NHS
Ayrshire
& Arran

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock

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

Date 30/06/2026
Our Ref LW\3010776241
Your Ref 100009
Enquires to Lauren
Telephone 01563 827076

E-mail SubjectAccessRequest@aapct.scot.nhs.uk

Dear Sir/Madam

GENERAL DATA PROTECTION REGULATION (GDPR) SUBJECT ACCESS REQUEST
RE: Caroline Welsh - 9 St. Michaels Place, Kilwinning Ayrshire, KA13 6FA

I refer to your recent letter requesting access to your client's medical records under the above Act.

I have now had the approval of the relevant Clinicians to provide you with a copy of the notes and enclose herewith the relevant documents.

I would be grateful if you could email the above address or return the tear-off slip to confirm safe receipt of the documents.

Yours faithfully,

Mr R H Bryden
Head of Health Records Services

Please return to: Legal Desk, Health Records, University Hospital Crosshouse, Kilmarnock Road, Kilmarnock, KA2 0BE

I acknowledge safe receipt of the copies of medical records pertaining to:

Caroline Welsh 3010776241

- **CarePartner Records**
- **NHS Ayrshire and Arran Hospital Records**

Signed: ---------- Date: ----------

Designation: ----------

NHS AYRSHIRE AND ARRAN RECORDS

CAREPARTNER RECORDS

TEMPORARY COVER

CHI – 3010776241

NAME – CAROLINE WELSH

Care Partner

Welsh, Caroline

Date of Birth 30-Oct-1977 (48y) **undefined Female** **CHI Number** 3010776241

History for Summary of contact

From 29/04/1926 Until 29/04/2026

Assessed 18th Dec 2024 at 15:33

Summary of contact	

Dear Dr Hamilton,

Re: Caroline Welsh, 9 St Michaels Place, Kilwinning, KA13 6FA

I am writing with an update regarding Ms Welsh following my prior correspondence, advising she had reached the top of the psychology treatment wait list. I had met with Ms Welsh on two occasions (20 June and 11 July 2024), where time was spent initially reviewing how things had been since her initial assessment appointment on 20 February 2024. I refer you to this prior correspondence for more detail.

Since I last wrote to you, Ms Welsh has attended 5 appointments (5 and 19 August 2024; 26 September 2024; 24 October 2024 and 28 November 2024), not attended 3 (19 September 2024; 14 and 31 October 2024) and cancelled 1 (29 July 2024). Ms Welsh's sporadic attendance interrupted the flow of treatment. When I last met with Ms Welsh she reflected on stressors that had surfaced and opted to be discharged from North Ayrshire Community Mental Health Service (NACMHs). Nonetheless Ms Welsh did report finding psychological formulation work to be helpful in assisting her with increased understanding as to the underpinning factors to her struggles with mental health. Some time was also spent considering how Ms Welsh regulates her emotions and on anxiety management strategies, however she tended to adoption of her longstanding avoidant coping style. Please see below for a summary of my contact with Ms Welsh.

Ms Welsh presented with some emotional dysregulation influenced by stressors. She reported difficulties in keeping with depression and anxiety including intrusive thoughts and compulsive behaviours. Her anxiety was at the forefront of her presentation. Ms Welsh wondered if she had ADHD and I explained to Ms Welsh that any such traits could be viewed as being on a continuum and that she would not meet threshold for assessment within NACMHs. I signposted Ms Welsh to NEST advising they have resources she may find to be of help. You will recall Ms Welsh also spoke of her diagnosis of Fibromyalgia in 2016 and reported symptoms including widespread pain and other related symptoms including brain fog, concentration difficulties and tiredness and fatigue. She said these symptoms flare when she is stressed. Ms Welsh was not reporting suicidal thoughts or DSH to be an issue. There is no problematic alcohol or substance misuse.

Ms Welsh reflected that she felt stressors had exceeded her ability to cope in her usual way since February 2023 following the death of her friend. She spoke of a number of other stressors she had been contending with including her husband's health, financial strain and stress associated with her own physical health. Ms Welsh identified a primarily avoidant coping style including keeping busy and engaging in distraction. Ms Welsh reflected on a range of prior experiences that she felt shaped her sense of self, others and environment growing up. She spoke of a range of adverse experiences including (but not limited to) her parents splitting when she was 2 and her father going to prison when she was 3. Regarding the latter, she said this related to an altercation between her father and a neighbour with the neighbour subsequently dying. In addition to her experience of sexual abuse by a neighbour and a cousin at 10, Ms Welsh recalled a further adverse experience from her mother's boyfriend that she and her mother reported to the police when she was a teenager. At 13 she recalled being locked in a house by a male and spoke of the adversity felt by this incident. Ms Welsh recalled a few house moves and there was social work involvement with Ms Welsh spending time in care as a teenager. Ms Welsh reflected she did not feel her parents could meet her needs and her mother struggled to provide her with structure. She recalled pleasant memories at a grandparent's house where she felt safe.

Ms Welsh identified a range of beliefs that developed from her experiences such as herself as not being normal, not fitting in, not deserving of and not being in control. She identified beliefs she developed of others as being loving, unpredictable and not being able to meet her needs and the world as a confusing place. To avoid activation of negative beliefs, Ms Welsh felt she had come to cope by putting others needs before her own functioning, a means of others not struggling in the way she had, and overcommitting as a means to feel accepted. She also reflected that in speaking about her feelings she could feel exposed, and so chooses not to, and of holding a concern that others may react badly should she do so. Regarding the latter, Ms Welsh tested

Care Partner

Welsh, Caroline

Date of Birth 30-Oct-1977 (48y) **undefined** Female **CHI Number** 3010776241

History for Summary of contact

From 29/04/1926 **Until** 29/04/2026

this out during treatment by sharing some of her struggles with trusted others and she reported this to be a positive experience. Ms Welsh recognised factors that maintain her mental health struggles in the here and now including withdrawal, engaging in self-criticisms, and over-analysis, in addition to overcommitting and putting others needs before her own. Ms Welsh recognised she has a focus on engaging with practical demands and can suppress struggle. Regarding the former, Ms Welsh recognised this can contribute to her feelings of burn out and the importance of setting time aside for her self-care. Ms Welsh could better understand why not feeling in control is a trigger to exacerbation of her anxiety difficulties in the here and now.

Ms Welsh recognises she demonstrates resilience. She has managed to continue with her necessary tasks and has engaged with pleasurable tasks. Ms Welsh spoke of some holidays she went on during our contact such as to Prestwick in her new caravan and a Cruise. When she was on holiday to York and then Southerness she reported to have accidently mixed up her prescribed medication and took the morning dose at night, and vice versa. I had encouraged her to speak to a GP at the GP Practice about this.

When I last met with Ms Welsh on 28 November 2024 she spoke of chest pain with the watch that she wears showing her oxygen levels to be low. She said she thought she had sleep apnoea and intended to link in with the GP Practice about this. She said she thinks this is why she is waking up during the night. Ms Welsh also spoke of her Carpal Tunnel flaring up, and that her arms were numb and wondered if she had heart problems related to the physical symptoms experienced. I encouraged Ms Welsh to link in with the GP Practice as regards these symptoms. She said she was also going to request bloods via the GP. Ms Welsh spoke of the stress related to her husband's deterioration in his health. She spoke of staff depletion in her current work and had an interview for role as Senior Healthcare Support Worker in the NHS on the 29 November 2024.

Ms Welsh has now been discharged from NACMHs. If you have any questions please do not hesitate to contact me on the above number.

Yours Sincerely,

Assessed 5th Dec 2024 at 13:15

Summary of contact

Dear Ms Welsh,

Following your therapy appointments within North Ayrshire Community Mental Health Service, I am writing to you with the information as discussed, regarding a service you may find of help to link in with. The service is called NEST (Neurodevelopmental Empowerment and Strategy Team). NEST provides information on resources and services in Ayrshire for people experiencing neuro-divergence and their families.
Website: https://www.nest.scot
Enquiries: info@nest.scot

It was helpful to understand what you found to be of benefit from the therapy appointments, with time spent making sense of your mental health struggles, and in learning some coping strategies to add to those strategies you had already identified as helpful.

If in future you feel further support is required from North Ayrshire Community Mental Health Service you can request re-referral via your GP Practice.

Yours Sincerely,

Welsh, Caroline

Date of Birth 30-Oct-1977 (48y) undefined Female CHI Number 3010776241

History for Summary of contact

From 29/04/1926 Until 29/04/2026

Assessed 28th Nov 2024 at 14:00

Summary of contact/details
Ms Welsh completed the Core 34, BAI and BDI2. Core 34 - total sore 71. BAI - total score 35. BDI2 - total score 32 She has reported finding benefit in engaging in formulation of her difficulties and identified strategies to manage her symptoms. Current stressors relating to family stressors and work stressors that Ms Welsh is attending to and detracted from focus on psychological therapy at this time. Ms Welsh in agreement that discharge from psychology with signposting to NEST to aid in what she describes as traits in keeping with ADHD. Ms Welsh links in with relevant services for assistance with her physical health. She spoke of chest pain and her watch shows that ygen levels are low and she thinks she has sleep apnoea and intends to link in with her GP practice about this. She said she ...inks this is why she is waking up during the night. She said she has carpal tunnel and this is flaring up, and her arms are numb and wonder if she has heart problems related to the physical symptoms she is experiencing. I encouraged Ms Welsh to link in with the GP Practice as regards these symptoms. She said she is going to request bloods via the GP. She said she is busy attending to son who is living with her making his meals and doing his washings and going to the hospital with her husband to his appointments. She said she is due to go to an interview tomorrow to combined assessment at Crosshouse Hospital for role as senior healthcare support worker. She said she feels can recognise triggers now and making sense of associated emotions, thoughts, behaviours and body changes. She said she uses distraction primarily as a way to manage difficulty. She is not experiencing suicidal thoughts or engaging in DSH. She is not reporting problematic alcohol or illicit drug use.

Assessed 13th Nov 2024 at 11:06

Summary of contact/details
Dear Ms Welsh, PSYCHOLOGY OUTPATIENT APPOINTMENT rther to our telephone conversation, please see details below of your next psychology appointment: Date: Thursday 28th November 2024 Time: 2.00pm Clinician: Dr Erin Toal, Consultant Clinical Psychologist Location: Ardrossan Health Centre Central Avenue ARDROSSAN KA22 7DX In fairness to others on the wait list waiting to be seen, if you do not attend or cancel this appointment, you will be discharged from the psychology service. This is in fairness to others on the wait list waiting to be seen. Yours sincerely

Care Partner

Welsh, Caroline

Date of Birth 30-Oct-1977 (48y) **undefined** Female **CHI Number** 3010776241

History for Summary of contact

From 29/04/1926 Until 29/04/2026

Assessed 31st Oct 2024 at 13:40

Summary of contact	
Dear Ms Welsh I was sorry not to see you at your appointment on 31 October 2024 at 11.00am in Ardrossan Health Centre. If you would like another appointment to be arranged then kindly contact my secretary at the above number within 14 days of the date of this letter. Please ensure that you indicate any restrictions that you may have on times suitable for meeting. If I do not hear from you I shall assume you wish no further appointments at this time and will discharge you from my care. I look forward to hearing from you. Yours sincerely	

Assessed 31st Oct 2024 at 11:00

Summary of contact/details	
Ms Welsh DNA'D clinic appointment. To request an opt in letter is sent.	

Assessed 24th Oct 2024 at 14:00

Summary of contact/details	
Ms Welsh advised that she had tried to call to advise would not make her most recent appointment there as she had over slept. She said she could not get through to advise of this. Ms Welsh said she managed to enjoy her holiday. Reviewed completed 5 aspects in brief and Ms Welsh encouraged to consider unhelpful thinking habits engaged in. Ms Welsh said she is opening up to people more and has told some friends, her son and her husband is aware that she is in therapy, as well as a lady who does her eyebrows. She spoke of the latter experience consisting of reciprocal sharing. Ms Welsh said she has also told her husband and son, sister and a work colleague about her experience with her father aged 3. Ms Welsh reflected it was a lot for a 3 year old to take on. Ms Welsh felt that she has not shown vulnerability to others influenced by being hurt in the past and when her trust has been broken. She said when she shared about her father she felt she betrayed him as he was a very private man. She recalled an experience at 13 when she was locked in a house by a man aged around 18 or 19. She said she had never shared this experience with anyone before. Ms Welsh reflected that prior adverse experiences can pop in to her mind and we discussed this in relation to the emotion regulation systems (threat - drive - soothe). Psycho education was conducted on the threat - drive - soothe system and fight/flight/freeze response and psycho education commenced on the physiological impact of anxiety on the body - to continue next session. Safe place visualisation conducted and Ms Welsh reflected on a soothing image as well as a sad memory that was conjured during this practice that felt a surprise to her. We discussed revisiting this practice next session with Ms Welsh playing around with this visualisation and considering an imagined place to compare and contrast experience with linkage to the emotion regulation systems considered. Ms Welsh continues to not experience suicidal thoughts. No DSH reported.	

Assessed 15th Oct 2024 at 11:54

Summary of contact/details	
Dear Ms Welsh Following your non-attendance at your scheduled outpatient psychology appointment on Monday 14th October 2024 at 9.30am at Saltcoats Health Centre, I am writing to remind you of your next scheduled appointment on Thursday 24th October 2024 at	

Care Partner

Welsh, Caroline

Date of Birth 30-Oct-1977 (48y) undefined Female CHI Number 3010776241

History for Summary of contact

From 29/04/1926 Until 29/04/2026

2.00pm at Ardrossan Health Centre.

If you do not attend this appointment we can only assume you do not wish to be seen at this time and you will be discharged from the psychology service at North Ayrshire Community Mental Health Team. This is in fairness to others on the psychology wait list waiting to be seen.

Yours Sincerely,

Assessed 14th Oct 2024 at 09:30

Summary of contact/details	
Ms Welsh DNA'd clinic appointment. To send a letter to Ms Welsh advising if she does not attend her next scheduled appointment on the 24th October at 2pm then it can only be assumed she does not wish to be seen at this time and will be discharged from the psychology service at NACMHs.	

Assessed 26th Sep 2024 at 15:00

Summary of contact/details	
Apologised to Ms Welsh as was running 10 minutes late in clinic and she presented as understanding of this. Ms Welsh said she feels her increased levels of stress felt have been influenced by the physical health of her husband and said his physical health state has deteriorated. She said she also felt stressed when her husband's daughter and her children visited on a weekend. She said she enjoyed this and that the stress felt she identified in linking back to longitudinal formulation as to the core belief being activated as to not feeling in control. Ms Welsh said she thinks she has traits of ADHD and said this is because she struggles to focus. We spoke of this symptom also being a symptom of anxiety and discussion as to traits and symptoms being on a continuum including ADHD and anxiety symptoms and linkage to symptoms and impact on functioning was discussed. Time was spent reflecting on Ms Welsh's strengths including her identified coping strategy of working to complete one task at a time to assist in completing day to day necessary and pleasurable tasks. Ms Welsh used an analogy of spoons with each spoon representing a task and that when she completes one task that takes away one of the spoons and her concern that she may run out of spoons on any given day eliciting stress for her. Time was spent linking this analogy into recapping on the bucket analogy. Ms Welsh showed me a video from social media of an individual speaking about ADHD in relation to busy thoughts. She said her head always has lots of thoughts and can experience many at any given time. Time was spent recapping on the longitudinal formulation and linking to 5 aspects and UTHs identified to a situation eliciting an anxiety response. Time was spent deciphering thoughts from emotions from body changes. Ms Welsh had not completed 5 aspects between appointments and rationale for between session practice was discussed. Ms Welsh said she was not experiencing suicidal thoughts or DSH upon enquiry. She said she is looking forward to going on a cruise overall.	

Assessed 19th Sep 2024 at 15:00

Summary of contact/details	
Ms Welsh DNA'd clinic appointment. I called Ms Welsh in light of time since last appointment due to Ms Welsh's holiday and my own annual leave. Ms Welsh said she was at work, could speak for a short while, and had thought the appointment was tomorrow. I said I could see we have a further one scheduled on 26th September 2024 at 15.00 at Ardrossan Health Centre and Ms Welsh said she would attend this appointment. I asked Ms Welsh was there anything she wanted to check in with prior to this appointment and Ms Welsh said she enjoyed her fortnights holiday and was in York and then Southerness. She said upon return from annual leave on Friday there she feels as if she has over committed herself with work and said her husbands physical health has not been good. She said on holiday she took a handful of her prescribed medication away with her and usually in the dosette boxes and got mixed up and thinks was taking morning medication at night and vice versa. She said she does not think it matters	

Care Partner

Welsh, Caroline

Date of Birth 30-Oct-1977 (48y) **undefined Female** **CHI Number** 3010776241

History for Summary of contact

From 29/04/1926 Until 29/04/2026

too much and got mixed up and I said it would be helpful for her to speak to a GP at the GP Practice about this, directed her to GP Practice. Ms Welsh said she is not experiencing suicidal thoughts upon enquiry. She said her current prescription for medication is amitriptyline, sertraline and naproxen.

Assessed 19th Aug 2024 at 09:30

Summary of contact/details	
Added to the longitudinal formulation. Psycho education on 5 aspects and linkage to longitudinal formulation and the process of considering helpful coping strategies to assist with her distress and anxiety difficulties. Psycho education on unhelpful thinking habits was conducted. Ms Welsh reflected on UTHs she can fall into and completed a 5 aspects at the appointment. She reflected at the appointment her liking to be in control and how this makes sense from her prior life experiences where she did not feel in control e.g. parental split, father's imprisonment, transition to care. Ms Welsh recognised not feeling in control to be a trigger for her anxiety difficulties in the here and now.	

Assessed 5th Aug 2024 at 09:30

Summary of contact/details	
Added to longitudinal formulation Ms Welsh said she enjoyed her holiday to Prestwick in her new caravan with her husband. She said she recently attended training as regards how to tow her caravan and found this helpful and got a certificate. She said her car is in the garage this morning and her sister dropped her off for todays appointment and stepdaughter is going to pick her up. She said her husband is attending hospital appointment. Ms Welsh said she realised she listens to 90s music and that this got her through her childhood and that it reminds her of both pleasant and unpleasant memories. She said when she cleans she listens to 90s music. She recalled an instance at 15 when she was with her mother and her mother's boyfriend in her mother's boyfriends house and said they had all been drinking alcohol following her buying her mother vodka with her first wage and her mother's boyfriend tried it on with her. She said he attempted to rub himself on her body and she called her mother to advise him of what he had tried to do. She said her mother went to the police station with her and each gave a statement and she returned to the home in Helensburgh she had previously resided in for a few weeks. She said she told her boyfriend at the time who she was with at 14/15 to 16 and his mother. She spoke of feeling a bit invalidated by his mother and at the same time it was helpful to speak to her. Ms Welsh said when feeling stressed her symptoms of Fibromyalgia flare and she tries to look to engage in stress management strategies. Ms Welsh spoke of getting in to a lot of debt, that she was left in debt in 2003 when split from ex-partner and nearly lost her house and her sister moved in to help with the children. She said she was in council tax and rent arrears and then got a trusteed and paid £30 for 2 years and then had a clean slate and addressed council tax ensuring not to miss payments. She said she is back up in debt and is going to get a consolidation to assist with the debt and said debt is on credit cards and loans. She said she had taken a £10000 loan upon return to Scotland and at the time was paying £500 in rent and £500 for a caravan and the pandemic started.	

Assessed 26th Jul 2024 at 15:27

Summary of contact/details	
Telephone call to Ms Welsh. This followed Ms Welsh calling and leaving a message with a secretary to advise she cannot attend Mondays psychology appointment at 9.30am however could attend later that day or else if not possible will keep the next appointment on 5th August at 9.30am. Ms Welsh said to me that she is going to the caravan this weekend and travelling back Monday and why requires later appointment if possible and if not will attend on 5th August appointment. I advised clinic slots are full and Ms Welsh asked if there is a cancellation if she could be contacted. I advised could do so however sometime there is a lag between a cancellation and clinician notification of this however would do so if timely or else would be seeing her on 5th August. Ms Welsh thanked me for the call.	

Care Partner

Welsh, Caroline

Date of Birth 30-Oct-1977 (48y) **undefined** Female **CHI Number** 3010776241

History for Summary of contact

From 29/04/1926 **Until** 29/04/2026

Assessed 20th Jul 2024 at 16:48

Summary of contact	

Dear Dr Hamilton

Re: Caroline Welsh, 9 St Michaels Place, Kilwinning, KA13 6FA

I am writing to advise that Ms Welsh has recently reached the top of the psychology wait list to commence psychological intervention, and I have met with her on two occasions to date, on the 20 June 2024 and 11 July 2024. This followed an sessment appointment to ascertain suitability for specialist level psychological intervention on the 20 February 2024.

You will recall from the assessment that Ms [redacted] spoke of difficulties in keeping with anxiety, including intrusive thoughts and compulsive behaviours, and wondered if she has ADHD. At the appointments with me she also reported that since February 2023, following the death of her friend that we discussed as a stress factor, she has been experiencing daily images of her experiences of sexual abuse by a neighbour and a cousin when 10 eliciting distress, whereas previously she would experience these images infrequently. She said she felt her prescription of Sertraline is helping slightly with this symptom. Ms Welsh also spoke of other current stressors including her husband's health, financial strain, and stress associated with her physical health.

Regarding her physical health, Ms Welsh said she was due to have a colonoscopy on the 15 July 2024 to investigate her passing water when having bowel movements since the beginning of April 2024. Ms Welsh also spoke of her diagnosis of Fibromyalgia in 2016 and that she experiences widespread pain and other related symptoms including brain fog, concentration difficulties and tiredness and fatigue. She said she has been prescribed Amitriptyline to help with the pain.

In terms of risk, Ms Welsh said she sometimes thinks she would be at peace if she were not here. She said she does not identify this as a suicidal thought and has a fear of dying. She said she has never had suicidal thoughts. She did not report issues with DSH nor problematic alcohol use. She said she does not drink much alcohol. She reported historic but not current illicit drug use. From 13 to her early 20s Ms Welsh said she tried a range of drugs - cannabis, ecstasy, speed, cocaine, and acid. She said this was ith peers and alcohol likely featured.

Ms Welsh has been offered a period of psychological formulation of her difficulties and consideration as to anxiety management strategies. This is in keeping with her goals that she identified at the outset.

I am next due to see Ms Welsh on the 29 July 2024 and I will update you on her progress, or otherwise, in due course. In the meantime if you have any questions please do not hesitate to contact me on the above number.

Yours Sincerely,

Assessed 18th Jul 2024 at 11:30

Summary of contact/details	

Added to longitudinal formulation.
Ms Welsh said she went for the colonoscopy at Ayr Hospital and has been advised that it looked fine however biopsies have been taken. Ms Welsh said she had been prescribed Orlistat by a GP in March 2024 and lost 2 stone since. She said she had taken over the course of March 2024 and then when passing water at start of April 2024 stopped taking the Orlistat. She said there is always something happening as regards her health and she liaise with GP Practice about this. She said she has had issues with her liver and that her blood sugars fluctuate and that she is always looking to loose weight. She spoke of comfort eating over the years. She said she has been a carrier for hemochromatosis and this is monitored via the GP Practice. She said she can forget to eat if

Welsh, Caroline

Date of Birth 30-Oct-1977 (48y) **undefined** Female **CHI Number** 3010776241

History for Summary of contact

From 29/04/1926 **Until** 29/04/2026

she is taken up with tasks. She said she can loose motivation to complete tasks if she stops midway through such as what happened when she was painting a garden fence. She said she was weeding the monoblock and feeling anxious as regards ensuring done perfectly and was feeling distressed if could not complete and said as a result spent hours on it and forgot to eat dinner recently. At the moment she said if working she will have porridge and then 4 ginger biscuits for breakfast and a coffee and then a sandwich and soup for lunch and then pasta and garlic bread for dinner. She said she does not have much fluid intake and will have a carbonated drink if working. She said when not working she may not have 3 meals, yesterday she said she had a banana for lunch. She said she took laxatives years ago when trying to loose weight. She recalled a period of comfort eating following her mother's death when she went up to a size 24 12 years ago before going on to loose 4 stone. She said she lost half a stone following the colonoscopy.

Ms Welsh said she can be impulsive and recently bought a caravan as did her sister and 2 friends bought one together so 3 caravans purchased in total.

In going through the longitudinal formulation -

Ms Welsh's half siblings from mother's relationship with [redacted].

Brother [redacted]9.

Ms Welsh spoke of many house moves. She said she initially lived in Pollok and then when of nursery age moved to Cambuslang. Then when in p5 moved back to Pollok. She said her mother's relationship with [redacted] was on and off and that historically her relationship with [redacted] was volatile. She said she is on good terms with [redacted] now. She said since 3 her behaviour was hard to manage. She felt the influence of this was when her father had an altercation with a neighbour and the neighbour died and he ended up in prison. Ms Welsh said her mother split with [redacted] at 13/14. At 13 she went in to care. She said social work got involved upon return to Pollok when she was 9 and in p5. She said her father moved houses a lot and there were periods of time she did not see him following his release from prison. She said her mother in later years advised her father was released from prison on a technicality. She said her brother [redacted] resided with their father and she stayed with her mother and then their parents would swap them round in terms of access so she never spent much time with [redacted] aside from when he resided with her and her mother when their father was in prison. She recalled her father living in different areas in Glasgow such as Priesthill, and Sighthill and periods when he was in homeless accommodation. She said she was in care 13 to 17 and the last time she had contact with her father was at 17. She said she had moved in to the same block of flats in Sighthill following leaving care and one night her father was at her door drunk and physically attacked her and she called the police and he was lifted. She said this was because he did not like her boyfriend who was 33 and she was 17. She said she has since found out he has died.

Ms Wels said her son [redacted](26) [redacted] is the individual who was 33 and she was 17 as regards the above. She said they split when she was 21/22 and said he was too controlling. She said they are still in contact and spoke of being civil to one another. Her sons [redacted] and [redacted] both 21 father [redacted] she said she met him in 2001 and they married in 2023 and soon split. She said she had not realised the extent of his mental health difficulties, that he had been struggling with depression and later found out he had been given a diagnosis of BPD. She said he had alcohol struggles and would not always tell the truth about things. She said she does not have contact with [redacted]. She said she met her now current husband [redacted] and that it has been the longest and most stable relationship she has been in.

Ms Welsh said she is happy for her notes from NHS GG&C to be requested to assist with formulation of difficulties. This relates to her recalling she was an inpatient at Yorkhill Hospital for 6 months and then commuted to the hospital for 6 months as a day patient. She said she thinks this was for those struggling with mental health struggles and was 9 at the time. She said she is happy for me to request these notes and said she could not recall much about her experience expect contact with a psychiatrist who she could not understand as regards what they were saying.

At 13 when Ms Welsh went in to care she said at the time her mother had found she had the contraceptive pill and she was dating a 17 year old boy at the time. She said she thinks her mother assumed she was having sex when this was not the case. She said the police came and took her to the station and then a social worker took her to a children's unit in Helensburgh and then after 6 months she moved to a unit in Glasgow. She said her mother struggled to cope with her behaviours over the years and that care was the best thing for her. She said she had positive experiences in care and her relationship with her mother improved. She spoke of a period when she was having sex with boys from 13/14 to her early 20s and felt she was seeking comfort in the wrong places influenced by her experience of sexual abuse at 10.

Care Partner

Welsh, Caroline

Date of Birth 30-Oct-1977 (48y) **undefined** Female **CHI Number** 3010776241

History for Summary of contact

From 29/04/1926 Until 29/04/2026

Assessed 11th Jul 2024 at 11:30

Summary of contact/details	

Ms Welsh completed several self-report measures - Core 34 total score 72; BAI total score 17; BDI2 total score 24.

The goals were established for therapy consistent with what was identified at the initial assessment appointment. Period of psychological formulation and considering strategies to manage anxiety difficulties.

Ms Welsh said she could attend todays appointment and had advised the psychology secretary this at the end of yesterday. She said she is due to have her colonoscopy on Monday and will be sent the medication on Sunday to take prior to the procedure. She said she has a pre-op appointment in the telephone later today. She said since the beginning of April 2024 she has been passing water when having bowel movements and the procedure is to investigate this.

Psycho education on Beck's longitudinal formulation and Biopsychosocial perspective and bucket analogy discussed. Ms Welsh said she would identify as having a medium bucket with quite a lot of current stress factors related to her husband's current health, friend's death last year, current financial strain. She said she has over the years got on with things and put things to the side after having dealt with things however is struggling to do this now and linked this to feeling overwhelmed. She said she has a couple of holes in the bucket to help drain the water away such as engaging in problem solving and we discussed how we could consider coping strategies in session. Ms Welsh spoke of background factors influencing her current symptomology. She said she was sexually abused at 10 on one occasion by a neighbour and a few times at 10 by a cousin and over the years had experienced images infrequently related to these experiences and would then feel shame. She said she felt it was because she let it happen and enjoyed the attention and we spent time discussing that she was not at fault as regards these experiences and the perpetrators should not have done what they did. She said since February 2023 following the death of her friend she said she has been experiencing these images daily and said Sertraline is helping slightly. She said when she experiences these images she is very distressed - 6 or 7 / 10 (0-not distressed to 10-distressed). She said she is not feeling in control and we spoke of this influencing her anxiety levels also.

s Welsh said she thinks she has OCD. When I asked her what makes her think this she spoke of compulsions she said she engages in - counting markers on the road, toe tapping and counting inside her mind, refraining from touching door handles with her bare hands as she does not like germs and also spraying her mattress so dust mites do not get on her body. Regarding the door handles and spraying the mattress Ms Welsh said when I asked her what her worst fear would be if she did not engage in this she said it is she does not like germs and had not thought deeply into this. She said she would not like the feeling of germs or bugs. Ms Welsh said she does a deep clean of her house once a week as she does not like germs. She said she wondered about ADHD and when I asked what had her think she struggled with this she spoke of finding it hard to concentrate and impulsivity.

Ms Welsh said since childhood she has liked feeling in control. She said she can be hard on herself and felt she was frustrating me in speaking about her difficulties. I assured Ms Welsh this was not the case, that I am here to be of help and we discussed how further time spent in psychological formulation will assist Ms Welsh with sense making as regards her difficulties. I enquired with Ms Welsh if she would like to initially spend time considering strategies to manage her anxiety difficulties and she said she did not mind what order things were done in whether consideration of strategies first or in engaging in psychological formulation. Ms Welsh presented as anxious during session, consistent with prior session and it was difficult to at times orientate to areas of focus of structured treatment plan. Ms Welsh's speech was fast in rate, tone and rhythm.

Assessed 10th Jul 2024 at 14:18

Summary of contact/details	

Care Partner

Welsh, Caroline

Date of Birth 30-Oct-1977 (48y) **undefined** Female **CHI Number** 3010776241

History for Summary of contact

From 29/04/1926 **Until** 29/04/2026

Psychology secretary sent email correspondence to advise that - Caroline Welsh has called to say she needs to cancel for tomorrow as advised she has just received a telephone call from the hospital to advise they have a cancellation for a procedure that she has been waiting on (colonoscopy). She advised that she also has a further appointment arranged with you for the same time next Thursday though so be fine to attend this. She has apologised about having to miss her appointment but says this is a procedure that she needs to get done and at the end of the call she advised that they need to send her out medication to take prior to the procedure tomorrow and this has not yet arrived, therefore if she doesn't get it in time she won't be able to have the procedure, and will still be able to attend appointment with you.
Psychology secretary asked patient to call at end of day to advise if will be attending psychology appointment tomorrow.

Assessed 20th Jun 2024 at 13:30

Summary of contact/details

Ms Welsh said she has a husband [redacted] and children [redacted]. She said her friend died last year (March, 2023) of cancer. She has an older brother and two younger half siblings (sister and brother) as a result of her mother going on to meet a new partner.

Ms Welsh was diagnosed with Fibromyalgia in 2016 and said she has been prescribed Amitriptyline to help with the pain she experiences. She said she experiences widespread pain. She spoke of other symptoms such as widespread pain, brain fog, concentration difficulties, tiredness and fatigue.

In 2016 she said she moved to England and ran 5 pubs with her husband across Rotherham, Sheffield, and Doncaster. She said they lived in Rotherham. She said [redacted] already lived in England and soon moved to Sweden as he had met a woman online. Ms Welsh said they returned to Scotland in 2019 at Christmas, just prior to the pandemic and she returned to her job as a carer, something she had done for 10 years prior to her move to England. She said they had initially secured a private let in Irvine and then moved to a purpose built house in Kilwinning. She said this was because her husband was diagnosed with bone marrow cancer, myeloma. She said he is disabled and in a wheelchair and is at risk of bone fractures. She said he has just finished chemotherapy. Ms Welsh said his prognosis was between 8 and 10 years and now they are 5 years in and his health has deteriorated over time.

Ms Welsh feels her anxiety has been influenced by not feeling in control. She said when stressed this flares up her fibromyalgia. Ms Welsh said she does not cry in general and does not like showing people her vulnerable side. She said she does not tend to tell people things as her trust has been betrayed in the past. She recalled experiencing a recurring dream related to her father battering a man who later died and he went to prison for this. She said she went to the front door and saw her father and this man covered in blood and her father told her he was teaching him a lesson. Ms Welsh said she stopped talking to her father at 17 and he died when she was 19 and she found out about his death 10 years after his passing. She said her mother died related to pulmonary fibrosis. She said she found out her father had a heart attack when she was 16 and a pacemaker was fitted 2 years later.

Ms Welsh said she sometimes thinks she would be at peace if she were not here. She said she does not identify this as a suicidal thought and has a fear of dying. She said she has never had suicidal thoughts.

From age 13 to her early 20s Ms Welsh said she tried a range of drugs - cannabis, ecstasy, speed, cocaine, acid. She said this was with peers and alcohol likely featured. She said she does not drink much alcohol and did not identify her usage as problematic.

Ms Welsh said she was keen to read a text she had put together that reflected difficulties she had noticed over the last year. She said she does not like feeling restricted or trapped, does not like loud noises, forgetfulness, struggling to hold conversations, experiencing obsessions and impulsivity. She said her obsessions can take up most of her time for example getting obsessed with baking cakes and can do nothing else and most recently had to put cross stitching on the back burner. She said she can get very moody and frustrated and experience self-doubt. She said she does not trust her own judgement and she hates rejection. She

Care Partner

Welsh, Caroline

Date of Birth 30-Oct-1977 (48y) **undefined** Female **CHI Number** 3010776241

History for Summary of contact

From 29/04/1926 **Until** 29/04/2026

said she can get overwhelmed and procrastinate and can be perfectionistic. She said she cant cope with loud noises. She said she does not like walking in to new places and can loose confidence easily. She said her Sertraline was increased to 150mg this year. She said she can over commit herself and does not like being the centre of attention, is exhausted and burnt out. She said she tends to people please and gets disappointed at silly things.

She said she has experienced diarrhea for 2 months and this is getting investigated.

She spoke of financial strain - £600 on a credit card and £9000 in a loan and she has a car payment and her husband has £3000 to pay off.

essed 4th Mar 2024 at 13:15

Summary of contact	

Dear Ms Barbour

Re: Caroline Welsh, 9 St Michaels Place, Kilwinning, KA13 6FA

Thank you for your referral of the above lady to North Ayrshire Psychology Team within the Adult Community Mental Health Service. I met with Mrs Welsh on 20 February 2024 to discuss suitability and readiness to engage in high intensity psychological therapy. Below you will find details and outcome of the assessment.

Presenting Problem
Mrs [redacted] informed me that she is struggling with anxiety. She describes general anxiety and worry but also intrusive thoughts and compulsive behaviours. She said that she has a need for control and feels panicky when she does not have this. She informed me that she compartmentalises her thoughts and behaviours such as taking one day at a time and breaking down activities into small steps. Mrs Welsh also mentioned that she can be impulsive regarding hobbies and activities with the family and wondered whether she had ADHD, as this behaviour has occurred throughout her life. She also mentioned a history of trauma including a difficult childhood and disruptive behaviour.

Mrs Welsh currently copes by tensing her hands and generally trying to keep busy.
Her goals for therapy include managing her feelings of anxiety and the need for control, and understanding how past experiences may be contributing towards her current difficulties.

Symptoms
Mrs [redacted] informed me that she is also dealing with a high-level stress as she is a carer for her husband who has cancer. She also lost a friend previously to cancer. She told me that she puts on a front and others will think she is coping ok, but she is struggling. She feels a weight on her chest and a sense of dread daily. She also described rumination and worry, and paying attention to small details. Mrs Welsh stated that she has to do things a certain number of times such as told helping and will count often also (e.g. number of tiles on the room, number of steps to the door).
She experiences headaches, sweating and her heart racing.

Mrs Welsh said that sleep is difficult and she can struggle to fall asleep and stay asleep. She said that she has little appetite and at times can forget to eat. She told me that her energy is up and down throughout the day and her mood is generally fine if she is feeling in control. She said that both her motivation and concentration are low and she denied any current paranoia. She said that she does at times hear a crowd of voices but this only lasts for a couple of seconds and she is not aware of what they are saying. She informed me that both her long-term and short-term memory are not great.

Risk
Mrs Welsh denied any current self-harm, suicidal thoughts, plan or intent to end her life. She denied any current recreational drug

Welsh, Caroline

Date of Birth 30-Oct-1977 (48y) **undefined** Female **CHI Number** 3010776241

History for Summary of contact

From 29/04/1926 **Until** 29/04/2026

or alcohol use. She denied any current forensic involvement. She has fibromyalgia but no other physical health concerns. She has three adult sons. She is currently prescribed 45 mg amitriptyline, 500 mg naproxen, 150 mg of sertraline, and omeprazole.

Current Situation
Mrs Welsh currently lives with her husband [redacted] and her two youngest children [redacted]. She works as a carer with the council and works 30 hours a week 4 days on and 4 days off. She is also a carer for her husband who spends her time out of work engaging in sport activities with the family, cleaning the house and "pottering around" to keep busy. She is not in education but is studying Swedish on her own time.

Mrs Welsh informed me that her mother died in 2011 of Pulmonary Fibrosis. She had a difficult relationship with her mother in childhood but it was better in adulthood. Mrs Welsh said that her father died in 1995 of a heart attack, he was in and out of her life. She has three siblings, an older brother [redacted] who lives in London who she does not speak to often, younger brother [redacted] who she has a good relationship with, and a younger sister [redacted] who is her best friend. She said that she has a brilliant relationship with her husband [redacted] however is heartbroken that he has cancer. She also has 2 other good friends [redacted] and [redacted] She has a good relationship with her three sons, and her eldest son [redacted] has his own place.

History
Mrs Welsh informed me that her parents separated when she was around the age of three. She left with her mother and visit her father occasionally. On one occasion when she was at her father's she was woken up at night by arguing and witnessed her father battering her neighbour. She said that her father went to prison but this was not for a long time. She told me that she had bad behaviour in childhood and was cheeky and disobedient. She told me that at the age of 10 she was in a psychiatric hospital for six months and was then seen as an outpatient for six months.

She told me that she was sexually assaulted by a neighbour and her cousin when she was around 10. She said that her mother struggled to care for her and she went into care at the age of 14-17. She said that she did have a good time when in care and it was positive and the structure helped.

Mrs Welsh told me that she did ok academically in Primary School but she was shy and was called names by her peers. She only attended two years of secondary school and then skipped a lot in her third and fourth years. At the age of 15/16 she said that she "let boys use her body" as she believes she was seeking comfort. She went to college after leaving school at the age of 15 to study fashion. She then worked within textiles as a sore for several years before completing training to become a carer. She has been working as a carer for 30 years. In 1995 Mrs Welsh was living in England and was not in contact with her father following a fall-out and she was not aware that he had died.

In adulthood Mrs Welsh said that she has generally been [redacted] and impulsive and lacked structure. 7 years ago she was struggling with back pain and went to her GP for investigations as she was feeling forgetful and tired. Around this time her husband was diagnosed with cancer they caught it "in the early stages". He did not start chemotherapy for another three years. They moved to England in 2016 and moved back to Scotland in December 2019. Mrs Welsh was working around 70 hours a week to compensate for her husband not working. She lost a close friend to cancer last year and helped her with organising the funeral as she feels that she pushed herself too hard. She then hit rock bottom and was crying often and could not leave her bed. She was also a carer for her mother before her death in 2011.

Outcome
Mrs Welsh has clear and specific goals for therapy and appears committed to engage in high intensity psychological therapy. I have agreed to place her on our Psychology Treatment waiting list. She is aware of current wait times and informed me that she can keep herself safe.

If you have any questions regarding the above please do not hesitate to get in touch.

Yours Sincerely,

Care Partner

Welsh, Caroline

Date of Birth 30-Oct-1977 (48y) **undefined** Female **CHI Number** 3010776241

History for Summary of contact

From 29/04/1926 Until 29/04/2026

Assessed 20th Feb 2024 at 09:15

Summary of contact/details	

Assessment:
I met with Mrs Welsh on 20/02/24 to discuss suitability and readiness to engage in high intensity psychological therapy. Below you will find details and outcome of the assessment.

Presenting Problem
Mrs [redacted] informed me that she is struggling with anxiety. She describes general anxiety and worry but also intrusive thoughts ıd compulsive behaviours. She said that she has a need for control and feels panicky when she does not have this. She informed ...e that she compartmentalises her thoughts and behaviours such as taking one day at a time and breaking down activities into small steps. Mrs Welsh also mentioned that she can be impulsive regarding hobbies and activities with the family and wondered whether she had ADHD as this behaviour has occurred throughout her life. She also mentioned a history of trauma including a difficult childhood and disruptive behaviour.
Mrs Welsh currently copes by tensing her hands and generally trying to keep busy.
Her goals for therapy include managing her feelings of anxiety and the need for control, and understanding how past experiences may be contributing towards her current difficulties.

Symptoms
Mrs [redacted] informed me that she is also dealing with a high-level stress as she is a cleaner for her husband who has cancer. She also lost a friend previously to cancer. She told me that she puts on a front and others will think she is coping ok, but she is struggling. She feels a weight on her chest and a sense of dread daily. She also described rumination and worry, and paying attention to small details. Mrs Welsh stated that she has to do things a certain number of times such as told helping and will count often also (e.g. number of tiles on the room, number of steps to the door). She experiences headaches, sweating and her heart racing.

Mrs Welsh said that sleep is difficult and she can struggle to fall asleep and stay asleep. She said that she has little appetite and at mes can forget to eat. She told me that her energy is up and down throughout the day and her mood is generally fine if she is feeling in control. She said that both her motivation and concentration are low and she denied any current paranoia. She said that she does at times she a crowd of voices but this only lasts for a couple of seconds and she is not aware of what they are saying. She informed me that both her long-term and short-term memory are not great.

Risk
Mrs Welsh denied any current self-harm, suicidal thoughts, plan or intent to end her life. She denied any current recreational drug or alcohol use. She denied any current forensic involvement. She has fibromyalgia but no other physical health concerns. She has three adult sons. She is currently prescribed 45 mg amitriptyline, 500 mg naproxen, 150 mg of sertraline, and omeprazole.

Current Situation
Mrs Welsh currently lives with her husband [redacted] and her two youngest children [redacted] She works as a carer with the council and works 30 hours a week 4 days on and 4 days off. She is also a carer for her husband who spends her time out of work engaging in sport activities with the family, trading the house and "pottering around" to keep busy. She is not in education but is studying Swedish on her own time.

Mrs Welsh informed me that her mother died in 2011 of Pulmonary Fibrosis. She had a difficult relationship with her mother in childhood but it was better in adulthood. Mrs Welsh said that her father died in 1995 of a heart attack, he was in and out of her life. She has three siblings, an older brother [redacted] who lives in London who she does not speak to often, younger brother [redacted] who she has a good relationship with, and a younger sister [redacted] who is her best friend. She said that she has a brilliant relationship with her husband Brian however is heartbroken that he has cancer. She also has 2 other good friends [redacted] and [redacted] She has a good relationship with her three sons, and her eldest son [redacted] has his own place.

Care Partner

Welsh, Caroline

Date of Birth 30-Oct-1977 (48y) **undefined** Female **CHI Number** 3010776241

History for Summary of contact

From 29/04/1926 **Until** 29/04/2026

History

Mrs Welsh informed me that her parents separated when she was around the age of three. She left with her mother and visit her father occasionally. On one occasion when she was at her father's she was woken up at night by arguing and witnessed her father battering her neighbour. She said that her father went to prison but this was not for a long time. She told me that she had bad behaviour in childhood and was cheeky and disobedient. She told me that at the age of 10 she was in a psychiatric hospital for six months and was then seen as an outpatient for six months. She told me that she was sexually assaulted by a neighbour and her cousin when she was around 10. She said that her mother struggled to care for her and she went into care at the age of 14-17. She said that she did have a good time when in care and it was positive and the structure helped.

Mrs Welsh told me that she did ok academically in Primary School but she was shy and was called names by her peers. She only attended two years of secondary school and then skipped a lot in her third and fourth years. At the age of 15/16 she said that she "let boys use her body" as she believes she was seeking comfort. She went to college after leaving school at the age of 15 to study fashion. She then worked within textiles as a sore for several years before completing training to become a carer. She has been working as a carer for 30 years. In 1995 Mrs Welsh was living in England and was not in contact with her father following a fall-out and she was not aware that he had died.

In adulthood Mrs Welsh said that she has generally been [redacted] and impulsive and lacked structure. 7 years ago she was struggling with back pain and went to her GP for investigations as she was feeling forgetful and tired. Around this time her husband was diagnosed with cancer they caught it "in the early stages". He did not start chemotherapy for another three years. They moved to England in 2016 and moved back to Scotland in December 2019. Mrs Welsh was working around 70 hours a week to compensate for her husband not working. She lost a close friend to cancer last year and helped her with organising the funeral as she feels that she pushed herself too hard. She then had rock bottom and was crying often and could not leave her bed. She was also a carer for her mother before her death in 2011.

Outcome

Mrs Welsh has clear and specific goals for therapy and appears committed to engage in high intensity psychological therapy. I have agreed to place her on our Psychology Treatment waiting list. She is aware of current wait times and informed me that she can keep herself safe.

Ayrshire Mental Health Risk Assessment Framework v3

Date of Activity 28 November 2024 14:00 by Dr. Erin Toal **Status** Closed
Centre of Care North Ayrshire CMHT

Ayrshire Mental Health Risk Assessment Framework

Assessment completed by

Individual clinician

Mental state

Mental state

Green

Note: Ms Welsh is experiencing ongoing mental health struggles however can be managed within her own supports. Discharge letter in process. She has reported finding benefit in engaging in formulation of her difficulties and identified strategies to manage her symptoms. Current stressors relating to family stressors and work stressor that Ms Welsh is attending to and detracted from focus on psychological therapy at this time. Ms Welsh in agreement that discharge from psychology with signposting to NEST to aid in what she describes as traits in keeping with ADHD.

Engagement

Engagement with services

Green

Medication management

Green

Risk of absconding

Green

Risk of suicide/self-harm

Risk of self-harm

Green

Note: Does not report DSH.

Risk of suicide

Green

Note: Does not report experiencing suicidal thoughts.

Risk of harm to or from others

Risk of harm to others

Green

Abuse issues

Amber

Note: Ms Welsh denied any current abuse concerns. Prior sexual assault x2 in childhood at age 10 can have an influence as regards her current difficulties.

Neglect/Vulnerability issues (consider ASP/AWIA)

Green

Child protection concerns

Not applicable

Child well-being concerns

Not applicable

Risk from substance misuse

Substance misuse

Green

Note: Ms Welsh did not report current problematic alcohol or illicit drug use.

Social and personal risks

Support network

Green

Note: Identifies supportive people in her network - family and friends.

Physical health

Amber

Note: Ms Welsh links in with relevant services for assistance with her physical health. During input has had a colonoscopy. Ms Welsh has spoken of her diagnosis of Fibromyalgia in 2016 and that she experiences widespreac pain and other related symptoms including brain fog, concentration difficulties and tiredness and fatigue. She has been prescribed Amitriptyline to help with the pain. At todays appointment she spoke of chest pain and her watch shows that oxygen levels are low and she thinks she has sleep apnoea and intends to link in with her GP practice about this. She said she thinks this is why she is waking up during the night. She said she has carpal tunnel and this is flaring up, and her arms are numb and wonder if she has heart problems related to the physical symptoms she is experiencing. I encouraged Ms Welsh to link in with the GP Practice as regards these symptoms.

Occupation of time

Green

Note: Ms Welsh resides with her husband and family. She works as a carer with the council and works 30 hours a week 4 days on and 4 days off. She is due to attend interview for a job as a senior healthcare sup[port worker tomorrow in the NHS and said as regards her current job that she works long hours and they are short staffed anc is exhausted. She is carer for her husband who is about to start chemotherapy. She studies Swedish in her own time.

Housing and finances

Green

Note: See prior ARAF - 20.06.2024. Some financial strain.

Any other issues

Any other issues

Not recorded

Overall Impression of Risk

Overall Impression of Risk

Green

Note: Ms Welsh is not experiencing suicidal thoughts. She is not reporting DSH. She does not report problematic alcohol/illicit drug misuse. Identified supportive people in her network. Increase in scores on BAI and BDI2 compared to outset situated within increase in stressors - recently found out husband's cancer has surfaced and due to start chemotherapy. Ms Welsh said she feels there has been benefit from sense making of her difficulties and has strategies she finds helpful in the management of her symptoms.

Immediate Risk Management Plan

Immediate Risk Management Plan

Ms Welsh is experiencing ongoing mental health struggles however can be managed within her own supports. She has identified strategies to manage her symptoms to be helpful. Will write to Ms Welsh as regards signposting to NEST to aid in what she describes as traits in keeping with ADHD where there are resources and self management group options. Supportive people identified in her network. Is aware can request re-referral back via GP to NACMHs in the future. Ms Welsh said she hopes there is not a need for this as found benefit from formulation of her difficulties, developed insights and considered ways can manage symptoms.

Ayrshire Mental Health Risk Assessment Framework v3

Date of Activity 20 June 2024 13:30 by Dr. Erin Toal **Status** Closed
Centre of Care North Ayrshire CMHT

Ayrshire Mental Health Risk Assessment Framework

Assessment completed by

Individual clinician

Mental state

Mental state

Green

Note: Ms Welsh presented as anxious in keeping with her presenting struggles. Her rate of speech was fast and she could speak at length as to her struggles reflecting her keenness to convey her struggles with it taking time to re-orientate to questions.

Engagement

Engagement with services

Green

Medication management

Green

Risk of absconding

Green

Risk of suicide/self-harm

Risk of self-harm

Green

Note: Ms Welsh did not report DSH.

Risk of suicide

Green

Note: Ms Welsh said she sometimes thinks she would be at peace if she were not here. She said she does not identify this as a suicidal thought and has a fear of dying. She said she has never had suicidal thoughts.

Risk of harm to or from others

Risk of harm to others

Green

Abuse issues

Amber

Note: As per ARAF on 20.02.2024 - Ms Welsh denied any current abuse concerns. However marked as amber du to sexual assault x2 in childhood at age 10 that is likely contributing towards current difficulties

Neglect/Vulnerability issues (consider ASP/AWIA)

Green

Child protection concerns

Not applicable

Child well-being concerns

Not applicable

Risk from substance misuse

Substance misuse

Green

Note: Ms Welsh did not problematic alcohol use. She said she does not drink much alcohol. She reported historic but not current illicit drug use. From 13 to her early 20s Ms Welsh said she tried a range of drugs - cannabis, ecstasy, speed, cocaine, and acid. She said this was with peers and alcohol likely featured.

Social and personal risks

Support network

Green

Note: Ms Welsh identified supportive people in her network. From ARAF on 20.02.2024 - Mrs Welsh informed me that her mother died in 2011 of Pulmonary Fibrosis. She had a difficult relationship with her mother in childhood bu it was better in adulthood. Mrs Welsh said that her father died in 1995 of a heart attack, he was in and out of her life. She has three siblings, an older brother [redacted] who lives in London who she does not speak to often, younger brother [redacted] who she has a good relationship with, and a younger sister [redacted] who is her best friend. She said that she has a brilliant relationship with her husband [redacted] however is heartbroken that he has cancer. She also has 2 other good friends [redacted]. She has a good relationship with her three sons [redacted], and her eldest son [redacted] has his own place.

Physical health

Amber

Note: Ms Welsh said she was due to have a colonoscopy on the 15.07.2024 to investigate her passing water whei having bowel movements since the beginning of April 2024. Ms Welsh also spoke of her diagnosis of Fibromyalgia in 2016 and that she experiences widespread pain and other related symptoms including brain fog, concentration difficulties and tiredness and fatigue. She said she has been prescribed Amitriptyline to help with the pain.

Occupation of time

Green

Note: From ARAF on 20.02.2024 - Mrs Welsh currently lives with her husband [redacted] and her two youngest children [redacted] and [redacted] She works as a carer with the council and works 30 hours a week 4 days on and 4 days off. She is also a carer for her husband who spends her time out of work engaging in sport activities with the family trading the house and "pottering around" to keep busy. She is not in education but is studying Swedish on her ow time.

Housing and finances

Amber

Note: Ms Welsh said she lives in a purpose built house in Kilwinning. She said this was because her husband was diagnosed with bone marrow cancer, myeloma. She said he is disabled and in a wheelchair and is at risk of bone fractures. She said he has just finished chemotherapy and the house has adaptations implemented. Ms Welsh spoke of financial strain - £600 on a credit card and £9000 in a loan and she has a car payment and her husband has £3000 to pay off.

Any other issues

Any other issues

Not recorded

Overall Impression of Risk

Overall Impression of Risk

Green

Note: Ms Welsh is not currently experiencing suicidal thoughts, she has identified supportive people in her network, is in employment, has a diagnosis of Fibromyalgia and associated symptoms and ongoing investigation related to her passing water for the last couple of months - is due a colonoscopy. No misuse of substances reported and keen to engage in psychological intervention.

Immediate Risk Management Plan

Immediate Risk Management Plan

Ms Welsh is in receipt of OHH/Duty/Crisis numbers.
She has been offered psychological intervention in keeping with her goals - a period of psychological formulation and anxiety management strategies.

Ayrshire Mental Health Risk Assessment Framework v3

Date of Activity 20 February 2024 09:15 by Dr. Heather Jamieson **Status** Closed
Centre of Care North Ayrshire CMHT

Ayrshire Mental Health Risk Assessment Framework

Assessment completed by

Individual clinician

Mental state

Mental state

Green

Note: I met with Mrs Welsh on 20/02/24 to discuss suitability and readiness to engage in high intensity psychological therapy. Below you will find details and outcome of the assessment. Presenting Problem Mrs [redacted] informed me that she is struggling with anxiety. She describes general anxiety and worry but also intrusive thoughts and compulsive behaviours. She said that she has a need for control and feels panicky when she does not have this. She informed me that she compartmentalises her thoughts and behaviours such as taking one day a a time and breaking down activities into small steps. Mrs Welsh also mentioned that she can be impulsive regardin hobbies and activities with the family and wondered whether she had ADHD as this behaviour has occurred throughout her life. She also mentioned a history of trauma including a difficult childhood and disruptive behaviour. Mrs Welsh currently copes by tensing her hands and generally trying to keep busy. Her goals for therapy include managing her feelings of anxiety and the need for control, and understanding how past experiences may be contributing towards her current difficulties. Symptoms Mrs [redacted] informed me that she is also dealing with a high level stress as she is a cleaner for her husband who has cancer. She also lost a friend previously to cancer. She told me that she puts on a front and others will think she is coping ok, but she is struggling. She feels a weight on her chest and a sense of dread daily. She also described rumination and worry, and paying attention to small details. Mrs Welsh stated that she has to do things a certain number of times such as told helping and will count often also (e.g. number of tiles on the room, number of steps to the door). She experiences headaches, sweating and her heart racing. Mrs Welsh said that sleep is difficult and she can struggle to fall asleep and stay asleep. She said that she has little appetite and at times can forget to eat. She told me that her energy is up and down throughout the day and her mood is generally fine if she is feeling in control. She said that both her motivation and concentration are low and she denied any current paranoia. She said that she does at times she a crowd of voices but this only lasts for a couple of seconds and she is not aware of what they are saying. She informed me that both her long-term and short-term memory are not great. Risk Mrs Welsh denied any current self-harm, suicidal thoughts, plan or intent to end her life. She denied any current recreational drug or alcohol use. She denied any current forensic involvement. She has fibromyalgia but no other physical health concerns. She has three adult sons. She is currently prescribed 45 mg amitriptyline, 500 mg naproxen, 150 mg of sertraline, and omeprazole [redacted] Current Situation Mrs Welsh currently lives with her husband [redacted] and her two youngest children [redacted]. She works as a carer with the council and works 30 hours a week 4 days on and 4 days off. She is also a carer for her husband who spends her time out of work engaging in sport activities with the family, trading the house and "pottering around" to keep busy. She is not in education but is studying Swedish on her own time. Mrs Welsh informed me that her mother died in 2011 of Pulmonary Fibrosis. She had a difficult relationship with her mother in childhood but it was better in adulthood. Mrs Welsh said that her father died in 1995 of a heart attack, he was in and out of her life. She has three siblings, an older brother [redacted] who lives in London who she does not speak to often, younger brother [redacted] who she has a good relationship with, and a younger siste [redacted] who is her best friend. She said that she has a brilliant relationship with her husband [redacted] however is heartbroken tha he has cancer. She also has 2 other good friends [redacted] and [redacted] She has a good relationship with her three sons, and her eldest son [redacted] has his own place. History Mrs Welsh informed me that her parents separated when she was around the age of three. She left with her mother and visit her father occasionally. On one occasion when she was at her father's she was woken up at night by arguing and witnessed her father battering her neighbour. She said that her father went to prison but this was not for a long time. She told me that

she had bad behaviour in childhood and was cheeky and disobedient. She told me that at the age of 10 she was i a psychiatric hospital for six months and was then seen as an outpatient for six months. She told me that she was sexually assaulted by a neighbour and her cousin when she was around 10. She said that her mother struggled to care for her and she went into care at the age of 14-17. She said that she did have a good time when in care and was positive and the structure helped. Mrs Welsh told me that she did ok academically in Primary School but she was shy and was called names by her peers. She only attended two years of secondary school and then skipped a lot in her third and fourth years. At the age of 15/16 she said that she "let boys use her body" as she believes she was seeking comfort. She went to college after leaving school at the age of 15 to study fashion. She then worked within textiles as a sore for several years before completing training to become a carer. She has been working as a carer for 30 years. In 1995 Mrs Welsh was living in England and was not in contact with her father following a fall-out and she was not aware that he had died. In adulthood Mrs Welsh said that she has generally been [redacted] and impulsive and lacked structure. 7 years ago she was struggling with back pain and went to her GP for investigations as she was feeling forgetful and tired. Around this time her husband was diagnosed with cancer the caught it "in the early stages". He did not start chemotherapy for another three years. They moved to England in 2016 and moved back to Scotland in December 2019. Mrs Welsh was working around 70 hours a week to compensate for her husband not working. She lost a close friend to cancer last year and helped her with organising the funeral as she feels that she pushed herself too hard. She then had rock bottom and was crying often and could not leave her bed. She was also a carer for her mother before her death in 2011. Outcome Mrs Welsh has clear and specific goals for therapy and appears committed to engage in high intensity psychological therapy. I have agreed to place her on our Psychology Treatment waiting list. She is aware of current wait times and informed me that she can keep herself safe.

Engagement

Engagement with services

Green

Medication management

Green

Note: She is currently prescribed 45 mg amitriptyline, 500 mg naproxen, 150 mg of sertraline, and omeprazole.

Risk of absconding

Green

Risk of suicide/self-harm

Risk of self-harm

Green

Note: Denied any current self-harm

Risk of suicide

Green

Note: Mrs Welsh denied any current suicidal thoughts, plan or intent to end her life.

Risk of harm to or from others

Risk of harm to others

Green

Note: Denied any harm towards others

Abuse issues

Amber

Note: Denied any current abuse concerns. However marked as amber due to sexual assault x2 in childhood at ag 10 that is likely contributing towards current difficulties

Neglect/Vulnerability issues (consider ASP/AWIA)

Green

Child protection concerns

Not applicable

Note: Three sons are adults: [redacted] 26); [redacted] 1); [redacted] 20)

Child well-being concerns

Not applicable

Risk from substance misuse

Substance misuse

Green

Note: She denied any current recreational drug or alcohol use.

Social and personal risks

Support network

Green

Note: Mrs Welsh informed me that her mother died in 2011 of Pulmonary Fibrosis. She had a difficult relationship with her mother in childhood but it was better in adulthood. Mrs Welsh said that her father died in 1995 of a heart attack, he was in and out of her life. She has three siblings; an older brother [redacted] who lives in London who she does not speak to often, younger brother [redacted] who she has a good relationship with, and a younger sister [redacted] who is her best friend. She said that she has a brilliant relationship with her husband Brian however is heartbroken that he has cancer. She also has 2 other good friends [redacted] and [redacted] She has a good relationship with her three sons [redacted] and her eldest son [redacted] has his own place.

Physical health

Green

Note: Has Fibromyalgia

Occupation of time

Green

Note: Mrs Welsh currently lives with her husband [redacted] and her two youngest children [redacted] She works as a carer with the council and works 30 hours a week 4 days on and 4 days off. She is also a carer for her husband who spends her time out of work engaging in sport activities with the family, trading the house and "pottering around" to keep busy. She is not in education but is studying Swedish on her own time.

Housing and finances

Green

Any other issues

Any other issues

Green

Overall Impression of Risk

Overall Impression of Risk

Green

Immediate Risk Management Plan

Immediate Risk Management Plan

No current suicidal risk, good social support, no forensic involvement or environmental concerns, physical pain but no ongoing investigations, no substance misuses. Committed to engage in therapy. Aware of wait times - added to psychology treatment list.

CMHS Referral Vetting (v2)

Date of Activity 22 November 2023 15:36 by Karen Renucci **Status** Closed
Centre of Care North Ayrshire CMHT

Referral Details

UCPN

101031429763M

Reason for Referral

Obsessions/Compulsions

Referral via Occupational Health

No

Pregnancy/Perinatal Mental Health

Not known

Veteran or Armed Forces

No

Vetting

Initial vetting date

23 November 2023

Initial vetting outcome

Psychology referral for Input to aid symptoms of obsessions and compulsions
Comment: Stated has had a traumatic childhood and has been able to 'cope with it as I am a strong person'. But advised being triggered by her friends? death in February, she died 2 weeks following diagnosis and husband currently terminally ill and she is his carer, stated 'the lines are blurred as I'm now a carer at work and a carer at home'. States has OCD tendencies (not diagnosed). When asked in which way she feels she struggles with obsessions or compulsions, she stated it is 'cleanliness, germs, perfectionism, I can't be out of routine, if my husband makes soup and puts something different in I hit the roof'. Reports can be up all night cleaning. Gets family involved at ?sometimes as late as 11 at night, I call it OCD by proxy?. States routines and cleaning are ?constant?.
Reported difficult childhood, Mum and Dad split when she was 3, lived with Mum, witness Dad 'severely maim a neighbour' when she was 3 or 4, states had nightmares about this until 16. 'This is when it all started'. Was placed in care at 12 'due to my behaviour, I wouldn't go to school'. Stated Mum 'couldn't give me what I needed' but spoke about same in financial terms, stated she 'loved and cared for me but couldn't give me what I needed', stated ?I ate beans on toast when she smoked. Care was the best thing, they looked after me and helped me'. When asked if she had experienced any abuse prior to care she began to cry and stated 'yes?. Caroline disclosed childhood sexual abuse, states at 9 'the neighbours son did sexual stuff to me as a one off, I didn't stop him, I liked the attention, then I used my body to get attention hoping someone would take me away from home'. States at the same time her cousin was sexually abusing her for 'a wee while, maybe couple of years'.
Asked about past psychiatric input. Stated she saw psychologist inpatient for one year ('6 months inpatient, 6 months outpatient) stated this was a talking therapy and did not help and cannot remember what preceded this referral. No

other psychiatric input prior to counselling currently received. Mood: Irritable, overwhelmed. Anxiety: No panic or physical symptoms but ^^ generalised anxiety. Sleep 'all over the place' since February, normally ok.
No current thoughts of suicide or self harm. Denied problematic alcohol use. No illicit substance use. No forensic history.

23.11.23 Referral vetting: S/N B McCormick. PSYCHOLOGY: routine MHP referral, see above, requesting Psychology input. Patient has no history with local mental health services. Referral passed to Psychology for screening.

Secondary vetting date

29 November 2023

Secondary vetting outcome

Vetted by KD, CO, HJ, IMcI, PB, LM, KR, KF and LM
Agreed outcome: History of trauma, self reported OCD symptoms and looking to change these. Accepted and referred for Psychology Assessment

Referral accepted

Referral accepted

Date referral rejected

Rejected referral reason (if applicable)

Not applicable

Rejected referral actions (if applicable)

Not applicable

CORE - Outcome Measure

Date of Activity 11 July 2024 11:30 by Dr. Erin Toal **Status** Closed
Centre of Care North Ayrshire CMHT

Outcome Measure

Date form given

11 July 2024

Stage completed

During therapy (review)

Episode

Not Recorded

Over the last week

I have felt terribly alone and isolated

Not at all

I have felt tense, anxious or nervous

Often

I have felt I have someone to turn to for support when needed

Not at all

I have felt OK about myself

Only occasionally

I have felt totally lacking in energy and enthusiasm

Often

I have been physically violent to others

Not at all

I have felt able to cope when things go wrong

Only occasionally

I have been troubled by aches, pains or other physical problems

Most or all of the time

I have thought of hurting myself

Not at all

Talking to people has felt too much for me

Most or all of the time

Tension and anxiety have prevented me doing important things

Often

I have been happy with the things I have done

Sometimes

I have been disturbed by unwanted thoughts and feelings

Often

I have felt like crying

Often

I have felt panic or terror

Sometimes

I made plans to end my life

Not at all

I have felt overwhelmed by my problems

Most or all of the time

I have had difficulty getting to sleep or staying asleep

Often

I have felt warmth or affection for someone

Most or all of the time

My problems have been impossible to put to one side

Most or all of the time

I have been able to do most things I needed to do

Sometimes

I have threatened or intimidated another person

Not at all

I have felt despairing or hopeless

Sometimes

I have thought it would be better if I were dead

Not at all

I have felt criticised by other people

Often

I have thought I have no friends

Not at all

I have felt unhappy

Only occasionally

Unwanted images or memories have been distressing me

Often

I have been irritable when with other people

Most or all of the time

I have thought I am to blame for my problems and difficulties

Sometimes

I have felt optimistic about my future

Only occasionally

I have achieved the things I wanted to

Sometimes

I have felt humiliated or shamed by other people

Sometimes

I have hurt myself physically or taken dangerous risks with my health

Not at all

Total Scores

W

13.000

P

33.000

F

26.000

R

0.000

All items

72.000

All minus R

72.000

Mean Scores

W

3.250

P

2.750

F

2.167

R

0.000

All items

2.118

All minus R

2.571

Assessment attached

Assessment attached

Not Recorded

CORE - Outcome Measure (v2)

Date of Activity 28 November 2024 14:00 by Dr. Erin Toal **Status** Closed
Centre of Care North Ayrshire CMHT

Outcome Measure

Date form given

28 November 2024

Stage completed

Last therapy session

Episode

1 Episode

Over the last week

F. I have felt terribly alone and isolated

Only occasionally (1)

P. I have felt tense, anxious or nervous

Most or all of the time (4)

F. I have felt I have someone to turn to for support when needed

Only occasionally (3)

W. I have felt OK about myself

Only occasionally (3)

P. I have felt totally lacking in energy and enthusiasm

Most or all of the time (4)

R. I have been physically violent to others

Not at all (0)

F. I have felt able to cope when things go wrong

Only occasionally (3)

P. I have been troubled by aches, pains or other physical problems

Often (3)

R. I have thought of hurting myself

Not at all (0)

F. Talking to people has felt too much for me

Most or all of the time (4)

P. Tension and anxiety have prevented me doing important things

Often (3)

F. I have been happy with the things I have done

Only occasionally (3)

P. I have been disturbed by unwanted thoughts and feelings

Only occasionally (1)

W. I have felt like crying

Most or all of the time (4)

P. I have felt panic or terror

Sometimes (2)

R. I made plans to end my life

Not at all (0)

W. I have felt overwhelmed by my problems

Most or all of the time (4)

P. I have had difficulty getting to sleep or staying asleep

Most or all of the time (4)

F. I have felt warmth or affection for someone

Sometimes (2)

P. My problems have been impossible to put to one side

Often (3)

F. I have been able to do most things I needed to do

Sometimes (2)

R. I have threatened or intimidated another person

Not at all (0)

P. I have felt despairing or hopeless

Sometimes (2)

R. I have thought it would be better if I were dead

Not at all (0)

F. I have felt criticised by other people

Only occasionally (1)

F. I have thought I have no friends

Not at all (0)

P. I have felt unhappy

Not at all (0)

P. Unwanted images or memories have been distressing me

Only occasionally (1)

F. I have been irritable when with other people

Most or all of the time (4)

P. I have thought I am to blame for my problems and difficulties

Only occasionally (1)

W. I have felt optimistic about my future

Only occasionally (3)

F. I have achieved the things I wanted to

Only occasionally (3)

F. I have felt humiliated or shamed by other people

Often (3)

R. I have hurt myself physically or taken dangerous risks with my health

Not at all (0)

Total Scores

W (Total Scores)

14

P (Total Scores)

28

F (Total Scores)

29

R (Total Scores)

0

All items (Total Scores)

71

All minus R (Total Scores)

71

Mean Scores

W (Mean Scores)

3.50

P (Mean Scores)

2.33

F (Mean Scores)

2.42

R (Mean Scores)

0.00

All items (Mean Scores)

2.09

All minus R (Mean Scores)

2.54

Assessment attached

Assessment attached

Not Recorded

NHS AYRSHIRE AND ARRAN HOSPITAL RECORDS

TEMPORARY COVER

CHI – 3010776241

NAME – CAROLINE WELSH

MSK Form

NHS Ayrshire & Arran

Demographics			
Forename	Caroline	**CHI**	3010776241
Surname	Welsh	**Telephone Number**	07875530530
DOB	1977-10-30	**Sex**	Female
Address	9 St. Michaels Place Kilwinning KA13 6FA		

Referral Source: AHP **Referral Date:** 28-Oct-2025

Clinician: Lisa Lawson **Designation:** MSK Podiatrist **Professional Group:** Podiatry

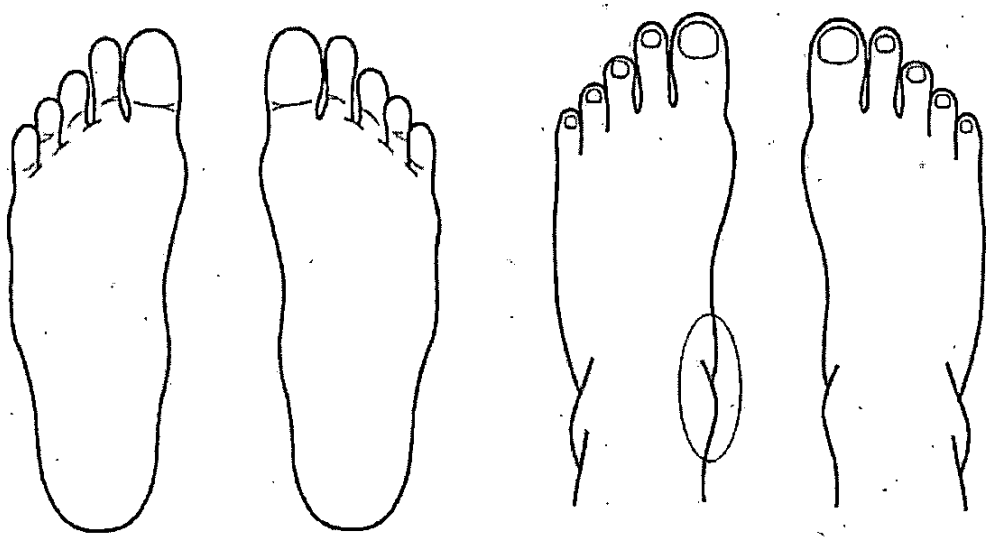
Initial Assessment ☑

MSK Service Subjective Assessment **Consent Obtained** ☑ **Date/Time** 05-Nov-2025 09:00

Presenting Condition
(main problem, area, nature and severity of pain / symptoms)

Pain left ankle medial aspect- bought own orthotics which have improved symptoms. History since Jan 2025. No history of injury. Pain with right knee - attending physio.

Feet Chart



VAS: Best 2 / 10 Worst 8 / 10

Red Flags Yes ☐ No ☑

Aggravating Factors

after rest

Easing Factors

walking

Functional limitations (ADL, dressing, walking, stairs)

stairs

Daily Pattern (am / pm / sleep disturbance)

after rest			
History of presenting condition			
Gradual ☑ Traumatic Onset ☐ Sudden ☐ N/A ☐			
Previous Treatment	Yes ☐ No ☑		
Investigations	Yes ☐ No ☑		
Date of Injury		**Date of Surgery**	
Clinic Follow Up	NA ☐		
General Health / Previous Medical History			
Heart	☐		
Epilepsy	☐		
BP	☑		
Cancer	☐		
Asthma	☐		
Recent unexplained weight loss	☐		
Diabetes	☐		
Osteoporosis	☐		
Thyroid problems	☐		
Allergies	☐		
Previous Surgery			
Other			
fibromyalgia			
Medication			

Neuropathic
Amitriptyline ☑ Gabapentin ☐ Pregabalin ☐ Nortriptyline ☐

NSAID's
Aspirin ☐ Ibuprofen ☐ Naproxen ☐ Diclofenac ☐ Etoricoxib ☐ Celecoxib ☐ Meloxicam ☐

Analgesics
Paracetamol ☐ Codeine ☐ Dihydrocodeine ☐ Tramadol ☑ Morphine ☐ Co-codamol ☐

Anticoagulants
Rivaroxaban ☐ Apixaban ☐ Edoxaban ☐ Warfarin ☐ Dabigatran ☐

Antiplatelets
Aspirin ☐ Clopidogrel ☐

Blood Pressure
Amlodopine ☐ Bisoprolol ☐ Propranolol ☐ Ramipril ☑ Lisinopril ☐ Bendroflumethazide ☐

PPI
Omeprazole ☑ Lansoprazole ☐

DMARD's
Methotrexate ☐ Sulfasalazine ☐ Hydroxychloroquine ☐ Leflunomide ☐

Statins
Atorvasatatin ☐ Simvastatin ☐ Rosuvastatin ☐ Metformin ☐

Other

Social History

Home Circumstances:

Lives with family

Sports / Hobbies / Interests:

walking, cycling

Occupation

health care support worker

At work Yes☐ No☑

Off with presenting condition Yes☐ No☑

Date last at work 28-Sep-2025

Additional Information

WATOM:

non smoker

Biopsychosocial ⓘ

Comments (if applicable)

What are your expectations of coming here today?

advice

MSK Hand Therapy Initial Assessment

Active Range of Movement Hand (AROM)

Active Range of Movement Forearm/Wrist (AROM)

Grip Strength

Objective Examination

Observation (posture, deformity, muscle wasting, colour change, swelling)

vertical left foot, supinated right foot

Range of Movement (active & passive)

within normal ranges

Muscle Power

lower limb MRC bilaterally 5/5

Neurological Examination (myotomes/dermatomes/reflexes/Babinski)

Palpation

pain at medial aspect left ankle on palpation

Gait

Special Tests

Provisional Diagnosis

query post tib tendinopathy with referred anterior ankle pain.

Problems

symptoms of fibromyalgia

Goals
reduce ankle pain
Plan **Goals and Plan agreed ☑**
opt in by end March 2026
Treatment
Fitted interpod 4 degree orthotics size lge with full covers and written instructions Provided moderate ankle exercises with leaflet Provided dble heel raises x 10 x 3 per day Discussed benefits to rigid/ rocker soled footwear. To consider conversation with GP for Duloxetine for fibromyalgia instead of amitriptyline

Exercise ☐

Acupuncture Screening ☐

Injection Checklist/Patient Consent ☐

Hydrotherapy Screening ☐

Podiatry Steroid Injection Therapy ☐

Adverse Reaction ☐

NHS Ayrshire & Arran MSK AHP Note

NHS Ayrshire & Arran

Demographics			
Forename	Caroline	CHI	3010776241
Surname	Welsh	Telephone Number	
DOB	1977-10-30	Sex	Female
Address	9 St. Michaels Place Kilwinning KA13 6FA		

Consent to Treatment Obtained ☑

Date	22-Oct-2025	Clinician	Gillian Murray
Designation	B7 PT	Professional Group	Physiotherapy

Clinical Note

S - No change to right knee. Managing ex's although WB work can be painful. Currently off work due to high BP, GP has started on Ramipril. Also reports that left ankle pain has flared up past few weeks, most significant medially and occasionally at foot arch. Understands importance of wgt loss to help with joint pains but admits to low motivation with this at present.
O - Right AROM knee ISQ.
SI improved quads.
Full AROM left ankle, pain at end range inversion. Increased pronation left foot. Pain on resisted inversion left ankle. Tender left arch and medial ankle.
A - ?left tib post issue. Improvement in right knee strength / function seen but subjectively no change
Rx - Discussed weight mx - not keen to attend any third sector options for weight mx or exercise due to time issues - declined ANA referral - will try independent healthy eating
Encouraged to get back out on bike
RV of HEP - no progressions made
Agreed podiatry referral for advice re left foot / ankle
P - RV impact of above 6/52

Consent to Treatment Obtained ☑

Date	26-Aug-2025	Clinician	Morton Sinclair
Designation	B5 MSK PT	Professional Group	Physiotherapy

Clinical Note

S// VCO as per PT protocol. Pt seen on behalf for Gillain Murray for this appt. Caroline reports that she is now taking paracetamol 2 tabs morning and night more regularly which she feels is helping with her pain. She reports struggles with 2 external steps at her work which usually brings on her pain. Reports managed out twice cycling with plans to do this again. She denies going for any walks outwit her work. She does report she is doing her exercises daily and feels increased ease as she has performed them.

O// Gait NAD
Full AROM at knees
MP// 4+/5 right knee flexion and extension, 5/5 left knee flexion

SLR x5 bilat - nil lag, increased effort reported on right
STS - equal weight bearing over both LL's
DL heel raise - achieved with nil issues
SL heel raise - increased effort reported but managed well
Step up - achieved well but with increased challenge on right, requiring upper limb support

Rx: 1) HEP progressed. Green t/band given
2) Reassured that hurt does not always = harm

A// Caroline progressing well as strength increasing on both resisted and functional testing. Caroline reports nil issues following completion of HEP after progression.

P// Rv with Gillian Murray in 4/52.

Morton Sinclair

HEP
Provided for:

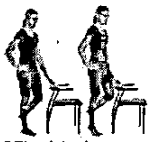
©Physiotools

Chair Squat

Stand tall with your feet approximately hip-width apart and weight distributed evenly on both feet.
Make sure the chair behind you is at a suitable distance from you.

Bend your knees and hips and squat down onto the chair. Knees and toes should be pointing in the same direction. Sit down lightly and push back up to the starting position using your front thighs and buttock muscles.

Repeat 10 times.



©Physiotools

Slow Heel Raises

Stand on one leg and take support.

Slowly rise up on to your toes and hold at the top. M the weight evenly on the ball of the foot. Then slowly your heel back down.

Repeat 10 times.

©Physiotools

Step Up

Start by standing behind a step and lift one leg onto the step.

Step up and straighten your hip and knee. Maintain hip-knee-toes alignment. Return to the starting position.

Repeat 10 times.

©The Hygenic Cor...

Aim: Great to help strengthen the outer hip muscles.

Instructions:
Place loop of band around your knees. Be sure the l taut. Keep your knees apart against the pull of the b while you walk.

Reps 10

Exercise ☐

Acupuncture Screening ☐

Injection Checklist/Patient Consent ☐

Hydrotherapy Screening ☐

Podiatry Steroid Injection Therapy ☐

Adverse Reaction ☐

MSK Form

NHS Ayrshire & Arran

Demographics			
Forename	Caroline	**CHI**	3010776241
Surname	Welsh	**Telephone Number**	
DOB	1977-10-30	**Sex**	Female
Address	9 St. Michaels Place Kilwinning KA13 6FA		

Referral Source: GP **Referral Date:** 30-Jul-2025

Clinician: Gillian Murray **Designation:** B7 PT **Professional Group:** Physiotherapy

Initial Assessment ☑

MSK Service Subjective Assessment **Consent Obtained** ☑ **Date/Time**

Presenting Condition
(main problem, area, nature and severity of pain / symptoms)

PC - Pain in both knees

HPC - Longstanding episodic knee pain. Approx 8/12 ago noticed gradual onset bilat knee and ankle pain, left knee and ankles have settled, right knee medial pain now main issue. No trauma / injury. Occ right knee swelling. No giving way. No locking. Occ clicking / grinding.

Aggs - In/out car, twisting, sit to stand, walking - on feet long periods, stairs
Eases - TENS, PK

Please Select...

VAS: Best 1 / 10 Worst 9 / 10

Red Flags Yes ☐ No ☑

Aggravating Factors

a/a

Easing Factors

a/a

Functional limitations (ADL, dressing, walking, stairs)

Avoiding stairs. Max walking time 10mins. Unable to paddle board

Daily Pattern (am / pm / sleep disturbance)

Sleep disturbed occ by knees, often by restless legs.

History of presenting condition

Gradual ☑ / Traumatic Onset ☐ N/A ☐

Previous Treatment	Yes ☐ No ☑		
Investigations	Yes ☑ No ☐	XR mild degenerative changes both knees	
Date of Injury		**Date of Surgery**	
Clinic Follow Up	NA ☐		

General Health / Previous Medical History

Heart	Yes ☐ No ☑	**Epilepsy**	Yes ☐ No ☑
BP	Yes ☐ No ☑	**Cancer**	Yes ☐ No ☑
Asthma	Yes ☐ No ☑	**Recent unexplained weight loss**	Yes ☐ No ☑
Diabetes	Yes ☐ No ☑	**Osteoporosis**	Yes ☐ No ☑
Thyroid problems	Yes ☑ No ☐		

Previous Surgery

Hysterectomy / appendicectomy / prolapse repair

Other

Restless legs / back pain / fibromyalgia / awaiting results thyroid function

Medication

Amitryptiline / omeprazole / naproxen / certraline

Social History

Home Circumstances:

Lives with husband and sons

Sports / Hobbies / Interests:

Paddle boarding / kayaking

Occupation

Care assistant at XH

At work Yes ☑ No ☐

Additional Information

WATOM:

Biopsychosocial ⓘ

Comments (if applicable)

Worried about worsening in future - enjoys job and keen to stay at work

What are your expectations of coming here today?

Has no idea what she can do to manage this

☐ MSK Hand Therapy Initial Assessment

☐ Active Range of Movement Hand (AROM)

☐ Active Range of Movement Forearm/Wrist (AROM)

☐ Grip Strength

☑ Objective Examination

Observation (posture, deformity, muscle wasting, colour change, swelling)

Overweight. Reduced right quads. Antalgic first few steps after sit to stand. Flat footed bilat - has had insoles in the past

Range of Movement (active & passive)

Full AROM both knees with ERP on right knee flexion
Hip PROM full painfree bilat

Muscle Power

Quads right Gd 4, left Gd 4+
Hams right Gd 4+, left Gd 5

Static Muscle Tests

Nerve Tests (SLR/PKB)

Neurological Examination (myotomes/dermatomes/reflexes/Babinski)

Palpation

Tender right knee medial joint line

Gait

a/a

Special Tests

+ve PFJ compression
-ve ligs
+ve right knee meniscal for pain

Provisional Diagnosis

Early OA both knees - right more symptomatic

Problems

Pain / Overweight / Deconditioned / Reduced right quads

Goals

Encourage weight loss / increase knowledge re self mx of OA / increase activity levels / increase general strength and fitness / right LL strength

Plan **Goals and Plan agreed** ☑

Advice / 3rd sector / consider OA class / rehab / exercise prog / ?CSI

Treatment

Discussed conservative mx of OA knee - incl weight mx and exercise
Issued with Versus Arthritis booklet - try sitting knee ext holds / SLR / mini squat from exercise section
Discussed graded activity - short walks / cycling which she is keen to start
Caroline asking re ?injection - discussion re pros /cons of this - agreed to start addressing above issues first though CSI could be considered in future if felt approp
RV 4/52

Exercise ☐

Acupuncture Screening ☐

Injection Checklist/Patient Consent ☐

Hydrotherapy Screening ☐

Podiatry Steroid Injection Therapy ☐

Adverse Reaction ☐

24/1 SUSAN

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?	Unique Care Pathway Number: 101025020409S **REFERRAL LETTER** MEDICAL IN CONFIDENCE	CHI:3010776241

DTE 4/4/22
25/6/22

REFERRAL TO

Spinal R5A1 AA Back Pain	Ethnic Origin	-
	Language interpreter req'd	-
	Religion	-
	Religious Observance	-
Musculoskeletal Triage and Treatment NHS Ayrshire & Arran	Vision Impairment	-
	Hearing Impairment	-
	Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	03-Dec-2021
Date submitted	12-Dec-2021

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

13 Mossgiel Drive
Irvine Ayrshire
KA12 0QT

07875 530 520 Contact number(s)

-

REGISTERED GP DETAILS

Name	Dr Vickie Bothwell		
GMC code	4615183	GP code	21733
Practice name	Frew Terrace Surgery (16883)		
Practice code	80698		

Practice address

9 Frew Terrace
Irvine

Contact number(s)

Voice: 01294 272326
Facsimile: 01294 312614

REFERRING PRACTITIONER DETAILS

Name	Dr. Nicola Begg		
GMC code	7041256	GP code	20257
Practice name	Frew Terrace Surgery (80698)		
Practice code	80698		

Practice address

9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Contact number(s)

Voice: 01294 272326

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: See letter - KG

Comment: Dear Colleague,
I recently referred this woman with back pain. Please see the attached original referral.
Thank you for your letter back explaining that she would not be seen specifically with a view to getting an MRI. The patient understands this and is keen to be seen non the less to have physiotherapy to try and improve her symptoms.

Yours sincerely

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Back pain, unspecified	-	-	-	22-Apr-2016	22-Apr-2016
Soft tissue disorders NOS	-	-	Minor soft tissue injury (R) hand	31-Mar-2016	31-Mar-2016
Menorrhagia	-	-	-	03-Apr-2013	03-Apr-2013
Stress incontinence	-	-	-	11-Sep-2009	11-Sep-2009
[M]Compound naevus	-	-	(R) toe - no malignancy	19-Aug-2008	19-Aug-2008
[D]Dysphonia	-	-	-	29-Nov-2006	29-Nov-2006
Spontaneous vaginal delivery	-	-	Baby Male - birthweight 5.050 kgs	06-Jun-2003	06-Jun-2003
Spontaneous vaginal delivery	-	-	Baby Female - birthweight 4.60 kgs	21-Jul-2002	21-Jul-2002
Spontaneous vaginal delivery	-	-	Baby male - birthweight 3.380 kgs	09-Feb-1998	09-Feb-1998
[X]Other migraine	-	-	-	08-Mar-1995	08-Mar-1995
Burn of the face, head or neck	-	-	Facial burns from heat lamp	09-Jan-1994	09-Jan-1994
Anterior knee pain	-	-	-	31-Aug-1993	31-Aug-1993
Soiling - encopresis	-	-	-	08-Sep-1980	08-Sep-1980
Constipation	-	-	-	13-Aug-1980	13-Aug-1980

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Mammography	-	-	No worrying changes	27-Sep-2021	27-Sep-2021
Other diagnostic ultrasound	-	-	L breast - No worrying changes	27-Sep-2021	27-Sep-2021
Abdominal hysterectomy with conservation of ovaries	-	-	-	26-Sep-2013	26-Sep-2013
Ultrasound scan of abdomen and pelvis	-	-	-	03-Jan-2012	03-Jan-2012
Anterior and posterior repair	-	-	-	14-Jul-2010	14-Jul-2010
Other diagnostic ultrasound	-	-	(R) breast - NAD	18-Nov-2004	18-Nov-2004
Blood group A Rh(D) positive	-	-	-	09-Jan-2002	09-Jan-2002
Dye test of fallopian tube	-	-	-	11-Mar-1997	11-Mar-1997
Appendicectomy NEC	-	-	-	13-Apr-1993	13-Apr-1993

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

Drug name	BNF code	Formulation	Dosage	Frequency	Duration

					Course started		Last Prescribed Date
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN EACH DAY	-	23-Jun-2021	-	11-Nov-2021
Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	56 tablet	ONE OR TWO BE TAKEN AT NIGHT	-	17-Feb-2020	-	11-Nov-2021

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Naproxen Tablets 500 mg	1001010P0AAAEAE	56 TABLET	ONE TO BE TAKEN TWICE A DAY	-	18-Oct-2021	52 Days	11-Nov-2021

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status: Number per day ? (not known)

Alcohol consumption: Units per day ? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 1010249324941

REFERRAL LETTER

CHI:3010776241Â

MEDICAL IN CONFIDENCE

REFERRAL TO

Spinal R5A1
AA Back Pain

Musculoskeletal Triage and Treatment
NHS Ayrshire & Arran

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	RoutineÂ Â Â
Date of referral	23-Nov-2021
Date submitted	23-Nov-2021

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

13 Mossgiel Drive
Irvine Ayrshire
KA12 0QT

Contact number(s)

-

REGISTERED GP DETAILS

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Practice code	80698		

Practice address

9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Contact number(s)

Voice: 01294 272326

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results
Presenting complaint

Description: see letter ks

Comment: Dear Colleague,

I would be grateful for your input with this 44 year old woman who has chronic sciatica. She has had previous investigations and pain clinic input down in England but not for several years. If there were any surgical interventions that were likely to help she would certainly consider this and I wonder if it would be worthwhile getting an MRI scan.

She has chronic pain in the left upper posterior thigh which intermittently radiates down the leg to the knee and sometimes all the way down to the bottom of the leg. She has no neurological symptoms or cauda equina symptoms. There are no red flags. The pain is really limiting. She works as a carer and only manages due to having a supportive work partner who helps her out when her pain is bad. She also cares for her husband who has myeloma and her pain makes this difficult too. She told me she had x-rays a few years ago in England which were also normal. She is taking Amitriptyline 20 mg and Naproxen. She has fibromyalgia.

On examination she has no tenderness of the lumber spine or sacro iliac joints. She is tender in both groins but not over her greater trochanters. Her straight leg raise is actually negative bilaterally. Passive hip movements are not painful. She has a normal neurological examination of her lower limbs apart from an absent right ankle jerk.

She works for North Ayrshire Council and had over recent months been engaged with a physiotherapist which was arranged through her work. She has been carrying out exercises as advised and feel these helped to a certain extent but not enough. She is keen to know if anything further can be done.

Yours sincerely

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Back pain, unspecified	-	-	-	22-Apr-2016	22-Apr-2016
Soft tissue disorders NOS	-	-	Minor soft tissue injury (R) hand	31-Mar-2016	31-Mar-2016
Menorrhagia	-	-	-	03-Apr-2013	03-Apr-2013
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Soiling - encopresis	-	-	-	08-Sep-1980	08-Sep-1980
Constipation	-	-	-	13-Aug-	13-Aug-1980

1980

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
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Blood group A Rh(D) positive	-	-	-	09-Jan-2002	09-Jan-2002
Dye test of fallopian tube	-	-	-	11-Mar-1997	11-Mar-1997
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Recent medication (Any medication issued within last 90 days not shown above)

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Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status: Number per day ? (not known)

Alcohol consumption: Units per day ? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Signature of referring doctor (or other professional) Date

Ayrshire Central Hospital

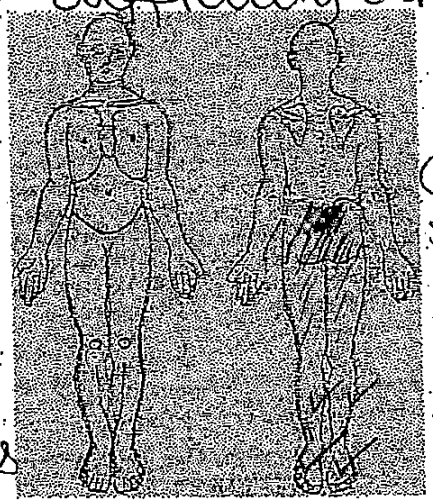
CHI 3010776241
30/10/1977 F
Welsh, Caroline
13 Mossgiel Drive
Irvine, KA12 0QT
DR N Begg, 7041256/80698
Frew Terrace Surgery
Ayrshire, KA12 9DY

Physiotherapy Department

Date: 24/1/22

Physio: S KNOX

Back stiff in morning
- difficulty dressing



(L) & (R) sometimes both

Constant back ache + tightness
Int posterior leg pain
at end day & if tired - get jumpy
+ lying in bed. Dang stretches good.
- paraesthesia
Sleep - occasionally disturbed but get comfy. Sleeps on side c topper

H"x Gradual onset / 10 yrs ago
Agg by pregnancies
Bad episode 6yrs ago - back "chuck"

SH/ Home Carer 30-45hrs
Changed lifestyle - stress
Lives c husband + 2 boys
Previously @ gym

GH/ Fibromyalgia → fatigue
- CVS - BP
- diabetes
- epilepsy

DH/ Amitryptiline } helps
Naproxyn
Omeprazole

Physio ACH
Physio @ work na phone

What are your expectations of coming here today?
What do you think is causing the problem?
Are you worried about this pain / condition?

↓ exs

(2)

CHI 3010776241
30/10/1977
Welsh, Caroline F
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Frew Terrace Surgery
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ADS: pt reports
clear

F to floor ↑ back P
then eases

E stiff

SE stiff + sore

Gait NAD

DIAGNOSIS
NSK low back pain c radiation to post thighs in 44 yr old Caucasian

PROBLEM LIST (including psychosocial)
1. ↓ lumbar ROM
2. Fatigue / ↓ fitness
3. ↑ BMI pt reports
4. ongoing pain

AGREED GOALS
↑ed ROM
↑ fitness
manage P.

PLAN (circle pain management advice if appropriate and add any other interventions)
Explain pain Pacing Sleep advice Graded exposure
Graded activity Stress management advice

Pt managing Sx well & keen to progress
Still doing exs from work Physio as finds those helpful
Review ROM & f2f

Signposted to:
Handouts provided:

Signed SKNOX
SKNOX PTC

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DR N Begg, 7041256/88698
Frew Terrace Surgery
Ayrshire, KA12 9DY

NHS
Ayrshire & Arran

DATE: 24/1/22

CAUDA EQUINA SYNDROME

	YES	NO	COMMENTS/ACTIONS
Saddle anaesthesia or paraesthesia		✓	
Urinary retention		✓	
Difficulty with micturition		✓	
Urinary incontinence		✓	
Faecal incontinence or loss of sensation during bowel movement		✓	
Widespread or progressive motor weakness in legs		✓	
Gait disturbance		✓	
Change in ability to achieve erection or ejaculate			n/a
Loss of sensation in genitals during sexual intercourse, or change in ability to climax		✓	
Cue card given			
Written information given			Pt aware

Physiotherapist name (print and sign) SKNOX
SKNOX PTL

CHI 3010776241
30/10/1977
Welsh, Caroline F
13 Mossglel Drive
Irvine, KA12 8QT
DR N Begg, 7041256/80698
Frew Terrace Surgery
Ayrshire, KA12 9DY

NHS Ayrshire & Arran

DATE: 24/1/22

SPINAL RED FLAG CHECKLIST

	YES	NO	COMMENTS/ACTION
Patient under 20 yrs or first episode over 55 yrs		✓	
Past medical history cancer		✓	
Unexplained weight loss 5-10% of body weight in 3-6 months		✓	heavier than would like 2-3 stone.
Thoracic pain		✓	
Systemic steroid use		✓	
Systemically unwell		✓	
Widespread bizarre/neurological symptoms		✓	
Structural deformity			not reported.
Violent trauma		✓	
History of IVDA or HIV			n/a
Persisting severe restriction of lumbar flexion, less than 5cm on skin marking technique			
Subjective history not matching objective findings		✓	
Clinical concern		✓	
CERVICAL SPECIAL QUESTIONS	YES	NO	COMMENTS/ACTIONS
Dizziness			
Diplopia			
Drop attacks			
Dysarthria			
Dysphagia			
Nausea			

Physiotherapist name (print and sign)

SKNOX
SKNOX PTL

MSK
Musculoskeletal Service

NHS
Ayrshire & Arran

Telephone Consultation Front Sheet

CHI 3010776241
30/10/1977 F
Welsh, Caroline
13 Mossgiel Drive
Irvine, KA12 0QT
DR-N Begg, 7041256/80698
Frew Terrace Surgery
Ayrshire, KA12 9DY

Patient name:

CHI number:

Telephone numbers:

Email Address:

The opening dialogue below MUST be completed with every patient

Hello, can I speak with ..... (patient's full name)

My name is ..... and I am calling from NHS Ayrshire & Arran's Physiotherapy department.

I am calling today in relation to your Physiotherapy referral. Is now an ok time for me to speak to you about that?

In order to comply with GDPR guidelines we need to confirm two pieces of information before we can proceed.

Date	Consent ✓✗	Date of Birth ✓✗	Postcode/First Line of Address ✓✗
24/1/22	✓	✓	✓

On completion of the above move onto next phase of assessment with patient as per the standard operating procedure

Physiotherapist Signature SKNOX Date:

SKNOX. PTL

4/2/22

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Frew Terrace Surgery
Ayrshire, KA12 9DY

S feels she struggles c different types of back P (low lumbar) + post leg/thigh pain despite ex's + activity
Scale to stand then move/ bend again

de, lumbar ROM - fixed ext^n
F to feet ⊕ low lumbar mvt *
E fair " *
SF ↓↓ " ①-⑤ *

hip ROM good ①=⑤ ↓L3-L5 * stiff
neuro - mm power ①=⑤
reflexes ①-⑤
A bracing spinal muscles
+ ↓ mvt L2-L5
R/ Explanation - need to adapt ex's
sit: slump + stretch
FIL single + double leg
trans abd in st
pelvic hit
P Pt happy to continue + opt in if necessary SKWX

25/4/22 S. Back pain persists but 'manageable' SKWX
tel appt still takes naproxyn occasional leg(s) pain only. Main issue - b/lat plantar fasciitis not settling despite self help measures (insoles) Dang/dB of stretching legs/feet - keen to see RSK Pod. will do TBR. Continue back ex's mainline SKWX

MSK
Musculoskeletal Service

MSK Covid-19 Face to Face

Health Screening Form

CHI 3010776241
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Welsh, Caroline F
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Irvine, KA12 0QT
DR N Begg, 7041256/80698
Frew Terrace Surgery
Ayrshire, KA12 9DY

SUSD

ALL questions to be completed prior to entering the department/treatment area. If the patient answers yes to any of the questions shown below then they are required to leave the department and the appointment re-scheduled until a later date. The patient should be advised to contact the COVID-19 testing centre and self isolate as per the current guidance.

Questions
Are you currently showing any signs or symptoms of Covid-19? • Increased temperature • New persistent cough • New shortness of breath • New loss of taste or smell
Have you been in contact with anyone with the above symptoms?
Have you been contacted by the Test and Protect Service recently and asked to isolate?
Have you recently returned from out with the U.K and require to isolate?

Appointment Date	Time questions asked	Screening Questions Completed Yes/No	Patient Safe to Enter Department Yes/No	Printed Name Signature
4/2/22	12pm			

Version 1 – May 2021

Paed – ☐

Tick if appropriate

NHS Ayrshire & Arran

MSK Referral

Date:	25/04/2022
Patient Name:	Caroline Welsh
Address:	13 Mossgiel Drive
	Irvine
Tel No:	07875 530530
CHI:	3110776241
BMI:	Increased – pt says she's 2-3 stone heavier than she'd like
GP:	Dr Begg
Practice:	Frew Terrace Surgery

Referrer Name:	Susan Knox
Discipline:	MSK Physiotherapy
Base:	ACH
Tel No:	01294 323190

I wish to refer this patient to *(please mark with X)*:-

Physiotherapy:		Occupational Therapy:	
MSK Podiatry:	X	MSK Podiatry 2nd opinion Clinic:	
Orthotics:		Paediatrics / Rainbow House: (Primary Aged Children)	

Clinical presentation including history:-

Caroline is attending Physiotherapy with long standing low back pain which she continues to manage well.

She is also c/o bilateral plantar fasciitis – she's had a problem with this previously and it settled with insoles and exercises. On this occasion it's persisting despite her attempts at self-management and she feels it's wearing her down along with the back pain.

Previous management:-

Stretching exercises and Caroline has purchased "half insoles" and new shoes.

Reason for referral:-

Please can you see Caroline regarding her bilateral plantar fasciitis? This isn't directly related to the condition we're seeing her for so she realises she won't be prioritised.

Thanks, Susan

StarT Tool	Low	Med	High		Low	Med	High
STarT Back				2nd			
STarT MSK				Score			

OUTCOME MEASURES		Initial Vas	End Vas
Hand/Elbow/Wrist	D A S H		
Shoulder	Quick Dash		
Knee	Oxford Knee Score		
Hip	Oxford		
Foot/Ankle	Manchester Oxford		

Is patient continuing to receive care from referrer? *(please mark with 'X)*	Yes	X	No	

I am grateful for your help with this patient.

Review October 2022

MSK
Musculoskeletal Service

MSK DISCHARGE REPORT

NHS
Ayrshire
& Arran

Patient Name:	Caroline Welsh
Address:	9 St. Michaels Terrace, Kilwinning, Ayrshire, KA13 6FF
CHI:	3010776241
GP:	Dr N Begg
Consultant:	
Referrer Source:	
Referral Date:	03/12/2021
Start Date:	24/01/2022
Discharge Date:	04/07/2022
No. of treatments:	3
Discharge Reason:	Treatment complete
Treatment Outcome:	
Therapist:	Susan Knox
Location:	PHYSIOTHERAPY DEPARTMENT AYRSHIRE CENTRAL HOSPITAL

Dear Dr Begg

Diagnosis: Low back pain and bilateral plantar fasciitis

Advised re exercise programme for stretching lumbar spine. Back pain more manageable but feet very troublesome therefore advised re stretched & referred onto MSK Podiatry for further assessment.

Yours sincerely,
Authorised on 04/07/2022 17:55:15 by Susan Knox.
Susan Knox
04/07/2022

To: F.HAMILTON

University Hospital Crosshouse Emergency Department
Kilmarnock
Crosshouse Hospital
KA2 0BE
Tel: 01563 827751/827762

DUTY CONSULTANT: DR LAURA MCKECHNIE

PATIENT DETAILS

Patient Name	Caroline Welsh
CHI Number	3010776241
DOB	30/10/1977
Address	9 ST. MICHAELS PLACE,KILWINNING,AYRSHIRE,, KA13 6FA

ATTENDANCE DETAILS

Arrival Date & Time	03/03/2023 20:03
Attendance Number	XH-23-009146-1
Diagnosis	Chest pain
Treatment	Analgesia
Investigations	
Additional Information	45 year old female presenting with palpitations and chest pain. Bloods nil of note. Trop <3. Pyrexic 38.3, HR 110. Impression: likely viral URTI. Discharged home with worsening advice.

DISCHARGE DETAILS

Discharge Date & Time	03/03/2023 23:35
Left Department Date & Time	03/03/2023 23:09
	Discharge, no follow up Usual place of residence
Child Protection	None
Adult Protection /Concern Referral?	No
Clinician Seen	Sophie McCreadie,Sophie McCreadie

Obs 7.

Crosshouse EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

A/E No: XH-23-009146-1
Date & Time: 03 Mar 2023 20:03

CHI No: 3010776241

Caroline WELSH

Duty Consultant: DR LAURA MCKECHNIE

Date of Birth: 30 Oct 1977
Age: 45 Years
Sex: F

GP:
F Hamilton
Oxenward Surgery
3 Oxenward Road
Kilwinning
KA13 6EH
01294 551555

Marital Status: Other/Unknown

Religion: None
Ethnicity: White Scottish

Address:
9 ST MICHAELS PLACE
KILWINNING
AYRSHIRE

KA13 6FA

Next of Kin:

Attendances
Last 12mths 1
Total: 7

Special Case:

Phone Numbers:
Home: 07875 530 530
Mobile:

Accompanied by: Unaccompanied

Employer/School:
nac
Not at School

Triage Time: 20:28 **Triage Nurse:** Sarah Bell **Triage Group:** Yellow

Resp Rate	O2 Sat%	PFR
18	99	

Pulse	BP	E	M	V
118	155/110			

Allergies: Not Known

BMstix	NEWS	Temp	Weight
		37.5	

Visual Acuity
R:
L:

Pain Score Triage: 6

I give consent for details of my injury to be given to the Police
Signed .....

Triage details:
Palpitations, SOB and bilateral arm pain radiating from shoulders to fingers since 12 noon
Treatment
ECG
Special Needs
NONE
Clinical Frailty Score:
Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered I know this may affect my recovery.
Signed ..... Witness: ..... Witness: .....

Disch A+E clinic Paed Tr # Eye ENT Max Facial
Ward OP Ward IP

3010776241

Caroline Welsh CHI: 3010776241 A/E No: XH-23-009146-1

Drug	Dose	Route	Time/Freq	Signature	Given By	Date	Time
PARACETAMOL	1g	O	2305			31/3	1305

Kardex started? ☐ *Further drug prescriptions on Drug Kardex, do not print further ED Cards*

PVC 1	Size/Colour	Location	Initials	PVC 2	Size/Colour	Location	Initials

	Device	Flow Rate l/min	%O2 for Venturi	Target SpO2	Prescribed by	Started by	Stopped by
Oxygen							
Changed to							

Clinician Name: S. McCreadie **Date:** 03/03/23

Grade: FY2 **Time:** 21 20

45 ♀ presenting with palpitations (L) arm heaviness and chest tightness. Associated nausea, states feels generally unwell. Notes pain down entirety of (L) arm with associated paraesthesia in hand. Woke up with arm sx, ongoing for past 3 weeks, worse this am. Describes pain between shoulde blades also. Over last 3 weeks b/l elbow pain in am. GP switched naproxen to meloxicam on Wednesday for this issue. Brief headache earlier today, now settled. Feeling cold prior to presentation this evening. ø SOB.

PMHx: Chronic back pain, Migraine, Fibromyalgia

DHx: Meloxicam, Amitriptyline, Salbutamol, Omeprazole

NKDA

FHx: Father died from MI in 50's

OE: HS 1+II+0 ø rash. SOT

Obs: RR 18, SpO2 99% RA, HR 118, BP 155/110, Temp 37.5

PEARL

RUL LUL

Power 5/5 5/5

<Sensation Intact>

Plan: ECG

Bloods → incl troponin

23:00 Trop <3, inflam markers (N). Pyrexic 38.3, HR 103. Likely viral illness. Discharged (H) with worsening advice.

NHS Ayrshire & Arran NEWS – National Early Warning Score

NHS Ayrshire & Arran

301077624 1
WELSH Caroline
9 ST. MICHAELS PLACE, KILWINNING
KA13 6FA
DOB: 30/10/1977
XH-23-009146-1

	Ward	Date	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

	Resp rate	BP	HR
Acceptable parameter's			
Dr/ANP initials			
Date			
Dr/ANP discontinue date/sign			

Sp02 Scale 2 **Target 88-92%**
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

Patient on home oxygen Y☐ N☐
If yes, add details of oxygen therapy

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	Think: Risk of Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS2

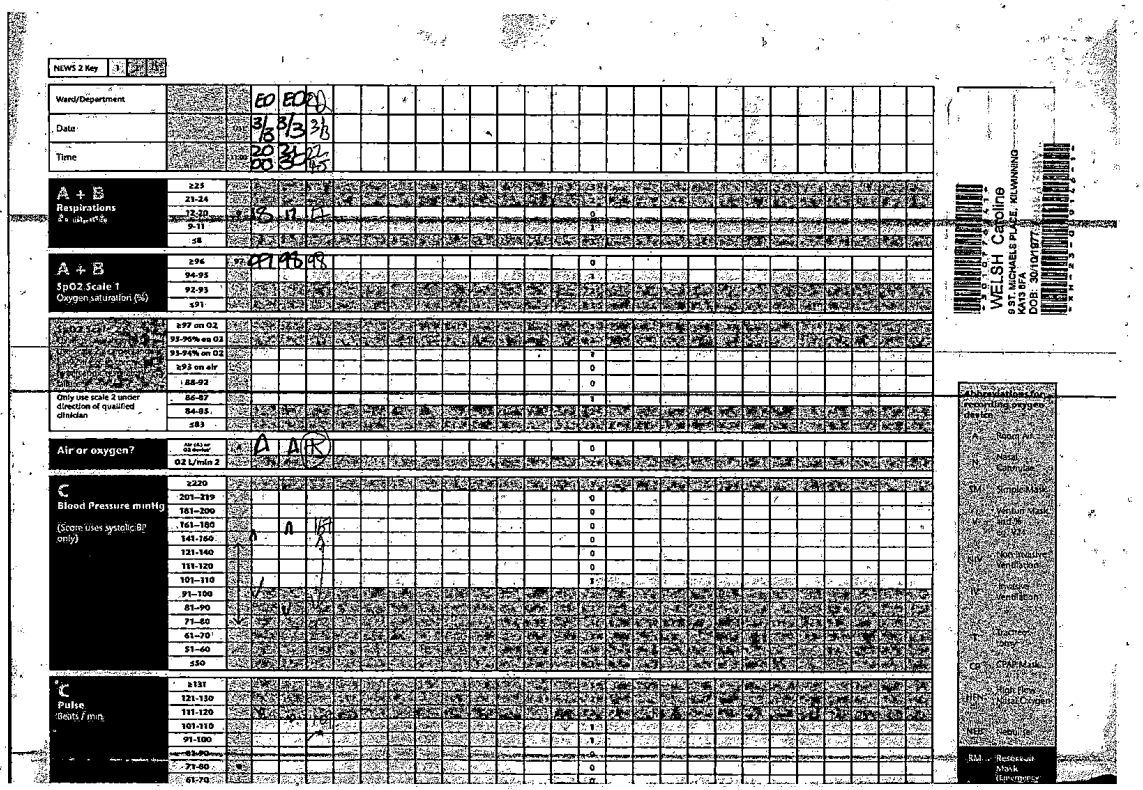
Following MDT discussion, it has been agreed that this patient no longer has a requirement for NEWS2

Responsible Clinician: Print Name .....

Designation: .....

Date: ..... Time: .....

NEWS2



NEWS 2 Key

Ward/Department	60 BCD
Date	31/8 8/3 2/8
Time	20 31 07 00 39 05

A + B Respirations per minute

| | | |

[redacted]	51-60														0																		
	41-50																																
	31-40																																
	≤30																																
D* Any changes in neuro response, complete GCS. Immediate medical review. Check Blood Glucose. Complete 4AT*.	A Alert		A	A	A										0																		
	C New Confusion																																
	V Verbal																																
	P Pain																																
	U Unresponsive																																
E Temperature °C	≥39																																
	38.1-39.0														1																		
	37.1-38.0		0	0	0										0																		
	36.1-37.0														0																		
	35.1-36.0														1																		
	≤35.0																																
NEWS Total			0	2	2	1																											
Blood glucose			20																														
Pain / function score			21																														
Time PI last performed			10.20																														
Must be reviewed by doctor? Y/N			N																														
CCG indicated? Y/N			N																														
Time NEWS due			22.00																														
Escalation of care Y/N			N																														
Initials			AS	BJ	VB	SH																											

*if 4AT>4 commence TIME bundle

Pain Score										
Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.										
No Pain	Mild Pain			Moderate Pain			Severe Pain			
0	1	2	3	4	5	6	7	8	9	10

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

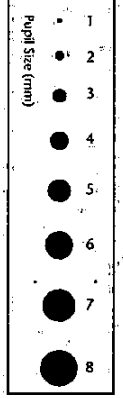
Glasgow Coma Scale

Date:		11/1																												
Time:		11.00																												
Eyes Open	Spontaneous	4																												
	To speech	3																												
	To pain	2																												
	None	1																												
Best Verbal Response	Orientated	5																												
	Confused	4																												
	Inapp. words	3																												
	Incomp. sounds	2																												
	None	1																												
Best motor response	Obeys commands	6																												
	Localise pain	5																												
	Withdrawal to pain	4																												
	Abnorm. flexion to pain	3																												
	Extension to pain	2																												
	None	1																												
GCS TOTAL																														
PUPILS	R Size																													
	R Reaction																													
	L Size																													
	L Reaction																													
LIMB MOVEMENT	ARMS Normal power																													
	ARMS Mild weakness																													
	ARMS Severe weakness																													
	ARMS Abnormal flexion																													
	ARMS Extension																													
	ARMS No response																													
	LEGS Normal power																													
	LEGS Mild weakness																													
	LEGS Severe weakness																													
	LEGS Extension																													
	LEGS No response																													
Initials		AB																												

Pupil Reaction and size

S = sluggish
+ = reaction
- = no reaction

Pupil Size (mm)



I	Identity self/area/patient
S	Situation - what is your concern?
B	Background - relevant Hx/reason for admission
A	Assessment - A-E findings/NEWS2 score.
R	Recommendation - what do you need & when.

NEWS > 5 THINK SEPSIS Apply SEPSIS 6 within 1 hour

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

Crosshouse Emergency Department

UHC ED CSW Blood Requesting Form

WELSH Caroline
8 ST. MICHAELS PLACE, KILWINNING
KA13 6FA
DOB: 30/10/1977

Where is the patient?

WR

ECG Yes ☐ No ☐

Post Triage Request (circle required)		
Cannula	Yes ☐ No ☐	
		Additional to consider
Abdo Pain	FBC, UE, LFT, CRP, Amylase, VBG	Coag and G&S if bleeding/severe pain
Cardiac chest Pain	FBC, UE, Trop	
Sepsis	FBC, UE, CRP, Coag, Cultures, VBG	
Delirium	FBC, UE, LFT, CRP, VBG	CK if long lie
Shortness of Breath/ Pleuritic CP	FBC, UE, CRP	VBG D-Dimer for ? PTE – Speak to EPIC
Overdose	FBC, UE, LFT, CK	VBG >4hr Paracetamol / Salicylate Coag/INR if paracetamol OD
Hip Pain	FBC, UE, LFT, bone profile, Coag, G&S	
TIA/Stroke	FBC, Coag, UE, Lipids, LFTS, CRP	
ON WARFARIN OR DOAC? ADD COAG/INR		

OR

Request by clinician							
Cannula		Yes ☐ No ☐					
Troponin	☐		☐	Paracetamol	☐	VBG	☐
FBC	☐	UE	☐	Salicylate	☐	Needlestick: 2 whites	☐
Coag	☐	LFT	☐	Glucose	☐	Other:	☐
INR	☐	CRP	☐	G&S	☐		☐
D-Dimer	☐	Bone Profile	☐	Blood Cultures	☐		☐

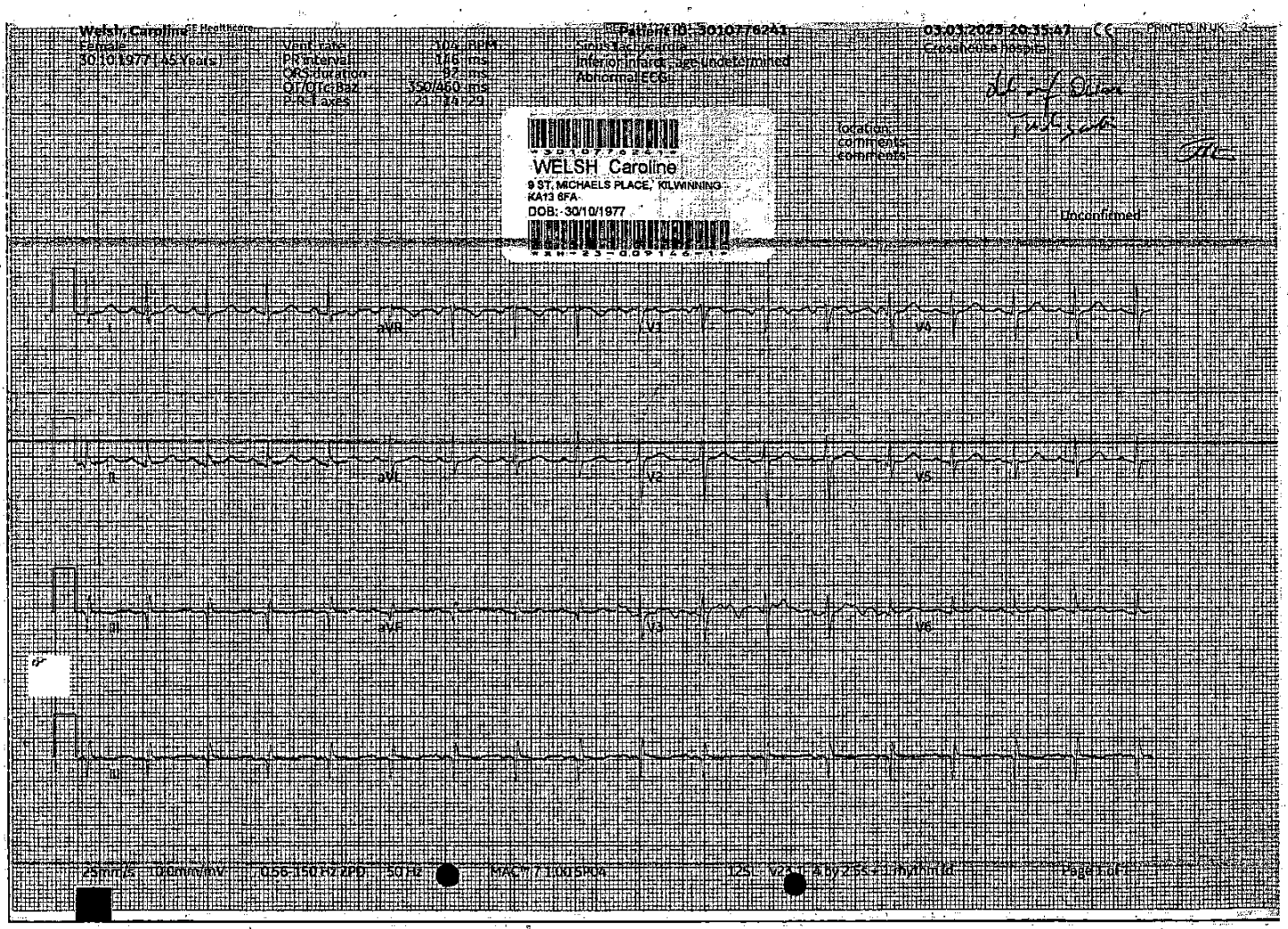
Search "Draw Order" on Athena for information on blood bottles required for tests

Please Return Request Form To Patient Notes Once Bloods Taken and Sign Actioned by

Requested By_____ Request actioned by_____

Date_____ Time_____ Time_____

Author: JM
Version 1.1 Feb 2023


Welsh Carolina
Female
30/10/1977 (45 Years)
Vent. rate 104 BPM
PR interval 146 ms
QRS duration 92 ms
QT/QTc/Bazett 350/460 ms
P-R-T axes 21 74 29
Patient ID: 3010776241
Sinus tachycardia
Inferior infarct, age undetermined
Abnormal ECG
03.03.2025 20:35:47
Cross House Hospital
location:
comments:
comments:
WELSH Caroline
9 ST. MICHAELS PLACE, KILWINNING
KA13 6FA
DOB: 30/10/1977
Unconfirmed
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
25mm/s 10.0mm/mV 0.56-150Hz zpd 50Hz 6AC 71005P04 12S v2.0 (c) A by 2.5s r1 rhythm1d Page 1 of 1

Crosshouse Hospital
Emergency Department
Tel: 01563 827762 / 827751
(ED Secretaries Mon-Fri 9am-5pm Tel: 01563 827757 (Out of Hours queries

Emergency Department Discharge Letter

To: J.DEAN

Re: Caroline Welsh
13 MOSSGIEL DRIVE,IRVINE,AYRSHIRE,, KA12 0QT
DOB: 30/10/1977
ED Attendance No: XH-20-038007-1
CHI No.: 3010776241

Attendance Details
ıte of Attendance: 20/08/2020 **Time of Attendance:** 23:01:00
Presenting Complaint: back pain **Duty Consultant:** Dr CRAWFORD MCGUFFIE
Additional Information: No Attendances in Last 12 months:1 Total Number of Attendances:6

Diagnosis	Chest pain,,
Treatment	Take home drugs
Investigations	X-Ray,
Discharge formation:	Discharge, Usual place of residence no follow up
Additional Information	acute onset left sided chest pain. feels like muscular pain which she usually gets in lower back. pain on deep inspiratoin: CXR, Ddimer, CRP, ECG - normal. WCC raised ?LRTI. treated with amoxicillin and analgesia
Discharged by:	Mohyudin Dingle,Spec Trainee Year 6

If you have any queries about this patient, please contact one of the staff at the above number

RM 4

Patient Information		Date:	20/08/2020
CAROLINE WELSH		Incident Number:	CR006735881
Age/Gender:	42y Old Female		
Address:	13 MOSSGIEL DRIVE IRVINE,KA12 0QT	Incident Type:	EMG
DOB:	30/10/1977	Incident Location:	13 MOSSGIEL DRIVE IRVINE, KA12 0QT
CHI:			
Ethnicity:			

Scottish Ambulance Service

Presenting Complaint

BACK SPASM.

Additional Comments

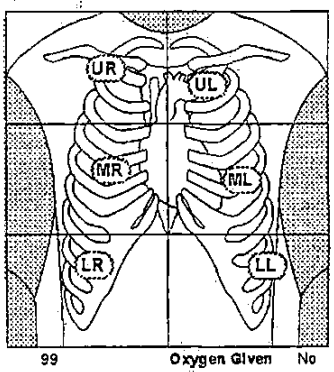
999 CALL TO A 42YOF BACK PAIN. O/A PT IN LIVING ROOM. PT HAS BEEN AT WORK TODAY SHE THINKS SHE HAS BENT FUNNILY AND FELT A SUDDEN STABBING PAIN WHICH EASED. ONCE HOME PAIN HAS WORSENED INITIALLY FELT LIKE TRAPPED WIND BUT FEELING LIKE A BACK SPASM. OBS AS RECORDED. NO PAIN ON PALPATION. PT STATES SHE NORMALLY GETS BACK SPASMS BUT IN HER LOWER BACK. PAIN THE SAME JUST A DIFFERENT LOCATION. ENTONOX GIVEN BUT PAIN ONLY SLIGHTLY EASED. DIFFICULT TO TAKE DEEP BREATHS.

PATIENT ASSESSMENT

AVPU	Alert	<C>	No
A	Clear		

B — Breathing Adequately: Yes

UR	Normal Percussion, Normal Breath Sounds, Normal Air Entry	UL	Normal Percussion, Normal Breath Sounds, Normal Air Entry
MR	Normal Percussion, Normal Breath Sounds, Normal Air Entry	ML	Normal Percussion, Normal Breath Sounds, Normal Air Entry
LR	Normal Percussion, Normal Breath Sounds, Normal Air Entry	LL	Normal Percussion, Normal Breath Sounds, Normal Air Entry



Respiratory Rate 22 SPO2 99 Oxygen Given No

C

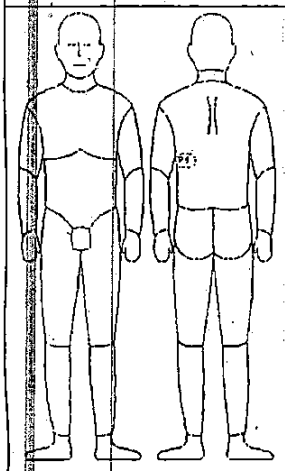
Pulse Rate	BP	Cap Refill	ECG Rhythm
120	164/95	<=2 Secs	Sinus Tachy

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right	Peripheral	3 Lead12 Lead

D

GCS	Eyes	Voice	Motor	PEARL
15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	Yes

E



Pain

ID	Body Part	Pain Scale
P1	Back Body	8

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
22:50	108	20							37.7						E0000099
22:20	120	22	164/95	99	<=2 Secs	15	Alert		38.1		Sinus Tachy				E0000099

NEWS

Time	Clinical Risk	NEWS
22:50	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	1
22:20	MEDIUM Immediate Clinical Risk. Treat as per Clinical Practice Guidelines. This patient should be conveyed to hospital.	5

Drugs

Time	Drug	Dosage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID
22:30	Entonox		PRN	INH				E0000099

HISTORY

AMPLE

Allergies	None
Medication	AMITRIPTYLINE
Past Medical History	FIBROMYALGIA
Last Eaten	>4 Hours Ago
Events Prior	BACK SPASM

Social History

Lives alone	No	Living With	FAMILY	Patient Occupation	CARER

Patients General Appearance	Normal,
Patient Mobility	Fully Mobile,
Patient Communication	No Help Required,
Patient Clinical Risk Factors	None Identified,
Patient Enviromental Risk Factors	None Identified,

CLOSE RECORD

Treatment On Scene	Non Emergency				

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No		

INCIDENT LOG

Time Call Received	21:57	Allocated	21:58	Mobile	22:00
First Resource On Scene		Crew On Scene	22:13	Crew Left Scene	22:36
Crew At Hosp		Receiving Hospital	CROSSHOUSE HOSPITAL	Clear Time	

Crew ID	Crew Grade	Driver
E9887901	Ambulance Technician	YES
E0000099	Paramedic	NO

Rm 4

CROSSHOUSE HOSPITAL
EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

A/E No: **XH-20-038007-1**

CHI No: **3010776241**

Date: **20 Aug 2020** Time: **23:01**

Consultant: **Dr CRAWFORD MCGUFFIE**

GP
Dr. J DEAN
BOURTREEHILL MEDICAL PRACTICE
THE HEALTH CENTRE
CHEVIOT WAY
IRVINE
KA11 1JU

Incident Date: **20 Aug 2020**
Incident Time: **23:01**

Martial Status: **Single**

Sex: **F**

Ethnicity White Scottish

Religion None

Attendances in last 12mths **0**

Total Attendances Count **5**

Special case

WELSH
Caroline

Date of Birth: **30 Oct 1977** Age: **42 Years**

Address:
13 MOSSGIEL DRIVE
IRVINE
AYRSHIRE

KA12 0QT

Phone Numbers:
Home: 07875 530 530

Employer/School
nac Not at School

Next of Kin:
Welsh
13 MOSSGIEL DRIVE
IRVINE
AYRSHIRE
KA12 0QT

Partner
Home Tel: 07930244113

Accompanied By:
Unaccompanied

Triage Time 23:08 **Triage Nurse** Hazel Miller **Triage Group** Green

Resp Rate	02 Sat%	PFR
24	98	

Pulse	BP	E	M	V
91	145 /93			

Allergies: **Not Known**

BMstix	Alcohol	Temp	Weight
		36.6	

Visual Acuity R L

Pain Score (Triage) 8

Pain Score (Discharge)

Triage details
BIBA sudden onset of pain in middle of back, states had similar before but higher up now, pain worse on inspiration

Treatment
ECG
Clinical Frailty Score:

Special Needs
NONE

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed..... Witness..... Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....

Disch A+E clinic Paed Tr. # eye ENT Max Facial Ward OP Ward IP

*3010776241

Co-CODAMOL 30/500 TT PO QIDS 2 A/E No. XH-20-038909-N

Drug	Dose	route	time/frequency	signature	quantity/given by
Co-CODAMOL 30/500	TT	PO	2320		Klassick
~~ASPIRIN~~	~~300MG~~	~~PO~~			
DICLOFENAC	50MG	PO	2320		Klassick
AMOXICILLIN	500MG	PO	TDS		NJ
IBUPROFEN	400MG	PO	TDS		MJ

PVC1	Size/Colour	Location	Initials	PVS2	Size/Colour	Location	Initials

	Device	Flow Rate l/min	%O2 for Venturi	Target SpO2	Prescribed by	Started by	Stopped by
Oxygen							
~~Changed to~~							

DOCTOR / ENP: DINCLG STG Time: 20/8/20 2325

PCJ Acute onset Left back pain DIJ MKH

HPCJ AMYTRIPTYLIN

Tends to get back pain

Driving for work

Acute onset Left sided Mid thoracic PMHJ

back pain Fibromyalgia

Sharp

Pain on Movement + Deep breath

Catching Spasm / Pain

N. & vomit.

N. analgesia taken SMJ

BIBA → ECG = NSR Lives with husband

Obs = NR 12s OK — D

T 38.1

Pt has but in pain to

NS — D Abd. FHT ECG → NSR @ 88bpm

Back — Nurse to palpate

Max pain → MOI to script

S.Wing up / lying down → pain to

CXR → ETD on bronchioles and Lobes

No obvious pneumonic changes

o PTX

XH-20-038007-1 CHI Number: 3010776241

NHS Ayrshire & Arran

Accident & Emergency Nursing Documentation Form

WELSH Caroline
13 MOSSGIEL DRIVE
IRVINE
KA12 0QT

DOB: 30/10/1977

PRF: ☐
NHS24 doc: ☐

Receiving Nurse(s): Winnie

Care taken over by:

Date: 20 Aug 2020
Time: 23:01

Additional information for admission complaint:
BIBA sudden onset of pain in middle of back, states had similar before but higher up now, pain worse on inspiration

BACKGROUND

Relevant PMH relating to presenting complaint:
Nerve pain

Allergies: Yes (No) Unknown

Anticoagulant: Yes (No) Unknown

Insulin: Yes (No) Unknown

Next of Kin details (if different from A&E Card):
Name:
Relationship: Contact No:

ASSESSMENT

MEWS/PAWS score: 3
GCS: 15
Name band in situ: (Yes) No
Own medications: Yes No
Cognitive impairment: Yes No 4AT

Any medications given by paramedics?
Entonox.
O2 therapy Yes No Amount:
PVC inserted pre-hospital Yes No

ECG Yes No
X-ray Yes No
CT Yes No

McKillop Tool Sepsis Six Big Six
Delirium Bundle

IV	Bloods	Cultures	Gases	Trop	Waterlow
PVC	Yes No	Size/Colour	Location		

Mobility status:
Independent

Package of Care Yes No

Ongoing Assessment

Y (yes) N(no) (NA) Not Applicable (I) Independent (R) Refused (S)Sleeping

	On Arrival	Time	Time	Time	Time	Time	Time	Time
Area								
Clothing Bag								
Skin inspected								
Pain assessed								
Possessions to hand								
Fluid/Food offered	N/A							

	Nursing Notes
20/08/20	
2320	BIBA back pain
	Had entonox with SAS
	Await ED review

Ward Admitted To	

Write or attach label
HCR Number:
CHI Number: 3010776241
Surname: Welsh
Sex: Female
Forename: Caroline
Address: 13 MOSSGIEL DRIVE, IRVINE AYRSHIRE KA12 0QT
Date of Birth: 30 Oct 1977

MEDICAL CONTINUATION SHEET

DATE	
24/8/12	DirCLE ST6 cont.
	c. Hx, LRTI
	PE
	Mosaic SKIN injury
	ANAESTHA
	(P) DDIMER
	U+E/CRP
	FBC + BV.
	DirCLE ST5
	DDIMER –Ve
	CRP <5
	WCC 14.5
	NG 9.8
	(P) D/C on Analgesia
	+ AMOXICILLIN
	DIRCLE ST6 (MS Fever ↑↑ WCC)

Forename: Caroline **Surname:** Welsh

XH-20-038007-1

Date : 20 Aug 2020

DATE		

Graphic Controls Ltd Printed in UK

ID:
Name:carline welsh
Sex:Female Birth Date:30-Oct-1977 42 Years
cm kg mmHg
Medication:
Symptoms:
History:

20-Aug-2020 23:04

I100 Sinus rhythm
9110 ** normal ECG **

Vent rate 88 bpm
PR int 158 ms
QRS dur 90 ms
QT/QTc int 348/ 422 ms
P/QRS/T axis 8/ 15/ 37 °
RV5/SV1 amp 0.890/ 0.725 mV
RV5+SV1 amp 1.615 mV

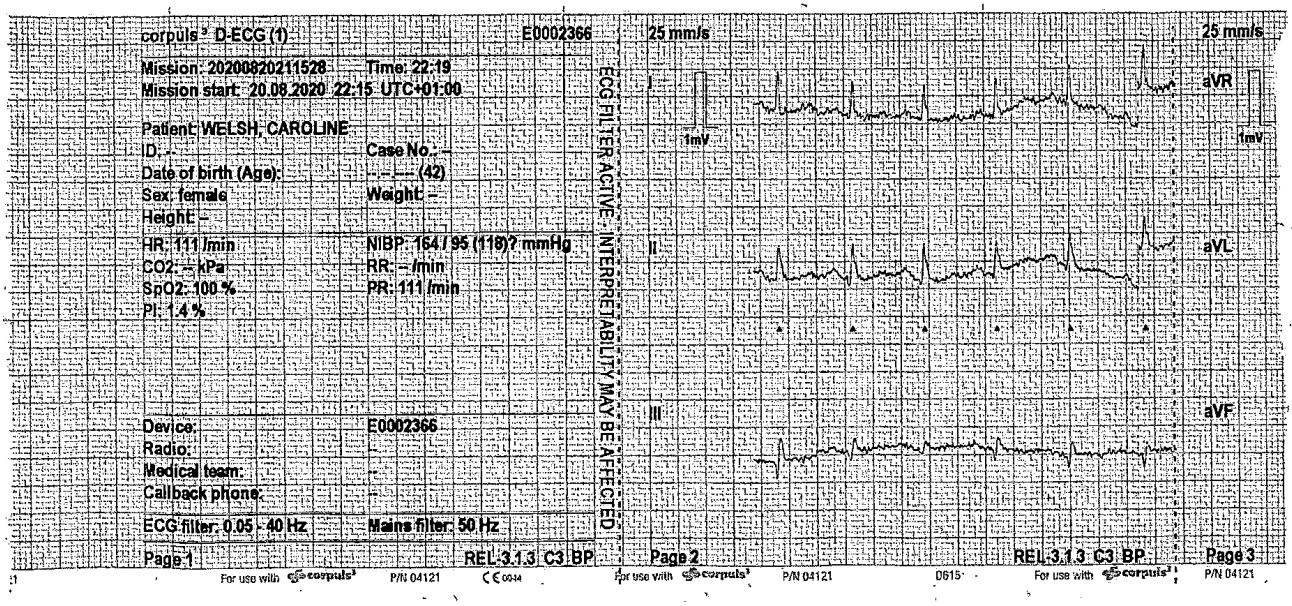
Unconfirmed Report
Reviewed by:

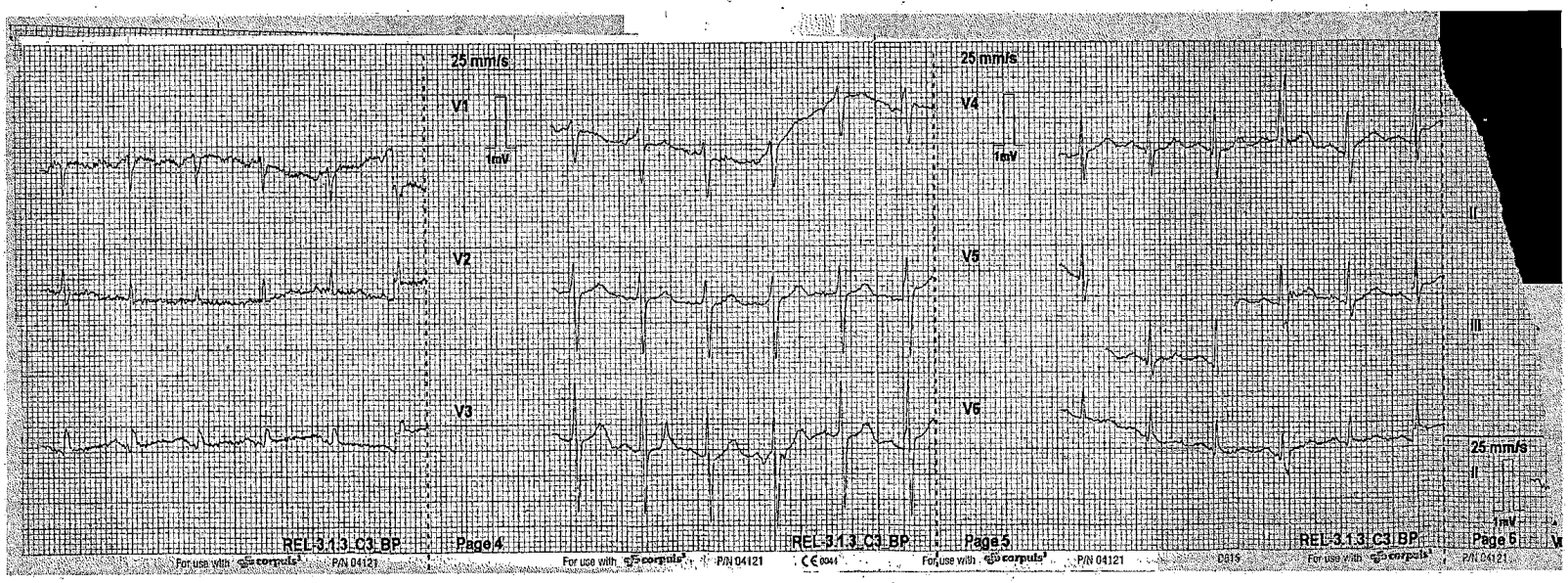
10 mm/mV 25 mm/s Filter: H50 d 35 Hz 10 mm/mV

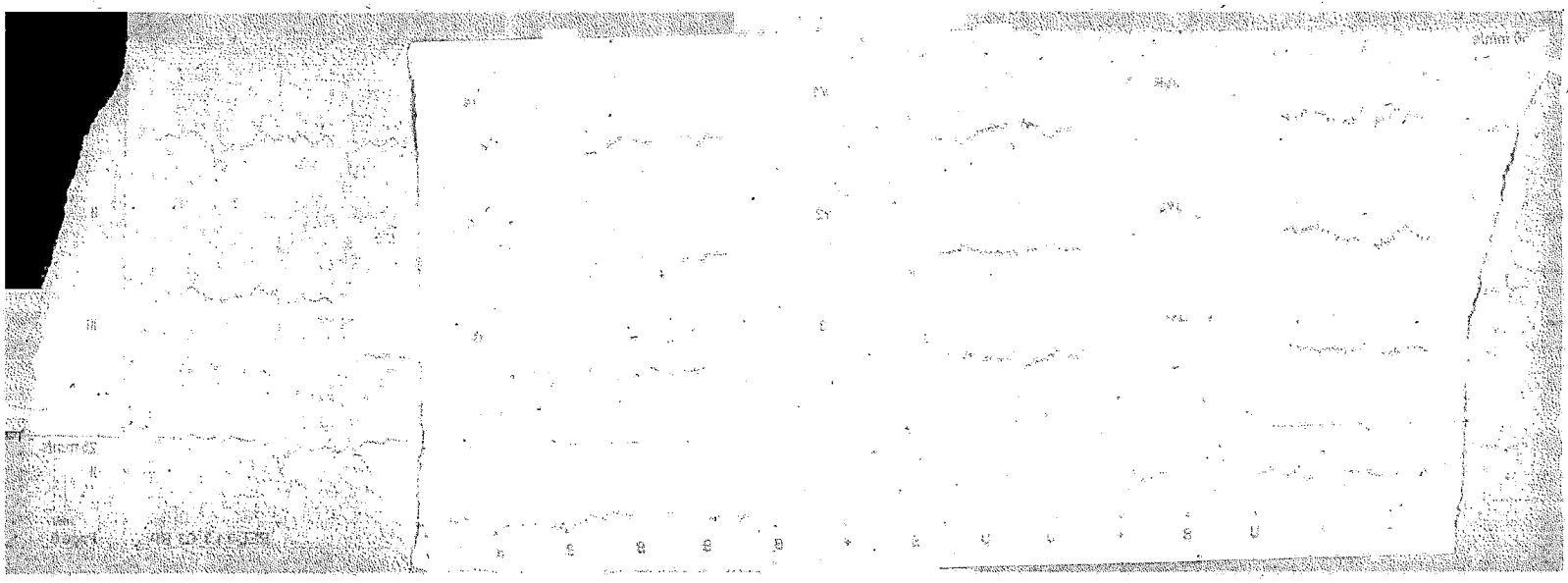
10 mm/mV

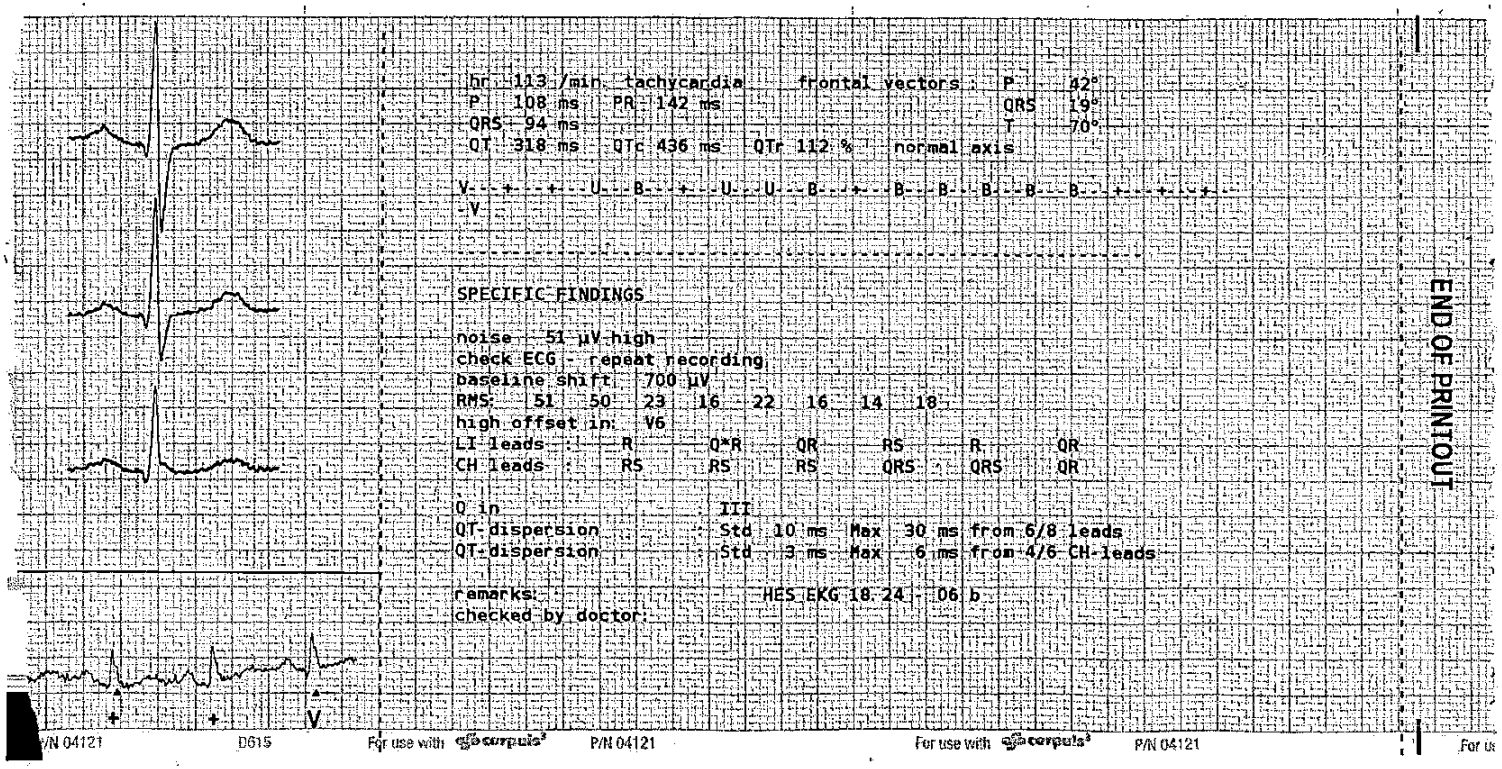
I aVR V1 V4
II aVL V2 V5
III aVF V3 V6

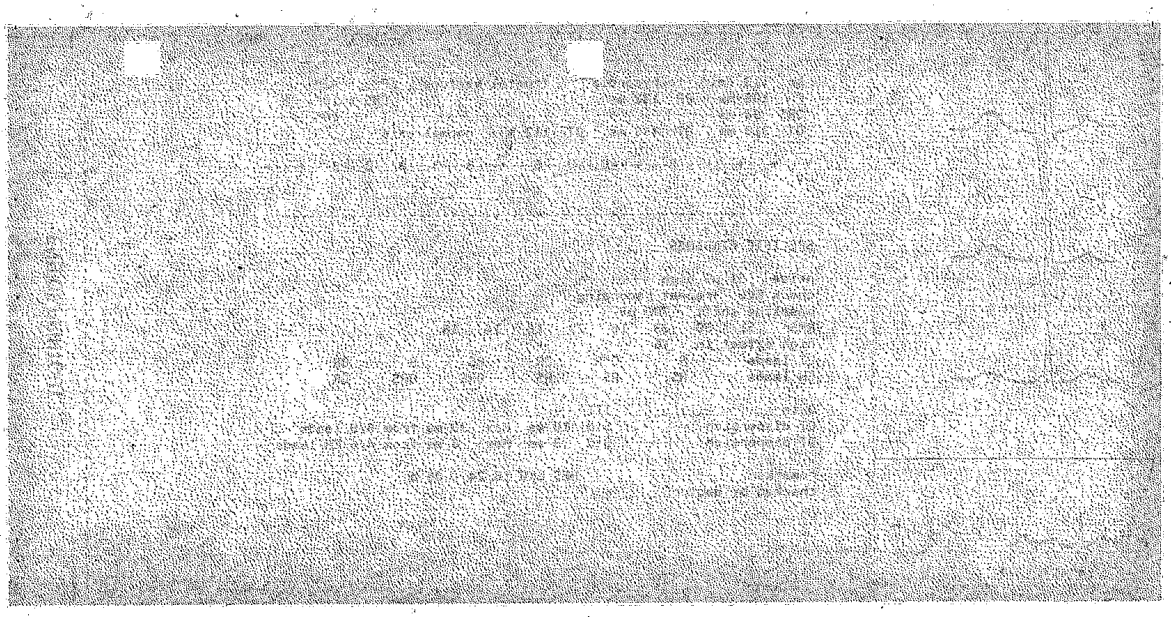
Rhythm II 10 mm/mV


corpuls³ D-ECG (1)
E0002366
Mission: 20200820211528
Time: 22:19
Mission start: 20.08.2020 22:15 UTC+01:00
Patient: WELSH, CAROLINE
ID: –
Case No.: –
Date of birth (Age): --.--.--- (42)
Sex: female
Weight: –
Height: –
HR: 111 /min
NIBP: 164 / 95 (116)? mmHg
CO2: – kPa
RR: – /min
SpO2: 100 %
PR: 111 /min
PI: 1.4 %
Device:
E0002366
Radio:
Medical team:
–
Callback phone:
–
ECG filter: 0.05 - 40 Hz
Mains filter: 50 Hz
Page 1
REL 3.1.3 C3 BP
For use with corpuls³ P/N 04121
ECG FILTER ACTIVE: INTERPRETABILITY MAY BE AFFECTED
25 mm/s
I
1mV
II
III
aVR
aVL
aVF
Page 2
For use with corpuls³ P/N 04121 0615
25 mm/s
1mV
REL 3.1.3 C3 BP
Page 3
For use with corpuls³ P/N 04121


25 mm/s
V1
1mV
V2
V3
25 mm/s
V4
1mV
V5
V6
II
III
25 mm/s
II
1mV
REL-3.1.3_C3_BP
Page 4
For use with corpuls3 P/N 04121
REL-3.1.3_C3_BP
Page 5
For use with corpuls3 P/N 04121
CE 0044
REL-3.1.3_C3_BP
Page 6
For use with corpuls3 P/N 04121
0819




hr 113 /min tachycardia
P 108 ms PR 142 ms
QRS 94 ms
QT 318 ms QTc 436 ms QTr 112 %
frontal vectors : P 42°
QRS 19°
T 70°
normal axis
V - - + - - + - - U - - B - - + - - U - - U - - B - - + - - B - - B - - B - - B - - B - - + - - + - - + -
-V
SPECIFIC FINDINGS
noise 51 µV-high
check ECG - repeat recording
baseline shift 700 µV
RMS: 51 50 23 16 22 16 14 18
high offset in: V6
LI leads : R Q*R QR RS R QR
CH leads : RS RS RS QRS QRS QR
Q in III
QT-dispersion : Std 10 ms Max 30 ms from 6/8 leads
QT-dispersion : Std 3 ms Max 6 ms from 4/6 CH-leads
remarks:
HES EKG 18.24 - 06 b
checked by doctor:
END OF PRINTOUT
P/N 04121
D615
For use with cardio² P/N 04121
For use with cardio² P/N 04121
For us



Neuro NEWS

National Early Warning Score

NHS Ayrshire & Arran

	Date	Ward
Admitted		
Transferred		
Transferred		

Special Instructions - to be completed by Medical Team

A total NEWS score of _____ due to _____ or individual parameter range of _____ is acceptable for this patient because _____

_____

Please escalate if _____

_____

Print _____ Sign _____ Designation _____

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

A total NEWS score of _____ due to _____ or individual parameter range of _____ is acceptable for this patient because _____

_____

Please escalate if _____

_____

Print _____ Sign _____ Designation _____

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

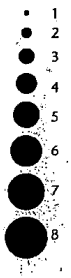
See NEWS Actions Reference Tool for local escalation policy

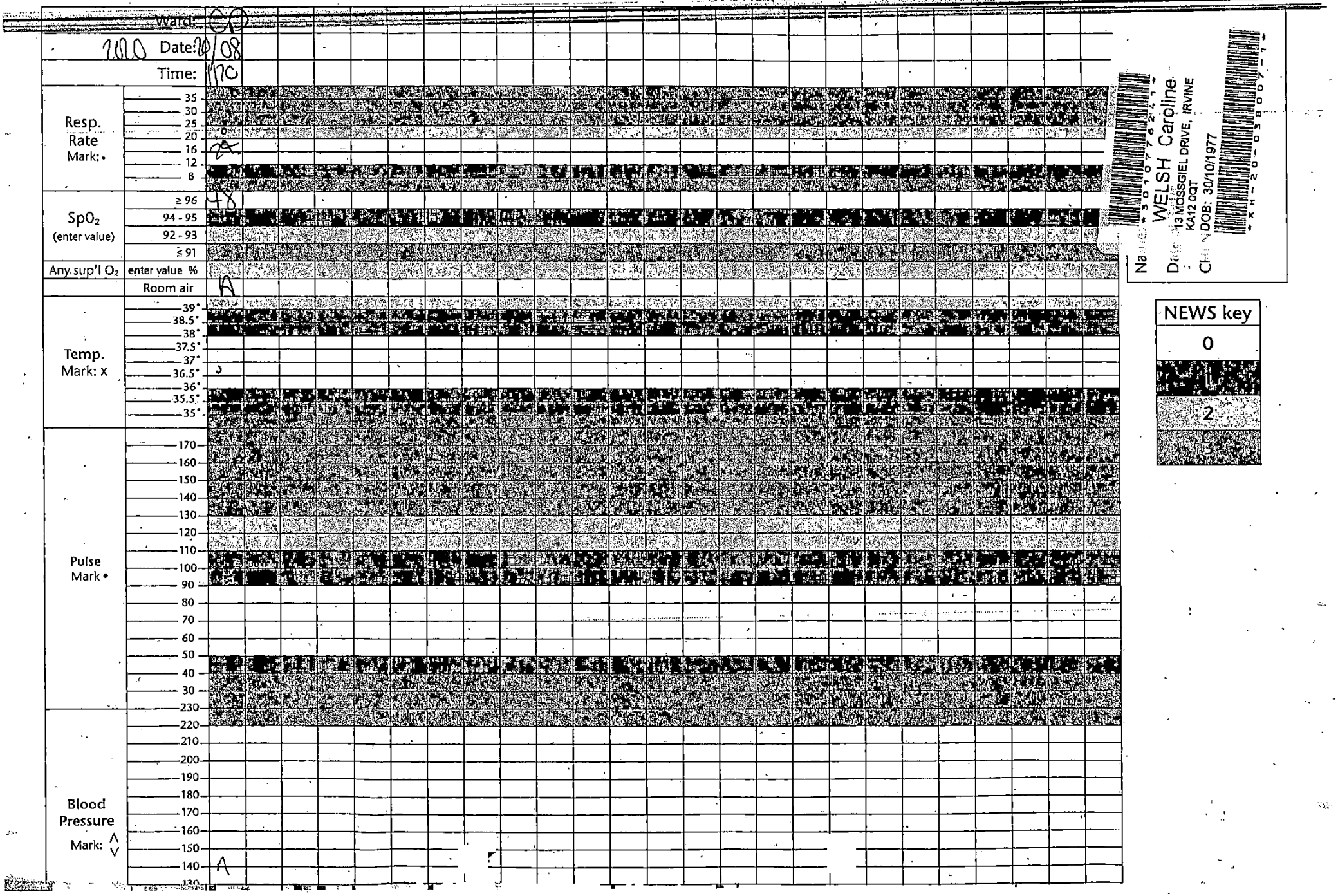
News score	Frequency of monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations
Aggregate 1-4	Minimum 4 hourly	• Inform trained nurse • Trained Nurse assessment - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate
Aggregate 5 or more *or* **any single red score**	Increase frequency to a minimum of 1 hourly	• Trained Nurse assessment • Inform medical team caring for the patient and dual response • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately • Inform medical team caring for the patient - this should be at least senior medical staff level. If unable to attend promptly, escalate to consultant or Emergency Response Team. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. • Consider referral to high dependency or ITU.

[redacted]

NEWS SCORE using Systolic BP	120		
	110		
	100		
	90		
	80		
	70		
	60		
	50		
Conscious Level. Mark: •	Alert	A	
	Verbal		
	Pain		
	Unresponsive		
Eyes Open	Spontaneous	4	
	To speech	3	
	To pain	2	
	None	1	
Best Verbal Response	Orientated	5	
	Confused	4	
	Inapp. words	3	
	Incomp. sounds	2	
	None	1	
Best motor response	Obeys commands	6	
	Localise pain	5	
	Withdrawal to pain	4	
	Abnorm. flexion to pain	3	
	Extension to pain	2	
	None	1	
GCS TOTAL			
PUPILS R	Size		
	Reaction		
PUPILS L	Size		
	Reaction		
LIMB MOVEMENT ARMS	Normal power		
	Mild weakness		
	Severe weakness		
	Spastic flexion		
	Extension		
	No response		
LIMB MOVEMENT LEGS	Normal power		
	Mild weakness		
	Severe weakness		
	Extension		
	No response		
Total NEWS (with all obs)		3	
Obs due			
Pain			
Nausea			
Initials		[illegible]	

Pupil size (mm)




Ward:
Date:
Time:
Resp. Rate Mark: •
35
30
25
20
16
12
8
SpO2 (enter value)
≥ 96
94 - 95
92 - 93
≤ 91
Any sup'l O2
enter value %
Room air
Temp. Mark: x
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse Mark •
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
Blood Pressure Mark: ^ v
WELSH Caroline
13 MOSSGIEL DRIVE, IRVINE
KA12 0QT
DOB: 30/10/1977
NEWS key
0
1
2

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10.

Use the diagram below to assist the patient if required. If the patient is unable to communicate, refer to an alternative pain scoring tool eg. Abbey, and use your clinical skills to determine level of pain severity.

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

Nausea and Vomiting	
0	None
1	Mild (Not distressing - no retching/vomiting)
2	Moderate (Troublesome - occasional retching/vomiting)
3	Severe (Distressing - frequent retching/vomiting)

Physiological Parameter	NEWS - NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate			9-11	12-20		21-24	
Oxygen Saturations		92 - 93	94-95	>96			
Any Supplementary Oxygen		Yes		No			
Temperature			35.1-36.0	36.1-38.0°	38.1-39	≥39.1	
Pulse			41-50	51-90	91-110	111-130	
Systolic BP		91-100	101-110	111-219			
Conscious Level				A			

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

Notes

NHS Ayrshire & Arran

Area Laboratory **Clinical Biochemistry**

WELSH,CAROLINE
13 Mossgiel Drive
Irvine
KA120QT

CHI No. 3010776241
Unit No.
DOB 30/10/1977
Sex F

Clinician: Dr Thomas Hopkins
Request Location: XH Hosp. A&E Dept.

This report to : Dr Thomas Hopkins , XH Hosp. A&E Dept.

	Result	Units	Normal Range
CRP	<5	mg/L	2.0 - 10

1 AUG 2020

21 AUG 2020

EMERGENCY DEPARTMENT	
No Action	✓
Inform GP	
Inform Ward	
Phone Cancer Tracker	
Signature	J Mullig

Lab No 20B291274 Date Collected 21/08/20 00:00 Authorised By BHI W7AUQPRO Service Account

Printed 21/08/20 Time 21:11 Page 1 of 1

If you have received this report in error, please return to the Clinical Biochemistry Laboratory

NHS Ayrshire & Arran — **Area Laboratory Haematology**

WELSH,CAROLINE
13 Mossgiel Drive
Irvine
KA120QT

CHI No. 3010776241
Unit No.
DOB 30/10/1977
Sex F

Clinician: Dr Thomas Hopkins
Request Location: XH Hosp. A&E Dept.

This report to : Dr Thomas Hopkins , XH Hosp. A&E Dept.

	Result	Units	Normal Range
Prothrombin time	11	Seconds	9.0 - 12.0
APTT	26	Seconds	22.0 - 28.0
Fibrinogen	3.02	g/L	1.80 - 3.60
D-dimers	230	ng/mL	0 - 500
Note	Age adjusted D-Dimer is now in use in NHSA&A. This result has not been adjusted for age - please refer to ADTC 302 for guidance.		

21 AUG 2020

EMERGENCY DEPARTMENT

No Action	✓
Inform GP	
Inform Ward	
Phone Cancer Tracker	
Signature	JMulligs

Lab No 20B291274 — Date Collected 21/08/20 00:00 — Authorised By Julie Logan
Printed 21/08/20 05:19 — Sample Type Blood — Page 1 of 1

If you have received this report in error, please return to the Haematology Laboratory

SIMS717

NHS Ayrshire & Arran — **Area Laboratory Haematology**

WELSH,CAROLINE
13 Mossgiel Drive
Irvine
KA120QT

CHI No. 3010776241
Unit No
DOB 30/10/1977
Sex F

Clinician Dr Thomas Hopkins
Request Location XH Hosp A&E Dept

This report to : Dr Thomas Hopkins , XH Hosp A&E Dept

		Result	Units	Normal Range
Haemoglobin		130	g/L	122 - 165
White Cell Count	High	14.5	10*9/L	3.9 - 11.1
Platelets		264	10*9/L	150 - 400
RBC		4.08	10*12/L	3.88 - 4.99
Haematocrit		0.38	%	0.36 - 0.48
MCV		93	fL	82 - 98
MCH		31.9	pg	27.3 - 32.6
MCHC		342	g/L	316 - 349
Neutrophils	High	9.8	10*9/L	1.8 - 7.4
Lymphocytes		3.6	10*9/L	1.1 - 5.0
Monocytes	High	1.0	10*9/L	0.2 - 0.9
Eosinophils		0.1	10*9/L	0.1 - 0.7
Basophils		0.1	10*9/L	0.0 - 0.1

EMERGENCY DEPARTMENT	
No Action	✓
Inform GP	
Inform Ward	
Phone Cancer Tracker	
Signature	

21 AUG 2020

Lab No 20B291274 — Date Collected 21/08/20 00:00 — Authorised By BHI W7AUQPRO Service Account

Printed 21/08/20 05:19 — Sample Type Blood — Page 1 of 1

If you have received this report in error, please return to the Haematology Laboratory

STAS712

Department of Radiology

NHS Ayrshire & Arran

Accident & Emergency Dept
Crosshouse hospital
Kilmarnock Road
Kilmarnock
KA2 0Be

RADIOLOGY REPORT

CHI NUMBER: 3010776241 **Examination Number:** 38569774 **Examination Date:** 20/08/2020
Name: WELSH, CAROLINE DOB: 30/10/1977
Address: 13 MOSSGIEL DRIVE, AYRSHIRE, IRVINE, KA12 0QT – CC: -

Referring Department / Location: Accident & Emergency
Crosshouse Hospital
Kilmarnock Road
Crosshouse
Ayrshire
KA2 0BE

Referring Consultant: Dr. C. McGuffie **Clinical Specialty:** Accident & Emergency

Date Dictated: 28/08/2020 **Typed by:** None

Examination: XR Chest

Clinical Indication

acute onset left sided chest pain r/o pneumothorax

Report:

The lungs and pleural spaces are clear. No evidence of pneumothoraces. Cardiomediastinal contours are normal. The bony thoracic cage is also normal.

Dictating Radiologist / Clinical Specialist **Ramachandran, Pothera (Loc)**

Verified by: Ramachandran, Pothera (Loc)

Fac.

Mr J Stevenson
E.D. Consultant
G.M.C. 2921812

Examination Number: 38569774 **Examination Date:** 20/08/2020
Name: WELSH, CAROLINE DOB: 30/10/1977
Dose :- 1.07 dGy cm2

To F Hamilton
Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

University Hospital Crosshouse
Emergency Department
Crosshouse Hospital, Kilmarnock
KA2 0BE
Tel: 01563 827751 / 827762

DUTY CONSULTANT: 0

PATIENT DETAILS

Patient name	**Caroline Welsh**
CHI Number	3010776241
DOB	30/10/1977
Address	9 ST. MICHAELS PLACE KILWINNING AYRSHIRE KA13 6FA

ATTENDANCE DETAILS

Attendances prev12mths	0
Total Attendances	7
Arrival Date & Time	22/04/2016 at 09:35
Attendance Number	XH-16-024720-1
Diagnosis	Back pain

Drugs:

Treatment	Advice
Investigations	
Additional Information	Ongoing back pain, has been seeing GP, back pain now improving. Woke last night with one episode of small volume urinary incontinance . There were no concerning features on examination today and no further incontinance. It was noted she has been feeling tired since starting oxycodone. As her pain is under control she was advised to try simple analgesia such as paracetamol and ibuprofen initially. Advised of worsening signs and when to seek help. Will attend GP in one week to discuss ongoing chronic back pain.

DISCHARGE DETAILS

Discharge Date & Time	22 Apr 2016 11:0711:07
Left Dept. Date & Time	22 Apr 2016 11:05
Outcome	Discharge, Primary Care follow up Usual place of residence 0
Further Referral	
Child Protection	
Adult Protection/Concern	
Clinician Seen	CIARA O'BRIEN FY2

DAGSHAGIEN

RMS

CROSSHOUSE HOSPITAL
EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

A/E No: **XH-16-024720-1**

CHI No: **3010776241**

Date: **22 Apr 2016** Time: **09:35**

Consultant: **Dr Joanne Mulligan**

GP
Dr. WD CAMPBELL
BOURTREEHILL MEDICAL PRACTICE
THE HEALTH CENTRE
CHEVIOT WAY
IRVINE
KA11 1JU

Incident Date: **22 Apr 2016**
Incident Time: **09:35**

Martial Status: **Married / civil partner**

Sex: **F**

Ethnicity Scottish

Religion None

Attendances in last 12mths **1**

Total Attendances Count **4**

Special case

WELSH
Caroline

Date of Birth: **30 Oct 1977** Age: **38 Years**

Address:
26 LEWIS TERRACE
IRVINE

Phone Numbers:
Home: 215887

Employer/School
nac Not at School

Next of Kin:
Welsh
26 LEWIS TERRACE
IRVINE

Partner
Home Tel: 07930244113

Accompanied By:
Husband

Triage Time 09:52 **Triage Nurse** Audrey Wallace **Triage Group** Yellow

Resp Rate | 02 Sat% | PFR

Pulse | BP | E M V

Allergies: **Not Known**

BMstix | **Alcohol** | **Temp** | **Weight**

Visual Acuity R L

Pain Score (Triage) 97

Pain Score (Discharge)

Triage details
seen by gp last week re chronic backpain, last night incontinent of urine

Treatment
NONE

Special Needs
NONE

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed.....Witness.....Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....

Disch | A+E clinic | Paed Tr. # | cyc | ENT | Max Facial | Ward OP | Ward IP

3010776241

A/E No. XH-16-024720-I

Drug	Dose	route	time/frequency	signature	quantity/given by

PVC1	Size/Colour	Location	Initials	PVC2	Size/Colour	Location	Initials

	Device	Flow Rate l/min	%O2 for Venturi	Target SpO2	Prescribed by	Started by	Stopped by
Oxygen							
Changed to							

DOCTOR / ENP: C.O'BRIEN F42 Time: 10.30

38yr ♀ Back pain

Background: chronic back pain for last 10yrs
last week → worse pain → lower spine + shooting down legs, felt stiff + kept seizing up.
Seen by GP → oxycodone + diazepam.
back pain + stiffness has been improving.
last night → woke up + had been incontinant of urine
Now no further incontinance. No pain passing urine
feels systemically well. No loss of bowel control. No saddle anaesthesia
No numbness/tingling in legs/feet.
able to walk → relieves pain.

PMHx → Previous hysterectomy + urolene tape. 7yr ago.
↳ no incontinance since

DHx

SHx Care worker.

Off alert

good RoM on thoracic + lumbar spine
No pain on palpation spinous processes.
Straight leg raise to ~90° - no back pain.
(N) sensation in Lower Limbs.
(N) Power Lower Limbs.
(N) reflexes bilaterally.

Urinalysis - Negative.
apyrexial.
obs satisfactory.

Discharge

No ongoing red flag symptoms, no concerns on exam.
D(H) with advice

NHS Ayrshire & Arran

MEWS CHART

(with Neuro - Observations)

Write or attach label	
HCR No:	
CHI No:	[illegible]
Surname:	
Forename:	[illegible] Sex:
Address:	
Date of Birth	

DATE	12/4/16																								
TIME (24 hour clock)	09:55																								
Temperature (°C)	40																								40
	39																								39
	38																								38
	37																								37
	36																								36
	35																								35
BLOOD PRESSURE	210																								210
	200																								200
	190																								190
	180																								180
Record this way	170																								170
	160	A																							160
	150	|																							150
	140	|																							140
	130	|																							130
	120	|																							120
	110	|																							110
	100	√																							100
	90																								90
	80																								80
	70																								70
Record this way	60																								60
	50																								50
HEART RATE	40																								40
	30																								30
Respiratory Rate		20																							
O_2		A																							

Saturation	99

MEWS SCORE for EACH of the INDIVIDUAL OBSERVATIONS

Temperature (°C)	0
BP (Systolic)	0
Heart Rate	0
Respiratory Rate	0
S_PO_2	0
Urine Output	0
CNS	0

MEWS SCORE - TOTALS

Record the total MEWS scores for each set of observations this way

6	
5	
4	
3	
2	
1	
0	/

Sedation Score	0
Pain Score (On Movement)	2
Nausea Score	0

C Eyes Open	Spontaneously	4	/
	To speech	3	
	To pain	2	
	None	1	
C Best Verbal Response	Orientated	5	/
	Confused	4	
	Inaprop. words	3	
	Incomp. sounds	2	
	None	1	
C Best Motor Response	Obeys commands	6	/
	Localise pain	5	
	Withdrawl to pain	4	
	Abnormal flexion to pain	3	
	Extension to pain	2	
	None	1	
	GCS TOTAL		15/15

PUPILS	R	Size
		Reaction
	L	Size
		Reaction

LIMB MOVEMENTS	ARMS	Normal power
		Mild weakness
		Severe weakness
		Spastic flexion
		Extension
		No response
	LEGS	Normal power
		Mild weakness
		Severe weakness
		Extension
		No response

PUPIL SCALE (mm)

1 2 3 4 5 6 7 8

Initials	AW

STA4202

To F Hamilton
Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

University Hospital Crosshouse
Emergency Department
Crosshouse Hospital, Kilmarnock
KA2 0BE
Tel: 01563 827751 / 827762

DUTY CONSULTANT: DR DAVID CHUNG

PATIENT DETAILS

Patient name	**Caroline Welsh**
CHI Number	3010776241
DOB	30/10/1977
Address	9 ST. MICHAELS PLACE KILWINNING AYRSHIRE KA13 6FA

ATTENDANCE DETAILS

Attendances prev12mths	0
Total Attendances	7
Arrival Date & Time	03/01/2012 at 14:55
Attendance Number	XH-12-000538-1

Diagnosis

Drugs:
Treatment
Investigations
Additional Information

DISCHARGE DETAILS

Discharge Date & Time	03 Jan 2012 15:3715:37
Left Dept. Date & Time	
Outcome	Admitted 0 GP admission
Further Referral	
Child Protection	

Adult Protection/Concern
Clinician Seen

1755

RM4

CROSSHOUSE HOSPITAL
EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

A/E No: **XH-12-000538-1**

CHI No: **3010776241**

Date: **03 Jan 2012** Time: **14:55**

Consultant: **Dr David Chung**

GP
WILLIAM WD CAMPBELL
BOURTREEHILL MEDICAL PRACTICE
BOURTREEHILL HEALTH CENTRE
01294 211993

Incident Date: **03 Jan 2012**
Incident Time: **14:55**

Martial Status: **Married / civil partner**

Sex: **F**

Religion None

Attendances in last 12mths **0**

Total Attendances Count **2**

WELSH
Caroline

Date of Birth: **30 Oct 1977** Age: **34 Years**

Address:
26 LEWIS TERRACE
IRVINE

Phone Numbers:
Home: 215887

Employer/School
nac

Next of Kin:
Welsh
26 LEWIS TERRACE
IRVINE

Partner
Home Tel: 215887

Accompanied By:
Husband

Special case

Triage Time 15:03 **Triage Nurse** Elaine McIlwraith **Triage Group** Yellow

Resp Rate	02 Sat%	PFR
16	98	

Pulse	BP	E	M	V
110	163 /93			

Allergies: **Not Known**

BMstix	Alcohol	Temp	Weight
		37.2	

Visual Acuity R L

Pain Score (Triage)

Pain Score (Discharge)

Triage details -2834
Abdo pain and PV bleeding. Gyn review. Casenotes requested.

BETA HCG -VE

Treatment
NONE

Special Needs
NONE

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed.....Witness.....Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....

Disch A+E clinic Paed Tr.. # eye ENT Max Facial Ward OP Ward IP

XH-12-000538-1

WA206

NHS 24 FAX REPORT

NHS 24 ID:	Call ID: 11101306	**Site:**	Orkney
CHI #:	3010776241	**Caller Name:**	
Surname:	WELSH	**Date/Time Call Received:**	03/01/2012 14:03
Forename:	CAROLINE		
DOB:	30/10/1977	**Date Call Completed:**	
Gender:	Female	**Time Call Completed:**	
Address:	26 Lewis Terrace	**Call Priority:**	CS0
	Broomlands	**Call Reason:**	PV BLEEDING WORSENING 10 MIN SEE AV
	Irvine	**Current Location:**	26 Lewis Terrace
			Broomlands
	Ayrshire/KA11 1HJ		Irvine
PH NO:	07875530530 (Return)		Ayrshire/KA11 1HJ
		Special Directions:	Front Door
		Current PH NO:	07875530530 (Return)
Care Provider:	NELSON, JAGBIR	**Care Provider Details:**	THE HEALTH CENTRE
			CHEVIOT WAY
			BOURTREEHILL,IRVINE
			KA11 1JU
			Scotland
Temporary Resident:	No		

Referred To:	AYRSHIRE & ARRAN Hub	**Recommended Action:**	Pt advised to go to A&E - For Information Only

CLINICAL SUMMARY

HEAVY PV BLEEDING FOR 3/7 AND WORSENING,RETURN CALLER, STOOD FROM TABLE FLOODED THROUGH CLOTHES, LARGE CLOTS BRIGHT RED BLOOD, SHAKY AND TEARY, PAIN IN LOWER ABDO AND BACK. IS TAKING TRANEXAMIC ACID, HAS SOAKED THROUGH 4 PADS SINCE 10.30AM, VAGINAL EXAMINATION ON FRIDAY, VERY ANXIOUS AS DOES NOT WANT TO BE EMBARRESSED IN WAITING ROOM, OUTCOME A&E ASAP

PAST MEDICAL HISTORY

MEDICAL PROBLEMS

THROAT NODULES, PELVIC FLOOR REPAIR

MEDICATIONS

NIL

ALLERGIES

NIL

Referred Clinical Notes:

T:
P:
R:
BP:

Print Name: **Signature:**

466693

NHS Ayrshire & Arran

MEWS CHART

(with Neuro - Observations)

Write or attach label

HCR No:

CHI No:

Surname: Welsh

Forename: Caroline Sex:

Address:

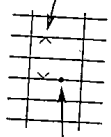
Date of Birth

DATE	5/12
TIME (24 hour clock)	1505

Temperature (°C): 40, 39, 38, 37, 36, 35

BLOOD PRESSURE: 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30

Record this way



Record this way

HEART RATE

Respiratory Rate	16
O_2	A
Saturation	98

MEWS SCORE for EACH of the INDIVIDUAL OBSERVATIONS

Temperature (°C)	0																												
BP (Systolic)	0																												
Heart Rate	1																												
Respiratory Rate	0																												
SpO_2	0																												
Urine Output	0																												
CNS																													

MEWS SCORE - TOTALS

Record the total MEWS scores for each set of observations this way

3																													
2																													
1																													
0																													

Sedation Score	0																												
Pain Score (On Movement)	2																												
Nausea Score	0																												

C	Eyes Open	Spontaneously	4																										
		To speech	3																										
		To pain	2																										
		None	1																										
M	Best Verbal Response	Orientated	5																										
		Confused	4																										
		Inaprop. words	3																										
		Incomp. sounds	2																										
S		None	1																										
C	Best Motor Response	Obeys commands	6																										
		Localise pain	5																										
		Withdrawl to pain	4																										
		Abnormal flexion to pain	3																										
		Extension to pain	2																										
E		None	1																										
		GCS TOTAL																											
PUPILS	R	Size																											
		Reaction																											
	L	Size																											
		Reaction																											
LIMB MOVEMENTS	ARMS	Normal power																											
		Mild weakness																											
		Severe weakness																											
		Spastic flexion																											
		Extension																											
		No response																											
	LEGS	Normal power																											
		Mild weakness																											
		Severe weakness																											
		Extension																											
		No response																											

STA4202

Initials	AM																												

PUPIL SCALE (mm)

1 2 3 4 5 6 7 8

To F Hamilton
Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

University Hospital Crosshouse
Emergency Department
Crosshouse Hospital, Kilmarnock
KA2 0BE
Tel: 01563 827751 / 827762

DUTY CONSULTANT: DR DAVID CHUNG

PATIENT DETAILS

Patient name	**Caroline Welsh**
CHI Number	3010776241
DOB	30/10/1977
Address	9 ST. MICHAELS PLACE KILWINNING AYRSHIRE KA13 6FA

ATTENDANCE DETAILS

Attendances prev12mths	0
Total Attendances	7
Arrival Date & Time	27/12/2009 at 17:05
Attendance Number	XH-09-065503-1
Diagnosis	DVT ? Lower leg Left

Drugs:

Treatment	Assessed and referred
Investigations	X-Ray Chest
Additional Information	?dvt admitted to cdu

DISCHARGE DETAILS

Discharge Date & Time	28 Dec 2009 16:5916:59
Left Dept. Date & Time	27 Dec 2009 20:40
Outcome	Admitted 0 0 CDU
Further Referral	
Child Protection	
Adult Protection/Concern	
Clinician Seen	SUMIT GAJREE ED SHO

CROSSHOUSE HOSPITAL
EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

A/E No: XH-09-065503-1

CHI No: 3010776241

Date: 27 Dec 2009 Time: 17:05

Consultant: Dr David Chung

GP: W Campbell
BOURTREEHILL HEALTH CENTR
CHEVIOT WAY

Incident Date: 27 Dec 2009
Incident Time: 17:05

Martial Status: Married / civil partner

Sex: F

MORRIN
Caroline

Date of Birth: 30 Oct 1977 Age: 32 Years

Address:
26 LEWIS TERRACE
IRVINE

Next of Kin:
Brian Welsh
26 LEWIS TERRACE
IRVINE

Partner
Home Tel: 215887

Religion: None

Previous Attendance Count: 1

Phone Numbers:
Home: 215887

Employer/School
nac

Accompanied By:
Partner

Special case

Triage Time 17:16 Triage Nurse Carol McNeil Triage Group Yellow

Resp Rate 12 02 Sat% 98 PFR

Pulse 96 BP 136/82 E M V

Allergies: Not Known

BMstix Alcohol Temp 37.5 Weight

R L Pain Score (Triage) Pain Score (Discharge)

Triage details
pt with painful lt calf. nhs 24 referral ? DVT

Treatment
Advice - verbal

Special Needs
NONE

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed..... Witness..... Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....

Disch A+E clinic Paed Tr. # eye ENT Max Facial Ward OP Ward IP

XH-09-065503-1

Drug	Dose	route	time/frequency	signature	quantity/given by

DOCTOR / ENP: JUMIT GAJREE Time: 7.20 pm

See DVT COU sheet

Clinical Decisions Unit (CDU)
Suspected Deep Venous Thrombosis (DVT)- Ambulatory Care

Patient Addressograph

MORRIN Caroline

28 LEWIS TERRACE, IRVINE

DOB 30/10/1977

Date & Time of arrival in A/E- 27/12/2009 17:05

Date & Time of arrival in CDU-

Date & Time left CDU

- ☐ Discharged
- ☐ Admit Medical/ Resp
- ☐ Admit HDU
- ☐ Admit other speciality

Please ensure that the patient fits the criteria for pathway management as outlined below

Inclusion Criteria (Ambulatory Care Management)	☑ Clinical suspicion of Deep Venous Thrombosis ☐ **Thrombophlebitis with clinical suspicion of DVT- must have d-dimer performed**
Exclusion criteria (requires admission to AMAU)	☐ Unable to attend as OP- immobility, no contact number, cognitive impairment- discuss with CDU staff if unsure ☐ Pregnancy (with discretion) ☐ Severe, uncontrolled hypertension (with discretion) ☐ Massive leg swelling and suspected PTE (consider PTE pathway) ☐ Significant active co- morbid disease ☐ Known bleeding tendency- discuss management with haematologist ☐ **Rule out Charcot's joint in patients with diabetes** **Please note that patients from Nursing Home care are singularly not excluded from Ambulatory Care- discuss with Clinical Decisions Unit staff.**

MORRIN Caroline
26 LEWIS TERRACE, IRVINE
DOB: 30/10/1977

Management Protocol- Ambulatory Care

Presentation	**Suspected Deep Venous Thrombosis**
Management in A&E	☑ Assessment by Medical Staff; Review history and examination **Investigations:** ☑ Venepuncture- FBC; U&E's; D-dimer; LFT's; ESR; CRP; Blood glucose **Observations:** ☑ MEWS; Pain Score **Medical Management** ☑ Wells Clinical Probability Score; Analgesia
Management in CDU	**Observations:** ☐ MEWS; Pain Score; Calf measurements ☐ Weight (in kgs)- **Investigations:** ☐ Venepuncture- FBC; U&E's; D-dimer; LTF's; ESR; CRP; Blood glucose; ☐ MRSA screen **Treatment:** ☐ Wells Clinical Probability Score ☐ Risk Factor Stratification **Assign probability score and apply to the Decision Flowchart for suspected DVT on page 4.**
Criteria for admission (at any time)	☐ Patient develops any of the exclusion criteria on page 1 ☐ Unstable patient ☐ Discuss abnormal blood results

MORRIN Caroline
28 LEWIS TERRACE, IRVINE
DOB: 30/10/1977

Discharge Criteria- Ambulatory Care

Criteria for discharge from the DVT service (after any review)

☐ Low/ moderate Clinical Probability Score combined with a D-Dimer < 500 (consider alternative diagnosis prior to discharge)

☐ Ultrasound scan negative ☐ Rescan negative

Differential diagnosis, please treat as:

Refer to rheumatology	Yes/ No	Arterial insufficiency	Yes/ No
Cellulitis	Yes/ No	IV/oral antibiotics	Yes/ No
Superficial thrombophlebitis	Yes/ No	Refer to vascular surgery	Yes/ No
Musculoskeletal	Yes/ No	No further investigation	Yes/ No
Refer to G.P	Yes/ No	Other (please specify)	

Please note Bakers Cyst diagnosis should follow the complete treatment plan as a suspected DVT and is not on first scan an alternative diagnosis.

☐ Patient advised of diagnosis and treatment plan ☐ Painfree with/ without analgesia

☐ Letter to G.P. ☐ Social circumstances permit discharge

Criteria for discharge from DVT service- Positive DVT

Patients with a positive diagnosis of DVT should meet the following criteria prior to discharge from the DVT out-patient service:

☐ INR >/ = 2 for two consecutive days

☐ Counselling on warfarin therapy has taken place

☐ Warfarin dose prescribed for discharge ☐ Painfree with/ without analgesia

☐ Patient is compliant and safe with warfarin therapy

☐ Appointment made for anticoagulant clinic/ follow up arrangements made with GP/ District Nurse

☐ Patient advised of diagnosis and treatment plan ☐ Assess need for thrombophilia screen

☐ Letter to G.P. ☐ Social circumstances permit discharge

Criteria for discharge from DVT service- Positive DVT unable to warfarinise

Patients with a positive diagnosis of DVT who have been assessed as unsafe to be anticoagulated with warfarin should meet the following criteria prior to discharge from the DVT out-patient service:

☐ Identify competent other responsible for administration of daily LMWH injection or education on self administration

☐ Two week supply of Low Molecular Week Heparin ☐ Painfree with/ without analgesia

☐ Appointment made for first platelet check after 7- 10 days of daily LMWH injections.

☐ Patient advised of diagnosis and treatment plan ☐ Assess need for thrombophilia screen

☐ Letter to G.P. ☐ Social circumstances permit discharge

District Nurse/ Nursing Home anticoagulation

If District Nurse continuing anti- coagulation

☐ Appropriate supply of LMWH injections ☐ Copy of prescription

☐ Copy of immediate discharge prescription ☐ Painfree with/ without analgesia

☐ Communication with DN/ Nursing Home re; management plan

☐ Patient advised of diagnosis and treatment plan ☐ Assess need for thrombophilia screen

☐ Letter to G.P. ☐ Social circumstances permit discharge

Reviewed by Ashley Strannigan Dec 2009

Determining the clinical probability of DVT (Well's criteria)

Left Calf (cm)	Right Calf (cm)
46.5	46.0

Criteria	Points	Score	Points	Score
Active Cancer (treatment ongoing or within previous 6 months or palliative)	1	0	1	
Paralysis, paresis or recent plaster immobilisation of lower extremities	1	0	1	
Recently bedridden for more than 3 days or major surgery within last 4 weeks	1	1	1	
Localised tenderness along distribution of deep venous system	1	1	1	
Entire leg swelling	1	0	1	
Calf swollen by > 3cm compared to asymptomatic leg (10cm below tibial tuberosity)	1	0	1	
Pitting oedema (greater in symptomatic leg)	1	0	1	
Collateral superficial veins (non varicose)	1	0	1	
Pregnant or on OCP/HRT	1	0	1	
Previous DVT/PTE	1	0	1	
Alternative diagnosis as likely or greater than that of DVT	-2		-2	
TOTAL SCORE		2		

Interpretation of Well's criteria score:

Score (points based on Well's score)	Probability of DVT
> or = 3	High
1 – 2	Moderate
0	Low

Wells Score 1 2 Date/ Time 27/12/2009 1920

Name SUMIT GANGEE PMP Signature

Wells Score 2 _____ Date/ Time _____

Name _____ Signature _____

Reviewed by Ashley Strannigan Dec 2009

XH-09-065503-1
MORRIN Caroline
26 LEWIS TERRACE, IRVINE
DOB: 30/10/1977
3010776241

Suspected DVT– Decision Flowchart

LOW [ ] MODERATE [✓] HIGH [ ]

Please proceed management of the patient using the decision flowchart based on the clinical probability assigned by the Wells Clinical Probability Score and D- Dimer result.

Possible DVT

Assess suitability for out-patient management

Assess Wells Clinical Probability Score

Low/moderate

High

D-dimer negative

D-dimer Positive

D-dimer positive or negative

DVT excluded. Consider alternative diagnosis

Treat as DVT and arrange Ultrasound scan

- Patients with a mod/high Well's score should be rescanned if 1st scan negative (irrespective of d-dimer result).
- High probability group **only** to receive LMWH until rescan.

Negative Diagnosis for DVT

Positive Diagnosis for DVT

Consider review of this patient if no definitive diagnosis is made prior to discharge at any part of the patients journey.

Assess patient suitability for warfarin anticoagulation.
If patient is assessed unable to be anti- coagulated with warfarin please refer to the attached guideline for the management of this patient group.

Every patient with diagnosis positive for DVT should be considered and assessed for RAL Standard Class 2 Graduated Compression Stockings. See guideline and assessment flowchart.

Consider the need for thrombophilia screening after completion of anti- coagulation treatment.

Reviewed by Ashley Strannigan Dec 2009

Ensure the appropriate patient information leaflet is g
journey.

MORRIN Caroline
26 LEWIS TERRACE, IRVINE
DOB: 30/10/1977

Medical Notes – Deep Venous Thrombosis

If the patient is assessed as being unsafe/ at risk of incompliance with warfarin therapy please refer to the attached guideline for the management of this patient group- IVDA's; Alcohol Abuse; Cognitive Impairment; Poor Venous Access; at risk of falls; Active cancer or active treatment of cancer.

Date and time 19.20 27/12/09

Presenting complaint
Pain in (L) calf for 3 days. °radiation slight swelling. dull ache constantly present.
°cough, °CP, °SOB
can walk fine. can also expd pain in lower thigh

Past Medical history

Past History
Recent pelvic floor operation 24/11/2009
not been wearing teds
has been mobile.
previous laparotomy/ appendicectomy

Previous admissions with ?DVT	☐ Yes	☑ No
Previous admissions with proven DVT	☐ Yes	☑ No
Previous admission with proven PE	☐ Yes	☑ No
Previous admissions to CDU	☐ Yes	☑ No
Other – please specify	☐ Yes	☐ No

Smoker	Reason not for warfarin therapy	POD's Yes/ No Consent to use POD's Yes/No
NO	NO	

Risk factors for Deep Venous Thrombosis

Risk factors	Yes	No	Comments
History of immobilisation		✓	
Recent surgery (within the past 4 weeks, note type of surgery)	✓		Pelvic floor surg (GA)
Cancer (within the past 6 months or on palliative care)		✓	
Lower limb problems (trauma or mobility problems eg. Paralysis)		✓	
Pregnancy or < 6 weeks post natal		✓	
Medical illness		✓	
Thrombophilia (eg. Protein S, Factor V Leiden)		✓	
Strong family history of DVT/PE		✓	
Previous history of objectively diagnosed DVT/PE		✓	
Oestrogen containing contraceptive pill or hormone replacement therapy		✓	
IV drug use		✓	
Recent long journey (in last 4 weeks) - > 6 hours in duration		✓	

NHS Ayrshire & Arran

Multidisciplinary Medicines Recor

Must be started by Admitting Clinician

MORRIN Caroline
26 LEWIS TERRACE, IRVINE
DOB: 30/10/1977

Source of Information (Use at least two sources) (Tick)

Patient	✓	Emergency Care Summary	
Relative/Carer		Nursing Home Chart	
Patient's Own Drugs		Previous Discharge Letter	
GP Referral Letter		Repeat Prescription slip	
GP Practice		Other (Please state)	

Admission Medicines

Name, Form, Route (specify if not oral)	Dose	Frequency	Action: Suspend	Amend	Stop	Comments (if medicine suspended, amended stopped or inaccurate)	Pharm Initials
NIL NK							

Action Note: Unless otherwise indicated below, medicine should be continued on prescription sheet

OTC/ Herbal/ homeopathic/ illicit substances	Further information eg compliance aid, recent discontinued medicines

Adverse Reactions/Allergies

None Known ☑

Medicine/ Substance	Reaction

Are you satisfied this medication history is complete and accurate? Yes ☑ No ☐

If **No** what further action is necessary (Contact GP etc) ..... Tick when resolved ☐

Reviewed by Ashley Strannigan Dec 2009

MORRIN Caroline
26 LEWIS TERRACE, IRVINE
DOB: 30/10/1977

Examination Findings

Date and Time: 27/12/09 19[2r]

General: looks comfortable
RR 12 SpO2 98% A. HR 96 BPM (N) 136/82 37°

Chest: clear
good air
nil added

CVS: HR I + II + 0
JVP ←

Abdomen: overweight
appendix scar
soft + non-tender
guarding

Other: (L) ? slightly more swollen than (R)
not red + not tender
size (L) = 46.8 size (R) = 46.0

Impression/Diagnosis

? DVT

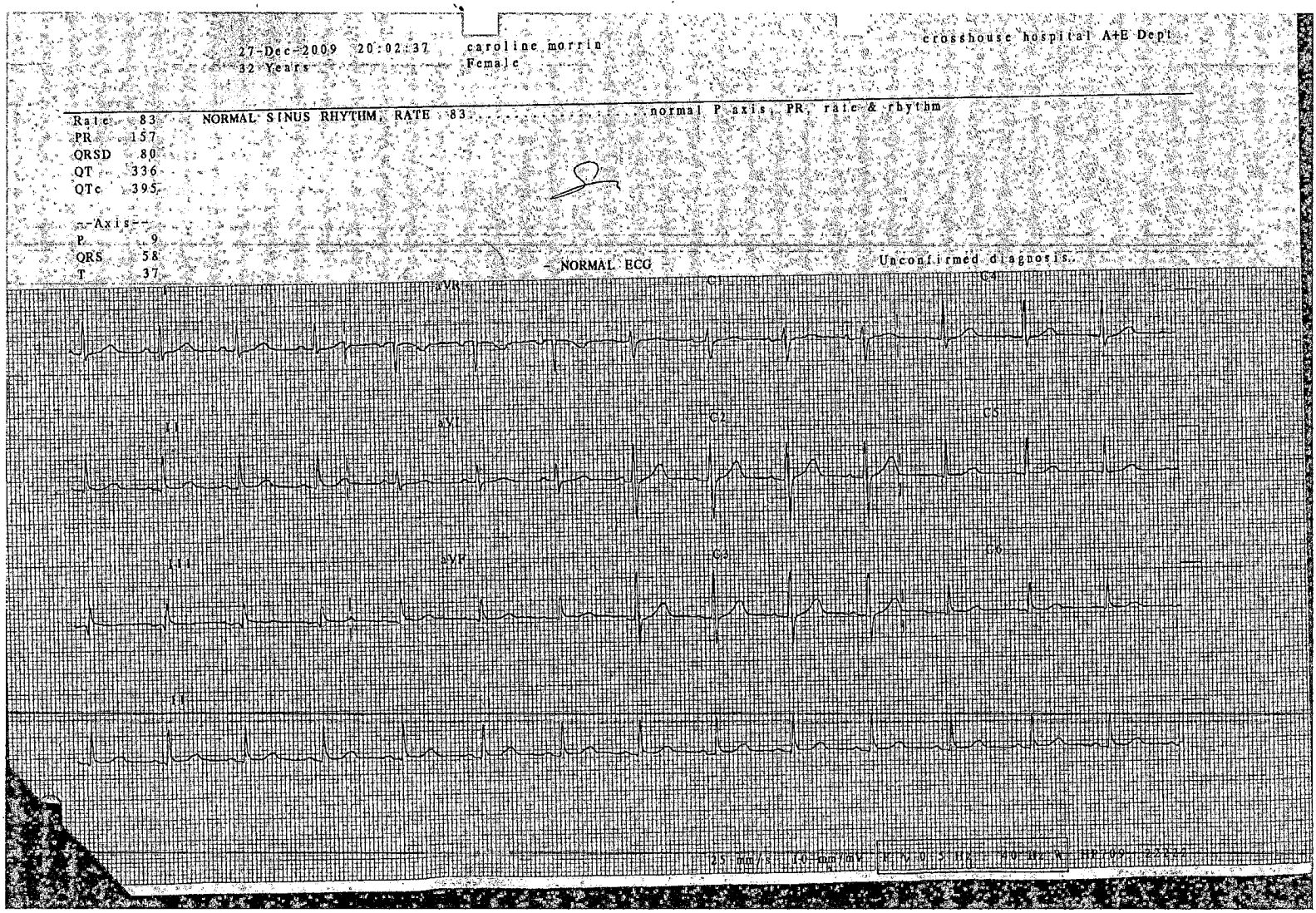
home if D-dimer -ve

Management Plan

1. IV access + bloods inc d-dimer
2. CXR, ECG → Sinus rate 83
3. → Nil focal → nil acute
4.

Signature: ..... Print Name: SUMIT GARG Page No: .....

Date: 27/12/09 Time: 1940


27-Dec-2009 20:02:37
32 Years
caroline morrin
Female
crosshouse hospital A+E Dept
Ratc 83
PR 157
QRSD 80
QT 336
QTc 395
--Axis--
P 9
QRS 58
T 37
NORMAL SINUS RHYTHM, RATE 83 ..... normal P axis, PR, ratc & rhythm
- NORMAL ECG -
Unconfirmed diagnosis..
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
25 mm/s 10 mm/mV
HP 0.9

MEDICAL IN CONFIDENCE

Admission Form V3

MEDICAL RECORD

HOSPITAL CODE	HOSPITAL NAME	Case Reference Number:
XHI	Crosshouse Hospital	XHI466693

ADM. DETAILS

DATE	TIME	TYPE	REASON	ADM/TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
27/12/2009	20:22:00	36	11	12	Inpatient	//		C

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E
CDU	Other (filler code)	Accident & Emergency	Dr D Chung		

PATIENT

TITLE	SURNAME	FORENAME(1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
Mrs	Morrin	Caroline		32	30/10/1977	F	M

ADDRESS 26 Lewis Terr
Irvine

ALT/PREV.SURNAME MORRIN

OCCUPATION

CHI No. 3010776241

POSTCODE KA11 1HJ TELEPHONE No. 01294 215887

OCCUPATION(HUSBAND/FATHER)

HEALTH BOARD RESIDENCE

HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

REF G.P.

NAME

G.P. CODE PRACTICE

CONTRACT No. FH STATUS

ADDRESS

TEL No. POSTCODE

REG G.P.

NAME Jagbir Nelson

G.P. CODE 3558018 PRACTICE GP Practice

CONTRACT No. FH STATUS

ADDRESS Bourtreehill Health Centre,
Cheviot Way,
Boortreehill,

TEL No. 01294 211993 POSTCODE KA11 1JU

NAME Brian Welsh

RELATIONSHIP Fiance

ADDRESS 26 Lewis Terr
Irvine

DAY PHONE.No. 01294215887 NIGHT PHONE.No.

MISC

RELIGION NONE

VISIT REQ. BY CHAPLAIN YES/NO
No

PENSION BOOK No.

Admission

MAIN DIAGNOSIS

SPECIAL WARNINGS

OTHER CONDITIONS (D.G.2)

OTHER CONDITIONS (D.G.3)

SMR04 SMR50

M.H. STATUS PREVIOUS PSYCH. CARE CONTRIBUTORY SOCIAL FACTOR

DISCHARGE SUMMARY

Requested by: Agnes Dempster 27 Dec 2009 20:23

DISCH. DETAILS

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
27/12/09						

DISCH./TRANSF. TO	READY FOR DISCH.	HOSPITAL NAME	CODE	WARD	SPECIALTY	CONSULTANT CODE
Home				CD4	Medical	chung

SMR04	TYPE OF CARE PROVIDED		ECT-1st TREATMENT DATE		ECT-NUMBER OF TREATMENTS	

DIAGNOSIS & OPERATIONS

		SPECIAL WARNINGS
MAIN DIAGNOSIS		
OTHER CONDITIONS (D.G.2)		
(D.G.2)		
(D.G.3)		
(D.G.4)		
(D.G.5)		
(D.G.6)		

	CODE	DATE
MAIN OPERATIONS		
OTHER OPERATION (O.P.2)		
(O.P.3)		
(O.P.4)		

LOCAL USE NATIONAL USE

MEDICAL IN CONFIDENCE

Admission Form V3

Chung Pic 26/1/12

MEDICAL RECORD

HOSPITAL CODE	HOSPITAL NAME	Case Reference Number:
XHI	Crosshouse Hospital	XHI466693

ADM. DETAILS

DATE	TIME	TYPE	REASON	ADM/TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
23/11/2009	14:33:00	11	11	10	Inpatient	10/9/2009	Inpatient	

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E
6	Other (filler code)	Gynaecology	Dr Wael Agur		

PATIENT

TITLE	SURNAME	FORENAME(1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
Mrs	Morrin	Caroline		32	30/10/1977	F	M

ADDRESS 26 Lewis Terr
Irvine

ALT/PREV.SURNAME MORRIN

OCCUPATION

CHI No. 3010776241

POSTCODE KA11 1HJ TELEPHONE No. 01294 215887

OCCUPATION(HUSBAND/FATHER)

HEALTH BOARD RESIDENCE

HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

REF G.P.

NAME Jagbir Nelson
G.P. CODE 3558018 PRACTICE GP Practice
CONTRACT No. FH STATUS

ADDRESS Bourtreehill Health Centre, Cheviot Way, Boortreehill,
TEL No. 01294 211993 POSTCODE KA11 1JU

REG G.P.

NAME Jagbir Nelson
G.P. CODE 3558018 PRACTICE GP Practice
CONTRACT No. FH STATUS

ADDRESS Bourtreehill Health Centre, Cheviot Way, Boortreehill,
TEL No. 01294 211993 POSTCODE KA11 1JU

NAME Brian Welsh
RELATIONSHIP Fiance

ADDRESS 26 Lewis Terr
Irvine

DAY PHONE.No. 01294215887 NIGHT PHONE.No.

MISC

RELIGION NONE

VISIT REQ. BY CHAPLAIN YES/NO
No

PENSION BOOK No.

Admission

MAIN DIAGNOSIS | SPECIAL WARNINGS
OTHER CONDITIONS (D.G.2)
OTHER CONDITIONS (D.G.3)

SMR04 SMR50

M.H. STATUS | PREVIOUS PSYCH. CARE | CONTRIBUTORY SOCIAL FACTOR

DISCHARGE SUMMARY

Requested by: Tracy Inglis 23 Nov 2009 14:33

DISCHARGE

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
27-11-09	10:10					

DISCH./TRANSF. TO	READY FOR DISCH.	HOSPITAL NAME	CODE	WARD	SPECIALTY	CONSULTANT CODE
Home						

SMR04	TYPE OF CARE PROVIDED		ECT-1st TREATMENT DATE		ECT-NUMBER OF TREATMENTS	

DIAGNOSIS & OPERATIONS

		SPECIAL WARNINGS
MAIN DIAGNOSIS		
OTHER CONDITIONS (D.G.2)		
(D.G.2)		
(D.G.3)		
(D.G.4)		
(D.G.5)		
(D.G.6)		

	CODE	DATE
MAIN OPERATIONS		
OTHER OPERATION (O.P.2)		
(O.P.3)		
(O.P.4)		

LOCAL USE | NATIONAL USE

MEDICAL IN CONFIDENCE

Admission Form V3

MEDICAL RECORD

	HOSPITAL CODE: XHI	HOSPITAL NAME: Crosshouse Hospital					CASE RECORD NUMBER: XHI466693		
ADM. DETAILS	DATE: 23/12/2007	TIME: 22:47:00	TYPE: 36	REASON: 11	ADM/TRANS. FROM: 10	INPAT./DAYCASE: Inpatient	DATE ON W.L.: //	W.L. TYPE	PATIENT CATEGORY
	WARD: 6	S. FACILITY: Other (filler code)	SPECIALTY: Gynaecology	CONSULTANT: Dr Elaine Melrose			FROM LOCATION	W.G.E	

PATIENT

TITLE	SURNAME	FORENAME(1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
Mrs	Morrin	Caroline		30	30/10/1977	F	M

ADDRESS: 26 Lewis Terr, Irvine

ALT/PREV.SURNAME: HARMON

OCCUPATION

C.H.I. NUMBER: 3010776241

POSTCODE: KA11 1EZ

TELEPHONE No.

OCCUPATION(HUSBAND/FATHER)

HEALTH BOARD RESIDENCE

HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

REF G.P.

NAME

G.P. CODE

PRACTICE

CONTRACT No.

FH STATUS

ADDRESS

TEL No.

POSTCODE

GP

NAME: Robert Wagner

G.P. CODE: 1462973

PRACTICE: GP Practice

CONTRACT No.

FH STATUS

ADDRESS: Bourtreehill Health Centre, Cheviot Way, Boortreehill,

TEL No.: 01294 211993

POSTCODE: KA11 1JU

NOK

NAME

RELATIONSHIP

ADDRESS

DAY PHONE.No.

NIGHT PHONE.No.

MISC

RELIGION: NK

VISIT REQ. BY CHAPLAIN YES/NO: No

PENSION BOOK No.

Admission

MAIN DIAGNOSIS		SPECIAL WARNINGS
OTHER CONDITIONS (D.G.2)		
OTHER CONDITIONS (D.G.3)		

SMR04

SMR50

M.H. STATUS	PREVIOUS PSYCH. CARE	CONTRIBUTORY SOCIAL FACTOR

DISCHARGE SUMMARY

Requested by: Agnes Dempster — 23 Dec 2007 22:48

DISCH. DETAILS							
	DATE: 24/12/07	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
	DISCH./TRANSF. TO: Home	READY FOR DISCH.	HOSPITAL NAME	CODE	WARD: 9	SPECIALTY: Gyn	CONSULTANT CODE: Melrose
	SMR04	TYPE OF CARE PROVIDED		ECT-1st TREATMENT DATE		ECT-NUMBER OF TREATMENTS	

DIAGNOSIS AND

MAIN DIAGNOSIS		SPECIAL WARNINGS
OTHER CONDITIONS (D.G.2)		
(D.G.2)		
(D.G.3)		
(D.G.4)		
(D.G.5)		
(D.G.6)		

MEDICAL IN CONFIDENCE

Admission Form V3

MEDICAL RECORD

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
XHI	Crosshouse Hospital	XHI1466693

ADM. DETAILS

DATE	TIME	TYPE	REASON	ADM/TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
23/12/2007	22:47:00	36	11	10	Inpatient	//		

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E
6	Other (filler code)	Gynaecology	Dr Elaine Melrose		

PATIENT

TITLE	SURNAME	FORENAME(1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
Mrs	Morrin	Caroline		30	30/10/1977	F	M

ADDRESS 26 Lewis Terr
Irvine

ALT/PREV.SURNAME HARMON

OCCUPATION

C.H.I. NUMBER 3010776241

POSTCODE KA11 1EZ TELEPHONE No.

OCCUPATION(HUSBAND/FATHER)

HEALTH BOARD RESIDENCE

HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

REF G.P

NAME
G.P. CODE PRACTICE
CONTRACT No. FH STATUS

ADDRESS
TEL No. POSTCODE

REG G

NAME Robert Wagner
G.P. CODE 1462973 PRACTICE GP Practice
CONTRACT No. FH STATUS

ADDRESS Bourtreehill Health Centre,
Cheviot Way,
Bourtreehill,
TEL No. 01294 211993 POSTCODE KA11 1JU

NOK

NAME

RELATIONSHIP

ADDRESS

DAY PHONE.No. NIGHT PHONE.No.

MISC

RELIGION NK

VISIT REQ. BY CHAPLAIN YES/NO
No

PENSION BOOK No.

Admission

MAIN DIAGNOSIS

OTHER CONDITIONS (D.G.2)

OTHER CONDITIONS (D.G.3)

SPECIAL WARNINGS

SMR04

SMR50

M.H. STATUS | PREVIOUS PSYCH. CARE | CONTRIBUTORY SOCIAL FACTOR

MH

DISCHARGE SUMMARY

Requested by: Agnes Dempster 23 Dec 2007 22:48

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
24/12/07						
DISCH./TRANSF. TO: Home	READY FOR DISCH.	HOSPITAL NAME	CODE	WARD 6	SPECIALTY GYN	CONSULTANT CODE MELROSE
SMR04	TYPE OF CARE PROVIDED		ECT-1st TREATMENT DATE		ECT-NUMBER OF TREATMENTS	

DIAGNOSIS AND

	SPECIAL WARNINGS
MAIN DIAGNOSIS	
OTHER CONDITIONS (D.G.2)	
(D.G.2)	
(D.G.3)	
(D.G.4)	
(D.G.5)	
(D.G.6)	

MEDICAL IN CONFIDENCE

ADMISSION FORM V3

MEDICAL RECOF

D/ROON

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
A111H	CROSSHOUSE HOSPITAL	XH2-466693

ADMISSION DETAILS

DATE	TIME	TYPE	REASON	ADM./TRANS. FROM	INPAT/DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
08/01/01	10:08	11	11	10 PRNAD	IP	01/12/00		1 3 NHS

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E.
5A	11	EAR, NOSE & THROAMR	P WARDROP		0

PATIENT

TITLE SURNAME	FORENAME (1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
MISS HARMON	CAROLINE		23	30/10/1977	F	

ADDRESS: 29(H) SLOAN AVENUE
IRVINE

ALT./PREV. SURNAME:

OCCUPATION:

C.H.I. NUMBER: 3010773188

POSTCODE: KA12 0HR

TELEPHONE No.: 01294204148

OCCUPATION (HUSBAND/FATHER):

HEALTH BOARD OF RESIDENCE: Ayrshire and Arran

HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

REF. G.P.

NAME	G.P. CODE	PRACTICE	CONTRACT No.	FH STATUS
MACDONALD E	1351903	8034411	SAC04	N

ADDRESS: TOWNHEAD SURGERY
6/8 HIGH ST IRVINE
TEL No.: 01294 73131
POSTCODE: KA120AY

REF. G.P.

NAME	G.P. CODE	PRACTICE	CONTRACT No.	FH STATUS
MACDONALD E	1351903	8034411	SAC04	N

ADDRESS: TOWNHEAD SURGERY
6/8 HIGH ST IRVINE
TEL No.: 01294 73131
POSTCODE: KA120AY

NEXT OF KIN

NAME: KATHLEEN DOCHERTY
RELATIONSHIP: MOTHER

ADDRESS: 8 CRAIG VIEW
SPRINGSIDE
DAY PHONE No.: 01294216008
NIGHT PHONE No.:

MISC.

RELIGION	VISIT REQ. BY CHAPLAIN YES/NO	PENSION BOOK No.
NONE	N	

Admission

MAIN DIAGNOSIS		SPECIAL WARNINGS
OTHER CONDITIONS (D.G.2)		
OTHER CONDITIONS (D.G.3)		

MR04

SMR50

CH. STATUS	PREVIOUS PSYCH. CARE	CONTRIBUTORY SOCIAL FACTOR

DISCHARGE SUMMARY

DISCHARGE DETAILS

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
9/1					ENT	Wardrop
DISCH./TRANSF. TO	**READY FOR DISCH.**	**HOSPITAL: NAME**	**CODE**	**WARD**	**SPECIALTY**	**CONSULTANT CODE**
Home						
SMR04	TYPE OF CARE PROVIDED		ECT - 1st TREATMENT DATE		ECT - NUMBER OF TREATMENTS	

DIAGNOSES AND OPERATIONS

			CODE	SPECIAL WARNINGS
MAIN DIAGNOSIS	recurrent tonsillitis	(2)	J039	
OTHER CONDITIONS (D.G.2)	RWL	(1)	Z5310	
(D.G.3)	DIARRHOEA	(3)	K529	
(D.G.4)	VOMITING	(4)	R11X	
(D.G.5)				
(D.G.6)				

	CODE	DATE
MAIN OPERATIONS		
OTHER OPERATION (O.P.2)		
(O.P.3)		
(O.P.4)		

LOCAL [illegible] 08/01/01 10 NATIONAL

Confidential - Clinical Information

Dermatology Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
0345 646 0565

www.nhsaaa.net

NHS Ayrshire & Arran

Dr F Hamilton
Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Our Ref: SR/MT/

Ref Date: 16/02/2026
Date Dictated: 16/02/2026
Date Typed: 16/02/2026
Enquiries to NECU Admin
Direct Line: 0345 646 0565
Email: GJNH.NecuAdmin@gjnh.scot.nhs.uk

Dear Dr Hamilton,

CAROLINE WELSH **DOB: 30/10/1977** **CHI No: 3010776241**
9 ST. MICHAELS PLACE, KILWINNING, AYRSHIRE, KA13 6FA

This patient attended AA for excision biopsy pf a lesion over the back. Pathology has confirmed a benign cyst. We will discharge them back to your care.

Yours sincerely

Authorised on 16/02/2026 15:41:18 by Typist Maggie Thomson, on behalf of Sameena Rashid.

Sameena Rashid
Locum Consultant Plastic & Dermatological Surgeon (NECU)
GMC 6026574

Caroline Welsh
9 St. Michaels Place
Kilwinning
Ayrshire
KA13 6FA

INVESTING IN VOLUNTEERS

NHS AYRSHIRE & ARRAN

Dermatological Surgery

Procedure Notes

Date 19.01.26

Procedure EXCISION OF LESION

Site MARGE POSTERIOR TH DIMPLE

CHI: 3010776241
Welsh, Caroline
9 St. Michaels Place
Kilwinning
KA13 6FA
30/10/1977
Dr F Hamilton
MRN: 3010776241

Surgical Notes

Local Anaesthetic used:

___% Lidocain & Adrenaline 1:200,000 ☐ .....

0.5% Bupivicaine & Adrenaline 1:200,000 ☑ 10mls

___% Lidocaine plain ☐ .....

Informed consent	☑	Bi-Polar	Yes / (No) / NA
Aseptic technique	☑	Hyfrecator & Smoke Evacuator	(Yes) / No / NA
Haemostasis	☑	Wound Dressing	(Yes) / No / NA

Sutures

Subcuticular	☑	Number	x2	Type	4/0 VICRYL
Cuticular	☑	Number	x5	Type	3/0 VICRYL RAPIDE

Margins: Peripheral Margin 4mm Deep Margin SC Fat only

Other Comments: 12 sticture marking suture Steristrips Mepore Marcaine

Post Surgical Care

Removal of sutures: Days N/A Location: GP / Dermatology unit

Provided with wound care information leaflet ☑ Spare dressings given: (Yes) / No / NA

Follow-up (Yes) / No If Yes, When? PENDING MDT

Post Surgical Checks

Sharps disposed of: Blade ☑ Punch ☐ Suture ☒ x 2 LA needle ☐ Curette ☐

No. of Specimens for pathology 1 Confirmed in Pathology Jar(s) and labels match ☐

Signed (Doctor/Nurse) SL Print name TIGER

Job Title LOCUM CONSULTANT Date 19.01.26

Confirmation that Specimens in Pathology Jar(s) and labels match

Signed SL Print name A STRANG

Job Title WTA Date 19/1/26

NHS AYRSHIRE & ARRAN

Dermatological surgery

Checklist

Date 19.01.26

Procedure EXCISION OF LESION

Site ON BACK

HCR
CHI: 3010776241
CHI Welsh, Caroline
Sum 9 St. Michaels Place
Kilwinning
Fore KA13 6FA
30/10/1977
Add Dr F Hamilton
MRN: 3010776241
Date of Birth:

The following have been discussed with the patient

- Medication
  - Taking aspirin — Yes / No
  - Taking warfarin — Yes / No
  - Taking clopidogrel — Yes / No
  - Taking Apixaban/Edoxaban or other DOAC — Yes / No
- Pacemaker — Yes / No

- Allergy to:
  - Local anaesthetic — Yes / No
  - Rubber / latex — Yes / No (SKIN GLUE)
  - Dressings / adhesives — Yes / No
  - Benzoates/Hydroxybenzoate/Parabens — Yes / No
  - Sodium metabisulphite/Sulfites — Yes / No
  - Others LA

CENTRAL DECONTAMINATION UNIT
AYRSHIRE CENTRAL HOSPITAL KA12 8SS
TAG SET AYR H/FIELD SUITE
DERM 27
AYR HFIELD SUITE DERM
ID W1266HF27
LOT 00344
STERILE
2025-11-25 2026-11-24

- Site of surgery agreed — Yes / No
- Result to be forwarded to patient — Yes / No
  - contact dermatology if not arrived after 12 weeks

- The following risks associated with skin surgery have been discussed with the patient:
  - Scar, which may be prominent — Yes / No
  - Wound break-down — Yes / No
  - Recurrence — Yes / No / NA
  - Infection — Yes / No
  - Bleeding — Yes / No
  - Wound care advice - written leaflet — Yes / No

I agree to the procedure(s) described above and confirm that the risks and intended benefits have been explained to me:

Signed (Patient or Guardian) X C Welsh PRINT X CAROLINE WELSH

Signed (Healthcare professional) SL PRINT TIGSTUN

Job Title LOCUM CONSULTANT DATE 19.01.26

NHS Ayrshire & Arran Clinical Notes

NHS Ayrshire & Arran

Demographics			
Forename	Caroline	**CHI**	3010776241
Surname	Welsh	**Telephone Number**	
DOB	1977-10-30	**Sex**	Female
Address	9 St. Michaels Place Kilwinning KA13 6FA		

Date	19-Jan-2026	**Clinician**	Tilston-3665747

Clinical Note

UHA -Minor Surgery-NECYU Dr Rasheed
Excision lesion right upper back at bra-line-? BCC ? Neurofibroma
See proforma
Await path

MSK Inter Disciplinary Referral

NHS Ayrshire & Arran

Demographics			
Date	28-Oct-2025	**Patient Name**	Caroline Welsh
Address	9 St. Michaels Place Kilwinning KA13 6FA		
Telephone Number	07875530530	**CHI**	3010776241
DOB	1977-10-30	**Sex**	Female
BMI	38	**GP**	Dr Woodburn
Practice	Oxenward Surgery, Kilwinning		
Referrer Name	Gillian Murray	**Discipline**	Physiotherapy
Base	AC	**Tel No.**	01294 323190

I wish to refer this patient to:

Physiotherapy ☐ Occupational Therapy ☐ MSK Podiatry ☑ Orthotics ☐ Paediatrics/Rainbow House: (Primary Aged Children) ☐

Clinical presentation including history

Attending MSK physiotherapy with right sided knee pain (mild OA). Also complains of left sided ankle and foot pain, most significant at medial aspect ?tibialis posterior issue. This has been symptomatic on and off for many years and previously had orthotics which were helpful. No significant limitation to left ankle ROM. Pain on resisted inversion. Tender medially left ankle / arch. Appearance of 'over pronation'.

Previous management

Currently working on right knee strengthening and graded activity. Referred to Weight Management by GP.

Reason for referral

For assessment / advice regarding left foot / ankle pain.

Is patient continuing to receive care from referrer? Yes ☑ No ☐

NHS Ayrshire & Arran On W/L ☑
Surgical Booking Form

Diagnosis 1 BCC
Location 1 Right Back
Size 1 6mm
Procedure 1 Excision
Clinical Margin 4 mm
Diagnosis 2 _____
Location 2 _____
Size 2 _____
Procedure 2 _____
Clinical Margin _____ mm

Date 17/10/25 Under 16? ___
Consultant Rashid (NECU)
Requesting Clinician Rashid (NECU)

Caroline Welsh
Patient Label
CHI: 3010776244

07875530530.

Mark Pathology Cons DDAS

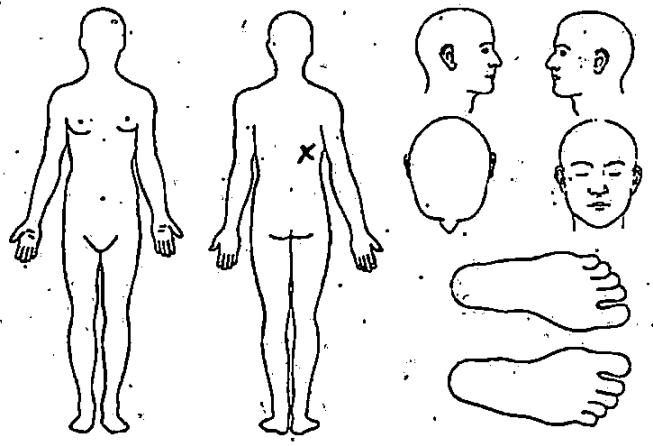
Pathology form to be marked
☐ URGENT MELANOMA
☐ URGENT
☑ Routine BCC.
Bleeding Risk: YES / (NO)

☐ Anticoagulant/Antiplatelet
Agent_____

☐ INR required

☐ Bleeding disorder
_____

☐ **Pacemaker: Yes / (No)**



Photos available ☑ Consultant Connect

Allergy/Anaphylaxis Risk: YES / (NO)
☐ Local anaesthetic
☐ Latex/rubber
☐ Benzoates/hydroxybenzoate/ parabens/sodium metabisulphite/sulphites
☐ Anaphylactic reaction
☐ Dressings/adhesives
☐ Other allergy _____

Immunosuppressed : YES / (NO)
Reason:

Consent / Risks and alternative options discussed ☑ by phone 17/10/25
Surgical booklet given to patient? ☐
Incapacity form required ☐
Incapacity form completed ☐

Infective Risk: YES / (NO)
☐ HIV ☐ Hepatitis B ☐ Hepatitis C ☐ Other

Surgical List
☐ Group A – Punch and C&C body
☑ Group B – Simple excision body up to ~1cm
☐ Group C – Punch, incisional biopsy, or C&C head and neck
☐ Group D – Excision body up to ~1.5cm
☐ Group E – Simple excision head and neck up to ~0.5cm
☐ Group F – More complex, larger lesions, and digits

Book as
☐ UCS
☐ Urgent
☑ Routine available any tmr.

☑ Single
☐ Double

View results

Respondent

240 Sameena Rashid

03:16
Time to complete

1

Patient CHI *

3010776241

The value must be a number

2

Patient Name *

Caroline Welsh

3

Date of Birth *

30/10/1977

4

Requesting Clinician *

Sameena Rashid

5

Date of Request *

14/10/2025

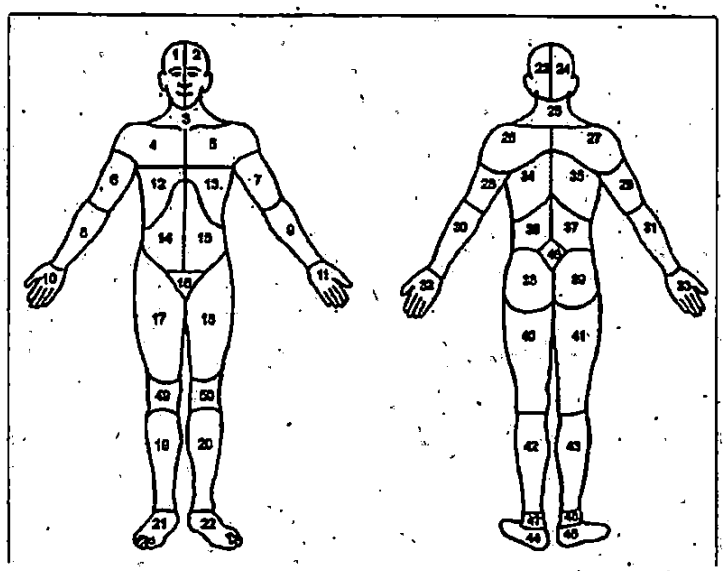
6

Diagnosis 1 *

BCC

7

Location (Please state section number along with description) *



Back

8

Procedure Required *

- (●) Excision
- ( ) Incision
- ( ) Punch
- ( ) Curette/Shave
- ( ) Other

9

Size (mm) *

6

10

Clinical Margin (mm) *

3

11

Is a there a 2nd diagnosis requiring biopsy? *

- ○ Yes
- ◉ No

12

Book as *

- ○ UCS
- ◉ Urgent
- ○ Routine

13

Slot size *

- ◉ Single
- ○ Double

14

Marking of pathology form *

- ○ URGENT MELANOMA
- ◉ URGENT
- ○ ROUTINE

15

Bleeding Risk *

- ○ YES
- ◉ NO

16

Pacemaker? *

- ○ Yes
- ◉ No

17

Any other relevant information

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 1010379382585

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

North Intermediate Care & Rehab Community ServicesAJA2
AA Inter Care & Rehab

Intermediate Care & Rehab Community Services
SCI Gateway Virtual Location code

Ethnic Origin	Not Stated
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	14-Oct-2025
Date submitted	14-Oct-2025

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

9 St Michaels Place
Kilwinning
KA13 6FA

Contact number(s)

Voice: 07875 530 530

REGISTERED GP DETAILS

Name	Dr Fiona Hamilton		
GMC code	7042380	GP code	21709
Practice name	Oxenward Surgery (16888)		
Practice code	80768		

Practice address

Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire & Arran

Contact number(s)

Voice: 01294 551555

REFERRING PRACTITIONER DETAILS

Name	Dr. Caroline Woodburn		
GMC code	4507556	GP code	21687
Practice name	Oxenward Surgery (80768)		
Practice code	80768		

Practice address

3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Contact number(s)

Voice: 01294 551555

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Weight management

Comment: I would be grateful if this 47 year old female could be seen who has hypertension and is obese with BMI 38.6. She is really struggling to lose weight which I feel would be beneficial for her in terms of joint pains and hypertension control and I feel some input from the Weight Management Service would be most beneficial to her. She is in agreement to this and I would be grateful if she could be added to the waiting list for review. Many thanks.

Examinations and Investigations

Services/Profession referring to:	Weight Management Service	-
Height:	172	-
Weight(kg):	114.2	-
BMI:	38.6	-
Never smoked tobacco:		25-Sep-2025
Never smoked tobacco:		26-Mar-2025
Never smoked tobacco:		20-Jul-2022
Alcohol consumption, 0 units/week:		25-Sep-2025
Trivial drinker - <1u/day:		19-Dec-2023
Alcohol consumption, 2 units/week:		20-Jul-2022
30 mins/day of at least mod intensty physc activity >=5 week: 5		25-Sep-2025
Aerobic exercise 3+ times/week:		20-Jul-2022

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Essential hypertension	-	-	-	13-Oct-2025	13-Oct-2025
Obstructive sleep apnoea	-	-	-	21-Jul-2025	21-Jul-2025
Colitis	-	-	collagenous	10-Sep-2024	10-Sep-2024
Back pain, unspecified	-	-	-	22-Apr-2016	22-Apr-2016
Soft tissue disorders NOS	-	-	Minor soft tissue injury (R) hand	31-Mar-2016	31-Mar-2016
Menorrhagia	-	-	-	03-Apr-2013	03-Apr-2013
Stress incontinence	-	-	-	11-Sep-2009	11-Sep-2009
[M]Compound naevus	-	-	(R) toe - no malignancy	19-Aug-2008	19-Aug-2008
[D]Dysphonia	-	-	-	29-Nov-2006	29-Nov-2006
Spontaneous vaginal delivery	-	-	baby male - birthweight 5.050kgs	06-Jun-2003	06-Jun-2003
Spontaneous vaginal delivery	-	-	Baby female - birthweight 4.60kgs	21-Jul-2002	21-Jul-2002
Spontaneous vaginal delivery	-	-	Baby male - birthweight 3.380kgs	09-Feb-1998	09-Feb-1998

Migraine	-	-	-	08-Mar-1995	08-Mar-1995
Burn of the face, head or neck	-	-	Facial burns from heat lamp	09-Jan-1994	09-Jan-1994
Anterior knee pain	-	-	-	31-Aug-1993	31-Aug-1993
Soiling - encopresis	-	-	-	08-Sep-1980	08-Sep-1980
Constipation	-	-	-	13-Aug-1980	13-Aug-1980

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Carrier of haemochromatosis HFE gene mutation	-	-	-	23-May-2023	23-May-2023
Other diagnostic ultrasound	-	-	Left breast no worrying changes	27-Sep-2021	27-Sep-2021
Mammography	-	-	No worrying changes	27-Sep-2021	27-Sep-2021
Abdominal hysterectomy with conservation of ovaries	-	-	-	26-Sep-2013	26-Sep-2013
Ultrasound scan of abdomen and pelvis	-	-	-	03-Jan-2012	03-Jan-2012
Anterior and posterior repair	-	-	-	14-Jul-2010	14-Jul-2010
Other diagnostic ultrasound	-	-	(R) breast - NAD	18-Nov-2004	18-Nov-2004
Blood group A Rh(D) positive	-	-	-	09-Jan-2002	09-Jan-2002
Dye test of fallopian tube	-	-	-	11-Mar-1997	11-Mar-1997
Appendicectomy NEC	-	-	-	13-Apr-1993	13-Apr-1993

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Paracetamol Tablets 500 mg	0407010H0AAAMAM	112 tablet	TWO TO BE TAKEN UP TO FOUR TIMES PER DAY	-	16-Jul-2025	-	06-Aug-2025
Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	21-Apr-2023	-	06-Aug-2025
Naproxen Tablets 500 mg	1001010P0AAAEAE	112 tablet	ONE TO BE TAKEN TWICE A DAY	-	08-Mar-2023	-	06-Aug-2025
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAHAH	56 TABLET	ONE TO BE TAKEN	-	01-Nov-2022	-	06-Aug-2025

			AT NIGHT				
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN EACH DAY	-	28-Jul-2022	-	06-Aug-2025

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Ramipril Capsules 5 mg	0205051R0AAACAC	28 CAPSULE	ONE TO BE TAKEN EACH MORNING	-	13-Oct-2025	28 Days	13-Oct-2025
Tramadol Hydrochloride Capsules 50 mg	040702040AAAAAA	30 capsule	1-2 NOCTE	-	13-Oct-2025	15 Days	13-Oct-2025
Paracetamol Tablets 500 mg	0407010H0AAAMAM	100 TABLET	ONE OR TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	13-Oct-2025	12 Days	13-Oct-2025
Codeine Phosphate Tablets 15 mg	0407020C0AAADAD	56 TABLET	ONE OR TWO TO BE TAKEN THREE TO FOUR TIMES A DAY WHEN REQUIRED	-	10-Oct-2025	42 Days	10-Oct-2025
Amoxicillin Capsules 500 mg	-	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY	-	29-Sep-2025	5 Days	29-Sep-2025
Fluticasone Propionate And Azelastine Nasal spray 50 micrograms/dose + 137 micrograms/dose	-	120 DOSE	USE ONE SPRAY IN EACH NOSTRIL TWICE A DAY	-	27-Aug-2025	42 Days	27-Aug-2025
Naseptin Nasal Cream	1202030S0BBAAAA	15 GRAM	APPLY FOUR TIMES A DAY FOR 10 DAYS	-	27-Aug-2025	42 Days	27-Aug-2025
Evorel Transdermal patches 50 micrograms/24 hrs	0604011G0BFAABB	8 PATCH	ONE PATCH TO BE APPLIED TWICE WEEKLY - PLEASE SEE NURSE	-	15-Aug-2025	68 Days	10-Sep-2025

Sertraline Hydrochloride Tablets 100 mg	0403030Q0AAABAB	56 tablet	FOR REVIEW BEFORE FURTHER ISSUE ONE TO BE TAKEN EACH DAY	-	25-Aug-2023	-	06-Aug-2025

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status: Number per day ? (not known)

Alcohol consumption: Units per day ? (not known)

Additional relevant information

Administrative information

Referred By:Resident GP

Social circumstances

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

Dermatology Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
0345 646 0565

www.nhsaaa.net

Confidential - Clinical Information

Caroline Welsh
9 St. Michaels Place
Kilwinning
Ayrshire
KA13 6FA

Our Ref: SR/MT

Clinic Date: 05/09/2025
Date Dictated: 05/09/2025
Date Typed: 03/10/2025
Enquiries to NECU Admin
Direct Line: 0345 646 0565
Email: GJNH.NecuAdmin@gjnh.scot.nhs.uk

Dear Caroline Welsh,

CAROLINE WELSH DOB: 30/10/1977 CHI No: 3010776241
9 ST. MICHAELS PLACE, KILWINNING, AYRSHIRE, KA13 6FA

You have recently attended to have photographs taken of a lesion on your back in relation to a previous referral to dermatology by your GP.

The photographs, along with the GP's referral letter have now been reviewed. I would recommend that the lesion is removed so that we can confirm the diagnosis. This procedure will be done under local anaesthetic. Appended is some information on having this type of skin procedure.

You will receive notification once the results of the biopsy are available and will be informed if any further treatment or follow up is required.

Yours sincerely

Authorised on 07/10/2025 16:57:51 by Typist Maggie Thomson, on behalf of Sameena Rashid.

Sameena Rashid
Locum Consultant Plastic & Dermatological Surgeon (NECU)
GMC 6026574

Dr F Hamilton
Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Skin Biopsy Excision – Patient Info

You are due to attend for a skin biopsy. This leaflet gives more information about the biopsy procedure.

Before the biopsy

- As the procedure is under local anaesthetic there is no specific preparation and you can eat and drink as normal before the procedure.
- The biopsy team will explain the procedure to you and will ask you to sign a consent form.
- If you are taking warfarin, please have your INR checked 2-5 days before the procedure and bring the results with you to the biopsy appointment.

During the biopsy

- Your appointment is for a skin excision. This procedure involves complete removal of a skin lesion under local anaesthetic. The local anaesthetic means that you shouldn't feel any pain during the procedure. The procedure will usually take 30-60 minutes.
- The wound will be closed with stitches – sometimes these will dissolve, and sometimes they will need to be removed at your GP practice.
- Occasionally larger wounds may require a skin graft. If it is not possible to perform this procedure on the day then a smaller biopsy may be taken and you may be referred onto a different team to perform the excision procedure.

After the biopsy

- The biopsy will leave a scar – the biopsy team will discuss this in more detail on the day. The biopsy team will let you know the type of stitches you have had and whether/ when they need to be removed.
- The procedure will not affect your ability to drive afterwards.
- You will be given a leaflet with aftercare advice. If the wound becomes red, swollen or discharges pus then please see your GP as there may be an infection and you may require antibiotics.
- You should receive a letter with the results of the biopsy afterwards.
- You can expect to receive a letter within 4-6 weeks from the biopsy date.

Confidential - Clinical Information

Department of Respiratory and General Medicine
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX

NHS Ayrshire & Arran

www.nhsaaa.net

Caroline Welsh
9 St. Michaels Place
Kilwinning
Ayrshire
KA13 6FA

Our Ref:	CC/JC
Hospital No:	
Clinic Date:	21/07/2025
Date Dictated:	21/07/2025
Date Typed:	21/07/2025
Enquiries to	Sleep Service Secretary
Direct Line:	01292 616793 (Answerphone)
Ext. Number:	16793
Email:	julie.connery@aapct.scot.nhs.uk

Dear Caroline Welsh,

CAROLINE WELSH DOB: 30/10/1977 CHI No: 3010776241
9 ST. MICHAELS PLACE, KILWINNING, AYRSHIRE, KA13 6FA

Thank you for completing the home sleep study recently. I've now seen the results from this.

The sleep study does show some obstructive sleep apnoea (pauses in your breathing at night). Given the sleep symptoms that you have, trialling treatment with CPAP equipment is appropriate. We will add you to the waiting list for a CPAP trial through the sleep team in Glasgow. Unfortunately, there are long wait times for this equipment and the team will be in touch with an appointment as soon as is feasible.

The enclosed leaflet explains a bit more about CPAP, and what happens next with appointments. You can see a bit more about what CPAP equipment involves at our team's CPAP setup and support YouTube videos at the weblink https://bit.ly/YoutubeGlasgowCPAP

Important steps which will also help your sleep apnoea are:-

- Losing weight if you are overweight.
- Stopping smoking, if you smoke.
- Having a regular sleep routine which is long enough (typically 7 hours or more per night) and with a comfortable sleeping arrangement.
- Reducing or stopping any medications which contribute to sleep disruption and daytime sleepiness. Your GP could review your medicines with you if needed.

Please also find enclosed my information leaflet on sleep diagnoses and driving issues. It is important to be aware of these and follow the recommendations.

INVESTING IN VOLUNTEERS

We haven't arranged an appointment at the medical sleep clinic for now. If you have questions about your sleep assessment or things that you'd like to discuss with the medical team before your CPAP trial then please get in touch with the Glasgow secretary Keira McLellan (T: 0141 451 6088 or via switchboard: 0141 211 3000 Extension 86088 as an alternative) and we would get you onto our waiting list for a sleep clinic telephone appointment.

Yours sincerely

Authorised on 21/07/2025 14:40:02 by Typist Julie Connery, not verified by Consultant Chris Carlin.

Chris Carlin
Consultant Physician Sleep & Respiratory Medicine
GMC: 4708058

Dr F Hamilton
Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

NHS Ayrshire and Arran (NECU) Dermatology Patient Questionnaire

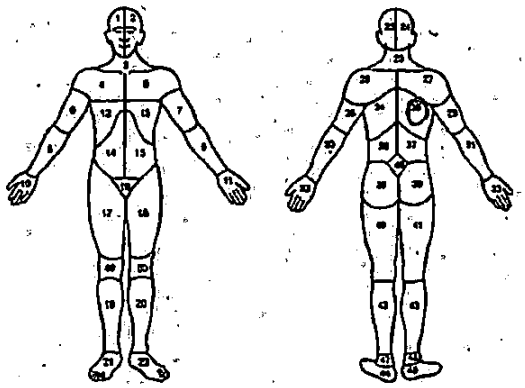
NHS Ayrshire & Arran

You have been referred about a lesion (sometimes called a mole, growth or lump).
To assist in assessing your lesion, please complete the followi

CHI: 3010776241
Welsh, Caroline
9 St. Michaels Place
Kilwinning
KA13 6FA
30/10/1977
Dr F Hamilton
MRN: 3010776241

Patient Details	
Name	
CHI Number	
Address	

On the body map provided, please confirm the location of the lesion by circling the section of the body..



How long have you had the lesion?
4 YRS APROX

Do you have any symptoms from the lesion? (Please tick all that apply)	
Itch	
Pain	✓

Do you think the lesion has changed?					
✓	Bigger		Smaller	✓	Crusting
	Darker		Lighter		More colours
	Change in shape	✓	More raised	✓	bleeding
	Formed a non- healing skin break (ulcer		Itchy	✓	Painful

Do you have any history of skin cancer, (If yes what type?)

No

Do you have any family history of skin cancers, (If yes what cancer and which family member?

NONE

Have you lived or worked abroad in a warm country for 6 months or more?			
	Yes	✓	No

In the sun would you describe your skin as (please tick):	
	Protect carefully as I will burn easily and never tan
	I will burn easily but might tan a little
✓	I will burn if not careful but can tan
	I'm more likely to tan than burn
	I never burn and tan easily
Do you or have you in the past (Please tick all that apply):	
✓	Used sunbeds regularly for any period of time?
	Used Melanotan?

NHS Ayrshire and Arran (NECU) Dermatology Patient Questionnaire

NHS Ayrshire & Arran

You have been referred about a lesion (sometimes called a mole, growth or lump).
To assist in assessing your lesion, please complete the following questionnaire.

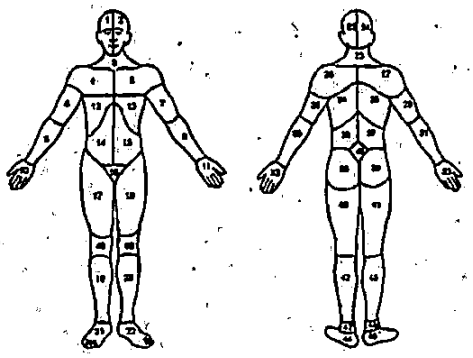
Do you have any health conditions, especially any that have been diagnosed after your referral? (Please list and include any skin conditions)
Are you on any regular medications (include any you buy yourself)?
YES AMITRIPTYLINE SERTRALINE NAPROXEN OMEPRAZOLE HORMONE PATCH
Are you taking any medication to thin your blood or have any conditions that make you more likely to bleed (please list below)?
Do you take any immune suppressing medication or have any conditions that affect your immune system? Sometimes this is called immunocompromised and would include transplant recipients, blood disorders, biologic medications and long term oral steroid tablets. NO
Are you or could you be pregnant?
NO
Do you have a pacemaker, metal heart valve or implanted defibrillator?
NO
Do you have any disabilities or circumstances where you might require assistance at a clinic or skin surgery appointment? NO
Would you be willing or able to attend an appointment outside of your local health Board if need be?
YES

Images captured are stored securely within NHS Scotland, as part of your patient record, and will support diagnosis of my lesion by qualified medical professionals. Storage of medical images are in accordance with NHS Scotland and NHS Golden Jubilee data privacy policy, which are accessible at https://www.nhsinform.scot/care-support-and-rights/health-rights/confidentiality-and-data-protection/how-the-nhs-handles-your-personal-health-information/ and https://www.nhsgoldenjubilee.co.uk/site-information/privacy-policy. A copy can be provided by staff in clinic.

I consent to my anonymous images being used for teaching and research purposes.	
✓	Yes
	No

As the Patient or Parent/Legal Guardian of the patient, I confirm that I have answered the above to the best of my ability and that this form along with images captured will be used to assess my lesion and inform future treatment if required.	
Signed	A Jones

For Image Practitioner Use (Please circle all areas captured and annotate with date and timestamp from CC portal)



Notes:

Confidential - Clinical Information

Gastroenterology Unit
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 825231

www.nhsaaa.net

NHS Ayrshire & Arran

Dr F Hamilton
Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Our Ref: MA/JMML
Hospital No:
Clinic Date: 03/05/2025
Date Dictated: 12/05/2025
Date Typed: 21/05/2025
Enquiries to Jaki Lynch
Direct Line: 01563 825231
Ext. Number: 25231
Email: Jacqueline.lynch@aapct.scot.nhs.uk

Dear Dr Hamilton,

CAROLINE WELSH DOB: 30/10/1977 CHI No: 3010776241
9 ST. MICHAELS PLACE, KILWINNING, AYRSHIRE, KA13 6FA

Forty seven year old Caroline Welsh, with background of obesity and likely Microscopic Colitis was reviewed in Gastroenterology Outpatient Clinic on 3rd May 2025. You started her on Orlistat early last year and she started having significant diarrhoea after starting it. It took quite a few months after stopping for symptoms to completely settle. For the last few months she has only gone to the toilet once a day or every second day, stools can be loose sometimes but there is no obvious diarrhoea, rectal bleeding or weight loss. There is no family history of Coeliac Disease or IBD. Colonoscopy did not show any pathology but chronic biopsies were suggestive of Microscopic Colitis. She has been taking Naproxen twice a day, which can also sometimes show some features of Microscopic Colitis. Other than NSAID's, there is also a significant association with gluten tolerance and there is no coeliac serology result available.

As she is currently well, there is no indication for any treatment. Recent routine bloods were satisfactory but no result of TTG available.

I have explained all of the above to Ms Welsh. She will avoid NSAID's. Coeliac Disease taken today and, if positive, we will need gastroscopy with duodenal biopsies to confirm Coeliac Disease. People who are positive for Coeliac Disease are generally respond to gluten free diet and do not need any specific treatment. She knows that if she starts to have intermittent mild diarrhoea, she can take Imodium or Codeine as needed. Should symptoms become frequent with significant diarrhoea, she would be a candidate for a course of reducing dose of Budesonide but she has not had any diarrhoea for more than 6 months. We will see her again in about 6 months.
Note; Routine bloods satisfactory and TTG is negative. Negative TTG and no need for OGD / D2 biopsies.

INVESTING IN VOLUNTEERS

Yours sincerely

Authorised on 24/05/2025 08:09:27 by Dr Mohammad Azam.

Dr Mohammad Azam
Locum Cons. in Gastroenterology
GMC: 6136353

Write or attach label

HCR I CHI: 3010776241
CHI N Welsh, Caroline
Sum: 9 St. Michaels Place
Kilwinning
Fore KA13 6FA
Addi 30/10/1977
Dr F Hamilton
..... MRN: 3010776241
Date of Birth.....

STA0238

DATE

5.5.25

WGT - 108 kgs
HGT - 172
Bmi - 36

Waten Armour
ATOP

Dietician after
Orlistats
- Now settled.

FH (Gt) wil
Colo by
Colo
- Likely Microscopic
Colitis

(P) + observe (No Symptoms)
+ TFTs
- Avoid NSAIDs
- R.V 6/12

MEDICAL

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101036388955V

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

KneeC8A4
AA Knee

Musculoskeletal Triage and Treatment
NHS Ayrshire & Arran

Ethnic Origin	Not Stated
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	07-May-2025
Date submitted	07-May-2025

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

9 St Michaels Place
Kilwinning
KA13 6FA

Contact number(s)

Voice: 07875 530 530

REGISTERED GP DETAILS

Name	Dr Fiona Hamilton		
GMC code	7042380	GP code	21709
Practice name	Oxenward Surgery (16888)		
Practice code	80768		

Practice address

Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire & Arran

Contact number(s)

Voice: 01294 551555

REFERRING PRACTITIONER DETAILS

Name	Dr. Nicola McNeil		
GMC code	7411160	GP code	22012
Practice name	Oxenward Surgery (80768)		
Practice code	80768		

Practice address

3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Contact number(s)

Voice: 01294 551555

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: knee pain

Comment: This 47 year old lady has been having trouble with pain in both of her knees, this is worse at night and when resting. She is already on anti-inflammatory and amitriptyline she is on her feet a lot with work but there is no specifically targeted exercises. I feel she would benefit from your assessment and some targeted therapy she struggles most with change in direction and I wonder if she has some wear and tear in her cartilage's . Many thanks Dr N McNeil

Examinations and Investigations

Height:	172	-
Weight(kg):	104	-
BMI:	34.75	-
Never smoked tobacco:	26-Mar-2025	
Never smoked tobacco:	20-Jul-2022	
Trivial drinker - <1u/day:	19-Dec-2023	
Alcohol consumption, 2 units/week:	20-Jul-2022	
Aerobic exercise 3+ times/week:	20-Jul-2022	

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Colitis	-	-	collagenous	10-Sep-2024	10-Sep-2024

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Carrier of haemochromatosis HFE gene mutation	-	-	-	23-May-2023	23-May-2023

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Sertraline Hydrochloride Tablets 50 mg	0403030Q0AAAAAA	56 TABLET	1 DAILY - 150MG DAILY DOSE	-	31-Oct-2023	-	30-Apr-2025
Sertraline Hydrochloride Tablets 100 mg	0403030Q0AAABAB	56 tablet	ONE TO BE TAKEN EACH DAY	-	25-Aug-2023	-	30-Apr-2025
Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	21-Apr-2023	-	30-Apr-2025
Naproxen Tablets 500	1001010P0AAAEAE	112 tablet	ONE TO BE	-	08-Mar-	-	30-Apr-2025

mg			TAKEN TWICE A DAY		2023		
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAHAH	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	01-Nov-2022	-	30-Apr-2025
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN EACH DAY	-	28-Jul-2022	-	30-Apr-2025

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Fusidic Acid And Hydrocortisone Acetate Cream 2 % + 1 %	-	30 GRAM	APPLY THINLY ONCE A DAY AS DIRECTED	-	02-May-2025	42 Days	02-May-2025
Evorel Transdermal patches 50 micrograms/24 hrs	0604011G0BFAABB	24 patch	ONE PATCH TO BE APPLIED TWICE WEEKLY	-	26-Mar-2025	42 Days	26-Mar-2025

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Social circumstances

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

Mr V Manda
General Surgical Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 825012

www.nhsaaa.net

NHS Ayrshire & Arran

Confidential - Clinical Information

Dr F Hamilton
Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Our Ref: VM/HC
Hospital No:
Clinic Date: 26/03/2025
Date Dictated: 26/03/2025
Date Typed: 26/03/2025
Enquiries to Mandy McLeish
Direct Line: 01563 825012
Ext. Number: 25012
Email: Mandy.McLeish@aapct.scot.nhs.uk

Dear Dr Hamilton,

CAROLINE WELSH DOB: 30/10/1977 CHI No: 3010776241
9 ST. MICHAELS PLACE, KILWINNING, AYRSHIRE, KA13 6FA

I had a telephone consultation with Mrs Welsh today. As you know she had problems with urgency and frequency of stools since summer of last year and underwent colonoscopy which macroscopically was normal but showed a possibility of collagenous colitis on random biopsies.

Mrs Welsh said that her symptoms are much better than what they were before and she has never had an episode as bad as she did last summer. She is a bit more careful with her diet and overall she thinks her symptoms are much better.

I have explained the colonoscopy itself was normal but the random biopsies raised the possibility of non-specific colitis but as her symptoms are much better nothing more needs to be done and we would rather see how she gets on. If she has any further flare ups then she might need referral to Gastroenterology but certainly at this stage, as she is doing well she doesn't need further follow up with me. Should she have any issues she should be referred to Gastroenterology.

Many thanks.

Yours sincerely

Authorised on 26/03/2025 17:25:56 by Vijay Manda.

Vijay Manda
Locum Consultant in General Surgery
GMC: 6036999

INVESTING IN VOLUNTEERS

Write or attach label

CHI: 3010776241
Welsh, Caroline
9 St. Michaels Place
Kilwinning
KA13 6FA
30/10/1977
Dr F Hamilton
MRN: 3010776241

Sex: .....

Date of Birth: .....

STA0173

DATE

28/3/25 -
SOND
TC

Mandar.

F/u.

Pt well.

Colonoscopy last year → NAD
Random Bx — ? collagenous colitis.

Plan: D/c.

If further symptoms →
Ref to gastro to Gastro

3291

SURGICAL

NHS Ayrshire & Arran

Pre-clinic Sleep Questionnaire

Patient details:

Name: CAROLINE WELSH.

CHI: 3010 776 241

Date: 3/2/25

Sleep questions:

Do you often experience:-	Yes	No	Comments
Unrefreshed Sleep?	✓		
Tiredness during the day?	✓		
Problems with concentration/attention	✓		
Need to take daytime naps?	✓		
At night:-			
Do you snore?	✓		
Do you often waken yourself choking or with snoring?			often
Are you seen to stop breathing during sleep?	✓		
Do you need to use the bathroom frequently?		✓	
Are your restless?	✓		
Do you frequently talk or move abnormally during sleep?	✓		
Do you frequently act out dreams?		✓	

Medical History: _____

List medication: AMITRIPTYLINE 30mg OMEPRAZOLE 20mg SERTRALINE 150mg NAPROXEN 500mg x2

PTO

What is your Occupation: SENIOR HEALTHCARE ASSISTANT

Do you have a standard driving license? (Y)/N

Do you have a HGV/OCV driving license? Y/(N)

Have you had any issues with sleepiness whilst driving? (Y)/N

Epworth Sleepiness Questionnaire

This questionnaire is to assess how likely you are to dose off or fall asleep in the following situations.

Epworth Sleepiness Scale

Situation	Chance of Dozing (0–3)			
Sitting and reading	0	1	(2)	3
Watching television	0	1	(2)	3
Sitting inactive (meeting, movie, church)	0	1	(2)	3
As a passenger in a car – for an hour – no break	0	1	(2)	3
Lying down to rest in the afternoon	0	1	2	(3)
Sitting and talking to someone	0	1	(2)	3
Sitting quietly after lunch (had no alcohol)	0	1	(2)	3
Stopped at a light or in traffic	(0)	1	2	3
				Total Score

0 = would never doze
1 = slight chance ofdozing
2 = moderate chance of dozing
3 = high chance ofdozing

Sleep routine:

What time to you go to bed? 11PM

Do you do/use any of these in the evening/in bed? Watch TV? Y/N

Use computer? Y/N

Mobile Phone? (Y)/N

When do you get up in morning? 6.45AM

Do you have any sleep interruptions? SOMETIMES

Do you work shift? (Y)/N

PTO

Department of Otolaryngology
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE

NHS Ayrshire & Arran

Confidential - Clinical Information

www.nhsaaa.net

Dr F Hamilton
Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Our Ref: AW/CMcL
Hospital No: 3010776241
Clinic Date: 12/12/2024
Date Dictated: 12/12/2024
Date Typed: 14/12/2024
Enquiries to Christine McLeish
Direct Line: 01563 827368
Ext. Number: 27368
Email: christine.mcleish@aapct.scot.nhs

Dear Dr Hamilton,

CAROLINE WELSH DOB: 30/10/1977 CHI No: 3010776241
9 ST. MICHAELS PLACE, KILWINNING, AYRSHIRE, KA13 6FA

Diagnosis: Dry nose
Management: Saline douching
Naseptin Cream

Mrs Welsh has problems breathing through her nose but also crusting in her nose. I think the root cause has been of the Amitriptyline and then the addition of Sertraline which have a strong anticholinergic side-effect and have dried her nose out. Once it has become crusty inside, she has got into a vicious cycle.

I have asked her to rinse her nose twice a day with salt water and apply some Naseptin Cream. She has structurally a narrow nose and we spoke about the Breathe-Right nasal strips.

Examination of her nose with a flexible fibre-optic scope showed a normal posterior nose and postnasal space and I have discharged her from follow-up with this reassurance.

Yours sincerely

Authorised on 17/12/2024 17:54:33 by Mr Andrew Whymark.

Mr A Whymark
Consultant ENT Surgeon
GMC 4188403

INVESTING IN VOLUNTEERS

185084 STA0216.qxp_OT5 NHS1

10-12-2024 18:41 LOT 00289
7204160
ENT SCOPE 160
)0 00009(7003)2412101841
)00.99(240)0F0C011975

CHI: 3010776241
Welsh, Caroline
9 St. Michaels Place
Kilwinning
KA13 6FA
30/10/1977
Dr F Hamilton
MRN: 3010776241

EWS

STA0216

DATE	HISTORY

EXAMINATION

General

Mouth and Pharynx

Neck

Ears

TREATMENT

Cantel	RapidAER
Serial No	RAD142
Start	15h 20m
End	15h 38m
Date	10-12-2024
Cycle No	13336
Load Operator	37
Name	CONNOR MILLER
Unload Operator	34
Name	Christopher Hannah
-- Hookup --	
Hookup No	301
Serial No	301-035
Barcode	
-- Endoscope --	
OLYM	ENF-GP2
Serial No	7204160
Barcode	E25
Revision	a
IMS Verify	Enabled
Control	Pass
IMS Verify	Pass
Contact Time	5 Minutes
Last SD	10-12-2024 at 06h 16m
Suction	Not tested
Biopsy	Not tested
Water	Not tested
Air	Not tested
Aux 1	Not tested
Aux 2	Not tested
RB	Not tested
Leak Test	Av Pres 183 mb
-- Conductivity --	
Detergent	1456 uS
Disinfectant	1390 uS
Final Rinse	20 uS
-- Temperature --	
Detergent	24.6 deg
Disinfectant	26.1 deg
Final Rinse	20.3 deg
-- Chemical Batch/Lot & Serial No --	
Detergent	24000617/0000000076
Part B	24000703/8000002758
Part A	24000700/A0000001561

OTOLARYNGOLOGY

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101034525705L

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

Ear, Nose & Throat (ENT)C5
AA Gen Ref - PMH Med & High

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
Ayrshire
KA2 0BE

Ethnic Origin	Not Stated
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	**Urgent**
Date of referral	18-Oct-2024
Date submitted	18-Oct-2024

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

9 St Michaels Place
Kilwinning
KA13 6FA

Contact number(s)

Voice: 07875 530 530
Voice: 07875530530

REGISTERED GP DETAILS

Name	Dr Fiona Hamilton		
GMC code	7042380	GP code	21709
Practice name	Oxenward Surgery (16888)		
Practice code	80768		

Practice address

Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire & Arran

Contact number(s)

Voice: 01294 551555

REFERRING PRACTITIONER DETAILS

Name	Dr. Catherine Lobb		
GMC code	3054129	GP code	24619
Practice name	Oxenward Surgery (80768)		
Practice code	80768		

Practice address

3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Contact number(s)

Voice: 01294 551555

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Bleeding from both nostrils

Comment: Dear Doctor I would be grateful if you could consider upgrading this referral for this 46 year old woman that was originally sent back in February of this year. She has been getting progressive symptoms of bleeding from both nostrils and also has a sensation that her nostrils are collapsing. She has previously been wearing something to keep her nostrils paintent but has now found that this has not been improving her symptoms at all. She is getting daily episodes of bleeding and finds that she is sometimes getting clots in her nose which can cause her nose to become blocked. She normally breathes through her nose and is finding this is causing progressive symptoms of shortness of breath especially whilst talking when she is unable to breath through her nose at all. She has had a course of Naseptin with no improvement in symptoms at all. She had initially presented today with the worry that her sats on occasion were low however these have been readings from an apple watch and sats were entirely normal today and she has not had any symptoms of shortness of breath other than due to an inability to breath through her nostril. On examination today there was very little to see in the nose but they were very narrow it was very difficult to see further in. In light of the breathless symptoms she is getting especially with the increase in bleeding she is experiencing on a regular basis I would be grateful if her referral could possibly be upgraded. Yours sincerely Dr Fiona Leitch Locum GP

Examinations and Investigations

Height:	172	-
Weight(kg):	104	-
BMI:	34.75	-
Never smoked tobacco:		20-Jul-2022
Trivial drinker - <1u/day:		19-Dec-2023
Alcohol consumption, 2 units/week:		20-Jul-2022
Aerobic exercise 3+ times/week:		20-Jul-2022

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Colitis	-	-	collagenous	10-Sep-2024	10-Sep-2024

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Carrier of haemochromatosis HFE gene mutation	-	-	-	23-May-2023	23-May-2023

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Sertraline Hydrochloride Tablets 50 mg	0403030Q0AAAAAA	56 TABLET	1 DAILY - 150MG DAILY DOSE	-	31-Oct-2023	-	16-Sep-2024
Sertraline Hydrochloride Tablets 100 mg	0403030Q0AAABAB	56 tablet	ONE TO BE TAKEN EACH DAY	-	25-Aug-2023	-	16-Sep-2024

Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	21-Apr-2023	-	16-Sep-2024
Co-Codamol 15/500 Tablets	-	100 tablet	TAKE ONE TO TWO TABLETS UP TO 4 TIMES DAILY IF REQUIRED	-	12-Apr-2023	-	29-Nov-2023
Naproxen Tablets 500 mg	1001010P0AAAEAE	112 tablet	ONE TO BE TAKEN TWICE A DAY	-	08-Mar-2023	-	16-Sep-2024
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAHAH	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	01-Nov-2022	-	16-Sep-2024
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN EACH DAY	-	28-Jul-2022	-	16-Sep-2024

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Sertraline Hydrochloride Tablets 50 mg	0403030Q0AAAAAA	28 TABLET	ONE TO BE TAKEN EACH DAY - 150MG DOSE - INTERIM RX TO SYNCH MEDS	-	26-Jul-2024	28 Days	26-Jul-2024
Sertraline Hydrochloride Tablets 100 mg	0403030Q0AAABAB	28 TABLET	ONE TO BE TAKEN EACH DAY - 150MG DOSE - INTERIM RX TO SYNCH MEDS	-	26-Jul-2024	42 Days	26-Jul-2024

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Social circumstances

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

General Surgical Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 825154

www.nhsaaa.net

Confidential - Clinical Information
INTERNAL REFERRAL

Gastroenterology
Referral Management Service
Kilmarnock Road
Kilmarnock

Our Ref:	VM/SD
Hospital No:	
Clinic Date:	10/09/2024
Date Dictated:	06/09/2024
Date Typed:	10/09/2024
Enquiries to	Endoscopy Secretary
Direct Line:	01563 825154
Ext. Number:	25154
Email:	aa.uhcendosecs@aapct.scot.nhs.uk

Dear Gastroenterology,

CAROLINE WELSH DOB: 30/10/1977 CHI No: 3010776241
9 ST. MICHAELS PLACE, KILWINNING, AYRSHIRE, KA13 6FA

I would much appreciate your advice and input regarding further management of Caroline Welsh. She is a 46 year old lady who is otherwise fit and well. I have been seeing her in clinic for symptoms of loose stool, urgency, weight loss and positive q-FIT of 22. She underwent a colonoscopy which was microscopically normal and random biopsies from the left side of the colon confirmed the presence of collagenous colitis. As the patient is quite symptomatic I would very much appreciate your advice and input regarding the management of this.

Yours sincerely

Authorised on 10/09/2024 16:58:01 by Vijay Manda.

Vijay Manda
Locum Consultant in General Surgery
GMC: 6036999

RMS Management Service
NHS
Ayrshire & Arran
Ayrshire
KA2 0BE

Confidential - Clinical Information

General Surgical Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 825154

www.nhsaaa.net

NHS Ayrshire & Arran

Caroline Welsh
9 St. Michaels Place
Kilwinning
Ayrshire
KA13 6FA

Our Ref:	VM/SD/
Hospital No:	
Ref Date:	10/09/2024
Date Dictated:	06/09/2024
Date Typed:	10/09/2024
Enquiries to	Endoscopy Secretary
Direct Line:	01563 825154
Ext. Number:	25154
Email:	aa.uhcendosecs@aapct.scot.nhs.uk

Dear Caroline Welsh,

CAROLINE WELSH DOB: 30/10/1977 CHI No: 3010776241
9 ST. MICHAELS PLACE, KILWINNING, AYRSHIRE, KA13 6FA

I am writing to let you know that you recently had a colonoscopy for your symptoms of loose stools, urgency and weight loss as well as your stool test being positive. The colonoscopy its self was normal and some random biopsies were taken from the left side of your colon which showed some mild inflammation and collagenous colitis. This could itself be responsible for your symptoms and as this is a medical condition, I have referred to you gastroenterology for further advice and input.

Yours sincerely

Authorised on 10/09/2024 16:57:48 by Vijay Manda.

Vijay Manda
Locum Consultant in General Surgery
GMC: 6036999

Dr F Hamilton
Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

General Surgical Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE

www.nhsaaa.net

Caroline Welsh
9 St. Michaels Place
Kilwinning
Ayrshire
KA13 6FA

Our Ref:	VM/CM/
Hospital No:	**3010776241**
Ref Date:	15/07/2024
Date Dictated:	09/09/2024
Date Typed:	11/09/2024
Enquiries to	Endoscopy Secretary
Direct Line:	01563 825156
Ext. Number:	25156
Email:	aa.uhcendosecs@aapct.scot.nhs.uk

Dear Caroline Welsh,

CAROLINE WELSH DOB: 30/10/1977 CHI No: 3010776241
9 ST. MICHAELS PLACE, KILWINNING, AYRSHIRE, KA13 6FA

I am writing to let you know that the biopsies that were taken from the colon show some mild inflammation of your colon. This is very non-specific. I will arrange a telephone clinic appointment to see how your symptoms are and we will take it from there.

Yours sincerely

Authorised on 11/09/2024 16:03:15 by Vijay Manda.

Vijay Manda
Locum Consultant in General Surgery
GMC: 6036999

Dr F Hamilton
Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Mr V Manda – q-FIT Clinic
General Surgical Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 825012

www.nhsaaa.net

Confidential - Clinical Information

NHS Ayrshire & Arran

Dr F Hamilton
Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Our Ref:	VM/GD
Hospital No:	**3010776241**
Clinic Date:	03/07/2024
Date Dictated:	03/07/2024
Date Typed:	03/07/2024
Enquiries to	Mandy McLeish
Direct Line:	01563 825012
Ext. Number:	25012
Email:	Mandy.McLeish@aapct.scot.nhs.uk

Dear Dr Hamilton,

CAROLINE WELSH DOB: 30/10/1977 CHI No: 3010776241
9 ST. MICHAELS PLACE, KILWINNING, AYRSHIRE, KA13 6FA

Thank you for referring Mrs Welsh to the clinic. I had a telephone consultation with her today. She is a 46 year old lady who gives a 2 month history of change in bowel habits to loose stools and increased frequency. This is also associated with urgency. She has been prescribed Loperamide without having much effect. She is quite distressed with this. She denies noticing any blood or mucus in the stools. She had lost some weight but she has gained the weight back. She is eating healthy now, she was initially afraid of eating because it was causing her to have more diarrhoea. She did a q-FIT test recently which has come back ever so slightly positive at 22.4.

She is generally otherwise well and no other major medical problems. There is no family history of any bowel cancers or inflammatory bowel disease.

I explained to Mrs Welsh that her symptoms could be a variety of reasons like either inflammatory bowel disease or IBS or wear and tear of the bowel called diverticular disease and given her symptoms she will need a colonoscopy and then we will take it from there. I have requested this for her and I will get in touch with her once the results are back.

Yours sincerely

Authorised on 04/07/2024 15:40:28 by Vijay Manda.

Vijay Manda
Locum Consultant in General Surgery
GMC: 6036999

INVESTING IN VOLUNTEERS

Endoscopy Secretary
Endoscopy Suite
Ground Floor
University Hospital Crosshouse
Kilmarnock
KA2 0BE

on endoscopy waiting list

Confidential - Clinical Information

Oral & Maxillofacial Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 827300

www.nhsaaa.net

NHS Ayrshire & Arran

Ms Shona Jackson
Dental Surgeon
Seagate Dental
8 Seagate
Irvine
KA12 8RH

Our Ref:	DB/DF
Hospital No:	3010776241
Date Dictated:	08/08/2024
Date Typed:	08/08/2024
Enquiries to	Miss Boyd's Secretary
Direct Line:	01563 827300
Ext. Number:	27300

Dear Ms Jackson,

CAROLINE WELSH DOB: 30/10/1977 CHI No: 3010776241
9 ST. MICHAELS PLACE, KILWINNING, AYRSHIRE, KA13 6FA

Thank you referring this patient regarding the retained roots of her LL6 following attempted extraction.

We invited the patient to attend for imaging prior to an outpatient appointment for treatment and she has failed to attend.

Unfortunately due to waiting list pressures I can't offer another appointment at this stage.

I would ask you to re-assess the patient in primary care and, if the roots remain in situ, then please re-refer with up to date imaging.

Thanks in anticipation.

With kind regards.

Yours sincerely

Authorised on 08/08/2024 16:04:50 by Debbie Boyd.

Miss Deborah Boyd
BDS FDSRCPS MBChB MRCS FRCS (OMFS)
Consultant Oral and Maxillofacial Surgeon
Clinical Director Head & Neck Services
Training Programme Director OMFS
GMC: 6163323

INVESTING IN VOLUNTEERS

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101033116088S

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

Cancer SuspectedC1A1
AA Colorectal UCS

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
Ayrshire
KA2 0BE

Ethnic Origin	Not Stated
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	URGENT - CANCER IS SUSPECTED
Date of referral	22-May-2024
Date submitted	22-May-2024

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

9 St Michaels Place
Kilwinning
KA13 6FA

Contact number(s)

Voice: 07875 530 530

REGISTERED GP DETAILS

Name	Dr Fiona Hamilton		
GMC code	7042380	GP code	21709
Practice name	Oxenward Surgery (16888)		
Practice code	80768		

Practice address

Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire & Arran

Contact number(s)

Voice: 01294 551555

REFERRING PRACTITIONER DETAILS

Name	Stewart McMinn		
GMC code	4424987	GP code	80768
Practice name	Oxenward Surgery (80768)		
Practice code	80768		

Practice address

3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Contact number(s)

Voice: 01294 551555

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: SOPC

Comment: I would be gretaful for your assesmen of Caroline she has on fh or ph of gut problems. For the last 6 weeks she has been having abdominal cramps and loose bowel motions 4-8 times per day. She has also had reduced appetite and no has lost 3-4 kilograms. We under took her usual blood parameters fbc/u+es/lfts . All were normal depsite mildly elevated esr of 42. She denies and blood PR we sent a stool culture which was negative and I also treated her with some metronidazole to see if she might have had some diverticulitis . Unfortunately nil has helped. I have given her a qfit test today to complete and started her on codeine and loperamide to control her symptoms. She has some red flag symptoms so I wondered if she may need further investigation? Many thanks for your opinion. Yours sincerely Dr Stewart McMinn

Examinations and Investigations

Duration of Symptoms:	----Select-----	-
Previous Colonic Problems:	no	-
History of colorectal cancer in 1st degree relative:	----Select-----	-
Height:	172	-
Weight(kg):	104	-
BMI:	34.75	-
Never smoked tobacco:		20-Jul-2022
Trivial drinker - <1u/day:		19-Dec-2023
Alcohol consumption, 2 units/week:		20-Jul-2022
Aerobic exercise 3+ times/week:		20-Jul-2022

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Diarrhoea symptom NOS	-	-	for 3 weeks	15-May-2024	15-May-2024

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Carrier of haemochromatosis HFE gene mutation	-	-	-	23-May-2023	23-May-2023

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Sertraline Hydrochloride Tablets 50 mg	0403030Q0AAAAAA	56 TABLET	1 DAILY - 150MG DAILY DOSE	-	31-Oct-2023	-	24-Apr-2024
Sertraline Hydrochloride Tablets 100 mg	0403030Q0AAABAB	56 tablet	ONE TO BE TAKEN EACH DAY	-	25-Aug-2023	-	24-Apr-2024
Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	21-Apr-2023	-	02-Apr-2024

Co-Codamol 15/500 Tablets	-	100 tablet	TAKE ONE TO TWO TABLETS UP TO 4 TIMES DAILY IF REQUIRED	-	12-Apr-2023	-	29-Nov-2023
Naproxen Tablets 500 mg	1001010P0AAAEAE	112 tablet	ONE TO BE TAKEN TWICE A DAY	-	08-Mar-2023	-	02-Apr-2024
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAHAH	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	01-Nov-2022	-	02-Apr-2024
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN EACH DAY	-	28-Jul-2022	-	02-Apr-2024

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Loperamide Hydrochloride Capsules 2 mg	0104020L0AAAAAA	60 capsule	TWO TO BE TAKEN IMMEDIATELY THEN ONE AFTER EACH LOOSE STOOL FOR UP TO 5 DAYS	-	20-May-2024	42 Days	20-May-2024
Codeine Phosphate Tablets 30 mg	0407020C0AAAEAE	56 TABLET	ONE TO BE TAKEN THREE OR FOUR TIMES A DAY WHEN REQUIRED FOR LOOSE STOOLS	-	20-May-2024	42 Days	20-May-2024
Metronidazole Tablets 400 mg	0501110C0AAAJAJ	15 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	15-May-2024	5 Days	15-May-2024
Loperamide Hydrochloride Capsules 2 mg	0104020L0AAAAAA	30 CAPSULE	TWO TO BE TAKEN IMMEDIATELY THEN ONE AFTER EACH LOOSE STOOL FOR UP TO 5 DAYS	-	15-May-2024	42 Days	15-May-2024
Orlistat Capsules 120 mg	0405010P0AAAAAA	84 CAPSULE	ONE TO BE TAKEN WITH EACH MAIN MEAL UP TO THREE TIMES A DAY	-	03-Apr-2024	42 Days	03-Apr-2024

Orlistat Capsules 120 mg	0405010P0AAAAAA	84 CAPSULE	ONE TO BE TAKEN WITH EACH MAIN MEAL UP TO THREE TIMES A DAY	-	23-Feb-2024	28 Days	23-Feb-2024

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Social circumstances

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

Oral & Maxillofacial
Department
University Hospital
Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 827070

www.nhsaaa.net

NHS Ayrshire & Arran

Caroline Welsh
9 St. Michaels Place
Kilwinning
Ayrshire
KA13 6FA

Our Ref:	RB/MC
Hospital No:	3010776241
Clinic Date:	04/04/2024
Date Dictated:	04/04/2024
Date Typed:	04/04/2024
Enquiries to	RMS
Direct Line:	01563 827070
Ext. Number:	27070
Email:	

Dear Caroline Welsh,

CAROLINE WELSH **DOB: 30/10/1977** **CHI No: 3010776241**

9 ST. MICHAELS PLACE, KILWINNING, AYRSHIRE, KA13 6FA

We sent you a letter a few weeks ago advising that you have been on the Oral/Maxillofacial Service outpatient waiting list for some time.

We asked that you contact us to confirm whether:

- You still require an appointment with the service or
- You no longer require an appointment so we can remove you from the waiting list.

According to our records we have not received any response. Please note that you will now be removed from the waiting list.

If you have any queries in relation to this letter please contact Referral Management Service 01563 827070.

Yours sincerely

Referral Management Service

INVESTING IN VOLUNTEERS

Ms Shona Jackson
Dental Surgeon
Seagate Dental
8 Seagate
Irvine
KA12 8RH

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101032442847F

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

DermatologyA7
AA Gen Ref - PMH Med & High

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
Ayrshire
KA2 0BE

Ethnic Origin	Not Stated
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	12-Mar-2024
Date submitted	13-Mar-2024

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

9 St Michaels Place
Kilwinning
KA13 6FA

Contact number(s)

Voice: 07875 530 530
Voice: 07875530530

REGISTERED GP DETAILS

Name	Dr Fiona Hamilton		
GMC code	7042380	GP code	21709
Practice name	Oxenward Surgery (16888)		
Practice code	80768		

Practice address

Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire & Arran

Contact number(s)

Voice: 01294 551555

REFERRING PRACTITIONER DETAILS

Name	Dr. Nicola McNeil		
GMC code	7411160	GP code	22012
Practice name	Oxenward Surgery (80768)		
Practice code	80768		

Practice address

3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Contact number(s)

Voice: 01294 551555

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: FOR ADVICE PLEASE

Comment: Thank you for reviewing this lesion on this 44 year old lady's back. It appeared about 3 years ago and intermittently becomes inflamed, bigger, stinging and then resolves and settles again although it never disappears. I thought this may represent a dermatofibroma however the story of this waxing and waning made me a little concerned and I would appreciate your advice on how to proceed. Many thanks.

Examinations and Investigations

Height:	172	-
Weight(kg):	109.6	-
BMI:	37.18	-
Never smoked tobacco:		20-Jul-2022
Trivial drinker - <1u/day:		19-Dec-2023
Alcohol consumption, 2 units/week:		20-Jul-2022
Aerobic exercise 3+ times/week:		20-Jul-2022

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Carrier of haemochromatosis HFE gene mutation	-	-	-	23-May-2023	23-May-2023

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Sertraline Hydrochloride Tablets 50 mg	0403030Q0AAAAAA	56 TABLET	1 DAILY - 150MG DAILY DOSE	-	31-Oct-2023	-	26-Feb-2024
Sertraline Hydrochloride Tablets 100 mg	0403030Q0AAABAB	56 tablet	ONE TO BE TAKEN EACH DAY	-	25-Aug-2023	-	26-Feb-2024
Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	21-Apr-2023	-	07-Feb-2024
Co-Codamol 15/500 Tablets	-	100 tablet	TAKE ONE TO TWO TABLETS UP TO 4 TIMES DAILY IF REQUIRED	-	12-Apr-2023	-	29-Nov-2023
Naproxen Tablets 500 mg	1001010P0AAAEAE	112 tablet	ONE TO BE TAKEN TWICE A DAY	-	08-Mar-2023	-	07-Feb-2024

Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAHAH	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	01-Nov-2022	-	07-Feb-2024
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN EACH DAY	-	28-Jul-2022	-	07-Feb-2024

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Orlistat Capsules 120 mg	0405010P0AAAAAA	84 CAPSULE	ONE TO BE TAKEN WITH EACH MAIN MEAL UP TO THREE TIMES A DAY	-	23-Feb-2024	28 Days	23-Feb-2024
Neomycin And Chlorhexidine Hydrochloride Cream 0.5 % + 0.1 %	-	15 gram	USE 4 TIMES A DAY	-	16-Jan-2024	42 Days	16-Jan-2024

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Resident GP

Social circumstances

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101032268904F

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

Respiratory MedicineAQ
AA Respiratory

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
Ayrshire
KA2 0BE

Ethnic Origin	Not Stated
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	23-Feb-2024
Date submitted	27-Feb-2024

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

9 St Michaels Place
Kilwinning
KA13 6FA

Contact number(s)

Voice: 07875 530 530

REGISTERED GP DETAILS

Name	Dr Fiona Hamilton		
GMC code	7042380	GP code	21709
Practice name	Oxenward Surgery (16888)		
Practice code	80768		

Practice address

Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire & Arran

Contact number(s)

Voice: 01294 551555

REFERRING PRACTITIONER DETAILS

Name	Dr. Fiona Hamilton		
GMC code	7042380	GP code	21709
Practice name	Oxenward Surgery (80768)		
Practice code	80768		

Practice address

3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Contact number(s)

Voice: 01294 551555

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: ?sleep apnoea

Comment: Sleep Apnoea Clinic Dear Colleague Many thanks for assessing this 46 year old lady with ?sleep apnoea. She reports she snores when she is sleeping and her husband reports that there are pauses in her breathing when she is asleep. She feels tired all the time and her bloods do not show any obvious causes for this. Her Epworth Sleepiness Score is 16. Her BMI is 37. I have advised her regarding weight loss and she is going to try Orlisat for that. I would most appreciate your assessment. Many thanks. Yours sincerely Dr Fiona Hamilton

Examinations and Investigations

Height:	172	-
Weight(kg):	110	-
BMI:	37.18	-
Never smoked tobacco:	20-Jul-2022	
Trivial drinker - <1u/day:	19-Dec-2023	
Alcohol consumption, 2 units/week:	20-Jul-2022	
Aerobic exercise 3+ times/week:	20-Jul-2022	

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Carrier of haemochromatosis HFE gene mutation	-	-	-	23-May-2023	23-May-2023

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Sertraline Hydrochloride Tablets 50 mg	0403030Q0AAAAAA	56 TABLET	1 DAILY - 150MG DAILY DOSE	-	31-Oct-2023	-	29-Nov-2023
Sertraline Hydrochloride Tablets 100 mg	0403030Q0AAABAB	56 tablet	ONE TO BE TAKEN EACH DAY	-	25-Aug-2023	-	29-Nov-2023
Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	21-Apr-2023	-	07-Feb-2024
Co-Codamol 15/500 Tablets	-	100 tablet	TAKE ONE TO TWO TABLETS UP TO 4 TIMES DAILY IF REQUIRED	-	12-Apr-2023	-	29-Nov-2023
Naproxen Tablets 500 mg	1001010P0AAAEAE	112 tablet	ONE TO BE TAKEN	-	08-Mar-2023	-	07-Feb-2024

			TWICE A DAY				
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAHAH	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	01-Nov-2022	-	07-Feb-2024
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN EACH DAY	-	28-Jul-2022	-	07-Feb-2024

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Orlistat Capsules 120 mg	0405010P0AAAAAA	84 CAPSULE	ONE TO BE TAKEN WITH EACH MAIN MEAL UP TO THREE TIMES A DAY	-	23-Feb-2024	28 Days	23-Feb-2024
Neomycin And Chlorhexidine Hydrochloride Cream 0.5 % + 0.1 %	-	15 gram	USE 4 TIMES A DAY	-	16-Jan-2024	42 Days	16-Jan-2024
Co-Codamol 30/500 Tablets	0407010F0AAAHAH	50 tablet	TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	15-Nov-2023	57 Days	30-Nov-2023

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Social circumstances

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101032038996A

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

Ear, Nose & Throat (ENT)C5
AA Gen Ref - PMH Med & High

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
Ayrshire
KA2 0BE

Ethnic Origin	Not Stated
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	01-Feb-2024
Date submitted	09-Feb-2024

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

9 St Michaels Place
Kilwinning
KA13 6FA

Contact number(s)

Voice: 07875 530 530
Voice: 07875530530

REGISTERED GP DETAILS

Name	Dr Fiona Hamilton		
GMC code	7042380	GP code	21709
Practice name	Oxenward Surgery (16888)		
Practice code	80768		

Practice address

Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire & Arran

Contact number(s)

Voice: 01294 551555

REFERRING PRACTITIONER DETAILS

Name	Dr. Fiona Hamilton		
GMC code	7042380	GP code	21709
Practice name	Oxenward Surgery (80768)		
Practice code	80768		

Practice address

3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Contact number(s)

Voice: 01294 551555

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Nosebleeds with sensation of nostrils collapsing

Comment: Dear Doctor Many thanks for assessing this 46 year old lady with nosebleeds and also has a sensation that her nostrils collapse when she's taking a deep breath in. She tells me she wears a 'cage' to keep her nostrils patent when she is in bed and she snores loudly. On examination both nostrils inflamed around little's area and there were no masses seen in her nose. I have given her naseptin to try and advised her to stop using the cage incase this is causing the inflammation of the nostrils. I would be most grateful if she could be seen for ENT review to see whether she does have a problem with her nostrils collapsing. Many thanks. Yours sincerely Dr Fiona Hamilton

Examinations and Investigations

Height:	172	-
Weight(kg):	111	-
BMI:	37.52	-
Never smoked tobacco:	20-Jul-2022	
Trivial drinker - <1u/day:	19-Dec-2023	
Alcohol consumption, 2 units/week:	20-Jul-2022	
Aerobic exercise 3+ times/week:	20-Jul-2022	

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Carrier of haemochromatosis HFE gene mutation	-	-	-	23-May-2023	23-May-2023

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribe Date
Sertraline Hydrochloride Tablets 50 mg	0403030Q0AAAAAA	56 TABLET	1 DAILY - 150MG DAILY DOSE	-	31-Oct-2023	-	29-Nov-2023
Sertraline Hydrochloride Tablets 100 mg	0403030Q0AAABAB	56 tablet	ONE TO BE TAKEN EACH DAY	-	25-Aug-2023	-	29-Nov-2023
Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	21-Apr-2023	-	29-Nov-2023
Co-Codamol 15/500 Tablets	-	100 tablet	TAKE ONE TO TWO TABLETS UP TO 4 TIMES DAILY IF REQUIRED	-	12-Apr-2023	-	29-Nov-2023

Naproxen Tablets 500 mg	1001010P0AAAEAE	112 tablet	ONE TO BE TAKEN TWICE A DAY	-	08-Mar-2023	-	29-Nov-2023
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAHAH	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	01-Nov-2022	-	29-Nov-2023
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN EACH DAY	-	28-Jul-2022	-	29-Nov-2023

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Neomycin And Chlorhexidine Hydrochloride Cream 0.5 % + 0.1 %	-	15 gram	USE 4 TIMES A DAY	-	16-Jan-2024	42 Days	16-Jan-2024
Melolin Dressing 5 cm x 5 cm	20030100070	25 dressing	AS DIRECTED	-	22-Nov-2023	43 Days	23-Nov-2023
Micropore Surgical Tape 5.0 cm x 5 m	20100000533	1 tape	AS DIRECTED	-	22-Nov-2023	43 Days	23-Nov-2023
Co-Codamol 30/500 Tablets	0407010F0AAAHAH	50 tablet	TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	15-Nov-2023	57 Days	30-Nov-2023

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Social circumstances

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101031708924M

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

GastroenterologyA9
AA Gen Ref - PMH Med & High

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
Ayrshire
KA2 0BE

Ethnic Origin	Not Stated
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	22-Dec-2023
Date submitted	27-Dec-2023

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

9 St Michaels Place
Kilwinning
KA13 6FA

Contact number(s)

Voice: 07875 530 530
Voice: 07875530530

REGISTERED GP DETAILS

Name	Dr Fiona Hamilton		
GMC code	7042380	GP code	21709
Practice name	Oxenward Surgery (16888)		
Practice code	80768		

Practice address

Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire & Arran

Contact number(s)

Voice: 01294 551555

REFERRING PRACTITIONER DETAILS

Name	Dr. Fiona Hamilton		
GMC code	7042380	GP code	21709
Practice name	Oxenward Surgery (80768)		
Practice code	80768		

Practice address

3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Contact number(s)

Voice: 01294 551555

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: ?hemochromatosis with raised ferritin and deranged LFT's

Comment: Dear Doctor I am writing regarding this 46 year old lady who has raised ferritin and slightly deranged LFT's. In October 2022 she had hemochromatosis genetics checked and was found to be a carrier. She drinks alcohol very occasionally every few months if there is a social occasion. In comparison to one year ago her raised transaminases have got slightly worse. I have referred her for a liver ultrasound scan and will get the rest of her bloods checked for a liver screen. I would most appreciate your assessment regarding the cause of her deranged LFT's. I would appreciate your assessment. Many thanks. Yours sincerely Dr Fiona Hamilton

Examinations and Investigations

Height:	172	-
Weight(kg):	111	-
BMI:	37.52	-
Never smoked tobacco:		20-Jul-2022
Trivial drinker - <1u/day:		19-Dec-2023
Alcohol consumption, 2 units/week:		20-Jul-2022
Aerobic exercise 3+ times/week:		20-Jul-2022

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Carrier of haemochromatosis HFE gene mutation	-	-	-	23-May-2023	23-May-2023

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Sertraline Hydrochloride Tablets 50 mg	0403030Q0AAAAAA	56 TABLET	1 DAILY - 150MG, DAILY DOSE	-	31-Oct-2023	-	29-Nov-2023
Sertraline Hydrochloride Tablets 100 mg	0403030Q0AAABAB	56 tablet	ONE TO BE TAKEN EACH DAY	-	25-Aug-2023	-	29-Nov-2023
Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	21-Apr-2023	-	29-Nov-2023
Co-Codamol 15/500 Tablets	-	100 tablet	TAKE ONE TO TWO TABLETS UP TO 4 TIMES DAILY IF REQUIRED	-	12-Apr-2023	-	29-Nov-2023
Naproxen Tablets 500	1001010P0AAAEAE	112 tablet	ONE TO BE TAKEN	-	08-Mar-	-	29-Nov-2023

mg			TWICE A DAY		2023		
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAHAH	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	01-Nov-2022	-	29-Nov-2023
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN EACH DAY	-	28-Jul-2022	-	29-Nov-2023

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Melolin Dressing 5 cm x 5 cm	20030100070	25 dressing	AS DIRECTED	-	22-Nov-2023	43 Days	23-Nov-2023
Micropore Surgical Tape 5.0 cm x 5 m	20100000533	1 tape	AS DIRECTED	-	22-Nov-2023	43 Days	23-Nov-2023
Co-Codamol 30/500 Tablets	0407010F0AAAHAH	50 tablet	TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	15-Nov-2023	57 Days	30-Nov-2023
Flucloxacillin Capsules 500 mg	0501012G0AAABAB	28 capsule	ONE TO BE TAKEN FOUR TIMES A DAY	-	16-Oct-2023	7 Days	16-Oct-2023
Fusidic Acid Cream 2 %	1310012F0AAABAB	15 gram	APPLY THREE TO FOUR TIMES A DAY	-	02-Oct-2023	42 Days	02-Oct-2023
Co-Codamol 30/500 Tablets	0407010F0AAAHAH	50 tablet	TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	27-Sep-2023	6 Days	27-Sep-2023

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Social circumstances

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101031429763M

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

Community Mental Health Services - North G1AD
AA Adult Mental Health

Community Mental Health Services - Adult
NHS Ayrshire & Arran

Ethnic Origin	Not Stated
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	22-Nov-2023
Date submitted	22-Nov-2023

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

9 St Michaels Place
Kilwinning
KA13 6FA

Contact number(s)

Voice: 07875 530 530

REGISTERED GP DETAILS

Name	Dr Fiona Hamilton		
GMC code	7042380	GP code	21709
Practice name	Oxenward Surgery (16888)		
Practice code	80768		

Practice address

Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire & Arran

Contact number(s)

Voice: 01294 551555

REFERRING PRACTITIONER DETAILS

Name	Emma Barbour, MHP Oxenward Surgery Kilwinning		
GMC code	Unknown	GP code	-
Practice name	Ayrshire Medical Group (81012)		
Practice code	81012		

Practice address

The Health Centre
20 Main Street
Stevenston
KA20 3AB

Contact number(s)

Voice: 01294 464141

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Psychology referral for Input to aid symptoms of obsessions and compulsions

Comment: Stated has had a traumatic childhood and has been able to 'cope with it as I am a strong person'. But advised being triggered by her friends? death in February, she died 2 weeks following diagnosis and husband currently terminally ill and she is his carer, stated 'the lines are blurred as I'm now a carer at work and a carer at home'. States has OCD tendencies (not diagnosed). When asked in which way she feels she struggles with obsessions or compulsions, she stated it is 'cleanliness, germs, perfectionism, I can't be out of routine, if my husband makes soup and puts something different in I hit the roof'. Reports can be up all night cleaning. Gets family involved at ?sometimes as late as 11 at night, I call it OCD by proxy?. States routines and cleaning are ?constant?. Reported difficult childhood, Mum and Dad split when she was 3, lived with Mum, witness Dad 'severely maim a neighbour' when she was 3 or 4, states had nightmares about this until 16. 'This is when it all started'. Was placed in care at 12 'due to my behaviour, I wouldn't go to school'. Stated Mum 'couldn't give me what I needed' but spoke about same in financial terms, stated she 'loved and cared for me but couldn't give me what I needed', stated ?I ate beans on toast when she smoked. Care was the best thing, they looked after me and helped me'. When asked if she had experienced any abuse prior to care she began to cry and stated 'yes?. Caroline disclosed childhood sexual abuse, states at 9 'the neighbours son did sexual stuff to me as a one off, I didn't stop him, I liked the attention, then I used my body to get attention hoping someone would take me away from home'. States at the same time her cousin was sexually abusing her for 'a wee while, maybe couple of years'. Asked about past psychiatric input. Stated she saw psychologist inpatient for one year ('6 months inpatient, 6 months outpatient) stated this was a talking therapy and did not help and cannot remember what preceded this referral. No other psychiatric input prior to counselling currently received. Mood: Irritable, overwhelmed. Anxiety: No panic or physical symptoms but ^^ generalised anxiety. Sleep 'all over the place' since February, normally ok. No current thoughts of suicide or self harm. Denied problematic alcohol use. No illicit substance use. No forensic history.

Examinations and Investigations

If referral is urgent, has this been discussed with duty clinician:	No	-
1. Are there current active thoughts of self harm, is there a plan?:	No	-
Is there a History of suicidal or self harm injurious behaviours?:	No	-
Any history or current threat of violence or aggression, considerations to staff safety?:	No	-
Any social circumstances or previous psychiatric history impacting on current presentation?:	No	-
Considerations of vulnerability /Child Protection Issues/ First presentation Psychosis/ Peri-Natal:	No	-
Height:	172	-
Weight(kg):	111	-
BMI:	37.52	-
Never smoked tobacco:		20-Jul-2022
Alcohol consumption, 2 units/week:		20-Jul-2022
Aerobic exercise 3+ times/week:		20-Jul-2022

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date

Carrier of haemochromatosis HFE gene mutation	-	-	-	23-May-2023	23-May-2023

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Sertraline Hydrochloride Tablets 50 mg	0403030Q0AAAAAA	56 TABLET	1 DAILY - 150MG DAILY DOSE	-	31-Oct-2023	-	31-Oct-2023
Sertraline Hydrochloride Tablets 100 mg	0403030Q0AAABAB	56 tablet	ONE TO BE TAKEN EACH DAY	-	25-Aug-2023	-	31-Oct-2023
Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	21-Apr-2023	-	09-Oct-2023
Co-Codamol 15/500 Tablets	-	100 tablet	TAKE ONE TO TWO TABLETS UP TO 4 TIMES DAILY IF REQUIRED	-	12-Apr-2023	-	09-Oct-2023
Naproxen Tablets 500 mg	1001010P0AAAEAE	112 tablet	ONE TO BE TAKEN TWICE A DAY	-	08-Mar-2023	-	09-Oct-2023
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAHAH	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	01-Nov-2022	-	09-Oct-2023
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN EACH DAY	-	28-Jul-2022	-	09-Oct-2023

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Co-Codamol 30/500 Tablets	0407010F0AAAHAH	50 tablet	TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	15-Nov-2023	42 Days	15-Nov-2023
Flucloxacillin Capsules 500 mg	0501012G0AAABAB	28 capsule	ONE TO BE TAKEN FOUR TIMES A DAY	-	16-Oct-2023	7 Days	16-Oct-2023
Fusidic Acid Cream 2 %	1310012F0AAABAB	15 gram	APPLY THREE TO FOUR	-	02-Oct-2023	42 Days	02-Oct-2023

			TIMES A DAY				
Co-Codamol 30/500 Tablets	0407010F0AAAHAH	50 tablet	TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	27-Sep-2023	6 Days	27-Sep-2023
Sertraline Hydrochloride Tablets 50 mg	0403030Q0AAAAAA	56 TABLET	1 DAILY - 150MG DAILY DOSE	-	18-Jul-2023	104 Days	08-Sep-2023

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Other Agency

Social circumstances

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 1010311693145

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

Podiatry - HRR1A2
AA AHPs

AHP - South
SCI Gateway Virtual Location
NHS Ayrshire & Arran

Ethnic Origin	Not Stated
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	**Urgent**
Date of referral	26-Oct-2023
Date submitted	26-Oct-2023

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

9 St Michaels Place
Kilwinning
KA13 6FA

Contact number(s)

Voice: 07875 530 530

REGISTERED GP DETAILS

Name	Dr Fiona Hamilton		
GMC code	7042380	GP code	21709
Practice name	Oxenward Surgery (16888)		
Practice code	80768		

Practice address

Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire & Arran

Contact number(s)

Voice: 01294 551555

REFERRING PRACTITIONER DETAILS

Name	Dr. Caroline Woodburn		
GMC code	4507556	GP code	21687
Practice name	Oxenward Surgery (80768)		
Practice code	80768		

Practice address

3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Contact number(s)

Voice: 01294 551555

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Ingrown Toenail

Comment: Dear Colleague This 45 year old female is having difficulties with an ingrown toenail on the right great toe. Despite antibiotics the area is not settling and she is in pain with discharge constantly. I would be grateful if she could be seen for further treatment. Many thanks for arranging this. Yours sincerely Dr Caroline Woodburn

Examinations and Investigations

Height:	172	-
Weight(kg):	111	-
BMI:	37.52	-
Never smoked tobacco:		20-Jul-2022
Alcohol consumption, 2 units/week:		20-Jul-2022
Aerobic exercise 3+ times/week:		20-Jul-2022

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Carrier of haemochromatosis HFE gene mutation	-	-	-	23-May-2023	23-May-2023

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Sertraline Hydrochloride Tablets 100 mg	0403030Q0AAABAB	56 tablet	ONE TO BE TAKEN EACH DAY	-	25-Aug-2023	-	05-Sep-2023
Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	21-Apr-2023	-	09-Oct-2023
Co-Codamol 15/500 Tablets	-	100 tablet	TAKE ONE TO TWO TABLETS UP TO 4 TIMES DAILY IF REQUIRED	-	12-Apr-2023	-	09-Oct-2023
Naproxen Tablets 500 mg	1001010P0AAAEAE	112 tablet	ONE TO BE TAKEN TWICE A DAY	-	08-Mar-2023	-	09-Oct-2023
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAHAH	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	01-Nov-2022	-	09-Oct-2023
Omeprazole Capsules	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN	-	28-Jul-2022	-	09-Oct-2023

(Gastro-Resistant) 20 mg			EACH DAY				

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Flucloxacillin Capsules 500 mg	0501012G0AAABAB	28 capsule	ONE TO BE TAKEN FOUR TIMES A DAY	-	16-Oct-2023	7 Days	16-Oct-2023
Fusidic Acid Cream 2 %	1310012F0AAABAB	15 gram	APPLY THREE TO FOUR TIMES A DAY	-	02-Oct-2023	42 Days	02-Oct-2023
Co-Codamol 30/500 Tablets	0407010F0AAAHAH	50 tablet	TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	27-Sep-2023	6 Days	27-Sep-2023
Sertraline Hydrochloride Tablets 50 mg	0403030Q0AAAAAA	56 TABLET	1 DAILY - 150MG DAILY DOSE	-	18-Jul-2023	104 Days	08-Sep-2023

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Social circumstances

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

NHS
Ayrshire
& Arran

Caroline Welsh
9 St. Michaels Place,
Kilwinning,
Ayrshire,
KA13 6FA

Date 02/10/2023

Our Ref: DYRTR/KM/3010776241

Dear Caroline Welsh

Musculoskeletal (MSK) Services Department (including Orthotics Services) - NHS Ayrshire and Arran

This is an information letter to inform you that your referral has been removed from our waiting list due to the following reason:

- You failed to respond to your letter advising you to contact the department to organise your appointment to start your treatment.

We have advised your **Referring Practitioner.**

Further advice on musculoskeletal problems and management can be found at:

www.nhsinform.co.uk/msk

MSK Services

Copy to referrer:
Dr F Hamilton
Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101029222775B

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

Elbow, Wrist and Hand R5A2
AA Elbow, Wrist and Hand

Musculoskeletal Triage and Treatment
NHS Ayrshire & Arran

Ethnic Origin	Not Stated
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	04-Apr-2023
Date submitted	04-Apr-2023

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

9 St Michaels Place
Kilwinning
KA13 6FA

Contact number(s)

Voice: 07875 530 530

REGISTERED GP DETAILS

Name	Dr Fiona Hamilton		
GMC code	7042380	GP code	21709
Practice name	Oxenward Surgery (16888)		
Practice code	80768		

Practice address

Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire & Arran

Contact number(s)

Voice: 01294 551555

REFERRING PRACTITIONER DETAILS

Name	Dr. Catherine Lobb		
GMC code	3054129	GP code	24619
Practice name	Oxenward Surgery (80768)		
Practice code	80768		

Practice address

3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Contact number(s)

Voice: 01294 551555

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: bilaterla elbow pain

Comment: This 45 year old care worker complains of pain in both elbows ongoing despite various analgesics and topical diclofenac. She has changed her mattress and pillows, her elbows are particular sore first thing in the morning. She does have a past diagnosis of fibromyalgia. Recent bloods have been normal. She appears tender on both sides. She is getting a bit discouraged by the persistence of her symptoms and I would be grateful for your assessment and input. Many thanks Dr C J Lobb

Examinations and Investigations

How long has the patient had this episode of symptoms?:	> 3 Months	-
Where is the patients pain?:	Elbow	-
Does the patient have stiffness and/or swelling?:	No	-
Is there a history of trauma?:	No	-
Height:	172	-
Weight(kg):	111	-
BMI:	37.52	-
Never smoked tobacco:		20-Jul-2022
Alcohol consumption, 2 units/week:		20-Jul-2022
Aerobic exercise 3+ times/week:		20-Jul-2022

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Knee joint pain	-	-	-	09-Feb-2023	09-Feb-2023

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Naproxen Tablets 500 mg	1001010P0AAAEAE	112 tablet	ONE TO BE TAKEN TWICE A DAY	-	08-Mar-2023	-	08-Mar-2023
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAHAH	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	01-Nov-2022	-	27-Feb-2023
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN EACH DAY	-	28-Jul-2022	-	27-Feb-2023

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed

							Date
Alginate Raft-forming Oral Suspension Sugar Free	-	500 ml	5 ML AFTER MEALS AND BEFORE BED	-	08-Mar-2023	42 Days	08-Mar-2023
Meloxicam Tablets 15 mg	1001010AAAAABAB	30 TABLET	ONE TO BE TAKEN DAILY	-	01-Mar-2023	30 Days	01-Mar-2023
Naproxen Tablets 500 mg	1001010P0AAAEAE	112 tablet	ONE TO BE TAKEN TWICE A DAY	-	26-Sep-2022	-	27-Feb-2023

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Social circumstances

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101029222775B

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

Elbow, Wrist and Hand R5A2
AA Elbow, Wrist and Hand

Musculoskeletal Triage and Treatment
NHS Ayrshire & Arran

Ethnic Origin	Not Stated
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	04-Apr-2023
Date submitted	04-Apr-2023

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

9 St Michaels Place
Kilwinning
KA13 6FA

Contact number(s)

Voice: 07875 530 530

REGISTERED GP DETAILS

Name	Dr Fiona Hamilton		
GMC code	7042380	GP code	21709
Practice name	Oxenward Surgery (16888)		
Practice code	80768		

Practice address

Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire & Arran

Contact number(s)

Voice: 01294 551555

REFERRING PRACTITIONER DETAILS

Name	Dr. Catherine Lobb		
GMC code	3054129	GP code	24619
Practice name	Oxenward Surgery (80768)		
Practice code	80768		

Practice address

3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

Contact number(s)

Voice: 01294 551555

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: bilaterla elbow pain

Comment: This 45 year old care worker complains of pain in both elbows ongoing despite various analgesics and topical diclofenac. She has changed her mattress and pillows, her elbows are particular sore first thing in the morning. She does have a past diagnosis of fibromyalgia. Recent bloods have been normal. She appears tender on both sides. She is getting a bit discouraged by the persistence of her symptoms and I would be grateful for your assessment and input. Many thanks Dr C J Lobb

Examinations and Investigations

How long has the patient had this episode of symptoms?:	> 3 Months	-
Where is the patients pain?:	Elbow	-
Does the patient have stiffness and/or swelling?:	No	-
Is there a history of trauma?:	No	-
Height:	172	-
Weight(kg):	111	-
BMI:	37.52	-
Never smoked tobacco:		20-Jul-2022
Alcohol consumption, 2 units/week:		20-Jul-2022
Aerobic exercise 3+ times/week:		20-Jul-2022

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Knee joint pain	-	-	-	09-Feb-2023	09-Feb-2023

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Naproxen Tablets 500 mg	1001010P0AAAEAE	112 tablet	ONE TO BE TAKEN TWICE A DAY	-	08-Mar-2023	-	08-Mar-2023
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAHAH	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	01-Nov-2022	-	27-Feb-2023
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN EACH DAY	-	28-Jul-2022	-	27-Feb-2023

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed

							Date
Alginate Raft-forming Oral Suspension Sugar Free	-	500 ml	5 ML AFTER MEALS AND BEFORE BED	-	08-Mar-2023	42 Days	08-Mar-2023
Meloxicam Tablets 15 mg	1001010AAAAABAB	30 TABLET	ONE TO BE TAKEN DAILY	-	01-Mar-2023	30 Days	01-Mar-2023
Naproxen Tablets 500 mg	1001010P0AAAEAE	112 tablet	ONE TO BE TAKEN TWICE A DAY	-	26-Sep-2022	- -	27-Feb-2023

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Social circumstances

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 1010279138179

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

Oral and Maxillofacial SurgeryC13
AA OMFS

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
Ayrshire
KA2 0BE

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	08-Nov-2022
Date submitted	08-Nov-2022

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

9 St Michaels Place
Kilwinning
KA13 6FA

Contact number(s)

Voice: 07875530530

REGISTERED GP DETAILS

Practice address

REFERRING HCP DETAILS

Name	ShonaJackson
GMC Code	-
Organisation Name	Seagate Dental Practice Irvine
Location Code	A00652D

Organisation address

8 Seagate
Irvine
KA12 8RH

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: retained roots LL6

Comment: Attempted extraction LL6 in practice October 2022-crown fractured off and roots left in situ. See PA attached. On/off pain since extraction. One course of antibiotics has been taken. I would appreciate it if you could examine Caroline for surgical extraction retained roots LL6. Many thanks

Examinations and Investigations

Main Complaint:	Dentoalveolar Surgery
Interpreter Required?:	No
Additional Relevant Medical History:	Medications: Amitriptyline, Naproxen, Omeprazole Allergies: Latex Non-smoker Alcohol nil

Reason for referral

Care type requested: Dental

Expected outcome: Dental

Past medical history

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

No current medications recorded

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

No recent medications recorded

Clinical warnings

Smoking status

Alcohol consumption

Additional relevant information

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

For Office/Consultant Use Only - **Please circle appropriate destination/priority**

	Ayr		**Crosshouse**	
Urgent	**Soon**	**Routine**	**Early (X-Ray)**	**Late**

MSK
Musculoskeletal Service

MSK DISCHARGE REPORT

NHS
Ayrshire
& Arran

Patient Name:	Caroline Welsh
Address:	9 St. Michaels Terrace, Kilwinning, Ayrshire, KA13 6FF
CHI:	3010776241
GP:	Susan Knox
Consultant:	
Referrer Source:	physio
Referral Date:	
Start Date:	19/05/2022
Discharge Date:	8/09/2022
No. of treatments:	1
Discharge Reason:	Treatment complete
Treatment Outcome:	Did not require opt in facility
Therapist:	Lisa Lawson
Location:	ACH

Dear Susan, Thanks for your referral of the above patient.

Diagnosis: Caroline presented with symptoms of bilateral plantar fasciitis. She was provided with exercises a long with footwear advice and ice therapy.

Actions for GP/Follow up recommendations:

Referred on to ___n/a_____(if applicable)

Yours sincerely,
Authorised on 08/09/2022 09:56:55 by Lisa Lawson.
Lisa Lawson
08/09/2022

MSK
Musculoskeletal Service

MSK DISCHARGE REPORT

NHS
Ayrshire
& Arran

Patient Name:	Caroline Welsh
Address:	9 St. Michaels Terrace, Kilwinning, Ayrshire, KA13 6FF
CHI:	3010776241
GP:	Dr N Begg
Consultant:	
Referrer Source:	
Referral Date:	03/12/2021
Start Date:	24/01/2022
Discharge Date:	04/07/2022
No. of treatments:	3
Discharge Reason:	Treatment complete
Treatment Outcome:	
Therapist:	Susan Knox
Location:	PHYSIOTHERAPY DEPARTMENT AYRSHIRE CENTRAL HOSPITAL

Dear Dr Begg

Diagnosis: Low back pain and bilateral plantar fasciitis

Advised re exercise programme for stretching lumbar spine. Back pain more manageable but feet very troublesome therefore advised re stretched & referred onto MSK Podiatry for further assessment.

Yours sincerely,
Authorised on 04/07/2022 17:55:15 by Susan Knox.
Susan Knox
04/07/2022

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101025020409S

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

Spinal R5A1
AA Back Pain

Musculoskeletal Triage and Treatment
NHS Ayrshire & Arran

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	03-Dec-2021
Date submitted	12-Dec-2021

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

13 Mossgiel Drive
Irvine Ayrshire
KA12 0QT

Contact number(s)

-

REGISTERED GP DETAILS

Name	Dr Vickie Bothwell		
GMC code	4615183	GP code	21733
Practice name	Frew Terrace Surgery (16883)		
Practice code	80698		

Practice address

9 Frew Terrace
Irvine

Contact number(s)

Voice: 01294 272326
Facsimile: 01294 312614

REFERRING PRACTITIONER DETAILS

Name	Dr. Nicola Begg		
GMC code	7041256	GP code	20257
Practice name	Frew Terrace Surgery (80698)		
Practice code	80698		

Practice address

9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Contact number(s)

Voice: 01294 272326

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: See letter - KG

Comment: Dear Colleague, I recently referred this woman with back pain. Please see the attached original referral. Thank you for your letter back explaining that she would not be seen specifically with a view to getting an MRI. The patient understands this and is keen to be seen non the less to have physiotherapy to try and improve her symptoms. Yours sincerely

---

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Back pain, unspecified	-	-	-	22-Apr-2016	22-Apr-2016
Soft tissue disorders NOS	-	-	Minor soft tissue injury (R) hand	31-Mar-2016	31-Mar-2016
Menorrhagia	-	-	-	03-Apr-2013	03-Apr-2013
Stress incontinence	-	-	-	11-Sep-2009	11-Sep-2009
[M]Compound naevus	-	-	(R) toe - no malignancy	19-Aug-2008	19-Aug-2008
[D]Dysphonia	-	-	-	29-Nov-2006	29-Nov-2006
Spontaneous vaginal delivery	-	-	Baby Male - birthweight 5.050 kgs	06-Jun-2003	06-Jun-2003
Spontaneous vaginal delivery	-	-	Baby Female - birthweight 4.60 kgs	21-Jul-2002	21-Jul-2002
Spontaneous vaginal delivery	-	-	Baby male - birthweight 3.380 kgs	09-Feb-1998	09-Feb-1998
[X]Other migraine	-	-	-	08-Mar-1995	08-Mar-1995
Burn of the face, head or neck	-	-	Facial burns from heat lamp	09-Jan-1994	09-Jan-1994
Anterior knee pain	-	-	-	31-Aug-1993	31-Aug-1993
Soiling - encopresis	-	-	-	08-Sep-1980	08-Sep-1980
Constipation	-	-	-	13-Aug-1980	13-Aug-1980

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Mammography	-	-	No worrying changes	27-Sep-2021	27-Sep-2021
Other diagnostic ultrasound	-	-	L breast - No worrying changes	27-Sep-2021	27-Sep-2021
Abdominal hysterectomy with conservation of ovaries	-	-	-	26-Sep-2013	26-Sep-2013

Ultrasound scan of abdomen and pelvis	-	-	-	03-Jan-2012	03-Jan-2012
Anterior and posterior repair	-	-	-	14-Jul-2010	14-Jul-2010
Other diagnostic ultrasound	-	-	(R) breast - NAD	18-Nov-2004	18-Nov-2004
Blood group A Rh(D) positive	-	-	-	09-Jan-2002	09-Jan-2002
Dye test of fallopian tube	-	-	-	11-Mar-1997	11-Mar-1997
Appendicectomy NEC	-	-	-	13-Apr-1993	13-Apr-1993

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN EACH DAY	-	23-Jun-2021	-	11-Nov-2021
Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	56 tablet	ONE OR TWO BE TAKEN AT NIGHT	-	17-Feb-2020	-	11-Nov-2021

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Naproxen Tablets 500 mg	1001010P0AAAEAE	56 TABLET	ONE TO BE TAKEN TWICE A DAY	-	18-Oct-2021	52 Days	11-Nov-2021

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101024932494I

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

Spinal R5A1
AA Back Pain

Musculoskeletal Triage and Treatment
NHS Ayrshire & Arran

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	23-Nov-2021
Date submitted	23-Nov-2021

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

13 Mossgiel Drive
Irvine Ayrshire
KA12 0QT

Contact number(s)

-

REGISTERED GP DETAILS

Name	Dr Vickie Bothwell		
GMC code	4615183	GP code	21733
Practice name	Frew Terrace Surgery (16883)		
Practice code	80698		

Practice address

9 Frew Terrace
Irvine

Contact number(s)

Voice: 01294 272326
Facsimile: 01294 312614

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Name	Dr. Nicola Begg		
GMC code	7041256	GP code	20257
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Practice code	80698		

Practice address

9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Contact number(s)

Voice: 01294 272326

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: see letter ks

Comment: Dear Colleague, I would be grateful for your input with this 44 year old woman who has chronic sciatica. She has had previous investigations and pain clinic input down in England but not for several years. If there were any surgical interventions that were likely to help she would certainly consider this and I wonder if it would be worthwhile getting an MRI scan. She has chronic pain in the left upper posterior thigh which intermittently radiates down the leg to the knee and sometimes all the way down to the bottom of the leg. She has no neurological symptoms or cauda equina symptoms. There are no red flags. The pain is really limiting. She works as a carer and only manages due to having a supportive work partner who helps her out when her pain is bad. She also cares for her husband who has myeloma and her pain makes this difficult too. She told me she had x-rays a few years ago in England which were also normal. She is taking Amitriptyline 20 mg and Naproxen. She has fibromyalgia. On examination she has no tenderness of the lumber spine or sacro iliac joints. She is tender in both groins but not over her greater trochanters. Her straight leg raise is actually negative bilaterally. Passive hip movements are not painful. She has a normal neurological examination of her lower limbs apart from an absent right ankle jerk. She works for North Ayrshire Council and had over recent months been engaged with a physiotherapist which was arranged through her work. She has been carrying out exercises as advised and feel these helped to a certain extent but not enough. She is keen to know if anything further can be done. Yours sincerely

---

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Back pain, unspecified	-	-	-	22-Apr-2016	22-Apr-2016
Soft tissue disorders NOS	-	-	Minor soft tissue injury (R) hand	31-Mar-2016	31-Mar-2016
Menorrhagia	-	-	-	03-Apr-2013	03-Apr-2013
Stress incontinence	-	-	-	11-Sep-2009	11-Sep-2009
[M]Compound naevus	-	-	(R) toe - no malignancy	19-Aug-2008	19-Aug-2008
[D]Dysphonia	-	-	-	29-Nov-2006	29-Nov-2006
Spontaneous vaginal delivery	-	-	Baby Male - birthweight 5.050 kgs	06-Jun-2003	06-Jun-2003
Spontaneous vaginal delivery	-	-	Baby Female - birthweight 4.60 kgs	21-Jul-2002	21-Jul-2002
Spontaneous vaginal delivery	-	-	Baby male - birthweight 3.380 kgs	09-Feb-1998	09-Feb-1998
[X]Other migraine	-	-	-	08-Mar-1995	08-Mar-1995
Burn of the face, head or neck	-	-	Facial burns from heat lamp	09-Jan-1994	09-Jan-1994

Anterior knee pain	-	-	-		31-Aug-1993	31-Aug-1993
Soiling - encopresis	-	-	-		08-Sep-1980	08-Sep-1980
Constipation	-	-	-		13-Aug-1980	13-Aug-1980

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Mammography	-	-	No worrying changes	27-Sep-2021	27-Sep-2021
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Abdominal hysterectomy with conservation of ovaries	-	-	-	26-Sep-2013	26-Sep-2013
Ultrasound scan of abdomen and pelvis	-	-	-	03-Jan-2012	03-Jan-2012
Anterior and posterior repair	-	-	-	14-Jul-2010	14-Jul-2010
Other diagnostic ultrasound	-	-	(R) breast - NAD	18-Nov-2004	18-Nov-2004
Blood group A Rh(D) positive	-	-	-	09-Jan-2002	09-Jan-2002
Dye test of fallopian tube	-	-	-	11-Mar-1997	11-Mar-1997
Appendicectomy NEC	-	-	-	13-Apr-1993	13-Apr-1993

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

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Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN EACH DAY	-	23-Jun-2021	-	11-Nov-2021
Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	56 tablet	ONE OR TWO BE TAKEN AT NIGHT	-	17-Feb-2020	-	11-Nov-2021

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Naproxen Tablets 500 mg	1001010P0AAAEAE	56 TABLET	ONE TO BE TAKEN TWICE A DAY	-	18-Oct-2021	52 Days	11-Nov-2021

Clinical warnings Smoking status Alcohol consumption

Lifestyle risks

	Number per day	Units per day
Exercise status: Not Known	? (not known)	? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

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

General Surgical Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
Tel 01563 826792

www.nhsaaa.net

Confidential - Clinical Information

Sister Esther Bull
Advanced Nurse Practitioner
Frew Terrace Surgery
Frew Terrace
IRVINE
KA12 9DY

Our Ref: ST/LG
Hospital No:
Clinic Date: 27/09/2021
Date Dictated: 27/09/2021
Date Typed: 01/10/2021
Enquiries to Lee Gracie
Direct Line: Tel 01563 826792
Ext. Number: 26792
Email: Lee.Gracie@aapct.scot.nhs.uk

Dear Sister Bull,

CAROLINE WELSH DOB: 30/10/1977 CHI No: 3010776241
13 MOSSGIEL DRIVE, IRVINE, AYRSHIRE, KA12 0QT

Thank you for referring this 43 year old who I saw in the clinic today. She is complaining of left sided breast lump. She had no risk factors of note.

On examination there is a slight nodular area in the area of patient concern superiorly in the left breast but this is not clinically concerning. Mammogram and ultrasound were performed which show no worrying changes and she was reassured and discharged.

Yours sincerely

Authorised on 04/10/2021 08:39:32 by Sian Tovey.

Sian Tovey
Consultant Breast Surgeon
GMC: 4552491

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101024061722R

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

General Surgery (excl Vascular)C11
AA Breast Disease

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
Ayrshire
KA2 0BE

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	10-Aug-2021
Date submitted	10-Aug-2021

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

13 Mossgiel Drive
Irvine Ayrshire
KA12 0QT

Contact number(s)

-

REGISTERED GP DETAILS

Name	Dr Vickie Bothwell		
GMC code	4615183	GP code	21733
Practice name	Frew Terrace Surgery (16883)		
Practice code	80698		

Practice address

9 Frew Terrace
Irvine

Contact number(s)

Voice: 01294 272326
Facsimile: 01294 312614

REFERRING PRACTITIONER DETAILS

Name	Esther Bull ANP		
GMC code	0000000	GP code	-
Practice name	Frew Terrace Surgery (80698)		
Practice code	80698		

Practice address

9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Contact number(s)

Voice: 01294 272326

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: see letter ks

Comment: Dear Colleague, Thank you for seeing this 43 year old lady who presented today with a 2 day history of a tender breast lump in her left breast. On examination there were no enlarged lymph glands, no nipple abnormalities, no skin abnormalities, however, there was a tender lumpiness in the upper region of the left breast between 12 and 2 o'clock position. There was no redness. Many thanks for seeing her as she is very anxious. She is not on any HRT or hormonal treatments and there is no family history of breast disease. Yours sincerely

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Back pain, unspecified	-	-	-	22-Apr-2016	22-Apr-2016
Soft tissue disorders NOS	-	-	Minor soft tissue injury (R) hand	31-Mar-2016	31-Mar-2016
Menorrhagia	-	-	-	03-Apr-2013	03-Apr-2013
Stress incontinence	-	-	-	11-Sep-2009	11-Sep-2009
[M]Compound naevus	-	-	(R) toe - no malignancy	19-Aug-2008	19-Aug-2008
[D]Dysphonia	-	-	-	29-Nov-2006	29-Nov-2006
Spontaneous vaginal delivery	-	-	Baby Male - birthweight 5.050 kgs	06-Jun-2003	06-Jun-2003
Spontaneous vaginal delivery	-	-	Baby Female - birthweight 4.60 kgs	21-Jul-2002	21-Jul-2002
Spontaneous vaginal delivery	-	-	Baby male - birthweight 3.380 kgs	09-Feb-1998	09-Feb-1998
[X]Other migraine	-	-	-	08-Mar-1995	08-Mar-1995
Burn of the face, head or neck	-	-	Facial burns from heat lamp	09-Jan-1994	09-Jan-1994
Anterior knee pain	-	-	-	31-Aug-1993	31-Aug-1993
Soiling - encopresis	-	-	-	08-Sep-1980	08-Sep-1980
Constipation	-	-	-	13-Aug-1980	13-Aug-1980

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Abdominal hysterectomy with conservation of ovaries	-	-	-	26-Sep-2013	26-Sep-2013
Ultrasound scan of abdomen and pelvis	-	-	-	03-Jan-2012	03-Jan-2012

Anterior and posterior repair	-	-	-	14-Jul-2010	14-Jul-2010
Other diagnostic ultrasound	-	-	(R) breast - NAD	18-Nov-2004	18-Nov-2004
Blood group A Rh(D) positive	-	-	-	09-Jan-2002	09-Jan-2002
Dye test of fallopian tube	-	-	-	11-Mar-1997	11-Mar-1997
Appendicectomy NEC	-	-	-	13-Apr-1993	13-Apr-1993

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	ONE TO BE TAKEN EACH DAY	-	23-Jun-2021	-	22-Jul-2021
Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	56 tablet	ONE OR TWO BE TAKEN AT NIGHT	-	17-Feb-2020	-	22-Jul-2021

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

No recent medications recorded

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

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

MSK
Musculoskeletal Service

NHS
Ayrshire
& Arran

Dr N Begg
Frew Terrace Surgery
9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

CHI: 3010776241 Date: 28/07/2021
Name: CAROLINE WELSH

Dear Dr Begg

MSK Physiotherapy referral

Many thanks for referring this patient. We regret to inform you that we are unable to accept this referral to MSK Physiotherapy due the following reason(s);

The patient has been referred for consideration of MRI when there is no apparent clinical indication to pursue this. The referral states that she has a long term history of back pain, chronic pain with a fibromyalgia diagnosis and no current red flag symptoms. As such it would be very unlikely that this patient would be appropriate for imaging and any onward referral for potential surgical intervention. Additionally, our service cannot offer MRI scanning in isolation, the Msk spinal pathway suggests that in the absence of red flag symptoms the patient must follow a course of active physiotherapy prior to any appropriate clinical escalation.

Additional Comments:

We would be happy to accept further referral for this patient if she is willing to engage with active physiotherapy advice and management. Escalation would only be considered if the patient fails to progress and clinically appropriate based on assessment.

Yours sincerely

Authorised on 24/11/2021 10:28:33 by Ross Farro.

Ross Farro
Physiotherapist

MSK Physiotherapy Team
NHS Ayrshire & Arran

https://www.nhsaaa.net/musculoskeletal-service-msk/

MSK
Musculoskeletal Service

MSK DISCHARGE REPORT

NHS
Ayrshire
& Arran

Patient Name:	Caroline Welsh
Address:	26 Lewis Terrace, Irvine, Ayrshire, KA11 1HJ
CHI:	3010776241
GP:	Dr BK Alexander
Consultant:	
Referrer Source:	Dr BK Alexander
Referral Date:	23/04/2015
Start Date:	06/07/2015
Discharge Date:	11/12/2015
No. of treatments:	8
Discharge Reason:	Treatment complete
Treatment Outcome:	Failed to continue
Therapist:	Mark Duffy
Location:	PHYSIOTHERAPY CLINIC AYRSHIRE CENTRAL HOSPITAL

Dear Dr BK Alexander

Diagnosis: Mechanical low back pain

Patient cancelled and then failed to attend follow up appointment and has therefore been discharged.

Yours sincerely,
Authorised on 11/12/2015 15:49:38 by Mark Duffy.
Mark Duffy
11/12/2015

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 1010091021590

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

Spinal R5A1
AA Back Pain

Musculoskeletal Triage and Treatment
NHS Ayrshire & Arran

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral Routine
Date of referral 22-Apr-2015
Date submitted 23-Apr-2015

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

26 Lewis Terrace
BROOMLANDS
IRVINE
KA11 1HJ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	0		
GMC code	0000000	GP code	0
Practice name	Bourtreehill Medical Practice (16875)		
Practice code	80306		

Practice address

Bourtreehill Medical Practice
Cheviot Way
Bourtreehill
Irvine

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr. Barbara Alexander		
GMC code	3331932	GP code	24198
Practice name	Bourtreehill Medical Practice (80306)		
Practice code	80306		

Practice address

The Health Centre
Cheviot Way
Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: See Letter

Comment: Thank you for seeing this patient who works in the care sector. Over the last few years she has been having increasing problems with her lumbosacral spine, particularly on the right side. She has recurrent episodes of acute spasm radiating deep into the buttock and then down in the back of her leg towards the knee. She has had physiotherapy in the past which has helped to an extent and she keeps herself generally physically fit. There is no bony tenderness but she has significant muscular spasm in the paraspinal region on the right side. She is concerned as to whether she may have nerve root compression and I would agree that the radiation of pain is in keeping with this. I would, therefore, appreciate your opinion with regards to her further management. At present she is on analgesia, anti-inflammatories and a muscle relaxant in the form of Baclofen.

Examinations and Investigations

Height:	170	-
Weight(kg):	99	-
BMI:	34.22	-
Never smoked tobacco:		13-Sep-2012
Never smoked tobacco:		04-Feb-2011
Never smoked tobacco:	Disease: SPICE Smoking, priority=2	11-Nov-2009
Never smoked tobacco:	Disease: SPICE Smoking, priority=2	13-Jan-2009
Never smoked tobacco:	1 SMOKING.clm - No Action Required	14-Apr-2004
Never smoked tobacco:	Z Smoker$$ Status.clm - No Action Required	24-Apr-2002
Current non-smoker:	priority=2	24-Apr-2002
Trivial drinker - <1u/day:	Z Alcohol Intake$$.clm - No Action Required	24-Apr-2002

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Migraine	-	-	-	01-Jan-1991	01-Jan-1991

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Abdominal hysterectomy	-	-	conservation of ovaries	28-Sep-2013	28-Sep-2013

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Naproxen Tablets 500 mg	1001010P0AAAEAE	56 TABLET	ONE TO BE TAKEN TWICE A DAY	-	10-Jul-2014	-	09-Apr-2015
Diazepam Tablets 2 mg	0401020K0AAAHAH	10 tablet	TO BE TAKEN AS DIRECTED	-	10-Jul-2014	-	09-Apr-2015

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Baclofen Tablets 10 mg	1002020C0AAAIAI	60 tablet	ONE TO BE TAKEN TWO OR THREE TIMES A DAY	-	21-Apr-2015	42 Days	21-Apr-2015
Co-Codamol 30/500 Tablets	0407010F0AAAHAH	100 TABLET	ONE OR TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	09-Apr-2015	42 Days	09-Apr-2015
Amoxicillin Capsules 500 mg	-	21 capsule	ONE TO BE TAKEN THREE TIMES A DAY	-	22-Jan-2015	7 Days	22-Jan-2015

Clinical warnings

Smoking status

Alcohol consumption

Lifestyle risks

Exercise status: Not Known

Number per day
? (not known)

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

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

Confidential - Clinical Information

Gynaecology Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 521133
01563 825439
www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Dr J Taylor
Bourtreehill Medical Practice
The Health Centre
Cheviot Way
Irvine
KA11 1JU

Our Ref:	VF/DB
Hospital No:	
Clinic Date:	09/12/2013
Date Dictated:	09/12/2013
Date Typed:	09/12/2013
Enquiries to	Ms Donna Blair
Direct Line:	01563 825095
Ext. Number:	25095
Email:	Donna.Blair@aaaht.scot.nhs.uk

Dear Dr Taylor,

CAROLINE WELSH DOB: 30/10/1977 CHI No: 3010776241
26 LEWIS TERRACE, IRVINE, AYRSHIRE, KA11 1HJ

Caroline returned for post-operative review having had a total abdominal hysterectomy with conservation of the ovaries performed in September. She is feeling very well after her operation and has no regrets about proceeding with hysterectomy. Her bowel and bladder function is normal and she has managed sexual intercourse without any trouble.

Her wound has healed well on examination today.

I am pleased to see her looking so well after her operation and I am happy to discharge her from your care. She is considering returning to work soon and will discuss this further with yourself. As you are already aware her histology was benign and I have reassured her about this today.

Yours sincerely

Authorised on 10/12/2013 16:31:23 by Vivian Franklin.

Vivian Franklin
Consultant Obstetrician and Gynaecologist
GMC: 4706207

INVESTING IN VOLUNTEERS

Gynaecology

In. STA 0617

Confidential - Clinical Information

Gynaecology Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 521133
01563 825095
www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Dr J Taylor
Bourtreehill Medical Practice
Bourtreehill Health Centre
Cheviot Way, Bourtreehill
Irvine
KA11 1JU

Our Ref: VF/DB
Hospital No:
Ref Date: 02/10/2013
Date Dictated: 07/10/2013
Date Typed: 09/10/2013
Enquiries to Ms Donna Blair
Direct Line 01563 825095
Ext. Number 25095
Email Donna.Blair@aaaht.scot.nhs.uk

Dear Dr Taylor,

CAROLINE WELSH DOB: 30/10/1977 CHI No: 3010776241
26 LEWIS TERRACE, IRVINE, AYRSHIRE, KA11 1HJ

DATE OF ADMISSION: 26.09.2013

DATE OF DISCHARGE: 28.09.2013

PROCEDURE: Total abdominal hysterectomy
Conservation of ovaries

INDICATION: Menorrhagia

Caroline opted to proceed with hysterectomy as more conservatives measures had failed to control her heavy menstrual loss. At laparotomy she was found to have a bulky uterus with a normal looking pelvis. The procedure itself was very vascular due to the large uterus and her blood loss was slightly above average at 800mls. Post operatively she had a drain inserted which had a minimal output and was removed the following day. She made a good post operative recovery with discharge haemoglobin of 10.9.

We will review her in the Gynaecology Clinic in 6 to 8 weeks time. The histology results are outstanding and I will drop you a line once they are available.

Yours sincerely

Authorised on 10/10/2013 10:22:19 by Vivian Franklin.

Vivian Franklin
Consultant Obstetrician and Gynaecologist
GMC: 4706207

INVESTING IN YOU

Gynaecology

Confidential - Clinical Information

Gynaecology Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 521133
01563 825095
www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Caroline Welsh
26 Lewis Terrace
Irvine
Ayrshire
KA11 1HJ

Our Ref:	VF/DB/
Hospital No:	
Ref Date:	11/11/2013
Date Dictated:	09/10/2013
Date Typed:	10/10/2013
Enquiries to	Ms Donna Blair
Direct Line:	01563 825095
Ext. Number:	25095
Email:	Donna.Blair@aaaht.scot.nhs.uk

Dear Caroline,

CAROLINE WELSH DOB: 30/10/1977 CHI No: 3010776241
26 LEWIS TERRACE, IRVINE, AYRSHIRE, KA11 1HJ

We now have the results of the histology after your recent operation. I am happy to report that this shows no abnormalities. We will see you back in the Gynaecology Clinic for follow up.

Yours sincerely

Authorised on 10/10/2013 16:36:32 by Vivian Franklin.

Vivian Franklin
Consultant Obstetrician and Gynaecologist
GMC: 4706207

Dr J Taylor
Bourtreehill Medical Practice
Bourtreehill Health Centre
Cheviot Way, Bourtreehill
Irvine
KA11 1JU

INVESTING IN YOUNG

Gynaecology

Confidential - Clinical Information

Gynaecology Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 521133
01563 825485
www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Caroline Welsh
26 Lewis Terrace
Irvine
Ayrshire
KA11 1HJ

Our Ref: VF/DB
Hospital No:
Date Dictated: 17/06/2013
Date Typed: 17/06/2013
Enquiries to Mrs Donna Blair
Direct Line: 01563 825095
Ext. Number: 25095
Email: donna.blair@aaaht.scot.nhs.uk

Dear Caroline Welsh,

Thank you for informing us that you will be unavailable for treatment from 17.06.2013 to 06.10.2013.

Your name is currently on the waiting list under the care of Dr Franklin and your Treatment Time Guarantee date has been amended to reflect your period of unavailability accordingly.

Should you have any questions or your circumstances change again, please contact Donna Blair.

Yours sincerely

Authorised on 17/06/2013 16:57:32 by Typist Donna Blair, not verified by Consultant.
Vivian Franklin
Consultant Obstetrician
GMC: 4706207

Your views are important to us. We welcome your comments, concerns and feedback.

Please call free to 0800 169 1441, email customercare@aapct.scot.nhs.uk, or use the 'Quick feedback' button on the home page of our website, www.nhsaaa.net, to tell us what you think.

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Gynaecology Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 521133
01563 825485
www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Caroline Welsh
26 Lewis Terrace
Irvine
Ayrshire
KA11 1HJ

Our Ref:	JBDB
Hospital No:	
Date Dictated:	03/06/2013
Date Typed:	03/06/2013
Enquiries to	Mrs Donna Blair
Direct Line:	01563 825095
Ext. Number:	25095
Email:	donna.blair@aaaht.scot.nhs.uk

Dear Caroline ,

I can confirm that your name has been added to the gynaecology waiting list from 31.05.2013 under the care of Dr Franklin, Consultant Gynaecologist.

Under the Patient Rights (Scotland) Act 2011 you now have a right to receive your planned treatment within 12 weeks of the date you were added to the waiting list. This is called the treatment time guarantee. On behalf of NHS Ayrshire & Arran I want to reassure you that we are committed to this guarantee.

Please find enclosed an information leaflet about the treatment time guarantee which you may find helpful.

If you have changed address or telephone number please contact Donna Blair so that we can update our records. It would also be helpful to know if you are available to attend at short notice or have holidays planned in the near future.

Yours sincerely

Authorised on 03/06/2013 12:58:05 by Typist Donna Blair, not verified by Consultant.
Mr John G. Burns
Chief Executive

Enc Patient Information Leaflet (Treatment Times Guarantee)

Your views are important to us. We welcome your comments, concerns and feedback.

Please call free to 0800 169 1441, email customercare@aapct.scot.nhs.uk, or use the 'Quick feedback' button on the home page of our website, www.nhsaaa.net, to tell us what you think.

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Gynaecology Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 521133
01563 825485
www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Dr BK Alexander
Bourtreehill Medical Practice
Bourtreehill Health Centre
Cheviot Way, Bourtreehill
Irvine
KA11 1JU

Our Ref:	VF/DB
Hospital No:	
Clinic Date:	31/05/2013
Date Dictated:	31/05/2013
Date Typed:	06/06/2013
Enquiries to	Mrs Donna Blair
Direct Line:	01563 825095
Ext. Number:	25095
Email:	donna.blair@aaaht.scot.nhs.uk

Dear Dr Alexander,

CAROLINE WELSH DOB: 30/10/1977 CHI No: 3010776241
26 LEWIS TERRACE, IRVINE, AYRSHIRE, KA11 1HJ

Caroline was reviewed again in the Gynaecology Clinic today. As you are aware she has previously had treatment with Decapeptyl and the Mirena coil for her heavy menstrual loss. Unfortunately her symptoms are still as bad and she is really getting no respite from her bleeding.

Caroline has made a big effort to lose weight and her BMI has now dropped from 41 to 36. She is keen to proceed with total abdominal hysterectomy and I think this seems a reasonable option. We have added her to the waiting list for TAH with conservation of the ovaries. She is aware that some additional weight loss will help her post operative recovery and she is very motivated to do this. She will be sent an appointment for this in due course.

Yours sincerely

Authorised on 10/06/2013 10:12:41 by Vivian Franklin.

Vivian Franklin
Consultant Obstetrician
GMC: 4706207

INVESTING IN VOLUNTEERS

DR FRANKLIN H
55

Dr. W. D. Campbell
Dr. C. P. Johnston
Dr. B. K. Alexander
Dr. J. Taylor
Dr. R. A. A. Joseph
Dr. C. E. Black

BOURTREEHILL MEDICAL PRACTICE

Cheviot Way,
Bourtreehill,
IRVINE
Ayrshire,
KA11 1JU

Tel: 01294 211993
Fax: 01294 218461

www.bourtreehillmedicalpractice.co.uk

Gynaecology Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE

Ref: BKA/MM

3rd April 2013

Dear Colleague,

RE; CAROLINE WELSH, 26 LEWIS TERRACE, IRVINE. KA11 1HJ
CHI; 3010776241

This patient has been reviewed by Gynaecology over the course of the last year with a problem of persisting menorrhagia. In the past she has had three Prostap injections and also had tried Tranexamic Acid and Norethisterone. In May of last year she had a Mirena Coil fitted with a view to possible endometrial oblation if this was unsuccessful. She did have a clinic appointment in November of last year which unfortunately she was not able to keep and as such was discharged from the clinic. However, she reports that she continues to have significant bleeding problems and has requested further consultation to consider the alternative possibility of a surgical option to her problem.

Thank you for your review.

Yours sincerely,

.....
DR B K ALEXANDER.

Lactive COPD.
WF.
9/4/13

emailed appts
9/4/13 ST
LK

- 5 APR 2013

Confidential - Clinical Information

Gynaecology Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 521133
01563 827975
www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Dr J Taylor
Bourtreehill Medical Practice
Bourtreehill Health Centre
Cheviot Way, Bourtreehill
Irvine
KA11 1JU

Our Ref:	FI/DB
Hospital No:	
Clinic Date:	09/11/2012
Date Dictated:	09/11/2012
Date Typed:	12/11/2012
Enquiries to	Ms Donna Blair
Direct Line:	01563 825095
Ext. Number:	25095
Email:	donna.blair@aaaht.scot.nhs.uk

Dear Dr Taylor,

CAROLINE WELSH DOB: 30/10/1977 CHI No: 301 077 6241
26 LEWIS TERRACE, IRVINE, AYRSHIRE, KA11 1HJ

Ms Welsh was unable to attend the planned Gynaecology Clinic appointment on the 09.11.2012. I have looked through her notes and I understand that at her last clinic appointment she had the Mirena IUS fitted for symptoms of menorrhagia.

I trust that this has controlled her symptoms. We have not arranged any further follow up at this time but would be happy to see her back if you felt she had concerns that would benefit from gynaecological input.

Yours sincerely

Authorised on 13/11/2012 17:20:39 by Francis Inyang.

Dr F Inyang
Locum Consultant in Gynaecology and Obstetrics
GMC No 6085982

Gynaecology

INVESTING IN VOLUNTEERS

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101004505157V

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

Spinal R5A1
AA Back Pain

Musculoskeletal Triage and Treatment
NHS Ayrshire & Arran

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	16-Nov-2012
Date submitted	16-Nov-2012

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

26 Lewis Terrace
BROOMLANDS
IRVINE
KA11 1HJ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	0		
GMC code	0000000	GP code	0
Practice name	Bourtreehill Medical Practice (16875)		
Practice code	80306		

Practice address

Bourtreehill Medical Practice
Cheviot Way
Bourtreehill
Irvine

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr. David Jordan (G.P. Registrar)		
GMC code	6148083	GP code	15547
Practice name	Bourtreehill Medical Practice (80306)		
Practice code	80306		

Practice address

Bourtreehill Health Centre
Cheviot Way
Boortreehill
Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: See Letter

Comment: I would appreciate your help with this 35 year old lady with lower back pain. She has had ongoing debilitating back pain over the last three months despite physiotherapy. She has no red flags in terms of her pathology but she does have lumbar tenderness, not in the mid-line, more on the right side. She is increasingly frustrated due to this and would like to be re-referred to your service. I would be grateful if you would see her. Many thanks

Examinations and Investigations

Height:	170	-
Weight(kg):	119.5	-
BMI:	41.35	-
Never smoked tobacco:		13-Sep-2012
Never smoked tobacco:		04-Feb-2011
Never smoked tobacco:	Disease: SPICE Smoking, priority=2	11-Nov-2009
Never smoked tobacco:	Disease: SPICE Smoking, priority=2	13-Jan-2009
Never smoked tobacco:	1 SMOKING.clm - No Action Required	14-Apr-2004
Never smoked tobacco:	Z Smoker$$ Status.clm - No Action Required	24-Apr-2002
Current non-smoker:	priority=2	24-Apr-2002
Trivial drinker - <1u/day:	Z Alcohol Intake$$.clm - No Action Required	24-Apr-2002

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Migraine	-	-	-	01-Jan-1991	01-Jan-1991

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

No current medications recorded

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Co-Codamol 30/500 Tablets	0407010F0AAAHAH	100 TABLET	ONE OR TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	15-Nov-2012	12 Days	15-Nov-2012
Naproxen Tablets 250 mg	1001010P0AAADAD	56 TABLET	ONE TO BE TAKEN TWICE A DAY	-	15-Nov-2012	28 Days	15-Nov-2012
Meptazinol Tablets 200 mg	0407020L0AAABAB	30 tablet	ONE TO BE TAKEN THREE	-	13-Sep-2012	42 Days	13-Sep-2012

			TIMES A DAY				
Paracetamol Tablets 500 mg	0407010H0AAAMAM	150 tablet	TWO TO BE TAKEN FOUR TIMES A DAY	-	13-Sep-2012	42 Days	13-Sep-2012
Naproxen Tablets 500 mg	1001010P0AAAEAE	56 TABLET	ONE TO BE TAKEN TWICE A DAY	-	10-Sep-2012	42 Days	10-Sep-2012

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

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

Hospital use only	Clinic	Day Date	Time	Hospital No.
				6

Transport required?

Unique Care Pathway Number: 1010034270607

REFERRAL LETTER

MEDICAL IN CONFIDENCE

CHI:3010776241

REFERRAL TO

Oral and Maxillofacial SurgeryC13
AA OMFS

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
Ayrshire
KA2 0BE

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	02-Apr-2012
Date submitted	02-Apr-2012

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

26 Lewis Terrace
Irvine
KA11 1HJ

Contact number(s)

Voice: 01294 215887
Voice: 07875530530

REGISTERED GP DETAILS

Practice address

REFERRING HCP DETAILS

Name	Gwyneth Thompson
GMC Code	-
Organisation Name	ACH Dental Department
Location Code	A103H

Organisation address

Admin Block
Kilwinning Road
Irvine
KA12 8SS

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Extractions required of remaining three third molars (teeth 18, 38 and 48)

Comment: Pain from cheek biting bilaterally due to carious third molars causing localised trauma to inside of cheek. Very limited access meaning cons not appropriate, patient wishes teeth to be extracted ideally all at same visit if deemed appropriate by Oral Surgery dept.

Examinations and Investigations

Third Molars:	Yes
Apicectomy:	No
Dentoalveolar Surgery:	No
TMJ Dysfunction:	No
Salivary Gland Disease:	No
Facial Deformity:	No
Oral Medicine:	No
Skin Lesion:	No
Trauma:	No
Suspected Oral Cancer:	No
Infection:	No
Other:	No
Past Dental History:	Yes
Past Dental History details:	Patient presented as a new patient to me with this as her main complaint.
Interpreter Required?:	No
Relevant Medical History:	None
Relevant Medication:	None
Relevant Allergies:	None
Relevant Intolerances:	None

Reason for referral

Care type requested: Dental

Expected outcome: Dental

Past medical history

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

No current medications recorded

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

No recent medications recorded

Clinical warnings Smoking status Alcohol consumption

Additional relevant information

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

For Office/Consultant Use Only - **Please circle appropriate destination/priority**

Ayr			Crosshouse	
Urgent	**Soon**	**Routine**	**Early (X-Ray)**	**Late**

Oral & Maxillofacial Dept
Consultant Clinic
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

Ms Gwyneth Thompson
ACH Dental Department
Admin Block
Kilwinning Road
Irvine
KA12 8SS

Clinic Date	8 August 2012
Date Typed	12 September 2012
Our Ref	SH/MM/X/3010776241
Enquiries to	Mr Hislop's Secretary
Extension	27488
Direct line	01563 827488
Fax	01563 827300
E-mail	denise.fagan@aaaht.scot.nhs.uk

Dear Ms Thompson

CAROLINE WELSH, 26 LEWIS TERRACE, IRVINE KA11 1HJ
DOB 30.10.1977

Many thanks for asking me to see this patient. Unfortunately she has failed to attend for consultation today. In view of this I have arranged no further appointments at this time.

With kind regards.

Yours sincerely

W S Hislop FRCS FDSRCS FDSRCPS
Consultant Oral & Maxillofacial/Head & Neck Surgeon

Maxillofacial

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 1010034270607

REFERRAL LETTER

MEDICAL IN CONFIDENCE

CHI:3010776241

REFERRAL TO

Oral and Maxillofacial SurgeryC13
AA OMFS

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
Ayrshire
KA2 0BE

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	02-Apr-2012
Date submitted	02-Apr-2012

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

26 Lewis Terrace
Irvine
KA11 1HJ

Contact number(s)

Voice: 01294 215887
Voice: 07875530530

REGISTERED GP DETAILS

Practice address

REFERRING HCP DETAILS

Name	Gwyneth.Thompson
GMC Code	-
Organisation Name	ACH Dental Department
Location Code	A103H

Organisation address

Admin Block
Kilwinning Road
Irvine
KA12 8SS

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Extractions required of remaining three third molars (teeth 18, 38 and 48)

Comment: Pain from cheek biting bilaterally due to carious third molars causing localised trauma to inside of cheek. Very limited access meaning cons not appropriate, patient wishes teeth to be extracted ideally all at same visit if deemed appropriate by Oral Surgery dept.

Examinations and Investigations

Third Molars:	Yes
Apicectomy:	No
Dentoalveolar Surgery:	No
TMJ Dysfunction:	No
Salivary Gland Disease:	No
Facial Deformity:	No
Oral Medicine:	No
Skin Lesion:	No
Trauma:	No
Suspected Oral Cancer:	No
Infection:	No
Other:	No
Past Dental History:	Yes
Past Dental History details:	Patient presented as a new patient to me with this as her main complaint.
Interpreter Required?:	No
Relevant Medical History:	None
Relevant Medication:	None
Relevant Allergies:	None
Relevant Intolerances:	None

Reason for referral

Care type requested: Dental

Expected outcome: Dental

Past medical history

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

No current medications recorded

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

No recent medications recorded

Clinical warnings Smoking status Alcohol consumption

Additional relevant information

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

For Office/Consultant Use Only - **Please circle appropriate destination/priority**

	Ayr		Crosshouse	
Urgent	**Soon**	**Routine**	**Early (X-Ray)**	**Late**

Oral & Maxillofacial Department
University Hospital Crosshouse
KILMARNOCK
KA2 0BE

Date: 10th July 2012
Your Ref: Diagnostic/Review 21 June 2012
Our Ref: SH/SP/466693
CHI: 3010776241
Enquiries to: Mr Hislop's Secretary
Extension: 27488
Direct Line: 01563 827488
Fax: 01563 827300
E-mail: denisefagan@aaaht.scot.nhs.uk

Mrs G Thompson
Dental Surgeon
Ayrshire Central Hospital
Kilwinning Road
IRVINE
KA12 8SS

Dear Mrs Thompson

CAROLINE WELSH, 26 LEWIS TERRACE, IRVINE KA11 1HJ

Many thanks for asking me to see this patient.

Unfortunately she has failed to attend for consultation today. In view of this I have arranged no further appointments at this time.

With kind regards

Yours sincerely

Stuart Hislop FRCS FDSRCS FDSRCPS
Consultant in Maxillofacial Surgery

Maxillofacial

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 1010038211326

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

Back PainR5A1
AA Back Pain

Musculoskeletal Triage and Treatment
NHS Ayrshire & Arran

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	26-Jun-2012
Date submitted	27-Jun-2012

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

26 Lewis Terrace
BROOMLANDS
IRVINE
KA11 1HJ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	0000000		
GMC code	0000000	GP code	000000
Practice name	Bourtreehill Medical Practice (16875)		
Practice code	80306		

Practice address

Bourtreehill Medical Practice
Cheviot Way
Bourtreehill
Irvine

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr. Robert Joseph		
GMC code	4361642	GP code	22985

Practice address

Bourtreehill Health Centre
Cheviot Way
Boortreehill

Practice name	Bourtreehill Medical Practice (80306)	Irvine KA11 1JU	
Practice code	80306		Contact number(s)
		Voice: 01294 211993	

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: As below

Comment: Dear Colleague, For over a year now, this thirty four year old patient has been having right pain in the right sacral iliac joint region as well as down the right lower limb. She reports that the pain is always there, sometimes being worse than at other times. The pain is down the posterior aspect of the right lower limb. There is no paraesthesia, numbness or weakness and there is no incontinence. She has had physiotherapy which she found unhelpful. Clinically she was noted to be comfortable at the time of assessment. She did have decreased lumber flexion and some right sacral iliac joint discomfort. Straight leg raise was 90 degrees in both sides. There was no lower limb weakness appreciated. This patient continues to suffer from low back and lower limb pain and I would be grateful for your assessment and input with regard to her further management. Yours sincerely,

Examinations and Investigations

Height:	170	-
Weight(kg):	106.92	-
BMI:	42.28	-
Never smoked tobacco:		04-Feb-2011
Never smoked tobacco:	Disease: SPICE Smoking, priority=2	11-Nov-2009
Never smoked tobacco:	Disease: SPICE Smoking, priority=2	13-Jan-2009
Never smoked tobacco:	1 SMOKING.clm - No Action Required	14-Apr-2004
Never smoked tobacco:	Z Smoker$$ Status.clm - No Action Required	24-Apr-2002
Current non-smoker:	priority=2	24-Apr-2002
Trivial drinker - <1u/day:	Z Alcohol Intake$$.clm - No Action Required	24-Apr-2002

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Migraine	-	-	-	01-Jan-1991	01-Jan-1991

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

No current medications recorded

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Meptazinol Tablets 200 mg	0407020L0AAABAB	30 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	18-Jun-2012	10 Days	18-Jun-2012
Capsaicin Cream	-	45 GRAM	APPLY TWICE	-	07-Jun-	42 Days	07-Jun-2012

0.025 %			A DAY		2012		
Meloxicam Tablets 7.5 mg	1001010AAAAAAAA	60 tablet	ONE TO BE TAKEN DAILY	-	18-Apr-2012	60 Days	18-Apr-2012
Naproxen Tablets 500 mg	1001010P0AAAEAE	56 TABLET	ONE TO BE TAKEN TWICE A DAY	-	29-Mar-2012	42 Days	29-Mar-2012

Clinical warnings

Smoking status

Alcohol consumption

Lifestyle risks

Exercise status: Not Known

Number per day
? (not known)

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

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

Hospital use only	Clinic	Day / Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 1010034270607

REFERRAL LETTER

MEDICAL IN CONFIDENCE

CHI:3010776241

REFERRAL TO

Oral and Maxillofacial SurgeryC13
AA OMFS

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
Ayrshire
KA2 0BE

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	02-Apr-2012
Date submitted	02-Apr-2012

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

26 Lewis Terrace
Irvine
KA11 1HJ

Contact number(s)

Voice: 01294 215887
Voice: 07875530530

REGISTERED GP DETAILS

Practice address

REFERRING HCP DETAILS

Name	Gwyneth Thompson
GMC Code	-
Organisation Name	ACH Dental Department
Location Code	A103H

Organisation address

Admin Block
Kilwinning Road
Irvine
KA12 8SS

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Extractions required of remaining three third molars (teeth 18, 38 and 48)

Comment: Pain from cheek biting bilaterally due to carious third molars causing localised trauma to inside of cheek. Very limited access meaning cons not appropriate, patient wishes teeth to be extracted ideally all at same visit if deemed appropriate by Oral Surgery dept.

Examinations and Investigations

Third Molars:	Yes	-
Apicectomy:	No	-
Dentoalveolar Surgery:	No	-
TMJ Dysfunction:	No	-
Salivary Gland Disease:	No	-
Facial Deformity:	No	-
Oral Medicine:	No	-
Skin Lesion:	No	-
Trauma:	No	-
Suspected Oral Cancer:	No	-
Infection:	No	-
Other:	No	-
Past Dental History:	Yes	-
Past Dental History details:	Patient presented as a new patient to me with this as her main complaint.	-
Interpreter Required?:	No	-
Relevant Medical History:	None	-
Relevant Medication:	None	-
Relevant Allergies:	None	-
Relevant Intolerances:	None	-

Reason for referral

Care type requested: Dental

Expected outcome: Dental

Past medical history

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

No current medications recorded

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

No recent medications recorded

Clinical warnings Smoking status Alcohol consumption

Additional relevant information

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

For Office/Consultant Use Only - **Please circle appropriate destination/priority**

	Ayr		Crosshouse	
Urgent	**Soon**	**Routine**	**Early (X-Ray)**	**Late**

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

Key: O ORAL — SL SUBLINGUAL — PR PER RECTUM
IM INTRAMUSCULAR — ID INTRADERMAL — PV PER VAGINA
IV INTRAVENOUS — INH INHALATION — IT INTRATHECAL
SC SUBCUTANEOUS — NEB NEBULISED

V CHI: 3010776241
H Welsh, Caroline
C 26 Lewis Terrace
St KA11 1HJ
Fc 30/10/1977
Ac Dr J Taylor
MRN: XHI466693
Date of Birth .....

KNOWN SENSITIVITY NKDA

1.	2.

SUSPECTED ADVERSE REACTION

MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION									OTHER		ROUTE (See Key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED	
				6am	8am	10am	12md	2pm	6pm	8pm	10pm	12mn						DATE	INITIAL
	A																		
	B																		
	C																		
	D																		
	E																		
	F																		
	G																		
	H																		
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	J																		
	K																		
	L																		
	M																		
	N																		
	O																		
	P																		
	R																		
	S																		
	T																		
	V																		

JMcC/80185

STA0235

MEDICINES TO BE GIVEN ONCE (BLOCK CAPITALS)

PHARM.	TO BE GIVEN DATE	TO BE GIVEN TIME	APPROVED NAME OF MEDICINE	DOSE	ROUTE (See Key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	11/5/12	0930	Paracetamol	1g	O	I. Smollett.	Hayes	10am

HOSPITAL SERVICES
DEPARTMENT OF GYNAECOLOGY

Crosshouse Hospital
KILMARNOCK
KA2 0BE
Telephone: 01563 521133
www.nhsayrshireandarran.com

Direct Dial: 01563 825095
Fax: 01563 827975
E-mail: donna.blair@aaaht.scot.nhs.uk

Our Ref: IS/DB/3010776241
Typed: 17.05.2012

Dr Sokolova's Gynaecology Clinic – ACH – 11.05.2012

Dr Alexander
Bourtreehill Health Centre
Cheviot Way
Irvine
KA11 1LZ

Dear Dr Alexander

CAROLINE WELSH, 26 LEWIS TERRACE, IRVINE. KA11 1HJ. DOB; 30.10.1977

This lady was referred to myself by one of my colleagues for the problem of menorrhagia. She is currently 34 years old and has had a long standing problem with her periods and that they are prolonged and heavy. She had 3 Prostap injections in the past and now is one month after the last injection at the moment and has no bleeding at all. In the past she tried Tranexamic acid and Norithisterone pretty much for the best part of the last 6 years, however did not appear to be beneficial as she still continued to bleed. I am pleased to say that she managed to lose some weight and that her BMI is 37 (down from 41 previously).

I was sad to hear that her mum past away in August last year and she had a lot of problems coping with grief and also menorrhagia. I note that she was admitted to Crosshouse Hospital in December last year and at the time passed gloop like tissue vaginally however histology confirmed this was indeed remnants of the endometrium with the evidence of some progestogenic effect with Norithisterone that she was taking at the time. I reassured her about this today. She has also been suffering from a lot of back pain and I explained that this is not related to her gynaecological problems and she herself feels that even when she is on Prostap the back pain was unchanged which is supportive of that theory.

We discussed further treatment options today in terms of either having a Mirena coil fitted or have endometrial ablation.

Cont'd...

Gynaecology

I explained that I would be happy to do the ablation procedure for her. I think it would be sensible in the first instance to try the Mirena coil to try and curtail her bleeding. She is happy to go ahead with this and we were able to fit the Mirena coil today uneventfully in the clinic today. I hope this will be of help to her symptoms and I will see her for further review in 6 months time.

Yours sincerely

Dr I Sokolova
Locum Consultant in Obstetrics & Gynaecology

Gynaecology

INVESTING IN VOLUNTEERS

Gynaecology Department
Crosshouse Hospital
KILMARNOCK
KA2 0BE

NHS
Ayrshire
& Arran

Our Ref: JM/MC/X
CHI No: 3010776241
Date: 16.02.12
Dictated: 09.02.12
Enquiries: Mandy Nimbley
Extension: 27888
Direct: 01563 827888
Fax: 01563 827975
Email: Mandy.nimbley@aaaht.scot.nhs.uk

Dr B Alexander
Bourtreehill Health Centre
Cheviot Way
Bourtreehill
IRVINE
KA11 1JU

DR MIHESO - GYNAECOLOGY CLINIC – 09.02.12

Dear Dr Alexander

CAROLINE WELSH 26 LEWIS TERRACE IRVINE KA11 1HJ
DOB: 30/10/1977

I reviewed your patient at the Gynaecology Clinic today. She has just had her second Decapeptyl injection and her bleeding is much better. Her pain is also more manageable and she says this is usually in the lower back and right side. She is desperate for something to be done in terms of definitive treatment for her periods and pain. She has been off work for 5 months and feels that this has not helped with her weight loss. She certainly feels that her appetite has gone up after she started the injection and she feels tired and sleepy most of the time. She is adamant that she does not wish Mirena IUS which I have suggested to her today. She is also not keen to carry on with the injections as she has read that they should be given for the maximum of 3 months.

I have emphasised to her that both ablation and hysterectomy carry significant surgical and anaesthetic risks. I advised her to carry on losing weight and for us to consider this at a later stage. At this point she started persisting that a decision has to be made today or else she would have to take a second opinion. I agreed with the suggestion that she gets a second opinion although she wanted this done immediately. This was beyond my control. In the end she stomped out of the clinic. After agreeing to have a second opinion I will ask one of my colleagues to see her in the near future.

Yours sincerely

JOHNSTONE MIHESO
LOCUM CONSULTANT GYNAECOLOGIST
GMC: 6048408

Cc

www.nhsayrshireandarran.com

→ My Card
Discuss – continue wt loss (BMI = 44)
– continue GnRH analogues
– consider Novosure

INVESTING IN VOLUNTEERS

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

NHS
Ayrshire & Arran

Our Ref: VF/DB/X/ 3010776241

Date: 02.02.2012

Enquiries: Donna Blair
Extension: 25095
Direct: 01563 825095
Fax: 01563 827975
Email: Donna.Blair@aaaht.scot.nhs.uk

Dr B Alexander
Bourtreehill Health Centre
Cheviot Way
Irvine
KA11 1LZ

Dear Dr Alexander

RE: CAROLINE WELSH, 26 LEWIS TERRACE, IRVINE. KA11 1HJ.
DOB: 30.10.1977

DATE OF ADMISSION: 03.01.2012

DATE OF DISCHARGE: 06.01.2012

COMMENTS:

Caroline was admitted to the Gynaecology Ward as an emergency with vaginal bleeding and abdominal pain. As you are aware she has been on Norithisterone treatment for menorrhagia and is under review by Dr Miheso at the Gynaecology Clinic. During her admission she had an episode of severe pain and passed a large fragment of tissue which was reported as a decidual cast (endometrium altered by progesterone). Beta HCG was negative and haemoglobin was 12.6. She was given a Prostap injection with a view to short term cessation of her periods. This helped to settle her bleeding down over the next 24 to 48 hours and she was discharged home. I note she has a gynaecology follow up appointment with Dr Miheso to discuss further management. She is aware that a total abdominal hysterectomy would not be a first line of treatment given her BMI is 41 but she maybe a suitable candidate for endometrial ablation.

Kind regards

Dr V Franklin
Consultant Obstetrician & Gynaecologist

CC: Dr Miheso

Dr Johnstone Miheso
Locum
Obstetrics &
GMC U48408
INVESTING IN VOLUNTEERS

STA0849

NHS AYRSHIRE & ARRAN

Crosshouse Hospital Discharge

268507 (6)

* PLEASE PRINT HEAVILY USING BALL POINT PEN

G.P. Taylor

Write or attach label

HCR No: 30107762 41
CHI No:
Surname: Weston Sex: F
Forename: Caroline
Address: 26 Lewis Terrace
Date of Birth: 30/10/71

Ward: 6
Consultant: Franklin
Date of Admission: 3/1/12
Date of Discharge: 6/1/12
(or date of death)
Clinic Appointment: 3 months

Services Arranged: ☐ Home help ___ times week ☐ Meals on wheels ☐ District Nurse ☐ Other
Discharged to: ☑ Home ☐ Stay with relatives ☐ Other hospital ☐ Nursing home ☐ Other ☐ Died

Discharge Diagnosis (if admitted due to an injury, include place of accident & site of injury)	If multiple Day Case admission, list dates of admission
1 PV bleed on norethisterone. Preg -ve	
2 endometrial thickening 2° to norethisterone	
3	
4	
5	

Operations / Procedures
1 USS (N) ovary/adnexa/kidney
2 thickened endometrium 18.5mm
3 no mass
4

Discharge Medication (7 days supply will be dispensed unless otherwise stated by doctor)

For Pharmacy use

Drug Name and formulation	Dose	Frequency	Route	Duration (cont/stop)	Quantity and strength	Notes
Norethisterone	5mg	tds	O	7	21x5mg	
Naproxen	250mg	qds	O	7	28x250mg	sand 2x32
Carbocisteine	1g	tds	O	10 days	100x500mg	
Tranexamic acid	1g	tds	O	10 days	30x500mg	
Norethisterone	2.5mg	nocte	O	/C	28x2.5mg	
Tinidazole	1g	TID	O	Review	own supply	
Norethisterone	10mg	TID	O	Review		

pharmacy date 6/1/12 | dispensed by | checked by

Additional Information (e.g. awaiting histology or other results, patients progress)

GP - can you please prescribe prostap im injection 3.75mg once per month. Last injection 6/1/12. Norethisterone high dose short term only.

A finished consultant episode letter will follow.

Signature _____

PRINT NAME _____ Date 6/1/2012

N.B. DISCHARGE MEDICATION IS FOR INFORMATION ONLY. FAXED COPY HAS NOT BEEN CHECKED BY DOCTOR. ON RECEIPT OF HARD COPY, FAXED COPY CAN BE DESTROYED.

Ward Clerkess: _____ / Dictated: _____ / Typed: _____ / Signed: _____ / Mailed: _____

NHS Ayrshire & Arran

MEWS CHART

(with Neuro - Observations)

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693

DATE	3/11/12	3/11/12	3/11/12	4/11/12	4/11/12	4/11/12	5/11/12	6/11/12	6/11/12	6/11/12	7-11-12	7-11-12	7-11-12
TIME (24 hour clock)	1505	1600	2116	8.20	11.10	2100	0825	2013	0830	1730	0015	0915	1300	1800
Temperature (°C)														
BLOOD PRESSURE		113/76	153/89	147/76		130/77	133/84	147/77						
HEART RATE		70				77		77						
Respiratory Rate	16	15	18	16	16	11	16	11	14	15	16	19	16	16
O2 Saturation	98	99	98	98	96	96	98	96	99	99	95	94	97	98

MEWS SCORE for EACH of the INDIVIDUAL OBSERVATIONS																										
Temperature (°C)																										
BP (Systolic)																										
Heart Rate																										
Respiratory Rate																										
SpO_2																										
Urine Output																										
CNS																										
MEWS SCORE - TOTALS																										
Record the total MEWS scores for each set of observations this way	6																									
	5																									
	4																									
	3																									
	2																									
	1																									
	0																									
Sedation Score																										
Pain Score (On Movement)																										
Nausea Score																										
C Eyes Open	Spontaneously	4																								
	To speech	3																								
	To pain	2																								
	None	1																								
M Best Verbal Response	Orientated	5																								
	Confused	4																								
	Inaprop. words	3																								
	Incomp. sounds	2																								
S	None	1																								
C	Obeys commands	6																								
Best Motor Response	Localise pain	5																								
	Withdrawl to pain	4																								
	Abnormal flexion to pain	3																								
	Extension to pain	2																								
E	None	1																								
GCS TOTAL																										
PUPILS	R	Size																								
		Reaction																								
	L	Size																								
		Reaction																								
LIMB MOVEMENTS	ARMS	Normal power																								
		Mild weakness																								
		Severe weakness																								
		Spastic flexion																								
		Extension																								
		No response																								
	LEGS	Normal power																								
		Mild weakness																								
		Severe weakness																								
		Extension																								
		No response																								

PUPIL SCALE (mm)

1 2 3 4 5 6 7 8

STA4202

NHS Ayrshire & Arran

Area Laboratory — Haematology

WELSH,CAROLINE
26 Lewis Terrace
Irvine
Ayrshire
KA11 1HJ

CHI No. 3010776241
Unit No.
DOB 30/10/1977
Sex F

Clinician: Unknown Clinician
Request Location: XH Hosp. Ward 6

This report to : Unknown Clinician , XH Hosp. Ward 6

	Result	Units	Normal Range
Haemoglobin	12.4	g/dL	12.2 - 16.5
White Cell Count	8.0	10*9/L	3.9 - 11.1
Platelets	291	10*9/L	150 - 400
RBC	4.18	10*12/L	3.88 - 4.99
Haematocrit	0.38	%	0.36 - 0.48
MCV	91	fl	82 - 98
MCH	29.7	pg	27.3 - 32.6
MCHC	32.5	g/dL	31.6 - 34.9
Neutrophils	3.7	10*9/L	1.8 - 7.4
Lymphocytes	3.5	10*9/L	1.1 - 5.0
Monocytes	0.6	10*9/L	0.2 - 0.9
Eosinophils	0.1	10*9/L	0.1 - 0.7
Basophils	0.0	10*9/L	0.0 - 0.1

JB-53005

Lab No 12B007240
Printed 07/01/12 07:39

Date Collected 06/01/12 15:50
Sample Type Blood

Authorised By SYSTEM

If you have received this report in error, please return to the Haematology Laboratory

Gynaecology Department
Crosshouse Hospital
KILMARNOCK
KA2 0BE

Our Ref:	JM/MC/X
CHI No:	3010776241
Date:	16.02.12
Dictated:	09.02.12
Enquiries:	Mandy Nimbley
Extension:	27888
Direct:	01563 827888
Fax:	01563 827975
Email:	Mandy.nimbley@aaaht.scot.nhs.uk

Dr B Alexander
Bourtreehill Health Centre
Cheviot Way
Bourtreehill
IRVINE
KA11 1JU

DR MIHESO - GYNAECOLOGY CLINIC – 09.02.12

Dear Dr Alexander

CAROLINE WELSH 26 LEWIS TERRACE IRVINE KA11 1HJ
DOB: 30/10/1977

I reviewed your patient at the Gynaecology Clinic today. She has just had her second Decapeptyl injection and her bleeding is much better. Her pain is also more manageable and she says this is usually in the lower back and right side. She is desperate for something to be done in terms of definitive treatment for her periods and pain. She has been off work for 5 months and feels that this has not helped with her weight loss. She certainly feels that her appetite has gone up after she started the injection and she feels tired and sleepy most of the time. She is adamant that she does not wish Mirena IUS which I have suggested to her today. She is also not keen to carry on with the injections as she has read that they should be given for the maximum of 3 months.

I have emphasised to her that both ablation and hysterectomy carry significant surgical and anaesthetic risks. I advised her to carry on losing weight and for us to consider this at a later stage. At this point she started persisting that a decision has to be made today or else she would have to take a second opinion. I agreed with the suggestion that she gets a second opinion although she wanted this done immediately. This was beyond my control. In the end she stomped out of the clinic. After agreeing to have a second opinion I will ask one of my colleagues to see her in the near future.

Yours sincerely

JOHNSTONE MIHESO
LOCUM CONSULTANT GYNAECOLOGIST
GMC: 6048408

Cc

INVESTING IN VOLUNTEERS

Gynaecology

Dr Franklin
Consultant Gynaecologist
Ward 6
Crosshouse Hospital

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

Our Ref: VF/DB/X/ 3010776241

Date: 02.02.2012

Dr B Alexander
Bourtreehill Health Centre
Cheviot Way
Irvine
KA11 1LZ

Enquiries: Donna Blair
Extension: 25095
Direct: 01563 825095
Fax: 01563 827975
Email: Donna.Blair@aaaht.scot.nhs.uk

Dear Dr Alexander

RE: CAROLINE WELSH, 26 LEWIS TERRACE, IRVINE. KA11 1HJ.
DOB: 30.10.1977

DATE OF ADMISSION: 03.01.2012

DATE OF DISCHARGE: 06.01.2012

COMMENTS:

Caroline was admitted to the Gynaecology Ward as an emergency with vaginal bleeding and abdominal pain. As you are aware she has been on Norithisterone treatment for menorrhagia and is under review by Dr Miheso at the Gynaecology Clinic. During her admission she had an episode of severe pain and passed a large fragment of tissue which was reported as a decidual cast (endometrium altered by progesterone). Beta HCG was negative and haemoglobin was 12.6. She was given a Prostap injection with a view to short term cessation of her periods. This helped to settle her bleeding down over the next 24 to 48 hours and she was discharged home. I note she has a gynaecology follow up appointment with Dr Miheso to discuss further management. She is aware that a total abdominal hysterectomy would not be a first line of treatment given her BMI is 41 but she maybe a suitable candidate for endometrial ablation.

Kind regards

Dr V Franklin
Consultant Obstetrician & Gynaecologist

CC: Dr Miheso

INVESTING IN VOLUNTEERS

Gynaecology

19/01/12

Johnstone

RE CAROLINE WELSH CHI 3010776241 Tel: 07875 530530

Mrs Welsh phoned to ask for an early appointment, possibly in the next couple of weeks? She is still bleeding.

Thanks Mandy

Give early appointment as requested.
12.1.20
23/01/12.

CUMBERNAULD

Our Ref: ASN/
CHI No: 3010776241
Date: 10th January 2012

Dr B Alexander
Bourtreehill Health Centre
Cheviot Way
Bourtreehill
IRVINE

Enquiries: Mrs Mandy Nimbley
Extension: 27888
Direct: 01563 827888
Fax: 01563 825485

Dr Miheso Gynaecology Clinic – 29th December 2011

Dear Dr Alexander

RE: CAROLINE WELSH (30/10/1977) 26 LEWIS TERRACE, IRVINE.

I saw Caroline in the Gynaecology Out-patient Clinic of Dr Miheso today. She is a 34 year old para 3 woman presenting with heavy irregular periods. She has been on Tranexamic Acid and Norethisterone for about 2 years without any improvement. In the last 6 months her bleeding has become heavier with associated the passage of clots. Pelvic ultrasound scan done in 2010 revealed a slightly bulky uterus and no other pelvic abnormality. She had anterior and posterior repair and transobturator tape insertion in 2009.

On examination her BMI was 41. Speculum examination revealed a healthy looking cervix. Not much was felt on bimanual examination due to the patient's BMI.

I have discussed the other options of treatment with Caroline. She is unhappy to have a Mirena coil at the moment because the previous intrauterine coils she had inserted were removed because of severe pelvic pain. In view of this I have given her a prescription for Decapeptyl 11.25mg 3 monthly to have for 6 months. I have counselled her to further reduce her weight before she is considered for endometrial ablation.

Yours sincerely

AKINOLA SHITTU
REGISTRAR IN GYNAECOLOGY

CONFIDENTIAL

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101002694803G

REFERRAL LETTER

MEDICAL IN CONFIDENCE

CHI:3010776241

REFERRAL TO

GynaecologyF2
AA Gynaecology

Crosshouse Hospital
Kilmarnock Road
Kilmarnock
Ayrshire
KA2 0BE

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	20-Oct-2011
Date submitted	20-Oct-2011

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

26 Lewis Terrace
BROOMLANDS
IRVINE
KA11 1HJ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	0000000		
GMC code	0000000	GP code	000000
Practice name	Bourtreehill Medical Practice (16875)		
Practice code	80306		

Practice address

Bourtreehill Medical Practice
Cheviot Way
Bourtreehill
Irvine

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr. Barbara Alexander		
GMC code	3331932	GP code	24198
Practice name	Bourtreehill Medical Practice (80306)		
Practice code	80306		

Practice address

Bourtreehill Health Centre
Cheviot Way
Boortreehill
Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: As below

Comment: Thank you for seeing this patient who has been troubled over the last year with increasing menorrhagia and lengthening cycle. She had a taping procedure done for a prolapse two years ago and really since this time her period has become more erratic and recently she is bleeding more than three weeks out of four. She did have an Implanon in up until two years ago and is currently on no hormonal contraceptive. She is currently using Tranexamic Acid which is lightening the bleed. On examination she is obese and therefore clinical findings were limited. She is understandably looking for a long term solution to her dysfunctional bleeding. I have discussed the possibility of endometrial oblation or the option of a Mirena Coil.Thank you for your help with her management.Yours sincerely,

Examinations and Investigations

Height:	170	-
Weight(kg):	114	-
BMI:	39.79	-
Never smoked tobacco:		04-Feb-2011 00:00
Never smoked tobacco:	Disease: SPICE Smoking, priority=2	11-Nov-2009 00:00
Never smoked tobacco:	Disease: SPICE Smoking, priority=2	13-Jan-2009 00:00
Never smoked tobacco:	1 SMOKING.clm - No Action Required	14-Apr-2004 00:00
Never smoked tobacco:	Z Smoker$$ Status.clm - No Action Required	24-Apr-2002 00:00
Current non-smoker:	priority=2	24-Apr-2002 00:00
Trivial drinker - <1u/day:	Z Alcohol Intake$$.clm - No Action Required	24-Apr-2002 00:00

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Migraine	-	-	-	01-Jan-1991	01-Jan-1991

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

No current medications recorded

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Tranexamic Acid Tablets 500 mg	0211000P0AAACAC	60 TABLET	TWO TO BE TAKEN THREE TIMES A DAY	-	11-Oct-2011	42 Days	11-Oct-2011
Tramadol Hydrochloride Capsules 50 mg	040702040AAAAAA	56 CAPS	1 Cap Twice daily	-	20-Sep-2011	42 Days	20-Sep-2011
Naproxen Tablets 500 mg	1001010P0AAAEAE	56 TABLET	ONE TO BE TAKEN TWICE A DAY	-	15-Sep-2011	42 Days	15-Sep-2011
Tranexamic Acid Tablets 500 mg	0211000P0AAACAC	60 TABLET	TWO TO BE TAKEN THREE TIMES A DAY	-	24-Aug-2011	10 Days	24-Aug-2011
Omeprazole			ONE TO BE				

Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 CAPSULE	TAKEN TWICE A DAY	-	11-Aug-2011	97 Days	19-Oct-2011
Naproxen Tablets 500 mg	1001010P0AAAEAE	56 TABLET	ONE TO BE TAKEN TWICE A DAY	-	11-Aug-2011	28 Days	11-Aug-2011

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101002563064W

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

PhysiotherapyR5
AA Physiotherapy

Ayrshire Central Hospital
Kilwinning Road
Irvine
KA12 8SS

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	21-Sep-2011
Date submitted	21-Sep-2011

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

26 Lewis Terrace
BROOMLANDS
IRVINE
KA11 1HJ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	0000000		
GMC code	0000000	GP code	000000
Practice name	Bourtreehill Medical Practice (16875)		
Practice code	80306		

Practice address

Bourtreehill Medical Practice
Cheviot Way
Bourtreehill
Irvine

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr. Robert Wagner		
GMC code	1462973	GP code	22284
Practice name	Bourtreehill Medical Practice (80306)		

Practice address

Bourtreehill Health Centre
Cheviot Way
Boortreehill
Irvine
KA11 1JU

Practice code	80306	Contact number(s)
		Voice: 01294 211993

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: As below

Comment: This lady was sent an appointment by yourselves but missed this due to a bereavement, on phoning she was told she would need to be re-referred. the original referral is as follows:- I would be grateful if this woman could be seen by physiotherapy. She is getting a considerable amount of persistent back pain that is affecting her ability to work. She is significantly overweight and this must be adversely affecting her pain but, despite analgesics and some ho,e physio and manipulation, she is continuing to suffer pain. I would be grateful for your advice. Many thanks

Examinations and Investigations

Duration of Symptoms:	> 18 Weeks	-
Is referring condition affecting work:	Yes	-
Does visit pose risk to Therapist?:	No	-
Height:	170	-
Weight(kg):	114	-
BMI:	39.79	-
Never smoked tobacco:		04-Feb-2011
Never smoked tobacco:	Disease: SPICE Smoking, priority=2	11-Nov-2009
Never smoked tobacco:	Disease: SPICE Smoking, priority=2	13-Jan-2009
Never smoked tobacco:	1 SMOKING.clm - No Action Required	14-Apr-2004
Never smoked tobacco:	Z Smoker$$ Status.clm - No Action Required	24-Apr-2002
Current non-smoker:	priority=2	24-Apr-2002
Trivial drinker - <1u/day:	Z Alcohol Intake$$.clm - No Action Required	24-Apr-2002

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Migraine	-	-	-	01-Jan-1991	01-Jan-1991

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

No current medications recorded

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Tramadol Hydrochloride Capsules 50 mg	040702040AAAAAA	56 CAPS	1 Cap Twice daily	-	20-Sep-2011	42 Days	20-Sep-2011
Naproxen Tablets 500 mg	1001010P0AAAEAE	56 TABLET	ONE TO BE TAKEN TWICE A DAY	-	15-Sep-2011	42 Days	15-Sep-2011

Tranexamic Acid Tablets 500 mg	0211000P0AAACAC	60 TABLET	TWO TO BE TAKEN THREE TIMES A DAY	-	24-Aug-2011	10 Days	24-Aug-2011
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	28 CAPSULE	ONE TO BE TAKEN EACH DAY	-	11-Aug-2011	42 Days	11-Aug-2011
Naproxen Tablets 500 mg	1001010P0AAAEAE	56 TABLET	ONE TO BE TAKEN TWICE A DAY	-	11-Aug-2011	28 Days	11-Aug-2011
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	28 CAPSULE	ONE TO BE TAKEN EACH DAY	-	12-Jul-2011	28 Days	12-Jul-2011
Diclofenac Sodium E/c tablets 50 mg	-	84 tablet	ONE TO BE TAKEN THREE TIMES A DAY WITH OR AFTER FOOD	-	12-Jul-2011	42 Days	12-Jul-2011

Clinical warnings

Smoking status

Alcohol consumption

Lifestyle risks

Exercise status: Not Known

Number per day
? (not known)

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101002270246U

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

PhysiotherapyR5
AA Physiotherapy

Ayrshire Central Hospital
Kilwinning Road
Irvine
KA12 8SS

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	14-Jul-2011
Date submitted	14-Jul-2011

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

26 Lewis Terrace
BROOMLANDS
IRVINE
KA11 1HJ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	0		
GMC code	0000000	GP code	0
Practice name	Bourtreehill Medical Practice (16875)		
Practice code	80306		

Practice address

Bourtreehill Medical Practice
Cheviot Way
Bourtreehill
Irvine

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr. Robert Wagner		
GMC code	1462973	GP code	22284
Practice name	Bourtreehill Medical Practice (80306)		

Practice address

Bourtreehill Health Centre
Cheviot Way
Boortreehill
Irvine
KA11 1JU

Practice code	80306	Contact number(s)
		Voice: 01294 211993

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: See Letter

Comment: I would be grateful if this woman could be seen by physiotherapy. She is getting a considerable amount of persistent back pain that is affecting her ability to work. She is significantly overweight and this must be adversely affecting her pain but, despite analgesics and some home physio and manipulation, she is continuing to suffer pain. I would be grateful for your advice. Many thanks

Examinations and Investigations

Height:	170	-
Weight(kg):	114	-
BMI:	39.79	-
Never smoked tobacco:		04-Feb-2011
Never smoked tobacco:	Disease: SPICE Smoking, priority=2	11-Nov-2009
Never smoked tobacco:	Disease: SPICE Smoking, priority=2	13-Jan-2009
Never smoked tobacco:	1 SMOKING.clm - No Action Required	14-Apr-2004
Never smoked tobacco:	Z Smoker$$ Status.clm - No Action Required	24-Apr-2002
Current non-smoker:	priority=2	24-Apr-2002
Trivial drinker - <1u/day:	Z Alcohol Intake$$.clm - No Action Required	24-Apr-2002

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Migraine	-	-	-	01-Jan-1991	01-Jan-1991

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

No current medications recorded

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	28 CAPSULE	ONE TO BE TAKEN EACH DAY	-	12-Jul-2011	28 Days	12-Jul-2011
Diclofenac Sodium E/c tablets 50 mg	-	84 tablet	ONE TO BE TAKEN THREE TIMES A DAY WITH OR AFTER FOOD	-	12-Jul-2011	42 Days	12-Jul-2011

Tranexamic Acid Tablets 500 mg	0211000P0AAACAC	60 TABS	1 Tab 4 times daily	-	21-Apr-2011	42 Days	21-Apr-2011
Norethisterone Tablets 5 mg	0604012P0AAAAAA	84 TABS	1 Tab 3 times daily	-	21-Apr-2011	42 Days	21-Apr-2011

Clinical warnings

Smoking status

Alcohol consumption

Lifestyle risks

Exercise status: Not Known

Number per day
? (not known)

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

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

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

Ayrshire Central Clinic – 9.12.10

Our Ref: WA/LS/466693
CHI: 3010776241
Date: 16.12.10
Enquiries: Laura Smith
Extension: 25225
Direct: 01563 825225
Fax: 01563 827975
Email: Laura.Smith@aaaht.scot.nhs.uk

Dr Wagner
Bourtreehill Medical Centre
Cheviot Way
IRVINE
KA11 1JU

Dear Dr Wagner

CAROLINE WELSH 26 LEWIS TERRACE IRVINE KA11 1HJ
DOB: 30.10.77

I saw Mrs Welsh today in the urogynaecology clinic. She is very pleased with the Buscopan you prescribed her which as sorted out the abdominal spasms. She does not require any further treatment at the moment.

I have discharged her back to your care.

Kind regards
Yours sincerely

DR W AGUR
MD MRCOG
CONSULTANT GYNAECOLOGIST AND OBSTETRICIAN
SUBSPECIALIST UROGYNAECOLOGIST

Dr. R.M. Wagner
Dr. W.D. Campbell
Dr. C.P. Johnston
Dr. B.K. Alexander
Dr. J. Nelson
Dr. R.A.A. Joseph
Dr. C.E. Black

BOURTREEHILL MEDICAL PRACTICE
www.bourtreehillmedical practice.co.uk

Cheviot Way
Bourtreehill, IRVINE
Ayrshire KA11 1JU
Tel. 01294-211993
Fax. 01294-218461

466693

Your reference:-
Our reference:- WDC/EQ

Date 11th October 2010

Dr. W. Agur,
Consultant Gynaecologist,
Crosshouse Hospital,
KILMARNOCK, KA2 OBE

Dear Dr. Agur,

RE: CAROLINE WELSH, 26 LEWIS TERRACE, BROOMLANDS, IRVINE
D.O.B. 30.10.77 6241 : HOSPITAL NO. 466693

I would be grateful if this lady could be reviewed. She has had several months history of chronic pelvic pain and has seen yourselves in the past. She is now starting to get to the end of her tether with this pain. She has had an ultrasound scan done which, unfortunately, didn't shown her ovaries and it is being repeated to see if these can be seen. We are having great difficulty controlling her pain and I would be grateful for your advice again as to where we go with this lady.

Yours sincerely,

.....
DR. W.D. CAMPBELL

ACH please soon

Notes please Thx

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 101001000453D

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

Podiatry R1A
AA Podiatry

Miller Road Clinic
32 Miller Road
Ayr
KA7 2BN

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	14-Sep-2010
Date submitted	14-Sep-2010

PATIENT DETAILS

Surname	Welsh
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

26 Lewis Terrace
BROOMLANDS
IRVINE
KA11 1HJ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	0		
GMC code	0000000	GP code	0
Practice name	Bourtreehill Medical Practice (16875)		
Practice code	80306		

Practice address

Bourtreehill Medical Practice
Cheviot Way
Bourtreehill
Irvine

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr. C. Black (G.P. Locum)		
GMC code	6078295	GP code	A2228
Practice name	BOURTREEHILL HEALTH CENTRE (80306)		
Practice code	80306		

Practice address

Cheviot Way
Bourtreehill
Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Plantar fasciitis

Comment: Dear colleague, I would be grateful if you could help this young lady out who presents with a story of plantar fasciitis especially of the right heel. She has tried physio, non-steroidal anti-inflammatories and OTC insoles with no improvement in her symptoms. I would appreciate your opinion regarding insoles/foot support. Kind regards,

Examinations and Investigations

Which Foot:	Right	-
Signs & Symptoms of Ischaemia:	No	-
Signs & Symptoms of Neurological Deficit:	No	-
.:	Care Programme - Biomechanics	-
Height:	170	-
Weight(kg):	112	-
BMI:	39.79	-
Never smoked tobacco:	Disease: SPICE Smoking, priority=2	11-Nov-2009
Never smoked tobacco:	Disease: SPICE Smoking, priority=2	13-Jan-2009
Never smoked tobacco:	1 SMOKING.clm - No Action Required	14-Apr-2004
Never smoked tobacco:	Z Smoker$$ Status.clm - No Action Required	24-Apr-2002
Current non-smoker:	priority=2	24-Apr-2002
Trivial drinker - <1u/day:	Z Alcohol Intake$$.clm - No Action Required	24-Apr-2002

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Migraine	-	-	-	01-Jan-1991	01-Jan-1991

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

No current medications recorded

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
TRIMETHOPRIM TABLETS 200MG	0501080W0AAAEAE	6 TABS	1 Tab Twice daily	-	19-Jul-2010	-	18-Jun-2010
OMEPRAZOLE CAPSULES 20MG	0103050P0AAAGAG	56 CAPS	1 Cap In the morning	-	19-Jul-2010	-	18-Jun-2010
NAPROXEN EC TABLETS 500MG	1001010P0AAAIAI	56 TABS	1 Tab Twice daily	-	19-Jul-2010	-	24-Jun-2010
ORLISTAT CAPSULES 120MG	0405010P0AAAAAA	84 CAPS	1 Cap 3 times daily	-	19-Jul-2010	-	18-Jun-2010
TRAMADOL HYDROCHLORIDE CAPSULES 50MG	040702040AAAAAA	100 CAPS	1 or 2 Caps 4 times	-	19-Jul-2010	-	28-Jun-2010

daily
prn

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status	Alcohol consumption
Number per day	Units per day
? (not known)	? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

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

PATIENT SERVICES

Department of General Surgery
Mr E Leung, Consultant Colorectal Surgeon
Direct Line: ☎ **01563 826978**
Fax No: 🖷 **01563 825171**
Secretary: Mrs Julie Samson
Email: Julie.Samson@aapct.scot.nhs.uk

Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE
Telephone: 01563 521133

www.show.scot.nhs.uk/aaaht

NHS
Ayrshire & Arran

55

Our ref: EL/JS/466693
CHI No: 3010776241

Dictated: 27.09.20.10
Typed: 04.10.2010

SURGICAL CLINIC

Dr Wagner
Bourtreehill Health Centre
Cheviot Way
IRVINE
KA11 1JU

Dear Dr Wagner

CAROLINE WELSH 26 LEWIS TERRACE BROOMLANDS IRVINE KA11 1HJ
DOB: 30.10.1977

I saw this lady in the clinic today who had an anterior and posterior repair with a trans obturator tape for prolapse about 8 months ago. She was well until about 2 months ago when she developed severe pelvic pain again. She describes her pain as colicky in nature and being worse on certain movements and also during her period. She has noticed that her period has now become more irregular. She denies any other associated GI or GU symptoms. She has a past history of laparoscopy and appendicectomy.

General examination revealed obesity. Abdominal examination revealed no obvious palpable mass or abdominal wall hernia.

I suspect her symptoms are related to her recent pelvic operation which, according to the patient, is actually now getting better. She already had an ultrasound scan of her pelvis in July of this year which showed no obvious abnormality. I have now reassured her and discharged her back to Dr Agur's care.

Yours sincerely

Mr E Leung MD FRCS
CONSULTANT SURGEON
COLORECTAL & GENERAL SURGERY

Copy to ***Dr W Agur, Consultant Gynaecologist, Gynaecology Department, Crosshouse Hospital***

Awarded for excellence

PATIENT SERVICES

Department of General Surgery
Mr E Leung, Consultant Colorectal Surgeon
Direct Line: ☎ **01563 826978**
Fax No: 🖷 **01563 825171**
Secretary: Mrs Julie Samson
Email: Julie.Samson@aapct.scot.nhs.uk

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Our ref: EL/JS/466693
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CONSULTANT SURGEON
COLORECTAL & GENERAL SURGERY

Copy to *Dr W Agur, Consultant Gynaecologist, Gynaecology Department, Crosshouse Hospital*

Awarded for excellence

Surgical

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

Ayrshire Central Clinic 01.07.10

Our Ref: WA/MC/466693
CHI: 3010776241
Date: 08.07.10

Dr Wagner
Bourtreehill Medical Practice
Cheviot Way
Bourtreehill
IRVINE
KA11 1JU

Enquiries: Laura Smith
Extension: 25225
Direct: 01563 825225
Fax: 01563 827975
Email: Laura.Smith@aaaht.scot.nhs.uk

Dear Dr Wagner

CAROLINE WELSH 26 LEWIS TERRACE BROOMLANDS IRVINE KA11 1HJ
DOB: 30/10/1977

I have seen Mrs Welsh in the urogynaecology clinic at 7 months following her operation. She had an anterior and posterior repair with a trans obturator tape. She said the operation was a success up until 3 weeks ago when she felt something "popping" deep in the pelvis and that was followed by suprapubic and right iliac fossa pain as well as deep dyspareunia. The abdominal pain is bad enough she takes Tramadol.

Examination revealed no prolapse and there is no bulge sensation but a dragging feeling.

An abdominal pelvic ultrasound scan will be arranged to exclude any gynaecological reason for this pain. I have reassured Mrs Welsh that this pain has nothing to do with the operation. There is also a possibility of abdominal wall hernia and I am going to ask one of my colleagues in the general surgery department to see her.

With kind regards.

Yours sincerely

DR WAEL AGUR
MD MRCOG
CONSULTANT GYNAECOLOGIST AND OBSTETRICIAN
SUBSPECIALIST UROGYNAECOLOGIST

Cc Dr Wagner

2/12 ago
- Pain started.
- Lower abdo
- Cramping.
- Worse in movement & period.
- Emergency period.
- GI/GU.
- Lap. Appendicectomy

Gynaecology

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

Ayrshire Central Clinic 01.07.10

Our Ref: WA/MC/466693
CHI: 3010776241
Date: 09.07.10

Dr Ed Leung
Consultant Surgeon
Surgical Department
Crosshouse Hospital

Enquiries: Laura Smith
Extension: 25225
Direct: 01563 825225
Fax: 01563 827975
Email: Laura.Smith@aaaht.scot.nhs.uk

Dear Ed

CAROLINE WELSH 26 LEWIS TERRACE BROOMLANDS IRVINE KA11 1HJ
DOB: 30/10/1977

I wonder if you would see Mrs Welsh (GP letter attached).

I performed a vaginal repair operation (anterior and posterior repair with a trans obturator tape) last November and everything was okay until 3 weeks ago. She felt something "popping" followed by right iliac fossa pain and suprapubic pain. There was some tenderness on examination over these 2 areas. Her BMI is 36.8 and it is difficult to asses the abdominal wall properly. I wonder if she has a hernia.

With kind regards.

Yours sincerely

DR WAEL AGUR
MD MRCOG
CONSULTANT GYNAECOLOGIST AND OBSTETRICIAN
SUBSPECIALIST UROGYNAECOLOGIST

Enc GP letter

Gynaecology

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

NHS
Ayrshire & Arran

Ayrshire Central Clinic 01.07.10

Our Ref: WA/MC/466693
CHI: 3010776241
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MD MRCOG
CONSULTANT GYNAECOLOGIST AND OBSTETRICIAN
SUBSPECIALIST UROGYNAECOLOGIST

Enc GP letter

Clinic
27/9/10
9.00 am.

STA 5000

NHS
Ayrshire & Arran

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

Ayrshire Central Clinic 01.07.10

Our Ref: WA/MC/466693
CHI: 3010776241
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Dr Wagner
Bourtreehill Medical Practice
Cheviot Way
Bourtreehill
IRVINE
KA11 1JU

Enquiries: Laura Smith
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Mr Ed Leung

With kind regards.

Yours sincerely

DR WAEL AGUR
MD MRCOG
CONSULTANT GYNAECOLOGIST AND OBSTETRICIAN
SUBSPECIALIST UROGYNAECOLOGIST

Cc Dr Wagner

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

Ayrshire Central Clinic 01.07.10

Our Ref: WA/MC/466693
CHI: 3010776241
Date: 09.07.10

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Consultant Surgeon
Surgical Department
Crosshouse Hospital

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SUBSPECIALIST UROGYNAECOLOGIST

Enc GP letter

Gynaecology

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

Ayrshire Central Clinic 01.07.10

Our Ref: WA/MC/466693
CHI: 3010776241
Date: 08.07.10

Dr Wagner
Bourtreehill Medical Practice
Cheviot Way
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Yours sincerely

DR WAEL AGUR
MD MRCOG
CONSULTANT GYNAECOLOGIST AND OBSTETRICIAN
SUBSPECIALIST UROGYNAECOLOGIST

Cc Caroline Welsh

Gynaecology

Patient Services

Clinical Decisions Unit
Crosshouse Hospital
Kilmarnock KA2 OBE

Enquires to: Lorraine Ritchie
Direct Line: 01563 825056
E-mail: Lorraine.Ritchie@aaaht.scot.nhs.uk

Ref No: KF/LR/466693
CHI No: 3010776241

Dictated: 28/12/2009
Typed: 08/01/2010

Dr W Campbell
Bourtreehill Medical Practice
Health Centre
Cheviot Way
IRVINE
KA11 1JU

Dear Dr Campbell

RE CAROLINE MORRIN, 26 LEWIS TERRACE, IRVINE DOB 30/10/77

Admitted: **27/12/09**
Discharged: **27/12/09**
Diagnosis: **Left calf pain – DVT excluded**

Mrs Morrin presented to the Clinical Decisions Unit on the 27 December 2009 with a 3 day history of pain in her left calf, there was some slight swelling present. Other previous medical history includes a recent pelvic floor operation in November 2009 and a laparotomy.

On examination she had a Well's score of 2, which is moderate, one point being given for having had major surgery within the last 4 weeks and one point for localised tenderness along the distribution of the deep venous system.

Routine bloods were obtained which showed D-dimers of 209. Therefore no Doppler ultrasound scan was required. At this point Mrs Morrin was reviewed by Dr Pathmanathan who advised on regular analgesia and the possibility of it being sciatic nerve pain.

Mrs Morrin was then discharged from the Clinical Decisions Unit with DVT excluded and advised to re-attend her GP if her symptoms did not resolve.

Yours sincerely

Karen Figgins
Charge Nurse in CDU

Mr D Chung
Consultant in Emergency Medicine

MEDICAL

STA0849

NHS AYRSHIRE & ARRAN

Crosshouse Hospital Discharge

161200

G.P.

* PLEASE PRINT HEAVILY USING BALL POINT PEN

HCR No: XHI466693
CHI No: MORRIN CAROLINE
Surname: 26 LEWIS TERR
Forenames: IRVINE
Address: KA11 1HJ 30/10/1977
Date of B: Dr J NELSON
BOURTREEHILL HEALTH CENTRE
CHEVIOT WAY,
CHI 3010776241

Ward: W6
Consultant:

Date of Admission:
Date of Discharge:
(or date of death)
Clinic Appointment:

Services Arranged: ☐ Home help ___ times week ☐ Meals on wheels ☐ District Nurse ☐ Other
Discharged to: ☐ Home ☐ Stay with relatives ☐ Other hospital ☐ Nursing home ☐ Other ☐ Died

Discharge Diagnosis (if admitted due to an injury, include place of accident & site of injury)	If multiple Day Case admission, list dates of admission
1 Anterior + posterior vaginal prolapse	
2	
4	
5	

Operations / Procedures
1 Removal of IUCD
2 Anterior colporraphy + Posterior Colporaphy
3 EUT
4 Excision of anal Tags

Discharge Medication (7 days supply will be dispensed unless otherwise stated by doctor)

For Pharmacy use

Drug Name and formulation	Dose	Frequency	Route	Duration (cont/stop)	Quantity and strength	Notes
Co Codamol 30/500	1	QDS	PO	7/7	1×56×30/500	
Dr Cellacfrac	50ml	TDS	PO	5/7	1×15×5ml	
Lactulose	15ml	BD	PO	5/7	1×300ml	
Senna	1	OD	PO	5/7	1×30×7.5ml	7.5ml
Trimethoprim	300mg	BD	PO	7/7		
Omeprazole	20mg	ON	PO	Own Supply		

pharmacy date 27/11/09 | dispensed by Kmee. | checked by

9.43

Additional Information (e.g. awaiting histology or other results, patients progress)

FU - Dr Agu GOPD 3/12

A finished consultant episode letter will follow.

Signature _____

PRINT NAME Gherzie Date 27/11/2009

N.B. DISCHARGE MEDICATION IS FOR INFORMATION ONLY. FAXED COPY HAS NOT BEEN CHECKED BY DOCTOR. ON RECEIPT OF HARD COPY, FAXED COPY CAN BE DESTROYED.

Ward Clerkess: _____ / Dictated: _____ / Typed: _____ / Signed: _____ / Mailed: _____

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

Our Ref: WA/DB/466693
CHI: 3010776241
Date: 02.12.09

Dr Wagner
Bourtreehill Medical Practice
Cheviot way
Irvine

Enquiries: Laura Smith
Extension: 25225
Direct: 01563 825225
Fax: 01563 827975
Email: Laura.Smith@aaaht.scot.nhs.uk

Dear Dr Wagner

RE: CAROLINE MORRIN, 26 LEWIS TERRACE, IRVINE.
DOB: 30.10.1977

DATE OF ADMISSION:	23.11.09
DATE OF SURGERY:	24.11.09
OPERATION:	Anterior colporrhaphy, posterior colporrhaphy, transobturator tape, removal of anal skin tags and removal of intrauterine contraceptive device.
INDICATION:	Stage 2 cystocele, stage 2 rectocele. No dynamic stress incontinence
INTRA-OP COMPLICATIONS:	None
POST-OP COMPLICATIONS:	None
DATE OF DISCHARGE:	27.11.09
FOLLOW UP:	Follow up in 3 months time

Kind regards

Dr W Agur
Consultant in Gynaecology and Obstetrics

Gynaecology

NHS
Ayrshire & Arran

HOSPITAL SERVICES
DEPARTMENT OF GYNAECOLOGY

Crosshouse Hospital
KILMARNOCK
KA2 0BE
Telephone: 01563 521133
www.show.scot.nhs.uk/aaaht

Direct Dial: 01563 825225
Fax: 01563 827975
E-mail: laura.smith@aaaht.scot.nhs.uk

Our Ref: LO/LS/466693
CHI No: 3010776241

Date Typed: 14.10.09

Dr W Agur
Consultant Gynaecologist
Crosshouse Hospital

Dear Dr Agur

CAROLINE MORRIN 26 LEWIS TERRACE IRVINE DOB: 30.10.77

Caroline attended for urodynamics today prior to surgery which is scheduled for November.

During the flow part of the study she voided over 900mls and admits to having been an infrequent voider. The rest of the urodynamics was carried out and stress leakage was noted occasionally throughout the study. She was able to empty her bladder once the catheter was removed but was unable to do this with the catheter in situ. The bladder scan at the end of the test showed that the bladder was empty and she initially had residual of 67mls prior to the test.

I have asked Caroline to do timed voiding. She does admit she goes for long periods of time without voiding anything at all and I have therefore advised her to avoid every 3 to 4 hours.

Kind regards
Yours sincerely

Leanne Oliver
Continence Nurse Advisor

Please ensure SI-TOT is on the list of procedures Mrs Morrin is booked for.
15/10

HOSPITAL SERVICES
DEPARTMENT OF GYNAECOLOGY

Crosshouse Hospital
KILMARNOCK
KA2 0BE
Telephone: 01563 521133
www.show.scot.nhs.uk/aaaht

Direct Dial: 01563 825225
Fax: 01563 827975
E-mail: laura.smith@aaaht.scot.nhs.uk

Our Ref: LO/LS/466693
CHI No: 3010776241

Date Typed: 14.10.09

Dr W Agur
Consultant Gynaecologist
Crosshouse Hospital

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Kind regards
Yours sincerely

Leanne Oliver
Continence Nurse Advisor

Gynaecology

Posted 28.9.9.

Oct 8th 2.30

01294 215887

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

NHS
Ayrshire & Arran

Ayrshire Central Clinic – 10.10.09

Our Ref: WA/LS/466693
CHI: 3010776241
Date: 11.09.09
Enquiries: Laura Smith
Extension: 25225
Direct: 01563 825225
Fax: 01563 827975
Email: Laura.Smith@aaaht.scot.nhs.uk

Mrs Leanne Oliver
Continence Nurse Advisor
MacDonald Suite
Lister Centre,
Crosshouse Hospital

Dear Dr Oliver

CAROLINE MORRIN 26 LEWIS TERRACE IRVINE DOB: 30.10.77

- Stress incontinence

I would be very grateful if you would arrange urodynamics for this lady.

She is complaining of pure stress urinary incontinence (no overactive bladder symptoms). She has done pelvic floor exercises regularly and they were not successful. She is having a vaginal repair operation soon and if urodynamics stress incontinence is confirmed a mid-urethral tape will be placed at the same time.

A copy of the GP letter is attached for further information.

Kind regards
Yours sincerely

DR W AGUR
MD MRCOG
CONSULTANT GYNAECOLOGIST AND OBSTETRICIAN
SUBSPECIALIST UROGYNAECOLOGIST

P.P.

DR Habib

FOR SURGERY IN NOV.

STA 5000

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

NHS
Ayrshire & Arran

Ayrshire Central Clinic – 10.10.09

Our Ref: WA/LS/466693
CHI: 3010776241
Date: 11.09.09
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Email: Laura.Smith@aaaht.scot.nhs.uk

Dr R Wagner
Bourtreehill Medical Practice
Cheviot Way
IRVIVE
KA11 1JU

Dear Dr Wagner

CAROLINE MORRIN 26 LEWIS TERRACE IRVINE DOB: 30.10.77

- Lump coming down
- Stress incontinence

Thank you for referring this lady to my urogynaecology clinic where I saw her today.

She is a 31 year old mother of 3 and is working as a home carer. She had an appendicectomy and laparoscopy in the past and is on Omerpazole and Reductil (for weight loss). Her husband has had a vasectomy.

A lump coming down is really bothersome to her. There is significant interference with sexual activity and she scored a 8/10 on the bothersome scale. She also suffers from pure stress incontinence when coughing, sneezing and physical activities. There are no voiding dysfunctions symptoms and no excessive drinking. She also noted disfiguring anal skin tags.

Examination revealed a stage 2 cysto-urethrocele and also a stage 2 rectocele. The skin tags were noted.

Mrs Morrin has performed pelvic floor muscle training regularly and is keen to have further programs. She was keen to have a repair procedure and her family is complete (partner had a vasectomy). She understands that further treatment for prolapse and incontinence may be required if she went on to have another baby. Her name was added to the waiting list for anterior and posterior repair with removal of anal skin tags. A mid-urethral tape (SI-TOT) will be inserted at the same time if urodynamics confirm bladder neck weakness.

Kind regards
Yours sincerely

DR W AGUR
MD MRCOG
CONSULTANT GYNAECOLOGIST AND OBSTETRICIAN
SUBSPECIALIST UROGYNAECOLOGIST

cc. Leanne Oliver Continence Nurse Advisor
Caroline Morrin

P.P. DR. Habib

STA 5000

Inf. 680
Voided 890

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

Ayrshire Central Clinic – 10.10.09

Our Ref: WA/LS/466693
CHI: 3010776241
Date: 11.09.09
Enquiries: Laura Smith
Extension: 25225
Direct: 01563 825225
Fax: 01563 827975
Email: Laura.Smith@aaaht.scot.nhs.uk

Dr R Wagner
Bourtreehill Medical Practice
Cheviot Way
IRVIVE
KA11 1JU

Dear Dr Wagner

CAROLINE MORRIN 26 LEWIS TERRACE IRVINE DOB: 30.10.77

- Lump coming down
- Stress incontinence

Thank you for referring this lady to my urogynaecology clinic where I saw her today.

She is a 31 year old mother of 3 and is working as a home carer. She had an appendicectomy and laparoscopy in the past and is on Omerpazole and Reductil (for weight loss). Her husband has had a vasectomy.

A lump coming down is really bothersome to her. There is significant interference with sexual activity and she scored a 8/10 on the bothersome scale. She also suffers from pure stress incontinence when coughing, sneezing and physical activities. There are no voiding dysfunctions symptoms and no excessive drinking. She also noted disfiguring anal skin tags.

Examination revealed a stage 2 cysto-urethrocele and also a stage 2 rectocele. The skin tags were noted.

Mrs Morrin has performed pelvic floor muscle training regularly and is keen to have further programs. She was keen to have a repair procedure and her family is complete (partner had a vasectomy). She understands that further treatment for prolapse and incontinence may be required if she went on to have another baby. Her name was added to the waiting list for anterior and posterior repair with removal of anal skin tags. A mid-urethral tape (SI-TOT) will be inserted at the same time if urodynamics confirm bladder neck weakness.

Kind regards
Yours sincerely

DR W AGUR
MD MRCOG
CONSULTANT GYNAECOLOGIST AND OBSTETRICIAN
SUBSPECIALIST UROGYNAECOLOGIST

cc Leanne Oliver Continence Nurse Advisor
Caroline Morrin

JMcC/60798

Gynaecology

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

Ayrshire Central Clinic – 10.10.09

Our Ref: WA/LS/466693
CHI: 3010776241
Date: 11.09.09
Enquiries: Laura Smith
Extension: 25225
Direct: 01563 825225
Fax: 01563 827975
Email: Laura.Smith@aaaht.scot.nhs.uk

Mrs Leanne Oliver
Continence Nurse Advisor
MacDonald Suite
Lister Centre
Crosshouse Hospital

Dear Dr Oliver

CAROLINE MORRIN 26 LEWIS TERRACE IRVINE DOB: 30.10.77

- Stress incontinence

I would be very grateful if you would arrange urodynamics for this lady.

She is complaining of pure stress urinary incontinence (no overactive bladder symptoms). She has done pelvic floor exercises regularly and they were not successful. She is having a vaginal repair operation soon and if urodynamics stress incontinence is confirmed a mid-urethral tape will be placed at the same time.

A copy of the GP letter is attached for further information.

Kind regards
Yours sincerely

DR W AGUR
MD MRCOG
CONSULTANT GYNAECOLOGIST AND OBSTETRICIAN
SUBSPECIALIST UROGYNAECOLOGIST

JMcC/60798

Gynaecology

CIKT

486693

Hospital use only	Clinic DRAGUR	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Gynaecology F2
AA Gen Ref - PMH Med & High

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

Crosshouse Hospital

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

Hospital unit no.

Email address

Urgency of referral Routine

PATIENT DETAILS

Surname	Morrin
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

26 Lewis Terrace
BROOMLANDS
IRVINE
KA11 1HJ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	0		
GMC code	0000000	GP code	0
Practice name	Bourtreehill Medical Practice		
Practice code	80306		

Practice address

Cheviot Way
Bourtreehill Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr. Robert Wagner		
GMC code	1462973	GP code	22284
Practice name	BOURTREEHILL HEALTH CENTRE (80306)		
Practice code	80306		

Practice address

CHEVIOT WAY
BOORTREEHILL
IRVINE
KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

CROSSHOUSE HOSPITAL
23 JUL 2009
ADDED TO OUTPATIENTS WAITING LIST

Dates please

MEDICAL RECORDS
CROSSHOUSE HOSPITAL
03 JUL 2009
URGENT
SOON
ROUTINE ✓

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: See Letter

Comment: I would be grateful if you would see this woman who is complaining of symptoms suggestive of vaginal prolapse. She is adamant that she is feeling both the front wall and the front wall of her vagina descend at various times, particularly when coughing, lifting and straining. She is very conscious of the fact she has fairly large anal tags as well. She feels that her sexual relationships with her husband have been totally ruined by this feeling of prolapse. She does have an IUCD in situ.

Vaginal examination did reveal fairly lax vaginal walls and a small degree of an anterior vaginal prolapse. However, I could not detect a posterior vaginal prolapse.

I would be grateful if you would see Mrs. Morrin and advise her regarding her vaginal symptoms. She is significantly overweight but is making a very determined effort to lose weight at the moment with some success.

Many thanks for seeing her.

Examinations and Investigations

Never smoked tobacco:	14-Apr-2004 00:00
Never smoked tobacco:*	24-Apr-2002 00:00
Never smoked tobacco:	13-Jan-2009 00:00
Current non-smoker:	24-Apr-2002 00:00
Trivial drinker - <1u/day:	24-Apr-2002 00:00

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset
Normal delivery in a completely normal case	-	-	-	-
Normal delivery in a completely normal case	-	-	-	-
Migraine	-	-	-	-
[V]Behavioural problems	-	-	-	-

Current and recent medication

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration
Co-Codamol	04.07.01.0	30mg/500mg Effervescent TABS	2 Tabs	every 4 to 6 hours	08-Jun-2009	-
Meloxicam	10.01.01.0	TABS 7.5MG	1 Tab	In the morning	14-May-2009	-
Trimethoprim	05.01.08.0	TABS 200MG	1 Tab	morning and night	27-Apr-2009	-
Tramadol Hydrochloride	04.07.02.0	CAPS 50MG	1 Cap	Twice daily	07-Apr-2009	-
Co-Codamol	04.07.01.0	30mg/500mg Effervescent TABS	2 Tabs	every 4 to 6 hours	07-Apr-2009	-

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status: Number per day ? (not known)

Alcohol consumption: Units per day ? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Family conditions

Description	Modifier	Extension	Relation to patient
FH: Ischaemic heart dis. >60	-	-	-
FH: CVA/stroke	-	-	-
FH: Ischaemic heart dis. <60	-	-	-

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

GynaecologyF2
AA Gen Ref - PMH Med & High

Crosshouse Hospital

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	03-Jul-2009
Date submitted	03-Jul-2009

PATIENT DETAILS

Surname	Morrin
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

26 Lewis Terrace
BROOMLANDS
IRVINE
KA11 1HJ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	0		
GMC code	0000000	GP code	0
Practice name	Bourtreehill Medical Practice		
Practice code	80306		

Practice address

Cheviot Way
Bourtreehill Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr. Robert Wagner		
GMC code	1462973	GP code	22284

Practice address

CHEVIOT WAY
BOORTREEHILL

Practice name	BOURTREEHILL HEALTH CENTRE (80306)	IRVINE KA11 1JU	
Practice code	80306	Contact number(s)	
		Voice: 01294 211993 Facsimile: 01294 218461	

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: See Letter

Comment: I would be grateful if you would see this woman who is complaining of symptoms suggestive of vaginal prolapse. She is adamant that she is feeling both the front wall and the front wall of her vagina descend at various times, particularly when coughing, lifting and straining. She is very conscious of the fact she has fairly large anal tags as well. She feels that her sexual relationships with her husband have been totally ruined by this feeling of prolapse. She does have an IUCD in situ. Vaginal examination did reveal fairly lax vaginal walls and a small degree of an anterior vaginal prolapse. However, I could not detect a posterior vaginal prolapse. I would be grateful if you would see Mrs. Morrin and advise her regarding her vaginal symptoms. She is significantly overweight but is making a very determined effort to lose weight at the moment with some success. Many thanks for seeing her.

Examinations and Investigations

Never smoked tobacco: 14-Apr-2004
Never smoked tobacco: 24-Apr-2002
Never smoked tobacco: 13-Jan-2009
Current non-smoker: 24-Apr-2002
Trivial drinker - <1u/day: 24-Apr-2002

Reason for referral

Care type requested: Out Patient
Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Normal delivery in a completely normal case	-	-	-	-	-
Normal delivery in a completely normal case	-	-	-	-	-
Migraine	-	-	-	-	-
[V]Behavioural problems	-	-	-	-	-

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

No current medications recorded

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Co-Codamol	04.07.01.0	30mg/500mg Effervescent TABS	2 Tabs	every 4 to 6 hours	08-Jun-2009	-	-
Meloxicam	10.01.01.0	TABS 7.5MG	1 Tab	In the morning	14-May-2009	-	-

Trimethoprim	05.01.08.0	TABS 200MG	1 Tab	morning and night	27-Apr-2009	-	-
Tramadol Hydrochloride	04.07.02.0	CAPS 50MG	1 Cap	Twice daily	07-Apr-2009	-	-
Co-Codamol	04.07.01.0	30mg/500mg Effervescent TABS	2 Tabs	every 4 to 6 hours	07-Apr-2009	-	-

Clinical warnings

Smoking status

Alcohol consumption

Lifestyle risks

Exercise status: Not Known

Number per day
? (not known)

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Family conditions

Description	Modifier	Extension	Relation to patient	Date of onset	Recorded Date
FH: Ischaemic heart dis. >60	-	-	-	-	-
FH: CVA/stroke	-	-	-	-	-
FH: Ischaemic heart dis. <60	-	-	-	-	-

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

ESHANKS (Consultant)
Ear, Nose & Throat (ENT)C5
AA Gen Ref - PMH Med & High

Crosshouse Hospital

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	27-Feb-2009
Date submitted	02-Mar-2009

PATIENT DETAILS

Surname	Morrin
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

26 Lewis Terrace
BROOMLANDS
IRVINE
KA11 1HJ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	Dr J Nelson
GMC code	3558018 GP code A24228
Practice name	Bourtreehill Medical Practice
Practice code	80306

Practice address

Cheviot Way
Bourtreehill Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr A Rashid

Practice address

Cheviot Way

GMC code	6073956	GP code	A1568
Practice name	Bourtreehill Medical Practice		
Practice code	80306		

Bourtreehill Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: See reason for referral

Comment: I would be grateful for your opinion on this young lady. She is a 31-year-old lady who has suffered from recurrent tonsillitis. She was seen at your clinic in 2006, flexible fibre-optic nasopharyngolaryngoscopy demonstrated bilateral vocal cord nodules. Cord mobility was normal. She was referred to a Speech Therapist and felt that this was beneficial. She has now attended complaining of multiple episodes of voice hoarseness. She tells me that she gets an episode once a month and as she is employed as a Carer this is now affecting her job. Caroline also complains of recurrent episodes of tonsillitis. I note that many years previously she was due to have a tonsillectomy however she self-discharged after a disagreement with staff. From our records it does appear that her recurrent tonsillitis has now settled. I feel this lady's episodes of recurrent voice hoarseness are related to her vocal chord nodules. Caroline feels that this is now affecting her work significantly and I would be grateful for your opinion with regards to further treatment.

Examinations and Investigations

Never smoked tobacco: 14-Apr-2004

Trivial drinker - <1u/day: 24-Apr-2002

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Normal delivery in a completely normal case	-	-	-	-	-
Normal delivery in a completely normal case	-	-	-	-	-
Migraine	-	-	-	-	-
[V]Behavioural problems	-	-	-	-	-

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

No current medications recorded

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Omeprazole	01.03.05.0	CAPS 20MG	1 Cap	In the morning	25-Feb-2009	-	-
Co-Codamol	04.07.01.0	8mg/500mg Effervescent	2 Tabs	Take as required	25-Feb-	-	-

		TABS			2009		
Diclofenac Sodium	10.01.01.0	Dispersible TABS 50MG	1 Tab	3 times daily	25-Feb-2009	-	-
Amoxicillin	05.01.01.3	CAPS 250MG	1 Cap	3 times daily	13-Jan-2009	-	-

Clinical warnings

Smoking status

Alcohol consumption

Lifestyle risks

Exercise status: Not Known

Number per day ? (not known)

Units per day ? (not known)

Additional relevant information

Administrative information

Referred By:Resident GP

Family conditions

Description	Modifier	Extension	Relation to patient	Date of onset	Recorded Date
FH: Ischaemic heart dis. >60	-	-	-	-	-
FH: CVA/stroke	-	-	-	-	-
FH: Ischaemic heart dis. <60	-	-	-	-	-

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

DermatologyA7
AA General Referral PMH High

Crosshouse Hospital

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	30-Apr-2008
Date submitted	30-Apr-2008

PATIENT DETAILS

Surname	Morrin
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

26 Lewis Terrace
BROOMLANDS
IRVINE
KA11 1HJ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	Dr J Nelson		
GMC code	3558018	GP code	A24228
Practice name	Bourtreehill Medical Practice		
Practice code	80306		

Practice address

Cheviot Way
Bourtreehill Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr K Marshall

Practice address

Cheviot Way

GMC code	6071687	. GP code	A1548
Practice name	Bourtreehill Medical Practice		
Practice code	80306		

Bourtreehill Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: See reason for referral

Comment: I would be grateful if you could see this lady who has a mole on the medial aspect of her right little toe. She has had a mole here for as long as she can remember but thinks that over the past few months it has at least doubled in size and at times she feels that her toe feels uncomfortable underneath. On examination there is a flat naevus on the proximal medial aspect of her little toe. There is some peeling of the skin round about but I think this is more likely due to Athlete's Foot. The mole has ununiform pigment and I would be grateful for your assessment. I have given her Canesten cream to treat her Athlete's Foot in the meantime.

Examinations and Investigations

Never smoked tobacco: 14-Apr-2004

Current non-smoker: 24-Apr-2002

Trivial drinker - <1u/day: 24-Apr-2002

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Normal delivery in a completely normal case	-	-	-	-	-
Migraine	-	-	-	-	-

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

No current medications recorded

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Clotrimazole	13.10.02.0	CREAM 1%	Apply	3 times daily	29-Apr-2008	-	-
Omeprazole	01.03.05.0	CAPS 20MG	1 Cap	In the morning	01-Apr-2008	-	-
Sibutramine Hydrochloride Monohydrate	04.05.02.0	CAPS 10MG	1 Cap	Daily	01-Apr-2008	-	-
Sibutramine Hydrochloride Monohydrate	04.05.02.0	CAPS 10MG	1 Cap	Daily	14-Feb-2008	-	-

Omeprazole	01.03.05.0	CAPS 20MG	1 Cap	In the morning	14-Feb-2008	-	-

Clinical warnings

Smoking status

Alcohol consumption

Additional relevant information
Family conditions

Description	Modifier	Extension	Relation to patient	Date of onset	Recorded Date
FH: CVA/stroke	-	-	-	-	-
FH: Ischaemic heart dis. >60	-	-	-	-	-
FH: Ischaemic heart dis. <60	-	-	-	-	-

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

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

Our Ref:EBM/MG/ 0000466693
CHI No: 3010776241
Date: 11/04/2008

Dr R M Wagner
Health Centre
Cheviot Way
IRVINE KA11 1JU

Enquiries: Michele Garrett
Extension: 2875
Direct: 01563 577875
Fax: 01563 577975

Dear Dr Wagner

Re: CATHERINE MORRIN, 26 LEWIS TERRACE IRVINE, 30/10/1977

This lady did not attend for her ultrasound examination. I trust this means her symptoms are under control and I will not make any further arrangements to see her unless I hear from you to the contrary.

Yours sincerely

E B MELROSE
CONSULTANT GYNAECOLOGIST
GMC NO: 1345498

Gynaecology

JMcC/60798

466693

Department of Radiology

Crosshouse Hospital
Kilmarnock Road
Crosshouse
Kilmarnock
KA2 0BE

NHS
Ayrshire & Arran

Gynaecology OP

Date **March 18, 2008**
Your Ref
Our Ref 3010776241

Enquiries to
Direct line **01563 577115**
Fax
E-mail

Caroline Morrin, 26 Lewis Terr, Irvine, , KA11 1EZ, 3010776241

Dear Dr.E. Melrose
The above named patient failed to attend for an US Pelvis (Transvaginal)

They have not responded to our letter asking them to contact the department to arrange a further appointment. We have therefore removed this patient from our waiting list.
We have written to them to inform them of this.

We will be happy to accept a re-referral should you feel this necessary

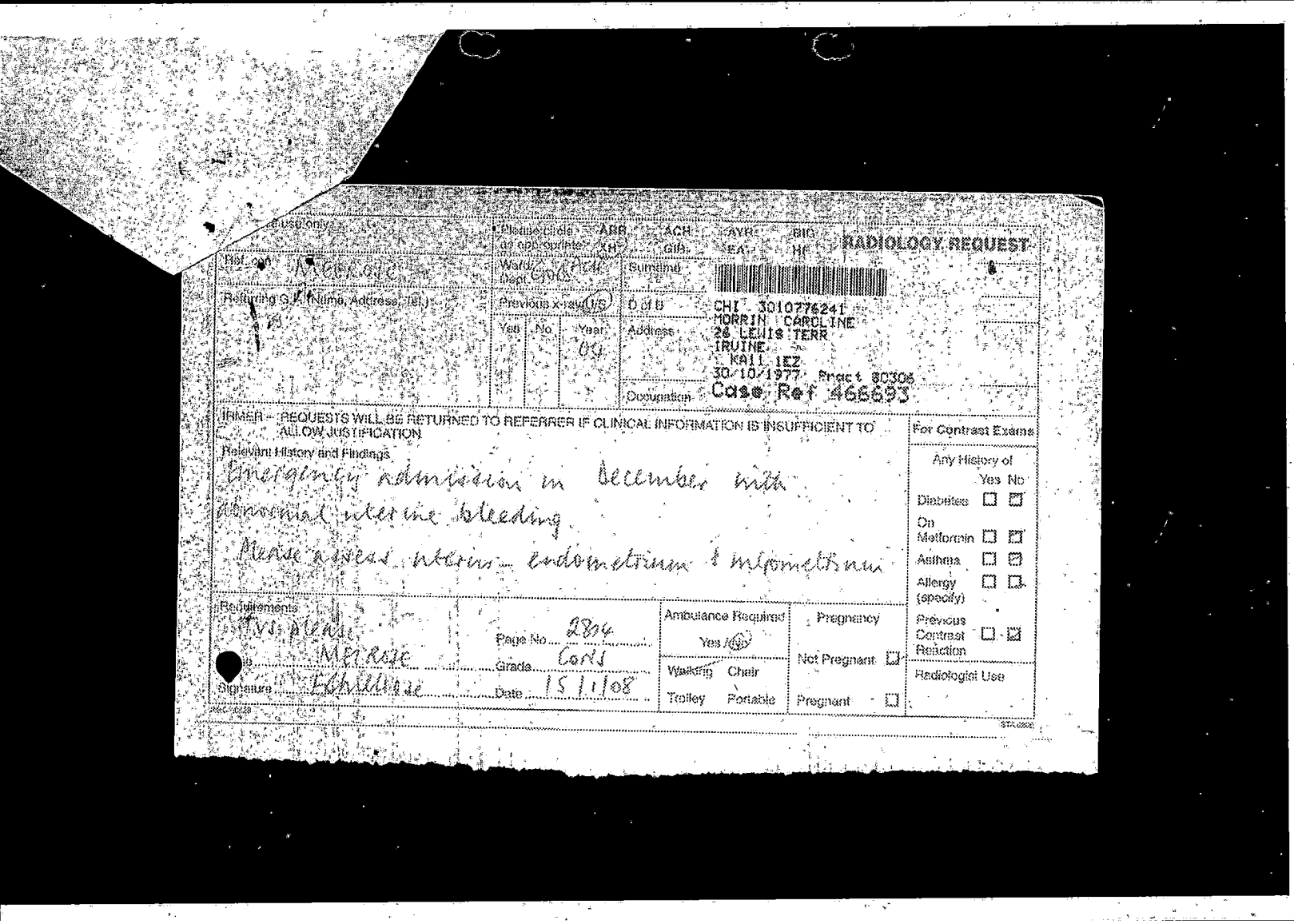
Yours Sincerely

L Haulin

Appointments Secretary

notes
no action
notes please
EBM
✓ EBM
no action
?GOPD appt

25 MAR 2008



X-ray Only | Please circle as appropriate: ABR XH | ACH GIB | AYH EA | BIC HF

RADIOLOGY REQUEST

Ref by: Mcenroe

Ward/Dept: CHOG

Surname:

Referring G.P. (Name, Address, Tel.):

Previous x-ray(s): Yes / No / Year: 06

D of B:

Address: CHI 3010776241
MORRIN CAROLINE
28 LEWIS TERR
IRVINE
KA11 1EZ
30/10/1977 Proact 80306

Occupation:

Case Ref 466693

PRIMER – REQUESTS WILL BE RETURNED TO REFERRER IF CLINICAL INFORMATION IS INSUFFICIENT TO ALLOW JUSTIFICATION

Relevant History and Findings:

Emergency admission in December with abnormal uterine bleeding.

Please assess uterine endometrium & myometrium

Requirements: TVS please

Page No: 284

Grade: Cons

Sig: McEnroe

Signature: EMcEnroe

Date: 15/1/08

Ambulance Required: Yes

Walking / Chair / Trolley / Portable

Pregnancy: Not Pregnant / Pregnant

For Contrast Exams

Any History of: Yes / No

Diabetes

On Metformin

Asthma

Allergy (specify)

Previous Contrast Reaction

Radiologist Use

SRC0002

STA 0617

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

Our Ref: EBM/MG/ 0000466693
CHI No: 3010776241
Date: 11/01/2008

Dr R M Wagner
Health Centre
Cheviot Way
IRVINE KA11 1JU

Enquiries: Michele Garrett
Extension: 2875
Direct: 01563 577875
Fax: 01563 577975

Dear Dr Wagner

Re: CATHERINE MORRIN, 26 LEWIS TERRACE IRVINE, 30/10/1977

This lady was admitted as an emergency on the 23rd December with recurrent vaginal bleeding. She had tried all manner of contraception in an attempt to improve her bleeding without success. The bleeding seemed to respond to Tranexamic Acid and Norethisterone. She went home on Christmas eve and has an out-patient ultrasound pending.

She will be seen in the out-patient clinic thereafter.

Yours sincerely

card sent 16/1/08

E B MELROSE
CONSULTANT GYNAECOLOGIST
GMC NO: 1345498

Gynaecology

JMcC/60738

STA0849

NHS AYRSHIRE & ARRAN

Crosshouse Hospital Discharge

90659 (36)

G.P.

* PLEASE PRINT HEAVILY USING BALL POINT PEN

Patient Details:

Surname: M XH 466693
First
Addr: MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1EZ
DOB: 30/10/1977
Unit No: DR R WAGNER
(or date of) CHEVIOT WAY
BOURTREEHILL HEALTH CENTRE
CHI 3010776241

Ward: 6
Consultant: Dr Melrose
Date of Admission: 23/12/07
Date of Discharge: 24/12/07
(or date of death)
Clinic Appointment:

Services A: CHI ☐ Home help ___ times week ☐ Meals on wheels ☐ District Nurse ☐ Other

Discharged to: ☐ Home ☐ Stay with relatives ☐ Other hospital ☐ Nursing home ☐ Other ☐ Died

Discharge Diagnosis (if admitted due to an injury, include place of accident & site of injury)	If multiple Day Case admission, list dates of admission
1 PV bleeding	
2 For U/S as O/P	
3	
4	
5	

Operations / Procedures
1
2
3
4

XH 466693
CHI 3010776241

Discharge Medication (7 days supply will be dispensed unless otherwise stated by doctor)

For Pharmacy use

Drug Name and formulation	Dose	Frequency	Route	Duration (cont./stop)	Quantity and strength	Notes
TRANEXAMIC ACID	1g	TID	PO	4/7	24 x 500mg	
NORETHISTERONE	5mg	TID	PO	3/52	63 x 5mg	3/12

pharmacy date 24/12/07 dispensed by checked by:

Additional Information (e.g. awaiting histology or other results, patients progress)

A finished consultant episode letter will follow

Signature

PRINT NAME Miss M Date 24/12/2007

N.B. DISCHARGE MEDICATION IS FOR INFORMATION ONLY. FAXED COPY HAS NOT BEEN CHECKED BY DOCTOR. ON RECEIPT OF HARD COPY, FAXED COPY CAN BE DESTROYED.

Ward Clerkess: _____ / Dictated: _____ / Typed: _____ / Signed: _____ / Mailed: _____

To F Hamilton
Oxenward Surgery
3 Oxenward Road
Kilwinning
Ayrshire
KA13 6EH

University Hospital Crosshouse
Emergency Department
Crosshouse Hospital, Kilmarnock
KA2 0BE
Tel: 01563 827751 / 827762

DUTY CONSULTANT: 0

PATIENT DETAILS

Patient name	**Caroline Welsh**
CHI Number	3010776241
DOB	30/10/1977
Address	9 ST. MICHAELS PLACE KILWINNING AYRSHIRE KA13 6FA

ATTENDANCE DETAILS

Attendances prev12mths	0
Total Attendances	7
Arrival Date & Time	23/12/2007 at 20:31
Attendance Number	XH-07-063183-1
Diagnosis	PV bleeding,not pregnant -1

Drugs:

Treatment	Other
Investigations	
Additional Information	pv bleeding-4/52,worse with clots-4/7.refered to gynaecology.

DISCHARGE DETAILS

Discharge Date & Time	23 Dec 2007 22:2722:27
Left Dept. Date & Time	
Outcome	Admitted 0 0 Gyn
Further Referral	Obs/Gynae
Child Protection	
Adult Protection/Concern	
Clinician Seen	RAMA KRISHNA YERRA 0

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

Our Ref:LB/LM/ 0000466693
CHI No: 3010776241
Date: 04/06/2007

Dr I Jamieson
The Portacabins
Ayrshire Central Hosp
Kilwinning Road

Enquiries: C Gardner
Extension: 2873
Direct: 01563 577873
Fax: 01563 577975

Dear Dr Jamieson

Re: CATHERINE MORRIN, 4 CRAIGNAW PLACE IRVINE, 30/10/1977

Caroline attended the Gynaecology Clinic on the 18th May 2007. She was previously seen requesting sterilisation in November 2006. At that time my Registrar explained that her raised BMI precluded her from safe laparoscopic sterilisation. He discussed various other contraceptive methods with her. Caroline was given a target weight of 86kgs before she would be suitable for surgery.

On attendance today her weight is 107.1kg and her BMI is 36.8. I have explained that she is still above the threshold criteria for such surgery and have recommended that she contact yourself when she reaches 86kgs for a new referral. I have again discussed various contraceptive methods with her today and given her leaflets on the Mirena IUS.

Caroline is extremely anxious about having her Implanon removed and has requested that this be done under general anaesthetic at the time of her sterilisation. Unfortunately I am not licensed for Implanon insertion or removal and have explained this to Caroline today. I have recommended that she contact the Family Planning Clinic or the person who inserted this.

Yours sincerely

LUCIE BUCK
CONSULTANT GYNAECOLOGIST

Gynaecology

GYNAECOLOGY DEPARTMENT
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE

Our Ref: TT/FK/ 0000466693
CHI No: 3010776241
Date: 06/12/2006

Dr I Jamieson
The Portacabins
Ayrshire Central Hosp
Kilwinning Road

Enquiries: C Gardner
Extension: 2873
Direct: 01563 577873
Fax: 01563 577975

Dear Dr Jamieson

Re: ~~CATHERINE~~ Caroline MORRIN, 4 CRAIGNAW PLACE IRVINE, 30/10/1977

Thank you for referring this 29 year old para 3 for laparoscopic sterilisation. She is currently using an implant for contraception and is unhappy with this as she has some discomfort at the insertion site. She has also had irregular bleeding with the implant and had to use Norethisterone to control this.

We discussed alternative forms of contraception including other hormone contraception and the Mirena coil, however she was still keen on lapasoscopic sterilisation. We discussed the risk of complications, advantages and disadvantages. Her BMI is around 38 and she is unfit for a day case procedure, we have given her a target weight of around 86kg and she is already enrolled on a weight loss programme. She has requested a review appointment in 6 months time and is keen to go ahead with the lap sterilisation once her target weight is acheived.

Yours sincerely

TONY THOMAS
SHO 3 IN GYNAECOLOGY

Gynaecology

22/12

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

CHI:3010776241

MEDICAL IN CONFIDENCE

REFERRAL TO

Ear, Nose & Throat (ENT)C5
AA Gen Ref - PMH Med & High

Crosshouse Hospital

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	*Soon*
Date of referral	07-Nov-2006
Date submitted	07-Nov-2006

PATIENT DETAILS

Surname	Morrin
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

4 Craignaw Place
BOURTREEHILL
IRVINE
AYRSHIRE
KA11 1EZ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	0
GMC code	0000000 GP code 0
Practice name	Bourtreehill Medical Practice
Practice code	80306

Practice address

Cheviot Way
Bourtreehill Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr. Robert Joseph

Practice address

Cheviot Way
Bourtreehill Irvine

GMC code	0000000	GP code	A2298
Practice name	Bourtreehill Medical Practice		
Practice code	80306		

KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: See Letter

Comment: This patient has been having intermittent hoarseness for the past three months. This is associated with a strange feeling in her throat. The hoarseness seems to resolve for a couple of days, only to return for much longer periods. She is known to have large tonsils and examination does reveal large tonsils today but these are not inflamed. Her hoarse voice is indeed noted. Clinical examination is, otherwise, unremarkable. I would very much appreciate your assessment.

Examinations and Investigations

Never smoked tobacco: 14-Apr-2004
Never smoked tobacco: 24-Apr-2002
Current non-smoker: 24-Apr-2002
Trivial drinker - <1u/day: 24-Apr-2002

Reason for referral

Care type requested: Out Patient
Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Normal delivery in a completely normal case	-	-	-	-	-
Normal delivery in a completely normal case	-	-	-	-	-
Migraine	-	-	-	-	-
[V]Behavioural problems	-	-	-	-	-

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

No current medications recorded

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Sibutramine Hydrochloride Monohydrate	04.05.02.0	CAPS 10MG	1 Cap	Daily	06-Nov-2006	-	-
Norethisterone	06.04.01.2	TABS 5MG	1 Tab	3 times daily	06-Nov-2006	-	-
Omeprazole	01.03.05.0	CAPS 20MG	1 Cap	In the morning	06-Nov-2006	-	-
Omeprazole	01.03.05.0	CAPS 20MG	1 Cap	In the morning	16-Oct-	-	-

					2006		
Norethisterone	06.04.01.2	TABS 5MG	1 Tab	3 times daily	16-Oct-2006	-	-
Chlorhexidine Gluconate	12.03.04.0	Sf Mouthwash Mint SOL 0.2%	10 ml	4 times daily	09-Oct-2006	-	-
Trimovate	13.04.00.0	CREAM	Apply	Twice daily	04-Oct-2006	-	-
Zineryt	13.06.01.0	LOT	Apply	morning and night	29-Sep-2006	-	-
Metronidazole	05.01.11.0	TABS 400MG	1 Tab	morning and night	29-Sep-2006	-	-
Sibutramine Hydrochloride Monohydrate	04.05.02.0	CAPS 10MG	1 Cap	Daily	29-Sep-2006	-	-
Omeprazole	01.03.05.0	CAPS 20MG	1 Cap	In the morning	20-Sep-2006	-	-
Canesten Combi	07.02.02.0	Pessary And Cream	1 to be inserted	At night	20-Sep-2006	-	-
Norethisterone	06.04.01.2	TABS 5MG	1 Tab	3 times daily	18-Sep-2006	-	-
Sibutramine Hydrochloride Monohydrate	04.05.02.0	CAPS 10MG	1 Cap	Daily	05-Sep-2006	-	-
Econazole Nitrate	07.02.02.0	Single Dose PESS 150MG	1 to be inserted	At night	05-Sep-2006	-	-
Norethisterone	06.04.01.2	TABS 5MG	1 Tab	3 times daily	24-Aug-2006	-	-

Clinical warnings Smoking status Alcohol consumption

Additional relevant information

Family conditions

Description	Modifier	Extension	Relation to patient	Date of onset	Recorded Date
FH: CVA/stroke	-	-	-	-	-
FH: Ischaemic heart dis. >60	-	-	-	-	-
FH: Ischaemic heart dis. <60	-	-	-	-	-

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

Hospital use only	Clinic	Day Date	Time	Hospital No.
	Dr Buck.			466693

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Gynaecology F2
AA General Referral PMH High

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

Crosshouse Hospital

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

Hospital unit no. -

Email address -

Urgency of referral Routine

PATIENT DETAILS

Surname	Morrin
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

4 Craignaw Place
BOURTREEHILL
IRVINE
AYRSHIRE
KA11 1EZ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	0		
GMC code	0000000	GP code	0
Practice name	Bourtreehill Medical Practice		
Practice code	80306		

Practice address

Cheviot Way
Bourtreehill Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr. Robert Wagner		
GMC code	1462973	GP code	22284
Practice name	BOURTREEHILL HEALTH CENTRE (80306)		
Practice code	80306		

Practice address

CHEVIOT WAY
BOORTREEHILL
IRVINE

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

CROSSHOUSE HOSPITAL
29 SEP 2006
ADDED TO OUTPATIENTS WAITING LIST

CROSSHOUSE HOSPITAL
07/9/06
25 AUG 2006
URGENT
SOON
ROUTINE ✓

To see Lucie Bucle re BMI.

20.9.6.

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: See Letter

Comment: I would be grateful if you would see this woman and consider her request for sterilisation. Mrs. Morrin has three children. She is absolutely convinced that she wishes to have permanent sterilisation despite the fact that she is now a single mother bringing up these three kids. She has, at the moment, the implant insitu which did cause some initial bleeding problems.

Mrs. Morrin is very heavy with a BMI of around 41. However, she is also on Reductil in an attempt to lose weight.

I would be grateful if you would see her and consider her request.

Examinations and Investigations

Never smoked tobacco: 14-Apr-2004 00:00
Never smoked tobacco: 24-Apr-2002 00:00
Current non-smoker: 24-Apr-2002 00:00
Trivial drinker - <1u/day: 24-Apr-2002 00:00

Reason for referral

Care type requested: Out Patient
Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset
Normal delivery in a completely normal case	-	-	-	-
Normal delivery in a completely normal case	-	-	-	-
Knee pain	-	-	-	-
Migraine	-	-	-	-
[V]Behavioural problems	-	-	-	-

Past procedures

Description	Laterality	Modifier	Date performed
Oral contraception -no problem	-	-	-
Diagnostic laparoscopy of female pelvis	-	-	-
Emergency appendicectomy	-	-	-

Current and recent medication

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration
Sibutramine Hydrochloride Monohydrate	04.05.02.0	CAPS 10MG	1 Cap	Daily	05-Sep-2006	-
Econazole Nitrate	07.02.02.0	Single Dose PESS 150MG	1 to be inserted	At night	05-Sep-2006	-
Norethisterone	06.04.01.2	TABS 5MG	1 Tab	3 times daily	24-Aug-2006	-
Ferrous Fumarate	09.01.01.1	TABS 210MG	1 Tab	Twice daily	11-Jul-2006	-
Prochlorperazine Maleate	04.06.00.0	TABS 5MG	1 Tab	3 times daily	11-Jul-2006	-
Cerazette	07.03.02.1	TABS 75MICROGRAMS	1 Tab	Daily	10-Jul-2006	-
Mefenamic Acid	10.01.01.0	CAPS 250MG	1 or 2 Caps	Twice daily	04-Jul-2006	-

Clinical warnings

Smoking status

Alcohol consumption

Additional relevant information

Family conditions

Description	Modifier	Extension	Relation to patient
FH: Ischaemic heart dis. >60	-	-	-
FH: CVA/stroke	-	-	-
FH: Ischaemic heart dis. <60	-	-	-

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

CHI:3010776241

REFERRAL TO

GynaecologyF2
AA General Referral PMH High

Crosshouse Hospital

Ethnic Origin	-
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	05-Sep-2006
Date submitted	07-Sep-2006

PATIENT DETAILS

Surname	Morrin
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

4 Craignaw Place
BOURTREEHILL
IRVINE
AYRSHIRE
KA11 1EZ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	0		
GMC code	0000000	GP code	0
Practice name	Bourtreehill Medical Practice		
Practice code	80306		

Practice address

Cheviot Way
Bourtreehill Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr. Robert Wagner		
GMC code	1462973	GP code	22284
Practice name	BOURTREEHILL HEALTH CENTRE (80306)		
Practice code	80306		

Practice address

CHEVIOT WAY
BOORTREEHILL
IRVINE

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: See Letter

Comment: I would be grateful if you would see this woman and consider her request for sterilisation. Mrs. Morrin has three children. She is absolutely convinced that she wishes to have permanent sterilisation despite the fact that she is now a single mother bringing up these three kids. She has, at the moment, the implant insitu which did cause some initial bleeding problems. Mrs. Morrin is very heavy with a BMI of around 41. However, she is also on Reductil in an attempt to lose weight. I would be grateful if you would see her and consider her request.

Examinations and Investigations

Never smoked tobacco: 14-Apr-2004
Never smoked tobacco: 24-Apr-2002
Current non-smoker: 24-Apr-2002
Trivial drinker - <1u/day: 24-Apr-2002

Reason for referral

Care type requested: Out Patient
Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Normal delivery in a completely normal case	-	-	-	-	-
Normal delivery in a completely normal case	-	-	-	-	-
Knee pain	-	-	-	-	-
Migraine	-	-	-	-	-
[V]Behavioural problems	-	-	-	-	-

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Oral contraception -no problem	-	-	-	-	-
Diagnostic laparoscopy of female pelvis	-	-	-	-	-
Emergency appendicectomy	-	-	-	-	-

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

No current medications recorded

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Sibutramine Hydrochloride Monohydrate	04.05.02.0	CAPS 10MG	1 Cap	Daily	05-Sep-2006	-	-
Econazole Nitrate	07.02.02.0	Single Dose PESS 150MG	1 to be inserted	At night	05-Sep-	-	-

					2006		
Norethisterone	06.04.01.2	TABS 5MG	1 Tab	3 times daily	24-Aug-2006	-	-
Ferrous Fumarate	09.01.01.1	TABS 210MG	1 Tab	Twice daily	11-Jul-2006	-	-
Prochlorperazine Maleate	04.06.00.0	TABS 5MG	1 Tab	3 times daily	11-Jul-2006	-	-
Cerazette	07.03.02.1	TABS 75MICROGRAMS	1 Tab	Daily	10-Jul-2006	-	-
Mefenamic Acid	10.01.01.0	CAPS 250MG	1 or 2 Caps	Twice daily	04-Jul-2006	-	-

Clinical warnings

Smoking status

Alcohol consumption

Additional relevant information

Family conditions

Description	Modifier	Extension	Relation to patient	Date of onset	Recorded Date
FH: Ischaemic heart dis. >60	-	-	-	-	-
FH: CVA/stroke	-	-	-	-	-
FH: Ischaemic heart dis. <60	-	-	-	-	-

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

JHD/CL/466693
CHI Number: 3010776241

☎ *Direct Line:* *01563 827861 Christine Lees*
E-mail: *christine.lees@aaaht.scot.nhs.uk*
Fax Number: *01563 827974*
NHS AYRSHIRE & ARRAN, HOSPITAL SERVICES
DEPARTMENT OF OTOLARYNGOLOGY/HEAD AND NECK SURGERY,
CROSSHOUSE HOSPITAL, KILMARNOCK, KA2 OBE
MR J H DEMPSTER – WAITING LIST INITIATIVE CLINIC

28th May 2009
Dic 23.05.09

Dr A Rashid
Bourtreehill Medical Practice
Cheviot Way
IRVINE

Dear Dr Rashid

CAROLINE MORRIN, 26 LEWIS TERRACE, BROOMLANDS, IRVINE, DOB 30.10.77

DIAGNOSIS: ***DYSPHONIA, INTERMITTENT SORE THROATS***
MANAGEMENT:

Thank you for your letter on this lady who had 2 problems. With regard to her recurring sore throats as you correctly report, these were diminished in severity and only happening once a year and as such do not justify any surgical intervention. There was no real evidence of nodules today on fibreoptic examination and I think her voice is something that she will just have to continue to treat conservatively with speech and language therapy advice. She does seem a rather tense individual which will not help and she should try and relax, breathe properly and follow the usual advice and I doubt if there is a great deal that one could do.

Kind regards.

Yours sincerely

MR J H DEMPSTER
CONSULTANT ENT SURGEON

Awarded for excellence

JMcC/60803

Otolaryngology

R

4660 693

Hospital use only	Clinic	Day Date	Time	Hospital No.
	MISS SHANKS			

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

E SHANKS (Consultant)
Ear, Nose & Throat (ENT) C5
AA Gen Ref - PMH Med & High

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

Crosshouse Hospital

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

Hospital unit no. -

Email address -

Urgency of referral Routine

PATIENT DETAILS

Surname	Morrin
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

26 Lewis Terrace
BROOMLANDS
IRVINE
KA11 1HJ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	Dr J Nelson		
GMC code	3558018	GP code	A24228
Practice name	Bourtreehill Medical Practice		
Practice code	80306		

Practice address

Cheviot Way
Bourtreehill Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr A Rashid		
GMC code	6073956	GP code	A1568
Practice name	Bourtreehill Medical Practice		
Practice code	80306		

Practice address

Cheviot Way
Bourtreehill Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

MEDICAL RECORDS
CROSSHOUSE HOSPITAL
02 MAR 2009
URGENT
SOON
ROUTINE EMS 02/3
AUDIOLOGY

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: See reason for referral

Comment: I would be grateful for your opinion on this young lady. She is a 31-year-old lady who has suffered from recurrent tonsillitis. She was seen at your clinic in 2006, flexible fibre-optic nasopharyngolaryngoscopy demonstrated bilateral vocal cord nodules. Cord mobility was normal. She was referred to a Speech Therapist and felt that this was beneficial. She has now attended complaining of multiple episodes of voice hoarseness. She tells me that she gets an episode once a month and as she is employed as a Carer this is now affecting her job. Caroline also complains of recurrent episodes of tonsillitis. I note that many years previously she was due to have a tonsillectomy however she self-discharged after a disagreement with staff. From our records it does appear that her recurrent tonsillitis has now settled. I feel this lady's episodes of recurrent voice hoarseness are related to her vocal chord nodules. Caroline feels that this is now affecting her work significantly and I would be grateful for your opinion with regards to further treatment.

Examinations and Investigations

Never smoked tobacco: 14-Apr-2004 00:00

Trivial drinker - <1u/day: 24-Apr-2002 00:00

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset
Normal delivery in a completely normal case	-	-	-	-
Normal delivery in a completely normal case	-	-	-	-
Migraine	-	-	-	-
[V]Behavioural problems	-	-	-	-

Current and recent medication

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration
Omeprazole	01.03.05.0	CAPS 20MG	1 Cap	In the morning	25-Feb-2009	-
Co-Codamol	04.07.01.0	8mg/500mg Effervescent TABS	2 Tabs	Take as required	25-Feb-2009	-
Diclofenac Sodium	10.01.01.0	Dispersible TABS 50MG	1 Tab	3 times daily	25-Feb-2009	-
Amoxicillin	05.01.01.3	CAPS 250MG	1 Cap	3 times daily	13-Jan-2009	-

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status: Number per day ? (not known)

Alcohol consumption: Units per day ? (not known)

Additional relevant information

Administrative information

Referred By: Resident GP

Family conditions

Description	Modifier	Extension	Relation to patient
FH: Ischaemic heart dis. >60	-	-	-
FH: CVA/stroke	-	-	-
FH: Ischaemic heart dis. <60	-	-	-

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

m1= 10/1/07

Speech and Language
Therapy Department
Crosshouse Hospital
Crosshouse KA2 0BE

NHS
Ayrshire
& Arran

Miss E M Shanks
Consultant ENT Surgeon
Crosshouse Hospital
Crosshouse

Date 6th March 2007

Our Ref KW/CAS

Enquiries to Keri Wilson
Extension 2140
Direct line (01563) 577140
Fax (01563) 577131
E-mail

CHI: 3010776241
UNIT NO: 466693

Dear Miss Shanks

Re: Caroline Morrin, 4 Craignaw Place, Irvine, KA11 1EZ

Ms Morrin attended initial triage clinic appointment at Crosshouse and it was suggested she would be admitted for further assessment and therapy. However, due to work and family commitments she has been unable to attend any other appointments.

With the basic advice given at the initial appointment, fortunately improvements have been made and Ms Morrin believes her voice has almost returned to normal. It did certainly sound stronger on the telephone.

I advised that if there is any deterioration in the near future to contact the department directly.

Yours sincerely

Keri Wilson

Keri Wilson
Speech and Language Therapist

c.c. Dr Joseph
Cheviot Way
Bourtreehill
Irvine
KA11 1JU

✓

EMP

Awarded for excellence

MJ/CMcL/466693
CHI No: 3010776241

✉ christine.mcleish@aaaht.scot.nhs.uk
☎ 01563 577368 (Direct Line)
🖷 01563 577974
DEPARTMENT OF OTOLARYNGOLOGY
MISS E M SHANKS

Department of Otolaryngology
CROSSHOUSE HOSPITAL
KILMARNOCK KA2 0BE

20th December 2006
Adult ENT Clinic 19/12/06

Dr R Joseph
Bourtreehill Medical Practice
Cheviot Way
Bourtreehill
IRVINE
KA11 1JU

Dear Dr Joseph

CAROLINE MORRIN, 4 CRAIGNAW PLACE, BOURTREEHILL, IRVINE (30/10/77)

This patient was seen for review. There is no improvement in her voice. She complained of a change in her voice for the last 3-4 months. She tells me her voice quality fluctuates. She is a carer and uses her voice a lot. She also suffers from reflux for which she takes Losec tablets which help her. She denies any dysphagia. I am told recent blood tests are all normal.

On examination, her voice sounded strained today. Throat and palpation of neck were normal. Flexible fibre-optic nasopharyngolaryngoscopy which was carried out after anaesthetising her nose with Cophenylcaine spray, showed bilateral vocal nodules. No other abnormality was seen. Cord mobility is normal.

Her voice problem is probably secondary to vocal nodules. After discussion with her, I have referred her to the Speech & Language Therapists. I have also advised her to carry on taking Losec tablets.

A review appointment, if necessary, will be arranged after speech therapy. She has already been supplied with a voice care leaflet.

Yours sincerely

DR MANDAR JOG
STAFF GRADE ENT SURGEON

cc:
Ms Yvonne Hamilton
Speech & Language Therapist
CROSSHOUSE HOSPITAL

Awarded for Excellence

Otolaryngology

EMS/CMcL/466693
CHI No: 3010776241

✉ christine.mcleish@aaaht.scot.nhs.uk
☎ 01563 577368 (Direct Line)
🖷 01563 577974
DEPARTMENT OF OTOLARYNGOLOGY
MISS E M SHANKS

Department of Otolaryngology
CROSSHOUSE HOSPITAL
KILMARNOCK KA2 0BE

29th November 2006
Adult ENT Clinic 28/11/06

Dr R Joseph
Bourtreehill Medical Practice
Cheviot Way
Bourtreehill
IRVINE
KA11 1JU

Dear Dr Joseph

CAROLINE MORRIN, 4 CRAIGNAW PLACE, BOURTREEHILL, IRVINE (30/10/1977)

Thank you for referring Caroline, who complains of intermittent dysphonia for the past 3 months. She has no associated pain or dysphagia and has a past history of recurrent tonsillitis. She has had no acute infections in the past 6 months, although she did have an upper respiratory tract infection this morning. She is a non-smoker and takes Omeprazole for gastro-oesophageal reflux. She told me her thyroid function has been satisfactory in the past.

On examination, the nasal airways were clear with a mild degree of alar collapse. Her tonsils remain enlarged. Fibre-optic examination revealed some general inflammation around the pharynx and larynx. I was unable to gain a clear view of her vocal cords due to the large quantity of mucus present. Her neck was clear on palpation.

I have issued her with a voice care leaflet and advised her to carry out regular steam inhalations. She appears to be suffering from chronic laryngitis and will be reviewed in 3 weeks' time to ensure her symptoms are improving.

Yours sincerely

MISS E M SHANKS
CONSULTANT ENT SURGEON

Awarded for Excellence

Otolaryngology

PREV M' WARD RO, 2000

Mc R

Hospital use only	Clinic	Day / Date	Time	Hospital No.
	MS SHANKS	TUES 28/11/06	10:55	466693

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Ear, Nose & Throat (ENT) C5
AA Gen Ref - PMH Med & High

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

Crosshouse Hospital

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

Hospital unit no.

Email address

Urgency of referral Soon

PATIENT DETAILS

Surname	Morrin
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

4 Craignaw Place
BOURTREEHILL
IRVINE
AYRSHIRE
KA11 1EZ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	0
Code	0000000 GP code 0
Practice name	Bourtreehill Medical Practice
Practice code	80306

Practice address

Cheviot Way
Bourtreehill Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr. Robert Joseph
GMC code	0000000 GP code A2298
Practice name	Bourtreehill Medical Practice
Practice code	80306

Practice address

Cheviot Way
Bourtreehill Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

MEDICAL RECORDS
CROSSHOUSE HOSPITAL
07 NOV 2006

URGENT	
SOON	✓
ROUTINE	
AUDIOLOGY	

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: See Letter

Comment: This patient has been having intermittent hoarseness for the past three months. This is associated with a strange feeling in her throat. The hoarseness seems to resolve for a couple of days, only to return for much longer periods. She is known to have large tonsils and examination does reveal large tonsils today but these are not inflamed. Her hoarse voice is indeed noted. Clinical examination is, otherwise, unremarkable.

I would very much appreciate your assessment.

Examinations and Investigations

Never smoked tobacco: 14-Apr-2004 00:00
Never smoked tobacco: 24-Apr-2002 00:00
Current non-smoker: 24-Apr-2002 00:00
Trivial drinker - <1u/day: 24-Apr-2002 00:00

Reason for referral

Care type requested: Out Patient
Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset
Normal delivery in a completely normal case	-	-	-	-
Normal delivery in a completely normal case	-	-	-	-
Migraine	-	-	-	-
[V]Behavioural problems	-	-	-	-

Current and recent medication

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration
Sibutramine Hydrochloride Monohydrate	04.05.02.0	CAPS 10MG	1 Cap	Daily	06-Nov-2006	-
Norethisterone	06.04.01.2	TABS 5MG	1 Tab	3 times daily	06-Nov-2006	-
Omeprazole	01.03.05.0	CAPS 20MG	1 Cap	In the morning	06-Nov-2006	-
Omeprazole	01.03.05.0	CAPS 20MG	1 Cap	In the morning	16-Oct-2006	-
Norethisterone	06.04.01.2	TABS 5MG	1 Tab	3 times daily	16-Oct-2006	-
Chlorhexidine Gluconate	12.03.04.0	Sf Mouthwash Mint SOL 0.2%	10 ml	4 times daily	09-Oct-2006	-
Trimovate	13.04.00.0	CREAM	Apply	Twice daily	04-Oct-2006	-
Zineryt	13.06.01.0	LOT	Apply	morning and night	29-Sep-2006	-
Metronidazole	05.01.11.0	TABS 400MG	1 Tab	morning and night	29-Sep-2006	-
Sibutramine Hydrochloride Monohydrate	04.05.02.0	CAPS 10MG	1 Cap	Daily	29-Sep-2006	-
Omeprazole	01.03.05.0	CAPS 20MG	1 Cap	In the morning	20-Sep-2006	-
Canesten Combi	07.02.02.0	Pessary And Cream	1 to be inserted	At night	20-Sep-2006	-
Norethisterone	06.04.01.2	TABS 5MG	1 Tab	3 times daily	18-Sep-2006	-
Sibutramine Hydrochloride Monohydrate	04.05.02.0	CAPS 10MG	1 Cap	Daily	05-Sep-2006	-
Econazole Nitrate	07.02.02.0	Single Dose PESS 150MG	1 to be inserted	At night	05-Sep-2006	-

Norethisterone	06.04.01.2	TABS 5MG	1 Tab	3 times daily	24-Aug-2006	-

Clinical warnings

Smoking status

Alcohol consumption

Additional relevant information

Family conditions

Description	Modifier	Extension	Relation to patient
FH: CVA/stroke	-	-	-
FH: Ischaemic heart dis. >60	-	-	-
FH: Ischaemic heart dis. <60	-	-	-

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

PW/JLD/466693

DEPARTMENT OF OTOLARYNGOLOGY - MR P WARDROP

☎: *DIRECT LINE - 01563 577326*

Date Typed: 24/01/01

Mr Jim Sinclair
Surgical Directorate Support Manager
CROSSHOUSE HOSPITAL

Dear Jim

RE: CAROLINE HARMON, ~~29H SLOAN AVENUE, IRVINE.~~ (30/10/1977)

Thank you for passing on this Solicitors letter for comment. Although this lady was under my care, I was away when she came in for her surgery.

I was a little surprised to see that she considered the incident grounds for consulting her Solicitor. She has been given another date for her operation.

I have made enquiries on the Ward and I understand that no other patients fell ill after the evening meal on Monday 8th January 2001, so I think it is most unlikely that she has had any kind of food poisoning and I was also surprised at the speed which she sought legal representation, after such a trivial incident. I have no other comments, other than that we expect her in due course for another date for admission.

Yours sincerely

P WARDROP
CONSULTANT ENT SURGEON

Otolaryngology

PW/JLD/466693

DEPARTMENT OF OTOLARYNGOLOGY - MR P WARDROP

☎: *DIRECT LINE - 01563 577326*

Date Dictated: 23/01/01
Date Typed: 23/01/01

Dr C MacDonald
Townhead Surgery
6 - 8 High Street
IRVINE

Dear Dr MacDonald

RE: CAROLINE HARMON, 29H SLOAN AVENUE, IRVINE. (30/10/1977)

This young lady had diarrhoea and vomiting prior to her tonsillectomy on the 8th December 2000 and the procedure was cancelled. I have asked for her to be sent another date.

On looking at the notes, I see you were sent a discharge summary saying that her diarrhoea and vomiting was post-operative but this is a mistake.

I understand that she took the unusual step of going to a Solicitor the week after the event, claiming that she got food poisoning from the Hospital food. The complaint is currently going through the usual channels but I have to say that this sounds a most unlikely scenario, since no other patients are known to have had similar symptoms at that same mealtime.

I suspect you will hear more from the Trust Offices, when the complaint reaches its conclusion.

Yours sincerely

P WARDROP
CONSULTANT ENT SURGEON

Otolaryngology

DEPARTMENT OF OTOLARYNGOLOGY

PG/JLD/0000466693

Consultant in Charge : P WARDROP

Dr C E Macdonald
TOWNHEAD SURGERY
6/8 HIGH ST
IRVINE

Date : 18/01/2001
Dictated: 18/01/2001

Dear Dr Macdonald

CAROLINE HARMON 30/10/1977 29(H) SLOAN AVENUE IRVINE

ADMITTED:08/01/2001 DISCHARGED: 09/01/2001

DIAGNOSIS:RECURRENT TONSILLITIS

OPERATION:TONSILLECTOMY

This patient was admitted for the above procedure. Post-operatively, she had some nausea and vomiting, this settled down and she was discharged the following day.

No Followup required.

Yours sincerely

P GLEN
SHO IN ENT

NO.
Pt did not have operation.
New date needs sent.
PG 23/1/01

Otolaryngology

PW/JAW/466693

DEPARTMENT OF OTOLARYNGOLOGY
P. WARDROP, F.R.C.S.
☎[01563] 577326 Fax. [01563] 577974

Dict. 27th November, 2000
Typed 8th December, 2000

Dr C E MacDonald
Townhead Surgery
6-8 High Street
IRVINE

Dear Dr MacDonald

CAROLINE HARMON, ~~29H~~ SLOAN AVENUE, IRVINE [30/10/77]

This lady saw Mr. Singh a year ago when troubled with recurrent tonsillitis and was planned for observation.

In the last 12 months she has had at least 4 episodes suggestive of tonsillitis and I have, therefore, listed her for tonsillectomy and explained the operation and the 1% risk of haemorrhage.

Yours sincerely,

P. WARDROP, F.R.C.S.
CONSULTANT E.N.T. SURGEON

Otolaryngology

RSS/JAW/466693

☎[01563] 577893
DEPARTMENT OF OTOLARYNGOLOGY
R. S. SINGH, O.B.E., F.R.C.S.

Dict. 29th September, 1999
Typed 30th September, 1999

Dr A K Das
The Health Centre
Main Street
STEVENSTON

Dear Dr Das

CAROLINE HARMON, 10A LUNDHOLM ROAD, STEVENSTON [30/10/77]

Thank you for your letter about this young lady who has had recurring tonsillitis, with one very bad episode about 3 months ago which responded to antibiotics.

Her tonsils remain large, but there is no cervical lymphadenopathy.

I am not keen to make any decision at this stage and have arranged to see her again in December, or sooner if required.

Yours sincerely,

R. S. SINGH, O.B.E., F.R.C.S.
CONSULTANT E.N.T. SURGEON

Otolaryngology

)

)

Patient Services
Crosshouse Hospital
Kilmarnock
KA2 OBE

DEPARTMENT OF DERMATOLOGY

Dr. Marshall,
Bourtreehill Medical Practice,
Cheviot Way,
Bourtreehill,
Irvine.

Date	13th October, 2008
Clinic/ Dictated:	25th September, 2008
Our Ref	CMD/JH/466693
CHI NO:	3010776241
Enquiries to	Mrs Jean Harris
Extension	27928
Direct line	01563 827928
Fax	01563 827978
E-mail	JeanHarris@aaaht.scot.nhs.uk

Dear Dr. Marshall,

RE: CAROLINE MORRIN, 26 LEWIS TERRACE, IRVINE, (30.10.77)

Your patient failed to attend for a review appointment at the Skin Clinic today and did not contact the Appointments Office.

As you know the diagnostic biopsy taken from the lesion on her right 5th toe showed a benign compound naevus.

I have not arranged for a further appointment routinely, but would be glad to see her again if you had any concern about her.

Yours sincerely

C. M. DWYER,
CONSULTANT DERMATOLOGIST.

Dermatology

Patient Services
Crosshouse Hospital
Kilmarnock
KA2 OBE

Date 19TH August, 2008
Dictated 15TH August, 2008

DEPARTMENT OF DERMATOLOGY

Our Ref CMD/JH/466693
CHI NO: 3010776241
Enquiries to Mrs Jean Harris
Extension 27928
Direct line 01563 827928
Fax 01563 827978
E-mail JeanHarris@aaaht.scot.nhs.uk

PRIVATE AND CONFIDENTIAL

Ms. Caroline Morrin,
26 Lewis Terrace,
IRVINE.
KA11 1EZ.

Dear Ms. Morrin,

I am glad to report that the test biopsy taken from your toe showed part of a benign compound naevus with no evidence of malignancy.

We will review you at the clinic as planned.

Yours sincerely

C. M. DWYER,
CONSULTANT DERMATOLOGIST.

Dermatology

Patient Services
Crosshouse Hospital
Kilmarnock
KA2 OBE

Date 19TH August, 2008
Dictated 15TH August, 2008

DEPARTMENT OF DERMATOLOGY

Our Ref CMD/JH/466693
CHI NO: 3010776241
Enquiries to Mrs Jean Harris
Extension 27928
Direct line 01563 827928
Fax 01563 827978
E-mail JeanHarris@aaaht.scot.nhs.uk

Dr. Marshall,
Bourtreehill Medical Practice,
Cheviot Way,
Bourtreehill,
Irvine.

Dear Dr. Marshall,

RE: CAROLINE MORRIN, 26 LEWIS TERRACE, IRVINE, (30.10.77)

Histology of the punch biopsy taken from this patient's right 5th toe has been reported as showing a benign compound naevus with no evidence of malignancy.

We will ensure that she has a review appointment for the clinic. 25/9

Yours sincerely

C. M. DWYER,
CONSULTANT DERMATOLOGIST.

Dermatology

Patient Services
Crosshouse Hospital
Kilmarnock
KA2 OBE

DEPARTMENT OF DERMATOLOGY

Date	5th June, 2008
Clinic/ Dictated	30th May, 2008
Our Ref	CMD/JH/466693
CHI NO:	3010776241
Enquiries to	Mrs. Jean Harris
Extension	27928
Direct line	01563 827928
Fax	01563 827978
E-mail	Jean.Harris@aaaht.scot.nhs.uk

Dr. Marshall,
Bourtreehill Medical Practice,
Cheviot Way,
Bourtreehill,
Irvine.

Dear Dr. Marshall,

RE: CAROLINE MORRIN, 26 LEWIS TERRACE, IRVINE, (30.10.77)

Thank you for referring this patient regarding a pigmented lesion the medial aspect of her right 5th toe. She has been aware of this lesion for ten years or more and reports that it has gradually enlarged over that period. She has not noticed any recent change. She saw a programme on TV and thought that she should seek advice.

On examination, there is a 1.0 x approximately 0.6 cm. slightly thickened lesion on the side of her toe. Most of the lesion was pink with some tan and light brown rather speckled elements.

This is probably a benign naevus. It does show some variability but is not obviously sinister. I am unsure as to the implications of her history. It is on an awkward site. I discussed management options with her. It seems desirable to obtain histology. We will arrange a punch biopsy from the lesion as soon as possible. I arranged for a clinical photograph to be taken.

She has an appointment for review.

Yours sincerely

8/7

C. M. DWYER,
CONSULTANT DERMATOLOGIST

7 Dole

Dermatology

N. Paw

Hospital use only	Clinic Dr Dinges	Day Date 30/5/08	Time 10.15	Hospital No. 466693

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Dermatology A7
AA General Referral PMH High — **Consultant / receiving practitioner and/or specialty clinic**

Crosshouse Hospital — **Hospital and hospital address**

Hospital unit no. -

Email address -

Urgency of referral Routine

PATIENT DETAILS

Surname	Morrin
Forename(s)	Caroline
Title	-
Sex	Female
Date of birth	30-Oct-1977
CHI no.	3010776241

Patient's address

26 Lewis Terrace
BROOMLANDS
IRVINE
KA11 1HJ

Contact number(s)

Voice: 215887

REGISTERED GP DETAILS

Name	Dr J Nelson		
GMC code	3558018	GP code	A24228
Practice name	Bourtreehill Medical Practice		
Practice code	80306		

Practice address

Cheviot Way
Bourtreehill Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

REFERRING PRACTITIONER DETAILS

Name	Dr K Marshall		
GMC code	6071687	GP code	A1548
Practice name	Bourtreehill Medical Practice		
Practice code	80306		

Practice address

Cheviot Way
Bourtreehill Irvine
KA11 1JU

Contact number(s)

Voice: 01294 211993
Facsimile: 01294 218461

30/4/08
URGENT
SOON
ROUTINE
GPWSI
UNLIKELY TO BE C

30/5/08

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: See reason for referral

Comment: I would be grateful if you could see this lady who has a mole on the medial aspect of her right little toe. She has had a mole here for as long as she can remember but thinks that over the past few months it has at least doubled in size and at times she feels that her toe feels uncomfortable underneath. On examination there is a flat naevus on the proximal medial aspect of her little toe. There is some peeling of the skin round about but I think this is more likely due to Athlete's Foot. The mole has ununiform pigment and I would be grateful for your assessment. I have given her Canesten cream to treat her Athlete's Foot in the meantime.

Examinations and Investigations

Never smoked tobacco: 14-Apr-2004 00:00
Current non-smoker: 24-Apr-2002 00:00
Trivial drinker - <1u/day: 24-Apr-2002 00:00

Reason for referral

Care type requested: Out Patient
Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset
Normal delivery in a completely normal case	-	-	-	-
Migraine	-	-	-	-

Current and recent medication

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration
Clotrimazole	13.10.02.0	CREAM 1%	Apply	3 times daily	29-Apr-2008	-
Omeprazole	01.03.05.0	CAPS 20MG	1 Cap	In the morning	01-Apr-2008	-
Sibutramine Hydrochloride Monohydrate	04.05.02.0	CAPS 10MG	1 Cap	Daily	01-Apr-2008	-
Sibutramine Hydrochloride Monohydrate	04.05.02.0	CAPS 10MG	1 Cap	Daily	14-Feb-2008	-
Omeprazole	01.03.05.0	CAPS 20MG	1 Cap	In the morning	14-Feb-2008	-

Clinical warnings Smoking status Alcohol consumption

Additional relevant information

Family conditions

Description	Modifier	Extension	Relation to patient
FH: CVA/stroke	-	-	-
FH: Ischaemic heart dis. >60	-	-	-
FH: Ischaemic heart dis. <60	-	-	-

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

CROSSHOUSE HOSPITAL
CROSSHOUSE
KILMARNOCK
KA2 0BE

CONSULTANT SURGEON– MISS P WHITFORD

PW/LC/466693

Direct Line: 01563 577870
Fax: 01563 577979

24 November 2004

Dr Jamieson
Health Centre
Cheviot Way
Bourtreehill
IRVINE

Dear Dr Jamieson

CATOLINE MORRIN 4 CRAIGNAW PLACE IRVINE DOB 30.10.77

Further to your patient's visit to my clinic, I now have the result of their ultrasound. This was reported as follows –

ULTRASOUND RIGHT BREAST (18.11.04)

"Clinical history: right nipple discharge. Long standing. Right breast pain. No discharge elicited in clinic. No lump evident.

Nipple areola region. No evident abnormality."

We have therefore discharged her from the clinic.

Yours sincerely

PHILIPPA WHITFORD
CONSULTANT SURGEON

Surgical

SURGICAL DEPARTMENT
CROSSHOUSE HOSPITAL
CROSSHOUSE
KILMARNOCK
KA2 0BE

CONSULTANT SURGEON– MISS P WHITFORD

PW/LC/466693

☎ Direct Line: 01563 577870
Fax: 01563 577979

24 November 2004

Mrs Caroline Morrin
4 Craignaw Place
IRVINE
KA11 1EZ

Dear Mrs Morrin

Further to your visit to my clinic, I now have the result of your ultrasound. I am happy to say that this was satisfactory.

We have therefore discharged you from the clinic.

Yours sincerely

PHILIPPA WHITFORD
CONSULTANT SURGEON

Surgical

)

)

SURGICAL DEPARTMENT
CROSSHOUSE HOSPITAL
CROSSHOUSE
KILMARNOCK
KA2 0BE

CONSULTANT SURGEON– MISS P WHITFORD

SH/LC/466693

Direct Line: 01563 577870
Fax: 01563 577979

RAPID ACCESS BREAST CLINIC

Dic: 30.09.04
Typ: 07.10.04

Dr Jamieson
Health Centre
Cheviot Way
Bourtreehill
IRVINE

Dear Dr Jamieson

CAROLINE MORRIN 4 CRAIGNAW PLACE IRVINE DOB 30.10.77

Thank you for your letter. I reviewed this 26 year old lady at Miss Whitford's clinic this afternoon. She has presented with a long standing discharge from her right nipple which is not frequent and is mostly during the night. This is not blood stained. There is no previous history of breast disease and no family history of breast cancer. She is para 3 and otherwise fit and healthy.

On clinical examination both breasts were symmetrical. There are no skin or nipple changes and no lump was palpable in either breast. Both axillae were clear. On squeezing the right nipple there was no discharge.

I have explained to her that this could be duct ectasia or fibroadenosis. I have arranged for an outpatient ultrasound examination of her right breast and we will write both to you and to the patient with the result of this. I haven't arranged for any clinical appointment. We will call her back to the clinic if there is any need.

Yours sincerely

UIS

SARHANG HUSSEIN
SHO III

Surgical

Dr. Bob Wagner
Dr. David Campbell
Dr. Colin Johnston
Dr. Barbara Alexander
Dr. Jagbir Nelson
Mr. Bob Faulks, Practice Mgr

BOURTREEHILL MEDICAL PRACTICE

Cheviot Way
Bourtreehill, Irvine
Ayrshire KA11 1JU
Tel. 01294-211993
Fax. 01294-218461

Fax Cover

Date: 20 - 8 - 04 Time:

To BREAST CLINIC APPT

Fax. No. 01563 577057

From

Title/Position

This facsimile may contain information protected by the physician-patient privilege. You must not act on or use the information if you are not the intended recipient without the permission of the originator, who should be informed if it has been received in error.

Message

Number of pages including this one 3

BMP
BOURTREEHILL MEDICAL PRACTICE

Visual ☐
Hearing ☐
Chair User: Yes ☐ No ☐

REFERRAL LETTER

MEDICAL IN CONFIDENCE

Br MR OSMAN 9/9/04 130 466693

RAL TO

Breast Clinic

Consultant / receiving practitioner and/or specialty clinic

Hospital and Hospital address

Hospital unit no.

Postcode

Email address

ncy of referral (give reason if other than routine)

x ☐ Soon ☑ Routine ☐

Left (R) sided discharge from nipple & discomfort. No mass felt

IT DETAILS

ame(s)

s surname

MORRIN, Caroline
3010776241
4 Craigneu Place
IRVINE
KA11 1EI
Practice Registrar
Cheviot Way, Bourtreehill
M DATE

birth

Patient's address

Postcode

Telephone no.

ERED GP DETAILS

JAMIESON.

code

ffier

ess

ne no.

Practice address

Cheviot Way
Drs Wagner, Campbell, Johnston
Alexander & Nelson
Bourtreehill Medical Practice
Cheviot Way, Bourtreehill
Irvine KA11 1JU
Postcode

ING PRACTITIONER DETAILS (if different from above)

f referring ner or

e no.

Address of referring practitioner or agency

Postcode

MEDICAL RECORDS
CROSSHOUSE HOSPITAL
20 AUG 2004
URGENT

12 Moran | 4 Craigton Place | DoB. 30.10.77

AST REFERRAL PROFORMA

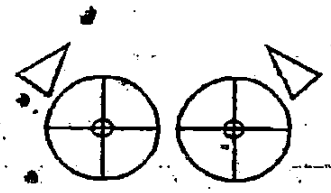
Has patient had mammogram in last 12 months? YES ☐ NO ☑ If yes please indicate: screening ☐ or symptomatic ☐
If symptomatic please indicate if previous Mammogram at Ayr or Crosshouse

Please indicate breast in which abnormality noted: RIGHT ☑ LEFT ☐ BILATERAL ☐

Guidance for Completion of Form:
- Please answer the question above and tick a minimum of one box in one of the 6 categories below.
- Patient details should be provided on a separate page.

REASON FOR REFERRAL:		GUIDANCE OFFERED:
1. Breast Lump: *Please give brief description in box below and indicate position of lump on diagram.*		
New Discrete Lump	☑	Refer
Proven cystic disease	☐	Consider aspiration by GP
New asymmetrical nodularity	☐	Refer
Longstanding symmetrical nodularity		Reassure
Sebaceous cyst/simple skin lesion		Reassure
2. Skin Changes:		
Skin tethering, fixation or ulceration	☐	Refer
Nipple eczema		If eczema elsewhere – treat with topical steroid initially
Abscess or breast inflammation	☐	Refer if does not settle after one course of antibiotics
Intertrigo/hidradenitis		Reassure –treat in practice as appropriate
3. Nipple Symptoms:		
Nipple indrawing - NEW	☐	Refer
Nipple indrawing – LONGSTANDING		Reassure
Discharge > 50years	☐	Refer
Discharge < 50years:-		
Multiple duct discharge –ve for blood		Reassure (advise not to express)
Single duct and/or +ve for blood	☑	Refer
High serum prolactin	☐	Check drugs/pituitary scan - Refer Endocrinologist
4. Breast Pain:		
< 50 years	☐	Refer
> 50 years –ISSUE PATIENT ADVISE LEAFLET	☑	Eliminate/reduce all caffeine drinks (incl. De-caf) tea, coffee, cola and saturated fats. Advise to take a supplement high in Gamolenic Acid (such as Starflower Oil/Evening Primrose Oil) – For at least 6 months
Pain not responding to initial treatment	☐	Refer
5. Family History:		
Guide		(First degree = mother or sister)
		(Second degree = grandmother, granddaughter, aunt or niece)
Risk is increased if associated with ovarian cancer.		
Asymptomatic patients may be referred directly to Genetic clinic, at patient request.		
Only mother with breast cancer diagnosed at > 40		Reassure
One first degree relative with one of the following:		
Bilateral breast cancer		Refer to genetic clinic if requested
Breast cancer at < 40 years		Refer to genetic clinic if requested
Male breast cancer		Refer to genetic clinic if requested
Two first degree relatives		Refer to genetic clinic if requested
Three or more first or second degree relatives		Refer to genetic clinic if requested

6. Cosmetic: Patients with purely cosmetic problems such as asymptomatic asymmetry or dissatisfaction with breast size should be referred to the Plastic Surgery service.



Additional Information:

BAN future appts c/o unilateral discharge from (R) nipple – Negative for blood. Also c/o (L) breast discomfort – NO evidence of mastitis, lumps or hyperkeratosis. Advised RE tea/coffee (denies drinking).

Nil breast lumps felt upon examination 19.8.04

466693 IHF

PF

Acute Hospitals NHS Trust
DEPARTMENT OF OBSTETRICS

Ayrshire Central Hospital
Kilwinning Road
Irvine KA12 8SS
Telephone: 01294 274191
Fax: 01294 313497
www.show.scot.nhs.uk/aaaht
Direct Tel 01294 323387

NHS
Ayrshire & Arran

Our Ref: EBM/JH/M074152

26 July 2002

Dr SC Sharma
The Surgery
16 Eglinton Street
IRVINE
KA12 8AS

Dear Dr Sharma

CAROLINE HARMON, 4 CRAIGNAW PLACE, IRVINE
D.O.B. 30/10/1977

After a pregnancy when Caroline was troubled by panic attacks, she entered labour on 21 July 2002 at term and progressed very well to the normal delivery of a male infant weighing 4.6kgs. Formula feeding was preferred and mother and babe returned home on 22 July 2002.

Latterly in her pregnancy, her panic attacks were much less prominent although during labour she was a little anxious. I would be happy for you to undertake post-natal review.

Yours sincerely

Elaine Melrose

E B MELROSE
CONSULTANT OBSTETRICIAN

cc Dr D O'Neill, Consultant Physician, Crosshouse Hospital
(Unit No. 466693)

Awarded for excellence

Chairman Professor Gordon M Wilson
Chief Executive Stephen J Greep

STA 0398

MEDICAL UNIT - DR DAVID O'NEILL

DIRECT TEL: 01563 577905
DIRECT FAX: 01563 577972
E-MAIL: Eleanor.Wright@aaaht.scot.nhs.uk

DO/EW/466693

12 June 2002

Dr Melrose
Consultant Obstetrician
Ayrshire Central Hospital
IRVINE

Dear Dr Melrose

CAROLINE HARMON 4 CRAIGNAW PLACE IRVINE 30.10.77

I saw this 24-year-old woman at my out-patient clinic on 4 June 2002. She was at 33 weeks gestation in her second pregnancy and she had no serious problems during her first pregnancy, although she had a history of mild hypertension, which apparently settled during the first pregnancy. She is a non-smoker and is on no medication. She takes minimal caffeine.

There is no history of syncope and no relevant family history.

She told me that she had experienced episodes of a fast heart beat associated with faintness. She felt as if she did not have enough oxygen getting through to her brain and this produced a feeling of panic with breathlessness and dizziness.

On examination she was overweight. The heart rate was quite labile and ranged from 70-110 during this consultation. Blood pressure was 126/68. She was not breathless at rest. The chest was clear and there were no cardiac murmurs.

The resting ECG showed a sinus tachycardia of 115 beats per minute, but was otherwise unremarkable.

I did not suspect any important pathology and wondered about hyperventilation as an explanation for some of her symptoms.

I arranged for ambulatory monitoring of the ECG to assess whether she had a persistent tachycardia. This showed an average heart rate of 98 beats per minute with a minimal heart rate of 58 beats per minute and a maximum heart rate of 160 beats per minute.

Cont/...

Medical

[redacted]

[redacted]ROLINE HARMON 466693

2 June 2002

I would be reluctant to do more tests if her symptoms settled with reassurance. I have however heard from you that she has had further symptoms. If these are persistent then an isotope lung scan would be indicated in case of occult of PTE. There is however no consistent breathlessness and she does not have a persistent tachycardia, so this diagnosis is fairly unlikely. Please let me know if there are any problems.

With kind regards.

Yours sincerely

DAVID O'NEILL
CONSULTANT PHYSICIAN

Medical

[redacted]

NP 4/6/02 466675 1.00

Acute Hospitals NHS Trust
DEPARTMENT OF OBSTETRICS

Ayrshire Central Hospital
Kilwinning Road
Irvine KA12 8SS
Telephone: 01294 274191
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Direct Tel 01294 323387

NHS
Ayrshire & Arran

Our Ref: EBM/JH/M074152

08/05/2002

Dr D O'Neill
Consultant Cardiologist
Crosshouse Hospital
KILMARNOCK

Dear Dr O'Neill

CAROLINE HARMON, 4 CRAIGNAW PLACE, IRVINE KA11 1EZ
D.O.B. 30/10/1977
GP: ~~Dr Sharma, 16 Eglinton Street, Irvine~~

I wonder if you would be good enough to see this lady who has developed dizzy attacks and faintness during her pregnancy from 28+ weeks until now at 30 weeks. She is a 24 year old para one and has had no previous problems ~~with~~ of this nature. Her problems seem to occur with an awareness of her heart racing and she does have a tachycardia of approximately 110 beats per minute. Her blood pressure appears to range between 140/90 and 104/54 when she feels unwell, as she did when she attended the clinic on 8 May 2002. ECG shows no evidence of dropped beats or ectopic beats but simply a tachycardia. I would be grateful for your on-going advice with this patient and she is anticipating hearing from you directly.

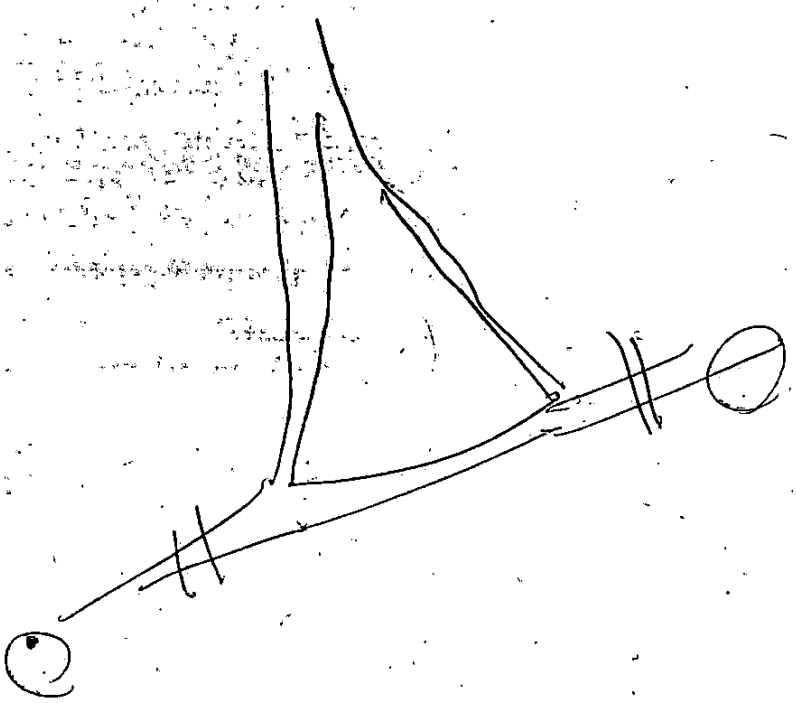
Yours sincerely

Elaine Melrose

E B MELROSE
CONSULTANT OBSTETRICIAN

CLINICAL NOTES

SEE FILING ARRANGEMENTS ON INSIDE FRONT COVER



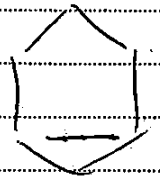
CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
KA11 1HJ
30/10/1977
Dr. J Taylor
MRN: XHI466693

STA0143

DATE

9/8/13. Postop r/v.

10wks post TAH.
feeling great now.
Flwy ✓ Boing ✓ SI ✓.
No concerns. Histology (N) ✓
Mentioned yellow discharge some weeks - explained
ovaries still working so (~) progestogenic effect.

Abdn:  Soft
wound healed well.

(P) Reassured re histology.
D/C.

Dr Vivian Franklin
Consultant
Obstetrician & Gynaecologist
GMC 47uo207

GYNAECOLOGY

DATE

NHS Ayrshire & Arran

Write or attach label

HC CHI: 3010776241
CH Welsh, Caroline
Su 26 Lewis Terrace
Fo Irvine
Ac KA11 1HJ
... 30/10/1977
D. Dr J Taylor
MRN: XHI466693

GYNAECOLOGY

DATE	
26.9.13 9/5	D1 TAH BSO Uplift Drain → Minimal Urine → clear No complaints / Operation explained Plan FBC today Remove Drain / Catheter Home Sat / Sunday Keen to have Emla cream on the skin during removal of Staples Analgesia
27/9/13	Day 1 post op. Operation explained. TAH, no need for smears. Still has ovaries/tubes. Vascular, (N) Hb yesterday. Rpt FBC today. MEWS = 0. GSD ✓ Not mobilising yet. (P) Catt/drain out ✓ Clear fluids. Staples out d5. Mobilise. Dr Vivian Franklin Consultant Obstetrician & Gynaecologist GMC 4706207
28/9/13 W6 1025	IRELAND ST7 Hb 12.4 TAH 26/9/13 obs (A) No wind pain apyrexial worries about mobilising O/E SOB wound clean non tender no distension

DRS 6064

DATE

clothing to her patients
seen sitting up comfortably and

(P) (1) Bus cgarm
(2) mobilise
(3) Home today

(Heart 57

CONSENT FOR OPERATION

STA1057

Write or attach label
HC CHI: 3010776241
Cl Welsh, Caroline
S 26 Lewis Terrace
F Irvine
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693
Date c.

I .....of .....

.....hereby consent to

* undergo / the submission of my

* child..... / ward

- rupture organ damage
- Bleeding
- Infection
- VTE.

the operation of Total abdominal hysterectomy (conservation of ovaries)

the nature and purpose of which have been explained to me by Dr./Mr.* FRANKLIN

I also consent to such further of alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to section 1 (2) patients.)

Date 26/9/13 Signed C Welsh
(Patient/Parent/Guardian)

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian.*

Date 26/9/13 Signed
(Medical/Dental Practitioner)*

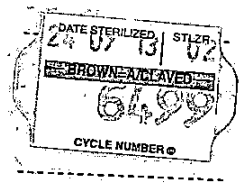
*DELETE AS APPROPRIATE

Note: This form is not to be used for any operation where there is a specific consent form with explanations.

Any deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature.

CONSENT FOR OPERATION

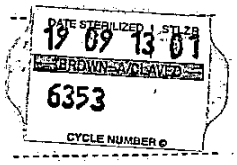
+44 (0) 1454 318373
www.meditrax.co.uk



Roger Clamp Set XH02

Gyn
ACHU02442337 M

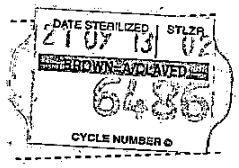
TAPE H
44 (0) 1454
www.meditrax.co.uk



Abdominal
Hysterectomy XH 13

Gyn
ACHU02440761 M

TAPE HERE
44 (0) 1454 318373
www.meditrax.co.uk



MVS Set XH24

Gyn
ACHU02441453 M

Anaesthetic Record

Proposed procedure: TAM

Elective	✓
Scheduled Urgent	
Urgent	
Emergency	

Write or attach label

HCR No: .....

CHI No: .....

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693 DSU

Sex: .....

Consent form signed	Y / N
Incapacity form	Y / N
Fasted	Y / N
SASM Consultant:	
Informed	Y /

Preoperative Assessment: Assessor: SPIERS 26-9-13 Date: Grade: 2

History

Previous GA: No problems.

FH:

CVS: Blackouts - only related to "squeamishness"

Exercise Tolerance: Good - no CP. 2 flights no problem

Resp.: None - Anxious. Remembers prev extraction ~~but~~ recalls being intubated + paralysed. Sadness + deep extraction if poss.

Reflux: ✓

Smoking: No.

Alcohol & Recreational Drugs:

Recent Medication

Naproxen (backache). ↳ not today 500 bd. (Sdpatch) tends to constipate.

Allergies: Latex (contact)

Examination

Mouth opening: ✓

Teeth: mixed, large piercing

HR:

BP: 120/70 left

Weight: 102

Height:

BMI:

Hb	
WCC	
Plats	✓
Urea	
Creat.	
Na	
K	✓
ECG	SR.
CXR	
OTHER:	

Discussed:

Fasting	☐
Premed	☐
Induction	☑
Analgesia	☑
Suppositories	☐
Monitoring:	☑
Other	

Regional Block: Complications discussed pre-operatively

Failure	☐
Hypotension	☐
Headache	☐
Numbness	☐
Urine Retention	☐
Nerve Damage	☐
L.A. Toxicity	☐
Patient agrees	Y / N
Handout	Y / N
Other	

Preoperative Instructions

Fasting: Time
As Protocol ☐
Light breakfast
Fluids - allow:
still juices / water till:

Usual Medicines: Unless otherwise instructed give all medicines except insulin, oral hypoglycaemics and anticoagulants.
Give all except:
Give only:

Premedication drugs: Date Time
Signed:
Given at / by

Operation done:

Date: 26-9-13 Location: Th 10 Start time: 1345 End time:

Surgeon(s): FRANKLIN

Anaesthetic Assistant: M Henderson

Anaesthetist(s): Spiers Grade: Cons GMC No. 4318802

Remarks Uneventful ☐ Significant events / Critical incidents Hazard warnings

Effect of premed

STA0093

ANAESTHETIC RECORD

Monitoring				Checks			Ventilation	Access		Induction
ECG	✓	Boots	✓	**Anaesthetic Machine**			**Circuit**	Site of Cannula	Size	IV ✓ Gas..... Pre O_2 RSI.....
NIBP	✓	Fluid Warmer	✓	Anaes room	Theatre ✓		Circle ✓	DLH	20G	Face Mask Anaesthetic
SpO_2	✓	Warm Air	✓	**Position:**			Bain	"	18G	Airway: Oral..... Nasal.....
$ETCO_2$	✓	Padded Mat		supine			T Piece	.....	.....	LMA: Size..... Type.....
F_iO_2	✓	TED Stocks	✓	Pressure Care			HME Filter ✓	A Line	Site	ETT: Size 8 Cuff ✓
NMT	✓	Tourniquet Press. Time		Eye Care			**Ventilation**			Type Mallinckrodt
ET Agent	✓			Throat Pack	In	Out	Pressure Cont ✓	CVP !	Site	Laryngoscopy grade 1
Temp.	✓			Thromboprophylaxis ✓			Volume Cont			Notes:
Urine Cath.	-			Antibiotic	Dose	Time	Spont. Resp.	Insertion Notes:		
CVP				Augmentin	1.2g		Press Sup.			
IBP							Manual IPPV			

12:30

Drugs \ Time	1400	1430	1500
Propofol	30+20+30		
Fentanyl	100mcg		
Rocuronium	40mg	10	
Dexamethasone	8mg		
Diclofenac	75mg IM/Slow		
Paracetamol	1g		
Morphine	2 2 3	3	2 2
Ondansetron		4mg	
Glycopyrolate/Neostigmine			500/2.5
Glycopyrolate		200mcg	
Ephedrine		6	

Recovery 1605

	1615	1625	1630	1645	1655	1715
SpO_2	99	100	99	99	99	99
$ETCO_2$	4	4	4	4	4	4
MAC ET Agent	1.2	1.1	1.0	1.1	1.1	1.0
fiO_2	0.4	0.4	0.4	0.4	0.4	0.4
Temp						37

	1400	1415	1430	1445	1500	1515	1530
SpO_2	100	100	100	100	100	100	100
$ETCO_2$	4.6	5.1	5.2	4.7	4.8	4.7	5.2
MAC ET Agent	1.2	1.3	1.3	1.3	1.3	1.3	1.3
fiO_2	0.4	0.35	0.33	0.37	0.34	0.34	0.34

O_2 ✓ N_2O ☐ Air ✓ Sev ☐ Des ✓ Iso ☐ Halo ☐ Others ☐

200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

Fluids ① ② ③ ④

Blood Loss

Urine Output

Regional & Local Anaesthetic Techniques		Notes & Events
Spinal	☐	Notes
Epidural	☐	
N. Block.....		
Wound Infiltration	☐	
Full Aseptic	☐	
Entry Site:.....		
Needle Used:.....		
Catheter; Y / N		

200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
20
10

	Fluid In	Vol.
1	Hartmanns	500
2	Hartmanns	500
3	Sedahsia	500
4	Hartmans	500

Postoperative Instructions:			Reviewed by
Routine monitoring & care			
O_2 ...4.....l/min till awake or.....hrs			
Humidified O_2 % as required to maintain O_2 Sat > 95%			
Morphine 1mg/ml IV up to 10mg as required for pain in recovery	(YES)	Signed.....	
Paracetamol 1g IV in recorvery if required for pain	YES	Signed.....	
Ondansetron 4mg IV in recovery if required for nausea	YES	Signed.....	
Cyclizine 50mg IV in recovery if required for nausea	(YES)	Signed.....	
IV fluids as charted	☑ Special instructions		Sign off completed chart
Drug therapy as charted	Encourage oral fluids Check FBC + coag results.		

Time	Recovery Notes	Drugs
		2mgs Morphine IV via pca @ 16.25 Anon
		3mgs morphine IV via pca @ 1730 Anon

RECOVERY CARE PLAN

ACTIVITY	COMMENTS AND ACTION TAKEN	TIME	INITIAL
Airway Self-maintained ☑ Jaw thrust/Chin lift ☐ Guedel ☐ LMA ☐ ETT ☐ Nasopharyngeal ☐ Tracheostomy ☐	Time Conscious 1625	1625	AW
Breathing Oxygen Therapy L/min 4 %/humidified ✓ Face mask ☑ Nasal ☐ Tracheostomy ☐ SAO2 100 Respiratory Rate 11	Time O2 discontinued ..... SAO2 Air	1625	AW
Circulation NIBP ☑ SAO2 ☑ Pulse from: ECG ☑ SAO2 Probe ☑ ECG ☑ Arterial Line ☐ Site ..... Central Line ☐ CXR performed @ .....hrs CXR reviewed by medical staff Yes ☐ No ☐		1625	AW
Circulation Wound dressing ..... clean & dry ..... Wound drains No ..... Location ..... Bleeding from further sites Yes ☑ No ☐ (e.g vaginal/rectal/nasal) Pressure areas inspected Yes ☑ No ☐ N/A ☐	Total Drainage on discharge ..... 0 .....mls slight P.V.	1630	AW
Hydration IV Acess ☑ Sub Cut Cannula ☐ Further IV fluids prescribed Yes ☑ N/A ☐ Transfusion required ☐ Catheter in situ (Y) N Free drainage ☑ Hourly Volumes ☐ Has passed Urine Y / N Volume .....mls	S/B DR FOLEY Re: catheter related irritation. Instillagel applied as per hse instructions with good relief.	1630	AW
Disability Patient alert and orientated ☑ CSM Monitored ☐ Diabetic ☐ GKI in progress ☐ Blood glucose ..... Neurological Obs required ☐ Eye observations required ☐	A (V) P U.	1625	AW
Temperature Admission Recovery Temperature 37 Warm Blanket ☐ Bair Hugger ☐ Fluid Warmer ☐ Other.....	Discharge Temperature	1630	AW
Pain Management Intravenous Analgesia ☑ Local ☐ Spinal ☐ Epidural ☐ Spinal/Epidural ☐ Intrathecal Opiates ☐ PCA ☐ Regional Block ☐ IV Paracetamol ☑ **Analgesia Required in recovery** ☐ Analgesia effective Yes ☐ No ☐	**Analgesia administered in recovery**	1630	AW
Management of Nausea and Vomiting Dexamethasone ☑ Cyclizine ☐ Ondansetron ☑ Other..... **Antiemetic Required in recovery** ☐ Antiemetic effective Yes ☐ No ☐	**Anti-emetics administered in recovery**	1630	AW

NHS Ayrshire & Arran

OPERATIVE CARE PLAN

CHI: 3010776241
Surname: Welsh, Caroline
Forename: 26 Lewis Terrace
Address: Irvine
KA11 1HJ
30/10/1977
Ward or I: Dr J Taylor
MRN: XHI466693

Ward 6 Date 26/9/13 Theatre 10

Proposed Operation TAH

Pre-Medication Time Given 0900 6AM

Fasted from: Time WATER 6AM.

Paediatrics Last feed / drink

Last Immunisation 9TH.

GKI Yes ☐ No ☐ Glucose Reading ☐

Patient Weight Kg 82kg

Identified Allergies: Specify latex gloves - hands break out? metals localised rash, urticaria (Belt Buckles)

CHECK 1 Pre op

Surgical site marking and patient verification

- ☐ Check patient identity
- ☐ Check reliable documentation/results
- ☐ Images to ascertain intended surgical site
- ☐ Intended site marked with an arrow using indelible pen
- ☐ Decision not to mark – state reason below

.....

Signature confirming surgical check complete

In the event of this section being incomplete – Reception Nurse to communicate with Theatre to establish action to be taken.

Operating Surgeon

Signature .....

Print .....

CHECK 2 - 3 Surgical site marking and patient verification	Ward/DSU			R/Recovery			Anaesthetic		
	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
Identification Bracelet	✓			✓			✓		
Consent Form signed				✓			✓		
AWI Consent if applicable			✓			✓		✓	
Operation Site marked clearly			✓			✓			✓
Bone bank consent form (Ortho only)			✓			✓			✓
Dentures removed			✓			✓			✓
Caps/Crowns/Loose teeth: Specify		✓			✓			✓	
Nail Polish/Jewellery/Make-up: Removed	✓			✓			✓		
Rings taped/Body Piercing tongue				✓			✓		
Pad or Tampon		✓			✓			✓	
Catheter in situ		✓				✓		✓	
re-op Shower	✓			✓			✓		
Skin Prep/Clipped: If required			✓		✓			✓	
Paper Pants		✓		✓	✓		✓	✓	
Patient's Label included	✓			✓			✓		
Hearing Aid		✓			✓			✓	
Inhalers		✓			✓			✓	
Pillows extra: Number			✓			✓			✓
B.H.C.G. (Pregnancy Test) NEG	✓			✓			✓		
Urinalysis NAD	✓			✓			✓		
Case Notes	✓			✓			✓		
X Rays/Images		✓			✓			✓	
Pathology/Lab results	✓			✓			✓		
Haemoglobin 13.2	✓			✓			✓		
Blood X matched					✓		✓		✓
E.C.G. if applicable	✓			✓			✓		
Other: Specify TED				✓					
Normothermia: Pre-Warm				Pre-op Temp			37.3		

Any other relevant information: (e.g. high risk or changes to general health) .....

.....

Ward Nurse *(signature)* ..... Print JONNOUETON

Rec-Recovery Nurse *(signature)* ..... Print SBOYCE

Anaesthetic Nurse *(signature)* ..... Print H TENNYSON

ANAESTHETIC CARE GIVEN

Pulse 62 BP 128/70 SPo2 99% on

Antibiotic: Time Given:

G.A.		Rapid Sequence	
L.M.A.	Size		
ET Tube	Size	8	
Face Mask			
Throat Pack			
Throat Pack removed			
N.G. Tube			

Spinal	✓
Epidural	
Combined Spinal/Epidural	
Local Anaesthetic	
Nerve Block	
Eye Protection: Yes ✓ No	

Infusion Device

PCA	
TIVA	
Baxter Colleague	
Alaris	
Bodyguard	

INVASIVE MONITORING

IBP		Cardiac Output		CVP	

Patient Positioning

		RIGHT ARM	
Supine	✓	On board	
Prone		At side	✓
Lithotomy		Across chest	
Trendelenburg		Other	
Rev-Trendelenburg		**LEFT ARM**	
Jack Knife		On board	✓
Right lateral		At side	
Left lateral		Across chest	
Traction Table		Other	
Lloyd Davis			
Deck Chair			

Diathermy Application

Bi-polar	
Mono-polar Diathermy site	
Site	
Diathermy Pad applied correctly and checked	

TOURNIQUET

Arm right		Arm left	
Leg right		Leg left	
Digit right		Digit left	
Time on right		Time on left	
Total Tourniquet time right		Total Tourniquet time left	

PERI-OPERATIVE CARE

Patient protection safety

Arm supports	✓	Sand bag	
Pelvic support i.e. padding		Shoulder vac pac (beanbag)	
Lateral support i.e. padding		Bair Hugger	✓
Padding bony prominences		Fluid warmer	
Heel rest	✓	Core temp probe	
Head ring		OR Pad	
Prone head ring		Other: State	
Stirrups			
Pillows	✓		

Evaluation pre and post-operative

Pre op		Post op
	Pressure area checked	
	Diathermy site checked	
	Tourniquet site checked	

DVT Prophylaxis

Fragmin	✓
Ted stockings	✓
Pre-op aspirin/Clopidogrel	
Flowtron leggings	✓
Time on 1400	Time off

Limb + machine function checks	1 hr	2 hr	3 hr	4 hr	5 hr

Skin Prep solution used Chlorhexidine

Given by (Name) K Taylor

Specimens taken:

Yes ☐ No ☐ Bacteriology ☐ Pathology ✓

Other Hospital ☐ Bone bank ☐ State total (in box) ☐ (except bone bank)

Signature nurse receiving specimens from scrub person M. Henderson

Blood loss measured Yes ☐ No ☐ Total ☐

Patient Catheterised in Theatre Nurse ☐ Doctor ☐ Catheter size ☐ mls in balloon ☐

Skin closure Monocryl	Wound drainage
Dressing	Local anaesthetic infiltration

Identified problem	Nursing intervention	Outcome

Check 4

Surgical site marking and patient verification Theatre: Surgical, Anaesthetic and Theatre team prior to commencement of surgery **should pause for verbal briefing to confirm the following** ☐ Correct patient ☐ Consent form correct and signed by patient and clinician ☐ Proposed operation ☐ Operation site marked ☐ Availability of required image studies plus pathology results	**Signature of Operating Surgeon or Senior Member of Theatre Team to confirm check completed** **Sign**..... **Print**..... **Time**..... **Date**.....	**Surgeon only to complete and sign if discrepancy has been identified** **Nature of discrepancy**..... .... **Decision taken**..... .... **Sign**..... **Print**..... When there is a discrepancy, a senior member of staff will follow the adverse incident policy.

DAY SURGERY ESCORT DETAILS

Name..... Address.....

..... Telephone No.....

Time into recovery..... **Conscious state**.....

Time conscious..... **Operation site**.....

Oxygen Therapy..... **Hudson Mask**.....

Nasal Cannula.....

Time transfer..... **Nurse Signature**.....

PROGRESSIVE RECOVERY

...n by Surgeon YES / NO Anaesthetist YES / NO

Wound Check: Time..... Comments .....

DISCHARGE DETAILS

Post-op Phone Call	Yes ☐	No ☐	Post-op instructions	Yes ☐	No ☐
Observations stable	Yes ☐	No ☐	GP letter given	Yes ☐	No ☐
Tolerating oral fluids	Yes ☐	No ☐	Follow up appointment given	Yes ☐	No ☐
Venflon removed	Yes ☐	No ☐	Community call arranged	Yes ☐	No ☐
Wound site satisfactory	Yes ☐	No ☐	Discharge medication given	Yes ☐	No ☐
Passed Urine	Yes ☐	No ☐			

Date of Discharge ..... Time of Discharge.....

Nurse's Signature .....

Date: 26/9/13 Theatre: 10

PATIENT Sex M F

PROCEDURE

Speciality gyn Surgery Class 3

OPCS 4 Code

CASE FORM

Consultant Family Admit Type 3

Ward 6 Admit Date 26/9/13

Custom Op Type: 1

Procedure

Delays

Actual Procedure Total abdominal hysterectomy

Post-op directions FBC, coag taken post op
Repeat Day 1
Withold Fragmin until bloods results available

Follow-up instructions Drain out when stops draining
GOPD 6-8/52

Sign: Surg Date: 25/9/13

CASE FORM

Counts and Dressings

Scrub Nurse Check Sign Initial

Final Check Sign Initial

Tray out Check Sign Initial

TIMES

Sent for Patient available Anaesthetic begin

Pt. in theatre Surgery starts Surgery stops

Pt. out theatre Clean up starts Recovery in 1605

Clean up stop Recovery out 1710 DS Disc.

STAFF

MEDICAL	NURSING		
Actual Surgeon	Anaesthetic Nurse	Circulating Nurse	
1st Assistant	Scrub Nurse	Circulating Nurse	
2nd Assistant	Scrub Nurse	Circulating Nurse	
Anaesthetist 1	Scrub Nurse	Circulating Nurse	
Anaesthetist 2	ODP	ODP	
Aux	Aux	Other	

ANAESTHETIC

Type General ASA 2 Controlled Drugs Fentanyl / Morphine

PACU

Recovered by 1. [illegible] 2.

Released to

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693

ADMISSION TYPE
1. 23 hour
2. Day Surgery
3. Elective In Patient
4. Emergency In Patient

SURGERY CLASS
1. Minor
2. Intermediate
3. Major
4. Supercomplex

OPERATION TYPE
1. Elective in hrs.
2. Elective out hrs.
3. Emergency in hrs.
4. Emergency out hrs.
5. Emergency Weekend/PH's
6. Elective Weekend/PH's

REASON FOR DELAY
1. Patient not ready
2. Lack nursing staff on ward
3. Patient not in specified ward

ANAESTHETIC TYPE
1. General
2. Epidural
3. General Epidural
4. Local anaesthetic
5. No anaesthetic
6. Sedation
7. Spinal
8. Spinal Sedation
9. Nerve Block

RELEASED TO
1. Ward
2. I.T.U.
3. H.D.U.
4. D.S.U.
5. 23 hour
6. Other

NHS Ayrshire & Arran

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
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30/10/1977
Dr J Taylor
MRN: XHI466693

DATE 26/9/13

SURGEON DR FRANKLIN.

ANAESTHETIST DR SPIERS.

ASSISTANT

DR RUSHD (ST4), DR SIMPSON

OPERATION PERFORMED

TAH (conservation ovaries).

DESCRIPTION OF PROCEDURE

Findings: Bulky 15/40 size uterus
(N) tubes/ovaries.
(N) pelvis.

Procedure: C/S/Catth.
Low transverse incision
Routine entry. Vascular ++.
Round + ovarian ligs clamped cut
ligated - 1/0 vicryl thro'out.
Peritoneum/bladder ↓
Uterine arts, U-S ligs + cardinal ligs
ligated.
Specimen removed → Path.

OPERATION

DRAINS ..... PACKS .....

SPECIAL INSTRUCTIONS TO WARD

Signature .....

DRS 5964

Uterine angles secured.
Vagina closed c continuous suture.
2x haemostatic sutures ® vaginal angle.
Multiple areas of ooze from bladder base.
Fibrillar applied to bladder base.
Haemostasis ✓.
Size 14A drain inserted.
Fibrillar to uterus muscles as generalised ooze
Sheath - Loop PDS.
Fat - 2/0 vicryl.
Skin - staples.
EBL = 800ml. SNT ✓.

(P) for FBC, coag - taken ✓.
Rpt FBC morn.
TEDS, withheld heparin until blood results available
Specimen → Path.
Drain out once stops draining. Staples d5.
Catheter out morn if well.
Good 6-8 hrs.

Dr Vivian Franklin
Consultant
Obstetrician & Gynaecologist
GMC 4706207

NHS Ayrshire & Arran

CROSSHOUSE HOSPITAL
PATIENT SAFETY CHECKLIST

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693

Date: 26/9/13 Theatre: 10 Adult: ✓ Child:

Proposed Procedure: TAH

Surgeon: FRANKLIN Anaesthetist: SPEIRS

PRE-OPERATIVE (Completed pre-op by Ward/DSU staff) Ward DSU *If DSU record Temp:*

Fasted From: 6pm 25/9/13	**Paediatrics:** Fasted from.....
Any known allergies? LATEX GLOVES	Last Immunisation.....
Diabetic Y ☐ N ✓ Glucose reading ☐	**Urinalysis** Y ✓ N ☐
VTE Assessment: Prescribed: Y ☐ N ☐	**Pre-op:** TEDS ✓ LMWH ☐ Other

RECEPTION: **Time:** 1230 **Temp:** 37.3 **Warm Blanket Given:** Y ☐ N ✓

ANAESTHETIC ROOM: **Time:** 1345 **Temp:** 36.8

Anaesthetic Pause Read out loud with Anaesthetist & Anaesthetic Nurse - confirm with patient:

Identity Site Procedure Consent Y ✓ N ☐ Surgical Site marked Y ☐ N ☐ N/A ✓ Spinal/Epidural Y ☐ N ✓

Any relevant information/comments

THEATRE: **Time into Theatre:** 1345

	Y	N
Perioperative Briefings		
Huddle: Was patient discussed at the team Huddle before start of list?	✓	☐
Time Out: *before start of surgery:* Read out loud and confirm with Surgeon, Anaesthetist, Scrub Nurse as per 'Time-Out' poster - with all staff listening? **COMMENT:**	✓	☐
Time operation started (knife to skin): 1408 Op > 1hr?	☐	☐
Prophylactic Antibiotics		
Are they prescribed for procedure? *(If antibiotics given after start of surgery that were not prescribed before start of surgery then do not record)*	✓	☐
Name of antibiotic(s) given: AUGMENTIN		
Time(s) given: 1405 Given 60 mins prior knife to skin	✓	☐
If not given on time please state reason:		
DVT Prophylaxis		
Was DVT Prophylaxis prescribed?	✓	☐
Was DVT Prophylaxis carried out?	✓	☐
Method used: *(record all used)* AE Stockings ✓ Flowtrons ✓ Fragmin 2500u ☐ 5000u ☐ Other ☐		
Temperature Control		
Patient Temperature 36.8 Ambient Temperature 22.8		
Heating methods used: Bair Hugger ✓ Warm Blkt ☐ Warm Fluids ✓ Other ☐		
Team Debrief		
At the end of the procedure or end of list - Surgeon, Anaesthetist, Scrub Nurse and theatre team discuss: *(at wound closure)* **Were there any problems? What went well? Are there any learning points?**	**Debrief:** Done ☐ Not Done ☐ At end of list ✓	
Comments:		

RECOVERY: DSU ☐ R&R ☐ **Time into Recovery:**

Temperature Control	Glycaemic Control
Patient Temperature	Glucose Reading *if patient diabetic*
If temperature low what was done?	**If glucose not done state reason:**

Please comment on any other issues that have arisen perioperatively. Has any issue been put on SPSP performance board? Y N Datix? Y N

CHI: 3010776241
Welsh; Caroline
26 Lewis Terrace
Irvine
[illegible]1 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693

SS IN THEATRE

TOTAL BLOOD LOSS

SWABS	DRY WEIGHT	WET WEIGHT	DIFFERENCE	RUNNING TOTAL
5 & S	60	190	130	130
5 & S	60	310	250	380
5 & S	60	243	183	565
2 ABD	60	360	240	803

NHS Ayrshire & Arran

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693
Date of Birth:

GYNAECOLOGY

DATE	
26/9/13	Preop. For TAH, conservation ovaries. Has lost further 8kg since COPD. No Hx abnormal smears - aware may do subtotal. Risks discussed. Consent ✓. Asking re 'plastics' procedure to skin - explained this is not done by gynaecology. Plastic surgery referral; unlikely to get on NHS. Dr Vivian Franklin Consultant Obstetrician & Gynaecologist GMC 4706207
26/9/13 17.00	Post op Groggy. Finding catheter intatiy - try instillagel. - if still struggling can consider removal once more awake. May require in-out catheter if cannot PU. Brief explanation of procedure. EBL = 800ml. Recheck FBC tomorrow. I will review again mane. Dr Vivian Franklin Consultant Obstetrician & Gynaecologist GMC 4706207

DATE

Write or attach label

HCR No: .....

CH XHI466693

Sur WELSH CAROLINE

For 26 LEWIS TERR

Addr IRVINE KA11 1HJ 30/10/1977

..... Dr. J NELSON BOURTREEHILL HEALTH CENTRE,

Date CHEVIOT WAY, CHI 3010776241

STA0212PS

DATE	
21/6/12	DNA
8/8/12	DNA.

DATE

1755

RM4

CROSSHOUSE HOSPITAL
EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

A/E No: **XH-12-000538-1**

CHI No: **3010776241**

Date: **03 Jan 2012** Time: **14:55**

Consultant: **Dr David Chung**

GP
WILLIAM WD CAMPBELL
BOURTREEHILL MEDICAL PRACTICE
BOURTREEHILL HEALTH CENTRE
01294 211993

Incident Date: **03 Jan 2012**
Incident Time: **14:55**

Martial Status: **Married / civil partner**

Sex: **F**

WELSH
Caroline

Date of Birth: **30 Oct 1977** Age: **34 Years**

Address:
26 LEWIS TERRACE
IRVINE

Next of Kin:
Welsh
26 LEWIS TERRACE
IRVINE

Partner
Home Tel: 215887

Religion None

Attendances in last 12mths **0**

Total Attendances Count **2**

Phone Numbers:
Home: 215887

Employer/School
nac

Accompanied By:
Husband

Special case

Triage Time 15:03 **Triage Nurse** Elaine McIlwraith **Triage Group** Yellow

Resp Rate	02 Sat%	PFR
16	98	

Pulse	BP	E	M.	V
110	163 /93			

Allergies: **Not Known**

BMstix	Alcohol	Temp	Weight
		37.2	

Visual Acuity R ~ L

Pain Score (Triage)

Pain Score (Discharge)

Triage details -2834
Abdo pain and PV bleeding. Gyn review. Casenotes requested.

BETA HCG -VE

Treatment
NONE

Special Needs
NONE

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed.....Witness.....Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....

Disch A+E clinic Paed Tr. # eye ENT Max Facial Ward OP Ward IP

XH-12-000538-1

2909

WARD.

Drug	Dose	route	time/frequency	signature	quantity/given by

DOCTOR / ENP: Time:

Write or attach label

HC
CH CHI: 3010776241
Welsh, Caroline
Su 26 Lewis Terrace
For KA11 1HJ
30/10/1977
Adı Dr J Taylor
MRN: XHI466693
Date of Birth

STA 0142

GYNAECOLOGY

DATE	
3/1/12	GYN arcau 34 ♀ PV bleeding + abdo pain. Previous gyn history - 6 year hx of erratic PV bleeding - had implant 2 year heavy bleeding - on tranexamic acid + norethisterone. Then tried coil - came out when gave dau - current - stopped 2 years ago. Since Aug last year on norethisterone + tranexamic acid - very light occasional bleeding since then. gyn op appt - 30/12/11 Dr Milroy. Sue appt PV bleeding, clots ++. Heavy bleeds are last 2/7 - 5 pads in total few hours + passed tissue. crampy abdo pain for 2/7 "like labour". Pain eases off when passes clot. no contraception - husband vasectomy. para 3+0, youngest child 8 years old - all SVD. Prev surg appendicectomy laparoscopy 2009. Prev MEDS norethisterone. tranexamic acid.

vicc074029

DATE

HR 103 · BP 113/70 37.4 RR 15 99% RA

9/12/

SNT
↓ bs tone

3x pads soaked with blood + large piece of tissue
Looks placental.

bhcg-ve in ED.

imp - heavy PV bleeding - passed amount of tissue

Admit
pan/ bloods inc a+s. + bhcg.
2/ review with reg.
3/ analgesia

MWABA
UPSTR
FOURTH

Spoke with Dr Anderson
more tissue passed, agai looks ? placental.

fresh red blood, cervix closed
PV - bulky advanced uterus, ? retained products

imp ? placental tissue ? endometrial canc

Await pathology. ? repeat
TV USS tomorrow if

MWANZA
UPSTR
FOURTH.

4/1/12 WR SHO

(34) PV bleeding - maternal removed on PV speculum yesterday and sent for pathology. Bhcg -ve. periods have been erratic for years but more bad 6 mths. (N) USS pelvis - 2cms ago following laparoscopy for lower pelvic pain in 2009.
Removed debris examined + appeared. PV bleeding continues but now like a period. NO CLOTS, abdominal pain lower (R) side mainly but much better than yesterday since maternal removed.

→

Write or attach label

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693

Date of Birth

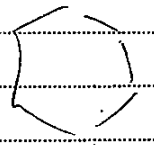
STA 0142

GYNAECOLOGY

DATE

4/1/12 cont on ward

O/E: looks well, comfortable, mobilised easily onto bed
obs stable, apyrexial

91  ASH, undistended
mild suprapubic + RIF tenderness
no guarding/rebound
no masses.

Issue: PV bleeding ? cause.

(P) await pathology results
FBC/U+E today
on C+I)
for pelvic USS today (ordered yesterday)
Likely obs
patient aware need to await USS + pathology
which can take home to get heard before confirmation
of discharge

Dr McGillivray
SHO

5/1/12 USS. 9.10 Tomorrow am.
- can go out on pass in the afternoon
but to come back this evening
bleeding like a period light at present.

A Hamm
Specialty Doctor.

6-1-2012 On A Warden in Cancer Day.

~~For~~ Observations -, Normal
. Very anxious.
. Explained Scan results →

DATE

Bulky uterus
- Thickened Endometrium 18.5 mm
- Normal ovaries
- No Focal leisons could be seen.

Histology result RIV (for products passed)

→ No evidence of intrauterine gestation

- patient is tearful and wants
- Been advised before by Dr. Miheso to try prostap injections
- Not Been Taking any Mefenamic or Tranexamic acid.
- Happy to try injections (prostap)
- Wants to speak to Dr Miheso for ~~try &~~ to get Booked for Surgical options ~~/~~ Ablation or hysterectomy

Plan
1) started on prostap injection + Tibolone (caddback)
2) Mefenamic acid + Tx acid to start
3) To liase with Dr. Miheso to see if as inpatient Vs outpatient appointment to get booked for surgery

Shuttle previous documentation noted.
p.m Decapept 1/-3 given.
plan- 1-m deapept 1/-11 ~~given~~
1/12 after this appointment - Gyn clinic appointment to be considered 6/12 a hysterectomy

Dr. A. Ibrahim
Gynaecology Reg.
G.M.C. 7049436

(No pre History continuation sheets available on W6 so had to write on OPD sheets) Dr. A. Ibrahim

STA0143

Write or attach label

HCR No:
CHI No: 3010776241
Surname: Welsh
Forename: Caroline Sex:
Address: 26 Lewis Terrace
Date of Birth 30-10-1977

DATE

6-1-2012 15.45 Dr. A Ibrahim Gyn. On call Reg

Notes Reviewed

patient had already been given prostap injection

Discussed notes & plans of Dr. Shittu with Dr. Miheso.

In view of the fact that the patient already had prostap injection given.

The plan ~~was~~ is (as discussed with Dr. Miheso)

1) Continue with prostap injections

1 monthly X 6 month + Tibalone (add back)

Mefenamic + Tx acid to continue.

2) GOPD R/V in 3 months time

(secretary to Dr. Miheso - Mandy - informed)

3) FBC to be repeated in view of patient still passing blood clots

4) Home when bleeding is settling down

Dr. A Ibrahim
Gynae Reg on call
BK 704496

7-1-2012 9.10 Dr. A. Ibrahim Gynae Reg/on call

Normal obs → (N)

Bloods → HB → 12.6 gm/dl. +1B on Admission → 13 gm/dl

patient is telling that bleeding is now like a trickle, however complaining of intermittent lower abdominal pain.

just been started on TTT, yesterday.

GYNAECOLOGY

McC/74854

DATE

- tearful and dr said she can't even wait for 4th day's to see what happens with medication
- ~~Begging~~ Very adament to have surgery

Though I have explained before that this might not be ~~an~~ for her first option, given that she is T & H.T and this T surgical risk.

- dr plan
  to speak to consultant/on call about her

Dr. A Thrul
Spin Reg
GMC 7044668

7/1/12. 11.45hrs
Menorrhagia, admitted as passing clots + decidual cast. (Confirmed on histology).
Still ↑ heavy bleeding.
Note Hb = 12.6 today.
Had prostap injection yesterday.
Pt keen for surgical intervention.
Feels upset about level of bleeding; can't function as normal.
Explained need to get bleeding + pain under control first then plan surgery (ablation) to optimise result. BMI = 41 ∴ not suitable for TAH.
(P) Stay in pt currently.
Change NSAID to diclofenac (mefenamic acid not helping).
Add norethisterone 10mg tds as short term measure.
If bleeding settles over W/E → (H) ↓ F/U by Dr Mikeos.
If still here next week can D/W Dr Mikeos re listing for surgical procedure.

Dr A. Thrul

7-1-12 16.30
Dr. A. Thrul
Bleeding settling down well
feeling well. Normal obs
(P) Home

Dr Vivian Franklin
Consultant
Obstetrician & Gynaecologist
GMC 4706207

Write or attach label

HCR No: 3610776244
CHI No:
Surname: WELSH
Forename: CAROLINE Sex:
Address:

Date of Birth 30/10/77

STA0143

DATE

F/2 DUFFY

7/1/12
1800

ATSP re: Pyrexia of 38°C.

- Obs otherwise normal.
- Patient feeling "Brilliant"
PV bleeding settling. Cramping also much improved.
No Urinary symptoms, No cough, No infective symptoms.

Seen for home FBC from 6/1/12 (N).
Given advice to report any change in symptoms to G.P.

2857
AP2

9/2/12

GOOD
stopped Norethisterone after discharge.
Been on norethisterone for last part of 6yrs.
no hormones
lower back / Rt side.
now spotting.
on monthly inj.

If work for 5 months: Career. PD
1/1 appointment, tried all formulations, stopped all Rx 1 yr.
IUS: not working.

GYNAECOLOGY

DATE

9/2/12:

Not keen for coag on with injs: Sonp has only 7 weeks for injections

Not going to take any more hrg Rx apart from OP.

Offered 2nd opinion. Initially agreed but wants that done immediately. Consultant Gedwantee.

Stormed out of clinic, very threatening behaviour.

Dr Johnstone Mheso
Locum Consultant
Obstetrics & Gynaecology
GMC 6048408

11/5/12

34y.o.

menorrhagia
long standing
Prev. seen by Dr Mheso
Had 3 Prostap inj., now off them for a month

BMI now 37. (↓ 109 kg).

P3 (SVD x 3). managed to ↓ BMI (preo 41).

Tried Tranexamic acid + NET → for last 6 years.

currently amenorrhoea.

discussed: Mirena
Novasure (will be happy to do)

Happy to try mirena today

Uterine sound length 8 cm
ectropion and lip of Cx
bulky Rt uterus.

Mirena (vi) inserted

SU 6/12

IUCD Insertion Set
Gyn Clinic ACH06

HWD GYN

Write or attach label

HCR No: .....

CHI 3010776241
WELSH CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ
30/10/1977. Pract 80306
Case Ref 466693

STA0143

DATE 11/5/12

(cont). 11 172.7 W 109 kg BMI 37

Mirena®
20 micrograms/24 hours
intrauterine delivery system
Levonorgestrel

Dr Inna Sokolova
Locum Consultant
Obstetrics & Gynaecology
GMC 6063527

To be inserted by a qualified practitioner
Keep out of reach and sight of children
For intrauterine use only

Sterile unless the pouch is damaged or open
Further information and instructions are given in the enclosed leaflets

PL 00010/0547

PL Holder
Bayer plc
Bayer House, Strawberry Hill
Newbury, Berkshire RG14 1JA

POM

80403586

[redacted]

— 1 sterile levonorgestrel intrauterine system
— 52 mg levonorgestrel

LOT [redacted] To be inserted before
TUCODFE 11.2014

31/5/13. Bleedy no better c Mirena. (35) ↑ Para 3 - 3 x SVD

Keen to proceed to hysterectomy.

Ht - 1.69 m.

Wt = 104kg.

BMI = 36.

Bleedy erratic - bleedy 4 wks at a time.
- heavy but not as bad as previously.

Prev - laparoscopy
- appendicectomy.

Wishes TAH c COM ovaries. Doesn't want ablation

GYNAECOLOGY

McC774854

DATE

Risks discussed ✓

Leaflet ✓

⇒ WL

Dr Vivian Franklin
Consultant
Obstetrician & Gynaecologist
GMC 4706207

NHS 24 FAX REPORT

NHS 24 ID:	Call ID: 11101306	**Site:**	Orkney
CHI #:	3010776241	**Caller Name:**	
Surname:	WELSH	**Date/Time Call Received:**	03/01/2012 14:03
Forename:	CAROLINE		
DOB:	30/10/1977	**Date Call Completed:**	
Gender:	Female	**Time Call Completed:**	
Address:	26 Lewis Terrace Broomlands Irvine Ayrshire/KA11 1HJ	**Call Priority:**	CS0
		Call Reason:	PV BLEEDING WORSENING 10 MIN SEE AV
		Current Location:	26 Lewis Terrace Broomlands Irvine Ayrshire/KA11 1HJ
PH NO:	07875530530 (Return)		
		Special Directions:	Front Door
		Current PH NO:	07875530530 (Return)
Care Provider:	NELSON, JAGBIR	**Care Provider Details:**	THE HEALTH CENTRE CHEVIOT WAY BOURTREEHILL,IRVINE KA11 1JU Scotland
Temporary Resident:	No		

Referred To:	AYRSHIRE & ARRAN Hub	**Recommended Action:**	Pt advised to go to A&E - For Information Only

CLINICAL SUMMARY

HEAVY PV BLEEDING FOR 3/7 AND WORSENING,RETURN CALLER, STOOD FROM TABLE FLOODED THROUGH CLOTHES, LARGE CLOTS BRIGHT RED BLOOD, SHAKY AND TEARY, PAIN IN LOWER ABDO AND BACK. IS TAKING TRANEXAMIC ACID, HAS SOAKED THROUGH 4 PADS SINCE 10.30AM, VAGINAL EXAMINATION ON FRIDAY, VERY ANXIOUS AS DOES NOT WANT TO BE EMBARRESSED IN WAITING ROOM, OUTCOME A&E ASAP

PAST MEDICAL HISTORY

MEDICAL PROBLEMS

THROAT NODULES, PELVIC FLOOR REPAIR

MEDICATIONS

NIL

ALLERGIES

NIL

Referred Clinical Notes:

T:

P:

R:

BP:

Print Name: **Signature:**

466693

6 yea

hypo
nebulise PCA
coin

3 kids. 3rd
8 years ago.

2 year op
may end yea - exam me
Ang. → bleeding easily.

bad pain - esp when pass out the
buds back up.
fever comp.

dic - no.

BP nil
fri - pr bleeding patches
→ can't see spots
gum today.
Cuts injects
tooth - nil pain

varicose.
Preg - ve

Mile

NKDA.
nebulise 3 hrly.
Ang. Spirometry
2 hrly

naproxen.

XHI466693
WELSH CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE,
CHEVIOT WAY,
CHI 3010776241

STA0143

DATE

29/12/11
8.50 am

Height 171-5cm. Charlene RGN
M Wilson
Weight 121-4kgs.
BMI = 41

GYNAECOLOGY

IMcC/74854

DATE

XHI466693
WELSH CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE,
CHEVIOT WAY,
CHI 3010776241
Date CHI 3010776241

STA0143

DATE

10/9/09

31yrs. Para3 NVD, Home Carer
~~Loops x1~~ Appendicectomy
Laparotomy ↑BMI
Overgrowth
Reduced / post loss
Partner had a vasectomy

CIO

Lap Cystodesis 3-4mo
8/10

Pure SUI 8/10 Trambordine
NO UD not exactly dribbly.

~~Recent UTI~~

Bowel: constipated. incomplete emptying
Anal tags

OE

Stage II Cystocele 0/1-7
Stage I-II Rectocele 0/3/8
Anal skin tags -2-1-8

PW

Anterior +/- Posterior Rep. + anal
+ Removal of skin tags +/- MUT (SI-TOT)
Vaginal keen on post Repair

Urodynamics

GYNAECOLOGY

JMcC/74854

DATE

25/11/09 Day 1 Postop. Op. explained
All well apart from UTI sy — plan
Plan — Urinalysis - Antibiotics if necessary
Citrates
Keep Catheter in

28/11/09 Dr Riad
Gently PV done — no haematoma
Instillagel applied topically
(P) As above
M Riad

26/11/09 WR Dr Azgur
9:00
All well
Feels better
(P) Catheter out today
urine analysis
- if all well home later today
M Riad

27/11/09 Dr Riad SPR
8:45
Feels better
passing urine
opened her bowels
Mobilized
(P) Home today
M Riad

NHS
Ayrshire & Arran

Weight	115.6
Height	170
BMI	40

XHI466693
WELSH CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE,
CHEVIOT WAY,
CHI 3010776241

Urogynaecology Clinic

Date:

Age: Parity: Mode:

C/O:----------

SUI: for——— yr
Bothersome: —/10

OAB: for——— yr
Bothersome: —/10

Pads:
UTI:

Fluid intake:

Voiding symptoms:

Vaginal bulge: Bothersome: —/10

Previous treatment (PFMT / Antimuscarinic):

Bowels: Sexual activity:

LMP / Menopause: Contraception: Last smear: Smoking: Allergy:

Co-morbidity	Medications

Previous surgery	Year

Examination:

Abdominal:
Vaginal: Atrophy:

Impression:

Plan:

Most bothersome symptoms
1-
2-
3-

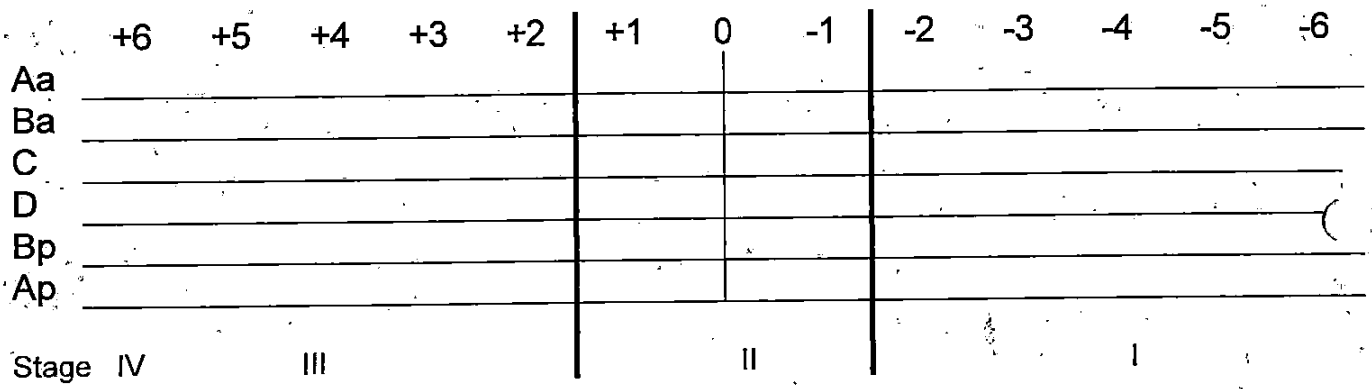
Signature:

NHS
Ayrshire & Arran

Pelvic Organ Prolapse Quantification Chart (POPQ)

Patient Label

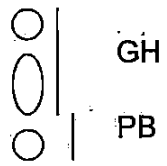
Position: Supine / sitting / standing

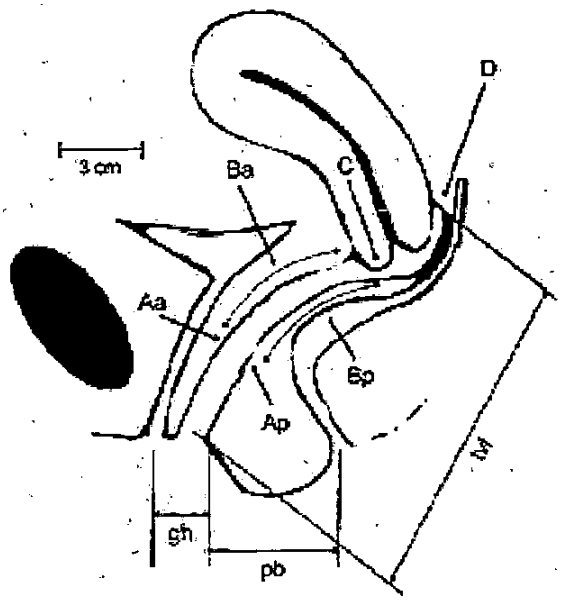


Genital hiatus..... cms

Perineal body..... cms

Total vaginal length..... cms





Notes:

Completed by.....Date.....

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JMcC/54467 STA0270

General Hospitals Division
Crosshouse Hospital

CROSSHOUSE
KILMARNOCK KA2 0BE
Telephone: (01563) 521133

Gyn UNIT

Consultant Dr. M. Hesso

Dear Dr Dr S. Nelson

Re:

CHI 3010776241
WELSH CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ
30/10/1977 Pract 80306
Case Ref 466693

This patient was seen at the clinic on

DIAGNOSIS Heavy menstrual Period

I have recommended the following treatment

1 m. Decapeptyl 11.25mg
x3 monthly x 2 courses

A more detailed letter will / will not follow

Yours sincerely

S Nelson

WHITE - GP YELLOW - PATIENT PINK - CASENOTE

Write or attach label

XHI466693
WELSH CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE,
CHEVIOT WAY,
CHI 3010776241

STA0143

DATE

1/7/10

9/12/10. Pt sorted on Buscopan
No tt req.
late periods Prozac tab.
Discharged

GYNAECOLOGY

DATE

29/12/11

Gyn - Oncology

Age - 34yrs

OHC - Cancer. Cx Cancer.

Parity - 3. - No previous

LMP - irregular bleeding. cancer screen

Contraception - Vasectomy.

C/o - Heavy irregular periods - 6/12.

- Continuous. diff. to say if the big IMB or not

- No PCB+

- AFS clots.

- No dysmenorrhoea.

- ?Discharge.

Bowel & urinary -

- Feels tired no fever cp 50 pc.

- PS - 8 4 D x 3.

- Gyn - Ant. & posterior repair 2010

- TOT

- Medical condition -

- Regular medication - Norethisterone & tranexamic acid.

- Allergy - 0

- Live with husband. Smoking - ex/stopped - 5 years

- USS - 27/10/2010.

- Poor image.

- AV wt. 10.6 x 4.1 x 5.7.

Endometrial thickness - 2.2 No focal echo. demonstrated.

Ovaries rt (N). (Lt) not visualised.

No masses. No free fluid.

- O/E - G.C fair/satisfactory - BMI - 41.

- Speculum exam - Cx - healthy looking

- Bimanual Exam - NAD much fat & Lgh Sml.

Write or attach label

HCI XHI466693
CH WELSH CAROLINE
Sur 26 LEWIS TERR
For IRVINE
KA11 1HJ 30/10/1977
Ad Dr. J NELSON
BOURTREEHILL HEALTH CENTRE,
CHEVIOT WAY,
Da CHI 3010776241

STA0143

DATE

Ass - heavy menstrual bleeding
investigations (to medical hxt)

- Mirena - pt expressed unhappiness with it as previous coil in same vicinity of severe pelvic pain.

Plan - Decapeptyl
- 1.m - 11.25mg 3/12/y x 2 doses

to for Endometrial Ablation after weight reduction -
L07875530530.

See in 3/12

GYNAECOLOGY

DATE

XHI466693
WELSH CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE,
CHEVIOT WAY,
CHI 3010776241

Initial Number

ICIQ-VS-10/05

CONFIDENTIAL

VAGINAL SYMPTOMS QUESTIONNAIRE

Many people experience vaginal symptoms some of the time. We are trying to find out how many people experience vaginal symptoms, and how much they bother them. We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

Please write in today's date: 01 (DAY) 07 (MONTH) 10 (YEAR)

Please write in today's date: (DAY) (MONTH) (YEAR)

Vaginal symptoms

1a. Are you aware of dragging pain in your lower abdomen?

- never ☐ 0
- occasionally ☐ 1
- sometimes ☐ 2
- most of the time ☐ 3
- all of the time ☑ 4

1b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

2a. Are you aware of soreness in your vagina?

- never ☐ 0
- occasionally ☐ 1
- sometimes ☑ 2
- most of the time ☐ 3
- all of the time ☑ 4

2b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

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3a. Do you feel that you have reduced sensation or feeling in or around your vagina?

- never ☑ 0
- occasionally ☐ 1
- sometimes ☐ 2
- most of the time ☐ 3
- all of the time ☐ 4

3b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

Prolapse is a common condition affecting the normal support of the pelvic organs, which results in descent or 'dropping down' of the vaginal walls and/or the pelvic organs themselves. This can include the bladder, the bowel and the womb. Symptoms are usually worse on standing up and straining (e.g. lifting, coughing or exercising) and usually better when lying down and relaxing.

Prolapse may cause a variety of problems. We are trying to find out how many people experience prolapse, and how much this bothers them. We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

4a. Do you feel that your vagina is too loose or lax?

- never ☐ 0
- occasionally ☐ 1
- sometimes ☐ 2
- most of the time ☐ 3
- all of the time ☐ 4

4b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

5a. Are you aware of a lump or bulge coming down in your vagina?

- never ☐ 0
- occasionally ☐ 1
- sometimes ☐ 2
- most of the time ☑ 3
- all of the time ☐ 4

5b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

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6a. Do you feel a lump or bulge come out of your vagina, so that you can feel it on the outside or see it on the outside?

never	☑ 0
occasionally	☐ 1
sometimes	☐ 2
most of the time	☐ 3
all of the time	☐ 4

6b. How much does this bother you?
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
not at all — a great deal

7a. Do you feel that your vagina is too dry?

never	☑ 0
occasionally	☐ 1
sometimes	☐ 2
most of the time	☐ 3
all of the time	☐ 4

7b. How much does this bother you?
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
not at all — a great deal

No

8a. Do you have to insert a finger into your vagina to help empty your bowels?

never	☑ 0
occasionally	☐ 1
sometimes	☐ 2
most of the time	☐ 3
all of the time	☐ 4

8b. How much does this bother you?
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
not at all — a great deal

9a. Do you feel that your vagina is too tight?

never	☑ 0
occasionally	☐ 1
sometimes	☐ 2
most of the time	☐ 3
all of the time	☐ 4

9b. How much does this bother you?
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
not at all — a great deal

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Sexual matters

We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

10. Do you have a sex life at present?

yes ☐ 0
no, because of my vaginal symptoms ☑ 1
no, because of other reasons ☐ 2

If NO, go to question 14

11a. Do worries about your vagina interfere with your sex life?

never ☐ 0
occasionally ☐ 1
sometimes ☐ 2
most of the time ☐ 3
all of the time ☑ 4

11b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

12a. Do you feel that your relationship with your partner is affected by vaginal symptoms?

never ☐ 0
occasionally ☐ 1
sometimes ☐ 2
most of the time ☐ 3
all of the time ☑ 4

12b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

13. How much do you feel that your sex life has been spoilt by vaginal symptoms?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

Quality of Life

We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

14. Overall, how much do vaginal symptoms interfere with your everyday life?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

Thank you very much for answering these questions.

ICIQ-VS 10/05

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Expectations from Treatment

Section 1: Please ring a number between 0 (strongly disagree) and 10 (strongly agree)

I expect to:

1. **Get rid of the bulge**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

2. **Be more comfortable and socially confident**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

3. **Get on with my housework**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

4. **Enjoy my job**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

5. **Feel much better in general (physically and emotionally)**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

6. **Enjoy sexual life in general**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

7. **Be able to exercise or do sport regularly**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

Section 2: (Please complete section 2 ***AFTER*** you receive treatment)

1. **My expectations have been met**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

2. **I am satisfied with the outcome of my treatment**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

3. **I need no further treatment**
   0 1 2 3 4 5 6 7 8 9 10
   Strongly disagree — strongly agree

VAGINAL SYMPTOMS QUESTIONNAIRE

SCORING

(This section is for administrative use only)

Patient number

☐☐ ☐☐ ☐☐ ☐☐☐

Vaginal symptoms score

Vaginal symptom score – 2x (dragging pain) + 2x (soreness in vagina) + (reduced sensation) + 2x (vagina too loose) + 2x (lump felt inside) = 2x (lump seen outside) + 2x (vagina too dry) + (faecal evacuation)

symptom*	score	weighted score
Q1. 'dragging pain'		x 2 =
Q2. 'soreness in vagina'		x 2 =
Q3. 'reduced sensation'		x 1 =
Q4. 'vagina too loose'		x 2 =
Q5. 'lump felt inside'		x 2 =
Q6. 'lump seen outside'		x 2 =
Q7. 'vagina too dry'		x 2 =
Q8. 'faecal evacuation'		x 1 =
	Total vaginal symptoms score	

*(Note: Q9. 'vagina too tight', is primarily for detecting a potential post-treatment complication and is therefore not included in the scoring).

Sexual matters score

Sexual matters score = (sex-life spoilt) + 8x (worries about vagina interfere with sex-life) + 8x (relationship affected)

sexual matter	score	weighted score
Q11. 'worries about vagina interfere with sex-life'		x 8 =
Q12. 'relationship affected'		x 8 =
Q13. 'sex life spoilt'		x 1 =
	Total sexual matters score	

Quality of life score

Quality of life	score
Q14. 'quality of life affected'	

Initial Number

XHI466693
WELSH CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE,
CHEVIOT WAY,
CHI 3910776241

DAY 01 MONTH 07 YEAR 10
Today's date

Many people leak urine some of the t[ime] / many people leak urine, and how much this bothers them. We w[ould] like you to answer the following questions, thinking about how you have been, on ave[rage,] over the last FOUR WEEKS.

1. Please write in your date of birth: DAY 30 MONTH 10 YEAR 77

2. Are you (tick one): Female ☐ Male ☐

3. How often do you leak urine? (Tick one box)

never	☑ 0
about once a week or less often	☐ 1
two or three times a week	☐ 2
about once a day	☐ 3
several times a day	☐ 4
all the time	☐ 5

4. We would like to know how much urine <u>you think</u> leaks.
How much urine do you <u>usually</u> leak (whether you wear protection or not)? (Tick one box)

none	☐ 0
a small amount	☐ 2
a moderate amount	☐ 4
a large amount	☐ 6

5. Overall, how much does leaking urine interfere with your everyday life?
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**
not at all — a great deal

6. When does urine leak? (Please tick all that apply to you)

never – urine does not leak	☑
leaks before you can get to the toilet	☐
leaks when you cough or sneeze	☐
leaks when you are asleep	☐
leaks when you are physically active/exercising	☐
leaks when you have finished urinating and are dressed	☐
leaks for no obvious reason	☐
leaks all the time	☐

(please continue overleaf)

Thank you very much for answering these questions.

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URGENCY SCALE

How urgent is your desire to go to the toilet (please circle one)

No Urgency | Mild Urgency (easily tolerated & can finish usual activities) | Moderate urgency (enough to shorten usual activities) | Severe Urgency (stops all activities)

Expectations from Treatment

Section 1: **Please ring a number between 0 (strongly disagree) and 10 (strongly agree)**

I expect to:

1. ***Have*** **less urinary leakage and use less pads/protection**
   0 1 2 3 4 5 6 7 8 9 (10)
   Strongly disagree — strongly agree

2. ***Be*** **dry and stop using pads/protection**
   0 1 2 3 4 5 6 7 8 9 (10)
   Strongly disagree — strongly agree

3. ***Be*** **more comfortable and socially confident**
   0 1 2 3 4 5 6 7 8 9 (10)
   Strongly disagree — strongly agree

4. ***Get*** **on with my housework**
   0 1 2 3 4 5 6 7 8 9 (10)
   Strongly disagree — strongly agree

5. ***Enjoy*** **my job**
   0 1 2 3 4 5 6 7 8 9 (10)
   Strongly disagree — strongly agree

6. ***Feel*** **much better in general (physically and emotionally)**
   0 1 2 3 4 5 6 7 8 9 (10)
   Strongly disagree — strongly agree

7. ***Enjoy*** **sexual life in general**
   0 1 2 3 4 5 6 7 8 9 (10)
   Strongly disagree — strongly agree

8. ***Be*** **able to exercise or do sport regularly**
   0 1 2 3 4 5 6 7 8 9 (10)
   Strongly disagree — strongly agree

Section 2: (Please complete section 2 ***AFTER*** you receive treatment)

1. My expectations have been met

0	1	2	3	4	5	6	7	8	9	10
Strongly disagree										strongly agree

2. I am satisfied with the outcome of my treatment

0	1	2	3	4	5	6	7	8	9	10
Strongly disagree										strongly agree

3. I need no further treatment

0	1	2	3	4	5	6	7	8	9	10
Strongly disagree										strongly agree

NHS Ayrshire & Arran

Write or attach label

HCR N XHI466693
CHI No MORRIN CAROLINE
Surnan 26 LEWIS TERR
Forena IRVINE
Addres KA11 1HJ 30/10/1977
..... Dr. J NELSON
Date of Birth BOURTREEHILL HEALTH CENTRE
CHEVIOT WAY.
CHI 3010776241

Consultant: DR AGUR

Date: 3/11/09

Operation Planned: Anterior & posterior repair
Insertion of mid-urethral tape & removal of
anal skin tag.
Q32

LMP: week ago. Parity: 3 + 0
3 x SVD

Relevant History:
Oblcafort and Bridge & chest
reinforcement.

Alcohol <10 units/week.

Smoking: Never/Ex/.....Day

Allergies NKDA

Past Medical History: Appendectomy ~~87~~ 92
laparoscopy 96

Systemic Enquiry
CVS CP° palpitations° PND° ankles swelling°
RS SOB° cough° sputum° wheeze°
GUT dysuria°, Frequency°, color/pallidge°
GI Abdo pain°, bowel habit change°, weight loss°
occasionally
Neuro headache°, fits/funny turns blackouts°
weakness°, paresthesia°

A E DM HBP CVA MI TB RF

Drug History: IUD. Orlistat 3 tabs 120mg
Omeprazole 20mg od

Physical Examination: T BP P

CVS NS I + II + 0 Resp: chest clear.
pulse regular

ABDO: SNT.

Investigation	Results
FBC	
Group & Save	Yes / No
Units	Yes / No No
Sodium	
Potassium	
Chloride	
Bicarbonate	

Investigation	Results
CA125	
Glucose	
ECG	
CXR	
Pregnancy Test	
Consent	Yes / No
Fragmin	

Comments..... Fit for surgery.....

.....

.....

.....

.....

Print Name ..... C. KERR ..... Signature .....

JMcC/90135

STA4078PN

GYNAECOLOGY

Write or attach label

HCR CHI Surn Fore Addr Date

XHI 466693
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ
30/10/1977

Ward/Dept

STA 0142

GYNAECOLOGY

DATE	
25/11/9	WR Dr Read / Bradnock / Monson Day 1 post Ant + Post PFR + TOT + Excision anal tag Catheter sore. Pain controlled. Apyrexial. Obs normal. (P) Lt gel around catheter. Remain in for 48h. Bloods tomorrow. BKC 872
26/11/09	F92 ATSP re Fall in shower pt felt faint prior to Fall no SOB / CP. loss of consciousness ? length pt put back in bed HR 62 BP 111/57 sat 97% (A) pt only c/o back pain on Lifting back after Fall from seat in shower. pt comfortable at present Impression Vasovagal with P/V later (273)

JMcC/74029

DATE

CONSENT FOR OPERATION

HCR
CHI I CHI 3010776241
Surna MORRIN CAROLINE
Foren 26 LEWIS TERR
Addres IRVINE KA11 1HJ Pract 80306
30/10/1977
Case Ref 466693
Date of Birth

STA1057

I Caroline Morrin of

to

undergo / the submission of my child / ward

the operation of Anterior Repair +/- Posterior Repair + Removal of anal tags +/- MUT (SIFOT) + Removal of Mirena coil

the nature and purpose of which have been explained to me by

Dr./Mr.* AGUR

Rare but possible complications: infection, bleeding, clots in the legs/lungs, bladder/bowel damage, difficulties in bladder emptying, recurrence of prolapse, over-active bladder symptoms, urinary leakage, mesh erosion, persistent vaginal discharge, pain during sexual intercourse, groin pain,

Rare but possible complications: infection, bleeding, clots in the legs/lungs, bladder/bowel damage, difficulties in bladder emptying, recurrence of prolapse, over-active bladder symptoms, urinary leakage, mesh erosion, persistent vaginal discharge, pain during sexual intercourse, groin pain, unknown long-term outcome & complications

ADNA 24/11/09

I also consent to such further of alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to section 1 (2) patients.)

Date 10.9.09 Signed C Morrin
(Patient/Parent/Guardian)
C Morrin 24/11/09

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian.*

Date 10.9.09 Signed
(Medical/Dental Practitioner)*
24/11/09 ADONAN

*DELETE AS APPROPRIATE

Note: This form is not to be used for any operation where there is a specific consent form with explanations.

Any deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature.

JMcC/74329

CONSENT FOR OPERATION

Anaesthetic Record

Proposed procedure:	Elective ✓
	Scheduled Urgent
	Urgent
	Emergency
Consent form signed Y / N	SASM Consultant:
Incapacity form Y / N	
Fasted Y / N	Informed Y / N

Write or attach label

HCR No: XHI466693
CHI No: MORRIN CAROLINE
Surname: 26 LEWIS TERR
Forename: IRVINE KA11 1HJ 30/10/1977
Address: Dr. J NELSON
BOURTREEHILL HEALTH CENTRE
CHEVIOT WAY,
Date of : CHI 3010776241

Preoperative assessment: Assessor: Date: Location: ASA Grade:

History

Previous GA: Yes, no problems. – (aware of ETT and end of surgery, ? residual paralysis).

FH:

CVS: Fit + well.

Resp:

Reflux: Heartburn well controlled by omeprazole – Brought on by drinks + spicy foods.

Other: Wears cat removed during procedure.

Examination

HR:

BP:

Weight:

Height:

BMI:

Airway Assessment

Mouth opening: MP3.

Teeth: OK.

Smoking: No

Alcohol:

Recreational Drugs:

Hb / WCC / Plats / Urea / Creat. OK. **/ Na / K / ECG / CXR / OTHER**

Recent Medication

Omeprazole, Zoneal.

Allergies

NKDA.

Discussed:

- Fasting ☐
- Premed ☐
- Induction ☐
- Analgesia ☐
- Suppositories ☐
- Monitoring: ☐

Regional Block: Complications discussed pre-operatively

- Failure ☐
- Hypotension ☐
- Headache ☐
- Numbness ☐
- Nerve Damage ☐
- Patient agrees Y / N
- Handout Y / N

Premedication:

Fasting: Time
Light Breakfast

Fluids: Allow still juices / water till:

Usual medicines:

Give all:
Give only:
Give all except:

Drugs: Date: Time:

24/11/09 TEMAZEPAM 30mg PO 1Pm. MWatt

Given at / by: MH 12.50

Date: 24/11/09 Operation done: Pelvic floor Repair Location: THS Start time: 1515 End time: Surgeon(s): Agm

Anaesthetic assistant: Yvonne

Anaesthetist(s): Ravmy SG / Watson cms
Grade:

Remarks: Significant Events / Critical Incidents Hazard Warnings

Uneventful Y/N

Effect of Premed

McC/80183 STA0093

ANAESTHETIC RECORD

Monitoring	
ECG	✓
NIBP	✓
SpO_2	✓
$ETCO_2$	✓
ET Agent	✓
F_iO_2	✓
NMT	
Temp.	
Urine Cath.	
CVP	
IBP	
Boots	
Fluid Warmer	✓
Warm Mattress	✓
Bair Hugger	✓

Machine Check
Anaesthetic room ☑
Theatre ☑

Circuit
Circle ☑ Bain ☐
Tpiece ☐ HME ☐

Ventilation
IPPV: Pressure Cont ☐
Volume Cont ☐
Spont Respiration ☑
Press Support ☐

Induction: Intravenous ☑ Gas ☐
Pre O_2 ☑ RSI ☐

Face Mask ☐
Airway: Oral ☐ Nasal ☐
LMA: Size 4.0 Type i-gel
ETT: Size..... Cuff ☐
Type.....
Throat Pack In ☐ Out ☐

Laryngoscopy Grade.....
Laryngoscopy Notes

Position Laparotomy
Pressure Care ☑
Eye Care ☑
Thromboprophylaxis ☐
Antibiotic..... COAMOXICLAV
Dose..... 1.2gm
Time..... 1535

Time	15	30	45	16	30	17	30
FENTANYL		75µg					
PROPOFOL		200+30mg					
MORPHINE		4mg		+2	+4		
DEXAMETHASONE		8mg					
DICLOFENAC		50mg					
ONDANSETRON		4mg					
PARACETAMOL		1gm					
EPHEDRINE		6mg+6					

T36.3°C

1703 1710 1720 1730 1740

220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30

O_2 ☐
N_2O ☐
Air ☑
Sev ☑
Des ☐
Iso ☐
Halo ☐
Others ☐

S_pO_2	99	98	97	96	97	96	95	95	99	99	99	100	100
$ETCO_2$	5.7	6.3	6.6	6.8	5.4	6.4	6.6	6.6	OR	6	6	6	6
ET Agent	2.0	2.0	2.0	2.2	2.1	2.4	2.4	2.4	Resps	18	14	18	12	14
F_iO_2	.36	.36	.34	.33	.31	.37	.35	.32	Sed	N	N	1	1	1
									Pain	C	C	0	0	0
									Nausea	R	R	0	0	0
									Mews					0

N fluids 0 (2)

Blood Loss
Urine Output

Cannula	18G	Site	RDH
A Line			
CVP			
Insertion Notes			

Regional Anaesthetic technique:

Spinal ☐ Full aseptic ☐

Epidural ☐ Entry site:

N. Block ☐ Needle used:

Wound Inf. ☑ Catheter: Y/N

by the surgeon with local anaesthetic at the end

Anaesthetic / Recovery

Fluid In

	Infusion 1	Vol
1	RL	500ml
2	RL	500 ml

	Infusion 2	Vol

Events Key

Total	
Blood Loss	
Urine Output	

Time

Recovery

Reviewed by

Postoperative instructions

Routine monitoring & care ☑

O_2 2–4 l/min for 6 hrs ☑

Humidified O_2 % as required to maintain O_2 Sat > 95% ☑

Morphine 1mg/ml iv up to 10mg as required for pain in recovery (YES) Signed.....

Ondansetron 4mg iv in recovery if required for nausea (YES) Signed.....

iv fluids as charted ☐ Special instructions

Drug therapy as charted ☑

24/11/09 Recovery

NOTES

DATE

1702: No conscious responses, breathing spontaneously. Laryngeal mask in situ O^2 at 6l.
Vital signs charted
Minimal PV staining
Urethral catheter in situ - draining clear urine. K Patel
MORPHINE 10mg
DICLOFENAC 50mg
Paracetamol 1g
Dexamethasone 8mg
Ondansetron 4mg
(given intraoperatively)
1713: Conscious response - LMA expelled
O^2 now at 4l via hudson mask.
Not tolerating mask - Nasal cannula put in situ
Seen by surgeon, and anaesthetist - aware of hypotension - unconcerned. K Patel
1730. Slight PV bleeding
Sanitary towel in situ
Minimal PR staining.
Pt tachycardic since waking but beginning to settle - please observe.
Catheter draining good amount of urine. K Patel
Pressure areas satisfactory
1740 Heart rate settling to 95-100bpm at rest Return to ward. K Patel

NHS Ayrshire & Arran

OPERATIVE CARE PLAN

Surnar CHI 3010776241
Forena MORRIN CAROLINE
Addres 26 LEWIS TERR
IRVINE
KA11 1HJ
30/10/1977 Pract 80306
Ward (Case Ref 466693

Ward 6D Date 24/11/09 Theatre

Proposed Operation ANT + POST Repair

Pre-Medication Time Given 1250pm

Fasted from: Time WAM - 0600

Paediatrics Last feed / drink

Last Immunisation

GKI Yes ☐ No ☑ Glucose Reading ☐ Patient Weight Kg ☐

Identified Allergies: Specify NKA + Latex - Resin

CHECK 1 Pre op

Surgical site marking and patient verification

- ☐ Check patient identity
- ☐ Check reliable documentation/results
- ☐ Images to ascertain intended surgical site
- ☐ Intended site marked with an arrow using indelible pen
- ☐ Decision not to mark – state reason below

.....

Signature confirming surgical check complete

In the event of this section being incomplete – Reception Nurse to communicate with Theatre to establish action to be taken.

Operating Surgeon

Signature .....

Print .....

CHECK 2 - 3 Surgical site marking and patient verification	Ward/DSU			R/Recovery			Anaesthetic		
	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
Identification Bracelet	✓			✓			✓		
Consent Form signed	✓			✓			✓		
AWI Consent if applicable			✓			✓			✓
Operation Site marked clearly						✓			✓
Bone bank consent form (Ortho only)			✓			✓			✓
Dentures removed		✓			✓			✓	
Caps/Crowns/Loose teeth: Specify		✓			✓			✓	
Nail Polish/Jewellery/Make-up: Removed	✓					✓			✓
Rings taped/Body Piercing	✓				✓	REMOVED		✓	
Pad or Tampon	✓			✓			✓		
theter in situ		✓			✓			✓	
e-op Shower	✓			✓			✓		
Skin Prep/Clipped: If required	✓			✓			✓		
Paper Pants	✓			✓			✓		
Patient's Label included	✓			✓			✓		
Hearing Aid		✓			✓			✓	
Inhalers		✓			✓			✓	
Pillows extra: Number					✓			✓	
B.H.C.G. (Pregnancy Test) 23/11/09 -ve	✓						✓		
Urinalysis NAD	✓						✓		
Case Notes							✓		
X Rays/Images								✓	
Pathology/Lab results								✓	
Haemoglobin 13.3 11/11/09				✓			✓		
Blood X matched ..... 1 G+S 24/11/09				✓			✓		
E.C.G. if applicable		✓						✓	
Other: Specify								✓	
Normothermia: Pre-Warm				Pre-op Temp			36.9		

Any other relevant information: (e.g. high risk or changes to general health) Name tied with Dr O's informed - esp to go head

Ward Nurse *(signature)* M. Haggans Print .....

Rec-Recovery Nurse *(signature)* K. Watt Print K. WATT

Anaesthetic Nurse *(signature)* Print

ANAESTHETIC CARE GIVEN

Pulse 90 BP 124/68 SPo2 98 (A)

Antibiotic: Augmentin @ 1525 Time Given:

G.A.	✓	Rapid Sequence	
L.M.A.	I-Gel	Size	4
ET Tube		Size	
Face Mask			
Throat Pack			
Throat Pack removed			
N.G. Tube			

Spinal	
Epidural	
Combined Spinal/Epidural	
Local Anaesthetic	
Nerve Block	
Eye Protection: Yes ✓ No	

Infusion Device

PCA	
TIVA	
Baxter Colleague	
Alaris	
Bodyguard	
INVASIVE MONITORING	
IBP	Cardiac Output	CVP

Patient Positioning

Supine		**RIGHT ARM**	
Prone		On board	
Lithotomy	✓	At side	
Trendelenburg		Across chest	✓
Rev-Trendelenburg		Other	
Jack Knife		**LEFT ARM**	
Right lateral		On board	
Left lateral		At side	
Traction Table		Across chest	✓
Lloyd Davis		Other	
Deck Chair			

Diathermy Application

Bi-polar	
Mono-polar Diathermy site	
Site	(R) Thigh
Diathermy Pad applied correctly and checked	✓

TOURNIQUET

Arm right		Arm left	
Leg right		Leg left	
Digit right		Digit left	
Time on right		Time on left	
Total Tourniquet time right		**Total Tourniquet time left**	

PERI-OPERATIVE CARE

Patient protection safety

Arm supports	✓	Sand bag	
Pelvic support i.e. padding		Shoulder vac pac (beanbag)	
Lateral support i.e. padding	✓	Bair Hugger	✓
Padding bony prominences		Fluid warmer	✓
Heel rest		Core temp probe	
Head ring		OR Pad	
Prone head ring		Other: State	
Stirrups	✓		
Pillows	✓		

Evaluation pre and post-operative

Pre op		Post op
✓	Pressure area checked	✓
✓	Diathermy site checked	✓
	Tourniquet site checked	

DVT Prophylaxis

Fragmin	✓
Ted stockings	✓
Pre-op aspirin/Clopidogrel	
Flowtron leggings	
Time on	**Time off**

	1 hr	2 hr	3 hr	4 hr	5 hr
Limb + machine function checks					

Skin Prep solution used Hibidil

Given by (Name) Am Whalen

Specimens taken:

Yes ☐ No ✓ Bacteriology ☐ Pathology ☐

Other Hospital ☐ Bone bank ☐ State total (in box) ☐ (except bone bank)

Signature nurse receiving specimens from scrub person

Blood loss measured Yes ☐ No ✓ Total ☐

Patient Catheterised in Theatre Nurse ☐ Doctor ✓ Catheter size 12/g mls in balloon 10mls

Skin closure 3/0 Vicryl Rapide
3-0 Monof Rapide Skintags

Dressing —

Wound drainage —

Local anaesthetic infiltration 40mls 1% Lycaine 1% with c diluted with 200mls Saline
=> 140mls used in total.

Identified problem	Nursing intervention	Outcome

Check 4

Surgical site marking and patient verification **Theatre:** Surgical, Anaesthetic and Theatre team prior to commencement of surgery **should pause for verbal briefing to confirm the following** ☑ **Correct patient** ☑ **Consent form correct and signed by patient and clinician** ☑ **Proposed operation** ☐ **Operation site marked** ☐ **Availability of required image studies plus pathology results**	**Signature of Operating Surgeon or Senior Member of Theatre Team to confirm check completed** **Sign.** ..... **Print** L Peagie **Time** 1526 **Date** 24/11/09	**Surgeon only to complete and sign if discrepancy has been identified** **Nature of discrepancy** .... **Decision taken** .... **Sign.** ..... **Print** ..... When there is a discrepancy, a senior member of staff will follow the adverse incident policy.

DAY SURGERY ESCORT DETAILS

Name ..... Address .....

..... Telephone No.....

Time into recovery ..... **Conscious state** .....

Time conscious ..... **Operation site** .....

Oxygen Therapy ..... **Hudson Mask** .....

Nasal Cannula .....

Time transfer ..... **Nurse Signature** .....

I RESSIVE RECOVERY

Seen by Surgeon YES / NO Anaesthetist YES / NO

Wound Check: Time ..... Comments .....

DISCHARGE DETAILS

Post-op Phone Call	Yes ☐	No ☐	Post-op instructions	Yes ☐	No ☐
Observations stable	Yes ☐	No ☐	GP letter given	Yes ☐	No ☐
Tolerating oral fluids	Yes ☐	No ☐	Follow up appointment given	Yes ☐	No ☐
Venflon removed	Yes ☐	No ☐	Community call arranged	Yes ☐	No ☐
Wound site satisfactory	Yes ☐	No ☐	Discharge medication given	Yes ☐	No ☐
Passed Urine	Yes ☐	No ☐			

Date of Discharge ..... Time of Discharge .....

Nurse's Signature .....

Date: 24/11/09 | Theatre: 5

Attach patients addressogram

CHI 3010776241
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ
30/10/1977 Pract 80306
Case Ref 466693

PATIENT | Sex M | | F | ✓

PROCEDURE

Speciality: G4N. | Surgery Class: 3

OPCS 4 Code:

CASE FORM

Consultant: Dr Aqur | Admit Type: 23/11/09

Ward: 6 | Admit Date: 3

Custom | Op Type: 1

Procedure

Delays:

Actual Procedure: Removal of IUCD, Anterior Colporrhaphy + posterior Colporrhaphy + TOT + Removal of perianal tags.

Post-op directions: Catheter to stay for 4 8 hours
-oral Galexin & Metronidazole for 3/7

Follow-up instructions: GOPD 3/12

Sign: K M. Date: 24/11/09

1. 23 hour
2. Day Surgery
3. Elective In Patient
4. Emergency In Patient

SURGERY CLASS
1. Minor
2. Intermediate
3. Major
4. Supercomplex

OPERATION TYPE
1. Elective in hrs.
2. Elective out hrs.
3. Emergency in hrs.
4. Emergency out hrs.
5. Emergency Weekend/PH's
6. Elective Weekend/PH's

REASON FOR DELAY
1. Patient not ready
2. Lack nursing staff on ward
3. Patient not in specified ward

ANAESTHETIC TYPE
1. General
2. Epidural
3. General Epidural
4. Local anaesthetic
5. No anaesthetic
6. Sedation
7. Spinal
8. Spinal Sedation
9. Nerve Block

CASE FORM

Counts and Dressings

Scrub Nurse Check	Sign	Initial
Final Check	Sign	Initial
Tray out Check	Sign	Initial

TIMES K WAITE

Sent for	1410	Patient available		Anaesthetic begin	1519
Pt. in theatre	1523	Surgery starts	1528	Surgery stops	17.00
Pt. out theatre	17.25	Clean up starts	17.25	Recovery in	1702
Clean up stop	17.15	Recovery out	1742	DS Disc.	

STAFF

MEDICAL	NURSING			
Actual Surgeon	Dr Aqur	Anaesthetic Nurse	Y Pledi	Circulating Nurse L Reggie
1st Assistant	Dr Riedl	Scrub Nurse	D Murdoch	Circulating Nurse J Boyd
2nd Assistant		Scrub Nurse		Circulating Nurse A M White
Anaesthetist 1	Dr Ranning	Scrub Nurse		Circulating Nurse
Anaesthetist 2	Dr Watson	ODP		ODP
Aux	P Brown	Aux		Other

ANAESTHETIC

Type: 1 | ASA: 2 | Controlled Drugs: Pentazocine + Morphine

PACU

Recovered by 1. K Falconer 2.

Released to

RELEASED TO
1. Ward
2. I.T.U.
3. H.D.U.
4. D.S.U.
5. 23 hour
6. Other

T.s.s.u instrument labels

CHI 3010776241
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ
30/10/1977 Pract 80306
Case Ref 466693

STA0215

DATE 24/11/09

SURGEON Dr. M RIAD / Dr. W AGUR

ANAESTHETIST

ASSISTANT

OPERATION PERFORMED Removal of IUCD + Anterior Colporrhaphy + Posterior Colporrhaphy + TOT + Excision of anal tags.

DESCRIPTION OF PROCEDURE

Intended procedure:	Anterior + Posterior Colporrhaphy
Performed procedure:	Anterior + Posterior Colporrhaphy
Indication	Anterior & Posterior Compartment Prolapse
Anaesthesia	General Anaesthesia
Patient Position	Lithotomy
EUA	Stage II Cystocele. Stage II Rectocele
Catheterisation	Foley's catheter
Infiltration	20 mls Xylocaine 1% + 1:200,000 Adrenaline diluted in 100 mls saline. 30 mls infiltrated anteriorly & 30 mls posteriorly.
Incision	Longitudinal vaginal wall incisions
Procedure	Self-retaining vaginal retractor used (Lone Star®). Vaginal skin dissected off the vesico-vaginal fascia. Good native tissues; fascial plication performed with continuous PDS® 1 stitches including the pubo-cervical ligament and anterior lip of the cervix on each side.
Closure	Vaginal skin sutured with continuous locked Vicryl® 0.
Operating Time	45 min
EBL	<30 mls
Postoperative Instructions	No Pack. Catheter out 48 hours.

IUCD Removed

See the back for continuation →

DRAINS ..... PACKS .....

SPECIAL INSTRUCTIONS TO WARD

Signature .....

OPERATION

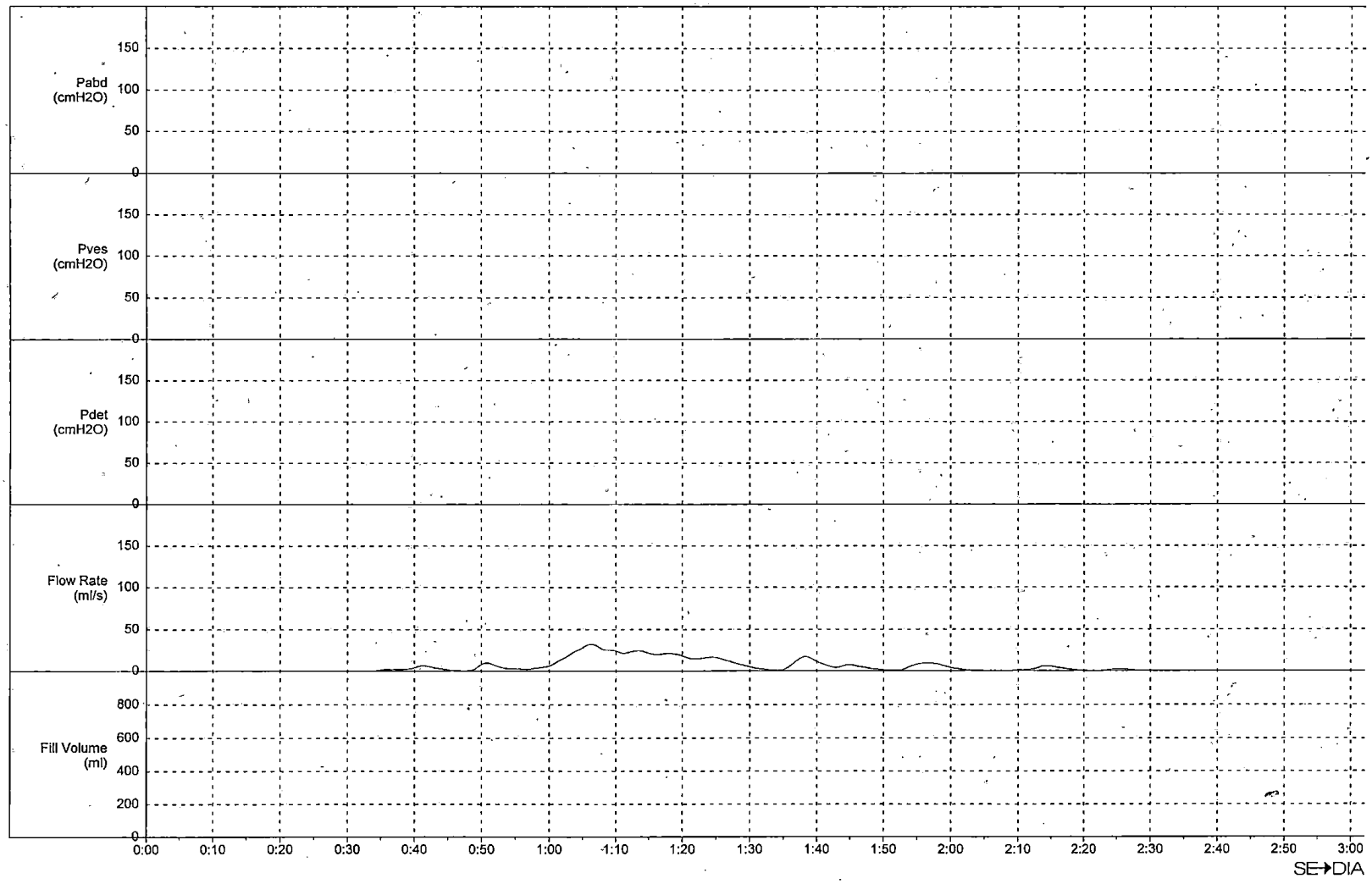
JMcC/74602

Continuation

Intended procedure:	Trans-Obturator Tape
Performed procedure:	Trans-Obturator Tape
Anaesthesia	GA
Patient Position	Lithotomy
EUA	Urethral hypermobility
Catheterisation	Foley's catheter
Infiltration	20 mls Xylocaine + Adrenaline
Incision	Longitudinal suburethral incision + 2 longitudinal labio-crural incisions at the level of the clitoris
Procedure	Lateral suburethral dissection till the perineal membrane underneath the pubic ramus on both sides. The Boston Scientific Obtryx was used. The helical needles passed through the obturator membrane and muscle, around the pubic ramus, piercing the perineal membranes to emerge suburethrally. Tape is placed tension-free underneath the urethra and the ends were cut flush with the skin.
Closure	Vicryl® number 0 to vagina, Vicryl rapide® to skin
Operating Time	20 min
EBL	<50 mls
Postoperative Instructions	Catheter out in 48 hours

Excision of anal skin tag.
Local anaesthetic infiltrated.
Skin tags excised using diathermy.
Vicryl 2/0 used to stitch the skin.
Uneventful procedure.

H Fadl
26/11/09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Pves (cmH2O)
Pdet (cmH2O)
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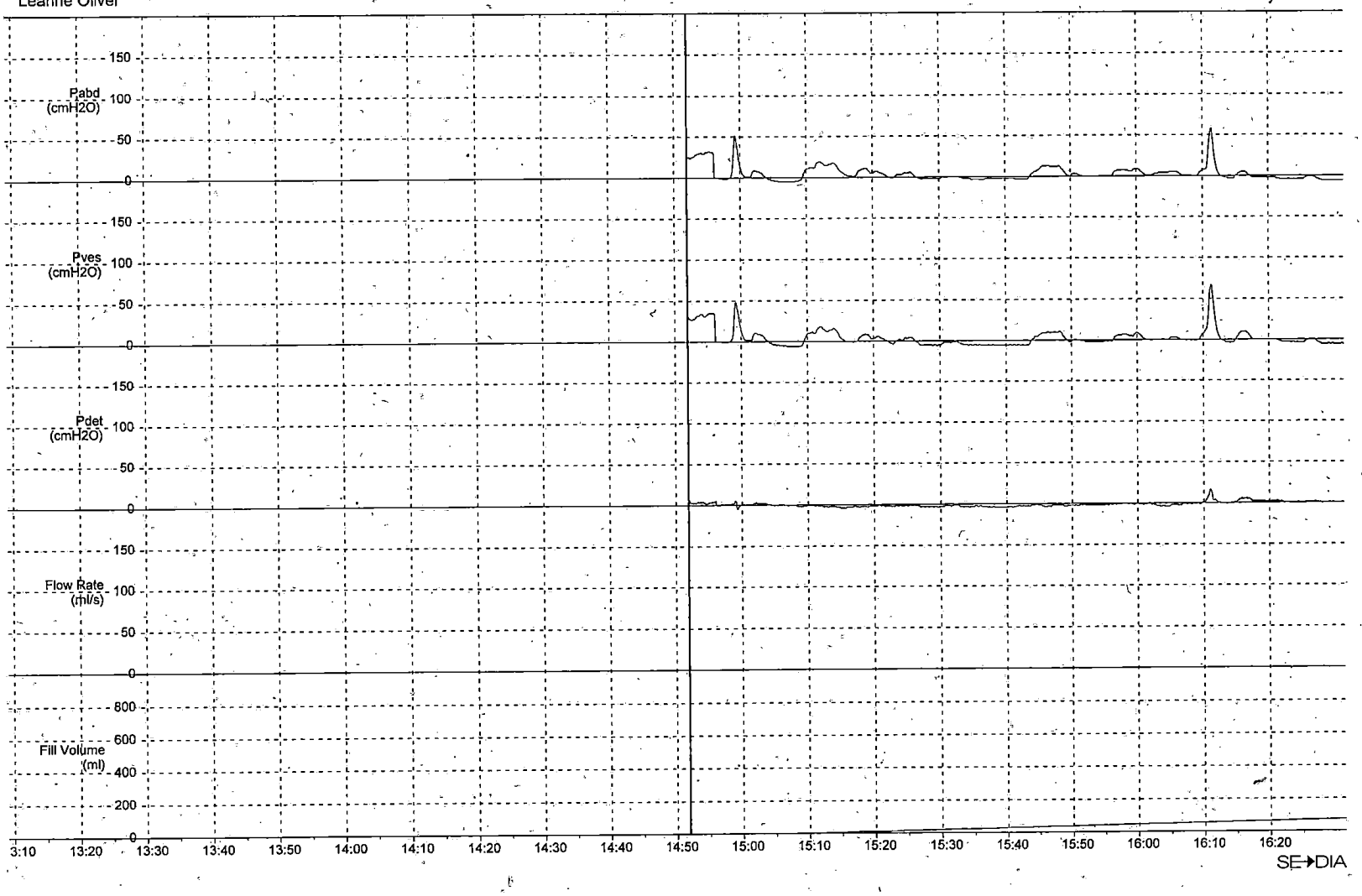
SE→DIA

Leanne Oliver

Urodynamics



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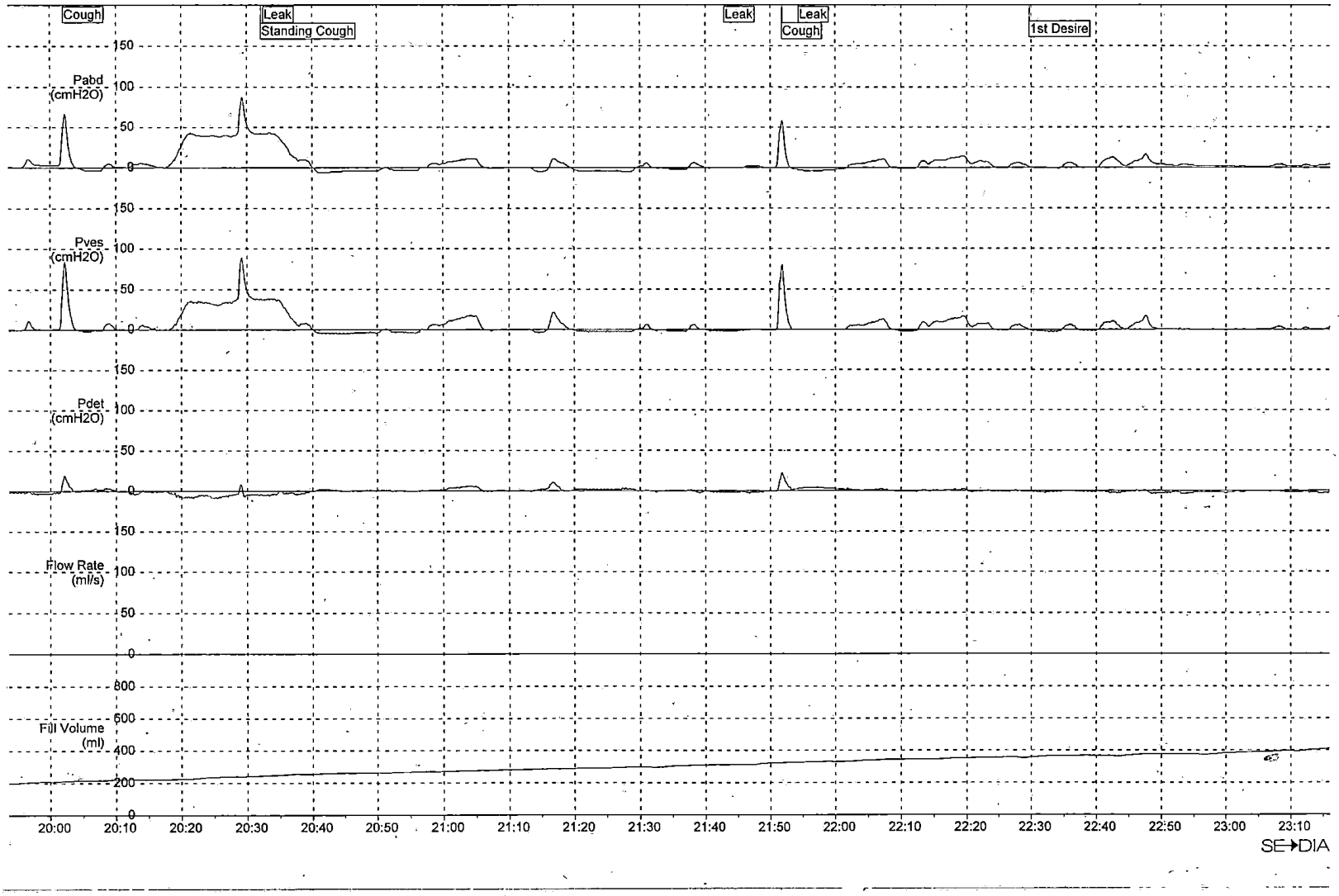
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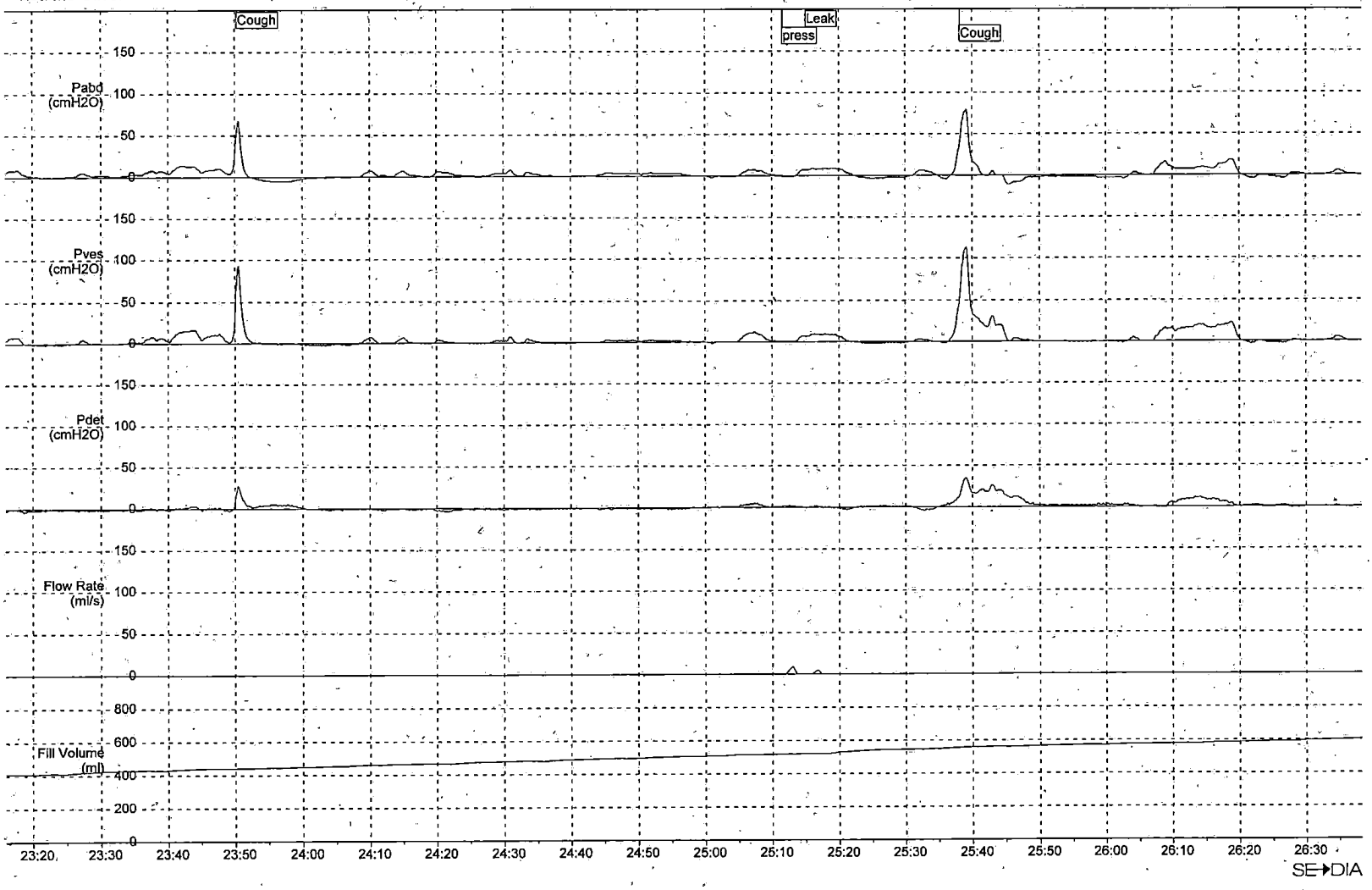
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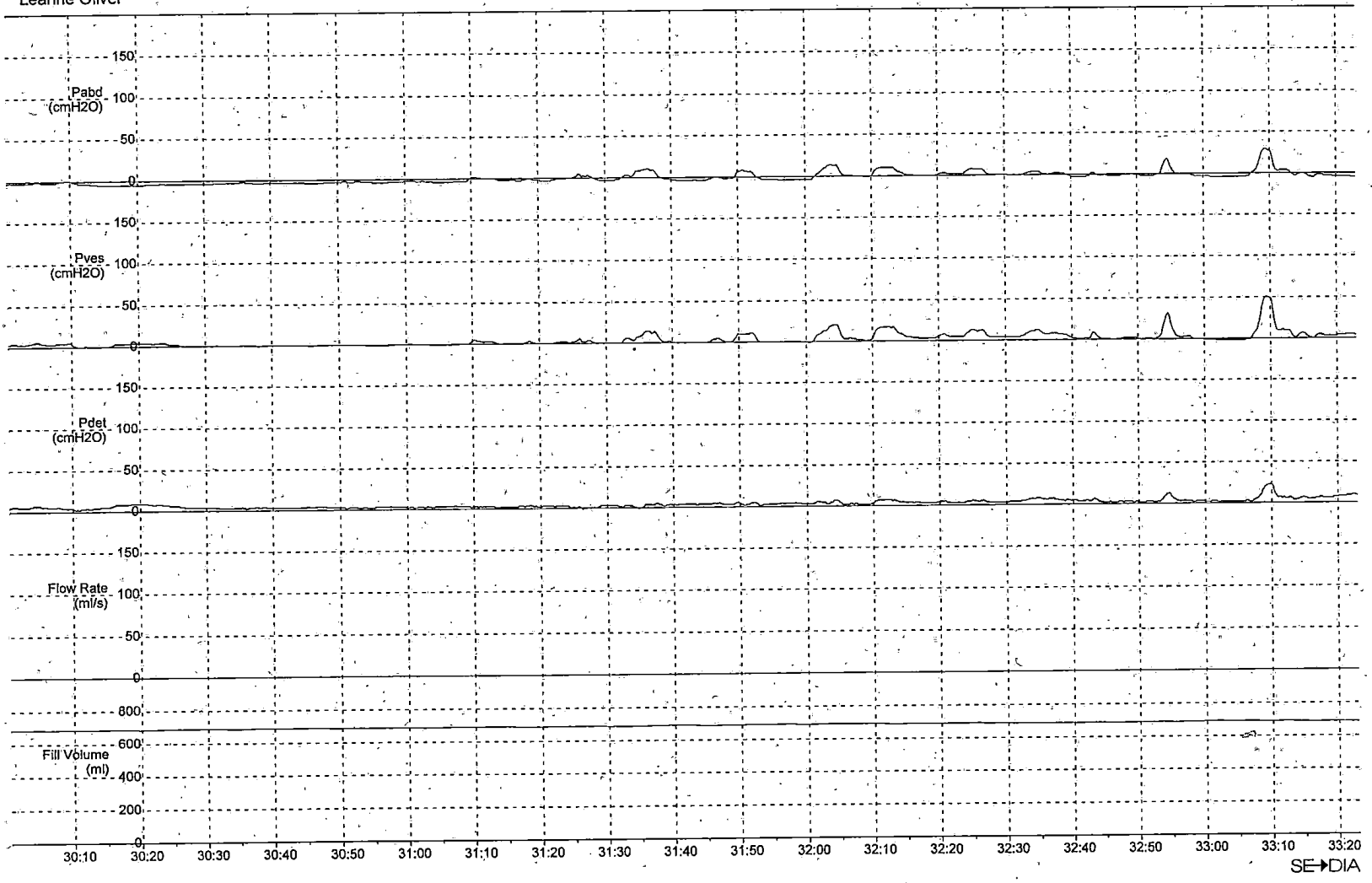
SE→DIA

Leanne Oliver

Urodynamics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Flow Rate (ml/s)
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Fill Volume (ml)
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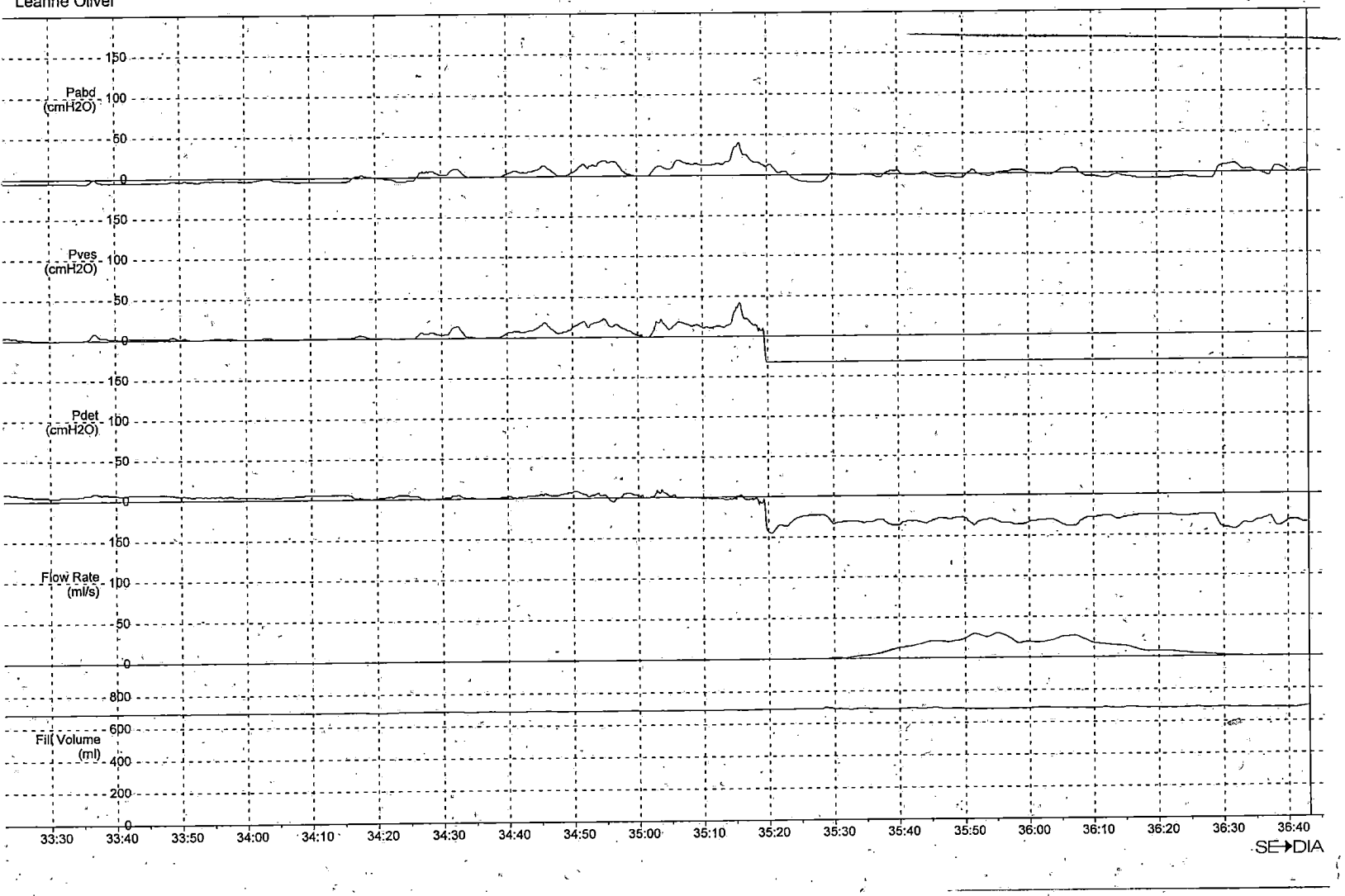
SE→DIA

Leanne Oliver

Urodynamics



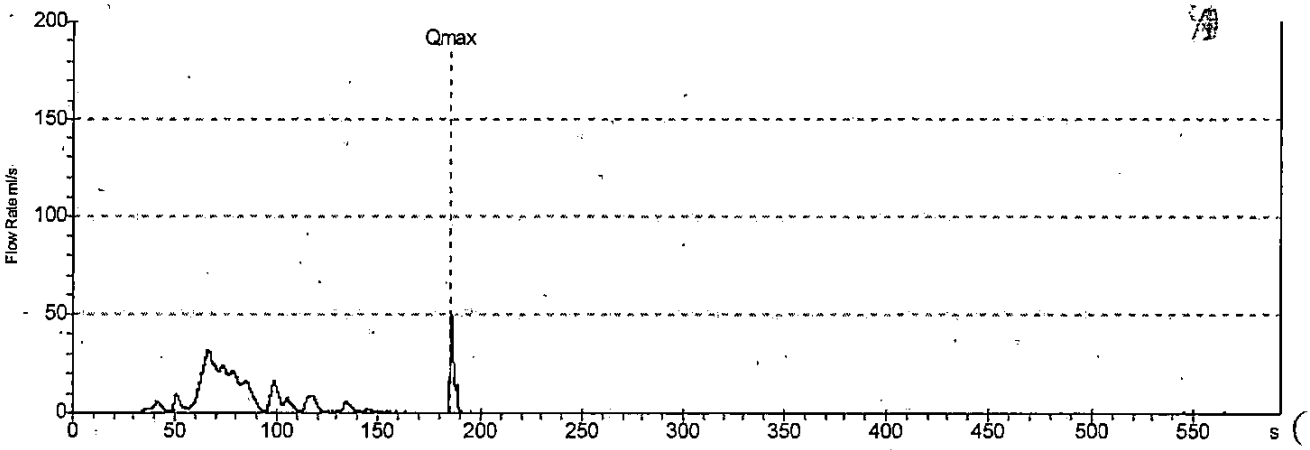
Crosshouse Hospital
Urodynamics
Dr Agur
Kilmarnock

SE→DIA

Morrin Caroline	F
466693	30.10.1977

Flow Study

08.10.2009 14:23:21 Leanne Oliver



Total Volume	V	4	ml
Volume at Maximum Flow Rate	VQmax	-1	ml
Maximum Flow Rate	Qmax	50.1	ml/s
Average Flow Rate	Qave	0.03	ml/s
Time to Maximum Flow Rate	tQmax	151.6	s
Voiding Time	tvoid	559.3	s
Flow Time	tflow	115.4	s
Residual Volume	Vresidual	67	ml

Crosshouse Hospital
Urodynamics
Dr Agur
Kilmarnock

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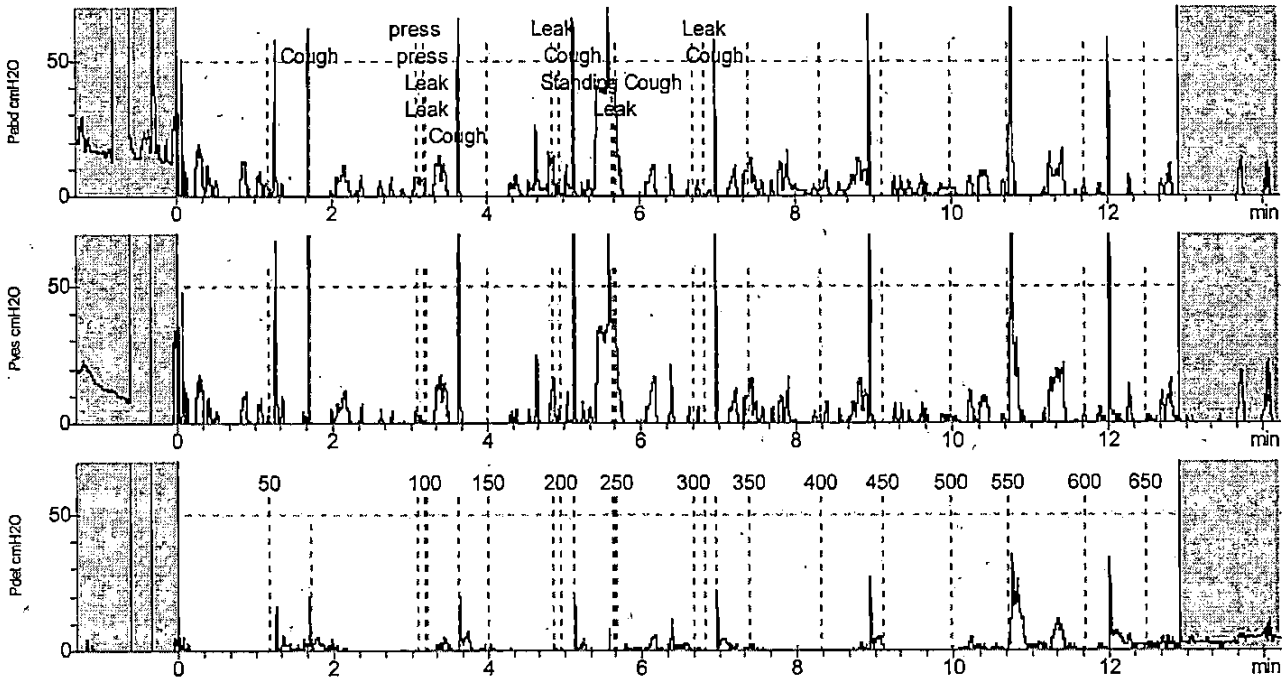
Morrin Caroline F
466693 30.10.1977

Fill Cystometry

08.10.2009 14:23:21 Leanne Oliver



Event	Vol/ml	dVol/ml	Pdet	dP cmH2O	Comp ml/cmH2O
Start	0	0	3	0	0
Leak	100	100	-5	-8	Infinite
Leak	101	101	-5	-8	Infinite
Leak	192	192	0	-3	Infinite
Leak	245	245	-5	-8	Infinite
Leak	310	310	-2	-5	Infinite
Leak	327	327	3	0	Infinite
1st Desire	357	357	-1	-4	Infinite
Leak	521	521	0	-3	Infinite
Strong Desire	668	668	2	-1	Infinite
Strong Desire	675	675	2	-1	Infinite
100ml	101	101	-5	-8	Infinite
200ml	201	100	-1	4	25
300ml	301	100	-1	0	Infinite
400ml	401	100	-1	0	Infinite
500ml	501	100	0	1	100
Overall Compliance = Infinite ml/cmH2O	1	100	-1	**PdetMax = 35cmH2O**	
Residual Volume = 67ml	682	682	3	**Voided Volume = 0ml**	

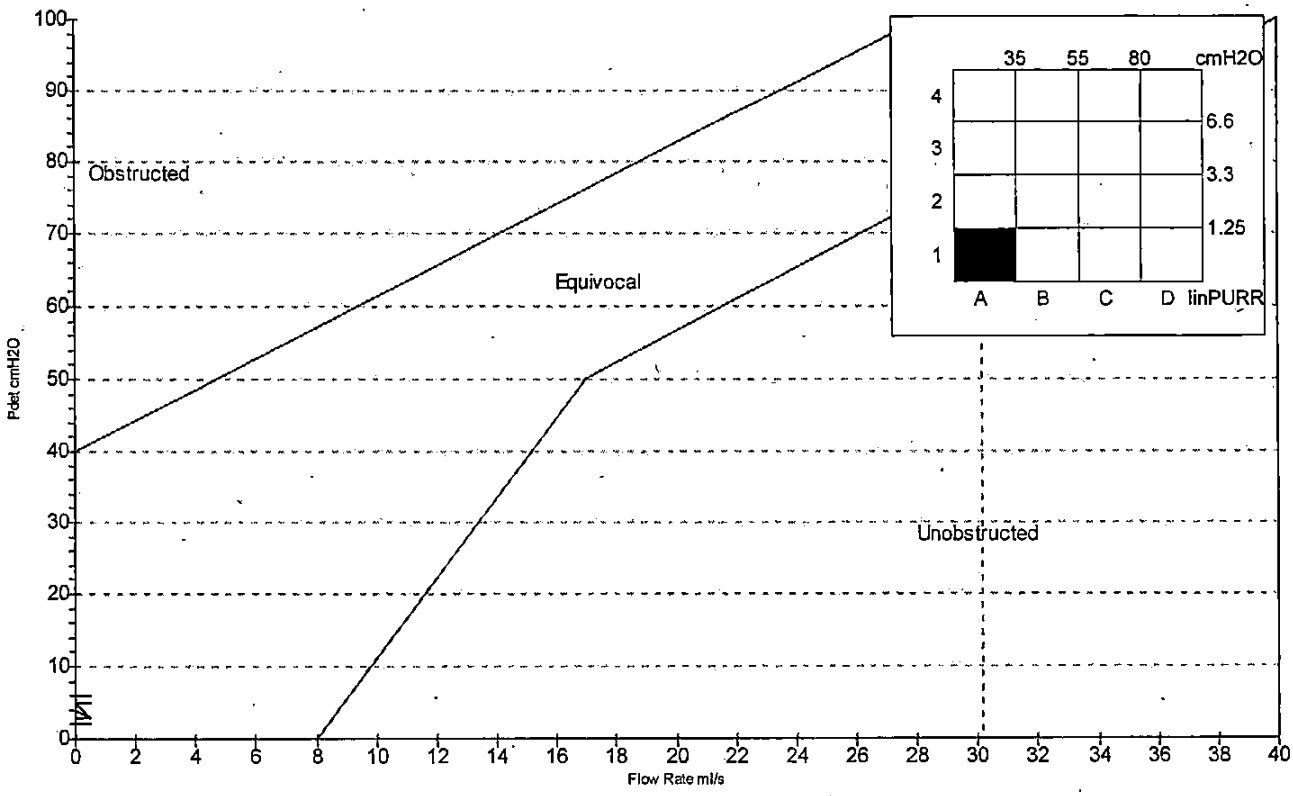
Crosshouse Hospital
Urodynamics
Dr Agur
Kilmarnock

SE→DIA

Morrin Caroline	F
466693	30.10.1977

Flow Study

08.10.2009 14:23:21 Leanne Oliver



Total Volume	V	874	ml
Maximum Flow Rate	Qmax	30.2	ml/s
Volume at Maximum Flow Rate	VQmax	400	ml
Time to Maximum Flow Rate	tQmax	25.8	s
Voiding Time	tvoid	66.4	s
Flow Time	tflow	65.3	s
Average Flow Rate	Qave	13.38	ml/s
Residual Volume	Vresidual		ml

		Pdet	Pves
Start Pressure	cmH2O	3	-1
Opening Pressure	cmH2O	-26	-32
Qmax Pressure	cmH2O	-32	-32
Pmuo Pressure	cmH2O	-43	-32
Maximum Pressure	cmH2O	23	51

LinPURR = 0.36

STA 0143

Surnam CHI 3010776241
Forena MORRIN CAROLINE
Addres 4 CRAIGNAW PLACE
IRVINE
KA11 1EZ
30/10/1977 Pract 80330
Ward Case Ref 466693

DATE
17/11/06

- 29 yr old P3 referred for laparoscopic sterilisation

- current hx: using implanon
  - ↳ x 1 month
  - ↳ unhappy as arm feels very uncomfortable
  - ↳ had it for 2 years
  - ↳ currently starting on N.E.T.S. my T.O.S. for control bleeding

M.H.

C.M.P.: Not sure ... 2 months ago
- ↳ was bleeding for 15 weeks prior to the same.
- ↳ started at time of insertion of implanon

P3 < 3 4 8 } → S.V.D. ... 3 months ago

Med his: Migraine

Surg his: A. laparoscopy ... 9 yrs ago

O/E BMI 38

P.A.: Pendulum

Discussed alternative forms of contraception
- ↳ home
- ↳ Mirena

Room for L.A.P. steq
- ↳ Procedure, complications discussed

GYNAECOLOGY

DATE

complications due to ↑ BMI discussed

↳ target wt 8.6 kg

Alternatives wt loss Nov

Reasons review 6 mth

T. Thorn
SHO

18.5.07 GOPD

Wt 107.1 kg

H 1.70

Bm 36.8

Discussed risks + need for BMI to be ≤ 30 for safer laps approach

Discussed contraceptive options esp mirena (leaflet given)

Asking for implanon to be removed under GA

Explained I am not licenced for insertion or removal of implanon must contact FPC or GP who put it in

Discharged until wt 86 kg

Lucie Buck

WHITE, IN

XH 466693

Surname ..... MORRIN

Forenames ..... CAROLINE

Address ..... 4 CRAIGNAW PLACE
IRVINE
KA11 1EZ

..... 30/10/1977

..... DR I JAMIESON
THE SURGERY
AYRSHIRE CENTRAL HOSPITAL

Ward or Department. CHI 3010776241

STA 0143

DATE

17/11/06

GYNAECOLOGY

JMcC/60789

DATE

CROSSHOUSE HOSPITAL - ACCIDENT AND EMERGENCY DEPARTMENT

KM9

Triage time: 20:35 Triage nurse: THOMSON Triage: Yellow

resp rate	19	sat O2%	96%	PFR	
pulse	99	BP	168/91	GCS	15
allergy	Not known				
BMstix		breath alcohol		temp	36.2
urine					
VA	R L	pain score	97		
accompanied by:	Unaccompanied	review score			
		discharge score			

Triage details

NHS 25 Ref - Worsening PV bleeding for 4/7 - States having to change pad constantly - Now passing clots

treatment

I give consent for details of my injury to be given to the Police.

Signed .....

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed..... Witness..... Witness.....

Surname: MORRIN
Forename: CAROLINE

marital status: M
sex: F

A/E No.: 07063183
Consultant: C MCGUFFIE
date/time attendance: 23/12/2007 20:31

Date of birth: 30/10/1977
age: 30

Address: 26 LEWIS TERRACE
IRVINE
alt: N
Post code:

special case

GP: WD CAMPBELL
address
BOURTREEHILL HEALTH CENTRE
CHEVIOT WAY
BOORTREEHILL
IRVINE
KA11 1JU
phone
01294 211993

this problem+total att: 1 + 1

Phone: 213116

incident: date/time: Not known

next of kin
address
relationship
phone

Occup
religion
employer
school

hospital number: M074152

disch | A+E clinic | paed tr. | # | eye | ENT | max facial | ward - OP | ward - IP (6) | x-ray? Y / N

STA0098

JMcC/61959

Drug	Dose	route	time / frequency	Signature	Given by / quantity

Time: 21.03 DOCTOR: R. YERRA NHS 24 Referral

30 ♀ PC: PV bleeding ↑ clots —

HPC - PV bleeding fresh blood since 4/52, since 4/7 → PV bleed with golfball size clots. Needing to change Pads every 15-20 minutes.

- Associated mild niggling lower abdominal pain ~ 4/7.
- NO PV discharge - NO urinary symptoms/ Bowel
- Last cervical smear 12/12 ago → normal.
- Contraceptive implant device in (R) upper arm — 12/12 ago → PV bleed for 17/52.
- IUCD removed 1 year ago
- Usually 6/52 periods. Breaks for 3-4/7
- LMP 4/52 ago

PMH: To commenced on OCP by GP 4/7 ago.

Nil

P_3

Medication. NKDA OE: PR: 90, regular RR: 19 BP: 168/91

P/A: soft, non-tender, no guarding, BS present

Chest / CVS: NAD.

Dx: PV bleed menorrhagia ? cause.

(P) Referred to Gynaecology (D) 29:20. (Ward 6)

R. YERRA SHO

29 NORETHISTERONE 5mg TID o.

TI 1g TIDO.

NHS 24 CLINICAL REFERRAL/NOTES

NHS 24 ID:	8355316	**Site:**	Glasgow
CHI #:	3010776241	**Caller Name:**	
Surname:	MORRIN	**Date Call Received:**	23/12/2007
Forename:	CAROLINE	**Time Call Received:**	19:36:12
DOB:	30/10/1977	**Date Call Completed:**	
Gender:	Female	**Time Call Completed:**	
Address:	26 Lewis Terrace Broomlands Irvine Ayrshire/KA11 1HJ	**Call Priority:**	0
		Call Reason:	WORENING PERIOD BLEEDING, 1 WEEKS, SEE A/V
PH NO:	01294215887 (Home)		
Current Location:	26 Lewis Terrace Broomlands Irvine Ayrshire/KA11 1HJ		
Special Directions:	Back Door		
Current PH NO:	01294215887 (Home)		
Care Provider:	NELSON, JAGBIR	**Care Provider Details:**	THE HEALTH CENTRE CHEVIOT WAY BOURTREEHILL,IRVINE KA11 1JU Scotland
Temporary Resident:	No		

Referred To:	**Recommended Action:**

CLINICAL SUMMARY

VAGINAL BLEEDING/ WEAK FOR 4 WEEKS AND WORSENING VAGINAL BLEEDING. SOAKING SANITARY TOWEL EVERY 20 MINS FOR 4 DAYS, HAS PASSED 4 LARGE CLOTS IN LAST HOUR, PELVIC PAIN 1 HR.CONTRACEPTIVE IMPLANT INSERTED 1 YR AGO, INITIALLY BLED FOR 17/52. ADVISED A&E CROSSHOUSE ASAP.

PAST MEDICAL HISTORY

NIL

MEDICATIONS

NIL

ALLERGIES

NIL

WRITE, IMPRINT OR ATTACH

Surname .....
Forenames ....
Address.....
.....
STA 0142 Ward or Departme

A&E Num: 07063183
MORRIN CAROLINE
26 LEWIS TERRACE
IRVINE

Female
30/10/1977
CHI Num:
PAS Num: M074152

DATE

23/12/17
2260

A&E Referral
30 Para 3 to 4
(bags 9.5, 4/10).

Recurrent PV bleed since started contraception
Attempted pills, IUCD, R2,
implant at (R) arm
GP tended to stop all medication & remove implant.
PV bleed stopped when pills were stopped
∴ Implant not removed.

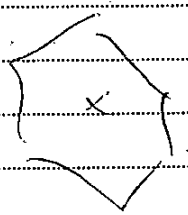
Bleeding started 4/52 ago
Initially brown
Now worsening, ? flooding episode
"Runny" with clots

No recent sexual intercourse.

Asso mild suprapubic pain
dizziness / lethargy.

PMHx: nil
OHx: Normal
DHx: nil
GHx: Regular cycle
every 4 weeks
menorrhagia

O/E Fresh PV bleed oozing out



Soft nontender.

GYNAECOLOGY

IMacG/30787

DATE

Haemodynamically stable.

Imp: PV bleed 2° implant ?
2° ? other causes

(P) IV access 16G x 2, G&S
D/W SpR for norethisterone
TX.
If Hb low → IV fluid
SpR will examine at ward 6

24/12/07
0015

Seen by Dr Saravanan

FFLA5368

80yrs
P3+0

Irregular bleeding with implanon.
Continuous bleeding PV for 4 weeks & increase since last 4 days.
No dysmenorrhoea

Smear: Last year - (N)

O/E: Obs. (N)

Abdomen Soft. No palpable mass.

Speculum: Cx bulky - looks (N)
AVE / ECC taken.

Bimanual: Difficult to assess uterine size.
Adnexae (N) -

Imp: DUB
Irregular bleeding ? Implanon.

Plan: NET + TA
Pelvic scan tomorrow & review
(to r/o fibroids)

P Saravanan/SHO

Surname

Forename CHI 3010776241
MORRIN CAROLINE

Address 26 LEWIS TERR
IRVINE
KA11 1EZ
30/10/1977 Pract 80306

STA 0142 Ward or D Case Ref 466693

DATE

24-12-07
0915.

Comfortable.
Hb 12.9. bleeding not so much this am.
wishes to go home this morning
— Plan: request outpatient US pelvis (exclude fibroids)
d/c & Tranexamic acid
Norethisterone.

MAHunter 2809
HUNTER SpR

GYNAECOLOGY

JM:C/60787

DATE

A&E Department

Date: Sunday 27-Dec-09 **Agency Phone No.**

Patient Name: Caroline Morrin Sex: F **Date of Birth:** 30-Oct-1977 **Age:** 32 years

Address: 26 Lewis Terrace Broomlands **Own Doctor:** Nelson, J

Surgery: Provider Group

Irvine

KA11 1HJ

Home Tel: 01294 215887

Case Origin: NHS24 **Case Number:** 32470

Caller Name: Caroline **Tel:** **Case Priority:** Within 4 Hours

NHS24 Clinical Summary

Clinical summary created by: (Non-Clinical User) (Glasgow) [27/12/2009 16:12:35]
X FOR X AND UNTRIAGED CALL PASSED TO PARTNER TO ACTION

Latest Consultation Details **Consulted By:** McTaggart, Wilson **Cons. Begin:** 16:21

Cons. Finished: 16:33

Is concerned re. a DVT.
1/12 post pelvic floor repair. Overweight.
Dull, deep, ill-localised pain above/below left knee posteriorly. No obvious swelling/colour changes.
Sore, throbbing to move.

Examination Details:

Clinical Codes:

N245. Pain in limb

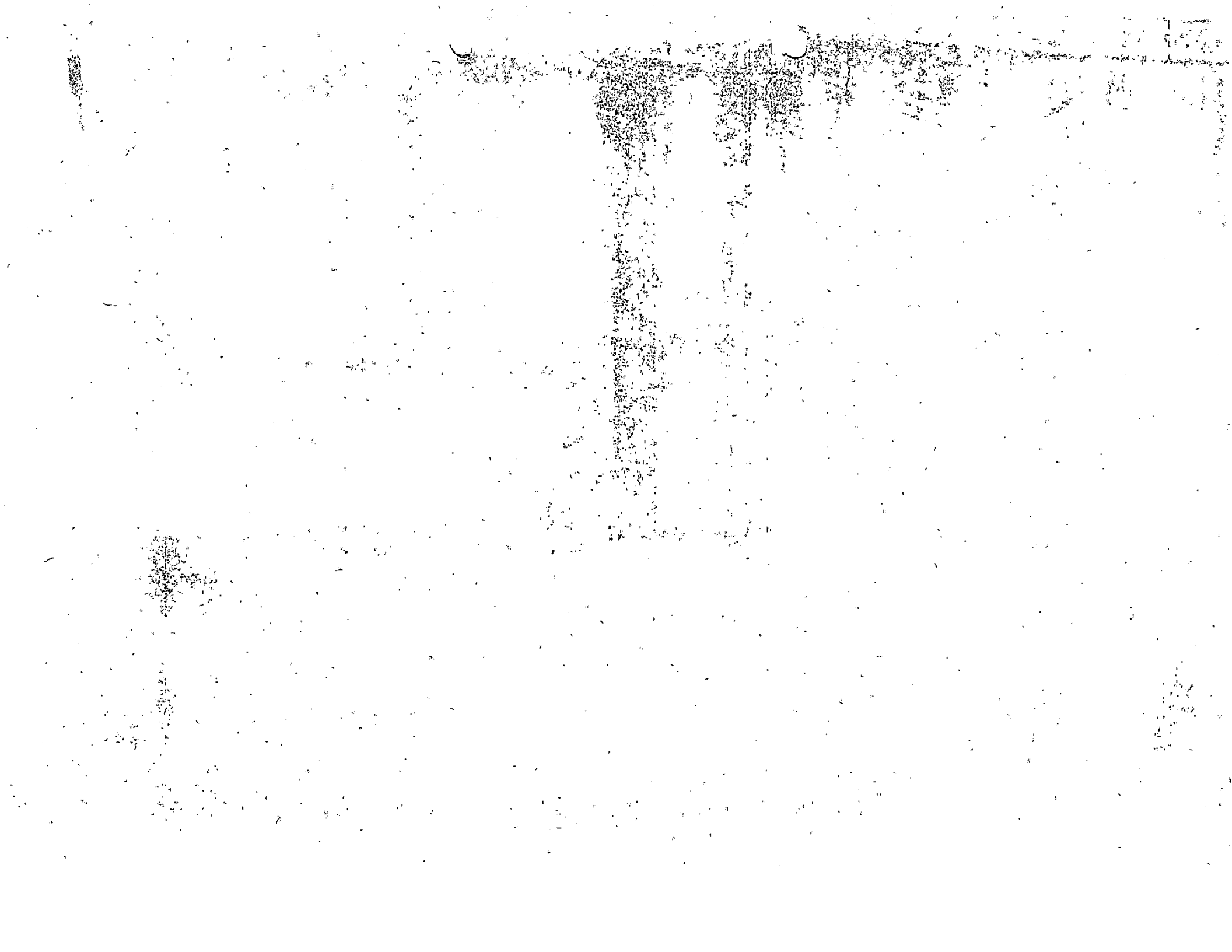
Advised attend A/E XH this evening. She was intendin doing this, and quite happy to go.
With thanks.

Prescription Items:

Diagnosis:

Hard to say if DVT or not, and from hx physical examination probably would add little/affect management.
Has at least a couple of risk factors for DVT and best get screened for this with symptoms.

Agency Questions and Answers



SCANNED ☑

CROSSHOUSE HOSPITAL
EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

A/E No: XH-09-065503-1

CHI No: 3010776241

Date: 27 Dec 2009 **Time:** 17:05

Consultant: Dr David Chung

GP
W Campbell

BOURTREEHILL HEALTH CENTR
CHEVIOT WAY

Incident Date: 27 Dec 2009
Incident Time: 17:05

Martial Status: Married / civil partner

Sex: F

MORRIN
Caroline

Date of Birh: 30 Oct 1977 **Age:** 32 Years

Address:
26 LEWIS TERRACE
IRVINE

Next of Kin:
Brian Welsh
26 LEWIS TERRACE
IRVINE

Partner
Home Tel: 215887

Religion: None

Previous Attendance Count: 1

Phone Numbers:
Home: 215887

Employer/School
nac

Accompanied By:
Partner

Special case

Triage Time 17:16 **Triage Nurse** Carol McNeil **Triage Group** Yellow

Resp Rate	02 Sat%	PFR
12	98	

Pulse	BP	E	M	V
96	136/82			

Allergies: Not Known

BMstix **Alcohol** **Temp** 37.5 **Weight**

R L

Pain Score (Triage)

Pain Score (Discharge)

Triage details
pt with painful lt calf..nhs 24 referral ? DVT

Treatment
Advice - verbal

Special Needs
NONE

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed.....Witness.....Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....

Disch A+E clinic Paed Tr. # eye ENT Max Facial Ward OP Ward IP

XH-09-065503-1

A/E No. XH-09-065503-1

Drug	Dose	route	time/frequency	signature	quantity/given by

DOCTOR / ENP: JUMIT GAJREE Time: 7:20 pm

See DVT COV sheet

Clinical Decisions Unit (CDU)
Suspected Deep Venous Thrombosis (DVT)- Ambulatory Care

Patient Addressograph

MORRIN Caroline

Ne 26 LEWIS TERRACE, IRVINE

Co

Alt DOB: 30/10/1977

Date & Time of arrival in A/E- 27/12/2009 17.05

Date & Time of arrival in CDU- 2040 27/12/09

Date & Time left CDU ☑ Discharged

2140 27/12/09

☐ Admit Medical/ Resp

☐ Admit HDU

☐ Admit other speciality

Please ensure that the patient fits the criteria for pathway management as outlined below

Inclusion Criteria (Ambulatory Care Management)	☑ Clinical suspicion of Deep Venous Thrombosis ☐ **Thrombophlebitis with clinical suspicion of DVT- must have d-dimer performed**
Exclusion criteria (requires admission to AMAU)	☐ Unable to attend as OP- immobility, no contact number, cognitive impairment- discuss with CDU staff if unsure ☐ Pregnancy (with discretion) ☐ Severe, uncontrolled hypertension (with discretion) ☐ Massive leg swelling and suspected PTE (consider PTE pathway) ☐ Significant **active** co- morbid disease ☐ Known bleeding tendency- discuss management with haematologist ☐ **Rule out Charcot's joint in patients with diabetes** **Please note that patients from Nursing Home care are singularly not excluded from Ambulatory Care- discuss with Clinical Decisions Unit staff.**

Reviewed by Ashley Strannigan Dec 2009

MORRIN Caroline
26 LEWIS TERRACE, IRVINE

DOB 30/10/1977

Management Protocol- Ambulatory Care

Presentation	**Suspected Deep Venous Thrombosis**
Management in A&E	☑ Assessment by Medical Staff; Review history and examination **Investigations:** ☑ Venepuncture- FBC; U&E's; D-dimer; LFT's; ESR; CRP; Blood glucose **Observations:** ☑ MEWS; Pain Score **Medical Management** ☑ Wells Clinical Probability Score; Analgesia
Management in CDU	**Observations:** ☑ MEWS; Pain Score; Calf measurements ☑ Weight (in kgs)- **Investigations:** ☑ Venepuncture- FBC; U&E's; D-dimer; LTF's; ESR; CRP; Blood glucose; ☐ MRSA screen **Treatment:** ☑ Wells Clinical Probability Score ☐ Risk Factor Stratification. **Assign probability score and apply to the Decision Flowchart for suspected DVT on page 4.**
Criteria for admission (at any time)	☐ Patient develops any of the exclusion criteria on page 1 ☐ Unstable patient ☐ Discuss abnormal blood results

MORRIN Caroline
26 LEWIS TERRACE, IRVINE

DOB: 30/10/1977

Discharge Criteria- Ambulatory Care

Criteria for discharge from the DVT service (after any review)	☑ Low/ moderate Clinical Probability Score combined with a D-Dimer < 500 (consider alternative diagnosis prior to discharge) ☐ Ultrasound scan negative ☐ Rescan negative **Differential diagnosis, please treat as:** Refer to rheumatology Yes/ No; Arterial insufficiency Yes/ No Cellulitis Yes/ No; IV/oral antibiotics Yes/ No Superficial thrombophlebitis Yes/ No; Refer to vascular surgery Yes/ No Musculoskeletal Yes/ No; No further investigation Yes/ No Refer to G.P Yes/ No; Other (please specify) Sciatica **Please note Bakers Cyst diagnosis should follow the complete treatment plan as a suspected DVT and is not on first scan an alternative diagnosis.** ☑ Patient advised of diagnosis and treatment plan ☑ Painfree with/ without analgesia ☑ Letter to G.P. ☑ Social circumstances permit discharge
Criteria for discharge from DVT service- **Positive DVT**	**Patients with a positive diagnosis of DVT should meet the following criteria prior to discharge from the DVT out-patient service:** ☐ INR >/ = 2 for two consecutive days ☐ Counselling on warfarin therapy has taken place ☐ Warfarin dose prescribed for discharge ☐ Painfree with/ without analgesia ☐ Patient is compliant and safe with warfarin therapy ☐ Appointment made for anticoagulant clinic/ follow up arrangements made with GP/ District Nurse ☐ Patient advised of diagnosis and treatment plan ☐ Assess need for thrombophilia screen ☐ Letter to G.P. ☐ Social circumstances permit discharge
Criteria for discharge from DVT service- **Positive DVT unable to warfarinise**	**Patients with a positive diagnosis of DVT who have been assessed as unsafe to be anticoagulated with warfarin should meet the following criteria prior to discharge from the DVT out-patient service:** ☐ Identify competent other responsible for administration of daily LMWH injection or education on self administration ☐ Two week supply of Low Molecular Week Heparin ☐ Painfree with/ without analgesia ☐ Appointment made for first platelet check after 7- 10 days of daily LMWH injections. ☐ Patient advised of diagnosis and treatment plan ☐ Assess need for thrombophilia screen ☐ Letter to G.P. ☐ Social circumstances permit discharge
District Nurse/ Nursing Home anticoagulation	**If District Nurse continuing anti- coagulation** ☐ Appropriate supply of LMWH injections ☐ Copy of prescription ☐ Copy of immediate discharge prescription ☐ Painfree with/ without analgesia ☐ Communication with DN/ Nursing Home re; management plan ☐ Patient advised of diagnosis and treatment plan ☐ Assess need for thrombophilia screen ☐ Letter to G.P. ☐ Social circumstances permit discharge

Determining the clinical probability of DVT (Well's criteria)

MORRIN Caroline
26 LEWIS TERRACE, IRVINE
DOB: 30/10/1977

Left Calf (cm)-	Right Calf (cm)-
46.5 cm	46.0

Criteria	Points	Score	Points	Score
Active Cancer(treatment ongoing or within previous 6 months or palliative)	1	0	1	0
Paralysis, paresis or recent plaster immobilisation of lower extremities	1	0	1	0
Recently bedridden for more than 3 days or major surgery within last 4 weeks	1	1	1	1
Localised tenderness along distribution of deep venous system	1	1	1	1
Entire leg swelling	1	0	1	0
Calf swollen by > 3cm compared to asymptomatic leg (10cm below tibial tuberosity)	1	0	1	0
Pitting oedema (greater in symptomatic leg)	1	0	1	0
Collateral superficial veins (non varicose)	1	0	1	0
Pregnant or on OCP/HRT	1	0	1	0
Previous DVT/PTE	1	0	1	0
Alternative diagnosis as likely or greater than that of DVT	-2		-2	
TOTAL SCORE		2		2

Interpretation of Well's criteria score:

Score (points based on Well's score)	Probability of DVT
> or = 3	High
1 – 2	Moderate ✓
0	Low

Wells Score 1- 2 Date/ Time 27/12/2009 1920

Name SUMIT GAJREE F42 Signature

Wells Score 2- 2 Date/ Time 27/12/09

Name CLOUTTS Signature

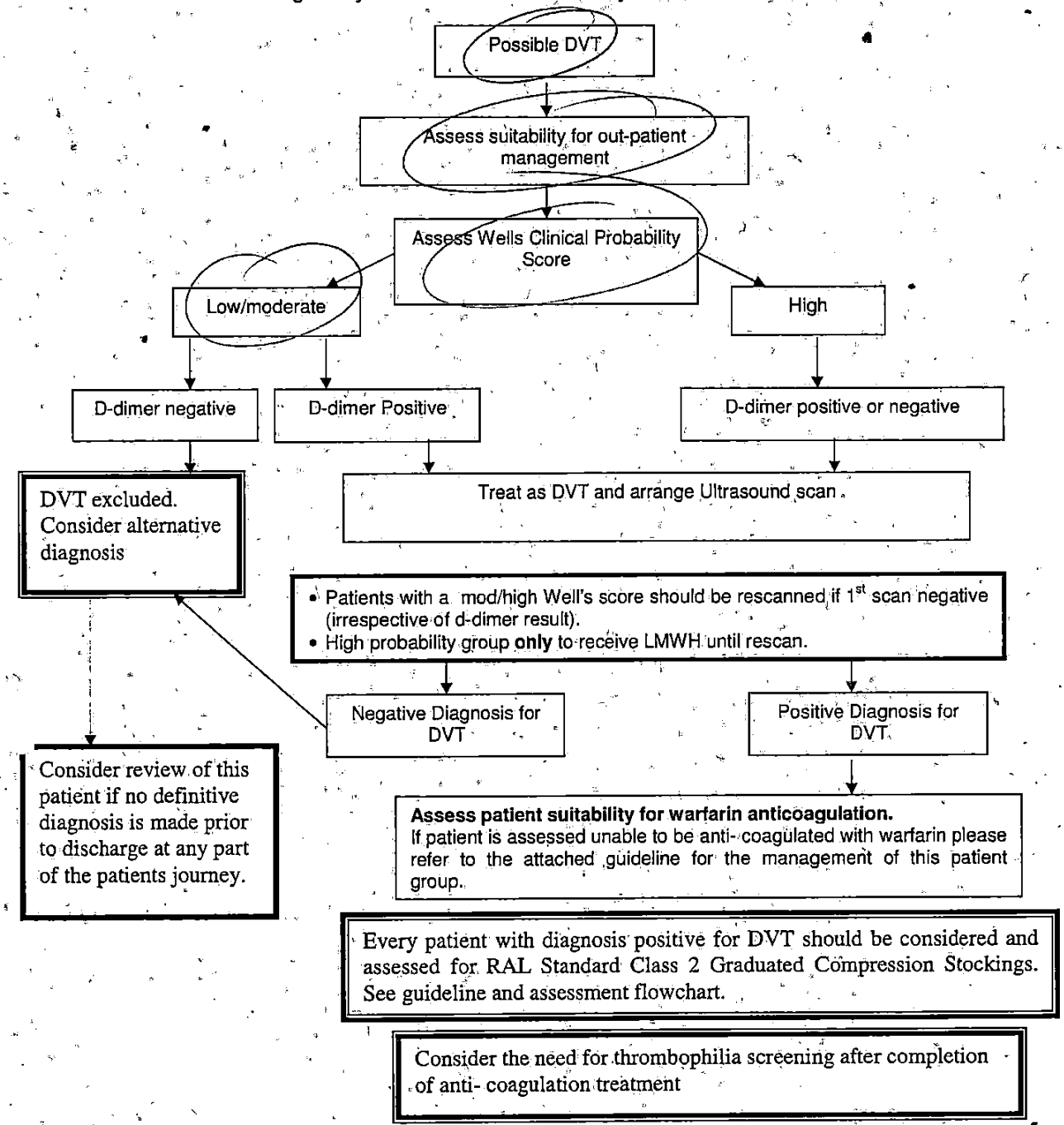
Reviewed by Ashley Strannigan Dec 2009

XH-09-065503-1
MORRIN Caroline
26 LEWIS TERRACE, IRVINE
DOB: 30/10/1977
3010776241

Suspected DVT– Decision Flowchart

LOW [ ] MODERATE [✓] HIGH [ ]

Please proceed management of the patient using the decision flowchart based on the clinical probability assigned by the Wells Clinical Probability Score and D- Dimer result.



Reviewed by Ashley Strannigan Dec 2009

XH-09-065503-1

Ensure the appropriate patient information leaflet is g journey.

MORRIN Caroline
26 LEWIS TERRACE. IRVINE
DOB: 30/10/1977
3010776241

Medical Notes – Deep Venous Thrombosis

If the patient is assessed as being unsafe/ at risk of incompliance with warfarin therapy please refer to the attached guideline for the management of this patient group- IVDA's; Alcohol Abuse; Cognitive Impairment; Poor Venous Access; at risk of falls; Active cancer or active treatment of cancer.

Date and time 19.20 27/12/09

Presenting complaint
Pain in (L) calf for 3 days. °radiation. slight swelling. dull ache constantly present.
°cough, °CP, °SOB
°can walk fine. also c/o pain in lower thigh

Past Medical history

Past History			
Recent pelvic floor operation 24/11/2009 not been wearing teds har been mobile. previous laparotomy appendicectomy	Previous admissions with ?DVT	☐ Yes	☑ No
	Previous admissions with proven DVT	☐ Yes	☑ No
	Previous admission with proven PE	☐ Yes	☑ No
	Previous admissions to CDU	☐ Yes	☑ No
	Other – please specify	☐ Yes	☐ No

Smoker	Reason not for warfarin therapy	POD's Yes/ No Consent to use POD's Yes/No
NO	NO	

Risk factors for Deep Venous Thrombosis

Risk factors	Yes	No	Comments
History of immobilisation		✓	
Recent surgery (within the past 4 weeks, note type of surgery)	✓		Pelvic floor surg (GA)
Cancer (within the past 6 months or on palliative care)		✓	
Lower limb problems (trauma or mobility problems eg. Paralysis)		✓	
Pregnancy or < 6 weeks post natal		✓	
Medical illness		✓	
Thrombophilia (eg. Protein S, Factor V Leiden)		✓	
Strong family history of DVT/PE		✓	
Previous history of objectively diagnosed DVT/PE		✓	
Oestrogen containing contraceptive pill or hormone replacement therapy		✓	
IV drug use		✓	
Recent long journey (in last 4 weeks) - > 6 hours in duration		✓	

rshire
& Arran

Multidisciplinary Medicines Recor

Must be started by Admitting Clinician

Source of Information (Use at least two sources) (Tick)

Patient	✓	Emergency Care Summary	
Relative/Carer		Nursing Home Chart	
Patient's Own Drugs		Previous Discharge Letter	
GP Referral Letter		Repeat Prescription slip	
GP Practice		Other (Please state)	

MORRIN Caroline
26 LEWIS TERRACE, IRVINE

DOB: 30/10/1977

Admission Medicines			Action Note: Unless otherwise indicated below, medicine should be continued onprescription sheet				
Name, Form, Route (specify if not oral)	Dose	Frequency eg 3X	Suspend	Amend	Stop	Comments (if medicine suspended, amended stopped or inaccurate)	Pharm initials
NIL MEDS							

OTC/ Herbal/ homeopathic/ illicit substances	Further information eg compliance aid, recent discontinued medicines

Adverse Reactions/Allergies
None Known ✓

Medicine/ Substance	Reaction

Are you satisfied this medication history is complete and accurate? Yes ✓ No ☐

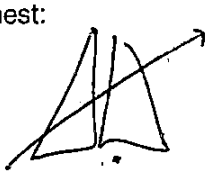
If **No** what further action is necessary (Contact GP etc) ..... Tick when resolved ☐

Reviewed by Ashley Strannigan Dec 2009

Examination Findings

Date and Time 27/12/09 1925

General: looks comfortable
RR 12 SpO2 98% RA. HR 96 BPM (N) 136/82 37°

Chest: 
clear
good air
nil added

CVS: HR I + II + 0
JVP ←

Abdomen:
overweight
appendix scar
soft + non-tender
+ marrer.

Other:
(L) ? slightly more swollen than (R)
not red + not tender
size (L) = 46·8 size (R) = 46·0

Impression/ Diagnosis	Management Plan
? DVT home if D-dimer (-ve)	1. IV access + bloods inc d-dimer 2. CXR, ECG. → Sinus rate 83 3. → Nil focal · nil acute 4.

Signature ..... Print Name SUMIT GANDHI Page No .....

Date 27/12/09 Time 1940

MORRIN Caroline
26 LEWIS TERRACE. IRVINE
DOB: 30/10/1977

Investigations Performed

	Nurse signature	Area performed	Time performed	Reason if not performed
FBC, Us&Es , CRP,ESR & BG		A1E	2030	
Clotting screen		A1E	2030	
D-Dimer		A1E	2030	
Lower Limb Ultrasound (1)				
Lower Limb Ultrasound (2)				
Other (Please specify)				

Investigation results

	Result	Signature	Date/ Time	
Urea	5·0			D-Dimer 2031 27/12/09 209
Creatinine	71			
Sodium	141			Lower Limb Ultrasound (1)- Date
Potassium (must have result prior to commencing LMWH)	3·9			
Chloride	104			
Bicarbonate	26			Lower Limb Ultrasound (2)- Date
Hb	13·6			
WCC	9·1			
Platelets (must have result prior to commencing LMWH)	254			Other (please specify)
PT	10			
INR				
Fib	277			Blood Glucose
APTT	27			Weight
CRP				Right Calf Left Calf

Reviewed by Ashley Strannigan Dec 2009

MORRIN Caroline
26 LEWIS TERRACE, IRVINE
DOB: 30/10/1977

Risk Assessment

All risk assessments to be completed in full during stay in CDU

Risk Assessment	Signature	Date/ Time
MRSA		27/12/09 2000
Cotsides		
Falls		
MUST (consider reason for admission and individual patient condition)		

In addition all risks assessments to be completed in full prior to admission to any ward area from CDU

Risk Assessment	Signature	Date/ Time
MUST		
Waterlow		
Moving and Handling		

Before applying Graduated Compression Stockings assess for signs of arterial insufficiency/ disease and consider appropriateness of Graduated Compression Stocking.

Sizing of Below Knee Graduated Compression Stockings for patients diagnosed with DVT.

1- RAL Standard Compression Class 2- 23- 32mmHg

2- Measure length- Standard/ Petite cm

3- Measure calf- cm

4- Measure ankle- cm

5- Mediven Plus- Open toe Mediven Elegance- Closed toe Mediven Active

6- Colour preference

7- Identify stocking Size _____ Colour_____

8- Pip code _____

XH1466693
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE,
CHEVIOT WAY,
CHI 3010776241

Risk Assessment

All risk assessments to be completed in full during stay in CDU

Risk Assessment	Signature	Date/ Time
MRSA		
Cotsides		
Falls		
MUST (consider reason for admission and individual patient condition)		

In addition all risks assessments to be completed in full prior to admission to any ward area from CDU

Risk Assessment	Signature	Date/ Time
MUST		
Waterlow		
Moving and Handling		

Before applying Graduated Compression Stockings assess for signs of arterial insufficiency/ disease and consider appropriateness of Graduated Compression Stocking.

Sizing of Below Knee Graduated Compression Stockings for patients diagnosed with DVT.

1- RAL Standard Compression Class 2- 23- 32mmHg

2- Measure length- Standard/ Petite cm

3- Measure calf- cm

4- Measure ankle- cm

5- Mediven Plus- Open toe Mediven Elegance- Closed toe Mediven Active

6- Colour preference

7- Identify stocking Size _____ Colour_____ Pip code _____

XHI466693
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE,
CHEVIOT WAY,
CHI 3010776241

Free text page (for use by all staff in CDU

Date/ Time	Comments/ Notes	Signature
27/12/09 2040	Admitted to CDU with ? DVT (L) leg has had ↑ pain and swelling for past 3 days. Patient has had recent pelvic floor op 4/52 ago. Moderate Wells score = 2. IV access ✓ await D-dimer level.	
2125	D-dimer 209 patient informed of same, awaiting medical review	
27.12.09 2130	HAVE DISCUSSED RESULTS & DW B. HAPPY TO GO HOME & ANTICOAGULATION TO L LEG PAIN AS DVT EXCLUDED HAS CONTACT CNS IF HOME. TO SEE GP IF ONGOING PROBLEMS & STATIC NERVE IRRITATION. Dr Gowri Pathmanathan	ST3 A&E
27/12/09 2130	As above, discharged home. Advised to see GP if symptoms persist, probable sciatica, patient has own analgesia at home. Discharged, no follow-up required.	

Patient's name/addressograph

Free text page (for use by all staff in CDU

Date/ Time	Comments/ Notes	Signature

Patient's name/addressograph

Free text page (for use by all staff in CDU

Date/ Time	Comments/ Notes	Signature

XHI466693
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE,
CHEVIOT WAY,
CHI 3010776241

NHS Ayrshire and Arran – Crosshouse Hospital

Clinical Decisions Unit – Discharge Sheet

Please document the patient's journey here:

Admitted to Ward(state ward)	✓	Discharged home	YES
Reason for admission	✓	Date/Time discharged	2140 27/12/09
Time left CDU	2140	Out-patient clinic (specify)	GP

If patient is discharged please complete the following checklist BEFORE discharge:

MOBILITY independant	PERSONAL CLEANSING AND DRESSING independant
EATING AND DRINKING independant	SOCIAL SERVICE (Does care package require to be recommenced) NURSING HOME independant
DISTRICT NURSE ✓	TRANSPORT has own.
DISCHARGE PRESCRIPTION Date & Time written..... Date & Time available.....	Patient counselled on present and new medicines YES ☐ NO ☐ Signature
OUT PATIENT ARRANGEMENTS MADE N/A	DISCHARGE ADVICE Advised to see GP if symptoms persist or worsen
COMMUNICATION WITH GP ✓ IMMEDIATE DISCHARGE LETTER ✓	PATIENT INFORMATION LEAFLET ✓

Discharging Nurse
Signature.....Print Name.....Date/ Time.....27/12/09 2140

Reviewed by Ashley Strannigan Dec 2009

STA 0216

Write or attach label

HC
XHI466693
Cl MORRIN CAROLINE
St 26 LEWIS TERR
IRVINE
Fc KA11 1HJ 30/10/1977
Ac Dr. J NELSON
BOURTREEHILL HEALTH CENTRE,
CHEVIOT WAY,
Da CHI 3010776241

OTOLARYNGOLOGY

DATE

23/5/19

HISTORY

31 ... GAH - Ung NSAIDS

S→D since childhood — ric Ci x1/year x1/year
white spots.

Voice: hoarse ca 4x glucose

3rd
cable
non-smoke

EXAMINATION

General

Nose

Mouth and Pharynx

Y, prom

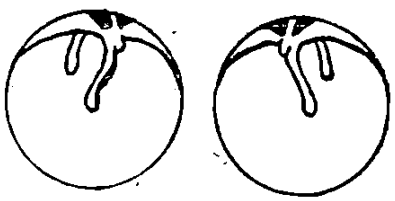
Post Nasal Space

Neck

Larynx

Ears

R. L.



TREATMENT

(D)

4McC/73758

DATE

WRITE IN PRINT OUTPATIENT LABEL

Surn XH 466693

Fore MORRIN, CAROLINE

Addr 4 CRAIGNAW PLACE
IRVINE
KA11 1EZ

... 30/10/1977

War DR I JAMIESON
THE SURGERY
AYRSHIRE CENTRAL HOSPITAL
CHI 3010776241

STA 0216

DATE

28/11/06

HISTORY

GP ref. Career x 2½

Pg Intermittent dysphonia

URTI at present

x 3/12. varies in severity

No Pain No dysphagia

Recurrent Tonsillitis 2-3/yr

PMH nil of note

non-smoker

EXAMINATION

General

Some tightness in chest.
- seeing GP at present ? stress.

Anxious ++ hoarse

omeprazole - GORD now resolved

Thyroid OL in past.

Nose

AR: - some Alar collapse.

Mouth and Pharynx

large T's.

Post Nasal Space

Fibreoptic: ⊖ side
Catarrh ++
General inflammation

Neck

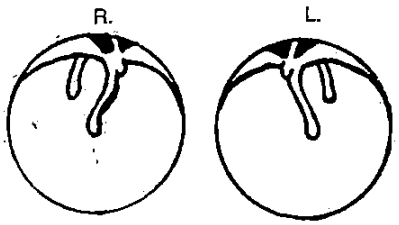
✓

Larynx

No clear view

Ears

R. L.



TREATMENT

Rev. 3/52

Voice care leaflet EMS

? spray nose next time

ENT LARYNGOLOGY

IMcC/81654

DATE
19.12.06

29 ♀
4/52 change in voice 3-4/12

PMH: Reflux: Losec.

Fluctuates.
Bloods OK.

Allergy: Nil

Voice - use +

Reflux +

No dysphagia

Non Smoker

Carer.

O/E Strained voice.

T N (N)

Flexiscope (LA spray) difficult.
Bilateral vocal nodules. nil else

- Adv
- ct Losec
- Speech Rx
- ? Review after SALT

M

AYRSHIRE AND ARRAN HEALTH BOARD

STA 0216

XH 466693

Surname... HARMON CAROLINE
Forenames.. 10A LUNDHOLM ROAD
Address.... STEVENSTON
KA20 3AB
30/10/1977
DR A DAS
STEVENSTON HEALTH CENTRE
Ward or Dep STEVENSTON
CHI 3010773188

OTOLARYNGOLOGY

DATE

29.9.99

HISTORY

Hearing Tests for few years.
Very 3 months → Ventilation tube

EXAMINATION

General

Nose ✓

Mouth and Pharynx

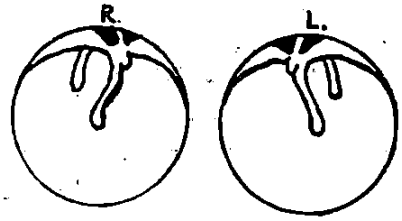
Tonsils

Post Nasal Space ✓

Neck No lumps

Larynx

Ears



TREATMENT

SF December

DATE
29.12.99 FTR

27/12/00 RSVP
Still Hbled.
X4 in 1yr

W/L T's op risks explained.

07833 874 909.

01294 ~~⊠~~ 216008 (mother)

PHARMACY
CDs

ENT ADMISSION FORM

(Adult)

NON8167

Name: Unit No: XH 466693

Address: HARMON CAROLINE
29(H) SLOAN AVENUE
IRVINE
KA12 0HR

D.o.B. 30/10/1977

DR.C MACDONALD
TOWNHEAD SURGERY
6/8 HIGH ST
CHI 3010773188

DATE: 8/1/01

AGE: 23 **SEX:** M/F F

Surgeon : Singh ☐ Sood ☐ Mr Warnock
Afzal ☐ Shanks ☐
Dempster ☐ Gaikwad ☐

Type of Admission: Emergency ☐ Routine ☑ Day Case ☐

PROCEDURE: TONSILLECTOMY

HPC hx tonsillitis, + hospital admission with
tonsils (down in England 3wks ago)

PMH (Surgical) Appendix
Impetigo
Acute Abdo - V. similar

(Medical) MI ☐ IHD ☐ CVA ☐ HBP ☐ RhF ☐
DM ☐ Epil ☐ Asth ☐ COAD ☐ TB ☐

Other: Nil

DH Allergies: None

Drugs: None

SH Smoker: Y/N ..... cpd Alcohol: nil ☐ occ ☑ mod ☐ heavy ☐

Occupation ..... Lives with: Dad

Otolaryngology

EXAMINATION Apyrexial ☐ ✓ Pyrexial ..... °C

J ☐ A ☐ Cy ☐ Cl ☐ Ly ☐

Specify: .....

CVS P: 80 reg/~~irreg~~ BP: [/]

HS: I + II + 0

Other: .....

RESP Chest: Clear ☐ ✓

	R	L
A/E:	☐ ✓	☐ ✓
Crepit:	☐	☐
Ronchi:	☐	☐

Other: .....

ABDO

Soft ☐
Non-Tender ☐
NAD ☐

Other: .....

ENT A, above

Check List

FBC ☐ CXR ☐ Consent ☐ ✓
U&E ☐ ECG ☐ Kardex ☐
X-match ☐

Signature: ..... Date: 8/1/07

WRITE IMPRINT OR ATTACH LABEL

Su XH 466693 No. A

Fo HARMON. CAROLINE
29(H) SLOAN AVENUE
Ac IRVINE
KA12 0HR
...
W 30/10/1977

DR.C MACDONALD
TOWNHEAD SURGERY
6/8 HIGH ST
CHI 3010773188

STA0149

DATE

2000hrs ATSP re: vomiting ++.
1½hr Hx of vomiting - No blood
Previously well
Abd pain - initially upper abd now generalised
lower abd pain
- colicky
- intermittent
- relieved ⊂ vomiting

1x episode of diarrhoea
Feels constipated.
Last Menstrual period 2/52 - ⓐ
No previous episodes
last past urine ~½hr ago

Ate. Egg Mayonaise sandwich
· Steak pie - tea.
Cu IUCD in situ
No smell / dysuria / ↑ frequency

PMH - Appendicectomy
Laparotomy

O/E Pale BP Pulse 80
Anuria ++

Soft abd
BS present - No abnormality
Generalised tenderness

PR - non tender.
- small firm faeces present
- Nil else

imp: ?Viral
?Subacute obstruction.

· Urine hCg.

plan: · IV Metoclopramide · O_2
· IV Morphine · FBC / U+Es / Amylase / LFTs
· IV Fluids · CXR / AXR

OTOLARYNGOLOGY

DATE
09/01/01

Wk. Sp leg.
Settling -
Further episodes of N + V 7D.

plan: - Clear fluids
- Observe
Check Bloods ✓

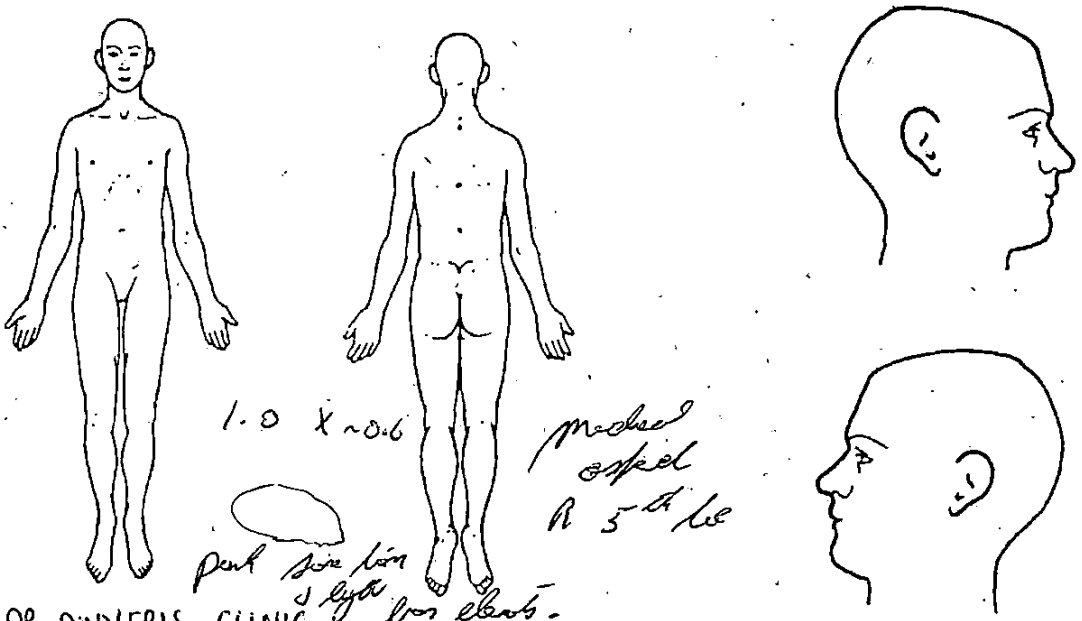
SHO
OAKES

XH 466693

Surname MORRIN CAROLINE
Forenam 26 LEWIS TERR
IRVINE
Address KA11 1EZ 30/10/1977
DR.R WAGNER
CHEVIOT WAY
Ward or BOURTREEHILL HEALTH CENTRE
CHI 3010776241

STA 0128

DATE



Medical aspect R 5th toe

OR DWYERIS CLINIC

30/5/08

(SO) (N) GP referral. Pearl all life

+ -> changing mole inbetween 2 toes on her (R) foot

-> doubled in size over the last 10 years Gradual enlarged over 10 yrs

-> °itch, °pain, °bleeding. No recent change.

-> °FH of melanoma Pt says forgets on TV drops eldest

-> Foreign travel with SP (factor 20) Not aware of any side

-> Can burn easily. Podvol ointment cream bowel re G.P.

PMH nil of note DH Omeprazole 20mg.

Reductol

Holiday sen Pt Thinks, Skin heels once Home care

GP felt mis was a benign naevus + Athlete's foot.

She has not used any canestan cream since this consultation.

OE R foot

1cm naevus (speckled pigmentation)

irregular outline

imp ? benign

Probable benign naevus

Some variability, but not obviously sinister

? Herbert

DERMATOLOGY

cCJ51489

DATE

Plan Overlewood sch

For punch biopsy

✓ photo

7.6mm Barrier

4/12 Please re off ✓ vessel

8/7/18 Punch biopsy 6mm done

Aseptic technique

Consent obtained

Sample sent histology

No micro ops noted

25/9/18 DNA P.B.

NHS Ayrshire & Arran

WRITE IMPRINT OR ATTACH LABEL

Surn
Fore: CHI 3010776241
MORRIN CAROLINE
Addr: 26 LEWIS TERR
IRVINE
KA11 1EZ
30/10/1977 Pract 80306
Ward Case Ref 466693

Checklist for Staff Disposing of Sharps

PLEASE REMEMBER MULTIPLES OF EQUIPMENT MAY HAVE BEEN USED DURING THE PROCEDURE

Please remove and dispose of the following

	Yes	No	Not applicable
Surgical blades	☑	☐	☐
Suture needles	☑	☐	☐
Disposable punches	☑	☐	☐
Disposable curettes	☐	☐	☑
Needles	☑	☐	☐

All sharps removed safely and correctly

Signature..... Date 8/7/8

DT

DERMATOLOGY SURGERY
Procedure Notes

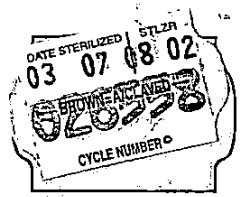
HCR No:
CHI No: CHI 3010776241
Surname: MORRIN CAROLINE
Forename: 26 LEWIS TERR IRVINE KA11 1EZ
Address: 30/10/1977 Pract 80306 Case Ref 466693
Date of Birth:

Date 8/7/18
Procedure PUNCH BIOPSY
Site RIGHT medial aspect 5th toe

Local Anaesthetic		mls
2% Xylocaine & adrenaline 1:200,000	☐	
1% Xylocaine & adrenaline 1:200,000	☐	
2% Xylocaine plain	☐	
1% Xylocaine plain	☑	2

Notes

Aseptic technique
Consent obtained
Sample sent for histology



Sutures

Subcuticular	☐	Number	Type .....
Cuticular	☑	Number 3	Type 4-0 Ethilon
Removal		Days 7	(GP) / Dermatology unit

Follow-up Yes / (No)

Signed (Healthcare professional) ..... PRINT Clinton

Job Title FY2 TAR

DERMATOLOGY SURGERY CHECKLIST

Department of Dermatology
NHS Ayrshire & Arran

HCR
CHI: CHI 3010776241
Surna: MORRIN CAROLINE
Foren: 26 LEWIS TERR
Addr: IRVINE KA11 1EZ
30/10/1977 Pract 80306
Case Ref 466693
Date of Birth: _____

Procedure of PUNCH BIOPSY
Site RIGHT MEDIAL ASPECT 5th toe

The following have been discussed with the patient

- Medication
  - Taking aspirin — Yes / (No)
  - Taking warfarin — Yes / (No)
  - Stop warfarin — Yes / No / (NA)
  - Pacemaker — Yes / (No)
- Allergy to:
  - Local anaesthetic — Yes / (No)
  - Rubber / latex — Yes / (No) → Rubber gloves causes dermatitis after prolong use.
  - Dressings / adhesives — Yes / (No)
  - Others .....
- Site of surgery agreed — (Yes) / No
- Risks associated with skin surgery:
  - Scar, which may be prominent — (Yes) / No
  - Wound break-down — Yes / (No)
  - Recurrence — Yes / (No) / NA
  - Infection — Yes / (No)
  - Bleeding — Yes / (No)
  - Wound care advice - written leaflet — (Yes) / No

Signed (Patient or Guardian) X C Morrin PRINT .....

Signed (Healthcare professional) [signature] PRINT Chung

Job Title F7STAR

Date 8/7/18

CONSENT FOR PROCEDURE

STA1058

Write or attach label

HCR No.

CHI 3010776241
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1EZ
30/10/1977 Pract 80306
Case Ref 466693

I .....of .....

.....hereby consent to

* undergo / the submission of my

* child / ward .....

the procedure of PUNCH Biopsy - (R)ight medial toe (5th)

the nature and purpose of which have been explained to me by

Dr./~~Mr.~~* CMorrin

I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned procedure and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to section 1 (2) patients.)

Date 8/7/18 Signed X CMorrin
(Patient/Parent/Guardian)*

I confirm that I have explained the nature and purpose of this procedure to the patient/parent/guardian.*

Date 8/7/18 Signed
(Medical/Dental Practitioner)*

*DELETE AS APPROPRIATE

Note: This form is not to be used for any procedure where there is a specific consent form with explanations.

Any deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature.

CONSENT FOR PROCEDURE

JMcC/80940

XH 466693

Surname ..	HARMON CAROLINE
Forenames	41CRAIGNAW PLACE
Address ...	IRVINE
.....	KA11 1EZ 30/10/1977
.....	DR.C JOHNSTON
STA0238 Ward or De	CHEVIOT WAY
	BOURTREEHILL HEALTH CENTRE
	CHI 3010776241

DATE
4.6.02

Ht - 5ft 7ins
Wt - 16st (101.6kgs)
Urine - NAD
33/52 ↳ 7-d preg.
PH Nil
NBP — settled when pregnancy
FH: CVA — family ; neuro family
Dad MI
Drugs O
Non Smoker
Minimal Caffeine
Attacks ↑ fast HR + tantrum / pre syncope
feels like no O2 / falling ↓ BP / brain + panic
HR → more panic → breathless → dizziness
Calming down.
— ↓ event
HR - rate labile 110 → 70
BP 120/68
chest ✓ no murmurs
ECG
24 h tape

DATE

33 ENT Clinic Horley 2-15PM COA & GP

Hospital use Only | Clinic Mr. Wardop | Day Date 27/11/00 | Time | Hospital No. 466693 | GP112

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category: Routine ☐ Soon ☐ Urgent ☐

Hospital CROSSHOUSE Date 26/10/00 | CHI No: 6241

Please arrange for this patient to attend the ENT clinic of Dr/Mr

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Patient's Surname HARMON | Maiden Surname

First Names CAROLINE | Single/Married/Widowed/Other

Address 29H SLOAN AVENUE | Date of Birth 30/10/77

IRVINE | Patient's Occupation

KA12 0HR

Postal Code | Contact telephone number

Has the patient attended hospital before? YES / NO If "YES" please state:

Name of Hospital

Year of attendance | Hospital No.

If the patient's name and/or address has/have changed since then please give details:

Name, Address and Telephone number of MEDICAL / DENTAL PRACTITIONER

Dr C MacDonald
Townhead Surgery
6/8 High Street
IRVINE KA12 0AY

Tel: 01294 273131

Please use rubber stamp

Can patient attend at short notice? YES / NO

If YES, minimum notice required days

CONSULTATION & MANAGEMENT -LC

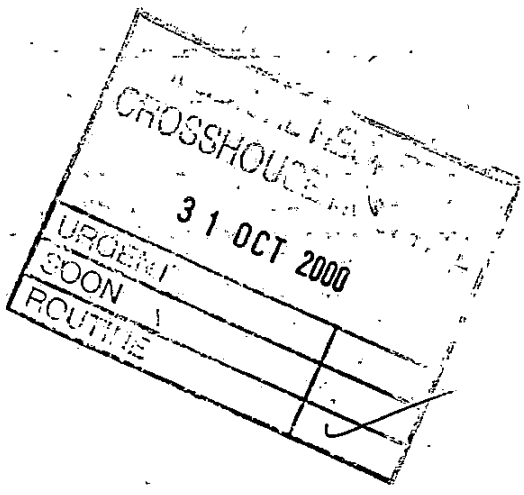
80344

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

Dear Dr

I understand this lady attended your clinic in the past with trouble with her throat and consideration at that time was being given to tonsil removal but it was deferred. Miss Harmon is once again being troubled by her throat and has very angry, nasty and unhealthy looking tonsills and I wonder if she could be seen for consideration of tonsil removal.

Yours sincerely



Diagnosis / provisional diagnosis:

Present drug treatment and potential special hazards:

X-ray (women of childbearing age). Date of first day of L.M.P.

Relevant X-rays available from: No. (if known)

Signature

355-2104

CoA
CGP

29

Hospital use Only | Clinic Singh ENT | Day Date Wed 29/9/99 | Time 3.10 | Hospital No. NN 466693 | GP112

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category
Routine ☐ Soon ☐ Urgent ☐

CHI No.

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Hospital CROSSHOUSE Date 11.8.99

Please arrange for this patient to attend the E.N.T. clinic of Dr/Mr

Patient's Surname HARMON Maiden Surname

First Names CAROLINE Single/Married/Widowed/Other

Address 10A LUNDHOLM ROAD Date of Birth 30.10.77
STEVENSTON

Patient's Occupation

Postal Code KA20 3AB Contact telephone number

Has the patient attended hospital before? YES / NO If "YES" please state:

Name of Hospital New Patient To Area

Year of attendance .... Hospital No. ....

If the patient's name and/or address has/have changed since then please give details:

Can patient attend at short notice? YES / NO

If YES, minimum notice required ..... days

Name, Address and Telephone number of MEDICAL / DENTAL PRACTITIONER

DR A.K. DAS
HEALTH CENTRE
STEVENSTON

Please use rubber stamp

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

Dear Rajinder

I shall appreciate if you could kindly see this patient who has just recently joined my list. She claimed that she has been having upper respiratory tract infection. Infact repeated tonsillitis for almost last two years.

On examination today her tonsils are grossly enlarged and infected. I have prescribed a course of Amoxycillin.

I shall appreciate if you could see with a view whether surgery will benefit or not.

Caroline is not allergic to anything and is not on any medication at present.

Thank you very much for seeing her.

Yours sincerely

MEDIC ... HOSPITAL
19 AUG 1999
URGE
SOON
ROUT

Diagnosis / provisional diagnosis:

Present drug treatment and potential special hazards:

X-ray (women of childbearing age). Date of first day of L.M.P.

Relevant X-rays available from: No. (if known)

Signature

355-2104

Printed for The Stationery Office . Dd8457208,08/97, R.P.(53791)

466693 - PWS ML.

Pinderfields & Pontefract Hospitals NHS Trust

To ENT Dept -

Crosshouse Hospital

Kilmarnock

Ayrshire.

14/12/00.

Dear Doctor, this is a short note to inform you that one of your patients already on W/L for tonsillectomy (Caroline Harman, 30/10/77, 29A Sloan Ave, Irvine, Ayrshire) was admitted to us with a (L) Quinsy 2 days ago, treated with incision + IV Benzylpenicillin/IV Flagyl/analgesia/IVI etc

Yours Dr M. Lumb
SHO/ENT Surgery
Bleep 199.

Stephen
PW.

NHS
Chairman - Sue Campbell; Chief Executive - Tony Woolgar
Pinderfields General Hospital, Aberford Road,
Wakefield, WF1 4DG. Tel: 01924 201688 Fax: 01924 814864

POSITIVE ABOUT DISABLED PEOPLE

CONSENT FOR OPERATION

STA1057

Surr XH 466693
Fore HARMON CAROLINE
Add 29(H) SLOAN AVENUE IRVINE KA12 0HR
DR C MACDONALD TOWNHEAD SURGERY 6-8 HIGH ST CH1 3010773188
30/10/1977

I ..... of .....

..... hereby consent to

* undergo / the submission of my * child ..... / ward

the operation of TONSILLECTOMY

the nature and purpose of which have been explained to me by

Dr./Mr.* MCINTOSH

I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to Section 1 (2) patients.)

Date 8/1/01 Signed X C HARMON
(Patient/Parent/Guardian)*

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian.*

Date 8/1/01 Signed .....
(Medical/Dental Practitioner)*

* DELETE AS APPROPRIATE

Note: This form is not to be used for any operation where there is a specific consent form with explantions.

Any deletions, insertions or amendments to the form are to be made before the explantion is given and the form submitted for signature.

CONSENT FOR OPERATION

Anaesthetic Record

Elective	✓
Scheduled urgent	
Urgent	
Emergency	
Consultant Informed	

XH 466693

Su: HARMON CAROLINE
Fo: 29(H) SLOAN AVENUE
Ad: IRVINE
KA12 OHR
DR.C MACDONALD
W: TOWNHEAD SURGERY
6/8 HIGH ST
CHI 3010773188

DOB 30/10/1977

Proposed procedure: STA 0093

TONSILLECTOMY

Preoperative assessment: ASA: B.P.

previous GA - Appendicectomy } no problems
Laparoscopy

No Diabetes / Epilepsy / Asthma.
No sore throat / chest infection at moment
Finished Antibiotics 3 wks ago
Non Smoker.

Teeth: no crowns / caps
Cervical ext.
MP III

Weight
Dentition

Hb
Biochem
Urea
Creat
Na
Cl
K
HCO_3
ECG
CXR

Recent drug therapy:
Nil

Allergies: NKDA.

Premedication:

Fasting: Time
Full Breakfast
Light Breakfast

Fluids: Allow still juices/water till:

Usual medicines:

Give all
Give only:

Drugs: Date Time

Nitrazepam 10mg } 10pm
Ranitidine 150mg } 8.1.01

Nitrazepam 10mg
Ranitidine 150mg
Emla cream
MST 10mg.

Given at / by
~~S.Tan~~
S 9.1.01.

Monitoring	
ECG	
NIBP	
S_pO_2	
$ETCO_2$	
ET Agent	
f_iO_2	
NMT	
Temp	
Urine cath.	
CVP	
IBP	
Boots	
Fluid warmer	
Warm mattress	

Anaesthetic technique

Injection: R/L Infusion(s) Right - Left -

Induction $PreO_2$ ☐ Cricoid ☐ Inhalation ☐ IV ☐
Airway Oral ☐ Nasal ☐ LMA ☐ Size,
Intubation Oral ☐ Nasal ☐ Cuff ☐ Size Type
Laryngoscopy Grade ☐ Laryngoscopy notes:

Spray ☐ Pack ☐ Respiration Spont ☐ IPPV ☐
Ventilator: Ohmeda ☐ Circuit: Circle ☐ Bain ☐ T piece ☐
Position:
Pressure care:

Local Anaesthetic technique

Spinal ☐
Epidural ☐
N. Block ☐
Wound Inf ☐

Date: Operation:

Anaesthetist(s)

Anaesthetic Nurse:

Surgeon(s)

Notes

Effect of premed:

ANAESTHETIC RECORD

Time

220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
S_pO_2
$ETCO_2$
ET Agent
f_iO_2

	Fluid In				Fluid Out		
	Infusion 1	Vol.	Infusion 2	Vol.		Urine	Blood

To meet Uft at front Door.
16^{30}.

NHS Ayrshire & Arran

Endoscopy Suite

Ayr Hospital

Patient Care Pre Assessment

DATE –

ADMISSION TIME –

CHI Number	3010776241
Name	WELSH, Caroline
Sex	Female
Date of Birth	30 Oct 1977 (46 years)
Address	9 St. Michaels Place, Kilwinning, KA13 6FA
Phone	07875530530

KA13 6FA 30/10/1977 Dr F Hamilton

Procedure/Date/Time	Colonoscopy 15/07/24 @ 1345pm	Reason for procedure: CIBH to loose stools and increased frequency. qFIT 22.4	
Endoscopist	Jane Moir		
Consultant	Mr Manda		
Have you had this before?	No		
Preferred Name	Caroline		
Sedation	Yes	Fully discussed	Yes
Throat spray	No		
Entonox	N/A	PGD Criteria met	N/A

NOK/Contact Relationship	Husband – Brian	Updated		Mode of Transport: car
Contact Number	07930244113	Updated		
Responsible Adult to Take Home	Brian	Updated		
Responsible Adult Overnight	Brian	Updated		
		Phoned:	Yes ☑ No ☐ FB	

Medical/Surgical History

Pregnant	Yes ☐	No ☒	N/A ☐		
Liver Disease	Yes ☐	No ☒			
Hypertension	Yes ☐	No ☒			
Anaemia (or any other blood problems)	Yes ☐	No ☒			
Cardiac Problems	Yes ☐	No ☒			
Respiratory Problems	Yes ☐	No ☒			
Surgery	Yes ☒	No ☐	Appendectomy, laparoscopy, hysterectomy, Gynaecology surgery		

Others (Specify): Carrier of Haemochromatosis HFE gene mutation, Fibromyalgia

Weight Stable Yes ☐ No ☒ loss 1 stone

Glaucoma	Yes ☐	No ☒			
CVA	Yes ☐	No ☒			
Epilepsy	Yes ☐	No ☒			
Arthritis	Yes ☐	No ☒			
MRSA/CDIFF	Yes ☐	No ☒			
ICD	Yes ☐	No ☒	Cardio Aware ☐		
Pacemaker	Yes ☐	No ☒	Dependant ☐ Non dependant ☐		
Diabetes	Yes ☐	No ☒	Type:	BM:	

KA13 6FA 30/10/1977 Dr F Hamilton

Family History	None	**Diarrhoea/Constipation**	Yes/Yes
Current Medication : **Sertraline** **Amitryptiline** **Co-Codamol** **Naproxen** **Omeprazole**		**Bleeding/Mucus**	No/Yes
		Urgency/Rectal Irritation	Yes/No
		Medication Updates:	
Allergies: Latex			
Anticoagulation Medication: None			
Date last taken		**Warfarin**	**INR**
			Date/Time

Fasting and Bowel Prep Discussed	Fully Discussed		
Procedure Explained/Risk and Complications	Fully Discussed		
Special Instructions	Take meds 2 hrs after bowel prep stop drinking from 1130am on am of test		
Fit for Procedure	Yes		
Medical Opinion Requested	No	**Outcome**	
Any problems/concerns **Emotional needs** **Vulnerabilities** **Additional comments**	Spoke to Sophie as no prep or letters as yet she has arranged Crosshouse hospital Endoscopy Unit to give bowel prep in case it does not arrive in time. Caroline aware to collect 11/07/24 after 420pm. Caroline happy to do this.		
Pre – Assessed By	**Michelle Henderson**	**Date**	**11/07/24**
Any changes or updates required in admission			

NHS Ayrshire & Arran

Endoscopy Suite

Ayr Hospital

Patient Care Pathway

CHI: 3010776241
Welsh, Caroline
9 St. Michaels Place
Kilwinning
KA13 6FA
30/10/1977
Dr F Hamilton

Time Seen _____

Date _____ Patient Preferred Name _____

Procedure _____ Age _____

Consultant _____ Throat Spray ☐

Endoscopist _____ Sedation ☐

Previous Endoscopy ☐ Yes ☐ No Entonox ☐

NOK/ Contact Name _____ Relationship _____

Telephone Number _____ Phoned Yes ☐ No ☐

Does Patient have an Escort Yes ☐ No ☐ Waiting ☐ Returning ☐

Time Returning _____

Type of Transport Car ☐ Ambulance ☐ Taxi ☐ Other ☐ _____

Responsible Adult to take Home Yes ☐ No ☐ not required ☐

Responsible Adult at Home Yes ☐ No ☐ Who? _____

Warfarin Yes ☐ No ☐ INR ☐ Date / Time _____

Anticoagulant Medication * Yes ☐ No ☐ Type _____

Clopidogrel* Yes ☐ No ☐ *Date last taken _____

Aspirin* Yes ☐ No ☐

Pacemaker Yes ☐ No ☐

ICD Yes ☐ No ☐ Cardiology to be contacted _____

Diabetes Yes ☐ No ☐ Type _____ BM _____

Emotional factors, anxieties, communication needs, additional comments:

Verbal consent given to display name on white board Yes ☐ No ☐

Medical/ Surgical History

Weight _____ stable Yes ☐ No ☐

Pregnant	Yes ☐ No ☐ N/A ☐	Glaucoma	Yes ☐ No ☐
Liver Disease	Yes ☐ No ☐	CVA	Yes ☐ No ☐
Hypertension	Yes ☐ No ☐	Epilepsy	Yes ☐ No ☐
Anaemia (or other blood problems)	Yes ☐ No ☐	Arthritis	Yes ☐ No ☐
Heart Disease	Yes ☐ No ☐	MRSA/ CDIFF	Yes ☐ No ☐
Respiratory Problems	Yes ☐ No ☐		
Surgery	Yes ☐ No ☐		

Others (specify): _____

_____

_____

Reasons for attending Endoscopy: _____

_____

_____

_____

Current Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Allergies: Yes ☐ No ☐

Latex Yes ☐ No ☐

1. _____
2. _____
3. _____
4. _____

Pre- Procedure Checklist

CHI: 3010776241
Welsh, Caroline
9 St. Michaels Place
Kilwinning
KA13 6FA
30/10/1977
Dr F Hamilton

Name Band Yes ☑ No ☐

Casenotes Yes ☑ No ☐

CJD Questionnaire Yes ☑ No ☐

Consent Yes ☑ No ☐

Fasted Food Yes ☑ No ☐

Fasted Fluids Yes ☑ No ☐

Mobility Independent ☑ Minimal Help ☐ Dependent ☐

Piercings Yes ☑ No ☐

Jewellery removed and retained by patient Yes ☑ No ☐ Other In Situ

Jewellery taped Yes ☑ No ☐

Metal Implants Yes ☐ No ☑ Where? _____

Bowel Prep **Picolax** ☐ **Enema** ☐ **Kleenprep** ☐ **Moviprep** ☐ **Other** ☐ Plenvue

Lower GI Procedures Modesty Pants offered Yes ☐ No ☐ Accepted ☐ Declined ☐

Pre-procedure Observations: O2 sat 98% / P 84 / BP 174/116/ 155/107. T36.4 145/93

Patient's understanding of Procedure Full ☐ Partial ☐ Comment _____

Explanation given **Yes** ☐ **Declined** ☐

IV Cannula Yes ☐ No ☐ N/A ☐ Site (L) Arm by WHOM SJ

Nurse Signature F.Buckley Time _____ Date 15/7/24

Patient Requiring ERCP

Bloods Checked (including coagulation screen) Yes ☐ No ☐

FBC ☐ Amylase ☐ U&E ☐ LFTs ☐ Temperature _____

LMP if applicable (see X-ray form) ☐

Nurse Signature _____ Time _____ Date _____

Preparation for Procedure

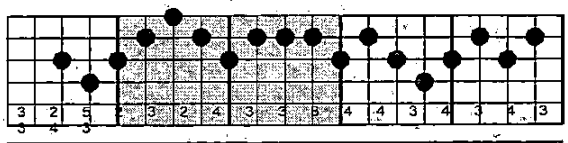
PAUSE

Patient ID	☑	Consent	☑
Procedure	☑	Fasted	☑
Medications	☑	Bowel Prep	☑
Anticoagulants	☑	Glaucoma	☑
Past Medical History	☑	Metal Implants	☑
Clinical Indications	☑	Pre-Procedure Observations	☑
Allergies	☑	Scope No/ Validation	☑

Denture removed Yes ☐ No ☐ N/A ☑ Loose Teeth Yes ☐ No ☐ N/A ☑

Hearing Aid removed Yes ☐ No ☐ N/A ☑ Glasses removed Yes ☐ No ☐ N/A ☑

Medication	Dose	Route	Time	Prescribed by	Given by
Midazolam	3mg	IV	1445		[illegible]
Diazemuls					
Pethidine					
Fentanyl	75mcg	I.V	1445		[illegible]
Buscopan					
Lignocaine Throat Spray					
Lignocaine 1%					
Entonox					
Saline 0.9%					
Final Flush Saline 0.9%	3mg.	IV	1445		[illegible]
Oxygen	21	nasal	cont	HBN 21004	AH
Phosphate Enema					
Gentamicin					



OBSERVATION CHART

Write or attach label

HCR No:
CHI No:
Surname:
Forename: Sex:
Address:

Date of Birth:

Time/ Intra Post

Time / Pulse BP

Time/ Intra Post	14 45	15 15	15 30	15 40	16 30
O2 therapy	RA	2L	2L	2L	A
O2 sats	99	98	98	99	99
Comfort Score[1]	–	1	1	0	–
Sedation Score [2]	–	2	2	2	–
Pain Score [3]	–	–	–	–	0
Nurse's Initials	AH	AH	AH	AB	GBL

[1]Comfort Score – during procedure

1 no discomfort resting comfortably throughout
2 one or two episodes of mild discomfort, well tolerated
3 >two episodes of discomfort, adequately tolerated
4 significant discomfort, experienced several times during procedure
5 extreme discomfort frequently during procedure

[2]Sedation Score

1 None (patient alert)
2 Mild (occasionally drowsy, easy to rouse)
3 Moderate (frequently drowsy, easy to rouse)
4 Severe, Somnolent (difficult to rouse)
5 Normal sleep (easily roused)

[3]Pain Score

0 no pain
1 mild pain
2 moderate pain
3 severe pain

Endoscopy Procedure performed: colon tbv

Nurses present: DW, AH

Specimens Taken:

Biopsies ☑ Polyps Retrieved ☐ Polyps to be Retrieved ☐ Aspirate ☐

Biopsies site: (L) colon, (R) colon

H Pylori Test ☐ Photograph ☐ Brush ☐

Other: _____

Diathermy plate ☐ Pad Site _____ Skin intact Yes ☐ No ☐

Time Procedure Commenced 1445 Completed 1530

Review Discharge: 15mins ☐ 30mins ☐ 1hour ☑ 2hours ☐ Rev by Doctor ☐

Diet Instructions: Normal Diet ☑ Soft Diet ☐ Fluids only ☐ Nil by Mouth ☐ Until 1630

Nursing Notes:

Tolerated well

NAD

R + L colonic bx for completeness

Await histology

Colorectal Nurse to be contacted: Yes ☐ No ☑

Follow up:

Mr. Manda

Nurse signature: _____ Time: 1520 Date: 15/7/24

Patient Discharge

Write or attach label
HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth:

Alert & orientated	Yes	☑	No	☐	Dentures returned	Yes	☐	No	☐	N/A	☑
Diet/ Fluids tolerated	Yes	☑	No	☐	Glasses returned	Yes	☐	No	☐	N/A	☑
Flatus passed	Yes	☑	No	☐ N/A ☐	Clothing returned	Yes	☑	No	☐	N/A	☐
Cannula removed	Yes	☑	No	☐ N/A ☐	Valuables returned	Yes	☐	No	☐	N/A	☑
Pacemaker assessment	Yes	☐	No	☐ N/A ☑	Transport arranged	Yes	☑	No	☐	N/A	☐
ICD turned on	Yes	☐	No	☐ N/A ☐							

Discharge advice and letter given Yes ☑ No ☐

Pain Score 0 ☑ 1 ☐ 2 ☐ 3 ☐

Sedation Score 1 ☑ 2 ☐

Patient Education leaflet Yes ☐ No ☑ If yes (specify)

Clinic Appointment to be made for

Arranged Yes ☐ No ☑

To be re-scoped Yes ☐ No ☑ details

Other follow-up Mr Manda

Discharged/ Home (circle as required) Time 1705

Alone/ accompanied (by whom) collected by husband at frontdoor

By Ambulance Yes ☐ No ☑ Relatives informed Yes ☐ No ☑

Transfer to Ward Yes ☐ No ☑

Spoken to by OMcNdD

Additional comments:

Patient fit for discharge
Results given and COK to patient
No further queries

Nurse Signature OMcNdD Date 16/7/24

Decontamination Checklist

- Steritrax Sticker Yes ☒ No ☐
- Validation Check Yes ☐ No ☐
- Traceability Check Yes ☐ No ☐
- '3 hour Rule' Check Yes ☐ No ☐

15/07/2024 16:31 LOT 0038
2255094
COLONOSCOPE 094
(01)00000000(7003)2407151631
(10)00387(240)0F0C00D15B
(a)

CHI: 3010776241
Welsh, Caroline

Endoscopy Nurse Signatures:

Nurse 1 D. Withers

Nurse 2 A. Roper

Decontamination Checklist

- Steritrax Sticker Yes ☐ No ☐
- Validation Check Yes ☐ No ☐
- Traceability Check Yes ☐ No ☐
- '3 hour Rule' Check Yes ☐ No ☐

Endoscopy Nurse Signatures:

Nurse 1 _____

Nurse 2 _____

CHI: 3010776241
Welsh, Caroline

NHS Ayrshire & Arran

Ayr Hospital Endoscopy Suite

NHS Ayrshire & Arran

CONSENT FORM

FOR A LOWER GASTRO-INTESTINAL ENDOSCOPY

CHI: 3010776241
Welsh, Caroline
9 St. Michaels Place
Kilwinning
KA13 6FA
30/10/1977
Dr F Hamilton

Patients Surname _____

Forename _____

Date of Birth _____

Address _____

_____

1. Please read this consent form and the information leaflet very carefully and fill in your details above.
2. If there is anything that you don't understand about the endoscopy, or if you want more information, please do not sign the form yet. You will be able to discuss any worries or questions with the endoscopy staff before the procedure.
3. If you understand all the information you have been given, then please sign below.

I agree to have an endoscopy of the lower bowel, either flexible sigmoidoscopy or colonoscopy.

I understand:

- that sedation may be used to assist in full examination of the bowel if colonoscopy
- that the endoscopy will be performed by a trained endoscopist
- that I can ask the endoscopist any questions that I may have concerning the procedure. Having signed the consent form I can still refuse the test.
- that any procedure in addition to the endoscopy, for example biopsies for histology will only be carried out if it is necessary, in my interests and can be justified for medical reasons
- these specimens may be used not only to help in diagnosing my condition but also anonymously to audit our performance and to assist with medical research

Signed Welsh Date 15/7/24

Please bring this form with you to the Endoscopy Suite

DRS 1022
Green

NHS Ayrshire & Arran

Risk Screening Questionnaire For TSE, CJD and vCJD involving low and medium risk tissue.

CHI: 3010776241
Welsh, Caroline
9 St. Michaels Place
Kilwinning
KA13 6FA
30/10/1977
Dr F Hamilton

Planned Procedure:	Colonoscopy

Questions 1 – 2 to be completed for all patients	Yes	No
1. Have you ever been notified that you are at risk of CJD or vCJD for public health purposes?		✓
2. What is the tissue risk of the procedure? (see table overleaf) High ☐ Medium ☐ Low ☐ If tissue risk is high, please use Risk Screening Questionnaire For TSE, CJD and vCJD involving high risk tissue.		

If the patient answers yes question 1, please take additional precautions for any instruments which have been or may come in contact with tissue of high or medium level infectivity.

If the patient answers no to question 1, there is no need to take any additional precautions

For further information, please contact Infection Control

Patient Risk (Q1)	Tissue Risk (Q2)		
	Low	Medium	High
Low	No Restrictions	No Restrictions	No Restrictions
High	No Restrictions	Single use instruments or Quarantine until advice sought from Infection Control	Single use instruments or Quarantine until advice sought from Infection Control

Name: F Buckley	Designation: RN
Signature: F Buckley	Date: 15/7/24

The vCJD questionnaire is to be used for all patients undergoing surgical or endoscopic procedures.

Table 1:- Examples of tissues with high and medium level infectivity

High	Medium
Brain Spinal cord Dura mater – implanted dura mater grafts prior to 1992 Cranial Nerves (specifically the entire optic nerve; only the intracranial components of the other cranial nerves) Cranial nerve ganglia Posterior eye (posterior hyaloid face, retina, retinal pigment epithelium, choroids, subretinal fluid, optic nerve) Pituitary gland	Spinal ganglia Anterior eye and cornea Olfactory epithelium Tonsil Appendix Spleen Thymus Fixed lymphoid tissue

Table 2:- Human TSE Diseases

Idiopathic Diseases	Sporadic CJD Sporadic Fatal Insomnia
Familial Diseases	Familial CJD, Gerstmann-Sträussler-Scheinker (GSS) Disease and Fatal Familial Insomnia
Acquired Diseases	Human agents: Kuru and iatrogenic CJD Bovine agent: Variant CJD

Notes on questions

	Question to Patient	Note to clinician
1	Have you ever been notified that you are at risk of CJD for public health purposes? If yes please specify	The CJD Incidents Panel has identified a number of individuals who are potentially at risk of CJD or vCJD for Public Health Purposes. If patient answers **NO**, surgery can proceed using normal infection control procedures. If patient answers **YES**, special infection control precautions should be taken. Contact infection control for further advice. If the patient is **unable to respond**, surgery can proceed using normal infection control procedures unless the procedure is likely to lead to contact with **high risk** tissue.

Patients response	**Action**
No to questions 1	Surgery / can proceed using normal infection control procedures.
Yes to questions 1	Further investigation into the nature of the patient's CJD risk should be undertaken by medical staff. The patient's CJD risk should be confirmed or rejected. Confirmation or rejection of CJD risk should be recorded in the patient's medical notes for future reference. If the patient is found to be at risk of CJD of vCJD following investigation, or the risk status is unknown at the time of the procedure, special infection control precautions should be taken. Contact infection control team for advice. If the patient is found to be at risk of CJD or vCJD they should be referred to their GP, who will need to inform them that they are at risk of CJD or vCJD and provide them with further information and advice. This is available from the CJD Incidents Panel: http://www.hpa.org.uk/infections/topics_az/cjd/information_documents.htm
Unable to respond to questions 1	Surgery or endoscopy should proceed using normal infection prevention and control procedures **unless** the procedure is likely to lead to contact with high risk tissue. If this is the case, please refer to the additional recommendations for high risk procedures. Contact infection control team for further advice.

NHS Ayrshire and Arran

Ayr Hospital

COLONOSCOPY REPORT

lame:	**Caroline WELSH (F)**	Address:	**9 St Michaels Place**
)ate of birth:	**30/10/1977**		**Kilwinning**
:HI No:	**3010776241**		**Ayrshire**
:ase note no.:	**CH466693**		**KA13 6FA**

:P:	**F Hamilton**	Procedure date:	**15th July 2024 (14:48)**
	Oxenward Surgery	Priority:	**Urgent**
	3 Oxenward Road	Status:	**Outpatient/NHS**
	Kilwinning	Hospital:	**Ayr Hospital**
	Ayrshire	Referring Cons:	**Mr Vijay Manda**
	KA13 6EH		

Indications
Loose stool and urgency, weight loss and Qfit 22.
Clinically important comments: Symptoms started when on orlistat, have slightly improved since discontinuing.
Consent for procedure confirmed with patient prior to examination.

Report
Bowel preparation with plenvu was fair.
A digital rectal examination was performed.
The colonoscope was inserted via the anus to the terminal ileum. The caecum was identified positively by the ileocecal valve, the appendicular orifice, the tri-radiate caecal fold and ileal intubation. The scope was retroflexed in the rectum.
The examination to the limit of insertion was normal.

Site c: An area extending from the proximal ascending to the hepatic flexure
Specimens: 2x biopsy.

Site d: An area extending from the mid descending to the proximal sigmoid
Specimens: 2x biopsy.

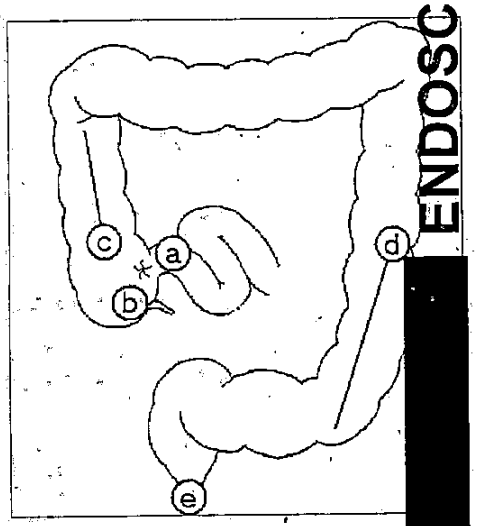
Advice/comments
Biopsies to exclude microscopic colitis.

Follow up
Awaiting pathology results. Return to the Referring Surgeon.

Consultant/Endosc
List consultant: Mr L
Endoscopist No1: Jane
Endoscopist No2: Lauren
Nurses: Staff Nurse Avril H
Danielle Withers

Instruments
CF-HQ290L-2255
Disposable forceps

Premedication
Fentanyl (IV) 75 ug
Midazolam (IV) 3 mg
Oxygen (Nasal) 2 l/



a: *Terminal ileum (photographed)*
b: *Caecum (photographed)*
c: *An area extending from the proximal ascending to the hepatic flexure*
d: *An area extending from the mid descending to the proximal sigmoid*
e: *Anal margin (photographed)*

ENDOSCOPY SUITE

Jane Moir
Colorectal Nurse / Endoscopist
c.c. Mr Vijay Manda (General Surgery)
Welsh, Caroline

NHS Ayrshire and Arran

Ayr Hospital

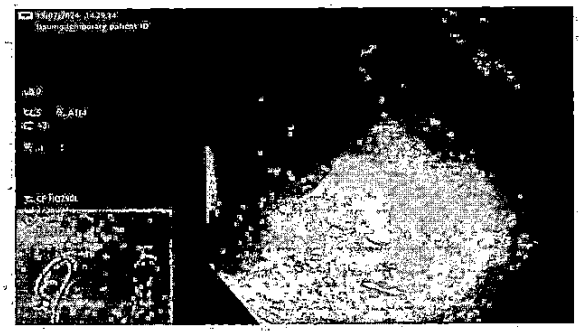
COLONOSCOPY REPORT

ne:	**Caroline WELSH (F)**	Address:	**9 St. Michaels Place**
te of birth:	**30/10/1977**		**Kilwinning**
HI No:	**3010776241**		**Ayrshire**
Case note no.:	**CH466693**		**KA13 6FA**

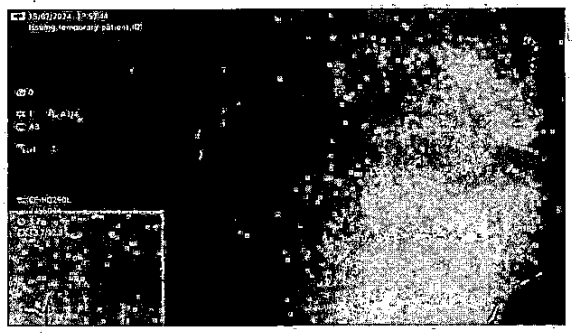
Procedure date: **15th July 2024 (14:48)**

Site a: Terminal ileum

Site b: Caecum



Site b: Caecum



Site e: Anal margin

ENDOSCOPY SUITE

Jane Moir
Colorectal Nurse / Endoscopist

CHI: 3010776241 **Name:** Caroline Welsh **Gender:** Female **DOB: 30/10/1977** **Age: 46 Yrs** **Phone:** 07875530530

Diagnostic Colonoscopy OP

Order Details

Diagnostic Colonoscopy OP

Change Item

Test Visit No		
Status	In Progress	In Progress
Receiving Location	Crosshouse Endoscopy C	
Priority	Urgent Suspected Cance	
S Date/Time	03/07/2024	
Start Time	14:16	
Requested By	Mr Vijay Manda	
Text1		
Patient Location when Ordered	Virtual Waiting Area	

Questions and Answers

Please see athena for Bowel Prep Guidelines

Please see athena for Bowel Prep Guidelines

Scanned Documents

Annotate Images

mr5439 mr5439

Clinical Questions and Answers

Clinical Indications: What clinical questions should this exam answer? (Please detail reason for this procedure and when this procedure should be completed) **CIBH to loose stools and increased frequency. qFIT 22.4**

Is the patient fit for Outpatient Bowel Prep? (If No, please state why?) **Yes**

Specify Preparation (Care with Picolax in Chronic Renal Disease, Heart Failure & Electrolyte Imbalance) **Moviprep x2 Sachets**

Relevant past medical history / Significant Major / Co-Morbidities / Respiratory or Neuromuscular Disorder **Nil Significant**

List to be booked on (please state in Other box if specific consultant) : **Pooled List**

Is the patient Diabetic? **No**

Does this patient have a pacemaker? **No**

Is this patient on Anticoagulants, if so please state the following mandatory requirements: Which drug? Indication? If drug can be stopped and if this patient will require 'Bridging' **No**

Is this patient on Anti-platelets, if so please state the following mandatory requirements: Which drug? Indication? If drug can be stopped and if this patient will require 'Bridging' **No**

Is the patient on Iron Therapy? **No**

What is the patient's Renal Function?

What is the date of the patient's last eGFR?

Does this patient have allergies?

Other Comments? (e.g. Translator Required? Which Language?)

Is this a repeat procedure?

Processing Notes

CM 4/7/24

Responsible Clinician: Mr Vijay Manda

User: mr5467

Audit Trail

Update

Alert Messages Alert Messages

BREAST

See Filing Arrangements on inside front cover

XH 466693

HARMON CAROLINE
4 CRAIGNAW PLACE
IRVINE
KA11 1EZ

30/10/1977

DR C JOHNSTON
CHEVIOT WAY
BOURTREEHILL HEALTH CENTRE
CHI 3010776241

BREAST

NHS Ayrshire

CROSSHOUSE HOSPITAL – BREAST CLINIC

Name
CHI: 3010776241
Welsh, Caroline
13 Mossgiel Drive
Irvine
GP: KA12 0QT
30/10/1977
Dr N Begg
MRN: XHI466693

Date: 27/9/25
Consultant: SJ
Referred by:
Seen By:

Please CIRCLE the appropriate number:

SYMPTOM: (1) Lump
2 Pain
3 Discharge – Type: X
Site:
4 Other (specify)
5 Duration:

SITE: 1 Right
2 Both
(3) Left

AGE:
LMP: 43

RISK FACTORS: Prev. Hist.: nil

Family History: nil

Age at Menarche:
Age at Menopause:

Parity:
Age at 1st Pregnancy:
Breast Feed: Duration:

Use of CCP:
0 – None
1 – Current
2 – Previous X

Hysterectomy

Use of HRT: Duration:

GENERAL HEALTH:

DRUG HISTORY:

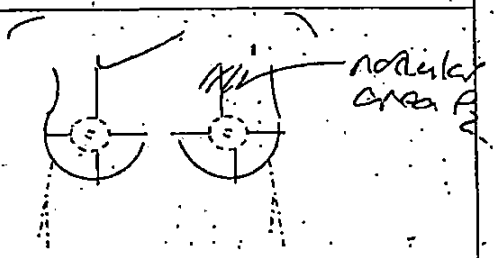
DRUG ALLERGIES:

OTHER ALLERGIES:

SMOKER / NON SMOKER

EXAMINATION:

IF LUMP PRESENT SPECIFY: Size.....cm
1. Multiple lumps, No:
2. Nipple Retraction:
3. Deep Fixation:
4. Skin Fixation / Ulceration:
5. Enlarged Nodes:



CLINICAL IMPRESSION:

P1. Normal on Examination
P2. Benign
P3. Unsure - probably Benign
P4. Unsure – possibly Malignant
P5. Malignant

INVESTIGATIONS REQUESTED:

0. None
(1) Mammography
(2) Ultrasound
3. Core Biopsy
4. FNA, LN, Breast lump
5. Cyst. Asp. CYTO
6. Nipple Smear
7. Other (specify) .....

RESULTS:
MAMMOGRAPHY: R: 1 2 3 4 5 L: 1 2 3 4 5

ULTRASOUND: R: 1 2 3 4 5 L: 1 2 3 4 5

LIKELY DIAGNOSIS:

1. Normal
2. Cancer
3. Cyst
4. Fibroadenoma
5. Duct Ectasia
6. Fat Necrosis
7. Other

OUTCOME:

1. Discharged
2. Review.....Days / Weeks
3. Waiting List
4. Drug Therapy
5. Other

Name: CHI 3010776241
MORRIN CAROLINE
4 CRAIGNAW PLACE
IRVINE
KA11 1EZ

GP: 30/10/1977 Pract 80330
Case Ref 466693

Date:

Consultant:

Referred by:

Please CIRCLE the appropriate number

SYMPTOM:
1. Lump
2. Pain
3. Discharge: Type: occasionally
Site:
4. Other (specify)
5. Duration

SITE:
1. Right
2. Both
3. Left

AGE: 26

LMP:

RISK FACTORS: Prev Hist. —

Family Hist: —

Parity: 3

Breast Feed:

Use of CCP:
0. None
1. Currant
2. Previous

Age at Menarche:
Age at Menopause:
Age at 1st Pregnancy

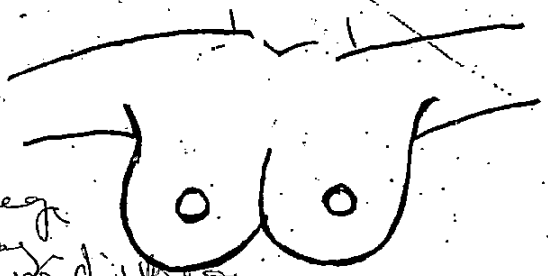
MEDICAL HISTORY

Healthy

EXAMINATION:

If LUMP present specify: SIZE _____cms

1. Multiple lumps, No.
2. Enlarged nodes
3. Nipple retraction
4. Deep fixation
5. Skin fixation/ulceration



no lump
no nipple change
no skin change
on palpation no discharge

CLINICAL IMPRESSION:

1. Benign
2. Unsure – benign
3. Unsure – malignant
4. Malignant

INVESTIGATIONS REQUESTED:

0. None
1. Mammography
2. FNA
3. Cyst Asp.CYTO
4. Ultrasound
5. Tru-cut
6. Smear
7. Other (specify) .....
8. Biopsy

RESULTS:

FNA

R.	L.
1	1
2	2
3	3
4	4
5	5

Benign
Suspicious – Benign
Suspicious – Malignant
Malignant
Inadequate

MAMMOGRAPHY

R.	L
1	1
2	2
3	3
4	4
5	5

DIAGNOSIS:

1. Normal
2. Cyst
3. Fibroadenoma
4. Fibroadenosis
5. Duct Ectasia
6. Fat Necrosis
7 Cancer
8. Other

OUTCOME:

1. Discharged
2. Review .....months
3. Operation
4. Drug treatment

XH 466693

Surname ..... MORRIN
Forenames ... CAROLINE
Address ..... 4 CRAIGNAW PLACE
IRVINE
KA11 1EZ
30/10/1977
DR.I JAMIESON
THE SURGERY
AYRSHIRE CENTRAL HOSPITAL
CHI 3010776241
CHI 3010776241

STA 0173 Ward or Dept

DATE

9/9/04 pt Canc. to 30/9/04

SURGICAL

[IMMI Run: 729]

SOUTH GLASGOW HOSPITALS
IMMUNOLOGY REPORT
(Tel 0141 347 8872/0141 354 9337)

Surname	WELSH	Location:	Biochemistry
Forename:	CAROLINE		Crosshouse Hospital
DOB/Age:	30.10.77 Sex: Female		Kilmarnock
CHI/Unit No:	3010776241		Ayrshire & Arran H.B.
Address:	9 ST. MICHAELS PLACE	Requestor:	I Cochrane
Diagnosis:		Ext Labno:	25B756358
Details:			

AZAM GAST

03/05/25

Lab No: B,25.3542837.Y
Collected: 03.05.25 Received: 07.05.25 15:11
Authorised: 14.05.25 Authorised by: Automatic release by sys

COELIAC SEROLOGY

TTG Ab (IgA)	1.9	U/mL	(0.0-7.0)

07/06

25B756358

Comments:

I Coeliac Serology: IgA TTG Ab = IgA Tissue Transglutaminase Ab.
Normal = <7.0, equivocal = 7.0-10.0, positive = >10.0.
If screening for coeliac disease, this result is only valid if the person was eating gluten at least twice a day for previous 6 weeks
If known to have coeliac disease,
this negative result suggests adherence to gluten free diet.
IgA coeliac serology has reduced sensitivity if total IgA <0.2g/l

Date reported: 14.05.25

PATIENT: WELSH, CAROLINE
UPI: 3010776241
REF: 25B705146

DOB: 30/10/1977
SEX: F
CONSULTANT/GP: Duty Biochemist

SOURCE: Crosshouse - Biochemistry
SENDER:

Specimen No. : QB184614N
Date Taken : 03/05/2025
Time Taken : 15:52
Date Received : 07/05/2025
Time Received : 12:18

Azam
Gast
03/05/25

Faecal Elastase	>500	ug/g	(200 - 1000)	(a)

(a) Reference range >200ug/g faeces

N

07/06

Results obtained from Serum, Plasma or Whole Blood unless otherwise stated.

09/05/2025 15:15

NHS Lanarkshire

NHS Lanarkshire Clinical Laboratories
Monklands - 01236 748748

Patient ID Number	*Patient Name*	*Date of Birth*	*Sex*	*Lab Number*
CHI No: **3010776241**	**WELSH Caroline**	**30/10/1977**	**F**	**4059208969**
NHSL No:				

Requesting clinician: **NOT GIVEN**
Requesting Location: **qFIT-Ayr**
copy to Address:

Clinical History
NONE GIVEN.

Results relate to blood unless otherwise specified

Special Biochemistry					
Faecal haemoglobin FIT	H	22.4	ugHb/g	0.0	- 9.9

04 JUN 2024

Specimen Collected	*Specimen Receipt*	*Report Printed*	*Authorised*	*page 1/1*
28/05/24 15H53M	28/05/24 15H54M	29/05/24 11H51M	Auto	

UK Covid-19 Test Report

Result

SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2) detection result **negative**

Patient Details

Surname	Welsh
Forename	Caroline
CHI	3010776241
Date of birth	1977-10-30
Sex	Female
Address	13 MOSSGIEL DRIVE IRVINE AYRSHIRE KA120QT

Specimen Details

Specimen Processed Date	08-01-2022 05:19
Test Start Date	06-01-2022 16:09
Test End Date	06-01-2022 16:09
GP Practice	80698
Specimen Number	AAI64429141
Administration Method	self

End of Report

Report Date: 20/01/2022

UK Covid-19 Test Report

Result

SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2) detection result **negative**

Patient Details

Surname	Welsh
Forename	Caroline
CHI	3010776241
Date of birth	1977-10-30
Sex	Female
Address	13 MOSSGIEL DRIVE IRVINE AYRSHIRE KA120QT

Specimen Details

Specimen Processed Date	04-01-2022 10:21
Test Start Date	03-01-2022 12:26
Test End Date	03-01-2022 12:26
GP Practice	80698
Specimen Number	AAI64836628
Administration Method	self

End of Report

Report Date: 18/01/2022

MICROBIOLOGY

STA0246

yrshire & Arran Acute Hospitals NHS Trust

Area Laboratory MI[illegible]OW

MORRIN,CAROLINE
26 Lewis Terr
Irvine
KA11 1HJ

CHI No. 3010776241
Unit No.
DOB 30/10/1977
Sex F

Clinician: Dr David Chung
Request Location: XH Hosp. Clinical Decisions

This report to Dr David Chung XH Hosp. Clinical Decisions Unit

MRSA Culture	Negative

LabNo 09M510119
Printed 29/12/09 10:07

Date coll 27/12/09 21:10

Sample: Nasal swab

Authorised by SYSTEM
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STA0246

14 PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW

Ayrshire & Arran Acute Hospitals NHS Trust

Area Laboratory — Microbiology

MORRIN,CAROLINE
26 Lewis Terr
Irvine

KA11 1HJ

CHI No. 3010776241
Unit No.
DOB 30/10/1977
Sex F

Clinician: Dr E Walker
Request Location: XH Hosp. Ward 6

Agar D's

466693

This report to Dr E Walker XH Hosp. Ward 6

Microscopy

White blood cells	65	/uL	(normal range 0-41)
Red blood cells	42	/uL	(normal range 0-45)
Epithelial cells	1	/uL	(normal range 0-55)

Culture

1) >100,000 Escherichia coli

	1)
Amoxycillin	S
Ampicillin	S
Cephalexin	S
Co-amoxiclav	S
Nalidixic acid	S
Nitrofurantoin	S
Trimethoprim	S
Gentamicin	S

Comment: Treatment for asymptomatic catheter-related bacteriuria is not indicated.

LabNo 09M306113
Printed 01/12/09 08:47

Date coll 26/11/09 17:00

Sample: Catheter specimen urine

Authorised by Dr Gordon Downie
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MORRIN,CAROLINE
26 Lewis Terr
Irvine

KA11 1HJ

CHI No. 3010776241
Unit No.
DOB 30/10/1977
Sex F

Clinician: Dr Wael Agur
Request Location: XH Hosp. Ward 6

This report to **Dr Wael Agur** **XH Hosp. Ward 6**

Microscopy			
White blood cells	241	/uL	(normal range 0-41)
Red blood cells	6651	/uL	(normal range 0-45)
Epithelial cells	31	/uL	(normal range 0-55)
Culture	No growth		

Please note sterile pyuria

LabNo 09M306148
Printed 30/11/09 10:04

Date coll 26/11/09 16:00

Sample: Mid-stream urine

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Ayrshire & Arran Acute Hospitals NHS Trust — Area Laboratory — Microbiology

MORRIN,CAROLINE
26 Lewis Terr
Irvine
KA11 1HJ

CHI No. 3010776241
Unit No.
DOB 30/10/1977
Sex F

Clinician: Dr E Walker
Request Location: XH Hosp. Ward 6

This report to **Dr E Walker** **XH Hosp. Ward 6**

Microscopy			
White blood cells	65	/uL	(normal range 0-41)
Red blood cells	42	/uL	(normal range 0-45)
Epithelial cells	1	/uL	(normal range 0-55)
Comment	Culture to follow		

LabNo 09M306113
Printed 28/11/09 13:05

Date coll 26/11/09 17:00
Sample: Catheter specimen urine

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Ayrshire & Arran Acute Hospitals NHS Trust

MORRIN,CAROLINE
26 Lewis Terr
Irvine
KA11 1HJ

CHI No. 3010776241
Unit No:
DOB 30/10/1977
Sex F

Clinician: Dr Wael Agur
Request Location: XH Hosp. Ward 6

This report to **Dr Wael Agur** **XH Hosp. Ward 6**

Microscopy			
White blood cells	241	/uL	(normal range 0-41)
Red blood cells	6651	/uL	(normal range 0-45)
Epithelial cells	31	/uL	(normal range 0-55)
Comment	Culture to follow		

LabNo 09M306148
Printed 27/11/09 13:09

Date coll 26/11/09 16:00
Sample: Mid-stream urine

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MORRIN,CAROLINE
26 Lewis Terr
Irvine
KA11 1HJ

CHI No. 3010776241
Unit No.
DOB 30/10/1977
Sex F

Clinician: Dr E Walker
Request Location: XH Hosp. Ward 6

This report to **Dr E Walker** **XH Hosp. Ward 6**

Microscopy			
White blood cells	65	/uL	(normal range 0-41)
Red blood cells	42	/uL	(normal range 0-45)
Epithelial cells	1	/uL	(normal range 0-55)
Comment	Culture to follow		

LabNo 09M306113 Date coll 26/11/09 17:00 Authorised by SYSTEM
Printed 27/11/09 13:09 Page 1 of 1
Sample: Catheter specimen urine Telephone 01563 827420

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Ayrshire & Arran Acute Hospitals NHS Trust

Area Laboratory — Microbiology

MORRIN,CAROLINE
26 Lewis Terr
Irvine
KA11 1HJ

CHI No. 3010776241
Unit No.
DOB 30/10/1977
Sex F

Clinician: Unknown Clinician
Request Location: XH Hosp Pre-op Assessment Unit

3/11/9

This report to **Unknown Clinician** **XH Hosp Pre-op Assessment Unit**

MRSA Culture	Negative

LabNo 09M493751
Printed 04/11/09 16:17

Date coll 03/11/09 15:40
Sample: Throat swab

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Ayrshire & Arran Acute Hospitals NHS Trust

Area Laboratory — Microbiology

MORRIN,CAROLINE
26 Lewis Terr
Irvine
KA11 1HJ

CHI No. 3010776241
Unit No.
DOB 30/10/1977
Sex F

Clinician: Unknown Clinician
Request Location: XH Hosp Pre-op Assessment Unit

5/11/09

This report to **Unknown Clinician** **XH Hosp Pre-op Assessment Unit**

MRSA Culture	Negative

LabNo 09M493750 — Date coll 03/11/09 15:40 — Authorised by SYSTEM
Printed 04/11/09 16:17 — Sample: Nasal swab — Page 1 of 1
Telephone 01563 827420

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Ayrshire & Arran Acute Hospitals NHS Trust

Area Laboratory — Microbiology

MORRIN,CAROLINE
26 Lewis Terr
Irvine
KA11 1HJ

CHI No. 3010776241
Unit No.
DOB 30/10/1977
Sex F

Clinician: Dr Wael Agur
Request Location: XH Hosp Pre-op Assessment Unit

This report to **Dr Wael Agur** **XH Hosp Pre-op Assessment Unit**

RA 4/11/9

Microscopy			
White blood cells	67	/uL	(normal range 0-41)
Red blood cells	8	/uL	(normal range 0-45)
Epithelial cells	9	/uL	(normal range 0-55)
Comment	Culture to follow		

LabNo 09M298264
Printed 04/11/09 06:33

Date coll 03/11/09 13:30

Sample: Mid-stream urine

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Ayrshire & Arran Acute Hospitals NHS Trust — Area Laboratory — Microbiology

MORRIN,CAROLINE
26 Lewis Terr
Irvine
KA11 1HJ

CHI No. 3010776241
Unit No.
DOB 30/10/1977
Sex F

Clinician: Dr Wael Agur
Request Location: XH Hosp Pre-op Assessment Unit

This report to **Dr Wael Agur** **XH Hosp Pre-op Assessment Unit**

4/11/9

Microscopy			
White blood cells	67	/uL	(normal range 0-41)
Red blood cells	8	/uL	(normal range 0-45)
Epithelial cells	9	/uL	(normal range 0-55)
Culture	No growth		

RECEIVED
04 NOV 2009

LabNo 09M298264
Printed 04/11/09 13:12

Date coll 03/11/09 13:30
Sample: Mid-stream urine

Authorised by SYSTEM
Page 1 of 1
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Ayrshire & Arran Acute Hospitals NHS Trust — Area Laboratory — Microbiology

MORRIN	*Patient No.*	3010776241	*Clinician*	Dr E Melrose	
CAROLINE	*Unit No.*	CH466693	*Request Location*	Ward 6	
26 LEWIS TERR	*DOB*	30/10/1977		Crosshouse Hospital	
IRVINE KA11 1EZ	*Sex*	F			

This Report To **Dr E Melrose Crosshouse Hosp. Ward 6**

White blood cells	1	/ul (normal range 0-40/ul)	
Red blood cells (Non-haemolysed)	13,524	/ul (normal range 0-45/ul)	High
Epithelial cells	10	/ul (normal range 0-55/ul)	
Casts	0	/ul (normal range 0-1/ul)	

31/0.18

Only specimens with flagged WBC and/or BACTERIAL COUNT are cultured.

Lab No M.07.309005.1 *Date/Time* 23/12/2007 23:30 *Authorised By* Auto Authorised User for DeptMIC

Printed 24/12/2007 11:33 *Sample* Mid stream urine *Page* 1 OF 1 *Date* 24/12/2007

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Ayrshire & Arran Acute Hospitals NHS Trust — Area Laboratory — Microbiology

MORRIN	*Patient No.*	3010776241	*Clinician*	Unknown Clinician
CAROLINE	*Unit No.*		*Request Location*	Unknown Location
26 LEWIS TERR	*DOB*	30/10/1977		Crosshouse Hospital
IRVINE KA11 1EZ	*Sex*	F		

This Report To **Unknown Clinician Crosshouse Hosp. Unknown Location** Dr Melrose

MRSA Methicillin resistant Staph aureus not isolated (MRSA)

Dr 3/12.

Lab No M.07.191789.7 *Authorised By* Audrey Brown

Printed 26/12/2007 11:36 *Sample Type* Unknown site *Page* 1 OF 1 *Date* 26/12/2007

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Ayrshire & Arran Acute Hospitals NHS Trust

Area Laboratory — Microbiology

MORRIN
CAROLINE
26 LEWIS TERR
IRVINE KA11 1EZ

Patient No. 3010776241
Unit No. CH466693
DOB 30/10/1977
Sex F

Clinician Dr E Melrose
Request Location Gynaecology Clinic
Crosshouse Hospital

This Report To **Dr E Melrose Crosshouse Hosp. Gynaecology Clinic**

Pus cells	None seen
Candida sp.	NOT isolated
Trichomonas	NOT seen.
Culture yields	No significant bacterial growth
Gardnerella vaginalis	NOT seen.

Vaginal swabs are unsuitable for N. gonorrhoeae culture. Please send a cervical or endocervical swab if this investigation is required.

3/12 VB

Lab No M.07.101323.8 Date/Time Coll 24/12/2007 00:25 Authorised By Elaine Higgins

Printed 26/12/2007 10:02 Sample Type High vaginal swab Page 1 OF 1 Date 26/12/2007

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...EDGE OF REPORT ALONG LINE BELOW

Ayrshire & Arran Acute Hospitals NHS Trust

Area Laboratory — Microbiology

MORRIN
CAROLINE
26 LEWIS TERR
IRVINE KA11 1EZ

Patient No. 3010776241
Unit No. CH466693
DOB 30/10/1977
Sex F

Clinician Dr E Melrose
Request Location Gynaecology Clinic
Crosshouse Hospital

This Report To Dr E Melrose Crosshouse Hosp. Gynaecology Clinic

Chlamydia trachomatis	not detected by PCR

3/12/10

Lab No M.07.101324.6 Date/Time Coll 24/12/2007 10:25 Authorised By Auto Authorised User for DeptMIC

Printed 27/12/2007 10:30 Sample Chlamydia transport medium Cervical swab 1 OF 1 Date 27/12/2007

If you have received this report in error, please return to the Microbiology Laboratory

Patient ID	3010776241:OHCP	**Patient Name**	WELSH, Caroline
Sex	Female	**Date Of Birth**	30-Oct-1977
Responsible Doctor	Dr Sameena Rashid	**Observation Date**	19-Jan-2026 09:30
Hospital	Ayr Hosp Dermatology Clinic	**Modified**	19-Jan-2026 09:30
Document Status	Final		

Reporting Pathologist 1 Final

Diagnexia Pathologist

Authorised by: Final

29/01/2026 15:28 Diagnexia Pathologist

Histology Report Final

CLINICAL HISTORY

Purple/skin coloured papule.
?BCC
?neurofriboma.

MACROSCOPY

EXCISION OF LESION RIGHT BACK, 4MM MARGIN: Piece of skin measuring 10 x 9mm with upto 5mm of underlying tissue, suture marks the 12 o'clock margin with a central depression which measures 4x2mm which lies 2mm from the 9 o'clock margin.

Green 6, Blue 3, Orange 12, Yellow 9

MICROSCOPY

Sections show skin incorporating a cyst lined by squamous epithelium and filled with keratin debris. There is evidence of rupture with foreign body giant cell reaction and pigment laden macrophages

Diagnosis
Epidermoid cyst

Codes
T01000 M33410 P1141

Reported: 29 January 2025
e - signed by Dr Bharati Musthyala

HISTOLOGY

Responsible Doctor
Mr Vijay Manda
Hospital
Ayr Hosp Endoscopy Unit
Document Status
Final
Observation Date
15-Jul-2024 14:48
Modified
15-Jul-2024 14:48
Final**Reporting Pathologist 1**
Diagnexia Pathologist
Final**Authorised by:**
23/08/2024 09:44 Diagnexia Pathologist
Final**Histology Report**
CLINICAL HISTORY

Indications. Loose stool and urgency, weight loss and Qfit 22.

The examination to the limit of insertion was normal.

MACROSCOPY

A. 2 COLONIC BIOPSIES FROM (c) AN AREA EXTENDING FROM THE PROXIMAL ASCENDING TO THE HEPATIC FLEXURE: Pale fragment measuring 3 x 2 x 2 mm.

B. 2 COLONIC BIOPSIES FROM (d) AN AREA EXTENDING FROM THE MID DESCENDING TO THE PROXIMAL SIGMOID: 2 Tan fragments largest measuring 3 x 2 x 2 mm.

MICROSCOPY

Specimen A

Microscopic Findings
A&B. Histology shows fragments of colonic type mucosa demonstrating similar appearances in each specimen. There is overall preservation of a normal glandular architecture. There is diffuse mild expansion of the lamina propria by a mixed inflammatory infiltrate comprising mainly plasma cells and eosinophils. There is mild patchy surface intraepithelial lymphocytosis. In addition, there is diffuse subepithelial

collagen deposition, present in both specimens but much more prominent within the proximal colonic specimen. There is no significant active inflammation. No ulceration or granulomatous inflammation is seen. There are no features to indicate any specific infectious process or any neoplastic process. In summary, the histological features are those of the collagenous subtype of microscopic colitis.

Diagnosis
Random right and left colonic mucosa
Collagenous colitis

Codes
T67010 D6219 M40000 P1160

Specimen B

Microscopic Findings
See A

Diagnosis
See A

Codes
T67010 D6219 M40000 P1160

Reported: 22nd August 2024
e - signed by Dr Maurice Loughrey

NHS AYRSHIRE and ARRAN
PATHOLOGY DEPARTMENT - CROSSHOUSE HOSPITAL

HISTOPATHOLOGY REPORT **Laboratory No.: 13P017516**

Name: CAROLINE WELSH
DOB: 30/10/1977 **Sex:** F
Address: 26 LEWIS TERRACE
IRVINE KA11 1HJ

CHI No: 3010776241
Sender: Dr Vivian Franklin
Source: XH Hosp. Ward 6
Date Taken: 26/09/13 **Date Recvd:** 27/09/13

CLINICAL HISTORY

Hysterectomy for menorrhagia. Mirena coil in-situ. Friable tissue.

UTERUS AND CERVIX

Uterus and cervix minus appendages weighing 194g and measuring 117 x 75 x 55mm with a 40mm diameter parous cervix with protruding threads. A stump of right Fallopian tube 15 x 3mm is attached. On opening, an IUCD is in-situ. The endometrium appears soft and friable and the myometrium has a striated pattern.

MICROSCOPY

The cervix is unremarkable. The endometrium has a decidualised stroma and inactive glands in keeping with Mirena effects. The myometrium is unremarkable. No malignancy is seen.

Reported by: Dr J A Lang
Authorised by: Joyce Lang
First Print: 03/10/13
Current Print: 03/10/13

Please note: The Pathology Department does not issue "Copy to" reports.
This report has now been authorised and is available electronically.

08 OCT 2013

Radiology Results displayed are **verified reports only**

DEPARTMENT OF HISTOLOGY

Name: **Caroline WELSH** D.o.B: **30/10/1977** Sex: **F**

Address: **26 Lewis Terr, , Irvine, , KA11 1HJ**

Requester: **Dr Vivian Franklin** Sample Date: **03/01/2012**

Coded Sample Comments:

CHI No.: **3010776241**

Patient ID: **3010776241**

Laboratory Number: **0012P000019** Sample Site: **Unspecified**

Location: **XH Hosp. Ward 6**

Comment

Investigation: HISTOLOGY **Auth. Date:** 05/01/2012 17:34

Histology Report : CLINICAL HISTORY

PV bleeding and passing tissue. ?placental BHCG negative

TISSUE FROM VAGINA

Two pieces of ?decidual tissue, larger 105 x 60 x 18mm, smaller 90 x 35 x 15mm. Tissue grey/brown and haemorrhagic. The inner lining appears puckered and thickened and pale.

MICROSCOPY

The sections show bulky fragments of endometrium with marked stromal decidualisation. The glands are inactive. No evidence of current or recent intrauterine gestation is seen. Extrauterine pregnancy cannot be excluded, although the negative BHCG is noted. Is there any history of recent progestogenic hormone therapy?

Reporting Pathologist 1 : Dr J A Lang

Authorised by: : 05/01/2012 17:34 Dr Joyce Lang

HISTOLOGY REPORT

NHS AYRSHIRE and ARRAN
PATHOLOGY DEPARTMENT - CROSSHOUSE HOSPITAL

HISTOPATHOLOGY REPORT **Laboratory No.: 12P000019**

Name:	**CAROLINE WELSH**				
DOB:	**30/10/1977**	**Sex: F**	**CHI No:**	**3010776241**	
Address:	**26 Lewis Terrace**		**Sender:**	**Dr Vivian Franklin**	
	Irvine		**Source:**	**XH Hosp. Ward 6**	
	Ayrshire	**KA11 1HJ**	**Date Taken:**	**03/01/12**	**Date Recvd: 04/01/12**

CLINICAL HISTORY

PV bleeding and passing tissue. ?placental BHCG negative

TISSUE FROM VAGINA

Two pieces of ?decidual tissue, larger 105 x 60 x 18mm, smaller 90 x 35 x 15mm. Tissue grey/brown and haemorrhagic. The inner lining appears puckered and thickened and pale.

MICROSCOPY

The sections show bulky fragments of endometrium with marked stromal decidualisation. The glands are inactive. No evidence of current or recent intrauterine gestation is seen. Extrauterine pregnancy cannot be excluded, although the negative BHCG is noted. Is there any history of recent progestogenic hormone therapy?

Yes.

fitted
W
30/1/12

Reported by: **Dr J A Lang** **Authorised by:** **Dr Joyce Lang**
First Print: 06/01/12
Current Print: 06/01/12

Please note: The Pathology Department does not issue "Copy to" reports.
This report has now been authorised and is available electronically.

AYRSHIRE and ARRAN ACUTE HOSPITALS NHS TRUST

PATHOLOGY DEPARTMENT - CROSSHOUSE HOSPITAL

HISTOPATHOLOGY REPORT

Laboratory No.: **P.08.011279**

Name:	CAROLINE MORRIN	Hospital No:	CH466693	Date Taken:	08/07/2008
D.O.B.:	30/10/1977	Sender:	Dr C Dwyer	Date Recvd:	09/07/2008
Patient ID:	3010776241	Source:	Crosshouse Hosp. Ward 2E		

CLINICAL HISTORY

Right 5th toe (medial aspect) 1 x 0.6mm pigmented lesion increasing in size.

PUNCH BIOPSY OF SKIN RIGHT FIFTH TOE

A 5mm punch biopsy of slightly grey skin with underlying tissue to 2mm.

MICROSCOPY: Sections show a benign compound naevus. There is no evidence of malignancy.

Reported By: Dr I Graham

Trimmed by: B.M.S. - Zoe Cole

Date Printed: 15/07/2008 LMV

This Report to: Dr C Dwyer Crosshouse Hosp. Ward 2E

XR Knee both

Patient ID	3010776241:OHCP	**Patient Name**	WELSH, Caroline
Sex	Female	**Date Of Birth**	30-Oct-1977
Performed	03-Jun-2025 14:20	**Order Number**	AA15135092401
Ordering Provider	Hamilton	**Status**	Final

General Final

:
:
:
: Patient Name: Caroline, Welsh
: Patient Address: 9 St Michaels Place, KA13 6FA
: DOB: 30/10/1977
: Patient ID: 3010776241
: Accession Number: AA15135092401
: Referring Cons: Fiona Hamilton (GP Oxen)
: Referring Dept: GP
: Visit Type: GP
: Site: University Hospital Crosshouse
:
:
: 51350924 03/06/2025 XR Knee both
: _
:
:
:
: Clinical Indications
: Pain both knees getting worse, trauma to left knee 4 weeks ago
: ?OA
:
:
: Report
:
: Left knee:
:
: Narrowing, subchondral sclerosis and osteophytosis is seen at the tibiofemoral joint space. Small marginal osteophytes are noted at the patellar articular surface
: Findings are in keeping with mild degenerative change which has progressed when compared with imaging dated 02/03/2023.
: No other significant bone or joint abnormality is identified; in particular no evidence of a healing fracture.
:
: Right knee:
:
: Narrowing seen at the medial tibiofemoral joint space and small marginal osteophytes are noted at the patellar articular surface.
: Findings are in keeping with early degenerative change which has not significantly progressed when compared with imaging dated 28.9.2022
:
: Murrells, V(Rep.Radiographer RA34400)
:
: Reported by: Vicki Murrells (Reporting Radiographer)
Reported By:Vicki Murrells
Released By:Vicki Murrells

XR Knee both

Patient ID	3010776241:OHCP	**Patient Name**	WELSH, Caroline
Sex	Female	**Date Of Birth**	30-Oct-1977
Performed	03-Jun-2025 14:20	**Order Number**	AA15135092401
Ordering Provider	Hamilton	**Status**	Final

XR Orthopantomogram full

Patient ID	3010776241:OHCP	**Patient Name**	WELSH, Caroline
Sex	Female	**Date Of Birth**	30-Oct-1977
Performed	13-Aug-2024 11:14	**Order Number**	AA15104936501
Ordering Provider	Miss Deborah Boyd.	**Status**	Final

General

Final

:
:
:
: Report
: To comply with the Ionising Radiation (Medical Exposure) Regulations 2017, this examination requires a report. Under certain instances the referring clinician has agreed to record their evaluation in the patient's clinical notes, thus complying with these regulations. If such evaluation is not possible the referring clinician must request a radiologist's report through the Diagnostic Imaging Manager.
:
: Medical Imaging Department
:
: Reported by: AUTO REPORT
Reported By:AUTO REPORT
Released By:AUTO REPORT

US Abdomen

Patient ID	3010776241:OHCP	**Patient Name**	WELSH, Caroline
Sex	Female	**Date Of Birth**	30-Oct-1977
Performed	26-Jan-2024 16:13	**Order Number**	AA15085072701
Ordering Provider	Hamilton	**Status**	Final

General

Final

: Patient Name: Caroline, Welsh
: Patient Address: 9 St. Michaels Place, KA13 6FA
: DOB: 30/10/1977
: Patient ID: 3010776241
: Accession Number: AA15085072701
: Referring Cons: Fiona Hamilton (GP Oxen)
: Referring Dept: GP
: Visit Type: GP
: Site: Ayrshire Central Hospital (Irvine)
:
: 50850727 26/01/2024 US Abdomen
: _
:
:
: Clinical Indications
: Abnormal LFT for over 1 year, raised ferritin too. Carrier for haemochromatosis. USS liver to check for pathology please.
:
: Report
: The liver appears normal in size and contour with a diffusely increased echogenicity suggestive of fatty infiltration/parenchymal change. No focal pathology identified. Normal directional flow within the main portal vein.
:
: Normal appearances of the pancreas, abdominal aorta, gallbladder (no stones), biliary tree, kidneys and spleen.
:
: No abdominal free fluid.
:
:
: Keegan, Emma (Sonographer)
:
: Reported by: Emma Keegan (Reporting Sonographer)
Reported By:Emma Keegan
Released By:Emma Keegan

XR Knee Lt

Patient ID	3010776241:OHCP	**Patient Name**	WELSH, Caroline
Sex	Female	**Date Of Birth**	30-Oct-1977
Performed	02-Mar-2023 09:25	**Order Number**	AA15054481701
Ordering Provider	MacLeod (GP Physio)	**Status**	Final

General Final

: Patient Name: Caroline, Welsh
: Patient Address: 9 St Michaels Place, KA13 6FA
: DOB: 30/10/1977
: Patient ID: 3010776241
: Accession Number: AA15054481701
: Referring Cons: Ryan MacLeod (OxenwardPhysio)
: Referring Dept: GP
: Site: Ayrshire Central Hospital (Irvine)

: 50544817 02/03/2023 XR Knee Lt

: Clinical Indications
: 2/12 hx left knee joint pain. Remains quite painful and restricted knee extension. Tender fibular head. Any #? NMR 1

: Report

: Left knee:

: No effusion, acute bony injury or evidence of healing fracture is seen.
: A small bony excrescence is seen at the medial aspect of the proximal tibia in keeping with a pes anserinus spur.

: Slater, K (Rep.Radiographer RA38007)

: Reported by: Kirsty Slater (Reporting Radiographer)
Reported By: Kirsty Slater
Released By: Kirsty Slater

XR Hand Rt

Patient ID	3010776241:OHCP	**Patient Name**	WELSH, Caroline
Sex	Female	**Date Of Birth**	30-Oct-1977
Performed	28-Sep-2022 14:44	**Order Number**	AA15042686501
Ordering Provider	Hamilton	**Status**	Final

General Final

: Patient Name: Caroline, Welsh
: Patient Address: 9 St Michaels Place, KA13 6FA
: DOB: 30/10/1977
: Patient ID: 3010776241
: Accession Number: AA15042686502
: Referring Cons: Fiona Hamilton (Oxenward)
: Referring Dept: GP
: Site: Ayrshire Central Hospital (Irvine)

: 50426865 28/09/2022 XR Hand Rt

: 50426865 28/09/2022 XR Chest

: Clinical Indications
: Had covid6 weeks ago, SOBOE and sweating ++. O/E Chest wheeze upper zones.
: Pain right hand for few weeks, no h.o trauma.
: ?OA right hand ?lung pathology

: Report
: 50426865 28/09/2022 XR Hand Rt
: No bone or joint abnormality is seen.

: 50426865 28/09/2022 XR Chest

: The lungs are clear. The cardiomediastinal shadows are normal.
: No new lesion is seen compared with previous radiographs of 2020 and 2009.

: Ajiboye, Khadija (Locum Radiologist, 7800300)

: Reported by: Khadija Ajiboye (Locum Radiologist)
Reported By:
Released By:Khadija Ajiboye

XR Chest

Patient ID	3010776241:OHCP	**Patient Name**	WELSH, Caroline
Sex	Female	**Date Of Birth**	30-Oct-1977
Performed	28-Sep-2022 14:44	**Order Number**	AA15042686502
Ordering Provider	Hamilton	**Status**	Final

General Final

: Patient Name: Caroline, Welsh
: Patient Address: 9 St Michaels Place, KA13 6FA
: DOB: 30/10/1977
: Patient ID: 3010776241
: Accession Number: AA15042686502
: Referring Cons: Fiona Hamilton (Oxenward)
: Referring Dept: GP
: Site: Ayrshire Central Hospital (Irvine)

: 50426865 28/09/2022 XR Hand Rt

: 50426865 28/09/2022 XR Chest

: Clinical Indications
: Had covid6 weeks ago, SOBOE and sweating ++. O/E Chest wheeze upper zones.
: Pain right hand for few weeks, no h.o trauma.
: ?OA right hand ?lung pathology

: Report
: 50426865 28/09/2022 XR Hand Rt
: No bone or joint abnormality is seen.

: 50426865 28/09/2022 XR Chest

: The lungs are clear. The cardiomediastinal shadows are normal.
: No new lesion is seen compared with previous radiographs of 2020 and 2009.

: Ajiboye, Khadija (Locum Radiologist, 7800300)

: Reported by: Khadija Ajiboye (Locum Radiologist)
Reported By:
Released By: Khadija Ajiboye

XR Mammogram Both

Patient ID	3010776241:OHCP	**Patient Name**	WELSH, Caroline
Sex	Female	**Date Of Birth**	30-Oct-1977
Performed	27-Sep-2021 17:00	**Order Number**	AAA5002615901
Ordering Provider	Dr S Tovey	**Status**	Final

General Final

: Patient Name: CAROLINE, WELSH
: Patient Address: 13 Mossgiel Drive, KA12 0QT
: DOB: 30/10/1977
: Patient ID: 3010776241
: Accession Number: AAA5002615901
: Referring Cons: Sian Tovey (Cons)
: Referring Dept: General OP Dept
: Site: Ayrshire Central Hospital (Irvine)

: 50026159 27/09/2021 XR Mammogram Both
: –

: Clinical Indications
: c/o lump left. o/e vague nodular area 12oclock, p2. can discharge if imaging benign

: Report
: Bilateral mammograms

: Bilaterally there is mixed density breast pattern. No suspicious features seen. M1.

: McHardy, M (Cons Radiologist 7576356)

: Reported by: Maret McHardy (Radiologist), Dr Penny Law (Locum Radiologist)
Reported By:Dr Penny Law
Released By:Dr Penny Law

US Breast Lt

Patient ID	3010776241:OHCP	**Patient Name**	WELSH, Caroline
Sex	Female	**Date Of Birth**	30-Oct-1977
Performed	27-Sep-2021 17:00	**Order Number**	AAA5002616001
Ordering Provider	Dr S Tovey	**Status**	Final

General Final

: Patient Name: CAROLINE, WELSH
: Patient Address: 13 Mossgiel Drive, KA12 0QT
: DOB: 30/10/1977
: Patient ID: 3010776241
: Accession Number: AAA5002616001
: Referring Cons: Sian Tovey (Cons)
: Referring Dept: General OP Dept
: Site: Ayrshire Central Hospital (Irvine)

: 50026160 27/09/2021 US Breast Lt

: Clinical Indications
: c/o lump left. o/e vague nodular area 12oclock, p2. can discharge if imaging benign

: Report
: Ultrasound examination of left breast

: In the upper aspect of the left breast in the area of patient's concern there is mixed glandular and fatty nodularity noted. No suspicious features seen. U1.

: Patient discharged.

: McHardy, M (Cons Radiologist 7576356)

: Reported by: Maret McHardy (Radiologist)
Reported By:
Released By:Maret McHardy

General

Performed	20-Aug-2020 23:43	Order Number	AA13856977401
Ordering Provider	Ramachandran	Status	Final

General Final

```
:
: 20 August 2020, 23:43:00
: 20 August 2020, 23:43:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 3010776241   Examination Number: 38569774   Examination Date: 20/08/2020
: Name:   WELSH, CAROLINE  DOB:  30/10/1977
: Address:  13 MOSSGIEL DRIVE, AYRSHIRE, IRVINE, KA12 0QT -- CC: -
: Referring Department / Location: Accident & Emergency
: Crosshouse Hospital
: Kilmarnock Road
: Crosshouse
: Ayrshire
: KA2 0BE
: Referring Consultant:  Dr. C. McGuffie        Clinical Specialty:   Accident & Emergency
: Date Dictated: 28/08/2020                  Typed by:  None
: Examination:  XR Chest
:
: Clinical Indication
:
: acute onset left sided chest pain r/o pneumothorax
:
:
: Report:
: The lungs and pleural spaces are clear.  No evidence of pneumothoraces.  Cardiomediastinal contours are normal.  The bony thoracic cage is also normal.
:
:
: Dictating Radiologist / Clinical Specialist    Ramachandran, Pothera (Loc)
:
: Verified by: Ramachandran, Pothera (Loc)
Reported By: Pothera (Loc) Ramachandran
Released By: Pothera (Loc) Ramachandran
Released On: 28/08/2020 12:43
```

Report History

Final Report from **Revive**	6 years ago

Access History

General

Performed	31-Mar-2016 13:04	Order Number	AA13414252801
Ordering Provider	Blower.Caroline (Con Radiographer)	Status	Final

General Final

```
:
: 31 March 2016, 13:04:00
: 31 March 2016, 13:09:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 3010776241   Examination Number: 34142528   Examination Date: 31/03/2016
: Name:   WELSH, CAROLINE  DOB:  30/10/1977
: Address:  26 LEWIS TERRACE, , IRVINE,  -- CC: -
: Referring Department / Location: Accident & Emergency
: Crosshouse Hospital
: Kilmarnock Road
: Crosshouse
: Ayrshire
: KA2 0BE
: Referring Consultant: Dr. C. McGuffie
: Date Dictated: 01/04/2016              Typed by:  None
: Examination:  XR Hand Rt
:
: Clinical Indication
:
: Hit hand on bannister bony tender over base of 5th MC and carpal bones.
:
:
: Report:
: No acute bony injury is seen.
:
:
: Dictating Radiologist / Clinical Specialist    Blower.Caroline (Con Radiographer)
:
: Verified by: Blower.Caroline (Con Radiographer)
Reported By: Blower.Caroline (Con Radiographer)
Released By: Blower.Caroline (Con Radiographer)
Released On: 01/04/2016 11:56
```

Report History

Final Report from **Revive**	10 years ago

Access History

Crosshouse Hospital
Kilmarnock Road
Crosshouse
Kilmarnock
KA2 0BE

NHS Ayrshire & Arran

RADIOLOGY REPORT

CHI NUMBER: 3010776241 **Examination Number:** 31499423 **Examination Date:** 06/01/2012
Name: Welsh, Caroline DOB: 30/10/1977
Address: 26 Lewis Terr, Irvine, , KA11 1HJ -- **CC:** -
Referring Department / Location: Dr V Franklin (O&G)
Referring Consultant: Dr V Franklin
Date Dictated: 06/01/2012 **Typed by:** None
Examination: US Pelvis (Transvaginal)

Clinical Indication

heacy pv bleeding, generalised lower abdominal pains, PV speculum - removal of products. ? pathology unkown. bhcg neg. ? uterine pathology

Report:

TA and TV scans done.
Bulky anteverted uterus with no focal abnormality demonstrated. The endometrium was thickened to 18.5mm.
Normal appearance of the ovaries, bladder and both kidneys.
No adnexal masses or free fluid demonstrated.

Dictating Radiologist / Clinical Specialist **Catherine Raeside (Sonographer)**

Verified by: Catherine Raeside (Sonographer)

Fite
W
30/1/12.

3010776241] Examination Number: 31499423 Examination Date: 06/01/2012
Name: Welsh, Caroline DOB: 30/10/1977
Dose :-

Radiology Results displayed are **verified reports only**

All results from Occupational Health and GUM clinics **are suppressed.**
All Gonorrhoea, Chlamydia and Pertussis results **are suppressed.**
Samples requesting the following will have **all results from that sample suppressed** - HIV, HepB, HepC and Syphilis.

DEPARTMENT OF RADIOLOGY

Name: **Caroline WELSH** D.o.B: **30/10/1977** Sex: **F** CHI No.: **3010776241**
Patient ID: **3010776241**
Address: **26 Lewis Terr, , Irvine, , KA11 1HJ** Attendance Number: **AA13085490401** Sample Site: **Radiology**
Requester: **()** Location: **BLANK**
Examination Date: **19/07/2010 10:59**
Authorised by:

Examination: US **Auth. Date:** 20/07/2010 08:53

19 July 2010, 10:59:00
19 July 2010, 10:59:00

RADIOLOGY REPORT
CHI NUMBER: 3010776241 Examination Number: 30854904 Examination Date: 19/07/2010
Name: Welsh, Caroline DOB: 30/10/1977
Address: 26 Lewis Terr, Irvine, , KA11 1HJ -- CC: -
Referring Department / Location: Dr W Agur

Referring Consultant: Dr W Agur
Date Dictated: 19/07/2010 Typed by: None
Examination: US Pelvis (Transabdominal)

Clinical Indication:
Severe pelvic pain

Report:
Transabdominal scan done.
Anteverted uterus normal in size measuring 10.3 x 5x 6.3 cm. Normal endometrial thickness of 11.8 mm. No focal abnormality demonstrated.
The ovaries were not identified due to overlying bowel gas. No adnexal or pelvic mass. No free fluid.
Both kidneys are normal in size and appearance.

Dictating Radiologist / Clinical Specialist Claire Wilson (Sonographer)

Verified by: Claire Wilson (Sonographer)
Reported By: Claire Wilson (Sonographer)
Released By: Claire Wilson (Sonographer)
Released On: 20/07/2010 08:53

M Ford
To file
15/8/10

RADIOLOGY REPORT

Gynaecology

466693

SS

Department of Radiology

Crosshouse Hospital
Kilmarnock Road
Crosshouse
Kilmarnock
KA2 0BE

NHS
Ayrshire
& Arran

RADIOLOGY REPORT

CHI NUMBER: 3010776241 **Examination Number:** 30854904 **Examination Date:** 19/07/2010
Name: Welsh, Caroline DOB: 30/10/1977
Address: 26 Lewis Terr, Irvine, , KA11 1HJ -- **CC:** -
Referring Department / Location: Dr W Agur
Referring Consultant: Dr W Agur
Date Dictated: 19/07/2010 **Typed by:** None
Examination: US Pelvis (Transabdominal)

Clinical Indication:

Severe pelvic pain

Report:

Transabdominal scan done.
Anteverted uterus normal in size measuring 10.3 x 5x 6.3 cm. Normal endometrial thickness of 11.8 mm. No focal abnormality demonstrated.
The ovaries were not identified due to overlying bowel gas. No adnexal or pelvic mass. No free fluid.
Both kidneys are normal in size and appearance.

Dictating Radiologist / Clinical Specialist **Claire Wilson (Sonographer)**

Verified by: Claire Wilson (Sonographer)

To file
M Ford
27/7/10

CHI NUMBER: 3010776241 **Examination Number:** 30854904 **Examination Date:** 19/07/2010
Name: Caroline Welsh DOB: 30/10/1977
3010776241

RADIOLOGY

STA0169

14	PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW
13	PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW
12	PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW
11	PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW
10	PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW
9	PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW
8	PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW
7	PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW
6	PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW

PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE

Name: MORRIN,CAROLINE — X-RAY REPORT Crosshouse Hospital
4 CRAIGNAW PLACE
IRVINE
Sex: F AVB DOB: 30/10/1977 Requesting Dr: WHITFORD,P.
Location: SOFW
Unit #: A9000273109 Exam Date/Time: 18/11/04 0812

Chk-in #	Order	Code	Exam
1117800	0002	2560	US Breast R.

Clinical history: right nipple discharge. Long standing. Right breast pain. No discharge elicited in clinic. No lump evident.

ULTRASOUND RIGHT BREAST

Nipple areolar region. No evident abnormality.

Reported By: Michael Dean Typed By: CK 19/11/04 1332

Verified

23/11

DEPARTMENT OF RADIOLOGY

KALAMAZOO S-1034832-12x8¼ V © Copyright

STA0169

14
13
12
11
10

Crosshouse Hospital

X-RAY REPORT

Name: HARMON,CAROLINE
29H SLOAN AVE
IRVINE

Sex: F DOB: 30/10/77
Location: 5A
Unit #: A9000221860

Requesting Dr: WARDROP,P.
Exam Date/Time: 08/01/01 2114

~~Chic in #~~	~~Order~~	~~Code~~	~~Exam~~
774204	0001	1045	Chest
774204	0001	1700	Abdomen

466693
Mr Newland 9/1

#A&E Number : N/A

The heart is not enlarged. The lung fields are clear.

No specific abnormality in the abdomen.

Reported By: George McLaughli Typed By: CK 09/01/01 1014

Verified

DEPARTMENT OF RADIOLOGY

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OR IOPTIC and AUDIOMETRIC

PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW

Bayer HealthCare LLC
Clinitek Status®
Patient Caroline moran
Pv Bleed

Multistix® 8 SG
Test date 12-23-2007
Time 10:12PM
Operator
Test number 0069
Color Not Entered
Clarity Not Entered

GLU Negative
KET 15 mg/dL
SG 1.020
BLO Large
pH 7.0
PRO >=300 mg/dL
NIT Positive
LEU Large

S.A.F.E.R.
Twin Flexible Endoscope Reprocessor Validation Results

ORTHOPTIC and AUDIOMETRIC

STA0247

14 ▶ PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW

13 ▶ PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW

12 ▶ PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW

11 ▶ PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW

2 ▶ PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW

S.A.F.E.R.

Twin Flexible Endoscope
Reprocessor
Validation Results

Date 19 /12 /06
Time 11 :02 :00
Ser. Number 035286
Operator Loading
Susan Lever

Instrument IDs 0011 0011

Detergent Addition
Confirmed
Cycle Count No. 01057
Lid Closed :PASS
Leak Test(s) :PASS
Filling wash
Flush Contact 3mins
Channel Patency :PASS
Draining :PASS
Fill/Rinse
Flush Contact 60sec
Channel Patency :PASS
Filling Sterilox
Contact 5mins
Channel Patency :PASS
Draining :PASS
Final Rinse
Flush Contact 40secs
Channel Patency :PASS
Draining :PASS
Air filtration :PASS
Operator Unloading
Door West
Lid Open :PASS

CYCLE PASS

Time 11 :37
Lid Open :PA

CHI 301 0776241
MORRIN CAROLINE
4 CRAIGNAN PLACE
IRVINE
KA11 1EZ
30/10/1977
Case Ref 46693
Proc 80330

ORTHOPEDIC and AUDIOMETRIC

PEEL AWAY STRIP & PLACE TOP EDGE OF REPORT ALONG LINE BELOW	

ResMed

ApneaLink - Report of 04/02/2025 13:56

Treating physician
Dr Carlin

Referral to

Patient data

First name:	Caroline	Patient ID:	3010776241
Last Name:	Welsh	DOB:	30/10/1977
Street:		Height:	0 cm
City, ST, Zip:		Weight:	0 kg
Phone:		BMI:	kg/m²

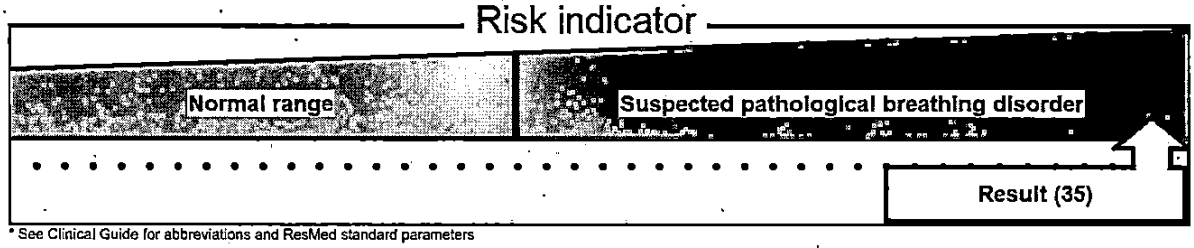
Recording

Date:	04/02/2025
Start:	00:01 .
End:	07:43 .
Duration:	7 h 42 min

Evaluation

Start:	00:11 .
End:	07:41 .
Duration:	7 h 28 min

Risk indicator



* See Clinical Guide for abbreviations and ResMed standard parameters

Analysis (Flow evaluation period: 7 h 28 min / SpO_2 evaluation period: 6 h 34 min)

Indices		Normal	Result	
AHI*:	31.1	< 5 / h	Average breaths per minute [bpm]:	11.95
RI*:	35.3	< 5	Breaths:	5354
Apnea index:	0	< 5 / h	Apneas:	0
UAI:	0		Unclassified apneas:	0
OAI:	0		Obstructive apneas:	0
CAI:	0		Central apneas:	0
MAI:	0		Mixed apneas:	0
Hypopnea index:	31.1	< 5 / h	Hypopneas:	232
% Flow lim. Br. without Sn (FL):	43	< Approx. 60	Flow lim. Br. without Sn (FL):	2318
% Flow lim. Br. with Sn (FS):	6	< Approx. 40	Flow lim. Br. with Sn (FS):	326
			Snoring events:	1940
ODI Oxygen Desaturation Index*:	37.1	< 5 / h	No. of desaturations:	244
Average saturation:	92	94% - 98%	Saturation <= 90% :	104 min (26%)
Lowest desaturation:	78	-	Saturation <= 85% :	44 min (11%)
Lowest saturation:	75	90% - 98%	Saturation <= 80% :	1 min (0%)
Baseline Saturation:	97	%		
Minimum pulse:	60	> 40 bpm		
Maximum pulse:	217	< 90 bpm		
Average pulse:	81	bpm		
Proportion of probable CS epochs:	0	0%		

Analysis status: Edited manually (Hypopneas based on flow only)

Analysis parameters used (User-defined)

Apnea [1%; 10s; 80s; 1.0s; 20%; 60%; 5%]; Hypopnea [50%; 10s; 100s; 1.0s]; Snoring [6.0%; 0.3s; 3.5s; 0.5s]; Desaturation [4.0%]; CSR [0.50]

Comments

Indices indicate severe OSAHS
Elevated ODI indicating CPAP trial
ESS15
G Toole

RESMED

Name: Caroline Welsh Date: 04/02/2025

Patient ID/Ref No.: 3010776241

Physician to fill out this section

☐ **Refer directly to sleep specialist _____ for consultation and possible polysomnography testing due to sleep screening of AHI of 31.1.**

Patient complaints of:		ICD-9
Daytime sleepiness (hypersomnia, unspecified)	_____	780.54
Other _____	_____	_____
Other _____	_____	_____

Co-morbid diagnoses:		ICD-9
Essential hypertension	_____	401
CHF	_____	428.0
Diabetes mellitus	_____	250.0
Cardiovascular disease	_____	429.2
Other _____	_____	_____
Other _____	_____	_____

Note: Only AHI and Cheyne Stokes probability are a result of the ApneaLink calculation

Notes:

Ordering Physicians Signature: _____ DEA#_____

WELSH, CAROLINE ID: 30 '6241 18-Jun-2013 15:25:32 C SHOUSE HOSPITAL

30-Oct-1977
Female Caucasian

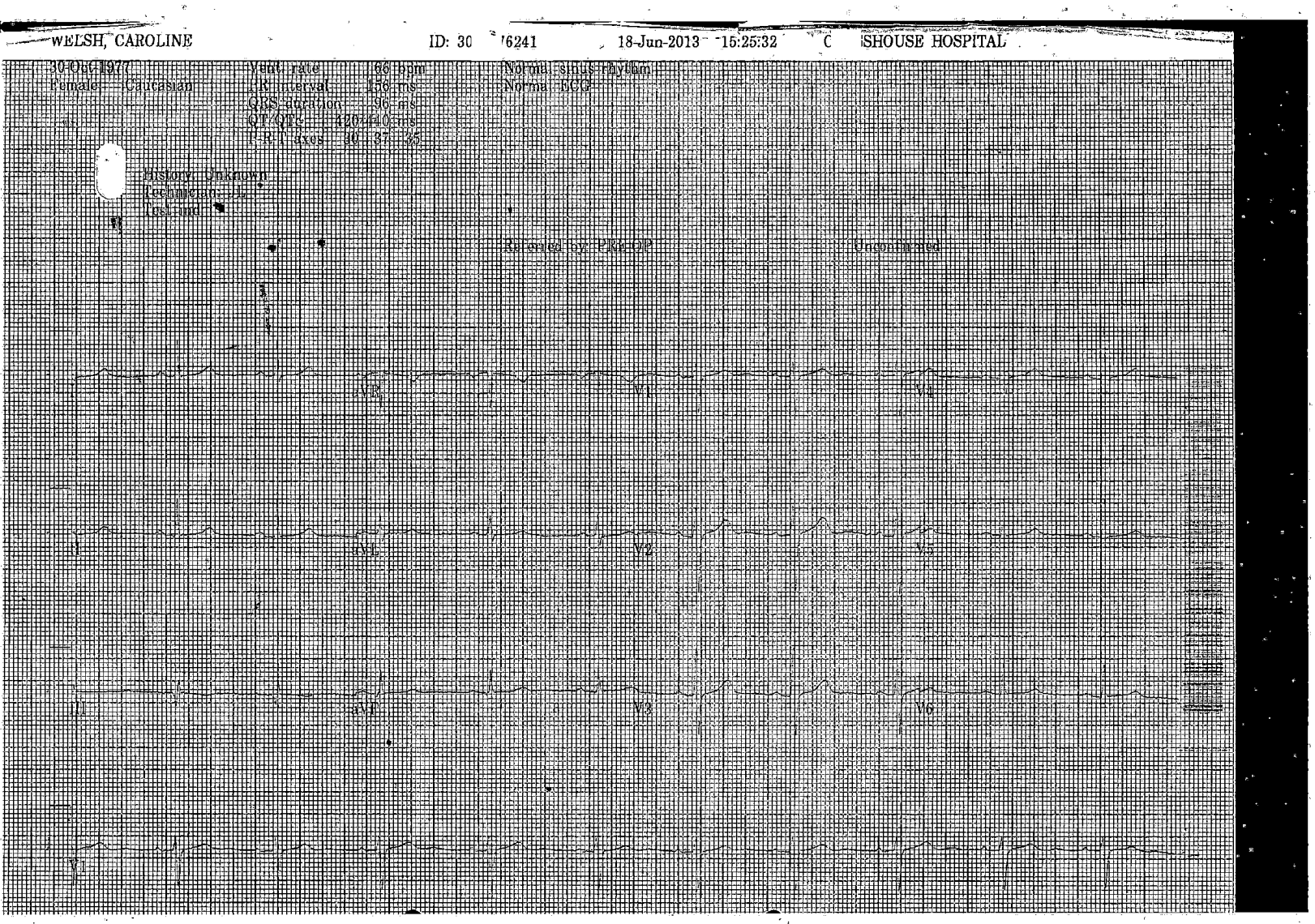
Vent. rate 66 bpm
PR interval 156 ms
QRS duration 96 ms
QT/QTc 420/440 ms
P-R-T axes 30 37 35

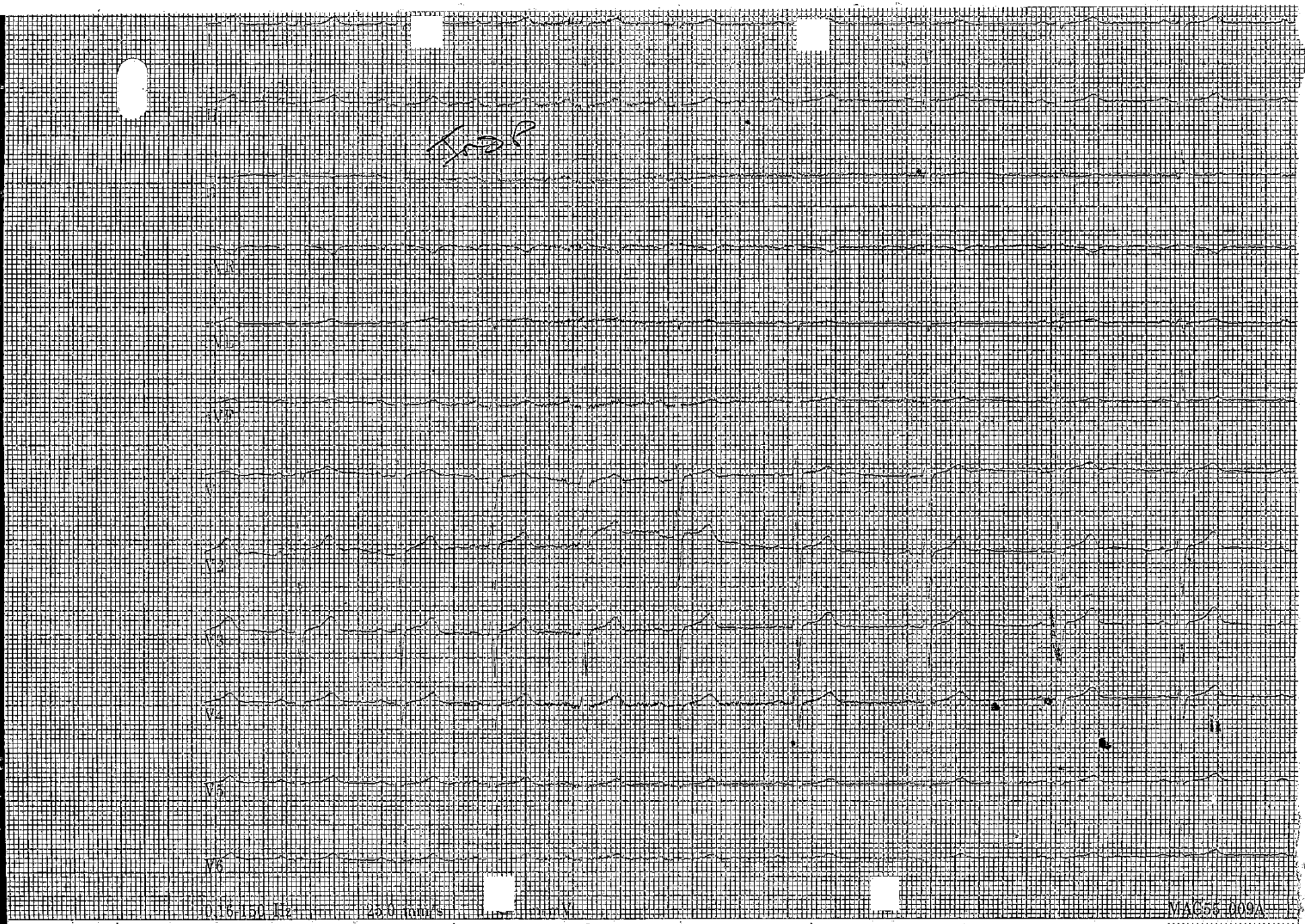
Normal sinus rhythm
Normal ECG

History: Unknown
Technician: FE
Test ind:

Referred by: PRACP

Unconfirmed





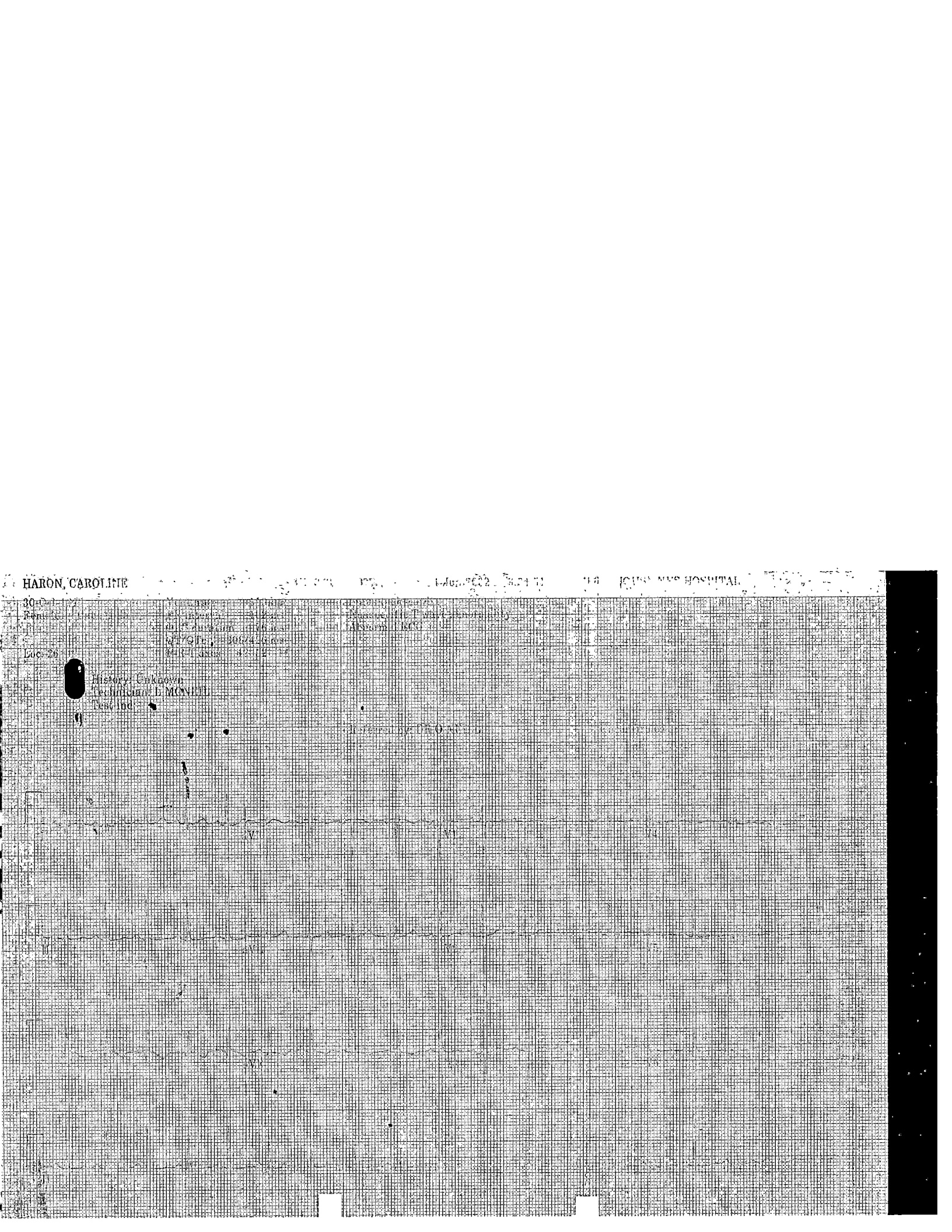
MQE 9402-020 | Graphic Controls Ltd | Printed in UK

27-Dec-2009 20:02:37 caroline morris crosshouse hospital A&E Dept
32 Years Female

Rate 83 NORMAL SINUS RHYTHM, RATE 83 ..... Normal P axis, PR, QRS & rhythm
PR 157
QRSD 80
QT 336
QTc 395

--Axis--
P 0
QRS 58
T 37

NORMAL ECG Unconfirmed diagnosis



Zymed

ZYMED HOLTER REPORT
1201 North Rice Avenue #B
Oxnard, California 93030
(800) 524-8884

PATIENT DEMOGRAPHICS

Last Name	HARMON	**Physician**	DR ONEILL
First Name	CAROLINE	**Scanned By**	P TURNBULL
Middle Initial		**Reading Physician**	
ID Number	466693	**Test Date**	04/06/02
Date Of Birth	30/10/77	**Analysis Date**	05/06/02
Sex	F	**Hookup Time**	09:40
Source	MOPD	**Recording Time**	23 hr 37 min
Billing Code		**Analysis Time**	23 hr 37 min
Recorder Format	Digitrak Plus	**User Field #1**	
Reason for Test	PAROX TACHYCARDIA	**User Field #2**	
Medications			

Heart Rate Data

Total Beats	: 138565
Min HR	: 58 BPM at 02:06:49
Avg HR	: 98 BPM
Max HR	: 160 BPM at 09:02:42

Heart Rate Variability

ASDNN 5	: 42.9 msec
SDANN 5	: 89.9 msec
SDNN	: 100.6 msec

ST Episode Analysis

		Ch1	Ch2	Ch3
Min ST Level	:	-	-	-
Max ST Level	:	-	-	-
ST Episodes	:	-	-	-

Pacer Analysis

Single Paced Beats	: -
Dual Paced Beats	: -
Fusion Beats	: -

Ventricular Ectopy

Total VE Beats	: 0 (0.0%)
Vent Runs	: 0
Beats	: 0
Longest	: 0
Fastest	: 0 BPM
Triplets	: 0 Events
Couplets	: 0 Events
Single/Interp PVC	: 0/0
R on T	: 0
Single/Late VE's	: 0/0
Bi/Trigeminy	: 0/0 Beats

Supraventricular Ectopy

Total SVE Beats	: 10 (0.0%)
Atrial Runs	: 0
Beats	: 0
Longest	: 0
Fastest	: 0 BPM
Atrial Pairs	: 1 Event
Drop/Late	: 0/7
Longest N-N	: 1.3 sec at 01:58:19
Single PAC's	: 1
Bi/Trigeminy	: 0/0 Beats

INTERPRETATION

Signed : **Date :**

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Narrative Summary

Monitoring started at 09:40 and continued for 23 hr 37 min. The average heart rate was 98 BPM. The minimum heart rate was 58 BPM, occurring at 02:06:49. The maximum heart rate was 160 BPM, occuring at 09:02:42.

The patient's rhythm included 6 hr 16 min 28 sec of tachycardia. The fastest single episode of tachycardia occurred at 08:40:03, lasting 27 min 55 sec, with maximum heart rate of 160 BPM.

Supraventricular ectopic activity consisted of 10 beats, of which, 2 were in atrial couplets, 7 were late beats, 1 was single PACs. The longest R-R interval was 1.3 seconds occurring at 01:58:19. The longest N-N interval was 1.3 seconds occurring at 01:58:19.

QT interval averaged 362 ms during the monitored period. QTc interval averaged 458 ms during the monitored period. Maximum QT interval was 438 ms during the monitored period, occuring at 17:07:00. Maximum QTc interval was 602 ms during the monitored period, occuring at 17:55:30. Minimum QT interval was 258 ms during the monitored period, occuring at 09:01:30. Minimum QTc interval was 390 ms during the monitored period, occuring at 04:28:00. The percent of average QTc greater than 450 ms was 46%.

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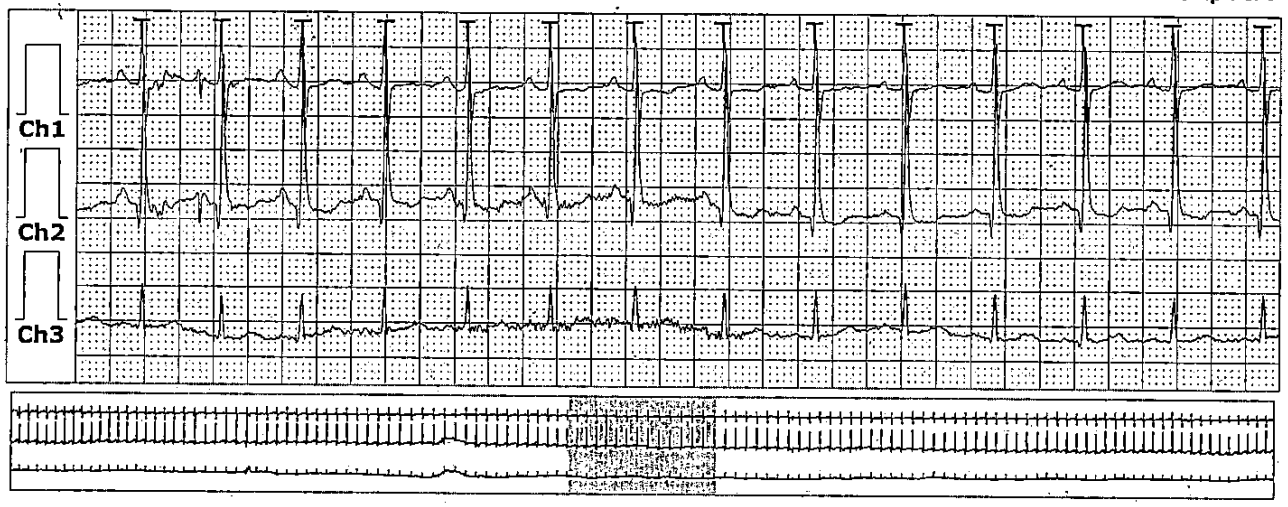
SELECTED STRIPS

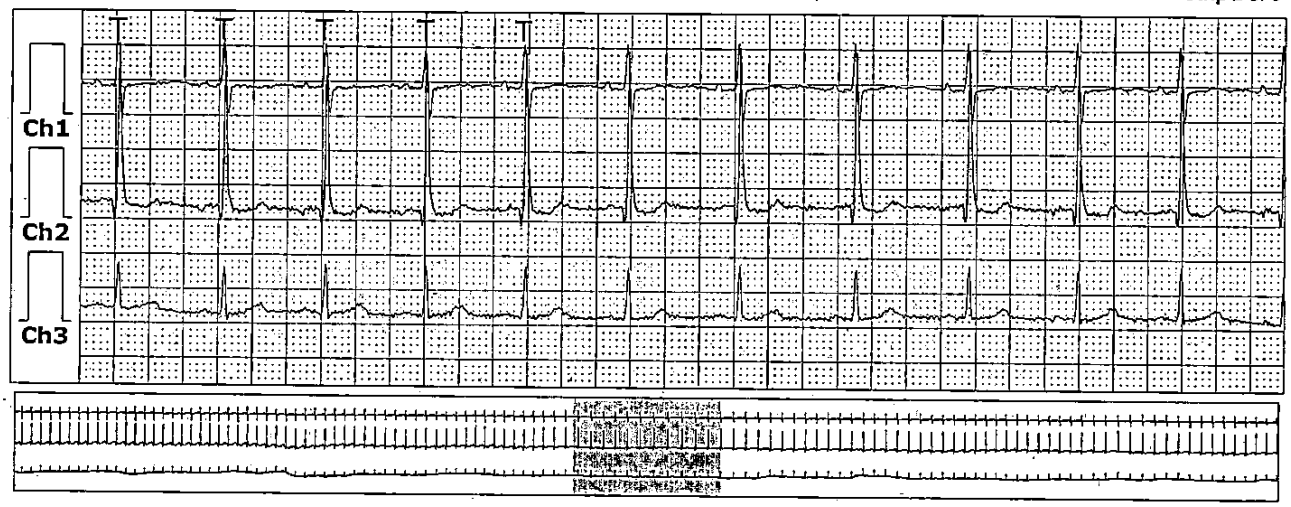
09:40:50 120 BPM Size x1,x1,x1 Tachy

Strip 1 of 6



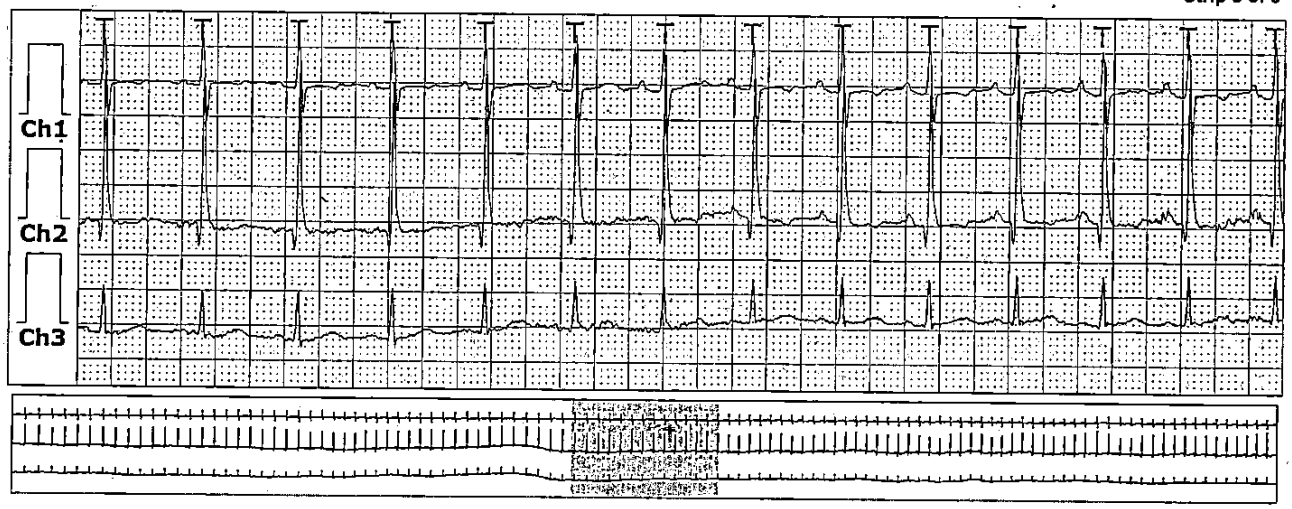
09:58:52 98 BPM Size x1,x1,x1 Tachy

Strip 2 of 6



11:50:17 114 BPM Size x1,x1,x1 Tachy

Strip 3 of 6



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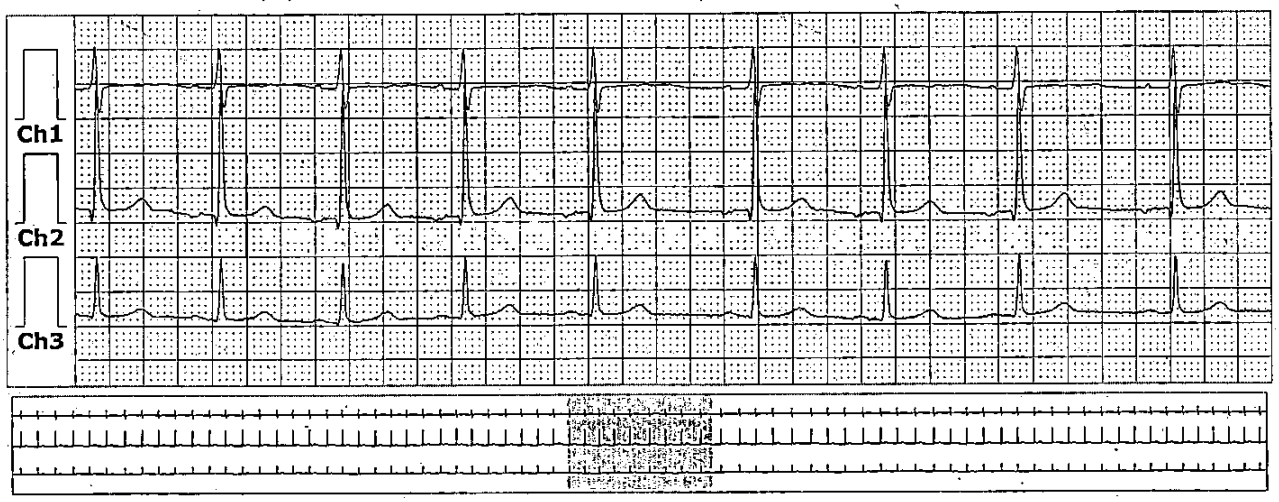
SELECTED STRIPS

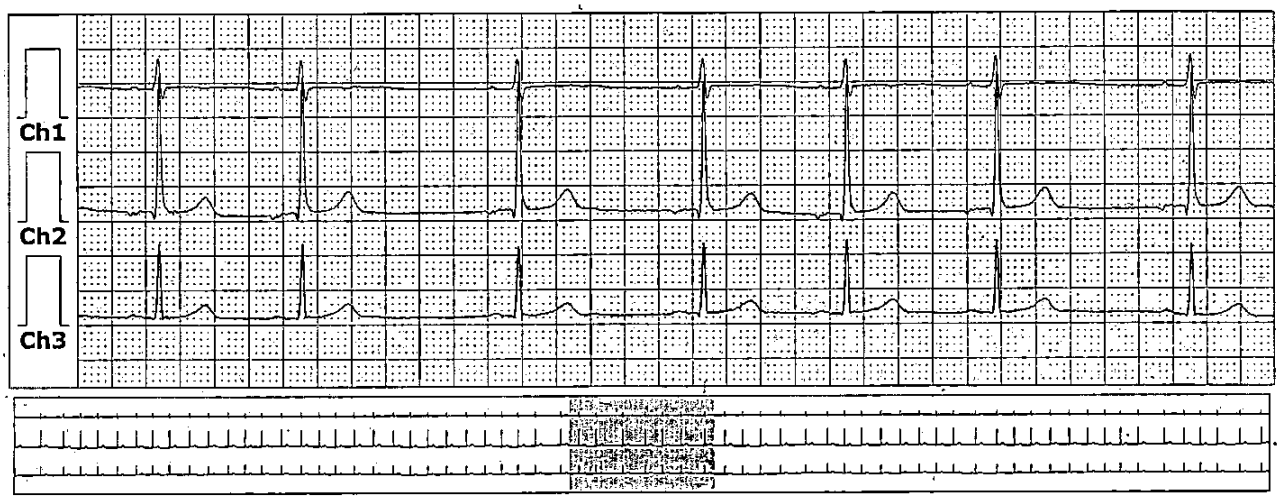
00:38:33 76 BPM Size x1,x1,x1 New Label - NORMAL SINUS RHYTHM

Strip 4 of 6



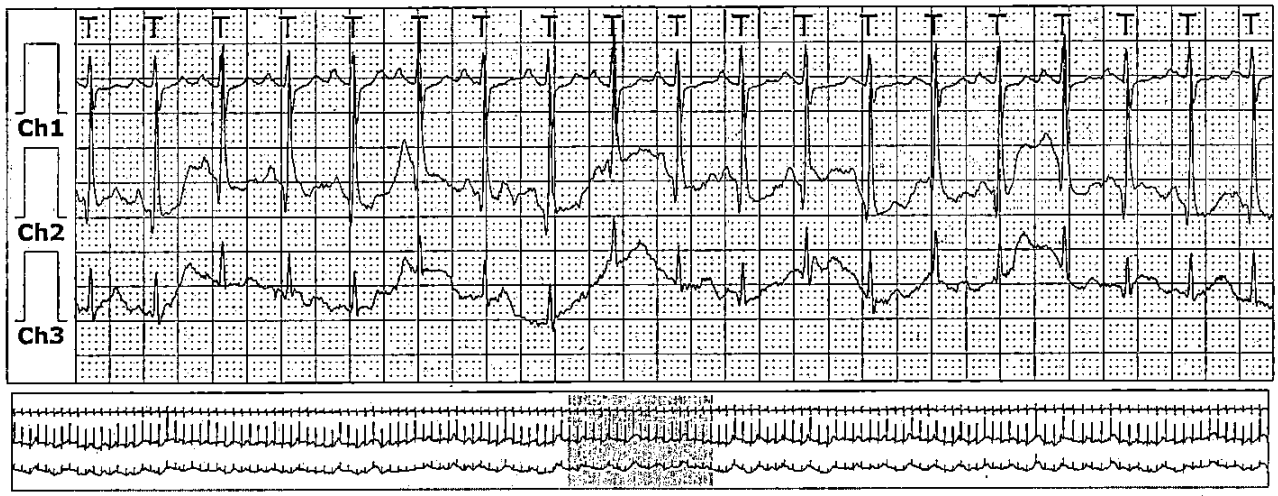
02:06:45 58 BPM Size x1,x1,x1 Min HR

Strip 5 of 6



09:02:38 160 BPM Size x1,x1,x1 Max HR

Strip 6 of 6



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Crosshouse Hospital Solo

Ward/Dept. OP | Consultant W ONeill | STA0136

Physical signs/Diagnosis

Pregnant.
Paroxysmal tachycardia.

Digoxin/Drugs

Date 4/6/02

Surn: CHI 3010776241
Forer: HARMON CAROLINE
4 CRAIGMAW PLACE
IRVINE
Addr: KA11 1EZ
30/10/1977 Proj: 80344
Case Ref 466693

12Lead E.C.G.	✓	Echocardiogram	✓
24hour Ambulatory Monitoring	✓	Phono-Cardiogram	
Exercise Tolerance Test	4/6	Others	

Date Monitored 4/6/02

Please be sure to record activity when symptoms occur.

ACTIVITY EXAMPES: Position changes (sitting, lying down, walking) Eating, Smoking, etc.

SYMPTOM EXAMPLES: Pain in chest, arm, neck or face. Sickness, Palpitations, Dizziness, Short of breath, etc.

Subw.

CROSSHOUSE HOSPITAL
CARDIOLOGY DEPARTMENT

Time am/pm	Activity	Symptoms
0945	Tapeon	anxious SOB

Name Caroline Harmon

Age Sex F

Doctor DR O'Neill

Hospital X House

Medicines being taken and dosage

12 or 24 Hours 24 Time on

Date Monitored 4/6/02

Please be sure to record activity when symptoms occur.

ACTIVITY EXAMPES: Position changes (sitting, lying down, walking) Eating, Smoking, etc.

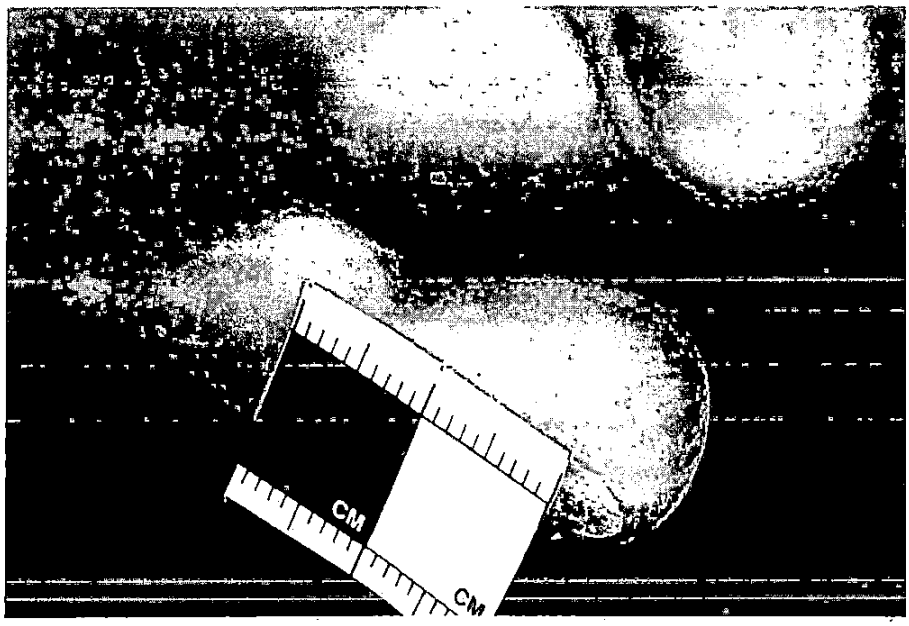
SYMPTOM EXAMPLES: Pain in chest, arm, neck or face. Sickness, Palpitations, Dizziness, Short of breath, etc.

Consent Level A

Clinical Photographs

NHS Ayrshire & Arran

Patients Name	Caroline MORRIN
Hospital Number	466693
Date	30/05/2008
Reference Number	72157
Consultant	Dr Dwyer



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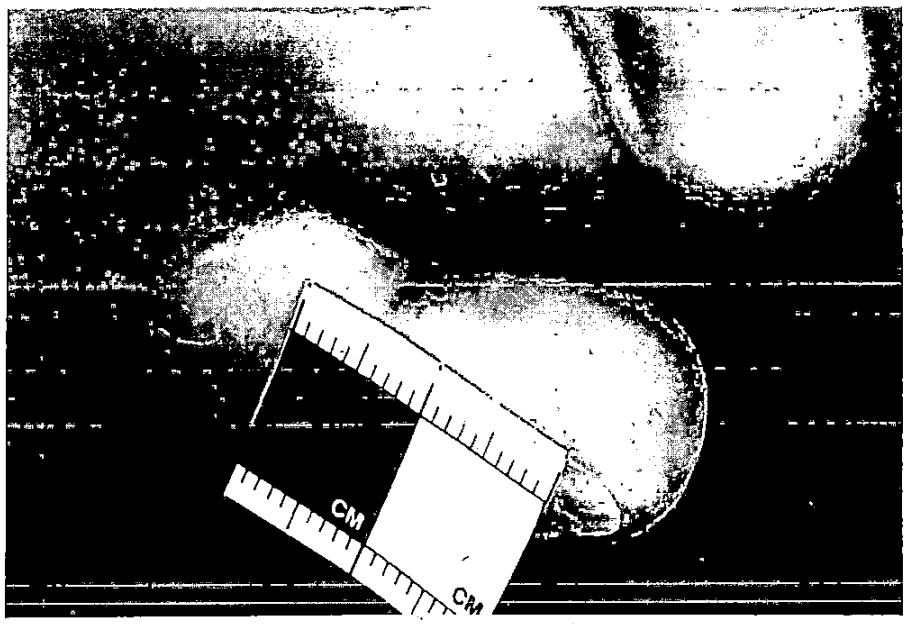
Consent Status: A = Medical Records Only, B = Casenotes & Teaching, C = Patient to Patient

Consent Level A

Clinical Photographs

NHS Ayrshire & Arran

Patient's Name	Caroline MORRIN
Hospital Number	466693
Date	30/05/2008
Reference Number	72157
Consultant	Dr Dwyer



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Tel No 07875530530

01294-215887

NHS
Ayrshire & Arran

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
N KA11 1HJ ....
30/10/1977
C Dr J Taylor ....
MRN XHI466693

Date: 31/5/13

PRE-OPERATIVE ASSESSMENT

Previous MRSA Y ☐ N ☐ MRSA Positive Y ☐ N ☐

Planned operation: TOTAL ABDOMINAL HYSTERECTOMY WITH CONSERVATION OF OVARIES

Consultant: DR FRANKLIN

Anaesthetist:

Date of Admission: 26/9/13 Time: 10·00

Date of Surgery: ~~To be arranged~~ 26/9/13 am list ☐ pm list ☑

Surgically suitable for:-

Day Surgery ☐ 23 Hour ☐ Same day admission ☑ In Patient ☑ CPET ☐

Clinical Team Signatures

ALL STAFF COMPLETING THE DOCUMENTATION **MUST** COMPLETE THIS SECTION BELOW.

NAME (BLOCK CAPITALS)	JOB TITLE	WARD, PAGE No or BASE	SIGNATURE	INITIALS
F.A MCGARVEY	HCA	POA	FA McGarvey	FAMG
JSKENE	PHYSIO	POA	JSkene	JS
A-JAMIESON	HCA	POA	A-Jamieson	AJ
LM FERGUSON	NP	POA	LM Ferguson	LMF
F KING	POA MANGR	3367	Fking	FK
FIONA PRENTICE	NP	POA	FPrentice	FP.

Problem identification

To be completed at end of assessment and thereafter

Problem	Action Taken	Sign	Date	Outcome	Sign	Date

Stage 1: Pre-operative Assessment Form

Age: 35 years

Prefers to be known as: Caroline

Patient's Telephone Numbers

Home:

Work:

Mobile: 07875530530

Occupation Carer

Write or attach label

HCR No:

CHI

Sur CHI: 3010776241
Welsh, Caroline
For 26 Lewis Terrace
Ad Irvine
KA11 1HJ
... 30/10/1977
D: Dr J Taylor
MRN: XHI466693

Observations at Stage 1 pre-operative assessment

BP: 120 / 70	HR: Reg/Irreg 68	Temp: 37.5°C	Resps: 12	SaO2: 98-99% on air %
Height: 169 m	Weight: 104.4 kg	BMI: 36 *If <19 refer to dietitian*	Urinalysis:	

1.70 102.0 (92kg) 35.3

Emergency Contact Details:

Name Brian Welsh

Relationship Husband

Address 26 lewis Terrace
Broomlands
Irvine

To be given information on condition? Yes ☑ No ☐

Home

Work

Mobile 07580068018

Contactable Day ☑ Night ☑

Aware of admission Y ☑ N ☐

Living Arrangements

Who do you live with?

Alone ☐ With adult(s) ☑

With dependents?

Children ☑ Adult requiring care ☐

Do you have special living conditions?

Residential home ☐ Nursing home ☐

Homecare services ☐

Stairs?

Outside ☐ How many?

Inside ☑ How many? 10ish

Day surgery patients only

Will you have a responsible adult (aged 18 or over) to take you home by car or taxi? Y ☑ N ☐

(public transport is not acceptable)

Will you have a responsible adult (aged 18 or over) to stay with you for 24 hours post-op? Y ☐ N ☐

Do you have access to a telephone? Y ☐ N ☐

Do you live within a 1 hour car journey of the hospital? Y ☐ N ☐

Patient's Signature Date

	Yes	No	Details
Have you had any operations or admissions to hospital? Please give details	✓		appendicectomy Laparoscopy pelvic repair
Have you or your family had any serious anaesthetic problems in the past? Please give details			ND

What exercise are you able to do?	Yes	No
Walk indoors around the house?	✓	
Do light housework like dusting or washing dishes?	✓	
Walk 100-200 yards on level ground slowly?	✓	
Walk on level ground at a brisk pace?	✓	
Climb 2 flights of stairs without stopping?	✓	
Do moderate exercise like play tennis or dancing?	✓	
If NO to any of the above, are you limited by:-		
Arthritis?		✓
Breathlessness?		✓
Angina or chest pain?		✓
Nerve or muscle disorder (e.g. multiple sclerosis, muscular dystrophy)		✓
Other reason:- please state (e.g. amputation)		✓

Have you ever suffered from any of the following? (If YES, please give details)	Yes	No	Details
High blood pressure	✓		95/96 Pre pregnancy was on meds fine since
Angina or chest pain		✓	chest pain central sternal this week - lasted a couple of days then went away itself - had been stressed
Heart attack		✓	
Heart murmur		✓	
Heart failure or fluid in your lungs		✓	
Palpitations or an irregular heart beat	✓		2002 when pregnant
Breathlessness at rest		✓	
Blackouts (if yes, what were you doing at the time?)	✓		Xray throat (needle) showering after surgery
Stroke or TIA (mini-stroke)		✓	
Disease of the nerves or muscles (e.g. Parkinson's Disease, multiple Sclerosis)		✓	
Epilepsy, convulsions or fits		✓	

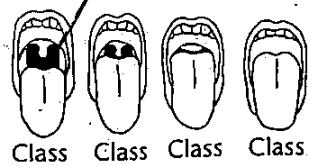
	Yes	No	Details
Asthma requiring regular treatment / inhalers		✓	
Chronic bronchitis or emphysema (COPD)		✓	
Any other respiratory illness		✓	
Sleep apnoea (obstructed breathing while sleeping)		✓	
Ankylosing spondylitis		✓	
Neck or jaw restrictions		✓	
Thyroid disorder		✓	
Diabetes - diet or tablet controlled		✓	
- or do you inject insulin to control this			
Chronic kidney disease		✓	
Anaemia or other blood disorder in the last year		✓	
Peripheral Vascular disease		✓	
Severe bleeding or bruising problems ?		✓	PV bleeding
Blood clots in the lungs or legs		✓	
Jaundice or other liver disease		✓	
Skin disorders		✓	
Problems with bowels, bladder / urinary problems		✓	
Heartburn, hiatus hernia or peptic ulcer	✓		Heartburn not recently due to diet
How many pillows do you sleep with?	2		
Any other serious illness		✓	
Smoking status Smoker ☐ No. per day ☐ Non smoker ☑ Ex smoker ☐ Date stopped ☐			
How many units of alcohol per week? Screening score (5)			APROX once ~~Per~~ Per month
If female, date of LMP has mirena coil	?		

Do you have any allergies?

Allergies						Nature of problem
Latex	☑	Nuts	☒	Fruits	☒	hands break out with latex Gloves -
Elastoplast	☒	Metals ?	☐	None	☐	has reacted to belt buckles in the past - can wear cosmetic jewel
Medication	☐	State:				NKDA - localised rash irritation
Other	☐	State:				

Page 4/5 completed by Patient / Nurse / both (Please circle)

Airway Assessment



Class 1 | Class 2 | Class 3 | Class 4

Modified Mallampati's classification of pharyngeal appearance

Write or attach label

HCP ....
CH CHI: 3010776241 ....
Sur Welsh, Caroline ....
For 26 Lewis Terrace ....
Add Irvine ....
.... KA11 1HJ ....
.... 30/10/1977 ....
.... Dr J Taylor ....
Date .... MRN: XHI466693 ....

Neck Movement

Full range of movement ☑
Difficult ☐
Mouth open Good ☑ Poor ☐

Dentition

Own teeth ☑ Loose teeth ☐
Dentures ☐ Full ☐ Partial ☐
Upper ☐ Lower ☐

Caps / Crowns / Bridge / Braces
State site.....

Body Piercing ☑ * tongue
Glasses ☐
Contacts ☐
Hearing Aid ☐
Prostheses ☐ State tongue ear x2
Pacemaker ☐
Stents ☐

Date	Time	Notes / other relevant information	Inits

Information given:

Written ☐ GA ☑ Pain ☑ Anaesthetic overview ☑ Spinal ☐
Epidural ☐ Procedure specific ☐ (state) lap hysterectomy - enhanced recovery
Other ☐ (state) Martini wd b Board
Verbal ☐ Visiting times ☐ No smoking policy ☐ Info given re smoking cessation Y ☐ N ☐
Fasting ☐ Other ☐ (state).....
Ranitidine issued as per PGD ☐

Alcohol screening tool completed ☐ vCJD screening tool completed ☐ Medicines reconciliation form completed ☐

Advise patient to have minimal belongings in ward/DSU due to difficulty with storage

Surplus tissue authorisation Discussed Y ☐ N ☐ Online form completed Y ☐ N ☐

Outcome of Stage 1 assessment (pre-op staff to complete) Patient Signature:.....

TCI ☐ Telephone assessment ☐ Appoint to POA ☐

Patient accepted as anaesthetically suitable for:- (pre-op staff to complete)

Day Case ☐ 23 Hour ☐ Same day admission ☐ In patient ☐

Stage 1 Assessment Nurse	Name: L. M. FERGUSON	Sign: L M Ferguson
	Designation: SSN	Date 18/6/13

6

Stage 2:
Clinical Examination

Or attach label

CHI: 3010776241
Welsh, Caroline
HC 26 Lewis Terrace
C' Irvine
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XH1466693

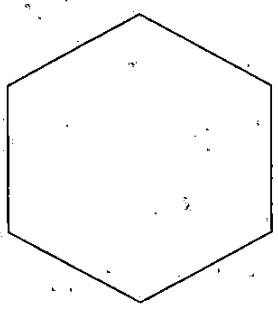
Date of Birth.....

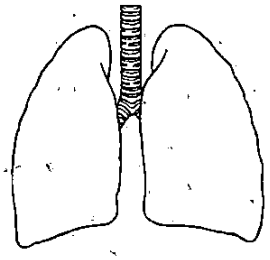
Have any changes been made to medication since Stage 1 Pre-op? Yes ☐ No ☐

Have there been any changes to health/social circumstances since Stage 1 Pre-op Yes ☐ No ☐

Clinical Examination

Cardiovascular		Respiratory	
Heart rate/regularity	68 REG	Chest expansion	L=R
JVP	not	Percussion	L=R
Carotid Bruits	checked	Breath sounds	vesicular
Heart sounds/Murmurs	I + II + 0	Trachea	central
Peripheral Oedema	nil	Finger clubbing	nil





Date	Time	Notes / other relevant information	Inits
18/6/13		Attended pre op assessment	
		ECG ☑	
		Bloods ☑	
19-6	pm	Email to Dr Franklin /Secy re Possible latex	
		allergy. suggest 1st on A.M. list	PF

Stage 2	Name: L. M FERGUSON	Sign: LM Ferguson
Assessment Nurse	Designation: SSN	Date 18/6/13

Multidisciplinary Medicines Reconciliation Form

Must be started by admitting Clinician within 24 hours

Source of information (use at least two sources) (Tick)

Patient	☑	Emergency care summary	☐
Relative / Carer	☐	Nursing home chart	☐
Patient's own drugs	☐	Previous discharge letter	☐
GP referral letter	☐	Repeat prescription slip	☐
GP practice	☐	Other (Please state)	☐

Admission Medicines			Action Note: Unless otherwise indicated below medicine should be continued on prescription sheet				
Name, From, Route (epecify if not oral)	Dose	Frequency	Suspend	Amend	Stop	Comments (if medicine suspended, amended, stopped or inaccurate)	Pharm initials if change
naproxyn		B.D					

OTC / Herbal / homeopathic / illicit substances	Further information e.g. compliance aid, recent discounted medicines

Adverse reactions / allergies None known ☐ or

Medicine / Substance	Reaction
NKOA	

Signature LM Ferguson Print Name L M FERGUSON Designation SSN Date 18/6/13 Beep No.....

Are you satisfied this medication history is complete and accurate? Yes ☐ No ☐

If NO what further action is necessary (Contact GP etc).....Tick when resolved ☐

Pharmacist review signature (initial changes / additions above).....Date / Time.....Beep No.....

Anaesthetic referral ☐

Reason for referral: chest pain symptoms

Referred by: Dr Ferguson Date 18/6/13

Anaesthetist's Name: Signature:

GMC No. Date

Date	Time	Outcome of anaesthetic review	Inits
18/6/13	1450	35 yr old non-smoker BMI 35.1, 3/7 central chest pain, relieved spontaneously, has been feeling stressed. ECG (N)	
		In my opinion, OK to proceed. Dr S Janie Collie Consultant Anaesthetist GMC No: 3540824	

Outcome of Stage 2 Assessment

TCI ☐

Postponed ☐ Reason.....

Cancelled ☐ Reason.....

Day Surgery ☐

23hr ☐

Same Day Admission ☐

In Patient ☐

Stage 2 Assessment Nurse	Name: Designation:	Sign: Date

Write or attach label

HCR No: .....

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693

Sex: .....

Date	Time	Notes / other relevant information	Inits

Date	Time	Notes / other relevant information	Inits

Write or attach label

HCR No: .....

C .....

S CHI: 3010776241 .....

Welsh, Caroline .....

26 Lewis Terrace .....

Irvine .....

KA11 1HJ .....

30/10/1977 .....

Dr J Taylor .....

MRN: XHI466693 .....

Date	Time	Notes / other relevant information	Inits

Investigations

Investigation	Requested (Date)	Reviewed by	Date reviewed	Repeated (Date)	Reviewed by	Date reviewed
FBC	18/6/13	[illegible]	19-6			
Group & Save	18/6/13	[illegible]	19/6			
X Match						
Urea & Electrolytes	18/6/13	[illegible]	19-6			
LFT	18/6/13	[illegible]				
Blood Glucose						
HbA1C						
TFT						
INR						
Coag	18/6/13	[illegible]	19-6			
CXR						
PEFR		1 / 2 / 3			1 / 2 / 3	
Spirometry						
ECG	18/6/13					
ECHO						
Urinalysis						
MSSU/CSU						
Pregnancy Test						
Sputum						
MRSA						
MRSA						
Audio/Tymps						
Photography						
Other						

Alcohol Screening Pre-operative Assessment Form

(to be completed by nursing staff)

Write or attach label

HCR No: .....

CHI No: .....

Surname: .....

.....Sex: .....

.....

.....

.....

CHI: 3010776241
Welsh, Caroline
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To be completed by pre-op ass

Questions	0	1	2	3	4	
A. How often do you have a drink Containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	1
B. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 or 8	10 or more	4
C. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
D. How often during the last year have you failed to do what was normally expected of you because of your drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
E. Has a relative or friend or doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the past year		Yes during the past year	
1. Alcohol screening score **Only record if score is 5 or above**					**Score**	5

Only continue if score is 5 or above

2. Was this discussed with patient?	Yes ☑	No ☐	Don't know ☐
3. Was patient offered referral to alcohol liaison services?	Yes ☐	No ☐	Don't know ☑
4. Did patient accept offer of referral?	Yes ☐	No ☐	Don't know ☑

If patient refused please indicate why?

a. Don't feel I have a problem

b. I am already receiving treatment/help at present

If patient indicates they are receiving help please use following line to give their comment on the help/support used .....

c. I don't feel this is a priority for me at present

d. Yes, I drink but I don't want to change anything

e. There is nothing that can be done to help me

f. Other. Please specify.....

5. Was patient given a Self Help Pack? Yes ☐ No ☐ Patient refused ☐

NHS Ayrshire & Arran

Risk Screening Questionnaire for TSE, CJD and vCJD involving low and medium risk tissue.

Write or attach label

HCR No: .....

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Questions 1-2 to be completed for all patients	Yes	No
1. Have you ever been notified that you are at risk of CJD for public health purposes		✓
2. What is the tissue risk of the procedure? **High** ☐ **Medium** ☐ **Low** ☑ If the tissue risk is high, please use Risk Screening Questionnaire for TSE, CJD and vCJD involving high risk tissue.		

If the patient answers yes question 1, please take additional precautions for any instruments which have been or may come in contact with tissue of high or medium level infectivity.

If the patient answers no to question 1, there is no need to take any additional precautions.

For further information, please contact Infection Control.

Patient Risk (Q1)	**Tissue Risk (Q2)**		
	Low	**Medium**	**High**
Low	No restrictions	No restrictions	No restrictions
High	No restrictions	Single use instruments or Quarantine until advice sought from Infection Control	Single use instruments or Quarantine until advice sought from Infection Control

NHS Ayrshire & Arran

Estimated Discharge Date:
Refer to Multidisciplinary discharge plan
Actual Discharge Date:

IN-PATIENT ADULT ADMISSION / DISCHARGE BOOKLET

Property handed over for safe keeping
PLACE STICKER HERE

Name: Caroline Welsh

CHI number: 3010776241

Date: 26/9/13

STA5238

Guidance

This booklet is to be used for all adult in-patients within NHS Ayrshire & Arran with a predicted length of stay of longer than 24 hours. If any aspect of the patient profile and assessment is not completed at the point of admission, ongoing completion of this booklet is essential. All staff are responsible to ensure that documentation is fully completed.

Patients that have been assessed pre operatively will have a pre op assessment document and the supporting Elective In-patients booklet.

The booklet can be used by all members of the multidisciplinary team.

The booklet should be kept in an appropriate place to protect patient confidentiality.

The booklet is also to be used for handover between staff.

Other documents will be needed to supplement the use of this booklet; these may be kept at the patient bedside as needed for the patient.

Other documents to be used in conjunction with the booklet are:

- Care plans
- Fluid balance chart
- Modified Early Warning Score (MEWS) Observation chart (relevent to the patient)
- Peripheral Vascular Cannula monitoring chart
- Prescription recording chart
- High risk infusion chart
- Subcutaneous syringe driver chart
- Theatre care booklet (should be kept in the patients records, not to be kept at the bedside)
- Nutrition / food charts
- Wound assessment document
- Repositioning chart
- Continence assessment
- Stool chart

This booklet and all of the above documents are provided from Procurement and Registry and should not be photocopied.

Other specific ward based documentation may also be required. This is available through the charge nurse.

When the patient is discharged the booklet must be filed in the nursing section of the patient's records.

Record Keeping

Record keeping is an integral part of nursing and midwifery practice. It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow. Good record keeping is an integral part of nursing and midwifery practice. You need to assume that any entries you make in a patient or client record will be scrutinised at some point.

Record Keeping, NMC. July 2009

Consent to display limited information

Patient consents to display limited information about care (e.g. bedrails, diet, mobility) on a chart at the bedside. Verbal consent given Yes ☐ No ☐ Nurse signature.....

If the patient has declined to consent to information being displayed at the bed space please provide information here

.....

.....

.....

Informed Consent and Capacity

While undertaking the patient's clinical assessment, if you have any concerns regarding the patient's capacity and ability to make healthcare decisions, please refer to medical staff for assessment under the Adults With Incapacity (Scotland) Act 2000 and document your actions within the nursing notes. Refer to the Consent policy for further guidance.

Information about the patient can be obtained from relatives and carers including legal guardians (e.g. guardianship through the social work department)

Relatives and carers cannot make decisions for patients except in certain circumstances where they hold Welfare Guardianship or Power of Attorney extending to health care decisions under the Adults With Incapacity (Scotland) Act 2000.

Vulnerable Patients

A vulnerable patient is a person who is or may be in need of community care services by reason of mental or other disability, age or illness. A vulnerable patient is or may be unable to take care of him or herself, or is unable to protect him or herself from significant harm or serious exploitation.

(Who Decides - Lord Chancellors Department (1997)

A vulnerable patient may be a person who:

- Has a physical or sensory disability
- Is physically frail or has a chronic illness
- Has a mental illness or dementia
- Has a learning disability
- Is old and frail
- Is a substance misuser
- Has social or emotional problems

A person's vulnerability will depend on their circumstances and environment, and each case must be considered individually

Do you view this patient as being a vulnerable patient? **Yes ☐** **No ☐**

If Yes, implement the Vulnerable Patient Assessment Questionaire

To support your plan of care for this patient you may find it helpful to contact one of the services below:

Learning Disability Liaison Nurse Specialist:	01294 322171 (north)
	01292 614911 (south)
	01563 578574 (east)
Dementia Liaison Nurse	01563 541202
Mental Health Liaison Nurses (Elderly Services)	01563 541202
Psychiatric Liaison Nurse (general hospitals)	01563 826120
Advocacy Services	01294 608664 (north)
	01292 264396 (south)
	01563 574442 (east)
Hospital Social work team	Hospital site contacts through switchboard.

Clinical Team Signatures

All staff completing the documentation **must** complete this section

Name (BLOCK CAPS)	Designation	Ward/ Page No	Signature	Initials
J Middleton	S/N	6	J Middleton	JM
JACKIE HOUSTON	S/N	6	J. Houston	JH.
MARGARET FORBES	S/N	6	M Forbes	MF

Clinical Team Signatures

All staff completing the documentation **must** complete this section

Name (BLOCK CAPS)	Designation	Ward/ Page No	Signature	Initials

PERSONAL DETAILS

Personal Details

GP (name & address) ..... Dr Taylor.

Patient's Age 35

Write or attach label

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Ad
... 30/10/1977
Da Dr J Taylor
MRN: XH1466693

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
KA11 1HJ

SPECIFIC ALERT

Previous known – MRSA Yes ☐ No ☐
or - Extended Spectrum Beta Lactamases (ESBL) Yes ☐ No ☐
Other infectious condition? Yes ☐ No ☐
specify.....

Allergies (food, latex, other) LATEX.
METAL.
None known ☐

DRUG ALLERGY / SENSITIVITY YES/NO

Drug name:	Symptoms experienced:
NKDA	

Prefers to be addressed as: Caroline

Receiving Consultant:

Allocated Consultant: Dr Franklin

Emergency ☐ Elective ☐

Admission Date 26/9 Time 10s

From where: Home.

Accompanied by:

Do you have a religion? Yes ☐ No ☐

Would you like to be visited by the hospital Chaplin? Yes ☐ No ☐

Reason for admission (including patient account)

heavy ~~periods~~ periods.

Provisional diagnosis

Ward/Dept (1) ..... (2) ..... (3) .....

Date of transfer...../...../.....

First Contact / Significant Other

Name: Brian.

Address: A/A.

Relationship to patient: Husband

Contact No(s): Home: 07580068018
Mobile:

Aware of Admission?: Yes ☐ No ☐
Contact Overnight?: Yes ☐ No ☐

Overnight Contact No:.....

Second Contact / Significant Other

Name:.....

Address:.....

Relationship to patient:

Contact No(s): Home:.....
Mobile:.....

Aware of Admission?: Yes ☐ No ☐
Contact Overnight?: Yes ☐ No ☐

Overnight Contact No:.....

Consent to share information: (Yes) / No

If yes with whom? Husband

Any exceptions?

What information are the above aware of?

Who can messages be left with?

CHI: 3010776241
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Observations on admission / General Appearance

Temp	Pulse	BP	Resps	O^2 Sats	Pallor	Conscious Level	Glucometer Reading	Last Menstrual Period (If Appropriate)	Pregnancy Test (If Appropriate)
36.4	67	128/76	16	99.		fully alert.		Bleeds all the time	neg

Urinalysis: Protein ☐ Blood ☐ Glucose ☐ Other ☐

MSSU (mid stream sample of urine) collected? Yes ☐ No ☐ NAD

Previous medical, surgical and mental health history (including operations, treatments and investigations with the corresponding dates)

Details	Date if applicable
Appendicectomy	
Laparoscopy	
P.E.R - 2yrs ago.	
Episode of chest pain - notes reviewed by Dr Collie pre op: "OK to proceed" as per notes	

PERSONAL DETAILS

Record of specimens, procedures, surgery & investigations since admission	Initials	Date	Patient aware of results?	Initials	Date
TAH, conservation of ovaries	OH	26/9/13			

Medication used at home (including herbal / over the counter)

For patient's current medication please refer to the Multi-disciplinary Medicines Reconciliation Form if available. If not present complete below:

Drug	Dose	Frequency	Route
Naproxyn	500.	B.D.	oral
	at present		

PERSONAL DETAILS

CHI: 3010776241
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Home Circumstances

Contact the hospital Social Work Dept to obtain Single Shared Assessment (SSA1) if appropriate.
Requested ☐ No SSA1 available ☐ Name of Social Worker/Contact .....

Do you have a carer? Yes ☐ No ☐

Do you live:-

Alone ☐
With elderly / infirm partner ☐
With healthy partner / family ☑
Does carer require additional support ☐
(Consider referral to social work) ☐

Are you a carer Yes ☐ No ☐

Who for:

Children ☐
Elderly relative ☐
Other ☐

Please specify: .....
Who is caring for them currently? Please detail .....
.....

Family ☐ Social Worker ☐
Nursing Home ☐ Neighbour ☐
Respite Centre ☐

Describe Family Living Arrangements:

lives with husband.
3 boys. 15, 11, 10.

Type of House (circle):

Steps at entrance ☐ How many? .....
Stairs inside ☐ How many? .....
Toilet: Upstairs ☐ Downstairs ☐
Bedroom: Upstairs ☐ Downstairs ☐

Community Services In Use	Frequency	Informed of Admission	Informed By/Comments
Home Care Yes ☐ No ☑		Yes ☐ No ☐	
Meals on Wheels Yes ☐ No ☑		Yes ☐ No ☐	
Sheltered Housing Yes ☐ No ☑		Yes ☐ No ☐	
Day Hospital Yes ☐ No ☑		Yes ☐ No ☐	
Community Nurse Yes ☐ No ☑		Yes ☐ No ☐	
Visited by Specialist Nurse Yes ☐ No ☐ Specify.....		Yes ☐ No ☐	
SPARRA Yes ☐ No ☐		Yes ☐ No ☐	

If Yes, contact Case Manager Name..... Contact Number.....

Discharge

Will personal transport be available for discharge: Yes ☑ No ☐ Patient has keys: Yes ☑ No ☐
Predicted discharge: Complex ☐ Straight forward ☐
Discharge co-ordinator informed Yes ☐ No ☐

Initials of Nurse..... Date.....

PERSONAL DETAILS

Admission Checklist

	Yes	No	N/A
ID band in situ	✓		

Verbal ward information given to patient and/or relatives:	Yes	No	N/A
Call buzzer			
Toilets / Bathroom			
Mealtimes			
Visiting times/policy			
Infection control / hand hygiene			
Fire alarm procedure			
Valuables			
Smoking			
Other.....			

Patient information leaflets given as applicable:	Yes	No	N/A
Ward information			
Nutritional Care			
Tissue Viability			
Continence			
Falls / Bedrails			

Other (specify) Date given

_____ _____ ☐

_____ _____ ☐

_____ _____ ☐

Patient's Property

You are advised to restrict to a minimum amount of property, including cash and other valuables, brought into hospital and to hand to the nurse in charge of your admission, as soon as possible, any articles you wish to be kept in safe custody for which a receipt will be given to you. You are responsible for property belonging to you not handed over for safe custody.

Anything handed over for safe keeping will not be kept indefinately in the ward safe but will be sent to the cashier's office. This includes cash, spectacles, hearing aids, dentures and other personal items and valuables.

Signature of Patient / Significant Other ..... Date .....

Property Handed Over For Safe Keeping: Yes ☐ No ☐ Sticker on front page ☐

Date Taken to Cashier:..... Cash & Valuables Ref No:..... Date Returned:.....

Initials of Nurse..... Date.....

Lifestyle Assessment

Write or attach label
CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693

Communicating	Yes	No	Problems / needs
Are there any specific communication needs? e.g. Impaired speech, impaired hearing, registered blind, language barrier, dyslexia, learning difficulty. (Complete learning disability assessment if appropriate)	☐	☑	
Interpreter required	☐	☑	
Wears glasses / contact lens	☐	☑	
Hearing aid R / L / Bi lateral (if private aid or glasses, refer to patient property notice)	☐	☑	No probs

Breathing	Yes	No	Problems / needs
Normal rate/rhythm	☑	☐	
Cough	☐	☑	
Breathlessness	☐	☑	
Equipment used e.g. inhalers etc	☐	☑	
Home oxygen/nebulisers used	☐	☑	
Airway e.g. tracheostomy	☐	☑	No probs
Smoker	☐	☑	

Please ensure smoking algorithm is completed for smokers and patients trying to stop.

Controlling body temperature	Yes	No	Problems / needs
Apyrexial on admission	☑	☑	
Do they feel the cold	☐	☑	T 36.4
Night sweats	☐	☑	

Eating & drinking	Yes	No	Problems / needs
Any known food allergies	☐	☑	
Recent appetite normal	☑	☐	
Swallowing ability impaired	☐	☑	(if YES consider referral to SALT)
Nausea/vomiting	☐	☑	
Special dietary needs, e.g. therapeutic diet, ethnic, cultural & religious considerations, nutritional supplements	☐	☑	
Feeding aids/assistance required	☐	☑	
Nutritional Care in Hospital leaflet given	☐	☑	(All patients must be given this leaflet)
Does patient have any food preferences? (likes/dislikes)	☐	☑	

Specify: Eating..... Drinking.....

Does the patient consent to following a therapeutic diet ☐ ☐ Nurses Initials.....

Alcohol intake (>50units consider referral to Alcohol liaison team): Referral made Yes ☐ No ☐ Date.....

Date / time last alcohol drink taken and amount :.....

Mobilising	Yes	No	Problems / needs
Independent walking ability	☑	☐	
Aids needed	☐	☑	
Falls history	☐	☑	
Bed rest restrictions	☐	☑	no probs.
Podiatry problems	☐	☑	
Limiting factors e.g. pain	☐	☑	

Eliminating	Yes	No	Problems / needs
Normal Bowel activity	☑	☐	
Normal Bladder activity	☑	☐	no probs.

Please ensure continence assessment is completed if required.

Personal cleansing & dressing	Yes	No	Problems / needs
Independent	☑	☐	
Requires assistance e.g. showering, hair washing,oral care	☐	☐	
Use of dressing aids	☐	☐	

Specify:.....

.....

Please complete oral assessment tool if required.

Condition of skin - assess any wounds / lesions / stomas			
Religious or cultural requirements that impact on patients' personal care	☐	☐	
Is an OT referral needed?	☐	☐	

Working & recreation	Yes	No	Problems / needs
Currently in occupation	☐	☐	carer - N.A.C.
Hobbies	☐	☐	Bakes cakes
Impact of illness on work or recreation?	☐	☐	

Sleeping	Yes	No	Problems / needs
Usual pattern	☑	☐	
Sedation used	☐	☐	no probs
What helps			

Personal awareness	Yes	No	Problems / needs
Possible altered body image	☐	☐	
Privacy/modesty issues	☐	☐	not discussed
Impact of illness on family / partner - attitude / support issues	☐	☐	
Worries regarding emotional problems/ dying	☐	☐	

Write or attach label

CHI: 3010776241
Welsh, Caroline
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30/10/1977
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MRN: XHI466693

State of mind	Yes	No	Problems / needs
Orientated to time and place	☑	☐	.....
Signs of anxiety / confusion: Confused ☐ Mildly anxious ☑ Highly anxious/distressed ☐			
Any current or previous psychological or psychiatric history? (e.g. depression, self harm)	☐	☑	.....
Undergoing any current treatment/therapy If yes, name of	☐	☑	.....
Consultant/CPN.....			.....
History of dementia	☐	☑	.....
Memory problems	☐	☑	.....
Any phobias	☐	☑	.....

If this patient has a known cancer, please consider using the Distress Thermometer. For information contact Psychosocial Oncology on (01294) 323552

Spiritual or religious needs	Yes	No	needs
Does the patient wish to state their religion?	☐	☐	
Specify:			nil.
Any specific religious needs/practices that place limitations on the patient's care? (refer to religions and cultures manual)	☐	☐	....

Initials of Nurse..... Date.....

Assessment of this patient may highlight the need for referral to other disciplines. Discuss with the patient and obtain the patient's verbal consent. This should be recorded on the multidisciplinary discharge pages.

Subsequent Lifestyle Assessment

Please re-assess following 2nd and 4th week of in-patient stay.

CHANGES DUE TO PRESENT CONDITION		
	Re-assessment 1 Date of assessment: Time of assessment:	Re-assessment 2 Date of assessment: Time of assessment:
Communicating		
Breathing		
Controlling Body Temperature		
Eating and Drinking		
Mobilising		
Eliminating		
Personal cleansing / dressing		
Working and recreation		
Sleeping		
Personal awareness		
State of mind		
Spiritual or religious needs		

1st Re-assessment Initials ..... Date .....

2nd Re-assessment Initials ..... Date .....

Patient Screening & Risk Assessment

CHI: 3010776241
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After completing the patient's lifestyle assessment decide which risk assessments your patient needs.

Tick the box to confirm assessment tool activated.

YES	N/A		
☑	☐	**Pressure Area Care – Waterlow**	**mandatory**
☐	☐	**Falls**	**over 65 / history of falls**
☑	☐	**Bedrails**	**mandatory**
☑	☐	**Moving and Handling**	**mandatory**
☑	☐	**MUST**	**mandatory**
☐	☐	**MRSA**	**mandatory**
☐	☐	**Oral Care**	
☐	☐	**Continence**	
☐	☐	**Smoking**	

All appropriate assessments **must** be undertaken for every patient.

You may use your professional judgement to decide which assessment tools are most relevant to your patient. It is not necessary to complete all risk assessments for every patient.

In exceptional circumstances your professional judgement may decide that this patient is exempt from a particular mandatory assessment. You must clearly document the reason for this decision.

Initials of Nurse ..... Date: .....

NHS Ayrshire & Arran

Adapted Waterlow Pressure Area
- Risk Assessment Chart

More than one score/category can be used:
10+= 'At Risk': 15+= 'High Risk': 20+ ='Very High Risk'

Complete assessment on admission/1st visit. If there is a change in individual's condition and repeat regularly accoring to local protocol.

		Date	26/9								
		Time	12nc								
Sex											
Male	1										
Female	2		2								
Age											
14 – 49	1										
50 – 64	2										
65 – 74	3		1								
75 – 80	4										
81+	5										
Build/Weight for Height (BMI=weight in Kg/height in m²)											
Average – BMI 20-24.9	0										
Above average – BMI 25-29.9	1										
Obese – BMI > 30	2		1								
Below average – BMI < 20	3										
Continence											
Complete/catheterised	0										
Incontinent urine	1										
Incontinent faeces	2		1								
Doubly incontinent (urine & faeces)	3										
Skin Type – Visual Risks Area											
Healthy	0										
Tissue paper (thin/fragile)	1										
Dry (appears flaky)	1										
Oedematous (puffy)	1										
Clammy (moist to touch)/pyrexia	1		1								
Discoloured (bruising/mottled)	2										
Broken (established ulcer)	3										
Mobility											
Fully mobile	0										
Restless/fidgety	1										
Apathetic (sedated/depressed/reluctant to move)	2		1								
Restricted (restricted by severe pain or disease)	3										
Bedbound (unconscious/unable to change position/traction)	4										
Chairbound (unable to leave chair without assistance)	5										
Nutritional Element											
Unplanned weight loss in past 3-6 months < 5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2										
BMI >20 Score **0**, BMI 18.5-20 Score **1**, BMI <18.5 Score **2**	0-2		1								
Patient acutely ill or no nutritional intake > 5 days	2										
Special Risks – Tissue Malnutrition											
Multiple organ failure/terminal cachexia	8										
Single organ failure e.g. cardiac, renal, respiratory	5										
Peripheral vascular disease	5		1								
Anaemia = Hb < 8	2										
Smoking	1										
Special Risks – Neurological Deficit											
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6		1								
Special Risks – Surgery/Trauma											
On table > 6 hours	8										
Orthopaedic/ below waist/spinal (up to 48 hours post op)	5		1								
On table > 2 hours (up to 48 hours post op)	5										
Special Risks – Medication											
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max4*	4										
		Total Score	5								
		Initials	[illegible]								

Ensure plan of care is implemented / reviewed for all identified areas of concern.

NHS Ayrshire & Arran

Adapted Waterlow Pressure Area
- Risk Assessment Chart

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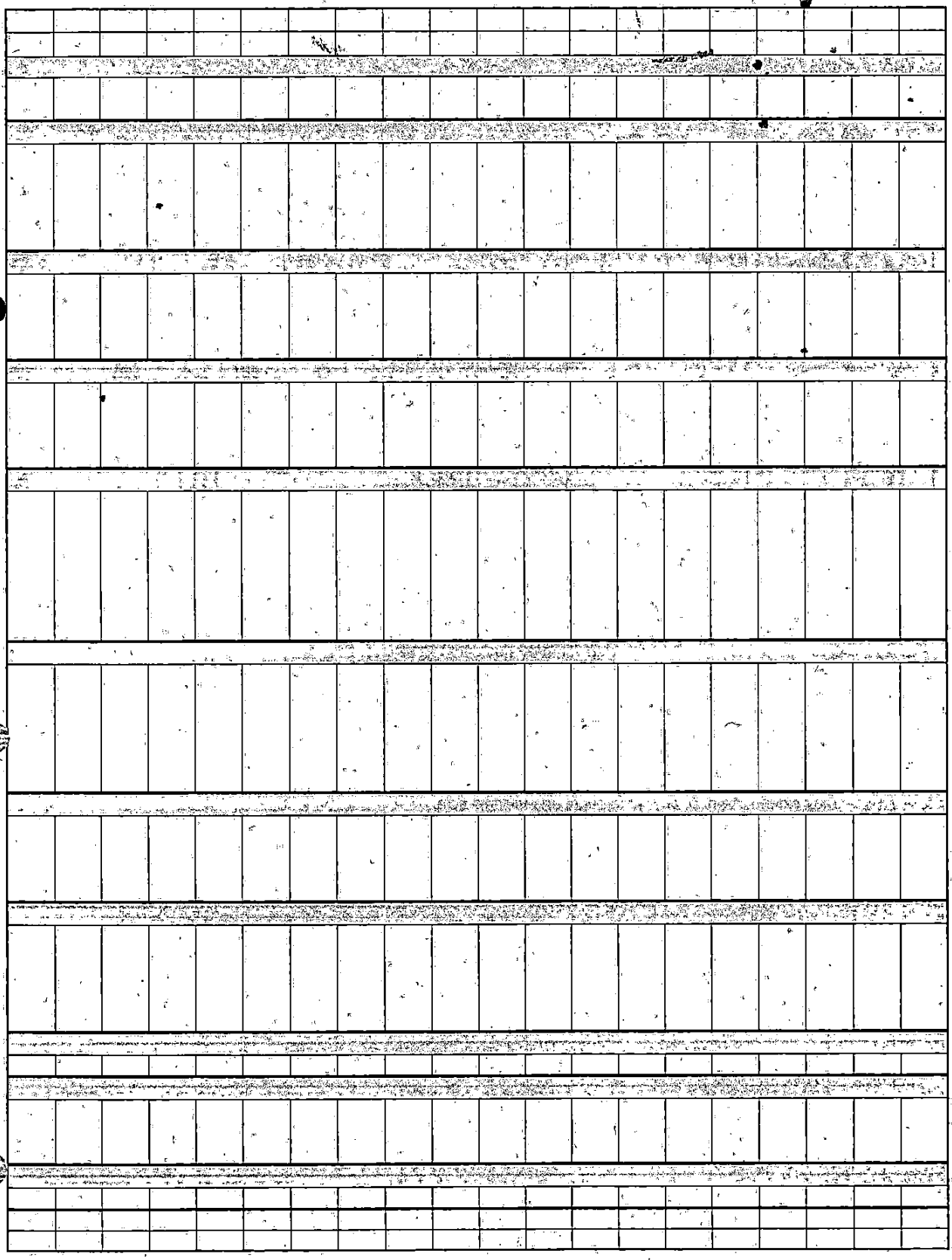
Date of Birth: .....

More than one score/category can be used:
10+= 'At Risk': 15+= 'High Risk': 20+ ='Very High Risk'

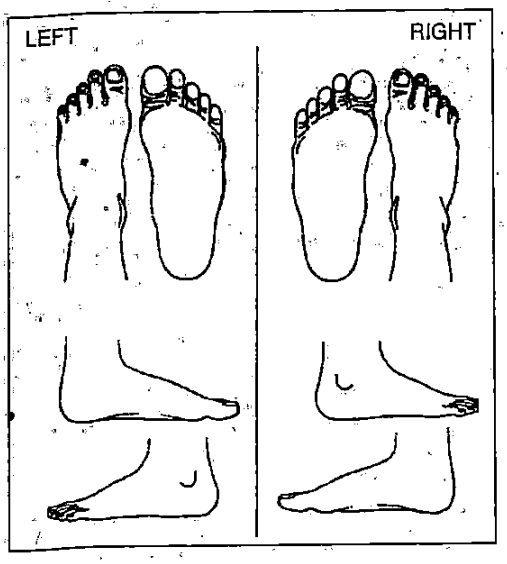


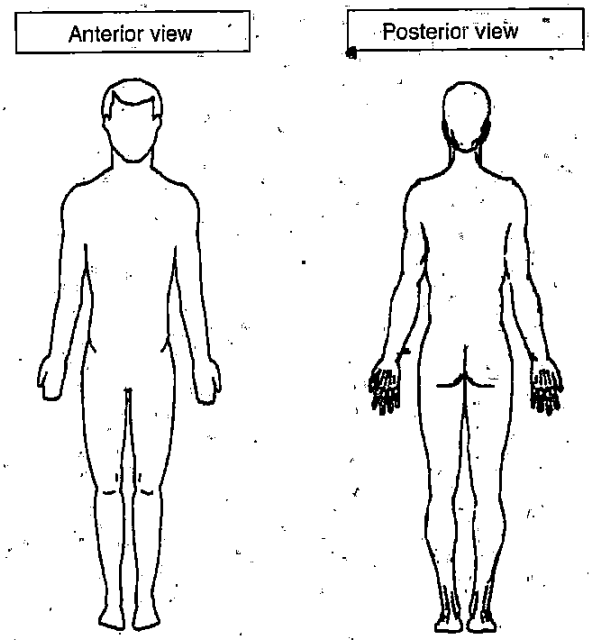
SCORE		
<10	Low Risk	Re-assess weekly or if condition changes
10+	At Risk	Re-assess twice weekly or if condition changes
15+	High Risk	Re-assess on alternate days
20+	Very High Risk	Assess daily

Within long term care, e.g. care of the elderly, if the Waterlow score remains unchanged for a period of 2 weeks as per score guidance and the probability of change is small, the Waterlow assessment can be carried out a minimum of once a month providing there is no change (good or bad) in the patients condition.

Pressure Ulcer Record

Indicate by curling, numbering and dating all pressure damage on diagrams, then complete the box below. Initiate care plan / wound assessment chart.





Scottish Adapted EPUAP(European Pressure Ulcer Advisory Panel)

Pressure Ulcer Grading Tool

GRADE 1 Non-blanchable erythema (redness) of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.

GRADE 2 Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.

GRADE 3 Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia.

GRADE 4 Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

Date	No of Ulcer(s)	Location of Ulcer(s)	Grade of Ulcer(s)	Electronic Report	Datix Insert Ref	Signature	Print Name

Pressure ulcers may deteriorate from Grade 1 or Grade 4, but can not be reversed and should be documented as a healing grade of pressure ulcer, e.g. healing grade 4.

NHS Ayrshire & Arran

Pressure Prevention Care Plan

Patient Problem / Need					
Patient has a Waterlow score of.....and is at risk of developing pressure ulcers					
Patient has a pressure ulcer(s) grade.....					
Goal					
Patient's skin will remain intact					
To promote healing of ulcer and prevent infection					
Date	**Time**	**Init/s**	**Planned Nursing Intervention**		
			Calculate and record the Waterlow score on admission and recalculate as the patient's condition changes and on a regular basis		
			Inspect the patient's skin especially over bony prominences on admission and at regular intervals and document findings □ Skin condition on admission.....		
			Select pressure reducing equipment according to patient need □ ..... □ ..... □ ..... □		
			When in bed encourage and facilitate position changes using 30 degree tilt (indicate frequency below) □		
			The patient should not sit out of bed for longer than 2 hours without being repositioned (for acutely ill patients return to bed for a minimum of 1 hour)		
			Use sliding sheets to prevent shear and friction during movement in bed (Sliding sheets should not be left under the patient)		
			Initiate a skin inspection and repositioning chart according to identified risk		
			When the patient is incontinent refer to the skin care guideline Encourage a healthy, well balanced diet and adequate fluid intake		
			If the patient has a grade 2 or above pressure ulcer a wound assessment chart is required		
			This care plan has been discussed and agreed with the patient as appropriate:		

Slips, Trips and Falls Assessment Tool

Write or attach label

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Date of admission:.....

Please assess ALL patients with a history of falls or over 65 years.

- Each category must be filled in
- If the patient does not meet any of the criteria N/A to be entered in box
- You can have more than one score for some categories

	Ward Name: Assessment Date and Time of Day			Date: Time:	Date: Time:	Date: Time:	Date: Time:
ITEM	**SCORE**			**SCORE**	**SCORE**	**SCORE**	**SCORE**
GENDER	1 = Male 2 = Female						
AGE	1 = 16-70 years 2 = 71-80 years 3 = 81+ years						
GAIT/MANNER OF WALKING (with usual aid)	1 = Hesitant 3 = Unsteady / Falls back / Unable to walk						
COGNITION	3 = Any degree of disorientation						
SENSORY	1 = Poor hearing 1 = Poor sight 2 = Poor balance 2 = Uncoordinated limb movement or loss of sensation in lower limbs						
FALL HISTORY	1 = Fall(s) in street 1 = Fall(s) in the ward 2 = Fall(s) at home						
MEDICATIONS(see over for examples)	1 = Sedation/analgesics 1 = Tranquillisers 1 = Cardiovascular drugs 1 = Bladder medication						
MEDICAL HISTORY (see over for examples)	1 = Altered endocrine/electrolyte balance 1 = Neurological Disorders 1 = Other (i.e. arrhythmia's, blackouts etc.) 1 = Incontinent of urine and/or faeces						
ACTIVITY AND MOBILITY	1 = Independently mobile with or without usual aid 2 = Needs assistance and/or supervision with transfers or mobility 2 = Needs the assistance of 1-2 people to transfer to toilet/commode 3 = Bed/chair bound but moves/rolls unsafely						
	TOTAL						
Level of Risk	**LOW (L) = 6-8**	**MEDIUM (M)= 9-12**					
Initials							

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Slips, Trips and Falls Assessment Tool

What Happens Once You Have A Score?

- If the patient has **scored >6** the appropriate actions should be implemented using the Slips, Trips and Falls care plan.
- For low risk patients follow actions in the green section only of the action list.
- For medium risk patients follow actions in the green and yellow sections of the action list.
- For high risk patients follow actions in the green, yellow and red sections of the action list.

Re Assessment Occurs:

- Weekly
- When the patient's condition changes (i.e. patient falls/post surgery/change in medication/cognitive state changes.)

If the patient has a slip, trip or fall whilst an in-patient, Datix should be completed and it should also be recorded here.

Date	Time of day	Location	Injuries?	Circumstances	Datix number

Medication examples:

SEDATION / ANALGESICS	TRANQUILLISERS / ANTIDEPRESSANTS	CARDIOVASCULAR DRUGS (those that reduce BP)	BLADDER MEDICATION
• Nitrazepam • Temazepam • Tramadol • Co-codamol	• Risperidone • Haloperidol • Amitryptyline • Alcohol	• Atenolol • Isosorbide Mononitrate • Digoxin • GTN • Diltiazem • Diuretics • Ace-inhibitors	• Doxazosin • Oxybutynin • Tamsulosin (Flomax)

Medical History examples:

Examples of **Altered endocrine / electrolyte balance**	Examples of **Neurological Disorders**	Examples of **"Other"**
• Diabetes • Hyponatraemia • Low calcium • Low potassium	• Parkinson's Disease • Stroke • Head Injury	• Arrhythmia's • Osteoporosis • Postural hypo / hypertension • Peripheral Neuropathy • Intermittent heart block • Epilepsy

NHS Ayrshire & Arran

Slips Trips & Falls - Care Plan

(To be used in conjunction with the slips, trips and falls assessment tool)

Problem Number: Date of Birth.....

Patient Problem/Need
Patient is considered to be at risk of falling

Goal
To promote and maintain patient safety and reduce the risk of falls

Date	Time	Intls	Planned Nursing Interventions - Intls	Discontinued Date/Time	
			Orientate patient and family/carers to ward environment on admission and each shift		
			Ensure call bell within reach		
			Explain importance about calling for help when needed		
			Ensure patient is aware of their own safety needs		
			Ensure that bedside table and key belongings are within easy reach		
			Ensure patient wears appropriate and well fitting footwear at all times		
			Request family/carers to bring in appropriate and well fitting footwear		
			Ensure patient wears appropriate clothing		
			Ensure that patient is wearing hearing aid if appropriate		
			Ensure that patient is wearing spectacles if appropriate		
			Advise family/carers how to orientate patient		
			Advise family/carers how to assist with interventions		
			Ensure that patient/family receives an explanation of risk and the measures in place to minimise this risk and document outcome		
			Ensure that bed area and pathways to all facilities are free of clutter at all times		
			Ensure that standard bed frame is used and left in a low position with brakes on		
			Select a chair that is the appropriate height and design for the patient (seek guidance from Physio and OT)		
			When in use ensure that chair/commode brakes are secure		

				Ensure that area is illuminated appropriately at night time		
				Liaise with medical team re: medication review		
				Consider referral to Physiotherapy, Occupational Therapy, Social Work		
				Monitor lying and standing blood pressure		
				Supervise patient when transferring as per moving and handling risk assessment		
				Supervise patient when mobilising as per moving and handling risk assessment		
				Offer toileting facilities as appropriate		
				Ensure that patient is cared for in an area proximal to toilet facilities, if possible		
				Encourage family, if present, to sit with patient (as appropriate)		
				Encourage family/carers to report to nursing station when ending their visit		
				Consider appropriate equipment in liaison with Physio and/or OT		
				Ensure yellow sticker is inserted into patient's notes after each fall		
				Patients who may be confused or have had repeated falls where possible should be cared for in an area within the ward that is within easy view of nursing staff		
				Check on patient every 15 minutes		
				Consider one to one supervision of the patient		
				Consider the use of a low level variable height bed		
				Discuss with medical staff re hip protector		
				Consider alternative supervision i.e. have patient sitting at nursing station		
				Above care plan has been discussed and agreed with the patient and/or family/carer.		

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Bed Rails Risk Assessment

Date of admission: 26/9

Please assess **ALL** patients on admission to your ward / departments

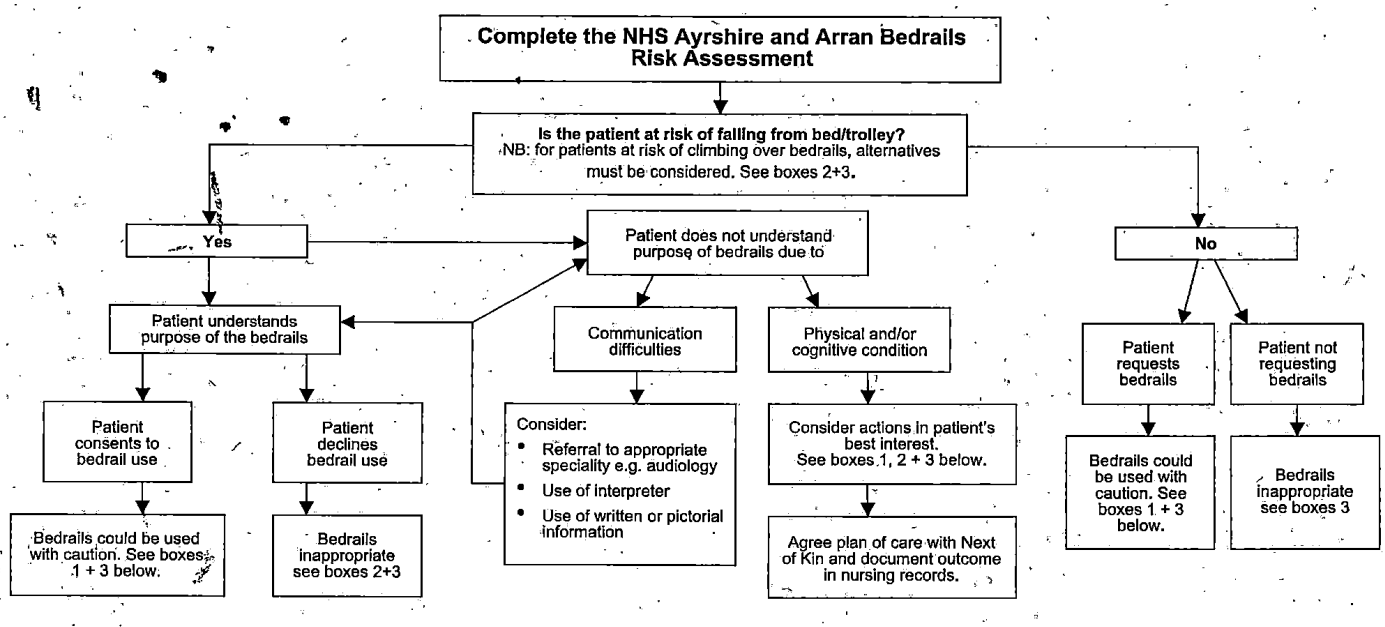
- Each statement must be answered – Circle answer
- Complete Risk Assessment in conjunction with Bedrails Algorithm overleaf
- Refer to Guidelines – Safe Use of Bedrails in In-patient Settings

Re Assessment Occurs:

- Weekly
- When the patient's condition changes (i.e. patient falls/post surgery / change in medication / cognitive state changes.)
- **Ensure clear identification of change in use of bedrails**

Risk Factors	Ward: 6 Date: 26/9 Time:	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:
1. Is the patient at risk of falling from bed?	YES (NO)	YES / NO	YES / NO	YES / NO
2. Is the patient at risk of intentionally climbing over bedrails?	YES / (NO)	YES / NO	YES / NO	YES / NO
3. Is the patient at risk of unintentionally falling from the bed / trolley?	YES / (NO)	YES / NO	YES / NO	YES / NO
4. Does the patient understand the purpose of the bedrails? Consider communication difficulties and physical / cognitive condition.	YES / (NO)	YES / NO	YES / NO	YES / NO
5. Does the patient consent to the use of bedrails?	(YES) / NO	YES / NO	YES / NO	YES / NO
Has the Bedrails Algorithm been followed	YES ☑ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
According to the Bedrails Algorithm are bedrails required / appropriate?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
If 'Yes', complete a bedrails care plan. **If 'No', state reason why bedrails are not required:** _____				
INITIALS	2			

BEDRAILS ALGORITHM



1. If bedrails are used consider:

- Risk of entrapment and harm to limbs
- Risk of patient climbing over the top
- The psychological effect of their use on the patient
- Use of a dynamic pressure relief mattress increases the height of the bed

2. Alternatives to bedrails

- A5 Use of variable height bed
- Additional mattress/crash mat beside bed
- Close observation of patient
- Ensure bed returned to lowest height after care delivery
- Ensuring patient needs anticipated e.g. drinks are accessible, regular toileting, call bell to hand etc
- Nursing patient on mattress on the floor should be a last resort and safety checks should be made for hot pipes, electric sockets etc. Moving & handling risk assessment for staff must be undertaken.

3. Remember to document in nursing records:

- Date and time assessment made
- Rationale for decision made in care plan
- Actions taken, including discussion with Next of Kin
- Care planning

Assessment should be made:

- On admission
- If patient's condition changes
- Weekly

Write or attach label

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Safe use of bed rails - Care Plan

Patient Problem/Need
The patient is at risk of falling out of bed due to ..... (e.g. cognitive or physical condition)

Goal
To promote and maintain patient safety and reduce the risk of falling out of bed

Date	Time	Intls	Planned Nursing Interventions	Discontinued Date/Time	Intls
			Ensure assessment is made on admission, when patient's condition changes, and weekly as a minimum.		
			Ensure rationale for decision made re; the use of bedrails is clearly documented.		
			Consider psychological effects of bedrail usage on patient and where appropriate ensure the patient's consent to their use		
			Ensure risk of entrapment is minimised by careful positioning of patient prior to operating bedrails.		
			If detachable bed rails used, ensure the gap between the top end bedrail and head of bed is less than 6cm and more than 25cm		
			If detachable bed rails used, ensure the gap between the bottom end of bedrail and foot of bed is more than 25cm		
			Continually monitor risk of patient climbing over the top of bed rails and assess the use of bed rails as necessary Discuss with the patient, the need to share information with other nurses and health care workers re; the use of bedrails, and document within the nursing documentation whether the patient consents to display information at the bed space.		
			Ensure the 'bedrails chart' at the bed space is clearly marked to guide the use of bedrails and is updated following re-assessment		
			Provide Falls/Use of Bedrails information leaflet to patient. Where the patient is incapacitated, ensure that relative/carer is given a leaflet and information about the assessment for bedrails is provided.		
			Ensure all actions, including discussions with relative/carer are documented.		
			Refer to the Safe Use of Bed Rails in Adult In-Patient Settings Guideline for further guidance on the management of bedrails		
			Re-assess the need for bedrail use at least weekly or as the patient's condition indicates and document on the risk assessment chart		
			This care plan has been discussed and agreed with the patient as appropriate.		

Moving & Handling Patient Risk Assessment

All Patients:

A hoist is for lifting patients and must not be used for transporting between rooms.
A mechanical aid **must** be used for bathing unless independently mobile.
A mechanical aid **must** be used if assistance is required from the floor.
Sliding aids should be used bed to trolley/bed (specify number of handlers)

Special Alerts: Date:	26.9.				
Overweight / Obese (BMI definition)	–				
Restricted use of limbs	–				
Poor standing ability	–				
Sedation of lethargy	–				
Irrational behaviour / confusion	–				
Unable to co-operate					
Acute pain					
Recent surgery					

Additional Comments: Fully mobile + independant.

Sling specification	Type	Size

Assessment of Risk:

Low Risk: Independently mobile / supervision only required. Aids required should be specified in care plan.

Moderate Risk: Requires physical assistance from one or more handlers. Is able to stand or partially bear weight and has no more than one special alert.

High Risk: a) Is unable to bear weight and requires assistance.
b) 2 or more special alerts present and requires assistance.

Aids, equipment and a minimum of 2 handlers recommended to move a patient.

Specify Level of Risk

Date:						
Low risk						
Moderate risk						
High risk						
Assessors Initials						

If the patient is independently mobile and self caring, there is no requirement to complete the following pages.

Moving & Handling Patient Risk Assessment

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Date:						
1. Moving in bed:						
a) Handlers require to assist rolling in bed. *Specify number in grid.*	a)					
b) Handlers required to insert and pull sliding sheets. *Specify number in grid.*	b)					
c) Can sit with assistance from 1 or 2 handlers (rotation). *Specify number in grid.*	c)					
d) Equipment required.	d)					
2. Sitting to Standing:						
a) 1 handler assists from the side with oblique hold on the patient's back.	a)					
b) 2 handlers assist from the side with oblique hold on the patient's back.	b)					
c) 1 handler assists from the side and 1 from the front.	c)					
d) Aids required:	d)					
3. Mobilising:						
a) Does not mobilise.	a)					
b) Mobilises independently.	b)					
c) Support required from side by 1 handler.	c)					
d) Support from side by 2 handlers.	d)					
e) Requires to be followed by staff member and wheelchair when mobilising.	e)					
f) Aids required:	f)					
4. Transfers: (chair / wheelchair / commode/ toilet / bed)						
a) Walking transfer with assistance of 1 handler.	a)					
b) Walking transfer with assistance of 2 handlers.	b)					
c) On bed rest.	c)					
d) Assistance of 1 handler and equipment.	d)					
e) Assistance of 2 handlers and equipment. *Specify number in grid.*	e)					
5. Adjusting Clothing / Personal Hygiene:						
a) Can use support / grabrails while assistance is given with clothing.	a)					
b) Requires support from 1 handlers while another assists with clothing.	b)					
c) Requires 2 handlers and equipment.	c)					
6. Repositioning in chair / wheelchair:						
a) Tilt and slide.	a)					
b) One way sliding sheet. *Specify number in grid*	b)					
c) Specify equipment *Specify number in grid*	c)					
Assessors initials						

NHS Ayrshire & Arran

Nutritional Screening 'Malnutrition Universal Screening Tool' ('MUST')

To be completed within **24 hours** of admission

Step 1: Measure height and weight to get a BMI score.
Step 2: Note percentage unplanned weight loss and score.
Step 3: Establish acute disease effect and score.
Step 4: Add scores from steps 1, 2 and 3 together to obtain risk of malnutrition.
Step 5: Follow the management guidance appropriate to the risk category and commence the corresponding care plan.

Screening Results

Please indicate if measurements are Measured (M), Reported (R), or Estimated (E)

Date / Time 26.9.13					
Ward	6.				
Height M( ) R( ) E( )	169 m				
Current weight (Kg)	92Kg( )	Kg( )	Kg( )	Kg( )	Kg( )
BMI					
Is patient within obese category?	Y/N	Y/N	Y/N	Y/N	Y/N
Usual weight (Kg)	Kg				
Signature					
MUST					
Step 1: BMI Score > 20 (> 30 = Obese).....0 18.5 - 20.....1 < 18.5.....2	0				
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: < 5%.....0 5-10% .....1 > 10%.....3	0				
Step 3: Acute Disease Effect Score If patient is acutely ill and there has been or is likely to be no nutritional intake for > 5 days.....2 Not applicable 0	0				
Step 4: Overall Risk of Malnutrition Total:					
Step 5:		1 = Medium Risk			

Referrals	Date Referred	Signature
Dietitian		
Speech & Language Therapy		
Occupational Therapy		
Nutritional Support Team		
Dental Service		

MUST Screening

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STEP 1
BMI Score

BMI kg / m2	Score
> 20 (>30) obese	= 0
18.5 - 20	= 1
< 18.5	= 2

STEP 2
Weight Loss Score

Unplanned weight loss in past 3-6 months	Score
< 5	= 0
5 - 10	= 1
> 10	= 2

STEP 3
Acute Disease Effect Score

If patient is acutely ill AND there has been or is likely to be no nutritional intake for > 5 days
Score 2

STEP 4
Overall Risk of Malnutrition

Add scores together to calculate overall Risk of Malnutrition

Score 0	Score 1	Score 2 or more
[redacted]	*Medium Risk*	[redacted]

STEP 5
Nutritional Management Guidelines

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Nutritional Management Guidelines

	MUST Score 1	[redacted]
Low risk - *Routine Clinical Care* ▯ Commence and implement the **Low Risk Care Plan** ▯ Monitor and review care plan ▯ **Repeat screening** **Acute** .....**Weekly** **Continuing Care** .....**Monthly**	**Medium risk** - *Observe* ▯ Commence and implement the **Medium Risk Care Plan** ▯ Document dietry intake for 3 days on a Food Record Chart ▯ Encourage oral intake ▯ Assist patient to choose appropiate meals / snacks and offer full cream milk or suitable alternative to drink with and between meals. ▯ Monitor and review care plan ▯ Repeat screening weekly	**Hight risk** - *Treat* ▯ Commence and implement the **High Risk Care Plan** ▯ Refer to dietitian. Include MUST score ▯ Continue food chart ▯ Offer maximum encouragement ▯ Monitor and review care plan ▯ Repeat screening weekly unless detrimental or no benefit is expected from nutritional support e.g. immenent death. Use own judgement and document rationale for not treating.

- For low risk patients implement interventions in the [redacted] section of the care plan, as appropriate.
- For medium risk patients implement interventions in the [redacted] and YELLOW sections of the care plan.
- For high risk patients implement interventions in the [redacted] YELLOW and [redacted] sections of the care plan.

- **Always use your own professional judgement when screening patients and making referrals.**
- **Consider patients who require an immediate referral.**
- **Consider initial admission information relating to eating and drinking needs and preferences.**
- **When completing Step 2 always subtract the most recent weight with the usual weight.**

NHS Ayrshire & Arran

Malnutrition Universal Screening Tool (MUST) Multidisciplinary Care Plan

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693

Patient Problem/Need
Nutritional screening has identified patient as being at Low ☐ Medium ☐ High ☐ risk of malnutrition

Goal
To meet patients nutritional and fluid requirements. To prevent weight loss and promote weight gain, as appropriate.
For Low Risk patients consider interventions in the **green** section of the care plan as appropriate.
For Medium Risk patients follow interventions in the **green and** sections of the care plan.
For High Risk patients follow interventions in the **green,** **and red** sections of the care plan.
Allied Health Professionals: consider interventions appropriate for speciality on the reverse of the form.

Date	Time	Init's		Planned Nursing Interventions	Discontinued Date/Time	Init's
29/9	c	L		**Low Risk Care Plan**		
				Monitor and review care plan and **repeat screening weekly** or monthly if in continuing care.		
				Consider individual and/or therapeutic dietary requirements.		
				Assist patient to select appropriate meals from menu card.		
				Provide encouragement and assistance with eating and drinking as required.		
				Ensure fresh drinking water is offered regularly and available at all times, where clinically appropriate.		
				Consider patient's positioning and support oral hygiene, if required		
				This care plan has been discussed and agreed with the patient as appropriate.		
				Medium Risk Care Plan		
				Commence food chart for a minimum of 3 days. Only discontinue if/when dietary intake is adequate.		
				If intake is insufficient, offer patient full cream milk or suitable alternative to drink with and between meals and suitable additional snacks.		
				Record accurate fluid intake/output on fluid balance chart until established that oral intake is adequate. If intake per 24hrs is inadequate, consider IV/SC fluids.		
				Monitor and review care plan and **repeat screening weekly**		
				High Risk Care Plan		
				Refer to Dietitian, ensuring the 'MUST' score is included.		
				Monitor and review care plan and **repeat screening weekly**		
				Discontinue food chart only when advised by Dietitian		

Date	Time	Intls			Discontinued Date/Time	Intls
				Dietetic Intervention		
				Document outcome of dietetic assessment.		
				Estimate patient's daily protein, energy and fluid requirements.		
				If nutritional requirements cannot be met orally, consider artificial nutritional support with the multi-disciplinary team and the patient/carer.		
				Provide patient and carer if appropriate, with nutritional advice and support which meets their individual needs.		
				Nutrition Support Team (NST) Intervention		
				Document the outcome of NST assessment by team member.		
				Document required actions and inform patient and multi-disciplinary team as appropriate.		
				Speech and Language Therapy (SLT) Intervention		
				Document outcome of SLT swallowing assessment.		
				Document the recommended compensatory strategies/modified diet as appropriate. Ensure patient and multi-disciplinary team are aware.		
				Occupational Therapy (OT) Intervention		
				Document outcome of OT assessment.		
				Document any additional requirements and inform patient and multi-disciplinary team as appropriate.		
				Dental Intervention		
				Document the outcome of Dental assessment/consultation.		
				Document any required actions and inform patient and multi-disciplinary team as appropriate.		
				Physiotherapy Intervention		
				Document the outcome of Physiotherapy assessment.		
				Document any required actions and inform patient and multi-disciplinary team as appropriate.		

MRSA SCREENING
CLINICAL RISK ASSESSMENT (CRA)

NHS Ayrshire & Arran

COMPLETE FOR ALL ACUTE HOSPITAL ADMISSIONS (Ayr & Crosshouse Hospital Only)

ATTA CHI: 3010776241 Patie Welsh, Caroline CHI: 26 Lewis Terrace Irvine Date KA11 1HJ 30/10/1977 Ward Dr J Taylor MRN: XHI466693	**Completed by if not using admission booklet** Name: Designation: Signature: Date / Time:

FORM COMPLETED IN		
	Pre-op	
	Admitting Ward	

	Yes	No	Don't know
1. Has the patient had any **previous history of MRSA** colonisation or MRSA infection at any time in the past?		✓	
2. Is the patient currently **resident in a care home or institutional setting** (ie prison, homeless, hostel) or **transferred from another hospital?**		✓	
3. Does the patient **have a wound/ulcer or indwelling medical device** which was present before admission to this hospital?		✓	

OUTCOME OF CRA

Any of the above three questions answered **'yes'**	▪ Screen nose and perineum (& wound or device where applicable) ▪ Manage patient as if MRSA positive (isolate if possible) ▪ Complete next section of the CRA
All three of the above questions **'no' or 'don't know'**	▪ Patient is likely to be at low risk of MRSA and can be managed as normal in accordance with the Infection Control Policy. Do not complete the remainder of the form.
Direct admission to 4 high risk specialties (renal, orthopaedics, vascular / cardiothoracic, intensive care)	▪ Complete CRA and take a screen from nose and perineum (& wound or device where applicable) regardless of the outcome of answering the 3 questions above.

SCREENING ACTIONS ('YES' TO ANY CRA QUESTION & 4 HIGH RISK SPECIALTIES)

	Nose	Perineum	Wound	Device	Other
MRSA screening swabs taken **Tick all applicable (inc dates)**					

ISOLATION ACTIONS ('YES' TO ANY CRA QUESTION) (See definitions in footer)

	Patient isolated in a single room	Patient cohorted, with other high risk patients, dedicated nursing	Patient cohorted, with no dedicated nursing staff	Patient separated
Detail of action completed **Tick all applicable (inc dates)** *Particularly if unable to isolate – please state reasons				

LABORATORY RESULTS

Date results received	Result of swab (positive or negative)	Name (PRINT)

**HPS ISOLATION DEFINITIONS

Isolated: Patient is placed in a single room with hand washing facilities, ideally with ensuite toilet and shower where available. Isolation should be undertaken according to the HPS Infection Control Contact Precautions Policy

Cohorting: Patient is placed in a room and cared for by dedicated nursing staff along with other patients who are MRSA screen positive. Cohorting should be undertaken according to the HPS Infection Control Contact Precautions Policy.

Separated: Patients who are MRSA screen positive are housed within the same room as patients who are not MRSA positive but are separately by at least three feet from any adjacent persons by use of closed bed curtains. This is considered to be a step down from full cohorting. These patients do not have separate nursing staff. Separation should be undertaken according to the HPS Infection Control Contact Precautions Policy

http://www.hps.scot.nhs.uk/haic/ic/standardinfectioncontrolprecautions-sicps.aspx

ADULT CONTINENCE ASSESSMENT PATHWAY

On Admission

Write or attach label

HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

Does your bladder ever cause you embarrassment, pain or concern?

Do your bowels ever cause you embarrassment, pain or concern?

No ☐

Yes ☐

Have you had an appointment and been supplied products for this problem?

Yes ☐

No ☐

Contact nurse who carried out assessment to access a copy
(i.e. District Nurse, Health Visitor etc)

Re-assess if required

Return copy following telephone contact to appropriate nurse on discharge
(i.e. District Nurse, Health Visitor etc)

Initiate assessment

Offer continence leaflet

Prior to discharge, contact appropriate nurse and send a copy of the assessment
(i.e. District Nurse, Health Visitor etc)

Initials: ..... Date: .....

Oral Health Risk Assessment (Review 4-weekly)

Rapid Assessment Questions		Circle which is appropriate		Suggested outcome/actions if "Yes" circled
Does the patient need assistance in carrying out their own basic oral care?		Yes	No	If you have answered yes to any of these questions please complete full oral health risk assessment below and review 4-weekly
Does the patient have dentures?		Yes	No	
Is the patient suffering from mouth pain?		Yes	No	
What is your normal mouth care routine at home? (for initial assessment only)		Details		
When did you last see a dentist? **(If more than 5 years, refer to dentist)**		Details		
Are you having any problems with your teeth or mouth?		Details		
Patient Assessment		**Circle which is appropriate**		**Suggested outcome/actions if "Yes" circled**
Smoking habits	Smoker? (which may increase risk of gum disease and oral cancer)	Yes	No	Note amount per day on profile Consider smoking cessation
Dexterity problems	Having difficulty holding toothbrush?	Yes	No	May need supervision/help with mouth care Consider OT adaptation
Cognitive function	Evidence of short-term memory loss and/or confusion?	Yes	No	May need supervision/help with mouth care
Oral Assessment – use tongue compressor and pen torch to examine oral cavity		**Circle which is appropriate**		**Suggested nursing care if "Yes" circled**
Lips	Dry /cracked?	Yes	No	Apply an emollient e.g. lubricating gel
Tongue	Dry/coated?	Yes	No	Clean with soft toothbrush and toothpaste Offer frequent fluids
	Evidence of ulceration/soreness?	Yes	No	**If yes, refer to Salaried Dental Services (SDS)* or advise patient to contact their dentist on discharge**
Gums/soft tissue	Evidence of soreness, ulceration, bleeding gums or whiteness?	Yes	No	**If yes, refer to SDS* or advise patient to contact their dentist on discharge**
Saliva	Dry mouth? (xerostomia) could be side-effect of medication e.g. antidepressants, anticonvulsants etc.	Yes	No	Offer frequent fluids and/or iced water If symptoms persistent refer to dentist
Teeth	Natural top teeth?	Yes	No	Encourage independence with cleaning teeth night and morning. Use toothbrush and fluoride toothpaste (see Basic Oral Care Guideline for concentration of fluoride)
	Natural lower teeth?	Yes	No	
	Evidence of plaque/debris?	Yes	No	Supervise/help with oral care Use toothbrush and fluoride toothpaste
Dentures	Top denture?	Yes	No	Supervise/help with cleaning dentures night and morning with mild soap and water; rinse dentures after meals. Clean teeth as above Remove dentures at night and leave to soak in water with appropriate solution
	Lower denture?	Yes	No	
	Dentures and natural teeth?	Yes	No	
	Denture marked with patient's name?	Yes	No	If no, refer to SDS* for marking
Pain	When eating/drinking?	Yes	No	**If yes, refer to SDS* or advise patient to contact their dentist on discharge**
	Caused by teeth/ dentures?	Yes	No	
Swallowing	Difficulty with swallowing?	Yes	No	Supervise/help with cleaning teeth and/or dentures and oral cavity after each meal
Nutrition	NBM/Fluid/dietary intake poor?	Yes	No	May require 2 hourly mouthcare Check whether oral problems contributing
	Dehydrated?	Yes	No	
	On energy - dense diet or prescribed supplements/snacks?	Yes	No	Consider high fluoride toothpaste if have natural teeth (2800ppm F)

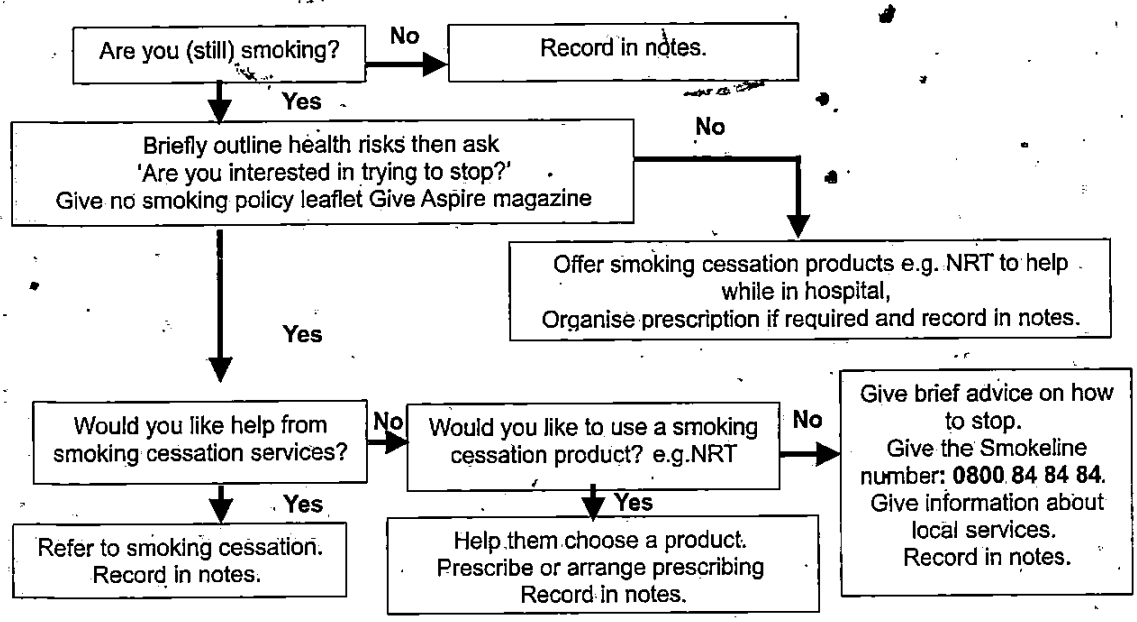
Signed.....

Date.....

*Dental Services Helpline: 01563 578 664
For urgent care or advice on weekdays
NHS 24: 08454 24 24 24
For dental emergencies out-of-hours

NHS Ayrshire & Arran

Algorithm for smoking



Referral made: Yes ☐ No ☐ Date.....

Smoking Disclaimer

Section 1 - for patient disclaimer

I.....(print name) have been provided with information regarding the smoking ban in NHS wards / departments introduced via the Smoking, Health and Social Care Act 2005. I have read and understood this information. I have been advised against leaving the ward / department. In particular I understand that my decision will affect the medical attention I receive and that NHS Ayrshire & Arran cannot provide medical attention to me while I am absent from the ward / department. I therefore accept that the staff cannot be responsible for my care whilst I am absent from the ward.

Witness Name .....

Witness Signature .....

Signed .....

Date.....Time .....

Section 2 - for escort disclaimer

To be completed by adult escort where patient is dependant upon assistance to leave the ward to smoke against medical / nursing advice.

I.....(print name) will escort.....(patient) as he / she leaves the ward / department to smoke. I have been advised of the risks to the patient of being absent from the ward / department. I acknowledge that the patient and I have both been advised against this course of action. In particular I understand that NHS Ayrshire & Arran cannot provide medical care and attention while he / she is absent from the ward / department. I agree to take responsibility for the patient while he / she is absent from the ward / department.

Witness Name .....

Witness Signature .....

Signed .....

Date.....Time .....

An escort disclaimer form should be completed for each new escort during the patients hospital stay and filed with the nursing notes.

Summary problem list

List the nursing problems/needs identified in the patient assessment. Commence appropriate care plans for the identified problems/needs or implement an individual/specialist care plan for specific problems. Allocate the appropriate care plan code next to the problem. Add any new problems as they arise e.g. post-operative care.

Problems / needs identified	Care plan / chart (Code)	Date achieved / Discontinued	Initials

ASSESSMENT

CARE PLAN

Care Plans and Monitoring Charts

Record of care plans and monitoring charts implemented for the patient. List additional specific care plans and monitoring charts and allocate each with a number.

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693

Code	Care plan / monitoring chart	Code	Additional specific care plans / monitoring charts
		EXAMPLE	
A	Admitted as an emergency	1	
B	Breathing	2	
C	Catheter	3	
D	Cleansing and dressing	4	
E	Elimination	5	
F	Falls	6	
G	Bedrails	7	
H	Mobilising	8	
J	Communication	9	
K	Pre-operative	10	
L	Post-operative	11	
M	Wound Management	12	
N	Pressure area care	13	
O	Oral hygiene	14	
P	Pain management	15	
R	MUST - Eating & Drinking	16	
S	Emotional well being / Anxiety	17	
T	MRSA	18	
V	MEWS chart	19	
W	Fluid balance chart	20	
X	Peripheral Vascular Cannula chart	21	

Evaluation of patient care

Registered staff must countersign entries made by students and nursing assistants who have not yet been deemed competent in the delegated skill of record keeping.

Write or attach label

HCI CHI: 3010776241
CHI Welsh, Caroline
Sur 26 Lewis Terrace
Fore Irvine
Add KA11 1HJ
..... 30/10/1977
Date Dr J Taylor
MRN: XHI466693

Date & Time	Careplan Code	Evaluation of Patient's Care	Initials
26.9	K.	A/A for theatre this pm. No bed available on admission. Caroline appears accepting of situation. Obs. stable. ECG in casenotes. Awaits consent & anaesthetic review. TEDS given. Urinalysis NAD. Prepared for theatre.	J.
26/9/13	18.00	Returned from theatre. O2 via N/C cath 2L, abdovac drain til req. P.C.A. I.V fluids insitu. min P.V loss noted. activating PCA when needed. Taking oral fluids. Observations as charted, mews 0.	AH.
26/9/13 2000		Tea & toast given. Small amount tolerated. Activating PCA.	ES
2200		IV fluids continue On therapy remains 2 litres. Wound clean & dry. minimal drainage in abdovac. minimal pv loss. Catheter draining clear urine. Reluctant to change position in bed after reassurance moved position. Tolerated yoghurt. Refused co-codamol but naproxen administered at patients request. mews-0.	
27/9/13 0700		Continues to activate PCA. mews-0 Activating PCA. Catheter output excellent wit wound staining.	ES

EVALUATION OF CARE

Evaluation of patient care

Registered staff must countersign entries made by students and nursing assistants who have not yet been deemed competent in the delegated skill of record keeping.

Date & Time	Careplan Code	Evaluation of Patient's Care	Initials
		Minimal drainage in abdovac.	
		Slept for spells overnight.	
27/9/13	08.45	observations & medications as	
		charted. Breakfast taken. P.C.A	
		discontinued, venflons x2	
		removed from (L) hand. Await	
		ward round before removing	
		drain & cath.	HH.
27/9/13	10.10	Seen by doctors on ward round;	
		plan - FBC & remove catheter	
		& drain, for home sat/sun.	
		Keen to have emla cream to	
		skin for removal of staples.	HH.
27/9/13	10.40	Catheter removed 1100mls in bag.	
		Abdo vac drain removed (20mls)	
		with no problems. Seen by DR	
		Franklin, chase FBC, staples	
		out day 5, encourage to mobilise	HH
27/9/13	12.00	Up to shower, felt a bit dizzy	
		and sick, sat in chair for a	
		bit. Then went for a shower	
		No problems. Sitting in chair	
		for lunch now.	HH
27/9/13	16.25	Settled day so far, abdo wound	
		has min staining to centre, min	
		P.V loss. Says she has been	
		unable to P.U. Bladder scan	
		done - 72mls residual. Hb 12.0	HH
27/9/13	17.20	Patient states she P.U alot	
		but did not use a shell as she	
		didn't think she was going to	
		manage. Asked her to use shell	HH
		next time.	
27/9/13	18.30	Taking diet & fluids, no new issues.	HH
27/9/13	2200	Mews-0	
		States has voided urine x2 in	
		Toilet no samples given.	
		Advised to give samples as	

EVALUATION OF CARE

Evaluation of patient care

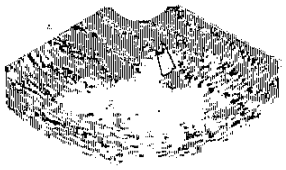
Registered staff must countersign entries n
assistants who have not yet been deemec
skill of record keeping.

Write or attach label

3010776241
e: WELSH
ne: CAROLINE Sex:
Birth: 30/10/1977

BioCon-500
WARD 6
2013/09/27 16:21
ID:

Volume: 29



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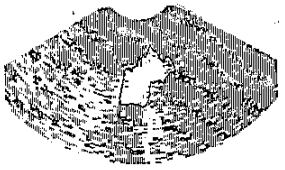
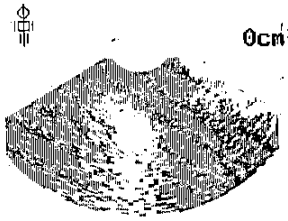
2013/09/27 16:22
ID:

Volume: 72





Date & Time	Careplan Code		Initials
		Staff ne	r output
		Shells g	ent.
		Tolerati	uids.
		Wound	
		Nil pv l	
28/9/13		Routine	wer. BS
0630		Settled	ght. No
		further	s given. BS
28/9/13	08.00	up to sit	tion taken
		a charted.	n Nalay
28/9/13	09.00	Assisted bat	old p.v. loss
		noted. Has p	Spontaneously. Nalay
28/9/13	10.00	Temperature 37.5	espirations 16
		SpO2 98%. C	tights in situ. Nalay
		Slight bruising	
28/9/13	11.00	seen by Darct	A lotus
		later today.	ogy. Nalay
28/9/13	14.10	Passing flatus	r. Nalay
28/9/13	1620	message left	rmacher A
28/9/13	16.20	District Nurse	30/9/13 and
		repeat alternate	ing 2/10/13. Nalay

EVALUATION OF CARE

Evaluation of patient care

Registered staff must countersign entries r ...nursing assistants who have not yet been deemed competent in the delegated skill of record keeping.

Write or attach label

3010776241

Surname: WELSH

Forename: DARSHNE Sex:

Address:

Date of Birth: 30/10/1977

Date & Time	Careplan Code	Evaluation of Patient's Care	Initials
		Staff need to monitor output	
		Shells given to patient.	
		Tolerating diet & fluids.	
		Wound satisfactory.	
		Nil PV loss.	
28/9/13		Routine analgesia given.	GS
0630		Settled & slept overnight. No	
		further urine samples given	GS
28/9/13	08.00	Up to sit for breakfast, medication taken	
		as charted. Complaining of mild pain	NRobey
28/9/13	09.00	Assisted bath taken, moderate old p.v. loss	
		noted. Has passed 400ml of urine spontaneously.	NRobey
28/9/13	10.00	Temperature 37.5°C BP 117/69 pulse 74 respirations 16	
		SpO2 98%. Wound dressing removed staples in situ.	NRobey
		Slight bruising noted at left side.	
28/9/13	11.00	Seen by Doctor, can be discharged home	
		later today. Script sent to Pharmacy.	NRobey
28/9/13	14.10	Passing flatus feeling slightly better.	NRobey
28/9/13	1620	message left with DN answermachine	L
28/9/13	16.20	District Nurse to assess wound post 30/9/13 and	
		remove alternate staples on 1/10/13 remaining 2/10/13.	NRobey

EVALUATION OF CARE

Evaluation of patient care

Registered staff must countersign entries made by students and nursing assistants who have not yet been deemed competent in the delegated skill of record keeping.

Date & Time	Careplan Code	Evaluation of Patient's Care	Initials

Multi-Disciplinary Discharge Plan

All entries must be dated, timed and initialled.

Estimated Discharge Date ..... Medically fit Date .....

Ready for Discharge Date ..... Actual discharge date 28/9/13 Time 15.50

Identified Problem: Patient's continuing needs to facilitate discharge

Goal / Aim: To ensure planned safe timeous discharge planned in partnership with the patient / relatives / carer and staff

Nursing Interventions

Date Time		Completion date	Initials
	Clarify patients admission details are complete, and continuing needs are identified to ensure appropriate referrals to the Multidisciplinary Team (MDT). Refer to discharge folder Re: multidisciplinary roles and responsibilities.		

Multi-Disciplinary Referrals: Discuss with patient and obtain patients consent for referrals. Record referrals made or contact details for staff outwith Hospital if not on admission information

Referral Date	Referral Initials		First Seen Date	First Seen Initials
		Physiotherapist		
		Occupational Therapist		
		Dietitian		
		SALT (Speech and Language Therapist)		
		Pharmacist Does Patient have a medication concordance / compliance aid? Y N If Y refer to ward clinical pharmacist		
		Specialist Nurse		
28/9/13	15.00	District Nurse	28/9/13	[illegible]
		Social Worker		
		Home Care Organiser		
		Discharge Co-ordinator		
		Podiatrist		
		Smoking Cessation Service		
		Other e.g. Mental Health Team, Psychologist (Specify):		

Multi-Disciplinary Interventions

	Has the patient been assessed as requiring a home visit Y N N/A If so record date..... And ensure patient has clothes and house keys		
	Does the patient require a discharge planning meeting Y N N/A If yes to the above contact social work, inform district nurse if appropriate..... and members of MDT Record Date.....		
	Ensure that the relevant information related to Nutrition, Falls, Continence, Pressure Area Care etc as identified in screening tools and care plans is communicated with the patient and relevant others eg. carer, social services, district nurse as appropriate.		

DISCHARGE PLANNING

Multi-Disciplinary Discharge Plan

Write or attach label

H CHI: 3010776241
C Welsh, Caroline
S 26 Lewis Terrace
F Irvine
A KA11 1HJ
30/10/1977
Dr J Taylor
D MRN: XH1466693

DISCHARGE PLANNING

	Discharge Requirements				Completion date	Initials
	Discharge Medicines ordered					
	Patients own medication returned					
28/9/13	Check patients medication with patient / carer before discharge				28/9/13	NK
	7 day supply of dressings, continence aids, catheters or stoma products. (new patients must be given a 7 day supply and refer to district nurse for re-assessment)					
	Nutritional Supplements: New patients must be given a 7 day supply					
	Written advice / information on self-care and lifestyle including diet					
28/9/13	Cannula removed	(Y)	N	N/A	28/9/13	NK
	Follow-up arrangement given	Y	N	N/A		
	If patient not for resuscitation, complete DNAR discharge plan					
	If patient requires specialist interventions (e.g. home oxygen therapy) complete specialist discharge plan. Specify					

Discharge Arrangements:- Require a **minimum of 24 hrs notice** (those needing enteral feeding will require longer)

Alert Note: Any changes made to discharge date must be communicated to patient / relative / carer and all services involved ☐

Re-inform all services involved when new date is established ☐

	Discuss and agree discharge date with patient / relative / carer and all members of multi-disciplinary team		
	Discuss and document all discharge plans with patient and / or relative / carer and services		

Transport

Those able to make their own transport arrangements should be encouraged to do so

28/9/13	Own ☑	Ambulance ☐	am ☐	pm ☐	Reference No:	28/9/13 NK

Equipment Needs - Note: that which is **essential** for discharge will be provided on discharge

	Equipment Type	Arranged By	Expected Delivery Date	Delivery Confirmed
	Physio (specify)			
	OT (specify)			
	Commode			
	Hospital Bed			
	Pressure Mattress			
	Wheelchair			
	Oxygen Cylinder and / or Concentrator			
	Enteral Feeding Equipment			
	Other (specify)			

NHS Ayrshire & Arran

Wd 6 SBAR Communication Sheet

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693
Date of Birth: .....

Situation

Name: Cardine Welsh **Age:** 35yrs **Consultant** Dr. Franklin

Reason for Admission TAH

Operation performed:

Date:

Background

Relevant Past Medical History

Heavy PV bleeding
Repair 2 yrs ago.

Allergies

Latex - hands break out with latex gloves
? metals - has reacted to belt buckles
- localised rash irritation

Assessment - How the patient is.

MDT referrals	Date
Palliative care	
OT	
Physio	
Dietician	
D/N	

Imaging	Date	✓
CT		
USS		
TVS		
MRI		
OPP		

Recommendation – Treatment Plan

Pack **Cath** **Wound**

Drain **Eating and Drinking**

Catheter Care **Personal Care**

Mobility **Fragmin**

N
(
A 26 Lewis Terrace
Irvine
KA11 1HJ
D
Sl

CHI: 3010776241
Welsh, Caroline
30/10/1977
Dr J Taylor
MRN: XHI466693

AYRSHIRE & ARRAN ACUTE HOSPITALS

INFUSION THERAPY RECORDING CHART

SHEET NUMBER: .....

PATIENT WEIGHT: .....

ALLERGIES: .....

1 MEDICINE AND DILUTION DETAILS (to be completed by PRESCRIBER before start of therapy) Consult Pharmacy prior to prescribing additives

MEDICINE	Total Amount of Drug (mg)	Diluent	Total Volume (mls)	Drug Concentration (mg / ml)	Route of Administration	Prescriber's Signature
1 Morphine	50mg	-	~~1mg/ml~~ 50mls	1mg/ml.	IV PCA	DJS
Additive 1						
Additive 2						

2 DOSE AND FLOW RATE DETAILS (to be completed by PRESCRIBER)

	Date	Start Time	Dose or Range to be Administered (Dose / Weight / Time)	Required Flow Rate Setting or Range (mls / hour - mm / time)	If Range, Actual Flow Rate to be commenced (mls / hour - mm / time)	Prescriber's Signature
Initial rate	26-9-13	1500	1mg bolus 5min lockout via PCA.			MJS
New rate						
New rate						
New rate						
New rate						
New rate						

3 PREPARATION / PRODUCT DETAILS (where a pre-prepared solution is available, the batch number should be recorded under the *Drug* section below)

	Date	Time	Prepared by	Checked by	Batch Number Drug(s)	Batch Number Diluent
Initial Preparation	26/9/13	1500	AJ	JW	20577	
Replacement 1						
Replacement 2						

4 MONITORING AND DEVICE SELECTION (To be completed by Nurse / Prescriber before start of therapy)

Infusion Device Selected	IVAC PCAM
Serial / Equipment Number	15650
Monitoring Requirements	1 PAIN
	2 (RESP, SEDATION)

Replacement 3											3	Saphenous
Replacement 4											4	IV site.

5 ADMINISTRATION CHECK (To be completed in full by Nursing Staff) — **HOURLY**

Date	Time Infusion Checked or Stopped	Total Volume Infused	Volume Remaining (Approximate)	Actual Rate Setting	Check by
26/9/13			4.8mls		
26/9/13	17.50	12mls	37mls	1ml/hr	DJ/JH
26/9/13	18.30	16 mls	33 mls	1ml/hr	JH
26/9/13	2030	26mls	23mls	1ml/hr	ES
26/9/13	2130	28mls	21ml	1ml/hr	ES
26/9/13	2230	28mls	21ml	1ml/hr	ES
"	2330	30	19ml	"	ES
27/9/13	0030	30	20	"	KS
27/9/13	0130	31	20mls	"	KS
27/9/13	0230	33ml	18mls	1ml/hr	ES
27/9/13	0430	35ml	16mls	1ml/hr	ES
27/9/13	0600	38mls	13mls	"	ES
27/9/13	0640	39ml	12ml	1ml/hr	ES
27/9/13	07.55	40mls	11mls	1ml/hr	JH
27/9/13	08.30	41mls	10mls	1ml/hr	JH

6 START / STOP / RATE CHANGE CHECK The reason for the alteration must always be recorded.

Time Infusion Started / Restarted	Rate Setting	Started / Restarted by	Checked by	10 minute check	Reason for change in rate / stop. Comments
1625	1mg/ml	Range	DJ		1625 2mg morphine via PCA (clinician override) DJ.
					1730 3mg morphine via PCA JH
					Pump discontinued.

STA3013

NHS Ayrshire & Arran

Fluid and Low Risk Infusion Therapy Recording Chart

Ward/Department ..... 6 .....

Consultant .....

CHI: 3010776241
H Welsh, Caroline
C 26 Lewis Terrace
S Irvine
F KA11 1HJ
/ 30/10/1977
. Dr J Taylor
L MRN: XHI466693

		Fluid (use block letters) Electrolyte addictive 3	Vol (ml) Mmols 4	Route of Admin 5	Duration Rate 6	Pump Yes/No 7	Mon Time every (hrs / mins) 8	Signatures 9	Batch Nos 10	Given by Added by 11	Start Time 12
A	26/9/13	Hartmans	500	IV	125ml/hr	Y			B601T40	J. Blewett	17.55
B	26/9/13	HARTMANNS	500	IV	4°				13601T40	Blewett	2220
C	26/9/13	HARTMANNS	500	IV	40				13901T40	Blewett	
D	26/9/13	HARTMANNS	500	IV	40						
E	26/9/13	HARTMANNS	500	IV	40						
F											
G											
H											
I											
J											
K											
L											

Use this chart of infusions of Fluids, Electrolytes (less than 40 mmol per litre potassium chloride), Blood, Blood Products and T.P.N.
If a volumetric pump is used the monitoring section on the reverse must be completed.

RS 5925

If a volumetric pump is used for any infusion on the previous page, the infusion ID should be noted on the chart below and the monitoring details completed at intervals specified by the prescriber of the infusion.

The **INFUSION CHECKS** box should be ticked to indicate that the following checks have been made: **Pump Rate, Infusion site, Vol. remaining in bag is approx. as expected, patient's condition.**

INF I.D. 1	Vol. Pump Make 2	Serial Number 3	Date 4	Time 5	Vol. Fused (from pump) 6	Infusion Checks 7	Signed 8

NHS Ayrshire & Arran

Fluid Intake and Output Chart

Write or attach label

HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

DATE 27/9/13						YESTERDAY'S BALANCE			
	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8									
9	200								
10									
11	250					Catheter	(1100 mls)		20 mls
12									
13									
14									
15									
16									
17									
18						Pux2 in toilet			
19									
20									
21									
22									
23									
24									
1									
2									
3									
4									
5									
6									
7									
TOTAL						(a)	(b)	(c)	(d)

INTAKE =	ml	(e) Insensible loss * = OUTPUT = (a + b + c + d)	ml

BALANCE = (Intake minus output)	ml

Average Adult = 600 ml + 100ml per each 0.5 °C temperature elevation.

DRS 5944

NHS Ayrshire & Arran

Fluid Intake and Output Chart

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693
Date of Birth: .....

DATE 26/9/13						YESTERDAY'S BALANCE			
	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8									
9									
10									
11									
12									
13									
14									
15									
16									
17		500 (hartmans)							
18									
19									
20									
21						250mls			
22		500	hartmans						
23									
24									
1									
2									
3									
4		500	hartmans						
5									
6									
7						2l 100			
TOTAL						(a)	(b)	(c)	(d)

INTAKE = 700	ml	(e) Insensible loss * = OUTPUT = 2650 (a + b + c + d)	ml
BALANCE = (Intake minus output)	ml		

* Average Adult = 600 ml + 100ml per each 0.5 °C temperature elevation.

DRS 5944

NHS Ayrshire & Arran

Fluid Intake and Output Chart

Write or attach label

HCR No: .....
CHI No: .....
Surname: WELSH
Forename: CAROLINE Sex: F
Address: .....
.....
Date of Birth: 30-10-77

DATE 28/9/13						YESTERDAY'S BALANCE			
	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8	350ml								
9/10	100ml					400ml			
10	150ml								
11	150ml								
12									
13	250ml								
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
1									
2									
3									
4									
5									
6									
7									
TOTAL						(a)	(b)	(c)	(d)

INTAKE =	ml	(e) Insensible loss * = OUTPUT = (a + b + c + d)	ml

BALANCE = (Intake minus output)	ml

* Average Adult = 600 ml + 100ml per each 0.5 °C temperature elevation.

DRS 5944

NHS Ayrshire & Arran

Fluid Intake and Output Chart

Write or attach label

HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

DATE						YESTERDAY'S BALANCE			
	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
1									
2									
3									
4									
5									
6									
7									
TOTAL						(a)	(b)	(c)	(d)

INTAKE =	ml	(e) Insensible loss * = OUTPUT = (a + b + c + d)	ml

BALANCE = (Intake minus output)	ml

Average Adult = 600 ml + 100ml per each 0.5 °C temperature elevation.

DRS 5944

GYNAECOLOGY SURGERY PHYSIOTHERAPY SHEET

OPERATION TAH

Name
Unit No
D.O.B.
(Place s

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693

Physio No.....
Date of Assessment 18/6/13
Date of Admission 8/7/13
Date of Surgery .....
Consultant FRANKLIN
Physiotherapist JSkene | J.S KENE
P.O.A

Present Condition

menorrhagia

FOR TAH

Past Medical History

Backpain ? related to gyn problems

PFR '09

BMI - 36.

Drug History

See kardex

Social History

Lives c husband

Carer

Chest Assessment

no acute problems

Transfer and Mobility Assessment

Ind.

Pre Operative Assessment

- [x] Deep Breathing Exercises
- [x] Protected Coughing
- [x] Post operative rehabilitation discussed
- [x] Pelvic Floor Exercises
- [x] Pelvic Tilting/Knee Rolling/Abdominal Exercises
- [x] Post operative booklet explained/supplied

JSkene

Comments

Date	27/09/13		
Post-op Day	(1)		
Subjective	Well Not been up		
Observations	catheter + wound drain still in situ		
Chest Assessment	clear		
Mobility Assessment	I		
Deep Breathing Exercises	✓		
Protected Coughing	✓		
Circulation	✓		
Pelvic Floor Exercises	✓		
Knee Rolling	✓		
Pelvic Tilting	✓		
Discharge Talk	✓		
Plan	DISCH		
Signature	Gail Tait		
Print	GAIL TAIT		

NHS Ayrshire & Arran

MEWS CHART

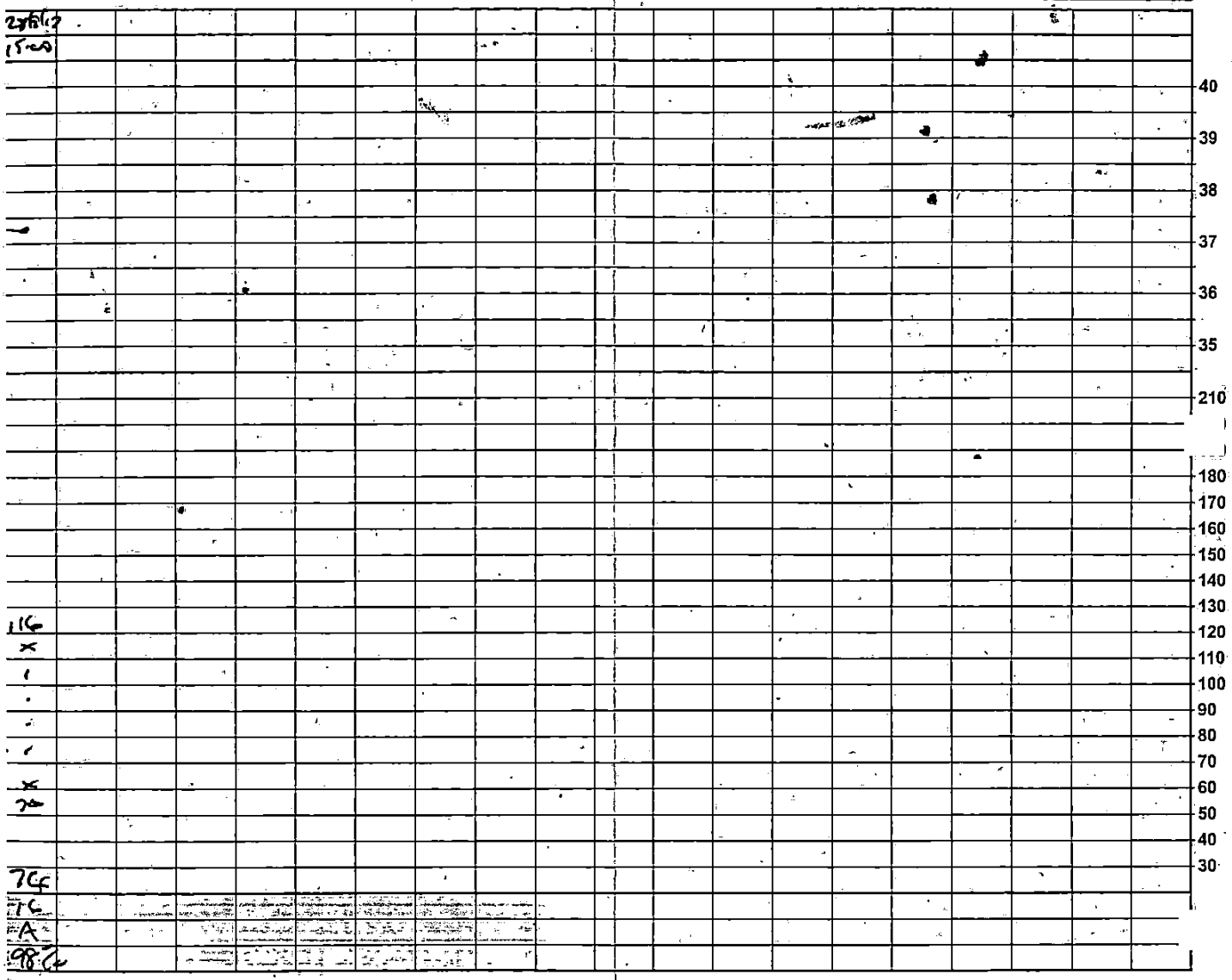
DATE	26/9	26/9	26/9	26/9	26/9	26/9	26/9	26/9	27/9	27/9	27/9	27/9	27/9	27/9	27/9	27/9	28/
TIME (24 hour clock)	12.00	17.50	18.30	20.30	21.30	22.30	23.30	00.30	01.30	02.30	04.30	06.30	08.20	16.30	20.00	10.	
Temperature (°C) 40																9	
39																	
38																	
37																	
36																	
35																	
BLOOD PRESSURE 210																	
200																	
190																	
180																	
170																	
160																	
150																	
140																	
130	128																N
120																	
110																	
100																	
90																	
80																	
70																	
60																	
50																	
40																	
HEART RATE 30																	
Respiratory Rate	16	14	14	14	12	16	14	14	14	15	16	16	15	14	16	1	
O_2	A	2L	2L	~~2L~~ A	A	2L	2L	2L	2L	2L	2L	A	A	A	A	A	
Saturation	99	100	100	97	97	100	100	100	100	100	100	95	97	100	98	9	

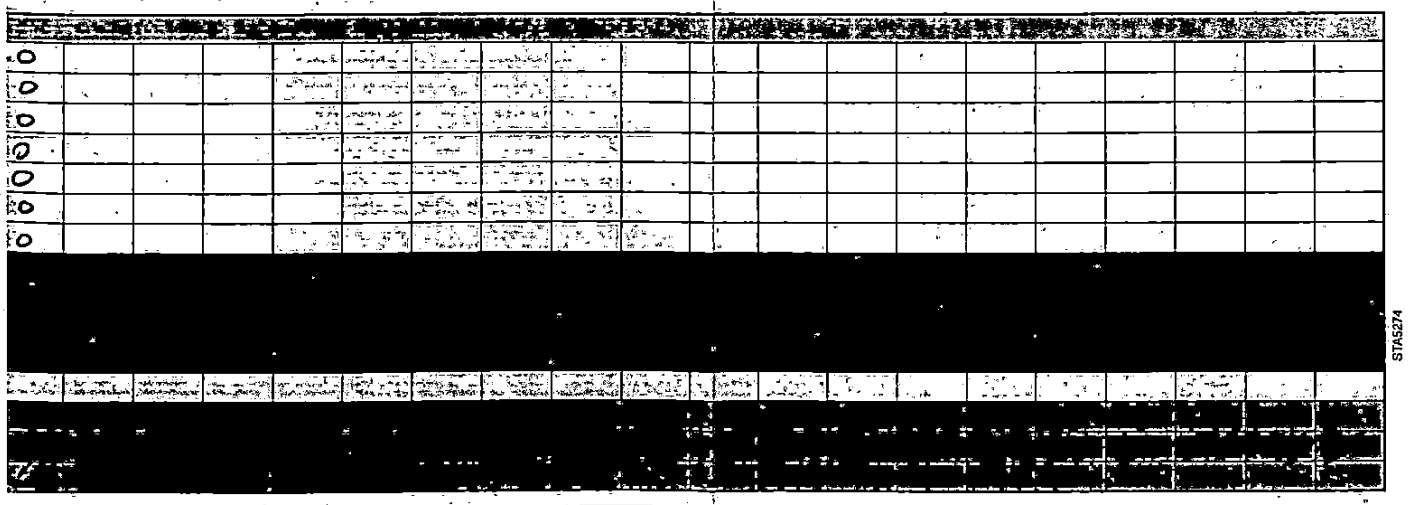
MEWS SCORE for EACH of the INDIVIDUAL OBSERVATIONS																
Temperature (°C)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	C
BP (Systolic)																C
Heart Rate																0
Respiratory Rate																0
S_pO_2																0
Urine Output																0
CNS																0
MEWS SCORE - TOTALS																
3																
2																
1																
0																

Record the total MEWS scores for each set of observations this way

Sedation Score	0	1	0	0	0	0	0	0	3	0	0	0	0	0	0	0
Pain Score (On Movement)	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2
Nausea Score	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Initials																N

HCI CHI: 3010776241
CHI Welsh, Caroline
Sum 26 Lewis Terrace
Fore Irvine
Add KA11 1HJ
30/10/1977
Dr J Taylor
Date MRN: XHI466693





STAS274

Surname	
Forenai	CHI: 3010776241
Addres:	Welsh, Caroline 26 Lewis Terrace Irvine KA11 1HJ 30/10/1977
Date of	Dr J Taylor
Sex	MRN: XHI466693
Ward / Department	

NHS Ayrshire & Arran
ACTIVITY OF LIVING

Maintaining safe environment

Identify problems/needs

Patient has been admitted for surgery

	Date

Goal/Aim : Post op – to monitor and alleviate symptoms – to minimise and treat complications

Date	Time	Initials	Planned care	Discontinued Date	Discontinued Time	Initials
			Monitor and record vital signs			
			½ hourly			
			Hourly			
			2 hourly			
			4 hourly			
28/9/13	15.00	NF	Twice daily	28/9/13	15.00	NF
			Monitor urinary output via catheter			
			Carry out catheter care as per protocol			
			Remove when instructed			
28/9/13	08.00	NF	Monitor output to ensure adequate volumes	28/9/13	08.00	NF
			Give patient controlled analgesia as per protocol / give epidural as per Protocol			
			Administer oxygen therapy as prescribed and monitor effects			
			Monitor PV Loss			
			Hourly			
			2 hourly			
28/9/13	08.00	NF	Twice daily	28/9/13	08.00	NF
28/9/13	08.00	NF	Manage wound site and drain as appropriate and instructed	28/9/13	15.00	NF
			staples to wound.			
28/9/13	08.00	NF	Give all medications prescribed and monitor effects	28/9/13	08.00	NF
28/9/13	08.00	NF	Maintain adequate nutrition (refer to nutrition risk score chart)			
28/9/13	08.00	NF	Monitor nausea / vomiting			
28/9/13	08.00	NF	Offer anti emetics as prescribed			
			Administer IV fluid as prescribed			
			Maintain accurate fluid balance chart			

DRS5003

CONTINUED OVER

Date	Time	Initials	Planned care	Discontinued Date	Discontinued Time	Initials
			Offer tea and toast 1st post op morning if bowel sounds present			
			Allow patient to choose own menu			
			Mobilise as condition indicates (refer to moving and handling chart)	28/9/13	15.00	NF
			Maintain level of hygiene	28/9/13	09.00	NF
			Give appropriate level of assistance which ensures patients needs are met	28/9/13	08.00	NF
			Maintain dignity and comfort	28/9/13	08.00	NF
			Encourage daily shower	28/9/13	08.00	NF
			Assess skin and potential pressure areas			
			Record waterlow score as condition indicates			
			Monitor bowel activity NAD	28/9/13	08.00	NF
			Give aperient as required			
			Promote restful sleep			
			Give night sedation if prescribed and desired			
			Report any deviation from the normal to medical staff and act on their instructions	28/9/13	15.00	NF

CONTINUED OVER

Surname	
Forenames	
Address	CHI: 3010776241 Welsh, Caroline 26 Lewis Terrace Irvine KA11 1HJ
Date of Birth	30/10/1977
Sex	Dr J Taylor MRN: XHI466693
Ward / Department	

NHS Ayrshire & Arran

ACTIVITY OF LIVING

Maintaining safe environment

Identify problems/needs

Patient has been admitted for major surgery

	Date

Goal/Aim : Provide effective pre-operative care and to minimise risk complication

Date	Time	Initials	Planned care	Discontinued Date	Discontinued Time	Initials
			Monitor and record baseline observations			
			Obtain urine sample for			
			☑ Ward testing NAD			
			☑ Pregnancy test, if applicable neg			
			Report any deviation from normal to medical staff			
			Obtain MRSA Swabs if appropriate			
			Fully prepare patient for theatre:			
			☑ Give pre op talk	26.9		2
			☐ Offer educational literature			
			☐ Give all prescribed medications and monitor effects			
			☐ Ensure patient has been sent by phyisotherapist			
			☐ Administer bowel prep as prescribed, if required			
			☐ Fast as per anaesthetists instructions			
			☐ Carry out specific instructions from anaesthetist			
			☑ Ensure patient is wearing anti-embolic stockings	26.9		2
			☑ Check patient has correct ID bracelet	26.9		2
			☐ Check patient has given informed consent			
			☐ Remove prosthesis as necessary			
			☐ Give prescribed premedication as prescribed			
			☑ Ensure all relevant documentation is available to accompany patient to theatre including as appropriate ECG, Xray and blood results	26.9		2
			☐ Complete theatre check list			

DRS5001

Date	Time	Initials	Planned care	Discontinued		Initials
				Date	Time	

NHS Ayrshire & Arran

Hospital to Community
Nursing Referral Form

White copy to Community Nurse
Yellow copy file in nursing notes

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XH1466693
Date of Birth:
STA2104

Community Nurse telephoned : Verbal report given: Yes / No Message left Yes / No Comment ..... Date 28/9/13

Recorded Diagnosis TOTAL ABDOMINAL HYSTERECTOMY Patient Aware: Yes ☐ No ☐ Comments CONSERVATION OF OVARIES ON 26/9/13

Specific Alert

Allergies Yes ☑ No ☐ Specify LATEX, METAL

MRSA Positive Yes ☐ No ☑ c-diff Positive Yes ☐ No ☐

Beta Lactamases (ESBL) Positive Yes ☐ No ☑

Treatment Details: .....

First Contact / Significant Other

Name BRIAN WELSH Relation to patient HUSBAND

Contact numbers 07580068018 Address AS PATIENTS

Informed of Transfer Yes ☑ No ☐

Aware of diagnosis Yes ☑ No ☐ Comment .....

Treatment To Be Continued Please assess abdominal wound + ? Staples 30/9/13

wound staples to be removed alternate 1/10/13

Follow up appointments arranged Yes ☐ NA ☐ 2/10/13 remaining staples

Alert and Orientated : Yes ☑ No ☐ Confused Yes ☐ NA ☐

Comments .....

Degree Of Dependency

Ambulant	☑	Bath in Bed	☐	Uses Toilet	☑
Ambulant with help	☐	Bathroom with help	☐	Commode	☐
Chair/Bed fast	☐	Unaided	☐	Bed Pan	☐

Hoist required Yes ☐ NA ☐

Stair lift required Yes ☐ NA ☐

Assessed by Physio Yes ☐ NA ☐ Occupational Therapist Yes ☐ NA ☐

Speech & Language Therapist Yes ☐ NA ☐ **History of falls** Yes ☐ No ☑

Continent: Yes ☑ No ☐ Faeces ☐ Urine ☐ Catheter in Situ ☐ Reason for insertion .....

Catheter location: Urethral ☐ Supra public ☐ Catheter make ..... size .....

Date catheter inserted/changed ..... Continence assessment completed Yes ☐ No ☐ NA ☐

Self care with stoma Yes ☐ No ☐ NA ☐

Skin Integrity: Site of wound/s : ..... Dressing frequency .....

Type of dressing .....

Dressing prescription: Yes ☐ NA ☐ 7 Days Starter Pack Given Yes ☐ No ☐ NA ☐

Pressure Areas : Healthy ☐ Pressure Ulcer/s Yes ☐ No ☐ Number ☐

Location ..... Grade/s .....

Eating and drinking:

Unaided ☐ With Help ☐ Dependant ☐ Special equipment required Yes ☐ NA ☐ MUST Score .....

Aids and adaptations .....

Referrals made Social services Yes ☐ NA ☐ Home Care Yes ☐ NA ☐ Specialist Nurse Yes ☐ NA ☐ AHP Yes ☐ NA ☐

Name ..... Designation ..... Contact details .....

Name ..... Designation ..... Contact details .....

Other Details .....

Referring Nurse M. FORBES Signature M Forbes Date 28/9/13 Tel. No 01563 522833 Ward 6 Hospital CROSSHOUSE

NHS Ayrshire & Arran

MRSA SCREENING
CLINICAL RISK ASSESSMENT (CRA)

COMPLETE FOR ALL ADMISSIONS (Ayr & Crosshouse Hospital Only)

CHI: 3010776241
ATTA Welsh, Caroline
Patie 26 Lewis Terrace
Irvine
CHI: KA11 1HJ
Date 30/10/1977
Ward/ Dr J Taylor
MRN: XHI466693

Completed by if not using admission booklet
Name: L. M FERGUSON
Designation: SSN
Signature: L M Ferguson
Date / Time: 18/6/13

FORM COMPLETED IN		
	Pre-op	✓
	Admitting Ward	

	Yes	No	Don't know
1. Has the patient had any **previous history of MRSA** colonisation or MRSA infection at any time in the past?		✓	
2. Is the patient currently **resident in a care home or institutional setting** (ie prison, homeless, hostel) or **transferred from another hospital?**		✓	
3. Does the patient **have a wound/ulcer or indwelling medical device** which was present before admission to this hospital?		✓	

OUTCOME OF CRA

Any of the above three questions answered **'yes'**	▪ Screen nose and perineum (& wound or device where applicable) ▪ Manage patient as if MRSA positive (isolate if possible) ▪ Complete next section of the CRA
All three of the above questions **'no' or 'don't know'**	▪ Patient is likely to be at low risk of MRSA and can be managed as normal in accordance with the Infection Control Policy. Do not complete the remainder of the form.
Direct admission to 4 high risk specialties (renal, orthopaedics, vascular / cardiothoracic, intensive care)	▪ Complete CRA and take a screen from nose and perineum (& wound or device where applicable) regardless of the outcome of answering the 3 questions above.

SCREENING ACTIONS ('YES' TO ANY CRA QUESTION & 4 HIGH RISK SPECIALTIES)

	Nose	Perineum	Wound	Device	Other
MRSA screening swabs taken **Tick all applicable (inc dates)**					

ISOLATION ACTIONS ('YES' TO ANY CRA QUESTION) (See definitions in footer)

	Patient isolated in a single room	Patient cohorted, with other high risk patients, dedicated nursing	Patient cohorted, with no dedicated nursing staff	Patient separated
Detail of action completed **Tick all applicable (inc dates)** *Particularly if unable to isolate – please state reasons				

LABORATORY RESULTS

Date results received	Result of swab (positive or negative)	Name (PRINT)

HPS ISOLATION DEFINITIONS
Isolated: Patient is placed in a single room with hand washing facilities, ideally with ensuite toilet and shower where available. Isolation should be undertaken according to the HPS Infection Control Contact Precautions Policy
Cohorting: Patient is placed in a room and cared for by dedicated nursing staff along with other patients who are MRSA screen positive. Cohorting should be undertaken according to the HPS Infection Control Contact Precautions Policy.
Separated: Patients who are MRSA screen positive are housed within the same room as patients who are not MRSA positive but are separately by at least three feet from any adjacent persons by use of closed bed curtains. This is considered to be a step down from full cohorting. These patients do not have separate nursing staff. Separation should be undertaken according to the HPS Infection Control Contact Precautions Policy
http://www.hps.scot.nhs.uk/haiic/ic/standardinfectioncontrolprecautions-sicps.aspx

NHS Ayrshire & Arran

PAIN SCORING CHART

Pain Score must be assessed on each drug round, documented and Initialled accordingly.

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693

Date	28/3/13																													
Time	08																													
PAIN																														
3																														Severe
2	✓	✓																												Moderate
1																														Mild
0																														No Pain
SEDATION																														
3																														Unconscious
2																														Asleep / difficult to rouse
1																														Asleep / drowsy / easy to rouse
0	✓	✓																												Awake
NAUSEA																														
3																														Severe nausea +/- frequent vomiting
2	✓	✓																												Moderate nausea +/- occasional vomiting
1																														Mild nausea – no vomiting
n																														No nausea no vomiting
ACTION TAKEN																														
	As charted	As charted																												Refer to Acute Pain team analgesia guidelines. e.g. Regular analgesia given or PRN analgesia given, patient refused. Any problems please page the Acute Pain Team on 3305.
Initials	N	NF																												Please initial at each assessment.

DRS 1073

NHS Ayrshire & Arran

PAIN SCORING CHART

Pain Score must be assessed on each drug round, documented and Initialled accordingly.

Write or attach label

HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

Date																												
Time																												
PAIN																												
3																												Severe
2																												Moderate
1																												Mild
0																												No Pain
SEDATION																												
3																												Unconscious
2																												Asleep / difficult to rouse
1																												Asleep / drowsy / easy to rouse
0																												Awake
NAUSEA																												
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1																												Mild nausea – no vomiting
n																												No nausea no vomiting
ACTION TAKEN																												
																												Refer to Acute Pain team analgesia guidelines. e.g. Regular analgesia given or PRN analgesia given, patient refused. Any problems please page the Acute Pain Team on 3305.
Initials																												Please initial at each assessment.

SHEET No .....
Name.... Welsh, Caroline
Age ..... 26 Lewis Terrace
Consultc Irvine
Hospital KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693
CHI: 3010776241

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
26/9/13								A B E		
Init.								JH		
27/9/13		A B E		G		D G		A E 9		
Init.		JH		JH		JH		JH		
28/9/13	G @ C&D	A C E		G	H					
Init.	JH	NF		NF	NF					
Init.										
Init.										
Init.										
Init.										

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
Init.										
Init.										
Init.										
Init.										
Init.										
Init.										
Init.										

SHEET No .....

Name .....

Age .....

Consultant .....

Hospital .....

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

Key: O ORAL | SL SUBLINGUAL | PR PER RECTUM | IM INTRAMUSCULAR | ID INTRADERMAL | PV PER VAGINA | IV INTRAVENOUS | INH INHALATION | IT INTRATHECAL | SC SUBCUTANEOUS | NEB NEBULISED

CHI: 3010776241
Ch Welsh, Caroline
Su 26 Lewis Terrace
Fo Irvine
Ad KA11 1HJ
30/10/1977
Dr J Taylor
Da MRN: XHI466693

KNOWN SENSITIVITY

1.	2.

SUSPECTED ADVERSE REACTION

MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION 6am	8am	10am	12md	2pm	6pm	8pm	10pm	12mn	OTHER		ROUTE (See Key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED DATE	DISCONTINUED INITIAL
	A 26-9-13	Naproxen	500mg		✓					✓					O				
	B 26-9-13	Co-codamol	30/500		✓			✓	✓		✓				O			27/9	Cap
	C 26 9 13	Ondansetron	4mg	as	reqd			nausea			vomiting		8hly		O/IV				
	D 26 9 13	Dalteparin	5000u						✓						S/C				
	E 26 9 13	Lactulose	10mls		✓						✓				O	while on opioids			
	F 26 9 13	Morphine	see chart						PCA						IV				
	G 27/9	PARACETAMOL	1GRAM		✓		✓		✓		✓				PO				
	H 27/9/13	BUSCOPAM	20mg		✓			✓			✓				PO				
	I																		
	J																		
	K																		
	L																		
	M																		
	N																		
	O																		
	P																		
	R																		
	S																		
	T																		
	V																		

STA0235

MEDICINES TO BE GIVEN ONCE (BLOCK CAPITALS)

PHARM.	TO BE GIVEN		APPROVED NAME OF MEDICINE	DOSE	ROUTE (See Key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	DATE	TIME						

NHS Ayrshire & Arran

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
Irvine
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693
Date of Birth:

Adult Peripheral Intravenous Cannula Monitoring and Recording Sheet

All peripheral IV cannula should be resited every 72 hours. Refer to Infection Control Manual for further information. All new cannula insertions must be recorded on the table below.

Cannula Code	Cannula Size/ Colour	Cannula Location	Date Inserted	Date Due Removed	Comments	Signature/ Designation
A	PINK + GREEN	LEFT HAND	26/9/13	28/9/13	Cited in theatre NOV Spains	PP K Taylor
B						
C						
D						
E						
F						

All patients with peripherally inserted intravascular cannula must have the insertion site CHECKED AT LEAST DAILY for signs of infection/phlebitis and this observation documented. Heparin flushes must NOT be administered routinely and only when prescribed.

Cannulas should be flushed as per Patient Group Direction for the administration of flushes. Summary guide and frequency of flush administration:

- All sodium chloride 0.9% flushes must be administered by aseptic technique and recorded on either drug prescription chart or on electronic prescribing system by the administering staff nurse trained in IV administration.
- Pre, between & post IV medication administration as determined by prescribed IV medication.
- Every 8 hours to maintain patency, where no continuous infusion is in place or the patient is not receiving IV medication at least 8 hourly.

In exceptional circumstances it may be necessary for a cannula to remain in situ for longer than 72hours. In this instance the rationale for this must be recorded in the patient's care plan and care and maintenance of the cannula and site is of the highest standard.

Check the patient's cannula site against the 5 criteria and tick the appropriate yes/no box. You must date, time and sign on each occasion that a cannula is checked.

Cannula Code	Date	Time	1 Has the cannula been used in the past 24 hours?	2 Absence of inflammation and/or extravasation?	3 The cannula dressing is intact?	4 The cannula has been inserted for <72 hrs?	5 Hand hygiene before and after all procedures?	If answer is NO to any of the 5 criteria the cannula should be removed. What has been done?	Sign and print name and designation
			Yes ☐	Yes ☐	Yes ☐	Yes ☐	Yes ☐	Cannula left in situ ☐	
			No ☐	No ☐	No ☐	No ☐	No ☐	Cannula removed ☐	

Cannula Code	Date	Time	1 Has the cannula been used in the past 24 hours?	2 Absence of inflammation and/or extra vasation?	3 The cannula dressing is intact?	4 The cannula has been inserted for <72 hrs?	5 Hand hygiene before and after all procedures?	If answer is NO to any of the 5 criteria the cannula should be removed. **What has been done?**	Sign and print name and designation
			Yes ☐	Yes ☐	Yes ☐	Yes ☐	Yes ☐	Cannula left in situ ☐	
			No ☐	**No ☐**	**No ☐**	**No ☐**	**No ☐**	**Cannula removed ☐**	
Cannula Code	Date	Time	1 Has the cannula been used in the past 24 hours?	2 Absence of inflammation and/or extra vasation?	3 The cannula dressing is intact?	4 The cannula has been inserted for <72 hrs?	5 Hand hygiene before and after all procedures?	If answer is NO to any of the 5 criteria the cannula should be removed. **What has been done?**	Sign and print name and designation
			Yes ☐	Yes ☐	Yes ☐	Yes ☐	Yes ☐	Cannula left in situ ☐	
			No ☐	**No ☐**	**No ☐**	**No ☐**	**No ☐**	**Cannula removed ☐**	
Cannula Code	Date	Time	1 Has the cannula been used in the past 24 hours?	2 Absence of inflammation and/or extra vasation?	3 The cannula dressing is intact?	4 The cannula has been inserted for <72 hrs?	5 Hand hygiene before and after all procedures?	If answer is NO to any of the 5 criteria the cannula should be removed. **What has been done?**	Sign and print name and designation
			Yes ☐	Yes ☐	Yes ☐	Yes ☐	Yes ☐	Cannula left in situ ☐	
			No ☐	**No ☐**	**No ☐**	**No ☐**	**No ☐**	**Cannula removed ☐**	
Cannula Code	Date	Time	1 Has the cannula been used in the past 24 hours?	2 Absence of inflammation and/or extra vasation?	3 The cannula dressing is intact?	4 The cannula has been inserted for <72 hrs?	5 Hand hygiene before and after all procedures?	If answer is NO to any of the 5 criteria the cannula should be removed. **What has been done?**	Sign and print name and designation
			Yes ☐	Yes ☐	Yes ☐	Yes ☐	Yes ☐	Cannula left in situ ☐	
			No ☐	**No ☐**	**No ☐**	**No ☐**	**No ☐**	**Cannula removed ☐**	

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

Key: O ORAL; IM INTRAMUSCULAR; IV INTRAVENOUS; SC SUBCUTANEOUS; SL SUBLINGUAL; ID INTRADERMAL; INH INHALATION; NEB NEBULISED; PR PER RECTUM; PV PER VAGINA; IT INTRATHECAL

Write, Imprint or attach label

HCR No: .....
CHI No: 301077624
Surname: WELSH
Forename: CAROLINE Sex: F
Address: 26 LEMS TERRACE
IRVINE
Date of Birth 30-10-77

KNOWN SENSITIVITY NKDA.

1.	2.

SUSPECTED ADVERSE REACTION

MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION: 6am	8am	10am	12md	2pm	6pm	8pm	10pm	12mn	OTHER	ROUTE (See Key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED: DATE	INITIAL
A	~~2/11/12~~	~~CO-CODAMOL 30/500~~	~~2 tabs~~			PRN		max			6			PO			3/11/12	
B	5/11/12	OCTAROU	50 mg			PRN		8						PO				
C	5/11/12	PARACETAMOL	1g			PRN		4-6						PR/IV				
D	5/11/12	LORATADINE	10mg		✓									PO				
E	6/1	~~metronidazole~~															6/1	
F	6/1	~~tranexamic acid~~															6/1	
G	~~6~~ 6/1	tranexamic acid	1g		✓			✓			✓			PO	10days			
H	6/1	~~tranexamic acid~~	~~500mg~~		✓			✓			✓			PO			7/11/12	Dr.
I	~~7~~ 6/1	~~BRETHISTERONE~~	10mg		✓			✓			✓							
J																		
K																		
L																		
M																		
N																		
O																		
P																		
R																		
S																		
T																		
V																		

JMcC/80185

STA0235

MEDICINES TO BE GIVEN ONCE (BLOCK CAPITALS)

PHARM.	TO BE GIVEN DATE	TO BE GIVEN TIME	APPROVED NAME OF MEDICINE	DOSE	ROUTE (See Key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	5/1/12.	10pm.	Temazepam	10mg	O	A Manns	Beckett	21.10
	6/1/12.		promab	3.75mg	IM	MG	J. Newton	13.20
~	6/1/12		Temazepam	1ml	oral	S Clo	Keeton	2315

SHEET No .....

Name .....

Age .....

Consultant .....

Hospital .....

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
2/1/12										A C 19.00
	Init.									JH
4/1/12								A		A C 08.10
	Init.							KM A D	B C 23:15	14.00 JH JH
5/1/12		(A) D		A						
	Init.				G H			KM C G H	KM	BHC C 12.20
6/1/12		B A C D G H		C	B G I	C		63		JH
	Init.	BP		DP	DP	DP				
7/1/12										
	Init.									
	Init.									
	Init.									

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

STA 0236

SHEET No .....

Name.....

Age .....

Consultant .....

Hospital .....

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

NHS Ayrshire & Arran

Wd 6 SBAR Communication Sheet

CHI: 3010776241
HC Welsh, Caroline
Ch 26 Lewis Terrace
Sui KA11 1HJ
For 30/10/1977
Adc Dr J Taylor
..... MRN: XHI466693
Dat .....

Situation

Name: Caroline Welsh. Age: 34 Consultant

Reason for Admission/operation:

Abdo pain, bleeding passing clots.

Background

Relevant Past Medical History

Allergies

NKA

Assessment - How the patient is

MEWS Score

MDT referrals	Date
Palliative care	
D/N	
OT	
Physio	
Dietician	

Recommendation – Treatment Plan

Pack	Cath	Wound
Drain		Eating and
Catheter Care		Personal C
Mobility		

901

				ICIQ-VS-10/05

Initial Number **CONFIDENTIAL**

VAGINAL SYMPTOMS QUESTIONNAIRE

Many people experience vaginal symptoms some of the time. We are trying to find out how many people experience vaginal symptoms, and how much they bother them. We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

Please write in today's date: 09 (DAY) 12 (MONTH) 10 (YEAR)

Please write in your date of birth: 30 (DAY) 10 (MONTH) 77 (YEAR)

Vaginal symptoms

1a. Are you aware of dragging pain in your lower abdomen?

- never ☐ 0
- occasionally ☑ 1
- sometimes ☐ 2
- most of the time ☐ 3
- all of the time ☐ 4

1b. How much does this bother you?
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**
not at all — a great deal

2a. Are you aware of soreness in your vagina?

- never ☑ 0
- occasionally ☐ 1
- sometimes ☐ 2
- most of the time ☐ 3
- all of the time ☐ 4

2b. How much does this bother you?
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**
not at all — a great deal

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3a. Do you feel that you have reduced sensation or feeling in or around your vagina?

never	☑ 0
occasionally	☐ 1
sometimes	☐ 2
most of the time	☐ 3
all of the time	☐ 4

3b. How much does this bother you?
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**
not at all — a great deal

Prolapse is a common condition affecting the normal support of the pelvic organs, which results in descent or 'dropping down' of the vaginal walls and/or the pelvic organs themselves. This can include the bladder, the bowel and the womb. Symptoms are usually worse on standing up and straining (e.g. lifting, coughing or exercising) and usually better when lying down and relaxing.

Prolapse may cause a variety of problems. We are trying to find out how many people experienc prolapse, and how much this bothers them. We would be grateful if you could answer the followin questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

4a. Do you feel that your vagina is too loose or lax?

never	☑ 0
occasionally	☐ 1
sometimes	☐ 2
most of the time	☐ 3
all of the time	☐ 4

4b. How much does this bother you?
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**
not at all — a great deal

5a. Are you aware of a lump or bulge coming down in your vagina?

never	☑ 0
occasionally	☐ 1
sometimes	☐ 2
most of the time	☐ 3
all of the time	☐ 4

5b. How much does this bother you?
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**
not at all — a great deal

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6a. Do you feel a lump or bulge come out of your vagina, so that you can feel it on the outside or see it on the outside?

never	☑ 0
occasionally	☐ 1
sometimes	☐ 2
most of the time	☐ 3
all of the time	☐ 4

6b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

7a. Do you feel that your vagina is too dry?

never	☑ 0
occasionally	☐ 1
sometimes	☐ 2
most of the time	☐ 3
all of the time	☐ 4

7b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

8a. Do you have to insert a finger into your vagina to help empty your bowels?

never	☑ 0
occasionally	☐ 1
sometimes	☐ 2
most of the time	☐ 3
all of the time	☐ 4

8b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

9a. Do you feel that your vagina is too tight?

never	☑ 0
occasionally	☐ 1
sometimes	☐ 2
most of the time	☐ 3
all of the time	☐ 4

9b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

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Sexual matters

We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

10. Do you have a sex life at present?

- yes ☑ 0
- no, because of my vaginal symptoms ☐ 1
- no, because of other reasons ☐ 2

If NO, go to question 14

11a. Do worries about your vagina interfere with your sex life?

- never ☑ 0
- occasionally ☐ 1
- sometimes ☐ 2
- most of the time ☐ 3
- all of the time ☐ 4

11b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

12a. Do you feel that your relationship with your partner is affected by vaginal symptoms?

- never ☑ 0
- occasionally ☐ 1
- sometimes ☐ 2
- most of the time ☐ 3
- all of the time ☐ 4

12b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

13. How much do you feel that your sex life has been spoilt by vaginal symptoms?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

Quality of Life

We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

14. Overall, how much do vaginal symptoms interfere with your everyday life?

Please ring a number between 0 (not at all) and 10 (a great deal)

(**0**) 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

Thank you very much for answering these questions.

ICIQ-VS 10/05

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Expectations from Treatment

Section 1: Please ring a number between 0 (strongly disagree) and 10 (strongly agree)

I expect to:

1. **Get rid of the bulge**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

2. **Be more comfortable and socially confident**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

3. **Get on with my housework**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

4. **Enjoy my job**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

5. **Feel much better in general (physically and emotionally)**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

6. **Enjoy sexual life in general**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

7. **Be able to exercise or do sport regularly**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

Section 2: (Please complete section 2 ***AFTER*** you receive treatment)

1. **My expectations have been met**
   0 1 2 3 4 5 6 7 8 (9) **10**
   Strongly disagree — strongly agree

2. **I am satisfied with the outcome of my treatment**
   0 1 2 3 4 5 6 7 8 9 (10)
   Strongly disagree — strongly agree

3. **I need no further treatment**
   0 1 2 3 4 5 6 7 8 (9) **10**
   Strongly disagree — strongly agree

VAGINAL SYMPTOMS QUESTIONNAIRE

SCORING

(This section is for administrative use only)

Patient number

Vaginal symptoms score

Vaginal symptom score – 2x (dragging pain) + 2x (soreness in vagina) + (reduced sensation) + 2x (vagina too loose) + 2x (lump felt inside) = 2x (lump seen outside) + 2x (vagina too dry) + (faecal evacuation)

symptom*	score	weighted score
Q1. 'dragging pain'		x 2 =
Q2. 'soreness in vagina'		x 2 =
Q3. 'reduced sensation'		x 1 =
Q4. 'vagina too loose'		x 2 =
Q5. 'lump felt inside'		x 2 =
Q6. 'lump seen outside'		x 2 =
Q7. 'vagina too dry'		x 2 =
Q8. 'faecal evacuation'		x 1 =
	Total vaginal symptoms score	

*(Note: Q9. 'vagina too tight', is primarily for detecting a potential post-treatment complication and is therefore not included in the scoring).

Sexual matters score

Sexual matters score = (sex-life spoilt) + 8x (worries about vagina interfere with sex-life) + 8x (relationship affected)

sexual matter	score	weighted score
Q11. 'worries about vagina interfere with sex-life'		x 8 =
Q12. 'relationship affected'		x 8 =
Q13. 'sex life spoilt'		x 1 =
	Total sexual matters score	

Quality of life score

Quality of life	score
Q14. 'quality of life affected'	

Initial Number

ICIQ-UI Short Form

CONFIDENTIAL

DAY MONTH YEAR
Today's date

Many people leak urine some of the time. We are trying to find out how many people leak urine, and how much this bothers them. We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

1. Please write in your date of birth: 30 10 57
DAY MONTH YEAR

2. Are you (tick one): Female ☑ Male ☐

3. How often do you leak urine? (Tick one box)

never	☑	0
about once a week or less often	☐	1
two or three times a week	☐	2
about once a day	☐	3
several times a day	☐	4
all the time	☐	5

4. We would like to know how much urine <u>you think</u> leaks.
How much urine do you <u>usually</u> leak (whether you wear protection or not)? (Tick one box)

none	☑	0
a small amount	☐	2
a moderate amount	☐	4
a large amount	☐	6

Overall, how much does leaking urine interfere with your everyday life?
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**
not at all — a great deal

6. When does urine leak? (Please tick all that apply to you)

never – urine does not leak	☑
leaks before you can get to the toilet	☐
leaks when you cough or sneeze	☐
leaks when you are asleep	☐
leaks when you are physically active/exercising	☐
leaks when you have finished urinating and are dressed	☐
leaks for no obvious reason	☐
leaks all the time	☐

(please continue overleaf)

Thank you very much for answering these questions.

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URGENCY SCALE

How urgent is your desire to go to the toilet (please circle one)

No Urgency	Mild Urgency (easily tolerated & can finish usual activities)	Moderate urgency (enough to shorten usual activities)	Severe Urgency (stops all activities)

Expectations from Treatment

Section 1: Please ring a number between 0 (strongly disagree) and 10 (strongly agree)

I expect to:

1. **Have less urinary leakage and use less pads/protection**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

2. **Be dry and stop using pads/protection**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

3. **Be more comfortable and socially confident**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

4. **Get on with my housework**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

5. **Enjoy my job**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

6. **Feel much better in general (physically and emotionally)**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

7. **Enjoy sexual life in general**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

8. **Be able to exercise or do sport regularly**
   0 1 2 3 4 5 6 7 8 9 **10**
   Strongly disagree — strongly agree

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Section 2: (Please complete section 2 ***AFTER*** you receive treatment)

1. My expectations have been met

0	1	2	3	4	5	6	7	8	9	10
Strongly disagree										strongly agree

2. I am satisfied with the outcome of my treatment

0	1	2	3	4	5	6	7	8	9	10
Strongly disagree										strongly agree

3. I need no further treatment

0	1	2	3	4	5	6	7	8	9	10
Strongly disagree										strongly agree

Thank you very much for answering these questions.

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NHS Ayrshire & Arran

Estimated Discharge Date:

Refer to Multidisciplinary discharge plan

Actual Discharge Date:

IN-PATIENT ADULT ADMISSION / DISCHARGE BOOKLET

Property handed over for safe keeping

PLACE STICKER HERE

CHI: 3010776241
Nam Welsh, Caroline
26 Lewis Terrace
KA11 1HJ
CHI 30/10/1977
Dr J Taylor
Date MRN: XHI466693

Guidance

This booklet is to be used for all adult in-patients within NHS Ayrshire & Arran with a predicted length of stay of longer than 24 hours. If any aspect of the patient profile and assessment is not completed at the point of admission, ongoing completion of this booklet is essential. All staff are responsible to ensure that documentation is fully completed.

Patients that have been assessed pre operatively will have a pre op assessment document and the supporting Elective In-patients booklet.

The booklet can be used by all members of the multidisciplinary team.

The booklet should be kept in an appropriate place to protect patient confidentiality.

The booklet is also to be used for handover between staff.

Other documents will be needed to supplement the use of this booklet; these may be kept at the patient bedside as needed for the patient.

Other documents to be used in conjunction with the booklet are:

- Care plans
- Fluid balance chart
- Modified Early Warning Score (MEWS) Observation chart (relevent to the patient)
- Peripheral Vascular Cannula monitoring chart
- Prescription recording chart
- High risk infusion chart
- Subcutaneous syringe driver chart
- Theatre care booklet (should be kept in the patients records, not to be kept at the bedside)
- Nutrition / food charts
- Wound assessment document
- Repositioning chart
- Continence assessment
- Stool chart

This booklet and all of the above documents are provided from Procurement and Registry and should not be photocopied.

Other specific ward based documentation may also be required. This is available through the charge nurse.

When the patient is discharged the booklet must be filed in the nursing section of the patient's records.

Record Keeping

Record keeping is an integral part of nursing and midwifery practice. It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow. Good record keeping is an integral part of nursing and midwifery practice. You need to assume that any entries you make in a patient or client record will be scrutinised at some point.

Record Keeping, NMC. July 2009

Consent to display limited information

Patient consents to display limited information about care (e.g. bedrails, diet, mobility) on a chart at the bedside. Verbal consent given Yes ☐ No ☐ Nurse signature.....

If the patient has declined to consent to information being displayed at the bed space please provide information here

.....

.....

.....

Informed Consent and Capacity

While undertaking the patient's clinical assessment, if you have any concerns regarding the patient's capacity and ability to make healthcare decisions, please refer to medical staff for assessment under the Adults With Incapacity (Scotland) Act 2000 and document your actions within the nursing notes. Refer to the Consent policy for further guidance.

Information about the patient can be obtained from relatives and carers including legal guardians (e.g. guardianship through the social work department)

Relatives and carers cannot make decisions for patients except in certain circumstances where they hold Welfare Guardianship or Power of Attorney extending to health care decisions under the Adults With Incapacity (Scotland) Act 2000.

Vulnerable Patients

A vulnerable patient is a person who is or may be in need of community care services by reason of mental or other disability, age or illness. A vulnerable patient is or may be unable to take care of him or herself, or is unable to protect him or herself from significant harm or serious exploitation.

(Who Decides - Lord Chancellors Department (1997)

A vulnerable patient may be a person who:

- Has a physical or sensory disability
- Is physically frail or has a chronic illness
- Has a mental illness or dementia
- Has a learning disability
- Is old and frail
- Is a substance misuser
- Has social or emotional problems

A person's vulnerability will depend on their circumstances and environment, and each case must be considered individually

Do you view this patient as being a vulnerable patient? **Yes ☐** **No ☐**

If Yes, implement the Vulnerable Patient Assessment Questionaire

To support your plan of care for this patient you may find it helpful to contact one of the services below:

Learning Disability Liaison Nurse Specialist:	01294 322171 (north)
	01292 614911 (south)
	01563 578574 (east)
Dementia Liaison Nurse	01563 541202
Mental Health Liaison Nurses (Elderly Services)	01563 541202
Psychiatric Liaison Nurse (general hospitals)	01563 826120
Advocacy Services	01294 608664 (north)
	01292 264396 (south)
	01563 574442 (east)
Hospital Social work team	Hospital site contacts through switchboard.

Clinical Team Signatures

All staff completing the documentation **must** complete this section

Name (BLOCK CAPS)	Designation	Ward/ Page No	Signature	Initials
JACKIE HOUSTON	S/N	6	J. Houston	JH

Clinical Team Signatures

All staff completing the documentation **must** complete this section

Name (BLOCK CAPS)	Designation	Ward/ Page No	Signature	Initials

PERSONAL DETAILS

Personal Details

GP (name & address) .....

.....

.....

.....

Patient's Age .....

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693

SPECIFIC ALERT	
Previous known – MRSA	Yes ☐ No ☐
or - Extended Spectrum Beta Lactamases (ESBL)	Yes ☐ No ☐
Other infectious condition?	Yes ☐ No ☐
specify.....	
Allergies (food, latex, other) .... None known ☑	

DRUG ALLERGY / SENSITIVITY YES/NO	
Drug name:	Symptoms experienced:
	NKA

Prefers to be addressed as:	Receiving Consultant:	Allocated Consultant:	Emergency ☐ Elective ☐

Admission Date 31/1/12 Time 18.30

From where: A+E

Accompanied by: HUSBAND -

Do you have a religion? Yes ☐ No ☑

Would you like to be visited by the hospital Chaplin? Yes ☐ No ☐

Reason for admission (including patient account)

Pelvic Pain
Bleeding, clots.

Provisional diagnosis

Ward/Dept (1) ..... (2) ..... (3) .....

Date of transfer...../...../.....

First Contact / Significant Other

Name: Brian Welsh.

Address: S/A.

.....

.....

Relationship to patient: HUSBAND.

Contact No(s): Home:
Mobile: 07580 068 018

Aware of Admission?: Yes ☑ No ☐
Contact Overnight?: Yes ☑ No ☐

Overnight Contact No:.....

Second Contact / Significant Other

Name:.....

Address:.....

.....

.....

Relationship to patient:

Contact No(s): Home:.....
Mobile:.....

Aware of Admission?: Yes ☐ No ☐
Contact Overnight?: Yes ☐ No ☐

Overnight Contact No:.....

PERSONAL DETAILS

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C Welsh, Caroline
S 26 Lewis Terrace
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D

Consent to share information: Yes / No

If yes with whom? other staff.

Any exceptions?

What information are the above aware of?

Who can messages be left with?

Observations on admission / General Appearance

Temp	Pulse	BP	Resps	O^2 Sats	Pallor	Conscious Level	Glucometer Reading	Last Menstrual Period (If Appropriate)	Pregnancy Test (If Appropriate)
37.3	102	113/70	15	99		Lucid			-ve 3/1/12.

Urinalysis: Protein ☑ Blood ☑ Glucose ☐ Other ☐

MSSU (mid stream sample of urine) collected? Yes ☑ No ☐ 3/1/12

Previous medical, surgical and mental health history (including operations, treatments and investigations with the corresponding dates)

Details	Date if applicable
previous gyn repairs	Nov '09'
Laparoscopy	
Appendicectomy.	

PERSONAL DETAILS

Record of specimens, procedures, surgery & investigations since admission	Initials	Date	Patient aware of results?	Initials	Date

Medication used at home (including herbal / over the counter)

For patient's current medication please refer to the Multi-disciplinary Medicines Reconciliation Form if available. If not present complete below:

Drug	Dose	Frequency	Route
Tranexamic Acid			
Norethisterone			
Omeprazole			
naproxen			

PERSONAL DETAILS

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693

Home Circumstances

Contact the hospital Social Work Dept to obtain Single Shared Assessment (SSA1) if appropriate.
Requested ☐ No SSA1 available ☐ Name of Social Worker/Contact .....

Do you have a carer? Yes ☐ No ☑

Do you live:-

Alone ☐
With elderly / infirm partner ☐
With healthy partner / family ☑
Does carer require additional support ☐
(Consider referral to social work) ☐

Are you a carer Yes ☐ No ☐

Who for:

Children ☑
Elderly relative ☐
Other ☐

Please specify: 13, 9, 8.

Who is caring for them currently? Please detail .....

Family ☐ Social Worker ☐
Nursing Home ☐ Neighbour ☐
Respite Centre ☐

Describe Family Living Arrangements:

mid Terrace.

Type of House (circle):

Steps at entrance ☑ How many? 1
Stairs inside ☑ How many? 12
Toilet: Upstairs ☑ Downstairs ☐
Bedroom: Upstairs ☑ Downstairs ☐

Community Services in Use		Frequency	Informed of Admission	Informed By/Comments
Home Care	Yes ☐ No ☐		Yes ☐ No ☐	
Meals on Wheels	Yes ☐ No ☐		Yes ☐ No ☐	
Sheltered Housing	Yes ☐ No ☐		Yes ☐ No ☐	
Day Hospital	Yes ☐ No ☐		Yes ☐ No ☐	
Community Nurse	Yes ☐ No ☐		Yes ☐ No ☐	
Visited by Specialist Nurse Yes ☐ No ☐ Specify.....			Yes ☐ No ☐	
SPARRA	Yes ☐ No ☐		Yes ☐ No ☐	

If Yes, contact Case Manager Name..... Contact Number.....

Discharge

Will personal transport be available for discharge: Yes ☐ No ☐ Patient has keys: Yes ☐ No ☐
Predicted discharge: Complex ☐ Straight forward ☐
Discharge co-ordinator informed Yes ☐ No ☐

Initials of Nurse..... Date..... 3/1/12

PERSONAL DETAILS

Admission Checklist

	Yes	No	N/A
ID band in situ	✓		

Verbal ward Information given to patient and/or relatives:	Yes	No	N/A
Call buzzer	✓		
Toilets / Bathroom	✓		
Mealtimes	✓		
Visiting times/policy	✓		
Infection control / hand hygiene	✓		
Fire alarm procedure	✓		
Valuables	✓		
Smoking			✓
Other.....	✓		

Patient information leaflets given as applicable:	Yes	No	N/A
Ward information			
Nutritional Care			
Tissue Viability			
Continence			
Falls / Bedrails			

Other (specify) Date given

_____ _____ ☐

_____ _____ ☐

_____ _____ ☐

Patient's Property

You are advised to restrict to a minimum amount of property, including cash and other valuables, brought into hospital and to hand to the nurse in charge of your admission, as soon as possible, any articles you wish to be kept in safe custody for which a receipt will be given to you. You are responsible for property belonging to you not handed over for safe custody.

Anything handed over for safe keeping will not be kept indefinately in the ward safe but will be sent to the cashier's office. This includes cash, spectacles, hearing aids, dentures and other personal items and valuables.

Signature of Patient / Significant Other X. C Walker Date.....

Property Handed Over For Safe Keeping: Yes ☐ No ☐ Sticker on front page ☐

Date Taken to Cashier:..... Cash & Valuables Ref No:..... Date Returned:.....

Initials of Nurse..... Date..... 31/1/12

Lifestyle Assessment

CHI: 3010776241
Welsh, Caroline
26 Lewis Terrace
KA11 1HJ
30/10/1977
Dr J Taylor
MRN: XHI466693

Communicating	Yes	No	Problems / needs
Are there any specific communication needs? e.g. Impaired speech, impaired hearing, registered blind, language barrier, dyslexia, learning difficulty. (Complete learning disability assessment if appropriate)	☐	☑	
Interpreter required	☐	☑	
Wears glasses / contact lens	☐	☑	
Hearing aid R / L / Bi lateral (if private aid or glasses, refer to patient property notice)	☐	☑	

Breathing	Yes	No	Problems / needs
Normal rate/rhythm	☑	☐	
Cough	☐	☑	
Breathlessness	☐	☑	
Equipment used e.g. inhalers etc	☐	☑	
Home oxygen/nebulisers used	☐	☑	
Airway e.g. tracheostomy	☐	☑	
Smoker	☐	☑	

Please ensure smoking algorithm is completed for smokers and patients trying to stop.

Controlling body temperature	Yes	No	Problems / needs
Apyrexial on admission	☑	☐	
Do they feel the cold	☐	☑	
Night sweats	☐	☑	

Eating & drinking	Yes	No	Problems / needs
Any known food allergies	☐	☑	
Recent appetite normal	☑	☐	
Swallowing ability impaired	☐	☑	(if YES consider referral to SALT)
Nausea/vomiting	☐	☑	
Special dietary needs, e.g. therapeutic diet, ethnic, cultural & religious considerations, nutritional supplements	☐	☑	
Feeding aids/assistance required	☐	☑	
Nutritional Care in Hospital leaflet given	☐	☑	(All patients must be given this leaflet)
Does patient have any food preferences? (likes/dislikes)	☐	☐	

Specify: Eating..... Drinking.....

Does the patient consent to following a therapeutic diet ☐ ☐ Nurses Initials.....

Alcohol intake (>50units consider referral to Alcohol liaison team): Referral made Yes ☐ No ☐ Date.....

Date / time last alcohol drink taken and amount :.....

Mobilising	Yes	No	Problems / needs
Independent walking ability	☑	☐	.....
Aids needed	☐	☑	.....
Falls history	☐	☑	.....
Bed rest restrictions	☐	☑	.....
Podiatry problems	☐	☑	.....
Limiting factors e.g. pain	☐	☑	.....

Eliminating	Yes	No	Problems / needs
Normal Bowel activity	☑	☐	.....
Normal Bladder activity	☑	☐	.....

Please ensure continence assessment is completed if required.

Personal cleansing & dressing	Yes	No	Problems / needs
Independent	☑	☐	.....
Requires assistance e.g. showering, hair washing,oral care	☐	☑	.....
Use of dressing aids	☐	☑	.....

Specify:.....

.....

Please complete oral assessment tool if required.

Condition of skin - assess any wounds / lesions / stomas			.....
Religious or cultural requirements that impact on patients' personal care	☐	☐	.....
Is an OT referral needed?	☐	☐	.....

Working & recreation	Yes	No	Problems / needs
Currently in occupation	☑	☐	carer
Hobbies	☐	☐	.....
Impact of illness on work or recreation?	☑	☐	.....

Sleeping	Yes	No	Problems / needs
Usual pattern	☑	☐	.....
Sedation used	☐	☑	.....
What helps			.....

Personal awareness	Yes	No	Problems / needs
Possible altered body image	☐	☐	.....
Privacy/modesty issues	☐	☐	.....
Impact of illness on family / partner - attitude / support issues	☐	☐	.....
Worries regarding emotional problems/ dying	☐	☐	.....

Write or attach label

HC CHI: 3010776241
CH Welsh, Caroline
Sur 26 Lewis Terrace
For KA11 1HJ
Ad 30/10/1977
.... Dr J Taylor
Dat MRN: XHI466693

State of mind	Yes	No	Problems / needs
Orientated to time and place	☑	☐	.....
Signs of anxiety / confusion: Confused ☐ Mildly anxious ☐ Highly anxious/distressed ☐			
Any current or previous psychological or psychiatric history? (e.g. depression, self harm)	☐	☑	.....
Undergoing any current treatment/therapy If yes, name of Consultant/CPN.....	☐	☑	.....
History of dementia	☐	☑	.....
Memory problems	☐	☑	.....
Any phobias	☐	☑	.....

If this patient has a known cancer, please consider using the Distress Thermometer. For information contact Psychosocial Oncology on (01294) 323552

Spiritual or religious needs	Yes	No	needs
Does the patient wish to state their religion?	☐	☑	
Specify:			.....
Any specific religious needs/practices that place limitations on the patient's care? (refer to religions and cultures manual)	☐	☐	....

Initials of Nurse..... JH ..... Date..... 3/1/12 .....

Assessment of this patient may highlight the need for referral to other disciplines. Discuss with the patient and obtain the patient's verbal consent. This should be recorded on the multidisciplinary discharge pages.

Subsequent Lifestyle Assessment

Please re-assess following 2nd and 4th week of in-patient stay.

CHANGES DUE TO PRESENT CONDITION		
	Re-assessment 1 Date of assessment: Time of assessment:	Re-assessment 2 Date of assessment: Time of assessment:
Communicating		
Breathing		
Controlling Body Temperature		
Eating and Drinking		
Mobilising		
Eliminating		
Personal cleansing / dressing		
Working and recreation		
Sleeping		
Personal awareness		
State of mind		
Spiritual or religious needs		

1st Re-assessment Initials ..... Date .....

2nd Re-assessment Initials ..... Date .....

Patient Screening & Risk Assessment

CHI: 3010776241
H Welsh, Caroline
C 26 Lewis Terrace
Si KA11 1HJ
F 30/10/1977
A Dr J Taylor
MRN: XHI466693
Date of Birth .....

After completing the patient's lifestyle assessment decide which risk assessments your patient needs.

Tick the box to confirm assessment tool activated.

YES	N/A		
☑	☐	**Pressure Area Care – Waterlow**	**mandatory**
☐	☑	**Falls**	**over 65 / history of falls**
☑	☐	**Bedrails**	**mandatory**
☑	☐	**Moving and Handling**	**mandatory**
☑	☐	**MUST**	**mandatory**
☑	☐	**MRSA**	**mandatory**
☐	☐	**Oral Care**	
☐	☐	**Continence**	
☐	☑	**Smoking**	

All appropriate assessments **must** be undertaken for every patient.

You may use your professional judgement to decide which assessment tools are most relevant to your patient. It is not necessary to complete all risk assessments for every patient.

In exceptional circumstances your professional judgement may decide that this patient is exempt from a particular mandatory assessment. You must clearly document the reason for this decision.

Initials of Nurse ..... JH ..... Date: 3/1/12

NHS Ayrshire & Arran

Adapted Waterlow Pressure Area
- Risk Assessment Chart

More than one score/category can be used:

10+= 'At Risk': 15+= 'High Risk': 20+ ='Very High Risk'

Complete assessment on admission/1st visit. If there is a change in individual's condition and repeat regularly accoring to local protocol.

		Date	31/1/12								
		Time	18.40								
Sex											
Male	1		2								
Female	2										
Age											
14 – 49	1										
50 – 64	2										
65 – 74	3		1								
75 – 80	4										
81+	5										
Build/Weight for Height *(BMI=weight in Kg/height in m²)*											
Average – BMI 20-24.9	0										
Above average – BMI 25-29.9	1										
Obese – BMI > 30	2										
Below average – BMI < 20	3										
Continence											
Complete/catheterised	0										
Incontinent urine	1										
Incontinent faeces	2										
Doubly incontinent (urine & faeces)	3										
Skin Type – Visual Risks Area											
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										
Chairbound (unable to leave chair without assistance)	5										
Nutritional Element											
Unplanned weight loss in past 3-6 months < 5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2										
BMI >20 Score **0**, BMI 18.5-20 Score **1**, BMI <18.5 Score **2**	0-2										
Patient acutely ill or no nutritional intake > 5 days	2										
Special Risks – Tissue Malnutrition											
Multiple organ failure/terminal cachexia	8										
Single organ failure e.g. cardiac, renal, respiratory	5										
Peripheral vascular disease	5										
Anaemia = Hb < 8	2										
Smoking	1										
Special Risks – Neurological Deficit											
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6										
Special Risks – Surgery/Trauma											
On table > 6 hours	8										
Orthopaedic/ below waist/spinal (up to 48 hours post op)	5										
On table > 2 hours (up to 48 hours post op)	5										
Special Risks – Medication											
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max4*	4										
		Total Score									
		Initials									

Ensure plan of care is implemented / reviewed for all identified areas of concern.

NHS Ayrshire & Arran

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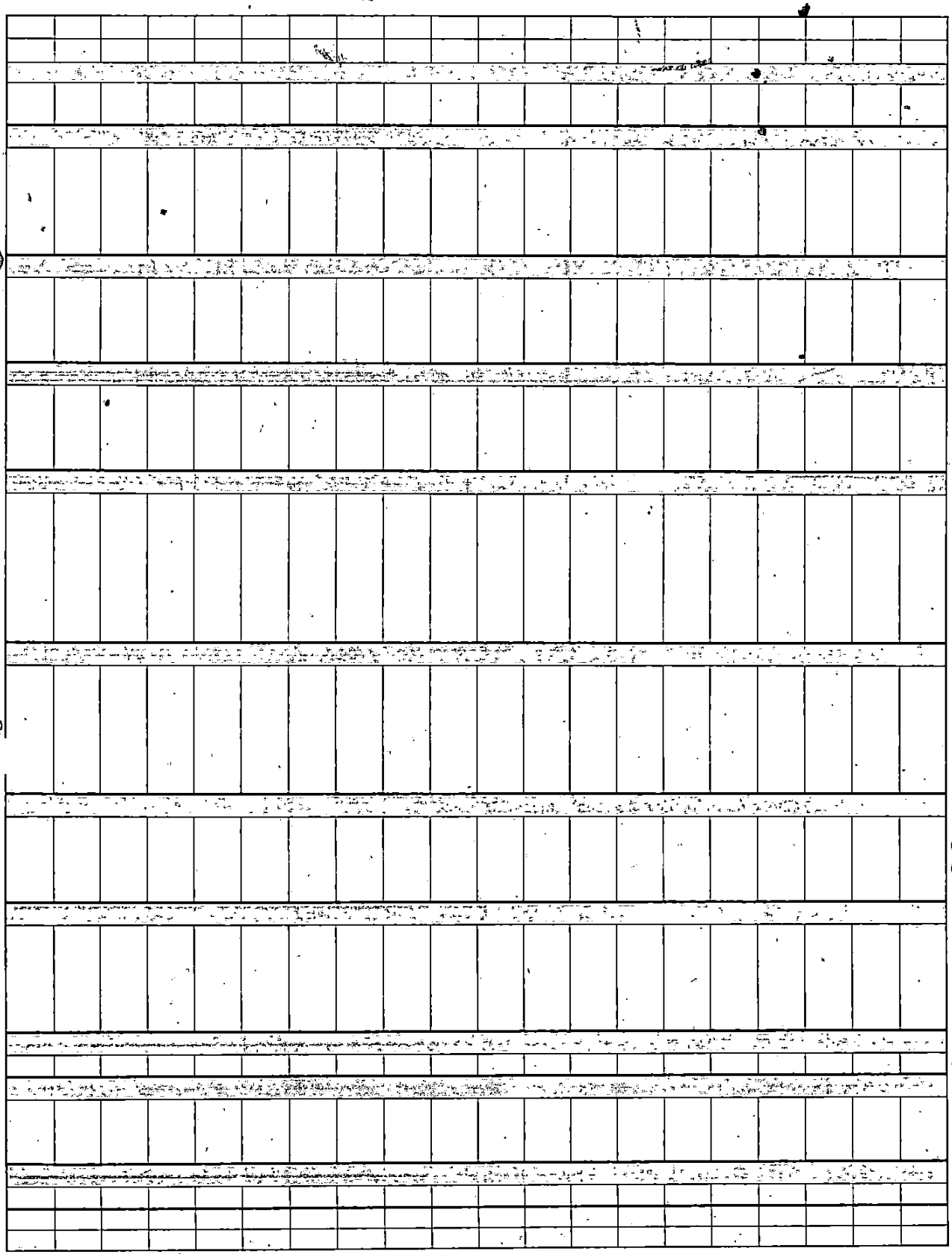
A 30/10/1977
. Dr J Taylor
D MRN: XHI466693

Adapted Waterlow Pressure Area
- Risk Assessment Chart

More than one score/category can be used:

10+= 'At Risk': 15+= 'High Risk': 20+ ='Very High Risk'

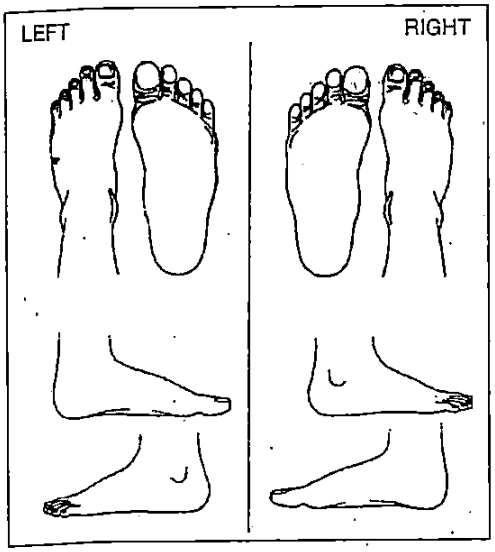


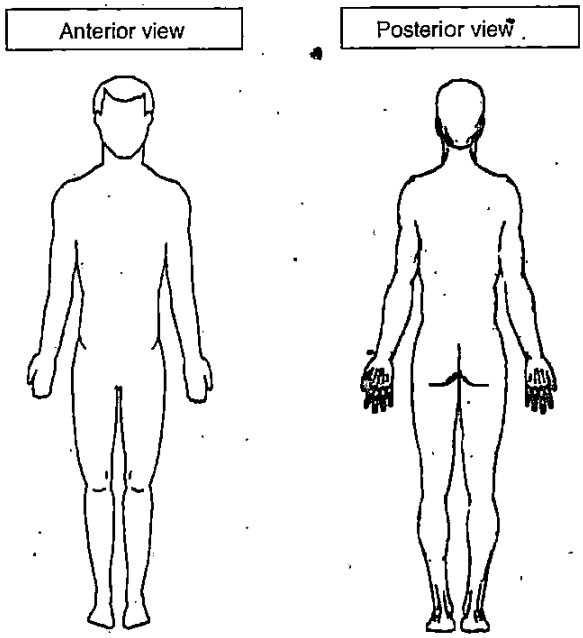
SCORE	
<10 Low Risk	Re-assess weekly or if condition changes
10+ At Risk	Re-assess twice weekly or if condition changes
15+ High Risk	Re-assess on alternate days
20+ Very High Risk	Assess daily

Within long term care, e.g. care of the elderly, if the Waterlow score remains unchanged for a period of 2 weeks as per score guidance and the probability of change is small, the Waterlow assessment can be carried out a minimum of once a month providing there is no change (good or bad) in the patients condition.

Pressure Ulcer Record

Indicate by curling, numbering and dating all pressure damage on diagrams, then complete the box below. Initiate care plan / wound assessment chart.





Scottish Adapted EPUAP(European Pressure Ulcer Advisory Panel)

Pressure Ulcer Grading Tool

GRADE 1 Non-blanchable erythema (redness) of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.

GRADE 2 Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.

GRADE 3 Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia.

GRADE 4 Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

Date	No of Ulcer(s)	Location of Ulcer(s)	Grade of Ulcer(s)	Electronic Report	Datix Insert Ref	Signature	Print Name

Pressure ulcers may deteriorate from Grade 1 or Grade 4, but can not be reversed and should be documented as a healing grade of pressure ulcer, e.g. healing grade 4.

NHS Ayrshire & Arran

Pressure Prevention Care Plan

Patient Problem / Need					
Patient has a Waterlow score of.....and is at risk of developing pressure ulcers					
Patient has a pressure ulcer(s) grade.....					
Goal					
Patient's skin will remain intact					
To promote healing of ulcer and prevent infection					
Date	**Time**	**Init's**	**Planned Nursing Intervention**		
			Calculate and record the Waterlow score on admission and recalculate as the patient's condition changes and on a regular basis		
			Inspect the patient's skin especially over bony prominences on admission and at regular intervals and document findings • Skin condition on admission.....		
			Select pressure reducing equipment according to patient need • ..... • ..... • ..... •		
			When in bed encourage and facilitate position changes using 30 degree tilt (indicate frequency below) •		
			The patient should not sit out of bed for longer than 2 hours without being repositioned (for acutely ill patients return to bed for a minimum of 1 hour)		
			Use sliding sheets to prevent shear and friction during movement in bed (Sliding sheets should not be left under the patient)		
			Initiate a skin inspection and repositioning chart according to identified risk		
			When the patient is incontinent refer to the skin care guideline Encourage a healthy, well balanced diet and adequate fluid intake		
			If the patient has a grade 2 or above pressure ulcer a wound assessment chart is required		
			This care plan has been discussed and agreed with the patient as appropriate.		

Slips, Trips and Falls Assessment Tool

Date of admission:.....

Please assess ALL patients with a history of falls or over 65 years.

- Each category must be filled in
- If the patient does not meet any of the criteria N/A to be entered in box
- You can have more than one score for some categories

Write or attach label

HCR No:.....
CHI No: .....
Surname:.....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

N/A.

	Ward Name: Assessment Date and Time of Day			Date: Time:	Date: Time:	Date: Time:	Date: Time:
ITEM	**SCORE**			**SCORE**	**SCORE**	**SCORE**	**SCORE**
GENDER	1 = Male 2 = Female						
AGE	1 = 16-70 years 2 = 71-80 years 3 = 81+ years						
GAIT/MANNER OF WALKING (with usual aid)	1 = Hesitant 3 = Unsteady / Falls back / Unable to walk						
COGNITION	3 = Any degree of disorientation						
SENSORY	1 = Poor hearing 1 = Poor sight 2 = Poor balance 2 = Uncoordinated limb movement or loss of sensation in lower limbs						
FALL HISTORY	1 = Fall(s) in street 1 = Fall(s) in the ward 2 = Fall(s) at home						
MEDICATIONS(see over for examples)	1 = Sedation/analgesics 1 = Tranquillisers 1 = Cardiovascular drugs 1 = Bladder medication						
MEDICAL HISTORY (see over for examples)	1 = Altered endocrine/electrolyte balance 1 = Neurological Disorders 1 = Other (i.e. arrhythmia's, blackouts etc.) 1 = Incontinent of urine and/or faeces						
ACTIVITY AND MOBILITY	1 = Independently mobile with or without usual aid 2 = Needs assistance and/or supervision with transfers or mobility 2 = Needs the assistance of 1-2 people to transfer to toilet/commode 3 = Bed/chair bound but moves/rolls unsafely						
	TOTAL						
Level of Risk	**LOW (L) = 6-8**	**MEDIUM (M)= 9-12**	[redacted]				
Initials							

Slips, Trips and Falls Assessment Tool

Write or attach label

HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

What Happens Once You Have A Score?

- If the patient has **scored >6** the appropriate actions should be implemented using the Slips, Trips and Falls care plan.
- For low risk patients follow actions in the green section only of the action list.
- For medium risk patients follow actions in the green and yellow sections of the action list.
- For high risk patients follow actions in the green, yellow and red sections of the action list.

Re Assessment Occurs:

- Weekly
- When the patient's condition changes (i.e. patient falls/post surgery/change in medication/cognitive state changes.)

If the patient has a slip, trip or fall whilst an in-patient, Datix should be completed and it should also be recorded here.

Date	Time of day	Location	Injuries?	Circumstances	Datix number

Medication examples:

SEDATION / ANALGESICS	TRANQUILLISERS / ANTIDEPRESSANTS	CARDIOVASCULAR DRUGS (those that reduce BP)	BLADDER MEDICATION
• Nitrazepam • Temazepam • Tramadol • Co-codamol	• Risperidone • Haloperidol • Amitryptyline • Alcohol	• Atenolol • Isosorbide Mononitrate • Digoxin • GTN • Diltiazem • Diuretics • Ace-inhibitors	• Doxazosin • Oxybutynin • Tamsulosin (Flomax)

Medical History examples:

Examples of **Altered endocrine / electrolyte balance**	Examples of **Neurological Disorders**	Examples of **"Other"**
• Diabetes • Hyponatraemia • Low calcium • Low potassium	• Parkinson's Disease • Stroke • Head Injury	• Arrhythmia's • Osteoporosis • Postural hypo / hypertension • Peripheral Neuropathy • Intermittent heart block • Epilepsy

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N/A

Slips Trips & Falls - Care Plan

(To be used in conjunction with the slips, trips and falls assessment tool)

Date of Birth.....

Problem Number: **Patient Problem/Need**

Patient is considered to be at risk of falling

Goal

To promote and maintain patient safety and reduce the risk of falls

Date	Time	Intls	Planned Nursing Interventions	Intls	Discontinued Date/Time	
			Orientate patient and family/carers to ward environment on admission and each shift			
			Ensure call bell within reach			
			Explain importance about calling for help when needed			
			Ensure patient is aware of their own safety needs			
			Ensure that bedside table and key belongings are within easy reach			
			Ensure patient wears appropriate and well fitting footwear at all times			
			Request family/carers to bring in appropriate and well fitting footwear			
			Ensure patient wears appropriate clothing			
			Ensure that patient is wearing hearing aid if appropriate			
			Ensure that patient is wearing spectacles if appropriate			
			Advise family/carers how to orientate patient			
			Advise family/carers how to assist with interventions			
			Ensure that patient/family receives an explanation of risk and the measures in place to minimise this risk and document outcome			
			Ensure that bed area and pathways to all facilities are free of clutter at all times			
			Ensure that standard bed frame is used and left in a low position with brakes on			
			Select a chair that is the appropriate height and design for the patient (seek guidance from Physio and OT)			
			When in use ensure that chair/commode brakes are secure			

				Ensure that area is illuminated appropriately at night time		
				Liaise with medical team re: medication review		
				Consider referral to Physiotherapy, Occupational Therapy, Social Work		
				Monitor lying and standing blood pressure		
				Supervise patient when transferring as per moving and handling risk assessment		
				Supervise patient when mobilising as per moving and handling risk assessment		
				Offer toileting facilities as appropriate		
				Ensure that patient is cared for in an area proximal to toilet facilities, if possible		
				Encourage family, if present, to sit with patient (as appropriate)		
				Encourage family/carers to report to nursing station when ending their visit		
				Consider appropriate equipment in liaison with Physio and/or OT		
				Ensure yellow sticker is inserted into patient's notes after each fall		
				Patients who may be confused or have had repeated falls where possible should be cared for in an area within the ward that is within easy view of nursing staff		
				Check on patient every 15 minutes		
				Consider one to one supervision of the patient		
				Consider the use of a low level variable height bed		
				Discuss with medical staff re hip protector		
				Consider alternative supervision i.e. have patient sitting at nursing station		
				Above care plan has been discussed and agreed with the patient and/or family/carer.		

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Bed Rails Risk Assessment

Date of admission: 3/1/12

Please assess **ALL** patients on admission to your ward / departments

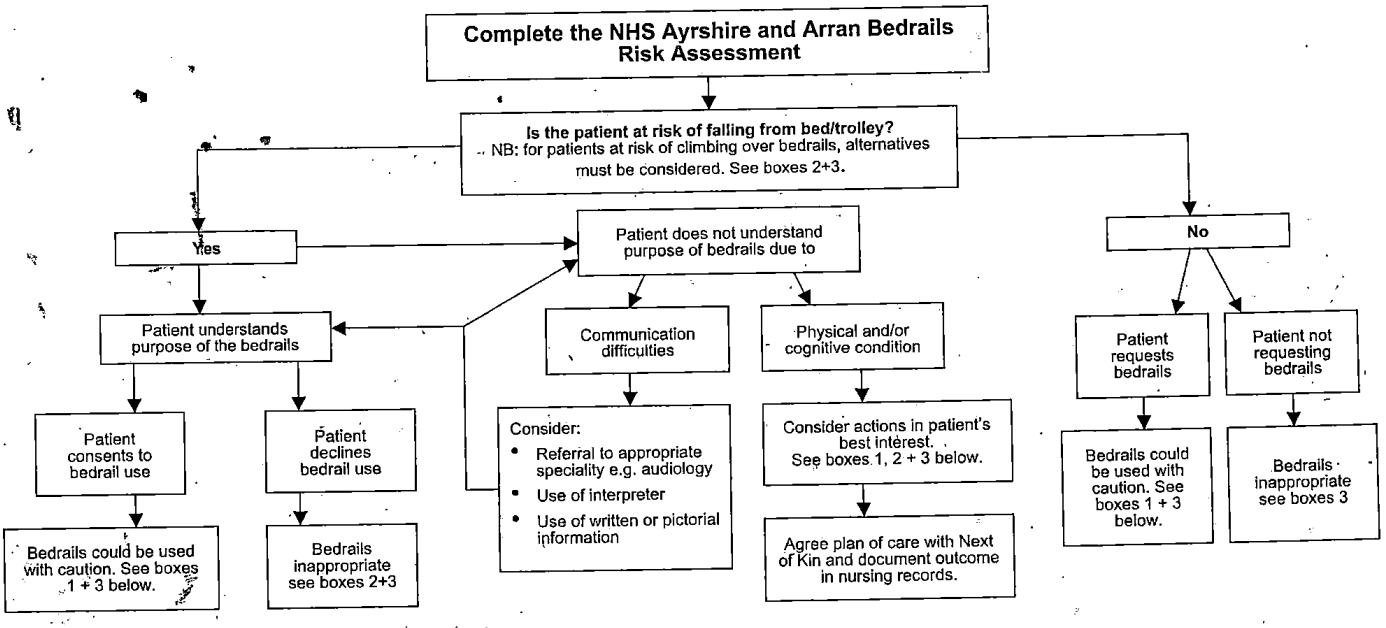
- Each statement must be answered – Circle answer
- Complete Risk Assessment in conjunction with Bedrails Algorithm overleaf
- Refer to Guidelines – Safe Use of Bedrails in In-patient Settings

Re Assessment Occurs:

- Weekly
- When the patient's condition changes (i.e. patient falls/post surgery / change in medication / cognitive state changes.)
- **Ensure clear identification of change in use of bedrails**

Risk Factors	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:
1. Is the patient at risk of falling from bed?	YES / (NO)	YES / NO	YES / NO	YES / NO
2. Is the patient at risk of intentionally climbing over bedrails?	YES / (NO)	YES / NO	YES / NO	YES / NO
3. Is the patient at risk of unintentionally falling from the bed / trolley?	YES / (NO)	YES / NO	YES / NO	YES / NO
4. Does the patient understand the purpose of the bedrails? Consider communication difficulties and physical / cognitive condition.	(YES) / NO	YES / NO	YES / NO	YES / NO
5. Does the patient consent to the use of bedrails?	(YES) / NO	YES / NO	YES / NO	YES / NO
Has the Bedrails Algorithm been followed	YES ☑ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
According to the Bedrails Algorithm are bedrails required / appropriate?	YES ☑ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
If 'Yes', complete a bedrails care plan. **If 'No', state reason why bedrails are not required:** _____				
INITIALS	JH			

BEDRAILS ALGORITHM



1. If bedrails are used consider:

- Risk of entrapment and harm to limbs
- Risk of patient climbing over the top
- The psychological effect of their use on the patient
- Use of a dynamic pressure relief mattress increases the height of the bed

2. Alternatives to bedrails

- A5 Use of variable height bed
- Additional mattress/crash mat beside bed
- Close observation of patient
- Ensure bed returned to lowest height after care delivery
- Ensuring patient needs anticipated e.g. drinks are accessible, regular toileting, call bell to hand etc
- Nursing patient on mattress on the floor should be a last resort and safety checks should be made for hot pipes, electric sockets etc. Moving & handling risk assessment for staff must be undertaken.

3. Remember to document in nursing records:

- Date and time assessment made
- Rationale for decision made in care plan
- Actions taken, including discussion with Next of Kin
- Care planning

Assessment should be made:

- On admission
- If patient's condition changes
- Weekly

Write or attach label

HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

Safe use of bed rails - Care Plan

Patient Problem/Need
The patient is at risk of falling out of bed due to ..... (e.g. cognitive or physical condition)

Goal
To promote and maintain patient safety and reduce the risk of falling out of bed

Date	Time	Init's	Planned Nursing Interventions	Discontinued Date/Time	Init's
			Ensure assessment is made on admission, when patient's condition changes, and weekly as a minimum.		
			Ensure rationale for decision made re; the use of bedrails is clearly documented.		
			Consider psychological effects of bedrail usage on patient and where appropriate ensure the patient's consent to their use		
			Ensure risk of entrapment is minimised by careful positioning of patient prior to operating bedrails.		
			If detachable bed rails used, ensure the gap between the top end bedrail and head of bed is less than 6cm and more than 25cm		
			If detachable bed rails used, ensure the gap between the bottom end of bedrail and foot of bed is more than 25cm		
			Continually monitor risk of patient climbing over the top of bed rails and assess the use of bed rails as necessary Discuss with the patient, the need to share information with other nurses and health care workers re; the use of bedrails, and document within the nursing documentation whether the patient consents to display information at the bed space.		
			Ensure the 'bedrails chart' at the bed space is clearly marked to guide the use of bedrails and is updated following re-assessment		
			Provide Falls/Use of Bedrails information leaflet to patient. Where the patient is incapacitated, ensure that relative/carer is given a leaflet and information about the assessment for bedrails is provided.		
			Ensure all actions, including discussions with relative/carer are documented.		
			Refer to the Safe Use of Bed Rails in Adult In-Patient Settings Guideline for further guidance on the management of bedrails		
			Re-assess the need for bedrail use at least weekly or as the patient's condition indicates and document on the risk assessment chart		
			This care plan has been discussed and agreed with the patient as appropriate.		

Moving & Handling Patient Risk Assessment

All Patients:

A hoist is for lifting patients and must not be used for transporting between rooms.
A mechanical aid **must** be used for bathing unless independently mobile.
A mechanical aid **must** be used if assistance is required from the floor.
Sliding aids should be used bed to trolley/bed (specify number of handlers)

Special Alerts: Date:					
Overweight / Obese (BMI definition)					
Restricted use of limbs					
Poor standing ability					
Sedation of lethargy					
Irrational behaviour / confusion					
Unable to co-operate					
Acute pain					
Recent surgery					

Additional Comments:

Sling specification	Type	Size

Assessment of Risk:

Low Risk: Independently mobile / supervision only required. Aids required should be specified in care plan.

Moderate Risk: Requires physical assistance from one or more handlers. Is able to stand or partially bear weight and has no more than one special alert.

High Risk: a) Is unable to bear weight and requires assistance.
b) 2 or more special alerts present and requires assistance.

Aids, equipment and a minimum of 2 handlers recommended to move a patient.

Specify Level of Risk

Date:						
Low risk						
Moderate risk						
High risk						
Assessors Initials						

If the patient is independently mobile and self caring, there is no requirement to complete the following pages.

Moving & Handling Patient Risk Assessment

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Date:	3/1/12					
1. Moving in bed:						
a) Handlers require to assist rolling in bed. *Specify number in grid.*	a) 1					
b) Handlers required to insert and pull sliding sheets. *Specify number in grid.*	b)					
c) Can sit with assistance from 1 or 2 handlers (rotation). *Specify number in grid.*	c)					
d) Equipment required.	d)					
2. Sitting to Standing:						
a) 1 handler assists from the side with oblique hold on the patient's back.	a)					
b) 2 handlers assist from the side with oblique hold on the patient's back.	b)					
c) 1 handler assists from the side and 1 from the front.	c)					
d) Aids required:	d) INDEPENDENT					
3. Mobilising:						
a) Does not mobilise.	a)					
b) Mobilises independently.	b)					
c) Support required from side by 1 handler.	c)					
d) Support from side by 2 handlers.	d)					
e) Requires to be followed by staff member and wheelchair when mobilising.	e)					
f) Aids required:	f)					
4. Transfers: (chair / wheelchair / commode/ toilet / bed)						
a) Walking transfer with assistance of 1 handler.	a) INDEPENDENT					
b) Walking transfer with assistance of 2 handlers.	b)					
c) On bed rest.	c)					
d) Assistance of 1 handler and equipment.	d)					
e) Assistance of 2 handlers and equipment. *Specify number in grid.*	e)					
5. Adjusting Clothing / Personal Hygiene:						
a) Can use support / grabrails while assistance is given with clothing.	a)					
b) Requires support from 1 handlers while another assists with clothing.	b)					
c) Requires 2 handlers and equipment.	c)					
6. Repositioning in chair / wheelchair:						
a) Tilt and slide.	a)					
b) One way sliding sheet. *Specify number in grid*	b)					
c) Specify equipment *Specify number in grid*	c)					
Assessors initials	JH					

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Nutritional Screening 'Malnutrition Universal Screening Tool' ('MUST')

To be completed within **24 hours** of admission

Step 1: Measure height and weight to get a BMI score.
Step 2: Note percentage unplanned weight loss and score.
Step 3: Establish acute disease effect and score.
Step 4: Add scores from steps 1, 2 and 3 together to obtain risk of malnutrition.
Step 5: Follow the management guidance appropriate to the risk category and commence the corresponding care plan.

Screening Results

Please indicate if measurements are Measured (M), Reported (R), or Estimated (E)

Date / Time	3/1/12				
Ward	6				
Height M( ) R( ) E( )	5'7" m				
Current weight (Kg)	Kg ( )	Kg ( )	Kg ( )	Kg ( )	Kg ( )
BMI					
Is patient within obese category?	Y/N	Y/N	Y/N	Y/N	Y/N
Usual weight (Kg)	Kg				
Signature					
MUST					
Step 1: BMI Score > 20 (> 30 = Obese).....0 18.5 - 20.....1 < 18.5.....2					
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: < 5%.....0 5-10%.....1 > 10%.....3					
Step 3: Acute Disease Effect Score If patient is acutely ill and there has been or is likely to be no nutritional intake for > 5 days.....2 Not applicable.....0					
Step 4: Overall Risk of Malnutrition Total:					
Step 5:		1 = Medium Risk			

Referrals	Date Referred	Signature
Dietitian		
Speech & Language Therapy		
Occupational Therapy		
Nutritional Support Team		
Dental Service		

MUST Screening

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D:

STEP 1
BMI Score

BMI kg / m2	Score
> 20 (>30) obese	= 0
18.5 - 20	= 1
< 18.5	= 2

STEP 2
Weight Loss Score

Unplanned weight loss in past 3-6 months	Score
< 5	= 0
5 - 10	= 1
> 10	= 2

STEP 3
Acute Disease Effect Score

If patient is acutely ill AND there has been or is likely to be no nutritional intake for > 5 days
Score 2

STEP 4
Overall Risk of Malnutrition

Add scores together to calculate overall Risk of Malnutrition

Score 0	Score 1	Score 2 or more
[redacted]	*Medium Risk*	[redacted]

STEP 5
Nutritional Management Guidelines

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Nutritional Management Guidelines

	MUST Score 1	[redacted]
Low risk - *Routine Clinical Care* • Commence and implement the **Low Risk Care Plan** • Monitor and review care plan • **Repeat screening** **Acute** .....**Weekly** **Continuing Care**.....**Monthly**	**Medium risk** - *Observe* • Commence and implement the **Medium Risk Care Plan** • Document dietry intake for 3 days on a Food Record Chart • Encourage oral intake • Assist patient to choose appropiate meals / snacks and offer full cream milk or suitable alternative to drink with and between meals. • Monitor and review care plan • Repeat screening weekly	**Hight risk** - *Treat* • Commence and implement the **High Risk Care Plan** • Refer to dietitian. Include MUST score • Continue food chart • Offer maximum encouragement • Monitor and review care plan • Repeat screening weekly unless detrimental or no benefit is expected from nutritional support e.g. immenent death. Use own judgement and document rationale for not treating.

- For low risk patients implement interventions in the [redacted] section of the care plan, as appropriate.
- For medium risk patients implement interventions in the [redacted] and YELLOW sections of the care plan.
- For high risk patients implement interventions in the [redacted] YELLOW and [redacted] sections of the care plan.

- **Always use your own professional judgement when screening patients and making referrals.**
- **Consider patients who require an immediate referral.**
- **Consider initial admission information relating to eating and drinking needs and preferences.**
- **When completing Step 2 always subtract the most recent weight with the usual weight.**

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Malnutrition Universal Screening Tool (MUST) Multidisciplinary Care Plan

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ASSESSMENT FORMS

Patient Problem/Need
Nutritional screening has identified patient as being at Low ■ Medium ■ High ■ risk of malnutrition

Goal
To meet patients nutritional and fluid requirements. To prevent weight loss and promote weight gain, as appropriate.
For Low Risk patients consider interventions in the **green** section of the care plan as appropriate.
For Medium Risk patients follow interventions in the **green and** yellow sections of the care plan.
For High Risk patients follow interventions in the **green,** yellow **and red** sections of the care plan.
Allied Health Professionals: consider interventions appropriate for speciality on the reverse of the form.

Date	Time	Int/s		Planned Nursing Interventions	Discontinued Date/Time	Int/s
			■	**Low Risk Care Plan**		
			■	Monitor and review care plan and **repeat screening weekly** or monthly if in continuing care.		
			■	Consider individual and/or therapeutic dietary requirements.		
			■	Assist patient to select appropriate meals from menu card.		
			■	Provide encouragement and assistance with eating and drinking as required.		
			■	Ensure fresh drinking water is offered regularly and available at all times, where clinically appropriate.		
			■	Consider patient's positioning and support oral hygiene, if required		
			■	This care plan has been discussed and agreed with the patient as appropriate.		
			■			
				Medium Risk Care Plan		
				Commence food chart for a minimum of 3 days. Only discontinue if/when dietary intake is adequate.		
				If intake is insufficient, offer patient full cream milk or suitable alternative to drink with and between meals and suitable additional snacks.		
				Record accurate fluid intake/output on fluid balance chart until established that oral intake is adequate. If intake per 24hrs is inadequate, consider IV/SC fluids.		
				Monitor and review care plan and **repeat screening weekly**		
			■	**High Risk Care Plan**		
			■	Refer to Dietitian, ensuring the 'MUST' score is included.		
			■	Monitor and review care plan and **repeat screening weekly**		
			■	Discontinue food chart only when advised by Dietitian		
			■			

Date	Time	Intls			Discontinued Date/Time	Intls
				Dietetic Intervention		
				Document outcome of dietetic assessment.		
				Estimate patient's daily protein, energy and fluid requirements.		
				If nutritional requirements cannot be met orally, consider artificial nutritional support with the multi-disciplinary team and the patient/carer.		
				Provide patient and carer if appropriate, with nutritional advice and support which meets their individual needs.		
				Nutrition Support Team (NST) Intervention		
				Document the outcome of NST assessment by team member.		
				Document required actions and inform patient and multi-disciplinary team as appropriate.		
				Speech and Language Therapy (SLT) Intervention		
				Document outcome of SLT swallowing assessment.		
				Document the recommended compensatory strategies/modified diet as appropriate. Ensure patient and multi-disciplinary team are aware.		
				Occupational Therapy (OT) Intervention		
				Document outcome of OT assessment.		
				Document any additional requirements and inform patient and multi-disciplinary team as appropriate.		
				Dental Intervention		
				Document the outcome of Dental assessment/consultation.		
				Document any required actions and inform patient and multi-disciplinary team as appropriate.		
				Physiotherapy Intervention		
				Document the outcome of Physiotherapy assessment.		
				Document any required actions and inform patient and multi-disciplinary team as appropriate.		

NHS Ayrshire & Arran

MRSA Admission Screening Assessment Form

Admissions to Ayr & Crosshouse (excluding day cases, paediatrics, psychiatry and Ayrshire Maternity Unit) please obtain either:

Nasal Screen (All Patients unless screen already obtained at Pre-op Assessment)

or

Full Screen (If known positive or a direct admission to ICU, orthopaedics, oncology, vascular or renal)

Admissions to **all other** areas not detailed above require the following risk assessment to be undertaken to determine whether an MRSA screen is required.

1. Has the patient been a hospital in-patient in the preceding 12 months? Yes ☐ No ☑
2. Has patient been transferred from another hospital? Yes ☐ No ☑
3. Is patient resident in a Nursing Home? Yes ☐ No ☑

If the answer to any of the above questions is YES please send a nasal swab to lab requesting 'MRSA screen'

4. Has patient been previously positive for MRSA? (check case notes for 'Clinical Alert') Yes ☐ No ☐

If patient has been previously positive for MRSA please send a full 'MRSA Screen' to Lab (see below for information on screen samples)

Admitting Nurse.....

Screen sent ☐ Date and Time.....

Is Patient screen result: **Positive** ☐ **Negative** ☐

If positive identify site.....Date.....(commence MRSA care plan)

MRSA SCREENING (Full Screen)

Left and Right nostrils (use same swab for both nostrils)

Throat

Perineum

Any skin lesion (if present)

Catheter Specimen of Urine – CSU (if patient has a urinary catheter)

Sputum (if expectorating)

METHOD

1. Use Dry Sterile Swabs (blue topped swabs)
2. Ensure swabs are correctly identified
3. Dip the swab into sterile normal saline before swabbing the area
4. When doing the nostrils, place moist swab against the anterior nares and rotate the swab at least 5 times in each nostril, maintaining firm contact with the mucosal
5. when swabbing skin areas use reasonable friction

Complete a multiple request form and request 'MRSA Screen'
All MRSA screening samples from individual patients can be put on one multiple form.

Good hand hygiene will help prevent the spread of MRSA

ADULT CONTINENCE ASSESSMENT PATHWAY

On Admission

Write or attach label

HCR No:.....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

Does your bladder ever cause you embarrassment, pain or concern?

Do your bowels ever cause you embarrassment, pain or concern?

Yes ☐ → No ☐

Have you had an appointment and been supplied products for this problem?

Yes ☐ → Contact nurse who carried out assessment to access a copy *(i.e. District Nurse, Health Visitor etc)*

→ Re-assess if required

→ Return copy following telephone contact to appropriate nurse on discharge *(i.e. District Nurse, Health Visitor etc)*

No ☐ → Initiate assessment

→ Offer continence leaflet

→ Prior to discharge, contact appropriate nurse and send a copy of the assessment *(i.e. District Nurse, Health Visitor etc)*

Initials: ..... Date:.....

Oral Health Risk Assessment (Review 4-weekly)

Rapid Assessment Questions		Circle which is appropriate		Suggested outcome/actions if "Yes" circled
Does the patient need assistance in carrying out their own basic oral care?		Yes	No	If you have answered yes to any of these questions please complete full oral health risk assessment below and review 4-weekly
Does the patient have dentures?		Yes	No	
Is the patient suffering from mouth pain?		Yes	No	
What is your normal mouth care routine at home? (for initial assessment only)		Details		
When did you last see a dentist? **(If more than 5 years, refer to dentist)**		Details		
Are you having any problems with your teeth or mouth?		Details		
Patient Assessment		**Circle which is appropriate**		**Suggested outcome/actions if "Yes" circled**
Smoking habits	Smoker? (which may increase risk of gum disease and oral cancer)	Yes	No	Note amount per day on profile Consider smoking cessation
Dexterity problems	Having difficulty holding toothbrush?	Yes	No	May need supervision/help with mouth care Consider OT adaptation
Cognitive function	Evidence of short-term memory loss and/or confusion?	Yes	No	May need supervision/help with mouth care
Oral Assessment – use tongue compressor and pen torch to examine oral cavity		**Circle which is appropriate**		**Suggested nursing care if "Yes" circled**
Lips	Dry /cracked?	Yes	No	Apply an emollient e.g. lubricating gel
Tongue	Dry/coated?	Yes	No	Clean with soft toothbrush and toothpaste Offer frequent fluids
	Evidence of ulceration/soreness?	Yes	No	**If yes, refer to Salaried Dental Services (SDS)* or advise patient to contact their dentist on discharge**
Gums/soft tissue	Evidence of soreness, ulceration, bleeding gums or whiteness?	Yes	No	**If yes, refer to SDS* or advise patient to contact their dentist on discharge**
Saliva	Dry mouth? (xerostomia) could be side-effect of medication e.g. antidepressants, anticonvulsants etc.	Yes	No	Offer frequent fluids and/or iced water If symptoms persistent refer to dentist
Teeth	Natural top teeth?	Yes	No	Encourage independence with cleaning teeth night and morning. Use toothbrush and fluoride toothpaste (see Basic Oral Care Guideline for concentration of fluoride)
	Natural lower teeth?	Yes	No	
	Evidence of plaque/debris?	Yes	No	Supervise/help with oral care Use toothbrush and fluoride toothpaste
Dentures	Top denture?	Yes	No	Supervise/help with cleaning dentures night and morning with mild soap and water; rinse dentures after meals. Clean teeth as above Remove dentures at night and leave to soak in water with appropriate solution
	Lower denture?	Yes	No	
	Dentures and natural teeth?	Yes	No	
	Denture marked with patient's name?	Yes	No	If no, refer to SDS* for marking
Pain	When eating/drinking?	Yes	No	**If yes, refer to SDS* or advise patient to contact their dentist on discharge**
	Caused by teeth/ dentures?	Yes	No	
Swallowing	Difficulty with swallowing?	Yes	No	Supervise/help with cleaning teeth and/or dentures and oral cavity after each meal
Nutrition	NBM/Fluid/dietary intake poor?	Yes	No	May require 2 hourly mouthcare Check whether oral problems contributing
	Dehydrated?	Yes	No	
	On energy - dense diet or prescribed supplements/snacks?	Yes	No	Consider high fluoride toothpaste if have natural teeth (2800ppm F)

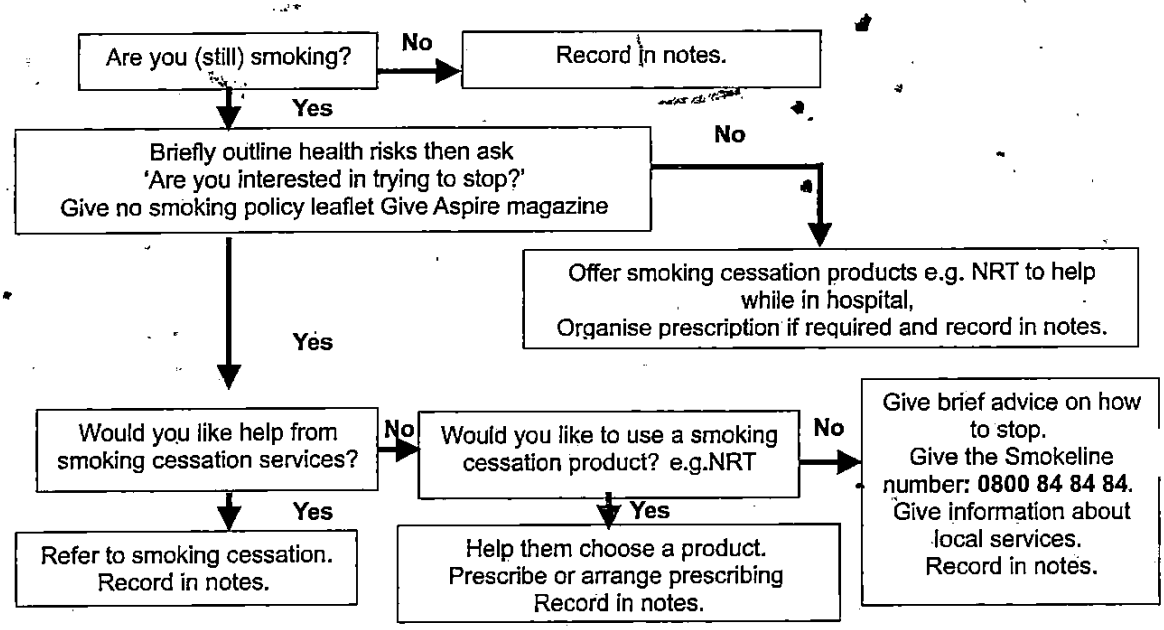
Signed.....

Date.....

*Dental Services Helpline: 01563 578 664
For urgent care or advice on weekdays,
NHS 24: 08454 24 24 24
For dental emergencies out-of-hours

NHS Ayrshire & Arran

Algorithm for smoking



Referral made: Yes ☐ No ☐ Date.....

Smoking Disclaimer

Section 1 - for patient disclaimer

I.....(print name) have been provided with information regarding the smoking ban in NHS wards / departments introduced via the Smoking, Health and Social Care Act 2005. I have read and understood this information. I have been advised against leaving the ward / department. In particular I understand that my decision will affect the medical attention I receive and that NHS Ayrshire & Arran cannot provide medical attention to me while I am absent from the ward / department. I therefore accept that the staff cannot be responsible for my care whilst I am absent from the ward.

Witness Name .....

Witness Signature .....

Signed .....

Date.....Time.....

Section 2 - for escort disclaimer

To be completed by adult escort where patient is dependant upon assistance to leave the ward to smoke against medical / nursing advice.

I.....(print name) will escort.....(patient) as he / she leaves the ward / department to smoke. I have been advised of the risks to the patient of being absent from the ward / department. I acknowledge that the patient and I have both been advised against this course of action. In particular I understand that NHS Ayrshire & Arran cannot provide medical care and attention while he / she is absent from the ward / department. I agree to take responsibility for the patient while he / she is absent from the ward / department.

Witness Name .....

Witness Signature .....

Signed .....

Date.....Time.....

An escort disclaimer form should be completed for each new escort during the patients hospital stay and filed with the nursing notes.

Summary problem list

List the nursing problems/needs identified in the patient assessment. Commence appropriate care plans for the identified problems/needs or implement an individual/specialist care plan for specific problems. Allocate the appropriate care plan code next to the problem. Add any new problems as they arise e.g. post-operative care.

Problems / needs identified	Care plan / chart (Code)	Date achieved / Discontinued	Initials

Care Plans and Monitoring Charts

Record of care plans and monitoring charts implemented for the patient. List additional specific care plans and monitoring charts and allocate each with a number.

Write or attach label

HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

Code	Care plan / monitoring chart	Code	Additional specific care plans / monitoring charts
		EXAMPLE	CHEST DRAIN CARE PLAN
A	Admitted as an emergency	1	
B	Breathing	2	
C	Catheter	3	
D	Cleansing and dressing	4	
E	Elimination	5	
F	Falls	6	
G	Bedrails	7	
H	Mobilising	8	
J	Communication	9	
K	Pre-operative	10	
L	Post-operative	11	
M	Wound Management	12	
N	Pressure area care	13	
O	Oral hygiene	14	
P	Pain management	15	
R	MUST - Eating & Drinking	16	
S	Emotional well being / Anxiety	17	
T	MRSA	18	
V	MEWS chart	19	
W	Fluid balance chart	20	
X	Peripheral Vascular Cannula chart	21	

CARE PLAN

Evaluation of patient care

Registered staff must countersign entries made by students and nursing assistants who have not yet been deemed competent in the delegated skill of record keeping.

Write or attach label

HC CHI: 3010776241
Ch Welsh, Caroline
Su 26 Lewis Terrace
Fo KA11 1HJ
Ad 30/10/1977
.... Dr J Taylor
Da. MRN: XHI466693

Date & Time	Careplan Code	Evaluation of Patient's Care	Initials
3/1/12	18.45	Patient admitted to ward	
		via A + E, observations as	
		charted, orientated to	
		ward and nurse call system	
		explained. Seen in treatment	
		room by doctor, passing	
		clots - obtained and sent	
		to labs for pathology.	
		Await results. for T.V.S	
		tomorrow. Appears settled	
		for now. Analgesia given.	JH
3/1/12	21.00	OBSERVATIONS STABLE, SCORE 0 ON MEWS	
		CHART	
		STATES THAT SITE IS COMFORTABLE, REFUSED	
		ANALGESIA.	
		STATES THAT P.V. BLEED HAS LESSENED	KH
		SPOKE TO DR RE KARNER TO HAVE Co-Co	
		ONLY	KH
		URINE:- +++ BLOOD, +++ PROTEIN, + KETONES, TRACE LEUC.	
		MSSU SENT.	
		BETA -VE	KH
4/1/12	06:30	APPEARS TO HAVE SETTLED AND SLEPT OVERNIGHT	KH
4/1/12	10.30	Observations and medications	
		as charted. P.V bleeding	
		better today. Taking diet &	
		fluids. Seen by doctor,	
		Plan - for T.V.S ~~ES~~ await	
		pathology results.	JH
4/1/12	13.10	Analgesia refused at lunch	
		time, advised patient just	
		to ask if needed.	JH
4/1/12	15.00	Co Codamol given as requested.	JH
4/1/12	18.30	Appears to have had a	
		settled day, no complaints.	
		off the ward for family just now.	JH
5/1/12	22.20	Observations stable Score 0 on MEWS chart.	
		Had Co-Codamol before settling	KH

EVALUATION OF CARE

Evaluation of patient care

Registered staff must countersign entries made by students and nursing assistants who have not yet been de competent in the delegated skill of record keeping.

Date & Time	Careplan Code	Evaluation of Patient's Care	Ini
5/1/12 3am		Unable to sleep. Worried. Reassurance given.	
6/1/12 3am.		Has sat up most of the night walking T.V	
	Pc	Obs. stable.	
		Awaits time for scan.	
	Dna	- Still awaits continues to be	
		externally anxious regarding cause	
		of pv bleeding. Very keen to	
		go home. Doctor informed of	
		mental of self discharge,	
		Ultrasound dept contacted.	
		Time / date for scan initially	
		requested as O.P. — attempt	
		to request In-patient A.S.A.P.	
		- ? not available today.	
		For discussion with Dr Blair.	
	1300	Discussed with Dr Yang —	
		scan now 910 6/1/11. - allowed	
		home for ayteno and will	
		return this pm.	
	1900	- Returned to ward. No heavy pv	
		bleeding whilst at home Vc clots, Hus	
		roumed earlier. Minimal + seen	
		pv on return to ward. Advised	
		to change into nightwear and	
		go into bed. Obs. still to be checked.	
3/1/12	20:0	OBSERVATIONS STABLE. SCORE O. ON M.E.W.S.	
		CHART	
		P.V. LOSS NOW LESSENED, NO CLOTS, JUST WATERY	
		BLOOD	
	23:0	HAD TEMAZEPAM 10mg PO PR	
		RECEIVED ANALGESIA	
	23:16	CHECKED P.V. LOSS (IN TOILET) BRIGHT RED BLOOD, SMALL	
		CLOTS	
6/1/12	00:15	CHATTED TO CAROLINE FOR A WHILE. SHE STATED	
		THAT HER MOTHER DIED LAST AUGUST AND THAT	
		BECAUSE SHE WAS IN XHH IN A SIDEROOM, SHE	
		KEEPS THINKING OF HER. REASSURANCE GIVEN.	
		WILL TAKE HER TEMAZEPAM @ 00:30 AM.	

EVALUATION OF CARE

Evaluation of patient care

Registered staff must countersign entries made by students and nursing assistants who have not yet been deemed competent in the delegated skill of record keeping.

CHI: 3010776241
HC Welsh, Caroline
Cl 26 Lewis Terrace
St KA11 1HJ
Fc 30/10/1977
Ad Dr J Taylor
MRN: XHI466693
Dat

Date & Time	Careplan Code	Evaluation of Patient's Care	Initials
6/1/12 6:30		CAROLINE HAS MANAGED TO HAVE A DECENT SLEEP AFTER TAKING TRAMADOL BEFORE SETTLING	KM
6/1/2012 10.30hrs		Diet and fluids taken. Attended for TV scan. Awaiting result. Obs stable as charted. PV loss moderate+, fresh with clots being passed. Caroline remains anxious and is keen for home but worried how she will cope with this (heavy) bleeding at home.	SH
6/1/12	13.30	Doctor spoke with patient regarding scan results, to have mefenamic acid and tranexamic acid for 10 days. + prostap injection 3.75mg, given as prescribed.	
	1700	Caroline keen to remain in ward overnight for P.V. loss to be assessed, feels she may get frightened and alarmed at home if worsens.	JH
6/1/12 2200		MEWS-0	
		Night sedation requested States PV loss continues reassurance given.	
		Medications given as charted.	
6/1/12		Self caring with shower	GS
2345		Night sedation given	GS
1/12 0630		Slept for spells overnight	GS
7.1.12 1200hrs		settled morning. Shadeled independently. Remains anxious about PV bleeding. Patient also c/o back pain - refused stronger analgesia as states it doesn't work. Patient spoke at length	

EVALUATION OF CARE

Evaluation of patient care

Registered staff must countersign entries made by students and nursing assistants who have not yet been deeme competent in the delegated skill of record keeping.

Date & Time	Careplan Code	Evaluation of Patient's Care	Initial:
		~~DW~~ Patient with Dr Franklin's it was explained that before surgical intervention (which is what patient has requested) the bleeding & pain needs to be controlled to optimise result of surgery. Patient to remain in hospital for the time being, Mefenamic Acid discontinued & re-commenced on ~~Wednesday~~ re-lease. If bleeding settles for dc home with follow-up by Dr Mineso. ~~Discussed~~ Patient appears happy with plan. Obs as charted, MEWS=1 due to hypertension.	
7.1.12 1620		Patient keen to go home. States bleeding has now settled. Reviewed by registrar. ~~Discharge~~ can be discharged home today	
7.1.12 1800		MEWS=2, T 38°. Dr Duffy reviewed patient (see medical notes) Patient can go home.	

EVALUATION OF CARE

Tear off along perfor

NHS Ayrshire & Arran

MEWS CHART

DATE	27/12																
TIME (24 hour clock)	2040																
Temperature (°C)	40																
	39																
	38																
	37	●															
	36																
	35																
BLOOD PRESSURE Record this way	210																
	200																
	190																
	180																
	170																
	160																
	150																
	140	^															
	130																
	120																
	110																
	100																
	90																
	80	✓															
	70																
	60																
Record this way HEART RATE	50																
	40																
	30																
Respiratory Rate		14															
O_2		A															
Saturation		98															

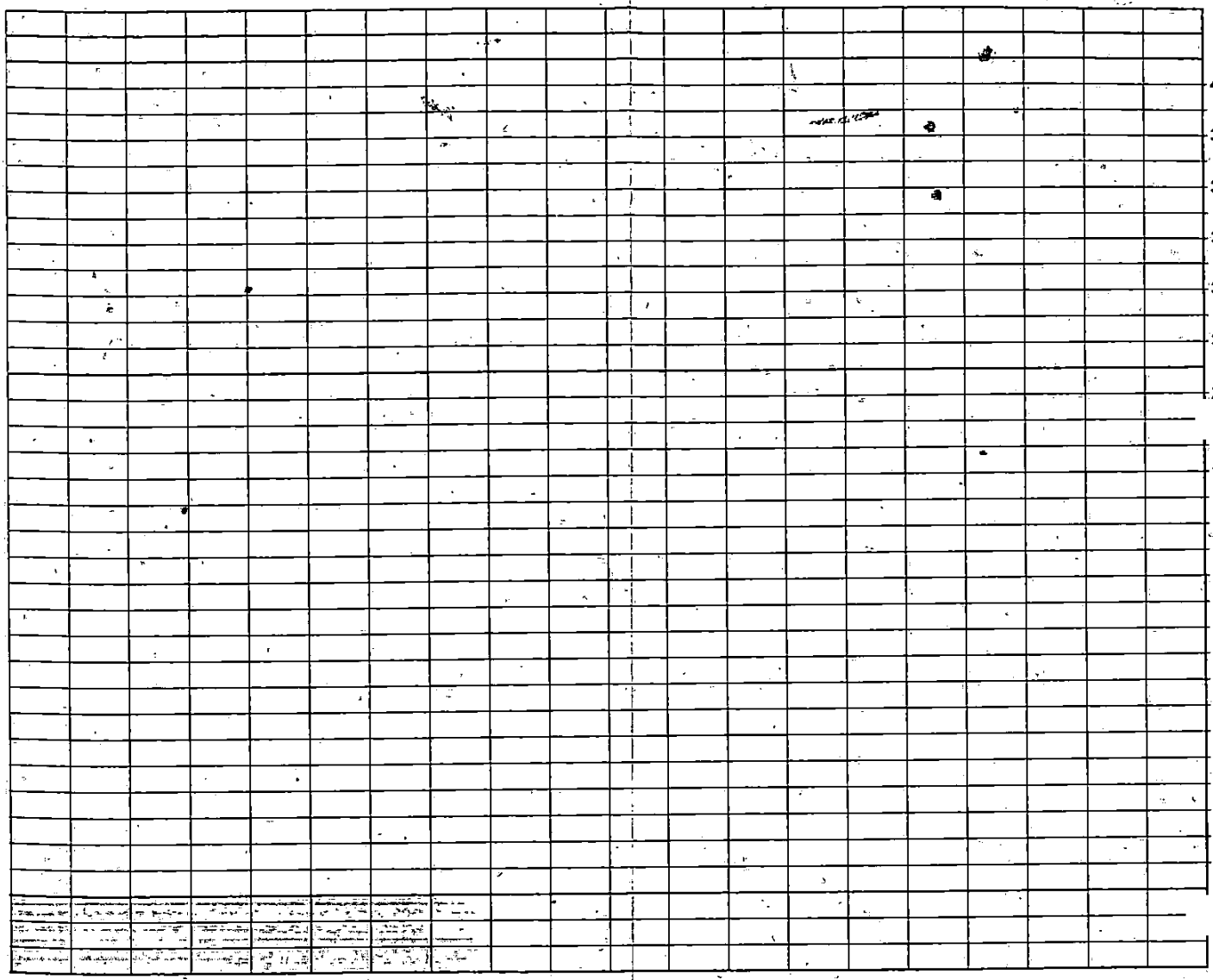
MEWS SCORE FOR EACH OF THE INDIVIDUAL OBSERVATIONS																	
Temperature (°C)	0																
BP Systolic	0																
Heart Rate	0																
Respiratory Rate	0																
SpO2	0																
Urine	0																
CNS	0																
MEWS SCORE - TOTALS																	
Record the total MEWS scores for each set of observations this way	3																

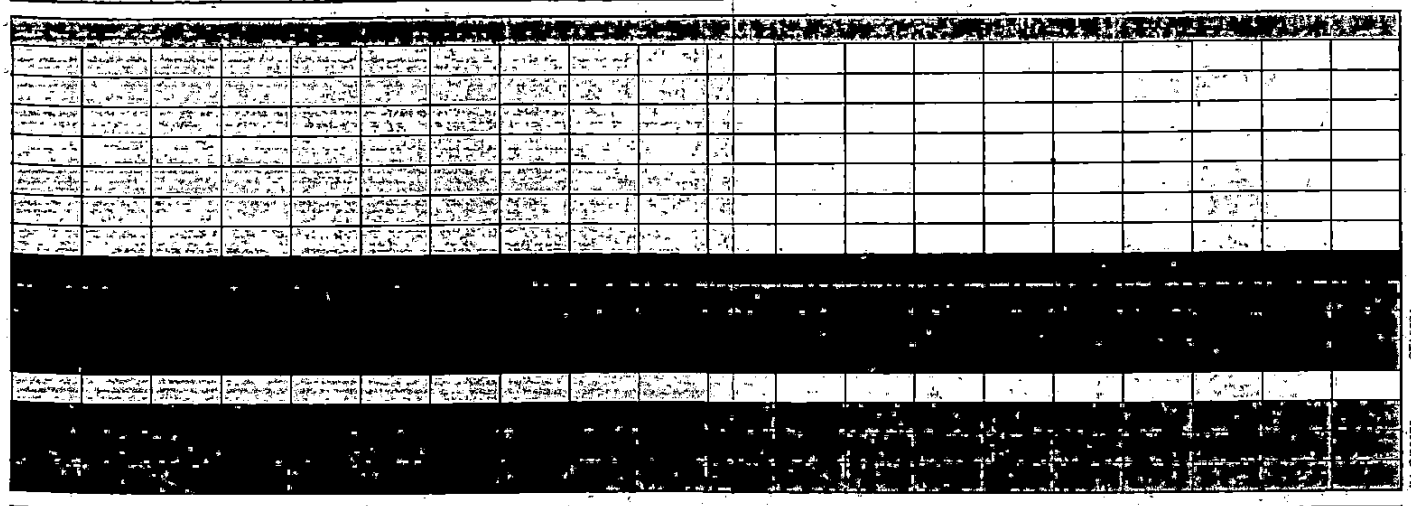
Sedation Score	0																
Pain Score (On Movement)	0																
Nausea Score	0																
Initials	[illegible]																

me when chart is finished.

...attach label

XHI466693
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE,
CHEVIOT WAY,
CHI 3010776241





STA5274

JMC/83076

Write or attach label

XHI466693

MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE,
CHEVIOT WAY,
CHI 3010776241

NHS Ayrshire & Arran

MRSA Admission Screening Assessment Form

Admissions to Ayr & Crosshouse (excluding day cases, paediatrics, psychiatry and Ayrshire Maternity Unit) please obtain either:

- **Nasal** Screen (All Patients unless screen already obtained at Pre-op Assessment)

or

- **Full** Screen (If known positive or a direct admission to ICU, orthopaedics, oncology, vascular or renal)

Please ensure both copies of these admission screen forms are marked with a red dot

Admissions to **all other** areas not detailed above require the following risk assessment to be undertaken to determine whether an MRSA screen is required.

1. Has the patient been a hospital in-patient in the preceding 12 months? Yes ☑ No ☐
2. Has patient been transferred from another hospital? Yes ☐ No ☑
3. Is patient resident in a Nursing Home? Yes ☐ No ☑

If the answer to any of the above questions is YES please send a nasal swab to lab requesting 'MRSA screen'

4. Has patient been previously positive for MRSA? (check case notes for 'Clinical Alert') Yes ☐ No ☑

If patient has been previously positive for MRSA please send a full 'MRSA Screen' to Lab (see below for information on screen samples)

Admitting Nurse .....

Screen sent ☑ Date and Time....27/12/09 2050

Is Patient screen result:

Positive ☐ **Negative** ☐ If positive identify site ..... Date .....

MRSA SCREENING (Full Screen)

Left and Right nostrils (use same swab for both nostrils)
Throat
Perineum
Any skin lesion (if present)
Catheter Specimen of Urine – CSU (if patient has a urinary catheter)
Sputum (if expectorating)

METHOD

1. Use Dry Sterile Swabs (blue topped swabs)
2. Ensure swabs are correctly identified
3. Dip the swab into sterile normal saline before swabbing the area
4. When doing the nostrils, place moist swab against the anterior nares and rotate the swab at least 5 times in each nostril, maintaining firm contact with the mucosal
5. when swabbing skin areas use reasonable friction

Complete a multiple request form and request 'MRSA Screen'
ALL MRSA screening samples from individual patients can be put on one multiple form.

GOOD HAND HYGIENE WILL HELP PREVENT THE SPREAD OF MRSA

NHS Ayrshire & Arran

Write or attach label

HCR N XHI466693
CHI Nc MORRIN CAROLINE
Surnar 26 LEWIS TERR
Forena IRVINE
Addres KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE
CHEVIOT WAY,
CHI 3010776241
Date of Birth 32 yrs

Pre-operative Assessment

Previous MRSA Y ☐ N ☑
MRSA +ve Y ☐ N ☐

Screening form to be completed for all admissions

Marital Status ENGAGED / LIVING WITH FIANCE
Religion *(if patient wishes to state)* none
Occupation: CARER
Hobbies / Interests: SOCIALISING, ACTIVITIES WITH OWN CHILDREN

1st Contact Details:
Name BRIAN WELSH
Relationship PARTNER
Address S/A as above
Home 01294 215887
Work
Mobile 07792 031294
To be given information on condition? Yes ☑ No ☐
Contactable Day ☑ Night ☑
Aware of admission Y ☑ N ☐

2nd Contact Details:
Name Kathleen Docherty
Relationship Mother
Address 29 Mull Cres, Broomlands Irvine
Home 01294 221582
Work
Mobile 07879 297880
To be given information on condition? Yes ☑ No ☐
Contactable Day ☑ Night ☑
Aware of admission Y ☑ N ☐

Planned operation: Anterior PFR + Posterior PFR

Dr Agur Consultant: Anaesthetist:
23/11/09 Date of Admission: 24/11/09 Date of Surgery:
wdb 14.00 Time of Admission: Estimated Date of Discharge:

Surgically suitable for:- *(surgeon to complete)*
Day Surgery ☐ 23 Hour ☐ Same day admission ☐ In Patient ☐

Anaesthetically suitable for:-
Day Surgery ☐ 23 Hour ☐ Same day admission ☐ In Patient ☑

Operation performed: 24/11/09 ANT + Post Repair Renal d/ IUCD + EXD anal tags both 48N

Observations at pre-operative assessment

BP: 136/84	HR: 80 Reg/Irreg	Temp: 37.4	Resps: 16	SaO2: 98 %	
Height: 171 m	Weight: 118 kg	BMI: 28.2 *If < 19 refer to dietitian*	Urinalysis: TR Protein, ++ leuc		

Day surgery patients only

Will you have a responsible adult (aged 18 or over) to take you home by car or taxi? *(public transport is not acceptable)* Y ☐ N ☐
Will you have a responsible adult (aged 18 or over) to stay with you for 24 hours post-op? Y ☐ N ☐
Do you have access to a telephone? Y ☐ N ☐
Do you live within a 1 hour car journey of the hospital? Y ☐ N ☐
Day surgery patients only Accept ☐ Reject ☐

PATIENT'S SIGNATURE:

Assessment Nurse Name:

Sign: S. Mill Date: 3/11/09

STA4231

Lives:-

Alone ☐
With elderly/infirm partner ☐
With healthy partner/family ☑
Identify carer/s .....
Does carer require additional support ☐
Details .....
.....
No of dependants 3 → 6yo 7yo 11yo
Who is caring for dependants? Partner
.....
Nursing home ☐
Residential care ☐
Home care services ☐
Community nursing service ☐
Services aware of admission ☐

Type of House: Two storey

Stairs inside ☑ How many? 1 Night-
Stairs outside ☑ How many? one
Toilet Upstairs ☑ Downstairs ☐
Bedroom, Upstairs ☑ Downstairs ☐

Personal Hygiene

Independent ☑
Requires assistance ☐
Able to dress independently ☑
Requires assistance ☐

Nutrition *(Please record details on problem identification page)* On orlastat

No special requirements ☐
Therapeutic diet *(state)* Low Fat / Low Calorie
Requires Cultural / Ethnic Diet *(state)* .....
(If special diet required, inform Dietitian at pre-op stage)
Loss of appetite ☐
Nausea / Vomiting ☐
Referral to dietician: Clinic ☐ Ward ☐
Dysphagia *(Consider referral to SALT for assessment)*

IF BMI < 19 Refer to Dietitian ensuring Dietitian is aware that patient has just attended pre-op and date of admission if known. The patient will be sent the first available appt.

NUTRITION RISK SCORE TO BE COMPLETED ON ADMISSION TO WARD

Elimination I.B.S. in past.

Bowel function: Frequency: Every 2-3 days

No problems ☑ Constipation ☐
Loose stools ☐ Blood / Mucus / Pus ☐

If constipated, advise to seek advice from pharmacist about commencing / increasing stool softener / laxative before hospital admission

Urinary function:

No problems ☑ Frequency ☐
Urgency ☐ Dribbling ☐
Hesitancy ☐ Incontinence ☐
Nocturia ☐ Catheter ☐

Skin

Skin intact ☑ Broken ☐
Psoriasis ☐ Eczema ☐
Rash ☐ Wound/Ulcer ☐
If wound/ulcer, please swab for C/S & MRSA

Podiatry N.a.
.....

Dentures: Own teeth ☑

Upper ☐ Lower ☐
Caps / Crowns ☐ Full ☐
Partial ☐ Bridge ☐

Body piercings:

Site/s: 4 Tongue + Ears
Advised to remove before surgery? ☑

Prostheses: ☐ None

Mobility:

Independent ☑
Stick(s) ☐ Frame ☐
Wheelchair ☐ Hoist ☐

Communication

Communicates effectively ☑
Impaired speech ☐ Visual aids ☐
Learning Difficulty ☐
Please undertake LD Assessment
Primary language English Y ☐ N ☐
If no state .....
Interpreter Arranged ☐ TBA ☐
Ability to understand written communication *e.g. Dyslexia*
.....
.....
Dysphasia ☐

Hearing

Normal ☐ Dull ☑ R. side
Hearing aid Left ☐ Right ☐ Bilateral ☐

Visual impairment

Wears glasses ☐ Contact lenses ☐

Emotional state

Alert /Orientated ☑ Confused ☐
Mildly anxious ☐ Highly anxious / distressed ☐

Sleep

No problems ☑ Hours per night: 6-7
Medication required ☐

Discharge planning

Own transport ☑ **Hospital transport** ☐
Patient has keys ☐
Complex ☐ Straightforward ☐
Discharge co-ordinator informed Y ☐ N ☐

Previous medical and surgical history **(please list what, when and where)**

Appendicectomy 17 yrs ago.
Laparoscopy 17 yrs ago.

Have you had?	Yes	No	Comments
1. A general anaesthetic (GA)?	✓		
2. Complications with previous GA? *(please list all relevant details)*		✓	Felt aware of airway in her mouth.
3. Has anyone in your family ever had a problem with an anaesthetic? *(please document all relevant information)*		✓	
4. Any hospital admissions in the past year?		✓	
5. Are you taking any drugs, tablets or medication including herbal, clopidogrel, warfarin, recreational drugs? *(please list)*	✓		Patient's medication stored in ward Y ☐ N ☐

Name	Dose	Frequency	Name	Dose	Frequency
omeprazole		Daily			
orlistat	120mg	T.i.D			

H.R.T.? Y ☐ N ☑ Name ..... No Herbal's

O.C.P.? Y ☐ N ☑ Name ..... Mirena Coil in-situ

L.M.P. ..... 23.1.2019 .....

Advise patient re continuation / stopping medication prior to surgery.

No recreation drugs for 24 hrs pre-op.

6. Smoke? Y ☐ N ☑ How many per day? ..... Want to stop? Y ☐ N ☐

Information given re smoking cessation service / contact numbers? Y ☐ N ☐

7. Drink alcohol? Y ☑ N ☐ Alcohol screening score *(see additional form)* ..... 4 .....

Offer referral to Alcohol Liaison Nurse if indicated. Accepted Y ☐ N ☐ Referred Y ☐ N ☐

Inform patient to have no alcohol for 24 hours pre-operatively.

8. Are you allergic to anything? Y ☑ N ☐

Please specify source of allergy and type of reaction e.g. rash, swelling, sickness, diarrhoea, collapse, other

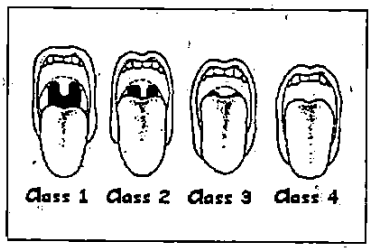
Source of Allergy	Type of Reaction	Other allergies (specify)	Type of Reaction
Medication (specify): NKA		Nickel	Skin reaction.
Elastoplast Y ☐ N ☑			
Latex Y ☑ N ☐	Skin reaction.		
Fruits / Nuts Y ☐ N ☑			

Have you ever suffered from:	Yes	No	Details
Cardiovascular / Respiratory			
9. M.I. (heart attack) or Angioplasty? *(If in past 6 months, not suitable for DSU)* *(Ask about exercise tolerance)*		✓	
10. Angina / chest pain / heart murmur / stents / pacemaker? *(Ask about exercise tolerance)*		✓	
11. Palpitations?		✓	
12. Hypertension?		✓	
13. Rheumatic fever? + / - swollen ankles?		✓	
14. Blood clot / thrombosis / embolus / DVT?		✓	
15. Claudication / peripheral neuropathy?		✓	
16. Blood disorders/bruising/bleeding/anaemia?		✓	
17. Asthma/wheeze/breathlessness? *(Ask about exercise tolerance)*		✓	
18. C.O.P.D. / TB? *(Ask about exercise tolerance)*		✓	
19. Cough / sputum?		✓	
Central Nervous System			
20. C.V.A. / T.I.A.? *(stroke / mini-stroke)*		✓	
21. Epilepsy / fits / seizures / convulsions?		✓	
22. Fainting / dizzy spells?	✓		Recently - thinks related to stress.
Gastro-Intestinal			
23. Heartburn / indigestion / gastric reflux? How many pillows do you sleep with? 1	✓		on omeprazole
24. Hiatus hernia?		✓	
25. Liver problems / jaundice / hepatitis / biliary?		✓	
26. Bowel disorders?		✓	
Renal / Genito-Urinary / musculo-skeletal / other			
27. Kidney / urinary problems?		✓	
28. Muscle disease or progressive weakness?		✓	
29. Arthritis or joint problems?		✓	
30. Diabetes?		✓	
31. Thyroid problems?		✓	
32. Any other serious illnesses? *(please list)*		✓	

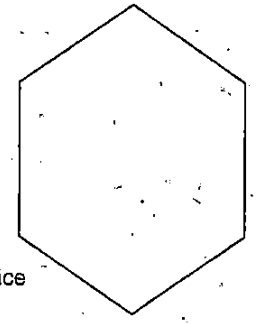
Clinical Examination

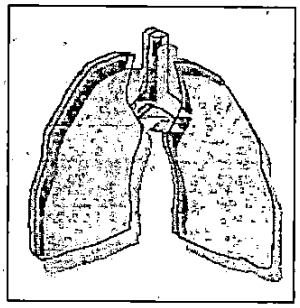
Cardiovascular	Respiratory
Heart rate / regularity	Chest expansion
JVP	Percussion
Carotid Bruits	Breath sounds
Heart sounds / Murmurs	Trachea
Peripheral Oedema	Finger clubbing

Surgical Examination



Modified Mallampati's classification of pharyngeal appearance





Neck movement

Full range of movement ☑
Difficult ☐
Mouth opening Good ☑ Poor ☐

Body piercings ☐

State site/s Tongue + Ears

Advise to remove prior to surgery. ☐

Dentition

Own teeth ☑ Loose teeth ☐
Dentures ☐ Full ☐ Partial ☐
Upper ☐ Lower ☐
Caps / Crowns / Bridge / Braces ☐

State site/s .....

Further comments:

.....

.....

.....

.....

.....Continue over if necessary

Medical Staff Name *(print)* .....Designation.....

Signature .....Page no. .....Date .....

Further comments *(Cont)*:

Medical Staff Name *(print)* ..... Designation .....

Signature ..... Page no. ..... Date .....

Investigations

Investigation	Requested (Date)	Reviewed by	Date reviewed	Repeated (Date)	Reviewed by	Date reviewed
FBC	3/11/09	NAD	4/11/9			
Group & Save	3/11/09	L/Tergu	4/11/9			
X Match						
Urea & Electrolytes	3/11/09	NAD	4/11/9			
LFT	3/11/09	NAD	4/11/9			
TFT						
Blood Glucose	3/11/09	5.0	4/11/9			
BM						
HbA1C						
INR						
Coag						
CXR						
PEFR		1 2 3			1 2 3	
Spirometry						
ECG						
Urinalysis	3/11/09	23/11/09 NAD				
MSSU/CSU	3/11/09	No growth	4/11/9			
Pregnancy Test		-ve 23/11/09				
Sputum						
MRSA N + T	3/11/09	-ve x2	4/11/9			
Audio/Tymps						
Photography						
Other						

Problem identification

To be completed at end of assessment and thereafter

Problem	Action Taken	Sign	Date	Outcome	Sign	Date

Medicines issued at pre-operative assessment as per PGD (patient group direction)

Ranitidine ☐ Sign:.....Other ☐ .....(state) Sign: .....

Picolax ☐ Sign:.....Other ☐ .....(state) Sign: .....

Information given:

Written	☑	Visiting times	☑
Verbal	☑	No smoking policy	☑
Fasting	☐	Other	☐ State .....

Evaluation and Progress of Care

1.	Basic care and hygiene	4	Mobility	7	Wound Care	10	Special Needs
2	Nutrition	5	Observations	8	Specimens & Investigation	11	Communication
3	Elimination	6	Technical Care	9	Sleep	12	Other relevant information

Date	Time	No	Evaluation and progress of care	Inits
			Seen by: Nurse ☑ Pharmacist ☐ Physiotherapist ☐ Occupational therapist ☐ Bone Bank Nurse ☐ Anaesthetist ☐ SHO / JHO ☐ Consultant ☐ Other (state) ☐	
3/11/09			Attended pre-op assessment.	
			Observations as charted	
			Bloods + MRSA swabs taken.	
			Seen by SHO	SM.

Evaluation and Progress of Care

1	Basic care and hygiene	4	Mobility	7	Wound Care	10	Special Needs
2	Nutrition	5	Observations	8	Specimens & Investigation	11	Communication
3	Elimination	6	Technical Care	9	Sleep	12	Other relevant information

Date	Time	No	Evaluation and progress of care	Inits

To be completed on admission

Ward ..... 6 ..... Speciality ..... Gyn .....

Consultant ..... DJ Ayer ..... Admitting Nurse ..... M. Haggis .....

Please confirm details with patient and record any changes in health / circumstances since attending the pre-operative assessment clinic. **Also, for female patients aged 12 – 55, please confirm LMP and if there is any risk of pregnancy, perform HCG pregnancy test.**

Evaluation and Progress of Care

1	Basic care and hygiene	4	Mobility	7	Wound Care	10	Special Needs
2	Nutrition	5	Observations	8	Specimens & Investigation	11	Communication
3	Elimination	6	Technical Care	9	Sleep	12	Other relevant information

Date	Time	No	Evaluation and progress of care	Inits
23/11/09	1430		A/A ANT+Post Repair. Bloods ☐ CTS ☐ Urine ☐ Beta -ve	ID
			MSA ☐ Consent ☐ obs Satis pre-optalk ☐ given	
			Settled into ward ———	MM
24/11/09	6am		Appeared to have settled night.	
			Still to be seen by anaesthetist Gm	
			Tea + toast given. Gm	
24/11/09	0850		own meds ~~except~~ given	MM
24/11/09	12:30		prepared for theatre. Premed given	MM
24/11/09	1800		Returned to ward. O² therapy cath: CBSTDS	
			Steady PU loss. ~~Conc~~ obs Satis	
24/11/09	18:20		Oramorph 10mg given for Pain relief	MM

Property retained by patient

I understand articles/valuables (e.g. jewellery, money, spectacles, hearing aids, personal items) retained by me are my own responsibility.

Signature of patient ..... C Morris .....

Date: ..... 3/11/09 .....

Property handed over for safe keeping

Y ☐ N ☐

Date taken to safe: .....

Cash & Valuables Ref. No. .....

Date returned: .....

Date	Time	No	Evaluation and progress of care	Inits

Print Name	Initials	DES	Signature	Print Name	Initials	DES	Signature
S. MILLAR	SM	S/N	S. Mill				
A. JAMIESON	AJ	HCA	Alison Jamieson				
L M FERGUSON	LF	SN	LM Ferguson				
M HAGGART	MH	S/N	M. Haggart OT				
D WALKER	DW	S/N					

DES - Designation **SR** - Sister **SSN** - Snr Staff Nurse **SN** - Staff Nurse

STN - Student Nurse **HCA** - Health Care Assistant **PHY** - Physiotherapist

OCT - Occ Therapist **PHA** - Pharmacist **BB** - Bone Bank Nurse

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NHS Ayrshire & Arran

XHI466693
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE.
CHEVIOT WAY.
CHI 3010776241

MRSA Admission Screening Assessment Form

Admissions to Ayr & Crosshouse (excluding day cases, paediatrics, psychiatry and Ayrshire Maternity Unit) please obtain either:

- **Nasal** Screen (All Patients unless screen already obtained at Pre-op Assessment)

or

- **Full** Screen (If known positive or a direct admission to ICU, orthopaedics, oncology, vascular or renal)

Please ensure both copies of these admission screen forms are marked with a red dot

Admissions to **all other** areas not detailed above require the following risk assessment to be undertaken to determine whether an MRSA screen is required.

1. Has the patient been a hospital in-patient in the preceding 12 months? Yes ☐ No ☐
2. Has patient been transferred from another hospital? Yes ☐ No ☐
3. Is patient resident in a Nursing Home? Yes ☐ No ☐

If the answer to any of the above questions is YES please send a nasal swab to lab requesting 'MRSA screen'

4. Has patient been previously positive for MRSA? (check case notes for 'Clinical Alert') Yes ☐ No ☐

If patient has been previously positive for MRSA please send a full 'MRSA Screen' to Lab (see below for information on screen samples)

Admitting Nurse .....

Screen sent ☐ Date and Time..... pre op.

Is Patient screen result:

Positive ☐ **Negative** ☐ If positive identify site ..... Date .....

MRSA SCREENING (Full Screen)

Left and Right nostrils (use same swab for both nostrils)
Throat
Perineum
Any skin lesion (if present)
Catheter Specimen of Urine – CSU (if patient has a urinary catheter)
Sputum (if expectorating)

METHOD

1. Use Dry Sterile Swabs (blue topped swabs)
2. Ensure swabs are correctly identified
3. Dip the swab into sterile normal saline before swabbing the area
4. When doing the nostrils, place moist swab against the anterior nares and rotate the swab at least 5 times in each nostril, maintaining firm contact with the mucosal
5. when swabbing skin areas use reasonable friction

Complete a multiple request form and request 'MRSA Screen'
ALL MRSA screening samples from individual patients can be put on one multiple form.

GOOD HAND HYGIENE WILL HELP PREVENT THE SPREAD OF MRSA

NHS Ayrshire & Arran

MEWS CHART

DATE	23/11/19	23/11/19	24/11/19
TIME (24 hour clock)	1430	2215	1150

Temperature (°C): 40, 39, 38, 37, 36, 35

BLOOD PRESSURE — Record this way: 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30 — Record this way

HEART RATE

Respiratory Rate	14	15	14
O_2	A	A	A
Saturation	98	96	98

	MEWS SCORE for EACH of the INDIVIDUAL OBSERVATIONS		
Temperature (°C)	0	0	0
BP (Systolic)	0	0	0
Heart Rate	0	0	0
Respiratory Rate	0	0	0
SpO	0	0	0
Urine Output	0	0	0
CNS	0	0	0
MEWS SCORE - TOTALS			
Record the total MEWS scores for each set of observations this way	3		

Sedation Score	0	0	0
Pain Score (On Movement)	0	0	0
Nausea Score	0	0	0
Initials	HM	KM	HM

The other chart is inside.

H XHI466693
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S 26 LEWIS TERR
F IRVINE
KA11 1HJ 30/10/1977
A Dr. J NELSON
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D CHEVIOT WAY,
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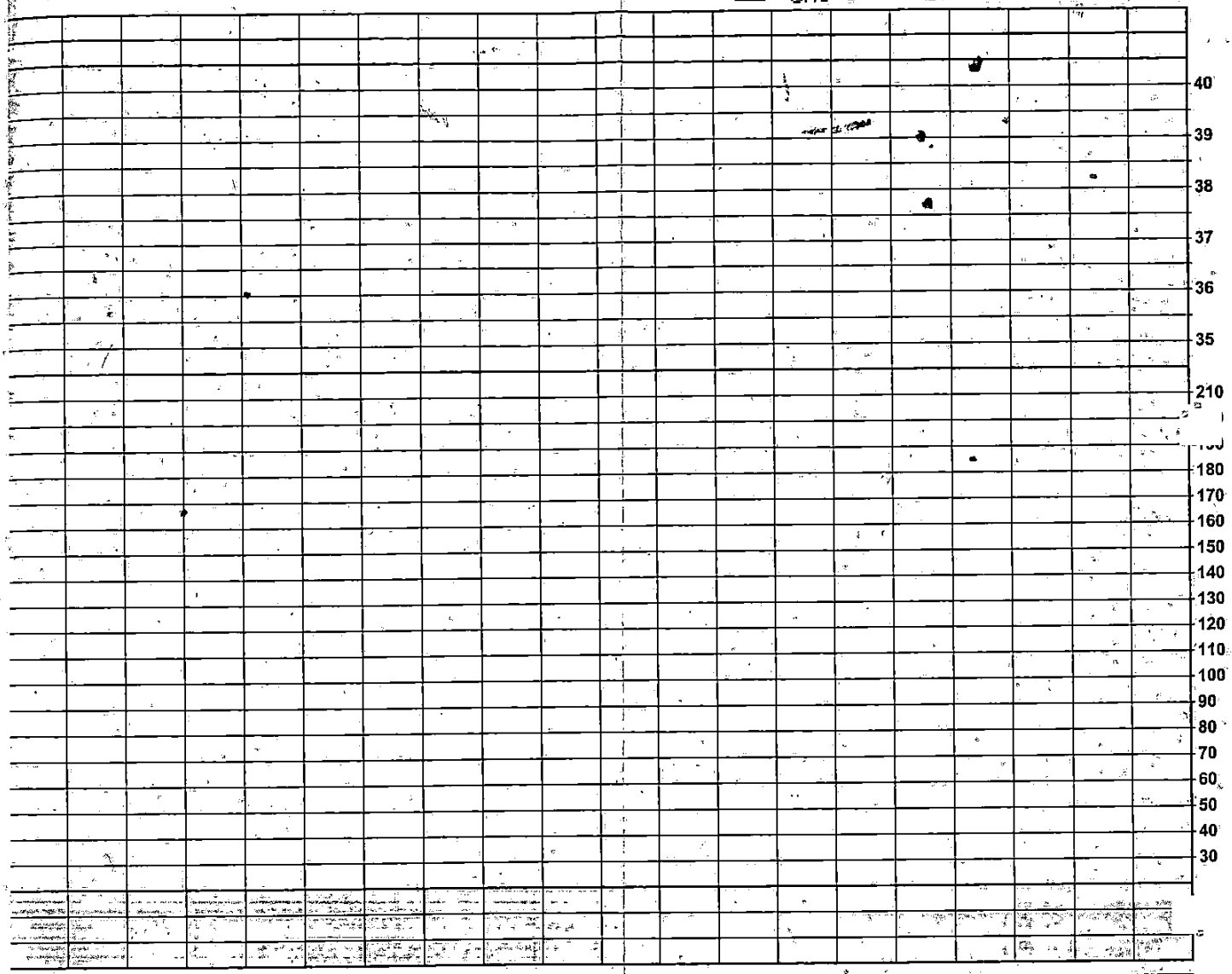

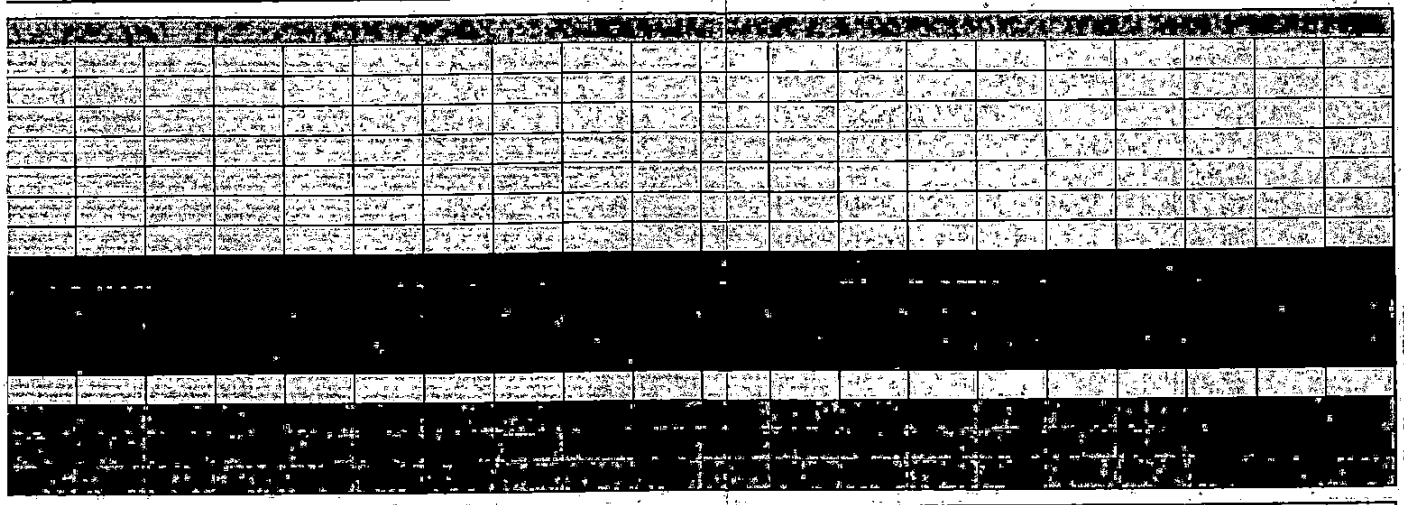

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Moving/Handling Assessment

Admission Date 23/11/09

Write or attach label

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S IRVINE
F KA11 1HJ 30/10/1977
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BOURTREEHILL HEALTH CENTRE
CHEVIOT WAY,
CHI 3010776241
Date of Birth

Assessment Categories		Tick as appropriate							
			1	2	3	4	5	6	7
	AMBULATION	**DATE**		24/11	25/11				
1	Walks independently			✓	✓				
2	Needs supervision								
3	Needs 1/2 people to assist (specify)								
4	Uses walking aid type:								
5	Unable to walk								
6	Other / Specify: Theatre Day			✓					
	BED TRANSFERS								
1	Manages in/out independently			✓	✓				
2	Needs supervision								
3	Needs 1/2 people to assist (specify)								
4	Needs mechanical assist (specify)								
5	On bedrest								
6	Needs 1/2/3 people to change position Specify number:								
7	May be at risk of falling/attempting to get out of bed - needs supervision								
8	Other / Specify: Theatre Day			—					
	ARMCHAIR								
1	Transfers independently in/out chair			✓	✓				
2	Needs supervision								
3	Needs 1/2 people to assist (specify)								
4	Needs specific seating due to disability Specify:								
5	At risk of falling / may attempt to rise from chair unaided - needs supervision								
6	Other / Specify: Theatre Day			—					

			1	2	3	4	5	6	7
	TOILET / COMMODE	DATE		24/11	25/11				
1	Uses independently		✓						
2	Needs supervision								
3	Needs help of 1/2 people (specify number)								
4	Needs high toilet seat								
5	Needs mechanical assistance (specify)								
6	Bedfast uses bedpan / urinals								
7	At risk of falling - needs close supervision			✓					
	catheter				✓				
	BATHING								
1	Independent		✓						
2	Needs supervision				✓				
3	Needs help of 1/2 people (specify number)								
4	Needs mechanical assistance (specify)								
5	Bed bath only			✓					

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Write or attach label

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Nutritional Screening
'Malnutrition Universal Screening Tool' ('MUST')

To be Completed within 24 Hours of Admission

Step 1: Measure height and weight to get a BMI score.

Step 2: Note percentage unplanned weight loss and score.

Step 3: Establish acute disease effect and score.

Step 4: Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition.

Step 5: Follow the management guidance appropriate to the risk category and commence the corresponding care plan.

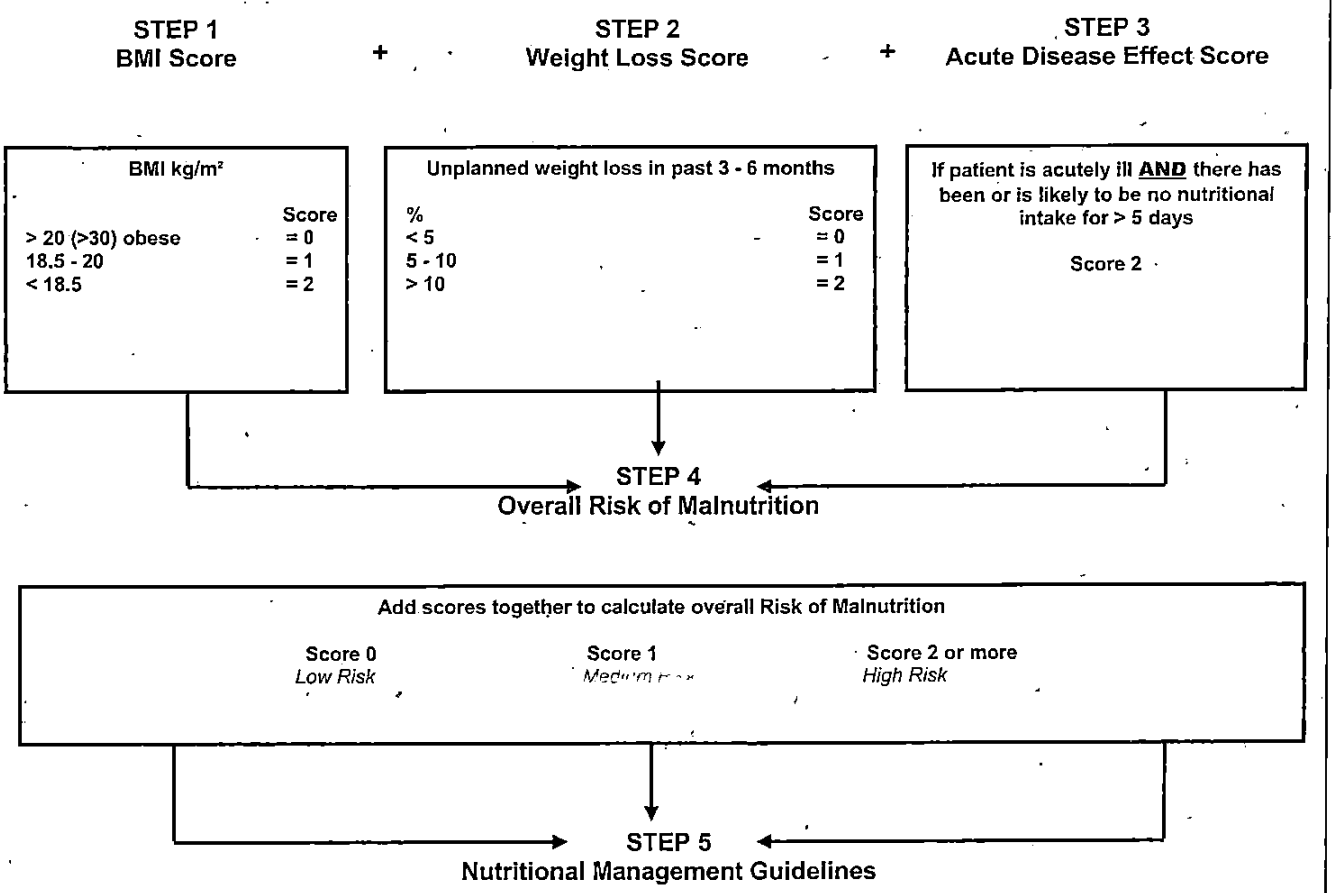
Screening Results

Please indicate if measurements are Measured (M), Reported (R) or Estimated (E)

Date	23/11/09				
Ward	4				
Height (metres) M ( ) R ( ) E ( )	171 m				
Current weight (Kg)	111.8 Kg ( )	Kg ( )	Kg ( )	Kg( )	Kg( )
BMI	38.2				
Is patient within obese category?					
Usual Weight (Kg)	Kg				
Signature					
'MUST'					
Step 1: BMI Score > 20 (> 30 = Obese) ..... 0 18.5 – 20 ..... 1 < 18.5 2	0				
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: < 5% ..... 0 5-10% ..... 1 >10% 2	0				
Step 3: Acute Disease Effect Score If patient is acutely ill and there has been or is likely to be no nutritional intake for > 5 days,.....Score 2 Not applicable ..... Score 0	0				
Step 4: Overall Risk of Malnutrition Total:	0				
Step 5:	0 = Low Risk	1 = Medium Risk	2 or more = High Risk		

Referrals	Date Referred	Signature
Dietitian		
Speech and Language Therapy		
Occupational Therapy		
Nutritional Support Team		
Dental Service		

'MUST' Screening



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Nutritional Management Guidelines:

MUST Score 0	MUST Score 1	MUST Score 2 or More
Low risk - *Routine Clinical Care* • Commence and implement the **Low Risk Care Plan** • Monitor and review care plan • **Repeat screening:** Acute .....Weekly Continuing Care ..... Monthly	Medium risk - *Observe* • Commence and implement the **Medium Risk Care Plan** • Document dietary intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose appropriate meals/ snacks and offer full cream milk or suitable alternative to drink with and between meals. • Monitor and review care plan • Repeat screening weekly.	High risk - *Treat* * • Commence and implement the • **High Risk Care Plan** • Refer to Dietitian, include MUST score • Continue food chart. • Offer maximum encouragement. • Monitor and review care plan • Repeat screening weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death. Use own judgement and document rationale for not treating.

- For low risk patients implement interventions in the **green** section of the care plan, as appropriate.
- For medium risk patients implement interventions in the **green** and **yellow** sections of the care plan.
- For high risk patients implement interventions in the **green, yellow and red** sections of the care plan.
- Always use your own professional judgement when screening patients and making referrals.
- Consider patients who require an immediate referral.
- Consider initial admission information relating to eating and drinking needs and preferences.
- When completing Step 2 always subtract the most recent weight with the 'usual' weight.

NHS Ayrshire & Arran

Pressure Sore Risk Assessment Tool
Waterlow Pressure Sore Risk Assessment

SCORE		
<10	Low risk	Re-assess weekly or if condition changes
10+	At risk	Re-assess twice weekly or if condition changes
15+	High Risk	Re-assess on alternate days
20+	Very high risk	Assess daily

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Date of Birth: .....

Waterlow Risk Assessment		Initials	MH	JS/ND												
		Date	23/11	24/11/25/11												
Body weight for height		No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14
	Average	0														
	Above average	1	1	1	1											
	Obese	2														
	Below average	3														
Continence																
	Completely catheterised	0														
	Occasionally Incontinent	1	0	0	0											
	Cath. Incontinence of Faeces	2														
	Doubly Incontinent	3														
Skin Type: Visual Risk Areas																
	Healthy	0														
	Tissue Paper/Dry	1	0	0	0											
	Oedematous/Clammy (temp)	1														
	Discoloured	2														
	Broken Spot	3														
Mobility																
	Fully	0														
	Restless/Figity	1	0	5	0											
	Apathetic	2														
	Restricted	3														
	Inert/Traction	4														
	Chairbound	5														
Age/Sex																
	Male/Female	1/2	2	2	2											
	14 – 49	1	1	1	1											
	50 – 64	2														
	65 – 74	3														
	75 - 80	4														
	80+	5														
Appetite																
	Average	0														
	Poor	1	0	3	0											
	NG Tubes/Fluids only	2														
	nbm - Anorexic	3														
Special Risks – Tissue Malnutrition																
	eg Terminal Cachexia	8														
	Cardiac failure	5	0													
	Peripheral Vascular Disease	5		0	0											
	Anaemia	2														
	Smoking	1														
Neurological Deficit																
	eg Diabetes. MS, CVA		0	0	0											
	Motor-sensory Paralegia	4-6														
Major Surgery/Trauma																
	Orthopaedic Below waist, Spinal	5	0	0	0											
	On table >2 hours	5														
Medication																
	Cytotoxics, Highdose Steriods	4	0	0	0											
	Anti-inflammatory															
		Total Score	4	12	4											

Date	Waterlow Score	Comments (eg treatment, mattress, etc.)	Date of next assessment due	Signed
(Admission)	4	low, bed	25/11/09	MHaggan
24/11/9	12	ext MSK, assess Day 1 post op	25/11/09	[illegible]
25/11	4	bed, mat	1/12/09	[illegible]

Pressure Sore Site and Treatment Plan

Indicate on the diagram the site(s) of any pressure sores.

Site Codes

PM1 Occipital

PM2 Scapula

PM3 Elbows

PM4 Vertebrae

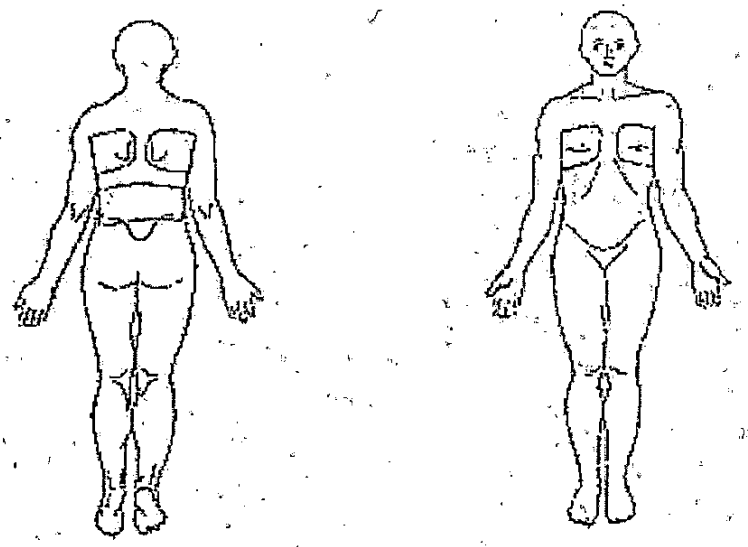
PM5 Sacrum

PM6 Buttocks

PM7 Heels

PM8 Malleoli

PM9 Other



Date	Site/Code	Stage	Treatment	Comments	Signed

Classification

Stage 0 – Blanching hyperaemia – the skin is intact but momentary finger pressure onto the site of erythema, following a prolonged period of pressure on the skin causes the skin to blanch.

Stage I – Non-balancing hyperaemia – the erythema remains when light finger pressure is applied. The area stays red more than 5 minutes after the relief of pressure indicating there is some damage to the micro-circulation.

Stage II – Partial thickness skin loss involving epidermis and/or dermis. The sore is superficial and presents clinically as an abrasion, blister or shallow crater.

Stage III – Full thickness skin loss involving damage to subcutaneous tissue that may extend down to, but not through, underlying fascia. The sore presents clinically as a deep crater with or without undermining of adjacent tissue.

Stage IV – Full thickness skin loss with extensive, tissue necrosis or damage to muscle, bone or supporting structures (eg tendon or joint capsule). Note: Undermining and sinus tracts may also be associated with Stage IV pressure sores.

Surname	
Forename	
Address	XHI466693 MORRIN CAROLINE 26 LEWIS TERR IRVINE KA11 1HJ 30/10/1977
Date of b	Dr. J NELSON BOURTREEHILL HEALTH CENTRE
Sex	CHEVIOT WAY, CHI 3010776241
Ward / Department	

NHS Ayrshire & Arran

ACTIVITY OF LIVING

Emotional Needs

Identify problems/needs

Patient has been admitted Gynaecology

	Date

Goal/Aim : Admission : to reduce anxiety and promote understanding

Date	Time	Initials	Planned care	Discontinued		Initials
				Date	Time	
23/11/09	PM	MH	Orientate to ward/staff/environment			
〃	〃	〃	Explain nurse call system			
〃	〃	〃	Inform patient about Named Nurse			
〃	〃	〃	Explain planned care to patient			
〃						
23/11	PM	MH	Ensure patient understands pre and post operative management			
〃	〃	〃	Allow time to voice fears and reiterate information as necessary			
23/11	PM	MH	Ensure family have contact number and a note of visiting arrangements			
23/11	PM	MH	Ensure patient and family have some indication of when surgery will			
〃	〃	〃	take place			
23/11	PM	MH	Obtain patients consent to inform relatives of patients management			
			Arrange meeting with consultants where requested			
〃						
〃						

DRS5000

Date	Time	Initials	Planned care	Discontinued		Initials
				Date	Time	

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NHS Ayrshire & Arran
ACTIVITY OF LIVING

Maintaining safe environment

Identify problems/needs

Patient has been admitted for surgery

	Date

Goal/Aim : Post op – to monitor and alleviate symptoms – to minimise and treat complications

Date	Time	Initials	Planned care	Discontinued Date	Discontinued Time	Initials
			Monitor and record vital signs			
			½ hourly			
			Hourly			
24/11/09	2000	LB	2 hourly			
			4 hourly			
?	?	?	Twice daily	27/11/09	10:10	LB
24/11/09	2000	LB	Monitor urinary output via catheter			
24/11/09	2000	LB	Carry out catheter care as per protocol	?	?	?
24/11/09	2000	LB	Remove when instructed			
24/11/09	2000	LB	Monitor output to ensure adequate volumes			
		LB N/A	Give patient controlled analgesia as per protocol / give epidural as per Protocol	?	?	?
24/11/09	2000	LB	Administer oxygen therapy as prescribed and monitor effects	?	?	?
			Monitor PV Loss			
			Hourly			
24/11/09	2000	LB	2 hourly			
	?		Twice daily	27/11/09	10:10	LB
24/11/09	2000	LB	Manage wound site and drain as appropriate and instructed	27/11/09	10:10	LB
24/11/09	2000	LB	Give all medications prescribed and monitor effects	27/11/09	10:10	LB
24/11	2000	LB	Maintain adequate nutrition (refer to nutrition risk score chart)	27/11/09	10:10	LB
	2000	LB	Monitor nausea / vomiting	↓	↓	↓
↓	2000	LB	Offer anti emetics as prescribed			
	2000	LB	Administer IV fluid as prescribed	?	?	?
	2000	LB	Maintain accurate fluid balance chart	27/11/09	10:10	LB

DRS5003

CONTINUED OVER

Date	Time	Initials	Planned care	Discontinued Date	Discontinued Time	Initials
28/11	0700		Offer tea and toast 1st post op morning if bowel sounds present	?	?	?
25/11	0900		Allow patient to choose own menu	27/11/09	10:10	
28/11	0900		Mobilise as condition indicates (refer to moving and handling chart)	27/11/09	10:10	
			Maintain level of hygiene			
			Give appropriate level of assistance which ensures patients needs are met			
			Maintain dignity and comfort			
			Encourage daily shower			
			Assess skin and potential pressure areas			
			Record waterlow score as condition indicates			
			Monitor bowel activity			
			Give aperient as required			
			Promote restful sleep			
			Give night sedation if prescribed and desired			
			Report any deviation from the normal to medical staff and act on their instructions			

CONTINUED OVER

Surname	
Forenam	XHI466693
Address	MORRIN CAROLINE 26 LEWIS TERR IRVINE KA11 1HJ 30/10/1977 Dr. J NELSON BOURTREEHILL HEALTH CENTRE CHEVIOT WAY,
Date of bi	
Sex	CHI 3010776241
Ward / Department	

NHS Ayrshire & Arran

ACTIVITY OF LIVING

Maintaining safe environment

Identify problems/needs

Patient has been admitted for major surgery

	Date

Goal/Aim : Provide effective pre-operative care and to minimise risk complication

Date	Time	Initials	Planned care	Discontinued		Initials
				Date	Time	
23/11/99	pm	MM	Monitor and record baseline observations			
			Obtain urine sample for			
23/11/99		MM	☐ Ward testing			
			☐ Pregnancy test, if applicable			
			Report any deviation from normal to medical staff			
			Obtain MRSA Swabs if appropriate			
23/11	pm	MM	Fully prepare patient for theatre:			
			☑ Give pre op talk			
			☑ Offer educational literature			
			☑ Give all prescribed medications and monitor effects			
			☑ Ensure patient has been sent by phyisotherapist			
			☑ Administer bowel prep as prescribed, if required			
			☑ Fast as per anaesthetists instructions			
			☑ Carry out specific instructions from anaesthetist			
			☑ Ensure patient is wearing anti-embolic stockings			
			☑ Check patient has correct ID bracelet			
			☑ Check patient has given informed consent			
			☑ Remove prosthesis as necessary			
			☑ Give prescribed premedication as prescribed			
			☑ Ensure all relevant documentation is available to accompany patient to theatre including as appropriate ECG, Xray and blood results			
			☑ Complete theatre check list			

DRS5001

Date	Time	Initials	Planned care	Discontinued		Initials
				Date	Time	

Surname	
Forename	XHI466693 MORRIN CAROLINE
Address	26 LEWIS TERR IRVINE KA11 1HJ 30/10/1977
Date of bir	Dr. J NELSON BOURTREEHILL HEALTH CENTRE
Sex	CHEVIOT WAY, CHI 3010776241
Ward / Department	

NHS Ayrshire & Arran

ACTIVITY OF LIVING

Maintaining safe environment

Identify problems/needs Prepare patient for discharge

	Date

Goal/Aim : Discharge

Date	Time	Initials	Planned care	Discontinued Date	Discontinued Time	Initials
27.11.09	10:10	dJ	Record discharge observations	27/11/09	10:10	dJ
			Ensure patient and family have been given information from support			
			Agencies			
			Ensure patient has seen the physio			
			Ensure patient has review clinic appointments and referrals have been			
			Organised			
			Given information about			
			Pain control			
			Wound hygiene / care			
			Vaginal discharge			
			Sexual intercourse			
			Driving/swimming			
			Returning to work (give sick line, if appropriate)			
			Activity eg lifting			
27/11/09	10:10	dJ	Ensure patient has	27/11/09	10:10	dJ
↓	↓	↓	GP letter			
			Discharge prescription	↓	↓	↓
			DN letter			

DRS5004

Date	Time	Initials	Planned care	Discontinued		Initials
				Date	Time	

NHS Ayrshire & Arran

NURSING NOTES

Write or attach label

XHI466693
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE
CHEVIOT WAY,
CHI 3010776241

DATE	
24/11/09 2000	Observations satisfactory as charted. O2 therapy continues. Catheter patent draining adequate volumes of clear urine. pr loss minimal. Drinking freely, advised to reduce intake to avoid nausea.
2nd	Keen for diet, light diet taken and tolerated. Routine analgesia as charted.
2245	c/o pain, oramorph 10mg given with good effect. Encouraged to alter position in bed for comfort. JB
25/11/09 0800	Had a settled rest of night. Observations as charted. pr loss minimal. Catheter patent, draining good volumes. c/o pain 10mg Oramorph given orally. JB
25/11/09 0900	Managing diet & fluid. catheter patent & draining well. Assisted with shave. Vaso vagal episode BP 99/48. Pulse 92. SpO_2 96%. Min PV loss. Remains pale but recovered well. No irritation from catheter. Otherwise well. DD
25/11/09 1530	No discomfort at catheter site. Metilagel administered with no effect. Complaining bitterly of pain. S/B Dr. Aird catheter to remain & commence

DATE	
	on potassium citrate. No further complaints at present
2100	Walker removed. Managing good diet & fluids c/o urine pain - advised to mobilise - very reluctant. Advises some PV loss - asked to inspect pad at next change. Obs remain satisfactory. Went to shower independently. Leans catheter bypassing a little up to sit in chair at present. No c/o pain
25/11/09 2100	Observations as charted, PV loss minimal. Continues to do cystitis, effercitrate given. Analgesia and laxatives as charted prior to settling.
26/11/09 0600	Appeared settled overnight.
26/11/09 1130	Settled morning self caring with ASL's. Catheter removed urine slightly haematuric feels much more comfortable now catheter removed advised to drink & provide 3x samples on urine. S/B D/ Agur happy for Caroline to go home later today Observations satisfactory. Min/mod PV loss - small clots noted. Managing diet & fluids mobilising much better today c/o urinary pain - but managing to part
26/11/09 1205	Patient in shower - buzzed for assistance Dressings loosed from incision

NHS Ayrshire & Arran

NURSING NOTES

XHI466693
HC MORRIN. CAROLINE
CH 26 LEWIS TERR
Su IRVINE
KA11 1HJ 30/10/1977
Fo Dr. J NELSON
Ad BOURTREEHILL HEALTH CENTRE
.... CHEVIOT WAY,
Da. CHI 3010776241

DATE	
	Managed to gain entry. Bathroom extremely hot & steamy. Patient found on shower stool. Very pale in appearance claimed she had fallen onto floor & hurt her back. Back appeared a bit red on spinal area. Checked over by Dr Kerr. Observations satisfactory as charted. Appears to be ok Dr Kerr will check back area later. Allow patient to recover meantime. Resting at present.
26/11/09 13⁰⁰	No back injury incurred. Checked by Dr Kerr
15⁰⁰	C/o sore head. Paracetamol 500mg given
16⁰⁰	Headache improved. Passed 30mls dk urine Blood stained urine Blood +++ protein & nitrates. MSW sent
19⁰⁰	Has passed further small amount of urine feels a lot easier when passing advised will continue to monitor output meantime Obs satisfactory. Nil PV c/o's
26/11/09. MS.	Patient passed 500ml of urine at care. Clear urine, advised to increase fluid.

DRS 5737

DATE	
	Intake Observations Satisfactory as charted, Medication given as charted, patient appears to have settled. no complaints offered.
27/11/09 11'am	Date No LR30597. re respect ax chart re skewed on 26/11/09
27/11 09⁰⁰	S/B Registrar, parent can go home today. HEWS=0 Nil Pv loss. Perineum clean and dry. Anus a little swollen but clean and dry. Bowels have moved.
OPP ✓	
27/11 10⁰⁰	Felt a little nauseated/ dizzy in shower. Felt 'panicky'. BP ↓, but observations within normal limits. Dr Young informed
27/11 10¹⁰	HEWS=0. Feels better. Dr Young happy for parent to be discharged. Caroline not willing to wait for discharge. prescription says someone will collect later. GP letter posted.

NHS Ayrshire & Arran

PAIN SCORING CHART

Write or attach label

HC XHI466693
CH MORRIN CAROLINE
Su 26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
For Dr J NELSON
Adc BOURTREEHILL HEALTH CENTRE
CHEVIOT WAY
CHI 3010776241
Date of Birth

Pain Score must be assessed on each drug round, documented and initialled accordingly.

Date	24/11	24/11	25/11	25/11	26/11																							
Time	21:15	22:45	08:00	12:00	08:00	11:47																						
PAIN																												
3																												Severe
2	✓	✓	✓																									Moderate
1				✓	✓																							Mild
0																												No pain
SEDATION																												
3																												Unconscious
2																												Asleep / difficult to rouse
1																												Asleep / drowsy / easy to rouse
0	✓	✓	✓	✓	✓																							Awake
NAUSEA																												
3																												Severe nausea +/- frequent vomiting
2																												Moderate nausea +/- occasional vomiting
1	✓	✓	✓	✓	✓																							Mild nausea - no vomiting
0																												No nausea - no vomiting
BOWELS MOVED																												
YES	✓	✓	✓	✓	✓																							
NO																												
ACTION TAKEN																												
	As charted	Kramerph Declined	Paracetamol Declined																									Refer to Acute Pain team analgesia guidelines. e.g. Regular analgesia given or PRN analgesia given, patient refused. Any problems please page the Acute Pain Team on: 3305 (Crosshouse Hospital) or 6181 (Ayr Hospital)
Initials	AS	K	P		SJ																							Please initial at each assessment

STA 4134 JMcG73774

NHS Ayrshire & Arran

PAIN SCORING CHART

Write or attach label
HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth

Pain Score must be assessed on each drug round, documented and initialled accordingly.

Date																												
Time																												
PAIN																												
3																												Severe
2																												Moderate
1																												Mild
0																												No pain
SEDATION																												
3																												Unconscious
2																												Asleep / difficult to rouse
1																												Asleep / drowsy / easy to rouse
0																												Awake
NAUSEA																												
3																												Severe nausea +/- frequent vomiting
2																												Moderate nausea +/- occasional vomiting
1																												Mild nausea - no vomiting
0																												No nausea - no vomiting
BOWELS MOVED																												
YES																												
NO																												
ACTION TAKEN																												
																												Refer to Acute Pain team analgesia guidelines. e.g. Regular analgesia given or PRN analgesia given, patient refused. Any problems please page the Acute Pain Team on: 3305 (Crosshouse Hospital) or 6181 (Ayr Hospital)
Initials																												Please initial at each assessment

STA 4134 JM=5/73774

Write or attach label

XHI466693
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE
CHEVIOT WAY
CHI 3010776241
Date of Birth 30/10/77

Fluid Intake and Output Chart

FAN0386

DATE 26/4/09

YESTERDAY'S BALANCE output 1900

	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8	150								
9						150mls catheter			
10	150							removed	
11									
12									
13	100								
14									
15	150					20ml.			
16									
17						30 mls (blood stained)			
18	150					80			
19	400								
20									
21	250					150			
22									
23						500			
24									
1									
2									
3									
4									
5									
6									
7									
TOTAL						(a)	(b)	(c)	(d)

JMcC/74024

INTAKE =	ml	(e) Insensible loss* = OUTPUT = (a + b + c + d)	ml
BALANCE = (Intake minus output)	ml		

* Average Adult = 600 ml + 100 ml per each 0.5°C temperature elevation.

Fluid Intake and Output Chart

FAN0386

Write or attach label
HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth .....

DATE						YESTERDAY'S BALANCE			
	INTAKE (ml)					**OUTPUT (ml)**			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
1									
2									
3									
4									
5									
6									
7									
TOTAL						(a)	(b)	(c)	(d)

INTAKE =	ml	(e) Insensible loss* = **OUTPUT =** (a + b + c + d)	ml

BALANCE = (Intake minus output)	ml

* Average Adult = 600 ml + 100 ml per each 0.5°C temperature elevation.

Write or attach label

XHI466693
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977 F
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE
CHEVIOT WAY.
CHI 3010776241
FAN0386 Date of Birth

Fluid Intake and Output Chart

DATE 25-11-09 | YESTERDAY'S BALANCE 1450

	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18						900	Emptied		
19									
20									
21									
22	150								
23									
24									
1									
2									
3									
4									
5									
6						1000	(E)		
7									
TOTAL						(a) 1900	(b)	(c)	(d)

INTAKE =	ml	(e) Insensible loss* = OUTPUT = (a + b + c + d) 1900	ml
BALANCE = (Intake minus output)	ml		

* Average Adult = 600 ml + 100 ml per each 0.5°C temperature elevation.

Write or attach label

HCR No: .....

CHI No: .....

Surname: MURRIN

Forename: CAROLYN Sex: F

Address: .....

.....

Date of Birth 30/10/77

FAN0386

Fluid Intake and Output Chart

DATE 24-11-09

YESTERDAY'S BALANCE

INTAKE (ml)						OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22						750 CBD			
23									
24									
1									
2									
3									
4									
5									
6						700 CBD			
7									
TOTAL						(a)	(b)	(c)	(d)

JMcC/74024

INTAKE =	ml	(e) Insensible loss* = OUTPUT = 1450 (a + b + c + d)	ml

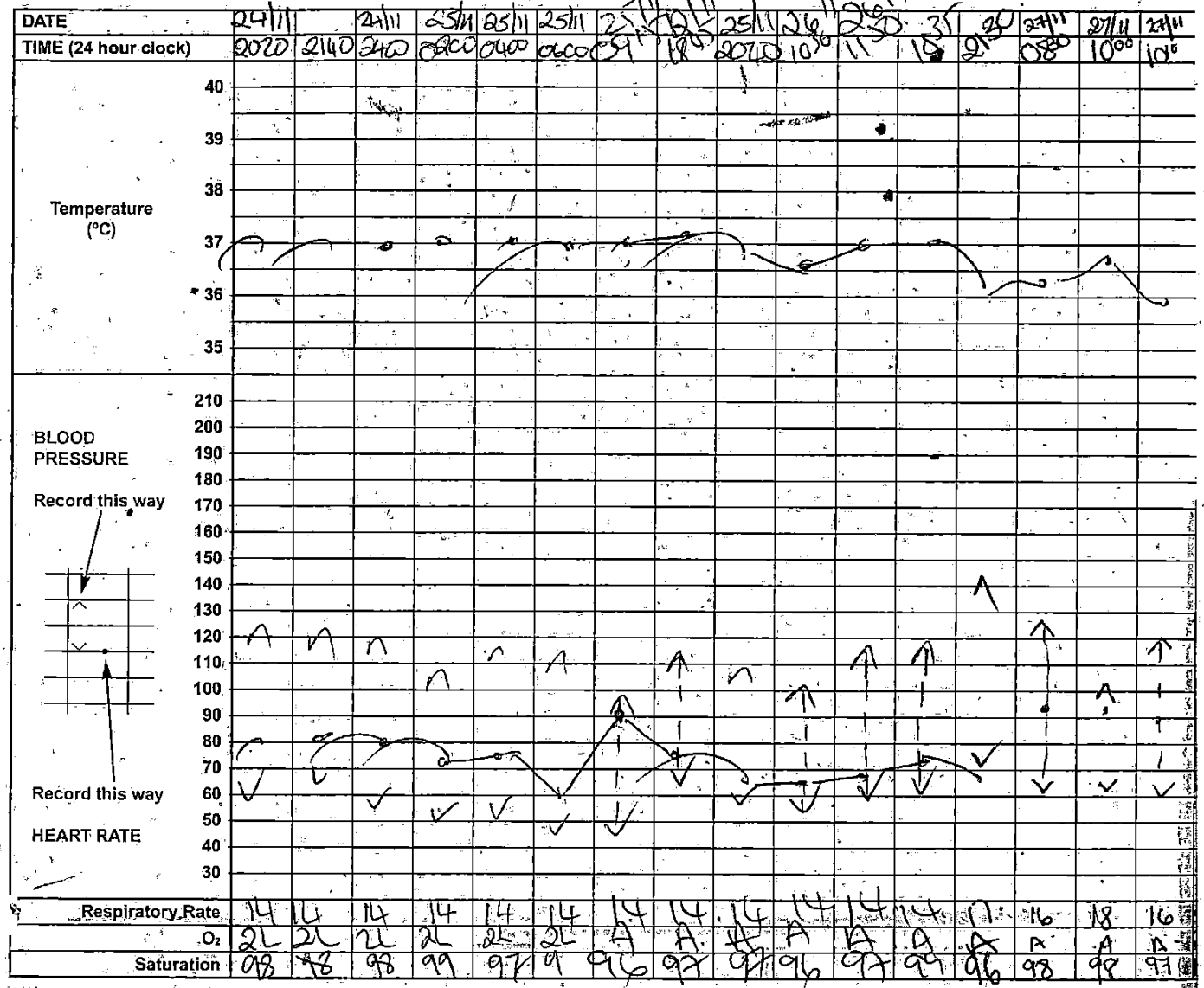
BALANCE = (Intake minus output)	ml

* Average Adult = 600 ml + 100 ml per each 0.5°C temperature elevation.

Tear off along perforated

NHS Ayrshire & Arran

MEWS CHART



MEWS SCORE FOR EACH OF THE INDIVIDUAL OBSERVATIONS																
Temperature (°C)																
BP Systolic																
Heart Rate																
Respiratory Rate																
SpO2																
Urine Output																
CNS																
MEWS SCORE - TOTALS																

Record the total MEWS scores for each set of observations this way

Sedation Score																
Pain Score (On Movement)																
Nausea Score																
Initials																

chart is finished.

XHI466693
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE
CHEVIOT WAY.
CHI 3010776241
Date of Birth

40
39
38
37
36
35
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30

STA5274

JMcC/83076

SHEET No XHI466693

Name MORRIN, CAROLINE

Address 26 LEWIS TERR
IRVINE.
KA11 1HJ

Age 30/10/1977

Cons'nt Dr J NELSON

Hosp'l BOURTREEHILL HEALTH CENTRE
CHEVIOT WAY
CHI 3010776241

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
24/11/09		A						B C		F @ 1830 F @ 2245
	Init.	MM						JJ		HW JJ
25/11/09	F	A B C		C G		G H		C G H I		H @ 1230 K
	Init.	JB						JJ		
26/11/09		A C E G H		C G		G H		C H G	I J LM	K @ 1501
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

IMoC/60566

SHEET No .....

Name .....

Age .....

Consultant .....

Hospital .....

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Use the chi number

Print to be ok please

JMcC/60568

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

STA 0236

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

Key: O ORAL; IM INTRAMUSCULAR; IV INTRAVENOUS; SC SUBCUTANEOUS; SL SUBLINGUAL; ID INTRADERMAL; INH INHALATION; NEB NEBULISED; PR PER RECTUM; PV PER VAGINA; IT INTRATHECAL

XHI466693

Write, Impr: MORRIN, CAROLINE
HCR No: .... 26 LEWIS TERR
CHI No: ..... IRVINE
Surname: .. KA11 1HJ 30/10/1977
Forename: .. Dr. J NELSON
Address: ..... BOURTREEHILL HEALTH CENTRE
..... CHEVIOT WAY,
Date of Birth ..... CHI 3010776241

KNOWN SENSITIVITY

1.	2.

SUSPECTED ADVERSE REACTION

MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION: 6am	8am	10am	12md	2pm	6pm	8pm	10pm	12mn	OTHER	ROUTE (See Key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED DATE	DISCONTINUED INITIAL
	A 23.11.09	OMEPRAZOLE			✓									O				
	B 24.11.09	PARACETAMOL	1gm		✓		✓		✓		✓			O				
	C 24.11.09	DICLOFENAC	50mg		✓			✓			✓			O				
	D 24.11.09	PROCHLORPERAZINE	3mg	6-8hrly PRN for Nausea & Vomiting										Buccal				
	E 24.11.09	CYCLIZINE	50mg	8 hrly PRN for Nausea & Vomiting										IM/IV/O				
	F 24.11.09	OROMORPH	10-20mg	2 hrly PRN for Pain										O				
	G 25 11	Coradamol 30/500	TT			4-6 hr								O				
	H 25 11	Potassium citrate MR	1 tab		3 x daily									O				
	I 25 11	Lactulose	15ml		✓						✓			O				
	J 25 11	Senna	TT								✓			O				
	K 26/11	TRAMADOL	50mg										4-6 PRN	O				
	L																	
	M																	
	N																	
	O																	
	P																	
	R																	
	S																	
	T																	
	V																	

JMcC/80185

STA0235

MEDICINES TO BE GIVEN ONCE (BLOCK CAPITALS)

PHARM.	TO BE GIVEN DATE	TO BE GIVEN TIME	APPROVED NAME OF MEDICINE	DOSE	ROUTE (See Key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	23/11/9	10pm	Temazepam	10mg	O			
	26/11/09		TEMEZEPAM	10mg	O	O-Morris	[redacted]	08:50

Patient Services

NHS Ayrshire & Arran

PRE-OPERATIVE ASSESSMENT QUESTIONNAIRE

Name: CAROLINE MORRIN Age: 32

X/H 466693

Telephone Numbers:

Home: 01294 215887 Work:

Mobile: 07890 072768

Dear Patient

It is necessary for all patients to attend a Pre-operative Assessment Clinic before surgery and we would be grateful, therefore, if you could attend an appointment for **PRE-OPERATIVE ASSESSMENT** at

PRE-OP ASSESSMENT UNIT, CROSSHOUSE HOSPITAL on:

Date: TUESDAY 03/11/09 **Time: 2:00 P.M.**

Please bring the following with you:-

- **THIS QUESTIONNAIRE, COMPLETED**
- **ALL YOUR MEDICINES IN THEIR ORIGINAL CONTAINERS, INCLUDING HERBAL MEDICINES**
- **A URINE SAMPLE IN A STERILE CONTAINER OBTAINABLE AT YOUR G.P. SURGERY**

During this visit you will be assessed in preparation for your stay. Any investigations required will be undertaken at this time. This visit could therefore take between 2-3 hours, depending on the number of patients to be seen and the investigations that you may require to have.

If you are 45 years of age or over we would be grateful if you would, on arrival go directly to the Cardiology Department (opposite X Ray) on the ground floor of the main hospital building, 15 minutes prior to your appointment time in the Pre-Op Assessment Unit. However if you have had an ECG within the last 6 months there is no need for you to attend this part of the pre-op, you should therefore go straight to the Pre-Op Assessment Unit for the rest of your tests.

We would be grateful if you would confirm your intention to attend your pre-operative appointment by telephoning 01563 825004.

PLEASE NOTE THAT FAILURE TO ATTEND YOUR PRE-OPERATIVE ASSESSMENT APPOINTMENT CAN JEOPARDISE YOUR THEATRE SLOT AND MAY RESULT IN YOUR NAME BEING REMOVED FROM THE WAITING LIST.

If you require an ambulance to travel please call 01563 825004.

Please provide the following details for 2 contacts.

	1st contact	2nd contact
Name:	BRIAN WELSH	KATHLEEN DOCHERTY
Relationship:	PARTNER	MOTHER
Address:	26 LEWIS TERRACE BROOMLANDS IRVINE	29 MULL CRESCENT BROOMLANDS IRVINE
Telephone Nos:		
Home	01294 215887	01294 221582
Work		
Mobile	07792 031 294	07879 297 880

Please detail any previous illnesses you have had (please state dates if known)

NONE

Please give details of any previous operations you have had (please state dates if known)

APPENDISECTOMY 17 years ago
LAPAROSCOPY 12 years ago

Do you have, or have you ever had, any of the following?

Shortness of breath	Y ☐N ☑	Do you smoke?	Y ☐N ☑
Bronchitis/Asthma	Y ☐N ☑	How many per day?	
Heart attack	Y ☐N ☑	Do you regularly cough or bring up phlegm?	Y ☐N ☑
Angina or chest pain	Y ☐N ☑	Do you drink alcohol?	Y ☑N ☐
High Blood Pressure	Y ☑N ☐	How much per week?	LESS THAN 10 UNITS PER WEEK
Diabetes	Y ☐N ☑	Do you have any allergies? (please list)	Y ☐N ☑
1st Day of last menstrual period			

Do you have any holidays planned? If so, please state dates you are unavailable for admission:-

Are you able to take a short notice cancellation? Yes ☐ No ☐
If yes, please indicate the minimum notice you would require.
24 hours ☐ 48 hours ☐ Other (state) _____

On occasion some patients are offered the opportunity to have their operation carried out at another hospital. If this was offered to you, please indicate where you would be willing to go, if any?

	Yes	**No**
Carrick Glen	☐	☐
Golden Jubilee	☐	☐

If you have any questions you would like to ask at your assessment, please write them down here as a reminder.

Initial number

ICIQ-VS 10/05

CONFIDENTIAL

CHI 3010776241
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ
30/10/1977 Pract 80306
Case Ref 466693

VAGINAL SYMPTOMS QUESTIONNAIRE

Many people experience vaginal symptoms some of the time. We are trying to find out how many people experience vaginal symptoms, and how much they bother them. We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

Please write in today's date: 10 (DAY) 09 (MONTH) 09 (YEAR)

Please write in your date of birth: 30 (DAY) 10 (MONTH) 77 (YEAR)

Vaginal symptoms

1a. Are you aware of dragging pain in your lower abdomen?

- never ☐ 0
- occasionally ☑ 1
- sometimes ☐ 2
- most of the time ☐ 3
- all of the time ☐ 4

1b. How much does this bother you?
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 (10)
not at all — a great deal

2a. Are you aware of soreness in your vagina?

- never ☐ 0
- occasionally ☐ 1
- sometimes ☑ 2
- most of the time ☐ 3
- all of the time ☐ 4

2b. How much does this bother you?
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 (10)
not at all — a great deal

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3a. Do you feel that you have reduced sensation or feeling in or around your vagina?

not at all	☐ 0
a little	☐ 1
somewhat	☑ 2
a lot	☐ 3

3b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 (8) 9 10

not at all — a great deal

Prolapse is a common condition affecting the normal support of the pelvic organs, which results in descent or 'dropping down' of the vaginal walls and/or the pelvic organs themselves. This can include the bladder, the bowel and the womb. Symptoms are usually worse on standing up and straining (e.g. lifting, coughing or exercising) and usually better when lying down and relaxing.

Prolapse may cause a variety of problems. We are trying to find out how many people experience prolapse, and how much this bothers them. We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

4a. Do you feel that your vagina is too loose or lax?

not at all	☐ 0
a little	☐ 1
somewhat	☑ 2
a lot	☐ 3

4b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 (8) 9 10

not at all — a great deal

5a. Are you aware of a lump or bulge coming down in your vagina?

never	☐ 0
occasionally	☐ 1
sometimes	☐ 2
most of the time	☐ 3
all of the time	☑ 4

5b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 (10)

not at all — a great deal

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6a. **Do you feel a lump or bulge come out of your vagina, so that you can feel it on the outside or see it on the outside?**

- never ☑ 0
- occasionally ☐ 1
- sometimes ☐ 2
- most of the time ☐ 3
- all of the time ☐ 4

6b. **How much does this bother you?**
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**
not at all — a great deal

7a. **Do you feel that your vagina is too dry?**

- never ☑ 0
- occasionally ☐ 1
- sometimes ☐ 2
- most of the time ☐ 3
- all of the time ☐ 4

7b. **How much does this bother you?**
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**
not at all — a great deal

8a. **Do you have to insert a finger into your vagina to help empty your bowels?**

I dont want to do this but it feels it would Probably help if idid!

- never ☐ 0
- occasionally ☐ 1
- sometimes ☐ 2
- most of the time ☐ 3
- all of the time ☐ 4

8b. **How much does this bother you?**
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 (10)
not at all — a great deal

9a. **Do you feel that your vagina is too tight?**

- never ☑
- occasionally ☐
- sometimes ☐
- most of the time ☐
- all of the time ☐

9b. **How much does this bother you?**
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**
not at all — a great deal

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Sexual matters

We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

10. Do you have a sex life at present?

- yes ☑ 1
- no, because of my vaginal symptoms ☐ 0
- no, because of other reasons ☐ 2

If NO, please go to question 14

11a. Do worries about your vagina interfere with your sex life?

- not at all ☐ 0
- a little ☐ 1
- somewhat ☐ 2
- a lot ☑ 3

11b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 (10)

not at all — a great deal

12a. Do you feel that your relationship with your partner is affected by vaginal symptoms?

- not at all ☐ 0
- a little ☑ 1
- somewhat ☐ 2
- a lot ☐ 3

12b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 (10)

not at all — a great deal

13. How much do you feel that your sex life has been spoilt by vaginal symptoms?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 (8) 9 10

not at all — a great deal

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Quality of life

We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

14. Overall, how much do vaginal symptoms interfere with your everyday life?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 (8) 9 10

not at all a great deal

Thank you very much for answering these questions.

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VAGINAL SYMPTOMS QUESTIONNAIRE

SCORING

(This section is for administrative use only)

Patient number

Vaginal symptoms score

Vaginal symptom score = 2×(dragging pain) + 2×(soreness in vagina) + (reduced sensation) + 2×(vagina too loose) + 2×(lump felt inside) + 2×(lump seen outside) + 2×(vagina too dry) + (faecal evacuation)

symptom*	score	weighted score
Q1. 'dragging pain'	1	x 2 = 2
Q2. 'soreness in vagina'	2	x 2 = 4
Q3. 'reduced sensation'	2	x 1 = 2
Q4. 'vagina too loose'	2	x 2 = 4
Q5. 'lump felt inside'	4	x 2 = 8
Q6. 'lump seen outside'	0	x 2 =
Q7. 'vagina too dry'	0	x 2 =
Q8. 'faecal evacuation'		x 1 =
Total vaginal symptoms score		22

*(Note: Q9, 'vagina too tight', is primarily for detecting a potential post-treatment complication and is therefore not included in the scoring)

Sexual matters score

Sexual matters score = (sex-life spoilt) + 8×(worries about vagina interfere with sex-life) + 8×(relationship affected)

sexual matter	score	weighted score
Q11. 'worries about vagina interfere with sex-life'	3	x 8 = 24
Q12. 'relationship affected'	1	x 8 = 8
Q13. 'sex life spoilt'	8	x 1 = 8
Total sexual matters score		40

Quality of life score

quality of life	score
Q14. 'quality of life affected'	8

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The British Society of Urogynaecology
BSUG.NET online data collection Form

Responsible Clinician:_____ Data Gathered by: _____- Date:_____

Patient Details

Surname :	
Date of birth :	

CHI 3010776241
MORRIN CAROLINE
3 LEWIS TERR
VINE
KA11 1HJ
30/10/1977 Pract 80306
Case Ref 466693

Create a New Episode

Episode type

Incontinence +/- Prolapse		**Prolapse only**	✓

Shaded Questions are NOT applicable to 'Prolapse only' cases.

Pre-Op Tab

Pre-surgery Quality of Life

ICIQ-UI Score (0-21)	
ICIQ-VS Score (0-53)	
ICIQ-SM Score (0-58)	
Other Quality of Life scores	

Pre-op preparation

Pelvic floor exercises offered : Choose from: (Unanswered, No, Yes)	
Who supervised the exercises : Choose from:(Unanswered, Continence advisor, Declined, PFE ,GP, Nurse specialist, Physiotherapist Self-examination)	
Pre-op urodynamics performed : Choose from:(Unanswered No Yes)	
Pre-op Urodynamic diagnosis : Choose from :(Unanswered, Unanswered ,Normal, USI, Occult USI, DOA,Mixed USI+DOA, Overflow/chronic retention, Voiding dysfunction, Fistula (vesico-vaginal), Fistula (other), Urethral diverticulum(	
Procedure-specific information leaflet given: Choose from: (Unanswered No Yes)	

This data is Private and Confidential and should be used in accordance with the Calldicott Guidelines.

Pop-Q Assessment

Aa Not Done or -10cm - +10cm		**Ba** Not Done or -10cm - +10cm		**C** Not Done or -10cm - +10cm		**Anterior vaginal Wall (a):** N/A or 0, I, II ,III , IV	
Gh Not Done or -10cm - +10cm		**Pb** Not Done or -10cm - +10cm		**tvi** Not Done or -10cm - +10cm		**Posterior vaginal Wall (a).** N/A or 0, I, II ,III , IV	
Ap Not Done or -10cm - +10cm		**Bp** Not Done or -10cm - +10cm		**D** Not Done or -10cm - +10cm		**Cervix (cx).** N/A or 0, I, II ,III , IV	
						Cuff (c). N/A or 0, I, II ,III , IV	

Previous Surgery - _____
(Choose from Surgery list Appendix A)

Other – Please state : _____

Surgery Tab

Surgery

Operation Date : DD/MM/YYYY	
Main Incontinence Surgery : (Choose from Surgery list Appendix A)	
Incontinence Surgery Type: Choose From: Unanswered / Primary / Repeat	
Main Prolapse Surgery : *NB Prolapse only cases* (Choose from Surgery list Appendix A)	
Prolapse Surgery Type: *NB Prolapse only cases* Choose From: Unanswered / Primary / Repeat	
Prolapse Graft Used: Choose from: None/ Type 1 prolene mesh/ Other mesh/ Pelvisoft/Pelvicol/ SIS/ Other Biological/ Other Mesh	

BMI Calcalculator: Height (M) _____ Weight (Kg) _____ BMI (W / $H^{2)}$ = _____

Anaesthetic/surgeonAnaesthetic used : Choose from: (Unanswered/ LA;LA + Sedation / Spinal / GA + Epidural/ Caudal / GA + Caudal;GA)	
Senior Surgeon Present: Choose from: (Consultant, Specialty Trainee (ST), Subspec. Trainee (SST), Staff grade, FTSTA, Other)	
Grade Of Operator: Choose from: (Unanswered;Consultant;SHO;SHO III;SpR;Staff Grade;SST)	

This data is Private and Confidential and should be used in accordance with the Calldicott Guidelines.

Intra-operative information

Ureteric injury: Choose from: (Unanswered;Yes ; No)		**Vascular Injury:** Choose from: (Unanswered;Yes ; No)	
Bladder Injury: Choose from: (Unanswered;Yes ; No)		**Blood loss > 500ml:** Choose from: (Unanswered;Yes ; No)	
Bowel Injury: Choose from: (Unanswered;Yes ; No)		**Peri-operatiove blood transfusion:** Choose from: (Unanswered;Yes ; No)	
Neurologicial Injury: Choose from: (Unanswered;Yes ; No)			

Post-Op Tab

Post-op Morbidity

Return to theatre for procedure-related event within 72 hrs Choose from: (Unanswered;Yes ; No)	
Catheterisation required for more than 10 days post-op Choose from: (Unanswered;Yes ; No)	
Return to hospital within 30 days for procedure related event Choose from: (Unanswered;Yes ; No)	

Post-op / Followup

How was follow-up carried out Choose from: (Unanswered;Outpatient visit;Postal questionnaire;Online)	
What is the follow-up interval Choose from: (Unanswered;6 Weeks;3 Months;6 Months;12 Months)	
Global Impression of Outcome for Incontinence Choose from: (0-Unanswered;1-Greatly worse;2-Moderately worse;3-Slightly worse;4-No change;5-Slightly improved;6-Moderately improved;7-Greatly improved)	
Global Impression of Outcome for Prolapse Choose from: (0-Unanswered;1-Greatly worse;2-Moderately worse;3-Slightly worse;4-No change;5-Slightly improved;6-Moderately improved;7-Greatly improved;n/a)	

Post-surgery Quality of Life

ICIQ-UI Score (0-21)	
ICIQ-VS Score (0-53)	
ICIQ-SM Score (0-58)	
Other Quality of Life scores	

This data is Private and Confidential and should be used in accordance with the Calldicott Guidelines.

Pop-Q Assessment

Aa Not Done or -10cm - +10cm		**Ba** Not Done or -10cm - +10cm		**C** Not Done or -10cm - +10cm		**Anterior vaginal Wall (a).** N/A or 0, I, II ,III , IV	
Gh Not Done or -10cm - +10cm		**Pb** Not Done or -10cm - +10cm		**tvi** Not Done or -10cm - +10cm		**Posterior vaginal Wall (a).** N/A or 0, I, II ,III , IV	
Ap Not Done or -10cm - +10cm		**Bp** Not Done or -10cm - +10cm		**D** Not Done or -10cm - +10cm		**Cervix (cx).** N/A or 0, I, II ,III , IV	
						Cuff (c). N/A or 0, I, II ,III , IV	

Post-op / Followup

Graft problems Choose from: (Unanswered;None;Erosion;Extrusion;Defective healing;Infection)	
Change in stress urinary incontinence (i.e. leakage with activity) Choose from: (Unanswered;Worse;No change;Improved;Cured;Not present)	
Urinary urge incontinence : Choose from: (Unanswered;Worse;No change;Improved;Cured;Not present;New symptom)	
Does patient require catheters Choose from: (Unanswered;No;Yes)	
If Yes, were they required pre-op Choose from: (Unanswered;No;Yes)	

Notes:

This data is Private and Confidential and should be used in accordance with the Calldicott Guidelines.

Appendix A – Surgery Types

- Unanswered
- None
- Anterior repair (AR) + BNB
- Artificial Urinary Sphincter
- Cystoscopic BNI-Macroplastique
- Cystoscopic BNI- Collagen
- Cystoscopic BNI-Tegress
- Cystoscopic BNI-Other
- Periurethral BNI
- Non-Cystoscopic BNI-Zuidex
- Non-Cystoscopic BNI-Durasphere
- Non-Cystoscopic BNI-MIS
- Non-Cystoscopic BNI-Other
- Colposuspension-Open
- Colposuspension-Laparoscopic
- Combined A/V Sling (Aldridge)
- MMK
- Stamey Procedure
- Retropubic MUS-TVT
- Retropubic MUS-Sparc
- Retropubic MUS-IVS
- Retropubic MUS-Uretex
- Retropubic MUS-Safyre
- Retropubic MUS-Advantage
- Retropubic MUS-Pelvilace
- Retropubic MUS-Other
- TVT-Obturator
- TOT-Monarc
- TOT-Aris
- TOT-Uretex TO
- TOT-Pelvilace TO
- TOT-Safyre-t
- TOT-Other
- TVT-Secur
- Laparoscopic Urethropexy
- Cystoscopic Botox Injection
- Urethral Diverticulectomy
- Vaginal closure fistula
- Abdominal Closure fistula
- Insertion Suprapubic Catheter
- Anterior repair (AR)
- AR+graft
- Manchester Repair
- Vaginal Hysterectomy
- Vaginal Hysterectomy+AR
- LAVH
- LAVH+BSO
- Transobturator AR (TOAR)-Perigee
- TOAR-Prolift
- TOAR-Avaulta
- TOAR-Other
- Posterior Repair (PR)
- PR + graft
- PR+Perineorrhaphy
- PR+Perineorrhaphy+Graft
- Recto-enterocoele repair
- Recto-enterocoele repair+graft
- Ischiorectal Mesh Posterior Repair (IMPR)-Apogee
- IMPR-Prolift
- IMPR-Avaulta
- IMPR-Other
- Posterior IVS
- Total Vaginal Mesh (TVM)- Prolift
- TVM-Apogee+Perigee
- TVM-Avaulta
- TVM-Other
- Paravaginal Repair-Vaginal
- Paravaginal Repair-Abdominal
- Paravaginal Repair-Laparoscopic
- Sacrocolpopexy-Open
- Sacrocolpopexy-Laparoscopic
- Sacrospinous Fixation
- Sacrospinous Hysteropexy
- Iliococcygeal fixation
- Sacrocolpohysteropexy-Open
- Sacrocolpohysteropexy-Laparoscopic
- Sacrocolpocervicopexy-Open
- Sacrocolpocervicopexy-Laparoscopic
- Laparoscopic Suture Hysteropexy
- Laparoscopic Uterosacral Plication
- Moscowitz
- Halban
- Colpoclesis
- Colpectomy
- Cystoscopy
- Insertion of S/P Catheter
- Laparoscopy
- Hysteroscopy/D+C
- Endometrial ablation
- Endometrial resection
- TAH
- TAH+USO
- TAH+BSO
- Subtotal TAH
- Subtotal AH+USO
- Subtotal AH +BSO
- Unilateral salpingo-oophorectomy
- Bilateral salpingo-oophorectomy
- Ovarian Cystectomy
- Therapeutic L'scopy-endometriosis
- Therapeutic Laparoscopy-Other
- Laparoscopic TAH
- Laparoscopic TAH+BSO
- Myomectomy
- Fenton's Procedure

This data is Private and Confidential and should be used in accordance with the Calldicott Guidelines.

23678

Dr AGUR

CONSULTANT GYNAECOLOGIST

WAITING LIST SHEET CLINIC DATED 1099

Place sticker

CHI 3010776241
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ
30/10/1977 Pract 80306
Case Ref 466693

Procedure: Anterior Repair + Removal of skin tags +/- Posterior Repair +/- MUT (SITOT)

Patient BMI:
Day case ☐ In-patient ☐
Date on w/l Date tci

Priority:
Urgent ☐
Soon ☐
Routine ☑

S/N canc: Yes ☐ No ☐

TEL CONTACTS
Home _____
Work _____
Mobile _____

Place sticker

Name _____
Unit no _____
Address _____
_____
DOB _____

Procedure:

Patient BMI
Day case ☐ In-patient ☐
Date on w/l ☐ Date tci ☐

Priority:
Urgent ☐
Soon ☐
Routine ☐

S/N canc: Yes ☐ No ☐

TEL CONTACTS
Home _____
Work _____
Mobile _____

Place sticker

Name _____
Unit no _____
Address _____
_____
DOB _____

Procedure:

Patient BMI
Day case ☐ In-patient ☐
Date on w/l Date tci

Priority:
Urgent ☐
Soon ☐
Routine ☐

S/N canc: Yes ☐ No ☐

TEL CONTACTS
Home _____
Work _____
Mobile _____

Place sticker

Name _____
Unit no _____
Address _____
_____
DOB _____

Procedure:

Patient BMI
Day case ☐ In-patient ☐
Date on w/l Date tci

Priority:
Urgent ☐
Soon ☐
Routine ☐

S/N canc: Yes ☐ No ☐

TEL CONTACTS
Home _____
Work _____

		Mobile _____

NHS Ayrshire & Arran

Risk Screening Questionnaire For TSE, CJD and vCJD

XHI466693
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ 30/10/1977
Dr. J NELSON
BOURTREEHILL HEALTH CENTRE,
CHEVIOT WAY,
CHI 3010776241

Planned Procedure:

Question	Yes	No
Assess Tissue Risk for all Patients		
1. Does Procedure involve High or Medium risk tissue? If yes what tissue?		✓
Before asking the following questions, please check case notes and referral letter for all patients.		
2. Is there any mention of CJD status? If yes, please specify.		✓
3. Does the patient display any signs of an undiagnosed neurological illness involving cognitive behaviour or ataxia? *(If telephone assessment, please complete this on admission)* If yes, please specify.		✓
Ask all patients the following question		
4. Have you ever been notified that you are at risk of CJD for public health purposes? If yes, please detail.		✓
Proceed with following questions only if the patient answers if their procedure involves contact with HIGH RISK tissue.		
5. Is there any history of CJD or other Prion disease in your family? If yes, please specify.		
6. Have you ever received growth hormone or gonadotrophin treatment from human pituitary glands? What year? _____ What country? _____		
7. Have you had brain or spinal cord surgery prior to 1992? If yes, please detail.		

If **YES to any** of Q2 -7 above, consider Patient Risk as High Risk.
If **No to all** questions consider patient Low Risk.

Patient Risk (Q2-7)	Tissue Risk (Q1)		
	Low	**Medium**	**High**
Low	No Restrictions	No Restrictions	No Restrictions
High	No Restrictions	Single use instruments or Quarantine until advice sought from Infection Control	Single use instruments or Quarantine until advice sought from Infection Control

Name	S MILLAR.	Designation	SIN
Signature	S. Mill	Date	3/11/09

Risk Screening Guidance Notes for TSE, CJD and vCJD

The vCJD questionnaire is to be used for all patients undergoing surgical or endoscopic procedures.

Table 1:- Examples of tissues with high medium level infectivity

High	Medium
Brain Spinal cord Dura mater Cranial Nerves (specifically the entire optic nerve; only the intracranial components of the other cranial nerves) Cranial nerve ganglia Posterior eye Pituitary gland	Spinal ganglia Anterior eye and cornea Olfactory epithelium Tonsil Appendix Spleen Thymus Other lymphoid tissue

Table 2:- Human TSE Diseases

Idiopathic Diseases	Sporadic CJD Sporadic Fatal Insomnia
Familial Diseases	Familial CJD, Gerstmann-Sträussler-Scheinker (GSS) Disease and Fatal Familial Insomnia
Acquired Diseases	Human agents: Kuru and iatrogenic CJD Bovine agent: Variant CJD

Notes for questions 4 - 7 *(Taken from Infection Control Guidance on Human Transmissible Spongiform Encephalopathy (TSE) including Creutzfeldt-Jacob Disease (CJD) and variant Creutzfeldt-Jacob Disease (vCJD) Issue 2 April 2007)*

	Question to Patient	Note to clinician
4	Have you ever been notified that you are at risk of CJD for public health purposes? If yes please specify	The CJD Incidents Panel has identified a number of individuals who are potentially at risk of CJD or vCJD for Public Health Purposes. If patient answers **NO**, surgery / endoscopy can proceed using normal infection control procedures unless the procedure is likely to lead to contact with **high risk** tissue. If patient answers **YES**, special infection control precautions should be taken. Contact infection control for further advice. If the patient is **unable to respond**, surgery / endoscopy can proceed using normal infection control procedures unless the procedure is likely to lead to contact with **high risk** tissue.
5	Have you any history of CJD or other prion disease in your family? If yes please specify	Patient should be considered to be at risk from familial forms of CJD linked to genetic mutations if they have had: 1. Genetic testing, which has indicated that they are at significant risk of developing CJD or other prion disease; 2. A blood relative known to have a genetic mutation indicative of familial CJD 3. 2 or more blood relatives affected by CJD or other prion disease
6	Have you ever received growth hormone or gonadotrophin treatment? If yes please specify:- i) whether the hormone was derived from human pituitary glands ii) the year of treatment iii) whether the treatment was received in the UK or in another country	Recipients of hormone derived from human pituitary glands, e.g. growth hormone or gonadotrophin, have been identified as at risk of CJD. In the UK, the use of human derived growth hormone was discontinued in 1985 but human derived products may have continued to be used in other countries. In the UK, the use of human derived gonadotrophin was discontinued in 1973 bur may have continued in other countries after this time.
7	Have you ever had surgery on your brain or spinal cord before August 1992?	People who underwent neurosurgical procedures or operations for a tumour or cyst of the spine before August 1992 may have received a graft of dura mater, and should be treated as at risk, unless evidence can be provided that dura mater was not used.

Patients response	Action
No to questions 5-7	Surgery / endoscopy can proceed using normal infection control procedures.
Yes to questions 5-7	Further investigation into the nature of the patient's CJD risk should be undertaken by medical staff. The patient's CJD risk should be confirmed or rejected. Confirmation or rejection of CJD risk should be recorded in the patient's medical notes for future reference. If the patient is found to be at risk of CJD of vCJD following investigation, or the risk status is unknown at the time of the procedure, special infection control precautions should be taken. Contact infection control team for advice. If the patient is found to be at risk of CJD or vCJD they should be referred to their GP, who will need to inform them that they are at risk of CJD or vCJD and provide them with further information and advice. This is available from the CJD Incidents Panel: http://www.hpa.org.uk/infections/topics_az/cjd/information_documents.htm
Unable to respond to questions 5-7	A family member, someone close to the patient or in the case of a child, someone with parental responsibility should be asked the CJD questions prior to surgery / endoscopy. If the family member or someone close to the patient is not able to provide a definitive answer to the CJD risk questions, the surgery / endoscopy should proceed but ALL INSTRUMENTS SHOULD BE QUARANTINED FOLLOWING THE PROCEDURE. The patient's GP should be contacted after the surgery / endoscopy, and enquiries made as to whether the patients is at risk of CJD / vCJD according to the CJD questions. If the GP is uncertain about any of the questions the instruments should be kept in quarantine. Contact infection control team for further advice.

British Society of Urogynaecology

CHI 3010776241
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ
30/10/1977 Pract 80306
Case Ref 466693

PATIENT INFORMATION ON THE BRISTISH SOCIETY OF UROGYNAECOLOGY DATABASE

Dear patient,

You have been listed for an operation as treatment of urinary incontinence and / or vaginal prolapse. We would like your permission to collect some important information about you and your operation to ensure that we continue to provide the best surgical procedures possible. We emphasise that all information drawn from this will be anonymous so that nobody apart from your Consultant team will have any identifying information about you.

The British Society of Urogynaecology (BSUG) is our national group of gynaecologists with a special interest and expertise in the treatment of incontinence and prolapse. We have agreed that we should try and audit our operation results to ensure that the procedures we perform are as safe and effective as possible. To do this we need to keep a national web-based database where we can record information about your condition, your operation and the overall outcome of your procedure. This information will be collected by the medical team looking after you and they will ask you to complete further questionnaires for the database a few months after your procedure.

It is important that we attempt to audit the outcome of treatments we provide so that we can ensure that women get the best care possible. Once again we emphasise that no identifying information about you can be seen except by your own Consultant and their medical team.

If you agree to let us enter information about your condition, procedure and outcome on the BSUG database please sign overleaf. You have the right to decline participation and to withdraw your consent at any stage with no impact on the care provided.

Further information can be found at www.bsug.net.

Please sign overleaf

If you AGREE, please sign here:

I agree to my personal (limited to name, hospital number and DOB), clinical and surgical data being placed on the BSUG national computer database for audit purposes. I am aware that any data used in presentations or reports will be anonymous so that it will not be possible to identify me.

Caroline Morris 10/9/09 C Morris

Name of Patient Date Signature

Wael Agha 10.9.9

Name of person taking consent Date Signature

If you DO NOT AGREE, please sign here:

I DO NOT agree to my personal, clinical and surgical data being placed on the BSUG national computer database for audit purposes.

Name of Patient Date Signature

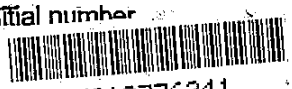
Name of person taking consent Date Signature

ICIQ-UI Short Form

Initial number

CONFIDENTIAL

DAY MONTH YEAR
Today's date 9



CHI 3010776241
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1HJ
30/10/1977 Pract 80306
1 Case Ref 466693

time. We are trying to find out how many people leak urine, We would be grateful if you could answer the following ive been, on average, over the PAST FOUR WEEKS.

n: 30 10 77
DAY MONTH YEAR

2 **Are you** *(tick one)*: Female ☑ Male ☐

3 **How often do you leak urine?** *(Tick one box)*

Pure Stress

- never ☐ 0
- about once a week or less often ☑ 1
- two or three times a week ☐ 2
- about once a day ☐ 3
- several times a day ☐ 4
- all the time ☐ 5

4 **We would like to know how much urine <u>you think</u> leaks.**
How much urine do you <u>usually</u> leak (whether you wear protection or not)?
(Tick one box)

- none ☐ 0
- a small amount ☑ 2
- a moderate amount ☐ 4
- a large amount ☐ 6

5 **Overall, how much does leaking urine interfere with your everyday life?**
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 (8) 9 **10**
not at all — a great deal

ICIQ score: sum scores 3+4+5 ☐☐

6 **When does urine leak?** *(Please tick all that apply to you)*

- never – urine does not leak ☐
- leaks before you can get to the toilet ☐
- leaks when you cough or sneeze ☑
- leaks when you are asleep ☐
- leaks when you are physically active/exercising ☑
- leaks when you have finished urinating and are dressed ☐
- leaks for no obvious reason ☐
- leaks all the time ☐

Thank you very much for answering these questions.

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NHS Ayrshire & Arran

ALCOHOL SCREENING PRE-OPERATIVE ASSESSMENT FORM

WRITE OR ATTACH LABEL

XHI466693
HCR N MORRIN CAROLINE
CHI N 26 LEWIS TERR
Surnai IRVINE
Foreni KA11 1HJ 30/10/1977
Addre Dr. J NELSON
..... BOURTREEHILL HEALTH CENTRE
Date o. CHEVIOT WAY, CHI 3010776241

To be completed by pre-op assessment team with patient

Date of pre operative assessment 3 / 11 / 09.

Questions	0	1	2	3	4	
A. How often do you have a drink Containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	3
B. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 or 8	10 or more	3
C. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	0
D. How often during the last year have you failed to do what was normally expected of you because of your drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	0
E. Has a relative or friend or doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the past year		Yes during the past year	0
1. Alcohol screening score **Only record if score is 5 or above**					**Score**	6

Only continue if score is 5 or above

2. Was this discussed with patient? ☐ Yes ☐ No ☐ Don't know

3. Was patient offered referral to alcohol liaison services? ☐ Yes ☐ No ☐ Don't know

4. Did patient accept offer of referral? ☐ Yes ☐ No ☐ Don't know
If patient refused please indicate why?

a. Don't feel I have a problem ☐

b. I am already receiving treatment/help at present ☐

If patient indicates they are receiving help please use following line to give their comment on the help/support used .....

c. I don't feel this is a priority for me at present ☐

d. Yes, I drink but I don't want to change anything ☐

e. There is nothing that can be done to help me ☐

f. Other. Please specify ☐ .....

5. Was patient given a Self Help Pack? ☐ Yes ☐ No ☐ Patient refused

JMcC/71937

HCR CHI 3010776241
CHI MORRIN CAROLINE
Surn 26 LEWIS TERR
IRVINE
KA11 1HJ
Fore 30/10/1977 Pract 80306
Addi Case Ref 466693
Date of Birth

Fluid Intake and Output Chart

FAN0386

DATE 24-11-09

YESTERDAY'S BALANCE

	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8									
9									
10									
11									
12									
13									
14									
15						CRD			
16		1000	Hartmanns in theatre						
17									
18									
19									
20									
21									
22									
23									
24									
1									
2									
3									
4									
5									
6									
7									
TOTAL						(a)	(b)	(c)	(d)

JMcC/740

INTAKE =	ml	(e) Insensible loss* = OUTPUT = (a + b + c + d)	ml
BALANCE = (Intake minus output)	ml		

* Average Adult = 600 ml + 100 ml per each 0.5°C temperature elevation.

Write or attach label
HCR No: .....
CHI No: .....
Surname: .....
Forename: .....Sex: .....
Address:.....
.....
Date of Birth.....

Fluid Intake and Output Chart

FAN0386

DATE						YESTERDAY'S BALANCE			
	INTAKE (ml)					OUTPUT (ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
1									
2									
3									
4									
5									
6									
7									
TOTAL						(a)	(b)	(c)	(d)

INTAKE =	ml	(e) Insensible loss* = **OUTPUT =** (a + b + c + d)	ml

BALANCE = (Intake minus output)	ml

* Average Adult = 600 ml + 100 ml per each 0.5°C temperature elevation.

NHS Ayrshire & Arran

Patient Profile

WRITE IMPRINT OR ATTACH LABEL

Surn:
Forei: CHI 3010776241
MORRIN CAROLINE
Addr: 26 LEWIS TERR
IRVINE
KA11 1EZ
30/10/1977 Pract 80306
Ward: Case Ref 466693

male

Date of Admission 23/12/04 Time 1030 hr
Type of Admission Emergency / Elective
From where A&E.
Age 30y/o Religion ———
Marital Status Separated.

Next of Kin
Aware of Admission YES ☑ NO ☐
Name Kathleen Docherty
Relationship mum
Address 29 Mull Cres
Broomlands.
Contact No. 221582 (01294)
Alternative Next of Kin Name Alan McGinlay
Relationship Boyfriend
Address
Contact No.
GP Dr Nelson Bourtreehill Consultant

SUMMARY OF PRESENTING CONDITION

PV bleeding for 4 wks.

PREVIOUS HEALTH PROBLEMS

appendicectomy 15 yrs ago. (Southern General)
laparoscopy 10 yrs ago. (pantefract / General)

backache - 4 wks.

MEDICATION USED AT HOME

DRUG	DOSAGE
voltarol	prn
cocodamol	prn

ALLERGIES NKA

Stored in ward YES ☐ NO ☐ Date Sign
Returned to patient ☐ Relative ☐

RECORD OF INVESTIGATIONS PROCEDURES AND SURGERY

Date	Procedure/Surgery	Patient aware of result

JMcC/62512

S

ADMISSION ASSESSMENT

Home circumstances

Living alone YES ☐ NO ☑ identify carer(s) lives with sister.

Type of house m. of terrace.

Stairs at entrance YES ☐ NO ☑ How many?

Toilet upstairs YES ☑ NO ☐

Bedroom upstairs YES ☑ NO ☐

COMMUNITY SERVICES

Home help	YES ☐	NO ☑	District Nurse	YES ☐	NO ☐
Meals on Wheels	YES ☐	NO ☑	Day Hospital	YES ☐	NO ☑
Sheltered house	YES ☐	NO ☐	Nursing Home	YES ☐	NO ☑
Visited by Specialist Nurse	YES ☐	NO ☑			

Which services informed of admission

DISCHARGE

Will personal transport be available for discharge YES ☑ NO ☐

Predicted discharge Complicated ☐ Uncomplicated ☐

PATIENTS PROPERTY

Property retained by patient:

I understand articles/valuables retained by me are my own responsibility.

Signature of patient or next of kin X CMorrin. Date:

Property handed over for safe keeping:

Date taken to safe: Cash and valuables Ref. No. Date Returned:

OBSERVATION ON ADMISSION

Temperature	Pulse	BP	Respiration	O2 Saturation	Colour	LMP	BHCG	Glucostix
37.9	88	142/73	19	100		bled constantly for 4wks.	-ve beta	-ve

URINALYSIS +++ leucocytes ++ blood, ++ protein. Midstream Urine sent for C+S YES ☑ NO ☐ Date 23/12/05.

Methicillen resistant staphyloccus aureus YES ☑ NO ☐ Date Result

Swabs sent. 23/12/05

Print Name	IN	Grade	Signature	Print Name	IN	Grade	Signature
LMcKeon	LM	S/N	Lesley McKeon				

IN - Initials DES - Designation SN - Staff Nurse EN - Enrolled Nurse STN - Student Nurse

CHI 3010776241
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1EZ
30/10/1977 Pract 80306
Case Ref 466693

NHS Ayrshire & Arran
Women & Children's Services
ACTIVITIES OF LIVING

		PROBLEMS / NEEDS
1. MAINTAINING A SAFE ENVIRONMENT		
Orientate to time and place	Yes ☐ No ☐	3 alert &
Skin intact	Yes ☐ No ☑	orientated
Waterlow Assessment Score		

		PROBLEMS / NEEDS
2. BREATHING		
Smoker	Yes ☐ No ☑	
Number per day		

		PROBLEMS / NEEDS
3. CONTROLLING BODY TEMPERATURE		
Apyrexial on admission	Yes ☐ No ☐	T37.4

		PROBLEMS / NEEDS
4. EATING & DRINKING		
Special diet	Yes ☐ No ☑	normal diet
Type of diet		
Refer to dietitian	Yes ☐ No ☐	
Nutrition score		
Wears dentures:	Top ☐ Bottom ☐ Partial ☐	own teeth

		PROBLEMS / NEEDS
5. ELIMINATING		
Normal bowel activity	Yes ☐ No ☐	no problems
Incontinent	Bladder ☐ Bowel ☐	

		PROBLEMS / NEEDS
6. COMMUNICATING		
Glasses	Yes ☐ No ☑	
Contact lenses	Yes ☐ No ☑	
Hearing aid	Yes ☐ No ☑	
Speech difficulty	Yes ☐ No ☑	

DRS5002

		PROBLEMS / NEEDS
7. MOBILISING Independent Moving & Handling Assessment	Yes ☑ No ☐ Yes ☐ No ☐	Independant.

		PROBLEMS / NEEDS
8. PERSONAL CLEANSING & DRESSING Independent Assistance with	Yes ☐ No ☐	Independant.

		PROBLEMS / NEEDS
9. WORKING & RECREATION Occupation Alcohol units per week Drugs	Yes ☐ No ☐	carer. - home help. Social drinker.

		PROBLEMS / NEEDS
10. SLEEPING Sleeping problems Night sedation	Yes ☐ No ☐ Yes ☐ No ☐	usually sleeps well.

		PROBLEMS / NEEDS
11. EXPRESSING SEXUALITY Possible altered image	Yes ☐ No ☐	

		PROBLEMS / NEEDS
12. EMOTIONAL PROBLEMS/NEEDS/DYING History of depression History of anxiety Information Restriction Specific Concerns	Yes ☐ No ☑ Yes ☐ No ☑ Yes ☐ No ☐	

Comments:

SIGNATURE OF NURSE ..... DATE 23/2/07

DESIGNATION S/N

NHS Ayrshire & Arran

Surnar
Forena CHI 3010776241
MORRIN CAROLINE
Addres 26 LEWIS TERR
IRVINE
KA11 1EZ
30/10/1977 Pract 80306
Ward or Case Ref 466693

MRSA Admission Screening

ASSESSMENT FORM

1. Has patient been a hospital in-patient in the preceding 12 months? YES / (NO)

2. Has patient been transferred from another hospital? YES / (NO)

3. Is patient resident in a Nursing Home? YES / (NO)

Is a carer / home help. ✓

If the answer to any of the above questions is YES *please send a nasal swab to Lab requesting "MRSA Screen".*

4. Has patient been previously positive for MRSA (eg check case notes for "Clinical Alert") YES / (NO)

If patient has been previously positive for MRSA *please send a full "MRSA Screen" to Lab.*

For information on screen samples please see overleaf

Signature of Admitting Nurse L McLean

Screen sent ☑ Date 23/12/07

- Is patient screen result **positive / negative** Date.....
- If positive identify site ☐ and where appropriate, commence MRSA core care plan.

Signature of nurse.....

ALL PATIENTS admitted to ICU and Orthopaedics, Oncology, Vascular and Renal wards must be routinely screened for MRSA on admission.

Thank you for your co-operation

MRSA SCREENING (Full Screen)

Please send swabs from the following areas:

Left and right nostrils (use same swab for both nostrils)

Throat

Perineum

Any skin lesion (if present)

CSU (if patient has a urinary catheter)

Sputum (if expectorating)

Method

- Use Dry Sterile Swabs (Blue Topped Swabs).
- Ensure swabs are correctly identified.
- Dip the swab into sterile normal saline before swabbing the area.
- When doing the nostrils place moist swab firmly against the anterior nares and rotate the swab at least 5 times in each nostril, maintaining firm contact with the mucosal surface - use the same swab for both nostrils.
- When swabbing skin areas use reasonable friction.

Complete a multiple request form and request "MRSA Screen".

ALL MRSA screening samples from individual patients can be put on one multiple form.

GOOD HAND HYGIENE WILL HELP PREVENT THE SPREAD OF MRSA

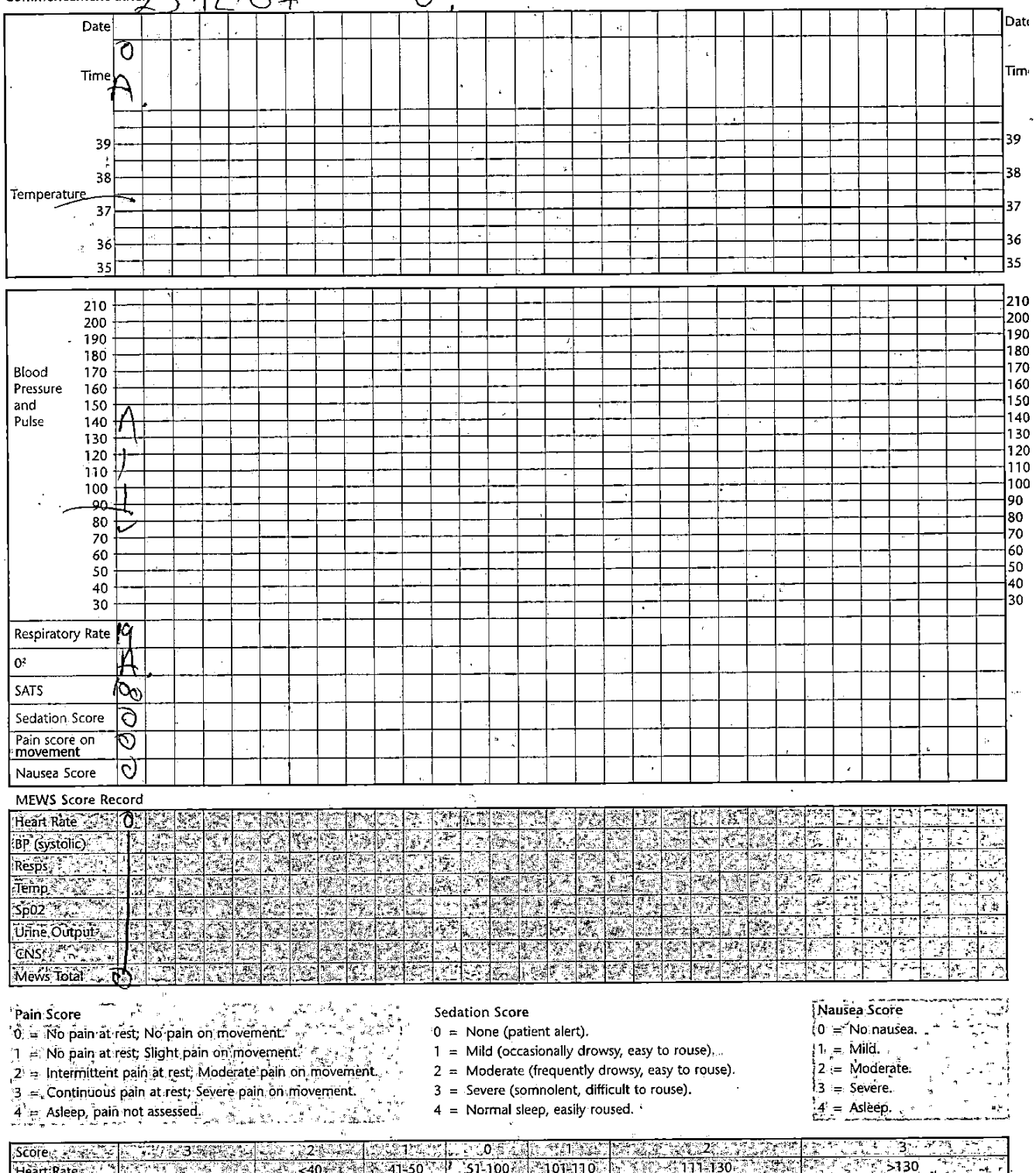
NHS Ayrshire & Arran

TPR, BP, Pain, Sedation, Nausea & Mews Chart

If MEWS Discontinued, record reason in medical notes

Surname. ....
Forename ....
CHI 3010776241
MORRIN CAROLINE
26 LEWIS TERR
Address .. IRVINE
KA11 1EZ
30/10/1977 Pract 80306
Case Ref 466693
Ward or Department .....

Commencement date: 23/12/07 Ward: 6 MEWS Discounted Date: DR:



MEWS Score Record

Heart Rate	0
BP (systolic)	1
Resps	1
Temp	0
Sp02	0
Urine Output	0
CNS	0
Mews Total	2

Pain Score
0 = No pain at rest; No pain on movement.
1 = No pain at rest; Slight pain on movement.
2 = Intermittent pain at rest; Moderate pain on movement.
3 = Continuous pain at rest; Severe pain on movement.
4 = Asleep, pain not assessed.

Sedation Score
0 = None (patient alert).
1 = Mild (occasionally drowsy, easy to rouse).
2 = Moderate (frequently drowsy, easy to rouse).
3 = Severe (somnolent, difficult to rouse).
4 = Normal sleep, easily roused.

Nausea Score
0 = No nausea.
1 = Mild.
2 = Moderate.
3 = Severe.
4 = Asleep.

Score	3	2	1	0	1	2	3
Heart Rate		<40	41-50	51-100	101-110	111-130	>130
BP (systolic)	<70	71-80	81-100	101-179	180-199	>200	
Resps		<8		8-20	21-25	26-30	>30
Temp		<35		35.1-37.9		>38	
Sp02	<80	<90 on oxygen	<90 on air				
Urine Output	<80ml in 4hr (Cath)						<150ml in 6hr (Non Cath)
CNS	Unresp	Pain	Verbal	Alert		New Agitated / Confused	

MODIFIED EARLY WARNING SCORE (MEWS) OBSERVATION CHART

Patient Addressograph	Consultant: Patient's Weight:

A MEWS Score must be calculated everytime a patient observations are recorded unless the patient is receiving palliative care only. If MEWS Score 4 or more then call the appropriate doctor / nurse using the guideline below. Increased frequency of observations (minimum hourly) should be commenced and a note of action taken by the nurse should be documented in the MEWS action sheet. A detailed report in the medical notes using the MEWS Assessment Casenote Record should be completed by the first responder.

MEWS 4 or More or concern with condition

CALL FY1 OR HOSPITAL AT NIGHT TEAM

Dr unable to attend within 30 minutes or MEWS increased by 2

MEWS 6 or More or rapid deterioration

Call appropriate SHO or HAN TEAM

Dr unable to attend within 20 minutes or MEWS increased by 2

Discuss with Consultant - refer to HDU / ITU

HOW TO CALCULATE MEWS SCORE

- Do Not and Pain Score to MEWS Score.
- All MEWS Scores must be completed by suitably trained nursing staff.
- Completed ALL vital signs and record MEWS score in highlighted area.

MEDICAL / HaN GUIDELINES

If RR>25	Review patient / CXR +/- ABGS / PEF - Definitive Therapy
If SpO2<80	Ensure accuracy Review patient - prescribe oxygen / ABGs
If Sys BP<100	Review monitoring *(cardiac / oximetry / urine output etc)* IV access Review patient / drug cardex
Consider	IV fluid bolus - reassess TREAT UNDERLYING CAUSE
If HR>130	IV access / Review Patient - *Consider ECG / U&E's*
If unresponsive	Assess airway / BM / GCS

PAIN ASSESSMENT & MANAGEMENT GUIDELINES

How to score pain: Score current pain on movement.

0 NONE	- Continue to assess pain with every set of observations (At least daily)
1 MILD	- Prescribe simple analgesia at regular intervals. Score pre / post administration of analgesia.
2 MODERATE	- Consider adding weak opiod PRN. Assess score 4 hourly.
3 SEVERE	- Add strong opiod and refer to APN. Assess score 2-4 hourly.

PERSISTENT PAIN - REFER TO ACUTE PAIN TEAM OR ON CALL ANAESTHETIST OUT OF HOURS

NAUSEA SCORE

1 MILD - Consider anti-emetic

2 MOD - Administer anti-emetic

3 SEVERE - Consider Doctor

SEDATION SCORE

1 MILD - Record 4 hourly

2 MOD - Assess GCS / Use of sedatives

3 SEVERE - Withheld sedatives and contact Doctor

NHS Ayrshire & Arran
Drug and Therapeutics Committee

Adult Peripheral Intravenous Cannula Recording Sheet and Flush Recording Sheet

Policy Statement - All patients with peripherally inserted intravascular access device must have the access site checked at least daily for signs of infection/phlebitis and score charted. If IV site score 1 frequency of site inspection should increase to 4 hourly. Cannula site will be inspected when bolus injections are administered, IV infusion flow rates altered and when IV infusion bags are changed. Cannulas should be flushed as per Patient Group Direction Number AAAHT/PGD2.

NB All peripheral IV cannula should be resited every 72 hours. Refer to Infection Control manual for further information.
HEPARIN NOT TO BE USED ROUTINELY. IF USED, MUST BE PRESCRIBED ON MEDICINE ADMINISTRATION CHART

	VISUAL INSPECTION SCORE	ACTION
IV site appears healthy	0 (No signs of phlebitis)	OBSERVE CANNULA
One of the following is evident • Slight pain near IV site or • Slight Redness near IV site	1 (Possibly first signs of phlebitis)	INCREASE FREQUENCY OF CANNULA OBSERVATION
o Pain at the IV site o Erythema o Swelling o Induration o Pyrexia	2	REMOVE CANNULA CONSIDER TREATMENT RESITE CANNULA IF REQUIRED

RECORD OF CANNULA INSERTION

CANNULA CODE	CANNULA SIZE / COLOUR	CANNULA LOCATION	DATE INSERTED	DATE DUE REMOVED	COMMENTS
A	Green	(L) arm	23/12/04		
B					
C					
D					
E					
F					

JMcC/63864

STA4220/9

Written by: Ronald Preston, Lecturer Practitioner Approved by: AAAHTDTC 28 February 2002 **Review Date: March 2004**

NHS Ayrshire & Arran
Drug and Therapeutics Committee

Adult Peripheral Intravenous Cannula Recording Sheet and Flush Recording Sheet

WRITE, IMPRINT OR ATTACH LABEL
Surname ..... Hosp. No .....
Forenames ..... Sex .....
Address ..... DoB .....
.....
Ward or Dept. .....

Enter cannula code and visual inspection score and volume of flush for each cannula in the box and initial after sodium chloride 0.9% flush has been administered. The volume of the flush should be recorded on fluid balance sheet if appropriate.

08.00			Int			Int			Int			Int			Int			Int			Int
10.00			Int			Int			Int			Int			Int			Int			Int
12.00			Int			Int			Int			Int			Int			Int			Int
14.00			Int			Int			Int			Int			Int			Int			Int
18.00			Int			Int			Int			Int			Int			Int			Int
22.00			Int			Int			Int			Int			Int			Int			Int
00.00			Int			Int			Int			Int			Int			Int			Int
Other Times			Int			Int			Int			Int			Int			Int			Int
			Int			Int			Int			Int			Int			Int			Int

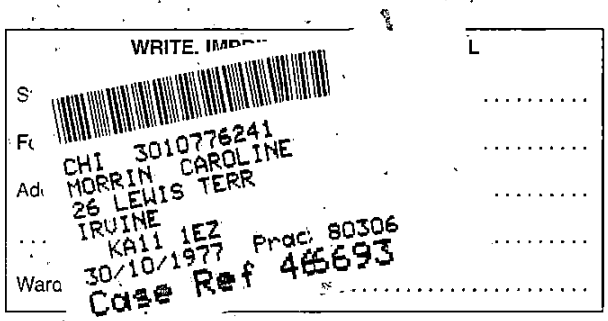
KEY: use the letter R to denote that the patient has refused to have their cannula flushed.

NUTRITION RISK SCORE

To be completed ***within the first 24 hours*** of admission

Please circle the relevant score from each section (only select **ONE** score from each section)

Select the highest score that applies.



Ward: 6

Date of Admission: 23/12/07

Height: 5'7" **Weight:** 112 kg **BMI:** 38

Weight (kg)
BMI = Height ²(m)
(or refer to BMI chart)

WEIGHT LOSS (in last 3 months)	**0** No weight loss	**1** 0-3 kg Weight loss	**2** >3-6 kg Weight loss	**3** >6 kg Weight loss
B.M.I.	**0** >20	**1** 18 or 19	**2** 15 - 17	**3** <15
APPETITE	**0** Good appetite - manages most of 3 meals / day		**2** Poor appetite. Poor intake - leaving >½ meals	**3** Appetite nil or virtually nil. Unable to eat NBM (no food for >4 meals)
ABILITY TO EAT / RETAIN FOOD	**0** No difficulties eating. Independent No diarrhoea or vomiting.	**1** Problems feeding (needs aides). Regurgitation / vomiting / mild diarrhoea.	**2** Swallowing difficulties chewing / denture problems. Slow to feed. Moderate V+/ or D. Needs help with feeding.	**3** Unable to take food orally. Complete Dysphagia. Severe vomiting +/or diarrhoea.
STRESS	**0** No stress factor.	**1** **MILD** Minor surgery. Minor infection.	**2** **MODERATE** Chronic disease. Major surgery / infection. Fractures. Pressure sores. CVA. Inflammatory bowel disease. Other GI disease.	**3** **SEVERE** Multiple injuries. Multiple fractures. Multiple deep pressure sores. Severe sepsis. Carcinoma / Malignant disease.

JMcC/63859 STA4220/4

SCORE ON ADMISSION**.....**

SCORE	0-3 LOW RISK	4-5 NEEDS MONITORING	6-15 HIGH RISK
ACTION TO BE TAKEN	• No action necessary. • Check weight weekly.	• Check weight weekly. • Encourage with eating and drinking. • Refer to Dietitians for supplements if required. • Repeat score weekly and refer to dietitian if no improvement.	• Refer to Dietitian +/or Nutrition Support Team.

ACTION TAKEN .....

.....

.....

Nurse signature .....

REPEATED ASSESSMENTS TO BE DONE <u>WEEKLY</u>

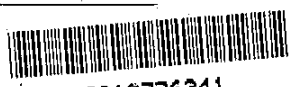
DATE	WEIGHT	BMI	SCORE	ACTION TAKEN	NURSE SIGNATURE

NHS Ayrshire & Arran

Pressure Sore Risk Assessment Tool

Waterlow Pressure Sore Risk Assessment

SCORE		
<10	Low Risk	Re-assess weekly or if condition changes
10+	At Risk	Re-assess twice weekly or if condition changes
15+	High Risk	Re-assess on alternate days
20+	Very High Risk	Assess daily



CHI 3010776241
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1EZ
30/10/1977 Pract 80306
Case Ref 466693

Waterlow Risk Assessment		Initials														
		Date														
Body weight for height		**No.**	1	2	3	4	5	6	7	8	9	10	11	12	13	14
	Avarage	0														
	Above Avarage	1														
	Obese.	2	2													
	Below Average	3														
Continence																
	Completely Catheterised	0														
	Occasionally Incontinent	1														
	Cath. Incontinence of Faeces	2	0													
	Doubly Incontinent	3														
Skin Type: Visual Risk Areas																
	Healthy	0														
	Tissue Paper/Dry	1														
	Oedematous/Clammy (temp)	1	0													
	Discoloured	2														
	Broken Spot	3														
Mobility																
	Fully	0														
	Restless/Figity	1	1													
	Apathetic	2														
	Restricted	3														
	Inert/Traction	4														
	Chairbound	5														
Age/Sex																
	Male/Female	1/2	2													
	14 - 49	1														
	50 - 64	2														
	65 - 74	3	1													
	75 - 80	4														
	80+	5														
Appetite																
	Avarage	0														
	Poor	1	0													
	NG Tubes/Fluids only	2														
	nbm - Anorexic	3														
Special Risks - Tissue Malnutrition																
	eg Terminal Cachexia	8														
	Cardiac Failure	5														
	Peripheral Vascular Disease	5														
	Anaemia	2														
	Smoking	1														
Neurological Deficit																
	eg Diabetes, MS, CVA, Motor-sensory Paralegia	4-6														
Major Surgery/Trauma																
	Orthopaedic Below waist, spinal	5														
	On table >2 hours	5														
Medication																
	Cytotoxic, Highdose Steroids	4														
	Anti-inflammatory															
		Total Score	6													

Date	Waterlow Score	Comments (eg. treatment, mattress, etc.)	Date next assessment due	Signed
(Admission)	6.	on admission.		

JMcC/63960

Reference:
Waterlow: A risk assessment card. (1985). Waterlow J. Vol 81 pp48-55

STA4220/5

Pressure Sore Site and Treatment Plan

Indicate on the diagram the site(s) of any pressure sores.

Site Codes

PM1 Occipital

PM2 Scapula

PM3 Elbows

PM4 Vertebrae

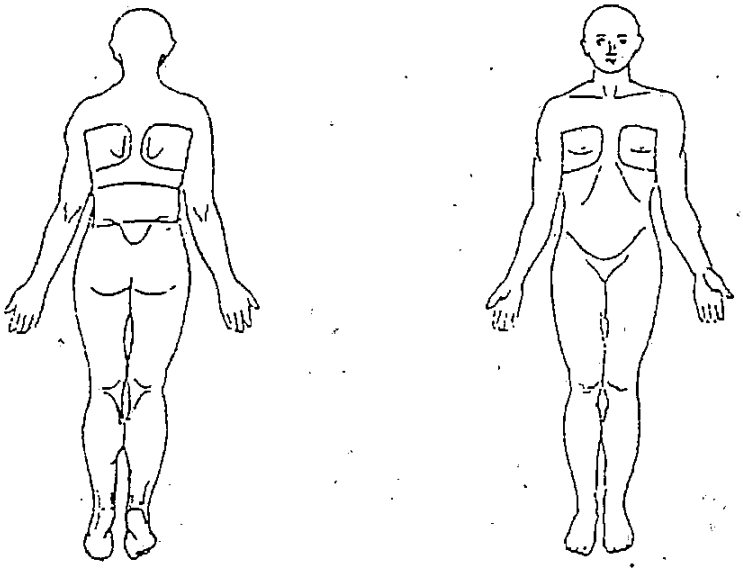
PM5 Sacrum

PM6 Buttocks

PM7 Heels

PM8 Malleoli

PM9 Other



Date	Site/Code	Stage	Treatment	Comments	Signed

Classification

Stage 0 - Blanching hyperaemia - the skin is intact but momentary finger pressure onto the site of erythema, following a prolonged period of pressure on the skin causes the skin to blanch.

Stage I - Non-blanching hyperaemia - the erythema remains when light finger pressure is applied. The area stays red more than 5 minutes after the relief of pressure indicating there is some damage to the micro-circulation.

Stage II - Partial thickness skin loss involving epidermis and/or dermis. The sore is superficial and presents clinically as an abrasion, blister or shallow crater.

Stage III - Full thickness skin loss involving damage to subcutaneous tissue that may extend down to, but not through, underlying fascia. The sore presents clinically as a deep crater with or without undermining of adjacent tissue.

Stage IV - Full thickness skin loss with extensive, tissue necrosis or damage to muscle, bone or supporting structures (eg tendon or joint capsule). Note: Undermining and sinus tracts may also be associated with Stage IV pressure sores.

NHS Ayrshire & Arran

WRITE, IMPRINT OR ATTACH

Su
For
Adc CHI 3010776241
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1EZ
Ward 30/10/1977 Pract 80306
Case Ref 466693

Moving & Handling Patient Risk Assessment

All Patients:

A hoist is for lifting patients and must not be used for transporting between rooms.
A mechanical aid **must** be used for bathing unless independently mobile.
A mechanical aid **must** be used if assistance is required from the floor.
Sliding aids should be used bed to trolley / bed (specify number of handlers)

Special Alerts: **Date:**					
Overweight / Obese (BMI definition)					
Restricted use of limbs					
Poor standing ability					
Sedation or lethargy					
Irrational behaviour / confusion					
Unable to co-operate					
Acute pain					
Recent surgery					

Additional Comments:

low risk.

Assessment of Risk:

Low Risk: Independently mobile / supervision only required. Aids required should be specified in care plan.

Moderate Risk: Requires physical assistance from one or more handlers. Is able to stand or partially bear weight and has no more than one special alert.

High Risk: a) Is unable to bear weight and requires assistance.
b) 2 or more special alerts present and requires assistance.

Aids, equipment and a minimum of 2 handlers recommended to move a patient.

Specify Level of Risk

Date:	23/12/04					
LOW RISK	✓					
MODERATE RISK						
HIGH RISK						
Assessors Initials						

If the patient is independently mobile and self caring, there is no requirement to complete the following pages

Moving and Handling Care Plan

	Date:						
1.	**Moving in bed:**						
a)	Handlers require to assist rolling in bed. *Specify number in grid.*	a)					
b)	Handlers required to insert and pull sliding sheets. *Specify number in grid.*	b)					
c)	Can sit with assistance from 1 or 2 handlers (rotation). *Specify number in grid.*	c)					
d)	Equipment required:	d)					
2.	**Sitting to Standing:**						
a)	1 handler assists from the side with oblique hold on the patient's back.	a)					
b)	2 handlers assist from the side with oblique hold on the patients back.	b)					
c)	1 Handler assists from the side and 1 from the front.	c)					
d)	Aids required:	d)					
3.	**Mobilising:**						
a)	Does not mobilise.	a)					
b)	Mobilises independently.	b)					
c)	Support required from side by 1 handler.	c)					
d)	Support from side by 2 handlers.	d)					
e)	Requires to be followed by staff member and wheelchair when mobilising.	e)					
d)	Aids required:	f)					
4.	**Transfers: (chair / wheelchair / commode / toilet /bed)**						
a)	Walking transfer with assistance of 1 handler.	a)					
b)	Walking transfer with assistance of 2 handlers.	b)					
c)	On bed rest.	c)					
d)	Assistance of 1 handler and equipment.	d)					
e)	Assistance of 2 handlers and equipment. *Specify equipment.*	e)					
5.	**Adjusting Clothing / Personal Hygiene:**						
a)	Can use support / grabrails while assistance is given with clothing.	a)					
b)	Requires support from 1 handler while another assists with clothing.	b)					
c)	Requires 2 handlers and equipment.	c)					
6.	**Repositioning in chair / wheelchair:**						
a)	Tilt and slide.	a)					
b)	One way sliding sheet. *Specify number of handlers in grid.*	b)					
c)	*Specify aids and equipment:*	c)					
Assessors Initials							

JMcC/63863

STA4220/8

Surname CHI 3010776241
MORRIN CAROLINE
26 LEWIS TERR
Forename IRVINE
KA11 1EZ Pract 80306
30/10/1977 Case Ref 466693
Address ....
Ward/Dept. ....

NURSING NOTES

23/12/07.

DATE	
	C/A this pm with 4wk history of vaginal bleeding & clots. Seen attending GP re this. dysfunctional bleed for 18months. Bloods taken in a&e. Venflon inserted. MRSA swabs taken. LM'Lea.
11p	Ward urinalysis, +++ leucocytes, protein ++ blood +++. -ve beta. MSSU obtained and sent. Awaiting review by Speciality reg. S/B SHO - hospital at night team in A&E. Medication prescribed. Pv bleeding moderate LM'Lea. with medium size clots. LM'L
12mn.	Medication as documented. LM'L
	May have diet & fluids. LM'L
24/12/07	12.15a S/B Dr Savanur, registrar. Abdominal examination and vaginal examination carried out. HVS & chlamydia swabs taken. for scan am if possible. ?? may go home after this and to attend gynae clinic depending on scan results. LM'Lea
7a	Pv loss minimal fresh. LM'L
	Seen by Dr Hunter, can go home, to have scan as outpatient. EMiller

DATE

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

Key: O ORAL | SL SUBLINGUAL | PR PER RECTUM
IM INTRAMUSCULAR | ID INTRADERMAL | PV PER VAGINA
IV INTRAVENOUS | INH INHALATION | IT INTRATHECAL
SC SUBCUTANEOUS | NEB NEBULISED

Write, Imprint c

Surname ....
Forenames ...
.....
Address: .....
.....

CHI 3010776241
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1EZ
30/10/1977 Pract 80306
Case Ref 466693
CHI Num.
PAS Num M074152

KNOWN SENSITIVITY

1.	2.

SUSPECTED ADVERSE REACTION

MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES ... ALS)

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION 6am	8am	10am	12md	2pm	6pm	8pm	10pm	12mn	OTHER		ROUTE (See Key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED DATE	INITIAL
	A 23/12/11	NORETHISTERONE	5mg		✓			✓			✓				O				
	B 23/12/11	TRANEXAMIC ACID	1g		✓			✓			✓				O				
	C																		
	D																		
	E																		
	F																		
	G																		
	H																		
	I																		
	J																		
	K																		
	L																		
	M																		
	N																		
	O																		
	P																		
	R																		
	S																		
	T																		
	V																		

JMcC/60565

STA 0235

MEDICINES TO BE GIVEN ONCE (BLOCK CAPITALS)

PHARM.	TO BE GIVEN		APPROVED NAME OF MEDICINE	DOSE	ROUTE (See Key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	DATE	TIME						

SHEET No .....

Name.....

Age .....

Consultan

Hospital ..

CHI 3010776241
MORRIN CAROLINE
26 LEWIS TERR
IRVINE
KA11 1EZ
30/10/1977 Pract 80306
Case Ref 466693

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6 a.m	8 a.m	) p.m	12 m.n	Other Administrations
23				A	
12				B	
27	Init.			m.	
24		A B			
12/	Init.	SL.			
07					
	Init.				
	Init.				
	Init.				
	Init.				
	Init.				
	Init.				

Date	6 a.m.	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

SHEET No .....

Name .....

Age .....

Consultant .....

Hospital .....

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record ~~A~~

If patient absent record ~~A~~ If medicine not available record ~~A~~

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

JMcC/60566

Date	6 a.m	8 a.m	10 a.m	12 m.d	2 p.m	6 p.m	8 p.m	10 p.m	12 m.n	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

STA 0236

T.P.R., B.P. & Pain Chart

Surnar XH 466693

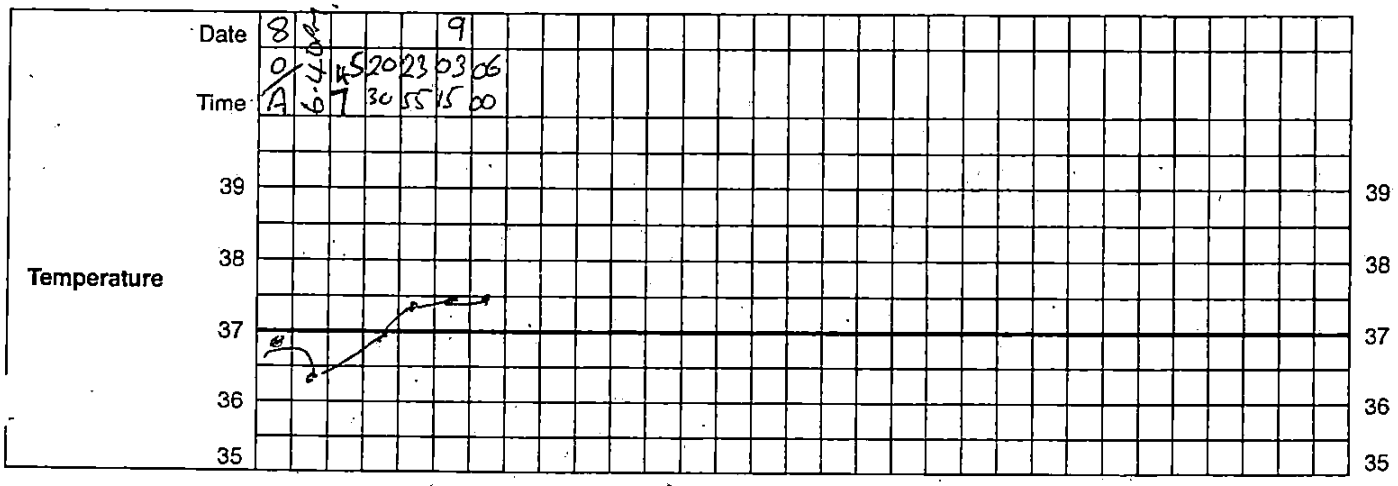
Forena HARMON CAROLINE
29(H) SLOAN AVENUE
..... IRVINE
KA12 OHR

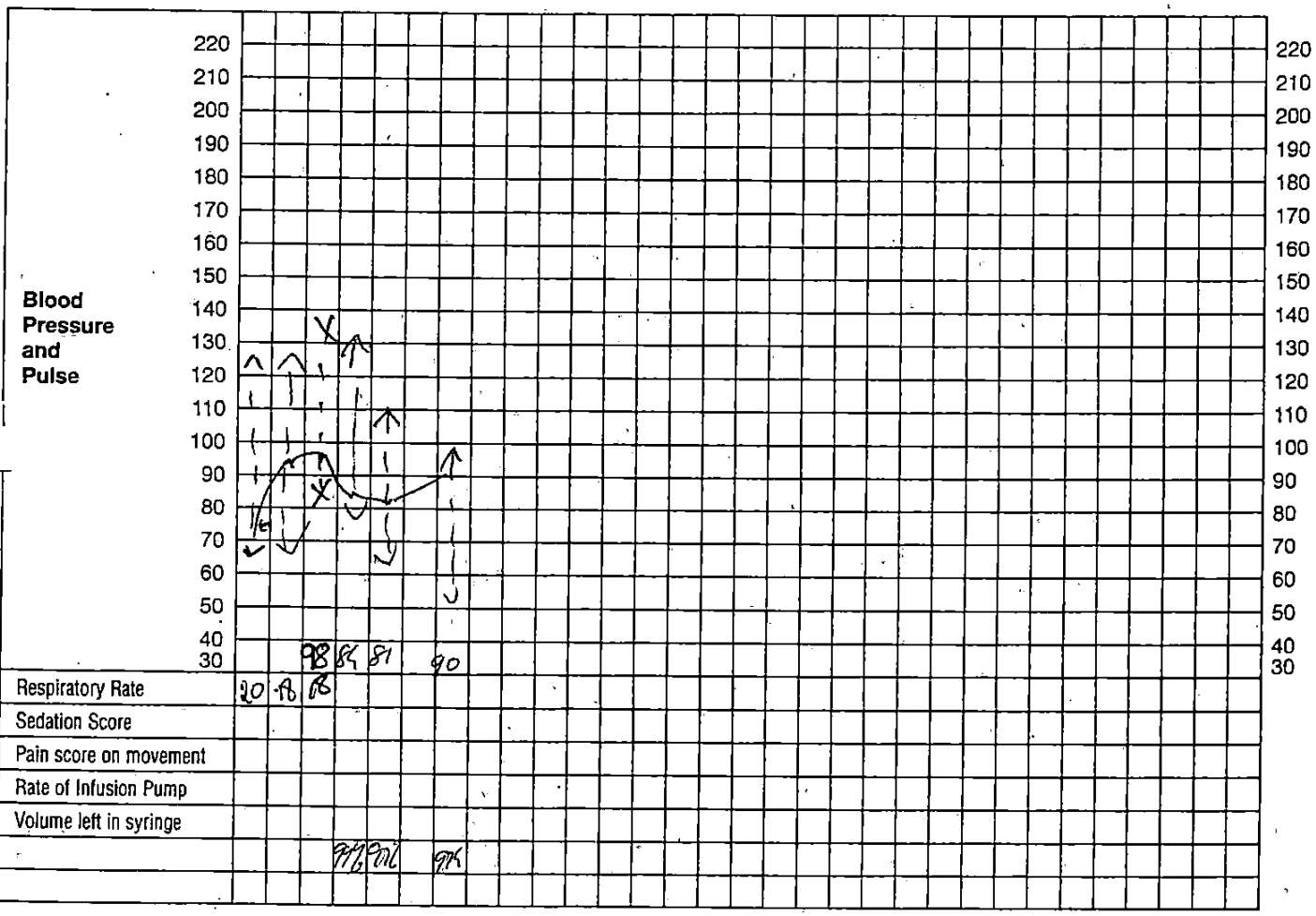
Addres 30/10/1977

..... DR.C MACDONALD
..... TOWNHEAD SURGERY

Ward/C 6/8 HIGH ST
CHI 301C773188

Commencement date: 8/10/01 Ward: Named Nurse: Consultant:





Pain Score

0 = No pain at rest; No pain on movement.
1 = No pain at rest; Slight pain on movement.
2 = Intermittent pain at rest;Moderate pain on movement.
3 = Continuous pain at rest; Severe pain on movement.
S = Asleep, pain not assessed.

Sedation Score

0 = None (patient alert).
1 = Mild (occasionally drowsy, easy to rouse).
2 = Moderate (frequently drowsy, easy to rouse).
3 = Severe (somnolent, difficult to rouse).
S = Normal sleep, easily roused.

For analgesia advice call .....Bleep.....Phone .....

Surname ..... Hosp. No. .....

Forenames ..... Sex .....

..... D.O.B. .....

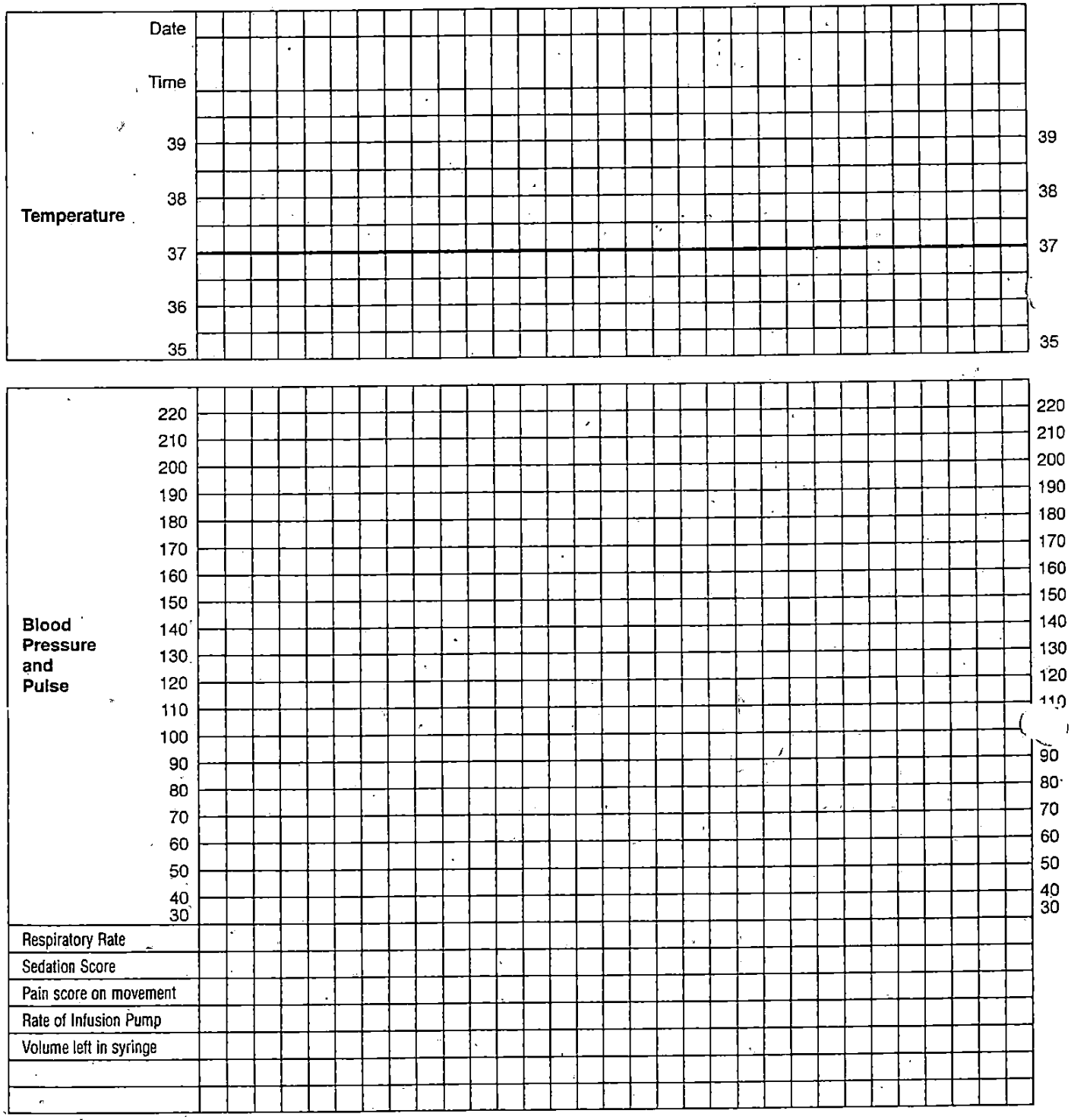
Address .....

.....

Ward/Dept. .....

T.P.R., B.P. & Pain Chart

Commencement date: / / Ward: Named Nurse: Consultant:



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2 = Moderate (frequently drowsy, easy to rouse).
3 = Severe (somnolent, difficult to rouse).
S = Normal sleep, easily roused.

For analgesia advice call .....Bleep.....Phone .....

AYRSHIRE AND ARRAN ACUTE HOSPITALS NHS TRUST

Home to Hospital Transfer of Care Form

Please complete this form and give it to the nurse who admits you to the ward. If you want you can ask someone else to complete the form on your behalf (such as, a friend, family member, home help or nurse). This information will help hospital staff to anticipate your need for services and support after discharge from hospital.

Stick patient ID label here

Next of Kin:

name KATHLEEN DOCHERTY

address 8 CRAIGVIEW

SPRINGSIDE

AYRSHIRE

telephone 01294 216008

relationship MOTHER

patient's phone number 01294 204148

Tick the appropriate box for each question and give details of any help.

About your ability to perform tasks of daily living:	YES	NO	If NO, do you need to use an aid and/or get help from another? (such as husband/wife, son/daughter, nurse, home help etc.)
Can you walk outdoors unaided?	✓		
Can you walk indoors unaided?	✓		
Can you shop for groceries unaided?	✓		
Can you cook meals unaided?	✓		
Can you do your laundry unaided?	✓		
Can you do housework unaided?	✓		
Can you go up/down stairs unaided?	✓		
Can you bathe/shower unaided?	✓		
Can you get in/out of bed unaided?	✓		
Can you go to the toilet unaided?	✓		
Can you dress/undress unaided?	✓		

Please record any other information that you feel is relevant.

.....

.....

.....

Tick the appropriate box for each question.

About your home/community circumstances	YES	NO
Do you live alone?	✓	
Are you responsible for caring for another person?	✓	
Have you been recently bereaved?		✓
Do you have someone to look after your house whilst you are in hospital?	✓	
Are you disabled?		✓
Do you have to climb stairs to enter your home?	✓	
Do you have to climb stairs inside your home?	✓	
Do you have any difficulty heating your home?		✓

Please list the names of all medications you regularly take (state if none).

Drugs/Treatments prescribed by your doctor	Drugs/Treatments not prescribed by your doctor
NONE	

Please list the services you receive in the community (state if none).

Name of service (such as district nurse, home help)	staff member's name	phone number
NONE		

Please record any other information that you feel is relevant.

.....

.....

.....

.....

please give this to the hospital nurse who will sign it

checked by: .....(signature of named nurse) on ...../...../..... (date)

AYRSHIRE AND ARRAN ACUTE HOSPITA , NHS TRUST

XH 466693

Address
Name .. HARMON CAROLINE
Address 29(H) SLOAN AVENUE
IRVINE
KA12 OHR
30/10/1977
DR.C MACDONALD
TOWNHEAD SURGERY
6/8 HIGH ST
D.O.B.. CHI 3010773188

Fluid and Low Risk Infusion Therapy Recording Chart

Ward/Dept .....

Consultant .....

INF I.D. 1	Date 2	Fluid (use block letters) Electrolyte additive 3	Vol(ml) mmols 4	Route of Admin. 5	Duration Rate 6	Pump Yes/No 7	Mon Time every(hrs/mins) 8	Signatures 9	Batch Nos. 10	Given by Added by 11	Start time 12
A	8-4-01	HARTMANN'S SOL	500ML	IV					00I29 BP		19 30
B	08/01/01	5% DEXTROSE KCL 13.5mmol/L	500 ML	IV	40				99 J 25 BK		23 00
C	08/01/01	0.9% NaCl	500	IV	40				00K 29 BP		06 40
D	08/01/01	5% Dextrose KCL 13.5mmol/L	500	IV	40						
E											
F											
G											
H											
I											
J											
K											
L											

Use this chart for infusions of Fluids, Electrolytes (less than 40 mmol per litre potassium chloride), Blood, Blood Products and T.P.N.
If a volumetric pump is used the monitoring section on the reverse must be completed.

STA4015

If a volumetric pump is used for any infusion on the previous page, the infusion ID should be noted on the chart below and the monitoring details completed at intervals specified by the prescriber of the infusion.

The **INFUSION CHECKS** box should be ticked to indicate that the following checks have been made : **Pump Rate, Infusion site, Vol. remaining in bag is approx. as expected, patient's condition.**

INF I.D. 1	VOL. PUMP MAKE 2	SERIAL NUMBER 3	DATE 4	TIME 5	VOL INFUSED (from pump) 6	INFUSION CHECKS 7	SIGNED 8

NORTH AYRSHIRE AND ARRAN NHS TRUST
Hospital To Home Transfer Of Care Form

PATIENT DETAILS

Name CAROLINE HARMON	Hosp No 466693
Addr 29(H) SLOAN AVENUE	GP MACDONALD, CHARLES
IRVINE	GP Practice IRVINE
	GP Phone 01294 273131
Phone 01294204148	CHI No
Key holder: Y	

Key Holder Demographics And Notes

Name:	
Address:	
Phone No:	
Relationship:	

Admit Date 08/01/2001	Projected Discharge Date 09/01/2001
Consultant WARDROP	Actual Discharge Date / /
Named Nurse J. KILPATRICK SIDE A	Mode of Transport CAR
Ward 5A	

On discharge, patient plans to stay:	CHECKED BEFORE DISCHARGE Initials	Date
		/ /

atient Name: HARMON, CAROLINE
ate Of Birth: 30/10/1977
onsultant: WARDROP

Hosp. No: 466693
Ward: 5A
GP: MACDONALD, CHARLES

FINAL PATIENT AND CARER INFORMATION

Summary Diagnosis/Operation (as directed by consultant)
TO BE RECALLED AT LATER DATE.

Patient Informed/Understands Diagnosis	09/01/2001	KILPATRICK, JOYCE
Family Informed/Understands Diagnosis	09/01/2001	KILPATRICK, JOYCE
Confirmed Date of Discharge	09/01/2001	KILPATRICK, JOYCE
Hospital or Own Transport Arranged for (hrs)	09/01/2001	KILPATRICK, JOYCE
Outpatient Appointment Arrangements TO BE RECALLED AT LATER DATE.		KILPATRICK, JOYCE

Medications on discharge:	Yes/No	Name
patient's own drugs returned		
patient able to administer own medication		
patient's medication will be supervised by another -		
patient advised to contact GP regarding medication within 0 days 0 weeks of discharge		

Patient Name: HARMON, CAROLINE
Date Of Birth: 30/10/1977
Consultant: WARDROP

Hosp. No: 466693
Ward: 5A
GP: MACDONALD, CHARLES

Health and social care services that have been notified of the discharge and advice on time of first contact.

Name of Service	Name of Service Provider	Phone	Advised to see within ... (specify time or N/A)
			days of discharge
			days of discharge
			days of discharge
			days of discharge
			days of discharge
			days of discharge
			days of discharge

IMPORTANT PATIENT INFORMATION - IF YOU ARE AT ALL WORRIED OR FEEL THAT YOUR SYMPTOMS/CIRCUMSTANCES HAVE CHANGED, YOU SHOULD CONTACT YOUR GP OR RELEVANT SERVICE PROVIDER EARLIER.

Other relevant information: eg. investigations and results known and pending
There are no additional notes or comments

Completed By: J Kilpatrick

on 09/01/01

Received By: _____

on ___/___/_____

Sent To:

PATIENT ADMISSION RECORD - PATIENT RECORD DATA REPORT

CRN/Unit Number.....:466693
CHI Number.....: 0
Surname.....:HARMON
Forename.....:CAROLINE
Maiden Name.....:
Date Of Birth...:30/10/1977
Age: (Years:023 Months:02 Days:09)
Sex.....:F Pref/Name:
Consultant:WARDROP
Allergies: Food: N Drug: N Other: N

Address:29(H) SLOAN AVENUE
IRVINE

City...:
Postcode:KA12 0HR Phone:01294204148

Pre Admission.:N Admit Type:W/L
Pre-Admit Date: / / Time:00:00
Pre-Admit Ward: Bed:
Pre-Assessment: Adm. Hx:N
Proj. Adm Date: / / Time:00:00
Admit Date....:08/01/2001 Time:10:08
Admit Ward....:5A Bed:000028
Prime Admit Dx:TONSIL DISSECTION
Secondary Admission Diagnosis: ENT
Pat. Type.....:ENT
Adm Type: W/L Patient On Pass: N
Named Nurse..:J. KILPATRICK
Adm Nurse/Clrk..:KILPATRICK, J
Is Patient MRSA ? N
Patient Category: NHS

Marital Status.:.SINGLE
s This Patient Been An Inpatient Within The Last 12 Months: N
guage Spoken:
Understands....:
Religion:NONE
Nationality....:BRITISH
Occupation:
Special Considerations:
From: HOME
Source Of Referral: G.P.

ADMISSION DETAILS:

Temp: 36.8 Pulse: 72 Resp: 20 B.P.: 124/68 Hght: 0 '0 " Wgt: 0
Urinalysis..:
Operative Procedures: TONSIL DISSECTION

Medications Prior To Admission:N Prior Med. Hx:Y
Patient Spoken To - Dr. Name: Date: / / Time: 00:00
Reason for Admission As Stated By Patient:
TONSILLS OUT
Relative Notified Of Admission: Y
Relative/Friend Understanding Of Reason For Admission:
UNDERSTANDS
ative Spoken To -
ation:PARTNER Dr/Nurse Name: Date: / / Time:00:00
Admit Ward...: 5A Current Ward.: 5A
Admit Bed....: 000028 Current Bed..: 000028
Property/ Valuables: .IN OWN POSSESSION
Clothing.....: RETAINED BY PATIENT
Hospital Info. Book Given.: Identification Band: Y
Projected Discharge Date: 10/01/2001 Discharge Code:
Clergy Visit.....: Research Patient Code: 0

NEXT OF KIN DETAILS:
Surname...: DOCKERTY Forename..: KATHLEEN
Relation..: MOTHER
Address...: 8, CRAIGVIEW
SPRINGSIDE

Postcode..:
Home Phone: Work: Extension:

PATIENT ADMISSION RECORD - PATIENT RECORD DATA REPORT

PATIENT.....: HARMON, CAROLINE
CURRENT WARD...: 5A
CURRENT BED....: 000028

EMERGENCY CONTACT DETAILS:
Surname...: Forename..:
Relation..:
Address...:

Postcode..:
Home Phone: Work: Extension:

GENERAL PRACTITIONER DETAILS:
Surname...: MACDONALD Forename: CHARLES , E
Address...:
TOWNHEAD SURGERY
IRVINE
Postcode..: KA120AY

CONSULTANT/MR. 1 DETAILS:
Surname...: WARDROP Forename:
Admit Clerk:

CONSULTANT/MR. 2 DETAILS:
Surname...: Forename:

ALLERGIES:
Food Allergies
None

Drug Allergies
None

Other Allergies
None

PATIENT ADMISSION RECORD - PATIENT RECORD DATA REPORT

PATIENT.....: HARMON, CAROLINE
CURRENT WARD...: 5A
CURRENT BED....: 000028

Prior Medical History

Date	Reason	Hospital / Physician
01/01/1901	QUINSY	
01/01/1901	APPENDICECTOMY	

NOTE: Dates of 01/01/01 indicate actual date is unknown.
Dates of 01/01 and year indicate only the year was known.

NO PRIOR MEDICATION HISTORY ON FILE

ANY OTHER RELEVANT INFORMATION:

Ayrshire & Arran
ACUTE HOSPITALS NHS TRUST

Patient Profile

WRITE, IMPRINT OR ATTACH LABEL

XH 466693

Surna HARMON CAROLINE
Foren 29(H) SLOAN AVENUE
Addre IRVINE
KA12 0HR
30/10/1977
DR.C MACDONALD
TOWNHEAD SURGERY
Ward 6/8 HIGH ST
CHI 3010773188

Date of Admission 8-1-01 Time ~~Last~~ 10·30
Type of Admission Emergency / Elective
From where
Age Religion
Marital Status

Next of Kin Name
Aware of Admission YES ☐ NO ☐
Name
Relationship
Address

Contact No. 01294 204148
Alterntive Next of Kin Name
Relationship
Address

Contact No

GP DR MACDONALD Consultant MR WARROP

SUMMARY OF PRESENTING CONDITION

TONSILLECTOMY

PREVIOUS HEALTH PROBLEMS

Quinsy (England 3/52 ago)
Appendicectomy

MEDICATION USED AT HOME

DRUG	DOSAGE
none	

ALLERGIES none

Stored in ward YES ☐ No ☐ Date Sign
Returned to patient ☐ Relative ☐

ALL STAFF PLEASE READ

When using this profile please use ink and complete this section. Only then can initials be used when recording care.

Print Name	Initials	Signature	Print Name	Initials	Signature
JOYCE KILPATRICK	JK	Joyce Kilpatrick			

ADMISSION ASSESSMENT

Home circumstances

Living alone YES ☑ with small son. NO ☐ identify carer(s)

Type of house

Stairs at entrance YES ☐ NO ☐ How many?

Toilet upstairs YES ☐ NO ☐

Bedroom upstairs YES ☐ NO ☐

COMMUNITY SERVICES

Home help	YES ☐	NO ☐	District Nurse	YES ☐	NO ☐
Meals on Wheels	YES ☐	NO ☐	Day Hospital	YES ☐	NO ☐
Sheltered house	YES ☐	NO ☐	Nursing Home	YES ☐	NO ☐

Visited by Specialist Nurse YES ☐ NO ☐

Which services informed of admission

DISCHARGE

Will personal transport be available for discharge YES ☑ NO ☐

Predicted discharge Complicated ☐ Uncomplicated ☐

PATIENTS PROPERTY

Property retained by patient:

I understand articles/valuables retained by me are my own responsibility.

Signature of patient or next of kin Date

Property handed over for safe keeping:

Date taken to safe: Cash and valuables Ref. No.: Date returned:

OBSERVATION ON ADMISSION

Temperature	Pulse	BP	Respiration	O2 Saturation	Colour	LMP	BHCG	Glucostix
36.8	72	124/68	20					

URINALYSIS

Midstream Urine sent for C+S YES ☐ NO ☐ Date

Methicillen resistant staphyloccus aureus swab sent YES ☐ NO ☐ Date Result

RECORD OF INVESTIGATIONS PROCEDURES AND SURGERY

Date	Procedure/Surgery	Patient aware of result

Ayrshire & Arran
ACUTE HOSPITALS NHS TRUST

Activities of Living Assessment on Admission

XH 466693 ABEL
HARMON CAROLINE
Surn: 29(H) SLOAN AVENUE
IRVINE
Fore: KA12 0HR
30/10/1977
Addr: DR C MACDONALD
TOWNHEAD SURGERY
6/8 HIGH ST
CHI 3010773188
Ward or Dept.

MAINTAINING A SAFE ENVIRONMENT Orientated to time and place YES ☑ NO ☐ Skin intact YES ☐ NO ☐ Waterlow Assessment Score Wound YES ☐ NO ☐	PROBLEMS / NEEDS
BREATHING Smoker YES ☐ NO ☑ Number per day	PROBLEMS / NEEDS
CONTROLLING BODY TEMP Apyrexial on admission YES ☐ NO ☐	PROBLEMS / NEEDS
EATING AND DRINKING Mouth Assessed YES ☐ NO ☐ Special Diet YES ☐ NO ☐ Type of Diet Normal Weight 13st 12lbs Height 5'7" Refer to Nutritional Assessment	PROBLEMS / NEEDS
MOBILISING Independent YES ☐ NO ☑ Refer to Moving and Handling Assessment	PROBLEMS / NEEDS
ELIMINATING Normal Bowel Activity ✓ Last Bowel Motion Incontinent Bladder ☐ Bowel ☐ Catheterised YES ☐ NO ☐ Stoma YES ☐ NO ☐	PROBLEMS / NEEDS

COMMUNICATING Glasses YES ☐ NO ☑ Contact Lenses YES ☐ NO ☑ Hearing Aid YES ☐ NO ☑ Speech Difficulty YES ☐ NO ☑	PROBLEMS / NEEDS
PERSONAL CLEANSING AND DRESSING Independent YES ☑ NO ☐ Assistance with	PROBLEMS / NEEDS
WORKING AND RECREATION Occupation Hobbies Alcohol intake	PROBLEMS / NEEDS
SLEEPING Pattern Night sedation YES ☑ NO ☐ Sleeps with pillows	PROBLEMS / NEEDS
EXPRESSING SEXUALITY Possible altered body image YES ☐ NO ☐ Wears dentures Top ☐ Bottom ☐ Partial ☐ Crowns ☐ Any other prosthesis	PROBLEMS / NEEDS
DYING / EMOTIONAL PROBLEMS / NEEDS General mood on admission Specific worries re-admission Specific history of depression	PROBLEMS / NEEDS

Signature of Admitting Nurse _____ Date _____

Sign Named Nurse _____ from _____ to _____

Sign Named Nurse _____ from _____ to _____

Sign Named Nurse _____ from _____ to _____

FAN1286

XH 466693

Surn HARMON CAROLINE
29(H) SLOAN AVENUE
IRVINE
For KA12 OHR

DR.C MACDONALD 30/10/1977
TOWNHEAD SURGERY
Adc 6/8 HIGH ST
CHI 3010773188

Ward/Dept. 5A -

NURSING NOTES

DATE	
08/01/01	Arranged admission for theatre tomorrow JK

DATE

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

KEY: O ORAL; IM INTRAMUSCULAR; IV INTRAVENOUS; SC SUBCUTANEOUS; SL SUBLINGUAL; ID INTRADERMAL; INH INHALATION; NEB NEBULISED; PR PER RECTUM; PV PER VAGINA; IT INTRATHECAL

XH 466693

Write HARMON CAROLINE
Surr 29(H) SLOAN AVENUE
Fore IRVINE
..... KA12 OHR
..... DR.C MACDONALD 30/10/1977
Adc TOWNHEAD SURGERY
6/8 HIGH ST
CHI 3010773188

.o. .....
.....
.....
.....
Dept.....

KNOWN SENSITIVITY

1.	2.

SUSPECTED ADVERSE REACTION

MEDICINE	ADVERSE EFFECT
1. NKDA	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION: 6 am	8 am	10 am	12 md	2 pm	6 pm	8 pm	10 pm	12 mn	OTHER		ROUTE (see key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED: DATE	INITIAL
	A 08/01/01	SYMPTOMATIC RELIEF POLICY																	
	B 08/01/01	METOCLOPRAMIDE	10mg	8°	as required for Nausea										IM/IV				
	C 08/01/01	MORPHINE	5mg	2°	as required for Pain										IM/IV				
	D 08/01/01	BUSCOPAN	20mg	6°	as required for Abd pain										IM/IV				
	E 08/01/01	LACTULOSE	10mls		✓						✓				O				
	F																		
	G																		
	H																		
	I																		
	J																		
	K																		
	L																		
	M																		
	N																		
	O																		
	P																		
	R																		
	S																		
	T																		
	V																		

STA 0235

MEDICINES TO BE GIVEN ONCE (BLOCK CAPITALS)

PHARM.	TO BE GIVEN		APPROVED NAME OF MEDICINE	DOSE	ROUTE (see key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	DATE	TIME						

XH 466693

HARMON CAROLINE
29(H) SLOAN AVENUE
IRVINE
KA12 OHR

30/10/1977

DR.C MACDONALD
TOWNHEAD SURGERY
6/8 HIGH ST
CHI 3010773188

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
9/10/81		E A 8.50 am								2020 B+C CH
	Init.	EJ								
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

SHEET No .....

MEDICINE RECORDING SHEET

Name .....

Age .....

Consultant .....

Hospital .....

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
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	Init.									