A&E Records

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E5975610
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E5975610

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Emergency Care Note Episode/Ref: E5975610 A+E Nurse SJH 3/14/25 09:03 Fiona Kennie (NMR)	This patient presented to the emergency department today with left foot inj and following Triage assessment they were signposted to a more appropriate service (see below). Signposting leaflet detailing how to access alternative services was provided. Additional relevant information (optional): Kind regards, F Kennie S/N Signposting to community services include the following: Signposting to Minor Injury Unit (MIU) Signposting feedback could be provided to St John's Hospital Emergency Department using the following contact details: Email: loth.sjhedsignposting@nhslothian.scot.nhs.uk Professional-to-professional phone number: 07814765812 Any queries please contact A&E Reception on 01506 523011

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr McNutt
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 14/03/2025

Emergency Discharge Summary

Patient	Gillian McAteer Flat 1 Carron Court Bathgate EH48 2QF	**CHI**	**2305821425**
		Date of Birth / Age	23/05/1982 (42 years)
		UHPI	800325165E
		A&E Attendance Number	E5975610
Attendance Date	14/03/2025		
Attendance Time	08:48		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	14/03/2025		
Discharge To		**Final Triage**	8 - Suitable for redirection
		Attendances in the last 12 months	2

Dear Dr McNutt

Presentation: left foot inj. FK 0900
Diagnosis: Redirected to alternative community service
Procedures: None

This patient presented to the emergency department today with left foot inj and following Triage assessment they were signposted to a more appropriate service (see below).

Signposting leaflet detailing how to access alternative services was provided.

Additional relevant information (optional):

Kind regards,

F Kennie S/N

Signposting to community services include the following:

Signposting to Minor Injury Unit (MIU)

Signposting feedback could be provided to St Johns Hospital Emergency Department using the following contact details:

Email: loth.sjhedsignposting@nhslothian.scot.nhs.uk

Professional-to-professional phone number: 07814765812

Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

A+E Nurse SJH, Nurse

NHS Lothian

St John's Hospital at Howden
Accident and Emergency Department
Howden Road West
Livingston
West Lothian EH54 6PP

Accident and Emergency

Dr McNutt
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 14/03/2025

Outpatient Clinic Letter

Patient	Gillian McAteer Flat 1 Carron Court Bathgate EH48 2QF	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (42 years) 800325165E
Attendance Date	14/03/2025		
Consultant	SJH MIU		

Dear Dr McNutt

PC - Left foot injury
HPC - 1/7, tripped over a wire in bedroom and describes inverting ankle. Complaining of pain and swelling since. Mobile and weight bearing with limp. Taken paracetamol since injury.

PMH - Nil
Meds - Antidepressants
Allergies - Nil known

O/E Left foot - Swollen, bruised med and lat mal, no deformity, skin intact. Bony tender posterior and tip lat mal and 3rd to 5th mt, nvi distally. Cap refill <2secs. FROM - no laxity.
No bony tenderness, swelling or deformity to Left knee, fib head, med mal, achilles, calcaneum, 1st to 2nd mt or toes.

X-ray Left foot/ankle - No bony injury noted.

Imp - Sprain

Management - ankle sti advice given (written and verbal), regular otc analgesia advised, elevate limb, supportive footwear recommended, to return if further concerns.

NHS Lothian - Referral Letter

Referral To	St John's Hospital Flow Centre Referral LI Flow Centre Referral
Urgency of referral	Urgent
Date of referral	01/10/2024
Date submitted	01/10/2024
UCPN	101034360583K

PATIENT DETAILS

CHI number:	2305821425
Name:	MISS GILLIAN MCATEER
Date of birth:	23/05/1982
Sex:	Female

Contact Details

1 CARRON COURT
SOUTH LOCH PARK
BATHGATE
EH48 2QF

Voice (Mobile) : 07562628486

REFERRING PRACTITIONER DETAILS

Name:	Dr. Andrew McNutt (GMC: 3327924)
Practice:	Simpson Medical Group (78132)
Phone:	Voice : 01506 654444

Practice address

Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

CLINICAL INFORMATION

Reason for Referral:	exacerbation of copd
Main Referral Text:	thank you for reviewing this 42 year old who is awaiting ix for possible copd. she has been unwell for 5 days with fever, sob, wheeze. she was given doxycyline in ooh 2 days ago, but feeling worse. she is using salbutamol multiple times per day. o/e /e sats 99% HR 77 BP 152/106 HR 24 26. looks sob.chest clear, no wheeze. no ankle oedema tmep 38.1 I suspect she has a viral infection, but on the account on her sob I would be grateful if she was seen. E Green

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
COVID-19 confirmed by laboratory test			14/10/2021	14/10/2021
Glue ear	New event	bilateral plus retraction.	17/02/2021	17/02/2021
Nasal congestion			17/02/2021	17/02/2021
Menorrhagia		[TRUNCATED]heavy periods over past year - lasting up to 10 days, previously every 28 days but over past 2/12 coming very 2 wks so only small break between, struggling to get smear done, bleeding sta	21/03/2014	21/03/2014
Low mood		[TRUNCATED]stopped fluox 2 weeks ago as felt getting too fat with it, mood low, struggling to cope with kids alone, now with family /friends for 1 week, referred to swd by ooh last night she says, a	04/06/2013	04/06/2013
Rapid expulsion of placenta			05/09/2012	05/09/2012
Anaemia during pregnancy, childbirth and the puerperium			05/09/2012	05/09/2012
Caesarean delivery		female	05/09/2012	05/09/2012
[X]Unspecified fall			08/10/2011	08/10/2011
Head injury		admitted overnight for observation	08/10/2011	08/10/2011

Head injury		08/10/2011	08/10/2011
Finger fracture	left ring	06/08/2008	06/08/2008
Otitis media NOS	right	24/05/2007	24/05/2007
Dyspepsia		30/05/2005	30/05/2005
Normal delivery in a completely normal case		19/10/2004	19/10/2004
[X]Mental and behav disorders assoc with the puerperium NEC		13/01/2004	13/01/2004
Normal delivery in a completely normal case	Female	09/05/2003	09/05/2003
Female pelvic inflammatory diseases		09/10/2000	09/10/2000
Nondependent alcohol abuse	and drug abuse	13/03/1999	13/03/1999
Haemorrhoids		11/02/1999	11/02/1999
Acute tonsillitis		11/02/1999	11/02/1999
[X]Intentional self poisoning/exposure to noxious substances	ectasy,hash alcohol	14/03/1998	14/03/1998
Misuse of drugs NOS		14/03/1998	14/03/1998
Child on protection register		29/06/1993	29/06/1993
Maltreatment syndromes		29/06/1993	29/06/1993
Fracture of clavicle		25/01/1987	25/01/1987
Intussusception	surgery	01/12/1982	01/12/1982

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Septoplasty of nose NEC			19/12/2017	19/12/2017
Insertion of grommet	bilateral		24/01/2015	24/01/2015
Contraception	Claim expiry date: 27/12/1997. NOTES: SCHERING PC4.		27/12/1996	27/12/1996

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Sertraline 100mg tablets	tablet	2 TABLET(S) DAILY		08/12/2016		25/09/2024
Chlorpromazine 50mg tablets	tablet	TAKE 1 AT NIGHT		08/12/2016		25/09/2024

Clinical warnings

Allergies

Description	Comment	Modifier	Start Date	Recorded Date
Adverse reaction to amoxycillin	Drug code for allergy: Amoxicillin 250mg capsules, Reaction type: Allergy, Certainty of allergy: Likely, Severity of allergy: Moderate.		26/06/2014	26/06/2014
URTICARIA			13/09/1996	13/09/1996

Additional information

Patient Weight in Kilograms:107.955
Patient Height in Metres:1.676
Patient BMI:38.4
Patient Blood Pressure (Systolic):145
Patient Blood Pressure (Diastolic):96
Smoking history (Screening):Cigarette smoker Date Recorded:25-Apr-2024
Smoking history (Encounters):Cigarette smoker Date Recorded:25-Apr-2024
Alcohol history (Screening):Drinks occasionally Date Recorded:25-Apr-2023
Alcohol history (Encounters):Drinks occasionally Date Recorded:25-Apr-2023
Exercise history (Screening):Exercise grading Date Recorded:19-Oct-1999
Exercise history (Encounters):Exercise grading Date Recorded:19-Oct-1999

NHS Lothian

Immediate Outpatient Letter

Serial number 1007955

IN CONFIDENCE

Hospital : SJH Department : RESP Consultant : Nicole

Name and address of General Practitioner	Mr/Mrs/Miss Surname: First Name: Address: **Weight (where applicable)**
Dr Mcnair Loan Mc	800325165E /E5825069 F MCATEER Gillian Imogen 23-May-82 CHI: 230 582 1425 78132 AP McNutt Flat 1 West Lothian S/D EH48 2QF

Your patient attended the clinic on: 1/10/14

Recommendations/comments:

Likely exacerbation of diagnosed COPD.

Follow-up advice: To attend hospital for further review in _____

To attend GP surgery Y / N

Follow-up required Y / N

Medication: The following medicines are recommended. Only those items that must be initiated immediately have been provided from the hospital pharmacy, as indicated under the 'Quantity to be provided' section.

Pharmacy use:

Medicine and Form	Dose	Administration Times	Additional Instructions (including length of treatment course)	Quantity to be provided *	LIF **	Dispensed/ Issued by:	Checked by:
1. PREDNISOLONE	40mg	1 am		5 days			
2. PARACETAMOL	1 g	4 daily	1 week				
3.							
4.							
5.							
6.							

N.B. * A 14 day supply should be provided from the hospital if required unless a shorter or longer course is appropriate.

** Tick the box if the medicine is not on the Lothian Joint Formulary, and include an explanatory note for non-Formulary medicines under Recommendations/comments.

Prescribed by : _____ (sign) Date : 1/10/14

Nicole (print)

Contact for advice : _____ Tel/bleep no. : _____

WHITE COPY - TO PHARMACY *PINK COPY - G.P.* *BLUE COPY - CASENOTES*

RIE 334

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E4885286
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E4885286

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Emergency Care Note Episode/Ref: E4885286 Dr Jacob Phillip Salkin 11/27/21 17:13 Dr Jacob Salkin	IMPRESSION/DIFFERENTIAL DIAGNOSIS: No abnormality detected CLINICAL NOTES: Clinical note: 27/11/2021 15:03 39F PC: R eye injury HPC: Was punched in the eye 1 week previously whilst at an event. Since then developed right behind the eye pressure 3 days previously which has been gradually worsening. Also feels pain around the right eye and in her right forehead. Blurry vision but no overt changes in vision. Says that paracetamol takes the edge off. Also feels that she can see floaters in her vision (multiple small stars when she bends down). No previous eye problems. Following her injury developed periorbital bruising and swelling (which has now mostly settled). Denise vomitting, loss of consciousness or changes to sensation/weakness. PMH: Previous septoplasty in 2017 DH: Sertralline SH: Not currently working, Smokes and drinks alcohol O/E: Normal visual acuity (6/6) in both eyes Right eye conjunctival redness Normal affferant pupilliary reflexes and PEARL Oxybuprocaine applied and fluroscein dye given No foreign body seen on examination of right eye. Normal eye movements, no nystagmus or double vision. No signs of swelling or bruising seen periorbitally. X-ray facial bones: No signs of orbital floor fracture Examined + X-ray reviewed + D/W Dr Stevenson (ED consultant) Normal eye movements NAD with opthalmoscope D/W Kyle (Opthalmology registrar at the Royal) ?Blunt trauma uveitis Would like to see Gillian in the Eye Pavillion in Edinburgh at 11:30am tomorrow for review. Ward E2. I have advised Gillian to speak to NHS 24 if worsening symptoms/reduced vision for further advice.

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr McNutt
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 27/11/2021

Emergency Discharge Summary

Patient	Gillian McAteer Flat 1 Carron Court Bathgate EH48 2QF	**CHI**	**2305821425**
		Date of Birth / Age	23/05/1982 (39 years)
		UHPI	800325165E
		A&E Attendance Number	E4885286
Attendance Date	27/11/2021		
Attendance Time	14:24		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	27/11/2021		
Discharge To	Eye Clinic	**Final Triage**	4 - Standard
		Attendances in the last 12 months	1

Dear Dr McNutt

Presentation: r eye inj was punched in eye 1/52 ago increased pain although taking regular paracetamol sensitive light no vision disturbance kgray 14.37
Diagnosis: No abnormality detected
Procedures: None
Drugs given in A&E: None
Discharge Drugs:

IMPRESSION/DIFFERENTIAL DIAGNOSIS:

No abnormality detected

CLINICAL NOTES:
Clinical note: 27/11/2021
15:03

39F

PC: R eye injury

HPC: Was punched in the eye 1 week previously whilst at an event.
Since then developed right behind the eye pressure 3 days previously which has been gradually worsening. Also feels pain around the right eye and in her right forehead.

Blurry vision but no overt changes in vision.
Says that paracetamol takes the edge off. Also feels that she can see floaters in her vision (multiple small stars when she bends down).
No previous eye problems.
Following her injury developed periorbital bruising and swelling (which has now mostly settled).
Denise vomitting, loss of consciousness or changes to sensation/weakness.

PMH: Previous septoplasty in 2017

DH: Sertralline

SH: Not currently working, Smokes and drinks alcohol

O/E: Normal visual acuity (6/6) in both eyes
Right eye conjunctival redness
Normal affferant pupilliary reflexes and PEARL
Oxybuprocaine applied and fluroscein dye given
No foreign body seen on examination of right eye.
Normal eye movements, no nystagmus or double vision.
No signs of swelling or bruising seen periorbitally.

X-ray facial bones: No signs of orbital floor fracture

Examined + X-ray reviewed + D/W Dr Stevenson (ED consultant)

Normal eye movements
NAD with opthalmoscope

D/W Kyle (Opthalmology registrar at the Royal)

?Blunt trauma uveitis

Would like to see Gillian in the Eye Pavillion in Edinburgh at 11:30am tomorrow for review. Ward E2.

I have advised Gillian to speak to NHS 24 if worsening symptoms/reduced vision for further advice.

Yours Sincerely,

Dr Jacob Phillip Salkin, Doctor

NHS LOTHIAN
Emergency Department
Adult Majors
Prescription, Administration & Observation Record

NHS Lothian

Addressograph
Name: Gillian Mcatee
DOB: 23/05/1982
CHI: 230582 1425

The section below must be completed before any medicine is prescribed/given

Previous Adverse Reactions	NKDA	Weight kgs Actual / Estimate	Date

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)
1647 27/11	Co-Codamol	30/500	1-2 QDS PRN	ORAL	30	5 days	JACOB SALKIN		

National Early Warning Score 2 (NEWS2) Chart

NEWS Key 0 1 2 3																				
	Date:																			
	Time:																			
A+B Respirations Breaths/min	≥25									3										
	21-24									2										
	18-20																			
	15-17																			
	12-14																			
	9-11									1										
	≤8									3										
A+B SpO_2 Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%	≥96																			
	94-95									1										
	92-93									2										
	≤91									3										
SpO_2 Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure * **ONLY** use Scale 2 under the direction of a qualified clinician	≥97 on O_2									3										
	95-96 on O_2									2										
	93-94 on O_2									1										
	≥93 on air																			
	88-92																			
	86-87									1										
Tick box if using SpO_2 Scale 2 ☐	84-85									2										
Sign:	≤83									3										
Air or Oxygen? Oxygen is a drug and prescribed by target range	A = Air																			
	O^2 L/min or %									2										
	Device																			
C Blood Pressure mmHg Score uses Syntolic BP only If manual BP mark as M	≥220									3										
	201-219																			
	181-200																			
	161-180																			
	141-160																			
	121-140																			
	111-120																			
	101-110									1										
	91-100									2										
	81-90									3										
	71-80																			
	61-70																			
	51-60																			
	≤50																			
C Pulse Beats/min Manual pulse	≥131									3										
	121-130									2										
	111-120																			
	101-110									1										
	91-100																			
	81-90																			
	71-80																			
	61-70																			
	51-60																			
	41-50									1										
	31-40									3										
	≤30																			
D Consciousness Score for new onset of confusion (no score if chronic)	Alert																			
	New Confusion									3										
	V																			
	P																			
	U																			
E Temperature °C	≥39.1°									2										
	38.1-39.0°									1										
	37.1-38.0°																			
	36.1-37.0°																			
	35.1-36.0°									1										
	≤35.0°									3										
NEWS TOTAL																				
Monitoring frequency																				
Escalation of care Y/N																				
Blood Glucose reading or N/A																				
Pain score (0-10)																				
Initials																				

Reproduced from Royal College of Physicians. National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS. Updated report of a working party. London: RCP, 2017.

NEWS of 5 or more?
Think Sepsis!

In a patient with a **NEWS of 5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Signs of Infection

- Temperature <36°c or >38°c
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Blood sugar >7.7 in non-diabetic

Addressograph

Name:

DOB:

CHI:

NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Special Instructions		

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

		Date		
		Time		
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4	Eyes closed by swelling = C
		To speech	3	
		To pain	2	
		None	1	
	Best Verbal Response	Orientated	5	Endotracheal tube or tracheostomy = T
		Confused	4	
		Inappropriate words	3	
		Incomprehensible sounds	2	
		None	1	
	Best Motor Response	Obey commands	6	Always record the best arm response
		Localise to pain	5	
		Flexion to pain	4	
		Abnormal flexion	3	
		Extension to pain	2	
		None	1	
		Total GCS Score		
	Right Pupil	Size		+ reacts - no reaction c. eye closed
		Reaction		
	Left Pupil	Size		
		Reaction		
LIMB MOVEMENT	ARMS	Normal power		Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
	LEGS	Normal power		
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
		Initials		

Pupil Scale mm 1 • 2 ● 3 ● 4 ● 5 ● 6 ● 7 ● 8 ●

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	**IV Line(s)**	**Oral Input**		**Input**		**Urine**		**Gastric**	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E3357755
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E3357755

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Emergency Care Note Episode/Ref: E3357755 Dr Anton Z Barrington 9/2/16 13:16 Michael Smith	Psychiatric diagnoses:,- depression,- previous alcohol and substance misuse with inpatient detox,- multiple acute social stressors,,Current psychiatric medication,- sertraline 150mg OD,- diazepam 2mg PRN up to TDS,,Plan:,- short course of PRN chlorpromazine to aid sleep,- refer to ACAST for crisis support and assessment,- please could you arrange for her to have an appointment with Dr Heath if possible,,Dear Doctor,,,I saw Mrs McAteer in SJH A&E on 02/09/16. She presents with suicidal ideation in the context of multiple social stressors.,,Currently her mood is low, sleep is very poor, and she is eating erratically - this is exacerbated by her dependence at present on the local food bank, and she has been prioritising the nutrition of her 4 year old daughter.,, Over the past week and a half she has been feeling What is the point of being here and ruminating about taking an overdose to go to sleep and get away from my problems. She says that she would not do this as she is too scared, and also acknowledges her children as protective factors.,,In the past year her two eldest children have gone to live with their father, and she has not had contact with them until last Thursday. She found that they had changed a lot over the past few months and feels distressed that she percieves herself to have let them down by being unable to look after them. She is next due to see them tomorrow and is unsure if she can face doing this, although she does want to rebuild her relationship with them.,,Recently she has also had financial difficulties due to an investigation into her child support payments and is consequently in debt; she is recieving support from a council worker once weekly and they are helping her to resolve this.,,She has regular support from a Circle worker with WLDAS who did want her to come to A&E yesterday; Mrs McAteer dislikes being told what to do, as she percieved this, and so preferred to come on her own today. She normally works with a worker called June who has been off work for the past three weeks.,,She also finds herself socially isolated; her relationship with her mother is turbulent and she describes her friends as not real friends - only really interested in the party scene and not interested in providing emotional support. She has also been self isolating as finding she does not have the energy to see other people.,,Currently she is drinking around once a week.,,MSE:,Mrs McAteer presented as an appropriately dressed and poorly kempt woman in her thirties. She made reasonably good eye contact, her posture was slumped and she was tearful throughout the entirety of our consultation. Her speech was of normal rate and rhythm. There was no evidence of formal thought disorder or responding to abnormal stimuli. She is troubled by thoughts of wanting to not be here any more and of taking an overdose to sleep and never wake up. She has insight into her mental state and the causes of this. Cognition was not formally assessed but she was oriented to TPP.,,Plan:,I discussed her situation with consultant psychiatrist Dr Barrington and formulated a plan of action. I have provided her with a seven day script for chlorpromazine 50mg nocte to aid sleep. We will refer her to ACAST for crisis support and assessment, rather than admitting her at this stage, and they will liaise with Dr Barrington who is the sector psychiatric consultant. She is also very keen to see Dr Heath, who she had previously built up a working relationship with that she found very helpful. She has been finding it difficult to make an appointment as I gather Dr Heath is unavoidably very busy; would it be possible for an appointment to be arranged with her please.,,All best wishes,,Yours sincerely,Mike Smith,LAT CT1 Psychiatry,St John's Hospital,,Any queries please contact A&E Reception on 01506 523011 ,,

NHS Lothian

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Bathgate
EH48 2SS

Date: 02/09/2016

Emergency Discharge Summary

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI**	**2305821425**
		Date of Birth / Age	23/05/1982 (34 years)
		UHPI	800325165E
		A&E Attendance Number	E3357755
Attendance Date	02/09/2016		
Attendance Time	10:38		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	02/09/2016		
Discharge To	GP Care - No Appt	**Final Triage**	3 - Urgent
		Attendances in the last 12 months	2

Dear Dr Heath

Presentation:	psych
Diagnosis:	None
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

Psychiatric diagnoses:
- depression
- previous alcohol and substance misuse with inpatient detox
- multiple acute social stressors

Current psychiatric medication
- sertraline 150mg OD
- diazepam 2mg PRN up to TDS

Plan:
- short course of PRN chlorpromazine to aid sleep
- refer to ACAST for crisis support and assessment

- please could you arrange for her to have an appointment with Dr Heath if possible

Dear Doctor,

I saw Mrs McAteer in SJH A&E on 02/09/16. She presents with suicidal ideation in the context of multiple social stressors.

Currently her mood is low, sleep is very poor, and she is eating erratically - this is exacerbated by her dependence at present on the local food bank, and she has been prioritising the nutrition of her 4 year old daughter.

Over the past week and a half she has been feeling "What is the point of being here" and ruminating about taking an overdose to "go to sleep and get away from my problems". She says that she would not do this as she is too scared, and also acknowledges her children as protective factors.

In the past year her two eldest children have gone to live with their father, and she has not had contact with them until last Thursday. She found that they had changed a lot over the past few months and feels distressed that she percieves herself to have let them down by being unable to look after them. She is next due to see them tomorrow and is unsure if she can face doing this, although she does want to rebuild her relationship with them.

Recently she has also had financial difficulties due to an investigation into her child support payments and is consequently in debt; she is recieving support from a council worker once weekly and they are helping her to resolve this.

She has regular support from a Circle worker with WLDAS who did want her to come to A&E yesterday; Mrs McAteer dislikes being told what to do, as she percieved this, and so preferred to come on her own today. She normally works with a worker called June who has been off work for the past three weeks.

She also finds herself socially isolated; her relationship with her mother is turbulent and she describes her friends as "not real friends - only really interested in the party scene" and not interested in providing emotional support. She has also been self isolating as finding she does not have the energy to see other people.

Currently she is drinking around once a week.

MSE:
Mrs McAteer presented as an appropriately dressed and poorly kempt woman in her thirties. She made reasonably good eye contact, her posture was slumped and she was tearful throughout the entirety of our consultation. Her speech was of normal rate and rhythm. There was no evidence of formal thought disorder or responding to abnormal stimuli. She is troubled by thoughts of wanting to not be here any more and of taking an overdose to sleep and never wake up. She has insight into her mental state and the causes of this. Cognition was not formally assessed but she was oriented to TPP.

Plan:
I discussed her situation with consultant psychiatrist Dr Barrington and formulated a plan of action. I have provided her with a seven day script for chlorpromazine 50mg nocte to aid sleep. We will refer her to ACAST for crisis support and assessment, rather than admitting her at this stage, and they will liaise with Dr Barrington who is the sector psychiatric consultant. She is also very keen to see Dr Heath, who she had previously built up a working relationship with that she found very helpful. She has been finding it difficult to make an appointment as I gather Dr Heath is unavoidably very busy; would it be possible for an appointment to be arranged with her please.

All best wishes,
Yours sincerely
Mike Smith
LAT CT1 Psychiatry
St John's Hospital

Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Anton Z Barrington, Doctor

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E3248708
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E3248708

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Emergency Care Note Episode/Ref: E3248708 Paula Gemmell 4/17/16 11:29 Paula Gemmell	, ,Clinical note: 33 yr old housewife,PC Painful L knee hip,PH 3/7 moving furniture now tender,FWB,Allergies Nil,Med Fluroxitine,PMH Depression,o/e,No swelling redness bruising or heat skin intact NVI distally ,can SLR flex and extend no laxity on drawers test and mcmurrays produces no grating or grinding,can cross over leg and abduct no bony tenderness in hip,Imp Grade 1 sprain,Plan PRICE advice,reg analgesia,if further problems attend GP,,,,,,Any queries please contact A&E Reception on 01506 523011

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Heath
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 18/04/2016

Emergency Discharge Summary

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI**	**2305821425**
		Date of Birth / Age	23/05/1982 (33 years)
		UHPI	800325165E
		A&E Attendance Number	E3248708
Attendance Date	17/04/2016		
Attendance Time	10:37		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	17/04/2016		
Discharge To	GP Care - No Appt	**Final Triage**	4 - Standard
		Attendances in the last 12 months	1

Dear Dr Heath

Presentation:	l knee prob
Diagnosis:	None
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

Clinical note: 33 yr old housewife
PC Painful L knee hip
PH 3/7 moving furniture now tender
FWB
Allergies Nil
Med Fluroxitine
PMH Depression
o/e
No swelling redness bruising or heat skin intact NVI distally
can SLR flex and extend no laxity on drawers test and mcmurrays produces no grating or grinding

can cross over leg and abduct no bony tenderness in hip
Imp Grade 1 sprain
Plan PRICE advice
reg analgesia
if further problems attend GP

Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Paula Gemmell, Nurse Practitioner

NHS Lothian
University Hospital Services

Department of Emergency Medicine

LOT 163

Clinical Director Dr. D.Caesar
Clinical Nurse Manager Mrs. Karen McFarlane
ST. JOHN'S HOSPITAL
Howden Road West, Livingston EH54 6PP
Tel: 01506 523000

NHS Lothian

A/E no. E3248708
Previous no E2597716
UHPI no. 800325165E
CHI no. 2305821425

DGP.

PATIENT INFORMATION

Surname McAteer
Forename Gillian
Date of Birth 23/05/1982
Age 33 Yrs Sex F

Address 18 Cherry Avenue
Bathgate
West Lothian
Postcode EH48 1NA
Telephone 07712184504

Contact Address [redacted]

Complaint 1 knee prob
Allergies

Attendances in last 12 months: 0 School:

General Practitioner

L Heath
Address
Simpson Medical Group
Bathgate Primary Care Centr
EH48 2SS
Telephone 01506 654444

Date and Time of Attendance
17/04/2016 10:37
Incident Date & Time: 16/04/2016
Mode of Arrival
Private Transport
Source of Referral
Self Referral to A&E

Temp	Pulse Rate	BP	RR	Sats O_2/air	BM	PF best	Alcometer	GCS	SEWS
		/		%		:		/15 e__v__m__	

Presenting Complaint:

History of Presenting Complaint:

Assessment:

Triaged no.: 1 2 3 4 7 *(circle)* Senior Doctor Informed? Y / N time.....

BLOODS Routine ☐ Troponin ☐ Amylase ☐ TOX ☐ Other ☐ _____ Bloods Done ☐ _____

time due..... (time of OD.....)

PVC Started (time) .....

ECG Required ☐ Done ☐ Time.....

X-RAYS CXR ☐ Other ☐ _____

URINALYSIS Required ☐ Done ☐ HCG: + / – *(circle)* MSU Sent: Y / N

PAIN SCORE ___/10 Analgesia ☐ Time.....

Peripheral Venous Cannula Insertion *Complete all sections*
Date:..... Time:..... Operator:.....

Size		Position		Standard technique	
Blue	☐	LEFT	☐	Handwash	☐
Pink	☐	RIGHT	☐	Gloves	☐
Green	☐	Hand	☐	CHD skin prep	☐
Orange	☐	Forearm	☐	Aseptic insertion	☐
Brown	☐	ACF	☐	Needle free port	☐
Grey	☐	Foot	☐	Dressing labelled	☐

Difficulties/complications/deviation from standard technique-
Operator Signature:.....

Are any 2 of the following present:

1. temp >383 or <36 ☐
2. HR > 90 ☐
3. RR > 20 ☐
4. WCC > 12 or < 4 ☐
5. BM > 7 (+ not diabetic) ☐
6. age > 70 ☐
7. signs of infection ☐

>2 → think sepsis and triage up start Sepsis 6

FAST + / – *(circle)* Onset Time: .....
Stroke Test

Speciality Informed ☐ time ..... Speciality:.....

Time of Triage: .....

Triaged by: *(sign)* .....

(print) .....

Clinician: *(sign)* .....

(print) .....

Clinical Notes

3/7 - moving furniture
pain in L knee/hip
All -
Med - Fluoxetine
PMH - depression

Housewife, 33yr old

c/e
- no swelling, redness, bruising
seen walked with crutches

Care Providers Name:..... Signature:.....

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E2597716
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E2597716

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Emergency Care Note Episode/Ref: E2597716 Dr Bjarni Eyvindson 11/6/13 22:53 Dr Bjarni Eyvindson	, ,Clinical Note: ,31y female history of alcohol excess and drug abuse. Lives alone with her 3 children (11y, 9y and 14 month). Social work have recently been involved and she is currently not allowed to stay on her own with the children. Is therefore staying with her mother along with her children. Social work are trying to arrange a rehab placement. Today been drinking heavily, bottle of vodka and 1L of cider. Has also had speed. Tonight was alone at her own address. Texted her mother that she wanted to kill herself. Says she took a few Chlorpromazine tablets tonight. Mother contacted police who brought her to A&E for assessment. ,PMH: Alcohol excess. Drug abuse. Depression. Anxiety. ,Med: Citalopram. Propranolol.,All: NKDA,SH: See above. Usually lives alone. Drinks daily. Using speed on daily basis. ,Ex: GCS 15. Intoxicated. ,Apyrexial. Normal vital signs. ,Normal physical examination. ,Op: Alcohol intoxication. Drug abuse. Depression. Suicidal ideation. ,Tx: ,Patient taken 2-3 tabl Chlorpromazine which don't require any treatment. ,Patient is medically fit for discharge,D/w police. Police will observe overnight and bring back tomorrow for psych assessment,Psych SHO on call informed and will hand over tomorrow morning. ,D/c police care,Any queries please contact A&E Reception on 01506 523011 ,

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Holden
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 06/11/2013

Emergency Discharge Summary

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI**	**2305821425**
		Date of Birth / Age	23/05/1982 (31 years)
		UHPI	800325165E
		A&E Attendance Number	E2597716
Attendance Date	06/11/2013		
Attendance Time	22:01		
Mode of Arrival	Police		
Source of Referral	Police		
Discharge Date	06/11/2013		
Discharge To	Police Care	**Final Triage**	3 - Urgent
		Attendances in the last 12 months	3

Dear Dr Holden

Presentation:	suicidal
Diagnosis:	None
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

Clinical Note:
31y female history of alcohol excess and drug abuse. Lives alone with her 3 children (11y, 9y and 14 month). Social work have recently been involved and she is currently not allowed to stay on her own with the children. Is therefore staying with her mother along with her children. Social work are trying to arrange a rehab placement. Today been drinking heavily, bottle of vodka and 1L of cider. Has also had speed. Tonight was alone at her own address. Texted her mother that she wanted to kill herself. Says she took a few Chlorpromazine tablets tonight. Mother contacted police who brought her to A&E for assessment.
PMH: Alcohol excess. Drug abuse. Depression. Anxiety.
Med: Citalopram. Propranolol.
All: NKDA
SH: See above. Usually lives alone. Drinks daily. Using speed on daily basis.

Ex: GCS 15. Intoxicated.
Apyrexial. Normal vital signs.
Normal physical examination.
Op: Alcohol intoxication. Drug abuse. Depression. Suicidal ideation.
Tx:
Patient taken 2-3 tabl Chlorpromazine which don't require any treatment.
Patient is medically fit for discharge
D/w police. Police will observe overnight and bring back tomorrow for psych assessment
Psych SHO on call informed and will hand over tomorrow morning.
D/c police care
Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Bjarni Eyvindson, Doctor

Emergency Medicine
NHS LOTHIAN UNIVERSITY HOSPITALS DIVISION

ST. JOHN'S HOSPITAL
Howden Road West
Livingston
EH54 6PP Tel: 01506 523000

NHS Lothian

A/E no. E2597716
Previous no. E2533176

(9)

UHPI no. 800325165E
CHI no. 2305821425

PATIENT INFORMATION

Surname McAteer
Forename Gillian
Date of Birth 23/05/1982
Age 9 Yrs Sex F

Address 18 Cherry Avenue
Bathgate
West Lothian
Postcode EH48 1NA
Telephone 07933 445 731

Contact Address [redacted]

Complaint suicidal
Allergies

Attendances in last 12 months: 2 School:

General Practitioner

Name
RW Holden
Address
Simpson Medical Group
Bathgate Primary Care Centr
EH48 2SS
Telephone 01506 654444

Date and Time of Attendance
06/11/2013 22:01
Incident Date & Time: 06/11/2013
Mode of Arrival
Police
Source of Referral
Police

T	P	RR	BP	BM	SpO2	PEFR	Height	Weight	Alco
36.0	101	14	111/48						

Initial Assessment Argument with family – Police involvement. Brought in by Police after stating she was feeling suicidal. States at triage "no longer feels suicidal – now just tired." Smells of alcohol

Signature J Davies Time 22.19

Print Name JDAVIES Triage Cat 3

Urinalyis	Leuc	Nit	Blood	Protein	Glucose	Ketones	SG	PH

Clinical Notes admits drinking 2x 2L bottles of cider and taking speed & Hash.

Time seen	22.30
Alcohol	
Investigations	
Procedures	
Drugs given in Dept.	
Diagnosis	

MED: Citalopram Ropranolol

Diagnosis Alcohol intoxication.

Name (print) DR GYLFADOTTIR Signature

Clinical Notes Continued

Once Only Prescriptions

	Drug	Dose	Route	Prescribed By	Given By	Time
A						
B						
C						
D						
E						

Additional Nursing Notes

PMH alcohol & amphetimine addiction.

Meds antidepressant.

Allergies Not known.

Social History awaiting rehab

Accompanied by Police.

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E2533176
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E2533176

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Emergency Care Note Episode/Ref: E2533176 A and E Locum Doctor 8/7/13 16:40 Michele Open	31 year old admission with 'not coping' ,,Known to suffer from post natal depression, on citalopram ,,Struggling to cope at home, with life Patient quite upset, difficulty establishing a hx, however seems to be predominantly due to social issues. Px's sister has taken taken in children (aged 10, 8 years old and 11 months) , ,Mutliple attempts to end life but 'not worked' for past several months ,last attempt this morning with 'buzz and kill' (inhaling spray insectisde) ,When asked if intentional pre-planned attempts, responded with i don't know, i just keep trying and trying,,After attempts she feels dissapointed that attempts have been unsuccessful and tries again.,Unable to say how often she attempts to end life,Drinking large amounts of alcohol and illicit drug use ,Px and family keen for pysch r/v,,Social situation- normally lives with three children, however sister has taken children from last night. Sister quite supportive, ,,Plan - d/w Dr Kennedy (cons pych) - to have a psych r/v in ward 17. ,This patient has been admitted to St John's hospital and a further letter will follow. ,Any queries please contact A&E Reception on 01506 523011 ,,

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Holden
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 07/08/2013

Emergency Discharge Summary

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI**	**2305821425**
		Date of Birth / Age	23/05/1982 (31 years)
		UHPI	800325165E
		A&E Attendance Number	E2533176
Attendance Date	07/08/2013		
Attendance Time	14:55		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	07/08/2013		
Discharge To	Ward 17 SJH	**Final Triage**	3 - Urgent
		Attendances in the last 12 months	3

Dear Dr Holden

Presentation:	alcohol, drug probs?
Diagnosis:	adm 17
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

31 year old admission with 'not coping'

Known to suffer from post natal depression, on citalopram

Struggling to cope at home, "with life" Patient quite upset, difficulty establishing a hx, however seems to be predominantly due to social issues. Px's sister has taken taken in children (aged 10, 8 years old and 11 months)

Mutliple attempts to end life but 'not worked' for past several months
last attempt this morning with 'buzz and kill' (inhaling spray insectisde)
When asked if intentional pre-planned attempts, responded with "i don't know, i just keep trying and trying,"
After attempts she feels dissapointed that attempts have been unsuccessful and tries again.
Unable to say how often she attempts to end life

Drinking large amounts of alcohol and illicit drug use
Px and family keen for pysch r/v

Social situation- normally lives with three children, however sister has taken children from last night. Sister quite supportive,

Plan - d/w Dr Kennedy (cons pych) - to have a psych r/v in ward 17.
This patient has been admitted to St John's hospital and a further letter will follow.
Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

A&E Locum Doctor, Doctor

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E2432421
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E2432421

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Emergency Care Note Episode/Ref: E2432421 A+E Nurse SJH 3/18/13 06:32 Lynsey Love	This patient was assessed in A&E and felt appropriate for referral to Lothian Unscheduled Care Service. ,Any queries please contact A&E Reception on 01506 523011

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Holden
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 18/03/2013

Emergency Discharge Summary

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI**	**2305821425**
		Date of Birth / Age	23/05/1982 (30 years)
		UHPI	800325165E
		A&E Attendance Number	E2432421
Attendance Date	18/03/2013		
Attendance Time	05:38		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	18/03/2013		
Discharge To	Transfer to out of hours (triaged in A&E)	**Final Triage**	4 - Standard
		Attendances in the last 12 months	2

Dear Dr Holden

Presentation:	l ear prob
Diagnosis:	lucs
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

This patient was assessed in A&E and felt appropriate for referral to Lothian Unscheduled Care Service.
Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

A+E Nurse SJH, Nurse

Emergency Medicine
NHS LOTHIAN UNIVERSITY HOSPITALS DIVISION

ST. JOHN'S HOSPITAL
Howden Road West
Livingston
EH54 6PP Tel: 01506 523000

NHS Lothian

A/E no. E2432421
Previous no. E2298971 LUCS
UHPI no. 800325165E
CHI no. 2305821425

PATIENT INFORMATION

Surname McAteer
Forename Gillian
Date of Birth 23/05/1982
Age 30 Yrs Sex F

Address 18 Cherry Avenue
Bathgate
West Lothian
Postcode EH48 1NA
Telephone 07933445731

Contact Address [redacted]

Complaint Ear prob
Allergies NO.

Attendances in last 12 months: 1 School:

General Practitioner

Name
RW Holden
Address
Simpson Medical Group
Bathgate Primary Care Centr
EH48 2SS
Telephone 01506 654444

Date and Time of Attendance
18/03/2013 05:38
Incident Date & Time: 18/03/2013
Mode of Arrival
Private Transport
Source of Referral
Self Referral to A&E

T	P	RR	BP	BM	SpO2	PEFR	Height	Weight	Alco
36.1	85	16	115/82		97% on RA				

Initial Assessment: Since yesterday evening pain in L ear reduced hearing + flu cold symptoms sore blocked Has taken analgesia Noted on in L ear

Signature [illegible] Time 0545

Print Name Triage Cat. 4

Urinalyis	Leuc	Nit	Blood	Protein	Glucose	Ketones	SG	PH

Clinical Notes

App at LUCS 06.10AM

Time seen	
Alcohol	
Investigations	
Procedures	
Drugs given in Dept.	
Diagnosis	

Diagnosis

Name (print) Signature

Clinical Notes Continued

Once Only Prescriptions

	Drug	Dose	Route	Prescribed By	Given By	Time
A						
B						
C						
D						
E						

Additional Nursing Notes

PMH

Meds

Allergies

Social History

Accompanied by

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E2298971
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E2298971

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Emergency Care Note Episode/Ref: E2298971 Dr Lindsay A Reid 9/5/12 11:28 Dr Lindsay Reid	Resus I,,Patient arrived in sister's car at front door.,,Term +1,Sudden onset of PV bleeding while at shopping centre.,Had a sudden pain in lower abdo prior to this.,,Previous scan - placenta not low,,On arrival,A - maintaining,B - RR 25, Spo2 99% air,C - warm, HR 100, BP 140/84, haemorrhage PV,D - GCS 15,E,,Imp - placental abruption,,IVA x2, bloods inc clotting, major haemorrhage.,Obs/ anaesthetist in attendance,Pt transferred to theatre.,,This patient has been admitted to St John's hospital and a further letter will follow. ,,Any queries please contact A&E Reception on 01506 523011 ,

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Holden
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 05/09/2012

Emergency Discharge Summary

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI**	**2305821425**
		Date of Birth / Age	23/05/1982 (30 years)
		UHPI	800325165E
		A&E Attendance Number	E2298971
Attendance Date	05/09/2012		
Attendance Time	10:52		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	05/09/2012		
Discharge To	SJH Labour Suite	**Final Triage**	1 - Immediate Resuscitation
		Attendances in the last 12 months	3

Dear Dr Holden

Presentation:	bleeding/40wks preg
Diagnosis:	None
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

Resus I

Patient arrived in sister's car at front door.

Term +1
Sudden onset of PV bleeding while at shopping centre.
Had a sudden pain in lower abdo prior to this.

Previous scan - placenta not low

On arrival
A - maintaining

B - RR 25, Spo2 99% air
C - warm, HR 100, BP 140/84, haemorrhage PV
D - GCS 15
E

Imp - placental abruption

IVA x2, bloods inc clotting, major haemorrhage.
Obs/anaesthetist in attendance
Pt transferred to theatre.

This patient has been admitted to St John's hospital and a further letter will follow.

Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr L Reid, Doctor

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E2142901
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E2142901

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Emergency Care Note Episode/Ref: E2142901 Dr Unknown 2/1/12 20:02 Kate Miller	This patient has been admitted to St John's hospital and a further letter will follow. ,Any queries please contact A&E Reception on 01506 523011

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Holden
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 01/02/2012

Emergency Discharge Summary

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI**	**2305821425**
		Date of Birth / Age	23/05/1982 (29 years)
		UHPI	800325165E
		A&E Attendance Number	E2142901
Attendance Date	31/01/2012		
Attendance Time	13:24		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	31/01/2012		
Discharge To	Early Pregnancy Unit	**Final Triage**	3 - Urgent
		Attendances in the last 12 months	2

Dear Dr Holden

Presentation:	pv bleed/10 wks preg
Diagnosis:	This patient has been admitted to St John's hospital and a further letter will follow.
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

This patient has been admitted to St John's hospital and a further letter will follow.
Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Unknown, Consultant

Emergency Medicine
NHS LOTHIAN UNIVERSITY HOSPITALS DIVISION

ST. JOHN'S HOSPITAL
Howden Road West
Livingston
EH54 6PP Tel: 01506 523000

NHS Lothian

A/E no. E2142901 EPU
E2066076
Previous no.
UHPI no. 800325165E
CHI no. 2305821425

PATIENT INFORMATION

Surname McAteer
Forenames Gillian
Date of Birth 23/05/1982
Age 29 Yrs Sex F

Address 18 Cherry Avenue
Bathgate
West Lothian
Postcode EH48 1NA
Telephone 07708534279

Contact Address [redacted]

Complaint pv bleed/10 wks preg
Allergies NKDA.

Attendances in last 12 months: 1
School:

General Practitioner

Name
RW Holden
Address
Simpson Medical Group
Bathgate Primary Care Centr
EH48 2SS
Telephone 01506 654444

Date and Time of Attendance
31/01/2012 13:24
Incident Date & Time: 30/01/2012
Mode of Arrival
Private Transport
Source of Referral
Self Referral to A&E

T	P	RR	BP	BM	SpO2	PEFR	Height	Weight	Alco
35.9	82	16.	146/92		100% RA.				

Initial Assessment 10weeks pregnant - had PV bleed 2/7 ago - bleeding stopped but has began again today. lower abdominal cramps. Due to see EPU for early scan tomorrow.

Signature EDOD Time 1330 LMP 25/11/12
Print Name GP HUB. Triage Cat. 3.

Urinalyis	Leuc	Nit	Blood	Protein	Glucose	Ketones	SG	PH

Clinical Notes

3rd pregnancy (has 2 children).

Time seen	
Alcohol	
Investigations	
Procedures	
Drugs given in Dept.	
Diagnosis	

Diagnosis

Name (print) Signature

Clinical Notes Continued

Once Only Prescriptions

	Drug	Dose	Route	Prescribed By	Given By	Time
A						
B						
C						
D						
E						

Additional Nursing Notes

PMH N.I

Meds N.I

Allergies NKDA

Social History

Accompanied by

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E2066076
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E2066076

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: E2066076 Dr Jenna MA McNeillis 10/8/11 20:41 Jenna MA McNeillis	PC: Head injury,,29 year old female was having a few drinks (5 vodkas) this afternoon, around 1500 she let the dog out she then fell down the stairs, she sumersaulted twice, hit her head off a plater wall and then landed at the bottom of the stairs, slamming the door shut,She then states that she lost conciousness for around 4 hours,At 1900 she came round and went next door to her neighbour who phoned for an ambulance,Complaining of a pressure feeling at the back of her head,Remembers everything before and after the event,No vomiting after the fall,Has been acting like her normal self since the event,No dizziness, change in vision,States that she had a couple of seconds of numbness/ tingling in her right leg but this has now settled,,No sig PMH, no regular meds, NKDA,,O/E:,P 102, RR 18, BP 155/96, Sats 99%RA, alcometer 0.71,Large boggy swelling over occiput ,No c-spine tenderness,No spinal tenderness,CN II-XII intact,Tone, power, sensation and reflexes normal all 4 limbs,HS I+II+O,Chest clear, good a/e throughout,Abdo SNT, bowel sounds present,,Head injury - ? 4hour LOC,Pt discussed with Dr Rennie ,Plan:,Admit - for neuro obs,If any deterioration then for CT overnight,,Pt reviewed by Dr Rennie,Pt now becoming more distressed and still complaining of pain - decision to CT head now,,Ct head normal - verbal report by Dr Khan,Pt accepted by Obs Ward,,Any queries please contact A&E Reception on 01506 523011

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr RW Holden
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 09/10/2011

Emergency Discharge Summary

Patient	Gillian McAteer 18 Cherry Avenue Bathgate West Lothian EH48 1NA	**CHI**	**2305821425**
		Date of Birth / Age	23/05/1982 (29 years)
		UHPI	800325165E
		A&E Attendance Number	E2066076
Attendance Date	08/10/2011	**Contact**	Iqbal Maureen 50 Athol Terrace Bathgate West Lothian EH48 4DF
Attendance Time	19:47		
Mode of Arrival	Emergency Ambulance		
Source of Referral	Self Referral to A&E		
Discharge Date	08/10/2011		
Discharge To			

Dear Dr RW Holden

Presentation: head inj

PC: Head injury

29 year old female was having a few drinks (5 vodkas) this afternoon, around 1500 she let the dog out she then fell down the stairs, she sumersaulted twice, hit her head off a plater wall and then landed at the bottom of the stairs, slamming the door shut
She then states that she lost conciousness for around 4 hours
At 1900 she came round and went next door to her neighbour who phoned for an ambulance
Complaining of a pressure feeling at the back of her head
Remembers everything before and after the event
No vomiting after the fall
Has been acting like her normal self since the event
No dizziness, change in vision
States that she had a couple of seconds of numbness/tingling in her right leg but this has now settled

No sig PMH, no regular meds, NKDA

O/E:
P 102, RR 18, BP 155/96, Sats 99%RA, alcometer 0.71
Large boggy swelling over occiput
No c-spine tenderness
No spinal tenderness
CN II-XII intact
Tone, power, sensation and reflexes normal all 4 limbs
HS I+II+O
Chest clear, good a/e throughout
Abdo SNT, bowel sounds present

Head injury - ?4hour LOC

Pt discussed with Dr Rennie
Plan:
Admit - for neuro obs
If any deterioration then for CT overnight

Pt reviewed by Dr Rennie
Pt now becoming more distressed and still complaining of pain - decision to CT head now

Ct head normal - verbal report by Dr Khan
Pt accepted by Obs Ward

Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Jenna MA McNeillis, Doctor

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E1439786
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E1439786

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Emergency Care Note Episode/Ref: E1439786 Dr Clementine Johns 3/13/09 17:46	Partial thickness laceration to right pinkie. Cleaned and steristripped. Discharged.

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E1301749
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E1301749

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Emergency Care Note Episode/Ref: E1301749 Margaret Robertson 8/6/08 Margaret Robertson	Shut Lt ring finger in car door. Swollen, bruised volar aspect distal phalynx. Able to flex , extend with difficulty. No sub-ungual haematoma. Xray # tuft distal phalynx. Neighbour strap. Elevation and ice. Simple analgesia. RAE 1week if any problems.

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E919368
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E919368

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Historic SJH A&E Conversion Data Episode/Ref: E919368 Dr P Freeland 2/29/08 17:45	A&E Doctor 1: DR J WRATE,Time Seen: 18:10,Alcohol: 1,Provisonal Diagnosis: 3100,Drug 1: Nil ,Investigation 1: Nil ,Destination: H,Examination: UNWELL,Primary Diagnosis: DRUG / ALCOHOL CONSUMPTION

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E919369
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E919369

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Historic SJH A&E Conversion Data Episode/Ref: E919369 Dr P Freeland 2/29/08 17:45	A&E Doctor 1: NURSE PRACTITIONER,Time Seen: 10:30,Alcohol: 0,Provisonal Diagnosis: 14CQ,Drug 1: Nil ,Investigation 1: Plain X-Ray ,Destination: ,Examination: R ANKLE INJ,Primary Diagnosis: R ANKLE SPRAIN

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E919363
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E919363

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Historic SJH A&E Conversion Data Episode/Ref: E919363 Dr P Freeland 2/29/08 17:45	A&E Doctor 1: NURSE PRACTITIONER,Time Seen: 18:20,Alcohol: 0,Provisonal Diagnosis: 14CR,Drug 1: Nil ,Investigation 1: Plain X-Ray ,Destination: ,Examination: LT GT TOE INJ,Primary Diagnosis: SOFT TISSUE INJ L GT TOE

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E919371
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E919371

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Historic SJH A&E Conversion Data Episode/Ref: E919371 Dr P Freeland 2/29/08 17:45	A&E Doctor 1: DR C WHEELDON,Time Seen: 16:00,Alcohol: 0,Provisonal Diagnosis: 26HO,Drug 1: Nil ,Investigation 1: Midstream Specimin Urine ,Destination: ,Examination: PV BLEED,Primary Diagnosis: PV BLEED - MENSTRUATION

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E919374
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E919374

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Historic SJH A&E Conversion Data Episode/Ref: E919374 Dr P Freeland 2/29/08 17:45	A&E Doctor 1: DR N ABBEYSINGHE,Time Seen: 19:35,Alcohol: 0,Provisonal Diagnosis: 11CJ,Drug 1: Nil ,Investigation 1: Nil ,Destination: ,Examination: LAC L HAND,Primary Diagnosis: LAC L HAND

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E919364
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E919364

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Historic SJH A&E Conversion Data Episode/Ref: E919364 Dr P Freeland 2/29/08 17:45	A&E Doctor 1: DR S THOMAS,Time Seen: 07:20,Alcohol: 0,Provisonal Diagnosis: 21KG,Drug 1: Ibratropium ,Drug 2: Other ,Investigation 1: Full Blood Count ,Investigation 2: Blood Sugar ,Investigation 3: U & E ,Investigation 4: Plain X-Ray ,Destination: WARD 23,Examination: SMOKE INHALATION,Primary Diagnosis: SMOKE INHALATION

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E919375
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E919375

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Historic SJH A&E Conversion Data Episode/Ref: E919375 Dr P Freeland 2/29/08 17:45	A&E Doctor 1: DR P CROSBIE,Time Seen: 20:45,Alcohol: ,Provisonal Diagnosis: 6130,Investigation 1: Nil ,Destination: ,Examination: SPIKED DRINK?,Primary Diagnosis: WHAT PBOBLEM WAS?

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E919373
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E919373

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Historic SJH A&E Conversion Data Episode/Ref: E919373 Dr P Freeland 2/29/08 17:45	A&E Doctor 1: DR E MCCLELLAND,Time Seen: 01:45,Alcohol: 1,Provisonal Diagnosis: 3400,Investigation 1: Nil ,Destination: ,Examination: DRUG ABUSE,Primary Diagnosis: UNABLE TO COPE

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E919370
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E919370

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Historic SJH A&E Conversion Data Episode/Ref: E919370 Dr P Freeland 2/29/08 17:45	A&E Doctor 1: DR T WARD,Time Seen: 01:20,Alcohol: 2,Provisonal Diagnosis: 4210,Drug 1: Nil ,Investigation 1: Other ,Destination: WARD 23,Examination: D + I,Primary Diagnosis: ALCOHOL INTOXICATION

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E919367
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E919367

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Historic SJH A&E Conversion Data Episode/Ref: E919367 Dr P Freeland 2/29/08 17:45	A&E Doctor 1: DR T WARD,Time Seen: 23:35,Alcohol: ,Provisonal Diagnosis: 16BM,Investigation 1: Nil ,Destination: ,Examination: ASSAULT/ ABDO PAIN,Primary Diagnosis: BRUISING TO ABDO WALL

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E919366
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E919366

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Historic SJH A&E Conversion Data Episode/Ref: E919366 Dr P Freeland 2/29/08 17:45	A&E Doctor 1: DR R PERRY,Time Seen: 23:45,Alcohol: 2,Provisonal Diagnosis: 3100,Drug 1: Nil ,Investigation 1: Nil ,Destination: ,Examination: D + I,Primary Diagnosis: ACUTELY INTOXICATED

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E919365
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E919365

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Historic SJH A&E Conversion Data Episode/Ref: E919365 Dr P Freeland 2/29/08 17:45	A&E Doctor 1: DR T WARD,Time Seen: 02:50,Alcohol: ,Provisonal Diagnosis: 4290,Drug 1: Nil ,Investigation 1: Nil ,Destination: HOME,Examination: DRUG OD,Primary Diagnosis: ABDO PAIN UPSET FOLLOWING INGESTIONOF ECTASY,HASH,ALCOHOL

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	E919372
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	E919372

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Historic SJH A&E Conversion Data Episode/Ref: E919372 Dr P Freeland 2/29/08 17:45	A&E Doctor 1: DR A SCOTT,Time Seen: 18:40,Alcohol: 0,Provisonal Diagnosis: 12CQ,Drug 1: Nil ,Investigation 1: Plain X-Ray ,Destination: ,Examination: R ANKLE INJ,Primary Diagnosis: SPRAINED R ANKLE

In Patient Records

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

General Medicine

Dr McNutt
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 16/10/2024

Inpatient Discharge Summary

Patient	Gillian McAteer Flat 1 Carron Court Bathgate EH48 2QF	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (42 years) 800325165E
Ward	SJH Emergency Medical Assessment - EMA	**Admission Date**	01/10/2024
Consultant	Dr Imogen BJ Smith	**Discharge Date**	01/10/2024

Dear Dr McNutt

FINAL DISCHARGE SUMMARY

Dear Doctor,

I have nothing further to add to the immediate discharge summary below, which you should already have received.

Yours sincerely,

Dr Imogen BJ Smith
Consultant Physician

e-checked

IS/BL
Date dictated: 11.10.24
Date typed: 16.10.24

Diagnosis
1. Likely exacerbation of undiagnosed COPD

Treatment : already on doxycycline (started by GP OOH), given 5 days of prednisolone and new salbutamol inhaler

This lady was seen in EMA today with a dry cough, wheeze and breathlessness on exertion. She is a known heavy smoker. She had been seen by GP out of hours 48 hours previously and started on doxycycline but had not felt much better and had also developed worsening pain between her scapula.

She denied any haemoptysis or sputum. On examination she looked well and sats were 97% on room air. She was not hypoxic. CXR was unremarkable and bloods were OK including a D dimer (97). Her chest was clear when I saw her, but she had been wheezy when first admitted to EMA.

She was keen to get home and reassured by results. I have given her a 5 day course of prednisolone and a new salbutamol inhaler (hers had run out). She was discharged home with worsening advice, her GP has already requested spirometry.

Yours sincerely

Joanne Mackie (consultant in Acute and General Medicine)

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

General Medicine

Dr McNutt
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 01/10/2024

Inpatient Discharge Summary

Patient	Gillian McAteer Flat 1 Carron Court Bathgate EH48 2QF	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (42 years) 800325165E
Ward	SJH Emergency Medical Assessment - EMA	**Admission Date**	01/10/2024
Consultant	Dr Imogen BJ Smith	**Discharge Date**	

Dear Dr McNutt

Diagnosis
1. Likely exacerbation of undiagnosed COPD

Treatment : already on doxycycline (started by GP OOH), given 5 days of prednisolone and new salbutamol inhaler

This lady was seen in EMA today with a dry cough, wheeze and breathlessness on exertion. She is a known heavy smoker. She had been seen by GP out of hours 48 hours previously and started on doxycycline but had not felt much better and had also developed worsening pain between her scapula.

She denied any haemoptysis or sputum. On examination she looked well and sats were 97% on room air. She was not hypoxic. CXR was unremarkable and bloods were OK including a D dimer (97). Her chest was clear when I saw her, but she had been wheezy when first admitted to EMA.

She was keen to get home and reassured by results. I have given her a 5 day course of prednisolone and a new salbutamol inhaler (hers had run out). She was discharged home with worsening advice, her GP has already requested spirometry.

Yours sincerely

Joanne Mackie (consultant in Acute and General Medicine)

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Ear Nose and Throat

Dr McNutt
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 14/08/2023

Inpatient Discharge Summary

Patient	Gillian McAteer Flat 1 Carron Court Bathgate EH48 2QF	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (41 years) 800325165E
Ward	SJH Day Surgery Centre	**Admission Date**	08/08/2023
Consultant	Dr Louise McMurran	**Discharge Date**	08/08/2023

Dear Dr McNutt

Date of admission:
08/08/23

Date of discharge:
08/08/23

Surgeon:
L McMurran

Consultant:
L McMurran

Procedure:
Removal of right grommet

Findings:
Right grommet with some irritation around the myringotomy

Operation:
The procedure was prepped and draped. Grommet was removed. The edges of the perforation were scratched to encourage healing. Cilodex drops applied.

Plan:

Home later today
No routine follow up
Keep ear dry for 6-8 weeks to allow tympanic membrane perforation to heal

Yours sincerely,

Dr. Louise McMurran
Consultant Otologist
LM/CW 14/08/2023

Secretary Contact: 0131 536 1027

St John's Hospital Day Surgery Booklet

NHS Lothian ENT

800325165E F 23/05/1982
McAteer, Gillian
Flat 1,
Carron Court,
Bathgate,
West Lothian, EH48 2QF
CHI 2305821425
78132 AP McNutt

Date: 8/8/23 Time patient arrived: 1100

Consultant: LM

Theatre no: 3

Next of kin details

[redacted]

	Ward	Theatre Reception	Anaesthetic Room
• Patient ID: bracelets x2 / Allergy band	✓	✓	✓
• Consent form signed TO BE SIGNED	☐	☐	☐
• Operation site marked or obvious	☐ / n/a	☐ / n/a	☐ / n/a
• Patient Hospital notes / ward charts (inc. results / kardex / anaesthetic chart)	✓	✓	✓
• Bladder emptied	✓	✓	
• Underwear: disposable / removed (ON)	✓ / n/a	☒ / n/a	☐ / n/a
• Contact lens removed	☐ / n/a	☐ / n/a	☐ / n/a
• Prosthesis removed	☐ / n/a	☐ / n/a	☐ / n/a
• Hearing aid / glasses with patient	☐ / n/a	☐ / n/a	☐ / n/a
• Jewellery / piercings removed / taped	✓ / n/a	☐ / n/a	☐ / n/a
• TEDS	✓ / n/a	✓ / n/a	☐ / n/a
• Pre-med / pre-op analgesia given	☐ / n/a	☐ / n/a	☐ / n/a
• Fasted from: TEA (WHITE) 07'30		LMP	
• Patient pregnant STS	Yes ☐ No ☐		
• Blood glucose level if required	Value	Time	
• Patient temperature in anaesthetic room	Value	Time	

PATIENT BELONGINGS-(tick if present)

	Reception	Recovery
Glasses	X	✓
Dentures	X	X
Hearing Aids	X	X
Other: Studers	X	✓
Dressing gown HF		KB

Initial

TRAK alerts:

Signatures: MSutherland HFleming RS

Names: MHAIRI SUTHERLAND HFleming

- Post op surgical visit ☐ (not needed)
- Post op anaesthetic visit ☐ (not needed)
- Observations stable and satisfactory ✓
- Alert, orientated & ambulant ✓
- Drinking and eating ✓
- Analgesia satisfactory ✓
- No nausea / vomiting ✓
- Passed urine ✓
- Operation site satisfactory ☐
- IV access device removed ✓
- Post op instructions understood ✓
- GP letter provided ✓
- Follow up appointment made ✓ (n/a)
- Take home medicines ✓ (n/a)
- Dressings provided ☐ (n/a)
- Physiotherapy organised ☐ (n/a)
- Community care organised ☐ (n/a)
- Sick absence note provided ☐ (n/a)

Discharge time: 1840 Date: 8/8/23

Signature of Nurse: RobA Patient Signature: [redacted]

Received discharge:

Day Surgery Centre
St John's Hospital, Howden Road West,
Livingston, West Lothian, EH54 6PP.
Phone: 01506 524105
www.nhslothian.scot.nhs.uk

NHS Lothian

Consent for Operation

800325165E **F** 23/05/1982
McAteer, Gillian
Flat 1,
Carron Court,
Bathgate,
West Lothian, EH48 2QF
CHI 2305821425
78132 AP McNutt

Consultant: McMURRAN

Planned procedure: Removal of Right Appendix

Common risks: Bleeding Infection

Less common risks: Perforation

I confirm that I have explained to the patient in terms in which my judgement are suited to his / her understanding (and / or to one of his / her parents or guardians), the proposed operation, investigation or treatment, including options available, and if relevant, the need for anaesthesia or sedation.

Signature: Date: 08/08/23

Name and status of practitioner: McMURRAN

Re-confirmation of consent on the day of admission

Signature: Date:

Name and status of practitioner:

Medical Students
- I agree to allow students to be present in theatre (tick box): Yes ☐ No ☐
- I agree to be examined by a medical student whilst under general anaesthesia in theatre: Yes ☐ No ☐

Medical Photography (I agree to being photographed)
- For my medical records for the purpose of diagnosis and treatment: Yes ☐ No ☐
- For the purpose of teaching and education: Yes ☐ No ☐
- For the purpose of publication: Yes ☐ No ☐
- To be shown to other patients (as an example): Yes ☐ No ☐

Tissue for medical research and teaching
When you have tissue removed as part of a medical investigation, operation or procedure, such as a blood test, some tissue may be left over after the laboratory tests have been completed. This tissue could be kept without your name or the details, so that it is impossible to know whom the tissue came from, and used for research or teaching, to improve laboratory tests, or to see how many people in an area might have a disease or an infection.

Do you agree? Yes ☐ No ☐

To the patient (or parent or guardian if appropriate)

1. Please read this form and the notes overleaf very carefully.
2. If there is anything that you don't understand about the explanation or if you want more information, you should ask the practitioner before signing.
3. Please check that all the information on the form is correct. If it is and you understand the explanation, then sign the form.

I am the patient / parent / guardian (delete as necessary)

I agree ☐ To what is proposed which has been explained to me by the practitioner named above.

I understand
- ☐ That anaesthesia (general / regional / local) or sedation will be needed.
- ☐ That the procedure may not be done by the practitioner who has been treating me so far.
- ☐ That any procedure in addition to the investigation or treatment described on this form will only be carried out of it is necessary and in my best interests and can be justified for medical reasons.

I have told ☐ The practitioner about the procedures I have noted below which I would wish not to be carried out without my having the opportunity to consider them first.

.....

Signature: X ..... Name: Gillian McAteer

Notes to all Health Practitioners (Doctors, Dentists, Nurses, Professionals Allied to Medicine)

A patient has an absolute legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way that they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to the treatment at any time. The patient's consent to treatment should be recorded on this consent form (further guidance is given in NHS Lothian's Policy Statement).

Notes to Patients

The health practitioner is here to help you. He or she will explain the proposed treatment and what the alternatives are. You can ask any questions and seek further information. You can refuse treatment.

You should be provided with sufficient information to allow you to come to a decision as to whether to consent to the treatment proposed.

The type of information you should receive should include:

1. Nature of your condition and proposed procedures, including degree of urgency.
2. Benefits to be reasonably accepted of the procedure.
3. Nature and probability of material (= significant) risks involved, including consideration of ratio of risks and benefits.
4. Inability of the practitioner to predict results.
5. Irreversibility of the procedure, if that is the case.
6. The likely result of not having the proposed treatment or procedure.
7. Alternatives available, including their risks and benefits.

You may ask for a relative, a friend or a nurse to be present.

Training doctors, dentists, nurses and other health professionals is essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor, dentist, nurse or other health professional.

You may however decline to be involved in the formal training of medical, dental, nursing and other students without this adversely affecting your care and treatment. You must tell a senior doctor or nurse if you do not wish students to be involved in your care and you should write this on the consent form in the space for things that you do not wish to happen without you being given the chance to consider them first.

Medical History (refer to pre-admission documents if available)

Please list any allergies and describe nature of allergy

Amoxicillin.

Please list current medications and tick those taken today

sertaline 100mg ✓.	
Chlopromazine	
Beclometasone.	
Mometasone	

Please complete the following if you were NOT assessed by the pre-admission service

Have you had any problems with anaesthesia in the past? Yes ☐ No ☒

Please provide details of any problems:

Has anyone in your family had problems with anaesthesia? Yes ☐ No ☒

Please provide details of any problems:

Please provide any other information about your family medical history that you think we should know about:

Please list any operations you have had with their approximate dates:

Grommets Septoplasty.
Bowel surgery

Have you currently or ever had any of the following? If so please provide approximate dates and any other details you feel might be useful

	Yes	No
• High blood pressure		✓
• Heart attack		✓
• Angina / chest pains		✓
• Stroke or transient ischaemic attack		✓
• Heart murmur		✓
• Pacemaker (please indicate when last checked)		✓
• Tendency to faint easily		✓
• Shortness of breath	✓	
• Asthma or bronchitis		✓
• Current cold or cough		✓
• Diabetes		✓
• Epilepsy		✓
• Anaemia or bleeding tendency		✓
• Indigestion, heartburn or hiatus hernia		✓
• Muscle disease or weakness		✓
• Arthritis		✓
• If female, are you pregnant?		✓

Do you smoke? Yes ☑ No ☐ If so, how much per day? 10-15 daily

Do you drink alcohol? Yes ☑ No ☐

How much do you drink on average each week? (one bottle of wine = 9 units)

When did you last have an alcoholic drink? ~~10-6-23~~ 4/8/2023

Anaesthetic Record

Pre-op information

ASA III BP 126/84 PULSE 66 SpO_2 97 Temp 36.5 Wt 110 Ht 163 BMI 42

Pmhx - Panc. GA - N.I issues. Amnaz - M.P.I M.v. 73 NBLL S.P. RA

Dhx Sensorineural FHxAn? - Nil

Spinal? - 10-15 qd.

Allergies - Amoxicillin

Information given to patient: GA - Panc / Small Tumour / Cancer.

Anaesthesia details

Anaesthetist(s) name & grade: R SMITH (CONS) N CAMPBELL (STR) Date: 8/8/23

Supervising Consultant:

Machine check ☑ Trained assistant ☐ Prelist brief / Surgical pause ☐

Vascular access (site / device / size)

22G R hand

Induction

Propofol 180 mg

Fentanyl 100mcg

Rocuronium 50mg

cefuroxime 50mg

dexamethasone 8mg

Maintenance Air/O2/Sevo.

Airway / Circuit / Machine

Circle / airway CSE / #7 (5) Facemask RAE

Easy to hand ventilate? Yes ☑

Laryngoscopy grade Gr I Direct

Monitors:

Minimal monitoring ☐

Others

Eye care: Tape ☑ Lubricant ☐ Padded ☑

Pressure care ☐

Fluid warmer ☐

Warming blanket ☐

DVT prophylaxis ☑ n/a ☐

Post Op DVT prophylaxis ☐ n/a ☐

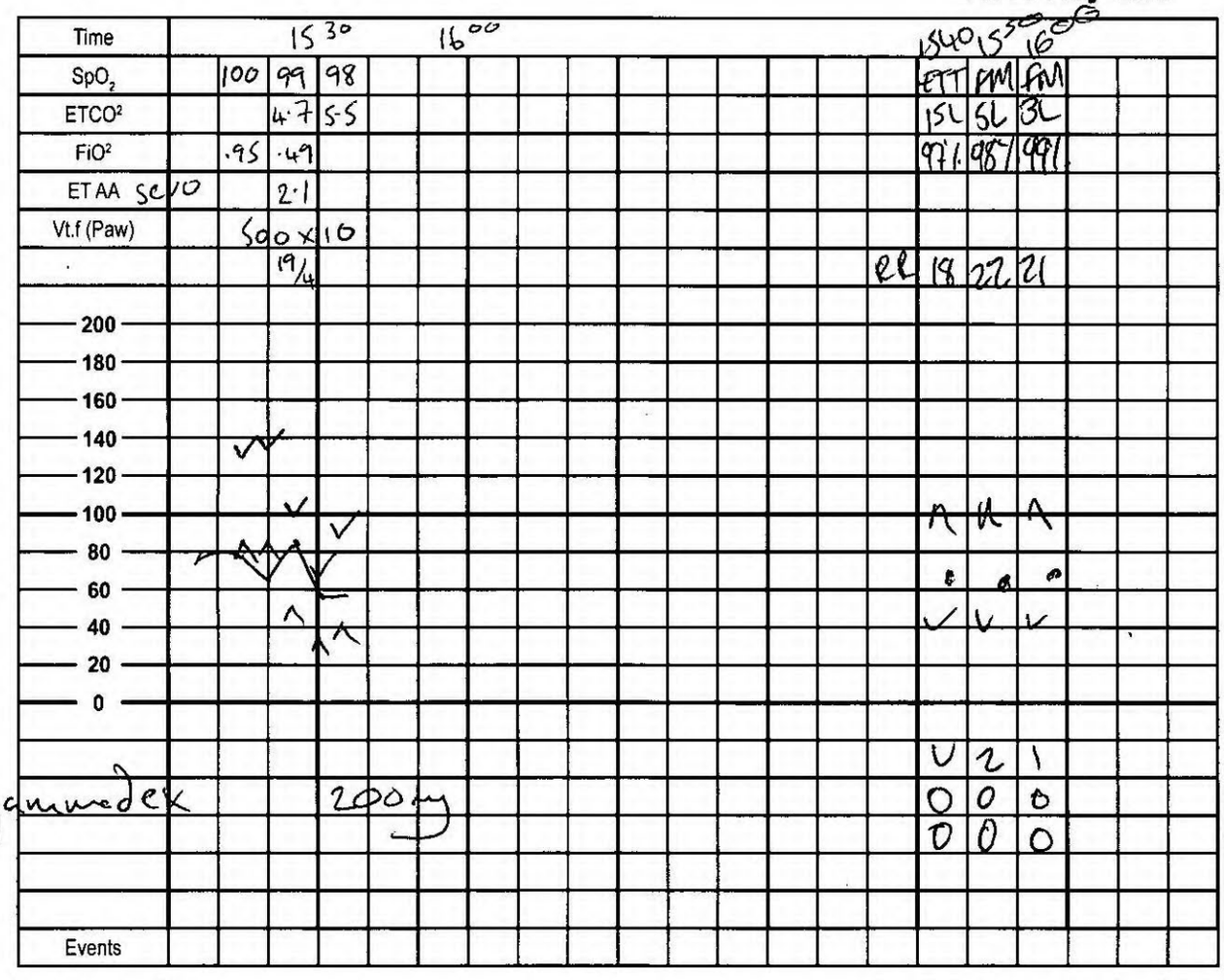
Antibiotics ☐ n/a ☐

Patient / Limb position

Supine

Significant issues or events

Recovery Obs



Suggammadex 200mg

PL 148 - 500

Temp 36·2

salbutamol inhaler

5 puffs at inhalation
5 puffs at exhalation

wheeze / bronchospasm

Recovery

Anaesthetist instructions: Routine obs ☑ O_2 as needed to maintain SpO_2>93% ☑

Tick if you want to see patient before discharge ☐

Recovery comments:

Arrived into Recovery @ 1540 following a GA, ETT insitu - expelled @ 1545 by the anaesthetist with no issues → cont 5L O_2 via facemask

IV access (R) hand - plasmalyte 148 500mls in progress - capped when completed

no issues to (R) ear - cotton wool in place

tolerating water orally

no complaints of pain or nausea

NEWS - 3

Arrival time in recovery: 1540 Time discharged to ward: 1610

Recovery nurse: KBoyle Signature:

Prescription and administration record

If an additional prescription chart is in use tick this box ☐

Codes for non-administration of prescribed medicine

If a dose is not administered as prescribed, initial and enter a code in the column with a circle drawn round the code according to the reason as follows:

Patient refuses	1	Vomiting / nausea	8
Patient not present on ward	2	Time varied on Dr's instructions	9
Medicines not available (**check ordered**)	3	Once only / pm medication given	10
Instructions not clear or legal	4	Dose withheld on Dr's instructions	**X**
Nil by mouth	5	Possible drug reaction / side effect	12
Asleep / drowsy	6	Self administered by patient	13
Administration route not available (**check for an alternative**)	7	Other reasons	14

Pre-operative and once only medication

Date	Time	Drug / PGD No.	Dose	Route	Prescriber Signature / Name	Time given	Given by	Checked by
8/8	Theatre Recovery	FENTANYL	100 microg max total	IV	[signature]			

Regular Therapy

Drug		Date				
PARACETAMOL		Time				
Dose	Route	6				
1g	Oral	(8)				
Signature / Name	Start Date	(12)				
		14				
Notes	Pharmacy	(18)				
		(22)				

Drug		Date				
		Time				
Dose	Route	6				
		8				
Signature / Name	Start Date	12				
		14				
Notes	Pharmacy	18				
		22				

Drug		Date				
IBUPROFEN		Time				
Dose	Route	6				
400mg	Oral	(8)				
Signature / Name	Start Date	(12)				
		14				
Notes	Pharmacy	(18)				
		(22)				

Drug		Date				
		Time				
Dose	Route	6				
		8				
Signature / Name	Start Date	12				
		14				
Notes	Pharmacy	18				
		22				

Drug		Date				
		Time				
Dose	Route	6				
		8				
Signature / Name	Start Date	12				
		14				
Notes	Pharmacy	18				
		22				

Drug		Date				
		Time				
Dose	Route	6				
		8				
Signature / Name	Start Date	12				
		14				
Notes	Pharmacy	18				
		22				

As Required Therapy

Drug		Date				
MORPHINE		Time				
Dose & Frequency	Route	Dose / Route				
10mg hourly	Oral	Initials				
Signature / Name	Start Date	Date				
	8/8	Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
Paracetamol		Time				
Dose & Frequency	Route	Dose / Route				
1g nocte QDS	oral	Initials				
Signature	Start Date	Date				
	8/8	Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
TRAMADOL		Time				
Dose & Frequency	Route	Dose / Route				
50-100mg 4⁰	Oral / IV	Initials				
Signature / Name	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
		Time				
Dose & Frequency	Route	Dose / Route				
		Initials				
Signature / Name	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
DIHYDROCODEINE		Time				
Dose & Frequency	Route	Dose / Route				
30mg 4⁰	Oral	Initials				
Signature / Name	Start Date	Date				
	8/8	Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
		Time				
Dose & Frequency	Route	Dose / Route				
		Initials				
Signature / Name	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
CYCLIZINE		Time				
Dose & Frequency	Route	Dose / Route				
50mg 8⁰	Oral/IV/IM	Initials				
Signature / Name	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
		Time				
Dose & Frequency	Route	Dose / Route				
		Initials				
Signature / Name	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
ONDANSETRON		Time				
Dose & Frequency	Route	Dose / Route				
4mg 6⁰	Oral/IV/IM	Initials				
Signature / Name	Start Date	Date				
	8/8	Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
		Time				
Dose & Frequency	Route	Dose / Route				
		Initials				
Signature	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Surgeon's Operation Notes

800325165E **F** 23/05/1982
McAteer, Gillian
Flat 1,
Carron Court,
Bathgate,
West Lothian, EH48 2QF
CHI 2305821425
78132 AP McNutt

Consultant: McMurray

M / F

Surgeon	Assistants	Scrub Nurse	Operation
McMurray	—	Joan Edwards	Removal of ~~Right~~ Granuloma

Surgeon's operation notes

Findings: Right Granuloc ~ some irritation on TM.

Procedure: Removed.
Scratched edge of peel to encourage healing.
Glodex drops.

Plan: Home as able
No Routine R/V

McMurray

Surgeon's operation notes - continued

Ward instructions

Complete sickness absence note as necessary
Tick if you want to see patient before discharge ☐

Signature: .....

Name: ..... Date: .....

Theatre Equipment Stickers

Day Surgery Centre
St John's Hospital, Howden Road West,
Livingston, West Lothian, EH54 6PP.
Phone: 01506 524105
www.nhslothian.scot.nhs.uk

NHS Lothian

Discharge Letter

800325165E F 23/05/1982
McAteer, Gillian
Flat 1,
Carron Court,
Bathgate,
West Lothian, EH48 2QF
CHI 2305821425 M / F
78132 AP McNutt

Consultant:
Operator:
GP:

Dear Doctor,

Your patient underwent the following operation or investigation and will be discharged today.

Operation / Investigation:

Findings / Results:

Further treatment is planned as follows:

Removal of sutures:

Follow up arrangements:

Sickness absence form has been issued for: days / weeks

DISCHARGE Prescription	Dose / Timing / Route	No. of days	Prescriber: Sign / Name	Dispenser: Sign / Name	Checked by
Paracetamol 500mg	Two tablets every 6 hours PRN				
Ibuprofen 400mg	One tablet every 6 hours PRN				
Dihydrocodeine 30mg	One tablet every 6 hours PRN				

CONTROLLED Drug Prescription (delete those not required)	Dose	Frequency	Total Quantity Supplied in figures & words	Prescribers Signature & Name	Pharmacy Disp/check
Tramadol 50mg capsules	ONE or TWO capsules	4 hourly PRN Max 400mg daily	..... capsules ..... capsules		
Morphine sulphate 10mg MR tablets	..... mg ..... tabs	Twice daily	..... tablets ..... tablets		
Morphine sulphate 10mg/5ml oral solution	..... mg	..... Hourly PRN Max..... times daily	..... millilitres ..... millilitres		

Signature: Date:

Name: Phone. no:

Top copy (White) Patient's copy Second copy (Yellow) GP's copy Third copy (Blue) Pharmacy copy

Day Surgery Centre
St John's Hospital, Howden Road West,
Livingston, West Lothian, EH54 6PP.
Phone: 01506 524105
www.nhslothian.scot.nhs.uk

NHS Lothian

Discharge Letter

800325165E F 23/05/1982
McAteer, Gillian
Flat 1,
Carron Court,
Bathgate,
West Lothian, EH48 2QF
CHI 2305821425 M / F
78132 AP McNutt

Consultant: [illegible]
Operator:
GP:

Dear Doctor,

Your patient underwent the following operation or investigation and will be discharged today.

Operation / Investigation: [illegible]

Findings / Results:

Further treatment is planned as follows: [illegible]

Removal of sutures: [illegible]

Follow up arrangements: [illegible]

Sickness absence form has been issued for: days / weeks

DISCHARGE Prescription	Dose / Timing / Route	No. of days	Prescriber: Sign / Name	Dispenser: Sign / Name	Checked by
Paracetamol 500mg	Two tablets every 6 hours PRN				
Ibuprofen 400mg	One tablet every 6 hours PRN				
Dihydrocodeine 30mg	One tablet every 6 hours PRN				

CONTROLLED Drug Prescription (delete those not required)	Dose	Frequency	Total Quantity Supplied in figures & words	Prescribers Signature & Name	Pharmacy Disp/check
Tramadol 50mg capsules	ONE or TWO capsules	4 hourly PRN Max 400mg daily	..... capsules ..... capsules		
Morphine sulphate 10mg MR tablets	..... mg ..... tabs	Twice daily	..... tablets ..... tablets		
Morphine sulphate 10mg/5ml oral solution	..... mg	..... Hourly PRN Max ..... times daily	..... millilitres ..... millilitres		

Signature: Date: 23/5/23.

Name: Phone. no:

Top copy (White) Patient's copy Second copy (Yellow) GP's copy Third copy (Blue) Pharmacy copy

NHS Lothian

I[illegible] Plan

800325165E F
MCATEER Gillian
23-May-82 CHI: 230 582 1425
78132 AP McNutt
Flat 1 West Lothian
EH48 2QF

Consultant: Ms MCMURRAN

Theatre no: 3

Local Anaesthetic Patients

Observations	Sp02	HR
	O2 required	

Pre-list Briefing Yes ☑ No ☐

Surgical Pause Yes ☑ No ☐

Date: 8/8/23 Time: 15:25 Signature: h dallas

Patient Position (tick all that apply)

Supine ☑	Prone ☐	Lloyd Davies ☐
Neck Extension ☐	Lateral Right Down ☐	Lateral Left Down ☐
Traction ☐	Other	

Table fitting and attachments (tick all that apply)

Mattress Type: MAQUET					
Anaesthetic Screen	☐	Arm Board	☐	Arm Rest	☐
Arm Retainer 2x	☑	Arm Table	☐	Head Ring	☐
Heel Pad	☐	Lateral Supports	☐	Oxford Help	☐
Pillow	☑	Sandbag	☐	Warming Blanket	☐
Other					

Ted Stockings		Pneumatic Boots	
On ☑	Off ☐	On ☑	Off ☐

Catheter			
Type:	Indwelling: ☐ Temporary: ☐	Cath. Bag: ☐ Urometer: ☐	Prep:
Size:	Time inserted:	Lubricant:	Balloon Capacity:
Signature:			

Tourniquet (tick all that apply)

Site		Side		Time	
Ankle	☐	Right	☐		
Arm	☐	Right	☐	Time on:	
Thigh	☐	Left	☐	Time off:	
Digit	☐		☐	Total time	
Surgeon informed at:		1hr ☐	2hr ☐		

Diathermy Plate Position (tick all that apply)

Site		Side		Type	
Abdomen	☐		☐		
Back	☐		☐		
Buttock	☐	Left	☐	Monopolar	☐
Thigh	☐	Right	☐	Bi-Polar	☐
Other:					
Skin condition on plate removal:		Intact ☐		Broken ☐	

Skin Prep (tick all that apply)

Betadine	☐	Betadine Alcoholic	☐	Betadine Scrub	☐
Chloraprep	☐	Chlorhexidine 0.5% in spirit	☐	IPA	☐
Tisept	☐	Other	☐	None	☐

Peri-Operative Infiltration		Wound Lavage	
Type:	Amount:	Type:	Amount:

Prosthesis / Implants (put traceability labels on last page or back of consent form)	
Yes	Details
No	

Procedure Performed

REMOVAL OF GROMMET RIGHT EAR

Intraoperative Counts

Initial Count	Intraoperative	Intraoperative/ Handover	Final
Correct: Yes ☑ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☑ No ☐
Signature: h. dalley			h. dalley
Discrepancy:			
Action taken:			

Drains

Type:
Site:
Sutured in Yes No

Skin Closure

Sutures:
Staples:
Non Closure:

Packs

Dressings

Splints

Type	Site
POP Backslab	
POP CAST	
Zimmer	
Nasal Splints	
Other	

Blood Loss

Swabs:
Suction:
Total: NIL

Specimens

Pathology:
Microbiology:
Other:

Tissue uplift by Porter (as per protocol)

Handover to Recovery		
Yes ☑	No ☐	N/A ☐

	Print	Sign
Scrub Nurse	SSN J. Edwards	J Edwards

Traceability Labels

12 of council directive 93/42/EEC concerning medical devices

MINOR EAR TRAY - ENT

ID- A000063
2023/08/04 ENT007
Edinburgh Royal Infirmary

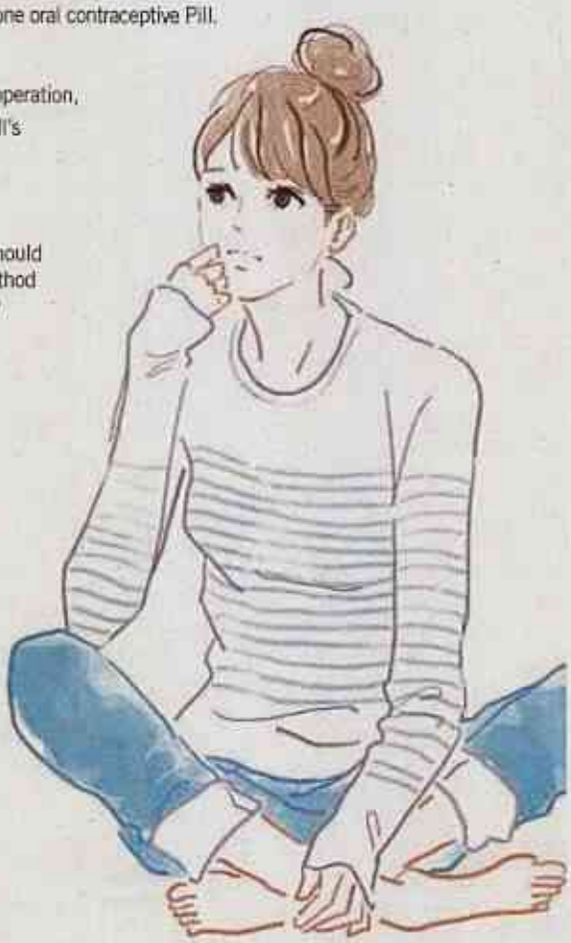
As part of the anaesthetic care for your operation, you have been given a medicine called sugammadex.

Sugammadex (also known as Bridion) is used to speed up recovery of your muscles after an operation.

Sugammadex can affect hormonal contraceptives so it is important to follow this advice.

Sugammadex can make hormonal contraceptives - including the 'Pill', vaginal ring, implants or a hormonal IntraUterine System (IUS) - less effective because it reduces how much you get of the progestogen hormone. The amount of progestogen lost by using Sugammadex is about the same as missing one oral contraceptive Pill.

- If you are taking **the Pill** on the same day as your operation, follow the instructions for a missed dose in the Pill's package leaflet.
- If you are using **other** hormonal contraceptives (for example a vaginal ring, implant or IUS) you should use an additional non-hormonal contraceptive method (such as a condom) for the next 7 days and follow the advice in the package leaflet.



Always read the Bridion patient information leaflet for more information.

Reporting of side effects. If you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in the package leaflet. You can also report side effects directly via the Yellow Card Scheme at www.mhra.gov.uk/yellowcard or by searching for MHRA Yellow Card in the Google Play or Apple App Store. By reporting side effects you can help provide more information on the safety of this medicine.

MSD

Merck Sharp & Dohme Limited
Registered Office: Hertford Road, Hoddesdon, Hertfordshire EN11 9BU
Registered in England No. 620771

GB-XBR-00013. Date of preparation: January 2019.

Created and produced by MSD

National Early Warning Score 2 (NEWS2) Chart

NHS Lothian

800325165E F
Na MCATEER Gillian
23-May-82 **CHI:** 230 582 1425
78132 AP McNutt
D(Flat 1 West Lothian
EH48 2QF
CH

Date chart commenced: .....

This is chart number ..... of this admission

Conscious Level Chart to be completed when clinically indicated

| | | |

Addressograph

800325165E F
MCATEER Gillian
23-May-82 **CHI:** 230 582 1425
78132 AP McNutt
Flat 1 West Lothian
EH48 2QF

NEWS of 5 or more?

Think Sepsis!

In a patient with a **NEWS** of **5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Special Instructions:
Only to be completed under the direction of a senior member of the medical team

A total NEWS of _____ or individual parameter of _____
is acceptable for this patient because _____

Please escalate if _____

Print _____ Sign _____ Designation _____

Date _____ Time _____ *(only valid if signed and dated)*

***Regardless of NEWS always Escalate if concerned about a patient's condition. Escalate immediately if clinical observations cannot be obtained**

NEWS TOTAL	Monitoring Frequency	Clinical Response Document concerns/decisions in patients clinical notes
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 Urgent response threshold	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart

Codes for recording oxygen delivery on the NEWS2 observations chart

A	breathing air	**RM**	reservoir mask
N	nasal cannula (document in litres)	**TM**	tracheostomy mask
SM	simple mask	**CP**	CPAP mask
V	venturi mask and percentage (e.g device = V, % = 40)	**H**	humidified oxygen and percentage (e.g device = H, L/min or % = 40)
NIV	patient on NIV system	**OTH**	Other specify

Date / Time																
Circulation																
Sensation																
Movement																

NEWS Key 0 1 2 3		Date:	31/8/2023																										Date
		Time:	09A		1605	1650																							Time
A+B Respirations Breaths/min		≥25																											≥25
		21-24																											21-24
		18-20			20																								18-20
		15-17	16			16																							15-17
		12-14																											12-14
		9-11																											9-11
		≤8																											≤8
A+B SpO_2 Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%		≥96	97		98	97																							≥96
		94-95																											94-95
		92-93																											92-93
		≤91																											≤91
SpO_2 Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure		≥97 on O_2																											≥97 on O_2
		95-96 on O_2																											95-96 on O_2
		93-94 on O_2																											93-94 on O_2
		≥93 on air																											≥93 on air
* ONLY use Scale 2 under the direction of a qualified clinician		88-92																											88-92
		86-87																											86-87
Tick box if using SpO_2 Scale 2		84-85																											84-85
Sign:		≤83																											≤83
Air or Oxygen? Oxygen is a drug and prescribed by target range		A = Air	A			✓																							A = Air
		O^2 L/min or %			2L																								O^2 L/min or %
		Device			RM																								Device
C Blood Pressure mmHg Score uses Systolic BP only If manual BP mark as M		≥220																											≥220
		201-219																											201-219
		181-200																											181-200
		161-180																											161-180
		141-160																											141-160
		121-140	A																										121-140
		111-120			109																								111-120
		101-110			^	^																							101-110
		91-100																											91-100
		81-90	✓																										81-90
		71-80																											71-80
		61-70				✓																							61-70
		51-60																											51-60
		≤50																											≤50
C Pulse Beats/min Manual pulse		≥131																											≥131
		121-130																											121-130
		111-120																											111-120
		101-110																											101-110
		91-100																											91-100
		81-90																											81-90
		71-80																											71-80
		61-70	^																										61-70
		51-60																											51-60
		41-50																											41-50
		31-40																											31-40
		≤30																											≤30
D Consciousness Score for new onset of confusion (no score if chronic)		Alert	✓			✓																							Alert
		New Confusion																											New Confusion
		V																											V
		P																											P
		U																											U
E Temperature °c		≥39.1°																											≥39.1°
		38.1-39.0°																											38.1-39.0°
		37.1-38.0°																											37.1-38.0°
		36.1-37.0°	^		36.2																								36.1-37.0°
		35.1-36.0°																											35.1-36.0°
		≤35.0°																											≤35.0°
NEWS TOTAL			0		3	1																							**Total**
Monitoring frequency						12H																							Monitoring
Escalation of care Y/N						N																							Escalation
Initials			MG		KO	MS																							Initials
Urine output recorded Y/N					N	N																							Urine output
Blood Glucose level or N/A					N/A	N/A																							Blood Glucose
Pain score (0-10)					0	0																							Pain
Nausea score (0-3)					0	0																							Nausea
Motor Block score (0-4) or N/A					N/A	N/A																							Motor Block

RECOVERY

Reproduced from: Royal College of Physicians. National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS. Updated report of a working party. London: RCP, 2017.

NHS Lothian

Preoperative Assessment - Anaesthetic Summary Report

UHPI:	CHI:	Surname:	Forename:	DoB:
800325165E	2305821425	McAteer	Gillian	23/05/1982 (41y 2m)

Planned Procedure: removal of grom right ear +/- fat ? myringoplasty

Assessment type:	Patient present		
Assessment Date:	08/06/2023	**Hospital:**	St John's Hospital at Howden
Procedure Date:	14/06/2023	**Surgeon:**	Dr Louise McMurran
TCI Date:	14/06/2023	**Interpreter:**	No
TCI Time:	11:00	**Pref Language:**	English

Allergies / Adverse Reactions

Allergy	Nature of Reaction	Comments
Amoxicillin	Urticaria	

Smoking / Alcohol / Lifestyle

Lifestyle Choice	Lifestyle Details
Alcohol status	Currently exceeds weekly recommended limits
Smoking status	Current smoker

Functional Activity

Walk uphill (MET 8).

TRAK Alerts

allergy

Red Flags

BMI: 41.59

Frailty Flags

Past Medical History

Depression
Anxiety
long standing and on medication
Severe hearing impairment

Previous Surgery

Bowel surgery as a result of intussusception 1982
Grommets insertion 2015
Septoplasty 2017

NHS Lothian

Preoperative Assessment - Anaesthetic Summary Report

UHPI:	CHI:	Surname:	Forename:	DoB:
800325165E	2305821425	McAteer	Gillian	23/05/1982 (41y 2m)

Medications/Pharmaceutical Care Issues (or see ECS Report)

Sertraline 100mgs x2 daily
Chlopromazine 50mgs at night
Beclometasone 50micrograms 2 sprays BD
Mometasone 50micrograms 2 puffs daily/prn for cough.

Observations Information

Date & Time	08/06/23 14:42	08/06/23 14:42
Weight(kg)	110.5	
Height/Length(cm)	163	
BMI	41.59	
SpO2	97	
Heart Rate	82	
Blood Pressure Systolic	153	
Blood Pressure Diastolic	91	
Comments		

Date & Time	08/06/23 14:42
Most recent BMI	41.59
Most recent Weight	110.5

Airway Assessment

Neck flexion/extension:	Full Movement
Mouth opening:	3 finger breadths (~5cm)
Thyromental distance:	6.5cm or more
Mallampati:	I
Jaw subluxation:	Class A
Previous airway pathology, surgery, or radiotherapy:	No
Details:	

VTE Risks

Risk Evaluation	Score
Caprini	3

Peri Operative Risk (30 days)

No peri operative risk prediction recorded

Waterlow Score

Not assessed

UHPI:	CHI:	Surname:	Forename:	DoB:
800325165E	2305821425	McAteer	Gillian	23/05/1982 (41y 2m)

Information Provided to Patient

Fasting:

Medication:

Medication instructions:

The following written information was provided:

Pre Operative Assessment Note

Date/Time	Created User	Note
08/06/2023 16:20	Christine Cochrane	Seen in clinic with DOSA for grommet removal BMI 41 BM 5.8mmol/L On medication for depression and anxiety. Other obs okay Still smoking 15-20 day. Referral to stop smoking team today Will arrive fasting and organise someone to stay post op as lives with daughter aged 12 years

Clinical Notes

No clinical notes recorded

Nursing Information

Next of Kin

12/ 23 hr Patients

Journey home <90mins:	Yes
Patient agreed to be accompanied by responsible adult will be at home with patient, at least overnight:	Yes
Responsible adult will be at home with patient, at least overnight:	Yes
Patient advised not to drive or operate machinery within 24 hours of operation:	
Patient advised not to drink alcohol within 24 hous of operation:	Yes

Transport / Interpreter bookings

Ambulance required:	
Date booked:	
Ambulance booking reference:	
Interpreter required:	
Preferred language:	English
Has the interpreter been booked:	
Interpreter booking ref:	
Religion:	

Urinalysis

Date & Time	08/06/23 14:42	08/06/23 14:42
Glucose mg/dl		
Bilirubin		
Ketones mg/dL		
Specific Gravity		
Blood Ery/uL		
pH		
Protein mg/dL		
Urobilinogen		
Nitrite		
Leucocytes (leu/ul)		
Urinary pregnancy test		
Notes (inc appearance of urine)		NAD
Comments		

Anaesthetic Record

Pre-op information

ASA III BP 126/84 PULSE 66 SpO_2 97 Temp 36.5 Wt 110 Ht 163 BMI 42

PMHx - PNEV GA - N.I issues. Ammaz - M.P.I

M.U. 7J.

FAMHX? - MH NAUC

Drug Sensitivities

S.P. IA.

Specific? - 10-15 cpd.

ALLERGIES - Amoxicillin

Information given to patient: GA - RAW / Sore throat / hoarseness.

Anaesthesia details

Anaesthetist(s) name & grade: R SMITH (CONS) N CAMPBELL (STR) Date: 8/8/23

Supervising Consultant:

Machine check ☑ Trained assistant ☐ Prelist brief / Surgical pause ☐

Vascular access (site / device / size)

22G R hand

Induction

Propofol 180 mg

Fentanyl 100mcg

Rocuronium 50mg

Cefuroxime 50mg

Dexamethasone 8mg

Maintenance Air/O2/Sevo

Airway / Circuit / Machine

Circle / airway CO2 / #7 (S) Facemask RAE

Easy to hand ventilate? Yes ☑

Laryngoscopy grade Gr I Direct

Monitors:

Minimal monitoring ☑

Others

Eye care — Tape ☑ Lubricant ☐ Padded ☑

Pressure care ☐

Fluid warmer ☐

Warming blanket ☐

DVT prophylaxis ☑ n/a ☐

Post Op DVT prophylaxis ☐ n/a ☐

Antibiotics ☐ n/a ☐

Patient / Limb position

Supine

Significant issues or events

Recovery Obs

Time	15 30	16 00	1540 1530 1600
SpO_2	100 99 98		ETT PM PM
$ETCO^2$	4·7 5·5		15L 5L 3L
FiO^2	·95 ·49		97↓ 98↑ 99↑
ET AA sevo	2·1		
Vt.f (Paw)	500 x 10		
	19/4		RL 18 22 21
200			
180			
160			
140	✓✓		
120			
100	✓ ✓		A A A
80			
60			● ● ●
40	^ ^		✓ ✓ ✓
20			
0			
			U 2 1 (Sedation)
Sugammadex	200mg		0 0 0 (Pain)
			0 0 0 (Nausea)
Events			

PL 148 - 500

Temp 36·2

salbutamol inhaler

5 puffs at inhalation
5 puffs at exhalation

wheeze / bronchospasm

Recovery

Anaesthetist instructions: Routine obs ☑ O_2 as needed to maintain SpO_2>93% ☑

Tick if you want to see patient before discharge ☐

Recovery comments:

Arrived into Recovery @ 1540 following a GA, ETT insitu - expelled @ 1545 by the anaesthetist with no issues → cont 5L O^2 via facemask

w access (R) hand - plasmalyte 148 500mls in progress + capped when completed

no issues to (R) ear - cotton wool in place

tolerating water orally

no complaints of pain or nausea

NEWS - 3

Arrival time in recovery: 1540 Time discharged to ward: 1610

Recovery nurse: KBO/E Signature:

Day Surgery Centre
St John's Hospital, Howden Road West,
Livingston, West Lothian, EH54 6PP.
Phone: 01506 524105
www.nhslothian.scot.nhs.uk

NHS Lothian

Consent for Operation

800325165E **F** 23/05/1982
McAteer, Gillian
Flat 1,
Carron Court,
Bathgate,
West Lothian, EH48 2QF
CHI 2305821425
78132 AP McNutt

Consultant: McMURRAN

Planned procedure: Removal of Right Ovarian

Common risks: Bleeding infection

Less common risks: Perforation

I confirm that I have explained to the patient in terms in which my judgement are suited to his / her understanding (and / or to one of his / her parents or guardians), the proposed operation, investigation or treatment, including options available, and if relevant, the need for anaesthesia or sedation.

Signature: [signature] Date: 08/08/23

Name and status of practitioner: McMURRAN

Re-confirmation of consent on the day of admission

Signature: Date:

Name and status of practitioner:

Medical Students
- I agree to allow students to be present in theatre (tick box): Yes ☐ No ☐
- I agree to be examined by a medical student whilst under general anaesthesia in theatre: Yes ☐ No ☐

Medical Photography (I agree to being photographed)
- For my medical records for the purpose of diagnosis and treatment: Yes ☐ No ☐
- For the purpose of teaching and education: Yes ☐ No ☐
- For the purpose of publication: Yes ☐ No ☐
- To be shown to other patients (as an example): Yes ☐ No ☐

Tissue for medical research and teaching
When you have tissue removed as part of a medical investigation, operation or procedure, such as a blood test, some tissue may be left over after the laboratory tests have been completed. This tissue could be kept without your name or the details, so that it is impossible to know whom the tissue came from, and used for research or teaching, to improve laboratory tests, or to see how many people in an area might have a disease or an infection.

Do you agree? Yes ☐ No ☐

To the patient (or parent or guardian if appropriate)

1. Please read this form and the notes overleaf very carefully.
2. If there is anything that you don't understand about the explanation or if you want more information, you should ask the practitioner before signing.
3. Please check that all the information on the form is correct. If it is and you understand the explanation, then sign the form.

I am the patient / parent / guardian (delete as necessary)

I agree ☐ To what is proposed which has been explained to me by the practitioner named above.

I understand
- ☐ That anaesthesia (general / regional / local) or sedation will be needed.
- ☐ That the procedure may not be done by the practitioner who has been treating me so far.
- ☐ That any procedure in addition to the investigation or treatment described on this form will only be carried out of it is necessary and in my best interests and can be justified for medical reasons.

I have told ☐ The practitioner about the procedures I have noted below which I would wish not to be carried out without my having the opportunity to consider them first.

Signature: X Gillian McAteer Name: Gillian McAteer

Notes to all Health Practitioners (Doctors, Dentists, Nurses, Professionals Allied to Medicine)

A patient has an absolute legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way that they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to the treatment at any time. The patient's consent to treatment should be recorded on this consent form (further guidance is given in NHS Lothian's Policy Statement).

Notes to Patients

The health practitioner is here to help you. He or she will explain the proposed treatment and what the alternatives are. You can ask any questions and seek further information. You can refuse treatment.

You should be provided with sufficient information to allow you to come to a decision as to whether to consent to the treatment proposed.

The type of information you should receive should include:

1. Nature of your condition and proposed procedures, including degree of urgency.
2. Benefits to be reasonably accepted of the procedure.
3. Nature and probability of material (= significant) risks involved, including consideration of ratio of risks and benefits.
4. Inability of the practitioner to predict results.
5. Irreversibility of the procedure, if that is the case.
6. The likely result of not having the proposed treatment or procedure.
7. Alternatives available, including their risks and benefits.

You may ask for a relative, a friend or a nurse to be present.

Training doctors, dentists, nurses and other health professionals is essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor, dentist, nurse or other health professional.

You may however decline to be involved in the formal training of medical, dental, nursing and other students without this adversely affecting your care and treatment. You must tell a senior doctor or nurse if you do not wish students to be involved in your care and you should write this on the consent torm in the space for things that you do not wish to happen without you being given the chance to consider them first.

Surgeon's Operation Notes

800325165E F 23/05/1982
McAteer, Gillian
Flat 1,
Carron Court,
Bathgate,
West Lothian, EH48 2QF
CHI 2305821425
78132 AP McNutt

Consultant: McMurran

M / F

Surgeon	Assistants	Scrub Nurse	Operation
McMurran	—	Joan Fowlers	Removal of ~~Right~~ Granuloma

Surgeon's operation notes

Findings: Right Granuloc ~ same irritation on TM.

Procedure: Removed.
Scratched edge of perf to encourage healing.
Glodex drops.

Plan: Home as able
No Routine R/V

McMurran

Surgeon's operation notes - continued

Ward instructions

Complete sickness absence note as necessary
Tick if you want to see patient before discharge ☐

Signature: .....

Name: ..... Date: .....

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Heath
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 06/01/2018

Inpatient Discharge Summary

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (35 years) 800325165E
Specialty	Ear Nose and Throat	**Admission Date**	19/12/2017
Ward	SJH Day Surgery Centre		
Consultant	Dr David EC Baring	**Discharge Date**	20/12/2017

Dear Dr Heath

Date of Admission: 19 December 2017
Date of Discharge: 20 December 2017
Diagnosis: Right nasal deviation
Procedure: Septoplasty
Surgeon: Mr D Baring
Follow up: 3 months SJH

Ms McAteer attended with a history of nasal congestion particularly on the right side. She had a right septal deviation which was corrected with a septoplasty.

Post operatively she made a good recovery and was discharged the following day. I have asked her to use regular Nasonex until I review her again in 3 months, hopefully at which time things will be improved.

Please let me know if she runs into any problems.

Yours sincerely

Mr D Baring
Consultant ENT Surgeon
(dictated but not signed for expediency)

Preoperative assessment document 1: ELECTIVE

PREOPERATIVE ASSESSMENT

Date 6/12/17 Adm. type: **ELECTIVE**

800325165E F 23/05/1982 ian

Name **McAteer, Gillian**
DoB 18 Cherry Avenue,
Unit no. Bathgate,
CHI West Lothian,
EH48 1NA
CHI 2305821425
78132 L Heath

Assessing hospital: SGH Clinic POA

Patient present ☑ Telephone assessment ☐

Check registration details : correct ☐ changed ☑

Reason for admission / Planned surgery or procedure .

Septoplasty

Dates when on holiday / not available

Planned date of surgery 19/12/17 Consultant DECB

Day case ☑ 23h stay ☐ Expected stay ..... days ☐

Day of surgery admission ☑ Other admission date ..... / ..... / .....

Admission time 15-30

Key to Initials of ALL STAFF completing this ICP

Print name	Designation	Initials	Signature	Date
1. CAROL WILSON	CSW	CW	CLO	6/12/17
2. K COOPER	SW	KC		6/12/17
3.				
4.				
5.				
6.				

ADVERSE REACTIONS / ALLERGIES Describe reaction

NKDA

No latex allergy

Preoperative assessment for elective surgery

Date

800325165E F 23/05/1982
Nam McAteer, Gillian
DoB 18 Cherry Avenue,
Bathgate,
Unit West Lothian,
CHI EH48 1NA
CHI 2305821425
78132 L Heath

PATIENT's DETAILS

TITLE: Mr / Mrs / (Miss) / Ms / Other..... Marital Status: Single

Age: 36 Occupation: full time mum

Prefers to be known as Gillian

Tel. Nos. Home .....
Work .....
Mobile 07562628486

GP Dr Hacken / Simpsons
GP Address Bathgate Community care centre
GP tel no. 01506 654446

Ethnic Origin: ..... First Language: English ☑ Other ☐ .....

Interpreter Required : Yes ☐ No ☑
(see Intranet> Healthcare > A-Z > Translation, Interpretation & Communication Support)

Religion: ..... *(If Jehovah's Witness attach appropriate form)*

Request for visit from hospital chaplain / minister of religion: Yes ☐ No ☑

NEXT OF KIN

[redacted]

Work .....
Mobile .....
Aware of admission Yes ☑ No ☐

SECOND CONTACT (If required)

Name: .....
Relationship: .....
Address: .....
.....
.....
Contact nos: Home .....
Work .....
Mob .....
Aware of admission Yes ☐ No ☐

Who to contact in an emergency

Mum

COMMON ABBREVIATIONS USED IN THIS DOCUMENT

BM	Capillary blood glucose (aka cBG)	**Ht**	height	**R/O**	Removal of
BMI	Body Mass Index	**IV**	Intravenous	**RA**	Rheumatoid arthritis
BP	Blood pressure	**ICP**	Integrated Care Pathway	**RF**	Renal failure
C&S	Culture and Sensitivity	**kg**	Kilograms	**RR**	Respiratory Rate
cm	Centimetre	**LMP**	Last menstrual period	**SEWS**	Standardised Early Warning Score
COPD	Chronic Obstructive Pulmonary Disease	**MI**	Myocardial infarction		
		MUST	Malnutrition Screening Tool	**TB**	Tuberculosis
DoS	Day of surgery	**N/A**	Not applicable	**Temp**	Temperature
DVT	Deep vein thrombosis	**NOK**	Next of kin	**U&E**	Urea and electrolytes
ECG	Electrocardiograph	**OA**	Osteo arthritis	**VTE**	Venous thromboembolism
EDD	Estimated Date of Discharge	**OPD**	Out patient department	**Wt**	Weight
ERAS	Enhanced Recovery After Surgery	**P**	Pulse		
FBC	Full blood count	**PE**	Pulmonary embolus		
HRT	Hormone replacement therapy	**PMHx**	Past medical history		

Preoperative assessment for elective surgery

Date

Name
DoB
Unit no.
CHI

800325165E F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 L Heath

PRESENTING COMPLAINT / HISTORY

(R) Nasal obstruction

Patient aware of condition? Yes ☑ No ☐ *Detail awareness of eg, malignancy etc)*

Mood / Concerns with regard to current treatment plan? NO

PAST Medical history Include year and place

Asthma since childhood mild
Depression

(or: No to all questions and else nil of note ☐)

800325165E F
MCATEER Gillian
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Preoperative assessment for elective surgery

History (1)

Date

Name
DoB
Unit no.
CHI

PREVIOUS Operations Include year and place

Bil Grommets insertion 01/15

(or: No to all questions and nil of note ☐)

Any problems with surgery or anaesthesia **in the past**? Include year and place
(include details of airway problems, if any)

(or: No to all questions and nil of note ☑)

Any significant **family** (blood relatives) medical / surgical / anaesthetic history we should know about?

Dad missed heart Beat

(or: No to all questions and nil of note ☐)

BASIC OBSERVATIONS

Height 163 m	Weight 116·7 kg	BMI 43·6 kg / m²
MUST Score	Pt concerned about weight? Yes ☐ No ☐	SpO_2 96 % (on air)
Pulse rate 81 / min	BP 1 135 / 84 mmHg	BP 2 / mmHg
BP 3 / mmHg	BP 4 / mmHg	Temp °C
Urinalysis NAD		

Preoperative assessment document 1: ELECTIVE

Preoperative assessment for elective surgery

History (2)

Date

Name
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Unit no.
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MEDICATION HISTORY (prescription, over the counter, homeopathic, herbal. etc)

(Remember inhalers / eyedrops / creams / injections)

If diabetic, include Diabetes ICP in notes

MEDICINE (approved name)	Strength	Dose	Route	Frequency	**COMMENTS**
1. Sertraline	200mg		O	1 x Mane	
2. Chlorpromazine	50mg		O	1 x Nocte	
3. Salbutamol	100mcg		O	2 puffs	PRN last used ages ago
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					

How was medication history obtained? *(Must be by two methods)*

N/A ☐ GP letter ☐ Medications available ☑ Patient ☑ Relative / carer ☐ Repeat prescription ☐

ECS on Trak ☐ Pharmacy-supplied "Dosette" box (or other compliance aid)? ☐

Community Pharmacy ☐ Name ..... tel. number .....

Informed of *Use of own medicines* policy? Yes ☐ No ☐ N/A ☐

Use of own medicines form completed? Yes ☐ No ☐ N/A ☐

Advised of LUHD's use of supplementary prescribers? Yes ☐ No ☐ N/A ☐

ADVERSE REACTIONS / ALLERGIES – ensure recorded on p1

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Preoperative assessment for elective surgery

Review of Systems (1)

Summarise actions In "Summary of Assessment"
If YES is circled for any main question, expand on severity / frequency / duration / recent changes – what, when, how, etc

Name
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CARDIOVASCULAR SYSTEM

Any history of: high blood pressure ☐, angina ☐, atrial fibrillation ☐, heart murmur ☐, MI ☐, rheumatic fever ☐, DVT / PE ☐, stroke or TIA ☐ ?

Do you get

Chest pain	No ☐	Yes ☐
Short of breath	No ☐	Yes ☐
Ankle swelling	No ☐	Yes ☐

No to all questions and nil else of note ☑

Requires medical referral? Yes ☐ No ☑

RESPIRATORY SYSTEM

Any history of: asthma ☑, TB ☑, COPD ☐ ?

Do you / have you

A cough?	No ☐	Yes ☐
Sputum or phlegm	No ☐	Yes ☐
Coughed up blood	No ☐	Yes ☐
Get wheezy	No ☐	Yes ☐

Grandfather had TB
family all checked out NAD

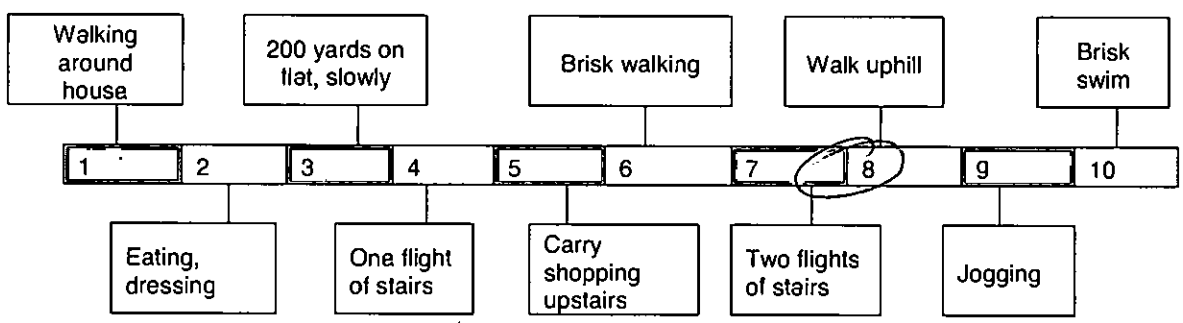
No to all questions and nil else of note ☑

Requires medical referral? Yes ☐ No ☑

FUNCTIONAL CAPACITY

Patient's occupation / former occupation ..... Not working .....

Maximum equivalent activity (Please ring number in box, = MET Score) :



Estimated MET score..... 7 - 8 ..... *(highest ringed number)*

What limits activity?		Comments
Nil	☐	
Arthritis / leg pain / back pain	☐	
Angina	☐	
Shortness of breath	☐	
Other	☐	

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Preoperative assessment for elective surgery

Review of Systems (2)

Summarise actions In "Summary of Assessment"
If YES is ticked, expand on severity / frequency / duration / recent changes – what, when, how, etc

Name
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DIGESTIVE SYSTEM *see also 'Nutrition'*

Do you / have you

- Any recent appetite changes — No ☐ Yes ☐
- Vomited any blood — No ☐ Yes ☐
- Heartburn / indigestion [including when lying flat] — No ☐ Yes ☐
- Stomach pain — No ☐ Yes ☐
- Changes in bowel movements, black or bloody stools — No ☐ Yes ☐ Haemorrhoids
- History of jaundice? ☒

No to all questions and nil else of note ☐ Requires medical referral? Yes ☐ No ☑

ENDOCRINE system

Diabetes mellitus ☐ Type 1 ☐ Type 2 ☐
treatment: insulin ☐, tablets ☐, diet ☐, other ☐
Thyroid condition ☐
Other endocrine condition ☐ .....

No to all questions and nil else of note ☐ Requires medical referral? Yes ☐ No ☑

SKIN

Any skin diseases? No ☐ Yes ☐ (Eczema, psoriasis etc ~~please specify~~)

.....

describe any action required on page 16

No to all questions and nil else of note ☐ Requires medical referral? Yes ☐ No ☐

NERVOUS system

Any history of epilepsy ☒, "blackouts" ☐?

If Yes, describe

.....

Do you get

- Severe headaches, migraines — No ☐ Yes ☐
- Eye problems — No ☐ Yes ☐
- Faints, dizziness, muscle weakness or tingling sensations — No ☐ Yes ☐

No to all questions and nil else of note ☑ Requires medical referral? Yes ☐ No ☑

SLEEPING / LYING FLAT

Sleep: well ☐, disturbed ☑ *describe* ..... Mind over mine.....
Any sleeping medication / treatment — No ☑ Yes ☐
Are you able to lie flat comfortably: — No ☐ *describe* .....Yes ☑

Sleep Apnoea — No ☑ Yes ☐ No orthopnea.
CPAP machine used — No ☑ Yes ☐
If more than 1 year since PAT test contact Estates ☐ ref. no. .....

Preoperative assessment for elective surgery

Review of Systems (3)

Summarise actions In "Summary of Assessment"

If **YES** is ticked, expand on severity / frequency / duration / recent changes – what, when, how, etc

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GENITO-URINARY system URINE SAMPLE SENT FOR C & S Yes ☐, or, N/A ☐

Any history of Renal conditions / intervention ☐ No to all questions and nil of note ☑

When passing urine, do you

Pass blood or have pain	No ☐	Yes ☐
Need to pass urine very frequently	No ☐	Yes ☐
Find your sleep disturbed by having to pass urine frequently?	No ☐	Yes ☐
Experience difficulty – slow to start, dribble etc	No ☐	Yes ☐
Required/s catheterisation:	No ☐	Yes ☐

requires medical referral? Yes ☐, No ☑

Female patients only

Date of LMP ..... Details of last period ..... Details of cycle ..... days *(normal, light, heavy)*

Date of last cervical smear .....Method of contraception ..... or N/A ☐ . Parity .....

Pregnancy test on day of surgery discussed* Yes ☐ No ☐ **If <50yrs or within 2 years of any bleeding*

(See A&T Intranet guideline "Pregnancy testing before surgery").

BLOOD DISORDERS Any history of anaemia ☐, other blood disorders ☐ ?

If Yes, describe

.....

.....

.....

OTHER ILLNESSES: e.g. any history of cancer ☐, arthritis: OA ☐, RhA ☐ ?

.....

Maternal Gran lung CA

Dad ? stomach CA

Grandad

or, No to all questions and nil of note ☑

Please also complete

Prion disease risk factor assessment *(Appendix 1)*			☑
Local venous thrombo-embolism risk assessment *(Appendix 3a or b)*			☑
4AT assessment *(Appendix 4)*	☐	*or* **completed on Trak**	☐
MUST score *(Appendix 5)*	☐	*or* **completed on Trak**	☐

Preoperative assessment for elective procedure		
Airway Assessment	Name	800325165E F 23/05/1982 McAteer, Gillian
(For completion only by anaesthesia or pre-admission staff)	DoB	18 Cherry Avenue,
	Unit no.	Bathgate,
	CHI	West Lothian,
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		CHI 2305821425
		78132 L Heath

Where appropriate, record more fully in 'Summary of Assessment'

DOES THE PATIENT APPEAR TO HAVE COMPLICATED DENTITION: Yes ☐ No ☑

DENTITION – patient's report

R	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8 L
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Mark

D: Denture L: loose teeth/filling

B: Bridge

C: Crown

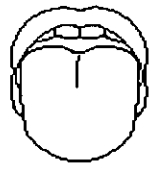
Dental abscess / issues: No , Yes

AIRWAY ASSESSMENT

1. Patient can flex and extend neck normally?	Yes ☑ No ☐
2. Patient can open mouth >3cms (2 finger breadths)?	Yes ☐ No ☐
3. Patient can protrude jaw so that lower teeth are in front of upper teeth?	Yes ☑ No ☐
4. Thyromental distance >6.5cm?	Yes ☑ No ☐
5. Previous history of difficult intubation?	Yes ☐ No ☑

6. Mallampati classification:

Seated patient protrudes tongue as far as possible. From patient eye level, assess pharyngeal structures.

Class I	Class II	Class III	Class IV
☐	☐	☑	☐ 
Soft palate, uvula, fauces and pillars all visible.	Soft palate, uvula, & fauces visible, pillars obscured.	Only soft palate visible.	Soft palate not visible.

If the faucial pillars (palatoglossal & palatopharyngeal arches) & uvula cannot be seen (because they are obscured behind the base of the tongue, grades III & IV), visualisation of the glottis at laryngoscopy is likely to be more difficult

The following airway findings require referral to anaesthetist:

See local / specialty specific guidelines

Preoperative assessment for elective surgery

Examination by medical staff

Summarise actions in "Summary of Assessment"

addressograph label, *or,*

Name

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PHYSICAL EXAMINATION

Pale	Cyanosed	Clubbed	Jaundiced
Lymphoedenopathy			
Hydration			
Skin			
Thyroid			
Breasts			
Any fevers/chills recently?			

CVS

Pulse

BP (Erect/Supine)

JVP (Jugular Venous Pressure)

Apex Beat

Heart Sounds

Oedema

PHYSIOLOGY SCORE
Please tick

Cardiac*
- No failure
- CVS drugs
- Peripheral oedema
- Warfarin therapy
- Raised JVP

ECG*
- Normal
- Atrial Fibrillation
- Abnormal rhythm
- Recent Q, ST/T changes

RS

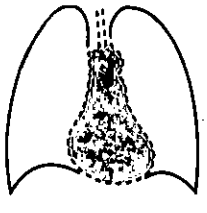
Respiratory Rate

Trachea

Expansion

PN (Percussion Notes)

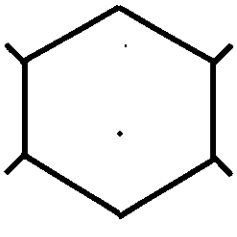
BS (Breath Sounds)



Respiratory*
- Nil
- SOBOE
- Limiting dyspnoea
- Dyspnoea at rest

CxR*
- Normal
- Borderline CM
- Cardiomegaly
- Mild COAD
- Moderate COAO
- Fibrosis
- Consolidation

Abdomen:



- Masses
- Liver
- Spleen / Kidneys
- Bowel sounds
- Herniae
- Genitalia
- PR
- FOB

Vaginal Examination: (if indicated)

Rectal Examination (if indicated)

CNS/Locomotor

Assessing Doctor:

Signature ..... print name:.....

Date:..... time: designation .....

Preoperative assessment document 1: ELECTIVE

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Preoperative assessment for elective procedure

Nursing & Social Assessment (1)

Summarise actions in "Summary of Assessment"

Name
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PAIN ASSESSMENT

Does patient attend a Pain Clinic or have an established history of chronic pain? Yes ☐ No ☐

If so please ask patient to score pain, out of 10 (0 = no pain, 10 = worst pain imaginable) _____

Has previous pain or nausea control after surgery been unsatisfactory? Yes ☐ No ☐

Does patient use regular opioid analgesic:
(eg. MST / Oxycodone / Fentanyl)? Yes ☐ No ☐

Does patient have regular use of high dose mild opiates:
(eg. Dihydrocodeine / Tramadol)? Yes ☐ No ☐

If the patient answers YES to any of above questions, did you contact anyone about pain management Yes ☐ No ☐

If Yes, whom? *name* ..... *and detail outcome in 'Summary of assessment'*

HEALTH PROMOTION

CIGARETTE SMOKING Non smoker ☐ Recent ex-smoker ☐ stopped ..... (date)

Smoker ☑ Number of cigarettes smoked per day ....10.....

Ever tried to stop? Yes ☐ No ☐ Intending to try the Vapour 1:1 Nicotine

Advised of the value of stopping and the risks to health of continuing to smoke cigarettes ☑

Discussed with patient implications of no smoking policy within the hospital and grounds ☑

Identified ways of managing before admission e.g. consult GP ☐ nicotine patches ☐

Interested at all in stopping now? Yes ☐ No ☐ ....Intending....using....the....Vapour....

If would like to stop, detail information given to assist .....

ALCOHOL INTAKE None ☐

Daily intake .....units OR Weekly intake .....16.....units

(1 unit of alcohol = small glass of wine, or 25 ml pub measure of spirit, or half pint of ordinary strength lager/beer/cider
Current daily guidelines for sensible drinking: men 3 – 4 Units per day or less, women 2 – 3 Units per day or less.

Any patient concerns about his/her alcohol intake? .....

If yes, detail information given to assist .....

OTHER MOOD ALTERING SUBSTANCES: None ☑ Yes ☐ (Specify below)

.....

Is the patient concerned about his / her substances use? .....

If yes, detail information given to assist.....

WEIGHT CONCERNS Is the patient concerned about his / her weight No ☐ Yes ☑

If yes, detail information given to assist .....Aware She is overweight.....

COMMUNICATION & PERCEPTION

SIGHT:	No aids	☐	Glasses	☐	Contact Lenses ☐	Registered Blind	☐
HEARING:	Satisfactory	☐	Difficulties	☑ Both		Hearing Aid(s)	☑
SPEECH:	Normal	☐	Impaired (eg after stroke)	☐		Sign Language	☐
	Interpreter	☐	Other aid or assistance	☐			

Preoperative assessment for elective procedure

Nursing & Social Assessment (2)

Summarise actions in "Summary of Assessment"

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Lives with Husband / Wife / Partner / Other (*specify*) ☑ ..... Alone ☐

ARE YOU ARE CARER FOR ANYONE (*specify*) Yes ☐ ..... No ☐

LEARNING DISABILITIES Yes ☐ No ☑
If Yes, refer to Learning Disabilities Liaison Nurse: *Contacted Yes / No detail outcome*

HOUSING
House ☐ Bungalow ☐ Ground Floor Flat ☐ Flat ☐ on .....floor
Residential / Part IV ☐ Nursing Home ☐ Hostel ☐ No Fixed Abode ☐
Bedroom: upstairs ☐ downstairs☐ Bathroom: upstairs ☐ downstairs☐

STAIRS: None
Outside: ..... (number) Inside: ..... (number) Lift ☐
Does patient have any difficulty with the stairs? Yes ☐ *(specify)* .....No ☐

EQUIPMENT None: ☐
Toilet aids ☐ Shower cubicle ☐ Shower over bath ☐ Bath aids ☐ Bath only ☐
Bed Rail ☐ Trolley ☐ Dressing Aids ☐ Commode ☐ High Chair ☐
If Yes to any please specify level of independence.....

MANUAL HANDLING and MOBILITY Hand Dominance – L ☐ R ☐ See p4 for BMI .....
Is the patient independent Yes ☐ No ☐
If No specify aids used: .....
Specify assistance required: e.g. hoist etc .....
☐ If hoist, is it supplied by NHS Lothian: Yes ☐ No ☐ – refer to **Manual Handling** guidelines
☐ If patient weighs >25st [160 kg] – refer to 'Heavy patient' procedure in **Manual Handling** guidelines
Tick if patient requirements indicate staff should be aware of this guideline in caring for this patient & specify actions required from these guidelines

Falls Risk Assessment (STRATIFY)

Admitted with fall or fall since admission	Yes ☐ No ☐
Confused or agitated	Yes ☐ No ☐
Function impaired by poor vision	Yes ☐ No ☐
Frequent toileting	Yes ☐ No ☐
Help to transfer/walk (No, if bed bound)	Yes ☐ No ☐

Complete a Falls Care Plan if:
Yes to two or more, or if this admission was precipitated by a fall, or patient has fallen since admission
Completed Yes ☐ No ☐

HYGIENE No concerns ☐
Requires Assistance ☐ - *give details*
.....
.....

FEEDING & NUTRITIONAL ASSESSMENT MUST score ....0.....
.....
.....

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Nursing & Social Assessment (3)

Summarise actions in "Summary of Assessment"

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SKIN CONDITIONS

Do you have a history of skin disorders ☐, leg ulcers / pressure sores ☐, circulation problems ☐?

Dressings, if applicable (including frequency of changes, by whom etc). Detail 'Summary Of Assessment'

.....

.....

Please also complete the Waterlow pressure care guide *(Appendix 2)* ☒

Total score =

Nursing & Social assessment completed by:	**Print name:**	**Date**
Signature / initials*: RMC		6/12/17

* initials are acceptable **IF** an entry has been completed on pg 2

Please obtain & confirm the patient's consent before contacting any of the staff or groups below

Patients Signature_____

HOME SUPPORT	N/A	MON	TUE	WED	THU	FRI	SAT	SUN	CONTACT NAME / NUMBER
District Nurse									
Health Visitor									
Social Worker									
Stoma Therapist									
Dietician									
Home Help									
Private Home Care									
CPN									
Frozen Meal Service									
Day Centre									
Day Hospital									
Other1 *specify*									
Other2 *specify*									

Preoperative assessment for elective procedure **Overall Summary of Assessment**	Name DoB Unit no. CHI

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Medical Referral required No ☑ Yes ☐ Surgeon ☐ GP ☐ other ☐

If Yes, reason .....

.....

Name of doctor spoken to .....

Information, eg medical notes / care pathway / results, referred to anaesthetist No ☐ Yes ☐

Discussion with anaesthetist required: No ☐ Yes ☐ Seen by anaesthetist No ☐ Yes ☐

Referral reason .....

.....

Name of consultant anaesthetist spoken to / contacted .....

INVESTIGATIONS REQUESTED

See: Pre-operative assessment of patients before elective surgery - a general guide (Intranet)

FBC ☐ U&E ☐ LFTs ☐ Coagulation screen ☐ Group & save ☐

ECG ☐ CXR ☐ Echocardiogram ☐ PFTs ☐ Chlamydia swab ☐

Other (specify) ☐ .....BM.....bacteriuria.....

.....

OVERALL SUMMARY OF ASSESSMENT (free text space on pp 15 -16)

☐ Proceed to book for surgery

☐ Further review / investigations required before final decision (*Specify below*)

Waiting list office:

Early on am list ☐ Diabetic ☐ Possible difficult airway ☐ High BMI ☐

Haematology involvement ☐

Assessing Doctor: / Nurse

Signature .....Print Name: Cooper

Date: 6/12/17 Time: 10.50 Designation SN

800325165E F 23/05/1982

Preoperative assessment for elective procedure

Overall Summary of Assessment and further notes

Name	**McAteer, Gillian**
DoB	18 Cherry Avenue,
Unit no.	Bathgate,
CHI	West Lothian,
	EH48 1NA
	CHI 2305821425
	78132 L Heath

OVERALL SUMMARY OF ASSESSMENT

Date/time		initial
6/12/17	Observations Satisfactory. To come in fasted to Bosa on 19/12/17 @ 15.30hrs. PMH- Depression Obesity Asthma	

Preoperative assessment for elective procedure **Overall Summary of Assessment and further notes**	addressograph label, *or,* Name DoB Unit no. CHI

OVERALL SUMMARY OF ASSESSMENT		
Date/time		initial

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Preoperative assessment for elective procedure

OVERALL SUMMARY OF ASSESSMENT
continued

INFORMATION

Patient informed that he / she must arrange transport home by car or taxi ☑

Patient informed that he / she must accompanied by responsible adult for 24h ☑

Leaflets given:

Inpatient booklet ☑ Visiting Hours ☑ Operation ☑ Your spinal anaesthetic ☑ Epidurals

for pain relief after surgery ☐ Pain relief ☑ Physio Booklet ☐

Other (specify) ☐ .....

INTEGRATED CARE PATHWAY

If to be commenced on an ICP, specify which major : .....

Any supplementary ones?: .....

TRANSPORT Ambulance required ☐ Date/time.....

Date of booking / Order ref no..... / .....

OPERATIVE PREPARATION Skin Prep Required Yes ☐ No ☐ Glycerine Suppositories Yes ☐ No ☐

Other (specify) .....

NURSE SPECIALIST REFERRALS *tick if applicable & give details*

Stoma Nurse contacted ☐ ..... *(if applicable, insert Stoma Care plan in Booklet)*

Other Nurse Specialist contacted ☐ (*specify*) .....

Pre-Admission Nurse

Signature / Print: [signature] Designation: SN Date: 6/12/17

Planning for discharge

friend will collect on discharge

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Preoperative assessment for elective procedure

PRION Disease Risk Factors

Name
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NOTE: Only approximately 1 in 10,000 patients will be classified as "maybe at risk")

Please ask the patient question 1.

The assessor should consider, and answer, the three bullet points.

Ask the patient questions 2 - 5

If the answer is "yes" to any question, follow the appropriate path on the NHS Lothian CJD Risk Assessment flow sheet.

1. Have you ever been contacted as "at risk of CJD for public health purposes? ①....	N	Y
• Is there any mention of CJD or v CJD in referral letter?	N	Y
• Does the patient have a neurological disease with cognitive impairment or ataxia, of uncertain diagnosis?	N	Y
• Is the operation likely to involve contact with "high risk" tissues?⑥	N	Y
If "yes" to this question, ask if the patient has received a transfusion of blood, or blood products, since 1980?	N	Y
2. Has anyone in your family suffered from CJD?	N	Y
3. Has you or anyone in your family had genetic testing that suggests you or they are at risk of CJD?	N	Y
4. Have you ever had treatment with growth hormone or gonadotrophin?	N	Y
5. Have you ever had an operation on your brain or spinal cord? ②.....	N	Y

① The key phrase is *"at risk for public health purposes"*.
Since 2003 blood transfusions have not been accepted from those who, themselves, have received blood in the UK since 1980 (Previously Transfused Donors), but this alone should not generate a "yes" response.

② The question refers to operations for cyst or tumour of spinal cord.
Previous operations on the vertebral column (e.g. laminectomy, discectomy, decompression) are not of concern and should not generate a "yes response. See note ⑥ for list of high risk neural tissues

⑥ High Risk tissues for patients with vCJD and at risk of vCJD include:
Brain, spinal cord, dura mater, cranial nerve ganglia, cranial nerves (specifically, the entire optic nerve but only the intracranial components of other cranial nerves), posterior eye (specifically, posterior hyaloids face, retina, retinal pigment epithelium, choroid, sub-retinal fluid, optic nerve), and the pituitary gland.
If in doubt for this patient and this procedure consult senior staff.

WATERLOW PRESSURE CARE GUIDE

Appendix 2

Undertake and document risk assessment within 6 hours of admission

Date and time must be documented
Reassess every day

				Date:							
				Initials:							
				Time:							
Gender	Male		1								
	Female		2								
Age	14-49		1								
	50-64		2								
	65-74		3								
	75-80		4								
	81+		5								
Build / weight for height (kg / m^2)	Average	BMI 20-24.9	0								
	Above average	BMI 25.29.9	1								
	Obese	BMI > 30	2								
	Below average	BMI < 20	3								
Continence	Continent / catheterised		0								
	Incontinent of urine		1								
	Incontinent of faeces		2								
	Doubly incontinent (urine & faeces)		3								
Skin type (Visual risk assesment)*	Healthy		0								
	Tissue paper (thin / fragile)		1								
	Dry (appears flaky)		1								
	Oedematous (puffy)		1								
	Clammy (moist to touch / pyrexia)		1								
	Discoloured (bruising / mottled)		2								
	Broken (established ulcer)		3								
Mobility	Fully mobile		0								
	Restless /fidgety		1								
	Apathetic (sedated / depressed / reluctant to move)		2								
	Restricted (restricted by severe pain or disease)		3								
	Bedbound (unconscious / unable to change position / traction)		4								
	Chair bound (unable to leave chair without assistance)		5								
Nutritional element*	Unplanned weight loss in past 3-6 months										
	< 5%		0								
	5-10%		1								
	> 10%		2								
	BMI > 20		0								
	BMI 18.5-20		1								
	BMI < 18.5		2								
	Patient acutely ill or no nutritional intake > 5 days		2								
Special risks Tissue malnutrition	Smoking		1								
	Anaemia = Hb < 8		2								
	Single organ failure e.g. cardiac, renal, respiratory		5								
	Peripheral vascular disease		5								
	Multiple organ failure / terminal cachexia		8								
Neuro-deficit	Diabetes / MS / CVA /motor / sensory / paraplegia		4-6								
Surgery / Trauma	Orthopaedic / below waist / spinal (up to 48 hours post op)		5								
	On operating table > 2 hours (up to 48 hours post op)		5								
	On operating table > 6 hours		8								
Medication	Cytotoxic, anti-inflammatory, long term / high dose steroid		4								
			TOTAL SCORE								

DATE+TIME	SCORE	EQUIPMENT USED/NEEDED	COMMENTS	SIGNATURE

Total: 10+ = at risk, 15+ = at high risk, 20+ = at very high risk

RISK ASSESSMENT for VENOUS THROMBOEMBOLISM: ELECTIVE SURGICAL / O&G / DSU / 23 HOUR PATIENTS

Appendix 3a

Risk Assessments should be performed for all patients at pre-operative assessment clinic / ward / DSU

Patients should be reassessed every 48 – 72 hours, or sooner if condition changes.

Date of admission 19/12/17 Date of assessment 6/12/17

Assessed by R Cooper Designation SN

800325165E F
MCATEER Gillian
Name 23-May-82 CHI:230 582 1425
DoB 76132 L Heath
18 Cherry Avenue West Lothian
Unit no. EH48 1NA
CHI

Does the patient have thrombosis risk factors? (tick ✓all that apply)	
Age > 60	
Obesity BMI ≥ 30	✓
Active cancer	
Previous VTE	
Family history of VTE: 1 first degree relative suffered VTE at age <50 years *or* > 1 first degree relative with VTE history regardless of age	
Varicose veins (for major general or orthopaedic surgery, low risk after varicose vein surgery)	
Known thrombophilia (no need to repeat thrombophilia screen)	
Other thrombotic states (*See note on p24*)	
Hormone therapy (inc combined OCP, HRT, tamoxifen, raloxifen)	
Pregnancy, *or* < 6 weeks since delivery (Intranet: *Obstetric VTE Prophylaxis & Treatment Policy*)	
Combined anaesthesia and surgery time > 90 mins	✓
Pelvic or lower limb surgery and combined anaesthesia and surgery time > 30 mins	
Post operative immobility	

NO (no ticks) → **PHARMACOLOGICAL PROPHYLAXIS NOT REQUIRED**

Reassess every 48-72hrs, or sooner if condition change

YES (one or more ticks)

Does the patient have bleeding risk factors? (tick ✓all that apply)	
Bleeding disorder (eg haemophilia, von Willebrand's disease)	
Coagulopathy , including warfarin or heparin therapy	
Thrombocytopenia <70 x 10^9/L	
Active peptic ulcer	
Actual or potential bleeding site (inc planned neuro, spinal, eye, or thyroid surgery)	
Acute stroke (seek advice) *or* CNS surgery within last 3 months	
Spinal or epidural anaesthesia possible (consult anaesthetist if in doubt)	
Severe uncontrolled hypertension (≥ 230 / 120 mmHg)	
Severe liver disease	
Renal failure (see over)	
Previous history of heparin induced thrombocytopenia (HIT) (see over)	

NO (no ticks) → **PRESCRIBE PROPHYLAXIS ACCORDING TO LOCAL POLICY**

Reassess every 48-72hrs, or sooner if condition changes

YES (one or more ticks) → **NOT FOR PHARMACOLOGICAL PROPHYLAXIS**

(unless requested by consultant)
Consider mechanical prophylaxis eg TED stockings, unless contra-indicated
Reassess patient every 48 to 72 hours, or sooner if condition changes.

FINAL DECISION (CIRCLE)

For VTE Thromboprophylaxis YES / NO Prescribed by assessor YES / NO

If not prescribed by assessor, enter name of Dr informed _____

Patient informed YES / NO Information leaflet provided YES / NO

Appendix 2

Preoperative assessment for elective procedure

Caprini VTE Risk factor assessment

Name 800325165E F 23/05/1982
McAteer, Gillian
DoB 18 Cherry Avenue,
Bathgate,
Unit no. West Lothian,
EH48 1NA
CHI CHI 2305821425
78132 L Heath

1 point each

- ☐ Age 41-60 years
- ☐ Minor surgery planned
- ☐ History of prior major surgery (<1 month)
- ☐ Varicose veins
- ☐ History of inflammatory bowel disease
- ☐ Swollen legs (current)
- ☑ Obesity (BMI >25)
- ☐ Acute myocardial infarction
- ☐ Congestive heart failure (<1 month)
- ☐ Sepsis (<1 month)
- ☐ Serious lung disease incl. pneumonia (<1 month)
- ☐ Abnormal pulmonary function (COPD)
- ☐ Medical patient currently at bed rest
- ☐ Other risk factors: .....

↳ → → → → → → → → → →Subtotal a [1]

2 points each

- ☐ Age 60-74 years
- ☐ Arthroscopic surgery
- ☐ Malignancy (present or previous)
- ☑ Major surgery (> 45 minutes)
- ☐ Laparoscopic surgery (> 45 minutes)
- ☐ Patient confined to bed (> 72 hours)
- ☐ Immobilizing plaster cast (< 1 month)
- ☐ Central venous access

↳ → → → → → → → → → →Subtotal b [2]

3 Points each

- ☐ Age over 75 years
- ☐ History of DVT / PE
- ☐ **Family history of thombosis***
- ☐ Positive Factor V Leiden
- ☐ Positive Prothrombin 20120A
- ☐ Elevated serum homocysteine
- ☐ Positive lupus anticoagulant
- ☐ Elevated anticardiolipin antibodies
- ☐ Heparin-induced thrombocytopenia (HIT)
- ☐ Other congenital or acquired thrombophilia
- ↓ Type:.....

↳ → → → → → → → → → →Subtotal c [ ]

**most frequently missed risk factor*

*NB: **The Lothian University Hospitals Antithrombotic Guide (Adults) Version 3.2, April 2012, is available on the Intranet***

5 Points each

- ☐ Elective major lower extremity arthroplasty
- ☐ Hip, pelvis or leg fracture (<1 month)
- ☐ Stroke (<1 month)
- ☐ Multiple trauma (<1 month)
- ☐ Acute spinal cord injury (paralysis)(<1 month)

↳ → → → → → → → → → →Subtotal d [ ]

1 point each (For women only)

- ☐ Oral contraceptives or hormone replacement therapy
- ☐ Pregnancy or postpartum (<1 month)
- ☐ History of unexplained stillborn infant, recurrent (≥3) spontaneous abortion(s), premature birth with toxaemia or growth-restricted infant.

↳ → → → → → → → → → →Subtotal e [ ]

Total Caprini Score
(Subtotals a + b + c + d +e) [3]

Caprini score	Risk	Regime
0 - 1	Low	Early ambulation
2 - 4	Moderate	Elastic stockings†
5 +	High	Elastic stockings† & dalteparin

† *with intermittent pneumatic compression in theatre*

Potential contraindications to dalteparin

- ☐ Active bleeding
- ☐ Current oral anticoagulants (aspirin, clopidogrel, warfarin etc)
- ☐ Low platelet count (<100x10^9/l)
- ☐ Heparin induced thrombocytopenia (HIT)
- ☐ Poor renal function (eGFR <30)

Potential contraindications to elastic stockings

- ☐ Severe peripheral arterial disease
- ☐ Peripheral neuropathy
- ☐ Massive leg oedema
- ☐ Major leg deformity
- ☐ Dermatitis (active/severe)
- ☐ Pulmonary oedema

4AT	addressograph label, or, Name DoB Unit no. CHI

Appendix 4

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**
Clearly abnormal	**4**

[2] AMT4

Age, date of birth, place (name of the hospital or building), current year.

No mistakes	**0**
1 mistake	**1**
2 or more mistakes / untestable	**2**

[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

Achieves 7 months or more correctly	**0**
Starts but scores < 7 months / refuses to start	**1**
Untestable (cannot start because unwell, drowsy, inattentive)	**2**

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hours

No	**0**
Yes	**4**

4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or cognitive impairment unlikely (but delirium still possible if information from [4] is incomplete) If any score greater than zero nurses (if undertaking assessment) should escalate concerns so that a diagnosis may be made

Date	Time	Score	Action Plan	Initial

GUIDANCE NOTES

The 4AT is a screening instrument designed for rapid and sensitive initial assessment of cognitive impairment and delirium. A score of 4 or more *suggests* delirium but is not diagnostic: more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. Items 1-3 are rated *solely on observation of the patient at the time of assessment.* Item 4 requires information from one or more source(s), eg. your own knowledge of the patient, other staff who know the patient (eg. ward nurses), GP letter, case notes, carers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

Alertness: Altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item.

AMT4 (Abbreviated Mental Test - 4): This score can be extracted from items in the full AMT if done immediately before.

Acute Change or Fluctuating Course: Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/or paranoid thoughts ask the patient questions such as, "Are you concerned about anything going on here?"; "Do you feel frightened by anything or anyone?"; "Have you been seeing or hearing anything unusual?" In general hospital settings psychotic symptoms most often reflect delirium rather than functional psychosis

Malnutrition Universal Screening Tool See: Intranet> Healthcare>A-Z>MalnutritionUniScreenTool>Documents> MUST.pdf	Addressograph, or Name DOB Unit no. / CHI

Patient referred to dietician previously? Yes ☐ No ☐	Currently under care of dietician? Yes ☐ No ☐	
Usual weight kg (before admission).....	Height.....	BMI.....

Guidance

Step 1	**Step 2**	**Step 3**	**Step 4**
BMI	*Unplanned weight loss (% of usual weight) in past 3 - 6 months.*	*Is patient acutely ill without, or likely to be without, nutritional intake for > 5 days?*	*Calculate MUST score*
Points >20 0 18.5 - 20 1 <18.5 2	Points 5% 0 5.1 -10% 1 >10% 2	Points No 0 Yes 2	Add points in steps 1, 2 & 3 Total MUST score = ...

Step 5: Develop care plan.

Score 0 = Low risk	*Score 1 = Medium risk*	*Score ≥ 2*
• Normal clinical care • Repeat screening weekly	• Observe • Document dietary intake for 3 days – if improvement - little clinical concern – if no improvement - clinical concern – follow local policy (snack list available) • Repeat screening weekly	• Refer to dietician • Improve and increase overall nutritional intake (refer to local policy / snack list) • Monitor and review care plan weekly *Unless detrimental, or no benefit is expected from nutritional support e.g. imminent death.*

Date **Time**				**This section is intended for elective preoperative assessment clinics**		
Weight	BMI	Step 1	Step 2	Step 3	Step 4	Step 5
Action Plan						

Date **Time**				**Week 1**		
Weight	BMI	Step 1	Step 2	Step 3	Step 4	Step 5
Action Plan						

Date **Time**				**Week 2**		
Weight	BMI	Step 1	Step 2	Step 3	Step 4	Step 5
Action Plan						

Carbapenemase Producing Enterobacteriaceae (CPE) Risk Assessment

NHS Lothian

800325165E F 23/05/1982

Name	McAteer, Gillian
QoB	18 Cherry Avenue, Bathgate, West Lothian, EH48 1NA
UHPI or	CHI 2305821425 78132 L Heath

To prevent the spread of CPE, all patients must be risk assessed for CPE at pre-admission or on admission

File this form in the patient's medical record

Is the patient in any of the following groups?

- ☐ History of CPE
- ☐ Known exposure to CPE
- ☐ Direct transfer from any healthcare facility outside Scotland
- ☒ Inpatient in healthcare facility outside Scotland during the previous 12-months
- ☒ Holiday dialysis

If the patient falls into one or more group from above continue with this Risk Assessment
If the patient does not fall into any group no further action is required

1. • Send a rectal swab or stool specimen to the microbiology laboratory requesting a Carbapenemase Producing Enterobacteriaceae (CPE) Screen
   • If urinary catheter in situ or wound present specimens should also be sent from these sites
   • Refer to How to Screen for CPE (found in the CPE Toolkit) for further information

2. • Patients must be isolated with contact precautions in place if they are in one of the following categories i.e. high risk of CPE
   a. History of CPE or Known Exposure to CPE
   b. Direct transfer from any healthcare facility outside Scotland
   c. Inpatient at healthcare facility in a high risk country† during the previous 12-months
   d. Holiday dialysis in a high risk country†.

   †see over page for high risk countries and regions

   • Patients identified as high risk of CPE must have 3 sets of screening specimens collected at least 48 hours apart for example on day 1, day 3 and day 5
   • At least one screening set should include a stool specimen
   • Patients must only be moved out of isolation after discussion with the Infection Prevention and Control Team

3. If patient has history of CPE manage as positive and start the Initial Checklist for Confirmed CPE

4. If patient is not at high risk of CPE (point 2 above) and unless the patient requires isolation for other reasons apply standard precautions whilst waiting for screening results

Signature	Designation	Date	Site	Ward
[signature]	SN	6/12/17	SJH	POA

see **Risk Factors for CPE Colonisation** and **High Risk Countries and Regions** on page two

Risk Factors for CPE Colonisation

There is strong evidence that cross-border transfer of patients is associated with a risk of CPE transmission when:

- Patients are transferred from hospitals in areas with high rates of CPE
- Patients have received recent medical care abroad in areas with high rates of CPE

The risk is greatest in direct hospital transfers and those patients with:

- Intensive care admission and prolonged hospital stay
- Complicated surgical problems
- Trauma / burns / combat injuries
- Underlying immunosuppression (particularly transplantation)
- Indwelling devices or wounds
- Exposure to broad spectrum antibiotics including carbapenems, fluoroquinolones, cephalosporins and anti-pseudomonal penicillins

Healthcare Associated CPE and Community Acquired CPE are known to be prevalent in the following High Risk Countries and Regions

- Note that the following list is not exhaustive
- Community Acquired CPE is of particular concern in India, Pakistan and Bangladesh
- Admission to any healthcare facility abroad should be considered when making a risk assessment
- Lack of data from a country or region not included in the list may reflect lack of reporting or detection rather than lack of a carbapenemase problem and underestimate prevalence of CPE

United Kingdom

- London
- North West England

Other Countries and Regions

- Balkan States
- Bangladesh
- Central America
- China
- Columbia
- Crete
- Cyprus
- France
- Greece
- India
- Ireland
- Israel
- Italy
- Japan
- Malta
- Middle East
- North Africa
- Pakistan
- Poland
- Puerto Rico
- South America
- South East Asia
- Spain
- Taiwan
- Turkey
- USA

St John's Hospital Day Surgery Booklet ENT

NHS Lothian

800325165E F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 L Heath

Date: 19/12/17. Time patient arrived: 1450

Consultant: Baring.

Theatre no: 02

Next of kin details

[redacted]

Escort details

[redacted]

Pre-op checks

	Ward	Theatre Reception	Anaesthetic Room
• Patient ID: bracelets x2 / ~~Allergy band~~ NONE	☑	☑	☑
• Consent form signed	☑	☑	☑
• Operation site marked or obvious	☑ / n/a	☐ / n/a	☑ / n/a
• Patient Hospital notes / ward charts (inc. results / kardex / anaesthetic chart)	☑	☑	☑
• Bladder emptied	☑	☑	
• Underwear: disposable / removed	☑ / n/a	☐ / n/a	☐ / n/a
• Contact lens removed	☐ / n/a	☐ / n/a	☐ / n/a
• Prosthesis removed	☐ / n/a	☐ / n/a	☐ / n/a
• Hearing aid / glasses with patient at home	☐ / n/a	☐ / n/a	☐ / n/a
• Jewellery / piercings removed / taped	☑ / n/a	☑ / n/a	☐ / n/a
• TEDS	☐ / n/a	☐ / n/a	☐ / n/a
• Pre-med / pre-op analgesia given	☐ / n/a	☐ / n/a	☐ / n/a
• Fasted from: E. 11.20. toast+egg. D. 15.00 water		LMP	
• Patient pregnant	Yes ☐ No ☑		
• Blood glucose level if required NA.	Value	Time	
• Patient temperature in anaesthetic room	Value	Time	

Other issues including TRAK alerts:

asthma - inhaler.

Signatures: G Woodall [signature] [signature]

Names: GEORGE WOODALL ASHLEIGH ANDERSON OTP

Nurse led discharge

• Post op surgical visit	☑ / not needed	• IV access device removed	☑
• Post op anaesthetic visit	☑ / not needed	• Post op instructions understood	☑
• Observations stable and satisfactory	☑	• GP letter provided	☑
• Alert, orientated & ambulant	☑	• Follow up appointment made TBA	☐ ~~n/a~~
• Drinking and eating	☑	• Take home medicines	☑ n/a
• Analgesia satisfactory	☑	• Dressings provided	☑ n/a
• No nausea / vomiting	☑	• Physiotherapy organised	☐ n/a
• Passed urine	☑	• Community care organised	☐ n/a
• Operation site satisfactory	☑	• Sick absence note provided	☐ n/a

Discharge time: 0830 Date: 20/12/17

Signature of Nurse: [signature] Name: M TAYLOR

Day Surgery Centre
St John's Hospital, Howden Road West,
Livingston, West Lothian, EH54 6PP.
Phone: 01506 524105
www.nhslothian.scot.nhs.uk

NHS Lothian

Consent for Operation

Affix patient label

800325165E F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 L Heath

Patient's name:
Hospital numbe
Date of birth:
CHI:

Consultant: BAZIN

Planned procedure: STERILISATION

Common risks: bleed deform infect numbness future recurrence

Less common risks:

I confirm that I have explained to the patient in terms in which my judgement are suited to his / her understanding (and / or to one of his / her parents or guardians), the proposed operation, investigation or treatment, including options available, and if relevant, the need for anaesthesia or sedation.

Signature: Date: 19/12/17

Name and status of practitioner: BAZIN

Re-confirmation of consent on the day of admission

Signature: Date:

Name and status of practitioner:

Medical Students
- I agree to allow students to be present in theatre (tick box): Yes ☐ No ☐
- I agree to be examined by a medical student whilst under general anaesthesia in theatre: Yes ☐ No ☐

Medical Photography (I agree to being photographed)
- For my medical records for the purpose of diagnosis and treatment: Yes ☐ No ☐
- For the purpose of teaching and education: Yes ☐ No ☐
- For the purpose of publication: Yes ☐ No ☐
- To be shown to other patients (as an example): Yes ☐ No ☐

Tissue for medical research and teaching
When you have tissue removed as part of a medical investigation, operation or procedure, such as a blood test, some tissue may be left over after the laboratory tests have been completed. This tissue could be kept without your name or the details, so that it is impossible to know whom the tissue came from, and used for research or teaching, to improve laboratory tests, or to see how many people in an area might have a disease or an infection.

Do you agree? Yes ☐ No ☐

To the patient (or parent or guardian if appropriate)

1. Please read this form and the notes overleaf very carefully.
2. If there is anything that you don't understand about the explanation or if you want more information, you should ask the practitioner before signing.
3. Please check that all the information on the form is correct. If it is and you understand the explanation, then sign the form.

I am the patient / parent / guardian (delete as necessary)

I agree ☐ To what is proposed which has been explained to me by the practitioner named above.

I understand
- ☐ That anaesthesia (general / regional / local) or sedation will be needed.
- ☐ That the procedure may not be done by the practitioner who has been treating me so far.
- ☐ That any procedure in addition to the investigation or treatment described on this form will only be carried out of it is necessary and in my best interests and can be justified for medical reasons.

I have told ☐ The practitioner about the procedures I have noted below which I would wish not to be carried out without my having the opportunity to consider them first.

.....

Signature: ..... Name: Gillian MCAteer

Notes to all Health Practitioners (Doctors, Dentists, Nurses, Professionals Allied to Medicine)

A patient has an absolute legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way that they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to the treatment at any time. The patient's consent to treatment should be recorded on this consent form (further guidance is given in NHS Lothian's Policy Statement).

Notes to Patients

The health practitioner is here to help you. He or she will explain the proposed treatment and what the alternatives are. You can ask any questions and seek further information. You can refuse treatment.

You should be provided with sufficient information to allow you to come to a decision as to whether to consent to the treatment proposed.

The type of information you should receive should include:

1. Nature of your condition and proposed procedures, including degree of urgency.
2. Benefits to be reasonably accepted of the procedure.
3. Nature and probability of material (= significant) risks involved, including consideration of ratio of risks and benefits.
4. Inability of the practitioner to predict results.
5. Irreversibility of the procedure, if that is the case.
6. The likely result of not having the proposed treatment or procedure.
7. Alternatives available, including their risks and benefits.

You may ask for a relative, a friend or a nurse to be present.

Training doctors, dentists, nurses and other health professionals is essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor, dentist, nurse or other health professional.

You may however decline to be involved in the formal training of medical, dental, nursing and other students without this adversely affecting your care and treatment. You must tell a senior doctor or nurse if you do not wish students to be involved in your care and you should write this on the consent form in the space for things that you do not wish to happen without you being given the chance to consider them first.

Medical History (refer to pre-admission documents if available)

Please list any allergies and describe nature of allergy

NKDA

Please list current medications and tick those taken today

Sertraline 200 mg ✓
~~etoposide 50mg~~
CHLORPROMAZINE 50mg. OD.
Salbutamol 0mg 2 puffs PRN.

OIC (anaesthetic)

Please complete the following if you were NOT assessed by the pre-admission service

Have you had any problems with anaesthesia in the past? Yes ☐ No ☑

Please provide details of any problems: Prev CA OIC.

Has anyone in your family had problems with anaesthesia? Yes ☐ No ☑

Please provide details of any problems: ~~Nana~~ heartbeat 2nd

No other anaes problem

Please provide any other information about your family medical history that you think we should know about: father passed heart murmur., Diabetes
Nan - Diabetes type II, mother COPD, pt has asthmer

Please list any operations you have had with their approximate dates:

Febuary 2016 for my ears, Emergency Section 2012.

Have you currently or ever had any of the following? If so please provide approximate dates and any other details you feel might be useful

	Yes	No		Yes	No
• High blood pressure		✓	• Current cold or cough		✓
• Heart attack		✓	• Diabetes		✓
• Angina / chest pains		✓	• Epilepsy		✓
• Stroke or transient ischaemic attack		✓	• Anaemia or bleeding tendency		✓
• Heart murmur		✓	• Indigestion, heartburn or hiatus hernia		✓
• Pacemaker (please indicate when last checked)		✓	• Muscle disease or weakness		✓
• Tendency to faint easily		✓	• Arthritis		✓
• Shortness of breath	✓		• If female, are you pregnant?		-
• Asthma or bronchitis	✓				

No reflux

PMH: mild asthma, Depression

Do you smoke? Yes ☑ No ☐ If so, how much per day? 10

Do you drink alcohol? Yes ☑ No ☐ socially.

How much do you drink on average each week? (one bottle of wine = 9 units) 16 units

When did you last have an alcoholic drink? ~~2nd Dec 2017~~
Sat 17th Dec 2017.

eat 11:20
drink 15:00

Anaesthetic Record

Pre-op information

L. 18.

ASA ..... BP 138/90 PULSE 72 SpO_2 97% RA Temp 36.8 Wt 116.7 Ht 1.63m BMI 43.6

MP 2 TMD > 6.5 Cannulate
Teeth OK some loose no cap / crown

Information given to patient: risk ✓ headache, nausea, sore throat, dental damage, pain. Brain is life threatening rare

Anaesthesia details

Anaesthetist(s) name & grade: R Smith Cons Date: 19.12.17

Supervising Consultant: .....

Machine check ☐ ~~✓~~ Trained assistant ☑ Prelist brief / Surgical pause ☐ ~~✓~~

Vascular access (site / device / size)
20G (R) hand

TIVA see over

Induction
Propofol mg

Maintenance TIVA

Airway / Circuit / Machine
COETT #7.5 (S) (Lac) RAE
Laryngoscopy grade 1

Easy to hand ventilate? Yes ☑ ~~✓~~

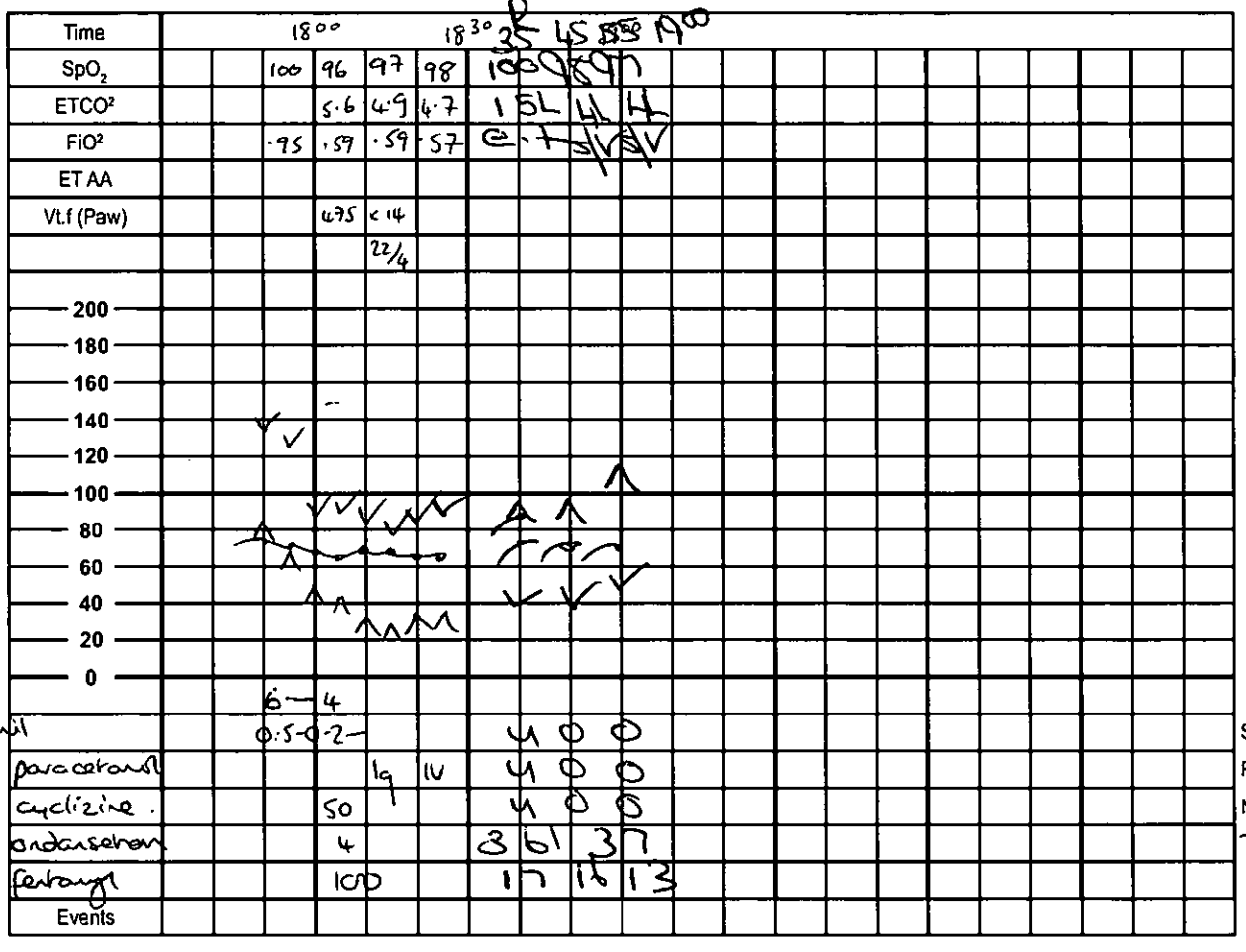
Monitors:
Minimal monitoring ☑ ~~✓~~
Others

Eye care — Tape ☑ ~~✓~~ / Lubricant ☐ / Padded ☐
Pressure care ☑ ~~✓~~
Fluid warmer ☐
Warming blanket ☐
DVT prophylaxis ☐ n/a ☐
Post Op DVT prophylaxis ☐ n/a ☐
Antibiotics ☐ n/a ☐

Patient / Limb position
Supine

Significant issues or events

Recovery Obs



PL 148 – 500.

diclofenac 75 in IVI.

Co-phenadeine 2 Swl to

Recovery

Anaesthetist instructions: Routine obs ☑ O_2 as needed to maintain SpO_2>93% ☑

Tick if you want to see patient before discharge ☐

Recovery comments:

Recovery following G.A. E.t. tube extubated at 1840. HL O^2 via face mask, coughing ttt, Nebulisers as charted

No obvious oozing from nose.

No complaints of pain.

sips of water tolerated.

Ven flon capped off R hand.

Arrival time in recovery: ..... Time discharged to ward: .....

Recovery nurse: L. Bell Signature: S/N L. Bell

Prescription and administration record

If an additional prescription chart is in use tick this box ☐

Codes for non-administration of prescribed medicine

If a dose is not administered as prescribed, initial and enter a code in the column with a circle drawn round the code according to the reason as follows:

Patient refuses	1	Vomiting / nausea	8
Patient not present on ward	2	Time varied on Dr's instructions	9
Medicines not available (check ordered)	3	Once only / pm medication given	10
Instructions not clear or legal	4	Dose withheld on Dr's instructions	X
Nil by mouth	5	Possible drug reaction / side effect	12
Asleep / drowsy	6	Self administered by patient	13
Administration route not available (check for an alternative)	7	Other reasons	14

Pre-operative and once only medication

Date	Time	Drug / PGD No.	Dose	Route	Prescriber Signature / Name	Time given	Given by	Checked by
19/12/17	1850	SALBUTAMOL	2.5mg	Neb	RJS.	1851	L. [illegible]	
19/12/17	Theatre Recovery	FENTANYL	100 microg max total	IV	RSMITH			

Regular Therapy

Drug		Date				
PARACETAMOL		Time				
Dose	Route	8				
1g	Oral	8				
Signature / Name	Start Date	12				
		14				
Notes	Pharmacy	18				
		22				

Drug		Date				
		Time				
Dose	Route	8				
		8				
Signature / Name	Start Date	12				
		14				
Notes	Pharmacy	18				
		22				

Drug		Date				
IBUPROFEN		Time				
Dose	Route	8				
400mg	Oral	8				
Signature / Name	Start Date	12				
		14				
Notes	Pharmacy	18				
		22				

Drug		Date				
		Time				
Dose	Route	8				
		8				
Signature / Name	Start Date	12				
		14				
Notes	Pharmacy	18				
		22				

Drug		Date				
		Time				
Dose	Route	8				
		8				
Signature / Name	Start Date	12				
		14				
Notes	Pharmacy	18				
		22				

Drug		Date				
		Time				
Dose	Route	8				
		8				
Signature / Name	Start Date	12				
		14				
Notes	Pharmacy	18				
		22				

diclofenac in meals

As Required Therapy

Drug		Date				
MORPHINE		Time				
Dose & Frequency	Route	Dose / Route				
10mg hourly	Oral	Initials				
Signature / Name	Start Date	Date				
	19/12	Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date	19/12	2nd dose		
Paracetamol		Time	1815	2300		
Dose & Frequency	Route	Dose / Route	1g/IV	1g PO		
1g max QDS	oral	Initials	RS	KG		
Signature	Start Date	Date				
RSMITH	19.12.17	Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
TRAMADOL		Time				
Dose & Frequency	Route	Dose / Route				
50-100mg 4⁰	Oral / IV	Initials				
Signature / Name	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date	20/12/17	20/12/17		
Ibuprofen		Time	0800	0830		
Dose & Frequency	Route	Dose / Route	400mg PO	400mg PO		
400mg	oral	Initials	KG	KG		
Signature / Name	Start Date	Date				
RSMITH	20.12.17	Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date	19/12			
DIHYDROCODEINE		Time	2200	0500		
Dose & Frequency	Route	Dose / Route	30mg PO	30mg PO		
30mg 4⁰	Oral	Initials	KG	KG		
Signature / Name	Start Date	Date				
	19/12	Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
		Time				
Dose & Frequency	Route	Dose / Route				
		Initials				
Signature / Name	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date	19/12			
CYCLIZINE		Time	1815			
Dose & Frequency	Route	Dose / Route	50mg/IV			
50mg 8⁰	Oral/IV/IM	Initials	RS			
Signature / Name	Start Date	Date				
	19/12	Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
		Time				
Dose & Frequency	Route	Dose / Route				
		Initials				
Signature / Name	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
ONDANSETRON		Time				
Dose & Frequency	Route	Dose / Route				
4mg 6⁰	Oral/IV/IM	Initials				
Signature / Name	Start Date	Date				
	19/12	Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
		Time				
Dose & Frequency	Route	Dose / Route				
		Initials				
Signature	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Surgeon's Operation Notes

Affix patient label

Patient's name:
Hospital numbe
Date of birth:
CHI:

800325165E F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 L Heath

Consultant: BARNL

Surgeon	Assistants	Scrub Nurse	Operation
BARNL			SEPTOPLASTY

Surgeon's operation notes

I- (R) NASAL OBSTRUCTION

F- (B) DNS - tip ✓
cosmesis ✓

P- (L) MONOPLANE FIXATION LIGOSAN 4mm
BILATERAL FLAPS
POST/INF BONE EXCISED
CART → ⊥
ANT COLUMELLA POCKET
B/O VICRYL LOCKED SUTURE
H/O VICRYL QUILTED
NASENTIN

POST OP- EBS
(A) LATER / TOMORROW
F/U 3/12 JOH BARNL CLINIC

BARNL
CONS 461973

Surgeon's operation notes - continued

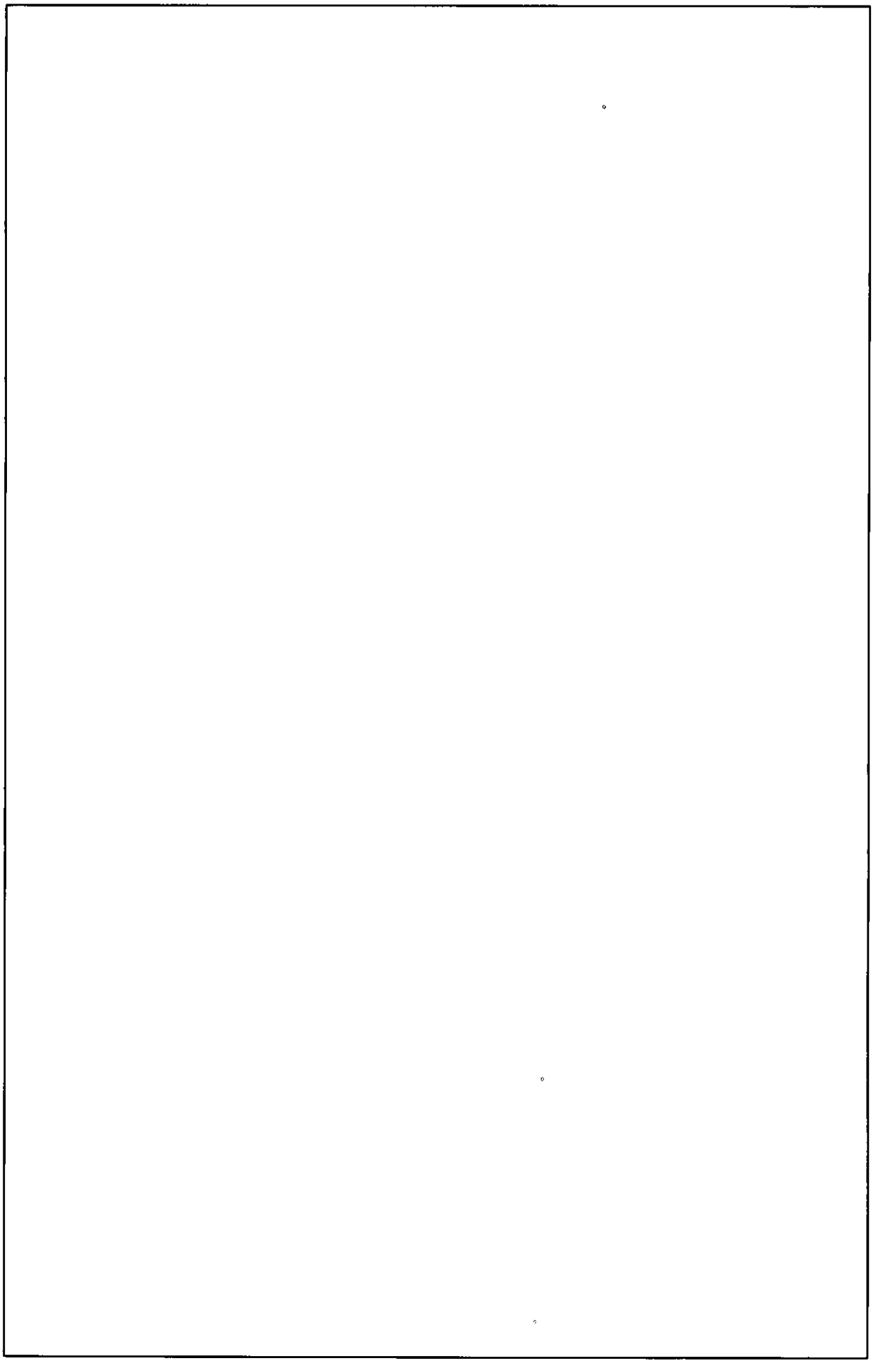
Ward instructions

Complete sickness absence note as necessary
Tick if you want to see patient before discharge ☐

Signature: .....

Name: ..... Date: .....

Theatre Equipment Stickers



Day Surgery Centre
St John's Hospital, Howden Road West,
Livingston, West Lothian, EH54 6PP.
Phone: 01506 524105
www.nhslothian.scot.nhs.uk

NHS Lothian

Discharge Letter

Affix patient label

Patient 800325165E F 23/05/1982
Hospita **McAteer, Gillian**
Date of 18 Cherry Avenue,
CHI: Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425

Dear Dc 78132 I. Heath

Consultant: RAMM
Operator:
GP:

Your patient underwent the following operation or investigation and will be discharged today.

Operation / Investigation:

Findings / Results:

Further treatment is planned as follows:

Removal of sutures:

Follow up arrangements: 3/12 STI Review Clinic

Sickness absence form has been issued for: days / weeks

DISCHARGE Prescription	Dose / Timing / Route	No. of days	Prescriber: Sign / Name	Dispenser: Sign / Name	Checked by
Paracetamol 500mg	Two tablets every 6 hours PRN	7			
Ibuprofen 400mg	One tablet every 6 hours PRN	7			
Dihydrocodeine 30mg	One tablet every 6 hours PRN	7			
Naproxen	Twice daily	3/12			

CONTROLLED Drug Prescription (delete those not required)	Dose	Frequency	Total Quantity Supplied in figures & words	Prescribers Signature & Name	Pharmacy Disp/check
Tramadol 50mg capsules	ONE or TWO capsules	4 hourly PRN Max 400mg daily	..... capsules ..... capsules		
Morphine sulphate 10mg MR tablets	..... mg ..... tabs	Twice daily	..... tablets ..... tablets		
Morphine sulphate 10mg/5ml oral solution	..... mg	..... Hourly PRN Max ..... times daily	..... millilitres ..... millilitres		

Signature: Date: 19/12/17

Name: Phone. no:

Top copy (White) Patient's copy Second copy (Yellow) GP's copy Third copy (Blue) Pharmacy copy

Day Surgery Centre
St John's Hospital, Howden Road West,
Livingston, West Lothian, EH54 6PP.
Phone: 01506 524105
www.nhslothian.scot.nhs.uk

NHS Lothian

Discharge Letter

Affix patient label
800325165E F 23/05/1982
Patient's **McAteer, Gillian**
Hospital I 18 Cherry Avenue,
Date of b Bathgate,
CHI:..... West Lothian,
EH48 1NA
CHI 2305821425
78132 I. Heath

Consultant: RAN Nc
Operator: .....
GP: .....

Dear Doctor,

Your patient underwent the following operation or investigation and will be discharged today.

Operation / Investigation: .....
.....
.....

Findings / Results: .....
.....
.....

Further treatment is planned as follows: .....
.....
.....

Removal of sutures: .....

Follow up arrangements: 3/52 SPA Rheum Clinic
.....

Sickness absence form has been issued for: days / weeks

DISCHARGE Prescription	Dose / Timing / Route	No. of days	Prescriber: Sign / Name	Dispenser: Sign / Name	Checked by
Paracetamol 500mg	Two tablets every 6 hours PRN				
Ibuprofen 400mg	One tablet every 6 hours PRN				
Dihydrocodeine 30mg	One tablet every 6 hours PRN				
Naproxen	Tid PRN c/s.	3/52			

CONTROLLED Drug Prescription (delete those not required)	Dose	Frequency	Total Quantity Supplied In figures & words	Prescribers Signature & Name	Pharmacy Disp/check
Tramadol 50mg capsules	ONE or TWO capsules	4 hourly PRN Max 400mg daily	..... capsules ..... capsules		
Morphine sulphate 10mg MR tablets	.....mg .....tabs	Twice daily	..... tablets ..... tablets		
Morphine sulphate 10mg/5ml oral solution	.....mg	..... Hourly PRN Max..... times daily	..... millilitres ..... millilitres		

Signature: ..... Date: 19/5/17

Name: RAN Nc Phone. no: .....

Top copy (White) Patient's copy Second copy (Yellow) GP's copy Third copy (Blue) Pharmacy copy

NHS Lothian

800325165E F
MCATEER Gillian
23-May-82 CHI: 230 582 1425
78132 L Heath
18 Cherry Avenue West Lothian
EH48 1NA

e Plan

Consultant: MR BARING

Theatre no: 2

Local Anaesthetic Patients

Observations	Sp02	HR
	O2 required	

Pre-list Briefing Yes ☑ No ☐

Surgical Pause Yes ☑ No ☐

Date: 19/12/17 Time: 1805 Signature: LEArmstrong

Patient Position (tick all that apply)

Supine ☑	Prone ☐	Lloyd Davies ☐
Neck Extension ☐	Lateral Right Down ☐	Lateral Left Down ☐
Traction ☐	Other	

Table fitting and attachments (tick all that apply)

Mattress Type: MAQUET		
Anaesthetic Screen ☐	Arm Board ☐	Arm Rest ☐
Arm Retainer ☐	Arm Table ☐	Head Ring ☐
Heel Pad ☐	Lateral Supports ☐	Oxford Help ☐
Pillow ☐	Sandbag ☐	Warming Blanket ☐
Other		

Ted Stockings		Pneumatic Boots	
On ☑	Off ☐	On ☑	Off ☐

Catheter			
Type:	Indwelling: ☐ Temporary: ☐	Cath. Bag: ☐ Urometer: ☐	Prep:
Size:	Time inserted:	Lubricant:	Balloon Capacity:
Signature:			

Tourniquet (tick all that apply)

Site		Side		Time	
Ankle	☐	Right	☐		
Arm	☐	Right	☐	Time on:	
Thigh	☐	Left	☐	Time off:	
Digit	☐		☐	Total time	
Surgeon informed at:		1hr ☐	2hr ☐		

Diathermy Plate Position (tick all that apply)

Site		Side		Type	
Abdomen	☐		☐		
Back	☐		☐		
Buttock	☐	Left	☐	Monopolar	☐
Thigh	☐	Right	☐	Bi-Polar	☐
Other:					
Skin condition on plate removal:		Intact ☐		Broken ☐	

Skin Prep (tick all that apply)

Betadine	☐	Betadine Alcoholic	☐	Betadine Scrub	☐
Chloraprep	☐	Chlorhexidine 0.5% in spirit	☐	IPA	☐
Tisept	☐	Other	☐	None	☐

Peri-Operative Infiltration		Wound Lavage	
Type: LIGNOSPAN SPECIAL	Amount: 2-2mls	Type:	Amount:

Prosthesis / Implants (put traceability labels on last page or back of consent form)

Yes	Details
No	

Procedure Performed

SEPTOPLASTY

Intraoperative Counts

Initial Count	Intraoperative	Intraoperative/ Handover	Final
Correct: Yes ☑ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☑ No ☐
Signature:			
Discrepancy:			
Action taken:			

Drains

Type:
Site:
Sutured in Yes No

Skin Closure

Sutures: NICRYL
Staples:
Non Closure:

Packs

Dressings

nasopore.

Splints

Type	Site
POP Backslab	
POP CAST	
Zimmer	
Nasal Splints	
Other	

Blood Loss

Swabs: Minimal	
Suction: Minimal	
Total: Minimal	

Specimens

Pathology:
Microbiology:
Other:

Tissue uplift by Porter (as per protocol)

Handover to Recovery		
Yes ☑	No ☐	N/A ☐

	Print	Sign
Scrub Nurse	SN P Riley	

Traceability Labels

ROtrak
Lothian - Septal

Pack Name RMT4443-REVD

Cat No W312652

Lot No 2017-09

Date Expiry Date: 2020-09

Rocialle, Wales
Tel: +44 (0) 1443 471300
Fax: +44 (0) 1443 471301
www.rocialle.com

NHS LOTHIAN – PROGRESS NOTES

HOSPITAL: WARD:

NAME: D.o.B.

800325165E F (36) DB
MCATEER Gillian
23-May-82 CHI:230 582 1425
78132 L Heath
18 Cherry Avenue West Lothian
EH48 1NA

Date/time Block name Profession	
19/12/17	Patient admitted to day surgery for Septoplasty under GA. Returned to ward at 19.00pm. Required nebuliser in recovery. Plan △ will need to remain for nasonex △ F/U 3/12 DB clinic – DMorland SHO
20/12/17	Observations stable as charted NEWS 0-1 due to systolic BP. No complaints of pain or nausea. Tolerating diet & fluids Mobilising to toilet to pass urine. Not required further Nebuliser Slight core noted - nasal drip pad in situ. Slept well overnight. — CMcG RGN
0700	NEWS 0. Cannula removed. — CMcG RGN
0830	no new issues. NEWS 0 D/C home with nasonex.

LOT 104

Date/time Block name Profession	

National Early Warning Score (NEWS) Chart

NHS Lothian

800325165E F
MCATEER Gillian
23-May-82 **CHI:** 230 582 1425
78132 L Heath
18 Cherry Avenue West Lothian
EH48 1NA

Consultant: Baring Date chart commenced: 19/12/17
This is chart number 02 this admission
Weight: Actual 116.7 kgs Estimated kgs
ASU: Ward: DSU.

Conscious Level Chart to be completed when clinically indicated

		Date		
		Time		
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4	
		To speech	3	
		To pain	2	
		None	1	
	Best Verbal Response	Orientated	5	Endotracheal tube or Tracheostomy = T
		Confused	4	
		Inappropriate words	3	
		Incomprehensible sounds	2	
		None	1	
	Best Motor Response	Obey commands	6	Always record the best arm response
		Localise to pain	5	
		Flexion to pain	4	
		Abnormal flexion	3	
		Extension to pain	2	
		None	1	
		Total GCS Score		
	Right Pupil	Size		+ reacts - no reaction c. eye closed
		Reaction		
	Left Pupil	Size		
		Reaction		
LIMB MOVEMENT	ARMS	Normal power		Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
	LEGS	Normal power		
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
		Initials		

Pupil Scale mm 1 2 3 4 5 6 7 8

REMEMBER
- **Record all observations** on NEWS chart
- **Document any** deterioration in the notes - remember the Structured Response Tool
- **Escalate** your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

	Assess	Possible Actions
AIRWAY	Is the airway - • Patent • At Risk • Obstructed	→ Suction if indicated → Head tilt, chin lift/jaw thrust → Airway Adjuncts → Administer Oxygen → Call 2222 if at risk
BREATHING	• Respiratory rate • SpO2 • Accessory muscle use • Noises +/- percussion, palpation & auscultation • Position / posture	→ Administer prescribed Oxygen to maintain saturations 94%-98% (NB COPD 88%-92%) → Monitor SpO2 / ABGs → Consider chest x-ray → Treat underlying cause → Call 2222 if not breathing
CIRCULATION	• Pulse • Blood Pressure • Capillary refill time • Core temperature / colour • Urine output • Consider 4 body cavities for fluid & blood loss (4 + on the floor) • Monitor drain losses	→ Obtain IV access → Obtain blood samples → Prepare fluid challenge → Initiate Fluid Balance Chart → Call 2222 if no circulation → Consider initiating Major Haemorrhage Protocol → Monitor response to actions
DISABILITY A = Alert V = Voice / Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • Blood Glucose • Drugs	→ Re-assess GCS → Check blood glucose if less than 4mmols/litre activate hypoglycaemia protocol → Check Drug Chart → Remember accurate documentation
EXPOSURE	• Top to toe examination • Look for evidence of blood loss / rashes / drains / wounds etc	→ Control bleeding → Treat any underlying conditions identified → Reassess → Maintain patient's dignity → Evaluate actions

Pain Assessment and Management Guidelines

Cancer-related pain: Always score worst pain in the last 24 hours or since last assessment: refer to Palliative Care Guidelines

Acute Pain: Score current pain on movement, e.g. deep breathing: refer to Acute Pain Guidelines

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

↓

Call Medical staff / Senior Nurse / Nurse Practitioner

↓

For further advice contact:

ACUTE	PALLIATIVE
Mon-Fri: Bleep Acute Pain Team Out of Hours: On-call Anaesthetist	Mon-Fri: Bleep Palliative Care Team Out of Hours: Via Switchboard

Pain Score	Nausea Score 0-3	Epidural Motor Block Score please do not √ motor block column
0 None Continue to assess pain at least daily	**0 - No Nausea**	0 - **Full Power**
1-3 Mild Continue to assess pain with routine observations, must be at least daily	**1 - Nausea** Consider anti-emetic	**1 - Weak but able to raise legs**
4-5 Moderate Assess, administer and review analgesia as appropriate for patient	**2 - Nausea / Vomiting** Administer anti-emetic	**2 - Able to bend knees**
6-10 Severe Assess, administer and review analgesia as appropriate for patient	**3 - Persistent Nausea &/or Vomiting** Contact Doctor	**3 - Minimal movement** **4 - Paralysis**
Using appropriate Lothian Guidelines	**Using guidelines prescribe / give anti-emetics and review**	If score 2 or above please immediately contact the Acute Pain Team or On-Call Anaesthetist if out of hours

Ref: MPS NHS Lothian 2016 Date of Publication - April 2016 Review Date - April 2017 LOT367

NEWS Key 0 1 2 3	Date:									Date
	Time:									Time
Respiratory Rate	≥25									≥25
	21-24									21-24
	12-20	18	13	16	16	16	16	14	16	16	12-20
	9-11									9-11
	≤8									≤8
Sp02	Chronic Hypoxia ≥88	Default ≥96	97%	98	98	100	96	96	96	97	97	Default ≥96 / Chronic Hypoxia ≥88
		94-95										94-95
Medical Signature required to use scale for patients with Chronic Hypoxia	86-87	92-93										92-93 / 86-87
Sign:	≤85	≤91										≤91 / ≤85
	Unrecordable											Unrecordable
Inspired 02	% or litres		RA		RA	A	A	A	A	(A)	A	% or litres
Temperature		≥39°										≥39°
		38°										38°
		37°	36.8									37°
		36°										36°
		≤35°										≤35°
NEWS SCORE uses Systolic BP		230										230
		220										220
		210										210
		200										200
		190										190
		180										180
		170										170
		160										160
		150										150
If manual BP mark as M		140	138									140
		130		114						127		130
		120										120
		110			95	V		V	V		1	110
		100										100
		90	90									90
		80								80 L		80
		70										70
		60			58	1	1	1				60
		50										50
	Unrecordable											Unrecordable
Heart Rate		>140										>140
		130										130
		120										120
		110										110
		100										100
		90										90
		80	72									80
		70										70
		60										60
		50										50
		40										40
		30										30
	Regular Y/N		✓	✓	✓					?	?	Regular Y/N
Conscious Level	Alert		✓	✓	✓	✓	✓	✓	✓	A	✓	Alert
	V / P / U											V / P / U
	New Confusion											New Confusion
Total NEWS score			0	0	2	1	0	0	0	0	0	**Total NEWS score**
Urine output recorded Y/N			✓							✓	✓	Urine output recorded
Blood Glucose			4.0		5.2						4.5	Blood Glucose
Frequency of Observations			12		4						4	Frequency of Obs.
Structured Response Tool Y/N			✓		✓						✓	SRT Y/N
Escalation Y/N			✓		✓						✓	Escalation Y/N
Pain score (0-10)			0		0	0	3	0	5	7		Pain score (0-10)
Nausea score (0-3)			0		0	0	0	0	0	0		Nausea score (0-3)
Motor Block score (0-4)			0									Motor Block score (0-4)
Circulation												Circulation
Sensation												Sensation
Movement												Movement
Initials												Initials

Patient Name:	CHI:

Special Instructions - to be completed by Medical Team

A total NEWS score of ____ or individual parameter of ____ is acceptable for this patient because ____

Please escalate if ____

Print ____ Sign ____ Designation ____

Date ____ Time ____ *(only valid if signed and dated)*

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

NEWS Score	Frequency of Observations	Clinical Response
Total 0*	**Minimum 12 hourly / 4 hourly in admission areas**	• Continue routine NEWS monitoring with every set of observations.
Total 1 - 4*	**Minimum 4 hourly** Consider Structured Response Tool Consider Fluid Balance Chart	• Inform registered nurse • Registered nurse assessment using ABCDE • Review frequency of observations • Inform Nurse in Charge • **If ongoing concern, escalate to Medical Team**
Total 5 - 6* or 3 in one parameter	**Increase frequency to a minimum of 1 hourly** Start Structured Response Tool Start Fluid Balance Chart	• Registered nurse assessment • Inform Nurse in Charge • Escalate to Medical Team as per local escalation • Urgent medical assessment • Management plan to be discussed with Senior Trainee or above • Consider level of monitoring required in relation to clinical care
Total 7* or more	**Continuous monitoring of vital signs** Start Structured Response Tool Start Fluid Balance Chart	• Registered nurse to assess immediately • Inform Nurse in Charge • Request immediate assessment by Senior Trainee or above • Case to be discussed with supervising Consultant • If appropriate contact Critical Care for review

NEWS ≥4 Think Sepsis

Are any 2 or more SIRS criteria present?

RECOGNISE

Temperature	<36°c or >38°c
Pulse	>90 beats/min
White Cell Count	<4 or >12
Respiratory Rate	> 20 bpm
Mental State	New confusion
Blood Sugar	>7.7mmol/L in non-diabetic

and clinical suspicion of infection = SEPSIS

Apply Sepsis 6 within 1 hour

RESUSCITATE

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

Anaesthetic Record

Pre-op information

R. 18.

ASA ____ BP 138/90 PULSE 72 SpO_2 97% RA Temp 36.8 Wt 116.7 Ht 1.63m BMI 43.6

MP 2 TMD > 6.5 Cervical
Teeth OK some loose no cap / caps

Information given to patient: risk ✓ headache, nausea, sore throat, dental damage, pain. Sedation is like modern care

Anaesthesia details

Anaesthetist(s) name & grade: R Swire Cons Date: 19.12.17

Supervising Consultant: ____

Machine check ☐ ✓ Trained assistant ☑ ✓ Prelist brief / Surgical pause ☐ ✓

Vascular access (site / device / size)
20G (R) hand

TIVA see ove

Induction
Propofol mg

Maintenance TIVA

Airway / Circuit / Machine
COETT #7.5 (5) (fac)
RAE)
aestiva / circle

Easy to hand ventilate? Yes ☑ ✓

Laryngoscopy grade 1

Monitors:
Minimal monitoring ☑ ✓
Others

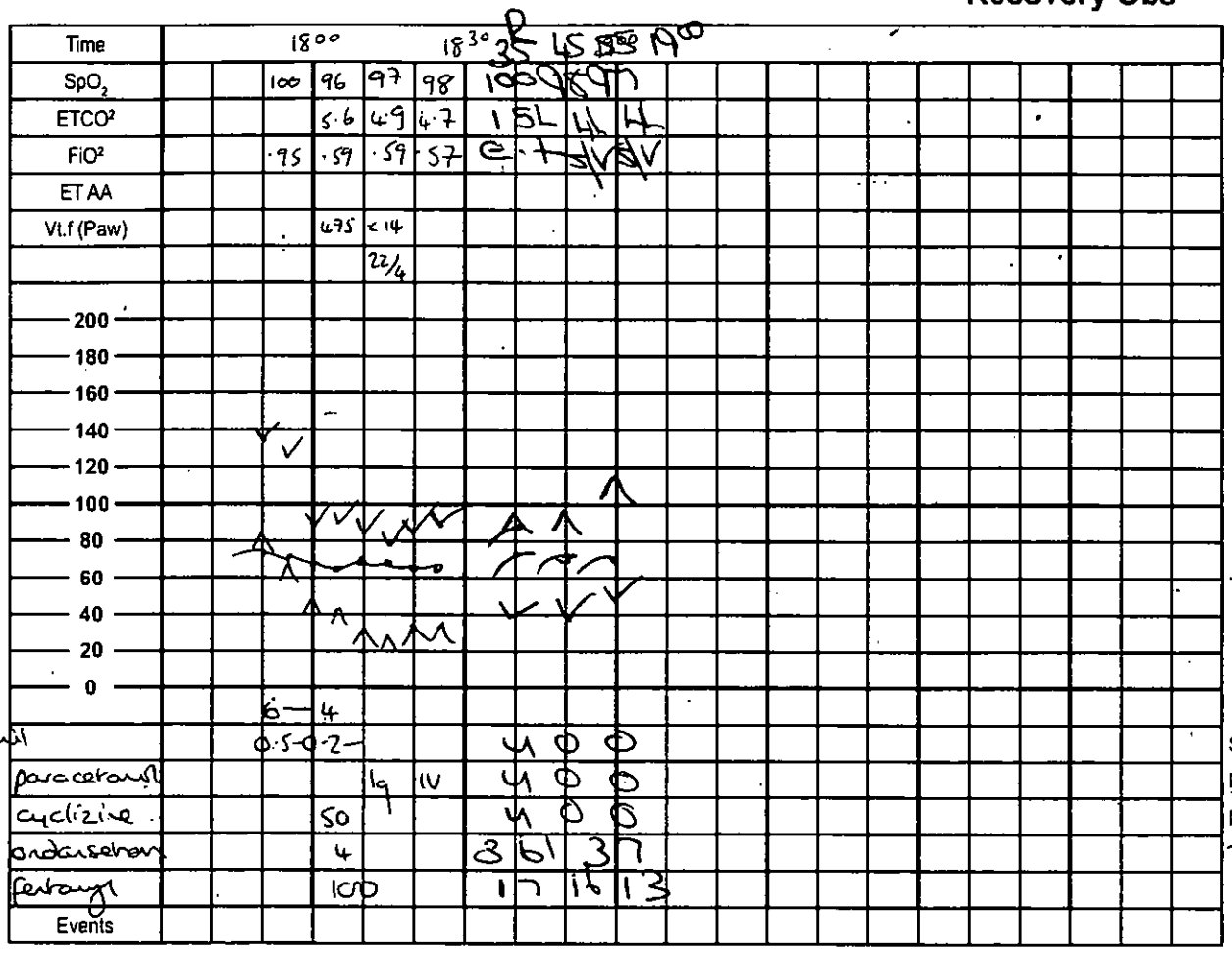
Eye care
Tape ☑ ✓
Lubricant ☐
Padded ☐

Pressure care ☑ ✓
Fluid warmer ☐
Warming blanket ☐
DVT prophylaxis ☐ n/a ☐
Post Op DVT prophylaxis ☐ n/a ☐
Antibiotics ☐ n/a ☐

Patient / Limb position
supine

Significant issues or events

Recovery Obs



PL 168 – 500.

diclofenac 75 in IVI.

Co-phenelgaie 2 Sml to nose

Recovery

Anaesthetist instructions: Routine obs ☑ O_2 as needed to maintain SpO_2>93% ☑

Tick if you want to see patient before discharge ☐

Recovery comments:

Recovery following G.A. E.t. tube extubated at 1840. HL O^2 via face mask, coughing ++, Nebulisers as charted
No obvious oozing from nose.
No complaints of pain.
sips of water tolerated.
Venflon capped off R hand.

Arrival time in recovery: ..... Time discharged to ward: .....

Recovery nurse: L Bell Signature: S/N L. Bell

Surgeon's Operation Notes

Affix patient label

Patient's name:
Hospital numbe
Date of birth:
CHI:

800325165E F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 L Heath

Consultant: BARW.

Surgeon	Assistants	Scrub Nurse	Operation
BARW			SEPTOPLASTY

Surgeon's operation notes

I- (R) NASAL OBSTRUCTION

F- (R) ONS - tip ✓
cosmesis ✓

P- (L) MONOTRAN FIXATION LIGOSURE 4cms
BLADDER FLAPS
POST/INF SEPT EXCISED
CART → ⊥
ANT CONCHAL POCKET
B/O VICRYL LOCKED SUTURE
H/O VICRYL QUILTED
MADE IN

POST OP- EDS
(H) LATER / TOMORROW
F/U 3/12. JOHN BARW CLINIC

BARW
CONS 461973

Surgeon's operation notes - continued

Ward instructions

Complete sickness absence note as necessary.
Tick if you want to see patient before discharge ☐

Signature: .....

Name: ..... Date: .....

Day Surgery Centre
St John's Hospital, Howden Road West,
Livingston, West Lothian, EH54 6PP.
Phone: 01506 524105
www.nhslothian.scot.nhs.uk

NHS Lothian

Consent for Operation

Affix patient label

800325165E F 23/05/1982
Patient's name: McAteer, Gillian
Hospital number: 18 Cherry Avenue,
Date of birth: Bathgate,
CHI: West Lothian,
EH48 1NA
CHI 2305821425
78132 L Heath

Consultant: BAINE

Planned procedure: SEPTOPLASTY

Common risks: bleed deform infect numbn pain recurr

Less common risks:

I confirm that I have explained to the patient in terms in which my judgement are suited to his / her understanding (and / or to one of his / her parents or guardians), the proposed operation, investigation or treatment, including options available, and if relevant, the need for anaesthesia or sedation.

Signature: Date: 14/12/17

Name and status of practitioner: BAINE

Re-confirmation of consent on the day of admission

Signature: Date:

Name and status of practitioner:

Medical Students

- I agree to allow students to be present in theatre (tick box): Yes ☐ No ☐
- I agree to be examined by a medical student whilst under general anaesthesia in theatre: Yes ☐ No ☐

Medical Photography (I agree to being photographed)

- For my medical records for the purpose of diagnosis and treatment: Yes ☐ No ☐
- For the purpose of teaching and education: Yes ☐ No ☐
- For the purpose of publication: Yes ☐ No ☐
- To be shown to other patients (as an example): Yes ☐ No ☐

Tissue for medical research and teaching

When you have tissue removed as part of a medical investigation, operation or procedure, such as a blood test, some tissue may be left over after the laboratory tests have been completed. This tissue could be kept without your name or the details, so that it is impossible to know whom the tissue came from, and used for research or teaching, to improve laboratory tests, or to see how many people in an area might have a disease or an infection.

Do you agree? Yes ☐ No ☐

To the patient (or parent or guardian if appropriate)

1. Please read this form and the notes overleaf very carefully.
2. If there is anything that you don't understand about the explanation or if you want more information, you should ask the practitioner before signing.
3. Please check that all the information on the form is correct. If it is and you understand the explanation, then sign the form.

I am the patient / parent / guardian (delete as necessary)

I agree
- ☐ To what is proposed which has been explained to me by the practitioner named above.

I understand
- ☐ That anaesthesia (general / regional / local) or sedation will be needed.
- ☐ That the procedure may not be done by the practitioner who has been treating me so far.
- ☐ That any procedure in addition to the investigation or treatment described on this form will only be carried out of it is necessary and in my best interests and can be justified for medical reasons.

I have told
- ☐ The practitioner about the procedures I have noted below which I would wish not to be carried out without my having the opportunity to consider them first.

.....

Signature: ..... Name: Gillian MCAteer

Notes to all Health Practitioners (Doctors, Dentists, Nurses, Professionals Allied to Medicine)

A patient has an absolute legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way that they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to the treatment at any time. The patient's consent to treatment should be recorded on this consent form (further guidance is given in NHS Lothian's Policy Statement).

Notes to Patients

The health practitioner is here to help you. He or she will explain the proposed treatment and what the alternatives are. You can ask any questions and seek further information. You can refuse treatment.

You should be provided with sufficient information to allow you to come to a decision as to whether to consent to the treatment proposed.

The type of information you should receive should include:

1. Nature of your condition and proposed procedures, including degree of urgency.
2. Benefits to be reasonably accepted of the procedure.
3. Nature and probability of material (= significant) risks involved, including consideration of ratio of risks and benefits.
4. Inability of the practitioner to predict results.
5. Irreversibility of the procedure, if that is the case.
6. The likely result of not having the proposed treatment or procedure.
7. Alternatives available, including their risks and benefits.

You may ask for a relative, a friend or a nurse to be present.

Training doctors, dentists, nurses and other health professionals is essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor, dentist, nurse or other health professional.

You may however decline to be involved in the formal training of medical, dental, nursing and other students without this adversely affecting your care and treatment. You must tell a senior doctor or nurse if you do not wish students to be involved in your care and you should write this on the consent form in the space for things that you do not wish to happen without,you being given the chance to consider them first.

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Heath
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 04/02/2015

Inpatient Discharge Summary

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI**	**2305821425**
		Date of Birth / Age	23/05/1982 (32 years)
		UHPI	800325165E
Specialty	Ear Nose and Throat Medinet	**Admission Date**	24/01/2015
Ward	SJH Day Surgery Centre		
Consultant	Mr Frank O Agada	**Discharge Date**	24/01/2015

Dear Dr Heath

Procedure: Bilateral grommets

Post operative plan: To go home today. To be seen in the Medinet Clinic in 4 - 6 weeks time.

Yours sincerely

(Not checked/signed due to expediency - EPO responsible to inform GP of any amendments/updates)

Mr Frank O Agada
ENT Consultant
MEDINET

All enquiries regarding this episode please contact:

Departmental Secretary for External Providers Office
(Medinet)
Ground Floor
Woodlands House
Astley Ainslie Hospital
Tel. - 0131 446 4515

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Holden
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 13/10/2011

Inpatient Discharge Summary

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (29 years) 800325165E
Specialty	Accident and Emergency	**Admission Date**	08/10/2011
Ward	SJH Obs Ward		
Consultant	Mr Martin DJ McKechnie	**Discharge Date**	09/10/2011

Dear Dr Holden

This 29yr female was admitted to the observation ward for neurological observations after sustaining a head injury falling down the stairs whilst intoxicated at home. No vomiting. Mild headache controlled by paracetamol.

O/E
large boggy swelling over occiput.
GCS 15/15, PEARL, Cranial nerves all intact.
Full range of movement in C spine, mild tenderness over C1, C2.
Mobilising well.

CT head - normal.
She was deemed fit for discharge home, to stay the night with her mum. Given head injury advice.

Should you need further information please contact...
Observation Ward, SJH.

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

Yours sincerely.....

Staff Signature..... PrintName.....

Designation..... Date..... Time.....

Progress Notes

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	I0006022516
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	I0006022516

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0006022516 Dr Imogen BJ Smith 10/1/24 19:57 Dr Joanne Mackie	D dimer negative - 97 home with prednisolone, salbutamol and worsening statement as per plan below ** advice given re smoking cessation** J Mackie cons

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	I0006022516

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0006022516 Dr Imogen BJ Smith 10/1/24 20:03 Dr Joanne Mackie	Diagnosis 1. Likely exacerbation of undiagnosed COPD Treatment : already on doxycycline (started by GP OOH), given 5 days of prednisolone and new salbutamol inhaler This lady was seen in EMA today with a dry cough, wheeze and breathlessness on exertion. She is a known heavy smoker. She had been seen by GP out of hours 48 hours previously and started on doxycycline but had not felt much better and had also developed worsening pain between her scapula. She denied any haemoptysis or sputum. On examination she looked well and sats were 97% on room air. She was not hypoxic. CXR was unremarkable and bloods were OK including a D dimer (97). Her chest was clear when I saw her, but she had been wheezy when first admitted to EMA. She was keen to get home and reassured by results. I have given her a 5 day course of prednisolone and a new salbutamol inhaler (hers had run out). She was discharged home with worsening advice, her GP has already requested spirometry. Yours sincerely Joanne Mackie (consultant in Acute and General Medicine)

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	I0006022516

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0006022516 Nurse 10/1/24 20:17 Caitlin McMahon	D/c home with TTO. Own transport.

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	I0006022516

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0006022516 Dr Imogen BJ Smith 10/16/24 10:59 Beth Love	FINAL DISCHARGE SUMMARY Dear Doctor, I have nothing further to add to the immediate discharge summary below, which you should already have received. Yours sincerely, Dr Imogen BJ Smith Consultant Physician e-checked IS/BL Date dictated: 11.10.24 Date typed: 16.10.24 Diagnosis 1. Likely exacerbation of undiagnosed COPD Treatment : already on doxycycline (started by GP OOH), given 5 days of prednisolone and new salbutamol inhaler This lady was seen in EMA today with a dry cough, wheeze and breathlessness on exertion. She is a known heavy smoker. She had been seen by GP out of hours 48 hours previously and started on doxycycline but had not felt much better and had also developed worsening pain between her scapula. She denied any haemoptysis or sputum. On examination she looked well and sats were 97% on room air. She was not hypoxic. CXR was unremarkable and bloods were OK including a D dimer (97). Her chest was clear when I saw her, but she had been wheezy when first admitted to EMA. She was keen to get home and reassured by results. I have given her a 5 day course of prednisolone and a new salbutamol inhaler (hers had run out). She was discharged home with worsening advice, her GP has already requested spirometry. Yours sincerely Joanne Mackie (consultant in Acute and General Medicine)

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	I0006022516

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0006022516 Nurse 10/1/24 17:58 Sophie Phipps	Xpert Resp. Multiplex PCR (Cephied) SARS-COV PCR: Negative Influenza A: Negative Influenza B : Negative RSV : Negative Date Performed: 01/10/24 Performed by: S.Phipps S/N

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	I0006022516

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0006022516 Dr Imogen BJ Smith 10/1/24 19:45 Dr Joanne Mackie	EMA cons review - J Mackie Seen by medical student - many thanks (documentation to follow) Current heavy smoker - no formal diagnosis of COPD but likely undiagnosed (GP has requested spirometry) Unwell for the last 5 days - seen by OOH 2 days ago and started on doxycycline but hasn't noted much improvement Not started on steroids and blue salbutamol inhaler has run out Has noted a pleuritic chest pain between her scapula last few days No haemoptysis Dry cough No fevers O/E has been in and out for cigarettes all afternoon is SOB on exertion but no hypoxic and not overtly distressed on exertion chest sounds clear just now - medical student had noted wheeze earlier febrile with GP but obs OK here and sats 97% RA (NEWS 0) no peripheral oedema CXR - clear bloods OK - no D dimer not had ECG cephid negative Imp need to rule out PE likely infective exacerbation of undiagnosed COPD - could be viral Plan ECG add D dimer if D dimer OK - home with course of prednisolone and new salbutamol inhaler, can complete current course of Abxs if D dimer positive and ECG OK - Tx dose dalteparin and back to SDEC for CTPA mane

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	I0006022516

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0006022516 Dr Imogen BJ Smith 10/1/24 19:50 Bai Ze Tan (Medical Student)	Bai Ze Medical Student Entry PC: shortness of breath, chest tightness, dry cough for 2 days HPC: Previous chest infection April 2024, resolved after GP prescribed antibiotics Experienced episode of SOB Sunday 29/09/24, dialed 111, OOH appointment arranged and prescribed doxycycline. Did not resolve chest infection. Been with GP today, who has referred her to EMA query COPD exacerbation. Systemic Review Cardiology - chest tightness, heart racing Respiratory - SOB, dry cough GI - denies nausea, vomiting PMH - nil PDH - Salubutamol (ran out using her daughters) Allergies: penicillin SH - Lives at home with her two daughters - Two storey home with a single flight of stairs, able to mobilise around - 20 pack year smoking history - Drinks 10-20 pints alcohol a week FH - 2 daughter have asthma - Says asthma runs in the family O/E NEWS: 0 She is visibly out of breath, stop between each sentence HS I+II+0, tachycardic (just walked to reception for cigarette) Chest is clear No pedal oedema Investigation CXR - clear Impression - Unresolved chest infection - Undiagnosed COPD Plan - ECG - D-dimer, if negative discharge - Awaiting spirometry results Consultant - Dr J Mackie

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	I0005707638
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	I0005707638

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005707638 Dr Louise McMurran 8/14/23 13:13 Craig Walker	Date of admission: 08/08/23 Date of discharge: 08/08/23 Surgeon: L McMurran Consultant: L McMurran Procedure: Removal of right grommet Findings: Right grommet with some irritation around the myringotomy Operation: The procedure was prepped and draped. Grommet was removed. The edges of the perforation were scratched to encourage healing. Cilodex drops applied. Plan: Home later today No routine follow up Keep ear dry for 6-8 weeks to allow tympanic membrane perforation to heal Yours sincerely, Dr. Louise McMurran Consultant Otologist LM/CW 14/08/2023 Secretary Contact: 0131 536 1027

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	I0004347328
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	I0004347328

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0004347328 Dr David EC Baring 1/6/18 08:23 Elizabeth Melville	Date of Admission: 19 December 2017,Date of Discharge: 20 December 2017,Diagnosis: Right nasal deviation ,Procedure: Septoplasty,Surgeon: Mr D Baring,Follow up: 3 months SJH,,Ms McAteer attended with a history of nasal congestion particularly on the right side. She had a right septal deviation which was corrected with a septoplasty.,,Post operatively she made a good recovery and was discharged the following day. I have asked her to use regular Nasonex until I review her again in 3 months, hopefully at which time things will be improved.,,Please let me know if she runs into any problems.,,Yours sincerely,,,,Mr D Baring,Consultant ENT Surgeon,(dictated but not signed for expediency),

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	I0003593992
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	I0003593992

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0003593992 Mr Frank O Agada 2/4/15 12:47 Joyce Woodford	Procedure: Bilateral grommets,,Post operative plan: To go home today. To be seen in the Medinet Clinic in 4 - 6 weeks time. ,,Yours sincerely,,(Not checked/signed due to expediency - EPO responsible to inform GP of any amendments/updates),,Mr Frank O Agada,ENT Consultant ,MEDINET,,All enquiries regarding this episode please contact:,,Departmental Secretary for External Providers Office,(Medinet),Ground Floor,Woodlands House,Astley Ainslie Hospital,Tel. - 0131 446 4515 ,,

Patient & GP Information

UHPI Number	800325165E
CHI Number	2305821425
Episode Number	I0002832030
Surname/Forename	McAteer, Gillian
Date of Birth	5/23/82
Sex	Female
Patient Address.	Flat 1 Carron CourtBathgate EH48 2QF
Registered GP	A Black
GP Address.	Simpson Medical Group,Bathgate Primary Care Centre,Whitburn Road,Bathgate EH48 2SS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	McAteer, Gillian
UHPI Number	800325165E

Episode Number	I0002832030

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0002832030 Mr Martin DJ McKechnie 10/9/11 20:25 Kirsty Maclean	This 29yr female was admitted to the observation ward for neurological observations after sustaining a head injury falling down the stairs whilst intoxicated at home. No vomiting. Mild headache controlled by paracetamol.,,O/E,large boggy swelling over occiput.,GCS 15/15, PEARL, Cranial nerves all intact.,Full range of movement in C spine, mild tenderness over C1, C2.,Mobilising well.,,CT head - normal.,She was deemed fit for discharge home, to stay the night with her mum. Given head injury advice., ,Should you need further information please contact...,Observation Ward, SJH., ,Information contained in this letter has been discussed with the patient/carer.,,Yours sincerely....., ,Staff Signature..... PrintName.....,,Designation..... Date..... Time.....,

Clinic Letters

NHS Lothian

St John's Hospital at Howden
Howden Road West
Livingston
West Lothian
EH54 6PP

Gynaecology - Colposcopy

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 19/02/2026

Outpatient Clinic Letter

Patient	Gillian McAteer Flat 1 Carron Court Bathgate EH48 2QF	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (43 years) 800325165E
Attendance Date	11/02/2026		
Consultant	Lesley A Downie		

Dear Dr Black

Further to your recent attendance at the smear clinic, your smear has come back as normal, which is very reassuring.

You are on routine recall and should have your next smear taken in 5 years time.

Kind regards.

Yours sincerely

Leslie Downie
Colposcopy Nurse Specialist

CC GP - Sent electronically

This sheet should only be used for essential patient information not currently captured electronically (e.g. diagrams).

Anything documented on this sheet will be scanned and made available to view electronically via SCI Store

NHS Lothian

Essential Scanning Sheet

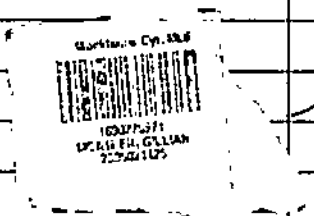
PATIENT PROGRESS NOTES /COMMUNICATION SHEET

Nan 800325165E F 23/05/1982
McAteer, Gillian
Flat 1,
DOE Carron Court,
Bathgate,
West Lothian, EH48 2QF
Unit CHI 2305821425
78132 A Black

Hospital ☐ OPD ☐ Ward ☐ Clinical area

State Action/s taken After Exception Reporting
Each entry should be dated and timed

Date and Time	Progress notes / Problems Action Taken and Investigations Required	Signature (Print name & designation)
11/2/26	Referred by GP as unable to view cx. past history: NO medical problems Para – 2 x SVD + 1 CS LMP – 10/2/26. Septrin. clopromazine. KNA. Has taken mayaro.	



Authorised: Nov 2022
Review: Nov 2025

Essential Scanning Sheet

This sheet should only be used for essential patient information not currently captured electronically (e.g. diagrams).

NHS Lothian

Anything documented on this sheet will be scanned and made available to view electronically via SCI Store

PATIENT PROGRESS NOTES /COMMUNICATION SHEET	Addressograph, or Name OOB Unit No./CHI

Hospital ☐ **OPD** ☐ **Ward** ☐ **Clinical area**

State Action/s taken After Exception Reporting
Each entry should be dated and timed

Date and Time	Progress notes / Problems Action Taken and Investigations Required	Signature (Print name designation)

Authorised: Nov 2022
Review: Nov 2025

S/N Bourne GP. 19/2/26.

Cervical Screening Request Form (Complete)

Request Id	1690270971
DOB / CHI	2305821425
Name	MCATEER, GILLIAN
CHI Address	1 CARRON COURT, SOUTH LOCH PAR, BATHGATE, EH48 2OF
Correspondence	

Sample Taker ID	Deputy Charge Nurse Lesley Downie
Sender Location	Out Patients 3 St. Johns
Sender Address	St. Johns Hospital, Howden Road West, Livingston, EH54 6PP
Practice Address	Bathgate Primary Care Cen, Whitburn Road, Bathgate, EH48 2SS

Type of Sample	Cervical
Appearance of Cervix	Normal
Current HRT	No
I.U.C.D.	No
Post Natal	No
Currently Immunosuppressed	No

Refer	No Referral
Observations	No Referral
Date Of Exam	11 Feb 2026
Date Sample Taken	11 Feb 2026
Last Menstrual Period	10 Feb 2026

Clinical Comments	gp unable to view cervix referred to opd3 smear taken wait for results
Signature Of Requester	Deputy Charge Nurse Lesley Downie

Virology Result:	hr-HPV Negative
Cytology Result	
Recall Advice	Routine Recall - 5 Years
Infection(s)	
Cytology Report	

MCATEER, GILLIAN
2305821425

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Ear Nose and Throat

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 18/02/2021
Date/Time Printed: 29/04/2026 08:45
Our Ref: 800325165E
CHI: 2305821425

Patient:	Miss Gillian McAteer Flat 1 Carron Court West Lothian Bathgate EH48 2QF	**UHPI:** **Date of Birth:**	800325165E 23/05/1982
Specialty:	Ear Nose and Throat	**Consultant:**	Dr David EC Baring

Diagnosis:
Bilateral glue ear plus retraction.
Nasal congestion.
Treatment:
Regular Nasonex nasal spray 2 puffs right plus left nose, once daily long term.
GP Action:
Please place on repeat prescription.
Follow up:
3 months with hearing test.

Mrs McAteer attends today with longstanding issues with congestion of her ears. She gets occasional discharge and tinnitus. There are no issues with vertigo. Her nose is blocked in addition. She is not using any sprays, she smokes 10 a day.

Examination today shows a snotty nose and mucosa but a straight septum. Both tympanic membranes had small attic retractions with no evidence of significant debris collection. Unfortunately a hearing test had not been performed. I have given her a prescription for Nasonex and asked her to cut down on her smoking and we will see her back in 3 months.

Yours sincerely

Mr David E C Baring
Consultant ENT Surgeon DECB/KF

Dictated but not signed for expediency.

Respiratory Physiology Service

Name: GILLIAN MCATEER **DOB:** 23-May-1982

Sex: F **Age:** 42.7 **Ht:** 1.650m **Wt:** 113.0kg **BMI:** 41.5

CHI: 2305821425 **Report to:** Dr A McNutt, Bathgate MP

Exhaled Fraction of Nitric Oxide Report

FeNO (ppb)	5

Spirometry predict methodology: Global Lung Initiative (GLI) 2012

Clinical Details (20-Jan-2025): SMOKER; ?- C.O.P.D.;

Ventolin Inhaler taken 24hrs prior to test.

FeNO < 25 ppb = Low Probability of eosinophilic inflammation. Symptoms unlikely to respond to corticosteroids.

FeNO 25 - 40 ppb = Intermediate - interpret in conjunction with other clinical information if patient is symptomatic may respond to corticosteroids.

FeNO >40 ppb = High probability of eosinophilic inflammation. Symptoms highly likely to respond to corticosteroids.

Respiratory Physiology Service

Name: GILLIAN MCATEER **DOB:** 23-May-1982

Sex: F **Age:** 42.7 **Ht:** 1.650m **Wt:** 113.0kg **BMI:** 41.5

CHI: 2305821425 **Report to:** Dr A McNutt, Bathgate MP

Peak Expiratory Flow Report

		Predicted	Range*
Baseline PEF (L/Min)	356	401	312 - 490
Post Bronchodilator PEF (L/Min)			

* This range encompasses 90% of the normal distribution

Spirometry predict methodology: Global Lung Initiative (GLI) 2012

Clinical Details (20-Jan-2025): SMOKER; ?- C.O.P.D.;

Respiratory Physiology Service

Name: GILLIAN MCATEER **DOB:** 23-May-1982

Sex: F **Age:** 42.7 **Ht:** 1.650m **Wt:** 113.0kg **BMI:** 41.5

CHI: 2305821425 **Report to:** Dr A McNutt, Bathgate MP

Ventilatory Capacity Report

Date			20-Jan-2025					
	Value	Value	Value	%Pred	Predicted	Range*		
Ventilatory Capacity								
FEV1 (L)			3.06	100	3.05	2.42	-	3.66
VC (L)			4.21	112	3.75	2.98	-	4.55
FEV1/VC (%)			72.7		81.6	70.7	-	90.7
PEFR (L/Min)			356	89	401	312	-	490

* This range encompasses 90% of the normal distribution

Spirometry predict methodology: Global Lung Initiative (GLI) 2012

Clinical Details (20-Jan-2025): SMOKER; ?- C.O.P.D.;

Acceptability criteria was met.
Primary care report:
Baseline spirometry is within normal range.
No reversibility test as results exceed predicted values.
No evidence of COPD on baseline spirometry.
FeNO = 5ppb = Low Probability of eosinophilic inflammation. Symptoms unlikely to respond to corticosteroids.
LF/SB

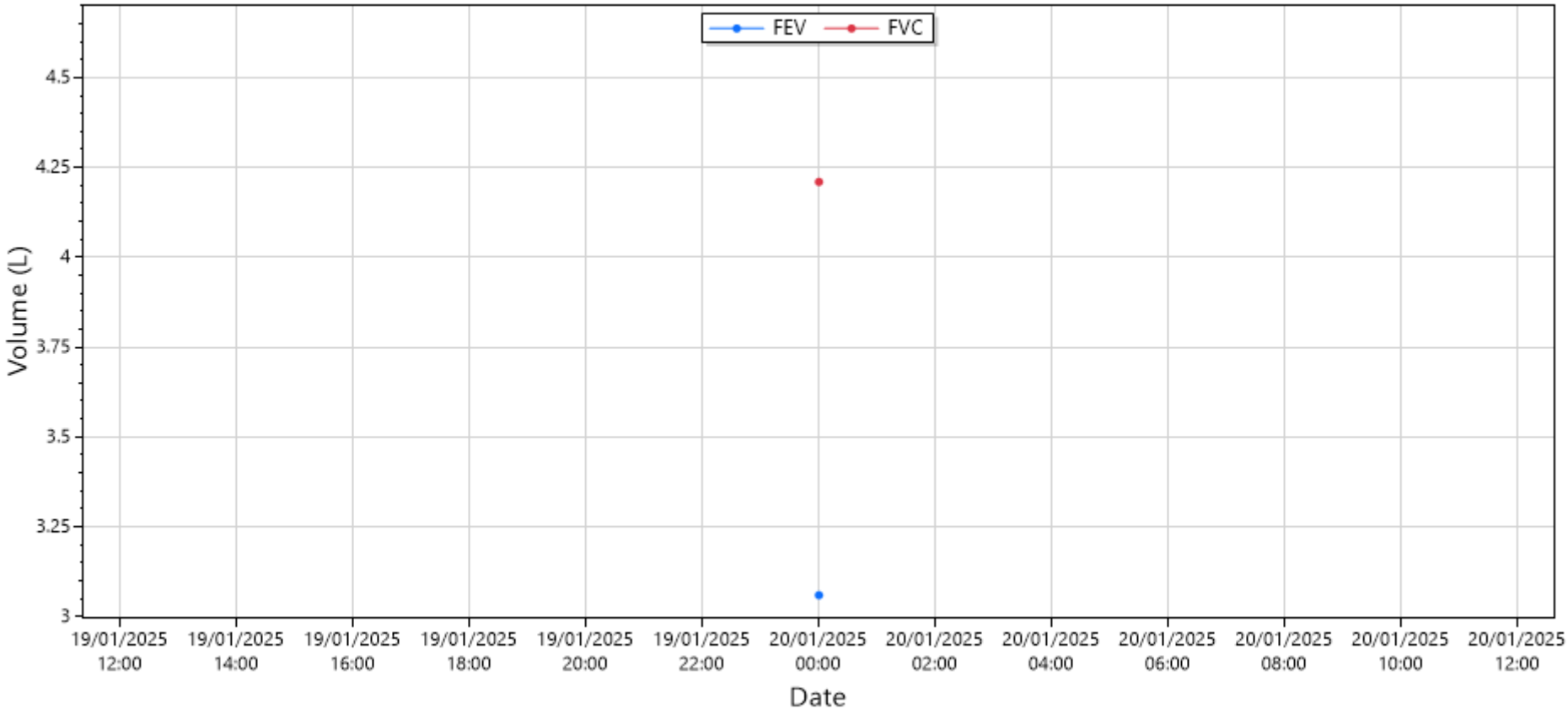
Respiratory Physiology Service

Name: GILLIAN MCATEER **DOB:** 23-May-1982

Sex: F **Age:** 42.7 **Ht:** 1.650m **Wt:** 113.0kg **BMI:** 41.5

CHI: 2305821425 **Report to:** Dr A McNutt, Bathgate MP

Ventilatory Capacity Graph



University Hospitals Division

Princess Alexandra Eye Pavilion
Chalmers Street
EH3 9HA

Ophthalmology

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 30/11/2021
Date/Time Printed: 29/04/2026 08:45
Our Ref: 800325165E
CHI: 2305821425

Patient:	Miss Gillian McAteer Flat 1 Carron Court West Lothian Bathgate EH48 2QF	**UHPI:** **Date of Birth:**	800325165E 23/05/1982
Specialty:	Ophthalmology	**Consultant:**	PAEP Consultants ARC

DIAGNOSIS:
Blunt trauma uveitis.

VISUAL ACUITY: (unaided)
Right eye 6/9, improving to 6/6 with pinhole
Left eye 6/5

INTRAOCULAR PRESSURE: (Icare)
Right eye 11mmHg
Left eye 20mmHg

OCULAR MEDICATION:
Dexamethasone 0.1%, 1 drop to the right eye 4 times a day for 1 week, then 3 times a day for 1 week, then twice a day for one week, then once a day for 1 week.
Cyclopentolate 1%, 1 drop to the right eye 3 times a day for 7 days.

FOLLOW UP:
In St John's Hospital in 2-3 weeks.

COMMENT:
I saw this patient as part of my on-call with Dr Schmoll today.

She was attacked approximately 1 week ago and had significant bruising and swelling around her right eye which has now settled. However, since then she has had increasing pain, photophobia and hepiphora. She also feels her eye is red compared to the other

Ophthalmology

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 30/11/2021
Date/Time Printed: 29/04/2026 08:45
Our Ref: 800325165E
CHI: 2305821425

eye and her vision is mildly reduced. She has no diplopia and no shadows or curtains suggestive of a retinal detachment.

On examination there is mild bruising and swelling still evident over the right eye and the conjunctiva of the right eye is injected. Both corneas appear clear. The anterior chamber of the right eye is deep with approximately 20 cells per high powered field and no hyphema or odious blood. Examination of the posterior reveals no commotio and no inflammation of the vitreous, no vitreous haemorrhage and I was unable to identify any breaks or tears, there was also no tobacco dust in the vitreous.

These findings are in keeping with a blunt trauma uveitis following her assault. Accordingly I have started her on a steroid reducing regime as above and dilating drops. She will be reviewed in St. John's in approximately 2-3 weeks.

Yours sincerely

DR K WILSON
STR

Cc:
Dr Jacob Philip Sakin
Emergency Dept
St. John's Hospital
LIVINGSTON
EH54 6PP

Cc: Patient

KW/JD

NHS Lothian

St John's Hospital at Howden
Outpatient Department 4
Howden Road West
Livingston
West Lothian EH54 6PP

Ear Nose and Throat

Dr McNutt
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 21/02/2023

Outpatient Clinic Letter

Patient	Gillian McAteer Flat 1 Carron Court Bathgate EH48 2QF	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (40 years) 800325165E
Attendance Date	20/01/2023		
Consultant	ENT Registrar SJH		

Dear Dr McNutt

Diagnoses
Bilateral chronic mucosal otitis media
Rhinitis with right sided septal deviation - underwent septoplasty in 2017

Management
List fro removal of grommet right ear +/- fat plug myringoplasty
Continue Nasonex nasal spray

I caught up with Mrs McAteer in the ENT clinic today. She is still struggling with her ears. The left side remains blocked and the right side is continually discharging mucoid foul smelling discharge. She feels that her breathing in her right nostril is reduced again post septoplasty. She has gained little benefit also from the use of Nasonex nasal spray.

Examination of her ears today revealed healthy canal on the left side with a retracted pars tensa and pars flaccida and with fluid behind the tympanic membrane. On the right side there was evidence of a grommet remaining insitu. There was mucoid discharge coming through this which was suctioned clear. Anterior rhinoscopy revealed an anterior septal deflection to the right hand side narrowing the external nasal valve and reducing nasal airflow on cold spatula testing. Flexible nasendoscopy revealed rhinitic nasal mucosa. Examination of post nasal space was clear of any adenoidal enlargement but there was a mucus trail discharging from her left eustachian tube orifice. The right eustachian tube orifice was clear.

Mrs McAteer is in an unfortunate cycle whereby treating one symptom has led to an exacerbation of another. Her primary concern today was discharge from the right ear and so I think we should proceed with a grommet removal, following this the edges can be freshened and either some spongistan or a fat plug can be used to aid the healing

process. We should see her in clinic again following this removal for an assessment of her symptoms. I am not sure that there is any straightforward treatment option but I wonder whether she may be a candidate for a eustachian tube dilatation in the future. I am not sure revision septoplasty would be of any great benefit if she did not feel the previous septoplasty improved her ear symptoms.

Yours sincerely

Electronically verified and signed by Dr Michael Hopkins
SpR in ENT
MH/SM 17/02/2023

CH 2e

EAR, NOSE AND THROAT

No. 800325165E F 23/05/1982
NAME **McAteer, Gillian**
Flat 1,
Carron Court,
Bathgate,
West Lothian, EH48 2QF
CHI 2305821425
78132 AP McNutt

HISTORY

NOSE:

NASO-PHARYNX:

PHARYNX:

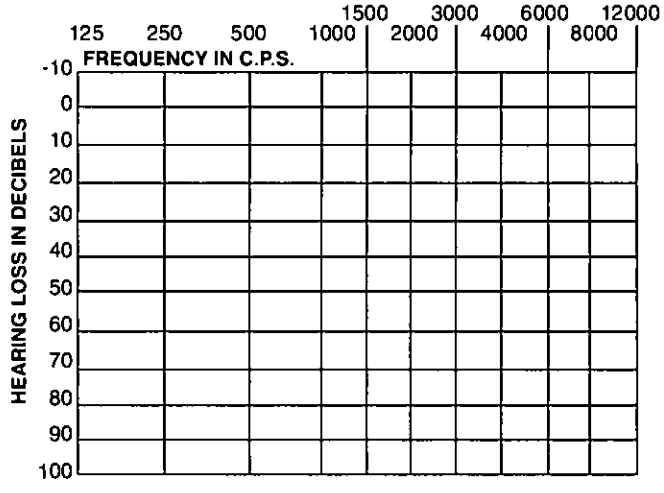
MOUTH:

LARYNX:

RIGHT EAR:

LEFT EAR:

AUDIOGRAM



	RIGHT	LEFT
WHISPERED VOICE		
CONVERSATIONAL VOICE		
RINNE		
WEBER		
ABC		

WLT 368

DATE	

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Ophthalmology

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 20/12/2021
Date/Time Printed: 29/04/2026 08:45
Our Ref: 800325165E
CHI: 2305821425

Patient:	Miss Gillian McAteer Flat 1 Carron Court West Lothian Bathgate EH48 2QF	**UHPI:**	800325165E
		Date of Birth:	23/05/1982
Specialty:	Ophthalmology	**Consultant:**	Dr Paul J Steptoe

DIAGNOSIS:
Traumatic uveitis right eye November 2021

VISUAL ACUITY:
Right eye: 6/6
Left eye: 6/5

INTRAOCULAR PRESSURE:
Right eye: 13mmHg
Left eye: 11mmHg

MEDICATION:
1. Complete course of topical maxidex
2. Stop cyclopentolate eye drops

ACTION FOR GP:
Nil

COMMENT:
Mrs McAteer was reviewed in clinic today. Thankfully her eye inflammation has settled and her fundus has been unaffected.

MANAGEMENT:
I have reassured her of today's findings and explained that her vision should improve further as the cyclopentolate wears off and her pupil reacts again.

FOLLOW UP

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Ophthalmology

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created:	20/12/2021
Date/Time Printed:	29/04/2026 08:45
Our Ref:	800325165E
CHI:	2305821425

Discharged

Kind regards,

Electronically checked/signed by Dr Steptoe

Dr Paul Steptoe
Consultant Ophthalmologist

cc
Mrs Gillian McAteer

PJS/cf

NHS Lothian

St John's Hospital at Howden
Outpatient Department 1
Howden Road West
Livingston
West Lothian EH54 6PP

Ophthalmology

Dr McNutt
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 22/12/2021

Outpatient Clinic Letter

Patient	Gillian McAteer Flat 1 Carron Court Bathgate EH48 2QF	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (39 years) 800325165E
Attendance Date	20/12/2021		
Consultant	Dr Paul J Steptoe		

Dear Dr McNutt

DIAGNOSIS:
Traumatic uveitis right eye November 2021

VISUAL ACUITY:
Right eye: 6/6
Left eye: 6/5

INTRAOCULAR PRESSURE:
Right eye: 13mmHg
Left eye: 11mmHg

MEDICATION:
1. Complete course of topical maxidex
2. Stop cyclopentolate eye drops

ACTION FOR GP:
Nil

COMMENT:
Mrs McAteer was reviewed in clinic today. Thankfully her eye inflammation has settled and her fundus has been unaffected.

MANAGEMENT:
I have reassured her of todays findings and explained that her vision should improve further as the cyclopentolate

wears off and her pupil reacts again.

FOLLOW UP
Discharged

Kind regards,

Electronically checked/signed by Dr Steptoe

Dr Paul Steptoe
Consultant Ophthalmologist

cc
Mrs Gillian McAteer

PJS/cf

EYE DEPARTMENT NEW PATIENT FORM

PDSMA.

11.00.

NUMBER

NAME 800325165E F 23/05/1982

ADDR McAteer, Gillian
Flat 1,
Carron Court,
Bathgate,
West Lothian, EH48 2QF
CHI 2305821425
78132 AP McNutt

NHS Lothian

DATE 20/12/21

REFERRAL PAGP

TRAUMA (C) [redacted] VIS.

HISTORY

PoH NONE

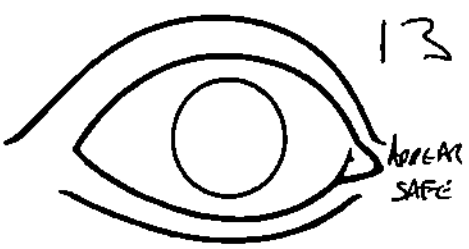
PMH NONE

MEDS COPRAMINE CARBOMAZEPINE

NKDA.

NO EPILEPSY.

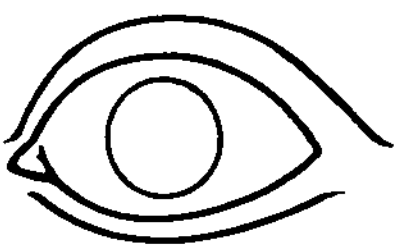
RIGHT EYE			LEFT EYE		
VISUAL ACUITY	Distant	Near	VISUAL ACUITY	Distant	Near
Unaided	6/6-2.	N4	Unaided	6/5	N4
Corrected	PH NO IMPROV.		Corrected	PH NO IMPROV	
OWN GLASSES			OWN GLASSES		



13 ICARE IOP 11

APPEAR SAFE

AC APPEAR SAFE



REACTIVE (ALREADY DILATED)

PUPILS REACTIVE

Ø RAPD Ø

DILATED (L) ONLY @ 11:05

(R) ALREADY DILATED NO ISSUES 11:05

Documentation ☑

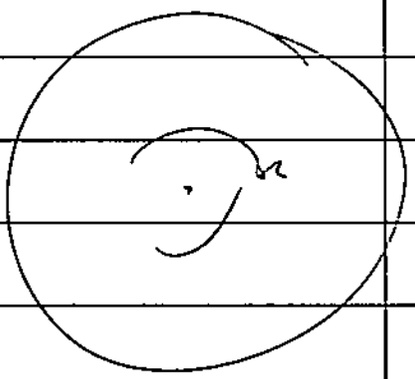
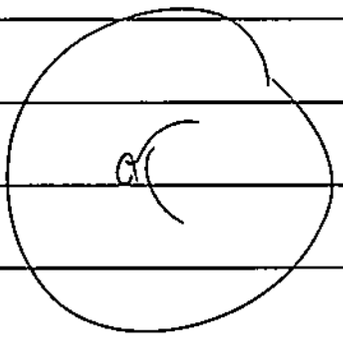
clear cornea clear

No depth asymetry

Normal AC

clear lens

WLT 386

Date	FURTHER NOTES		
	RIGHT EYE	LEFT EYE	
			
mrf			
	resolved		
(3)	discharge		Paul Steptoe GMC: 7072825

University Hospitals Division
Lauriston Building
39 Lauriston Place
Edinburgh
EH3 9EN

Ear Nose and Throat

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 17/02/2023
Date/Time Printed: 29/04/2026 08:45
Our Ref: 800325165E
CHI: 2305821425

Patient:	Miss Gillian McAteer Flat 1 Carron Court West Lothian Bathgate EH48 2QF	**UHPI:**	800325165E
		Date of Birth:	23/05/1982
Specialty:	Ear Nose and Throat	**Consultant:**	ENT Registrar SJH

Diagnoses
Bilateral chronic mucosal otitis media
Rhinitis with right sided septal deviation - underwent septoplasty in 2017

Management
List fro removal of grommet right ear +/- fat plug myringoplasty
Continue Nasonex nasal spray

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Mrs McAteer is in an unfortunate cycle whereby treating one symptom has led to an exacerbation of another. Her primary concern today was discharge from the right ear and so I think we should proceed with a grommet removal, following this the edges can be freshened and either some spongistan or a fat plug can be used to aid the healing process. We should see her in clinic again following this removal for an assessment of her symptoms. I am not sure that there is any straightforward treatment option but I wonder whether she may be a candidate for a eustachian tube dilatation in the future. I am not sure revision septoplasty would be of any great benefit if she did not feel the previous septoplasty improved her ear symptoms.

University Hospitals Division

Lauriston Building
39 Lauriston Place
Edinburgh
EH3 9EN

Ear Nose and Throat

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 17/02/2023
Date/Time Printed: 29/04/2026 08:45
Our Ref: 800325165E
CHI: 2305821425

Yours sincerely

Electronically verified and signed by**Dr Michael Hopkins**
SpR in ENT
MH/SM 17/02/2023

NHS Lothian

Princess Alexandra Eye Pavilion
Outpatient Department
Chalmers Street
Edinburgh
EH3 9HA

Ophthalmology

Dr McNutt
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 02/12/2021

Outpatient Clinic Letter

Patient	Gillian McAteer Flat 1 Carron Court Bathgate EH48 2QF	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (39 years) 800325165E
Attendance Date	28/11/2021		
Consultant	PAEP Consultants ARC		

Dear Dr McNutt

DIAGNOSIS:
Blunt trauma uveitis.

VISUAL ACUITY: (unaided)
Right eye 6/9, improving to 6/6 with pinhole
Left eye 6/5

INTRAOCULAR PRESSURE: (Icare)
Right eye 11mmHg
Left eye 20mmHg

OCULAR MEDICATION:
Dexamethasone 0.1%, 1 drop to the right eye 4 times a day for 1 week, then 3 times a day for 1 week, then twice a day for one week, then once a day for 1 week.
Cyclopentolate 1%, 1 drop to the right eye 3 times a day for 7 days.

FOLLOW UP:
In St Johns Hospital in 2-3 weeks.

COMMENT:
I saw this patient as part of my on-call with Dr Schmoll today.

She was attacked approximately 1 week ago and had significant bruising and swelling around her right eye which has now settled. However, since then she has had increasing pain, photophobia and hepiphora. She also feels her

eye is red compared to the other eye and her vision is mildly reduced. She has no diplopia and no shadows or curtains suggestive of a retinal detachment.

On examination there is mild bruising and swelling still evident over the right eye and the conjunctiva of the right eye is injected. Both corneas appear clear. The anterior chamber of the right eye is deep with approximately 20 cells per high powered field and no hyphema or odious blood. Examination of the posterior reveals no commotio and no inflammation of the vitreous, no vitreous haemorrhage and I was unable to identify any breaks or tears, there was also no tobacco dust in the vitreous.

These findings are in keeping with a blunt trauma uveitis following her assault. Accordingly I have started her on a steroid reducing regime as above and dilating drops. She will be reviewed in St. Johns in approximately 2-3 weeks.

Yours sincerely

DR K WILSON
STR

Cc:
Dr Jacob Philip Sakin
Emergency Dept
St. Johns Hospital
LIVINGSTON
EH54 6PP

Cc: Patient

KW/JD

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Gynaecology - Colposcopy

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 19/02/2026
Date/Time Printed: 29/04/2026 08:45
Our Ref: 800325165E
CHI: 2305821425

Patient:	Miss Gillian McAteer Flat 1 Carron Court West Lothian Bathgate EH48 2QF	**UHPI:**	800325165E
		Date of Birth:	23/05/1982
Specialty:	Gynaecology - Colposcopy	**Consultant:**	Lesley A Downie

Further to your recent attendance at the smear clinic, your smear has come back as normal, which is very reassuring.

You are on routine recall and should have your next smear taken in 5 years time.

Kind regards.

Yours sincerely

Leslie Downie
Colposcopy Nurse Specialist

CC GP - Sent electronically

NHS Lothian

St John's Hospital at Howden
Outpatient Department 4
Howden Road West
Livingston
West Lothian EH54 6PP

Ear Nose and Throat

Dr Gillespie
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 18/02/2021

Outpatient Clinic Letter

Patient	Gillian McAteer Flat 1 Carron Court Bathgate EH48 2QF	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (38 years) 800325165E
Attendance Date	17/02/2021		
Consultant	Dr David EC Baring		

Dear Dr Gillespie

Diagnosis:
Bilateral glue ear plus retraction.
Nasal congestion.
Treatment:
Regular Nasonex nasal spray 2 puffs right plus left nose, once daily long term.
GP Action:
Please place on repeat prescription.
Follow up:
3 months with hearing test.

Mrs McAteer attends today with longstanding issues with congestion of her ears. She gets occasional discharge and tinnitus. There are no issues with vertigo. Her nose is blocked in addition.She is not using any sprays, she smokes 10 a day.

Examination today shows a snotty nose and mucosa but a straightseptum. Both tympanic membranes had small attic retractions with no evidence of significant debris collection. Unfortunately a hearing test had not been performed. I have given her a prescription for Nasonexand asked her to cut down on her smoking and we will see her back in 3 months.

Yours sincerely

Mr David E CBaring
Consultant ENT Surgeon DECB/KF

Dictated butnot signed for expediency.

EAR, NOSE AND THROAT

17/1/21

800325165E F 23/05/1982 CH 2e

No. **McAteer, Gillian**

NAME Flat 1,
Carron Court,
Bathgate,
West Lothian, EH48 2QF

CHI 2305821425

78132 C Gillespie

HISTORY

R > L HL ocmd disch
tnt RHL no vertigo.
pmi gut

Nose blocked (R) > (L). no discharge
SOSA. no sprays.

DM- Sertraline NKDA. SM- Smok 10/d.
prochlorperazine

NOSE:

Swollen septum SMT-

NASO-PHARYNX:

PHARYNX:

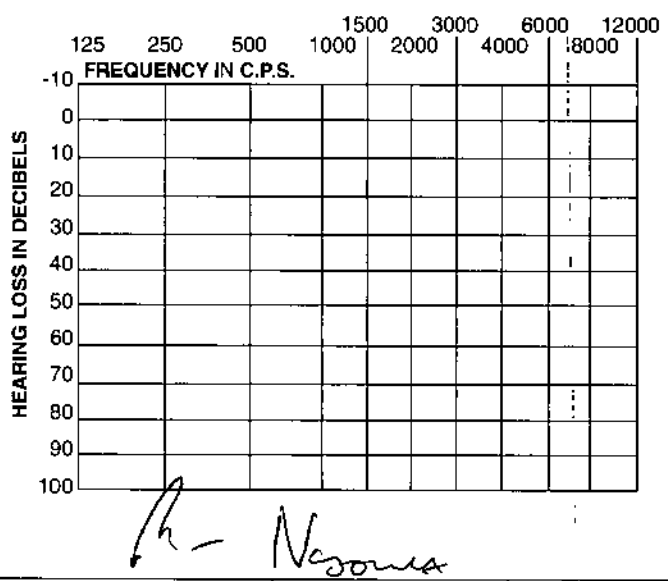
MOUTH:

LARYNX:

RIGHT EAR:

LEFT EAR:

AUDIOGRAM



R - Nasoma

	RIGHT	LEFT
WHISPERED VOICE	R/O 3/12 SMT	
CONVERSATIONAL VOICE		
RINNE		
WEBER		
ABC		

WLT 368

DATE	

University Hospitals Division

Lauriston Building
39 Lauriston Place
Edinburgh
EH3 9EN

Ear Nose and Throat

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 17/05/2018
Date/Time Printed: 29/04/2026 08:48
Our Ref: 800325165E
CHI: 2305821425

Patient:	Miss Gillian McAteer Flat 1 Carron Court West Lothian Bathgate EH48 2QF	**UHPI:**	800325165E
		Date of Birth:	23/05/1982
Specialty:	Ear Nose and Throat	**Consultant:**	Dr David EC Baring (Extra)

Diagnosis:
Post op septoplasty December 2017.
Follow up:
On request.

Mrs McAteer attends following her septoplasty. Things have healed well. Her airway is improved but there is an element of valve collapse on sharp inspiration. As such I have suggested that she tries some Breathe Right strips. She can get these at the counter at the chemists. If these are failing to work and she has got ongoing problems we would be happy to see her again at your request. The next step would be an open approach septorhinoplasty and spreader grafts in all likelihood and as such involves a whole further degree of complexity. At this stage Mrs McAteer is not inclined to go down this line but remains an option in the future should her condition change.

Yours sincerely

Mr David E C Baring
Consultant ENT Surgeon DECB/KF

NHS Lothian

Dr RW Holden
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

St John's Hospital
Howden Road West
LIVINGSTON
West Lothian
EH54 6PP
Contact: Ann Reid
Telephone: 01506 523997
ann.reid@nhslothian.scot.nhs.uk
Reference: AR / SJC
30/10/2018

Dear Dr Holden

Patient Details:		
	CHI Number	2305821425
	Unit Number	800325165E
	Name	Gillian Mcateer
	Date of Birth	23/05/1982
	Address	18 Cherry Avenue, Boghall Bathgate EH48 1NA

Your patient was seen at the clinic on 29/10/2018 and at this visit, a colposcopy was done but no treatment was undertaken.

Colposcopy assessment was Normal.

No smear was taken.

No cervical biopsy was taken.

The test results indicate that no further treatment of your patient is necessary. Your patient has therefore been discharged from the colposcopy clinic. I recommend that a follow up smear should be taken in 12 months time.

Your patient has been advised of the results and that she will be invited to attend for her next smear test. Your patient will therefore appear on your Recommended Call List (RCL) on SCCRS in due course.

Yours sincerely

Dr S J COURT
ASSOCIATE SPECIALIST

Copy to:

Colposcopy Clinic Card – New Referrals Only

PATIENT DETAILS

78132 L Heath
Affix 800325165E F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 L Heath

APPOINTMENT DETAILS

Hospital: St. Johns. Code:
Consultant: SJCcolP
Appointment Date: 29/10/18 Time: 15:30
Type of Episode: New Outpatient [1]
Attendance Status: 1: Attended [1]; 2: Cancelled by Patient; 3: Cancelled by Clinic; 5: Attended but Could NOT Wait; 8: Did not Attend DNA
LMP: 10/7/- Parity 3 1xCLS
Contraception: nil.

NEW REFERRAL DETAILS (captured for 1st visits only)

Date of Referral: 26/9/18 Date of Referral Smear: /8/18

*** Reason for referral**
0: Not known
1: Abnormal screening smear [1]
2: Abnormal test after colposcopy
3: Clinically suspicious cervix
4: Suspicious symptoms
5: Other

Main Referral Symptom
0: Not known
1: None [1]
2: IMB
3: PCB
4: Discharge
5: PMB
6: Other

*** Referral Cytology**
0: Not known
1: No smear
2: Negative (normal smear)
3: Unsatisfactory
4: Borderline change in squamous cells
5: Low grade dyskaryosis [5]
12: Borderline change in endocervical cells
6: High grade dyskaryosis (moderate)
7: High grade dyskaryosis (severe)
8: High grade dyskaryosis? invasive
9: Glandular Abnormality
10: Endocervical Adenocarcinoma
11: Endometrial or other malignancy

***HPV Status at Referral**
1: Positive
2: Negative
99: None

*** Referral Source**
1: GP [1]
2: Consultant same unit
3: Consultant other unit, same HBrd
4: Consultant other unit, other HBrd
6: Prison / Penal establishments
9: Other (includes armed forces)
0: Comm.Health services(FamPlan)

200/month

Previous Cervical Surgery
0: Not Known
1: None
2: LLETZ
3: Cold Coagulation
4: Laser Ablation
5: Cone Laser/Knife
6: Cryotherapy
7: Trachelectomy
8: Cervical Amputation
9: Hysterectomy

Yes
?

Year of Treatment (up to 5 can be recorded)

1. Smoker Y N
2 Discussed risks Y N
3 Refferred to sss Y N

COLPOSCOPY ASSESSMENT DETAILS

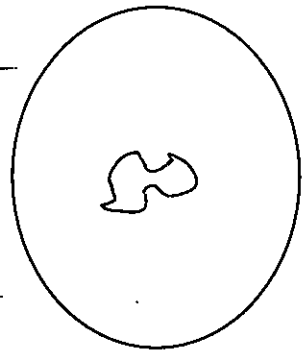
*Colposcopy Done: Yes [1] No
**Colposcopist Name: Coula
Findings:
**SCJ Visualised Yes [1] No
Acetowhite
Mosaic
Punctation
Atypical Vessels

**Transformation Zone Classification
0: Not known
1: Type I - Fully visualised [1]
2: Type II – In to canal but visualised
3: Type III – Not fully visualised

*Patient Pregnant? Yes No [1] Expected Date of Delivery: /__/__/__

****Colposcopic Opinion Cervical**
1: No cervix
2: Normal [2]
3: HPV/Inflamm/benign
4: CIN/low grade
5: CIN/high grade
6: Invasion
7: Other
8: Not performed

****Colposcopic Opinion Vaginal**
1: Normal [1]
2: HPV/Inflamm/benign
3: VaIN/low grade
4: VaIN /high grade
5: Invasion
6: Other
7: Not performed



No HW.

Please tick all appropriate boxes
* Denotes mandatory item for all new referrals
** Mandatory if colposcopy / Biopsy / Treatment / Smear done at visi

MEDICAL HISTORY
Anxiety/Depression
PSD.

MEDICATION
Sertraline
Chlorpromazine

ALLERGIES
Nil

DIAGNOSTIC PROCEDURE / TREATMENT DETAILS

*Cervix Biopsy Type
1: No biopsy ✓
2: Directed biopsy
3: Multiple directed biopsy
4: Excisional biopsy (LLETZ)
5: Wedge Biopsy

**Cervix Histology Result 1
1: Unsatisfactory
2: Normal
3: CIN1
4: CIN2
5: CIN3
6: Invasive Squamous (Ia1)
7: Invasive Squamous (Ia2)
8: Invasive Squamous (>1a)
9: CGIN
11: Invasive Adenocarcinoma
12: Other

Cervix Histology Result 2
1: Unsatisfactory
2: Normal
3: CIN1
4: CIN2
5: CIN3
6: Invasive Squamous (Ia1)
7: Invasive Squamous (Ia2)
8: Invasive Squamous (>1a)
9: CGIN
11: Invasive Adenocarcinoma
12: Other

**Definitive Histology (Highest)
1: Unsatisfactory
2: Normal
3: CIN1
4: CIN2
5: CIN3
6: Invasive Squamous (Ia1)
7: Invasive Squamous (Ia2)
8: Invasive Squamous (>1a)
9: CGIN
11: Invasive Adenocarcinoma
12: Other
13: None

*Was Vaginal Biopsy Done? Yes ☐ No ✓

**Vaginal Biopsy Result
1: Unsatisfactory
2: Normal
3: VaIN1
4: VaIN2
5: VaIN3
6: Invasive vaginal carcinoma
7: Other

Excision Complete (LLETZ)
1: Complete
2: Endo cervix – incomplete
3: Ecto cervix – incomplete
4: Both - incomplete
5: Inconclusive

*Was smear done at Visit? Yes ☐ No ✓

**Smear Result
1: Negative (normal smear)
2: Unsatisfactory
3: Borderline change in squamous cells
4: Low grade dyskaryosis
11: Borderline change in endocervical cells
5: High grade dyskaryosis (moderate)
6: High grade dyskaryosis (severe)
7: High grade dyskaryosis? invasive
8: Glandular Abnormality
9: Endocervical Adenocarcinoma
10: Endometrial or other malignancy

**HPV Status
1: Positive
2: Negative
99: None

*Procedure / Treatment Performed
1: None ✓
2: LLETZ
3: Cold coagulation
4: Laser ablation
5: Cone (laser or knife)
6: Cryotherapy
7: Trachelectomy
8: Cervical amputation
9: Hysterectomy

**Analgesia Administered
1: No analgesia ✓
2: Local analgesia
3: General/regional anaesthesia

Patient consent obtained? Yes ☐ No ☐

FOLLOW UP CARE / MANAGEMENT PLAN

*Planned follow-up care / treatment
1: Colposcopy clinic appointment
2: Hospital smear clinic appointment
3: Treatment – Inpatient / Day Case
4: Treatment – Outpatient
5: Cancer Treatment
6: Discharge
7: Other care or treatment ✓

No months to next follow up
Recommend Interval to next smear (months) 12 12

Standard Letter number: Patient 10 GP 17 Dictated letter only: Yes ☐ No ☐

NOTES:

CHAPERONE SIGNATURE

SIGNATURE [signature] DATE 29/10/18

Please tick all appropriate boxes
* Denotes mandatory item for all new referrals
** Mandatory if colposcopy / Biopsy / Treatment / Smear done at visit

NHS
Lothian

Ms Gillian Mcateer
18 Cherry Avenue
Boghall
Bathgate
EH48 1NA

St John's Hospital
Howden Road West
LIVINGSTON
West Lothian
EH54 6PP
Contact: Ann Reid
Telephone: 01506 523997
ann.reid@nhslothian.scot.nhs.uk
Reference: AR / SJC
30/10/2018

Dear Ms Mcateer

CHI number: 2305821425 Unit number: 800325165E

Thank you for attending the clinic on 29/10/2018.

The test results indicate that you no longer require to attend the colposcopy clinic. I recommend that your next smear should be taken in 12 months time.

Your GP has been advised of your results. You will be contacted nearer the time to make arrangements for your next smear appointment.

If you have any concerns please contact your own GP or alternatively contact your consultant's secretary on 01506 523000 and we will do our best to help you.

Yours sincerely

Dr S J COURT
ASSOCIATE SPECIALIST

Copy to:

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Ear Nose and Throat

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 11/08/2017
Date/Time Printed: 29/04/2026 08:49
Our Ref: 800325165E
CHI: 2305821425

Patient:	Miss Gillian McAteer Flat 1 Carron Court West Lothian Bathgate EH48 2QF	**UHPI:**	800325165E
		Date of Birth:	23/05/1982
Specialty:	Ear Nose and Throat	**Consultant:**	Otology SPR

Gillian was brought to the Otology Clinic for review. She currently has a discharging ear on the right side. As you know she uses hearing aids on both sides and when last seen a year ago the right grommet was in situ. I was unable to suction our her right ear canal which was full of debris as there was no functioning suctioning available in clinic. I prescribed Ciloxan drops on the right side to be used for one week t.d.s. and we will see her back in clinic in 2 weeks time.

Her left ear canal and tympanic membrane were fine.

Kind regards.

Yours sincerely

Mr David Ellul
Locum ENT Consultant DE/KF

Dictated but not signed for expediency.

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Ear Nose and Throat

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created:	11/08/2017
Date/Time Printed:	29/04/2026 08:49
Our Ref:	800325165E
CHI:	2305821425

Copy to:

Dr Gillian MacDougall
Consultant ENT Surgeon

Laura Robertson
ENT Clinic
OPD 4
St John's Hospital

NHS Lothian

St John's Hospital at Howden
Outpatient Department 4
Howden Road West
Livingston
West Lothian EH54 6PP

Dr Heath
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 24/05/2018

Outpatient Clinic Letter

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (36 years) 800325165E
Specialty **Consultant**	Ear Nose and Throat Dr David EC Baring	**Attendance Date**	14/05/2018

Dear Dr Heath

Diagnosis:
Post op septoplasty December 2017.
Follow up:
On request.

Mrs McAteer attends following her septoplasty. Things have healed well. Her airway is improved but there is an element of valve collapse on sharp inspiration. As such I have suggested that she tries some Breathe Right strips. She can get these at the counter at the chemists. If these are failing to work and she has got ongoing problems we would be happy to see her again at your request. The next step would be an open approach septorhinoplasty and spreader grafts in all likelihood and as such involves a whole further degree of complexity. At this stage Mrs McAteer is not inclined to go down this line but remains an option in the future should her condition change.

Yours sincerely

Mr David E C Baring
Consultant ENT Surgeon DECB/KF

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Ear Nose and Throat

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 10/11/2017
Date/Time Printed: 29/04/2026 08:49
Our Ref: 800325165E
CHI: 2305821425

Patient:	Miss Gillian McAteer Flat 1 Carron Court West Lothian Bathgate EH48 2QF	**UHPI:**	800325165E
		Date of Birth:	23/05/1982
Specialty:	Ear Nose and Throat	**Consultant:**	Mr DW Sim

Mrs McAteer's right grommet remains in situ and patent.

She complains of reduced middle ear ventilation in the left side with a middle ear effusion with a conductive component at the lower frequencies.

As you know she has previously received a hearing aid fitting and has found this to be helpful.

The main symptom of concern at the moment relates to right nasal obstruction and postnasal discharge.

Otological examination showed the right grommet to be in situ and patent. The left grommet has extruded and she has again developed an effusion.

Endoscopic examination of the nose and nasopharynx was normal apart from a right sided deviated nasal septum.

Mrs McAtter has already received a hearing aid fitting and has found this to be effective for help with auditory rehabilitation.

She is keen to achieve help with her nasal symptoms.

I have scheduled her for a septoplasty.

I have given her advice on the procedure along with its potential benefits, limitations and risks.

In the meantime I have given her advice on continuing ear care.

Yours sincerely

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Ear Nose and Throat

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created:	10/11/2017
Date/Time Printed:	29/04/2026 08:49
Our Ref:	800325165E
CHI:	2305821425

Mr D W Sim MSc FRCSEd (ORL)DLO
GMC No. 2584980
Consultant ENT Surgeon DWS/KF

NHS Lothian

St John's Hospital at Howden
Outpatient Department 4
Howden Road West
Livingston
West Lothian EH54 6PP

Dr Heath
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 14/11/2017

Outpatient Clinic Letter

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (35 years) 800325165E
Specialty **Consultant**	Ear Nose and Throat Mr DW Sim	**Attendance Date**	06/11/2017

Dear Dr Heath

Mrs McAteer's right grommet remains in situ and patent.

She complains of reduced middle ear ventilation in the left side with a middle ear effusion with a conductive component at the lower frequencies.

As you know she has previously received a hearing aid fitting and has found this to be helpful.

The main symptom of concern at the moment relates to right nasal obstruction and postnasal discharge.

Otological examination showed the right grommet to be in situ and patent. The left grommet has extruded and she has again developed an effusion.

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In the meantime I have given her advice on continuing ear care.

Yours sincerely

Mr D W Sim MSc FRCSEd (ORL)DLO
GMC No. 2584980
Consultant ENT Surgeon DWS/KF

CH 2e

EAR, NOSE AND THROAT

No.

NAME 800325165E F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 1 Heath

6/11/17
16/43

HISTORY

(R) Grinding
hearing (L) hearing.
Vertigo.

Bleed rec (R)
Mucope.
Facial twitch.

Plan

NOSE:

NASO-PHARYNX: Mucope (R).

PHARYNX:

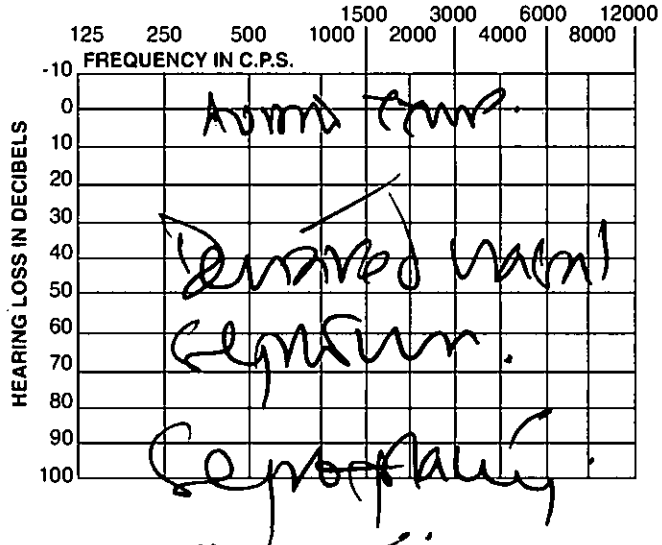
MOUTH:

LARYNX:

RIGHT EAR: (R) Cerumen Epithelium

LEFT EAR: (L) Cerumen.

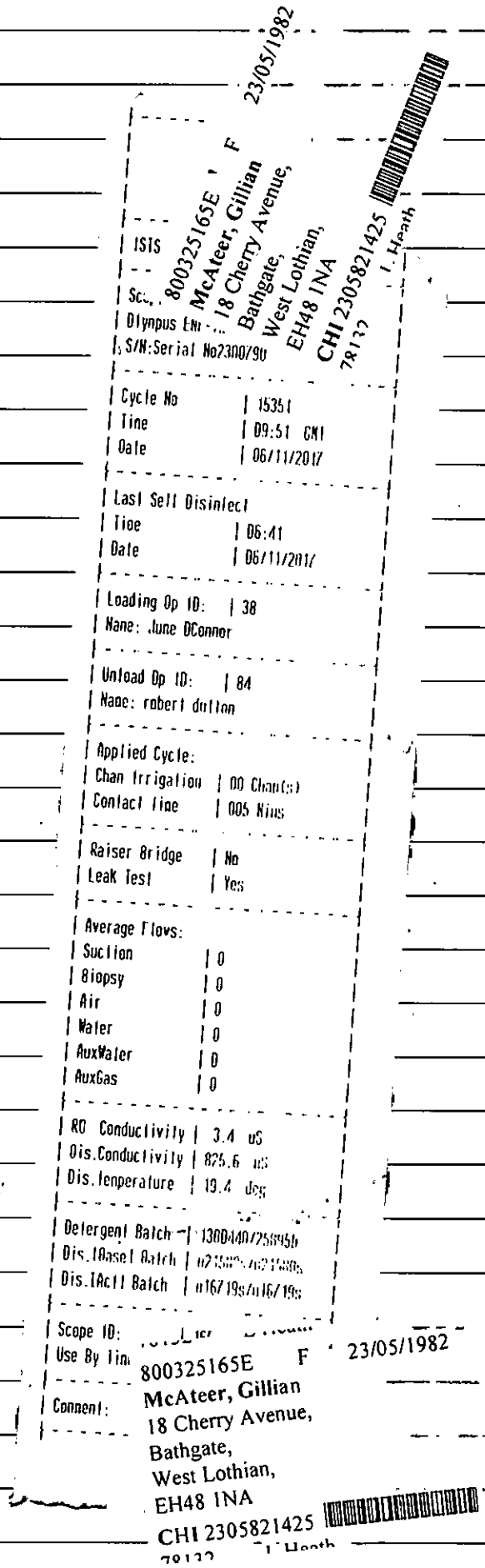
AUDIOGRAM



	RIGHT	LEFT
WHISPERED VOICE		
CONVERSATIONAL VOICE		
RINNE		
WEBER		
ABC		

WLT 368

DATE


23/05/1982
800325165E F
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
ISIS
Olympus
S/N:Serial No2300/90
Cycle No 15351
Time 09:51 GMT
Date 06/11/2017
Last Self Disinfect
Time 06:41
Date 06/11/2017
Loading Op ID: 38
Name: June OConnor
Unload Op ID: 84
Name: robert dutton
Applied Cycle:
Chan Irrigation 00 Chan(s)
Contact Time 005 Mins
Raiser Bridge No
Leak Test Yes
Average Flows:
Suction 0
Biopsy 0
Air 0
Water 0
AuxWater 0
AuxGas 0
RO Conductivity 3.4 uS
Dis.Conductivity 825.6 uS
Dis.Temperature 19.4 deg
Detergent Batch
Dis.Rinse Batch
Dis.IAct1 Batch
Scope ID:
Use By Time
Comment:
800325165E F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425

OTOsuite™

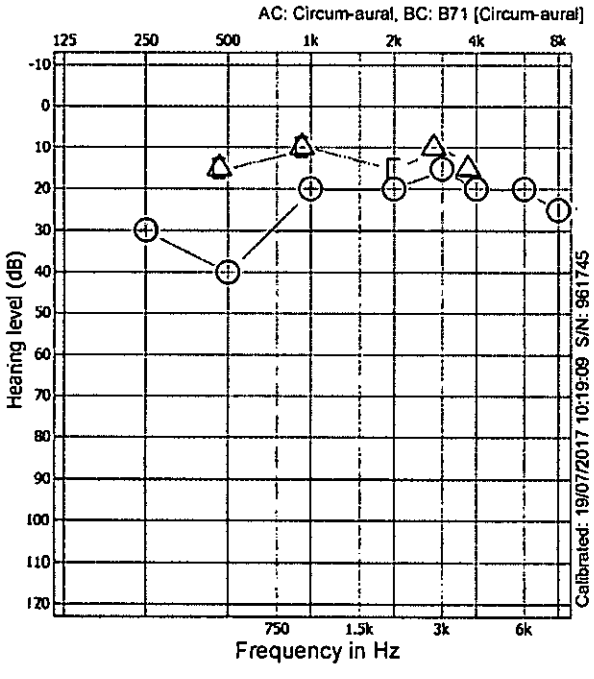
GILLIAN MCATEER
T121693
Age:35
Date of birth:23/05/1982
Report Date: 06/11/2017
Tester: LV

Adult Audiology
OPD4 St John's Hospital
Howden Road West
Livingston
EH54 6PP

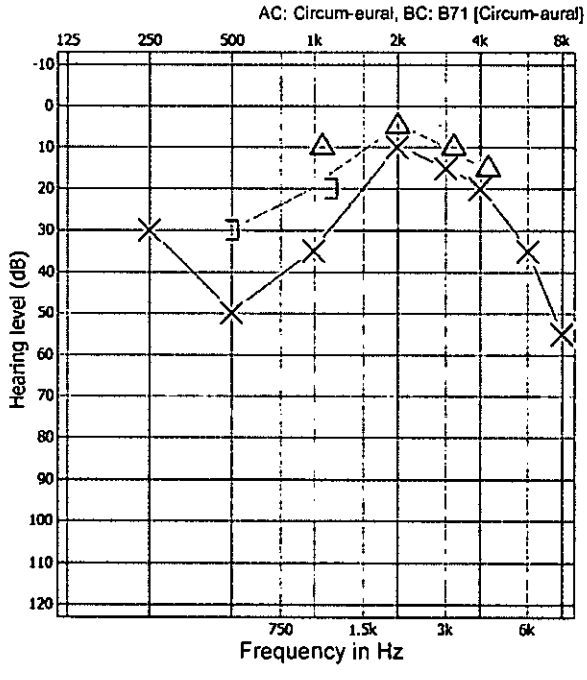
NHS Lothian

Report comments:

RIGHT (06/11/2017)



LEFT (06/11/2017)



Speech	SDT		SRT		WRS / SRS 1				WRS / SRS 2				MCL	UCL
	dB HL	[m]	dB HL	[m]	%	dB HL	[m]	S/N	%	dB HL	[m]	S/N	dB HL	dB HL
Right														
Left														
Bin														
Note	1					2								
Aided														
Note	1					2								

Legend					
L		R		Masked	
×		○	AC	×	○
△	△	△	BC	⊐	⊏
S	S	S	SF	S	S
M		M	MCL		
U		U	UCL		
ˬ	˩	˭	NR		

PTA	AC: 500, 1k, 2k, 4k BC: 500, 1k, 2k, 4k
Aud Method:	

PTA (dB HL) / AI (%)			
	AC	BC	AI
Right	25	13	80
Left	28	17	62

Signed by:

OTOsuite

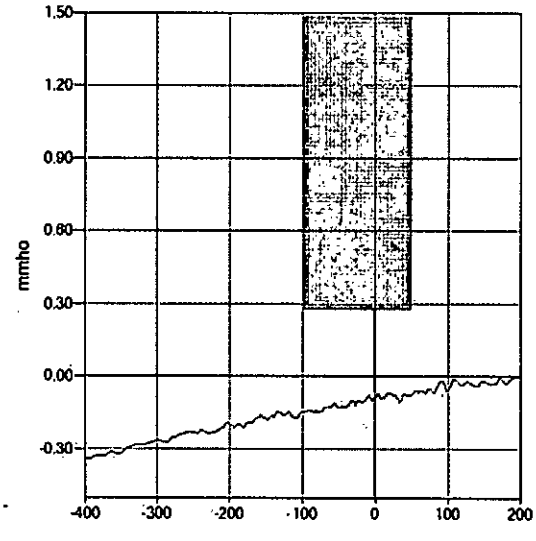
GILLIAN MCATEER
T121693
Age:35
Date of birth:23/05/1982
Report Date: 06/11/2017
Tester: LV

Adult Audiology
OPD4 St John's Hospital
Howden Road West
Livingston
EH54 6PP

NHS Lothian

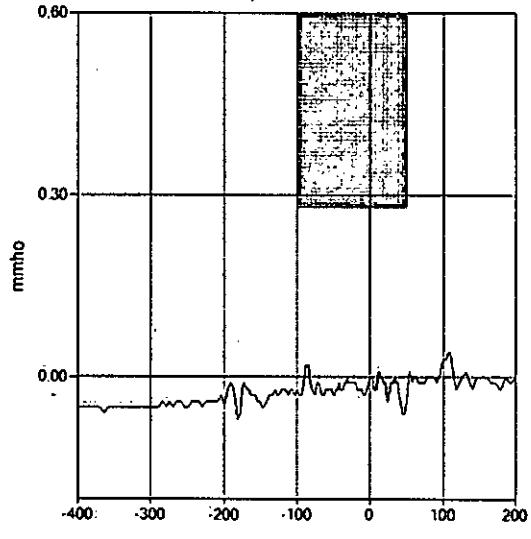
Report comments:

RIGHT (06/11/2017)



Tymp		
Tone	226	Hz
SA		mmho
TPP		daPa
ECV	2.20	ml
TW		daPa
Type	B	

LEFT (06/11/2017)



Tymp		
Tone	226	Hz
SA		mmho
TPP		daPa
ECV	0.35	ml
TW		daPa
Type	B	

Reflex	Threshold (dB HL)					Decay (s)	
	500	1k	2k	4k	BBN	500	1k
R Ipsi							
L Ipsi							
R Contra							
L Contra							

Probe tone:

NHS Lothian

NHS LOTHIAN ENT SURGERY BOOKING FORM

Date: 6/4/17 Consultant: MR GIM. (RHINOLOGY)

Addre 800325165E F 23/05/1982
Name **McAteer, Gillian**
DoB 18 Cherry Avenue,
Unit n Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 L Heath

Patients Telephone Numbers:
H .....
W .....
Mob 07562628486

Diagnosis DEVIATED NASAL SEPTUM.

Procedure SEPTOPLASTY

Anaesthetic: GA ☑ LA ☐

Theatre Time: 1 hrs _____ mins (include Anaesthetic time)

Priority: 62 day ☐ Urgent ☐ Routine ☑

Admission: Same day ☐ Inpatient ☐ 23 Hrs ☑ Estimated Stay : ..... Days

Pooled List: Yes ☑ No ☐

Interpreter : Yes ☐ No ☐

Hospital: SJH ☐ RHSC ☐

Short Notice: Yes ☐ No ☐

External Provider

Not suitable because of
Poor Health ☐
Poor mobility ☐
Complex case ☐
Patient willing to go
Yes ☐ No ☐

Unavailability: From _____ to _____

Pre-assessment: Anti-Coagulation Therapy ☐ Stop..... days Diabetic ☐

BMI ____ Other _____

Care Level: ITU/HDU ☐ LEVEL I ☐ WARD ☐ DOSA ☑

Referral : OP ☑ Ward ☐ GP ☐ Other ☐

Medical Records: RIE ☐ SJH ☑ ROODLANDS ☐ Other ☐

Print Name: M Gim **Signature** _____

Version Nov 2015

University Hospitals Division

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Urology

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 29/09/2014
Date/Time Printed: 29/04/2026 08:49
Our Ref: 800325165E
CHI: 2305821425

Patient:	Miss Gillian McAteer Flat 1 Carron Court West Lothian Bathgate EH48 2QF	**UHPI:** **Date of Birth:**	800325165E 23/05/1982
Specialty:	Urology	**Consultant:**	Mr Mohammed Belal

OUR REF: MB/LW DATE TYPED: 29th September 2014

I would be grateful if you would kindly perform physiotherapy for pelvic floor excercises on this lady with mixed urinary incontinence.

I think she would benefit from your expertise.

Many thanks

Yours sincerely

Mr M Belal
Consultant Surgeon
MEDINET

Departmental Secretary for External Providers Office
Astley Ainslie Hospital
Tel. - 0131 446 4515

NHS Lothian

St John's Hospital at Howden
Outpatient Department 4
Howden Road West
Livingston
West Lothian EH54 6PP

Dr Heath
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 11/08/2017

Outpatient Clinic Letter

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (35 years) 800325165E
Specialty **Consultant**	Ear Nose and Throat Otology SPR	**Attendance Date**	07/08/2017

Dear Dr Heath

Gillian was brought to the Otology Clinic for review. She currently has a discharging ear on the right side. As you know she uses hearing aids on both sides and when last seen a year ago the right grommet was in situ. I was unable to suction our her right ear canal which was full of debris as there was no functioning suctioning available in clinic. I prescribed Ciloxan drops on the right side to be used for one week t.d.s. and we will see her back in clinic in 2 weeks time.

Her left ear canal and tympanic membrane were fine.

Kind regards.

Yours sincerely

Mr David Ellul
Locum ENT Consultant DE/KF

Dictated but not signed for expediency.

Copy to:

Dr Gillian MacDougall
Consultant ENT Surgeon

NHS Lothian

Immediate Outpatient Letter

IN CONFIDENCE

Serial number 431924

Hospital : WGH Department : ENT Consultant : [illegible]

Name and address of General Practitioner

800325165E F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425 [redacted]
78132 L Heath
Weight (where applicable)

Unit No.:

Date of Birth:

Your patient attended the clinic on: 7/8/17

Recommendations/comments:

Follow-up advice: To attend hospital for further review in _____

To attend GP surgery Y / N

Follow-up required (Y / N) 2 hr

Medication: The following medicines are recommended. Only those items that must be initiated immediately have been provided from the hospital pharmacy, as indicated under the 'Quantity to be provided' section.

Pharmacy use:

	Medicine and Form	Dose	Administration Times	Additional Instructions (including length of treatment course)	Quantity to be provided *	LJF **	Dispensed/ Issued by:	Checked by:
1.	Chlorhexidine 1.5%	3 hr	✓ + ✓	1 week				
2.	(with 0.1% cetrimide)							
3.								
4.								
5.								
6.								

N.B. * A 14 day supply should be provided from the hospital if required unless a shorter or longer course is appropriate.

** Tick the box if the medicine is not on the Lothian Joint Formulary, and include an explanatory note for non-Formulary medicines under Recommendations/comments.

Prescribed by : _____ (sign) Date : 7/8/17

[illegible] (print)

Contact for advice : _____ Tel/bleep no. : _____

WHITE COPY - TO PHARMACY *PINK COPY - G.P.* *BLUE COPY - CASENOTES*

RIE 334

AUDIOGRAM
Clinic AuditBase
Audiometer

Name MISS. GILLIAN MCATEER
Hospital no.: T121693 NHS no.: 2306821425
Address 18 CHERRY AVENUE BOGHALL BATHGATE Date of birth: 23/05/1982

Date	Doctor
07/08/2017	DR C HAYWARD

Diagnosis

Remark

Ear drum status
Normal R Comment
Normal Comment

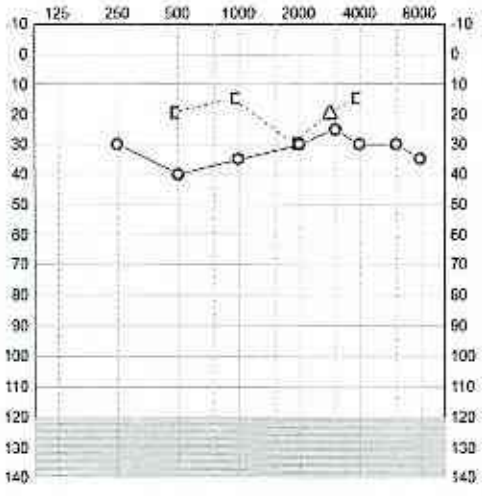
Meas. result
Reliab. Comment

Audiogram no: 1
Made by

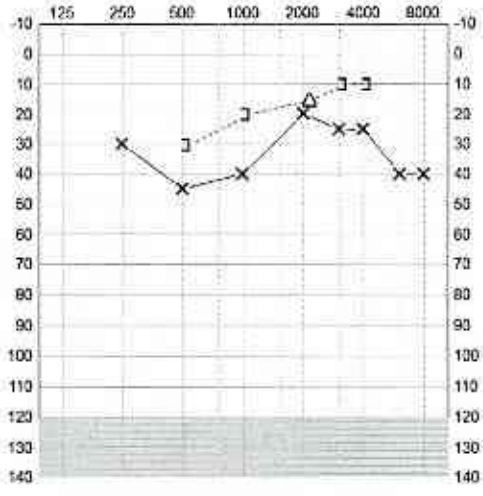
Comments

	Tone Mean value BCL	Tone Mean value HTL	Speech audiogram speech treshold dB	Mask-ing dB	Reflex dB	Max speech rec 1 & 2 (discrimination ability) %	dB	Mask	%	dB	Mask
R	22	35									
L	22	35									

Right



Left



Masking dB	125	250	500	750	1000	1500	2000	3000	4000	6000	8000	
HTL R:												Ins. masked
HTL L:												
BTL R:			65		60		30		45			R
BTL L:			60		55			45	50			L

Audiogram notes:

Tympanometry results:

Canal Vol cm3 Compliance cm3 Pressure daPa

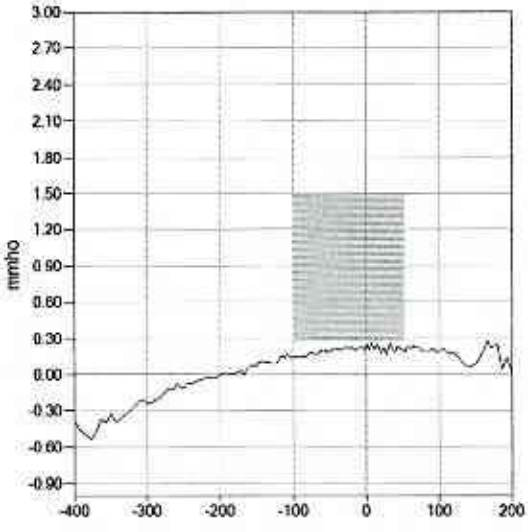
Right ear
Left ear

Tympanometry comments:

GILLIAN MCATEER
T121693
Age:35
Date of birth:23/05/1982
Report Date: 07/08/2017
Tester: MN

Report comments:

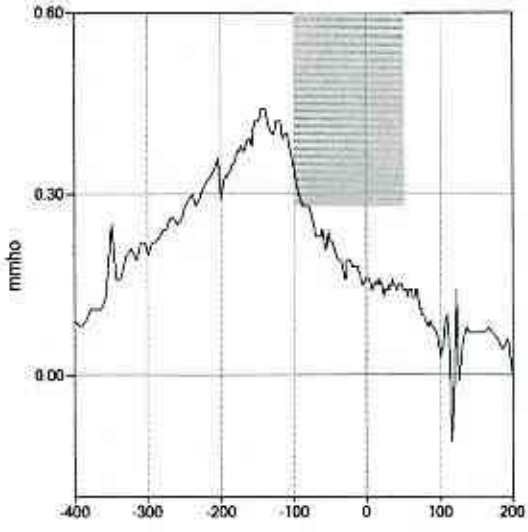
RIGHT (07/08/2017)



daPa

Tymp		
Tone	226	Hz
SA		mmho
TPP		daPa
ECV	1.16	ml
TW		daPa
Type	B	

LEFT (07/08/2017)



daPa

Tymp		
Tone	226	Hz
SA	0.43	mmho
TPP	-139	daPa
ECV	1.16	ml
TW	228	daPa
Type	C	

Reflex	Threshold (dB HL)					Decay (s)	
	500	1k	2k	4k	BBN	500	1k
R Ipsi							
L Ipsi							
R Contra							
L Contra							

Probe tone:

University Hospitals Division

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Urology

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 02/03/2015
Date/Time Printed: 29/04/2026 08:49
Our Ref: 800325165E
CHI: 2305821425

Patient:	Miss Gillian McAteer Flat 1 Carron Court West Lothian Bathgate EH48 2QF	**UHPI:** **Date of Birth:**	800325165E 23/05/1982
Specialty:	Urology	**Consultant:**	Mr Mohammed Belal

INFORMATION LETTER 7.2.15

MB/LR Dictated: 7.2.15 Typed: 2.3.15.

This lady did not attend for her Urodynamics appointment today after having confirmed. I assume her problems are much better and therefore we will discharge her back to your care. Please re-refer back if this is not the case.

Yours sincerely

(not checked/signed due to expediency - EPO responsible to inform GP of any amendments/ updates)

Mr Mohammed Belal
Consultant Urologist
MEDINET

All enquiries regarding this episode please contact:

Departmental Secretary for External Providers Office
(Medinet)
Ground Floor
Woodlands House
Astley Ainslie Hospital
Tel. - 0131 446 4515

University Hospitals Division

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Urology

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created:	02/03/2015
Date/Time Printed:	29/04/2026 08:49
Our Ref:	800325165E
CHI:	2305821425

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Heath
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 26/07/2017

Outpatient Clinic Letter

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (35 years) 800325165E
Specialty	Ear Nose and Throat	**Attendance Date**	
Consultant	Mr DW Sim		

Dear Dr Heath

Mrs McAteer did not attend for her ENT out patient review appointment on 10 July 2017.

A further appointment has not been sent. Should you still wish her to be seen please re-refer her.

Yours sincerely

Mr D W Sim MBChB MSc FRCSEd (ORL) DLO
Consultant ENT Surgeon

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Ear Nose and Throat

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 20/11/2014
Date/Time Printed: 29/04/2026 08:49
Our Ref: 800325165E
CHI: 2305821425

Patient:	Miss Gillian McAteer Flat 1 Carron Court West Lothian Bathgate EH48 2QF	**UHPI:**	800325165E
		Date of Birth:	23/05/1982
Specialty:	Ear Nose and Throat	**Consultant:**	Mr Neelappan Umapathy

Thank you for referring Gillian to our clinic. She complains of mixed hearing loss.

Bone conduction thresholds were around 20dB, air conduction thresholds around 40dB with flat tympanogram. I have discussed the options with her and she is happy to ahead with a grommet insertion. I have listed her for surgery.

Yours sincerely,

Mr Neelappan Umapathy
Medinet Consultant ENT Surgeon NU/LB

(Not checked/signed due to expediency - EPO responsible to inform GP of any amendments/ updates)

All enquiries/correspondence regarding this episode please contact:
Departmental Secretary for External Providers Office
[Medinet]
Ground Floor
Woodlands House
Astley Ainslie Hospital
Tel. - 0131 446 4515

NHS Lothian

St John's Hospital at Howden
Outpatient Department 4
Howden Road West
Livingston
West Lothian EH54 6PP

Dr Heath
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 05/07/2016

Outpatient Clinic Letter

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (34 years) 800325165E
Specialty **Consultant**	Ear Nose and Throat Mr DW Sim	**Attendance Date**	28/06/2016

Dear Dr Heath

Mrs McAteer's right grommet remains in situ and patent. The left grommet has now extruded. Audiometric testing today showed mild binaural sensorineural hearing loss.

Given her level of hearing loss and the fact she was troubled with binaural subjective tonal tinnitus I think she has reached a point where she would benefit from binaural hearing aid fitting for help with auditory rehabilitation and tinnitus management.

I have given her a copy of the Tinnitus Information Pack.

She will be seen for review in 6 months.

Yours sincerely

Mr D W Sim MSc FRCSEd (ORL)DLO
GMC No. 2584980
Consultant ENT Surgeon DWS/KF

CH 2e

EAR, NOSE AND THROAT

BNSELNOTTA

11.00 28-6-16

No. 800325165E F 23/05/1982
NAME **McAteer, Gillian**
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 I. Heath

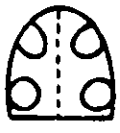
HISTORY

30 Q. / · Catarrh
feels heavy fullness. —
ringing in both ears. /

pt Grommets. Dr

Keep in touch

NOSE:



NASO-PHARYNX:

PHARYNX:

MOUTH:

LARYNX:

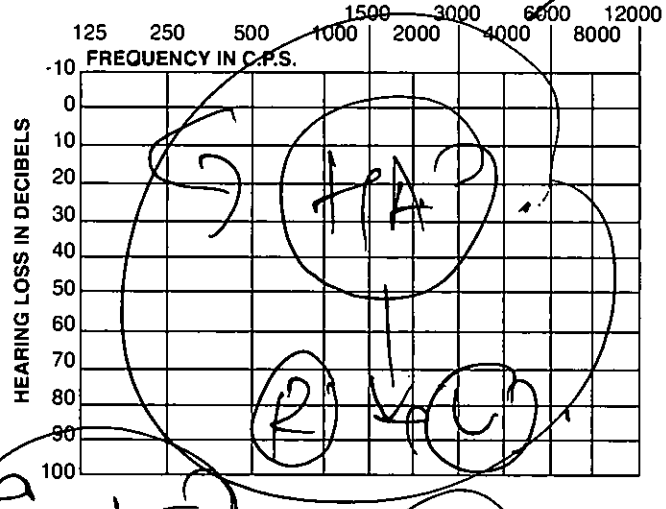
RIGHT EAR:

gingivitis & pterek

LEFT EAR:

our. /

AUDIOGRAM



ringing.

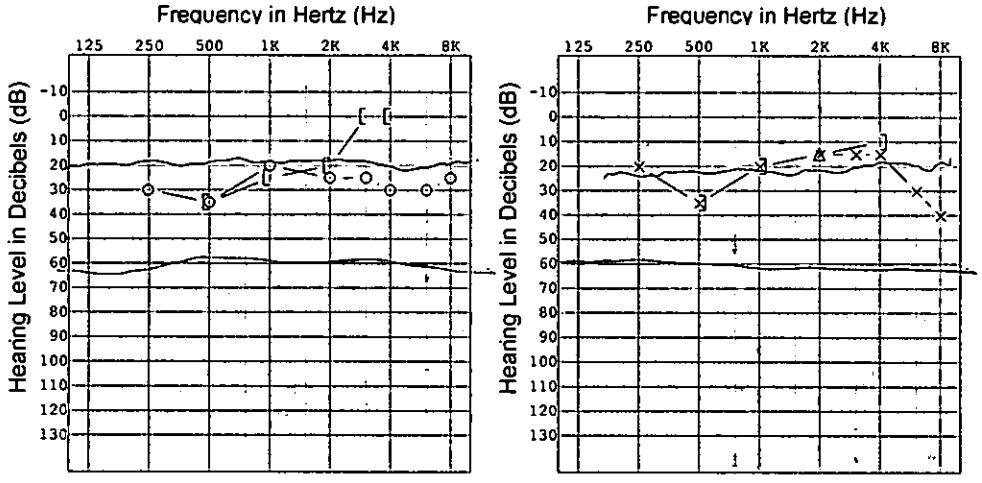
	RIGHT	LEFT
WHISPERED VOICE		
CONVERSATIONAL VOICE		
RINNE		
WEBER		
ABC		

WLT 368

DATE	
	28/6/16 PLACED ON THE STH W/L FOR A(R) SF ISSUE.

Hearing Evaluation Report

Client Name: MCATEER, GILLIAN
Client No.: T121693
Birth date: 23/05/1982
Date of Evaluation: 28/06/2016



Legend	R	Binaural	L
HTL Not Masked	O		X
HTL Masked	O		X
BCL Not Masked	Δ	Δ	Δ
BCL Masked	[		]
MCL	M	M	M
UCL	∟		⌟
FF Unaided	O	B	X
FF-A Aided	◈	◈	◈

Effective Masking Levels

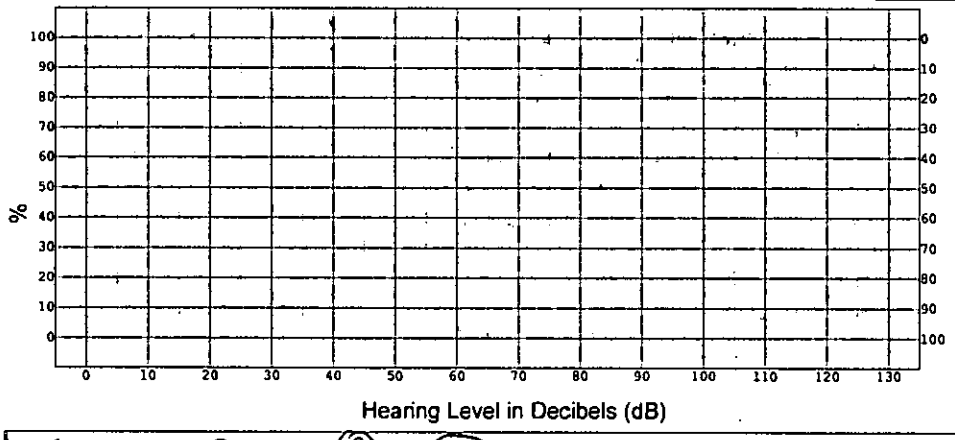
Non-Test Ear		125	250	500	750	1000	1500	2000	3000	4000	6000	8000
HTL	L											
	R											
BCL	L											
	R			65		75		45	45	50		

Speech Notes

Make/Model	
Calibration Date	
Test Reliability	
Comments	
Test Material	
User Defined 2	

Pure Tone Notes

Make/Model	
Calibration Date	
Test Method	
Test Reliability	
Comments	
User Defined 1	
User Defined 2	



Legend	R	Binaural	L

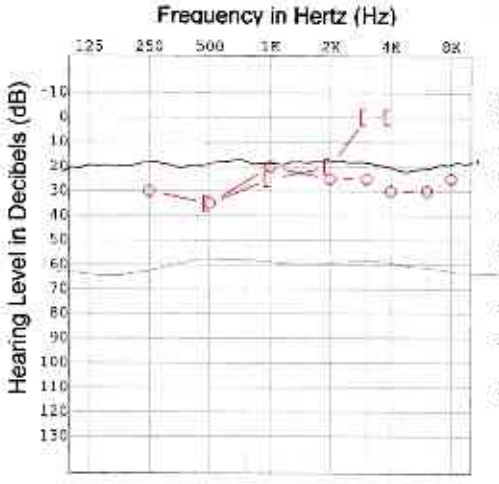
Report Comments

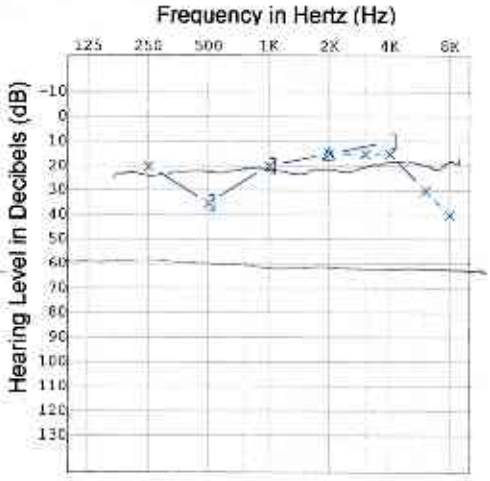
TYMPS FLAT (R) - (L)

Signature: _____ **Date:** 28/6/16

Hearing Evaluation Report

Client Name: MCATEER, GILLIAN
Client No.: T121693
Birth date: 23/05/1982
Date of Evaluation: 28/06/2016





Legend	R	Binaural	L
HTL Not Masked	O		X
HTL Masked	O		X
BCL Not Masked	△	△	△
BCL Masked	[		]
MCL	M	M	M
UCL	⌊		⌋
FF Unaided	O	B	X
FF-A Aided	◈	◈	◈

Effective Masking Levels

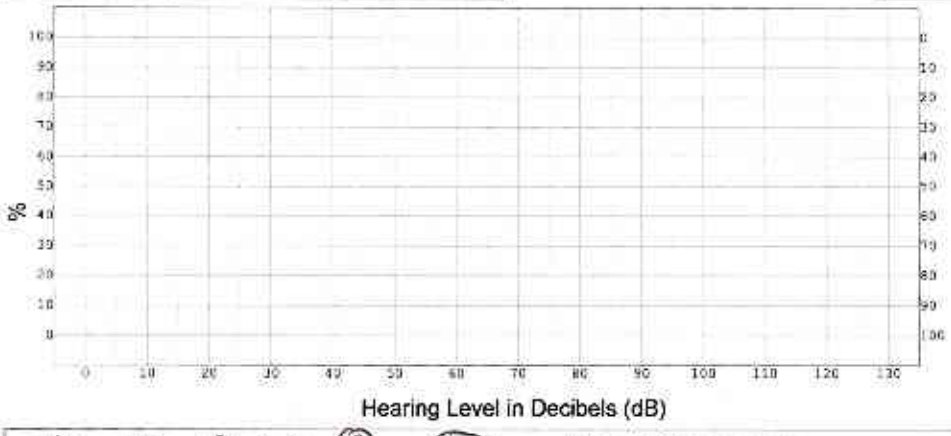
Non-Test Ear		125	250	500	750	1000	1500	2000	3000	4000	6000	8000
HTL	L											
	R											
BCL	L											
	R			65		75		45	45	50		

Speech Notes

Make/Model	
Calibration Date	
Test Reliability	
Comments	
Test Material	
User Defined 2	

Pure Tone Notes

Make/Model	
Calibration Date	
Test Method	
Test Reliability	
Comments	
User Defined 1	
User Defined 2	



Legend	R	Binaural	L

TYMPS FLAT (R) - (L)

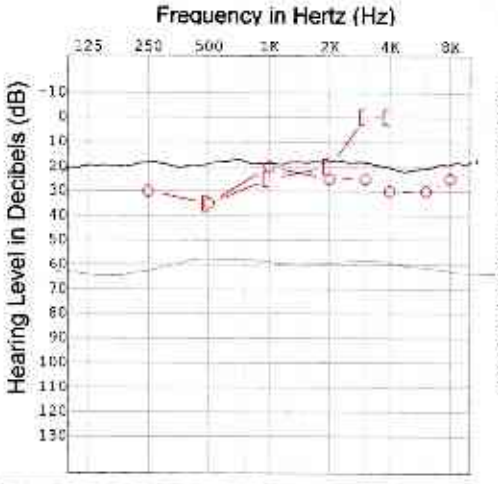
Report Comments

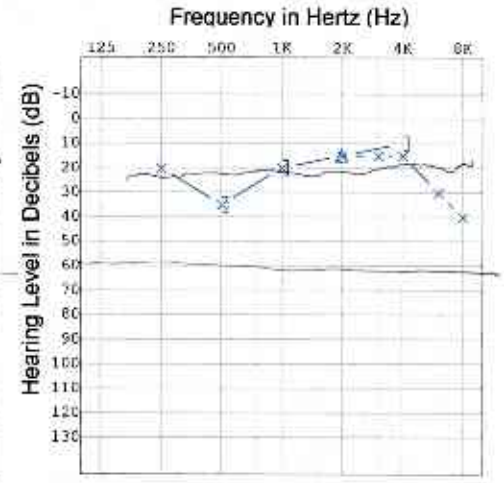
Signature:

Date: 28/6/16

Hearing Evaluation Report

Client Name: MCATEER, GILLIAN
Client No.: T121693
Birth date: 23/05/1982
Date of Evaluation: 28/06/2016





Legend

	R	Binaural	L
HTL Not Masked	O		X
HTL Masked	O		X
BCL Not Masked	△	△	△
BCL Masked	[		]
MCL	M	M	M
UCL	∟		⌟
FF Unaided	O	B	X
FF-A Aided	◈	◈	◈

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	R											
BCL	L											
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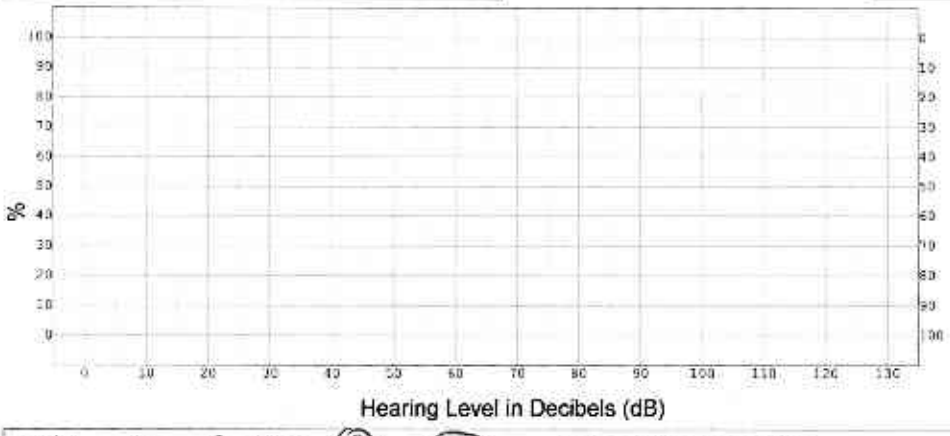
Make/Model	
Calibration Date	
Test Reliability	
Comments	
Test Material	
User Defined 2	

Pure Tone Notes

Make/Model	
Calibration Date	
Test Method	
Test Reliability	
Comments	
User Defined 1	
User Defined 2	



Legend

	R	Binaural	L

TYMPS FLAT (R) - (L)

Report Comments

Signature:

Date: 28/6/16

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Ear Nose and Throat

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 09/02/2016
Date/Time Printed: 29/04/2026 08:49
Our Ref: 800325165E
CHI: 2305821425

Patient:	Miss Gillian McAteer Flat 1 Carron Court West Lothian Bathgate EH48 2QF	**UHPI:**	800325165E
		Date of Birth:	23/05/1982
Specialty:	Ear Nose and Throat	**Consultant:**	Mr Mohammed Iqbal Syed

I reviewed Miss McAteer in the ENT Clinic today. She underwent a bilateral grommet insertion under the Medinet ENT Consultant in February 2015. She did benefit from the grommet insertion once the grommets were in but she now feels that her hearing has got worse.

Examination of both eardrums showed small central perforations, the grommet in the left side was lying in the ear canal embedded in wax.

I have explained to her that we should give time for tympanic membrane perforations to heal. I have arranged to review her back in 3 months and advised on water precaution and we will repeat her hearing test on arrival.

Thanking you.

Kind regards.

Yours sincerely

Mr Iqbal Syed
Locum ENT Consultant IS/KF

Dictated but not signed for expediency.

NHS Lothian

St John's Hospital at Howden
Outpatient Department 4
Howden Road West
Livingston
West Lothian EH54 6PP

Dr Heath
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 09/02/2016

Outpatient Clinic Letter

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (33 years) 800325165E
Specialty	Ear Nose and Throat	**Attendance Date**	01/02/2016
Consultant	Mr Mohammed Iqbal Syed		

Dear Dr Heath

I reviewed Miss McAteer in the ENT Clinic today. She underwent a bilateral grommet insertion under the Medinet ENT Consultant in February 2015. She did benefit from the grommet insertion once the grommets were in but she now feels that her hearing has got worse.

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Kind regards.

Yours sincerely

Mr Iqbal Syed
Locum ENT Consultant IS/KF

Dictated but not signed for expediency.

DATE	NURSING NOTES - Continuatic
12-16	MIXSENTRE
12.15	

800325165E F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 L. Heath

B/L grommet Insertion
Feb 2015

O/E B/L drums
central perfor's

99%

grommet in EAC.

Rx

Amox 3/12 c tds
7/52

1-87 6

WLT 349

DATE	NURSING NOTES - Continuation

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Ear Nose and Throat

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 05/07/2016
Date/Time Printed: 29/04/2026 08:49
Our Ref: 800325165E
CHI: 2305821425

Patient:	Miss Gillian McAteer Flat 1 Carron Court West Lothian Bathgate EH48 2QF	**UHPI:**	800325165E
		Date of Birth:	23/05/1982
Specialty:	Ear Nose and Throat	**Consultant:**	Mr DW Sim

Mrs McAteer's right grommet remains in situ and patent. The left grommet has now extruded. Audiometric testing today showed mild binaural sensorineural hearing loss.

Given her level of hearing loss and the fact she was troubled with binaural subjective tonal tinnitus I think she has reached a point where she would benefit from binaural hearing aid fitting for help with auditory rehabilitation and tinnitus management.

I have given her a copy of the Tinnitus Information Pack.

She will be seen for review in 6 months.

Yours sincerely

Mr D W Sim MSc FRCSEd (ORL)DLO
GMC No. 2584980
Consultant ENT Surgeon DWS/KF

NHS Lothian

Western General Hospital
Outpatient Department
Lower Ground Floor
Anne Ferguson Building
Crewe Road South
Edinburgh EH4 2XU

Dr Heath
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 02/03/2015

Outpatient Clinic Letter

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (32 years) 800325165E
Specialty **Consultant**	Urology Medinet Mr Mohammed Belal	**Attendance Date**	27/09/2014

Dear Dr Heath

INFORMATION LETTER 7.2.15

MB/LR Dictated: 7.2.15 Typed: 2.3.15.

This lady did not attend for her Urodynamics appointment today after having confirmed. I assume her problems are much better and therefore we will discharge her back to your care. Please re-refer back if this is not the case.

Yours sincerely

(not checked/signed due to expediency - EPO responsible to inform GP of any amendments/updates)

Mr Mohammed Belal
Consultant Urologist
MEDINET

All enquiries regarding this episode please contact:

Departmental Secretary for External Providers Office
(Medinet)
Ground Floor
Woodlands House
Astley Ainslie Hospital
Tel. - 0131 446 4515

NHS Lothian

Western General Hospital
Outpatient Department
Lower Ground Floor
Anne Ferguson Building
Crewe Road South
Edinburgh EH4 2XU

Dr Heath
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 14/10/2014

Outpatient Clinic Letter

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (32 years) 800325165E
Specialty **Consultant**	Urology Medinet Mr Mohammed Belal	**Attendance Date**	27/09/2014

Dear Dr Heath

OUR REF: MB/LWDATE TYPED: 29th September 2014

DIAGNOSIS
Mixed urinary incontinence

Thank you for referring this pleasant 32-year-old lady who attended today with mixed urinary incontinence for 2 years, since the birth of her last child. She has a mixture of both storage and stress incontinence but the storage is marginally worse than the stress. She informs me that she does suffer from nocturia once or twice per night and her flow is pretty good, though she has a feeling of incomplete emptying. She currently wears 4 pads per day.

She is para 3 with the last being a caesarean section. She has recently been on the alcoholic rehab programme and she is now actively trying to lose weight. She is, however, drinking between 3-4 litres fluid per day and I have suggested that she needs to reduce this. She is otherwise well and she is currently on Fluoxetine, which she has recently started. She denies any allergies. She is a housewife and smokes between 15-20 cigarettes per day.

I examined this lady, and was chaperoned by the staff nurse, today in clinic. This demonstrated an upper scar, which she informs she had as a child for bowel surgery. Abdominal examination was otherwise unremarkable. Pelvic/vaginal examination did not elicit stress urinary incontinence and the pelvic floor excercises were 3/5 on the Oxford scale.

I have given her a leaflet on pelvic floor excercises and informed her that I will formally refer her to the physiotherapists to improve her pelvic floor. In addition, I have asked her to complete a frequency volume chart and I will book her for standard urodynamics. I would be grateful if you could give her a trial of Vesicare (Solifenacin 5mg once per day) for the foreseeable future.

Yours sincerely

Mr M Belal
Consultant Surgeon
MEDINET

Departmental Secretary for External Providers Office
Astley Ainslie Hospital
Tel. - 0131 446 4515

NHS Lothian

Western General Hospital
Outpatient Department
Lower Ground Floor
Anne Ferguson Building
Crewe Road South
Edinburgh EH4 2XU

Dr Heath
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 14/10/2014

Outpatient Clinic Letter

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI** **Date of Birth / Age** **UHPI**	**2305821425** 23/05/1982 (32 years) 800325165E
Specialty **Consultant**	Urology Medinet Mr Mohammed Belal	**Attendance Date**	27/09/2014

Dear Dr Heath

OUR REF: MB/LWDATE TYPED: 29th September 2014

I would be grateful if you would kindly perform physiotherapy for pelvic floor excercises on this lady with mixed urinary incontinence.

I think she would benefit from your expertise.

Many thanks

Yours sincerely

Mr M Belal
Consultant Surgeon
MEDINET

Departmental Secretary for External Providers Office
Astley Ainslie Hospital
Tel. - 0131 446 4515

University Hospitals Division

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Urology

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 29/09/2014
Date/Time Printed: 29/04/2026 08:50
Our Ref: 800325165E
CHI: 2305821425

Patient:	Miss Gillian McAteer Flat 1 Carron Court West Lothian Bathgate EH48 2QF	**UHPI:** **Date of Birth:**	800325165E 23/05/1982
Specialty:	Urology	**Consultant:**	Mr Mohammed Belal

OUR REF: MB/LW DATE TYPED: 29th September 2014

DIAGNOSIS
Mixed urinary incontinence

Thank you for referring this pleasant 32-year-old lady who attended today with mixed urinary incontinence for 2 years, since the birth of her last child. She has a mixture of both storage and stress incontinence but the storage is marginally worse than the stress. She informs me that she does suffer from nocturia once or twice per night and her flow is pretty good, though she has a feeling of incomplete emptying. She currently wears 4 pads per day.

She is para 3 with the last being a caesarean section. She has recently been on the alcoholic rehab programme and she is now actively trying to lose weight. She is, however, drinking between 3-4 litres fluid per day and I have suggested that she needs to reduce this. She is otherwise well and she is currently on Fluoxetine, which she has recently started. She denies any allergies. She is a housewife and smokes between 15-20 cigarettes per day.

I examined this lady, and was chaperoned by the staff nurse, today in clinic. This demonstrated an upper scar, which she informs she had as a child for bowel surgery. Abdominal examination was otherwise unremarkable. Pelvic/vaginal examination did not elicit stress urinary incontinence and the pelvic floor excercises were 3/5 on the Oxford scale.

I have given her a leaflet on pelvic floor excercises and informed her that I will formally refer her to the physiotherapists to improve her pelvic floor. In addition, I have asked her to complete a frequency volume chart and I will book her for standard urodynamics. I would be grateful if you could give her a trial of Vesicare (Solifenacin 5mg once per day) for the foreseeable future.

Yours sincerely

University Hospitals Division

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Urology

Dr Black
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created: 29/09/2014
Date/Time Printed: 29/04/2026 08:50
Our Ref: 800325165E
CHI: 2305821425

Mr M Belal
Consultant Surgeon
MEDINET

Departmental Secretary for External Providers Office
Astley Ainslie Hospital
Tel. - 0131 446 4515

NHS Lothian

Lauriston Building
ENT Outpatient Department
Lauriston Place
Edinburgh
EH3 9HA

Dr Heath
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date: 21/11/2014

Outpatient Clinic Letter

Patient	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**CHI**	**2305821425**
		Date of Birth / Age	23/05/1982 (32 years)
		UHPI	800325165E
Specialty	Ear Nose and Throat Medinet	**Attendance Date**	16/11/2014
Consultant	Mr Neelappan Umapathy		

Dear Dr Heath

Thank you for referring Gillian to our clinic. She complains of mixed hearing loss.

Bone conduction thresholds were around 20dB, air conduction thresholds around 40dB with flat tympanogram. I have discussed the options with her and she is happy to ahead with a grommet insertion. I have listed her for surgery.

Yours sincerely,

Mr Neelappan Umapathy
Medinet Consultant ENT Surgeon NU/LB

(Not checked/signed due to expediency - EPO responsible to inform GP of any amendments/updates)

All enquiries/correspondence regarding this episode please contact:
Departmental Secretary for External Providers Office
[Medinet]
Ground Floor
Woodlands House
Astley Ainslie Hospital
Tel. - 0131 446 4515

Referrals

NHS Lothian - Referral Letter

Referral To	St John's Hospital Gynaecology - Colposcopy LI Colposcopy
Urgency of referral	Routine
Date of referral	24/11/2025
Date submitted	24/11/2025
UCPN	101038336633F

PATIENT DETAILS

CHI number:	2305821425
Name:	MISS GILLIAN MCATEER
Date of birth:	23/05/1982
Sex:	Female

Contact Details

1 CARRON COURT
SOUTH LOCH PARK
BATHGATE
EH48 2QF

Voice (Mobile) : 07562628486

REFERRING PRACTITIONER DETAILS

Name:	Dr. Alan Black (GMC: 7420958)
Practice:	Simpson Medical Group (78132)
Phone:	Voice : 01506 654444

Practice address

Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

CLINICAL INFORMATION

Reason for Referral:	Request for smear
Main Referral Text:	Dear colleague, I wonder if you are able to see this 43 year old woman with BMI of 40 whom our Practice Nurse and ANP have unfortunately both been unable to visualise her cervix for a smear despite multiple attempts. Results in 2024 were positive for HPV with no other abnormality. Thank you

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
COVID-19 confirmed by laboratory test			14/10/2021	14/10/2021
Glue ear	New event	bilateral plus retraction.	17/02/2021	17/02/2021
Nasal congestion			17/02/2021	17/02/2021
Menorrhagia		[TRUNCATED]heavy periods over past year - lasting up to 10 days, previously every 28 days but over past 2/12 coming very 2 wks so only small break between, struggling to get smear done, bleeding sta	21/03/2014	21/03/2014
Low mood		[TRUNCATED]stopped fluox 2 weeks ago as felt getting too fat with it, mood low, struggling to cope with kids alone, now with family /friends for 1 week, referred to swd by ooh last night she says, a	04/06/2013	04/06/2013
Rapid expulsion of placenta			05/09/2012	05/09/2012
Anaemia during pregnancy, childbirth and the puerperium			05/09/2012	05/09/2012
Caesarean delivery		female	05/09/2012	05/09/2012
[X]Unspecified fall			08/10/2011	08/10/2011
Head injury		admitted overnight for observation	08/10/2011	08/10/2011
Head injury			08/10/2011	08/10/2011
Finger fracture		left ring	06/08/2008	06/08/2008
Otitis media NOS		right	24/05/2007	24/05/2007

Dyspepsia		30/05/2005	30/05/2005
Normal delivery in a completely normal case		19/10/2004	19/10/2004
[X]Mental and behav disorders assoc with the puerperium NEC		13/01/2004	13/01/2004
Normal delivery in a completely normal case	Female	09/05/2003	09/05/2003
Female pelvic inflammatory diseases		09/10/2000	09/10/2000
Nondependent alcohol abuse	and drug abuse	13/03/1999	13/03/1999
Haemorrhoids		11/02/1999	11/02/1999
Acute tonsillitis		11/02/1999	11/02/1999
[X]Intentional self poisoning/exposure to noxious substances	ectasy,hash alcohol	14/03/1998	14/03/1998
Misuse of drugs NOS		14/03/1998	14/03/1998
Child on protection register		29/06/1993	29/06/1993
Maltreatment syndromes		29/06/1993	29/06/1993
Fracture of clavicle		25/01/1987	25/01/1987
Intussusception	surgery	01/12/1982	01/12/1982

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Exhaled nitric oxide test	5ppb = low probability of eosinophilic inflammation. Symptoms unlikely to respond to corticosteroids.		20/01/2025	20/01/2025
Septoplasty of nose NEC			19/12/2017	19/12/2017
Insertion of grommet	bilateral		24/01/2015	24/01/2015
Contraception	Claim expiry date: 27/12/1997. NOTES: SCHERING PC4.		27/12/1996	27/12/1996

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Sertraline 100mg tablets	tablet	2 TABLET(S) DAILY		08/12/2016		17/11/2025
Chlorpromazine 50mg tablets	tablet	TAKE 1 AT NIGHT		08/12/2016		17/11/2025

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Clotrimazole 1% cream	gram	APPLY TWO TO THREE TIMES DAILY		03/11/2025		03/11/2025
Wegovy FlexTouch 0.25mg/0.37ml solution for injection 1.5ml pre-filled pens (Novo Nordisk Ltd)	pre-filled disposable injection	PRIVATE. SUPPLIED ELSEWHERE - [more]		06/10/2025		06/10/2025

Clinical warnings

Allergies

Description	Comment	Modifier	Start Date	Recorded Date
Adverse reaction to amoxycillin	Drug code for allergy: Amoxicillin 250mg capsules, Reaction type: Allergy, Certainty of allergy: Likely, Severity of allergy: Moderate.		26/06/2014	26/06/2014
URTICARIA			13/09/1996	13/09/1996

Additional information

Patient Weight in Kilograms:113

Patient Height in Metres:1.65

Patient BMI:40.2
Patient Blood Pressure (Systolic):145
Patient Blood Pressure (Diastolic):96
Smoking history (Screening):Cigarette smoker Date Recorded:25 Apr 2024
Smoking history (Encounters):Cigarette smoker Date Recorded:25-Apr-2024
Alcohol history (Screening):Drinks occasionally Date Recorded:25 Apr 2023
Alcohol history (Encounters):Drinks occasionally Date Recorded:25-Apr-2023
Exercise history (Screening):Exercise grading Date Recorded:19 Oct 1999
Exercise history (Encounters):Exercise grading Date Recorded:19-Oct-1999

NHS Lothian - Referral Letter

Referral To	St John's Hospital Respiratory Physiology LI L Primary Care Spirometry
Urgency of referral	Routine
Date of referral	25/04/2024
Date submitted	25/04/2024
UCPN	101032855727A

PATIENT DETAILS

CHI number:	2305821425
Name:	MISS GILLIAN MCATEER
Date of birth:	23/05/1982
Sex:	Female

Contact Details

1 CARRON COURT
SOUTH LOCH PARK
BATHGATE
EH48 2QF

Voice (Mobile) : 07562628486

REFERRING PRACTITIONER DETAILS

Name:	Dr. Andrew McNutt (GMC: 3327924)
Practice:	Simpson Medical Group (78132)
Phone:	Voice : 01506 654444

Practice address

Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

CLINICAL INFORMATION

Reason for Referral:	Intermittent respiratory symptoms ? COPD as long smoking history
Main Referral Text:	This 41 year old lady has had 2 courses of antibiotics recently for " chest infections". She has used her daughter's Salbutamol inhaler with some effect. She continues to smoke 10-15/day O/e today Peak flow 340L/min (expected 434lL/min) throat NAD , chest clear, pulse 98bpm regular, temperature 36.6oC, pulse ox 98%. Imp COPD Thanks for your assessment Dr A McNutt

Investigations

Description	Result Date
Has patient had previous spirometry? :	No
I authorise any required tests for this patient, including all required medicines for the test to be administered by qualified NHS Staff? :	true
If asthma is suspected, I authorise the Respiratory Physiologist to proceed to a Challenge test if deemed appropriate. This involves inhalation of a maximum cumulative dose of 635mg Mannitol as per protocol? :	Yes

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
COVID-19 confirmed by laboratory test			14/10/2021	14/10/2021
Glue ear	New event	bilateral plus retraction.	17/02/2021	17/02/2021
Nasal congestion			17/02/2021	17/02/2021
Menorrhagia		[TRUNCATED]heavy periods over past year - lasting up to 10 days, previously every 28 days but over past 2/12 coming very 2 wks so only small break between, struggling to get smear done, bleeding sta	21/03/2014	21/03/2014

Low mood	[TRUNCATED]stopped fluox 2 weeks ago as felt getting too fat with it, mood low, struggling to cope with kids alone, now with family /friends for 1 week, referred to swd by ooh last night she says, a	04/06/2013	04/06/2013
Rapid expulsion of placenta		05/09/2012	05/09/2012
Anaemia during pregnancy, childbirth and the puerperium		05/09/2012	05/09/2012
Caesarean delivery	female	05/09/2012	05/09/2012
[X]Unspecified fall		08/10/2011	08/10/2011
Head injury	admitted overnight for observation	08/10/2011	08/10/2011
Head injury		08/10/2011	08/10/2011
Finger fracture	left ring	06/08/2008	06/08/2008
Otitis media NOS	right	24/05/2007	24/05/2007
Dyspepsia		30/05/2005	30/05/2005
Normal delivery in a completely normal case		19/10/2004	19/10/2004
[X]Mental and behav disorders assoc with the puerperium NEC		13/01/2004	13/01/2004
Normal delivery in a completely normal case	Female	09/05/2003	09/05/2003
Female pelvic inflammatory diseases		09/10/2000	09/10/2000
Nondependent alcohol abuse	and drug abuse	13/03/1999	13/03/1999
Haemorrhoids		11/02/1999	11/02/1999
Acute tonsillitis		11/02/1999	11/02/1999
[X]Intentional self poisoning/exposure to noxious substances	ectasy,hash alcohol	14/03/1998	14/03/1998
Misuse of drugs NOS		14/03/1998	14/03/1998
Child on protection register		29/06/1993	29/06/1993
Maltreatment syndromes		29/06/1993	29/06/1993
Fracture of clavicle		25/01/1987	25/01/1987
Intussusception	surgery	01/12/1982	01/12/1982

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Septoplasty of nose NEC			19/12/2017	19/12/2017
Insertion of grommet	bilateral		24/01/2015	24/01/2015
Contraception	Claim expiry date: 27/12/1997. NOTES: SCHERING PC4.		27/12/1996	27/12/1996

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Sertraline 100mg tablets	tablet	2 TABLET(S) DAILY		08/12/2016		09/04/2024
Chlorpromazine 50mg tablets	tablet	TAKE 1 AT NIGHT		08/12/2016		09/04/2024

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Salbutamol 100micrograms/dose inhaler CFC free	dose	1 TO 2 PUFFS UP TO FOUR TIMES[more]		25/04/2024		25/04/2024
AeroChamber Plus Flow-Vu Anti-Static (Trudell Medical UK Ltd)	device	AS DIRECTED		25/04/2024		25/04/2024
Doxycycline 100mg capsules	capsule	TAKE TWO CAPSULES ON THE FIRS[more]		25/04/2024		25/04/2024

Clinical warnings

Allergies

Description	Comment	Modifier	Start Date	Recorded Date
Adverse reaction to amoxycillin	Drug code for allergy: Amoxicillin 250mg capsules, Reaction type: Allergy, Certainty of allergy: Likely, Severity of allergy: Moderate.		26/06/2014	26/06/2014
URTICARIA			13/09/1996	13/09/1996

Additional information

Patient Weight in Kilograms:107.955
Patient Height in Metres:1.676
Patient BMI:38.4
Patient Blood Pressure (Systolic):145
Patient Blood Pressure (Diastolic):96
Smoking history (Screening):Cigarette smoker Date Recorded:25 Apr 2024
Smoking history (Encounters):Cigarette smoker Date Recorded:25-Apr-2024
Alcohol history (Screening):Drinks occasionally Date Recorded:25 Apr 2023
Alcohol history (Encounters):Drinks occasionally Date Recorded:25-Apr-2023
Exercise history (Screening):Exercise grading Date Recorded:19 Oct 1999
Exercise history (Encounters):Exercise grading Date Recorded:19-Oct-1999

NHS Lothian - Imaging Request

Please note that this request will become invalid if the patient does not attend within 30 days of this request

Referral To	St John's Hospital Clinical Radiology L Radiology Walk in
Urgency of referral	Routine
Date of referral	28/04/2023
Date submitted	28/04/2023
UCPN	101029444208E

PATIENT DETAILS

CHI number:	2305821425
Name:	MISS GILLIAN MCATEER
Date of birth:	23/05/1982
Sex:	Female

Contact Details

1 CARRON COURT
SOUTH LOCH PARK
BATHGATE
EH48 2QF

Voice (Mobile) : 07562628486

REFERRING PRACTITIONER DETAILS

Name:	Dr. Andrew McNutt (GMC: 3327924)
Practice:	Simpson Medical Group (78132)
Phone:	Voice : 01506 654444

Practice address

Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

INVESTIGATION REQUESTED

Test Requested: Chest

Reason for Request: pt has on-going cough for 6 weeks not resolving. examination clear with wheeze. ?infection

CLINICAL INFORMATION

Investigations

Description	Result	Date
Chronic Cough :	true	
Please provide smoking status :	Smoker	
Suspected :	Infection	
Could the patient be pregnant? :	No	

Signature of requesting doctor **Designation** **Date**

Radiology Walk In is available Monday to Friday as follows:

Lauriston Building	8:30am - 4:00pm
Leith Community Treatment Centre	8:30am - 4:00pm
Midlothian Community Hospital	9:15am - 12:30pm
East Lothian Community Hospital (Roodlands)	8:30am - 4:00pm
Royal Hospital for Sick Children - **Children Only**	9:00am - 4:30pm (Except public holidays)
Royal Infirmary of Edinburgh	9:00am - 4:30pm
St John's Hospital	8:30am - 5:00pm
Western General Hospital	8:00am - 5:00pm (Main xray Department)

NHS Lothian

WLL

NHS LOTHIAN ENT SURGERY BOOKING FORM

Date: 20/1/2020 Consultant: M. D. BRAING / L. McMurra

Addr 25165E F 23/05/1982
Nam **Ateer, Gillian**
Do at 1,
Ur Carron Court,
Bathgate,
West Lothian, EH48 2QF
CHI 2305821425
78132 AP McNutt

Patients Telephone Numbers:
H .....
W .....
Mob 07562628486

Diagnosis Chronic Mucosal Otitis Media

Procedure Removal of Grommet Myringoplasty EAC

+/- FAT Plug Myringoplasty

Anaesthetic: GA ☑ LA ☐

Theatre Time: 1 hrs 0 mins (include Anaesthetic time)

Priority: 62 day ☐ Urgent ☐ Routine ☑

Admission: Day Case ☑ Inpatient ☐ Estimated Stay : ..... Days

Pooled List: Yes ☒ No ☑ (D. McMurra 1st please)

Interpreter : Yes ☐ No ☑

Hospital: SJH ☑ RHSC ☐

Short Notice: Yes ☑ No ☐

Pacemaker/CIED Yes ☐ No ☑

Unavailability: From _____ to _____

Pre-assessment: Anti-Coagulation Therapy ☐ Stop..... days Diabetic ☐

BMI ____ Other _____

Care Level: ITU/HDU ☐ LEVEL I ☐ WARD ☐ DOSA ☑

External Provider

Not suitable because of
Poor Health ☐
Poor mobility ☐
Complex case ☐
Patient willing to go
Yes ☐ No ☐

Referral : OP ☑ Ward ☐ GP ☐ Other ☐

Medical Records: RIE ☐ SJH ☑ ROODLANDS ☐ Other ☐

Patient willing to be seen by medical students when pre-admitted: Yes No

Print Name: M. Robins **Signature** _____

OL/ AS FEB 2019

NHS Lothian - Referral Letter

Referral To	St John's Hospital Respiratory Physiology L Primary Care Spirometry
Urgency of referral	Routine
Date of referral	14/01/2020
Date submitted	14/01/2020
UCPN	101020428259P

PATIENT DETAILS

CHI number:	2305821425
Name:	MISS GILLIAN MCATEER
Date of birth:	23/05/1982
Sex:	Female

Contact Details

18 CHERRY AVENUE
BOGHALL
BATHGATE
WEST LOTHIAN
EH48 1NA

Voice (Mobile) : 07562628486

REFERRING PRACTITIONER DETAILS

Name:	Dr Callum Gillespie (GMC: 7264563)
Practice:	Simpson Medical Group
Phone:	Voice : 01506654444

Practice address

BATHGATE PRIMARY CARE CENTRE
WHITBURN ROAD
BATHGATE
WEST LOTHIAN
EH48 2SS

CLINICAL INFORMATION

Reason for Referral: persistent cough in smoker occasionally breathless, ? COPD

Main Referral Text:

Dear Colleagues,

I would be grateful if you could carry our spirometry on this 37 year old woman, who is a smoker and who presents with a persistent cough, occasionally breathless, ? COPD ? asthma

Kind Regards

Investigations

Description	Result	Date
Has patient had previous spirometry? :	No	
I authorise any required tests for this patient, including all required medicines for the test to be administered by qualified NHS Staff? :	true	
If asthma is suspected, I authorise the Respiratory Physiologist to proceed to a Challenge test if deemed appropriate. This involves inhalation of a maximum cumulative dose of 635mg Mannitol as per protocol? :	Yes	

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Sertraline 100mg tablets	tablet	2 TABLET(S) DAILY		08/12/2016		06/01/2020
Chlorpromazine 50mg tablets	tablet	TAKE 1 AT NIGHT		08/12/2016		17/12/2019
Mometasone 50micrograms/dose nasal spray	dose	2 PUFFS IN EACH NOSTRIL ONCE DAILY		08/01/2018		22/11/2019

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed

				Date
Salbutamol 100micrograms/dose inhaler CFC free	dose	INHALE ONE OR TWO PUFFS IF RE[more]	14/01/2020	14/01/2020
AeroChamber Plus (Trudell Medical UK Ltd)	device	USE AS DIRECTED	14/01/2020	14/01/2020
Clarithromycin 500mg tablets	tablet	ONE TO BE TAKEN TWICE A DAY F[more]	09/01/2020	09/01/2020
Diazepam 2mg tablets	tablet	UP TO 1 THREE TIMES DAILY	08/11/2019	08/11/2019

Clinical warnings

Allergies

Description	Comment	Modifier	Start Date	Recorded Date
Adverse reaction to amoxycillin	Drug code for allergy: Amoxicillin 250mg capsules, Reaction type: Allergy, Certainty of allergy: Likely, Severity of allergy: Moderate.		26/06/2014	26/06/2014
URTICARIA			13/09/1996	13/09/1996

Additional information

Smoking history (Encounters):Cigarette smoker Date recorded:14-Aug-2018
Alcohol history (Encounters):Heavy drinker 7 9u/day Date recorded:26 Apr 2017
Exercise history (Encounters):Exercise grading Date recorded:19-Oct-1999
Patient Weight in Kilograms:107.955
Patient Height in Metres:1.676
Patient BMI:38.4
Patient Blood Pressure (Systolic):145
Patient Blood Pressure (Diastolic):96

NHS Lothian - Imaging Request

Referral To	St John's Hospital Clinical Radiology L Radiology Walk In
Urgency of referral	Routine
Date of referral	14/01/2020
Date submitted	14/01/2020

PATIENT DETAILS

CHI number:	2305821425
Name:	MISS GILLIAN MCATEER
Date of birth:	23/05/1982
Sex:	Female

Contact Details

18 CHERRY AVENUE
BOGHALL
BATHGATE
WEST LOTHIAN
EH48 1NA

Voice (Mobile) : 07562628486

REFERRING PRACTITIONER DETAILS

Name:	Dr Callum Gillespie (GMC: 7264563)
Practice:	Simpson Medical Group
Phone:	Voice : 01506654444

Practice address

BATHGATE PRIMARY CARE CENTRE
WHITBURN ROAD
BATHGATE
WEST LOTHIAN
EH48 2SS

INVESTIGATION REQUESTED

Test Requested: Chest

Reason for Request: smoker, cough for 4 weeks, occasional breathlessness ? signs of COPD

CLINICAL INFORMATION

Investigations

Description	Result	Date
Please provide smoking status :	Smoker	
Could the patient be pregnant? :	Blank	

NHS Lothian - Referral Letter

Referral To	St John's Hospital Ear, Nose and Throat (ENT) - Ear L Basic SIGN Referral
Urgency of referral	Routine
Date of referral	27/06/2019
Date submitted	27/06/2019
UCPN	101019021551T

PATIENT DETAILS

CHI number:	2305821425
Name:	MISS GILLIAN MCATEER
Date of birth:	23/05/1982
Sex:	Female

Contact Details

18 CHERRY AVENUE
BOGHALL
BATHGATE
WEST LOTHIAN
EH48 1NA

Voice (Mobile) : 07562628486

REFERRING PRACTITIONER DETAILS

Name:	Dr. Julie Thomson (GMC: 2619343)
Practice:	Simpson Medical Group (78132)
Phone:	Voice : 01506 654444

Practice address

Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

CLINICAL INFORMATION

Reason for Referral:	middle ear effusion
Main Referral Text:	Dear Doctor, Thank you for seeing this 37 year old lady who is well known to the ENT department with nasal problems and middle ear effusions. She has a septoplasty in 2017, but has continued nasal congestion since. In the last 4 weeks she has C/O pain in her right ear, with possibly some further reduction in hearing. O/E congested narrow nasal passages Left TM very retracted Right TM looks as if bubbles of fluid more in the attic area than elsewhere Yours sincerely, Julie Thomson

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Menorrhagia		[TRUNCATED]heavy periods over past year - lasting up to 10 days, previously every 28 days but over past 2/12 coming very 2 wks so only small break between, struggling to get smear done, bleeding sta	21/03/2014	21/03/2014
Low mood		[TRUNCATED]stopped fluox 2 weeks ago as felt getting too fat with it, mood low, struggling to cope with kids alone, now with family /friends for 1 week, referred to swd by ooh last night she says, a	04/06/2013	04/06/2013
Rapid expulsion of placenta			05/09/2012	05/09/2012
Anaemia during pregnancy, childbirth and the puerperium			05/09/2012	05/09/2012
Caesarean delivery		female	05/09/2012	05/09/2012
[X]Unspecified fall			08/10/2011	08/10/2011
Head injury		admitted overnight for observation	08/10/2011	08/10/2011
Head injury			08/10/2011	08/10/2011
Finger fracture		left ring	06/08/2008	06/08/2008
Otitis media NOS		right	24/05/2007	24/05/2007
Dyspepsia			30/05/2005	30/05/2005

Normal delivery in a completely normal case		19/10/2004	19/10/2004
[X]Mental and behav disorders assoc with the puerperium NEC		13/01/2004	13/01/2004
Normal delivery in a completely normal case	Female	09/05/2003	09/05/2003
Female pelvic inflammatory diseases		09/10/2000	09/10/2000
Nondependent alcohol abuse	and drug abuse	13/03/1999	13/03/1999
Haemorrhoids		11/02/1999	11/02/1999
Acute tonsillitis		11/02/1999	11/02/1999
[X]Intentional self poisoning/exposure to noxious substances	ectasy,hash alcohol	14/03/1998	14/03/1998
Misuse of drugs NOS		14/03/1998	14/03/1998
Child on protection register		29/06/1993	29/06/1993
Maltreatment syndromes		29/06/1993	29/06/1993
Fracture of clavicle		25/01/1987	25/01/1987
Intussusception	surgery	01/12/1982	01/12/1982

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Septoplasty of nose NEC			19/12/2017	19/12/2017
Insertion of grommet	bilateral		24/01/2015	24/01/2015
Contraception	Claim expiry date: 27/12/1997. NOTES: SCHERING PC4.		27/12/1996	27/12/1996

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Sertraline 100mg tablets	tablet	2 TABLET(S) DAILY		08/12/2016		03/06/2019
Chlorpromazine 50mg tablets	tablet	TAKE 1 AT NIGHT		08/12/2016		03/06/2019
Mometasone 50micrograms/dose nasal spray	dose	2 PUFFS IN EACH NOSTRIL ONCE DAILY		08/01/2018		25/06/2019

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Clarithromycin 500mg tablets	tablet	1 TABLET TWICE A DAY		25/06/2019		25/06/2019
Erythromycin 250mg gastro-resistant tablets	tablet	1 TABLET FOUR TIMES A DAY		11/06/2019		11/06/2019
Sertraline 100mg tablets	tablet	2 TABLET(S) DAILY		08/12/2016		10/05/2019
Chlorpromazine 50mg tablets	tablet	TAKE 1 AT NIGHT		08/12/2016		10/05/2019
Chlorpromazine 50mg tablets	tablet	TAKE 1 AT NIGHT		08/12/2016		09/04/2019
Sertraline 100mg tablets	tablet	2 TABLET(S) DAILY		08/12/2016		09/04/2019

Clinical warnings

Allergies

Description	Comment	Modifier	Start Date	Recorded Date
Adverse reaction to amoxycillin	Drug code for allergy: Amoxicillin 250mg capsules, Reaction type: Allergy, Certainty of allergy: Likely, Severity of allergy: Moderate.		26/06/2014	26/06/2014
URTICARIA			13/09/1996	13/09/1996

Additional information

Smoking history (Encounters):Cigarette smoker Date recorded:14-Aug-2018

Alcohol history (Encounters):Heavy drinker - 7-9u/day Date recorded:26-Apr-2017
Exercise history (Encounters):Exercise grading Date recorded:19 Oct 1999
Patient Weight in Kilograms:107.955
Patient Height in Metres:1.676
Patient BMI:38.4
Patient Blood Pressure (Systolic):145
Patient Blood Pressure (Diastolic):96

NHS Lothian - Referral Letter

Referral To	Royal Infirmary of Edinburgh Gynaecology - Colposcopy
Urgency of referral	Routine
Date of referral	21/09/2018
Date submitted	21/09/2018
UCPN	129000115085W
Referral From	SCCRS - Scottish Cervical Call Recall System

PATIENT DETAILS

CHI number:	2305821425
Name:	GILLIAN MCATEER
Date of birth:	23/05/1982
Sex:	Female

Contact Details

18 CHERRY AVENUE
BOGHALL
BATHGATE
WEST LOTHIAN
EH48 1NA

REGISTERED GP DETAILS

Name:	R HOLDEN
Practice:	SIMPSON MEDICAL GROUP
Phone:	

Practice address

BATHGATE PRIMARY CARE CEN
WHITBURN ROAD
BATHGATE
EH48 2SS

REFERRING HCP DETAILS

Name:	
Organisation name:	RIE Cyt. Edinburgh

Organisation address

Royal Infirmary Edinburgh
51 Little France Crescent
Edinburgh
EH16 4SA

CLINICAL INFORMATION

Cytology Result:	Low grade dyskaryosis	**Exam Date:**	/ /
Virology Result:		**Auth Date:**	19/09/2018
Immunosuppressed:	No	**Healthboard:**	NHS Lothian

Smear Taker Name: Practice nurse Caroline Stephens

Smear Taker Address

BATHGATE PRIMARY CARE CEN,
WHITBURN ROAD,
BATHGATE,
EH48 2SS,

Smear Taker Comments

Not using contraception, smoker

Laboratory Name: RIE Cyt. Edinburgh

Laboratory Address

Royal Infirmary Edinburgh
51 Little France Crescent
Edinburgh
EH16 4SA

Laboratory Comments:

NoBATHGATE PRIMARY CARE CENWHITBURN ROADBATHGATEEH48 2SSNot using contraception, smokerThe sample shows Borderline and low grade (mild) squamous cell dyskaryosis. In view of three instances of low-grade abnormality during the last ten years a colposcopic assessment is recommended.

NHS Lothian - Imaging Request

Referral To	St John's Hospital Clinical Radiology L Radiology Walk In
Urgency of referral	Routine
Date of referral	30/10/2014
Date submitted	30/10/2014

PATIENT DETAILS

CHI number:	2305821425
Name:	MISS GILLIAN MCATEER
Date of birth:	23/05/1982
Sex:	Female

Contact Details

18 CHERRY AVENUE
BOGHALL
BATHGATE
WEST LOTHIAN
EH48 1NA

Voice (Mobile) : 07712184504

REFERRING PRACTITIONER DETAILS

Name:	Dr Alice Wilson (GMC: 7334398)
Practice:	Simpson Medical Group
Phone:	Voice : 01506654444

Practice address

BATHGATE PRIMARY CARE CENTRE
WHITBURN ROAD
BATHGATE
WEST LOTHIAN
EH48 2SS

INVESTIGATION REQUESTED

Test Requested:	**Chest**
Reason for Request:	Thanks for seeing this 32 year old lady with a 4-6 week history of cough, intially fever and two trials on ABx with ongoing creps left upper lobe. ?Ongoing infection

CLINICAL INFORMATION

Investigations

Description	Result	Date
Chest signs :	true	
Infection :	true	
Please provide smoking status :	Smoker	
Suspected :	Infection	
Could the patient be pregnant? :	Blank	

NHS Lothian - Referral Letter

Referral To	St John's Hospital Ear, Nose & Throat (ENT) L Basic SIGN Referral
Urgency of referral	Routine
Date of referral	03/09/2014
Date submitted	03/09/2014
UCPN	1010078329565

PATIENT DETAILS

CHI number:	2305821425
Name:	MISS GILLIAN MCATEER
Date of birth:	23/05/1982
Sex:	Female

Contact Details

18 CHERRY AVENUE
BOGHALL
BATHGATE
WEST LOTHIAN
EH48 1NA

Voice (Mobile) : 07712184504

REFERRING PRACTITIONER DETAILS

Name:	Dr. Lorna Heath (GMC: 4532473)
Practice:	Simpson Medical Group (78132)
Phone:	Voice : 01506 654444

Practice address

Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

CLINICAL INFORMATION

Reason for Referral: hearing difficulty/L posterior TM perforation

Main Referral Text: I would be grateful if you could see this 32 year old female who has noticed that her hearing has deteriorated over the past 3 4 months. This had been apparent which she was attending an alcohol rehabilitation programme and she was examined by a doctor and found to have a perforated ear drum. She has reattended the surgery due to ongoing hearing difficulties and was concerned the perforation is not healing. She has no discharge and is otherwise well. She has no previous history of ear nose and throat problems.

On examination she has a small posterior perforation of the left tympanic membrane. The right tympanic membrane is normal. I would be grateful if you could arrange further assessment regarding her hearing and perforation.

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Low mood		[TRUNCATED]stopped fluox 2 weeks ago as felt getting too fat with it, mood low, struggling to cope with kids alone, now with family /friends for 1 week, referred to swd by ooh last night she says, a	04/06/2013	04/06/2013
Rapid expulsion of placenta			05/09/2012	05/09/2012
Anaemia during pregnancy, childbirth and the puerperium			05/09/2012	05/09/2012
Caesarean delivery		female	05/09/2012	05/09/2012
Normal delivery in a completely normal case			19/10/2004	19/10/2004
[X]Mental and behav disorders assoc with the puerperium NEC			13/01/2004	13/01/2004
Normal delivery in a completely normal case		Female	09/05/2003	09/05/2003
Nondependent alcohol abuse		and drug abuse	13/03/1999	13/03/1999
Misuse of drugs NOS			14/03/1998	14/03/1998
[X]Intentional self poisoning/exposure to noxious substances		ectasy,hash alcohol	14/03/1998	14/03/1998

Child on protection register		29/06/1993	29/06/1993
Maltreatment syndromes		29/06/1993	29/06/1993
Fracture of clavicle		25/01/1987	25/01/1987
Intussusception	surgery	01/12/1982	01/12/1982

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Contraception	Claim expiry date: 27/12/1997. NOTES: SCHERING PC4.		27/12/1996	27/12/1996

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
White soft paraffin 50% / Liquid paraffin 50% ointment	gram	APPLY GENEROUSLY THREE TIMES DAILY		03/09/2014		03/09/2014
Terbinafine 1% cream	gram	APPLY ONCE OR TWICE A DAY		03/09/2014		03/09/2014
Fluoxetine 20mg capsules	capsule	TAKE ONE IN THE MORNING		03/09/2014		03/09/2014
Citalopram 10mg tablets	tablet	TAKE ONE DAILY		03/09/2014		03/09/2014
Citalopram 20mg tablets	tablet	TAKE ONE DAILY FOR 1 WEEK		03/09/2014		03/09/2014
Citalopram 20mg tablets	tablet	2 TABLET DAILY		25/08/2014		25/08/2014
Citalopram 20mg tablets	tablet	2 TABLET DAILY		28/07/2014		28/07/2014

Clinical warnings

Allergies

Description	Comment	Modifier	Start Date	Recorded Date
URTICARIA			13/09/1996	13/09/1996

Additional information

Smoking history (Encounters):Current smoker	Date recorded:08-Jul-2014
Alcohol history (Encounters):Stopped drinking alcohol	Date recorded:08-Jul-2014
Exercise history (Encounters):Exercise grading	Date recorded:19-Oct-1999
Patient Weight in Kilograms:107.955	
Patient Height in Metres:1.676	

Lab and Radiology Reports

Serum lipids

Description	Value	Range	Unit	Normalcy	Notes
Cholesterol	**6.0**		**mmol/L**	**A**	
HDL Chol.	1.4	1.1 1.7	mmol/L		
Chol:HDLC Ratio	4.3				
LDL Chol.	**3.2**		**mmol/L**	**A**	
Triglyceride	**3.1**	**0.8 - 2.1**	**mmol/L**	**R**	

Requestor Comments

CVD project.

Report Information

Requestor	Nurse, Practice
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	SB663789Q
Sample Date	05/01/2026 11:50:00

First | Previous | Next | Last

HbA1c level

Description	Value	Range	Unit	Normalcy	Notes
HbA1c (IFCC)	31	20 41	mmol/mol		(BHBAIF)

Test Comments

(BHBAIF) HbA1c is NOT increased.

Requestor Comments

HbA1c for diagnosis
CVD project.

Report Information

Requestor	Nurse, Practice
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	SB663893K
Sample Date	05/01/2026 11:50:00

First | Previous | Next | Last

XR Ankle Lt

XR Ankle Lt

Clinical History
bony tender tip and posterior lat mal and 3rd to 5th mt post inversion injury. ?#

9026046 14/03/2025 XR Ankle Lt
No fracture. Ankle mortise is intact.

9026047 14/03/2025 XR Foot Lt
No fracture identified. Normal alignment of the metatarsals relative to the tarsal bones.

—
Dr Matthew Tse GMC: 7474641
Radiology Consultant.

Reporting Radiologist: Dr Matthew WD Tse

XR Foot Lt

XR Foot Lt

Clinical History
bony tender tip and posterior lat mal and 3rd to 5th mt post inversion injury. ?#

9026046 14/03/2025 XR Ankle Lt
No fracture. Ankle mortise is intact.

9026047 14/03/2025 XR Foot Lt
No fracture identified. Normal alignment of the metatarsals relative to the tarsal bones.

Dr Matthew Tse GMC: 7474641
Radiology Consultant.

Reporting Radiologist: Dr Matthew WD Tse

Report Information

Requestor	Coxhead, Mandy
Requesting Location	(SJHOPAE) SJH A&E OPD - Accident and Emergency Outpatient Dept
Report Identifier	51509556
Sample Date	14/03/2025 11:08:00

First | Previous | Next | Last

Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	128	115 165	g/L		
Red cell count	4.20	3.8 5.8	10^12/L		
Haematocrit	0.378	0.36 0.47	ratio		
Mean cell volume	90	78 98	fL		
Mean Cell Hb	30.5	27.0 32.0	pg		
White cell count	8.0	4 11	10^9/L		
Neutrophil Count	4.35	2 7.5	10^9/L		
Lymphocyte Count	2.86	1.5 4.5	10^9/L		
Monocyte Count	0.55	0.2 0.8	10^9/L		
Eosinophil Count	0.22	0.04 0.4	10^9/L		
Basophil Count	0.03	0.01 0.1	10^9/L		
Platelet count	311	150 400	10^9/L		
Mean cell Hb conc.	339	310 360	g/L		

Sample Comments

53033..

Requestor Comments

chest pain

Report Information

Requestor	Smith, Dr Imogen BJ
Requesting Location	(SJHEMA) SJH Emergency Medical Assessment EMA
Report Identifier	SH297522Z
Sample Date	01/10/2024 17:12:00

Liver function tests

Description	Value	Range	Unit	Normalcy	Notes
Bilirubin	4	3 21	umol/L		
ALT	10	10 50	U/L		
Alk.Phos	64	40 125	U/L		

Sample Comments

53033..

Requestor Comments

chest pain

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Urea	3.8	2.5 - 6.6	mmol/L		
Creatinine	55	50 - 98	umol/L		
Sodium	138	135 - 145	mmol/L		
Potassium	4.5	3.6 - 5	mmol/L		
TCO2	23	22 - 30	mmol/L		
eGFR (/1.73m2)	>60		ml/min		

Sample Comments

53033..

Requestor Comments

chest pain

Serum C reactive protein level

Description	Value	Range	Unit	Normalcy	Notes
C Reactive Prot	**6**	**0 - 5**	**mg/L**	**R**	

Sample Comments

53033..

Requestor Comments

chest pain

Cardiac enzymes

Description	Value	Range	Unit	Normalcy	Notes
HS Troponin T	4	1 - 9	ng/L		

Sample Comments

53033..

Requestor Comments

chest pain

Report Information

Requestor	Smith, Dr Imogen BJ
Requesting Location	(SJHEMA) SJH Emergency Medical Assessment - EMA
Report Identifier	SB043447B
Sample Date	01/10/2024 17:12:00

First | Previous | Next | Last

Plasma glucose level

Description	Value	Range	Unit	Normalcy	Notes
Glucose	4.7		mmol/L		
Spec type Rand/Fast	Unknown				

Sample Comments

53033..

Requestor Comments

chest pain

Report Information

Requestor	Smith, Dr Imogen BJ	
Requesting Location	(SJHEMA) SJH Emergency Medical Assessment	EMA
Report Identifier	SB043451P	
Sample Date	01/10/2024 17:12:00	

Coagulation/bleeding test

Description	Value	Range	Unit	Normalcy	Notes
Prothrombin Time	11.0	9.0 12.0	sec		
INR (Warfarin)	1.0		ratio		
APTT	26	21.0 28.0	sec		
APTT Ratio	1.0		ratio		
Fibrinogen (Clauss)	3.9	1.5 4.0	g/L		
VTE Exclusion	97	0 250	ng/ml		

Sample Comments

53033..

Requestor Comments

chest pain

Report Information

Requestor	Smith, Dr Imogen BJ
Requesting Location	(SJHEMA) SJH Emergency Medical Assessment EMA
Report Identifier	SH297519H
Sample Date	01/10/2024 17:12:00

First | Previous | Next | Last

XR Chest

XR Chest

Clinical History
SOB and ongoing cough, ? infection

8625289 01/10/2024 XR Chest

Normal cardiac, mediastinal and hilar contours.
The lungs are clear with normal pulmonary vascularity.
No change from previous radiographs.

—
Dr Colin Turnbull. GMC: 1327812
Consultant Radiologist.

Reporting Radiologist: Dr Colin Turnbull

Report Information

Requestor	Mackie, Dr Joanne
Requesting Location	(SJHEMA) SJH Emergency Medical Assessment EMA
Report Identifier	49995335
Sample Date	01/10/2024 16:50:00

First | Previous | Next | Last

SARS-CoV-2

Status: Final - Results stored and verified

SARS CoV 2 Negative	Negative by PCR	(4J3R200)

Test Comments

(4J3R200) Sample taken at (Opposite) Blackburn Partnership Centre. Sample analysed in the National Lighthouse Laboratory (Glasgow)

Report Information

Requestor	Unknown
Requesting Location	Simpson Medical Group
Report Identifier	AAO54696236
Sample Date	23/01/2022 11:45:00

XR Facial Bones

XR Facial Bones

Clinical History
Punched in the right eye 1 week previously. Since last 3 days developing worsening right eye pain + around the eye + right forehead. ?Orbital floor fracture

6079410 27/11/2021 XR Facial Bones

No fracture demonstrated.

—
Dr Andrew Baird. GMC: 6031015
Consultant Radiologist.

Reporting Radiologist: Dr Andrew Baird

Report Information

Requestor	Salkin, Dr Jacob Phillip
Requesting Location	(SJHAE) SJH A&E
Report Identifier	40589916
Sample Date	27/11/2021 15:32:00

First | Previous | Next | Last

SARS-CoV-2

Status: Final - Results stored and verified

SARS CoV 2 Positive	Positive by PCR	(4J3R100)

Test Comments

(4J3R100) Sample taken at (Opposite) Blackburn Partnership Centre. Sample analysed in the National Lighthouse Laboratory (Glasgow)

Report Information

Requestor	Unknown
Requesting Location	Simpson Medical Group
Report Identifier	AAN27082647
Sample Date	14/10/2021 12:57:00

First | Previous | Next | Last

SARS-CoV-2

Status: Final - Results stored and verified

SARS CoV 2 Negative	Negative by PCR	(4J3R200)

Test Comments

(4J3R200) Sample taken at RTS Edinburgh Airport. Sample analysed in the National Lighthouse Laboratory (Glasgow)

Report Information

Requestor	Unknown
Requesting Location	Simpson Medical Group
Report Identifier	AAN31163233
Sample Date	14/09/2021 15:12:00

First | Previous | Next | Last

SARS-CoV-2

Status: Final - Results stored and verified

SARS CoV 2 Negative	Negative by PCR	(4J3R200)

Test Comments

(4J3R200) Sample analysed in the National Lighthouse Laboratory (Glasgow)

Report Information

Requestor	Unknown
Requesting Location	Simpson Medical Group
Report Identifier	AAH51628152
Sample Date	15/07/2021 08:43:00

First | Previous | Next | Last

SARS-CoV-2

Status: Final - Results stored and verified

SARS CoV 2 Negative	Negative by PCR	(4J3R200)

Test Comments

(4J3R200) Sample taken at (Opposite) Blackburn Partnership Centre. Sample analysed in the National Lighthouse Laboratory (Glasgow)

Report Information

Requestor	Unknown
Requesting Location	Simpson Medical Group
Report Identifier	AAK44505771
Sample Date	12/06/2021 14:14:00

First | Previous | Next | Last

SARS-CoV-2

Status: Final - Results stored and verified

SARS CoV 2 Negative	Negative by PCR	(4J3R200)

Test Comments

(4J3R200) Sample analysed in the National Lighthouse Laboratory (Glasgow)

Report Information

Requestor	Unknown
Requesting Location	Simpson Medical Group
Report Identifier	AAE56342094
Sample Date	01/04/2021 12:55:00

First | Previous | Next | Last

SARS-CoV-2

Status: Final - Results stored and verified

SARS CoV 2 Negative	Negative by PCR	(4J3R200)

Test Comments

(4J3R200) Sample analysed in the National Lighthouse Laboratory (Glasgow)

Report Information

Requestor	Unknown
Requesting Location	Simpson Medical Group
Report Identifier	AAH42943899
Sample Date	18/01/2021 15:00:00

First | Previous | Next | Last

SARS-CoV-2

Status: Final - Results stored and verified

SARS CoV 2 Negative	Negative by PCR	(4J3R200)

Test Comments

(4J3R200) Sample analysed in the National Lighthouse Laboratory (Glasgow)

Report Information

Requestor	Unknown
Requesting Location	Simpson Medical Group
Report Identifier	AAC09127091
Sample Date	04/11/2020 16:00:00

First | Previous | Next | Last

Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	137	115 160	g/L		
Red cell count	4.61	3.8 5.8	10^12/L		
Haematocrit	0.407	0.37 0.47	ratio		
Mean cell volume	88.0	78 98	fL		
Mean Cell Hb	29.7	27.0 32.0	pg		
White cell count	7.6	4.0 11.0	10^9/L		
Neutrophil Count	3.84	2.0 7.5	10^9/L		
Lymphocyte Count	2.96	1.5 4.0	10^9/L		
Monocyte Count	0.50	0.2 0.8	10^9/L		
Eosinophil Count	0.28	0.04 0.4	10^9/L		
Basophil Count	0.02	0.01 0.1	10^9/L		
Platelet count	307	150 400	10^9/L		
Mean cell Hb conc.	337	310 360	g/L		

Requestor Comments

3 weeks of leg neuropathy ? cause.

Report Information

Requestor	REG), Dr Joanna R Norwood (GP
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	SH834453W
Sample Date	30/01/2019 09:59:00

Plasma glucose level

Description	Value	Range	Unit	Normalcy	Notes
Glucose (Random)	5.1	3.8 7.7	mmol/L		

Requestor Comments

3 weeks of leg neuropathy ? cause.

Report Information

Requestor	REG), Dr Joanna R Norwood (GP
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	SB852620Z
Sample Date	30/01/2019 09:59:00

Blood haematinic levels

Description	Value	Range	Unit	Normalcy	Notes
Vitamin B12	508	180 2000	ng/L		
Serum Folate	4.5	2.8 20	ug/L		

Requestor Comments

Query Hypothyroid

3 weeks of leg neuropathy ? cause.

Thyroid function tests

Description	Value	Range	Unit	Normalcy	Notes
TSH	2.5	0.20 - 4.50	mU/L		
Free T4	12	9 - 21	pmol/L		

Requestor Comments

Query Hypothyroid

3 weeks of leg neuropathy ? cause.

Bone Group

Description	Value	Range	Unit	Normalcy	Notes
Calcium	2.44	2.2 2.6	mmol/L		
Adjustd Calcium	2.49	2.1 2.6	mmol/L		
Phosphate	1.09	0.8 1.4	mmol/L		
Albumin	39	36 47	g/L		

Requestor Comments

Query Hypothyroid

3 weeks of leg neuropathy ? cause.

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Creatinine	58	50 - 98	umol/L		
Sodium	138	135 - 145	mmol/L		
Potassium	4.8	3.6 - 5.0	mmol/L		
eGFR (/1.73m2)	>60				

Requestor Comments

Query Hypothyroid

3 weeks of leg neuropathy ? cause.

Report Information

Requestor	REG), Dr Joanna R Norwood (GP
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	SB852673R
Sample Date	30/01/2019 09:59:00

Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	132	115 160	g/L		
Red cell count	4.48	3.8 5.8	10^12/L		
Haematocrit	0.395	0.37 0.47	ratio		
Mean cell volume	88.0	78 98	fL		
Mean Cell Hb	29.5	27.0 32.0	pg		
White cell count	8.6	4.0 11.0	10^9/L		
Neutrophil Count	4.81	2.0 7.5	10^9/L		
Lymphocyte Count	2.87	1.5 4.0	10^9/L		
Monocyte Count	0.61	0.2 0.8	10^9/L		
Eosinophil Count	0.27	0.04 0.4	10^9/L		
Basophil Count	0.02	0.01 0.1	10^9/L		
Platelet count	316	150 400	10^9/L		
Mean cell Hb conc.	334	310 360	g/L		

Requestor Comments

altered sensation hands, swollen ankles, tiredness.

Report Information

Requestor	Heath, Dr Lorna
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	SH322526V
Sample Date	16/09/2016 11:55:00

Plasma glucose level

Description	Value	Range	Unit	Normalcy	Notes
Glucose	4.4		mmol/L		
Spec type Rand/Fast	Rand(<11)				

Requestor Comments

altered sensation hands, swollen ankles, tiredness.

Report Information

Requestor	Heath, Dr Lorna
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	SB007179M
Sample Date	16/09/2016 11:55:00

Blood haematinic levels

Description	Value	Range	Unit	Normalcy	Notes
Vitamin B12	390	180 2000	ng/L		
Serum Folate	5.2	2.8 20	ug/L		

Requestor Comments

Patient is not known to have a thyroid condition.
altered sensation hands, swollen ankles, tiredness.

Thyroid function tests

Description	Value	Range	Unit	Normalcy	Notes
TSH	2.9	0.2 - 4.5	mU/L		
Free T4	10	9 - 21	pmol/L		

Requestor Comments

Patient is not known to have a thyroid condition.
altered sensation hands, swollen ankles, tiredness.

Bone Group

Description	Value	Range	Unit	Normalcy	Notes
Calcium	2.32	2.2 2.6	mmol/L		
Adjustd Calcium	2.41	2.2 2.6	mmol/L		
Albumin	36	36 47	g/L		

Requestor Comments

Patient is not known to have a thyroid condition.
altered sensation hands, swollen ankles, tiredness.

Liver function tests

Description	Value	Range	Unit	Normalcy	Notes
Bilirubin	3	3 - 21	umol/L		
ALT	12	10 - 50	U/L		
Alk.Phos	61	40 - 125	U/L		
GGT	31	5 - 35	U/L		

Requestor Comments

Patient is not known to have a thyroid condition.
altered sensation hands, swollen ankles, tiredness.

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Creatinine	59	50 98	umol/L		
Sodium	138	135 145	mmol/L		
Potassium	4.3	3.6 5.0	mmol/L		
eGFR (/1.73m2)	>60				

Requestor Comments

Patient is not known to have a thyroid condition.
altered sensation hands, swollen ankles, tiredness.

Report Information

Requestor	Heath, Dr Lorna
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	SB007218Z
Sample Date	16/09/2016 11:55:00

Erythrocyte sedimentation rate

Description	Value	Range	Unit	Normalcy	Notes
ESR	**22**	**3 - 15**	**mm/hr**	**R**	

Requestor Comments

altered sensation hands, swollen ankles, tiredness.

Report Information

Requestor	Heath, Dr Lorna
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	SH235775D
Sample Date	16/09/2016 11:55:00

St Johns Micro Culture LTG

Set Comments

Micro,Culture & Sensitivities
  Large numbers of Pseudomonas aeruginosa isolated
  Small numbers of Anaerobes isolated
Please see RefHelp for guidance on management of otitis externa. RefHelp gives advice on preventive measures, topical treatments, and when to refer to ENT.

Requestor Comments

Otitis externa - given flumetasone/clioquinol drops.

Report Information

Requestor	(FY2), Dr Anneliese Flatt
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	JG278478G
Sample Date	29/07/2016 15:37:00

First | Previous | Next | Last

XR Chest

XR Chest

Clinical details

XR Chest
Thanks for seeing this 32 year old lady with a 4-6 week history of cough, intially fever and two trials on ABx with ongoing creps left upper lobe.
?Ongoing infection / Chest

Report
Heart and mediastinal contours normal.
Lungs clear. Normal pulmonary vasculature.

Reporting Radiologist: Dr Alan Simms

Report Information

Requestor	HEPBURN, ALICE
Requesting Location	Simpson Medical Group
Report Identifier	19305401
Sample Date	31/10/2014 10:14:00

Urine culture RIE

Set Comments

```
Urine culture
  No growth
```

Requestor Comments

```
Urinary incontinence
```

Report Information

Requestor	McCartney, David J
Requesting Location	(GSLEAP) LEAP Loth&Edin Abstinence Proj
Report Identifier	MU191014P
Sample Date	24/04/2014 10:00:00

Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	149	115 160	g/L		
Red cell count	4.75	3.8 5.8	10 ^12/L		
Haematocrit	0.440	0.36 0.46	Ratio		
Mean cell volume	93.0	78 96	fl		
Mean cell Hb.	31.4	27.0 32.0	pg		
White cell count	8.9	4.0 11.0	10^9/l		
Neutrophil Count	4.46	2.0 7.5	10 ^9/L		
Lymphocyte Count	3.31	1.2 4.0	10 ^9/L		
Monocyte Count	0.75	0 0.8	10 ^9/L		
Eosinophil Count	0.33	0 0.5	10 ^9/L		
Basophil Count	0.03	0 0.1	10 ^9/L		
Platelet count	274	150 400	10 ^9/l		
Mean cell Hb conc.	339	310 360	g/L		

Requestor Comments

Menorrhagia

Report Information

Requestor	Heath, Dr Lorna
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	SH813225J
Sample Date	02/04/2014 10:00:00

Blood haematinic levels

Description	Value	Range	Unit	Normalcy	Notes
Ferritin	27	15 200	ug/L		

Requestor Comments

IRREGULAR HEAVY PERIODS

Thyroid function tests

Description	Value	Range	Unit	Normalcy	Notes
TSH	1.86	0.2 - 4.5	mU/L		
Free T4	12	9 - 21	pmol/L		

Requestor Comments

IRREGULAR HEAVY PERIODS

Liver function tests

Description	Value	Range	Unit	Normalcy	Notes
Bilirubin	6	3 21	umol/L		
ALT	26	10 50	U/L		
Alk.Phos	65	40 125	U/L		
GGT	**64**	**5 - 35**	**U/L**	**R**	

Requestor Comments

IRREGULAR HEAVY PERIODS

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Urea	4.2	2.5 - 6.6	mmol/L		
Creatinine	62	60 - 120	umol/L		
Sodium	138	135 - 145	mmol/L		
Potassium	4.2	3.6 - 5.0	mmol/L		
eGFR (/1.73m2)	>60				

Requestor Comments

IRREGULAR HEAVY PERIODS

Report Information

Requestor	Heath, Dr Lorna
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	SB130739M
Sample Date	02/04/2014 10:00:00

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Plasma glucose level

Description	Value	Range	Unit	Normalcy	Notes
Glucose	**2.1**		**mmol/L**	**A**	
Spec type Rand/Fast	Rand(<11)				

Requestor Comments

IRREGULAR HEAVY PERIODS

Report Information

Requestor	Heath, Dr Lorna
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	SB130740N
Sample Date	02/04/2014 10:00:00

Chlamydia DNA detection	
Abbott realtime Chlamydia	Negative

Requestor Comments

No clinical details on request form

Aptima GC test LTG group	
Abbott realtime Gonorrhoea	Negative

Requestor Comments

No clinical details on request form

Report Information

Requestor	Thomson, Dr Julie
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	MC674375W
Sample Date	27/12/2012 11:00:00

St Johns Micro Culture LTG

Set Comments

```
Micro,Culture & Sensitivities
  Large numbers of Anaerobes isolated
   Sensitive : Metronidazole.
```

Report Information

Requestor	Midwife
Requesting Location	(GSKINGM) Midwives, Bathgate (Kingsgate)
Report Identifier	JG166665A
Sample Date	13/09/2012 09:39:00

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Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	**95**	**115 - 160**	**g/L**	**A**	
Red cell count	**3.07**	**3.8 - 5.8**	**10 ^12/L**	**A**	
Haematocrit	**0.274**	**0.36 - 0.46**	**Ratio**	**R**	
Mean cell volume	89.0	78 96	fl		
Mean cell Hb.	30.9	27.0 32.0	pg		
Mean cell Hb conc.	34.7	31.0 36.0	g/dl		
White cell count	9.6	4.0 11.0	10^9/l		
Neutrophil Count	6.06	2.0 7.5	10 ^9/L		
Lymphocyte Count	2.56	1.2 4.0	10 ^9/L		
Monocyte Count	**0.81**	**0 - 0.8**	**10 ^9/L**	**A**	
Eosinophil Count	0.18	0 0.5	10 ^9/L		
Basophil Count	0.02	0 0.1	10 ^9/L		
Platelet count	222	150 400	10 ^9/l		

Sample Comments

54111..

Report Information

Requestor	Cooper, Dr TK
Requesting Location	(SJH11) Ward 11, St John's Hospital
Report Identifier	SH442447H
Sample Date	07/09/2012 10:14:00

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Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	**103**	**115 - 160**	**g/L**	**A**	
Red cell count	**3.35**	**3.8 - 5.8**	**10 ^12/L**	**A**	
Haematocrit	**0.294**	**0.36 - 0.46**	**Ratio**	**R**	
Mean cell volume	88.0	78 96	fl		
Mean cell Hb.	30.7	27.0 32.0	pg		
Mean cell Hb conc.	35.0	31.0 36.0	g/dl		
White cell count	**15.5**	**4.0 - 11.0**	**10^9/l**	**A**	
Neutrophil Count	**11.46**	**2.0 - 7.5**	**10 ^9/L**	**A**	
Lymphocyte Count	3.06	1.2 4.0	10 ^9/L		
Monocyte Count	**0.91**	**0 - 0.8**	**10 ^9/L**	**A**	
Eosinophil Count	0.09	0 0.5	10 ^9/L		
Basophil Count	0.02	0 0.1	10 ^9/L		
Platelet count	226	150 400	10 ^9/l		

Sample Comments

54125..

Report Information

Requestor	Cooper, Dr TK
Requesting Location	(SJHLW) Labour Ward, St John's Hosp.
Report Identifier	SH441963K
Sample Date	05/09/2012 16:52:00

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Report

Clinical Summary

This is the third pregnancy of Gillian McAteer, date of birth 23.05.82. No information given on previous pregnancies. Placental abruption at 40+1 weeks gestation. It was a livebirth.

Specimen

Placenta.

Macroscopy

The specimen received is a singleton placenta with a tightly coiled 24cm length of eccentrically inserted cord with fourteen coils and three vessels. The trimmed weight of the placenta is 489g and it measures 14 x 1.5cm.

Specimen trimmed by: Dr M J Evans.

Microscopy

Histological sections of umbilical cord confirm the presence of three vessels. There is no vasculitis or funisitis. Sections of the extra placental membranes show an appropriate structure of the amnion with no acute chorioamnionitis. The maternal vasculature shows appropriate adaptation. Sections of the placenta show appropriate maturation for stated gestation. Columnar metaplasia of the amnion is noted over the fetal surface presumed secondary to the toxic effects of meconium. There is haemorrhage with focal disruption of the basal plate in keeping with the history of antepartum haemorrhage.

Singleton placenta - Term delivery. Haemorrhagic disruption of basal plate in keeping with history of APH.

Test Comments

(RPT)	Pathologists :
(RPT)	Paediatric Pathology Team
(RPT)	Dr Margaret J Evans

Sample Comments

Suffix Placenta

Report Information

Requestor	Cooper, Dr TK
Requesting Location	(SJHLW) Labour Ward, St John's Hosp.
Report Identifier	UB020171C/12
Sample Date	05/09/2012 14:59:00

Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	124	115 160	g/L		
Red cell count	4.13	3.8 5.8	10 ^12/L		
Haematocrit	0.364	0.36 0.46	Ratio		
Mean cell volume	88.0	78 96	fl		
Mean cell Hb.	30.0	27.0 32.0	pg		
Mean cell Hb conc.	34.1	31.0 36.0	g/dl		
White cell count	**14.2**	**4.0 - 11.0**	**10^9/l**	**A**	
Neutrophil Count	**9.83**	**2.0 - 7.5**	**10 ^9/L**	**R**	
Lymphocyte Count	3.27	1.2 4.0	10 ^9/L		
Monocyte Count	**0.89**	**0 - 0.8**	**10 ^9/L**	**A**	
Eosinophil Count	0.16	0 0.5	10 ^9/L		
Basophil Count	0.02	0 0.1	10 ^9/L		
Platelet count	255	150 400	10 ^9/l		

Sample Comments

Bjarni Eyvindsson A&E

Report Information

Requestor	Thomson, Dr Julie
Requesting Location	(SJHAE) SJH A&E
Report Identifier	SH441814Z
Sample Date	05/09/2012 10:57:00

Liver function tests

Description	Value	Range	Unit	Normalcy	Notes
Bilirubin	8	3 21	umol/L		
ALT	28	10 50	U/L		
Alk.Phos	**177**	**40 - 125**	**U/L**	**R**	

Sample Comments

Bjarni Eyvindsson A&E

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Urea	**2.4**	**2.5 - 6.6**	**mmol/L**	**R**	
Creatinine	**49**	**60 - 120**	**umol/L**	**R**	
Sodium	136	135 - 145	mmol/L		
Potassium	4.5	3.6 - 5.0	mmol/L		
TCO2	**19**	**22 - 30**	**mmol/L**	**R**	
eGFR (/1.73m2)	>60				

Sample Comments

Bjarni Eyvindsson A&E

Report Information

Requestor	Thomson, Dr Julie
Requesting Location	(SJHAE) SJH A&E
Report Identifier	SB591606G
Sample Date	05/09/2012 10:57:00

Coagulation/bleeding test

Description	Value	Range	Unit	Normalcy	Notes
Prothrombin Time	**10**	**10.5 - 13.5**	**s**	**R**	
INR (Warfarin)	0.9				
APTT	30	26 36	s		
APTT Ratio	1.0	0.8 1.2			
Fibrinogen (Clauss)	**4.6**	**1.5 - 4.0**	**g/l**	**R**	

Sample Comments

Bjarni Eyvindsson A&E

Report Information

Requestor	Thomson, Dr Julie
Requesting Location	(SJHAE) SJH A&E
Report Identifier	SH441820S
Sample Date	05/09/2012 10:57:00

Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	**109**	**115 - 165**	**g/L**	**R**	
Red cell count	**3.79**	**3.8 - 5.8**	**10 ^12/L**	**R**	
Haematocrit	**0.320**	**0.37 - 0.47**	**Ratio**	**R**	
Mean cell volume	84	78 98	fl		
Mean cell Hb.	28.8	27 32	pg		
Mean cell Hb conc.	34.1	31.0 36.0	g/dl		
White cell count	8.6	4 11	x10^9/l		
Neutrophil Count	5.64	2 7.5	x10^9/l		
Lymphocyte Count	2.20	1.5 4	x10^9/l		
Monocyte Count	0.57	0.2 0.8	x10^9/l		
Eosinophil Count	0.16	0.04 0.4	x10^9/l		
Basophil Count	0.02	0.01 0.1	x10^9/l		
Platelet count	232	150 350	10 ^9/l		

Requestor Comments

No clinical details on request form

Report Information

Requestor	Thomson, Dr Julie
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	QB615718E
Sample Date	17/07/2012 18:54:00

Liver function tests

Description	Value	Range	Unit	Normalcy	Notes
Bilirubin	4	3 21	umol/L		
ALT	23	10 50	U/L		
Alk.Phos	80	40 125	U/L		
GGT	23	5 35	U/L		

Requestor Comments

Pregnant

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Urea	**2.1**	**2.5 - 6.6**	**mmol/L**	**R**	
Creatinine	**43**	**60 - 120**	**umol/L**	**R**	
Sodium	137	135 - 145	mmol/L		
Potassium	4.1	3.6 - 5.0	mmol/L		
eGFR (/1.73m2)	>60				

Requestor Comments

Pregnant

Report Information

Requestor	Thomson, Dr Julie
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	SB548306E
Sample Date	17/07/2012 16:35:00

Full blood count - FBC

Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	**109**	**115 - 160**	**g/L**	**A**
Red cell count	**3.71**	**3.8 - 5.8**	**10 ^12/L**	**R**
Haematocrit	**0.345**	**0.36 - 0.46**	**Ratio**	**R**
Mean cell volume	93.0	78 96	fl	
Mean cell Hb.	29.4	27.0 32.0	pg	
Mean cell Hb conc.	31.6	31.0 36.0	g/dl	
White cell count	10.1	4.0 11.0	10^9/l	
Neutrophil Count	6.72	2.0 7.5	10 ^9/L	
Lymphocyte Count	2.52	1.2 4.0	10 ^9/L	
Monocyte Count	0.68	0 0.8	10 ^9/L	
Eosinophil Count	0.15	0 0.5	10 ^9/L	
Basophil Count	0.02	0 0.1	10 ^9/L	
Platelet count	256	150 400	10 ^9/l	

Requestor Comments

28 weeks gest

Report Information

Requestor	GP/Locum/Trainee/Unknown
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	SH632653R
Sample Date	14/06/2012 13:26:00

First | Previous | Next | Last

US Obstetric Fetal Anomaly Scan

US Obstetric Fetal Anomaly Scan

Clinical details

Gestation by EDD = 4/09/2012 = 19 w 4d

Report
Single fetus. FH seen.
HC 162 mms FL 31 mms AC 148 mms

Placental site: posterior - not low lying.
Liquor volume: average

Anatomy checked = cerebellum, cisterna magna, fetal nose and lips, 4 chamber heart, great vessel crossover, thorax, stomach, kidneys, anterior abdominal wall, bladder, limbs, spine.

No gross abnormality demonstrated.

Reporting Radiologist: Julie Eastwood

Report Information

Requestor	Fraser, M/W Vanda S
Requesting Location	(RIEXOUS) Obstetric / Gynae Ultrasound RIE
Report Identifier	11806279
Sample Date	13/04/2012 15:15:00

Parvovirus B19 IgG level

Description	Value	Range	Unit	Normalcy	Notes
Parvovirus B19 IgG	17.50				(ZB19G2)

Test Comments

(ZB19G2) Parvovirus B19 IgG Antibody: POSITIVE (Index >1.1)
(ZB19G2) Evidence of past infection
(ZB19G2)

Parvovirus B19 IgM level

Description	Value	Range	Unit	Normalcy	Notes
Parvovirus B19 IgM	0.10				(ZB19M2)

Test Comments

(ZB19M2) Parvovirus B19 IgM Antibody: NEGATIVE (Index <0.9)
(ZB19M2) ---------- ---------- ---------- ---------- ----------

Report Information

Requestor	Known, Cons Not
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	MS112598Q
Sample Date	28/02/2012 18:03:00

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US Obstetric Booking

US Obstetric Booking

Clinical details

Booking and NT scan.

Report
Single active fetus with fetal heartbeat seen.

C.R.L. 52 mms.
Measurements suggest a gestation of 11 weeks and 6 days.

Ultrasound EDD = 4/09/12
NT = 1.5mms
No further booking scan required.

Reporting Radiologist: Julie Eastwood

Report Information

Requestor	Fraser, M/W Vanda S
Requesting Location	(RIEXOUS) Obstetric / Gynae Ultrasound RIE
Report Identifier	11476343
Sample Date	20/02/2012 13:15:00

Antenatal screening

Description	Value	Range	Unit	Normalcy	Notes
gestation days	6				
gestation weeks	11	11 20			
trisomy 21 risk 1 in	6781	151 100001			
Trisomy 21 risk interpretation	Not increased				
maternal weight	90		kg		
Smoking Status	Yes				
Maternal age at EDD	30.29		yrs		
T21 age risk at term 1 in	934				
Family origin	Caucasian				
Crown rump length	52		mm		
Corrected free beta hcg MOM	1.13				
Corrected PAPPA MOM	0.82				
Nuchal Translucency	1.5		mm		
nuchal translucency MOM	1.18				

Report Information

Requestor	Midwife
Requesting Location	(GSBATX) Bathgate Primary Care Centre
Report Identifier	QC868407H
Sample Date	20/02/2012 12:08:00

US Obstetric (Other)

US Obstetric (Other)

Clinical details

Para 2+0. LMP 25/11/11. Had some fresh red pv loss with abdo cramps yesterday.,both settling today

Report
Intrauterine gestation sac containing a yolk sac & 22 mm fetal pole. Fetal heart motion seen.
This suggests a gestation of 8 weeks & 5days.
No adnexal masses or free fluid seen.

Reporting Radiologist: Sonia Easton

Report Information

Requestor	McPherson, M/W Jane H
Requesting Location	(SJHOBEPU) SJH Obste OP EPU Obstetrics OP EPU
Report Identifier	11657670
Sample Date	01/02/2012 10:12:00

St Johns Micro Culture LTG

Set Comments

Micro,Culture & Sensitivities
Microscopy
  No Leucocytes seen
Culture
  Vaginal commensals
  No Candida species isolated

Sample Comments

K.Elliott

Report Information

Requestor	given, Not
Requesting Location	(SJH10OP) Ward 10 OPD, St John's Hosp
Report Identifier	JG146886R
Sample Date	31/01/2012 14:30:00

Hep B surface Antigen

Description	Value	Range	Unit	Normalcy	Notes
Hep B surface Ag qualitative	0.19				(ZARBSQ)

Test Comments

(ZARBSQ) Hepatitis B surface Antigen : NEGATIVE
(ZARBSQ)

Requestor Comments

Full antenatal screen offered and accepted

HIV antibody/antigen (Duo)

Description	Value	Range	Unit	Normalcy	Notes
HIV Ag/Ab COMBO:	0.08	0.00 - 0.89			(ZARHIC)

Test Comments

(ZARHIC) HIV Antigen/Antibody COMBO assay: NEGATIVE (Index <0.9)
(ZARHIC) ---------- ---------- ---------- ---------- ----------

Requestor Comments

Full antenatal screen offered and accepted

Rubella screening test

Description	Value	Range	Unit	Normalcy	Notes
CMIA for Rubella IgG Antibody:	40.6	10 999	IU/mL		(ZARRUG)

Test Comments

(ZARRUG) Rubella IgG Antibody : POSITIVE (>9.9 IU/mL)
(ZARRUG) Rubella antibodies present : >=10 IU
(ZARRUG)

Requestor Comments

Full antenatal screen offered and accepted

Syphilis serology

Description	Value	Range	Unit	Normalcy	Notes
Anti-Treponemal IgG Antibody:	0.05	0.00 - 0.89			(ZARSYG)

Test Comments

(ZARSYG) Anti-Treponemal IgG antibody: NEGATIVE (Index <0.9)
(ZARSYG) (Negative <0.9, Equivocal 0.9-1.1, Positive >1.1)
(ZARSYG) ---------- ---------- ---------- ---------- ----------
(ZARSYG)

Requestor Comments

Full antenatal screen offered and accepted

Report Information

Requestor	Midwife
Requesting Location	(GSBATX) Bathgate Primary Care Centre
Report Identifier	MS103832D
Sample Date	20/01/2012 15:36:00

St Johns Micro Urine Cult LTG

Set Comments

Urine Micro Culture & Sens

Culture

No significant bacteriuria

Requestor Comments

Health Centre Booking Sample

Report Information

Requestor	Midwife
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	JU191416K
Sample Date	20/01/2012 14:15:00

Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	131	115 160	g/L		
Red cell count	4.33	3.8 5.8	10 ^12/L		
Haematocrit	0.398	0.36 0.46	Ratio		
Mean cell volume	92.0	78 96	fl		
Mean cell Hb.	30.3	27.0 32.0	pg		
Mean cell Hb conc.	32.9	31.0 36.0	g/dl		
White cell count	10.0	4.0 11.0	10^9/l		
Neutrophil Count	6.54	1.8 7.5	10 ^9/L		
Lymphocyte Count	2.42	1.2 4.0	10 ^9/L		
Monocyte Count	0.73	0 0.8	10 ^9/L		
Eosinophil Count	0.22	0 0.5	10 ^9/L		
Basophil Count	0.04	0 0.1	10 ^9/L		
Platelet count	332	150 400	10 ^9/l		

Requestor Comments

Booking clinic

Report Information

Requestor	Midwife
Requesting Location	(GSBATX) Bathgate Primary Care Centre
Report Identifier	SH580184M
Sample Date	20/01/2012 11:00:00

CT Head

CT Head

Clinical details:
Fall downstairs today, boggy haematoma occiput, states 4 hour LOC, becoming more agitated, severe headache

CT Head (Unenhanced Scan):

Findings:

No acute infarct, haemorrhage, mass or surface collection. Normal ventricular system and basal cisterns. No significant bony abnormality.

Clinical team informed.

Reported by Dr Z Khan.

Reporting Radiologist: Dr Zubair A Khan

Report Information

Requestor	
Requesting Location	(SJHAE) SJH A&E
Report Identifier	10873505
Sample Date	08/10/2011 21:34:00

First | Previous | Next | Last

Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	133	115 160	g/L		
Red cell count	4.18	3.8 5.8	10^12/L		
Haematocrit	0.385	0.36 0.46	Ratio		
Mean cell volume	92.2	78 96	fl		
Mean cell Hb.	31.7	27.0 32.0	pg		
Mean cell Hb conc.	34.4	28.0 35.0	g/dl		
White cell count	8.4	4.0 11.0	x10^9/l		
Neutrophil Count	5.20	1.8 7.5	x10 ^9/L		
Lymphocyte Count	2.30	1.2 4.0	x10 ^9/L		
Monocyte Count	0.60	0 0.8	x10 ^9/L		
Eosinophil Count	0.30	0 0.5	x10 ^9/L		
Basophil Count	0.00	0 0.1	x10 ^9/L		
Platelet count	282	150 400	x10^9/l		

Requestor Comments

Weight gain

Erythrocyte sedimentation rate

Description	Value	Range	Unit	Normalcy	Notes
ESR	12	3 - 15	mm/hr		

Requestor Comments

Weight gain

Report Information

Requestor	Finnie, Dr RM
Requesting Location	(GSDED) Dedridge Health Centre
Report Identifier	SH272465B
Sample Date	29/06/2009 11:00:00

Thyroid function tests

Description	Value	Range	Unit	Normalcy	Notes
TSH	1.76	0.2 4.5	mU/L		
Free T4	12	9 21	pmol/L		

Requestor Comments

Weight gain

Liver function tests

Description	Value	Range	Unit	Normalcy	Notes
Bilirubin	8	3 - 16	umol/L		
ALT	14	10 - 50	U/L		
Alk.Phos	62	40 - 125	U/L		
GGT	28	5 - 55	U/L		
Albumin	43	35 - 50	g/L		

Requestor Comments

Weight gain

Serum total protein

Description	Value	Range	Unit	Normalcy	Notes
Total Protein	74	60 80	g/L		

Requestor Comments

Weight gain

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Urea	3.5	2.5 - 6.6	mmol/L		
Creatinine	67	60 - 120	umol/L		
Sodium	136	135 - 145	mmol/L		
Potassium	4.3	3.6 - 5.0	mmol/L		
Chloride	105	95 - 107	mmol/L		
eGFR (/1.73m2)	>60				

Requestor Comments

Weight gain

Endocrine studies

Description	Value	Range	Unit	Normalcy	Notes
LH	6	2.0 9.0	U/L		
FSH	8	3.0 9.0	U/L		

Set Comments

FSH & LH normal for early follicular or luteal phase.

Requestor Comments

Weight gain

Report Information

Requestor	Finnie, Dr RM
Requesting Location	(GSDED) Dedridge Health Centre
Report Identifier	SB598694C
Sample Date	29/06/2009 11:00:00

Plasma glucose level

Description	Value	Range	Unit	Normalcy	Notes
Glucose	5.2		mmol/L		
Glucose spec.	Unknown				

Requestor Comments

Weight gain

Report Information

Requestor	Finnie, Dr RM
Requesting Location	(GSDED) Dedridge Health Centre
Report Identifier	SB598695T
Sample Date	29/06/2009 11:00:00

Chlamydia DNA detection	
Chlamydia trachomatis PCR :	Negative

Report Information

Requestor	Known, Cons Not
Requesting Location	(GSDED) Dedridge Health Centre
Report Identifier	MC489831P
Sample Date	10/06/2009 15:57:00

St Johns Micro Preg test LTG	
Pregnancy Test:	Negative (Detects 25iu/L HCG)

Report Information

Requestor	GP/Locum/Trainee/Unknown
Requesting Location	(GSDED) Dedridge Health Centre
Report Identifier	JS009799G
Sample Date	10/06/2009 14:14:00

First | Previous | Next | Last

XR Finger Little Rt

XR Finger Little Rt

Clinical details

cut right pinkie on glass soft tissue xray

Report
No evidence of retained radio opaque foreign body.

Reporting Radiologist: Dr Peter MacLean

Report Information

Requestor	
Requesting Location	(SJHAE) SJH A&E
Report Identifier	4855412
Sample Date	13/03/2009 17:09:00

XR Finger Ring Lt

XR Finger Ring Lt

Clinical details

crush inj to 4th mc, bruised and tender

Report
There is a burst fracture of the tuft of the terminal phalanx of the ring finger.

Reporting Radiologist: Rona A Thomson

Report Information

Requestor	
Requesting Location	(SJHAE) SJH A&E
Report Identifier	3366489
Sample Date	06/08/2008 18:26:00

First | Previous | Next | Last

Genito-urinary microscopy

Microscopy 1	No excess of Leucocytes

Requestor Comments

Vaginal Discharge

Genito-urinary culture

```
   Vaginal commensals
1) A growth of Bacteroides sp.
   This may be part of the normal flora
   No Neisseria isolated
```

Requestor Comments

Vaginal Discharge

Report Information

Requestor	HAY, D.
Requesting Location	(BFH) Simpson Medical Group
Report Identifier	M073480/06
Sample Date	19/10/2006 00:00:00

First | Previous | Next | Last

Report

```
Squamous cells show reactive change and
nuclear changes bordering on dyskaryosis.
Please repeat in 6 months.              *
```

Test Comments

(RPT)	Date of Previous Smear : 10/05/2005
(RPT)	Reason for Smear : Risk Group
(RPT)	Patient Condition : IUCD
(RPT)	Appearance of Cervix : Normal
(RPT)	Patient Symptoms : Discharge
(RPT)	Medical Codes : Vaginal cervical cytologic material Transformation Zone Cells Present Atypia, cytologic

Sample Comments

Suffix Liquid based cytology

Report Information

Requestor	McNutt, Dr Andrew PW
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	UC037732P/06
Sample Date	22/06/2006 17:57:00

First | Previous | Next | Last

Genito-urinary microscopy

Microscopy 1	No excess of Leucocytes

Requestor Comments

Vaginal Discharge

Genito-urinary culture

Vaginal commensals
No Neisseria isolated

Requestor Comments

Vaginal Discharge

Report Information

Requestor	MCNUTT, A.
Requesting Location	(BFH) Simpson Medical Group
Report Identifier	M043496/06
Sample Date	22/06/2006 00:00:00

First | Previous | Next | Last

Report

```
Groups of squamous cells show moderate
dyskaryosis at least.                    *

Please refer for colposcopy.             *
```

Test Comments

(RPT) Reason for Smear : Routine Recall
(RPT) Patient Condition : IUCD
(RPT) Appearance of Cervix : Normal
(RPT) Patient Symptoms : Discharge
(RPT) Medical Codes : Jackie Doran Moderate Dyskaryosis
(RPT) Medical Codes : Vaginal cervical cytologic material Transformation Zone Cells Present CIN 2

Sample Comments

Suffix Liquid based cytology

Report Information

Requestor	Holden, Dr Robert W
Requesting Location	(GSSIM) Bathgate, Simpson Med Pract.
Report Identifier	UC027727V/05
Sample Date	10/05/2005 08:23:00

First | Previous | Next | Last

Blood

Description	Value	Range	Unit	Normalcy	Notes
gestation weeks	17	16 19		N	
gestation days	5				
maternal weight	94		kg		
Wt. adjusted AFP MOM	1.16	0.20 1.99		N	
wt adj hcg mom	0.42	0.20 3.99	mom	N	
trisomy 21 risk	34354	251 50001		N	
trisomy 18 risk	34863	251 50001		N	
NTD Risk	Not increased				
Trisomy 21 risk interpretation	Not increased				
trisomy 18 risk interpretation	Not increased				

Report Information

Requestor	Cooper, Dr TK
Requesting Location	(SJHANC) Antenatal Clinic, St John's
Report Identifier	QC841419Z
Sample Date	05/05/2004 00:00:00

Maternity Notes

Mother

UHPI Number	CHI Number	First Forename	Surname	Date of Birth
800325165E	2305821425	Gillian	McAteer	5/23/82

Children

UHPI Number	CHI Number	First Forename	Surname	Date of Birth
700611840B	0509128300	Luci	McAteer	9/5/12

Special Features Plan

Special Features Plan	Difficulty dealing with labour pain - requests epidural.
Create User/Date/Time	Vanda S Fraser - 09/08/2012 - 14:13
Last Update User/Date/Time	Vanda S Fraser - 09/08/2012 - 14:13

AN Booking Part 1

Height (in metres)	1.62
Weight (in Kgs)	89.5
BMI	34.1
Blood Group	O
Rhesus status	Rh Positive
Occupation	Catering assistant - TESCO
Have you been taking Folic acid?	Yes
Folic acid dose	<12weeks 400mcg
Have you been taking vitamin D	
Have you been taking Healthy Start vitamins	
Have you been taken any other pregnancy vitamins/supplements	
What do you know about healthy eating during pregnancy?	
Do you have any special dietary needs?	Eats mixed diet
Dietetic referral made	
Dietetic details	
What do you know about the benefits of physical activity in pregnancy?	
Advice given	
Do you go to the Dentist regularly	yes
Are there any health and safety issues related to your work?	NOne, risk assessment done

AN Booking Part 1

Previous history	
Age >35	
BMI >30	Yes
Parity >4	
Medical history	
Other	
Thrombosis Risk	Low
Have you ever had a general anaesthetic	Yes
Previous difficult intubation	
Sensitivity to anaesthetic drugs	
Abnormal spinal, neck or facial anatomy	
Family/personal history of Suxamethonium apnoea or malignant hyperpyrexia	
weight> 120kg	
Anaesthetic referral sent?	
Have you ever had a cervical smear?	Yes
Date of smear	July 2011
Comments (inc colposcopy referral/treatment)	Colposcopy 2009
Next smear due?	Postnatally, on annual review
What do you know about drinking alcohol in pregnancy?	
How many units of alcohol did you drink each day before you were pregnant?	
How many units of alcohol a day are you drinking now	0
How many units of alcohol do you drink in an	0

AN Booking Part 1

average week	
If drinking, are you drinking at home, in clubs/ pubs	
Offer patient a brief intervention if pregnant and drinking alcohol	
Offer patient a brief intervention if prior to pregnancy alcohol consumption above recommended limits	Y
Referral for advice on reducing drinking	Yes
Consent for follow up	Yes
What do you know about smoking in pregnancy?	
Have you smoked in the 12 months prior to pregnancy?	Current smoker
Date stopped	
Number per day	10
CO level	
CO Date	
Do you or anyone in the household currently smoke?	
Are you interested in getting help to stop?	
Referral made to smoking cessation service	
Smoking Brief Intervention offered	
Risks on exposure to cigarette smoke whilst pregnant explained	Yes
Have you used any street drugs, gas or glue in the last year?	No
If yes - are you currently using any street drugs, gas or glue?	No

AN Booking Part 1

Substances used	None
Have you ever injected drugs?	No
Are there signs of Problem Drug Use	
Referral for advice on substance abuse	
Referred to Substance Misuse Midwife	
Outcome of referrals	
Do you currently or have you ever attended an addiction service (inc smoking and alcohol)	
Addiction Service Details	
Self harm	
Self Harm Details	
Overdose	
Overdose Details	
Are you taking any prescribed medication - currently or recently stopped?	Lactulose since pregnancy
Are you taking any over the counter preparations or medications not prescribed?	
During the past month, have you often been bothered by feeling down, depressed or hopeless?	
During the past month, have you often been bothered by having little interest or pleasure in doing things?	
If yes to either question – is this something you feel you need or want help with?	
Are any of the problems on-going at the moment?	
Are you getting any help with the problems at the moment?	

AN Booking Part 1

Details of any agency providing mental health support	
Are they aware of current pregnancy?	
MH referral needed	
MH referral details	
MW Countersigning StM signature	
Create User/Date/Time	Vanda S Fraser - 20/01/2012 - 10:47
Last Update User/Date/Time	Vanda S Fraser - 15/03/2012 - 14:47
**** Archive Data ****	
Cervical smear	
Pattern of alcohol use	
Oral drug misuse(inc. Dispensing)	
Other Intravenous drug use	
How many units of alcohol were you drinking prior to pregnancy being confirmed	22
Referred to CDPS	
Risks explained	
Are you exposed to cigarette smoke at home?	
How many units of alcohol did you drink each week before you became pregnant	22
What was the maximum units of alcohol you would drink per day before you became pregnant	6
Have the risks of drinking alcohol in pregnancy been explained to you	Yes

AN Booking Part 2

Do you have Support Needs	No
Are you still in school	No
Are you living in or leaving looked after care services	No
Do you feel you have someone to support you through the pregnancy	Yes
Are you in temporary housing	No
Do you need further advice on finances benefits or housing issues	No
Qualifies for Healthy Start Vouchers	
Referral to income maximisation services	
Money and debt advice services	
Financial capability support	
If you have other children do they live with you	
Who looks after them	
Have you ever needed social work assistance	Yes
Have you ever been involved in the Criminal Justice System?	
Do you have difficulty reading	No
Do you have difficulty filling in forms or writing letters	No
Do you consider yourself to have a physical disability	No
Do you consider yourself to have a mental disability or learning difficulties	No
Do you get support or have you ever had support with independent living?	
Support referral needed	

AN Booking Part 2

Support referral details	
Social work	
Social work - Job Title	
Health Visitor/Public Health Nurse	
Health Visitor/Public Health Nurse - Job Title	
Other involved workers	
Other involved workers - Job Title	
Religious & Cultural Comments	
Is Blood Transfusion acceptable to you	Yes
Blood Transfusion Comments	
Was the patient asked about female genital cuttings or piercings?	
If no, why was the question not asked?	
Other reason	
Did the patient disclose having cuttings or piercings done?	
Further details	
Was the patient referred to a Alnisa Midwife?	
Refugee or asylum seeker	
Have you had a full medical examination since arriving in the UK?	
Referred to GP	
Family member with TB in last 5 years	
Has either parent or any grandparent been born in a high prevalence area	
Is family member likely to live for > 3 months in a high prevalence area	
Baby requires BCG	

AN Booking Part 2

State country if Family from country with high prevalence TB	
TB Risk	
TB Comments	
Have you ever been notified that you are at increased risk of CJD or vCJD for public health purposes	
Parent Education class - Interested?	Yes
Leaflets given	Yes
Antenatal education sessions discussed	
Date	
Booked to attend (AN education sessions)	
Your guide to screening tests during pregnancy	
FW8 Maternity exemption form	Y
Mat B1	
Parent's Guide to Money	
Guide to maternity benefits	Y
Pregnancy and work	
Ready Steady Baby	Y
information on wearing a car seat belt	
Reduce the risk of cot death	
Off to a good start all you need to know about B/F	Y
Breast feeding and returning to work	
Your guide to newborn screening tests	
Your baby's hearing screen	
BCG and your baby	

AN Booking Part 2

Talking about postnatal depression	
How to stop smoking & stay stopped	Y
Any other information leaflets given	Bounty Pack
Importance of skin to skin contact	Yes
Baby led feeding	Yes
Rooming in / Keeping baby near	Yes
Benefits of B/F to the baby	Yes
Benefits of B/F to mother	Yes
Effective positioning & attachment	Yes
Effect of teats, dummies & nipple shields	Yes
No other food or drink needed for 6 months	Yes
DVD - From Bump to Breastfeeding	Yes
DVD discussed - date	
If mother declines any part of feeding discussion - please detail	
Comments	Advised to start pregnancy supplements.
MW Countersigning StM signature	
Create User/Date/Time	Vanda S Fraser - 20/01/2012 - 10:47
Last Update User/Date/Time	Vanda S Fraser - 15/03/2012 - 14:47
**** Archive Data ****	
Attended Infertility clinic	
RS	
Breasts	
CNS	

AN Booking Part 2

CVS	
Are you affected by Domestic abuse	
Breast feeding discussed/charter	
Other screening	
HEBS leaflet	
Folic Acid supplements	Yes
Female genital cutting or piercing	
Female genital cutting or piercing Comments	
Help available with feeds	Yes
Baby's sleeping place	Yes
Infant feeding check list	Update now
Your baby your choice	
Routine Blood tests inc. HIV	Yes
Hospital information	
Vitamin K information	
Health in Pregnancy Grant	

Antenatal check

Gestation (in weeks)	8
Weight in late pregnancy (Kg)	
Has thrombosis risk changed?	
Fundal height (Archived)	not checked
Lie	
Back on	
Presentation	
Presentation /5ths palpable	
Position	
Fetal heart rate	
Fetal movement felt (Archived)	Too early
Normal fetal movement discussed & 'Your Baby's Movements' leaflet given? (Archived)	
Is Follow Up to Brief Intervention required?	
Alcohol units per week - Currently	
Maximum units per day - Currently	
Systolic Blood Pressure	100
Diastolic blood pressure	70
Oedema	
Oedema present	
Urinalysis	
Urinalysis abnormalities	
Comments	Booking bloods with consent. Wishes NT screening and FA scan. Has nausea and breast tenderness. Sleep disturbed, tired, emotional. Constipation, has lactulose. Discussed smoking cessation, has reduced to 10 daily.
Plans for care	MW 8/52
MW Countersigning StM signature	
Create User/Date/Time	Vanda S Fraser - 20/01/2012 - 11:02
Last Update User/Date/Time	Vanda S Fraser - 20/01/2012 - 11:02

Antenatal check

Gestation (in weeks)	15.2
Weight in late pregnancy (Kg)	
Has thrombosis risk changed?	
Fundal height (Archived)	19
Lie	
Back on	
Presentation	
Presentation /5ths palpable	
Position	
Fetal heart rate	152
Fetal movement felt (Archived)	Yes
Normal fetal movement discussed & 'Your Baby's Movements' leaflet given? (Archived)	
Is Follow Up to Brief Intervention required?	
Alcohol units per week - Currently	
Maximum units per day - Currently	
Systolic Blood Pressure	130
Diastolic blood pressure	60
Oedema	No
Oedema present	
Urinalysis	NAD
Urinalysis abnormalities	
Comments	Aware of flutters. Difficulty coping at home. See maternity summary.
Plans for care	MW4/52
MW Countersigning StM signature	
Create User/Date/Time	Vanda S Fraser - 15/03/2012 - 14:57
Last Update User/Date/Time	Vanda S Fraser - 15/03/2012 - 14:57

Antenatal check

Gestation (in weeks)	19.2
Weight in late pregnancy (Kg)	98
Has thrombosis risk changed?	
Fundal height (Archived)	21
Lie	
Back on	
Presentation	
Presentation /5ths palpable	
Position	
Fetal heart rate	152
Fetal movement felt (Archived)	Yes
Normal fetal movement discussed & 'Your Baby's Movements' leaflet given? (Archived)	
Is Follow Up to Brief Intervention required?	
Alcohol units per week - Currently	
Maximum units per day - Currently	
Systolic Blood Pressure	106
Diastolic blood pressure	70
Oedema	Yes
Oedema present	fingers/hands
Urinalysis	
Urinalysis abnormalities	
Comments	Has carpal tunnel syndrome. Feels discomfort also over upper arms. Information and advice given. Aware of some flutters. In touch leaflet given. All results filed. Double appointment booked to allow time for discussion. Home life now more settled, Gillian feeling able for coping. Has support of mum and ex partner. Follow up appointment with GP due and Gillian will make this in the next 2/52. Mood stable. Has thrush, prescription requested from GP
Plans for care	MW 5/52
MW Countersigning StM signature	
Create User/Date/Time	Vanda S Fraser - 12/04/2012 - 14:29
Last Update User/Date/Time	Vanda S Fraser - 12/04/2012 - 14:38

Antenatal check

Gestation (in weeks)	24.2
Weight in late pregnancy (Kg)	102
Has thrombosis risk changed?	
Fundal height (Archived)	27
Lie	
Back on	
Presentation	
Presentation /5ths palpable	
Position	
Fetal heart rate	148
Fetal movement felt (Archived)	Yes
Normal fetal movement discussed & 'Your Baby's Movements' leaflet given? (Archived)	
Is Follow Up to Brief Intervention required?	No
Alcohol units per week - Currently	0
Maximum units per day - Currently	
Systolic Blood Pressure	104
Diastolic blood pressure	68
Oedema	Yes
Oedema present	fingers/hands,ankles
Urinalysis	NAD
Urinalysis abnormalities	
Comments	Gillian feels that she is puffy fingered and her feet too. Felt her face also puffy at the weekend. Headaches random and alleviated by paracetomol. BP today normal, no proteinurea. Weight gain good and encouraged. Chat re diet again, cutting down smoking. Tired, work is physical. Not taking any alcohol. Continue support and monitoring. Suggest eye test.
Plans for care	MW 4/52
MW Countersigning StM signature	
Create User/Date/Time	Vanda S Fraser - 17/05/2012 - 14:22
Last Update User/Date/Time	Vanda S Fraser - 17/05/2012 - 14:22

Antenatal check

Gestation (in weeks)	28.2
Weight in late pregnancy (Kg)	
Has thrombosis risk changed?	
Fundal height (Archived)	32
Lie	
Back on	
Presentation	Breech
Presentation /5ths palpable	
Position	
Fetal heart rate	140
Fetal movement felt (Archived)	Yes
Normal fetal movement discussed & 'Your Baby's Movements' leaflet given? (Archived)	
Is Follow Up to Brief Intervention required?	
Alcohol units per week - Currently	
Maximum units per day - Currently	
Systolic Blood Pressure	120
Diastolic blood pressure	60
Oedema	Yes
Oedema present	fingers/hands
Urinalysis	NAD
Urinalysis abnormalities	
Comments	Routine bloods for Hb and antibody screen. Off work just now, feels headaches less since having time off. Has 2 further weeks to work following which holidays and maternity leave. Baby is active.
Plans for care	MW 5/52
MW Countersigning StM signature	
Create User/Date/Time	Vanda S Fraser - 14/06/2012 - 16:23
Last Update User/Date/Time	Vanda S Fraser - 14/06/2012 - 16:23

Antenatal check

Gestation (in weeks)	33.2
Weight in late pregnancy (Kg)	
Has thrombosis risk changed?	
Fundal height (Archived)	35
Lie	Longitudinal
Back on	
Presentation	
Presentation /5ths palpable	
Position	
Fetal heart rate	140
Fetal movement felt (Archived)	Yes
Normal fetal movement discussed & 'Your Baby's Movements' leaflet given? (Archived)	
Is Follow Up to Brief Intervention required?	
Alcohol units per week - Currently	
Maximum units per day - Currently	
Systolic Blood Pressure	105
Diastolic blood pressure	70
Oedema	Yes
Oedema present	fingers/hands,ankles
Urinalysis	NAD
Urinalysis abnormalities	
Comments	Recent appt. with GP concerns re yellowness in eyes but settled today. Bloods were taken and result normal. Hb still 109 so self treating. Backache just above pelvis, simple analgesia and comfort measures. Baby is active.
Plans for care	MW 3/52
MW Countersigning StM signature	
Create User/Date/Time	Vanda S Fraser - 19/07/2012 - 11:51
Last Update User/Date/Time	Vanda S Fraser - 19/07/2012 - 11:51

Antenatal check

Gestation (in weeks)	36.2
Weight in late pregnancy (Kg)	107
Has thrombosis risk changed?	
Fundal height (Archived)	37
Lie	Longitudinal
Back on	Right
Presentation	Cephalic
Presentation /5ths palpable	3/5ths
Position	ROL
Fetal heart rate	144
Fetal movement felt (Archived)	Yes
Normal fetal movement discussed & 'Your Baby's Movements' leaflet given? (Archived)	
Is Follow Up to Brief Intervention required?	
Alcohol units per week - Currently	0
Maximum units per day - Currently	
Systolic Blood Pressure	110
Diastolic blood pressure	62
Oedema	No
Oedema present	
Urinalysis	NAD
Urinalysis abnormalities	
Comments	Has been moving less today. One good kick this morning and at palpation further kick felt by mum. Chat about expected movements and also in touch advice. Further discussion around any concerns and has support network in place. No post natal concerns, more anxious about labour. Previous difficult deliveries, keen for epidural.
Plans for care	MW 2/52
MW Countersigning StM signature	
Create User/Date/Time	Vanda S Fraser - 09/08/2012 - 14:05
Last Update User/Date/Time	Vanda S Fraser - 09/08/2012 - 14:05

Antenatal check

Gestation (in weeks)	38.2
Weight in late pregnancy (Kg)	
Has thrombosis risk changed?	
Fundal height (Archived)	39
Lie	Longitudinal
Back on	Right
Presentation	Cephalic
Presentation /5ths palpable	3/5ths
Position	
Fetal heart rate	140
Fetal movement felt (Archived)	Yes
Normal fetal movement discussed & 'Your Baby's Movements' leaflet given? (Archived)	
Is Follow Up to Brief Intervention required?	
Alcohol units per week - Currently	0
Maximum units per day - Currently	0
Systolic Blood Pressure	120
Diastolic blood pressure	70
Oedema	Yes
Oedema present	ankles
Urinalysis	NAD
Urinalysis abnormalities	
Comments	Still anxious about labour. Went late with previous labours. Offered sweep at term. Stable mood and all settled at home. No concerns. Feeling lots of pressure, has had some PV discharge, not offensive or itchy. Small spot of blood when wiping today. To contact SJH if any concerns, fresh bleeding. Advised optimum positioning, ? OP at present. Baby is active.
Plans for care	MW 2/52, Offer sweep
MW Countersigning StM signature	
Create User/Date/Time	Vanda S Fraser - 23/08/2012 - 13:51
Last Update User/Date/Time	Vanda S Fraser - 23/08/2012 - 13:51

Antenatal tests - planning

Booking bloods & MSU - Offered	
Booking bloods & MSU - Accepted	
Booking bloods & MSU - Date taken	1/20/12
Repeat BI Group & Antibody check - Offered	
Repeat BI Group & Antibody check - Accepted	
Repeat BI Group & Antibody check - Date taken	
Repeat FBC - Offered	
Repeat FBC - Accepted	
Repeat FBC - Date taken	
Have you received info on Pertussis vaccine ?	
Have you received the Pertussis vaccine?	
Pertussis Vaccine Date	
Repeat RBG - Offered	
Repeat RBG - Accepted	
Repeat RBG - Date taken	
Prophylactic Anti D - Req'd /discussed	
Prophylactic Anti D - Offered	
Prophylactic Anti D - Accepted	
Prophylactic Anti D - Date taken	
Prophylactic Anti D - Gestation	
Prophylactic Anti D - Batch	
Prophylactic Anti D - Dose	
Has the Anti D info leaflet been given?	
Chlamydia - opportunistic testing for < 20 yr olds - Offered	
Chlamydia - opportunistic testing for < 20 yr olds - Accepted	
Chlamydia - opportunistic testing for < 20 yr olds - Date taken	
Which tests declined - inc reason	
HIV - Discussed & offered	
HIV - Date discussed & offered	

Antenatal tests - planning

HIV - Accepted	
HIV recounselled	
HIV - Date taken	
HIV - Comments	
HIV - Result returned	
HIV - Actioned if abnormal	
Hepatitis B - Discussed & offered	
Hepatitis B - Date discussed & offered	
Hepatitis B - Accepted	
Hepatitis B recounselled	
Hepatitis B - Date taken	
Hepatitis B - Comments	
Hepatitis B - Result returned	
Hepatitis B - Actioned if abnormal	
Hepatitis C - Discussed & offered	
Hepatitis C - Date discussed & offered	
Hepatitis C - Accepted	
Hepatitis C recounselled	
Hepatitis C - Date taken	
Hepatitis C - Comments	
Hepatitis C - Result returned	
Hepatitis C - Actioned if abnormal	
Syphilis - Discussed & offered	
Syphilis - Date discussed & offered	
Syphilis - Accepted	
Syphilis recounselled	
Syphilis - Date taken	
Syphilis - Comments	
Syphilis - Result returned	
Syphilis - Actioned if abnormal	
Rubella - Discussed & offered	
Rubella - Date discussed & offered	
Rubella - Accepted	
Rubella - Date taken	
Rubella - Comments	
Rubella - Result returned	
Rubella - Actioned if abnormal	

Antenatal tests - planning

Rubella - Actioned if abnormal	
Haemoglobinopathy - Have you been screened for Haemoglobinopathy before?	
Haemoglobinopathy - Date	
Haemoglobinopathy - Status	
Haemoglobinopathy - Has baby's father been offered screening?	
Haemoglobinopathy - Date father offered screening	
Thalassaemia - Discussed & offered	
Thalassaemia - Date discussed & offered	
Thalassaemia - Accepted	
Thalassaemia - Date taken	
Thalassaemia - Comments	
Thalassaemia - Result returned	
Thalassaemia - Actioned if abnormal	
Sickle Cell - Discussed & offered	
Sickle Cell - Date discussed & offered	
Sickle Cell - Accepted	
Sickle Cell - Date taken	
Sickle Cell - Comments	
Sickle Cell - Result returned	
Sickle Cell - Actioned if abnormal	
Written information given and discussed (FTS)	
Date discussed and offered (FTS)	
Accepted and consented (FTS)	
Accepted and consented to (FTS)	
Comments (FTS)	
Result returned (FTS)	
Actioned if abnormal (FTS)	
Date consented (FTS)	2/20/12
Date sample taken (FTS)	
Written information given and discussed (STS)	
Date discussed and offered (STS)	
Accepted and consented (STS)	
Accepted and consented to (STS)	

Antenatal tests - planning

Comments (STS)	
Result returned (STS)	
Actioned if abnormal (STS)	
Date consented (STS)	
Date sample taken (STS)	
Written information given and discussed (NIPT)	
Date discussed and offered (NIPT)	
Accepted and consented to (NIPT)	
Reason for NIPT (old)	
Directed to electronic information (old)	
Women's choice	
Test result	
Date sample taken (NIPT)	
Date of test result	
Repeat sample result	
Date of repeat sample result	
Abnormal Results - Action taken	[redacted]
Dating scan - Discussed & offered	
Dating scan - Accepted	
Nuchal Translucency scan 11-13 wks - Discussed & offered	
Nuchal Translucency scan 11-13 wks - Accepted	
Fetal Anomaly scan - Discussed & offered	
Fetal Anomaly scan - Accepted	
Detailed scan - Discussed & offered	
Detailed scan - Accepted	
Detailed scan - Weeks	
Detailed scan - Card given to woman	
Growth Scan 1 - Arranged	
Growth Scan 1 - Date arranged for	
Growth Scan 1 - Comments	
Growth Scan 2 - Arranged	
Growth Scan 2 - Date arranged for	
Growth Scan 2 - Comments	
Growth Scan 3 - Arranged	

Antenatal tests - planning

Growth Scan 3 - Date arranged for	
Growth Scan 3 - Comments	
Other Scans	
MW Countersigning StM signature	
Create User/Date/Time	Vanda S Fraser - 20/01/2012 - 10:50
Last Update User/Date/Time	Kirsteen Kelly - 20/02/2012 - 16:34
**** Archive Data ****	
Screening for Spina Bifida due	
Repeat FBC - Due	
Screening for Down's syndrome - due	2/20/12
Repeat BI group and Antibody check - due	
Screening for Haemaglobinopathy - due	
Screening for Edwards Syndrome - Due	
Repeat Random Blood Glucose - due	
Screening for Haemaglobinopathy - done	
Screening for Haemoglobinopathy required	
Repeat Random Blood Glucose required	
Repeat FBC required	
Repeat Blood group and Antibody check Required	
Screening for Spina Bifida - Done	
Screening for Edwards Syndrome - Done	
Chlamydia (if under 25) required	
Woman has information for vaccination programme	
Have you been vaccinated recently for swine flu?	
Swine flu vacc date	
Down's Syndrome offered	
Down's Syndrome offered date	
Down's -2- offered	
Down's -2- offered date	

Pregnancy support centre visit

Reason for attendance	
Time first seen	
Pain	
Duration of pain	
Bleeding	
Duration of Bleeding	
Fetal demise at booking scan	
Follow up	
Review appointment PSC / EPU	
Reason for Review appointment	
Attendance outcome	
Advice	
Scenario	
Is Anti D required?	
Date of Pre clerking	
Time of Pre-clerking	
Date of procedure	
Time of procedure	
Location of procedure	
Clinical Summary	Attended EPU yesterday with pv loss and abdo cramps which are both settling today USS results Ongoing IUP of 8w6d
MW countersigning StM signature	
Create User/Date/Time	Jane McPherson - 01/02/2012 - 11:45
Last Update User/Date/Time	Jane McPherson - 01/02/2012 - 11:45
**** Archive Data ****	
emergency contact details given	0
Patient will contact PSC	0
location of Pre-clerking	
daybed location	
cervical priming	0
G&S	0
visit outcome	
Patient considering options	0

Pregnancy support centre visit

Patient considering options	0
Natural management review required	0
Daybed appointment	
mifepristone prescribed	0
Consent given	0
Cytogenetics	0

Mother

UHPI Number	CHI Number	First Forename	Surname	Date of Birth
800325165E	2305821425	Gillian	McAteer	5/23/82

Operation note

Category of C/S	Category 1 - Stat
Date of Decision	9/5/12
Time of Decision	11:00
Decision made by	Dr S Rane
Date of start of procedure/ incision	9/5/12
Time of start of procedure/ incision	11:06
Procedure concluded date	9/5/12
Procedure concluded time	11:26
Delay Reason	
Surgical Pause completed?	
Gestation (in weeks)	40.1
Presentation	Cephalic
Position	Direct Occipito Anterior
Liquor colour	Clear
Procedure	Emergency LUSCS
Findings	Live baby. Partial abruption about 200mls of Retroplacenta clot Cord PH normal
Delivery Indication	Abruption
Obstetrician	Dr Johnson O Ogunyale
Grade	Staff Grade
Consultant present	Dr S Rane
Assistant	Dr Juliana J Moni
Anaesthetist	
Type of Anaesthetic	General
Operation Note	Cleaned and Draped. Suprapubic skin incision. Transverse lower segment Uterine incision. Live baby delivered cephalic and manually in good condition. Placenta delivered by CCT. about 200mls Retropalcenta clotts Uterus cleaned inside with dry gauze. Uterus closed in 2 layers with polysorb Rectus sheath closed with polysorb Skin closed subcut with vicryl

Operation note

Additional Procedures	
Antacids prior to surgery	
Other antacid	
Prophylactic antibiotics given at inc	Yes
Time antibiotics given (hh:mm)	
Type of Antibiotic	Cefuroxime 1.5g
Sutures used	Vicryl
Swabs, Instruments and needles cc	Yes
Packs used?	No
Tubes normal?	Yes
Tubes abnormal	
Ovaries normal?	Yes
Ovaries abnormal	
Uterus normal?	Yes
Uterus abnormal	
Blood Loss	1000mls
Colour of urine draining via cathete	Urine Clear
Vaginal toilet performed?	Yes
Lochia	
Is an Oxytocic infusion required	Yes
Foley Catheter	Yes
Duration of Catheter	
Are phrophylactic antibiotics requir	
Prophylactic Antibiotic Details	
Thromboprophylaxis prescribed	Yes
Observations	Routine
Analgesics	
Routine FBC	Yes
Routine FBC Details	Tomorrow 6/9/12
Is DATIX required & completed?	
Create User/Date/Time	Dr Johnson Ogunyale - 05/09/2012 - 11:45
Last Update User/Date/Time	Dr Johnson Ogunyale - 05/09/2012 - 11:45
**** Archive Data ****	
Operation Performed	
Obstetrician Grade	
Operative Delivery Indication	

Mother

UHPI Number	CHI Number	First Forename	Surname	Date of Birth
800325165E	2305821425	Gillian	McAteer	5/23/82

Daily P/N Maternal Checks

No. of days postnatal	
Temperature check	37
Respirations	14
Pulse	84
Systolic BP	118
Diastolic BP	60
Lochia	Red/Pink minimal odourless
Fundus - involuting	
Fundus	
Fundus - other observations	
Type of Feeding	Mixed Feeding
Breasts	Comfortable
Management	Wishes to breast feed - baby cool initially + Gillian too sore to feed - cup feed x2
Perineum	
Wound	
General wellbeing & pain assessment	
Adequate analgesia	
Sutures to be removed	
Have sutures been removed	
Legs	Oedema mild
Mobility exercises & prevention of clots explained	
Revised Thrombosis Risk	High Risk
LMWH Required	
Passed urine post delivery	
PU problems	
Bowels Moved	No
Haemorrhoids problem	
Problem controlling bowels?	
Pelvic floor exercises discussed?	
Pelvic floor problems?	
FBC test	
Postnatal HB last taken	
Summary of Assessment & Care	Comfortable - tolerating fluids + diet Obs stable Catheter in situ - diuresis good Wound dressing in situ Awaiting FBC result prior to stopping IV fluids

Daily P/N Maternal Checks

MW Countersigning StM signature	
Create User/Date/Time	Karen Nattan - 05/09/2012 - 18:11
Last Update User/Date/Time	Karen Nattan - 05/09/2012 - 18:11
**** Archive Data ****	
Retaining urine	
Catheter inserted	
Catheter in situ	
Catheter removed	
Treatment required - Bowels	
Treatment required - Haemorrhoids	
General wellbeing and pain assessment	

Daily P/N Maternal Checks

No. of days postnatal	3
Temperature check	36.4
Respirations	14
Pulse	84
Systolic BP	106
Diastolic BP	63
Lochia	Red/Pink minimal odourless
Fundus - involuting	2 cm below umbilicus
Fundus	Central
Fundus - other observations	Firm
Type of Feeding	Mixed Feeding
Breasts	Comfortable
Management	
Perineum	
Wound	Clean and dry
General wellbeing & pain assessment	Feels well. Analgesia as kardex effective.
Adequate analgesia	
Sutures to be removed	No
Have sutures been removed	
Legs	Oedema Moderate
Mobility exercises & prevention of clots explained	
Revised Thrombosis Risk	Moderate Risk
LMWH Required	
Passed urine post delivery	Yes
PU problems	No
Bowels Moved	No
Haemorrhoids problem	No
Problem controlling bowels?	
Pelvic floor exercises discussed?	
Pelvic floor problems?	
FBC test	Yes
Postnatal HB last taken	9/7/12
Summary of Assessment & Care	Routine post natal care. FBC taken today. Assist with feeding.
MW Countersigning StM signature	
Create User/Date/Time	Janice McPherson - 07/09/2012 - 10:33
Last Update User/Date/Time	Janice McPherson - 07/09/2012 - 10:33

Daily P/N Maternal Checks

**** Archive Data ****	
Retaining urine	
Catheter inserted	
Catheter in situ	
Catheter removed	
Treatment required - Bowels	
Treatment required - Haemorrhoids	
General wellbeing and pain assessment	

Daily P/N Maternal Checks

No. of days postnatal	4
Temperature check	36
Respirations	
Pulse	80
Systolic BP	133
Diastolic BP	77
Lochia	Red/Pink minimal odourless
Fundus - involuting	2 cm below umbilicus
Fundus	Central
Fundus - other observations	Firm
Type of Feeding	Breast Feeding - Exclusive
Breasts	Comfortable
Management	
Perineum	
Wound	Clean and dry
General wellbeing & pain assessment	
Adequate analgesia	Yes
Sutures to be removed	No
Have sutures been removed	
Legs	Oedema mild
Mobility exercises & prevention of clots explained	Yes
Revised Thrombosis Risk	Moderate Risk
LMWH Required	
Passed urine post delivery	Yes
PU problems	No
Bowels Moved	Yes
Haemorrhoids problem	No
Problem controlling bowels?	No
Pelvic floor exercises discussed?	No
Pelvic floor problems?	No
FBC test	
Postnatal HB last taken	
Summary of Assessment & Care	
MW Countersigning StM signature	
Create User/Date/Time	M/W Lynne R Reid - 08/09/2012 - 10:43
Last Update User/Date/Time	M/W Lynne R Reid - 08/09/2012 - 10:43
****** Archive Data ******	

Daily P/N Maternal Checks

Retaining urine	
Catheter inserted	
Catheter in situ	
Catheter removed	
Treatment required - Bowels	
Treatment required - Haemorrhoids	
General wellbeing and pain assessment	

Daily P/N Maternal Checks

No. of days postnatal	5
Temperature check	36
Respirations	
Pulse	83
Systolic BP	117
Diastolic BP	61
Lochia	Average
Fundus - involuting	2 cm below umbilicus
Fundus	Central
Fundus - other observations	Firm
Type of Feeding	Breast Feeding - Exclusive
Breasts	Comfortable
Management	feeding well.
Perineum	
Wound	Bruised
General wellbeing & pain assessment	wound clean and dry, small amount of bruising. disolvable stitches.
Adequate analgesia	Yes
Sutures to be removed	No
Have sutures been removed	
Legs	Oedema mild
Mobility exercises & prevention of clots explained	Yes
Revised Thrombosis Risk	High Risk
LMWH Required	
Passed urine post delivery	Yes
PU problems	No
Bowels Moved	Yes
Haemorrhoids problem	
Problem controlling bowels?	
Pelvic floor exercises discussed?	
Pelvic floor problems?	
FBC test	Yes
Postnatal HB last taken	9/7/12
Summary of Assessment & Care	feels well, would like home today.
MW Countersigning StM signature	
Create User/Date/Time	Alicia Brodie - 09/09/2012 - 09:26
Last Update User/Date/Time	Alicia Brodie - 09/09/2012 - 09:27
****** Archive Data ******	

Daily P/N Maternal Checks

Retaining urine	
Catheter inserted	
Catheter in situ	
Catheter removed	
Treatment required - Bowels	
Treatment required - Haemorrhoids	
General wellbeing and pain assessment	

Postnatal check lists

Handling my baby safely	Yes
Choosing nappies for my baby	Yes
Changing my baby's nappies	Yes
Caring for my baby's cord	Yes
A 'Top and Tail' wash/caring for my baby's skin	Yes
Bathing my baby	Yes
How to reduce the risk of cot death	Yes
Signs that my baby is well	Yes
Signs that my baby may be ill	Yes
Car safety and home safety	Yes
Registering the birth	Yes
Registering with a GP	Yes
Do you still have a copy of Ready Steady Baby	Yes
Positioning myself for breastfeeding	Yes
Positioning my baby for breastfeeding	Yes
Principles of good attachment	Yes
How to recognise my baby is feeding well	Yes
When my milk 'comes in'	Yes
Baby's needs - exclusive breastfeeding for around the 1st 6 months of life	Yes
Why dummies/teats should not be used	Yes
How to hand express my breast milk	Yes
Expressing breast milk - sterilising equipment	Yes
Expressing breast milk - safe storage	Yes
Signs that my baby is feeding well and thriving	Yes
Breastfeeding support in my community	Yes
Using bottled milk/disposable teats in the maternity unit	Yes
Importance of good hand hygiene	Yes
Sterilising equipment	Yes
Making a formula feed correctly and safely (following manufacturer's instruction)	Yes
Giving a formula feed correctly and safely	Yes
Choosing the right type of formula for my new baby (whey based)	Yes
Signs that my baby is feeding well and thriving (Bottle)	Yes
Baby's feeding and sleeping pattern for the first few days of life	Yes
Baby led feeding	Yes
Rooming in at the maternity unit	Yes

Postnatal check lists

Sharing a bed with my baby - risks discussed	Yes
Winding baby	Yes
Comments	experienced Mum.
MW Countersigning StM signature	
Create User/Date/Time	Alicia Brodie - 09/09/2012 -
Last Update User/Date/Time	Alicia Brodie - 09/09/2012 -

Postnatal Discharge checks

Thromboembolic prophylaxis	Yes
Irregular maternal antibodies	No
Details for irregular antibodies	
Anti D Needed	No
Anti D given	
Anti D batch number	
Rubella vaccine needed	No
Rubella vaccine given	
Is cervical smear due?	Yes
When is cervical smear due?	post natal
Risk of passive smoking to baby explained	Yes
Current smoker (no. per day)	10
Smoker during pregnancy	Yes
Date if stopped smoking	
Importance of healthy eating and maintaining a healthy weight discussed	Yes
Discussion details	
Is there an increased risk of P/N depression?	Yes
Contact made with Perimental Health Team?	No
6 week P/N check required?	Yes
Postnatal check arrangements	Mum to arrange with GP
Discharge medication	Yes
Discharge from community care	Yes
Date of discharge from community care	9/24/12
Handover to HV complete	Yes
Handover to HV details	Baby to HV 14.9.12
GIRFEC Lead professional (if relevant)	
Did the woman attend Antenatal classes?	No
Contraception/Sexual Health discussed?	Yes
Details	barrier discussed. Knows to speak to GP at 6 week check for more permanent contraception.
Contraceptive method chosen	
Other method chosen	
Contraception method given	
Other contraception given	
Reason not given	
Follow-up appt details	
Follow-up appt - other details	

Postnatal Discharge checks

CE discussed	Yes
CE discussion	see above
CE given	No
Reversible contraception discussed	
P/N Blood transfusion given?	No
Repeat Hb required?	Yes
Hb date due	9/26/12
Last Hb date taken	9/7/12
Last Hb result	95
Renal tract dilatation	
Details for Renal tract dilatation	
Mother Infection	
Details for Mother infection	
Underwent routine AN screening	Yes
Details for AN screening	
Pelvic Floor	No
Pelvic Floor details	
Passing Urine	No
Passing Urine details	
Bowel Function	No
Bowel Function details	
Breasts	No
Breasts details	
Perineum/Abdomen	Yes
Perineum/Abdomen details	Abdominal wound infection being treated
Were any signs of a wound infection detected?	
Date infection identified	
Involves only skin and subcutaneous tissue of the incision	
Please select all of the symptoms applicable	
Lochia/Menstruation	No
Lochia/Menstruation details	
Further contraception discussion required	
Contraceptive method given.	
Other contraception	
Reason not given.	
Follow-up appt details.	
Follow-up appt - other details.	
Sterilisation After Delivery	None

Postnatal Discharge checks

Diabetes- SMR02	No
Additional info for Mother & Baby	experienced Mum. 2.10.12 Mum not discharged until 19 days postnatal because of wound infection. Antibiotics started Day 8 and swab taken. Swab result indicated bacteroides so further antibiotics given. Wound check 24.9.12 shows good healing. No further visits. BP 130/80
M/W countersigning STM	
Create User/Date/Time	Alicia Brodie - 09/09/2012 - 11:16
Last Update User/Date/Time	Vanda S Fraser - 02/10/2012 - 16:30
**** Archive Data ****	
Postnatal infection	
Oral contraceptives discussed	
Barrier contraceptives discussed	
Feeding at discharge from Hospital	
Baby-1 Discharged To	
Health Visitor Base baby is transferred to	
Baby-2 Discharged To	
Baby-3 Discharged To	
BCG vaccination given	
Feeding at discharge from Community Care	
Baby discharge medication (please list medications)	
Baby first medical check	
Hepatitis B vaccination needed?	
Hepatitis B vaccination given	
Reason for Hep B vaccine	
Was HBIG given to baby?	
Date HBIG given	
Vitamin K 2nd oral dose arranged	
Vitamin K 2nd oral dose date	
Discharge medication details (please list medications)	

McAteer, Gillian CHI - 2305821425

Date	Time	User	Occupation	Notes
9/5/12	11:39 AM	Karen Nattan	Midwife	Written in retrospect "Emergency call from A+E - Major APH - obstetricians in attendance " Code 1 Em C/S 1100 transferred directly to theatre - USS confirmed FH present " VE + catheterisation by Dr S Zaher" 1107 Knife to skin 1108 Live Girl - Cried immediately - Paeds in attendance - No resus required Apgars 9+9 Cord PH 7.340 A 7.355V BE -2.2 Bwgt 2720g
9/5/12	11:57 AM	Karen Nattan	Midwife	Placenta sent to pathology
9/5/12	1:14 PM	Karen Nattan	Midwife	Still in theatre recovery baby cool T35.8 Breast feed attempted but Gillian too sore - cup feed given with consent 15ml Aptamil
9/5/12	1:35 PM	Karen Nattan	Midwife	Back to room 1 Obs stable - BP 150/90 Good effect from analgesia Urine output 40ml in past hour IV syntocinon 40u in progress at 125ml/hr minimal lochia - slight spotting on wound dressing
9/5/12	3:11 PM	Karen Nattan	Midwife	"Obs stable - diuresis good " IV syntocinon continues TED stockings fitted as prescribed "For FBC @1700 " Dalteparin prescribed for 1800
9/5/12	3:39 PM	Karen Nattan	Midwife	Syntocinon infusion complete Catheter on to free drainage
9/5/12	5:09 PM	Karen Nattan	Midwife	Remains stable "Lochia minimal " No further wound soakage Obs now 2hrly "FBC to lab " Bed bathed - has managed light diet
9/5/12	6:39 PM	Karen Nattan	Midwife	Hb 103g d/l - Dalteparin given as prescribed Babys temp now 36.9A Has fixed and sucked well at breast Mum and baby fit for transfer to postnatal ward

9/5/12	7:04 PM	Karen Nattan	Midwife	IV fluids discontinued
9/5/12	7:40 PM	Leigh-Ann Gallagher	Midwife	"19.30-care taken over by S/M L.Gallagher Gillian comfortable at present observations stable as recorded on SEWS chart awaiting transfer to ward 11 once visiting time finishes "
9/5/12	11:00 PM	Dr Sunit M Rane	Consultant	SMR R/V A&E 2222 CALL ATTENDED- EMERGENCY IN A&E- NO FURTHER INFORMATION ON BLEEP TERM PREGNANCY HEAVY BLEED PV- APPROX 500MLS CONSCIOUS- NOT ABLE TO ASSESS FETAL WELLBEING IN A&E- NO SONIC AID AND NO USS MACHINE FLUID RESUS COMMENCED IN A&E- TRANSFER TO LW OT IN LW OT USS: CEPHALIC FH+ WITH DECELERATION SEEN ON USS VE: CERVIX 1 CM DILATED FOR LSCS UNDER GA EMERG LSCS BY DR JOHNSON -ABRUPTION, WITH 200MLS RETROPLACENTAL CLOT - BABY ALIVE AND WELL TO RESUS - BLOOD LOSS 1000 MLS
9/6/12	1:04 AM	Doris Gardner	Midwife	written in retrospect due to ward activity. sews score 0. t- 36.7 p- 68 b/p 109/ 58. mimimal soakage to wound dressing . lochia average. diuresis good. tolerating fluid and light diet. analgesia given as charted. assistance given with breast feeding. very tired. baby given 0.6mls of ebm and a small formula cup feed at mums request
9/6/12	7:15 AM	Doris Gardner	Midwife	sews score remains 0 this morning. no soakage towound dressing . lochia average. diuresis very good. keen to have src removed. aware of voiding policy. assistance given with breast feeding
9/6/12	4:29 PM	M/W Emma Campbell	Midwife	"APOLOGIES AS WRITTEN IN RETROSPECT DUE TO HIGH LEVELS OF WARD ACTIVITY " Since first thing this morning Gillian has struggled to get on top of her pain Initially was given oromorph which had good effect then once reviewed by Anaesthetis staff had a stat dose of Diclofenac which again seemed to work Managed to pass first void since catheter out @ 110 350mls on comode as to sore to get up to toilet . However second sample Gillian managed to get up and walk to toilet 500mls passed therefore voiding policy completed, Lochia is minimal she has not managed up into shower as yet but will try after visiting.
9/6/12	7:29 PM	M/W Emma Campbell	Midwife	@ 1800 "Gillian is better this evening pain has settled and analgesia now taking good effect " "Maternal obs - MP 86 temp 36.4 Bp 119/63 Resps 16 Sats 96% on air " "also continues to mobolise well having some difficulties with feeding today apologies given as I have not been able to give alot off assistance due to ward activity but Gillian is happy at present and knows to buzz for assistance with feeding if required "
9/6/12	9:27 PM	Elizabeth Fleming	Midwife	20.55 Gillian tried to breastfeed baby with assisstance, baby would not fix or suck, Gillian happy for baby to have a formula topup by bottle.Gillian shown how to use medellla pump.Plan to try baby at breast in 3 hours and topup if neccessary.
9/7/12	7:08 AM	Denise Findlay	Midwife	"0630 Gillian has fed 3-4hourly as planned baby tried at the breast each feed, but not sustaining sucking.EBM and formula top ups given . "
9/7/12	12:16 PM	Janice McPherson	Midwife	WRITTEN IN RETROSPECT. "Nursery Nurse noted at baby's daily check this am that feed chart had not been updated overnight. On talking

				to Gillian she stated that baby had not fed overnight. I advised her that we had been handed over from night staff that baby had been feeding 3-4 hrly overnight (and this is also documented on TRAK), and although had tried at breast would not suck therefore ahd been toppe up. Gillian disputes this and says the baby only had the small amounts of EBM she had expressed. Gillian stated that she tried the baby with formula from the bottle but baby would not take it. Gillian did not buzz staff to let them know this. " "I have spoken to some members of staff who were on duty overnight and they assure me that baby was fed overnight. " "I have apologised to Gillian for any possible mix up overnight and have reiterated the feeding plan, as before, to her for over the day. Try 3-4hrly breast feeds, if baby does not fix and feed to express and topup with EBM/ formula. Gillian happy with this plan. I have suggested to Gillian that she should fill in the feed chart to prevent any further misunderstandings. Gillian agrees to this. " "I have spoken to Melissa Kallat who will see Gillian and advise her where necessary. " "Baby did not fix and feed at breast this am therefore baby topped up with EBM/formula by cup. "
9/7/12	2:22 PM	Janice McPherson	Midwife	"Gillian assisted to put baby in skin to skin. Assistance given with baby at breast. Baby initially a bit more awake. Fixed and had a few sucks on a few occassions. Tried laid back position and rugby ball position. Baby has a few sucks then pushes nipple back out with tongue. " "Mum expressed 5 mls EBM and this given to baby by cup. Mum shown how to cup feed to enable her to cup feed baby next time. " "Melissa Kallat in to see Gillian and took over after 5mls EBM given as baby appeared more awake therefore baby was to be tried at breast again. "
9/7/12	2:23 PM	Janice McPherson	Midwife	"Hb 95g/dl today therefore SHO asked to prescribe ferrous sulphate. " "Gillian well otherwise. " "Analgesia as kardex. " "New TED stockings given as previous ones very blood stained. "
9/7/12	2:41 PM	Janice McPherson	Midwife	"Ticklist and leaflets given. "
9/7/12	3:12 PM	Melissa Kallat (do not use)		"I have spent time today with Gillian amd baby Luci reviewing positioning & atachment. Gillian is able to position baby well & we used cradle hold & 'laid back' postions to encourage Luci to feed. She opens her mouth widely but is reluctant to suck effectively. Plan has been agreed to try baby to the breast first,but if she does not attach & suck then to offer expressed breast milk via cup & only if baby requires more , to offer formula via cup. I supervised Gillian cup feeding & she managed well. Infomation sheet given. We decided that Gillian would express again after the afternoon visiting. "
9/7/12	4:25 PM	Janice McPherson	Midwife	"Gillian buzzed. Had managed to get baby onto breast and baby was feeding well. Came off after a few minutes but was still rooting and looking to feed. Babygro off and baby latched back onto breast and feeding well. I will check baby again shortly to see how long she fed for. Gillian delighted. "
9/7/12	5:31 PM	Janice McPherson	Midwife	"Gillian aware of baby's weight loss of 7%. Continue 3-4hrly breast feeds. Topups if required. "
9/7/12	6:32 PM	Janice McPherson	Midwife	"Analgesia and dalteparin as kardex. " "Wishes to try baby at breast again prior to visiting. "
9/8/12	12:29 AM	Rebecca Kingon-Rouse	Health Visitor	Down to assist with breast feeding, plan as discussed earlier with SM E Fleming, to feed 3 hourly, skin to skin now prior to feed, and if baby not breast feeding earlier volume of ebm to be given. "Suggested to Gillian to put baby skin to skin however she has just fed baby 15mls of formula as baby had woken up early. Baby now fast asleep. Advised that she she should have buzzed us for assistance in putting baby to breast, Gillian indicates that it didnt occur to buzz for help. Discussed feeding methods at length and Gillian states that she does wish to breast feed, advised not to give any further formula top ups without discussing plan of feeding with staff if wishing to continue trying to breast feed. "

				Gillian wishing to try baby at breast in one hour, advised re skin to skin and to buzz for assistance. " "
9/8/12	12:56 AM	Elizabeth Fleming	Midwife	Written in retrospect: 21.00 Gillian has tried baby at breast but said baby has not fixed to feed.Baby given a formula topup, Gillian used medulla pump,, EBM in fridge.Plan to try baby at breast in 3 hours and topup if neccessary with EBM and/or formula. 22.00 Observations stable, SEWS score = 0.
9/8/12	2:40 AM	Elizabeth Fleming	Midwife	01.20 Gillian wakened to have skin to skin with baby. 01.30 Baby awake, tried at breast, both sitting up in bed and lying down on side, a few sucks taken whilst on side. 01.45 Topup of EBM given by cup (10ml) followed by 10ml of Aptamil given by cup. Gillian expressed with Medela pump, EBM put in fridge. Plan to waken baby at 04.45 and try feeding at 05.00, Gillian happy with this.
9/8/12	6:29 AM	Elizabeth Fleming	Midwife	Gillian has tried baby at breast 3 hourly overnight. 05.00 Baby had skin to skin. prior to trying baby at breast. baby attempted to attach but did not fix to feed. 05.30 Baby given 10ml of EBM, by cup, which was taken well.Attempted to give remainder of formula topup by cup and syringe, but baby would not take it. therefore Mum agreeable to baby having topup by teat, took this well. Mum has expressed 30ml, which is in fridge.
9/8/12	6:37 PM	M/W Lynne R Reid	Midwife	Gillian has been well today, breastfeeding is becoming established and baby has been feeding regularly and for sustained periods, initially with lots of support from midwifery staff. Maternal observations within normal range as per SEWS.
9/8/12	11:15 PM	Karen Auld	Midwife	Analgesia given as prescribed. Feels she is getting constipated Lactulose 10mls PO given. Observations stable as per SEWS. Minimal assistance with breast feeding
9/9/12	5:59 AM	Karen Auld	Midwife	Gillian needing minimal assistance with feeding overnight. Keen for discharge home today
9/9/12	10:06 AM	Eugene O Connor	Doctor	r/v for D/c "day 4 EMCS - for placental abruption 1000mls " Feeling well today up mobilising "PU'd, bowels moved, " "Min pinkish lochia, " OBS- BP 117/61, pulse 83, sats 98% RA, temp 36.2 O/E appears well abdo soft, non tender Fundus - firm , 2FB below umbilicus , wound dry and healing well PLAN discharged on FeSO4
9/9/12	11:03 AM	Alicia Brodie		Daily check satisfactory as charted. Seen by SHO for review and happy with patient.
9/9/12	3:18 PM	Alicia Brodie		1330. Discharged home well. Knows to contact us if any worries.
		Kirsty MacQueen		

Case Notes

University Hospitals Division

Princess Alexandra Eye Pavilion
Outpatient Department
Chalmers Strect
Edinburgh
EH3 9HA

NHS Lothian

Department of Ophthalmology

Dr McNutt
Simpson Medical Group
Bathgatc Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created 30/11/2021
Date Authorised
Date/Time Printed 30/11/2021 13:10
Our Ref 800325165E
CHI 2305821425

Outpatient Clinic Letter

Ophthalmology

Patient:	Miss Gillian McAtcer	**UHPI:**	800325165E
	Flat 1 Carron Court Bathgate EH48 2QF	**Date of Birth:**	23/05/1982
		Attendance Date:	28/11/2021
Clinic Code:	OP/ARCONCALL		
Specialty:	Ophthalmology		
Consultant:	PAEP Consultants ARC		

Dear Dr McNutt,

DIAGNOSIS:
Blunt trauma uveitis.

VISUAL ACUITY: (unaidcd)
Right eye 6/9, improving to 6/6 with pinhole
Left eye 6/5

INTRAOCULAR PRESSURE: (Icare)
Right eye 11mmHg
Left eye 20mmHg

OCULAR MEDICATION:
Dexamethasone 0.1%, 1 drop to thc right eye 4 times a day for 1 week, then 3 times a day for 1 week, then twice a day for one week, then once a day for 1 week.
Cyclopentolate 1%, 1 drop to the right eye 3 times a day for 7 days.

FOLLOW UP:
In St John's Hospital in 2-3 wecks.

COMMENT:

University Hospitals Division

Princess Alexandra Eye Pavilion
Outpatient Department
Chalmers Street
Edinburgh
EH3 9HA

NHS Lothian

I saw this patient as part of my on-call with Dr Schmoll today.

She was attacked approximately 1 week ago and had significant bruising and swelling around her right eye which has now settled. However, since then she has had increasing pain, photophobia and hepiphora. She also feels her eye is red compared to the other eye and her vision is mildly reduced. She has no diplopia and no shadows or curtains suggestive of a retinal detachment.

On examination there is mild bruising and swelling still evident over the right eye and the conjunctiva of the right eyc is injected. Both corneas appear clear. The anterior chamber of the right eye is deep with approximately 20 cells per high powered field and no hyphema or odious blood. Examination of the posterior reveals no commotio and no inflammation of the vitreous, no vitreous haemorrhage and I was unable to identify any breaks or tears, therc was also no tobacco dust in the vitreous.

These findings are in keeping with a blunt trauma uveitis following her assault. Accordingly I have started her on a steroid reducing regime as above and dilating drops. She will be reviewed in St. John's in approximately 2-3 weeks.

Yours sincercly

DR K WILSON
STR

Cc:
Dr Jacob Philip Sakin
Emergency Dept
St. John's Hospital
LIVINGSTON
EH54 6PP

Cc: Paticnt

KW/JD

07900 638 414 G.P. visit Wed

SJ 325165E F 23/05/82 MCATEER GILLIAN 1 CARLYLE TERRACE BATHGATE EH48 1BX	Consultant TRC / Parity 1+0 Date 19.10.04 / Time 04:52 Type SVD / Reason if ins. Blood Loss 400ml / Perineum Intact Placenta Complete / Membranes Complete Mat blood grp O POS / Gestation 42 wks Baby CRN 4240213M / Gender female Apgar 9:9 / Weight 3280g
Baby Resuscitation Y/N	

POSTNATAL WARD ORIENTATION

TONI

Date	YES	NO		YES	NO
Welcome Book			Baby facilities		
Midwife Call System	✓		Baby clothes		
Location of light/radio	✓		Safety precautions		
Location of shower/toilet	✓		No Smoking policy		
Use of bidet			Changing baby on the bed		
Meal times/menus			Carrying baby around ward		
Security Precautions			Visiting times		
Leaving baby unattended			Out of hours visiting		

CARING FOR YOUR BABY

Do you feel happy with:	Date		Mother's Signature	Midwife's signature
Nappy changing		Y N		
Caring for the cord		Y N		
Bathing		Y N		
Feeding Baby Breast		Y N	Competent	G Cdgahay
Expressing		Y N	Mum	S/M
Sterilising baby equipment		Y N		
Feeding Baby Bottle		Y N		
Making formula feeds		Y N		

TRANSFER TO HOME & BEYOND

Date	Yes	No		Yes	No
Anti D Given		✓	Rubella Vaccine given		✓
Discharge script	✓		Bounty pack	✓	
HB 11.8 g/L (20/10/04	✓		Registration card to parents	✓	
Discharge address/phone no correct	✓		6 week PN check	✓	
Paediatric check (Dr.... Misra....)	✓	Date 20/10/04	Obstetric Check (Dr.....)	N/A	Date
OFC 34.5cms	✓		CHI form	✓	
Length 50cm	✓				
Guthrie done		Date	Guthrie consent		
Namebands checked/correct	Midwives signature G Cdgahay S/M		Mother's signature C McAteer		

LEAFLETS DISTRIBUTED/DISCUSSED

				HANDOVER/DATE	SIGNATURE
Discharge info	✓	Equipment sterilisatioo	✓		
B/F information	✓	Car safety	✓	MIDWIFE	
A/F information	✓	Contraceptioo	✓	HEALTH VISITOR	
Prevention of SIDS	✓	Physio leaflet	✓		

Postnatal Visits 0 1 2 3 4 5 6 7 8 9 10

Sat phone request PKL

Monitor

THURS

WLT 426

WEST LOTHIAN HEALTHCARE NHS TRUST

GENERAL PRACTITIONER AND COMMUNITY MIDWIFERY DISCHARGE TRANSFER FORM

.....District

325165
Gilla McAteer 23/5/82
1 Carlyle Terrace
Bathgate EH48 1BX

Age 20 Marital Status

Hospital St John's Hospital Ward 11 Date of Discharge 20/10/04

Home Address G.P. Dr Williamson

Address Youngs Park

Tel No: 01506 [illegible] P. Ward

Temp. Address

Tel No: Tel No: [illegible]

Parity 1+0 No. of Living Children 1 Comments

Early Discharge Booked/Unbooked Blood Group O Rh+

Ante-natal complications

MOTHER

Date of delivery 19/10/04 Time 10:32 Length of labour 5hrs 15 mins Spontaneous/Induced

Method of delivery: Spontaneous SVD Other Indication Prolonged 2nd stage,

Complications Blood loss 400 mls

Placenta Complete Membranes Complete, Intact

State of perineum on discharge Intact - Comfortable Hb 118g/l

Treatment and/or complications Nil except for analgesia given

Almevax: Immune Anti-D Immunoglobulin: N/A

BABY

Sex Male Apgar score 9-9 Gestation T+11

Weight at birth 3210 OFC 34.5cms Length 50cms Cord Clamp Severed Guthrie Test: YES/NO

Weight on discharge 3280g Feeding Breast

Any special problems

Treatment and/or complications Passed hearing test in L ear

M 'W's Signature G Colquhoun S/M (Student)

EARLY DISCHARGE Has G.P. been telephoned? YES/NO By whom?

Testes Descended L. YES/NO

Testes Descended R. YES/NO

Hips L. NORMAL/ABNORMAL

Hips R. NORMAL/ABNORMAL

Signature

SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE

BATHGATE EH48 1BX

Affix Label

Use BLACK ink/RED ink for abnormal findings

DATE	19/10/04	20/10/04	21/10/04	23.10.04	25.10.4
Days in Postnatal		(2)	(3)	(5)	(7)
Fundal height & Abdominal Palpation		Fundus firm, central @2/3	Firm @ 4/5 fingerbreadths	Phoned anxious re feeding	S+T (·)
PV loss/lochia		Pink, reducing,	Reducing	Bad night last night	RBO
Breasts		Full, comfortable	comfortable	supplied gradually filling not feeding	Lactating well.
Perineum		Comfortable	comfy	Advice re feeding Baby BF sides	comfy.
Abdominal wound		✓	Mood stable just now	Generally Fixing Baby on well	AFTER PAINS.
Legs		NAD	aching/tight	Baby herself	muscular.
Oedema		NIL	✓	check not done	+ oedem ankles.
Urine		PU Good volumes	PU	- as concentrated on feeding	PU.
Bowels		BNO	NBO	Feeling well	B.O. SMOOTH.
Temperature, Pulse & BP		T: 35.6 P: 78 BP: 120/76.	365 120/80.	Otherwise	T 36.8
HB		* 118g/l.	—		
PRINT NAME Signature Designation		Hamdick. Midwife S/M	C Imrie V Fraser	G.M.Cun F.M.Midwife	A-G (Colquhoun)

20/10/04 DIC to routine PIN care ic advice & script for analgesia.

G. Colquhoun S/M (COLQUHOUN)

23.10.04 6pm - Phoned to check on progress with feeding - improved as day had gone on. will phone if needs visit before Monday G.M.Cun

Affix Label

Use BLACK ink/RED ink for abnormal findings

DATE	28.10.04				
Days in Postnatal	(10)				
Fundal height & Abdominal Palpation	Just palpable				
PV loss/lochia	minimal				
Breasts	comfy filling and supplying comfy				
Perineum					
Abdominal wound Mood	No trace to feel low tired				
Legs	no pain				
Oedema	—				
Urine	PU				
Bowels	BO				
Temperature, Pulse & BP	All checks normal				
HB	—				
PRINT NAME Signature Designation	V-Fraser				

28.10. (10) Final Visit — Breastfeeding - discouraged as baby feeding low 2 hours or a little and minimal wet between. Feeding observed, consider strategies to increase supply, discussed low down, delay. Acknowledged difficulties and might have to sustain this commitment.

TOTHV

Baby CRN Mother's CRN Mother's Name

Use BLACK ink/RED ink for abnormal findings

DATE	25-10-4	26-10-4	28-10-04		
Age in days	(7)	(8)	(10)		
Eyes	CLEAR	B/L	bright/alert		
Mouth	MOIST	Support	clear		
Head	SATIS	visit. none	—		
Skin/Colour	PINK	Comfort holding	Pink.		
Cord	ON DRY.	feeding	off		
Namebands	365		365		
Temperature			U		
Weight			— HV to follow 32(0)		
Urine	wet.	P.U.	P.U +++		
Stool- colour & Consistency	NBO. 5 DAYS BOWEL SOUNDS	NBO. 6 DAYS DISCUSSED PASSING	NBO - smeary around darks yellow.		
Guthrie	PASSED ME. A. EARLY	LOTS OF STATUS.	—		
Feeding- method & comments	BF on demand.		breast frequent.		
PRINT NAME Signature Designation	AT-B (TOWARD)	AT-B (TOWARD)	V. Raven		

(7) needed feeding support - actually latched on well with no problems this time. AT-

(10) No stools for 7 days. Urine ++, P.U +++. Chat with GP's who are not concerned at this time. HV will be notified. V. Raven RM

Baby CRN 424023M Mother's CRN 325165E Mother's Name Gillian McAteer
Use BLACK ink/RED ink for abnormal findings

DATE	19.10.04	20/10/04	21.10.04	22.10.04	23.10.04
Age in days	1	(2)	(3)	(4)	(5)
Eyes	clean + clear.	clean + clear	clean.	clear	clear
Mouth	clean + moist.	clean + moist	clean	clear	clean moist
Head	Slight moulding	Slight moulding	✓		
Skin/Colour	Pink	Pink	pink	pink	pink
Cord	on + secure.	clamp secure	clamp removed	off	on day
Namebands	x2 correct	x2 correct	✓		
Temperature	36.3 ↑36.8°C	↑36.9°	36.9	36.7	36.6
Weight	3280g	—			
Urine	NPU.	pu.	Pu - urates	Pu	Pu
Stool- colour & Consistency		mec.	Changing stool	NBO	BO
Guthrie			✓		
Feeding- method & comments	Breast.	Breast feeding.	Breast frequent feeds	Brx Frequent	BF frequently
PRINT NAME Signature Designation	E Allan	Morag Brash	Kim Kaser V. Fraser	A. Russell	

ANTENATAL

Name GILLIAN MCATEER	Special Features	Recommendations
Age 22yrs.	BMI 36	
Height 5'4"		
Parity 1+0		
Blood Group		
Ultrasound		
Date 29.3.04.		
CRL/BPD		
Final EDD		

Date	Wks	Weight (Kg)	Urine P	Urine S	BP	Fundus (cm) / Girth	Pres.	Level	FHH	Hb / Rhesus	Oed
24-2-04	7+4	96	MSU		RR/80	Not palpated					

HOSPITAL: ST JOHNS

LOTHIAN AND BORDERS AREAS
MATERNITY SERVICES ANTENATAL CARD

ANTENATAL No.

Case Ref. No. 325165
Consultant DR. COOPER.
GP's Name DR HOLDEN
Address SIMPSON PRAC. BATHGATE.
Post Code 654444.
Tel No MIDWIVES-651828
Practice No. VANDA FRASER. ANN RUSSELL, ANNE EDWARDS

Date of Birth 23/05/82
Age 22
M (S) DLV / SEP / WID
Maiden Name —
Date of Marriage —
Religion —
Occupation Mum.
Date of Leaving

Surname
SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX
CHI Number 079006 3841 4.
[redacted]
Date of 1st Appt. (G.P.)

OBSTETRIC HISTORY

DATE	Wks	Place	Method	Wt	Sex	Complications	Feeding	Outcome
9-05-03	42	SSH	SVD	2880	F	NONE - Induction post-dates - PND	BR x 2/7	A R W
						[redacted]		

BOOKING EXAMINATION

Data LMP 01-01-04 (Certain / Uncertain) Bleeding since LMP NO
EDD 1 08-10-04 2

Cycle: Regular / Irregular > 31 days
Contraceptive:
Date Stopped:
IUCD in Situ:

FAMILY HISTORY

		Relevant Details:
Twins	No/Yes	
TB	No/Yes	
Diabetes	No/Yes	Grandmother IDDM FATHER
Hypertension	No/Yes	
Hereditary Disease	No/Yes	
Hearing Disorders	No/Yes	
Other	NO abnormalities	

MEDICAL HISTORY

		Relevant Details:
Operations	No/Yes	~~Bowels~~ Intussusception surgery at 8 months
G.A. - Side Effects	No/Yes	
Blood Transfusions	No/Yes	
Significant Illnesses	No/Yes	1) Depression Counselling weekly.
Medication	No/Yes	2) Constipation - chronic
Allergies	No/Yes	
Infartility Clinic	No/Yes	
Accidents/Fractures	No/Yes	

Rubella Status: Immune/Not Known

SOCIAL HISTORY Support from mum, Unplanned pregnancy. Smoking - 12. /day
Living on flat with 9 month old daughter. Alcohol — 0
Drugs — NO

CLINICAL EXAMINATION

Relavant Details:

AS	☐
Teeth	☐
RS	☐
Breasts	☐
CVS	☐
VV's	☐
CNS	☐
Haemorrhoids	☐
Pelvic Exam.	☐

INVESTIGATIONS

TEST	DATE	RESULT
Hb	24.2.04	12.4g
Blood Group		O
Rhesus		Pos.
TPHA		NEG
Rubella Abs		IMMUNE
Uricult/MSU		NSB
Smear		
Other		

Patient Care Proposed by G.P.: Consultant / Shared / Full G.P.
G.P. Post-Natal / Early Discharge / G.P./F.P. Advice

Signed ..... G.P.

Agreed ..... Cons.

Perentcraft : Hospital / Community

Social Referral : Home Help / Dietician

TEST	RESULT
HIV	NEG
HEPB	NEG

West Lothian Healthcare Division

St. John's Hospital at Howden
Howden Road West
Livingston
West Lothian EH54 6PP
Telephone 01506 419666
www.show.scot.nhs.uk/wlt

NHS Lothian

Stop for Life Project
Smoking Cessation Clinic
OUR REF: AF/LS
DATE: 24th September 2004
EXT: 3291
CLIENT NO: 0104/04/O

Dr Holden
Simpson Medical Practice
Bathgate Primary Care Centre

Dear Dr Holden,

RE: Gillian MacTeer, 1 Carlyle Terrace, Bathgate EH48
D.O.B: 23.05.82

Further to my letter of 27th July 2004, Gillian has managed to stop smoking for up to 10 days on 2 occasions since her Quit date of 28th July. When I saw her this week Gillian reported having relapsed and is smoking up to 10 cigarettes per day. I have advised her throughout not smoke and use nicotine replacement therapy.

We have discussed her motivation and Gillian has decided against a further Quit attempt until after delivery. She is happy to take part in the 'Stop for Life' follow-up programme and I will contact her again following delivery.

I have also reminded her not to use nicotine replacement therapy unsupervised while pregnant or breast-feeding.

Thank you once again for your help.

Yours sincerely,

Anne Finnie

Anne Finnie
Stop for Life Project Midwife
CC Vanda Fraser, Community Midwife

SIGNED BY
NO ACTION SCRIPT
29 SEP 2004
APPT NOTES TO G.P.
COMMENT TO VANDA
FILED BY

Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS
11/08/04

To whom it may concern,
This letter is written in order to support Gillian McAteer in her application for rehousing. Gillian is expecting her baby in October and will then have two infants under 18 months. It will be very difficult for her to manage up and down stairs etc. She would also prefer to be accommodated where she can have direct access to a garden.

Yours truly
Anne Edwards
Midwife
Newland Medical Practice

WLT 426

WEST LOTHIAN HEALTHCARE NHS TRUST

GENERAL PRACTITIONER AND COMMUNITY MIDWIFERY DISCHARGE TRANSFER FORM

West Lothian District

SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX

Age 29 Marital Status Single

Hospital St Johns Hospital Ward 11 Date of Discharge 20/10/04

Home Address [illegible] G.P. Dr Williamson

[illegible] Drive Address [illegible]

Tel. No: [illegible] Tel. No: [illegible]

Temp. Address

Tel. No: Tel. No:

Parity 1+0 No. of Living Children 1 Comments

Early Discharge Booked/Unbooked Blood Group O pos

Ante-natal complications

MOTHER

Date of delivery 19/10/04 Time 0132 Length of labour 5hrs 15/60 Spontaneous/Induced

Method of delivery: Spontaneous SVD Other Indication Prolonged 2nd stage

Complications Blood loss 450mls

Placenta Whole + complete Membranes Whole + complete

State of perineum on discharge Intact - Comfortable Hb 118g/l

Treatment and/or complications D/C script for analgesia given

Almevax: Immune Anti-D Immunoglobulin: N/A

BABY

Sex Girl Apgar score 9-9 Gestation T+11

Weight at birth 3740 OFC 34.5cms Length 50cms Cord Clamp Secure Guthrie Test: YES/NO

Weight on discharge 3280g Feeding Breast

Any special problems

Treatment and/or complications Passed hearing test

M 'W's Signature G Colquhoun S/N

EARLY DISCHARGE Has G.P. been telephoned? YES/NO By whom? June

Testes Descended L. YES/NO

Testes Descended R. YES/NO Sarah Hay

Hips L. NORMAL/ABNORMAL

Hips R. NORMAL/ABNORMAL

Signature

HOSPITAL: ST JOHNS

BOBS
LOTHIAN AND BORDERS AREAS
MATERNITY SERVICES ANTENATAL CARD

ANTENATAL No.: HOSP COPY

Case Ref. No. 325165
Consultant DR. COOPER.
GP's Name DR HOLDEN
Address SIMPSON PRAC. BATHGATE.
Post Code 654444.
Tel No MIDWIVES-651828
Practice No.
VANDA FRASER.
ANN RUSSELL, ANNE EDWARDS

Date of Birth 23/05/82
Age 22
M (S) DLV / SEP / WID
Maiden Name
Data of Marriage
Raligion
Occupation MUM.
Date of Leeving

Surnama

SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX

CHI Number 079006 38414
[redacted]
Date of 1st Appt. (G.P.)

OBSTETRIC HISTORY

DATE	Wks	Place	Method	Wt	Sex	Complications	Feeding	Outcome
9-05-03	42	SSH	SVD	2880	F	NONE - Induction Post-dates - PND	BR x 2/7	A R W
						[redacted]		

BOOKING EXAMINATION

Data — LMP 01-01-04 — (Certain) Uncertain — Bleeding since LMP NO — EDD 1 08-10-04 2 S 31)

Cycle: Regular / Irregular > 31 days
Contraceptive:
Data Stopped:
IUCD in Situ:

FAMILY HISTORY — Relevent Details:

Twins	No/(Yes)	
TB	(No)/Yes	
Diabetes	No/(Yes)	Grandmother IDDM
Hypertension	No/(Yes)	FATHER
Hereditary Disease	(No)/Yes	
Hearing Disorders	(No)/Yes	
Other	NO abnormalities	

MEDICAL HISTORY — Relevant Details:

Operations	No/(Yes)	~~Bowels~~ Intassception Surgery at 8 months
G.A. - Side Effects	(No)/Yes	
Blood Transfusions	(No)/Yes	(1) Depression
Significant Illnesses	No/(Yes)	Counselling weekly.
Medication	(No)/Yes	(2) Constipation - chronic
Allergies	(No)/Yes	
Infartility Clinic	(No)/Yes	
Accidents/Fractures	(No)/Yes	

Rubella Status: Immune/Not Known

SOCIAL HISTORY Support from mum, unplanned pregnancy. Living on/off with 9 month old daughter
(Smoking) - 12 /day
Alcohol - 0
Drugs - NO

CLINICAL EXAMINATION — Relevant Details:

AS	☐
Teeth	☐
RS	☐
Breasts	☐
CVS	☐
VV's	☐
CNS	☐
Haemorrhoids	☐
Pelvic Exam.	☐

INVESTIGATIONS

TEST	DATE	RESULT
Hb	24.2.04	12.9
Blood Group		O
Rhesus		Pos.
TPHA		NEG
Rubella Abs		IMMUNE
Uricult/MSU		NSB
Smear		
Other		

Patient Care Proposed by G.P.: Consultant (Shared) Full G.P.
(G.P. Post-Natal) Early Discharge G.P./F.P. Advice

Signed ..... G.P.

Agreed ..... Cons.

Parentcraft : Hospital / (Community)

Social Referral : Home Help / Dietician

TEST	RESULT
HIV	NEG
HEPB	NEG

ANTENATAL

Name GILLIAN MCATEER	Special Features	Recommendations
Age 22 yrs.	BMI 36	
Height 5'4"		
Parity 1+0		
Blood Group O POS		
Ultrasound		
Date 29.3.04.		
CRL/BPD		
Final EDD 8-10-04		

Date	Wks	Weight (Kg)	Urine P	Urine S	BP	Fundus (cm) / Girth	Pres.	Level	FHH	Hb / Rhesus	Oed
24-2-04	7+4	96	MSU		RR/80	Not palpated					
5/5/04	17+	94	–	–	110/70	17			✓		

DELIVERY		POST NATAL & PAEDIATRIC	
Special Features	Recommendations	Special Features	Recommendations

BMI 36

Comments	Weeks/Placa to return	Signature and Designation
Scan Booked 29/03/04		
Booking bloods with consent. Screening		(ATKINSON) D. Atkinson SIM
AFP 16 wks: Yes / No; GP / Hospital; Date		(FRASER) V. Fraser CMW
discussed. Mood stable at booking		
Well. AFP = consent.		

DELIVERY		POST NATAL & PAEDIATRIC	
Special Features	Recommendations	Special Features	Recommendations

BMI 36

Comments: Scan Booked 29/03/04	Weeks/Place to return	Signature and Designation
Booking bloods with consent. Screening		(ATKINSON) D. Atkinson SIM
AFP 16 wks: (Yes) / No — GP / Hospital — Data		(FRASER)
discussed. Mood stable at booking		V. Fraser CM

ST. JOHNS'S HOSPITAL
DAY ASSESSMENT UNIT

Date: 27/9/04.

Visit No: 2 (1st > Growth Scan)

SJ 325165E
MCATEER F 23/05/82
GILLIAN
1 CARLYLE TERRACE
BATHGATE
EH48 1BX

Parity: 1
Gestation: 38+3.
Date Consultant Informed:

Consultant: TKC.

Reason for Referral: ↓FM. Fell at the weekend. Checked by CMW today, otherwise appears well. Slight backache & dull lower abdominal ache over the past 7-10 days. ° regular contractions felt. °PV loss.

Tests requested:

Clinical Findings:

Other Investigations:

Palpation:

CTG: FH baseline 135 bpm good variability 5-15 bpm ½ accelerations ↑ 160 bpm 0 decelerations

Urinalysis: Occasional tightenings felt, not regular

BP: 1. 2. 3. 4. 5.

Blood Results: Hb: Plt: Urate:

Biophysical Profile:

Plan: Gillian reassured by CTG, felt plenty FM while CTG in situ. Otherwise no lasting aches or pains from fall. Occasional tightenings noted & shown, but not regular contractions as yet.

Follow up Arrangements: → RANC Advised to contact clm/Ward 10 if any concerns re FM or contact LW if labour establishes

Sign and print name:

LAITHEN slm

If Required:

Assessment By Obstetrician

History:

Findings:

Investigations:

Diagnosis and Management Plan:

Follow up Arrangements:

Sign and Print Name:

St. JOHN'S HOSPITAL at HOWDEN
DAY ASSESSMENT REFERRAL

Date: 13-9-04 Referred by: CM

SJ 325165E F 23/05/82 Parity: 1+0
MCATEER
GILLIAN
1 CARLYLE TERRACE Gestation: 36+3
BATHGATE EH48 1BX
Consultant: TKC

Reasons(s) for referral for Day Assessment (*please tick*)

- ☐ Hypertension
- ☐ Post-Dates
- ☐ Bad Obstetric History
- ☐ Multiple Pregnancy
- ☐ Other (*specify*) _____
- ☐ IUGR
- ☐ Weight loss
- ☐ Reduced Fetal Movement
- ☐ Potential diabetic

Tests being requested:

- ☐ Blood pressure profile
- ☐ Cardiotocograph
- ☐ Ultrasound profile
- ☐ Blood tests (*specify*) _____
- ☐ Kick chart
- ☐ Urine testing/MSSU

Plan for review after assessment complete:

- ☐ Medical staff:
- ☐ Midwifery staff
- ☐ Referring doctor/on-call registrar

Plan for follow-up (*assuming tests are normal*):

- ☐ Review at clinic
- ☐ Review for Day
- ☐ Arrange admission
- ☐ Date
- ☐ Assessment Date
- ☐ Date

Results

1.	Blood pressure	(1)	(2)	(3)	(4)
2.	Urine Testing:				
3.	Blood tests:	Hb	Plts	Urate	Other
4.	CTG:				
5.	Ultrasounds:				

Comments: HC & AC just below 50th centile
BPD & FL just above 5th centile
LV normal
Home → RAC

WLT 655

HOSPITAL: ST JOHNS

LOTHIAN AND BORDERS AREAS
MATERNITY SERVICES ANTENATAL CARD

ANTENATAL No.

Case Ref. No. 325165
Consultant DR. COOPER.
GP's Name DR HOLDEN
Address SIMPSON PRAC. BATHGATE.
Post Code 654444.
Tel No MIDWIVES-651828
Practice No.
ANN RUSSELL, ANNE EDWARDS, VANDA FRASER.

Data of Birth 23/05/82
Age 22
M / S / DIV / SEP / WID
Maiden Name
Data of Marriage
Religion
Occupation MUM
Date of Leaving

Surname
SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX
CHI Number 0790063 8414
[redacted]
Date of 1st Appt. (G.P.)

OBSTETRIC HISTORY

DATE	Wks	Place	Method	Wt	Sex	Complications	Feeding	Outcome
9-05-03	42	SSH	SVD	8lb0	F	~~NONE~~ - Induction	BF x 2/7	ARW
						post-dates - PND		
						[redacted]		

BOOKING EXAMINATION

Data
LMP 01-01-04
Certain / Uncertain
Bleeding since LMP NO
EDD 1 08-10-04 2 S=1

Cycle
Regular / Irregular > 31 days
Contraceptive:
Data Stopped:
IUCD in Situ:

FAMILY HISTORY — Relevant Details:

Twins	No/Yes	
TB	No/Yes	
Diabetes	No/Yes	Grandmother IDDM
Hypertension	No/Yes	FATHER
Hereditary Disease	No/Yes	
Hearing Disorders	No/Yes	
Other	NO abnormalities	

MEDICAL HISTORY — Relevant Details:

Operations	No/Yes	~~Bowels~~ Intussusception surgery at 8 months
G.A. - Side Effects	No/Yes	
Blood Transfusions	No/Yes	
Significant Illnesses	No/Yes	1) Depression Counselling weekly.
Medication	No/Yes	2) Constipation - chronic
Allergies	No/Yes	
Infartility Clinic	No/Yes	
Accidents/Fractures	No/Yes	

Rubella Status: Immune/Not Known

SOCIAL HISTORY Support from mum, Unplanned pregnancy. Smoking - 12 /day
Living on flat with 9 month old daughter. Alcohol - 0
Drugs - NO

CLINICAL EXAMINATION — Relevant Details:

AS	☐
Teeth	☐
RS	☐
Breasts	☐
CVS	☐
VV's	☐
CNS	☐
Haemorrhoids	☐
Vaginal Exam.	☐

INVESTIGATIONS

TEST	DATE	RESULT
Hb	24.2.04	12.9
Blood Group		O
Rhesus		Pos.
TPHA		NEG
Rubella Abs		IMMUNE
Uricult/MSU		NSB
Smear		
Other		

Antenatal Care Proposed by G.P.: Consultant / Shared / Full G.P.
Post-Natal Early Discharge G.P./F.P. Advice

Ian Cooper
..... G.P.
..... Cons.

Parentcraft : Hospital / Community
Social Referral : Home Help / Dietician

TEST	RESULT
HIV	NEG
HEPB	NEG

ANTENATAL

Name GILLIAN MCATEER	Special Features	Recommendations
Age 22yrs.	BMI 36	
Height 5'4"		
Parity 1+0		
Blood Group O POS		
Ultrasound		
Date 29.3.04. = 12+6.		
CRL/BPD 5=D		
Final EDD 8-10-04		

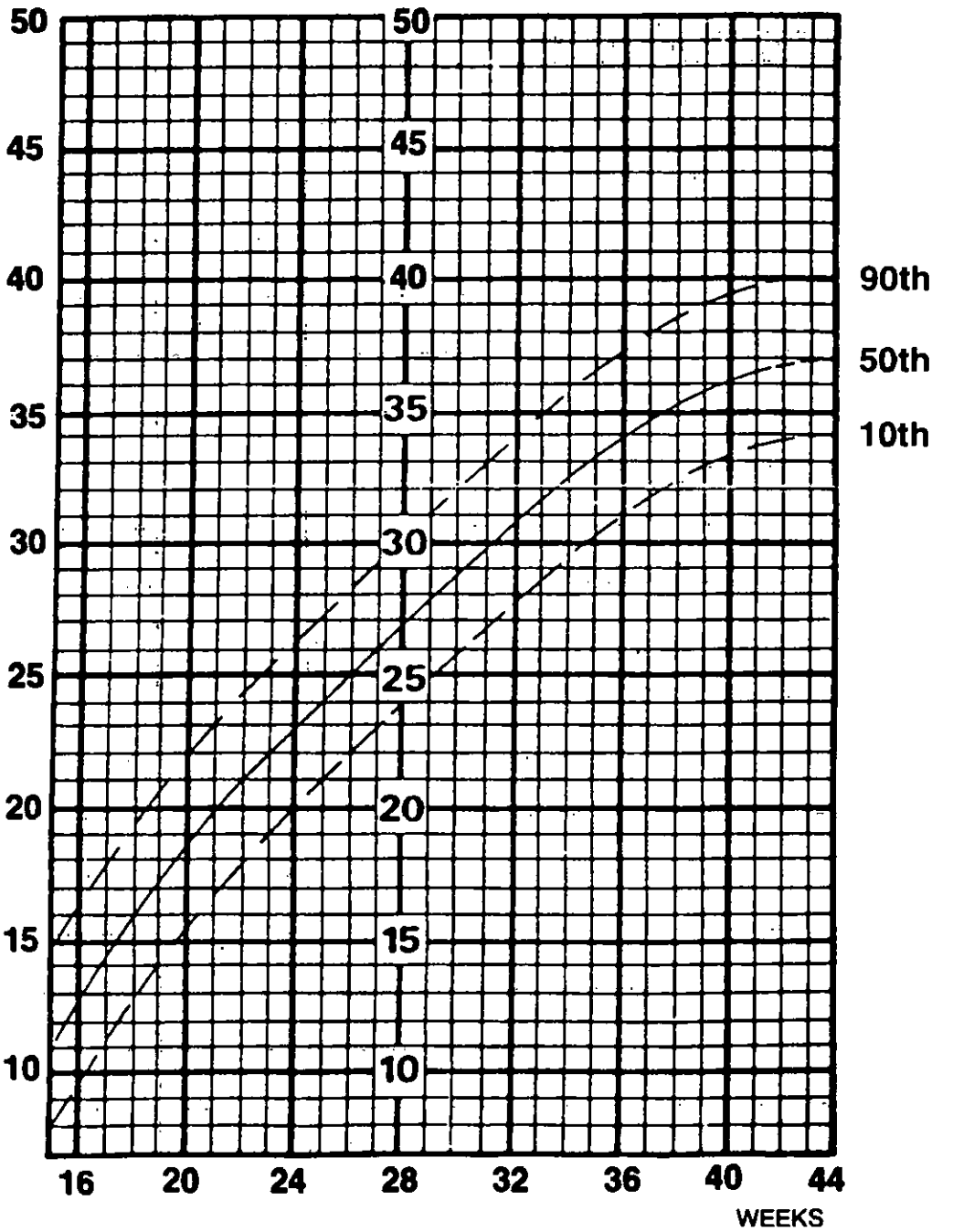
Date	Wks	Weight (Kg)	Urine P	Urine S	BP	Fundus (cm) / Girth	Pres.	Level	FHH	Hb / Rhesus	Oed
24-2-04	7+4	96	MSU		KQ/60	Not palpated					
5/5/04	17+	94	—	—	110/70	17			✓		
10.6.04	23.	97.	Neg		90/50	24 cm			✓		
15.7.4	27+5		Neg	Neg	95/60				✓		
27.7.4	28+5		Neg		100/50	31			✓		
			Specimen								
11.8.4	31+5	1	Neg	Neg	100/60	34 cm.	C	↑	✓	✓ 129	
		1									
25.8.4	35+5	101	Neg	Neg	100/60	37cm	C	↓	✓		
23.9.04	38+1		Neg		112/70	36 cm	Cph	2/5	✓		
27.9.04	38+3	Self reported				39 cm	Cph	?2/5	✓		

BMI 36

Commanta Scan Booked 29/03/04	Weeks/Place to return	Signatura and Designation
Booking bloods with consent. Screening		(ATKINSON) D. Atkinson SIM
AFP 16 wka: Yes / No; GP / Hospital; Data		(FRASER) V. Fraser CIM
discussed. Mood stable at booking		
Well AFP ✓ consent.		Thorpe
Feeling movement.	(5).	V. Fraser.
well, active baby – consent chart moments – discuss Kick chart.	(1)	AT ts. (Examiner) cm.
attended physio – support belt supplied. Kick chart – is having 10 kicks a day and feels much happier.	(3)	AT ts. cm (Examiner)
Well active baby.	(3).	AT ts. cm (Examiner)
feels reassured. active baby. growth scan arranged for 13.9.4 @ 2:45.	(2).	AT ts. cm (Examiner)
GPSS – 7. Baby active. Aching thighs, explained headaches. Fell on Saturday, splits, feels the force heavily down below, minimal movement. Ofdal FMF 1 felt. FH variable 120-132.	(2).	V. Fraser
		V. Fraser.

Fundal Height Chart

S. F. Height
cms



WLT 442

SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE

BATHGATE EH48 1BX

Sheet 11

Date	Wks	Weight (Kg)	Urine P	Urine S	BP	Fundus (cm) / Girth	Pres.	Level	FHH	Hb / Rhesus	Oed
7.10.04	40		NEG		118/70	39cm.	Cephx	3/5	✓		
14.10.04	40+6.		NEG		110/70	39cm	Cephx	2-3/5	✓		

WLT 467

CONTINUATION SHEET

Date and Time	Name Gillian McAleer No.	Signature and Designation
7-10-24	keen to get delivered. Ind ☺	
	T+10. Sweep offered for T+5.	V. Raper CM
	Sweep = Co soft mid position	
	partially effaced. Os admits	
	one finger Cephalic at -2 1/4 S.	
	Membranes close to head.	
	LOP - sweep. Explained possible	
	discharge. Advised.	V. Raper.

CONTINUATION SHEET

Date and Time	Name GILLIAN MCATEER No. 325165	Signature and Designation
18/10/04 0930	Admitted to Ward 10 for IOL	
T+10	for postdates. Gillian aware	
	of induction procedure, happy	
	to proceed. Occasional tightenings	
	noted only, show noted following	
	membrane sweep by clm on 14/10/04	
	O/A T36°C P80 BP 100/72	
	O/P fundus = dates	
	longitudinal lie.	
	cephalic pres.	
	back to mat (L)	
	head 3/5th palpable	[AYTHEN]
1000	CTG commenced. (pre prostin)	[signature] S/N
	Midwives checklist completed	
1100	CTG discontinued reactive	
	trace + FM +++ some loss of	
	contact @ times due to some	
	baseline 120-135 bpm good	
	variability 5-20 bpm + accelerations	
	↑ 165 bpm 0 decelerations	[signature] S/N
	0 contractions	
1105	VE to assess in view of giving	
	prostin + consent	

ANTENATAL INPATIENT SHEET

Nama GILLIAN MCATEER No. 325165

Data and Tima		Signature and Designation
18/10/04 1105	Cx posterior, softening, 2 cms long	
	OS admits a finger	
	PP-2T IS membrane felt	
	BS 4 Prostin 1mg given to	
	posterior fornix FH 117-124 bpm	(ALTHEN)
	following	
1139	Post prostin (1) CTG commenced	
1210	CTG discontinued reactive	
	trace baseline 115 bpm good	
	variability 5-15 bpm & accelerations	
	↑ 160 bpm 0 decelerations	
	0 tightening. Gillian is aware	
	of backache. Encouraged to	(ALTHEN)
	mobilise	
1410	Gillian not in ward & present,	
	was aware that 2° check	
	would be done	
1445	2° check FH 121 bpm c sonicaid	
	Gillian aware of irregular mild	
	tightenings	
1635	Pre Prostin (2) CTG commenced	
1725	CTG discontinued initially	
	reactive then 30 min sleep trace	

	ANTENATAL INPATIENT SNEET	
Data and Tima	Nama GILLIAN MCATEER No. 325165	Signature and Designation
18/10/04 1725	baseline 120 bpm variability 5-10 bpm	
	beaming reactive following	
	baseline 115 bpm good variability	
	5-15 bpm 4 accelerations ↑ 145 bpm	
	0 decelerations. Tightening 2-3:10	(A.ITHEN)
	mild	
1735	VE to assess progress in view	
	of giving further prostin 4 consent	
	Cx posterior, softening 2cms long	
	OS admits a finger	
	PP-2 ↑15 BS 4, no change	
	from previous VE. Prostin 1mg	
	given to posterior fornix	
	FH 117 bpm following.	
1810	Post Prostin (2) CTG commenced.	
1900	Reactive trace then paper jammed	
	in CTG → recommenced sleep	
	trace 115 bpm followed by:	
	reactive trace baseline 120 bpm	
	good variability 5-15 bpm 4	
	accelerations ↑ 170 bpm 0 decelerations	
	Contractions 2:10 mild regular → discontinued	
	Gillian plans to mobilise	

SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX

MIDWIVES CHECKLIST

PLEASE SIGN AND DATE WHEN DISCUSSED

1. MOBILITIY IN LABOUR as much as possible
2. MONITORING (Indications for continuous monitoring discussed and excluded) yes
3. PAIN RELIEF aware of options
4. A.R.M. consent given as per LOL
5. POSITION FOR DELIVERY wait + see
6. EPISIOTOMY consent if necessary
7. SYNTOMETRINE consent
8. KONAKION Consent IM
9. SKIN-TO-SKIN CONTACT yes

LAITCHEY

4

Hospital: St John

Labour Ward

Observation Chart

Name/or Addressograph

SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX

Consultant TKC

	Date	Time	T	P	BP	FHR	Reason for Admission and Gestation
Admission to Labour Ward	19/10/04	20:20	36°	80	130/80	140	T+11 10L

Onset of Contractions	18/10/04	23:45	Parity 1+0	EDD 8/10/04
Rupture of Membranes	Spont. (Artf.)	00:50	Blood Grp. O RhD	Hb 112

Cervical Scora	0	1	2	3	Scora
Dilatation	< 1	1-2cm	2-4cm	> 4	
Length of Cx	> 4cm	2-4	1-2cm	< 1	
Station	−3	−2	−1/0	+	
Consistancy	firm	average	soft		
Position	post	mid/ant			

Urinalysis O/A

Induction (Yes)/No Total

Spacial Instructions

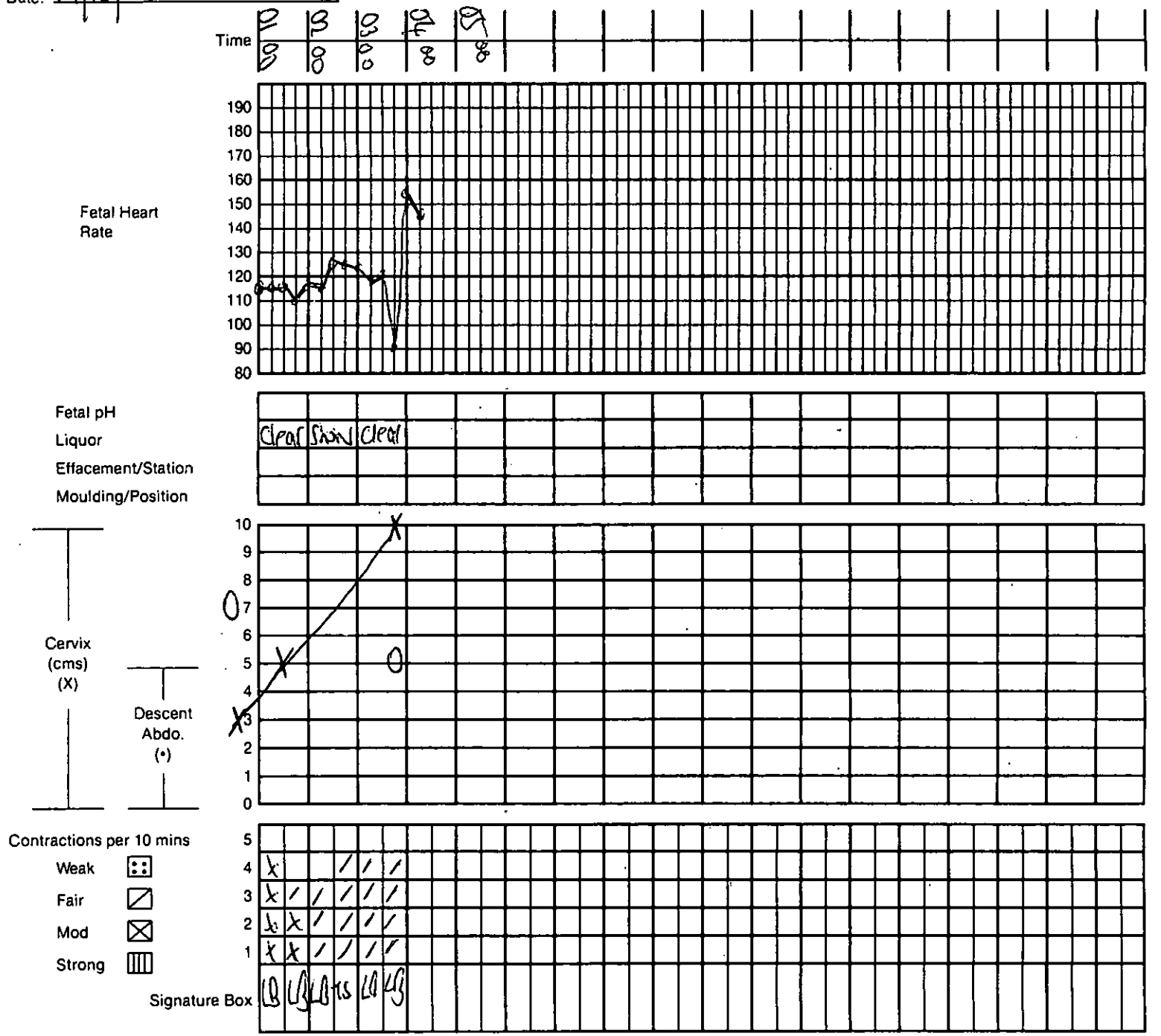
Specify Induction Mathod: Prostin x1mg ARM

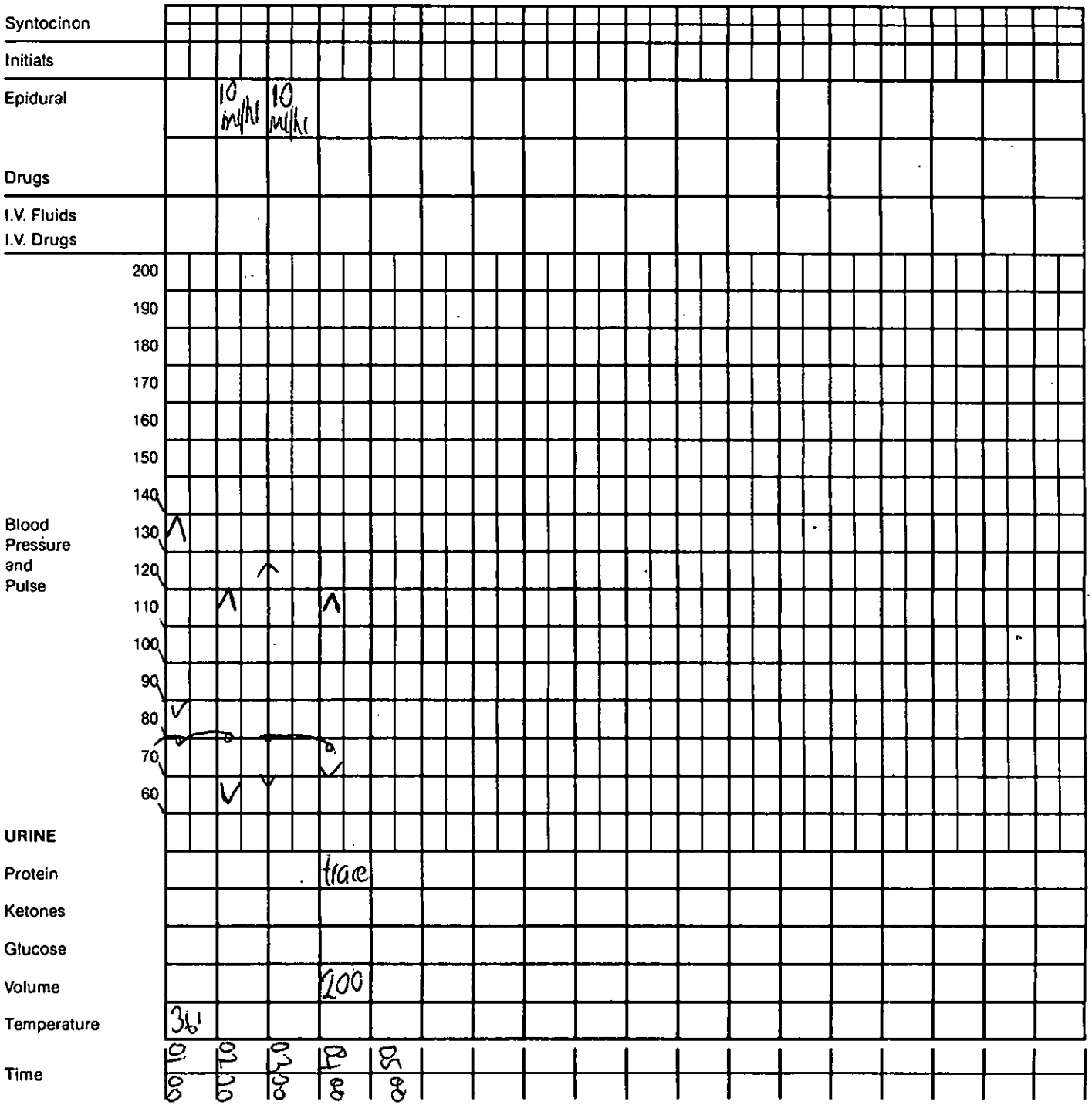
Birth Plan Discussed: YES

Date and Time	COMMENTS	Signature and Designation
18/10/04 21⁰⁰	2° check - FHR between 124 -	
	140bpm over 1minute, ° decelerations.	
	Gillian aware of contractions every	
	5 minutes - none reported by myself	E. Fleming (FLEMINGE) S/M
21⁴⁵	Gillian having a bath.	
22⁰⁰	Paracetamol 1g and dihydrocodeine	
	30mgs given orally.	E. Fleming S/M.
23⁰⁰	2° check - Gillian asleep - not	
	disturbed	E Fleming S/M
23⁵⁵	Gillian's contractions becoming	
	more painful, although short	
	lasting 1:2'. FHR @ 130bpm	E Fleming S/M

WLT 454

Date: 19/10/24


Time
09 15
09 30
09 45
10 00
Fetal Heart Rate
190
180
170
160
150
140
130
120
110
100
90
80
Fetal pH
Liquor
Effacement/Station
Moulding/Position
Clear
Show
Clear
Cervix (cms) (X)
Descent Abdo. (•)
10
9
8
7
6
5
4
3
2
1
0
Contractions per 10 mins
Weak
Fair
Mod
Strong
5
4
3
2
1
Signature Box
LB
LB
TS
LB
LB


Syntocinon
Initials
Epidural
10 ml/hr
10 ml/hr
Drugs
I.V. Fluids
I.V. Drugs
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
Blood Pressure and Pulse
URINE
Protein
trace
Ketones
Glucose
Volume
200
Temperature
36'
Time
01 00
02 00
03 00
04 00
05 00

Date and Time	COMMENTS	Signature and Designation
19/10/04 12mn	Gillian requesting transfer to DLS.	
	DLS contacted, for transfer	E. Flemig SM
00:10	Transfer to Delivery Suite, Care	
	taken over by MyselF JIM L	
	Black. Gillian Contracting 3:10	
	Shorbloshing Entonox commenced	
	OA T: 36.1°C P: 80 BP: 130/10	
	O/P Long Lie	
	Cephalic Presentation	
	Back to maternal Rt	
	Head	
00:30	CTG commenced, Gillian requesting	
	IM analgesia	CBM(C)
00:35	Diamorphine 10mg + Cyclizine 50mg IM	L Flemig SM
00:45	FH Reactive 120 bpm Good BBV	
	with FM up to 140 bpm,	
	Contracting 2-3:10 difficult to	CBM(C)
	palpate not recorded by Loo.	L Flemig SM
00:50	VE performed with Lorett with	
	view to ARM.	
	Cx posterior, soft, 50% effaced	
	Os 3cm dilated	
	p.p. well applied @ 1.5-2	
	Forewaters felt - ARM performed	

WLT 467

CONTINUATION SHEET

Date and Time	Name Gillian McAteer No. 325465E	Signature and Designation
19.10.04	Clear liquor draining	(BLACK)
	FHHR during + following procedure.	Gillian McAteer SHM
	Above findings explained to	
	Gillian + her partner Derek contacted	
01:20	FH non reassuring trace baseline	
	110 bpm BBV 3-5 bpm shallow	
	Early Ds noted to 105 bpm	
	appears to be contracting 4:10	
	(difficult to palpate) abdominal	
	with contractions	
01:25	Requesting epidural DIW Sr Saunders	
	for FSE prior to epidural to	
	ensure recording of FH. Gillian	
	declined it.	Gillian McAteer SHM
01:30	VE with consent to apply FSE	
	Cx soft, central, fully effaced	
	Ds 5 cm dilated	
	p.p. well applied @ IS-2	(BLACK)
	FSE applied + recording 120-140 bpm	Gillian McAteer SHM
	Gillian informed of progress	
	Anaesthetist contacted	
01:45	IV cannula inserted (L) hand	
	Bloods taken for FBC + G+S (in fridge)	Progress SHM

19.10.24	CONTINUATION SHEET	
Date and Time	Name Gillian McAteer No. 325165E	Signature and Designation
01[50]	Sitting up for epidural FH 116bpm.	(BLACK)
02[00]	Epidural sited FH 115bpm	L Gillian Quinn
02[10]	BP 140/100 Gillian distressed	
02[15]	BP 156/91 02[20] BP 136/82	
	FH 115bpm BBV 5-10bpm	
	Fleeting Early D's continue to	
	80 bpm contracting 3:10.	
	Version occluded Oxacillerist	(BLACK)
	resiting.	L Gillian Quinn
02[30]	Verified resited and running	
	BP 120/65	
02[35]	Oxacillerist present, Epidural	
	infusion commenced.	L Gillian Quinn
03[00]	CTG trace; FH Baseline 115-120bpm.	
	Reactive. Good beat to beat	
	variation >5bpm. Accelerations ↑	
	135bpm noted. Fleeting early	
	decelerations ↓ 80bpm noted.	
	Contracting approximately 4:10,	
	felt with difficulty on palpation;-	
	Manually marked onto CTG trace.	Tammy Smith St/mw.
03[35]	Deep Early ↓ noted to 60bpm	
	with recovery over 1 min to	

WLT 467

CONTINUATION SHEET

Date and Time	Name Gillian McAteer No. 325165E	Signature and Designation
19.10.04	baseline, ↓ Further Deep ↓'s	
	Will VE to assess progress	CBL/GK
	meantime observe trace.	L Jackson.
0345	Further Deep early ↓ noted to 70bpm	
	recovery over 1 minute to	
	baseline, Gillian aware of	
	pressure plan → VE to assess progress	
0350	~~VE to~~ In + Out catheter	
	passed with assist - 200mls Trace of Apticin	
	VE performed with assist to	
	assess progress.	
	Fully Dilated	
	p.p. well applied @ 1.5	
	Ron position procedure.	
	FHHR during + following ~~contraction~~	L Jackson.
	Findings explained to Gillian	
	plan → if CTG reassuring await	
	an hour to allow fetal descent	CBL/GK
	then commence active pushing.	L Jackson
0430	CTG continues baseline 120-140bpm	
	Good BSV occasional early ↓'s	
	continue to 100bpm reassessable	
	recovery to baseline ; contractions	

	CONTINUATION SHEET	
Date and Time	Name Gillian McAtee No.	Signature and Designation
19.10.04	3:10 Co-ordinate clay page	
	tapes applied to aid U.A.	
	active pushing commenced.	
04^40	Vx visible + advancing.	
	Into lithotomy.	
04^45	FH - 90bpm. Vx advancing	
04^50	FH 124bpm. Pushing very	
	well.	
04^52	SVD live Girl - Apgars 9:9.	
05^00	3rd stage by CCT	J Saunders Snr (SAUNDERS.
06^15	Cotton bodbarked, Observation /	
	Stable epidural catheter	
	removed and intact	
	for transfer to postnatal ward.	

5

Name: Gillian McAteer CRN: 325165E Area Unique No. 424023M

LABOUR AND DELIVERY

Mode of Delivery/Time	SVD.
Presentation at Delivery	Cephalic

STAGE	Date	Start Time	Length (Hrs)
First	18·10·04	23:45	4hr 5mins
Second	19·10·04	03:50	1hr 2 mins
Third		04.52	.8 mins
End of Third/Total		05.00	
Membs. Rupt. (Calculate to and 2nd Stage)	19·10·04	00·50	3hr 2 mins

FETAL DISTRESS	1st Stage	2nd Stage
Meconium		
Bradycardia: Baseline		
Deceleration: Early	✓	✓
Late		
Variable		
Techycerdia		
Irregularity		
Fetal Blood Sample		

PLACENTA WEIGHT g. ✓

Delivery: Controlled Cord Traction ✓
Manual Ramoval
Other .....

Complete	✓	Membranes x2	
Incomplete		Complete	✓
Doubtful		Incomplete	
Retroplacental Clot		Doubtful	
Calcification			
Infarction			
Other			

Cord Length: cm — No. of Vessels 3

Insertion Type Lateral — Abnormality

BLOOD LOSS 400 ml.

Episiotomy INTACT
Laceration
Sphincter inv.

Suture Material
No. for removal
Signature

Oxytocic drugs at delivery: Syntometrine 1ml

Time 06:00
Temp 36.2°C
Pulse 80
B.P. 130/70

Fundus firm
Bladder empty following delivery

INFANT SUMMARY

	1	2
Time	04:52	
Sex	Female	
Weight (g)	3209	

APGAR	1	5	10	1	5	10
Haart Rate	2	2				
Respiration	2	2				
Muscle Tone	2	2				
Reflaxas	2	2				
Colour	1	1				
Total	9	9				
Time 1st Resp.	Birth					
Time Sust. Resp.	Birth					

RESUSCITATION

	1	2
Nil (incl. Clearing Airway)	✓	
Mask and IPPV		
Intub and IPPV (no drugs)		
Intub and IPPV (with drugs)		
Transferred to Ward		
Special Nursery: Specify		
Other		

Remarks on Resuscitation or Delivery:

Konakion Given: YES/~~NO~~ IM

Cord Blood Taken: ~~YES~~/NO

Specify Reason

SPECIFY NAMES OF FOLLOWING:

Senior Person Present: SJT Saunders

Midwife:

Delivered by: SJM L Black

Resuscitated by:

Identification by: SJM L Black / MUM

WLT 696

DELIVERY		POST NATAL & PAEDIATRIC	
Special Features	Recommendations	Special Features	Recommendations
		Prev P/N depression	

STATE ON DISCHARGE Day (2) SVD - Well. Date 20/10/04

Perineum Intact - Comfortable.

Breasts Full / Comfortable

B.P. 120 / 76

Hb 118g/l.

Drugs

Prescriptions Provided

Iron

Antibiotics

Rubella Vaccine N/A. Batch No.

Anti-D Immunoglobulin Batch No.

Other

Contraception Discussed & leaflet given.

Remarks D/C script for analgesia given.

Examiner/Designation G. Calquhoun s/m (CALQUHOUN)

Infant Feeding - Breast/Artificial Breast feeding well.

Baby's Haalth on Discharga — Passed hearing test

Discharge Weight 3200 Kg Follow-up

S.B. N.N.D. G.P. phonad by on

6 WEEKS OR FIRST POST NATAL VISIT G.P./ Hosp-Dept. Date/Time

Mother's Health Baby's Health

Menstruation, with dates

Vaginal Discharge Lactation

Illness since leaving Hospital

Other Symptoms B.P. / Wt.

Abdomen Hb Urine

Perineum Pelvic Floor Function

Cervix Smeared

Uterus

Appendages

Treatment

Contraceptive Advice

Examiner/Designation Date

St John's Hospital at Howden, Livingston, EH54 6PP. Tel: 01506 422757

Haematology
(CPA Accredited)

S325165 Sex F Date of Birth 23 May 1982
2305821425

Surname MCATEER Forename Gillian

Address 1 CARLYLE TERRACE
EH48 1BX

Consultant/GP
Dr T.K. COOPER
Ward 11 St John's

E4

Date Printed : 20 Oct 2004

Clinical Details 400mls BLOOD LOSS 2 DAYS POST-NATAL

Specimen collection		Date Time Labno.	20/10/04 11:10 H0639480	11/08/04 11:00 H0609888			
Hb	(115-165 g/l)		**118**	**112**			
RBC	(3.80-5.80 x 10^{12}/l)		3.83	3.64			
Hct	(0.370-0.470)		0.343	0.321			
MCV	(80-99 fl)		**90**	**88**			
MCH	(27.0-32.0 pg)		31.0	30.8			
WBC	(4.0-11.0 x 10^9/l)		**13.6**	**10.5**			
Neutrophils	(2.0-7.5 x 10^9/l)		9.3	7.6			
Lymphocytes	(1.5-4.0 x 10^9/l)		3.3	2.2			
Monocytes	(0.2-0.8 x 10^9/l)		1.0	0.6			
Eosinophils	(0.0-0.4 x 10^9/l)		0.1	0.2			
Basophils	(0.0-0.1 x 10^9/l)		0.0	0.0			
Platelets	(150-450 x 10^9/l)		**307**	**249**			

Morphology / Comment

Reference Range is age, sex, method and reagent related and is linked to the current result.

St John's Hospital at Howden, Livingston, EH54 6PP. Tel: 01506 422757

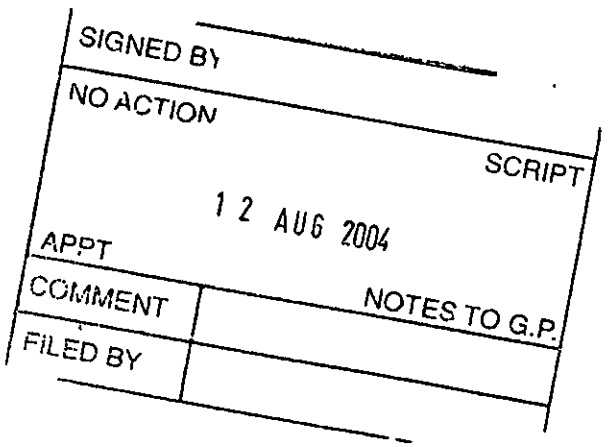
Haematology
(CPA Accredited)

S325165 Sex F Date of Birth 23 May 1982 2305821425	Consultant/GP
Surname MCATEER Forename Gillian	Ms Community MIDWIFE Newland Medical Practice
Address 1 CARLYLE TERRACE BATHGATE EH48 1BX	Date Printed : 11 Aug 2004

Clinical Details 31/40

Specimen collection		Date Time Labno.	11/08/04 11:00 H0609888
Hb	(115-165 g/l)		112
RBC	(3.80-5.80 x 10^{12}/l)		3.64
Hct	(0.370-0.470)		0.321
MCV	(80-99 fl)		**88**
MCH	(27.0-32.0 pg)		30.8
WBC	(4.0-11.0 x 10^{9}/l)		**10.5**
Neutrophils	(2.0-7.5 x 10^{9}/l)		7.6
Lymphocytes	(1.5-4.0 x 10^{9}/l)		2.2
Monocytes	(0.2-0.8 x 10^{9}/l)		0.6
Eosinophils	(0.0-0.4 x 10^{9}/l)		0.2
Basophils	(0.0-0.1 x 10^{9}/l)		0.0
Platelets	(150-450 x 10^{9}/l)		249

Morphology / Comment



Reference Range is age, sex, method and reagent related and is linked to the current result.

St John's Hospital at Howden, Livingston, EH54 6PP. Tel: 01506 422757

Haematology
(CPA Accredited)

S325165 Sex F Date of Birth 23 May 1982
2305821425

Surname MCATEER Forename Gillian

Address 1 CARLYLE TERRACE
EH48 1BX

Consultant/GP
Dr Simon NICHOLSON MLW
Out-Patient St John's

Date Printed : 24 Mar 2004
File Permanently

Clinical Details [redacted]

Specimen collection	Date Time Labno.	24/03/04 09:00 H0553631	24/02/04 10:30 H0541759	11/05/03 11:40 H0426815	20/03/03 16:30 H0407862	03/10/02 17:30 H0347187
Hb	(115-165 g/1)	120	124	107	106	119
RBC	(3.80-5.80 x 10^{12}/1)	3.95	4.06	3.51	LA	3.85
Hct	(0.370-0.470)	0.348	0.357	0.315	LA	0.341
MCV	(80-99 f1)	88	88	90	LA	88
MCH	(27.0-32.0 pg)	30.4	30.5	30.6	LA	30.8
WBC	(4.0-11.0 x 10^9/1)	9.2	9.3	13.6	LA	9.3
Neutrophils	(2.0-7.5 x 10^9/1)	6.2	6.3	9.7	LA	6.0
Lymphocytes	(1.5-4.0 x 10^9/1)	2.2	2.3	2.9	LA	2.6
Monocytes	(0.2-0.8 x 10^9/1)	0.4	0.5	0.7	LA	0.4
Eosinophils	(0.0-0.4 x 10^9/1)	0.3	0.1	0.2	LA	0.2
Basophils	(0.0-0.1 x 10^9/1)	0.0	0.0	0.1	LA	0.1
Myelocytes	(x 10^9/1)				LA	
Promyelocytes	(x 10^9/1)				LA	
Blast Cells	(x 10^9/1)				LA	
NRBC	(/100 WBC)				LA	
Platelets	(150-450 x 10^9/1)	211	287	328	LA	239

Morphology / Comment

H0407862 20/03/03 Hb only due to age of sample - sample dated 200303 and arrived at lab 240303.

Reference Range is age, sex, method and reagent related and is linked to the current result.

[redacted]

MCL 1/5/04

Appt 1/5/04 TCC608

PATIENT:	MCATEER, GILLIAN		**UPI:**	SJ325165E	**REF:**
DOB:	23/05/1982	**SEX:** F	**CONSULTANT/GP:**	Cons Not Given	
SOURCE:	Simpson Medical Practice		**SENDER:**		

MATERNAL SERUM SCREENING REPORT

Date of sample	05/05/2004
Date eample received	07/05/2004
Sample number	QC841419Z
EDD	08/10/2004
Gestation	17 weeks 5 days
Maternal weight	94 kg
Weight adjusted AFP MOM	1.16
Weight adjusted HCG MOM	0.42
NTD Risk	Not increased
Trisomy 21 Risk	Not increased
Trisomy 18 Riek	Not increased

Commente

The maternal weight, date of sampling, date of birth and the EDD are all used to calculate the risks. If the incorrect information is supplied, the reported interpretation may be invalid. For further details refer to The Guidelines for Users dated 11 May 2001.

Date of report : 12/05/2004 Time 15:24 Authorised by : CMS

For enquiries please phone 0131 537 1910/1

SIGNED BY
NO ACTION SCRIPT
14 MAY 2004
APPT NOTES TO G.P.
COMMENT
FILED BY

SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX

NHS Lothian

Consent for screening tests offered in pregnancy
Spina Bifida, Down's Syndrome and Edward's Syndrome

I have received the information leaflet ***"A Parent's Guide to the screening test for Spina Bifida and Down's Syndrome"*** and information sheet about Edward's Syndrome. I have read them and discussed the tests I am being offered with a health professional.

I understand that these tests will tell me if there is an increased chance of my baby having Spina Bifida, Down's Syndrome or Edward's Syndrome. I realise that the tests cannot identify every baby with one of these conditions. I also realise that the blood tests will not give a definite answer.

I understand that the laboratory may store my blood sample for quality assurance purposes. I also understand that my stored blood sample may be used to improve the quality of future screening services.

I understand that I may freely decide not to have any or all the tests if that is my preference.

☑ **I wish** ☐ **do not wish** to be screened for Spina Bifida

☑ **I wish** ☐ **do not wish** to be screened for Down's syndrome and Edward's Syndrome

Signature: ..... **Date** 5/5/04

Name: GILLIAN MCATEER

Witness: TARA COOPER ..... **(Health professional)**
(Please sign and print name)

Designation: Consultant **Date** 5/5/04

Department of Transfusion Medicine
New Royal Infirmary Edinburgh, Little France, Old Dalkeith Road,
Edinburgh. Tel: (0131) 242 7502

CPA

IMMUNOHAEMATOLOGY

Name (Surname & Forename) & Address:
MCATEER, GILLIAN
50 ATHOL TERRACE
BATHGATE
EH48 4DF

EDD / Gestⁿ: 08/10/2004 / 08 weeks

Date Specimen Received: 25/02/2004

Report Date: 25/02/2004

Sex: Female
D.O.B.: 23/05/1982 CHI / Unit No.: 325165

SNBTS No.: 6276811

Results for Specimen No: **245713X**

Comments:

ABO / RhD: **O RhD Positive**

Additional Blood Groups:

Red Cell Antibody Screen: **Negative**

Other Screening Results:

Signed: .....

Report Destination:
COMMUNITY MIDWIVES

Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Copies of Report to:

Department of Transfusion Medicine
New Royal Infirmary Edinburgh, Little France,
Old Dalkeith Road, Edinburgh Tel: (0131) 242 7502

CPA

Specimen Number:
Bar Code

Request For Further Serological Investigation

Name (Surname & Forename) & Address:

MCATEER, GILLIAN
50 ATHOL TERRACE
BATHGATE
EH48 4DF

Time & Date Specimen Received:

Report Destination:
COMMUNITY MIDWIVES
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Copies of Report to:

Sex: Female
D.O.B.: 23/05/1982 SNBTS No.: 6276811
Unit No.: 325165

Please detail any additional information or changes since last sample:

Anti-D Prophylaxis YES/NO:
(If Yes, Please Give Date & Reason)

EDD / Gestⁿ: 08/10/2004 Date Sample Taken: ..... Requested By: .....

St John's Hospital at Howden, Livingston, EH54 6PP. Tel: 01506 422757

Haematology
(CPA Accredited)

S325165 Sex F Date of Birth 23 May 1982
2305821425

Surname MCATEER Forename Gillian

Address 1 CARLYLE TERRACE
EH48 1BX

Consultant/GP
Ms Community MIDWIFE
Simpson Medical Group

Date Printed : 24 Feb 2004

Clinical Details BOOKING

Specimen collection Date / Time / Labno.		24/02/04 10:30 H0541759	11/05/03 11:40 H0426815	20/03/03 16:30 H0407862	03/10/02 17:30 H0347187
Hb	(115-165 g/l)	124	107	106	119
RBC	(3.80-5.80 x 10^{12}/l)	4.06	3.51	LA	3.85
Hct	(0.370-0.470)	0.357	0.315	LA	0.341
MCV	(80-99 fl)	88	90	LA	88
MCH	(27.0-32.0 pg)	30.5	30.6	LA	30.8
WBC	(4.0-11.0 x 10^9/l)	9.3	13.6	LA	9.3
Neutrophils	(2.0-7.5 x 10^9/l)	6.3	9.7	LA	6.0
Lymphocytes	(1.5-4.0 x 10^9/l)	2.3	2.9	LA	2.6
Monocytes	(0.2-0.8 x 10^9/l)	0.5	0.7	LA	0.4
Eosinophils	(0.0-0.4 x 10^9/l)	0.1	0.2	LA	0.2
Basophils	(0.0-0.1 x 10^9/l)	0.0	0.1	LA	0.1
Myelocytes	(x 10^9/l)			LA	
Promyelocytes	(x 10^9/l)			LA	
Blast Cells	(x 10^9/l)			LA	
NRBC	(/100 WBC)			LA	
Platelets	(150-450 x 10^9/l)	287	328	LA	239

Morphology / Comment

H0407862 20/03/03 Hb only due to age of sample - sample dated 200303 and arrived at lab 240303.

Reference Range is age, sex, method and reagent related and is linked to the current result.

MICROBIOLOGY

ST. JOHN'S HOSPITAL AT HOWDEN
LIVINGSTON 01506 419666

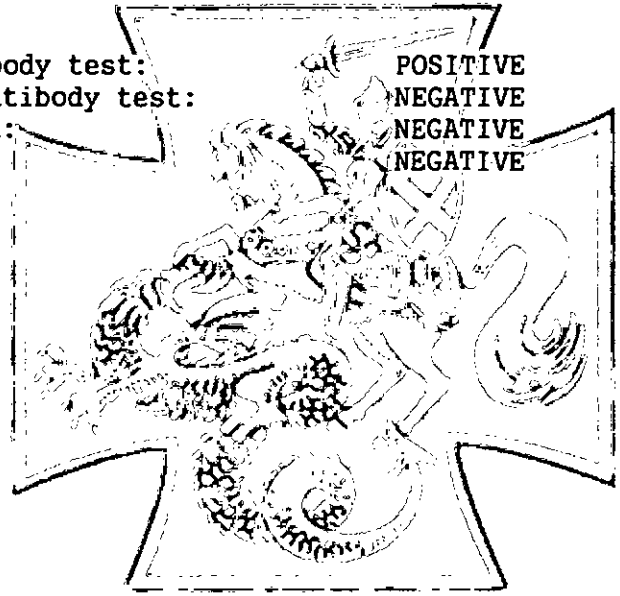
S325165
ENT No.: 2305821425 SEX: F DOB: 23 May 1982 CONSULTANT/GP: Ms Community MIDWIFE

MCATEER, Gillian
1 CARLYLE TERRACE

Simpson Medical Group

No.: M013753/04
Venous blood Booking Sample (Health Centre)

Rubella IgG antibody test:	POSITIVE
T.pallidum IgG antibody test:	NEGATIVE
HIV antibody test:	NEGATIVE
HBsAg test:	NEGATIVE



WLT 685

SPECIMEN(S): Venous blood
TAKEN ON: 24 Feb 2004 DATE RECEIVED: 24 Feb 2004
AUTHORISED BY: MIJ
DATE AUTHORISED: 27 Feb 2004

NUMBER

.....HOSPITAL

NAME

BACTERIOLOGY MOUNT

9

8

7

6

5

4

3

PAT

MICROBIOLOGY

ST. JOHN'S HOSPITAL AT HOWDEN
LIVINGSTON 01506 419666

PATIENT No.: S325165
2305821425 SEX: F DOB: 23 May 1982 CONSULTANT/GP: Ms Community MIDWIFE

LAB MCATEER, Gillian
1 CARLYLE TERRACE Simpson Medical Group

A.D. No.: M013699/04

Urine sample Booking Sample (Health Centre)

No significant bacteriuria

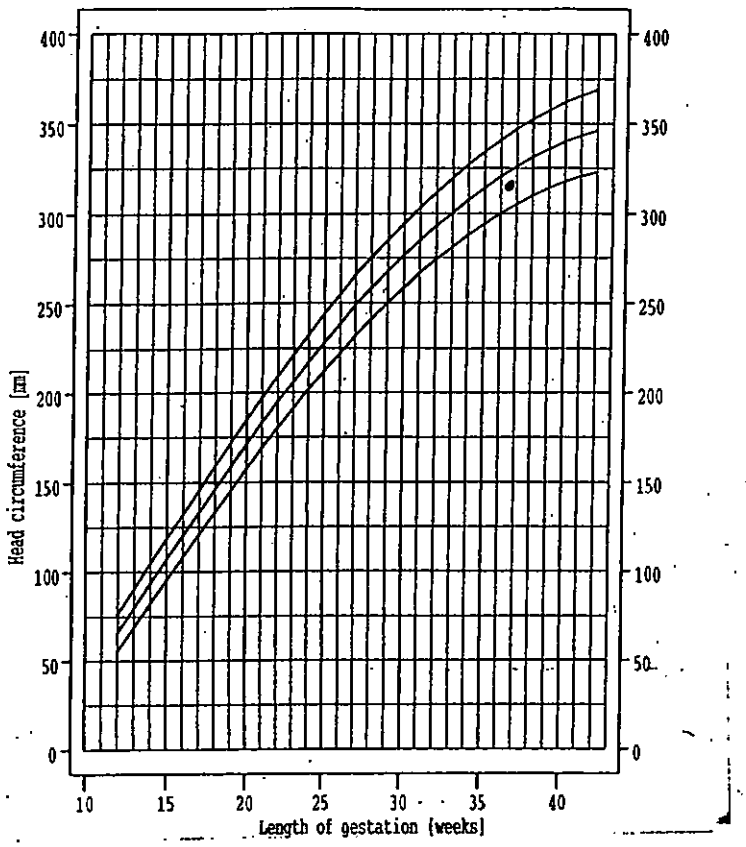
WLT 885

SPECIMEN(S): Urine sample
TAKEN ON: 24 Feb 2004 DATE RECEIVED: 24 Feb 2004 AUTHORISED BY: MIJ
DATE AUTHORISED: 25 Feb 2004

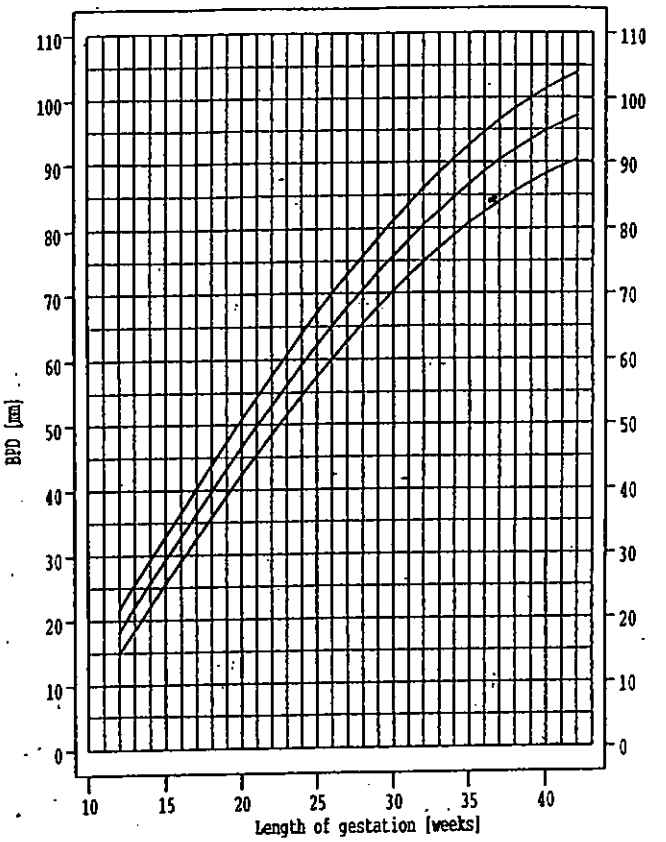
WLT 340

SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX

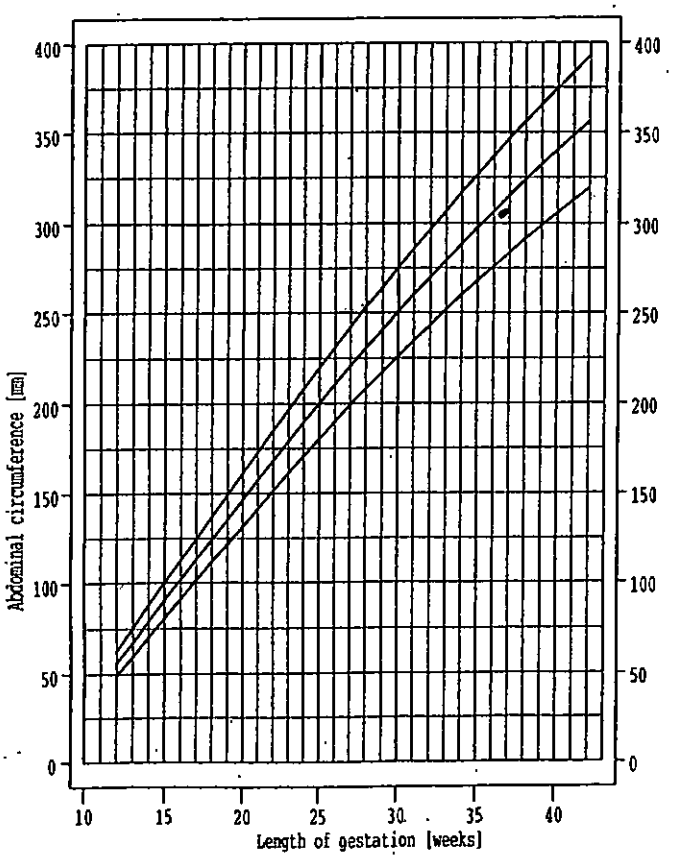
4. Head circumference (derived from diameters)
(b) using biparietal diameter outer–inner



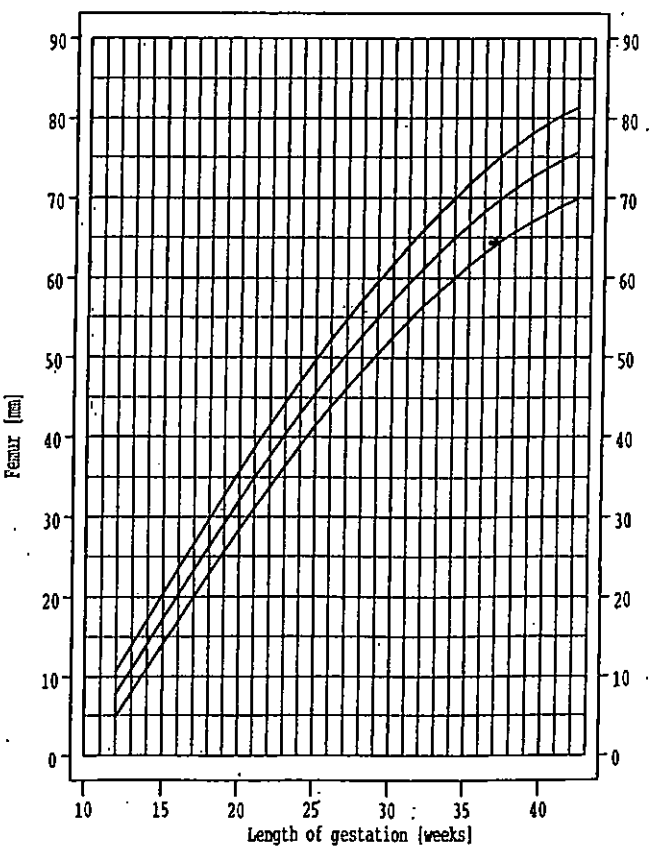
2. Biparietal diameter (outer–inner)



5. Abdominal circumference (derived from diameters)



7. Femur length



Copyright © Lyn Chitty and I

Copyright © Lyn Chitty and Doug

US Obst
Gestation today 36 weeks and 3 days.
Growth scan for large for dates.
Single active foetus with heartbeat identified.
Cephalic presentation.
BPD 84mm
HC 316mm
AC 308mm
FL 64mm
EFW 2.4kg.
Bladder, stomach and both kidneys identified.
Average liquor volume.
Anterior placenta.

pl/CAF Signed by CAF 13/09/04

MCATEER gillian
13/09/04 KIN.KnsgFH
0325165 23/05/B2 # 25775
1 carlyle terrace Bathgate
US Obst

PROVISIONAL REPORT

MCATEER gillian
13/09/04
0325165 23/05/82
1 carlyle terrace Bathgate
US Obst

KIN.Kns
#025775 ah

Growth scan for LFD

Wk

weeks and 3 days.

active foetus with heartbeat seen. ✓

is Antenatal

volume SIC

ents

nographer

Presentation R (9) L

BPD 84 mm

HC 316 mm

AC 308 mm

FL 64 mm

EFW 2·4 Kg ± 15%.

Bladder ✓
Stomach ✓
Kidneys ✓

Waterston and Groves. Telephone: (01620) 829871

US Obst
On going intra-uterine pregnancy.
CRL 26mm suggesting 9 weeks and 2 days.

No reason for pain / bleeding noted.
Both ovaries noted.
No free fluid noted in the pelvis.

~~SH/SH Signed by SH 09/03/04~~
MCATEER gillian
09/03/04 PJD EPU
0325165 23/05/82 # 25775
1 carlyle terrace Bathgate
US Obst

.....HOSPITAL

NAME

X-RAY MOUNT

9
8
7
6
5
4
3
2
1

ST. JOHN'S HOSPITAL AT HOWDEN

X RAY REPORT

US Obst
Booking scan. 12+4 weeks by LMP.
Single fetus. Fetal heart pulsations and movement seen.
Stomach noted.
Anterior placenta.

CRL 61mm
BPD 19mm
Measurements suggest a gestation of 12 weeks and 6 days.

WGC	J.T.L	G	TN
SATS			
NOTES PLEASE			

0 1 APR 2004

COLLECT RX		FILED BY	
MAKE APPT.			
REPEAT TEST		DATE	

~~SH/SH~~ ~~Signed by SH~~ ~~30/03/04~~
MCATEER gillian
29/03/04 BGE.BathgGP
0325165 23/05/82 # 25775
1 carlyle terrace Bathgate
US Obst

Watsetton and Groves, Telephone (01820) 826671

WLT

EARLY PREGNANCY UNIT (E.P.U.)

Name: SD 325165E F 23/05/82 MCAIEER GILLIAN 1 CARLYLE TERRACE BATHGATE EH48 1BX Post Code: Tel. No: 07900638414	G.P.: Dr Holden Bathgate Tel.No:

Unit No	DOB:	Consultant: PD

Former Surname: Previous Attendance at SJH/BGH Y/N

Booked - G.P. (Y)/N M/W (Y)/N Hosp Y/N

Admitted to E.P.U. Date: 9/3/04 Time: 1000.

LMP: 1.1.04. Gestation: Medication: nil

P.O.H.: 1+0 Allergies: nil

History: PV bleeding 7/3 through to 8/3 'period-like' with associated sharp lower abdo pain. Nil PV loss today. Abdo discomfort only.

Temp: Pulse: BP:

Scan Result:- IUP. Fetal pole ± FHS ⇒ 9+2 weeks. No reason for pain/bleed noted

Bloods taken:- Blood Group Confirmed by Sample/Prev notes/ Patient held card/other

FBC Hb= W.B.C= Plts=
BHCG

Anti D required: Y/N Batch no:
Expiry date:

Speculum Examination:- HVS + Chlamydia swab taken.

Findings:

Diagnosis:- ongoing IUP. Reassured by scan. Eunie S/M (JAMIE)

WLT 670

SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX

NHS Lothian

Consent for routine blood tests offered in pregnancy

I have received the information leaflet "*Routine blood tests in pregnancy*". I have read it and discussed the tests I am being offered with a health professional.

I understand the purpose of each of the tests and the importance of the results.

I understend that the laboratory may stora serum for quality assurance purposes. I also understand that my stored blood sample may be used to improve the quality of future screening services.

I understand that I may freely decide not to have any or all of the tests if that is my preference.

☐ **I wish to have all the tests recommended**

☐ **I wish to have all the tests except those noted below**

Signature: G. McAteer **Date** 24/2/04

Name: Gillian McAteer

Witness : Debra Mcansan SIm **(Health professional)**

(Please sign and print name)

Designation: Student Midwife **Date** 24-02-04

St John's Hospital
Obstetric Epidural Infusion Chart

Date:-

Infusion details

SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX

Solution:-
0·1% BUPIV +
2mcg/ml FENTANYL

Pump serial no.

Please record 5 min. BP's and top-ups given on the usual epidural observation chart.
Prescribed Infusion rate:

1. 10 ml/hr Time:- 02:35
2. ml/hr Time:- Reason for change:-

Please note: DOUBLE CHECK with attending midwife that the settings on the pump are correct. Please ask midwife to record the volume infused every 15 minutes for the first half-hour to ensure the pump is functioning correctly. Subsequent recordings should be done on the hour from the commencement of the infusion.

Duration of infusion	Time	Volume Infused	BP	Resp Rate	Sedation Score	Pain Score	Straight leg Raising R / L	Sensory Level R / L	Top-up comments
Zero mins									
15 mins	02:50	2·5	172/91	12	0	0	1 2		
30 mins	03:05	5·2mls	125/69	14	0	0	1 1		
60 mins	03:35	10·8 ML	117/70	12	0	0	1 1	T7 T9	
2 hours	04:35								
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									

PLEASE INFORM ANAESTHETIST IF:-

1. **Patient becomes hypotensive (Systolic pressure< 100mmHg or *) *[*enter value*]**
2. **Pain score of 2 or3, 20 minutes after top-up.**
3. **Respiratory rate <10/min**
4. **Patient unable to lift legs off the bed (Straight leg raising grade 3)**
5. **Patient becomes difficult to rouse. (sedation score 2 or 3.)**

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

Sedation Score
0 = alert, orientated
1 = drowsy, easily roused
2 = rouses only to pain
3 = unrousable
s = asleep

Straight leg raising
0 = full power
1 = slightly weak, able to lift
2 = weak, difficult to lift
3 = unable to lift straight leg

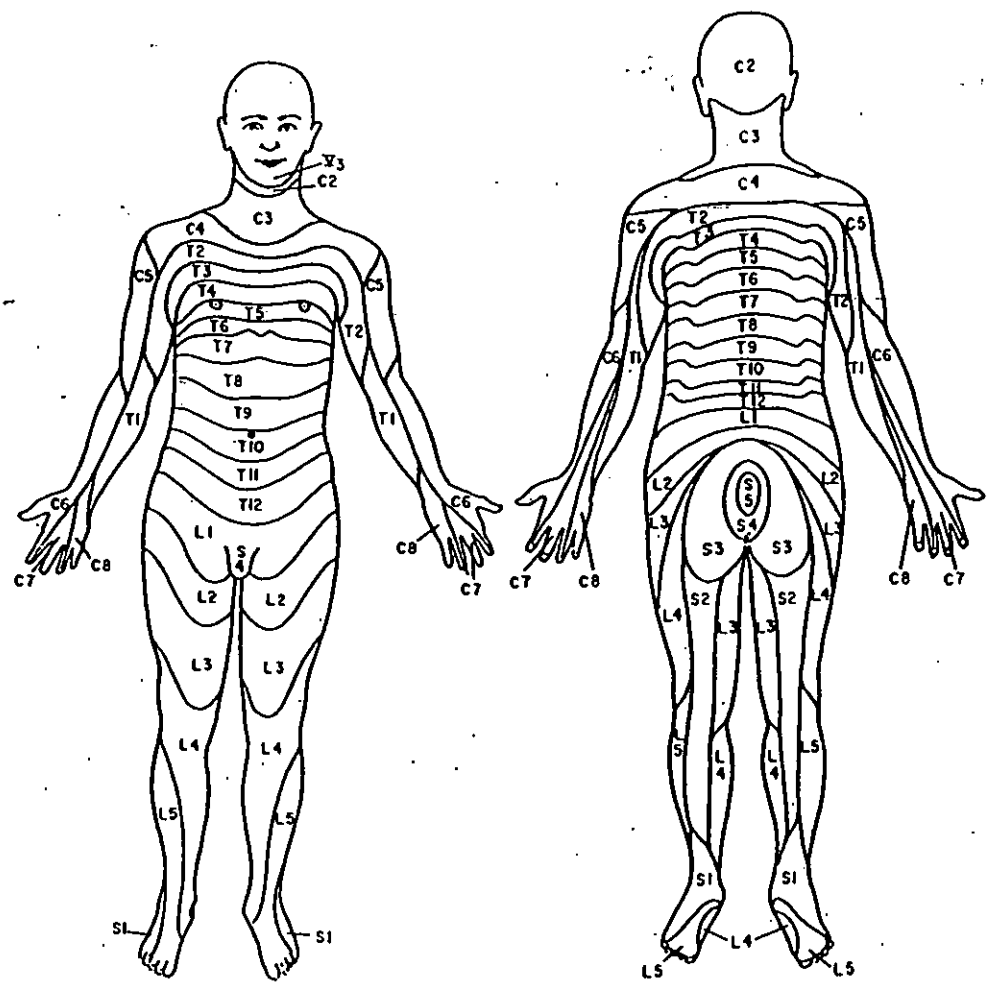


Figure 2–3. Segmental dermatomes in man. (Adapted from Hansen and Schliack, 1962.)

ST JOHN'S HOSPITAL AT HOWDEN

OBSTETRIC ANAESTHETIC RECORD

SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE - -- EH48 1BX

Date 19/10/04

PREOPERATIVE CONDITION

Indications including stage in labour
1st stage.
Analgesia
5cm.

General Health
Citramels

Previous anaesthetic
Prev failed epidural → no block.
Spinal → Epidural.

Investigations, X-match

PREMEDICATION (Drug, dose, route, time)	Prescribed by	Given by / time given
1 Ranitidine 150mg PO @ 0100 By midwives		0100
2		
3		

ADDITIONAL PRE-OP INSTRUCTIONS INCLUDING FASTING TIME

ANAESTHETIC TECHNIQUE (State site, needle type, depth of space, catheter mark at skin)
Epidural. Limb. Caesar Supervising.

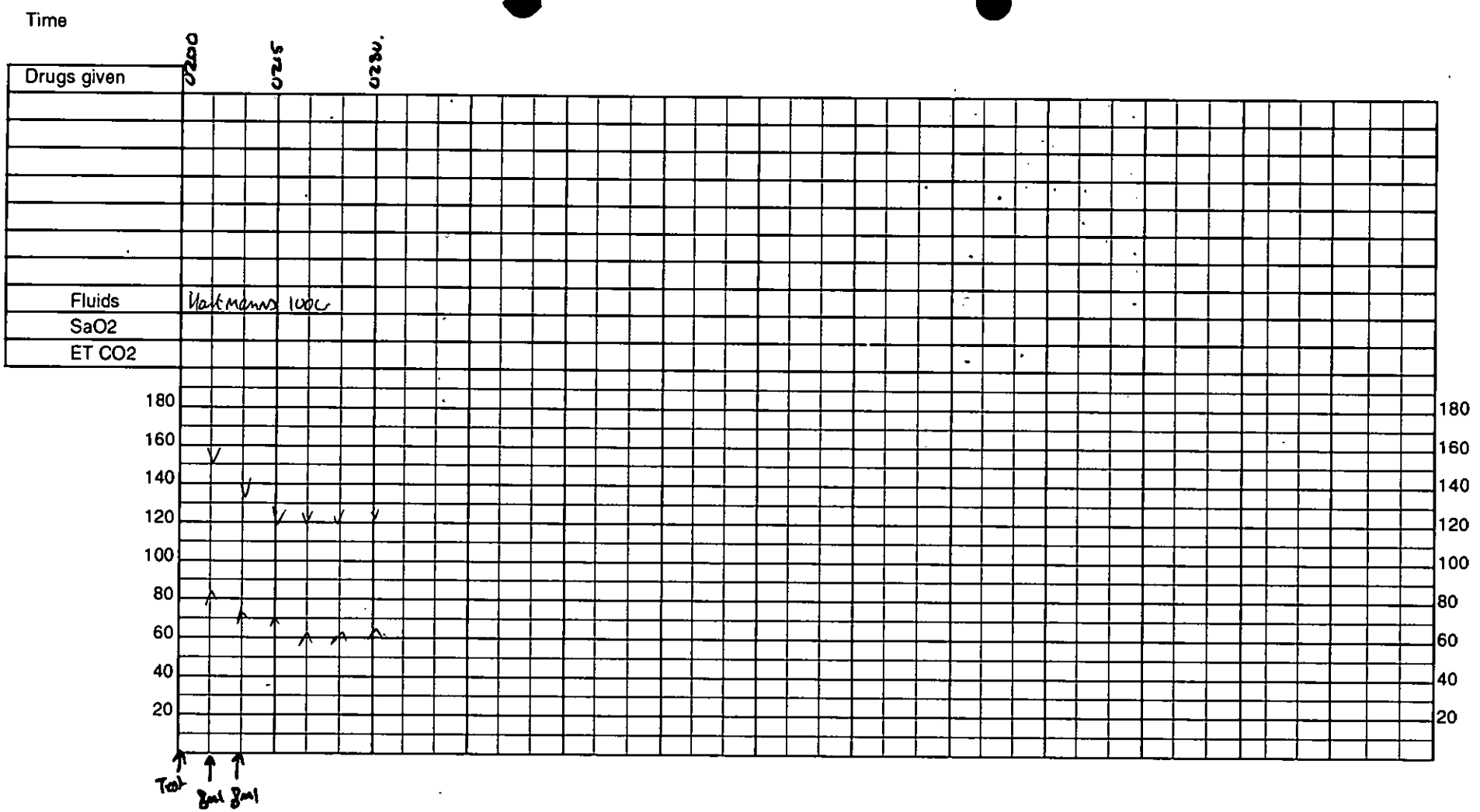
1 Sitting.
Cill aseptis - gown, hat, gloves.
Betadine skin prep
4ml 2% lignocaine to skin
18g Tuohy.
LORS @ 7cm.
Catheter fed easily. Neurosus ✓ - ve aop
4ml 2% lignocaine test dose

2

Anaesthetist Limb.

RECOVERY / POST-OP INSTRUCTIONS

Signed _____ (Anaesthetist)



0200 Test dose.
0205 } 2ml 0.1% Bupivacaine + 2μg/ml fentanyl.
0210 }

0230 - 50μg fentanyl, 10ml 0.25% Levobupivacaine.
Block R>L. (R)TH DL1. Le(L) side:
feeling rectal pressure and low back pain with contraction.
Infusion commenced @10ml/hr.

IN CONFIDENCE

A21

IMMEDIATE DISCHARGE LETTER

West Lothian Healthcare NHS Trust

WLT 14

NAME & ADDRESS OF GENERAL PRACTITIONER:

DR HOGDEN
SIMPSON PRACTICE
BATHGATE

Please use BLOCK LETTERS

SURNAME: SJ 325165E F 23/05/82
MCATEER
FIRST NAM GILLIAN
ADDRESS: 1 CARLYLE TERRACE
BATHGATE EH48 1BX

HOSPITAL: SJH | WARD/DEPT.: 11 | CONSULTANT: TKC

DISCHARGE:

Your Patient { Attended / Was admitted } on 18/10/04 and was discharged { (Home) / To } ____ On 20/10/04

PRINCIPAL DIAGNOSIS/OPERATION:

SVD on 19/10/04 Baby girl.

TREATMENT/COMMENTS:

IOL on 18/10/04

DIAGNOSIS DISCUSSED

G.P.	
Patient	
Next of Kin	

FOLLOW-UP

HOSPITAL

Further Review { Place / Date / Time }

Further Investigations Pending:

G.P.
Further Treatment Advised:

To attend G.P. Surgery	
Unable to attend Surgery	
Follow-up not required	

DOMICILIARY SUPPORT

Arranged by Hospital:

Recommended:

MEDICATION ON DISCHARGE

Pwf check MM

DRUGS	Form of Preparation e.g. Tabs.	Strength	Dose	TIMES OF ADMINISTRATION	Anticipated Length of Course	Quantity of Drugs Requested from Pharmacy
DICLOFENAC	tabs		50 mg	8 hrly prn pain	7 days	28 ✓
DIHYDROCODEINE	tabs		30 mg	6 hrly prn pain	5 days	28 ✓
Paracetamol	tabs		1g	4-6 hrly prn pain	7 days	60 x 500mg

DRUG SENSITIVITY:

CHILD-PROOF CONTAINER YES/NO

A DISCHARGE LETTER WILL/WILL NOT FOLLOW ja KL MARSHALL SHO. Medical Officer.

PHARMACY: A 3 (number) day course has been dispensed. Special Formulation of Medicine { Yes - see att. details / No }

Date Dispensed 20/10/04

Authorised Signature P Dyburgh

NOTE. If drugs are required, all three copies should be sent to Pharmacy for completion.

WHITE COPY - Given to Patient for Delivery to G.P. PINK COPY - TO BE RETAINED IN CASE NOTES. BLUE COPY - TO BE RETAINED BY PHARMACY.

St. John's Hospital, Livingston

PRESCRIPTION AND ADMINISTRATION RECORD

NHS Lothian

Hospital/Ward: 10 Consultant: TKC

Weight: Height:

DISCHARGE PRESCRIPTION

Date Completed: Completed by:

N. SJC325165E F 23/05/82
MCATEER
Pa GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX

(Attach printed label here)

CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINE

If a dose is not administered as prescribed, initial and enter a code in the column with a circle drawn round the code according to the reason as follows:

Patient Refuses	1	Vomiting/nausea	8
Patient not present on ward	2	Time varied on Dr's instructions	9
Medicines not available	3	Once only/prn medication given	10
Instructions not clear or legal	4	Dose withheld on Dr's instructions	11
Nil by mouth	5	Possible drug reaction/side effect	12
Asleep/drowsy	6	Self administered by patient	13
Unable to swallow/Route not available	7	Other reasons	14

ONCE ONLY

Date	Time	Drug (Approved Name)	Dose	Method of Administration	Doctor's Signature	Time Given	Given By
18/10/04		PROSTIN GEL	1mg	PV		1105	
18/10/04		Paracetamol	1g	o		2200	
18/10/04		Dihydrocodeine	30mg	o		2200	
18/10/04		Diamorphine	10 Mg	IM	PGD 111	0035	JS
18/10/04		Cyclizine	50 Mg	IM	PGD 101	0035	JS
19/10/04		Ranitidine	150 Mg	o	PGD 105	0100	
19/10/04		Syntometrine	1ml	I/M	PGD	0452	JS

OTHER MEDICINE CHARTS IN USE

Date	Type of Chart

DRUG SENSITIVITIES

NIL KNOWN

WLT972

Name: ..... D.O.B. .....

REGULAR THERAPY

		Date →	19/10/04 20														
		Time →	19/10														
Drug (Approved Name): PARACETAMOL																	
Dose: 1g	Route: PO	8		GC													
Signature: [signature]	Start Date: 19/10	13		[signature]													
Notes	Pharmacy	18		ll													
		22		23/10 01:20													
Drug (Approved Name): DICLOFENAC																	
Dose: 50mg	Route: PO	8		GC													
Signature: [signature]	Start Date: 19/10	13		[signature]													
Notes	Pharmacy	18		ll													
		22															
Drug (Approved Name)																	
Dose	Route	8															
		13															
Signature	Start Date																
Notes	Pharmacy	18															
		22															
Drug (Approved Name)																	
Dose	Route	8															
		13															
Signature	Start Date																
Notes	Pharmacy	18															
		22															
Drug (Approved Name)																	
Dose	Route	8															
		13															
Signature	Start Date																
Notes	Pharmacy	18															
		22															
Drug (Approved Name)																	
Dose	Route	8															
		13															
Signature	Start Date																
Notes	Pharmacy	18															
		22															
Drug (Approved Name)																	
Dose	Route	8															
		13															
Signature	Start Date																
Notes	Pharmacy	18															
		22															

Name: ..... D.O.B. .....

REGULAR THERAPY

		Date →																
		Time →																
Drug (Approved Name)																		
Dose	Route																	
		8																
		13																
Signature	Start Date																	
		18																
Notes	Pharmacy																	
		22																
Drug (Approved Name)																		
Dose	Route	8																
		13																
Signature	Start Date																	
		18																
Notes	Pharmacy																	
		22																
Drug (Approved Name)																		
Dose	Route	8																
		13																
Signature	Start Date																	
		18																
Notes	Pharmacy																	
		22																
Drug (Approved Name)																		
Dose	Route	8																
		13																
Signature	Start Date																	
		18																
Notes	Pharmacy																	
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Drug (Approved Name)																		
Dose	Route	8																
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Signature	Start Date																	
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Drug (Approved Name)																		
Dose	Route	8																
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Signature	Start Date																	
		18																
Notes	Pharmacy																	
		22																
Drug (Approved Name)																		
Dose	Route	8																
		13																
Signature	Start Date																	
		18																
Notes	Pharmacy																	
		22																

Name: ..... D.O.B. .....

AS REQUIRED THERAPY

Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											

Name: ..... D.O.B. .....

AS REQUIRED THERAPY

Drug (Approved Name)		Date	18/9	20/10									
DIHYDROCODEINE		Time	19/10	01:20									
Dose & Frequency	Route	Dose	30mg	30mg									
30mg up to 4/24	PO	Initials	ll.	ef									
Signature	Start Date	Date											
	19/10	Time											
Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											

Name: ..... D.O.B. .....

REGULAR THERAPY

| | | |

[redacted]

Addressograph label	Consultant: IKC	Parity 0+0
SJ 325165E F 23/05/82 MCATEER GILLIAN 1 CARLYLE TERRACE BATHGATE EH48 1BX	Date 23.05.03	Time 21.59
	Type SVD	Reason if instrumental
	Blood Loss 150	Perineum Intacts
Baby Resuscitation: Y (N)	Placenta Complete (Y) N	Membranes Complete Y (N) Ragged
	Baby CRN 420004K	Gestation 41+5
	Weight 2880	Gender female
	Apgar 9:9	

Postnatal Ward Orientation

Date	Yes	No		Yes	No
Welcome Book	✓		Baby Facilities	✓	
Midwife call System	✓		Baby clothes	✓	
Location of light/radio	✓		Safety Precautions		
Location of Shower/Toilet	✓		No Smoking Policy	✓	
Use of bidet	✓		Changing Baby on the bed	✓	
Meal times/Menus	✓		Carrying baby around ward	✓	
Security Precantions	✓		Visiting times	✓	
Leaving baby alone	✓		Out of hours visiting	✓	

Caring For Your Baby

Do you feel happy with:	Date		Mother's Signature	Midwife's Signature
Nappy Changing	10/5/03	(Y) N		SM G.B.A
Caring for the cord	10/5/03	(Y) N		
Bathing		Y N		
Feeding Baby — Breast		Y N		
Hand Expressing		Y N		
Sterilising of Baby Equipment		Y N		
Feeding Baby — Bottle		Y N		
Making of Formula Feeds		Y N		

Transfer to home and beyond check list

Date	Yes	No		Yes	No
Anti-D - Given		✓	Robella Vaccine - Given		✓
Script for discharge drugs		✓	Bounty Pack	✓	
Hb	✓		Registration Card to parents	✓	
Disc address/phone no correct	✓		6 week postnatal check		
Paediatric Check Date 11/5/03			Obstetric Check - if applicable	N/A	
Dr's Name IK			Dr's Name		
OFC	33.8		CHI Form	✓	
Length	47				
Guthrie Date done	16/5/03		Guthrie consent	✓	

Namebands checked / correct (Yes) / No Sign: Midwife [signature] Mother [signature]

Leaflets distributed / discussed

Discharge information	✓		Making of Formula Feeds		
Breastfeeding book if required			Sterilising of Baby Equipment	✓	
Breastfeeding Support Groups	✓		Prevention of SIDS	✓	
Car Safety	✓		Contraception	✓	

At community handover signed by

Midwife Health Visitor [signature] 20/5/03

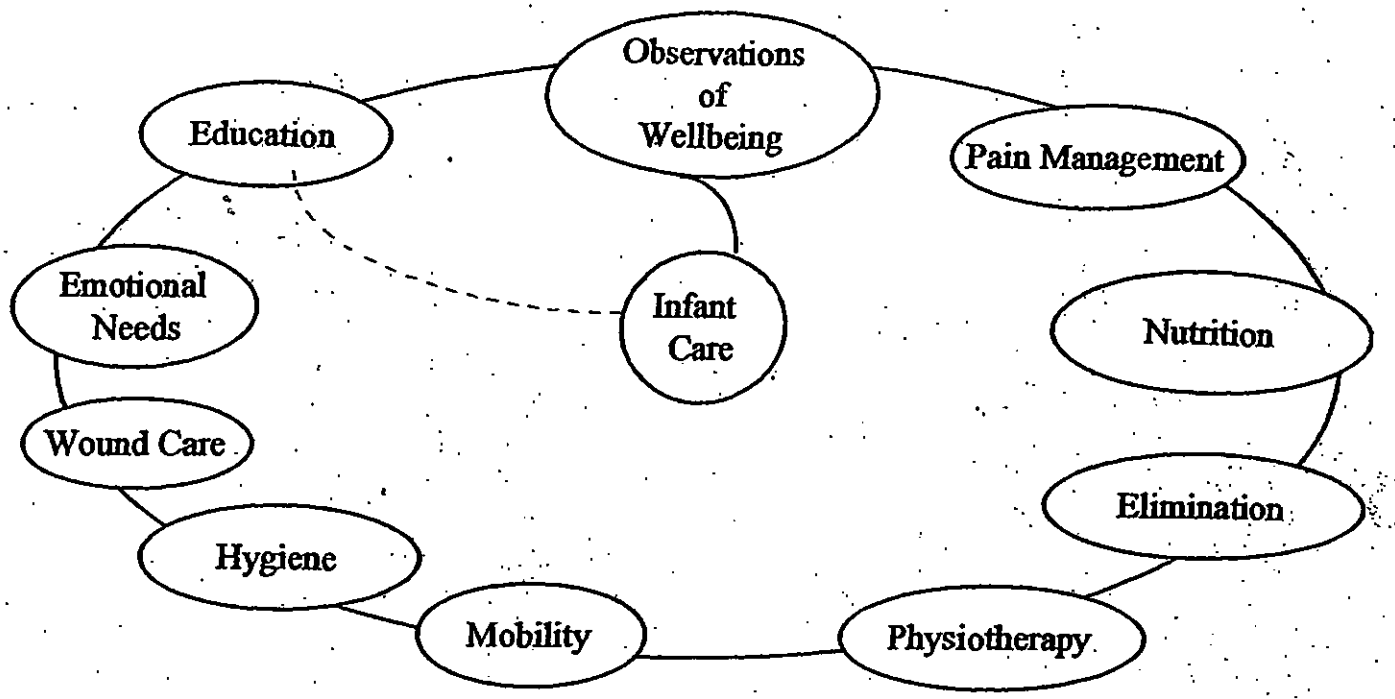
Postnatal Visits 0 1 2 3 4 5 6 7 8 9 10 11

Tues Thurs Fri SAT SUN MON Tues

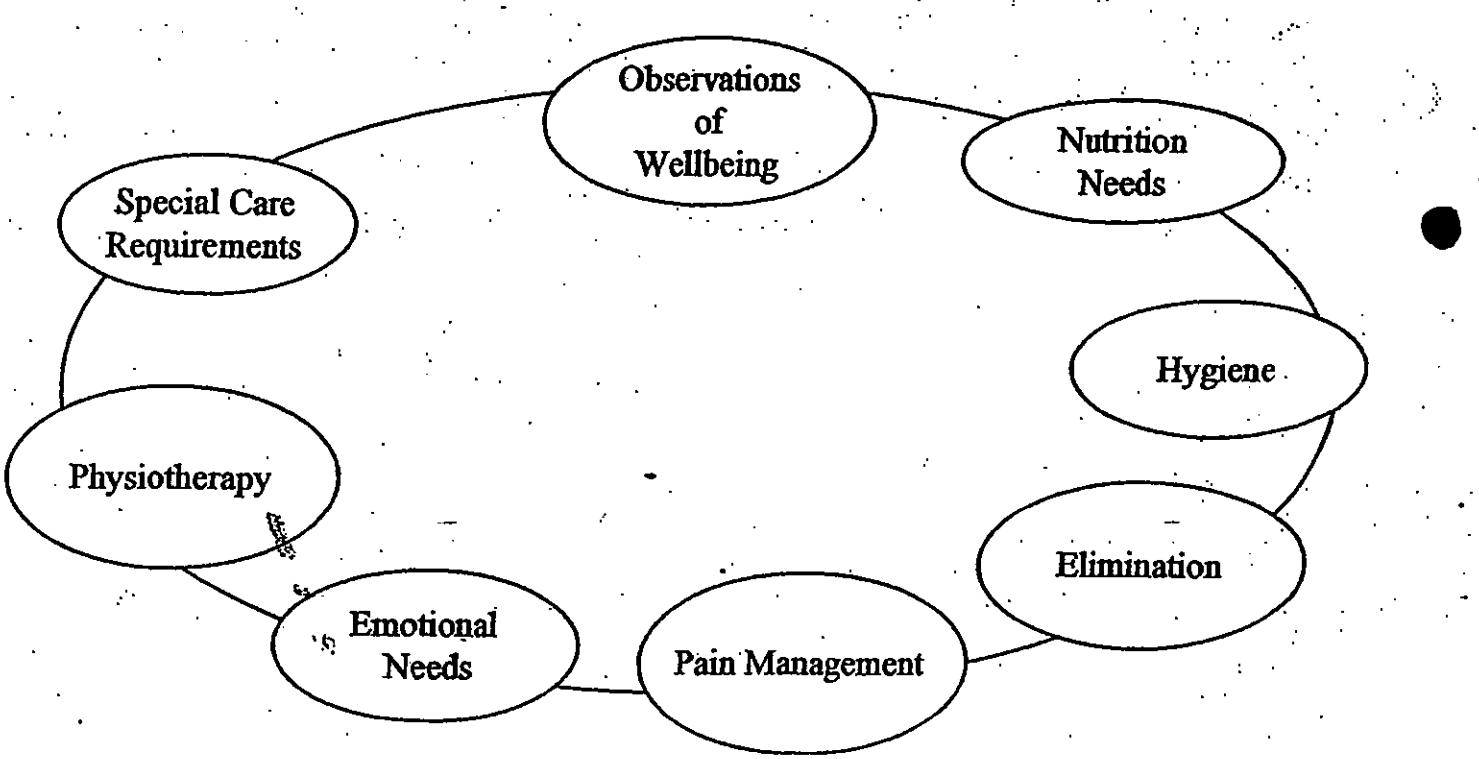
Discharged 21.5.03

These headings are guidelines to focus writing the maternal or baby evaluations, concisely under the relevant heading if required.

Maternal Circle of Care



Infant Circle of Care



WLT 426

WEST LOTHIAN HEALTHCARE NHS TRUST

GENERAL PRACTITIONER AND COMMUNITY MIDWIFERY DISCHARGE TRANSFER FORM

WEST LOTHIAN District

CASE REFERENCE No. 32515

Name GILLIAN MCMILLAN

Age 21 Marital Status

Hospital ST. JOHNS Ward 11 Date of Discharge 12/5/03.

Home Address 1 CAIRNHILL TERRACE G.P. DR THOMSON

BATHGATE EH48 1BX Address YOUNG HC.

Tel. No: 079006 35414.

Temp. Address

Tel. No: Tel. No:

Parity 0+0 No. of Living Children 0 Comments

Early Discharge Booked/Unbooked Blood Group O P

Ante-natal complications NONE

MOTHER

Date of delivery 9.5.03 Time 21.59 Length of labour 7 1/2 Spontaneous/~~Induced~~

Method of delivery: Spontaneous SVD Other Indication

Complications NONE Blood loss 150ml.

Placenta NORMAL COMPLETE Membranes INTACT. CLEAR

State of perineum on discharge INTACT. Hb 11/5/03

Treatment and/or complications

Almevax: N/A Anti-D Immunoglobulin: N/A

BABY

Sex GIRL Apgar score 9.9 Gestation 41 WKS.

Weight at birth 2550 OFC 33.8 Length 47 Cord ON Guthrie Test: YES/NO

Weight on discharge ~~NOW~~ 2.680 Feeding BREAST.

Any special problems

Treatment and/or complications

M 'W's Signature Hannah S/M.

EARLY DISCHARGE Has G.P. been telephoned? YES/NO By whom?

Testes Descended L. ~~YES/NO~~

Testes Descended R. YES/NO

Hips (L. NORMAL/ABNORMAL

Hips (R. NORMAL/ABNORMAL

Signature

DAILY BABY OBSERVATIONS | Baby's CRN 4200004K.

Mother's CRN 3251655 | Mother's Name Gillian McAteer

Please write all findings in notes

Normal findings: Use BLACK INK **Abnormal findings:** Use RED INK

Date	10.5.03	11-5-03	12/5/03		14/05/03
Age in days	(1)	(2)	(3)	(4)	(5)
Eyes	clear	Clear x2	clear	Clean.	clean & clear.
Mouth	clean.	Clean & moist	clean	clean.	clean.
Head	sl bruised	nad.	NAD	—	—
Skin/Colour	Pink.	pink.	pink	Pink.	pink.
Cord	clamp secure	Clamp on - secure	Clamp off	on-dry	on, dry.
Namebands	x2 checked.	x2 checked	x2 correct	—	—
Temperature	36.7 35.9	36.6	36.7	36 (Edna cover)	36.4. feels warm.
Weight	2880.	—	2.680 wasg.	—	—
Urine	HPU.	PU	PU	PU	PU
Stool - colour & consistency	HNBO.	BO-mec	BO	NBO.	BNO today. discussed.
Guthrie Test		—		—	—
Feeding Method & Comments	Breast	B/F on demand	BI	Breast A/F x2 Advised	B/F has been better. settling well. 3-4 hourly.
Signature: Designation	MC Sutherland SIM.	C. Phillips St. M/W.	Yeuch NAT SIS	V. Fraser CMN	L. Henderson (STM).

MMelrose (Melrose) STM.

DAILY BABY OBSERVATIONS		Baby's CRN		
Mother's CRN	Mother's Name			
Please write all findings in notes				
Normal findings: Use BLACK INK **Abnormal findings:** Use RED INK				
Date	15/5/03	16/5/03	18.5.03	21.5.03
Age in days	(6)	(7)	(9)	(12)
Eyes	clean & clear	clean & clear	clear	flagging
Mouth	clean & moist	clean & moist	clean moist	nor. disturbed
Head	NAD	NAD	sutures	↓
Skin/Colour	pink	pink	pink	↓
Cord	ar, clean & dry	ar, clean & dry	Seperating	off
Namebands	—	—		
Temperature	36.5	36.6	37.2	—
Weight	—	—		—
Urine	PU	PU	PU	
Stool - colour & consistency	BNO	BNO passing wind	BO soft formed regularly now.	
Guthrie Test	—	—		
Feeding Method & Comments	changed to A/F. settled well overnight.	3-4oz 4 hourly settling well	3-4oz 3-4 hrly settled between sick a couple of times	A/F. Baby fed well
Signature: Designation	L. Henderson (ST1/n)	L. Henderson (ST1/n)	[illegible]	V. Fraser

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CONTINUATION SHEET

Date and Time	Name Baby McAteer. No. 4200074K.	Signature and Designation
10/5/03 08³⁰	Baby's temp ↓ 35⁹, wrapped up warmly and placed on a heat pad. Plan to recheck temp in 1 hour.	(MELROSE). M Melrose st/m
09³⁵	Temp ↑ 36'. bot was out of cot. Baby placed back in cot with heat pad. Parents advised to try & leave baby in cot for 1 hour.	(MELROSE). M Melrose st/m
12⁴⁵.	Re-checked baby's temp - 36⁷c.	J. Gillies S/Hm
15/5/03	Jaimie - bee had large vomit last night but settled following. Cillian breast-fed yesterday day-time but decided to bottle-feed after vomiting and has bottle-fed since. Cillian feels happier that she has made this decision. Discussed BF with her and offered help, however Cillian has decided against breast-feeding.	L. Henderson (St/M)

DAILY MOTHER'S OBSERVATIONS

Mother's CRN 325165E | Mother's Name Gillian McAteer

Please write all findings in notes
Normal findings: Use BLACK INK Abnormal findings: Use RED INK

Date	10·5·03	11-5-03	12·5·03	13·5·03	14/5/03
Age in Postnatal	(1)	(2)	(3)	(4)	(5)
Fundal height & Abdominal Palpation	firm ⊙ +1 finger	firm, central 2f ↓ ⊙	fundus ⊙·3	firm ⊙ - S/P	firm & central SP +1 Rb
PV Loss/Lochia	Red minimal	red, average	Red	Small clot X1. Not examined	brown, minimal.
Breasts	soft Nipples ✓	soft, tender nipples	L/nipple Cracked	Reducing pain Comfy filling	raise tender when latching on (L)
Perineum	clean.	clean	—	comfy.	comfy.
Abdominal Wound	NAD	—	—	Mood Stable. Mainly	mood good.
Legs	NAD	nad	NAD	no pain	no pain
Oedema	legs, fingers	puffy ankles	legs ankles	++	legs & ankles ++
Urine	HM.	PU	PU	PU	PU
Bowels	BNO.	BNO	BO	BO.	BO.
Temperature, Pulse & BP	T 36·8 Pulse 84. BP 117/74.	T 36·2 P 80 BP 120/76	T 36 P 80 120/70	36 88 100/70	T-36·7.
HB		Taken 11/5 11·35		—	—
Signature: Designation	H C Sutherland S/M	C. Phillips St. M/W	Thank S/M	C M Fraser N Fraser	L. Henderson (S/M)

MMelrose S(M (MSGrad).

DAILY MOTHER'S OBSERVATIONS

Mother's CRN	Mother's Name

Please write all findings in notes
Normal findings: Use BLACK INK **Abnormal findings:** Use RED INK

Date	15/5/03	16/5/03	17.5.03	18.5.03	21.5.03
Age in Postnatal	(6)	(7)	(8)	(9)	(12)
Fundal height & Abdominal Palpation	not palpable.	not palpable.	Packed visit message	not palpated	Nil Palpable
PV Loss/Lochia	scanty.	med minimal.	left on phone + thro'door	stopped.	Scanty
Breasts	full. advised.	full comfy leaking		comfortable	leaking
Perineum	comfy	comfy		comfy	—
Abdominal Wound	mood good. slept well last night.	mood good sleep good appetite good.			Mood Stable.
Legs	tender as out walking yesterday.	- NAD			—
Oedema	feet & ankles	feet & ankles		feet & ankles improving	—
Urine	PU	PU.		PU ✓	PU
Bowels	BO.	BO.		BO ✓	BO.
Temperature, Pulse & BP	T-36.8 P-96.	T-36.6		BP 130/70 P 80 T 38.9	86? 80. 80/70
HB	—	—			
Signature: Designation	L. Henderson GT(M).	L. Henderson GT(M).	[signature]	[signature]	[signature]

WLT 467

CONTINUATION SHEET

Date and Time	Name GILLIAN MCATEER No. 325165E.	Signature and Designation
10.5.03 0830	Venflon removed at maternal request.	(MELROSE) M Melrose. St/M.
13.5.03	Breastfeeding :) Has used formula as baby unable to latch on right breast. Fed formula at time of visit so not included to latch. Rugby hold explained	V. Fraser
14/5/03	Gillian happier with B/F now, baby seems more settled and is sleeping for 3-4 hours. Has found rugby hold easier.	L. Henderson (St/M)
15/5/03	changed to ALF - see notes on baby notes.	L. Henderson (St/M)
21.5.03 (12)	Final Visit ~~Breasts~~ - normal Contraception - has pill. Support - has group. and knows to if required	V. Fraser

MHW

NHS Lothian: ICP for routine Ante-Natal Care -

LIAISON SHEET: Case reference number:

date started: date completed:

Aim this section is to record Medical history & develop recommendations for your Ante-natal care:

Your occupation	Maiden/previous name	Partner's name	Religion

NHS
SCOTLAND

Parental Consent for Newborn blood spot screening for Phenylketonuria, Congenital Hypothyroidism & Cystic Fibrosis

You will have received an information leaflet describing the newborn blood spot screening tests for Phenylketonuria, Congenital Hypothyroidism and Cystic Fibrosis. The leaflet also explains what happens to the screening results and the blood spot cards after testing is complete.

As a parent you are asked to decide, first of all whether you wish your baby to have these screening tests, and then whether you agree that any positive screening results can be registered on special computerised lists (called databases) which are used to follow progress and treatment of children identified with one of the above conditions. There are separate databases for Phenylketonuria, Congenital Hypothyroidism and Cystic Fibrosis and access to the information in each is strictly controlled and subject to the Data Protection Act. The information can be used to monitor the screening programmes and help plan their future development. Participation is entirely voluntary and patients can ask to have their details withdrawn at any time. Consent to be included on a National register shall be sought following a positive diagnosis.

We also need your permission to use any of the blood spots left over after testing is complete for further anonymised research in newborn screening. (If further research was to be "patient identifiable" we would always contact you again to seek your approval).

Before considering the statements 1-3 please read and sign below:

I confirm that I have received and read the leaflet "*A Parent's Guide to Newborn Blood Spot Screening for Phenylketonuria, Congenital Hypothyroidism and Cystic Fibrosis*". I have had this information explained to me and understand the reasons for testing and the consequences of the results.

Signature :.....(Parent)

Baby's Name Jaimie-lee Fisher Date of birth 9/5/03 CHI Number 420004K

Please read the following 3 statements and delete as appropriate.

1. I wish/~~do not~~ **wish** my baby to be tested for Phenylketonuria
   I wish/~~do not~~ **wish** my baby to be tested for Congenital Hypothyroidism
   I wish/~~do not~~ **wish** my baby to be tested for Cystic Fibrosis

2. I agree/~~do not agree~~ for the storage of my baby's blood spot specimen beyond the 12 month testing period

3. I agree/~~do not agree~~ to the use of any left over blood spots for anonymised research.

Signature :.....(Parent) Date 16/5/03

Witness :L. Henderson (ST.(Midwife) Date 16/5/03

WEST LOTHIAN HEALTHCARE NHS TRUST
POSTNATAL DEPRESSION
RISK FACTORS CHECKLIST

PATIENT NAME - SJ 325165E F 23/05/82
MCATEER
GILLIAN

ADDRESS- 1 CARLYLE TERRACE
BATHGATE EH48 1BX

GP NAME AND ADDRESS -

---

1) **PREVIOUS PERSONAL HISTORY ~ mental health problems**
If Yes, give details **YES/NO**

2) **FAMILY HISTORY ~ mental health problems**
If Yes, give details **YES/NO**

---

3) **ANY PREVIOUS PREGNANCY LOSSES ~ miscarriage, TOP, stillbirth, Neonatal death (details from booking form)** **YES/NO**

4) **RECENT ADVERSE LIFE EVENTS ~ bereavement, relationship difficulties, Loss of employment, etc?** Anxious about employment
If Yes, give details **YES/NO**

5) **FAMILY SUPPORT AVAILABLE ~ family nearby? Supportive?**
Give details keeping with mum/brother **YES/NO**

6) **SOCIAL SUPPORT ~ close friends, other people who are supportive?**
Give details **YES/NO**

7) **OTHER CHILDREN UNDER 5 YEARS OLD?** **YES/NO**
How many and age?

8) **CHILDHOOD HISTORY ~ happy childhood? Lived with parents?**
Any other relevant details

Code 1. **YES/NO**

WLT 426

WEST LOTHIAN HEALTHCARE NHS TRUST

GENERAL PRACTITIONER AND COMMUNITY MIDWIFERY DISCHARGE TRANSFER FORM

.....District

CASE REFERENCE No.

Name

Age Marital Status

Hospital..... Ward..11..... Date of Discharge..16/5/03.....

Home Address..... G.P. .....

..... Address.....

Tel. No:..... .....

Temp. Address..... .....

....

Tel. No:..... Tel. No:.....

Parity..0+0..... No. of Living Children..0..... Comments.....

Early Discharge..... Booked/Unbooked..... Blood Group..O+.....

Ante-natal complications..None.....

MOTHER

Date of delivery..15.05.03.. Time..21.59.... Length of labour..7hrs 6m.....Spontaneous/Induced

Method of delivery: Spontaneous..SVD..... Other..... Indication.....

Complications..None..... Blood loss..150ml.....

Placenta..Not checked (complete..... Membranes..Not examined (Postnatal.....

State of perineum on discharge..Intact.....Hb.11/5/03.....

Treatment and/or complications..... .....

Almevax: ..N/A..... Anti-D Immunoglobulin: ..N/A.....

BABY

Sex..Male..... Apgar score..9:9..... Gestation..41 wks.....

Weight at birth..3580..... OFC..33.8.....Length..47..... Cord..On..... Guthrie Test: ~~YES~~/NO

Weight on discharge..~~4kg~~ 2.680..... Feeding..Breast.....

Any special problems.....

Treatment and/or complications .....

M 'W's Signature..Hannah S/M.....

EARLY DISCHARGE

Has G.P. been telephoned? YES/NO By whom?.....

Testes Descended L. ~~YES~~/NO .....

Testes Descended R. ~~YES~~/NO .....

Hips (L.) NORMAL/ABNORMAL .....

Hips (R.) NORMAL/ABNORMAL.....

Name to Queen Heather

Signature.....

NHS Lothian: **ICP for routine Ante Natal Care** pilot v.1c	SJ 325163E F 23/05/82 MCATEER GILLIAN 50 ATHOL TERRACE BATHGATE EH48 4DF
This is my pathway of care & I wish to be known as: GILLIAN	

G.P.: DR. Holden Practice SIMPSON PRAC. Address: BATHGATE & Tel. no.: 654444		Locality: WEST.	
		Obstetrician: DR. COOPER	Midwife: VANDA FRASER
Date contacted GP practice:		*Note: full contact details of staff involved is in section 2*	

This style of documentation is called an Integrated Care Pathway [ICP].
It is intended as a guide to treatment and an aid to documenting patients' progress.

Information for expectant mothers

This documentation represents the record of your care while you are pregnant. Please carry it with you whenever possible as it gives a full and accurate picture to any clinicians who you involve in your Ante-Natal care. It includes sections for all clinical staff to complete, as well as the pages on blue coloured paper which are specifically for you to write in. Please look after it well & add your own notes to the coloured paper pages as you think of them

Information for Clinicians

Please ensure that you complete an entry on the Signature sheet at the back of the booklet.
You should find the sections are a complete record for the different phases of care.
Insert extra 'Additional Information', or 'Routine Visit' sheets as necessary.

This pathway represents the care expected for a majority of your patients. If a patient needs care other than that noted, this is referred to as a 'Variance'. [Note in space & expand on 'Variance' sheet]
Clinicians are free to exercise their own professional judgements as appropriate. However any alteration to the practice identified within this ICP should be noted as a 'Variance' in notes.

Index to this document

section 1	USEFUL CONTACTS, Checklist of Actions	on white paper
section 2	'Liaison' card, Initial or Booking Clinic	on pink paper
section 3	Mother's notes, Plans, "Talkback", APPOINTMENT LIST	on blue paper
section 4	Routine clinic visits, (*whether local or hospital*)	on white paper
section 5	Additional Information / Variance / Signature sheets	

Useful contacts:	tel. numbers	& addresses
Midwife	651828.	
GP	654444	
Hospital	419666	
Health Visitor	630771	Shona Russell
Partner at work		
Next of Kin	Parents.	N/A.
Who would you like us to contact first if we needed to?		

Addressograph, or
Name
Address
Dob
Ref no.

Routine Ante-Natal Care Checklist [note: w = week of pregnancy]

AIM: to show you the activities of routine Ante-Natal Care		Date planned for action	Date Completed	Variance
ANTE-NATAL CARE				
i	1st Consultation / Booking Visit – pregnancy info. supplied [see section 2]		3·10·02	
ii	"Risk Card" started No.			
iii	Post Natal Depression ICP started: No ☐, Yes ☑, N/A ☐		3.10.02	
iv	Pattern of 4-6 week visits agreed		3-10-02	
v				
vi	Preparation for parenthood started		21.11.02	
vii	16w AFP / HCG explanation ~~& test~~		3rd 10.02	
viii				
ix	Pattern of 4-6 week visits continued			
x	'Preparation for Parenthood' continued			
xi	20/22w discussion of employment, social, domestic issues / Domestic violence: including MAT B.1, or N/A ☐			
xii	Advantages of Breastfeeding discussed			
xiii				
xiv				
xv	Pattern of 4-6 week visits continued			
xvi	'Preparation for Parenthood' continued			
xvii	28w Antibodies if Rhesus negative or N/A ☐			
xviii	28w Further Maternal bloods, Random Blood Sugar			
xix				
xx				
xxi	32/34w Information on Breastfeeding, Babycare, and Birthplans			
xxii				
xxiii	34w HB level checked, Antibodies if Rhesus negative			
xxiv				
xxv	36/38w Birthplans, Presentation	2-4-03	VF	
xxvi				
xxvii	If required: 41w Discussion about Delivery, Priming & Induction	2/4/03	NF.	
xxviii				
xxix				

Note any Variances from Pathway with a code letter & explain more fully on Variance sheet at end of Pathway.

SJ 325165E F 23/05/82
MCATEER
GILLIAN
50 ATHOL TERRACE 20.
BATHGATE EH48 4DF

NHS Lothian: **ICP for routine Ante-Natal Care** – pilot v.1c

LIAISON SHEET: Case reference number:
date started: date completed:

AIM: this section is to record Medical history & develop recommendations for your Ante-natal care.

GP DR. HOLDEN	Your Occupation PRODUCTION WINDERICK	Maiden/previous name / or, same ☐	Partner's name, & date of birth DEREK FISHER [redacted] 31/4
Tel. 654844			Occupation: ENGINEER
Home no. 07900638414	Work tel. no. /	Religion / PROT.	His work contact no.

OBSTETRIC HISTORY

Date	Wks	Place	Method	Wt	Sex	Complications	Feeding	Outcome

LMP details at 'Booking'

LMP: date started 20.7.02.
Certain ☐, Unsure ☐
Bleeding since LMP? Yes ☐, No ☐

Cycle: Regular ☑, Irregular ☐, > 31 days ☐
Oral Contraception In last 3m? Y ☑, N ☐ date stopped: July 2002
date of +ve Preg. Test 10.9.02

Provisional dates: 27.4.03. Agreed EDD: 27.4.03
Provisional by US: 24.4.03
Scan report: 16.10.02 CRL ☐, BPD ☐ 12+4
If TWINS, refer to specialist care

FAMILY HISTORY

		Recommendation
TB	Yes ☐, No ☑	
Diabetes: 1° relative with Type II	Yes ☐, No ☑	Random Blood Glucose at 'Booking' & 28w
Hypertension	Yes ☑, No ☐	Consider more frequent BP checks in 3rd Trimester
Pre-Eclampsia: 1° relative	Yes ☐, No ☑	Consider more frequent BP checks in 3rd Trimester
Hereditary Disease	Yes ☐, No ☑	D/W Consultant, & record in 'Special Features' over
Hearing Disorder	Yes ☐, No ☑	If Yes, record in section 4
Other:	Yes ☐, No ☐	
Other:	Yes ☐, No ☐	

MEDICAL HISTORY

		Recommendation / Comments
Operations	Yes ☑, No ☐	If YES to any of these 8 medical conditions, detail & consider referral: Intussusception – Surgery @ 8 months age. Constipation – Chronic. – variety of medication.
G.A. side effects	Yes ☐, No ☑	
Blood Transfusions	Yes ☐, No ☑	
Significant Illnesses	Yes ☑, No ☐	
Medication	Yes ☑, No ☐	
Allergies	Yes ☐, No ☑	
Infertility Clinic	Yes ☐, No ☑	
Accidents / Fractures	Yes ☐, No ☑	Consider referral to Physio / Anaesthetist
Back problems / pain	Yes ☐, No ☑	Ensure up-to-date with smear – no special action
Colposcopy Clinic - previous visit	Yes ☐, No ☑	Consultant referral
I.U.C.D. in situ	Yes ☐, No ☑	Consider Action / referral
Mental Health Problems:	Yes ☑, No ☐	
Other:	Yes ☐, No ☑	

SJ 325165E F 23/05/82
MCATEER
GILLIAN
50 ATHOL TERRACE
BATHGATE EH48 4DF

NHS Lothian: **ICP for routine Ante-Natal Care** – pilot v.1

Liaison Card: page 2

SOCIAL HISTORY *Detail as required*

Unplanned baby but accepting
Living with mum and brother.
Boyfriend - Derek Fisher [redacted]

Other Risk Factors

Smoking Status: Never ☐, Ex- ☐, Current ☑
If smoker, detail 10 daily.

Recreational Drugs: Y ☐, N ☑, Ever ☐
(non-prescribed)
use Drug Liaison sheet if appropriate

Alcohol History: Y ☑ N ☐
If Yes, detail Socially but not now.
if appropriate, use Selective file

Interpreting, Special Needs & Dietary requirements to be noted in Special Features overleaf

Body Mass
Weight: 76 kg
If wt >120kg, refer to Anaesthetist
Height: 5'4" m
BMI ..... *If BMI <20 or >35 refer to Anaesthetist*

Urinalysis	Ketone	Protein	Glucose	Blood
BP	..... /			

Bloods: Booking Bloods discussed & consent given ☑
Signed V. Craven

AFP/HCG Discussed Y ☑, N ☐. Undecided
Return Date given: Y ☐, N ☐: date 21/11/02
AFP result: Further Action required? Y ☐, N ☐.

CF Discussed Y ☑, N ☐. Undecided
Return Date given: Y ☐, N ☐: date 21/11/02
CF result:

INVESTIGATIONS
If appropriate use Supplementary Information file

Test	Date	Result:
Hb	3.10.02	119g Hct 0.34
Blood Group		O
Rhesus		Pos.
TPHA		Neg
Rubella Ab's		Immune
Random Blood Sugar		—
was it <2h ☐ or >2h☐ since food or drink?		
HIV		Neg
Hep B		Neg
Smear	—	—
Uricult / MSU		NSB.

Referrals To consider			
	Ante-Natal Physiotherapy?	Required? Y ☐, N ☑	
	Dietitian?	Required? Y ☑, N ☐	
	Interpreting Services?	Required? Y ☐, N ☑ - book via 0131-242- 8181	
	Special Needs?	Required? Y ☐, N ☑	
	Anaesthetic referral	Required? Y ☐, N ☑	

Note any Variances from Pathway with a code letter & explain more fully on Variance sheet at end of Pathway.

2.2

SJ 325165E F 23/05/82
MCATEER
GILLIAN
50 ATHOL TERRACE
BATHGATE EH48 4DF

SPECIAL FEATURES Recommendations *(multi-disciplinary)*	Variance
Use for clinical Issues, other than recorded previously, with recommendations ANTENATAL *consented to open Supplementory Information file* ☐	Initials & Variances [V]
DELIVERY	
POSTNATAL & PAEDIATRIC	

Note any Variances from Pathway with a code letter & explain more fully on Variance sheet at end of Pathway.

Other comments at 'Booking' – *please ensure all comments are signed & dated.* [illegible]

3-10/21 weeks on booking. Fitt. Fundus just palpable VF

Signed: date: ..... / .... / .....

Addressograph, or
Name
Address
Dob
Ref no.

Health Promotion – *see also "Ready Steady Baby"*			
Supplements	Folic Acid 400micrograms if <12 weeks:	prescribed ☑ or, N/A >12 w ☐	
		prescribed ☐	
Information supplied	"Ready Steady Baby"	☑	
	Delivery Choices	☐	
	Breast Feeding discussion	☐	
	Smoking in pregnancy	Risk Factors? ☑ or N/A	
		☐	
	Exemption Certificate	☑	
	Practice Leaflet	☐	
		☐	
	Hospital information leaflet	☐	
	Screening Leaflets	☑	
		☐	

Healthy Living – WHAT'S ON LOCALLY
Note any Variances from Pathway with a code letter & explain more fully on Variance sheet at end of Pathway.

2.4

NHS Lothian: **ICP for routine Ante-Natal Care – pilot v.1c**

4.1

SJ 325165E. F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1DX

Date: 21.11.02 Gestation 17+4

Content of Care see CHECKLIST for issues in week 16, 18, 22, 28, 34, 36						Initials	Variance
Investigations:				BP: 100/50		VF	
Urinalysis	K	P Neg	G Neg	B	MSU ✓		
Mother	Pres.	Level		Oedema ✓			
and baby	Fetal Heart ✓	FM's		Fundal Height 16-21b			
Added this week: AFP/HCG ☐, Random Blood Glucose ☐ Rh –ve ☐, Hb ☐, DAU ☐							
Result :							

CLINICAL ISSUES (multi-disciplinary) *Please initial all entries*

AFP taken.
CF screening
Information re classes.

Issues for next clinic Consultant Appt

Date: 18/12/02 Gestation 21+

Content of Care see CHECKLIST for issues in week 16, 18, 22, 28, 34, 36						Initials	Variance
Investigations:				BP: 110/70		TCC	
Urinalysis,	K	P —	G —	B	MSU		
Mother	Pres.	Level		Oedema			
and baby	Fetal Heart ✓	FM's ?		Fundal Height 20			
Added this week: AFP/HCG ☐, Random Blood Glucose ☐ Rh –ve ☐, Hb ☐, DAU ☐							
Result :							

CLINICAL ISSUES (multi-disciplinary) *Please initial all entries*

Issues for next clinic

SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX

NHS Lothian: **ICP for routine Ante-Natal Care – pilot v.1**
4.2

Date: 30.1.03	Gestation 27+5		
Content of Care see CHECKLIST for issues in week 16, 18, 22, 28, 34, 36		Initials	Variance
Investigations:	BP: 108/55		
Urinalysis	K — P Neg G Neg. B — MSU		
Mother	Pres.	Level	Oedema		
and baby	Fetal Heart	FM's	Fundal Height		
Added this week:	AFP/HCG ☐, Random Blood Glucose ☐	Rh –ve ☐, Hb ☐, DAU ☐		
Result :				

CLINICAL ISSUES (multi-disciplinary) *Please initial all entries*

Issues for next clinic

Date: 27.2.03	Gestation 32		
Content of Care see CHECKLIST for issues in week 16, 18, 22, 28, 34, 36		Initials	Variance
Investigations:	BP: 110/60		
Urinalysis	K	P Tr	G Neg.	B	MSU		
Mother	Pres.	Level	Oedema		
and baby	Fetal Heart ✓	FM's ✓	Fundal Height	AR	
Added this week:	AFP/HCG ☐, Random Blood Glucose ☐	Rh –ve ☐, Hb ☐, DAU ☐		
Result :				

CLINICAL ISSUES (multi-disciplinary) *Please initial all entries*

well, active baby.

Issues for next clinic

NHS Lothian: **ICP for routine Ante-Natal Care – pilot v.1c**

4.2

Date: 20.3.08 Gestation 34+4.

Content of Care see CHECKLIST for issues in week 16, 18, 22, 28, 34, 36						Initials	Variance
Investigations:				BP: 112 / 60.			
Urinalysis	K ✓	P Neg	G Neg	B ✓	MSU –	VF	
Mother	Pres. Ceph	Level 3/5		Oedema			
and baby	Fetal Heart ✓	FM's ✓		Fundal Height 35cm			
Added this week: AFP/HCG ☐, Random Blood Glucose ☐ Rh –ve ☐, Hb ☐, ~~DAU~~ ☐							
Result :							

CLINICAL ISSUES (multi-disciplinary) *Please initial all entries*

Still having low abdo. ache, explained effect of hormones, head descending VF. (2) Hbb.

Issues for next clinic Home Visit – EPDS, Birthplan

Date: 2.4.08 Gestation 36+3.

Content of Care see CHECKLIST for issues in week 16, 18, 22, 28, 34, 36						Initials	Variance
Investigations:				BP: 120 / 68.			
Urinalysis	K	P Neg	G Neg	B	MSU	VF	
Mother	Pres. Ceph.	Level 3/5.		Oedema			
and baby	Fetal Heart ✓	FM's ✓		Fundal Height 36 cm			
Added this week: AFP/HCG ☐, Random Blood Glucose ☐ Rh –ve ☐, Hb ☐, DAU ☐							
Result :							

CLINICAL ISSUES (multi-disciplinary) *Please initial all entries*

V.D.

EPDS – 9

Birthplan discussed VF.

Hb Result – 10b9.

Issues for next clinic

SJ 325165E
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE
EH48 1BX

F 23/05/88
Address
DoB
Ref no.

NHS Lothian: **ICP for routine Ante-Natal Care – pilot v.1c**
4.2

Date: 17.4.03 Gestation 38+4.

Content of Care see CHECKLIST for issues in week 16, 18, 22, 28, 34, 36 | Initials | Variance

Investigations:			BP: 110 / 64	Initials	Variance
Urinalysis	K ~~—~~	P N	G N	B ~~—~~	MSU ~~—~~
Mother	Pres. Cephn	Level 2-3\5	Oedema	VP	
and baby	Fetal Heart ✓	FM's ✓	Fundal Height 35cm.		

Added this week: AFP/HCG ☐, Random Blood Glucose ☐ Rh –ve ☐, Hb ☐, DAU ☐

Result :

CLINICAL ISSUES (multi-disciplinary) *Please initial all entries*

Baby active (1)

Issues for next clinic

Date: 24.4.03 Gestation 39+4.

Content of Care see CHECKLIST for issues in week 16, 18, 22, 28, 34, 36 | Initials | Variance

Investigations:			BP: 130 / 68	Initials	Variance
Urinalysis	K	P Neg	G Neg	B	MSU
Mother	Pres. Cephn	Level 2-3\5	Oedema	VC	
and baby	Fetal Heart ✓	FM's ✓	Fundal Height 37cm		

Added this week: AFP/HCG ☐, Random Blood Glucose ☐ Rh –ve ☐, Hb ☐, DAU ☐

Result :

CLINICAL ISSUES (multi-disciplinary) *Please initial all entries*

Baby remains active.
Discussed induction.
May consider sweep (1)

Issues for next clinic Membrane sweep

NHS Lothian: **ICP for routine Ante-Natal Care – pilot v.1** 4.2

JJ 325165E
MCALLER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX
[illegible] 23/05/02

Date: 1.5.03	Gestation T+4

Content of Care see CHECKLIST for issues in week 16, 18, 22, 28, 34, 36						Initials	Variance
Investigations:				BP: 110 / 60.			
Urinalysis	K –	P –	G –	B –	MSU		
Mother	Pres. C–	Level 4/5		Oedema –			
and baby	Fetal Heart ✓	FM's ✓		Fundal Height 38			

Added this week: AFP/HCG ☐, Random Blood Glucose ☐ Rh –ve ☐, Hb ☐, DAU ☐

Result :

CLINICAL ISSUES (multi-disciplinary) *Please initial all entries*

Head remains 4/5th Palpable.
Membrane sweep not done.
I.O.L. arranged 7.5.03 at 11[30]. Ward (10).

Issues for next clinic

Date:	Gestation					Initials	Variance
Content of Care see CHECKLIST for issues in week 16, 18, 22, 28, 34, 36							
Investigations:				BP: /			
Urinalysis	K	P	G	B	MSU		
Mother	Pres.	Level		Oedema			
and baby	Fetal Heart	FM's		Fundal Height			

Added this week: AFP/HCG ☐, Random Blood Glucose ☐ Rh –ve ☐, Hb ☐, DAU ☐

Result :

CLINICAL ISSUES (multi-disciplinary) *Please initial all entries*

Issues for next clinic

Addressograph, or
Name
Address
Dob
Ref no.

Date:	Gestation

Content of Care see CHECKLIST for issues in week 16, 18, 22, 28, 34, 36							Initials	Variance
Investigations:				BP: /				
Urinalysis	K	P	G	B	MSU			
Mother	Pres.	Level		Oedema				
and baby	Fetal Heart	FM's		Fundal Height				
Added this week:	AFP/HCG ☐, Random Blood Glucose ☐			Rh –ve ☐, Hb ☐, DAU ☐				
Result :								

CLINICAL ISSUES (multi-disciplinary) *Please initial all entries*

Issues for next clinic

Date:	Gestation							
Content of Care see CHECKLIST for issues in week 16, 18, 22, 28, 34, 36							Initials	Variance
Investigations:				BP: /				
Urinalysis,	K	P	G	B	MSU			
Mother	Pres.	Level		Oedema				
and baby	Fetal Heart	FM's		Fundal Height				
Added this week:	AFP/HCG ☐, Random Blood Glucose ☐			Rh –ve ☐, Hb ☐, DAU ☐				
Result :								

CLINICAL ISSUES (multi-disciplinary) *Please initial all entries*

Issues for next clinic

Addressograph, or
Name
Address
Dob
Ref no.

Multi-disciplinary Additional Notes *(Use this for new information not held elsewhere, ensuring all entries are initialled / dated*

NHS Lothian: **ICP for routine Ante-Natal Care** – pilot v.1c

Addressograph, or
Name
Address
Dob
Ref no.

Variances: all staff to identify & record variances.

Break down into types: a) Mother /baby /Relative, b) Clinical staff, c) Hospital System, d) Community/External.

Types of Variance Codes

A. Mother /baby /relative	B. Clinical Staff	C. Hospital System	D. Community/ external

Record of Variance

date	Time	Description of issue with documentation	Reason for Variance from documentation	Action taken (*and outcome if possible*)	Variance code	Initials
18/12/02	pm	Chaise constipated	Getting wise & pregnancy	Has lactulose + suppositories	(a)	TCC
/						
/						
/						
/						
/						

4.4

SJ 325165E
MCATEER
GILLIAN
50 ATHOL TERRACE
BATHGATE
EH48 4DF

NHS Lothian: ICP for routine Ante-Natal Care – pilot v.1

Key to Initials of ALL STAFF completing this ICP

	Print name	Designation	Initials	Signature	date
1	VANDA FRASER	CM	V.F.	V. Fraser	3.10.02
2	TARA COOPER	Cons	TCC	Tara Cooper	18/12/02
3	ANNA KANNO	C/M	AK.	AK to.	27.7.3
4	ANN RUSSELL	c/m	ear	e Russell	1.503
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					

This sheet is an essential record of all the staff who have completed part of this documentation. This allows each entry to be traced to an individual member of the clinical staff.

4.5

Addressograph, or
Name
Address
Dob
Ref no.

Key to ABBREVIATIONS and Medical terms used within this ICP.

Abbreviation	Short for	Abbreviation	Short for
1. R.B.G.	Random Blood Glucose	2. LMP	Last Menstrual Period
3. C.F.	Cystic Fibrosis	4. G.A.	General Anaesthetic
5. B.P.	Blood Pressure	6. TB	Tuberculosis
7. I.U.C.D.	Intrauterine Contraceptive Device ('the coil' etc.)	8. EDD or, DD	Estimated Date of Delivery, Date of Delivery
9. U.S.	Ultrasound Scanning	10. AFP / HCG	"Double Test", referred to in "Ready, Steady, Baby" [page 41]
11. H.C.G.		12. Hb	Haemoglobin (iron content of blood)
13. C.R.L.	Crown Rump length (a measure of .....)	14. BPD	Biparietal Diameter (an ultrasound measurement of the baby's head)
15. 1° relative	Mother, father, son, daughter, brother, sister	16.	
17. B.M.I.	Body Mass Index (a measure of body size/fatness)	18.	
19.		20.	

4.6

1

HOSPITAL

LOTHIAN AND BORDERS AREAS

MATERNITY SERVICES ANTENATAL CARD

ANTENATAL No.

Case Ref. No.	Date of Birth	Surname
Consultant	Age	First Name(s)
	M / S / DIV / SEP / WID	Address
GP's Name	Maiden Name	
Address	Date of Marriage	Post Code Tel No.
Post Code	Religion	CHI Number
Tel No	Occupation	Husbands Name & Occupation Age
Practice No.	Date of Leaving	Date of 1st Appt. (G.P.)

OBSTETRIC HISTORY

DATE	Wks	Place	Method	Wt	Sex	Complications	Feeding	Outcome

BOOKING EXAMINATION

Date LMP

Certain 1
Uncertain EDD
Bleeding since LMP 2

Cycle
Regular
Irreguler > 31 deys

Contraceptive:
Date Stoppad:
IUCD in Situ:

FAMILY HISTORY — Relevant Details:

Twins	No/Yes
TB	No/Yes
Diabetes	No/Yes
Hypertension	No/Yes
Hereditary Oisease	No/Yes
Hearing Disorders	No/Yes
Other	

MEDICAL HISTORY — Relevant Deteils:

Operetions	No/Yes
G.A. - Side Effects	No/Yes
Blood Trensfusions	No/Yes
Significent Illnesses	No/Yes
Medicetion	No/Yes
Allergies	No/Yes
Infertility Clinic	No/Yes
Accidents/Fractures	No/Yes
Rubella Status: Immune/Not Known	

SOCIAL HISTORY

Smoking /day
Alcohol
Drugs

CLINICAL EXAMINATION — Relevant Details:

AS	☐
Teeth	☐
RS	☐
Breasts	☐
CVS	☐
VV's	☐
CNS	☐
Haemorrhoids	☐
Pelvic Exem.	☐

INVESTIGATIONS

TEST	DATE	RESULT
Hb		
Blood Group		
Rhesus		
TPHA		
Rubella Abs		
Uricult/MSU		
Smear		
Other		

Petiant Care Proposed by G.P.: Consultant Shered Full G.P.
G.P. Post-Natal Early Discharge G.P./F.P. Advice

Signed ..... G.P.

Agreed ..... Cons.

Perentcreft : Hospital / Community

Social Referrel : Home Help
Dietician

ANTENATAL

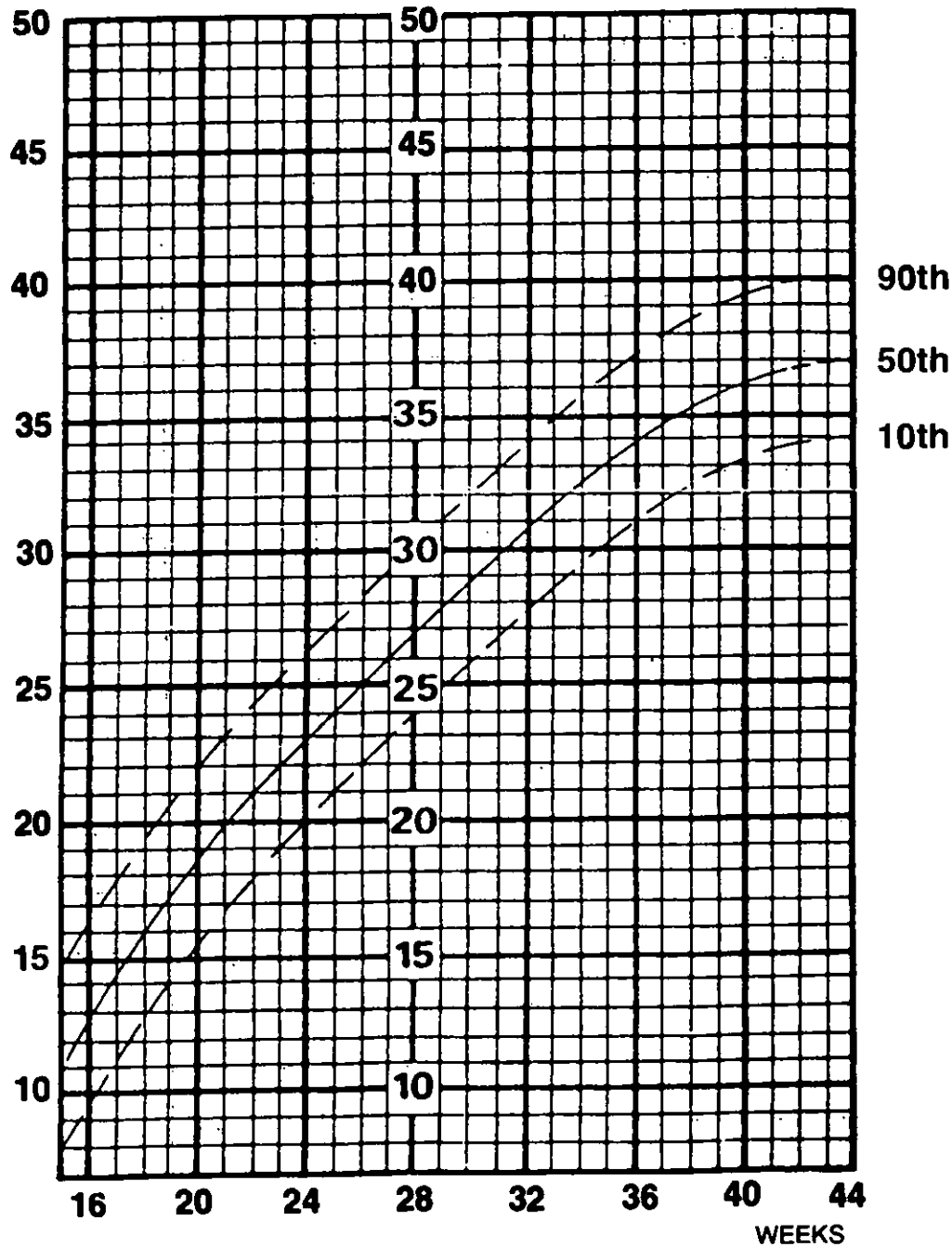
Name	Special Features	Recommendations
Age		
Height		
Parity		
Blood Group		
Ultrasound		
Date		
CRL/BPD		
Finel EDD		

Date	Wks	Weight (Kg)	Urine		BP	Fundus (cm) / Girth	Pres.	Level	FHH	Hb / Rhesus	Oed
			P	S							

Commenta				Weeks/Place to return	Signature and Designation
AFP 16 wks	Yes No	GP Hospital	Data		

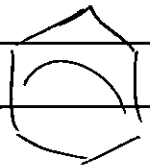
Fundal Height Chart

S. F. Height
cms



WLT 442

	ANTENATAL INPATIENT SHEET	
Data and Tima	Nama Gillian McAteer No.	Signature and Designation
17/3/03	Referred from west doc	
01 00	? lower abdo pain.	
	34^{+5}/40 gestation.	
	O/A not distressed	
	T. P. 102 BP 130/74	
	No c/o urinary symptoms	
	but urine is cloudy	
	+ protein. MSU ✓	
	No tightenings ° PV loss.	
	O/E Long lie	
	Cephalic, gree.	
	Back to mat (L)	
	Commenced CTG.	
	Fetal tachycardia noted	s/m P Dumond.
17/3/03	SHO Review.	
01.25.	GP referral.	
	20?, Prim. 34^{+3} weeks.	
	Lower abdo. pain for 3 hours.	
	Pain intermittent. Has now gone.	
	Worse on movement.	
	No nausea/vomiting	
	No urinary symptoms.	
	Bowels moved today.	

	ANTENATAL INPATIENT SHEET	
Date and Time	Name No.	Signature and Designation
	- Fetal movements felt.	
	Pregnancy uneventful so far.	
	O/E Undistressed.	
	P 90 BP 130/74 T 36	
	Abdo  grand uterus. FH = dates. Cephalic presentation	
	CTG - reassuring.	
	NSR contracting.	
	Imp Musculoskeletal pain	
	? UTI (+ protein in urine)	
	(P) Home & analgesia	
	Return if req'd	
	MSU sent.	J McCallum (McCALLUM SHO)
01.30	CTG discontinued.	
	Fetal tachycardia settled	
	Baseline 140 bpm	
	Good BBV.	
	Reactive trace.	S/M R Drummond

SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX

MIDWIVES

PLEASE SIGN AND DATE WHEN DISCUSSED

1. MOBILITIY IN LABOUR As mobile as possible.
2. MONITORING (indications for continuous monitoring discussed and excluded) discussed
3. PAIN RELIEF options discussed.
4. A.R.M. As for IOL
5. POSITION FOR DELIVERY wait & see
6. EPISIOTOMY discussed, consent given if necessary.
7. SYNTOMETRINE consent given IM
8. KONAKION consent given IM.
9. SKIN-TO-SKIN CONTACT

07/05/03
10.30
Angela Steele SIM
(STEELE)

[redacted]

WLT 467

SJ 325165E [illegible] F 23/05/82

MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX

Date and Time	Name	Signature and Designation
07/05/03 11⁰⁰	Admitted to ward 10 for 10L for post dates at T+10.	
	O/A T 36⁸ P 90 BP 110/70.	
	O/P Fundus -38cm.	
	Long lie.	
	Cephalic presentation	
	Back to maternal left.	
	Head 4/5 palpable.	
	CTG commenced.	
	Induction procedure explained.	
	and midwives checklist completed	Angela Steele (STEELE) SM
12⁰⁵	CTG discontinued. Extended trace	
	due to initial LOC Reactive	
	trace good bbv. Baseline initially	
	155 bpm then 140 bpm & accelerations	
	↑ 170 bpm & decelerations.	Angela Steele SM.
12²⁰	VE performed & consent & view	
	to give prostin.	
	Cx - posterior, 75% effaced, average	
	consistency.	
	External os admits a fingertip	
	Internal os closed. Bishops score 2.	
	2mg prostin gel inserted into posterior fornix	Angela Steele SM.

CONTINUATION SHEET No 325165

Date and Time	Name Gillian McATEER [redacted] No. [redacted]	Signature and Designation
12.50	Post prostin CTG commenced	Angela Steele S/M
13.45	CTG - FH baseline 125bpm, reactive trace & accels. 1	
	160bpm, good BLV. 0 cons	[illegible]
7.5.03. 15.45	Check - F.H.H.R 120-128bpm.	
	Gillian is not aware of tightenings at present and none palpable, she	
	is aware of mild "period like" pain.	WALLACE
	Encouraged to mobilize in meantime.	M Wallace S/M.
18.00.	Pre. prostin C.T.G commenced.	
	F.H baseline. 125-130 bpm	
	Reactive trace; accelerations ↑ 160bpm	
	good variability, 0 decelerations	
	Tightenings mild 3:10.	
18.40	V.E performed with consent to assess	
	progress. External genitalia appears	
	normal. Cx posterior, soft, 75%	
	effaced. Os admits a finger tip	
	Tightenings mild 3:10.	
	Bishop Score 3.	
	In view of findings 1mg Prostin	
	inserted into posterior fornix.	
19.20.	Post. Prostin C.T.G commenced.	M Wallace S/M

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CONTINUATION SHEET

Date and Time	Name Gillian McAteer No. 325165	Signature and Designation
7.5.03	Sleep trace initially F.H baseline 125-130 bpm becoming more reactive with accelerations ↑ 155 bpm, acceptable variability, ° decelerations, mild irregular tightenings 3-4 : 10.	WALLACE M Wallace
21[30].	Gillian remains aware of tightenings using birthing Ball at present to release Back pain otherwise well.	L. Watson stu
22[00] hrs	Check - FHHR @ 122-145 bpm over 3 minutes before, during and after tightening. Gillian still aware of irregular tightenings @ present. comfortable @ the moment. Encouraged to rest and await events. Aware to buzz staff if requires pain relief.	M. Clark S/M (CLARK)
23[00].	GILLIAN C/O BACKACHE - GOING FOR A WARM BATH — TRIED TO GET A TENS MACHINE - NONE AVAILABLE.	M Blackie S/M

	CONTINUATION SHEET	
Date and Time	Name GILLIAN Mc. ATEER No. 325165	Signature and Designation
8/5/03	GILLIAN ASLEEP.	M Blake. S/M.
00.10 MN.	GILLIAN AWAKE - C/O BACKACHE	
00.40	AND LOWER ABDO. CRAMPS. -	
	TIGHTENINGS FELT. F.H.H.R Reg. 148.	
	PARACETAMOL TABS. 1g AND HYDROCODIENE	
	30MG. GIVEN.	M Blake. S/M
02.00.	GILLIAN ASLEEP.	M Blake. S/M
04.00.	GILLIAN REMAINS ASLEEP.	M Blake. S/M
06.10.	GILLIAN AWAKE - REQUESTING	
	PARACETAMOLS - AWARE OF BACKACHE.	
	F.H.H. Reg. 130.	M Blake. S/M
08.00	Has contracted irregularly	
	overnight but now settled	
	Pre-prostin CTG commenced.	K Hegarty (SM)
08.15.	Observations P 80 BP 122/80 T 35.4	M Wallace NALLACE S/M
	F.H baseline 130-135 bpm Reactive trace	
	accelerations ↑ 150 bpm. Good variability	
	° decelerations. ° tightenings.	
	V.E with consent with a view to giving	
	further Prostin. External genetalia	
	appears normal, Cervix soft, mid	
	position, Os 1cm dilated	
	Cx 1-2cm long; Bishop Score = 6	
	P.P - 3 above I.S, fairly well applied.	
	Findings discussed with Gillian & Derek.	

WLT 467

CONTINUATION SHEET

Date and Time	Name Gillian McAteer No. 325165	Signature and Designation
8.5.03	1mg Prostin gel inserted into posterior	WALLACE
	fornix. F.H.H.R 148 following procedure.	MWallace s/nr
09.25	Post Prostin C.T.G commenced:	
	F.H baseline: 125-130 bpm, Reactive	
	trace, accelerations ↑ 150 bpm,	
	Acceptable variability, no deceleration.	
	Gillian aware of back ache and lower	
	abdo pain. Encouraged to mobilize	
	in meantime.	MWallace s/nr
12.00 mid-day	Check - F.H.H.R. 140-145 bpm.	
	Gillian aware of back ache and low	
	abdo pain. Has felt occasional	
	tightenings, encouraged to mobilize.	
13.30	Paracetamol tabs 1g given for pain	
14.10	Gillian back on CTG with consent	L. Dawse (DAWSE) ST/M
	1500 Sp R STOCK	
	-RN: - PG - 10L for Post maturity	
	CTG - Reactive	
	O/E: - Abdo: FH = 35cm. Longitudinal	
	Cephalic 2/5	
	PV: Cx 1-2cm dil. Posterior. Firm.	
	1cm long - Membranes swept	
	Prostin 1G post fornix	→

CONTINUATION SHEET

Date and Time	Name Gillian McAteer No. 325165	Signature and Designation
	Plan: - CTG 1°	
	- R/V 6° with view to	
	ARM — if suitable for	
	ARM rest overnight	(DOOLEY)
	+ send to LW in 7am.	
	- if not favourable	
	for further Img. Prostin	
14.45	C.T.G. F.H. baseline 130-135 bpm.	
	Reactive trace with accelerations	
	↑ 155 bpm, 0 decelerations, acceptable	
	variability. uterine activity not	
	noted on C.T.G. Gillian is	WALLACE
	aware of irregular tightenings and	Mdallace S/M
	back ache.	
16[15]	& Post-Prostin CTG. Baseline 110 bpm. Normal	
	variability. Accelerations noted. Period of LOC	
	for 12min due to FM. Remainder of	
	trace reactive with good variability. Some	M McGRATH (GREIG).
	irregular contractions noted.	
18[00]	Gillian's contractions are 4:10	
	moderate. FHH, 140 bpm on ~~dopplex~~.	(DOWSE)
	Sonic-aid.	S/M

WLT 467

CONTINUATION SHEET

Date and Time	Name GILLIAN MCATEER No. 325165	Signature and Designation
8/5/03	Reviewed	
21²⁰	PA - Cephl 3/5	
	V/E - Cervix 1 cm dilated, 2 cm long, post	
	- soft.	
	Would be difficult ARM	
	→ 1mg PGE₂ given.	
	CTG - reassuring.	
	Pt Reamen in re ? c/s	
	to ARM	
		Gillian
		(Syst).
22⁰⁵hrs	POSE prostin CTG commenced	
	V/C consent to assess fetal	
	wellbeing + uterine	
	activity.	M. Clark S/M (CLARK)
22³⁵	CTG discontinued @ Gillian's	
	request. FH baseline	
	difficult to determine due	
	to reactivity and FM++.	
	Good beat to beat	
	variability. UA - tightening	
	2-3:10 irregular and	
	short lasting. Gillian up	

8/5/03 - CONTINUATION SHEET

Date and Time	Name Gillian McAteer No. 325165.	Signature and Designation
	for walk. Will recommence CTG trace when she returns to ward.	(CLARK) M. Clark S/M.
2339 hrs	Gillian back to ward. feeling really uncomfortable. Not keen for CTG to be recomenced. In day room to use gym ball.	(CLARK) M. Clark S/M
0005	Gillian requesting TENS. TENS borrowed from LW. TENS applied and instructions for use given.	M. Clark S/M.
0035	FHHR @ 122-143 bpm over 3 minutes. before during and after a tightening. ° decelerations noted. Gillian remains aware of irregular uterine activity. Good effect from TENS machine. Aware to let staff know if she becomes sore. Trying to sleep meantime.	S/M M. Clark (CLARK)

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CONTINUATION SHEET

Date and Time	Name Gillian McAteer No. 325165.	Signature and Designation
9/5/03 0200.	GILLIAN AWAKE C/O BACKACHE & ABDO. PAINS. ONE TIGHTENING FELT IN 10 MINS., FHR Reg. 130	
	~~Co~~-DYHYDROCODEINE 30 mg GIVEN.	MDblarke. S/M
0430	GILLIAN ASLEEP.	MDblarke. S/M
0600.	GILLIAN AWAKE AND WISHING TO GO OUT OF WARD "FOR A WALK".	MDblarke. S/M
0745	Commenced CTG. Observations T 35.8 P 88 BP 119/76. Gillian aware of mild irregular uterine activity	St M (M'GOINNESS) Nicoli Mlunin
0810	CTG discontinued. Reactive trace good bbv, baseline 125 bpm +ve accelerations 155 bpm, -ve decelerations, mild irregular uterine activity. Gillian mobilising upstairs for breakfast. For review	Nicoli Mlunin
0915	WR	
	Some VA overnight.	
	PA - Gph 3/5	
	V/E - Cervix 1-2 cm dilated, mid ant, Soft	
	→ for ARM	
		Gordon (SpR)

	CONTINUATION SHEET	
Date and Time	Name Gillian McAfee No. 325145E	Signature and Designation
9/5/03 1015	Gillian transferred to Labour Ward	
	Care taken over by myself S/M L	
	Black. Gillian c/o irregular UA	
	over morning only. Ding to toilet	
	PRN	
	T = 36.5°C P = 86 BP = 120/70	
	O/E = Long Lie	
	Cephalic Presentation	
	Back to maternal left	
	Head ?3/5th palpable.	(BLACK)
	CTG commenced prior to ARM.	L Black S/M
1045	CTG discontinued, Reactive Trace	
	Baseline 125-130 bpm with ↑'s up	
	to 155 bpm. No decelerations	
	Uterine activity 1:10 Mins/moderate	
	on palpation.	L Black S/M
1100	VE performed with consent with	
	view to ARM.	
	Cervix mid posterior 1-2 cm long soft	
	Os 1-2 cm dilated	
	P.P. Fairly well applied @ 1.5-2 to 3 cm	(membranes close to lead)
	No cord No vessels felt	
	ARM performed, small amount	

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Hospital: St Johns.

Name/or Addressograph

Labour Ward

Observation Chart

Consultant TKC.

	Data	Time	T	P	BP	FHR	Reason for Admission and Gestation
Admission to Labour Ward	9/5/03	10¹⁵	36⁵	86	12/70	140	IOL @ T+10.

			Parity	EDD
Onsat of Contractions			O+O	27/4/03
Rupture of Membranes	~~Spont.~~ Artf.	9/5/03 11⁰⁰	Blood Grp. O POS	Hb

Cervical Score	0	1	2	3	Score
Dilatation	<1	1-2cm	2-4cm	>4	
Length of Cx	>4cm	2-4	1-2cm	<1	
Station	−3	−2	−1/0	+	
Consistancy	firm	averaga	soft		
Position	post	mid/ant			

Urinalysis O/A

Induction Yes/No Total

Spacial Instructions

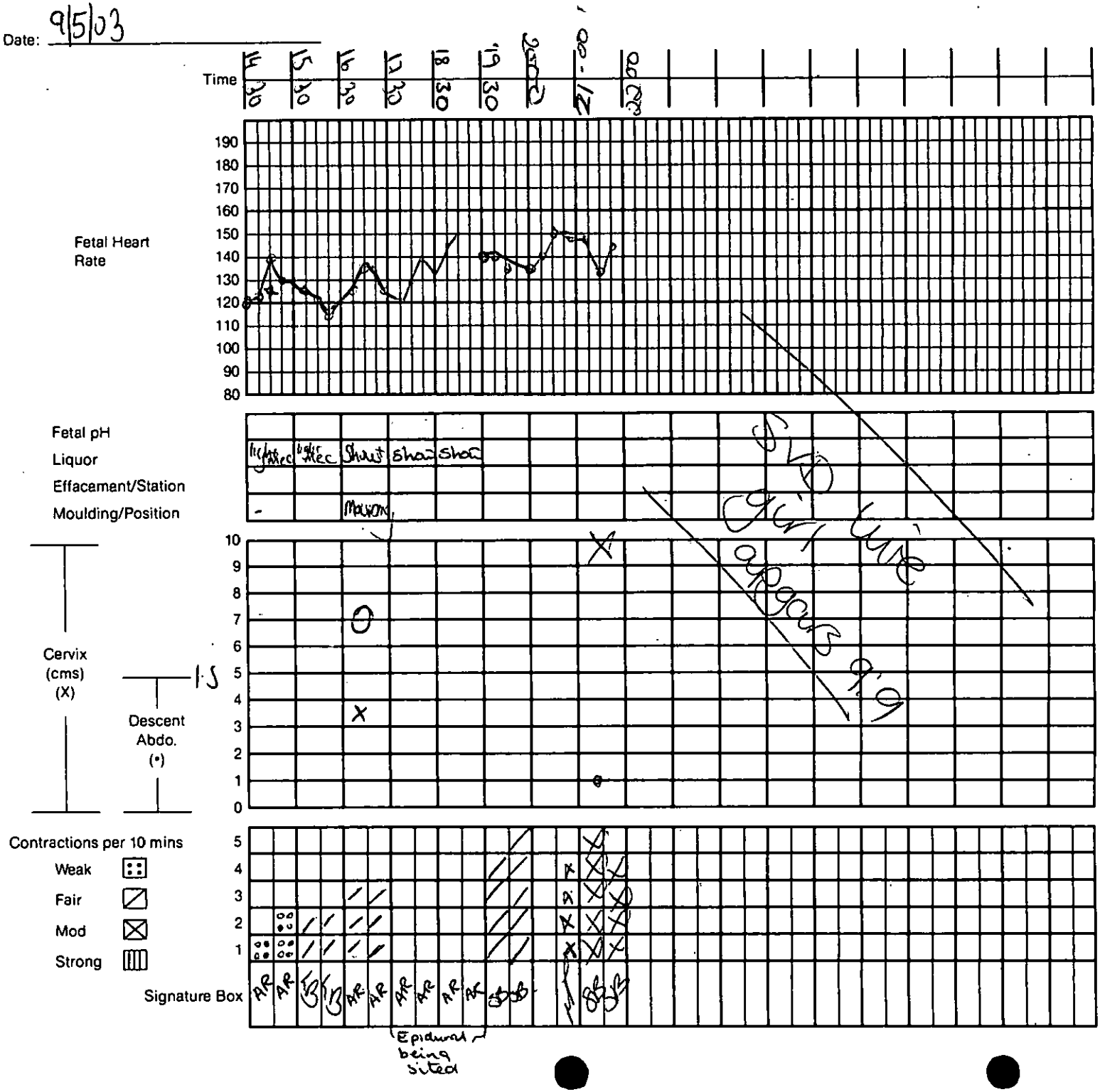
Specify Induction Method: Prostin + 7mg Syntocinon ARM

Birth Plan Discussed:

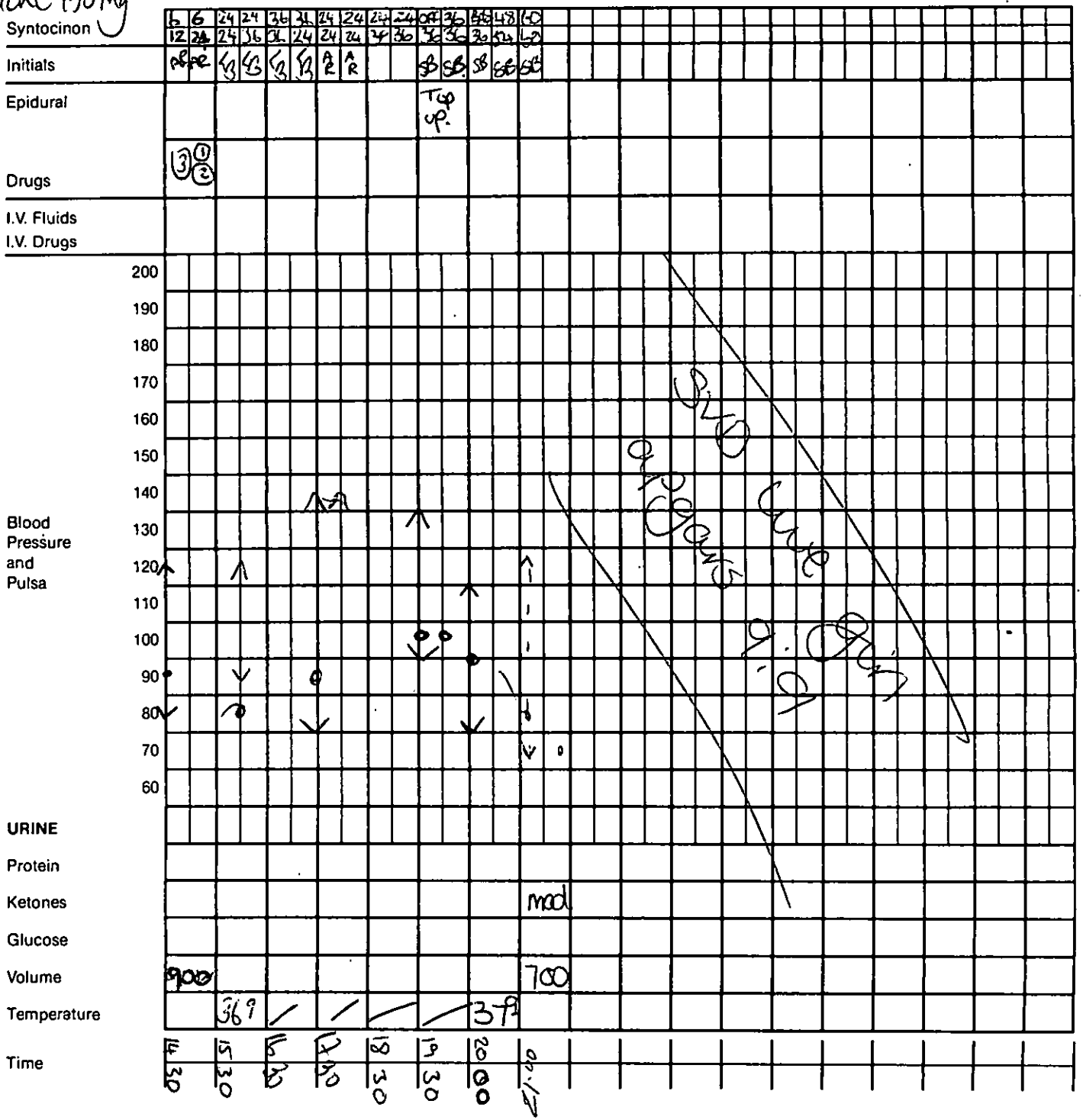
Data and Tima	COMMENTS	Signature and Designation
	Clear liquor drained old prostin ++.	
	p.p. well applied @ 1-5-2 to 3cm.	
	FHHR 130-140 bpm Following	(BLACK)
	procedure	L/Pack SIM
	Gillian along to Day Room to	
	Mobilise.	
11¹⁰	Gillian out to Capital shop.	L/Pack SIM
11⁴⁵	Gillian back from walk, Contracting	
	2:10 now Feeling sorer advised	
	to Mobilise meantime. FH 120/135 bpm (BLACK)	
	Perky liquor on pad-charcoal.	L/Pack SIM
12¹⁵	FH 120-130 bpm Contracting 2 to 3:10	

WLT 454

Date: 9/5/03


Time
14:20
15:20
16:30
17:30
18:30
19:30
20:30
21:00
22:30
Fetal Heart Rate
190
180
170
160
150
140
130
120
110
100
90
80
Fetal pH
Liquor
Effacement/Station
Moulding/Position
light mec
light mec
Shout
Shout
Shout
-
Mouldy
SVD Cord Prolapse 9.19
Cervix (cms) (X)
Descent Abdo. (•)
10
9
8
7
6
5
4
3
2
1
0
1·5
Contractions per 10 mins
Weak
Fair
Mod
Strong
5
4
3
2
1
Signature Box
AR
Epidural being sited

① Diamorphine 10mg IM
② Cyclizine 50mg IM.
③ Ranitidine 150mg



Date and Time	COMMENTS	Signature and Designation
9/5/03	Fair/Moderate on palpation.	LBlack s/m
13³⁰ hrs	Sanitary pad inspected light meconium stained liquor on pad	
	Gillian informed of this and explanation given, Contracting 2 to 3:10 Fair/mod will discuss	
	Synto with reg. version to be visited.	(BLACK) LBlack s/m
13⁴⁰	CTG recommenced due to meconium stained liquor. P-90 BP-120/80	LBlack s/m
14⁰⁰	D/W Dr. Nad. for Syntocinon infusion. Verbal read. Bloods in fridge	LBlack s/m
14²⁰	Syntocinon infusion commenced at 6 mU/hr as per protocol.	LBlack s/m.
	CTG continues Reactive Trace initially Baseline 125 bpm with 1's up to 160 bpm Trace becoming sleep trace over last 10 minutes.	
	Uterine activity not picked up well by Toco on palpation 2 to 3:10	(BLACK)
	Fair on palpation.	LBlack s/m
14³⁰	Gillian ~~up~~ ERROR to toilet on to side	
	becoming sore with tightenings.	LBlack s/m
14⁵⁰	Syntocinon ↑ 12 mU/hr UA 4:10	LBlack s/m

WLT 467

CONTINUATION SHEET

Date and Time	Name Gillian McAteer No. 325165E	Signature and Designation
15^{20}	Contractions 2:10 mild	
	IV Syntocinon ↑ 24mls/hr	
	FH baseline 135. BBV of 15bpm	
	accelerations ↑ 155.° decelerations	
	Gillian finding contractions	
	sore - has tried entonox but	
	does not like it - requesting	
	injection for pain. PU - 900mls	
	of clear urine, pad changed -	
	light mec. stained liquor	A. Russell ST/N
15^{25}	10mg Diamorphine given IM	
	50mg Cyclizine given IM	
15^{45}	Gillian doesn't feel diamorphine	
	has helped with pain, discussed it	
	with uterine activity keen for	
	epidural.	
15^{50}	Anaesthetist contacted	
15^{55}	Gillian changed into gown,	
	Anaesthetist arrived sitting up	(BLACK)
	FH 110 bpm.	L Black SIM
16^{10}	IV Hartmans commenced	
	epidural being sited (test dose 2% Lignocaine 4ml)	
16^{15}	Epidural sited (see anaesthetic record)	

	CONTINUATION SHEET	
Date and Time	Name Gillian McAteer No. 325165E	Signature and Designation
16^{20}	BP 150/90 Synto ↑36 mU/hr.	
	(delayed due to siting of epidural)	(BLACK) LBlackpSM
16^{25}	BP 145/85 16^{30} BP 140/85	
16^{35}	BP 150/85 Gillian remains	
	tearful with UA. Epidural	
	infusion commenced.	
16^{45}	Gillian remains sore anaesthetist	
	back further 5 mls of 2% lignocaine	(BLACK) LBlackpSM
	given.	
	CTG continues Reactive trace	
16^{50}	BP 150/85 Baseline 125 bpm with	
	↑'s present up to 165 bpm	
	periods of LOC on CTG.	
	Uterine activity remains difficult	
	to palpate 3-4:10 Fair/moderate	
	on palpation.	
16^{55}	Gillian distressed tt with UA,	
	doesn't feel epidural has helped.	
	Gillian happy for VE and FSE	
	to be applied (due to difficulty	
	in recording FHR) to assess if	
	fully dilated or distressed tt.	
17^{00}	VE performed with consent to	

WLT 467

CONTINUATION SHEET

Date and Time	Name Gillian McAteer No. 325165E	Signature and Designation
9/5/03	aware progress.	
	Cervix anterior, thin, fully effaced	
	3-4 cm dilated	
	p.p. well applied @ 1.5-2cm	
	moulding ++ Fetal Position not	
	determined. FSE applied	
	FH 140 bpm and recording. Heavy	
	show ++ during examination and	(BLACK)
	on examining finger.	LBlackSIM
	Gillian and Derek informed of	
	findings	
17 15	Further epidural top-up by	
	anaesthetist 50 micrograms Fentanyl	(BLACK)
	5mls 2% Lignocaine given.	LBlackSIM
17 20	BP 155/90 Synto ↓ 24mU/hr	
	as Gillian distressed ++.	
17 30	BP 140/75 Anaesthetist back	(BLACK)
	will resite epidural.	LBlackSIM
17 40	Gillian lying on Right side.	
17 50	Procedure started for spinal 7 her	
	epidural.	
18 00	Spinal in site BP 145/85	
18 05	Epidural being re-sited	A. Russell ST/N

	CONTINUATION SHEET	
Date and Time	Name Gillian McAteer No. 325165E	Signature and Designation
18[10]	Epidural still being re-sited	
	BP 145/85.	A. Russell ST/4
18[15]	Back Pain break (covered by SHM A Russell), Anaesthetist still trying to site epidural CTG continues Baseline 130 bpm with Ns up to 155 bpm. Shallow Ds noted to 120 bpm with quick recovery to baseline C° early Ds TOCs not on site) will observe and recommence toco when epidural sited.	L Black SM
18[30]	Anaesthetist unable to site epidural will contact over Anaesthetist Gillian now moved into semi-recombant position good effect from spinal toco recommenced.	L Black SM
18[50]	Synto ↑ 36mU/M no UA felt on palpation Gillian not feeling UA since spinal.	L Black SM
	Anaesthetist arrived	
18[55]	Gillian sitting up for siting of epidural.	CB L Black SM
1915	Care taken over by SHM Brown	S Brown SHM

WLT 467

CONTINUATION SHEET

Date and Time	Name Gillian Mcateer No.	Signature and Designation
1916	Testdose as per anaesthetic record.	
	Registrar asked to come and review CTG	
9/05/03	Reviewed.	
19.25	Gillian having 3rd try at the epidural as she is very sore — hence the delay in putting up Syntocinon infusion	
	CTG- Toco not picking up very well	
	On palpation contractions are mild 3in10.	
	CTG- variability ↓ in parts.	
	? shallow early decelerations ↑. Contractions need to be palpated & marked.	
	Anaesthetist in the room presently for analgesia. To observe for now.	P. Durga Devi (SpR)
19.35	Gillian distressed ++	
	∴ Syntocinon stopped until epidural effective. Anaesthetist still in room	S Brown RM
1945	Syntocinon recommenced at 3bu/hr. Gillian appear comfortable now.	
1955	P110 T 37.9 BP 120/80.	

	CONTINUATION SHEET	
Date and Time	Name Gillian McAteer No. 325165	Signature and Designation
2000	Paracetamol 1g given oral	BROWN SIM
2010	Variable decelerations noted on CTG	
	Dr. Devi asked to review.	
	To observe meantime and	
	increase syntocinon as contractions	
	fair. 20.15 Synto ↑ 18 mU/hr.	BROWN SIM
2020	Variable decelerations continue,	
	baseline 145bpm with	
	decelerations ↓ 110bpm,	
	normal variability throughout.	BROWN SIM
2040	BREAK - mlup -	Mpowell SCM. (POWELL)
2045	Synto ↑ 5mU/hr.	
	Early decelerations continues	
	Variability is good.	
	Contractions not being recorded on	
	CTG - feels mod - 5 in 10.	
	Gillian is pain free & sleeping.	MLP
2115	VE to assess. Catheterized -	
	700ml urine obtained.	
	Caput visible when labia parted.	
	Cx fully dilated, occiput anterior	
	position LOT.	

WLT 467

CONTINUATION SHEET

Date and Time	Name Gillian McAleer No. 325165	Signature and Designation
	CTG continues to have variable decelerations ↓80 bpm, SIB Dr. Devi (Registrar), to commence active pushing at 10pm unless CTG becomes worse.	BRAUN SIM.
21.40	Asked he see mace Having late decelerations ↓ 90 bpm good recovery Dr Devi informed	(HATTON) Hatton gn
21.55	Active pushing commenced	
2150	Vx visible	
21.55	84 ~~2200~~	
~~2205~~	~~2210~~	Brown SIM
2159	SVD live girl. Cord x2 round neck & body x1	
2205	Placenta & membranes delivered by CCT	
	Epidural & Synto disconected	
2315	Baby to the breast.	
0020	Bed - booked.	
	Obs T 36° P 88 BP 110/70	
	lochia average	Brown

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Name: Gillian McAteer CRN: 325165E Area Unique No. 4210101041K

LABOUR AND DELIVERY

Mode of Delivery/Time	SVD 2159
Presentation at Delivery	Cephalic

STAGE	Date	Start Time	Length (Hrs)
First	29.05.03	1430	7hrs 5min
Second	"	2135	24min
Third	"	2159	6min
End of Third/Total	"	2205	7hrs35
Membs. Rupt. (Calculate to end 2nd Stage)	"	1100	10hrs59

FETAL DISTRESS	1st Stage	2nd Stage
Meconium	✓	
Bradycardia: Baseline		
Deceleration: Early		
Late		
Variable	✓	✓
Tachycardia		
Irregularity		
Fetal Blood Sample		

PLACENTA WEIGHT g.

Delivery:	
Controlled Cord Traction	✓
Manual Removal	
Other	

Complete	✓
Incomplete	
Doubtful	
Retroplacental Clot	
Calcification	
Infarction	
Other	

Membranes

Complete	
Incomplete	
Doubtful	✓

Cord Length: cm No. of Vessels 3

Insertion Type Central Abnormality

BLOOD LOSS 150 ml.

Episiotomy: Labial graze

Laceration:

Sphincter inv.:

Suture Material: Not sutured

No. for removal:

Signature:

Oxytocic drugs at delivery: Syntometrine Im.

Time 00.39 Temp 36 Pulse 88 B.P. 119/80

Fundus firm@1fb Bladder HNPU

INFANT SUMMARY

	1	2
Time	2159	
Sex	female	
Weight (g)	2880g	

APGAR	1	5	10	1	5	10
Heart Rate	2	2				
Respiration	2	2				
Muscle Tone	2	2				
Reflexes	2	2				
Colour	1	1				
Total	9	9				

Time 1st Resp. at birth

Time Sust. Resp. <1min

RESUSCITATION

	1	2
Nil (incl. Clearing Airway)	✓	
Mask and IPPV		
Intub and IPPV (no drugs)		
Intub and IPPV (with drugs)		
Transferred to Ward		
Special Nursery: Specify		
Other		

Remarks on Resuscitation or Delivery:

Konakion Given: (YES)/NO

Cord Blood Taken: YES/(NO)

Specify Reason

SPECIFY NAMES OF FOLLOWING:

Senior Person Present: Dr. Devi

Midwife: SM S Brown

Delivered by: S. Brown

Resuscitated by:

Identification by: SMS Brown + Parents

WLT 696

DELIVERY		POST NATAL & PAEDIATRIC	
Special Features	Recommendations	Special Features	Recommendations

STATE ON DISCHARGE ..... Date .....

Perineum .....

Breests .....

B.P. /

Hb

Drugs — Iron .....

Antibiotics .....

Prescriptions Provided — Rubella Veccine ..... Batch No. .....

Anti-D Immunoglobulin ..... Batch No. .....

Other .....

Contraception .....

Remarks .....

Exeminer/Designetion .....

Infent Feeding - Breast/Artificiel .....

Baby's Health on Discharge .....

Discharge Weight ..... Kg Follow-up .....

S.B. N.N.D. G.P. phoned by ..... on .....

6 WEEKS OR FIRST POST NATAL VISIT G.P./ Hosp-Dept. ..... Date/Time .....

Mother's Health ..... Beby's Health .....

Menstruetion, with detes .....

Vaginel Discharge ..... Lactation .....

Illness since leaving Hospital .....

Other Symptoms .....

Abdomen .....

B.P. / Wt.

Hb Urine

Perineum ..... Pelvic Floor Function .....

Cervix ..... Smeared .....

Uterus .....

Appendeges .....

Treatment .....

Contraceptive Advice .....

Exeminer/Designation ..... Date .....

ST JOHN'S HOSPITAL AT HOWDEN

OBSTETRIC ANAESTHETIC RECORD

Date 9/5/13

Name SJ 325165E F 23/05/82
MCATEER
GILLIAN
Unit No 1 CARLYLE TERRACE
D.o.B BATHGATE EH48 1BX

PREOPERATIVE CONDITION Epidural

Indications including stage in labour
Primip – Syntocinon running, maternal request for Epidural
Epidural risks incl. – failure ↓ BP; Headache, nerve injury

General Health
usually well
°↑ BP
°Bleeding Problems.

Previous anaesthetic

Investigations, X-match

PREMEDICATION (Drug, dose, route, time)	Prescribed by	Given by / time given
1		
2		
3		

ADDITIONAL PRE-OP INSTRUCTIONS INCLUDING FASTING TIME

ANAESTHETIC TECHNIQUE (State site, needle type, depth of space, catheter mark at skin)

1 Epidural / Full Asepsis / Sitting
5ml 2% lig to skin L34
18G Tuohy
LOR to saline at 5.5cm °Blood °CSF °Paraesthesiae
Catheter threaded easily
10cm at skin
Test dose 2% lig – 4ml → NAD
Top up marcain 0.25% 5ml 1635 + 5ml 1637
2% lig 1650

2 (1800hrs) Spinal 25G Whitacre
L34 → clear CSF
1ml 0.25% marcain
+ 25µg fentanyl
→ Good effect. 18G Epidural L23 → LOR to saline at 7cm → blood on threading catheter & aspd not clearing with N/Saline

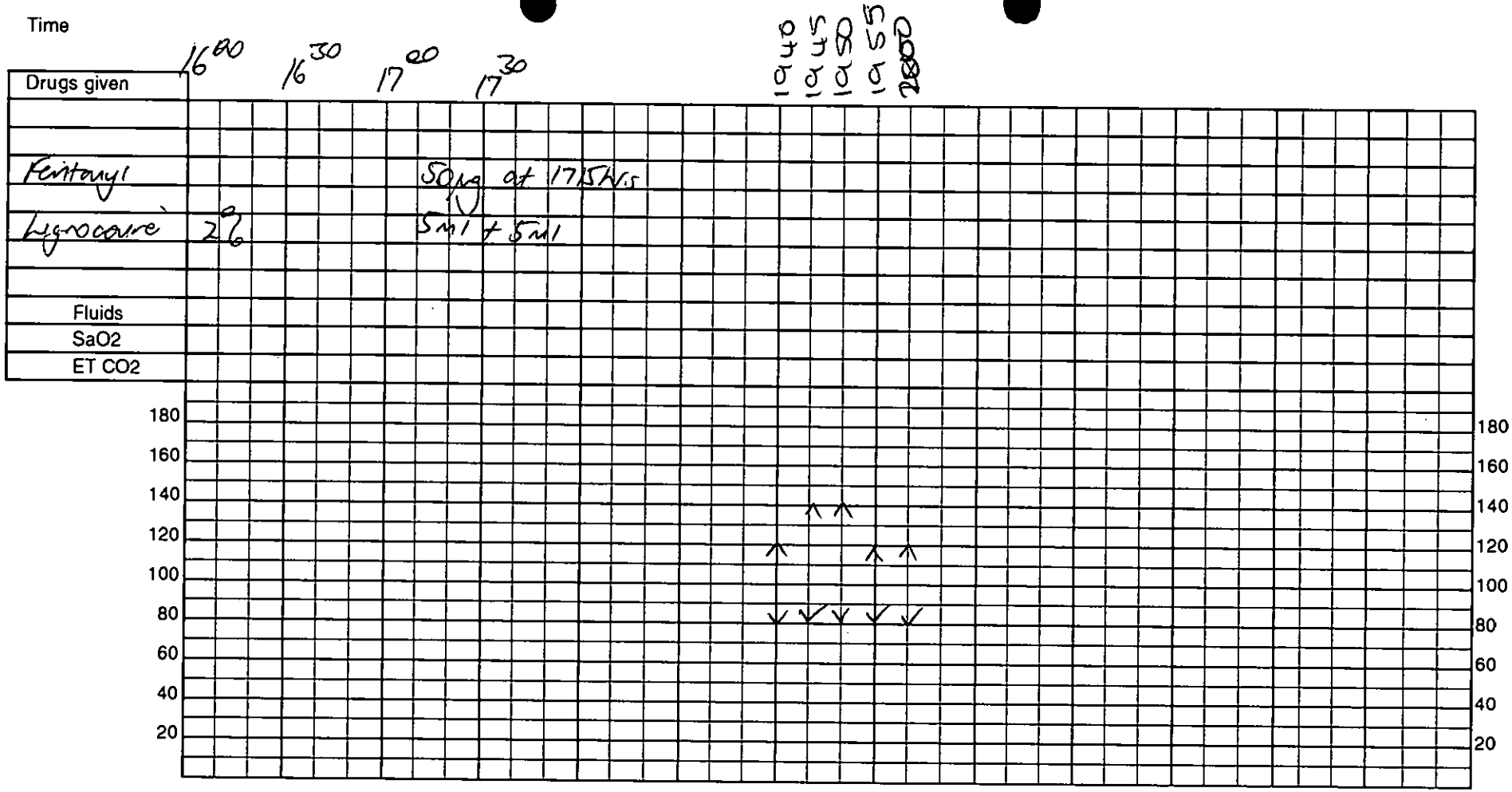
Anaesthetist PATEL

RECOVERY / POST-OP INSTRUCTIONS
→ Reports no pain relief at 1730hrs despite top ups bilat block to T12.

Routine Epidural Care.

→ repeat epidural 1920hrs Dr I Patel see over
- asked to retry epidural by Dr J. Patel. after failed attempts on ward by herself.

Signed J Clarke (Anaesthetist)



1730 hrs BIAFB block to T11-12 only + pain + despite top ups

→ CSE 1800 hrs.

1ml Marcain 0.25% + 25 μg fentanyl

1940h top up 6ml 0.25% chirocaine.
+ 1ml clonidine - 75 μg
+ 1ml fentanyl 50 μg
- pain lower back + abdomen

2005h. pt. pain free - happy with analgesia at present
block to cold T11/T9.

F/20h. epidural

new 16G Tuohy needle for each attempt
strict asepsis

L3/4 LOR to N/Saline - unable to feed catheter.

L2/3 bony +++

L3/4 again - catheter fed easily
with paraesthesiae with blood/CSF

test dose 3ml 2% lignocaine -ve.

epidural infusion restarted

PARIC INSAO

A4

St John's Hospital at Howden, Livingston, EH54 6PP. Tel: 01506 422757

Haematology
(CPA Accredited)

S325165 Sex F Date of Birth 23 May 1982
2305821425

Surname MCATEER Forename Gillian

Address 1 CARLYLE TERRACE
EH48 1BX

Consultant/GP
Dr G.J. BEATTIE
Ward 11 St John's

Date Printed : 11 May 2003

Clinical Details Post-natal.

Specimen collection	Date Time Labno.	11/05/03 11:40 H0426815	20/03/03 16:30 H0407862	03/10/02 17:30 H0347187		
Hb	(115-165 g/1)	107	106	119		
RBC	(3.80-5.80 x 10^{12}/1)	3.51	LA	3.85		
Hct	(0.370-0.470)	0.315	LA	0.341		
MCV	(80-99 fl)	90	LA	88		
MCH	(27.0-32.0 pg)	30.6	LA	30.8		
WBC	(4.0-11.0 x 10^{9}/1)	13.6	LA	9.3		
Neutrophils	(2.0-7.5 x 10^{9}/1)	9.7	LA	6.0		
Lymphocytes	(1.5-4.0 x 10^{9}/1)	2.9	LA	2.6		
Monocytes	(0.2-0.8 x 10^{9}/1)	0.7	LA	0.4		
Eosinophils	(0.0-0.4 x 10^{9}/1)	0.2	LA	0.2		
Basophils	(0.0-0.1 x 10^{9}/1)	0.1	LA	0.1		
Myelocytes	(x 10^{9}/1)		LA			
Promyelocytes	(x 10^{9}/1)		LA			
Blast Cells	(x 10^{9}/1)		LA			
NRBC	(/100 WBC)		LA			
Platelets	(150-450 x 10^{9}/1)	328	LA	239		

Morphology / Comment

H0407862 20/03/03 Hb only due to age of sample - sample dated 200303 and arrived at lab 240303.

Reference Range is age, sex, method and reagent related and is linked to the current result.

SP

CYSTIC FIBROSIS CARRIER TESTING

Medical Genetics Section, MMC, Western General Hospital, Edinburgh

This screening test does not take account of any family history of Cystic Fibrosis

Surname: MCATEER
Forename: GILLIAN
D.O.B. 23/05/82 F
Address: 50 ATHOL TERRACE BATHGATE EH48 4DF

SJ 325165E

45332

Hospital number:

Consultant: TKC
Gestation: 17
Previously Tested?: Yes / No

Partner's name: [redacted]
Partner's D.O.B. [redacted]

Address for Report

COMMUNITY MIDWIFE
BATHGATE PRIMARY CARE CENTRE
WHITBURN ROAD: BATHGATE
EH48 2SS

Consent for Cystic Fibrosis mutation testing

I have read the information sheet and have discussed it with the baby's father and I understand that the test being offered to us identifies 80% of faulty cystic fibrosis genes (mutations) in the Scottish population.

Patient signature G. McAteer
Date: 21/11/02

Laboratory Number: 45332 M+F Tested by: DL
Checked by: LB

Couple Negative: ☑
No further action required
Residual risk to this pregnancy less than 1 in 10 000

Couple Positive: ☐
IMPORTANT
Please read attached letter

Cystic Fibrosis Carrier ☐
No further action required
There are no health risks associated with being a CF carrier.
Residual risk to this pregnancy 1 in 460

Name:

CF Mutation:

LOTHIAN UNIVERSITY HOSPITALS N.H.S. TRUST
Western General Hospital
Department of Clinical Biochemistry

SJ325165E MCATEER	GILLIAN	F	23/05/1982
Simpson Medical Practice	Midwife	Ref	
	Copy to/Attention:		

MATERNAL SERUM SCREENING REPORT

Date of sample	21/11/2002
Date sample received	22/11/2002
Sample number	QC826694V
EDD	27/04/2003
Gestation	17 weeks 4 days
Maternal weight	80 kg
Weight adjusted AFP MOM	1.53
Weight adjusted HCG MOM	1.17
NTD Risk	Not increased
Trisomy 21 Risk	Not increased
Trisomy 18 Risk	Not increased

Comments

The maternal weight, date of sampling, date of birth and the EDD are all used to calculate the risks. If the incorrect information is supplied, the reported interpretation may be invalid. For further details refer to The Guidelines for Users dated 11 May 2001.

Date of report : 26/11/2002 Time 13:19 Authorised by : WA

For enquiries please phone 0131 537 1910/1

SIGNED BY
SCRIPT
NO ACTION
28 NOV 2002
NOTES TO G.P.
APPT
COMMENT
FILED BY

Department of Transfusion Medicine
New Royal Infirmary Edinburgh, Little France, Old Dalkeith Road,
Edinburgh. Tel: (0131) 242 7502

CPA

IMMUNOHAEMATOLOGY

Name (Surname & Forename) & Address:
MCATEER, GILLIAN
50 ATHOL TERRACE
BATHGATE
EH48 4DF

EDD / Gestn: 27/04/2003 / 12 week(s)

Date Specimen Received: 07/10/2002

Report Date: 07/10/2002

D.O.B.: 23/05/1982 CHI / Unit No.: SJ325165E SNBTS No.: 6276811

Results for Specimen No: **1658743**

Comments:

ABO / RhD: **O RhD Positive**

Additional Blood Groups:

Red Cell Antibody Screen: **Negative**

Other Screening Results:

Signed:

Report Destination:
COMMUNITY MIDWIVES

Bathgate Health Centre
Mid Street
Bathgate
EH48 1PT

Copies of Report to:

Department of Transfusion Medicine
New Royal Infirmary Edinburgh, Little France,
Old Dalkeith Road, Edinburgh Tel: (0131) 242 7502

CPA

Specimen Number:
Bar Code

Repeat Request For Serological Investigation In Pregnancy

Name (Surname & Forename) & Address:
MCATEER, GILLIAN
50 ATHOL TERRACE
BATHGATE
EH48 4DF

Time & Date Specimen Received:

Report Destination:
Bathgate Health Centre
Mid Street
Bathgate
EH48 1PT

Copies of Report to:

D.O.B.: 23/05/1982 SNBTS No.: 6276811
Unit No.: SJ325165E

Please detail any additional information or changes since last sample:

Anti-D Prophylaxis YES/NO:
(If Yes, Please Give Date & Reason)

EDD / Gestn: 27/04/2003 Date Sample Taken: ..... Requested By: .....

St John's Hospital at Howden, Livingston, EH54 6PP. Tel: 01506 422757

Haematology
(CPA Accredited)

S325165 Sex F Date of Birth 23 May 1982
2305821425

Surname MCATEER Forename Gillian

Address 1 CARLYLE TERRACE
EH48 1BX

Consultant/GP
Ms Community MIDWIFE
Simpson Medical Group

Date Printed : 24 Mar 2003

Clinical Details 34+/40

Specimen collection	Date Time Labno.	20/03/03 16:30 H0407862	03/10/02 17:30 H0347187			
Hb	(115-165 g/1)	106	119			
RBC	(3.80-5.80 x 10^{12}/1)	LA	3.85			
Hct	(0.370-0.470)	LA	0.341			
MCV	(80-99 f1)	LA	88			
MCH	(27.0-32.0 pg)	LA	30.8			
WBC	(4.0-11.0 x 10^9/1)	LA	9.3			
Neutrophils	(2.0-7.5 x 10^9/1)	LA	6.0			
Lymphocytes	(1.5-4.0 x 10^9/1)	LA	2.6			
Monocytes	(0.2-0.8 x 10^9/1)	LA	0.4			
Eosinophils	(0.0-0.4 x 10^9/1)	LA	0.2			
Basophils	(0.0-0.1 x 10^9/1)	LA	0.1			
Myelocytes	(x 10^9/1)	LA				
Promyelocytes	(x 10^9/1)	LA				
Blast Cells	(x 10^9/1)	LA				
NRBC	(/100 WBC)	LA				
Platelets	(150-450 x 10^9/1)	LA	239			

Morphology / Comment

H0407862 20/03/03 Hb only due to age of sample - sample dated 200303 and arrived at lab 240303.

Reference Range is age, sex, method and reagent related and is linked to the current result.

MICROBIOLOGY

ST. JOHN'S HOSPITAL AT HOWDEN
LIVINGSTON 01506 419666

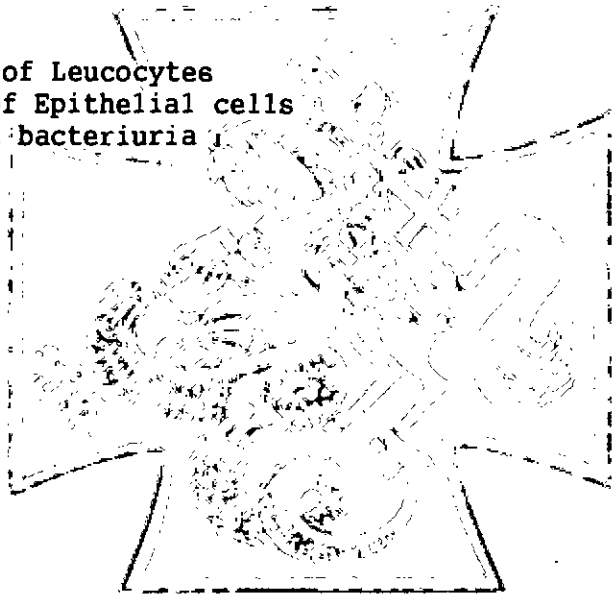
S325165
PATIENT No.: 2305821425 SEX: F DOB: 23 May 1982 CONSULTANT/GP: Dr T.K. COOPER

MCATEER, Gillian
50 ATHOL TERRACE

Delivery Suite St John's

LAB. No.: M018646/03

Mid stream urine ABDO PAIN



Moderate numbers of Leucocytes
Moderate number of Epithelial cells
No significant bacteriuria

WLT 685

SPECIMEN(S): Mid stream urine
TAKEN ON: 17 Mar 2003 DATE RECEIVED: 17 Mar 2003
AUTHORISED BY: MIJ
DATE AUTHORISED: 18 Mar 2003

MICROBIOLOGY

ST. JOHN'S HOSPITAL AT HOWDEN
LIVINGSTON 01506 419666

S325165

ENT No.: 2305821425 SEX: F DOB: 23 May 1982 CONSULTANT/GP: Ms Community MIDWIFE

MCATEER, Gillian
50 ATHOL TERRACE

Simpson Medical Group

No.: M067725/02

Venous blood — Booking Sample (Health Centre)

Rubella IgG antibody test:	POSITIVE
T.pallidum IgG antibody test:	NEGATIVE
HIV antibody test:	NEGATIVE
HBsAg test:	NEGATIVE

WLT 685

ECIMEN(S): Venous blood — AUTHORISED BY: MEM

KEN ON: 03 Oct 2002 DATE RECEIVED: 04 Oct 2002 DATE AUTHORISED: 11 Oct 2002

NUMBER

.....HOSPITAL

NAME

BACTERIOLOGY MOUNT

9
8
7
6
5
4
3

MICROBIOLOGY

ST. JOHN'S HOSPITAL AT HOWDEN
LIVINGSTON 01506 419666

S325165

TIENT No.: 2305821425 SEX: F DOB: 23 May 1982 CONSULTANT/GP: Ms Community MIDWIFE

MCATEER, Gillian
50 ATHOL TERRACE

Simpson Medical Group

B. No.: M067769/02

Mid stream urine — Booking Sample (Health Centre)

No significant bacteriuria

WLT 685

ECIMEN(S): Mid stream urine AUTHORISED BY: MKP

KEN ON: 03 Oct 2002 DATE RECEIVED: 04 Oct 2002 DATE AUTHORISED 07 Oct 2002

WLT 340

.....HOSPITAL

NAME

X-RAY MOUNT

9
8
7
6
5
4
3
2
1

WLT 635 ST. JOHN'S HOSPITAL AT HOWDEN X RAY

US Obst
BOOKING SCAN Gestation by LMP:12+6

Single live intra-uterine gestation. FH seen.

CRL =60 mms. BPD = 16 mms.

US measurements suggest gestation of 12 weeks 4 days

US gestation = Dates

Stomach, 4 limbs identified.

This scan is suitable for booking.

AG KB
Fil
Notes Plus
Normal / Abnormal
Date 17 OCT 2002

SRM/SRM Signed by SRM 16/10/02
MCATEER gillian
16/10/02 KIN.KnsgFH
0325165 23/05/82 # 25775
50 athol terrace Bathgate
US Obst

Waterston and Groves. Telephone: (01620) 826671

WLT 342

WEST LOTHIAN DOCTORS' CO-OPERATIVE LIMITED

Carmondean Health Centre, Deans, Livingston, West Lothian EH54 8PY

Telephone: 01506 438042 **Facsimile:** 01506 443243 Registered in Scotland: 164396

Referral to : Rose Drummond Labour Ward **Department :**

Patient's Name : Gillian Mc Steer
Date of Birth : 23-05-82
Address : 1 Carlyle Tce Bathgate
Phone No. : 07979 811047

Patient's Own GP : Dr J. Thomson
Practice Name : Simpson Medical Group
Practice Address :

Referral : Time: 00.50 Date: 17-03-03

Referring GP : J Mooney
Outcome Information Requested: ☐ Yes ☐ No

Drug History : (remember to advise patient to take drugs with them to hospital)
Taken medication for constipation

SOCIAL CIRCUMSTANCES :
Lives Alone ☐
Support Services in Place ☐
Vulnerable ☐

Presenting Complaint : Lower abdominal pain
35 weeks pregnant
No nausea/vomiting. No diarrhea/constipation. No urinary symptoms

Past Medical History : Nil of note

Examination Findings : Vital signs normal
Fundus = Dates
Abdomen soft slightly tender L renal area
Urinalysis NIT blood

Diagnosis : ?UTI
?Early labour.

Treatment Given :
Nil.

Sponsored by an educational grant from : Takeda

WLT 414

West Lothian Hospitals

FLUID (ADDITIVE MEDICINE) PRESCRIPTION SHEET

NAME SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX

UNIT NO.

Affix Addressograph Label

	DATE	FLUID (USE BLOCK LETTERS) ADDITIVE MEDICINE	Vol. (ml) Dose (mg)	Route of Admin.	Dur. of * Admin.	SIGNATURE	Serial No. Batch No.	Time Begun	Given by Added by
A	9/5/03	Hartman's Syntocinon	500 10iu	IV			8814 02/2005	14²⁰	
B									
C									
D									
E									
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

* RATE OF FLOW = VOL. OF FLUID (ml) x 15 (Drops/Min.) Duration (Mins.) (1ml = 15 drops)

Approximate Rate for 500 ml
1 hr. = 120 Drops/min. 6 hr. = 22 Drops/min.
4 hr. = 30 Drops/min. 8 hr. = 15 Drops/min.

KNOWN DRUG/MEDICINE SENSITIVITY
1 2

Obstetrics Anaesthetic Audit

Surname MCATEER Date 19 10 04

Forename GILLIAN

Unit No. 325165E Start time 01 : 40

* Please tick ☑ appropriate boxes. Use black or blue ink only.

Supervision Consultant ☐ Telephone ☐

In Hospital ☐

No ☐ Yes ☐ SPR ☑ Present ☑

Epidural or CSE **Anaesthetic Code:** 1st LIMB 2nd CAESAR 3rd ☐☐☐☐

Reason for Epidural:

Mat. request ☑ PIH ☐ Breech ☐ Mult. pregnancy ☐ Other ☐

Indication :

Labour ☑ El CS ☐ EM CS ☐ Ins. Del ☐ Man Rem Placenta ☐ Other ☐

Set Up: *Needle size:* 16 ☐ 18 ☑

Difficulty: Obesity ☐ Bony Obst. ☐ Oedema ☐ Difficult to thread catheter ☐

Blood Tap: Needle ☐ Catheter ☐ *Dural Tap:* Needle ☐ Catheter ☐

Maintenance: Bolus ☐ Infusion ☑

Drugs:

Ligno ☐ Bupiv ☑ Ropiv ☐ Fenl ☑ Diamorph ☐ Adren ☐ Others ☐

Problems: Unilat Block ☐ Missed seg. ☐ Perineal press ☐

Epidural Resited:

After intervention: Resolved ☐ Improved ☐ No change ☐ Action ☐

Spinal or CSE **Anaesthetic Code:** 1st ☐☐☐☐ 2nd ☐☐☐☐ 3rd ☐☐☐☐

Start Time: 09.00 - 17.00 ☐ 17.00 - 09.00 ☐

Indication:

Labour ☐ El CS ☐ EM CS ☐ Inst. Del ☐

Man Rem. Placenta ☐ Ineffective Regional ☐ Other ☐

Needle Type/Size:

Sprotte 24g ☐

Whitacre 25g ☐

Other ☐

Problems: Failed tap ☐ Failed block ☐ Other ☐

Drugs: Bupiv ☐ Ropiv ☐ Fent ☐ Diamorph ☐ Others ☐

Spinal Catheter: Yes ☐ No ☐

GA **Anaesthetic Code:** 1st ☐☐☐☐ 2nd ☐☐☐☐ 3rd ☐☐☐☐

Start Time: 09.00 - 17.00 ☐ 17.00 - 09.00 ☐

Reason for GA:

Mat. request ☐ Obs request ☐ Unsuit for regional ☐ Ineff. Region ☐ Other ☐

Indication: El CS ☐ EM CS ☐ Man Rem. Placenta ☐ Other ☐

Problems: Difficult intubation ☐ Failed intubation ☐ Aspiration ☐ Other ☐

Intubation Grade: I ☐ II ☐ III ☐ IV ☐

Follow-up Date ☐☐ ☐☐ ☐☐ Time ☐☐ : ☐☐

Home before follow-up: Yes ☐ No ☐

Mode of Delivery:

Spontaneous ☐
Low forceps ☐
Rotation forceps ☐
Ventouse ☐
Assisted breech ☐
CS ☐

Pain Relief:

In labour: Good ☐ Moderate ☐ Poor ☐

For Delivery: Good ☐ Moderate ☐ Poor ☐

Post Delivery Analgesia:

Opioid
iM IV PCA ☐
Epidural ☐
Spinal ☐

IM/IV OPIOD:

Number of doses ☐

NSAIDS:

Yes ☐ No ☐

Complications

Nil ☐

Headache ☐
Backache (review required) ☐
Pruritis ☐
Urinary retention (require intervention) ☐
Neurological ☐
Other ☐

→ **Blood Patch :** Yes ☐ No ☐

→ **Treatment of Complications Required:** Yes ☐ No ☐

ICU Admission: Yes ☐ No ☐

Indications: PIH ☐ Eclampsia ☐ PPH ☐ Cardiac Res ☐ Other ☐

Sheet No.: (1)

WEST LOTHIAN HEALTHCARE NHS TRUST

PRESCRIPTION SHEET

Name: .....

Rx

SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX

ant/GP TKC

Drug Sensitivities
none known

ORAL, INHALED, P.R. OR TOPICAL MEDICINES — REGULAR PRESCRIPTIONS

TIMES OF ADMINISTRATION

	Date	(Print in Capitals) Medicine	Dose	Method of Admin	Regular times 0800	1300	1800	2200	Prescribers Signature	Discontinued Date	Init.
A	7/5/3	Paracetamol	1g	O	6 hly prn						
B	3/5/3	Dihydrocodeine	30mg	O	4 hly prn						
C											
D											
E											
F											
G											
H											
J											
K											
L											
M											
N											
P											
R											
S											

ORAL, INHALED, P.R. OR TOPICAL MEDICINES — ONCE ONLY PRESCRIPTIONS

	Date	Prescribed Time	(Print in Capitals) Medicine	Dose	Method of Admin.	Prescribers Signature	Time Given	Given/ Cheeked by
	07/05		PROSTIN GEL	2mg.	PV	Bach	12^20	AB
	07/05		Prostin Gel	1mg	P.V	Bach	18.48	MH
	07/05		Paracetamol	1g.	O	Bach	19.15	MH/NMC
	08/05		Prostin Gel.	1mg	P.V.	Bach	09^00.	MH
	~~08/05~~		~~Ranitidine~~ no.					
	8/5/03		PROSTIN GEL	2mg	P.V.	Bach	15^00	
	8/5/03		PROSTIN GEL	1mg	P.V.	Bach	21^20.	
	9/5/03		Ranitidine	150mg	Oral	Bach	14 45	LB
	10.5.03		Lactulose	10ml	PO	Bach	12^0	MH

OTHER MEDICINE CHARTS IN USE

Chart	Initial/Tick	Chart	Initial/Tick
Anticoagulant Chart		Morphine Infusion Chart	
IV Fluid Chart		Epidural Infusion Chart	
Drug Infusion Chart			

Nam [illegible] 325165E F 23/05/82
[illegible]CATEER
[illegible]ILL IAN
Unit. 1 CARLYLE TERRACE
BATHGATE EH48 1BX

PRESCRIPTION SHEET *(Continued)*

PARENTERAL MEDICINES — REGULAR PRESCRIPTIONS

TIMES OF ADMINISTRATION

	Date	(Print in Capitals) Medicine	Dose	Method of Admin	Regular times 0800	1500	1800	2200	Prescribers Signature	Discontinued Date	Init.
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											

PARENTERAL MEDICINES — ONCE ONLY PRESCRIPTIONS

	Date	Prescribed Time	(Print in Capitals) Medicine	Dose	Method of Admin.	Prescribers Signature	Time Given	Given/ Checked by
	9/5/03		Diamorphine	10 mg	IM		1530	LB / CN
	9/5/03		Cyclizine	50 mg	IM		1530	LB / CN
	9/5/03		Syntometrine	1 ml	IM		2000	SB/

Name: GILLIAN McARTHUR

Unit No.: 325165

DRUG RECORDING SHEET

DATE	0600	0800		1300	17.30	1800	2200	OTHER TIMES		COMMENTS ON DISCREPANCIES
8/5/03	A INITIALS MDB	INITIALS	INITIALS	INITIALS	A INITIALS MN	AB INITIALS MNG	A B INITIALS MDB	00.45 A B INITIALS MDB	INITIALS	
9/5/03	0600 AB INITIALS MC	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	0200 B INITIALS MDB	2000 A INITIALS	
10/5/03	INITIALS	AB INITIALS CF	INITIALS	INITIALS	INITIALS	AB INITIALS RTJS	AG INITIALS DV	INITIALS	INITIALS	
11/5/03.	INITIALS	A B INITIALS JS.	INITIALS	B INITIALS RT	INITIALS	AB INITIALS KS	AB INITIALS DV.	INITIALS	INITIALS	
12/5/03	INITIALS	A B INITIALS JS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	
	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	
	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	

Na[illegible] SJ 325165E F 23/05/82
MCATEER
GILLIAN
Ur[illegible] 1 CARLYLE TERRACE
BATHGATE EH48 1BX

DRUG RECORDING SHEET

DATE		0800		1300		1800	2200	OTHER TIMES		COMMENTS ON DISCREPANCIES
	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	
	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	
	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	
	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	
	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	
	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	
	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	

Obstetrics Anaesthetic Audit

SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX

Surnar
Forena
Unit No.

Date 09 05 03

Start time 16 : 10

* Please tick ☑ appropriate boxes. Use black or blue ink only.

Supervision

Consultant ☑ Telephone ☐
In Hospital ☐
No ☐ Yes ☐ SPR ☐ Present ☐

Epidural or CSE

Anaesthetic Code: 1st 8715 2nd ☐☐☐☐ 3rd ☐☐☐☐

Reason for Epidural:

Mat. request ☑ PIH ☐ Breech ☐ Mult. pregnancy ☐ Other ☐

Indication :

Labour ☑ El CS ☐ EM CS ☐ Ins. Dcl ☐ Man Rem Placenta ☐ Other ☐

Set Up: *Needle size:* 16 ☐ 18 ☑

Difficully: Obesily ☐ Bony Obst. ☐ Oedema ☐ Difficult to thread catheter ☐

Blood Tap: Needle ☐ Catheter ☐ *Dural Tap:* Needle ☐ Catheter ☐

Maintenance: Bolus ☐ Infusion ☑

Drugs:

Ligno ☑ Bupiv ☑ Ropiv ☐ Fent ☑ Diamorph ☐ Adren ☐ Others ☐

Problems: Unilat Block ☐ Missed seg. ☐ Perineal press ☐

Epidural Resited:

After intervention: Resolved ☐ Improved ☐ No change ☐ Action ☐

Spinal or CSE

Anaesthetic Code: 1st ☐☐☐☐ 2nd ☐☐☐☐ 3rd ☐☐☐☐

Start Time: 09.00 - 17.00 ☐ 17.00 - 09.00 ☐

Indication:

Labour ☐ El CS ☐ EM CS ☐ Inst. Del ☐
Man Rem. Placenta ☐ Ineffective Regional ☐ Other ☐

Needle Type/Size:

Sprotte 24g ☐
Whitacre 25g ☐
Other ☐

Problems: Failed tap ☐ Failed block ☐ Other ☐

Drugs: Bupiv ☐ Ropiv ☐ Fent ☐ Diamorph ☐ Others ☐

Spinal Catheter: Yes ☐ No ☐

GA **Anaesthetic Code:** 1st ☐☐☐☐ 2nd ☐☐☐☐ 3rd ☐☐☐☐

Start Time: 09.00 - 17.00 ☐ 17.00 - 09.00 ☐

Reason for GA:

Mat. request ☐ Obs request ☐ Unsuit for regional ☐ Ineff. Region ☐ Other ☐

Indication: El CS ☐ EM CS ☐ Man Rem. Placenta ☐ Other ☐

Problems: Difficult intubation ☐ Failed intubation ☐ Aspiration ☐ Other ☐

Intubation Grade: I ☐ II ☐ III ☐ IV ☐

Follow-up Date 12/05/03 Time 09:50

Home before follow-up: Yes ☐ No ☐

Pain Relief:

In labour: Good ☐ Moderate ☑ Poor ☐

For Delivery: Good ☐ Moderate ☐ Poor ☐

Mode of Delivery:

Spontaneous ☑
Low forceps ☐
Rotation forceps ☐
Ventouse ☐
Assisted breech ☐
CS ☐

Post Delivery Analgesia:

Opioid
IM IV PCA ☐
Epidural ☐
Spinal ☐

IM/IV OPIOD:

Number of doses ☐

NSAIDS:

Yes ☐ No ☐

Complications

Nil ☑

Headache ☐
Backache (review required) ☐
Pruritis ☐
Urinary retention (require intervention) ☐
Neurological ☐
Other ☐

→ **Blood Patch :** Yes ☐ No ☐

→ **Treatment of Complications Required:** Yes ☐ No ☐

ICU Admission: Yes ☐ No ☐

Indications: PIH ☐ Eclampsia ☐ PPH ☐ Cardiac Res ☐ Other ☐

St John's Hospital
Obstetric Epidural Infusion Chart

Date:- 9/5/03

SJ 325165E F 23/05/82
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX

Infusion details

Solution:- Bupivacaine 0.1% 100ml + Fentanyl 1ml 2mg/ml

Pump serial no.

Please record 5 min. BP's and top-ups given on the usual epidural observation chart.
Prescribed Infusion rate:

1. 10 ml/hr Time:- 1640
2. 15 ml/hr Time:- 1715 Reason for change:- Low block

Please note: DOUBLE CHECK with attending midwife that the settings on the pump are correct. Please ask midwife to record the volume infused every 15 minutes for the first half-hour to ensure the pump is functioning correctly. Subsequent recordings should be done on the hour from the commencement of the infusion.

Duration of infusion	Time	Volume Infused	BP	Resp Rate	Sedation Score	Pain Score	Straight leg Raising R / L	Sensory Level R / L	Top-up comments
Zero mins									
15 mins	16.45	1.5	150/85	Crying	0	3	0 0		
30 mins	17.15	5.8	155/90	crying	0	3	0 0		
60 mins	17.30	10.1	140/75	22	0	3	0 0		
2 hours	~~2000~~	Discontinued			Recommenced 1915 hrs				As per Anaesthetic
3	2000	21.1	100/60	18	0	0	2 2	T11/T9	
4	21.00	36.2	126/74	17	1	0			
5									
6	Del. at 2159								
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									

PLEASE INFORM ANAESTHETIST IF:-

1. **Patient becomes hypotensive (Systolic pressure< 100mmHg or *) *[*enter value*]**
2. **Pain score of 2 or3, 20 minutes after top-up.**
3. **Respiratory rate <10/min**
4. **Patient unable to lift legs off the bed (Straight leg raising grade 3)**
5. **Patient becomes difficult to rouse. (sedation score 2 or 3.)**

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

Sedation Score
0 = alert, orientated
1 = drowsy, easily roused
2 = rouses only to pain
3 = unrousable
s = asleep

Straight leg raising
0 = full power
1 = slightly weak, able to lift
2 = weak, difficult to lift
3 = unable to lift straight leg

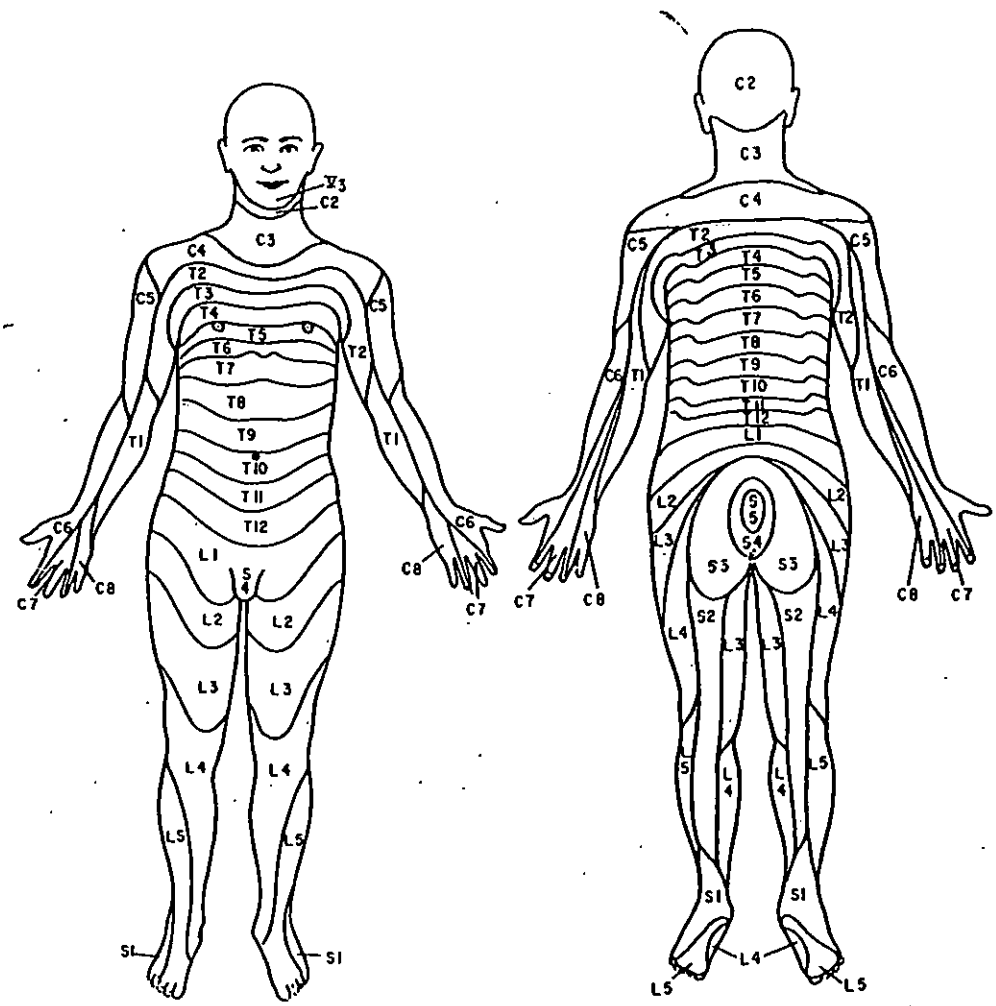


Figure 2–3. Segmental dermatomes in man. (Adapted from Hansen and Schliack, 1962.)

WEST LOTHIAN HEALTHCARE NHS TRUST

COMMUNITY SERVICES

COMMUNITY MIDWIVES
BASE: BATHGATE PRIMARY CARE CENTRE
WHITBURN ROAD
BATHGATE
EH48 2SS

Direct Line: 01506 651828
Community Reception: 01506 630771

Dear Gillian

An appointment has been made for you to attend Dr. Cooper's antenatal clinic at Bathgate Primary Care Centre on:

Wednesday: 18th December

at: 3.45pm

If you have any questions about this appointment or you are unable to attend, please phone us at the above number.

THINGS YOU NEED TO TAKE WITH YOU

- [x] Your notes
- [x] Your labour bag
- [ ] An old nightshirt or large T-shirt
- [x] Dressing gown
- [x] Pyjamas/nightshirt
- [ ] Socks
- [ ] Pants
- [ ] 2 towels
- [ ] Sanitary towels
- [ ] Bottled water/juice
- [ ] Tapes/CDs
- [ ] Snacks
- [ ] Refreshing wipes
- [ ] Phonecard/change
- [ ] Camera with film
- [ ] Slippers

WHAT YOU'LL NEED FOR THE MATERNITY WARD

For you

- [ ] Sanitary towels
- [x] Disposable/old pants
- [x] 2 pairs of pyjamas or front fastening nightshirts
- [ ] 2 comfortable outfits for wearing on the ward
- [ ] Feeding bras/supportive bras
- [ ] Magazines/book
- [ ] Fruit
- [ ] Bottled water
- [ ] Your makeup bag
- [x] Shampoo
- [x] Shower gel
- [ ] Hairdryer (check that you'll need one)
- [ ] Breast pads

For your baby

- [ ] 6 sleepsuits
- [ ] 6 bodysuits
- [ ] Scratch mitts
- [ ] Nappies
- [ ] Nappy bags
- [ ] Cotton wool
- [ ] Fragrance free baby wipes
- [ ] 3 cardis
- [ ] Shawl/wrap
- [ ] Baby bubble bath

COMING HOME

For you

- [ ] An outfit for wearing home
- [ ] Shoes
- [ ] Jacket/cardi

For your baby

- [ ] Daysuit/outfit
- [ ] Bootees/mitts
- [ ] Hat
- [ ] Padded/fleece outersuit or shawl
- [ ] Infant carrier car seat

Things To Think About

YOUR LABOUR

- Your birth partner(s)

partner [redacted]

- Getting induced

- Breaking your waters

don't mind

- Pain relief

Gas & Air - if Diamorphine if needed.

- Your position during labour

Speak at the time

- Foetal monitoring

- Episiotomy/natural tear

Would like episiotomy

- Caesarean section

A planned or emergency Caesarean section means that there are medical procedures to follow therefore some of your choices for labour are removed. However, you will be kept informed throughout the whole process and you should think about what you want afterwards so that you feel in control.

- How you feel about medical/midwifery students being present

Don't want any students present

- Extra info

Would like to have labour in birth pool, but birth out of birth pool.

THE BIRTH

- Assisted delivery

Partner

- The position I'd like for delivery

Wait and see

- Extra info

Want delivery on
labour bed

AFTER THE BIRTH

Once your baby has been delivered there are a few decisions th
you'll have to make so it's a good idea to think about what you want t
happen and incorporate it into your birth plan.

- Who I'd like to cut the umbilical cord

Partner - [redacted]

- The way I'd like my baby delivered

Wait and see

- The way I feel about my baby being cleaned or bathed

- How I feel about Vitamin K

Like to discuss this
further

- Delivering the placenta naturally or with an injection of
Syntometrine

- How I want to feed my baby

Try breastfeeding

- Extra info

USEFUL TELEPHONE NUMBERS

FOR YOU

Partner
Mobile .....
At work ..

[redacted]
Mobile .....
Home .....
At work ..

Your pare
Mobile .....
Home .....
At work ..

His parent
Mobile .....
Home .....
At work .....

Labour suite .....

Hospital .....

Your midwife .....

Your GP 01506 654444

Others .....

Your Partner .....

As you get closer to the birth make sure that your mobile phone has plenty of credit available. It's also a good idea to store essential numbers in the memory in case your waters break in the supermarket car park!

Remember that you won't be allowed to use a mobile phone in the hospital so you'll have to take plenty of change for the payphone.

SJ 325165E F 23/05/82
MCATEER
GILLIAN
50 ATHOL TERRACE
BATHGATE EH48 4DF

6. Appointments

Place	Date	Time	Purpose (e.g. Ante-Natal Education)	Comments
SJH X-Ray	16.10.02	@2.30	Booking Scan	
Bathgate H.C.	21.11.02	@3pm	Midwife Appt - Bordetella Screening Tests	
Bathgate H.C.	18th Dec	3.45pm	Cons Appt.	
Bathgate H.C.	30.1.03	2pm	Midwife - Vanda	
"	27th Feb.	4.15pm	Midwife.	
Bathgate HC.	19th Feb	2-4.15pm.	Physio group.	
Bathgate.	20.3.3	4pm	m.d.w.r.	
Home Visit	2nd April -	pm.		
Bathgate	17th April -	—		
"	24th April	5pm		
"	1.5.03.	4.15	pm. "	

5. Talkback *continued*

Addressograph, or
Name
Address

Dob
Ref no.

4. Comments / Suggestions / Notes

This space is for you as the mother, for your comments, suggestions or things you need to remember to ask which are not recorded in parts 1, 2 or 3 above.

5. Talkback

We would be pleased to have your comments on the care you received during your time with us. Please feel free to tell us about the good & bad things you encountered during your pregnancy, birth and postnatal period. Continue overleaf as required.

Addressograph, or
Name
Address
Dob
Ref no.

2. BIRTH PLAN

Please tell us if there are any things you would prefer during your labour and delivery. You may wish to state whether you want anyone present with you, methods of pain relief & any special needs: e.g. it may be helpful to refer back to 'Ready Steady Baby' for prompts.

3. POSTNATAL PLAN

Please tell us if there are any things you would like for your care after you have your baby. You may wish to consider how you will feed your baby, and if in hospital, when you wish to return home.

SJ 325165E F 23/05/02
MCATEER
GILLIAN
50 ATHOL TERRACE

BATHGATE EH48 4DF

PREGNANCY CARE PLAN

By now you will be aware that there are many options & choices available to you and your family throughout the pregnancy. During your pregnancy, labour and after you have your baby, we will try our best to accommodate any special requirements you may have. If there are any things in particular you would like or dislike, please discuss these with your midwife and feel free to write them on the next few pages.

1. Pregnancy Plan

Please tell us if there are any things you would like, or dislike, during your care before you have your baby. You may wish to discuss/review what types of care are available to you at this time, or anything that is worrying you: e.g. you may wish to discuss the benefits of breastfeeding..

Learners – we wish to ensure that all staff who care for you and your baby are properly trained. For this reason, staff who are undergoing training may be involved with your care. If you would rather not have such staff involved, please discuss this with your care co-ordinator.

3.1

Obstetrics Anaesthetic Audit

Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date ☐☐ ☐☐ ☐☐

Forename ☐☐☐☐☐☐☐☐☐☐☐☐

Unit No. ☐☐☐☐☐☐☐ Start time ☐☐ : ☐☐

* Please tick ☑ appropriate boxes. Use black or blue ink only.

Supervision Consultant ☐ Telephone ☐

In Hospital ☐

No ☐ Yes ☐ SPR ☐ Present ☐

Epidural or CSE **Anaesthetic Code:** 1st ☐☐☐☐ 2nd ☐☐☐☐ 3rd ☐☐☐☐

Reason for Epidural:

Mat. request ☐ PIH ☐ Breech ☐ Mult. pregnancy ☐ Other ☐☐☐☐

Indication :

Labour ☐ El CS ☐ EM CS ☐ Ins. Del ☐ Man Rem Placenta ☐ Other ☐☐☐☐

Set Up: *Needle size:* 16 ☐ 18 ☐

Difficulty: Obesity ☐ Bony Obst. ☐ Oedema ☐ Difficult to thread catheter ☐

Blood Tap: Needle ☐ Catheter ☐ *Dural Tap:* Needle ☐ Catheter ☐

Maintenance: Bolus ☐ Infusion ☐

Drugs:

Ligno ☐ Bupiv ☐ Ropiv ☐ Fent ☐ Diamorph ☐ Adren ☐ Others ☐☐☐☐

Problems: Unilat Block ☐ Missed seg. ☐ Perineal press ☐

Epidural Resited:

After intervention: Resolved ☐ Improved ☐ No change ☐ Action ☐☐☐☐

Spinal or CSE **Anaesthetic Code:** 1st ☐☐☐☐ 2nd ☐☐☐☐ 3rd ☐☐☐☐

Start Time: 09.00 - 17.00 ☐ 17.00 - 09.00 ☐

Indication:

Labour ☐ El CS ☐ EM CS ☐ Inst. Del ☐

Man Rem. Placenta ☐ Ineffective Regional ☐ Other ☐☐☐☐

Needle Type/Size:

Sprotte 24g ☐

Whitacre 25g ☐

Other ☐

Problems: Failed tap ☐ Failed block ☐ Other ☐

Drugs: Bupiv ☐ Ropiv ☐ Fent ☐ Diamorph ☐ Others ☐

Spinal Catheter: Yes ☐ No ☐

GA **Anaesthetic Code:** 1st ☐☐☐☐ 2nd ☐☐☐☐ 3rd ☐☐☐☐

Start Time: 09.00 - 17.00 ☐ 17.00 - 09.00 ☐

Reason for GA:

Mat. request ☐ Obs request ☐ Unsuit for regional ☐ Ineff. Region ☐ Other ☐

Indication: El CS ☐ EM CS ☐ Man Rem. Placenta ☐ Other ☐

Problems: Difficult intubation ☐ Failed intubation ☐ Aspiration ☐ Other ☐

Intubation Grade: I ☐ II ☐ III ☐ IV ☐

Follow-up Date ☐☐ ☐☐ ☐☐ Time ☐☐ : ☐☐

Home before follow-up: Yes ☐ No ☐

Pain Relief:

In labour: Good ☐ Moderate ☐ Poor ☐

For Delivery: Good ☐ Moderate ☐ Poor ☐

Mode of Delivery:

Spontaneous ☐
Low forceps ☐
Rotation forceps ☐
Ventouse ☐
Assisted breech ☐
CS ☐

Post Delivery Analgesia:

Opioid
IM IV PCA ☐
Epidural ☐
Spinal ☐

IM/IV OPIOD:

Number of doses ☐

NSAIDS:

Yes ☐ No ☐

Complications

Nil ☐

Headache ☐
Backache (review required) ☐
Pruritis ☐
Urinary retention (require intervention) ☐
Neurological ☐
Other ☐

→ **Blood Patch :** Yes ☐ No ☐

→ **Treatment of Complications Required:** Yes ☐ No ☐

ICU Admission: Yes ☐ No ☐

Indications: PIH ☐ Eclampsia ☐ PPH ☐ Cardiac Res ☐ Other ☐

11. At delivery the baby's cord is cut. Do you have any objections to this?

A: Yes B: (No) C: I would like to discuss this further

12. An injection of Konakion is given routinely to the baby at delivery to control the possibility of bleeding. Do you have any objection to this?

A: Yes B: No C: (I would like to discuss this further)

13. If you have to be delivered by Caesarean Section you may be given the choice of epidural or general anaesthesia, depending on the circumstances at the time. Do you wish to discuss this.

A: (Yes) B: No

14. St John's is a training hospital for Midwifery and Medical Students. Do you have any objections to their presence at your delivery?

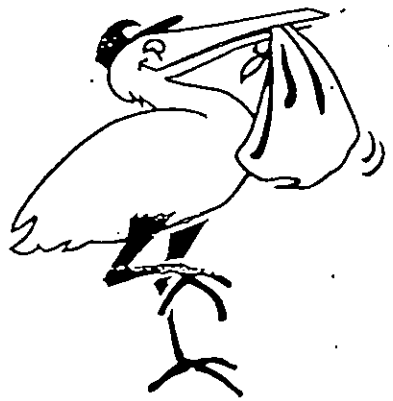
A: (Yes) B: No C: Wait and see

15. How do you wish to feed your baby?

A (Breast) B: Bottle C: Undecided

IT SHOULD BE NOTED THAT SINCE THE ULTIMATE RESPONSIBILITY FOR THE SAFE DELIVERY OF THE BABY RESTS WITH THE MIDWIFERY AND MEDICAL STAFF, IT MAY BE NECESSARY FOR THEM TO TAKE SOME ACTION WHICH IS NOT ACCEPTABLE ON YOUR BIRTH PLAN.

Birth Plan



The idea behind the birth plan is to help you plan your day in labour and make decisions about the delivery of your child.

This birth plan will enable you to choose from a number of options.

Circumstances may wake you want to change your plan at some time during pregnancy or labour. We suggest, therefore, that you complete the plan using a pencil as this will allow changes to be made easily.

Please circle/tick where appropriate:

1. Who do you wish to be your companion during labour?

   A: (Partner) B: Friend
   C: Mother D: Midwife

2. Do you wish him/her to be with you during your delivery?

   A: (Yes) B: No C: Wait and see

3. During early labour would you prefer:

   A: Walking B (Wait and see)
   C: Resting in bed

4. Continuous monitoring of you baby may be necessary if there are complications during your pregnancy or labour.

   If there are no complications which method of monitoring would you prefer?

   A: Monitoring by a Midwife listening with a stethoscope.

   B: Continuous monitoring with a machine.

   C: (Wait and see.)

5. What method of pain relief would you prefer?

   A: Breathing and relaxation

   B: (Entonox) (Gas and Air by mask or mouthpiece)

   C: Injection D: Wait and see

   E: Epidural F: Other

6. Our delivery beds allow you to take up any position which you find comfortable.

   During labour which position would you prefer?

   A: Propped up in bed B: Kneeling/squatting
   C: Lying on your side D: (Wait and see)

7. Vaginal examinations are performed when you are in labour. Do you have any objections to this?

   A: Yes B: (No) C: I would like to discuss this at the time

8. Your waters may be broken when you are in labour. Do you have any objection to this?

   A: Yes B: (No) C: I would like to discuss this at the time

9. An episiotomy (cut) is not performed routinely at delivery. Since it may be necessary would you like to discuss the possibility?

   A: (Yes) B: No

10. An injection of Syntometrine is given routinely at the birth of you baby (to control bleeding). Do you have any objection to this?

    A: Yes B: No C: (Would like to discuss this further)

WEST LOTHIAN HEALTHCARE NHS TRUST

COMMUNITY SERVICES

BATHGATE PRIMARY CARE CENTRE
WHITBURN ROAD
BATHGATE
EH48 2SS

01506 630771

Dear Parents to be,

"CONGRATULATIONS ON YOUR PREGNANCY"

Thank you for filling in the booking form. This gives us important information to prepare paperwork in advance of our first meeting with you. Your appointment will be arranged by phone or letter for a mutually convenient time. If you need to contact us before this, we are available during office hours, Monday to Friday at the number above. Please leave a message if no one can speak to you immediately.

Enclosed in your pack is information on folic acid tablets, leaflets that explain choices of where your baby could be born and the blood tests we offer routinely. Also enclosed is your personal copy of "READY STEADY BABY" which takes you through pregnancy, birth and the early years of your baby's life. We would like to direct your reading at this stage particularly to pages 7-16 which provides information about safe eating, exercise and general healthy lifestyle changes recommended with regard to alcohol intake and smoking.

Your first appointment will take about 1 hour. Apart from sharing information, we will be taking blood for routine tests, arranging your scan and planning your care.

There are 3 midwives based at Bathgate Primary Care Centre and as there are 3 medical practices, a named midwife is allocated to each practice. However, all the midwives are available should you need advice or information. Below is the allocation of midwives.

ANN RUSSELL:- KINGSGATE PRACTICE

ANNE EDWARDS:- NEWLAND PRACTICE

VANDA FRASER: - SIMPSON PRACTICE

We look forward to meeting you.

Community Midwives for Bathgate Primary Care Centre

PREPARATION FOR BIRTH AND PARENTING SESSIONS

Please join us at Bathgate Health Centre and St. John's Hospital for sessions to help you to prepare for the arrival of your baby.

Our aims are

- to enable you to prepare confidently for baby's birthday ahead;
- to inform so that you can make choices about what help you would like from midwives and your family.

Your contribution will be very important and the programme in place includes baby's father or companions who will be helping you. We hope that you will make friends with the other women who in turn will be a support for you once your baby is here.

The sessions at St. John's are held in the parenthood education room and are in the evening so that you and your partner/family can attend:

For parents whose babies are due in May June

TOUR: Labour & Postnatal ward	**Thursday 6.30pm**	..... 13th March
LABOUR TALK:	**Thursday 7pm.**	.....20th March
GOING HOME:	**Thursday 7pm.**	.....27th March.

You may also book yourself in for relaxation classes when you attend your evening session.

The sessions at Bathgate Primary Care Centre are held on Mondays at 2pm., in the Health Education room. We rarely have partners at these sessions as work commitments make it difficult. You are entitled to time off from work, within reason, to attend these classes.

INTRODUCTION: Meet other mums to be, decide what you want to discuss		..... 17th March
LABOUR & PAIN RELIEF:		.....24th March
FEEDING YOUR NEW BABY:		.....31st March.
BABY CARE & BEING HOME:	3rd Feb	..... 7th April
BREASTFEEDING WORKSHOP:	10th Feb	..... 14th April

POSTNATAL REUNION: This will be arranged once all the mums have delivered.

Also available to you are Aquanatal Sessions held on various days and different pools in W. Lothian.

Bathgate pool, Mid Street : Fridays 10.15 – 11.15am

Inveralmond High School: Tuesday 9.45 – 1045am. (creche available) Livingston

Broxburn Baths, Main Street: Mondays 12.00 – 1pm

Linlithgow : TUESDAY 12.15 – 1.15pm

Physiotherapy Sessions are specially run for early pregnancy and late pregnancy

Early Session, 16 weeks onward: Wednesday evening 5pm. to 6pm. To book your place please phone the community desk at Bathgate on 630771

Late Session, 30 weeks onward: Wednesday afternoon from 2pm. to 4.15pm. Book via the community desk again.

Hypnotherapy sessions are also available, please ask your midwife for details.

Natural Pain Relief

Relaxation - more efficient contractions, more oxygen to the baby and uterus, *giving* birth, keeping calm.

Massage - blocks pain messages, promotes relaxation, increases endorphins, involves partner - team effort?

Heat - hot water bottle, warm hands, warm flannels, warm socks.

Cold - cool packs, ice cubes, frozen peas, cold flannels, cold hands

Water - bath, shower, birth pool - increases endorphins, spray mist.

Scent - massage oil, room scenter, perfume, flowers, incense.

Music - personal stereo, tape player, radio, singing.

Movement - rocking, dancing, swaying, walking, changing position.

Position- upright if possible - but find what is most comfortable.

Breathing - helps you relax, helps to focus, helps to distract.

Focussing - look at flowers, picture, walpaper, clock, partner's eyes or face.

Distraction - singing, movement, tapping, breathing, noises.

Noise - groaning, moaning, sighing, singing, crying, grunting, screaming, growling, chanting.

Keeping busy - continuing doing what you were doing.

Environment - comfortable, being at home.

Supporters - people you relate to, people who are attuned and relaxed.

Good midwife - trusting relationship - you feel more relaxed.

Instincts - trusting yourself - *you <u>can</u> do it!*

Freedom - allowing yourself to do what you want, what feels right for *you.*

Smiling - releases endorphins - you will relax - open mouth.

Positive Thinking - *'one more contraction nearer your baby'*

Quietness / Dim light - help you relax, tune into your body / your baby, increases endorphins.

Imagery - thinking of contractions as *waves, strong, opening you up, letting the baby come down.*

Praise - from supporters and midwives - when things may be getting harder.

Knowledge and Understanding - don't fear the unknown!

Cuddles - from your partner, from your family.

Laughter - distracts and relaxes, increases endorphins.

It is well known that the position of your baby in your pelvis at the end of pregnancy and during labour will have a big influence on your labour and the way your baby is born.

If your baby is *anterior* you are:

- more likely to go into labour spontaneously;
- more likely to have a shorter, easier labour;
- less likely to need medical help, such as drugs, forceps or ventouse.

So how can you encourage your baby to lie in an anterior position?

Before labour begins

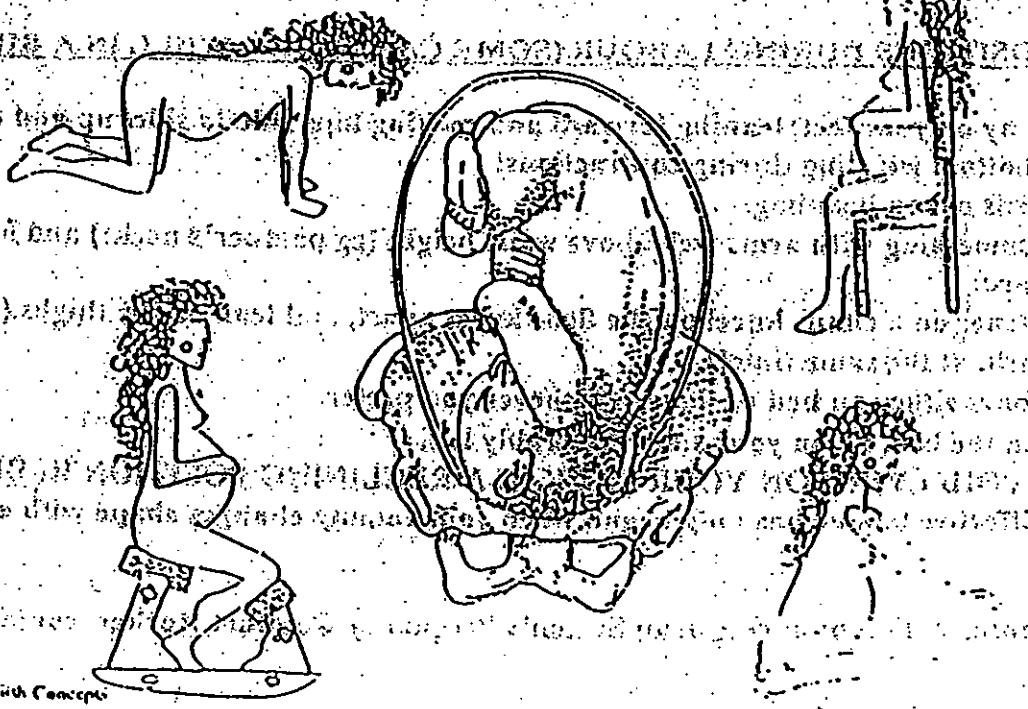
Use upright, forward-leaning postures, particularly during the last 6 weeks of pregnancy:

- watch television sitting on an upright chair or leaning forward over some cushions;
- if you are sitting in a sofa or armchair put cushions behind your back and under your bottom;
- try to rest lying on your side with your upper leg forward so the knee touches the mattress;
- go swimming and walking;
- avoid long trips in the car;
- try not to sit with your legs crossed;
- if you know your baby is breech or posterior you might like to try crawling for 10-20 minutes a day to encourage your baby to turn.

During labour

If your baby is still posterior when you go into labour you will probably feel the pain in your back. There is still time for your baby to turn before he or she is born. You can help your baby by:

- staying upright - kneel, lean forward;
- keeping mobile - walk around, change position.



Illustrations ©Birth Concepts

ADVICE FOR OPTIMAL FOETAL POSITIONING

This information is for expectant mums and their partners to encourage your baby to go into the ideal position for birth before labour begins. If your baby is coming head first and a single baby, (not multiple pregnancies), then from 34 weeks onwards this advice is given to encourage your baby to lie with its back to your left side/front, encouraging your baby to engage, thereby enjoying as normal and straightforward a birth as possible.

Please note this advice is only meant to complement your antenatal care, and may not be suitable for all women or all pregnancies. Always consult your childbirth/ health professionals.

DO : - Regularly use upright and forward leaning postures. This allows more available space in the pelvis for your baby to turn.
- Sit with knees lower than hips, with back straight as possible. Use pillows or cushions under the bottom and in the small of the back.
- Sit to read on a dining chair with elbows resting on dining table, knees apart, leaning slightly forward. (Similar posture used when sitting on the loo!)
- Sit facing chair back and resting arms on back of dining chair.
- Kneel on the floor leaning over a large beanbag or floor cushion to watch T.V.
- Use an office stool or *Jean Sutton's Pregnancy Comfort Rocker. Make sure knee pad is wider than seat to allow knees to be kept wide apart and hips to turn outwards.
- Put a wedge cushion under bottom when driving.
- Swim with abdomen forward.
- When resting/ sleeping, lie on your side, preferably left, with a pillow between the legs, the top knee resting on the bed.

IT IS IDEAL TO USE FORWARD LEANING POSTURES WHEN HAVING BRAXTON HICKS (PRACTICE CONTRACTIONS) AS THIS INCREASES THEIR EFFECTIVENESS WITH REGAI TO HELPING THE BABY MANOEUVER HIMSELF INTO THE OPTIMUM POSITION.

DON'T: - Relax in semi-reclining positions that have your knees higher than your hips.
- Take long trips in cars with bucket seats. If you must, use wedge cushion as above.
- Sit with legs crossed.
- Use squatting as an exercise in late pregnancy as this may force the baby's head into the pelvis before it is in the correct position.

USEFUL POSITIONS DURING LABOUR (SOME CAN WORK WELL IN A BIRTHING POOL)

If possible stay on your feet, leaning forward and rocking hips side to side/ up and down with each contra
Keep your bottom wiggling during contractions!
Lean forwards over a beanbag.
Hang onto something with arms well above waist height (eg partner's neck!) and let your body sag, turnb knees outward.
Sit your partner on a chair, kneel on the floor knees apart, and lean on his thighs. (This is great because h rub your back. at the same time!)
Get on all fours either on bed or floor, whichever you prefer.
If you are on the bed, lie on your side. Preferably left.
TRY TO AVOID LYING ON YOUR BACK IN A RECLINING POSITION IN BED.
n.b./ Effective labour has only begun when your tummy changes shape with each contraction.

*For more information on hiring Jean Sutton's Pregnancy Comfort Rocker contact: 0181 890 8298.

	What's going on	Physical changes	How you may feel
re-labour	This is the build up to labour proper. It can begin at any time, from a few hours to a few days before the start of regular contractions. Your cervix is beginning to be drawn up (to efface) and widen (dilate).	• Irregular, mild contractions; period-like pains; tightenings • Vaginal discharge • Dull pain in lower back • Blood-stained mucus or "show" • Diarrhoea • Regular contractions that stop and start	• Elation and excitement that the months of waiting are nearly over • Apprehensive as to what labour will be like • Impatient to get on with it • Sudden bursts of energy • Urge to prepare for the arrival of the baby - may take the form of wanting to clean the house
rly bour	Experts refer to the part of labour which takes you up to four centimetres dilated as the latent phase of the first stage. The cervix is fully drawn up (effaced), and is dilating, but labour can still stop for no apparent reason.	• Contractions mild, irregular, up to half an hour apart, lasting 20 to 30 seconds. • Irresistible tightening feeling with each contraction • Bloody jelly-like show • Diarrhoea • Pressure in your pelvis • Fatigue	• Full of anticipation, eager for labour to progress • Cheerful, talkative, sensitive to your surroundings • Apprehensive about what lies ahead and how much worse the pain will be • Frustrated if this stage is long
ctive bour	Now you are in established labour - what is known as the active phase of first stage. It lasts from around four centimetres dilation to around seven centimetres, and now there's no going back - labour will continue until your baby is born. You should certainly be in hospital by now, and may be monitored for a short time to assess your progress	• More regular contractions, usually two to five minutes apart and lasting 45 - 60 seconds. Contractions longer, stronger, with a peak. You may breathe instinctively more lightly over the peaks. • Face becomes flushed, you feel hot • Mouth and lips feel dry • Continuous low back pain • Pain may radiate to thighs • Bag of waters may burst • Increasing fatigue	• Less chatty and sociable, more introverted • No longer want to be left alone • Less sensitive to external environment, more concentrated on feelings coming from your body • Satisfaction that labour is progressing • Fearful about the increasing strength of contractions
ransition	This stage, which goes from seven or eight to 10 centimetres dilation, is the most turbulent and difficult. It can last from just a few minutes to several hours.	• Contractions one and a half to three minutes apart and lasting 60 to 120 seconds. • Nausea, shaking thighs, hot and cold flushes • Urge to push • Bag of waters breaks if it has not done so already • Intense lower back pain	• Overwhelmed, panicky, restless • Discouraged - want to go home and forget about having baby! • Snappy and intolerant with your attendants • Unable to make decisions or respond to questions clearly
econd age	This stage is when you actively push your baby out. It lasts from full dilation to birth and can be anything from a few minutes to several hours.	• Contractions three to five minutes apart. • Irresistible urge to push • Pressure in back passage • Drowsy and relaxed between contractions • Burning sensation as baby's head appears • Wonderful slippery feeling as baby slides out.	• More outwardly focused again • Renewed enthusiasm • Joy that at last you can do something to help your baby to be born • Possibly overwhelmed by pushing urge or afraid of splitting • Frustrated if this stage is long • Intense euphoria and elation baby is born.
hird age	The delivery of the placenta usually happens within 20 minutes or so if you have been given an injection of oxytocin, otherwise it may take longer	• Contractions begin to fade • Slippery feeling as placenta slides out • Gush of blood • Urge to bear down again as placenta is delivered	• Euphoric and relieved • Proud and triumphant • Close to partner • Wonder at baby • Forgetful of all pain • Possibly detached from baby

What to do	Birth partner's job	The professionals' job
• Accept this as a labour "warm up" • Conserve energy • Sleep, if it's night • Do a little light housework, go for a walk, listen to music, watch TV • Eat little and often; drink plenty • Use relaxation and breathing exercises if you need them • Stay on the move	• Reassure her this stage is normal • Stay with her yourself, or ensure she has other company, unless she wants to be alone - but make sure you are easily reachable • Help her keep her mind occupied - play a game, watch a video, chat • Encourage her to conserve energy, and to eat and drink regularly	• Reassure you both that what is happening is normal • Suggest ways to get comfortable and tell you to conserve energy • Encourage you to stay at home • If your membranes have burst (waters have gone), or there are any danger signs such as bleeding, tell you to come into hospital
• Continue as above • Use relaxation and breathing exercises as necessary • Stop what you are doing during a contraction and lean against a wall/your partner, kneel on all fours, experiment with positions • Stay mobile so gravity can help the descent of your baby	• Continue as above • Make sure you know the route to the hospital and have enough petrol in the car • Be prepared to take her into hospital when the professionals say she should go in, or if she feels she would be happier there • Encourage her to stay upright	• Continue as above • Advise you to stay at home for as long as you feel comfortable, so long as everything is straightforward • Advise you to come in if it is anticipated there may be problems
• Accept the progress of your labour • Meet each contraction with a slow deep breath • Think positive • Change positions frequently • Alternate active and resting positions • Don't lie on your back • Pass water once an hour • Moan or scream if you want to • Take a warm bath • Use other relaxation techniques • Breathe as your body dictates • Don't hold your breath	• Drive her to hospital • Give constant encouragement • Remind her to let go and take one contraction at a time • Supply ice chips or cool cloths • Massage her • Help her change positions • Remind her of her progress • Breathe with her • If she tenses when she closes her eyes, maintain eye contact when she opens them again • Liaise with the hospital staff • Don't be offended if she's irritable	• Admit you to hospital • Assess your labour's progress and you and your baby's wellbeing • Reassure you, answer questions, boost your confidence • Go over your birth plan • Check your progress at regular intervals • Suggest positions and comfort measures; remind you what to do • Suggest pain relief • Advise your birth companion on how to help you
• Abandon yourself to labour • Keep legs, buttocks, mouth and throat muscles loose and relaxed • Change positions • Go on all fours with head down to allow cervix to dilate fully • If you have an urge to push and the midwife says, "Not yet", try breathing to rhythm "huf-huff-blow"	• Stay calm and remind her constantly of the progress she's making and how well she's doing • Remind her this is the shortest part and soon her baby will be born • Maintain eye contact and help her breathe through contractions • Massage her back or thighs • Remind her to relax muscles	• Monitor progress and you and your baby's wellbeing • Perform an internal to see if you are fully dilated • Encourage you and tell you what good progress you're making • Reassure you that the baby will soon be here • Help you use gas and air
• Push only when you feel the urge • Experiment with different positions - kneeling, supported squat, all fours and so on. Avoid lying on your back • Bear down smoothly and don't hold your breath • Grunt and moan if you want to • Pant or blow as the baby's head crowns	• Get her into positions and support her if necessary • Encourage her to change positions if it helps her • Remind her to breathe • Don't play the cheerleader! • Wipe her face, offer drinks or ice • Hold mirror so she can see the baby descending • Focus on her - not her lower end	• Monitor you and your baby • Help you find a suitable position • Encourage you to push with the rhythm of your own body • Be ready to intervene with episiotomy or forceps if necessary • Check that the cord isn't around the baby's neck • Deliver baby • Give you an injection of oxytocin
• Breathe deeply and slowly during contractions • Push on instructions of midwife • Put baby to breast if placenta is slow in coming, to stimulate uterus to contract	• Kiss her and congratulate her on a job well done • Help her hold baby or cuddle baby yourself • Get something for her to drink and/or eat	• Check baby, assign Apgar score (the assessment of the baby's physical wellbeing) • Monitor your bleeding • Check placenta • Stitch up, if necessary

West Lothian Healthcare NHS Trust

NHS Lothian

Physiotherapy Antenatal Class

This class is designed for ladies that are about 30 weeks pregnant

It will be held on a Wednesday afternoon at Bathgate Health Centre from 2.00-4.15pm

To book a place please phone the Community Desk at Bathgate Health Centre on 01506 630 771

For more details please turn over

The class will cover & discuss:

- Positions for labour
- Relaxation/Massage
- Pain relief for labour
- Postnatal problems

This class is separate from any midwifery antenatal classes that you may be attending.

This class is intended for ladies who previously attended the early 16 week physiotherapy class held on Wednesday evenings.

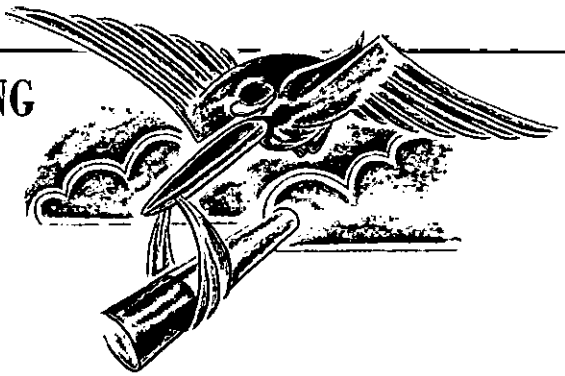
SMOKING

GIVING UP DURING PREGNANCY

PREGNANT WOMEN

STOP SMOKING

PREGNANCY AND SMOKING



Most women who smoke during pregnancy know that it can be harmful to their unborn baby. That's why many of them try to quit or at least cut down. As many smokers know it's not that easy, but it's important for you and your baby to stop completely. People say that giving up is difficult but it may be easier than you think.

For most people smoking becomes a habit, a part of everyday routine. If you are bored, it helps pass the time.

"The first thing you do when you're doing nothing is light up a fag."

You may be wary of trying to quit because you've seen others become irritable when they tried.

"Sometimes my husband throws the packet at me to shut me up! I just get that raggy!"

Or you might wonder how you can make the effort when your partner or friends smoke.

"I'd say to him, "but why are you smoking? You know I'm trying to stop" and he'd say, "Aye you're trying to stop smoking, not me".

You need to feel confident that you can stop smoking and now is a good time to think about your health. If you're a smoker, giving up smoking is the most important step you can take to improve your health.

By giving up smoking during pregnancy, your chances of having a miscarriage, a stillborn or low birthweight baby are greatly reduced. But it's not just the baby who benefits - you do too.

STOPPING SMOKING

Try to get support, from your partner, or a close friend, or a member of your family who you can talk to at difficult times. It may help to find someone who's also trying to give up, or someone who's already stopped smoking.

Your midwife, GP and Health Visitor will support you too. They will offer you encouragement and information. Ask for their help if you need it. They understand that it might be hard for you to stop.

"You need that back-up all the time, until you're 100% free of it yourself."

You may get cravings for a cigarette, but they don't last long. It might help you if you can find something to do to take your mind off it.

"A craving will last a few minutes - it's a sensation that goes through you and you think "Oh I need a cigarette". I just had to do something, like have a lollipop."

You get a spotless home when you're giving up - all that housework!

Tried going for long walks because I hardly ever smoke when I'm out walking.

Work out what helps you most.

It used to be miserable not having a cigarette after a meal, but now I have a coffee.

Remember your reasons for wanting to stop smoking.
Plan ahead to cope with difficult times.

I couldn't go day by day, I had to go hour by hour to keep myself off it.

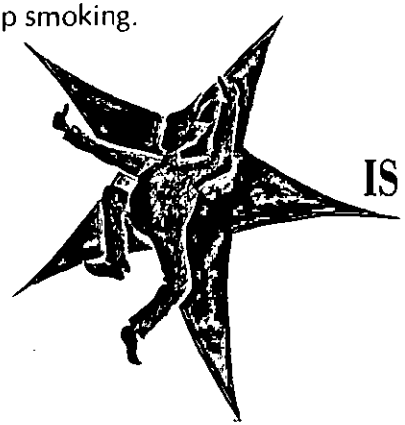
The first time I went to the pub and didn't have a fag, I came home and see the next morning, I felt dead chuffed. I was really pleased with myself that I'd managed it.

TIPS FOR STOPPING

I used to light a cigarette and leave it in an ashtray to burn down to the very bottom.

I went to bed early – I was in bed by 9 o'clock at night, so that I couldn't have a fag.

- Take each day at a time - or each hour at a time
- Get support from your family or a close friend to help keep you going
- Think of distractions when tempted to smoke - plan ahead so that you feel confident you can cope
- Phone Smokeline ,which has helped thousands of people to stop, for advice and a free booklet (tel. 0800 848484)
- Remind yourself of the benefits of not smoking
- Remember your reasons for wanting to give up smoking.



STOPPING SMOKING IS WORTH IT

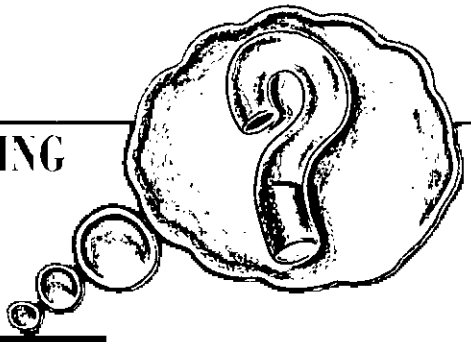
Try to keep in mind that giving up is positive. Even if you do return to smoking, don't think you're a failure. Work out why you started smoking again and how you can cope with this next time.

Decide to stop again.

Ask for help and support from people you know.

I think you need to be encouraged to stop smoking, not bullied into it because that way you just tend to get the hairs at the back of your neck up.

THINKING ABOUT YOUR SMOKING



SMOKING AND ME – PERSONAL DIARY

TIME	WHY DID I SMOKE?	HOW DID I FEEL ABOUT IT?

TOTAL NUMBER OF CIGARETTES SMOKED TODAY ☐
How do I feel about the number I have smoked today?

Which cigarettes could I have done without?

SMOKING AND ME – GOOD AND BAD

What's good about smoking?	What's bad about smoking?

What would I like to change about my smoking?

How could I start to do this?

What help do I need?

ASK YOUR MIDWIFE, HEALTH VISITOR OR GP FOR MORE COPIES OF THESE PAGES

SMOKING

GIVING UP DURING PREGNANCY

Health Education Board for Scotland

Woodburn House, Canaan Lane,
Edinburgh EH10 4SG

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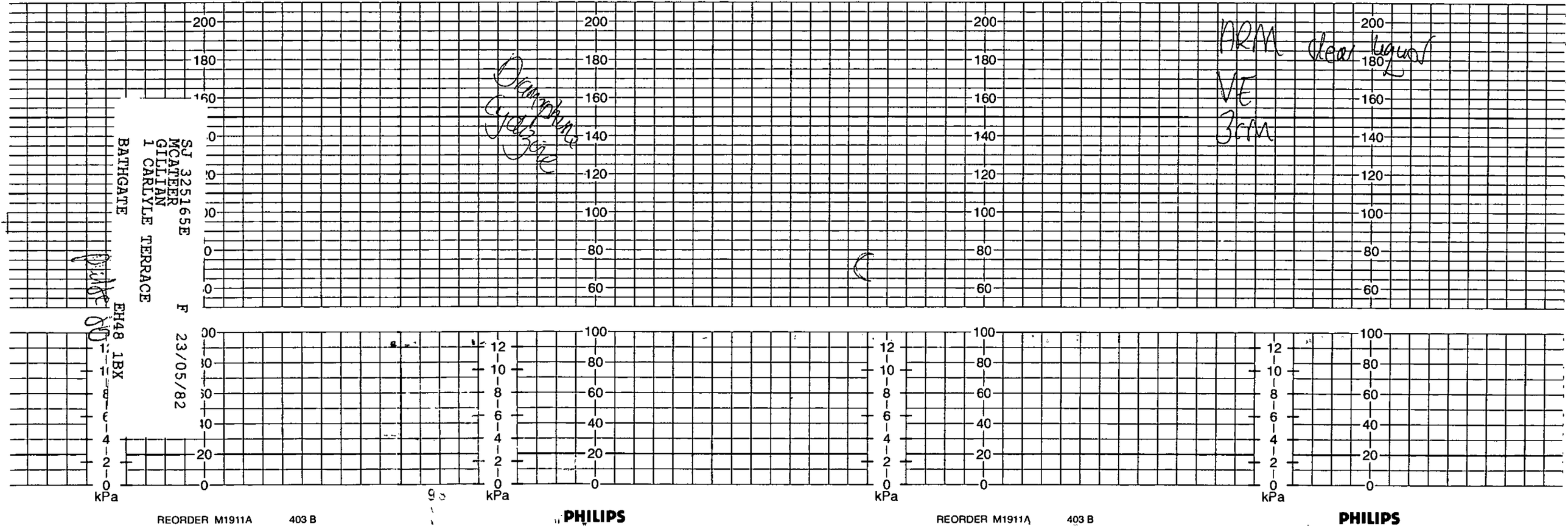
BK 1642 10/99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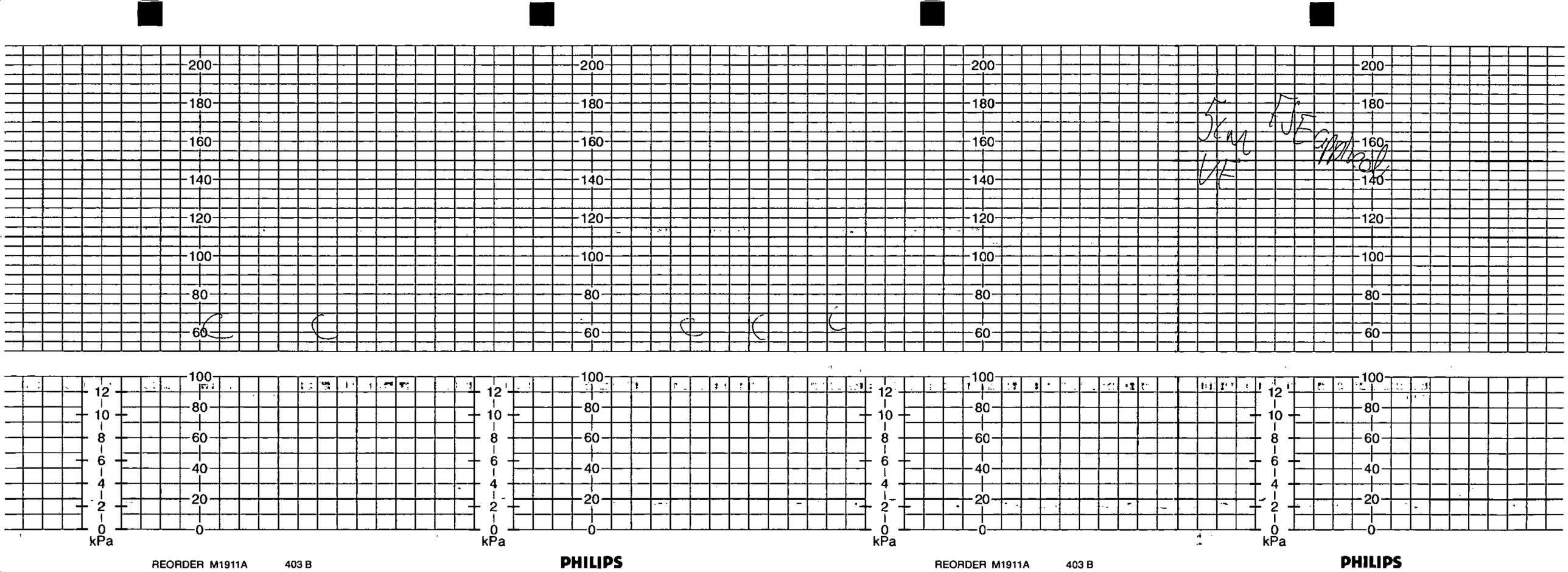
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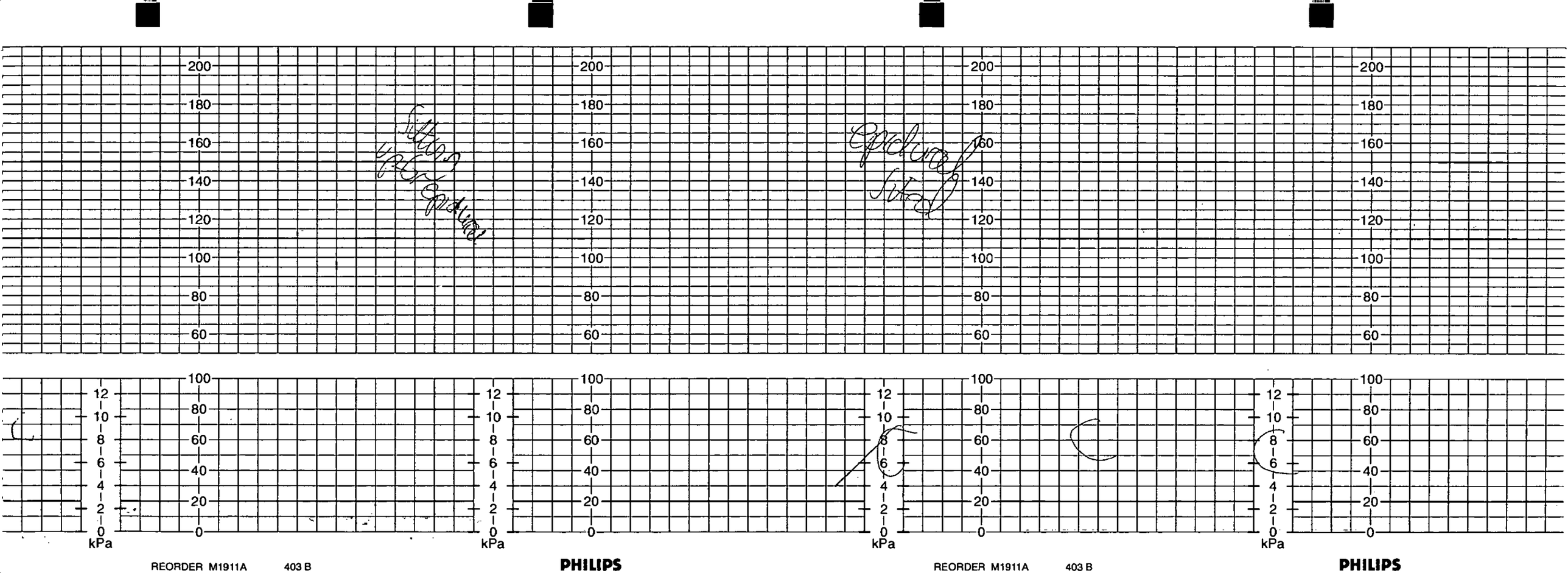
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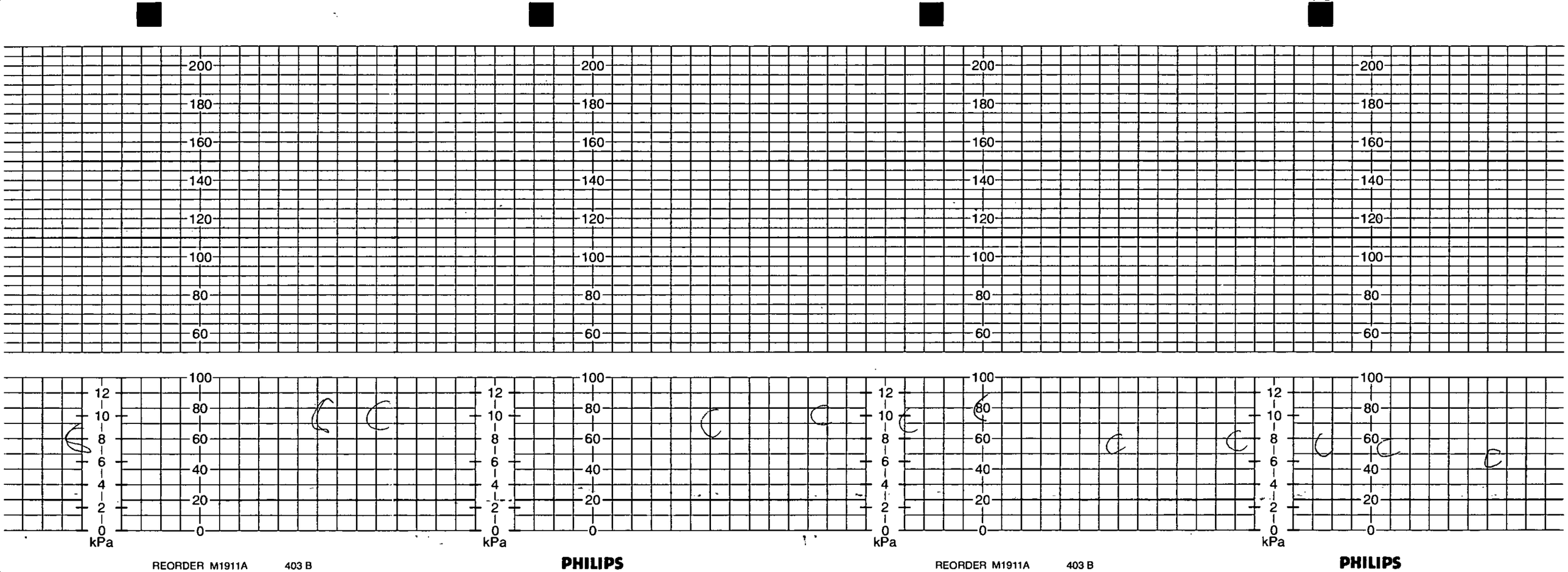
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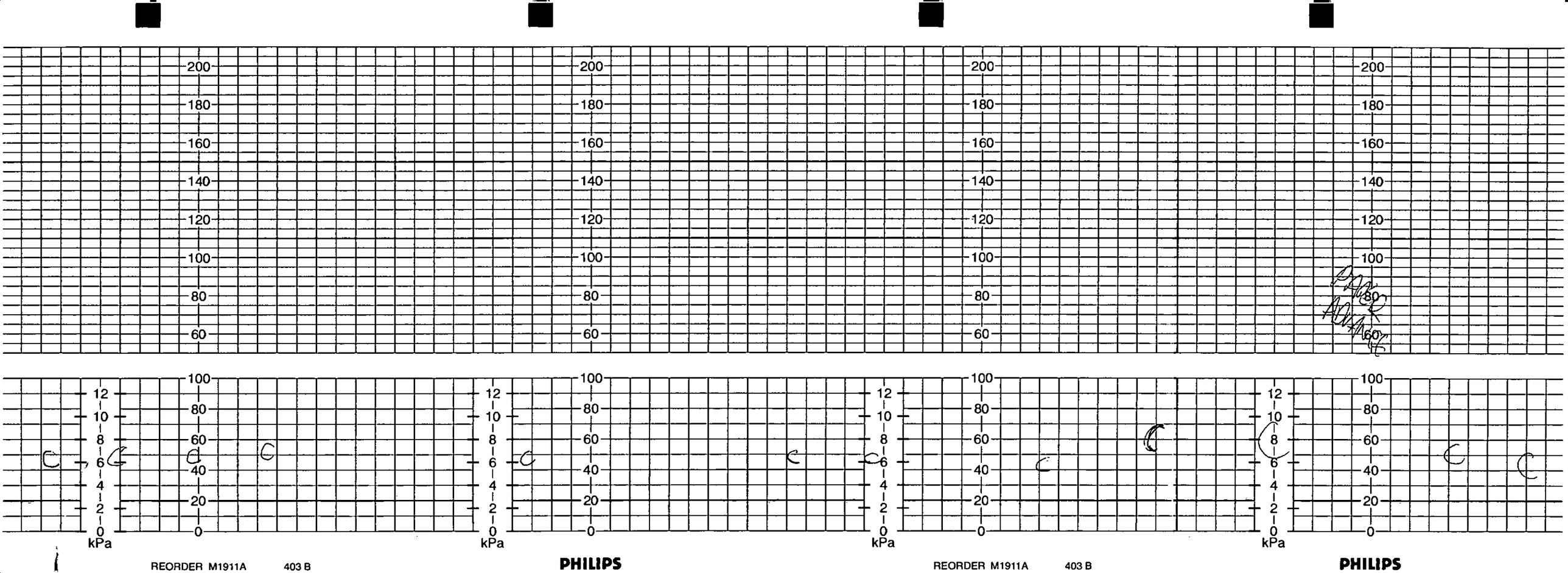
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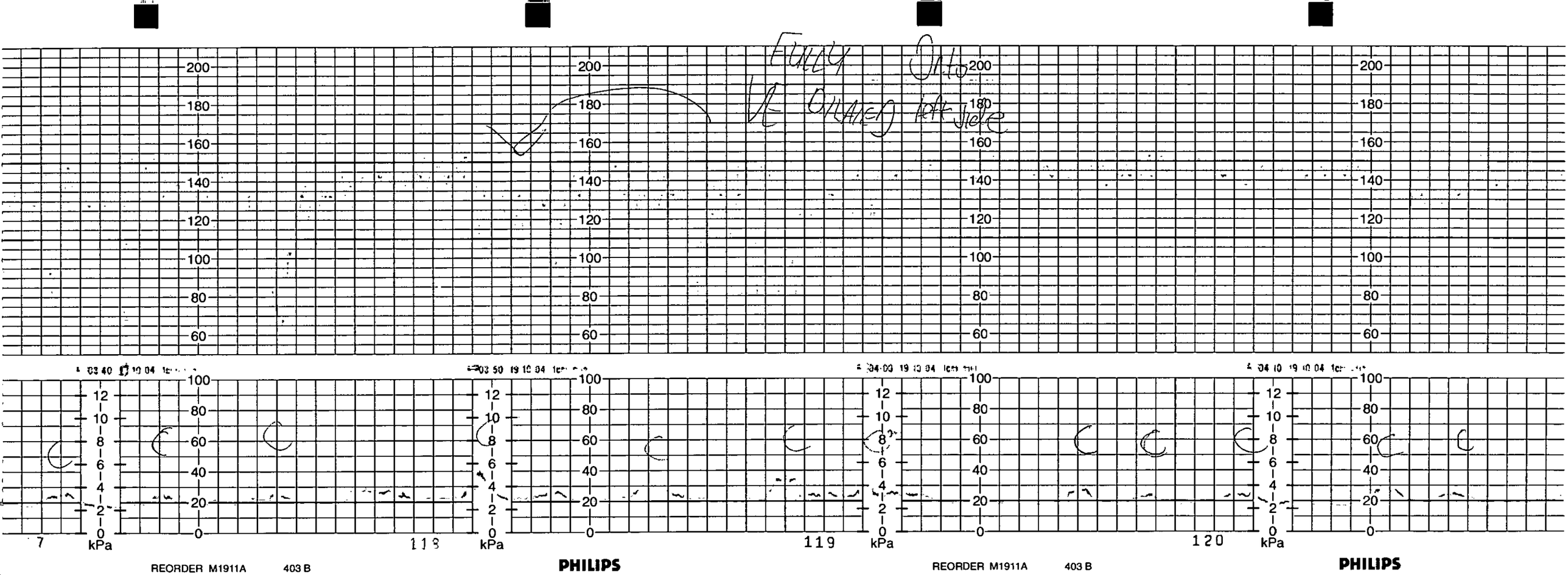
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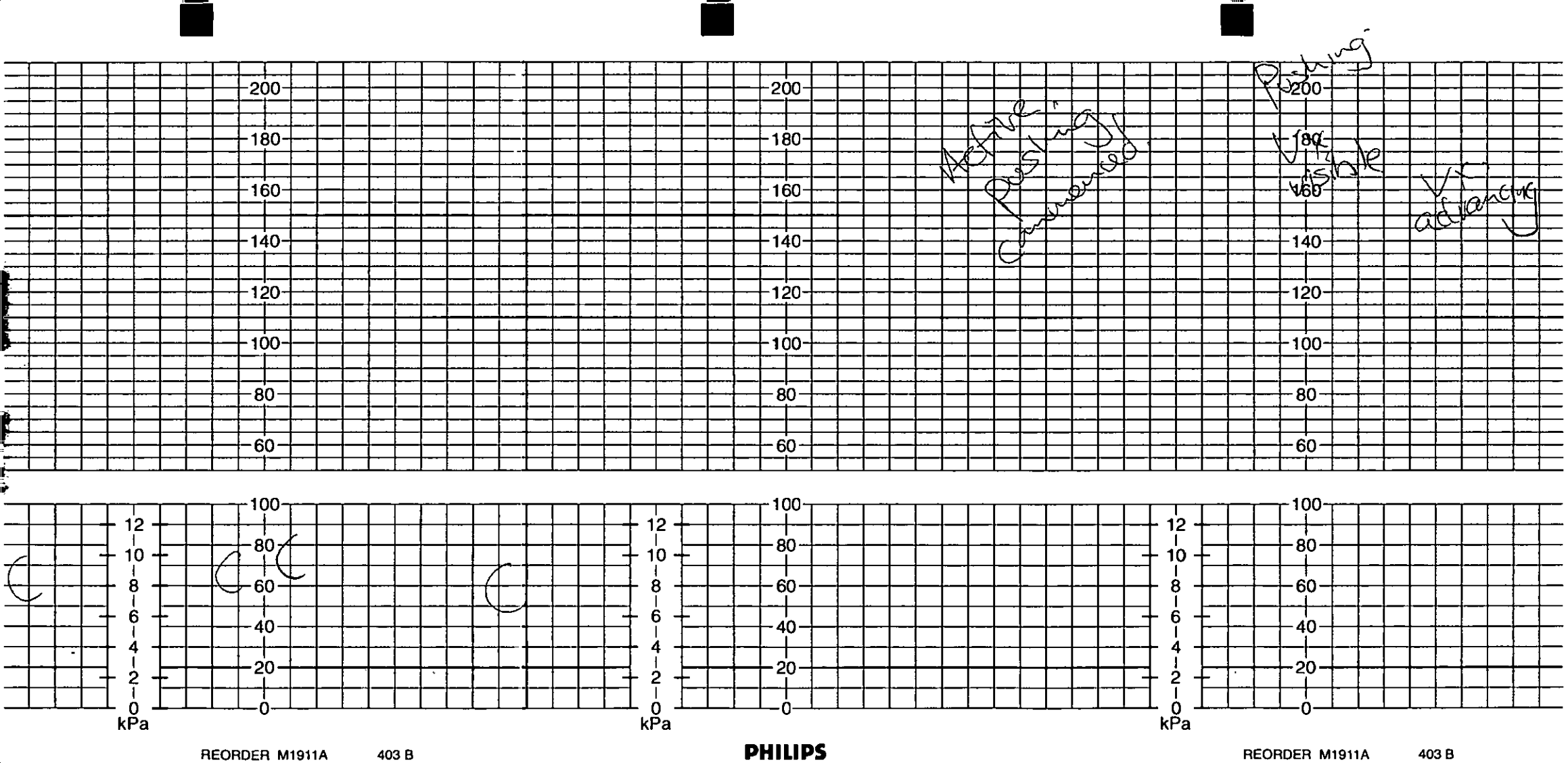
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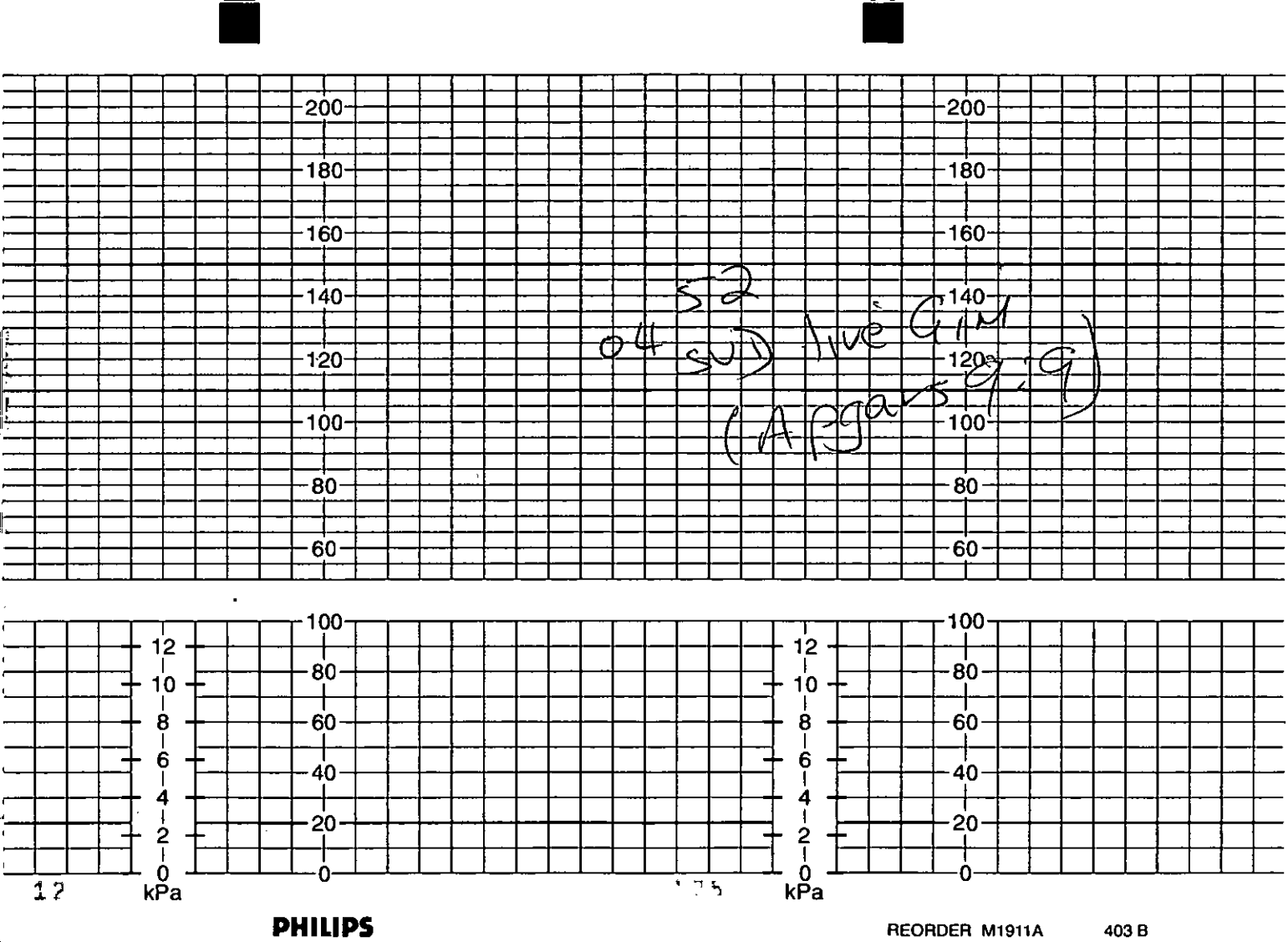
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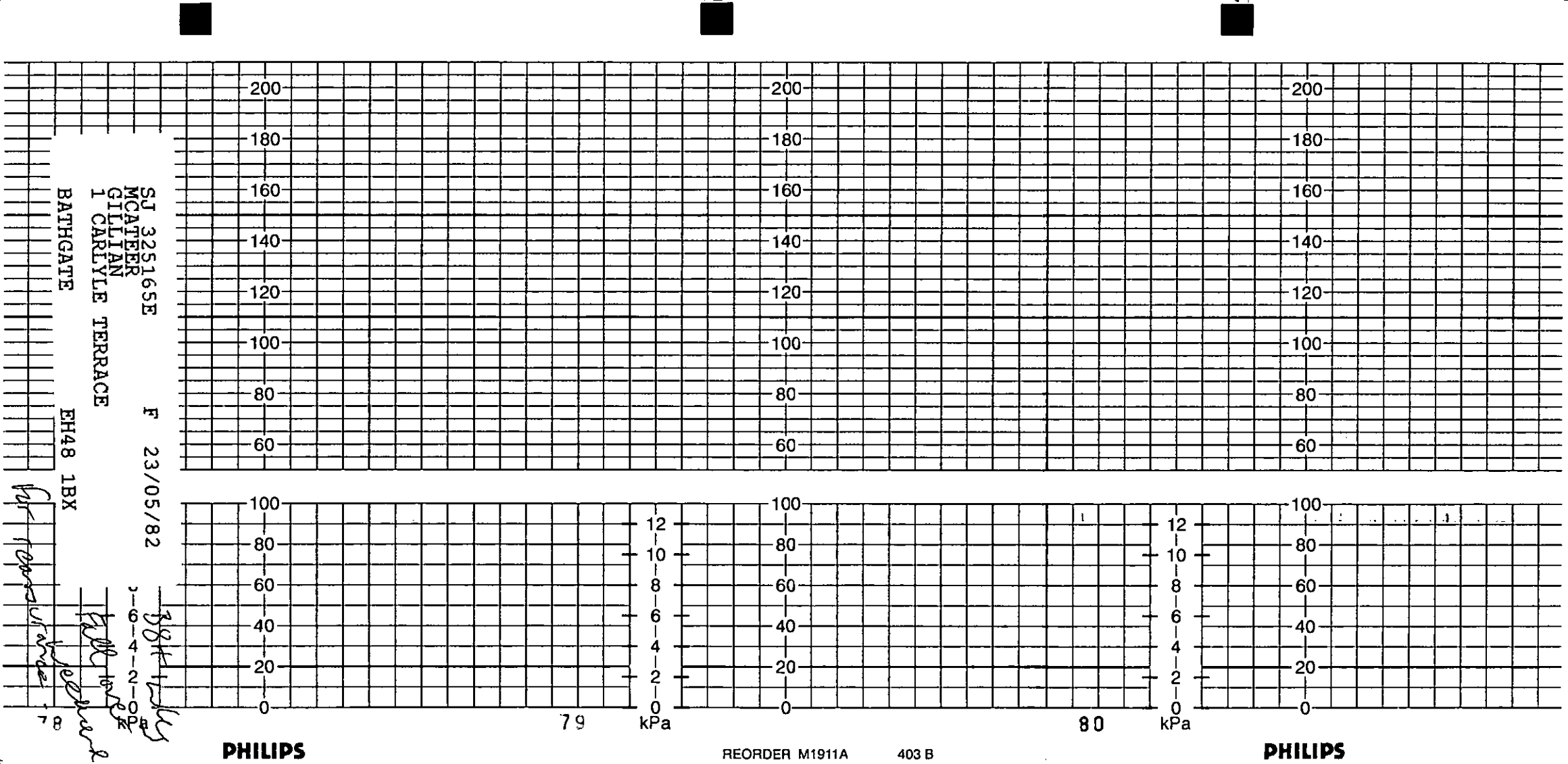
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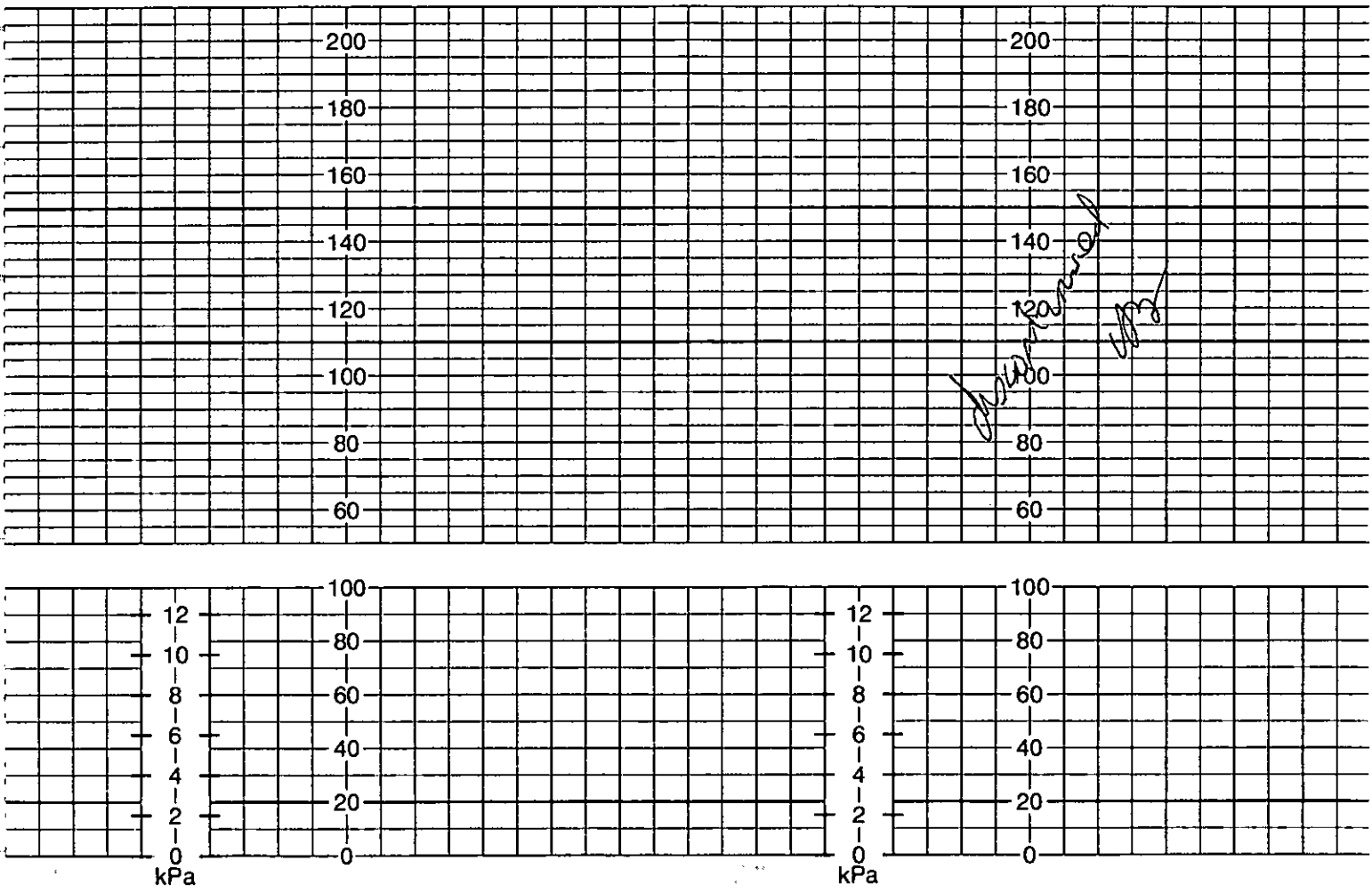
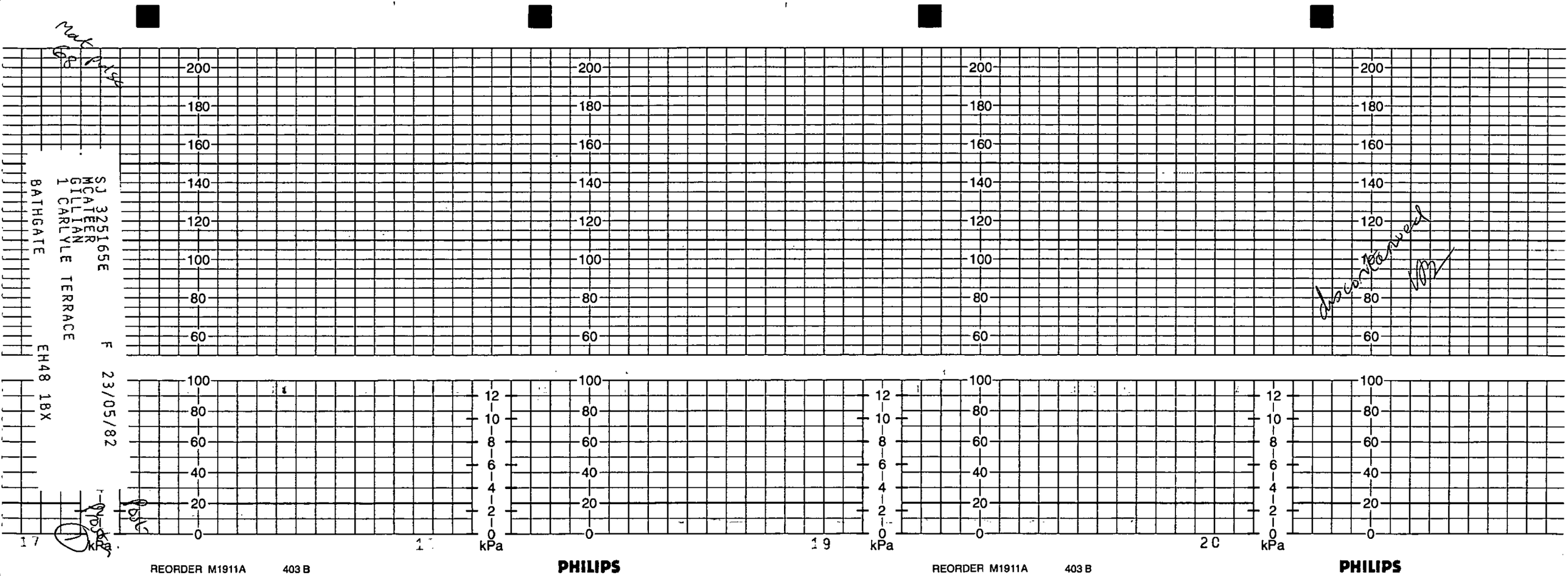
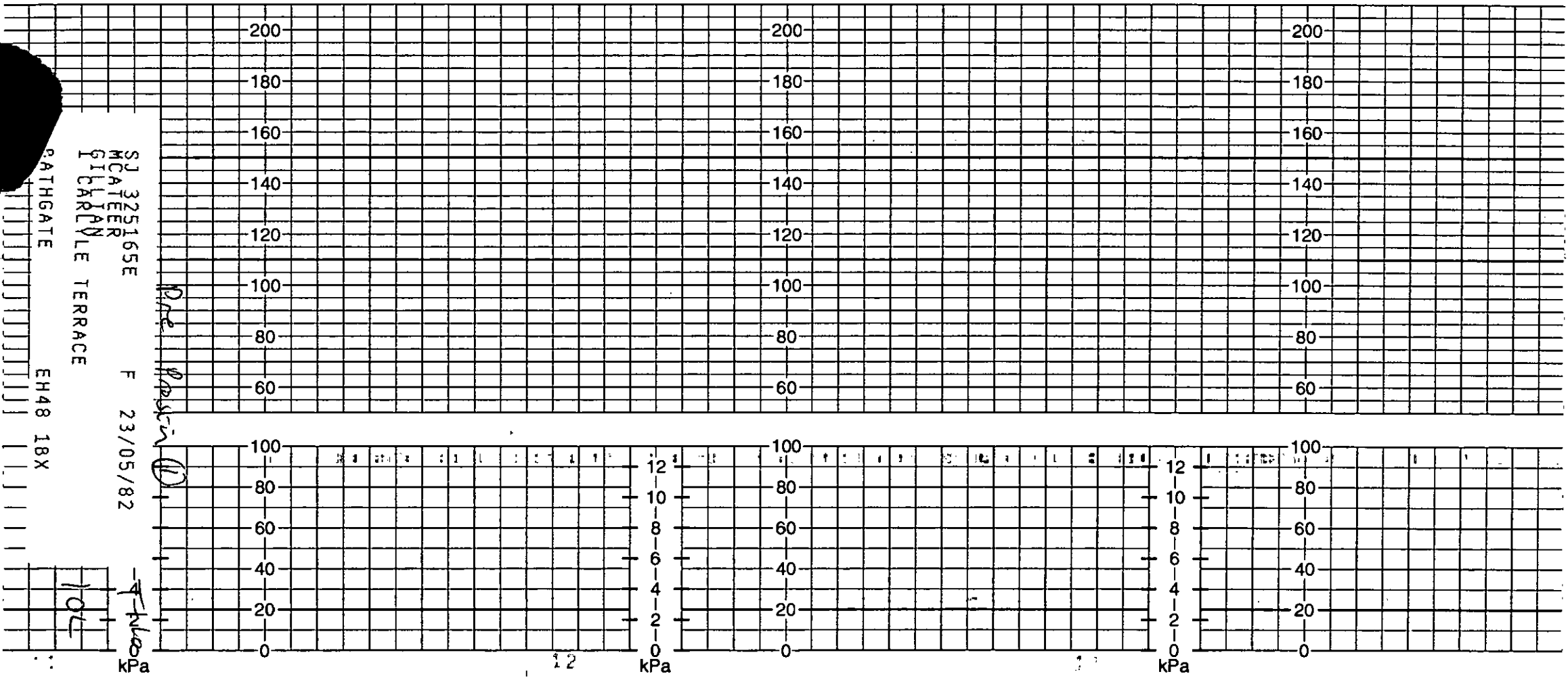
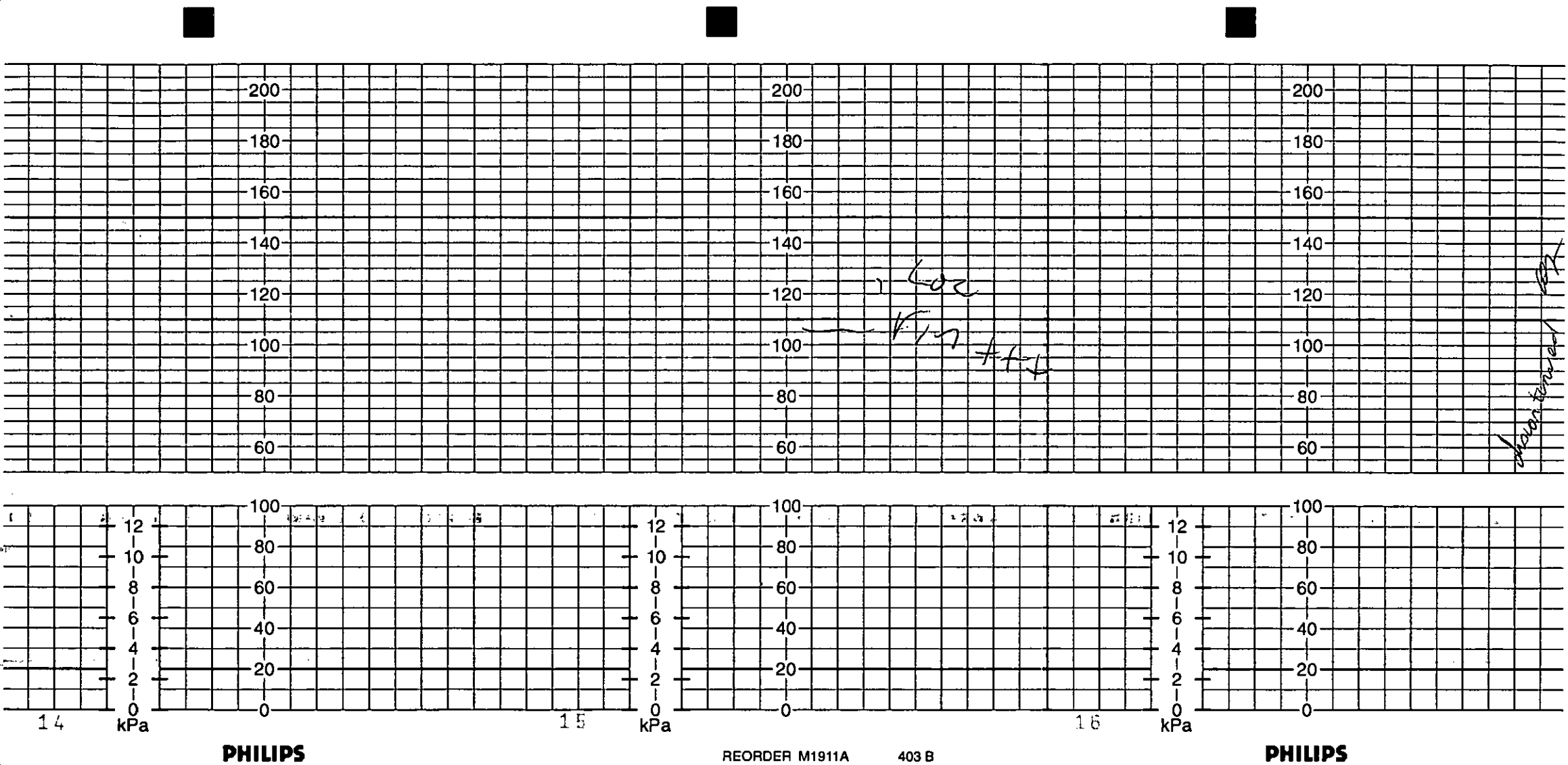
GILLIAN
1 CARLYLE TERRACE
BATHGATE
EH48 1BX
F 23/05/82
200
180
160
140
120
100
80
60
40
20
0
12
10
8
6
4
2
0
kPa
79
80
PHILIPS
REORDER M1911A 403 B
PHILIPS

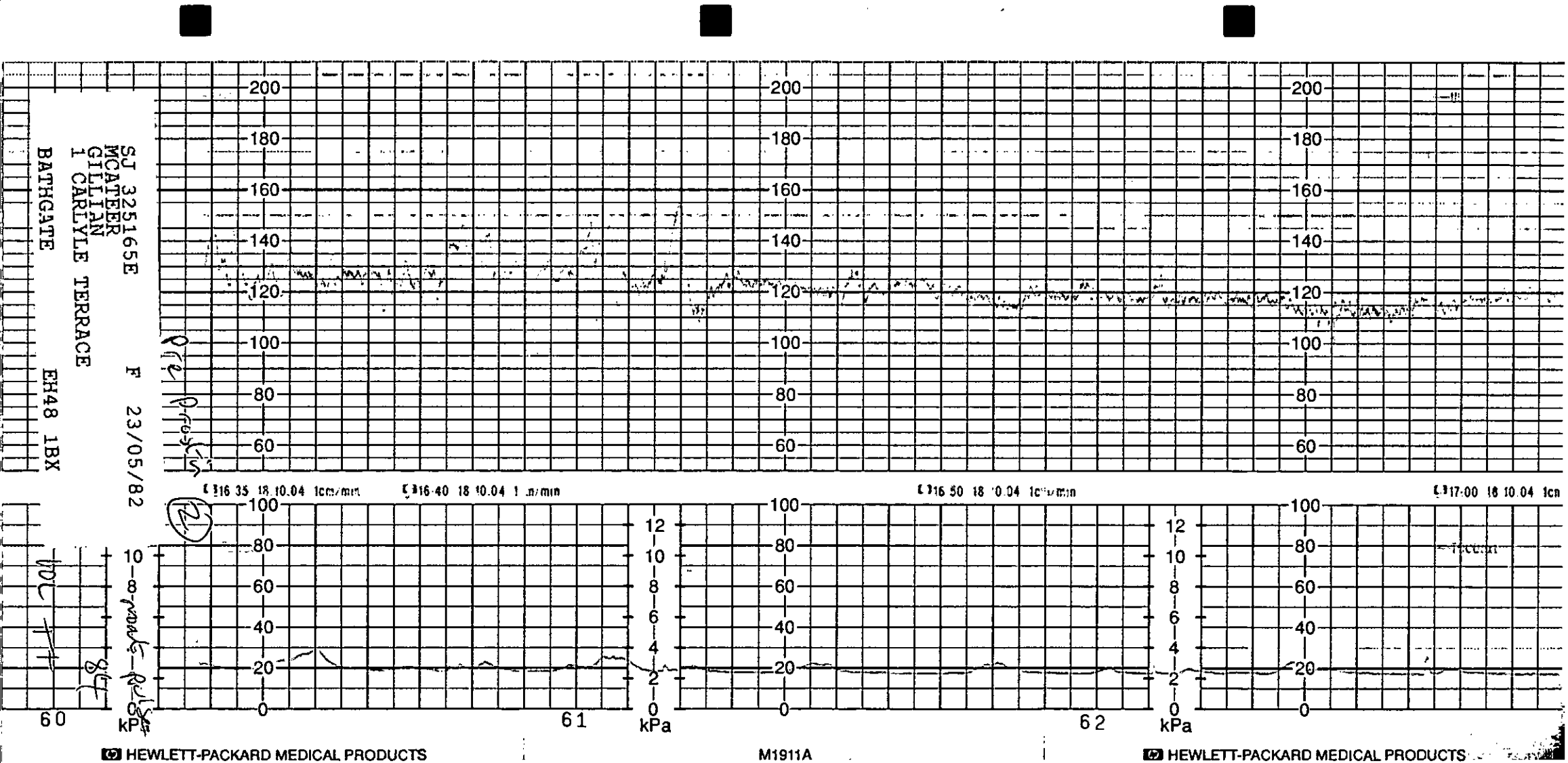


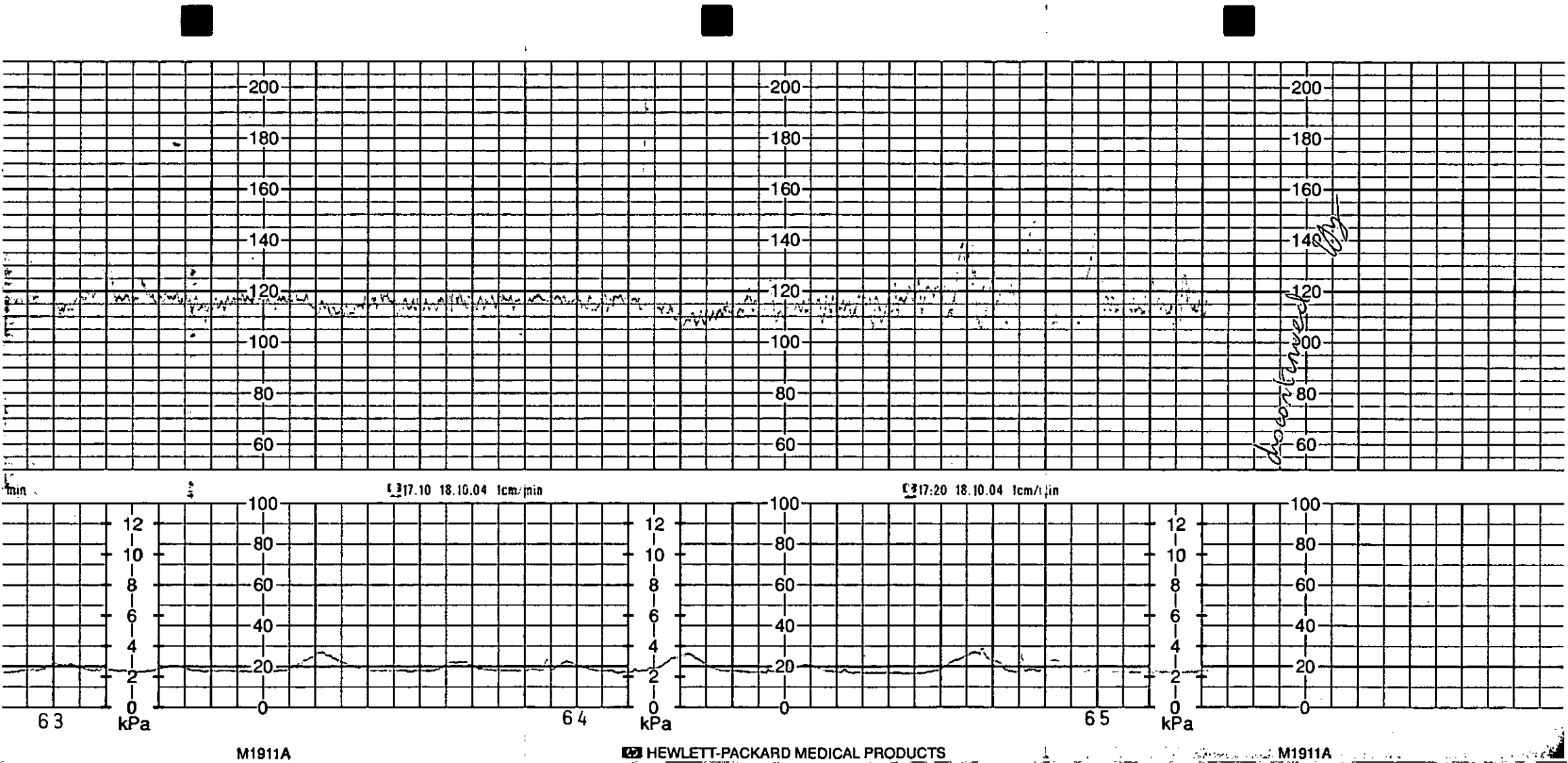
PHILIPS

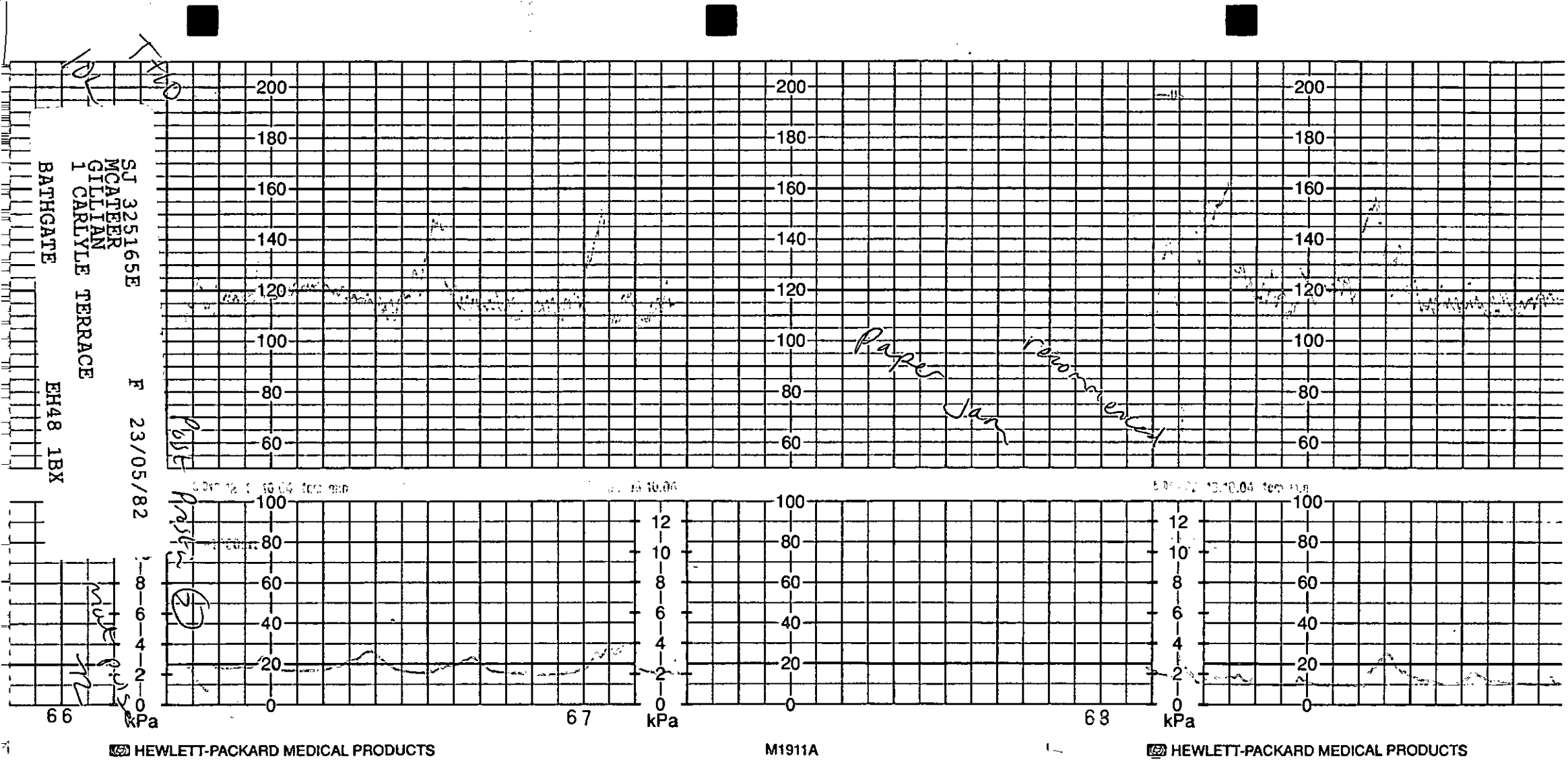

Max Mid Min
SJ 325165E
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE
EH48 1BX
F
23/05/82
discontinued
200
180
160
140
120
100
80
60
100
80
60
40
20
0
12
10
8
6
4
2
0
kPa
17
19
20
REORDER M1911A 403 B
PHILIPS

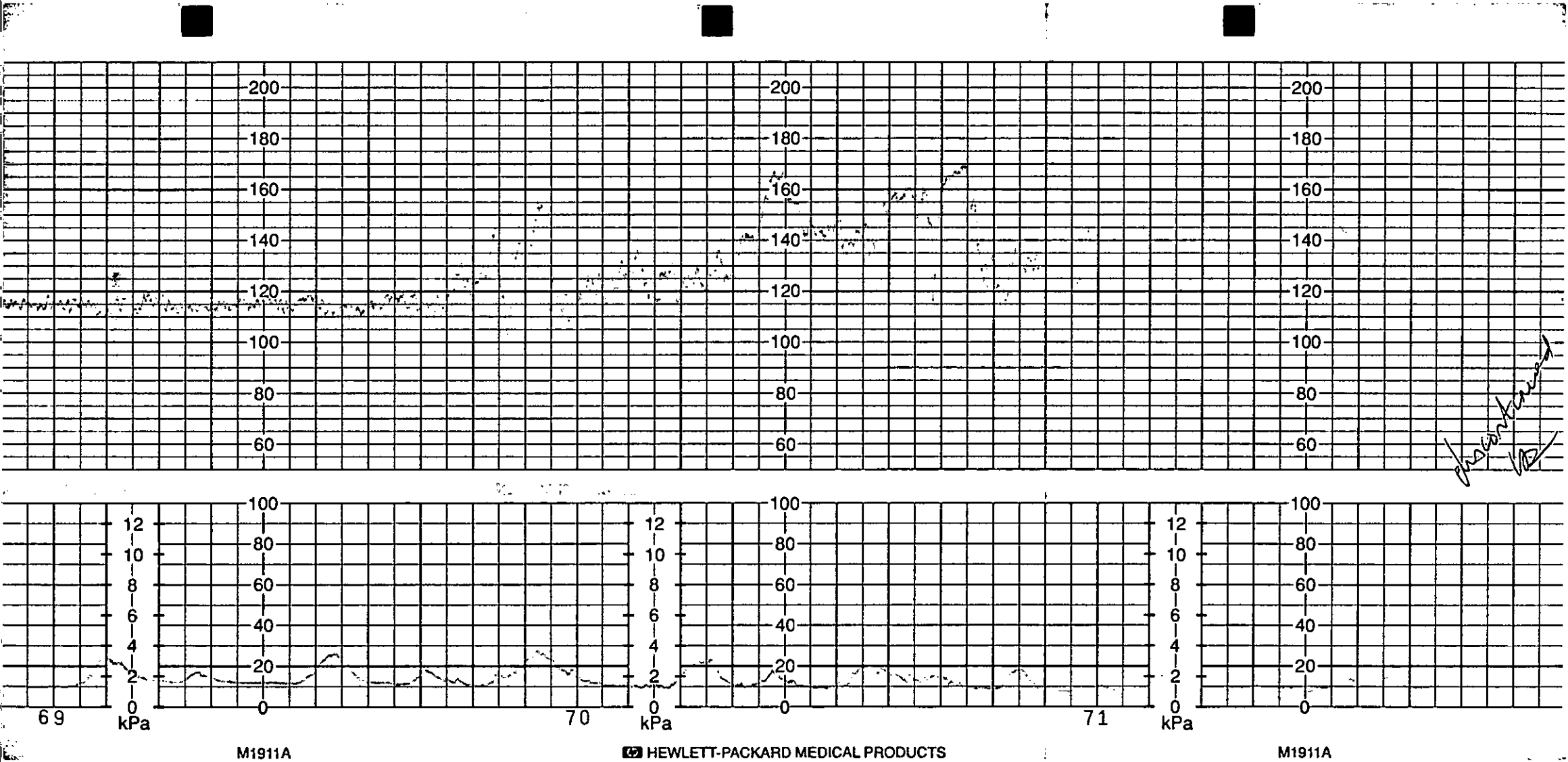

SJ 325165E
MCATEER
GILLIAN
CARLYLE TERRACE
F 23/05/82
PATHGATE
EH48 18X
200
180
160
140
120
100
80
60
40
20
0
12
10
8
6
4
2
kPa

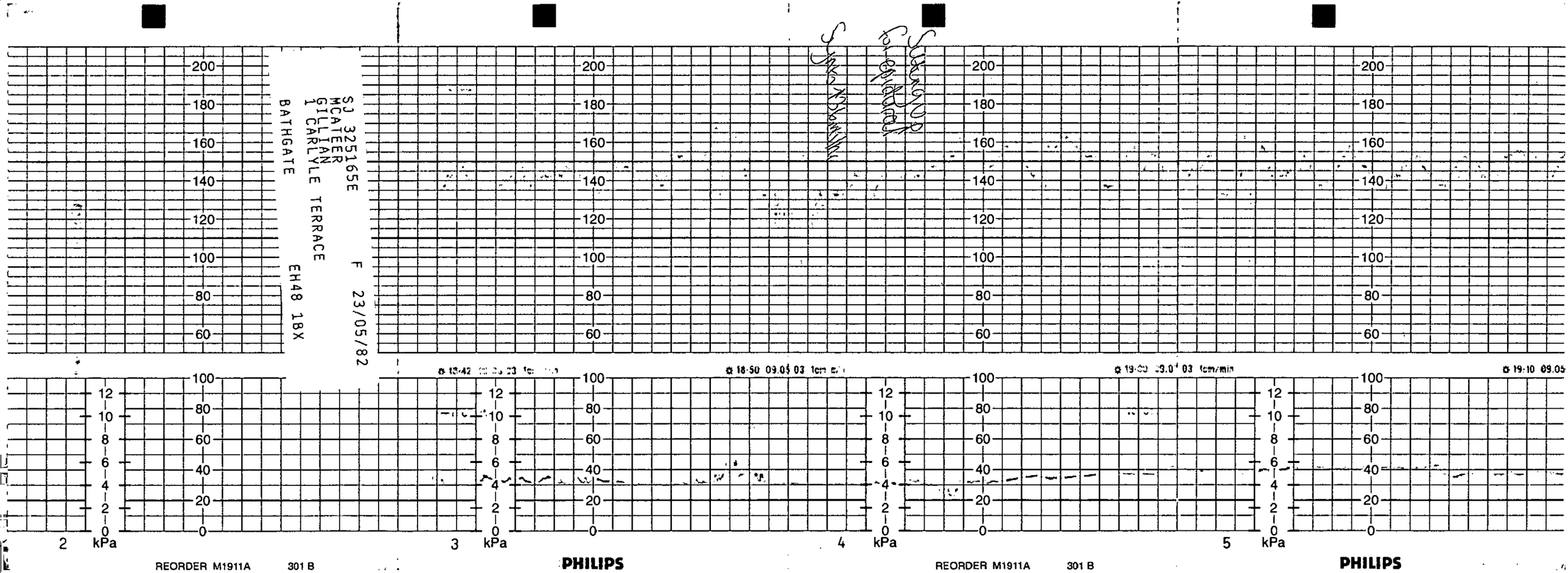

200
180
160
140
120
100
80
60
100
80
60
40
20
0
12
10
8
6
4
2
0
kPa
14
15
16
PHILIPS
REORDER M1911A 403 B
PHILIPS

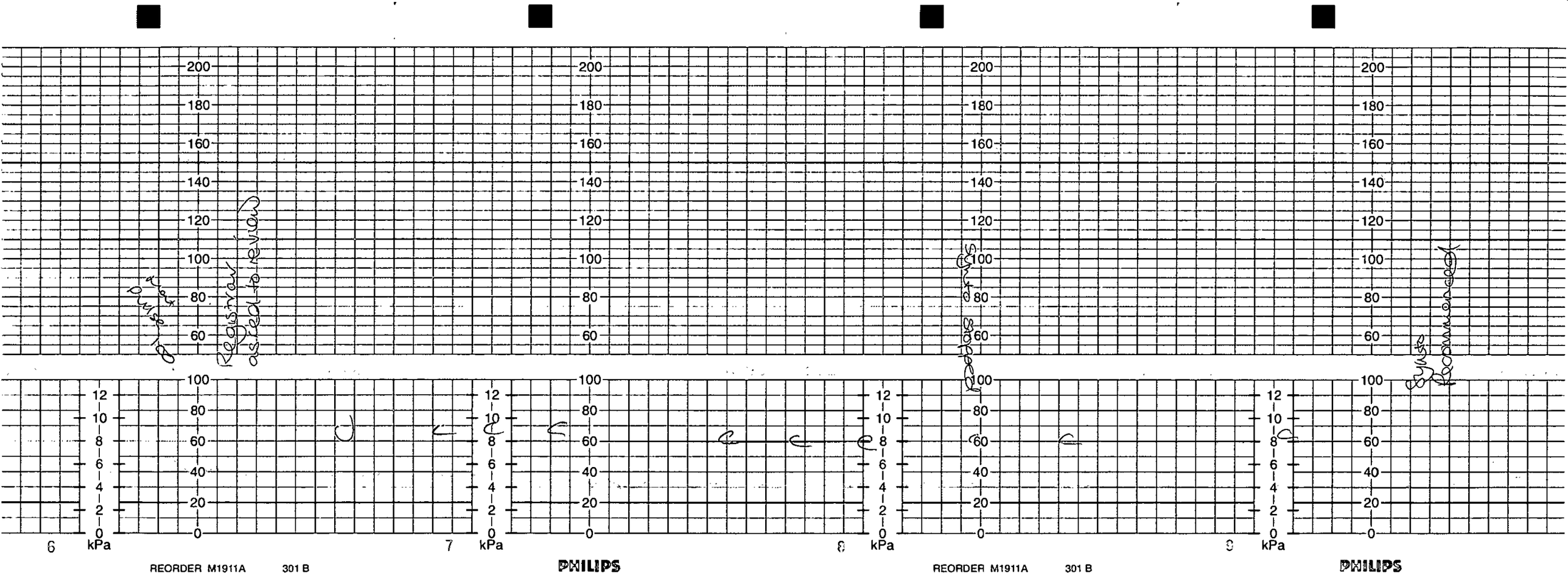

SJ 325165E
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE
EH48 1BX
F 23/05/82
200
180
160
140
120
100
80
60
16 35 18.10.04 1cm/min
16 40 18 10.04 1 cm/min
16 50 18 10.04 1cm/min
17:00 18 10.04 1cm
100
80
60
40
20
0
12
10
8
6
4
2
0
kPa
60
61
62
HEWLETT-PACKARD MEDICAL PRODUCTS
M1911A
HEWLETT-PACKARD MEDICAL PRODUCTS

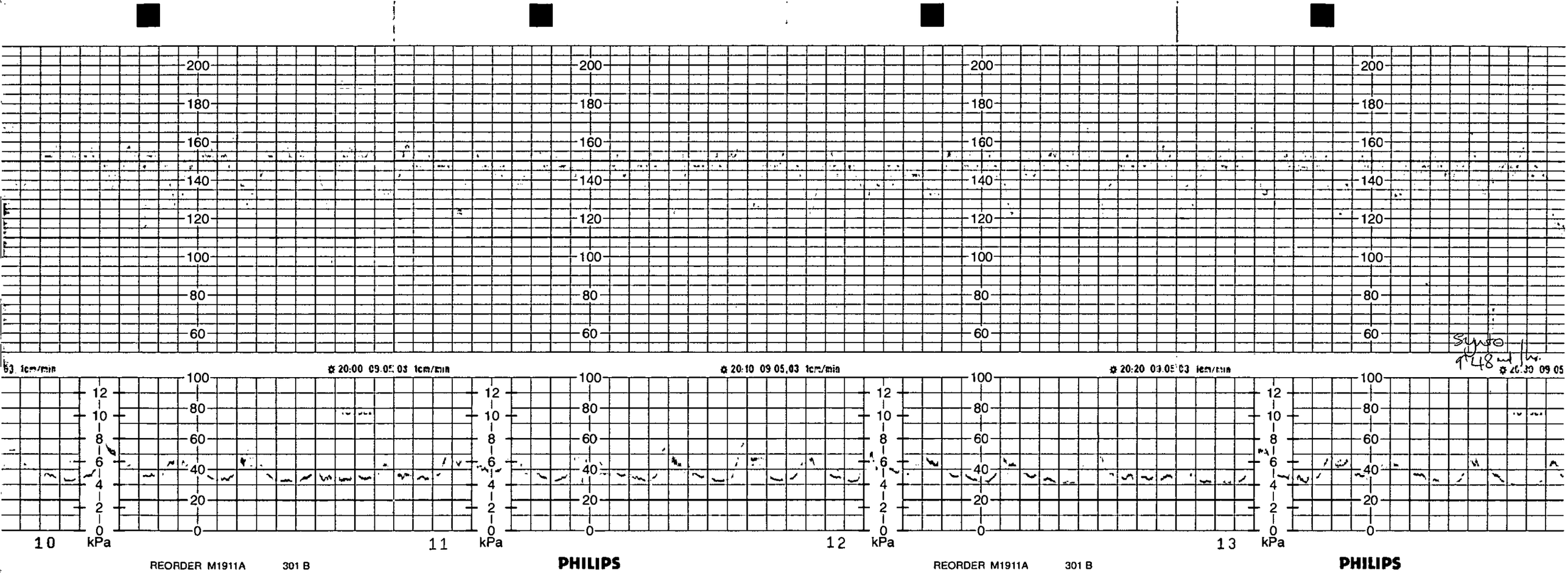

200
180
160
140
120
100
80
60
17:10 18.10.04 1cm/min
17:20 18.10.04 1cm/min
100
80
60
40
20
0
12
10
8
6
4
2
0
63
kPa
64
kPa
65
kPa
M1911A
HEWLETT-PACKARD MEDICAL PRODUCTS
M1911A

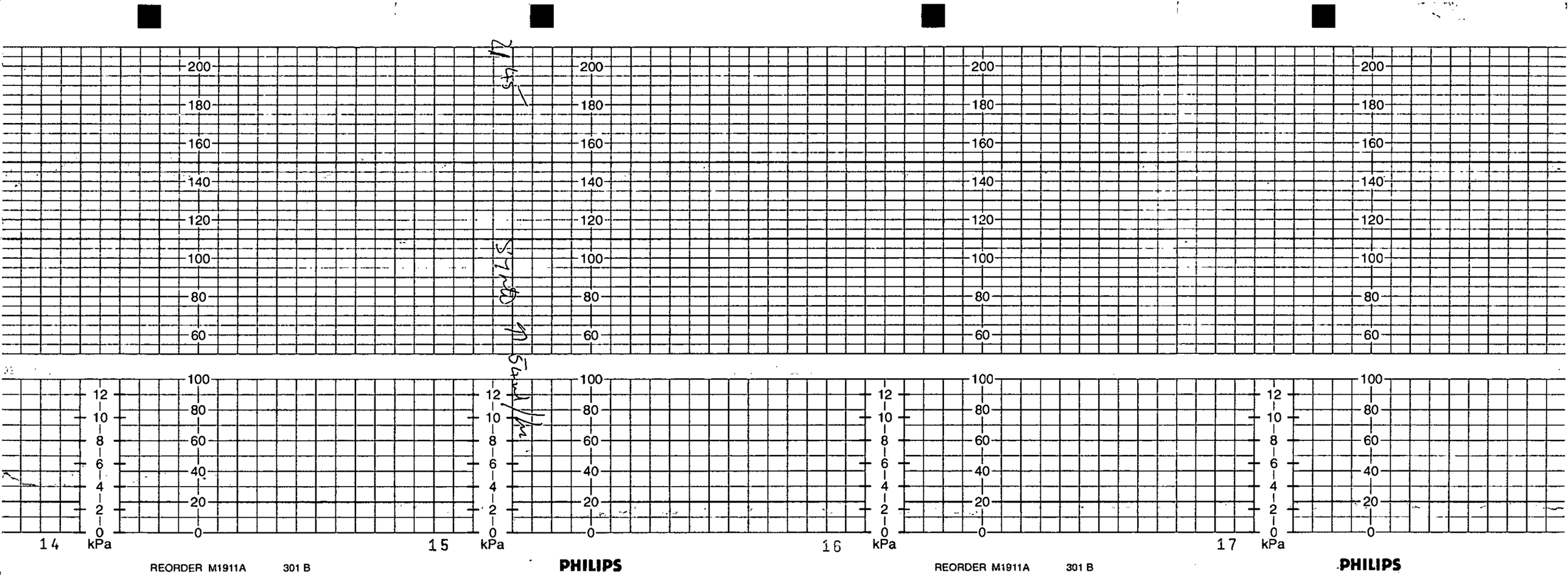

SJ 325165E
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE
EH48 1BX
F 23/05/82
200
180
160
140
120
100
80
60
40
20
0
12
10
8
6
4
2
kPa
66
67
68
HEWLETT-PACKARD MEDICAL PRODUCTS
M1911A
HEWLETT-PACKARD MEDICAL PRODUCTS

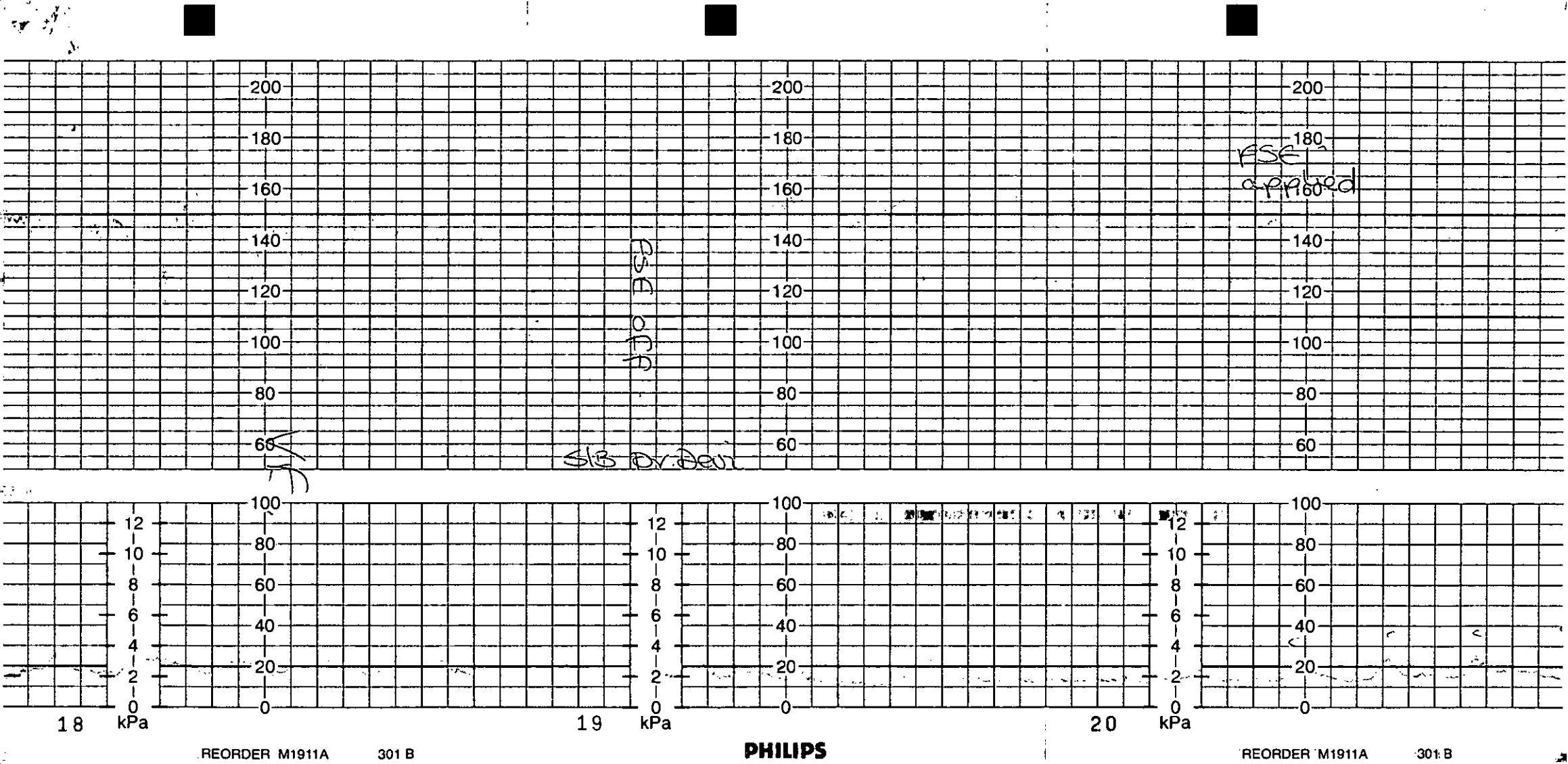

200
180
160
140
120
100
80
60
100
80
60
40
20
0
12
10
8
6
4
2
0
kPa
69
70
71
M1911A
HEWLETT-PACKARD MEDICAL PRODUCTS
M1911A

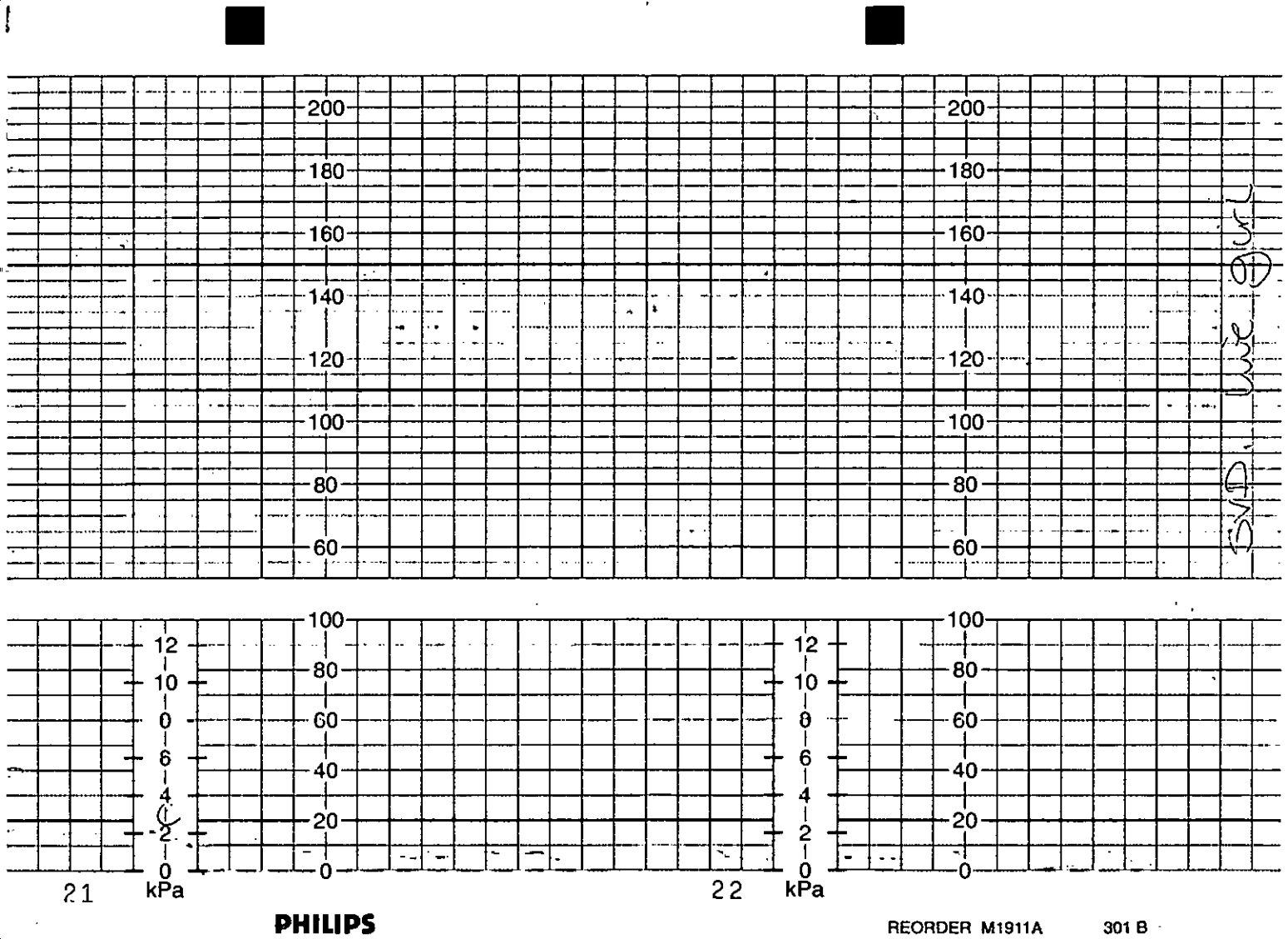

SJ 325165E
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE
EH48 1BX
F 23/05/82
200
180
160
140
120
100
80
60
100
80
60
40
20
0
12
10
8
6
4
2
0
2 kPa
3 kPa
4 kPa
5 kPa
REORDER M1911A 301 B
PHILIPS
REORDER M1911A 301 B
PHILIPS

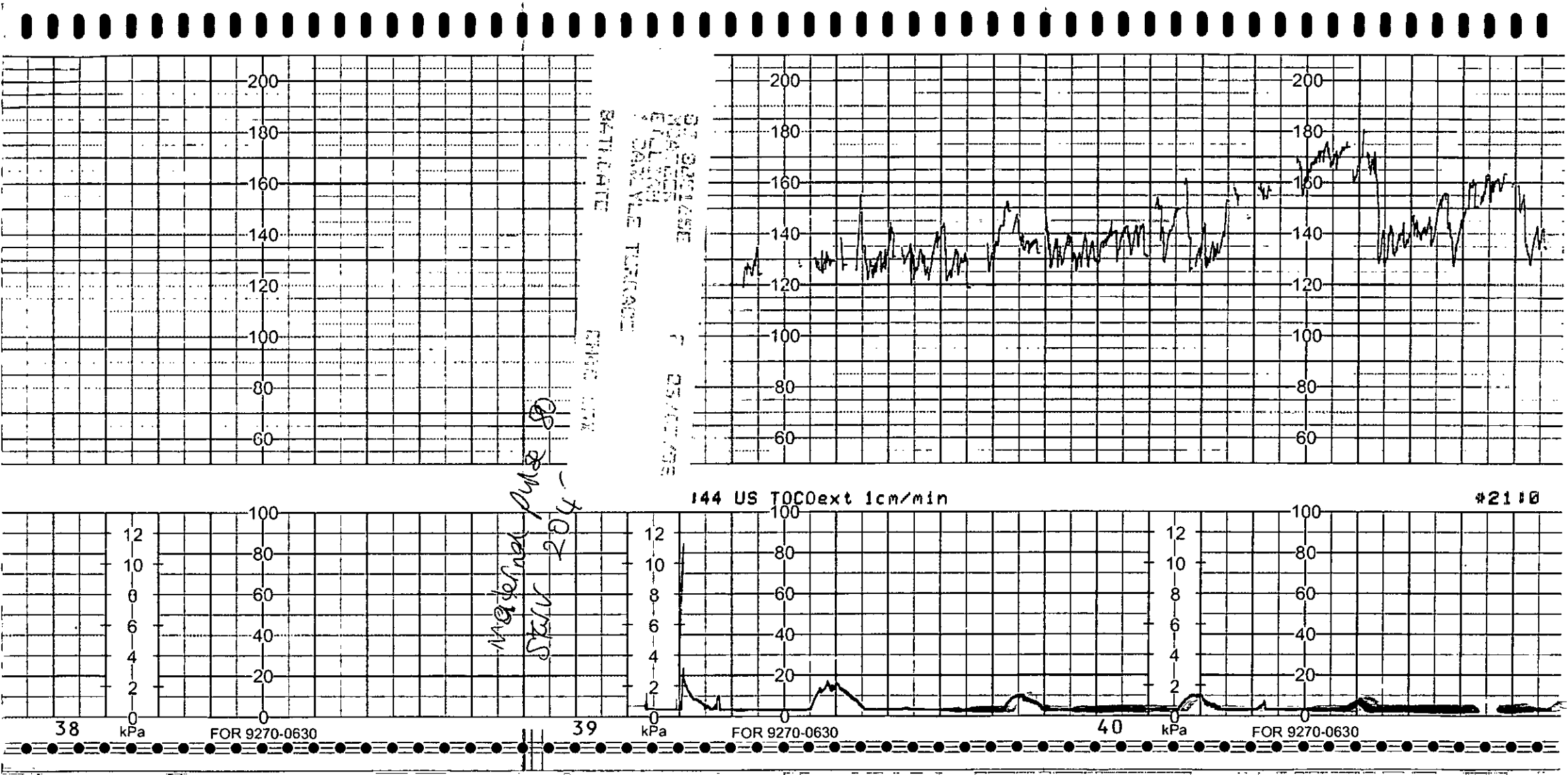

200
180
160
140
120
100
80
60
12
10
8
6
4
2
0
40
20
6 kPa
7 kPa
8 kPa
9 kPa
REORDER M1911A 301 B
PHILIPS
REORDER M1911A 301 B
PHILIPS

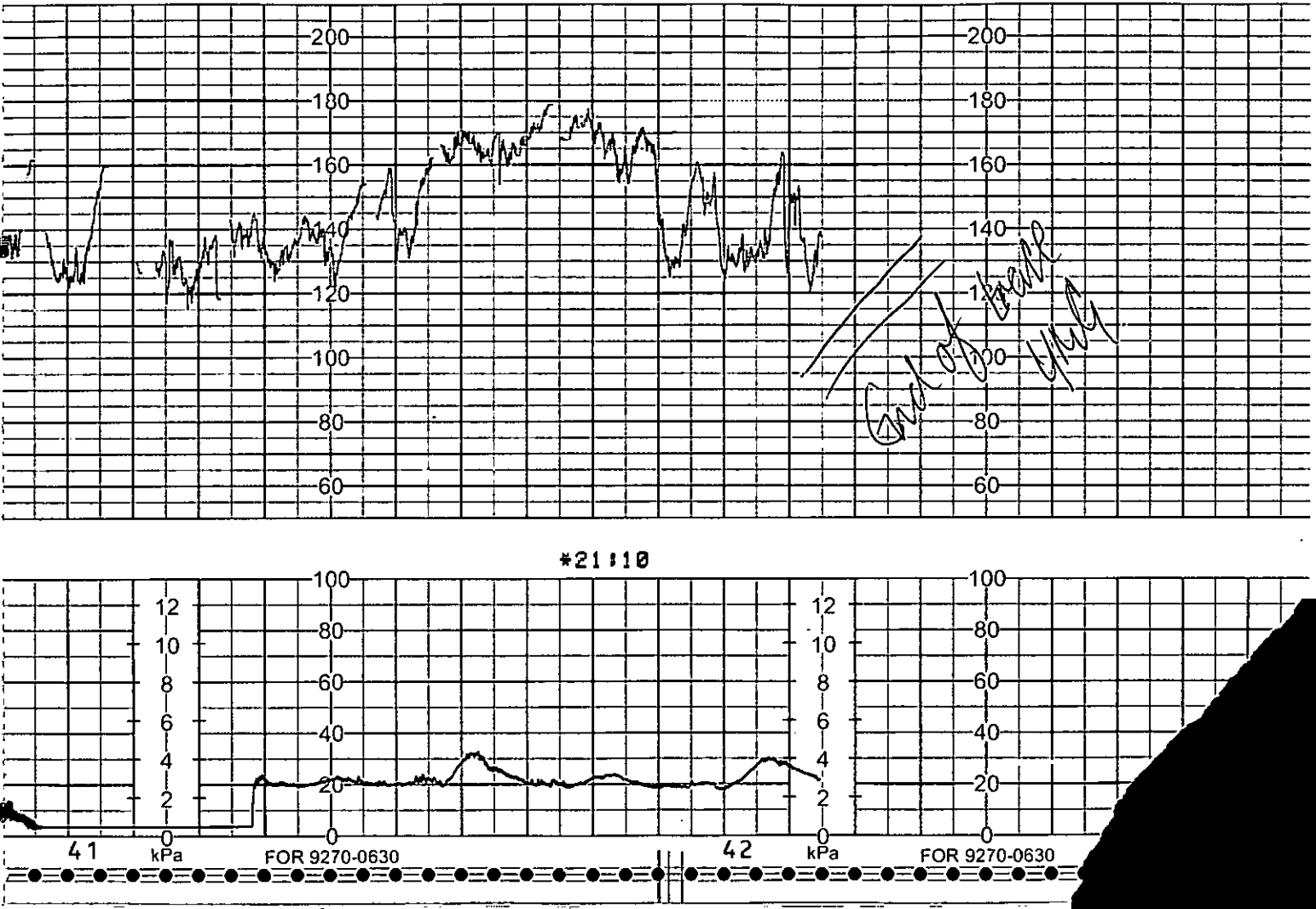

200
180
160
140
120
100
80
60
Systo
148 mm Hg
20:00 09.05.03 1cm/min
20:10 09 05,03 1cm/min
20:20 09.05.03 1cm/min
100
80
60
40
20
0
12
10
8
6
4
2
0
kPa
10
11
12
13
REORDER M1911A 301 B
PHILIPS
REORDER M1911A 301 B
PHILIPS

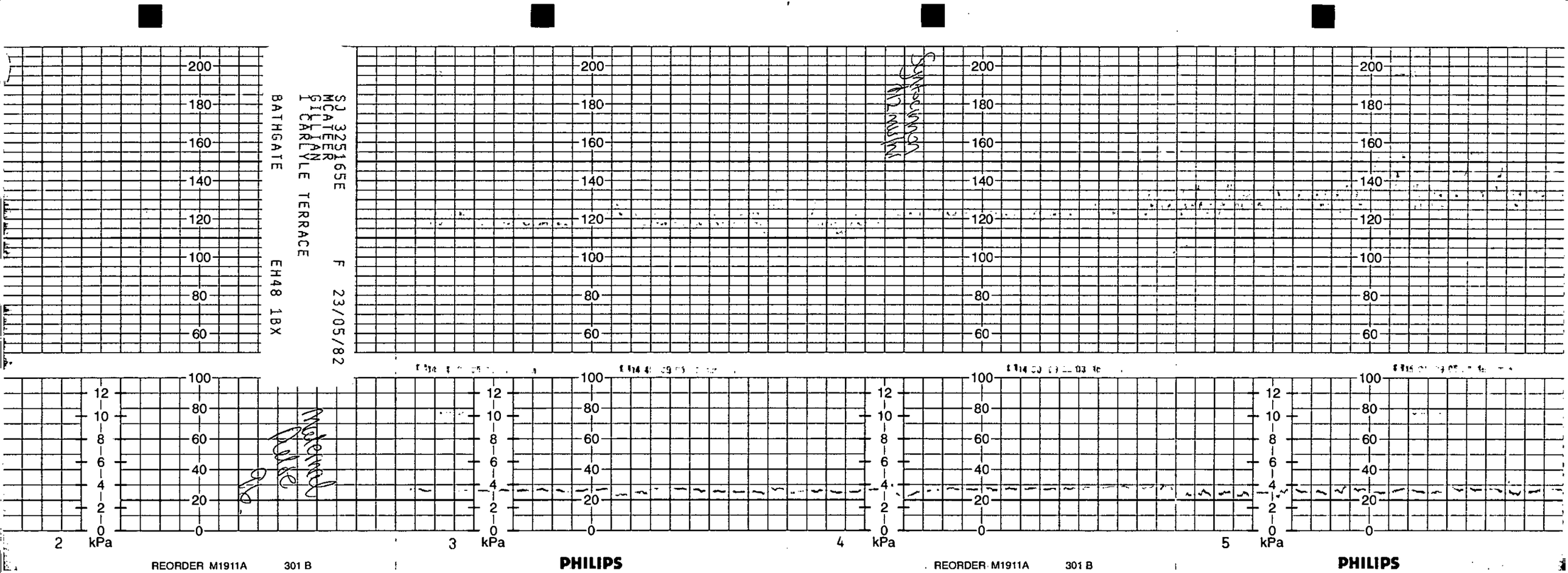

200
180
160
140
120
100
80
60
100
80
60
40
20
0
12
10
8
6
4
2
0
14 kPa
15 kPa
16 kPa
17 kPa
REORDER M1911A 301 B
PHILIPS
REORDER M1911A 301 B
PHILIPS

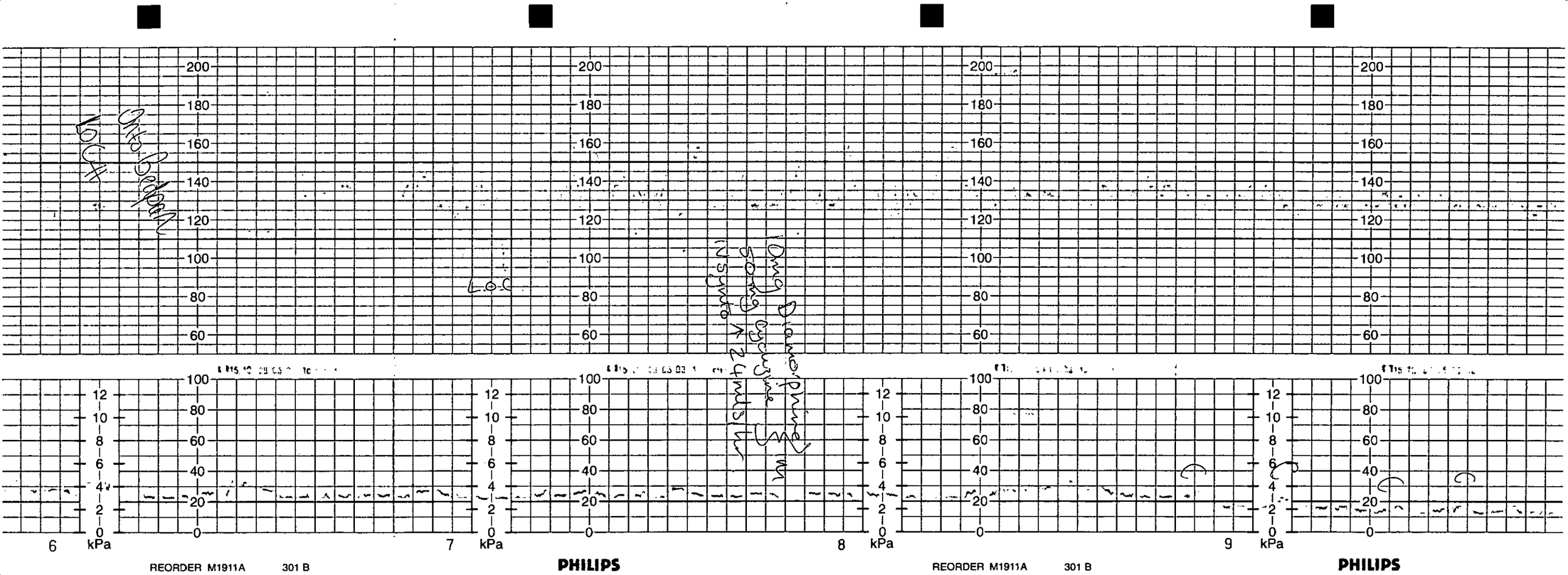

200
180
160
140
120
100
80
60
100
80
60
40
20
0
12
10
8
6
4
2
0
18 kPa
19 kPa
20 kPa
PSE 0.25
S13 Dr Devi
FSE
applied
REORDER M1911A 301 B
PHILIPS
REORDER M1911A 301 B

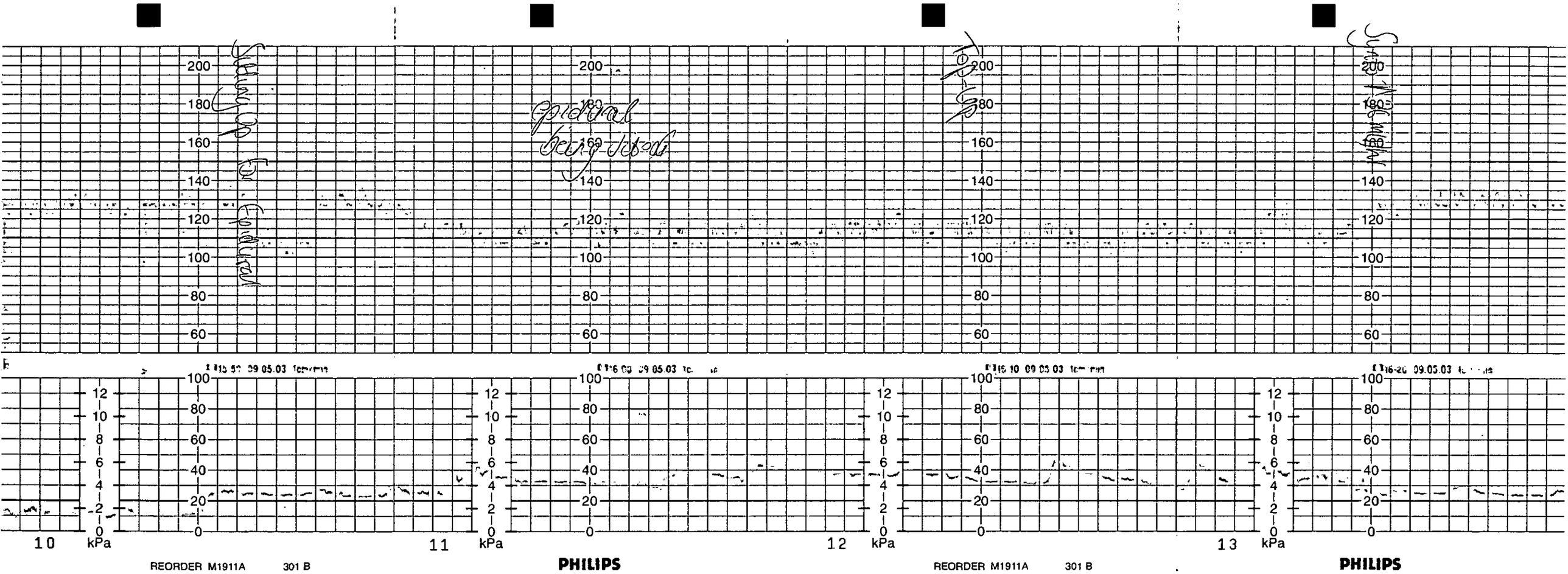

200
180
160
140
120
100
80
60
100
80
60
40
20
0
12
10
8
6
4
2
0
kPa
21
22
PHILIPS
REORDER M1911A
301 B

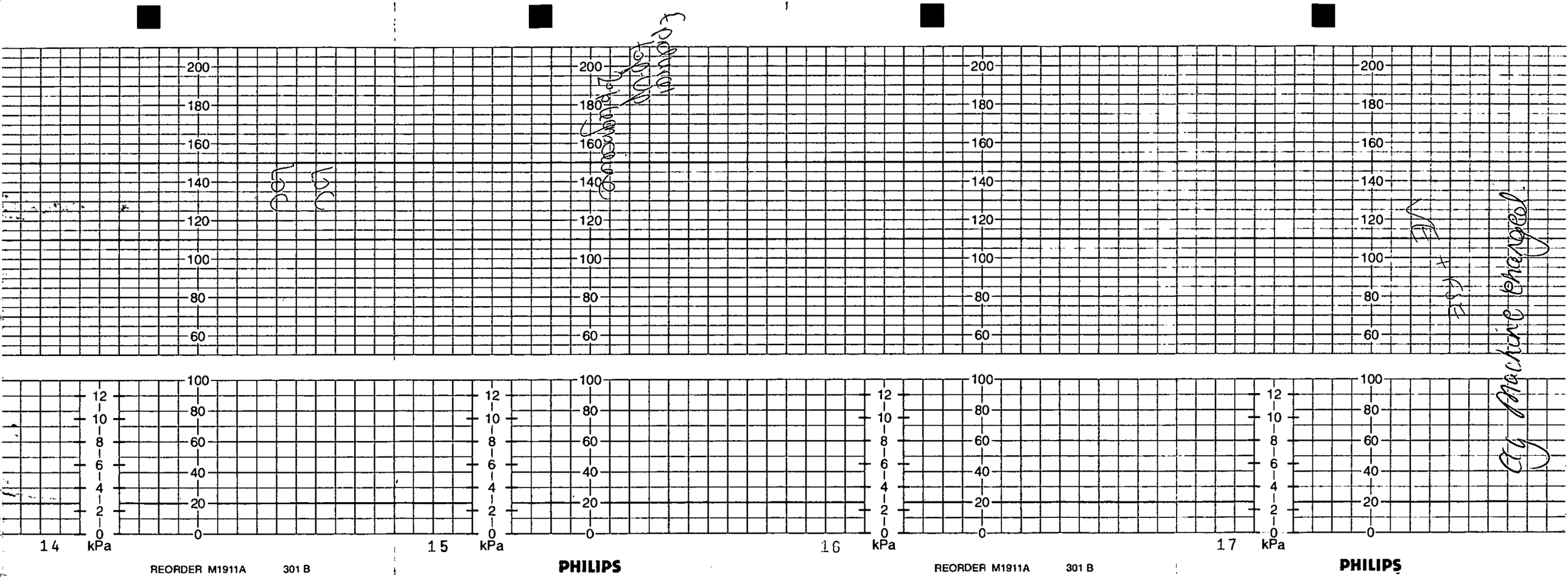

144 US TOCOext 1cm/min
#2110
38
39
40
kPa
FOR 9270-0630

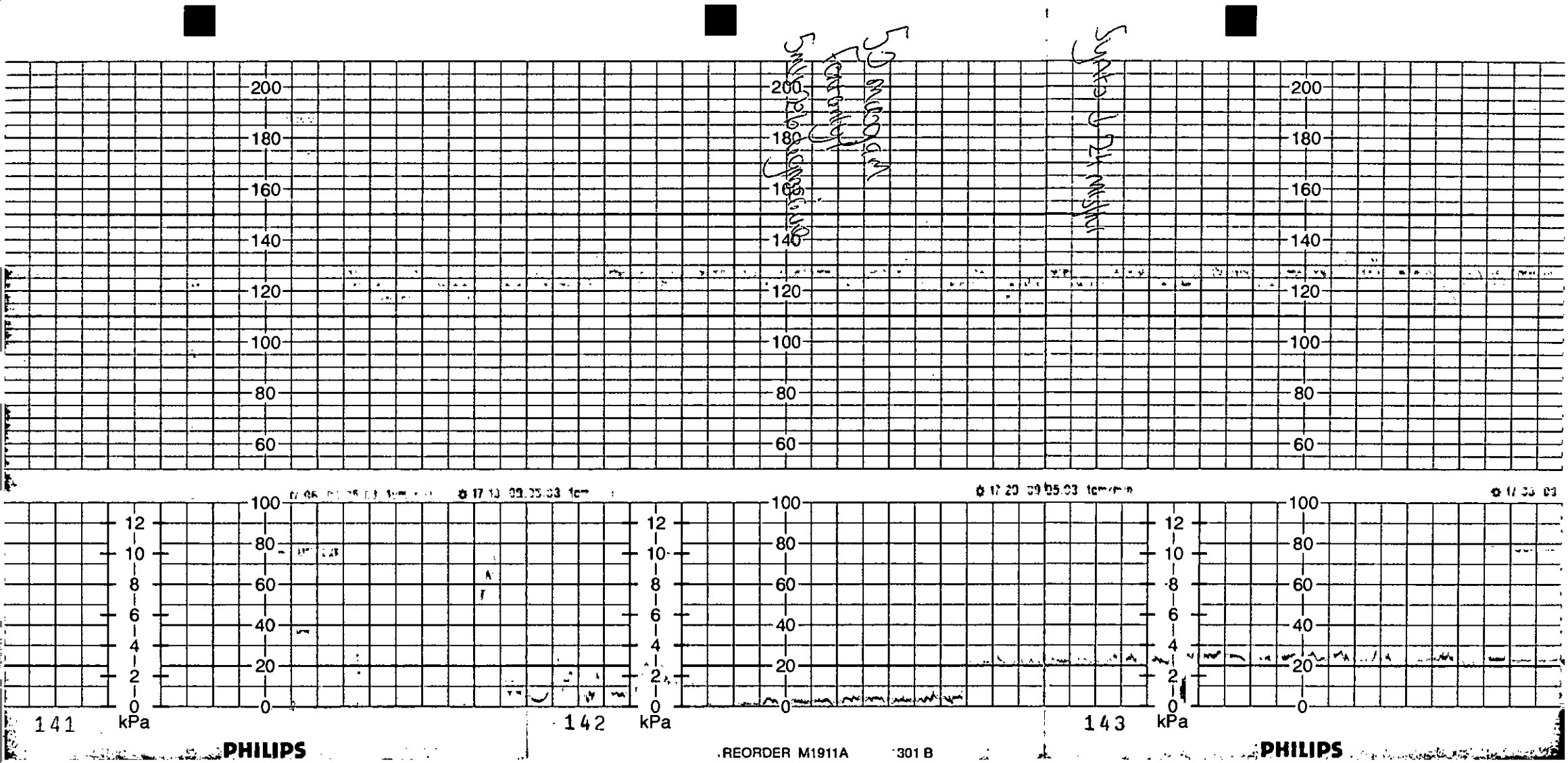

200
180
160
140
120
100
80
60
End of test
*21:10
12
10
8
6
4
2
0
41
kPa
FOR 9270-0630
42
kPa
FOR 9270-0630

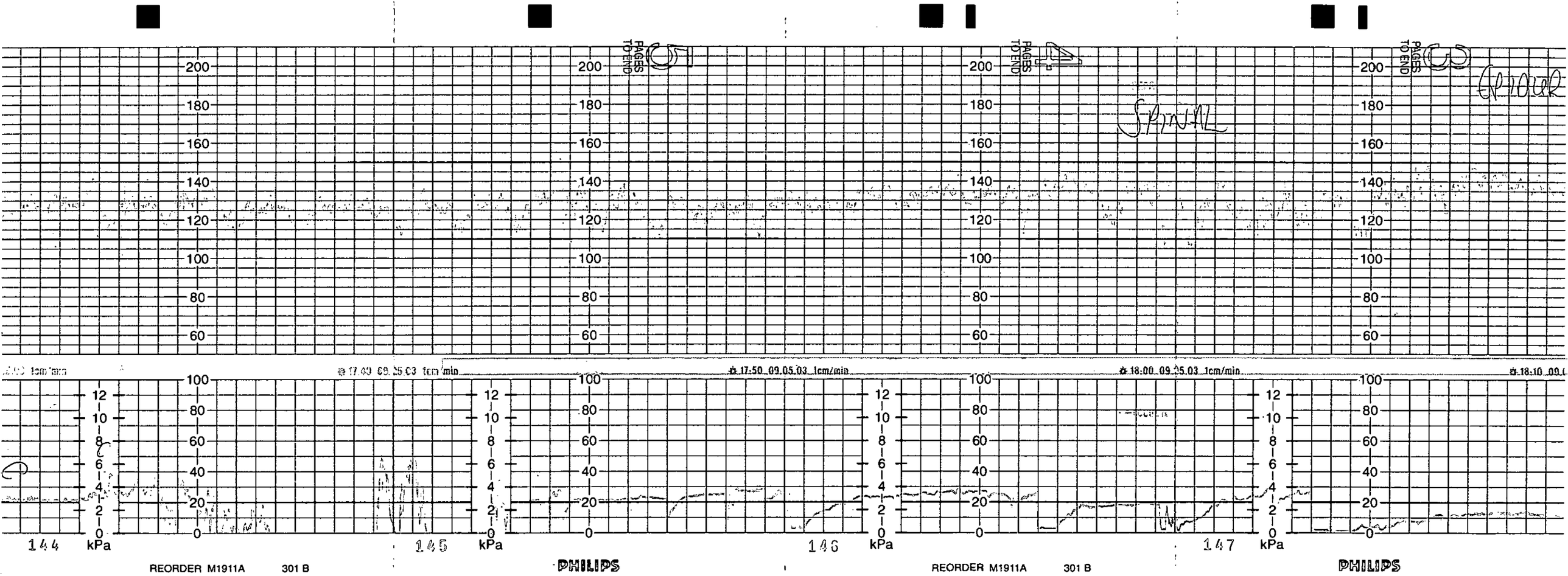

SJ 325165E
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE EH48 1BX
F 23/05/82
200
180
160
140
120
100
80
60
100
80
60
40
20
0
12
10
8
6
4
2
0
2 kPa
3 kPa
4 kPa
5 kPa
REORDER M1911A 301 B
PHILIPS

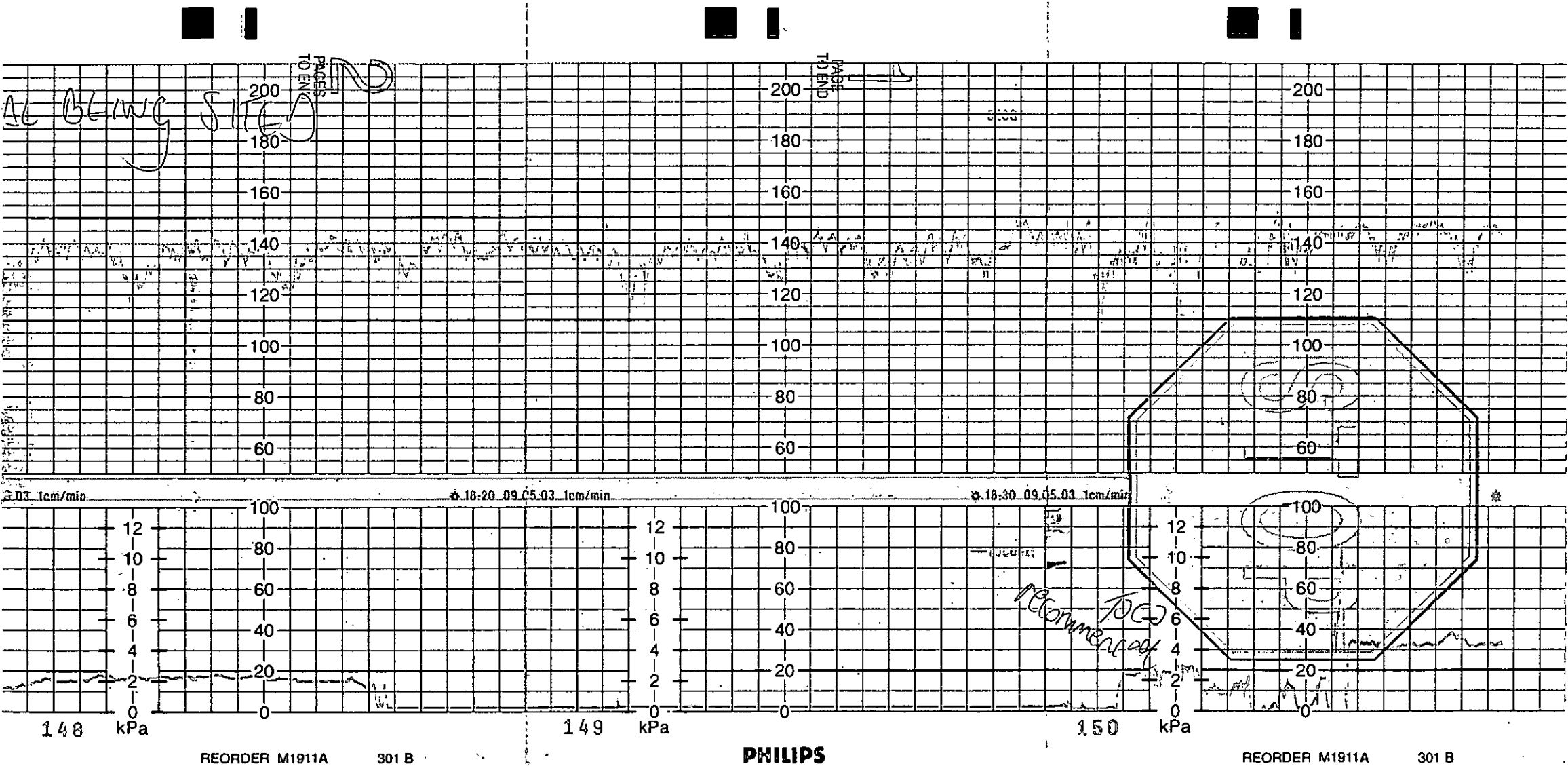

200
180
160
140
120
100
80
60
100
80
60
40
20
0
12
10
8
6
4
2
0
6 kPa
7 kPa
8 kPa
9 kPa
REORDER M1911A 301 B
PHILIPS
REORDER M1911A 301 B
PHILIPS

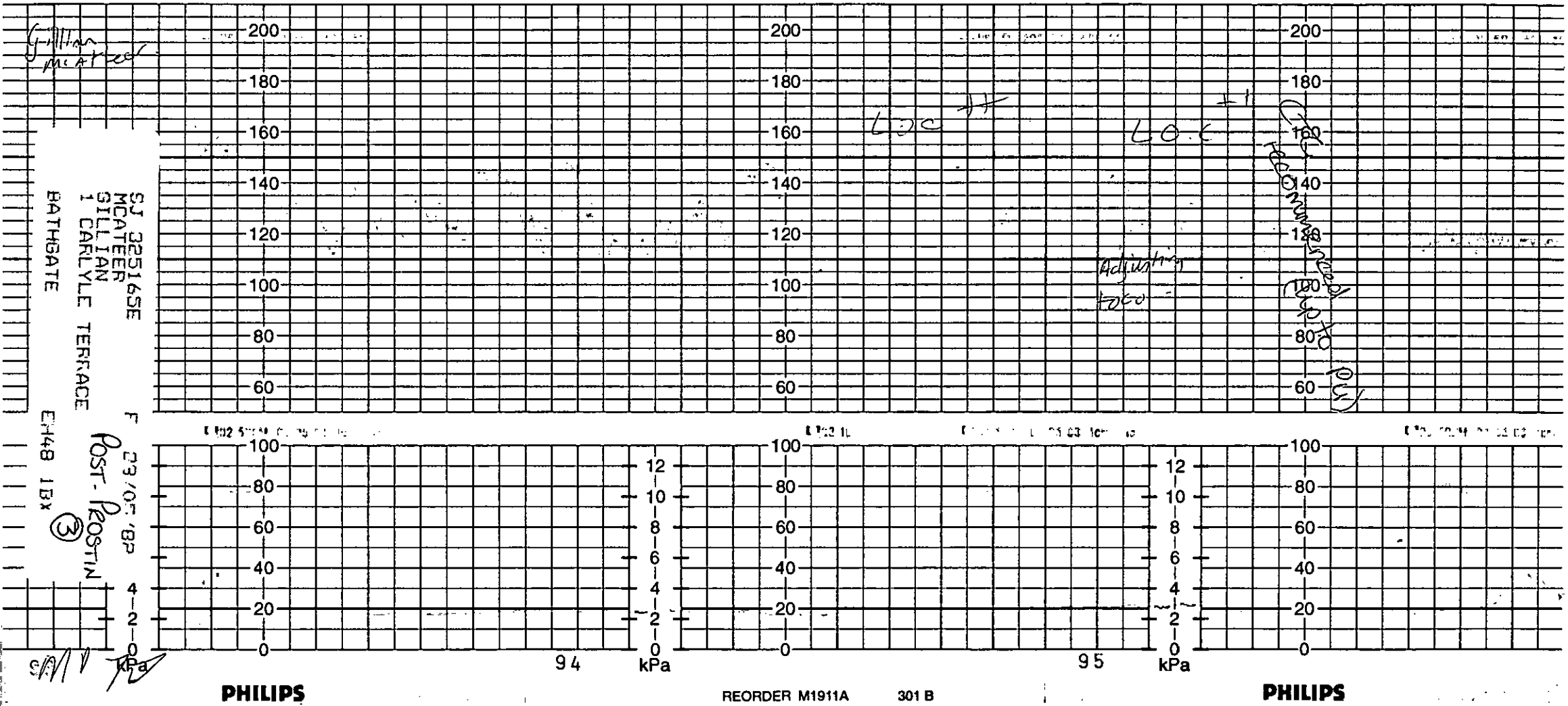

200
180
160
140
120
100
80
60
10
kPa
11
kPa
12
kPa
13
kPa
REORDER M1911A 301 B
PHILIPS
REORDER M1911A 301 B
PHILIPS

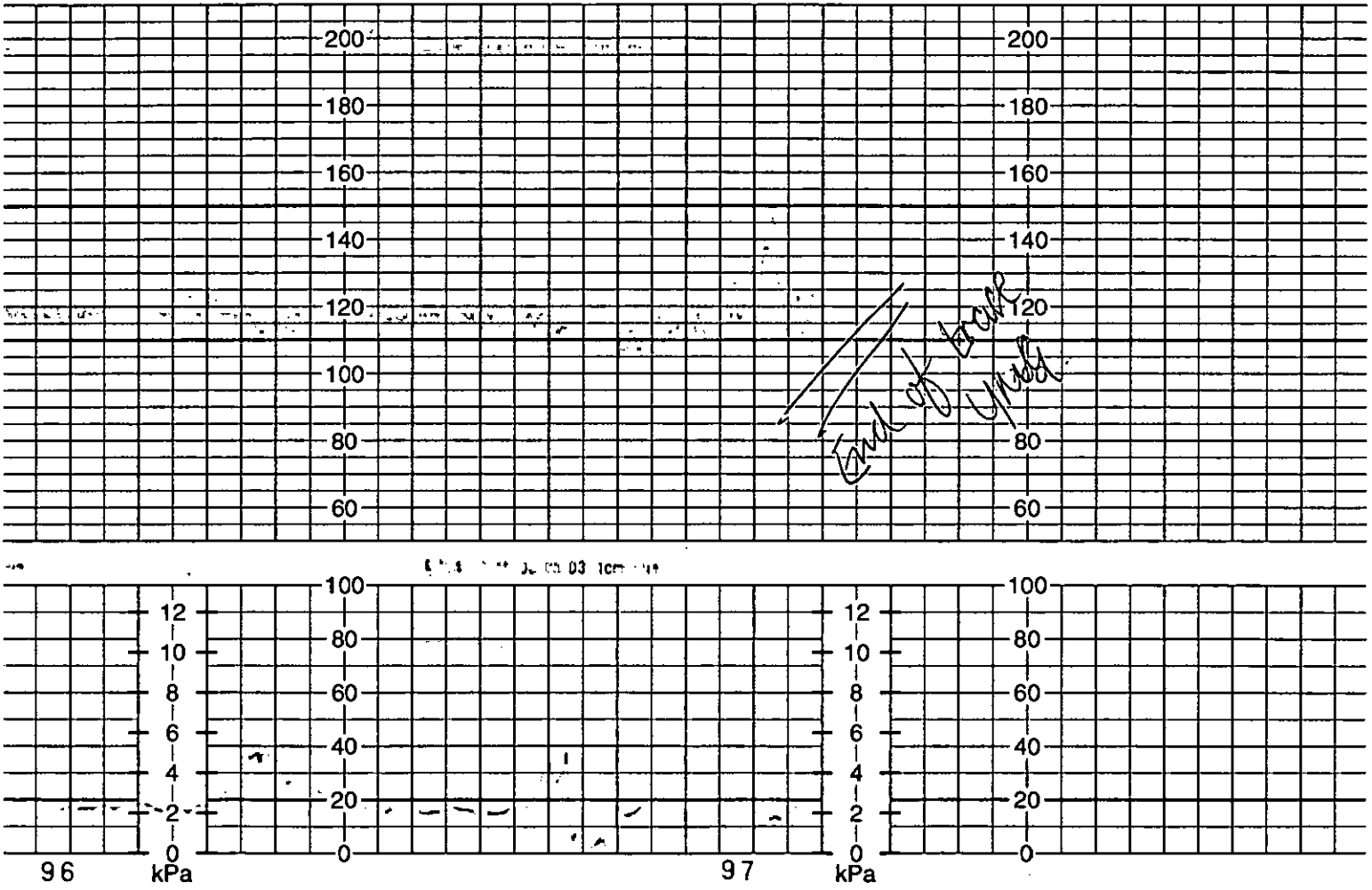

200
180
160
140
120
100
80
60
12
10
8
6
4
2
0
14 kPa
15 kPa
16 kPa
17 kPa
REORDER M1911A 301 B
PHILIPS
REORDER M1911A 301 B
PHILIPS


200
180
160
140
120
100
80
60
12
10
8
6
4
2
0
kPa
141
142
143
PHILIPS
REORDER M1911A
301 B
PHILIPS

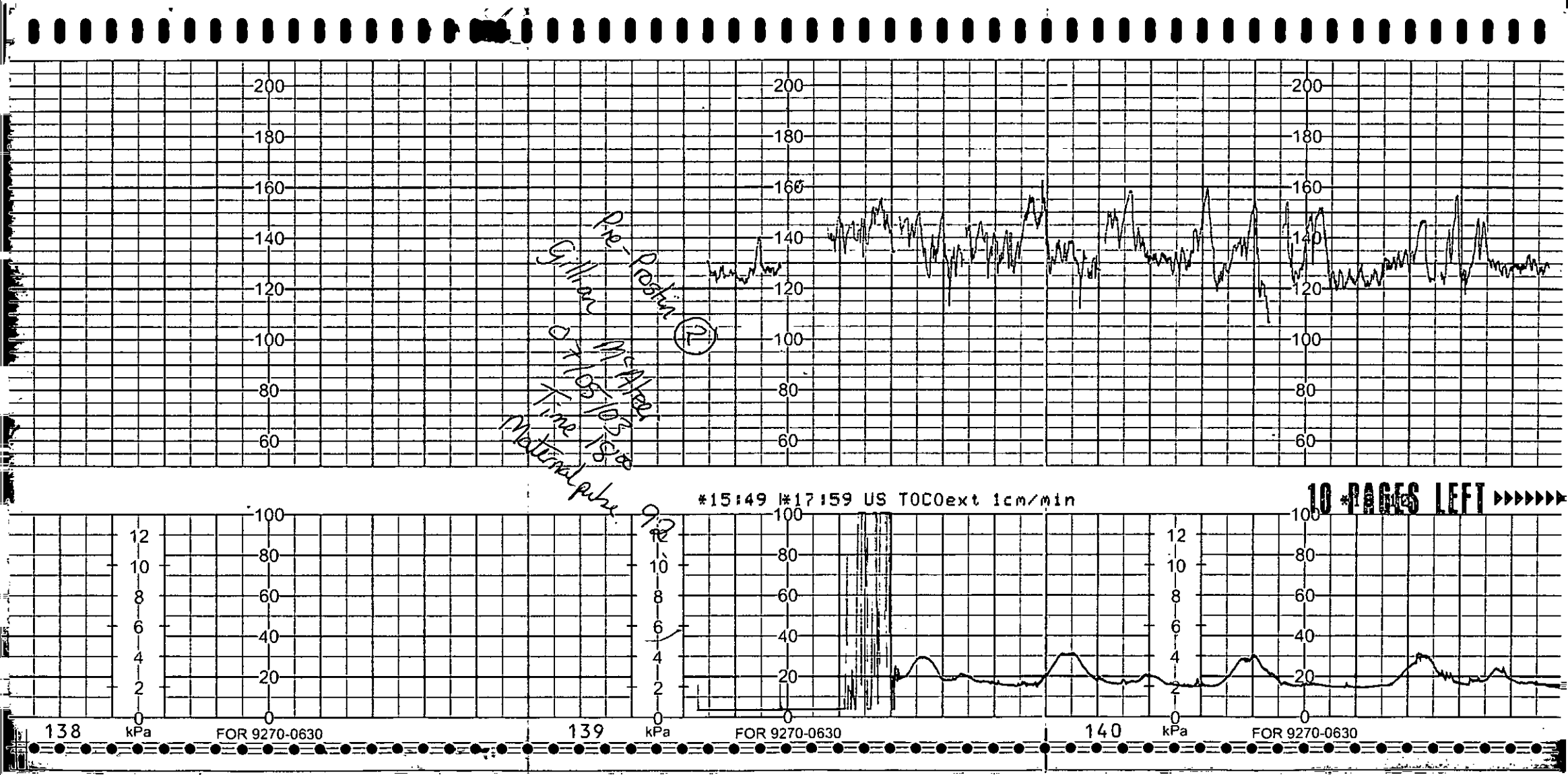

PAGES TO END
SPINAL
EPIDER
144
145
146
147
kPa
REORDER M1911A 301 B
PHILIPS
REORDER M1911A 301 B
PHILIPS

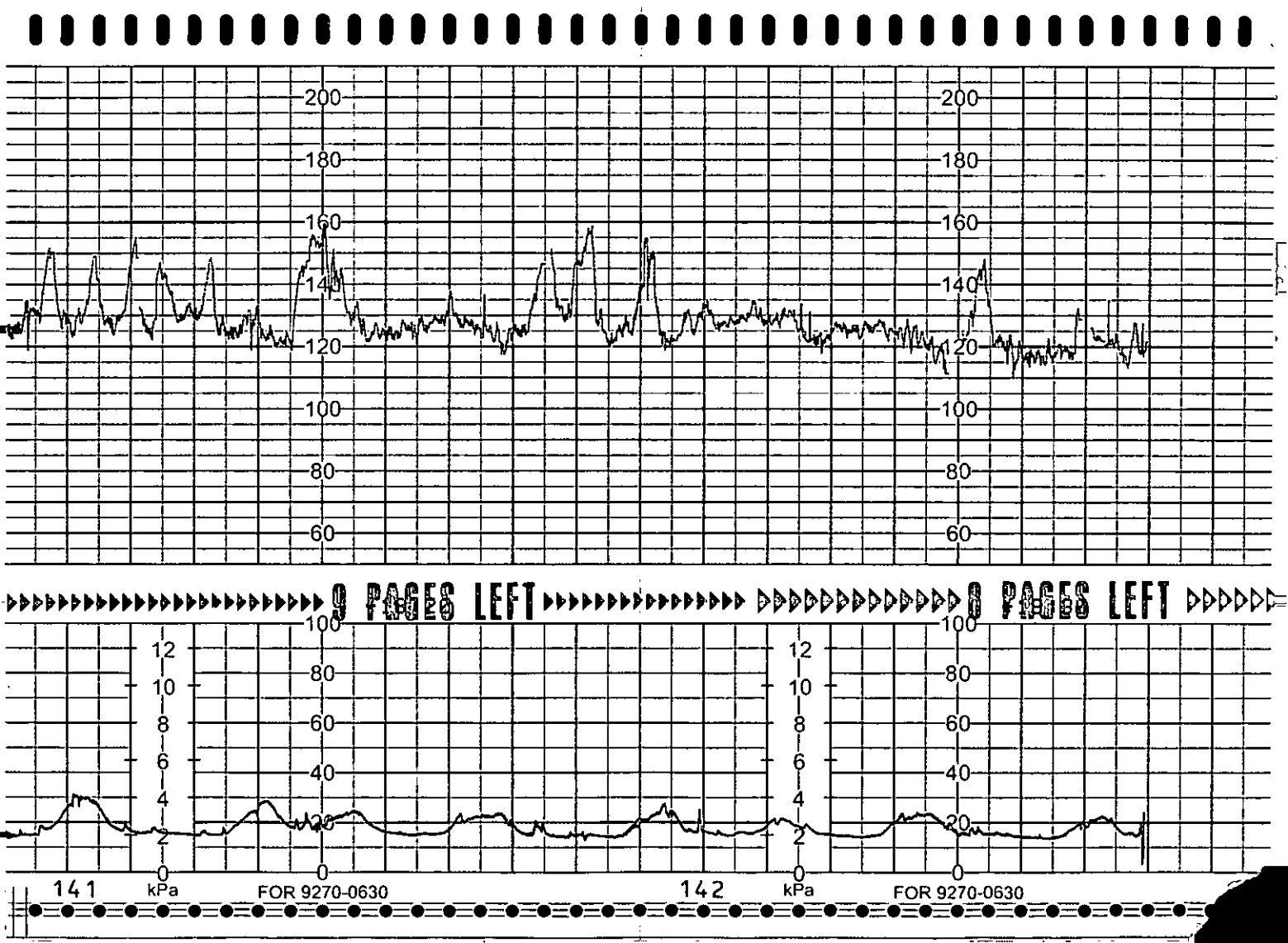

PAGES TO END
PAGES TO END
At bkwg site
18:20 09.05.03 1cm/min
18:30 09.05.03 1cm/min
Recommend
148 kPa
149 kPa
150 kPa
PHILIPS
REORDER M1911A 301 B
REORDER M1911A 301 B

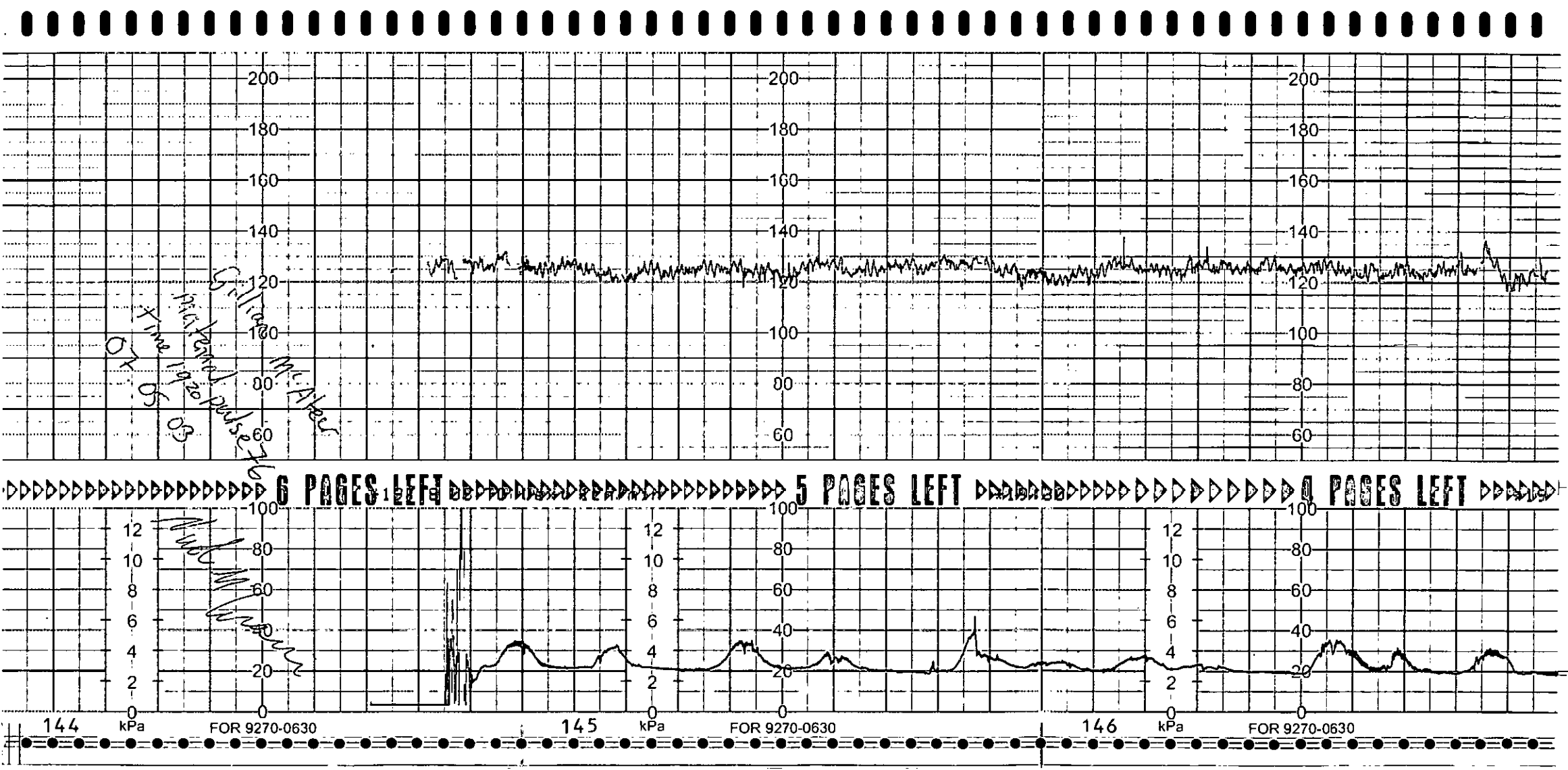

Gillian McAteer
SJ 325165E
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE
EH48 1BX
F
23/05/'8P
POST-PROSTIN
③
LOC
LOC
Adjusting
loco
Recommenced
Prostin
PGE
200
180
160
140
120
100
80
60
40
20
0
12
10
8
6
4
2
kPa
94
95
PHILIPS
REORDER M1911A 301 B
PHILIPS

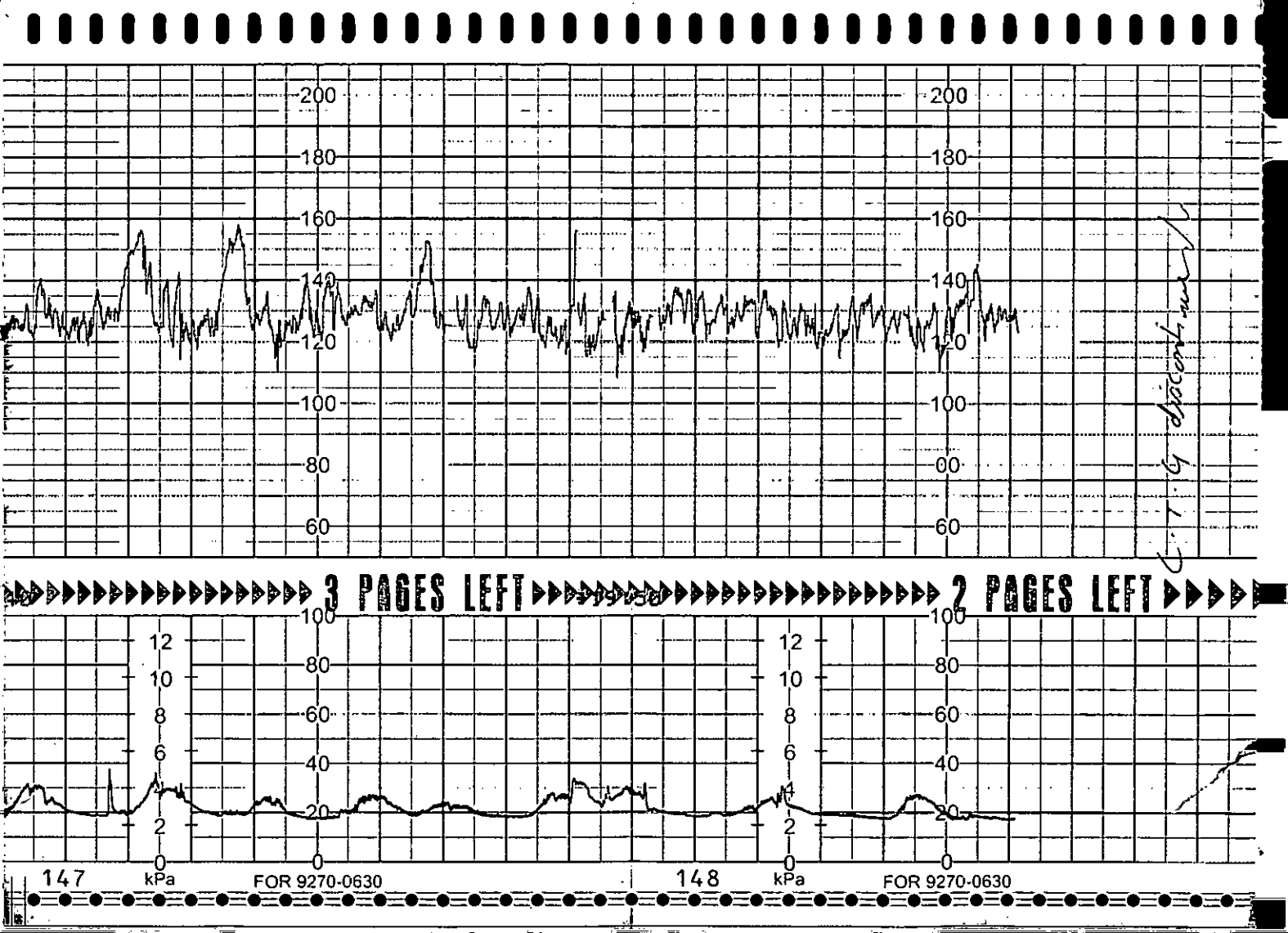

200
180
160
140
120
100
80
60
End of trace
100
80
60
40
20
0
12
10
8
6
4
2
0
96
kPa
97
kPa

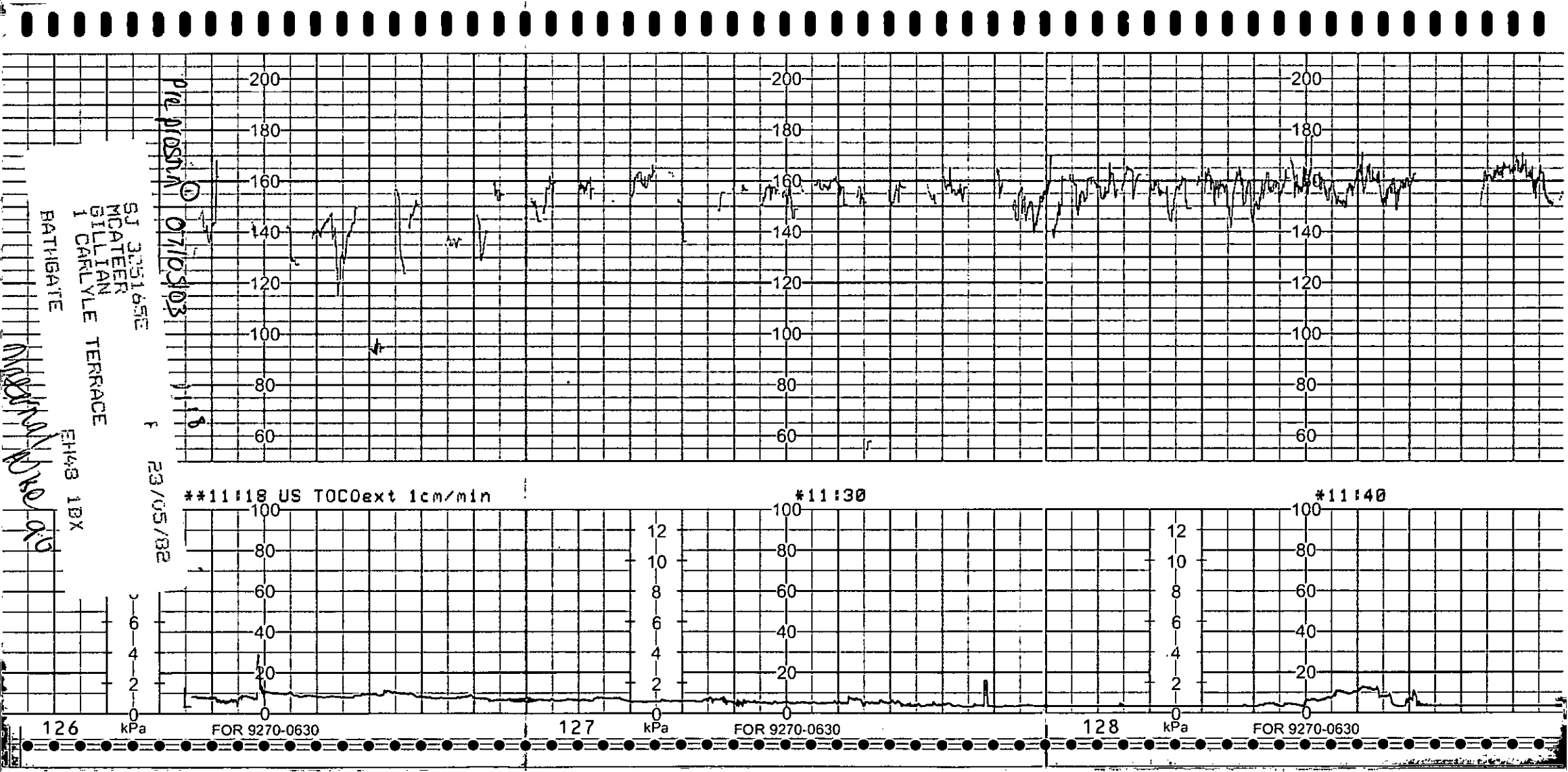
PHILIPS

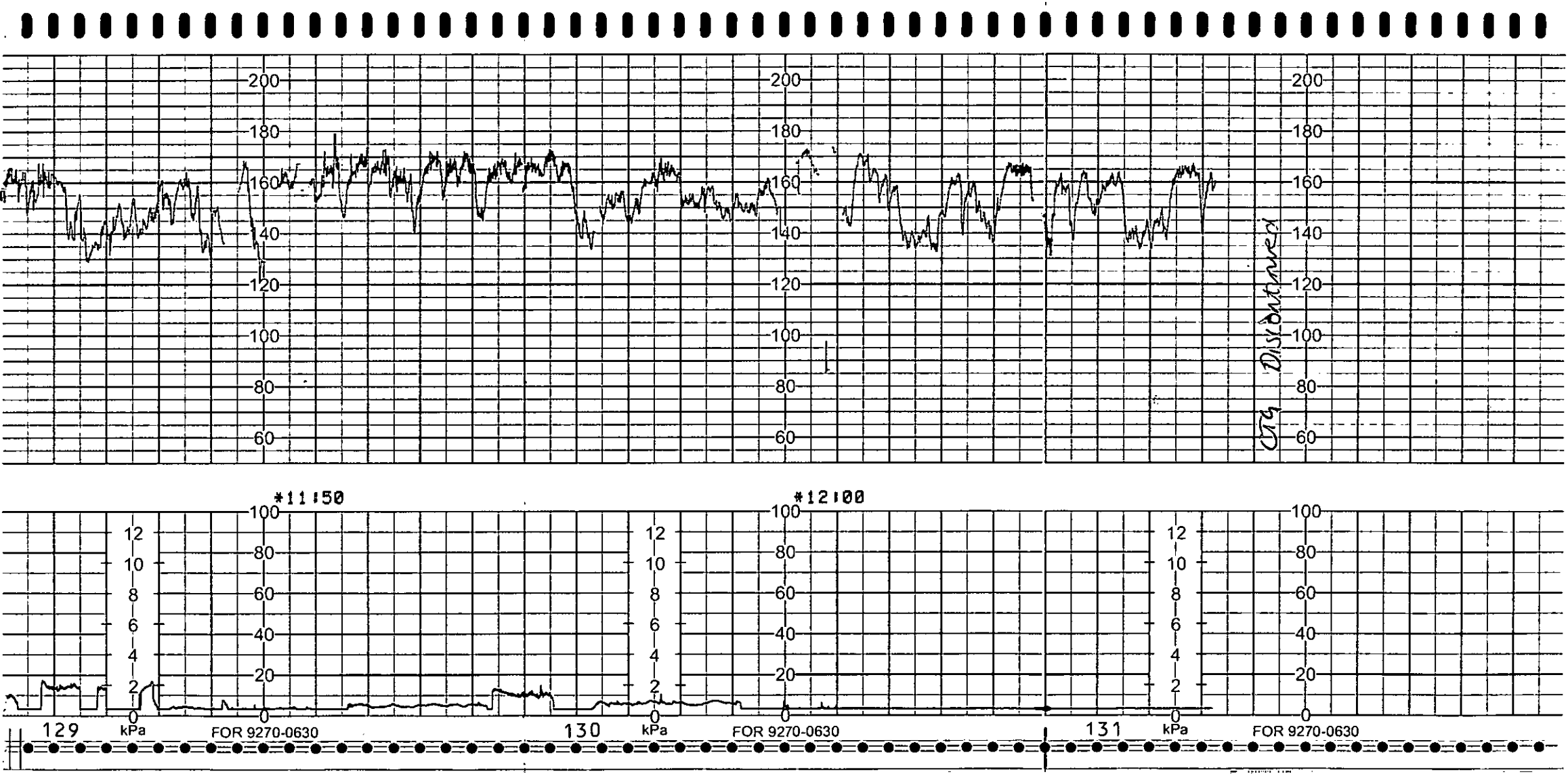

Pre-Postn (2)
Gillian McAteer
d.o.b 05/10/83
Time is 9:18
Natural pulse
*15:49 I*17:59 US TOCOext 1cm/min
10 *PAGES LEFT
138
139
140
kPa
FOR 9270-0630

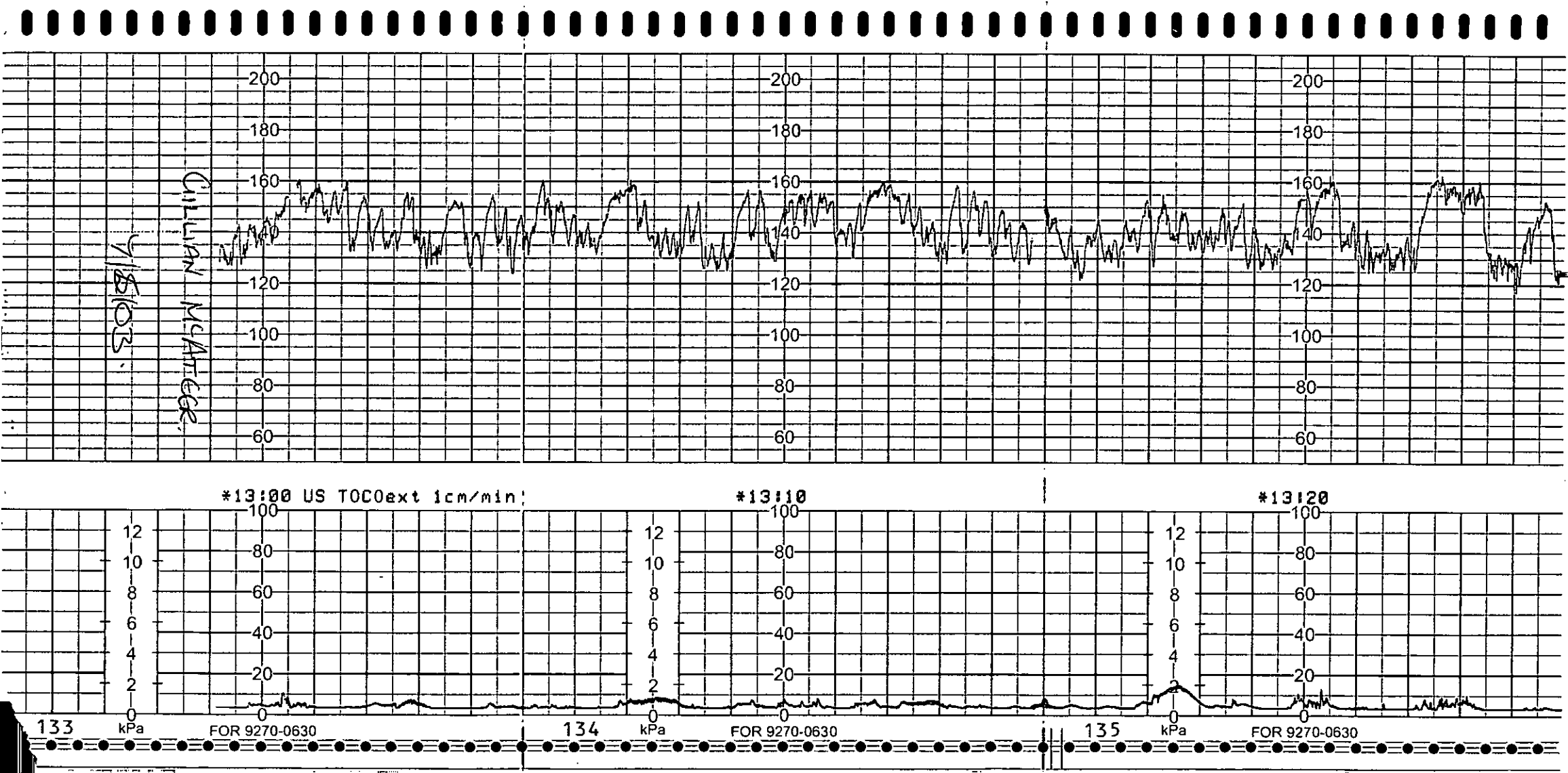

200
180
160
140
120
100
80
60
200
180
160
140
120
100
80
60
8 PAGES LEFT
8 PAGES LEFT
100
80
60
40
20
0
12
10
8
6
4
2
0
141
kPa
FOR 9270-0630
142
kPa
FOR 9270-0630

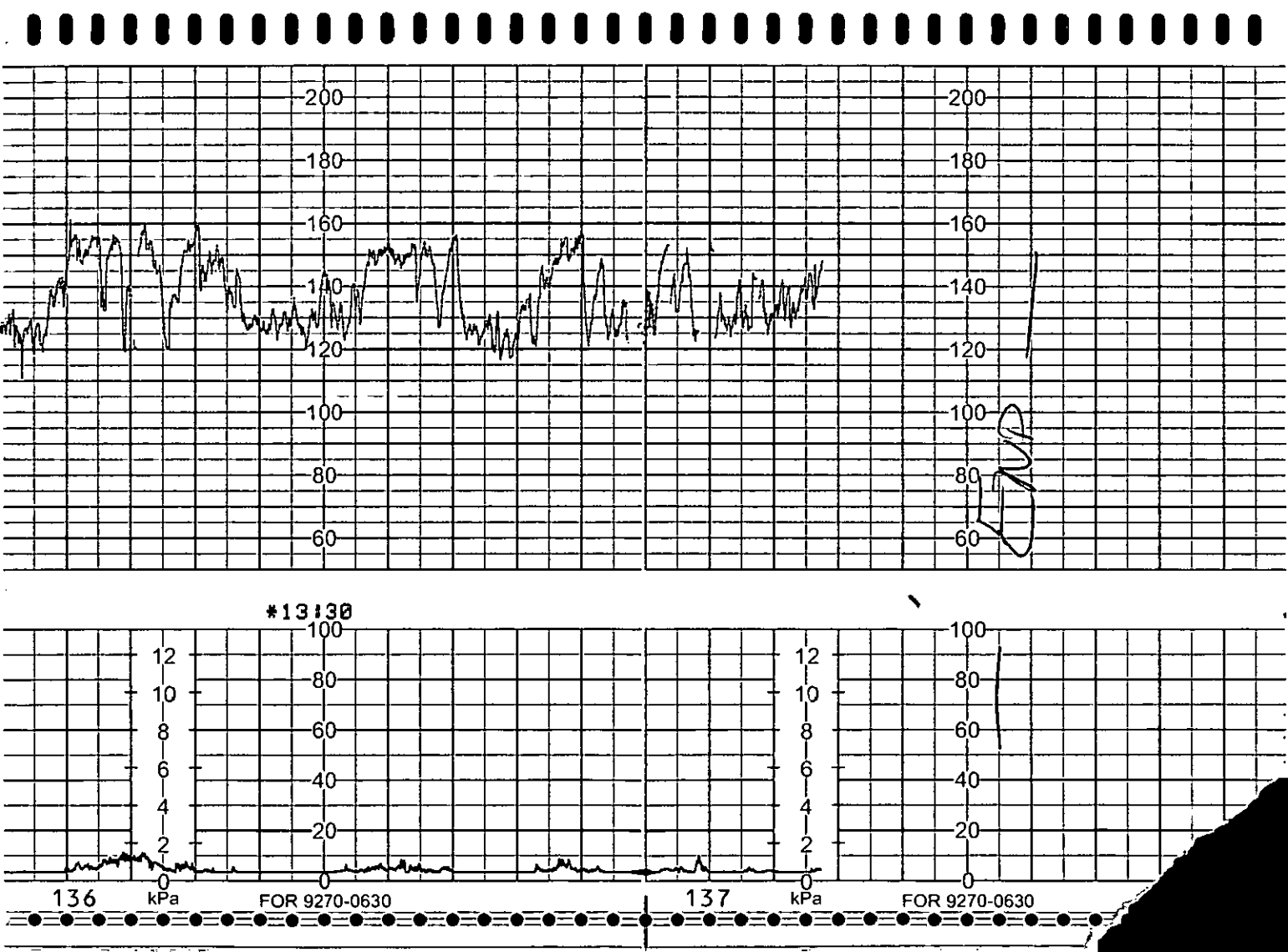

William McAbee
Time 1920 pulse 76
07 05 03
6 PAGES LEFT
5 PAGES LEFT
4 PAGES LEFT
144
145
146
kPa
FOR 9270-0630


200
180
160
140
120
100
80
60
200
180
160
140
120
100
00
60
3 PAGES LEFT
2 PAGES LEFT
100
80
60
40
20
0
12
10
8
6
4
2
0
147
kPa
FOR 9270-0630
148
kPa
FOR 9270-0630


SJ 3551655E
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE
EH48 1BX
23/05/82
Pre prosh @ 07/05/03
**11:18 US TOCOext 1cm/min
*11:30
*11:40
200
180
160
140
120
100
80
60
40
20
0
12
10
8
6
4
2
kPa
126
127
128
FOR 9270-0630


200
180
160
140
120
100
80
60
Disturbed
*11:50
*12:00
12
10
8
6
4
2
0
100
80
60
40
20
129
130
131
kPa
FOR 9270-0630


200
180
160
140
120
100
80
60
GILLIAN MCATEER
1/8/03
*13:00 US TOCOext 1cm/min
*13:10
*13:20
100
80
60
40
20
0
12
10
8
6
4
2
0
kPa
133
134
135
FOR 9270-0630


200
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136
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FOR 9270-0630
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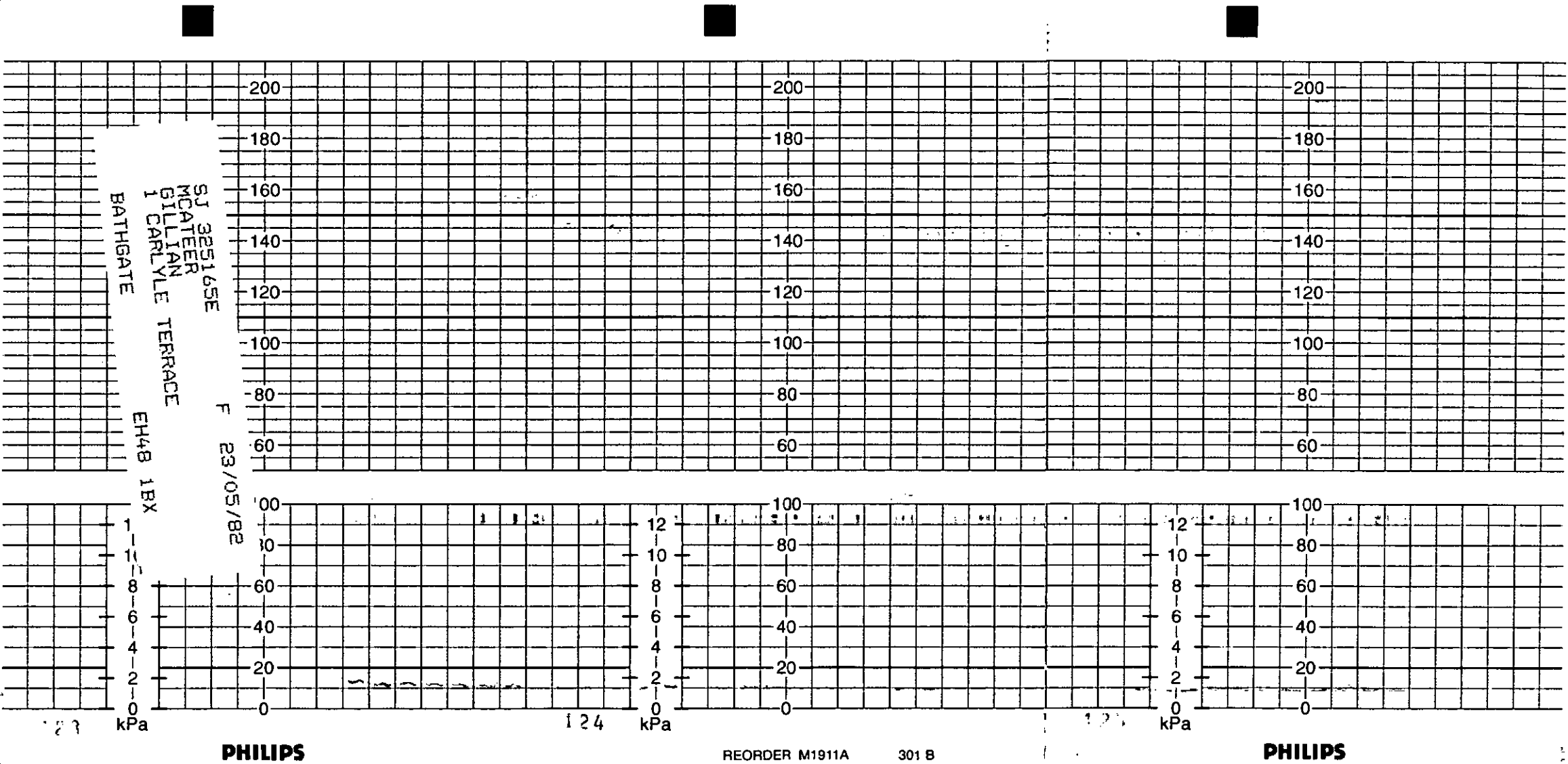
kPa
FOR 9270-0630


SJ 325165E
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE
EH48 1BX
F 23/05/82
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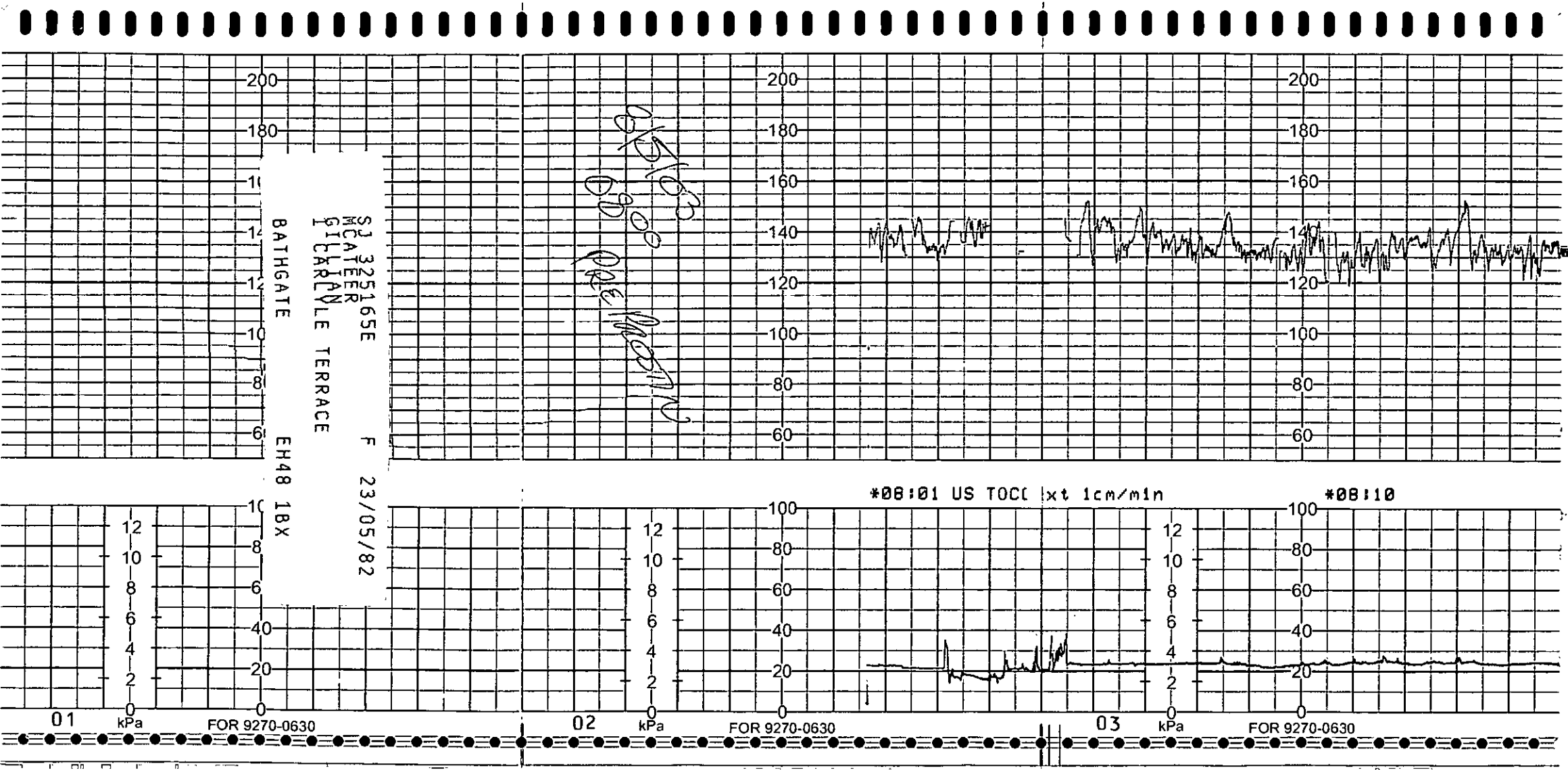
PHILIPS
REORDER M1911A 301 B


SJ 325165E
MCATEER
GILLIAN
CARLYLE TERRACE
BATHGATE
EH48 1BX
F
23/05/82
*08:01 US TOCO 1cm/min
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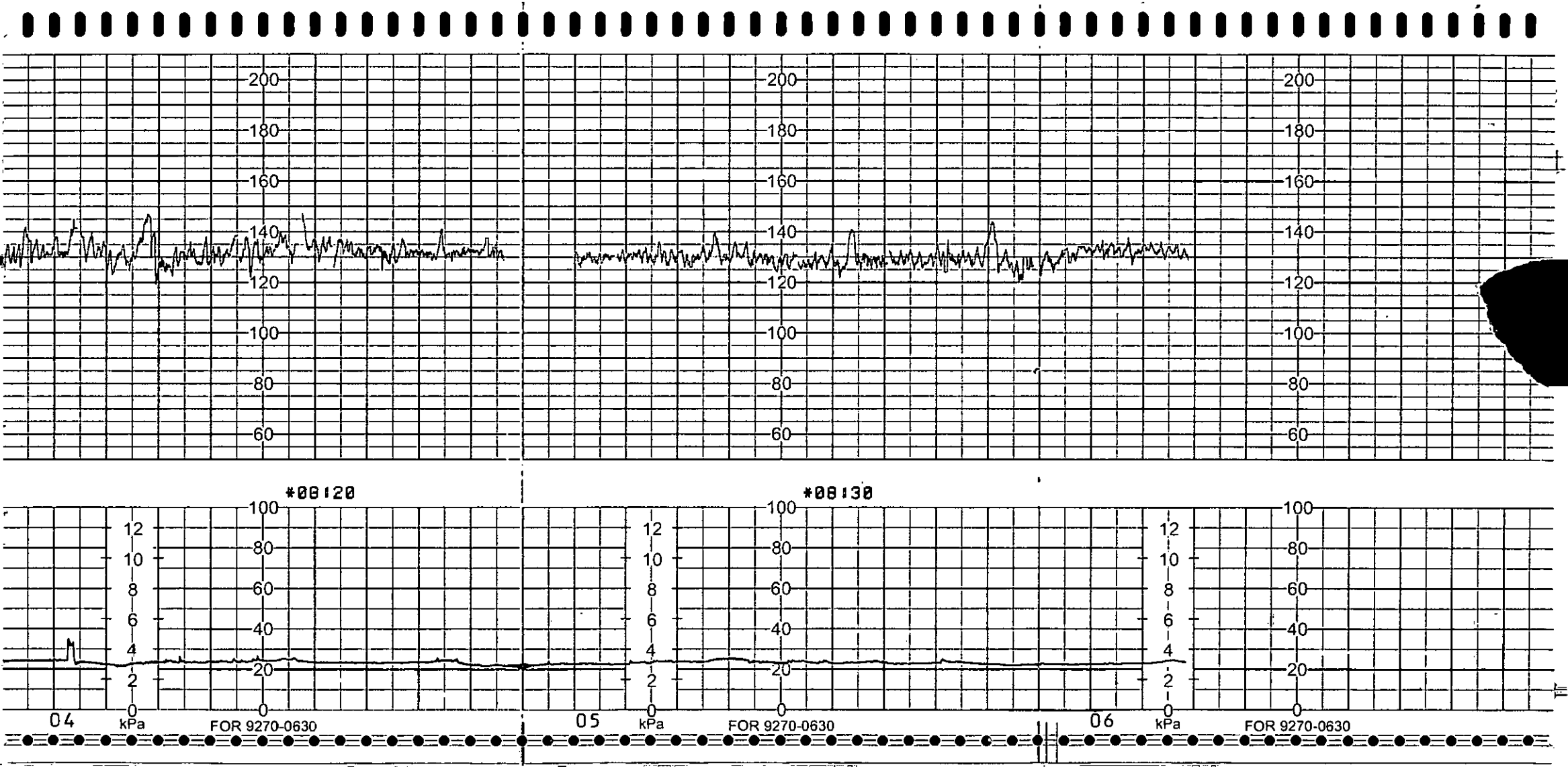
01
kPa
FOR 9270-0630
02
kPa
FOR 9270-0630
03
kPa
FOR 9270-0630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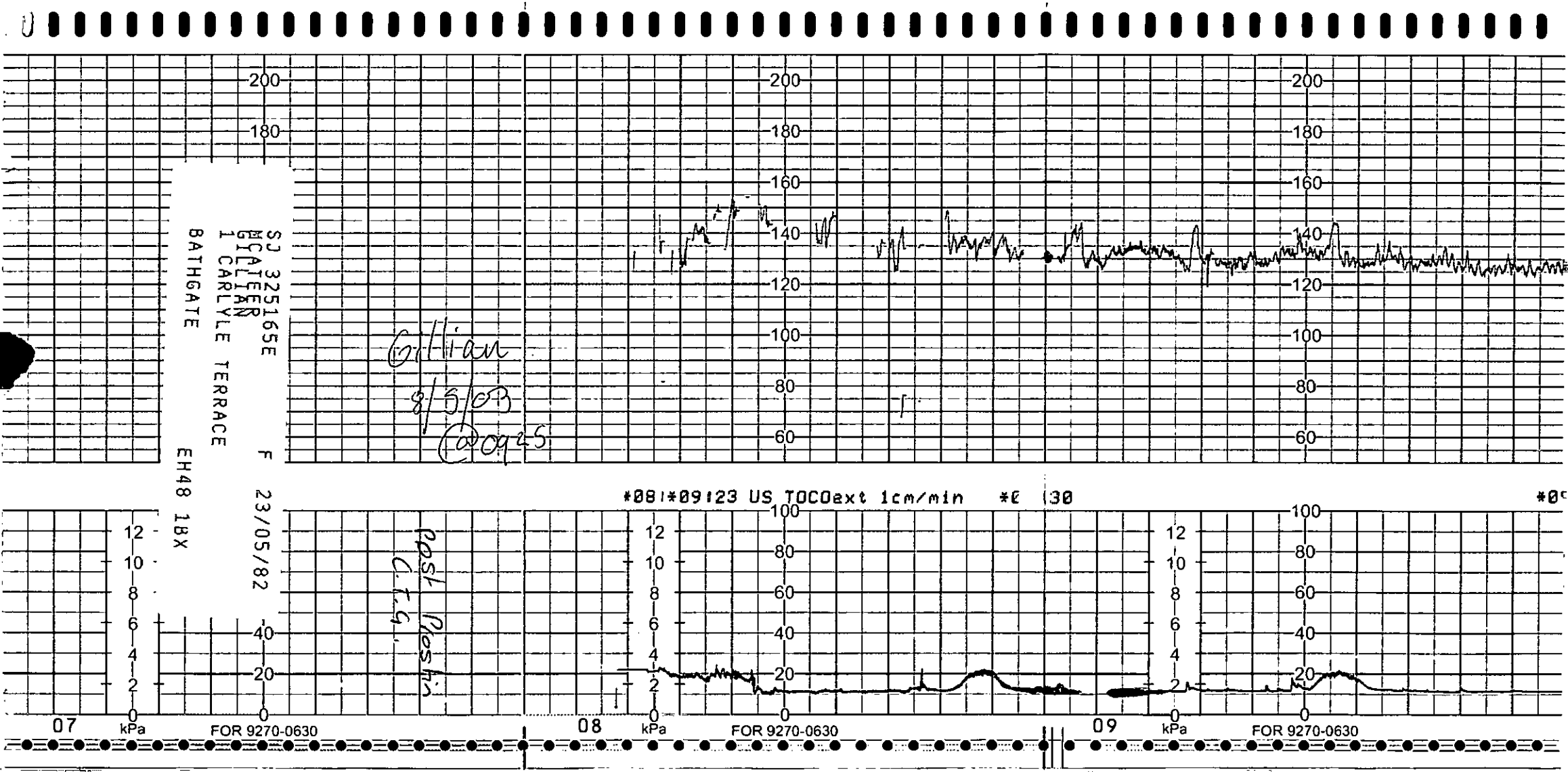
FOR 9270-0630


SJ 325165E
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE
EH48 1BX
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Gillian
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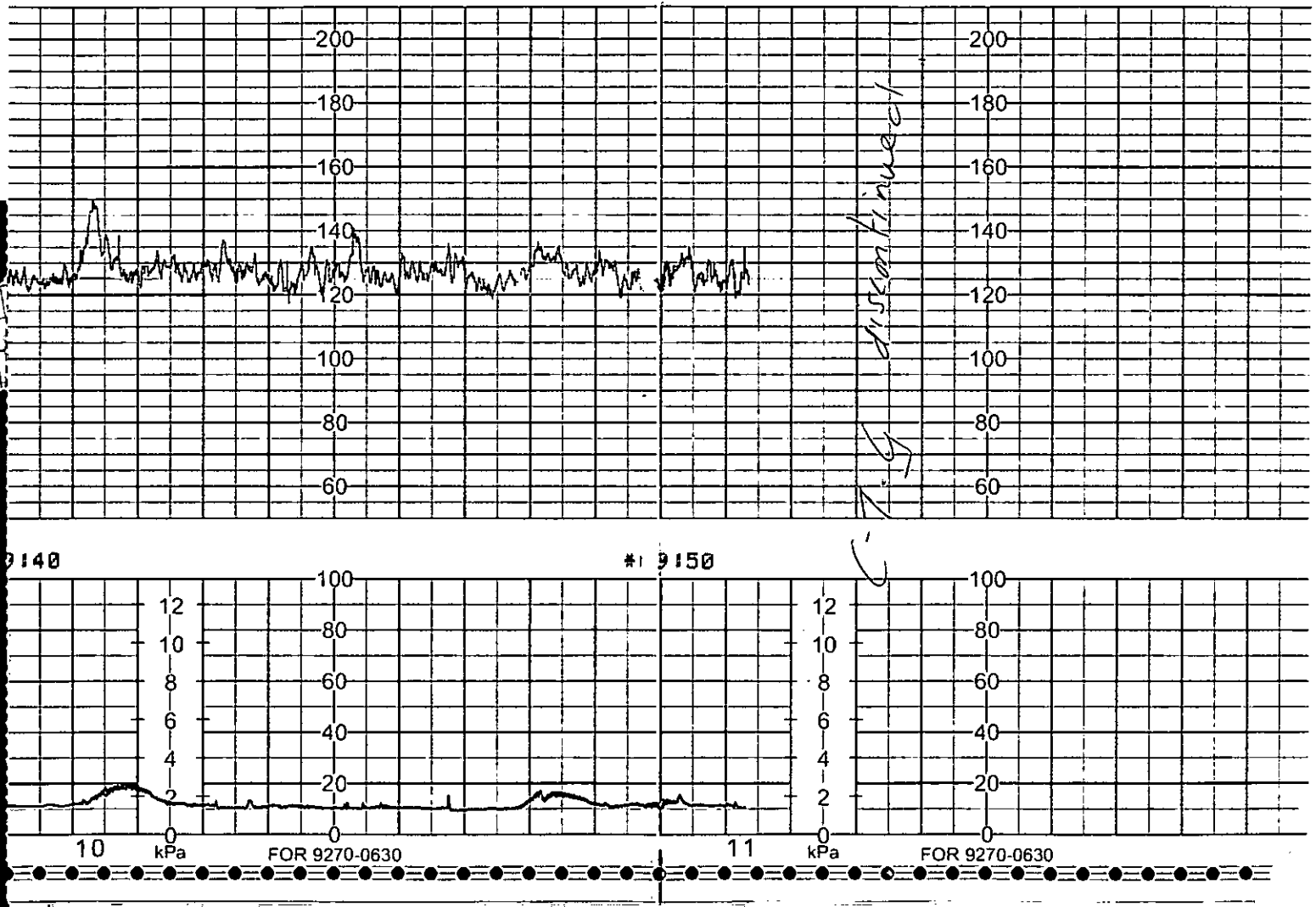
FOR 9270-0630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FOR 9270-0630
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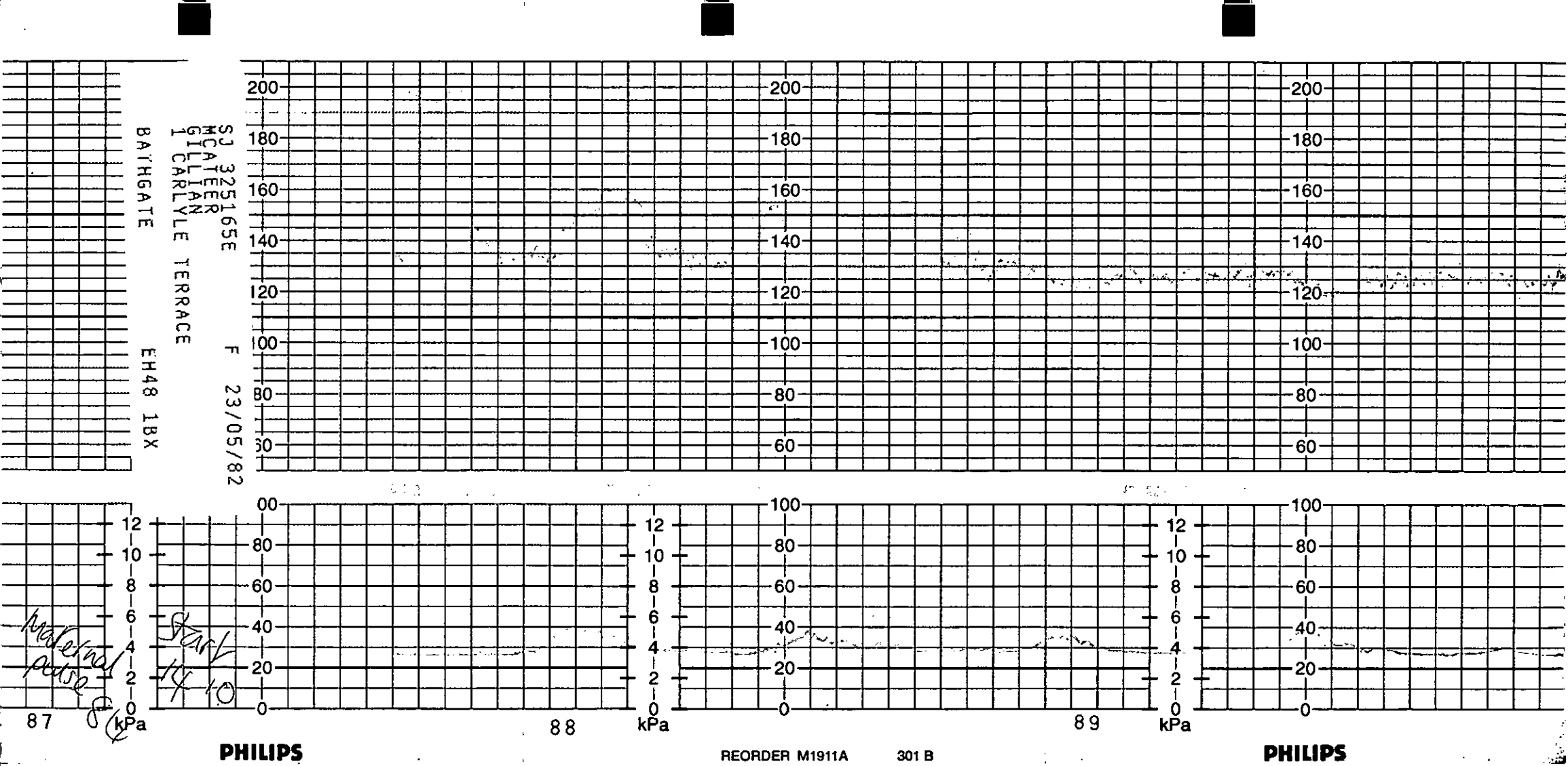
kPa
FOR 9270-0630


SJ 325165E
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE
EH48 1BX
F 23/05/82
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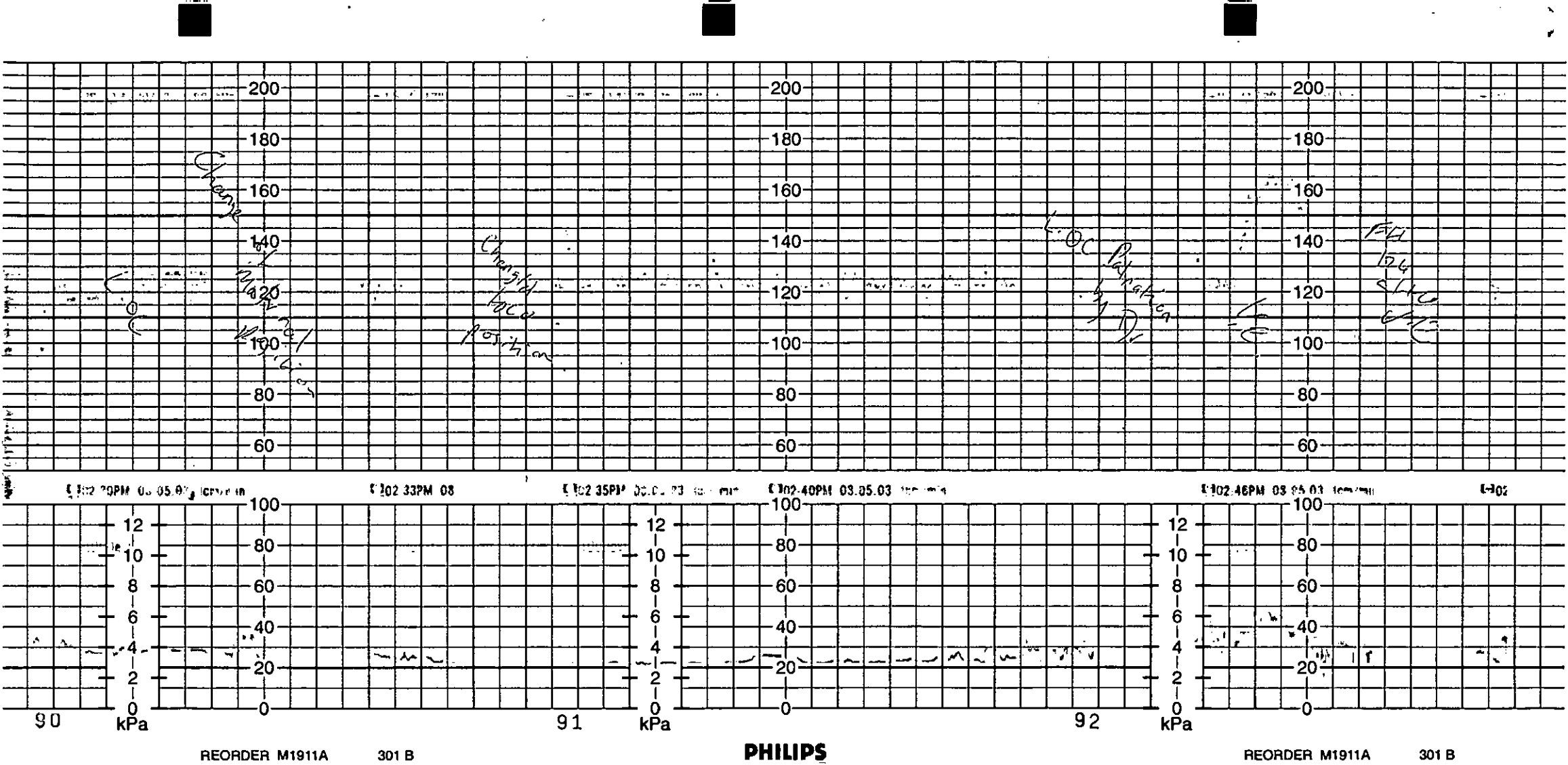
88
89
PHILIPS
REORDER M1911A 301 B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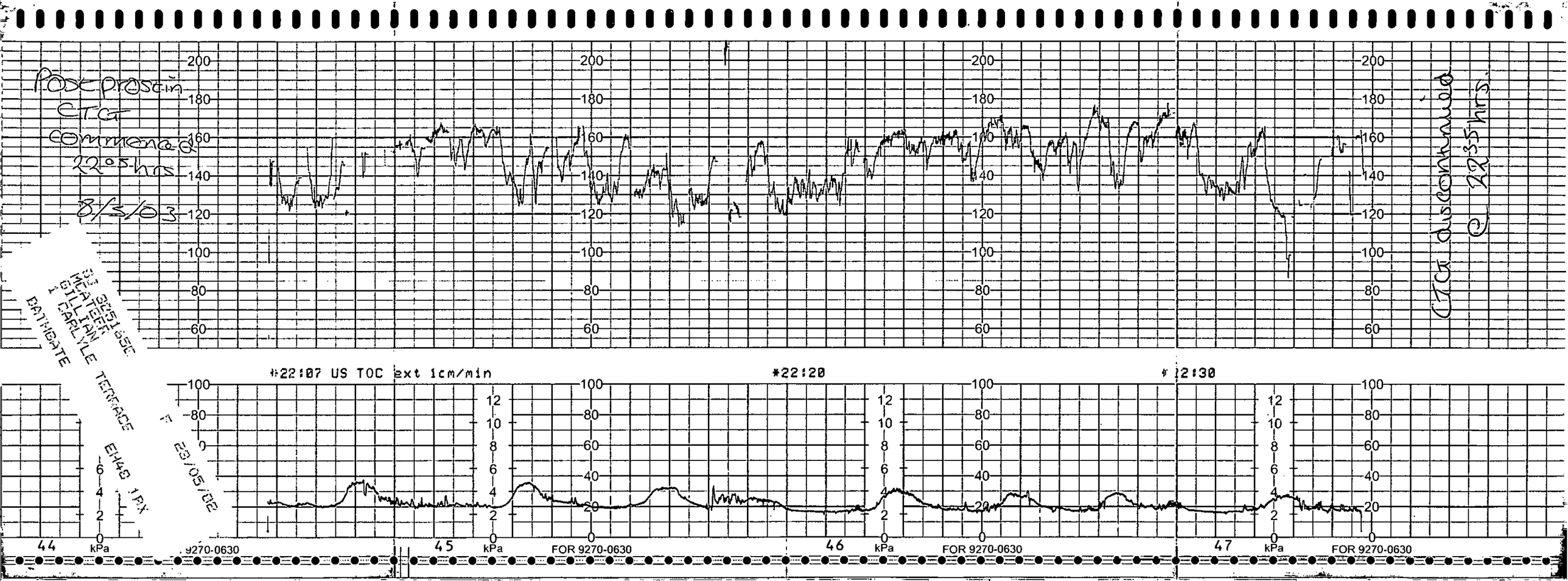
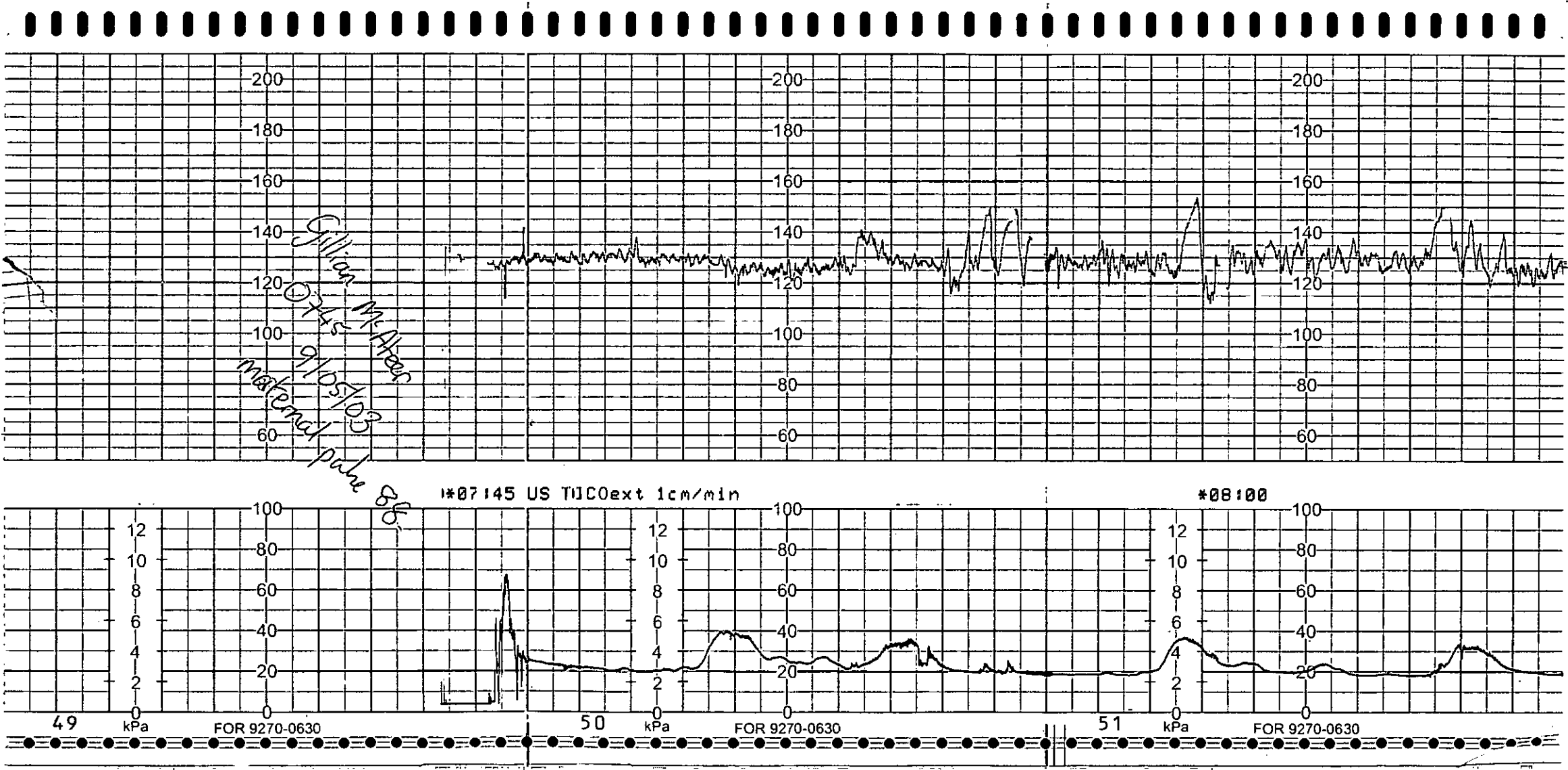
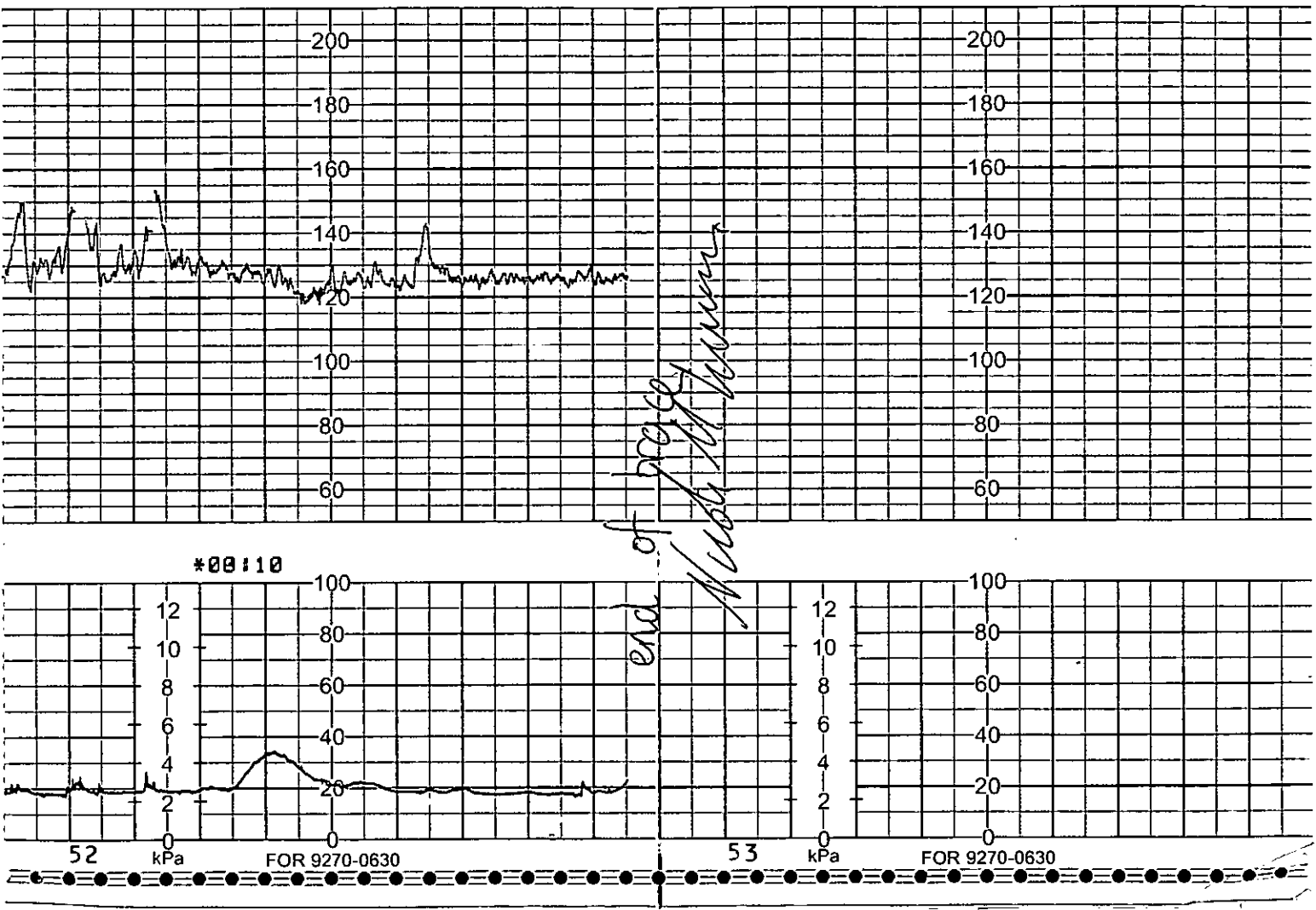
REORDER M1911A 301 B
PHILIPS
REORDER M1911A 301 B


Post procedure CTG commenced 22:05 hrs 23/5/03
CTG commenced 22:35 hrs
#22:07 US TOC ext 1cm/min
#22:20
#22:30
44
45
46
47
kPa
FOR 9270-0630


Gillian McAteer
0745
9/05/03
Maternal pain 8
I*07:45 US TOCOext 1cm/min
*08:00
49
50
51
kPa
FOR 9270-0630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FOR 9270-0630
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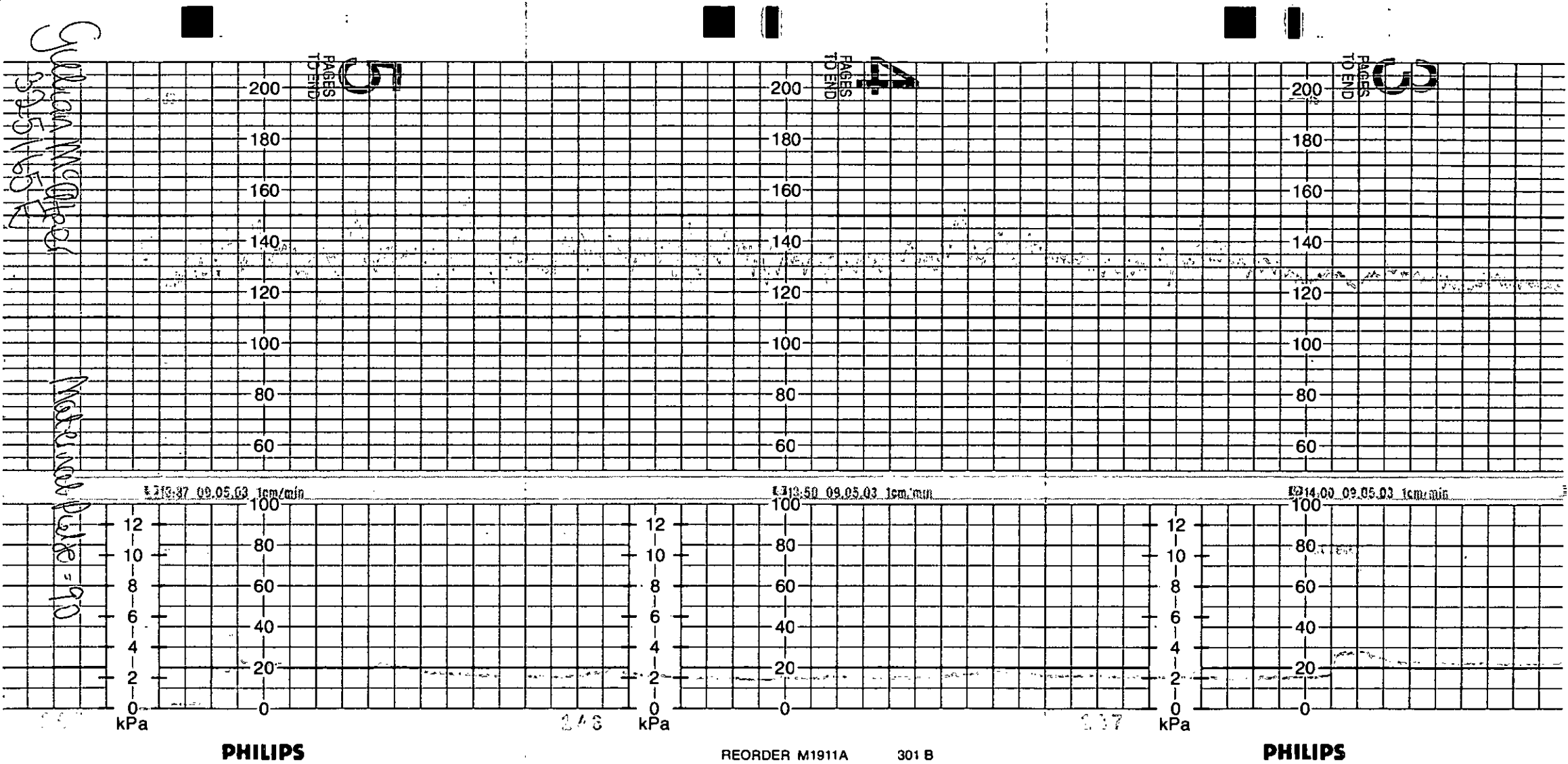
FOR 9270-0630


PAGES TO END
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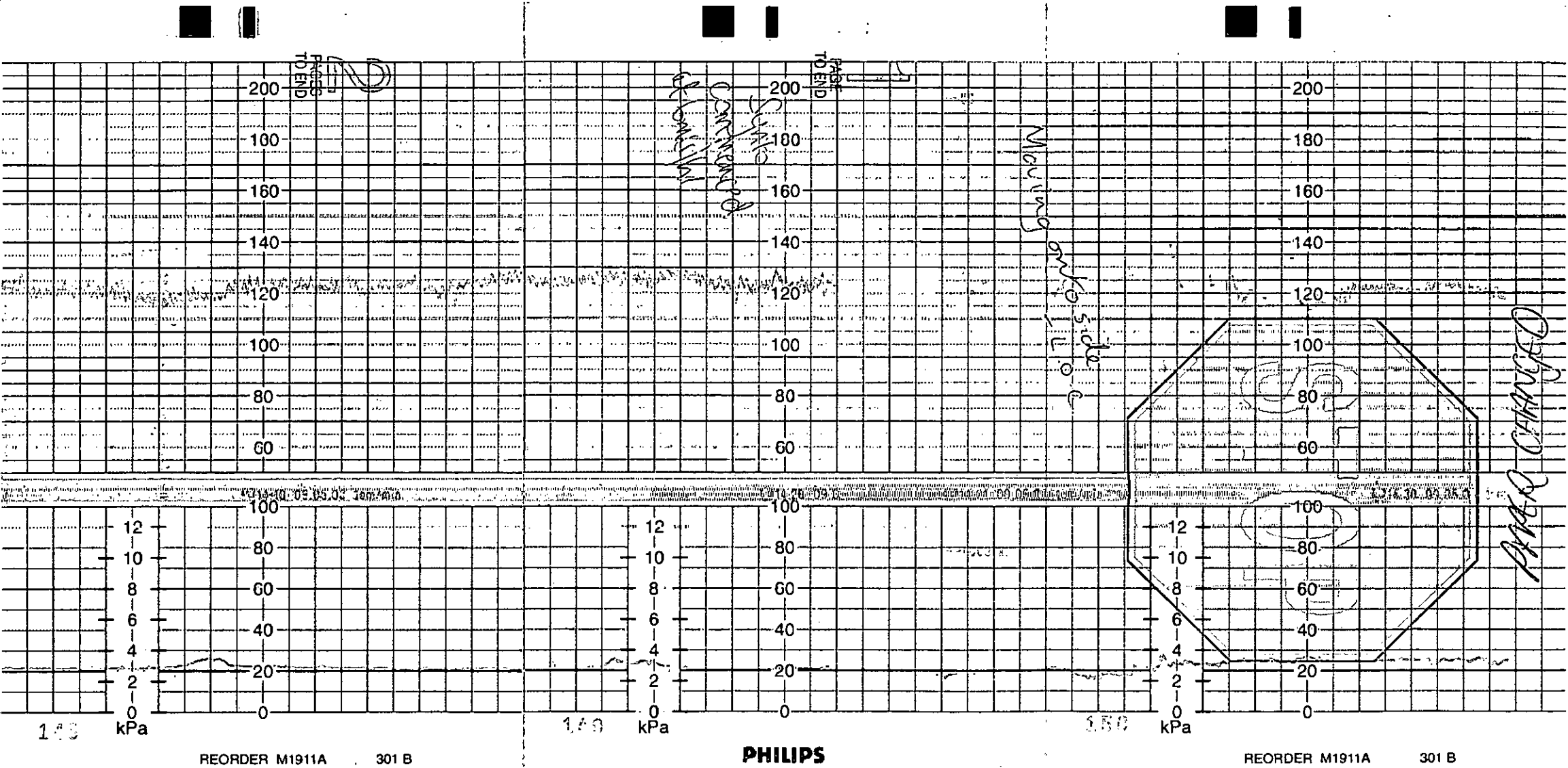
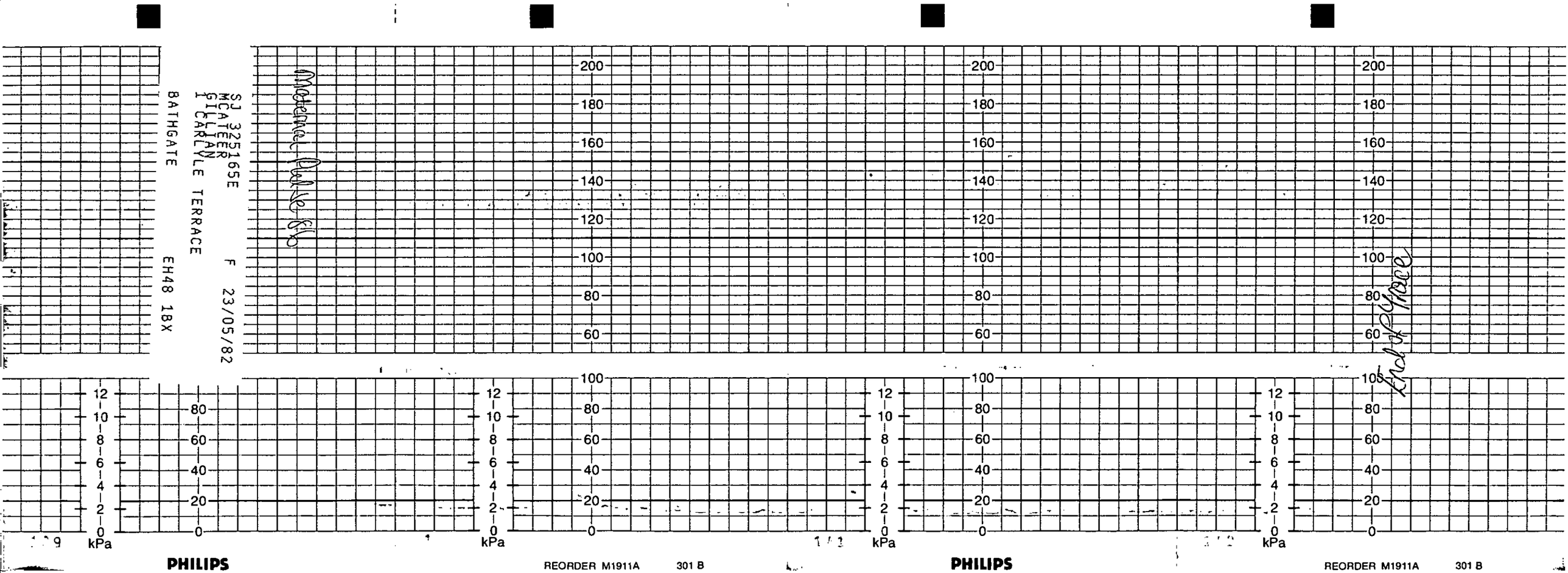
PHILIPS
REORDER M1911A 301 B



REORDER M1911A 301 B

PHILIPS

REORDER M1911A 301 B


SJ 325165E
MCATEER
GILLIAN
1 CARLYLE TERRACE
BATHGATE
EH48 1BX
F
23/05/82
Mobertal Public Rd
Andy Pryce
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PHILIPS
REORDER M1911A
301 B

WLT 426

WEST LOTHIAN HEALTHCARE DIVISION

GENERAL PRACTITIONER AND COMMUNITY MIDWIFERY DISCHARGE TRANSFER FORM

West Lothian ..... District

8003251651/E2298971 F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 RW Holden

Hospital St John's ..... Ward 11 ..... Date of Discharge 9/9/12.

Home Address 23 Cherry ..... G.P. J. W. Hilson

..... Address Simpson Medical

Tel. No: ..... Group

Temp. Address ..... Bathgate Primary

..... Care Centre

Tel. No: 07913344 5731 ..... Tel. No: 01506 634444

Parity 2+0 ..... No. of Living Children 2 ..... Comments

Early Discharge ..... Booked/Unbooked ..... Blood Group O Pos

Ante-natal complications .....

MOTHER

Date of delivery 9/9/12 ..... Time 11.08 ..... Length of Labour N/A ..... Spontaneous/Induced

Method of delivery: Spontaneous ..... Other Emerg CS ..... Indication Abruption

Complications ..... Blood loss *1000mls*

Placenta Complete ..... Membranes Complete.

State of perineum on discharge Abdominal wound. ..... Hb 7/9/12 Hb 95

Treatment and/or complications ..... on Fe SO4.

Almevax: Immune ..... Anti-D Immunoglobulin: N/A

BABY

Sex Female ..... Apgar score 9' 9'3 ..... Gestation Tri

Weight at birth 2720g ..... OFC 32cm ..... Length 49cm ..... Cord cord clamp on. ..... Guthrie Test: YES/NO

Weight on discharge 2950g ↓170g ..... Feeding Breast - well.

Any special problems .....

Treatment and/or complications .....

M 'W's Signature A Bradie

EARLY DISCHARGE Has G.P. been telephoned? YES/NO By whom? Given to Surgery. 9/9/12 Living

Testes Descended L. YES/NO .....

Testes Descended R. YES/NO .....

Hips L. NORMAL/ABNORMAL .....

Hips R. NORMAL/ABNORMAL .....

Signature .....

WLT 426

WEST LOTHIAN HEALTHCARE DIVISION

GENERAL PRACTITIONER AND COMMUNITY MIDWIFERY DISCHARGE TRANSFER FORM

District

800325165E/E2298971 F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 RW Holden

Hospital ..... Ward ..... Date of Discharge .....

Home Address ..... G.P. .....

..... Address .....

Tel. No: .....

Temp. Address .....

.....

Tel. No: ..... Tel. No: .....

Parity ..... No. of Living Children ..... Comments .....

Early Discharge ..... Booked/Unbooked ..... Blood Group .....

Ante-natal complications .....

MOTHER

Date of delivery ..... Time ..... Length of Labour ..... Spontaneous/Induced

Method of delivery: Spontaneous ..... Other ..... Indication .....

Complications ..... Blood loss .....

Placenta ..... Membranes .....

State of perineum on discharge ..... Hb .....

Treatment and/or complications .....

Almevax: ..... Anti-D Immunoglobulin: .....

BABY

Sex ..... Apgar score ..... Gestation .....

Weight at birth ..... OFC ..... Length ..... Cord ..... Guthrie Test: YES/NO

Weight on discharge ..... Feeding .....

Any special problems .....

Treatment and/or complications .....

M 'W's Signature .....

EARLY DISCHARGE

Has G.P. been telephoned? YES/NO By whom? .....

Testes Descended L. YES/NO .....

Testes Descended R. YES/NO .....

Hips L. NORMAL/ABNORMAL .....

Hips R. NORMAL/ABNORMAL .....

Signature .....

LE - N.

JLO - Dom Violence Report 28.6.12

Maternity Summary Record

Please use black ink

CONFIDENTIAL

1.9.2012

Personal details

CHI

Age

Surname/family name

First name(s) 800325165E F 23/05/1982
McAteer, Gillian

Likes to be ca 18 Cherry Avenue,
Bathgate,

Address West Lothian,
EH48 1NA

CHI 2305821425

78132 RW Holden

Postcode

Home ☎

Other ☎

Other ☎

Parity 2+ Agreed EDD 4/9/12

LMP 29/11/11 Blood group O Pos

Thrombosis risk

Low BMI 34.1

Allergies

None.

Change of details

Address

Postcode

Home ☎

Other ☎

Previous pregnancies 07708534299 . 07953445731

	Date	Outcome	Sex	Weight	Full name/comments
1	09/08/03	42 Induced SVD.	Girl	2870.	JAMIE-LEE FISHER - SGH - BR 45 2
2		Long process - Epidural.			+ PN Depression - support from HV
3	19/10/04	42 Induced	Girl	3400.	TONI MCATEER FISHER - SGH BR 45 2.
4		Epidural.			PN Depression - support
5					
6					

Health issues/special features (including regular medications)

Check Med Records - Le Bowel. Surgery.

Constipation since pregnancy - Lactulose

Plans for care

MSU NSB
Hb. 13.9
TPHA Neg
Rubella Pos
HIV Neg HEP.B. Neg

Blood Group

Planned type of antenatal care/place of birth

Lead professional

Designation

Change(s) to type of antenatal care/place of birth

Reason

Signed / /

Forename(s)

Surname/family name

Name _____ CHI

Partner/supporter details — Please tick if emergency contact ☐

Name [redacted]

Relationship PARTNER

Address [redacted]

Ho

Oth

Directions to home

Alternative/emergency contact

Name [redacted]

Relationship Mum

Booking completed by . . . . . Print . . . . . Designation . . . .

Date / / Gestation weeks Location . . . . . .

Date	Gestation	Further information/details of maternity care
Remember to sign each entry and print your signature alongside your first entry		
		Lives with children

NHS
SCOTLAND

Baby Record -
Midwifery Care

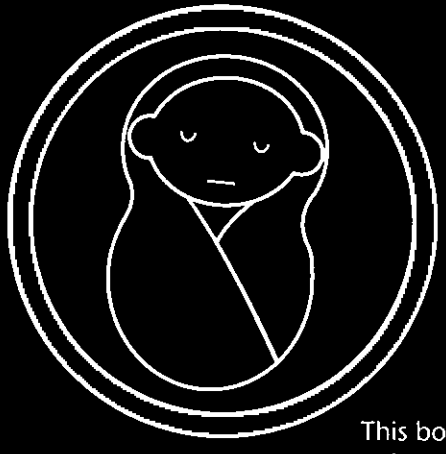
Confidential

PLEASE USE BLACK INK

[redacted]

BABY'S LABEL HERE

800325165E F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 RW Holden



If you find this record, please return it to the nearest Maternity Unit or General Practitioner surgery as soon as possible.

This booklet will document the care given to your baby in the first days in hospital and at home. When you and your baby are discharged from community midwifery care, the booklet will be returned to the baby's hospital medical record.

Complete this page by hand or affix hospital computer discharge summary here.

Postnatal discharge summary

Discharged from .....

To (address) ..... ✆ .....

GP ..... at ..... ✆ .....

Obstetrician ..... Midwife ..... Paediatrician .....

Labour, birth and postnatal period

Onset of labour ☐ Spontaneous ☐ Induced: indication .....

Mode of delivery ..... on ..... day ...../...../..... at ..... Sex .....

Indication ..... Presentation ..... Location .....

Gestation ..... Birthweight ..... g Blood loss ..... mls

APGARs ☐ 1 minute ☐ 5 minutes ☐ 10 minutes Placenta/membranes .....

Maternal blood group ..... Anti-D needed ☐ No ☐ Yes Anti-D given on ...../...../.....

Rubella status ..... Vaccination needed ☐ No ☐ Yes Vaccinated on ...../...../.....

Further details, including problems identified during pregnancy, labour, birth and the postnatal period/referrals, investigations or results pending: .....

.....

.....

Baby

CHI ..... Discharged home with mum ☐ No ☐ Yes

Feeding: type/comments .....

.....

.....

.....

.....

Length .....cm OFC .....cm Discharge Weight ..... g

BCG vaccination needed ☐ No ☐ Yes: given on ...../...../.....

Newborn blood spot screening done ☐ No: due on ...../...../..... ☐ Yes: on ...../...../..... ☐ Declined

Newborn hearing screening done ☐ No: due on ...../...../..... ☐ Yes: on ...../...../..... ☐ Declined

Vitamin K administered ☐ No ☐ Yes: details .....

Admitted to neonatal unit ☐ No ☐ Yes: details .....

Discharge medication ☐ No ☐ Yes: details .....

Further details, including problems identified/referrals, investigations or results pending: .....

.....

.....

.....

Summary completed by (print name) ..... Date / /

Signature: ..... Designation .....

Your baby's progress

PN Day	Date/ time	General condition: colour, appearance and fontanelles	Eyes	Feeding: type, frequency (and volume if botttle feeding) and condition of mouth	Skin: including buttocks and cord	Wet nappies	Dirty nappies	ID Check	Signed
5.	10.9.12 13.45	Pink. Alert Head NAD	clear	Breast, + EBM. Mouth clean + moist Keen to feed, difficult latching on L side Latching observed good on right side BST. Weight tomorrow	intact cord off and dry.	wet. x 3.	no BO. since Day 3.		V. Fraser
6.	11.9.12 12.45	Pink Alert	clear	was weighed yesterday 2550 weight 2620 ↑ 70g. Formula 20z 3hrly Mouth clean + moist	cord on dry	wet. all feeds	yellow soft x2		V Fraser
8.	13.9.12 13.15.	Pink Head NAD	clear.	Formula 30z 3hrly. Self waking Contented Mouth clean + moist	cord off skin intact	wet all feeds.	yellow x1-2 daily		V Fraser
9.	14.9.12. 14.50	Pink Head NAD	clear.	3-4oz. Settled. Sleeping at first	c	wet all feeds	yellow x2.		V Fraser

Your baby's progress

PN Day	Date/ time	General condition: colour, appearance and fontanelles	Eyes	Feeding: type, frequency (and volume if botttle feeding) and condition of mouth	Skin: including buttocks and cord	Wet nappies	Dirty nappies	ID Check	Signed
(10)	16/9 15:30	skin pink head NAD fontanelles healthy	clear & bright	AIF well 3-4/3 O/I thrush. Mum will phone MHS 24 & get prescription	Cord off	1ch of wet nappies	1ch of soft yellow nappies		P. Whitehead
Temperature 36.9 °C Route PH									
Temperature ..... °C Route									
Temperature ..... °C Route									
Temperature ..... °C Route									
Temperature ..... °C Route									

Your baby's progress

PN Day	Date/ time	General condition: colour, appearance and fontanelles	Eyes	Feeding: type, frequency (and volume if botttle feeding) and condition of mouth	Skin: including buttocks and cord	Wet nappies	Dirty nappies	ID Check	Signed
Temperature .....°C Route									
Temperature .....°C Route									
Temperature .....°C Route									
Temperature .....°C Route									
Temperature .....°C Route									

Your baby's progress

PN Day	Date/ time	General condition: colour, appearance and fontanelles	Eyes	Feeding: type, frequency (and volume if botttle feeding) and condition of mouth	Skin: including buttocks and cord	Wet nappies	Dirty nappies	ID Check	Signed
Temperature ..... °C Route									
Temperature °C Route									
Temperature °C Route									
Temperature °C Route									
Temperature °C Route									

Your baby's care

Date/time	Further information/planning, delivering and evaluating care

Your baby's care (continued)

Date/time	Further information/planning, delivering and evaluating care

Your baby's care (continued)

Date/time	Further information/planning, delivering and evaluating care

Your baby's care (continued)

Date/time	Further information/planning, delivering and evaluating care

Your baby's care (continued)

Date/time	Further information/planning, delivering and evaluating care

Your baby's care (continued)

Date/time	Further information/planning, delivering and evaluating care

Consent for Newborn Blood Spot Screening for Phenylketonuria, Congenital Hypothyroidism & Cystic Fibrosis

I have received and read the information leaflet "A Parent's Guide to Newborn Blood Spot Screening for Phenylketonuria, Congenital Hypothyroidism and Cystic Fibrosis" and have had an opportunity to discuss the tests I am being offered with a health professional. I understand the reasons for the tests and the consequences of the results. I also understand the significance of not having these tests performed. I am aware that my decision whether or not to have these tests will not affect the quality of care delivered by healthcare professionals.

Baby's Name ..... Date of birth ..../..../....

CHI Number .....

☐ I wish ☐ I do not wish my baby to be tested for Phenylketonuria

☐ I wish ☐ I do not wish my baby to be tested for Congenital Hypothyroidism

☐ I wish ☐ I do not wish my baby to be tested for Cystic Fibrosis

We also need to obtain your permission to store the blood spot card beyond the 12 month testing period and to use any of the blood spots left over after testing is complete for anonymised research, such as the development of new screening tests. If any research was proposed in which the researcher would be able to identify you or your baby, we would always contact you again to seek your approval.

☐ I agree ☐ I do not agree for the storage of my baby's blood spot specimen beyond the 12 month testing period

☐ I agree ☐ I do not agree to the use of any left over blood spots for anonymised research

Signature: ..... (Parent) Date ..../..../....

Witness: ..... (Health professional)

(Please sign and print name)

Designation: ..... Date ..../..../....

Discharge of baby from midwifery care

Date 14/9/12 Baby's age 9 days Assessed by V. Fraser

Weight chart

Postnatal day	Date	Time	Weight g	Details:- including percentage of birth weight lost
B Wt			2720	
4.			2550	↓ 170g. = 6.8%
6.	11-9-12	12.45	2620	= 100g from BWt: 3%

Vitamin K

Vitamin K ☑ Im ☐ Oral ☐ Declined

Repeat oral doses given on . . / . / By . . ☐ Declined

. . / . / By . . ☐ Declined

Feeding

☐ Breast ☑ Bottle ☐ Mixed ☐ Supplementary feeds given

Details . . . . . .

Vaccinations

BCG vaccination needed ☑ No ☐ Yes BCG given as prescribed on / /

Hepatitis B vaccination needed ☑ No ☐ Yes Hepatitis B vaccination given on . . / . /

Screening

Newborn bloodspot screening done on 10/9/12 By V. FRASER ☐ Declined

Newborn hearing screening done on 5/9/12 By ⊙ SOH ☐ Declined

Any problems identified

Jaundice ☑ No ☐ Yes ☐ SBR taken Highest SBR

Other . . . . . .

Hand over to health visitor complete ☐ No ☑ Yes

Follow-up appointments required ☑ No ☐ Yes

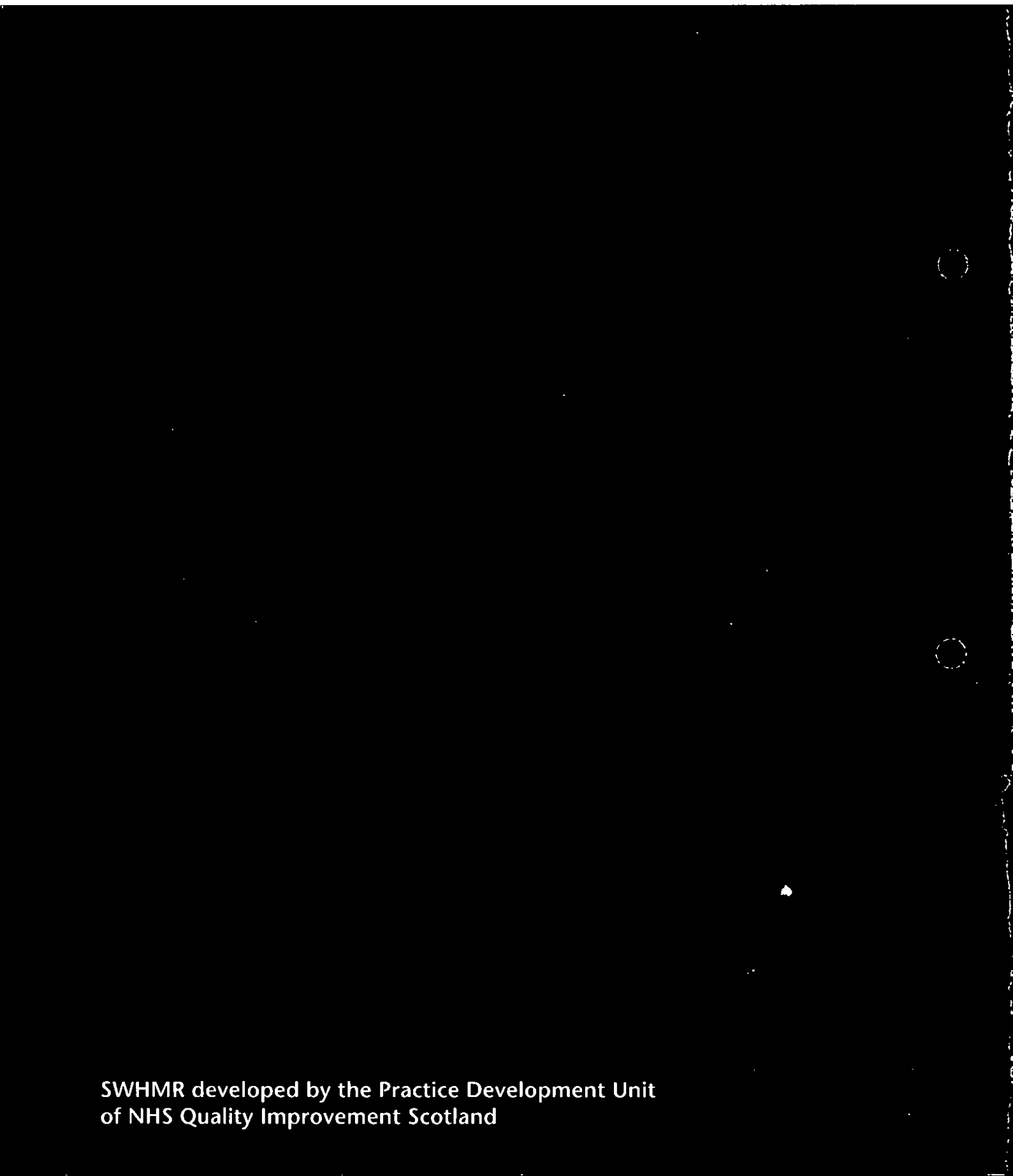
Other . . . . . .

Signed: V. Fraser Print name V. FRASER Date 14/9/12

Whose signature?

Whenever anyone writes in this record for the first time, they should fill in their details below.

Name (please print)	Signature	Job title
V. FRASER	V. Fraser.	elm



SWHMR developed by the Practice Development Unit
of NHS Quality Improvement Scotland

Name: Gillian McAteer CHI: 2305821425	**NHS Lothian-Maternity Handheld Record** Postnatal Record Summary	NHS Lothian

UHPI: 800325165E Age: 30 Parity: 2+0 EDD: 04 Sep 2012 Blood Gp: O Rh Positive

This is your Postnatal Record. It contains important information that will be used to help you and your maternity care team plan care for you and your baby. You will usually be asked to hold your record when you receive care at home / when you have been discharged home from a maternity unit. This will help communication between you and your maternity care team.

Some women may prefer not to hold their Postnatal Record. If you do not want to hold your record, please tell your midwife. Your midwife will arrange to hold your record for you, or for it to be kept at the maternity unit or your GP practice.

Please keep your Postnatal Record safe, confidential and protect it from damage. Please take it with you if you have any appointments at your health centre, GP practice or maternity unit. If you lose your Postnatal Record, please contact your midwife or maternity unit as soon as possible.

Your Postnatal Record remains the property of your NHS Board. At the end of your maternity care it will be returned to the NHS Board where it will be stored safely. If you would like a copy of your completed record, please speak to your midwife or contact the data controller of the NHS Board responsible for your care (there may be a small charge for this).

Details about how your personal information is used by staff within NHSScotland can be found in the leaflet 'Confidentiality - it's your right'. This is available from your midwife, GP practice or on-line at http://www.hris.org.uk. Follow the links on confidentiality, consent and having your say.

Help and advice: Please use the following services: West Lothian 3 - 01501 730 339

Contact Details

General Practitioner: **Address:** Tel: Practice Code	RW Holden Simpson Medical Group, Bathgate Primary Care Centr 01506 654444 78132/1	**Named Midwife:** **Midwifery Team:** **Base:**	Vanda Fraser West Lothian 3 - 01501 730 339
Maternity Unit: Tel: **Social Work Contact Details**	St John's Hospital at Howden	**Health Visitor:** **Base:** Tel:	 Simpson Medical Group, Bathgate Primary Care Centr

Domestic Abuse Helpline 0800 027 1234 (24 hours)
Scottish Women's Aid : www.scottishwomensaid.co.uk
NHS 24: 08454 24 24 24

Rape Crisis Scotland Helpline: 08088 01 03 02
(free number) 6pm to midnight
Email: info@rapecrisisscotland.org.uk

ADDITIONAL SUPPORT CONTACTS

()	()
()	

Run by: Eugene O Connor 09 Sep 2012 12:02

Postnatal Discharge Summary

Discharged from	Ward 11 SJH St John's Hospital at Howden				
To	18 Cherry Avenue, Bathgate, West Lothian, EH48 1NA			Tel No	07933445731
GP	RW Holden	At	Simpson Medical Group, Bathgate Primary Care Centr	Tel No	01506 654444
Named caseload holder as per KCND Pathways for Maternity Care					
Care Provider	M/W Vanda S Fraser	Named Midwife	Vanda Fraser	Paediatrician	
GIRFEC Lead Professional					

Labour, birth and postnatal period - Baby No 1

Parity:		2+0	
Onset of labour	None	Induced indication	
Mode of delivery	Emergency LUSCS	Sex	Female
		At	11:08
		Presentation	Occipito - Anterior
On	05/09/2012		
Indication for Intervention	Abruptio placentae	Livebirth/stillbirth	Livebirth
		Birthweight (g)	2720
Location	Consultant Unit	Placenta/ membranes	Complete
Gestation	40.1		
Blood Loss (mls)	1000		
Perineum		Suture material	
Abdominal Wound	No	Closed with	

APGARs	1 minute	9	5 minutes	9	10 minutes

Haemoglobin (g/dl)	95	Repeat needed	Yes	Taken on	07/09/2012
		Due	26/09/2012	Blood Transfusion	No
Blood group	O Rh Positive	Anti-D needed	No	Anti-D given on	
Irregular antibodies	No	Vaccination needed	No	Vaccinated on	
Rubella status	Immune				
Contraception/sexual health needs discussed	Yes	Contraception	None		
		barrier discussed. Knows to speak to GP at 6 week check for more permanent contraception.			
Cervical smear due	Yes	When is Smear Due? post natal			
Discharged medication	Yes	Details		Postnatal check required	Yes
		Paracetamol Caplets Ferrous Sulphate Tablets Diclofenac Sodium E/C Tablets Lactulose Solution Dihydrocodeine Tablets		Postnatal check arrangements	Mum to arrange with GP
Problems identified during pregnancy, labour, birth		None			
P/N investigations requested (see ePR for results)		Full blood count SJH - 05/09/2012 16:52 Full blood count SJH - 07/09/2012 10:14			

Your progress

Postnatal day	1	3	4	5		
Date / time	05/09/2012 18:11	07/09/2012 10:33	08/09/2012 10:43	09/09/2012 09:26		
General Wellbeing and Pain Assessment		Feels well. Analgesia as kardex effective.		wound clean and dry, small amount of bruising. disolvable stitches.		
TPR BP	T = 37, P = 84, R = 14 118/60	T = 36.4, P = 84, R = 14 106/63	T = 36, P = 80, R = 133/77	T = 36, P = 83, R = 117/61		
Mobility, exercise and preventing blood clots explained	No	No	Yes	Yes		
Revised postnatal thrombosis risk	High Risk	Moderate Risk	Moderate Risk	High Risk		
Breast	Comfortable- Wishes to breast feed - baby cool initially + Gillian too sore to feed - cup feed x2	Comfortable-	Comfortable-	Comfortable- feeding well.		
Fundus	, ,	Central, 2 cm below umbilicus, Firm	Central, 2 cm below umbilicus, Firm	Central, 2 cm below umbilicus, Firm		
Blood loss	Red/Pink minimal odourless	Red/Pink minimal odourless	Red/Pink minimal odourless	Average		
Perineum						
Abdominal Wound		Clean and dry	Clean and dry	Bruised		
Passing urine, bowels and pelvic floor	PU Problems-	PU Problems- No Bowels moved- No Haemorrhoids Problems- No Problems controlling bowels- Pelvic Floor problems-	PU Problems- No Bowels moved- Yes Haemorrhoids Problems- No Problems controlling bowels- No Pelvic Floor problems- No	PU Problems- No Bowels moved- Yes Haemorrhoids Problems-		

Plan of care	Comfortable - tolerating fluids + diet Obs stable Catheter in situ - diuresis good Wound dressing in situ Awaiting FBC result prior to stopping IV fluids	Routine post natal care. FBC taken today. Assist with feeding.		feels well, would like home today.		
Signed	Karen Nattan	Janice McPherson	Lynne Reid	Alicia Brodie		

Discharge from Midwifery care				
Date	Days postnatal	-62,704	Assessed by	Alicia Brodie
Special features identified (please sign and date each entry)	Please print the special features report			
BP 117 / 61				

General wellbeing including mental health

Current smoker / day 10	
Risk of passive smoking to baby explained	Yes

Don't smoke or allow anyone else to smoke in the same room as your baby. It's best if nobody smokes in the house, including visitors. Anyone wishing to smoke should go outside.
Do not smoke or allow anyone to smoke in a car your baby is travelling.
For further information about alcohol consumption following the birth see **www.readysteadybaby.org.uk**

Any Problems with the following:	
Passing urine	
Pelvic floor	
Bowel function	
Breasts	
Perineum / abdomen	
Lochia /menstruation	
Cervical smear due/date Yes	post natal
Additional info for Mother & Baby	experienced Mum.
Contraception:	**It is recommended that you commence a reliable method of contraception by Day 21**
Longer acting contraception (LAC)	Yes
Reversible contraception discussed	Contraception/Sexual Health: (www.sexualhealthscotland.co.uk)
Has LAC contraception been provided	No
Physical Exercise and Healthy Lifestyle Advice	
Importance of healthy eating and maintaining a healthy weight discussed	Yes
Details	
Handover to health visitor completed	
Health Plan Indicator allocated (include in handover to health visitor)	
Six week follow-up Appointment discussed / required	Yes

Consent for Newborn Blood Spot Screening for Phenylketonuria (PKU), Congenital Hypothyroidism (CHT), Cystic Fibrosis (CF), Sickle Cell Disorders (SCD) and Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCADD)

I have received and read the information leaflet "Your guide to newborn screening tests" and have had an opportunity to discuss the tests I am being offered with a health professional. I understand the reasons for the tests and the consequences of the results. I also understand the significance of not having these tests performed. I am aware that my decision whether or not to have these tests will not affect the quality of care delivered by healthcare professionals.

Baby's Name [redacted] Date of birth 5/9/12

CHI Number 0509128500

I wish — I do not wish my baby to be tested for Phenylketonuria

I wish — I do not wish my baby to be tested for Congenital Hypothyroidism

I wish — I do not wish my baby to be tested for Cystic Fibrosis

I wish — I do not wish my baby to be tested for Sickle Cell Disorders

I wish — I do not wish my baby to be tested for MCADD

I understand that the Newborn Blood Spot Screening Programme needs to obtain my permission to store the newborn blood spot card beyond the initial 12 month testing period and to use any of the blood spots left over after testing is complete for anonymised research, such as the development of new screening tests. If any research was proposed in which the researcher would be able to identify me or my baby, a member of staff from the Newborn Bloodspot Screening Programme would always contact me again to seek my approval.

I agree — I do not agree for the storage of my baby's blood spot sample beyond the initial 12 month testing period.

I agree — I do not agree to the use of any left over blood spots for anonymised research.

Signature: [signature] (Parent) Date 10/9/12

Signature: V. Fraser (Witness: Healthcare professional)

Print: V. FRASER

Designation: QIM Date 10/9/12

Note to healthcare professional – all relevant information needs to be recorded on the Newborn Blood Spot Card

Name: Baby Of Gillian McAteer CHI: 0509128300	**NHS Lothian - Maternity Handheld Record** Baby Summary Report	NHS Lothian
UHPI: 700611840B Age: 5 Days		

Postnatal discharge summary

Discharged from	Ward 11 SJH, St John's Hospital at Howden	Place of Birth	Consultant Unit
To (address)			
Tel			
GP	RW Holden		
At	Simpson Medical Group, Bathgate Primary Care Centre, Whitburn Road, Bathgate		
Tel	01506 654444		
Care Provider	M/W Vanda S Fraser		
Midwife Team	West Lothian 3 - 01501 730 339		
Paediatrician			
GIRFEC Lead Professional if relevant, e.g. Social Worker			
Named Caseload holder as per KCND Pathways			

Labour, birth and postnatal period

Onset of labour	None						
Induced indication							
Mode of delivery	Emergency LUSCS						
Day 05/09/2012	At 11:08	Sex	Female	Outcome	Livebirth		
Indication	Abruptio placentae						
Presentation	Occipito - Anterior						
Location	Consultant Unit						
Gestation	40.1						
Birthweight	2720		Blood loss (mls)		1000		
APGAR 1 minutes	9		APGAR 5 minutes		9		
APGAR 10 minutes							
Placenta/ Membranes	Retroplacental clot Complete						
Maternal blood group	O Rh Positive	Anti-D needed	No	Anti-D given on			
Rubella status	Immune	Vaccination needed	No	Vaccinated on			

Further details, including problems identified during pregnancy, labour, birth and the postnatal period/referrals, investigations or results pending:

experienced Mum.

Baby 1

CHI: 0509128300	UHPI: 7006118408	Discharged home with mum	Home with mum
Feeding type	8reast	Length (cm)	49
OFC (cm)	32	Discharged Weight (g)	2550
Follow-up required	No		
Admitted to neonatal unit	No		
Details			
Discharge medication	none		

Further details, including problems identified/referrals, investigations or pending:

Your Baby's Progress

Postnatal Day	Date / Time	Temp	Route	General condition, colour, appearance and fontanelles	Eyes	Feeding type, frequency (and volume if bottle feeding) and condition of	Skin, including buttocks and cord	Wet nappies	Dirty nappies	ID Check	Signed
5	09/09/2012 8:12	36.5	Skin	NAD	Clear	Breast Feeding	Healthy	yes	yes	Yes	Alicia Brodie
4	08/09/2012 8:51	36.6	Skin	NAD	Clear	Breast Feeding	Jaundiced	yes	yes	Yes	Fiona Gray
3	07/09/2012 8:00	36.9	Skin	NAD	Clear	Breast Feeding	Healthy	yes	yes	Yes	Morag Brash
2	06/09/2012 7:57	37	Skin	NAD		Breast Feeding	Healthy	yes	yes	Yes	Morag Brash
1	05/09/2012 18:16	36.9	Skin	NAD	Clear	Breast Feeding	Healthy			Yes	Karen Nattan

Your baby's care

Date	Time	Further multi-professional information / planning, delivering and evaluating care. Consideration should be given to parent child attachment during every care episode.
05/09/2012	1B:16	
06/09/2012	7:57	replaced 1 nameband
07/09/2012	8:00	baby appears well
08/09/2012	8:51	namebands checked and found correct baby alert and appears well
09/09/2012	8:12	namebands checked and found correct wrapped warmly to improve temperature - will recheck in 1 hour baby alert and appears well temperature rechecked - now 36.7 baby weighed - now2550g - down 170g from birthweight

Discharge of Baby from midwifery care

Date		Baby's Age	-2090 months 26 days	Assessed By	Alicia Brodie

Weight Observations

Day	Date	Time	Weight (g)	Comment	% Birthweight lost
1	05/09/2012	18:16	2,720		0.00
5	09/09/2012	9:53	2,550		6.25

Vitamin K

Vitamin K administered	IM		
Oral vitamin K - professional or parent administration			
Repeat oral dose (1) given		By	
Repeat oral dose (2) given on		By	

Feeding

Type of feed	Breast
Details	baby weighed, loss under 10%.Feeding well

Vaccinations

BCG vaccination needed	No	BCG date given	
Hepatitis B vaccination needed	No	Hepatitis B date given	
Hepatitis B immunoglobulin needed	No	Hepatitis B immunoglobulin date given	
Further information on immunisations is available at www.immunisationscotland.org.uk			

Screening

Newborn Blood Spot Screening done on		By	
Newborn hearing screening done on	05/09/2012	By	Alicia Brodie
Any significant risk/diagnosis of a haemoglobinopathy should be written in the Newborn Blood Spot card.			

Any problems identified

Jaundice		SBR Taken		Highest SBR	
Other	namebands checked and found correct				
Protect Your Baby's Natural Head Shape Leaflet Discussed		No	see www.scotland.gov.uk		
Hand over to health visitor/public health nurse complete		No			
Hand over to other named person i.e. GIRFEC lead		No			
Follow-up appointments required		No	Details		
Provide details of follow up required, who to and why					
Other					

Oral Health

It is recommended that you register your baby with a dentist around the age of 6 months. Many dentists participate in the ChildSmile Programme. More information is avaliable at www.child-smile.org.uk

NHS
SCOTLAND

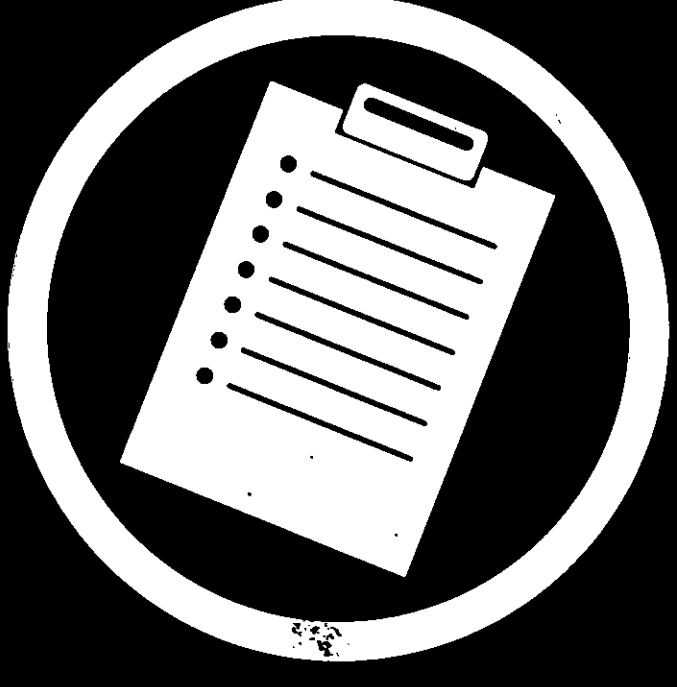
01506 524111 Wd 11

Postnatal Maternal Record

Confidential

PLEASE USE BLACK INK

Gillian McAteer 2F
800325165E F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 RW Holden



If you find this record, please return it to the nearest Maternity Unit or General Practitioner surgery as soon as possible.

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Please keep your Postnatal Record safe, confidential and protect it from damage. Please take it with you if you have any appointments at your health centre, GP practice or maternity unit. If you lose your Postnatal Record, please contact your midwife or maternity unit as soon as possible.

You can write in your Pregnancy Record where you see this symbol: ✍

Your Postnatal Record remains the property of your NHS Board. At the end of your maternity care it will be returned to the NHS Board where it will be stored safely with the rest of your maternity record. If you would like a copy of your completed record, please speak to your midwife or contact the data controller of the NHS Board responsible for your care.

Details about how your personal information is used by staff within NHSScotland can be found in the leaflet 'Protecting Personal Information'. This is available from your midwife, General Practitioner or on-line at http://www.show.scot.nhs.uk/confidentiality (see under 'Patient Guidance').

Help and advice Please use the following services

✆ ..... ✆ .....

Contact details

General Practitioner .....

Address .....

.....

✆ ..... Practice code .....

Named midwife .....

Midwifery team .....

Base .....

✆ .....

Maternity unit .....

✆ .....

✆ .....

Health Visitor .....

Base .....

✆ .....

Community support/other contacts

Social worker .....

Base .....

✆ .....

Name .....

Base .....

✆ .....

Other support/other contacts

Name .....

Base .....

✆ .....

Name .....

Base .....

✆ .....

Domestic Abuse Helpline (10am - 10pm: 7days a week) ✆ 0800 027 1234

Scottish Women's Aid ✆ 0131 475 2372 (national) ✆ ..... (local)

NHS 24 ✆ 0B454 24 24 24

Your postnatal care

The chart below is used to plan your postnatal care. Your midwife (and sometimes other members of your maternity team) will discuss and arrange your care with you, according to your needs and your baby's needs. Maternity staff will explain the reasons for each appointment or visit, as well as where it will take place, who with and when.

Day	Date	Time*	Reason for visit/appointment	Where & who with

*For some home visits an approximate time or 'morning' or 'afternoon' visit may be given.

Your notes

Please use this space to jot down any notes or questions about your care or your baby's care.

Complete this page by hand or affix hospital computer discharge summary here.

Postnatal discharge summary

Discharged from .....

To (address) ..... ✆ .....

GP ..... at ..... ✆ .....

Obstetrician ..... Midwife ..... Paediatrician .....

Labour, birth and postnatal period ☐ Gravida ☐ Para

Onset of labour ☐ Spontaneous ☐ Induced: indication .....

Mode of delivery ..... on ..... day ...../...../..... at ..... Sex .....

Indication ..... Presentation ..... Location .....

Livebirth/Stillbirth Gestation ..... Birthweight ..... g Blood loss ..... mls

APGARs ☐ 1minute ☐ 5 minutes ☐ 10 minutes Placenta/membranes .....

Perineum/abdominal wound ..... Sutures .....

Haemoglobin ..... g/dl on ...../...../..... Repeat ☐ Not needed ☐ done due on ...../...../.....

Blood group ..... anti-D needed ☐ No ☐ Yes anti-D given on ...../...../.....

Rubella status ..... Vaccination needed ☐ No ☐ Yes Vaccinated on ...../...../.....

Contraception/sexual health needs discussed ☐ No ☐ Yes

Details .....

.....

.....

Cervical smear due ☐ No ☐ Yes: due in ..... (month) 20 .....

Discharge medication ☐ No ☐ Yes: details .....

Postnatal check with ..... Arranged for ...../...../..... Mother to arrange ☐

Problems identified during pregnancy, labour/birth

.....

.....

.....

.....

.....

.....

Problems in the postnatal period/referrals, investigations or results pending

.....

.....

.....

.....

.....

.....

Summary completed by (Print name) ..... Date ...../...../.....

Signed ..... Designation .....

Your progress

Postnatal day	Date/ time use 24 hour clock	General wellbeing and pain assessment	Mobility, exercise and preventing blood clots	Breasts	Fundus	Blood loss	Perineum/ abdominal wound	Passing urine, bowels and pelvic floor	Plan of care	Signed
		T 36.3 P80 BP 120/80	Revised postnatal thrombosis risk	tender Nipple soft	Abdo soft	Reducing	Healing well intact.	PU BO	1/7. V. Fraser.	
5	10.9.12 1500	Mood - fragile at times. Appetite good Sleeping when able.	very puffy	difficulty latching not latching reported. Starting to fill.					Pain well managed.	
6	11.9.12 12.55	T 35.6. P72. Supported Mood stable. Adjusting as a family	puffy. No pain.	Difficulty Abdo reluctant to feed soft Feeds well Formula O/N Feeding Advice re breast care		Minimal	Healing Major - advice re bathing	PU BO	1/7 Redness wound. V. Fraser	
7		Phone Call.								
8	13.9.12 13.10	T 36.06 P80. BP 130/96 Just does not feel right may have done too much yesterday - resting Sleeping Eating OK Mood - stable, has family support	No pain oedema	leaking Abdo soft chaf - will contact GP Nor Formula feeding	Fundus	Red Increased. No clots. small offensive smell.	Staphey Cannulae - areas both sides and thigh/ smell. Red along wound.	PU BO - using lactulose for analgesia	Chat with GP. - Wound swab Consider antx. V. Fraser	

Your progress

Postnatal day	Date/ time use 24 hour clock	General wellbeing and pain assessment	Mobility, exercise and preventing blood clots	Breasts	Fundus	Blood loss	Perineum/ abdominal wound	Passing urine, bowels and pelvic floor	Plan of care	Signed
		T 35 P 80 BP 136/90	Revised postnatal thrombosis risk	Hdy but after	Abdo Soft	Nil	Stinging slight swell. Mainly tender areached.	PU	Adequate analgesia. Take rest and help from family. V. Rader.	
9.	14.9.12 14.00	Wanted on Augmentin x7days. Mood stable. Advised Hygeine								
							BD bathing loose clothing advised Good diet for healing.		M/W 2/7 Wound+BP check.	
(11)	16/9 15.30	Appetite & fluids good Still very tired feeding during night. Continually sleepy T 36.3 P 80 BP 140/90.	Lgs NAD No oedema.	Soft	Abdo soft.	Clots x 2 No clots Not offensive.	Wound still moist & some skin edges not quite together.	PU Catheterised Loochia.	Review 2/7	P. Lovelock
(13)	18/9/12	feels okay mood low - tired appetite - fair 80 133/93	legs NAD	Soft	Abdo Soft	Scant	Wound still moist	PU BO	3/7	M Cuffley
16	21/9/12	feels tired mood so so appetite improving 36' 84 135/80	legs NAD	Soft	Abdo Soft	Serosa Scant	Wound moist offensive	PU BO	3/7	M Cuffley

Your progress

Postnatal day	Date/ time use 24 hour clock	General wellbeing and pain assessment	Mobility, exercise and preventing blood clots Revised postnatal thrombosis risk	Breasts	Fundus	Blood loss	Perineum/ abdominal wound	Passing urine, bowels and pelvic floor	Plan of care	Signed
19	24.9.12	Wound pain resolved, healing well.							Discharged V. Kaler	

Your postnatal care

Date/time	Further information/planning, delivering and evaluating postnatal care
21/9/12	Wound Swab – awaited – now on metronidazole. Wound appears St inflammed but not broken down Mum advised re seek balls for visit on Monday for wound check M Effely

Date/time	Further information/planning, delivering and evaluating postnatal care

Feeling confident with your baby

Whether you are a first time parent, or if you have experience of looking after new babies, there may be things that you want to discuss and practice with maternity care staff. The list below can be used as a starting point to ensure that you feel confident meeting your baby's needs. Please sign off the items when you feel ready. Remember there can be lots to learn, and it can be quite normal for this to take a while.

Don't forget that your 'Ready, Steady, Baby!' book contains useful advice and information that you and your partner/supporter can refer to.

	Discussed/demonstration Date/signed (staff)	I feel confident Date/signed (mum/partner)
Handling my baby safely	...../...../.....	...../...../.....
Choosing nappies for my baby	...../...../.....	...../...../.....
Changing my baby's nappies	...../...../.....	...../...../.....
Caring for my baby's cord	...../...../.....	...../...../.....
A 'top and tail' wash/caring for my baby's skin	...../...../.....	...../...../.....
Bathing my baby	...../...../.....	...../...../.....
How to reduce the risk of cot death	...../...../.....	...../...../.....
Signs that my baby is well	...../...../.....	...../...../.....
Signs that my baby may be ill	...../...../.....	...../...../.....
Car safety and home safety	...../...../.....	...../...../.....
Registering the birth/registering with a General Practitioner	...../...../.....	...../...../.....

Other things I want to ask about: .....

.....

.....

.....

.....

.....

.....

.....

Information for you (indicate when received) ☐ ...../...../.....

Do you still have your copy of 'Ready, Steady, Baby!' ☐ No ☐ Yes ☐ ...../...../.....

☐ ...../...../..... ☐ ...../...../.....

☐ ...../...../..... ☐ ...../...../.....

Please remember that same health advice changes over time. Friends and relatives may be unaware of new guidance about preventing cot death. Please share your information with them to help keep your baby safe.

Breastfeeding your baby

Breastfeeding your baby may be a new experience for you, or you may already have skills and confidence. This section contains items for discussion, observation and support as you breastfeed your baby. Your midwife and maternity care team will support you. When you and your midwife feel you are confident with the items, you can then sign them off to mark your progress.

Your copy of 'Off to a Good Start: All you Need to Know about Breastfeeding your Baby' provides sound advice that you and your partner can refer to. Please let your midwife know if you need another copy.

	Discussed/demonstration Date/signed (staff)	I feel confident Date/signed (mum/partner)
Positioning myself for breastfeeding	...../...../.....	...../...../.....
Positioning my baby for breastfeeding	...../...../.....	...../...../.....
Principles of good attachment	...../...../.....	...../...../.....
How to recognise that my baby is feeding well	...../...../.....	...../...../.....
My baby's feeding and sleeping patterns for the first few days	...../...../.....	...../...../.....
'Baby led' feeding	...../...../.....	...../...../.....
When my milk 'comes in'	...../...../.....	...../...../.....
Rooming in at the maternity unit	...../...../.....	...../...../.....
Sharing a bed with my baby - the risks discussed	...../...../.....	...../...../.....
Winding my baby	...../...../.....	...../...../.....
My baby's needs (exclusive breastmilk for around the first six months of life)	...../...../.....	...../...../.....
Why dummies or teats should not be used	...../...../.....	...../...../.....
How to hand express my breastmilk		
Expressing breastmilk a) sterilising equipment	...../...../.....	...../...../.....
b) safe storage	...../...../.....	...../...../.....
Signs that my baby is feeding well and thriving	...../...../.....	...../...../.....
Breastfeeding support in my community	...../...../.....	...../...../.....

Other things that I want to ask about: .....

.....

.....

.....

Bottle feeding your baby

As with general baby care, you may already be skilled in making up formula feeds and bottle feeding your newborn baby, or it may be a new challenge. Your midwife and maternity care team will support you. The list below can be used to check that you feel confident bottle feeding your baby. Please sign off the items when you feel ready.

	Discussed/demonstration Date/signed (staff)	I feel confident Date/signed (mum/partner)
Using bottled milk/disposable teats in the maternity unit	...../...../.....	...../...../.....
The importance of good hand hygiene	...../...../.....	...../...../.....
Sterilising equipment	...../...../.....	...../...../.....
Making up a formula feed correctly and safely (always following the manufacturer's instructions)	...../...../.....	...../...../.....
Giving a bottle feed correctly and safely	...../...../.....	...../...../.....
Winding my baby	...../...../.....	...../...../.....
My baby's feeding and sleeping patterns for the first few days	...../...../.....	...../...../.....
'Baby led' feeding	...../...../.....	...../...../.....
'Rooming in' at the maternity unit	...../...../.....	...../...../.....
Sharing a bed with my baby - the risks discussed	...../...../.....	...../...../.....
Choosing the right type of milk for my new baby (whey based)	...../...../.....	...../...../.....
Signs that my baby is feeding well and thriving	...../...../.....	...../...../.....

Other things about feeding that I want to ask about: .....

Your questions or concerns

Being a parent with a new baby can be challenging and exciting, but also tiring and stressful. The following section is for you to write in. Please jot down anything that you or your partner wish to discuss with your midwife/the maternity team caring for you. Here are some suggestions:

How I feel I am coping

My mood and emotions

How I feel I am doing as a parent

Not liking my baby at the moment

Difficulties with my baby's feeding

Managing my tiredness

Questions about my baby

Coping with my baby's crying

My anxieties

Relationships with my family

Thinking about your pregnancy, labour and birth

Pregnancy, labour, birth and the time afterwards are unique experiences. They can have a powerful effect on how you feel and your relationships with your baby, partner, family and your maternity care team.

Your midwife will ask you about your experiences in the early days following the birth. You may have questions that you want to ask or issues to discuss – or you may not. You may find it helpful to think about your experiences of maternity care so far, and discuss events with your partner or the person supporting you. Please use the space below to jot down any questions or issues to discuss.

Please remember that you can talk to any member of your maternity care team (such as your midwife, General Practitioner or obstetrician) about your experiences *at any time after the birth*. Some women wish to do this a few weeks, or even many months after the birth, or if they are thinking about becoming pregnant again.

Your health after the birth

Blood tests/other tests and results				
Date	Time	Investigation	Indication	Result/actions

Discharge from midwifery care

Date 24/9/12 Days postnatal 19 Assessed by V. Rader

Special features identified (please sign and date each entry)

BP 135/80

General wellbeing and mental health

Current smoker? ☐ No ☑ Yes ..... /day

Risk of passive smoking to baby explained? ☐ No ☐ Yes

	Any problems		Details
Passing urine	☑ No	☐ Yes	
Pelvic floor	☑ No	☐ Yes	
Bowel function	☑ No	☐ Yes	
Breasts	☑ No	☐ Yes	
Perineum/abdomen	☑ No	☐ Yes	
Lochia/menstruation	☑ No	☐ Yes	
Cervical smear due	☑ No	☐ Yes	

Contraception and sexual health

Not in a relationship but aware of fertility

Concerns

Handover to health visitor completed ☐ No ☑ Yes Details .....

Six-week follow-up appointment discussed/arranged ☐ No ☐ Yes Details .....

Signed V. Rader Print name V. RADER Designation CM

Whose signature?

Whenever anyone writes in this record for the first time, they should fill in their details below.

Name (please print)	Signature	Job title
V. RABEK	V. Rabek	C/M
P LICKSTOD	P Lickstod	CM
M CEFFOLA	M Ceffola	C/M SR

Mental Health Mother and Baby Unit
St John's Hospital at Howden
Howden Road West
LIVINGSTON EH54 6PP

Dr A McNutt
Bathgate Primary Care Centre
Bathgate
West Lothian

Date: 25/05/2012
CHI No: 2305821425
Enquiries to: Janice McDowell
Extension: 54176
Direct Line: 01506 524176

Perinatal Mental Health Service

Dear Dr Andrew McNutt,

RE: Gillian McAteer. 18 Cherry Avenue, Bathgate, EH48 1NA.
DOB: 23/05/1982

Your patient was referred to the Perinatal Mental Health Service regarding her possible need for input from our team.

We have discussed her case at our referrals meeting and based on the information we have received the referral is not appropriate for our team. A more detailed email should have already been received explaining the reasons for this. If you have not received the email or wish to discuss further please contact me on the above number.

Yours sincerely

Fiona Murray
Consultant Psychiatrist
Perinatal Mental Health Service

Copies

Vanda Fraser
Bathgate Primary Care centre
Bathgate
West Lothian

Yvonne Smith, Health Visitor
Bathgate Primary care Centre
Bathgate
West Lothian

EARLY PREGNANCY UNIT (E.P.U.)

McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 RW Holden
800325165E F 23/05/1982
McAteer, Gillian

Tel. No:

G.P.:
Dr Holden,
Simpson Medical Group
Bathgate Primary Centr.

Tel. No:

Unit No:

DOB:

Consultant: PD.

Former Surname:

Previous Attendance at SJH/BGH Y/N

Booked – G.P. Y/N M/W Y/N Hosp Y/N

Admitted to E.P.U. Date: 31/1/12 Time: 1350.

LMP: 25/11/11. Gestation: 9+. Medication: None

P.O.H.: 2+0 - SVD. Allergies: NKDA.,

Referral from A+E Smokes 10 day. Aware of stop for life.

History: Some slight P.V loss yesterday like the start of a period with slight discomfort. Appeared to have settled this morning but whilst at work had gush of fresh blood & now on wiping. Some lower abdo. crampy discomfort.

Temp: 35.9 Pulse: 82 BP: 146/92. Has USS appt. from EPU tomorrow @ 10°° SHO asked to review.

Scan Result:–

Bloods taken:–

Bloods Group
Confirmed by Sample/Prev notes/Patient held card/other

FBC Hb= W.B.C= Plts=
BHCG

Anti D required: Y/N

Batch No:
Expiry Date:

Speculum Examination:–

HVS + Chlamydia swab taken.

Findings:

Diagnosis:–

DATE

3/1/12 GYNAE

14:15.

~~had phoned yesterday re PV bleeding and US had been arranged for 1/2/12 @ 10:00.~~

29 ♀ POVO 2+0 9+3.
x SVD.

PC: PV bleeding

HPC: - 2/7 intermittent fresh red PV bleeding - changed pad x3. stopped this morning
- At work this am when felt 'gush' PV ⇒ went to toilet - fresh red blood in pants not in pan. ∅ clots.
- still c/o some small amounts fresh red PV bleed on wiping. Not soaking through HOH never had to change clothes.
- 1/7 hx LOA abdo pain, crampy. Not ↑ in severity ∅ analgesia taken. ∅ exacerbating or relieving factors.
- ∅ urinary sx. Prone to constipation (not new)

PMH: nil. ? bowel blockage as a child

DH: nil. NKDA.

SH: smoker 10 cpd.

FH: Nil known.

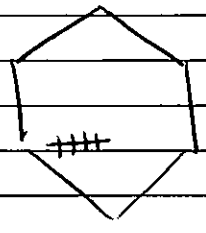
SMEAR: UTD. x1 abnormal smear - on 6/12 surveillance

SYSTEMS: nil.

O/E:

obs as documented. Note slight ↑ BP.

WLOP CRT < 2 sec moist mucous membranes.



Abdo very soft.
Non tender
BS present + (N).

speculum (with saline) - nil blood or old blood visible, healthy appearance to vulva, healthy but lax vaginal walls, closed cervical os, no blood in speculum.

Imp: Threatened miscarriage

PLAN: → HVS
→ for US tomorrow as planned
→ discharge (H) but advised to contact if any ↑ bleeding or worsening abdo pain

JOHNSON GPST 3555.

WLT 467

CONTINUATION SHEET

Date and Time	Name and Address	Signature and Designation
	18 Cherry Avenue, Bathgate, West Lothian, EH48 1NA	
	CHI 2305821425	
	78132 RW Holden	
	800325165E F 23/05/1982	
	McAteer, Gillian 18 Cherry Avenue,	
1/2/12	- Returned to EPU today for USS - PV loss and abdo cramps	
	Setting.	J Mpherson s/m
	USS Results:-	M PHERSON
	G-S ✓ Y-S ✓ 22mm F.P ✓ = 8w 5d	
	FLT	

	CONTINUATION SHEET	
Date and Time	Name No.	Signature and Designation

Emergency Medicine
NHS LOTHIAN UNIVERSITY HOSPITALS DIVISION

ST. JOHN'S HOSPITAL
Howden Road West
Livingston
EH54 6PP Tel: 01506 523000

NHS Lothian

A/E no. E2142901
Previous no. E2066076
UHPI no. 800325165E
CHI no. 2305821425

PATIENT INFORMATION

Surname McAteer
Forenames Gillian
Date of Birth 23/05/1982
Age 29 Yrs Sex F

Address 18 Cherry Avenue
Bathgate
West Lothian
Posteode EH48 1NA
Telephone 07708534279

Contact Address [redacted]

Complaint pv bleed/10 wks preg
Allergies NKDA.

Attendances in last 12 months: 1
School:

General Practitioner

Name
RW Holden
Address
Simpson Medical Group
Bathgate Primary Care Centr
EH48 2SS
Telephone 01506 654444

Date and Time of Attendanee
31/01/2012 13:24
Incident Date & Time: 30/01/2012
Mode of Arrival
Private Transport
Source of Referral
Self Referral to A&E

T	P	RR	BP	BM	SpO2	PEFR	Height	Weight	Alco
35.9	82	16.	146/92		100% RA.				

Initial Assessment 10weeks pregnant - had PV bleed 2/7 ago - bleeding stopped but has began again today. lower abdomnal cramps. Due to see EPU for early scan tomorrow.

Signature EDOD
Time 13:30
LMP 25/11/12
Print Name GP FY1.
Triage Cat. 3.

Urinalyis	Leuc	Nit	Blood	Protein	Glucose	Ketones	SG	PH

Clinical Notes

3rd pregnancy (has 2 children).

Time seen	
Alcohol	
Investigations	
Procedures	
Drugs given in Dept.	
Diagnosis	

Diagnosis

Name (print) Signature

14/9/12

To have Bloods 4/52.

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

NHS Lothian

PX LH.

14/9. – 11.40AM.
07708 534 279.
Left message on mobile to call us (CH)

Department of Obstetrics and Gynaecology

Dr Holden
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created 09/09/2012
Date Authorised
Date/Time Printed 09/09/2012 11:28
Our Ref 800325165E
CHI 2305821425

Patient: Gillian McAteer
18 Cherry Avenue
Bathgate
EH48 1NA

UHPI: 800325165E
Date of Birth: 23/05/1982

Ward: Ward 11 SJH

Admission Date: 05/09/2012

Consultant: Dr TK Cooper

Discharge Date: 09/09/2012

Discharge Medication	Dose	Frequency	Duration	Additional Info
Paracetamol Caplets	1000 MG	FOUR times daily	Short Term	32 tabs given.
Ferrous Sulphate Tablets	200 MG	THREE times DAILY	6 Weeks	100 tabs given
Diclofenac Sodium E/C Tablets	50 MG	THREE times DAILY	Short Term	28 tabs given
Lactulose Solution	10 ML	TWICE DAILY	Short Term	300mls given
Dihydrocodeine Tablets	30 MG	As Required	Short Term	30-60mg every 4-6 hours as required 15 tabs given

Dr P J Dewart (Consultant)
Dr T Narrainen-Poule (Consultant)
Secretary Mrs Meal
Tel: 01506 523988

Dr T K Cooper (Consultant)
Dr S Kallat (Consultant)
Secretary Miss Thompson
Tel: 01506 523996

Dr S C Nicholson (Consultant)
Dr A J MacLeod (Consultant)
Secretary Yvonne Scott
Tel: 01506 523984

Dr S M Rane (Consultant)
Dr T Narrainen-Poule (Consultant)
Secretary Mrs Wharram
Tel: 01506 523990

Dr S M Coutts (Consultant)
Dr GA Walker (Consultant)
Dr S J Court (Associate Specialist)
Secretary Miss Ann Reid
Tel: 01506 523997

Prescribed By ..... **Date** ..... **Print Name**.....
Dispensed By ..... **Date** ..... **Print Name**.....
Pharmacist Check ..... **Date** ..... **Print Name**.....
Final Check ..... **Date** ..... **Print Name**.....

PRINCIPAL DIAGNOSIS/PROCEDURE
1. EMLUSC for Placental Abruption 05/09/12

TREATMENT
Attended A+E with significant PV bleed. Taken to theatre for an emergency C-section, 200ml retroplacental blood clot identified. Bloods loss 1000ml. Delivered a live female infant. Post-op period uneventful. Hb 95 so started on iron replacement, GP to kindly recheck FBC in 4 weeks.

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL
Nil

13 SEP 2012

Hospital Copy Please Do Not Remove

800325165E McAteer Gillian EDD 04/09/2012 30 Years Current Gestation Parity 2 + 0 Ca Pr

Micro, C&S SJH

Summary

```
Micro,Culture \T\ Sensitivitie Specimen Type : Wound Swab Caesarian section
Micro,Culture \T\ Sensitivitie Micro,Culture & Sensitivities
                               . Large numbers of Anaerobes isolated
                                 Sensitive : Metronidazole.
```

prescribed by D. Black

Start Date 15/09/2012

Result Date 15/09/2012

Flagged

Order result

Read Date 20/09/2012

Read Time 16:10

Test Set Comments

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

NHS Lothian

Department of Obstetrics and Gynaecology

Dr Holden
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created 25/09/2012
Date Authorised
Date/Time Printed 25/09/2012 09:01
Our Ref 800325165E
CHI 2305821425

Patient: Gillian McAteer
18 Cherry Avenue
Bathgate
EH48 1NA

UHPI: 800325165E
Date of Birth: 23/05/1982

Ward: Ward 11 SJH

Admission Date: 05/09/2012

Consultant: Dr TK Cooper

Discharge Date: 09/09/2012

Dr P J Dewart (Consultant)
Dr T Narrainen-Poule (Consultant)
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Dr GA Walker (Consultant)
Dr S J Court (Associate Specialist)
Secretary Miss Ann Reid
Tel: 01506 523997

Inpatient Discharge Summary

Discharge Medication	Dose	Frequency	Duration	Additional Info
Paracetamol Caplets	1000 MG	FOUR times daily	Short Term	32 tabs given.
Ferrous Sulphate Tablets	200 MG	THREE times DAILY	6 Weeks	100 tabs given
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Dihydrocodeine Tablets	30 MG	As Required	Short Term	30-60mg every 4-6 hours as required 15 tabs given

Prescribed By ..... **Date** ..... **Print Name**.....
Dispensed By ..... **Date** ..... **Print Name**.....
Pharmacist Check ..... **Date** ..... **Print Name**.....
Final Check ..... **Date** ..... **Print Name**.....

This para 2 presented to A & E at term with a significant antepartum haemorrhage. This was felt to be a placental abruption. She was transferred immediately to the Labour ward and foetal heart decelerations were noted so emergency caesarean section was carried out under general anaesthesia. Baby was a girl weighing 2.72kg in good condition and there was a confirmed retroplacental clot. Total estimated blood loss was in the region of 1 litre.

she would be suitable for a trial of labour in a subsequent pregnancy.

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

NHS Lothian

Yours sincerely

DR T K COOPER
CONSULTANT GYNAECOLOGIST

Inpatient Discharge Summary

Named Midwife Vanda Tel 01506 651828

Visit)	Gestation	Type of Appointment	Clinic	What to Expect	Date
1	8 - < 12	Booking	Midwife	Maternal history	20.1.12.
	12	Scan	Hospital	Confirm EDD NT screening if wishing	20.2.12
2	16-18	Antenatal Clinic	Midwife	Discuss Results Guide to Fetal Movement and Parentcraft class info	15.3.12. 12.4.12 @ 2pm
12.4.12	18-22	Scan	Hospital	FAS if wished	13.4.12 @ 3.25
3	22-25	Antenatal Clinic	Midwife	Mat B1 given BF DVD	17.5.12 @ 2pm
4	28	Antenatal Clinic	Midwife	Routine bloods offered	14.6.12 @ 4pm
5	32	Antenatal Clinic	Midwife	Routine antenatal checks	9.7. @ 11.20
6	35/36	Antenatal Clinic	Midwife	Routine antenatal checks Weight and Newborn Screening	9.8.12 @ 1140
7	37/38	Antenatal Clinic	Midwife	Routine antenatal checks	23.8.12 @ 13.40
8	39/40	Antenatal Clinic	Midwife	Routine antenatal checks	6.9.12 @ 13.40.
9	40	Antenatal Clinic	Midwife	Routine antenatol checks – offer membrane sweep info given on I.O.L.	
10	41	Antenatal Clinic	Midwife	Routine antenatal checks – offer membrane sweep arrange I.O.L.	

NHS Lothian - Antenatal Appointment Record

NHS Lothian

		Feeling lots of pressure, has had some PV discharge, not offensive or itchy. Small spot of blood when wiping today. To contact SJH if any concerns, fresh bleeding. Advised optimum positioning, ? OP at present. Baby is active.	

Future Appointments

06/09/2012
13:40
ANC Bathgate HC Simpson
Medical Practice

Most women will begin to feel fetal movements between 18 and 24 weeks. You should be aware of fetal movements up to and including the onset of labour and should report if movements decrease or stop to the maternity unit as soon as possible. Do not wait until the next day to seek help.

NHS Lothian - Antenatal Appointment Record

Name: Gillian McAteer
CHI: 2305821425
UHPI: 800325165E Age: 30 Parity: 2 + 0 EDD: 04/09/2012 Blood Gp: O Rh Positive

Comments

Appointment Date / Time	Appointment Type	Comments	Plan of Care
20/01/2012 11:02	Antenatal Check	Booking bloods with consent. Wishes NT screening and FA scan. Has nausea and breast tenderness. Sleep disturbed, tired, emotional. Constipation, has lactulose. Discussed smoking cessation, has reduced to 10 daily.	MW 8/52
15/03/2012 14:57	Antenatal Check	Aware of flutters. Difficulty coping at home. See maternity summary.	MW4/52
12/04/2012 14:38	Antenatal Check	Has carpal tunnel syndrome. Feels discomfort also over upper arms. Information and advice given. Aware of some flutters. In touch leaflet given. All results filed. Double appointment booked to allow time for discussion. Home life now more settled, Gillian feeling able for coping. Has support of mum and ex partner. Follow up appointment with GP due and Gillian will make this in the next 2/52. Mood stable. Has thrush, prescription requested from GP	MW 5/52
17/05/2012 14:22	Antenatal Check	Gillian feels that she is puffy fingered and her feet too. Felt her face also puffy at the weekend. Headaches random and alleviated by paracetomol. BP today normal, no proteinurea. Weight gain good and encouraged. Chat re diet again, cutting down smoking. Tired, work is physical. Not taking any alcohol. Continue support and monitoring. Suggest eye test.	MW 4/52
14/06/2012 16:23	Antenatal Check	Routine bloods for Hb and antibody screen. Off work just now, feels headaches less since having time off. Has 2 further weeks to work following which holidays and maternity leave. Baby is active.	MW 5/52
19/07/2012 11:51	Antenatal Check	Recent appt. with GP concerns re yellowness in eyes but settled today. Bloods were taken and result normal. Hb still 109 so self treating. Backache just above pelvis, simple analgesia and comfort measures. Baby is active.	MW 3/52
09/08/2012 14:05	Antenatal Check	Has been moving less today. One good kick this morning and at palpation further kick felt by mum. Chat about expected movements and also in touch advice. Further discussion around any concerns and has support network in place. No post natal concerns, more anxious about labour. Previous difficult deliveries, keen for epidural.	MW 2/52
23/08/2012 13:51	Antenatal Check	Still anxious about labour. Went late with previous labours. Offered sweep at term. Stable mood and all settled at home. No concerns.	MW 2/52, Offer sweep

Most women will begin to feel fetal movements between 18 and 24 weeks. You should be aware of fetal movements up to and including the onset of labour and should report if movements decrease or stop to the maternity unit as soon as possible. Do not wait until the next day to seek help.

NHS Lothian - Antenatal Appointment Record

Name: Gillian McAteer
CHI: 2305821425
UHPI: 800325165E Age: 30 Parity: 2 + 0 EDD: 04/09/2012 Blood Gp: O Rh Positive

Appt Date/Time	20/01/2012 11:02	15/03/2012 14:57	12/04/2012 14:38	17/05/2012 14:22	14/06/2012 16:23	19/07/2012 11:51	09/08/2012 14:05	23/08/2012 13:51
Type of Appt	Antenatal Check	Antenatal Check	Antenatal Check	Antenatal Check	Antenatal Check	Antenatal Check	Antenatal Check	Antenatal Check
Gestation	7.3	15.2	19.2	24.2	28.2	33.2	36.2	38.2
Blood Pressure	100/70	130/60	106/70	104/68	120/60	105/70	110/62	120/70
Urinalysis		NAD		NAD	NAD	NAD	NAD	NAD
Oedema			fingers/hands	fingers/hands ankles	fingers/hands	fingers/hands ankles		ankles
Fundal Height	not checked	19	21	27	32	35	37	39
Lie						Longitudinal	Longitudinal	Longitudinal
Presentation					Breech		Cephalic	Cephalic
Fifths Palpable							3/5ths	3/5ths
Fetal Heart Rate		152	152	148	140	140	144	140
Fetal Movement Felt	Too early	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Visual Disturbance								
Headaches								
Epigastric Pain								
Biophysical Profile Score								
Membranes								
CTG								
VE								
Referred By								
Reason For Referral								

Most women will begin to feel fetal movements between 18 and 24 weeks. You should be aware of fetal movements up to and including the onset of labour and should report if movements decrease or stop to the maternity unit as soon as possible. Do not wait until the next day to seek help.

Name: Gillian McAteer CHI: 2305821425	**NHS Lothian-Maternity Handheld Record** LUHD Pregnancy Booking Record	NHS Lothian

UHPI: 800325165E | Age: 29 | Parity: 2+0 | EDD: 01 Sep 2012 | Blood Gp: O Pos

This is your Pregnancy Record. It contains important information that will be used to help you and your maternity care team plan care for you and your baby. You will usually be asked to carry your record during your pregnancy, as this will help communication between you and your maternity care team.

Some women may prefer not to carry their Pregnancy Record. If you do not want to carry your record, please tell your midwife. Your midwife will arrange to hold your record for you, or for it to be kept at the maternity unit or your GP practice.

Please keep your Pregnancy Record safe, confidential and protect it from damage. If you lose your Pregnancy Record, please contact your midwife or maternity unit as soon as possible.

Please remember to take your record with you to all health appointments during your pregnancy. For example, whenever you see your midwife, GP, obstetrician, physiotherapist or when you go for an ultrasound scan. Nearer the time when your baby is due, you may want to carry your Pregnancy Record with you when you go out and about.

Your Pregnancy Record remains the property of your NHS Board. At the end of your maternity care it will be returned to the NHS Board where it will be stored safely. If you would like a copy of your completed record, please speak to your midwife or contact the data controller of the NHS Board responsible for your care. (There may be a small charge for this.)

Details about how your personal information is used by staff within NHSScotland can be found in the leaflet 'Protecting Personal Information'. This is available from your midwife, GP practice or on-line at <http://www.show.scot.nhs.uk/confidentiality> (see under 'patient guidance').

Help and advice: Please use the following services: West Lothian 3 - ~~01501 730 339~~

Contact Details

Maternity Unit: Tel:	St John's Hospital at Howden 0131 536 2009	**Named Midwife:** **Midwifery Team:**	Vanda Fraser West Lothian 3 - ~~01501 730 339~~
Antenatal Clinic: Tel:	St John's Hospital at Howden 0131 536 2009	**General Practitioner:**	RW Holden
Delivery Suite: Tel:	St John's Hospital at Howden 0131 536 2009	**Address:**	Simpson Medical Group, Bathgate Primary Care Centre, Whitburn Road, Bathgate,Bathgate,EH48 2SS
Ultrasound Dept: Tel:	St John's Hospital at Howden 0131 242 2801	Tel: Practice Code	01506 654444 78132/1
Health Visitor: **Base:** Tel:		**Obstetrician:** **Base:** Tel:	M/W Vanda S Fraser St John's Hospital at Howden 0131 536 2009
Social Worker Contact Details			

Domestic Abuse Helpline (10am-10pm, 7 days a week) 0800 027 1234
Scottish Women's Aid 0131 475 2372

Local Information
Your Midwife or doctor will write details of local services below, e.g. antenatal clinic times, breastfeeding support groups and antenatal education sessions.

Please note that supervised students may be learning alongside the maternity staff who care for you. If you have any concerns or preferences about this, please speak to your midwife

Important Information

Surname / family name:	McAteer
First name:	Gillian
Previous Name:	
Likes to be called:	
Date of Birth:	23 May 1982
Your address:	18 Cherry Avenue, Bathgate, West Lothian, EH48 1NA
Home tel:	
Other tel:	, 07708534279
Occupation:	Catering assistant - TESCO
Planned place of birth:	Consultant Unit
Lead Professional:	Midwife

Your Partner/Supporter for this pregnancy

Name:	[redacted]
Occupation:	
Relationship to you:	
Partners date of birth:	
Address:	
Home tel:	
Other tel:	

Emergency contact person/next of Kin (if not your partner/supporter).
Who would you like contacted in an emergency

Name:	[redacted]
Relationship to you:	
Address:	
Home tel:	
Other tel:	

When is your baby due? - Your "Estimated Date of Delivery" or EDD
This information is used to work out when your baby is due. This is called your estimated date of delivery (EDD). It is helpful to think of your EDD as a "rough guide". Most babies are born during the fortnight before, or the fortnight after your EDD.

Agreed EDD:	01 Sep 2012
Date of the first day of bleeding of your last menstrual period (LMP):	25 Nov 2011
How sure are you of this date:	Certain
Average number of days between the first day of each period (monthly cycle):	28
Comments	
Have you had any vaginal bleeding since your last menstrual period:	No
Had you been using any contraception:	Yes
Type:	IUCD in situ N
[redacted] Stopped:	01 Aug 2011
Provisional EDD based on LMP and monthly cycle:	01 Aug 2012
EDD using dating scan:	
Agreed by:	Vanda S Fraser

Your previous pregnancies
Is Current Pregnancy with a New Partner? Yes Parity: 2+0

Pregnancy 1

Full Name	[redacted]		
Sex	Female	Date of birth	09 May 2003
Birth Weight	2870	Gestation	42
Type of Birth	Spontaneous Vertex Delivery	Place of Birth	SJH
		Outcome of Pregnancy	Livebirth
Labour Onset	Induction	Anaesthetic	Epidural
[redacted]	Normal		
Complications		Perineum	
Breast	Yes	Bottle	Yes

Comments: Uncomplicated pregnancy. Some postnatal depression, no treatment. Support from HV

Pregnancy 2

Full Name	[redacted]	Date of birth	19 Oct 2004
Sex	Female		
Birth Weight	3400	Gestation	42
Type of Birth	Spontaneous Vertex Delivery	Place of Birth	SJH
		Outcome of Pregnancy	Livebirth
Labour Onset	Induction	Anaesthetic	Epidural
Any Complications	Normal	Perineum	
Breast	Yes	Bottle	Yes

Comments: Uncomplicated pregnancy. Some postnatal depression but no treatment.

Your health (inc Mental Health)

Allergies:

	Description	Inactive
Diseases/Operations	Varicella without complication	Y
Details		
Diseases/Operations	Cervix	N
Details	2009 Treatment to cervix - follow up clear. Now on annual review.	
Diseases/Operations	Personal history of major surgery	N
Details	Bowel surgery as a baby - large abdominal scar just above umbilicus	
Diseases/Operations	Depressive episode	Y
Details	Post natal depression following both daughter's birth - No medication, support from HV	

Anaesthetic Risk

Have you ever had a general anaesthetic	Yes
Previous difficult intubation	No
Sensitivity to anaesthetic drugs	No
Family/personal history of Suxamethonium apnoea or malignant hyperpyrexia	No
Abnormal spinal, neck or facial anatomy	No
Weight> 120kg	No

Other Health Related Questions

Have you been taking folic acid	Yes
Started	< 12weeks 400mcg
Date of your last cervical smear	July 2011
Comments	Colposcopy 2009
Next smear due	Postnatally, on annual review
Your body mass index (BMI)	34.1
Weight at booking	89.5
Height	1.62
Do you go to the dentist regularly	yes
How many units of alcohol a week are you drinking now	0
How many units of alcohol did you drink each week before you became pregnant?	22
Have the risks of drinking alcohol in pregnancy been explained to you?	Yes
Referral for advice on reduced drinking	
Have you smoked cigarettes in the past 12 months prior to pregnancy	Yes
Do you smoke now	Yes
Current smokers: cigarettes smoked per day	10
Former smoker: date stopped	
Are you exposed to cigarette smoke at home	
Have the risks of smoking in pregnancy been explained to you	Yes
Have you been offered advice on how to stop smoking	No
Referral made to smoking cessation service	
Are you currently, or have you used street drugs, gases or glues?	No
Have you ever used Oral drugs	No
Details	
Have you ever injected drugs	No
Details	
Does your current partner use any street drugs, gas or glue	Oral -
Details	IV -
CDPS Referral for advice on substance abuse	
Referral to Substance Misuse Midwife	
Health and safety Discussed	NOne, risk assessment done
Diet Discussed	Eats mixed diet
Thrombosis Risk	Low Risk

Family Health (inc. Mental health)

Disease/ Details	Asthma (Immediate family members)/ Daughter J[redacted] and Gilian's father
Do you have a close family member (parent or sibling) with a history of bipolar disorder (manic depression) or any other serious mental illness	No

Ethnic origin

The term ethnic origin is to describe where your family originates from, as distinct from where you were born. This information will help us to decide which blood screening tests you should be offered and whether your baby may need a BCG (TB) vaccination.

How do you describe your ethnic origin	White Scottish
How do you describe baby's father's ethnic origin	White Scottish
What language do you usually use at home	English
Do you need help with interpreting, communicating	No
What is your current religion or faith, if any	No Religious Affiliation
Is blood transfusion acceptable to you	Yes
Comments	
Female circumcision	No
Comments	
Is there any other information that you feel is important for your maternity care? For example your beliefs, social conventions and customs, family structure, ceremonies, dress or diet	
Are you a refugee or asylum seeker	No

Medication

Are you taking any medication prescribed to you by a doctor, or have you stopped any medication recently	Lactulose since pregnancy
Over the counter medications	

No Home circumstances and support needs

Blood tests and other tests

During your pregnancy you will be offered several blood tests to check on your health and your baby's health. Your midwife will give your information leaflets on many of these tests. Maternity care staff will discuss all the blood tests with you. When you are sure that you understand about the tests, you will be asked if you want to have them done or not, and your wishes will be followed. For some of the blood tests you will be asked to sign a consent form.

Maternity care staff will tell you how to find out the results of any tests that you have. They will also organize any follow up care that may be needed.

Results should be filed between the 'your notes and questions pages' near the back of the notes so that they do not obscure the 'Special Features' boxes. Computer print outs can be hold punched and tagged into the record or the 'mount sheet' can be used for smaller results.

Test	Date Taken	Date when test due
Blood group	20 Jan 2012	
Full blood count	20 Jan 2012	
Rubella status	20 Jan 2012	
Syphillis	20 Jan 2012	
Hepatitis B	20 Jan 2012	
HIV	20 Jan 2012	
Screening for Spina Bifida/Downs Syndrome		
Screening for Edwards Syndrome		
Antibody check	20 Jan 2012	20 Feb 2012
Random blood glucose	20 Jan 2012	
Haemoglobinopathy - sickle cell and thalassaemia		
Chlamydia (if under 25) Mid stream urine specimen for bacteriology	20 Jan 2012	
Which test decline, including reason		
Test Results - action	07708534279	

If you have Rhesus Negative blood

Has this been discussed / plans made	
Signed	Vanda S Fraser

COMMENTS	Advised to start pregnancy supplements.

Infant feeding - Antenatal checklist	Discussed
Benefits of breastfeeding to the baby (protects against gastro-enteritis and diarrhea, urinary tract infections, ear infections and chest infections; may also protect against allergies and diabetes)	Yes
Benefits of breastfeeding to the mother (protects against breast cancer, ovarian cancer and hip fractures in later life)	Yes
No other food or drink needed (for up to 6 months)	Yes
Importance of skin-to-skin contact after delivery (keeps baby warm and calm, promotes bonding, helps breastfeeding)	Yes
Importance of good positioning an attachment	Yes
Baby led feeding	Yes
Problems with using teats, dummies, nipple shields	Yes
Help will be available with feeds	Yes
Importance of rooming-in/keeping baby nearby	Yes
Baby's sleeping place	Yes

Information for you

Your midwife or doctor will give you the following leaflets, booklets and information

		Given
Leaflets given and discussed		Yes
Forms	FW8 Maternity Exemption form (your entitlement to free prescriptions during pregnancy and for one year after your baby is born)	Yes
	Mat B1 form (for an employer or the Benefits Agency confirming your estimated date of delivery. You can ask for this form from your 20th week of pregnancy)	No
Benefits and Entitlements	'A Guide to Maternity Benefits' N1 17A www.dwp.gov.uk	Yes
	'Pregnancy and work: what you need to know as an employee' www.dti.gov.uk	No
Blood tests in pregnancy	'A Guide to Routine Blood Tests Offered During Pregnancy'	Yes
	'A Guide to the Screening test for Spina Bifida and Down's Syndrome'	No
Pregnancy, babycare and breastfeeding	'Ready, Steady, Baby!'	Yes
	Information on wearing a car seat belt safely during pregnancy	No
	'Reduce the Risk of Cot Death' www.sidscotland.org.uk	No
	'Off to a Good Start: All you Need to Know about Breastfeeding your Baby'	Yes
	'Breastfeeding and Returning to Work' www.healthscotland.com	No
	'A Parent's Guide to Newborn Blood Spot screening'	No
	'Your Baby's Hearing screen'	No
	'BCG and your baby' www.healthscotland.com	No
	'Talking about postnatal depression' www.healthscotland.com	No
	'Smoking - giving up during pregnancy: A guide for pregnant women who want to stop smoking' www.healthscotland.com	Yes
Comments	Bounty Pack	

Your preferences for labour and the birth of your baby

Please use the section below to write down your preferences for labour and birth. Alternatively you may wish to attach your own birth plan here. Plans for labour and birth will be individual. They depend on your wishes, your health, your circumstances and what is available at your maternity unit or in your home. You will probably find it helpful to discuss these issues with your birth partner, your midwife, and/or members of your maternity care team during your pregnancy.

During labour, members of your maternity care team will read this section and discuss it with you so they understand your preferences. However you may need to keep an open mind if complications arise for you or your baby. If this happens, your midwife or doctor will discuss events with you and your birth partner. They will be able to inform you of your options in your particular circumstances.

How do I feel about labour and birth?
What are my expectations?

Who do I want with me during labour and birth?

My environment for labour and birth
Things I might want to consider: privacy, quiet, my own music, food and drink, lighting, comfort aids such as pillows, bean bags, chairs or a mattress.

If everything is straightforward, how do I want my baby's heartbeat to be monitored during labour?
e.g. at intervals with a hand-held 'doppler' or ear-trumpet (Pinard stethoscope).
Do I understand when continuous electronic monitoring of my baby's heartbeat may be advised?

How will I cope with pain?
Things I might want to try: relaxation and breathing, changing my position, massage, water (shower, bath or water pool), complementary therapies, a T.E.N.S. machine, 'gas and air', injection of a morphine-related drug or an epidural? (Note: an epidural service is not available in all maternity units and at all times).

Vaginal examinations to assess my progress during labour
My feelings about these are:

How would I like to give birth?
My position for birth - kneeling, standing, squatting or sitting upright ?
Discovering the sex of my baby - do I want to find this out for myself?
Would I like my placenta to be delivered with or without an injection? (An injection often helps to reduce bleeding).

After my baby's birth
(Note: skin-to-skin contact with your baby is usually encouraged straight after birth)
Would I like my baby to have Vitamin K?

Other questions or special requirements that I have

If you have given birth before, you may want to think about your experiences. Please write down anything you would like your midwife or other maternity staff to know.

Discussion of preferences for labour and birth/issues arising
(Maternity care staff - please sign and date all entries)

Signature: ..... **Date** ../../..

Preparing for birth - what to pack in your bag

Here are some suggestions for what to take to the maternity unit. Please remember to take your Pregnancy Record, as it is very important. If you are having a home birth, your midwife will discuss other things that you will need to prepare.

For the birth	After the birth	
• comfortable clothes • music • snacks and drinks • toiletries • phone numbers • phone cards or change • camera • • • •	• clothes/nightwear for you • underwear • maternity bra • sanitary towels • breast pads • • • • • •	• clothes for going home • baby clothes – sleep suits, vests, scratch mits, hats and shawl • nappies • • •
		Please note If you are travelling by car your baby will need a properly fitted car seat for all journeys.

LOTHIAN UNIVERSITY HOSPITALS NHS TRUST
MEDICAL MICROBIOLOGY SERVICES

Microbiology Laboratory, St. John's Hospital,
Howden West, LIVINGSTON EH54 6PP

PIN/CHI: 2305821425 /2305821425 **D.O.B:** 23/05/1982
Patient: MCATEER, GILLIAN **Sex:** Female

Tel: 01506 523075

Report to:
Midwife
Address: Bathgate, Simpson Med Pract.

Date Taken: 20/01/2012
Time Taken: u/k

Date Received: 20/01/2012
Time Received: 14:15

Date Reported: 23/01/2012

Clinical Details Received:
Health Centre Booking Sample

Lab. Ref. No.:JU191416K Spec.:Urine, ante-natal
☐Urine Micro Culture & Sens
Culture
No significant bacteriuria

MC

Authorised by : Internal review For Dr Karen F Macsween

LOTHIAN UNIVERSITY HOSPITALS NHS TRUST
MEDICAL MICROBIOLOGY SERVICES

Specialist Virology Centre
Royal Infirmary of Edinburgh, 51 Little France Crescent
Edinburgh EH16 4SA

PIN/CHI: 2305821425 /2305821425 **D.O.B:** 23/05/1982
Patient: MCATEER, GILLIAN **Sex:** Female

Tel: 0131 242 6004/6027
0131 242 6029/6048
Internal 26004/26029

Report to: Midwife

Address: Bathgate Primary Care Centre

Date Taken: 20/01/2012
Time Taken: u/k

Date Received: 20/01/2012
Time Received: 15:36

Date Reported: 23/01/2012

Laboratory Number: MS103832D Specimen: Clotted Blood

Hep B surface Ag qualitative 0.19 ✓
Hepatitis B surface Antigen : NEGATIVE ✓

HIV Ag/Ab COMBO: 0.08 ✓
HIV Antigen/Antibody COMBO assay: NEGATIVE (Index <0.9)

CMIA for Rubella IgG Antibody: 40.6 IU/mL
Rubella IgG Antibody : POSITIVE (>9.9 IU/mL) ✓
Rubella antibodies present : >=10 IU

Anti-Treponemal IgG Antibody: 0.05 ✓
Anti-Treponemal IgG antibody: NEGATIVE (Index <0.9)
(Negative <0.9, Equivocal 0.9-1.1, Positive >1.1)

55

Authorised by : Internal review For Dr AP Gibb

'For ADULT SEROLOGY, RIE Virology is replacing analysis of white-capped clotted (serum) blood tubes with 7.5 ml S-Monovette Serum-Gel (Sarstedt) clotted (brown-capped) ones – product code 01.1602.001; ADULT MOLECULAR ANALYSIS should continue to be performed on 7.5 ml S-Monovette Potassium EDTA (Sarstedt) (red-capped) tubes – product code 01.1605.001. Thank you.'

Department of Laboratory Medicine — **Biochemistry, WGH**

PATIENT:	MCATEER, GILLIAN		**UPI:**	2305821425	**REF:**
DOB:	23/05/1982	**SEX:** F	**CONSULTANT/GP:**	Not given	n.o.p.
SOURCE:	Bathgate Primary Care Centre		**SENDER:**		

ANTENATAL SCREENING REPORT FOR FETAL DOWN'S SYNDROME

Combined chance of Down's Syndrome at term 1 in 6781

The outcome of the screening test has shown that your baby has only a low chance of Down's Syndrome. Therefore no further action is needed. Please remember that this is a screening test and does not completely rule out the presence of this condition.

TEST DETAILS PROVIDED		LABORATORY DATA	
Date of sample	20/02/2012	Date of sample receipt	21/02/2012
Date of scan	20/02/2012	Gestation at sample date	11 wks 6 days
Crown rump length	52 mm	Maternal age at EDD	30.29 yrs
Nuchal translucency	1.5 mm	Age related chance	1 in 934
Current smoker	Yes	Free beta HCG mom	1.13
Maternal weight	90 kg	PAPPA mom	0.82
Family origin	Caucasian	Nuchal translucency MOM	1.18

Comments

GS.

Please check this report carefully and ensure that the test details provided have been recorded correctly. If incorrect information has been used the screening test result may be invalid.

For more information refer to the National Protocol: Fetal Anomaly amd Down's Syndrome Screening (2D10).

Sample number : QC868407H
Date of report : 22/02/2012 Time 10:19

24 FEB 2012

Date Printed
Time Printed

Routine Haem Results | All Haem Results | Outstanding Orders - Haem | All Orders - Haem

Lab Cumulative Profile: Routine Haem Results [Across All Episodes]

Cumulative Graph

Test Items	Reference Range	Units	Q8615718E_ 120717 17/07/2012 18:54	5H632653R_ 120615 14/06/2012 13:26	5H580184M_ 120120 20/01/2012 11:00
Haemoglobin	115 - 165	g/L	109	109#	131#
White cell count	4 - 11	10^9/l	8.6	10.1#	10.0#
Neutrophil Count	2 - 7.5	10 ^9/L	5.64	6.72#	6.54#
Lymphocyte Count	1.5 - 4	10 ^9/L	2.20	2.52#	2.42#
Platelet count	150 - 350	10 ^9/l	232	256#	332#
			☑	☑	☑

View Result

NOT all results may be available in this record. The full and unequivocal laboratory record is available in iLAB/Apex.

Please ensure that your iLAB/Apex password is up to date

Results of orders placed through Trak should be seen in EPR but be aware that the patient may have more than one electronic record due to duplicate UHPI numbers. The results of any laboratory order booked into iLA8 manually, even if requested electronically may not display in Trak.

Department of Transfusion Medicine — IMMUNOHAEMATOLOGY
Royal Infirmary Edinburgh EH16 4SA
Tel : 0131 242 7501

Name (Surname & Forename) & Address:
MCATEER GILLIAN
18 CHERRY AVENUE
BATHGATE

EH48 1NA
Sex: Female
D.O.B.: 23/05/1982 CHI / Unit No.: 2305821425

EDD / Gestⁿ: 01/09/2012 - 27weeks
Date Specimen Received: 15/06/2012 15:52
Report Date: 18/06/2012
SNBTS No.: 9006276811

Results for Sample Number: 10320023543302
Date Drawn: 14/06/2012 Date Received: 15/06/2012 15:52

ABD : O
Rh D : Positive

Antibody Status : NAD (No Antibodies Detected)

Other Results

me

Comments

Signed: KTaggart

Report Destination:
MIDWIFE IN CHARGE
RECEPTION
Bathgate Primary Care Centre
Whitburn Road

Bathgate
EH48 2SS

Copies of Report to:
Bathgate Primary Care Centre
Whitburn Road

Bathgate
EH48 2SS

Department of Transfusion Medicine
Royal Infirmary Edinburgh EH16 4SA
Tel : 0131 242 7501
Request for Further Serological Investigation

Specimen Number:
Bor Code

Name (Surname & Forename) & Address:
MCATEER, GILLIAN
18 CHERRY AVENUE
BATHGATE

EH48 1NA

D.O.B.: 23/05/1982 SNBTS No.: 9006276811
Unit No.: 2305821425

Time & Date Specimen Received:

Report Destination:
MIDWIFE IN CHARGE
Bathgate Primary Care Centre
Whitburn Road
Bathgate EH48 2SS

Copies of Report to:

Please detail any additional information or changes since last sample:

Anti-D Prophylaxis YES/NO:
(If Yes, Please Give Date & Reason)

EDD / Gestⁿ: ..... Date Sample Taken: ..... Requested By: .....

Department of Transfusion Medicine
Royal Infirmary Edinburgh EH16 4SA
Tel :- 0131 242 7501

IMMUNOHAEMATOLOGY

Name (Surname & Forename) & Address:

MCATEER GILLIAN
18 CHERRY AVENUE
BATHGATE

EH48 1NA
Sex: Female
D.O.B.: 23/05/1982 CHI / Unit No.: 2305821425

EDD / Gest^{n}: 01/09/2012 - 6weeks

Date Specimen Received: 23/01/2012 09:35

Report Date: 23/01/2012

SNBTS No.: 9006276811

Results for Sample Number: 10320020917207

Date Drawn: 20/01/2012 Date Received: 23/01/2012 09:35

ABO : O
Rh D : Positive

Antibody Status : NAD (No Antibodies Detected)

Other Results

VF
TRAK

Comments

Signed:

Report Destination:
MIDWIFE IN CHARGE
RECEPTION
Bathgate Primary Care Centre
Whitburn Road

Bathgate
EH48 2SS

Copies of Report to:

Bathgate Primary Care Centre
Whitburn Road

Bathgate
EH48 2SS

Routine Haem Results | All Haem Results | Outstanding Orders - Haem | All Orders - Haem

Lab Cumulative Profile: Routine Haem Results [Across All Episodes]

Cumulative Graph

Test Items	Reference Range	Units	5H580184M_ 120120 20/01/2012 11:00
Haemoglobin	115 - 160	g/L	131
White cell count	4.0 - 11.0	x10^9/l	10.0
Neutrophil Count	1.8 - 7.5	x10^9/l	6.54
Lymphocyte Count	1.2 - 4.0	x10^9/l	2.42
Platelet count	150 - 400	10 ^9/l	332
			☑

View Result

NOT all results may be available in this record. The full and unequivocal laboratory record is available in iLAB/Apex.

Please ensure that your iLAB/Apex password is up to date

Results of orders placed through Trak should be seen in EPR but be aware that the patient may have more than one electronic record due to duplicate UHPI numbers. The results of any laboratory order booked into iLAB manually, even if requested electronically may not display in Trak.

PATHOLOGY

NHS Lothian, University Hospitals Division, 51 Little France Crescent, Edinburgh EH16 4SA
RIE: 0131 242 7147/8
RHSC: 0131 242 7147/8

MCATEER, GILLIAN

CHI Number 2305821425
Patient Number 2305821425
Date of Birth 23/05/1982
Date Received 05/09/2012

Specimen: UB020171C/12

Dr TK Cooper
Labour Ward, St John's Hosp.

Date Reported 02/10/2012
Time Reported 08:29

Clinical Summary

This is the third pregnancy of Gillian McAteer, date of birth 23.05.82. No information given on previous pregnancies. Placental abruption at 40+1 weeks gestation. It was a livebirth.

Specimen

Placenta.

Macroscopy

The specimen received is a singleton placenta with a tightly coiled 24cm length of eccentrically inserted cord with fourteen coils and three vessels. The trimmed weight of the placenta is 489g and it measures 14 x 1.5cm.

Specimen trimmed by: Dr M J Evans.

Microscopy

Histological sections of umbilical cord confirm the presence of three vessels. There is no vasculitis or funisitis. Sections of the extra placental membranes show an appropriate structure of the amnion with no acute chorioamnionitis. The maternal vasculature shows appropriate adaptation. Sections of the placenta show appropriate maturation for stated gestation. Columnar metaplasia of the amnion is noted over the fetal surface presumed secondary to the toxic effects of meconium. There is haemorrhage with focal disruption of the basal plate in keeping with the history of antepartum haemorrhage.

Singleton placenta - Term delivery. Haemorrhagic disruption of basal plate in keeping with history of APH.

Pathologists
Paediatric Pathology Team
Dr Margaret J Evans

File plea

Clinically Approved
Approved for printing by: Dr Margaret J Evans

ST JOHN'S HOSPITAL AT HOWDEN
RADIOLOGY CLINICAL REPORT

NHS Lothian

PATIENT NAME:	McAteer	Gillian	UHPI:	800325165E

CHI: 2305821425

Order Items:
US Obstetric Fetal Anomaly Scan

Clinical details

Gestation by EDD = 4/09/2012 = 19 w 4d

Report

Single fetus. FH seen.
HC 162 mms FL 31 mms AC 148 mms

Placental site: posterior - not low lying.
Liquor volume: average

Anatomy checked = cerebellum, cisterna magna, fetal nose and lips, 4 chamber heart, great vessel crossover, thorax, stomach, kidneys, anterior abdominal wall, bladder, limbs, spine.

No gross abnormality demonstrated.

JS

ADDRESS:	18 Cherry Avenue		DOB:	23/05/1982
	Bathgate		SEX:	Female
	EH48 1NA			

REFERRER:	
ADDRESS:	

Episode Consultant:	M/W Vanda S Fraser
Order Patient Location:	Obstetric / Gynae Ultrasound - RIE
Receiving Location:	SJH - US

Order Items(s):	Visit No	Date of Exam	Referring Clinician
US Obstetric Fetal Anomaly Scan	11806279	13/04/2012	M/W Vanda S Fraser

D.O.R:		Reporting Radiologist:	Julie Eastwood
D.O.T:	15/04/2012	Overseen by Radiologist:	
D.O.V:	15/04/2012	Verifying Radiologist:	Julie Eastwood
		Typist/Secretary:	Julie Eastwood
		Radiologist Signature:	

Printed 15/04/2012 11:46:24

ST JOHN'S HOSPITAL AT HOWDEN
RADIOLOGY CLINICAL REPORT

NHS Lothian

PATIENT NAME:	McAteer	Gillian	UHPI:	800325165E

CHI: 2305821425
Order Items:
US Obstetric Booking

Clinical details

Booking and NT scan.

Report

Single active fetus with fetal heartbeat seen.

C.R.L. 52 mms.
Measurements suggest a gestation of 11 weeks and 6 days.

Ultrasound EDD = 4/09/12
NT = 1.5mms
No further booking scan required.

ADDRESS:	18 Cherry Avenue		DOB:	23/05/1982
	Bathgate		SEX:	Female
	EH48 1NA			

REFERRER:	
ADDRESS:	

Episode Consultant:	M/W Vanda S Fraser
Order Patient Location:	Obstetric / Gynae Ultrasound - RIE
Receiving Location:	SJH - US

Order Items(s):	Visit No	Date of Exam	Referring Clinician
US Obstetric Booking	11476343	21/02/2012	M/W Vanda S Fraser

D.O.R:		Reporting Radiologist:	Julie Eastwood
D.O.T:	21/02/2012	Overseen by Radiologist:	
D.O.V:	21/02/2012	Verifying Radiologist:	Julie Eastwood
		Typist/Secretary:	Julie Eastwood
		Radiologist Signature:	

Printed 21/02/2012 13:15:15

Midwife
BGE
COPY

ST JOHN'S HOSPITAL AT HOWDEN
RADIOLOGY CLINICAL REPORT

NHS Lothian

PATIENT NAME:	McAteer	Gillian	UHPI:	800325165E

CHI: 2305821425
Order Items:
US Obstetric (Other)

mlw.

Clinical details

Para 2+0. LMP 25/11/11. Had some fresh red pv loss with abdo cramps yesterday.,both settling today

Report

Intrauterine gestation sac containing a yolk sac & 22 mm fetal pole. Fetal heart motion seen.
This suggests a gestation of 8 weeks & 5days.
No adnexal masses or free fluid seen.

17 FEB 2012

MC

ADDRESS:	18 Cherry Avenue		DOB:	23/05/1982
	Bathgate		SEX:	Female
	EH48 1NA			

REFERRER:	
ADDRESS:	

Episode Consultant:	M/W Vanda S Fraser
Order Patient Location:	SJH Obste OP EPU - Obstetrics OP EPU
Receiving Location:	SJH - US

Order Items(s):	Visit No	Date of Exam	Referring Clinician
US Obstetric (Other)	11657670	01/02/2012	M/W Jane H McPherson

D.O.R:		Reporting Radiologist:	Sonia Easton
D.O.T:	01/02/2012	Overseen by Radiologist:	
D.O.V:	01/02/2012	Verifying Radiologist:	Sonia Easton
		Typist/Secretary:	Sonia Easton
		Radiologist Signature:	

Printed 01/02/2012 10:25:40

Single Text Result

Surname: McAteer, G[redacted]an
UHPI: 800325165E
CHI: [redacted] 2305821425
DOB: 23/05/1982
Location:
Specialty: Obstetrics
Consultant: M/W Vanda S Fraser

NHS Lothian

Printed on: 01/02/2012 at 10:29 am

Order Name	Result Date Time
US Obstetric (Other)	01/02/2012 10:25

Result

Clinical details

Para 2+0. LMP 25/11/11. Had some fresh red pv loss with abdo cramps yesterday.,both settling today

Report
Intrauterine gestation sac containing a yolk sac & 22 mm fetal pole. Fetal heart motion seen.
This suggests a gestation of 8 weeks & 5days.
No adnexal masses or free fluid seen.

This list of patients' details is provided for its agreed purpose only. Please handle in accordance with the Caldicott principles and destroy this report immediately after use.

Consent for Screening for fetal abnormalities offered in pregnancy

800325165E F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 RW Holden

☑ I have received & discussed the leaflet 'A Guide To Screening Tests In pregnancy' with my midwife.

I wish / do not wish to be screened for Downs ~~& Edwards~~ Syndromes.

Screening for fetal abnormalities

During your pregnancy you will be offered several tests to check on your baby's health. These include ultrasound scans and may include blood tests to screen for risk of fetal abnormalities including Down's Syndrome and Spina Bifida.

Your local maternity team will explain what ultrasound scans will be offered to you and you will be asked to complete the appropriate consent for these tests.

The ultrasound scans you are likely to be offered by your local maternity services are:

☐ Dating scan ☑ Nuchal translucency scan 11-13 weeks ☑ Detailed scan at 20 weeks

☐ Growth scan as required ☐ Placental site scan as required ☐ Other

Consent for screening tests offered in pregnancy (Down's Syndrome and Neural tube defects)

I have received the information leaflet 'A Guide to the Screening Test for neural tube defects and Down's Syndrome' and have had an opportunity to discuss the tests I am being offered with a health professional. I understand the reasons for the tests and the consequences of the results. I also understand the significance of not having these tests performed. I am aware that my decision whether or not to have these tests will not affect the quality of care delivered by health care professionals during my pregnancy.

☑ I wish ☐ I do not wish to be screened for the risk of Neural tube defects

☑ I wish ☐ I do not wish to be screened for the risk of Down's Syndrome

Signature: [signature] Date 20/1/12

Witness: V. Fraser FRASER (Health professional)

(Please sign and print name)

Designation: CM Date 20/1/12

Consent for blood and other tests offered in pregnancy (Blood Group, Full Blood Count & Infectious Diseases)

800325165E F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 RW Holden

I have received the information leaflet *'A Guide to Routine Blood Tests Offered During Pregnancy'* and have had an opportunity to discuss the tests I am being offered with a health professional. I understand the reasons for the tests and the consequences of the results. I also understand the significance of not having these tests performed. I am aware that my decision whether or not to have these tests will not affect the quality of care delivered by health care professionals during my pregnancy.

- ☑ I wish ☐ I do not wish to be tested for Blood Group
- ☑ I wish ☐ I do not wish to be tested for Full Blood Count
- ☑ I wish ☐ I do not wish to be tested for Rubella status
- ☑ I wish ☐ I do not wish to be tested for Syphilis
- ☑ I wish ☐ I do not wish to be tested for Hepatitis B
- ☑ I wish ☐ I do not wish to be tested for HIV
- ☑ I wish ☐ I do not wish to be tested for Haemoglobinopathies
- ☑ I wish ☐ I do not wish to be tested for Chlamydia (aged under 25 years)
- ☐ I wish ☐ I do not wish to be tested for blood glucose levels
- ☐ I wish ☐ I do not wish to be tested for .....
- ☐ I wish ☐ I do not wish to be tested for .....

Signature: ..... Date 20/1/12

Witness: V. Fraser (Health professional)

(Please sign and print name)

Designation: CM Date 1/1/

Signature: V. FRASER Date 20/1/12

Lothian NHS Board

Public Health & Health Policy
Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG
www.nhslothian.scot.nhs.uk

NHS Lothian

Oate 8 July 2011
Your Ref
Our Ref

Enquiries to Linda Haggarty
Extension 35438
Direct Line 0131 465 5438
Email:graham.mackenzie@nhslothian.scot.nhs.uk
linda.haggarty@nhslothian.scot.nhs.uk

Dear Madam,

Pregnancy screening booklet

This pack includes a booklet called "Your guide to screening tests during pregnancy", produced by NHS Health Scotland.

The booklet provides information on the screening tests during pregnancy that are either already available, or are being introduced over coming months.

The screening tests for **sickle cell disease** and **thalassaemia** (pages 8 to 15 in the booklet) are planned for early 2012 in Lothian.

The other tests described in the booklet are currently available and your midwife and other healthcare professionals involved in your care will be able to discuss these tests with you.

Another booklet, "Your guide to newborn screening tests", will be provided later on in pregnancy.

If you have any questions about the timing of your booking appointment / ultrasound scan then please phone maternity services (0131 536 2009).

Yours faithfully,

Dr Graham Mackenzie
Consultant in Public Health Medicine

NHS Lothian

Information about having a baby in Lothian

Ready Steady Baby

NHS Health Scotland has produced a guide to being pregnant called Ready Steady Baby. Please collect a copy of this guide from your local health centre or GP surgery prior to your first appointment with your midwife.

More information can also be found at www.readysteadybaby.org.uk

'Ready Steady Baby' is available in Polish and in an 'easy read' format.

Having a scan – NHS Lothian's polices

NHS Lothian offers many different types of scans during pregnancy and we aim to perform these to a high standard. In order to ensure our ultrasound service is both effective and helpful to you we have the following policies.

Your notes (blue folder)
It is important that you bring your obstetric notes (blue folder) with you to all scan appointments. If you do not have your notes, we will not be able to screen for Down's syndrome on the first trimester ultrasound scan (11-14 weeks). Instead we will simply carry out the dating scan and will refer you back to your midwife to discuss alternative methods of screening for Down's syndrome.

Scan pictures
We are happy to give you a picture of your baby on request – up to a maximum of 3 pictures. Please be aware that it is not always possible to obtain a good picture of the baby if it is lying in an awkward position. If you wish, you may leave a small donation to cover costs.

Fetal sexing
If you would like to know the sex of your baby, please ask and the sonographer will look to see if they can find out. Please be aware that we will not always be able to see if the sex of the baby particularly if he/she is lying in an awkward position. Please also understand that we cannot be 100% certain when we say if it is a boy or girl. Please note we do not offer a scan simply to determine the sex of the baby.

In the scan room
You can usually take both your partner and, if required, an interpreter into the scan room with you. Young children may not be allowed because they can distract the sonographer. Please note, no videoing or personal photography is permitted during the examination.

Thank you for your co-operation

Where can I have my baby?

In Lothian, you have a number of options available for the birth of your baby. Your midwife, GP or consultant obstetrician will be happy to discuss these with you. They will support you to make the decision that is best for you and your baby.

Your options are:

At home

Midwives from the community midwifery teams will care for you in labour and at the birth in your own home. In certain circumstances, which your midwife will discuss with you, you may need to be transferred to hospital.

In hospital

You have the choice of two hospitals – St John's Hospital in Livingston or the Simpson Centre for Reproductive Health (Royal Infirmary of Edinburgh). Hospital midwives will care for you in labour and at the birth. Other healthcare professionals will also be there to assist if necessary.

Both hospitals offer a choice of pain relief including epidural and have aromatherapy and water birth facilities. Other equipment including birth balls, mats and pillows are available for your comfort in labour.

Both hospitals provide midwifery and obstetric care and have a special baby unit. The Simpson centre is the regional centre for complex pregnancy and childbirth and has a neonatal intensive care unit on site.

If either hospital is very busy you may be transferred to the other hospital. This is to ensure the safety of you and your baby.

In the Lothian Birth Centre

This centre is next to the Simpson Centre for Reproductive Health and offers a more homely environment. Midwives will care for you in one of the six birth rooms, each with its own birthing pool. Other equipment including birth balls, mats, aromastones and pillows is available in every room.

A range of pain relief, such as aromatherapy, water or gas and air, is available. If you would like an epidural, this will not be available in the birth centre and you will need to opt for a hospital birth.

In certain circumstances, such as complications arising in labour, which your midwife will discuss with you, you may need to be transferred to hospital.

Other options

Depending on where you live, you may want to ask your midwife about the possibility of having your baby in a hospital outwith Lothian

Who can I bring with me?
In addition to the support that we offer, you can bring your partner and/or another friend or relative with you to provide support during labour.

When do I need to decide?
You can make the decision at any point during your pregnancy. Your midwife will talk to you about the different options available. As your pregnancy progresses your plans may need to change but again your midwife will discuss this with you at the time.

Contact details:

St John's Hospital at Howden, Maternity Unit, Howden Road West, Livingstone, EH54 6PP
01506 523000

Simpson Centre for Reproductive Health, Royal Infirmary of Edinburgh, 51 Little France Crescent, Edinburgh, EH16 4SA
0131 536 1000

Lothian Birth Centre, Royal Infirmary of Edinburgh, 51 Little France Crescent, Edinburgh, EH16 4SA
0131 536 1000

If you have questions about any of the information provided above please speak to your midwife.

A Parent's Guide

to the

Maternity Services Lothian Infant Feeding Policy

All parents have the right to clear and impartial information to help them choose how to feed their baby. Our staff will support you in your choice.
Breastfeeding is the healthiest way to feed your baby and we recognise important benefits which breastfeeding provides for both you and your child. We encourage you to breastfeed your baby and all our staff have been specially trained to help you.

Ways in which we will help you feed your baby

Before your baby is born

- During your pregnancy you will be able to discuss feeding individually with a Midwife or Health Visitor who will answer any questions you may have.

After your baby arrives

- We recommend that you hold your new baby against your skin as soon as possible after birth. The staff will not interfere or hurry you but will be there to support you and to help you with your first feed.
- Our staff will show you how to hold your baby so that breastfeeding is comfortable, explain how to know your baby is feeding well and teach you how to express your milk by hand.
- If you have chosen to feed your baby with formula, staff will show you how to feed your baby with a bottle and explain how to make up a formula feed as safely as possible
- Maternity staff will help with feeds in the early days; health visiting staff will provide support later on.
- We encourage you to feed your baby whenever he or she seems hungry and we will explain to you how you can tell your baby is getting enough milk.
- Most babies do not need anything other than breastmilk until they are about six months old. If your baby needs some other food or drink before this, staff will fully explain the reason for this.
- We recommend that you keep your baby near you at all times, so you can get to know each other. If any medical procedures are necessary in hospital, you will always be able to accompany your baby. We will give you information about bed sharing and infant safety.
- While your baby is learning to breastfeed we recommend that you avoid using bottles, dummies and nipple shields – they can make it more difficult for your baby to learn how to breastfeed and for you to establish a good milk supply.
- We welcome breastfeeding in all areas of our premises.
- Before you go home from hospital we will give you a list of all the people you can contact for extra help and support with breastfeeding, or who can help if there is a problem.

This is a summary of the Infant Feeding Policy. Please ask a member of staff if you wish to see the full policy.

September 2011

PRESCRIPTION AND ADMINISTRATION RECORD

Standard Chart

800325165E/E2298971 F 23/05/1982

Hospital/Ward:	Consultant:
Weight:	Height:
If re-written, date:	
DISCHARGE PRESCRIPTION	
Date completed:	Completed by:

Name: McAteer, Gillian
18 Cherry Avenue,
CHI: Bathgate,
West Lothian,
DOB: EH48 1NA
CHI 2305821425
78132 RW Holden

OTHER MEDICINE CHARTS IN USE		PREVIOUS ADVERSE REACTIONS This section must be completed before any medicine is given		Completed by (sign & print)	Date
Date	Type of Chart	None known ☑			
		Medicine / Agent	Description of reaction		

CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINE

If a dose is not administered as prescribed, initial and enter a code in the column with a circle drawn round the code according to the reason as shown below. **Inform the responsible doctor in the appropriate timescale.**

1. Patient refuses
2. Patient not present
3. Medicines not available - CHECK ORDERED
4. Asleep / drowsy
5. Administration route not available - CHECK FOR ALTERNATIVE
6. Vomiting / nausea
7. Time varied on doctor's instructions
8. Once only / as required medicine given
9. Dose withheld on doctor's instructions
10. Possible adverse reaction / side effect

ONCE ONLY

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber - Sign + Print	Time Given	Given By
5.9.12	0400hrs	MORPHINE	up to 10mg	IV	Dr Doctorm	1950	CC / KN
5-9-12	13.50	TED STOCKING	1 Pair	TOPICAL		14.00	KN
6.9.12	11.00	DICLOFENAC	50mg	oral		11.20	
8/9/12	23.00	Cactus Rose	10ml	PO	Dr. Doctorm	23.00	VA

PTO

Name:..... D.O.B.:..... CHI Number:.....

REGULAR THERAPY

- Write clearly in block capitals, using a black ballpoint pen
- Use approved names for medicines
- Never alter a prescription
- Route of administration
  The only acceptable abbreviations are:

IV	- intravenous	SL	- sublingual	NG	- nasogastric
IM	- intramuscular	PR	- per rectum	ID	- intradermal
SC	- subcutaneous	PV	- per vagina	TOP	- topical
INHAL	- inhaled	NEB	- nebulised		

  Never abbreviate ORAL or INTRATHECAL
  Specify RIGHT or LEFT for eye and ear preparations

- Write the medicine dose clearly
  - The only acceptable abbreviations are:
    g - gram mg - milligram ml - millilitre
    all other doses must be written out in full eg. micrograms
  - Avoid decimal points eg. 100 micrograms (not 0.1mg). If unavoidable, write zero in front of the decimal point
  - Prescribe liquids by writing the dose in mg
  - For 'as required' medicines, state the symptoms to be relieved, the minimum time interval between doses and the maximum daily dose
  - Write units as 'units' not 'iu'

OXYGEN

Start Date	Start Time	Route Mask (%)	Route Prongs (l/min)	Prescriber - Sign + Print	Administered by	Stop Date	Stop Time

PRESCRIPTION

Patient's Own Medicine

Date → 5/9/12 6/9/12 7/9/12 8/9/12 9/9/12

Time ↓

Medicine (Approved Name): PARACETAMOL
Dose: 1g | Route: O | Notes | Start Date: 5.9.12 | Prescriber - sign + print: Dr DOCHERTY.
For Use | Quantity | Date | Pharmacy
6 | (8) | (12) | 14 | (18) | (22)
8: JM CR AB
12: JM CR AB
18: KW RC JM
22: DG JM CR IA

Medicine (Approved Name): OXYCONTIN
Dose: 10mg | Route: O | Notes: for 24hrs then re-assess | Start Date: 5.9.12 | Prescriber - sign + print: Dr DOCHERTY.
8: X X X
22: MW DG X
DUNLOP.

Medicine (Approved Name): DALTEPARIN
Dose: 5000iu | Route: SC | Notes | Start Date: 5.9.12 | Prescriber - sign + print: Dr DOCHERTY.
18: KW RC JM 9/9

Medicine (Approved Name): DICLOFENAC
Dose: 50 mg | Route: Oral | Notes | Start Date: 6.9.12 | Prescriber - sign + print
8: X X JM.
12: 10 GW JM.
18: X

PTO

Name: Gillian McAteer D.O.B.: 23/5/82 CHI Number:

PRESCRIPTION		Patient's Own Medicine	AS REQUIRED THERAPY														
Medicine (Approved Name): DIHYDROCODEINE		For Use	Date	05/9/12	6/9/12	8/9/12	8/9/12	7/9/12	7/9/12	7/9/12	7/11/12	8/9/12	8/9/12	8/9/12	8/9/12	9/9/12	
			Time	2000	0335	1310	1830	0400	0830	1720	2200	0225	0615	1300	1810		
Dose + frequency: 30-60mg 4°	Route: O	Quantity	Dose/Route	PO 60mg	60mg PO	30mg PO	30mg PO	60mg PO	30mg O	30mg O	30mg PO	30mg O	30mg 30mg	30mg PO	30mg O		
			Initials	CO	AC			HW	JM	JM	CP	CP	CP	CR	CR		
Notes: MAX 240mg / 24 HOURS	Start Date: 5.9.12	Date	Date	8/9/12	9/9/12												
			Time	2230	0300												
Prescriber - sign + print: PMJ DOCHERTY.		Pharmacy	Dose/Route	30mg PO	30mg PO												
			Initials	KA	KA												
Medicine (Approved Name): ONDANSETRON		For Use	Date														
			Time														
Dose + frequency: 4-8mg 8°	Route: O/IV	Quantity	Dose/Route														
			Initials														
Notes	Start Date: 5.9.12	Date	Date														
			Time														
Prescriber - sign + print: DMJ DOCHERTY.		Pharmacy	Dose/Route														
			Initials														
Medicine (Approved Name): ORAMORPH		For Use	Date														
			Time														
Dose + frequency: 20mg 2°	Route: O	Quantity	Dose/Route														
			Initials														
Notes	Start Date: 5.9.12	Date	Date														
			Time														
Prescriber - sign + print: DMJ DOCHERTY.		Pharmacy	Dose/Route														
			Initials														
Medicine (Approved Name): ORAMORPH.		For Use	Date	9/9/12													
			Time	0950													
Dose + frequency: 10mg 1°	Route: ORAL	Quantity	Dose/Route	5mg/5ml 10mg													
			Initials	[illegible]													
Notes: PRN	Start Date: 6.9.12	Date	Date														
			Time														
Prescriber - sign + print: [illegible]		Pharmacy	Dose/Route														
			Initials														
Medicine (Approved Name): TRAMADOL		For Use	Date	6/9/12	7/9/12	9/9/12											
			Time	1410	1055	0646											
Dose + frequency: 50mg 6hrly	Route: ORAL	Quantity	Dose/Route	50mg PO	50mg O	50mg PO											
			Initials	[illegible]	JM	KA											
Notes	Start Date: 6.9.12	Date	Date														
			Time														
Prescriber - sign + print: [illegible]		Pharmacy	Dose/Route														
			Initials														
Medicine (Approved Name):		For Use	Date														
			Time														
Dose + frequency	Route	Quantity	Dose/Route														
			Initials														
Notes	Start Date	Date	Date														
			Time														
Prescriber - sign + print		Pharmacy	Dose/Route														
			Initials														

stopped. JM 6/9/12

TURN OVER →

Name:..... D.O.B.:..... CHI Number:.....

REGULAR THERAPY

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓															
Medicine (Approved Name)		For Use	6															
Dose	Route	Quantity	8															
			12															
Notes	Start Date	Date	14															
			18															
Prescriber - sign + print		Pharmacy	22															
Medicine (Approved Name)		For Use	6															
Dose	Route	Quantity	8															
			12															
Notes	Start Date	Date	14															
			18															
Prescriber - sign + print		Pharmacy	22															
Medicine (Approved Name)		For Use	6															
Dose	Route	Quantity	8															
			12															
Notes	Start Date	Date	14															
			18															
Prescriber - sign + print		Pharmacy	22															
Medicine (Approved Name)		For Use	6															
Dose	Route	Quantity	8															
			12															
Notes	Start Date	Date	14															
			18															
Prescriber - sign + print		Pharmacy	22															
Medicine (Approved Name)		For Use	6															
Dose	Route	Quantity	8															
			12															
Notes	Start Date	Date	14															
			18															
Prescriber - sign + print		Pharmacy	22															
Medicine (Approved Name)		For Use	6															
Dose	Route	Quantity	8															
			12															
Notes	Start Date	Date	14															
			18															
Prescriber - sign + print		Pharmacy	22															
Medicine (Approved Name)		For Use	6															
Dose	Route	Quantity	8															
			12															
Notes	Start Date	Date	14															
			18															
Prescriber - sign + print		Pharmacy	22															
Medicine (Approved Name)		For Use	6															
Dose	Route	Quantity	8															
			12															
Notes	Start Date	Date	14															
			18															
Prescriber - sign + print		Pharmacy	22															

TURN OVER →

Name:..... D.O.B.:..... CHI Number:.....

REGULAR THERAPY

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓	7/9/12	8/9/12	9/9/12
Medicine (Approved Name): Ferrous Sulphate		For Use	6			
Dose: 200mg	Route: oral	Quantity	8	X	BS	AB
			12			
Notes: 6/52.	Start Date: 7/9.	Date	14	X	LR	AB
			18			
Prescriber - sign + print: LT		Pharmacy	22	CS	KA	
Medicine (Approved Name): diclofenac		For Use	6			
Dose: 50mg	Route: oral	Quantity	8	X	BS	AB
			12			
Notes	Start Date: 6/9	Date	14	X	LR	AB
			18			
Prescriber - sign + print: LT		Pharmacy	22	CS	KA	
Medicine (Approved Name): Lactulose		For Use	6			
Dose: 10mg BD	Route: PO	Quantity	8			AB
			12			
Notes	Start Date: 8/9/12	Date	14			
			18			
Prescriber - sign + print: L. Dunphy		Pharmacy	22			
Medicine (Approved Name)		For Use	6			
Dose	Route	Quantity	8			
			12			
Notes	Start Date	Date	14			
			18			
Prescriber - sign + print		Pharmacy	22			
Medicine (Approved Name)		For Use	6			
Dose	Route	Quantity	8			
			12			
Notes	Start Date	Date	14			
			18			
Prescriber - sign + print		Pharmacy	22			
Medicine (Approved Name)		For Use	6			
Dose	Route	Quantity	8			
			12			
Notes	Start Date	Date	14			
			18			
Prescriber - sign + print		Pharmacy	22			

Name:..... D.O.B.:..... CHI Number:.....

PRESCRIPTION		Patient's Own Medicine	AS REQUIRED THERAPY												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency	Route	Quantity	Dose/Route												
			Initials												
Notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose/Route												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency	Route	Quantity	Dose/Route												
			Initials												
Notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose/Route												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency	Route	Quantity	Dose/Route												
			Initials												
Notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose/Route												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency	Route	Quantity	Dose/Route												
			Initials												
Notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose/Route												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency	Route	Quantity	Dose/Route												
			Initials												
Notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose/Route												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency	Route	Quantity	Dose/Route												
			Initials												
Notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose/Route												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency	Route	Quantity	Dose/Route												
			Initials												
Notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose/Route												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency	Route	Quantity	Dose/Route												
			Initials												
Notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose/Route												
			Initials												

RADIOMETER ABL 700 SERIES

ABL700 Labour Ward		11:04:00	05/09/2012
PATIENT REPORT	Cord Gas - S 85uL	Sample #	27653

Identifications

Patient ID	800325165
Patient Last Name	mcateer
Operator	k mcintosh
Sample type	Arterial

Blood Gas Values

pH	7.340	
pCO_2	5.78	kPa
pO_2	3.10	kPa

Acid Base Status

$cBase(Ecf)_c$	-2.2	mmol/L
$cHCO_3(P,st)_e$	20.9	mmol/L

Notes

Calculated value(s)
Estimated value(s)

Printed 11:05:32 05/09/2012

RADIOMETER ABL 700 SERIES

ABL700 Labour Ward		11:06:00	05/09/2012
PATIENT REPORT	Cord Gas - S 85uL	Sample #	27654

Identifications

Patient ID	800325165
Patient Last Name	mcateer
Operator	k mcintosh
Sample type	Venous

Blood Gas Values

pH	7.355	
pCO_2	5.52	kPa
pO_2	5.78	kPa

Acid Base Status

$cBase(Ecf)_c$	-2.2	mmol/L
$cHCO_3(P,st)_e$	21.9	mmol/L

Notes

c Calculated value(s)
e Estimated value(s)

Printed 11:07:50 05/09/2012

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

NHS Lothian

Department of Obstetrics and Gynaecology

Dr Holden
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created	09/09/2012
Date Authorised	
Date/Time Printed	09/09/2012 11:28
Our Ref	800325165E
CHI	2305821425

Patient: Gillian McAteer
18 Cherry Avenue
Bathgate
EH48 1NA

UHPt: 800325165E
Date of Birth: 23/05/1982

Ward: Ward 11 SJH

Admission Date: 05/09/2012

Consultant: Dr TK Cooper

Discharge Date: 09/09/2012

Discharge Medication	Dose	Frequency	Duration	Additional Info
Paracetamol Caplets	1000 MG	FOUR times daily	Short Term	32 tabs given.
Ferrous Sulphate Tablets	200 MG	THREE times DAILY	6 Weeks	100 tabs given
Diclofenac Sodium E/C Tablets	50 MG	THREE times DAILY	Short Term	28 tabs given
Lactulose Solution	10 ML	TWICE DAILY	Short Term	300mls given
Dihydrocodeine Tablets	30 MG	As Required	Short Term	30-60mg every 4-6 hours as required 15 tabs given

Prescribed By ..... **Date** ..... **Print Name**.....
Dispensed By ..... **Date** ..... **Print Name**.....
Pharmacist Check ..... **Date** ..... **Print Name**.....
Final Check ..... **Date** ..... **Print Name**.....

PRINCIPAL DIAGNOSIS/PROCEDURE
1. EMLUSC for Placental Abruption 05/09/12

TREATMENT
Attended A+E with significant PV bleed. Taken to theatre for an emergency C-section, 200ml retroplacental blood clot identified. Bloods loss 1000ml. Delivered a live female infant. Post-op period uneventful. Hb 95 so started on iron replacement, GP to kindly recheck FBC in 4 weeks.

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL
Nil

Dr P J Dewart (Consultant)
Dr T Narrainen-Poulc (Consultant)
Secretary Mrs Meal
Tel: 01506 523988

Dr T K Cooper (Consultant)
Dr S Kallat (Consultant)
Secretary Miss Thompson
Tel: 01506 523996

Dr S C Nicholson (Consultant)
Dr A J MacLeod (Consultant)
Secretary Yvonne Scott
Tel: 01506 523984

Dr S M Rane (Consultant)
Dr T Narrainen-Poule (Consultant)
Secretary Mrs Wharram
Tel: 01506 523990

Dr S M Coutts (Consultant)
Dr GA Walker (Consultant)
Dr S J Coun (Associate Specialist)
Secretary Miss Ann Reid
Tel: 01506 523997

Inpatient Discharge Summary

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

NHS
Lothian

Cont'd... **Ref:** 800325165E **Patient Name:** Gillian McAteer

CHANGES TO DRUGS SINCE ADMISSION
Analgesia, Lactulose, Ferrous Sulphate

PREVIOUS ADVERSE DRUG REACTIONS
NDKA

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS
Nil

GP to please consider the following...
Please recheck FBC in 4 weeks

Should you need further information please contact...
Ward 11, SJH

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

Yours sincerely.....

Dr C Austin, FY2
Staff Signature..... PrintName.....

Designation..... Date..... Time.....

Patient/Carer Signature.....

This is an immediate discharge letter and a further letter may follow.

Inpatient Discharge Summary

800325165E F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA

Postnatal H ... ıry

Situation

CHI 2305821425
78132. RW Holden
Parity: 2+0
Gestation: T+1
Blood Group: O Pos
Allergies: NIL KNOWN

Background

Underlying medical conditions:

Current medication:

Assessment

Type of delivery: EM LUSCS
Time: 11·08
Blood loss: 1000ml
Perineum: Intact
Analgesia / Anaesthetic:
Bladder care (when did patient last pass urine)
CATHETER

Recommendations

Postnatal Care – Routine / High risk:

Special considerations:

Baby

Weight: 2720g
APGARS: 9:9
Method of feeding: BR.
Last feed given at: 1630
Has the baby passed meconium or urine? PU+
Temperature and time: 36·9 1630 Mec.
Special considerations?

SJH HOSPITAL

24 HOUR FLUID BALANCE CHART

DATE

800325165E/E2298971 F 23/05/1982
Surname: McAteer, Gillian
First Name: 18 Cherry Avenue,
Bathgate,
West Lothian,
Unit No: EH48 1NA
Ward: CHI 2305821425
78132 RW Holden

Previous 24 Hour Intake:- Output:- Balance:-

Oral Intake			Intravenous Intake				Output							
Time	Nature	Vol	Time	Nature	Line 1 Vol	Line 2 Vol	Time	Urine	Gastric	1 Drain	2 Drain	Use as required		
1400	Water	180	Th	A	500		1330	40ml						
			Th	B	500		1430	75ml						
1600	Juice	180	Th	C		500	1530	65ml						
			1205	D	1000			FREE DRAINAGE						
1800	Tea	200												
							1800	BAG CHANGED						
								1700ml						
TOTAL			TOTAL											

Total Intake

Total Output

BALANCE

WLT 343

.....HOSPITAL

24 HOUR FLUID BALANCE CHART

DATE

Surname

First Name

Unit No.

Ward

Previous 24 Hour Intake:-

Output:-

Balance:-

Oral Intake			Intravenous Intake				Output							
Time	Nature	Vol	Time	Nature	Line 1 Vol	Line 2 Vol	Time	Urine	Gastric	1 Drain	2 Drain	Use as required		
TOTAL			TOTAL											

Total Intake

Total Output

BALANCE

WLT 343

WLT 414

West Lothian Hospitals

FLUID (ADDITIVE MEDICINE) PRESCRIPTION SHEET

NAME 800325165E/E2298971 F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 RW Holden

UNIT No.

Affix Addressograph Label

	DATE	FLUID (USE BLOCK LETTERS) ADDITIVE MEDICINE	Vol. (ml) Dose (mg)	Route of Admin.	Dur. of ★ Admin.	SIGNATURE	Serial No. Batch No.	Time Begun	Given by Added by
A	5/9/12	N Saline	500	IV	~~Hcarbe~~ A/E				
B	5/9/12	N Saline	500	IV	Hcarbe				
C	5/9/12	R/Macrate Synthroid 40units	500	IV	125mls/ hr				
D	5/9/12	R/Lactate	1,000	IV	Stat		12323 T3F 01/2013	1005	CC
E	5.9.12	R/lactate	1000	IV	8°				
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

★ RATE OF FLOW = VOL. OF FLUID (ml) x 15
(Drops/Min.) Duration (Mins.) (1ml = 15 drops)

Approximate Rate for 500ml
1 hr. = 120 Drops/min. 6 hr. = 22 Drops/min.
4 hr. = 30 Drops/min. 8 hr. = 15 Drops/min.

KNOWN DRUG/MEDICINE SENSITIVITY
1 2

PRE-OPERATIVE CARE / RECEPTION

TICK OR CROSS BOXES

IDENTIBAND IN PLACE		CHARTS	
OPERATION SITE IDENTIFIED		CASE NOTES	
CONSENT FORM SIGNED		PRESCRIPTION (with antibiotics if prescribed)	
		ANAESTHETIC	
		FLUID BALANCE	
		XRAY / LAB RESULTS	
FASTED		PRESSURE SORE RISK ASSESSMENT FORM	
PRE-MED GIVEN		MAN. HANDLING RISK ASSESSMENT FORM	
ALLERGIES:		ORAL HYGIENE RISK ASSESSMENT FORM	
		TED STOCKINGS ON / OFF	
		WEIGHT	
		EMLA CREAM APPLIED	
SKIN CONDITION			
DENTURES OUT		CROWNS / LOOSE TEETN	
CONTACT LENSES OUT		JEWELLERY REMOVED / TAPED	
VISION HEARING		SPEECH MOBILITY	
MAKE UP / NAIL VARNISH REMOVED		MODESTY / COTTON PANTS ON	
OPERATION SITE SHAVED		COT SIDES ON	

SPECIFIC ANXIETIES EXPRESSED:

OTHER RELEVANT INFORMATION:

ANAESTHETIC CARE

ANAESTHETIC:

FACE MASK		LARYNGEAL MASK	
ENDO TRACHEAL TUBE		AIRWAY	

LINES INSERTED:

PERIPHERAL CANNULAE		BUTTERFLY	
ARTERIAL		CENTRAL	

CANNULATED SITE:

RIGHT HAND		RIGNT ARM	
LEFT HAND		LEFT ARM	
OTHER		.....	

EYE CARE:

TAPED		
OINTMENT		.....
DROPS		.....

ADDITIONAL INFORMATION:

SIGNATURE: DESIGNATION:

RW Holden 78132

THEATRE

OPERATING POSITION

SUPINE	X	LLOYD DAVIES	
LATERAL PRONE		KIDNEY	
NECK EXTENSION		KNEE / FOOT	
LITHOTOMY		TRACTION	
OTHER			

INFILTRATION

FITTINGS / ATTACHMENTS

HEEL PAD	X	ARM REST	
ARM BOARD		FOOT BOARD	
ARM TABLE	X	ANAES. SCREEN	
PELVIC SUPPORT		WEDGES	
LATERAL SUPPORT		PILLOWS	X
ARM RETAINERS		GOLLIGER	

STRAPS (Velcro / Rubber) .....

OTHER.....

WICK/PACK / ROLL IN WOUND

VAGINAL ☐ NASAL ☐

SPONGOSTAN ☐

TYPE.....

OTHER.....

PLASTER OF PARIS SPLINTING

PNEUMATIC BOOTS

FULL LENGTH		HALF LENGTH	X
TED STOCKINGS			

TOURNIQUET

TIME ON ☐☐

TIME OFF ☐☐

SITE: RIGHT ☐ THIGH ☐

LEFT ☐ ARM ☐

OTHER .....

SPECIMENS SENT

YES ☐ NO X

DIATHERMY PLATE POSITION

RIGHT	X	THIGH	X
LEFT		ABDOMEN	
MONOPOLAR	X	BACK	
BIPOLAR			

BLOOD LOSS

SWABS 400ml

SUCTION 300ml

TOTAL 700ml +

SKIN CLEANING SOLUTION

BETADINE (ALCOHOLIC)	
BETADINE (ANTISEPTIC)	X
CHLORHEXIDINE 0.5% IN SPIRIT	
TISEPT	

OTHER.....

PROSTHESIS

PERITONEAL LAVAGE

SALINE ☐ TETRACYCLINE ☐ OTHER.....

CATHETER

SIZE 12 F TYPE Foley

BALLOON CAPACITY 10ml. FREE DRAINAGE ☐ URIMETER X

DRAINS

REDIVAC ☐ LARGE/MEDIUM/MINI OTHER.....

CORRUGATED ☐ SILASTIC ☐ SUTURED IN YES ☐ NO ☐

SKIN CLOSURE

STAPLES ☐ STERI STRIPS ☐ OTHER.....

INTERRUPTED ☐ CONTINUOUS X SUBCUTICULAR ☐

WOUND DRESSING

MEPORE	X	JELONET		INADINE		SURGIPAD	
CREPE		PLASTER WOOL		DRESSING SWABS		OPSITE SPRAY	
PRESSURE		FLAVINE WOOL					

Sn/Peol.

P. 800325165E/E2298971 F 23/05/1982 CATEOL

McAteer, Gillian

18 Cherry Avenue,

Bathgate,

West Lothian,

EH48 1NA

CHI 2305821425

PATIENT UNIT NO.

ANAESTHETIST SIGHATURE DL Docherty | DL Watson

DATE 5/9/12

16494

LABORATORY TELEPHONE REPORT

Patient's Name	Hospital Unit No
Gulian m'Ateer	22.5.82

CLINICAL CHEMISTRY		HAEMATOLOGY	
Glucose	mmol/l	Hb	124 g/dl
Sodium	mmol/l	Hct	0.
Potassium	mmol/l	W.B.C.	14.2 $x10^9/l$
Chloride	mmol/l	Platelets	255 $x10^9/l$
CO_2	mmol/l		
Urea	mmol/l	Prothrombin Time	
Creatinine	µmol/l	Patient	secs
Amylase	IU/l	Control	secs
pO_2	kPa	Ratio	
pCO_2	kPa		
[H+]	nmol/l		
Base Excess	nmol/l		
Std HCO_3	nmol/l		

Message received at 11.15 a.m./p.m.

on 5/09/~~19~~2012 by

WLT462

NHS LOTHIAN — OBSTETRIC ANAESTHETIC RECORD

Proposed operation: Emergency CS

Date:

Time called:

Urgency: I - stat II - urgent III - scheduled IV - elective

800325165E/E2298971 F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 RW Holden

ANAESTHETIC ASSESSMENT

Assessor: RW/PD Cons ☑ SAS ☐ SPR ☑ SHO ☐ Other

Consent form signed and checked ☐ Date: Location:

Medical History (& see care pathway)

Presents @ A+E with severe PV bleeding.
~? abruption → (5)

Obstetric History

? Pre-eclampsia ☐ Placental position

Examination

HR BP

Booking Weight Height

BMI

Medications

Nil.

Herbal medicines

Allergies

NKDA.

ASA Grade

I (2) II III IV V E

Airway Assessment

Neck mobility
TM distance
Mallampati
Mouth opening
Jaw protrusion

Teeth

Previous anaesthetics ☐

Uneventful ☐

Family History

Alcohol
Smoking
Drugs
Reflux/GORD
Fasted

Investigations

FBC
U+E's Urate
Coagulation
G+S
Other

Information Given to Patient

PDPH	☐	Nerve damage	☐
Hypotension	☐	Pushing and pulling	☐
Nausea & Vomiting	☐	Risk of inst. del.	☐
Failure	☐	PR drug administration	☐
Pruritus	☐		

Top up prescription

1) _____ mls 0.1% bupivacaine + fentanyl 2 mcg/ml
for _____ doses, interval 30 min., posture: not supine
Signature Name

2) _____ mls 0.1% bupivacaine + fentanyl 2 mcg/ml
for _____ doses, interval 30 min., posture: not supine
Signature Name

Post-operative Remarks

	Y	N
★ *Uneventful anaesthetic*	☐	☐
★ *Significant events*		
★ *Critical Incidents*		
★ *Warnings/Hazards*		

PCEA / epidural infusion prescription

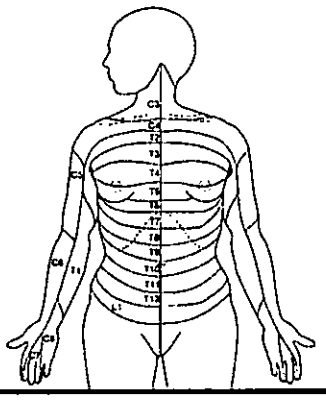
0.1% bupivacaine + fentanyl 2 mcg/ml
Bolus amount _____ ml
Time lockout _____ min
Infusion rate _____ ml / hour
Signature Name

LABOUR WARD

Anaesthetist(s): Grade:

Supervising Consultant: Informed: Y☐ N☐

Technique			Patient Position	
Epidural	16g	☐	Sitting	☐
	18g	☐	Lateral	☐
Spinal	24g	☐	**Loss of Resistance**	
	25g	☐	Air	☐
Other		☐	Saline	☐
CSE		☐	Depth of space _____ cm	
Interspace	_____		Catheter mark @ skin _____ cm	
Asepsis		☐		



Test Doses

Pain/paraesthesia on insertion

Complications/Comments

LABOUR WARD ONLY

SBP [mmHg] - v

DBP [mmHg] - ^

Pulse [bpm] - •

200 / 150 / 100 / 50 / 0

Time							
Top Up PCEA							
Total boluses delivered							
Total volume infused							
Block Height (R/L)							
Pain Score ½ hrly							
Sedation Score ½ hrly							
Bromage (R/L)							

Top Up	Vol	Drug / Concentration	Time	Given by	Checked by	Comments
1						
2						
3						
4						
5						
6						
7						
8						
9						

Pain Score
0 no pain
1 mild pain
2 moderate pain
3 severe pain
S sleeping

Sedation Score
0 alert, orientated
1 drowsy, easily roused
2 rouses only to pain
3 unrousable
S sleeping

Bromage
1 unable to move feet or knees
2 able to move feet only
3 just able to move knees
4 full flexion of knees & feet

Call Anaesthetist:

if pain score ≥ 2 30 minutes after top-up
if BP less than 100 mmHg
if block ≥ T6

THEATRE

Anaesthetist(s): [illegible] Grade:

Supervising Consultant: Informed: Y ☐ N ☐

Anaesthetic	Airway/Breathing	Monitoring	Regional Technique
Na^+ citrate ☑	Facemask ☐	Machine check/Initial ☑	Sitting ☐ Midline ☐
Ranitidine ☐	Oral/Nasal Airway ☐	Minimal monitoring ☑	Lateral ☐ Paramedian ☐
	LMA ☐	ECG ☑ PAW ☑	Asepsis ☐ Interspace ☐
Induction (I)	Size	SpO_2 ☑ Disconnect ☑	Spinal Epidural
Pre O_2 ☑	ETT ☐	NIBP ☑ PNS ☐	24g ☐ 16g ☐
Cricoid Pressure ☑	Size	FiO_2 ☑ Steth ☐	25g ☐ 18g ☐
STP 425mg		$ETCO_2$ ☑ Temp ☐	Other CSE ☐
Sux 100mg	Laryngoscopy Grade	Agent ☑ Urine ☐	Complications/comments
	1 2 3 4		Bilateral TAP blocks.
Maintenance	S.V. ☐ I.P.P.V. ☐	CVP ☐ A-line ☐	Full asepsis.
Agents		Initial Initial	US guided.
Gas Flow	Circuit Circle/CO_2 Abs	Fluid warmer ☑ Eye care ☑	10mls 0.125% bupiv
	Ventilator	Warming blanket ☐ Pressure care ☐	sides.
Reversal (R)	Nasha.	Patient/limb position	no problems.

Final Bromage R ☐ L ☐ Sacral block ☐ @ Time

Time	11:00	11:15	11:30			
Sensory block height R / L						
Modality						
150 SBP [mmHg] - v						
DBP [mmHg] - ^						
100 Pulse [bpm] - •						
50						
Temp 0						
EVENTS	A B		C			
SpO_2	98 91	96				
$ETCO_2$	3.6	3.7				
FiO_2	.5					
Fet Volatile 150	1.0 (in N_2O)					
Ventilation	IPPV 690x11	Rate 24/5.				
PAW						
CVP						
Fluids 1	1000mls CSL					
Fluids 2	1000mls CSL					
Urine						
Blood Loss						

EVENTS

A 11:05 Induct.
B 11:08 Del.
C TAP Block
D attempted
E →
F
G
H
I
J
K
L

TOTALS

Drugs							
Phenylephrine							
Oxytocin	5units.						
Antibiotic	Cefuroxime 1.5g						
Paracetamol							
Diclofenac							
Bupivacaine (spi/epi)							
Diamorphine (spi/epi)							
True Morphine	40mg. 15mg.						

DRUG DISPOSAL Total drug given = ml Total drug discarded = ml

WITNESSED BY: 1) 2) DATE:

RECOVERY ROOM

TIME IN: 1153

TIME OUT:

Name:

Hospital Number:

Date of Birth:

Affix Label

IV A Morphine 2mg/10ml cc/KN

IV B Morphine 2mg 1934 cc/KN

IV C Morphine 2mg 1959 cc/KN

IV D Morphine 2mg 1944 cc/KN

IV E Morphine 2mg 1950 cc/KN

F

(16/60)

TIME	1500			1540	1550	1600					
Airway	FM	FM	SV	SV	FM	FM	FM	FM			
Oxygen Therapy	SL	SL	A	A	SL	SL	SL	SL			
Sats	99	99	100	100	100	98	99	99			
Respiration	10	R	14	9	10	12	12	11			
Pain Score	7/10			5/10	4/10	3/10	3/10				
Nausea Score	0			0	0	0	0				
Sedation Score	2/1			0	0	0	0				
Urine Volume	300					350					
Wound Check	dry			dry	dry						
Drains											
Temperature	36										
Lochia	mod			NOT	SMALL						

200 / 150 / 100 / 50 / 0

SBP - v

MAP - x

DBP - ^

Pulse - •

Events											
Fluids	PR	SSL									
Drugs	Synto 10U	6/12									

Pain Score
0 No Pain
1 Mild Pain
2 Moderate Pain
3 Severe Pain
S Sleeping

Nausea Score
0 None
1 Mild
2 Moderate
3 Severe
T Requiring Treatment
S Sleeping

Sedation Score
0 Alert, orientated
1 Drowsy, easily roused
2 Rouses only to pain
3 Unrousable
S Sleeping

RECOVERY COMMENTS

Extubated in RR
O_2 by FM

Vital signs as charted above. Hypotonic in relation to gestation and EBL PV loss minimal/moderate not full thickness of PT Spiking to ward dressing. 1° Urination charted IV Synto + crystalloid in progress. 3rd fluid bag Baby in cot cuddle - small cup feed from mother/ written too tired + uncomfortable for feeding Fundus not yet checked Analgesia as charted

Name: CAW

Signature:

ANAESTHETIC INSTRUCTIONS

Oxygen 4 litres 6hrs.

Routine monitoring at 5 min intervals x ½ hr		☑
Fluids	As charted	☑
Analgesia	As charted	☑
Antiemetics	As charted	☑
Special Instructions		

Destination: Day case ☐ Ward ☑ HDU ☐ ITU ☐

Name

Signature

Contact No.

.....HOSPITAL

24 HOUR FLUID BALANCE CHART

DATE: 5/9/12

Surname: Cullan McAteer

First Name:

Unit No.:

Ward

Previous 24 Hour Intake:- Output:- Balance:-

Oral Intake			Intravenous Intake				Output							
Time	Nature	Vol	Time	Nature	Line 1 Vol	Line 2 Vol	Time	Urine	Gastric	1 Drain	2 Drain	Use as required		
							21:00	2200	bag changed					
							23:30	1000	in sac bag					
				6/9/12			00:15	1050	bag emptied					
							04:45	1100	bag changed					
							06:00	500	SRe removed					
Total			Total											

Total intake

Total output

Balance

LHB 341

.....HOSPITAL

24 HOUR FLUID BALANCE CHART

DATE:

Surname:

First Name:

Unit No.:

Ward

Previous 24 Hour Intake:- Output:- Balance:-

Oral Intake			Intravenous Intake				Output							
Time	Nature	Vol	Time	Nature	Line 1 Vol	Line 2 Vol	Time	Urine	Gastric	1 Drain	2 Drain	Use as required		
Total			Total											

Total intake

Total output

Balance

800325165E McAteer Gillian EDD 04/09/2012 30 Years Current Gestation Parity 2 + 0 Ca Pr

POSTNATAL CHECK LISTS

Please tick when discussed/demonstrated

Feeling Confident with Baby		**Breastfeeding Bat**	
Handling my baby safely	☑	Positioning myself for breastfeeding	
Choosing nappies for my baby	☑	Positioning my baby for breastfeeding	
Changing my baby's nappies	☑	Principles of good attachment	
Caring for my baby's cord	☑	How to recognise my baby is feeding well	
A 'Top and Tail' wash/caring for my baby's skin	☑	When my milk 'comes in'	
Bathing my baby	☑	Baby's needs - exclusive breastfeeding for around the 1st 6 months of life	
How to reduce the risk of cot death	☑	Why dummies/teats should not be used	
Signs that my baby is well	☑	How to hand express my breast milk	
Signs that my baby may be ill	☑	Expressing breast milk - sterilising equipment	
Car safety and home safety	☑	Expressing breast milk - safe storage	
Registering the birth	☑	Signs that my baby is feeding well and thriving	
Registering with a GP	☑	Breastfeeding support in my community	
Do you still have a copy of Ready Steady Baby	☑		

Bottle feeding Baby		**General feeding Check**
Using bottled milk/disposable teats in the maternity unit	☑	Baby's feeding and sleeping pattern for the first few days of li

- Importance of good hand hygiene ☑
- Sterilising equipment ☑
- Making a formula feed correctly and safely (following manufacturer's instruction) ☑
- Giving a formula feed correctly and safely ☑
- Choosing the right type of formula for my new baby (whey based) ☑
- Signs that my baby is feeding well and thriving ☑

Baby led feeding

Rooming in at the maternity unit

Sharing a bed with my baby - risks discussed

Winding baby

Comments

- **Feeling confident with your baby**
- **Breastfeeding your baby**
- **Bottle feeding your baby**

User JM163

Password

Update

MW Countersigning StM signature

Guide to Countersigning

Audit Trail

Print

Update Date	Update Time		Last Update User Code
Creation Date 07/09/2012	Creation Time	11:25	Creation User Code

Simpson Medical Group

Bathgate Primary Care Centre, Whitburn Road, Bathgate, EH48 2SS

~ ~ ~

Partners: Dr J Thomson, Dr A McNutt, Dr D Hay, Dr R Holden, Dr C Hayward
Phone: 01506 654444 Fax: 01506 635931

27 June 2012

Ms Gillian McAteer
18 Cherry Avenue
BATHGATE
EH48 1NA

Dear Gillian

Further to your recent blood test on 14 June, we would be grateful if you could make an appointment to have this repeated.

Yours sincerely

Catherine McLeod
Practice Manager

SEWS KEY 0 1 2 3

DATE: 5/9 | **TIME:** 10

RESP. RATE ≥36 / 31-35 / 21-30 / 9-20 / ≤8

SpO_2 ≥93 / 90-92 / 85-89 / <85

Inspired O_2% %

Humidifier Temp

TEMP >39° / 38° / 37° / 36° / 35° / 34°

SEWS SCORE uses Systolic BP

BLOOD PRESSURE 210 / 200 / 190 / 180 / 170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50

IF PRE-ECLAMPSIA SEE CAUTION FRONT PAGE

HEART RATE >140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50 / 40 / 30

SEDATION / NEURO SCORE

S	Sleep
0	Alert
1	Verbal
2	Pain
3	Unresp

urine output (ml)

UO<100mls/4hrs

Proteinuria

SEWS SCORE (with all obs)

PAIN: Severe 9-10 / 6-8; Moderate 4-5; Mild 1-3; None 0

BM

Lochia

Fundus

Drain (ml)

Wound

Anaesthetic Block Height

Movement

Obstetric Observation Chart

NHS Lothian

Consultant: _____

Date chart commenced: _____

This is chart number _____ **this admission**

Booking weight _____ **kgs** **BMI** _____

ASU: _____

A 800325165E/E2298971 F 23/05/1982
Name: McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
DOB:
CHI 2305821425
CHI No 78132 RW Holden

An Early Warning Score (SEWS) must be calculated every time observations are recorded and ALL components completed. If SEWS score >= 4 then follow flow chart and increase frequency of observations to at least hourly.

SEWS >=4	SEWS>=6 or rapid deterioration
↓	↓
Inform midwife in charge and obstetric senior trainee	Inform obstetric and anaesthetic senior trainees (consultants if above not readily available)

CAUTION

The SEWS relates to the SYSTOLIC BP only. If there are concerns re preeclampsia then separate documentation of DIASTOLIC pressure must be made along with target BP. Action should then be taken even if the SEWS score does not 'trigger'.

Intrathecal or Epidural Opioid

Drug:	Dose	Route	Time

Patient Controlled Analgesia (PCA)
(PLEASE ALSO PRESCRIBE ON DRUG CHART)

Drug:	Dose: / 50 ml 0.9% NaCl	Concentration: mg/ml	Antiemetic:	Dose:
InitialPCA bolus :	**Lockout time:**	**Signature**	**Name**	**Date/Time**
Amended to: **Amended to:**				

IMPORTANT

IF INTRATHECAL / EPIDURAL OR PCA OPIOIDS, PLEASE ENSURE THAT RESPIRATORY RATE, SEDATION, PAIN AND NAUSEA SCORES ARE RECORDED HOURLY FOR THE FIRST 12 HOURS AFTER INITIAL DOSE

Oxygen 2l/min via nasal prongs should be continued with PCA therapy

Respiratory Depression	Nausea/vomiting	Pruritus:
If respiratory rate less than 8 or the patient is difficult to rouse immediately call Anaesthetist and Obstetric Senior Trainee If APNOEA Respiratory arrest - Dial 2222	**1st line:** Cyclizine 50mg iv/im 8 hrly (if not in PCA) **2nd line:** Ondansetron iv 4mg 6hrly **3rd Line:** Prochlorperazine IM 12.5mg **4th Line:** Dexamethasone iv 8mg	Ondansetron 8mg iv/im Naloxone 100mcg iv increments titrated to effect Chlorphenamine 4mg oral

PERSISTENT PAIN - 6 OR ABOVE - CONSIDER MEDICAL REVIEW

Reorder Ref: WLT1016-Obs

How to calculate SEWS Score (document after each set of observations)

- **Do not add pain score to SEWS Score.**
- Record standard observations (RR, SpO_2, Temp, BP, HR, AVPU).
- Note whether observation falls in shaded "At Risk Zone". Score as per SEWS key.
- Add points scored and record total "SEWS Score" in bottom row of chart.
- Action as per guidelines on front of chart.

If RR >24	Review patient / CXR +/- gases / PEF (Peak Expiratory Flow) etc → Definitive Therapy
If SpO_2 sats <93%	Review probe ? accurate Review patient → prescribe oxygen on drug chart if indicated, consider ABGs.
If Temp >38	Blood cultures Other cultures Early antibiotic therapy if sepsis suspected.
If Systolic BP<100	Review monitoring *(cardiac / oximetry / urine output / invasive BP etc).* IV Access Review patient / drug kardex.
Consider:	IV fluid bolus and reassess. Care in preeclampsia. TREAT UNDERLYING CAUSE
Consider:	Hypovolaemia: *Dehydration, Blood loss* — Obstructive: *PE, Tamponade* — Distributive: *Sepsis, Anaphylaxis* — Cardiac: *Arrhythmia, Pump failure*
If Pulse >130	Review monitoring *(cardiac monitor indicated)* IV Access Review patient / ECG / electrolytes → Definitive Therapy
If responds to pain only or unresponsive	Assess airway, BM, GCS, neuro observation chart, review patient / kardex.
If BM <4	Give Oral Carbohydrate / IV Dextrose. Consider checking urgent laboratory blood glucose.

HOW TO ASSESS BP IN A PREGNANT PATIENT

Initial BP measurement must be manual
Appropriate sized cuff should be used
Diastolic BP reading is when the sound **disappears**

Systolic BP >160mmHg	Recheck manually in 15 mins and assess patient If BP still elevated – CONTACT SENIOR TRAINEE
Diastolic BP >100mmHg Or >20mmHg from booking	Recheck manually in 15 mins and assess patient If BP still elevated – CONTACT SENIOR TRAINEE
Diastolic BP >110mmHg	CONTACT OBSTETRIC SENIOR TRAINEE IMMEDIATELY
Urinalysis ++ protein	CONTACT OBSTETRIC SENIOR TRAINEE IMMEDIATELY

When assessing the patient the following symptoms may indicate severe pre-eclampsia and require further action

Headache	Visual disturbance	Facial oedema	Breathlessness
Epigastric pain	Right upper quadrant pain	Vomiting	Generalised oedema

Nausea Score (0-3)

0 = **No Nausea**
1 = **Nausea** (consider anti-emetic)
2 = **Nausea/Vomiting** (administer anti-emetic)
3 = **Persistent Nausea &/or Vomiting** (contact Dr).

PERSISTENT NAUSEA &/OR VOMITING: USING GUIDELINES PRESCRIBE/GIVE ANTI-EMETICS. REVIEW.

Adapted from NHS Lothian SEWS Observation Chart by Obstetric SEWS Group 2009. Approved by Lothian Maternity QIP & Lothian Clinical Documentation Group.

Historic Case Notes

O.P. CLINICAL NOTES

(Surgical)

NUMBER 800325165E F 23/05/1982

NAME McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA

CHI 2305821425

78132 L Heath

DATE

16/11/14

09³⁰

S/B Urogynaecology (Medwin)

H/O Hearing ↓ Nose ©

> 1 year

Otitis media ~~Ears~~

3 episodes x ~~years~~

Nose: ✓ Throat ✓

Neck lymphs: 0

Smoky: 10/day

~~Alcohol~~: Non alcoholic

E/C ✓ ✓ ✓

PTA: MTN (05)

(A): AC 50 BC: 25

(C): AC 60

Types: Flat both

Tx: CSOM / OME.

Op: Grommets (only partial ~~report~~)

BC over 25 dB.

Risks: Bleed, perf TC: Grommets.

St John's Hospital Day Surgery Booklet

NHS Lothian

ENT

8003251653 F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 RW Holden

Date: 24.1.15 Time patient arrived: 0730

Consultant: neo

Theatre no:

Next of kin details

Name: maureen IQBAL Relationship: mum

Address:

Phone no: 633860

Escort details

Name: maureen mum Phone no:

Pre-op checks

	Ward	Theatre Reception	Anaesthetic Room
• Patient ID: bracelets x2 / Allergy band	☑	☑	☐
• Consent form signed	☐	☑	☐
• Operation site marked or obvious	☐ / n/a	☐ / n/a	☐ / n/a
• Patient Hospital notes / ward charts (inc. results / kardex / anaesthetic chart)	☑	☑	☐
• Bladder emptied	☑	☑	
• Underwear: disposable / removed	☑ / n/a	☑ / n/a	☐ / n/a
• Contact lens removed	☑ / n/a	☐ / n/a	☐ / n/a
• Prosthesis removed	☐ n/a	☐ n/a	☐ / n/a
• Hearing aid / glasses with patient	☐ / n/a	☐ / n/a	☐ / n/a
• Jewellery / piercings removed (taped)	☑ / n/a	☐ / n/a	☐ / n/a
• TEDS	☐ / n/a	☐ / n/a	☐ / n/a
• Pre-med / pre-op analgesia given	☐ n/a	☐ / n/a	☐ / n/a
• Fasted from: food 19.30 clear coffee 0630		LMP month.	
• Patient pregnant	Yes ☐ No ☑		
• Blood glucose level if required	Value	Time	
• Patient temperature in anaesthetic room	Value	Time	

Other issues including TRAK alerts: KHB SN reception.

Signatures:

Names: J Russell

Nurse led discharge

• Post op surgical visit	☑ / not needed	• IV access device removed	☑
• Post op anaesthetic visit	☑ / not needed	• Post op instructions understood	☑
• Observations stable and satisfactory	☑	• GP letter provided	☑
• Alert, orientated & ambulant	☑	• Follow up appointment made	☐ n/a
• Drinking and eating	☑	• Take home medicines	☑ n/a
• Analgesia satisfactory	☑	• Dressings provided	☑ n/a
• No nausea / vomiting	☑	• Physiotherapy organised	☐ n/a
• Passed urine	☑	• Community care organised	☐ n/a
• Operation site satisfactory	☐	• Sick absence note provided	☐ n/a

Discharge time: 1535 Date: 24/1/15

Signature of Nurse: Gwen Hall Name: Gwen Hall

Day Surgery Centre
St John's Hospital, Howden Road West,
Livingston, West Lothian, EH54 6PP.
Phone: 01506 524105
www.nhslothian.scot.nhs.uk

NHS Lothian

Consent for Operation

Affix patient label

Patient's name: ..... Consultant: Acmm

Hospital number: .....

Date of birth: .....

CHI: ..... M / F

Planned procedure: .....

Groin MCT

Common risks: Infection pain bruising

Less common risks: TVN

I confirm that I have explained to the patient in terms in which my judgement are suited to his / her understanding (and / or to one of his / her parents or guardians), the proposed operation, investigation or treatment, including options available, and if relevant, the need for anaesthesia or sedation.

Signature: ..... Date: 24/1/2025

Name and status of practitioner: Acmm Consultant

Re-confirmation of consent on the day of admission

Signature: ..... Date: .....

Name and status of practitioner: .....

Medical Students

• I agree to allow students to be present in theatre (tick box):	Yes ☐	No ☐
• I agree to be examined by a medical student whilst under general anaesthesia in theatre:	Yes ☐	No ☐

Medical Photography (I agree to being photographed)

• For my medical records for the purpose of diagnosis and treatment:	Yes ☐	No ☐
• For the purpose of teaching and education:	Yes ☐	No ☐
• For the purpose of publication:	Yes ☐	No ☐
• To be shown to other patients (as an example):	Yes ☐	No ☐

Tissue for medical research and teaching

When you have tissue removed as part of a medical investigation, operation or procedure, such as a blood test, some tissue may be left over after the laboratory tests have been completed. This tissue could be kept without your name or the details, so that it is impossible to know whom the tissue came from, and used for research or teaching, to improve laboratory tests, or to see how many people in an area might have a disease or an infection.

Do you agree? Yes ☐ No ☐

To the patient (or parent or guardian if appropriate)

1. Please read this form and the notes overleaf very carefully.
2. If there is anything that you don't understand about the explanation or if you want more information, you should ask the practitioner before signing.
3. Please check that all the information on the form is correct. If it is and you understand the explanation, then sign the form.

I am the patient / parent / guardian (delete as necessary)

I agree
- ☐ To what is proposed which has been explained to me by the practitioner named above.

I understand
- ☐ That anaesthesia (general / regional / local) or sedation will be needed.
- ☐ That the procedure may not be done by the practitioner who has been treating me so far.
- ☐ That any procedure in addition to the investigation or treatment described on this form will only be carried out of it is necessary and in my best interests and can be justified for medical reasons.

I have told
- ☐ The practitioner about the procedures I have noted below which I would wish not to be carried out without my having the opportunity to consider them first.

.....

.....

Signature: C McAteer Name: Gillian McAteer

Notes to all Health Practitioners (Doctors, Dentists, Nurses, Professionals Allied to Medicine)

A patient has an absolute legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way that they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to the treatment at any time. The patient's consent to treatment should be recorded on this consent form (further guidance is given in NHS Lothian's Policy Statement).

Notes to Patients

The health practitioner is here to help you. He or she will explain the proposed treatment and what the alternatives are. You can ask any questions and seek further information. You can refuse treatment.

You should be provided with sufficient information to allow you to come to a decision as to whether to consent to the treatment proposed.

The type of information you should receive should include:

1. Nature of your condition and proposed procedures, including degree of urgency.
2. Benefits to be reasonably accepted of the procedure.
3. Nature and probability of material (= significant) risks involved, including consideration of ratio of risks and benefits.
4. Inability of the practitioner to predict results.
5. Irreversibility of the procedure, if that is the case.
6. The likely result of not having the proposed treatment or procedure.
7. Alternatives available, including their risks and benefits.

You may ask for a relative, a friend or a nurse to be present.

Training doctors, dentists, nurses and other health professionals is essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor, dentist, nurse or other health professional.

You may however decline to be involved in the formal training of medical, dental, nursing and other students without this adversely affecting your care and treatment. You must tell a senior doctor or nurse if you do not wish students to be involved in your care and you should write this on the consent form in the space for things that you do not wish to happen without you being given the chance to consider them first.

Medical History (refer to pre-admission documents if available)

Please list any allergies and describe nature of allergy

None

Please list current medications and tick those taken today

Fluoxetine 20mg 1 a day	

Please complete the following if you were NOT assessed by the pre-admission service

Have you had any problems with anaesthesia in the past? Yes ☐ No ☑

Please provide details of any problems:

Has anyone in your family had problems with anaesthesia? Yes ☐ No ☑

Please provide details of any problems:

Please provide any other information about your family medical history that you think we should know about:

Please list any operations you have had with their approximate dates:

Have you currently or ever had any of the following? If so please provide approximate dates and any other details you feel might be useful

	Yes	No
• High blood pressure		☑
• Heart attack		☑
• Angina / chest pains		☑
• Stroke or transient ischaemic attack		☑
• Heart murmur		☑
• Pacemaker (please indicate when last checked)		☑
• Tendency to faint easily		☑
• Shortness of breath		☑
• Asthma or bronchitis		☑
• Current cold or cough		☑
• Diabetes		☑
• Epilepsy		☑
• Anaemia or bleeding tendency		
• Indigestion, heartburn or hiatus hernia	☑	
• Muscle disease or weakness		☑
• Arthritis		☑
• If female, are you pregnant?		☑

Do you smoke? Yes ☑ No ☐ If so, how much per day? 15

Do you drink alcohol? Yes ☑ No ☐

How much do you drink on average each week? (one bottle of wine = 9 units) 8 units

When did you last have an alcoholic drink? 11/1/15

Anaesthetic Record

Pre-op information

ASA 1 BP 110/77 PULSE 74 SpO_2 97 Temp 36°C Wt ..... Ht ..... BMI .....

Overweight

Awake GA ok. NKDA

No CORD NSAIDs ok.

MPI.

→ AM DVT ... TMJA

Information given to patient: IV, GA, analgesia, anti-emetics.

app to ask Qs

Anaesthesia details

Anaesthetist(s) name & grade: ..... Date: 26/1/18

Supervising Consultant: .....

Machine check ☑ Trained assistant ☑ Prelist brief / Surgical pause ☑

Vascular access (site / device / size)

22G IVC (2 attempts)

Induction

Propofol 200 mg ... to ... IVC.

...

...

...

Maintenance ... IVC.

Airway / Circuit / Machine

...

...

Easy to hand ventilate? Yes ☐

Laryngoscopy grade

Monitors:

Minimal monitoring ☑

Others

Eye care	Tape	☑
	Lubricant	☐
	Padded	☐
Pressure care		☐
Fluid warmer		☐
Warming blanket		☐
DVT prophylaxis		☐ n/a ☑
Post Op DVT prophylaxis		☐ n/a ☐
Antibiotics		☐ n/a ☐

Patient / Limb position

Significant issues or events

Recovery Obs

Recovery 13

Time	To			1240	45	50	55	00	05	10												
SpO_2	96	99		100	100	099	95	95	95	95												
$ETCO^2$		41		15	15	H	RA	RA	LA	RA												
FiO^2				LMA	LMA	SV	SV	SV	SV	SV												
ET AA	1.9	2.4		1.4	1.6	1.6	1.7	1.6	1.7													loop
Vt.f (Paw)																						
				TEMP 37.4																		
200																						
180																						
160																						
140																						
120						✓																
100	✓	✓		✓	✓		✓	✓	✓	✓												
80																						
60																						
40																						
20																						
0																						
	% 100																					
Diuresis	75			4	4	1	1	1	1													Sedation
																						Pain
																						Nausea
Events	ES																					

Recovery

Anaesthetist instructions: Routine obs ☑ O_2 as needed to maintain SpO_2>93% ☐

Tick if you want to see patient before discharge ☐

Recovery comments:

Into recovery LMA insitu O2 @ 15 L/min - rejected @ 12 47
Face Mask @ 4L/min - breathing spontaneously
Temperature taken - axilla 37.4.
Water given - tolerated well
IVI in progress, venflon Right dorsum hand - capped @ 13 20
feeling comfortable, no nausea, no oozing observed from Eyes.

Arrival time in recovery: 12 39 Time discharged to ward: .....

Recovery nurse: D. DUGDALE Signature: Dugdale (Medinet)

Prescription and administration record

If an additional prescription chart is in use tick this box ☐

Codes for non-administration of prescribed medicine

If a dose is not administered as prescribed, initial and enter a code in the column with a circle drawn round the code according to the reason as follows:

Patient refuses	1	Vomiting / nausea	8
Patient not present on ward	2	Time varied on Dr's instructions	9
Medicines not available (**check ordered**)	3	Once only / pm medication given	10
Instructions not clear or legal	4	Dose withheld on Dr's instructions	**X**
Nil by mouth	5	Possible drug reaction / side effect	12
Asleep / drowsy	6	Self administered by patient	13
Administration route not available (**check for an alternative**)	7	Other reasons	14

Pre-operative and once only medication

Date	Time	Drug / PGD No.	Dose	Route	Prescriber Signature / Name	Time given	Given by	Checked by
24/1/18	0808	PGD119	1g	PO	PGD119	84	0850	
24.1.18	Theatre Recovery	FENTANYL	100 microg max total	IV	AM.			

Regular Therapy

Drug		Date				
PARACETAMOL		Time				
Dose	Route	6				
1g	Oral	(8)				
Signature / Name	Start Date	(12)				
		14				
Notes	Pharmacy	(18)				
		(22)				

Drug		Date				
		Time				
Dose	Route	6				
		8				
Signature / Name	Start Date	12				
		14				
Notes	Pharmacy	18				
		22				

Drug		Date				
IBUPROFEN		Time				
Dose	Route	6				
400mg	Oral	(8)				
Signature / Name	Start Date	(12)				
		14				
Notes	Pharmacy	(18)				
		(22)				

Drug		Date				
		Time				
Dose	Route	6				
		8				
Signature / Name	Start Date	12				
		14				
Notes	Pharmacy	18				
		22				

Drug		Date				
		Time				
Dose	Route	6				
		8				
Signature / Name	Start Date	12				
		14				
Notes	Pharmacy	18				
		22				

Drug		Date				
		Time				
Dose	Route	6				
		8				
Signature / Name	Start Date	12				
		14				
Notes	Pharmacy	18				
		22				

As Required Therapy

Drug		Date				
MORPHINE		Time				
Dose & Frequency	Route	Dose / Route				
10mg hourly	Oral	Initials				
Signature / Name	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
		Time				
Dose & Frequency	Route	Dose / Route				
		Initials				
Signature	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
TRAMADOL		Time				
Dose & Frequency	Route	Dose / Route				
50-100mg 4⁰	Oral / IV	Initials				
Signature / Name	Start Date	Date				
	27/1/15	Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
		Time				
Dose & Frequency	Route	Dose / Route				
		Initials				
Signature / Name	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
DIHYDROCODEINE		Time				
Dose & Frequency	Route	Dose / Route				
30mg 4⁰	Oral	Initials				
Signature / Name	Start Date	Date				
	24/1/15	Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
		Time				
Dose & Frequency	Route	Dose / Route				
		Initials				
Signature / Name	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
CYCLIZINE		Time				
Dose & Frequency	Route	Dose / Route				
50mg 8⁰	Oral/IV/IM	Initials				
Signature / Name	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
		Time				
Dose & Frequency	Route	Dose / Route				
		Initials				
Signature / Name	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
ONDANSETRON		Time				
Dose & Frequency	Route	Dose / Route				
4mg 6⁰	Oral/IV/IM	Initials				
Signature / Name	Start Date	Date				
	24/1/15	Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Drug		Date				
		Time				
Dose & Frequency	Route	Dose / Route				
		Initials				
Signature	Start Date	Date				
		Time				
Indication / Notes	Pharmacy	Dose / Route				
		Initials				

Surgeon's Operation Notes

Affix patient label

Patient's name: .....

Hospital number: .....

Date of birth: .....

CHI: ..... M / F

Consultant: ALADA

Surgeon	Assistants	Scrub Nurse	Operation
BARR			R+L GROMT

Surgeon's operation notes

F - R+L GRADE ATTIC RETRACTION
NO DEBRIS
TM (N)
ME DRY

P - AMT INF MYRINGOTOMY
SMALL GROMET
CLOXCIN DROPS START
} R+L

POST OP (H) LASER

F/U TSA & MEDIMET

BARRINGTON
COX
46 19730

Surgeon's operation notes - continued

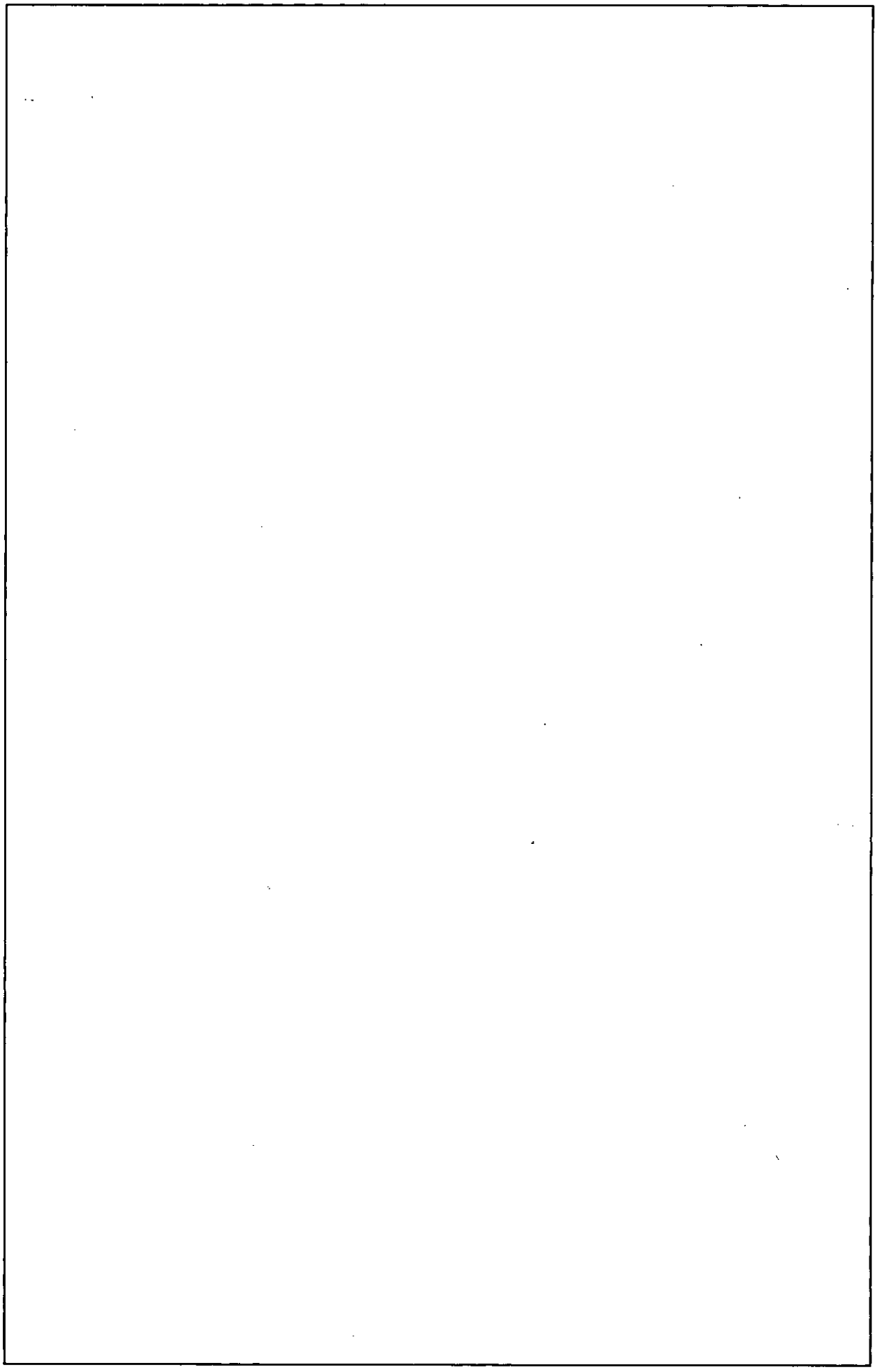
Ward instructions

Complete sickness absence note as necessary
Tick if you want to see patient before discharge ☐

Signature: .....

Name: ..... Date: .....

Theatre Equipment Stickers



Day Surgery Centre
St John's Hospital, Howden Road West,
Livingston, West Lothian, EH54 6PP.
Phone: 01506 524105
www.nhslothian.scot.nhs.uk

NHS Lothian

Discharge Letter

Affix patient label

Patient's name: .....

Hospital number: .....

Date of birth: .....

CHI: ..... M / F

Consultant: .....

Operator: .....

GP: .....

Dear Doctor,

Your patient underwent the following operation or investigation and will be discharged today.

Operation / Investigation: .....

Findings / Results: .....

Further treatment is planned as follows: .....

Removal of sutures: .....

Follow up arrangements: .....

Sickness absence form has been issued for: days / weeks

DISCHARGE Prescription	Dose / Timing / Route	No. of days	Prescriber: Sign / Name	Dispenser: Sign / Name	Checked by
Paracetamol 500mg	Two tablets every 6 hours PRN	3			
Ibuprofen 400mg	One tablet every 6 hours PRN				
Dihydrocodeine 30mg	One tablet every 6 hours PRN				

CONTROLLED Drug Prescription (delete those not required)	Dose	Frequency	Total Quantity Supplied In figures & words	Prescribers Signature & Name	Pharmacy Disp/check
Tramadol 50mg capsules	ONE or TWO capsules	4 hourly PRN Max 400mg daily	..... capsules ..... capsules		
Morphine sulphate 10mg MR tablets	..... mg ..... tabs	Twice daily	..... tablets ..... tablets		
Morphine sulphate 10mg/5ml oral solution	..... mg	..... Hourly PRN Max ..... times daily	..... millilitres ..... millilitres		

Signature: ..... Date: 24/1

Name: ..... Phone. no: .....

Top copy (White) Patient's copy Second copy (Yellow) GP's copy Third copy (Blue) Pharmacy copy

THEATRE 3

OPERATING POSITION

SUPINE	✓	LLOYD DAVIES	
LATERAL PRONE		KIDNEY	
NECK EXTENSION		KNEE / FOOT	
LITHOTOMY		TRACTION	
OTHER			

INFILTRATION N/A

FITTINGS / ATTACHMENTS

HEEL PAD		ARM REST	
ARM BOARD		FOOT BOARD	
ARM TABLE		ANAES. SCREEN	
PELVIC SUPPORT		WEDGES	
LATERAL SUPPORT		PILLOWS	X
ARM RETAINERS x2	✓	GOLLIGER	
STRAPS (Velcro / Rubber)			

OTHER.....

WICK/PACK / ROLL IN WOUND

N/A

VAGINAL ☐ NASAL ☐

SPONGOSTAN ☐

TYPE.....

OTHER.....

PLASTER OF PARIS SPLINTING

N/A

PNEUMATIC BOOTS

N/A

FULL LENGTH ☐ HALF LENGTH ☐

TED STOCKINGS ☐

SPECIMENS SENT

YES ☐ NO ✓

Surgical safety checklist – St Johns Hospital Operating List

Date 24/1/15

Pre-list briefing (Y) N

Surgical Pause (Y) N

Signed .....

Print name ALAN KILPATRICK Time.....

DIATHERMY PLATE POSITION

N/A

RIGHT	☐	THIGH	☐
LEFT	☐	ABDOMEN	☐
MONOPOLAR	☐	BACK	☐
BIPOLAR	☐		

BLOOD LOSS

SWABS.....

SUCTION.....

TOTAL..... Approx < 5mls

SKIN CLEANING SOLUTION

N/A

BETADINE (ALCOHOLIC)	☐
BETADINE (ANTISEPTIC)	☐
CHLORHEXIDINE 0.5% IN SPIRIT	☐
TISEPT	☐

OTHER.....

PROSTHESIS

Bilateral SHAH Grommits

PERITONEAL LAVAGE

SALINE ☐ TETRACYCLINE ☐ OTHER.....

CATHETER N/A

SIZE ..... TYPE.....

BALLOON CAPACITY ..... FREE DRAINAGE ☐ URIMETER ☐

DRAINS N/A

REDIVAC ☐ LARGE/MEDIUM/MINI ☐ OTHER.....

CORRUGATED ☐ SILASTIC ☐ SUTURED IN YES ☐ NO ☐

SKIN CLOSURE

N/A

STAPLES ☐ STERI STRIPS ☐ OTHER.....

INTERRUPTED ☐ CONTINUOUS ☐ SUBCUTICULAR ☐

WOUND DRESSING

N/A

MEPORE	☐	JELONET	☐	INADINE	☐
CREPE	☐	PLASTER WOOL	☐	DRESSING SWABS	☐
		FLAVINE WOOL	☐		

SURGIPAD ☐ OPSITE SPRAY ☐

EAR DROPS = Cilotan

800325165E F 23/05/1982

McAteer, Gillian

18 Cherry Avenue,

Bathgate,

West Lothian,

EH48 1NA

CHI 2305821425

78132 L Heath

MR Barings

PATIENT UNIT NO.

ANAESTHETIST SIGNATURE Dr Arnstein

DATE

Bilateral Grommet insertion

24/1/15

PRE-OPERATIVE CARE / RECEPTION

TICK OR CROSS BOXES

IDENTIBAND IN PLACE		CHARTS	
OPERATION SITE IDENTIFIED		CASE NOTES	
CONSENT FORM SIGNED		PRESCRIPTION (with antibiotics if prescribed)	
		ANAESTHETIC	
		FLUID BALANCE	
		XRAY / LAB RESULTS	
FASTED		PRESSURE SORE RISK ASSESSMENT FORM	
PRE-MED GIVEN		MAN. HANDLING RISK ASSESSMENT FORM	
ALLERGIES:		ORAL HYGIENE RISK ASSESSMENT FORM	
		TED STOCKINGS ON / OFF	
		WEIGHT	
		EMLA CREAM APPLIED	
SKIN CONDITION			
DENTURES OUT		CROWNS / LOOSE TEETH	
CONTACT LENSES OUT		JEWELLERY REMOVED / TAPED	
VISION HEARING		SPEECH MOBILITY	
MAKE UP / NAIL VARNISH REMOVED		MODESTY / COTTON PANTS ON	
OPERATION SITE SHAVED		COT SIDES ON	

SPECIFIC ANXIETIES EXPRESSED:

OTHER RELEVANT INFORMATION:

ANAESTHETIC CARE

ANAESTHETIC:

FACE MASK		LARYNGEAL MASK	
ENDO TRACHEAL TUBE		AIRWAY	

LINES INSERTED:

PERIPHERAL CANNULAE		BUTTERFLY	
ARTERIAL		CENTRAL	

CANNULATED SITE:

RIGHT HAND		RIGHT ARM	
LEFT HAND		LEFT ARM	
OTHER		.....	

EYE CARE:

TAPED		
OINTMENT		.....
DROPS		.....

ADDITIONAL INFORMATION:

SIGNATURE: **DESIGNATION:**

Day Surgery Centre
St John's Hospital, Howden Road West,
Livingston, West Lothian, EH54 6PP.
Phone: 01506 524105
www.nhslothian.scot.nhs.uk

NHS Lothian

Discharge Letter

8003231U3E F 23/03/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 RW Holden
M / F

Consultant: O'C 1.24
Operator: Rankine
GP:

Dear Doctor,

Your patient underwent the following operation or investigation and will be discharged today.

Operation / Investigation: R L Crown

Findings / Results:

Further treatment is planned as follows: 2

Removal of sutures:

Follow up arrangements:

Sickness absence form has been issued for: days / weeks

DISCHARGE Prescription	Dose / Timing / Route	No. of days	Prescriber: Sign / Name	Dispenser: Sign / Name	Checked by
Paracetamol 500mg	Two tablets every 6 hours PRN	7			
Ibuprofen 400mg	One tablet every 6 hours PRN				
Dihydrocodeine 30mg	One tablet every 6 hours PRN				

CONTROLLED Drug Prescription (delete those not required)	Dose	Frequency	Total Quantity Supplied in figures & words	Prescribers Signature & Name	Pharmacy Disp/check
Tramadol 50mg capsules	ONE or TWO capsules	4 hourly PRN Max 400mg daily	..... capsules ..... capsules		
Morphine sulphate 10mg MR tablets	.....mg .....tabs	Twice daily	..... tablets ..... tablets		
Morphine sulphate 10mg/5ml oral solution	.....mg	..... Hourly PRN Max..... times daily	..... millilitres ..... millilitres		

Signature: Date: 24/1/

Name: Phone. no:

Top copy (White) Patient's copy Second copy (Yellow) GP's copy Third copy (Blue) Pharmacy copy

800325165E F 23/05/1982 "'S Lothian
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 RW Holden

PREOPERATIVE ASSESSMENT

Date 13/01/15 Adm. type: **ELECTIVE**

Assessing hospital: SOH Clinic.....

Patient present ☑ Telephone assessment ☐

Check registration details : correct ☐ changed ☐

Reason for admission / Planned surgery or procedure

Grommet

Dates when on holiday / not available

Planned date of surgery 24/01/15 Consultant.....

Day case ☑ 23h stay ☐ Expected stay ..... days ☐

Day of surgery admission ☑ Other admission date ..... / ..... / .....

Admission time .....

Key to Initials of ALL STAFF completing this ICP

Print name	Designation	Initials	Signature	Date
1. JULIE ANDERSON	SN	JA	J Anderson	13/01/15
2.				
3.				
4.				
5.				
6.				

ADVERSE REACTIONS / ALLERGIES Describe reaction

NIL.

Preoperative assessment for elective surgery	addressograph label, *or,*
	Name
	DoB
Date	Unit no.
	CHI

PATIENT's DETAILS

TITLE: ~~Mr~~ / ~~Mrs~~ / Miss / ~~Ms~~ / ~~Other~~ Gillian McAteer Marital Status: Single

Age: 32 Occupation: Catering Ass

Prefers to be known as .....

Tel. Nos. Home .....

Work .....

Mobile 07712184504

GP Dr Heath

GP Address Bathgate (Simpsons)

GP tel no. 01506 654444

Ethnic Origin: White First Language: English ☒ Other ☐ Scottish

Interpreter Required : Yes ☐ No ☒

(see Intranet> Healthcare > A-Z > Translation, Interpretation & Communication Support)

Religion: ..... *(If Jehovah's Witness attach appropriate form)*

Request for visit from hospital chaplain / minister of religion: Yes ☐ No ☒

NEXT OF KIN

[redacted]

Aware of admission Yes ☑ No ☐

SECOND CONTACT (If required)

Name: [redacted]

Relations

Address:

.....

.....

Contact nos

Aware of admission Yes ☒ No ☐

Who to contact in an emergency

..... [redacted] .....

COMMON ABBREVIATIONS USED IN THIS DOCUMENT

BM	Capillary blood glucose (aka cBG)	**Ht**	height	**R/O**	Removal of
BMI	Body Mass Index	**IV**	Intravenous	**RA**	Rheumatoid arthritis
BP	Blood pressure	**ICP**	Integrated Care Pathway	**RF**	Renal failure
C&S	Culture and Sensitivity	**kg**	Kilograms	**RR**	Respiratory Rate
cm	Centimetre	**LMP**	Last menstrual period	**SEWS**	Standardised Early Waming Score
COPD	Chronic Obstructive Pulmonary Disease	**MI**	Myocardial infarction		
		MUST	Malnutrition Screening Tool	**TB**	Tuberculosis
DoS	Day of surgery	**N/A**	Not applicable	**Temp**	Temperature
DVT	Deep vein thrombosis	**NOK**	Next of kin	**U&E**	Urea and electrolytes
ECG	Electrocardiograph	**OA**	Osteo arthritis	**VTE**	Venous thromboembolism
EDD	Estimated Date of Discharge	**OPD**	Out patient department	**Wt**	Weight
ERAS	Enhanced Recovery After Surgery	**P**	Pulse		
FBC	Full blood count	**PE**	Pulmonary embolus		
HRT	Hormone replacement therapy	**PMHx**	Past medical history		

Preoperative assessment for elective surgery Date 13/01/15	addressograph label, *or,* Name DoB Unit no. CHI

PRESENTING COMPLAINT / HISTORY

Patient aware of condition? Yes ☑ No ☐ *Detail awareness of eg, malignancy etc*)

Mood / Concerns with regard to current treatment plan?

PAST Medical history Include year and place

(or: No to all questions and else nil of note ☐)

Preoperative assessment for elective surgery **History (1)** Date 13/01/15	addressograph label, *or,* Name DoB Unit no. CHI

PREVIOUS Operations Include year and place

Blocked Bowel 6 months old.
C-Section 2012. SGH.

(or: No to all questions and nil of note ☐)

Any problems with surgery or anaesthesia **in the past**? Include year and place
(include details of airway problems, if any)

NIL -

(or: **No** to all questions and nil of note ☐)

Any significant **family** (blood relatives) medical / surgical / anaesthetic history we should know about?

Father - Asthma, Hypertension

(or: No to all questions and nil of note ☐)

BASIC OBSERVATIONS

Height 162-6 m	Weight 115.2 kg	BMI 43-5 kg / m²
MUST Score	Pt concerned about weight? Yes ☐ No ☐	SpO_2 % (on air)
Pulse rate 84 / min	BP 1 / mmHg	BP 2 / mmHg
BP 3 121 / 84 mmHg	BP 4 / mmHg	Temp °C
Urinalysis		

Preoperative assessment for elective surgery **History (2)** Date 13/01/15	addressograph label *or* Name DoB Unit no. CHI

MEDICATION HISTORY (prescription, over the counter, homeopathic, herbal. etc)

(Remember inhalers / eyedrops / creams / injections)

If diabetic, include Diabetes ICP in notes

MEDICINE (approved name)	Strength	Dose	Route	Frequency	**COMMENTS**
1. Fluoxetine	20mg		oral	daily	
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					

How was medication history obtained? *(Must be by two methods)*

N/A ☐ GP letter ☐ Medications available ☐ Patient ☑ Relative / carer ☐ Repeat prescription ☐

ECS on Trak ☐ Pharmacy-supplied "Dosette" box (or other compliance aid)? ☐

Community Pharmacy ☐ Name ..... tel. number .....

Informed of *Use of own medicines* policy? Yes ☐ No ☐ N/A ☐

Use of own medicines form completed? Yes ☐ No ☐ N/A ☐

Advised of LUHD's use of supplementary prescribers? Yes ☐ No ☐ N/A ☐

ADVERSE REACTIONS / ALLERGIES – ensure recorded on p1

Preoperative assessment for elective surgery

Review of Systems (1)

Summarise actions In "Summary of Assessment"
If YES is circled for any main question, expand on severity / frequency / duration / recent changes – what, when, how, etc

addressograph label, *or,*
Name
DoB
Unit no.
CHI

CARDIOVASCULAR SYSTEM

Any history of: high blood pressure ☒, angina ☒, atrial fibrillation ☒, heart murmur ☒, MI ☒, rheumatic fever ☒, DVT / PE ☒, stroke or TIA ☒?

Do you get

Chest pain	No ☑	Yes ☐
Short of breath	No ☑	Yes ☐
Ankle swelling	No ☐	Yes ☐ sometimes

No to all questions and nil else of note ☐ Requires medical referral? Yes ☐ No ☑

RESPIRATORY SYSTEM

Any history of: asthma ☒, TB ☒, COPD ☑?

Do you / have you

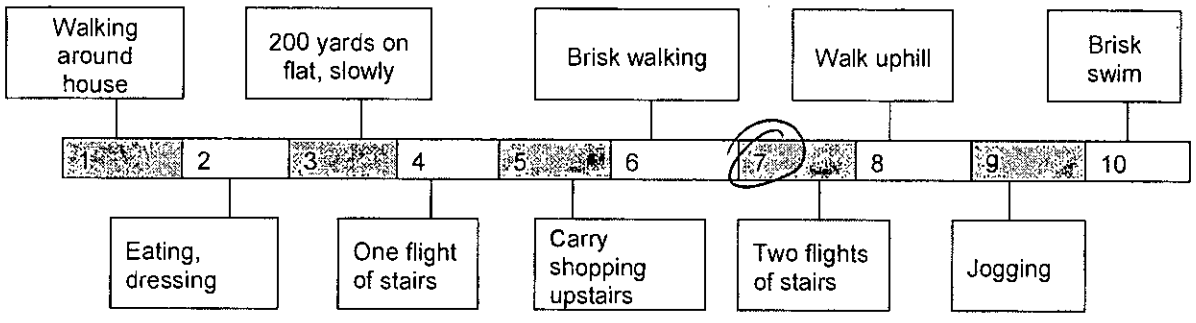
A cough?	No ☑	Yes ☐
Sputum or phlegm	No ☑	Yes ☐
Coughed up blood	No ☑	Yes ☐
Get wheezy	No ☑	Yes ☐

No to all questions and nil else of note ☐ Requires medical referral? Yes ☐ No ☑

FUNCTIONAL CAPACITY

Patient's occupation / former occupation .....

Maximum equivalent activity (Please ring number in box, = MET Score) :



Estimated MET score..... 8. ..... *(highest ringed number)*

What limits activity?		Comments
Nil	☐	
Arthritis / leg pain / back pain	☐	
Angina	☐	
Shortness of breath	☐	
Other	☐	

Preoperative assessment for elective surgery

Review of Systems (2)

Summarise actions In "Summary of Assessment"
If YES is ticked, expand on severity / frequency / duration / recent changes – what, when, how, etc

addressograph label, *or,*
Name
DoB
Unit no.
CHI

DIGESTIVE SYSTEM *see also 'Nutrition'*

Do you / have you

Any recent appetite changes	No ☒ Yes ☐
Vomited any blood	No ☒ Yes ☐
Heartburn / indigestion [including when lying flat]	No ☐ Yes ☒ Rennie.
Stomach pain	No ☒ Yes ☐
Changes in bowel movements, black or bloody stools	No ☒ Yes ☐
History of jaundice?	☒

No to all questions and nil else of note ☒ Requires medical referral? Yes ☐ No ☒

ENDOCRINE system

Diabetes mellitus ☒ Type 1 ☐ Type 2 ☐
treatment: insulin ☐, tablets ☐, diet ☐, other ☐
Thyroid condition ☒
Other endocrine condition ☐ .....
.....

No to all questions and nil else of note ☒ Requires medical referral? Yes ☐ No ☒

SKIN

Any skin diseases? No ☒ Yes ☐ (Eczema, psoriasis etc....please specify)

.....

describe any action required on page 16

No to all questions and nil else of note ☒ Requires medical referral? Yes ☐ No ☒

NERVOUS system

Any history of epilepsy ☒ "blackouts" ☒ ?

If Yes, describe

.....

Do you get

Severe headaches, migraines	No ☒ Yes ☐
Eye problems	No ☐ Yes ☐
Faints, dizziness, muscle weakness or tingling sensations	No ☒ Yes ☐

No to all questions and nil else of note ☒ Requires medical referral? Yes ☐ No ☐

SLEEPING / LYING FLAT

Sleep: well ☒, disturbed ☐ *describe* .....
Any sleeping medication / treatment No ☐ Yes ☐
Are you able to lie flat comfortably: No ☐ *describe* .....Yes ☒

Sleep Apnoea No ☒ Yes ☐
CPAP machine used No ☒ Yes ☐
If more than 1 year since PAT test contact Estates ☐ ref. no. .....

Preoperative assessment for elective surgery

Review of Systems (3)

Summarise actions In "Summary of Assessment"

If **YES** is ticked, expand on severity / frequency / duration / recent changes – what, when, how, etc

addressograph label, *or,*

Name

DoB

Unit no.

CHI

GENITO-URINARY system URINE SAMPLE SENT FOR C & S Yes ☐, or, N/A ☐

Any history of Renal conditions / intervention ☐ No to all questions and nil of note ☐

When passing urine, do you

Pass blood or have pain	No ☒ Yes ☐
Need to pass urine very frequently	No ☒ Yes ☐
Find your sleep disturbed by having to pass urine frequently?	No ☒ Yes ☐
Experience difficulty – slow to start, dribble etc	No ☒ Yes ☐
Required/s catheterisation:	No ☒ Yes ☐

requires medical referral? Yes ☐, No ☒

Female patients only

Date of LMP 29/12/14 Details of last period ..... Details of cycle 28 days

(normal, light, heavy)

Date of last cervical smear Uptodate Method of contraception Copper Coil or N/A ☐ . Parity 3+0

Pregnancy test on day of surgery discussed* Yes ☐ No ☐ **If <50yrs or within 2 years of any bleeding*

(See A&T Intranet guideline "Pregnancy testing before surgery").

BLOOD DISORDERS Any history of anaemia ☒, other blood disorders ☒ ?

If Yes, describe

.....

.....

.....

OTHER ILLNESSES: e.g. any history of cancer ☒, arthritis: OA ☒, RhA ☒ ?

.....

.....

.....

or, No to all questions and nil of note ☒

Please also complete

Prion disease risk factor assessment *(Appendix 1)*	☐		
Local venous thrombo-embolism risk assessment *(Appendix 3a or b)*	☐		
4AT assessment *(Appendix 4)*	☐	*or* **completed on Trak**	☐
MUST score *(Appendix 5)*	☐	*or* **completed on Trak**	☐

Preoperative assessment for elective procedure **Airway Assessment** **(For completion only by anaesthesia or pre-admission staff)**	addressograph label, *or,* Name DoB Unit no. CHI

Where appropriate, record more fully in 'Summary of Assessment'

DOES THE PATIENT APPEAR TO HAVE COMPLICATED DENTITION: Yes ☐ No ☒

DENTITION – patient's report

R	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8 L
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Mark

D: Denture L: loose teeth/filling

B: Bridge

C: Crown

Dental abscess / issues: No ☒ Yes ☐

AIRWAY ASSESSMENT

1. Patient can flex and extend neck normally?	Yes ☑ No ☐
2. Patient can open mouth >3cms (2 finger breadths)?	Yes ☑ No ☐
3. Patient can protrude jaw so that lower teeth are in front of upper teeth?	Yes ☑ No ☐
4. Thyromental distance >6.5cm?	Yes ☑ No ☐
5. Previous history of difficult intubation?	Yes ☐ No ☑

6. Mallampati classification:

Seated patient protrudes tongue as far as possible. From patient eye level, assess pharyngeal structures.

Class I	Class II	Class III	Class IV
☐	☑	☐	☐
Soft palate, uvula, fauces and pillars all visible.	Soft palate, uvula, & fauces visible, pillars obscured.	Only soft palate visible.	Soft palate not visible.

If the faucial pillars (palatoglossal & palatopharyngeal arches) & uvula cannot be seen (because they are obscured behind the base of the tongue, grades III & IV), visualisation of the glottis at laryngoscopy is likely to be more difficult

The following airway findings require referral to anaesthetist:

See local / specialty specific guidelines

Preoperative assessment for elective surgery

Examination by medical staff

Summarise actions in "Summary of Assessment"

addressograph label, or,

Name

DoB

Unit no.

CHI

PHYSICAL EXAMINATION

Pale Cyanosed Clubbed Jaundiced

Lymphoedenopathy

Hydration

Skin

Thyroid

Breasts

Any fevers/chills recently?

CVS

Pulse

BP (Erect/Supine)

JVP (Jugular Venous Pressure)

Apex Beat

Heart Sounds

Oedema

PHYSIOLOGY SCORE

Please tick

Cardiac*

- No failure
- CVS drugs
- Peripheral oedema
- Warfarin therapy
- Raised JVP

ECG*

- Normal
- Atrial Fibrillation
- Abnormal rhythm
- Recent Q, ST/T changes

RS

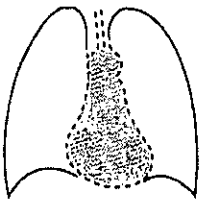
Respiratory Rate

Trachea

Expansion

PN (Percussion Notes)

BS (Breath Sounds)



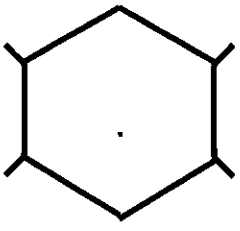
Respiratory*

- Nil
- SOBOE
- Limiting dyspnoea
- Dyspnoea at rest

CxR*

- Normal
- Borderline CM
- Cardiomegaly
- Mild COAD
- Moderate COAD
- Fibrosis
- Consolidation

Abdomen:



- Masses
- Liver
- Spleen / Kidneys
- Bowel sounds
- Hernlae
- Genitalia
- PR
- FOB

Vaginal Examination: (if indicated)

Rectal Examination (if indicated)

CNS/Locomotor

Assessing Doctor:

Signature ..... print name:.....

Date:..... time: designation .....

Preoperative assessment for elective procedure **Nursing & Social Assessment (1)** Summarise actions in "Summary of Assessment"	addressograph label, *or,* Name DoB Unit no. CHI

PAIN ASSESSMENT

Does patient attend a Pain Clinic or have an established history of chronic pain? Yes ☐ No ☑

If so please ask patient to score pain, out of 10 (0 = no pain, 10 = worst pain imaginable) _____

Has previous pain or nausea control after surgery been unsatisfactory? Yes ☐ No ☐

Does patient use regular opioid analgesic:
(eg. MST / Oxycodone / Fentanyl)? Yes ☐ No ☐

Does patient have regular use of high dose mild opiates:
(eg. Dihydrocodeine / Tramadol)? Yes ☐ No ☐

If the patient answers **YES** to any of above questions, did you contact anyone about pain management Yes ☐ No ☐

If Yes, whom? *name* ..... *and detail outcome in 'Summary of assessment'*

HEALTH PROMOTION

CIGARETTE SMOKING Non smoker ☐ Recent ex-smoker ☐ stopped ..... (date)

Smoker ☑ Number of cigarettes smoked per day 15.

Ever tried to stop? Yes ☐ No ☑

Advised of the value of stopping and the risks to health of continuing to smoke cigarettes ☐

Discussed with patient implications of no smoking policy within the hospital and grounds ☐

Identified ways of managing before admission e.g. consult GP ☐ nicotine patches ☐

Interested at all in stopping now? Yes ☐ No ☑ .....

If would like to stop, detail information given to assist .....

ALCOHOL INTAKE None ☐

Daily intake .....units OR Weekly intake 8. .....units

(1 unit of alcohol = small glass of wine, or 25 ml pub measure of spirit, or half pint of ordinary strength lager/beer/cider
Current daily guidelines for sensible drinking: men 3 – 4 Units per day or less, women 2 – 3 Units per day or less.

Any patient concerns about his/her alcohol intake? .....

If yes, detail information given to assist .....

OTHER MOOD ALTERING SUBSTANCES: None ☒ Yes ☐ (Specify below)

.....

Is the patient concerned about his / her substances use? .....

If yes, detail information given to assist.....

WEIGHT CONCERNS Is the patient concerned about his / her weight No ☐ Yes ☐

If yes, detail information given to assist .....

COMMUNICATION & PERCEPTION

SIGHT:	No aids	☑	Glasses	☐	Contact Lenses ☐	Registered Blind	☐
HEARING:	Satisfactory	☐	Difficulties	☐.....		Hearing Aid(s)	☐
SPEECH:	Normal	☑	Impaired (eg after stroke)	☐.....		Sign Language	☐
	Interpreter	☐	Other aid or assistance	☐.....			

Preoperative assessment for elective procedure **Nursing & Social Assessment (2)** Summarise actions in "Summary of Assessment"	addressograph label, *or,* Name DoB Unit no. CHI

Lives with Husband / Wife / Partner / Other (*specify*) ☐ ..... Alone ☐

ARE YOU ARE CARER FOR ANYONE (*specify*) Yes ☐ ..... No ☐

LEARNING DISABILITIES Yes ☐ No ☐
If Yes, refer to Learning Disabilities Liaison Nurse: *Contacted Yes / No detail outcome*

HOUSING
House ☐ Bungalow ☐ Ground Floor Flat ☐ Flat ☐ on .....floor
Residential / Part IV ☐ Nursing Home ☐ Hostel ☐ No Fixed Abode ☐
Bedroom: upstairs ☐ downstairs☐ Bathroom: upstairs ☐ downstairs☐

STAIRS: None ☐
Outside: ..... (number) Inside: ..... (number) Lift ☐
Does patient have any difficulty with the stairs? Yes ☐ *(specify)* .....No ☐

EQUIPMENT None: ☐
Toilet aids ☐ Shower cubicle ☐ Shower over bath ☐ Bath aids ☐ Bath only ☐
Bed Rail ☐ Trolley ☐ Dressing Aids ☐ Commode ☐ High Chair ☐
If Yes to any please specify level of independence.....

MANUAL HANDLING and MOBILITY Hand Dominance – L ☐ R ☐ See p4 for BMI .....
Is the patient independent Yes ☐ No ☐
If No specify aids used: .....
Specify assistance required: e.g. hoist etc .....
☐ If hoist, is it supplied by NHS Lothian: Yes ☐ No ☐ – refer to **Manual Handling** guidelines
☐ If patient weighs >25st [160 kg] – refer to 'Heavy patient' procedure in **Manual Handling** guidelines
Tick if patient requirements indicate staff should be aware of this guideline in caring for this patient & specify actions required from these guidelines

Falls Risk Assessment (STRATIFY)

Admitted with fall or fall since admission	Yes ☐ No ☐
Confused or agitated	Yes ☐ No ☐
Function impaired by poor vision	Yes ☐ No ☐
Frequent toileting	Yes ☐ No ☐
Help to transfer/walk (No, if bed bound)	Yes ☐ No ☐

Complete a Falls Care Plan if:
Yes to two or more, or if this admission was precipitated by a fall, or patient has fallen since admission
Completed Yes ☐ No ☐

HYGIENE No concerns ☐
Requires Assistance ☐ - *give details*
.....
.....

FEEDING & NUTRITIONAL ASSESSMENT MUST score .....
.....
.....

Preoperative assessment for elective procedure **Nursing & Social Assessment (3)** Summarise actions in "Summary of Assessment"	addressograph label, or, Name DoB Unit no. CHI

SKIN CONDITIONS

Do you have a history of skin disorders ☐ , leg ulcers / pressure sores ☐ , circulation problems ☐?

Dressings, if applicable (including frequency of changes, by whom etc). Detail 'Summary Of Assessment'

.....

.....

Please also complete the Waterlow pressure care guide *(Appendix 2)* ☐

Total score =

Nursing & Social assessment completed by: **Signature / initials*:**.....	**Print name:**	**Date**

* initials are acceptable **IF** an entry has been completed on pg 2

Please obtain & confirm the patient's consent before contacting any of the staff or groups below

Patients Signature_____

HOME SUPPORT	N/A	MON	TUE	WED	THU	FRI	SAT	SUN	CONTACT NAME / NUMBER
District Nurse									
Health Visitor									
Social Worker									
Stoma Therapist									
Dietician									
Home Help									
Private Home Care									
CPN									
Frozen Meal Service									
Day Centre									
Day Hospital									
Other1 *specify*									
Other2 *specify*									

Preoperative assessment for elective procedure **Overall Summary of Assessment**	addressograph label, *or,* Name DoB Unit no. CHI

Medical Referral required No ☑ Yes ☐ Surgeon ☐ GP ☐ other ☐

If Yes, reason .....

.....

Name of doctor spoken to .....

Information, eg medical notes / care pathway / results, referred to anaesthetist No ☐ Yes ☐

Discussion with anaesthetist required: No ☐ Yes ☐ Seen by anaesthetist No ☐ Yes ☐

Referral reason .....

.....

Name of consultant anaesthetist spoken to / contacted .....

INVESTIGATIONS REQUESTED

See: Pre-operative assessment of patients before elective surgery - a general guide (Intranet)

FBC ☐ U&E ☐ LFTs ☐ Coagulation screen ☐ Group & save ☐

ECG ☐ CXR ☐ Echocardiogram ☐ PFTs ☐ Chlamydia swab ☐

Other (specify) ☐ .....

.....

OVERALL SUMMARY OF ASSESSMENT (free text space on pp 15 -16)

☑ Proceed to book for surgery

☐ Further review / investigations required before final decision (*Specify below*)

Waiting list office:

Early on am list ☐ Diabetic ☐ Possible difficult airway ☐ High BMI ☑ 43.5

Haematology involvement ☐

Assessing Doctor: / Nurse

Signature .....Print Name:.....

Date: .....Time:.....Designation.....

Preoperative assessment for elective procedure **Overall Summary of Assessment and further notes**	addressograph label, *or,* Name DoB Unit no. CHI

OVERALL SUMMARY OF ASSESSMENT

Date/time		initial
13/01/15	Pre-op assessed for procedure as listed - enjoys good health, ↑ BMI, medication on page 5. OAndersonSN	

Preoperative assessment for elective procedure **Overall Summary of Assessment and further notes**	addressograph label, *or,* Name DoB Unit no. CHI

OVERALL SUMMARY OF ASSESSMENT

Date/time		initial

Preoperative assessment for elective procedure **OVERALL SUMMARY OF ASSESSMENT** *continued*	addressograph label, *or,* Name DoB Unit no. CHI

INFORMATION

Patient informed that he / she must arrange transport home by car or taxi ☐

Patient informed that he / she must accompanied by responsible adult for 24h ☐

Leaflets given:

Inpatient booklet ☐ Visiting Hours ☐ Operation ☐ Your spinal anaesthetic ☐ Epidurals for pain relief after surgery ☐ Pain relief ☑ Physio Booklet ☐

Other (specify) ☐ .....

INTEGRATED CARE PATHWAY

If to be commenced on an ICP, specify which major : .....

Any supplementary ones?: .....

TRANSPORT Ambulance required ☐ Date/time.....

Date of booking / Order ref no..... / .....

OPERATIVE PREPARATION Skin Prep Required Yes ☐ No ☑ Glycerine Suppositories Yes ☐ No ☑

Other (specify) .....

NURSE SPECIALIST REFERRALS *tick if applicable & give details*

Stoma Nurse contacted ☐ ..... *(if applicable, insert Stoma Care plan in Booklet)*

Other Nurse Specialist contacted ☐ (*specify*) .....

Pre-Admission Nurse

Signature / Print: Kandiran Anderson Designation: SIN Date: 13/01/15

Planning for discharge

.....

.....

.....

.....

.....

.....

Preoperative assessment for elective procedure **PRION Disease Risk Factors**	addressograph label, *or,* Name DoB Unit no. CHI

NOTE: Only approximately 1 in 10,000 patients will be classified as "maybe at risk")

Please ask the patient question 1.

The assessor should consider, and answer, the three bullet points.

Ask the patient questions 2 - 5

If the answer is "yes" to any question, follow the appropriate path on the NHS Lothian CJD Risk Assessment flow sheet.

1. Have you ever been contacted as "at risk of CJD for public health purposes? ①..... N Y
   - Is there any mention of CJD or v CJD in referral letter? ..... N Y
   - Does the patient have a neurological disease with cognitive impairment or ataxia, of uncertain diagnosis? ..... N Y
   - Is the operation likely to involve contact with "high risk" tissues?⑥ ..... N Y

     If "yes" to this question, ask if the patient has received a transfusion of blood, or blood products, since 1980? ..... N Y
2. Has anyone in your family suffered from CJD? ..... N Y
3. Has you or anyone in your family had genetic testing that suggests you or they are at risk of CJD? ..... N Y
4. Have you ever had treatment with growth hormone or gonadotrophin? ..... N Y
5. Have you ever had an operation on your brain or spinal cord? ②..... N Y

① The key phrase is *"at risk for public health purposes"*.
Since 2003 blood transfusions have not been accepted from those who, themselves, have received blood in the UK since 1980 (Previously Transfused Donors), but this alone should not generate a "yes" response.

② The question refers to operations for cyst or tumour of spinal cord.
Previous operations on the vertebral column (e.g. laminectomy, discectomy, decompression) are not of concern and should not generate a "yes response. See note ⑥ for list of high risk neural tissues

⑥ High Risk tissues for patients with vCJD and at risk of vCJD include:
Brain, spinal cord, dura mater, cranial nerve ganglia, cranial nerves (specifically, the entire optic nerve but only the intracranial components of other cranial nerves), posterior eye (specifically, posterior hyaloids face, retina, retinal pigment epithelium, choroid, sub-retinal fluid, optic nerve), and the pituitary gland.
If in doubt for this patient and this procedure consult senior staff.

WATERLOW PRESSURE CARE GUIDE

Appendix 2

Undertake and document risk assessment within 6 hours of admission

Date and time must be documented
Reassess every day

Date:	13/1/15									
Initials:	SA									
Time:	1830									

Gender	Male	1	✓							
	Female	2								
Age	14-49	1	✓							
	50-64	2								
	65-74	3								
	75-80	4								
	81+	5								
Build / weight for height (kg / m²)	Average BMI 20-24.9	0								
	Above average BMI 25-29.9	1								
	Obese BMI > 30	2	✓							
	Below average BMI < 20	3								
Continence	Continent / catheterised	0	✓							
	Incontinent of urine	1								
	Incontinent of faeces	2								
	Doubly incontinent (urine & faeces)	3								
Skin type (Visual risk assesment)*	Healthy	0	✓							
	Tissue paper (thin / fragile)	1								
	Dry (appears flaky)	1								
	Oedematous (puffy)	1								
	Clammy (moist to touch / pyrexia)	1								
	Discoloured (bruising / mottled)	2								
	Broken (established ulcer)	3								
Mobility	Fully mobile	0	✓							
	Restless / fidgety	1								
	Apathetic (sedated / depressed / reluctant to move)	2								
	Restricted (restricted by severe pain or disease)	3								
	Bedbound (unconscious / unable to change position / traction)	4								
	Chair bound (unable to leave chair without assistance)	5								
Nutritional element*	Unplanned weight loss in past 3-6 months									
	1 - ≤5%	0								
	1 - 5-10%	1								
	>10%	2								
	BMI > 20	0								
	BMI 18.5-20	1								
	BMI < 18.5	2								
	Patient acutely ill or no nutritional intake > 5 days	2								
Special risks	Smoking	1	✓							
Tissue malnutrition	Anaemia - Hb < 8	2								
	Single organ failure e.g. cardiac, renal, respiratory	5								
	Peripheral vascular disease	5								
	Multiple organ failure / terminal cachexia	8								
Neuro-deficit	Diabetes / MS / CVA / motor / sensory / paraplegia	4-6								
Surgery / Trauma*	Orthopaedic / below waist / spinal (up to 48 hours post op)	5								
	On operating table > 2 hours (up to 48 hours post op)	5								
	On operating table > 6 hours	8								
Medication	Cytotoxic, anti-inflammatory, long term / high dose steroid	4								
	TOTAL SCORE		5							

DATE+TIME	SCORE	EQUIPMENT USED/NEEDED	COMMENTS	SIGNATURE
13/1/15	5			

Total: 10+ = at risk, 15+ = at high risk, 20+ = at very high risk

RISK ASSESSMENT for VENOUS THROMBOEMBOLISM: ELECTIVE SURGICAL / O&G / DSU / 23 HOUR PATIENTS

Appendix 3a

Risk Assessments should be performed for all patients at pre-operative assessment clinic / ward / DSU

Patients should be reassessed every 48 – 72 hours, or sooner if condition changes.

Date of admission_____Date of assessment_____

Assessed by_____Designation_____

addressograph label, or,

Name

DoB

Unit no.

CHI

Does the patient have thrombosis risk factors? (tick ✓all that apply)	
Age > 60	
Obesity BMI ≥ 30	
Active cancer	
Previous VTE	
Family history of VTE: 1 first degree relative suffered VTE at age <50 years or > 1 first degree relative with VTE history regardless of age	
Varicose veins (for major general or orthopaedic surgery, low risk after varicose vein surgery)	
Known thrombophilia (no need to repeat thrombophilia screen)	
Other thrombotic states (Intranet: *Antithrombotic Guide*)	
Hormone therapy (inc combined OCP, HRT, tamoxifen, raloxifen)	
Pregnancy, or < 6 weeks since delivery (Intranet: *Obstetric VTE Prophylaxis & Treatment Policy*)	
Combined anaesthesia and surgery time > 90 mins	
Pelvic or lower limb surgery and combined anaesthesia and surgery time > 30 mins	
Post operative immobility	

→ **NO (no ticks)** → **PHARMACOLOGICAL PROPHYLAXIS NOT REQUIRED**

Reassess every 48-72hrs, or sooner if condition change

YES (one or more ticks)

Does the patient have bleeding risk factors? (tick ✓all that apply)	
Bleeding disorder (eg haemophilia, von Willebrand's disease)	
Coagulopathy , including warfarin or heparin therapy	
Thrombocytopenia <70 x 10^9/L	
Active peptic ulcer	
Actual or potential bleeding site (inc planned neuro, spinal, eye, or thyroid surgery)	
Acute stroke (seek advice) or CNS surgery within last 3 months	
Spinal or epidural anaesthesia possible (consult anaesthetist if in doubt)	
Severe uncontrolled hypertension (≥ 230 / 120 mmHg)	
Severe liver disease	
Renal failure (see over)	
Previous history of heparin induced thrombocytopenia (HIT) (see over)	

→ **NO (no ticks)** → **PRESCRIBE PROPHYLAXIS ACCORDING TO LOCAL POLICY**

Reassess every 48-72hrs, or sooner if condition changes

YES (one or more ticks) → **NOT FOR PHARMACOLOGICAL PROPHYLAXIS**

(unless requested by consultant)

Consider mechanical prophylaxis eg TED stockings, unless contra-indicated

Reassess patient every 48 to 72 hours, or sooner if condition changes.

FINAL DECISION (CIRCLE)

For VTE Thromboprophylaxis? YES / NO Prescribed by assessor YES / NO

If not prescribed by assessor, enter name of Dr informed _____

Patient informed YES / NO Information leaflet provided YES / NO

Preoperative assessment for elective procedure **Caprini VTE Risk factor assessment**	addressograph label, or, Name DoB Unit no. CHI

1 point each

- ❑ Age 41-60 years
- ❑ Minor surgery planned
- ❑ History of prior major surgery (<1 month)
- ❑ Varicose veins
- ❑ History of inflammatory bowel disease
- ❑ Swollen legs (current)
- ❑ Obesity (BMI >25)
- ❑ Acute myocardial infarction
- ❑ Congestive heart failure (<1 month)
- ❑ Sepsis (<1 month)
- ❑ Serious lung disease incl. pneumonia (<1 month)
- ❑ Abnormal pulmonary function (COPD)
- ❑ Medical patient currently at bed rest
- ❑ Other risk factors: .....

↳ → → → → → → → → → →Subtotal a ☐

2 points each

- ❑ Age 60-74 years
- ❑ Arthroscopic surgery
- ❑ Malignancy (present or previous)
- ❑ Major surgery (> 45 minutes)
- ❑ Laparoscopic surgery (> 45 minutes)
- ❑ Patient confined to bed (> 72 hours)
- ❑ Immobilizing plaster cast (< 1 month)
- ❑ Central venous access

↳ → → → → → → → → → →Subtotal b ☐

3 Points each

- ❑ Age over 75 years
- ❑ History of DVT / PE
- ❑ **Family history of thombosis***
- ❑ Positive Factor V Leiden
- ❑ Positive Prothrombin 20120A
- ❑ Elevated serum homocysteine
- ❑ Positive lupus anticoagulant
- ❑ Elevated anticardiolipin antibodies
- ❑ Heparin-induced thrombocytopenia (HIT)
- ❑ Other congenital or acquired thrombophilia
- ↓ Type:.....

↳ → → → → → → → → → →Subtotal c ☐

**most frequently missed risk factor*

*NB: **The Lothian University Hospitals Antithrombotic Guide (Adults) Version 3.2, April 2012, is available on the Intranet***

5 Points each

- ❑ Elective major lower extremity arthroplasty
- ❑ Hip, pelvis or leg fracture (<1 month)
- ❑ Stroke (<1 month)
- ❑ Multiple trauma (<1 month)
- ❑ Acute spinal cord injury (paralysis)(<1 month)

↳ → → → → → → → → → →Subtotal d ☐

1 point each (For women only)

- ❑ Oral contraceptives or hormone replacement therapy
- ❑ Pregnancy or postpartum (<1 month)
- ❑ History of unexplained stillborn infant, recurrent (≥3) spontaneous abortion(s), premature birth with toxaemia or growth-restricted infant.

↳ → → → → → → → → → →Subtotal e ☐

Total Caprini Score
(Subtotals a + b + c + d +e) ☐

Caprini score	Risk	Regime
0 - 1	Low	Early ambulation
2 - 4	Moderate	Elastic stockings†
5 +	High	Elastic stockings† & dalteparin

† *with intermittent pneumatic compression in theatre*

Potential contraindications to dalteparin

- ❑ Active bleeding
- ❑ Current oral anticoagulants (aspirin, clopidogrel, warfarin etc)
- ❑ Low platelet count (<100x10^9/l)
- ❑ Heparin induced thrombocytopenia (HIT)
- ❑ Poor renal function (eGFR <30)

Potential contraindications to elastic stockings

- ❑ Severe peripheral arterial disease
- ❑ Peripheral neuropathy
- ❑ Massive leg oedema
- ❑ Major leg deformity
- ❑ Dermatitis (active/severe)
- ❑ Pulmonary oedema

4AT	addressograph label, *or,* Name DoB Unit no. CHI

Appendix 4

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	0
Mild sleepiness for <10 seconds after waking, then normal	0
Clearly abnormal	4

[2] AMT4

Age, date of birth, place (name of the hospital or building), current year.

No mistakes	0
1 mistake	1
2 or more mistakes / untestable	2

[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

Achieves 7 months or more correctly	0
Starts but scores < 7 months / refuses to start	1
Untestable (cannot start because unwell, drowsy, inattentive)	2

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hours

No	0
Yes	4

4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or cognitive impairment unlikely (but delirium still possible if information from [4] is incomplete) If any score greater than zero nurses (if undertaking assessment) should escalate concerns so that a diagnosis may be made

Date	Time	Score	Action Plan	Initial

GUIDANCE NOTES

The **4**AT is a screening instrument designed for rapid and sensitive initial assessment of cognitive impairment and delirium. A score of **4** or more *suggests* delirium but is not diagnostic: more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. Items 1-3 are rated *solely on observation of the patient at the time of assessment.* Item **4** requires information from one or more source(s), eg. your own knowledge of the patient, other staff who know the patient (eg. ward nurses), GP letter, case notes, carers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

Alertness: Altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score **4** for this item.

AMT4 (Abbreviated Mental Test - 4): This score can be extracted from items in the full AMT if done immediately before.

Acute Change or Fluctuating Course: Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/or paranoid thoughts ask the patient questions such as, "Are you concerned about anything going on here?"; "Do you feel frightened by anything or anyone?"; "Have you been seeing or hearing anything unusual?" In general hospital settings psychotic symptoms most often reflect delirium rather than functional psychosis

Malnutrition Universal Screening Tool See: Intranet> Healthcare>A-Z>MalnutritionUniScreenTool>Documents> MUST.pdf	Addressograph, or Name DOB Unit no. / CHI

Patient referred to dietician previously? Yes ☐ No ☐	Currently under care of dietician? Yes ☐ No ☐	
Usual weight kg (before admission).....	Height.....	BMI.....

Guidance

Step 1	**Step 2**	**Step 3**	**Step 4**
BMI	*Unplanned weight loss (% of usual weight) in past 3 - 6 months.*	*Is patient acutely ill without, or likely to be without, nutritional intake for > 5 days?*	*Calculate MUST score*
Points >20 0 18.5 - 20 1 <18.5 2	Points 5% 0 5.1 -10% 1 >10% 2	Points No 0 Yes 2	Add points in steps 1, 2 & 3 Total MUST score = ...

Step 5: Develop care plan.

Score 0 = Low risk	*Score 1 = Medium risk*	*Score ≥ 2*
• Normal clinical care • Repeat screening weekly	• Observe • Document dietary intake for 3 days – if improvement - little clinical concern – if no improvement - clinical concern – follow local policy (snack list available) • Repeat screening weekly	• Refer to dietician • Improve and increase overall nutritional intake (refer to local policy / snack list) • Monitor and review care plan weekly *Unless detrimental, or no benefit is expected from nutritional support e.g. imminent death.*

Date **Time**				**This section is intended for elective preoperative assessment clinics**		
Weight	BMI	Step 1	Step 2	Step 3	Step 4	Step 5
Action Plan						

Date **Time**				**Week 1**		
Weight	BMI	Step 1	Step 2	Step 3	Step 4	Step 5
Action Plan						

Date **Time**				**Week 2**		
Weight	BMI	Step 1	Step 2	Step 3	Step 4	Step 5
Action Plan						

Emergency Medicine
NHS LOTHIAN UNIVERSITY HOSPITALS DIVISION

ST. JOHN'S HOSPITAL
Howden Road West
Livingston
EH54 6PP Tel: 01506 523000

NHS Lothian

A/E no. E2533176
E2432421
Previous no.
UHPI no. 800325165E
CHI no. 2305821425

AOM 17 GRV

PATIENT INFORMATION

Surname McAteer
Forename Gillian
Date of Birth 23/05/1982
Age Yrs Sex F

Address 18 Cherry Avenue
Bathgate
West Lothian
Postcode EH48 1NA
Telephone 07933 445 731

Contact Address [redacted]

Complaint alcohol, drug probs?
Allergies N-K

Attendances in last 12 months: 2
School:

General Practitioner

Name
RW Holden
Address
Simpson Medical Group
Bathgate Primary Care Centr
EH48 2SS
Telephone 01506 654444

Date and Time of Attendance
07/08/2013 14:55
Incident Date & Time: 07/08/2013
Mode of Arrival
Private Transport
Source of Referral
Self Referral to A&E

T	P	RR	BP	BM	SpO2	PEFR	Height	Weight	Alco 0.065

Initial Assessment No Answer From Waiting Room 15'8
Patient Has been Drinking Alcohol / taking "speed".
Is not coping recently / depressed recently / Has not been taking Anti-depressants.
Signature J.C Time 1535
Print Name SARA Leech. Triage Cat. 3

Urinalyis	Leuc	Nit	Blood	Protein	Glucose	Ketones	SG	PH

Clinical Notes

(P) W/D 17

- Admon = not coping
- multiple attempts to end life - Dr Kennedy
- = unclear whether planned
- - dismissed after attempts that attempts unsuccessful - review
- = unclear how often attempts are
- - ongoing matters
- - same has px meds (10 yr D/p 11 months)
- Care upday

Time seen
Assessment

Alcohol

Investigations

Procedures

Drugs given in Dept.

Diagnosis

(P) - D/W Dr Kennedy ⇒ admission in ward 17

Diagnosis

Name (print) JALI Signature

Clinical Notes Continued

Once Only Prescriptions

	Drug	Dose	Route	Prescribed By	Given By	Time
A						
B						
C						
D						
E						

Additional Nursing Notes

PMH

Meds - Citalopram.

Allergies

Social History

Accompanied by

Emergency Medicine
NHS LOTHIAN UNIVERSITY HOSPITALS DIVISION

ST. JOHN'S HOSPITAL
Howden Road West
Livingston
EH54 6PP Tel: 01506 523000

NHS Lothian

A/E no. E2298971
E2142901
Previous no.

UHPI no. 800325165E
CHI no. 2305821425

PATIENT INFORMATION

Surname McAteer
Forename Gillian
Date of Birth 23/05/1982
Age 30 Yrs Sex F

Address 18 Cherry Avenue
Bathgate
West Lothian
Postcode EH48 1NA
Telephone 07933445731

Contact Address [redacted]

Complaint bleeding/40wks preg
Allergies

Attendances in last 12 months: 2
School:

General Practitioner

Name
RW Holden
Address
Simpson Medical Group
Bathgate Primary Care Centr
EH48 2SS
Telephone 01506 654444

Date and Time of Attendance
05/09/2012 10:52
Incident Date & Time: 05/09/2012
Mode of Arrival
Private Transport
Source of Referral
Self Referral to A&E

T	P	RR	BP	BM	SpO2	PEFR	Height	Weight	Alco

Initial Assessment Brought in on trolley via carpark - bleeding heavily. Straight to Resus - Gynae obs post bleed/pad. Transferred to Labour Ward. Sister taken round. Jewellery removed and given to sister. Obs on sepsis chart with patient.

Signature [signature] Time 10 50

Print Name S CAMPBELL. Triage Cat. 1 - Resus.

Urinalysis	Leuc	Nit	Blood	Protein	Glucose	Ketones	SG	PH	

Clinical Notes

See attached

Time seen	
Alcohol	
Investigations	
Procedures	
Drugs given in Dept.	
Diagnosis	

Diagnosis

Name (print) Signature

Clinical Notes Continued

Once Only Prescriptions

	Drug	Dose	Route	Prescribed By	Given By	Time
A						
B						
C						
D						
E						

Additional Nursing Notes

PMH

Meds

Allergies

Social History

Accompanied by

Emergency Medicine
NHS LOTHIAN UNIVERSITY HOSPITALS DIVISION

ST. JOHN'S HOSPITAL
Howden Road West
Livingston
EH54 6PP Tel: 01506 523000

NHS Lothian

A/E no: E2298971 LS

Previous no. E2142901 EPR att.

UHPI no. 800325165E
CHI no. 2305821425

PATIENT INFORMATION

Surname McAteer
Forename Gillian
Date of Birth 23/05/1982
Age 30 Yrs Sex F

Address 18 Cherry Avenue
Bathgate
West Lothian
Postcode EH48 1NA
Telephone 07933445731 ~~03708534279~~

Contact Address [redacted]

Complaint bleeding/40wks preg
Allergies

Attendances in last 12 months: 2 School:

General Practitioner

Name
RW Holden
Address
Simpson Medical Group
Bathgate Primary Care Centr
EH48 2SS

Telephone 01506 654444

Date and Time of Attendance
05/09/2012 10:52
Incident Date & Time: 05/09/2012
Mode of Arrival
Private Transport

Source of Referral
Self Referral to A&E

T	P	RR	BP	BM	SpO2	PEFR	Height	Weight	Alco

Initial Assessment

Signature Time

Print Name Triage Cat.

Urinalyis	Leuc	Nit	Blood	Protein	Glucose	Ketones	SG	PH	

Clinical Notes

Time seen	10 50
Alcohol	—
Investigations	H, B XM
Procedures	—
Drugs given in Dept.	—
Diagnosis	HGP

see trail

Diagnosis Placental abruption.

Name (print) L Ron. Signature

Clinical Notes Continued

Once Only Prescriptions

	Drug	Dose	Route	Prescribed By	Given By	Time
A						
B						
C						
D						
E						

Additional Nursing Notes

PMH

Meds

Allergies

Social History

Accompanied by

Emergency Medicine
NHS LOTHIAN UNIVERSITY HOSPITALS DIVISION

ST. JOHN'S HOSPITAL
Howden Road West
Livingston
EH54 6PP Tel: 01506 523000

NHS Lothian

A/E no. E2066076
E1439786
Previous no.

UHPI no. 800325165E
CHI no. 2305821425

PATIENT INFORMATION

Surname McAtcer
Forenames Gillian
Date of Birth 23/05/1982
Age 29 Yrs Sex F

Address 18 Cherry Avenue
Bathgate
West Lothian
Postcode EH48 1NA
Telephone

Contact Address [redacted]

Complaint head inj
Allergies

Attendances in last 12 months: 0
School:

General Practitioner

Name
RW Holden
Address
Simpson Medical Group
Bathgate Primary Care Centr
EH48 2SS
Telephone 01506 654444

Date and Time of Attendance
08/10/2011 19:47
Incident Date & Time: 08/10/2011 15:00
Mode of Arrival
Emergency Ambulance
Source of Referral
Self Referral to A&E

T	P	RR	BP	BM	SpO2	PEFR	Height	Weight	Alcohol
	102	18	155/96		99%				0.71

Initial Assessment trip & fall downstairs today approx 1000hrs, stairs then woke up bottom of stairs @ 1900 smelling bank of head LOC ↓ alcohol No C-spine tenderness. PEARL. Laceration glued ↓ throughout.

Signature
Time 1955
Print Name
Triage Cat 2.

Urinalyis	Leuc	Nit	Blood	Protein	Glucose	Ketones	SG	PH

Clinical Notes

See TRAK

Time seen	2020
Alcohol	0.71
Investigations	
Procedures	
Drugs given in Dept.	
Diagnosis	11KA

Diagnosis HF GCS 15

Name (print) MONTELLS
Signature

Clinical Notes Continued

Once Only Prescriptions

	Drug	Dose	Route	Prescribed By	Given By	Time
A	Ibuprofen	400mg	PO	[illegible]	[illegible]	1955
B	Paracetamol	1g	PO	[illegible]	[illegible]	1955
C	[illegible]	[illegible]	[illegible]			
D	CODEINE	60mg	oral	[illegible]	[illegible]	2110
E						

Additional Nursing Notes

PMH

Meds

Allergies

Social History

Accompanied by

Lothian University Hospitals NHS Trust

ADULT UNITARY PATIENT RECORD

ADMITTING HOSPITAL St John's Hospital at Howden

TYPE OF ADMISSION : Emergency

PRESENTING COMPLAINTS/REASON FOR ADMISSION

1 head inj
2
3
4

Patient wishes to be known as:

NAME & ADDRESS (PATIENT LABEL)

Hospital No 800325165E F/M: F
DOB: 23/05/1982 Age: 29

Name: Gillian McAteer
Address: 18 Cherry Avenue
Bathgate
West Lothian
EH48 1NA

Telephone No:
Title - Mr / Mrs / Miss / Ms : Miss
Marital Status :
Religion : No Religious Affiliation
Ethnic Origin :

	ADMISSION WARD	DESTINATION WARD - 1st	DESTINATION WARD - 2nd
Ward No.	SJHOW		
Admission Date	08/10/2011		
Admission Time to Ward	22:36		
Admitting Nurse			
Consultant			

G.P.Details 3087831/781: 78132/1
RW Holden
Simpson Medical Group, Bathgat

EH48 2SS
Tel No : 01506 654444

NEXT OF KIN
RELATIONSHIP
Address:

Contact No.

FIRST CONTACT
RELATIONSHIP :
Address:

Contact No.

Patients Relative / Next of Kin Present on Admission Y/N
IF NO :
Date & Time of Notification : Signature :

Other comments: eg Night Call

Allergies / Sensitivities

CARDIO PULMONARY RESUSCITATION

Resuscitate / DO NOT Attempt Resuscitation (DNAR)
(Delete as appropriate)

Rationale if DNAR:

Signature: Print Name: Designation : Date & Time

Consultant Signature:
(Within 24 hrs) **Print Name:** **Date & Time**

	Date/Time	DNAR Status	Signature	Print Name	Designation	Consultant Signature
Change (1)						
Change (2)						

Please document rationale for change in the progess notes

Lothian University Hospitals Division
St. John's Hospital at Howden

NHS Lothian

DATE OF ADMISSION: 8/10/11

WARD: Observation

CONSULTANT: ATE

800325165E/E2066076 F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 RW Holden

PROCEDURE: Head Injury.

Please fill in the following questionnaire by circling Y for YES and N for NO. A doctor and nurse will come and discuss the questions with you later.

1. Have you ever had an operation before? Y/N

2. Have you or any of your relatives ever had a bad reaction to a general anaesthetic? ~~Y/N~~

3. Have you been/are you being treated by your G.P. or other hospital for a medical condition? Y/N

4. Have you ever had any of the following:-

a heart attack	Y/N	diabetes	Y/N
angina (chest pain)	Y/N	heartburn, hiatus hernia or stomach ulcer	Y/N
high blood pressure	Y/N	rheumatic fever	Y/N
a stroke	Y/N	jaundice (turned yellow)	Y/N
a fit or convulsion	Y/N	a clot on the lung	Y/N
asthma Childhood	Y/N	a clot in the leg	Y/N

5. Are you taking any medicines at the moment? Y/N
Please list medicines overleaf (tablets, patches, inhalers, injections, sprays):

MEDICINE	DOSE	TIMES TAKEN

6. If female, are you taking a contraceptive pill? Y/N

7. Are you allergic to any medicines or plasters etc? Y/N
Please list below:

8. Do you get palpitations or have an irregular heartbeat? Y/N

9. Do you get breathless easily? Y/N

10. Can you lie flat without getting breathless? Y/N

11. Do you have swollen ankles on most days? Y/N

12. Do you have any coughs or colds at the moment? Y/N

13. Do you suffer from sickness, diarrhoea or constipation? Y/N

14. Do you have kidney disease? Y/N

15. Do you have any pain or burning on passing water? Y/N

16. Do you need to pass water during the night? Y/N

17. If female are you/could you be pregnant? Y/N

18. Do you have blackouts or faint easily? Y/N

19. Do you have migraines? Y/N

20. Are there any illnesses that run in your family e.g. heart disease, blood disorders, muscle disorders etc? If so, please give details in the space below.

21. What do you do for a living? Catering assistent.

22. Who do you live with? Children.

23. Do you have home help, meals on wheels etc. Y/N

24. Do you smoke? Y/N

25. How many cigarettes do you smoke each day?

5 10 15 20 20+

Or how many ounces of tobacco each week? -------- oz.

26. If you have given up smoking, how long ago did you give up? ----- years ----- months.

27. On average, how many units of alcohol do you drink each week?

1 unit = half pint
or 1 glass of wine
or 1 measure of spirits

20+ units.

28. Do you require a special diet, e.g. vegetarian? Y/N
Please state:

29. Do you have a hearing aid? Y/N

30. Do you wear contact lenses or glasses? Y/N

31. Do you have false teeth? No/Top/Bottom/Both

32. Do you have crowns or loose teeth? Y/N

R L

Hospital staff, please mark in crowns or loose teeth as if looking at the patient.

Patient's signature: ..... Doctor's signature:.....

Date: ..... Date: .....

Nursing Assessment

Preferred Name:

1. **PAIN** locality: Head

|------|------|------|X-----|------|------|------|------|

none mild moderate severe

2. **MOBILITY** Independent.
Difficulties:

Aids required: n/a

3. **PERSONAL CARE** Self-caring.
Assistance required with ADL:

District nurse: n/a

Home help: n/a

Housing: Split level.

4. **SKIN** Intact.
Condition: good

Risk factors: none.

Current treatment:: none.

5. **SLEEP** Good sleeper.
Pattern:

Position:

Assistance required: none.

6. **PROVISIONAL DIAGNOSIS** Pt fully aware
Patient's perception: of reason for admissia

7. **OVERALL CONDITION**

8. **VALUABLES**
Locked in safe?

Signed: S/N K Foster
Date: 8/10/11

MULTIDISCIPLINARY INFORMATION/ PROGRESS NOTES

800325165E/E2066076 F 23/05/1982
Patie McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 RW Holden
Page

Date	
23⁰⁰ 8/10/11	Pt admitted to observation ward via A+E. Pt fell down stairs at home and states LOC ? 4hours. Pt intoxicated at time of fall. CT head - NAD. Pt GCS 15 on admission to ward. Pt orientated to staff, ward & nurse call system S/N K Easton
9/10/11 0445	(1) No complaints of pain. (2) Obs stable - news 0 - GCS 15 (4) Independent. (5) Has passed urine (9) Slept for long periods overnight. S/N K Easton
9/10/11 10¹⁵	WR Lynch Pt looks well, GCS 15 Obs stable. Headache this am, no vomiting Shx wrestalene with kids (7,8) - nav with mother. O/E Cspine full ROM, mild C1,C2 tenderness. diffuse occipital haematoma (N) eye movements CT last night normal. mobilising well, NAD on neurological examination (P) Home with head injury advice TOSTEN with Mum tonight. MacLean G

WLT 769

Date	
16/10	D/C home no F/U. Head injury advice given Scanned

NHS Lo

78132 RW Holden
800325165E/E2066076 F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425

:o be completed for all inpatients

Patient Name:
Address:

Date of Birth:
CHI Number:
Addressograph Label may be used

Estimated Date of Discharge: / /
Next of Kin:
Address:

Contact Number:

Discharge Summary 24/48 hours pre discharge		Date	Initial
1.Relevant Care Provider informed of discharge date(if applicable) Name: Contact Number:	Yes☐No ☐ N/A ☐		
2.Community nursing service contacted(if applicable) Name: Contact Number:	Yes ☐ No ☐ N/A ☐		
3.Does the patient have an unpaid carer Name: Contact Number:	Yes ☐ No ☐ N/A ☐		
4. Has the unpaid carer been involved in the discharge process and offered an assessment/ training	Yes☐ No ☐ Declined ☐		
5. Transport (if clinical need) booked ref no: Transport type: 2 Man Y /N 1 Man Y / N Stretcher Y / N Number of stairs: DNAR form competed	Yes ☐ No ☐ N/A ☐		
6. Patient education commenced, (if required) please specify education given, e.g. catheter care	Yes ☐ No ☐ N/A ☐		
7. Follow-up appointment booked Yes ☐ No ☐ Transport Yes ☐ Ref No:			
8. Does the patient need referred to LUCs	Yes ☐ No ☐ N/A ☐		
Discharge Summary 24 hours pre discharge			
1. Post care information leaflet given:	Yes ☐ No ☐ N/A ☐		
2. Discharge letter requested from medical staff/on board round	Yes ☐ No ☐ N/A ☐		
3. Community nursing letter/transfer letters completed (all relevant documents photocopied and attached: e.g. wound care plans)	Yes ☐ No ☐ N/A ☐		
4. Transport confirmed Ref Number:	Yes ☐ No ☐ N/A ☐		
5. Is patient applicable for discharge lounge? If yes, Inform discharge lounge and complete NHS Lothian transfer form ☐	Yes ☐ No ☐ N/A ☐		
6. Next of kin informed	Yes ☐ No ☐ N/A ☐		
7. Discharge letter obtained	Yes ☐ No ☐ N/A ☐		
8. Patient has keys to house? Reason it patient does not have keys:	Yes ☐ No ☐ N/A ☐		
Day of discharge			
1.Discharge medication given and explained to patient Patients own medication returned	Yes ☐ No ☐ N/A ☑ Yes ☐ No ☐ N/A ☑		
2. Copy of immediate discharge letter given to patient Community nursing letter given to patient(if applicable)	Yes ☐ No ☐ N/A ☑ Yes ☐ No ☐ N/A ☑		
3. Valuables returned to patient	Yes ☑ No ☐ N/A ☐		
4 Peripheral Vascular Cannula removed	Yes ☑ No ☐ N/A ☐		
5. Patient transferred to discharge lounge	Yes ☐ No ☐ N/A ☑		
6. Patient Administration System (e.g. TRAK/PIMS) updated at point of discharge.	Yes ☐ No ☐ N/A ☑		

Additional Information:

The patient is clinically fit for discharge
Signed S Easton

Last SEWS
Date 9/10/2011

_____ HOSPITAL

ACCIDENT AND EMERGENCY DEPARTMENT

INJURY / SHOCK CHART

NUMBER 78132 RW Holden

800325165E/E2066076 F 23/05/1982

NAME **McAteer, Gillian**

18 Cherry Avenue,

DATE OF E Bathgate,

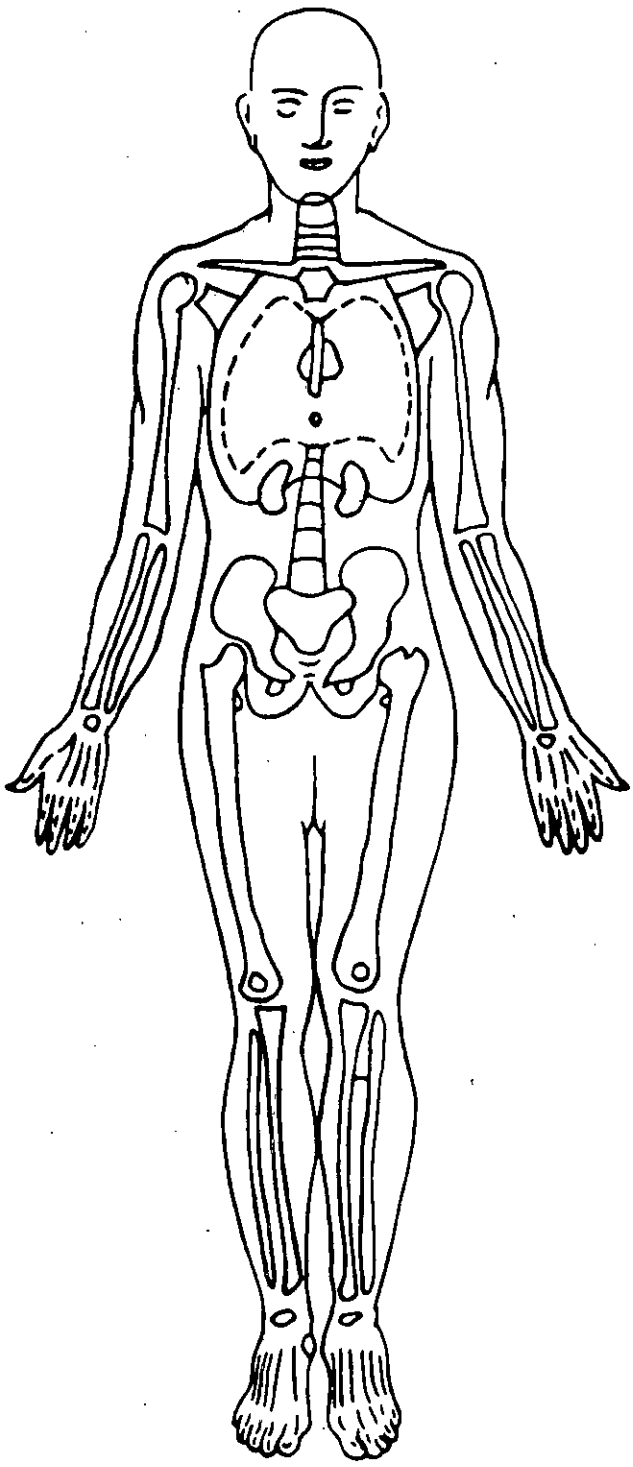
West Lothian,

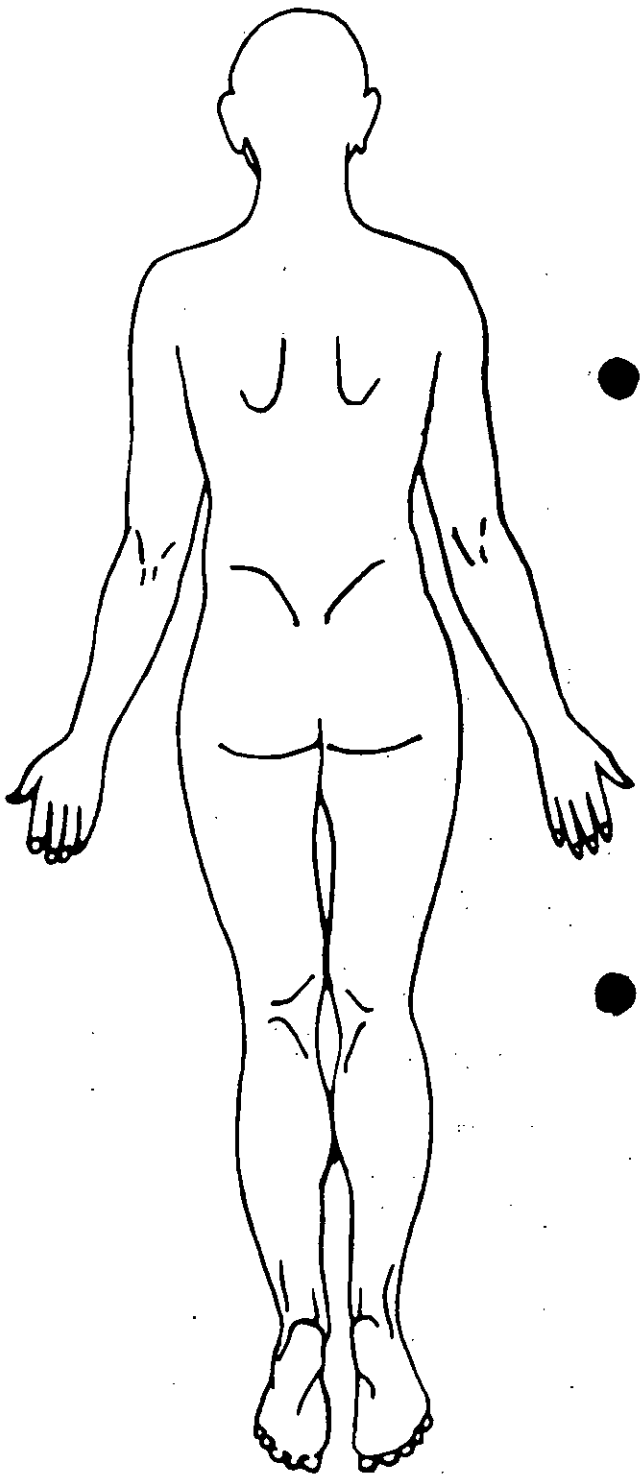
DATE EH48 1NA

CHI 2305821425

CONSULTANT

SUMMARY OF INJURIES





NAME: Gillian McAteer

DATE: 8/10/11 TIME: 2000

Pulse/Blood Pressure/Temperature/Respn./C.V.P.

TIME: 2000 2130 2200 2230 0130 0330 0630

Blood pressure and Pulse rate: 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

Respiration

Pupil size (m.m.): 1 2 3 4 5 6 7 8

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

PUPILS

		2000	2130	2200	2230	0130	0330	0630
right	Size	4	4	4	4	4	4	4
	Reaction	+	+	-	-	+	+	+
left	Size	4	4	4	4	4	4	4
	Reaction	+	+	-	-	+	+	+

+ reacts
— no raection
c. eye closed

COMA SCALE

			2000	2130	2200	2230	0130	0330	0630
Eyes Open	Spontaneously	4	4	V	V	V	V	V	V
	To speech	3							
	To pain	2							
	None	1							
Best Verbal Response	Orientated	5	5	V	V	V	V	V	V
	Confused	4							
	Inappropriate words	3							
	Incomprehens. sound	2							
	None	1							
Best Motor Response	Obeys commands	6	6	V	V	V	V	V	V
	Purposeful movement	5							
	Withdrawal	4							
	Flexion to pain	3							
	Extension to pain	2							
	None	1							

Eyes closed by swelling = C

Endotracheal tube or tracheostomy = T

Usually record the best arm response

	2000	2130	2200	2230	0130	0330	0630
G.C.S. Total Score (3 — 15)	15			15	15	15	15
Total Score (3 — 14)	15	15	15	R.			

LIMB MOVEMENTS

		2000	2130	2200	2230	0130	0330	0630
ARMS	Normal power							
	Mild weakness							
	Severe weakness							
LEGS	Normal power							
	Mild weekness							
	Severe waakness							

Record right (R) and laft (L) separetely if thera is e difference between the two sides.

C.V.P.

(R) Atrium = 0cms H_2O

Other measurements

INTRAVENOUS FLUIDS (mls)

I.V. Fluids Line 1	Time Started	I.V. Fluids Line 2	Time Started	I.V. Fluids Line 3	Time Sterted
Total Volume (Line 1)		Total Volume (Line 2)		Total Volume (Line 3)	

FLUIDS OUT (mls)

Urine	Gastric Aspirate	Suction	Other (Specify)

PROCEDURES

Procedure	Time Performed	Procedure	Time Performed

DRUGS GIVEN

Drug	Route	Time Given	Signature

ARTERIAL BLOOD GASES

Time								Clothing
H^+								
pCO_2								Valuables
HCO_{3-}								
pO_2								Relatives

St. John's Hospital, Livingston

PRESCRIPTION AND ADMINISTRATION RECORD

NHS Lothian

Hospital/Ward: Consultant:	—78132 — RW Holden Name of Patie : 800325165E/E2066076 F 23/05/1982
Weight: Height:	Patient Numt **McAteer, Gillian** 18 Cherry Avenue,
DISCHARGE PRESCRIPTION	D.O.B. Bathgate,
Date Completed: Completed by:	West Lothian, EH48 1NA CHI 2305821425

CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINE

If a dose is not administered as prescribed, initial and enter a code in the column with a circle drawn round the code according to the reason as follows:

Patient Refuses 1	Vomiting/nausea 8
Patient not present on ward 2	Time varied on Dr's instructions 9
Medicines not available - CHECK ORDERED 3	Once only/prn medication given 10
Instructions not clear or legal 4	Dose withheld on Dr's instructions X
Nil by mouth 5	Possible drug reaction/side effect 12
Asleep/drowsy 6	Self administered by patient 13
Administration route not available - CHECK FOR ALTERNATIVE 7	Other reasons 14

ONCE ONLY MEDICATION

Date	Time	Drug (Approved Name)	Dose	Route	If SRP PGD No.	Prescriber Signature	Time Given	Given By	Checked By

OTHER MEDICINE CHARTS IN USE

Date	Type of Chart

PREVIOUS ADVERSE DRUG REACTION

Medicine	Description of reaction

Name: ..... D.O.B. ..... Unit No. .....

OXYGEN	Start Date	Start Time	Mask (%)	Route or Prongs (l/min)	Prescriber – Sign	Administered by	Stop Date	Stop Time

REGULAR THERAPY

Drug (Approved Name)		Date / Time													
Dose	Route														
		8													
		13													
Signature	Start Date														
		18													
Notes	Pharmacy	22													
Drug (Approved Name)															
Dose	Route	8													
		13													
Signature	Start Date														
		18													
Notes	Pharmacy	22													
Drug (Approved Name)															
Dose	Route	8													
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Drug (Approved Name)															
Dose	Route	8													
		13													
Signature	Start Date														
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Notes	Pharmacy	22													
Drug (Approved Name)															
Dose	Route	8													
		13													
Signature	Start Date														
		18													
Notes	Pharmacy	22													
Drug (Approved Name)															
Dose	Route	8													
		13													
Signature	Start Date														
		18													
Notes	Pharmacy	22													

Name: ..... D.O.B. ..... Unit No. .....

AS REQUIRED THERAPY

Symptomatic Relief Policy (SRP)

Dose & Frequency:	Route:
As per Patient Group Directive (PGD)	As per Patient Group Directive (PGD)
Signature	Start Date

Delete if any item is to be excluded

PGD No.	Medication	Total Doses
401	Paracetamol	2
402	Simple Linctus	2
403	Co-Magaldrox	2
404	Gaviscon Liquid	2
405	Senna	2
406	Bisacodyl Suppositories	1
407	Sodium Citrate Enema	1

Drug (Approved Name) PARACETAMOL		Date	9/10/11											
		Time	0830											
Dose & Frequency 1g QDS	Route ORAL	Dose	1g											
		Initials	KR											
Signature	Start Date 8/10/11	Date												
		Time												
Indication/Notes	Pharmacy	Dose												
		Initials												
Drug (Approved Name) IBUPROFEN		Date												
		Time												
Dose & Frequency 400mg TDS	Route ORAL	Dose												
		Initials												
Signature	Start Date 8/10/11	Date												
		Time												
Indication/Notes	Pharmacy	Dose												
		Initials												
Drug (Approved Name)		Date												
		Time												
Dose & Frequency	Route	Dose												
		Initials												
Signature	Start Date	Date												
		Time												
Indication/Notes	Pharmacy	Dose												
		Initials												
Drug (Approved Name)		Date												
		Time												
Dose & Frequency	Route	Dose												
		Initials												
Signature	Start Date	Date												
		Time												
Indication/Notes	Pharmacy	Dose												
		Initials												
Drug (Approved Name)		Date												
		Time												
Dose & Frequency	Route	Dose												
		Initials												
Signature	Start Date	Date												
		Time												
Indication/Notes	Pharmacy	Dose												
		Initials												

Name: ..... D.O.B. ..... Unit No. .....

REGULAR THERAPY

Date / Time

Drug (Approved Name)	
Dose	Route
Signature	Start Date
Notes	Pharmacy

Times: 8, 13, 18, 22

Drug (Approved Name)	
Dose	Route
Signature	Start Date
Notes	Pharmacy

Times: 8, 13, 18, 22

Drug (Approved Name)	
Dose	Route
Signature	Start Date
Notes	Pharmacy

Times: 8, 13, 18, 22

Drug (Approved Name)	
Dose	Route
Signature	Start Date
Notes	Pharmacy

Times: 8, 13, 18, 22

Drug (Approved Name)	
Dose	Route
Signature	Start Date
Notes	Pharmacy

Times: 8, 13, 18, 22

Drug (Approved Name)	
Dose	Route
Signature	Start Date
Notes	Pharmacy

Times: 8, 13, 18, 22

Name: ..... D.O.B. ..... Unit No. .....

REGULAR THERAPY

Date →
Time ↓

Drug (Approved Name)			
Dose	Route	8	
		13	
Signature	Start Date		
Notes	Pharmacy	18	
		22	
Drug (Approved Name)			
Dose	Route	8	
		13	
Signature	Start Date		
Notes	Pharmacy	18	
		22	
Drug (Approved Name)			
Dose	Route	8	
		13	
Signature	Start Date		
Notes	Pharmacy	18	
		22	
Drug (Approved Name)			
Dose	Route	8	
		13	
Signature	Start Date		
Notes	Pharmacy	18	
		22	
Drug (Approved Name)			
Dose	Route	8	
		13	
Signature	Start Date		
Notes	Pharmacy	18	
		22	
Drug (Approved Name)			
Dose	Route	8	
		13	
Signature	Start Date		
Notes	Pharmacy	18	
		22	

Name: ..... D.O.B. ..... Unit No. .....

AS REQUIRED THERAPY

Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
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Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
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Signature	Start Date	Date											
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Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											
Drug (Approved Name)		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/Notes	Pharmacy	Dose											
		Initials											

Observation Chart

NHS Lothian

Consultant: SL

Date chart commenced: 8/10/11

This is chart number (1) **this admission**

Actual or estimated patient weight _____ **kgs**

ASU: _____

At 78132 RW Holden
800325165E/E2066076 F 23/05/1982
Name: McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
DOB:
Unit No: CHI 2305821425

An Early Warning Score (SEWS) must be calculated every time patient observations are recorded. If SEWS score 4 or more then call the appropriate doctor and nurse in charge using the guidelines below. Increased frequency of observations (minimum hourly) should be commenced and a detailed report in the patient's medical notes should be completed.

Early Warning Score 4 or more
or concern with a patients condition.

▼

Call Junior Doctor & Senior Nurse/Nurse Practitioner
If Dr cannot attend within 20 mins, they should arrange a Deputy.

▼

Practitioner/Dr unable to attend within 20 mins **or** SEWS increased by 2 **or** patient deteriorating.

▼

Early Warning Score 6 or more
or rapidly deteriorating patient.

▼

Call appropriate SHO/Registrar & Senior Nurse/Nurse Practitioner

▼

Dr unable to attend within 10 mins **or** SEWS increased by 2 **or** patient deteriorating.

▼

Call appropriate Registrar/Consultant
Consider ICU referral/review of treatment plan

Persistent Pain – 6 or above and unresponsive to guidelines

▼

Call Medical Staff/Senior Nurse/Nurse Practitioner

▼

For further advice contact:

ACUTE	CANCER-RELATED
Mon- Fri: Bleep Acute Pain Team	Mon- Fri: Bleep Palliative Care Team
Out of hours: On-call anaesthetist	Out of hours: via switchboard

Reorder Ref: WLT1016-Rev. 05/07

How to calculate SEWS Score

- **Do not add pain score to SEWS Score.**
- Record standard observations (RR, SpO_2, Temp, BP, HR, AVPU).
- Note whether observation falls in shaded "At Risk Zone". Score as per SEWS key.
- Add points scored and record total "SEWS Score" in bottom row of chart.
- Action as per guidelines on front of chart.

If RR >24	Review patient / CXR +/- gases / PEF (Peak Expiratory Flow) etc → Definitive Therapy			
If SpO_2 sats <93%	Review probe ? accurate Review patient → prescribe oxygen on drug chart if indicated, consider ABGs.			
If Temp >38	Blood cultures Other cultures Early antibiotic therapy if sepsis suspected.			
If Systolic BP<100	Review monitoring *(cardiac / oximetry / urine output / invasive BP etc).* IV Access Review patient / drug kardex.			
Consider:	IV fluid bolus and reassess. TREAT UNDERLYING CAUSE			
Consider:	Hypovolaemia	Obstructive	Distributive	Cardiac
	Dehydration	*PE*	*Sepsis*	*Arrhythmia*
	Blood loss	*Tamponade*	*Anaphylaxis*	*Pump failure*
If Pulse >130	Review monitoring *(cardiac monitor indicated)* IV Access Review patient / ECG / electrolytes → Definitive Therapy			
If responds to pain only or unresponsive	Assess airway, BM, GCS, neuro observation chart, review patient / kardex.			
If BM <4	Give Oral Carbohydrate / IV Dextrose. Consider checking urgent laboratory blood glucose.			

Pain Assessment & Management Guidelines

How to score pain:

Cancer-related pain: **Always** score **worst** pain in last 24 hours or since last assessment.
Acute pain: Score **current** pain on movement e.g. deep breathing.

Pain Score:		Action:
0	**NONE**	Continue to assess pain with every set of observations (**must be** at least daily).
1-3	**MILD**	Continue to assess pain with every set of observations (**must be** at least daily).
4-5	**MODERATE**	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
6-10	**SEVERE**	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.

PERSISTENT SEVERE PAIN (6 OR ABOVE), WHICH DISTRESSES THE PATIENT: REFER. SEE FLOW CHART OVER.

Lothian Guidelines

Cancer-related pain: Initiate Edinburgh Pain Assessment Tool (EPAT©) for pain score of 4 or above.
Use Palliative Care Guidelines.
Acute pain: Use Acute Pain Guidelines.

Nausea Score (0-3)

0 = **No Nausea**
1 = **Nausea** (consider anti-emetic)
2 = **Nausea/Vomiting** (administer anti-emetic)
3 = **Persistent Nausea &/or Vomiting** (contact Dr).

PERSISTENT NAUSEA &/OR VOMITING: USING GUIDELINES PRESCRIBE/GIVE ANTI-EMETICS. REVIEW.

© Quality Improvement Scotland (QIS) Illness Severity Criteria Subgroup, February 2005.
Edinburgh Pain Assessment Tool (EPAT©)

SEWS KEY 0 1 2 3		DATE: 8/10 9/10/11							
		TIME: 1800 2000 2200 0000 0200 0400 0600							
RESP. RATE	≥36	25							≥36
	31-35								31-35
	21-30								21-30
	9-20	18	18	16	16	16	16	18	16	9-20
	≤8								≤8
SpO_2	≥93	99	97	95	98	100	100	100	100	≥93
	90-92								90-92
	85-89								85-89
	<85								<85
Inspired O_2%	%	GTSW	RA			O/A	AIR	AIR	AIR	%
Humidifier Temp										
TEMP	>39°									>39°
	38°									38°
	37°									37°
	36°									36°
	35°									35°
	34°									34°
BLOOD PRESSURE	210									210
	200									200
	190									190
	180									180
	170									170
	160									160
	150									150
	140									140
	130									130
	120					115		100		120
	110									110
	100									100
	90									90
	80									80
	70					74				70
	60									60
	50							56		50
HEART RATE	>140									>140
	130									130
	120									120
	110									110
	100									100
	90									90
	80									80
	70									70
	60									60
	50									50
	40									40
	30									30
SEDATION / NEURO SCORE	S	Sleep								Sleep
	0	Alert								Alert
	1	Verbal								Verbal
	2	Pain								Pain
	3	Unresp								Unresp
UO<30mls/hr (3 hrs+)										UO<30
SEWS SCORE (with all obs)			1	0	0	0	0	0	0	SEWS
PAIN	Severe	9-10								9-10
		6-8								6-8
	Moderate	4-5								4-5
	Mild	1-3								1-3
	None	0					0	0	0	0
Nausea Score (0-3)							0	0	0	Nausea Score
BM										BM
Weight										Weight
Bowels										Bowels
Drain Type --										Drain Type
Wound										Wound
Circulation										Circulation
Sensation										Sensation
Movement						KE	AE	AE	AE	Movement

SEWS Chart

NHS Lothian

Name: 800325165E F MCATEER Gillian
DOB: 23-May-82 CHI: 230 582 1425
CHI: 78132 L Heath 18 Cherry Avenue West Lothian EH48 1NA

Consultant: Men
Date chart commenced: 24-1-15
This is chart number 1 this admission
Weight: Actual _____ kgs Estimated _____ kgs
ASU: _____

How to calculate a Standardised Early Warning (SEWS) in NHS Lothian

The clinical observations used to calculate a SEWS score are:

- Respiratory rate
- Oxygen saturation
- Temperature
- Systolic blood pressure
- Heart rate
- Sedation/Neurological score (AVPU)
- Urine output

The SEWS chart is colour coded to identify when a clinical observation is outside the normal range. A SEWS of 0-3 is allocated to each parameter using the SEWS key as shown.

SEWS KEY

0	1	2	3

All the observations have to be recorded and the total score added up and signed for. **A SEWS score of 4 or more** is an alert that a patient is acutely ill or deteriorating and an appropriate response using the escalation procedure is required... SEWS should NOT replace sound clinical judgement. Immediate action and appropriate escalation should take place if there are any concerns regarding a patient's clinical condition. Staff are accountable for seeking further help if not reassured by the response and action taken. Follow the ABCDE guidance on assessment and action and the flowchart for appropriate escalation.

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

Staff should use SBAR in all communications

Definition
- S ituation
- B ackground
- A ssessment
- R ecommendations

SEWS should guide the frequency of patients monitoring

SEWS SCORE OF 1-3 MINIMUM 4 HOURLY OBSERVATIONS	SEWS SCORE OF 3 IN ONE PARAMETER OR SEWS SCORE OF 4-5 MINIMUM 1 HOURLY OBSERVATIONS	SEWS SCORE OF 6 OR MORE CONTINUOUS MONITORING OF VITAL SIGNS

Respiratory distress: The presence of respiratory distress is an important sign of acute illness. The patient may complain of feeling breathless. Other signs include, looking breathless, using accessory muscles of respiration, pursed lip breathing and audible breathing. If the patient has signs of respiratory distress please record in notes.

Urinary output: If a patients fluid balance is of concern and urine output is measured hourly to 4 hourly they should be on a fluid balance chart where blood loss is also recorded. If urine output is sufficient the score entered on the SEWS chart is 0. If urine output for catheterised patients is less than 30mls per hour for more than 3hrs the score is 3. If a patient has not passed urine within 12 hours the score is 3.

Sepsis criteria met Y/N: If the patient has a SEWS score of 3 or more and two or more of the Systemic Inflammatory Response Syndrome (SIRS) criteria, chart this on the SEWS chart and initiate the sepsis 6 bundle which should be completed **within one hour**. If sepsis is suspected do not hesitate to act before the criteria are breached.

Pain: The pain score must be recorded in the chart. Refer to the pain assessment and management guidelines.

WLT1016 (02/2013)

ABCDE: ASSESSMENT AND CLINICAL RESPONSE TO SEWS TRIGGERS

	Assess	Possible Actions
AIRWAY	**Is the Airway –** • PATENT, • AT RISK, • OBSTRUCTED.	→ Suction if Indicated, → Head tilt, chin lift/jaw thrust → Airway Adjuncts, → Administer Oxygen, → Call 2222 if at Risk.
BREATHING	• Respiratory rate, • SpO2, • Accessory Muscle use • Noises +/- Percussion, Palpation & Auscultation, • Position/posture.	→ Administer prescribed Oxygen to maintain saturations 94%-98 % (NB COPD 88%-92%) → Monitor SpO2/ABGs → Consider Chest X-Ray → Treat underlying cause, → Call 2222 if not breathing.
CIRCULATION	• Pulse, • Blood Pressure, • Capillary refill time • Core Temp/Colour, • Urine Output, • Consider 4 body cavities for fluid/blood loss (4 + on the floor) • Monitor drain losses	→ Obtain IV access → Obtain blood samples → Prepare fluid challenge, → Initiate Fluid balance Chart → Call 2222 if no circulation → Consider initiating Major Haemorrhage Protocol → Monitor Response to actions
DISABILITY A = Alert V = Voice/Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat Hypoxia or Hypovolaemia, • Blood Glucose • Drugs.	→ Re-assess GCS → Check blood glucose if less than 4mmols/litre activate hypoglycaemia protocol → Check drug chart, → Remember Accurate Documentation
EXPOSURE	• Top to Toe examination, • Look for evidence of blood loss / rashes / drains / wounds etc,	→ Control bleeding, → Treat any underlying conditions identified, → Reassess, → Maintain patient's dignity. → Evaluate actions → Escalate if appropriate

Remember: to record all observations on SEWS chart & document any deterioration in the notes.
If at any point during your assessment you are concerned about your patient **- Call for help.**

Pain Assessment & Management Guidelines

How to score pain:

Cancer-related pain:		Always score **worst** pain in last 24 hours or since last assessment.
Acute pain:		Score current pain on movement e.g. deep breathing
Pain Score:		Action:
0	NONE	Continue to assess pain with every set of observations (**must be** at least daily)
1-3	MILD	Continue to assess pain with every set of observations (**must be** at least daily)
4-5	MODERATE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
6-10	SEVERE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.

PERSISTENT SEVERE PAIN (6 OR ABOVE), WHICH DISTRESSES THE PATIENT: REFER. SEE FLOW CHART BELOW.

Pain Assessment & Management Guidelines

Cancer-related pain: Initiate Edinburgh Pain Assessment Tool (EPAT©) for pain score of 4 or above.
Use Palliative Care Guidelines
Acute pain: Use Acute Pain Guidelines

Nausea Score (0-3)

0 = **No Nausea**
1 = **Nausea** (consider anti-emetic)
2 = **Nausea/Vomiting** (administer anti-emetic)
3 = **Persistent Nausea &/or Vomiting** (contact Doctor)

PERSISTENT NAUSEA &/OR VOMITING: USING GUIDELINES PRESCRIBE / GIVE ANTI-EMETICS. REVIEW.

| SEWS KEY 0 1 2 3 | | DATE: | 24/1/15 | 24/1 | | |

SJHRec RQ 27/11

NHS Lothian

NHS LOTHIAN ENT SURGERY BOOKING FORM

Date: 16.11.14 Consultant: Unspecified Clinician

Addressograph OR
800325165E F 23/05/1982
McAteer, Gillian
18 Cherry Avenue,
Bathgate,
West Lothian,
EH48 1NA
CHI 2305821425
78132 ... L Heath ...

Patients Telephone Numbers:
H .....
W .....
Mob 07907721845O4

PAC 13/1

Diagnosis OME ? (Mixed HL)

Procedure Grommets

Anaesthetic: GA ☑ LA ☐

Theatre Time: 0 hrs 30 mins (include Anaesthetic time)

Priority: 62 day ☐ Urgent ☐ Routine ☑

Admission: Same day ☑ Inpatient ☐ 23 Hrs ☐ Estimated Stay: ..... Days

Pooled List: Yes ☐ No ☐ External Provider ☑

Interpreter: Yes ☐ No ☑

Hospital: SJH ☑ RHSC ☐

Short Notice: Yes ☑ No ☐

Is patient suitable for external provider?
Yes ☑ No ☐
Is patient willing to go?
Yes ☑ No ☐
Not suitable because of (please state)
Poor Health ☐
Poor mobility ☐
Complex case
Poor Health ☐

Unavailability: From _____ to .....

Pre-assessment: Anti-Coagulation Therapy ☐ Stop..... Day's Diabetic ☐

Other _____

Care Level: ITU/HDU ☐ LEVEL I ☐ WARD ☐ DOSA ☐

Referral: OP ☑ Ward ☐ GP ☑ Other ☐

Medical Records: RIE ☐ SJH ☐ ROODLANDS ☐ Other ☐

Print Name: Unspecified Clinician **Signature** _____

Version: November 2013

NHS Lothian - Referral Letter

Referral To	St John's Hospital Ear, Nose \amp; Throat (ENT) L Basic SIGN Referral
Urgency of referral	Routine
Date of referral	03/09/2014
Date submitted	03/09/2014
UCPN	1010078329565

PATIENT DETAILS

CHI number:	2305821425
Name:	MISS GILLIAN MCATEER
Date of birth:	23/05/1982
Sex:	Female

Contact Details

18 CHERRY AVENUE
BOGHALL
BATHGATE
WEST LOTHIAN
EH48 1NA

Voice (Mobile) : 07712184504

REFERRING PRACTITIONER DETAILS

Name:	Dr. Lorna Heath (GMC: 4S32473)
Practice:	Simpson Medical Group (78132)
Phone:	Voice : 01506 6S4444

Practice address

Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

H/T 9.30

CLINICAL INFORMATION

Reason for Referral:	hearing difficulty/L posterior TM perforation
Main Referral Text:	I would be grateful if you could see this 32 year old female who has noticed that her hearing has deteriorated over the past 3-4 months. This had been apparent which she was attending an alcohol rehabilitation programme and she was examined by a doctor and found to have a perforated ear drum. She has reattended the surgery due to ongoing hearing difficulties and was concerned the perforation is not healing. She has no discharge and is otherwise well. She has no previous history of ear nose and throat problems.On examination she has a small posterior perforation of the left tympanic membrane. The right tympanic membrane is normal. I would be grateful if you could arrange further assessment regarding her hearing and perforation.

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Low mood		[TRUNCATED]stopped fluox 2 weeks ago as felt getting too fat with it, mood low, struggling to cope with kids alone, now with family /friends for 1 week, referred to swd by ooh last night she says, a	04/06/2013	04/06/2013
Rapid expulsion of placenta			05/09/2012	05/09/2012
Anaemia during pregnancy, childbirth and the puerperium			05/09/2012	05/09/2012
Caesarean delivery		female	05/09/2012	05/09/2012
Normal delivery in a completely normal case			19/10/2004	19/10/2004
[X]Mental and behav disorders assoc with the puerperium NEC			13/01/2004	13/01/2004

Normal delivery in a completely normal case	Female	09/05/2003	09/05/2003
Nondependent alcohol abuse	and drug abuse	13/03/1999	13/03/1999
Misuse of drugs NO5		14/03/1998	14/03/1998
[X]Intentional self poisoning/exposure to noxious substances	ectasy,hash alcohol	14/03/1998	14/03/1998
Child on protection register		29/06/1993	29/06/1993
Maltreatment syndromes		29/06/1993	29/06/1993
Fracture of clavicle		25/01/1987	25/01/1987
Intussusception	surgery	01/12/1982	01/12/1982

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Contraception	Claim expiry date: 27/12/1997. NOTE5: SCHERING PC4.		27/12/1996	27/12/1996

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
White soft paraffin 50% / Liquid paraffin 50% ointment	gram	APPLY GENEROUSLY THREE TIMES DAILY		03/09/2014		03/09/2014
Terbinafine 1% cream	gram	APPLY ONCE OR TWICE A DAY		03/09/2014		03/09/2014
Fluoxetine 20mg capsules	capsule	TAKE ONE IN THE MORNING		03/09/2014		03/09/2014
Citalopram 10mg tablets	tablet	TAKE ONE DAILY		03/09/2014		03/09/2014
Citalopram 20mg tablets	tablet	TAKE ONE DAILY FOR 1 WEEK		03/09/2014		03/09/2014
Citalopram 20mg tablets	tablet	2 TA8LET DAILY		25/08/2014		25/08/2014
Citalopram 20mg tablets	tablet	2 TABLET DAILY		28/07/2014		28/07/2014

Clinical warnings

Allergies

Description	Comment	Modifier	Start Date	Recorded Date
URTICARIA			13/09/1996	13/09/1996

8814738.41.676107.955

Additional information

Smoking history (Encounters):Current smoker Date recorded:08-Jul-2014
Alcohol history (Encounters):Stopped drinking alcohol Date recorded:08-Jul-2014
Exercise history (Encounters):Exercise grading Date recorded:19-Oct-1999
Patient Weight in Kilograms:107.9SS
Patient Height in Metres:1.676

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

NHS Lothian

Accident & Emergency

Dr Holden
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created 09/10/2011
Date Authorised
Date/Time Printed 10/10/2011 08:35
Our Ref 800325165E
CHI 2305821425

Patient:	Gillian McAteer 18 Cherry Avenue Bathgate EH48 1NA	**UHPI:**	800325165E
		Date of Birth:	23/05/1982
Ward:	SJH Obs Ward	**Admission Date:**	08/10/2011
Consultant:	Mr Martin DJ McKechnie	**Discharge Date:**	09/10/2011

Dr P Freeland
Dr J Fothergill
Mr M McKechnie
Dr P Leonard
Dr B Threlfall

Tel: Reception
01506 523011

Inpatient Discharge Summary

This 29yr female was admitted to the observation ward for neurological observations after sustaining a head injury falling down the stairs whilst intoxicated at home. No vomiting. Mild headache controlled by paracetamol.

O/E
large boggy swelling over occiput.
GCS 15/15, PEARL, Cranial nerves all intact.
Full range of movement in C spine, mild tenderness over C1, C2.
Mobilising well.

CT head - normal.
She was deemed fit for discharge home, to stay the night with her mum. Given head injury advice.

Should you need further information please contact...
Observation Ward, SJH.

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

Yours sincerely.....

Staff Signature... PrintName. BISCHOFF

Designation.... FY1 Date. 10/10/11 Time.....

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

NHS Lothian

Accident & Emergency

Dr Holden
Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

Date First Created 09/10/2011
Date Authorised
Date/Time Printed 09/10/2011 20:25
Our Ref 800325165E
CHI 2305821425

Patient: Gillian McAteer
18 Cherry Avenue
Bathgate
EH48 1NA

UHPI: 800325165E
Date of Birth: 23/05/1982

Ward: SJH Obs Ward

Admission Date: 08/10/2011

Consultant: Mr Martin DJ McKechnie

Discharge Date: 09/10/2011

Dr P Freeland
Dr J Fothergill
Mr M McKechnie
Dr P Leonard
Dr B Threlfall

Tel: Reception
01506 523011

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She was deemed fit for discharge home, to stay the night with her mum. Given head injury advice.

Should you need further information please contact...
Observation Ward, SJH.

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

Yours sincerely..... DJM McKechnie

Staff Signature..... PrintName.....

Designation..... Date..... Time.....

Patient/Carer Signature.....

E2066076

E1439786

800325165E

Dr RW Holden

Simpson Medical Group
Bathgate Primary Care Centre
Whitburn Road
Bathgate
EH48 2SS

McAteer
Gillian

18 Cherry Avenue
Bathgate
West Lothian

EH48 1NA

[redacted]

23/05/1982
29 Female

08/10/2011 19:47

Emergency Ambulance

Self Referral to A&E

PC: Head injury

29 year old female was having a few drinks (5 vodkas) this afternoon, around 1500 she let the dog out she then fell down the stairs, she sumersaulted twice, hit her head off a plater wall and then landed at the bottom of the stairs, slamming the door shut
She then states that she lost conciousness for around 4 hours
At 1900 she came round and went next door to her neighbour who phoned for an ambulance
Complaining of a pressure feeling at the back of her head
Remembers everything before and after the event
No vomiting after the fall
Has been acting like her normal self since the event
No dizziness, change in vision
States that she had a couple of seconds of numbness/tingling in her right leg but this has now settled

No sig PMH, no regular meds, NKDA

O/E:
P 102, RR 18, BP 155/96, Sats 99%RA, alcometer 0.71
Large boggy swelling over occiput
No c-spine tenderness
No spinal tenderness
CN II-XII intact
Tone, power, sensation and reflexes normal all 4 limbs
HS I+II+O
Chest clear, good a/e throughout
Abdo SNT, bowel sounds present

Head injury - ?4hour LOC
Pt discussed with Dr Rennie
Plan:
Admit - for neuro obs
If any deterioration then for CT overnight

Pt reviewed by Dr Rennie
Pt now becoming more distressed and still complaining of pain - decision to CT head now

Ct head normal - verbal report by Dr Khan
Pt accepted by Obs Ward

Dr Jenna MA McNeillis Doctor

Surgeon's Operation Notes

Affix patient label

Patient's name: .....

Hospital number: .....

Date of birth: .....

CHI: ..... M / F

Consultant: AGADA

Surgeon	Assistants	Scrub Nurse	Operation
BARR			R+L Grom

Surgeon's operation notes

F - R+L GRADE ATTIC RETRACTION
NO DEBRIS
TM (N)
ME DRY

P- AMT INF MENINGOTOMY
SMAM GROMT
CIPROFLOXACIN DROPS SOAT
} R+L

POST OP (H) LATER

F/U TSA & MEDINET

BARR
CON
4619720

Anaesthetic Record

Pre-op information

ASA 1 BP 110/73 PULSE 74 SpO_2 97 Temp 36°C Wt ..... Ht ..... BMI .....

Prev GA ok — Anuria — NKDA

No CoAD — NSAIDs ok

MPI

→ AM Dvt no use [illegible] — TMJA

Information given to patient: IV, GA, analgesia, anti-emetics

opp to ask q's

Anaesthesia details

Anaesthetist(s) name & grade: [illegible] Date: 26/1/15

Supervising Consultant: .....

Machine check ☑ Trained assistant ☑ Prelist brief / Surgical pause ☐

Vascular access (site / device / size)

[illegible]

Induction

Propofol [illegible] mg [illegible]

[illegible]

Maintenance [illegible]

Airway / Circuit / Machine

[illegible]

Easy to hand ventilate? Yes ☐

Laryngoscopy grade

Monitors:

Minimal monitoring ☑

Others

Eye care — Tape ☑ / Lubricant ☐ / Padded ☐

Pressure care ☐

Fluid warmer ☐

Warming blanket ☐

DVT prophylaxis ☐ n/a ☑

Post Op DVT prophylaxis ☐ n/a ☐

Antibiotics ☐ n/a ☐

Patient / Limb position

Significant issues or events

Recovery Obs

Recovery 13

Time				1240	45	50	55	00	05	10												
SpO_2	94	99		100	100	99	95	95	95	95												
$ETCO^2$		41		15	15	14	RA	RA	RA	RA												
FiO^2				LMA	LMA	BV	SV	SV	SV	SV												
ET AA	1.9	2.4		14	16	16	17	16	17													Resp
Vt.f (Paw)																						
					TEMP		37.4															
200																						
180																						
160																						
140																						
120						✓																
100	✓	✓		✓	✓		✓	✓	✓	✓												
80																						
60																						
40																						
20																						
0																						
	%																					
Diuresis				U	U	1	1	1	1													Sedation
																						Pain
																						Nausea
Events	[ ]																					

Recovery

Anaesthetist instructions: Routine obs ☑ O_2 as needed to maintain SpO_2>93% ☐

Tick if you want to see patient before discharge ☐

Recovery comments:

Into recovery LMA insitu O2 @ 15 L/min - reflected @ 12 47
Face Mask @ 4 L/min - breathing spontaneously
Temperature taken - axilla 37.4.
Water given + tolerated well
IVI in progress, Venflon Right dorsum hand - capped @ 13 20
feeling comfortable, no nausea, no oozing observed from Ears.

Arrival time in recovery: 12 39 Time discharged to ward: .....

Recovery nurse: D. DUGDALE Signature: Dugdale (Medical)

Day Surgery Centre
St John's Hospital, Howden Road West,
Livingston, West Lothian, EH54 6PP.
Phone: 01506 524105
www.nhslothian.scot.nhs.uk

NHS Lothian

Consent for Operation

Affix patient label

Patient's name: ..... Consultant: Acmoon

Hospital number: .....

Date of birth: .....

CHI: ..... M / F

Planned procedure: .....

Groin MG

Common risks: Infection pain bruising

Less common risks: TVT

I confirm that I have explained to the patient in terms in which my judgement are suited to his / her understanding (and / or to one of his / her parents or guardians), the proposed operation, investigation or treatment, including options available, and if relevant, the need for anaesthesia or sedation.

Signature: ..... Date: 21/1/2015

Name and status of practitioner: Acmoon Consultant

Re-confirmation of consent on the day of admission

Signature: ..... Date: .....

Name and status of practitioner: .....

Medical Students

- I agree to allow students to be present in theatre (tick box): Yes ☐ No ☐
- I agree to be examined by a medical student whilst under general anaesthesia in theatre: Yes ☐ No ☐

Medical Photography (I agree to being photographed)

- For my medical records for the purpose of diagnosis and treatment: Yes ☐ No ☐
- For the purpose of teaching and education: Yes ☐ No ☐
- For the purpose of publication: Yes ☐ No ☐
- To be shown to other patients (as an example): Yes ☐ No ☐

Tissue for medical research and teaching

When you have tissue removed as part of a medical investigation, operation or procedure, such as a blood test, some tissue may be left over after the laboratory tests have been completed. This tissue could be kept without your name or the details, so that it is impossible to know whom the tissue came from, and used for research or teaching, to improve laboratory tests, or to see how many people in an area might have a disease or an infection.

Do you agree? Yes ☐ No ☐

To the patient (or parent or guardian if appropriate)

1. Please read this form and the notes overleaf very carefully.
2. If there is anything that you don't understand about the explanation or if you want more information, you should ask the practitioner before signing.
3. Please check that all the information on the form is correct. If it is and you understand the explanation, then sign the form.

I am the patient / parent / guardian (delete as necessary)

I agree ☐ To what is proposed which has been explained to me by the practitioner named above.

I understand
- ☐ That anaesthesia (general / regional / local) or sedation will be needed.
- ☐ That the procedure may not be done by the practitioner who has been treating me so far.
- ☐ That any procedure in addition to the investigation or treatment described on this form will only be carried out of it is necessary and in my best interests and can be justified for medical reasons.

I have told ☐ The practitioner about the procedures I have noted below which I would wish not to be carried out without my having the opportunity to consider them first.

.....

.....

Signature: C McAteer Name: Gillian McAteer

Notes to all Health Practitioners (Doctors, Dentists, Nurses, Professionals Allied to Medicine)

A patient has an absolute legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way that they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to the treatment at any time. The patient's consent to treatment should be recorded on this consent form (further guidance is given in NHS Lothian's Policy Statement).

Notes to Patients

The health practitioner is here to help you. He or she will explain the proposed treatment and what the alternatives are. You can ask any questions and seek further information. You can refuse treatment.

You should be provided with sufficient information to allow you to come to a decision as to whether to consent to the treatment proposed.

The type of information you should receive should include:

1. Nature of your condition and proposed procedures, including degree of urgency.
2. Benefits to be reasonably accepted of the procedure.
3. Nature and probability of material (= significant) risks involved, including consideration of ratio of risks and benefits.
4. Inability of the practitioner to predict results.
5. Irreversibility of the procedure, if that is the case.
6. The likely result of not having the proposed treatment or procedure.
7. Alternatives available, including their risks and benefits.

You may ask for a relative, a friend or a nurse to be present.

Training doctors, dentists, nurses and other health professionals is essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor, dentist, nurse or other health professional.

You may however decline to be involved in the formal training of medical, dental, nursing and other students without this adversely affecting your care and treatment. You must tell a senior doctor or nurse if you do not wish students to be involved in your care and you should write this on the consent form in the space for things that you do not wish to happen without you being given the chance to consider them first.

E-Pacer PATIENT REPORT

Time	19:33	Date	08/10/2011

PATIENT AND INCIDENT DETAILS

Incident number	ED003159751 001
Name	GILLIAN MCATEER
Address	18 CHERRY AVE BATHGATE
Patient postcode	EH48 1NA
Age	29
Date of birth	23/05/1982
Gender	Female
Incident location	20 CHERRY AVENUE BATHGATE
Incident post code	EH48 1NA
Incident type	EMG
Call received	08/10/2011, 18:57
Call passed	08/10/2011, 18:57
Crew mobile	08/10/2011, 18:58
Crew at scene	08/10/2011, 19:08

PRIMARY SURVEY

RESPONSE

AVPU	Alert

AIRWAY

Airway assessment	Clear

BREATHING

Breathing rate	Fast
Respiratory rate	

CIRCULATION

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

C-SPINE INJURY

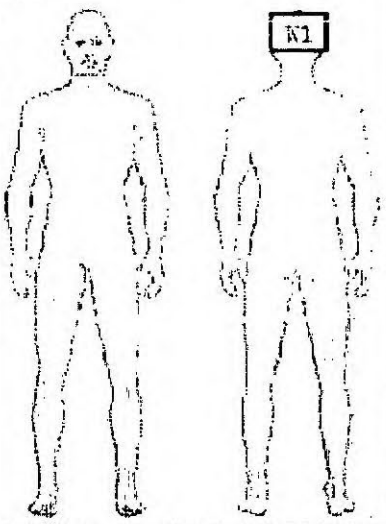
Suspicion of CSI	No evidence of C-spine injury

PATIENT CONSENT

Patient consent	Capacity to understand risks and treatment

INJURIES

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



AMPDS

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

GCS

Final GCS eye opening	Spontaneous
Final GCS verbal response	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	ECG	Pain score

1939	88	16	118/85	<2	-			100	15				4/10
19:19	104	22	134 / 104.	<2 secs	-	6.7	-	100	15	7.550	-		4/10

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	Normal

AMPLE

Allergies	None
Other allergies	
Medication	NONE
Past history	NONE
Last eaten	>5 hrs
Events prior	DRUNK HALF BOTTLE VODKA 1200HRS TODAY PRIOR TO INCIDENT

DRUGS, GASES AND PAIN RELIEF

Pain before	Drug / gas given	Time given	Dose given	Route	Batch No.	Pain after
-	Oxygen	19:20	85%	Inh	-	-

EMERGENCY SERVICES ON SCENE

Paramedic	Technician

SUBSTANCES AFFECTING CONDITION

Alcohol	

PATIENT HANDOVER

On arrival at scene	Seated
Scene removal	Walking
Transportation	Seated
Care delivery at hospital	Chair
Time of handover	19.40

FINAL OBSERVATION AND COMMENTS

FALLEN FORWARDS DOWN 3 INTERNAL STAIRS AT APPROX 1500HRS THIS AFTERNOON, CAN REMEMBER SHE STRUCK BACK OF HEAD ON PLASTER WALL BUT CLAIMS SHE WAS KOD FOR 4HRS, HAS FULL RECOLLECTION OF INCIDENT SPONGY HAEMATOMA TO OCCIPUT AREA, NO OBVIOUS DEPRESSION, NO C SPINE TENDERNESS. VISION OK, NO NAUSEA, APPEARS COMFORTABLE WHEN CONVERSING. LIVES ALONE	
Report ID	8424bf43-5ca6-407b-adb6-fbe56bc0135c

ST JOHN'S HOSPITAL AT HOWDEN
RADIOLOGY CLINICAL REPORT

NHS Lothian

PATIENT NAME:	McAteer	Gillian	UHPI:	800325165E

CHI: 2305821425

Order Items:
CT Head

Clinical details:
Fall downstairs today, boggy haematoma occiput, states 4 hour LOC, becoming more agitated, severe headache

CT Head (Unenhanced Scan):

Findings:

No acute infarct, haemorrhage, mass or surface collection. Normal ventricular system and basal cisterns. No significant bony abnormality.

Clinical team informed.

Reported by Dr Z Khan.

ADDRESS:	18 Cherry Avenue		DOB:	23/05/1982
	Bathgate		SEX:	Female
	EH48 1NA			

REFERRER:	
ADDRESS:	

Episode Consultant:	Dr Jenna MA McNeillis
Order Patient Location:	SJH A&E
Receiving Location:	SJH - CT

Order Items(s):	Visit No	Date of Exam	Referring Clinician
CT Head	10873505	08/10/2011	Dr Jenna MA McNeillis

D.O.R:	08/10/2011	Reporting Radiologist:	Dr Zubair A Khan
D.O.T:	09/10/2011	Overseen by Radiologist:	
D.O.V:	09/10/2011	Verifying Radiologist:	Dr Zubair A Khan
		Typist/Secretary:	Joanna S Murphy
		Radiologist Signature:	

Printed 09/10/2011 11:08:11

AUDIOGRAM
Clinic AuditBase
Audiometer

Name MISS. GILLIAN MCATEER
Hospital no.: T121693
Address 18 CHERRY AVENUE BOGHALL BATHGATE
NHS no.:
Date of birth: 23/05/1982

Date	Doctor
16/11/2014	DR C HAYWARD

Diagnosis

Remark

Ear drum status
Normal R Comment
Normal Comment

Meas. result
Reliab. Comment

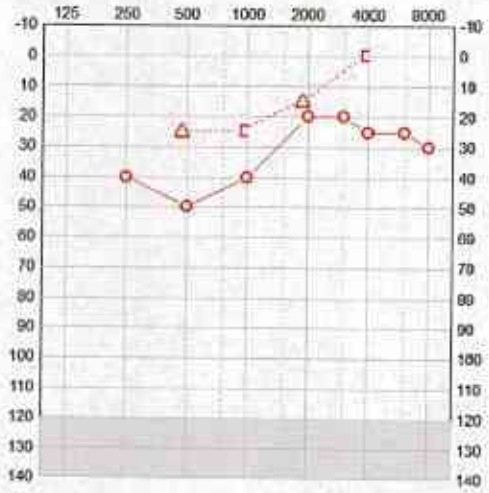
Audiogram no 1

Made by

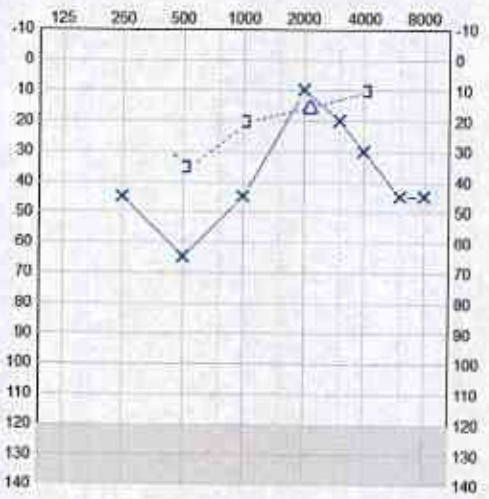
Comments

	Tone		Speech audiogram								
	Mean value		speech	Mask-	Reflex	Max speech rec 1 & 2 (discrimination ability)					
	BCL	HTL	treshold	ing							
			dB	dB	dB	%	dB	Mask.	%	dB	Mask.
R	22	37									
L	23	40									

Right



Left



Masking dB	125	250	500	750	1000	1500	2000	3000	4000	6000	8000	
HTL R:												Ins. masked
HTL L:												
BTL R:					75				60			R
BTL L:			80		70				65			L

Audiogram notes:

Tympanometry results:

Canal Vol cm3 Compliance cm3 Pressure daPa

Right ear
Left ear

Tympanometry comments: