
Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	139	130 180	g/L	
Red cell count	4.78	4.5 6.5	10 <sup>12</sup> /L	
Haematocrit	0.415	0.40 0.52	ratio	
Mean cell volume	87	78 98	fL	
Mean Cell Hb	29.1	27.0 32.0	pg	
White cell count	8.9	4.0 11.0	10 <sup>9</sup> /L	
Neutrophil Count	3.07	2.0 7.5	10 <sup>9</sup> /L	
Lymphocyte Count	4.05	1.5 4.5	10 <sup>9</sup> /L	
Monocyte Count	<b>0.97</b>	<b>0.2 - 0.8</b>	<b>10<sup>9</sup>/L</b>	<b>R</b>
Eosinophil Count	<b>0.68</b>	<b>0.04 - 0.4</b>	<b>10<sup>9</sup>/L</b>	<b>R</b>
Basophil Count	0.09	0.01 0.1	10 <sup>9</sup> /L	
Platelet count	321	150 400	10 <sup>9</sup> /L	
Mean cell Hb conc.	335	310 360	g/L	

**Requestor Comments**

back pain.

**Report Information**

Requestor Burns, Dr John R

Requesting Location (GSSIGB) Sighthill Red Medical Practice

Report Identifier HR394808Z

Sample Date 30/07/2025 12:13:00

**HbA1c level**

Description	Value	Range	Unit	Normalcy Notes
HbA1c (IFCC)	37	20 41	mmol/mol	(BHBAIF)
<b>Test Comments</b> (BHBAIF) HbA1c is NOT increased.				

**Requestor Comments**

HbA1c for diagnosis  
back pain.

**Report Information**

Requestor Burns, Dr John R  
Requesting Location (GSSIGB) Sighthill Red Medical Practice  
Report Identifier HB888306B  
Sample Date 30/07/2025 12:13:00

Serum Protein EPH / IGs				
Description	Value	Range	Unit	Normalcy Notes
IgA	5.30	0.8 - 4.5	g/L	R
IgG	13.38	6 15	g/L	
IgM	1.11	0.35 2.9	g/L	

**Requestor Comments**

Back pain  
Query Hypothyroid

**Report Information**

Requestor Burns, Dr John R  
Requesting Location (GSSIGB) Sighthill Red Medical Practice  
Report Identifier QB160154F  
Sample Date 30/07/2025 12:13:00

Serum total protein				
Description	Value	Range	Unit	Normalcy Notes
Total Protein	73	60 80	g/L	

**Requestor Comments**

Back pain  
Query Hypothyroid

Serum Protein EPH / IGs				
Prot E'phoresis	COMMENT			(BPEPH)
<b>Test Comments</b>				
(BPEPH)	Paraproteins not detected			

**Requestor Comments**

Back pain  
Query Hypothyroid

**Report Information**

Requestor Burns, Dr John R  
 Requesting Location (GSSIGB) Sighthill Red Medical Practice  
 Report Identifier QB160155C  
 Sample Date 30/07/2025 12:13:00

<b>Urine Protein Electrophoresis</b>
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Bence Jones Protein	Negative
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**Requestor Comments**

back pain.

**Report Information**

Requestor Burns, Dr John R

Requesting Location (GSSIGB) Sighthill Red Medical Practice

Report Identifier QB773693J

Sample Date 29/07/2025 14:40:00

**HbA1c level**

Description	Value	Range	Unit	Normalcy Notes
HbA1c (IFCC)	38	20 41	mmol/mol	(BHBAIF)
<b>Test Comments</b> (BHBAIF) HbA1c is NOT increased.				

**Requestor Comments**

HbA1c for diagnosis  
RLS and wellman check.

**Report Information**

Requestor Burns, Dr John R  
Requesting Location (GSSIGB) Sighthill Red Medical Practice  
Report Identifier HB988437L  
Sample Date 22/02/2024 11:21:00

Full blood count - FBC				
Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	141	130 180	g/L	
Red cell count	4.90	4.5 6.5	10 <sup>12</sup> /L	
Haematocrit	0.423	0.40 0.52	ratio	
Mean cell volume	86	78 98	fL	
Mean Cell Hb	28.8	27.0 32.0	pg	
White cell count	9.4	4.0 11.0	10 <sup>9</sup> /L	
Neutrophil Count	3.74	2.0 7.5	10 <sup>9</sup> /L	
Lymphocyte Count	4.11	1.5 4.5	10 <sup>9</sup> /L	
Monocyte Count	<b>1.05</b>	<b>0.2 - 0.8</b>	<b>10<sup>9</sup>/L</b>	<b>R</b>
Eosinophil Count	0.40	0.04 0.4	10 <sup>9</sup> /L	
Basophil Count	0.09	0.01 0.1	10 <sup>9</sup> /L	
Platelet count	345	150 400	10 <sup>9</sup> /L	
Mean cell Hb conc.	333	310 360	g/L	

**Requestor Comments**

RLS and wellman check.

**Report Information**

Requestor Burns, Dr John R

Requesting Location (GSSIGB) Sighthill Red Medical Practice

Report Identifier HR295330S

Sample Date 22/02/2024 11:21:00

**Blood haematinic levels**

Description	Value	Range	Unit	Normalcy Notes
Ferritin	26	20 300	ug/L	
Vitamin B12	219	180 2000	ng/L	
Serum Folate	5.4	2.8 20	ug/L	

**Requestor Comments**

Query Hypothyroid  
 RLS and wellman check.

**Bone Group**

Description	Value	Range	Unit	Normalcy Notes
Calcium	2.39	2.2 - 2.6	mmol/L	
Adjustd Calcium	2.41	2.2 - 2.6	mmol/L	
Phosphate	1.13	0.8 - 1.4	mmol/L	
Magnesium	0.87	0.7 - 1	mmol/L	
Albumin	38	36 - 47	g/L	

**Requestor Comments**

Query Hypothyroid  
 RLS and wellman check.

**Liver function tests**

Description	Value	Range	Unit	Normalcy Notes
Bilirubin	6	3 21	umol/L	
ALT	12	10 50	U/L	
Alk.Phos	78	40 125	U/L	
GGT	30	10 55	U/L	

**Requestor Comments**

Query Hypothyroid  
 RLS and wellman check.

**Serum lipids**

Description	Value	Range	Unit	Normalcy Notes
Cholesterol	4.8		mmol/L	
HDL Chol.	<b>1.6</b>	<b>0.9 - 1.4</b>	<b>mmol/L</b>	<b>R</b>
Chol:HDLC Ratio	3.0			
LDL Chol.	2.9		mmol/L	
Triglyceride	0.8	0.8 - 2.1	mmol/L	

**Requestor Comments**

Query Hypothyroid  
 RLS and wellman check.

**Urea and electrolytes**

Description	Value	Range	Unit	Normalcy Notes
Urea	3.2	2.5 6.6	mmol/L	
Creatinine	86	64 111	umol/L	
Sodium	140	135 145	mmol/L	
Potassium	4.6	3.6 5	mmol/L	
eGFR (/1.73m2)	>60		ml/min	

**Requestor Comments**

Query Hypothyroid  
 RLS and wellman check.

**Thyroid function tests**

Description	Value	Range	Unit	Normalcy Notes
TSH	1.3	0.23 - 5.6	mU/L	
Free T4	13	9 - 28	pmol/L	

**Requestor Comments**

Query Hypothyroid  
RLS and wellman check.

Serum urate level				
Description	Value	Range	Unit	Normalcy Notes
Urate	0.24	0.12 - 0.42	mmol/L	

**Requestor Comments**

Query Hypothyroid  
RLS and wellman check.

Tumour marker levels				
Description	Value	Range	Unit	Normalcy Notes
PSA	0.6	0 - 4	ug/L	

**Requestor Comments**

Query Hypothyroid  
RLS and wellman check.

**Report Information**

Requestor Burns, Dr John R  
Requesting Location (GSSIGB) Sighthill Red Medical Practice  
Report Identifier HB989011V  
Sample Date 22/02/2024 11:21:00

**XR Pelvis**

XR Pelvis

Clinical details

XR Pelvis

c/o progressive left groin and buttock discomfort ?OA hip prev hx of osteonecrosis left knee / Pelvis/Hips

Report

No previous to compare.

The joint spaces are preserved bilaterally with minimal osteophytic lipping of the superior acetabulum bilaterally. Normal appearance of the sacroiliac joints.

Dr S McLenachan

Consultant Radiologist

Suzanne.McLenachan@nhslothian.scot.nhs.uk

Reporting Radiologist: Dr Suzanne L McLenachan

**Report Information**

Requestor BURNS, JOHN

Requesting Location Sighthill Red Medical Practice

Report Identifier 33774526

Sample Date 16/09/2019 10:13:00

**MRI Knee Lt**

MRI Knee Lt

Clinical details

MRI Knee Lt

Left knee pain for last 6 months. No hx of trauma. Medial and lateral joint line. X-rays unremarkable. Meniscal?

Report

Both menisci are normal, as are the cruciate and collateral ligaments.

There is extensive oedema within the medial femoral condyle and an undisplaced subchondral fracture within the weight-bearing portion of the medial femoral condyle. Similar but much less marked findings are demonstrated within the weight-bearing portion of the lateral femoral condyle. The articular cartilage is well preserved throughout. There is a moderate sized knee joint effusion with a small amount of intra-articular debris.

Popliteus is normal, as are the quadriceps and patellar tendons and those of the pes anserinus and iliotibial tract.

Summary:

Undisplaced subchondral fracture within the medial femoral condyle with extensive bone marrow oedema.

Much less marked undisplaced subchondral fracture in the lateral femoral condyle.

In the absence of trauma, spontaneous osteonecrosis of the knee should be considered.

Normal menisci.

Dr Jonathan Foley

Consultant Radiologist, RIE/SJH

jon.foley@nhslothian.scot.nhs.uk

Reporting Radiologist: Dr Jonathan GD Foley

**Report Information**

Requestor Phillips, Dr Sally Anne

Requesting Location (RIEOPD6) RIE OPD6 Outpatient Department

Report Identifier 21357564

Sample Date 03/08/2015 19:15:00

**MRI Knee Lt**

MRI Knee Lt

Clinical details

MRI Knee Lt

Left knee pain for last 6 months. No hx of trauma. Medial and lateral joint line. X-rays unremarkable. Meniscal?

Report

Both menisci are normal, as are the cruciate and collateral ligaments.

There is extensive oedema within the medial femoral condyle and an undisplaced subchondral fracture within the weight-bearing portion of the medial femoral condyle. Similar but much less marked findings are demonstrated within the weight-bearing portion of the lateral femoral condyle. The articular cartilage is well preserved throughout. There is a moderate sized knee joint effusion with a small amount of intra-articular debris.

Popliteus is normal, as are the quadriceps and patellar tendons and those of the pes anserinus and iliotibial tract.

Summary:

Undisplaced subchondral fracture within the medial femoral condyle with extensive bone marrow oedema.

Much less marked undisplaced subchondral fracture in the lateral femoral condyle.

In the absence of trauma, spontaneous osteonecrosis of the knee should be considered.

Normal menisci.

Dr Jonathan Foley

Consultant Radiologist, RIE/SJH

jon.foley@nhslothian.scot.nhs.uk

Reporting Radiologist: Dr Jonathan GD Foley

**Report Information**

Requestor Phillips, Dr Sally Anne

Requesting Location (RIEOPD6) RIE OPD6 Outpatient Department

Report Identifier 21357564

Sample Date 03/08/2015 19:15:00

**XR Knee Lt**

XR Knee Lt

Clinical details

XR Knee Lt

56 year old gentleman c/o worsening anterior knee pain. Symptomatically in keeping with degenerative OA. / Knee left

Report

Joint spaces are preserved with no effusion or intraarticular loose body.

Reporting Radiologist: Dr Li Wong

**Report Information**

Requestor BURNS, JOHN

Requesting Location Sighthill Red Medical Practice

Report Identifier 20141880

Sample Date 12/02/2015 16:22:00

**Report**

Clinical Summary

Mohs' microsurgery. BCC - UB50639/11.  
Provisional diagnosis: BCC 27/04/11 UB50639/11.

Specimen

Debulk Excision Right Nasal Alar Rim.

Macroscopy

A crescent shaped piece of skin measuring 14 x 7 x 3 mm maximum dimension. This has a pale rough surface. Four transverse sections all taken in one cassette.

Specimen trimmed by: Linda Green, BMS

Microscopy

Sections show part of a basal cell carcinoma . This appears to be of mixed nodular and micronodular subtype in this debulk specimen.

**Test Comments**

- (RPT) Pathologists :
- (RPT) Skin Pathology Team
- (RPT) Dr Marie Mathers

**Sample Comments**

Suffix Skin Bx

**Report Information**

Requestor (Locum), Dr Lisa Naysmith  
Requesting Location (RIEDERM) Dermatology, RIE  
Report Identifier UB071927E/11  
Sample Date 21/11/2011 10:45:00

Plasma glucose level				
Description	Value	Range	Unit	Normalcy Notes
Glucose	4.9		mmol/L	

**Sample Comments**

dickinson21315

**Report Information**

Requestor given, Not

Requesting Location (RIEAE2) 2 IC, A&E

Report Identifier HB099273K

Sample Date 27/08/2011 13:39:00

<b>Full blood count - FBC</b>
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FBC Unsuitable	Clotted specimen.
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**Sample Comments**

dickinson21315

**Report Information**

Requestor given, Not

Requesting Location (RIEAE2) 2 IC, A&E

Report Identifier HR058080S

Sample Date 27/08/2011 13:39:00

<b>Bone Group</b>				
<b>Description</b>	<b>Value</b>	<b>Range</b>	<b>Unit</b>	<b>Normalcy Notes</b>
Calcium	2.57	2.1 2.6	mmol/L	
Adjustd Calcium	2.47	2.1 2.6	mmol/L	
Albumin	45	35 50	g/L	

**Sample Comments**

dickinson21315

<b>Liver function tests</b>				
<b>Description</b>	<b>Value</b>	<b>Range</b>	<b>Unit</b>	<b>Normalcy Notes</b>
Bilirubin	9	3 - 16	umol/L	
ALT	21	10 - 50	U/L	
Alk.Phos	85	40 - 125	U/L	

**Sample Comments**

dickinson21315

<b>Urea and electrolytes</b>				
<b>Description</b>	<b>Value</b>	<b>Range</b>	<b>Unit</b>	<b>Normalcy Notes</b>
Urea	3.1	2.5 6.6	mmol/L	
Creatinine	61	60 120	umol/L	
eGFR (/1.73m2)	>60			
Sodium	138	135 145	mmol/L	
Potassium	4.2	3.6 5.0	mmol/L	
TCO2	<b>21</b>	<b>22 - 30</b>	<b>mmol/L</b>	<b>R</b>

**Sample Comments**

dickinson21315

<b>Serum lipids</b>				
<b>Description</b>	<b>Value</b>	<b>Range</b>	<b>Unit</b>	<b>Normalcy Notes</b>
Cholesterol	<b>5.2</b>		<b>mmol/L</b>	<b>A</b>

**Sample Comments**

dickinson21315

**Report Information**

Requestor given, Not  
 Requesting Location (RIEAE2) 2 - IC, A&E  
 Report Identifier HB099269L  
 Sample Date 27/08/2011 13:39:00

**Report**

Clinical Summary

6 month history of growing ulcer.  
Provisional diagnosis: BCC.

Specimen

4 mm punch right nostril.

Macroscopy

The specimen consists of a punch biopsy of skin measuring 3 mm in diameter and 3 mm in depth. One all taken in one cassette with levels.

Specimen trimmed by: Linda Green, BMS.

Microscopy

Skin punch biopsy from the right nostril:

Part of a nodular and micronodular basal cell carcinoma.

**Test Comments**

- (RPT) Pathologists :
- (RPT) Skin Pathology Team
- (RPT) Dr Thomas Brenn

**Sample Comments**

Suffix Skin Bx

**Report Information**

Requestor Rees, Prof J L  
Requesting Location (RIEDERM) Dermatology, RIE  
Report Identifier UB050639Q/11  
Sample Date 15/04/2011 10:09:00

Full blood count - FBC				
Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	151	130 180	g/l	
Red cell count	5.10	4.5 6.5	x10 <sup>12</sup> /l	
Haematocrit	0.455	0.400 0.540	ratio	
Mean cell volume	89	78 98	fl	
Mean cell Hb.	29.6	27.0 32.0	pg	
Mean cell Hb conc.	33.2	31.0 35.0	g/dl	
White cell count	<b>13.6</b>	<b>4.0 - 11.0</b>	<b>x10<sup>9</sup>/l</b>	<b>R</b>
Neutrophil Count	<b>7.82</b>	<b>2.0 - 7.5</b>	<b>x10<sup>9</sup>/l</b>	<b>R</b>
Lymphocyte Count	<b>4.23</b>	<b>1.5 - 4.0</b>	<b>x10<sup>9</sup>/l</b>	<b>R</b>
Monocyte Count	<b>0.84</b>	<b>0.2 - 0.8</b>	<b>x10<sup>9</sup>/l</b>	<b>R</b>
Eosinophil Count	<b>0.60</b>	<b>0.04 - 0.4</b>	<b>x10<sup>9</sup>/l</b>	<b>R</b>
Basophil Count	0.08	0.01 0.1	x10 <sup>9</sup> /l	
Platelet count	336	150 350	x10 <sup>9</sup> /l	

#### Sample Comments

DR SCOTT/MCWHIRTER

#### Requestor Comments

None given

#### Report Information

Requestor Known, Cons Not

Requesting Location (REH6) Ward 6, Balcarres, REH

Report Identifier HR433880R

Sample Date 10/02/2011 05:00:00

**Thyroid function tests**

Description	Value	Range	Unit	Normalcy Notes
TSH	0.89	0.2 4.5	mU/L	
Free T4	13	9 21	pmol/L	

**Sample Comments**

DR SCOTT/MCWHIRTER

**Requestor Comments**

None given

**Liver function tests**

Description	Value	Range	Unit	Normalcy Notes
Bilirubin	4	3 - 16	umol/L	
ALT	22	10 - 50	U/L	
Alk.Phos	71	40 - 125	U/L	

**Sample Comments**

DR SCOTT/MCWHIRTER

**Requestor Comments**

None given

**Urea and electrolytes**

Description	Value	Range	Unit	Normalcy Notes
Urea	2.8	2.5 6.6	mmol/L	
Creatinine	<b>54</b>	<b>60 - 120</b>	<b>umol/L</b>	<b>R</b>
eGFR (/1.73m2)	>60			
Sodium	141	135 145	mmol/L	
Potassium	<b>5.8</b>	<b>3.6 - 5.0</b>	<b>mmol/L</b>	<b>R</b>
TCO2	23	22 30	mmol/L	

**Sample Comments**

DR SCOTT/MCWHIRTER

**Requestor Comments**

None given

**Report Information**

Requestor Known, Cons Not  
 Requesting Location (REH6) Ward 6, Balcarres, REH  
 Report Identifier HB476103Y  
 Sample Date 10/02/2011 05:00:00

**Plasma glucose level**

Description	Value	Range	Unit	Normalcy Notes
Glucose	5.1		mmol/L	
Glucose spec.	Random sample (<11 mmol/L)			

**Sample Comments**

DR SCOTT/MCWHIRTER

**Requestor Comments**

None given

**Report Information**

Requestor Known, Cons Not

Requesting Location (REH6) Ward 6, Balcarres, REH

Report Identifier HB476104W

Sample Date 10/02/2011 05:00:00

**Urine culture RIE****Set Comments**

Urine culture :

Sample unsuitable for flow cytometry

No growth

**Sample Comments**

21443..

**Report Information**

Requestor            Veiraiah, Dr Arvindan

Requesting Location (RIECAA6) AMU Bay 6

Report Identifier    MU493856L

Sample Date        24/12/2010 22:14:00

**Cardiac enzymes**

Description	Value	Range	Unit	Normalcy Notes
CK	87	55 - 170	U/L	

**Sample Comments**

21443 . .

**Urea and electrolytes**

Description	Value	Range	Unit	Normalcy Notes
Urea	<b>2.1</b>	<b>2.5 - 6.6</b>	<b>mmol/L</b>	<b>R</b>
Creatinine	60	60 - 120	umol/L	
eGFR (/1.73m2)	>60			
Sodium	141	135 - 145	mmol/L	
Potassium	4.4	3.6 - 5.0	mmol/L	
TCO2	25	22 - 30	mmol/L	

**Sample Comments**

21443 . .

**Report Information**

Requestor            Veiraiah, Dr Arvindan  
 Requesting Location (RIECAA6) AMU Bay 6  
 Report Identifier    HB142724E  
 Sample Date        24/12/2010 10:10:00

**Plasma glucose level**

Description	Value	Range	Unit	Normalcy Notes
Glucose	4.6		mmol/L	
Glucose spec.	Random sample (<11 mmol/L)			

**Report Information**

Requestor given, Not  
Requesting Location (RIEAE2) 2 IC, A&E  
Report Identifier HB142650L  
Sample Date 24/12/2010 02:32:00

Full blood count - FBC				
Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	142	130 180	g/l	
Red cell count	4.64	4.5 6.5	x10 <sup>12</sup> /l	
Haematocrit	0.417	0.400 0.540	ratio	
Mean cell volume	90	78 98	fl	
Mean cell Hb.	30.6	27.0 32.0	pg	
Mean cell Hb conc.	34.1	31.0 35.0	g/dl	
White cell count	7.8	4.0 11.0	x10 <sup>9</sup> /l	
Neutrophil Count	2.87	2.0 7.5	x10 <sup>9</sup> /l	
Lymphocyte Count	3.57	1.5 4.0	x10 <sup>9</sup> /l	
Monocyte Count	<b>0.91</b>	<b>0.2 - 0.8</b>	<b>x10<sup>9</sup>/l</b>	<b>R</b>
Eosinophil Count	0.34	0.04 0.4	x10 <sup>9</sup> /l	
Basophil Count	0.06	0.01 0.1	x10 <sup>9</sup> /l	
Platelet count	275	150 350	x10 <sup>9</sup> /l	

### Sample Comments

mackay .

### Report Information

Requestor given, Not

Requesting Location (RIEAE2) 2 IC, A&E

Report Identifier HR105115C

Sample Date 24/12/2010 02:32:00

Coagulation/bleeding test				
Description	Value	Range	Unit	Normalcy Notes
Prothrombin Time	11	10.5 13.5	s	
INR (Warfarin)	0.9			
APTT	31	26 36		
APTT Ratio (Heparin)	1.0	0.8 1.2		
Fibrinogen (Claus)	3.0	1.5 4.0	g/l	

**Sample Comments**

mackay .

**Report Information**

Requestor given, Not  
 Requesting Location (RIEAE2) 2 IC, A&E  
 Report Identifier HR105119J  
 Sample Date 24/12/2010 02:32:00

<b>Bone Group</b>				
Description	Value	Range	Unit	Normalcy Notes
Calcium	2.20	2.1 2.6	mmol/L	
Adjustd Calcium	2.16	2.1 2.6	mmol/L	
Albumin	42	35 50	g/L	

**Sample Comments**

mackay .

<b>Liver function tests</b>				
Description	Value	Range	Unit	Normalcy Notes
Bilirubin	6	3 - 16	umol/L	
ALT	19	10 - 50	U/L	
Alk.Phos	63	40 - 125	U/L	
GGT	<b>63</b>	<b>10 - 55</b>	<b>U/L</b>	<b>R</b>

**Sample Comments**

mackay .

<b>Urea and electrolytes</b>				
Description	Value	Range	Unit	Normalcy Notes
Urea	<b>1.7</b>	<b>2.5 - 6.6</b>	<b>mmol/L</b>	<b>R</b>
Creatinine	61	60 120	umol/L	
eGFR (/1.73m2)	>60			
Sodium	137	135 145	mmol/L	
Potassium	3.9	3.6 5.0	mmol/L	
TCO2	<b>19</b>	<b>22 - 30</b>	<b>mmol/L</b>	<b>R</b>

**Sample Comments**

mackay .

<b>Serum paracetamol level</b>	
Paracetamol	Not detected

**Sample Comments**

mackay .

<b>Serum salicylate level</b>	
Salicylate	Not detected

**Sample Comments**

mackay .

**Report Information**

Requestor given, Not  
 Requesting Location (RIEAE2) 2 IC, A&E  
 Report Identifier HB142654Q  
 Sample Date 24/12/2010 02:32:00

**Report**

Clinical Summary

Abdominal pain. Oesophagitis, hiatus hernia and duodenitis.

Specimen

Oesophagus at 35 cm.

Macroscopy

Four fragments.

Microscopy

Both squamous epithelium and gastric-type glandular mucosa, consistent with gastro-oesophageal junction, are included. The mucosa is inflamed and there is erosion of squamous epithelium, consistent with reflux. In addition, sparse helicobacteria are present on the surface of gastric mucosa. No dysplasia is seen.

Lower oesophagus (biopsy) - Inflamed gastro-oesophageal junction - Reflux oesophagitis and HP+ gastritis.

Medical Codes : Oesophagus - Inflammation

Medical Codes : Stomach - Inflammation

Medical Codes : Workload score - Workload score 1

**Sample Comments**

Suffix Oesophageal Bx

**Report Information**

Requestor Williamson, Nurse Pract. Lynn N

Requesting Location (RIEENDBR) RIE, Endoscopy/Bronch. Unit

Report Identifier UB018855D/10

Sample Date 02/08/2010 16:29:00

<b>Liver function tests</b>				
<b>Description</b>	<b>Value</b>	<b>Range</b>	<b>Unit</b>	<b>Normalcy Notes</b>
Bilirubin	5	3 16	umol/L	
ALT	24	10 50	U/L	
Alk.Phos	74	40 125	U/L	
GGT	50	10 55	U/L	

**Sample Comments**

Dr Ian Coulter FY2

<b>Serum paracetamol level</b>	
Paracetamol	Not detected

**Sample Comments**

Dr Ian Coulter FY2

**Report Information**

Requestor given, Not  
 Requesting Location (RIEAE2) 2 - IC, A&E  
 Report Identifier HB069142Z  
 Sample Date 27/07/2010 06:44:00

Liver function tests				
Description	Value	Range	Unit	Normalcy Notes
Bilirubin	3	3 16	umol/L	
ALT	16	10 50	U/L	
Alk.Phos	75	40 125	U/L	
GGT	33	10 55	U/L	
Albumin	37	35 50	g/L	

#### Sample Comments

haider A&E

Serum amylase level				
Description	Value	Range	Unit	Normalcy Notes
Amylase	14	0 - 100	U/L	

#### Sample Comments

haider A&E

Bone Group				
Description	Value	Range	Unit	Normalcy Notes
Calcium	2.29	2.1 2.6	mmol/L	
Phosphate	1.32	0.8 1.4	mmol/L	

#### Sample Comments

haider A&E

Urea and electrolytes				
Description	Value	Range	Unit	Normalcy Notes
Urea	2.5	2.5 - 6.6	mmol/L	
Creatinine	63	60 - 120	umol/L	
eGFR (/1.73m2)	>60			
Sodium	143	135 - 145	mmol/L	
Potassium	3.9	3.6 - 5.0	mmol/L	
TCO2	<b>21</b>	<b>22 - 30</b>	<b>mmol/L</b>	<b>R</b>

#### Sample Comments

haider A&E

Serum C reactive protein level				
Description	Value	Range	Unit	Normalcy Notes
C Reactive Prot	<b>6</b>	<b>0 - 5</b>	<b>mg/L</b>	<b>R</b>

#### Sample Comments

haider A&E

#### Report Information

Requestor given, Not  
 Requesting Location (RIEAE2) 2 IC, A&E  
 Report Identifier HB192389P  
 Sample Date 20/05/2010 05:30:00

Plasma glucose level				
Description	Value	Range	Unit	Normalcy Notes
Glucose	5.9		mmol/L	

**Sample Comments**

haider A&E

**Report Information**

Requestor given, Not

Requesting Location (RIEAE2) 2 IC, A&E

Report Identifier HB192390X

Sample Date 20/05/2010 05:30:00

Full blood count - FBC				
Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	142	130 180	g/l	
Red cell count	4.77	4.5 6.5	x10 <sup>12</sup> /l	
Haematocrit	0.421	0.400 0.540	ratio	
Mean cell volume	88	78 98	fl	
Mean cell Hb.	29.8	27.0 32.0	pg	
Mean cell Hb conc.	33.7	31.0 35.0	g/dl	
White cell count	7.4	4.0 11.0	x10 <sup>9</sup> /l	
Neutrophil Count	2.81	2.0 7.5	x10 <sup>9</sup> /l	
Lymphocyte Count	3.70	1.5 4.0	x10 <sup>9</sup> /l	
Monocyte Count	0.50	0.2 0.8	x10 <sup>9</sup> /l	
Eosinophil Count	0.34	0.04 0.4	x10 <sup>9</sup> /l	
Basophil Count	0.02	0.01 0.1	x10 <sup>9</sup> /l	
Platelet count	<b>355</b>	<b>150 - 350</b>	<b>x10<sup>9</sup>/l</b>	<b>R</b>

### Sample Comments

haider A&E

### Report Information

Requestor given, Not

Requesting Location (RIEAE2) 2 IC, A&E

Report Identifier HR171915P

Sample Date 20/05/2010 05:30:00

## US Abdomen

US Abdomen

Clinical details

RUQ Pain +++ Deranged LFT's. Normal CT KUB. ?Ductal Stone

Report

The left lobe of the liver is not clearly seen, it is presumably relatively small and lies under the costal margin.

The right liver shows normal parenchyma and no specific abnormality is seen in relation to it. No stones are seen in the gallbladder and the biliary tree is not dilated. The kidneys and spleen appear normal. The pancreas is obscured by bowel gas.

PLA/LO

Reporting Radiologist: Dr Paul Allan

### Report Information

Requestor

Requesting Location (RIE105) RIE Ward 105

Report Identifier 7455749

Sample Date 18/05/2010 16:10:00

**Sysmex tests LTG**

Epithelial cells : Few (MUEC)

**Test Comments**

(MUEC)

(MUEC) No Bacteriuria detected by Flow Cytometry

(MUEC)

**Sample Comments**

21077 . .

**Report Information**

Requestor Beaux, Mr Andrew de

Requesting Location (RIE107) RIE Ward 107

Report Identifier MU392641Q

Sample Date 17/05/2010 20:54:00

**CT KUB**

CT KUB

Clinical details

R sided flank and back pain. Severe ++, intermittent. Trace blood in urine. ?renal colic. Please also visualise aorta.

Report

Low dose technique. Allowing for this, there is no evidence of renal tract calcification. No evidence of hydronephrosis or hydroureter.

Unremarkable appearance to the colon, appendix and terminal ileum.

No free fluid or lymphadenopathy. No free gas.

Normal aorta.

No further significant finding.

Conclusion

Normal examination. No cause for symptoms identified.

FJP/CB

Reporting Radiologist: Fergus J Perks

**Report Information**

Requestor

Requesting Location (RIE107) RIE Ward 107

Report Identifier 7448735

Sample Date 17/05/2010 15:00:00

**XR Chest**

XR Chest

Clinical details

upper abdo pain ?perf

Report

Normal mediastinal contours. Lungs clear.

WC/JW

Reporting Radiologist: Dr Webster Chirambasukwa

**Report Information**

Requestor

Requesting Location (RIEAE2) 2 IC, A&E

Report Identifier 7447422

Sample Date 16/05/2010 14:02:00

**Urine culture RIE****Set Comments**

Urine culture :

Insufficient volume for Flow Cytometry

No significant growth

**Sample Comments**

d cullerton

**Report Information**

Requestor given, Not

Requesting Location (RIEAE2) 2 IC, A&E

Report Identifier MU392284X

Sample Date 16/05/2010 13:31:00

**Full blood count - FBC**

Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	150	130 180	g/l	
Red cell count	4.96	4.5 6.5	x10 <sup>12</sup> /l	
Haematocrit	0.435	0.400 0.540	ratio	
Mean cell volume	88	78 98	fl	
Mean cell Hb.	30.2	27.0 32.0	pg	
Mean cell Hb conc.	34.5	31.0 35.0	g/dl	
White cell count	9.0	4.0 11.0	x10 <sup>9</sup> /l	
Neutrophil Count	5.23	2.0 7.5	x10 <sup>9</sup> /l	
Lymphocyte Count	2.93	1.5 4.0	x10 <sup>9</sup> /l	
Monocyte Count	0.61	0.2 0.8	x10 <sup>9</sup> /l	
Eosinophil Count	0.20	0.04 0.4	x10 <sup>9</sup> /l	
Basophil Count	0.04	0.01 0.1	x10 <sup>9</sup> /l	
Platelet count	335	150 350	x10 <sup>9</sup> /l	

**Sample Comments**

d cullerton

**Report Information**

Requestor given, Not

Requesting Location (RIEAE2) 2 IC, A&E

Report Identifier HR170629J

Sample Date 16/05/2010 13:10:00

<b>Bone Group</b>				
Description	Value	Range	Unit	Normalcy Notes
Calcium	2.41	2.1 2.6	mmol/L	
Phosphate	1.20	0.8 1.4	mmol/L	
Albumin	41	35 50	g/L	

**Sample Comments**

d cullerton

<b>Liver function tests</b>				
Description	Value	Range	Unit	Normalcy Notes
Bilirubin	6	3 - 16	umol/L	
ALT	18	10 - 50	U/L	
Alk.Phos	74	40 - 125	U/L	
GGT	37	10 - 55	U/L	

**Sample Comments**

d cullerton

<b>Serum amylase level</b>				
Description	Value	Range	Unit	Normalcy Notes
Amylase	13	0 100	U/L	

**Sample Comments**

d cullerton

<b>Urea and electrolytes</b>				
Description	Value	Range	Unit	Normalcy Notes
Urea	<b>1.8</b>	<b>2.5 - 6.6</b>	<b>mmol/L</b>	<b>R</b>
Creatinine	75	60 - 120	umol/L	
eGFR (/1.73m2)	>60			
Sodium	140	135 - 145	mmol/L	
Potassium	3.7	3.6 - 5.0	mmol/L	
TCO2	<b>21</b>	<b>22 - 30</b>	<b>mmol/L</b>	<b>R</b>

**Sample Comments**

d cullerton

<b>Serum C reactive protein level</b>				
Description	Value	Range	Unit	Normalcy Notes
C Reactive Prot	2	0 5	mg/L	

**Sample Comments**

d cullerton

<b>Cardiac enzymes</b>				
Description	Value	Range	Unit	Normalcy Notes
Troponin I	<0.05	0 - 0.05	ug/L	M (BTROP)
<b>Test Comments</b>				
(BTROP)	Note revised lower cut-off for Troponin. Further			
(BTROP)	information on intranet: Laboratories in healthcare A-Z			

**Sample Comments**

d cullerton

**Report Information**

Requestor given, Not  
 Requesting Location (RIEAE2) 2 - IC, A&E  
 Report Identifier HB190936C  
 Sample Date 16/05/2010 13:10:00

**Plasma glucose level**

Description	Value	Range	Unit	Normalcy Notes
Glucose	6.5		mmol/L	

**Sample Comments**

d cullerton

**Report Information**

Requestor given, Not

Requesting Location (RIEAE2) 2 IC, A&E

Report Identifier HB190937T

Sample Date 16/05/2010 13:10:00

**Blood haematinic levels**

Description	Value	Range	Unit	Normalcy Notes
Vitamin B12	267	200 900	ng/L	
Serum Folate	5.0	5 20	ug/L	

**Report Information**

Requestor Heggie, Dr LJ  
Requesting Location (GSBONC) ANC Strathesk Medical Group Bonnyrigg  
Report Identifier HB810345A  
Sample Date 14/04/2009 08:45:00

<b>Full blood count - FBC</b>				
<b>Description</b>	<b>Value</b>	<b>Range</b>	<b>Unit</b>	<b>Normalcy Notes</b>
Haemoglobin	142	130 180	g/l	
Red cell count	4.76	4.5 6.5	x10 <sup>12</sup> /l	
Haematocrit	0.421	0.400 0.540	ratio	
Mean cell volume	88	78 98	fl	
Mean cell Hb.	29.8	27.0 32.0	pg	
Mean cell Hb conc.	33.7	31.0 35.0	g/dl	
White cell count	<b>17.4</b>	<b>4.0 - 11.0</b>	<b>x10<sup>9</sup>/l</b>	<b>R</b>
Neutrophil Count	<b>12.28</b>	<b>2.0 - 7.5</b>	<b>x10<sup>9</sup>/l</b>	<b>R</b>
Lymphocyte Count	3.68	1.5 4.0	x10 <sup>9</sup> /l	
Monocyte Count	<b>1.00</b>	<b>0.2 - 0.8</b>	<b>x10<sup>9</sup>/l</b>	<b>R</b>
Eosinophil Count	0.38	0.04 0.4	x10 <sup>9</sup> /l	
Basophil Count	0.08	0.01 0.1	x10 <sup>9</sup> /l	
Platelet count	<b>394</b>	<b>150 - 350</b>	<b>x10<sup>9</sup>/l</b>	<b>R</b>
<b>Erythrocyte sedimentation rate</b>				
<b>Description</b>	<b>Value</b>	<b>Range</b>	<b>Unit</b>	<b>Normalcy Notes</b>
ESR	<b>17</b>	<b>1 - 10</b>	<b>mm/hr</b>	<b>R</b>

#### Report Information

Requestor Combe, Dr JR  
 Requesting Location (GSBONC) ANC Strathesk Medical Group Bonnyrigg  
 Report Identifier HR883579Q  
 Sample Date 29/01/2009 12:40:00

Thyroid function test				
Description	Value	Range	Unit	Normalcy Notes
TSH	0.36	0.2 4.5	mU/L	
Free T4	11	9 21	pmol/L	
Liver function test				
Description	Value	Range	Unit	Normalcy Notes
Bilirubin	6	3 - 16	umol/L	
ALT	21	10 - 50	U/L	
Alk.Phos	88	40 - 125	U/L	
GGT	45	10 - 55	U/L	
Albumin	45	35 - 50	g/L	
Urea and electrolytes				
Description	Value	Range	Unit	Normalcy Notes
Urea	3.3	2.5 6.6	mmol/L	
Creatinine	64	60 120	umol/L	
eGFR (/1.73m2)	>60			
Sodium	140	135 145	mmol/L	
Potassium	4.4	3.6 5.0	mmol/L	
Blood haematinic levels				
Description	Value	Range	Unit	Normalcy Notes
Vitamin B12	242	200 - 900	ng/L	(H.B12)
Serum Folate	<b>4.8</b>	<b>5 - 20</b>	<b>ug/L</b>	<b>R</b> (H.SF)
Test Comments				
(H.B12)	Note borderline B12.Suggest repeat in 12 weeks			
(H.SF)	Note Borderline serum folate			

#### Report Information

Requestor Combe, Dr JR  
 Requesting Location (GSBONC) ANC Strathesk Medical Group Bonnyrigg  
 Report Identifier HB744995B  
 Sample Date 29/01/2009 12:40:00

**Full blood count - FBC**

Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	138	130 180	g/l	
Red cell count	4.63	4.5 6.5	x10 <sup>12</sup> /l	
Haematocrit	0.406	0.400 0.540	ratio	
Mean cell volume	88	78 98	fl	
Mean cell Hb.	29.8	27.0 32.0	pg	
Mean cell Hb conc.	34.0	31.0 35.0	g/dl	
White cell count	9.7	4.0 11.0	x10 <sup>9</sup> /l	
Neutrophil Count	3.96	2.0 7.5	x10 <sup>9</sup> /l	
Lymphocyte Count	<b>4.31</b>	<b>1.5 - 4.0</b>	<b>x10<sup>9</sup>/l</b>	<b>R</b>
Monocyte Count	<b>0.82</b>	<b>0.2 - 0.8</b>	<b>x10<sup>9</sup>/l</b>	<b>R</b>
Eosinophil Count	<b>0.58</b>	<b>0.04 - 0.4</b>	<b>x10<sup>9</sup>/l</b>	<b>R</b>
Basophil Count	0.06	0.01 0.1	x10 <sup>9</sup> /l	
Platelet count	<b>358</b>	<b>150 - 350</b>	<b>x10<sup>9</sup>/l</b>	<b>R</b>

**Set Comments**

RBC's anisocytic normochromic

**Requestor Comments**

DVLA assessment

**Report Information**

Requestor Ayles, Dr Anthony CM

Requesting Location (GSHERA) ANC Hermitage Medical Practice

Report Identifier HR874028P

Sample Date 06/01/2009 08:30:00

**Liver function test**

Description	Value	Range	Unit	Normalcy Notes
ALT	20	10 50	U/L	
AST	22	10 45	U/L	
GGT	42	10 55	U/L	

**Requestor Comments**

DVLA assessment

**Report Information**

Requestor Ayles, Dr Anthony CM

Requesting Location (GSHERA) ANC Hermitage Medical Practice

Report Identifier HB721133S

Sample Date 06/01/2009 08:30:00

<b>Liver function test</b>				
<b>Description</b>	<b>Value</b>	<b>Range</b>	<b>Unit</b>	<b>Normalcy Notes</b>
Bilirubin	4	3 16	umol/L	
ALT	17	10 50	U/L	
Alk.Phos	77	40 125	U/L	
GGT	29	10 55	U/L	
Albumin	44	35 50	g/L	

**Requestor Comments**

Alcohol excess?

<b>Serum amylase level</b>				
<b>Description</b>	<b>Value</b>	<b>Range</b>	<b>Unit</b>	<b>Normalcy Notes</b>
Amylase	23	0 - 100	U/L	

**Requestor Comments**

Alcohol excess?

<b>Urea and electrolytes</b>				
<b>Description</b>	<b>Value</b>	<b>Range</b>	<b>Unit</b>	<b>Normalcy Notes</b>
Urea	3.2	2.5 6.6	mmol/L	
Creatinine	84	60 120	umol/L	
Sodium	142	135 145	mmol/L	
Potassium	4.2	3.6 5.0	mmol/L	
TCO2	22	22 30	mmol/L	

**Requestor Comments**

Alcohol excess?

**Report Information**

Requestor            Known, Cons Not  
 Requesting Location (RIEAE) RIE Accident & Emergency  
 Report Identifier    HB147415G  
 Sample Date        28/07/2005 20:11:00

Full blood count - FBC				
Description	Value	Range	Unit	Normalcy Notes
Basophil Count	0.04	0.01 0.1	x10 <sup>9</sup> /l	
Eosinophil Count	0.36	0.04 0.4	x10 <sup>9</sup> /l	
Haemoglobin	147	130 180	g/l	
Haematocrit	0.429		ratio	
Lymphocyte Count	3.74	1.5 4.0	x10 <sup>9</sup> /l	
Mean cell Hb.	30.4	27.0 32.0	pg	
Mean cell Hb conc.	34.3	31.0 35.0	g/dl	
Mean cell volume	89	78 98	fl	
Monocyte Count	0.60	0.2 0.8	x10 <sup>9</sup> /l	
Neutrophil Count	2.91	2 7.5	x10 <sup>9</sup> /l	
Platelet count	278	150 350	x10 <sup>9</sup> /l	
Red cell count	4.83	4.5 6.5	x10 <sup>12</sup> /l	
White cell count	7.7	4.0 11.0	x10 <sup>9</sup> /l	

#### Requestor Comments

Alcohol excess?

#### Report Information

Requestor Known, Cons Not

Requesting Location (RIEAE) RIE Accident & Emergency

Report Identifier HR032256T

Sample Date 28/07/2005 20:11:00