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

NHS
Greater Glasgow and Clyde

MMA Legal

23 Goodlass Road

Building B

L24 9HJ

Date: 23rd June 2026

Your Ref: 100839

Our Ref: LAT/ACCESS/ES

Enquiries to: Emily Svensson

Direct Line: 0141 211 3020

Email: Emily.svensson@nhs.scot

Re: Subject Access Request under the General Data Protection Regulation

PATIENT: LISA HUGHES **D.O.B: 17/01/1980**

Thank you for your request received **2ND JUNE 2026** in which you seek a copy of your client's personal information.

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

QUEEN ELIZABETH UNIVERSITY HOSPITAL/ NEW VICTORIA HOSPITAL

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely

Legal Aspects Team

ELECTRONIC PATIENT RECORDS

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

Including:

BADGERNET	☐
CAREVUE	☐
. IEDICAL ILLUSTRATION	☐
METAVISION	☐
PHYSIOTHERAPY	☐
RADIOLOGY	☑
WEST MARC	☐
LABS	☐

Acute Services Division

Nursing Admission & Assessment

1. Admission

NHS Greater Glasgow and Clyde

1701806541
HUGHES F
Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

Hospital: QEUH	Ward: ARU3
Date of admission: 11/10/15	Time: 2030
Admitting Consultant:	Admitting Nurse: KLITTLE
Expected date of discharge: / /	

1. Patient Details

Preferred name: Lisa	Next of Kin (NoK): Agnes Haughey
Age: 35.	Relationship: Mother
Religion:	NoK Address: ^ Same
Telephone:	
GP:	NoK Telephone: 07769815357
GP address:	NoK Aware of admission: ☑ Yes ☐ No
	Consent for information to be given to relatives: ☐ Yes ☐ No
	Nominated family contact:
GP telephone:	Telephone - Day:
	Telephone - Evening:

Is the patient a carer? ☐ Yes ☐ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☐ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☐ No ☐ N/A

a. If 'Yes' please provide – Name: ..... Relationship: .....

Contact telephone number: .....

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☐ No ☐

If 'No' to 'b' please inform medical staff. Name of doctor informed: .....

2. Presenting Complaint / Diagnosis

Mixed OD of prescription meds.

Why does the patient think they are in hospital? *Use patients own words:*

3. Allergies (including food allergies)

No known allergies: ☐

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
			64.	106/60	16.	99	35.3

Urinalysis:	AMT4 Score	BM	NEWS Score	Weight Estimated / Actual	Height Estimated / Actual	BMI

5. Current Medication

Medicines reconciled on admission? ☐ Yes ☐ No

6. Relevant Past Medical History

depression.

7. Risk Assessment

MUST

1. Is the patient's BMI:
   - > 20 ..... Score 0
   - 18.5-20 ..... Score 1
   - <18.5 ..... Score 2

   Score ☐
2. Has the patient had unplanned weight loss in the past 3-6 months?
   - < 5% ..... Score 0
   - 5-10% ..... Score 1
   - >10% ..... Score 2

   Score ☐
3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:

   Score = 2

   Not applicable: Score = 0

   Score ☐

MUST Score: ☐

If score 1 or more, complete full Nutrition Profile

Name: .....

Address: .....

.....

DoB: .....

CHI number: .....

Affix patient data label

8. Cognitive Impairment

For all patients ≥ 65 years, ask the following 4 AMT questions:

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

If the patient does not answer all questions correctly then refer to medical staff.

AMT Score: ..... out of 4

Name of Doctor informed (if required)

..... Grade .....

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☐ Yes ☐ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☐ No ☐ Not known
2. Has the patient been admitted from a Care Home/ institutional setting, or another hospital? ☐ Yes ☐ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☐ No ☐ Not known

If 'Yes' to any of the above questions OR if the patient is admitted to a 'high impact speciality' e.g. Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CJD: **Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:**

☐ Yes ☐ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☐ No If 'Yes obtain rectal swab and send to microbiologty for CPE screen.

Rectal swab taken ☐ Patient refused ☐

10. Lifestyle

Smoking:

Does the patient smoke? ☐ Yes ☐ No

If 'Yes' how many per day:

Does the patient use nicotine replacement therapy? ☐ Yes ☐ No

Does the patient wish referral to Smoking Cessation Service?

☐ Yes ☐ No If 'Yes', date of referral: / /

Drugs: Does the patient use recreational drugs? ☐ Yes ☐ No If 'Yes' specify:

Alcohol (Men): How often do you have 8 or more drinks on one occasion:

☐ Never ☐ Less than monthly

☐ Monthly ☐ Weekly ☐ Daily or almost daily

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have 6 or more drinks on one occasion:

☐ Never ☐ Less than monthly

☐ Monthly ☐ Weekly ☐ Daily or almost daily

If 'Monthly' or more then complete FAST Tool.

1. Admission Documentation Completed By

Name (Please PRINT): KLITTLE	Signature: Klittle
Designation: S/N	Date: 11/10/15

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Hospital: QEUH	Ward: ARU3
Date of Assessment: 11/10/15	Time:

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

1. Breathing and Circulation

Breathing:

- ☑ No symptoms or history of respiratory problems
- ☐ Dyspnoeic at rest
- ☐ Dyspnoeic on minimal exertion
- ☐ Dyspnoeic on maximum exertion
- ☐ Productive / non-productive cough evident
- ☐ Normally receives oxygen therapy

If 'Yes' provide details:

Circulation:

- ☑ No symptoms
- ☐ Known cardiac or circulatory problems

Problem identified: ☐ Yes ☑ No If 'Yes' please describe

Initial

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

English

Interpreter: Required ☐ Not required ☑

If required, provide details and arrangement made:

.....

.....

Does the patient have:

a. Speech difficulties? ☐ Yes ☑ No

b. A learning disability e.g. Down's Syndrome? ☐ Yes ☑ No

If 'Yes' please specify:

.....

If 'Yes' contact Liaison Learning Disability Team.

Liaison Learning Disability Team contacted: ☐ Yes ☑ No

c. A learning difficulty e.g. dyslexia, dyspraxia? ☐ Yes ☑ No

If 'Yes' please specify:

.....

3. Senses

Senses:

Eyesight

- ☐ Normal vision
- ☐ Glasses – ☐ Distance ☐ Reading
- ☐ Prosthesis – ☐ Left ☐ Right
- ☐ Contact lenses
- ☐ Registered blind

Hearing

- ☐ Normal
- ☐ Hearing impaired
- ☐ Hearing aid – ☐ Left ☐ Right

4. Mental Status

Mental Status:

- ☐ Orientated
- ☐ Confused
- ☑ Distressed
- ☐ Aggressive /Abusive
- ☐ Unconcious

Problem identified: ☐ Yes ☑ No If 'Yes' please describe

Initial

5. Hydration and Nutrition

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

MUST Score: ..... **If score is 1 or more, complete a Nutrition Profile.**

Nutition Profile completed ☐ Yes ☐ No
If 'Yes' do not complete sections 5a to 5d.

- **If score is 0, reassess / screen patient in 7 days.**
- **Complete sections 5a to 5d.**

Date of reassessment: / /

5a 1. Food likes / dislikes:

5a 2. Fluid likes / dislikes:

5c. Help needed with eating and drinking:
☐ Yes ☐ No
If 'Yes' provide details:

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):
☐ Yes ☐ No
If 'Yes' specify diet needed:

5d. Texture Modified Diet needed?
☐ Yes ☐ No
If 'Yes' specify texture: A☐ B☐ C☐ D☐ E☐
Thickened Fluids required? ☐ Yes ☐ No
If 'Yes' specify stage required: 1☐ 2☐ 3☐

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

6. Elimination

Continent:	Incontinent:	NHS GGC Stool Chart commenced:
☐ Bladder ☐ Bowel	☐ Bladder ☐ Bowel	☐ Required ☐ Not required

Long-term urinary catheter in situ? ☐ Yes ☐ No If 'Yes' – Size: .....fg Make: .....
Date catheter last changed: / /

Continence assessment commenced:
☐ Yes ☐ No ☐ Not applicable

Containment products in use? Please specify:

☐ Bowels regular
☐ Constipated
☐ Diarrhoea / loose stools

Stoma: ☐ Yes ☐ No
If 'Yes' please specify and list appliances used:

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

7. Personal Hygiene, Oral Health and Skin Assessment

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Personal hygiene:
☐ Self-caring and independent
☐ Requires assistance

Specify assistance if required:

Oral health:

Self-caring and independent	☐ Yes	☐ No
Does the the patient have a sore mouth	☐ Yes	☐ No
Does the patient have a non healing mouth ulcer	☐ Yes	☐ No

If the patient has a sore mouth or non healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway) and implement Oral Care Bundle.

Oral Hygiene Care Bundle:
☐ Required ☐ Not required

Dentures:
☐ Not worn
☐ Upper set
☐ Lower set
☐ Full set
☐ Dentures with patient on admission

Skin assessment:
☐ Skin healthy with no evidence of damage
☐ Skin broken ☐ Skin oedematous ☐ Skin discoloured ☐ Skin clammy
If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: ☐ Yes ☐ No ☐ Not applicable
Pressure ulcer evident: ☐ Yes ☐ No
If 'Yes' please identify Grade and record on Pressure Ulcer record sheet – Grade: .....

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

8. Mobility

Patient fully mobile / independent? ☐ Yes ☐ No If 'No' complete Moving and Handling Assessment.

☐ Limited mobility
☐ Mobile with aid – Specify:
☐ Prosthesis – Specify:

Moving and Handling Plan commenced:
☐ Yes ☐ No

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

9. Maintaining a Safe Environment

Pain status:
Does the patient have pain? ☐ Yes ☐ No
If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details:

Bed rail assessment completed: ☐ Yes ☐ No

Bed rails required:
☐ Required ☐ Not required

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

0. Sleep and Rest

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Sleep habits:

☐ Less than 8 hours ☐ Afternoon nap
☐ Morning nap

Sleep difficulties:

☐ None ☐ Disturbed e.g. nocturia, insomnia
☐ Early wakening

Medication required: ☐ Yes ☐ No

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

1. Social Circumstances

☐ Employed ☐ Unemployed ☐ Retired
☐ Lives alone
☑ Lives with Family – ? 8 children
☐ Friend
☐ Dependants
☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:

☐ Social Services ☐ Unpaid carer e.g. family, friends
☐ Private Carers ☐ None

If support services in place, please provide details:

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

2. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission?

☐ Yes ☐ No

If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?

☐ Yes ☐ No

If 'Yes' please provide brief details:

Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?

☐ Yes ☐ No

If 'Yes' please provide brief details:

Ask the patient:

"Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?"

☐ Yes ☐ No ☐ Not at this time

If 'Yes' please specify faith group:

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

14. Anticipatory Care

(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☐ Not appropriate ☑

Is the **patient** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Is the **patient's family** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Preferred place of care:
Home: ☐ Hospital ☐ Hospice ☐

Preferred place of death:
Home: ☐ Hospital ☐ Hospice ☐

Current treatment – please identify (e.g. chemotherapy/ radiotherapy):

Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☐ Yes ☐ No
If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

15. Admission Assessment Completed By

Name (Please PRINT): KIRSTY LITTLE

Signature: K Little

Designation: STAFF NURSE

Date: 11/10/15

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
11/10/15 2050	35 year old female admitted to AEU3 with mixed OD of prescription meds & alcohol. found by parents this am. Patient drowsy ++ on admission, unable to assess & admit properly. News (2). T 35.3, BP 106/60.	

Clinical Notes continue on next page

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation
	Patient apparently lives at home with 8 children. Social work informed - await response. Telemetry in situ. Await R/V by medics	K Wood SHO
12/10/15. 0325	patient remains drowsy ++, GCS 13/15. Not passed urine since admission. BP ↓ 85 systolic.	
	DIN FYI for R/V, given 250 Stat ~~&~~ fluids. BM 3.4mmols; 5%	
	dextrose also given. BP now 103/64	K Wood SHO
12/10/15 0705	Remains drowsy & lethargic.	
	BP 100 systolic.	K Wood SHO

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - NURSING

1701806541
HUGHES F
Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

Date & Time		Signature, Print Name & Designation
12/10/15	Patient much more awake and chatting now. Observations stable. Telemetry rhythm showing 77bpm S.R. Psych review → will re-review later in day when patient more awake. Patient states she's still suicidal. Awaiting psych team to come back JMacDonald (S)	
1645	Patient settles. Psych team will come back tomorrow. Remains bright and alert Observations remain stable. JMacDonald (S).	
1900	BP slightly ↓ at 97 systolic. Other observations stable. Asked patient to drink more fluid.	JMacDonald (S).
	Bed available in SC • Handover given. ☑ • Bed available ☑ • NOK called ☑	conclave
13/10/15 0210	Transferred from ARU 3 Alert and given nurse call buzzer. Mobile with supervision as unsteady on feet. Changing own position in bed. Observations as charted. Not for any medication at the moment. No new skin issues. Appears settled	HMcNaught RGN

193443

Date & Time		Signature, Print Name & Designation
13.10.15	Addiction Liason nurse spoke to	
	me and said that Lisa	
	requires no addiction input.	
	Her only concern is that Social	
	Work are informed that Lisa	
	~~has~~ is an inpatient and has	
	a personality disorder and	
	that she has 8 children	
	and is unsure whether the	
	husband is looking after them	
	or not. SN Torriner has	
	said she is going to call	L Connelly (SN)
	S/W	CONNELLY
1200	Spoke to psychiatry nurse who	
	states Lisa will have to be	
	admitted to a psychiatric ward.	
	He has left message with the	
	bed manager and Lisa agrees	CONNELLY (SN)
	to being admitted.	L Connelly
1615	Settled day. Independent with	
	ADLs. No concerns voiced with	
	eliminations. Good diet + fluid	
	intake. NCNS as charted. Medication	
	withheld due to OD. For transfer	
	to ward 4B today. Ambulance	
	booked, NOK to be informed D,	
	handover to be given D.	JOEL SN.

1701806541
HUGHES F
Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

Care Plan

NHS Greater Glasgow and Clyde

Date Commenced and Signature	1. Breathing and circulation	Date Discontinued and Signature	Date Commenced and Signature	7. Personal Hygiene, oral care and skin care	Date Discontinued and Signature
11/10 LM	As per NEWS 4-6°		12/10/15 (XM)	Independent	
13.10.15 CD	Obs as per NEWS				
	2, 3. Communication and senses			8. Mobility	
11/10 LM	Patient drowsy ++		12/10/15 (XM)	Mobile with supervision	
13.10.15 CD	Can communicate needs				
	4. Cognitive status			9. Maintaining a safe environment	
11/10 LM	Drowsy (disoriented				
13.10.15 CD	Hurt) and orientated		13.10.15 CD	Buzzer system explained.	
	Getting to Know Me / What matters to me			10. Sleep and Rest	
			13.10.15 CD	Promote peaceful environment	
	5. Hydration and Nutrition			12. Privacy, dignity and sexuality	
11/10 LM	(NOTE)				
	6. Elimination			Negotiated care - Care discussed with patient / family Yes / No Patient able to participate Yes / No	
12/10/15 (XM)	Independent				

223591

Care Plan Guidance

Below are some prompt questions to help you record the individualised care that your patient requires during their inpatient stay. You should record the care that the nurse / nursing staff require to provide. The 'Negotiated Care' component provides opportunity to record any care that the patients family or carers are participating in and care that patients are being taught to support changing self care. If the patient is independent in any of the activities of living and requires no nursing intervention then you should record this in the relevant section.

When care changes a note should be made in the nursing clinical notes / progress notes to confirm why this is required.

1. Breathing and circulation	7. Personal Hygiene, oral care and skin care
Record frequency of observations, TPR BP and SAO2. Record any other care that the patient requires for their breathing or their circulation e.g. seating position, apex beat with radial pulse, pedal pulse measurement, lying and standing Blood Pressure measurement etc.	Does the patient need assistance with personal hygiene? If so what needs to be done. Do they require assistance with oral care? If so what is this. Does the patient require any specifc pressure area care outwith the Active Care documentation. If totally independent record 'self caring'.
2, 3. Communication and senses	**8. Mobility**
What assistance does the patient need with communication? If they use spectacles or a hearing aid what assistance do they needs with these? Does the patient require an interpreter?	Does the patient require assistance when mobilising? Does the patient use mobility aids? Is the patient at risk of falling? Record key information from falls risk assessment, e.g. Cannard tool, to prevent falls
4. Cognitive status	**9. Maintaining a safe environment**
What care is required to minimise risk of harm due to behavioural disturbance? Think about capacity and adults with incapacity and what you need to do with the patient to alleviate distress.	How is the patients pain being assessed? Is a specific pain assessment tool used? What does the patient require to maintain their safety?
Getting to Know Me / What matters to me	**10. Sleep and Rest**
The 'Getting to know me' Document should be used for all patients with cognitive impairment. Once completed by the patients relatives / carer record the key information to plan care in the care plan. Ask the patent what matters to them during their hospital stay and record in this area.	What would help the patient achieve a good nights rest? Does the patients sleep pattern need to be monitored? if yes record what needs to be done.
5. Hydration and Nutrition	**12. Privacy, dignity and sexuality**
Does the patient require any assistance with eating and / or drinking? Does the patient require a special diet? Do they require fluid balance monitoring?	What do you need to do to maintain the patients modesty and dignity?
6. Elimination	**Negotiated care -** Care discussed with patient / family Yes / No Patient able to participate Yes / No
Does the patient require assistance to go to the toilet? Do they use continence aids? Does their urinary output require to be monitored? Are the patients stools / bowel activity being monitored?	Discuss patient care needs with them. If the patient is learning a new self care procedure record their process and progress of learning. If the patient has a learning disability or dementia use the information obtained in the Getting to Know Me document to identify the care that the family / carer could participate in.

Nutrition Profile

NHS Greater Glasgow and Clyde

Name:  1701806541 HUGHES F Lisa, R 17/01/1980 8 Carham Crescent Glasgow, Lanarkshire G52 2HN	Date of admission: 11/10/15
Address:	Time:
DoB:	HOSPITAL: QEUH
CHI number:	Ward: 8C
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 1.65 metres Actual ☑ Patient/ carer reported ☐ Alternative measurement ☐

Weight: 55.9 kg Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☑ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☑

Please state:

Food Allergies: Yes ☐ No ☑ If 'Yes' please state:

Eating likes and dislikes (including appetite):	Drinking likes and dislikes:	Patient NBM Yes ☐ No ☑ If 'Yes' why?:
Likes most things		

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties, loose teeth), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental**? Yes ☐ No ☑

Please specify all factors:

Is the patient on oral nutritional supplements? Yes ☐ No ☑

If 'Yes' please state:

Is the patient experiencing oropharyngeal swallowing problems (excluding oesophageal issues e.g. GORD, Stricture)? Yes ☐ No ☑

If 'Yes' please complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS). If oesophageal problem present please discuss with medical staff.

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

If 'Yes' please state:

Has this patient received written information about inpatient food (e.g. "Food in Hospitals" leaflet)?

Yes ☐ No ☑ Not applicable (received on previous admission) ☐

Profile completed by: Name (PRINT): CDONNELLY Signature: C Donnelly Date: 13.10.15

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Is your patient on the Liverpool Care Pathway (LCP)? Yes ☐ No ☐

If 'Yes' please follow LCP advice as screening for malnutrition may not be appropriate.

Malnutrition Universal Screening Tool ('MUST')

Date	13/10											
Initials	CO											
Height (see page 1) 1.65 Weight	55.9											
Oedema or ascites present Y/N	N											
BMI (refer to chart on page 4)	20											
'MUST'												
Step 1: BMI Score (refer to chart on page 4) >20 (>30 = Obese) .....0 18.5 - 20 .....1 <18.5.....2	1											
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, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0											
Step 4: Overall Risk of Malnutrition Total:	1											

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	**LOW RISK – *Routine Clinical Care*** • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	**MEDIUM RISK – *Observe*** • Document dietary intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK – *Treat**** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

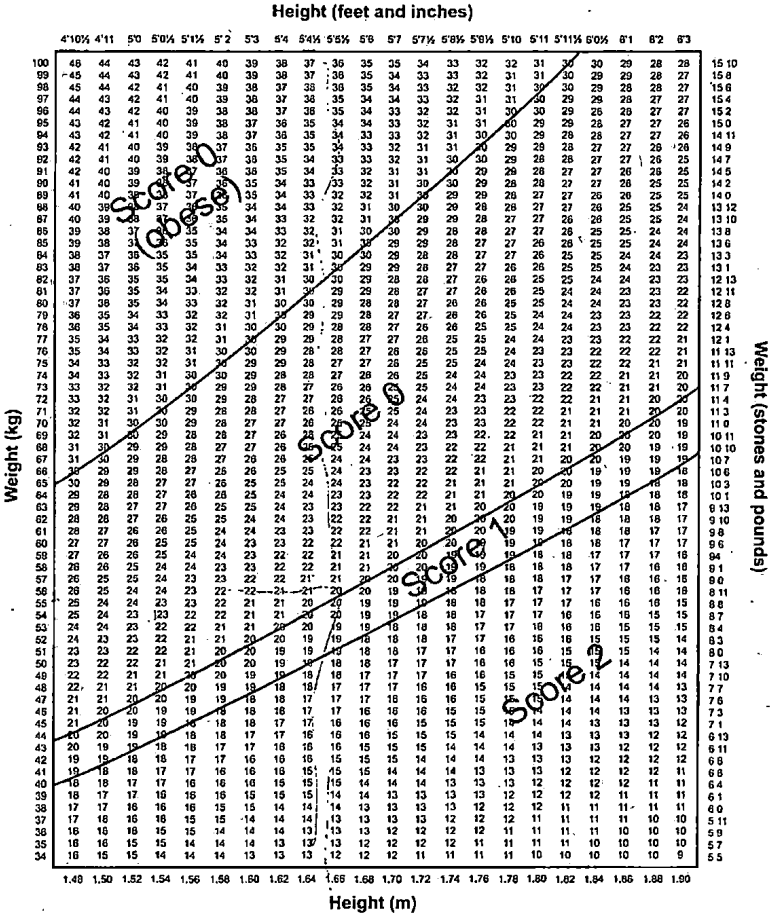
- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).
- REMEMBER TO CONSIDER YOUR PATIENT'S HYDRATION REQUIREMENTS.
- Ensure Discharge Plan includes most recent 'MUST' Score and any necessary follow-up requirements.

Referral Services		Referred by	Method of referral	Reason for referral
Nutritional Support Team	Date Referred / /			
Dietitian	Date Referred: / /			
Speech and Language Therapy	Date Referred: / /			
Occupational Therapy	Date Referred / /			
Dental Service	Date Referred / /			

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Action discussed with patient / carer	Review date	Name (PRINT) Signature/ Designation
13/10	1	Commence on food record chart. Review in 1 week.	Yes	17/10	SN

Step 1 - BMI Score



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-12.4 kg	>12.4 kg
126 kg	<6.3 kg	6.3-[illegible]	>12.6 kg

Weight before weight loss (st/lb)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

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Acute Services Division

Critical Care, High Dependency, Coronary Care

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: 1701806541 HUGHES Lisa, R F 17/01/198(

Ward: .....

CHI number: .... 8 Carham Crescent Glasgow, Lanarkshire G52 2HN .....Unit/Hospital number .....

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission to each ward.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Risk assessment and care plan reviewed monthly.

Referral Criteria for Hospital Falls Prevention Co-ordinator

1. Cannard score of 18+.
2. Second or subsequent fall
3. Significant Injury caused by a fall. (Significant Injury defined as any fracture, significant bruising or laceration to head or body.)

The patient should be referred with any of the above criteria.

General Safety Precautions

- Ensure patient has buzzer to hand
- Check patient has the manual dexterity and cognitive ability to operate buzzer
- Place personal items within easy reach
- Keep the bed in lowest position possible (use low bed if available)
- DO NOT leave patients with cognitive or mobility problems unattended on commodes, in toilets, baths or showers
- If noted that mobility / transfers are unsafe refer to physio / OT for assessment
- If patient wears glasses, ensure they are clean
- Ensure patient's footwear is adequate
- Lock wheels on all wheelchairs, beds, commodes and trolleys when in use
- Provide adequate lighting at night
- Request medication review if appropriate
- Clean up spills immediately
- Orientate patient to the ward environment

Cannard Falls Risk Assessment

(Must be completed within 24 hours of admission to ward)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 13/10 Ward: 8C	Date: Ward:	Date: Ward:	Date; Ward:	Date: Ward:	Date: Ward:	Date: Ward:
History of falls in the last 6 months	At home 1	In ward/ unit 2	None 0			0						
Sex	Male 1	Female 2				2						
Age	13-59 0	60-70 1	71-80 2	81+ 1		0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		2						
Medication type **	Medication for mental illness & drug / alcohol withdrawal 1	Drugs for CVS Support Medication 1	Sedatives / Analgesia / Night sedation 1	None of these 0		0						
Medical history	Cardiovascular Disease / Diabetes1	Confusion 1	Fits/ spasms 1	Incontinent 1	Inability to cooperate* 1	/						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed bound/ wheelchair 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		3						
				TOTAL SCORE		8						
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		See Below						
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves.				NURSE SIGNATURE		[signature]						

Please see back page for glossary of terms relating to the assessment above.

Falls Assessment Care Plan

Please tick all applicable nursing interventions

	NURSING INTERVENTIONS	Date: 13/10 Ward: 8C	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
Action code								
1	Prevention and general safety precautions discussed with patient and family.	✓						
2	Move to more observable area of ward to optimise supervision.							
3	Advise patient they may experience dizziness when they mobilise initially.	✓						
4	Two nurses to assist mobilisation if patient recovering from epidural.							
5	Observe trip hazard due to invasive lines, drains and catheters.							
6	Do not leave patient unattended when using commode, toilet or shower.							
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
8	Monitor lying and standing/ sitting BP and pulse.							
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.							
10	Commence continence assessment, refer to chart if appropriate.							
11	Refer to Physiotherapist.							
12	Request medication review.							
13	Select suitable seating (refer to policy).							
14	Review Transfer techniques.							
15	Bed rails/bumpers to be used (refer to policy).							
16	Falls map in use for seven days for patients who have had second or subsequent falls.							
17	Bed/chair monitor in use.							
18	Patient requires low bed / mattress on the floor (refer to policy).							
19	Patient requires one to one nursing care.							
20	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).							
21	Other interventions. Bumper	✓						
	SIGNATURE	[redacted]						

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camcolit or Priadel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevrin), antidepressants, Diazepam, Lorazepam and Amitriptyline.

CARDIOVASCULAR SYSTEM MEDICATION all antihypertensive medication and inotropes including Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilofruse.

SEDATIVES / ANALGESIA AT NIGHT include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane) Morphine PCA, Fentanyl, Tramadol and Oxcycontin.

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid).

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

1701806541
HUGHES
Lisa, R
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN
17/01/198(

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 individuals condition and repeat regularly according to local protocol

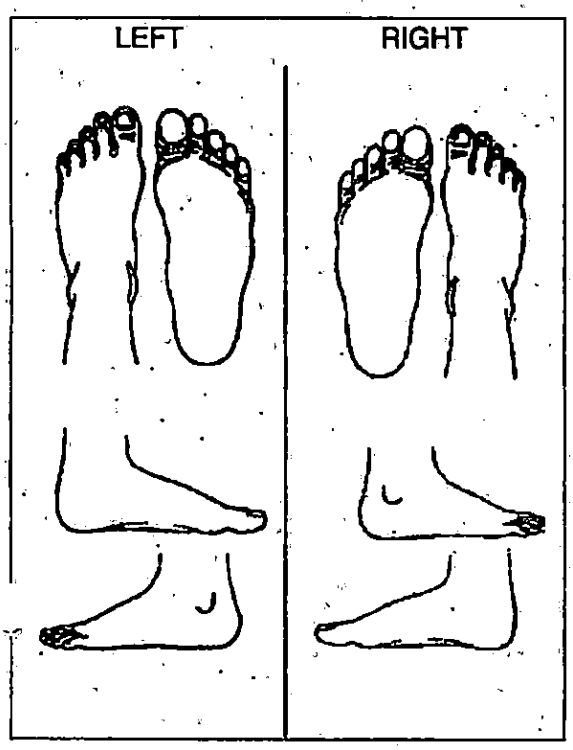
Sex									
Male	1								
Female	2	2	2						
Age									
14 -49	1	1	1						
50 -64	2								
65 - 74	3								
75 - 80	4								
81+	5								
Build/Weight for Height (BMI=weight in Kg/height in m²)									
Average - BMI 20-24.9	0	0	0						
Above average - BMI 25-29.9	1								
Obese - BMI > 30	2								
Below average - BMI < 20	3								
Continence									
Complete/catheterised	0	0	0						
Incontinent urine	1								
Incontinent faeces	2								
Doubly incontinent (urine & faeces)	3								
Skin Type - Visual Risks Area									
Healthy	0	0	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		1						
Apathetic (sedated/depressed/reluctant to move)	2								
Restricted (restricted by sever pain or disease)	3								
Bedbound (unconscious/unable to change position/traction)	4	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	0	/						
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 *Max 4*	4		/						
Total Score			4						
Date			13/10						
Initials			AM						
Time			11:05						

83826

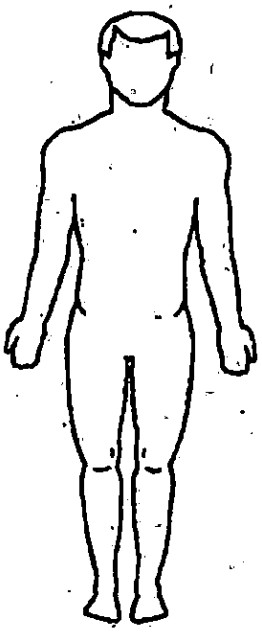
Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

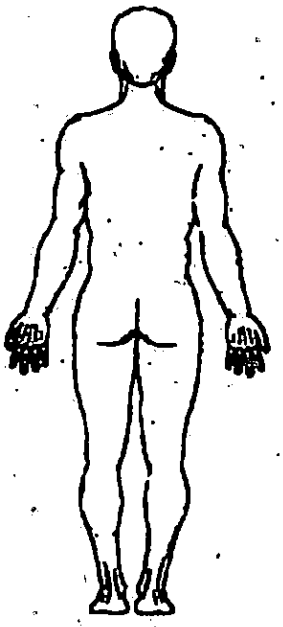
Indicate by circling and numbering all pressure damage on diagrams, then complete box below. Indicate care plan/wound assessment chart.



Anterior view



Posterior view



SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

GRADE 1 Non-blanchable erythema 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	NUMBER OF ULCER(S)	LOCATION OF ULCER(S)	GRADE OF ULCER(S)	LOCATION OF ULCER(S)

Pressure Ulcers may deteriorate from Grade 1 to Grade 4, but can not be reversed and should be documented as a healing grade of pressure ulcer, eg healing grade 4.

(23)

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address
1701806541
HUGHES F
Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN
CHI No.
DoB

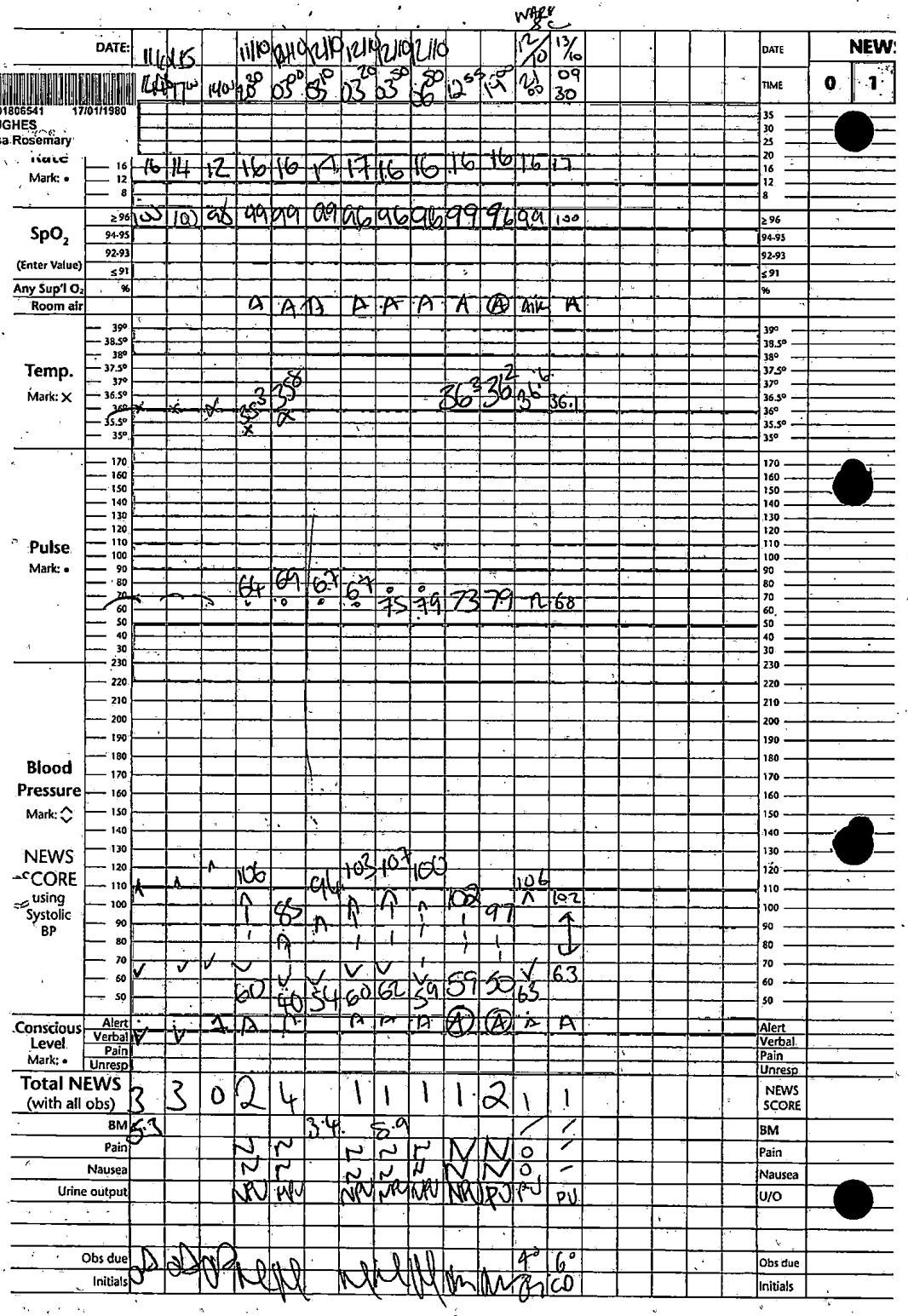
	Date	Ward
Admitted		
Transferred		
Transferred		

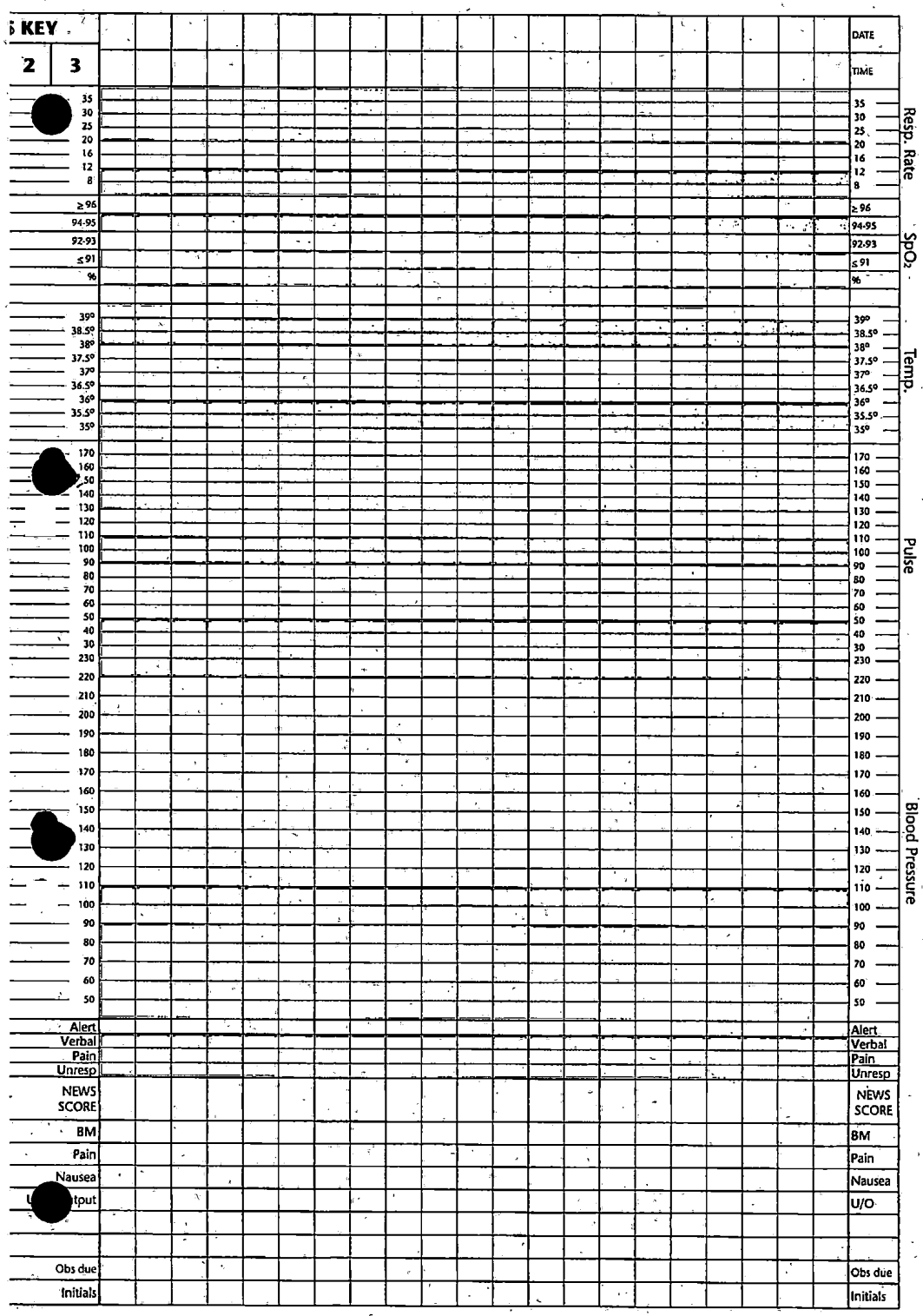
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

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** 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • 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. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE:
TIME
NEWS
701806541 17/01/1980
HUGHES
Lisa Rosemary
Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: X
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
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
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

| | | |

Lisa Hughes
35. Patient I.D. Label

Patient handover information

82

NHS Greater Glasgow and Clyde

Ward/To Ward: ARU3 → 8C

Transfer Date: 12/10/15

EDD:

8640311.

Presenting Complaint / Condition

Mixed Overdose. Lives at home with 8 kids

Allergies:

KNDA

Relevant Past Medical History: (including previous inpatient management issues)

Depression

Medicines Reconcilliation: Yes ☐ No ☐

Current Management: (Immediate handover details)

IV Access: Y / N	IV Medication: Y / N	IV Fluids: Y / N	Oxygen: %	Sews Mews	NG Y / N

Independent

Investigation Results:

seen by Psych - does not regret, would do it again

Investigations Pending:

Patient appears orientated	Yes ☐ No ☐ GCS
Mobility	Independent ☑ Assistance of 1 ☐ Assistance of 2 ☐ Fully Dependant ☐
Skin	Intact ☐ Other ☐ Waterlow Score ☐ Special Bed ☐
MUST	Yes ☐ No ☐
Alcohol Management Plan	Yes ☐ No ☐

Diet	Normal ☐ Special ☐ Fasting: Nil by mouth ☐
Property/ Valuables	Clothing: Dentures: Glasses:
Infection Risk / **MRSA Screen done**	Yes ☐ No ☐ / Yes ☐ No ☐
Patient Medication	Sent: Yes ☐ No ☐ N/A:
Relatives informed of transfer	Yes ☐ No ☐ mums NOK
CANNARD	Yes ☐ No ☐

Any other Issues:

P.T.O. if more space required

MIS 227737

Name of transferring nurse:

Name of receiving nurse:

Date:

IDLS ☐ Medication ☐ Discharged ☐

NURSING CARE PLAN
DISCHARGE LOUNGE - QUEEN ELIZABETH UNIVERSITY HOSPITAL

PATIENTS NAME Lisa Hughs DATE 13/10/15

ADDRESS Levenvale WARD/AREA/CLINIC 82

Please ensure section below is completed during telephone handover for discharges and transfers from wards.

Patient's Mobility e.g. aids/level of assistance. Independent
Known relevant medical history e.g. patient diabetic / epileptic / asthmatic etc/allergies none
Nursing intervention required e.g. assistance required with eating/drinking, catheter in situ/thickened fluids/Oxygen normal diet + fluids
Any other relevant information e.g. patient does not speak English, patient has been distressed etc A+O
Name of person giving handover Jacqueline

SIGNATURE [signature] PRINT NAME A Tonah DESIGNATION SN (5)

ON ARRIVAL AT THE LOUNGE

☑ Welcome the patient; explain the reason for moving to the lounge.
☑ Explain that there are toilet and changing facilities.

DISCHARGE LOUNGE CHECKLIST

Time Arrived: 18:50		Yes	No	N/A (OPD/Transfers)	COMMENTS
Time Departed: 18:56	Discharge Checklist received?	☐	☐	☑	
Discharge ☐ Transfer ☑ OPD ☐	Venflon removed in Discharge Lounge	☐	☐	☑	
Ambulance ☑					
Own Transport ☐	Discharge Medication Pack given in: Ward	☐	☐	☑	
	Discharge Lounge	☐	☐	☑	
Red Cross ☐	Blanket offered-accepted ☐ declined ☑				
Internal ☐	Suitable clothing	☐	☐	☑	
	Clothing offered	☐	☐	☑	
	Clothing offer declined	☐	☐	☑	
DNACPR form ☐					
Time Ambulance Re-ordered:	House Keys: Care Home	☐	☐	☑	
	On person	☐	☐	☑	
	Access	☐	☐	☐	

SIGNATURE [signature] PRINT NAME A Tonah DESIGNATION SN (5)

Document if refreshments have been offered to the patient and declined. Document all refreshments and snacks taken during the patient's stay. Document all nursing interventions carried out during patient's stay. ☐ Alternatively please tick if no nursing intervention was required			
DATE	**TIME**	**NURSING NOTES/EVALUATION**	**SIGNATURE & PRINT NAME**

[redacted]

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 13/10/15

Attach Addre [redacted] 1701806541
HUGHES F
Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

NHS Greater Glasgow and Clyde

Ward: SC

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr (6r)

1. Signed [redacted] Name HMcNaught Designation SN
2. Signed [redacted] Name U. Dick Designation SN
3. Signed ..... Name ..... Designation .....

Individual patient needs: Red mat required: Y (N) Bed rails: Y (N)
'Must do's' for me. Ask the patient if there is anything they want specifically done today:
.....

USE FOLLOWING CODE:
O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

		Times	00 00	08 15	12 40	13 20	18 20															
	1:	Pain: assess and address If in pain inform registered nurse Y / N or N/A	N	N	N	N	N															
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)	I	I	I	I	I															
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)	INT	/	INT	INT	/															
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)	I	I	I	I	I															
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B	I	I	B	/	/															
		Chair Assist to walk, stand or tilt (W /ST/ T)	/	/	/	/	/															
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces	I	I	I	I	I															
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)	N	N	N	N	N															
		Encourage the patient to drink? Y / N / N/A	S	S	Y	Y	Y															
		Food, snack or supplement taken? Y / N / N/A	S	S	Y	Y	Y															
	6.	ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S	Y	Y	Y	Y	Y															
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S	S	S	Y	Y	NT															
	8.	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A	NA	NA	NA	NA	NA															
		Nurse Initials	YM	JT	CD	CD	JT															

Attach Addressograph label

Ward: 8C

NHS Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

Dynamic Mattress:	NA
Cushion:	NA
Orthotic footwear:	NA
Moving & handling aids:	NA
Other:	NA.

Active Care variant sheet - Care Number

1. Pain
2. A / B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Date	Time	Number	Variation	Signed

CEDAR CODE 102083

MIS 258902

1701806541
HUGHES F
Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

Cl[illegible]t) Moving and Handling Risk Assessment Form

Patient's name:	Named Nurse:	If Patient is totally independent, tick here and go to date box	Risk: Low ✓ / Medium / High
	H McNaught.	✓	

BODY BUILD			
Obese		Tall	
Above average		Medium	✓
Average	✓	Short	
Below average			
RISK OF FALLS			
High		Low	

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

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

Transfers (Including To/From: Bed; Wheelchair; Commode; Toilet)

HOIST/STANDAID (Specify)	ASSISTANCE	SUPERVISION ✓	INDEPENDENT
Model:	People: 1 2 3	Additional Information:	
Sling type:	Walking aid (specify)		
Sling size:			

Toileting

HOIST/STANDAID	ASSISTANCE	SUPERVISION ✓	INDEPENDENT
	People: 1 2 3	Additional Information:	

Move on / off bed pan

HOIST	MANEOUVRE	ASSISTANCE	SUPERVISION ✓	N/A
	Roll patient	People 1	Additional Information:	
	Monkey pole	People 2		
	Patient bridges	People 3		

Move up / down bed

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT ✓
	Sliding sheet	People 1	Additional Information:	
	Monkey pole	People 2		
	Rope ladder	People 3		

Transfer to / from trolley (or bed etc.)

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION ✓	INDEPENDENT
	Patslide	People 1	Additional Information:	
	Other	People 2		
	Fabric sliding aid	People 3		

Sit up over side of bed

BED REST	ASSISTANCE	SUPERVISION	INDEPENDENT ✓
	People: 1 2 3	Additional Information (e.g. equipment to be used – swivel cushion):	

Into Bath or Shower

WHICH BATH	HANDLING AID	ASSISTANCE	SUPERVISION ✓	INDEPENDENT
Shower	Shower chair	People 1	Additional Information:	
Variable height bath	Bathing Hoist e.g. Alenti	People 2		
Bed bath	Sling lifting Hoist	People 3		

Walking

NO WALKING	WALKING AID (specify)	ASSISTANCE	SUPERVISION ✓	INDEPENDENT
		People 1	Distanced walked / Additional Information:	
		People 2		
		People 3		

Other Instructions

Recording Symbol:	/	X	*
Date Assessed:	12/10/15		
Assessor's signature:	[signature]		
Proposed Review date:	19/10/15		

05236

Transfers (Including To/From: Bed; Wheelchair; Commode; Toilet)

HOIST/STANDAID (Specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
Model:	People: 1 2 3	Additional Information:	
Sling type:	Walking aid (specify)		
Sling size:			

Toileting

HOIST/STANDAID	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information:	

Move on / off bed pan

HOIST	MANEOUVRE	ASSISTANCE	SUPERVISION	N/A
	Roll patient	People 1	Additional Information:	
	Monkey pole	People 2		
	Patient bridges	People 3		

Move up / down bed

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Sliding sheet	People 1	Additional Information:	
	Monkey pole	People 2		
	Rope ladder	People 3		

Transfer to / from trolley (or bed etc.)

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Patslide	People 1	Additional Information:	
	Other	People 2		
	Fabric sliding aid	People 3		

Sit up over side of bed

BED REST	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information (e.g. equipment to be used – swivel cushion):	

Into Bath or Shower

WHICH BATH	HANDLING AID	ASSISTANCE	SUPERVISION	INDEPENDENT
Shower	Shower chair	People 1	Additional Information:	
Variable height bath	Bathing Hoist e.g. Alenti	People 2		
Bed bath	Sling lifting Hoist	People 3		

Walking

NO WALKING	WALKING AID (specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
		People 1	Distanced walked / Additional Information:	
		People 2		
		People 3		

Other Instructions

Recording Symbol:	/	X	*
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

Please record all food and drink **taken** on this chart daily - e.g.
1 bowl porridge, 1 slice brown bread, 1 cup of tea with milk and sugar, 6 spoonfuls of soup, half portion of fish etc.

Day 4 (Date:)	Day 5 (Date:)	Day 6 (Date:)
Breakfast	Breakfast	Breakfast
Mid-morning	Mid-morning	Mid-morning
Lunch	Lunch	Lunch
Mid-afternoon	Mid-afternoon	Mid-afternoon
Evening meal	Evening meal	Evening meal
Bedtime	Bedtime	Bedtime

Food Assessment Chart

NHS
Greater Glasgow and Clyde

Ward:	Name:
8C	


1701806541
HUGHES F
Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

Please record all food and drink taken on this chart daily - e.g. 1 bowl porridge, 1 slice brown bread, 1 cup of tea with milk and sugar, 6 spoonfuls of soup, half portion of fish etc.

Special Instructions:

Day 1 (Date: 13.10.15)	Day 2 (Date:)	Day 3 (Date:)
Breakfast Rice crispies Tea.	Breakfast	Breakfast
Mid-morning Tea.	Mid-morning	Mid-morning
Lunch Beef curry & rice Soup	Lunch	Lunch
Mid-afternoon	Mid-afternoon	Mid-afternoon
Evening meal	Evening meal	Evening meal
Bedtime	Bedtime	Bedtime

over

[redacted]

Outline of current presentation and precipitating factors

35 ♀. OVERDOSE: mixed, UNKNOWN QUANTITY, UNKNOWN TIME (LAST NIGHT AT SOMEPOINT)

Ⓐ PATENT & PROTECTED.

Ⓑ SPONTANEOUS EFFECT
RR 16
SATS 98% AIR.
GOOD AE.
NIL ADDED SOUNDS.

Ⓒ HS 1+11+0.
PULSE REGULAR. 62.
BP 116/67.

Ⓓ E, V2 M5.
PEARL - SIZE 4.
ABDO SNT.
ECG: SR 64bpm. NO ACUTE.

EMPTY MEDICATION PACKETS.
POSSIBLE INGESTION OF UP TO:
[redacted] PROPRANOLOL. x10mg TABS.
VENLAFAXINE 24 x 100microgram TABLETS.
DIAZEPAM 14 x 5mg TABS
OLANZAPINE 28 x 10mg TABS

Previous mental health problems, self harm, addictions, medication etc

MEDS: OLANZAPINE
CITALOPRAM
DIAZEPAM (WHEN DISCHARGING)
VENLAFAXINE
SALBUTAMOL.

SH: LIVES WITH 3 CHILDREN.
PARTNER INTERMITTENTLY LIVES ± THERE.

Other relevant information; relationships, finances, employment, housing, physical health, childcare etc

Appearance	Behaviour	Speech
Mood	Thought	Insight

[redacted]

High/Moderate/Low

[redacted]

Summary [redacted] MIXED OD. ALERT & CONSCIOUS HERE.

Service Referred to	Time of Referral
PLAN: ① BLOODS, INC PARACETAMOL, TFTs, CK. ② MEDICAL ADMISSION	

[redacted]

Follow up and advice	Carer informed

Name and Designation of Consultant or Middle-Grade Involved in Reviewing Patient: MR RITCHIE (EM CONSULTANT).

male gender	y	n	u
age >18 and <65	y	n	u
depression	y	n	u
alcohol or drug use	y	n	u
separated, widowed, divorced	y	n	u
suicide plan/concealment	y	n	u
evidence of psychosis	y	n	u
ongoing suicial intent	y	n	u
lack of social support	y	n	u
chronic physical illness/pain	y	n	u
family history of suicide	y	n	u
family concerned about risk	y	n	u
disengaged/poor compliance	y	n	u
unemployed or retired	y	n	u
access to lethal means of harm	y	n	u
previous violent methods	y	n	u
history of self harm/overdose	y	n	u
previous psychiatric treatment	y	n	u
current psychiatric treatment	y	n	u
current use of benzodiazepines	y	n	u

If young people in foster or residential care are assessed, their social work team should be informed, (via standby SW if out-of-hours), *and* correspondence given to carers present.

Print Name STARK

Signature [signature]

Date & Time 11-10-15.

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Emergency Department
Mental Health Triage and Risk Assessme

1701806541 17/01/1980
HUGHES
Lisa Rosemary

NHS Greater Glasgow and Clyde

Patient Name _____

DoB _____ CHI _____

GCS	BM	HR	BP	RR	SaO_2	Temp
14/15	5.3	67	110/67	16	100	36

Or describe the patient's physical appearance/clothing if attending alone as they may leave before assessment

Is the patient a young person in foster care or in a residential care placement? Yes (No)

Is the patient a carer for a child or for a dependent adult? (Yes) No

Is there a child protection concern or concern for an adult at risk? (Yes) No

Overdose – will require medical assessment	✓
Self-Injury - will require wound management	
Other Mental Health Presentation	

Is the patient violent, aggressive or threatening?	Yes		(No)
Is the patient obviously distressed, markedly anxious or highly aroused?		Yes	(No)
Is the patient quiet and withdrawn?		(Yes)	No
Do you think the patient is behaving inappropriately to their situation?		Yes	(No)
Do you think the patient presents an immediate risk to you, to others, or to themselves?	(Yes)		No
Do you think the patient is likely to abscond prior to assessment?	Yes		(No)
Do you think the patient's presentation suggests either delusions or hallucinations?*	Yes		(No)
Do you think the patient's presentation suggests they feel their actions are being controlled?	Yes		(No)
Are you aware of a history of mental health problems or psychiatric illness?		Yes	(No)
Are you aware of a history of violence or self harm?		Yes	(No)
Is the patient currently expressing suicidal thoughts	Yes		(No)

*Delusions; false but firmly held views and ideas. Hallucinations; false external stimuli (e.g. visual or vocal) the patient thinks are real

Any responses in the first column **High Risk**

Other patients can be categorized as **Moderate Risk**

If *all responses* are in the third column **Low Risk**

High/Moderate/Low Risk

of self-harm/violence/absconding in department

	high risk – supervised *and* in the department moderate risk – supervised *or* in the department low risk – can be asked to wait if necessary

Patient location, supervised by…	Rm 23		
Blood sample time?		Toxbase Information Printed?	

Print Name [illegible]

Signature [illegible]

Date 4/10/15 Time 1446

Emergency Department Nursing Documentation

Presenting Complaint: O/D

Date and Time: 11/10/15

NHS Greater Glasgow and Clyde

Patient Addressograph Label

1701806541 17/01/1980
HUGHES
Lisa Rosemary

Named Nurse(s):

Patient preparation (Please tick when completed)	Initials:	Communication (Please tick when completed)	Initials:
Prepare patient for examination	☑	Communication Aids (spectacles / hearing aid)	☐
Provide blankets if required	☑	Relatives present?	☐
Clothing bagged, labelled and stored under trolley	☑	Relatives / NOK Informed called ambulance	☑
Name-band (if required)	☑	Interpreter required	☐
		Telephone interpretation required	☐

Observations and Investigations (Please tick when completed)		Initials:	
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☑	IV Cannula (if required) dated and timed	☑
Peak Flow 1. 2. 3.	☐	Blood samples taken	☑
12 Lead ECG	☑	Urinalysis and Specimen if indicated	☐
Cardiac Monitoring	☐	*Results:*	
X-rays performed	☐	HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no:	☐
Other: please add	☐	Weight:	☐

Screening Tools (Please circle or tick as appropriate)		Initials:	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection	Y / (N)	**Preliminary Pressure Ulcer Risk Assessment** The patient can reposition themselves whilst in the department?	(Y) / N
AMT 4 (if >65 years) SCORE	/4	There is no reported skin damaged other than presenting trauma?	(Y) / N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y / (N)	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	(Y) / N
Mental Health Triage Assessment	(Y) / N	**Waterlow Score** *If >10 commence Active Care*	☐
Child Protection considered (in line with policy)	Y / (N)	**Active Care** (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	☐
GMAWS	Y / (N)	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Swallow test (If CVA/stroke)	Y / (N)	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula dated and timed	☐	☐	
	Name band	☑	☐	
	AMT4	☐	☐	
	NEWS chart	☑	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☑	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☑	Always	
	Notes: medical notes, GP letter, PRF	☑	Always	
Investigations	CXR reviewed	☐	☐	
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Patient Addressograph Label

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes

Date and Time		Print Name and Signature
	Hx OD last night	
11/11/15	Mum called by family	NA
18[illegible]	R informed bed ward	NA

Patient Addressograph Label

Nursing Notes

Date and Time		Print Name and Signature

Emergency Department - Active Care

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour 2 hours

Signed ..... Name .....

Patient Addressograph Label

			Time							
	1.	**PAIN: Assess and address** If in pain inform registered nurse **Y or N/A**								
S	2.	**SKIN INSPECTION** A. Pressure areas checked:								
		B. Redness (R) / Discolouration (D) / Pressure Ulcer (PU)								
K	3.	**KEEP MOVING:** A. Have you moved or walked **Y / N / I** (independent)								
		B. Trolley Right side (30° tilt) – **R** Left Side (30° tilt) – **L** Back– **B**								
		C. Chair Assist to walk, stand or tilt **(W /ST/ T)**								
I	4.	**ELIMINATION:** Do you need the toilet? **I** = Independent **A** = Assistance given **IC** = patient incontinent of urine/faeces								
N	5.	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? **Y / N** (consider mouth care)								
		Encourage the patient to drink? **(If appropriate) Y / N / N/A**								
		Food, snack or supplement taken? **(if appropriate) Y / N / N/A**								
	6.	**ENVIRONMENT:** Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the trolley in lowest position?								
	7.	**INFORMATION: Ask:** Is there anything else I can help you with? Inform patient of the time of return.								
	8.	**ESCALATION:** Escalate any issues to the Registered Nurse / Dr. **Y / N/A**								
		Nurse Initials								

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant	☐ Repose Mattress	Time	No.	Variation	Signed
I = Independent	☐ Moving and handling aids				
NT = No thanks	☐ Other:				

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks – Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	**Neurological Deficit**	
Incontinent faeces	2	Broken (established ulcer)	3	**Nutritional Element**		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	**Mobility**		Unplanned weight loss In past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2		**Special Risks – Medication**	
Special Risks – Surgery/Trauma		Fully mobile	0			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
On table > 6 hours	8	Restless/Fidgety	1				
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5	Apathetic (sedated/depressed/ reluctant to move)	2	BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2		Risk Score 10+ = 'At Risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4				
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

Mental Health Service

Glasgow Liaison Psychiatry Service
Queen Elizabeth University Hospital
Management Building, Ground Floor
1345 Govan Road
GLASGOW
G51 4TF

Private & Confidential

Dr Finney
Cardonald Medical Practice
1831 Paisley Road West
Glasgow
G52 3SS

Date Rec'd: 13th October 2015
Date Typed: 14th October 2015

Our Ref:
Your Ref: MmC/JA/1250038

Direct Line: 0141 201 2422

Dear Dr Finney,

Re: Lisa Hughes; D.O.B: 17.01.80; CHI: 1701806541
Address: 8 Carham Crescent, Glasgow, G52 2HN

The above named patient was referred to the Liaison Psychiatry Team initially on the 12th October 2015 after being admitted to the Queen Elizabeth University Hospital the previous afternoon at 14.07hrs by ambulance after taking a mixed overdose of Olanzapine, Diazepam and Propranolol tablets. The overdose was taken at home in the presence of her eight children. The patient is a 35 year old woman who is currently known to mental health services, specifically under Brand Street Community Mental Health Team. She has a past history of depression. The patient appears to have taken a box containing 28 x Olanzapine tablets, box of 28 x Diazepam and two strips of Propranolol. She denied taking any Levothyroxine.

There was no alcohol consumed prior to the overdose. A combination of social stressors appears to be the trigger for this episode of self-harm. She is currently under bail conditions following an alleged incident with her ex-partner where she was accused of brandishing a knife in front of him and he is now charging her with attempting to cause him harm and disfigurement. With the court case pending, having to cope with her eight children, the pressure from her ex-partner as she states he is psychologically abusive and controlling and their recent separation, it appears her mood has become increasingly low over the past few months. Lisa states that she just puts a brave face on most of the time and describes herself as a good mother generally but has found it increasingly difficult to cope.

She described that she had been working throughout the house on the day and just felt a wave of increasing anxiety and went to sit in one of the rooms upstairs. She said she sat in the darkened room for about an hour when her daughter came up to find out what was wrong as she states she was crying incessantly and felt that she was having some sort of mental breakdown. She was not regretful of her actions and was suffering ongoing suicidality.

I initially assessed her in ARU3 of the Queen Elizabeth University Hospital where she remained in a medical setting overnight and I reviewed her again Ward 8C the

following day. She presented slightly better that the previous day and appeared to look better physically though stated she felt nothing had changed mentally and added that she does not feel that she is able to cope with life at present, especially with the legal issues that are hanging over her and generally feeling low in mood. She has been advised that the Social Work Department had to be informed because she took the overdose whilst in charge of her children. I understand that there is already social work involvement with her daughter Rachel who Lisa states was raped in 2013. Lisa is known to Brand Street and has a CPN, Bill Smith whom I have liaised with on a couple of occasions to update him on Lisa's presentation.

Medical History
Lisa suffers from asthma.

Current Medication
Olanzapine 10mg at night, Citalopram 20mg OD, Diazepam 5mg TID, Salbutamol Inhaler 1-2 puffs PRN, Levothyroxine 200mcg.

Drug, Alcohol & Smoking History
Lisa said that she last had a drink last Friday consisting of three brandies and said that this possibly ignited the incident with her ex-partner as she generally does not drink. She denied the use of any illicit substances.

Forensic History
She has one charge pending as a result of the incident with her partner last week. She has had no previous charges.

Personal History & Social Circumstances
These have been well documented in previous letters. She lives with her eight children aged 17rs, 15yrs, 13yrs, 11yrs, 10yrs, twins at 7yrs, 6yrs. Her ex-partner Neil had previously been in Barlinnie and she describes him as a controlling and psychologically abusive man but she admits that she still loves him. There is no significant family history of psychiatric disorder. She described suffering from quite severe mood swings recently She has regular contact with her mum and describes her as a good support. She describes herself as different from everyone else and felt that she never really fitted in. She describes herself as being a decent mother and that all she is living for is her children.

Mental State Examination
Lisa was orientated to time, place and person. Her speech was of normal rate and tone. Her eye contact was reasonable. She states her sleep pattern has been poor recently. She said her appetite has reduced recently and that her diet has been poor over the last few weeks. She described her mood as "no good". On a scale of 0-10 she rated her mood to be 4/10. She had no specific current suicidal thoughts but feels unsafe and worried about going home and how she is going to cope with things. She feels overwhelmed about everything that is happening at the moment. There was no evidence of any psychotic symptoms.

Impression
Lisa is a 35 year old woman with a history of depression who is known to mental health services. She has had no previous psychiatric admissions. I feel that this lady is struggling to cope with her life at present and could probably benefit from a crisis respite admission. I informed her CPN that I was arranging a psychiatric admission and a bed was identified in ward 4B, Leverndale Hospital and I informed the ward staff to make the appropriate transfer arrangements.

Yours sincerely

Michael McCann
Advanced Nurse Practitioner

Cc Bill Smith, CPN, Brand Street Resource Centre, 150 Brand Street, Glasgow, G51 1DH

SOUTH GLASGOW HOSPITALS DIVISION SOUTHERN GENERAL HOSPITAL

N U R S I N G P R O F I L E

Name: LISA ROSEMARY HUGHES Unit No: SG00953485 Acct No: IP0021875/11

Address: 8 CARHAM CRES
GLASGOW
G52 2HN
Tel: 07833990700

Consultant: BLYTH,KEVIN
DOB: 17/01/80 Age: 31
CHI: 1701806541
Rel: Marital Status: SIN

Ward: S20
Date: 25/04/11
Time: 0105

Next of Kin: HAUGHEY,AGNES
Address: 7 KIRKCONNELL DR
GLASGOW
Tel: 634 4947
Relationship: MOT

GP: SEMPLE, LINSEY LC
Practice Address: CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS
Tel: 0141 892 2548

Other Contact:
Tel: Relationship:

REASON FOR ADMISSION:- OD

SHORT SUMMARY:- KNOWN PSYC PROBLEMS, RECENTLY DIAGNOSED WITH BIPOLAR DISORDER. PHONED SISTER AT 8PM TO SAY SHE HAD INGESTED 10 X OLANZOPINE, 20 X 5MG DIAZEPAM AND ALCOHOL. OD OCCURED AT 19.30PM. INTOXICATED ON ADMISSION TO A E - GCS 8 IN DEPT.

PAST MEDICAL HISTORY	MEDICATIONS ON ADMISSION
- BIPOLAR Dx 5 WEEKS AGO	1)OLANZAPINE
- DEPRESSION	2)DIAZEPAM
- THYROIDECTOMY 2 TO HYPOTHYROIDISM	3)CITALOPRAM
-	4)ARIPIPRAZOLE
-	5)LEVOTHYROXINE
-	-

********** Allergies **********
*
*
*
*
****

ESTIMATED DATE OF DISCHARGE:

SOUTH GLASGOW HOSPITALS DIVISION SOUTHERN GENERAL HOSPITAL

N U R S I N G P R O F I L E

Name: LISA ROSEMARY HUGHES Unit No: SG00953485 Acct No: IP0021875/11

GENERAL ASSESSMENT

> GCS 9 ON ADMISSION.
CANNULATED ON WARD - NOW HAS IV ACCESS LEFT ACF.
SEWS 3 AS HYPOTENSIVE AT 91/54, AND BEST NEURO RESPONSE TO PAIN ONLY.
SKIN INTACT.
VERY UNKEMPT. SISTER PRESENT O/A/

SOCIAL/HOME BACKGROUND

> LIVES WITH HER 8 CHILDREN AGED BETWEEN 2 AND 13.
SMOKES - APPROX 25 DAILY
HAS ONLY RECENTLY BEGUN HEAVY DRINKING.
UNEMPLOYED.

RELATIVES AWARE OF ADM Y/N?:- Y Comment:

ACTIVITIES OF DAILY LIVING

MAINTAINING SAFE ENVIRONMENT: Cot Sides Required

COMMUNICATING: Withdrawn

BREATHING: Can Maintain Airway

EATING/DRINKING: Normal Diet

ELIMINATING: Normal Bowel Function
Normal Bladder Function

CLEANSING/DRESSING: No Assistance

TEMPERATURE: Apyrexial

MOBILISING: Independent

WORKING/PLAYING: Unemployed

SLEEPING: Good Sleep Pattern

SOUTH GLASGOW HOSPITALS DIVISION SOUTHERN GENERAL HOSPITAL

N U R S I N G P R O F I L E

Name: LISA ROSEMARY HUGHES Unit No: SG00953485 Acct No: IP0021875/11

DYING: Not Appropriate Discuss

SKIN CONDITION: SKIN INTACT

Does patient smoke? Y
Does patient want to stop smoking NOW? N
Has patient been referred to 'Stop Smoking Service'? N

BP: mmHG Pulse: /min Resp: /min SpO2: % Temp: C
Weight: Kg Height: ft. in / Metric: cm BM: BMI:
Waterlow Score: Urinalysis:

Highly Sensitive Document Y/N N Patient consent to share information Y/N Y

ompleted By (Sign):_____

Completed by: GILLIAN LILLIS on/at 25/04/11 0134 Report Number: 2504-0003

NHS Greater Glasgow and Clyde

Specialty: General Medicine

Nursing Admission Documentation eForm - Version 1.3

Hospital Name: Southern General Hospital

Patient Details		GP Details	
Name:	Lisa, Hughes	**Name:**	FINNEY, ALAN
Address:	8 Carham Crescent Glasgow Lanarkshire	**Address:**	Cardonald Medical Centre 1831 Paisley Road West Glasgow
Postcode:	G52 2HN	**Telephone:**	
Correspondence Address 1:		**Ward:**	20
Correspondence Address 2:		**Specialty:**	General Medicine
Correspondence Postcode:		**Date of Admission:**	05/06/2014
Telephone:		**Time:**	15:12
Patient Contact Number:	01412390191	**Admitting Consultant:**	dr BLYTH
I Number:	1701806541	**Expected Date Of Discharge**	
CRN:	64057442B, SG00953485, Z00286838	**Admitting Nurse:**	Sarah McLellan
D.O.B:	17/01/1980	**Consent:**	Yes
Age:	34	**Sensitivity:**	Sensitive
Sex:	Female		

Next of Kin / Person to Notify

	Next of Kin	Person to Notify
Name:	AGNES HAUGHEY	
Address:		
Landline:		
Mobile:	07769815357	
Relationship:	MOTHER	
NOK aware of admission:	Yes	**Consent for information to be given to relatives:** Yes
Nominated family contact - Day:		**Night:**

Does the patient have an appointed Welfare Guardian / Power of Attorney? No

Is the patient a carer? No

1. Presenting Complaint / Diagnosis

KNOWN ASTHMATIC, FEW DAYS OF SOB/WHEEZE AND DRY COUGH. TODAY HAD SEVERE PAIN IN ANTEREIOR CHEST WORSE WHEN BREATHING IN, WAS HYPOXIC IN A&E 92% ON AIR. GIVEN DALTEPARIN IN A&E

2.Patient Allergy Summary

3. Observations

Cannard:		**Pulse:**		**BP:**	/
Waterlow (if required):		**Resp:**		**SaO2:**	
EWS:	0	**Temp:**		**BM:**	
Height(m):	1.69	**Weight(kg):**	54	**BMI:**	19
Urinalysis:				**AMT4 Score:**	0

4. Current Medication

INHALERS

Medicines reconciled on admission? No

5 Relevant Past Medical History

ASTHMA
DEPRESSION

6 Risk Assessment

Patient's BMI	18.5 - 20
Has the patient had unplanned weight loss?	
Will the patient have a significantly reduced diet intake over the next 5 days?	
MUST Score	1
If MUST score 1 or more complete Nutrition Profile.	yes

7 MRSA Screening

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

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

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

RSA Lab Test Results

...ose	No	**Perineum**	No	**Throat**	No	**Other**	No	**Patient refused**	No

Other details:

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

8 Lifestyle

Does the patient smoke?	Yes	**How many each day?**	15
Refer to smoking cessation clinic?	No	**Referral made to Smoking Cessation Services?**	No
Does the patient use recreational drugs?	No		
How often does patient have 6 or more drinks on one occasion?			Never
FAST Tool completed?			No

9 Admission Documentation completed by

Name: Sarah McLellan **Designation:** Registered Nurse **Date:** 05/06/2014

...ursing Admission Assessment

1 Breathing and Circulation

Breathing

Symptoms or history of respiratory problems?	Yes	**Productive / non-productive cough evident?**	Yes
Dyspnoeic at rest?	NA	**Dyspnoeic on minimal exertion?**	NA
Dyspnoeic on maximum exertion?	NA	**Normally receives oxygen therapy?**	NA

Circulation

Symptoms?	NA	**Known cardiac or circulatory problems?**	NA

2 Communication and Mental Status

Assessment of ability to communicate:

What language does the patient speak	ENGLISH	**Interpreter Required?**	Not required
Does the patient have:	Speech difficulties:		No
	Learning difficulties (e.g. Down's syndrome):		No

Eyesight							
Normal vision?	Yes	**Glasses?**	NA	**Distance?**	NA	**Reading?**	NA
Prosthesis?	NA	**Left:**	NA	**Right:**	NA		
Contact Lenses?	NA	**Registered Blind?**	NA				
Hearing							
Normal?	Yes	**Hearing impaired?**	NA				
Hearing Aid?	NA	**Left:**	NA	**Right:**	NA		
Mental Status							
Orientated?	Yes	**Confused?**	NA	**Distressed?**	NA	**Unconscious?**	NA
Aggressive / Abusive	NA						

3. Hydration and Nutrition

Nutrition screening should be repeated in 7 days on the following date:	12/06/2014		
Nutrition screening required?	Required	**MUST Score:**	1

4. Elimination

Continent (Bladder):	Yes	**Continent (Bowel):**			Yes
Incontinent (Bladder):	NA	**Incontinent (Bowel):**			NA
Long term urinary catheter insitu?	No				
Continence assessment commenced?	No	**Specify any containment products in use:**			
Bowel regular?	Yes	**Constipated?**	NA	**Diarrhoea / loose stools?**	NA
Stoma:	No	**Specify and list appliances used:**			

5. Personal Hygiene, Oral Health and Skin Assessment

Personal Hygiene									
Self-caring and independent?	Yes			**Requires assistance?**			NA		
Oral Health									
Oral Care Bundle implemented?	NA								
Self-caring and independent?	Yes			**Evidence or oral ulceration,**					
Requires assistance?	No			**Oral Hygiene Care Bundle?**					
Dentures:	**Not Worn?**	Yes	**Upper set?**	NA	**Lower set?**	NA	**Full set?**	NA	**With patient on admission?**	NA
Skin Assessment									
Healthy & Intact?	Yes	**Broken?**	NA	**Clammy?**	NA	**Discoloured?**	NA	**Oedematous?**	NA
Wound Assessment Chart completed?		No				**Pressure ulcer evident?**			
						Grade:			0

6. Mobility

Patient fully mobile/independent?	Yes	**Prosthesis?**	No
Limited Mobility?	NA	**Mobile with aid?**	NA
Moving and handling plan commenced?	No		

7. Maintaining a Safe Environment

Patient status			
Does the patient have pain?	No		
Bed rail assessment completed?	Yes	**Bed rails required?**	No

8. Sleep and Rest

Sleep Habits		Sleep Difficulties	
Less than 8 hours?	NA	**None?**	Yes
Morning nap?	NA	**Early wakening?**	NA
Afternoon nap?	NA	**Disturbed e.g. nocturiapain?**	NA

Medication required?	No

9. Social Circumstances

Employed?	NA	**Unemployed?**	Yes	**Retired?**	NA
Lives alone?	NA	**Lives with family?**	Yes	**Lives with friend?**	NA
Lives with dependants?	NA	**Nursing Home?**	NA	**Residential?**	NA
Other?	NA	**Other detail:**			

Current care/ Support Service arrangements:

Social Services?	NA	**Private Carers (family/friends)?**	NA
Unpaid carer?	NA	**None?**	Yes
Immediate Action Taken:	LIVES AT HOME WITH PARTNER AND 8 KIDS		

10. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and / or sexuality that are relevant to admission?	No

11. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?	No	**Details:**	
Is there anything causing the patient a lot of anxiety at the ıe of admission that staff should be aware of?	No	**Details:**	
Did patient want ward staff to arrange for a hospital Chaplain to visit while in hospital?	No	**Faith group:**	

12. Anticipatory Care (where appropriate and relevant)

Is Appropriate?	Not appropriate

13 ction List

Action	Yes/No	Date
Waterlow completed?	NA	
Nutrition Profile Completed?	Yes	05/06/2014
Infection Control Team contacted?	NA	
Referral made to Smoking Cessation Service?	NA	
Alcohol Screening and Assessment Tool completed?	NA	
Interpreter arranged?	NA	
Oral Care Bundle implemented?	NA	
Wound Assessment chart completed?	NA	
essure Ulcer Record completed?	NA	
Moving and handling plan completed?	NA	
Bed rail assessment completed?	Yes	05/06/2014
Current Care / Support arrangements suspended?	NA	
Referral to Duty Social Worker?	NA	

14 dmission Assessment Completed By

Name:	Sarah McLellan	**Designation:**	Registered Nurse	**Date:**	05/06/2014

Nutrition Profile

Height:	1.69 m	**Actual:**		**Patient / carer reported:**	X	**Alternative measurement:**	
Weight:	54.00 kg	**Actual:**	X	**Patient / carer reported:**		**Alternative measurement:**	
Recent unplanned weight loss?	No						

Is there evidence of recent weight loss?	**No:**	X	**Loose Clothing:**		**Reduced food intake / apetite:**		**Swallowing problem:**	

Dietary requirements: (eg: vegetarian, vegan, halal, kosher etc):	No
Food allergies:	No
Eating Likes and Dislikes (including appetite):	
Drinking likes and dislikes:	
Is patient nil by mouth?	No
Are there any contributing factors that may affect food intake such as physical (eg: swallowing difficulties, loose teeth), physiological (eg: nausea), psychological (eg: dementia), social or environmental ?	No
Please specify all factors:	
Is the patient on oral nutritional supplements?	No
Is the patient experiencing oropharyngeal swallowing problems (excluding oesophageal ...ies eg: GORD, Stricture) ?	No
...here a need for equipment and / or assistance with eating and drinking?	No
Has this patient received written information about inpatient food (eg: "Food in Hospitals" leaflet) ?	No
Profile completed by: Sarah McLellan	**Date:** 05/06/2014

NOTE: This is ADMISSION DATA - Please refer to changes in Care Plan.

Is your patient on the Liverpool Care Pathway (LCP):	No

Referral Services	Referral Date	Referred by	Method of referral	Reason for referral
Nutritional Support Team				
Dietitian				
Speech & Language Therapy				
Occupational Therapy				
Dental Service				

Management Guidelines

Score of overall risk of malnutrition	Action required	
0	**LOW RISK - Routine Clinical Care - Repeat screening**	
	Hospital Acute	weekly
	Hospital Rehabilitation	monthly
1	**MEDIUM RISK - Observe - Document dietary intake for 3 days on a Food Record Chart. - Encourage oral intake. - Encourage patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. - Repeat screening weekly.**	
2 or more	**HIGH RISK - Treat* - Refer to Dietitian and document food intake for 3 days on a Food Record Chart. - Encourage oral intake. - Encourage patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. - Monitor and review care plan weekly. *Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.**	

Adult Peripheral Venous Cannulation (PVC)

Patient: Hughes, Lisa **CHI: 1701806541**

Date	Time	Site	Reason For Insertion	Flushed On Insertion
05/06/2014	12:00	R ACF		Unknown

PVC Maintenance Information

Modified V.I.P. (Visual Infusion Phlebitis) Score

IV site appears healthy		0	No phlebitis	**Observe Cannula**
ONE of the following is evident:	slight pain or redness near site	1	Possible first signs	**Observe Cannula**
TWO of the following are evident:	pain, redness, swelling	2	Early stage of phlebitis	**Re-site Cannula**
ALL of the following are evident:	pain, redness, hardening of surrounding tissue	3	Phlebitis / Thromboophlebitis **Re-site Cannula & seek Further Advice**	
As above including:	palpable venous cord	4		
As above including:	pyrexia	5		

Day 1 (24 hours after insertion)			Day 2		
All 5 questions must be answered. The PVC must be monitored at least once per day.					
1	Continuing clinical indication for PVC?		1	Continuing clinical indication for PVC?	
2	VIP Score		2	VIP Score	
3	PVC dressing dry & intact?		3	PVC dressing dry & intact?	
4	Was PVC dressing renewed?		4	Was PVC dressing renewed?	
5	Was PVC removed?		5	Was PVC removed?	

After Day 3 consider removal, if there is still a clinical reason justify rational to remain insitu:

Day 3			Day 4		
All 5 questions must be answered. The PVC must be monitored at least once per day.					
1	Continuing clinical indication for PVC?		1	Continuing clinical indication for PVC?	
	VIP Score		2	VIP Score	
3	PVC dressing dry & intact?		3	PVC dressing dry & intact?	
4	Was PVC dressing renewed?		4	Was PVC dressing renewed?	
5	Was PVC removed?		5	Was PVC removed?	

Client Specific (Inpatient) Moving and Handling Intervention Plan

Patient:	Hughes, Lisa	CHINumber:	1701806541

Is the client able to transfer and mobilise independently:	Yes	Overall Risk:	Low

General Information

BODY BUILD					
Height	1.69	Weight	54	RISK OF FALLS	

Problems with comprehension, behaviour, co-operation (specify):							
Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):							
Transfers (sit to stand to sit, including to / from bed; wheelchair; commode, toilet)							
Hoist:	No	**Standaid:**	No	**Walking aid (Specify):**			
Model:				**Sling Type:**		**Sling Size:**	
Supervision:	No			**Independent:**	No		
Additional Information:							
Toileting							
Hoist:	No	**Standaid:**	No				
Supervision:	No			**Independent:**	No		
Additional Information:							
Move on / off bed pan							
Hoist:	No						
Supervision:	No			**NA:**	No		
Manoeuvre	**Role patient:**	No		**Monkey pole:**	No	**Patient Bridges:**	No
Additional Information:							
Move up / down bed							
Hoist:	No						
Supervision:	No			**Independent:**	No		
Handling aids	**Sliding sheet:**	No		**Monkey pole:**	No	**Rope ladder:**	No
Additional Information:							
Lateral Transfers to / from trolley or bed							
t:	No						
Supervision:	No			**Independent:**	No		
Handling aids	**Rigid transfer board:**	No		**Other:**	No	**Sliding sheets:**	No
Additional Information:							
Sit up over side of bed							
		Bed Rest:	No				
Supervision:	No			**Independent:**	No		
Additional Information / Equipment to be used:							
Into Bath or Shower							
Equipment	**Shower:**	No	**Variable height bath:**	No	**Bed bath:**	No	
Supervision:	No			**Independent:**	No		

Handling aids	**Shower chair:**	No	**Bathing hoist e.g. Alenti:**	No	**Sling lifting hoist:**	No
Additional Information:						
Walking						
No Walking:	No		**Walking aid (Specify):**	Yes		
Supervision:	No		**Independent:**	No		
Distance walked / additional information:						
Other Instructions						
Date Assessed:	05/06/2014	**Assessor:**	Sarah McLellan	**Proposed Review Date**		

Cannard Risk Falls Assessment

Patient:	Hughes, Lisa	**CHI:**	1701806541

Cannard Summary

Admission Date	Assessment Date	Ward	Score	Action(s) Taken	Falls Assessment Assessed By	Nursing Interventions Actioned By
05/06/2014	05/6/2014	20	2	1	Sarah McLellan	Sarah McLellan

Falls Assessment

Date:	05/06/2014	**Ward:**	20	**Sex:**	**Age:**

History of falls in the last 6 months:

None

Sensory deficit:

None

Medication type:

None

Medical history:

Mobility:

Fully mobile

Gait:
Steady

TOTAL SCORE:	2		
Assessed by:	Sarah McLellan	**Designation:**	Registered Nurse

Action Codes

Action Code	Nursing Interventions	
	General	
1	General Safety Precautions discussed with patient / family	05/06/2014
2	Involve patient / relative / carer with fall prevention care plan	
3	Ensure Spectacles and Hearing Aids are worn if appropriate	
4	Ensure Footwear appropriate - alert family to bring in suitable shoes	
5	Refer to Podiatry, if appropriate	
6	Routine urine test	
7	Commence Continence assessment - follow local guidelines	
	Environment	
8	Observe and remove trip hazards - drip stands, drains, catheters etc	
9	DO NOT leave patient unattended when using toilet, shower or bath	
10	Non slip mat on chair or floor - follow advice from therapists	
11	Move to more observable area of the ward to optimise supervision	
12	Patient's level of supervision to be reviewed frequently	
13	Patient requires one to one nursing care	
	Documentation	
14	Update falls risk assessment and care plan after a fall or change in condition	
15	Complete a Bedrail risk assessment	
16	Undertake a pain assessment	
17	Document in nursing notes alternative safety measures, if bedrails not used	
18	Document in nursing notes episodes of risk taking activity	
19	Investigate triggers for risk taking using a chart to monitor behaviour	
20	Record patients bowel activity	
21	Assess patients bowel activity to exclude constipation	
22	Review the continence management programme	
23	Use Falls Map if patient has 2nd or subsequent falls - see policy	
24	Record fluid intake / output	
25	Patient/relatives/carers given inpatient falls prevention leaflet	
	Seating and Bed	
26	Select most suitable seating - refer to Falls Policy	
27	Refer to Occupational Therapist for seating and transfer advice	
28	Bed rails or bumpers to be used - refer to Falls Policy	
29	Patient requires low bed or mattress on the floor- strict policy adherence	

30	Bed or chair monitor to be used - refer to Falls Policy	
31	When bed / chair monitor removed - patient supervision should be increased	
32	Bed to be placed against wall to allow only one exit	
	Mobilisation	
33	Advise patient that they may experience dizziness on initial mobilisation	
34	Monitor pulse & lying and standing Blood Pressures (see instructions)	
35	Review need for assistance when mobilising	
36	Refer to Physiotherapist for transfer and mobility advice	
	Investigation	
37	Exclude delirium - check infection, pain, constipation, medication	
38	Assess cognitive ability using AMT4	
39	Request a review of medications	
40	Ensure medical staff and multidisciplinary team are aware of falls	
	Referrals	
41	Refer to Hospital Falls Prevention Coordinator - see criteria	
42	Complete MUST - refer to dietician if appropriate	
Other		
	Date of podiatry referral:	
	Actioned by:	Sarah McLellan

Further Investigations

If any intervention above has not been effective for the patient, please describe what action you have taken to address the situation.

	Date:		Actioned by:	

Falls Coordinator Only:

Instructions to Nursing Staff:				
	Date:		Name:	

There is no further information for this patient

Previous Patient Notes for Acute Specialties GGC (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		**Outpatient Note**
Date/Time: 25-Jan-2019 10:30	**Created By:** ST7 Acute Medicine . - Barun Lal	**Role:** Doctor - GGC
Specialty: Acute Specialties GGC	**Organisation:** Queen Elizabeth University Hospital	Sensitive

Note:

CXR done on 17/12/2018 reports Compared to previous x-ray there are healed left-sided rib fractures affecting sixth and seventh ribs. The bony thorax is otherwise intact. Normal cardiac and mediastinal contours. No focal active lung lesion. Bilateral nipple piercings noted.

NHS GGC Hospitals, Admission Document

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1701806541

Queen Elizabeth University Hospital

Total Att: 20

12 Mth Att: 1

Title: MISS

HUGHES — **Lisa Rosemary**

DOB: 17/01/1980 Age: 46y Sex: Female

2 LANGSTILE ROAD

Next of kin: MCGUIRE, Stephanie
Relationship: Daughter

Glasgow
Lanarkshire
G52 4AG
07858379780

GP: JD Datta
0141 892 2548

Attendance Date: 13/05/2026 Arrival Time: 01:45

Registration Time: 01:45 Date of Incident: 13/05/2026

Major Incident Desc:

Reason for Attendance: **right sided facial numbness, pressure in chest, headache**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score: **0**

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint: **Neurological Sensory Change**

Observation Date: **13/05/2026 02:00** Nurse name: **Nurse Deborah Mair**

RR	16	bpm
Oxygen	21	%
Air or O2		
SpO2	98	%
HR	77	bpm
BP	130/96	mmHg
CRT		
MAP	107	mmHg
AVPU		
Temp	36.1	C
EWS Total		

BM	6.7	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

Pupils-Right		Pupils-Left	
Size (mm)	4	Size (mm)	4
Reaction	Y	Reaction	Y

Nursing Notes: **c/o right side mouth tingling/numbness and intermittent right hand tingling for 1/52, started taking HRT patches last week.**

Patient ID label

1701606541 17/01/1980
HUGHES
Lisa Rosemary

Date	Emergency Department Notes
	Ambulance Proforma reviewed Yes / No Seen by (Doctor) E. ROYS - LEAHY Time seen 08:30
13/05/26 08:30	46F 1/52 hx of progressive altered sensation of Ⓡ tongue and Ⓡ chin / lower cheek. Started with right tip of tongue but has gradually progressed to Ⓡ lower chin. Feels like she is drooling and that mouth feels 'not right'. No facial droop. No slurred speech. No limb weakness or abnormal sensation. Reports headaches - pressure sensation 'like a vice' across head. No vomiting but feels nauseous. 6/12 hx of visual decline - increasing prescription with optician. No fevers. No rash. Headache not particularly worse at any time of day or positional. Also reports dizzy episodes every morning for last week - on waking then settles after a few seconds. Also reporting left sided chest pain since yesterday at 3pm - worse on inspiration. Reports often gets with anxiety. NO SOB. NO cough. NO calf pain or swelling. PMHx: EUPD. Anxiety + Low Mood. Migraines. Asthma. Autoimmune thyroiditis. DHx: Propranolol. Citalopram. Everol Sequi. Fluticasone. Salbutamol. Olanzapine. Trianune. Levothyroxine. NKDA. SHx: Wales. Non-smoker but vapes. Drinks 2-3 bottles of wine / day. - awaiting ARDS input. Started HRT in last week.

Patient ID label

1701806541 17/01/1980
HUGHES
Lisa Rosemary

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

O/E: Normal gait. GCS 15/15. PEARL.
NO visual field defects. No nystagmus. No double vision.
Power 5/5 bilaterally upper + lower limbs.



Reports altered sensation (R) lower face.
Otherwise cranial nerve exam (N).
FAST negative.

No past pointing. Rombergs negative but reports feels dizzy on testing.

Chest clear. No added sounds.
HS 1+11 +0. HR regular.

Differential Diagnosis/Problem List: Calves soft non-tender. NO erythema or swelling.

Imp: ?Migraine.
?peripheral neuropathy.

NEWS ☐ 0-7
RED FLAG ☐ (Tick)
SEPSIS ☐
CURB 6S ☐

Done/ completed	Immediate Managment Plan
	Plan: ECG — Wells score PE: 0.
	?Add on D-Dimer
	? Troponin.
	D/C with consultant - ?need for CT Head.
	Discussed with consultant Dr Milner - Intracranial cause unlikely. Rev CXR + ECG then (H) with warning advice + advice to seek GP input.

Signature: [redacted] Designation: FY2. Page No:

EVE NON-LEAHY

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

Patient ID label
1701809541 17/01/1980
HUGHES
Lisa Rosemary

Seen By: Print: Time Seen: Pg. No:

PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	
History of presenting complaint	

Past Medical History / Review of portal

Systemic Enquiry

Patient ID label

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history (>1 source preferred)	☐ Patient/Relative/carer ☐ Patient own drugs ☐ Repeat Prescription	☐ GP Phone call ☐ Com. Pharmacist	☐ ECS ☐ GP letter/summary
Other (please specify)			

Admission Medicines			Plan for Medicines (Dr complete)				Comments Reason for alteration
Name	Dose	Freq	Continue	Amend	Withhold	Stop	

Allergies	List any over-the-counter or alternative medicines
	Do medicines need further clarification ? ☐ Yes ☐ No
List collected by :	Plan approved by :
Designation : Date :	Designation : Date :

Pharmacy review	Comments	
Compliance aid : ☐ Yes ☐ No		Community pharmacist Phone
Reviewed by :	Designation :	Date :

Patient ID label

1701806541

Lisa Hughes

Social History \ Family History

Smoking History

Ex-smoker/Smoker _____ cpd _____ yrs ☐ Never smoked

Alcohol History

_____ Units/week FAST score if excess _____

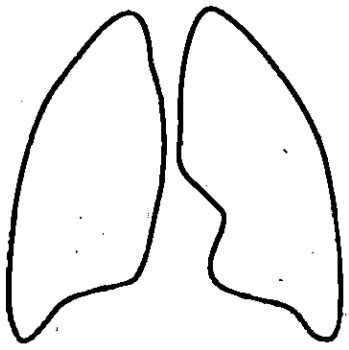
Recreational Drugs **Driving Status**

Social Circumstances (home, supports, functional status, occupation, travel)

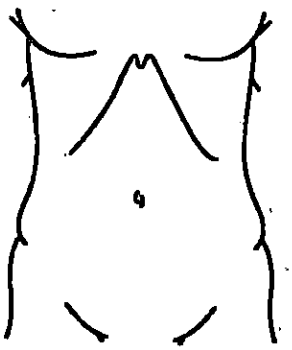
General Examination	
Temp:	RR:
Pulse:	CBG:
SpO_2:	Weight:
BP:	Urinalysis:

General Appearance:

Respiratory



Gastrointestinal System



Cardiovascular

Locomotor

Patient ID label

Neurological system

GCS: /15 E: /4 M: /6 V: /5

AMT 4 = age, DOB, place, year

AMT score ____ /4

Is the patient more confused/drowsy than normal: Y / N
If yes complete 4AT / TIME

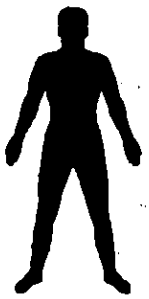
Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

Patient ID label

1701806541
Lisa Hughes

Key Results

CXR ECG

(Differential) diagnosis

NEWS ☐

Red Flag ☐

Sepsis ☐

CURB 65 ☐

Management Plan

☐ Thromboprophylaxis assessed ☐ Medicine Reconciliation ☐ 4AT/TIME
☐ Antimicrobial

Signature: PRINT NAME

PRINT GRADE

Page:

Patient ID label

Resuscitation Decision
Resuscitation status: FOR RESUSCITATION / DNA CPR (please circle)
If DNA CPR → Complete appropriate form

Senior Medical review
☐ Thromboprophylaxis assessed ☐ Medicine Reconciliation ☐ 4AT/TIME ☐ Antimicrobial ☐ DNACPR ☐ AWI if appropriate

Sepsis Six
- ☐ Antibiotics within 1 hour
- ☐ Appropriate Cultures
- ☐ Fluids
- ☐ Oxygen
- ☐ Lactate
- ☐ Fluid balance, consider catheter

Patient ID label

1701806541
Lisa Hughes

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED

Is the patient bed-bound or expected to have reduced mobility relative to normal for ≥2 days

☐ Yes

Does the patient have any of the following risk factors? Tick if apply

Active cancer or cancer treatment		Use of oestrogen containing contraceptive	
Age> 60		Hormone replacement therapy	
Dehydration		Pregnancy or <6 weeks post partum (seek specialist advice)	
Known thrombophillia		Critical care admission	
BMI >30		Varicose veins with phlebitis	
Personal/1st degree relative history of VTE		Current significant medical condition e.g. infection, inflammation, cardio resp disease	
Hip fracture			

☐ Yes

Does the patient have any of the following contraindications? Tick if apply

Active bleeding		Untreated inherited bleeding disorder	
Acquired bleeding disorder		Thrombocytopaenia <75 x109/l	
Thyroid, spinal, posterior eye or neurosurgery		Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR>2		Uncontrolled hypertension (>230/120)	
Acute stroke		Varicose veins	
Recent (<4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic			
Other - Document			

☐ No

Enoxaparin 40mg (reduce to 20mg if weighs < 50kg or eGFR <30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

☐ No

- No thromboprophylaxis
- Reassess (every 72 hours minimum)and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

☐ Yes

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum)and document

Patient informed ☐ Yes ☐ N/A
(only n/a if due to cognitive impairment or similar).
If N/A why? _____
Assessed by _____
Date _____

Patient ID label

Results

Date Time									
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165								
WCC	4.0 - 11.0								
Plts	150 - 450								
MCV	80 - 100								
Neut	2.0 - 7.5								
PT	9.0 - 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	( )								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146								
K+	3.5 - 5.3								
Cl-	95 - 108								
HCO3-	22 - 29								
Urea	2.5 - 7.8								
Creat	40 - 130								
eGFR									
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50								
AlkP	30 - 130								
Bil	<20								
ALT	<50								
AST	<40								
GGT	Male: <70 Female: <40								
ESR	Male: 1 -10 Female: 1 - 12								
CRP	<10								
Troponin hs I	Male: 0 - 34 Female 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate.									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 – 2.0								

Patient ID label

1701806541

Lisa Hughes

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO_2:

FiO2:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet	
Date: Time	

Patient ID label

1708 1701806541

Lisa Hughes

Continuation Sheet	
Date: Time	

Patient ID label

Continuation Sheet

Date: Time

Patient ID label

1701806541

Lisa Hughes

Continuation Sheet

Date: Time	

Patient ID label

Nursing Documentation

Done/ Time		

Once only prescriptions (including tetanus prophylaxis)

Date Given	Drug (Block Capitals)	Dose	Method of administration	Time of administration	Signature	Given by
8/5/26	Paracetamol	1g	PO	07:30		

Discharge prescription packs

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by

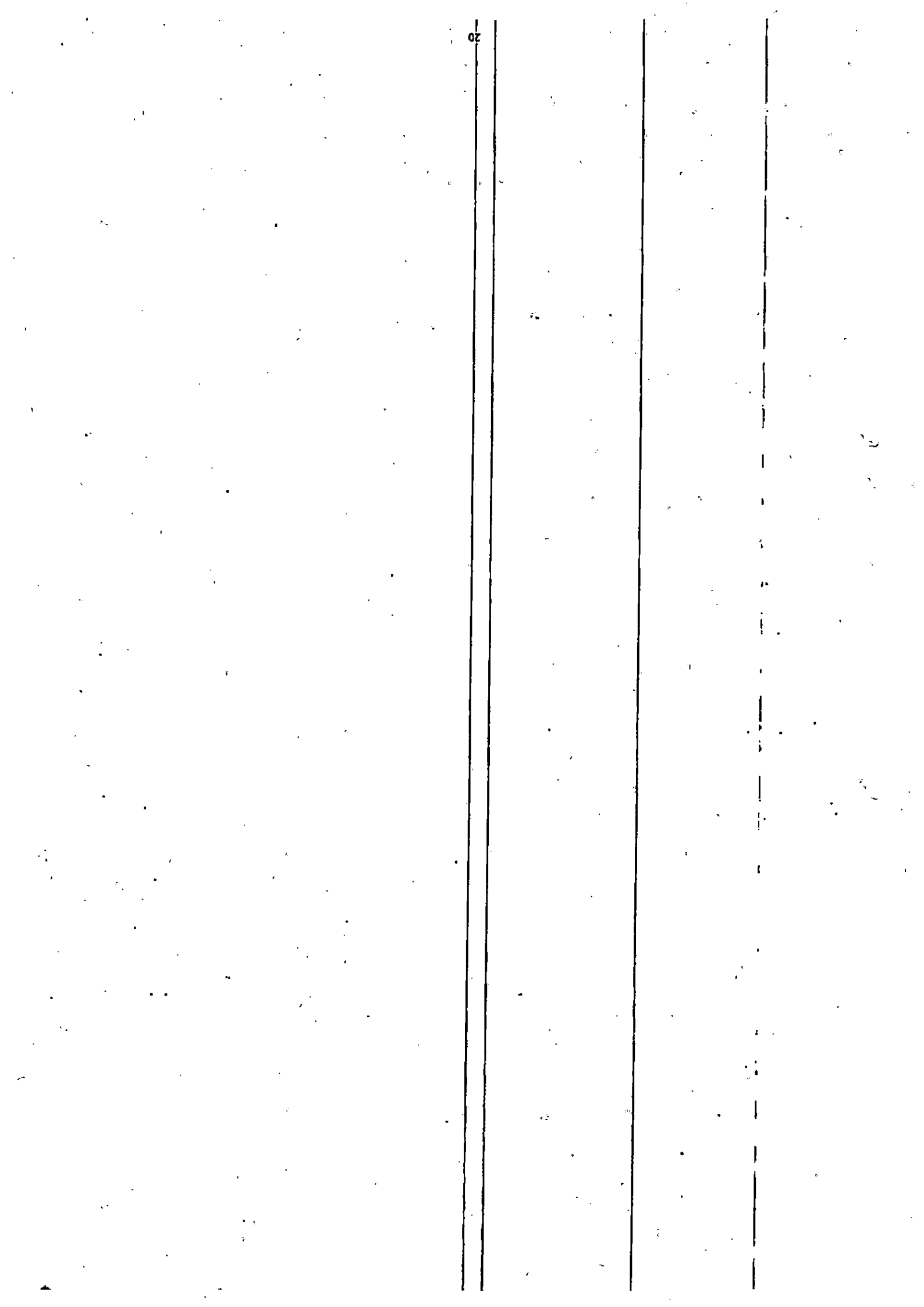
DISCHARGE CODES: Please Circle				Time Ready to Depart	
1. Admission	2. Discharge	3. Refer to G.P.	4. Transfer to other hospital (see below)		
5. Died	6. Refer to O.P. Clinic (see below)	7. Irregular Discharge	8. D.O.A.	Discharge Time	

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

Outpatient clinic specialty						Admission or specialty clinic consultant		
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify



HUGHES
Lisa Rosemary


20

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

SWA.

Queen Elizabeth University Hospital

CHI: 1701806541

Total Att: 18

12 Mth Att: 1

Title: MISS

HUGHES

Lisa Rosemary

DOB 17/01/1980 Age: 45y Sex: Female

2 LANGSTILE ROAD
Glasgow
Lanarkshire
G52 4AG
07858379780

Next of kin: HAUGHEY, AGNES
Relationship: Mother
07769815357

GP: JD Datta
0141 892 2548

Attendance Date: 24/02/2025 Arrival Time: 00:40

Registration Time: 00:40 Date of Incident: 16/02/2025

Major Incident Desc:

Reason for Attendance: nhs24 ref ed direct - HEAD INJURY-5 HOURS

Affix Label

Nursing Assessment

Alerts: Not Recorded Allergies: None Known Pain Score:

Triage Category: 3 Tetanus up to date/fully immunised:

Presenting Complaint: Head injury

Observation Date: 24/02/2025 01:05 Nurse name: Nurse Sarah Pirie

Temp	36.1	C
HR	92	bpm
BP	146/86	mmHg
MAP	106.00	mmHg
RR	18	bpm
SpO2	96	%
Oxygen	21	%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: WAS DIRECTLY HIT WITH HEAVY OBJECT TO BACK OF HEAD. FELL TO GROUND AND BLACKED OUT. GCS 15. NOT ANTICOAGULATED. NOT VOMITED- NO NAUSEA. FEELS UNSTEADY ON FEET AND SKAKEY. WENT TO GO TO BED AND FELT PAIN GOT WORSE.

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (Including Tetanus Prophylaxis)

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Patient Label

1701808641 17/01/1980
HUGHES
Lisa Rosemary

Queen Elizabeth University Hospital

NHS Greater Glasgow and Clyde

Adult Head Injury Worksheet

24/12/25

Seen by D.mcaw Date 0430 Time 0440

Description of and Mechanism of Injuries

struck tobogganed by heavy object fell on
wood on ice hard object - pavement tobogganed.

Continue on ED card if necessary

	Yes	No	Details if yes
Evidence of alcohol ingestion		✓	
Evidence of other drug use		✓	
Loss of consciousness	✓		A few seconds
Post-traumatic amnesia		✓	
Headache		✓	
Vomiting		✓	
Visual disturbance		✓	
Seizure since injury		✓	
Other neurological symptoms		✓	

Past Medical History

Migraines; Chronic pain
Asthma.
Anxiety

Drug History

See BCA

Allergies: Nil

Tetanus status Current

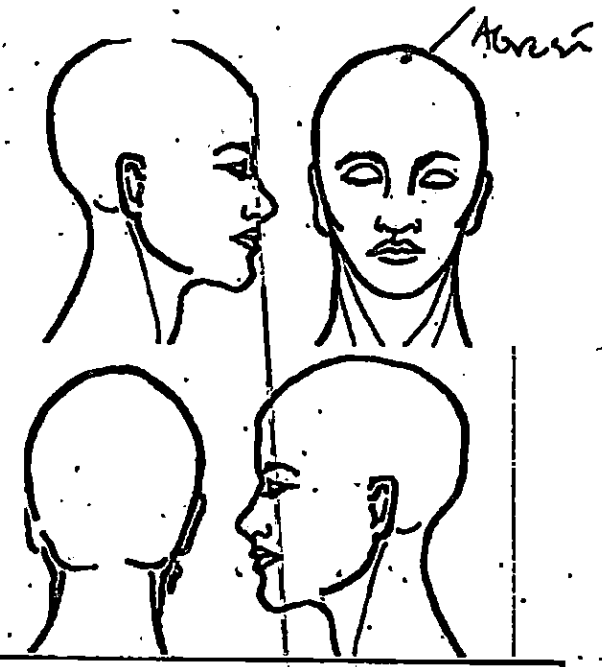
Anticoagulants

	Yes	No	
Warfarin		✓	INR:
Other anticoagulants		✓	Name:

Examination Findings

HR	92	RR	16	GCS	Score	Pupils	Left	Right
BP	126/96	SpO_2	98	E	4	Size	3	3
BM	6.2	Temp	36.2	M	6	Reactive	✓	✓
				V	5	Eye movements	✓	✓
				Total	15	Tympanic membranes	✓	✓

Neurological Examination				
	RUL	LUL	RLL	LLL
Sensation	✓	✓	✓	✓
Tone	✓	✓	✓	✓
Power	✓	✓	✓	✓
Reflexes	✓	✓	✓	✓



1701806541 17/01/1980
HUGHES
Lisa Rosemary

Examination Findings			
	Yes	No	
Palpable or visible skull fracture		✓	Details
Evidence of Basal Skull fracture		✓	Specify
Evidence of injury to neck		✓	Details

Investigations			
	Yes	No	Result
C-spine X-ray		✓	
CT Brain		✓	
Bloods		✓	
Facial Views		✓	

Impression	Treatment
Minor head injury	Analgesia advice D/S leaflet

Disposal			
	Yes	No	Time
Home with responsible adult with head injury advice card	✓		0440
Concussion advice discussed	✓		0440
Admit to ED head injury ward		✓	
Admitted to surgical HDU under ED		✓	
Discussed with Neurosurgical SpR at QEUH, no transfer		✓	
Transferred to care of Neurosurgeons at QEUH		✓	

Additional notes on ED card? Yes ☐ No ☐

Signed: _____ Print name: D. McCann Grade: ACP

Date	CLINICAL NOTES	
	Seen by (Dr)	Time seen

1701806541 17/01/1980
HUGHES
Lisa Rosemary

1701805541 17/01/1980
HUGHES
Lisa Rosemary

Date	

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant if admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By
24/2/25	Paracetamol	1g	PO	QDS		

NHS GGC Hospitals, Admission Document

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital

URH | RAH | ... | ... | WEST SCU | ...SCU | Stob | VOL | Q...

CHI: 1701806541

Sex: M ☐ F ☐

Surname: HUGHES

Forename: Lisa Rosemary

Total Att: 16

12 Mth Att: 1

Title: MISS

DOB: 17/01/1980

Age: 43y

1701806541
HUGHES
Lisa, R
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

8 Carham Crescent

Glasgow

Lanarkshire

G52 2HN

Tel:

Dob: Age:

Sex: Female

Next of kin: HAUGHEY, AGNES
Relationship: Mother

07769815357

GP: JD Datta

0141 892 2548

Tel:

Attendance Date: 03/01/2024 Arrival Time: 16:38

Registration Time: 16:38 Date of Incident: 03/01/2024

Date of Incident:

Major Incident Desc:

Major Incident description:

Reason for Attendance: SDUCC - OWN (R) SIDED HEADACHE

Nursing Assessment

Nursing Assessment

Alerts: Not Recorded Allergies: None Known Pain Score:

Triage Category: 3 Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 03/01/2024 18:30 Nurse name: Nurse Annaliza Guevarra

Temp	36.6	C
HR	79	bpm
BP	127/92	mmHg
MAP	103.67	mmHg
RR	16	bpm
SpO2	98	%
Oxygen		%
		bpm
		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight	71.4	kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Motor

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: Right sided headache and blurring of vision ?SAH

With correction? Reaction Reaction

Nursing Notes:

Patient ID label

Date	Emergency Department Notes	
	Ambulance Proforma reviewed Yes / No Seen by (Doctor)	Time seen

Pat

1701806541
HUGHES
Lisa, R
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

F
17/01/1980

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Differential Diagnosis/Problem List

NEWS ☐ 0-7

RED FLAG ☐ (Tick)

SEPSIS ☐

CURB 65 ☐

Done/ completed	Immediate Managment Plan

Signature: Designation: Page No:

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

1701806541
HUGHES
Lisa. R
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN
F
17/01/198(

Seen By: M. CLARK Print: M. CLARK Time Seen: 0130 Pg. No:
PRF Reviewed Yes / No 4/1/24

Presenting Complaint(s)	
Presenting complaint	Headache.
History of presenting complaint	43F - On 30/12/23 developed sudden onset sharp Right sided headache - Over same period developed visual blurring in R eye - Also pain at TMJ when opening and closing mouth. - Also associated pain around ear ° Tinnitus ° Discharge ° Vertigo ° Hearing loss. - Pain worse lying down and bending forward. - No trauma.

Past Medical History / Review of portal
- Asthma - Overdose - Thyroidectomy - EUPD.

Systemic Enquiry

Patient ID label

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history (>1 source preferred)
☐ Patient/Relative/carer ☐ GP Phone call ☐ ECS
☐ Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary
☐ Repeat Prescription

Other (please specify)

Admission Medicines			Plan for Medicines (Dr complete)				Comments Reason for alteration
Name	Dose	Freq	Continue	Amend	Withhold	Stop	
Lenothyroxine	175mcg	OD	✓				
Citalopram	20mg	OD	✓				
Clenil Modulite	100mg	2 Puffs BD	✓				
Olanzepine	10mg	OD.					

Allergies	List any over-the-counter or alternative medicines
NKDA	
	Do medicines need further clarification ? ☐ Yes ☐ No
List collected by :	Plan approved by :
Designation : Date :	Designation : Date :

Pharmacy review	Comments

Compliance aid : ☐ Yes ☐ No	Community pharmacist Phone
Reviewed by : Designation : Date :	

P.
1701806541
HUGHES
Lisa, R
8 Carham Crescent
Glasgow, Lanarkshire
G52 2H
F
17/01/198

Social History \ Family History

Smoking History

Ex-smoker/Smoker Vapes. cpd _____ yrs ☐ Never smoked

Alcohol History

Occasional Units/week FAST score if excess _____

Recreational Drugs **Driving Status**

None

Social Circumstances (home, supports, functional status, occupation, travel)

Work as a support worker.

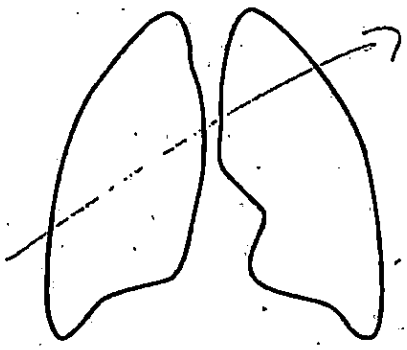
General Examination

Temp: 36.5	RR: 16.
Pulse: 79	CBG:
SpO_2: 96% RA	Weight:
BP: 113/74	Urinalysis:

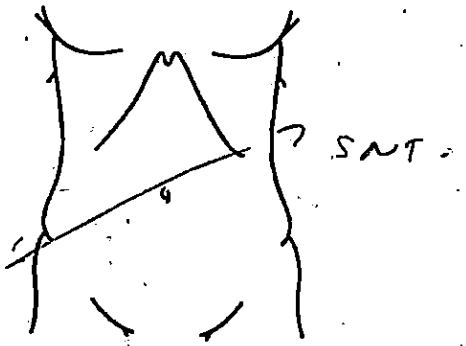
General Appearance:

Not overweight.

Respiratory



Gastrointestinal System



Cardiovascular

RS 14.1 (0

N.I oedema

Locomotor

Patient ID label

Neurological system

GCS: 15/15 E: /4 M: /6 V: /5

AMT 4 = age, DOB, place, year

AMT score ____ /4

Is the patient more confused/drowsy than normal: Y / N
If yes complete 4AT / TIME

* Unable to find ophthalmoscope.
2 x Broken ones in IAU *

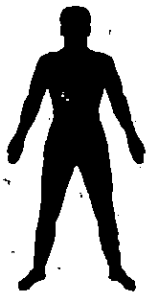
Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves: CN II - XII ✓

Neck: No stiffness.

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power	5	5	5	5
Co-ordination				
Sensation	N	N	N	N

Plantars: R L

Skin/Other

- Palpable temporal a. on R side.
- Tender on palpation of temples.
- Pain on movement of Jaw.

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Key Results

CXR Normal. ECG NSR. Rate 75.

(Differential) diagnosis

1. Likely TMJ Pain Disorder.
   - ↳ Exclude SAH
   - ↳ Seems too young for GCA but will add ESR.
   - ↳ C.V.ST other diagnosis to consider.

NEWS ☐
Red Flag ☐
Sepsis ☐
CURB 65 ☐

Management Plan

1. CT B ☑ (D/w Radiology Hub.) → Nil acute
2. Add ESR + D-dimer. ☑ Sinus
3. Analgesia.
4. Eye exam when ophthalmoscope found.
5. CXR. ☑

☑ Thromboprophylaxis assessed ☐ Medicine Reconciliation ☐ 4AT/TIME
☐ Antimicrobial

Signature: M. Clark PRINT NAME M. Clark
PRINT GRADE IMT1 Page:

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Resuscitation Decision

Resuscitation status: FOR RESUSCITATION / DNA CPR (please circle)

If DNA CPR → Complete appropriate form

Senior Medical review

VARMOUR IMT3 4/1/24

(93) Admitted overnight with headache. Seen in IAU, + had bloods, CXR + CTB and moved to SDUCC this am.

Bloods:
ESR ~~##~~ pending
D-dimer -ve
CRP 2 U+E's NAD
WCC 9.4 Hb 124 Plts 369
Coag (N)

CTB (req rep):
- nil acute but in-keeping with sinusitis

CXR:
- nil focal

From hx + examination + investigations I suspect TMJ pain / Sinusitis is most likely cause.

D/W pt: NEWS = 1 Temp 35.9°C
- reviewed history → mainly facial pressure, bit of altered sensation, dry nose
- bright + chatty
- pain/headache started 6/7 + has been able to go to work throughout
- maternal aunt had brain tumour

non-specific ill defined hypoattenuation ?SVD - MRI may help clarify

Plan/ - await formal CTB report + ESR
- (N) Thereafter with nasal ~~steroid~~ decongestant, advice re. regular analgesia and strict worsening advice + OP MRI/~~neuro~~ reg. + optician r/v

☐ Thromboprophylaxis assessed ☐ Medicine Reconciliation ☐ 4AT/TIME
☐ Antimicrobial ☐ DNACPR ☐ AWI if appropriate

Sepsis Six
- ☐ Antibiotics within 1 hour
- ☐ Appropriate Cultures
- ☐ Fluids
- ☐ Oxygen
- ☐ Lactate
- ☐ Fluid balance, consider catheter

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Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED

Is the patient bed-bound or expected to have reduced mobility relative to normal for ≥2 days.

☐ Yes

☐ No

- No thromboprophylaxis
- Reassess (every 72 hours minimum)and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

Does the patient have any of the following risk factors? Tick if apply			
Active cancer or cancer treatment		Use of oestrogen containing contraceptive	
Age> 60		Hormone replacement therapy	
Dehydration		Pregnancy or <6 weeks post partum (seek specialist advice)	
Known thrombophillia		Critical care admission	
BMI >30		Varicose veins with phlebitis	
Personal/1st degree relative history of VTE		Current significant medical condition e.g. infection, inflammation, cardio resp disease	
Hip fracture			

☐ Yes

☐ No

Does the patient have any of the following contraindications? Tick if apply			
Active bleeding		Untreated inherited bleeding disorder	
Acquired bleeding disorder		Thrombocytopaenia <75 x109/l	
Thyroid, spinal, posterior eye or neurosurgery		Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR>2		Uncontrolled hypertension (>230/120)	
Acute stroke		Varicose veins	
Recent (<4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic			
Other - Document			

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum)and document

☐ No

☐ Yes

Enoxaparin 40mg (reduce to 20mg if weighs < 50kg or eGFR <30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A
(only n/a if due to cognitive impairment or similar)
If N/A why? _____
Assessed by _____
Date _____

Patient ID label

Results

Date Time		3/1							
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165	124							
WCC	4.0 - 11.0	9.4							
Plts	150 - 450	369							
MCV	80 - 100								
Neut	2.0 - 7.5								
PT	9.0 - 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	( )								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146	137							
K+	3.5 - 5.3	4.4							
Cl-	95 - 108								
HCO3-	22 - 29								
Urea	2.5 - 7.8	3.8							
Creat	40 - 130	54							
eGFR		>60							
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50	38.							
AlkP	30 - 130	53							
Bil	<20	4							
ALT	<50	15							
AST	<40	19							
GGT	Male: <70 Female: <40								
ESR	Male: 1 -10 Female: 1 - 12								
CRP	<10								
Troponin hs I	Male: 0 - 34 Female 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60	2.41							
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 – 2.0								

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Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO_2:

FiO2:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet	
Date: Time	

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Continuation Sheet

Date: Time	

Patient ID label

Continuation Sheet

Date: Time	

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Continuation Sheet

Date: Time	

Patient ID label

Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

Date Given	Drug (Block Capitals)	Dose	Method of administration	Time of administration	Signature	Given by
4/1/24	PARACETAMOL	1000mg	O	1100		
4/1/24	IBUPROFEN	400mg	O	1100		

Discharge prescription packs

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by

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

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

Outpatient clinic specialty						Admission or specialty clinic consultant		
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

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WA

My Admission Record

NHS Greater Glasgow and Clyde

Name:
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Hospital: QEUH Ward: 1AU
Date of Admission: 4/1/23 Time: 0219
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name: LISA
Age: 43 Telephone Number:
Consultant:

Communication

What is your first language? English
Do you require an interpreter? Yes ☐ No ☑
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☑
Do you need someone to help you to communicate? Yes ☐ No ☑ If yes, who _____

Preferred first contact	**Preferred second contact**
Name: AGNES HAWKEY	Name:
Relationship: MOTHER	Relationship:
Address:	Address:
Telephone: 07415581488	Telephone:
Is this person aware of your admission? Yes ☑ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☑ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Headache + Blurred vision

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☐ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☑

Relevant past medical history

Asthma
Thyroidectomy

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☑ If yes, Who asked for a copy? _____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

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Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☐

OR

Does someone have Guardianship?

Yes ☐ No ☐

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy?_____ Date they asked for a copy ___/___/___ Date Obtained ___/___/___

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☐
2. Received holiday dialysis outside Scotland?	☐	☐
3. Been told that you have CPE?	☐	☐
4. Been in close contact with a person with CPE?	☐	☐

If the answer is yes to **ANY** of the questions in this section, you must

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☐	☐	☐
YES complete the following section			
1. Have you ever been told that you have MRSA?	☐	☐	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☐	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☐	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☐	☐

If **YES inform the IPCT** ☐

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Lifestyle

Smoking

Are you a: smoker ☐ ex- smoker ☑ when did you stop? _____

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☐

If a smoker, the NHSGGC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ___/___/___

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☑

If yes, please specify and refer to the NHSGGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

_____

_____

Alcohol

Do you drink alcohol? Yes ☑ No ☐

How often do you have more than 6 units of alcohol on one occasion:

Never ☐ Less than monthly ☐ Monthly ☑ Weekly ☐ Daily or almost daily ☐

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

Name (Please PRINT): SHOCATT Signature: SHOCATT

Designation: CN Date: 4/1/23

My Assessment Record

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Affix patient ID label

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems			
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?			
Do you have any difficulties with your speech?			
Do you have a Learning Disability?			
Do you have support from a Learning Disability Team? Contact details: _____			

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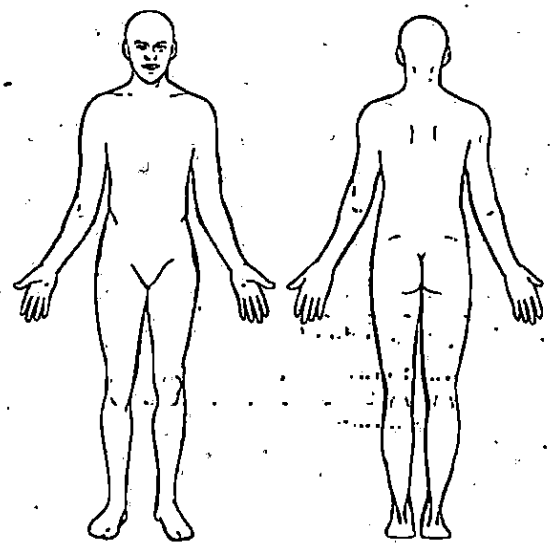
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3. Senses

Vision	**Yes** ✓	**No** ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		
Do you wear glasses?	✓		Distance ☐ Reading ☐ Both ☐
Do you have your glasses with you?	✓		
Do you wear contact lenses?		✓	
Do you have your lenses with you?		✓	
Do you wear a prosthesis?		✓	
Hearing	**Yes** ✓	**No** ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?			
Do you use a hearing aid?			
Do you have your hearing aid(s) with you?			
Pain	**Yes** ✓	**No** ✓	Assessment of the patient's pain
Do you have pain?	✓		

Can you describe where and what the pain is like?

Mark current pain on body chart



Have you had treatment / intervention for the pain?

N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale.

Can you describe any chronic pain that you have?

What makes the pain better?

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4. Cognitive Status THINK DELIRIUM

	Admission Presentation	Normal for the patient	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

NIL

What do you like to eat and drink?

What do you not like to eat and drink?

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet. Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

Name: [redacted]
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Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☑ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ___/___/___

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGGC Adult UCC Insertion and Maintenance Care Plan

owels

When did your bowels last move? yesterday

How often in a day/week do you have a bowel movement? Per day ☐ Per week ☐

Do you use any medication e.g. laxative to help your bowels move? Yes ☐ No ☐

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular	✓	✓	
Constipated			
Diarrhoea / loose stools			
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. if concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?		✓	
Do you require assistance with your stoma care?			
Have you brought any of your stoma products with you?			

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7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			
Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			
Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☐

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ **Adult wound assessment and management chart required**

N.B If Grade 2 pressure damage on ankle or below refer to Podiarty via TrakCare

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		✓

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8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent	✓	✓	
Unsteady when walking			
Do you use a mobility aid	Yes ☐	No ☑	
Do you have your mobility aid with you?	Yes ☐	No ☑	

N.B. If not fully mobile and independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?		✓	

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?		✓	
Do you do or use anything to help you sleep?		✓	

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11. Social Circumstances

Do you:

Live alone	☐	Live with family/ friend/ other	☑
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐

Other please specify_____ ☐

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?		✓
Do you support anyone (e.g. partner, children, relatives, animals)?		✓
Do they need support from someone else whilst you are in hospital?		✓
Would someone else be able to provide this support when you are in hospital? If yes, who?		✓

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☑

Healthcare Chaplain informed Yes ☐ N/A ☑

13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name: .....

Contact Details: .....

.....

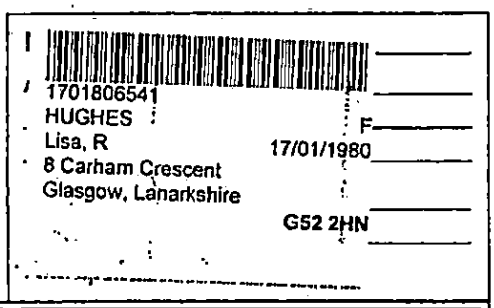
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How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☐ No ☐

If yes, has the help or support listed above been confirmed with the patient's family/ friends?
(please tick) Yes ☐ No ☐



Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?

Yes ☐ No ☐

Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐ Unemployed ☐

Self-employed ☐ Retired ☐

Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?

Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?

Yes ☐ No ☐ Not appropriate to ask at this time ☐

If yes would you like referred to a money advice service that can offer confidential advice/ support?

Yes ☐ No ☐ If yes when was patient referred ___ /___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?

Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☐

If yes when was patient referred ___ /___/___

Name:
1701806541
HUGHES
Lisa, R
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN
F
17/01/1980

Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)					
Generic Pain Scale Assessment Chart					
Abbey Pain Scale (if unable to self report pain)					
4AT and TIME for Detection, Management and Prevention of Delirium					
Getting to Know Me – Relatives to complete					
What Matters to Me					
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)					
Malnutrition Universal Screening Tool (MUST)	✓				
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan					
Bristol Stool Chart					
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓				
Adult Wound Assessment and Management Chart					
Moving and Handling Assessment					
Falls Risk Assessment	✓				
Bedrail Risk Assessment					

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
4/1/24 0329	SIB medics: likely TMJ disorder exclude SAH plan: CTBV esr + D-Dimer, CXR ✓	CN Orthogn

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AITIX patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
cont	patient currently being nursed on a trolley in a waiting area - no beds in the hospital. Apologies given.	CN SHOSA

N
A 1701806541 F
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D(Glasgow, Lanarkshire G52 2HN
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Aff

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation

Care Rounds Checklist

Date: 4/1/2024



Attach Add

Ward: 1A

NHS Greater Glasgow and Clyde

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr 4hr

1. Signed _____ Name _____ Designation CN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the pa… here is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

			Times																			
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N																			
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	N																			
S	3	SKIN INSPECTION Pressure areas checked:	N																			
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	N																			
K	4	KEEP MOVING Has the patient moved or walked?	Y																			
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	T																			
		Chair Assist to walk or stand (W/ST)	W																			
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I																			
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	N																			
		Drink taken?	Y																			
		Food, snack, or supplement taken?	Y																			
		Has oral hygiene been carried out as per care plan?	N																			
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y																			
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	N																			
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	N																			
		Care provider / role	SH																			

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

ml • 278936 v2.1 • GGC0098

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

1701806541 HUGHES Lisa, R F 8 Carham Crescent 17/01/1980 Glasgow, Lanarkshire G52 2HN	Hospital: Ward:	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

1 Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise?
3 Continence	Does the person have continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Inte..entional Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____

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FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward. Update weekly or on change of condition.

	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).					
2. Check walking aid (if required) is in reach and in use.					
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.					
4. Check footwear is safe (refer to NHSGGC Footwear guidance).					
5. If glasses are worn, check they are available and in use.					
6. If hearing aid/s are worn, check they are working and in use.					

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?										
2. Does the patient have cognitive impairment or a possible delirium?										
3. Does the patient attempt to walk alone although unsteady or unsafe?										
4. Does the patient or their relative have a fear or anxiety of the patient falling?										
5. Based on your clinical judgement, is this patient at high risk of falling?										
Signature of nurse completing assessment / update										

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: -----:------	Ward: Date: Time: -----:------	Ward: Date: Time: -----:------	Ward: Date: Time: -----:------	Ward: Date: Time: -----:------
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

NHSGGC Bedrail Risk Assessment

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NHS Greater Glasgow and Clyde

This Risk Assessment Tool is an aide memoire for staff. It should be used in conjunction with the Bedrail Guidance (see reverse) and Guidelines for Falls Prevention and Management (Adults).

Patient Nam

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

CHI Number

	Use guidance on the reverse of this document when completing this Risk Assessment	DATE								
		TIME								
		WARD								
		HOSPITAL								
	SECTION ONE – GENERAL		**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
1	Is the patient likely to fall, roll, slip or slide from the bed?									
2	Has the patient requested the use of bedrails?									
	IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
	SECTION TWO – COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?									
4	Is the patient stressed, delirious or restless?									
5	Is the patient small in stature?									
6	Does the patient have an unusually large or small head that might present an entrapment issue?									
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?									
	IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
	SECTION THREE – COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?									
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition									
10	Has the use of bedrails been discussed with relatives/carers?									
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?									
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?									
	IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
	SECTION FOUR – DECISION MAKING		**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
13	Will bedrails be used for this patient at the present time?									
14	Rationale for use of bedrails: (Please insert code in the box on the right)									
	A – Risk of falling from the bed									
	B – Risk of rolling from the bed									
	C – Risk of slipping from the bed									
	D – Risk of sliding from the bed									
	E – Patient request									
15	Bedrail risk assessment completed by:									
16	Bedrails checked by:									
17	Date									

Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here

A. Alternatives to bed rails:-

- Move the patient to a more observable area
- Increase patient observation
- Ensure the bed is returned to the lowest height appropriate to the patient needs, after care delivery
- Ensure patient needs are anticipated e.g. drinks are accessible, regular toileting, call bell to hand
- Nursing patient on mattress on the floor should be the last resort, and safety checks should be made for hot pipes, trailing wires, electrical sockets etc
- A generic moving and handling assessment must be carried out for staff caring for patients nursed on mattress on the floor.
- Contact Hospital Falls team for advice where appropriate

B. If bedrails are to be used, please consider the following:-

Is patient:-

- Stressed, delirious or restless
- At risk of entrapment
- At risk of climbing over the top of the bed rail
- At risk of being psychologically affected by the use of the bed rail

C. Safe use and application of bedrails:-

- If bedrail is fitted and there is a gap between the lower rail and the mattress then a bedrail should not be used
- If the gap between the bars on the bedrail is greater than 12cm then a bedrail should not be used
- If the bedrail moves away from the side of the mattress then a bedrail should not be used
- If the gap between the bedrail and the headboard is between 6cm and 25cm then a bedrail should not be used
- If the gap between the bedrail and the footboard is between 6cm and 25cm then a bedrail should not be used
- If the bedrail has not been fitted correctly then the bedrail should not be used
- If the bedrail is not secure then the bedrail should not be used
- If the bedrail is not compatible with the frame it will be fitted to then a bedrail should not be used
- If the bedrail is not in good working order then the bedrail should not be used

D. Record keeping:-

All of the following should be recorded:-

- Date and time of assessment
- Bedrail information leaflet given to patient and-or next of kin
- Rationale for decision in care plan or in AWI treatment plan
- Where bedrails are considered appropriate and patient has declined their use
- Any other actions implemented
- Care planning should be reviewed and updated as per record keeping standards

Bedrail risk assessments should be made as follows:-

- On admission
- If patient's condition changes or fall / suspected fall from bed
- Daily/weekly depending on the patient's status

Person Specific (Inpatient) Moving and Handling Assessment Form

PN 1701806541 HUGHES F 1 Lisa, R 17/01/1980 8 Carham Crescent Glasgow, Lanarkshire G52 2HN BMI cm	Named Nurse:		Person is totally independent (tick here and go to date box) ✓

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

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

Risk of Falls: Yes | No

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 / 2 / ≥3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 / 2 / ≥3	Additional Information:	
	Monkey pole			
	Independent bridging			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 / 2 / ≥3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 / 2 / ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Ateris)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	4/1/2024		
Assessor's signature:	[signature]		
Proposed Review date:			

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes ☐ No ☐		

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Model		Aid Type	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	

4. Move on / off bed pan

Hoist ☐	Manoeuvre ☐	Assistance ☐	Supervision ☐	N/A ☐
See No 2 Sit to Stand Transfers for details	Roll patient ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Person bridges ☐			

5. Move up / down bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Sliding sheets ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Rope ladder ☐			

6. Lateral Transfer to / from trolley / bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify) ☐			

7. Sit up over side of bed

Bed Rest ☐	Assistance ☐	Supervision ☐	Independent ☐
	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment ☐	Handling Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Shower ☐	Shower chair ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath ☐	Shower trolley ☐			
Bed bath ☐	Bathing hoist (eg Alerti) ☐			

9. Walking

No Walking ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
	see 'sit to stand transfers'	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Write or affix patient label

1701806541
HUGHES
Lisa, R
6 Carlham Crescent
Glasgow, Lanarkshire
G52 2HI

Name: _____
DOB: _____ 17/01/198_
Ward: _____

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete thi...

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ Resuscitation/Chest Pain ☐ IV Drugs ☐ Fluids ☐ Transfusion ☐

PVC inserted: Day 0	Date: ___/___/___ Hospital: _____ Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☐ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: ___/___/___

*Reason For Removal: _____

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : **Observe cannula**
One of the following is evident : slight pain or redness near site	1	Possible first signs : **Observe cannula**
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : **Remove & resite cannula**
All of the following are evident: pain, redness, hardening of surrounding tissue	3	**Phlebitis/Thrombophlebitis:** **Remove & resite cannula** **Seek further advice**
As above including: palpable venous cord	4	
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE is available reliably** (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

1701806541
HUGHES
Lisa, R
17/01/198[illegible]
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HR

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY:	
Date:	Date:	

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	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if 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 NEWS

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

Signed.....

Medical: .....

Date: .....

Glasgow Coma Scale

Pupil Reaction and size
S = sluggish
+ = reaction
- = no reaction
C = eyes closed

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

Date:
Time:

| | | |

NEWS 2 Key: 1 | 2 | 3

Date	1/11	3 1	4			
Time	11.00	18	23 Sun 20			
A + B Respirations Breaths/min	•	16	16	≥25	3	
				21-24	2	
				12-20	0	
				9-11	1	
				≤8	3	
A + B SpO2 Scale 1 Oxygen saturation (%)	97	98	96 97	≥96	0	
				94-95	1	
				92-93	2	
				≤91	3	
SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure. Only use scale 2 under direction of qualified clinician				≥97 on O2	3	
				93-96% on O2	2	
				93-94% on O2	1	
				≥93 on air	0	
				88-92	0	
				86-87	1	
				84-85	2	
				≤83	3	
Air or oxygen?	A	A	A	Air (A) or O2 device*	0	
				O2 L/min 2	2	
C Blood Pressure mmHg (Score uses systolic BP only)		113	113	≥220	3	
				201-219	0	
				181-200	0	
				161-180	0	
				141-160	0	
				121-140	0	
				111-120	0	
				101-110	1	
				91-100	2	
				81-90	3	
				71-80	3	
				61-70	3	
				51-60	3	
				≤50	3	
C Pulse Beats / min	•	74	74	≥131	3	
				121-130	2	
				111-120	2	
				101-110	1	
				91-100	1	
				81-90	0	
				71-80	0	
				61-70	0	
				51-60	0	
				41-50	1	
				31-40	3	
				≤30	3	
D Any changes in neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.	•	A	A A	A Alert	0	
				C New Confusion	3	
				V Verbal	3	
				P Pressure	3	
				U Unresponsive	3	
E Temperature	•	36.6	36.4	≥39	2	
				38.1-39.0	1	
				37.1-38.0	0	
				36.1-37.0	0	
				35.1-36.0	1	
				≤35.0	3	
NEWS Total	0	0	0			

Blood glucose	7.0	NA	
Pain / function score	0A	4/A	0/A 6/10
Time Pt last passed urine	10.20	PMM	U M
Fluid balance chart indicated Y/N	N	N	N N
GCS indicated Y/N	N	Y	Y Y
Time NEWS due	23.00		03:00
Escalation of care Y/N	N	N	N N
Initials	AB	AB	MO AB

1701806541
HUGHES
Lisa, R
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN
17/01/1980 F

Abbreviations for recording oxygen device

A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and % eg. V24
NIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
RM	Reservoir Mask (Emergency use only)

1701806541
HUGHES
Lisa, R
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN
17/01/1980 F

NEWS > 4 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

Think ACE

A	Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.
C	Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.
E	Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

NHS GGC Hospitals, Admission Document

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1701806541

Queen Elizabeth University Hospital

Total Att: 15

12 Mth Att: 0

Title: MISS

HUGHES

Lisa Rosemary

DOB 17/01/1980

Age: 43y

Sex: Female

8 Carham Crescent

Glasgow
Lanarkshire
G52 2HN

Next of kin: HAUGHEY, AGNES
Relationship: Mother
07769815357

GP: JD Datta
0141 892 2548

Attendance Date: 18/07/2023

Arrival Time: 14:30

Registration Time: 14:30

Date of Incident: 18/07/2023

Major Incident Desc:

Reason for Attendance: **chest heaviness sob and dizzy sensation in jaw**

Affix Label

Nursing Assessment

Alerts: Yes

Allergies: None Known

Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint: Chest Pain

Observation Date: 18/07/2023 15:44

Nurse name: Nurse Zoe Devlin

Temp	35.1	C
HR	82	bpm
BP	118/76	mmHg
MAP	90.00	mmHg
RR	19	bpm
SpO2	99	%
Oxygen	21	%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **"Self presents with chest pressure, SOB on exertion at work at weekend. Dizzy episodes. Complaining of pressure in jaw and left shoulder pressure. Similar presentation few years ago, low thyroid. "**

Patient ID label

Date	Emergency Department Notes
	Ambulance Proforma reviewed Yes / No · Seen by (Doctor) · Time seen

Called for bloods. DNA

Called for assessment DNA

DNW Dr Loughrey (GOCOMS).

Discharged without review

Patient ID label

1701808541 17/01/1980
HUGHES
Lisa Rosemary

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Differential Diagnosis/Problem List

NEWS ☐ 0-7

RED FLAG ☐ (Tick)

SEPSIS ☐

CURB 65 ☐

Done/ completed	Immediate Managment Plan

Signature:

Designation: Emma Davidson TANP

Page No:

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

Patient ID label



Seen By: Print: Time Seen: Pg. No:

PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	
History of presenting complaint	

Past Medical History / Review of portal

Systemic Enquiry

Patient ID label

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history (>1 source preferred)
☐ Patient/Relative/carer ☐ GP Phone call ☐ ECS
☐ Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary
☐ Repeat Prescription

Other (please specify)

Admission Medicines			Plan for Medicines (Dr complete)				
Name	Dose	Freq.	Continue	Amend	Withhold	Stop	Comments Reason for alteration

Allergies

List any over-the-counter or alternative medicines

List collected by :

Do medicines need further clarification ? ☐ Yes ☐ No

Designation : Date :

Plan approved by :

Designation : Date :

Pharmacy review

Comments

Compliance aid : ☐ Yes ☐ No

Community pharmacist Phone

Reviewed by : Designation : Date :

Patient ID label

1701606541 17/01/1980
HUGHES
Lisa Rosemary

Social History \ Family History

Smoking History

Ex-smoker/Smoker _____ cpd _____ yrs ☐ Never smoked

Alcohol History

_____ Units/week FAST score if excess _____

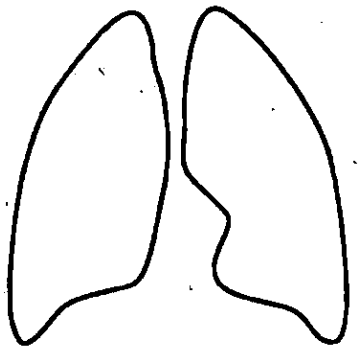
Recreational Drugs **Driving Status**

Social Circumstances (home, supports, functional status, occupation, travel)

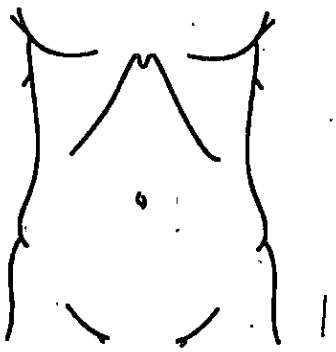
General Examination	
Temp:	RR:
Pulse:	CBG:
SpO_2:	Weight:
BP:	Urinalysis:

General Appearance:

Respiratory



Gastrointestinal System



Cardiovascular

Locomotor

Patient ID label

Neurological system

GCS: /15 **E: /4** **M: /6** **V: /5**

AMT 4 = age, DOB, place, year

AMT score ____ /4

Is the patient more confused/drowsy than normal: Y / N
If yes complete 4AT / TIME

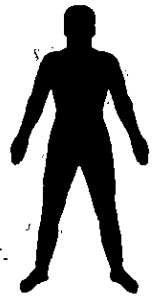
Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

Patient ID label

1701806541

Key Results

CXR

ECG

(Differential) diagnosis

NEWS ☐

Red Flag ☐

Sepsis ☐

CURB 65 ☐

Management Plan

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation

☐ 4AT/TIME

Signature:

PRINT NAME

PRINT GRADE

Page:

Patient ID label

Resuscitation Decision
Resuscitation status: FOR RESUSCITATION / DNA CPR (please circle)
If DNA CPR → Complete appropriate form

Senior Medical review
☐ Thromboprophylaxis assessed ☐ Medicine Reconciliation ☐ 4AT/TIME ☐ Antimicrobial ☐ DNACPR ☐ AWI if appropriate

Sepsis Six
- ☐ Antibiotics within 1 hour
- ☐ Appropriate Cultures
- ☐ Fluids
- ☐ Oxygen
- ☐ Lactate
- ☐ Fluid balance, consider catheter

Patient ID label

1701806546

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED

Is the patient bed-bound or expected to have reduced mobility relative to normal for ≥2 days

☐ Yes

☐ No

- No thromboprophylaxis
- Reassess (every 72 hours minimum)and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

Does the patient have any of the following risk factors? Tick if apply			
Active cancer or cancer treatment		Use of oestrogen containing contraceptive	
Age> 60		Hormone replacement therapy	
Dehydration		Pregnancy or <6 weeks post partum (seek specialist advice)	
Known thrombophillia		Critical care admission	
BMI >30		Varicose veins with phlebitis	
Personal/1st degree relative history of VTE		Current significant medical condition e.g. infection, inflammation, cardio resp disease	
Hip fracture			

☐ Yes

☐ No

Does the patient have any of the following contraindications? Tick if apply			
Active bleeding		Untreated inherited bleeding disorder	
Acquired bleeding disorder		Thrombocytopaenia <75 x109/l	
Thyroid, spinal, posterior eye or neurosurgery		Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR>2		Uncontrolled hypertension (>230/120)	
Acute stroke		Varicose veins	
Recent (<4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic			
Other - Document			

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum)and document

☐ No

☐ Yes

Enoxaparin 40mg (reduce to 20mg if weighs < 50kg or eGFR <30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A
(only n/a if due to cognitive impairment or similar)
If N/A why? _____
Assessed by _____
Date _____

Patient ID label

Results

Date									
Time									
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165								
WCC	4.0 - 11.0								
Plts	150 - 450								
MCV	80 - 100								
Neut	2.0 - 7.5								
PT	9.0 - 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	( )								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146								
K+	3.5 - 5.3								
Cl-	95 - 108								
HCO3-	22 - 29								
Urea	2.5 - 7.8								
Creat	40 - 130								
eGFR									
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50								
AlkP	30 - 130								
Bil	<20								
ALT	<50								
AST	<40								
GGT	Male: <70 Female: <40								
ESR	Male: 1 -10 Female: 1 - 12								
CRP	<10								
Troponin hs I	Male: 0 - 34 Female 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 – 2.0								

Patient ID label

1701806541

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO_2:

FiO2:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet	
Date: Time	

Patient ID label

1701806541

Continuation Sheet

Date: Time	

Patient ID label

Continuation Sheet

Date: Time

Patient ID label

1701806541

Continuation Sheet

Date: Time	

Patient ID label

Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

Date Given	Drug (Block Capitals)	Dose	Method of administration	Time of administration	Signature	Given by

Discharge prescription packs

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by

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

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

Outpatient clinic specialty						Admission or specialty clinic consultant		
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

1701806541

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Missed he call, still on WR

Queen Elizabeth University Hospital

CHI: 1701806541

Total Att: **15**

12 Mth Att: **0**

Title: **MISS**

HUGHES **Lisa Rosemary**

DOB **17/01/1980** Age: **43y** Sex: **Female**

8 Carham Crescent

Glasgow
Lanarkshire
G52 2HN

Next of kin: **HAUGHEY, AGNES**
Relationship: **Mother**
07769815357

GP: **JD Datta**
0141 892 2548

Attendance Date: **18/07/2023** Arrival Time: **14:30**

Registration Time: **14:30** Date of Incident: **18/07/2023**

Major Incident Desc:

Reason for Attendance: **chest heaviness sob and dizzy sensation in jaw**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint: **Chest Pain**

Observation Date: **18/07/2023 15:44** Nurse name: **Nurse Zoe Devlin**

Temp	35.1	C
HR	82	bpm
BP	118/76	mmHg
MAP	90.00	mmHg
RR	19	bpm
SpO2	99	%
Oxygen	21	%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **"Self presents with chest pressure, SOB ?collapse at work at weekend. Dizzy episodes. Complaining of pressure in jaw and left shoulder pressure. Similar presentation few years ago, low thyroid. "**

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date: 18/7/23 | CLINICAL NOTES

Seen by (Dr) M ROZWADOWSKA | Time seen 22.15

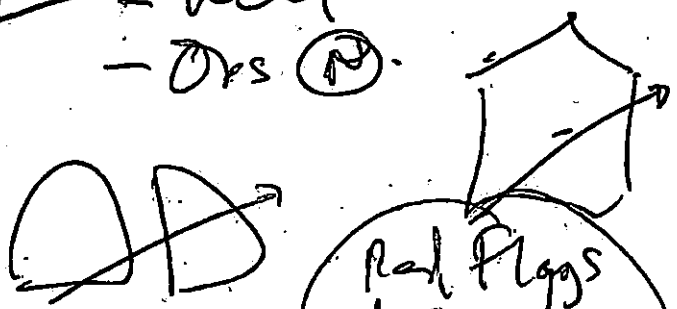
BACKGROUND: Normally fit + well.

(43) F

(PC) Chest discomfort, hyperventilating + light headed over last 2-3 weeks.

(HPC)
- Comes on randomly
- Not exertional
- Feels breathless.
- Tingly in chest / hands / face.
- Not sweaty.
- No SOB
- Good exercise tolerance
- No recent illness.

O/E
- Well
- Obs (N).



BS: [redacted]
HR: 80 reg

Red flags discussed thoroughly

- ECG (N)
- Bloods + troponin -ve

Impression - Anxiety / panic attack

Plan
- (PI)
- Trial of b-blocker
- F/U with GP

[redacted]

Date	CLINICAL NOTES
	 1701806541 17/01/1980 HUGHES Lisa Rosemary

Discharge Codes (Please CIRCLE)					Discharge date	
Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

MG 5

NHS GGC Hospitals, Admission Document

NHS Greater Glasgow and Clyde

CHI: 1701806541

Queen Elizabeth University Hospital

Total Att: 13

12 Mth Att: 1

Title: **MISS**

HUGHES

Lisa Rosemary

DOB **17/01/1980** Age: **40y** Sex: **Female**

8 Carham Crescent

Glasgow
Lanarkshire
G52 2HN
07563300068

Next of kin: **HAUGHEY, AGNES**
Relationship: **Mother**
07769815357

GP: **JD Datta**
0141 826 2548

Attendance Date: **14/07/2020** Arrival Time: **03:45**

Registration Time: **03:45** Date of Incident: **14/07/2020**

Major Incident Desc:

Reason for Attendance: **abdo pain**

A

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint: **Abdomen Pain**

Observation Date: **14/07/2020 03:54** Nurse name: **Nurse Samantha Birrell**

Temp	36.0	C
HR	69	bpm
BP	101/65	mmHg
MAP	77.00	mmHg
RR	17	bpm
SpO2	96	%
Oxygen	21	%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	4
Motor	6
Verbal	5
Total	**15**

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **BIBA 3/7 hx RUQ pain. Pain worse since 2am. Hx chronic constipation and ?not moved bowels in 6/7**

Patient ID label

Date	Emergency Department Notes	
14/07/20	Ambulance Proforma reviewed Yes / No Seen by (Doctor) BAUME CPST2	Time seen 0405.

40f RUQ pain.

Ongoing RUQ pain for 4-5 days.

Pain became severe suddenly ~ 1am tonight.

10/10 sharp. Worse on movement and deep inspiration

No cough/SOB.

No fevers/vomiting/fevers/rigors.

No GI upset. Chronic constipation passing flatus.

↑Urinary freq no dysuria/smell/purulence.

Pain ↓ 8/10 c co-codamol

PMH

Asthma

Autoimmune thyroiditis - thyroidectomy.

FUPD.

Sterilisation.

DH

Citalopram

Olanzapine

Levothyroxine

Salbutamol.

NKDA.

SH

Smoker 15/d.

No sig ETOH.

FH

Crohn's.

O/E In pain @ rest.

A-SM

B-RR 17. O2 6L RA.

C-HR 64 BP 101/65

WCC 10.4 Neut 6.1 Hb 124 Plt 342

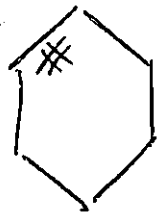
Amylase (N) LFTs (N). U&Es (N) CRP (N).

F 1701806541
HUGHES F
Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

D - (R)UA

F = 36°C



Tender RUQ
Murphy's +ve - guarding RUQ.
No Murphy pain/tenderness.

Differential Diagnosis/Problem List

? Biliary colic

NEWS [ ] 0-7
RED FLAG [ ] (Tick)
SEPSIS [ ]
CURB 65 [ ]

Done/ completed	Immediate Managment Plan
	IV Access Analgesia -> Reassess in pain decision
	Bloods further analysis awaiting
	ECG
	Erect CXR - NAD.
	Plan Surgeon will review in ED.

Signature: Designation: Page No:

GPST2 8825.

Printed: 14/07/2020 04:17:59

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 14/07/2020 04:17:25
Sample Type: **Venous**
Operator ID: OLDROYD0, MATTHEW

PLEASE I

Patient

ID:	1701806541
Last Name:	HUGHES
First Name:	LISA
Gender/Age:	Female, 40 years
Birth Date:	17/01/1980

Cartridge

Lot No.:	200417F
S/N:	00000000500066293
Exp. Date:	24/07/2020

Analyzer

Model:	GEM® *Premier 5000*
Area:	AH_L0ED_B
Name:	ED-MAJ-IN
S/N:	17030619

Results

			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	37.7	nmol/L	--	--	--	--
pCO_2	5.2	kPa	--	--	--	--
pO_2	7.7	kPa	--	--	--	--
Na^+	135	mmol/L	--	133	146	--
K^+	3.8	mmol/L	--	3.5	5.3	--
Cl^-	107	mmol/L	--	95	108	--
Ca^{++}	↓ 1.14	mmol/L	--	1.15	1.27	--
Hct	39	%	--	--	--	--
Glu	5.2	mmol/L	--	3.5	6.0	--
Lac	0.6	mmol/L	--	0.6	2.2	--
CO-Oximetry						
tHb	137	g/L	--	--	--	--
O_2Hb	↓ 83.7	%	--	95.0	98.0	--
COHb	↑ 7.6	%	--	0.5	1.5	--
MetHb	0.5	%	--	0.5	1.5	--
HHb	↑ 8.2	%	--	0.0	5.0	--
sO_2	↓ 91.1	%	--	95.0	98.0	--
Derived						
BE(B)	0.8	mmol/L	--	--	--	--
$HCO_3^-(c)$	25.3	mmol/L	--	--	--	--

↑↓ Outside Reference Range

Other Information

Operator Entered

Temp	37.0	°C

In-Patient Admission Notes

P: 1701806541
HUGHES
Lisa, R
8 Carham Crescent
Glasgow, Lanarkshire
F
17/01/1980
G52 2HN

14/7/20
6:30 J. Wohlgemut (ST4 Gen Surg)

Seen By: Print: Time Seen: Pg. No:

PRF Reviewed Yes / No

Presenting Complaint(s)

Presenting complaint	RUQ abdo pain 5/7
History of presenting complaint	- No vomiting - Not moved bowels for 5 days, but this is normal for her - No rigors / Not hot/cold - No jaundice symptoms - Passing urine - ↑ frequency but No dysuria - has gained weight during COVID-19 pandemic, was size 8, now size 10. - Had a "fry up" yesterday morning, which she doesn't normally have - thinks it may be related.
PMH - Depression - Thyroidectomy 2009 - Hysterectomy 2009 - Constipation	
	O/E NEWS = 3 Temp 35.8°, SBP 108 - abdo soft - Tender RUQ - mild - (-Murphy's Negative.
urine - trace protein bloods - wcc 10 - rest normal - serum bilirubin 13	
Impression -	Biliary Colic?

Past Medical History / Review of portal

Plan - Assess in Hot Clinic - 15/7/20 9Am
- Analgesia
- Discharged home with worsening advice.

J Wohl 87315

Systemic Enquiry

Patient ID label

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history (>1 source preferred)
☐ Patient/Relative/carer ☐ GP Phone call ☐ ECS
☐ Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary
☐ Repeat Prescription

Other (please specify)

Admission Medicines			Plan for Medicines (Dr complete)				Comments
Name	Dose	Freq	Continue	Amend	Withhold	Stop	Reason for alteration

Allergies	List any over-the-counter or alternative medicines
	Do medicines need further clarification ? ☐ Yes ☐ No
List collected by :	Plan approved by :
Designation : Date :	Designation : Date :

Pharmacy review:	Comments
Compliance aid : ☐ Yes ☐ No	Community pharmacist Phone
Reviewed by : Designation : Date :	

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Social History \ Family History

Smoking History

Ex-smoker/Smoker _____ cpd _____ yrs ☐ Never smoked

Alcohol History

_____ Units/week FAST score if excess _____

Recreational Drugs **Driving Status**

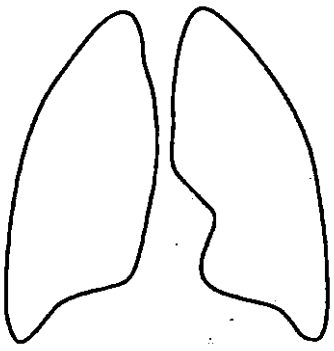
Social Circumstances (home, supports, functional status, occupation, travel)

General Examination

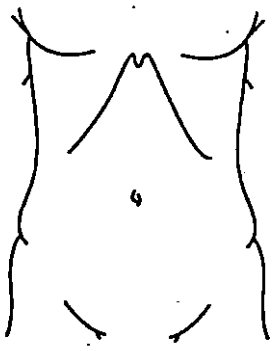
Temp:	RR:
Pulse:	CBG:
SpO_2:	Weight:
BP:	Urinalysis:

General Appearance:

Respiratory



Gastrointestinal System



Cardiovascular

Locomotor

Patient ID label

Neurological system

GCS: /15 E: /4 M: /6 V: /5

AMT 4 = age, DOB, place, year

AMT score ____ /4

Is the patient more confused/drowsy than normal: Y / N
If yes complete 4AT / TIME

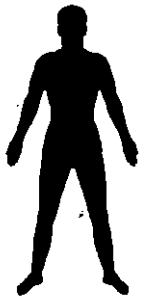
Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

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Key Results

CXR ECG

(Differential) diagnosis

NEWS ☐

Red Flag ☐

Sepsis ☐

CURB 65 ☐

Management Plan

☐ Thromboprophylaxis assessed ☐ Medicine Reconciliation ☐ 4AT/TIME
☐ Antimicrobial

Signature: PRINT NAME

PRINT GRADE Page:

Patient ID label

Resuscitation Decision

Resuscitation status: FOR RESUSCITATION / DNA CPR
(please circle)

If DNA CPR → Complete appropriate form

Senior Medical review

☐ Thromboprophylaxis assessed
☐ Antimicrobial
☐ Medicine Reconciliation
☐ DNACPR
☐ 4AT/TIME
☐ AWI if appropriate

Sepsis Six
- ☐ Antibiotics within 1 hour
- ☐ Appropriate Cultures
- ☐ Fluids
- ☐ Oxygen
- ☐ Lactate
- ☐ Fluid balance, consider catheter


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Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED

Is the patient bed-bound or expected to have reduced mobility relative to normal for ≥2 days

☐ Yes

Does the patient have any of the following risk factors? Tick if apply

Active cancer or cancer treatment		Use of oestrogen containing contraceptive	
Age> 60		Hormone replacement therapy	
Dehydration		Pregnancy or <6 weeks post partum (seek specialist advice)	
Known thrombophillia		Critical care admission	
BMI >30		Varicose veins with phlebitis	
Personal/1st degree relative history of VTE		Current significant medical condition e.g. infection, inflammation, cardio resp disease	
Hip fracture			

☐ Yes

Does the patient have any of the following contraindications? Tick if apply

Active bleeding		Untreated inherited bleeding disorder	
Acquired bleeding disorder		Thrombocytopaenia <75 x109/l	
Thyroid, spinal, posterior eye or neurosurgery		Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR>2		Uncontrolled hypertension (>230/120)	
Acute stroke		Varicose veins	
Recent (<4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic			
Other - Document			

☐ No

☐ Yes

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum)and document

☐ No

- No thromboprophylaxis
- Reassess (every 72 hours minimum)and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

Enoxaparin 40mg (reduce to 20mg if weighs < 50kg or eGFR <30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A
(only n/a if due to cognitive impairment or similar)
If N/A why? _____
Assessed by _____
Date _____

Patient ID label

Results

Date Time									
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165								
WCC	4.0 - 11.0								
Plts	150 - 450								
MCV	80 - 100								
Neut	2.0 - 7.5								
PT	9.0 - 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	( )								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146								
K+	3.5 - 5.3								
Cl-	95 - 108								
HCO3-	22 - 29								
Urea	2.5 - 7.8								
Creat	40 - 130								
eGFR									
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50								
AlkP	30 - 130								
Bil	<20								
ALT	<50								
AST	<40								
GGT	Male: <70 Female: <40								
ESR	Male: 1 -10 Female: 1 - 12								
CRP	<10								
Troponin hs I	Male: 0 - 34 Female 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 – 2.0								

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G52 2HN

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO_2:

FiO2:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet

Date: Time	

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Continuation Sheet	
Date: Time	

Patient ID label

Continuation Sheet

Date: Time	

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Continuation Sheet

Date: Time

Patient ID label

Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

Date Given	Drug (Block Capitals)	Dose	Method of administration	Time of administration	Signature	Given by
14/07	MORPHINE	3mg	IV	0025		
14/07	BUSCOPAN	10mg	IV	0420		
14/07	MORPHINE	3mg	IV	0550		

Discharge prescription packs

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by
14/7/20	CO-CODAMOL 30/500	2 tablets	PO	QDS		

DISCHARGE CODES: Please Circle

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

Time Ready to Depart	
Discharge Time	

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

Outpatient clinic specialty						Admission or specialty clinic consultant		
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify



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G52 2HN

Patient Information		Date:	14/07/2020
LISA HUGHES		Incident Number:	CR006638571
Age/Gender:	40Y Old Female	Incident Type:	EMG
Address:	8 CARLHAM CRES. G52 2HJ.	Incident Location:	8 CARHAM CRESCENT CARDONALD GLASGOW, G52 2HN
DOB:	17/01/1980		
CHI:			
Ethnicity:	White Scottish		

Scottish Ambulance Service

17018065411 17/01/1980
HUGHES
Lisa Rosemary

Presenting Complaint

RUQ PAIN

Additional Comments

INTERMITTENT 3/7 , CONSTANT SINCE 2 AM AFTER PASSING URINE HX CHRONIC CONSTIPATION UNSURE WHEN BOWELS LAST MOVED DESCRIBES PAIN AS SPASMING, URINE APPEARED NORMAL NO ODOUR / COLOUR CHANGES

PATIENT ASSESSMENT

AVPU	<C>
A	
B	
C	
D	
E	

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
03:15	80	20	120/83	98	<=2s	15	Alert		37.5	5.1	Sinus Rhythm				E9887836

NEWS

Time	Clinical Risk	NEWS
03:15		0

HISTORY

AMPLE

Allergies	None
Medication	CITALOPRAM , SLOW RELEASE LAXATIVE
Past Medical History	CONSTIPATION , STERILISED 2009
Last Eaten	>4 Hours Ago
Events Prior	RUQ PAIN INTERMITTENT 3/7 CONSTANT SINCE 2AM , RADIATING INTO RIGHT SHOULDER

Social History

Lives alone	No	Living With	PARTNER AND CHILDREN	Patient Occupation	Does Not Work,

Patients General Appearance	Normal,
Patient Mobility	Fully Mobile,
Patient Communication	No Help Required,
Patient Clinical Risk Factors	Smoker,
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	02:43	Allocated	02:52	Mobile	02:52
First Resource On Scene		Crew On Scene	03:14	Crew Left Scene	03:34
Crew At Hosp	03:41	Receiving Hospital	QUEEN ELIZABETH UNIVERSITY HOSPITAL	Clear Time	

Crew ID	Crew Grade	Driver
E0023205	Paramedic	YES
E9887836	Ambulance Technician	NO

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5

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Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
14/7/20	BIBA RUQ pain 3/7 hx intermittent	
03:55	ongoing since 2am. Hx Chronic	
	constipation. ? nots moved bowels	

Nursing notes - on admission

Date and Time		Name/Signature
14/7/20.	in b/7. Has not taken laxitives.	S Birrell S. BIRRELL/RN
04:15	Morphine IV ✓	AZ
	Buscopan IV ✓	AZ
14/7/20 0610	Fentanyl analgesia ✓. Comfort to	
	await surgical R/V.	RN

Triage

Patient prepared for exam - clothing bagged				Y	N
NEWS Chart	Y	N	X-rays	Y	N
ID band	Y	N			
Peak Flow	Y	N	Please specify		
12-lead ECG	Y	N	Urinalysis	Y	N
IV access	Y	N			
Blood samples	Y	N	Positive findings		
Blood Gas	Y	N	B-HCG	Y	N

Communication

GGC Red Bag with Patient (nursing home resident)	Y	N
Language or hearing difficulty	Y	N
Interpreter required	Y	N
what arrangements have been made?		
Relatives / Carer / Next of Kin present	Y	N
name,relationship,location,particular concerns		

Risk Assessments and Screening Tools

SEPSIS	Y	N	GMAWS	Y	N
FAST	Y	N	Adult Support and Protection	Y	N
Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
Falls Risk (clinical judgeument)	Y	N	Child Protection Concerns	Y	N

Signature:

Patient name .....

Patient CHI .....

or use sticker

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Care Rounds Checklist

I have evaluated and deemed that the frequency of care delivery over the next work shift,
based on the patient's most critical need, should be every (please circle) **1hr** **2hr** **3hr** **4hr**

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:
Y = Yes **N** = No **NA** = Not Applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** - Independent

			Times											
	1	**THINK DELIRIUM** Is the patient more confused/drowsy than normal?If yes inform registered nurse.												
	2	**PAIN: ASSESS AND ADDRESS.** Is the patient distressed or in pain?If yes inform registered nurse.												
S	3	**SKIN INSPECTION** Pressure areas checked?												
		R = RED **D** = Discloured **PU** - Pressure Ulcer **INT** = Intact **M**= Moisture												
K	4	**KEEP MOVING** Has the patient moved or walked?												
		Bed **R** =Right side (30°) tilt **L** =Left side (30°) tilt **B** =Back Chair **W/ST** = Assist to walk / stand												
		ELIMINATION. Does the patient need the toilet?												
I	5	**I** = Independent **A** - Assistance given **IC** = Incontinent (urine/faeces)												
N	6	**FOOD FLUIDS AND NUTRITIO.** Is the patient nil by mouth?												
		Drink taken?												
		Food, snack, or supplements taken?												
		Has oral hygiene been carried out as per care plan?												
	7	**ENVIRONMENT CHECK** Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?												
	8	**INFORMATION** Is there anything else I can help you with? Inform the patient of the time of return												
	9	**ESCALATION** Is there anything else I can help you with? Inform the patient of the time of return												
		Care provider												
		Role												

Ask the patient if there is anything they specifically want done today:

Patient name ...

1701806541 17/01/1980
HUGHES
Lisa Rosemary

Patient CHI ...

or use sticker

Hospital:	**Points to consider:**
Ward:	• **Use within 8 hrs of admission to care area** • **Re-assess daily and more frequently if a person's condition changes**

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PUDRA

1	**Pressure Damage**	Does the person have redness and/or existing pressure damage? **IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care** to avoid further damage occurring and complete the pressure ulcer interventional plan.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	**Mobility**	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	**Continence**	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	**Nutrition**	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	**Skin**	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	**Judgement**	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							_____hrly	
/ /	:							_____hrly	
/ /	:							_____hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S **Skin Inspection**	**S** **Surface**	**K** **Keep Moving**	**I** **Incontinence/ Moisture**	**N** **Nutrition**	**S** **Self Management/ Shared Care**
Check: • Pressure areas _____ hourly • Skin under medical devices _____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition ____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning _____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out _____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer **YES / NO** 2. Prevent Pressure Ulcers" leaflet given to patient/family/ carer **YES / NO**

Patient name .....

Patient CHI .....

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Nursing notes - discharge plannning

Date and Time		Name/Signature

Outcomes and outstanding issues

Date and Time		Name/Signature

Pause for Discharge or Transfer

GGC Red Bag with Patient (nursing home resident)	**Y**	**N**
Relatives / Carer with Patient	**Y**	**N**
Name Band	**Y**	**N**
Nursing Screening Tools Complete	**Y**	**N**
Bed Available	**Y**	**N**
SBAR complete	**Y**	**N**
NEWS Chart NEWS completed within 1 hour of transfer/discharge	**Y**	**N**
Prescriptions and fluid charts signed	**Y**	**N**
Cannula	**Y**	**N**
Notes Complete	**Y**	**N**
Analgesia	**Y**	**N**
Belongings	**Y**	**N**
Transport	**Y**	**N**
Signature:		

Contact with relatives

Signature:

Patient name .



Patient CHI .

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4AT assessment - for delirium and cognitive impairment

		Circle Score
(1) ALERTNESS This includes patients who may be markedly drowsy (eg. dificult to rouse and/or obviously sleepy during assessment) or agitated/ hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.	Normal (alert, but not agitated, through assessment) Mild sleepiness (<10 secs) after waking, then normal Clearly abnormal	0 0 4
(2) AMT4 Age, date of birth, place (name of the hospital/building), current year.	No mistakes 1 mistake 2 or more mistakes/untestable	0 1 2
(3) ATTENTION Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.	wAchieves 7 months or more correctly Starts but scores <7 months / refuses to start Untestable (cannot start, unwell, drowsy, inattentive	0 1 2
(4) ACUTE CHANGE OR FLUCTUATING COURSE Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs.	No Yes	0 4

4 or more possible delirium + /- cognitive impairment
1-3 possible cognitive impairment
0 delirium or severe cognitive impairment unlikey (but delirium still possibe if (4) information incomplete

TOTAL

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?			circle Y or N	
F	**Functional impairment**	(new or worsening) eg difficulty with self care	**Y**	**N**
R	**Resident**	in a care home	**Y**	**N**
A	**Altered mental state**	such as delirium or dementia (**4AT Assessment**)	**Y**	**N**
I	**Immobility/instability**	decline in mobility, difficulty mobilising without help, fall leading to presentation	**Y**	**N**
L	**Living at home with support**	on a daily basis (homecare, one visit or more per day)	**Y**	**N**

If YES to any of the criteria in Step 1 move to Step 2

Step 2 Would this person be better managed by another speciality team at present?	circle Y or N	
Clear need for other specialty input eg exacerbation of known long-term condition such as COPD	**Y**	**N**
Need for HDU/ITU (including non-invasive ventilation)	**Y**	**N**
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit	**Y**	**N**
Head injury with loss of consciousness	**Y**	**N**
Acute abdominal pain/ surgical presentation	**Y**	**N**
Upper GI Bleed	**Y**	**N**
Chest pain with suspected acute coronary syndrome	**Y**	**N**
Trauma with suspected fracture	**Y**	**N**

Are any of the criteria met?
If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.
If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

Nursing notes - ongoing care

Date and Time		Name/Signature

MI•262617-A v1.0

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

1701806541
HUGHES F
Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

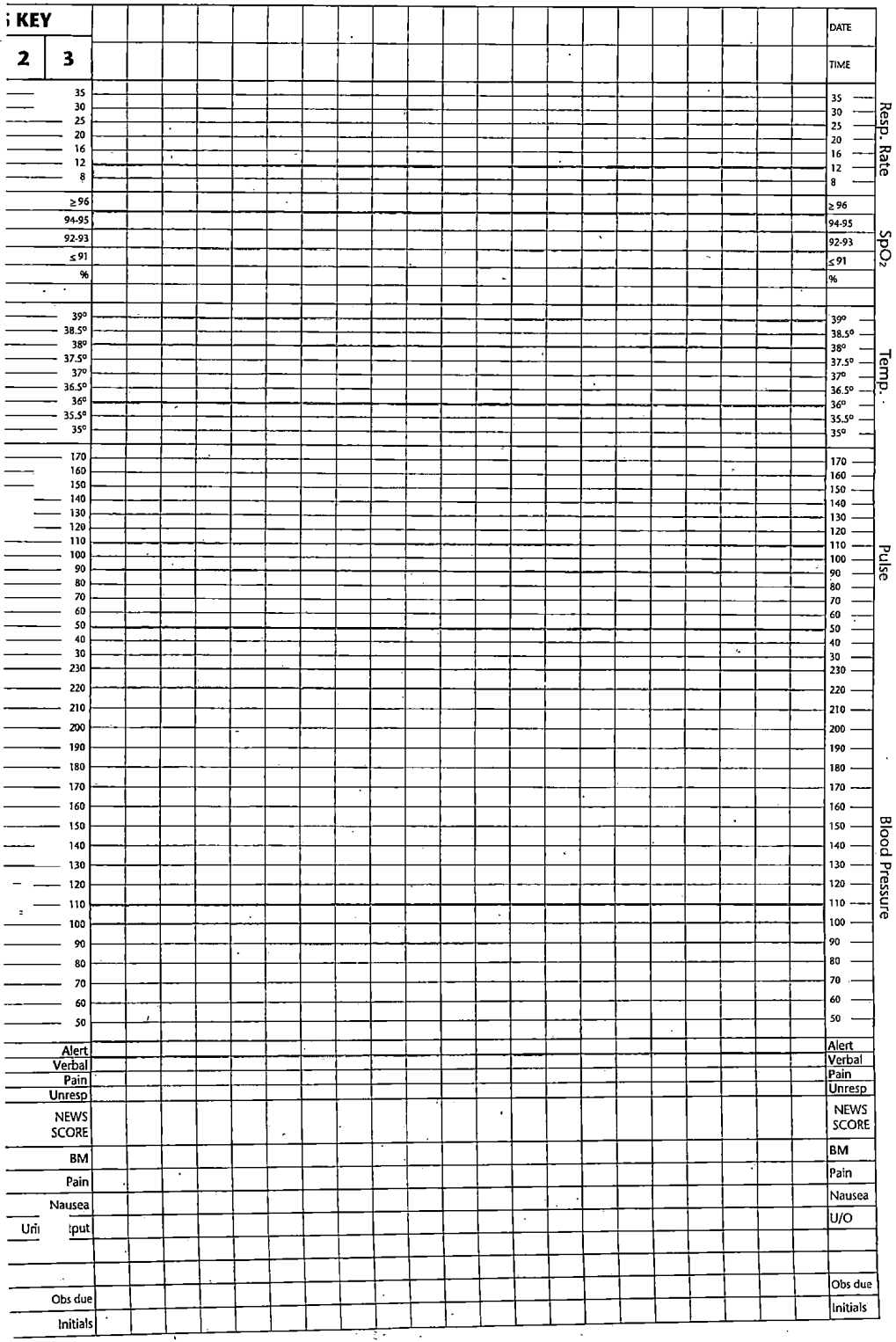
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

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** 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • 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. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

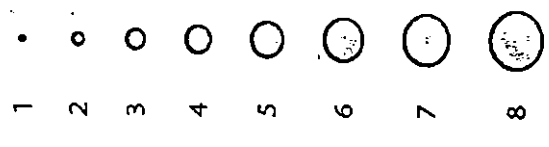
(5)

	DATE:	14/7/16																			DATE	NEWS 0	NEWS 1
	TIME:	20 45																			TIME		
Resp. Rate Mark: •	35																				35		
	30																				30		
	25																				25		
	20																				20		
	16	•	•																		16		
	12																				12		
	8																				8		
SpO_2 (Enter Value)	≥96	96	97																		≥96		
	94-95																				94-95		
	92-93																				92-93		
	≤91																				≤91		
Any Sup'l O_2	%																				%		
Room air		•	A																				
Temp. Mark: X	39°																				39°		
	38.5°																				38.5°		
	38°																				38°		
	37.5°																				37.5°		
	37°	380	356																		37°		
	36.5°	X																			36.5°		
	36°		X																		36°		
	35.5°																				35.5°		
	35°																				35°		
Pulse Mark: •	170																				170		
	160																				160		
	150																				150		
	140																				140		
	130																				130		
	120																				120		
	110																				110		
	100																				100		
	90																				90		
	80																				80		
	70	•																			70		
	60	69	•																		60		
	50																				50		
	40																				40		
	30																				30		
	230																				230		
Blood Pressure Mark: ^ v	220																				220		
	210																				210		
	200																				200		
	190																				190		
	180																				180		
	170																				170		
	160																				160		
	150																				150		
	140																				140		
	130																				130		
	120																				120		
NEWS SCORE using Systolic BP	110	101	97																		110		
	100	^	?																		100		
	90	1																			90		
	80	1																			80		
	70	v	v																		70		
	60	05	64																		60		
	50																				50		
Conscious Level Mark: •	Alert	•	•																		Alert		
	Verbal																				Verbal		
	Pain																				Pain		
	Unresp																				Unresp		
Total NEWS (with all obs)		1	3																		NEWS SCORE		
BM																					BM		
Pain			6-7																		Pain		
Nausea			0																		Nausea		
Urine output			NIL																		U/O		
Obs due																					Obs due		
Initials		SJ	OB																		Initials		


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)



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HUGHES
Lisa Rosemary

Neurological Observations

Date:																														
Time:																														
COMA SCALE	E Eyes open	Spontaneously	4																											Eyes closed by swelling = C
		To speech	3																											
		To pain	2																											
		None	1																											
	V Best Verbal response	Orientated	5																											Endotracheal tube or tracheostomy = T
		Confused	4																											
		Inappropriate words	3																											
		Incomprehensible sounds	2																											
		None	1																											
	M Best motor response	Obeys	6																											Usually record the best arm response
		Localises	5																											
		Flexion - withdrawal	4																											
		Flexion - abnormal	3																											
		Extension to pain	2																											
		None	1																											
	TOTAL SCORE																													
PUPILS	R	Size																												+ reacts – no reaction c. eyes closed
		Reaction																												
	L	Size																												
		Reaction																												
LIMB MOVEMENT	ARMS	Normal power																												Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																												
		Severe weakness																												
		Spastic flexion																												
		Extension																												
		No response																												
	LEGS	Normal power																												
		Mild weakness																												
		Severe weakness																												
		Spastic flexion																												
		Extension																												
		No response																												

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 patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital

CHI: 1701806541

Total Att: 12

12 Mth Att: 1

Title: **MISS**

HUGHES **Lisa Rosemary**

DOB: **17/01/1980** Age: **39y** Sex: **Female**

8 Carham Crescent

Glasgow
Lanarkshire
G52 2HN
07563300068

Next of kin: **HAUGHEY, AGNES**
Relationship: **Mother**
07769815357

GP: **JD Datta**
0141 892 2548

Attendance Date: **09/12/2019** Arrival Time: **12:06**

Registration Time: **12:06** Date of Incident: **06/12/2019**

Major Incident Desc:

Reason for Attendance: **groin pain**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **4** Tetanus up to date/fully immunised:

Presenting Complaint: **Hip Injury**

Observation Date: **09/12/2019 13:36**

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

Nurse name: **Nurse Jacqueline Templeton**

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils Right		Pupils Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **"Pain in the left hip and groin since saturday after intercourse. Seen GP this morning, Referred up from GP for X-ray. Taken co-codamol 8/500mg."**

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES
	Seen by (Dr) WICKHAM Time seen 1520

9/12/19

1701806541 17/01/1980
HUGHES
Lisa Rosemary

(39 ♀) c/o painful (L) Hip for 3/7 following intercourse
States she heard a 'pop' in (L) Hip.
Been wt bearing since, but painful
Taken simple analgesia
Attended ED ? # !

O/E
Walked into Dept
Legs = length
No palpable tenderness (L) Hip / Pelvis
↓ Power on (L) Hip flexion 3/5 due to pain
Int/Ext Rotation (N)
(N) Sensation

Imp: Soft tissue strain

(P) Advised movement as pain allows.

WICKHAM

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)				Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		
5. Died	6. Refer to OP Clinic (see below)	7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

AE. For XRay

Registration Details - Patient No: 5618

Personal details...		Address details...	
Date of birth	17/01/1980	Post Code	G52 2HN
Sex	F	House Name Flat No	
Surname	Hughes	No and Street	8 Carham Cres
Previous Surname		Village	
Forenames	Lisa Rosemary	Town	GLASGOW
Calling Name	Lisa	County	
Title	Miss		
Birth Surname			
Marital Status	Married		
Ethnic Origin	(White) British		

1701806541 17/01/1980
HUGHES
Lisa Rosemary

HA/HB Details...		Contact details...	
Trading partner	Greater Glasgow	Home Tel No	
CHI Number	1701806541	Work Tel No	
Registered GP	Dr Julia Datta	Mobile Tel No	07563300068
Usual GP	Dr Julia Datta	E Mail Address	
Residential Inst			
Branch Surgery			

Practice Information...		Distances	
Dispensing	N	Rural Mileage	
Hospital Number		Blocked Special	
Records At	Cardonald Medical Centre	Walking Quarters	

Further Information		Upload Consent	
Long/Short stay or Dead		SCI-DC Consent	Implied Consent (default)
Date of registration	23/02/2005		
Previous Address			
Next of Kin			
Next of Kin Contact Details			

AMS\CMS Details		Imported user defined fields	
AMS Consent	Yes	GPASS Patient ID	
Pharmacy Details	Lloydspharmacy-Paisley Road West,1851 Paisley Road West,Glasgow,Glasgow,(G52 3SX) (Org Id - 1530)	Contact	07884038836
Item Collected Check	Yes	Contact Relationship	239 0191
CMS Suitability Status	-1	AMS Consent Given	Yes
CMS Registration Status	2	SCIDC Consent Withdrawn	0
CMS Consent	-1		
Pharmacy Name			
Pharmacy Address			
STREAMING: Script Destination			

Medical Record

Problems

Active Problems		Authorised By	Code
24/10/2019	X-ray report received	Mrs Donald	9ND4
15/08/2014	DEXA - Dual energy X-ray photon absorptiometry Normal	Ms Clark	58E-1
18/07/2014	Asthma	Nurse Cree	H33
13/06/2014	Acute lower respiratory tract infection	Mrs Black	H062

13/06/2014	Closed fracture rib	Mrs Black	S120
14/05/2012	Personality disorder NOS Emotionally unstable personality disorder	Dr Llewelyn	E21z
21/03/2012	Laparoscopic bilateral female sterilisation	Dr McCallum	7E1C-2
18/05/2011	[X]Deliberate drug overdose / other poisoning Olanzapine, Diazepam amd alcholol Start Date: 24/04/2011	Mrs Bond	U20
25/04/2011	Cause of overdose - deliberate Olanzapine & Alcohol	cmann2	TK
24/04/2011	Poisoning - self-inflicted deliberate	Mrs Mann	TK
31/03/2011	Cause of overdose - deliberate	Maureen2	TK
25/06/2009	Autoimmune thyroiditis	cmann2	C052
08/06/2009	Thyroidectomy operations	Mrs Mann	7110
29/08/2008	Nontoxic multinodular goitre	cmann2	C011
12/12/2005	Asthma resolved Attack 1995	Mrs Stewart	21262
26/05/2004	CIN III - severe dyskaryosis + HPV	Dr Finney	4K24
27/09/1997	Head injury was assaulted	Dr Finney	S646
23/04/1994	[X]Overdose - paracetamol	Dr Finney	U200

1701806541 17/01/1980
HUGHES
Lisa Rosemary

Past Problems		Authorised By	Code
13/10/2015	**[X]Deliberate drug overdose / other poisoning**	Dr Finney	U20-1
27/03/2014	**Notes summary on computer**	Dr Finney	9344

Due Diary Entries		Authorised By	Code
28/06/2020	**Medication review**	Dr Finney	8B314
17/01/2020	**Follow-up thyroid assessment**	Miss MacLean	66B2.

Overdue Diary Entries		Authorised By	Code
13/07/2016	**Asthma monitor 2nd letter OVERDUE**	Mrs MacPherson	9OJ5.

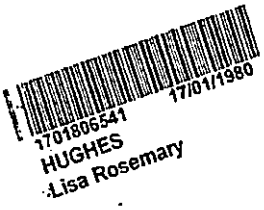
Alerts	Authorised By	Code
None		

Drug Allergies	Authorised By	Code
None		

Non Drug Allergies	Authorised By	Code
None		

Health Status	
24/05/2017	**Cervical smear result Cervical smear: negative**
26/09/2019	**Height 164 cm**
26/09/2019	**Weight 58 Kg**
26/09/2019	**Body Mass Index 21.56 kg/m2**
26/09/2019	**Blood pressure reading 135/80 mm Hg**
23/08/2019	**Blood pressure reading O/E - BP reading**
28/02/2019	**Smoking Status Cigarette smoker, 15 Cigarettes/day**
28/02/2019	**Exercise grading Aerobic exercise 2 times/week**
28/08/2013	**FH: Ischaemic heart dis. >60**

Consultations	
24/10/2019 13:58	Dr Alison McKean at Docman
History	xray L knee normal. see docman.
11/10/2019 16:44	Dr Rupert N Whitehead at Cardonald Medical Centre
History	chest tightness over the week, no calf pain/swelling, no haemoptysis/sputum - no autonomic features, not exertional - breathing "noisy" - known asthma, doesn't use inhalers.
Examination	PEFR 400 (best pred 450) sats 99% OA, HR 62 reg, CRT < 2 secs, RR 12, speaking full sentences, chest - mild wheeze throughout, no creps, HS pure, calves SNT. BP 130/76.
Comment	poorly controlled asthma - SABA in first instance, worsening statement given re: deterioration - get assessed if worsening as may need steroids - not indicated today.
Medication	Salbutamol Cfc-free inhaler 100 micrograms/puff *2 inhaler ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY*
-	
History	tightness/discomfort left leg - chronic, >3/12 - not sciatic, quite ill defined, no injuries. OE - good blood supply, NV intact, hip/knee/back full ROM, thigh 41cm bilat, calf 31cm bilat, slight pain w. stretching hamstrings only, no popliteal masses. No clear diagnosis but nil concerning - reassured.
26/09/2019	Miss Monica MacLean at Cardonald Medical Centre
Examination	Blood pressure reading 135/80 mm Hg
	O/E - height, 164 cm
	O/E - weight, 58 Kg
	Body Mass Index, 21.56
Comment	patient here for thyroid annual review/ feeling well today, no problems, thyroid medication is taken in the morning, and never misses this.
Follow up	Follow-up thyroid assessment (17/01/2020)
Test Request	Thyroid function tests - *Completed*
Additional	White British - ethnic category 2001 census
23/08/2019 14:59	Dr Alan Finney at Cardonald Medical Centre
History	EXTRA. See below. Still feels lethrgic and a bit light=headed, but no specifc symptoms(eg resp or UTI symptoms).
Examination	O/E - BP reading Chatty and appears well. Apyrexial (36.8). Pharynx NAD. No C adenopathy. Has sl discomfort in occiptal area, prob muscular from insertion of trapezius.
	Urinalysis = abnormal Leuc+++ Prot +
	O/E - pulse rate 84 beats/minute
	Blood pressure reading 116/66 mm Hg
Comment	Imp - ? UTI, ? Viral illness. Rx Nitrofurantoin as precaution as now Fri pm and going out for daughter's birthday tomorrow night.
Medication	Nitrofurantoin M/R capsules 100 mg *10 capsule ONE TO BE TAKEN TWICE A DAY FOR 5 DAYS*
20/08/2019 16:27	Dr Peter Horne at Cardonald Medical Centre
History	feeling very light headed & lathargic wanting to lay down B/P 93/104 ask for adv, tells me feeling lethargic, had a really busy week last week and forgot to take thyroxine tablets for a few days, no vomiting feeling otherwise systemicaally well
Comment	advised to go back onto thyroxine and drink plenty fluid etc will call back if not improving



Medication

Current Date Commenced	Drug Details	Date Last Issue	Authorised By	Type
09/12/2019	**Co-Codamol 8/500 Tablets** TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS) 50 TABLET	09/12/2019P	Dr Julia Datta	ACUTE
04/09/2018	**Citalopram Hydrobromide Tablets 20 mg** ONE TO BE TAKEN EACH DAY - DISPENSE WEEKLY 56 TABLET	21/10/2019P	Dr Claire McGill	REPEAT
04/09/2018	**Olanzapine Tablets 10 mg** ONE TO BE TAKEN EACH DAY - DISPENSE WEEKLY 56 tablet	21/10/2019P	Dr Claire McGill	REPEAT
	Levothyroxine Sodium Tablets 25 micrograms ONE			

16/05/2018	TO BE TAKEN EACH DAY 56 TABLET	21/10/2019P	Dr Claire McGill	REPEAT
16/05/2018	**Levothyroxine Sodium Tablets 50 micrograms** ONE TO BE TAKEN EACH DAY 56 TABLET	21/10/2019P	Dr Claire McGill	REPEAT
24/09/2015	**Salbutamol Cfc-free Inhaler 100 micrograms/puff** ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY 2 inhaler	11/10/2019P	Dr Julia Datta	REPEAT
04/10/2011	**Levothyroxine Sodium Tablets 100 micrograms** 1 TABS IN THE MORNING 56 TABLET	21/10/2019P	Dr Claire McGill	REPEAT



NHS GGC Hospitals, Admission Document

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1701806541

Queen Elizabeth University Hospital

Total Att: **11**

12 Mth Att: **0**

Title: **MISS**

HUGHES **Lisa Rosemary**

DOB: **17/01/1980** Age: **38y** Sex: **Female**

8 Carham Crescent
Glasgow
Lanarkshire
G52 2HN
07563300068

Next of kin: **HAUGHEY, AGNES**
Relationship: **Mother**
07769815357

GP: **JD Datta**
0141 892 2548

Attendance Date: **17/12/2018** Arrival Time: **16:38**

Registration Time: **16:38** Date of Incident: **17/12/2018**

Major Incident Desc:

Reason for Attendance: **own transport 2 weeks of intermittent chest pain ?stress rule out cardiac**

Affix Label

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **2** Tetanus up to date/fully immunised:

Presenting Complaint: **Chest Pain**

Observation Date: **17/12/2018 16:46** Nurse name: **Nurse Jennifer Michael**

Temp	**35.5**	C
HR	**86**	bpm
BP	**112/80**	mmHg
MAP	**90.67**	mmHg
RR	**18**	bpm
SpO2	**97**	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils Right		Pupils Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **2/52 central chest pain ?stress related. FHx IHD, obs stable**

Patient ID label

Date	Emergency Department Notes	
	Ambulance Proforma reviewed Yes / No Seen by (Doctor)	Time seen

Pat

1701806541
HUGHES
Lisa, R
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

F
17/01/1980

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Differential Diagnosis/Problem List	
	NEWS ☐ 0-7 RED FLAG ☐ (Tick) SEPSIS ☐ CURB 65 ☐

Done/ completed	Immediate Managment Plan

Signature: Designation: Page No:

PLEASE DO NOT WRITE HERE

Patient ID label
1701806541
HUGHES F
Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

Seen By: Print: Thomson Time Seen: 1850

PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	Chest pain.
History of presenting complaint RISKS FH IHD Smoker	38 year old female presents c 2/52 history of pain in chest, intermittent in nature; Had severe episode of chest pain last pm - radiated to (L) arm, "pins and needles" in fingers. ? SOB, not clammy. Patient was lying on the couch @ time. No N+V. Pain not aggravated by exertion, inspiration or movement. Has been under significant stress recently.

Past Medical History / Review of portal	
Asthma Closed rib fx.	OD Autoimmune thyroiditis
Personality disorder - emotionally unstable.	

Systemic Enquiry
See page 7.

1701806541 F
HUGHES 17/01/1980
Lisa, R
8 Carham Crescent
Glasgow, Lanarkshire G52 2HN

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history (>1 source preferred)
☐ Patient/Relative/carer ☐ GP Phone call ☑ ECS
☐ Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary
☐ Repeat Prescription

Other (please specify)

Admission Medicines			Plan for Medicines (Dr complete)				Comments Reason for alteration
Name	Dose	Freq	Continue	Amend	Withhold	Stop	
Citalopram	20mg	OD					
Olanzapine	10mg	OD					
Levothyroxine	175mcg	OD					
Salbutamol	100mcg	PLN					

Allergies	List any over-the-counter or alternative medicines
NKOA.	
	Do medicines need further clarification ? ☐ Yes ☐ No
List collected by :	Plan approved by :
Designation : Date :	Designation : Date :

Pharmacy review	Comments
Compliance aid : ☐ Yes ☐ No	Community pharmacist Phone
Reviewed by : Designation :	Date :

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F
17/01/198(

Social History \ Family History

Smoking History

Ex-smoker/Smoker _____ cpd _____ yrs ☐ Never smoked

Alcohol History

_____ Units/week FAST score if excess _____

Recreational Drugs **Driving Status**

Social Circumstances (home, supports, functional status, occupation, travel)

lives @ home. Independent

General Examination

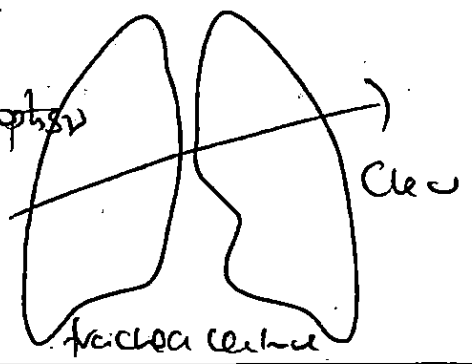
Temp:	35.5	RR:	18
Pulse:	86	CBG:	
SpO_2:	97%	Weight:	
BP:	112/80mmHg	Urinalysis:	

General Appearance:

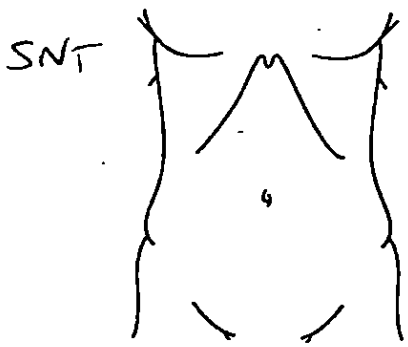
looks well.

Respiratory

o Cough
o SOB
o Haemoptysis



Gastrointestinal System



Cardiovascular

HS I + II + 0

JVP ↑

o CP @ exam

o Palpitations

oedema

Locomotor

Mobile

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G52 2HN
F
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Neurological system

GCS: /15 E: /4 M: /6 V: /5

AMT 4 = age, DOB, place, year

AMT score ____ /4

Is the patient more confused/drowsy than normal: Y / N
If yes complete 4AT / TIME

A V PU

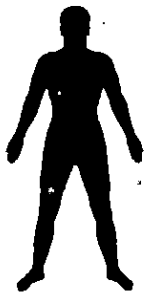
Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

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Key Results

CXR

requested

ECG

NSR c 0 acute ST/T wave changes.

(Differential) diagnosis

Exclude ACS

? Stress-related

NEWS ☐

Red Flag ☐

Sepsis ☐

CURB 65 ☐

Management Plan

① Bloods

② CXR

③ 12 lead ECG

④ Analgesics as PRN

⑤ If Trop ↑ - repeat as per pathway.

⑥ If -ve d/c c advice ? Anxiety related.

☐ Thromboprophylaxis assessed ☐ Medicine Reconciliation ☐ 4AT/TIME
☐ Antimicrobial

Signature: RJ

PRINT NAME RJ THOMSON

PRINT GRADE AMP.

Page:

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Resuscitation Decision

Resuscitation status: FOR RESUSCITATION / DNA CPR
(please circle)

If DNA CPR → Complete appropriate form

17/11/18 @ 1900.

Senior Medical review

Note Trop -ve.

ECG NSR c nil acute ST/T.

CXR ⊕

For medical r/v prior to discharge.

RJ
Nonsurg
ANP.

☐ Thromboprophylaxis assessed ☐ Medicine Reconciliation ☐ 4AT/TIME
☐ Antimicrobial ☐ DNACPR ☐ AWI if appropriate

Sepsis Six
- ☐ Antibiotics within 1 hour
- ☐ Appropriate Cultures
- ☐ Fluids
- ☐ Oxygen
- ☐ Lactate
- ☐ Fluid balance, consider catheter

Pati
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Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED

Is the patient bed-bound or expected to have reduced mobility relative to normal for ≥2 days

☐ Yes ☐ No

Does the patient have any of the following risk factors? Tick if apply

Active cancer or cancer treatment		Use of oestrogen containing contraceptive	
Age> 60		Hormone replacement therapy	
Dehydration		Pregnancy or <6 weeks post partum (seek specialist advice)	
Known thrombophillia		Critical care admission	
BMI >30		Varicose veins with phlebitis	
Personal/1st degree relative history of VTE		Current significant medical condition e.g. infection, inflammation, cardio resp disease	
Hip fracture			

- No thromboprophylaxis
- Reassess (every 72 hours minimum)and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

☐ Yes ☐ No

Does the patient have any of the following contraindications? Tick if apply

Active bleeding		Untreated inherited bleeding disorder	
Acquired bleeding disorder		Thrombocytopaenia <75 x109/l	
Thyroid, spinal, posterior eye or neurosurgery		Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR>2		Uncontrolled hypertension (>230/120)	
Acute stroke		Varicose veins	
Recent (<4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic			
Other - Document			

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum)and document

☐ No ☐ Yes

Enoxaparin 40mg (reduce to 20mg if weighs < 50kg or eGFR <30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A
(only n/a if due to cognitive impairment or similar)
If N/A why? _____
Assessed by _____
Date _____

Chol 3.4
Trig 1.0

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Results

Date		17/11/18							
Time		1850							
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165	128							
WCC	4.0 - 11.0	9.6							
Plts	150 - 450	351							
MCV	80 - 100	97.3							
Neut	2.0 - 7.5	5.7							
PT	9.0 - 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	( )								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146	139							
K+	3.5 - 5.3	4.5							
Cl-	95 - 108	107							
HCO3-	22 - 29								
Urea	2.5 - 7.8	2.4							
Creat	40 - 130	61							
eGFR		760							
Glucose	3.5 - 6.0	6.7							
Protein	60 - 80								
Albumin	35 - 50	37							
AlkP	30 - 130	43							
Bil	<20	6							
ALT	<50	18							
AST	<40	16							
GGT	Male: <70 Female: <40								
ESR	Male: 1 -10 Female: 1 - 12								
CRP	<10	2							
Troponin hs I	Male: 0 - 34 Female 0 - 16	<1							
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 – 2.0								

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Post Take Ward Round ~~IAU~~/ARU

Consultant: David Bell Date: 17/12/18 Time: 7.30pm

Summary

38 y/o ♀ c 2/52 Chest Pain

- Trop x 2
- CXR Clear ECG ✓
- Sx admits Hx stress ? likely
- Probably Canx.

→ Reassure

✓

Temp:
Pulse:
BP:
SpO_2:
FiO2:
RR:

Diagnosis:

DB

Plan:

Recommended Destination: _____
Suitable to board if required ☐ Yes ☐ No
Expected Date of Discharge: _____

Signature: _____
Designation: _____
Bleep Number: _____

Patient ID label

Continuation Sheet

Date: Time

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Continuation Sheet	
Date; Time	

Patient ID label

Continuation Sheet	
Date: Time	

Patient ID label

1701806541 17/01/1980
HUGHES
Lisa Rosemary

Continuation Sheet

Date: Time	

Patient ID label

Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

Date Given	Drug (Block Capitals)	Dose	Method of administration	Time of administration	Signature	Given by

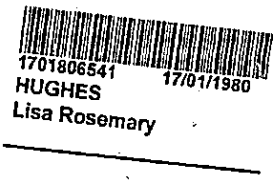
Discharge prescription packs

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by

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

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

Outpatient clinic specialty						Admission or specialty clinic consultant		
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify


1701806541 17/01/1980
HUGHES
Lisa Rosemary

1701806541 17/01/1980
HUGHES
Lisa Rosemary

Registration Details - Patient No: 5618

Personal details...		Address details...	
Date of birth	17/01/1980	Post Code	G52 2HN
Sex	F	House Name Flat No	
Surname	Hughes	No and Street	8 Carham Cres
Previous Surname		Village	
Forenames	Lisa Rosemary	Town	GLASGOW
Calling Name	Lisa	County	
Title	Miss		
Birth Surname			
Marital Status	Married		
Ethnic Origin	(White) British		

HA/HB Details...		Contact details...	
Trading partner	Greater Glasgow	Home Tel No	
CHI Number	1701806541	Work Tel No	
Registered GP	Dr Julia Datta	Mobile Tel No	07563300068
Usual GP	Dr Julia Datta	E Mail Address	
Residential Inst			
Branch Surgery			

Practice Information...		Distances	
Dispensing	N	Rural Mileage	
Hospital Number		Blocked Special	
Records At	Cardonald Medical Centre	Walking Quarters	

Further Information		Upload Consent	
Long/Short stay or Dead		SCI-DC Consent	Implied Consent (default)
Date of registration	23/02/2005		
Previous Address			
Next of Kin			
Next of Kin Contact Details			

AMS\CMS Details		Imported user defined fields	
AMS Consent	Yes	GPASS Patient ID	
Pharmacy Details	Lloydspharmacy-Paisley Road West,1851 Paisley Road West,Glasgow,Glasgow,(G52 3SX) (Org Id - 1530)	Contact	07884038836
Item Collected Check	Yes	Contact Relationship	239 0191
CMS Suitability Status	-1	AMS Consent Given	Yes
CMS Registration Status	2	SCIDC Consent Withdrawn	0
CMS Consent	-1		
Pharmacy Name			
Pharmacy Address			
STREAMING: Script Destination			

Medical Record

Problems

Active Problems		Authorised By	Code
15/08/2014	DEXA - Dual energy X-ray photon absorptiometry Normal	Ms Clark	58E-1
18/07/2014	Asthma	Nurse Cree	H33
13/06/2014	Acute lower respiratory tract infection	Mrs Black	H062
13/06/2014	Closed fracture rib	Mrs Black	S120

14/05/2012	Personality disorder NOS Emotionally unstable personality disorder	Dr Llewelyn	E21z
21/03/2012	Laparoscopic bilateral female sterilisation	Dr McCallum	7E1C-2
18/05/2011	[X]Deliberate drug overdose / other poisoning Olanzapine, Diazepam amd alchclol Start Date: 24/04/2011	Mrs Bond	U20
25/04/2011	Cause of overdose - deliberate Olanzapine & Alcohol	cmann2	TK
24/04/2011	Poisoning - self-inflicted deliberate	Mrs Mann	TK
31/03/2011	Cause of overdose - deliberate	Maureen2	TK
25/06/2009	Autoimmune thyroiditis	cmann2	C052
08/06/2009	Thyroidectomy operations	Mrs Mann	7110
29/08/2008	Nontoxic multinodular goitre	cmann2	C011
12/12/2005	Asthma resolved Attack 1995	Mrs Stewart	21262
26/05/2004	CIN III - severe dyskaryosis + HPV	Dr Finney	4K24
27/09/1997	Head injury was assaulted	Dr Finney	S646
23/04/1994	[X]Overdose - paracetamol	Dr Finney	U200

Past Problems		Authorised By	Code
13/10/2015	**[X]Deliberate drug overdose / other poisoning**	Dr Finney	U20-1
27/03/2014	**Notes summary on computer**	Dr Finney	9344

Due Diary Entries		Authorised By	Code
30/08/2019	**Thyroid disease monitoring**	Nurse Pryde	66B..
23/05/2019	**Medication review**	Dr Lynn	8B314

Overdue Diary Entries		Authorised By	Code
24/05/2018	**Cervical smear due OVERDUE** SCCRS Recall	Mrs Black	685F.
13/07/2016	**Asthma monitor 2nd letter OVERDUE**	Mrs MacPherson	9OJ5.

Alerts		Authorised By	Code
	None		

Drug Allergies		Authorised By	Code
	None		

Non Drug Allergies		Authorised By	Code
	None		

Health Status		
24/05/2017		**Cervical smear result Cervical smear: negative**
24/05/2017		**Height 164 cm**
24/05/2017		**Weight 63.5 Kg**
24/05/2017		**Body Mass Index 23.61 kg/m2**
17/12/2018		**Blood pressure reading O/E - blood pressure reading**
17/12/2018		**Blood pressure reading 129/79 mm Hg**
30/11/2017		**Smoking Status Smoker**
28/08/2013		**Exercise grading Aerobic exercise 0 times/week**
28/08/2013		**FH: Ischaemic heart dis. >60**

1701806541 17/01/1980
HUGHES
Lisa Rosemary

Consultations	
17/12/2018 14:38	Dr Katy Fisken at Cardonald Medical Centre
History	emer appmt, 2 weeks pain in chest, coming and going, last night partic severe episode, 8/10 severity, radiated to arm, lasted 15 mins. smoker. FH IHD mums side. Pain not typically exertional when has been occuring over past 2 weeks, wonders if related to stress, lots of family stress, during severe episode last night was worried was having heart attack, also worried about thyroid as feeling more tired recetnly
Examination	O/E - blood pressure reading Blood pressure reading 129/79 mm Hg HR 77 HS normal chest clear. abdo soft non tender
Comment	Atypical CP but in view of severe episode last nighter refer for ECG and trop, appmt to see nurse for bloods.
Test Request	Bone Profile - *Requested*, Urea and Electrolytes - *Requested*, Liver Function Tests - *Requested*, Lipid profile (inc. HDL) - *Requested*, Thyroid function tests - *Requested*, Full Blood Count - *Requested*
-	—
17/12/2018	Dr Niamh Carey at Telephone Consultation
History	has been exp tightening and chest pains which wont go away for 1 week now.
Comment	2wks constant ache in chest and L arm. Intermittent probs w SOB and palpitations. Never had before. No fhx. Under 'lot of stress w family lately'. Given emerg appt today, aware if worsens before TCB
-	—
28/11/2018	Nurse Sandra Pryde at Data Entry
Comment	Self taken swabs handed in - to lab.
Test Request	Chlamydia/Gonorrhoea PCR - Vulvovaginal - *Completed*, Low Vaginal Swab (C&S) - *Completed*
-	—
27/11/2018	Nurse Sandra Pryde at Data Entry
Comment	Called for swab results - not back. Portal checked - no record at the lab. Spoke to Lisa and I will leave swabs at reception for her to repeat.
Test Request	Chlamydia/Gonorrhoea PCR - Vulvovaginal - *Requested*, Low Vaginal Swab (C&S) - *Requested*
-	—
14/11/2018	Dr Niamh Carey at Cardonald Medical Centre
History	concerned as ex partner told her that she passed on STI to him. Last sexual exposure 3m ago. No STI symptoms, no prior hx STI. Advised can to self swabs and hand in
Test Request	Chlamydia/Gonorrhoea PCR - Vulvovaginal - *Completed*, Low Vaginal Swab (C&S) - *Completed*

1701806541

Medication

Current Date Commenced	Drug Details	Date Last Issue	Authorised By	Type
04/09/2018	**Citalopram Hydrobromide Tablets 20 mg** ONE TO BE TAKEN EACH DAY - DISPENSE WEEKLY 56 TABLET	13/11/2018P	Dr Claire McGill	REPEAT
04/09/2018	**Olanzapine Tablets 10 mg** ONE TO BE TAKEN EACH DAY - DISPENSE WEEKLY 56 tablet	13/11/2018P	Dr Claire McGill	REPEAT
16/05/2018	**Levothyroxine Sodium Tablets 25 micrograms** ONE TO BE TAKEN EACH DAY 56 TABLET	13/11/2018P	Dr Claire McGill	REPEAT
16/05/2018	**Levothyroxine Sodium Tablets 50 micrograms** ONE TO BE TAKEN EACH DAY 56 TABLET	13/11/2018P	Dr Claire McGill	REPEAT
24/09/2015	**Salbutamol Cfc-free Inhaler 100 micrograms/puff** ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY 2 Inhaler	03/09/2018P	Dr Julia Datta	REPEAT
04/10/2011	**Levothyroxine Sodium Tablets 100 micrograms** 1 TABS IN THE MORNING 56 TABLET	13/11/2018P	Dr Claire McGill	REPEAT

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

N
A 1701806541
HUGHES F
I, Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN
C
D.O.B

	Date	Ward
Admitted		
Transferred		
Transferred		

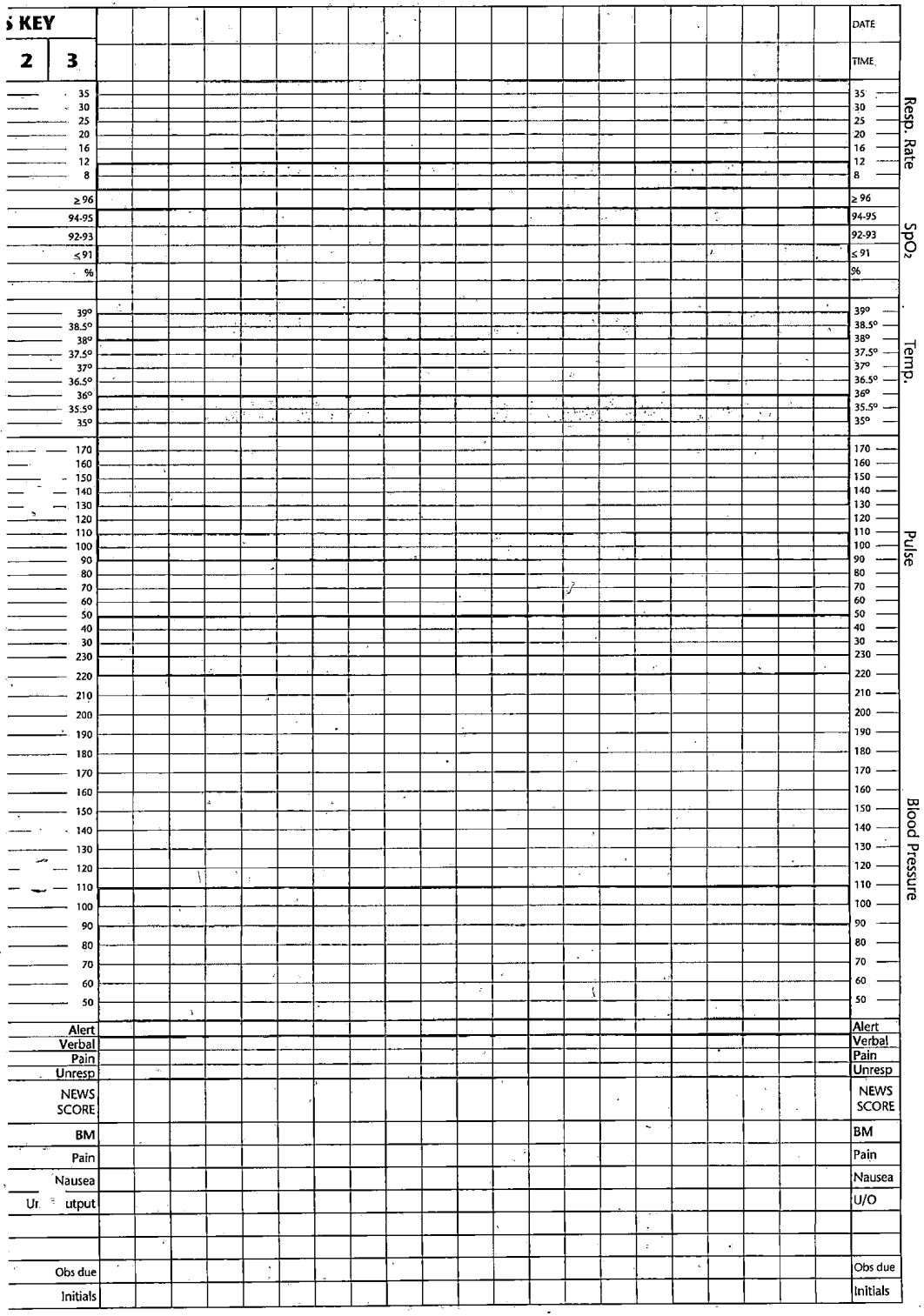
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

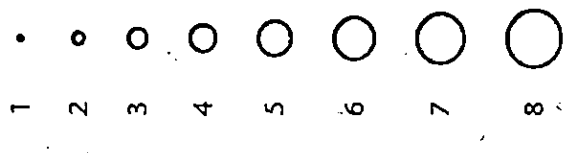
NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • 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. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

| | | |


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
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
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
Ur utput
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)



1701806541

Neurological Observations

Date:																									
Time:																									
COMA SCALE	E Eyes open	Spontaneously	4																						Eyes closed by swelling = C
		To speech	3																						
		To pain	2																						
		None	1																						
	V Best Verbal response	Orientated	5																						Endotracheal tube or tracheostomy = T
		Confused	4																						
		Inappropriate words	3																						
		Incomprehensible sounds	2																						
		None	1																						
	M Best motor response	Obeys	6																						Usually record the best arm response
		Localises	5																						
		Flexion - withdrawal	4																						
		Flexion - abnormal	3																						
		Extension to pain	2																						
		None	1																						
TOTAL SCORE																									
PUPILS	R	Size																							+ reacts – no reaction c. eyes closed
		Reaction																							
	L	Size																							
		Reaction																							
LIMB MOVEMENT	ARMS	Normal power																							Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																							
		Severe weakness																							
		Spastic flexion																							
		Extension																							
		No response																							
	LEGS	Normal power																							
		Mild weakness																							
		Severe weakness																							
		Spastic flexion																							
		Extension																							
		No response																							

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 patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital

CHI: 1701806541

Total Att: 10

12 Mth Att: 2

Title: **MISS**

HUGHES **Lisa Rosemary**

DOB: **17/01/1980** Age: **37y** Sex: **Female**

8 Carham Crescent

Glasgow
Lanarkshire
G52 2HN
0141 883 2693

Next of kin: **HAUGHEY, AGNES**
Relationship: **Mother**
07769815357

GP: **AA Finney**
0141 892 2548

Attendance Date: **21/04/2017** Arrival Time: **21:22**

Registration Time: **21:22** Date of Incident: **21/04/2017**

Major Incident Desc:

Reason for Attendance: **nhs ref personnel**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint: **Gynaecological Foreign Body**

Observation Date: **21/04/2017 21:29** Nurse name: **Nurse Lynsey Morrison**

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils Right		Pupils Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **NHS 24 referral - tampon stuck for 6/7**

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

NHS 24 FAX REPORT

1701806541 17/01/1980
HUGHES
Lisa Rosemary

NHS 24 ID:	Call ID: 19092820	**Site:**	Glasgow
CHI #:	1701806541	**Caller Name:**	
Surname:	HUGHES	**Date/Time Call Received:**	21/04/2017 20:50
Forename:	LISA		
DOB:	17/01/1980	**Date Call Completed:**	
Gender:	Female	**Time Call Completed:**	
Address:	8 Carham Crescent	**Call Priority:**	CS3
	Cardonald	**Call Reason:**	TAMPON STUCK 6 DAYS SEE AV
	Glasgow	**Current Location:**	8 Carham Crescent
			Cardonald
	G52 2HN		Glasgow
PH NO:	07704682721 (Return)		G52 2HN
		Special Directions:	Front Door
		Current PH NO:	07704682721 (Return)
Care Provider:	SEMPLE, LINSEY	**Care Provider Details:**	Drs Semple, Finney & Datta
			Cardonald Med Centre
			1831 Paisley Rd West Glasgow
			G52 3SS
			UK

Temporary Resident: No

Referred To: Glasgow and Clyde Hub **Recommended Action:** Pt advised to go to A&E - For Information Only

CLINICAL SUMMARY

TAMPON STUCK FOR 6 DAYS AND THOUGHT SHE HAD REMOVED IT AS SHE COULD NOT FEEL THE STRING. HAS FEELING OF PRESSURE T AND IS ABLE TO FEEL TAMPON INSIDE HER BUT IT IS SITTING HORIZONTALLY AND IS UNABLE TO REMOVE IT. FEELS UNWELL. ADVISED BY A&E ASAP - QEUH.

PAST MEDICAL HISTORY

MEDICAL PROBLEMS

16/40 WKS, THYROID REMOVED 2008, DEPRESSION

MEDICATIONS

NIL, AS PER ECS

ALLERGIES

NIL

Referred Clinical Notes:

T:
P:
R:
BP: /

Print Name: **Signature:**

Date		Seen by (Dr)	Time seen
21/4/17		1701806541 17/01/1980 HUGHES Lisa Rosemary	2245

GP ST2 POOLH

37 ♂ ? TAMPON STUCK.

PMH : P8+O

HPC : DOES NOT USUALLY USE TAMPONS – TRIED FOR FIRST TIME LAST WEEK – CHANGING EVERY 4 HOURS. LAST SATURDAY NIGHT WAS GOING TO INSERT ONE – CANNOT REMEMBER IF SHE DID OR NOT. THOUGHT IN AM SHE HAD NOT PUT ONE IN. OVER NEXT FEW DAYS THOUGHT SHE MAY HAVE TAMPON STUCK – HAD INTERCOURSE – 1st time in MONTHS – felt SOME PRESSURE. PRONE TO CONSTIPATION PASSING only small lumps "RABBIT poo"

WAS FEELING TO SEE IF TAMPON STILL STUCK = COULD FEEL SOMETHING in VAGINA "Under the SKin" + Also felt in her ANUS – Cancel so came in.

O/E/ Well – No Clinical feature of TOXIC SHOCK, Abdm soft



Date	CLINICAL NOTES

VAGINAL EXAMINATION WITH Auxiliary NURSE as CHAPERONE

NORMAL external Vaginal examinm.

Speculum examinm - PARUS Os, ECTROPION - N/I concerning
No TAMPON

P.V. examinm - Smooth firm mass Poster Vaginal Wall - Not HARD/CRAGGY - ? mobile - under VAGINAL MUCOSA.

P.R. examinm - Similarly felt firm substance at rectum Not tender, Mobile - EASY to incline - Seperate from Rectal mucosa - feels very much like HARD FAECES

→ FINGER on INSPECTION - FAECAL MATTER

IMP| Constipation - Patient felt firm Faeces at Poster Vaginal Wall - No wt loss/Blood loss/change Bowel Habit

Plan| LAXATIVES + Appoint GP EARLY NEXT Week FOR F/U P.R. Post DEFAECATION to ensure this was all faeces WHICH IT VERY MUCH feels like it IS.

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged		Not arranged		To be arranged			
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

17

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

Queen Elizabeth University Hospital

CHI: 1701806541

Total att: 9

18 Mth Att: 4

Title: Miss

HUGHES

Lisa Rosemary

DOB: 17/01/1980 Age: 36y Sex: Female

8 Carham Crescent

Glasgow
Lanarkshire
G52 2HN
0141 883 2693

Next of kin: HAUGHEY, AGNES
Relationship: Mother
07769815357

GP: AA Finney
0141 882 2648

Attendance Date: 08/08/2016 Arrival Time: 17:31

Registration Time: 17:31 Date of Incident: 08/08/2016

Major Incident Desc:

Reason for Attendance: **suicidal**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **2** Tetanus up to date/fully immunised:

Presenting Complaint: **General Generally Unwell**

Observation Date: **08/08/2016 17:48** Nurse name: **Nurse Tracey Buchan**

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils Right		Pupils Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **biba. pt found lying on ground by passer by & pt stated to them she was going to throw herself in the river. pt been drinking. pt recently had children removed from her home. pt aggressive o/a.**

Date	Emergency Department Notes	
8/8/16.	Seen by (Doctor) GPST 1.2 leung	Time seen 18:15

(36) BIBA, alcohol excess - intoxicated
+ claimed to be suicidal.

Taken over by consultant Dr Jason Lang
Pt verbally + physically abusive

Aleung GPST 1.2

PMH.

Overdose x 6.
Emotionally unstable personality disob
Asthma.

Meds.

Olanzapine
Citalopram
~~Amoxil~~ Diazepam
Levothyroxine
salbutamol

NKDA.

Date	Emergency Department Notes	
	Seen by (Doctor) LSPO (ED CONSULTANT)	Time seen

Went to see patient — was being verbally + physically abusive +++.
Police in attendance + called.
Patient not consenting to assessment — telling me to 'fuck off'.
All obs ⊙ + BM 5·1.
Note story — alcohol ++ — found by passerby ? smoked.
Sober episodes in past

1701806541 17/01/1980
HUGHES
Lisa Rosemary

Differential Diagnosis/Problem List

→ As so violent ERO immediate medical problem for patient/staff safety police taken into custody

SEWS ☐ 0-7
RED FLAG ☐ (Tick)
SIRS ☐
CURB 65 ☐

Done/ completed	Imediate Managment Plan

Signature: Designation: COSTEM Page No:

Acute Medical or Surgical Admission Unit Notes

Please affix patient ID label here

Initial Assessment

Seen by (print):

Time seen:

Presenting Complaint

History of Presenting Complaint

Past Medical History	Systemic Enquiry
	CVS RESP GI CNS/PNS GU Musculoskeletal

MEDICINES RECONCILIATION (ECS can be stapled here and annotated with plan for medicines. Please sign medicines plan.)

Source of medication history Patient ☐ Relative/ carer ☐ GP Surgery ☐ ECS ☐
PODs ☐ Com. Pharmacist ☐ GP letter ☐ Rpt Presc ☐

Admissions medicines			Plan for medicines				
Name	Dose	Frequency	Continue	Stop	Amend	Hold	Comments/ reason

1701806541 17/01/1980
HUGHES
Lisa Rosemary

Allergies	Medication needs
None known ☐	Further clarification? Yes ☐ No ☐
Completed by:	Designation: Date:

Drugs prescribed on admission checked and correct

Compliance aid? Yes ☐ No ☐

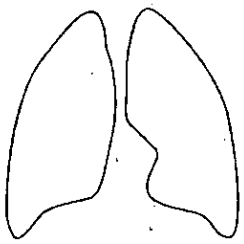
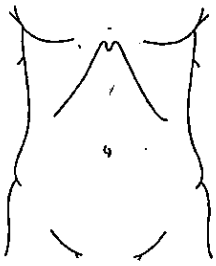
Comments:	Community Pharmacist
Reviewed by:	Designation: Date:

Affix patient ID label

Social History
Smoking History: Alcohol History: Other drug use?:

Home circumstances	General Examination	
	Temp:	RR:
	Pulse	BG:
	SpO2:	Weight:
	BP:	Urinalysis:

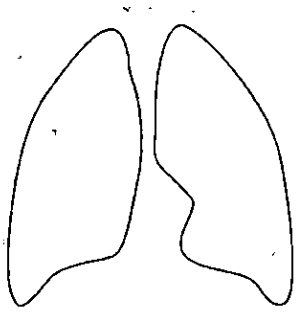
Cardiovascular Examination	General Observations

Respiratory Examination	Abdominal Examination
	

Neurogical and Other Examination (e.g. locomotor)

Cranial Nerves	GCS: E: M V: TOTAL AMT ☐ Fundoscopy:
Upper limb neurological examination	Lower limb neurological examination

Other

Key Results:	
CXR:	Urinalysis:
	ECG: 17/08/0654

Differential Diagnosis/Problem List	
	SEWS ☐ 0-7 RED FLAG ☐ (Tick) SIRS ☐ CURB 65 ☐

Immediate Managment Plan	Done/ Ordered	Checklist
		Medicines plan documented ☐
		Blood results receieved ☐
		Kardex ☐
		Antmicrobials as per Policy
		Yes ☐ No ☐
		If 'No' state reason:
		DVT prophylaxis indicated
		Yes ☐ No ☐
		DVT prophylaxis prescribed
		Yes ☐ N/A ☐

Doctor Completing Initial Assessment

Name (print): Signature: Designation:

Page No.

Please affix patient ID label here

Secondary or Senior Focused Review

Seen by (print):

Time seen:

Done/ completed	Continuing Managment Plan

Doctor Completing Initial Assessment

Signature: Designation: Page No.:

Scottish Ambulance Service Patient Report Form

1701806541 17/01/1980
HUGHES
Lisa Rosemary

Incident Number	CR003123341 on 08/08/2016 at 16:46		
Callsign		Incident Type	EMG
Crew1	E0040754 - Driver	Crew3	
Crew2	E1008560 - Attendant	Crew4	

INCIDENT LOG

Incident Location	PLANTATION SQUARE KINNING PARK BY HARPER MEMORIAL CHURCH PLANTATION SQUARE GOVAN GLASGOW	Incident Postcode	G51 1TG
Call Received	16:46 - 08/08/2016	Patient at Hospital	
Call Passed	16:48 - 08/08/2016	Patient Handover	
Crew Mobile	16:49 - 08/08/2016	Crew Clear	
Crew at Scene	16:59 - 08/08/2016	Clear Reason	
Crew Left Scene	17:14 - 08/08/2016		
Receiving Hospital	QUEEN ELIZABETH UNIVERSITY HOSPITAL		

DIAGNOSIS

Chief Complaint Code	25
Despatch Code	25D01 : Psy/Abnormal behave/Suicidal Not Alert/Weapons
Diagnostic Code	25B03 : 25B03 - Threatening Suicide

PATIENT DETAILS

Surname	HUGHS		
Forename	LISA		
Middle Initials		Sex	Male
DoB	17/01/1980	Age	36 years 6 months 22 days
Patient Address	8 CARHAM CRESCENT	Patient Postcode	
Patient Telephone		Ethnicity	

PATIENT CONSENT

Mental Capacity Assessed	Deemed Not To Have Capacity
Level of Consent	

PRIMARY SURVEY

AVPU Assessment	Alert
Catastrophic Haemorrhage	No
Airway Assessment	Clear
Breathing Rate	Normal
Respiratory Rate	20
Pulse	Normal
Most Peripheral Palpable Pulse Found	Radial
Skin Colour	Normal
Skin Texture	Dry
CSI Assessment	None

VITAL SIGNS

Time	Pulse	Rthm	AVPU	RR	SYS	DIA	PEF	BG	Temp	SpO2	PS	CRT	ECG	Sepsis	GCS	RTS	NEWS	ETCO2	Lactate
17:00	115	Reg	Alert	16	121	91		5.7	37	96			Normal sinus rhythm	1	15	7.8	2		
17:15	120				127	93				97				1		2.9	2		

AMPLE

Allergy Type	Unknown
Previous Medication	UNKOWN
Previous Medical History	UNKOWN
Events Prior To Incident	SUICIDAL

SEPSIS

Pulse	RR	SYS	Temp	GCS	BG	Pneumonia	UTI	Other infection	Abdo Pain	Diarrhoea	Abdo distension	Meningitis	Cellulitis	Septic arthritis	Wound infection	Infected indwelling device	No signs of infection
115	16	121	37	15	5.7	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
120		127				NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

GCS

Time	Eye Opening	Verbal Response	Motor Response	Total
17:00	Spontaneous	Orientated	Obeys Commands	15
17:15				0

ADDITIONAL COMMENTS AND OBSERVATIONS

999 CALL. O/A P/T LYING ON GROUND. P/T REPONDS TO PAIN. P/T WAS FOUND BYPASSER BY LYING ON GROUND. P/T STATED THAT SHE WAS ON HER WAY TO JUMP IN THE RIVER. MENTIONED RECNT REMOVAL OF CHILDRN FROM HER HOME. O/E P/T BECAME AGGRESSIVE IN AMBULANCE. GAVE OWN DOB AND ADDRESS THEN REFUSED ALL OTHER QUESTIONS. ADMITTED DRINKING 1BOTTLE OF WINE, DENIED DRUG USE. OBS AS SHOWN.

REPORT MANAGEMENT

Report ID	CR003123341-08082016171839		
Software Version	1.0.440	Report Type	Interim

Senior Doctor Review Seen by (print): Time seen:	Please affix patient ID label here 17/0806541

DVT Prophylaxis indicated Yes ☐ No ☐	Antimicrobials choice compliant Yes ☐ No ☐
DVT Prphylaxis prescribed Yes ☐ N/A ☐	If 'No' state reason
Medicines Reconciliation completed Yes ☐ No ☐	

Done/ completed	Continuing Managment Plan

Signature:	Designation:	Page No:

Please affix patient ID label here

Continuation Sheet	
Date: Time	

Continuation Sheet

1710806541

Date: Time	

Please affix patient ID label here

Continuation Sheet	
Date: Time	

Continuation Sheet

1701 806541

Date: Time

PLEASE DO NOT WRITE HERE

Attach GP Letter, Results or Emergency Care Summary

1710806541

Serial Blood Results								
	Date:							
	Time:							
	Signature:							
Sodium	135 - 146							
Potassium	3.5 - 5.3							
Chloride	95 - 108							
Urea	2.6 - 7.8							
Creatinine	40 - 130							
Estimated GFR								
Bicarbonate	22 - 29							
Glucose	3.5 - 6.0							
CRP	0 -10							
Magnesium	0.7 - 1.0							
Calcium	2.2 - 2.6							
Calcium Adj	2.2 - 2.6							
Phosphate	0.8 - 1.5							
Cardiac Enzymes & Liver Function Tests	**Normal Values**							
Troponin	<0.04							
CK	<150							
Amylase	0 - 100							
ALT	0 - 50							
Gamma-GT	0 - 70							
Alk Phos	30 - 130							
Total Bilirubin	0 - 20							
Albumin	35 - 50							
Haematology & Clotting Screen	**Normal Values**							
White Blood Count	4.0 - 11.0							
Haemoglobin	115 - 165							
Haematocrit	0.370 - 0.470							
MCV	80 - 100							
Platelet Count	150 - 410							
Neutrophils	1.8 - 7.7							
Lymphocytes	1 - 4.8							
Prothrombin Time	9 - 13							
PCT Ratio								
APTT	27 - 38							
APTT ratio	0.8 - 1.2							
Thrombin Time	10 - 16							
TCT Ratio								
Arterial Blood Gas	**Normal Values**							
H+	36 - 43							
PCO_2	4.5 - 6							
PO_2	10.5 - 13.5							
Base excess	+/- 2.5							
Bicarbonate	20 - 28							
FiO_2 (Inspired Oxygen)								
Other								

Emergency Department Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

Date Given	Drug (Block Capitals)	Dose	Method of administration	Time of administration	Signature	Given by

Discharge prescription packs

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by

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

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

Outpatient clinic specialty						Admission or specialty clinic consultant		
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

Police Room

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1701806541

Queen Elizabeth University Hospital

Total Att: 8

12 Mth Att: 3

Title: **MISS**

HUGHES **Lisa Rosemary**

DOB: **17/01/1980** Age: **36y** Sex: **Female**

8 Carham Crescent

Glasgow
Lanarkshire
G52 2HN
0141 883 2693

Next of kin: **HAUGHEY, AGNES**
Relationship: **Mother**
07769815357

GP: **AA Finney**
0141 892 2548

Attendance Date: **08/06/2016** Arrival Time: **00:38**

Registration Time: **00:38** Date of Incident: **08/06/2016**

Major Incident Desc:

Reason for Attendance: **cut lip**

Affix Label

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **08/06/2016 00:57** Nurse name: **Nurse Laura Cook**

Temp		C
HR	110	bpm
BP	122/78	mmHg
MAP		mmHg
RR		bpm
SpO2	97%	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **999 call. Alleged assault. With police due to aggression with crew. Family concerned RE: mental health issues.**

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES
	Seen by (Dr) Brain Time seen

1701806541 17/01/1980
HUGHES
Lisa Rosemary

8/6/16 BIBP.
Been assaulted
Intoxicated

Injuries to lip + (R) shoulder
no LOI

O/E abrasion (R) shoulder
small cut on lip
no mandibular pain
occlusion ok.

Plan d/c
mouth wash

N. Brain
7036791

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

1701806541 17/01/1980
HUGHES
Lisa Rosemary

Scottish Ambulance Service Patient Report Form

Incident Number	CR002987682 on 08/06/2016 at 23:56		
Callsign		Incident Type	EMG
Crew1	E0026697 - Driver	Crew3	E1011774 - Attendant
Crew2	E9888418 - Attendant	Crew4	

INCIDENT LOG

Incident Location	8 CARHAM CRESCENT CARDONALD GLASGOW	Incident Postcode	G52 2HN
Call Received	23:56 - 08/06/2016	Patient at Hospital	00:35 - 08/06/2016
Call Passed	00:06 - 08/06/2016	Patient Handover	-
Crew Mobile	00:06 - 08/06/2016	Crew Clear	-
Crew at Scene	00:12 - 08/06/2016	Clear Reason	
Crew Left Scene	00:28 - 08/06/2016		
Receiving Hospital	QUEEN ELIZABETH UNIVERSITY HOSPITAL		

DIAGNOSIS

Chief Complaint Code	04
Despatch Code	04B01A : Assault with Possibly Dangerous Area Injuries
Diagnostic Code	04A01A : 04A01A - Assault with Not Dangerous Proximal Injuries

PATIENT DETAILS

Surname	HUGHES		
Forename	LISA		
Middle Initials		Sex	Female
DoB	17/01/1980	Age	36 years 4 months 22 days
Patient Address	AS LOCUS	Patient Postcode	
Patient Telephone		Ethnicity	

PATIENT CONSENT

Mental Capacity Assessed	Deemed To Have Capacity
Level of Consent	Data Sharing With GP Denied By Patient, Lack Of Patient Consent, Risk Of Refusal Explained, Treatment Benefits Explained

PRIMARY SURVEY

AVPU Assessment	Voice
Catastrophic Haemorrhage	No
Airway Assessment	Clear
Breathing Rate	Normal
Respiratory Rate	16
Pulse	Normal
Most Peripheral Palpable Pulse Found	Radial
Skin Colour	Normal
Skin Texture	Dry
CSI Assessment	No Evidence Of C-Spine Injury

VITAL SIGNS

Time	Pulse	Rthm	AVPU	RR	SYS	DIA	PEF	BG	Temp	SpO2	PS	CRT	ECG	Sepsis	GCS	RTS	NEWS	ETCO2	Lactate
00:00	95	Reg	Voice	17	134	80		6.8	37.3			< 2 Secs	Normal sinus rhythm	2	4	5.0	4		
00:20	97	Reg	Voice	16	130	78			37.3					1	14	7.8	4		

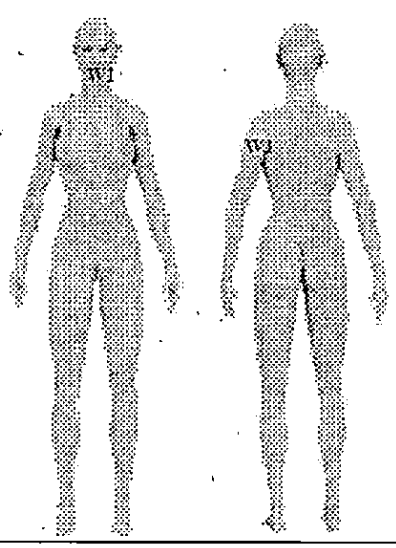
AMPLE

Allergy Type	None
Previous Medication	MEDS WITH PT
Previous Medical History	BIPOLAR, SPLIT PERSONALITY DISORDER.
Last Eaten Before Incident	4 Hours
Events Prior To Incident	ASSAULTED AT 22:00.

INJURIES



WOUND	W1	Abrasion, Laceration Treatment



RESPIRATORY SYSTEM

Respiratory Assessment	Normal

Bilateral air entry, Bilateral Movement, Trachea central

Respiratory Sites

PATIENT HANDOVER

Patient Mobility On Arrival	Seated	On Scene Removal	Chair
Patient Transportation	Lying	Care Delivery At Hospital	Trolley
Time Of Patient Handover	00:45		

SEPSIS

Pulse	*RR*	*SYS*	*Temp*	*GCS*	*BG*	*Pneumonia*	*UTI*	*Other infection*	*Abdo Pain*	*Diarrhoea*	*Abdo distension*	*Meningitis*	*Cellulitis*	*Septic arthritis*	*Wound infection*	*Infected indwelling device*	*No signs of infection*
95	17	134	37.3	4	6.8	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO .	NO
97	16	130	37.3	14		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

GCS

Time	*Eye Opening*	*Verbal Response*	*Motor Response*	*Total*
00:00	Spontaneous			4
00:20	To Voice	Orientated	Obeys Commands	14

SOCIAL ASSESSMENT

Patient Age	
Situation	
Risk Assessment	
Action Taken	Patient Conveyed To Hospital, Police Contacted
Additional Details Of Risk Or Concern	PREVIOUSLY ADMITTED TO LEVERNDALE

ADDITIONAL COMMENTS AND OBSERVATIONS

999CALL. PRU ON SCENE.PC ASSAULT. CUT TO LIP. GCS14. HAD 2.5 BOTTLES OF BUCKFAST. OE ALL OBS UNREMARKABLE. NO TX. POLICE TRABELED WITH PT.

REPORT MANAGEMENT

Report ID	CR002987682-08062016003602		
Software Version	1.0.413	Report Type	Interim

(2)

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

CHI: 1701806541

Queen Elizabeth University Hospital

Total Att: 7

12 Mth Att: 2

Title: **MISS**

HUGHES

Lisa Rosemary

DOB: **17/01/1980**

Age: **35y**

Sex: **Female**

8 Carham Crescent

Glasgow
Lanarkshire
G52 2HN
0141 883 2693

Next of kin: **HAUGHEY, AGNES**
Relationship: **Mother**
07769815357

GP: **AA Finney**
0141 892 2548

Attendance Date: **30/11/2015**

Arrival Time: **01:44**

Registration Time: **01:44**

Date of Incident: **30/11/2015**

Major Incident Desc:

Reason for Attendance: **assault, lieft shoulder pain, head inj, chest pain**

Nursing Assessment

Alerts: **Not Recorded**

Allergies: **None Known**

Pain Score:

Triage Category: **4**

Tetanus up to date/fully immunised:

Presenting Complaint: **Head Injury**

Observation Date: **30/11/2015 01:50**

Nurse name: **Nurse Kimberley McLean**

Temp	36.2	C
HR	97	bpm
BP	170	mmHg
MAP		mmHg
RR	15	bpm
SpO2	97	%
Oxygen	21	%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

Pupils-Right		Pupils-Left	
Size (mm)	4	Size (mm)	4
Reaction	+	Reaction	+

Nursing Notes: **in with police - alleged domestic assault - c/o pain to face head feet and left shoulder**

INTOXICATED

97607

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

1701806541 17/01/1980
HUGHES
Lisa Rosemary

Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date

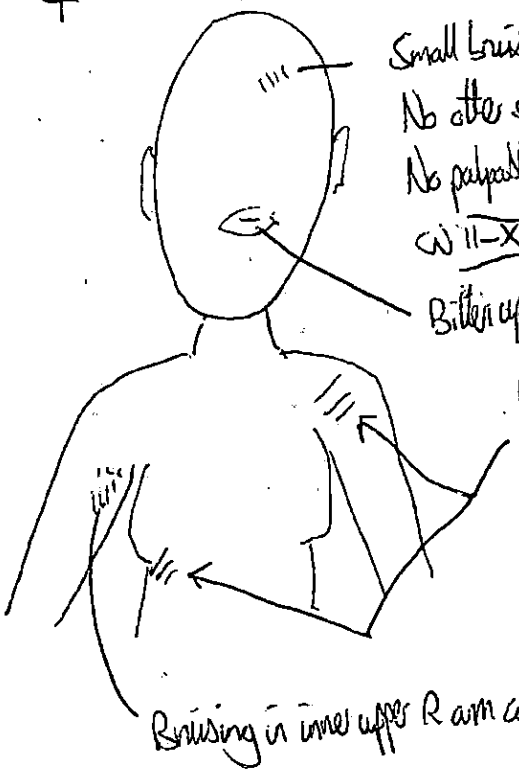
1701806541 17/01/1980
HUGHES
Lisa Rosemary

Seen by (Dr) GALLAGHER

Time seen 0150

35 ♀ alleged assault

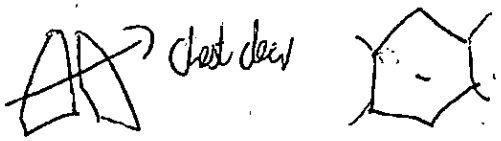
P 97
BP 114/70
RR 15
Sp_2 97%
T 36·2



Small bruise + small haematoma L forehead
No other signs of head / C-spine injury
No palpable #, no Battles / Panda bruising, no haemotympanum
CN II–XII intact, no vertebral tenderness
Bitten upper lip; dried blood
Pain in L shoulder and R ribcage with no bruising & no evidence of #

Bruising in inner upper R arm could be consistent with grabbing; fingerprint sized

Appears intoxicated, smiling & mood light / jovial



Chest clear

Story — Patient in Police Custody. Mum here. States she had ½ bottle of wine & prescribed meds today inc. diazepam, olanzapine, SSRI, felt well; went to bed. States male partner came to room & physically assaulted her — pushing her around, pulling her hair, grabbing her, slapping & punching her. No LoC.

Plan — Checked over as above.
Reassured no concerning findings req. Rx or hospitalisation
Discharged to Police custody with watering + hi. advice

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Intern now Room

Affix Label

CHI: 1701806541

Queen Elizabeth University Hospital

Total Att: **5**

12 Mth Att: **0**

Title: **MS**

HUGHES **Lisa Rosemary**

DOB: **17/01/1980** Age: **35y** Sex: **Female**

8 Carham Crescent
Glasgow
Lanarkshire
G52 2HN
0141 883 1442

Next of kin: **HAUGHEY, AGNES**
Relationship: **Mother**
07769815357

GP: **AA Finney**
0141 892 2548

Attendance Date: **02/10/2015** Arrival Time: **23:18**

Registration Time: **23:18** Date of Incident: **02/10/2015**

Major Incident Desc:

Reason for Attendance: **bibp - mental health (in police room)**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **03/10/2015 00:03** Nurse name: **Nurse Stuart Smith**

Temp	**36.2**	C
HR	**108**	bpm
BP	**123/79**	mmHg
MAP	**93.67**	mmHg
RR	**19**	bpm
SpO2	**100**	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils Right		Pupils Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **shouting and breaking furniture in house...has been drunking**

Cre

naire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

16/02/98 SPEARMINT IRVINE

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES
3-10-15.	Seen by (Dr) STARK. Time seen 01.40.

350 ♀. BIBP - MENTAL HEALTH ISSUES.

ARGUMENT WITH PARTNER AFTER ALCOHOL INTOXICATION
THROWING FURNITURE ABOUT.
FEELS SILLY NOW, REGRETFUL OF ACTIONS.
VOLATILE RELATIONSHIP WITH PARTNER, SEPARATED, HE IS FATHER OF THEIR 3 KIDS.

NO ACTIVE MENTAL HEALTH ISSUES.
NO OVERDOSE / SUBSTANCE MISUSE.
NOT SUICIDAL

NO CLINICAL WORK.

1701806541 17/01/1980
HUGHES
Lisa Rosemary

P STARK
CAT 1

PLAN: D/C INTO POLICE CUSTODY.
CHILD PROTECTION FORM

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	03-10-15
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		Discharge time	01.54
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.		

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged		Not arranged				To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

AE13 23 8C

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

Hospital (circle) | IRH | RAH | RHSC | GRI | WIG | VI | VIMIU | Stob | VOL | SGH

Tit

SU

CH

Loc

Pc:

Tel

Att

Reg

Res

Queen Elizabeth University Hospital

CHI: 1701806541

Total Att: 6

12 Mth Att: 1

Title: **MISS**

HUGHES **Lisa Rosemary**

DOB: **17/01/1980** Age: **35y** Sex: **Female**

8 Carham Crescent

Next of kin: **HAUGHEY, AGNES**
Relationship: **Mother**
07769815357

Glasgow
Lanarkshire
G52 2HN
0141 883 2693

GP: **AA Finney**
0141 892 2548

Attendance Date: **11/10/2015** Arrival Time: **14:07**

Registration Time: **14:07** Date of Incident: **11/10/2015**

Major Incident Desc:

Reason for Attendance: **BIBA...OVERDOSE**

Affix Label

Nursing Assessment

Alerts: **Not Recorded**

Allergies: **None Known** Pain Score:

Tetanus up to date/fully immunised:

Triage Category: **3**

Presenting Complaint: **Psychiatry DSH - Overdose**

Observation Date: **11/10/2015 14:46**

Temp	36	C
HR	67	bpm
BP	110/67	mmHg
MAP	81.33	mmHg
RR	16	bpm
SpO2	100	%
Oxygen		%

Nurse name: **Nurse Julie Anthoney**

BM	5.3	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	3
Motor	6
Verbal	5
Total	14

Pupils-Right		Pupils-Left	
Size (mm)	4	Size (mm)	4
Reaction	Y	Reaction	Y

Nursing Notes: **999 alcohol/mixed od- taken last night-diazepam propranolol levothyroxine olanzapine =empty packets found**

Mental Health Team

97607

Child Ass... Questionnaire

	YES	NO
Previo... (consider any relevant trauma from previous presentations)		
Histor... ...ie between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES
	Seen by (Dr) Time seen

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

Hospital (*circle*)	IRH	RAH	RHSC	GRI	WIG	VI	VIMIU	Stob	VOL	SGH

Title:	Sex: M ☐ F ☐
SURNAME:	Forename:
CHI:	Dob:: / Age:
Local add 1701806541 F HUGHES 17/01/1980 Lisa, R 8 Carham Crescent Glasgow, Lanarkshire G52 2HN	Next of kin: Relationship: Tel: GP:
Postcode:	
Tel:	Tel:

Attendance date:	Arrival time:	Date of Incident:
Registration time:	Major incident description:	
Reason for attendance:		

Affix Label

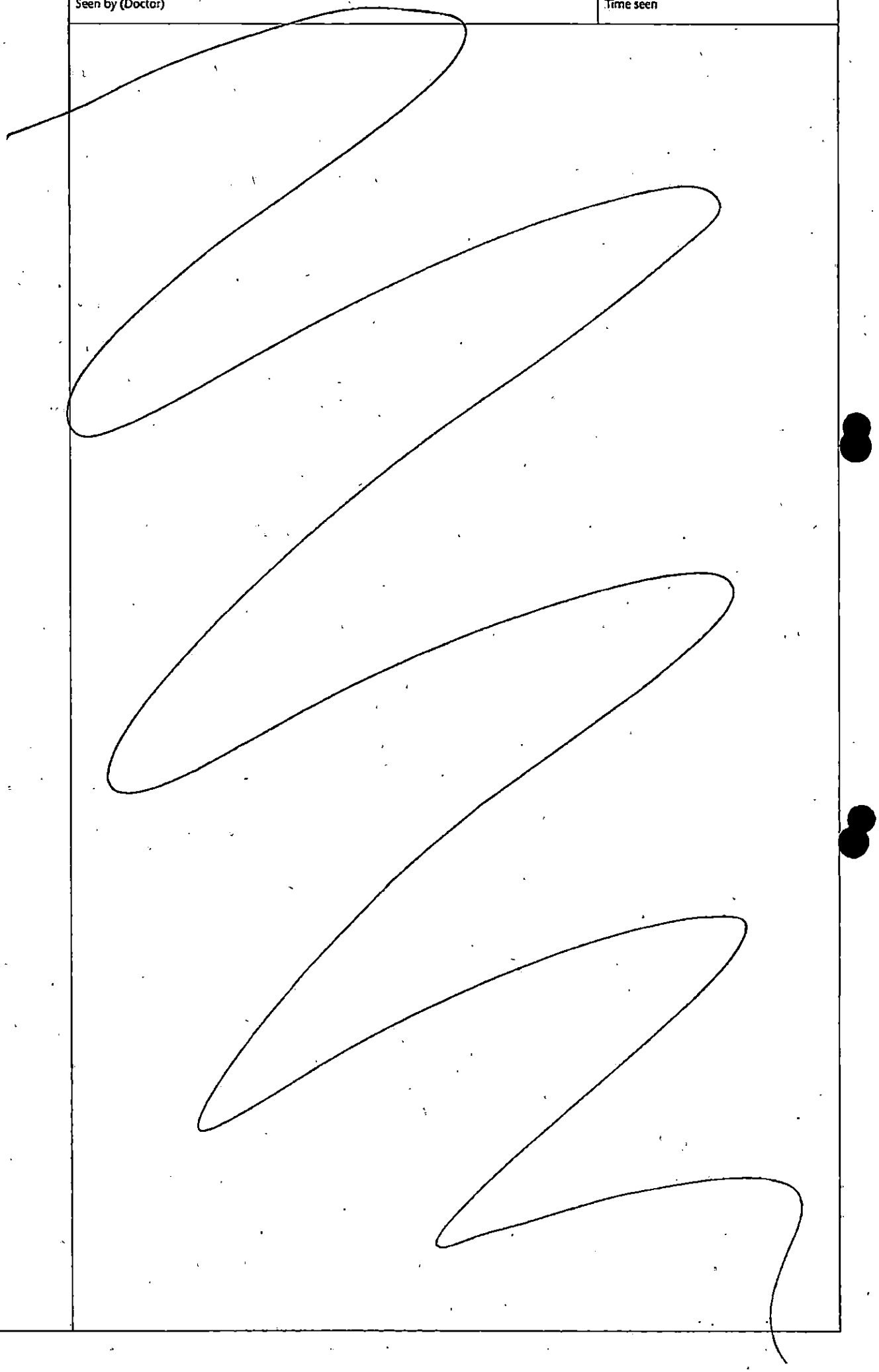
Nursing Assessment	Alerts:
Presenting complaint:	

Triage category:	Pain score:	Tetanus up-to-date / fully immunised?
Allergies:		

Observations date:			Time:			Nurse's name:	
Temperature		°C	BM		mmol/L	GCS	
HR		bpm	PF		l/min	Eyes	
BP		mmHg	Expected PF		l/min	Motor	
MAP		mmHg	Weight		kg	Verbal	
RR		bpm	Height		cm	Total	
SpO_2		%	Visual Acuity			Pupils – Right	Pupils – Left
Oxygen		%	Left	6/		Size	Size
			Right	6/		Reaction	Reaction
			With correction?				

Nursing Notes:

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen



Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Differential Diagnosis/Problem List

SEWS ☐ 0-7

RED FLAG ☐ (Tick)

SIRS ☐

CURB 65 ☐

Done/ completed	Imediate Managment Plan

Signature: Designation: Page No:

Acute Medical or Surgical Admission Unit Notes

Please affix patient ID label here

Initial Assessment

Seen by (print): KEARNS

Time seen: 20:25

Presenting Complaint

35 ♀ Deliberate mixed overdose.

History of Presenting Complaint

Unclear quantity/which tablets. Unclear timing.
Little useful history from pt.
Family report OD of prescribed meds + Etoh last night.

Undetectable paracetamol + salicylate.
(N) Coag (N) LFTs (N) ECG.

8 children at home - apparently in the care of pt.'s partner. unclear what ages.

Past Medical History

Moderate depressive episode.

Systemic Enquiry

CVS

RESP no Hx

GI no complaints

CNS/PNS

GU

Musculoskeletal

MEDICINES RECONCILIATION (ECS can be stapled here and annotated with plan for medicines. Please sign medicines plan.)

Source of medication history: Patient ☑ Relative/ carer ☐ GP Surgery ☑ ECS ☑
PODs ☐ Com. Pharmacist ☐ GP letter ☐ Rpt Presc ☐

Admissions medicines				Plan for medicines			
Name	Dose	Frequency	Continue	Stop	Amend	Hold	Comments/ reason
OLANZAPINE	10mg	NOCTE					
CITALOPRAM	20mg	OD					
DIAZEPAM	5mg	TID					
SALBUTAMOL	1-2 PUFFS	PRN.					
LEVOTHYROXINE	100 microgm	OD					
PROPRANOLOL	[illegible]	[illegible]					
	10-20mg	BD (PRN)					

Allergies: None known ☑

Medication needs

Further clarification? Yes ☐ No ☐

Completed by: [signature] Designation: Preregistration Pharmacist Date: 12/10/15

Drugs prescribed on admission checked and correct

Compliance aid? Yes ☐ No ☐

Comments:

Community Pharmacist: Lloyds Pharmacy, Paisley Rd West

Reviewed by: Designation: Date:

1701806541
HUGHES F
Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

Social History

Smoking History:

Alcohol History:

Other drug use?: .

Home circumstances

Apparently lives with 8 children!

General Examination

Temp: 36°	RR: 12
Pulse 70	BG:
SpO2: 98% @	Weight:
BP: 122/65	Urinalysis:

Cardiovascular Examination

HS I+II+0 regular pulse. warm peripheries

General Observations

Drowsy
Maintaining
Airway.

Respiratory Examination

Clear A/E

Abdominal Examination

SNT
°Organomegaly

Neurological and Other Examination (e.g. locomotor)

Cranial Nerves

GCS: 14 E: 3 M 6 V: 5 TOTAL

AMT 4/4 but ↓ drowsy

Fundoscopy:

Upper limb neurological examination

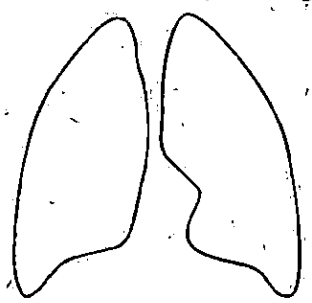
Lower limb neurological examination

Other

Key Results:

CXR:

Not done.



Urinalysis:

ECG:

NSR

Differential Diagnosis/Problem List

1. Deliberate OD
2. Potentially vulnerable children

SEWS ☐ 0-7

RED FLAG ☐ (Tick)

SIRS ☐

CURB 65 ☐

Immediate Managment Plan	Done/ Ordered	Checklist
Social work informed of at risk kids		Medicines plan documented ☐
Monitor (telemetry tonight)		Blood results received ☐
Repeat U/Es, FBC, LFTs, Bic, Mg now		Kardex ☐
+ Review when less drowsy		Antimicrobials as per Policy Yes ☐ No ☐
W'hold regular meds		If 'No' state reason:
		DVT prophylaxis indicated Yes ☐ No ☐
		DVT prophylaxis prescribed Yes ☐ N/A ☐

Doctor Completing Initial Assessment

Name (print): Signature: Designation:

Page No.

Please affix patient ID label here

Secondary or Senior Focused Review

Seen by (print): Suzuki

Time seen: 0830

12/5/15 ARH (2)

Noted Hx of OTD. - Scrotum → SW referred

NT yet fully conscious

Obs on arr BP / Sat² / pulse (x)

ECG done (N)

Discontinued of alcohol.

→ Review in pm: when responsive more awake.

(D)

Done/ completed	Continuing Managment Plan

Doctor Completing Initial Assessment

Signature: Designation: Page No.:

Senior Doctor Review Seen by (print): Time seen:	Please affix patient ID label here

DVT Prophylaxis Indicated	Yes ☐	No ☐	Antimicrobials choice compliant Yes ☐ No ☐
DVT Prphylaxis prescribed	Yes ☐	N/A ☐	If 'No' state reason
Medicines Reconciliation completed	Yes ☐	No ☐	

Done/ completed	Continuing Managment Plan

Signature:	Designation:	Page No:

Please affix patient ID label here

Continuation Sheet

Date: Time 12/10/15.

Liaison Psychiatry.
Patient assessed today on ward.
Intentional mixed overdose taken at home. No other drugs were in house at time.
Husband Social Work have been informed.
Ongoing relationship difficulties appear to be primary stressor, & ~~Partner~~ partner is currently facing charge of assault to cause harm to her father by headbutting 2 nurses at home last week.
She declines to discuss relationship with him as psychologically abusive.
Known to Mental Health Services.
Diagnosis of Emotionally Unstable Personality Disorder.
Does not report to acute.
Wishes she would have died.
Feels she would do same again if discharged home.
I will discuss case with her CPN and return to review further once medically stable.

Michael McCann
Liam Byrne

12/10/15
12:25 pm

pharmacy

NB Regular meds confirmed with patient, ECS and GP surgery and are as follows:-

- Olanzapine 10mg nocte
- Citalopram 20mg OD
- Diazepam 5mg TID
- Salbutamol 100micrograms/act inhaler (Ventolin) → 1-2puffs PRN.
- Levothyroxine 200micrograms OD
- Propranolol 10-20mg BD (PRN for anxiety).

Nothing on Kardex at present due to recent mixed overdose.
Thanks, Jenifer Wah Reg. Pharmacist

Ward #5376

10

Continuation Sheet

Date: Time

12/10/15.

Discuss / Review

From medical point of view
2 days + then there is only [illegible] to keep her. She had [illegible]
Please do ✓ what are their
intentions - perhaps she would be
ok to ✓ in any case!

13/10/15
0940

Acute Addiction Liaison (24 2825)
Patient declined assessment.
Advises she does not take illicit drugs, rarely drinks alcohol.
No observed alcohol or drug withdrawals.
Not known to Addiction Services
Patient has 8 children who are apparently with partner and apparently Social Workers have been informed. No clear evidence in notes of Child Protection; Safeguarding Plan Agreed; No management issues.
(1) Key Nurse Cara Donnelly agreed to contact the Social Work Department to ensure they are aware of admission and that the Children are safe with partner.
Referral otherwise noted.
Pam CHANCITY
Senior Addict - NMC

13/10/15
11.20

Ward Round — Dr Haq

Mixed OD
Paracetamol + Salicylate level (N)
Denies alcohol excess
Seen by Liaison Psych → Doesn't regret her action. Would do same if discharged home

11

Please affix patient ID label here

Continuation Sheet

Date: Time	
	(P) Medically stable A/w if liaison services
13/10/15	Liaison Psychiatry: Patient reviewed today Slight improvement in mental state. However continues to feel overwhelmed by current stressors. Does not feel she will cope if discharged home. Risk of further self-harm Patient feels is adept at putting on brave face even when struggling. Has taken significant overdose on background of social stressors. Probably warrants crisis Psychiatric respite admission due to this. I have contacted Psychiatric bed manager and left message on answering machine. Will update ward as soon as bed is identified. Discussed disposal arrangements with staff on ward. Many Thanks Michael McCann ANP Liaison Psychiatry

Continuation Sheet

Date: Time

PLEASE DO NOT WRITE HERE

Attach GP Letter, Results or Emergency Care Summary

Serial Blood Results								
	Date:	11/10						
	Time:	15:50						
	Signature:	HW						
Sodium	135 - 146	143						
Potassium	3.5 - 5.3							
Chloride	95 - 108	110						
Urea	2.6 - 7.8	2.5						
Creatinine	40 - 130	70						
Estimated GFR								
Bicarbonate	22 - 29							
Glucose	3.5 - 6.0	4.2						
CRP	0 - 10	4						
Magnesium	0.7 - 1.0							
Calcium	2.2 - 2.6							
Calcium Adj	2.2 - 2.6							
Phosphate	0.8 - 1.5							
Cardiac Enzymes & Liver Function Tests	Normal Values							
Troponin	<0.04							
CK	<150							
Amylase	0 - 100							
ALT	0 - 50	13						
~~Gamma GT~~	0 - 70							
Alk Phos	30 - 130	46						
Total Bilirubin	0 - 20	7						
Albumin	35 - 50	36						
Haematology & Clotting Screen	Normal Values							
White Blood Count	4.0 - 11.0	8.4						
Haemoglobin	115 - 165	130						
Haematocrit	0.370 - 0.470							
MCV	80 - 100							
Platelet Count	150 - 410	293						
Neutrophils	1.8 - 7.7	4.9						
Lymphocytes	1 - 4.8	2.4						
Prothrombin Time	9 - 13	13						
PCT Ratio		1.1						
APTT	27 - 38	30						
APTT ratio	0.8 - 1.2	1.0						
Thrombin Time	10 - 16	15						
TCT Ratio		1.0						
Arterial Blood Gas	Normal Values							
H+	36 - 43							
PCO_2	4.5 - 6							
PO_2	10.5 - 13.5							
Base excess	+/- 2.5							
Bicarbonate	20 - 28							
FiO_2 (Inspired Oxygen)								
Other								

Emergency Department Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

Date Given	Drug (Block Capitals)	Dose	Method of administration	Time of administration	Signature	Given by

Discharge prescription packs

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by

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

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

Outpatient clinic specialty						Admission or specialty clinic consultant		
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

Ward 4B 211 6511

Tel 883 2693.

Patient Name:	HUGHES F
CHI Number:	1701806541
Date of Birth:	Lisa, R 17/01/1980
Address:	8 Carham Crescent Glasgow. Lanarkshire Cowlairs G52 2HN

NHS Greater Glasgow and Clyde

GLASGOW LIAISON PSYCHIATRY SERVICE
ASSESSMENT

PIMS No.	

DATE	TIME	NAME & GRADE OF ASSESSOR	LOCATION OF ASSESSMENT
11/10/15	1030	[illegible]	ARU3 acute

GP DETAILS	NEXT OF KIN
Dr. AA Finney Drs Semple finney and datta Cardonald Medical Centre 1831 Paisley Road West Glasgow G52 3SS 892 2548	Agnes Haughey mother 07769815357

REFERRING CONSULTANT

ADVANCE STATEMENT YES / NO	NAMED PERSON YES / NO
If Yes, is a copy available - If not available then comment on patients verbal report of contents of the advance statement	If Yes, and different from N.O.K., please give details below
✓	✓

LEGAL STATUS	ETHNICITY
INFORMAL ☑ EDC ☐ STDC ☐ CTO RECALL ☐ OTHER ☐	Refused/Not provided by patient ☐ White Scottish.

SOURCE & REASON FOR REFERRAL

Self-Harm ☑ Liaison ☐ A&E ☐

DATE/TIME OF ADMISSION /HOW ATTENDED HOSPITAL

11.10.15 14.07

DATE/TIME OF SELF-HARM

999 BIBA mixed overdose + alcohol 2 Slits x Paracetamol Lorazepam Diazepam Empty packets

PAST PSYCHIATRIC HISTORY (including previous self-harm/GP treatment/admissions/detentions etc.)

Open to Bradshaw Court

TBI smith CPN missed 2 appts.

Continued under Additional Information ☐

PAST MEDICAL HISTORY (including previous head injuries/seizures/delirium tremens/ falls in last 12 months/thyroid/cardiac etc.)

Asthma..

Continued under Additional Information ☐

CURRENT MEDICATION (including compliance/side effects/drug allergies etc.)

Olanzapine 10mg nocte (sporadic)

Compliance variable

Citalopram 20mg od

Diazepam 5mg tds (take prn)

Salbutamol 1-2 puffs prn

Levothyroxine 200mg micrograms

Continued under Additional Information ☐

DRUG, ALCOHOL AND SMOKING HISTORY (including features of dependence and previous misuse)

Alcohol — last friday

1) NKS → no other value
no medications
no cannabis.

Continued under Additional Information ☐

FORENSIC HISTORY (including violence, contact with criminal justice system)

~~[illegible]~~

Accused attempting to assault partner last week.

no previous charges.

awaiting Court appearance

Continued under Additional Information ☐

PERSONAL HISTORY AND SOCIAL CIRCUMSTANCES (including birth/ development/ upbringing/ schooling/ abuse/ employment/ relationships/ children/ family history /supports/ dependents/ housing/ finances etc)

Neil

Been in Barnardos

Ex partner — Controlling. occasional physical abuse

8 children.

1 5 year old daughter was raped 2013

Family History — not known

Previous hx.

Mother has contact with partner

DETAILS OF SELF-HARM

35 year old woman

Mixed OD.

Unclear quantity [when asleep]

Unclear timing.

Undetectable paracetamol level

Sat in daughters room ~~x~~ responses to voice

Rachel daughter found her.

Continued under Additional Information ☐

PRESENTING COMPLAINT & HISTORY OF PRESENTING COMPLAINT (Including precipitants, courses, duration, somatic symptoms, etc)

Social work

Rachel 2013.

Suicide attempt

Suicide attempt

Suicide attempt

ADDITIONAL INFORMATION

8 children — apparently in care of relatives nearby.

Social worker Alex Mackelden from Swindon

No family support

Mum works full time — occasional support

Dad — absent

Shaking — 18 years on/off.

Ex partner — lies, threatening

Broke up June 2014

Court appearance — pending

Finding it hard to cope.

MENTAL STATE EXAMINATION (INCLUDES APPEARANCE & BEHAVIOUR, SPEECH, MOOD & AFFECT, THOUGHT FORM, THOUGHT CONTENT, ABNORMAL PERCEPTIONS, COGNITION, INSIGHT, SLEEP PATTERN, APPETITE, ETC:)

Sleep – not good
recently

appetite – eating less
poor diet in last 3 weeks

mood – no good

mood scale 07

Suicidal thoughts – always here

feels worried
stressed

MMSE completed ☐

HUGHES, LISA ID: 1701806551 11-Oct-2015 14:[redacted] SOUTH GLASGOW UNIVERSITY HOSPITAL

17-Jan-1980
Female Caucasian

Vent. rate [redacted] bpm
PR interval 150 ms
QRS duration 96 ms
QT/QTc 432/445 ms
P-R-T axes 77 47 41

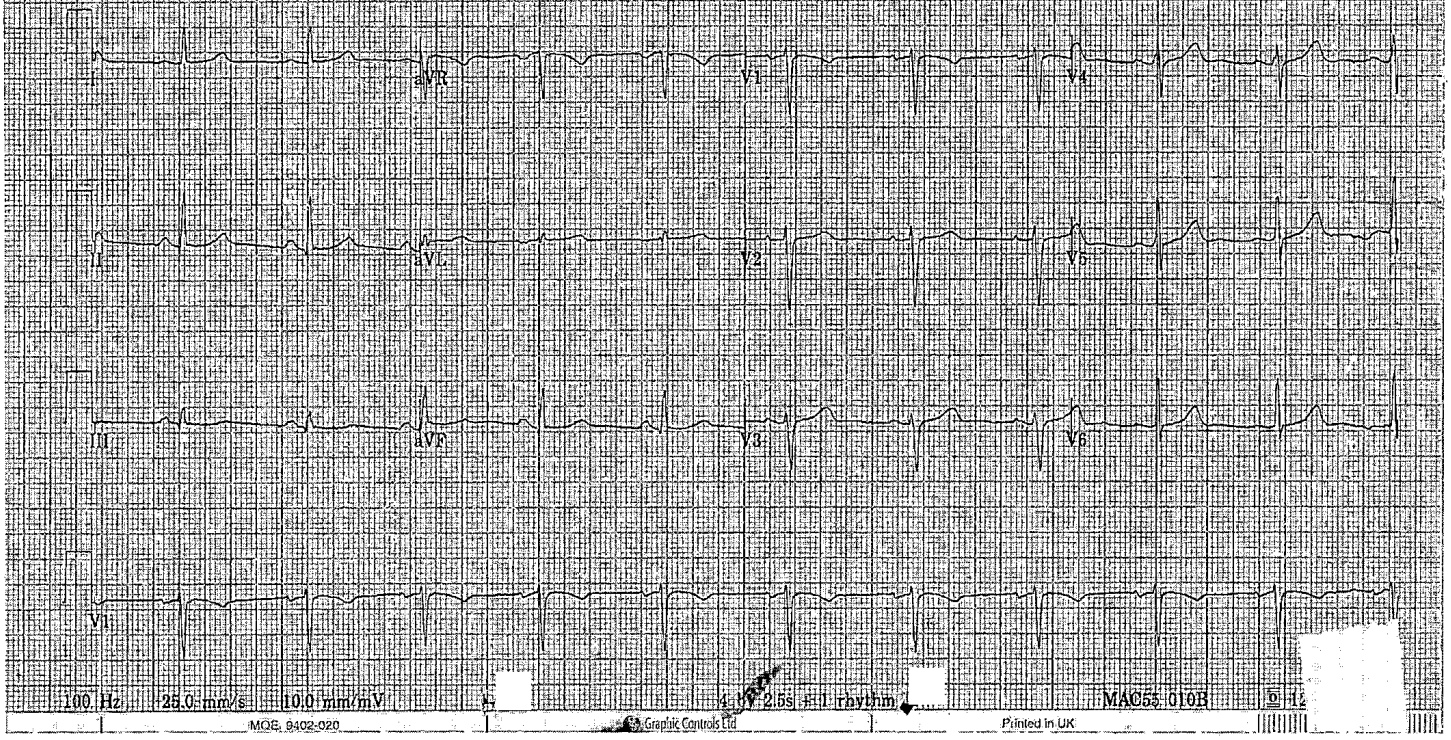
Normal sinus rhythm
Normal ECG

Technician:
Test ind:

Referred by:

Unconfirmed

COMMENTS:



100 Hz 25.0 mm/s 10.0 mm/mV [redacted] 4 x 2.5s + 1 rhythm [redacted] MAC55 010B

MQE 9402-020 Graphic Controls Ltd Printed in UK

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

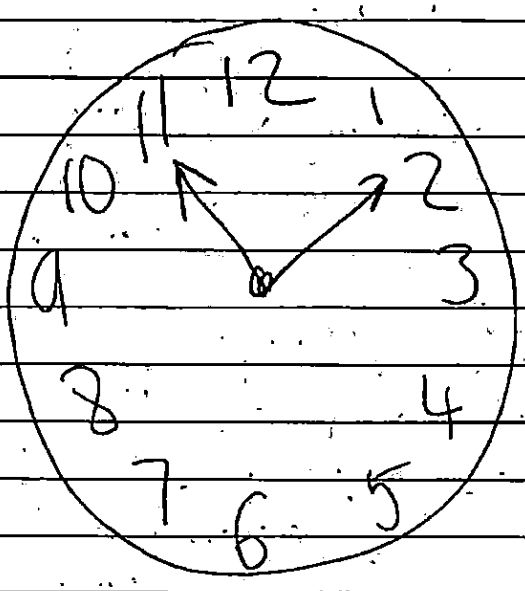
Please tick ✔ appropriate directorate

1701806541
HUGHES
Lisa, R
2 LANGSTILE ROAD
Glasgow, Lanarkshire
F
17/01/1980
G52 4AG

Date & Time		Signature, Print Name & Designation
	29/7/25	

Not Belong. – Myself.

Date & Time		Signature, Print Name & Designation
	O/E	Memory Power –
	(SEM)	Warmth –
		Thanks Tutors.
	→	→
	Orientation. for	Style –
	Time. Place.	→ Attitude. acc. –
	Person.	Smiling. Vapour.
		Days. →
	→ Regards ✓	Attitude



NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☐

Please tick ✔ appropriate directorate



Date & Time		Signature, Print Name & Designation
	29/7/2C-	
	— HA — Persistent	
	- Vision - Eyes - - Change in Vision.	
	- Vertigo ... - New Persistent ...	
	-> ly- 1/... - Never Before.	
	odd ... -	
	-> Visa? - 4 Flights. ? - - -	
	Name / Cousin / - - - ->	
	Ring Bell .. / - Line in Vision -> A/E.	
	- Ix.. CT Scan. / - / -> Nurse.	
	- ? ~~Tumour~~ 2006 -> - ->	
	Told. Slow. Growing Tumour 2006	
	Headed Response. ...	

83949 GGC0072

Date & Time		Signature, Print Name & Designation
	Informed by Nurse.	
	HO - Emergency	
	(P) Sick - only - Health	
	Facility - Storing	
	OM. | Painting	
	Vision - Blurring	Namrata
	(P) "on Working -	Weight
	Magnet - Hobby	
	Nil Allergies | Pregnant Nil.	
	Tight Band: Blood Band	
	Baby fine Boy Girl.	Shiv Ganga
	Tumour in Head	
	Neck to Hip - down	
	Surgical Worker	
	| Max Mistakes.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

1701806541
HUGHES F
Lisa, R 17/01/1980
2 LANGSTILE ROAD
Glasgow, Lanarkshire
G52 4AG

Date & Time		Signature, Print Name & Designation
	6/18 PR → 6/9 CF → 6/56	
	Dyspnoea with — Bronchitis.	
	— (B) Plates equivalent	
	— I/A.	

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Acute Services Division

Surgery and Anaesthetics Directorate

Department: Pre Op Assessment Unit

Specialty: General Surgery

NHS Greater Glasgow and Clyde

Hospital Name	Southern General

Patient Details		GP Details	
Name	HUGHES, LISA	Name	SEMPLE, LINSEY
Address	8 Carham Crescent GLASGOW G52 2HN	Address	CARDONALD MEDICAL CENTRE 1831 PAISLEY ROAD WEST GLASGOW G52 3SS
Correspondance Address	,	Telephone	
Correspondance Postcode		CRN Number	64057442B, SG00953485, Z00286838
Telephone	07766451921	Consent	Yes
Patient Contact Number	01412390191	Sensitivity	Sensitive
CHI Number	1701806541	Consultant Name	KHAUND
Sex	Female	Requires Transport	No
Date of Birth	17/01/1980	Religion	

Next of Kin / Person to Notify	Next of Kin	Person to Notify
Name	AGNES HUGHES	
Address	46 HOLLYBUSH ROAD, PENNILEE	
Landline	TBC	
Mobile		
Relationship	MOTHER.	

Assessment Details					
Assessor	VICKI CUNNINGHAM	Grade	5	Date	24/03/2011
Ward	VACH DSU.				

Surgery / Procedure Attending For
DIAGNOSTIC LAPAROSCOPY AND STERILISATION

Short Notice Availability	
Are you available at short notice?	Yes
Details	24-48 HRS NOTICE.

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Anaesthetic History

1. Previous GA

Have you had a General Anaesthetic before?	Yes
Were there any problems?	Yes

Anaphylaxis	No	Suxamethonium Sensitivity	No	Difficult Intubation	No
PONV	Yes	Malignant Hyperthermia Suspected	No	Other	No

2. Previous LA

Have you had a Local Anaesthetic before?	Yes
Were there any problems?	No

3. Dentition Risk

Do you have any loose teeth, caps or dentures?	Yes
Details	1 FRONT UPPER VENEER

4. Reduced neck movement

Do you have any neck or jaw stiffness?	No

5. Other Risk

Has anybody in your family had a serious reaction to an anaesthetic?	No

6. Heartburn

Do you suffer from heartburn or indigestion?	No

7. Sickle Cell Disease (risk factor)

Do you have sickle cell disease?	No
Are there risk factors for sickle cell disease?	No

Surgical History

8. Affects suitability for DSU or SDA

Have you ever had surgery?	Yes
Details of relevant surgical history	THYROIDECTOMY 2009 (MULTINODAL GOITRE.)
Will this affect the suitability for DSU?	No

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Have you ever had a serious surgical or anaesthetic complication?	No

Cardiovascular

9. Hypertension

Do you have high blood pressure?	No

10. Arrhythmias

Symptoms:	Irregular heartbeat	No	Palpitations	No	Atrial Fibrillation	No
How often does it occur?						
Are they assosciated with exercise?						
Does it cause you to faint?						

11. Angina

Do you suffer from Angina?	No

12. Heart Attack

Have you had a heart attack?	No

13. Heart Murmur

Do you have a heart murmur?	No

14. Blackouts

Do you suffer from blackouts?	No

15. Heart Failure

Have you been diagnosed with heart failure?	No

Respiratory

16. Asthma / Bronchitis / COPD / Emphysema

Do you have asthma, bronchitis, COPD, or emphysema?	No

17. URTI (Upper Respiratory Tract Infection)

Have you recently had a cold?	No

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Neurological	
18. Stroke	
Have you had a stroke or TIA?	No
19. Epilepsy	
Do you have epilepsy?	No
20. Neurological Disease	
Do you have any neurological or muscular disease?	No
21. Physical Disability	
Do you have a physical disability?	No
Haemotological	
22. Bleeding Disorder	
Do you suffer from prolonged bleeding or excessive bruising?	No
23. Previous DVT	
Have you had a DVT?	No
24. Anaemia	
Do you suffer from anaemia?	No
Miscellaneous	
25. Kidney Disease	
Do you have renal failure?	No
26. Liver Disease	
Do you have liver disease or suffer from jaundice?	No
27. Diabetes	
Do you have diabetes?	No
28. Arthritis	
Do you have arthritis?	No

CHI Number: 1701806541 Patient Name: HUGHES, LISA

29. CJD	
Has the patient ever been notified that they are at increased risk of CJD or vCJD for public health purposes?	No

30. Other	
Do you have any serious physical / psychiatric illness or learning difficult not already mentioned?	Yes
30a. Details	POST-NATAL DEPRESSION AND ANXIETY DISORDER.
30b. Do you require a carer?	No

Exercise Tolerance	
31. What best describes your level of fitness?	Climbs stairs without stopping

Social History		
32. How many units of alcohol each week?	0.00	units/week

33. Smoker	
Do you smoke?	Yes
How many each day?	23.00

34. Drug Abuse	
Do you currently or have you ever used intravenous or recreational drugs?	No

35. Pregnant	
LMP	
Are you pregnant?	No
Could you be pregnant?	No
Details	

36. Language	
Can the patient speak English?	Yes

Drug History
37. Drugs
List all drugs (including herbal remedies and complimentary medicines)

CHI Number: 1701806541 Patient Name: HUGHES, LISA

LEVOTHYROXINE 200MCG OLANZAPINE 10MG NOCTE DIAZEPAM 5MG TDS CITALOPRAM 10MG OD DEPO-PROVERA 3/12

Does the patient take any of the following?	
Anticoagulants	No
Clopidogrel	No
Aspirin	No
OCP	No
Digoxin	No
Amiodarone	No
Lithium	No
Diuretics	No
MAOIs	No

38. Herbal Remedies	
Are you taking any herbal remedies or complimentary medicine?	No

39. Steroids	
Have you taken regular oral steroids in the last year?	No

40. Allergies

Implants	
41. Pacemaker	
Do you have a pacemaker?	No

42. Prosthesis	
Do you have any implants?	No

43. Coronary stents	
Have you had coronary artery stents inserted?	No

Examination			
44. Age (years)	31		

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Weight (kg)	63.1		
Height (m)	1.66	BMI	23

45. Risk of sleep apnoea

Do you suffer from daytime sleepiness, restless sleep or witnessed breath holding during sleep?	No

How likely are you to fall asleep or doze in the following situations?	
a) Sitting and reading	
b) Watching TV	
c) Sitting inactive in a public place	
d) As a passenger in a car for an hour without a break	
e) Lying down to rest in the afternoon when circumstances permit	
f) Sitting and talking to someone	
g) Sitting quietly after lunch without alcohol	
h) In a car while stopped for a few minutes in traffic	
Status based on sleep apnoea score	Score

46. Blood Pressure

Systolic/Diastolic BP	128	/	79

47. Pulse

Pulse Rate	88	/ min
Rhythm	Regular	

48. Oxygen Saturation	99	%

49. Urine Analysis

Result	
Details	PATIENT UNABLE TO PROVIDE SAMPLE.

50. VTE Risk

Is patient at risk of VTE?	Yes	Do they require prophylaxis?	Yes

Day Surgery Criteria

51. Day Surgery Criteria

Is the procedure suitable for day surgery?	Yes

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Can transport be arranged?	Yes	Can an escort be arranged?	Yes
Is a carer available for 24 hours?	Yes	Is home access suitable?	Yes
Is there access to a telephone following discharge?	Yes	Is there easy access to a toilet?	Yes
Does the patient live within a one hour care journey?	Yes	Does the patient agree to be a day patient?	Yes

52. Admission Criteria	
Appropriate admission based on nursing assessment	DSU

Investigations		
Investigation	Required	Requested
FBC	Yes	Yes
Ferritin	No	No
Folate	No	No
B12	No	No
HbA1c	No	No
Glucose	No	No
Group & Save	Yes	Yes
Cross Matching	No	No
Coagulation Screen	No	No
Thrombophilia screen	No	No
Sickle Dex Test	No	No
Hb Electrophoresis	No	No
U&Es	No	No
LFTs	No	No
TFT	Yes	Yes
Lithium level	No	No
Digoxin level	No	No
Amylase	No	No
CRP	No	No
Calcium/Bone	No	No
ECG	No	No
ECHO	No	No
PEFR	No	No
PFT	No	No
C-Spine X-Ray	No	No
Chest X-Ray	No	No
MRSA Screening	No	No

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Pregnancy Test	No	No
Temperature	No	No

Pre-op Assessment Summary	
Assessor	VICKI CUNNINGHAM
Grade	5

Summary

PATIENT ASSESSED FOR DIAGNOSTIC LAPAROSCOPY AND STERILISATION AT DSU. HISTORY FROM PATIENT, NO NOTES AVAILABLE.

PREVIOUS GA, SUFFERS PONV.

PMH- THYROIDECTOMY FOR GOITRE
NODULES ON VOCAL CORDS, SUFFERS FROM HAORSENESS, KNOWN TO SALT:
POST-NATAL DEPRESSION AND ANXIETY DISORDER.

CLINICALLY STABLE AS CHARTED. PATIENT APPEARS FIT AND WELL.

ROUTINE BLOOD OBTAINED AS ABOVE. LETTER PROVIDED FOR PATIENT TO ATTEND VACH POA CLINIC ONCE DATED TO HAVE GR REPEATED.

MEETS DSU CRITERIA, FASTING INFORMATION PROVIDED.

Referrals and Type of admission - Recommended Admission pathway		
Referral by Nurse to:	Anaesthetist	No
	Surgeon	No
	Haematologist	No
	Cardiologist	No
	GP	No
	Cardiac Technician Pace Reset	No
	Cardiac Technician Pace Check	No
Nurse to arrange the attendance of:	Carer	No
	Interpreter	No
Nurse to:	Inform ward staff regarding the risk of alcohol withdrawl	No
Referral by Anaesthetist to:	Surgeon	No
	Haematologist	No
	Cardiologist	No
	Cardiac Technician	No
	GP	No
Type of admission to be decided by:	Nurse	
Type of Admission:	DSU	
Admission Deferred:	No	

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Advise to take usual anti-reflux medication	No
Dispensed Ranitidine as per PGD directive	No
Refer to smoking cessation clinic	No
Advise not to take "intravenous or recreational drug(s)" during the 24 hours before surgery (related to 33. Drug Abuse)	No
Anticoagulant advice	No
Clopidogrel advice	No
Aspirin advice	No
OCP advice	No
Provide Herbal Medicine Advice	No
Arrange for dialysis the day before surgery	No
Ensure facilities for dispensing methadone are available if the patient is taking methadone.	No
Print PEFR Advice Sheet	No
Print ECG Advice Sheet	No

Anaesthetist Assessment	
Anaesthetist	
Grade	
Summary	

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Acute Services Division

Surgery and Anaesthetics Directorate

Department: Pre Op Assessment Unit

Specialty: General Surgery

NHS Greater Glasgow and Clyde

Hospital Name	Southern General

Patient Details		GP Details	
Name	HUGHES, LISA	Name	SEMPLE, LINSEY
Address	8 Carham Crescent GLASGOW G52 2HN	Address	CARDONALD MEDICAL CENTRE 1831 PAISLEY ROAD WEST GLASGOW G52 3SS
Correspondance Address		Telephone	
Correspondance Postcode		CRN Number	64057442B, SG00953485, Z00286838
Telephone	07766451921	Consent	Yes
Patient Contact Number	01412390191	Sensitivity	Sensitive
CHI Number	1701806541	Consultant Name	KHAUND
Sex	Female	Requires Transport	No
Date of Birth	17/01/1980	Religion	

Next of Kin / Person to Notify	Next of Kin	Person to Notify
Name	AGNES HUGHES	
Address	46 HOLLYBUSH ROAD, PENNILEE	
Landline	TBC	
Mobile		
Relationship	MOTHER.	

Assessment Details					
Assessor	VICKI CUNNINGHAM	Grade	5	Date	24/03/2011
Ward	VACH DSU.				

Surgery / Procedure Attending For
DIAGNOSTIC LAPAROSCOPY AND STERILISATION

Short Notice Availability	Yes/No	Details
Available at short notice?	Yes	24-48 HRS NOTICE.

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Anaesthetic	Yes/No	Details/Problems
Previous GA	Yes	PONV;
Previous LA	Yes	
Detention Risk	Yes	1 FRONT UPPER VENEER
Neck/Jaw Stiffness	No	
Other Risk	No	
Heartburn	No	
Sickle Cell Disease	No	Risk factors for sickle cell disease: No
Sleep Apnoea Score		

Surgical History	Yes/No	Details/Problems
Affects suitability for DSU	No	
Relevent details of surgical history		THYROIDECTOMY 2009 (MULTINODAL GOITRE.)
Any serious surgical or anaesthetic complication	No	

Cardiovascular	Yes/No	Details/Problems
Hypertension	No	
Arrhythmias		
Angina	No	
Heart Attack	No	
Murmur	No	
Blackouts	No	
Heart Failure	No	

Respiratory	Yes/No	Details/Problems
Asthma/Bronchitis/COPD/Emphysema	No	
URTI	No	

Neurological	Yes/No	Details/Problems
Stroke	No	
Epilepsy	No	
Neurological Disease	No	
Physical Disability	No	

Haematological	Yes/No	Details/Problems
Bleeding Disorder	No	
Previous DVT	No	
Anaemia	No	

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Miscellaneous	Yes/No	Details/Problems
Kidney disease	No	
Liver disease/jaundice	No	
Diabetes	No	
Arthritis	No	
CJD Risk	No	

Any serious illness not already mentioned?	Yes	POST-NATAL DEPRESSION AND ANXIETY DISORDER.;

Exercise Tolerance	Yes/No		Yes/No		Yes/No
Climbs stairs without stopping	Yes	Climbs stairs with stopping	No	Cannot climb stairs	No

Social	Yes/No			
Alcohol (units/week)		0		
Smoker	Yes	23 cigs/wk		
Ex Smoker				
IV drug abuser	No		Methadone Req:	
Pregnant	No	LMP	Could Be Pregnant:	No

Drug History

List of all drugs (including herbal remedies and complimentary medicine)

LEVOTHYROXINE 200MCG
OLANZAPINE 10MG NOCTE
DIAZEPAM 5MG TDS
CITALOPRAM 10MG OD
DEPO-PROVERA 3/12

Patient takes the following drugs

Taking herbal remedies or complimentary medicine	No
Oral Steroids in past year	No

Does patient have any allergies?

Prosthesis/Implants	Yes/No				
Pacemaker	No	Date of last Check		Date of Insertion	
		Reason for insertion			
		Other Reason			
Prosthesis/Other	No				

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Examination

Weight (kg)	63.1	Height (m)	1.66	BMI	23	Temp	
Pulse (bpm)	88	Regular	Regular	BP	128/79		
SaO2 (%)	99						

Investigations

The below investigations are required.

24/03/2011

U&E	No	FBC	Yes	ECG	No
Glucose	No	Coag Screen	No	LFTs	No
Group & Save	Yes	Other	TFT;		

VTE Risk

Is patient at risk of VTE?	Yes	Do they require prophylaxis?	Yes

Admission Criteria

Appropriate admission based on nursing assessment	DSU

Pre-operative Assessment Summary

Assessor: VICKI CUNNINGHAM Grade: 5

PATIENT ASSESSED FOR DIAGNOSTIC LAPAROSCOPY AND STERILISATION AT DSU. HISTORY FROM PATIENT, NO NOTES AVAILABLE.

PREVIOUS GA, SUFFERS PONV.

PMH- THYROIDECTOMY FOR GOITRE
NODULES ON VOCAL CORDS, SUFFERS FROM HAORSENESS, KNOWN TO SALT.
POST-NATAL DEPRESSION AND ANXIETY DISORDER.

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ROUTINE BLOOD OBTAINED AS ABOVE. LETTER PROVIDED FOR PATIENT TO ATTEND VACH POA CLINIC ONCE DATED TO HAVE GR REPEATED.

MEETS DSU CRITERIA, FASTING INFORMATION PROVIDED.

Recommended Admission Pathway

Referral by nurse to:	
Nurse to arrange the attendance of:	
Nurse to:	
Referral by Anaesthetist to:	
Type of admission to be decided by:	Nurse
Type of Admission:	DSU
Admission Deferred:	No

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Anaesthetic Assessment	Anaesthetist:	Grade:

Acute Services Division

Surgery and Anaesthetics Directorate

Department of Pre Op Assessment Unit

Specialty: General Surgery

NHS Greater Glasgow and Clyde

PreAdmission Form Release 1.0

Hospital Name: Southern General

Patient Details		GP Details	
Name:	HUGHES, LISA	**Name:**	SEMPLE, LINSEY
Address:	8 Carham Crescent GLASGOW	**Address:**	CARDONALD MEDICAL CENTRE 1831 PAISLEY ROAD WEST GLASGOW G52 3SS
Postcode:	G52 2HN	**Telephone:**	
Correspondence Address 1:		**Consent:**	Yes
Correspondence Address 2:		**Sensitivity:**	Sensitive
Correspondence Postcode:		**Consultant Name:**	
Telephone:	07766451921	**Admission Date:**	
CHI Number:	1701806541	**Time:**	
N:	64057442B, SG00953485, Z00286838	**Ward:**	
D.O.B:	17/01/1980	**Procedure/Operation:**	

Observations

Temperature (celcius)		**Resps (per min)**		**Heart Rate (bpm)**	
Blood Pressure (mmHg)		**O2 Sats (%)**		**S/Mews Score**	
Changes Since POA?	*Yes*	*No*			

There are no allergies to display

Emergency Contact Numbers	
Name	
Relationship	
Phone	

Discharge	Yes	No
Estimated Date		
Transport Required		
Supervising Adult for Discharge		

Home Circumstances		Yes	No
Lives with Family Carer			
s Alone			
Elderly/Disabled Partner			
District Nurse	**days/wks**		
Home Help			
Other Services			

Medicines	Yes	No
Own Supplied		

Valuables	Yes	No
Valuables Returned		

MRSA		
Positive	**Negative**	**Unknown**

Activities of Daily Living	NOTE: NOT REQUIRED FOR DAY SURGERY
Safety and Comfort	
Breathing and circulation	
Maintaining Body Temp	
Personal Hygiene	
Elimination	
Sleep	
Mobility	
Eating and drinking	
Skin Condition/Waterlow score	
Communication (including anxiety & fear) Aids worn?	

Date		Admitted By	

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 02/06/2026

Consultant: Dr Michael Gillespie2

JD Datta
Drs Datta & Partners
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
Glasgow
G52 3SS

Dear JD Datta

Re: **Hughes Lisa Rosemary** DOB: **17/01/1980** CHI: **1701806541**
2 LANGSTILE ROAD
Glasgow G52 4AG

Attended on: **13/05/2026 at 01:45 hrs.** Departed on: **13/05/2026 at 10:21 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
right sided facial numbness, pressure in chest, headache

Nursing Assessment:
c/o right side mouth tingling/numbness and intermittent right hand tingling for 1/52, started taking HRT patches last week.

Investigations in ED:

1. Full Blood Count	**2. ESR**	**3. Urea and Electrolytes**
4. LFT	**5. Thyroid function tests**	**6. CRP**
7. Bone Profile	**8. Glucose**	**9. Lipid profile (inc. HDL)**
10. Ferritin	**11. Folate**	**12. Chol / Triglyceride**
13. Vitamin B12 (Active)	**14. Full Blood Count**	**15. Coagulation screen**
16. Urea and Electrolytes	**17. Glucose**	**18. LFT**
19. Bone Profile	**20. CRP**	**21. Chol / Triglyceride**

22. 12 Lead ECG (Emergency Dept Use Only)

23. XR Chest

Diagnosis:

Diagnosis	Side	Site
General Medical Examination		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

1/52 hx of progressive altered sensation of right lower face. FAST negative. Associated pressure like headache. No headache red flags. Also c/o left sided chest pain. Exam NAD. ECG NSR. CXR clear. Bloods NAD. Discharged home with worsening advice.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Eve Ross-Leahy
Doctor

Copies to:

1. JD Datta (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 24/02/2025

Consultant: Dr Michael Gillespie2

JD Datta
Drs Datta & Partners
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
Glasgow
G52 3SS

Dear JD Datta

Re: **Hughes Lisa Rosemary** DOB: **17/01/1980** CHI: **1701806541**
2 LANGSTILE ROAD
Glasgow G52 4AG

Attended on: **24/02/2025 at 00:40 hrs.** Departed on: **24/02/2025 at 04:39 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
nhs24 ref ed direct - HEAD INJURY-5 HOURS

Nursing Assessment:
WAS DIRECTLY HIT WITH HEAVY OBJECT TO BACK OF HEAD. FELL TO GROUND AND BLACKED OUT. GCS 15. NOT ANTICOAGULATED. NOT VOMITED- NO NAUSEA. FEELS UNSTEADY ON FEET AND SKAKEY. WENT TO GO TO BED AND FELT PAIN GOT WORSE.

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Superficial Injury of Other Parts of Head		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:
abrasion to top of head normal neurological exam worsening advice and discharge

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

Yours sincerely,
David McGlynn
Nurse

Copies to:
1. JD Datta (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 02/11/2024

Consultant: GGC ED Virtual Consultant

JD Datta
Drs Datta & Partners
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
Glasgow
G52 3SS

Dear JD Datta

Re: **Hughes Lisa Rosemary** DOB: **17/01/1980** CHI: **1701806541**
2 LANGSTILE ROAD
Glasgow G52 4AG

Attended on: **02/11/2024 at 15:01 hrs.** Departed on: **at hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
Virtual ED from NHS 24 RIB PAIN - 17 HOURS

Nursing Assessment:

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Contusion of Thorax		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Patient presented for virtual consultation, following Referral form NHS 24. ID and consent confirmed. .Presenting complaint: Fall - Rib pain .History Presenting Complaint: Walking down hill when slipped last night hitting left side of body off (low) crash barrier at 2200 falling to ground hitting left side. No Hi, assisted to feet, throbbing in left side at time. Home and slept ok if stayed in same position. Pain+ on wakening, took Paracetamol/Ibuprofen earlier with some result. Took partners Naproxen at 1825 with good result. O/E: bruising to left flank however not particularly painful at site of bruising, pain posterior left chest. Denies SOB, no cough, no fevers. Denies abdominal pain, normal bladder function, denies haematuria. States pain is much improved after taking Naproxen. .Past Medical History: Depression .Drug History: Citalopram, Olanzapine, Levothyroxine. .Allergies: NKDA .Social History: Not currently working. Lives with daughter. .Other Relevant Information: .Plan: Red flag symptoms ruled out. Advised continuing to treat as MSK with regular paracetamol & Ibuprofen or Naproxen. We have discussed the importance of deep breathing exercises. Aware if develops SOB/ Cough or any colour change to urine to seek review with GP, happy with plan.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Jennifer Gray
Nurse

Copies to:

1. JD Datta (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 04/01/2024

Consultant: Dr Allan Drummond

JD Datta
Drs Datta & Partners
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
Glasgow
G52 3SS

Dear JD Datta

Re: **Hughes Lisa Rosemary** DOB: **17/01/1980** CHI: **1701806541**
8 Carham Crescent
Glasgow G52 2HN

Attended on: **03/01/2024 at 16:38 hrs.** Departed on: **04/01/2024 at 11:18 hrs.**
Discharge Type: **01c - Discharge with referral** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
SDUCC - OWN (R) SIDED HEADACHE

Nursing Assessment:
Right sided headache and blurring of vision ?SAH

Investigations in ED:

1. Full Blood Count	**2. Coagulation screen**	**3. Urea and Electrolytes**
4. Glucose	**5. LFT**	**6. Bone Profile**
7. CRP	**8. CT Head**	**9. ESR**
10. XR Chest	**11. D - Dimer**	**12. Coagulation screen**

Diagnosis:

Diagnosis	Side	Site
Acute Sinusitis, Unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Any medication dispensed or changed is recorded in this letter in the free text below**

Clinician Notes:

Ms Hughes attended QEUH on 3/1/24 with facial pain, headache and blurred vision. Bloods and observations were reassuring. CXR showed no focal abnormality. CTB was performed and showed evidence of sinusitis in addition to 3 foci of ill-defined hypoattenuation in periventricular white matter which were felt to be none specific and likely represent small vessel ischaemic disease, with at least one being present from CTB in 2006. MRI brain has been requested as an outpatient to further define these abnormalities and Lisa is aware of this and was concerned as maternal aunt had brain tumour. I explained that I do not think CTB findings are likely to be cause of current headache or likely to represent malignancy but that MRI will give us a better idea. She has been discharged home with simple analgesia, prescription for nasal decongestant and advised to seek advice if on-going or worsening pain.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Victora Armour
Doctor

Copies to:

1. JD Datta (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel:
Fax: Patient attended
Email: Surgical GP Referrals unit

Date Completed: 14/07/2020

Consultant: Dr George Oommen

JD Datta
Drs Datta & Partners
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
Glasgow
G52 3SS

Dear JD Datta

Re: **Hughes Lisa Rosemary** DOB: **17/01/1980** CHI: **1701806541**
8 Carham Crescent
Glasgow G52 2HN

Attended on: **14/07/2020 at 03:45 hrs.** Departed on: **14/07/2020 at 08:49 hrs.**
Discharge Type: **01c - Discharge with referral** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
abdo pain

Nursing Assessment:
BIBA 3/7 hx RUQ pain. Pain worse since 2am. Hx chronic constipation and ?not moved bowels in 6/7

Investigations in ED:

1. XR Chest	**2. Amylase**	**3. CRP**
4. Urea and Electrolytes	**5. Bicarbonate**	**6. LFT**
7. Glucose	**8. HCG**	**9. Full Blood Count**
10. US Abdomen		

Diagnosis:

Diagnosis	Side	Site
Disorders of Gallbladder & Biliary Tract In Diseases Classified Elsewhere		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Biliary colic Reviewed by surgeons and for follow-up in the hot clinic

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

Yours sincerely,
Andrew Balme
Doctor

Copies to:
1. JD Datta (GP)
School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 09/12/2019

Consultant: Dr Jonny Gordon

JD Datta
Drs Datta fisken & mcgill
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
Glasgow
G52 3SS

Dear JD Datta

Re: **Hughes Lisa Rosemary** DOB: **17/01/1980** CHI: **1701806541**
8 Carham Crescent
Glasgow G52 2HN

Attended on: **09/12/2019 at 12:06 hrs.** Departed on: **09/12/2019 at 15:39 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
groin pain

Nursing Assessment:
Pain in the left hip and groin since saturday after intercourse. Seen GP this morning, Referred up from GP for X-ray. Taken co-codamol 8/500mg.

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Sprain and Strain of Hip		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Attended with left hip pain post intercourse 3/7 ago. Reassured no # clinically and likely soft tissue strain. Advised mobilise as pain allows with simple analgesia.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Matthew Wickham
Doctor

Copies to:

1. JD Datta (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2503 (8503)
Fax:
Email:

Date Completed: 17/12/2018

Consultant: Dr Alisdair MacConnachie

JD Datta
Drs Datta fisken & mcgill
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
Glasgow
G52 3SS

Dear JD Datta

Re: **Hughes Lisa Rosemary** DOB: **17/01/1980** CHI: **1701806541**
8 Carham Crescent
Glasgow G52 2HN

Attended on: **17/12/2018 at 16:38 hrs.** Departed on: **17/12/2018 at 19:43 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
own transport 2 weeks of intermittent chest pain ?stress rule out cardiac

Nursing Assessment:
2/52 central chest pain ?stress related. FHx IHD, obs stable

Investigations in ED:

1. Coagulation screen	**2. Urea and Electrolytes**	**3. Glucose**
4. LFT	**5. CRP**	**6. Chol / Triglyceride**
7. Full Blood Count	**8. Troponin I hs**	**9. Thyroid function tests**
10. XR Chest		

Diagnosis:

Diagnosis	Side	Site
Musculoskeletal chest pain (non - traumatic)		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Patient attended CDU with a 2/52 history of intermittent chest pain. O/E she was haemodynamicaly stable. Chest and cardiac auscultation unremarkable. She denied SOB and nausea and vomiting. 12 Lead ECG demonstrated NSR with no acute ST/T wave changes. CXR was NAD. She reported being under increasing stress, and wondered whether it was anxiety related. Troponin negative and all other bloods satisfactory. In view of the above results, I wonder whether this episode has been related to anxiety. She was reviewed by the Consultant and discharged home with reassurance. Regards, Robert Thomson, ANP.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Robert Thomson1
Nurse

Copies to:

1. JD Datta (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 22/04/2017

Consultant: Dr Hannah Smith

AA Finney
Drs Semple finney datta & fisken
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
Glasgow
G52 3SS

Dear AA Finney

Re: **Hughes Lisa Rosemary** DOB: **17/01/1980** CHI: **1701806541**
8 Carham Crescent
Glasgow G52 2HN

Attended on: **21/04/2017 at 21:22 hrs.** Departed on: **21/04/2017 at 23:10 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
nhs ref personnel

Nursing Assessment:
NHS 24 referral - tampon stuck for 6/7

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Constipation		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Mrs Hughes presented to ED with concern that she had a tampon stuck in her vagina. She could not remember removing a tampon and after some discomfort during intercourse she examined herself thinking this to be the cause. On examination in ED there was no evidence of foreign body in the vagina on bimanual and speculum examination. PV examination did reveal a posterior vaginal wall mass which felt rectal in origin. PR examination revealed hard stool in the rectum, the same as was felt at posterior vaginal wall, Mrs Hughes revealed it was this she had felt on her self examination. She was reassured that there was no tampon and that she was constipated. I have provided laxatives but I have asked her to present to yourself next week after she has moved her bowels for a follow up PR examination to make sure that it was all faecal material I was feeling and nothing more sinister. Thank you for providing this follow up.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Jack Pugh
Doctor

Copies to:

1. AA Finney (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2810/2811
Fax:
Email:

Date Completed: 10/08/2016

Consultant: Dr Jason Long

AA Finney
Drs Semple finney datta & fisken
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
Glasgow
G52 3SS

Dear AA Finney

Re: **Hughes Lisa Rosemary** DOB: **17/01/1980** CHI: **1701806541**
8 Carham Crescent
Glasgow G52 2HN

Attended on: **08/08/2016 at 17:31 hrs.** Departed on: **08/08/2016 at 18:47 hrs.**
Discharge Type: **04E Incomplete: Patient removed by police** Destination: **Other**
Previous ED Attendance in last 12 months: **4**

Presenting complaint
suicidal

Nursing Assessment:
biba. pt found lying on ground by passer by & pt stated to them she was going to throw herself in the river. pt been drinking. pt recently had children removed from her home. pt aggressive o/a.

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Suicidal Ideation		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Brought in by ambulance Possible suicidal ideation became very aggressive Taken into police custody

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Jason Long
Consultant

Copies to:

1. AA Finney (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2810/2811
Fax:
Email:

Date Completed: 08/06/2016

Consultant: Dr Phil Munro

AA Finney
Drs Semple finney datta & fisken
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
Glasgow
G52 3SS

Dear AA Finney

Re: **Hughes Lisa Rosemary** DOB: **17/01/1980** CHI: **1701806541**
8 Carham Crescent
Glasgow G52 2HN

Attended on: **08/06/2016 at 00:38 hrs.** Departed on: **08/06/2016 at 02:19 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **3**

Presenting complaint
cut lip

Nursing Assessment:
999 call. Alleged assault. With police due to aggression with crew. Family concerned RE: mental health issues.

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Open wound of lip and mouth		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Seen with police. Allegedly assaulted. Small lac on mucosal surface of lip. Abrasions over shoulder. D/c home with no follow up.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Neil Brain
Doctor

Copies to:

1. AA Finney (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 30/11/2015

Consultant: Dr Jason Long

AA Finney
Drs Semple finney datta & fisken
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
Glasgow
G52 3SS

Dear AA Finney

Re: **Hughes Lisa Rosemary** DOB: **17/01/1980** CHI: **1701806541**
8 Carham Crescent
Glasgow G52 2HN

Attended on: **30/11/2015 at 01:44 hrs.** Departed on: **30/11/2015 at 02:21 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
assault, lieft shoulder pain, head inj, chest pain

Nursing Assessment:
in with police - alleged domestic assault - c/o pain to face head feet and left shoulder

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Superficial injury of scalp		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Brought in in Police custody. Mum present. Reported drinking 1/2 bottle of wine before being physically assaulted by partner. States he pulled her hair, slapped and punched her head and torso, grabbed her and pinned he down, threw her about room. No LoC. O/E GCS 15, smiling and undistressed, intoxicated but not heavily so. Bruising to L forehead, swollen upper lip with some dried blood, bruising to upper inner R arm consistent with fingerprints, pain in L shoulder and R chest wall but no bruising / evidence of bony injury there. No further evidence of injury on CN, head and C-spine, chest, abdo and skeletal survey.Discharged in Police custody with head injury advice.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Paul Gallagher
Doctor

Copies to:

1. AA Finney (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2810/2811
Fax:
Email:

Date Completed: 13/10/2015

Consultant: Dr Nicola Littlewood

AA Finney,
Drs Semple finney and datta
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
Glasgow
G52 3SS

Dear AA Finney

Re: **Hughes Lisa Rosemary** DOB: **17/01/1980** CHI: **1701806541**
8 Carham Crescent
Glasgow G52 2HN

Attended on: **11/10/2015 at 14:07 hrs.** Departed on: **11/10/2015 at 19:10 hrs.**
Discharge Type: **02 - Admitted** Destination: **Admission to this Hospital**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
BIBA...OVERDOSE

Nursing Assessment:
999 alcohol/mixed od- taken last night-diazepam propranolol levothyroxine olanzapine =empty packets found

Investigations in ED:

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

Diagnosis:

Diagnosis	Side	Site
Deliberate self poisoning by and exposure to other and unspecified chemicals and noxious substances		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Mixed overdose of diazepam, propranolol, levothyroxine and olanzapine. Unknown quantity at unknown time, ?overnight at somepoint so >10 hours. Drowsy in department, E1V2M5, examination otherwise unremarkable. Admission to medics.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Fiona Stark
Doctor

Copies to:

1. AA Finney (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 03/10/2015

Consultant: Dr Nicola Littlewood

AA Finney
Drs Semple finney and datta
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
Glasgow
G52 3SS

Dear AA Finney

Re: **Hughes Lisa Rosemary** DOB: **17/01/1980** CHI: **1701806541**
8 Carham Crescent
Glasgow G52 2HN

Attended on: **02/10/2015 at 23:18 hrs.** Departed on: **03/10/2015 at 01:54 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
bibp - mental health (in police room)

Nursing Assessment:
shouting and breaking furniture in house...has been drunking

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
No Injury or Abnormality Detected		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Brought in by police after arguement with partner. Nil acute physical or mental health issues. Discharged with police.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Fiona Stark
Doctor

Copies to:

1. AA Finney (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

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

Date Completed: 09/06/2014

Consultant: Dr Jason Long

AA Finney
Drs Semple finney and datta
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
Glasgow
G52 3SS

Dear AA Finney

Re: **Hughes Lisa Rosemary** DOB: **17/01/1980** CHI: **1701806541**
8 Carham Crescent
Glasgow G52 2HN

Attended on: **05/06/2014 at 13:08 hrs.** Departed on: **05/06/2014 at 14:54 hrs.**
Discharge Type: **02 - Admitted** Destination: **Admission to same NHS healthcare provider**

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

Presenting complaint
gp ref for medics

Nursing Assessment:
R/P known asthmatic pt presents with several hour hx sob and associated left sided back/chest pain. Attended dept 2/7 for same.

Investigations in ED:

1. 12 Lead ECG	**2. Urea and Electrolytes**	**3. LFT**
4. Full Blood Count	**5. CRP**	**6. XR Chest**
7. D - Dimer	**8. Bone Profile**	**9. Magnesium**

Diagnosis:

Diagnosis	Side	Site
Pulmonary embolism without signs of acute cor pulmonale		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Pleuritic chest pain and asthma. But no wheeze and normal PEFR. Admitted to medics to exclude PE.

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

Yours sincerely,
Gillian Hadden
Doctor

Copies to:
1. AA Finney (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

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

Date Completed: 04/06/2014

Consultant: Dr Malcolm Gordon

LC Semple
Drs Semple finney and datta
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
Glasgow
G52 3SS

Dear LC Semple

Re: **Hughes Lisa Rosemary** DOB: **17/01/1980** CHI: **1701806541**
8 Carham Crescent
Glasgow G52 2HN

Attended on: **03/06/2014 at 02:37 hrs.** Departed on: **03/06/2014 at 04:08 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
med probs

Nursing Assessment:
only been diagnosed with asthma few weeks ago. been given inhaler. tonight became wheezy inhaler empty. distressed on crew arriving. o2 then nebs given with good effect undistressed on arrival

Investigations in ED:
1. XR Chest

Diagnosis:

Diagnosis	Side	Site
Asthma, unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

This lady presented with worsening of her SOB over the past week since new doors were fitted. The main reason for her attendance was that she ran out of her Salbutamol inhaler. She was speaking in full sentences and appeared undistressed. She had a borderline tachycardia of 100 with normal O2 sats. Her chest had scattered expiratory wheeze. Given that she is a smoker and complains of an ongoing cough for the past 3 weeks she had a CXR which did not show any consolidation. Her PEFR improved post Salbutamol nebuliser and this was felt to be a moderate asthma exacerbation. She was discharged home with a new inhaler. She was given smoking cessation advice and advised to see her GP to arrange referral for Spirometry to help with diagnosis of Asthma/COPD.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Paula Falconer
Doctor

Copies to:

1. LC Semple (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

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

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

Date Completed: 29/09/2013

Consultant: Dr Tim Parke

LC Semple
Drs Semple & Finney
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
Glasgow
G52 3SS

Dear LC Semple

Re: **Hughes Lisa Rosemary Rosemary** DOB: **17/01/1980** CHI: **1701806541**
8 Carham Crescent
Glasgow G52 2HN

Attended on: **29/09/2013 at 13:32 hrs.** Departed on: **29/09/2013 at 15:16 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
loss of hearing

Nursing Assessment:
Alleged assault by partner last night - pt says her head was struck against floor. No loc, but c/o feeling dizzy, also hearing in both ears affected

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Superficial injury of head, part unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
alleged domestic assault last night, head struck against hard floor. police involvement already. no neuro deficit. symptoms of concussion. head injury advice given

Followup : **none**
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Neil Stevenson
Doctor

Copies to:
1. LC Semple (GP)

School Address:

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

DR. LINSEY LC SEMPLE
CARDONALD MEDICAL CENTRE
1831 PAISLEY ROAD WEST
GLASGOW

G52 3SS
0141 892 2548

Dear Dr. LINSEY LC SEMPLE,

Your Patient	Name	: LISA ROSEMARY HUGHES
	DOB	: 17/01/1980
	Address	: 8 CARHAM CRESENT
		GLASGOW
		LANARKSHIRE
		G52 2HN

Consultant : MR CIERAN MCKIERNAN

Account # : AE0018097/12 Unit # : SG00953485 CHI # : 170

Attended at : 0953 on 01/03/2012
Left A&E at : 1309 on 01/03/2012

Reason for Visit : GP REF ?DVT

Diagnosis : Deep Vein Thrombosis : LEFT : Leg (lo

Investigations :

Treatments :

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given :

Additional Notes:
PRESENTED WITH POSSIBLE DVT LEFT LEG - LEFT CALF PAIN, SLIGHT SWELLING.. WELLS SCORE OF 0. D-DIMER 257 - REFERRED TO OUTPATIENT DVT PATHWAY. DOPPLER SCAN BOOKED FOR 14:00 TODAY. DALTEPARIN ADMINISTERED. TO BE FOLLOWED UP BY CDU STAFF AS PER O/P DVT PROTOCOL.

Follow Up :

Yours sincerely

DR. OWAIN LENG

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

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

DR. LINSEY LC SEMPLE
CARDONALD MEDICAL CENTRE
1831 PAISLEY ROAD WEST
GLASGOW

G52 3SS
0141 892 2548

Dear Dr. LINSEY LC SEMPLE,

Your Patient
Name : LISA ROSEMARY HUGHES
DOB : 17/01/1980
Address : 8 CARHAM CRES

GLASGOW
LANARKSHIRE
G52 2HN

Consultant : MR CIERAN MCKIERNAN

Account # : AE0034356/11 Unit # : SG00953485 CHI # : 170

Attended at : 2109 on 24/04/2011
Left A&E at : 0042 on 25/04/2011

Reason for Visit : OD

Diagnosis : Deliberate Self Poisoning : NOT APPLICABLE : See Add

Investigations :

Treatments :

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given : N

Additional Notes:
DELIBERATE OVERDOSE OLANZAPINE, VALIUM AND ALCOHOL. AGGRESSIVE AND UNCOOPERATIVE IN DEPT. ADMITTED MEDICS FOR PERIOD OF OBSERVATION.

Follow Up :

Yours sincerely

DR. EMMA CULLEN

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

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

DR. LINSEY LC SEMPLE
CARDONALD MEDICAL CENTRE
1831 PAISLEY ROAD WEST
GLASGOW

G52 3SS
0141 892 2548

Dear Dr. LINSEY LC SEMPLE,

Your Patient

Name : LISA ROSEMARY HUGHES
DOB : 17/01/1980
Address : 5 MOSSVIEW QUADRANT
FLAT 2/2
GLASGOW
LANARKSHIRE
G52 2TU

Consultant : MR CIERAN MCKIERNAN

Account # : AE0084520/09 Unit # : SG00953485 CHI # : 170

Attended at : 1200 on 26/09/2009
Left A&E at : 1320 on 26/09/2009

Reason for Visit : CHEST PAINS AND EPIGASTRIC PAINS

Diagnosis : See Additional Notes : NOT APPLICABLE : ---

Investigations :
: Electrocardiograph
: Chest X-Ray
: Urea/Electrolytes
: LFT's PROT/ALB/BIL/ALP/AST/ATL
: Amylase
: CRP Assay
: Full Blood Count

Treatments :

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given :

Additional Notes:
999 AFTER EPISODE OF EPIGASTRIC/CHEST PAIN WITH SOB. SYMPTOMS HAD ALMOST TOTALLY RESOLVED BEFORE AMBULANCE ARRIVED LEAVING ONLY EPIGASTRIC DISCOMFORT. SERIAL ECGs ESSENTIALLY NORMAL - RELUCTANT TO BE ADMITTED FOR "CARDIAC CAUSE EXCLUSION" - BLOODS NORMAL

Follow Up : NONE

Yours sincerely

DR. LESLEY LAUGHTON

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

Clinical letter - GP: RESULTS

NHS
Greater Glasgow and Clyde

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

Dr. AA Finney
Drs Semple finney and datta
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Main Switchboard: 0141 201 1100
Department: GENERAL MEDICINE
Contact Tel: 0141 201 1782
Enquiries to: mary.fay@ggc.scot.nhs.uk
Letter Date: 22/09/2014
Reference: AK/MGF
Dictated Date: 17/09/2014
Transcribed Date: 19/09/2014

Dear Dr Finney,

Lisa Rosemary Hughes; D.O.B: 17/01/1980; CHI: 1701806541
8 Carham Crescent, Glasgow, Lanarkshire, G52 2HN

Further to this lady's admission I have received results of her DEXA scan and spoken with radiology colleagues. Her DEXA scan was fine. We had planned to do an isotope bone scan just to make sure there was no more widespread bony disease. Following discussion with Dr Morrison, Consultant Radiologist who has examined her CTPA films, he is happy that the fracture appears clean and there was nothing to suggest anything pathological.

I am fairly comfortable with this and we have decided therefore not to proceed with the isotope bone scan. I expect her fracture was related to her coughing. We do see this albeit infrequently.

Yours sincerely

Andrew Kernohan
Consultant Physician

Electronically Signed: Dr Andrew Kernohan, Consultant

cc.

REGIONAL MAXILLOFACIAL UNIT
ASSOCIATE SPECIALIST: MRS PATRICIA M FINLAY

Secretary: 0141 232 7602
Fax No: 0141 232 7508
Email: Janice.Findlay2@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

PMF/JF

03/10/12

DR LINSEY LC SEMPLE
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr Semple

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485) CHI: 1701806541
8 CARHAM CRESENT, , GLASGOW, G52 2HN

This patient failed to attend her maxillofacial outpatient clinic appointment on 25/09/12. No further appointments will be sent.

Kind regards

Yours sincerely

Mrs Patricia M Finlay
Associate Specialist in Oral Maxillofacial Surgery

REGIONAL MAXILLOFACIAL UNIT
CONSULTANT: MR D A KOPPEL

Direct dial: 0141 232 7510
Fax no: 0141 232 7508
E-mail: Louise.Morgan@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

DAK/LEM
Typed: 29/05/12

DR LINSEY LC SEMPLE
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr Semple

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485) CHI: 1701806541
8 CARHAM CRESENT, , GLASGOW, G52 2HN

This patient failed a review appointment with regard to her temporomandibular joint problem. I can only assume all is well and I have not arranged to see her again.

Kind regards

Yours sincerely

Mr David A Koppel
Consultant Craniofacial/Oral and Maxillofacial Surgeon
Lead Clinician Regional Maxillofacial Unit

Clinic Letter

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Dr. JD Datta
Drs Datta & Partners
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Main Switchboard:	0141 201 1100
Department:	neurology
Contact Tel:	0141 232 7542
Enquiries to:	lynn.douglas@nhs.scot
Letter Date:	29/07/2025
Reference:	GG/CB
Dictated Date:	29/07/2025
Transcribed Date:	07/08/2025

Dear Dr. JD Datta,

Lisa Rosemary Hughes; D.O.B: 17 Jan 1980; CHI: 1701806541
2 LANGSTILE ROAD, Glasgow, Lanarkshire, G52 4AG

Attendance: Specialty - Neurology; Clinic - SUGGNE3-DR GORRIE HEADACHE TUESDAY AM
Date and Time of Appointment - 29/07/2025 09:00

Clinical Comments:
I reviewed Lisa in clinic, she attended on her own. She gives a history of head pain dating back approximately one and a half years, there is also issues with her memory and she has experienced these for about one and a half years. They appeared to be related to initially to some trigger of flights and travel, she had a dizzy spell and then a line in her vision that took her to A&E and at that time she was investigated with a CT scan and then an MRI scan. At that time she was told by a nurse that she had a benign tumour in her head dating back to 2006. This has been a fixed belief since then.

She has been experiencing headaches that are typically on the right side and are "horrible", they can have a dull and pulsating quality, her vision can be blurry and she can feel nauseated with a weight on her head and she can feel "wobbly" and not herself. It is a pressure like quality and also as if there is a tight band that is daily since being told that she's had a tumour in her head. She's had visual correction by her optician with varifocals but no other abnormalities identified on her optician review. The pain typically ranges between 7-8/10 and when it's more severe she would stop activity and go to her bed. She has no headache free days, some can be worse than others.

She has mental health issues being in toxic relationship in the past and has had a head injury many years ago when a bunk bed fell on her head, this caused a laceration but no loss of consciousness, she's had a thyroid tumour removed in the past that was benign and is on regular thyroxine replacement olanzapine and naproxen which she takes daily, there has been mood issues in the past.

On examination today she was orientated in time, place and person. She indicated that Donald Trump was in Scotland although she could not name where. She could repeat a sentence accurately and could draw a clock face with the numbers in the right place and the hands in the right place for the relevant time. She had difficulty remembering three objects after distraction. Visual acuity was reduced at 6/18 improving with pinhole to 6/9 on the right and counting fingers on the left is 6/36. She had normal visual fields to confrontation, normal looking fundi with no disc swelling or pallor, she had normal extraocular movements and normal facial power and normal facial sensation, tongue was normal on external inspection. She had normal coordination and gait with no evidence of ataxia on midline gait assessment and Romberg's test was normal. Power was normal although with some give-way qualities in her lower limbs and the right plantar was equivocal with regular withdrawal, otherwise she felt that sensation was less good on the left hand side compared to the right. Reflexes were particularly brisk and there was no particular increase in tone. BP 139/99.

Opinion; I suspect there is some migrainous feel to this ladies headaches, I suspect there is also a tension component given that there appeared to a regular phenomenon after being told that she had a brain tumour. I tried to give her some reassurance that this was unlikely given the non specific white matter abnormalities and the memory disturbance I have repeated her MRI imaging with contrast and performed a number of blood tests today (unremarkable) given her non specific symptoms, history and regular head pain. I have not organised further follow up, I would tend to treat her as having more migraine like headaches if this persists despite the reassurance of investigations if they are negative when they come back. There may also be a tension component driving some of this given the history to.

Your sincerely

Dr George Gorrie

Consultant Neurologist

Electronically Signed: Dr George Gorrie, Consultant

cc.

Southern General Hospital
Secondary Care Bone Densitometry Service
Telephone 0141 201 2721

Consultants: Dr AP Gallagher 0141 201 8278 Dr SJ Gallacher 0141 201 2721
Dr J Hinnie 0141 201 8281
Specialist Nurses: Sr Marion Harkness, Sr Angela Collie 0141 201 1769

Ref: MH/MH/1701806541

15-Aug-2014

Dr Brian Kennon
Consultant Physician
Southern General Hospital
1345 Govan Road
GLASGOW
G51 4TF

Dear Dr Kennon,

Lisa Hughes, DOB: 17-Jan-1980
8 Carham Crescent
Glasgow
Lanarkshire
G52 2HN

Chi 1701806541

Thank you for referring this patient for bone densitometry.

She was assessed on 08-Aug-2014.

The following clinical risk factors have been reviewed. These have been taken from the patient's self history questionnaire and treatment recommendations are based on this. The referring clinician should check the accuracy of these details. **Please note a copy of this report will be sent to the patient's general practitioner**

Scan Date: 08-Aug-2014			
Spine			
L2-L4	BMD: 1.268	TScore: 0.566	ZScore: 0.566
Scan Conclusions:			
Normal BMD			
Right Hip			
Neck of femur	BMD: 0.971	TScore: -0.100	ZScore: 0.000
Scan Conclusions:			
Normal BMD			

Osteoporosis Risk Factors
Past hx of fragility fracture(s)
History in past 5 years of smoking

Fracture Risk Factors
History of previous fracture
History in past 5 years of smoking

Fracture History
Rib (Aged 34)

Treatment Recommendations
No treatment required

Lifestyle Recommendations
Advise regular weight-bearing exercise appropriate to general health
Advise to stop smoking

Follow up
No follow up

Yours sincerely

Sister Marion Harkness
Osteoporosis Specialist Nurse

Dr A Gallagher
Consultant Physician

Dr Alison Winter
Consultant Surgeon
Department of Surgery

Clinic: 29/02/12
Dictated: 29/02/12
Typed: 13/03/12

The New Victoria Hospital
Grange Road
Glasgow
G42 9LF

e-mail: amanda.colquhoun@ggc.scot.nhs.uk
e-mail: rosemary.turner@ggc.scot.nhs.uk
Tel: 0141 347 8720

DR LINSEY LC SEMPLE
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr Semple

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485) CHI: 1701806541
8 CARHAM CRESENT, , GLASGOW, G52 2HN

Thank you for your referral of this 32 year old woman to Miss Winter's clinic. She has a 3 to 4 month history of a lump in her axilla. I understand that her bloods were all normal from her GP. There was nothing else. All things seem to have settled. She is not able to feel the lump. There is no past or family history of note.

On examination today there were no masses palpable in her right or left breast. Right axilla was normal. Left axilla had very slight thickening deep in the left axilla. I could not feel any definite lymph nodes. Ultrasound of the left axilla was normal. I therefore reassured her. On discussion of the ultrasound result her mother had come in with her. She said that her daughter has lost weight. I looked at all the blood results and these are all completely normal. Including blood film. I have therefore urged her to see her GP with regard to her weight loss. From a breast point of view and her left axilla everything was normal and I can find no areas of concern.

Yours sincerely

MARY ROUSE
SPECIALTY DOCTOR

REGIONAL MAXILLOFACIAL UNIT
ASSOCIATE SPECIALIST: MRS PATRICIA M FINLAY

Secretary: 0141 232 7602
Fax No: 0141 232 7508
Email: Janice.Findlay2@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

PMF/JF
Clinic: 15/11/11
Typed: 16/11/11

DR LINSEY LC SEMPLE
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr Semple

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485) CHI: 1701806541
8 CARHAM CRESENT, , GLASGOW, G52 2HN

This young lady was fitted with a bite raising appliance today. We will review her in six months to see how she is getting on.

Kind regards

Yours sincerely

Mrs Patricia M Finlay
Associate Specialist in Oral Maxillofacial Surgery

REGIONAL MAXILLOFACIAL UNIT
ASSOCIATE SPECIALIST: MRS PATRICIA M FINLAY

Secretary: 0141 232 7602
Fax No: 0141 232 7508
Email: Janice.Findlay2@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

PMF/JF
Clinic: 18/10/11
Typed: 20/10/11

DR LINSEY LC SEMPLE
CARDONALD MEDICAL CENTRE
~LASGOW
52 3SS

Dear Dr Semple

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485) CHI: 1701806541
8 CARHAM CRESENT, , GLASGOW, G52 2HN

Thank you for referring this patient who complains of a four month history of pain in the right side of the jaw. This is worse at night. It does not seem to stop her eating although she does report that eating causing her some discomfort. On examination she has obvious signs of tooth clenching including crenulations of the tongue and large tender masseters.

I explained the aetiology to her and we have arranged to construct a flexible lower splint, which may help support her jaw during the night and avoid clenching. I hope that we will be able to settle this with simple conservative means.

Kind regards

Yours sincerely

Mrs Patricia M Finlay
Associate Specialist in Oral Maxillofacial Surgery

DIRECTORATE OF OBSTETRICS, GYNAECOLOGY PAEDIATRICS

Dr Stewart Pringle
Dr Robert J S Hawthorn
Dr Marco Gaudoin
Dr Stein Bjornsson
Dr John Tierney
Dr Chris Hardwick
Dr Janice Gibson
Dr Hassan O Mohamed Ali
Dr Joanne Ellison (Locum Consultant)
Dr Sarju Mathew (Locum Consultant)

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Secretary's Tel No: 0141 201 2291
Fax No: 0141 201 2994

e-mail: myra.glass@ggc.scot.nhs.uk

Date Dictated: 10/08/11
Date Typed: 10/08/11
REF: AH/MCG

DR MCCALLUM
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr McCallum

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485) CHI: 1701806541
8 CARHAM CRES, GLASGOW, G52 2HN

Thank you for your letter about this lady.

I can confirm that she had a filshie clip sterilistion on 17th May 2011. We noticed during her operation previous evidence of loop excision and there is no evidence of endometriosis infection.

Yours sincerely

DR HASSAN O MOHAMED ALI
CONSULTANT OBSTETRICIAN GYNAECOLOGIST

DIRECTORATE OF OBSTETRICS, GYNAECOLOGY PAEDIATRICS

Dr Stewart Pringle
Dr Robert J S Hawthorn
Dr Marco Gaudoin
Dr Stein Bjornsson
Dr John Tierney
Dr Chris Hardwick
Dr Janice Gibson
Dr Hassan O Mohamed Ali
Dr Joanne Ellison (Locum Consultant)
Dr Sarju Mathew (Locum Consultant)

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Secretary's Tel No: 0141 201 2291
Fax No: 0141 201 2994

e-mail: myra.glass@ggc.scot.nhs.uk

Date Dictated: 24/05/11
Date Typed: 24/05/11
REF: AH/MCG

DR SEMPLE
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr Semple

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485) CHI: 1701806541
8 CARHAM CRES, GLASGOW, G52 2HN

Lisa had a diagnostic laparoscopy and examination to her cervix in the Day Surgery Unit on 17th May 2011.

She was found to have a normal cervix apart from the evidence of previous loop excision and her pelvis was absolutely normal along with normal tubes and ovaries. There is no evidence of endometriosis or infection. However, I have noticed that her right colon is quite distended and maybe the pain she is having is due to her bowel dysfunction rather than anything gynaecological.

Yours sincerely

DR HASSAN O MOHAMED ALI
CONSULTANT OBSTETRICIAN GYNAECOLOGIST

SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW
G51 4TF
Switchboard: 0141 201 1100

Direct Line: 0141 232 7953/7952/7951/7955/7971/7972

DEPARTMENT OF GYNAECOLOGY

Dr T Dow, Locum	Dr K Spowart
Dr K Hanretty	Dr C Taggart
Dr E Hadoura, Locum	Dr R Panigrahy, Locum
Dr J Richmond	Dr J Roberts
Dr S Pringle	Dr V McKay
Dr C Hardwick	Dr R Hawthorn
Dr A Khaund, Locum	Dr K Guerrero
Dr H Ali	Dr S Bjornsson

DEPARTMENT OF GYNAECOLOGY

Ref: AK/SB/SG0953485
Date: 10/03/2011

Dr Linsey Semple
Cardonald Medical Centre
1831 Paisley Road West
G52 3SS

Dear Dr Semple

Lisa Hughes - 17/01/1980 - CHI: 1701806541
8 Carham Crescent, Glasgow, Lanarkshire, G52 2HN

Thank you for referring this 31 year old para 8 (vaginal deliveries) who requests female sterilisation. She has also been seen recently with left iliac fossa pain which is constant and persistent. I note that pelvic ultrasound recently has been reported as normal. Bowel habit is also normal.

This lady is aware of the alternatives for contraception, including the Mirena coil. She is aware of the risks associated with female sterilisation including its irreversibility, failure rate, risk of ectopic pregnancy and risks of visceral damage/haemorrhage and infection.

Lisa has been listed for diagnostic laparoscopy + female sterilisation as a day case in the near future.

Kind regards.

Yours sincerely

Aradhana Khaund
Consultant Gynaecologist

DEPARTMENT OF OTOLARYNGOLOGY, HEAD AND NECK SURGERY

Ear, Nose and Throat Department
Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

Direct Line: 0141 232 7970
Fax No: 0141 232 7519
Email: yvonne.armstrong@ggc.scot.nhs.uk

Tel: 0141 201 1100
Fax: 0141 201 2999
www.nhsggc.org.uk

Dictated: 20/05/10
Typed: 21/05/10
Our Ref: AH/YAA

Speech Language Therapy
The Voice Team
Victoria Infirmary

Dear Colleague

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485) (1701806541)
8 CARHAM CRES, GLASGOW, G52 2HN

I would be most grateful if you could see this lady who complains of an intermittent dysphonia and a feeling of strain in her voice. She is a mother to eight children and does admit to being under some emotional strain. Ms Clark performed a thyroidectomy last year for a follicular adenoma and she is currently on 200mcg of Thyroxine.

On fibreoptic nasendoscopy today both vocal cords were fully mobile, she had a small bilateral vocal cord nodule at the junction of the anterior third and the posterior two-thirds.

I would be most grateful if you could arrange to see her for further treatment.

Yours sincerely

Anne Hitchings
Consultant ENT Surgeon

cc. Dr Semple, 1831 Paisley Road West, Glasgow, G52 3SS

1345 Govan Road
Glasgow G51 4TF
TEL: 0141-201-1100
FAX: 0141-201-2994

CONSULTANTS
Dr Stewart Pringle
Dr Valerie D Hood
Dr Robert JS Hawthorn
Dr Ian N Ramsay
Dr Janice Gibson
Dr John Tierney
Dr Christopher Hardwick
Dr Marco Gaudoin
Dr Hassan Ali
Dr Stein Bjornsson
SP/JR /CHI No: 1701806541
16/04/10

Dr Pringle's Secretary
Tel: 0141 201 1959
e:mail: june.reid@sgh.scot.nhs.uk

Dr Linsey Semple
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr Semple

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485)
8 CARHAM CRES, , GLASGOW, G52 2HN

Lisa has had two problems one is some pain during sex and the second is irregular vaginal bleeding, which seems to be settling now and I think is very likely to be due to her Depo Provera. I think she should stay on her Depo.

As far as the dyspareunia is concerned it is mostly pubic in origin and slightly variable.

On examination there was some vague lower abdominal tenderness and again on certain movements of the cervix seemed to cause discomfort but there was certainly no cervical excitation or any other signs of pelvic infection. I took a Chlamydia swab and I will write to you both if this is positive. Given that Lisa is on Depo the pelvic organs should be quiescent and I have strongly re-assured her but told her to come back to see me if the problem is not settling down.

Yours sincerely

STEWART PRINGLE
CONSULTANT OBSTETRICIAN AND GYNAECOLOGIST

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Dr. AA Finney
Drs Semple finney and datta
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

Main Switchboard: 0141 201 1100

Date of Completion: 17/06/2014

Email Enquiries to: mary.fay@ggc.scot.nhs.uk
Contact Tel Details: 0141 201 1782

Dictated: 13/06/2014
Transcribed: 16/06/2014

Dear Dr. AA Finney,

Patient

Name:	Hughes Lisa Rosemary
CHI:	1701806541
DOB:	17/01/1980
Address:	8 Carham Crescent
	Glasgow
	G52 2HN

Admission

Admitted:	05/06/2014 14:54
Discharged:	07/06/2014 16:00
Admission Type:	In Patient
Discharge to:	Private Residence - no additional detail added
Consultant:	Dr Brian Kennon
Specialty:	General Medicine

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

Diagnosis

Diagnosis	Code
Fracture of rib, closed	S22.30
Unspecified acute lower respiratory infection	J22.X

Clinical Comments:

The above patient was admitted on5/6/14 with increased SOB, wheeze and cough. There was a history of nocturnal cough and some anterior chest pain. On examination chest was clear with good air entry and no wheeze audible. CXR and ECG were unremarkable. D-dimer was negative. Inflammatory markers were elevated. Dalteparin was started before CTPA showed no evidence of PTE. It also demonstrated a recent fracture of the posterolateral left 7th rib which is likely the source

of chest pain on inspiration. She was started on antibiotics which should be continued for a further 5 days. We have started a step 2 inhaler (clenil modulite 200mcg). She is now fit for discharge with analgesia. We will arrange for an outpatient DEXA and isotope bone scan to be performed since there is no history of trauma to the ribs. We have sent blood for vitamin D and calcium levels today. Many thanks. Kind regards,

See IDL comments for details of admission.

Yours sincerely

Andrew Kernohan
Consultant Physician

Follow-up arranged: none

Electronically Signed: Dr Andrew Kernohan, Consultant

cc.

Hughes Lisa Rosemary CHI: 1701806541

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100
Date of Completion: 07/06/2014

Dr. AA Finney
Drs Semple finney and datta
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Dear Dr AA Finney,

Name	CHI	DoB	Address
Lisa Rosemary Hughes	1701806541	17/01/1980	8 Carham Crescent Glasgow G52 2HN

Admitted	Type	Discharged	Destination
05/06/2014 14:54	In Patient	07/06/2014	Private Residence - no additional detail added

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Brian Kennon	SGH Ward 1 - General Medicine	0141 201 1631

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: The above patient was admitted on5/6/14 with increased SOB, wheeze and cough. There was a history of nocturnal cough and some anterior chest pain. On examination chest was clear with good air entry and no wheeze audible. CXR and ECG were unremarkable. D-dimer was negative. Inflammatory markers were elevated. Dalteparin was started before CTPA showed no evidence of PTE. It also demonstrated a recent fracture of the posterolateral left 7th rib which is likely the source of chest pain on inspiration. She was started on antibiotics which should be continued for a further 5 days. We have started a step 2 inhaler (clenil modulite 200mcg). She is now fit for discharge with analgesia. We will arrange for an outpatient DEXA and isotope bone scan to be performed since there is no history of trauma to the ribs. We have sent blood for vitamin D and calcium levels today. Many thanks. Kind regards,

Dr Finn Begbie
FY1 Medicine

Treatments: None recorded.

Follow-up arranged: none

Planned Outpatient Investigations: DEXA, bone isotope scan

Final Discharge letter to follow: yes

Medication Info:

Allergies: No Allergy

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Amoxicillin Capsules	Oral	500	mg	THREE Times a Day	5 Days	disp
Citalopram Tablets	Oral	20	mg	ONCE a Day	Indefinite	POD
Clenil Modulite Inhaler (Beclometasone) 200micrograms/ puff	Inhaled	1	puff(s)	TWICE a day	Indefinite	disp
Co-codamol 30/500 Tablets	Oral	2	tablet(s)	FOUR Times a Day	2 Weeks	disp[
Diazepam Tablet	Oral	5	mg	THREE Times a Day	Indefinite	POD
Levothyroxine Tablets	Oral	200	micrograms	ONCE a Day	Indefinite	POD
Olanzapine Tablets	Oral	10	mg	At Night	Indefinite	POD
Salbutamol 200micrograms/metered dose Dry Powder Breath Actuated Inhaler	Inhaled	2	dose(s)	As Required	Indefinite	POD

New Medication Started: CLENIL MODULITE, CO-CODAMOL AND AMOXICILLIN

Medication Comment: No other changes to regular medicines

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Finn Begbie
Doctor

Prescription Review

Medications Reviewed by Pharmacist: Dominique Sweeney, Pharmacist
Dispensed Medications Checked by Pharmacy: Dominique Sweeney, Pharmacist
Nurse discharging patient: Anne Robertson, Nurse

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW, G51 4TF
TEL: 0141 201 1100

CLINICAL DECISION UNIT DISCHARGE LETTER

PATIENT: LISA ROSEMARY HUGHES
8 CARHAM CRESENT

GLASGOW
G52 2HN

DOB: 17/01/80
CHI: 1701806541
UNIT NO: SG00953485
ACCT NO: WA0003341/12
WARD: SCDUWA

GP: LINSEY LC SEMPLE
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

CONSULTANT: ANDREW KERNOHAN
ADMITTED:

ADMISSION TYPE: Ward Attender
DISCHARGE TO: HOME

ADMIT DATE:
DISCHARGE DATE: 14/03/12

PRESENTATION: SWOLLEN RIGHT LEG

DISCHARGING CONSULTANT: KERAN

MAIN DIAGNOSIS: ? PES ANSERINUS BURSITIS

OTHER DIAGNOSIS:NIL

FURTHER INFO: 2WEEK H/O PAIN SWELLING OF LEFT KNEE AND CALF, UNRELIEVED BY ANALGESIA, PAIN EXACERBATED BY DAILY ROUTINE EXERCISE.

INVESTIGATIONS: ROUTINE BLOODS
DDIMER
DOPPLER SCAN

INTERVENTIONS: NIL

REPORTS/UPDATE: DOPPLER SCAN PERFORMED X2 - 1 WEEK APART. BOTH -ve FOR DVT
NIL ACUTE ON EXAMINATION
HISTORY AND FEATURES IN KEEPING WITH MSK STRAIN.
D/C HOME WITH APPROPRIATE ADVICE

REPORTS TO BE TRACKED? Y

OP TESTS:

LETTER TO FOLLOW:

COMPLIANCE AID: N

DISCONTINUED DRUGS? N

NEW MEDICATION? N

MEDICATION COMMENTS: NO MEDICATION CHANGES

ALLERGIES: NKDA

FOLLOWUP? N DETAIL:

TIMESCALE:

SIGNED: NU.ROYDE ROY,DEREK
DESIGNATION: MED NURSE PRACTITIONER

PAGE NUMBER: 7614

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW, G51 4TF
TEL: 0141 201 1100

WARD 20 DISCHARGE LETTER

PATIENT: LISA ROSEMARY HUGHES
8 CARHAM CRES

GLASGOW
G52 2HN

DOB: 17/01/80
CHI: 1701806541
UNIT NO: SG00953485
ACCT NO: IP0021875/11
WARD: SCDU

GP: LINSEY LC SEMPLE
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

CONSULTANT: KEVIN BLYTH
ADMITTED: 25/04/11

ADMISSION TYPE: AE - Referral
DISCHARGE TO: HOME

ADMIT DATE: 25/04/11
DISCHARGE DATE: 26/04/11

PRESENTATION: OD

DISCHARGING CONSULTANT: SEMCO

MAIN DIAGNOSIS:

OTHER DIAGNOSIS:

FURTHER INFO: ADMITTED WTIH OVERDOSE OF OLANZAPINE AND DIAZEPAM. OBSERVED FOR 48 HOURS WITH NEUROLOGICAL OBSERVATIONS. SEEN BY LIAISON PSYCHIATRY, FIT FOR HOME.

INVESTIGATIONS:

INTERVENTIONS:

REPORTS/UPDATE: NO ADDITIONAL INFORMATION IS LIKELY TO BE FORTHCOMING.

YOURS SINCERELY

COLIN SEMPLE
CONSULTANT PHYSICIAN

REPORTS TO BE TRACKED? N

OP TESTS:

LETTER TO FOLLOW: N

COMPLIANCE AID: N

ISCONTINUED DRUGS? N

NEW MEDICATION? N

MEDICATION COMMENTS:

ALLERGIES:

FOLLOWUP? N DETAIL:

TIMESCALE:

SIGNED: FY1.MINSA MCMINN,SARAH
DESIGNATION: FOUNDATION DR YEAR 1

PAGE NUMBER: 7025

Letter to Patient:

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Lisa Hughes
2 LANGSTILE ROAD
Glasgow
Lanarkshire
G52 4AG

Main Switchboard:	0141 201 1100
Department:	Neurology
Contact Tel:	0141 232 7542
Enquiries to:	Lynn Douglas
Letter Date:	13/01/2026
Reference:	GG/LD
Dictated Date:	18/11/2025
Transcribed Date:	06/01/2026

Dear Lisa,

I now have the repeat scan of your brain. Importantly on the scan, there is no evidence of brain tumour.

Yours sincerely,

Dr George Gorrie

Consultant Neurologist

Electronically Signed: Dr George Gorrie, Consultant

cc. GP - sent electronically

Letter to Patient: Results Letter

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100
Department: Acute Medicine
Contact Tel: 0141 452 2322
Enquiries to: ggc.qeuhiausecretaries@ggc.scot.nhs.uk

Letter Date: 14/02/2024
Reference: CMcN/LC
Dictated Date: 13/02/2024
Transcribed Date: 14/02/2024

Lisa Hughes
8 Carham Crescent
Glasgow
Lanarkshire
G52 2HN

Dear Miss Hughes,

Many thanks for attending your outpatient MRI head that was requested as part of your assessment in our Same Day Urgent Care Centre on 03/01/2024. The MRI head was to further characterise areas of hypoattenuation that were present on your CT of your head on 04/01/2024. Results of this MRI show that the brain parenchyma (tissue) is normal for age. These areas of abnormalities are non-specific and do not have a classical feature of neuro-inflammation. This is reassuring. You still have evidence of sinusitis on your MRI head. Should this become more problematic or become a chronic problem, then your GP may wish to refer you to ENT for further evaluation. Further follow up from the Acute Medical service is no longer required at this stage.

Kind regards.

Yours sincerely,

Dr Christopher McNally

Consultant Physician in Acute Medicine

Electronically Signed: Dr Christopher McNally, Consultant

cc.

Letter to Patient: RESULTS

NHS
Greater Glasgow and Clyde

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

Lisa Hughes
8 Carham Crescent
Glasgow
Lanarkshire
G52 2HN

Main Switchboard: 0141 201 1100
Department: GENERAL MEDICINE
Contact Tel: 0141 201 1782
Enquiries to: mary.fay@ggc.scot.nhs.uk
Letter Date: 12/09/2014
Reference: AK/MGF
Dictated Date: 04/09/2014
Transcribed Date: 09/09/2014

Dear Mrs Hughes,

Further to your attendance for a bone scan I have the results. I am pleased to report that your bone mineral density was normal.

Yours sincerely

Andrew Kernohan
Consultant Physician

Electronically Signed: Dr Andrew Kernohan, Consultant

cc. Dr Finney
Cardonald Medical Centre
1831 Paisley Road West
Glasgow G52 3SS

Case No 7654253 **Case Active** 11/06/2025 21:38 **Case Type** Direct Referral ED

Patient Lisa Hughes **Sex** F **D.O.B** 17/01/1980 **Age** 45 years

Current Address
Capability Scotland Wallace Court 191 Main Road
Elderslie Johnstone

PA5 9ES

Home Address (if currently not at home)
2 Langstile Road Glasgow

G52 4AG

Current Phone: 07858 379780 **Home Phone:** **CHI:** 1701806541

Case Origin **Callers Name** Lisa **Callers Tel:**

Own Doctor Datta,Julia(424)
Surgery Drs Datta & Partners

NHS24 Received By Seyi Ogunbusola (Call Taker Si) ()
NHS24 Triage By Seyi Ogunbusola (Call Taker Si) ()
NHS24 Reported Condition
CHEST PAIN - 3 DAYS

NHS24 Triage Start 21:42
NHS24 Triage End 22:05
NHS24 Outcome AEP

NHS24 Recorded Allergies **NHS24 Recorded Medications** **NHS24 Recorded Medical History**

NHS24 Clinical Summary
Clinical summary created by: Seyi Ogunbusola (Call Taker Si) () [11/06/2025 23:08:02]
Reason for call: CHEST PAIN - 3 DAYS
11:06:2025 21:42:15 OGUNBUSOLAS.. LEFT SIDE NUMBNESS, IN ARM, PRESSURE ON SHOULDER. FEELS LIKE HEART GOING FAST SOMETIMES... PT FEELS CHEST PAIN IS TAKING HER BREATHE AWAY SOMETIMES.. PT IS SWEATY.. PT ADVISED TO GO TO ROYAL ALEXANDER HOSPITAL A&E..
11:06:2025 22:03:55 MUKANZUL.. CHEST PAINS RADIATING TO ARM AND NECK WITH SOB AND PALPITATIONS, NUMBNESS IN LEFT ARM, LEFT ARM FEELS HEAVIER, PAIN IN THE MIDDLE FINGER X 3 WHEN SHE MAKES AFIST, FEELING SWEATY MOST OF THE DAY, HAS HAD CHEST PAINS X 3 DAYS,.. BUT HAVE WORSENED TODAY, ADVISED A&E ASAP/1HR..
Outcome: Patient advised to go to A&E

NHS24 Disposition
Accident & Emergency (ASAP)

NHS24 NUrse Comments

Reported Condition **Received By** **Received**

TAS Assessment **Assessed By** **TAS Assess Start** **TAS Assess End**

Consultation **Consult By** **Consult Start** **Consult End**

Examination Details **Clinical Codes**

Diagnosis

Treatment

Prescriptions

Follow-up(s)

Case No 7562554 **Case Active** 23/02/2025 23:40 **Case Type** Direct Referral ED

Patient Lisa Hughes **Sex** F **D.O.B** 17/01/1980 **Age** 45 years
Current Address
2 Langstile Road Glasgow

Home Address (if currently not at home)

G52 4AG
Current Phone: 07858 379780 **Home Phone:** **CHI:** 1701806541

Case Origin **Callers Name** Lisa **Callers Tel:**

Own Doctor Datta,Julia(424)
Surgery Drs Datta & Partners

NHS24 Received By Norma Jane Ferguson (Call Taker Si) () **NHS24 Triage Start** 23:40
NHS24 Triage By Norma Jane Ferguson (Call Taker Si) () **NHS24 Triage End** 00:03
NHS24 Reported Condition **NHS24 Outcome** AEP
HEAD INJURY-5 HOURS

NHS24 Recorded Allergies **NHS24 Recorded Medications** **NHS24 Recorded Medical History**

NHS24 Clinical Summary
Clinical summary created by: Norma Jane Ferguson (Call Taker Si) () [24/02/2025 00:04:45]
Reason for call: HEAD INJURY-5 HOURS
23:02:2025 23:42:06 FERGUSONN3.. STRUCK ON HEAD WITH A HARD OBJECT-5 HOURS. PUNCTURE WOUND TO HEAD. HEAD PAIN. SHAKEY. POLICE ARRANGED AMBULANCE BUT PATIENT DID NOT WANT TO WAIT.. ADVISED TO ATTEND QEUH A&E ASAP..
24:02:2025 00:00:05 MCKENNAE5.. HEAD INJURY 5 HRS AGO.WAS ASSAULTED AND HIT WITH A HARD OBJECT TO HEAD. WAS OFFERED AN AMBULANCE BY POLICE BUT TOO LONG TO WAIT ... ON LYING DOWN PATIENT FELT HEAD THROBBING TO SITE AND TO BOTH SIDES. VISION . NP NAUSEA OR DIZZINESS. PARACETAMOL 2 HRS AGO NIL EFFECT . FEELS SHAKING TOP HALF OF BODY.. FELL TO FLOOR. AND LOC AT THE TIME . DISCUSSED AN AMBULANCE . PATIENT WILL ATTEND A&E BY TAXI A&E ASAP. STRONG WORSENING..
Outcome: Patient advised to go to A&E

NHS24 Disposition
Accident & Emergency (ASAP)

NHS24 NUrse Comments

Reported Condition **Received By** **Received**

TAS Assessment **Assessed By** **TAS Assess Start**
TAS Assess End

Consultation **Consult By** **Consult Start**
Consult End

Examination Details **Clinical Codes**

Diagnosis

Treatment

Prescriptions

Follow-up(s)

Case No 7461009 **Case Active** 02/11/2024 14:17 **Case Type** ED Telephone / Remote Consultation

Patient Lisa Hughes **Sex** F **D.O.B** 17/01/1980 **Age** 44 years

Current Address
2 Langstile Road Glasgow

G52 4AG

Current Phone: 07858 379780 **Home Phone:** **CHI:** 1701806541

Case Origin **Callers Name** Lisa **Callers Tel:**

Own Doctor Datta,Julia(424)
Surgery Drs Datta & Partners

NHS24 Received By Heather Cunningham (Call Taker Si) () **NHS24 Triage Start** 14:18
NHS24 Triage By Heather Cunningham (Call Taker Si) () **NHS24 Triage End** 14:49
NHS24 Reported Condition **NHS24 Outcome** AED4
RIB PAIN - 17 HOURS

NHS24 Recorded Allergies **NHS24 Recorded Medications** **NHS24 Recorded Medical History**

NHS24 Clinical Summary
Clinical summary created by: Heather Cunningham (Call Taker Si) () [02/11/2024 14:49:44]
Reason for call: RIB PAIN - 17 HOURSConfirmed Symptom(s):
Pain in upper back
Rib pain and/or painful to touch

Symptom(s) not found:
No current fever

Risk Factor(s):
No travel outside Europe in last 21 days or to an affected country

Call Detail(s):

02:11:2024 14:18:02 CUNNINGHAMH.. INCIDIENT LAST NIGHT. FELL OVER. SLIPPED ON PAVEMENT. WHOLE WEIGHT WENT IN TO SIDE OF METAL ROAD BARRIER. BREATHING OK. PAIN EXCRUCIATING... ?BROKEN BONE. BRUISING ON HIP, PAIN ABOVE THIS JUST BELOW BRA LINE. LOOKS RED IN COLOUR. FEELS NO SENSATION WHEN TOUCHED. WHEN APPLYING ICE PACK ON BACK HAD NO SENSATION... PAIN IN BACK AT LEFT HAND SIDE.. MORE AWARE OF PAIN WHEN BREATHING IN.. DW CS L MORTON. RIB AREA NUMBNESS, SWOLLEN AND BRUISED. TALKING IN SENTENCES. TAKING ANALGESIA. A&E SPEAK TO CLINICIAN 4...
Outcome: Speak to clinician within 4 Hrs

NHS24 Disposition
Accident & Emergency /.MIU within 4 Hours

NHS24 NUrse Comments

Reported Condition **Received By** **Received**

TAS Assessment **Assessed By** **TAS Assess Start** **TAS Assess End**

Consultation **Consult By** **Consult Start** **Consult End**

Examination Details **Clinical Codes**

Case No 7461009 **Case Active** 02/11/2024 14:17 **Case Type** ED Telephone / Remote Consultation

Diagnosis

Treatment

Prescriptions

Follow-up(s)

Neurology - Headache
1345 Govan Road
Glasgow
G51 4TF

28/06/2024

Dr A Hall
Drs Datta & Partners
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Dear Dr A Hall

Patient Name: Lisa Rosemary Hughes
CHI Number: 1701806541
Referral Date: 24/06/2024

Thank you for your referral. On this occasion I am unable to offer a consultation to your patient.

Please see the following reasons.

( ) Please refer to the referral guidance directory for referral criteria for this service.

https://www.nhsggc.scot/hospitals-services/services-a-to-z/referral-guidelines/

( ) Insufficient clinical information to allow specialty to triage this referral.

Enter free text here

( ) Other

If hx fits with chronic migraine you could trial candesartan and then atogepant 60mg per day. Ensure BP checked on later drug. Yes advise limiting triptan to 10 days per month, additional use of NSAID if she can tolerate one and anti emetic for abortive measures if significant nausea.
Enter free text here

Yours sincerely

Dr George Gorrie

User ID George Gorrie

SCGC Opwl Rem Ref Hosp Req V1

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments
Neurology - 29042024_Referral_761674

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Neurology - Headache GGC General Referral or Advice	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral Advice
Date of referral 23-Jun-2024 **Date sent** 23-Jun-2024

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541
Area of Residence	-

Patient's address
2 Langstile Road
GLASGOW
G52 4AG

Contact number(s)
Voice: 07858379780

1010334263104 Unique Care Pathway Number: 1010334263104

REGISTERED GP DETAILS

Name	Dr Julia Datta		
GMC code	4761778	GP code	04766
Practice name	Cardonald Medical Centre (18974)		
Practice code	52414		

Practice address
1831
Paisley Road West
Cardonald
Glasgow
G52 3SS

Contact number(s)
Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Amy Hall		
GMC code	7495632	GP code	99999
Practice name	Drs Datta & Partners (52414)		
Practice code	52414		

Practice address
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Contact number(s)

Voice: 0141 892 2548

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: advice on medication whilst awaiting appt

Comment: Dear Colleague

Further to my referral from April this lady continues to be struggling with episodic severe headaches and she continues to worry regarding diagnosis given previous nonspecific MRI findings. I have so far trialled her on amitryptilline, propranolol and topiramate to no avail either due to intolerable side effects or making no difference in frequency or severity of episodes. I wonder if you would suggest we trial anything different in the meantime? I am worried regarding overuse headaches with sumatriptan which she does find helpful but is using 6-12 per month at present. NSAIDs have been mildly beneficial acutely also.

Otherwise I wonder if her review needs expedited but I know this unlikely easily accommodated with wait times.

Your advice in the meantime would be appreciated

Regards
Dr A Hall

Reason for referral

Care type requested: Out Patient

Expected outcome: Advise

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
[X]Deliberate drug overdose / other poisoning	-	13-Oct-2015	13-Oct-2015
Asthma	-	18-Jul-2014	18-Jul-2014
Closed fracture rib	-	13-Jun-2014	13-Jun-2014
Acute lower respiratory tract infection	-	13-Jun-2014	13-Jun-2014
Personality disorder NOS	Emotionally unstable personality disorder	14-May-2012	14-May-2012
[X]Deliberate drug overdose / other poisoning	Olanzapine, Diazepam amd alchololStart Date: 24/04/2011	18-May-2011	18-May-2011
Cause of overdose - deliberate	Olanzapine & Alcohol	25-Apr-2011	25-Apr-2011
Poisoning - self-inflicted	deliberate	24-Apr-2011	24-Apr-2011
Cause of overdose - deliberate	-	31-Mar-2011	31-Mar-2011
Autoimmune thyroiditis	-	25-Jun-2009	25-Jun-2009
Nontoxic multinodular goitre	-	29-Aug-2008	29-Aug-2008
Asthma resolved	Attack 1995	12-Dec-2005	12-Dec-2005
Head injury	was assaulted	27-Sep-1997	27-Sep-1997
[X]Overdose - paracetamol	-	23-Apr-1994	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
DEXA - Dual energy X-ray photon absorptiometry	Normal	15-Aug-2014	15-Aug-2014
Laparoscopic bilateral female sterilisation	-	21-Mar-2012	21-Mar-2012
Thyroidectomy operations	-	08-Jun-2009	08-Jun-2009
CIN III - severe dyskaryosis	+ HPV	26-May-2004	26-May-2004

Family conditions (All priorities)

Description	Date of Onset
FH: Ischaemic heart dis. >60	28-Aug-2013

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started

						Date last issued
Clenil Modulite Cfc-free inhaler 100 micrograms/actuation	2	2 INHALER	TWO PUFFS TO BE INHALED TWICE A DAY	-	16-Dec-2020	09-Apr-2024
Olanzapine Tablets 10 mg	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	04-Sep-2018	09-Apr-2024
Salbutamol Cfc-free inhaler 100 micrograms/puff	2	2 inhaler	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	24-Sep-2015	09-Apr-2024
Levothyroxine Sodium Tablets 100 micrograms	56	56 TABLET	2 TABS IN THE MORNING	-	04-Oct-2011	17-Jun-2024

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Fluticasone Propionate And Azelastine Nasal spray 50 micrograms/dose + 137 micrograms/dose	120	120 dose	USE TWO SPRAYS TO NOSTRILS ONCE DAILY AFTER SALTWATER SPRAY	-	17-Jun-2024	17-Jun-2024
Sterimar Isotonic Nasal Spray 31.8 %	50	50 ml	USE TWICE DAILY TO EACH NOSTRIL EACH DAY BEFORE STEROID SPRAYS	-	17-Jun-2024	17-Jun-2024
Topiramate Tablets 25 mg	30	30 TABLET	ONE TABLET ONCE DAILY - REVIEW TO INCREASE AFTER 3-4 WEEKS	-	05-Jun-2024	05-Jun-2024
Ibuprofen Gel 5 %	50	50 GRAM (S)	APPLY TO THE AFFECTED AREA UP TO THREE TIMES A DAY	-	05-Jun-2024	05-Jun-2024
Mometasone Furoate Nasal spray 50 micrograms/dose	1	1 bottle	TWO SPRAYS EACH NOSTRIL TWICE A DAY	-	22-Apr-2024	22-Apr-2024
Topiramate Tablets 25 mg	30	30 TABLET	ONE TABLET ONCE DAILY - REVIEW TO INCREASE AFTER 3-4 WEEKS	-	22-Apr-2024	22-Apr-2024
Citalopram Hydrobromide Tablets 20 mg	56	56 tablet	TWO TO BE TAKEN EACH DAY (40MG)	-	10-Apr-2024	10-Apr-2024
Diazepam Tablets 2 mg	14	14 TABLET	ONE TO BE TAKEN UP TO TWICE A DAY	-	12-Feb-2024	12-Feb-2024
Doxycycline Hyclate Capsules 100 mg	11	11 capsule	TWO TO BE TAKEN ON THE FIRST DAY THEN ONE TO BE TAKEN EACH DAY FOR A FURTHER 9 DAYS	-	08-Feb-2024	08-Feb-2024
Mometasone Furoate Nasal spray 50 micrograms/dose	1	1 bottle	TWO SPRAYS EACH NOSTRIL TWICE A DAY	-	08-Feb-2024	08-Feb-2024
Diazepam Tablets 2 mg	21	21 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	25-Jan-2024	19-Feb-2024
Sumatriptan Succinate Tablets 50 mg	6	6 TABLET	ONE TO BE TAKEN AS DIRECTED WHEN REQUIRED	-	25-Jan-2024	28-May-2024
Citalopram Hydrobromide Tablets 20 mg	56	56 tablet	TWO TO BE TAKEN EACH DAY (40MG)	-	11-Jan-2024	11-Jan-2024

Aspirin Dispersible tablets 300 mg	32	32 TABLET	ONE OR TWO TO BE TAKEN EVERY 4 TO 6 HOURS WHEN REQUIRED	-	11-Jan-2024	11-Jan-2024
Omeprazole Capsules (Gastro-Resistant) 20 mg	28	28 capsule	ONE TO BE TAKEN EACH MORNING	-	11-Jan-2024	11-Jan-2024
Propranolol Hydrochloride Tablets 40 mg	84	84 TABLET	ONE TO BE TAKEN UP TO THREE TIMES A DAY	-	04-Jan-2024	10-Apr-2024
Levothyroxine Sodium Tablets 25 micrograms	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	16-May-2018	09-Apr-2024
Levothyroxine Sodium Tablets 50 micrograms	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	16-May-2018	09-Apr-2024

Blood Pressure

Date Recorded	Systolic	Diastolic
05-Jun-2024	127	79
03-Jan-2024	139	90
21-Aug-2023	124	81
01-Nov-2021	112	82
01-Dec-2020	120	80

Body Measurements

Date Recorded	Height	Weight	BMI
01-Nov-2021	164	70	26.03
01-Dec-2020	164	60	-
26-Sep-2019	164	58	21.56
28-Feb-2019	164	54	-
24-May-2017	164	63.5	23.61

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex-cigarette smoker, 20 cigs/day (past):		01-Nov-2021
Smoker 12 Cigarettes/day :		17-May-2021
Cigarette smoker, 15 Cigarettes/day:		28-Feb-2019
Smoker :		30-Nov-2017
Current smoker:		26-May-2015
Alcohol consumption, 40 units/week:		01-Nov-2021
Alcohol consumption, 1 units/week:		28-Feb-2019
Alcohol consumption, 1 units/week:		28-Aug-2013
Alcohol consumption, 1 units/week:		24-Jul-2012
Teetotaller:	Alcohol Intake$$.clm - No Action Required	01-Feb-2005
Aerobic exercise 3+ times/week:		01-Nov-2021
Aerobic exercise 2 times/week:		28-Feb-2019
Aerobic exercise 0 times/week:		28-Aug-2013
Aerobic exercise 2 times/week:		24-Jul-2012

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Referred By:Referring GP
Electronic Attachment Present:Yes

Social circumstances
Ethnic Origin: (White) British

Neurology - 29042024 Referral 761674

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Neurology - Headache GGC General Referral or Advice	—	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	—	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral	Urgent		
Date of referral	29-Apr-2024	**Date sent**	29-Apr-2024

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541
Area of Residence	-

Patient's address

2 Langstile Road
GLASGOW
G52 4AG

Contact number(s)

Voice: 07858379780

101032891780E

Unique Care Pathway Number: 101032891780E

REGISTERED GP DETAILS

Name	Dr Julia Datta		
GMC code	4761778	GP code	04766
Practice name	Cardonald Medical Centre (18974)		
Practice code	52414		

Practice address

1831
Paisley Road West
Cardonald
Glasgow
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Amy Hall		
GMC code	7495632	GP code	99999
Practice name	Drs Datta & Partners (52414)		
Practice code	52414		

Practice address

Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Contact number(s)

Voice: 0141 892 2548

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: worsening headaches with recent no specific changes on MRI ?possibility of MS

Comment: Dear Colleague

I refer this 44 year old lady who is suffering from worsening/severe generalised headaches since the beginning of January - initially reviewed by acute medicine ?SAH which showed 3 foci of illdefined hypoattenuation in periverntricular white matter on CT and sinus disease on MRI

She is still struggling with severe episodic headaches multiple times a week helped marginally by sumatriptan at the time and quiet rest but no better despite treatment for sinus issues or migraine prophylaxis propranolol and now topiramate (couldn't tolerate amitryptilline)

She tells me she is also suffering from overwhelming malaise and fatigue which she had put down to being stressed/anxious,but she is wondering whether after reading up on symptoms could be related to MS?

Her MRI/CT results seemed vague from the report and not obvious for demyelination and I felt this presentation more related to uncontrolled migraines but I would appreciate your opinion not being a specialist.

She has had an optician check with no optic neuritis and no limb changes but will continue to monitor and treat as migraines in the interim

Best
Dr A Hall

Reason for referral

Care type requested: Out Patient

Expected outcome: Investigate

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
[X]Deliberate drug overdose / other poisoning	-	13-Oct-2015	13-Oct-2015
Asthma	-	18-Jul-2014	18-Jul-2014
Closed fracture rib	-	13-Jun-2014	13-Jun-2014
Acute lower respiratory tract infection	-	13-Jun-2014	13-Jun-2014
Personality disorder NOS	Emotionally unstable personality disorder	14-May-2012	14-May-2012
[X]Deliberate drug overdose / other poisoning	Olanzapine, Diazepam amd alchololStart Date: 24/04/2011	18-May-2011	18-May-2011
Cause of overdose - deliberate	Olanzapine & Alcohol	25-Apr-2011	25-Apr-2011
Poisoning - self-inflicted	deliberate	24-Apr-2011	24-Apr-2011
Cause of overdose - deliberate	-	31-Mar-2011	31-Mar-2011
Autoimmune thyroiditis	-	25-Jun-2009	25-Jun-2009
Nontoxic multinodular goitre	-	29-Aug-2008	29-Aug-2008
Asthma resolved	Attack 1995	12-Dec-2005	12-Dec-2005
Head injury	was assaulted	27-Sep-1997	27-Sep-1997
[X]Overdose - paracetamol	-	23-Apr-1994	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
DEXA - Dual energy X-ray photon absorptiometry	Normal	15-Aug-2014	15-Aug-2014
Laparoscopic bilateral female sterilisation	-	21-Mar-2012	21-Mar-2012
Thyroidectomy operations	-	08-Jun-2009	08-Jun-2009
CIN III - severe dyskaryosis	+ HPV	26-May-2004	26-May-2004

Family conditions (All priorities)

Description	Date of Onset
FH: Ischaemic heart dis. >60	28-Aug-2013

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Clenil Modulite Cfc-free inhaler 100 micrograms/actuation	2	2 INHALER	TWO PUFFS TO BE INHALED TWICE A DAY	-	16-Dec-2020	09-Apr-2024
Olanzapine Tablets 10 mg	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	04-Sep-2018	09-Apr-2024
Levothyroxine Sodium Tablets 25 micrograms	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	16-May-2018	09-Apr-2024
Levothyroxine Sodium Tablets 50 micrograms	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	16-May-2018	09-Apr-2024
Salbutamol Cfc-free inhaler 100 micrograms/puff	2	2 inhaler	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	24-Sep-2015	09-Apr-2024
Levothyroxine Sodium Tablets 100 micrograms	28	28 TABLET	1 TABS IN THE MORNING	-	04-Oct-2011	09-Apr-2024

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Mometasone Furoate Nasal spray 50 micrograms/dose	1	1 bottle	TWO SPRAYS EACH NOSTRIL TWICE A DAY	-	22-Apr-2024	22-Apr-2024
Topiramate Tablets 25 mg	30	30 TABLET	ONE TABLET ONCE DAILY - REVIEW TO INCREASE AFTER 3-4 WEEKS	-	22-Apr-2024	22-Apr-2024
Citalopram Hydrobromide Tablets 20 mg	56	56 tablet	TWO TO BE TAKEN EACH DAY (40MG)	-	10-Apr-2024	10-Apr-2024
Diazepam Tablets 2 mg	14	14 TABLET	ONE TO BE TAKEN UP TO TWICE A DAY	-	12-Feb-2024	12-Feb-2024
Doxycycline Hyclate Capsules 100 mg	11	11 capsule	TWO TO BE TAKEN ON THE FIRST DAY THEN ONE TO BE TAKEN EACH DAY FOR A FURTHER 9 DAYS	-	08-Feb-2024	08-Feb-2024
Mometasone Furoate Nasal spray 50 micrograms/dose	1	1 bottle	TWO SPRAYS EACH NOSTRIL TWICE A DAY	-	08-Feb-2024	08-Feb-2024
Diazepam Tablets 2 mg	21	21 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	25-Jan-2024	19-Feb-2024
Sumatriptan Succinate Tablets 50 mg	6	6 TABLET	ONE TO BE TAKEN AS DIRECTED WHEN REQUIRED	-	25-Jan-2024	15-Apr-2024
Citalopram Hydrobromide Tablets 20 mg	56	56 tablet	TWO TO BE TAKEN EACH DAY (40MG)	-	11-Jan-2024	11-Jan-2024
Aspirin Dispersible tablets 300 mg	32	32 TABLET	ONE OR TWO TO BE TAKEN EVERY 4 TO 6 HOURS WHEN REQUIRED	-	11-Jan-2024	11-Jan-2024
Omeprazole Capsules (Gastro-Resistant) 20 mg	28	28 capsule	ONE TO BE TAKEN EACH MORNING	-	11-Jan-2024	11-Jan-2024
Propranolol Hydrochloride Tablets 40 mg	56	56 tablet	ONE TO BE TAKEN UP TO THREE TIMES A DAY AS REQUIRED	-	04-Jan-2024	04-Jan-2024
	84	84 TABLET		-	04-Jan-2024	

Propranolol Hydrochloride Tablets 40 mg			ONE TO BE TAKEN UP TO THREE TIMES A DAY			10-Apr-2024
Naproxen Tablets 500 mg	56	56 tablet	ONE TO BE TAKEN TWICE A DAY	-	04-Jan-2024	04-Jan-2024
Hyoscine Butylbromide Tablets 10 mg	100	100 tablet	TAKE TWO TABLETS UP TO FOUR TIMES A DAY AS REQUIRED	-	13-Nov-2023	13-Nov-2023
Ispaghula Husk Sugar and Gluten Free Effervescent granules 3.5 grams/sachet	120	120 SACHET	THE CONTENTS OF ONE SACHET TO BE TAKEN TWICE A DAY	-	13-Nov-2023	13-Nov-2023
Citalopram Hydrobromide Tablets 20 mg	28	28 TABLET	ONE TO BE TAKEN EACH DAY.	-	04-Sep-2018	22-Nov-2023

Blood Pressure

Date Recorded	Systolic	Diastolic
03-Jan-2024	139	90
21-Aug-2023	124	81
01-Nov-2021	112	82
01-Dec-2020	120	80
26-Sep-2019	135	80

Body Measurements

Date Recorded	Height	Weight	BMI
01-Nov-2021	164	70	26.03
01-Dec-2020	164	60	-
26-Sep-2019	164	58	21.56
28-Feb-2019	164	54	-
24-May-2017	164	63.5	23.61

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex-cigarette smoker, 20 cigs/day (past):		01-Nov-2021
Smoker 12 Cigarettes/day :		17-May-2021
Cigarette smoker, 15 Cigarettes/day:		28-Feb-2019
Smoker :		30-Nov-2017
Current smoker:		26-May-2015
Alcohol consumption, 40 units/week:		01-Nov-2021
Alcohol consumption, 1 units/week:		28-Feb-2019
Alcohol consumption, 1 units/week:		28-Aug-2013
Alcohol consumption, 1 units/week:		24-Jul-2012
Teetotaller:	Alcohol Intake$$.clm - No Action Required	01-Feb-2005
Aerobic exercise 3+ times/week:		01-Nov-2021
Aerobic exercise 2 times/week:		28-Feb-2019
Aerobic exercise 0 times/week:		28-Aug-2013
Aerobic exercise 2 times/week:		24-Jul-2012

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP
Electronic Attachment Present:No

Social circumstances
Ethnic Origin: (White) British

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

Ear, Nose & Throat (ENT) - Rhinology
1345 Govan Road
Glasgow
G51 4TF

20/02/2024

Dr C McGill
Drs Datta & Partners
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Dear Dr C McGill

Patient Name: Lisa Rosemary Hughes
CHI Number: 1701806541
Referral Date: 19/02/2024

Thank you for your referral. On this occasion I am unable to offer a consultation to your patient.

Please see the following reasons.

( ) Please refer to the referral guidance directory for referral criteria for this service.

https://www.nhsggc.scot/hospitals-services/services-a-to-z/referral-guidelines/

( ) Insufficient clinical information to allow specialty to triage this referral.

Enter free text here

( ) Other

I have seen her CT scan performed in Jan 2024. There is mild sinus mucosal thickening that does not explain a presentation with pain and mental distress. This findngs should be considered an incidental unrelated finding, especially since there is no history of symptomatology of sinusitis. No need for nasal sprays.

Yours sincerely

Mr David Ellul

User ID David Ellul

SCGC Opwl Rem Ref Hosp Req V1

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Ear, Nose & Throat (ENT) - Otology GGC ENT Otology	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address

Urgency of referral Urgent
Date of referral 16-Feb-2024 **Date sent** 16-Feb-2024

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541
Area of Residence	-

Patient's address

8 Carham Cres
GLASGOW
G52 2HN

Contact number(s)

Voice: 07858379780

101032200330G Unique Care Pathway Number: 101032200330G

REGISTERED GP DETAILS

Name	Dr Julia Datta		
GMC code	4761778	GP code	04766
Practice name	Cardonald Medical Centre (18974)		
Practice code	52414		

Practice address

1831
Paisley Road West
Cardonald
Glasgow
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Claire McGill		
GMC code	6115493	GP code	00442
Practice name	Drs Datta & Partners (52414)		
Practice code	52414		

Practice address

Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Contact number(s)

Voice: 0141 892 2548

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Advice/Review Please

Comment: Dear Dr,

I'd be very grateful of your input in this 44 year old lady.
She has been bothered with severe headaches since the start of January.
She initially had a CT scan which showed "3 foci of ill-defined hypoattenuation in periventricular white matter". This had increased when compared to a scan done years prior. As a result Lisa underwent an MRI scan for further analysis.
During this time there was a lot of mental and emotional distress and Lisa has had multiple consults with me.
Eventually she had her MRI scan which showed pan-inflammatory sinus disease.
To manage this I gave her a steroid nasal spray (mometasone furoate nasal spray) to use as well as a course of antibiotics (doxycycline 10 day course)- she feels this has not made any difference.

She still feels she has severe headaches and has ongoing mental distress. I am trying to manage this as best as I can and I am planning to refer her to the mental health team for support.

I am not sure if this pan-inflammatory sinus disease merits any further investigation or treatment. It's not something I know much about.

The scan report is on portal, I'd be grateful of your expert opinion +/- review if you felt this was appropriate.

Many Thanks,
Dr Omar Amin
GP Locum

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
[X]Deliberate drug overdose / other poisoning	-	13-Oct-2015	13-Oct-2015
Asthma	-	18-Jul-2014	18-Jul-2014
Closed fracture rib	-	13-Jun-2014	13-Jun-2014
Acute lower respiratory tract infection	-	13-Jun-2014	13-Jun-2014
Personality disorder NOS	Emotionally unstable personality disorder	14-May-2012	14-May-2012
[X]Deliberate drug overdose / other poisoning	Olanzapine, Diazepam amd alchololStart Date: 24/04/2011	18-May-2011	18-May-2011
Cause of overdose - deliberate	Olanzapine & Alcohol	25-Apr-2011	25-Apr-2011
Poisoning - self-inflicted	deliberate	24-Apr-2011	24-Apr-2011
Cause of overdose - deliberate	-	31-Mar-2011	31-Mar-2011
Autoimmune thyroiditis	-	25-Jun-2009	25-Jun-2009
Nontoxic multinodular goitre	-	29-Aug-2008	29-Aug-2008
Asthma resolved	Attack 1995	12-Dec-2005	12-Dec-2005
Head injury	was assaulted	27-Sep-1997	27-Sep-1997
[X]Overdose - paracetamol	-	23-Apr-1994	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
DEXA - Dual energy X-ray photon absorptiometry	Normal	15-Aug-2014	15-Aug-2014
Laparoscopic bilateral female sterilisation	-	21-Mar-2012	21-Mar-2012
Thyroidectomy operations	-	08-Jun-2009	08-Jun-2009
CIN III - severe dyskaryosis	+ HPV	26-May-2004	26-May-2004

Family conditions (All priorities)

Description	Date of Onset

FH: Ischaemic heart dis. >60 28-Aug-2013

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Clenil Modulite Cfc-free inhaler 100 micrograms/actuation	2	2 INHALER	TWO PUFFS TO BE INHALED TWICE A DAY	-	16-Dec-2020	22-Nov-2023
Olanzapine Tablets 10 mg	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	04-Sep-2018	22-Nov-2023
Levothyroxine Sodium Tablets 25 micrograms	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	16-May-2018	11-Jan-2024
Levothyroxine Sodium Tablets 50 micrograms	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	16-May-2018	11-Jan-2024
Salbutamol Cfc-free inhaler 100 micrograms/puff	2	2 inhaler	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	24-Sep-2015	22-Nov-2023
Levothyroxine Sodium Tablets 100 micrograms	28	28 TABLET	1 TABS IN THE MORNING	-	04-Oct-2011	11-Jan-2024

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Diazepam Tablets 2 mg	14	14 TABLET	ONE TO BE TAKEN UP TO TWICE A DAY	-	12-Feb-2024	12-Feb-2024
Doxycycline Hyclate Capsules 100 mg	11	11 capsule	TWO TO BE TAKEN ON THE FIRST DAY THEN ONE TO BE TAKEN EACH DAY FOR A FURTHER 9 DAYS	-	08-Feb-2024	08-Feb-2024
Mometasone Furoate Nasal spray 50 micrograms/dose	1	1 bottle	TWO SPRAYS EACH NOSTRIL TWICE A DAY	-	08-Feb-2024	08-Feb-2024
Diazepam Tablets 2 mg	21	21 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	25-Jan-2024	16-Feb-2024
Sumatriptan Succinate Tablets 50 mg	6	6 TABLET	ONE TO BE TAKEN AS DIRECTED WHEN REQUIRED	-	25-Jan-2024	16-Feb-2024
Citalopram Hydrobromide Tablets 20 mg	56	56 tablet	TWO TO BE TAKEN EACH DAY (40MG)	-	11-Jan-2024	11-Jan-2024
Aspirin Dispersible tablets 300 mg	32	32 TABLET	ONE OR TWO TO BE TAKEN EVERY 4 TO 6 HOURS WHEN REQUIRED	-	11-Jan-2024	11-Jan-2024
Omeprazole Capsules (Gastro-Resistant) 20 mg	28	28 capsule	ONE TO BE TAKEN EACH MORNING	-	11-Jan-2024	11-Jan-2024
Propranolol Hydrochloride Tablets 40 mg	56	56 tablet	ONE TO BE TAKEN UP TO THREE TIMES A DAY AS REQUIRED	-	04-Jan-2024	04-Jan-2024
Propranolol Hydrochloride Tablets 40 mg	56	56 tablet	ONE TO BE TAKEN UP TO THREE TIMES A DAY AS REQUIRED	-	04-Jan-2024	04-Jan-2024
Naproxen Tablets 500 mg	56	56 tablet	ONE TO BE TAKEN TWICE A DAY	-	04-Jan-2024	04-Jan-2024
Hyoscine Butylbromide Tablets 10 mg	100	100 tablet	TAKE TWO TABLETS UP TO FOUR TIMES A DAY AS REQUIRED	-	13-Nov-2023	13-Nov-2023

Ispaghula Husk Sugar and Gluten Free Effervescent granules 3.5 grams/sachet	120	120 SACHET	THE CONTENTS OF ONE SACHET TO BE TAKEN TWICE A DAY	-	13-Nov-2023	13-Nov-2023
Propranolol Hydrochloride Tablets 40 mg	56	56 tablet	ONE TO BE TAKEN UP TO THREE TIMES A DAY AS REQUIRED	-	08-Nov-2023	08-Nov-2023
Citalopram Hydrobromide Tablets 20 mg	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	04-Sep-2018	22-Nov-2023

Blood Pressure

Date Recorded	Systolic	Diastolic
03-Jan-2024	139	90
21-Aug-2023	124	81
01-Nov-2021	112	82
01-Dec-2020	120	80
26-Sep-2019	135	80

Body Measurements

Date Recorded	Height	Weight	BMI
01-Nov-2021	164	70	26.03
01-Dec-2020	164	60	-
26-Sep-2019	164	58	21.56
28-Feb-2019	164	54	-
24-May-2017	164	63.5	23.61

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex-cigarette smoker, 20 cigs/day (past):		01-Nov-2021
Smoker 12 Cigarettes/day :		17-May-2021
Cigarette smoker, 15 Cigarettes/day:		28-Feb-2019
Smoker :		30-Nov-2017
Current smoker:		26-May-2015
Alcohol consumption, 40 units/week:		01-Nov-2021
Alcohol consumption, 1 units/week:		28-Feb-2019
Alcohol consumption, 1 units/week:		28-Aug-2013
Alcohol consumption, 1 units/week:		24-Jul-2012
Teetotaller:	Alcohol Intake$$.clm - No Action Required	01-Feb-2005
Aerobic exercise 3+ times/week:		01-Nov-2021
Aerobic exercise 2 times/week:		28-Feb-2019
Aerobic exercise 0 times/week:		28-Aug-2013
Aerobic exercise 2 times/week:		24-Jul-2012

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) British

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Medical GGC Acute Med Patient Info	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Acute Assessment - Supplementary Information SCI Gateway Virtual Location code	——	**Hospital** and **hospital address** Hospital location code. G135G Email address -

Urgency of referral Routine
Date of referral 03-Jan-2024 **Date sent** 03-Jan-2024

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541
Area of Residence	-

Patient's address

8 Carham Cres
GLASGOW
G52 2HN

Contact number(s)

Voice: 07858379780

101031755582L | Unique Care Pathway Number: 101031755582L

REGISTERED GP DETAILS

Name	Dr Julia Datta		
GMC code	4761778	GP code	04766
Practice name	Cardonald Medical Centre (18974)		
Practice code	52414		

Practice address

1831
Paisley Road West
Cardonald
Glasgow
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Hamish McEwan		
GMC code	6111544	GP code	99999
Practice name	Drs Datta & Partners (52414)		
Practice code	52414		

Practice address

Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Contact number(s)

Voice: 0141 892 2548

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Sudden right sided headache.

Comment: Dear colleague, this 43yr old reports a sudden onset right sided headache that started 3 days ago. Pain reached maximum intensity at once. She has some right sided visual blurring. She was due to attend the optician today but I have asked her to cancel this and attend yourselves. I have explained to the patient that we need to exclude a subarachnoid haemorrhage.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
[X]Deliberate drug overdose / other poisoning	-	13-Oct-2015	13-Oct-2015
Asthma	-	18-Jul-2014	18-Jul-2014
Acute lower respiratory tract infection	-	13-Jun-2014	13-Jun-2014
Closed fracture rib	-	13-Jun-2014	13-Jun-2014
Personality disorder NOS	Emotionally unstable personality disorder	14-May-2012	14-May-2012
[X]Deliberate drug overdose / other poisoning	Olanzapine, Diazepam amd alchololStart Date: 24/04/2011	18-May-2011	18-May-2011
Cause of overdose - deliberate	Olanzapine & Alcohol	25-Apr-2011	25-Apr-2011
Poisoning - self-inflicted	deliberate	24-Apr-2011	24-Apr-2011
Cause of overdose - deliberate	-	31-Mar-2011	31-Mar-2011
Autoimmune thyroiditis	-	25-Jun-2009	25-Jun-2009
Nontoxic multinodular goitre	-	29-Aug-2008	29-Aug-2008
Asthma resolved	Attack 1995	12-Dec-2005	12-Dec-2005
Head injury	was assaulted	27-Sep-1997	27-Sep-1997
[X]Overdose - paracetamol	-	23-Apr-1994	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
DEXA - Dual energy X-ray photon absorptiometry	Normal	15-Aug-2014	15-Aug-2014
Laparoscopic bilateral female sterilisation	-	21-Mar-2012	21-Mar-2012
Thyroidectomy operations	-	08-Jun-2009	08-Jun-2009
CIN III - severe dyskaryosis	+ HPV	26-May-2004	26-May-2004

Family conditions (All priorities)

Description	Date of Onset
FH: Ischaemic heart dis. >60	28-Aug-2013

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Clenil Modulite Cfc-free inhaler 100 micrograms/actuation	2	2 INHALER	TWO PUFFS TO BE INHALED TWICE A DAY	-	16-Dec-2020	22-Nov-2023
Citalopram Hydrobromide Tablets 20 mg	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	04-Sep-2018	22-Nov-2023
Olanzapine Tablets 10 mg	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	04-Sep-2018	22-Nov-2023
	28	28 TABLET		-	16-May-2018	

Levothyroxine Sodium Tablets 25 micrograms			ONE TO BE TAKEN EACH DAY			22-Nov-2023
Levothyroxine Sodium Tablets 50 micrograms	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	16-May-2018	22-Nov-2023
Salbutamol Cfc-free inhaler 100 micrograms/puff	2	2 inhaler	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	24-Sep-2015	22-Nov-2023
Levothyroxine Sodium Tablets 100 micrograms	28	28 TABLET	1 TABS IN THE MORNING	-	04-Oct-2011	22-Nov-2023

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Hyoscine Butylbromide Tablets 10 mg	100	100 tablet	TAKE TWO TABLETS UP TO FOUR TIMES A DAY AS REQUIRED	-	13-Nov-2023	13-Nov-2023
Ispaghula Husk Sugar and Gluten Free Effervescent granules 3.5 grams/sachet	120	120 SACHET	THE CONTENTS OF ONE SACHET TO BE TAKEN TWICE A DAY	-	13-Nov-2023	13-Nov-2023
Propranolol Hydrochloride Tablets 40 mg	56	56 tablet	ONE TO BE TAKEN UP TO THREE TIMES A DAY AS REQUIRED	-	08-Nov-2023	08-Nov-2023
Propranolol Hydrochloride Tablets 40 mg	56	56 tablet	ONE TO BE TAKEN UP TO THREE TIMES A DAY AS REQUIRED	-	01-Aug-2023	01-Aug-2023

Blood Pressure

Date Recorded	Systolic	Diastolic
21-Aug-2023	124	81
01-Nov-2021	112	82
01-Dec-2020	120	80
26-Sep-2019	135	80
23-Aug-2019	116	66

Body Measurements

Date Recorded	Height	Weight	BMI
01-Nov-2021	164	70	26.03
01-Dec-2020	164	60	-
26-Sep-2019	164	58	21.56
28-Feb-2019	164	54	-
24-May-2017	164	63.5	23.61

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex-cigarette smoker, 20 cigs/day (past):		01-Nov-2021
Smoker 12 Cigarettes/day :		17-May-2021
Cigarette smoker, 15 Cigarettes/day:		28-Feb-2019
Smoker :		30-Nov-2017
Current smoker:		26-May-2015
Alcohol consumption, 40 units/week:		01-Nov-2021
Alcohol consumption, 1 units/week:		28-Feb-2019
Alcohol consumption, 1 units/week:		28-Aug-2013
Alcohol consumption, 1 units/week:		24-Jul-2012
Teetotaller:	Alcohol Intake$$.clm - No Action Required	01-Feb-2005
Aerobic exercise 3+ times/week:		01-Nov-2021
Aerobic exercise 2 times/week:		28-Feb-2019

Aerobic exercise 0 times/week:	28-Aug-2013
Aerobic exercise 2 times/week:	24-Jul-2012

Clinical warnings

Additional Support Needs
No known ASN requirements

Additional relevant information
Administrative information
Contact with patient today:Face to Face
Route of Travel:Private
Resuscitation Status:Resuscitate if required
Sp02:97
Systolic BP:139
Diastolic BP:90
Pulse:88
Patient's Conscious Level:Alert
OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Referred By:Referring GP
Electronic Attachment Present:No

Social circumstances
Ethnic Origin: (White) British

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments
Dermatology - 20221215_173321
Dermatology - 20221215_173355
Dermatology - 20221215_173424
Dermatology - 20221215_173315

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Dermatology GGC General Referral		**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF		**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral Routine MIGHT JUST NEED ADVICE PLEASE - SEE ABOVE
Date of referral 15-Dec-2022 **Date sent** 23-Dec-2022

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541
Area of Residence	-

Patient's address
8 Carham Cres
GLASGOW
G52 2HN

Contact number(s)
Voice: 07563300068

101028250575D Unique Care Pathway Number: 101028250575D

REGISTERED GP DETAILS

Name	Dr Julia Datta		
GMC code	4761778	GP code	04766
Practice name	Cardonald Medical Centre (18974)		
Practice code	52414		

Practice address
1831
Paisley Road West
Cardonald
Glasgow
G52 3SS

Contact number(s)
Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr HH THOMPSON

Practice address

GMC code	7090251	GP code	08249
Practice name	-		
Practice code	52414		

Contact number(s)

-

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: advice regarding rash - please see attached photos ? guttate psoriasis

Comment: Dear colleague,

many thanks for your advice regarding this 42 year old lady. She presented on 28th November concerned about several skin lesions. She reported that the first of these appeared in September, not long after swimming in a lake. She denies any tick bite or erythema migrans type rash but noticed a scaley pink itchy lesion to her left upper arm and another to her right calf. then several smaller scaley lesions appeared in November and promoted her attendance.

on examination the lesions looked a little fungal and scaley, the lesion on the leg being around 1-2 cm in size and round, the one on the upper arm being larger.

Miss Hughes represented today. the arm lesion has in fact settled with Daktacort however she now has developed more lesions to her legs and arms, particularly around her shoulders, as pictured.

I wonder if these lesions are in keeping with guttate psoriasis? However they are not as widespread as I would expect and there is no clear history of a possible infective trigger. I have prescribed dermol to use as an emollient and soap substitute and betnovate to apply to the lesions to hopefully help with itch.

Do you agree that guttate psoriasis is the most likely diagnosis here? And if so is there anything else you would suggest us trying? and at what point would referral be warranted?

many thanks,

yours faithfully,

Dr Holly thompson

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
[X]Deliberate drug overdose / other poisoning	-	13-Oct-2015	13-Oct-2015
Asthma	-	18-Jul-2014	18-Jul-2014
Closed fracture rib	-	13-Jun-2014	13-Jun-2014
Acute lower respiratory tract infection	-	13-Jun-2014	13-Jun-2014
Personality disorder NOS	Emotionally unstable personality disorder	14-May-2012	14-May-2012
[X]Deliberate drug overdose / other poisoning	Olanzapine, Diazepam amd alchololStart Date: 24/04/2011	18-May-2011	18-May-2011
Cause of overdose - deliberate	Olanzapine & Alcohol	25-Apr-2011	25-Apr-2011
Poisoning - self-inflicted	deliberate	24-Apr-2011	24-Apr-2011
Cause of overdose - deliberate	-	31-Mar-2011	31-Mar-2011
Autoimmune thyroiditis	-	25-Jun-2009	25-Jun-2009
Nontoxic multinodular goitre	-	29-Aug-2008	29-Aug-2008
Asthma resolved	Attack 1995	12-Dec-2005	12-Dec-2005
Head injury	was assaulted	27-Sep-1997	27-Sep-1997
[X]Overdose - paracetamol	-	23-Apr-1994	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
DEXA - Dual energy X-ray photon absorptiometry	Normal	15-Aug-2014	15-Aug-2014
Laparoscopic bilateral female sterilisation	-	21-Mar-2012	21-Mar-2012
Thyroidectomy operations	-	08-Jun-2009	08-Jun-2009
CIN III - severe dyskaryosis	+ HPV	26-May-2004	26-May-2004

Family conditions (All priorities)

Description	Date of Onset
FH: Ischaemic heart dis. >60	28-Aug-2013

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Clenil Modulite Cfc-free inhaler 100 micrograms/actuation	2	2 INHALER	TWO PUFFS TO BE INHALED TWICE A DAY	-	16-Dec-2020	10-Oct-2022
Citalopram Hydrobromide Tablets 20 mg	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	04-Sep-2018	16-Nov-2022
Olanzapine Tablets 10 mg	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	04-Sep-2018	16-Nov-2022
Levothyroxine Sodium Tablets 25 micrograms	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	16-May-2018	15-Dec-2022
Levothyroxine Sodium Tablets 50 micrograms	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	16-May-2018	15-Dec-2022
Salbutamol Cfc-free inhaler 100 micrograms/puff	2	2 inhaler	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	24-Sep-2015	10-Oct-2022
Levothyroxine Sodium Tablets 100 micrograms	28	28 TABLET	1 TABS IN THE MORNING	-	04-Oct-2011	15-Dec-2022

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Betamethasone Valerate Cream 0.1 %	30	30 GRAM	APPLY THINLY TO THE AFFECTED AREA ONCE OR TWICE DAILY	-	15-Dec-2022	15-Dec-2022
Dermol 500 Lotion	500	500 ml	FOR USE AS REQD FOR DRY SKIN AND AS SOAP SUBSTITUTE	-	15-Dec-2022	15-Dec-2022
Hydrocortisone And Miconazole Cream 1 % + 2 %	30	30 gram	APPLY THINLY TO THE AFFECTED AREA TWICE DAILY	-	28-Nov-2022	28-Nov-2022
Ferrous Fumarate Tablets 210 mg	168	168 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	22-Nov-2022	22-Nov-2022

Blood Pressure

Date Recorded	Systolic	Diastolic
01-Nov-2021	112	82
01-Dec-2020	120	80
26-Sep-2019	135	80
23-Aug-2019	116	66
11-Jan-2019	109	72

Body Measurements

Date Recorded	Height	Weight	BMI
01-Nov-2021	164	70	26.03
01-Dec-2020	164	60	-
26-Sep-2019	164	58	21.56
28-Feb-2019	164	54	-

24-May-2017	164	63.5	23.61

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex-cigarette smoker, 20 cigs/day (past):		01-Nov-2021
Smoker 12 Cigarettes/day :		17-May-2021
Cigarette smoker, 15 Cigarettes/day:		28-Feb-2019
Smoker :		30-Nov-2017
Current smoker:		26-May-2015
Alcohol consumption, 40 units/week:		01-Nov-2021
Alcohol consumption, 1 units/week:		28-Feb-2019
Alcohol consumption, 1 units/week:		28-Aug-2013
Alcohol consumption, 1 units/week:		24-Jul-2012
Teetotaller:	Alcohol Intake$$.clm - No Action Required	01-Feb-2005
Aerobic exercise 3+ times/week:		01-Nov-2021
Aerobic exercise 2 times/week:		28-Feb-2019
Aerobic exercise 0 times/week:		28-Aug-2013
Aerobic exercise 2 times/week:		24-Jul-2012

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) British

Dermatology - 20221215_173321
Dermatology - 20221215_173355
Dermatology - 20221215_173424
Dermatology - 20221215_173315

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

ECG GGC Direct Access ECG	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral Routine
Date of referral 11-May-2022 **Date sent** 11-May-2022

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541
Area of Residence	

Patient's address

8 Carham Cres
GLASGOW
G52 2HN

Contact number(s)

Voice: 07563300068

1010263000932 Unique Care Pathway Number: 1010263000932

REGISTERED GP DETAILS

Name	Dr Julia Datta		
GMC code	4761778	GP code	04766
Practice name	Cardonald Medical Centre (18974)		
Practice code	52414		

Practice address

1831
Paisley Road West
Cardonald
Glasgow
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Lynsey McMahon		
GMC code	7277409	GP code	09008
Practice name	Drs Datta & Partners (52414)		
Practice code	52414		

Practice address

Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Contact number(s)

Voice: 0141 892 2548

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: As per Indication for Referral

Comment: Patient complaining of dizziness. Is on citalopram and olanzapine which can both prolong qTC. Many thanks,

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
[X]Deliberate drug overdose / other poisoning	-	13-Oct-2015	13-Oct-2015
Asthma	-	18-Jul-2014	18-Jul-2014
Acute lower respiratory tract infection	-	13-Jun-2014	13-Jun-2014
Closed fracture rib	-	13-Jun-2014	13-Jun-2014
Personality disorder NOS	Emotionally unstable personality disorder	14-May-2012	14-May-2012
[X]Deliberate drug overdose / other poisoning	Olanzapine, Diazepam amd alchololStart Date: 24/04/2011	18-May-2011	18-May-2011
Cause of overdose - deliberate	Olanzapine & Alcohol	25-Apr-2011	25-Apr-2011
Poisoning - self-inflicted	deliberate	24-Apr-2011	24-Apr-2011
Cause of overdose - deliberate	-	31-Mar-2011	31-Mar-2011
Autoimmune thyroiditis	-	25-Jun-2009	25-Jun-2009
Nontoxic multinodular goitre	-	29-Aug-2008	29-Aug-2008
Asthma resolved	Attack 1995	12-Dec-2005	12-Dec-2005
Head injury	was assaulted	27-Sep-1997	27-Sep-1997
[X]Overdose - paracetamol	-	23-Apr-1994	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
DEXA - Dual energy X-ray photon absorptiometry	Normal	15-Aug-2014	15-Aug-2014
Laparoscopic bilateral female sterilisation	-	21-Mar-2012	21-Mar-2012
Thyroidectomy operations	-	08-Jun-2009	08-Jun-2009
CIN III - severe dyskaryosis	+ HPV	26-May-2004	26-May-2004

Family conditions (All priorities)

Description	Date of Onset
FH: Ischaemic heart dis. >60	28-Aug-2013

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Clenil Modulite Cfc-free inhaler 100 micrograms/actuation	2	2 INHALER	TWO PUFFS TO BE INHALED TWICE A DAY	-	16-Dec-2020	05-Apr-2022
Citalopram Hydrobromide Tablets 20 mg	28	28 TABLET	ONE TO BE TAKEN EACH DAY - DISPENSE WEEKLY	-	04-Sep-2018	05-Apr-2022
Olanzapine Tablets 10 mg	28	28 TABLET	ONE TO BE TAKEN EACH DAY - DISPENSE WEEKLY	-	04-Sep-2018	05-Apr-2022
Levothyroxine Sodium Tablets 25 micrograms	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	16-May-2018	05-Apr-2022
Levothyroxine Sodium Tablets 50 micrograms	28	28 TABLET	ONE TO BE TAKEN EACH DAY	-	16-May-2018	05-Apr-2022

Salbutamol Cfc-free inhaler 100 micrograms/puff	2	2 inhaler	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	24-Sep-2015	05-Apr-2022
Levothyroxine Sodium Tablets 100 micrograms	28	28 TABLET	1 TABS IN THE MORNING	-	04-Oct-2011	05-Apr-2022

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

No recent medications recorded

Blood Pressure

Date Recorded	Systolic	Diastolic
01-Nov-2021	112	82
01-Dec-2020	120	80
26-Sep-2019	135	80
23-Aug-2019	116	66
11-Jan-2019	109	72

Body Measurements

Date Recorded	Height	Weight	BMI
01-Nov-2021	164	70	26.03
01-Dec-2020	164	60	-
26-Sep-2019	164	58	21.56
28-Feb-2019	164	54	-
24-May-2017	164	63.5	23.61

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex-cigarette smoker, 20 cigs/day (past):		01-Nov-2021
Smoker 12 Cigarettes/day :		17-May-2021
Cigarette smoker, 15 Cigarettes/day:		28-Feb-2019
Smoker :		30-Nov-2017
Current smoker:		26-May-2015
Alcohol consumption, 40 units/week:		01-Nov-2021
Alcohol consumption, 1 units/week:		28-Feb-2019
Alcohol consumption, 1 units/week:		28-Aug-2013
Alcohol consumption, 1 units/week:		24-Jul-2012
Teetotaller:	Alcohol Intake$$.clm - No Action Required	01-Feb-2005
Aerobic exercise 3+ times/week:		01-Nov-2021
Aerobic exercise 2 times/week:		28-Feb-2019
Aerobic exercise 0 times/week:		28-Aug-2013
Aerobic exercise 2 times/week:		24-Jul-2012

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

Primary Reason for ECG::Risk of QT interval prolongation

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) British

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Oral and Maxillofacial Surgery GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Southern General Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral ROUTINE
Date of referral 01-Aug-2012 **Date sent** 02-Aug-2012

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541
Area of Residence	-

Patient's address

8 Carham Cres
GLASGOW
G52 2HN

Contact number(s)

Voice: 0141 239 0191

1010039874765

Unique Care Pathway Number: 1010039874765

REGISTERED GP DETAILS

Name	Dr Linsey Semple		
GMC code	2820354	GP code	07897
Practice name	Cardonald Medical Centre (18974)		
Practice code	52363		

Practice address

1831
Paisley Road West
Cardonald
Glasgow
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Linsey Semple		
GMC code	2820354	GP code	07897
Practice name	Drs Semple & Finney (52363)		
Practice code	52363		

Practice address

Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Contact number(s)

Voice: 0141.892 2548

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: BITE RAISING APPLIANCE
Comment: MR DA KOPPELL CLINIC

Dear Mr Koppell,

This girl was seen in November of last year and was given a bite raising appliance. She failed to attend her appointment on the 29th of May, but continues to have problems with right sided jaw pain and she wondered if you would possibly consider seeing her again. She promises to attend a future appointment.

Thank you for your time.

Yours sincerely,

DR KIRSTY MCCALLUM

Reason for referral

Care type requested: Out Patient
Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Personality disorder NOS	Emotionally unstable personality disorder	14-May-2012	14-May-2012
[X]Deliberate drug overdose / other poisoning	Olanzapine, Diazepam amd alchololStart Date: 24/04/2011	18-May-2011	18-May-2011
Cause of overdose - deliberate	Olanzapine & Alcohol	25-Apr-2011	25-Apr-2011
Poisoning - self-inflicted	deliberate	24-Apr-2011	24-Apr-2011
Cause of overdose - deliberate	-	31-Mar-2011	31-Mar-2011
Autoimmune thyroiditis	-	25-Jun-2009	25-Jun-2009
Nontoxic multinodular goitre	-	29-Aug-2008	29-Aug-2008
Asthma resolved	Attack 1995	12-Dec-2005	12-Dec-2005
Head injury	was assaulted	27-Sep-1997	27-Sep-1997
[X]Overdose - paracetamol	-	23-Apr-1994	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Laparoscopic bilateral female sterilisation	-	21-Mar-2012	21-Mar-2012
Thyroidectomy operations	-	08-Jun-2009	08-Jun-2009
CIN III - severe dyskaryosis	HPV	26-May-2004	26-May-2004

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Levothyroxine Sodium Tablets 100 micrograms	112	112 TABS	2 Tabs In the morning	-	04-Oct-2011	18-Jul-2012

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Trimethoprim Tablets 200 mg	6	6 TABLET	ONE TO BE TAKEN TWICE A DAY	-	28-Jun-2012	28-Jun-2012
Citalopram Hydrobromide Tablets 20 mg	28	28 TABS	1 Tab Daily	-	28-Jun-2012	18-Jul-2012
Diazepam Tablets 5 mg	84	84 tablet		-	28-Jun-2012	

			ONE TO BE TAKEN THREE TIMES A DAY-DISPENSE WEEKLY			18-Jul-2012
Olanzapine Tablets 10 mg	28	28 TABS	1 Tab At night	-	28-Jun-2012	18-Jul-2012
Erythromycin And Zinc Acetate Lotion 40 mg/ml 12 mg/ml	90	90 ml	APPLY TWICE DAILY	-	03-May-2012	03-May-2012
Citalopram Hydrobromide Tablets 20 mg	28	28 TABS	1 Tab Daily	-	27-Apr-2012	29-May-2012
Diazepam Tablets 5 mg	84	84 tablet	ONE TO BE TAKEN THREE TIMES A DAY-DISPENSE WEEKLY	-	27-Apr-2012	29-May-2012
Olanzapine Tablets 10 mg	28	28 TABS	1 Tab At night	-	27-Apr-2012	29-May-2012
Malathion Aqueous Lotion 0.5 %	800	800 ml	TO BE USED AS DIRECTED	-	29-Feb-2012	29-Feb-2012
Olanzapine Tablets 10 mg	28	28 TABS	1 Tab At night	-	29-Feb-2012	28-Mar-2012
Aripiprazole Tablets 10 mg	28	28 TABS	1 tab mane	-	29-Feb-2012	28-Mar-2012
Citalopram Hydrobromide Tablets 20 mg	28	28 TABS	1 Tab Daily	-	29-Feb-2012	28-Mar-2012
Diazepam Tablets 5 mg	84	84 tablet	ONE TO BE TAKEN THREE TIMES A DAY-DISPENSE WEEKLY	-	29-Feb-2012	28-Mar-2012

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Cigarette smoker, 10 cigarettes/day:		24-Jul-2012
Current smoker:	Smoking status.clm - Repeat after an Interval 1Y	07-Apr-2011
Current smoker:	Smoking Status.clm - Repeat after an Interval 12M	30-Mar-2011
Current smoker:	Smoking Status.clm - Repeat after an Interval 12M	04-Jun-2009
Current smoker:	Smoking status.clm - Repeat after an Interval 1Y	06-Jun-2008
Alcohol consumption, 1 units/week:		24-Jul-2012
Teetotaller:	Alcohol Intake$$.clm - No Action Required	01-Feb-2005
Aerobic exercise 2 times/week:		24-Jul-2012

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances
Ethnic Origin: (White) British

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

General Surgery - Breast GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Victoria Infirmary 55 Grange Road Glasgow G42 9LF	——	**Hospital** and **hospital address** Hospital location code. G306H Email address -

Urgency of referral ROUTINE
Date of referral 22-Dec-2011 **Date sent** 23-Dec-2011

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541
Area of Residence	-

Patient's address

8 Carham Cres
GLASGOW
G52 2HN

Contact number(s)

Voice: 0141 239 0191

101002970307N Unique Care Pathway Number: 101002970307N

REGISTERED GP DETAILS

Name	Dr Linsey Semple		
GMC code	2820354	GP code	07897
Practice name	Cardonald Medical Centre (18974)		
Practice code	52363		

Practice address

1831
Paisley Road West
Cardonald
Glasgow
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Linsey Semple		
GMC code	2820354	GP code	07897
Practice name	Drs Semple & Finney (52363)		
Practice code	52363		

Practice address

Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Contact number(s)

Voice: 0141 892 2548

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: AXILLARY LUMP

Comment: Dear Doctor,

This 31 year old lady has noticed a left painless axillary lumb 3 weeks ago. She was given antibiotics but it has not settled. She reports no symptoms of sweats or fever. Breast examination was essentially normal. There is a 3 centimetre firm mobile lump in her left axilla, with no signs of any other lymph adenopathy or hepatospenomegaly. I have arranged for her to have some blood tests including a blood film. Given the persistens of this lump I would be gratful for your further assessment. Thank you for seeing her.

Yours sincerely,

DR. ANGHARAD LLEWELYN.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
[X]Deliberate drug overdose / other poisoning	Olanzapine, Diazepam amd alchololStart Date: 24/04/2011	18-May-2011	18-May-2011
Cause of overdose - deliberate	Olanzapine & Alcohol	25-Apr-2011	25-Apr-2011
Poisoning - self-inflicted	deliberate	24-Apr-2011	24-Apr-2011
Cause of overdose - deliberate	-	31-Mar-2011	31-Mar-2011
Autoimmune thyroiditis	-	25-Jun-2009	25-Jun-2009
Nontoxic multinodular goitre	-	29-Aug-2008	29-Aug-2008
Asthma resolved	Attack 1995	12-Dec-2005	12-Dec-2005
Head injury	was assaulted	27-Sep-1997	27-Sep-1997
[X]Overdose - paracetamol	-	23-Apr-1994	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Thyroidectomy operations	-	08-Jun-2009	08-Jun-2009
CIN III - severe dyskaryosis	HPV	26-May-2004	26-May-2004

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Levothyroxine Sodium Tablets 100 micrograms	112	112 TABS	2 Tabs In the morning	-	04-Oct-2011	02-Dec-2011

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Flucloxacillin Capsules 500 mg	28	28 CAPSULE	ONE TO BE TAKEN FOUR TIMES A DAY	-	07-Dec-2011	07-Dec-2011
Diazepam Tablets 5 mg	84	84 tablet	ONE TO BE TAKEN THREE TIMES A DAY-DISPENSE WEEKLY	-	07-Dec-2011	07-Dec-2011
Diazepam Tablets 5 mg	21	21 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	29-Nov-2011	29-Nov-2011
	28	28 TABS	1 tab mane	-	23-Nov-2011	

Aripiprazole Tablets 10 mg						07-Dec-2011
Citalopram Hydrobromide Tablets 20 mg	28	28 TABS	1 Tab Daily	-	23-Nov-2011	07-Dec-2011
Olanzapine Tablets 10 mg	28	28 TABS	1 Tab At night	-	23-Nov-2011	07-Dec-2011
Diazepam Tablets 5 mg	84	84 TABS	1 Tab 3 times daily	-	17-Nov-2011	17-Nov-2011
Aripiprazole Tablets 10 mg	28	28 TABS	1 tab mane disp 2x wkly	-	21-Jul-2011	21-Jul-2011
Citalopram Hydrobromide Tablets 20 mg	28	28 TABS	1 Tab Daily disp wkly	-	21-Jul-2011	21-Jul-2011
Olanzapine Tablets 10 mg	28	28 TABS	1 Tab At night disp weekly	-	21-Jul-2011	21-Jul-2011
Diazepam Tablets 5 mg	84	84 TABS	1 tab disp dispwkly 3 times daily	-	21-Jul-2011	21-Jul-2011
Mebendazole Tablets Sugar Free 100 mg	-1	-1 INVALID	DELETED for reason of: Wrong patient ? 1 Tab	-	22-Aug-2011	22-Aug-2011
Mebendazole Tablets Sugar Free 100 mg	1	1 TABS	1 Tab	-	22-Aug-2011	22-Aug-2011
Citalopram Hydrobromide Tablets 20 mg	28	28 TABS	1 Tab Daily	-	24-Aug-2011	24-Aug-2011
Diazepam Tablets 5 mg	84	84 TABS	1 tab disp 3 times daily	-	24-Aug-2011	24-Aug-2011
Diclofenac Sodium E/c tablets 50 mg	84	84 TABS	1 Tab 3 times daily	-	24-Aug-2011	24-Aug-2011
Aripiprazole Tablets 10 mg	28	28 TABS	1 tab mane disp	-	24-Aug-2011	24-Aug-2011
Olanzapine Tablets 10 mg	28	28 TABS	1 Tab At night	-	24-Aug-2011	24-Aug-2011
Citalopram Hydrobromide Tablets 20 mg	28	28 TABS	1 Tab Daily	-	22-Sep-2011	22-Sep-2011
Olanzapine Tablets 10 mg	28	28 TABS	1 Tab At night	-	22-Sep-2011	22-Sep-2011
Aripiprazole Tablets 10 mg	28	28 TABS	1 tab mane	-	22-Sep-2011	22-Sep-2011
Co-Codamol 8/500 Tablets	112	112 TABS	1 or 2 Tabs 4 times daily	-	22-Sep-2011	22-Sep-2011
Diazepam Tablets 2 mg	168	168 TABS	2 Tabs 3 times daily	-	22-Sep-2011	22-Sep-2011
Diclofenac Diethylammonium Gel 1.16 %	100	100 GEL	Apply 3 times daily	-	13-Oct-2011	13-Oct-2011
Amoxicillin Capsules 500 mg	21	21 CAPS	1 Cap 3 times daily	-	13-Oct-2011	13-Oct-2011
Citalopram Hydrobromide Tablets 20 mg	28	28 TABS	1 Tab Daily	-	19-Oct-2011	19-Oct-2011
Diazepam Tablets 5 mg	84	84 TABS	1 Tab 3 times daily	-	19-Oct-2011	19-Oct-2011
Olanzapine Tablets 10 mg	28	28 TABS	1 Tab At night	-	19-Oct-2011	19-Oct-2011
Aripiprazole Tablets 10 mg	28	28 TABS	1 tab mane	-	19-Oct-2011	19-Oct-2011

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:	Smoking status.clm - Repeat after an Interval 1Y	07-Apr-2011
Current smoker:	Smoking Status.clm - Repeat after an Interval 12M	30-Mar-2011
Current smoker:	Smoking Status.clm - Repeat after an Interval 12M	04-Jun-2009
Current smoker:	Smoking status.clm - Repeat after an Interval 1Y	06-Jun-2008
Current smoker:	Smoking status.clm - Repeat after an Interval 1Y	04-Aug-2006
Teetotaller:	Alcohol Intake$$.clm - No Action Required	01-Feb-2005

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Oral and Maxillofacial Surgery GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Southern General Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral ROUTINE
Date of referral 25-Aug-2011 **Date sent** 26-Aug-2011

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa Rosemary
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541
Area of Residence	-

Patient's address

8 Carham Cres
GLASGOW
G52 2HN

Contact number(s)

Voice: 0141 239 0191

101002450038X | Unique Care Pathway Number: 101002450038X

REGISTERED GP DETAILS

Name	Dr LC Semple		
GMC code	2820354	GP code	G07897
Practice name	Cardonald Medical Centre		
Practice code	52363		

Practice address

1831 Paisley Road West
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Linsey Semple		
GMC code	2820354	GP code	07897
Practice name	Drs Semple & Finney (52363)		
Practice code	52363		

Practice address

Cardonald Medical Centre
1831 Paisley Road West
Glasgow

Contact number(s)

Voice: 0141 892 2548

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: TEMPORAL MANDIBULAR JOINT PROBLEMS

Comment: Dear doctor,

I would be grateful if you could see this young lady who has had recurrent problems with her right temporal mandibular joint. She has pain, difficulty opening her jaw and difficulty eating food. This has been a recurrent problem over the last few months and she feels it started after her sterilisation around three months ago. I do not know whether this may have occurred during her general anaesthetic rpocedure. Today I have given her anti-inflammatories to see if this might help. I did not see any mal occlusion of her teeth, and she is tender at the temporal mandibular joint. Examination of her ear was normal. I wonder if you could see her for advice and management of this.

Thank you for your time.
Yours sincerely,

DR KIRSTY MCCALLUM

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
[X]Deliberate drug overdose / other poisoning	Olanzapine, Diazepam amd alcholol	24-Apr-2011	18-May-2011
Cause of overdose - deliberate	Olanzapine & Alcohol	-	25-Apr-2011
Poisoning - self-inflicted	deliberate	-	24-Apr-2011
Cause of overdose - deliberate	-	-	31-Mar-2011
Autoimmune thyroiditis	-	-	25-Jun-2009
Nontoxic multinodular goitre	-	-	29-Aug-2008
Asthma resolved	Attack 1995	-	12-Dec-2005
Head injury	was assaulted	-	27-Sep-1997
[X]Overdose - paracetamol	-	-	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Laparoscopic bilateral female sterilisation	-	17-May-2011	24-Aug-2011
Laparoscopic bilateral female sterilisation	-	17-May-2011	27-May-2011
Equivalent quantities for all medication checked	-	-	18-Nov-2010
Rep.presc. monitoring NOS	-	-	18-Nov-2010
Thyroidectomy operations	-	-	08-Jun-2009
CIN III - severe dyskaryosis	+ HPV	-	26-May-2004

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Levothyroxine Sodium	112	TABS 100MICROGRAMS	2 Tabs	In the morning	15-Feb-2010	24-Aug-2011

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Diazepam	84	TABS 5MG	1 tab disp	3 times daily	24-Aug-2011	24-Aug-2011
Olanzapine	28	TABS 10MG	1 Tab	At night	24-Aug-2011	24-Aug-2011
Citalopram	28	TABS 20MG	1 Tab	Daily	24-Aug-2011	24-Aug-2011

Diclofenac Sodium	84	Ec TABS 50MG	1 Tab	3 times daily	24-Aug-2011	24-Aug-2011
Aripiprazole	28	TABS 10MG	1 tab	mane disp	24-Aug-2011	24-Aug-2011
Mebendazole	1	TABS 100MG	1 Tab	-	22-Aug-2011	22-Aug-2011
Aripiprazole	28	TABS 10MG	1 tab	mane disp 2x wkly	21-Jul-2011	21-Jul-2011
Olanzapine	28	TABS 10MG	1 Tab	At night disp weekly	21-Jul-2011	21-Jul-2011
Diazepam	84	TABS 5MG	1 tab disp dispwkly	3 times daily	21-Jul-2011	21-Jul-2011
Citalopram	28	TABS 20MG	1 Tab	Daily disp wkly	21-Jul-2011	21-Jul-2011
Olanzapine	28	TABS 10MG	1 Tab	At night disp weekly	29-Jun-2011	29-Jun-2011
Movicol	20	Lemon & Lime 13.8g SACH	1 sachet	up to TID	29-Jun-2011	29-Jun-2011
Diazepam	84	TABS 5MG	1 tab disp dispwkly	3 times daily	29-Jun-2011	29-Jun-2011
Aripiprazole	28	TABS 10MG	1 tab	mane disp 2x wkly	29-Jun-2011	29-Jun-2011
Citalopram	28	TABS 20MG	1 Tab	Daily disp wkly	29-Jun-2011	29-Jun-2011
Diazepam	84	TABS 5MG	1 tab disp dispwkly	3 times daily	15-Jun-2011	15-Jun-2011
Olanzapine	28	TABS 10MG	1 Tab	At night disp weekly	15-Jun-2011	15-Jun-2011
Aripiprazole	28	TABS 10MG	1 tab	mane disp 2x wkly	15-Jun-2011	15-Jun-2011
Citalopram	28	TABS 20MG	1 Tab	Daily disp wkly	15-Jun-2011	15-Jun-2011
Olanzapine	14	TABS 10MG	1 Tab	At night disp weekly	08-Jun-2011	08-Jun-2011
Diazepam	42	TABS 5MG	1 tab disp dispwkly	3 times daily	08-Jun-2011	08-Jun-2011
Aripiprazole	14	TABS 10MG	1 tab	mane disp 2x wkly	08-Jun-2011	08-Jun-2011
Citalopram	14	TABS 20MG	1 Tab	Daily disp wkly	08-Jun-2011	08-Jun-2011
Diazepam	42	TABS 5MG	1 tab disp disp 2 wkl	3 times daily	25-May-2011	25-May-2011
Aripiprazole	14	TABS 10MG	1 tab	mane disp 2x wkly	25-May-2011	25-May-2011
Olanzapine	14	TABS 10MG	1 Tab	At night disp 2 xwkly	25-May-2011	25-May-2011
Citalopram	14	TABS 20MG	1 Tab	Daily 2x wkly	25-May-2011	25-May-2011
Aripiprazole	14	TABS 10MG	1 tab	mane disp wkly	04-May-2011	04-May-2011
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	im	04-May-2011	04-May-2011
Olanzapine	14	TABS 10MG	1 Tab	At night disp wkly	04-May-2011	04-May-2011
Diazepam	42	TABS 5MG	1 tab disp 2x weekly	3 times daily	04-May-2011	04-May-2011
Citalopram	14	TABS 20MG	1 Tab	Daily disp wkly	04-May-2011	04-May-2011
Olanzapine	28	TABS 10MG	1 Tab	At night	20-Apr-2011	20-Apr-2011
Citalopram	28	TABS 20MG	1 Tab	Daily	20-Apr-2011	20-Apr-2011
Diazepam	42	TABS 5MG	1 tab up to	3 times daily	20-Apr-2011	

						20-Apr-2011
Aripiprazole	28	TABS 10MG	1 tab	mane	20-Apr-2011	20-Apr-2011
Citalopram	28	TABS 20MG	1 Tab	Daily	06-Apr-2011	06-Apr-2011
Diazepam	42	TABS 5MG	1 tab up to	3 times daily	06-Apr-2011	06-Apr-2011
Aripiprazole	28	TABS 10MG	1 tab	mane	06-Apr-2011	06-Apr-2011
Olanzapine	28	TABS 10MG	1 Tab	At night	06-Apr-2011	06-Apr-2011
Diazepam	21	TABS 5MG	1 tab up to	3 times daily	31-Mar-2011	31-Mar-2011
Diazepam	42	TABS 5MG	1 tab up to	Twice daily	16-Mar-2011	16-Mar-2011
Olanzapine	28	TABS 10MG	1 Tab	At night	16-Mar-2011	16-Mar-2011
Citalopram	28	TABS 20MG	1 Tab	Daily	16-Mar-2011	16-Mar-2011

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		07-Apr-2011
Current smoker:		30-Mar-2011
Current smoker:		04-Jun-2009
Current smoker:		06-Jun-2008
Current smoker:		04-Aug-2006
Current smoker:	20:	01-Feb-2005
Teetotaller:		01-Feb-2005

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Gynaecology - other GGC Gynae Gen Ref	—	**Consultant / receiving practitioner** and/or **specialty clinic**
Southern General Hospital 1345 Govan Road Glasgow G51 4TF	—	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral ROUTINE
Date of referral 26-Nov-2010 **Date sent** 02-Dec-2010

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa Rosemary
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541
Area of Residence	-

Patient's address

8 Carham Cres
GLASGOW
G52 2HN

Contact number(s)

Voice: 0141 239 0191

101001312281B Unique Care Pathway Number: 101001312281B

REGISTERED GP DETAILS

Name	Dr LC Semple		
GMC code	2820354	GP code	G07897
Practice name	Cardonald Medical Centre		
Practice code	52363		

Practice address

1831 Paisley Road West
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Linsey Semple		
GMC code	2820354	GP code	07897
Practice name	CARDONALD MEDICAL CENTRE (52363)		
Practice code	52363		

Practice address

1831 PAISLEY ROAD WEST
GLASGOW

Contact number(s)

Voice: 0141 892 2548

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: STERILISATION

Comment: Dear doctor,

I would be grateful if you could see this lady who is a para 7, and has 8 children with one set of twins in her second last pregnancy. She has decided that her family is now complete and is keen to be sterilised. I have explained the operation to her and she is keen to proceed. We also had a discussion about her left iliac fossa pain, which she was referred to yourselves about, earlier in the year. She was seen by Dr Pringle who reassured her that there was nothing to worry about, however he did say that she could come back if the pain was not settling down, and indeed it hasn't. I did an ultrasound which showed normal size and appearance of the uterus, endometrium and both ovaries. There were no adnexal masses or cysts seen. I wonder if you could see her both for consideration of sterilisation and also for the ongoing left iliac fossa pain. Finally she is taking Olanzapine, Aripiprazole and Diazepam and Depo Provera. She is also on Thyroxine. Thank you for your time.

Yours sincerely,

DR KIRSTY MCCALLUM

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date recorded
Autoimmune thyroiditis	-	25-Jun-2009
Nontoxic multinodular goitre	-	29-Aug-2008
Asthma resolved	Attack 1995	12-Dec-2005
Head injury	was assaulted	27-Sep-1997
[X]Overdose - paracetamol	-	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date recorded
Rep.presc. monitoring NOS	-	18-Nov-2010
Equivalent quantities for all medication checked	-	18-Nov-2010
Thyroidectomy operations	-	08-Jun-2009
CIN III - severe dyskaryosis	+ HPV	26-May-2004

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Levothyroxine Sodium	112	TABS 100MICROGRAMS	2 Tabs	In the morning	15-Feb-2010	28-Oct-2010

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Diazepam	63	TABS 5MG	1 tab up to	3 times daily if req	25-Nov-2010	25-Nov-2010
Aripiprazole	28	TABS 10MG	1 tab	mane	25-Nov-2010	25-Nov-2010
Olanzapine	28	TABS 10MG	1 Tab	At night	25-Nov-2010	25-Nov-2010
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	im	22-Nov-2010	22-Nov-2010
Mebendazole	2	TABS 100MG	2 tabs	to be taken		

					19-Nov-2010	19-Nov-2010
Diazepam	63	TABS 5MG	1 tab up to	3 times daily if req	28-Oct-2010	28-Oct-2010
Diazepam	42	TABS 5MG	1 tab up to	3 times daily if req	14-Oct-2010	14-Oct-2010
Olanzapine	28	TABS 10MG	1 Tab	At night	14-Oct-2010	14-Oct-2010
Aripiprazole	28	TABS 10MG	1 tab	mane	14-Oct-2010	14-Oct-2010
Diazepam	42	TABS 5MG	1 tab up to	3 times daily if req	29-Sep-2010	29-Sep-2010
Diazepam	21	TABS 5MG	1 tab up to	3 times daily if req	23-Sep-2010	23-Sep-2010
Diazepam	21	TABS 5MG	1 tab up to	3 times daily if req	17-Sep-2010	17-Sep-2010
Diazepam	21	TABS 5MG	1 tab up to	3 times daily if req	09-Sep-2010	09-Sep-2010
Aripiprazole	28	TABS 10MG	1 tab	mane	09-Sep-2010	09-Sep-2010
Olanzapine	28	TABS 10MG	1 Tab	At night	09-Sep-2010	09-Sep-2010
Diazepam	6	TABS 5MG	1 tab up to	3 times daily if req	07-Sep-2010	07-Sep-2010
Diazepam	21	TABS 5MG	1 tab up to	3 times daily if req	27-Aug-2010	27-Aug-2010
Diazepam	21	TABS 5MG	1 tab up to	3 times daily if req	19-Aug-2010	19-Aug-2010
Aripiprazole	28	TABS 10MG	1 tab	mane	19-Aug-2010	19-Aug-2010
Olanzapine	28	TABS 10MG	1 Tab	At night	19-Aug-2010	19-Aug-2010
Diazepam	14	TABS 5MG	1 tab up to	3 times daily if req	13-Aug-2010	13-Aug-2010
Diazepam	14	TABS 5MG	1 tab up to	3 times daily if req	09-Aug-2010	09-Aug-2010
Olanzapine	28	TABS 10MG	1 Tab	At night	26-Jul-2010	26-Jul-2010
Diazepam	21	TABS 5MG	1 tab	tds	26-Jul-2010	26-Jul-2010
Diazepam	42	TABS 5MG	1 tab	tds	05-Jul-2010	05-Jul-2010
Nicorette Icy White	105	Sf Medicated Chewing Gum 2MG	use	as directed	05-Jul-2010	05-Jul-2010
Diazepam	21	TABS 2MG	1 tab	tds prn	01-Jul-2010	01-Jul-2010
Olanzapine	28	TABS 10MG	1 Tab	At night	15-Jun-2010	15-Jun-2010
Paramax	24	Sf Effervescent SACH	1 sachet	as directed	15-Jun-2010	15-Jun-2010
Aripiprazole	28	TABS 10MG	1 tab	mane	14-Jun-2010	14-Jun-2010

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		04-Jun-2009
Current smoker:		06-Jun-2008

Current smoker:		04-Aug-2006
Current smoker:		15-Sep-2005
Current smoker:		01-Feb-2005
Current smoker:	20:	01-Feb-2005
Teetotaller:		01-Feb-2005

Investigations

Description/Question	Result/Comment	Date
Last smear result:	result not available -	

Clinical warnings

Additional Support Needs
No known ASN requirements

Additional relevant information
Administrative information

OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Ear, Nose & Throat (ENT) GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Southern General Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral ROUTINE
Date of referral 22-Apr-2010 **Date sent** 23-Apr-2010

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa Rosemary
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541
Area of Residence	-

Patient's address

8 Carham Cres
GLASGOW
G52 2HN

Contact number(s)

Voice: 07833990700

101000420839P | Unique Care Pathway Number: 101000420839P

REGISTERED GP DETAILS

Name	Dr LC Semple		
GMC code	2820354	GP code	G07897
Practice name	Cardonald Medical Centre		
Practice code	52363		

Practice address

1831 Paisley Road West
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Linsey Semple		
GMC code	2820354	GP code	07897
Practice name	CARDONALD MEDICAL CENTRE (52363)		
Practice code	52363		

Practice address

1831 PAISLEY ROAD WEST
GLASGOW

Contact number(s)

Voice: 0141 892 2548

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: HOARSENESS

Comment: Dear Colleague,

I would be most grateful if you could review this pleasant 30 year old lady who has problems with hoarseness. Lisa has been troubled with daily hoarseness for well over one month now which she feels is getting worse. Lisa had been physically very well in herself and has had no recent upper or lower respiratory tract problems. She is under quite a considerable amount of stress from her home circumstances revolving around a large family and a reported unsupportive partner. Lisa does have a background of multi nodular goitre and she feels at the time this was diagnosis she had a similar hoarseness, however her recent TFT's have been with normal limits and no new thyroid masses have been found. I would be most grateful if you could review her.

Kind Regards,

Yours sincerely,

DR. TERESA O'REILLY

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset
Autoimmune thyroiditis	-	25-Jun-2009
Nontoxic multinodular goitre	-	29-Aug-2008
Asthma resolved	Attack 1995	12-Dec-2005
Head injury	was assaulted	27-Sep-1997
[X]Overdose - paracetamol	-	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date performed
Thyroidectomy operations	-	08-Jun-2009
CIN III - severe dyskaryosis	+ HPV	26-May-2004

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Levothyroxine Sodium	112	TABS 100MICROGRAMS	2 Tabs	In the morning	15-Feb-2010	-

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Ibuprofen	56	TABS 400MG	1 tablet	tds	14-Apr-2010	-
Olanzapine	28	TABS 10MG	1 Tab	At night	07-Apr-2010	-
Olanzapine	28	TABS 10MG	1 Tab	At night	25-Feb-2010	-
Diclofenac Sodium	84	Ec TABS 50MG	1 Tab	3 times daily	15-Feb-2010	-
Omeprazole	28	CAPS 20MG	1 Cap	Daily	08-Feb-2010	-
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	-	18-Jan-2010	-
Olanzapine	28	TABS 15MG	1 Tab	At night	18-Jan-2010	-
Levothyroxine Sodium	84	TABS 100MICROGRAMS	2 Tabs	In the morning	18-Jan-2010	-
	28	TABS 100MICROGRAMS	1 Tab	Daily	10-Dec-2009	-

Levothyroxine Sodium						
Levothyroxine Sodium	28	TABS 50MICROGRAMS	1 Tab	In the morning	10-Dec-2009	-
Olanzapine	42	TABS 15MG	1 Tab	At night	10-Dec-2009	-
Levothyroxine Sodium	56	TABS 50MICROGRAMS	1 Tab	In the morning	10-Nov-2009	-
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	-	10-Nov-2009	-
Levothyroxine Sodium	56	TABS 100MICROGRAMS	1 Tab	Daily	10-Nov-2009	-
Olanzapine	28	TABS 15MG	1 Tab	At night	10-Nov-2009	-

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		04-Jun-2009
Current smoker:		06-Jun-2008
Current smoker:		04-Aug-2006
Current smoker:		15-Sep-2005
Current smoker:		01-Feb-2005
Current smoker:	20:	01-Feb-2005
Teetotaller:		01-Feb-2005

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Gynaecology GGC General Referral	—	**Consultant / receiving practitioner** and/or **specialty clinic**
Southern General Hospital 1345 Govan Road Glasgow G51 4TF	—	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral ROUTINE
Date of referral 04-Feb-2010 **Date sent** 05-Feb-2010

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa Rosemary
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541
Area of Residence	-

Patient's address

8 Carham Cres
GLASGOW
G52 2HN

Contact number(s)

Voice: 07788617061

101000174880R

Unique Care Pathway Number: 101000174880R

REGISTERED GP DETAILS

Name	Dr LC Semple		
GMC code	2820354	GP code	G07897
Practice name	Cardonald Medical Centre		
Practice code	52363		

Practice address

1831 Paisley Road West
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Linsey Semple		
GMC code	2820354	GP code	07897
Practice name	CARDONALD MEDICAL CENTRE (52363)		
Practice code	52363		

Practice address

1831 PAISLEY ROAD WEST
GLASGOW

Contact number(s)

Voice: 0141 892 2548

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: BLEEDING

Comment: Dear Doctor,

I would be most grateful if you could review this pleasant 29 year old lady who has had a 6 months history of irregular uterine bleeding. Miss Hughes has been on the Depo provera injection since around 2005, which appears to have suited her well. Miss Hughes has had 8 children without having any major problems only significant past medical history is that she had colposcopy for CIN3 severe dyskaryosis in May 2004. Subsequent smears have been normal.

Miss Hughes describes a rush of blood post coitally, with no associated pain. She has also been spotting on her days as well. She had a smear done by our Practice Nurse on 11th August 2009 who commented that she could see blood collected around the cervix. I do wonder if this is a problem due to Depo provera or if there is another cause for blood loss. Miss Hughes herself is very anxious regarding spotting, as her mother possibly had cervical cancer issues. I have given her a course of Norethisterone 5mg TDS for 10 day in the hope of arresting the bleeding, I would be grateful for your expert opinion.

Kind Regards,

Yours sincerely,

DR TERESA O'BRIEN

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset
Autoimmune thyroiditis	-	25-Jun-2009
Nontoxic multinodular goitre	-	29-Aug-2008
Asthma resolved	Attack 1995	12-Dec-2005
Head injury	was assaulted	27-Sep-1997
[X]Overdose - paracetamol	-	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date performed
Advice about long acting reversible contraception	:	25-Nov-2009
Thyroidectomy operations	-	08-Jun-2009
CIN III - severe dyskaryosis	+ HPV	26-May-2004

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Levothyroxine Sodium	56	TABS 25MICROGRAMS	1 Tab	Daily	11-Aug-2009	-
Levothyroxine Sodium	56	TABS 100MICROGRAMS	1 Tab	Daily	11-Aug-2009	-

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Levothyroxine Sodium	84	TABS 100MICROGRAMS	2 Tabs	In the morning	18-Jan-2010	-

Olanzapine	28	TABS 15MG	1 Tab	At night	18-Jan-2010	-
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	-	18-Jan-2010	-
Levothyroxine Sodium	28	TABS 50MICROGRAMS	1 Tab	In the morning	10-Dec-2009	-
Olanzapine	42	TABS 15MG	1 Tab	At night	10-Dec-2009	-
Levothyroxine Sodium	28	TABS 100MICROGRAMS	1 Tab	Daily	10-Dec-2009	-
Levothyroxine Sodium	56	TABS 100MICROGRAMS	1 Tab	Daily	10-Nov-2009	-
Levothyroxine Sodium	56	TABS 50MICROGRAMS	1 Tab	In the morning	10-Nov-2009	-
Olanzapine	28	TABS 15MG	1 Tab	At night	10-Nov-2009	-
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	-	10-Nov-2009	-
Levothyroxine Sodium	56	TABS 100MICROGRAMS	1 Tab	Daily	25-Sep-2009	-
Olanzapine	28	TABS 10MG	1 Tab	At night	25-Sep-2009	-
Levothyroxine Sodium	56	TABS 50MICROGRAMS	1 Tab	In the morning	25-Sep-2009	-

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		04-Jun-2009
Current smoker:		06-Jun-2008
Current smoker:		04-Aug-2006
Current smoker:		15-Sep-2005
Current smoker:		01-Feb-2005
Current smoker:	20:	01-Feb-2005
Teetotaller:		01-Feb-2005

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Gynaecology GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Southern General Hospital	——	**Hospital** and **hospital address** Hospital location code. G405H Email address

Urgency of referral ROUTINE
Date of referral 18-Aug-2009 **Date sent** 20-Aug-2009

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa Rosemary
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541
Area of Residence	

Patient's address

Fl 2-2
5 Mossview Quad
Cardonald
GLASGOW
G52 2TU

Contact number(s)

Voice: 07788617061

**	Unique Care Pathway Number:

REGISTERED GP DETAILS

Name	Dr LC Semple		
GMC code	2820354	GP code	G07897
Practice name	Cardonald Medical Centre		
Practice code	52363		

Practice address

1831 Paisley Road West
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Linsey Semple		
GMC code	2820354	GP code	07897
Practice name	CARDONALD MEDICAL CENTRE (52363)		
Practice code	52363		

Practice address

1831 PAISLEY ROAD WEST
GLASGOW

Contact number(s)

Voice: 0141 892 2548

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: BLEEDING

Comment: Dear Doctor,

I would be most grateful if you could review this pleasant 29 year old lady who has had a 2 months history of regular uterine bleeding. Miss Hughes has been on the Depo provera injection since around 2005, which appears to have suited her well. Miss Hughes has had 8 children without having any major problems only significant past medical history is that she had colposcopy for CIN3 severe dyskaryosis in May 2004. Subsequent smears have been normal.

Miss Hughes describes a rush of blood post coitally, with no associated pain. She has also been spotting on her days as well. She had a smear done by our Practice Nurse on 11th August 2009 who commented that she could see blood collected around the cervix. I do wonder if this is a problem due to Depo provera or if there is another cause for blood loss. Miss Hughes herself is very anxious regarding spotting, as her mother had severe uterine of the cervix but she cannot give me any more details on this. I have given her a course of Norethisterone 5mg TDS for 10 day in the hope of arresting the bleeding, I would be grateful for your expert opinion.

Kind Regards,

Yours sincerely,

DR. TERESA O'REILLY.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset
Autoimmune thyroiditis	-	25-Jun-2009
Nontoxic multinodular goitre	-	29-Aug-2008
Asthma resolved	Attack 1995	12-Dec-2005
Head injury	was assaulted	27-Sep-1997
[X]Overdose - paracetamol	-	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date performed
Thyroidectomy operations	-	08-Jun-2009
CIN III - severe dyskaryosis	+ HPV	26-May-2004

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Levothyroxine Sodium	56	TABS 100MICROGRAMS	1 Tab	Daily	11-Aug-2009	-
Levothyroxine Sodium	56	TABS 25MICROGRAMS	1 Tab	Daily	11-Aug-2009	-

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Norethisterone	30	TABS 5MG	1 Tab	tds	17-Aug-2009	-
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	-	04-Aug-2009	-
Olanzapine	28	TABS 10MG	1 Tab	Daily	04-Aug-2009	-
Olanzapine	28	TABS 10MG	1 Tab	Daily	24-Jul-2009	-

Olanzapine	10	TABS 5MG	1 Tab	At night	09-Jul-2009	-
Olanzapine	10	TABS 5MG	1 Tab	At night	30-Jun-2009	-
Levothyroxine Sodium	56	TABS 100MICROGRAMS	1 Tab	Daily	25-Jun-2009	-
Levothyroxine Sodium	56	TABS 25MICROGRAMS	1 Tab	Daily	25-Jun-2009	-
Flucloxacillin	28	CAPS 500MG	1 Cap	4 times daily	15-Jun-2009	-
DICLOFENAC 50 MG	84	TAB	1 Tab	3 times daily if reqd	12-Jun-2009	-
Tramadol Hydrochloride	100	CAPS 50MG	1 or 2 Caps	Take as required	12-Jun-2009	-
Paracetamol	100	TABS 500MG	2 Tabs	every 4 to 6 hours	12-Jun-2009	-
Liothyronine Sodium	84	TABS 20MICROGRAMS	Half Tab	3 times daily	12-Jun-2009	-
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	-	04-Jun-2009	-
Propranolol Hydrochloride	30	TABS 40MG	1 Tab	Daily	30-Apr-2009	-
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	-	30-Mar-2009	-

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		04-Jun-2009
Current smoker:		06-Jun-2008
Current smoker:		04-Aug-2006
Current smoker:		15-Sep-2005
Current smoker:		01-Feb-2005
Current smoker:	20:	01-Feb-2005
Teetotaller:		01-Feb-2005

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-21 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

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

MEDICINE PRESCRIPTION FORM

Hospital Name: SGUH

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐
Date _____ Name (Print) _____
Discharge Prescription Prepared & Reconciled YES ☐
Date _____ Name (Print) _____

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____
Address _____
Compliance Aid Details _____
Patient consent to share discharge information Y/N
Print & Sign _____

PATIENT DETAILS

1701806541
HUGHES
Lisa, R F
8 Carham Crescent 17/01/1980
Glasgow, Lanarkshire
G52 2HN

Hospi
DOB:
Date
Cons

Height:
Weight:
Surface area:
Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

	DATE →																								
	MONTH →																								
	RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)																								
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N																									
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N																									
SIGNATURE OF ASSESSOR																									
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N																									

Parenteral Drugs : Regular Prescription

																									Patient's Own Medicine
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**A** DRUG DOSE / ROUTE / DATE PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY STOPPED DATE: INITIALS:	Other time																							For Use Y/N
		0700-0900																							Qty:
		1200-1400																							Date:
		1600-1800																							Assessed by:
		2200-2400																							Ordered from Pharm.
		Other time																							
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**B** DRUG DOSE / ROUTE / DATE PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY STOPPED DATE: INITIALS:	Other time																							For Use Y/N
		0700-0900																							Qty:
		1200-1400																							Date:
		1600-1800																							Assessed by:
		2200-2400																							Ordered from Pharm.
		Other time																							
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**C** DRUG DOSE / ROUTE / DATE PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY STOPPED DATE: INITIALS:	Other time																							For Use Y/N
		0700-0900																							Qty:
		1200-1400																							Date:
		1600-1800																							Assessed by:
		2200-2400																							Ordered from Pharm.
		Other time																							

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

| | | |

Oral and Other Drugs: Regular Prescription

DATE / MONTH

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

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

H — DRUG: OLANZAPINE

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: w-hold OD

J — DRUG: CITALOPRAM

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: w-hold OD

K — DRUG: DIAZEPAM

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: w-hold OD

L — DRUG: LEVOTHYROXINE

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: w-hold OD

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG SALB

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE
MONTH

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

Patient's Own Medicine: For Use Y/N; Qty:; Date:; Assessed by:; Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

S DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

T DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

V DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

W DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

X DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

Y DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

AA DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

BB DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE
MONTH

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

Patient's Own Medicine
For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

CC DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

DD DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

EE DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FF DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

All Routes: As Required Prescriptions

Patient's Own Medicine

| | | |

BEFORE ADMISSION		DRUG			STOPPED	DATE:	DATE																				Patient's Own Medicine For Use Y/N
☐	RR	DOSE	ROUTE	INDICATION		INITIALS:	TIME																				Qty:
NEW DOSE ☐		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.		DATE:	DOSE																				Date:
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					GIVEN BY																				Assessed by:
																											Ordered from Pharm.
BEFORE ADMISSION		DRUG			STOPPED	DATE:	DATE																				For Use Y/N
☐	SS	DOSE	ROUTE	INDICATION		INITIALS:	TIME																				Qty:
NEW DOSE ☐		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.		DATE:	DOSE																				Date:
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					GIVEN BY																				Assessed by:
																											Ordered from Pharm.
BEFORE ADMISSION		DRUG			STOPPED	DATE:	DATE																				For Use Y/N
☐	TT	DOSE	ROUTE	INDICATION		INITIALS:	TIME																				Qty:
NEW DOSE ☐		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.		DATE:	DOSE																				Date:
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					GIVEN BY																				Assessed by:
																											Ordered from Pharm.
BEFORE ADMISSION		DRUG			STOPPED	DATE:	DATE																				For Use Y/N
☐	VV	DOSE	ROUTE	INDICATION		INITIALS:	TIME																				Qty:
NEW DOSE ☐		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.		DATE:	DOSE																				Date:
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					GIVEN BY																				Assessed by:
																											Ordered from Pharm.

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

Name LISA ROSEMARY HUGHES

CHI No 170180654 1

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

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Print & Sign your full name clearly against each prescription entry.

4. Time should be recorded in 24hr format e.g. 0600, 1800.

5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.

6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

7. The following metric unit abbreviations must be used –

Milligram = mg | Gram = g
Millilitre = ml | Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal must be written in full.

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010

Hughes, Lisa ID:1701806541 13-MAY-2026 10:15:27 GREATER GLASGOW SITE-QEED ROUTINE RECORD

17-JAN-1980 (46 yr)
Female Caucasian

Room:
Loc:1301

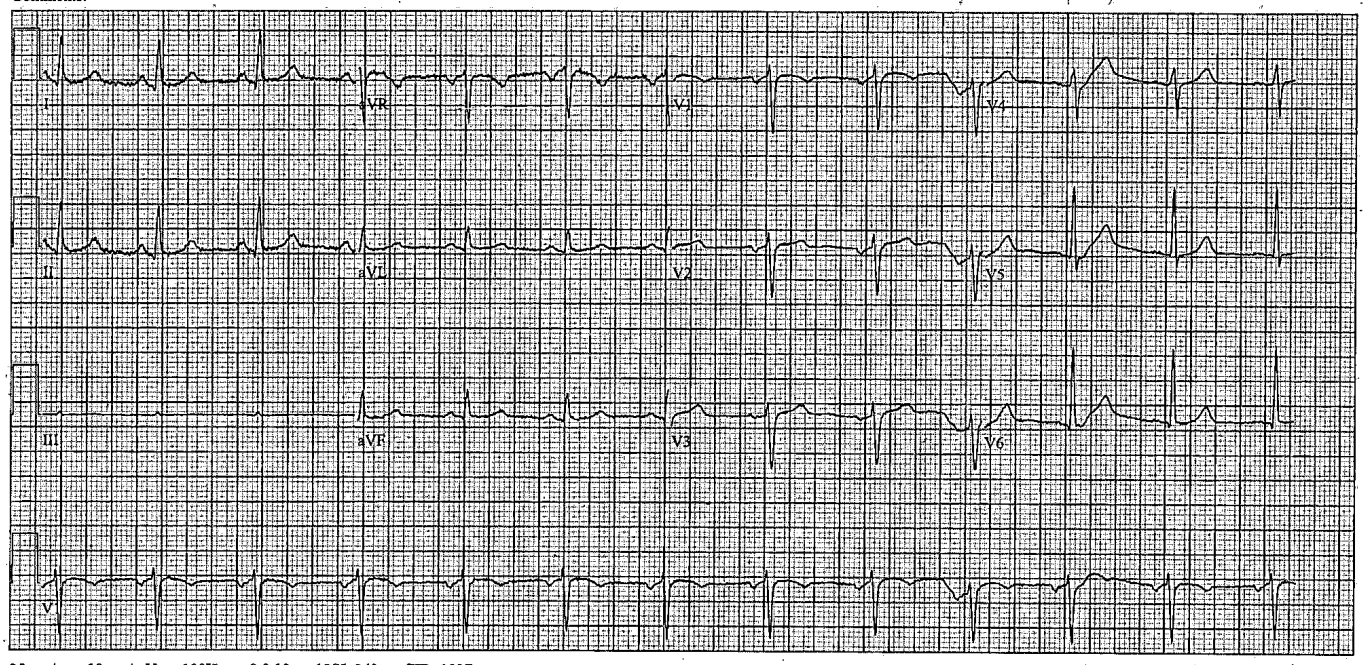
Vent. rate	74	BPM
PR interval	142	ms
QRS duration	100	ms
QT/QTc	400/444	ms
P-R-T axes	33 34	46

Normal sinus rhythm
Possible Left atrial enlargement
Borderline ECG

Technician: eve ross leahy
Test ind:

Unconfirmed

Comments:



25mm/s 10mm/mV 100Hz 9.0.10 12SL 243 CID: 1037

SID: 3252249 EID:13 EDT:. ORDER:

Hughes, Lisa ID:1701806541 27-MAY-2022 11:56:59 GREATER GLASGOW SITE-QEOPGP ROUTINE RECORD

17-JAN-1980 (42 yr)
Female Caucasian

Room:
Loc:1373

Vent. rate	72	BPM
PR interval	144	ms
QRS duration	84	ms
QT/QTc	392/429	ms
P-R-T axes	74 63	38

Normal sinus rhythm
Normal ECG

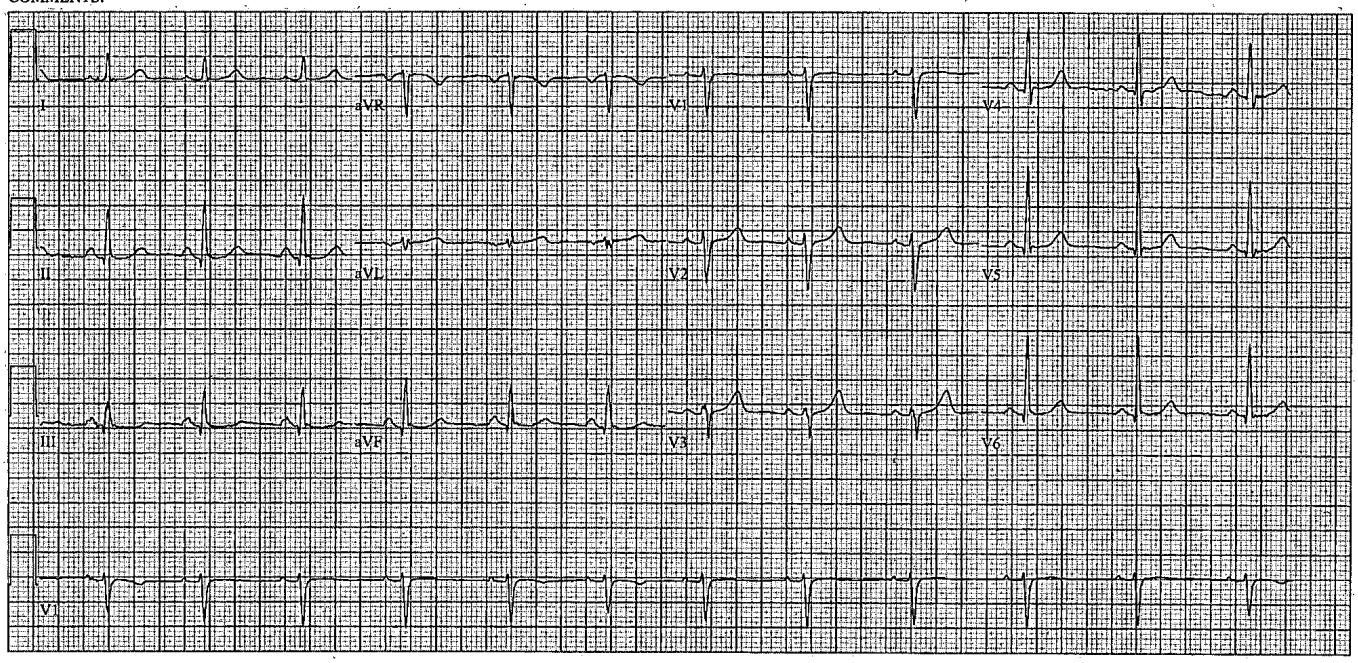
CONFIRMED BY SENIOR CARDIAC PHYSIOLOGIST
CMCC
Confirmed by Admin 7, Sys (21007) on 30/05/2022 16:19:08

Technician:SGH 320
Test ind:QTC

Referred by: QEOPGP DR MCMAHON

CONFIRMED ECG REPORT Sys Admin 7

COMMENTS:



25mm/s 10mm/mV 100Hz 9.0.10 12SL 241 HD CID: 58

SID: 3252249 EID:21007 EDT: 16:19 30-MAY-2022 ORDER:

HUGHES, Lisa ID:1701806541 05-JUN-2014 13:27:03 GREATER GLASGOW SITE-SGAE ROUTINE RECORD

17-JAN-1980 (34 yr)
Female Caucasian

Room:
Loc:301

Vent. rate	102	BPM
PR interval	124	ms
QRS duration	102	ms
QT/QTc	348/453	ms
P-R-T axes	85 54	37

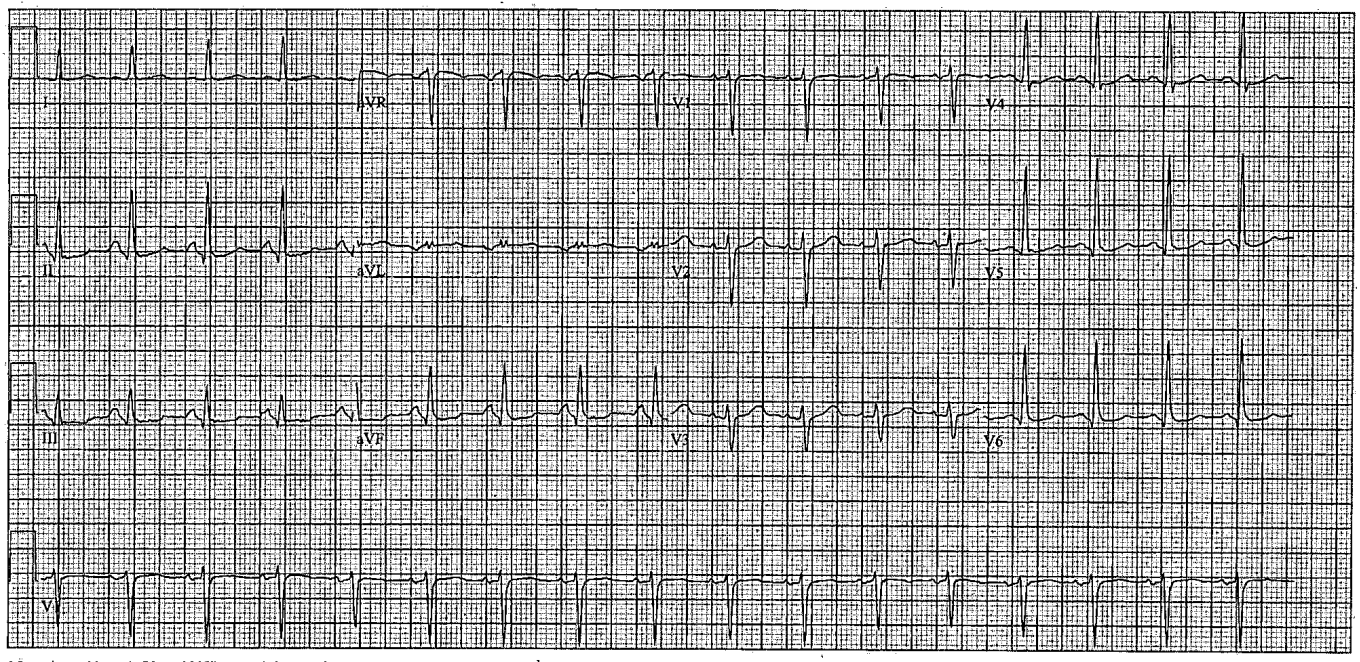
Sinus tachycardia

Technician: 324
Test ind:SOB

Referred by: SGAE DR LONG

UNCONFIRMED ECG REPORT Sys Admin 16

COMMENTS:



25mm/s 10mm/mV 100Hz 7.1.1 12SL 241 CID: 1

SID: 3252249 EID:21016 EDT: 15:30 06-JUN-2014 ORDER:

HUGHES, Lisa ID:1701806541 03-JUN-2014 02:50:22 GREATER GLASGOW SITE-SGAE ROUTINE RECORD

17-JAN-1980 (34 yr)
Female Caucasian

Room:
Loc:301

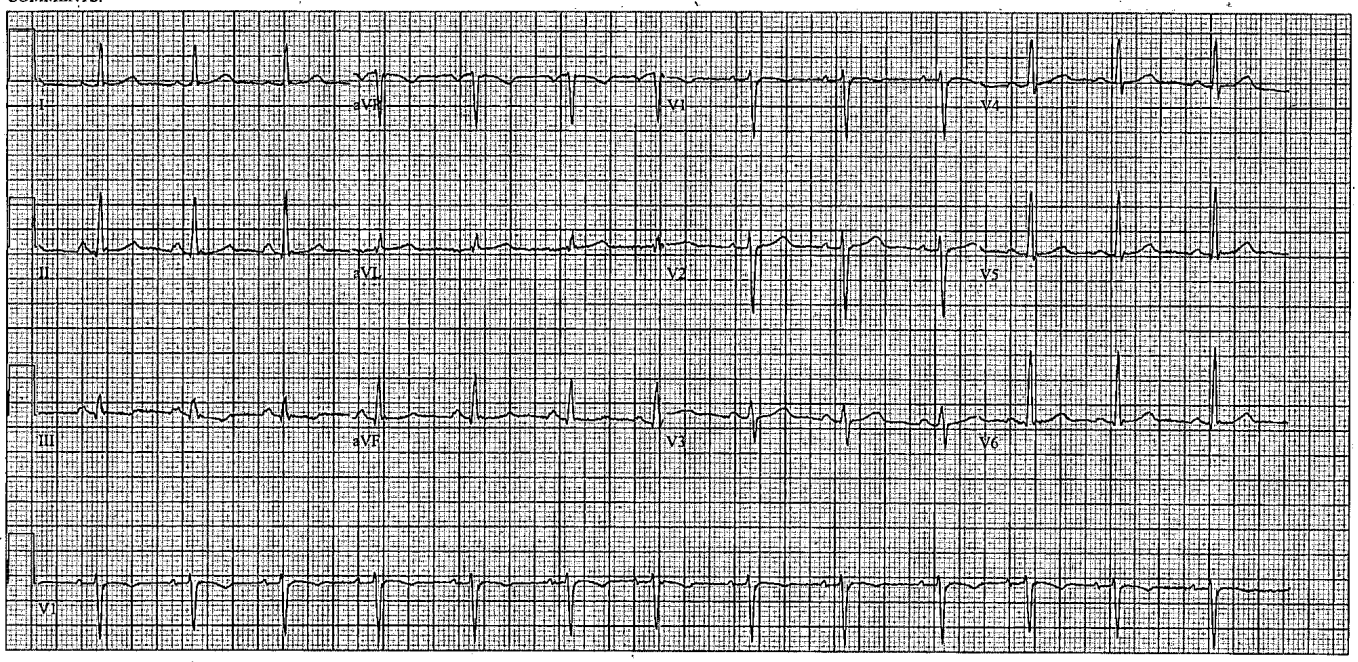
Vent. rate	81	BPM	Normal sinus rhythm
PR interval	146	ms	Normal ECG
QRS duration	90	ms	
QT/QTc	386/448	ms	
P-R-T axes	75 47	25	

Technician:SGH A/E STAFF
Test ind:

Referred by: SGAE

UNCONFIRMED ECG REPORT Sys Admin 2

COMMENTS:



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

SID: 3252249 EID:21002 EDT: 11:46 03-JUN-2014 ORDER:

HUGHES, LISA ID:1701806541 01-MAR-2012 13:01:42 GREATER GLASGOW SITE-SGAE ROUTINE RECORD

17-JAN-1980 (32 yr)
Female Caucasian

Room:
Loc:301

Vent. rate	74	BPM
PR interval	146	ms
QRS duration	84	ms
QT/QTc	380/421	ms
P-R-T axes	74 56	49

Normal sinus rhythm
Normal ECG

History:Unknown
Technician:SGH 316
Test ind:?DVT

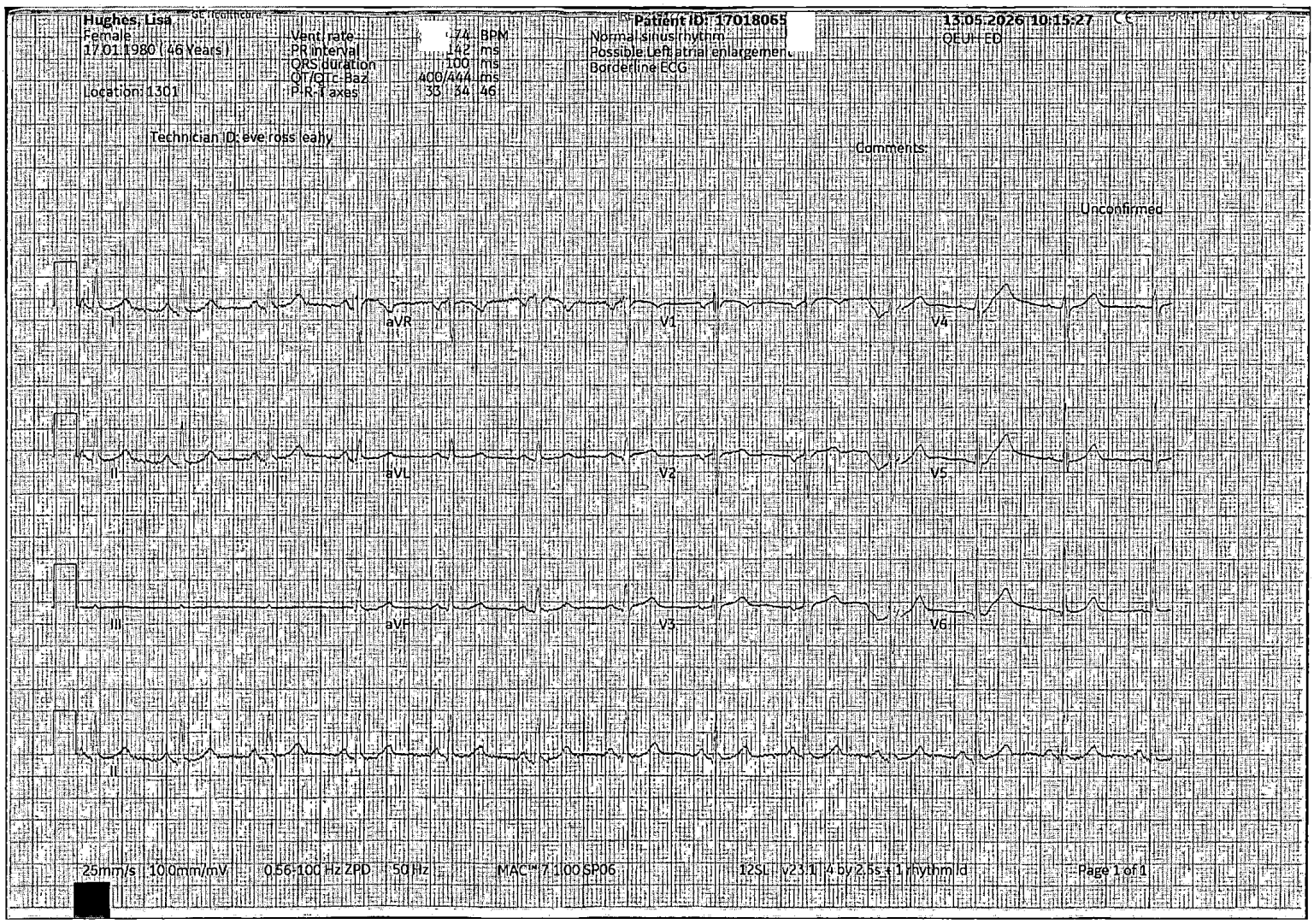
Referred by: SGAE CAS

UNCONFIRMED ECG REPORT Sys Admin 3



25mm/s 10mm/mV 150Hz 7.1.1 12SL 237 CID: 1

SID: 3252249 EID:21003 EDT: 18:14 02-MAR-2012 ORDER:


Hughes, Lisa
Female
17.01.1980 (46 Years)
Location: 1301
Technician ID: eve ross eahy
Patient ID: 17018065
13.05.2026 10:15:27
QEUH ED
Vent. rate 74 BPM
PR interval 142 ms
QRS duration 100 ms
QT/QTc-Baz 400/444 ms
P-R-T axes 33 34 46
Normal sinus rhythm
Possible Left atrial enlargement
Borderline ECG
Comments:
Unconfirmed
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
25mm/s 10.0mm/mV 0.56-100 Hz ZPD 50 Hz
MAC™ 7 100 SP06
12SL v23:1 4 by 2.5s + 1 rhythm ld
Page 1 of 1

HUGHES, LISA | ID: 170180654i | 3-Jan-2024. 18: | QUEEN ELIZABETH UNIVERSITY HOSPITAL

17-Jan-1980
Female

Loc: 1309

[redacted]

Technician:
Test ind.

Location:

Vent. rate	75	bpm
PR interval	164	ms
QRS duration	102	ms
QT/QTc	404/451	ms
P-R-T axes	57 29 35	

Normal sinus rhythm
Normal ECG

1701806541
HUGHES F
Lisa,R. 17/01/1980

Referred by:

Unconfirmed

I aVR V1 V4

II aVL V2 V5

III aVF V3 V6

II

100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + rhythm ld MAC55 009A 12SL v237

MQE 9402-020 Graphic Controls Ltd Printed in UK

HUGHES, LISA ID: 1701806541 18-Jul-2023 16: QUEEN ELIZABETH UNIVERSITY HOSPITAL

17-Jan-1980
Female

Vent. rate 66 bpm
PR interval 150 ms
QRS duration 104 ms
QT/QTc 398/423 ms
P-R-T axes 73 45 35

Normal sinus rhythm
Normal ECG

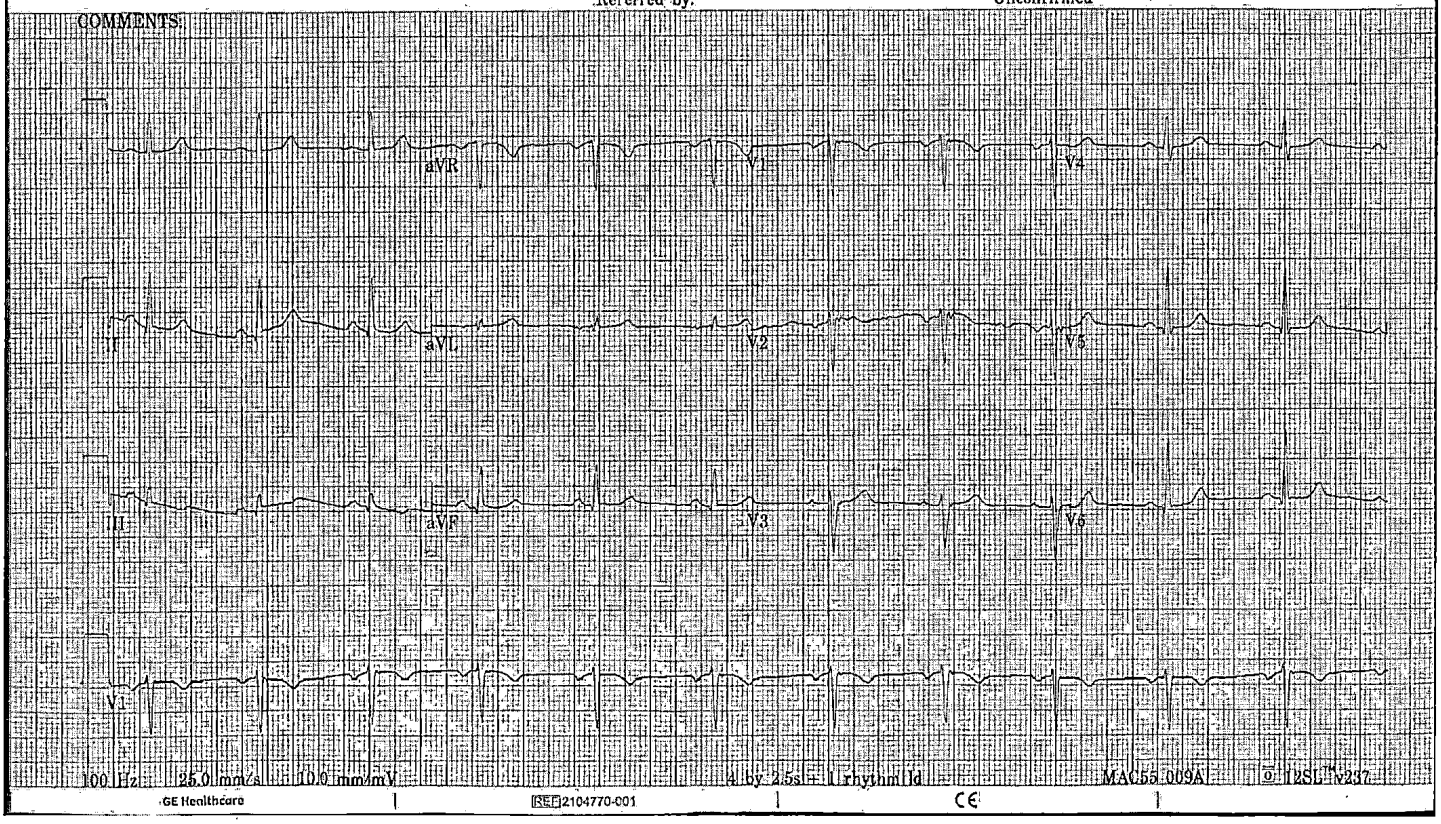
Loc: 1301

[redacted]

Technician:
Test ind:

Referred by: Unconfirmed

COMMENTS:



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC55 009A © 12SL™ v237

GE Healthcare REF 2104770-001 CE

HUGHS, LISA ID: 1701806541 14-Jul-2020 1:11 QUEEN ELIZABETH UNIVERSITY HOSPITAL

17-Jan-1980
Female

Loc: 1301

Vent. rate 73 bpm
PR interval 138 ms
QRS duration 88 ms
QT/QTc 402/442 ms
P-R-T axes 69 53 46

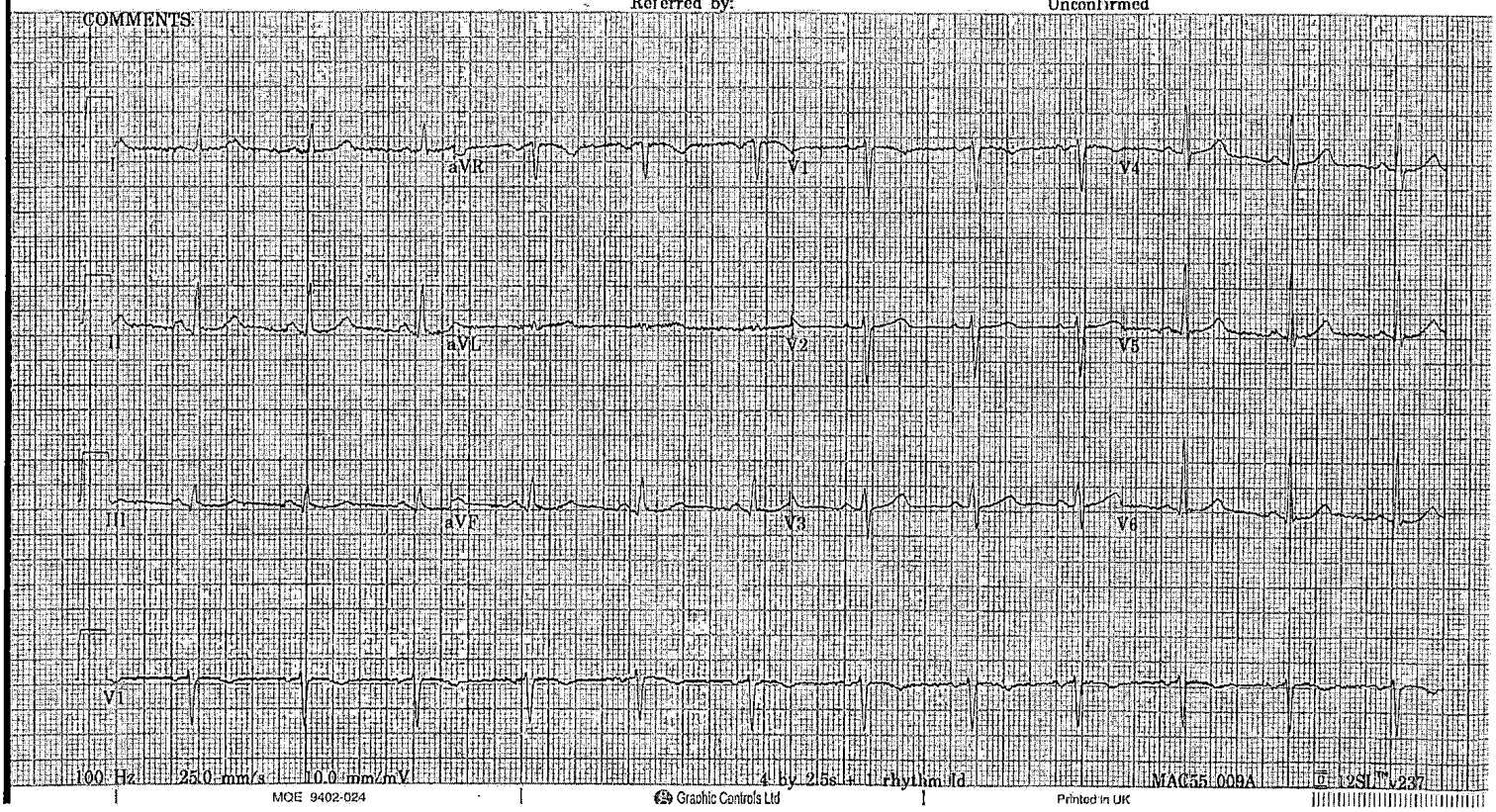
Normal sinus rhythm
Normal ECG

Technician:
Test ind:

1701806541
HUGHES F
Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

Referred by: Unconfirmed

COMMENTS:



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + rhythm ld MAC55 009A 2SL v237

MOE 9402-024 Graphic Controls Ltd Printed in UK

HUGHES, LISA ID: 1701806541 17-Dec-2018 16:56:22 QUEEN ELIZABETH UNIVERSITY HOSPITAL

17-Jan-1980
Female

Loc: 1302

Vent. rate ' ›pm
PR interval 130 ms
QRS duration 78 ms
QT/QTc 352/425 ms
P-R-T axes 84 55 24

Normal sinus rhythm with sinus ‹ thmia
Normal ECG

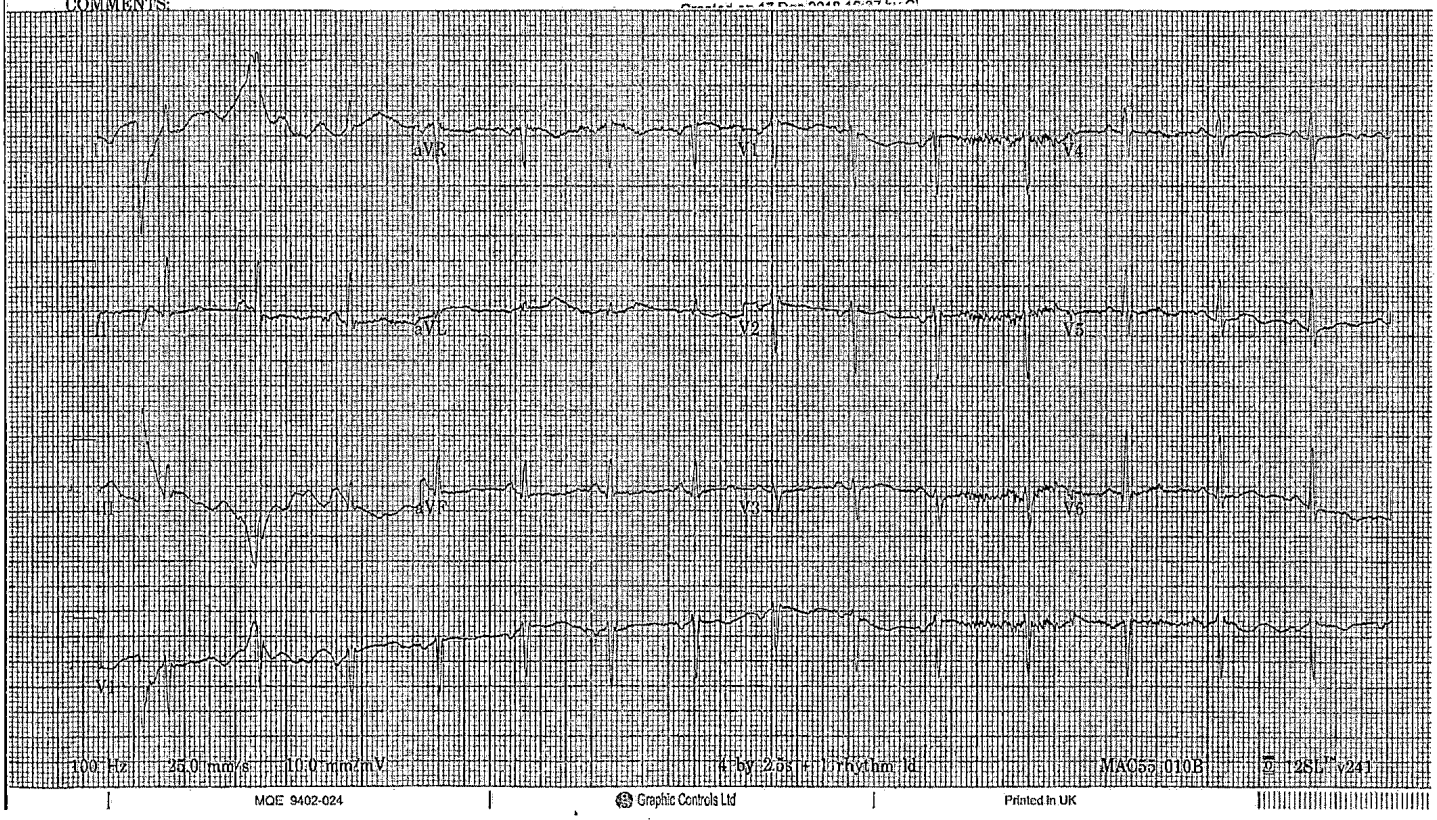
1701806541
HUGHES
Lisa, R
F
17/01/1980

Technician:
Test ind:

Referred b

Unconfirmed.

COMMENTS:



MOE 9402-024 Graphic Controls Ltd Printed In UK

HUGHES, LISA ID: 1701806541 17-Dec-2018 16:56:37 QUEEN ELIZABETH UNIVERSITY HOSPITAL

17-Jan-1980
Female

Loc: 1302

Vent. rate		bpm
PR interval	128	ms
QRS duration	90	ms
QT/QTc	352/423	ms
P-R-T axes	77 46 51	

Normal sinus rhythm
Possible Left atrial enlargement
Borderline ECG

1701806541
HUGHES F
Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

Technician:
Test ind:

Referred by:

Unconfirmed

COMMENTS:



MQE 9402-024 Graphic Controls Ltd Printed in UK

HUGH, LISA ID: 17-Dec-2018 18: QUEEN ELIZABETH UNIVERSITY HOSPITAL

17-Jan-1980
Female

Loc: 130°

Vent. rate 60 bpm
PR interval 132 ms
QRS duration 78 ms
QT/QTc 382/440 ms
P-R-T axes 79 53 36

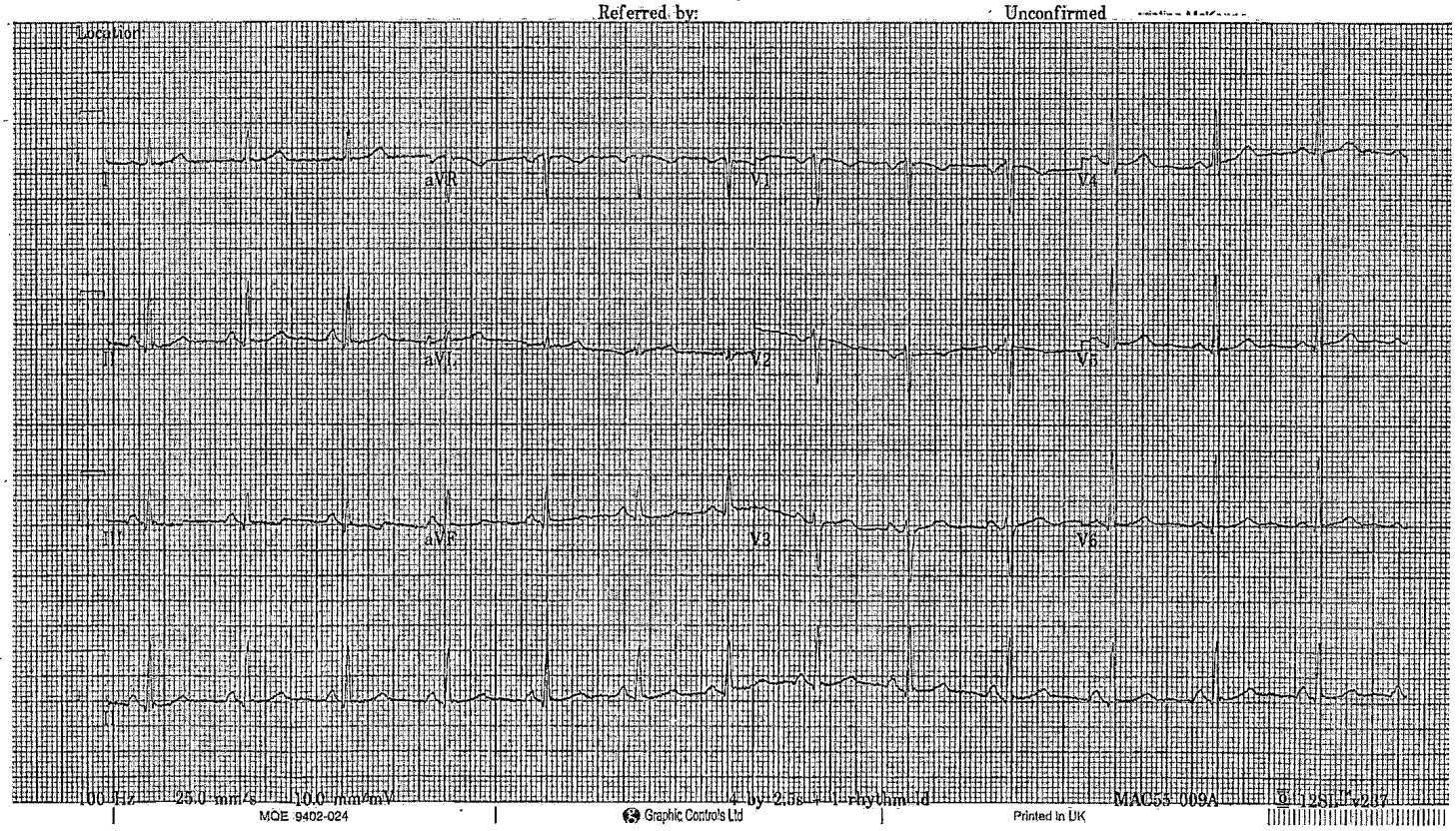
Normal sinus rhythm
Possible Left atrial enlargement

1701806541
HUGHES F
Lisa, R 17/01/1980

Technician:

Referred by: Unconfirmed

Location:



MQE 9402-024 Graphic Controls Ltd Printed in UK

HUGH, LISA ID: 17-Dec-2018 18 7 QUEEN ELIZABETH UNIVERSITY HOSPITAL

17-Jan-1980
Female

Loc: 13

Vent. rate	76	bpm
PR interval	128	ms
QRS duration	80	ms
QT/QTc	388/442	ms
P-R-T axes	78 53	37

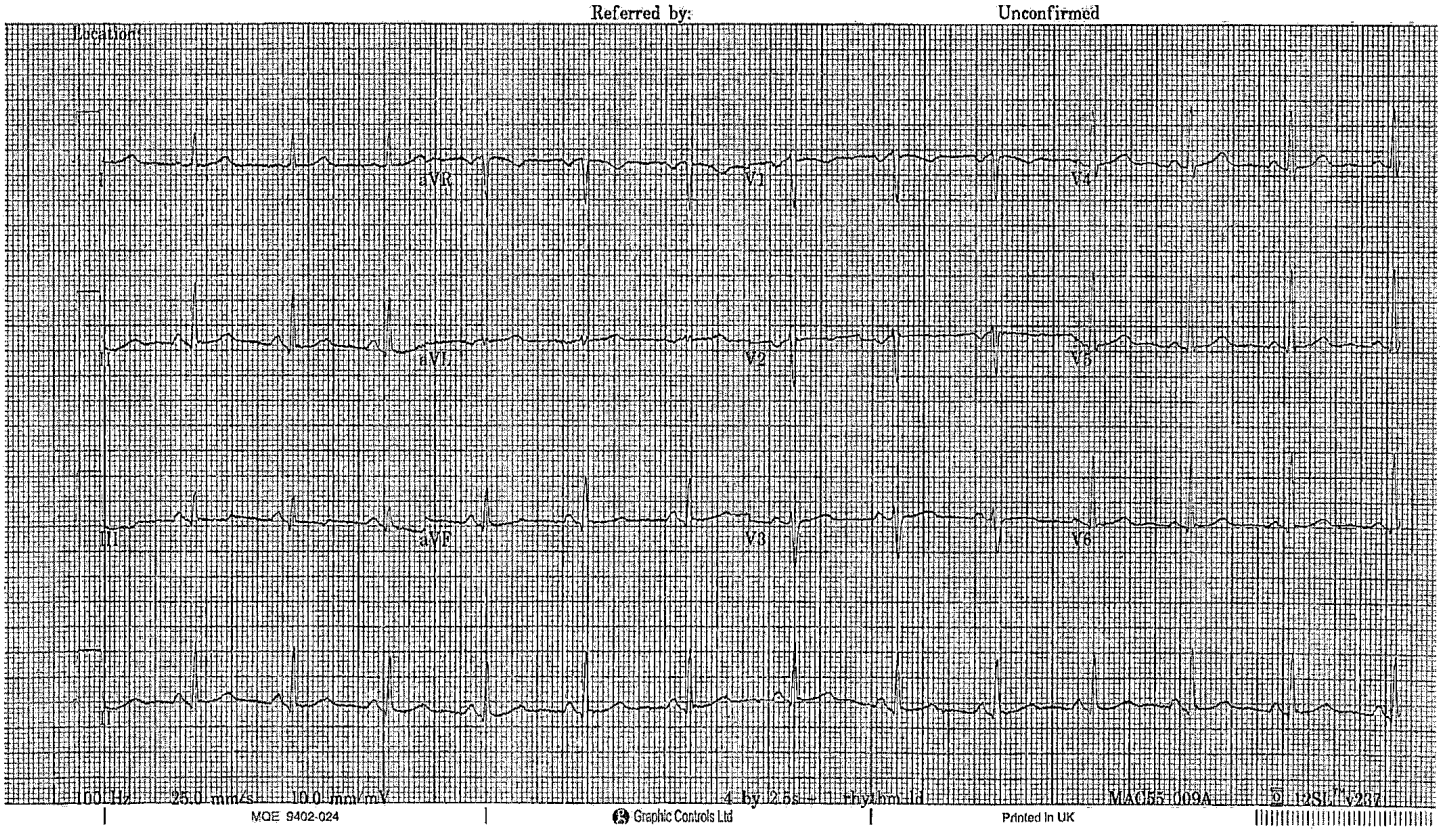
Normal sinus rhythm
Possible Left atrial enlargement

1701806541
HUGHES F
Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

Technician:

Referred by: Unconfirmed

Location:



10 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s rhythm II MAC55 009A 12SL v237

MQE 9402-024 Graphic Controls Ltd Printed in UK

HUGH, LISA ID: 17-Dec-2018 18:[illegible]4 QUEEN ELIZABETH UNIVERSITY HOSPITAL

17-Jan-1980
Female

Loc: 1308

Vent. rate [illegible] bpm
PR interval 130 ms
QRS duration 82 ms
QT/QTc 384/437 ms
P-R-T axes 80 52 39

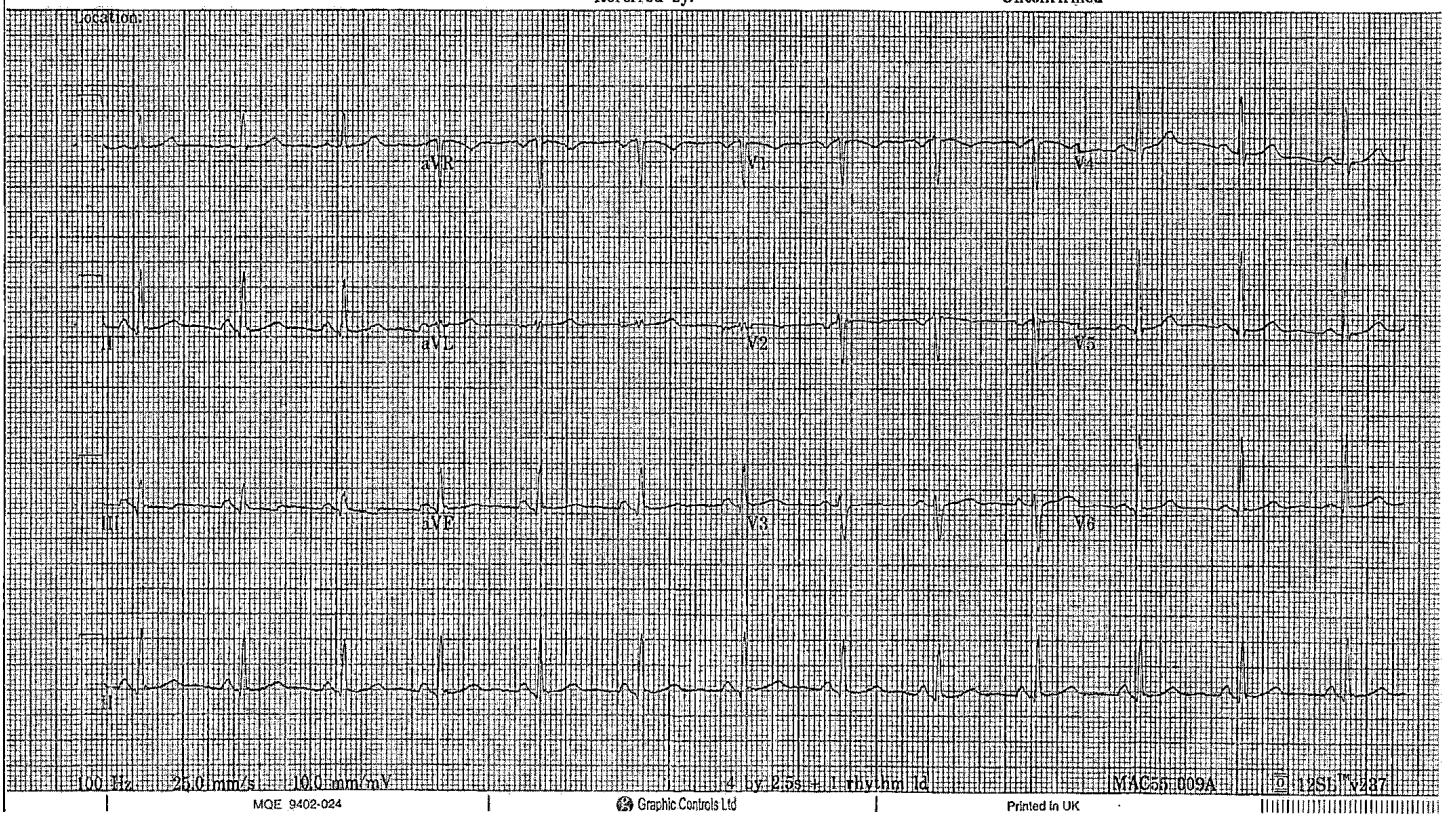
Normal sinus rhythm
Possible Left atrial enlargement

1701806541
HUGHES
Lisa, R
F
17/01/1980

Technician:

Referred by: Unconfirmed

Location:



MQE 9402-024 Graphic Controls Ltd Printed in UK

Direct Access Spirometry Report

OUTREACH SPIROMETRY SERVICE

Pre vs. Post Report

Patient Information

Name: Hughes, Lisa	**ID: 1701806541**	Birthdate: 17/01/1980
Height at test (cm): 166.0	Sex: Female	Smoking history (pk-yrs): 18
Weight at test (kg):	Age at test: 34	Predicted set: ECCS 1983/93, Polgar(Peds)1971

Comments: Dr Finney (52414)

Diagnosis:

Interpreted by:

Interpretation

MILD OBSTRUCTIVE PULMONARY IMPAIRMENT. Bronchodilator eliminates airflow obstruction. Results do not support a diagnosis of COPD but may indicate an asthmatic component. Suggest continuation with appropriate anti-asthma medication and re-enforcement of smoking cessation advice. SpO2 = 97%. MRC =1.Gemma Scanlon / R Vaughn

Site: KoKo750636

Physician:

Technician: G. Scanlon

Effort protocol: ATS 1994

Bronchodilator:

Test date/time: 18/07/14 13:30:46

Pre-BD Number of efforts performed: 5

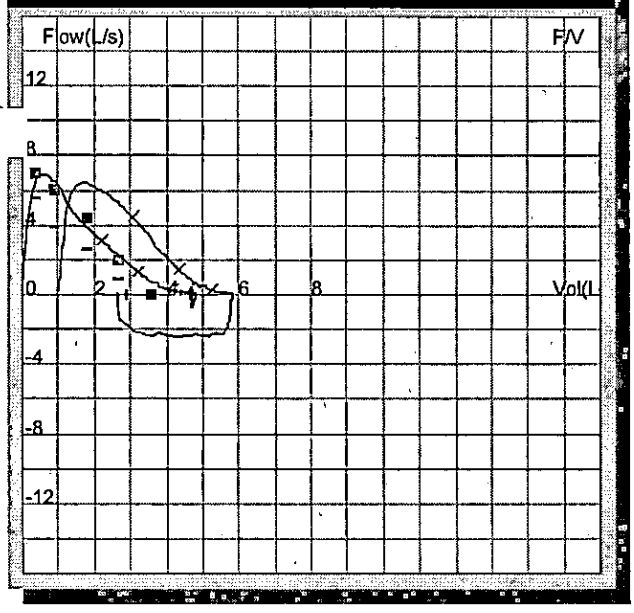
Post-BD Number of efforts performed: 6

Results

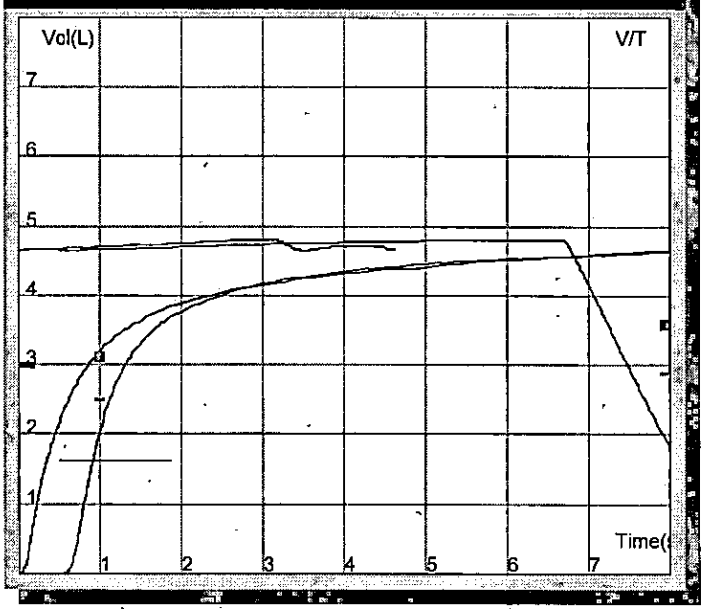
Result	Pred	Pre	%Prd	Post	%Prd	%Chg
FVC (L)	3.58	4.80	134%	4.78	134%	0%
FEV1 (L)	3.11	3.28	106%	3.50	113%	7%
FEV1/FVC	0.83	¤0.68		0.73		7%
FEF25-75% (L/s)	3.85	¤2.03	53%	2.65	69%	31%
PEFR (L/s)	7.01	6.89	98%	6.39	91%	-7%
Vext %	—	2.06	—	2.44	—	18%

Comments: Dr Finney (52414)

FVC Flow vs. Volume



FVC Volume vs. Time



XR Chest

Performed	13-May-2026 09:33	Received	13-May-2026 11:58
Reported	13-May-2026 11:56	Order Number	G405H43530460
Status	Final	Source System	MiSys

XR Chest Final
Lisa Rosemary Hughes
Clinical History :

46F pleuritic chest pain, rule out pneumothorax

XR Chest :
PA erect radiograph.

The lungs are clear. The heart is not enlarged. The mediastinal and hilar contours are normal. Old fractures of the left sixth and seventh rib.

Reported by: Dr Edit Gyomber
Verified by: Dr Edit Gyomber

MRI Head

Performed	04-Nov-2025 07:59	Received	14-Nov-2025 19:52
Reported	14-Nov-2025 19:50	Order Number	G588C42501555
Status	Final	Source System	MiSys

MRI Head Final
Lisa Rosemary Hughes
SEE REPORT FOR CLINICAL INFORMATION

MRI Head

Clinical Information: headche and memory reduction right planter equivicol previous mri ? whitematter abnormaities was told she had a benign brain tumour please clarify if on going whitematter abnormaitie sincresing if ther eis any sig of tumour or inflammation - (Information via Order Comms)

MRI Head

Comparison: 24/01/2024

Findings:
No diffusion restriction noted to suggest an acute infarct.
Normal brain parenchymal appearance and size of the ventricles for the patient's age.
Stable appearances of the bifrontal white matter left temporal white matter hyperintense T2 and FLAIR signals, no interval progression. There is no intracranial haemorrhage, mass effect or midline shift.
Unremarkable posterior fossa, no tonsillar herniation.
Sinuses demonstrate minimal mucosal thickening in the right maxillary otherwise rest are clear.
Mastoids are normal.
Bilateral orbits demonstrate no significant abnormality.
No sellar lesion.

Impression:
No acute or any concerning intracranial abnormality identified.
Stable white matter signal abnormality since 2024 of indeterminate significance.

Dr. Ahmed Kamal Nasir Khan, GMC: 7288105 (signed date, 2025-11-14, 19:50)
Consultant Radiologist
Teleconsult www.teleconsult.net
Email: servicedesk.uk@teleconsult.net
01908 086289

Reported by: TELECONSULT
Verified by: TELECONSULT

US Abdomen

Performed	02-Oct-2024 15:58	Received	03-Oct-2024 09:33
Reported	03-Oct-2024 09:31	Order Number	G405H41035969
Status	Final	Source System	MiSys

US Abdomen Final
Lisa Rosemary Hughes
Clinical History :
spasmodic RUQ pain with shoulder tip referral ?gallstones - missed last US due to wrong address on system - now updated

US Abdomen :
There are a few polyps within the otherwise normal gallbladder largest of which measures 0.4 cm. Polyps under 5 cm do not require any follow up as per GGC guidance. No intrahepatic dilatation and the CBD is normal in calibre.

Normal appearance of the liver, portal vein, spleen, pancreas (tail obscured), aorta both kidneys. No focal abnormality identified.

No free fluid.

Summary: Polyps identified within the otherwise normal gallbladder largest of which measures 0.4 cm. No follow-up required for polyps under 5 cm. No other focal abnormality identified.

Scan performed by R. Gilmore, trainee sonographer.
Static images reviewed by Wendy Nicol, sonographer.

Reported by: Ruairidh Gilmore (Trainee Sonographer) and Wendy Nicol (Sonographer)
Verified by: Wendy Nicol (Sonographer)

MRI Head

Performed	24-Jan-2024 16:31	Received	30-Jan-2024 10:40
Reported	30-Jan-2024 10:38	Order Number	G405H40472604
Status	Final	Source System	MiSys

MRI Head Final
Lisa Rosemary Hughes
Clinical History :
43F attended QEUH with a 7 day history headache and right facial pain on 3/1/23. CTB showed evidence of sinusitis. CTB also showed 3 small areas of hypoattenuation and report advised follow-up with MRI. Pt has approx. 1 year history of "brain fog" and a maternal aunt who had a brain tumour. ?further definition of hypoattenuation

Name of Procedure and Technique: MRI brain

Comparison: None

Findings:

The brain parenchyma, ventricles and sulci are normal for the age. Bifrontal white matter and left temporal white matter T2 high signal intensity area though non-specific do not have classical features of neuro inflammation. No restricted diffusion
No unusual vascular pathology. Sella, parasellar region and foramen magnum region is unremarkable. No orbital, calvarial, skull base abnormality is noted.

Inflammatory mucosal thickening right floor of maxillary sinus, bilateral ethmoid, left sphenoid sinus

Conclusion/recommendations:

Bifrontal, left temporal white matter T2 high signal intensity area are non-specific
Pan inflammatory sinus disease

Dr Changez .K. Jadun . Consultant Neuroradiologist, Medica Reporting Ltd

GMC: 6071500

If you are a clinician and have a query on this report, please call Medica on 01424 377 901 or email clinical@medicagroup.co.uk

Reported by: Dr Changez Jadun
Verified by: Dr Changez Jadun

XR Chest

Performed	04-Jan-2024 02:57	Received	12-Jan-2024 16:36
Reported	12-Jan-2024 16:34	Order Number	G405H40467801
Status	Final	Source System	MiSys

XR Chest Final
Lisa Rosemary Hughes
Clinical History :

43yo F, admitted generally unwell. CXR to look for evidence of infection

XR Chest :
Old posterolateral rib fractures on the left side. Bilateral nipple piercings noted. The heart is not enlarged. The lungs are clear.

Reported by: Dr Oliver Cram
Verified by: Dr Oliver Cram

CT Head

Performed	04-Jan-2024 02:50	Received	04-Jan-2024 09:59
Reported	04-Jan-2024 09:57	Order Number	G405H40467787
Status	Final	Source System	MiSys

CT Head Final
Lisa Rosemary Hughes
Clinical History :

43yo F, Admitted with sudden onset Right sided headache. New reduced visual acuity affecting R eye. NII other neurology. Some high pressure symptoms with headache worse lying flat. ? SAH

CT Head :
Unenhanced CT head. Comparison has been made to the previous CT dated 26/10/2006.

No acute ischaemia, hyperdense vessel, space-occupying lesion or intra or extra-axial haemorrhage.
Normal configuration of the ventricles and CSF spaces. The basal cisterns are patent.
The skull base and vault are intact. The mastoid air cells are clear. Fluid within the ethmoid sinuses and mucosal thickening in the left maxillary sinus.

Conclusion:
No acute intracranial findings.

Sticky note added to PACS.

Consultant review:
Three foci of ill-defined hypoattenuation in the periventricular white matter are nonspecific and may just represent small vessel ischaemic disease - at least 1 focus (adjacent to left lateral ventricle frontal horn) was likely apparent on the previous study. MRI may help clarify if there is ongoing clinical concern or atypical neurological findings.
Partial empty sella of doubtful clinical significance in isolation.

Reported by: Dr Cariss Little (SpR) and Dr Laura Paul
Verified by: Dr Laura Paul

XR Chest

Performed	18-Sep-2020 15:51	Received	23-Sep-2020 10:56
Reported	23-Sep-2020 10:54	Order Number	G405H36449706
Status	Final	Source System	MiSys

XR Chest Final
Lisa Rosemary Hughes
Clinical History :

40 year old lady background of asthma has had 4 month history of cough, shortness of breath and worsening wheeze. Slight weight loss. ?lung lesion

XR Chest :
Comparison made with 14/07/2020.

The cardiomediastinal contours are normal. No focal or diffuse pulmonary abnormality. Healed left lateral rib fractures. Bilateral nipple piercings.

Reported by: Dr Gordon Cowell
Verified by: Dr Gordon Cowell

US Abdomen

Performed	15-Jul-2020 10:49	Received	15-Jul-2020 12:38
Reported	15-Jul-2020 12:36	Order Number	G405H36363793
Status	Final	Source System	MiSys

US Abdomen Final
Lisa Rosemary Hughes
Clinical History :

Hot clinic appointment 15/7/20. RUQ pain for 5 days. Mild tenderness RUQ. Bloods normal. No known gallstones. ?evidence of biliary lithiasis?

US Abdomen:

There are a few gallstones seen within a thin walled gallbladder.
The CBD is a normal calibre.

The liver is normal in size, shape and echotexture.
No intrahepatic focal abnormality or duct dilatation.
The portal vein is patent with hepatopetal flow.

The right kidney is normal in appearance.
The left kidney is difficult to visualise, however no focal abnormality seen.

The pancreas, spleen and aorta are normal.

No free fluid.

Scanned by Sarah Mould, trainee sonographer.
Supervised by Claire Lindsay, sonographer.

Reported by: Sarah Mould (Sonographer) and Claire Lindsay (Radiog)
Verified by: Claire Lindsay (Radiog)

XR Chest

Performed	14-Jul-2020 04:43	Received	14-Jul-2020 10:42
Reported	14-Jul-2020 10:40	Order Number	G405H36363664
Status	Final	Source System	MiSys

XR Chest Final
Lisa Rosemary Hughes
Clinical History :

non-covid. RUQ pain, murphys +ve

XR Chest :
Normal cardiomediastinal contours. The lungs are clear. No subdiaphragmatic free gas. Old left 6th and 7th rib fractures. Bilateral nipple piercings.
No change since 17/12/2018.

Reported by: Dr Killian Mac A' BhÃ¡ird (SpR) and Dr Kirsty Slaven
Verified by: Dr Kirsty Slaven

XR Knee Lt

Performed	11-Oct-2019 15:06	Received	16-Oct-2019 07:14
Reported	16-Oct-2019 07:12	Order Number	G405H35489395
Status	Final	Source System	MiSys

XR Knee Lt Final
Lisa Rosemary Hughes
Clinical History :

left knee pain/trobbing for 2 months no trauma no trigger. no locking or buckling but pain when wearing heels. patient mob 07563300068. ?OA requested by DR A McKean GP locum gmc 6166060

XR Knee Lt :
No significant bone or joint abnormality identified.

Reported by: Dr Sean Kelly
Verified by: Dr Sean Kelly

XR Chest

Performed	17-Dec-2018 18:44	Received	28-Dec-2018 14:40
Reported	28-Dec-2018 14:38	Order Number	G405H34585001
Status	Final	Source System	MiSys

XR Chest Final
Lisa Rosemary Hughes
Clinical History :

CHEST PAIN INTERMITTENT OVER LAST 2/52. SMOKER. FAMILY HISTORY OF IHD.
Routine CXR please

XR Chest :
Compared to previous x-ray there are healed left-sided rib fractures affecting sixth and seventh ribs. The bony thorax is otherwise intact. Normal cardiac and mediastinal contours. No focal active lung lesion. Bilateral nipple piercings noted.

Reported by: Dr Oliver Cram
Verified by: Dr Oliver Cram

XR Lumbar spine

Performed	24-May-2016 10:26	Received	24-May-2016 11:02
Reported	24-May-2016 11:00	Order Number	G405H31471697
Status	Final	Source System	MiSys

XR Lumbar spine Final
Lisa Rosemary Hughes
Clinical History :
Fell 2 weeks ago from step ladder. Legs giving way due to pain. Tender L5/S1.

XR Lumbar spine :
No plain film evidence of bony injury. Sterilisation clips noted.

Reported by: Dr David Stobo
Verified by: Dr David Stobo

Bone Densitometry DXA

Performed	08-Aug-2014 09:56	Received	08-Aug-2014 12:10
Reported	08-Aug-2014 12:10	Order Number	G405H29154308
Status	Final	Source System	MiSys

Bone Densitometry DXA Final
Lisa Rosemary Hughes
The DXA scan can be viewed on the national PACS system.

The images will be assessed and interpreted by an osteoporosis specialist.

All DXA scan reports are now filed on the clinical portal under Service /Endocrinology-Bone metabolism clinical letter.

Reported by: Auto Reporting
Verified by: Angela McCall

CT Angiogram pulmonary

Performed	06-Jun-2014 13:19	Received	06-Jun-2014 14:29
Reported	06-Jun-2014 14:27	Order Number	G405H29149941
Status	Final	Source System	MiSys

CT Angiogram pulmonary Final
Lisa Rosemary Hughes
Clinical History :

34 yr old female admitted with left sided chest pain, worse on inspiration. known asthma. D dimer raised. ?PE

Reported by: Dr Andrew Christie**Verified by:** Dr Robert Shaw

CT Angiogram pulmonary :
Report issued by Dr. Shaw.
Routine protocol.
No PTE.
No acute intrapulmonary finding or pneumothorax.

There is a recent fracture of the posterolateral left 7th rib. For clinical correlation.

This will be the cause of the left sided pleuritic chest pain ,worse on inspiration.
Even in retrospect this is not visible due to overlap, on chest x-rays of 3rd and 5th June.

Reported by: Dr Robert Shaw**Verified by:** Dr Robert Shaw

XR Chest

Performed	05-Jun-2014 14:15	Received	06-Jun-2014 11:28
Reported	06-Jun-2014 11:26	Order Number	G405H29146181
Status	Final	Source System	MiSys

XR Chest Final
Lisa Rosemary Hughes
Clinical History :

SATS 92 LEFT CHEST PAIN ?LRTI ?PE

XR Chest :
PA erect. The no relevant changes from the previous film dated 03/06/2014.
Normal appearances of the heart, the lungs and the mediastinum.

Reported by: Dr Holger Eichler (Locum)
Verified by: Dr Holger Eichler (Locum)

XR Chest

Performed	03-Jun-2014 03:52	Received	04-Jun-2014 10:06
Reported	04-Jun-2014 10:03	Order Number	G405H29134384
Status	Final	Source System	MiSys

XR Chest Final
Lisa Rosemary Hughes
Clinical History :

? Asthma - provisional diagnosis by GP. Has had a cough for 3 months and trial of salbutamol. Ongoing SOB and wheeze. Smoker for about 20 yrs. ? hyperinflation/ changes in keeping with COPD.

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

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

US Doppler lower limb veins Lt

Performed	08-Mar-2012 10:19	Received	08-Mar-2012 11:14
Reported	08-Mar-2012 10:52	Order Number	G405H26683540
Status	Final	Source System	MiSys

US Doppler lower limb veins Lt Final
Lisa Hughes
Clinical History :
Attended for Doppler of the left leg. There is increased pain for 1 week. D-dimer 260. Wells, zero. Negative for DVT. Re-scan Doppler as per DVT protocol.

Examination performed and reported by Claire Telfer, Sonographer.

There is no evidence of DVT within the left common femoral vein, superficial femoral vein and the popliteal veins. The upper third of the left calf vessels appear patent. There is no evidence of a Baker's cyst within the left popliteal fossa.

Reported by: Claire Telfer
Verified by: Claire Telfer

US Doppler lower limb veins Lt

Performed	01-Mar-2012 13:27	Received	01-Mar-2012 17:06
Reported	01-Mar-2012 16:44	Order Number	G405H26682855
Status	Final	Source System	MiSys

US Doppler lower limb veins Lt Final
Lisa Hughes
Clinical History : ? DVT.

US Doppler lower limb veins Lt :

There is no DVT.

Reported by: Dr John Calder
Verified by: Dr John Calder

US Axilla Lt

Performed	29-Feb-2012 10:43	Received	01-Mar-2012 13:20
Reported	01-Mar-2012 12:58	Order Number	G306H26678035
Status	Final	Source System	MiSys

US Axilla Lt Final
Lisa Hughes
Clinical History : Had lump in left axilla. Bloods normal. Lump has diminished in size.

US Axilla Lt ;

Neither I nor the patient can really identify the abnormality. Ultrasound is normal.

Reported by: Dr Brian Mucci
Verified by: Dr Brian Mucci

US Pelvis

Performed	27-Oct-2010 10:20	Received	03-Nov-2010 12:35
Reported	03-Nov-2010 12:15	Order Number	G405H25324473
Status	Final	Source System	MiSys

US Pelvis Final
Lisa Hughes
Clinical History : Left iliac fossa pain intermittently. Worse during sexual intercourse. Colposcopy normal. Mildly tender left iliac fossa.

US Pelvis : Examination performed by Claire Bowman, Sonographer.

Normal size and appearances of the uterus, endometrium and both right and left ovaries. There are no adnexal masses nor cysts seen.

Both right and left kidneys appear normal measuring 13.2 cm and 12.4 cm respectively in bipolar diameter. Both kidneys have a smooth renal outline and good cortical thickness.

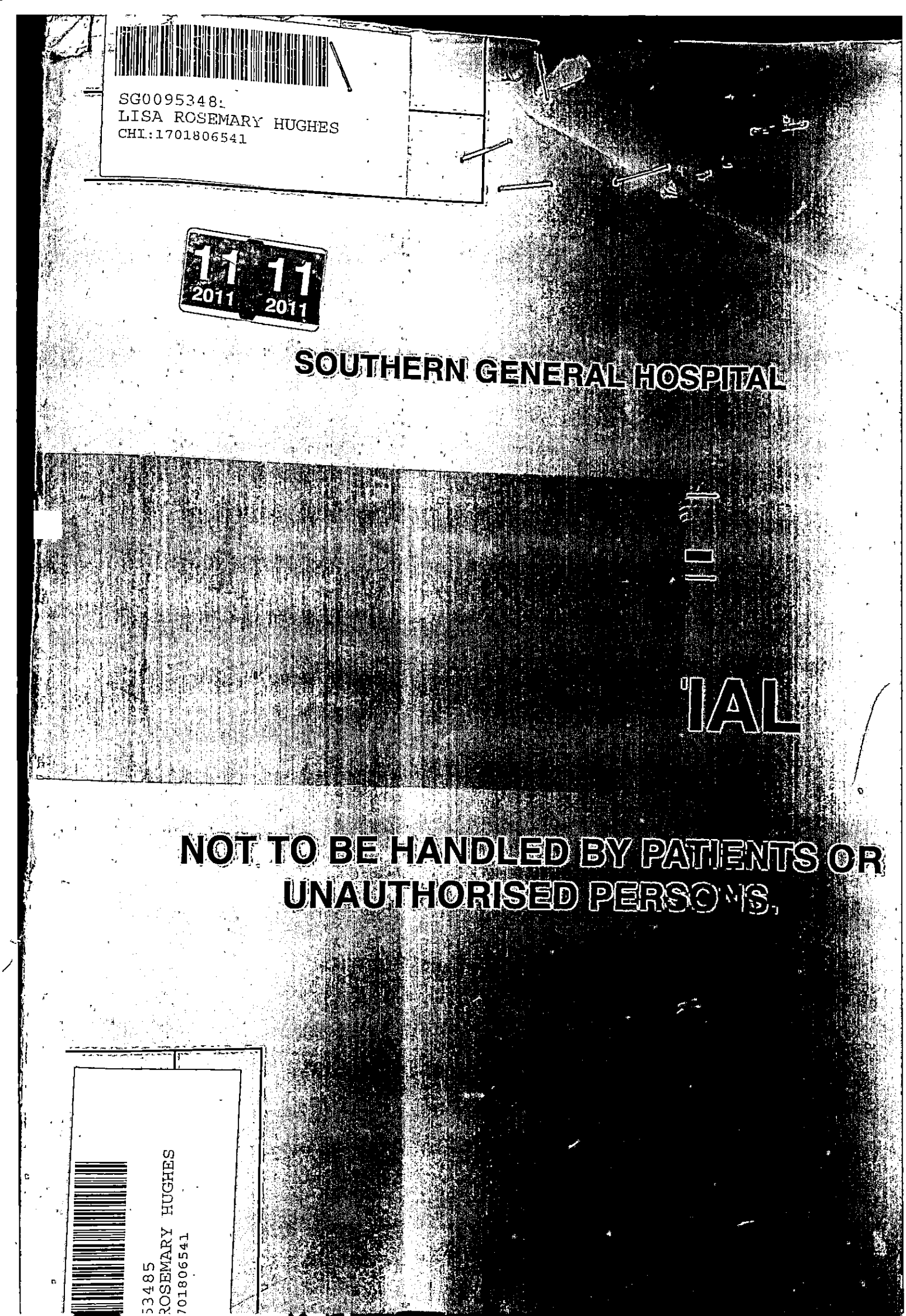
Reported by: Claire Bowman (Sonog)
Verified by: Claire Bowman (Sonog)

MANUAL PATIENT RECORDS

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

Including:

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


SG0095348
LISA ROSEMARY HUGHES
CHI:1701806541
11 2011
11 2011
SOUTHERN GENERAL HOSPITAL
IAL
NOT TO BE HANDLED BY PATIENTS OR
UNAUTHORISED PERSONS.
53485
ROSEMARY HUGHES
701806541

SOUTHERN GENERAL HOSPITAL NHS TRUST 3592 **1**

SURNAME (Block Letters)	FIRST NAME	UNIT No.
PARK HUGHES	LISA	953485

ADDRESS	OCCUPATION	DATE OF BIRTH
63 BARSHAW ROAD GLASGOW G52 4EE 8/10/1899		17.1.1980

NEXT OF KIN (Name and Address)

CHANGE OF ADDRESS
5 MOSSVIEW QUADRANT
FLAT 2/2
GLASGOW 07833990709
G43 2TH

NAME AND ADDRESS OF OWN DOCTOR
DR TREADGOLD
21 COWGLEN RD.

CHI
SG00953485
LISA ROSEMARY HUGHES
8 CARHAM CRES
GLASGOW 17/01/1980
G52 2HN CHI 1701806541

NAME AND ADDRESS OF OWN DOCTOR
Dr Semple / Fannie
Paisley Rd West Cardonald

BLOOD GROUP

SENSITIVITY

UNIT CASE RECORDS

GENERAL 0141		ORTHOPAEDIC	
INSTITUTE 239- 0191		PSYCHIATRIC	
MATERNITY		CHEST	

INDEX OF ATTENDANCES

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

DATE	CLINIC / WARD	DOCTOR	DIAGNOSIS / OPERATION	CODED	DISCH. DATE
16.6.96	Wo 20	Dr Park			14/6/96
4/10/99	Skin OP	Roberts			
17/1/05	ENT OP	Houghton			
~~28/2/05~~	~~ENT OP~~	~~HOUGHTON~~			
20/6/3	COLP OP	Mc/ENT			
21/4/4	" "	"			
12/5/4	" "	"			
24/11/4	" "	"			
28/2/6	ENT OP	HOUGHTON			
26.10.05	Col OP	& Myles			
3.4.06	GYN OP	PEARCE			
17.10.06	N log OP	Webb			
31/7/8	ENT	Clark			
24/7/08	ENT	CLARK			
2/8/8					

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

Final Discharge Letter

NHS Greater Glasgow and Clyde

Dr. AA Finney
Drs Semple finney and datta
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

Main Switchboard: 0141 201 1100

Date of Completion: 17/06/2014

Email Enquiries to: mary.fay@ggc.scot.nhs.uk
Contact Tel Details: 0141 201 1782

Dictated: 13/06/2014
Transcribed: 16/06/2014

Dear Dr. AA Finney,

Patient

Name:	Hughes Lisa Rosemary
CHI:	1701806541
DOB:	17/01/1980
ddress:	8 Carham Crescent
	Glasgow
	G52 2HN

Admission

Admitted:	05/06/2014 14:54
Discharged:	07/06/2014 16:00
Admission Type:	In Patient
Discharge to:	Private Residence - no additional detail added
Consultant:	Dr Brian Kennon
Specialty:	General Medicine

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

Diagnosis

Diagnosis	Code
Fracture of rib, closed	S22.30
Unspecified acute lower respiratory infection	J22.X

Clinical Comments:

The above patient was admitted on5/6/14 with increased SOB, wheeze and cough. There was a history of nocturnal cough and some anterior chest pain. On examination chest was clear with good air entry and no wheeze audible. CXR and ECG were unremarkable. D-dimer was negative. Inflammatory markers were elevated. Dalteparin was started before CTPA showed no evidence of PTE. It also demonstrated a recent fracture of the posterolateral left 7th rib which is likely the source

of chest pain on inspiration. She was started on antibiotics which should be continued for a further 5 days. We have started a step 2 inhaler (clenil modulite 200mcg). She is now fit for discharge with analgesia. We will arrange for an outpatient DEXA and isotope bone scan to be performed since there is no history of trauma to the ribs. We have sent blood for vitamin D and calcium levels today. Many thanks. Kind regards,

See IDL comments for details of admission.

Yours sincerely

Andrew Kernohan
Consultant Physician

Follow-up arranged: none

Electronically Signed: Dr Andrew Kernohan, Consultant

cc.

Hughes Lisa Rosemary CHI: 1701806541

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No **Consent for Sharing Withheld: No**

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100
Date of Completion: 07/06/2014

Dr. AA Finney
Drs Semple finney and datta
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Dear Dr AA Finney,

Name	CHI	DoB	Address
Lisa Rosemary Hughes	1701806541	17/01/1980	8 Carham Crescent Glasgow G52 2HN

Admitted	Type	Discharged	Destination
05/06/2014 14:54	In Patient	07/06/2014	Private Residence - no additional detail added

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Brian Kennon	SGH Ward 1 - General Medicine	0141 201 1631

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: The above patient was admitted on5/6/14 with increased SOB, wheeze and cough. There was a history of nocturnal cough and some anterior chest pain. On examination chest was clear with good air entry and no wheeze audible. CXR and ECG were unremarkable. D-dimer was negative. Inflammatory markers were elevated. Dalteparin was started before CTPA showed no evidence of PTE. It also demonstrated a recent fracture of the posterolateral left 7th rib which is likely the source of chest pain on inspiration. She was started on antibiotics which should be continued for a further 5 days. We have started a step 2 inhaler (clenil modulite 200mcg). She is now fit for discharge with analgesia. We will arrange for an outpatient DEXA and isotope bone scan to be performed since there is no history of trauma to the ribs. We have sent blood for vitamin D and calcium levels today. Many thanks. Kind regards,

Dr Finn Begbie
FY1 Medicine

Treatments: None recorded.

Follow-up arranged: none

Planned Outpatient Investigations: DEXA, bone isotope scan

Final Discharge letter to follow: yes

Medication Info:

Allergies: No Allergy

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Amoxicillin Capsules	Oral	500	mg	THREE Times a Day	5 Days	disp
Citalopram Tablets	Oral	20	mg	ONCE a Day	Indefinite	POD
Clenil Modulite Inhaler (Beclometasone) 200micrograms/ puff	Inhaled	1	puff(s)	TWICE a day	Indefinite	disp
Co-codamol 30/500 Tablets	Oral	2	tablet(s)	FOUR Times a Day	2 Weeks	disp[
Diazepam Tablet	Oral	5	mg	THREE Times a Day	Indefinite	POD
Levothyroxine Tablets	Oral	200	micrograms	ONCE a Day	Indefinite	POD
Olanzapine Tablets	Oral	10	mg	At Night	Indefinite	POD
Salbutamol 200micrograms/metered dose Dry Powder Breath Actuated Inhaler	Inhaled	2	dose(s)	As Required	Indefinite	POD

New Medication Started: CLENIL MODULITE, CO-CODAMOL AND AMOXICILLIN

Medication Comment: No other changes to regular medicines

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Finn Begbie
Doctor

Prescription Review

Medications Reviewed by Pharmacist: Dominique Sweeney, Pharmacist
Dispensed Medications Checked by Pharmacy: Dominique Sweeney, Pharmacist
Nurse discharging patient: Anne Robertson, Nurse

REGIONAL MAXILLOFACIAL UNIT
ASSOCIATE SPECIALIST: MRS PATRICIA M FINLAY

Secretary: 0141 232 7602
Fax No: 0141 232 7508
Email: Janice.Findlay2@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

PMF/JF

03/10/12

DR LINSEY LC SEMPLE
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr Semple

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485) CHI: 1701806541
8 CARHAM CRESENT, , GLASGOW, G52 2HN

This patient failed to attend her maxillofacial outpatient clinic appointment on 25/09/12. No further appointments will be sent.

Kind regards

Yours sincerely

Mrs Patricia M Finlay
Associate Specialist in Oral & Maxillofacial Surgery

Dr Alison Winter
Consultant Surgeon
Department of Surgery

Clinic: 29/02/12
Dictated: 29/02/12
Typed: 13/03/12

The New Victoria Hospital
Grange Road
Glasgow
G42 9LF

e-mail: amanda.colquhoun@ggc.scot.nhs.uk
e-mail: rosemary.turner@ggc.scot.nhs.uk
Tel: 0141 347 8720

DR LINSEY LC SEMPLE
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr Semple

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485) CHI: 1701806541
8 CARHAM CRESENT, , GLASGOW, G52 2HN

Thank you for your referral of this 32 year old woman to Miss Winter's clinic. She has a 3 to 4 month history of a lump in her axilla. I understand that her bloods were all normal from her GP. There was nothing else. All things seem to have settled. She is not able to feel the lump. There is no past or family history of note.

On examination today there were no masses palpable in her right or left breast. Right axilla was normal. Left axilla had very slight thickening deep in the left axilla. I could not feel any definite lymph nodes. Ultrasound of the left axilla was normal. I therefore reassured her. On discussion of the ultrasound result her mother had come in with her. She said that her daughter has lost weight. I looked at all the blood results and these are all completely normal. Including blood film. I have therefore urged her to see her GP with regard to her weight loss. From a breast point of view and her left axilla everything was normal and I can find no areas of concern.

Yours sincerely

MARY ROUSE
SPECIALTY DOCTOR

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

Attachments

REFERRAL TO

General Surgery - Breast
GGC General Referral

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

Victoria Infirmary
55 Grange Road
Glasgow
G42 9LF

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

Hospital location code.
G306H

Email address
-

Urgency of referral	ROUTINE		
Date of referral	22-Dec-2011	**Date sent**	23-Dec-2011

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541
Area of Residence	-

Patient's address

8 Carham Cres
GLASGOW
G52 2HN

Contact number(s)

Voice: 0141 239 0191

101002970307N Unique Care Pathway Number: 101002970307N

REGISTERED GP DETAILS

Name	Dr Linsey Semple		
GMC code	2820354	GP code	07897
Practice name	Cardonald Medical Centre (18974)		
Practice code	52363		

Practice address

1831
Paisley Road West
Cardonald
Glasgow
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Linsey Semple		
GMC code	2820354	GP code	07897
Practice name	Drs Semple & Finney (52363)		
Practice code	52363		

Practice address

Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Contact number(s)

Voice: 0141 892 2548

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: AXILLARY LUMP

Comment: Dear Doctor,

This 31 year old lady has noticed a left painless axillary lumb 3 weeks ago. She was given antibiotics but it has not settled. She reports no symptoms of sweats or fever. Breast examination was essentially normal. There is a 3 centimetre firm mobile lump in her left axilla, with no signs of any other lymph adenopathy or hepatospenomegaly. I have arranged for her to have some blood tests including a blood film. Given the persistens of this lump I would be gratful for your further assessment. Thank you for seeing her.

Yours sincerely,

DR. ANGHARAD LLEWELYN.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
[X]Deliberate drug overdose / other poisoning	Olanzapine, Diazepam amd alcholStart Date: 24/04/2011	18-May-2011	18-May-2011
Cause of overdose - deliberate	Olanzapine & Alcohol	25-Apr-2011	25-Apr-2011
Poisoning - self-inflicted	deliberate	24-Apr-2011	24-Apr-2011
Cause of overdose - deliberate	-	31-Mar-2011	31-Mar-2011
Autoimmune thyroiditis	-	25-Jun-2009	25-Jun-2009
Nontoxic multinodular goitre	-	29-Aug-2008	29-Aug-2008
Asthma resolved	Attack 1995	12-Dec-2005	12-Dec-2005
Head injury	was assaulted	27-Sep-1997	27-Sep-1997
[X]Overdose - paracetamol	-	23-Apr-1994	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Thyroidectomy operations	-	08-Jun-2009	08-Jun-2009
CIN III - severe dyskaryosis	HPV	26-May-2004	26-May-2004

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Levothyroxine Sodium Tablets 100 micrograms	112	112 TABS	2 Tabs In the morning	-	04-Oct-2011	02-Dec-2011

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued

Flucloxacillin Capsules 500 mg	28	28 CAPSULE	ONE TO BE TAKEN FOUR TIMES A DAY	-	07-Dec-2011	07-Dec-2011
Diazepam Tablets 5 mg	84	84 tablet	ONE TO BE TAKEN THREE TIMES A DAY-DISPENSE WEEKLY	-	07-Dec-2011	07-Dec-2011
Diazepam Tablets 5 mg	21	21 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	29-Nov-2011	29-Nov-2011
Aripiprazole Tablets 10 mg	28	28 TABS	1 tab mane	-	23-Nov-2011	07-Dec-2011
Citalopram Hydrobromide Tablets 20 mg	28	28 TABS	1 Tab Daily	-	23-Nov-2011	07-Dec-2011
Olanzapine Tablets 10 mg	28	28 TABS	1 Tab At night	-	23-Nov-2011	07-Dec-2011
Diazepam Tablets 5 mg	84	84 TABS	1 Tab 3 times daily	-	17-Nov-2011	17-Nov-2011
Aripiprazole Tablets 10 mg	28	28 TABS	1 tab mane disp 2x wkly	-	21-Jul-2011	21-Jul-2011
Citalopram Hydrobromide Tablets 20 mg	28	28 TABS	1 Tab Daily disp wkly	-	21-Jul-2011	21-Jul-2011
Olanzapine Tablets 10 mg	28	28 TABS	1 Tab At night disp weekly	-	21-Jul-2011	21-Jul-2011
Diazepam Tablets 5 mg	84	84 TABS	1 tab disp dispwkly 3 times daily	-	21-Jul-2011	21-Jul-2011
Mebendazole Tablets Sugar Free 100 mg	-1	-1 INVALID	DELETED for reason of: Wrong patient ? 1 Tab	-	22-Aug-2011	22-Aug-2011
Mebendazole Tablets Sugar Free 100 mg	1	1 TABS	1 Tab	-	22-Aug-2011	22-Aug-2011
Citalopram Hydrobromide Tablets 20 mg	28	28 TABS	1 Tab Daily	-	24-Aug-2011	24-Aug-2011
Diazepam Tablets 5 mg	84	84 TABS	1 tab disp 3 times daily	-	24-Aug-2011	24-Aug-2011
Diclofenac Sodium E/c tablets 50 mg	84	84 TABS	1 Tab 3 times daily	-	24-Aug-2011	24-Aug-2011
Aripiprazole Tablets 10 mg	28	28 TABS	1 tab mane disp	-	24-Aug-2011	24-Aug-2011
Olanzapine Tablets 10 mg	28	28 TABS	1 Tab At night	-	24-Aug-2011	24-Aug-2011
Citalopram Hydrobromide Tablets 20 mg	28	28 TABS	1 Tab Daily	-	22-Sep-2011	22-Sep-2011
Olanzapine Tablets 10 mg	28	28 TABS	1 Tab At night	-	22-Sep-2011	22-Sep-2011
Aripiprazole Tablets 10 mg	28	28 TABS	1 tab mane	-	22-Sep-2011	22-Sep-2011
Co-Codamol 8/500 Tablets	112	112 TABS	1 or 2 Tabs 4 times daily	-	22-Sep-2011	22-Sep-2011
Diazepam Tablets 2 mg	168	168 TABS	2 Tabs 3 times daily	-	22-Sep-2011	22-Sep-2011
Diclofenac Diethylammonium Gel 1.16 %	100	100 GEL	Apply 3 times daily	-	13-Oct-2011	13-Oct-2011
Amoxicillin Capsules 500 mg	21	21 CAPS	1 Cap 3 times daily	-	13-Oct-2011	13-Oct-2011
Citalopram Hydrobromide Tablets 20 mg	28	28 TABS	1 Tab Daily	-	19-Oct-2011	19-Oct-2011
Diazepam Tablets 5 mg	84	84 TABS	1 Tab 3 times daily	-	19-Oct-2011	19-Oct-2011
Olanzapine Tablets 10 mg	28	28 TABS	1 Tab At night	-	19-Oct-2011	19-Oct-2011
Aripiprazole Tablets 10 mg	28	28 TABS	1 tab mane	-	19-Oct-2011	19-Oct-2011

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:	Smoking status.clm - Repeat after an Interval 1Y	07-Apr-2011
Current smoker:	Smoking Status.clm - Repeat after an Interval 12M	30-Mar-2011
Current smoker:	Smoking Status.clm - Repeat after an Interval 12M	04-Jun-2009
Current smoker:	Smoking status.clm - Repeat after an Interval 1Y	06-Jun-2008
Current smoker:	Smoking status.clm - Repeat after an Interval 1Y	04-Aug-2006
Teetotaller:	Alcohol Intake$$.clm - No Action Required	01-Feb-2005

Clinical warnings

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

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

THE VICT[illegible] SURGERY DEPARTMENT

Name

Address

SG00953485
LISA ROSEMARY HUGHES
8 CARHAM CRES

GLASGOW
G52 2HN

17/01/1980
CHI 1701806541

Unit Number

Date of Birth
Sex/
Civil state

Occupation

Surgeon
DR WINTER

BOOK

VICTORIA	

SOON / URGENT

Booked by.....

Diagnosis

O.P. Treatment

at.....on.....

Date	History and Clinical Findings
29/2/12	32y old woman 3-4m history of lump in (R) axilla Bloods (N) [illegible] Nil else Seems to have settled PMH - Nil FH - Nil O/E  slight thickening ?LN US - (R) axilla (N) [illegible] See GP as says has lost weight

M. [illegible] (Reg)

[illegible] (Reg)

FORM 0164724 VIC 683

DOCTOR'S LETTER SHEET

UNIT NUMBER

REGIONAL MAXILLOFACIAL UNIT
CONSULTANT: MR D A KOPPEL

Direct dial: 0141 232 7510
Fax no: 0141 232 7508
E-mail: Louise.Morgan@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

DAK/LEM
Typed: 29/05/12

DR LINSEY LC SEMPLE
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr Semple

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485) CHI: 1701806541
8 CARHAM CRESENT, , GLASGOW, G52 2HN

This patient failed a review appointment with regard to her temporomandibular joint problem. I can only assume all is well and I have not arranged to see her again.

Kind regards

Yours sincerely

Mr David A Koppel
Consultant Craniofacial/Oral and Maxillofacial Surgeon
Lead Clinician Regional Maxillofacial Unit

0367709-SGH3Y

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

REGIONAL MAXILLOFACIAL UNIT
ASSOCIATE SPECIALIST: MRS PATRICIA M FINLAY

Secretary: 0141 232 7602
Fax No: 0141 232 7508
Email: Janice.Findlay2@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

PMF/JF
Clinic: 15/11/11
Typed: 16/11/11

DR LINSEY LC SEMPLE
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr Semple

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485) CHI: 1701806541
8 CARHAM CRESENT, , GLASGOW, G52 2HN

This young lady was fitted with a bite raising appliance today. We will review her in six months to see how she is getting on.

Kind regards

Yours sincerely

Mrs Patricia M Finlay
Associate Specialist in Oral & Maxillofacial Surgery

0367709-SGH3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

REGIONAL MAXILLOFACIAL UNIT
ASSOCIATE SPECIALIST: MRS PATRICIA M FINLAY

Secretary: 0141 232 7602
Fax No: 0141 232 7508
Email: Janice.Findlay2@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

PMF/JF
Clinic: 18/10/11
Typed: 20/10/11

DR LINSEY LC SEMPLE
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr Semple

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485) CHI: 1701806541
8 CARHAM CRESENT, , GLASGOW, G52 2HN

Thank you for referring this patient who complains of a four month history of pain in the right side of the jaw. This is worse at night. It does not seem to stop her eating although she does report that eating causing her some discomfort. On examination she has obvious signs of tooth clenching including crenulations of the tongue and large tender masseters.

I explained the aetiology to her and we have arranged to construct a flexible lower splint, which may help support her jaw during the night and avoid clenching. I hope that we will be able to settle this with simple conservative means.

Kind regards

Yours sincerely

Mrs Patricia M Finlay
Associate Specialist in Oral & Maxillofacial Surgery

0367709-SGH3Y

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

Attachments

REFERRAL TO

Oral and Maxillofacial Surgery
GGC General Referral

Consultant / receiving practitioner and/or specialty clinic

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

Hospital and hospital address

Hospital location code: G405H

Email address: -

Urgency of referral ROUTINE
Date of referral 25-Aug-2011 **Date sent** 26-Aug-2011

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa Rosemary
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541
Area of Residence	-

Patient's address

8 Carham Cres
GLASGOW
G52 2HN

Contact number(s)

Voice: 0141 239 0191

101002450038X Unique Care Pathway Number: 101002450038X

REGISTERED GP DETAILS

Name	Dr LC Semple		
GMC code	2820354	GP code	G07897
Practice name	Cardonald Medical Centre		
Practice code	52363		

Practice address

1831 Paisley Road West
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Linsey Semple		
GMC code	2820354	GP code	07897
Practice name	Drs Semple & Finney (52363)		
Practice code	52363		

Practice address

Cardonald Medical Centre
1831 Paisley Road West
Glasgow

Contact number(s)

Voice: 0141 892 2548

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: TEMPORAL MANDIBULAR JOINT PROBLEMS

Comment: Dear doctor,

I would be grateful if you could see this young lady who has had recurrent problems with her right temporal mandibular joint. She has pain, difficulty opening her jaw and difficulty eating food. This has been a recurrent problem over the last few months and she feels it started after her sterilisation around three months ago. I do not know whether this may have occurred during her general anaesthetic rpocedure. Today I have given her anti-inflammatories to see if this might help. I did not see any mal occlusion of her teeth, and she is tender at the temporal mandibular joint. Examination of her ear was normal. I wonder if you could see her for advice and management of this.

Thank you for your time.
Yours sincerely,

DR KIRSTY MCCALLUM

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
[X]Deliberate drug overdose / other poisoning	Olanzapine, Diazepam amd alcholol	24-Apr-2011	18-May-2011
Cause of overdose - deliberate	Olanzapine & Alcohol	-	25-Apr-2011
Poisoning - self-inflicted	deliberate	-	24-Apr-2011
Cause of overdose - deliberate	-	-	31-Mar-2011
Autoimmune thyroiditis	-	-	25-Jun-2009
Nontoxic multinodular goitre	-	-	29-Aug-2008
Asthma resolved	Attack 1995	-	12-Dec-2005
Head injury	was assaulted	-	27-Sep-1997
[X]Overdose - paracetamol	-	-	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Laparoscopic bilateral female sterilisation	-	17-May-2011	24-Aug-2011
Laparoscopic bilateral female sterilisation	-	17-May-2011	27-May-2011
Equivalent quantities for all medication checked	-	-	18-Nov-2010
Rep.presc. monitoring NOS	-	-	18-Nov-2010
Thyroidectomy operations	-	-	08-Jun-2009
CIN III - severe dyskaryosis	+ HPV	-	26-May-2004

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Levothyroxine Sodium	112	TABS 100MICROGRAMS	2 Tabs	In the morning	15-Feb-2010	24-Aug-2011

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Diazepam	84	TABS 5MG	1 tab disp	3 times daily	24-Aug-2011	24-Aug-2011

Olanzapine	28	TABS 10MG	1 Tab	At night	24-Aug-2011	24-Aug-2011
Citalopram	28	TABS 20MG	1 Tab	Daily	24-Aug-2011	24-Aug-2011
Diclofenac Sodium	84	Ec TABS 50MG	1 Tab	3 times daily	24-Aug-2011	24-Aug-2011
Aripiprazole	28	TABS 10MG	1 tab	mane disp	24-Aug-2011	24-Aug-2011
Mebendazole	1	TABS 100MG	1 Tab	-	22-Aug-2011	22-Aug-2011
Aripiprazole	28	TABS 10MG	1 tab	mane disp 2x wkly	21-Jul-2011	21-Jul-2011
Olanzapine	28	TABS 10MG	1 Tab	At night disp weekly	21-Jul-2011	21-Jul-2011
Diazepam	84	TABS 5MG	1 tab disp dispwkly	3 times daily	21-Jul-2011	21-Jul-2011
Citalopram	28	TABS 20MG	1 Tab	Daily disp wkly	21-Jul-2011	21-Jul-2011
Olanzapine	28	TABS 10MG	1 Tab	At night disp weekly	29-Jun-2011	29-Jun-2011
Movicol	20	Lemon & Lime 13.8g SACH	1 sachet	up to TID	29-Jun-2011	29-Jun-2011
Diazepam	84	TABS 5MG	1 tab disp dispwkly	3 times daily	29-Jun-2011	29-Jun-2011
Aripiprazole	28	TABS 10MG	1 tab	mane disp 2x wkly	29-Jun-2011	29-Jun-2011
Citalopram	28	TABS 20MG	1 Tab	Daily disp wkly	29-Jun-2011	29-Jun-2011
Diazepam	84	TABS 5MG	1 tab disp dispwkly	3 times daily	15-Jun-2011	15-Jun-2011
Olanzapine	28	TABS 10MG	1 Tab	At night disp weekly	15-Jun-2011	15-Jun-2011
Aripiprazole	28	TABS 10MG	1 tab	mane disp 2x wkly	15-Jun-2011	15-Jun-2011
Citalopram	28	TABS 20MG	1 Tab	Daily disp wkly	15-Jun-2011	15-Jun-2011
Olanzapine	14	TABS 10MG	1 Tab	At night disp weekly	08-Jun-2011	08-Jun-2011
Diazepam	42	TABS 5MG	1 tab disp dispwkly	3 times daily	08-Jun-2011	08-Jun-2011
Aripiprazole	14	TABS 10MG	1 tab	mane disp 2x wkly	08-Jun-2011	08-Jun-2011
Citalopram	14	TABS 20MG	1 Tab	Daily disp wkly	08-Jun-2011	08-Jun-2011
Diazepam	42	TABS 5MG	1 tab disp disp 2 wkl	3 times daily	25-May-2011	25-May-2011
Aripiprazole	14	TABS 10MG	1 tab	mane disp 2x wkly	25-May-2011	25-May-2011
Olanzapine	14	TABS 10MG	1 Tab	At night disp 2 xwkly	25-May-2011	25-May-2011
Citalopram	14	TABS 20MG	1 Tab	Daily 2x wkly	25-May-2011	25-May-2011
Aripiprazole	14	TABS 10MG	1 tab	mane disp wkly	04-May-2011	04-May-2011
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	im	04-May-2011	04-May-2011
Olanzapine	14	TABS 10MG	1 Tab	At night disp	04-May-	04-May-

				wkly	2011	2011
Diazepam	42	TABS 5MG	1 tab disp 2x weekly	3 times daily	04-May-2011	04-May-2011
Citalopram	14	TABS 20MG	1 Tab	Daily disp wkly	04-May-2011	04-May-2011
Olanzapine	28	TABS 10MG	1 Tab	At night	20-Apr-2011	20-Apr-2011
Citalopram	28	TABS 20MG	1 Tab	Daily	20-Apr-2011	20-Apr-2011
Diazepam	42	TABS 5MG	1 tab up to	3 times daily	20-Apr-2011	20-Apr-2011
Aripiprazole	28	TABS 10MG	1 tab	mane	20-Apr-2011	20-Apr-2011
Citalopram	28	TABS 20MG	1 Tab	Daily	06-Apr-2011	06-Apr-2011
Diazepam	42	TABS 5MG	1 tab up to	3 times daily	06-Apr-2011	06-Apr-2011
Aripiprazole	28	TABS 10MG	1 tab	mane	06-Apr-2011	06-Apr-2011
Olanzapine	28	TABS 10MG	1 Tab	At night	06-Apr-2011	06-Apr-2011
Diazepam	21	TABS 5MG	1 tab up to	3 times daily	31-Mar-2011	31-Mar-2011
Diazepam	42	TABS 5MG	1 tab up to	Twice daily	16-Mar-2011	16-Mar-2011
Olanzapine	28	TABS 10MG	1 Tab	At night	16-Mar-2011	16-Mar-2011
Citalopram	28	TABS 20MG	1 Tab	Daily	16-Mar-2011	16-Mar-2011

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		07-Apr-2011
Current smoker:		30-Mar-2011
Current smoker:		04-Jun-2009
Current smoker:		06-Jun-2008
Current smoker:		04-Aug-2006
Current smoker:	20:	01-Feb-2005
Teetotaller:		01-Feb-2005

Clinical warnings

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

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

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES

SG00953485
LISA HUGHES
5 MOSSVIEW QUADRANT
FLAT 2/2
GLASGOW 17/01/1980
G52 2TU CHI 1701806541

Date & Time		Signature, Print Name & Designation
	18.10.11	
	Ref. GP fc (R) sided facial pain	
	Worse at night	
	Clenching teeth at night	
	PMH/	
	Admits "stressful life	
	psychiatric history. Thyroidectomy	
	overdose attempt	
	Numerous hospital admissions.	
	O/E obvious clencher - large masseters	
	Tender masseters	
	Jaw moves to (E) on opening	
	Good range of jaw movement.	
	Try splint & conservative management	

193443

GCN SL

Acute Services Division
Southern General Hospital

NHS Greater Glasgow and Clyde

Gynaecology Department

Integrated Care Pathway - Emergency Admissions

Date 08/06/14 Ward GYN EMERGENCY

Time Seen: 16.40

Use addressograph label if available

Consultant DR TAGGART

Please print clearly in block capitals

SG00953485
HUGHES ,LISA ROSEMARY
8 CARHAM CRES

GLASGOW 17/01/1980
G52 2HN CHI 1701806541

Prefers to be called

Telephone 0141 239 0191

Occupation

Religion

Interpreter required (specify)

Date arranged

Comments

Next of kin

Name AGNES HUGHES

Address

Telephone Day 07769815357 Evening

Relationship MOTHER

Other contact

Address

Telephone Day Evening

Relationship

Relative aware of admission Yes ☑ No ☐

Comments

GP

Name DR McCANN

Address CARDONALD MEDICAL CENTRE

Telephone

Home circumstances / Social support

Lives with family ☑

Comments 8 children

Lives alone ☐

Nursing home ☐

Residential care ☐

Dependants ☐

Comments

Social support at present

District nurse Yes ☐ (days/week) No ☑

Cancelled Yes ☐ No ☐

Home help Yes ☐ (days/week) No ☑

Cancelled Yes ☐ No ☐

Cancelled by Date

Other services

(specify)

MRSA

History of MRSA Yes ☐ No ☑

If yes
Screened and infection control team informed of admission ☐

Comments

Any additional comments

NKDA. P8+0

hot sweats, abdo pain, lethargic

no urinary symptoms.

BO last week, on Senna.

(R) sided pain. nil PV bleeding.

3/52 post lap ster (Victoria

Nursing Assessment

Observations		Results
Temp	Yes ☑ No ☐	36.4°c
Pulse	Yes ☑ No ☐	89 bpm
BP	Yes ☑ No ☐	114/68
Respirations	Yes ☐ No ☐	
Sa 02	Yes ☑ No ☐	99%
Pain score (according to acute pain guidelines)	Yes ☑ No ☐	Mild pain
Height	Yes ☐ No ☐	
Weight	Yes ☐ No ☐	
BMI	Yes ☐ No ☐	
Waterlow score	Yes ☐ No ☐	
Moving/handling risk assessment	Yes ☐ No ☐	
Blood sugar if appropriate	Yes ☐ No ☑	N/A
Urinalysis	Yes ☑ No ☐	Trace protein
M'ssu if +ve urinalysis	Yes ☐ No ☐	
.egnancy test (if appropriate)	Yes ☑ No ☐	-VE

Other (Specify) _____

Activities of Daily Living

Communication / Mental State

Alert/orientated _____ ☐

Confused _____ ☐

Anxious/distressed _____ ☐

Details _____

Senses

Glasses _____ Yes ☐ No ☐

Hearing impaired _____ Yes ☐ No ☐

Hearing aid _____ Yes ☐ No ☐

Dentures _____ Yes ☐ No ☐

Other _____

Personal Hygiene

Independent _____ ☐

Dependant _____ ☐

Nutrition

Normal diet Yes ☐ No ☐

(If no specify requirements) _____

Elimination

Bowel function

Regular _____ Yes ☐ No ☐

If no please comment: _____

Constipation _____ Yes ☐ No ☐

Diarrhoea _____ Yes ☐ No ☐

Uses aperients _____ Yes ☐ No ☐

If yes which type _____

Bladder function

Regular no problems _____ Yes ☐ No ☐

If no please comment _____

Frequency _____

Dysuria _____

Nocturia x _____

Urgency _____

Retention _____

Sleeping

Difficulties in Sleeping Yes ☐ No ☐

If yes details _____

Medication _____

Expressing Sexuality

Sexually Active _____ Yes ☐ No ☐

Comments _____

Additional Coments

Acute Services Division
Southern General Hospital

NHS Greater Glasgow and Clyde

Gynaecology Department
Integrated Care Pathway - Emergency Admissions

SG00953485
HUGHES , LISA ROSEMARY
8 CARHAM CRES

GLASGOW 17/01/1980
G52 2HN CHI 1701806541

Date 8/6/11 Ward Gyn. Emerg.

Medical Assessment

Presenting complaint abdominal pain, lethargy, constipation ↓ appetite.

LMP not sure, was on Depo-provera Parity: P8 +0

Date of Last Smear / / Result:

Allergies: Contraception: depo - provera ~~by sterilization 3/52 ago~~

Triage Notes

R ____ BP 114/68 P 89 T 36.4 BM ____ SpO2 99% Expected PEF ____ PEF ____

Urine: Leuco — Prot trace ph — Blood — SG — Ket. — Gluc — Nitrites —

Pregnancy test Result: negative

8/6/11 Review.
17.20

GP referral
c/o RIF and umbilical pain since ~~by~~ sterilization 3 weeks ago.
constipated now for ~ 1 week
reduced appetite.

to

was feeling flushed, lethargic earlier today with mild pyrexia @ GP practice of 37.4°C.

On arrival looks well, haemodynamically stable, not in pain. Apyrexial 36.4°C. normotensive

PJA: abdomen soft, non tender, no guarding
no dysuric symptoms.

Refused internal examination today / prefers to have it done when comes back tomorrow.

P.T.O. →

Date: 8/6/11

(cont)

Imp: Constipation
? viral infection
However need to exclude appendicitis / ovarian pathology.
Pain unlikely to be related to Lx sterilization as it has now been 3 weeks since procedure and is stable + looks well.

Plan: return 9/6/11 for U/S + internal examination.
FBC, U+E, CRP today
laxatives.

1. Soko
for 6 (7519)

4.6.11 12⁰⁰ - Returned to Gyn emergency for R/V. BP 111/71, pulse 73 bpm, SaO2 98%, temp 35.7°c. Pain settled overnight. (F Macinnes

Bld results from 8/6/2011 - CRP-(12), WBC-6.4, Hb 123, Plt 314
U&E-(N).

Print Name: Signature:

Once Only Prescriptions

Date Given	Drug (Block Capitals)	Dose	Method of Adminstration	Time of Administration	Signature	Given By

Discharge Prescription Packs

Date Given	Drug (Block Capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

Seen not admitted letter given Yes ☐ No ☐

Follow-up Arrangement

Acute Services Divison

Gynaecology Emergency Department,
Maternity Building, Southern General Hospital

NHS
Greater Glasgow and Clyde

GP Information Summary

Patient name SG00953485 Ac HUGHES ,LISA ROSEMARY 17/01/1980 G52 2HN Practice Code: 52363 CHI:1701806541	GP Dr. Mc CALLUM GP Address: Cardonald Medical Centre
Telephone number	Unit No
Date of birth	CHI No
Date 9/6/2011	Consultant on call Dr Hamilton

Dear Colleague,

The above named patient was seen at the Gynaecology Emergency Department and did not require admission. The clinical details are as follows:

Date seen	9/6/2011
Under the care of	Dr Jayaj Prabhu (Reg) / Dr Hamilton (Cons)
Diagnosis	Constipation.
Investigations	FBC - (N). U&E (N). Speculum + Vaginal examination - normal. CRP - 12
Treatment	Coltrine Senna, Movicol to be added
Medication	I will be grateful if you could prescribe Movicol.
Additional information	

☐	The patient **has** been given an out-patient appointment on this date:	
☑	The patient has **not** been been given an out-patient appointment.	
Seen by	Dr Jayaj Prabhu	
Signature		

Patients name Lisa Rosemary Hughes DOB 17/1/1980 Unit number

Multi-professional Notes	Signature	Time
9/6/11		
Drugs → Feels well & Looks well		
→ not opened bowels for	line — Taking some	
PA. Just — ~AD		
PS: G. VS WNL		
VE: uterus normal S.I. mobile		
Both adnexa: NAD		
Imp: (a) Pelvic examination. should have been		
normal on laparoscopy. Back ache.		
Pt clinically well. discomfort mostly		
likely due to constipation		
Plan: Received		
Laxative —	Moved.	
	Spoke SHO	ST6

DR LINSEY C SEMPLE
DR ALAN A W FINNEY

Consultations by appointment
Tel: 0141 892 2548
Fax: 0141 892 2549

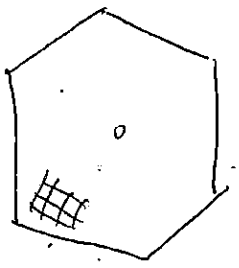
Cardonald Medical Centre
1831 Paisley Road West
GLASGOW
G52 3SS

CHI: 1701806541
HUGHES; Lisa Rosemary 17/01/1980
8 Carham Cres G52 2HN
0141 239 0191
Dr K McCallum | GMC 4613239
Cardonald Med Centre,
08/06/2011 15:50, Practice: 52363

Dear Dr

Thanks for seeing this young girl with temp, RIF, constipation and anorexia. She had a laparoscopic perforation 3/52 ago.

O/E. T 37.4 HR 89. Urinalysis NAD. 138/80.



Tender as marked.

See when coughing

Wounds ✓.

? complications of sterilisation

Imp ? early appendix

Urinalysis NAD.

Meds

NKDA.
Diazepam 5mg tid.
Citalopram 20mg 2nd + 40mg daily
Olanzapine 10mg od.
Aripiprazole 10mg od.
Levothyroxine 200mcg od.

PMH

lap ster 3/52 ago
Autoimmune thyroiditis

SOUTHERN GENERAL HOSPITAL

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW, G51 4TF
TEL: 0141 201 1100

3B

DOCTOR'S LETTER SHEET

UNIT NUMBER

WARD 20 DISCHARGE LETTER

PATIENT: LISA ROSEMARY HUGHES
8 CARHAM CRES

GLASGOW
G52 2HN

DOB: 17/01/80
CHI: 1701806541
UNIT NO: SG00953485
ACCT NO: IP0021875/11
WARD: SCDU

GP: LINSEY LC SEMPLE
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

CONSULTANT: KEVIN BLYTH
ADMITTED: 25/04/11

ADMISSION TYPE: AE - Referral
DISCHARGE TO: HOME

ADMIT DATE: 25/04/11
DISCHARGE DATE: 26/04/11

PRESENTATION: OD

DISCHARGING CONSULTANT: SEMCO

MAIN DIAGNOSIS:

OTHER DIAGNOSIS:

FURTHER INFO: ADMITTED WTIH OVERDOSE OF OLANZAPINE AND DIAZEPAM. OBSERVED FOR 48 HOURS WITH NEUROLOGICAL OBSERVATIONS. SEEN BY LIAISON PSYCHIATRY, FIT FOR HOME.

INVESTIGATIONS:

INTERVENTIONS:

REPORTS/UPDATE: NO ADDITIONAL INFORMATION IS LIKELY TO BE FORTHCOMING.

YOURS SINCERELY

COLIN SEMPLE
CONSULTANT PHYSICIAN

REPORTS TO BE TRACKED? N

OP TESTS:

LETTER TO FOLLOW: N

COMPLIANCE AID: N

DISCONTINUED DRUGS? N

NEW MEDICATION? N

MEDICATION COMMENTS:

ALLERGIES:

FOLLOWUP? N DETAIL:

TIMESCALE:

SIGNED: FY1.MINSA MCMINN,SARAH
DESIGNATION: FOUNDATION DR YEAR 1

PAGE NUMBER: 7025

0367710-SGH3B

ES 953485
at elsewhere

Mental Health Service

NHS
Greater Glasgow and Clyde

Dr McKay
Consultant Physician
Ward 20
Southern General Hospital
1345 Govan Road
GLASGOW
G51 4TF

Department of Clinical Psychological Medicine
Southern General Hospital
1345 Govan Road
GLASGOW
G51 4TF

Date Rec'd: 28th April 2011
Date Typed: 9th May 2011

Our Ref: MMcC/PS/1250038
Your Ref:

Direct Line: 0141 201 2422
Fax: 0141 201 2422
Email: Paul.Stubbs@ggc.scot.nhs.uk

Dear Dr McKay

Lisa Rosemary Hughes – (DOB – 17.01.1980) – CHI No. 1701806541
8 Carham Crescent, Glasgow G52 2HN

Thank you for the referral of the above named patient. She was referred to Liaison Psychiatry on 25th April 2011 following a mixed overdose of 10 x Olanzapine tablets and 20 x Diazepam tablets taken in combination with alcohol at 7.30 pm the previous day. Miss Hughes is currently known to Mental Health Services, specifically Rossdale CMHT. It would appear that she was very unco-operative and aggressive on admission. She had phoned her sister at approximately 8.00 pm after taking the tablets. It would appear her two children, aged 6 and 5, were present in the house at the time, but it would appear that her partner was also in the house. Initially on my arrival on to the ward she was extremely unresponsive and in quite a heavy drowsy state. However, she appeared to awaken quite abruptly and I managed to assess her from a risk point of view. She states that she feels extremely regretful about taking the overdose. She admits that she was quite intoxicated and was feeling quite stressed in dealing with her kids. She took an overdose about five weeks ago and admits that she has not been coping very well recently. She is under the care of Rossdale CMHT and her CPN is Marie Rooney and she also sees Staff Grade Psychiatrist, Dr Yousaf.

Current Medication
Olanzapine 10 mg nocte, Diazepam 5 mg tds, Citalopram 20 mg once daily, Aripiprazole 10 mg once daily, and Levothyroxine 200 mcgs.

It is unclear as to whether she was going to be discharged and I explained to staff that I had completed a risk assessment and I could return the following day if she remains in hospital to complete a fuller psychiatric assessment. The patient was orientated in time, place and person. Speech was of normal rate and tone. Eye contact reasonable. She denies any significant sleep disturbance or problems with her appetite. She states that she has been feeling quite distracted recently. No significant problems with her memory. Her mood at time of assessment does not appear particularly depressed. No ongoing suicidal thoughts. No evidence of any other psychiatric morbidity or any psychotic phenomena. I explained to Lisa that I

would liaise with her existing supports in order to ensure the appropriate follow-up arrangements and she was agreeable to this. I recommended that she be discharged as soon as deemed medically fit.

Yours sincerely

Michael McCann
Psychiatric Liaison Nurse

c.c. Dr L C Semple, Cardonald Medical Centre; 1831 Paisley Road West, Glasgow G52 3SS
Dr Yousaf, Staff Grade Psychiatrist, Rossdale CMHT, Resource Centre, 21 Haughburn Road, Pollok, Glasgow G53 6AB
Marie Rooney, CPN, (**AS ABOVE**)

TOXBASE .org
UK NPIS 0844 892 0111
Ireland NPIC (01) 809 2566
mail@toxbase.org

Search
Enter word Search
Advanced Search | Need help searching

NPIS National Poisons Information Service
A service commission Protection /

News General Info Specialist areas Chemicals Poisons Index A-Z Dosage Calculato

Diazepam **Updated 12/2009**

Type of Product

A benzodiazepine.

Ingredients

Diazepam
Tablets - 2 mg, 5 mg, 10 mg
Capsules - 2mg, 5mg (discontinued)
Oral solution/5 mL - 2 mg, 5 mg
Injection - 5 mg/ mL
Rectal tubes - 2 mg/mL, 4 mg/mL
Suppositories - 10 mg

Toxicity

Serious toxicity in children or adults is rare. Patients have recovered from deep coma following ingestio 2000 mg of diazepam within 48 hours (Greenblatt et al 1978).

After therapeutic dosing peak plasma concentrations occur within 30-90 minutes. Although the eliminat diazepam is 24 to 48 hours, a number of active agents are produced from metabolism, in particular desmethyldiazepam which has a half life up to 5 days (Martindale 2007).

When co-ingested with alcohol and other central nervous system depressants, the effects of benzodiaze potentially more severe.

ALERT BOX
Children or adults who have accidentally ingested less than 0.5 mg/kg and have no symptoms do not usually need referral to A&E.
Note: the frail elderly and those with severe liver disease are at risk of toxicity from lower doses.
Children and adults should be referred if **any** of the following apply:
• recent ingestion of 0.5 mg/kg or more.
• patient is symptomatic.
• patient has taken a deliberate overdose.

Benzodiazepine - features and management **Updated 03/2009**

Features

Benzodiazepines commonly cause drowsiness, ataxia, dysarthria and nystagmus. Coma, hypotension, b respiratory depression occasionally occur but are seldom serious if these drugs are taken alone. Coma u only a few hours but may be prolonged in elderly patients.

Benzodiazepine respiratory depressant effects are more serious in patients with severe chronic obstruct disease. Severe effects in overdose also include rhabdomyolysis and hypothermia.

Co-ingestion of alcohol and other central nervous system depressants potentiates the effects of benzod can increase toxicity.

Management

Suggested nursing care plan - click here

Flumazenil (Anexate), a benzodiazepine antagonist, is not advised as a routine diagnostic test in patien conscious level. It may sometimes be used as an alternative to ventilation in children who are naive to benzodiazepines, or in patients with COPD to avoid the need for ventilation. It is not necessary or appr of poisoning to fully reverse the benzodiazepine effect. Flumazenil has a short half-life (about an hour) situation an infusion may therefore be required.

Flumazenil is contraindicated when patients have ingested multiple medicines, especially after co-ingest benzodiazepine and a tricyclic antidepressant or any other drug that causes seizures. This is because th benzodiazepine may be suppressing seizures induced by the second drug; its antagonism by flumazenil severe status epilepticus that is very difficult to control.

Contraindications to the use of flumazenil include features suggestive of a tricyclic antidepressant inges wide QRS, or large pupils. Use in patients post-cardiac arrest is also contraindicated.

It should be used with caution in patients with a history of seizures, head injury, or chronic benzodiazep

1. Maintain a clear airway and adequate ventilation if indicated.
2. The benefit of gastric decontamination is uncertain. Consider activated charcoal (charcoal dose: 50 g g/kg for a child) in adults or children who have taken more than a potentially toxic amount within 1 h the airway can be protected.
3. Patients who are asymptomatic at 4 hours are unlikely to develop severe toxicity.
4. Monitor level of consciousness, respiratory rate, pulse oximetry and blood pressure in symptomatic p
5. Consider arterial blood gas analysis in patients who have a reduced level of consciousness (GCS < 8; or U) or have reduced oxygen saturations on pulse oximetry.
6. Correct hypotension by raising the foot of the bed and by giving an appropriate fluid challenge. Treat tachyarrhythmias appropriately.

   Children failing to respond to an appropriate intravenous fluid bolus require early discussion with th paediatric intensive care unit (PICU).

   Adults: If severe hypotension persists despite the above measures, then central venous pressure m be considered. Manage in a critical care area or involve the critical care outreach team.

   When hypotension is mainly due to decreased systemic vascular resistance, drugs with alpha-adrene such as noradrenaline or high dose dopamine (10-30 micrograms/kg/min) may be beneficial. The do vasopressor should be titrated against blood pressure.

   When hypotension is believed to be due to reduced cardiac output (e.g. where global hypokinesia is on echocardiography) inotropic drugs such as dobutamine, or in severe cases adrenaline, may be be

   NOTE: Both negative inotropic and vasodilator actions may both be present, particularly in mixed ov If severe hypotension further persists discuss with your local poisons information service: in the UK 0111, in Ireland NPIC (01) 809 2566.

   Click here for details you may be required to give when telephoning NPIS.
7. Supportive measures as indicated by the patient's clinical state.
8. Flumazenil (Anexate), a benzodiazepine antagonist, is available but should rarely be required. It may children who are naive to benzodiazepines or patients with COPD as an alternative to ventilation. Flu short half-life (about an hour) and in this situation an infusion may therefore be required.

   Flumazenil should not normally be used in patients with a history of seizures, head injury, chronic be use, co-ingestion of a benzodiazepine and tricyclic antidepressant or other proconvulsant - Instructio follow.

Southern General Hospital, Emergency Department

MAJORS

Tel Direct: 0141 201 1456/8 Switchboard: 0141 201 1100 Fax: 0141 232 7588

NHS Greater Glasgow and Clyde

(13-2)
Lives 8 children
- Partner.
Smoke 25/m
Alcohol X
(Recent 4 months)
Normal diet
BD ✓

Affix Label

NAME: HUGHES , LISA ROSEMARY
AGE:31 DOB:17/01/80
UNIT No: SG00953485
CONSULTANT: CIERAN MCKIERNAN
Account No: AE00343569/11
DATE:24/04/11
TIME: 2109
CHI#:1701806541

GP Name:	LINSEY LC SEMPLE	GP Phone No: 0141 892 2548 | 6
REASON FOR VISIT:	OD	
ALERTS:	(1)	(2) Asthma
ALLERGIES:	(1)	(2)
RELEVENT HISTORY:	BI POLAR	
MEDICATIONS:		
TRIAGE CATEGORY:	URGENT	TRIAGE NURSE: PAULINE MASON TRIAGE TIME 2110

TRANSCRIBED ANALGESIA :

OBSERVATION TEXT:

OD ? X10 OLANZOPINE AND ALCOHOL TODAY,ATTENDS PSYCH,RECENT DIAGNOSIS BIPOLAR,VERY UNCOOPERATIVE,AGGRESSIVE O/A SISTER IN LAW PRESENT

— Mother now here.

CPN - MARIE ROONEY

Enter/Edit Vital Signs

DATE	TIME	COMPLETED BY	DATE	TIME	COMPLETED BY
24/04/11	2111	NU.MASPA	24/04/11	2111	NU.MASPA

Visual Acuity

Left-6m	Right-6m

T	35.0		T			Correction Y/N	
HR	93		HR			Weight (kg)	
R	20		R			Breath Alcohol	
BP	120/67		BP			Pain Score	
Sa02	99	ON %	Sa02		ON %		
BG			BG				
PF			PF				
EPF							
E			E				
V			V				
M			M				

DISCHARGE CODES
1. Admission 2. L
5. Died 6. Refer to O.P. Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Discharge Time 0030

Ward No. (If admitted)		Transfer to Hospital				Consultant (if admitted)		
Outpatient clinic specialty						Admission or specialty clinic consultant		
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

Date	Emergency Department Notes	
	Seen by (Doctor) Quinn.	Time seen 2200

(31) F

PC Mixed overdose.

HPC. Known psychiatric problems - recent, diagnosis of bipolar disorder.

Phoned her sister at 2000 saying she had ingested 10x olanzapine, 20 x 5mg diazepam and alcohol.

OD occured at ~ 1930

aggressive & intoxicated on admission to department.

Mum and 2 sisters present.

No paracetamol ingested.

Patient has had long term problems with depression and has had a recent dx of bipolar. Just OD 5 weeks ago.

PMHx - Thyroidectomy & hypothyroidism 2°

DHx olanzapine 10mg nocte
diazepam 5mg TDS
citalopram 20mg OD.
Aripiprazole 10mg OD.
levothyroxine 200mcg mane.

SHx
Lives with partner.
8 children

o/e:
Sleeping.
GCS E1 V2 M5 8/15. Pupils RVR A - maintaining own airway

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

B- RR 16
Sats 98%
(L) → clear.

C- Warm and well perfused. CR < 2 secs.
pulse regular.
HR 90 bpm
BP 140/85 mmHg

ECG- not obtained, patient aggressive.

Imp - OD. Requires observation overnight regarding respiratory function.

Plan - IV access + bloods → attempted x 2, patient aggressive and uncooperative, too much of a needle stick injury risk.

Differential Diagnosis/Problem List

- refer medics.

ECG- sinus rhythm.

IV access attempted a third time. patient has scratched 2 members of nursing staff and myself.

SEWS ☐ 0-7

RED FLAG ☐ (Tick)

SIRS ☐

CURB 65 ☐

Done/ completed	Imediate Managment Plan
	We will keep her in dept for an hour to see if she observe and reattempt if she becomes more co-operative.
CO2O	Renewed pt. Sats 100%.
	GCS E3 V4 M6 → 13/15.
	IV access attempted a fourth time - remains aggressive and uncooperative. attempt failed.
	Transfer to ward.

Signature: Eli Designation: FY2 Page No:

Acute Medical or Surgical Admission Unit Notes

Please affix patient ID label here

Initial Assessment

Seen by (print): MCGreer

Time seen: 01:10

Presenting Complaint

Olanzapine & diazepam OD.

History of Presenting Complaint

Drank ~ 1 bottle rum.

Phoned sister to tell her she'd taken OD of olanzapine (10) & diazepam (20x5mg).

Variable agitated/aggressive & drowsy in ATC.

Past Medical History

bipolar disorder

Prev. ODs.

Systemic Enquiry

CVS

RESP

GI

CNS/PNS

GU

Musculoskeletal

MEDICINES RECONCILIATION (ECS can be stapled here and annotated with plan for medicines. Please sign medicines plan.)

Source of medication history Patient ☐ Relative/ carer ☐ GP Surgery ☐ ECS ☐
PODs ☐ Com. Pharmacist ☐ GP letter ☐ Rpt Presc ☐

Admissions medicines				Plan for medicines			
Name	Dose	Frequency	Continue	Stop	Amend	Hold	Comments/ reason
Olanzapine	10mg	nocte				✓	
Diazepam	5mg	tds				—	/
Citalopram	20mg	o	—				
Aripiprazole	10mg	od	✓				
Thyroxine	100mcg	od	✓				✓

Allergies	Medication needs
None known ☐	further clarification? Yes ☐ No ☐

Completed by: Designation: Date:

Drugs prescribed on admission checked and correct

Compliance aid? Yes ☐ No ☐

Comments:	Community Pharmacist

Reviewed by: Designation: Date:

Affix patient ID label

Social History

Smoking History:

Alcohol History:

Other drug use?:

Home circumstances

lives c partner & 8 children aged 13y - 2y/s.

General Examination

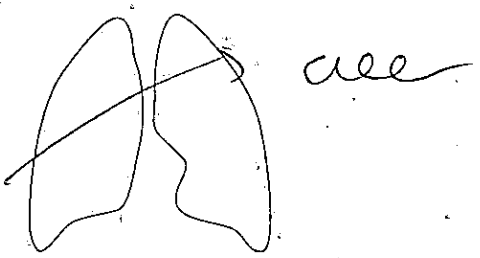
Temp: 36.8	RR:
Pulse 75	BG:
SpO2: 100% on RA	Weight:
BP: 91 154	Urinalysis:

Cardiovascular Examination

1 + 1 + 0

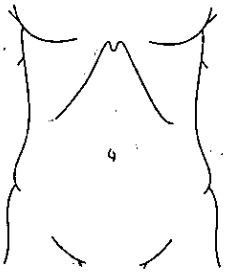
General Observations

Respiratory Examination



clear

Abdominal Examination



Soft

BS ✓

Neurological and Other Examination (e.g. locomotor)

Cranial Nerves

GCS: E: 2 M 4 V: 3 TOTAL 9/15

AMT ☐

Fundoscopy:

Moving all 4 limbs normally to pain/ Stimuli

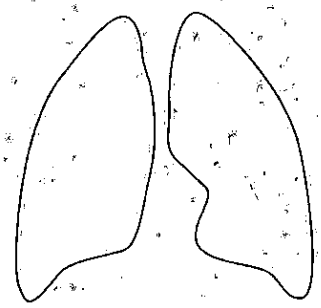
Upper limb neurological examination

Lower limb neurological examination

Other

Key Results:

CXR:



Urinalysis:

ECG:

(N) SR

Differential Diagnosis/Problem List

Mixed OD diazepine & lorazepam

currently GCS 9. Airway maintained

SEWS ☐ 0-7

RED FLAG ☐ (Tick)

SIRS ☐

CURB 65 ☐

Immediate Managment Plan	Done/ Ordered	Checklist
		Medicines plan documented ☐
(1) Bloods ordered		Blood results received ☐
		Kardex ☐
IVFs		Antmicrobials as per Policy
		Yes ☐ No ☐
Ψ RV when medically fit.		If 'No' state reason:
Neurobs / GCS hourly		
		DVT prophylaxis indicated
		Yes ☐ No ☐
		DVT prophylaxis prescribed
		Yes ☐ N/A ☐

Doctor Completing Initial Assessment

Name (print): McGeer Signature: Designation: SR6

Page No. 7310

Please affix patient ID label here

Secondary or Senior Focused Review

Seen by (print):

Time seen:

Done/ completed	Continuing Managment Plan

Doctor Completing Initial Assessment

Signature: Designation: Page No.:

Senior Doctor Review

Seen by (print):

Time seen: MCKay 25/4/11

Please affix patient ID label here

9/31

overdose of olanzapine + diazepam

Drank 1 bottle of rum

Prenas bipolar disorder

Spo2 98%

BP 110/43 P 98

Responds appropriately, moving all limbs

DVT Prophylaxis indicated	Yes ☐	No ☑	Antimicrobials choice compliant Yes ☐ No ☐
DVT Prphylaxis prescribed	Yes ☐	N/A ☐	If 'No' state reason
Medicines Reconciliation completed	Yes ☐	No ☐	

Done/ completed	Continuing Managment Plan
	ψ renew (may be too drowsy today)
	Stop IVI later if more alert

Signature: Designation: Page No:

(CONS)

Please affix patient ID label here

Continuation Sheet

Date: Time 28/4/11

Liaison Psychiatry
Thanks for referral. Patient not medically fit for assessment. Any concerns prior to assessment tomorrow contact Duty Psychiatrist at SGH page 7035.

[illegible]
Liaison Psychiatry

28/4/11

Liaison Psychiatry.
Patient became more alert whilst I was in ward. Continued initial MSE assessment. Remarked of amnesia. NO obvious suicidality. States she took overdose in response to stress at dealing with her children. Known to mental Health services. Will liaise with existing supports to secure follow up. Discharge me medically fit

[illegible]
Liaison Psychiatry

25/4/11
1415

More drowsy again
Spo2 98%
RR 9/59

Probably too drowsy to discharge
keep overnight ? CDU

Home tomorrow

[illegible]
[illegible]

26/4/11
[illegible]
CDU.
0930.

10

Continuation Sheet

Date: Time

Please affix patient ID label here

Continuation Sheet	
Date: Time	

For: PSAETRIAGE01
Su Apr 24, 2011 9:09 pm From: MACKENZIE,CATHERINE
Taken by: MEDITECH ()
********** THIS PATIENT REQUIRES TRIAGE **********

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

S ,LISA ROSEMARY. A&E Number: AE0034356/11 Unit Number:
85

its Address: 8 CARHAM CRES GLASGOW G52 2HN Tel: 07833990700

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

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

Patients GP: SEMPLE, LINSEY LC Practice: CARDONALD MEDICAL CENTRE Address:
CARDONALD MEDICAL CENTRE Tel: 0141 892 2548

Next of Kin: HAUGHEY,AGNES

Relationship: MOT

Address: 7 KIRKCONNELL DR GLASGOW

Tel: 634 4947

Continuation Sheet

Date: Time

E-Pacer PATIENT REPORT

Time	21 05	Date	24/04/2011

PATIENT AND INCIDENT DETAILS

Incident number	PA003736029.001
Name	LISA HUGHES.
Age	31
Date of birth	17/01/1980
Gender	Female
Incident location	8 CARHAM CRESCENT CARDONALD GLASGOW
Incident post code	G52 2HN
Incident type	EMG
Call received	24/04/2011, 19:38
Call passed	24/04/2011, 20:11
Crew mobile	24/04/2011, 20:11
Crew at scene	24/04/2011, 20:21

TREATMENT REFUSAL FORM

PRIMARY SURVEY

RESPONSE	
AVPU	Alert
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Normal
Respiratory rate	
CIRCULATION	
Pulse rate	Normal
Most peripheral pulse found	Radial
Cap refill rate	
Skin colour	Pale
Skin texture	Dry
C-SPINE INJURY	
Suspicion of CSI	No evidence of C-spine injury
PATIENT CONSENT	
Patient consent	Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment
Duty of care delegated to	SOGH A AND E

AMPDS

Dispatch code	23C01I	Intentional Overdosed and Not Alert
Final code	23B01	Overdose/Poisoning, Overdose (Without Priority Symptoms)

GCS

Final GCS eye opening	Spontaneous
Final GCS verbal response	Orientated
Final GCS motor response	Localised pain

VITAL SIGNS

Time hr : min	Pulse bpm	Resp. rpm	BP mm Hg	Cap refill (secs)	% Peak flow	Blood sugar mmol / l	Temp °C	SpO2 %	GCS Total	RTS	SEWS	ECG	Pain score
20:21	98	16	- / -	<2 secs	-	6.9	-	-	14	-	-	-	-

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Constricted	Constricted
Pupil reaction	Normal	Normal

AMPLE

Allergies	None
Other allergies	
Medication	CITALOPRAM, DIAZEPAM, LEVOTHYROXINE, OLANZAPINE
Past history	TUMOUR ON THYROID GLAND, THYROID REMOVED, BI POLAR DISORDER, MENTAL HEALTH PROBLEMS
Last eaten	>5 hrs
Events prior	PT HAS TAKEN ? 10-OLANZAPINE

PSYCHIATRIC RISK ASSESSMENT

Previous history of mental health problems	History of anxiety, History of depression, History of other mental health problems
Action	Patient conveyed to hospital

SOCIAL ASSESSMENT

Risk assessment	Risk of psychiatric threat
Action	Patient conveyed to hospital

EMERGENCY SERVICES ON SCENE

Paramedic	Technician

SUBSTANCES AFFECTING CONDITION

ARIRAZOLE

PATIENT HANDOVER

On arrival at scene	Seated
Scene removal	Chair
Transportation	Lying
Care delivery at hospital	Trolley
Time of handover	20:53

FINAL OBSERVATION AND COMMENTS

999 CALL FOR 30 Y O FEMALE ? O/D. O/A PTLYING ON COUCH, GCS 14 WITHDRAWS FROM PAIN. BM 6.9, PUPIL CONSTRICTED AND REACTIVE. O/E PT WOULD NOT ALLOW CREW TO TAKE OBS AND WITHDREW CONSENT. PT BECAME COMBATIVE AND CREW REQUESTED POLICE ATTENDANCE. CREW TRIED TO CALM PT DOWN AND WITH PT PARTNER AND SISTER IN LAW ASSISTANCE PT CONSENTED TO TRANSPORT BUT CREW WERE STILL UNABLE TO ATTAIN BASELINE OBS. POLICE ASSISTANCE STOOD DOWN. PT TAKEN TO SOGH A AND E.

Report ID	fafdee6a-1463-4a8a-bf5f-7f46e3e6de2a

South Glasgow Emergency Departments
Mental Health Triage

this side to be completed by triage nurse

name _____

DoB _____

CHI _____

affix label

1. Triage Observations

document physiological measurements

GCS	BM	Pulse	BP	Resps	SaO^2	Temp
~~15~~	4.5	92	120/67	22	96	35.0

patient accompanied by

2. Outline of presentation

tick those categories which apply and provide a brief summary

overdose (will require medical assessment)	
self injury (will require wound management)	
other psychiatric presentation (will require medical problems excluded)	

3. Initial presentation, appearance and behaviour

respond yes or no to each question

Is the patient violent, aggressive or threatening?	Yes		No
Is the patient obviously distressed, markedly anxious or highly aroused?		Yes	No
Is the patient behaving inappropriately to the situation?		Yes	No
Is the patient quiet and withdrawn?		Yes	No
Do you think the patient presents an immediate risk to you, him/herself, or others?	Yes		No
Do you think the patient is likely to abscond prior to assessment?	Yes		No
Do you think the patient is experiencing delusions or hallucinations?	Yes		No
Do you think the patient feels influenced or controlled by external forces?	Yes		No
Are you aware of a history of violence or self harm?		Yes	No
Are you aware of a history of mental health problems or psychiatric illness?		Yes	No

4. Triage Risk Assessment

indicate a category of risk by circling one

Any responses in the first column - the patient should be categorised **P1**, moved into the clinical area immediately (accompanied if appropriate), and assessed as soon as possible.

All responses in the last column - the patient should be categorised **P3**, and can wait for assessment, (accompanied if possible), ideally in a place other than the main waiting room.

All other patients should be categorised **P2**, and can wait for assessment, ideally in a place other than the main waiting room, although they should be moved into the department as soon as possible (accompanied if appropriate).

any responses in the first column
P1 - High Risk

other patients are likely to be
P2 - Moderate Risk

unless all responses in 3rd column
P3 - Low Risk

signature _____

date _____ time _____

Emergency Department Mental Health Assessment

this side to be completed by medical staff

Outline of current presentation and precipitating factors

Previous mental health problems or self-harm, including addiction; current medication etc

Other relevant information; physical health, employment, housing, relationships, childcare etc

Appearance	Behaviour
Speech	Mood
Thought	Insight

Suicide Risk Screen

Male Gender			
Age <18 or >65			
Depression			
Alcohol and recreational drug use			
Evidence of psychosis			
Separated, widowed, divorced			
Suicide plan/concealment			
Lack of social support			
Ongoing suicidal intent			
Chronic physical illness/pain			
Family history of suicide			
Family concerned about risk			
Disengaged/poor compliance			
Unemployed or retired			
Access to lethal means of harm			
Previous use of violent methods			
History of self-harm or overdose			
Previous psychiatric treatment			
Current psychiatric treatment			
Current use of benzodiazepines			

Summary and Risk Assessment

formulated on the basis of clinical assessment: more risk factors are suggestive of greater risk; negative responses in the four categories highlighted *may* allow patients to be categorised as 'low risk' and discharged to community follow up.

Indicate likelihood of a further episode of self harm in the short term (48 hrs)

High Risk

Moderate Risk

Low Risk

Plan for further assessment

1. "A Clinical Tool for Assessing Risk After Self-Harm." Cooper et al. Annals of Emergency Medicine. Oct 2006.
2. "Self-Harm," NICE Guideline 16. 2004 focuses on the assessment of risk in this period of immediate and short term care.

signature _____

date _____ time _____

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UK NPIS 0844 892 0111
Ireland NPIC (01) 809 2566
mail@toxbase.org

Olanzapine

Updated Revised* 10/2009

Type of Product

A thienobenzodiazepine for the treatment of schizophrenia.

Ingredients

Olanzapine
Tablets - 2.5 mg, 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg
Velotabs (orodispersible) - 5 mg, 10 mg, 15 mg, 20 mg
IM injection - 10 mg vial (5 mg/mL after reconstitution) ▼
IM injection (prolonged release suspension) – 210 mg, 300 mg or 405 mg per vial (150 mg/mL after reconstitution) ▼

Toxicity

Evidence suggests relatively low acute toxicity but massive ingestions may produce prolonged impairment of conscious level requiring mechanical ventilation. Ingestion of 600-700 mg resulted in coma lasting for several days (Tse et al, 2008).

Ingestion of up to 800 mg has resulted in drowsiness, slurred speech and mild anticholinergic features. A 59 year old woman died after ingesting up to 60 x 10 mg tablets (Elian, 1998).

Ingestion of 275 mg in a 14 year old produced, initially, loss of consciousness and somnolence within 1 hour. Within 2 hours she became agitated and aggressive. Severe extrapyramidal symptoms later developed 54 hours post ingestion (Theisen et al, 2005).

In children features reported include prolonged CNS depression, respiratory distress and anticholinergic symptoms and prolonged somnolence (persisting for 6 days)(Bond et al, 1999; Catalano et al, 1999).

Peak plasma levels occur 5-8 hours after oral administration and 15-45 minutes after intramuscular injection. In children the onset of features has been reported to occur 1 to 2 hours post-ingestion (Wong et al, 2004).

The therapeutic half life is between 30-38 hours, however this may be prolonged in overdose (Lennestal et al, 2007). Elimination tends to be longer in female than male patients and may also be prolonged in the elderly.

A post-injection syndrome has been reported following use of the sustained release olanzapine. A small percentage of patients receiving sustained release injections have developed sedation, delirium and/or extrapyramidal symptoms, usually within 3 hours of injection. Patients recovered fully by 24-72 hours after injection.

ALERT BOX
Children or adults who have accidentally ingested less than 1 mg/kg and have no symptoms do not need referral to hospital.

Children and adults who have recently ingested 1 mg/kg or more or who have symptoms and those who have taken deliberate overdoses should be referred.

Features

Central nervous system depression which may be prolonged.

Dilated pupils or miosis, blurred vision, hypotension, tachycardia, slurred speech, dry mouth or hypersalivation, ataxia and extrapyramidal symptoms are possible. Children may be at greater risk than adults of developing extrapyramidal symptoms (Theisen et al, 2005; Wong et al, 2004). Extrapyramidal symptoms may also be delayed, occurring up to 36-54 hours post ingestion (Chambers et al, 1998; Theisen et al, 2005).

Fluctuations in mental status from somnolence to agitation are recognised. Seizures and coma may occur in severely poisoned patients (Palenzona et al, 2004).

The most common symptoms reported in children are lethargy, tachycardia and agitation (Isbister et al, 2005).

Neuroleptic malignant syndrome (NMS) has been reported after therapeutic use (Stanfield and Privette, 2000; Srivastava et al, 2009). NMS has also been reported following acute overdose of olanzapine and chlorpromazine following abstinence of therapy for several weeks (Morris et al 2009).

Features of serotonin toxicity may occur (Verre M et al, 2008; Copra et al, 2004). These include CNS effects (including agitation or coma), autonomic instability (including hyperpyrexia), and neuromuscular excitability (including clonus and raised serum creatine kinase)

This syndrome is more likely to occur if the patient has been exposed to two or more drugs that increase the effect of serotonin in serotinergic synapses (by increasing release, reducing reuptake or metabolism, or stimulating serotonin receptors), either as an acute overdose or if taken regularly, for example - SSRIs, MAOIs, tricyclic antidepressants, venlafaxine, MDMA (ecstasy), amphetamines, cocaine, tramadol, triptans, linezolid and St John's Wort.

There may be a transient rise in plasma creatine kinase levels peaking 12 hours after ingestion. However this rarely produces significant impact on the clinical course (Waring et al, 2006; Martí-Bonmatí et al, 2003)

Management

Suggested nursing care plan - click here

1. Maintain a clear airway and adequate ventilation if indicated.
2. Consider oral activated charcoal (dose of charcoal: 50 g for adults; 1 g/kg for children) in adults and children who have ingested more than 1 mg/kg olanzapine within 1 hour. Activated charcoal has been shown to reduce the bioavailability of olanzapine by 50-60%.
3. Observe asymptomatic patients for at least 6 hours after ingestion. Monitor BP, pulse, respiration and conscious level. Perform 12 lead ECG. Symptomatic patients may require observation for 24 hours.
4. Correct hypotension by raising the foot of the bed and by giving an appropriate fluid challenge. Treat brady and tachyarrhythmias appropriately.

Children failing to respond to an appropriate intravenous fluid bolus require early discussion with the local paediatric intensive care unit (PICU).

Adults: If severe hypotension persists despite the above measures, then central venous pressure monitoring should be considered. Manage in a critical care area or involve the critical care outreach team.

When hypotension is mainly due to decreased systemic vascular resistance, drugs with alpha-adrenergic activity such as noradrenaline or high dose dopamine (10-30

micrograms/kg/min) may be beneficial. The dose of vasopressor should be titrated against blood pressure.

When hypotension is believed to be due to reduced cardiac output (e.g. where global hypokinesia is demonstrated on echocardiography) inotropic drugs such as dobutamine, or in severe cases adrenaline, may be beneficial.

NB: Both negative inotropic and vasodilator actions may both be present, particularly in mixed overdoses.

If severe hypotension further persists discuss with your local poisons information service: in the UK NPIS 0844 892 0111, in Ireland NPIC (01) 809 2566.

Click here for details you may be required to give when telephoning NPIS.

5. Reassure patients with acute dystonic reactions. These usually respond to procyclidine (click here for doses). Diazepam (0.1-0.3 mg/kg body weight) is an alternative. Repeat doses may be required for prolonged reactions.

   Note - acute dystonic reactions may occur up to 2-3 days after acute ingestion in a patient who is not normally receiving this drug. This is not a reason to keep patients in hospital but they should be warned that these occur very rarely and advised to return if they develop these symptoms.

6. Other measures as indicated by the patient's clinical condition.
7. For features and management of neuroleptic malignant syndrome click here.
8. For the features and management of serotonin syndrome click here.

Links

Nursing guide - antipsychotics
Activated charcoal
Procyclidine doses
References
Olanzapine in pregnancy

Serial Blood Results								
	Date:	25/4/11	25/4	~~25/4~~				
	Time:	0130	0700	~~1450~~				
	Signature:	MA						
Sodium	135 - 145	146	146					
Potassium	3.5 - 5.0	3.9	4.4					
Chloride	96 - 105	113	116					
Bicarbonate	24 - 29	21	20					
Urea	2.5 - 6.5	2.4	2.9					
Creatinine	55 - 120	54	57					
Glucose	3.5 - 5.5							
Magnesium	0.8 - 1.0							
Calcium	2.2 - 2.6	2.30						
Estimated GFR		760						
CRP	<10	3	4					
Cardiac Enzymes & Liver Function Tests	**Normal Values**							
Troponin	<0.04							
CK	<150							
[redacted]	0 - 100							
Total Prot	60 - 80	72	63					
Albumin	35 - 50	37	33					
Globulins	20 - 35	35	30					
Total Bilirubin	0 - 20	5	9					
Alk Phos	90 - 350	59	53					
AST	0 - 40	19	18					
ALT	0 - 50	19	17					
Haematology & Clotting Screen	**Normal Values**							
White cell count	4.0 - 11.0	5.8	7.4					
Hb (sex dependent)	130 - 180	131	123					
PCV	0.370 - 0.470							
MCV	76 - 100							
Platelet count	150 - 400	329	310					
Neutrophils	2.0 - 7.5	2.7	4.6					
Lymphocytes	1.5 - 4.0							
PT	10 - 13	13						
APTT	21 - 33	31						
INR	0.8 - 5.0							
Fibrogen	1.4 - 4.4							
Arterial Blood Gas	**Normal Values**							
H+	36 - 43							
PCO_2	4.5 - 6							
PO_2	10.5 - 13.5							
Base excess	+/- 2.5							
Bicarbonate	20 - 28							
FiO_2 (Inspired Oxygen)								
Other								
Paracetamol level								
Salicylate	<50							

Emergency Department Nursing Documentation

Done/Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

Date Given	Drug (Block Capitals)	Dose	Method of administration	Time of administration	Signature	Given by

Discharge prescription packs

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by

South Glasgow Hospitals

NHS Greater Glasgow and Clyde

STANDARDISED EARLY WARNING SCORING SYSTEM (SEWS)

Patient Observation Chart

Name LISA HUGHES

Address

HUGHES ,LISA ROSEMAR
SG00953485 17/01/80
CHI: 1701806541 F
Date Time
Spec./Sig.

Hospital No.

DOB

	Date	Ward	Consultant
Admitted			
Transferred			
Transferred			
Transferred			

This is Chart Number _____ during this admission

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

How to calculate SEWS Score

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

SEWS KEY

0	1	2	3

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

FURTHER SEWS SCORE SHOULD BE CHECKED

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

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

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

If SEWS continually 0-1 frequency of observations:

Date												
Frequency												

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

SEWS KEY			
0	1	2	3

NAME: Lisa Hughes DOB:

Date:		24/4		24/4				25/4			26/4							
Time:		2100		2205		0115	0634	0516		2100	0630							
RESP. RATE	36+																	
	31-35																	
	21-30																	
	9-20	20		16		18	16	16	16	16	14							
	≤8																	
SpO2	93+	99		98%		100	98%	98	96	99	98							
Numerical Value	90-92																	
	85-89																	
	<85																	
Inspired O2%	%	RA				TM	(A)	A	A	A	(A)							
TEMP.	39∞																	
	38∞						36.5				37.6							
	37∞					36.8		36.3	37.3	38.4								
	36∞																	
	35∞	35																
	34∞																	
BLOOD PRESSURE	210																	
	200																	
	190																	
	180		A+E→			Ward 22												
	170	↙																
	160																	
	150																	
	140			^			110/43											
	130					91/54				117	119							
	120	1						41		^	^							
	110						↑		96									
SEWS SCORE uses Systolic BP	100							^	^									
	90			✓		↑	↑											
	80																	
	70	✓				1	1	✓	✓	✓	✓							
	60					✓	✓	59	47	30	35							
	50	67																
	40																	
	150																	
	140																	
	130																	
	120																	
	110																	
	100																	
HEART RATE	90	93		90		75	98											
	80							85	82	97	88							
	70																	
	60																	
	50																	
	40																	
	30																	
	20																	
NEURO RESPONSE	Alert									✓	(A)							
	Verbal					NAD	✓	✓	✓									
	Pain	✓		✓		✓												
	Unresponsive																	
URINE OUTPUT	PU/NPU:	NPU				NPU	PU	~0	NPU		PU							
	UO<30mls/hr (3 hrs +)																	
SEWS SCORE:	with all observations	3				3	1	1	(2)	0	0							

PAIN refer to guideline p4		
	Severe	7-10
	Moderate	4-6
	Mild	1-3
	None	0
	N/V	

UNIT No. _____

SEWS KEY

0	1	2	3

Date:

Time:

36+

31-35

21-30

9-20

≤8

93+

90-92

85-89

<85

%

39∞

38∞

37∞

36∞

35∞

34∞

210

200

190

180

170

160

150

140

130

120

110

100

90

80

70

60

50

40

150

140

130

120

110

100

90

80

70

60

50

40

30

20

Alert

Verbal

Pain

Unresponsive

PU/NPU:

UO<30mls/hr

7-10

4-6

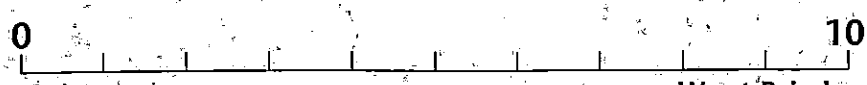
1-3

0

N/V

Pain Assessment & Management Guidelines

How to score pain:



No Pain — Worst Pain Imagineable

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

Guidelines

Cancer-related pain:

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

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

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

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

Acute pain:

Score current pain on movement e.g. deep breathing

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

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

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

Measuring Sedation

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

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

Measuring Nausea

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

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

NB: Review Treatment Plan

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

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

Consider:

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

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

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

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

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

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

0593467-SGH469

300953485
JGHES, LISA ROSEMARY
CARHAM CRES
LASGOW 17/01/1980
G52 2HN CHI 1701806541

tals
RVATION CHART

NHS Greater Glasgow and Clyde

25/21

| | | |

Basic Guide for Performing Neurological Observations

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

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

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

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

- Development of agitation or abnormal behaviour. (Do not automatically attribute to effects of alcohol or drug abuse.)
- Sustained decrease in conscious level of at least one point in the motor or verbal response, or two points in the eye opening response.
- Development of severe or increasing headache.

  Persisting vomiting.
- New or evolving neurological signs i.e. pupil inequality, asymmetry of limb or facial movement.

Eyes Open

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

Best Motor Response

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

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

Best Verbal Response

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

Pupils

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

Vital Signs

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

Limb movement

- **Normal power.** The patient matches resistance applied to any joint movement (pulls you towards them or pushes you away).
- **Mild weakness.** The patient moves against resistance but is easily overcome.
- **Severe weakness.** The patient able to move limb but not against resistance.
- **Spastic flexion.** The patient may flex or bend the arm at elbow and rotate wrist (spastic posture) whilst drawing arm across chest. Response is slower than in normal flexion to pain.
- **Spastic extension.** The patient may extend or straighten arm at elbow or may rotate arm towards.
- **No response.** Beware absence of response may be due to high spinal injury or muscle paralysing drugs.

References

SIGN, Aug 2000 - Early Management of Head Injury.

Advanced Trauma Life Support Manual 6th ed.(rev.1997),Chapt. 3, p94. American College of Surgeons,633 St. Clare St,Chicago.

Baillie L (2001) Developing Practical Nursing Skills, p269-284. Arnold. London

Frawley P (1990) Neurological Observations Nursing Times, 86 (35):Aug 29-Sep 4

The Royal Marsden Hospital (2000) Manual of Clinical Nursing Procedures, 5th ed. P376-384. Blackwell Science, London.

Teasdale G and Jennet B. (1974) Assessment of coma and impaired consciousness. Lancet. 2. 81-84;

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

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

Next review date: March. 2003

[redacted], [redacted] ID: 1101000541 24-Apr-2011 22:30:29 SOUTHERN GENERAL HOSPITAL

17-Jan-1980
Caucasian

Loc: 1

Vent. rate	96 bpm
PR interval	166 ms
QRS duration	106 ms
QT/QTc	364/459 ms
P-R-T axes	73 38 45

[redacted]nal sinus rhythm
Normal ECG

[redacted] History: Unknown
Technician:
Test ind:

Referred by: Unconfirmed

COMMENTS:



NHS Greater Glasgow and Clyde

Alcohol Screening & Assessment Tool

NHS Greater Glasgow and Clyde

Please Attach Patient Label



SG00953485
HUGHES ,LISA ROSEMARY
CHI:1701806541

Drink / Type	Units
Wine 12% (175 ml glass)	2.1 Units
Wine 12% (750ml bottle)	9.0 Units
Beer/Lager 4.5% (440ml can/bottle)	2.0 Units
Beer/Lager 4.5% (500ml can/bottle)	2.2 Units
Spirtis 40% (25ml measure)	1.0 Units
Spirits 40% (1/4 bottle 175ml)	7.0 Units
Spirits 40% (700 ml bottle)	28.0 Units
Cider 4% (300ml glass)	1.2 Units
Cider 4% (1 litre bottle)	4.0 Units
Strong/White Cider 8% (300ml glass)	2.4 Units
Strong/White Cider 8% (1 litre bottle)	8.0 Units
Alcopops 5% (275ml bottle)	1.4 Units

Number of Units = ABV (%) x Volume (litres)

eg A bottle of wine (750mls) which is 12% ABV = 12 x 0.75 = 9 Units
A glass of wine (200mls) which is 12% ABV = 12 x 0.2 = 2.4 Units

Fast Alcohol Screening Tool - FAST:

1. MEN: How often do you have EIGHT or more drinks on one occasion?
   WOMEN: How often do you have SIX or more drinks on one occasion?

   Note : 1 drink = 1 unit of alcohol (refer to table above)

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

3. How often during the last year have you failed to do what was normally expected of you because of drinking?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

   No ☐0 Yes, on one occasion ☐2 Yes, on more than one occasion ☐4

Total ☐

Score of 3 or more: FAST Positive

FAST Positive?

Yes ☐ No ☐

FAST 0-2:	Negative: No action required
FAST 3-8:	Hazardous Drinking: Advise regarding safe drinking levels and offer information leaflet and referral to GP for follow up/BI
FAST 9-16:	Probable Dependent Drinking: Advice as above, offer information leaflet and consider referral to specialist alcohol support service.

Acute Services Division

Hospital / Department: SGH

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: .....

Ward: .....

CHI number: .....

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8 CARHAM CRES
GLASGOW 17/01/1980
G52 2HN CHI 1701806541

.....

.....

ıspital number .....

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission to each ward.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Risk assessment and care plan reviewed monthly.

Referral Criteria for Hospital Falls Prevention Co-ordinator

1. Cannard score of 18+.
2. Second or subsequent fall
3. Significant Injury caused by a fall. (Significant Injury defined as any fracture, significant bruising or laceration to head or body.)

The patient should be referred with any of the above criteria.

General Safety Precautions

- Ensure patient has buzzer to hand
- Check patient has the manual dexterity and cognitive ability to operate buzzer
- Place personal items within easy reach
- Keep the bed in lowest position possible (use low bed if available)
- DO NOT leave patients with cognitive impairment unattended on commodes, in toilets, baths and showers.
- Patients with poor mobility, who are known not to ask for assistance, should not be left unattended on commodes, toilets, baths and showers.
- If noted that mobility / transfers are unsafe refer to physio / OT for assessment
- If patient wears glasses, ensure they are clean
- Ensure patient's footwear is adequate
- Lock wheels on all wheelchairs, beds, commodes and trolleys when in use
- Provide adequate lighting at night
- Request medication review if appropriate
- Clean up spills immediately
- Orientate patient to the ward environment

Cannard Falls Risk Assessment

(Must be completed within 24 hours of admission to each ward)

25/4/11

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: / Ward: 10	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				2						
Age	13-59 0	60-70 1	71-80 2	81+ 1		0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0								
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		1						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	1						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound/ wheel-chair 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		6						
				ACTION(S) TAKEN Enter action code(s) from Care Plan below								
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves				NURSE SIGNATURE		GL						

Please see back page for glossary of terms relating to the assessment above.

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Adult Intravenous (IV) Cannulation Care Plan

NHS Greater Glasgow and Clyde

Potential Complications of IV Cannulation

1. Redness, pain or inflammation at insertion site due to phlebitis or local infection
2. Local oedema due to infiltration
3. Bloodstream infection
4. Extravasation

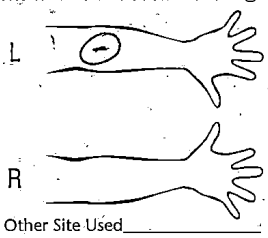
Required Interventions

The interventions below are required to minimise the above complications. Those highlighted in bold are necessary to assist in compliance with the Health Protection Scotland (HPS) Peripheral Vascular Catheter (PVC) Care Bundle.

1. **Hand hygiene must be performed before and after IV cannula insertion or manipulation is undertaken.**
2. Decontaminate the patients' skin for at least 30 seconds and allow to dry before inserting the IV cannula. Non-sterile gloves must be worn and the insertion site should never be directly touched.
3. **Document the date, time,** gauge and **site of IV cannula insertion below.** Use the date strip contained within the IV dressing to label the date of insertion on the cannula dressing.
4. Assess and document the reasons for insertion and removal of IV cannulae below. **The IV cannula site and ongoing clinical need should be assessed at least once per shift and must be documented in the Monitoring and Recording Chart overleaf.** When the IV cannula is not in use, maintain patency by flushing with 0.9% sodium chloride every 24 hours.
5. **The IV cannula should be changed every 72 hours or immediately if indicated by VIP score of 2 or more. If the patient has poor venous access, a risk assessment should be carried out using VIP scoring tool overleaf. If score is less than or equal to 1 then the decision can be documented by nursing staff in the chart overleaf to retain cannula up to a maximum of 96 hours. If the cannula has to remain in situ for longer than this, then this decision must be made and documented by medical staff.**
6. **Check IV cannula dressing is dry and intact and that site of insertion can be easily observed. Replace dressing immediately if indicated and document procedure overleaf.**
7. Ensure IV cannula has a needle-free access system with integrated extension. This must be decontaminated for at least 30 seconds and allowed to dry before and after use.
8. If there has been a breach in aseptic technique during insertion (e.g. cannula was inserted during an emergency) then the cannula must be replaced within 24 hours of insertion *. If the cannula has to remain insitu for longer than this, then this decision must be documented overleaf.

Cannula Insertion Site

Please mark successful cannulation with a number e.g. ① and failed cannulation with an Ⓕ



Other Site Used_____

Insertion Reason Codes

Emergency IV Access = E
Routine IV Access = R
Radiological Procedure = RP
Nil by Mouth = NBM
Chemotherapy = C
IV Fluids / IV Medicine Administration = IV
Blood = B
Other (Please state)

Removal Reason Codes

Not Required = NR
Phlebitis = P
Infiltration= I
Extravasation = E
Other (Please state)

Cannula Number	Date and Time	Inserted by (print name)	Insertion Reason Code	Gauge	Was aseptic technique breached?	Removed by (print name)	Date and Time	Removal Reason Code
①	25/4/11	~~AH~~ SJO	E	Green	Yes/No			
					Yes*/No			
					Yes*/No			
					Yes*/No			

dified V.I.P (Visual Infusion Phl tis) Score		
IV site appears healthy	0	No phlebitis OBSERVE CANNULA
One of the following is evident: • Slight pain or redness near IV site	1	Possible first signs OBSERVE CANNULA
Two of the following are evident: • Pain • Erythema • Swelling	2	Early stage of phlebitis RESITE CANNULA
All of the following are evident: • Pain along the path of the cannula • Erythema • Induration	3	Mid-stage phlebitis RESITE CANNULA and SEEK FURTHER ADVICE
All of the following are evident and extensive: • Pain along the path of cannula Erythema • Induration • Palpable venous cord	4	Advanced stage of phlebitis or start of thrombophlebitis RESITE CANNULA and SEEK FURTHER ADVICE
All of the following are evident and extensive: • Pain along path of cannula • Erythema • Induration • Pyrexia • Palpable venous cord	5	Advanced thrombophlebitis RESITE CANNULA and SEEK FURTHER ADVICE

IV Cannula Monitoring & Recording Chart

(Based on the HPS PVC Care Bundle)

Cannula Number	Date and Time	Appropriate Hand Hygiene Undertaken?	Has cannula been insitu for 72 hours?	Continuing Clinical Indication	VIP Score	IV Dressing Dry and Intact?	Comments / Action Taken	Initials
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		

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GLASGOW HOSPITALS
MANUAL HANDLING RISK ASSESSMENT

NHS Greater Glasgow and Clyde

Patient Named

If patient is totally independent, tick here and go to date box

BODY BUILD

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

RISK OF FALLS High | Low ✓

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

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

INTO BATH OR SHOWER

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

ASSISTANCE		SUPERVISION	✓	INDEPENDENT	

Staff required:

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

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

ASSISTANCE		SUPERVISION	✓	INDEPENDENT	

Additional Information

TOILETING

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

ASSISTANCE		SUPERVISION	✓	INDEPENDENT	

Additional Information

WALKING

NO WALKING		ASSISTANCE		SUPERVISION	✓	INDEPENDENT	

Staff required:

Walking Aid

Distance walked / additional information

MOVE UP/DOWN BED

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

ASSISTANCE		SUPERVISION		INDEPENDENT	✓

Additional Information (include details of any therapy beds used)

Staff required:

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED.PAN

Hoist		Roll Patient		Patient bridges		Monkey pole		Not used	✓

TRANSFER TO/FROM TROLLEY (or bed etc)

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

Date assessed: 25/4/11 Assessors signature:

Date reviewed									
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

INTO BATH OR SHOWER

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

ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:					

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

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

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information					

TOILETING

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

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information					

WALKING

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

VE UP/DOWN BED

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

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

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges		Monkey pole		Not used	

TRANSFER TO/FROM TROLLEY (or bed etc)

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

Date assessed:	Assessors signature:

Date reviewed									
essors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

Nutrition Profile

NHS Greater Glasgow and Clyde

Name:	Date of admission: 25/4/11
Address: SG00953485 HUGHES ,LISA ROSEMARY 8 CARHAM CRES GLASGOW G52 2HN	Time: 02:00
DoB: 17/01/1980	HOSPITAL: SGH
CHI num CHI 1701806541	Ward: 20
Affix patient data label	

To be recorded within 24 hours of admission*

Height: m/ft Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Weight: kg/stones Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☐

If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☐ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Eating and drinking likes and dislikes (including appetite and/or NBM status):

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☐

Please state:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental?** Yes ☐ No ☐

Please specify all factors:

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☐

Please state:

Profile completed by: Name (PRINT): Signature: Date:

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Malnutrition Universal Screening Tool ('MUST')

Date										
Initials										
Height (see page 1)	Weight									
Oedema or ascites present Y/N										
BMI										

'MUST'

Step 1: BMI Score (refer to chart on page 4)

>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% 2

Step 3: Acute Disease Effect Score

If patient is acutely ill and there has been or is likely to be no or virtually no food intake for > 5 days..... Score 2

Not applicable ..... Score 0

Step 4: Overall Risk of Malnutrition Total:

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	**LOW RISK** - *Routine Clinical Care* • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	**MEDIUM RISK** - *Observe* • Document dietary intake for 3 days on a Food Record Chart. • If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK** - *Treat** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Complete nursing checklist for swallowing difficulties if appropriate.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).

Referral Services

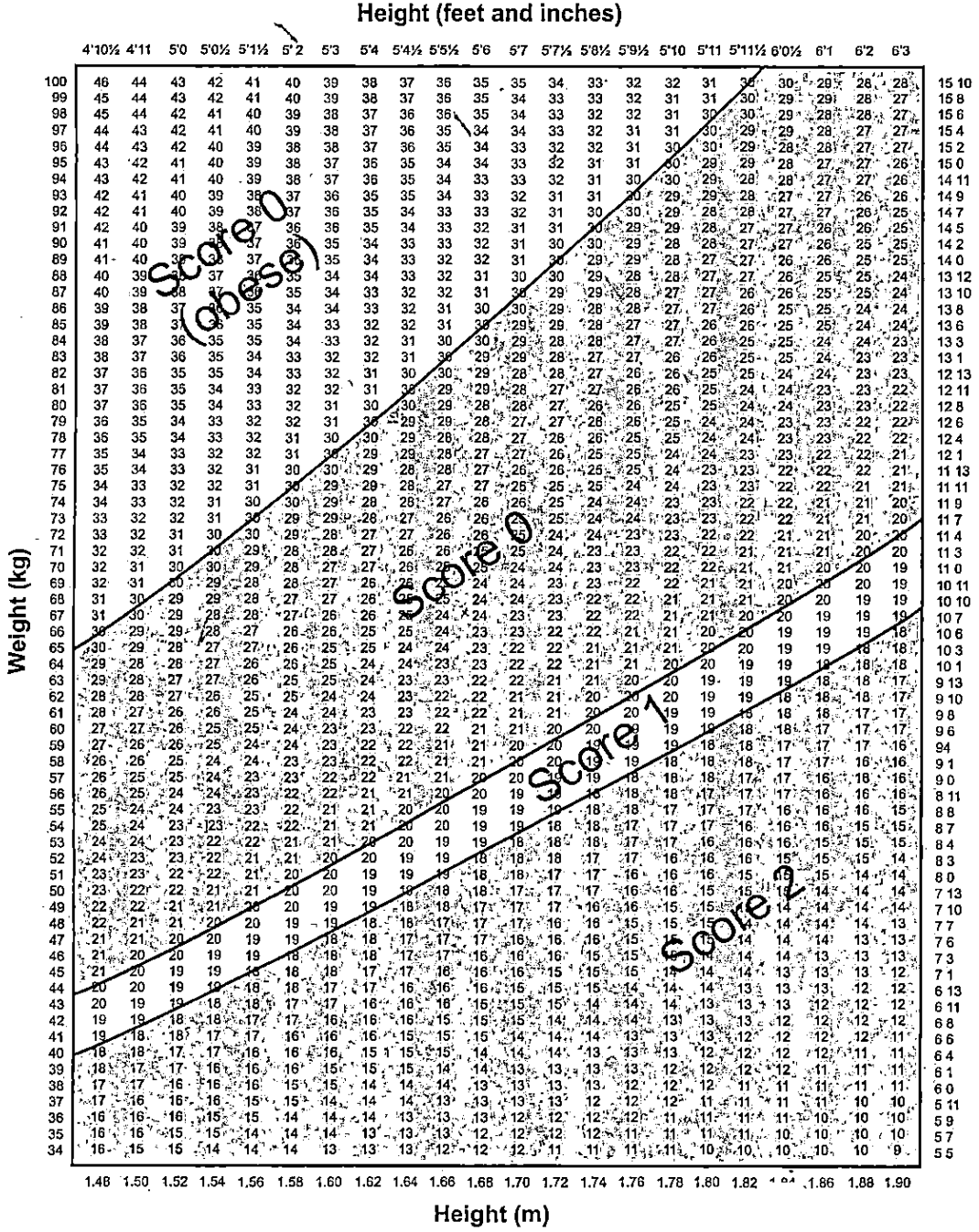
Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Review date	Name (PRINT) Signature/Designation

N.B. Ensure discharge plan includes most recent 'MUST' score and any necessary follow-up requirements.

Step 1 - BMI Score



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 W't loss <5%	Score 1 Wt loss 5-10%	Score 2 W't loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-12	>12.4 kg
126 kg	<6.3 kg	6.3-12...	>12.6 kg

Weight before weight loss (st/lb)	Score 0 W't loss <5%	Score 1 W't loss 5-10%	Score 2 W't loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

VI MEDICAL ILLUSTRATION • NUTRITION & DIET • 12366/01.09.08
STORES ORDER CODE 41850

'atient's Name: Lisa Hughes

).o.B.:

Init number:

Vard: 20

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

Date: 25/4/11 | **Previous 24 hour fluid balance -** Intake: | Output:

	Intake					Output		
Time	IV infusions	Volume	Enteral / Oral	Volume	Running Total	Urine	Drains (D), Vomit (V) Aspirate (A) etc	Running Tot
01								
02	NaCl	500						
03								
	NaCl	500				Fluid		
07	NaCl	500			1500	Void		
08			No breakfast	Refused (sleepy)				
09								
10								
11	5% Dextrose	500			2000			
12			Water	100	2100			
13								
	N. Saline	500			2600			
15								
						Void		
17			Tea	150	1750			
18								
19								
20	5% Dex	500						
21								
22								
23								
24								
	Individual Totals:							
				Total Intake:			**Total Output:**	

Final Fluid Balance +/-

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

NAME: Lisa Hughes WARD: 20 UNIT No.: SG0095385 D.O.B.: 17/1/80

DATE	TIME		FLUID/BLOOD	ADDITIVE	VOLUME OR DOSE	TIMING	DOCTORS SIGNATURE		BATCH No.	NURSES SIGNATURE			
							ORDERED BY	CANCELLED BY		DATE	TIME	GIVEN BY	CHECKED BY
25/4		A	N Saline		500	2°	Lmercer		11B16T4B	25/4/11	02:15	[illegible]	[illegible]
		B	N Saline		500	2°	[illegible]		11B16T4B	25/4/11	04:05	[illegible]	
		C	N Saline		500	4°	[illegible]		11B16T4B	25/4/11	0700	GL	
		D	5% Dextrose		500	2°	[illegible]		11A1414G	25/4/11	11[25]	EZ	
		E	0.9% NaCl		500	4°	[illegible]		11A2114E	25/4/11	14[00]	EZ	[illegible]
		F	5% Dextrose		500	4°	[illegible]		11A7447G	25/4/11	2010	[illegible]	
		G	0.9% NaCl		500	[illegible]	[illegible]						
		H											
		I											
		J											
		K											
		L											
		M											
		N											
		O											
		P											
		Q											
		R											

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

0268104 SGH 270

DIRECTORATE OF OBSTETRICS, GYNAECOLOGY & PAEDIATRICS

Dr Stewart Pringle
Dr Robert J S Hawthorn
Dr Marco Gaudoin
Dr Stein Bjornsson
Dr John Tierney
Dr Chris Hardwick
Dr Janice Gibson
Dr Hassan O Mohamed Ali
Dr Joanne Ellison (Locum Consultant)
Dr Sarju Mathew (Locum Consultant)

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Secretary's Tel No: 0141 201 2291
Fax No: 0141 201 2994

e-mail: myra.glass@ggc.scot.nhs.uk

Date Dictated: 10/08/11
Date Typed: 10/08/11
REF: AH/MCG

DR MCCALLUM
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr McCallum

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485) CHI: 1701806541
8 CARHAM CRES, GLASGOW, G52 2HN

Thank you for your letter about this lady.

I can confirm that she had a filshie clip sterilistion on 17th May 2011. We noticed during her operation previous evidence of loop excision and there is no evidence of endometriosis infection.

Yours sincerely

DR HASSAN O MOHAMED ALI
CONSULTANT OBSTETRICIAN & GYNAECOLOGIST

DR LINSEY C SEMPLE
DR ALAN A W FINNEY

Cardonald Medical Centre
1831 Paisley Road West
GLASGOW
G52 3SS

Consultations by appointment
Tel: 0141 892 2548
Fax: 0141 892 2549

KMC/CM
5TH July 2011

Dr Ali
Gynaecology Department
Southern General Hospital
Govan Road
GLASGOW

RE : Lisa Hughes, 17/1/80 6541, 8 Carham Crescent, GLASGOW G52 2HN

Dear Dr Ali,

I wonder if you could confirm which procedure this lady had carried out. On her hospital discharge letter it detailed that she had a Laparoscopic Sterilisation, on her letter from you it says that she had a Diagnostic Laparoscopy and examination of her cervix in the Day Surgery Unit on 17/5/11. Given that Lisa has 8 children I am keen to know that she has indeed been sterilised as she is not keen to be pregnant again. We have tried to clarify this with your secretary but have not managed to do so. Thank you for your time.

Yours sincerely,

DR. KIRSTY MCCALLUM.

SG00953485
HUGHES ,LISA ROSEMARY
8 CARHAM CRES

GLASGOW 17/01/1980
G52 2HN CHI 1701806541

'ORIA HOSPITAL
Surgery Unit
Pre-operative patient Questionnaire

For the attention of patients receiving a general anaesthetic/ sedation

Have you arranged a carer for 24hrs at home?	Yes /No
Do you have a cough, cold or nose trouble? (small)	Yes/ No
What time did you last have something to eat?	3.pm
What time did you last have something to drink?	6.am
ave you had any alcohol in the last 24hrs?	Yes/ No
If yes how much did you have?	

Patient Agreement

I understand that following day surgery I must

- Have a carer for the next 24 hrs
-

I understand that following day surgery I MUST NOT:

- Drive a vehicle or ride a bicycle for 24 hrs
- Drink any alcohol for 24 hrs
- Be alone in charge of a baby or child for 24 hrs
- Operate machinery, use a cooker or kettle for 24hrs
- Climb a ladder or work at heights for 24 hrs
- Sign any important documents for 24 hrs

I certify that I understand and will comply with these Restrictions

Patient's signature: Lisa Hughes Date:.....

Nurse's signature:.....Date:.....

CG 10/09

DIRECTORATE OF OBSTETRICS, GYNAECOLOGY & PAEDIATRICS

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Dr Marco Gaudoin
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Glasgow
G51 4TF
Secretary's Tel No: 0141 201 2291
Fax No: 0141 201 2994

e-mail: myra.glass@ggc.scot.nhs.uk

Date Dictated: 24/05/11
Date Typed: 24/05/11
REF: AH/MCG

DR SEMPLE
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr Semple

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485) CHI: 1701806541
8 CARHAM CRES, . GLASGOW, G52 2HN

Lisa had a diagnostic laparoscopy and examination to her cervix in the Day Surgery Unit on 17th May 2011.

She was found to have a normal cervix apart from the evidence of previous loop excision and her pelvis was absolutely normal along with normal tubes and ovaries. There is no evidence of endometriosis or infection. However, I have noticed that her right colon is quite distended and maybe the pain she is having is due to her bowel dysfunction rather than anything gynaecological.

Yours sincerely

DR HASSAN O-MOHAMED ALI
CONSULTANT OBSTETRICIAN & GYNAECOLOGIST

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Acute Services Division

Surgery and Anaesthetics Directorate

Department: Pre Op Assessment Unit

Specialty: General Surgery

NHS Greater Glasgow and Clyde

Hospital Name	Southern General

Patient Details		GP Details	
Name	HUGHES, LISA	Name	SEMPLE, LINSEY
Address	8 Carham Crescent GLASGOW G52 2HN	Address	CARDONALD MEDICAL CENTRE 1831 PAISLEY ROAD WEST GLASGOW G52 3SS
Correspondance Address	,	Telephone	,
Correspondance Postcode		CRN Number	64057442B, SG00953485, Z00286838
Telephone	07766451921	Consent	Yes
Patient Contact Number	01412390191	Sensitivity	Sensitive
CHI Number	1701806541	Consultant Name	KHAUND
Sex	Female	Requires Transport	No
Date of Birth	17/01/1980	Religion	

Next of Kin / Person to Notify	Next of Kin	Person to Notify
Name	AGNES HUGHES	
Address	46 HOLLYBUSH ROAD, PENNILEE	
Landline	TBC	
Mobile		
Relationship	MOTHER.	

Assessment Details					
Assessor	VICKI CUNNINGHAM	Grade	5	Date	24/03/2011
Ward	VACH DSU.				

Surgery / Procedure Attending For
DIAGNOSTIC LAPAROSCOPY AND STERILISATION

Short Notice Availability	Yes/No	Details
Available at short notice?	Yes	24-48 HRS NOTICE.

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Anaesthetic	Yes/No	Details/Problems
Previous GA	Yes	PONV;
Previous LA	Yes	
Detention Risk	Yes	1 FRONT UPPER VENEER
Neck/Jaw Stiffness	No	
Other Risk	No	
Heartburn	No	
Sickle Cell Disease	No	Risk factors for sickle cell disease: No
Sleep Apnoea Score		

Surgical History	Yes/No	Details/Problems
Affects suitability for DSU	No	
Relevent details of surgical history		THYROIDECTOMY 2009 (MULTINODAL GOITRE.)
Any serious surgical or anaesthetic complication	No	

Cardiovascular	Yes/No	Details/Problems
Hypertension	No	
Arrhythmias		
Angina	No	
Heart Attack	No	
Murmur	No	
Blackouts	No	
Heart Failure	No	

Respiratory	Yes/No	Details/Problems
Asthma/Bronchitis/COPD/Emphysema	No	
URTI	No	

Neurological	Yes/No	Details/Problems
Stroke	No	
Epilepsy	No	
Neurological Disease	No	
Physical Disability	No	

Haematological	Yes/No	Details/Problems
Bleeding Disorder	No	
Previous DVT	No	
Anaemia	No	

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Miscellaneous	Yes/No	Details/Problems
Kidney disease	No	
Liver disease/jaundice	No	
Diabetes	No	
Arthritis	No	
CJD Risk	No	

Any serious illness not already mentioned? Yes POST-NATAL DEPRESSION AND ANXIETY DISORDER.;

Exercise Tolerance	Yes/No		Yes/No		Yes/No
Climbs stairs without stopping	Yes	Climbs stairs with stopping	No	Cannot climb stairs	No

Social	Yes/No			
Alcohol (units/week)	[redacted]	0		
Smoker	Yes	23 cigs/wk		
Ex Smoker				
IV drug abuser	No		Methadone Req:	
Pregnant	No	LMP	Could Be Pregnant:	No

Drug History

List of all drugs (including herbal remedies and complimentary medicine)

LEVOTHYROXINE 200MCG
OLANZAPINE 10MG NOCTE
DIAZEPAM 5MG TDS
CITALOPRAM 10MG OD
DEPO-PROVERA 3/12

Patient takes the following drugs

Taking herbal remedies or complimentary medicine No

Oral Steroids in past year No

Does patient have any allergies?

Prosthesis/Implants	Yes/No		
Pacemaker	No	Date of last Check	Date of Insertion
		Reason for insertion	
		Other Reason	
Prosthesis/Other	No		

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Examination

Weight (kg)	63.1	Height (m)	1.66	BMI	23	Temp	
Pulse (bpm)	88	Regular	Regular	BP	128/79		
SaO2 (%)	99						

Investigations

The below investigations are required.

24/03/2011

U&E	No	FBC	Yes	ECG	No
Glucose	No	Coag Screen	No	LFTs	No
Group & Save	Yes	Other	TFT;		

VTE Risk

Is patient at risk of VTE?	Yes	Do they require prophylaxis?	Yes

Admission Criteria

Appropriate admission based on nursing assessment DSU

Pre-operative Assessment Summary

Assessor: VICKI CUNNINGHAM Grade: 5

PATIENT ASSESSED FOR DIAGNOSTIC LAPAROSCOPY AND STERILISATION AT DSU. HISTORY FROM PATIENT, NO NOTES AVAILABLE.

PREVIOUS GA, SUFFERS PONV.

PMH- THYROIDECTOMY FOR GOITRE
NODULES ON VOCAL CORDS, SUFFERS FROM HAORSENESS, KNOWN TO SALT.
POST-NATAL DEPRESSION AND ANXIETY DISORDER.

CLINICALLY STABLE AS CHARTED. PATIENT APPEARS FIT AND WELL.

ROUTINE BLOOD OBTAINED AS ABOVE. LETTER PROVIDED FOR PATIENT TO ATTEND VACH POA CLINIC ONCE DATED TO HAVE GR REPEATED.

MEETS DSU CRITERIA, FASTING INFORMATION PROVIDED.

Recommended Admission Pathway

Referral by nurse to:	
Nurse to arrange the attendance of:	
Nurse to:	
Referral by Anaesthetist to:	
Type of admission to be decided by:	Nurse
Type of Admission:	DSU
Admission Deferred:	No

CHI Number: 1701806541 Patient Name: HUGHES, LISA

Anaesthetic Assessment	Anaesthetist:	Grade:

Acute Services Division

Surgery and Anaesthetics Directorate

Department of Pre Op Assessment Unit

Specialty: General Surgery

NHS Greater Glasgow and Clyde

PreAdmission Form Release 1.0

Hospital Name: Southern General

Patient Details		GP Details	
Name:	HUGHES, LISA	**Name:**	SEMPLE, LINSEY
Address:	8 Carham Crescent GLASGOW	**Address:**	CARDONALD MEDICAL CENTRE 1831 PAISLEY ROAD WEST GLASGOW G52 3SS
Postcode:	G52 2HN	**Telephone:**	
Correspondence Address 1:		**Consent:**	Yes
Correspondence Address 2:		**Sensitivity:**	Sensitive
Correspondence Postcode:		**Consultant Name:**	
Telephone:	07766451921	**Admission Date:**	
CHI Number:	1701806541	**Time:**	
CRN:	64057442B, SG00953485, Z00286838	**Ward:**	
D.O.B:	17/01/1980	**Procedure/Operation:**	

Observations			
Temperature (celcius)		**Resps (per min)**	**Heart Rate (bpm)**
Blood Pressure (mmHg)		**O2 Sats (%)**	**S/Mews Score**
Changes Since POA?	*Yes* *No*		

There are no allergies to display

Emergency Contact Numbers
Name
Relationship
Phone

Discharge	Yes	No
Estimated Date		
Transport Required		
Supervising Adult for Discharge		

Home Circumstances		Yes	No
Lives with Family Carer			
Lives Alone			
Elderly/Disabled Partner			
District Nurse	**days/wks**		
Home Help			
Other Services			

Medicines	Yes	No
Own Supplied		

Valuables	Yes	No
Valuables Returned		

MRSA		
Positive	**Negative**	**Unknown**

Activities of Daily Living	NOTE: NOT REQUIRED FOR DAY SURGERY
Safety and Comfort	
Breathing and circulation	
Maintaining Body Temp	
Personal Hygiene	
Elimination	
Sleep	
Mobility	
Eating and drinking	
kin Condition/Waterlow score	
Communication (including anxiety & fear) Aids worn?	
Date	Admitted By

Telepath

MRN	**null**	Gender	**Female**
Name	**HUGHES, LISA**	Date Of Birth	**17-Jan-1980**
Encounter Number			

COPY ONLY DO NOT FILE

SOPRANO clinical workflow

Thyroid function

Time Collected	24-Mar-2011 11:00	**Time Received**	24-Mar-2011 15:21
Time Reported	25-Mar-2011 13:30	**Order Number**	R,11.1102353.P
Status	Final		

Comments

REQUESTOR**THYROIDECTOMY

Results

Test Name	Result	Units	Ref. Range	Abnormality	Status
TSH	*0.07	mU/L	0.35 - 5.00 mU/L	-	Final
Free T4	15.8	pmol/L	9.0 - 21.0 pmol/L		Final
Total T3					Final
Total T4					Final

* Abnormal

Prepared for Vicki Cunningham (Vicki Cunningham) on 30 March 2011 13:24:30

OK

Clinically

Adequate replacement

Telepath

MRN	**null**	Gender	**Female**
Name	**HUGHES, LISA**	Date Of Birth	**17-Jan-1980**
Encounter Number			

COPY ONLY DO NOT FILE

SOPRANO clinical workflow

Bloodbank

Time Collected	24-Mar-2011 00:00	**Time Received**	24-Mar-2011 14:12
Time Reported	24-Mar-2011 16:30	**Order Number**	R,11.0008730.Y
Status	Final		

Results

ResultOther Final

```
Sample tested at Southern General
 Blood Group: A     Rh(D): POS       Antibody Screen: Negative
          PLASMA RETAINED
          ZERO TOLERANCE POLICY ON SAMPLE LABELLING EFFECTIVE 05.10.09
```

Prepared for Vicki Cunningham (Vicki Cunningham) on 30 March 2011 13:25:00

Telepath

MRN	**null**	Gender	**Female**
Name	**HUGHES, LISA**	Date Of Birth	**17-Jan-1980**
Encounter Number			

COPY ONLY DO NOT FILE

SOPRANO clinical workflow

Full Blood Count

Time Collected	24-Mar-2011 11:25	**Time Received**	24-Mar-2011 14:38
Time Reported	24-Mar-2011 15:00	**Order Number**	H,11.3065750.E
Status	Final.		

Comments

REQUESTOR**FOR LAPAROSCOPY

Results

Test Name	Result	Units	Ref. Range	Abnormality	Status
White Blood Count	8.6	x10^9/l	4.0 - 11.0 x10^9/l		Final
Red Cell Count	4.18	x10^12/l	3.80 - 5.80 x10^12/l		Final
Haemoglobin	123	g/l	115 - 165 g/l		Final
Haematocrit	0.383	l/l	0.330 - 0.470 l/l		Final
Mean Cell Volume	91.6	fl	78.0 - 99.0 fl		Final
Mean Cell Hgb	29.4	pg	27.0 - 32.0 pg		Final
Platelet Count	312	x10^9/l	150 - 400 x10^9/l		Final
Neutrophils	5.6	x10^9/l	2.0 - 7.5 x10^9/l		Final
Lymphocytes	2.2	x10^9/l	1.5 - 4.0 x10^9/l		Final
Monocytes	0.6	x10^9/l	0.2 - 0.8 x10^9/l		Final
Eosinophils	0.3	x10^9/l	0.0 - 0.4 x10^9/l		Final
Basophils	0	x10^9/l	0.0 - 0.1 x10^9/l		Final

Prepared for Vicki Cunningham (Vicki Cunningham) on 30 March 2011 13:25:19

Patient Agreement to Investigation or Treatment

NHS Greater Glasgow and Clyde

CONSENT FORM

PATIENT

SG00953485
HUGHES ,LISA ROSEMARY
8 CARHAM CRES
GLASGOW 17/01/1980
G52 2HN CHI 1701806541

Hospital/Clinic/GP Practice .....

Patient's surname/family name :.....

Patient's first name(s): .....

Date of Birth___/____/_____ Gender: Male ☐ Female ☐

NHS/ CHI Number _____

Special requirements (e.g. other language/communication method) .....

.....

Responsible practitioner: .....

Job title: .....

STATEMENT FOR PRACTITIONER

(to be filled in by practitioner with appropriate knowledge of proposed procedure- see guidance notes)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side: (WRITTEN IN FULL)

Laparoscopy Salpingectomy
Right

+ M-Tube

I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedures above).

Signature of practitioner: .....

Name/Designation (Print) .....

Date 17/5/11

00526

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*

(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

I have been told about additional procedures which may become necessary during treatment. I have listed below **any procedures which I do NOT wish to be carried out without further discussion**

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- to the emergency administration of blood or blood products

Additionally you have to agree or disagree the following:-	**Agree**	**Disagree**
that information and/or images kept in records may be used anonymously for education, audit, and research with appropriate ethical approval, to improve the quality of patient care.	☐	☐
that surplus tissue or other biological material not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☐

PATIENT REFUSAL FOR BLOOD PRODUCTS

Please sign here if you refuse to consent to the emergency administration of blood or blood products. Even if this results in death.

Signature: ..... Date ...../...../.....

Practitioner Signature: ..... Date ...../...../.....

PATIENT/PARENT* AGREEMENT FOR TREATMENT

Signature: Lisa Hughes ..... Date 17/5/11

Name (Print): .....

THE VICTORIA INFIRMARY

OPERATION SHEET

SG00953485
HUGHES , LISA ROSEMARY
8 CARHAM CRES

GLASGOW
G52 2HN

17/01/1980
CHI 1701806541

FIRST NAMES (Block Letters)

N PERFORMED

Loop excision Julius
Biop & Cauterisation

AGE | REGISTRATION NUMBER

SURGEON | ASSISTANT | ANAESTHETIST

17/3/14

CLE Wood Rowan
Evidence of previous Loop Excision
Relevant full previous history
+ introduction of Colposcope.

Normal picture — no Evidence
of infection Endometriosis
Distended Cervical Rt side

a Julius Biop Applied
Access each Tube -

Gas - Cyn Removed
Local Anaesthetic
used Biop used

VIC 696
FORM 0168262

NEW VICTORIA ACH

ADDRESSOGRAPH **ADDITIONAL RECORDINGS**

PRIMARY RECOVERY

DATE&TIME 17/05/2011	10:10	10:15	10:20					
BP	114/67	110/52	106/65					
PULSE RATE ;	99	87	77					
ECG	S.R	S.R	S.R					
RESP.RATE	14	14	13					
AIRWAY	Own	Own	Own					
OXYGEN	~~6L~~	—	—					
SAO2 %	93	98	95					
COLOUR	Satis	Satis	Satis					
SEDATION SCORE 0/1/2/3	0	0	0					
NAUSEA SCORE 0/1/2/3	0	0	0					
PAIN SCORE 0/1/2/3	1	1	1					
PV BLEEDING	NiL	NiL	NiL					
1.WOUND (SITE:)	S. Stain	S. Stain	S. Stain					
C.S.M								
2.WOUND(SITE;_____)	DRY	DRY	DRY					
C.S.M								
TEMPERATURE								
SIGNATURE	M.P	M.P	M.P					

COMMENT

Acute Services Division
New Victoria Hospital

NHS
Greater Glasgow and Clyde

Day Surgery Unit, ACH
General Anaesthetic / Sedation Patient Care Plan

ORSOS No::

Note: Please complete this section when referring a patient.
Use addressograph label

SG00953485
HUGHES ,LISA ROSEMARY
8 CARHAM CRES
GLASGOW 17/01/1980
G52 2HN CHI 1701806541

Tele:
Mobile:

☐ Pending
☐ ECG
☐ Bloods
☐ Other (state):

☐ Rejected
☑ BMI
☐ BP /
☐ ECG
☐ Other (state):
☐ Letter sent to Consultant re:

☐ Accepted
Date:

Cancellation?
☐ Yes ☐ No

Holiday dates:

Consultant: ALI

Planned operation (please PRINT):
Lap Ster

☑ General Anaesthetic ☐ Sedation

Proposed date: / / ☐ TBA
07-5-11

Referring Surgeon (please PRINT)

Contact Name Agnes Haughey

Relationship: Mum.

Telephone: 07769815357

Escort Name (Partner at home)

Relationship:

Telephone:

GP
Address

Interpreter ☑ N/A ☐ Yes

Language:

Organised for (date): / /

Time from: hrs until: hrs

☐ GIS ☐ Global ☐ Other (state):

Company Ref or Reject No:

Additional Requirements / Comments

MIS • DAY SURGERY • 9706

Admission Observations and Pre-operative Instructions

Name

SG00953485
LISA ROSEMARY HUGHES
8 CARHAM CRES

GLASGOW 17/01/1980
G52 2HN CHI 1701806541

Observations	Time	0825	
% Sat O_2		99	
BP		123/85	
Pulse rate Regular / Irregular		84	
	Signature	[signature]	

Locker number:

Any change in health / circumstances since pre-assessment?	☑ No ☐ Yes (State):
Date of last menstrual period	3 years (on depo)
Are you or could you be pregnant?	no
Pregnancy test performed in DSU	Result: -ve test
Blood Group	

Pre-operative Checklist	Admit Nurse	Anaes Nurse	Comments
Pre-op questionnaire signed	✓	✓	
Escort arranged	✓	✓	
Carer arranged for 24 hours	✓	✓	
Patient last ate: 8pm hours	✓	✓	State:
Patient last drank: 6am hours	✓	✓	State: SIP OF WATER
Consent form signed	✓	✓	
Identification band	✓	✓	
Confirm operation and site (state)	✓	✓	Lap Ster
Operation site marked	NA	—	
Wound Site prepped	NA	—	
Has passed urine	✓	✓	
Any known allergies (list) NONE KNOWN	None	NIL KNOWN	
Premedication given	✓	✓	
Dentures	No	✓	
Any caps, crowns, loose teeth, etc (list)	✓	✓	Veneer 2/
Contact lenses, glasses	No	✓	
Artificial aids (specify)	No	✓	
Make-up, nail polish removed	Yes	✓	
Jewellery/piercings removed/ wedding ring taped	✓	✓	
Diathermy / IV sites may be shaved		✓	
Signature	[signature]		Date 17/5/11

Patient Information

SG00953485
HUGHES ,LISA ROSEMARY
8 CARHAM CRES

GLASGOW 17/01/1980
G52 2HN CHI 1701806541
Use addressograph label

ALLERGIES

Surgeon(s)	
Anaesthetist(s)	
Scrub nurse(s)	
Anaes. nurse(s)	

Patient position	Left arm secured	Right arm secured	Eyes taped	Warming blanket
☑ Supine	☐ On board	☐ On board	☐ Yes	☐ Yes (Temp:)
☐ Prone	☑ Across	☑ Across	☑ No	☑ No
☑ Lithotomy	☐ At side	☐ At side		

☐ Other (specify):

Tourniquet	Time on	Time off	Site satisfactory	Comments
Site:			☐ Yes ☐ No	
Site:			☐ Yes ☐ No	
Diathermy sites/s (state):			☐ Yes ☐ No	☑ Mono ☐ Bi
			☐ Yes ☐ No	
Pressure Area Policy followed			☐ Yes ☐ No	

Operation Performed

Laparoscopic Sterilisation

Filshie Clips - Lot 26712 Exp 2015

☑ GA ☐ LA ☐ Sedation: ☐ Regional block: 20 mls

Specimens: Chirocaine 5.0 mg.

Sutures: 2/0 Polysorb

Dressings: 2 Premapore

Packing:

Follow-up ☑ N/A ☐ Required (state): ☐ Organised

DSU discharge prescription ☐ N/A ☐ Prescribed

Primary Recovery — Time	9:40	9:45	9:50	9:55	10:00	10:05
BP	113/70	113/72	118/66	123/73	118/78	117/72
Pulse rate: Regular/Irregular	84	80	105	92	94	83
ECG rhythm	S.R	SR	ST	SR	SR	SR
Respiratory rate	24	18	12	12	14	13
Airway	LMA	LMA	Own	Own	Own	Own
Oxygen	15L	15L	6L	6L	6L	6L
% Sat O_2	99	100	100	100	100	100
Colour: Satis / Pale / Cyanosed	Pale	Pale	Pale	Satis	Satis	Satis
Sedation score 0 / 1 / 2 / 3	3	3	2	1	1	1
Nausea score S / 0 / 1 / 2 / 3	—	—	0	0	0	0
Pain score S / 0 - 10	—	—	4	8	8	5
PV bleeding	—	—	—	—	—	—
1. Wound (site:)	—	—	—	—	—	—
1. Colour/Sensitivity/Movement						
2. Wound (site:)						
2. Colour/Sensitivity/Movement						
Temperature	36.3°C					
Signature	M.P	M.P	M.P	M.P	M.P	M.P

Fentanyl given

Discharge Criteria

Name

Unit No

Use addressograph label

Vital Signs Pre-Mobilisation

Time	1210	
BP	103/66	
Pulse (Regular / Irregular)	79	
1. Wound Site Umbilical	Dry	
2. Wound Site lower	Slight ooze	
Signature		

Time hours	Yes	N/A	Comments
Stable vital signs			BP 114/58 Pulse 64.
Pain score satisfactory (score 0)	✓		
Sedation score satisfactory (alert / orientated 2)	✓		
Nausea score satisfactory (score 0)	✓		
1. Wound site satisfactory (site upper)	✓		
2. Wound site satisfactory (site lower)	✓		
PV bleeding satisfactory	✓		
Tolerating light diet	✓		
Tolerating oral fluids	✓		
Voided urine postoperatively	✓		
Advice given if not passed urine		✓	
Anti-D given		✓	
ECG electrodes and ID Bracelet removed	✓		
IV cannula removed	✓		
Packing / dressing removed		✓	
Follow-up arranged		✓	☐ By post ☐ Given
District Nurse arranged	✓		
Letter to GP given	✓		
Discharge medication given	✓		
Verbal and written post-op instructions given	✓		
Responsible adult escort	✓		

12-50 AM, Lisa felt 'dizzy' prior to discharge. BP 103/66. P79. Assisted back to bed. Anaesthetist prescribed Succastem which was given - Sfenlu
1320 - BP 116/60 P71. Feels a lot better. Sfenlu

Patient discharged by: Sfenlu at: 1345 hrs

Patient left DSU at: hrs Destination:

Discharged into the care of: Relationship:

[redacted]

Surgical Procedure Form

Consultant: (HAVN) TCI 17/5

SG00953485
LISA ROSEMARY HUGHES
8 CARHAM CRES

GLASGOW 17/01/1980
G52 2HN CHI 1701806541

Clinic Staff to Complete this Section

Patient Tel. No: 0141 239 0191 Patient E-Mail:.....

Available at Short Notice? <24hours ☐ 24-48 hrs ☑ 48hrs-1wk ☐

Dates not available:.....

Best time to phone: am ☐ pm ☐ Evening ☐ Anytime ☐

Interpreter required: No ☐ Yes ☐ Language.....

Consultant to complete this section

Proposed procedure: Diagnostic hysteroscopy + Sterilisation LA ☐ GA ☑ OPCS code:.....

Priority: Urgent ☐ In turn (Routine) ☐

ACH: Suitable for DSU ☑ 23 Hour Stay required ☐

IN PATIENT: In Patient Stay Required ☐ Suitable for same day admission ☐

Not suitable for same day admission ☐ Reason.....

Patient Consented Yes ☑ No ☐

Suitable for Generic waiting list: Yes ☐ No ☑ (my list)

Extra Operating Time Required? Yes ☐ No ☑

Special instructions/Equipment? .....

Signed ..... Print (CHAVN) Date 9/3/11

Pre Operative Assessment Staff to Complete this section

POA and fit for surgery:

ACH: as Day Case ☑ as 23 Hour Stay ☐

In patient: Same day admission ☐ Not suitable for Same Day Admission ☐

Consultant informed of any change from POA ☐

Signed: V. Cunn Print: CUNNINGHAM Date: 5/4/11

SG00953485
HUGHES ,LISA ROSEMARY
8 CARHAM CRES

GLASGOW
G52 2HN

17/01/1980
CHI 1701806541

Prescription Sheet No:

Valid only on the following date: / /

Once only prescriptions

Date	Medicine (BLOCK CAPITALS)	Dose	Route	Time for administration	Prescribers signature (full)	Administered by	Time given

As required prescriptions - Other medicines, incuding oxygen where flow rate, concentration and type of mask must be specified

Date	Medicine (BLOCK CAPITALS)	Dose	Route	Symptom	Minimum interval (hours)	Max. 24 hour dose	Prescribers signature (full)	Administered by	Time given
17/5/11	CODODAMOL 30/500	two tablets	PO	Pain	(4-6) hourly		RIFAI	[signature]	10:20

As required prescriptions - Injections

Date	Medicine (BLOCK CAPITALS)	Dose	Route	Symptom	Minimum interval (hours)	Max. 24 hour dose	Prescribers signature (full)	Administered by	Time given
17/5/11	ONDANSETRON	4mg	IV	N+V	8 hourly		RIFAI		
17/5/11	CYCLIZINE	50mg	IV	N+V	8 hourly		RIFAI		
17/5/11	BUCCASTEM	3mg	Buccal	N+V	12 hourly		RIFAI	[signature]	1AM

Discharge prescriptions

Date	Medicine (BLOCK CAPITALS)	Dose	Route	Symptom	Minimum interval (hours)	Number of days supply	Prescribers signature (full)	Issued by
17/5/11	CODODAMOL 30/500	two tablets	PO	Pain	(4-6) hourly	1 Pack	RIFAI	[signature]
	~~PARACETAMOL~~							
17/5/11	IBUPROFEN	400mg	PO	Pain	8 hourly	1 Pack	RIFAI	[signature]

If medicine discontinued because of adverse reaction, enter below

Medicine	Adverse reaction
1.	
2.	

Known medicine senstivities

1.
2.

Ward	Name of patient	Age / DOB	Height	Weight	Unit number	Consultant

South Glasgow Hospitals

ANAESTHETIC RECORD

NHS Greater Glasgow and Clyde

Date: / /

Pre-op instructions:

Fast for: AM Lunchtime PM List

Patient details

Name:

Unit N°:

Address: SG00953485
HUGHES ,LISA ROSEMARY
8 CARHAM CRES

GLASGOW 17/01/1980
G52 2HN CHI 1701806541

DOB

Proposed operation:

Assessor:

Ward:

Pre-op assessment

Previous G.A.'s:

CVS: HR BP /

Resp: } asymptomatic

Other (specify):
- Thyroidectomy · 2 years

Drugs:
Thyroxine
Olanzapine
Diazepam
Citalopram
Depo-Provera.

N.S.A.I.D's OK.

Allergies:
NKDA.

Fasted: OK.

Reflux: no

BMI:	Airway: good mo MP (I)	Dentition: + 2 veneers
Weight (kg):		

Investigations

Na+:	Hb:	Others (specify):
K+:	WCC:	
C1-:	Plts:	
HCO3-:	ECG:	
Urea:	CXR:	
Creat:	Glucose	

Urgency		A.S.A.
Elective	☐	1
Scheduled	☐	2
Urgent	☐	3
Emergency	☐	4
		5

Material risks explained ☐

Comments / Warnings

Anaesthesia.

Date: 17 / 5 / 2011

Machine check: ☑ Circuit check ☑

Cannula: 20 G, L/R (Hand) Arm Foot

Cannula: G, L/R Hand Arm Foot

Arterial site: | CVP site:

Patient position: supine

ECG ☐	NIBP ☐	S_pO_2 ☐
E_TCO_2 ☐	FiO_2 ☐	E_TAA ☐
ALL ABOVE ☑		
TOF ☐	CVP ☐	IABP ☐
Blood warmer ☐	Patient warmer ☐	
Anti DVT ☐	U/O ☐	Temp ☐

Fluids
(1) RL 500 ml
+ Diclofenac 75 mg

Pre O_2	ETT size:	LMA size: 4	Ventilation - Spontaneous ✓ / Controlled
Cricoid ☐	Oral / Nasal	Type:	
Airway - Oral / Nasal	Cuffed / Uncuffed	Pack: In / Out	

Circle ○	(Air) / N_2O	Laryngoscopy Grade:
Bain	(SEVO)	1 2 3 4
T-piece	ISO	
ADE	DES	

Time	9	10
	Gas Induction	
	Glycopyrrolate	200 mcg
	Fentanyl	75	25
	O_2 N_2O / Sevo →	O_2 / Air / Sevo
SpO_2	99	99
FiO_2	56	55
$ETCO_2$	6.0	5.5
E_TAA	2.7	2.7
Fluids	(1)	
Temperature		
180		
160		
140		
120		
100	✓ ✓ ✓	✓
80	0 0	0
60	^ ^ ^	^
40		
20		
CVP		
Blood loss		
Urine output		

Regional Anaesthesia / Other Procedures / Comments

20 ml 0.5% Chirocaine infiltrated by surgeon.

Operation Details

Lap / Ster

Theatre: ACH 6

Operation as proposed on page 1 ☐

Reversal given: Yes ☐ No ☐

Anaesthetist(s): R.fa.	Surgeon(s): Hassan.
Named Consultant:	Discussed with Consultant: Yes ☐ No ☐

Post Operative Care

A. Oxygen 4 **L/min OR** **% for** **hours OR SpO_2** ≥95 **% on air.**

B. Routine observations / postoperative care as per local protocol.

C. Appropriate DVT prophylaxis precribed: Yes ☐ N/A ☐

D. Anti-emetic given: Yes ☐ No ☑ Drug given:

E. Analgesia:

I.V. Morphine as per Recovery Algorithm - Sign		
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:

OR

I.V. Fentanyl as per Recovery Algorithm - Sign		
40 µm bolus - Time: 10 01	Sign: JEMLe	Witness: Dose.
40 µm bolus - Time: 10 08	Sign: JEMLe	Witness: Dose
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:

F. Post Operative fluids

Fluid (additive)	Volume	Rate	Sign	Start	Lot No.	Initials
Hartmanns	500	40	RIFAT	1005	11C11T4E Exp 04	JEMLe

Post operative notes / Comments

Post Operative Care

Time																	
SpO_2																	
O_2 L/min																	
Resp Rate																	
Airway																	
180																	
160																	
140																	
120																	
100																	
80																	
60																	
40																	
20																	
Temperature																	
CVP																	
Wound site																	
ffected limb ılse: +ve/-ve																	
Circulation Satisfactory:S Poor: P																	
Sensation +ve/-ve																	
Movement +ve/-ve																	
Sedation/Pain score																	
Nausea score																	

Time	Fluid in	Urine	Drain 1	Drain 2

Blood results / Drug given

Additional nursing comments

Waterlow Score ☐ **Intervention required:**

Discharge criteria met:	**Discharged to:**	**Recovery Nurse name:**	**Ward Nurse name:**
Yes ☐ NO ☐	Ward:	.....	.....
Comments:	HDU ☐ ITU ☐	Signature:	Signature: .....

VIC 638 Cat. No. 0163149 VI MEDICAL ILLUSTRATION • ANAES • 1985/6.05

SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW
G51 4TF
Switchboard: 0141 201 1100

Direct Line: 0141 232 7953/7952/7951/7955/7971/7972

DEPARTMENT OF GYNAECOLOGY

Dr T Dow, Locum	Dr K Spowart
Dr K Hanretty	Dr C Taggart
Dr E Hadoura, Locum	Dr R Panigrahy, Locum
Dr J Richmond	Dr J Roberts
Dr S Pringle	Dr V McKay
Dr C Hardwick	Dr R Hawthorn
Dr A Khaund, Locum	Dr K Guerrero
Dr H Ali	Dr S Bjornsson

DEPARTMENT OF GYNAECOLOGY

Ref: AK/SB/SG0953485
Date: 10/03/2011

Dr Linsey Semple
Cardonald Medical Centre
1831 Paisley Road West
G52 3SS

Dear Dr Semple

Lisa Hughes - 17/01/1980 - CHI: 1701806541
8 Carham Crescent, Glasgow, Lanarkshire, G52 2HN

Thank you for referring this 31 year old para 8 (vaginal deliveries) who requests female sterilisation. She has also been seen recently with left iliac fossa pain which is constant and persistent. I note that pelvic ultrasound recently has been reported as normal. Bowel habit is also normal.

This lady is aware of the alternatives for contraception, including the Mirena coil. She is aware of the risks associated with female sterilisation including its irreversibility, failure rate, risk of ectopic pregnancy and risks of visceral damage/haemorrhage and infection.

Lisa has been listed for diagnostic laparoscopy + female sterilisation as a day case in the near future.

Kind regards.

Yours sincerely

Aradhana Khaund
Consultant Gynaecologist

953485

OWL SP 10/12

Patient Details

Surname	HUGHES
Forename	LISA
CHI	1701806541
GP Details	SEMPLE, LINSEY CARDONALD MEDICAL CENTRE
Age	30
Hospital CRNs	64057442B, SG00953485, Z00286838

Referral Details

Date Received	02/12/2010 15:13:11
ReferralID	5659699
Priority	ROUTINE
New Priority	ROUTINE

Priority History

ROUTINE	02/12/2010 16:01:03	no priority reason given

Redirection Information

Specialty	Hospital	Reason	Redirected Date	Redirected By
Gynaecology - other	Southern General Hospital	Record Creation	02/12/2010 16:01	Helen Ipermakhou

Tracking/Vetting Details

Cancer Code	
Date Vetted	02/12/2010 17:26:37
Vetting Status	Vetted
Outcome	Direct OP Appointment
Vetted By	Bob Hawthorn

Tests

Clinics

Consultant		Site	Southern General Hospital

Instructions

HRCompleted	False

953485
IN/SG/SR L XL

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Gynaecology - other
GGC Gynae Gen Ref

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

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

— **Hospital and hospital address**

Hospital location code: G405H

Email address:

Urgency of referral ROUTINE
Date of referral 26-Nov-2010 **Date sent** 02-Dec-2010

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa Rosemary
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541

Patient's address

8 Carham Cres
GLASGOW
G52 2HN

Contact number(s)

Voice: 0141 239 0191

101001312281B Unique Care Pathway Number: 101001312281B

REGISTERED GP DETAILS

Name	Dr LC Semple		
GMC code	2820354	GP code	G07897
Practice name	Cardonald Medical Centre		
Practice code	52363		

Practice address

1831 Paisley Road West
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Linsey Semple		
GMC code	2820354	GP code	07897
Practice name	CARDONALD MEDICAL CENTRE (52363)		
Practice code	52363		

Practice address

1831 PAISLEY ROAD WEST
GLASGOW

Contact number(s)

Voice: 0141 892 2548

02 DEC 2010

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: STERILISATION

Comment: Dear doctor,

I would be grateful if you could see this lady who is a para 7, and has 8 children with one set of twins in her second last pregnancy. She has decided that her family is now complete and is keen to be sterilised. I have explained the operation to her and she is keen to proceed. We also had a discussion about her left iliac fossa pain, which she was referred to yourselves about, earlier in the year. She was seen by Dr Pringle who reassured her that there was nothing to worry about, however he did say that she could come back if the pain was not settling down, and indeed it hasn't. I did an ultrasound which showed normal size and appearance of the uterus, endometrium and both ovaries. There were no adnexal masses or cysts seen. I wonder if you could see her both for consideration of sterilisation and also for the ongoing left iliac fossa pain. Finally she is taking Olanzapine, Aripiprazole and Diazepam and Depo Provera. She is also on Thyroxine. Thank you for your time.

Yours sincerely,

DR KIRSTY MCCALLUM

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date recorded
Autoimmune thyroiditis	-	25-Jun-2009
Nontoxic multinodular goitre	-	29-Aug-2008
Asthma resolved	Attack 1995	12-Dec-2005
Head injury	was assaulted	27-Sep-1997
[X]Overdose - paracetamol	-	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date recorded
Rep.presc. monitoring NOS	-	18-Nov-2010
Equivalent quantities for all medication checked	-	18-Nov-2010
Thyroidectomy operations	-	08-Jun-2009
CIN III - severe dyskaryosis	+ HPV	26-May-2004

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Levothyroxine Sodium	112	TABS 100MICROGRAMS	2 Tabs	In the morning	15-Feb-2010	28-Oct-2010

Recent medication (Any medication issued within last 168 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Diazepam	63	TABS 5MG	1 tab up to	3 times daily if req	25-Nov-2010	25-Nov-2010
Aripiprazole	28	TABS 10MG	1 tab	mane	25-Nov-2010	25-Nov-2010
Olanzapine	28	TABS 10MG	1 Tab	At night	25-Nov-2010	25-Nov-2010
		Contraceptive Prefilled Syringe	to be		22-Nov-	22-Nov-

Depo-Provera	1	1ml INJ 150MG/ML	injected	im	2010	2010
Mebendazole	2	TABS 100MG	2 tabs	to be taken	19-Nov-2010	19-Nov-2010
Diazepam	63	TABS 5MG	1 tab up to	3 times daily if req	28-Oct-2010	28-Oct-2010
Diazepam	42	TABS 5MG	1 tab up to	3 times daily if req	14-Oct-2010	14-Oct-2010
Olanzapine	28	TABS 10MG	1 Tab	At night	14-Oct-2010	14-Oct-2010
Aripiprazole	28	TABS 10MG	1 tab	mane	14-Oct-2010	14-Oct-2010
Diazepam	42	TABS 5MG	1 tab up to	3 times daily if req	29-Sep-2010	29-Sep-2010
Diazepam	21	TABS 5MG	1 tab up to	3 times daily if req	23-Sep-2010	23-Sep-2010
Diazepam	21	TABS 5MG	1 tab up to	3 times daily if req	17-Sep-2010	17-Sep-2010
Diazepam	21	TABS 5MG	1 tab up to	3 times daily if req	09-Sep-2010	09-Sep-2010
Aripiprazole	28	TABS 10MG	1 tab	mane	09-Sep-2010	09-Sep-2010
Olanzapine	28	TABS 10MG	1 Tab	At night	09-Sep-2010	09-Sep-2010
Diazepam	6	TABS 5MG	1 tab up to	3 times daily if req	07-Sep-2010	07-Sep-2010
Diazepam	21	TABS 5MG	1 tab up to	3 times daily if req	27-Aug-2010	27-Aug-2010
Diazepam	21	TABS 5MG	1 tab up to	3 times daily if req	19-Aug-2010	19-Aug-2010
Aripiprazole	28	TABS 10MG	1 tab	mane	19-Aug-2010	19-Aug-2010
Olanzapine	28	TABS 10MG	1 Tab	At night	19-Aug-2010	19-Aug-2010
Diazepam	14	TABS 5MG	1 tab up to	3 times daily if req	13-Aug-2010	13-Aug-2010
Diazepam	14	TABS 5MG	1 tab up to	3 times daily if req	09-Aug-2010	09-Aug-2010
Olanzapine	28	TABS 10MG	1 Tab	At night	26-Jul-2010	26-Jul-2010
Diazepam	21	TABS 5MG	1 tab	tds	26-Jul-2010	26-Jul-2010
Diazepam	42	TABS 5MG	1 tab	tds	05-Jul-2010	05-Jul-2010
Nicorette Icy White	105	Sf Medicated Chewing Gum 2MG	use	as directed	05-Jul-2010	05-Jul-2010
Diazepam	21	TABS 2MG	1 tab	tds prn	01-Jul-2010	01-Jul-2010
Olanzapine	28	TABS 10MG	1 Tab	At night	15-Jun-2010	15-Jun-2010
Paramax	24	Sf Effervescent SACH	1 sachet	as directed	15-Jun-2010	15-Jun-2010
Aripiprazole	28	TABS 10MG	1 tab	mane	14-Jun-2010	14-Jun-2010

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		04-Jun-2009
Current smoker:		06-Jun-2008
Current smoker:		04-Aug-2006
Current smoker:		15-Sep-2005

Current smoker:		01-Feb-2005
Current smoker:	20:	01-Feb-2005
Teetotaller:		01-Feb-2005

Investigations

Description/Question	Result/Comment	Date
Last smear result:	result not available -	

Clinical warnings

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

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

SOUTHERN GENERAL HOSPITAL

6

SG00953485
LISA ROSEMARY HUGHES
8 CARHAM CRES

GLASGOW 17/01/1980
G52 2HN CHI 1701806541

GYNAECOLOGY SHEET

DATE	Reason for Attendance	Diagnosis / Treatment	
9/3/11			
	Previous Illness		
	Operations		
	Parity		
	Menarche	Cycle	Menopause
	L.M.P.	Contraception	
	Urinary Symptoms	DF	SI
		NF	Dysuria
	Examination By:		

953485

Hospital use only	Clinic	Day Date	Time	Hospital No.
	Dr Mitchings	20/9	9.10	

IN MA SG SR

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

(C) (XC)

REFERRAL TO

Ear, Nose & Throat (ENT)
GGC General Referral

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

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

— **Hospital and hospital address**

Hospital location code.
G405H

Email address

Urgency of referral	ROUTINE		
Date of referral	22-Apr-2010	**Date sent**	23-Apr-2010

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa Rosemary
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541

Patient's address

8 Carham Cres
GLASGOW
G52 2HN

Contact number(s)

Voice: 07833990700

101000420839P Unique Care Pathway Number: 101000420839P

REGISTERED GP DETAILS

Name	Dr LC Semple		
GMC code	2820354	GP code	G07897
Practice name	Cardonald Medical Centre		
Practice code	52363		

Practice address

1831 Paisley Road West
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Linsey Semple		
GMC code	2820354	GP code	07897
Practice name	CARDONALD MEDICAL CENTRE (52363)		
Practice code	52363		

Practice address

1831 PAISLEY ROAD WEST
GLASGOW

Contact number(s)

Voice: 0141 892 2548

SOUTHERN

ERAL

Urgent
At 22.4.10

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: HOARSENESS

Comment: Dear Colleague,

I would be most grateful if you could review this pleasant 30 year old lady who has problems with hoarseness. Lisa has been troubled with daily hoarseness for well over one month now which she feels is getting worse. Lisa had been physically very well in herself and has had no recent upper or lower respiratory tract problems. She is under quite a considerable amount of stress from her home circumstances revolving around a large family and a reported unsupportive partner. Lisa does have a background of multi nodular goitre and she feels at the time this was diagnosis she had a similar hoarseness, however her recent TFT's have been with normal limits and no new thyroid masses have been found. I would be most grateful if you could review her.

Kind Regards,

Yours sincerely,

DR. TERESA O'REILLY

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset
Autoimmune thyroiditis	-	25-Jun-2009
Nontoxic multinodular goitre	-	29-Aug-2008
Asthma resolved	Attack 1995	12-Dec-2005
Head injury	was assaulted	27-Sep-1997
[X]Overdose - paracetamol	-	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date performed
Thyroidectomy operations	-	08-Jun-2009
CIN III - severe dyskaryosis	+ HPV	26-May-2004

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Duration
Levothyroxine Sodium	112	TABS 100MICROGRAMS	2 Tabs	In the morning	15-Feb-2010	58 Days

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Duration
Ibuprofen	56	TABS 400MG	1 tablet	tds	14-Apr-2010	0 Days
Olanzapine	28	TABS 10MG	1 Tab	At night	07-Apr-2010	0 Days
Olanzapine	28	TABS 10MG	1 Tab	At night	25-Feb-2010	0 Days
Diclofenac Sodium	84	Ec TABS 50MG	1 Tab	3 times daily	15-Feb-2010	0 Days
Omeprazole	28	CAPS 20MG	1 Cap	Daily	08-Feb-2010	0 Days
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	-	18-Jan-2010	0 Days

Olanzapine	28	TABS 15MG	1 Tab	At night	18-Jan-2010	0 Days
Levothyroxine Sodium	84	TABS 100MICROGRAMS	2 Tabs	In the morning	18-Jan-2010	0 Days
Levothyroxine Sodium	28	TABS 100MICROGRAMS	1 Tab	Daily	10-Dec-2009	0 Days
Levothyroxine Sodium	28	TABS 50MICROGRAMS	1 Tab	In the morning	10-Dec-2009	0 Days
Olanzapine	42	TABS 15MG	1 Tab	At night	10-Dec-2009	0 Days
Levothyroxine Sodium	56	TABS 50MICROGRAMS	1 Tab	In the morning	10-Nov-2009	0 Days
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	-	10-Nov-2009	0 Days
Levothyroxine Sodium	56	TABS 100MICROGRAMS	1 Tab	Daily	10-Nov-2009	0 Days
Olanzapine	28	TABS 15MG	1 Tab	At night	10-Nov-2009	0 Days

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		04-Jun-2009
Current smoker:		06-Jun-2008
Current smoker:		04-Aug-2006
Current smoker:		15-Sep-2005
Current smoker:		01-Feb-2005
Current smoker:	20:	01-Feb-2005
Teetotaller:		01-Feb-2005

Clinical warnings

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

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

SG00953485
LISA HUGHES
5 MOSSVIEW QUADRANT
FLAT 2/2
GLASGOW 17/01/1980
G52 2TU CHI 1701806541

CLINICAL NOTES

DATE	
15.6.9	Treatment room review (FY2 WATERS LOCUM)
1800	
	29 ♀ total thyroidectomy for Thy3 follic. lesion 7 days ago. Well on discharge. Ca2+ (N) h5 (N)
	Currently - Intermittent episodes of sweating, palpitations + lightheadedness @ 3pm everyday (prior to picking children up from school) - once daily - Normal energy levels - Wound pain on (L) - no d/c, peri slightly swollen - No pins+needles although legs sometimes shaky on standing up. No carpo-pedal spasm or muscle twitching - Feels systemically well - No chest pain, SOB, stridor, tenderness. No hoarseness. - on Thyroxine 10mg tds
	Ole Well HR 80 reg Chatty BP at GP normal Not sweating, not clammy
	Wound healing well, no erythema, no swelling, no pus, no tenderness locally.

DATE

CLINICAL NOTES (Continued)

Imp: Well - possible T3 overreplacement

Plan (1) FBC, T3, TSH, Hb as per Miss Clerk's instructions

(2) Clinic to follow up a week on Thursday (9 days) & results.

ANC WATOS FY2 LOCUM CNT

Adj Calcium 2.31

CRP 3

T3 + TSH - will be done tomorrow

SOUTHERN GENERAL HOSPITAL

3G00953485
LISA ROSEMARY HUGHES
8 CARHAM CRES

GLASGOW 17/01/1980
G 2 2HN CHI 1701806541

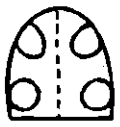
E.N.T. DEPARTMENT

DIAGNOSIS: 1.

2.

WAITING LIST FOR:			
DATE OF ADMISSION			
DATE OF DISCHARGE			

NOSE:



NASO-PHARYNX:

PHARYNX:



MOUTH:

LARYNX:



Small bilat VC nodules
Both VC Mobile

RIGHT EAR:



LEFT EAR:



	RIGHT	LEFT
WHISPERS		
CONVERSATIONAL VOICE		
LOUD VOICE		
RINNE		
WEBER		
BONE CONDUCTION		
AUDIOMETER TEST		
LABYRINTH TEST		

20/5/10

- Voice can 'go' when singing / talking
- Feels voice strained
- Fluctuates.

PROGRESS NOTES:

- No dysphagia.
- On 200mcg thyroxine last checked 2/12 ago.
- Total thyroidectomy 2009 - follicular adenoma.

Has 8 children.
Smokes occ'ly.
Neck —

Refer SLT

AT.

[redacted]

SOUTHERN GENERAL HOSPITAL

OPERATION REPORT

8

SG00953485
LISA HUGHES
5 MOSSVIEW QUADRANT
FLAT 2/2
GLASGOW 17/01/1980
G52 2TU CHI 1701806541

SURGEONS: Ms Clark
Ms Mcallister / Dr Asimakopoulos

DATE: 8.6.09

OPERATION PERFORMED

TOTAL THYROIDECTOMY

FINDINGS & PROCEDURE

Skin prep / drape.
transverse skin incision 4cm above sternal notch
superior and inferior subplatysmal plane skin flaps raised.
Strap muscles divided in midline.
(R) strap muscles divided transversely for access
Dissection and identification of superior pole (R) lobe and (L) lobe
External branch superior laryngeal nerve identified and preserved bilaterally
Superior pole vessels divided
middle thyroid veins divided } bilaterally
recurrent laryngeal nerves identified bilaterally and preserved
(L) recurrent laryngeal nerve not stimulating ~~well~~ but appeared intact
thyroid gland dissected bilaterally close to capsule
nodule on (R) lobe identified.

Haemostasis with bipolar diathermy
(L) + (R) size 15 Drains inserted + sutured with silk 2-0
Strap muscles sutures with 3-0 vicryl
closure of platysma with vicryl 3-0
skin closure 4-0 monocryl
steristrips to skin

Chirocaine 10mls injected

TISSUE SENT FOR PATHALOGICAL EXAMINATION

(1) specimen for frozen section → lymph node
(2) Full specimen sent for frozen section → papillary no evidence of malignancy

Signature.....

0367654-SGH

Post op 1 Routine Observations

2 Check calcium level at 9pm tonight

3 Drain removal when < 30mls over 24 hours

4 start T3 tomorrow

5 Fly Miss Clark OPC 2/52

K

(CMRMUSTER)
JTY.

9PM Ca adj 2.31 – same as pre op. K. Lang

9/6/09

8am Ca^{2+} + FBC repeated K. Lang.

DR Ms Clark - well (H). Later today if Ca^{2+} ok
Drain out.

K. Lang

pm Ca 2.05 Cadj 2.24 – can go (H)

10/6/9

Well today

(P) - (H) today with Link Fly.

- Ca^{+2} today.

S N S1739 – 007 988934
Major Neck Tray

S4768 – 006 1008679
ENT Bipolar Sets

S N S5449 – 003 1009579
Attractomat Tray

S4442 – 004 1008775
ENT Head & Neck Supp Insts. St

s6168 – 004 1005389
Harmonic Blue Handpiece (

NOTES FOR GUIDANCE

MEDICAL PRACTITIONER

A patient has the right to grant or withhold consent prior to examination, investigation, treatment or operation. The doctor must give the patient sufficient information, in a way that he/she can understand, about the procedure, any significant risks and the possible alternatives. In broad terms, a significant risk is one which is serious, but uncommon, or one which occurs frequently, even if it is not serious. You must give the patient enough time to read this form and ask any questions relating to it or their treatment. The patient must be allowed to decide whether he or she will agree to the procedure and they may refuse or withdraw consent at any time. Consent to a procedure must be recorded on this form.

The patient must give written consent to be examined by students during any procedure for which written consent is required. (See overleaf)

PATIENTS

The doctor is here to help you. He or she will explain the procedure, which you are entitled to refuse or withdraw consent at any time. You can ask any questions and ask for more information if you wish.

You may ask for a relative, friend or nurse to be present while the doctor explains the procedure and asks you to sign the form.

If an anaesthetic or sedation is to be administered by an anaesthetist, it will be his or her responsibility to discuss details with you before the procedure takes place.

Students need to learn how to examine patients and to see how procedures are done. This is important for the future of the health service. You may be asked to give consent to be examined by students during the procedure. It is up to you to decide whether to give your consent or not but, whatever you decide, it will not affect your treatment.

STATEMENT TO BE COMPLETED BY THE PATIENT

You should read this form and the notes below carefully. If there is anything you do not understand, ask the doctor for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the doctor named on this form.
- that the procedure might be carried out by a doctor other than the doctor who has been treating me so far.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to my medical treatment, to safeguard or promote my physical or mental health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below **any procedures which I do not wish to be carried out without further discussion.**

.....

I agree

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form.
- that the examination for the purposes of teaching will not be undertaken without my consent.
- that information and/or surgical images kept in the records may be used anonymously for education, audit and research approved by an ethics commitee, to improve the quality of patient care.

If you object to information and/or surgical images being used in this way, please tick box ☐

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

If you object to this tissue being used in this way, place a mark in the box ☐

Signature: X Lisa Hughes Date dd 29 mm 05 yy 09

Name *(PRINT)*: LISA HUGHES

Address: .....

EXAMINATION FOR THE PURPOSES OF TEACHING

(Please tick) **I agree** ☐ **I do not agree** ☐ to examination by a student during the procedure named on this form under the supervision of the senior doctor undertaking the procedure.

Signature: ..... Date dd mm yy

Name *(PRINT)*: .....

STATEMENT OF INTERPRETER *(where appropriate)*

I have interpreted the information above to the patient/responsible adult to the best of my ability and in a way in which I believe he/she can understand.

Signature: ..... Date dd mm yy

Name *(PRINT)*: .....

CONFIRMATION OF CONSENT

(to be completed by the patient when admitted for the procedure, if the form has been signed in advance)

I confirm that I have no further questions and wish the procedure to go ahead.

Signature: X Lisa Hughes Date dd 08 mm 05 yy 09

Name *(PRINT)*: .....

Address: .....

NHS SCOTLAND

Scottish Otorhinolaryngology, Head and Neck Surgery (ENT) Consent Form 1

Patient Agreement to Investigation or Treatment

PATIENT DETAIL (OR PRE-PRINTED LABEL)

NHS Organisation: .....

Patient's surname/family name: .....

Patient's first name(s): .....

Date of birth (dd mm yyyy) ☐☐ ☐☐ ☐☐☐☐

SG00953485
LISA HUGHES
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NHS number (or other identifier): ..... Male ☐ Female ☒

Special requirements (*e.g. other language/other communication method*): .....

Responsible medical practitioner: CJ Clark

Job title: CON

STATEMENT FOR MEDICAL PRACTITIONER

(to be filled by medical practitioner with appropriate knowledge of proposed procedure. See Notes for Guidance to Medical Practitioner overleaf)

Describe proposed operation, investigation or treatment. Where appropriate specify the site or side:

TOTAL THYROIDECTOMY + FROZEN SECTION.
RISKS OF SCAR, BLEEDING, HOARSENESS,
TRACHEOSTOMY, LOW CALCIUM + TABLETS.

I have explained the procedure named on this form to the patient in terms which, in my judgment, are suited to their understanding. In particular I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure e.g. blood transfusion.

[If you have provided any information leaflet/tape, please tick ☐ and specify title and version]

Signature of medical practitioner: .....

Name *(PRINT)*: CJ Clark Job title: CON

South Glasgow Hospitals

ANAESTHETIC RECORD

NHS Greater Glasgow and Clyde

Date: 8/6/19

Pre-op instructions:

Fast for: AM Lunchtime PM List

Patient

Name:

Unit Nº: SG00953485

Address: LISA HUGHES
5 MOSSVIEW QUADRANT
FLAT 2/2
GLASGOW
G52 2TU

17/01/1980
CHI 1701806541

DOB

Proposed operation: Thyroidectomy

Assessor: VINJIRAYER

Ward: 62

Pre-op assessment

Previous G.A.'s: Epidural – child birth

CVS: HR BP 126/85

Resp: Fit + well.

Other (specify):

Fasted:

Reflux: Ø

Drugs: Ø

N.S.A.I.D's OK

Allergies: Ø

BMI:	Airway:	Dentition:
Weight (kg):		

Investigations

Na+: 140	Hb: 125	Others (specify):	
K+: 4.4	WCC: 7.8		
Cl-: 111	Plts: 336		
HCO3-: 19	ECG:		
Urea: 3.4	CXR:		
Creat: 72.	Glucose		

Urgency		A.S.A.
Elective	☐	1
Scheduled	☐	2
Urgent	☐	3
Emergency	☐	4
		5

Comments / Warnings

Material risks explained ☐

Anaesthesia

Date: 8/6/19

Machine check: ☐ Circuit check ☐

Cannula: 18 G, L/R Hand Arm Foot

Cannula: G, L/R Hand Arm Foot

Arterial site: | CVP site:

Patient position: Supine 10° head up

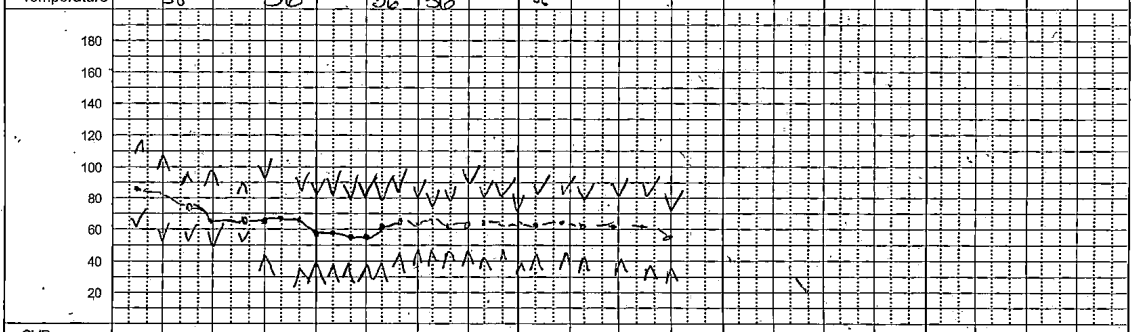
ECG ☐	NIBP ☐	S_pO_2 ☐
E_TCO_2 ☐	FiO_2 ☐	E_tAA ☐
ALL ABOVE ☑		
TOF ☐	CVP ☐	IABP ☐
Blood warmer ☑	Patient warmer ☑	
Anti DVT ☐	U/O ☐	Temp ☐

Fluids

Pre O_2	ETT size: 8.0	LMA size:	Ventilation - Spontaneous / Controlled	Circle / Air / N_2O
Cricoid ☐	Oral / Nasal	Type:		Bain / SEVO/AIR/O2
Airway - Oral / Nasal	Cuffed / Uncuffed	Pack: In / Out		T-piece / ISO
				ADE / DES

Laryngoscopy Grade: 1 2 3 4

Time		14:30		15:00				16:00		17:00	
Propofol	200mg										
Rocuronium	30mg										
Remifentanil	6.1	→ 0.2						→ 0.6			
Ketamine	50mg/kg/hr										
Ephedrine								4mg	5mg		
Phenylephrine											
SpO_2		99	100	100	100	100	98	99	99	99	98	100
FiO_2			81	56	.56	.55	.56	.56	.60	.56	.56	.55
$ETCO_2$			4.2	4.1	4.3	4.3	4.3	4.5	4.7	4.7	4.8	4.2
E_tAA			1.4	2.1	2.0	1.95	1.95	1.95	1.9	1.95	1.7	1.2
Fluids		2L Hartmans			400							
Temperature			35.8		36°		36.0°	36.1°		36.3		



CVP

Blood loss

Urine output

Regional Anaesthesia / Other Procedures / Comments

Operation Details **Theatre:** 1&2

Operation as proposed on page 1 ☑ Reversal given: Yes ☐ No ☑

Anaesthetist(s): Gee Gee : Dr. Vaughan	Surgeon(s): Miss Clarke
Named Consultant:	Discussed with Consultant: Yes ☑ No ☐

Post Operative Care

A. **Oxygen** 4 **L/min** ~~OR % for~~ tdd **hours** ~~OR~~ **SpO_2** 94 **% on air.**

B. **Routine observations / postoperative care as per local protocol.**

C. **Appropriate DVT prophylaxis precribed: Yes ☐ N/A ☐**

D. **Anti-emetic given: Yes ☑ No ☐ Drug given:** Dex 4mg

E. **Analgesia:**

I.V. Morphine as per Recovery Algorithm - Sign		
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:

OR

I.V. Fentanyl as per Recovery Algorithm - Sign		
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:

F. **Post Operative fluids**

Fluid (additive)	Volume	Rate	Sign	Start	Lot No.	Initials
R. Lactate	500 ml	4hr	G Gee			

Post operative notes / Comments

Morphine 5mg IV ± RR @ 1705 G Gee

Post Operative Care

Time	1700	1705	1710	1715	1725	1735	1745	1755	1805	1824
SpO_2	100	100	100	100	100	100	100	99	99	99%
O_2 L/min	5	5	5	5	5	5	AIR	AIR	AIR	AIR
Resp Rate	20	18	12	11	16	22	16	19	20	16
Airway	Own	Own	Own	Own	OW	OW	OW	OW	OW	OW
BP					121	109	122	124	121	
Pulse					82	54	72	69	71	
Temperature	36.3									
CVP										
Wound site										
Affected limb Pulse: +ve/-ve										
Circulation Satisfactory:S Poor: P	S	S	S	S	S	S	S	S	S	
Sensation +ve/-ve										
Movement +ve/-ve										
Sedation/Pain score	2/1	2/1	1/1	1/1	1/2	1/2	1/2	V/2	V	
Nausea score	0	0	0	0	0	0	0	0	0	
	TM	TM	TM	TM	29	29	29	29		

Time	Fluid in	Urine	Drain 1	Drain 2

Blood results / Drug given

Additional nursing comments

Morphine 5mg IV @ 1705PM, @ 1735PM still in pain
Co-Codamol 2tabs (30/500) Given @ 1745 - in water
Still drinking @ 1805

Waterlow Score ☐ **Intervention required:**

Discharge criteria met:	Discharged to:	Recovery Nurse name:	Ward Nurse name:
Yes ☑ NO ☐	Ward: 62	[signature]	.....
Comments:	HDU ☐ ITU ☐	Signature: [signature]	Signature: .....

VIC 638 Cat. No. 0163149 VI MEDICAL ILLUSTRATION • ANAES • 1985/6.05

THEATRE CARE PLAN
NEUROSURGERY

Southern General Hospital

PATIENT'S NAME Lisa Hughes		DATE 8-6-09 WARD 62	WATERLOW
ADDRESS			
D.O.B. 17-1-80	UNIT No. 00953485		
CONSULTANT			
Hb.	Blood available:		
		WEIGHT	

PRE-OPERATIVE CHECK LIST		WARD YES	WARD N/A	THEATRE YES	THEATRE N/A
1. Identification bracelet		✓		✓	
2. Consent form signed		✓		✓	
3. Theatre gown/modesty pants		✓		✓	
4. T.E.D. Stockings on		✓		✓	
5. Pre-Medication given at: Hrs. And other medication: Hrs.			✓		✓
6. Fasted from: 0130 ~~2400~~		✓		✓	
7. Allergies			✓	Nil known	
8. Artificial prosthesis removed			✓		✓
9. Dentures/capped/crowned/loose teeth			✓		✓
10. Nail polish/make-up/jewellery removed – nail polish on toes			✓		✓
11. Wedding ring taped			✓		✓
12. I.V. in situ			✓		✓
13. Urinary catheter in situ			✓		✓
14. To accompany patient:	Case Notes	✓		✓	
	Drug Kardex	✓		✓	
(Where appropriate)	Hearing Aid		✓		✓
	Glasses		✓		✓
	Other (Specify)		✓		✓
15. Patient positioned correctly on trolley		✓			
on undersheet – Head at down – tilt end					
16. Method of transfer: Pat Slide	Straight Lift	Other (Specify)	walk		

WARD NURSE SIGN	SCH
THEATRE/RECOVERY NURSE SIGN	
NAMED ANAESTHETIC NURSE	Ann McKay
NAMED THEATRE NURSE	

SGH 205 (0205205)

ANAESTHETIC ROOM CARE:

DATE: 08-6-9 BP: 127/76 P: 94 SaO_2: 99

ANAESTHETIST/S Dr Gordon	ANAESTHETIC NURSE ODP Muller
TYPE OF ANAESTHETIC: INTUBATED ☑	VENOUS ACCESS (LEFT) RIGHT
GA.WITH E.T.T. Standard 7-5 ☑	18G
L.M.A. ☐	
SEDATION/LA ☐	ARTERIAL MONITORING:
THROAT PACK ☐ REMOVED ☐	
EYE GEL/VASELINE GAUZE ☐	C.V.P. MONITORING
EYES TAPED WITH MICROPORE ☑	
NASOGASTRIC TUBE ☐	SPINAL DRAIN: PRE-OP ☐ POST-OP ☐
CATHETER	
ANAESTHETIC NURSE SIGNATURE: T. Muller	

INTRA-OPERATIVE CARE: METHOD OF TRANSFER:		PATIENT POSITION:	
	ROLL PATIENT ☐	SUPINE	☑
	PAT SLIDE ☑	PRONE	☐
	STRAIGHT LIFT ☐	SITTING	☐
	OTHER (SPECIFY) ☐	SEMI-SITTING	☐
		LEFT/RIGHT LATERAL	☐
		3-PIN HEADREST	☐
		SKULL TRACTION	☐
		OTHER (SPECIFY)	☐

PREVENTION OF INJURY	
PILLOW UNDER KNEES ☑	
HEELS ELEVATED ☑	DIATHERMY SITE LEFT (RIGHT)
LEFT ARM SECURED WITH J BOARD ☑	(THIGH)
ACROSS ☐	BUTTOCK
AT SIDE ☑	OTHER (SPECIFY)
HT ARM SECURED WITH J BOARD ☑	
ACROSS ☐	
AT SIDE ☑	
LATERAL SUPPORTS ☐	TOURNIQUET TIME ON TIME OFF
PADDING OF BONY PROMINENCES ☑	LEFT ARM/LEG
SEQUENTIAL STOCKINGS ☑	RIGHT ARM/LEG
WARMING BLANKET ☑	
GEL PADS ☑	

	PRE-OPERATIVE			POST-OPERATIVE		
EVALUATION	YES	NO	N/A	YES	NO	N/A
PRESSURE AREA CHECK	✓					
DIATHERMY SITE CHECK	✓					
TOURNIQUET SITE CHECK			✓			

PERI-OPERATIVE CARE:

SURGEON: Ms. clark	**SCRUB:** Sn Bailey ODP stu. Ingram
ASSISTANT: Ms McAllister	**CIRCULATING NURSE:** An Daly An Jordan.

OPERATION PROCEDURE: Thyroidectomy

SKIN CLOSURE Monocryl and Steristrips

DRESSING

DRAINS x2 15fr blakes secured a silk.

OTHER (E.G. PACKS)

10nts chirocaine (surgical)

SPECIMENS TAKEN:

PATHOLOGY: x2 Rozen Section x2 Path

BACTERIOLOGY:

OTHER (SPECIFY):

SWAB/NEEDLE/INSTRUMENT COUNT	SCRUB NURSE SIGN	CIRCULATING NURSE SIGN
CORRECT	A Daly	A Jordan.
INCORRECT		
APPROPRIATE ACTION TAKEN		

IMPLANTS

POST OPERATIVE / RECOVERY CARE

NAMED NURSE: ODP Grose / Millar

TIME IN RECOVERY 1700	**TIME OUT OF RECOVERY**
CONSULTANT/ANAESTHETIST Gordon	
PROCEDURE Total Thyroidectomy	

ANGIOGRAPHY	**IMAGING**
PUNCTURE SITE	**CT**
PEDAL PULSE	**MRI**
SHEATH SET	
AIRWAY REMOVED AT IN Theatre	**ICP MONITORING**
OXYGEN 5 **LITRES**	**VENTRIC DRAINS** – **HEIGHT**
HUDSON MASK ✓	– **DRAINAGE**
NASAL CANNULA	
SaO_2 100%	

I.V.ACCESS	**L** ☒	**R** ☐	**ARTERIAL LINE**	**C.V.P. LINE**
INFUSION RUNNING	☒	☐	**COMMENCED** ☐	**COMMENCED** ☐
CAPPED CANNULA/E			**IN SITU** ☐	**IN SITU** ☐
DISCONTINUED			**REMOVED** ☐	

PAIN CONTROL		**PAIN RELIEF**		**WOUND**	**DRAINS**	
PAIN FREE	☐	**IN SITU**	☐	**DRY** ☒	**PATENT**	☒
MILD	☐	**COMMENCED**	☐	**STAINING – SLIGHT** ☐	**BLOCKED**	☐
ANALGESIA As per Kardex				**– HEAVY** ☐	**DRAINAGE (MLS)**	☐

PRESSURE AREAS: **POTENTIAL PROBLEM** ☐ **NO PROBLEMS** ☐

~~NEURO OBS~~: ENT Obs – As per anaesthetic record

COMMENTS: IV Morphine given: 5mg @ 1705
1735 Still in pain

RECOVERY NURSE SIGNATURE: ODP Grose

South Glasgow University Hospitals
Southern General Hospital

NHS Greater Glasgow

Local Guidelines ENT/MAXFACS Surgery
Prophylaxis of Venous Thromboembolism

SG00953485
LISA HUGHES
5 MOSSVIEW QUADRANT
FLAT 2/2
GLASGOW 17/01/1980
G52 2TU CHI 1701806541

RISK FACTORS *Tick as appropriate.*

Please check all pertinent factors. NOTE: Each Risk Factor has a value of 1 unless otherwise indicated.

Patient Factors

- Age 41-60 ☐
- Age over 60 (2 Factors) ☐
- Obesity (> 20% of ideal body weight) ☐
- Severe acute medical illness ☐
- Current malignancy ☐
- Oestrogen/HRT (2 Factors) ☐
- Previous DVT / PE (6 Factors) ☐
- Hypercoaguable states (6 Factors) ☐

Operative Factors

Operation > 30 minutes (2 Factors) ☐
Operation > 4 hours (4 Factors) ☐
Free flap (4 Factors) ☐
Anticipated bed-rest > 24 hours (3 Factors) ☐

LOW RISK	MEDIUM RISK	HIGH RISK	VERY HIGH RISK
Tick as appropriate ☐ (0-1 Factor)	*Tick as appropriate* ☐ (2-3 Factors)	*Tick as appropriate* ☐ (4 - 5 Factors)	*Tick as appropriate* ☐ (> 5 Factors)
Early ambulation and hydration.	Graduated Compression Stockings (T.E.D.S.).	As for Medium Risk PLUS Kendall Sequel Compression Device (S.C.D) in theatre.	As for High Risk PLUS low molecular weight heparin. (T.E.D.S. + S.C.D. + L.M.W.H)

CONTRAINDICATIONS to T.E.D.S.

- Severe leg ischaemia / absent peripheral pulses.
- Pulmonary oedema or massive leg oedema.
- Local condition in which T.E.D.S. would interfere e.g. dermatitis.
- Thigh circumference > than listed in the fitting instructions.
- Extreme deformity of leg.

CONTRAINDICATIONS to S.C.D.

- Suspected existing D.V.T.
- As for T.E.D.S.

CONTRAINDICATIONS to L.M.W.H.

- Admitted with post-op haemorrhage.
- Uncorrected bleeding disorders, e.g.
  - Haemophilia.
  - Oral anticoagulants.
  - Platelet count $<70x10_9$ /L.
- Bleeding or potentially bleeding lesions:
  - Oesophageal varices.
  - Active peptic ulcer.
  - Recent (3 months) GI or intracranial bleed.
  - Intracranial aneurysm or angioma.
- Allergy.
- Heparin associated thrombocytopenia.

EXCLUSIONS

- Terminal palliation.
- Surgery under local anaesthetic unless identified as high risk (use T.E.D.S.).

PROPHYLAXIS

	Prescribed	Applied
Graduated Compression Stockings (T.E.D.S.)	☐	☐
Sequential Compression Device	☑	☐
Low Molecular Weight Heparin	☐	☐

Date: 29/5/14
Assessed by: [signature]
Signature: .....

IMcC/61013

Lead Clinicians Mr J. Crowther, Consultant Otolaryngologist, Mr J. Devine, Oral and Maxillofacial Consultant. Date approved January 2006. Review date January 2008.

VI MEDICAL ILLUSTRATION • CLIN EFFECT/ENT • 8088

Acute Services Division
Southern General Hospital and Victoria Infirmary
Directorate of Otolaryngology Head and Neck Surgery

NHS Greater Glasgow and Clyde

ENT Department

ADMIS

Unit Num SG00953485
Name: LISA HUGHES
Address: 5 MOSSVIEW QUADRANT
FLAT 2/2
GLASGOW
Date of b 17/01/1980 G52 2TU · CHI 1701806541

Use address label if available.

Date: 29/5/19
Arranged admission:
Emergency admission: → 8/6/19
Main complaint:

HPC: -Normally ; nurse - TVP 3
FNA
→ Total thyroidectomy + free graft

PMH - epidural ~ 2008 no DVT's, no PE's,
Ops/previous GAs: -

DM ☒ Epilepsy ☒ Jaundice ☒ Rh fever ☐ TB ☒

Bleeding tendency: ☒
Other:

Chest disease: Asthma ☒ COAD ☒

Heart disease: Angina ☒ MI ☒ MBP ☐

Allergies: NKDA

Drugs
Contraceptive pill: ☒ - Depoprovera contraceptive injection

Systems
General Health: no recent D+V no travel abroad no vags/colds no UTI's
Weight loss:

CVS
Chest pain ☒
Palpitations ☒
Ankle swelling ☒
Other (if relevant) ☐

RS
Cough ☒
SOB ☒
Sputum ☒

GI
Heart burn ☒
Abdo pain ☒

SH
Married Single (Esteticien) Widowed Divorced (circle as appropriate)
FULL TIME WORK

Tobacco: 20cpd for few years Alcohol: - Occupation:

General

Pyrexia ☐ Anaemia ☐ Jaundice ☐

ENT

Voice testing: _____

Weber: _____

Rinne Rt: _____

Lt: _____

Nose: _____

Oropharynx: _____

Indirect Laryngoscopy: _____

TMs Rt: _____ Lt: _____

EAM/Pinnae Rt: _____

Lt: _____

Mouth/dentition: ~~oun~~ ✗ | veneer

PNS: _____

Neck: _____

CVS

Pulse: min _____ reg/irreg _____ bp: _____

HS I ☐ II ☐ Added sounds ☐ Murmurs ☐ Peripheral oedema ☐

RS

Cyanosis ☐ Chest:

Abdo: - not examined

Neuro: - grossly intact
- not formally examined

Investigations

FBC _____ ☐

ESR _____ ☐

U&E _____ ☐

Bl.gluc _____ ☐

LFT _____ ☐

Photo _____ ☐

Monospot _____ ☐

Clotting _____ ☐

CXR _____ ☐

ECG _____ ☐

Audio _____ ☐

Tymp. _____ ☐

CT _____ ☐

Others: _____

Consent for:

- tonsillectomy
- Bloods
- Urine
- OPT Xrd

Signed: _____

7D

SOUTHERN GENERAL HOSPITAL
PATIENTS PROFILE

WARD / DEPT:	WGH ENT	NAMED NURSE:	
CONSULTANT:	Miss Clark	REFERRAL:	
DATE:	24/5/09		
PATIENTS NAME:	SG00953485 LISA HUGHES 5 MOSSVIEW QUADRANT 2493 FLAT 2/2 GLASGOW G52 2TU 17/01/1980 CHI 1701806541		
UNIT NUMBER:			
PREFERS TO BE CALLED:			
ADDRESS:			
TELEPHONE NUMBER:			
AGE: 29yrs	D.O.B.: 17-01-80	SEX: F	MARITAL STATUS: Single
OCCUPATION: housewife			
RELIGION: Prot	CLERGY / OTHER:	CONTACT REQUIRED:	CONTACTED:

REASON FOR ADMISSION:

For total thyroidectomy ? level VI neck dissection

For OP on 8/6/09 TCI mon 8/6 at 1030hrs

C&G 6/9 Total Thyroidectomy

PREVIOUS HEALTH HISTORY:

Childbirth Jan 2009

Feb ~~Jan~~ 2005 childbirth epidural twins

No previous GA's

KNOWN ALLERGIES: Nil known

SGH 308

PATIENTS PROFILE (cont'd)

MEDICATION ON ADMISSION:

Nil known

PATIENTS PRECEPTION OF CURRENT HEALTH STATUS:

Pt knows reason for admission

RELATIVES PRECEPTIONS OF PATIENTS HEALTH STATUS:

EMERGENCY CONTACT NAME:

NEXT OF KIN: Neil Irvine

RELATIONSHIP: partner

ADDRESS: SIA

PHONE NUMBER (DAY): | TELEPHONE NUMBER (NIGHT):

OTHER RELEVANT CONTACT: 078 33 99 0700

G.P.'s NAME: Dr Semple | Irvine

G.P.'s ADDRESS: Paisley rd west. Cardonald

G.P.'s TELEPHONE NUMBER:

Patient / Relative spoken to by	DATE	TIME	DOCTOR	NURSE

VALUABLES:	DISPOSAL	HOME	WARD	CASHIER'S OFFICE
CLOTHING:	DISPOSAL	HOME	WARD	CASHIER'S OFFICE

NURSES SIGNATURE: C. R. Beattie

SOUTHERN GENERAL HOSPITAL
NURSING ASSESSMENT

SG00953485
LISA HUGHES
5 MOSSVIEW QUADRANT
FLAT 2/2
GLASGOW
G52 2TU
17/01/1980
CHI 1701806541

PATIENTS NAME: | UNIT N

GENERAL ASSESSMENT ON ADMISSION:

well kempt
independent

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

lives at home with partner 2 children 8 x children

smokes 20 cigs daily
alcohol none

BMI = 22

BLOOD PRESSURE:	109/70	WEIGHT:	9'12 stones
PULSE:	94 bpm	HEIGHT:	5ft 5ins
RESPIRATIONS:	100% on AIR	URINALYSIS:	
TEMPERATURE:	36.6°C	WATERLOW SCORE:	

GH 310

NURSING ASSESSMENT (ASSESSMENT OF ACTIVITIES OF DAILY LIVING)

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

Independent with ADL's

NURSES SIGNATURE: C Beattie

Ward 62

SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: UNIT NO.

SG00953485
LISA HUGHES
5 MOSSVIEW QUADRANT
FLAT 2/2
GLASGOW
G52 2TU CHI 1701806541
17/01/1980

DATE	PROB. NO.	NURSING NOTES/EVALUATION	
29/5/09	1230	Seen at pre ass clinic	
		TCI on 8/6/09 time to be	
		confirmed.	
		For thyroidectomy on 8/6/09	
		Bloods done FBC U+E's LFT's	
		glucose cholesterol TFTs coag	
		& T+ mark done. Vital signs done	
		To see miss clark SNO x	
		Dr Gordon. Miss clark to confirm	
		date of op & time of admission	
		and FASTING instructions	
		Given directions to ward 62. &	
		contact nos ward 62	Clarke
8/6/09	DOS	Admitted to ward 62. For theatre	
		today. Vital signs stable on	
		admission. Fasting on arrival.	
		Prepared and checklisted.	
		Transfered to theatre.	Blanche
	19[00]	Returned to ward from theatre.	
		Alert + orientated on return.	
		IV fluids in progress. (L) + (R) size	
		15 drains insitu. For calcium level	
		check at 2100. Drain removal when	
		< 30ml over 24 hours. Follow-up 2/52.	
		Observations stable as charted.	
		Family present on return to ward.	S Algeo
9/6/09	ND	Calcium check carried out at 9pm.	
		IV fluids continue through night	
		Pt very tearful as cannula had to	
		be restited.	
		Drains remain insitu measured at	
		7am (L) 2mls (R) 6mls	
		Analgesia given prior to setting	
		Vital signs stable	Campbell
	WR.	For home this evening - Drain to be	
		removed - Same done covered with	
		steristrips + mepore.	
		Calcium levels stable.	
		Follow up to be arranged for 2/52.	
		Unable to get appointment at SGH	
		or VicInf. Please review in morning	
		with Miss Clark.	

0369438-SGH 306A

SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: UNIT NO. WARD:

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
		Feeling dizzy this afternoon- discontinued	
		CoCodamol 30/500 as ? codeine the	
		cause. Commenced on regular	
		paracetamol. Keep in overnight	
		and review in morning.	
	-	Taking diet + fluids.	
	-	Independant with ADLs.	
	-	Meds as per Kardex.	
	-	No other complaints offered.	
10/6/09	NO	Settled evening. observations	
		Satisfactory. Wound site	
		Satisfactory. Medications taken	
		Pod to settling. NO complaints	
		of nausea or dizziness. Slept well	
10/6/09	DS	settled morning.	
		independent with personal hygiene.	
		Medications given as per Kardex.	
		Diet and fluids taken well.	
		Reviewed by ENT team - for home	
		today. Discharge medications given	
		as per discharge prescription.	
		Appointment made for Southern	
		General Hospital @ MS Clark Clinic	
		on 9/52. Mother picked up patient	
		from the ward.	

Patient's name Lisa Hughes

Unit number SG0095348S

Ward 62.

Use addressograph label.

South Glasgow Hospitals

Pressure Ulcer Risk Assessment Record

NHS Greater Glasgow and Clyde

Modified Waterlow Risk Assessment

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

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

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

Action Plan

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

Further action

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

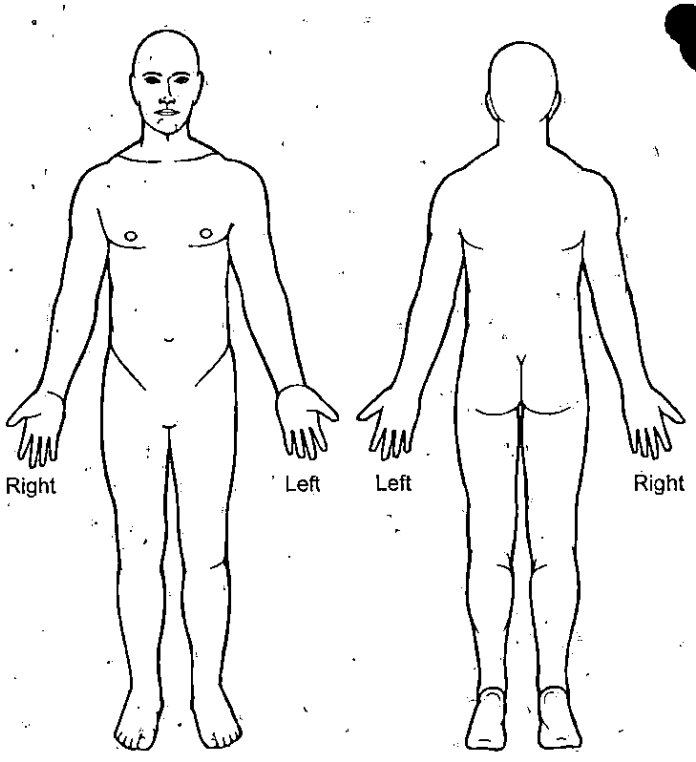
GRADE OF ULCER (Torrance)

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

RECORDING THE GRADE OF ULCER

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

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



SOUTH GLASGOW HOSPITALS
PATIENT MOVING AND HANDLING RISK ASSESSMENT

NHS Greater Glasgow and Clyde

S4 0095348 5

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

BODY BUILD

Obese		Tall		Problems with comprehension, behaviour, co-operation (specify)
Above average		Medium	✓	
Average	✓	Short		Handling constraints,e.g. disability, weakness, pain, skin lesions infusions (specify)
Below Average		Weight:		

RISK OF FALLS — High | | Low | |

INTO BATH OR SHOWER

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

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

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

TOILETING

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

WALKING

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

MOVE UP/DOWN BED

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

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges		Monkey pole		Not used	

TRANSFER TO/FROM TROLLEY (or bed etc)

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

Date assessed: 29/5/09	Assessors signature:

Date reviewed	8/06/09								
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

INTO BATH OR SHOWER

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

ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:					

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

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

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information					

TOILETING

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

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information					

WALKING

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

MOVE UP/DOWN BED

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

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

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges		Monkey pole		Not used	

TRANSFER TO/FROM TROLLEY (or bed etc)

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

Date assessed:	Assessors signature:

reviewed									
ssors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

Patient Agreement to Investigation or Treatment

NHS Greater Glasgow and Clyde

CONSENT FORM

PATIENT DETAILS (OR PRE-PRINTED LABEL)

Hospital/Clinic/GP Practice .....

Patient's surname/family name : .....

Patient's first name(s): .....

Date of Birth___/____/___ ale ☐

NHS/ CHI Number _____

Special requirements (e.g. ot d) .....

SG00953485
LISA ROSEMARY HUGHES
8 CARHAM CRES
GLASGOW 17/01/1980
G52 2HN CHI 1701806541

.....

Responsible practitioner: Dr A Kaur

Job title: .....

STATEMENT FOR PRACTITIONER

(to be filled in by practitioner with appropriate knowledge of proposed procedure- see guidance notes)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side: (WRITTEN IN FULL)

Diagnostic laparoscopy
± sterilisation.

✓ discussed risks ← visceral damage ± laparotomy
← haemorrhage
← infection

I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedures above).

Signature of practitioner: A Kaur

Name/Designation (Print) KAUR

Date 9/5/11

00526

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*

(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

I have been told about additional procedures which may become necessary during treatment. I have listed below **any procedures which I do NOT wish to be carried out without further discussion.**

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- to the emergency administration of blood or blood products

Additionally you have to agree or disagree the following:-	**Agree**	**Disagree**
that information and/or images kept in records may be used anonymously for education, audit, and research with appropriate ethical approval, to improve the quality of patient care.	☑	☐
that surplus tissue or other biological material not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☑	☐

PATIENT REFUSAL FOR BLOOD PRODUCTS

Please sign here if you refuse to consent to the emergency administration of blood or blood products. Even if this results in death.

NA

Signature: ..... Date ...../...../.....

Practitioner Signature: ..... Date ...../...../.....

PATIENT/PARENT* AGREEMENT FOR TREATMENT

Signature: X Lisa Hughes Date 9/3/11

Name (Print): X LISA HUGHES

Acute Services Division

Hospital / Department

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: .....

Ward: .....

CHI number: .....

SG00953485
LISA HUGHES
5 MOSSVIEW QUADRANT
FLAT 2/2
GLASGOW 17/01/1980
G52 2TU CHI 1701806541

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Mobile and 'at risk' patients should have risk assessment and care plan reviewed monthly.

Cannard Falls Risk Assessment

(Must be completed within 24 hours)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						DATE 8/6/09	DATE	DATE	DATE	DATE	DATE	DATE
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				2						
Age	60-70 1	71-80 2	81+ 1			0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		0						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed bound 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		4						
				ACTION(S) TAKEN Enter action code(s)		1						
SCORE 2 - 8 = LOW 9 - 12 = MEDIUM 13+ = HIGH RISK				NURSE SIGNATURE		[signature]						

** If you are in any doubt about whether a person's medicine belongs to one of the types listed ask the person or carer or please phone the number on the medicine container and ask the community or hospital pharmacist.

* Please see back page for clarification

NHS
Greater Glasgow and Clyde

Nutrition Profile

Na Ad SG00953485 LISA HUGHES CHI:1701806541 DoB	Date of admission: 8/06/09 Time: 09 30 HOSPITAL: SGH Ward: 62
CHI number:	
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 1.66 m/ft Actual ☑ Patient/ carer reported ☐ Alternative measurement ☐

Weight: 9½ kg/stones Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☑ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Eating and drinking likes and dislikes (including appetite and/or NBM status):

Good Appetite

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☑

Please state:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental**? Yes ☐ No ☑

Please specify all factors:

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

Please state:

Profile completed by: Name (PRINT): D Gondwe Signature: Dgondwe Date: 8/06/09

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Malnutrition Universal Screening Tool ('MUST')

Date	8/6/09									
Initials	DM									
Height (see page 1) 1.66 Weight	9½st									
Oedema or ascites present Y/N	N									
BMI	22									

'MUST'

Step 1: BMI Score (refer to chart on page 4) >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 <u>and</u> there has been or is likely to be no or virtually no food intake for > 5 days..... Score 2 Not applicable ..... Score 0	0								
Step 4: Overall Risk of Malnutrition Total:	0								

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	**LOW RISK** - *Routine Clinical Care* • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	**MEDIUM RISK** - *Observe* • Document dietary intake for 3 days on a Food Record Chart. • If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks **and** offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK** - *Treat** • Refer to Dietitian **and** document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks **and** offer full cream milk to drink with and between meals. • Monitor **and** review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Complete nursing checklist for swallowing difficulties if appropriate.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).

Referral Services

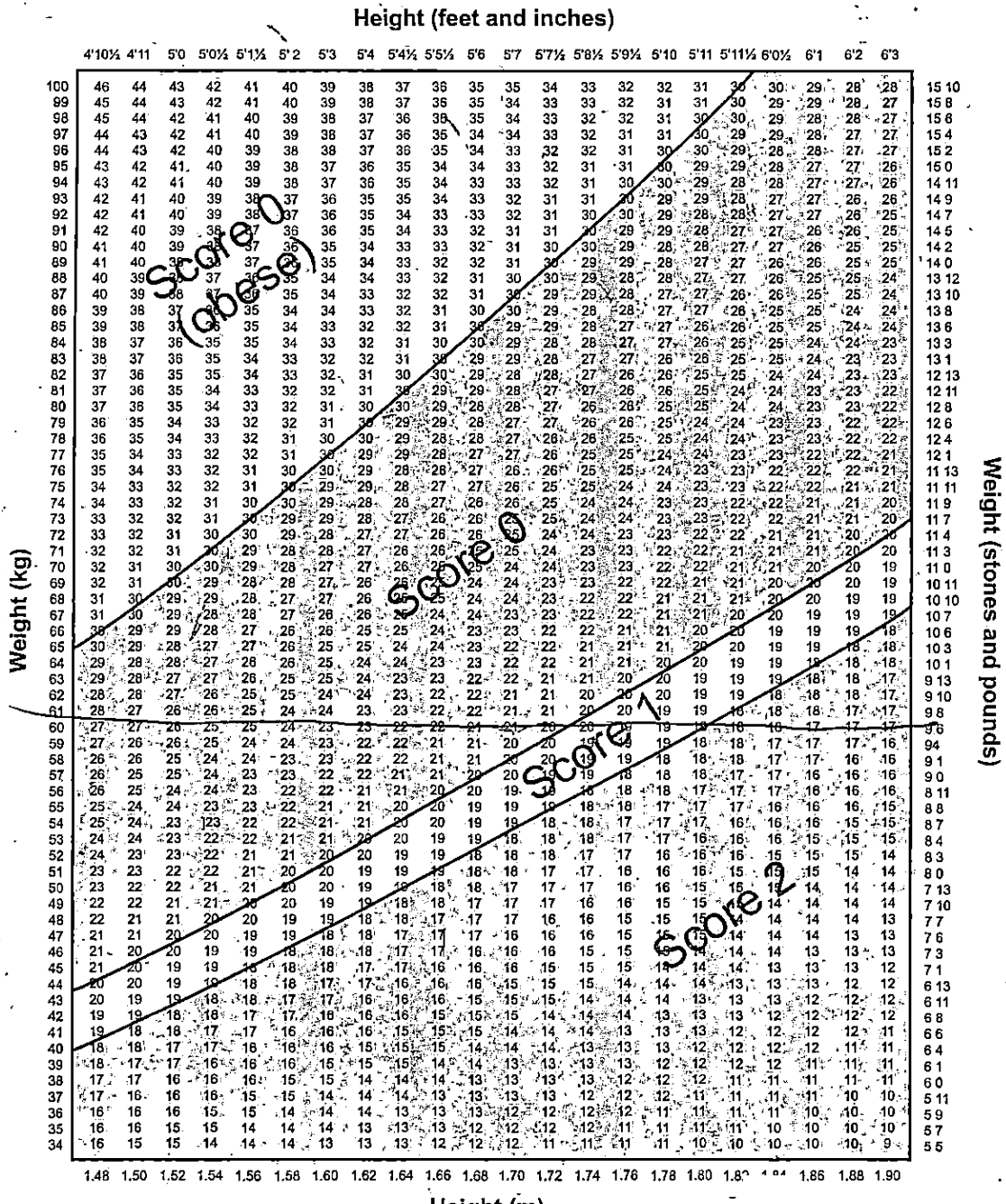
Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Review date	Name (PRINT) Signature/Designation
8/6/09	0	Review 1/52.		

N.B. Ensure discharge plan includes most recent 'MUST' score and any necessary follow-up requirements.

Step 1 - BMI Score



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 W't loss <5%	Score 1 Wt loss 5-10%	Score 2 W't loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-1	>12.4 kg
126 kg	<6.3 kg	6.3-1	>12.6 kg

Weight before weight loss (st/lb)	Score 0 W't loss <5%	Score 1 W't loss 5-10%	Score 2 W't loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

VI MEDICAL ILLUSTRATION • NUTRITION & DIET • 12366/01.09.08

STORES ORDER CODE 41850

SGH215
0006215

INSTITUTE OF NEUROLOGICAL SERVICES
Fluid Prescription Chart

Southern General Hospital

NASO-GASTRO FLUIDS

WATER	MILK	FEED	ADDITIVE	RINSE	TIMIMG	24 HOUR TOTAL

N. SALINE FOR I.V. DRUGS

ALLOW FOR THIS WHEN PRESCRIBING I.V. FLUIDS	VOLUME	HOW OFTEN	24 HOUR TOTAL

INTRAVENOUS FLUID PRESCRIPTION

FLUID & ADDITIVE	VOLUME DOSE	STARTING TIME	RATE DROPS/MIN	SIGNATURE	GIVEN/CAN
N. Saline 0.9%	500mls	2255	60		09805 T5 7 01/12 DH

TOTAL I.V. FLUIDS

TOTAL 24 HOUR FLUIDS

NAME Lisa Hughes

DATE 8/6/09

INSTITUTE OF NEUROLOGICAL SERVICES

Southern General Hospital

Fluid Prescription Chart

NASO-GASTRO FLUIDS

WATER	MILK	FEED	ADDITIVE	RINSE	TIMIMG	24 HOUR TOTAL

N. SALINE FOR I.V. DRUGS

ALLOW FOR THIS WHEN PRESCRIBING I.V. FLUIDS	VOLUME	HOW OFTEN	24 HOUR TOTAL

INTRAVENOUS FLUID PRESCRIPTION

FLUID & ADDITIVE	VOLUME DOSE	STARTING TIME	RATE DROPS/MIN	SIGNATURE	GIVEN/CAN

TOTAL I.V. FLUIDS	TOTAL 24 HOUR FLUIDS
NAME	DATE

South Glasgow Hospitals

NHS Greater Glasgow and Clyde

STANDARDISED EARLY WARNING SCORING SYSTEM (SEWS)

Patient Observation Chart

Na
Ad
SG00953485
LISA HUGHES
5 MOSSVIEW QUADRANT
FLAT 2/2
Ho GLASGOW 17/01/1980
G52 2TU CHI 1701806541
DO

	Date	Ward	Consultant
Admitted			
Transferred			
Transferred			
Transferred			

This is Chart Number_____during this admission

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

How to calculate SEWS Score

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

SEWS KEY

0	1	2	3

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

FURTHER SEWS SCORE SHOULD BE CHECKED

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

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

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

If SEWS continually 0-1 frequency of observations:

Date												
Frequency												

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

SEWS KEY			
0	1	2	3

NAME LISA HUGHES DOB 17/01/80

Date:		8/8	6/9		9/K													
Time:		10.30	18:55	2110														
RESP. RATE	36+																	
	31-35																	
	21-30																	
	9-20	16	16		K													
	≤8																	
SpO2	93+	100	98	96	98	98												
Numerical Value	90-92																	
	85-89																	
	<85																	
Inspired O2%	%	A	air	A	A	A												
TEMP.	39∞																	
	38∞																	
	37∞	36.8	36.2			37.2												
	36∞				36.8													
	35∞																	
	34∞																	
BLOOD PRESSURE	210																	
	200																	
	190																	
	180																	
	170																	
	160																	
	150																	
	140																	
	130	126				118												
	120	↑	111	110	↑	↑	104											
	110	↑	↑	↑	↑	↑	↑											
	100	↑	↑	↑	↑	↑	↑											
	90	↑	↑	↓	↑	↑	↑											
SEWS SCORE uses Systolic BP	80	85	↓	↓	73	↓	80											
	70		↓	↓	↓		↓											
	60		69	66														
	50																	
	40																	
	150																	
HEART RATE	140																	
	130																	
	120																	
	110																	
	100																	
	90	•		82														
	80		79		77.5													
	70																	
	60																	
	50																	
	40																	
	30																	
	20																	
NEURO RESPONSE	Alert	A.	alert	✓	✓	✓												
	Verbal																	
	Pain																	
	Unresponsive																	
URINE OUTPUT	PU/NPU:	PU.	NPU		PU	PU												
	UO<30mls/hr (3 hrs +)																	
SEWS SCORE:	with all observations	0.	0															
PAIN refer to guideline p4	Severe	7-10																
	Moderate	4-6																
	Mild	1-3																
	None	0	0.															
		N/V																

KD

UNIT No. SG0095348S

SEWS KEY			
0	1	2	3

Date:

Time:

36+
31-35
21-30
9-20
≤8

93+
90-92
85-89
<85
%

39∞
38∞
37∞
36∞
35∞
34∞

210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40

150
140
130
120
110
100
90
80
70
60
50
40
30
20

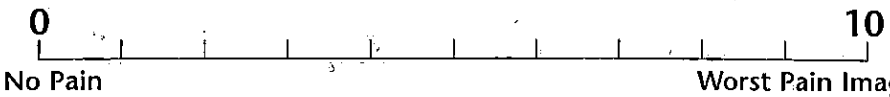
Alert
Verbal
Pain
Unresponsive

PU/NPU:
UO<30mls/hr

7-10
4-6
1-3
0
N/V

Pain Assessment & Management Guidelines

How to score pain:



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

Guidelines

Cancer-related pain:

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

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

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

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

Acute pain:

Score current pain on movement e.g. deep breathing

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

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

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

Measuring Sedation

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

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

Measuring Nausea

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

NB: Review Treatment Plan

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

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

Consider:

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

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

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

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

If responds to pain only or unresponsive
If BM<4
Assess airway, BM GCS, consider neuro obs chart, review patient/kardex.
Check urgent blood glucose/IV dextrose or oral carbohydrate

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's na

Unit numbe

CHI number: 3G00953485
LISA HUGHES
5 MOSSVIEW QUADRANT
FLAT 2/2
GLASGOW 17/01/1980
G52 2TU CHI 1701806541

Ward: 62

Discharge destination: Home

Estimated Discharge Date (1) / /

Estimated Discharge Date (2) / /

Final date of discharge : 10 /06 /09

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		DG	✓
Relative/carer informed		✓		Pt informed Mother mum.
Others informed: Care Home		✓		
Transport arranged				
Own transport (preferred option)	✓		DG	
Ambulance-1 man/ 2 man am/pm		✓		
Other: Flight, Air ambulance etc.		✓		
Discharge medication				
Discharge prescription completed	✓		DG	
Compliance aids e.g. Dossette Box (involve pharmacist)		✓		
Medication received	✓			
Medication explained to patient and/or relative/carer	✓			
Own medication returned to patient		✓		
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓		
Informed of discharge				
Social work/ Other agencies/Home help		✓	DG	
Physiotherapist		✓		
Occupational Therapist		✓		
Dietician		✓		
Speech and Language Therapist		✓		
Clinical Nurse specialist e.g. Care Home Liaison		✓		
Liaison/ District Nurse/Practice Nurse		✓		
Other discharge items				
Access arrangements (e.g. keys, door entry)		✓	DG	
Patients clothing available for day of discharge		✓		
Valuables e.g. cashier		✓		
Intravenous cannula removed	✓			
Equipment ordered (inc. walking aids) in place for discharge		✓		
Part 2 Discharge letter - Required		✓		
- Completed		✓		
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow	✓			
If unknown at time of discharge state reason		—		
Additional information / leaflets / factsheets	✓			

Time of Discharge: 11.30

Nurse's signature: Pauline.

Designation: SN

Date: 10 / 6 /09

South Glasgow Hospitals
Southern General Hospital, Glasgow G51 4TF. Tel. 0141 201 11..

P... Discharge Letter and Medicine Pres...tion Form - Confidential Ref No: 090585

NHS Greater Glasgow and Clyde

VIMI • DISCHARGE• 2725 SGH

Dear Doctor .....
Sur...

4 copies

Pati .....
Add SG00953485
LISA HUGHES
5 MOSSVIEW QUADRANT
FLAT 2/2
GLASGOW
DOE G52 2TU 17/01/1980 CHI 1701806541
Weight ..... CHI no: .....

Ward: 64 Tel: .....
Consultant: ENT
Specialty CLARK
Named Nurse: .....
Admission date: 8/6/9
Mode of admission ELECTIVE
Source of admission .....
Discharge date: 9/6/9

Follow-up arrangements
Clinic appointment made:
Yes ☐ No ☐ To follow ☑
Clinic name ENT
Date ... 2/52
Non-childproof containers required: Yes ☐ No ☐
Medicine compliance aids required: Yes ☐ No ☐
Specify: .....

Reason for admission, treatment, diagnosis, investigations, operations, complications:

Total Thyroidectomy. FU in 2 weeks clark
Miss Hutchison

Other information
Started on thyroxine
*SIN Wady Clark combination
11 H to 6 Dly pr — up to x Daily ...

MEDICINE	Dosage form	Dose	Times for administration: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 8	pm 10	Other times	Recommended duration of treatment after discharge	New Drug	New Dose	Number of days' supply	Dispensing Details (Pharmacy only)
~~LEVOTHYROXINE~~ Change	T																
Regular medications																	
DICLOFENAC	T	50 mg				6	8									7	28 Ap1
LIOTHYRONINE	T	10 micrograms														LONITEM	28 Gor
~~SECOBARBITAL~~	~~T~~	~~32/50~~														~~7~~	~~10 mins~~
PARACETAMOL	T	1g														7 day	
TRAMADOL	T	50/100g				4hly						PRN MAX				7 day	

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

Clinical Pharmacy check:
All known drug sensitivity / adverse reactions:

Dispensed by: ... Date: 9/6/9
Checked by:

WARD USE ONLY
Med. rec. on ward by: .....
Issued by: ..... Date: ... / ... / ...
Signature of recipient:

Doctor's name: P. ASHWORTH Signature: ..... Date 9/6/9
Doctor's grade: FY2 Pager number: 7012

Number of prescription sheets at discharge:

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

PRESCRIPTION FORM

Hospital Name: .....

SG00953485
LISA HUGHES
5 MOSSVIEW QUADRANT
FLAT 2/2
GLASGOW
G52 2TU
17/01/1980
CHI 1701806541

LS

Height:

Weight:

Surface area:

Date of writing discharge prescription: __/__/__

Ward: 62

Date of Admission: __/__/__

Consultant Name: CCARLY

Date and time this form prepared: __/__/__ Time:_____

Sheet No .....

2nd Prescription in use Yes or NO

DRUG SENSITIVITIES

NKDA

DVT Risk on Admission (SIGN Guideline)

High ☐ Moderate ☐ Low ☐

Assessed by: Date: __/__/__

OTHER CHARTS IN USE

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

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF PRESCRIBER	GIVEN BY	TIME GIVEN
8/4	Cozaar (50mg Alternative)	2 tabs	oral	1750	G. Gork	TYLER	1745

PATIENT'S NAME:

Parenteral Drugs: Regular Prescription

ADMINISTRATION

DATE

MONTH

A

DRUG Ted

DOSE 5 | ROUTE IV | DATE 29/5/25 | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

B

DRUG S-C-D

DOSE 7 | ROUTE SC | DATE 29/5/25 | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

C

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

D

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

Parenteral Drugs: Regular Prescription

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

DATE →
MONTH →

E

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

F

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

G

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

H

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE → 8 9 10

MONTH → 6 6 6

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

J DRUG: Paracetamol

DOSE: 1g | ROUTE: PO | DATE: 8/6/19 | STOPPED DATE: 8/6/19

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

K DRUG: Diclofenac.

DOSE: 50 | ROUTE: PO | DATE: 8/6/19 | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

L DRUG: LIOTHYRONINE

DOSE: 10 micrograms | ROUTE: PO | DATE: 8/6/19 | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: L-TRI-IODOTHYRONINE SODIUM

FOR PRESCRIBERS USE ONLY

M DRUG: Ceredzac 30/50

DOSE: 2 tabs | ROUTE: OD | DATE: 8/6/19 | STOPPED DATE: 9/6/19

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

Oral and Other Drugs: Regular Prescriptions

DATE → 9 10
MONTH → 6 6

N

DRUG: PARACETAMOL

DOSE	ROUTE	DATE	STOPPED
1g	PO	9/6/19	DATE:
			INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

P

DRUG

DOSE	ROUTE	DATE	STOPPED
			DATE:
			INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

R

DRUG

DOSE	ROUTE	DATE	STOPPED
			DATE:
			INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

S

DRUG

DOSE	ROUTE	DATE	STOPPED
			DATE:
			INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE →

MONTH →

T DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF PRESCRIBER

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

V DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF PRESCRIBER

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

W DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF PRESCRIBER

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

X DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF PRESCRIBER

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

Oral and Other Drugs: Regular Prescriptions

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

DATE
MONTH

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

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

PATIENT'S NAME:

Oral and Other Drugs: Regular Prescriptions

ADMINISTRATION

DATE

MONTH

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

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

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

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

LL DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

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

PATIENT'S NAME:

All Routes: As Required Prescriptions

ADMINISTRATION

MM DRUG: MORPHINE

DOSE: 10 mg | ROUTE: IM/SC | INDICATION: Pain

SIGNATURE OF PRESCRIBER | MAX.FREQUENCY: 1° | DATE: 8/6

STOPPED DATE: | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

DATE																										
TIME																										
DOSE																										
GIVEN BY																										

NN DRUG: CYCLIZINE

DOSE: 50 mg | ROUTE: ~~IM~~ ~~IV~~ | INDICATION: N/V

SIGNATURE OF PRESCRIBER | MAX.FREQUENCY: 8° | DATE: 8/6

STOPPED DATE: | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

DATE																										
TIME																										
DOSE																										
GIVEN BY																										

PP DRUG: ONDANSETRON

DOSE: 4 mg | ROUTE: ~~SC~~ IV | INDICATION: N/V.

SIGNATURE OF PRESCRIBER | MAX.FREQUENCY: 8° | DATE: 8/6

STOPPED DATE: | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

DATE																										
TIME																										
DOSE																										
GIVEN BY																										

RR DRUG: ~~Codeine phosphate~~

DOSE: 60 mg | ROUTE: | INDICATION: Pain when morphine off

SIGNATURE OF PRESCRIBER | MAX.FREQUENCY: 6° | DATE: 8/6

STOPPED DATE: ~~8/6~~ | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

DATE																										
TIME																										
DOSE																										
GIVEN BY																										

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

SS	DRUG: TRAMADOL			STOPPED DATE:	INITIALS:
DOSE: 50-100mg	ROUTE: PO	INDICATION: PAIN			
SIGNATURE OF PRESCRIBER:	MAX.FREQUENCY: 400mg/day			DATE: 9/6/19	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:					

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

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

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

DATE	
TIME	
DOSE	
GIVEN BY	

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

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

(Maximum number doses as per protocol)

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

Signature: _____ Date: _____

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

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Sign your full name clearly against each prescription entry.

4. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes.

5. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

6. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

7. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

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

Cat. No. 1538 Ver. 01/2009

953485 IN/MA/SR

(L) XL

Hospital use only	Clinic	Day / Date	Time	Hospital No.
	CLARK	THUR 31/7/08	9.15	

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

LOUISE CLARK (Consultant)
Ear, Nose & Throat (ENT) C5
G General Referral

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

Southern General Hospital

— **Hospital and hospital address**

Hospital location code.
G405H

Email address

Urgency of referral Routine
Date of referral 30-May-2008 **Date sent** 30-May-2008

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa Rosemary
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541

Patient's address

fl 2-2 5 Mossview Quad
Cardonald
GLASGOW
G52 2TU

Contact number(s)

Voice: 07833990700

SEEN BY GP DETAILS

Name	Dr LC Semple		
GMC code	2820354	GP code	G07897
Practice name	Cardonald Medical Centre		
Practice code	52363		

Practice address

1831 Paisley Road West
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING PRACTITIONER DETAILS

Name	Dr LC Semple		
GMC code	2820354	GP code	G07897
Practice name	Cardonald Medical Centre		
Practice code	52363		

TRAU... G

Practice address

1831 Paisley Road West
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

02 JUN 2008

...ERN GENERAL
...TAL

12.6.08

Department of Otolaryngology, Head and Neck Surgery
Direct Line: 0141 232 7543
Fax No: 0141 232 7519
Email: irene.borland@ggc.scot.nhs.uk

Ear, Nose and Throat Department
Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Tel: 0141 201 1100
Fax: 0141 201 2999
www.nhsgg.org.uk

Our Ref: LJC/IB/953485
CHI: 1701806541

Dictated: 08 June 2009
Typed: 10 June 2009

Dr Semple
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Dear Dr Semple

Re: Lisa Hughes, Flat 2-2, 5 Mossview Quadrant, Glasgow. G52 2TU
Dob: 17/01/80

Admitted	:	08/06/09
Surgery	:	08/06/09
Procedure	:	Total thyroidectomy Frozen section revealed 3 follicular lesions and no evidence on frozen section of anything else, but we await formal pathology
Discharge	:	To be decided – likely to be 10/06/09
Follow up	:	2 weeks for pathology

Kind regards.

Yours sincerely

Louise J Clark
Consultant ENT Surgeon

Department of Otolaryngology, Head and Neck Surgery
Direct Line: 0141 232 7543
Fax No: 0141 232 7519
Email: irene.borland@sgh.scot.nhs.uk

Ear, Nose and Throat Department
Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Tel: 0141 201 1100
Fax: 0141 201 2999
www.nhsgg.org.uk

Our Ref: LJC/IB/953485
CHI: 1701806541

Typed: 06 May 2009

Ms Lisa Hughes
Flat 2-2
5 Mossview Quadrant
Glasgow
G52 2TU

Dear Ms Hughes

Re: ENT Pre-Admission Clinic

An appointment has been arranged for you to attend Miss Clark's ENT Pre-Admission Clinic as follows: (see enclosed leaflet for details):

Date: Monday 01 June 2009
Time: 3.30pm
Venue: Pre-assessment clinic, 2nd floor, Institute of Neurological Sciences, (outside ward 62)

Please telephone 0141 232 7543 on receipt of this letter to confirm your appointment.

Please note that if you do not attend the Pre-Admission clinic, your admission date will be postponed.

Kind regards

Yours sincerely

Irene Borland
Secretary

Proposed theatre date: **08/06/09**
Procedure: **Total thyroidectomy/?level VI neck dissection**





Department of Otolaryngology, Head and Neck Surgery
Direct Line: 0141 232 7543
Fax No: 0141 232 7519
Email: irene.borland@ggc.scot.nhs.uk

Ear, Nose and Throat Department
Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Tel: 0141 201 1100
Fax: 0141 201 2999
www.nhsgg.org.uk

Our Ref: LJC/IB/953485
CHI: 1701806541

Dictated: 21 August 2008
Typed: 02 September 2008

Dr L Semple
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G51 3SS

Dear Dr Semple

Re: Lisa Hughes, Flat 2-2, 5 Mossview Quadrant, Glasgow, G52 2TU
Dob: 17/01/80

I reviewed this lady in clinic who is 15 weeks pregnant. The FNA today simply showed blood and was really insufficient for any major diagnosis. I await the ultrasound FNA which is next week. I have rechecked her thyroid functions since, with positive antibodies at a level of 568, she may become hypothyroid, thus it is probably worthwhile just watching her thyroid function during her pregnancy.

I have rechecked them again today and will send you the results.

I will see her in due course after her further ultrasound FNA.

Kind regards.

Yours sincerely

Louise J Clark
Consultant ENT Surgeon

Not on W/L yet.

Southern General Hospital Haematology System
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
SG00953485	HUGHES LISA	17.01.80	P	Ear,Nose,Throat

Specimen R,08.3195527.A Type Blood
Collected 11.09.08 12:25 A.Diag PREG THYRIOD ?ANAEMIC

.....FBC.....			
WBC	8.9	MCHC	33.7
RBC	3.78	RDW	13.6
HGB	113	MPV	10.6
PCV	0.335	PCT	0.290
MCV	89	PDW	12.3
MCH	29.9		
PLT	271		
NEUT	6.0		
LYMPH	1.95		
MONO	0.76		
EOSIN	0.22		
BASO	0.01		

Quit \ Earlier req \ Later req \ ED \ LD
Back <B> ..

Copy to GP
23/9/08

5

DATE	TREATMENT, CLINICAL and OPERATION NOTES	DATE	TREATMENT, CLINICAL and OPERATION NOTES
21/8/08	FNA insuffic U/S FNA next week 29/8		
	See 11/9		
	15/52 pregnant		J Cook
1-/3/09	Thy3 @ UCH		
	Risks - Scar, bleeding, recurrent laryngeal tracheostomy - need 12 months + TFT @ present		
	Repeat US & Fine @ for total Thyroidectomy discussed — consider take 2 operation or wait if bad further surveillance for @ UCH		

5

DATE	TREATMENT, CLINICAL and OPERATION NOTES	DATE	TREATMENT, CLINICAL and OPERATION NOTES

DOCTOR'S LETTER SHEET

UNIT NUMBER

INSTITUTE OF NEUROLOGICAL SCIENCES Southern General Hospital
DEPARTMENT OF NEUROLOGY 1345 Govan Road, Glasgow, G51 4TF
Telephone: 0141 201 1100

FN/MM/953485

☎ Direct: 0141 201 2472
Facsimile No: 0141 201 2510

SEMI-URGENT CLINIC
Consultant: Dr S Webb

Clinic: 17.10.06
Dictated: 9.11.06
Typed: 10.11.06

Dr L C Semple
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Dear Dr Semple

Lisa Rosemary HUGHES – dob: 17.1.80 – CHI 1701806541
Fl 2-2 5 Mossview Quadrant Cardonald Glasgow G52 2TU

Thank you for referring this lady to the Semi Urgent Clinic where she was seen on behalf of Dr Webb. She gives a 3 month history of daily headache. The headache is present on wakening but tends to worsen in the evening. It is bilateral but worse on the left and radiates to the neck and arm. It is a pressure-like sensation with left retro-orbital throbbing. On occasion it is also associated with numbness in her left cheek.

I note her past history of recurrent faints. She is a smoker smoking 10-15 per day. She is also on the mini pill but has stopped this and is now taking no contraception. She is also taking Amitriptyline 25 mg daily for the past week. She has a family history of migraine in her mother and sister.

On examination today there was no focal neurological signs.

In summary her headache has some migrainous features but given the neck symptoms I wonder she also has an element of cervicogenic headache. I suggested she continue with the Amitriptyline in the first instance and have arranged CT of brain and x-ray of her cervical spine. She may benefit from physiotherapy regarding the cervicogenic element I wondered if this could be arranged locally. If you do not have access to a physiotherapist please let me know and I will arrange it at the Southern General Hospital.

SDMI URGENT 17 OCT 2006 AT 3.30 PM SG 953485

DR WEBB ON CALL (C) (IN, MA, SR)

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required? No

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Neurology
G General Referral

Southern General Hospital

Consultant / receiving practitioner and/or specialty clinic

Hospital and hospital address

Hospital location code: G405H

Email address:

Urgency of referral ~~Routine~~ URGENT

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa Rosemary
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541

Patient's address

fl 2-2 5 Mossview Quad
Cardonald
GLASGOW
G52 2TU

Contact number(s)

Voice: 07833990700 Phone Switched Off

SEEN BY GP DETAILS

Name	Dr LC Semple
GMC code	2820354
GP code	G07897
Practice name	Cardonald Medical Centre
Practice code	52363

Practice address

1831 Paisley Road West
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING PRACTITIONER DETAILS

Name	Dr LC Semple
GMC code	2820354
GP code	G07897
Practice name	Cardonald Medical Centre
Practice code	52363

Practice address

1831 Paisley Road West
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

SOUTHERN GENERAL HOSPITAL
RECEIVED
12 OCT 2006

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: HEADACHES

Comment: Dear Doctor,

This 26 year old lady has had a 2 months history of severe left sided headaches over the parietal area. These are becoming more persistant and have not responded to simple analgesia or migraine treatment. She has had no visual symptoms with them and has attended an optician in recent weeks. She has been under extreme stress in recent weeks and has 5 children and social problems. However, I dont think that the headaches follow the pattern of simple tension headaches and there is no evidence of depression. She has had a normal neurological examination thoughout the time she has been attending us with these headaches. However, a few days ago she tells me that she passed out. There was no fitting. However, she now feels that her left hand grip is less strong although I could not ficit any abnormalities. In terms of past history Lisa was investigated when she was 10 at Yorkhill and diagnosed with syncope attacks, but they were unable diagnos epilepsy. I would appreciate your assessment.

Yours sincerely,

STELLA McMILLAN.

* COMMENCED ON 50MG AMITRYPTYLINE TODAY 10/10/06 ALSO CO-CODAMOL STOPPED AS PER DR TAYLOR — ONLY ON IBUPROFEN/PCM. *

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		04-Aug-2006
Current smoker:	20:	01-Feb-2005
Teetotaller:		01-Feb-2005

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

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

Pre-existing conditions (High & medium priority - all)

Description	Date recorded	Modifier	Extension	Date of onset
Asthma resolved	12-Dec-2005	-	Attack 1995	-
Head injury	27-Sep-1997	-	was assaulted	-
[X]Overdose - paracetamol	23-Apr-1994	-	-	-

Past procedures (High and medium priority - all)

Description	Laterality	Modifier	Date performed
CIN III - severe dyskaryosis	+ HPV	-	26-May-2004

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
Sumatriptan	04.07.04.1	TABS 50MG	1 Tab	Take as required	11-Sep-2006	-
Pizotifen	04.07.04.2	TABS 1.5MG	1 Tab	At night	11-Sep-2006	-
Cerazette	07.03.02.1	TABS 75MICROGRAMS	1 Tab	Daily	04-Sep-2006	-
Clotrimazole	07.02.02.0	Thrush CREAM 2%	Apply	morning and night	29-Aug-2006	-
Fluconazole	05.02.00.0	CAPS 150MG	1 Cap	single dose	29-Aug-2006	-
Co-Codamol	04.07.01.0	30/500mg CAPS	2 Caps	every 4 to 6 hours	07-Aug-2006	-
Nicorette	04.10.00.0	10mg/16 Hours PATCH	Apply	Daily	07-Aug-2006	-
Cerazette	07.03.02.1	TABS 75MICROGRAMS	1 Tab	Daily	01-Aug-2006	-

Clinical warnings

Smoking status

Alcohol consumption

(L) 953485
IN, MA, SG, SR

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?
No

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Neurology AH
G General Referral — **Consultant / receiving practitioner** and/or **specialty clinic**

Southern General Hospital — **Hospital** and **hospital address**

Hospital location code.
G405H

Email address

Urgency of referral Routine

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa Rosemary
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541

Patient's address

fl 2-2 5 Mossview Quad
Cardonald
GLASGOW
G52 2TU

Contact number(s)

Voice: 07833990700

SEEN BY GP DETAILS

Name	Dr LC Semple		
GMC code	2820354	GP code	G07897
Practice name	Cardonald Medical Centre		
Practice code	52363		

Practice address

1831 Paisley Road West
G52 3SS
03 OCT

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING PRACTITIONER DETAILS

Name	Dr LC Semple		
GMC code	2820354	GP code	G07897
Practice name	Cardonald Medical Centre		
Practice code	52363		

Practice address

1831 Paisley Road West
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: HEADACHES

Comment: Dear Doctor,

This 26 year old lady has had a 2 months history of severe left sided headaches over the parietal area. These are becoming more persistant and have not responded to simple analgesia or migraine treatment. She has had no visual symptoms with them and has attended an optician in recent weeks. She has been under extreme stress in recent weeks and has 5 children and social problems. However, I dont think that the headaches follow the pattern of simple tension headaches and there is no evidence of depression. She has had a normal neurological examination thoughout the time she has been attending us with these headaches. However, a few days ago she tells me that she passed out. There was no fitting. However, she now feels that her left hand grip is less strong although I could not licit any abnormalities. In terms of past history Lisa was investigated when she was 10 at Yorkhill and diagnosed with syncope attacks, but they were unable diagnos epilepsy. I would appreciate your assessment.

Yours sincerely,

STELLA McMILLAN.

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		04-Aug-2006
Current smoker:	20:	01-Feb-2005
Teetotaller:		01-Feb-2005

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

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

Pre-existing conditions (High & medium priority - all)

Description	Date recorded	Modifier	Extension	Date of onset
Asthma resolved	12-Dec-2005	-	Attack 1995	-
Head injury	27-Sep-1997	-	was assaulted	-
[X]Overdose - paracetamol	23-Apr-1994	-	-	-

Past procedures (High and medium priority - all)

Description	Laterality	Modifier	Date performed
CIN III - severe dyskaryosis	+ HPV	-	26-May-2004

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
Sumatriptan	04.07.04.1	TABS 50MG	1 Tab	Take as required	11-Sep-2006	-
Pizotifen	04.07.04.2	TABS 1.5MG	1 Tab	At night	11-Sep-2006	-
Cerazette	07.03.02.1	TABS 75MICROGRAMS	1 Tab	Daily	04-Sep-2006	-
Clotrimazole	07.02.02.0	Thrush CREAM 2%	Apply	morning and night	29-Aug-2006	-
Fluconazole	05.02.00.0	CAPS 150MG	1 Cap	single dose	29-Aug-2006	-
Co-Codamol	04.07.01.0	30/500mg CAPS	2 Caps	every 4 to 6 hours	07-Aug-2006	-
Nicorette	04.10.00.0	10mg/16 Hours PATCH	Apply	Daily	07-Aug-2006	-
Cerazette	07.03.02.1	TABS 75MICROGRAMS	1 Tab	Daily	01-Aug-2006	-

Clinical warnings Smoking status Alcohol consumption

SG00953485
LISA HUGHES
5 MOSSVIEW QUADRANT
FLAT 2/2
GLASGOW 17/01/1980
G52 2TU CHI 1701806541

CLINICAL NOTES

DATE

17/10/06

26

3/12 h/o headache.
- continuous headache worse @ pm
- (L) head → neck → arm.
- pressure, scalp tenderness, electric shock
- Hx
  - exacerbating factors. Menstrual. Hormone
  - photophobia - phonophobia

Assoc c numbness (L) cheek
- chewing/swallowing
- ?
- occ'nal vertigo

PMH. recurrent faints. Rx 10-15/day

DH Microgynon → stopped
antidepressant 50mg

FH migraine → mother } no neurological
→ sister } symptoms

DATE

CLINICAL NOTES (Continued)

d) E. no focal deficit

2)

A26/0

FAMILY PLANNING & SEXUAL HEALTH
DIRECTORATE

GIM 953485

Clinic Address: Caldowell Family Planning Berryknowes Rd.

Referring Doctor: A. Muskett

Date: 12.5.03

REQUEST FOR REFERRAL FOR COLPOSCOPIC ASSESSMENT

Hospital: Southern General.

Claremont ☐

16 MAY 2003

Please arrange for this patient to attend the COLPOSCOPY CLINIC

Routine ☑
Soon ☐
Urgent ☐

Patient Surname: HUGHES — First Name: Lisa.

Maiden Name: Nash

Address: Flat 2/2
5 Rossview Quadrant
Caldowell

Post Code: G52 2TU.

D.O.B.: 17.1.80

G.P. Name & Address:
Dr. Treadgold
Pollok Health Centre.

G.P. notified: Yes ☑ No ☐

Parity 3 + 0 = 10 — Smoker 20/day — Contraception: Condoms

Criteria for referral

Abnormal cytology:
- Borderline ☐
- Mild) ☑
- Moderate) dyskaroysis ☐
- Severe) ☐
- Other ☐

Smear No: S03 0007902 N

LHP

- Persistent unsatisfactory smear ☐
- Clinically suspicious cervix ☐
- Symptoms - postcoital bleeding ☐
  - persistent discharge ☐
- Cervical polyp ☐

Other: _____

Comments:

As confirmation of receipt of this referral, please could you notify us of the date of this patient's first appointment

95-3485 IN MAT

S/R

Hospital use Only	Clinic	Day Date	Time	Hospital No.	GP112B

Ambulance Transport Required:

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appt Category Routine ☐ Soon ☐ Urgent ☐

Hospital SOUTHERN GENERAL Date 14/09/05 CHI No. 1 7 0 1 8 0 6 5 4 1

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Please arrange for this patient to attend the COLPOSCOPY Clinic of

Patients Surname HUGHES Maiden Surname

First Names LISA Single/Married/Widowed/Other

Address FLAT 2/2 5 MOSSVIEW QUADRANT Date of Birth 17/01/80

GLASGOW Patient's Occupation

Postal Code G52 2TU Contact telephone number 07766 451 921 HB of Residence

Has the patient attended hospital before? If "YES" please state:

Name of Hospital

Year of Attendance Hospital No.

If the patients name and or address has have changed since then please give details:

Can patient attend at short notice?

If YES minimum notice required days

Name, Address and Telephone number of MEDICAL/DENTAL PRACTIONER

DR AAW FINNEY
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS
Tel No 0141 892 2548
Fax No 0141 892 2549

GP's Code AAWF/JH Practice Code 52363

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 Doctor

This 25 year old girl had been attending the Colposcopy clinic up until June 2004 because of CIN3 plus HPV but defaulted from her follow-up appointment in November 2004 as she was pregnant. She has now had her baby and I think it is important that she followed up and I would be grateful if you could send her out a further appointment to attend the clinic.

Please note that she has now changed GP since she was last seen by you. 16 SEP 2005

Yours sincerely

DR A A W FINNEY

SOUTHERN GENERAL HOSPITAL NHS TRUST

DIRECTORATE OF OBSTETRICS, GYNAECOLOGY & PAEDIATRICS

CONSULTANTS:
DR WM C M K NAISMITH
DR M J CARTY
DR VALERIE D HOOD
DR ROBERT J S HAWTHORN
DR I RAMSAY

1345 GOVAN ROAD
GLASGOW
G51 4TF
TEL: 0141 201 1100
FAX: 0141 201 2994
SECRETARY: 0141 201 2325
(Dr Hawthorn's Secretary - Carole)

SP/CJC/953485

09/02/98

Mrs Lisa Percy
House 40
60 Tarfside Oval
GLASGOW
G52 3AQ

Dear Mrs Percy

Following your recent visit to the hospital, the urine specimen has shown the presence of a slight infection which would benefit from treatment with antibiotics.

This is nothing for you to worry about, but I should be grateful if you could make an appointment to see your GP, who will arrange appropriate treatment.

Yours sincerely

DR S PRINGLE
REGISTRAR TO DR ROBERT J S HAWTHORN

cc: GP, Dr Treadgold, Pollok Health Centre - copy enclosed

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DIRECTORATE OF OBSTETRICS, GYNAECOLOGY & PAEDIATRICS

COLPOSCOPY CLINIC

Dr Robert J S Hawthorn (Consultant)
Dr Pyone Myint
Dr A Hassan
Dr Jeannette Crawford

1345 Govan Road
Glasgow
G51 4TF
☎ 0141 201 2323
Fax 0141 201 2994
(Colposcopy secretary – Margaret)

PM/MG/953485

24/06/03

Dr N Treadgold
Pollok Health Centre
21 Cowglen Road
GLASGOW
G53 6EW

Dear Dr Treadgold

Lisa Hughes – DoB 17.1.80.
2/2 5 Mossview Quad, Glasgow G52 2TU

The above young lady with mild dyskaryosis + HPV was seen at the colposcopy clinic on 20.6.03 where she tells me that she is 11 weeks in gestation.

I have explained and reassured her regarding mild smears + HPV infection. She has also been advised regarding smoking.

A review has been arranged for 6-8 weeks postnatal period.

Yours sincerely

Pyone Myint
Clinical Assistant
For Dr R J S Hawthorn

(Colposcopy secretary - Margaret - 0141 201 2323)

COLPOSCOPY CLINIC

Dr R J S Hawthorn (Consultant)
Dr A Hassan
Pyone Myint
Jeannette Crawford

Ref: PM/MG/953485

3 June 2004

Dr Treadgold
Pollok Health Centre
21 Cowglen Road
GLASGOW
G53

Dear Dr Treadgold

Re: **Lisa Hughes - 17-01-80**
2/2 5 Mossview Quad, Glasgow G52 2TU

Your patient returned to the clinic and biopsy found: CIN3.

This has been treated with: LLETZ - 26-05-04.

There were no complications and an appointment has been made for her to return to the clinic for colposcopic and cytological review in 6 months.

In the meantime if there is any unexpected bleeding, she has been advised to contact this clinic, and should she develop a foul smelling or coloured discharge, she has been advised to see you.

Yours sincerely

Pyone Myint

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DIRECTORATE OF OBSTETRICS, GYNAECOLOGY & PAEDIATRICS

COLPOSCOPY CLINIC

Dr Robert J S Hawthorn (Consultant)
Dr Pyone Myint
Dr A Hassan
Dr Jeannette Crawford

1345 Govan Road
Glasgow
G51 4TF
☎ 0141 201 1100
Fax 0141 201 2994
(Colposcopy secretary – Margaret 0141 201 2323)

PM/MG/953485

15 June 2004

Dr N Treadgold
Pollok Health Centre
21 Cowglen Road
GLASGOW
G53 6EW

Dear Dr Treadgold

Lisa Hughes – DoB 17.1.80.
2/2 5 Mossview Quad, Glasgow G52 2TU

The above patient's loop histology was reported as CIN3 + HPV.

With Good Wishes

Yours sincerely

Pyone Myint
Clinical Assistant
For Dr R J S Hawthorn

(Colposcopy secretary - Margaret - 0141 201 2323)

Colposcopy Clinic

Dr Robert J S Hawthorn (Consultant)
Dr Pyone Myint
Dr A Hassan
Dr Robina Khan

Ref: RK/MG/953485

30 November 2004

Ms Lisa Hughes
2/2 5 Mossview Quad
GLAGSOW
G52 2TU

Dear Ms Hughes

I am sorry you could not attend your recent colposcopy clinic appointment as arranged. It is in your own interest that you do so. Another appointment is enclosed. If this is not convenient, would you please let us know so that it can be reallocated and a more suitable appointment made for you.

You are reminded that you were attending the clinic for the follow-up of an abnormal smear result.

Yours sincerely

Pyone Myint
Clinical Assistant
For Dr R J S Hawthorn

cc. Dr Treadgold, Pollok Health Centre, 21 Cowglen Road, Glasgow G53.

DJH/LOC/953485

Direct Telephone Line: 0141 232 7512
Department Fax: 0141 232 7519

Dictated: 17 January 2005
Typed: 08 February 2005

DEPARTMENT OF OTOLARYNGOLOGY, HEAD AND NECK SURGERY

Dr n Treadgold
Pollok Health Centre
21 Cowglen Road
GLASGOW
G53 6EW

Dear Dr Treadgold

LISA HUGHES DOB 17/1/1980
FLAT 2/2, 5 MOSSVIEW QUADRANT, GLASGOE G52 2TU

Lisa was referred from Casualty having fallen and noticed some decreased hearing in the left ear.

On examination she had a small perforation in the left tympanic membrane. The injury occurred possibly three weeks ago and in the first instance I would like to review her in six weeks with an audiogram to see if there has been any spontaneous healing.

Yours sincerely

DAVID HOUGHTON
CONSULTANT ENT SURGEON

SOUTH GLASGOW UNIVERSITY HOSPITALS DIVISION
SOUTHERN GENERAL HOSPITAL

3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

DIRECTORATE OF OTOLARYNGOLOGY, HEAD & NECK SURGERY

Tel: 0141-232-7512
Fax: 0141-232-7519

Ref: DH/PCS/953485

Clinic/dictated: 28/02/2005
Typed: 09/03/2005

Dr N Treadgold
Pollok Health Centre
21 Cowglen Road
Glasgow
G53 6EN

Dear Dr Treadgold

LISA HUGHES DOB 17/01/1980
FLAT 2/2, 5 MOSSVIEW QUADRANT G52 2TU

This lady failed to attend a recent ENT Out-Patient appointment.

No further appointment has been arranged.

Yours sincerely

D Houghton
Consultant ENT Surgeon

S.G.H./3Y

(Colposcopy secretary - Margaret - 0141 201 2323)

Colposcopy Department

Dr R J S Hawthorn (Consultant)
Dr A Hassan (Associate Specialist)
Dr Pyone Myint
Dr Robina Khan

Ref: PM/MG/953485

20 December 2005

Ms Lisa Hughes
2/2 5 Mossview Quad
GLASGOW
G52 2TU

Dear Ms Hughes

I am sorry that you have been unable to attend either of your recent colposcopy clinic appointments. It is important that you attend so that we can check the neck of your womb to ensure that it is healthy.

Please telephone the clinic at 0141 201 2323 to make a further appointment, or contact your GP to discuss this.

Yours sincerely

Pyone Myint
Clinical Assistant
For Dr R J S Hawthorn

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Gynaecology
GGC General Referral

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

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

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

Hospital location code.
G405H

Email address
-

Urgency of referral ROUTINE
Date of referral 04-Feb-2010 **Date sent** 05-Feb-2010

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa Rosemary
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541

Patient's address

8 Carham Cres
GLASGOW
G52 2HN

Contact number(s)
Voice: 07788617061

101000174880R Unique Care Pathway Number: 101000174880R

REGISTERED GP DETAILS

Name	Dr LC Semple		
GMC code	2820354	GP code	G07897
Practice name	Cardonald Medical Centre		
Practice code	52363		

Practice address

1831 Paisley Road West
G52 3SS

Contact number(s)
Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Linsey Semple		
GMC code	2820354	GP code	07897
Practice name	CARDONALD MEDICAL CENTRE (52363)		
Practice code	52363		

Practice address

1831 PAISLEY ROAD WEST
GLASGOW

Contact number(s)
Voice: 0141 892 2548

5 - FEB 2010
SOUTHERN GENERAL HOSPITAL

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: BLEEDING

Comment: Dear Doctor,

I would be most grateful if you could review this pleasant 29 year old lady who has had a 6 months history of irregular uterine bleeding. Miss Hughes has been on the Depo provera injection since around 2005, which appears to have suited her well. Miss Hughes has had 8 children without having any major problems only significant past medical history is that she had colposcopy for CIN3 severe dyskaryosis in May 2004. Subsequent smears have been normal.

Miss Hughes describes a rush of blood post coitally, with no associated pain. She has also been spotting on her days as well. She had a smear done by our Practice Nurse on 11th August 2009 who commented that she could see blood collected around the cervix. I do wonder if this is a problem due to Depo provera or if there is another cause for blood loss. Miss Hughes herself is very anxious regarding spotting, as her mother possibly had cervical cancer issues. I have given her a course of Norethisterone 5mg TDS for 10 day in the hope of arresting the bleeding, I would be grateful for your expert opinion.

Kind Regards,

Yours sincerely,

DR TERESA O'BRIEN

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset
Autoimmune thyroiditis	-	25-Jun-2009
Nontoxic multinodular goitre	-	29-Aug-2008
Asthma resolved	Attack 1995	12-Dec-2005
Head injury	was assaulted	27-Sep-1997
[X]Overdose - paracetamol	-	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Comment	Date performed
Advice about long acting reversible contraception	:	25-Nov-2009
Thyroidectomy operations	-	08-Jun-2009
CIN III - severe dyskaryosis	+ HPV	26-May-2004

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Duration
Levothyroxine Sodium	56	TABS 25MICROGRAMS	1 Tab	Daily	11-Aug-2009	0 Days
Levothyroxine Sodium	56	TABS 100MICROGRAMS	1 Tab	Daily	11-Aug-2009	0 Days

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Duration
Levothyroxine Sodium	84	TABS 100MICROGRAMS	2 Tabs	In the morning	18-Jan-2010	0 Days

Olanzapine	28	TABS 15MG	1 Tab	At night	18-Jan-2010	0 Days
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	-	18-Jan-2010	0 Days
Levothyroxine Sodium	28	TABS 50MICROGRAMS	1 Tab	In the morning	10-Dec-2009	0 Days
Olanzapine	42	TABS 15MG	1 Tab	At night	10-Dec-2009	0 Days
Levothyroxine Sodium	28	TABS 100MICROGRAMS	1 Tab	Daily	10-Dec-2009	0 Days
Levothyroxine Sodium	56	TABS 100MICROGRAMS	1 Tab	Daily	10-Nov-2009	0 Days
Levothyroxine Sodium	56	TABS 50MICROGRAMS	1 Tab	In the morning	10-Nov-2009	0 Days
Olanzapine	28	TABS 15MG	1 Tab	At night	10-Nov-2009	0 Days
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	-	10-Nov-2009	0 Days
Levothyroxine Sodium	56	TABS 100MICROGRAMS	1 Tab	Daily	25-Sep-2009	0 Days
Olanzapine	28	TABS 10MG	1 Tab	At night	25-Sep-2009	0 Days
Levothyroxine Sodium	56	TABS 50MICROGRAMS	1 Tab	In the morning	25-Sep-2009	0 Days

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		04-Jun-2009
Current smoker:		06-Jun-2008
Current smoker:		04-Aug-2006
Current smoker:		15-Sep-2005
Current smoker:		01-Feb-2005
Current smoker:	20:	01-Feb-2005
Teetotaller:		01-Feb-2005

Clinical warnings

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

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

953485

IN
MA
SG
SR

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Gynaecology F2
GGC General Referral

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

Southern General Hospital

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

Hospital location code.
G405H

Email address

Urgency of referral ROUTINE
Date of referral 18-Aug-2009 **Date sent** 20-Aug-2009

PATIENT DETAILS

Surname	Hughes
Forename(s)	Lisa Rosemary
Title	Miss
Sex	Female
Date of birth	17-Jan-1980
CHI no.	1701806541

Patient's address

Fl 2-2
5 Mossview Quad
Cardonald
GLASGOW
G52 2TU

Contact number(s)

Voice: 07788617061

REGISTERED GP DETAILS

Name	Dr LC Semple		
GMC code	2820354	GP code	G07897
Practice name	Cardonald Medical Centre		
Practice code	52363		

Practice address

1831 Paisley Road West
G52 3SS

Contact number(s)

Voice: 0141 892 2548
Facsimile: 0141 892 2549

REFERRING GP DETAILS

Name	Dr. Linsey Semple		
GMC code	2820354	GP code	07897
Practice name	CARDONALD MEDICAL CENTRE (52363)		
Practice code	52363		

Practice address

1831 PAISLEY ROAD WEST
GLASGOW

Contact number(s)

Voice: 0141 892 2548

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: BLEEDING

Comment: Dear Doctor,

I would be most grateful if you could review this pleasant 29 year old lady who has had a 2 months history of regular uterine bleeding. Miss Hughes has been on the Depo provera injection since around 2005, which appears to have suited her well. Miss Hughes has had 8 children without having any major problems only significant past medical history is that she had colposcopy for CIN3 severe dyskaryosis in May 2004. Subsequent smears have been normal.

Miss Hughes describes a rush of blood post coitally, with no associated pain. She has also been spotting on her days as well. She had a smear done by our Practice Nurse on 11th August 2009 who commented that she could see blood collected around the cervix. I do wonder if this is a problem due to Depo provera or if there is another cause for blood loss. Miss Hughes herself is very anxious regarding spotting, as her mother had severe uterine of the cervix but she cannot give me any more details on this. I have given her a course of Norethisterone 5mg TDS for 10 day in the hope of arresting the bleeding, I would be grateful for your expert opinion.

Kind Regards,

Yours sincerely,

DR. TERESA O'REILLY.

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		04-Jun-2009
Current smoker:		06-Jun-2008
Current smoker:		04-Aug-2006
Current smoker:		15-Sep-2005
Current smoker:		01-Feb-2005
Current smoker:	20:	01-Feb-2005
Teetotaller:		01-Feb-2005

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Modifier	Extension	Date of onset
Autoimmune thyroiditis	-	-	25-Jun-2009
Nontoxic multinodular goitre	-	-	29-Aug-2008
Asthma resolved	-	Attack 1995	12-Dec-2005
Head injury	-	was assaulted	27-Sep-1997
[X]Overdose - paracetamol	-	-	23-Apr-1994

Past procedures (High and medium priority - all)

Description	Modifier	Date performed
Thyroidectomy operations	-	08-Jun-2009
CIN III - severe dyskaryosis	-	26-May-2004

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued	Duration
Levothyroxine	56	TABS	1 Tab	Daily	11-Aug-	-	0 Days

Sodium		100MICROGRAMS			2009		
Levothyroxine Sodium	56	TABS 25MICROGRAMS	1 Tab	Daily	11-Aug-2009	-	0 Days

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued	Duration
Norethisterone	30	TABS 5MG	1 Tab	tds	17-Aug-2009	-	0 Days
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	-	04-Aug-2009	-	0 Days
Olanzapine	28	TABS 10MG	1 Tab	Daily	04-Aug-2009	-	0 Days
Olanzapine	28	TABS 10MG	1 Tab	Daily	24-Jul-2009	-	0 Days
Olanzapine	10	TABS 5MG	1 Tab	At night	09-Jul-2009	-	0 Days
Olanzapine	10	TABS 5MG	1 Tab	At night	30-Jun-2009	-	0 Days
Levothyroxine Sodium	56	TABS 100MICROGRAMS	1 Tab	Daily	25-Jun-2009	-	0 Days
Levothyroxine Sodium	56	TABS 25MICROGRAMS	1 Tab	Daily	25-Jun-2009	-	0 Days
Flucloxacillin	28	CAPS 500MG	1 Cap	4 times daily	15-Jun-2009	-	0 Days
DICLOFENAC 50 MG	84	TAB	1 Tab	3 times daily if reqd.	12-Jun-2009	-	0 Days
Tramadol Hydrochloride	100	CAPS 50MG	1 or 2 Caps	Take as required	12-Jun-2009	-	0 Days
Paracetamol	100	TABS 500MG	2 Tabs	every 4 to 6 hours	12-Jun-2009	-	0 Days
Liothyronine Sodium	84	TABS 20MICROGRAMS	Half Tab	3 times daily	12-Jun-2009	-	0 Days
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	-	04-Jun-2009	-	0 Days
Propranolol Hydrochloride	30	TABS 40MG	1 Tab	Daily	30-Apr-2009	-	0 Days
Depo-Provera	1	Contraceptive Prefilled Syringe 1ml INJ 150MG/ML	to be injected	-	30-Mar-2009	-	0 Days

Clinical warnings

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-21 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

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

Acute Services Division

1345 Govan Road
Glasgow G51 4TF
TEL: 0141-201-1100
FAX: 0141-201-2994

NHS
Greater Glasgow and Clyde

Women and Children's Directorate
CONSULTANTS
Dr Stewart Pringle
Dr Valerie D Hood
Dr Robert JS Hawthorn
Dr Ian N Ramsay
Dr Janice Gibson
Dr John Tierney
Dr Christopher Hardwick
Dr Marco Gaudoin
Dr Hassan Ali
Dr Stein Bjornsson

Dr Pringle's Secretary
Tel: 0141 201 1959
e:mail: june.reid@sgh.scot.nhs.uk

SP/JR /CHI No: 1701806541
16/04/10

Dr Linsey Semple
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr Semple

LISA ROSEMARY HUGHES DOB: 17/01/80 (SG00953485)
8 CARHAM CRES, , GLASGOW, G52 2HN

Lisa has had two problems one is some pain during sex and the second is irregular vaginal bleeding, which seems to be settling now and I think is very likely to be due to her Depo Provera. I think she should stay on her Depo.

As far as the dyspareunia is concerned it is mostly pubic in origin and slightly variable.

On examination there was some vague lower abdominal tenderness and again on certain movements of the cervix seemed to cause discomfort but there was certainly no cervical excitation or any other signs of pelvic infection. I took a Chlamydia swab and I will write to you both if this is positive. Given that Lisa is on Depo the pelvic organs should be quiescent and I have strongly re-assured her but told her to come back to see me if the problem is not settling down.

Yours sincerely

STEWART PRINGLE
CONSULTANT OBSTETRICIAN AND GYNAECOLOGIST

Delivering better health

www.nhsggc.org.uk

40366

SOUTH GLASGOW UNIVERSITY HOSPITAL NHS TRUST
DIRECTORATE OF OBSTETRICS, GYNAECOLOGY AND PAEDIATRICS
1345 GOVAN ROAD
GLASGOW G51 4TF
FAX: 0141-201-2994

CONSULTANTS
Dr Stewart Pringle
Dr Valerie D Hood
Dr Robert JS Hawthorn
Dr Ian N Ramsay
Dr Janice Gibson
Dr John Tierney
Dr Christopher Hardwick
Dr Marco Gaudoin
Dr Hassan – Associate Specialist
(Dr Pringle's Secretary – June) - ☎Direct Dial: 0141-201-1959
e:mail june.reid@sgh.scot.nhs.uk

SA/JR/953485
5th April 2006

Dr Treadgold
Pollok Health Centre,
21 Cowglen Road,
Glasgow. G53 6EQ

Dear Dr Treadgold

RE: LISA HUGHES, 5 MOSSVIEW QUADRANT, FLAT 2/2, GLASGOW G52 2TU
DOB: 17.01.80

This lady had an appointment at Dr Pringle's Gynaecology Clinic on Monday 3rd April 2006 and failed to attend and did not contact us.

We have therefore not sent her a further appointment.

Yours sincerely

DR ALSAMOUA
REGISTRAR TO DR PRINGLE

WOMEN'S & CHILDREN'S DIRECTORATE

NHS Greater Glasgow and Clyde

ACUTE SERVICES DIVISION - SOUTHERN GENERAL HOSPITAL

1345 Govan Road, Glasgow, G51 4TF
Tel: 0141 201 1100
Fax: 0141 201 2994
Secretary: 0141 201 2353
e:mail mhairi.carruth@ggc.scot.nhs.uk

Dr Robert J S Hawthorn
Dr Stewart Pringle
Dr Stein Bjornsson
Dr Marco Gaudoin
Dr John Tierney
Dr Chris Hardwick
Dr Janice Gibson
Dr Hassan Ali
Dr Vanessa Mackay
Dr Karen Guerrero

VAM/MLC/953485

20/10/09

Dr Semple
1831 Paisley Road West
Glasgow
G52

Dear Dr Semple

Lisa Hughes DoB 17/01/1980 CHI 6541
5 Mossview Quadrant, G52 2TU

This lady did not attend the gynaecology clinic today. We have not arranged to see her again. Please re-refer if her problems persist.

Many thanks

Yours sincerely

Dr Vanessa Mackay
Consultant Obstetrician & Gynaecologist

SOUTHERN GENERAL HOSPITAL GYNAECOLOGY | WARD49/50 Gynaecology emergencies

ACCIDENT / EMERGENCY

name | Date of birth | RD

Lisa Hughes.

MA 953485
FN 4
SR 4

RUST

name | Date of birth

17/1/80.

FORENAM

5 MOSSVIEW QUADRANT FLAT 2/2.

POST CODE	TELEPHONE No. MOB	DATE OF BIRTH	SEX	MARITAL STATUS	RELIGION
G52 2TU.	07833990700	17/1/80	F	SINGLE	PROTESTANT

NEXT OF KIN NAME	RELATIONSHIP	FAMILY DOCTOR SURNAME	INITIALS
AGNES HAUGHEY	MOTHER.	SEMPLE	LC.

ADDRESS	ADDRESS
7 KIRKCONNELL DRIVE RUTHERGLEN GLASGOW	CARDONALD MEDICAL CENTRE 1831 PAISLEY ROAD WEST GLASGOW

POST CODE	TELEPHONE No.	POST CODE	TELEPHONE No.
	0141 634 4947.	G52 3SS.	0141 892 254

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

TIME OF ATTENDANCE	MODE OF TRANSPORT
	AMBULANCE _____ PUBLIC _____ OWN _____ NONE _____

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

ROAD TRAFFIC ACCIDENT PLACE	DETAILS
	FSP _____ DRIVER _____ M/C DRIVER _____ OTHER _____ BSP _____ PED. _____ M/C PASSENGER _____

REASON FOR ATTENDANCE

	TIME
TRIAGE	
DOCTOR	
NURSE	
LEFT DEPT.	

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

Dear Doctor,

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

Diagnosis

X-Ray film / ECG shows _____

Treatment given _____

Drugs _____ days supply of _____ has been given

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

Would you please arrange _____

DISCHARGE CODES: Please Circle

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

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

Follow Up	Not arranged _____	Arranged _____	To be arranged _____

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

Medical Officers Name (In Block Letters) | Signature of Medical Officer

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

SGH 458 0431551

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

DO NOT WRITE OR LEAN HERE PLEASE !

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)						
DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

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

TRIAGE NOTES
R _____ BP 135/89 P 96. T 36·5 BM _____ SpO_2 100 Expected PEF _____ PEF _____

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

Clearview -ve.

CONSULTANT Dr Taggart. SEEN BY NLYAU AT (TIME) 2:40pm.

DATE	CLINICAL NOTES
23/06	26y Para 5+0. PCa. RIF Pain HPCa. 7mth Hx of pelvic pain - always worse at night & w/ movement (heavy lifting. - deep dyspareunia (v. severe, now stopped having sex) - no dysuria, no diarrhoea/constipation, but often abdo pain - no PV discharge - amenorrhoeic 4mths. (Depo-Provera given 7mths ago, had 3mth bleeding). x2 episodic PV small bleed last wk. Analgesia (Paracetamol/Ibuprofen) w/ minimal effect. Gynae Hx 5 daughters (8yrs - 7mths) - all SVD. Colposcopy - "precancerous cells" - loop excision - [illegible] PMHx asthma ? allergic to mist. Oth Nil known with Depo Provera.

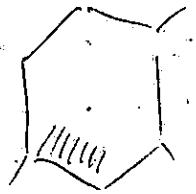
OPEN BEFORE WRITING

DATE

CLINICAL NOTES

2/3/04 Gyn Alert + Orientated. Fully mobile. Looks well.

Obs ⓐ BHCG neg



Soft
Tender RIF + suprapubic
° guarding ° rebound
° masses ° organomegaly
BSV. —

HVS + Chlamydia swab in GP practice 1wk ago → negative

IMP ? ovarian cyst. ? endometriosis.

Plan (as discussed w/ Reg)
U/S + Review.

3.30pm. U/S - R/V uterus 6 x 4 x 5cm
Rt ovary 4 x 1.9 x 1.8cm
Lt ovary 3.2 x 1.3 x 2cm
No cyst, mass or free fluid seen.

Discussed with Reg
- for O/P Review (Dr Pringle)
  - Thurs 6.4.06 1.30pm.
- ? benefit from diagnostic laparoscopy

Pt aware, analgesia advice given.

PRACTICE ACCREDITATION
RCGP Scotland
2003-2006

DR LINSEY C SEMPLE
DR ALAN A W FINNEY

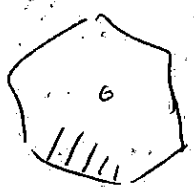
Cardonald Medical Centre
1831 Paisley Road West
GLASGOW
G52 3SS

Consultations by appointment
Tel: 0141 892 2548
Fax: 0141 892 2549

21/1/05

Dear Dr.

Lisa is a Para 5 with a 7 month old baby - all SVD. Since her last baby she has had some pelvic pain and pain on intercourse. She has had 2 pelvic examinations ~~change~~ the surgery and swabs are all normal. Since last night she has had severe pain in pelvic area + RIF. No urinary / systemic features. Has had Ibuprofen + paracetamol - not helping.

O/E  soft, tender ++ RIF and suprapubic area.

PMH - Nil of note
DH - Depot Provera
nil else
Thanks for seeing her

THE SOUTHERN GENERAL HOSPITAL

DATE _____

WARD 40 — GYNAECOLOGY EMERGENCY

INFORMATION SUMMARY

GP _____ PATIENT _____

ADDRESS _____ ADDRESS _____

_____ _____

_____ _____

_____ DATE OF BIRTH _____

_____ UNIT NUMBER _____

DEAR

THE ABOVE NAMED PATIENT WAS SEEN AS AN EMERGENCY AT THE GYNAECOLOGY DEPARTMENT AND NOT

ADMITTED (DATE SEEN) _____ UNDER THE CARE OF _____

DIAGNOSIS _____ INVESTIGATIONS _____

_____ _____

TREATMENT _____ MEDICATION _____

_____ _____

ADDITIONAL INFORMATION

_____

_____

_____

SHE HAS/HAS NOT BEEN GIVEN AN OUT-PATIENT APPOINTMENT ON _____

SEEN BY DR. _____ SIGNATURE _____

(BLOCK CAPITALS)

[redacted] **SOUTHERN GENERAL HOSPITAL** [redacted] 16A

HOSPITAL .....
CONSULTANT(S) .....
.....
PARITY .....
E.D.D .....

Surname HUGHES Hosp. No. .....
Other Names LISA D. of B. 17.1.80
Address ..... Sex .....
..... Clinic Ward .....

DATE	WARD DEPT.	MATURITY BY DATES	REPORT, DATE AND SIGNATURE
2.3.06	GYNE	TVS	Rt uterus 6 x 4 x 5 cm Lt ovary 4 x 1.9 x 1.8 cm Nt ovary 3.2 x 1.3 x 2 cm no cysts masses or free fluid seen. M. Inne).

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST
DIRECTORATE OF OBSTETRICS, GYNAECOLOGY & PAEDIATRICS
1345 Govan Road
GLASGOW G51 4TF
Tel: 0141 201 1100
Fax: 0141 201 2994

CONSULTANTS

Dr Stewart Pringle – Clinical Director
Dr Valerie D Hood
Dr Robert J S Hawthorn
Dr Ian N Ramsay
Dr Marco Gaudoin
Dr John Tierney
Dr Chris Hardwick
Dr Hassan – Locum Consultant

(Dr Gaudoin's Secretary - Karen) - ☎ Direct Dial: 0141 201 2348
✉ E-Mail: karen.mclay@sgh.scot.nhs.uk

SP/KM

09/03/2006

Dr L C Semple
Cardonald Medical Centre
1831 Paisley Road West
GLASGOW
G52 3SS

Dear Dr Semple

Lisa Hughes DOB 17.01.80
Flat 2/2, 5 Mossview Quadrant, GLASGOW

Lisa was seen in the Gynaecology Emergency Department with some right iliac fossa pain which has been going on for some months.

On examination, there was some mild right-sided tenderness and a scan showed unremarkable pelvic organs. Apparently, she is keen for further assessment of the pain and has an appointment to come to my clinic at the beginning of April 2006 to discuss if we should proceed to laparoscopy.

With kindest regards.

Yours sincerely

Stewart Pringle
Consultant Obstetrician & Gynaecologist

Patient Details

Name:	Lisa HUGHES	Unit no.:	8592
Address:	2/2 5 Mossview Quad	PAS no.:	0953485
	Glasgow	Phone no.:	
		Work no.:	
	G52 2TU	Mobile no.:	
GP		NHS no.:	0
Name:	Treadgold,	Date of birth:	17/01/80
Address:	Pollok Health Centre	Ethnic origin:	G.G.H.B.
	21 Cowglen Road	Religion:	(None)
	Glasgow	Marital status:	(None)
	G53		

Referral Details

Date:	02/06/03	Referrer:	
RMO:	Dr. Pyone Myint	Organisation:	
Specialty:	Colposcopy	Address:	
Source:	Family Planning/WWC		
Reason:	Ab. Screen. Smear		

Baseline

Method of contracept	None
Referring cytology	Mild dyskaryosis
Date ref. cytology	29/04/03
Laboratory ID	SGH
Ref.No. smear	S,03.0007902.N
Parity A	Three
Parity B	None
Pregnant	Yes
Pregnancy test	Positive
Patient smokes	Current smoker
Cigarettes per day	10
Genital warts - pat.	No
Genital warts - ptnr	No
Chlamydia	No
Past medical history	Nil
Allergies	No
Previous treatment	None

Colposcopist sign:

Pyone Myint

Event

Date	Type	Purpose
23/05/03	Registration	(None)
20/06/03	OP clinic attendance	New patient
21/04/04	OP DNA	New patient
27/04/04	Let:Pat DNA 1 visit	(None)
12/05/04	OP clinic attendance	New patient
26/05/04	OP clinic attendance	Treatment
03/06/04	Let:GP CIN treat f/u	(None)
24/11/04	OP DNA	Return - post treat.
25/11/04	Let:Pat DNA 1 visit	(None)
15/12/04	OP cancel appointmen	Other reason
26/10/05	OP DNA	Return - post treat.
01/11/05	Let:Pat DNA 1 visit	(None)
30/11/05	OP DNA	Return - post treat.
06/12/05	Let:Pat DNA 1 visit	(None)

Summary

Date	Cyto	CxBx	Treat	BxVag	BxVul	Bact	Chlam	Next
23/05/03								
20/06/03			N					
21/04/04								
27/04/04								
12/05/04	Await	CIN3	N			No	No	
26/05/04	ModD	CIN3	LLETZ					
03/06/04								
24/11/04								
25/11/04								
15/12/04								
26/10/05								
01/11/05								
30/11/05								
06/12/05								

Southern General MT Q002

Clinic Examination Sheet Team 1 **Printed on:** 12/12/05 15:42

Patient: Lisa HUGHES Return - post treat. Marital status: (None)

Due Date: 14/12/05 Unit Number: 8592 PAS Number 0953485

Examination sheet

FU Rx
104·1
105·2

Supervised by :
remarks >>
LMP :
date >>
Cervix present :
Yes
No
SCJ visible :
Yes
No
Cervical lesion :
Yes
No
Upper limit seen :
Yes
No
Vaginal lesion :
Yes
No
Vulval lesion :
Yes
No
Colp opinion: cx/vag :
remarks >>
Vulvoscopic opinion :
remarks >>
Tests (specify no.) :
Cytology
Cervical biopsy
Vaginal Biopsy
Vulval biopsy
Bacteriology
Chlamydia
Other
Treatment performed :
remarks >>
Anaesthesia :
Local
Other
Treatment comps. :
remarks >>
Excision :
Complete
Inconclusive
Incomp - endocervix
Incomp -ectocervix
Incomp - both
Planned follow-up :
remarks >>
Letters to send :
remarks >>

Southern General	MT	Q002
Clinic Examination Sheet	Team 1	Printed on: 28/11/05 11:55

Patient:	Lisa HUGHES	Return - post treat.	Marital status:	(None)
Due Date:	30/11/05	Unit Number: 8592	PAS Number	0953485

Examination sheet

Supervised by :
remarks >>
LMP :
date >>
Cervix present :
Yes
No
SCJ visible :
Yes
No
Cervical lesion :
Yes
No
Upper limit seen :
Yes
No
Vaginal lesion :
Yes
No
Vulval lesion :
Yes
No
Colp opinion: cx/vag :
remarks >>
Vulvoscopic opinion :
remarks >>
Tests (specify no.) :
Cytology
Cervical biopsy
Vaginal Biopsy
Vulval biopsy
Bacteriology
Chlamydia
Other
Treatment performed :
remarks >>
Anaesthesia :
Local
Other
Treatment comps. :
remarks >>
Excision :
Complete
Inconclusive
Incomp - endocervix
Incomp -ectocervix
Incomp - both
Planned follow-up :
remarks >>
Letters to send :
remarks >>

FIU Rx
1031
CC GP

Southern General MT Q002

Clinic Examination Sheet Team 1 **Printed on:** 21/10/05 09:46

Patient:	Lisa HUGHES	Return - post treat.		Marital status:	(None)
Due Date:	26/10/05	Unit Number:	8592	PAS Number	0953485

Examination sheet

RR - FIU Lietz (04) (03.1 CCGP

Supervised by :
remarks >>
LMP :
date >>
Cervix present :
Yes
No
SCJ visible :
Yes
No
Cervical lesion :
Yes
No
Upper limit seen :
Yes
No
Vaginal lesion :
Yes
No
Vulval lesion :
Yes
No
Colp opinion: cx/vag :
remarks >>
Vulvoscopic opinion :
remarks >>
Tests (specify no.) :
Cytology
Cervical biopsy
Vaginal Biopsy
Vulval biopsy
Bacteriology
Chlamydia
Other
Treatment performed :
remarks >>
Anaesthesia :
Local
Other
Treatment comps. :
remarks >>
Excision :
Complete
Inconclusive
Incomp - endocervix
Incomp -ectocervix
Incomp - both
Planned follow-up :
remarks >>
Letters to send :
remarks >>

Southern General MT Q002

Clinic Examination Sheet Team 1 **Printed on:** 18/11/04 14:11

Patient:	Lisa HUGHES	Return - post treat.		Marital status:	(None)
Due Date:	24/11/04	Unit Number:	8592	PAS Number	0953485

Examination sheet

Supervised by :
remarks >>
LMP :
date >>
Cervix present :
Yes
No
SCJ visible :
Yes
No
Cervical lesion :
Yes
No
Upper limit seen :
Yes
No
Vaginal lesion :
Yes
No
Vulval lesion :
Yes
No
Colp opinion: cx/vag :
remarks >>
Vulvoscopic opinion :
remarks >>
Tests (specify no.) :
Cytology
Cervical biopsy
Vaginal Biopsy
Vulval biopsy
Bacteriology
Chlamydia
Other
Treatment performed :
remarks >>
Anaesthesia :
Local
Other
Treatment comps. :
remarks >>
Excision :
Complete
Inconclusive
Incomp - endocervix
Incomp -ectocervix
Incomp - both
Planned follow-up :
remarks >>
Letters to send :
remarks >>

DCA 24.11.04
post LLETZ
103.1
CCCP

Southern General MT Q002

Clinic Examination Sheet Team 1 **Printed on:** 20/05/04 11:26

Patient: Lisa HUGHES Treatment Marital status: (None)

Due Date: 26/05/04 Unit Number: 8592 PAS Number 0953485

Examination sheet

Supervised by :

remarks >>

LMP :

date >>

Cervix present :

(Yes)

No

SCJ visible :

(Yes)

No

Cervical lesion :

(Yes)

No

Upper limit seen :

(Yes)

No

Vaginal lesion :

Yes

(No)

Vulval lesion :

Yes

(No)

Colp opinion: cx/vag :

remarks >> CIN

Vulvoscopic opinion :

remarks >>

Tests (specify no.) :

Cytology

Cervical biopsy

Vaginal Biopsy

Vulval biopsy

Bacteriology

Chlamydia

Other

Treatment performed :

remarks >> No LLETZ

Anaesthesia :

(Local)

Other

Treatment comps. :

remarks >>

Excision :

Complete ✓

Inconclusive

Incomp - endocervix

Incomp -ectocervix

Incomp - both

Planned follow-up :

remarks >> 6/12

Letters to send :

remarks >>

26.5.04

CIN3 for LLETZ

colp bone

CIN3 + HPV

ST 11.1 for CIN3

8

Southern General MT Q002

Clinic Examination Sheet Team 1 **Printed on:** 11/05/04 10:10

Patient:	Lisa HUGHES	New patient		Marital status:	(None)
Due Date:	12/05/04	Unit Number:	8592	PAS Number	0953485

Examination sheet

Supervised by :
remarks >>

LMP :
date >> 7/7

12.5.04

Had baby Feb 04
↓ CPD
P/N 12 wks.
PH

Cervix present :
(Yes)
No

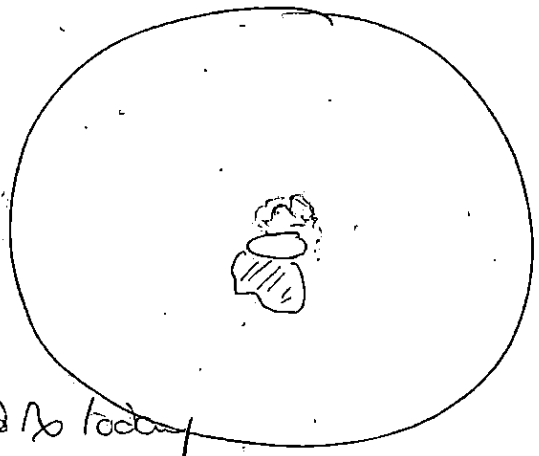
SCJ visible :
(Yes)
No

Cervical lesion :
(Yes)
No

Upper limit seen :
(Yes)
No

Vaginal lesion :
Yes
(No)

Vulval lesion :
Yes
(No)



Colp opinion: cx/vag :
remarks >> CIN 2 HPV.

Vulvoscopic opinion :
remarks >> declined Rx today

Tests (specify no.) :
Cytology ✓
Cervical biopsy ✓
Vaginal Biopsy
Vulval biopsy
Bacteriology
Chlamydia
Other

Treatment performed :
remarks >>

Anaesthesia :
Local
Other

Treatment comps. :
remarks >>

Excision :
Complete
Inconclusive
Incomp - endocervix
Incomp -ectocervix
Incomp - both

Planned follow-up :
remarks >> See 2 wks for Rx

Letters to send :
remarks >>

Southern General MT Q002

Clinic Examination Sheet Team 1 **Printed on:** 21/04/04 08:45

Patient:	Lisa HUGHES	New patient		Marital status:	(None)
Due Date:	21/04/04	Unit Number:	8592	PAS Number	0953485

Examination sheet

Supervised by :
remarks >>
LMP :
date >>
Cervix present :
Yes
No
SCJ visible :
Yes
No
Cervical lesion :
Yes
No
Upper limit seen :
Yes
No
Vaginal lesion :
Yes
No
Vulval lesion :
Yes
No
Colp opinion: cx/vag :
remarks >>
Vulvoscopic opinion :
remarks >>
Tests (specify no.) :
Cytology
Cervical biopsy
Vaginal Biopsy
Vulval biopsy
Bacteriology
Chlamydia
Other
Treatment performed :
remarks >>
Anaesthesia :
Local
Other
Treatment comps. :
remarks >>
Excision :
Complete
Inconclusive
Incomp - endocervix
Incomp -ectocervix
Incomp - both
Planned follow-up :
remarks >>
Letters to send :
remarks >>

New - Mild (May 03
Had baby Feb. 04
103-1
CCGP

Program: (none)
Package: (none)
Form: First visit sheet

20.6.03

23

8

Method of contracept

HRT

Current symptoms MED+CHPV

Parity A 3.

EDD 4/01/04

Parity B 0

Pregnant

Pregnancy test

11 wks gestation

Patient smokes 10CPD.

Cigarettes per day

Genital warts - pat.

Genital warts - ptnr

Chlamydia

Past medical history NIL.

Drugs

Allergies NIL.

Previous treatment

Diagnoses hqistory

Southern General MT Q002

Clinic Examination Sheet Team 1 **Printed on:** 16/06/03 10:14

Patient:	Lisa HUGHES	New patient		Marital status:	(None)
Due Date:	20/06/03	Unit Number:	8592	PAS Number	0953485

Examination sheet.

Supervised by :
remarks >>
LMP :
date >>
Cervix present :
Yes
No
SCJ visible :
Yes
No
Cervical lesion :
Yes
No
Upper limit seen :
Yes
No
Vaginal lesion :
Yes
No
Vulval lesion :
Yes
No
Colp opinion: cx/vag :
remarks >>
Vulvoscopic opinion :
remarks >>
Tests (specify no.) :
Cytology
Cervical biopsy
Vaginal Biopsy
Vulval biopsy
Bacteriology
Chlamydia
Other
Treatment performed :
remarks >>
Anaesthesia :
Local
Other
Treatment comps. :
remarks >>
Excision :
Complete
Inconclusive
Incomp - endocervix
Incomp -ectocervix
Incomp - both
Planned follow-up :
remarks >>
Letters to send :
remarks >>

Discussed mild smears + HPV
Reassured
advised re: smoking

in baby book.

see 6-8 wks post-natal

SOUTHERN GENERAL HOSPITAL

SG00953485
LISA HUGHES
FLAT2/2
5 MOSSVIEW QAUDRANT
GLASGOW 17/01/1980
G52 2TU CHI 1701806541

GYNAECOLOGY SHEET

DATE	Reason for Attendance	Diagnosis
12/4/10	~~Ø30~~ ♀	Treatment

1 year history of dyspareunia, irregular vaginal bleeding & suprapubic pain - which occurs every 2-3 days & is quite sharp in nature.

PV bleeding is minimal, spotting, ditabo occurs ~~post~~ post coitus.

Sera Clearly at time

Previous Illness Nil

Operations Thyroidectomy

Parity 7 ~~Ø~~ + 0 (1 twin)

Menarche 11 | Cycle Irregular | Menopause Nil

L.M.P. > 2 yrs ago | Contraception Depo prorera

Urinary symptoms Nil | DF - | SI

NF | Dysuria

Examination by: Medpt Laura Paul / SP

well, slim

Uterus & chlem anteverted size

Vagina a /

fibroid on fundus

tenderness / / / /

Bleeding settling

Uterus NS

Come back if worse / not

o cx exacerbation

regularly

Chlem sim

AON
HOUGHTON ENT 17/1/05 IYON 21'40E'1 4546 4/04

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

13.

NAME: LISA HUGHES AGE: 24 DOB: 17/01/80 CONSULTANT: PETER DAVIS
UNIT No: SG00953485 Account No: AE00454464/04 DATE: 28/12/04 TIME: 2059

GP Name:	NICHOLAS NJ TREADGOLD GP Phone No: 01415316860
REASON FOR VISIT:	COLLAPSE/HEADACHE
ALERTS:	(1) (2)
ALLERGIES:	(1) (2)
RELEVENT HISTORY:	
MEDICATIONS:	

TRIAGE CATEGORY: STANDARD TRIAGE NURSE: STEVE MACDOUGALL TRIAGE TIME: 2112

TRANSCRIBED ANALGESIA :

OBSERVATION TEXT:

COLLAPSE/HEADACHE FOR R/P.

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

T	36.6		T				Correction Y/N	
HR	94		HR				Weight (kg)	
R	18		R				Breath Alcohol	
BP	133/67		BP				Pain Score	
Sa02	99	ON %	Sa02		ON %			
BG			BG					
PF			PF					
EPF								
E			E					
V			V					
M			M					

D

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

Discharge Date: 28/12/04
Discharge Time: 2310.

Ward No. (If admitted)
Transfer to Hospital: next Wednesday
Consultant (If admitted)

Follow Up	Not arranged	Arranged	To be arranged

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

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

DO NOT WRITE

HERE PLEASE !

DATE	CLINICAL NOTES

SEEN BY (DR) MEICHAN TIME SEEN 22:15

Cr referral: 24 year old lady < 10 weeks pregnant with collapse

* Unwitnessed collapse.

Rel collapse – when walking from kitchen → livingroom ear meanding for prolonged period prior to fall. felt lightheaded ↳ collapsed to ground; caught herself – banged (R) ear.

– lying on floor for seconds
  - ? ringing / incontinence / tonic clonic seizures / jerky
  - ? pain total confusion.
– alert + oriented immediately afterward.

- chest pain / SOB palpitations
- haemoptysis / calf swelling.

* long history of simple provoked attacks.
Pt believes this was a simple faint.

- headache / weakness / visual changes / fits / ~~fevers~~ bleeds

PMH/
N/I
- DIETATHOME

FHX/ NAD

DHX/

SHX/
2 kids.

DATE

CLINICAL NOTES

O/E Alert + oriented. Unwell.

Ø JAUNDICE.

Vital signs

Pulse 70 bpm reg RR 12 Temp 36.6

BP 135/80 Sats 100% RA

CVS

- Warm + well perfused
- Pulse 70 bpm reg (N character + rate).
- JVP not raised
- Apex undisplaced HS I + II + 0
- 0 ankle oedema.

RS

- Trachea central
- CE (N)
- Vesicular BS
- 0 added sounds

GIT pregnant abdo

- 0 masses
- Soft non tender
- 0 organomegaly.
- BI ✓ + (N)

CNS

- PERL
- Sensation (N)
- Motor

	RUL	LUL	RLL	LLL
T				
D	5/5	5	5	5
R				

- Normal DTR
- CN II - XII intact.

Impression:

Simple paraparesis?

Plan

① FBC ☐

② U+E ☐

③ Bloods - RBS/creatinine/

④ ~~LFTs~~ ? DIC

⑤ Renal USS ✓ Maybe CXR

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

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

DISCHARGE PRESCRIPTION PACKS

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

HUGHES, LISA ID: 000958480 28-Dec-2004 23:03:29 SOUTHERN GENERAL HOSPITAL

17-Jan-1980
Female Caucasian

Loc: 12

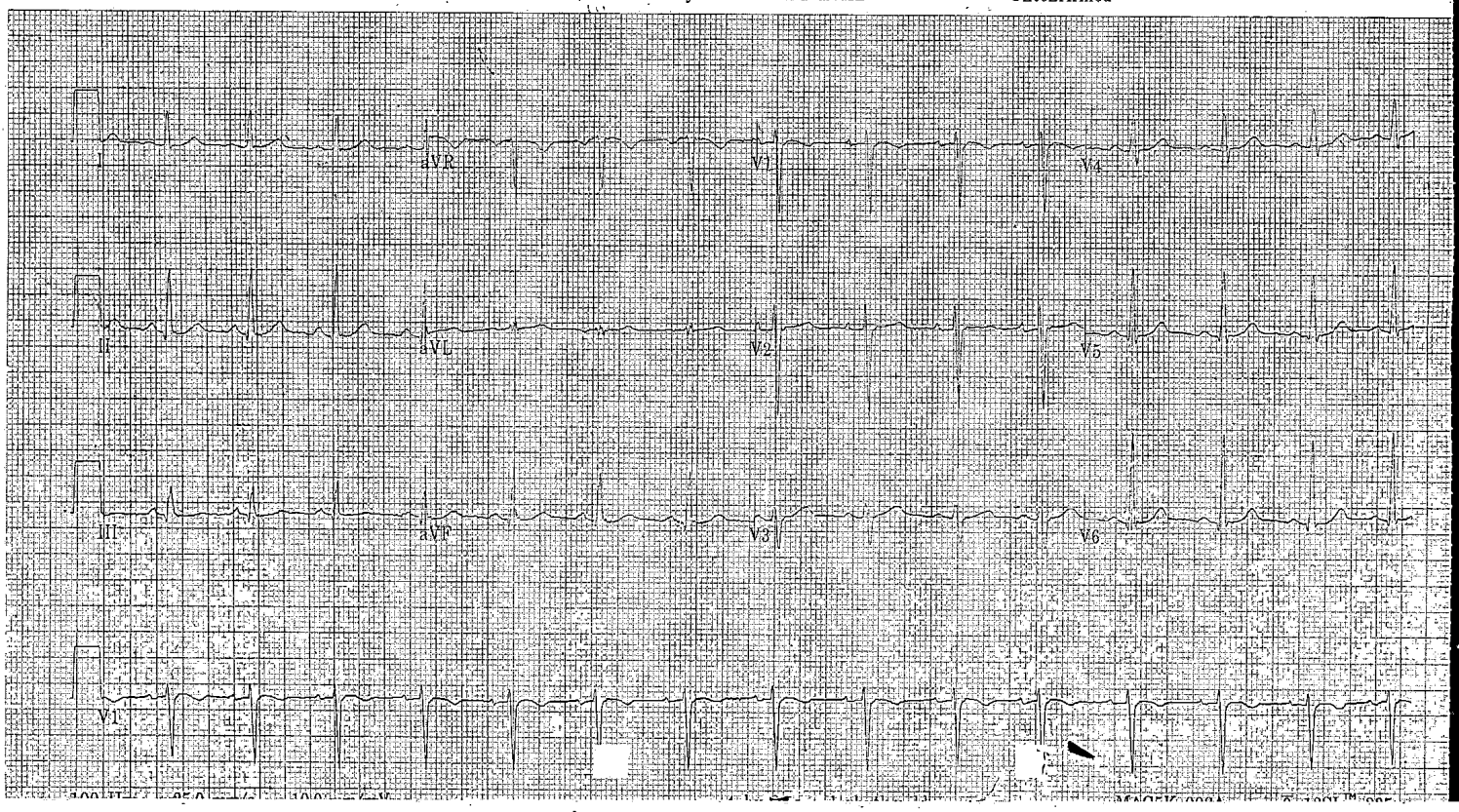
Vent. rate	89	bpm
PR interval	144	ms
QRS duration	88	ms
QT/QTc	354/430	ms
P-R-T axes	69 55 44	

Normal sinus rhythm
Normal ECG

Technician: N
Test ind: COLLAPSE

Referred by: DR LESLEY HALL

Unconfirmed



DOCTOR'S LETTER SHEET

UNIT NUMBER

KM/JG/0953485

4th October 1999

Dr R Jamieson
Registrar to Dr RJS Hawthorn
Dept Obstetrics & Gynaecology
Southern General Hospital
GLASGOW

Dear Dr Jamieson

LISA PERCY – DOB 17.01.80
0/2 BARSHAW ROAD, GLASGOW G52 4EE

Thank you for referring this 19 year old girl who is currently 15 weeks pregnant who complains of a pruritic eruption localised mostly to her legs which is aggravated by soap and worse at night time. She has a previous history of asthma and a family history of eczema.

On examination she has dry erythema of both posterior shoulders. She has excoriations and diffuse crusted eczema on her legs. She admits to frequent shaving of the full length of her legs using copious amounts of shaving foam.

I have suggested that she discontinues this meantime. I have given her some general advice regarding skin care and suggested she should use Diprobase emolient at least twice daily and Fucibet cream twice daily to the crusted itchy infected areas.

I have not arranged any routine review but would be happy to see her again if required.

Yours sincerely

KIRSTEEN MILLER
Clinical Assistant

Copy: Dr Treadgold, Pollok H/C, 21 Cowglen Road, Glasgow G53

DOCTOR'S LETTER SHEET

UNIT NUMBER

RP/MS/953485
Direct Line: 0141.201.1401

Dictated: 19 June 1996
Typed: 24 June 1996

Dr Treadgold
Pollok Health Centre
21 Cowglen Road
Glasgow
G53

Dear Dr Treadgold

LISA PERCY, 63 BARSHAW ROAD, G52 4EE
D.O.B. 17.1.1980

This young girl was admitted with alcohol intoxication. She had apparently taken one and a half bottles of vodka.

I am glad to say she made an uncomplicated recovery from the alcohol intoxication.

Yours sincerely

RICHARD PARK
CONSULTANT PHYSICIAN

Admitted: 16 June 1996
Discharged: 17 June 1996
Diagnosis: Alcohol intoxication
Drugs on discharge: None
Follow-up: None

DTR 4/10 · e 2.45

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST 953485
DIRECTORATE OF OBSTETRICS, GYNAECOLOGY & PAEDIATRICS GmI

Dr Wm C M K Naismith
Dr Matt J Carty
Dr Valerie D Hood
Dr Robert J S Hawthorn
Dr Ian N Ramsay
Dr Douglas Mack
Dr Andrew Kraszewski
Dr Neil McDougall

1345 Govan Road
GLASGOW
G51 4TF
Tel: 0141 201 1100
Fax: 0141 201 2994
Secretary: 0141 201 2236
(Dr Hawthorn's Secretary - Carole)

RJ/CJC/953485

TRACING SECTION
22 SEP 1999

14/09/99

Dr Dai Roberts
Consultant Dermatologist
Dermatology Department
Southern General Hospital NHS Trust

52293.
TREAD(-ery)

Dear Dr Roberts

LISA PERCY - DOB 17.01.80
0/2 63 BARSHAW ROAD, GLASGOW G52 4EE

I would be grateful if you could see this 19 year old girl who is currently 12 weeks pregnant. She was seen in the ante-natal clinic complaining of an itchy rash over her lowed limbs which she says is driving her mad. She is otherwise fit and well and has no significant past medical history.

On examining her she has what looks like a contact dermatitis rash for which she is currently using Calamine lotion.

I would however be grateful if you could see her and confirm this and offer any further medication that she could take during her pregnancy.

Yours sincerely

R JAMIESON
REGISTRAR TO DR R J S HAWTHORN

4/10/99

NHS TRUST

0953485
PERCY LISA
FLAT 0/2
63 BARSHAW ROAD
GLASGOW 17/01/[redacted]
G52 4EE CHI 17018[redacted]

DERMATOLOGY DEPARTMENT

DATE 4 OCT 1999

HISTORY

194R ♀ 15/40.

rash legs - flared dmg pregnancy.

Itch ++ aggravated by soap worse at

sun in 1st pregnancy night-time

GP - bath emollient

Asthma as a child. No prev. Hx skin disease

FH - eczema.

19/12 daughter. PMH NIL DHx NIL.

NKA.

EXAMINATION

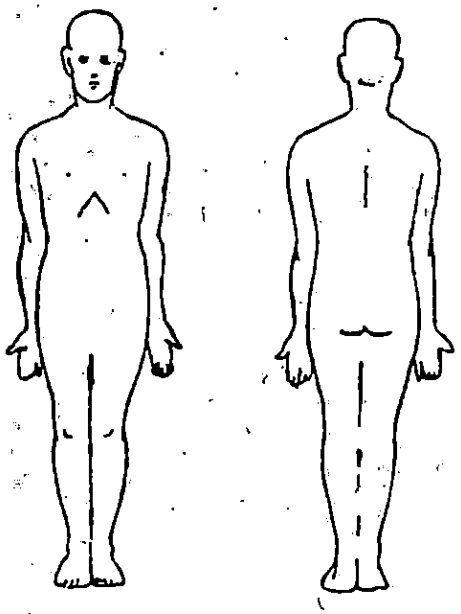
excoriations

dry eczema shoulders

crusted eczema - diffuse

legs

(showed full length legs)



DIAGNOSIS ECZEMA

INVESTIGATIONS Diprobase 500g

Fucibet cm 60g BD.

Stop shaving meantime

Advice

TREATMENT

UNMED

UIN ASSISTANT

ACCIDENT / EMERGENCY FORM **TREATMENT CARD**

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

(1)

AE No. 16 15GC1

SURNAME	FORENAMES
PERCY	LISA

ADDRESS: 63 BARSHAW RD GG

POST CODE	TELEPHONE No.	DATE OF BIRTH	SEX	MARITAL STATUS	RELIGION
G52 4AE		M. / 80	F	S	CofS

NEXT OF KIN NAME	RELATIONSHIP	FAMILY DOCTOR SURNAME	INITIALS
JAMES.	DAD	TREADGOLD	

ADDRESS	ADDRESS
S/A	P. H.C.

POST CODE	TELEPHONE No.	POST CODE	TELEPHONE No.
	/		

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

TIME OF ATTENDANCE: 8.30

MODE OF TRANSPORT
AMBULANCE _____ PUBLIC _____ OWN _____ NONE _____

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

ROAD TRAFFIC ACCIDENT PLACE

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

REASON FOR ATTENDANCE: C2H5OH INTOX / UNCONSCIOUS

	TIME
TRIAGE	
DOCTOR	2100
NURSE	
LEFT DEPT.	

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

Dear Doctor,

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

Diagnosis: ALCOHOL INTOX

X-Ray film / ECG shows 1

Treatment given: IVN + 5/0

Drugs _____ days supply of _____ has been given.

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

Would you please arrange _____

(5) **DISCHARGE CODES:** Please Circle

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

Ward No. (if admitted)	Transfer to Hospital	Consultant (if admitted)
20		

Follow Up	Not arranged	Arranged	To be arranged

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

Medical Officers Name (In Block Letters) RJ

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

Signature of Medical Officer

SGH 458 0431551

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

DO NOT WRITE OR LEAN HERE PLEASE !

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

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

DISCHARGE PRESCRIPTION PACKS

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

TRIAGE NOTES
R _____ BP 98/55 P 95 T _____ BM 5-8 SpO_2 96% on air Expected PEF _____ PEF _____

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

Drunk bottle of Vodka in Park today ? taken drugs
Unresponsive. Passed out in friends house.
Pupils 3 = and react.

M Shallcross

CONSULTANT Carey SEEN BY Tobin AT (TIME) 2100

DATE	CLINICAL NOTES
16/6/96	Ukranian patient No fam parents. Drinking 1½ litre bottle of Vodka today. walked to a neighbours house where she collapsed on floor. No evidence of injury. PMH /asthma DH/SH Ventolin Lorazepam No known allergies

OPEN BEFORE WRITING

DATE	CLINICAL NOTES

6/6

GCS now 7/15. E$_1$M$_2$V$_4$.

PERLA. Gag reflex Corneal reflex present

Motor

	(R)	(L)
Biceps	-ve	-ve
Triceps	-ve	-ve
Knee	-ve	-ve.
Ankle	+	+
Plantars	↓	↓

P. Sylvia regular BP 95/55

HSI + II - 10 ml added.

Trachea + IV removed-

Chest clear.

Lung

Alcohol intoxication — ? Cause.

Admit. Medicine 2D.

U+E, glucose, Paracetamol + salicylate levels

Tutor (Print)

SOUTHERN GENERAL HOSPITAL

5

Lisa Hughes
17.1.80

E.N.T. DEPARTMENT

DIAGNOSIS: 1.

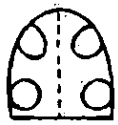
2.

WAITING LIST FOR:			
DATE OF ADMISSION			
DATE OF DISCHARGE			

HISTORY:

17.1.05
Lt ear & hearing following fall on 22.12.04

NOSE:



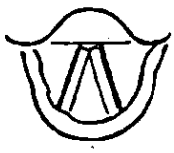
NASO-PHARYNX:

PHARYNX:



MOUTH:

LARYNX:



RIGHT EAR:



LEFT EAR:



	RIGHT	LEFT
WHISPERS		
CONVERSATIONAL VOICE		
LOUD VOICE		
RINNE		
WEBER		
BONE CONDUCTION		
AUDIOMETER TEST		
LABYRINTH TEST		

PROGRESS NOTES:

OP
Lt ear



~10-25% perf.
Clean

R TM N/A

Review 6/52

M+A

? myringoplasty

DATE	TREATMENT, CLINICAL and OPERATION NOTES	DATE	TREATMENT, CLINICAL and OPERATION NOTES

Call No:	1310311	Date : 28 Dec 2004	NHS 24 No:
Patients Name:	LISA HUGHES	D.O.B. Age 17/01/1980 24 Y	Callers Name

Address Today:	5 MOSSVIEW QUAD Glasgow	Home Address if different
Post Code:	G52 2TU	Post Code:
Phone Number	() - Home	Call Type Walk In
Name of GP:	Treadgold NJ	Time Call Received at NHS 24: 00:00
Surgery	408Pollok Health Centre	Time Details Received at GEMS: 19:58
Practice Number	408	Time Patient Arrived: 19.58
Fax Number	01415316866	Consultation Start time:
Speed Dial	024V	Consultation End time:
Dispatched To	CARDONALD	

Clinical Information

PASSED OUT FOR ABOUT 15 MINS PAIN IN LEFT EAR NOW WORSE

headache 3/7

Episode of LOC today. PMH 10/52.

C/o dizzy spell → LOC. ? sphinc dist ? ? ?

LISA HUGHES
SG00953485
17/01/80 F
Date_____ Time_____
Spec./Sig._____

CLINICAL NOTES

DATE	
28/12/14 1040	medical 8th (HMO) thanks letter. Gone referral of 24 yr ♀ collapse
HPC	10–12 weeks pregnant 3 5th child. Usually female ++ during pregnancy "faint" earlier today whilst @ home WC per HPC. fell → ⓒ ear, ?tho' ? head injury felt something pop v. well since apart from ↓ hearing in ⓛ ear. ? discharge from ear @ time of fall: ? recent perforations (in past) SOB.
MMH	nil ⓛ hearing OSE Then ⓒ Rx's Relpax ? dose ? rate
DH	?
SH	Smoker 10/day, ?alcohol.
ⓞ/E	v. well: ?Anxious. ?evidence HI Resp 36↑ BP 133/67 HR 94 reg Sat 99% RA
	PM ⇐ HS III to ?vertigo ?cardiac chest clear & good HS. Abd soft, non-tender.

DATE | CLINICAL NOTES (Continued)

FEBRILE FUNDI ~ (N) Shall
FROEM ear/Drain.
Bilateral deafness (C) ear → Cardinum wheel
CN otherwise WNL red rim around it. Washed tendons

Pure tone Sensori neural (N).

CT SK (89) (N) ear: OST (T wave ↓s

Impression: Sensorineural (fund → bacteriuria
to (C) ear.

Plan: Admit (H). Dr Ahmed
8103 2832

Dr to Sth.
Pt feel possibly
small perforation of
Lower (C) eardrum
: advised to keep ear
dry + clean + should
resolve spontaneously Dr

D/W ENT, advise R/V ENT clinic
next Wednesday.

Lisa Perry

CLINICAL NOTES

DATE	(16)
16/6/96	F ? alcohol intoxication
11.05pm	unconscious
	No history available
	No family members around
	Hx from A&E notes - brought in by father
	? took 1½ bottle of vodka
	walked to a neighbour's home + collapsed.
	No relatives attended WA20 - left pt in
	casualty - did not think any drugs
	were taken.
	PMH asthma.
	Drugs. ventolin / Seretide inhaler
	No known allergies.
	GE unconscious
	responds to pain
	Afebrile
	BP - 98/55
	P.R 80/m regular.
	pupils dilated + equal in size
	reacts sluggishly to light
	No neck stiffness
	fundi - No papilloedema
	Sag Reflex present (tested A&E)

DATE | CLINICAL NOTES (Continued)

tone - flaid all limbs
power - unable to assess
Reflexes - generally areflexia
Plantars ↓ ↓

JVP →
S1 S2 +0
° murmurs

Chest - trachea 5
AE all areas.
BS resonant.

Abdo
soft
non tender.
no masses
BSV.

A (16) Brought in unconscious : alcohol + overdose : drug abuse.

Na 131 FBC. Bm stix 5.4 mmol.
K 3.7 U+E treat + BS.
Cl 98 paracetamol level
HCO_3 32 salicylate level.
Urea 1.9 urine for drug screen.
Creat 68 Neuro obs.

AZ

SOUTHERN GENERAL HOSPITAL
NHS TRUST

7

LISA PERCY

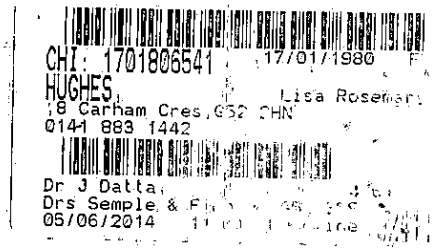
CLINICAL NOTES

DATE	
17/6/96	Alcohol intoxication..
	Better today
	No focal CNS signs
	RV
17/6	well
	Agreed
	D
	RV

DATE	CLINICAL NOTES (Continued)

DRS SEMPLE / FINNEY & DATTA
CARDONALD MEDICAL CENTRE
1831 PAISLEY ROAD WEST
GLASGOW
G52 3SS

TEL: 0141 892 2548 / 0141 211 6666



5/6/14

Receiving Physician

Thanks for seeing this 34 yr old lady with sudden onset (L) sided pleuritic pain since 5 am today. She attended A+E 2 days ago with a query exacerbation of asthma (moderate). She has SOB, dry cough using ventolin

O/E sats 96%. chest clear
HR 110
BP 102/69
PEFR 310

Imp PE ?? .. or muscular chest wall pain

PMH/Meds see summary enclosed

Thanks for seeing her.

Yours sincerely, Julia Datta

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1701806541

Southern General Hospital

Total Att: 4

12 Mth Att: 3

Title: **MS**

HUGHES **Lisa Rosemary**

DOB: **17/01/1980** Age: **34y** Sex: **Female**

8 Carham Crescent
Glasgow
Lanarkshire
G52 2HN
0141 883 1442

Next of kin: **HAUGHEY, AGNES**
Relationship: **Mother**
07769815357

GP: **AA Finney**
0141 892 2548

54kg

Attendance Date: **05/06/2014** Arrival Time: **13:08**

Registration Time: **13:08** Date of Incident: **05/06/2014**

Major Incident Desc:

Reason for Attendance: **gp ref for medics**

Affix Label

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint: **Respiratory Shortness of Breath**

Observation Date: **05/06/2014 13:13**

Temp	**35.6**	C
HR	**124**	bpm
BP	**108/60**	mmHg
MAP	**76.00**	mmHg
RR	**23**	bpm
SpO2	**92**	%
Oxygen		%

Nurse name: **Nurse Karen Bowden**

BM		mmol/L
PF	**340**	l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **R/P known asthmatic pt presents with several hour hx sob and associated left sided back/chest pain. Attended dept 2/7 for same.**

Date	Emergency Department Notes	
	Seen by (Doctor) GLHOLLOW (GPST)	Time seen 13:30

(34) Re-presents (GP referral) from 24 ago.

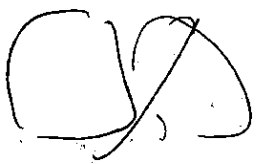
+ → Known asthmatic.

→ Few day hx of ↑ SOB/wheeze. Has had dry cough for 2/12. No sputum. No fevers.

→ Has had few days of anterior chest pain but at 5am this morning developed severe (L) posterior back pain, pleuritic in nature. Has taken Ibuprofen.

→ Hypoxic on arrival (92 on RA). Tachy 124 bpm. PEFR 340 (expected 500) RR 23 Apyrexial.

O/E (with 2L O_2) RR 23 Sats 100 on 2L O_2.
HR 96. Alert. Warm well perfused. Speaking full sentences.
BS 7+11+0



clear to wheeze, good air throughout. RV resonant. Trachea central. Tenderness to palpation (L) posterior chest wall. No bruises.

Abdo SNT.
Calfs SNT.
CVS - SR

Imp/ Hypoxic, tachy but no wheeze + (N) PEFR.
? PE. ? pneumothorax 2° to cough.

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

(9) IV access - wide bore
bloods
ABG - on 2L O_2 - H+ 31 PCO_2 3.2 PO_2 17 (was hyperventilating ++ due to fear of needles)
CXR - no pneumothorax
dalteparin
admit medics - thankyou.

Differential Diagnosis/Problem List		
	SEWS ☐	0-7
	RED FLAG ☐	(Tick)
	SIRS ☐	
	CURB 65 ☐	

Done/ completed	Imediate Managment Plan

Signature: Designation: Page No:

Acute Medical or Surgical Admission Unit Notes

Please affix patient ID label here

Initial Assessment: G. WALSH

Seen by (print):

Time seen: WARD 20. 5/6/14. 19-35

Presenting Complaint

34 f. - SOB.

History of Presenting Complaint

Worsening cough for 2/52. worse on lying flat.
- Assoc. nocturnal SOB.
- Seemed to follow episode of tonsilitis.
- recently had doors / skirting boards replaced → dust. HH.
- No sputum / haemoptysis.
- Sharp post. CP since 05.00. - woke with pain. Worse with cough / insp. No calf pain / swelling.
- No Asthma. exacs since childhood exercise.
- Pt. knows what ⓥ causes exacs but life stresses HH (daughter recently sexually assaulted + School troubles)

Past Medical History

Asthma. - childhood.

Thyroidectomy - follicular adenoma

Permanently disabled.

Systemic Enquiry

Allergic to cats → has cat.

CVS - nil.

RESP

GI nil.

CNS/PNS

GU nil.

Musculoskeletal - frequent distal paraesthesia + arm cramps (pre. thyroidectomy).

MEDICINES RECONCILIATION (ECS can be stapled here and annotated with plan for medicines. Please sign medicines plan.)

Source of medication history: Patient ☐ Relative/ carer ☐ GP Surgery ☐ ECS ☐
PODs ☐ Com. Pharmacist ☐ GP letter ☐ Rpt Presc ☐

Admissions medicines				Plan for medicines			
Name	Dose	Frequency	Continue	Stop	Amend	Hold	Comments/ reason
Levothyroxine	200mcg	od.	✓				
Olanzapine	10 mg	nocte.	✓				
Diazepam	5 mg	TDS.	✓				(WEEKLY DISPENSE)
Cetalopram	20 mg	OD	✓				
Salbutamol	2	PRN.					

Allergies	Medication needs
None known ☑	Further clarification? Yes ☐ No ☐
Completed by:	Designation: Date:

Drugs prescribed on admission checked and correct

Compliance aid? Yes ☐ No ☐

Comments:	Community Pharmacist
C/W ECS Pt not available ☐	

Reviewed by: [signature] Designation: PHARMACIST. Date: 6/6/14

Affix patient ID label

Social History

Smoking History: 15/day.

Alcohol History: nil.

Other drug use?:

Home circumstances

Unemployed
looks after ♀. 8 children

General Examination

Temp: 35.7	RR: 14.
Pulse 104.	BG:
SpO2: 97% on 2L.	Weight:
BP: 108/60.	Urinalysis:

Cardiovascular Examination

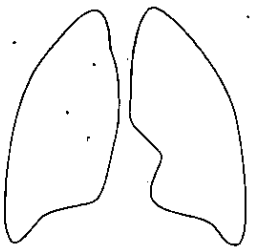
Caches SNT.
JVP ↔
HS I + II +o

General Observations

looks well.

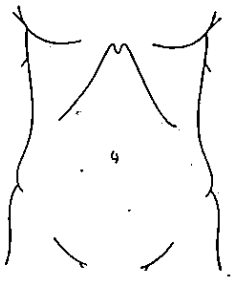
Respiratory Examination

Good A/E
nil added



Abdominal Examination

SNT
BS (N)



Neurological and Other Examination (e.g. locomotor)

Cranial Nerves

GCS: E: M V: TOTAL

AMT ☐

Fundoscopy:

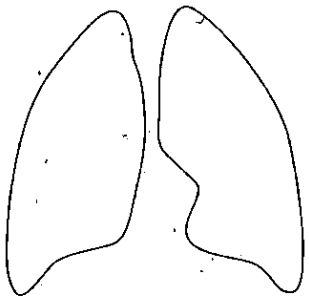
Upper limb neurological examination

Lower limb neurological examination

Other Post. (L) thoracic pain recreated by use of (L) arm.

Key Results: (N) Peak flow - up to 250

CXR: No obv. pneumothorax / consolidation



Urinalysis: Today 3+0.

ECG: Sinus tachy. QTc 453

Differential Diagnosis/Problem List

(1) Likely worsening of asthma symptoms with MSK chest pain + infective component.

(2). Given lack of chest signs, pain + ↑-D-Dimer → r/o VTE. (+ ↑ HR, ↓ SpO2).

(3). distal paraesthesia. / cramps.

SEWS ☐ 0-7

RED FLAG ☐ (Tick)

SIRS ☐

CURB 65 ☐

Immediate Management Plan — ?	Date/ Ordered	Checklist
(1) LMWH.		Medicines plan documented ☐
(2) ? V/Q, ? CTPA. - d/w radiology.		Blood results received ☐
(3) Monitor peak flow.		Kardex ☐
(4) Course of oral steroid — Add Step 2 inhaler		Antmicrobials as per Policy Yes ☐ No ☐
(5) Nebs PRN.		If 'No' state reason:
(6) Abx.		
(7) Smoking cessation team — keen to stop.		
(8) Avoid NSAIDs — taking prior to admission		
(9) Check Catt. / Weight		
(10) ? o/p PFTs		DVT prophylaxis indicated Yes ☐ No ☐
(11) Atypical screen		
		DVT prophylaxis prescribed Yes ☐ N/A ☐

Doctor Completing Initial Assessment

Name (print): G. MAYLOR Signature: G Maylor Designation: CT2

Page No.

Please affix patient ID label here

Secondary or Senior Focused Review

Seen by (print):

Time seen:

Done/ completed	Continuing Managment Plan

Doctor Completing Initial Assessment

ture:

Designation:

Page No.:

Hyperventilating

Patient Sample Report

Patient

ID:	1701806541
Last Name:	**HUGHES**
First Name:	**LISA**
Gender/Age:	Female, 34 years
Birth Date:	17.01.1980
Status:	**ACCEPTED**
Analyzed:	05.06.2014 13:55:09
Sample Type:	**Arterial**
Sample Number:	on 21 Q
Clinician:	
Operator ID:	G HADDEN

Analyzer

Model:	GEM® *Premier 4000*
Area:	SGH ED
Name:	RESUS
S/N:	08061612

Measured (37.0°C)		
cH	↓ 31.2	nmol/L
pCO_2	↓ 3.2	kPa
pO_2	↑ 17.2	kPa
Na^+	139	mmol/L
K^+	3.8	mmol/L
Cl^-	107	mmol/L
Glu	↑ 5.4	mmol/L
Lac	↓ 0.9	mmol/L

CO-Oximetry		
tHb	12.8	g/dL
O2Hb	↓ 93.9	%
COHb	↑ 4.4	%
MetHb	0.5	%
HHb	1.2	%
sO_2	↑ 98.7	%

Derived		
BE(B)	↓ -2.2	mmol/L
HCO_3^- (c)	↓ 19.2	mmol/L

Operator Entered		
Temp	37.0	°C

O2 and Vent Settings

FIO

Senior Doctor Review

Seen by (print): MCRAE

Time seen:

WD20 6/10/14 1115

Please affix patient ID label here

34 ♀ ① Asthma ③ Thyroidity → Follicl Adenoma
② Personality Disorder

⇒ Parents with patient ① told story pain left to then spine
Tend to tell heaven but SOB = pant more SOB on movement.
On admn ↑ HR = ↓ sats.
Exam Card → ° Spinal tenderness ° calf pain
BP 123/67 P103 Ant 98.1a T35.8C RR 16
CVS → hs pn Chest  CXR  Sats 98% RA
Tele Kelly ① putt dc will. CXR Res → 9/5
Lyprem Kelly needs CPE UTI heaven calls PTE

DVT Prophylaxis indicated	Yes ☑ No ☐	Antimicrobials choice compliant	Yes ☐ No ☐
DVT Prphylaxis prescribed	Yes ☑ N/A ☐	If 'No' state reason	
Medicines Reconciliation completed	Yes ☑ No ☐		

Done/ completed	Continuing Managment Plan
①	dalteparin CTPA. ↓ prophylaxis re
②	resp analysis
②	card enzymes 6 hrs
	Asthma ② sent Kelly + chest re

Signature: Designation: Page No:

Please affix patient ID label here

Continuation Sheet

Date: Time
3/6/14.

WR
No PTB on CSPA
— rib # seen
— denies trauma

No breast lumps
No red flag symptoms of dysmo

→ OP DEXA + isotope bone scan

→ D. here w/ analgesics
→ D ched Ca 2+/vit D.

WRWOTC

Continuation Sheet

Date: Time	

Please affix patient ID label here

Continuation Sheet

Date, Time

Continuation Sheet

Date: Time

PLEASE DO NOT WRITE HERE

Attach GP Letter, Results or Emergency Care Summary

Serial Blood Results								
	Date:	5/6/16.						
	Time:							
	Signature:							
Sodium	135 - 146	138.						
Potassium	3.5 - 5.3	4.0.						
Chloride	95 - 108	111						
Urea	2.6 - 7.8	2.0.						
Creatinine	40 - 130	57.						
Estimated GFR		>60.						
Bicarbonate	22 - 29							
Glucose	3.5 - 6.0							
CRP	0 -10	34						
Magnesium	0.7 - 1.0							
Calcium	2.2 - 2.6							
Calcium Adj	2.2 - 2.6							
Phosphate	0.8 - 1.5							
Cardiac Enzymes & Liver Function Tests	**Normal Values**							
Troponin	<0.04							
CK	<150							
Amylase	0 - 100							
ALT / AST	0 - 50	13/16.						
Gamma-GT	0 - 70							
Alk Phos	30 - 130	53.						
Total Bilirubin	0 - 20	7.						
Albumin	35 - 50	36						
Haematology & Clotting Screen	**Normal Values**							
White Blood Count	4.0 - 11.0	15.2						
Haemoglobin	115 - 165	132.						
Haematocrit	0.370 - 0.470							
MCV	80 - 100	89.						
Platelet Count	150 - 410	303.						
Neutrophils	1.8 - 7.7	11.0.						
Lymphocytes	1 - 4.8							
Prothrombin Time	9 - 13							
PCT Ratio								
APTT	27 - 38							
APTT ratio	0.8 - 1.2							
Thrombin Time	10 - 16							
TCT Ratio								
Arterial Blood Gas	**Normal Values**							
H+	36 - 43							
PCO_2	4.5 - 6							
PO_2	10.5 - 13.5							
Base excess	+/- 2.5							
Bicarbonate	20 - 28							
FIO_2 (Inspired Oxygen)								
Other								
0-0 iuse		272						
TFT = (N) in April.								

Emergency Department Nursing Documentation

Done/Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

e Given	Drug (Block Capitals)	Dose	Method of administration	Time of administration	Signature	Given by
5/6/14	DALTEPARIN	10000 units	SC	1485 -		CC

Discharge prescription packs

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by

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

Time Ready to Depart:
Discharge Time:

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

Outpatient clinic specialty | Admission or specialty clinic consultant

Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

FREQUENCY

SOUTHERN GENERAL HOSPITAL
SPECIALITY NHS TRUST

TEMPERATURE/CVP/
RESP/PULSE/BP. CHART

8A

NAME Lisa Percy AGE UNIT NO.

DATE 16/6

DAY

TIME 0-24 22 30 2016

NOTES

TEMPERATURE

BLOOD PRESSURE

PULSE

CVP/RESPNS.

41 40 39 38 37 36 35 — 170 160 150 140 130 120 110 100 90 — 80 70 60 50 — 40 30 20 10 0

240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0

INCIDENTS
DRUGS ETC.

On admission

SOUTHERN GENERAL HOSPITAL NHS TRUST
INSTITUTE OF NEUROLOGICAL SCIENCES, GLASGOW
OBSERVATION CHART

SGH 172

AME Lisa Percy

ECORD No.

DATE 16/6/96 17/6/96.

TIME 20 21 22 23 00 02 / 45 00 30 70 30 30

Eyes open
- Spontaneously
- To speech
- To pain
- None

Eyes closed by swelling = C

Best verbal response
- Orientated
- Confused
- Inappropriate Words
- Incomprehensible Sounds
- None

Endotracheal tube or tracheostomy = T

Best motor response
- Obey commands
- Localise pain
- Flexion to pain
- Extension to pain
- None

Usually record the best arm response

1 2 3 4 5 6 7 8

upil scale m.m.)

240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

Blood pressure and Pulse rate

Respiration

40 39 38 37 36 35 34 33 32 31 30

Temperature °C

PUPILS

		20	21	22	23	00	02
right	Size	3	4	4	4	5	3
	Reaction	+	+	S	+	+	+
left	Size	3	4	4	4	5	3
	Reaction	+	+	S	+	+	+

+ reacts
– no reaction
c, eye closed

LIMB MOVEMENT

ARMS
- Normal power
- Mild weakness
- Severe weakness
- Spastic flexion
- Extension
- No response

LEGS
- Normal power
- Mild weakness
- Severe weakness
- Extension
- No response

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

NHS Greater Glasgow

SOUTH GLASGOW UNIVERSITY HOSPITALS DIVISION

PATHOLOGY DEPARTMENT

CPA ACCREDITED

Name:	HUGHES LISA	Hospital No:	SG00953485
Address:	5 MOSSVIEW QUADRANT	CHI No:	1701806541
	FLAT 2/2	DoB:	17.01.80
	G52 2TU	Consultant:	Miss.L.Clark
Location:	Ear,Nose,Throat OPD, Vict		

Specimen: **FNA – thyroid Site not indicated**

CLINICAL HISTORY:
Multinodular goitre. Nil suspicious on ultrasound.

MACRO:
Three air dried, three wet fixed slides and a saline washout are received.

MICROSCOPY:
Microscopy shows blood, colloid and numerous groups of follicular epithelial cells, some of which have a Hurthle cell morphology. There is moderate nuclear pleomorphism and microfollicular structures are seen. There are no nuclear features to suggest papillary cancer. The appearances are consistent with a follicular lesion.

SUMMARY:
Thy 3.

Reported 01/9/08 GB/SKR

Electronically authorised by Dr G Bryson.

Reporting Pathologist:	Dr.G.W.Bryson		Page 1 of 1
Consultant Pathologist:	Dr.G.W.Bryson		
Date Received:	29.08.08	Lab No:	N,08.0002360.G
Date Typed:	02.09.08		

NHS Greater Glasgow

SOUTH GLASGOW UNIVERSITY HOSPITALS DIVISION
PATHOLOGY DEPARTMENT

CPA ACCREDITED

Name:	HUGHES LISA	Hospital No:	SG00953485
Address:	5 MOSSVIEW QUADRANT	CHI No:	1701806541
	FLAT 2/2	DoB:	17.01.80
	G52 2TU	Consultant:	Miss.L.Clark
Location:	Ward 62 SGH		

Specimen: **TOTAL THYROIDECTOMY**

CLINICAL HISTORY:
Total thyroidectomy for THY 3 follicular lesion.

MACRO:
A: Tissue - right inferior
A yellow-grey fragment 5 x 3 x 2mm (submitted for frozen section).

B: Thyroid - total
A total thyroidectomy, the right lobe 35 x 30 x 25mm, the isthmus 28 x 25 x 15mm and the left lobe 35 x 25 x 15mm (total weight 32 grams). Sections show three well cirscumscribed nodules, as follows:
A 28mm nodule in the right lobe.
A 15mm nodule in the right lobe.
A 23mm nodule in the isthmus.
(All three nodules submitted for frozen section).

C: Tissue - further right inferior
A soft yellow/white piece of tissue 5 x 2 x 2mm.

MICROSCOPY:
A: Sections show a lymph node with reactive features. This confirms the frozen section diagnosis.

B: Sections show three hyperplastic nodules. This confirms the frozen section diagnoses of follicular lesions. Within the nodules and in non-nodular thyroid parenchyma, there are scattered aggregates of lymphocytes, some including germinal centres. The appearances are suggestive of auto-immune thyroiditis. There is no evidence of malignancy.

C: Sections show a lymph node with reactive features only.

SUMMARY:
1. Multiple hyperplastic nodules of thyroid.
2. Auto-immune thyroiditis.

REPORTED 22/6/09 DRM/JMC

Seen 25/6/09

Reporting Pathologist:	Dr.D.R.McLellan		Page 1 of 1
Consultant Pathologist:	Dr.D.R.McLellan		
Date Received:	09.06.09	Lab No:	T,09.0009273.V
Date Typed:	24.06.09		

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address

1701806541 17/01/1980
HUGHES
Lisa Rosemary

CHI No:
DoB

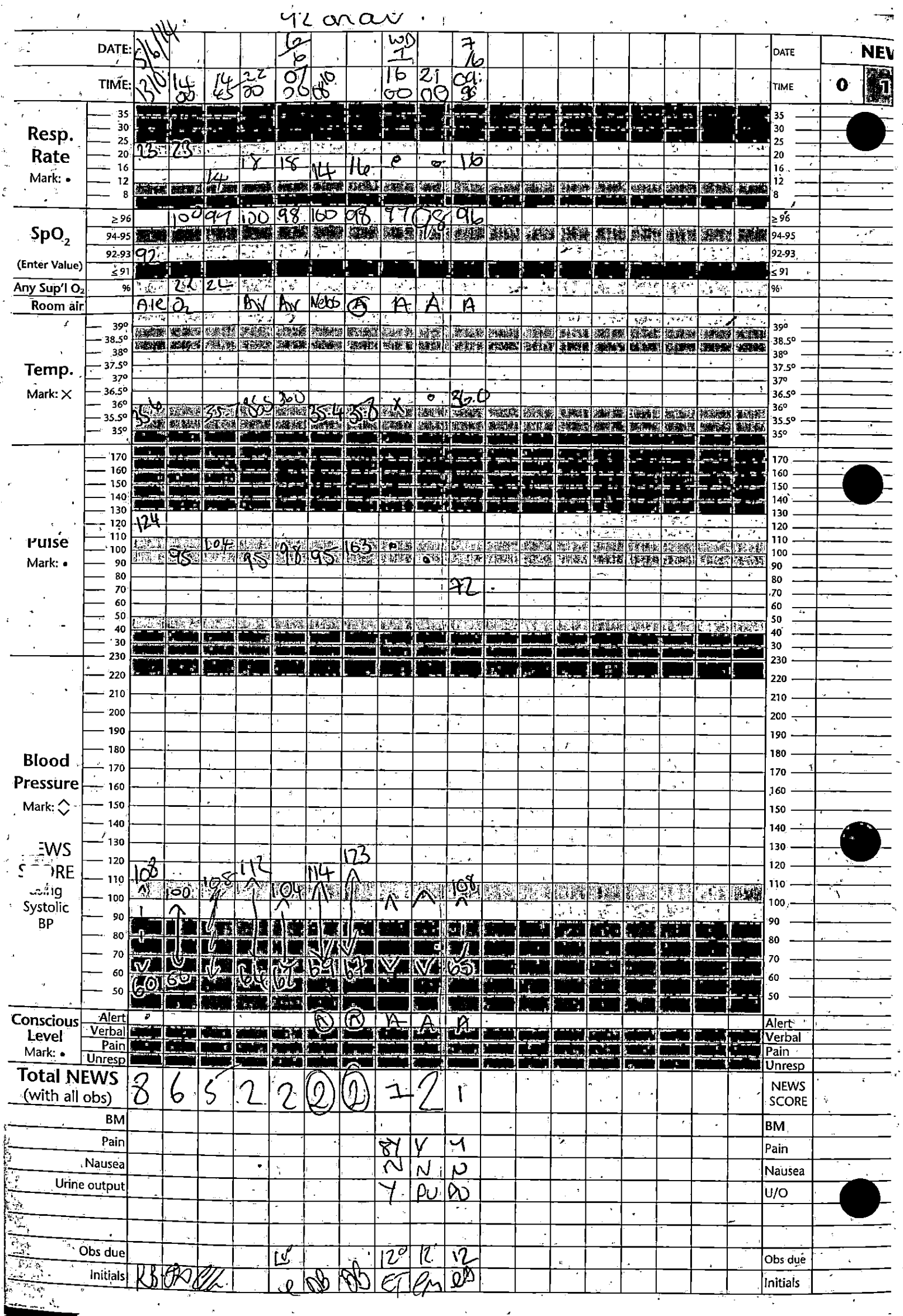
	Date	Ward
Admitted		
Transferred		
Transferred		

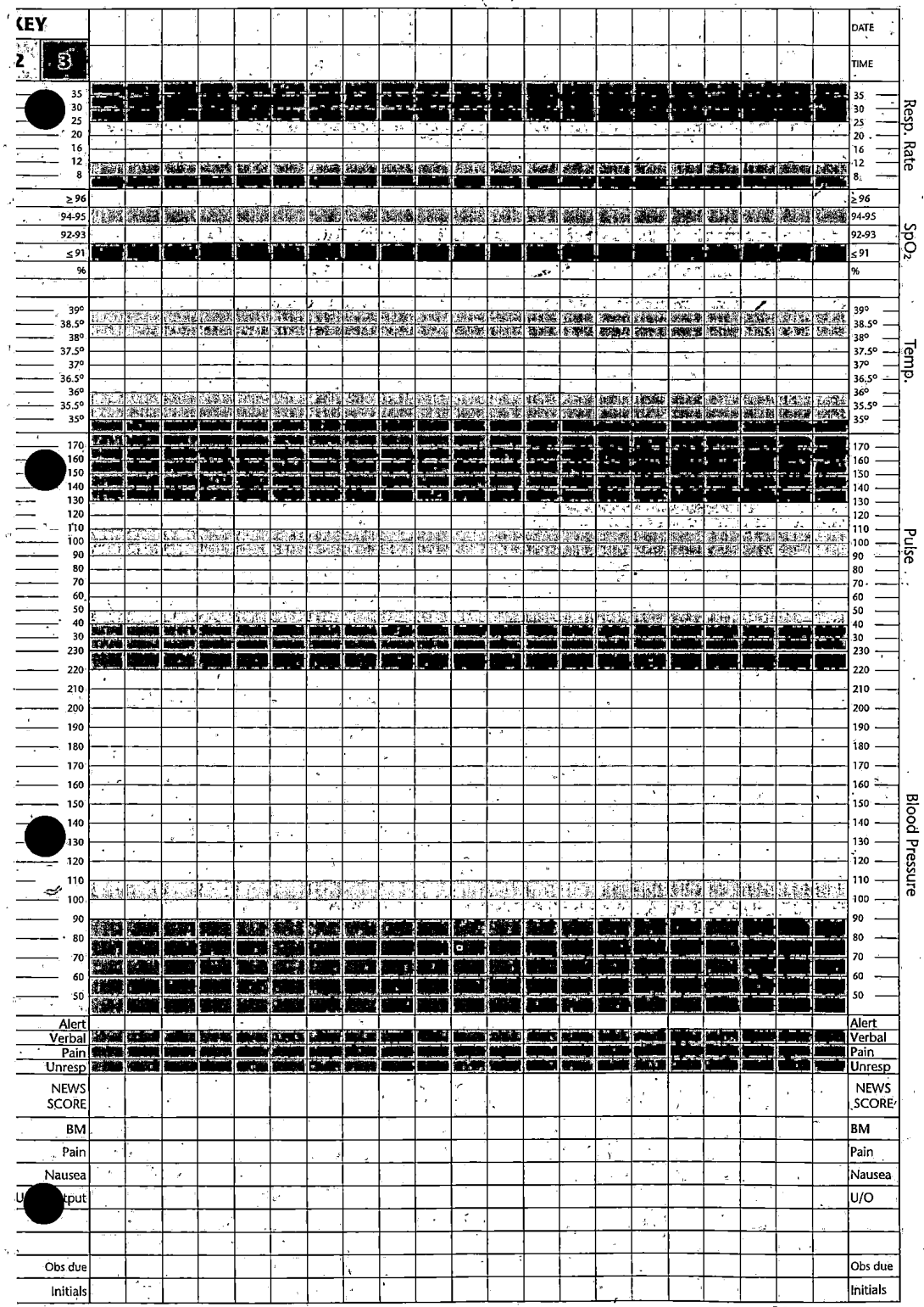
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

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 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • 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. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE
TIME
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: ×
Pulse
Mark: •
Blood Pressure
Mark: ^ v
NEWS SCORE
using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS
(with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
NEWS SCORE


KEY
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

Date:																									
Time:																									
COMA SCALE	E Eyes open	Spontaneously	4																						Eyes closed by dwelling = C
		To speech	3																						
		To pain	2																						
		None	1																						
	V Best Verbal response	Orientated	5																						Endotracheal tube or tracheostomy = T
		Confused	4																						
		Inappropriate words	3																						
		Incomprehensible sounds	2																						
		None	1																						
	M Best motor response	Obeys	6																						Usually record the best arm response
		Localises	5																						
		Flexion - withdrawal	4																						
		Flexion - abnormal	3																						
		Extension to pain	2																						
		None	1																						
	TOTAL SCORE																								
PUPILS	R	Size																							+ reacts – no reaction c. eyes closed
		Reaction																							
	L	Size																							
		Reaction																							
LIMB MOVEMENT	ARMS	Normal power																							Recordright (R) andleft (L) separatelyif there is a difference between the two sides
		Mild weakness																							
		Severe weakness																							
		Spastic flexion																							
		Extension																							
		No response																							
	LEGS	Normal power																							
		Mild weakness																							
		Severe weakness																							
		Spastic flexion																							
		Extension																							
		No response																							

Glasgow Coma Scale

Pupil size (mm)

1
2
3
4
5
6
7
8

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 patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

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

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

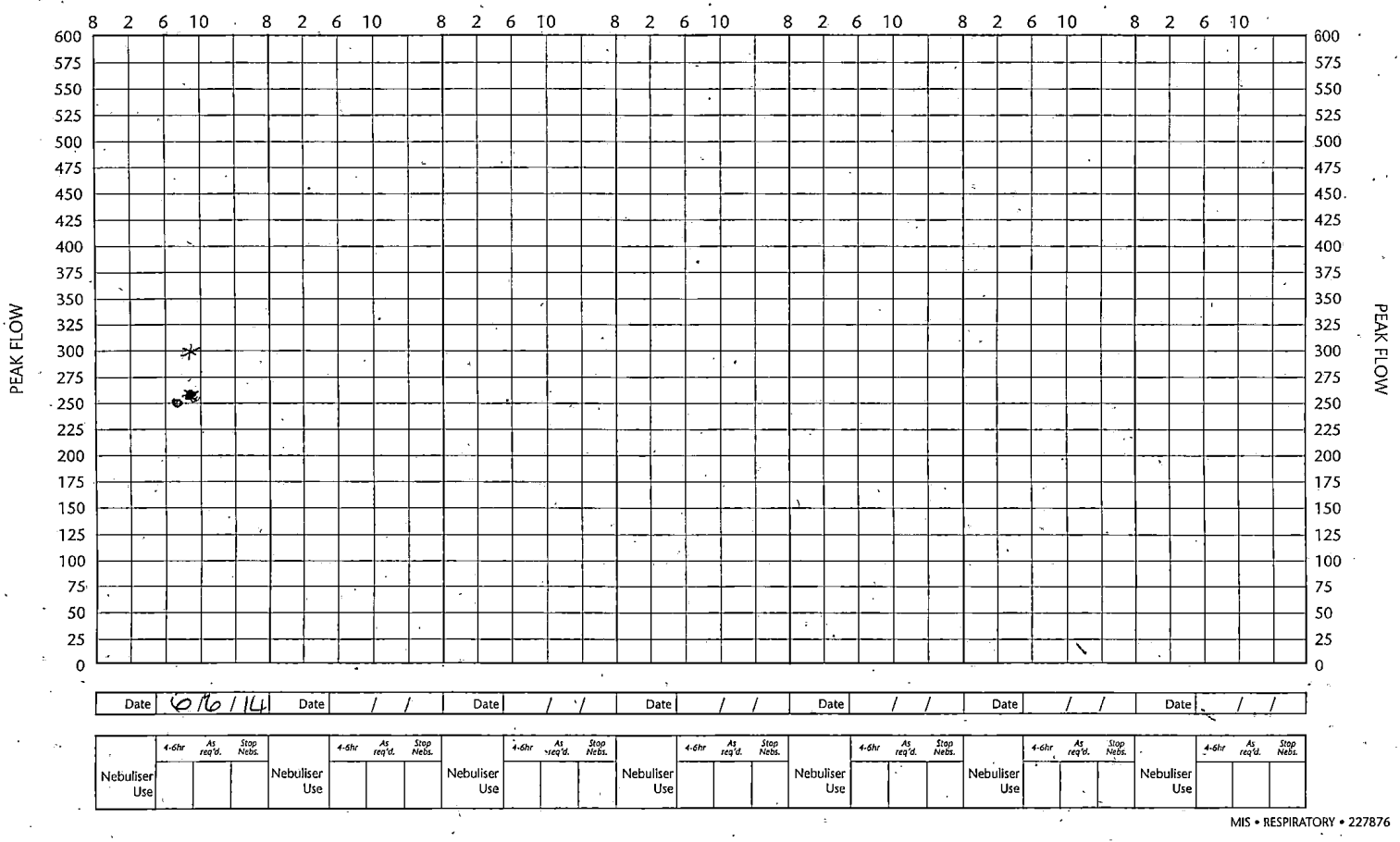
Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Name:_____ CHI:_____ Hospital:_____ Ward:_____

Peak Flow Pre and Post QID - indicate as: Pre ● Post ✳

Best / Pred PEFR:



| | | |

Acute Services Division

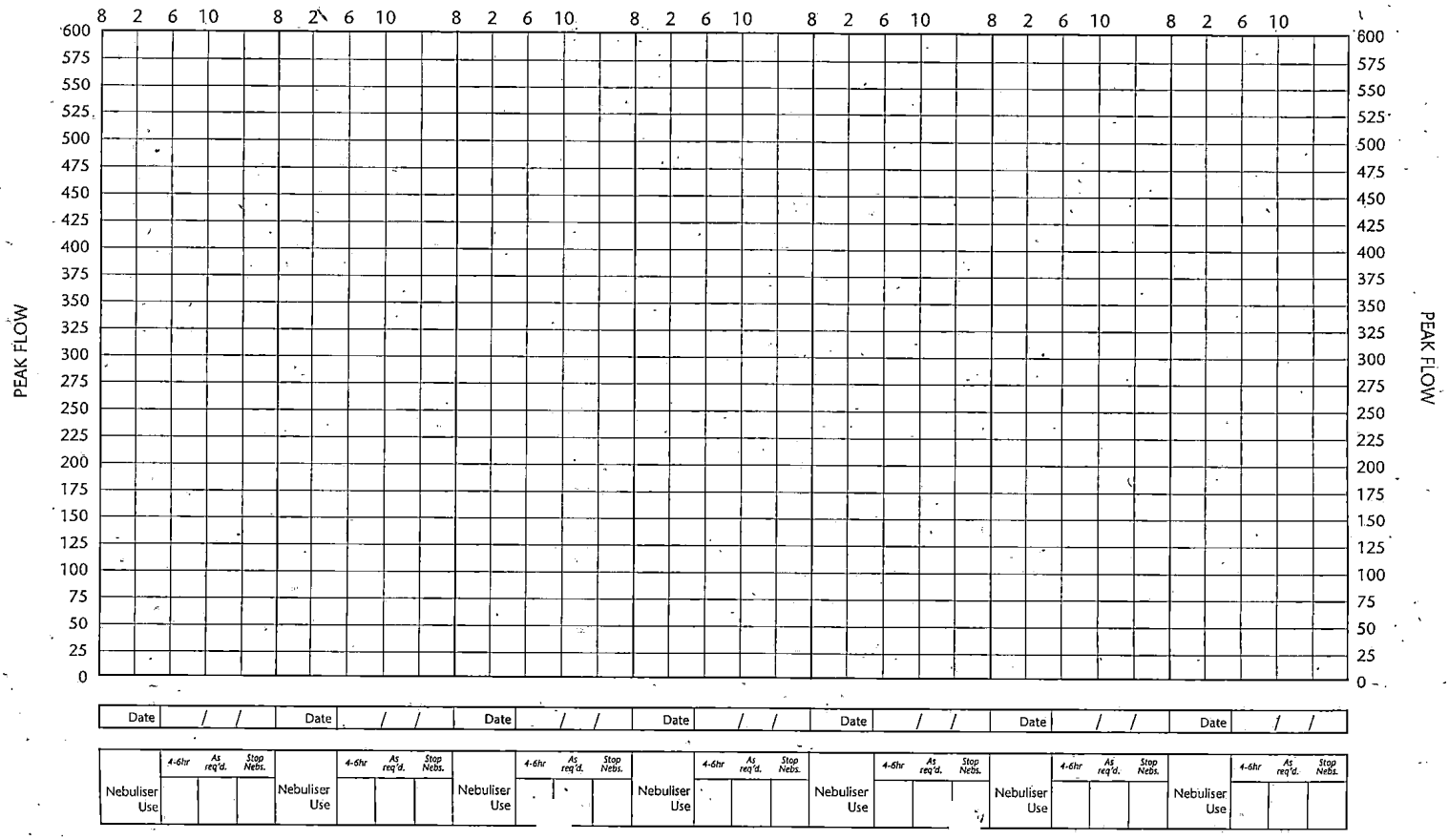
NHS Greater Glasgow and Clyde

Name: Lisa Hughes CHI: Hospital: SGH Ward: 20

Peak Flow Pre and Post QID - indicate as: Pre ● Post ✳

Best / Pred PEFR:

TIME



Date	/ /	Date	/ /	Date	/ /	Date	/ /	Date	/ /	Date	/ /	Date	/ /
Nebuliser Use	4-6hr / As req'd. / Stop Nebs.	Nebuliser Use	4-6hr / As req'd. / Stop Nebs.	Nebuliser Use	4-6hr / As req'd. / Stop Nebs.	Nebuliser Use	4-6hr / As req'd. / Stop Nebs.	Nebuliser Use	4-6hr / As req'd. / Stop Nebs.	Nebuliser Use	4-6hr / As req'd. / Stop Nebs.	Nebuliser Use	4-6hr / As req'd. / Stop Nebs.

Write or affix label	**Peripheral Vascular Cannula(PVC) Insertion & Maintenance**
Name: LISA HUGHES Address: CHI: 17-01-80 DOB: Hospital & Ward: 1 SC	

NHS Greater Glasgow and Clyde

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain,redness,swelling	2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain,redness,hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula Seek further advice
As above including: palpable venous cord	4	
As above including :pyrexia	5	

Insertion – Complete all sections

PVC inserted ED Theatre Ward_____	Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *[only if inserted in ward]*
Clinical indication IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☐	Other Please state:	

Insertion Criteria (If no: please explain in comments below)	Clean field used Yes ☐ No ☐ Unknown ☐	Hand hygiene Yes ☐ No ☐ Unknown ☐	Skin asepsis Yes ☐ No ☐ Unknown ☐	Dressing affixed Yes ☐ No ☐ Unknown ☐	Non touch technique (do not re- contaminate cleaned skin) Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

Date & time	PVC no.	Comments	Signature

Modified V.I.P (Infusion Phlebitis) Score	
IV site appears healthy	0 Phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1 Possible first signs : Observe cannula
Two or more of the following are evident: pain,redness,swelling	2 Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain,redness,hardening of surrounding tissue	3 Phlebitis/Thrombophlebitis: Remove & resite cannula Seek further advice
As above including: palpable venous cord	4
As above including :pyrexia	5

Insertion – Complete all sections

PVC inserted ED Theatre Ward_____		Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *[only if inserted in ward]*
Clinical indication	IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☐	Other Please state:	
Insertion Criteria (If no: please explain in comments below)	Clean field used Yes ☐ No ☐ Unknown ☐	Hand hygiene Yes ☐ No ☐ Unknown ☐	Skin asepsis Yes ☐ No ☐ Unknown ☐	Dressing affixed Yes ☐ No ☐ Unknown ☐	Non touch technique (do not re- contaminate cleaned skin) Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 2	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date & time	PVC no.	Comments	Signature

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

Client Specific (Inpatient) Moving and Handling Risk Assessment Form

Patient's name:	1701806541 17/01/1980 HUGHES Lisa Rosemary	Named Nurse:		If Patient is totally independent, tick here and go to date box		Risk: Low / Medium / High	

BODY BUILD				Problems with comprehension, behaviour, co-operation (specify):
Obese		Tall		
Above average		Medium		
Average		Short		
Below average				Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
RISK OF FALLS				
High		Low		

Transfers (Including To/From: Bed; Wheelchair; Commode; Toilet)

HOIST/STANDAID (Specify)	ASSISTANCE	SUPERVISION	INDEPENDENT	
Model:	People: 1 2 3			Additional Information:
Sling type:	Walking aid (specify)			
Sling size:				

Toileting

HOIST/STANDAID	ASSISTANCE	SUPERVISION	INDEPENDENT	
	People: 1 2 3			Additional Information:

Move on / off bed pan

HOIST	MANEOUVRE	ASSISTANCE	SUPERVISION	N/A	
	Roll patient	People 1			Additional Information:
	Monkey pole	People 2			
	Patient bridges	People 3			

Move up / down bed

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT	
	Sliding sheet	People 1			Additional Information:
	Monkey pole	People 2			
	Rope ladder	People 3			

Transfer to / from trolley (or bed etc.)

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT	
	Patslide	People 1			Additional Information:
	Other	People 2			
	Fabric sliding aid	People 3			

Sit up over side of bed

BED REST	ASSISTANCE	SUPERVISION	INDEPENDENT	
	People: 1 2 3			Additional Information (e.g. equipment to be used – swivel cushion):

Into Bath or Shower

WHICH BATH	HANDLING AID	ASSISTANCE	SUPERVISION	INDEPENDENT	
Shower	Shower chair	People 1			Additional Information:
Variable height bath	Bathing Hoist e.g. Atenti	People 2			
Bed bath	Sling lifting Hoist	People 3			

Walking

NO WALKING	WALKING AID (specify)	ASSISTANCE	SUPERVISION	INDEPENDENT	
		People 1			Distanced walked / Additional Information:
		People 2			
		People 3			

Other Instructions

Recording Symbol:	/	X	*
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

Continuation Sheet

Transfers (Including To/From: Bed; Wheelchair; Commode; Toilet)

HOIST/STANDAID (specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
Model:	People: 1 2 3	Additional Information:	
Sling type:	Walking aid (specify)		
Sling size:			

Toileting

HOIST/STANDAID	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information:	

Move on / off bed pan

HOIST	MANEOUVRE	ASSISTANCE	SUPERVISION	N/A
	Roll patient	People 1	Additional Information:	
	Monkey pole	People 2		
	Patient bridges	People 3		

Move up / down bed

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Sliding sheet	People 1	Additional Information:	
	Monkey pole	People 2		
	Rope ladder	People 3		

Transfer to / from trolley (or bed etc.)

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Patslide	People 1	Additional Information:	
	Other	People 2		
	Fabric sliding aid	People 3		

Sit up over side of bed

BED REST	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information (e.g. equipment to be used – swivel cushion):	

Into Bath or Shower

WHICH BATH	HANDLING AID	ASSISTANCE	SUPERVISION	INDEPENDENT
Shower	Shower chair	People 1	Additional Information:	
Variable height bath	Bathing Hoist e.g. Alenti	People 2		
Bed bath	Sling lifting Hoist	People 3		

Walking

NO WALKING	WALKING AID (specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
		People 1	Distanced walked / Additional Information:	
		People 2		
		People 3		

Other Instructions

Recording Symbol:	/	X	*
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

Nutrition Profile

NHS Greater Glasgow and Clyde

Name: 	Date of admission: / /
Address: 1701806541 HUGHES F Lisa, R 17/01/1980 8 Carham Crescent Glasgow, Lanarkshire G52 2HN	Time:
DoB:	HOSPITAL: JGH
CHI number:	Ward: ONE
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 5ft 4 1/2 metres Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Weight: 65.20 kg Actual ☑ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☑ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☑

Please state:

Food Allergies: Yes ☐ No ☑ If 'Yes' please state:

Eating likes and dislikes (including appetite):	Drinking likes and dislikes:	Patient NBM
likes: Mexican Chicken dislikes: fish	likes: Coca Cola, Un bru dislike: N/A	Yes ☐ No ☑ If 'Yes' why?:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties, loose teeth), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental**? Yes ☐ No ☑

Please specify all factors:

Is the patient on oral nutritional supplements? Yes ☐ No ☑

If 'Yes' please state:

Is the patient experiencing oropharyngeal swallowing problems (excluding oesophageal issues e.g. GORD, Stricture)? Yes ☐ No ☑

If 'Yes' please complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS). If oesophageal problem present please discuss with medical staff.

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

If 'Yes' please state:

Has this patient received written information about inpatient food (e.g. "Food in Hospitals" leaflet)?

Yes ☐ No ☐ Not applicable (received on previous admission) ☑

Profile completed by: Name (PRINT): D. Bryant Signature: D. Bryant Date: 06/06/14

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Is your patient on the Liverpool Care Pathway (LCP)? Yes ☐ No ☑

If 'Yes' please follow LCP advice as screening for malnutrition may not be appropriate.

Malnutrition Universal Screening Tool ('MUST')

Date	06/14											
Initials	VB											
Height (see page 1): 5'4 Weight	65 2'0											
Oedema or ascites present Y/N	N											
BMI (refer to chart on page 4)	24											

'MUST'

Step 1: BMI Score (refer to chart on page 4) >20 (>30 = Obese) .....0 18.5 - 20 .....1 < 8.5.....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 <u>and</u> there has been or is likely to be no, or virtually no, food intake for > 5 days..... Score 2 Not applicable ..... Score 0	0											
Step 4: Overall Risk of Malnutrition Total:	0											

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	LOW RISK – ***Routine Clinical Care*** • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	MEDIUM RISK – ***Observe*** • Document dietary intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks **and** offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	HIGH RISK – ***Treat**** • Refer to Dietitian **and** document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks **and** offer full cream milk to drink with and between meals. • Monitor **and** review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

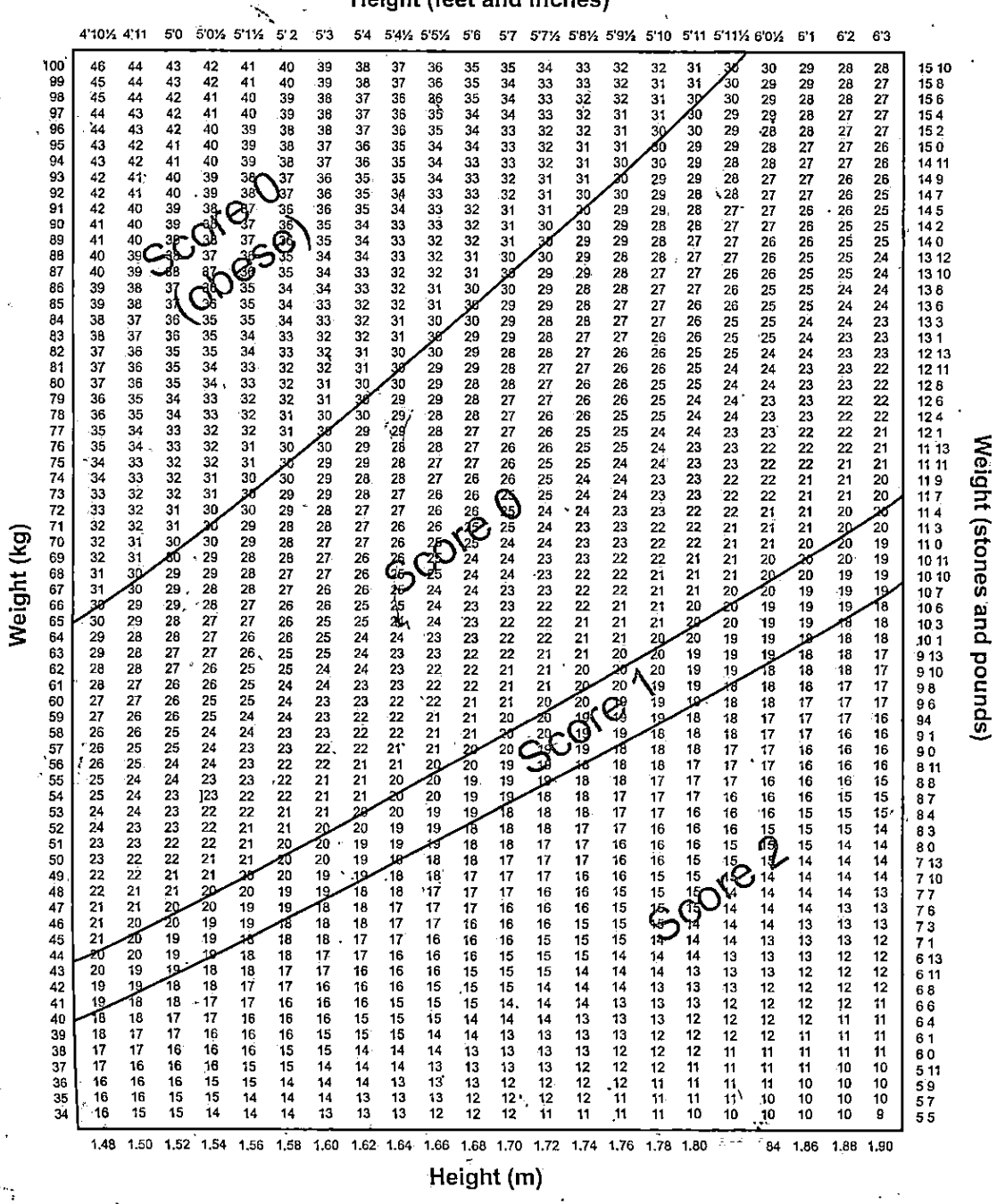
- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).
- REMEMBER TO CONSIDER YOUR PATIENT'S HYDRATION REQUIREMENTS.
- Ensure Discharge Plan includes most recent 'MUST' Score and any necessary follow-up requirements.

Referral Services		Referred by	Method of referral	Reason for referral
Nutritional Support Team	Date Referred / /			
Dietitian	Date Referred: / /			
Speech and Language Therapy	Date Referred: / /			
Occupational Therapy	Date Referred / /			
Dental Service	Date Referred / /			

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Action discussed with patient / carer	Review date	Name (PRINT) Signature/ Designation
06/6/14	0	Low risk, repeat in one week please!	yes	11/6/14	D. Bryant NM

Step 1 - BMI Score



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 W't loss <5%	Score 1 W't loss 5-10%	Score 2 W't loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2 kg	>12.4 kg
126 kg	<6.3 kg	6.3 kg	>12.6 kg

Weight before, weight loss (st/lb)	Score 0 W't loss <5%	Score 1 W't loss 5-10%	Score 2 W't loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

Medical Illustration Services • 235261
STORES ORDER CODE 41850

HUGHES, LISA ID: 1701806841 8-Jun-2014 13:27:03 SOUTHERN GENERAL HOSPITAL

17-Jan-1980
Female Caucasian

Loc: 301

Vent. rate	102	bpm
PR interval	124	ms
QRS duration	102	ms
QT/QTc	348/453	ms
P-R-T axes	85 54 37	

Sinus tachycardia

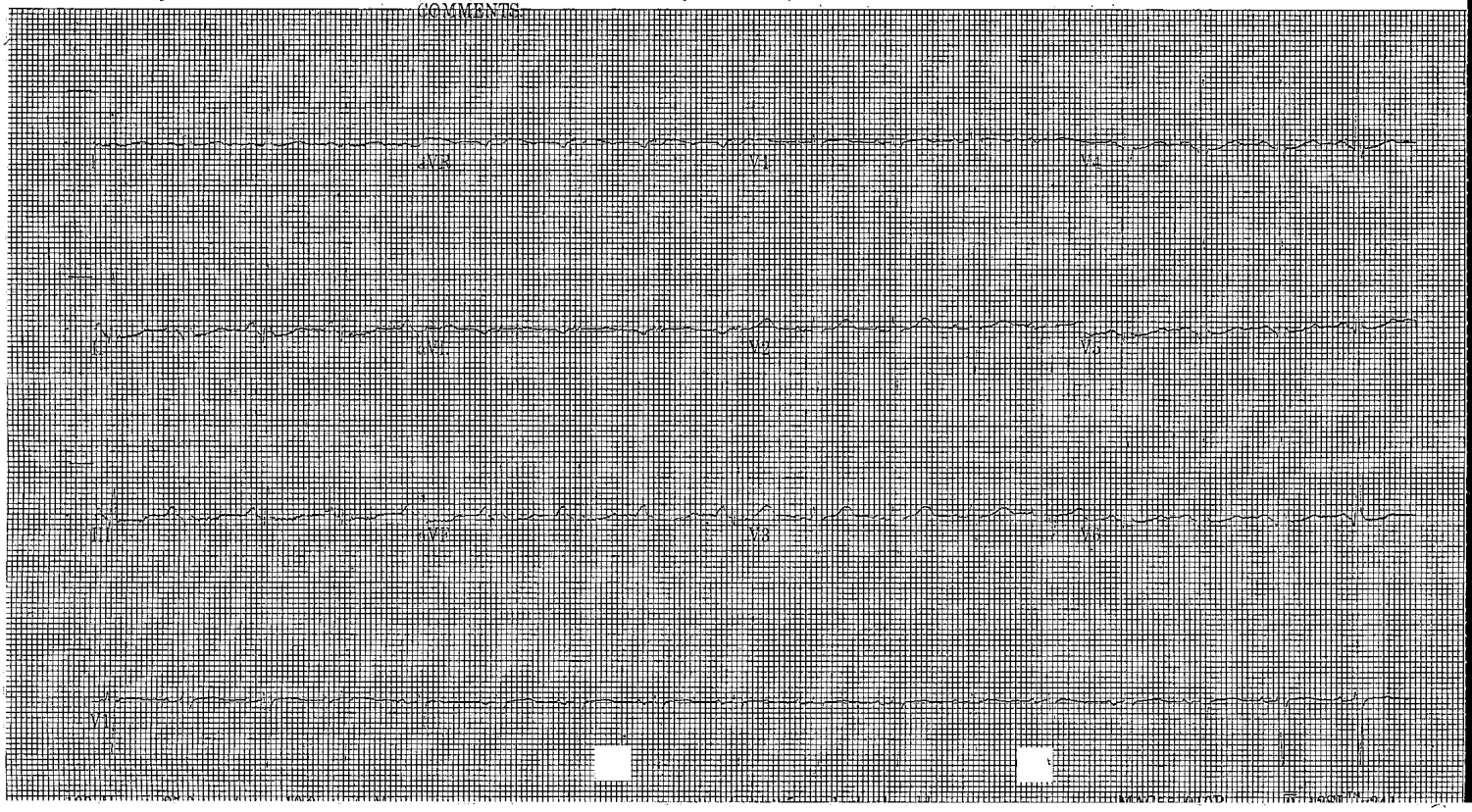
[redacted]

Technician: 324
Test ind: SOB

Referred by: DR LONG, SGAE

Unconfirmed

COMMENTS



Southern General NHS Trust Biochemistry Department
Patient enquiry ---- Express results

Reg	Surname	Inits	D.o B.	Sex	Loc.
ZC9612393	PERCY	L	17.01.80	F	20

Specimen R,96.0058268.Z Type Blood
Collected 17.06.96 08:00 A.Diag Unconscious

.....ELU.....		ALB	43
SOD	138	GLO	31
POT	3.7	T.BILI	5
CHL	101	ALP	146
CO2	21	AST	21
URE	5.2	ALT	13
CRE	79		
.....GLU.....			
GLU	3.1		
.....GGT.....			
GGT	15		
.....LFT.....			
T.Prot	74		

Quit \ Earlier req \ Later req
Back <Q> ..

TERMiTE 3.0 14:16:08 Session: 1 Page: 1

Southern General Hospital Haematology System
Patient enquiry ---- Express results

Reg	Surname	Inits	D.o.B.	Sex	Loc.
ZC9612393	PERCY	L	17.01.80	F	20

Specimen R,96.0057804.L Type Blood
Collected 17.06.96 * A.Diag UNCONSCIOUS DRUNK

.....FBC.....		BASO	0.04
WBC	18.0	MCHC	33.6
RBC	4.50	RDW	14.4
HGB	134	MPV	8.5
PCV	0.398	PCT	0.365
MCV	88	PDW	16.5
MCH	29.7		
PLT	429		
NEUT	16.3		
LYMPH	1.28		
MONO	0.44		
EOSIN	0.01		

FBC No Unit Number supplied. Computer number allocated.

Quit \ Earlier req \ Later req
Back <B> ..

TERMiTE 3.0 14:16:21 Session: 1 Page: 1

SOUTHERN GENERAL HOSPITAL NHS TRUST
PATIENTS PROFILE

WARD / DEPT: 20		NAMED NURSE:	
CONSULTANT: Dr PARK		REFERRAL: seen	
DATE: 16. 6. 96		TIME: 2230	
PATIENTS NAME: LISA PERCY			
UNIT NUMBER:			
PREFERS TO BE CALLED:			
ADDRESS: 63 BARSHAW ROAD GS2 4EE.			
TELEPHONE NUMBER: -			
AGE: 16	D.O.B.: 17. 1. 80	SEX: F	MARITAL STATUS: S
OCCUPATION:			
RELIGION: C/S	CLERGY / OTHER:	CONTACT REQUIRED:	CONTACTED:
REASON FOR ADMISSION:			

ALCOHOL INTOXICATION.
Drank 1½ litres of vodka today.
walked to friends house & collapsed on the floor.
Not smelling of alcohol on admission.

PREVIOUS HEALTH HISTORY: ~~Alcohol on admission.~~
ASTHMA

KNOWN ALLERGIES:

SGH 308

PATIENTS PROFILE (cont'd)

MEDICATION ON ADMISSION:

Ventolin

Becotide.

PATIENTS PRECEPTION OF CURRENT HEALTH STATUS:

Unconscious on admission.

RELATIVES PRECEPTIONS OF PATIENTS HEALTH STATUS:

Father present in casualty.

EMERGENCY CONTACT NAME: JAMES PERCY

NEXT OF KIN: JAMES PERCY

RELATIONSHIP: FATHER.

ADDRESS: 63 BARSHAW RD.

TELEPHONE NUMBER (DAY): —

TELEPHONE NUMBER (NIGHT):

OTHER RELEVANT CONTACT:

G.P.'s NAME: THREADGOLD.

G.P.'s ADDRESS:

G.P.'s TELEPHONE NUMBER:

Patient / Relative spoken to by	DATE	TIME	DOCTOR	NURSE

VALUABLES: DISPOSAL HOME WARD CASHIER'S OFFICE

CLOTHING: DISPOSAL HOME WARD ✓ CASHIER'S OFFICE

NURSES SIGNATURE:

SOUTHERN GENERAL HOSPITAL NHS TRUST
NURSING ASSESSMENT

PATIENTS NAME: Lisa PERCY	UNIT No.:	WARD: 20

GENERAL ASSESSMENT ON ADMISSION:

Unconscious on admission - responding to pain only. Pupils dilated, sluggish. Skin clean, intact.

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

Lives with father - nil else available on admission.

BLOOD PRESSURE:	99/48	WEIGHT:	
PULSE:	94	HEIGHT:	
RESPIRATIONS:		URINALYSIS:	
TEMPERATURE:	35.7	WATERLOW SCORE:	

NURSING ASSESSMENT (ASSESSMENT OF ACTIVITIES OF DAILY LIVING)

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

Not assessed c admission - patient unconscious

NURSES SIGNATURE:

SOUTHERN GENERAL HOSPITAL NHS TRUST

DEPARTMENT:

NAME: Lisa Percy UNIT NO. WARD: 20

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
16.6.96	2230	Admitted to ward via casualty with alcohol intoxication. Drank 1½ litres vodka today & collapsed in friends house.	
		Unconscious on admission, responding to pain only	
		BP 99/48 P 94 Temp 35°	Yasser (E)
17.6.96	0300.	Patient attempted to get up to toilet by climbing over cot sides entangling herself between rails. Nurse attempted to assist her & she became physically & verbally abusive.	S. Hutchison (E)
	0500	Actively sick x 2. 300 mls fluid content. Remain drowsy. Has passed urine.	[illegible] (E)
	WR —	SB Dr Park on morning ward round. Please encourage oral fluids & monitor. Will be seen on afternoon ward round. Possibly for discharge then	A Mackay (E)
	AM.	More awake after ward round. Oral fluids encouraged	C Smith (E).
	WR =	SB Dr Park on afternoon ward round; Father calling back later today (No phone.) For discharge home.	A Mackay (E)
	1700	Father & mother picked him up for discharge, after numerous phone calls by patient and nursing staff.	K Fazal (E)

SOUTHERN GENERAL HOSPITAL NHS TRUST

DEPARTMENT:

NAME: UNIT NO. WARD:

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE

Southern General Hospital NHS Trust
Waterflow Risk Assessment Card

NAMED NURSE

Name. Lisa Percy Unit Number. _____

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

A: BUILD/WEIGHT FOR HEIGHT		*
BMI		
20 - 24.9	Average	0
25 - 29.9	Above Average	1
> 30	Obese	2
< 20	Below Average	3

B: CONTINENCE	*
Complete/Catheterised	0
Occasional Incontinence	1
Cath/Incontinent Of Faeces	2
Doubly Incontinent	3

C: SKIN TYRE,VISUAL RISK AREAS	*
Healthy	0
Tissue Paper	1
Dry	1
Oedematous	1
Clammy (temp +)	1
Discoloured	2
Broken/Spot	3

D: MOBILITY	*
Fully	0
Restless/Fidgity	1
Apathetic	2
Restricted	3
Inert/Traction	4
Chairbound	5

E: SEX,AGE	*
Male	1
Female	2
14 - 49	1
50 - 64	2
65 - 74	3
75 - 80	4
80 +	5

F: APPETITE	*
Average	0
Poor	1
N.G. Tube/ Fluids only	2
NBM/Anorexic	3

SPECIAL RISKS	*
G: TISSUE MALNUTRITION	*
eg : Terminal Cachexia	8
Cardiac Failure	5
Peripheral Vascular disease	5
Anemia	2
Smoking	1
H: NEUROLOGICAL DEFICIT	*
eg: Diabetes, M.S., CVA, Motor/Sensory Paraplegia	4-6
I: MAJOR SURGERY/TRAUMA	*
Orthopaedic - Below waist, Spinal	5
On table > 2 hours	5
J: MEDICATIONS	*
Cytotoxics, High Dose Steroids, Anti-Inflammatory	4

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

Date	A	B	C	D	E	F	G	H	I	J	TOTAL	ASSESSOR SIGNATURE	REVIEW DATE
16696	-	-	-	3	3						6	[illegible]	17/6

WARD 20 (ACUTE RECEIVING UNIT) CARE PLAN

NAME: Lisa Percy CONSULTANT: Dr Park.

ADMISSION DATE: 16/6/96 at DATE OF BIRTH: 17/ (/80

NURSE COMPLETING CARE PLAN: *signed:* [signature]

Black ink:Initial prescription *Red ink:Changed or discontinued prescription*

RECORDING VITAL SIGNS

	1/2 hrly	1 hrly	2 hrly	4 hrly	8 hrly	Continuous
B.P.	☐	☐	☐	☑	☐	
Pulse: *radial/apex*	☐	☐	☐	☑	☐	
Temperature	☐	☐	☐	☑	☐	
Respirations	☐	☐	☐	☐	☐	
Cardiac monitor	☐	☐	☐	☐	☐	☐
Neurological obs.	☐	☑	☐	☐	☐	
C.V.P.	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	☐

	1/2hrly	1hrly	2hrly	4hrly	Pre meals	Daily
B.M. Stix	☐	☐	☐	☐	☐	☐

FLUID BALANCE

	1/2 hrly	1 hrly	2 hrly	4 hrly	8 hrly
I.V. Infusion	☐	☐	☐	☐	☐
Tranfusion:*blood/plasma/*____	☐	☐	☐	☐	☐
Urine volumes		☐	☐	☐	☐
Chest drainage:*gravity/low suction*		☐	☐	☐	☐
Gastric drainage (N/G):*gravity/low suction*		☐	☐	☐	☐

MEDICATIONS

	24%	28%	35%	40%	60%	100%	humidified
O2 Therapy	☐	☐	☐	☐	☐	☐	☐

Nebulised therapy ☐ Via: O2 ☐ Portaneb ☐

Frequency _____hrly _____hrly _____hrly

Peak flows: Pre/post nebuliser ☐ Daily ☐

Patients own medications: Stored in ward ☐ Returned to patient ☐

Transferred to ward _____ ☐

Analgesia prescribed ☐ *Frequency* _____hrly _____hrly

INTRAVENOUS CANNULA

seen

Inserted on:	16/6/96	Removed on:	17/6/96	Position:	(R) wrist
Inserted on:	/ /	Removed on:	/ /	Position:	
Inserted on:	/ /	Removed on:	/ /	Position:	
Inserted on:	/ /	Removed on:	/ /	Position:	

INFUSION PUMPS

Infusion pumps in use Yes ☐ No ☑ *See additional chart*

COLLECTION OF SPECIMENS: *Date and sign when collected*

Urine samples	Urinalysis ☐	MSSU/CSU ☐	EMU ☐
Requested on:	16/6/96	/ /	/ /
Collected on:	/ /	/ /	1 / / 2 / / 3 / /
	24hr Urine ☐	Benz Jones ☐	Osmolality ☐
Requested on:	/ /	/ /	/ /
Collected on:	/ /	/ /	/ /
Diabetic urinalysis requested:		Daily ☐	Random ☐

Sputum samples	C/S ☐	CYTOLOGY ☐	A.A.F.B. ☐
Requested on:	/ /	/ /	/ /
Collected on:	/ /	/ /	1 / / 2 / / 3 / /

Faecal samples	Stool ☐	3 day faecal fat ☐	F.O.B. ☐
Requested on:	/ /	/ /	/ /
Collected on:	/ /	/ /	1 / / 2 / / 3 / /

Wound care ☐

specify: _____

HYGIENE

bed bath ☑ *(2 nurses)* | assisted wash ☐ *(1 nurse)* | washing facilities in bed ☐ *(bed rest)*

shower/bath ☐ *(supervised)* | shower/bath ☐ *(independent)*

Mouth care ☑ 4 *hrly* | Eye care ☑ 4 *hrly* | Nasal care ☐ ____ *hrly* | Catheter care ☐ ____ *hrly*

MOBILITY

Waterlow score 6 | Bed/mattress required: ____

Specific lift recommended ☐ *specify:* ____

Lifting aid recommended ☐ *specify:* ____

Bed rest ☑ | Chair rest ☐ | Independent ☐

Mobile with two ☐ | with one ☐ | With supervision ☐

Cot sides required continuously ☑ | at night only ☐

Positional changes required 2 hrly ____ hrly ____ hrly

BLADDER/BOWEL CARE

Toilet facilities to be offered: in bed ☐ | at bedside ☑

wheel to toilet ☐ | walk to toilet ☐ | independent ☐

Urinary catheter in situ ☐ | Urodome required ☐

Continence aids required ☐ *specify:* ____

DIETARY NEEDS

Fasting ☐ | Fluids only ☐ | Fluid restriction ____ mls/24hrs

Normal diet ☑ | Special diet ☐ *specify:* ____

Nasogastric/gastrostomy feeding ☐ *intermittent/continuous*

T.P.N. ☐

Dietician required ☐ Contacted on: / /

ADDITIONAL INFORMATION

unconscious on admission

SERVICES REQUIRED

PHYSIO. ☐	requested: / /	referred: / /
O.T. ☐	requested: / /	referred: / /
S.T. ☐	requested: / /	referred: / /

SPECIALIST SERVICES REQUIRED

DIABETIC S/R ☐	requested: / /	referred: / /
NUTRITION S/R ☐	requested: / /	referred: / /
STROKE S/R ☐	requested: / /	referred: / /
STOMA S/R ☐	requested: / /	referred: / /
RESPIRATORY S/R ☐	requested: / /	referred: / /
SOCIAL WORK ☐	requested: / /	referred: / /
☐	requested: / /	referred: / /

INVESTIGATIONS

INVESTIGATION			TRANSPORT		
ORDERED	INVESTIGATION	DATE/TIME	AMBULANCE	ESCORT	BY
			Required ☐ Ordered ☐ Not required ☐	Required ☐ Not required ☐	Stretcher ☐ Chair ☐
			Required ☐ Ordered ☐ Not required ☐	Required ☐ Not required ☐	Stretcher ☐ Chair ☐
			Required ☐ Ordered ☐ Not required ☐	Required ☐ Not required ☐	Stretcher ☐ Chair ☐
			Required ☐ Ordered ☐ Not required ☐	Required ☐ Not required ☐	Stretcher ☐ Chair ☐
			Required ☐ Ordered ☐ Not required ☐	Required ☐ Not required ☐	Stretcher ☐ Chair ☐
			Required ☐ Ordered ☐ Not required ☐	Required ☐ Not required ☐	Stretcher ☐ Chair ☐

DISCHARGED 19/6/96

TRANSFER ARRANGEMENTS

Transfer to ward____on_____ Transfer to ward___on_____

Transfer arranged by_____ _____

Transport arranged by_____

SOUTH GLASGOW HOSPITALS DIVISION — SOUTHERN GENERAL HOSPITAL

NURSING PROFILE

Name: LISA ROSEMARY HUGHES Unit No: SG00953485 Acct No: IP00

Address: 8 CARHAM CRES
GLASGOW
G52 2HN
Tel: 07833990700

Consultant: BLYTH,KEVIN
DOB: 17/01/80 Age: 31
CHI: 1701806541
Rel:

Ward: S20
Date: 25/04/11
Time: 0105
Marital Status: SIN

Next of Kin: HAUGHEY,AGNES
Address: 7 KIRKCONNELL DR
GLASGOW
Tel: 634 4947
Relationship: MOT

GP: SEMPLE, LINSEY LC
Practice Address: CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS
Tel: 0141 892 2548

Other Contact:
Tel: Relationship:

REASON FOR ADMISSION:- OD

SHORT SUMMARY:- KNOWN PSYC PROBLEMS, RECENTLY DIAGNOSED WITH BIPOLAR DISORDER. PHONED SISTER AT 8PM TO SAY SHE HAD INGESTED 10 X OLANZOPINE, 20 X 5MG DIAZEPAM AND ALCOHOL. OD OCCURED AT 19.30PM. INTOXICATED ON ADMISSION TO A&E - GCS 8 IN DEPT.

PAST MEDICAL HISTORY

- BIPOLAR Dx 5 WEEKS AGO
- DEPRESSION
- THYROIDECTOMY 2 TO HYPOTHYROIDISM
-
-
-

MEDICATIONS ON ADMISSION

1) OLANZAPINE
2) DIAZEPAM
3) CITALOPRAM
4) ARIPIPRAZOLE
5) LEVOTHYROXINE
-

Allergies

ESTIMATED DATE OF DISCHARGE:

GENERAL ASSESSMENT

> GCS 9 ON ADMISSION.
CANNULATED ON WARD - NOW HAS IV ACCESS LEFT ACF.
SEWS 3 AS HYPOTENSIVE AT 91/54, AND BEST NEURO RESPONSE TO PAIN ONLY.
SKIN INTACT.
VERY UNKEMPT. SISTER PRESENT O/A/

SOCIAL/HOME BACKGROUND

> LIVES WITH HER 8 CHILDREN AGED BETWEEN 2 AND 13.
SMOKES - APPROX 25 DAILY
HAS ONLY RECENTLY BEGUN HEAVY DRINKING.
UNEMPLOYED.

RELATIVES AWARE OF ADM Y/N?:- Y Comment:

ACTIVITIES OF DAILY LIVING

MAINTAINING SAFE ENVIRONMENT: Cot Sides Required

COMMUNICATING: Withdrawn

BREATHING: Can Maintain Airway

EATING/DRINKING: Normal Diet

ELIMINATING: Normal Bowel Function
Normal Bladder Function

CLEANSING/DRESSING: No Assistance

TEMPERATURE: Apyrexial

MOBILISING: Independent

WORKING/PLAYING: Unemployed

SLEEPING: Good Sleep Pattern

SOUTH GLASGOW HOSPITALS DIVISION — SOUTHERN GENERAL HOSPITAL

NURSING PROFILE

Name: LISA ROSEMARY HUGHES Unit No: SG00953485 Acct No: IP0021875/11

DYING: Not Appropriate Discuss

SKIN CONDITION: SKIN INTACT

Does patient smoke? Y
Does patient want to stop smoking NOW? N
Has patient been referred to 'Stop Smoking Service'? N

BP: 91/54 mmHG Pulse: 75 /min Resp: 18 /min SpO2: 100 % Temp: 36.8 C
Weight: Kg Height: ft. in / Metric: cm BM: BMI:
Waterlow Score: Urinalysis:

Highly Sensitive Document Y/N N Patient consent to share information Y/N Y

Completed By (Sign): G. Lillis

Completed by: GILLIAN LILLIS on/at 25/04/11 0134 Report Number: 2504-0003

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: ARU

NAME: Lisa Hughes UNIT NO. WARD: 20

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
25/4/11	01A	Admitted to ward as per profile. Sews 3 as BP 91/54 & responsive only to pain on admission. PUPILS equal & reactive to light. Commenced on IV fluids 2 hourly.	
		Imp: Mixed OD olanzepine & diazepam currently GCS 9	
		Plan: Bloods awaited	
		IV Fs	
		↓ RIV when medically fit	
		Neuro obs hourly	– G. Gillen
	07.00	Slept soundly since admission to ward. Trauma mask insitu from A&E reduced to 28% venturi mask – pt now not tolerating mask & so discontinued. SpO2 98% on air – sews read 1. All vital signs within normal limits. GCS 13, still very sleepy this am. Mobile to toilet with assistance one night. PEARL. IV fluids continue 2 hourly.	– G. Gillen
25/4/11	WR	Seen by Dr McKay – Psych liason, continue IV fluids? Stop this afternoon —	Thanson
	10.50	Patient continues to remain drowsy at present. GCS 13-14/15, Observations as charted. Mobile to toilet independantly with supervision. Refused breakfast this morning. All medications given as per Kardex	EILEEN ZIOG Glen Hlob
	12.40	Patient reviewed by psych liasion; can go home when medically fit. Known to mental health services; patient will liase with them. —	Glen Hlob
	WR	Dr Mackay – ~~plan~~ observe. CDU.	Unable
	16.10	Patient continues to remain drowsy at times, GCS 15/15. Observations as charted; BP remains slightly hypotensive. Tolerating small amount of oral diet and fluids. IV fluids to continue until next bag prescribed is completed. For transfer to CDU, handover given, unable to contact next of kin —	Glen Hlob
25/4/11	16.15	Transfer from WJ 20	
		Mobile independantly	
		IV fluids continue Observations stable	Freeland

SOUTHERN GENERAL HOSPITAL

DEPARTMENT ARU.

NAME: Lisa Rosemary Hughes UNIT NO. WARD 20

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
25/4/11	19.00	mobile independantly to have another 1 bag of crystalloids as prescribed	Freeman
6/4/11	0000	Parent remains settled last bag of IVfluids running as prescribed Venflon positional Observations Stable pref to setting parent mobilising to bathroom independantly No new issues raised	Freeman
	06.00	Pt slept well. IVF complete. Nil complaints	Freeman
26/4/11	WR1	Seen by Dr Semple House.	Thomson

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's na

Unit numbe SG00953485
HUGHES ,LISA ROSEMARY
CHI numbe 8 CARHAM CRES
GLASGOW 17/01/1980
G52 2HN CHI 1701806541

Ward: 7

Discharge destination:

Estimated Discharge Date (1) / /

Estimated Discharge Date (2) / /

Final date of discharge : 26/4/11

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		GL	
Relative/carer informed	✓	✓		
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)	✓		GL	
Ambulance-1 man/ 2 man am/pm		✓		
Other: Flight, Air ambulance etc.		✓		
Discharge medication				
Discharge prescription completed		✓	GL	
Compliance aids e.g. Dossette Box (involve pharmacist)		✓		
Medication received		✓		
Medication explained to patient and/or relative/carer		✓		
Own medication returned to patient		✓		
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓		
Informed of discharge				
Social work/ Other agencies/Home help		✓	GL	
Physiotherapist		✓		
Occupational Therapist		✓		
Dietician		✓		
Speech and Language Therapist		✓		
Clinical Nurse specialist e.g. Care Home Liaison		✓		
Liaison/ District Nurse/Practice Nurse		✓		
Other discharge items				
Access arrangements (e.g. keys, door entry)		✓	GL	
Patients clothing available for day of discharge		✓		
Valuables e.g. cashier		✓		
Intravenous cannula removed	✓			
Equipment ordered (inc. walking aids) in place for discharge		✓		
Part 2 Discharge letter - Required		✓		
- Completed		✓		
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow		✓	GL	
If unknown at time of discharge state reason		✓		
Additional information / leaflets / factsheets				

Time of Discharge: 11.20

Nurse's signature: G. Lees Designation: SN Date: 26/4/11

FORM NUMBER 0005752

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

WRI
Surn SG00953485
HUGHES ,LISA ROSEMARY
Fore 8 CARHAM CRES
DoB GLASGOW
17/01/1980
Loc G52 2HN CHI 1701806541

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 individuals condition and repeat regularly according to local protocol

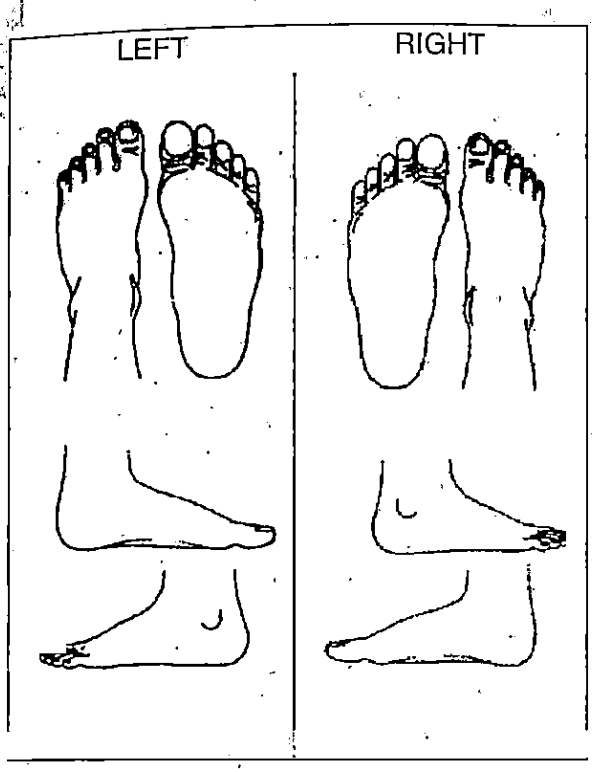
Sex									
Male	1								
Female	2	2							
Age									
14 -49	1	1							
50 -64	2								
65 - 74	3								
75 - 80	4								
81+	5								
Build/Weight for Height (BMI=weight in Kg/height in m²)									
Average - BMI 20-24.9	0								
Above average - BMI 25-29.9	1								
Obese - BMI > 30	2								
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 sever 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	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 *Max 4*	4								
Total Score		4							
Date									
Initials									
Time									

83826

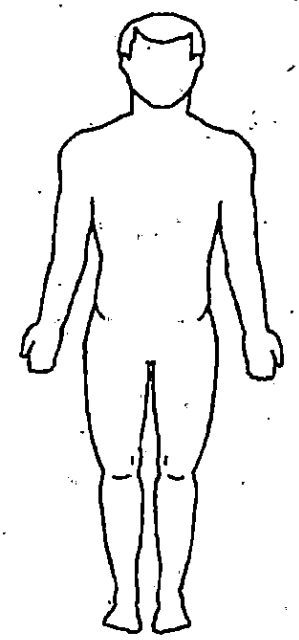
Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

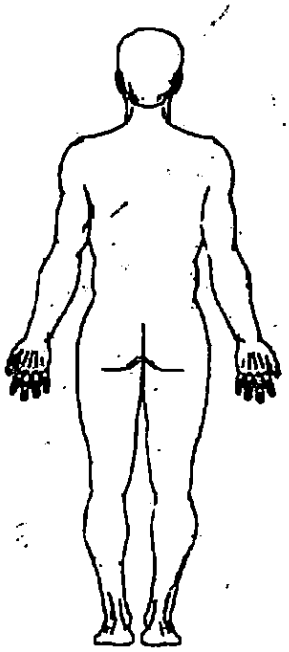
Indicate by circling and numbering all pressure damage on diagrams, then complete box below. Indicate care plan/wound assessment chart.



Anterior view



Posterior view



SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

GRADE 1 Non-blanchable erythema 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	NUMBER OF ULCER(S)	LOCATION OF ULCER(S)	GRADE OF ULCER(S)	LOCATION OF ULCER(S)

Pressure Ulcers may deteriorate from Grade 1 to Grade 4, but can not be reversed and should be documented as a healing grade of pressure ulcer, eg healing grade 4.

WARD 20 (ACUTE RECEIVING UNIT) CARE PLAN

CONSULTANT: Dr Blayne

ADMISSON DATE: 25/4/11

COMPLETED BY: G. Lees

RECORDING VITAL SIGNS

SG00953485
HUGHES ,LISA ROSEMARY
3 CARHAM CRES
GLASGOW 17/01/1980
G52 2HN CHI 1701806541

	1hrly	4hrly
B.P	☐	☑
Temperature	☐	☑
Pulse	☐	☑
Lying/standing B.P	☐	☐
Sats	☐	☑
Neurological obs	☐	☐
C.V.P	☐	☐
Telemetry	☐	

FLUID BALANCE

Fluid balance ☐ Fluid restriction _____ mls/24hrs

I.V INFUSION	Stat	1hrly	2hrly	4hrly	6hrly	8hrly
Crystaloids	☐	☐	☐	☐	☐	☐
Blood products	☐	☐	☐	☐	☐	☐

Urine volumes ☐ Free drainage ☐

BLADDER/BOWEL CARE

Toilet facilities to be offered: supra pubic/ catheter ☐ at bedside ☐ independent ☑

MEDICATIONS

O2 Therapy	24%	28%	35%	40%	60%	Trauma mask
	☐	☐	☐	☐	☐	☑
Humidified	☐					
Nasal Cannula	☐					
Nebulised therapy	☐					
Peak flows	☐					

INFUSION PUMPS

Infusion pumps in use Yes ☐ No ☑ See additional chart

HYGIENE

Bed bath	☐	assisted wash	☐	independent	☑
Mouth care	☐	eye care	☐	catheter care	☐

PRESSURE PREVENTION

Waterlow score ↓

Therapeutic mattress required ☐ ordered ☐

Positional changes required _____ hrly

Lifting aid recommended ☐ specify _____

MOBILITY

Bed rest	☐	Bed rest awaiting Tnl	☐	Tnl Result
Mobile with Supervision	☐	Independent	☐	
Cot sides required	☐			

DIETARY NEEDS

Fasting	☐	Fluids only	☐	Normal diet	☑
Special diet	☐	specify _____			
Nasogastric/gastrostomy feeding	☐	intermittent/continuous			

DIABETIC CARE

	Sliding scale	Pre-meals	Daily
B M Stix	☐	☐	☐
Diabetic urinalysis	☐		

INTRAVENOUS CANNULA

Inserted on: 25/4/14 01:30 Position: (L) ACF Removed on: _____

Inserted on: _____ Position: _____ Removed on: _____

MEDICINE PRESCRIPTION FORM

Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date _____ Name (Print) _____

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

Print & Sign _____

PATIENT DETAILS

Hospital Number:	Height:
DOB:	Weight:
Date of Admission: ___/___/___	Surface area:
Consultant Name:	Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N	
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N	
SIGNATURE OF ASSESSOR	
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N	

DATE →
MONTH →

RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

A

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time						
0700-0900						
1200-1400						
1600-1800						
2200-2400						
Other time						

B

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time						
0700-0900						
1200-1400						
1600-1800						
2200-2400						
Other time						

C

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time						
0700-0900						
1200-1400						
1600-1800						
2200-2400						
Other time						

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

						DATE →	25	26																							Patient's Own Medicine
						MONTH →	4	4																							For Use Y/N
BEFORE ADMISSION ☐	H	DRUG: Clozapine				Other time																									Qty:
	DOSE: 25mg	ROUTE: O	DATE: 25-4-11	STOPPED DATE:		0700-0900	EZ	GL																							Date:
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN): [illegible] mcgreer			STOPPED INITIALS:		1200-1400																									Assessed by:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					1600-1800																									Ordered from Pharm.
						2200-2400																									
						Other time																									
BEFORE ADMISSION ☐	J	DRUG: Aripiprazole				Other time																									For Use Y/N
	DOSE: 15mg	ROUTE: O	DATE: 25-4-11	STOPPED DATE:		0700-0900	EZ	Ø																							Qty:
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN): [illegible]			STOPPED INITIALS:		1200-1400																									Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					1600-1800																									Assessed by:
						2200-2400																									Ordered from Pharm.
						Other time																									
BEFORE ADMISSION ☐	K	DRUG: Thyroxine				Other time																									For Use Y/N
	DOSE: 200mcg.	ROUTE: O	DATE: 25-4-11	STOPPED DATE:		0700-0900	EZ	GL																							Qty:
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN): [illegible]			STOPPED INITIALS:		1200-1400																									Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					1600-1800																									Assessed by:
						2200-2400																									Ordered from Pharm.
						Other time																									
BEFORE ADMISSION ☐	L	DRUG				Other time																									For Use Y/N
	DOSE	ROUTE	DATE	STOPPED DATE:		0700-0900																									Qty:
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN)			STOPPED INITIALS:		1200-1400																									Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					1600-1800																									Assessed by:
						2200-2400																									Ordered from Pharm.
						Other time																									

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine: For Use Y/N; Qty:; Date:; Assessed by:; Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

S DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

T DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

V DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

W DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine
For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

| | | |

All Routes: As Required Prescriptions

BEFORE ADMISSION ☐	NEW DOSE ☐	NEW MEDICATION ☐					STOPPED DATE: INITIALS:	DATE	TIME	DOSE	GIVEN BY	Patient's Own Medicine	For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
			LL	DRUG													
			DOSE	ROUTE	INDICATION												
			PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:											
			ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY														
			MM	DRUG													
			DOSE	ROUTE	INDICATION												
			PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:											
			ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY														
			NN	DRUG													
			DOSE	ROUTE	INDICATION												
			PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:											
			ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY														
			PP	DRUG													
			DOSE	ROUTE	INDICATION												
			PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:											
			ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY														

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

Patient's Own Medicine

BEFORE ADMISSION		DRUG			STOPPED DATE: INITIALS:	DATE		For Use Y/N
		DOSE	ROUTE	INDICATION		TIME		Qty:
NEW DOSE		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:	DOSE		Date:
						GIVEN BY		Assessed by:
NEW MEDICATION		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						Ordered from Pharm.
BEFORE ADMISSION	SS	DRUG			STOPPED DATE: INITIALS:	DATE		For Use Y/N
		DOSE	ROUTE	INDICATION		TIME		Qty:
NEW DOSE		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:	DOSE		Date:
						GIVEN BY		Assessed by:
NEW MEDICATION		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						Ordered from Pharm.
BEFORE ADMISSION	TT	DRUG			STOPPED DATE: INITIALS:	DATE		For Use Y/N
		DOSE	ROUTE	INDICATION		TIME		Qty:
NEW DOSE		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:	DOSE		Date:
						GIVEN BY		Assessed by:
NEW MEDICATION		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						Ordered from Pharm.
BEFORE ADMISSION	VV	DRUG			STOPPED DATE: INITIALS:	DATE		For Use Y/N
		DOSE	ROUTE	INDICATION		TIME		Qty:
NEW DOSE		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:	DOSE		Date:
						GIVEN BY		Assessed by:
NEW MEDICATION		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						Ordered from Pharm.

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

Name Lisa Hughes

CHI No 1701866541

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

[illegible]stration by Symptomatic Relief Policy or other Protocol
- Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Print & Sign your full name clearly against each prescription entry.
4. Time should be recorded in 24hr format e.g. 0600, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

Milligram = mg
Gram = g
Millilitre = ml
Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010

NHS Greater Glasgow and Clyde

Specialty: General Medicine

Nursing Admission Documentation eForm - Version 1.3

Hospital Name: Southern General Hospital

Patient Details		GP Details	
Name:	Lisa, Hughes	**Name:**	FINNEY, ALAN
Address:	8 Carham Crescent Glasgow Lanarkshire	**Address:**	Cardonald Medical Centre 1831 Paisley Road West Glasgow
Postcode:	G52 2HN	**Telephone:**	
Correspondence Address 1:		**Ward:**	20
Correspondence Address 2:		**Specialty:**	General Medicine
Correspondence Postcode:		**Date of Admission:**	05/06/2014
Telephone:		**Time:**	15:12
Patient Contact Number:	01412390191	**Admitting Consultant:**	dr BLYTH
CHI Number:	1701806541	**Expected Date Of Discharge**	
CRN:	64057442B, SG00953485, Z00286838	**Admitting Nurse:**	Sarah McLellan
D.O.B:	17/01/1980	**Consent:**	Yes
Age:	34	**Sensitivity:**	Sensitive
Sex:	Female		

Next of Kin / Person to Notify

	Next of Kin	Person to Notify
Name:	AGNES HAUGHEY	
Address:		
Landline:		
Mobile:	07769815357	
Relationship:	MOTHER.	

NOK aware of admission: Yes **Consent for information to be given to relatives:** Yes

Nominated family contact - Day: **Night:**

Does the patient have an appointed Welfare Guardian / Power of Attorney? No

Is the patient a carer? No

1. Presenting Complaint / Diagnosis

KNOWN ASTHMATIC, FEW DAYS OF SOB/WHEEZE AND DRY COUGH. TODAY HAD SEVERE PAIN IN ANTEREIOR CHEST WORSE WHEN BREATHING IN, WAS HYPOXIC IN A&E 92% ON AIR. GIVEN DALTEPARIN IN A&E

2.Patient Allergy Summary

3. Observations

Cannard:	**Pulse:**	**BP:** /
Waterlow (if required):	**Resp:**	**SaO2:**
EWS: 0	**Temp:**	**BM:**
Height(m): 1.69	**Weight(kg):** 54	**BMI:** 19
Urinalysis:		**AMT4 Score:** 0

4. Current Medication

INHALERS

Medicines reconciled on admission? No

5 Relevant Past Medical History

ASTHMA
DEPRESSION

6 Risk Assessment

Patient's BMI	18.5 - 20
Has the patient had unplanned weight loss?	
Will the patient have a significantly reduced diet intake over the next 5 days?	
MUST Score	1
If MUST score 1 or more complete Nutrition Profile.	yes

7 MRSA Screening

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

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

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

MRSA Lab Test Results

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

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

8 Lifestyle

Does the patient smoke?	Yes	**How many each day?**	15
Refer to smoking cessation clinic?	No	**Referral made to Smoking Cessation Services?**	No
Does the patient use recreational drugs?	No		
How often does patient have 6 or more drinks on one occasion?			Never
FAST Tool completed?			No

9 Admission Documentation completed by

Name: Sarah McLellan **Designation:** Registered Nurse **Date:** 05/06/2014

Nursing Admission Assessment

3 Breathing and Circulation

Breathing

Symptoms or history of respiratory problems?	Yes	**Productive / non-productive cough evident?**	Yes
Dyspnoeic at rest?	NA	**Dyspnoeic on minimal exertion?**	NA
Dyspnoeic on maximum exertion?	NA	**Normally receives oxygen therapy?**	NA

Circulation

Symptoms?	NA	**Known cardiac or circulatory problems?**	NA

4 Communication and Mental Status

Assessment of ability to communicate:

What language does the patient speak	ENGLISH	**Interpreter Required?**	Not required
Does the patient have:	Speech difficulties:		No
	Learning difficulties (e.g. Down's syndrome):		No

Eyesight

Normal vision?	Yes	**Glasses?**	NA	**Distance?**	NA	**Reading?**	NA
Prosthesis?	NA	**Left:**	NA	**Right:**	NA		
Contact Lenses?	NA	**Registered Blind?**	NA				

Hearing

Normal?	Yes	**Hearing impaired?**	NA		
Hearing Aid?	NA	**Left:**	NA	**Right:**	NA

Mental Status

Orientated?	Yes	**Confused?**	NA	**Distressed?**	NA	**Unconscious?**	NA
Aggressive / Abusive	NA						

3. Hydration and Nutrition

Nutrition screening should be repeated in 7 days on the following date:	12/06/2014		
Nutrition screening required?	Required	**MUST Score:**	1

4. Elimination

Continent (Bladder):	Yes	**Continent (Bowel):**		Yes	
Incontinent (Bladder):	NA	**Incontinent (Bowel):**		NA	
Long term urinary catheter insitu?	No				
ontinence assessment commenced?	No	**Specify any containment products in use:**			
Bowel regular?	Yes	**Constipated?**	NA	**Diarrhoea / loose stools?**	NA
Stoma:	No	**Specify and list appliances used:**			

5 Personal Hygiene, Oral Health and Skin Assessment

Personal Hygiene

Self-caring and independent?	Yes	**Requires assistance?**	NA

Oral Health

Oral Care Bundle implemented?	NA		
Self-caring and independent?	Yes	**Evidence or oral ulceration,**	
Requires assistance?	No	**Oral Hygiene Care Bundle?**	

Dentures:	**Not Worn?** Yes	**Upper set?**	NA	**Lower set?**	NA	**Full set?**	NA	**With patient on admission?**	NA

Skin Assessment

Healthy & Intact?	Yes	**Broken?**	NA	**Clammy?**	NA	**Discoloured?**	NA	**Oedematous?**	NA
Wound Assessment Chart completed?				No		**Pressure ulcer evident?**			
						Grade:			0

6 Mobility

Patient fully mobile/independent?	Yes	**Prosthesis?**	No
Limited Mobility?	NA	**Mobile with aid?**	NA
Moving and handling plan commenced?	No		

7. Maintaining a Safe Environment

Patient status

Does the patient have pain?	No		
Bed rail assessment completed?	Yes	**Bed rails required?**	No

8. Sleep and Rest

Sleep Habits		**Sleep Difficulties**	
Less than 8 hours?	NA	**None?**	Yes
Morning nap?	NA	**Early wakening?**	NA
Afternoon nap?	NA	**Disturbed e.g. nocturiapain?**	NA

Medication required? No

9. Social Circumstances

Employed? NA	**Unemployed?** Yes	**Retired?** NA
Lives alone? NA	**Lives with family?** Yes	**Lives with friend?** NA
Lives with dependants? NA	**Nursing Home?** NA	**Residential?** NA
Other? NA	**Other detail:**	

Current care / Support Service arrangements:

Social Services? NA	**Private Carers (family/friends)?** NA
Unpaid carer? NA	**None?** Yes

Immediate Action Taken: LIVES AT HOME WITH PARTNER AND 8 KIDS

10. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and / or sexuality that are relevant to admission? No

11. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?	No	**Details:**
Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?	No	**Details:**
Did patient want ward staff to arrange for a hospital Chaplain to visit while in hospital?	No	**Faith group:**

12. Anticipatory Care (where appropriate and relevant)

Is Appropriate?	Not appropriate

13 Action List

Action	Yes/No	Date
Waterlow completed?	NA	
Nutrition Profile Completed?	Yes	05/06/2014
Infection Control Team contacted?	NA	
Referral made to Smoking Cessation Service?	NA	
Alcohol Screening and Assessment Tool completed?	NA	
Interpreter arranged?	NA	
Oral Care Bundle implemented?	NA	
Wound Assessment chart completed?	NA	
ressure Ulcer Record completed?	NA	
Moving and handling plan completed?	NA	
Bed rail assessment completed?	Yes	05/06/2014
Current Care / Support arrangements suspended?	NA	
Referral to Duty Social Worker?	NA	

14 dmission Assessment Completed By

Name: Sarah McLellan **Designation:** Registered Nurse **Date:** 05/06/2014

Nutrition Profile

Height:	1.69 m	**Actual:**		**Patient / carer reported:**	X	**Alternative measurement:**	
Weight:	54.00 kg	**Actual:**	X	**Patient / carer reported:**		**Alternative measurement:**	
Recent unplanned weight loss?	No						

Is there evidence of recent weight loss?	**No:**	X	**Loose Clothing:**		**Reduced food intake / apetite:**		**Swallowing problem:**	
Dietary requirements: (eg: vegetarian, vegan, halal, kosher etc):	No							
Food allergies:	No							
Eating Likes and Dislikes (including appetite):								
Drinking likes and dislikes:								
Is patient nil by mouth?	No							
Are there any contributing factors that may affect food intake such as physical (eg: swallowing difficulties, loose teeth), physiological (eg: nausea), psychological (eg: dementia), social or environmental ?							No	
Please specify all factors:								
Is the patient on oral nutritional supplements?	No							
Is the patient experiencing oropharyngeal swallowing problems (excluding oesophageal issues eg: GORD, Stricture) ?							No	
Is there a need for equipment and / or assistance with eating and drinking?	No							
Has this patient received written information about inpatient food (eg: "Food in Hospitals" leaflet) ?	No							
Profile completed by:	Sarah McLellan				**Date:**	05/06/2014		
NOTE: This is ADMISSION DATA - Please refer to changes in Care Plan.								
Is your patient on the Liverpool Care Pathway (LCP):	No							

Referral Services	Referral Date	Referred by	Method of referral	Reason for referral
Nutritional Support Team				
Dietitian				
Speech & Language Therapy				
Occupational Therapy				
Dental Service				

Management Guidelines

Score of overall risk of malnutrition	Action required	
0	**LOW RISK - Routine Clinical Care** **- Repeat screening**	
	Hospital Acute	weekly
	Hospital Rehabilitation	monthly
1	**MEDIUM RISK - Observe** **- Document dietary intake for 3 days on a Food Record Chart.** **- Encourage oral intake.** **- Encourage patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals.** **- Repeat screening weekly.**	
2 or more	**HIGH RISK - Treat*** **- Refer to Dietitian and document food intake for 3 days on a Food Record Chart.** **- Encourage oral intake.** **- Encourage patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals.** **- Monitor and review care plan weekly.** ***Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.**	

Adult Peripheral Venous Cannulation (PVC)

Patient: Hughes, Lisa **CHI: 1701806541**

Date	Time	Site	Reason For Insertion	Flushed On Insertion
05/06/2014	12:00	R ACF		Unknown

PVC Maintenance Information				
Modified V.I.P. (Visual Infusion Phlebitis) Score				
IV site appears healthy		0	No phlebitis	**Observe Cannula**
ONE of the following is evident:	slight pain or redness near site	1	Possible first signs	**Observe Cannula**
TWO of the following are evident:	pain, redness, swelling	2	Early stage of phlebitis	**Re-site Cannula**
ALL of the following are evident:	pain, redness, hardening of surrounding tissue	3	Phlebitis / Thromboophlebitis **Re-site Cannula & seek Further Advice**	
As above including:	palpable venous cord	4		
As above including:	pyrexia	5		

All 5 questions must be answered. The PVC must be monitored at least once per day.

Day 1 (24 hours after insertion)			Day 2		
1	Continuing clinical indication for PVC?		1	Continuing clinical indication for PVC?	
2	VIP Score		2	VIP Score	
3	PVC dressing dry & intact?		3	PVC dressing dry & intact?	
4	Was PVC dressing renewed?		4	Was PVC dressing renewed?	
5	Was PVC removed?		5	Was PVC removed?	

After Day 3 consider removal, if there is still a clinical reason justify rational to remain insitu:

All 5 questions must be answered. The PVC must be monitored at least once per day.

Day 3			Day 4		
1	Continuing clinical indication for PVC?		1	Continuing clinical indication for PVC?	
2	VIP Score		2	VIP Score	
3	PVC dressing dry & intact?		3	PVC dressing dry & intact?	
4	Was PVC dressing renewed?		4	Was PVC dressing renewed?	
5	Was PVC removed?		5	Was PVC removed?	

Client Specific (Inpatient) Moving and Handling Intervention Plan

Patient:	Hughes, Lisa	CHINumber:	1701806541

Is the client able to transfer and mobilise independently:	Yes	Overall Risk:	Low

General Information					
BODY BUILD					
Height	1.69	Weight	54	RISK OF FALLS	

Problems with comprehension, behaviour, co-operation (specify):	
Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):	

Transfers (sit to stand to sit, including to / from bed, wheelchair, commode, toilet)

Hoist:	No	**Standaid:**	No	**Walking aid (Specify):**			
Model:				**Sling Type:**		**Sling Size:**	
Supervision:	No			**Independent:**	No		
Additional Information:							

Toileting

Hoist:	No	**Standaid:**	No		
Supervision:	No	**Independent:**	No		
Additional Information:					

Move on / off bed pan

Hoist:	No						
Supervision:	No			**NA:**	No		
Manoeuvre	**Role patient:**		No	**Monkey pole:**	No	**Patient Bridges:**	No
Additional Information:							

Move up / down bed

Hoist:	No						
Supervision:	No			**Independent:**	No		
Handling aids	**Sliding sheet:**		No	**Monkey pole:**	No	**Rope ladder:**	No
Additional Information:							

Lateral Transfers to / from trolley or bed

st:	No						
Supervision:	No			**Independent:**	No		
Handling aids	**Rigid transfer board:**		No	**Other:**	No	**Sliding sheets:**	No
Additional Information:							

Sit up over side of bed

		Bed Rest:	No				
Supervision:	No			**Independent:**	No		
Additional Information / Equipment to be used:							

Into Bath or Shower

Equipment	**Shower:**	No	**Variable height bath:**	No	**Bed bath:**	No	
Supervision:	No		**Independent:**	No			

Handling aids	**Shower chair:**	No	**Bathing hoist e.g. Alenti:**	No	**Sling lifting hoist:**	No
Additional Information:						
Walking						
No Walking:	No		**Walking aid (Specify):**	Yes		
Supervision:	No		**Independent:**	No		
Distance walked / additional information:						
Other Instructions						
Date Assessed:	05/06/2014	**Assessor**	Sarah McLellan	**Proposed Review Date:**		

Cannard Risk Falls Assessment

Patient:	Hughes, Lisa	**CHI:**	1701806541

Cannard Summary

Admission Date	Assessment Date	Ward	Score	Action(s) Taken	Falls Assessment Assessed By	Nursing Interventions Actioned By
05/06/2014	05/6/2014	20	2	1	Sarah McLellan	Sarah McLellan

Falls Assessment

Date:	05/06/2014	**Ward:**	20	**Sex:**		**Age:**	

History of falls in the last 6 months

None

Sensory deficit

None

Medication type

None

Medical history

Mobility

Fully mobile

Gait
Steady

TOTAL SCORE:	2		
Assessed by:	Sarah McLellan	**Designation:**	Registered Nurse

Action Codes

Action Code	Nursing Interventions	
	General	
1	General Safety Precautions discussed with patient / family	05/06/2014
2	Involve patient / relative / carer with fall prevention care plan	
3	Ensure Spectacles and Hearing Aids are worn if appropriate	
4	Ensure Footwear appropriate - alert family to bring in suitable shoes	
5	Refer to Podiatry, if appropriate	
6	Routine urine test	
7	Commence Continence assessment - follow local guidelines	
	Environment	
8	Observe and remove trip hazards - drip stands, drains, catheters etc	
9	DO NOT leave patient unattended when using toilet, shower or bath	
10	Non slip mat on chair or floor - follow advice from therapists	
11	Move to more observable area of the ward to optimise supervision	
12	Patient's level of supervision to be reviewed frequently	
13	Patient requires one to one nursing care	
	Documentation	
14	Update falls risk assessment and care plan after a fall or change in condition	
15	Complete a Bedrail risk assessment	
16	Undertake a pain assessment	
17	Document in nursing notes alternative safety measures, if bedrails not used	
18	Document in nursing notes episodes of risk taking activity	
19	Investigate triggers for risk taking using a chart to monitor behaviour	
20	Record patients bowel activity	
21	Assess patients bowel activity to exclude constipation	
22	Review the continence management programme	
23	Use Falls Map if patient has 2nd or subsequent falls - see policy	
24	Record fluid intake / output	
25	Patient/relatives/carers given inpatient falls prevention leaflet	
	Seating and Bed	
26	Select most suitable seating - refer to Falls Policy	
27	Refer to Occupational Therapist for seating and transfer advice	
28	Bed rails or bumpers to be used - refer to Falls Policy	
29	Patient requires low bed or mattress on the floor- strict policy adherence	

30	Bed or chair monitor to be used - refer to Falls Policy	
31	When bed / chair monitor removed - patient supervision should be increased	
32	Bed to be placed against wall to allow only one exit	
	Mobilisation	
33	Advise patient that they may experience dizziness on initial mobilisation	
34	Monitor pulse & lying and standing Blood Pressures (see instructions)	
35	Review need for assistance when mobilising	
36	Refer to Physiotherapist for transfer and mobility advice	
	Investigation	
37	Exclude delirium - check infection, pain, constipation, medication	
38	Assess cognitive ability using AMT4	
39	Request a review of medications	
40	Ensure medical staff and multidisciplinary team are aware of falls	
	Referrals	
41	Refer to Hospital Falls Prevention Coordinator - see criteria	
42	Complete MUST - refer to dietician if appropriate	
Other		
	Date of podiatry referral:	
	Actioned by:	Sarah McLellan

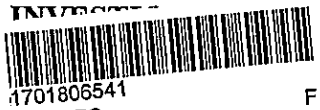
Further Investigations				
If any intervention above has not been effective for the patient, please describe what action you have taken to address the situation.				
	Date:		Actioned by:	
Falls Coordinator Only:				
Instructions to Nursing Staff:				
	Date:		Name:	

There is no further information for this patient

SOUTHERN GENERAL HOSPITAL

WARD 1

INVESTIGATION SHEET



1701806541 F

NAME:..... HUGHES 17/01/1980 .....
Lisa, R
8 Carham Crescent

CHI NO:..... Glasgow, Lanarkshire G52 2HN .....

DATE	INVESTIGATION	SIGN

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - NURSING

1701806541 F
HUGHES 17/01/1980
Lisa, R
8 Carham Crescent
Glasgow, Lanarkshire G52 2HN

Date & Time		Signature, Print Name & Designation
5/6/14	Admitted as per front profile, alert &	
	orientated. Vital signs stable.	
	Imp:- ? PE	
	- ? Pneumothorax 2° cough	
	Plan - pain	Smclellan.
pm5	Patient settled, mobile around ward	
	leaving ward for cigarettes	
	Eating & drinking	
	2L O2 via nasal cannula.	
	Nil complaints voiced.	Smclellan.
2130	Medic RIV: Imp	
	1) likely worsening of	
	asthma symptoms	
	infective component - ?	
	2) ↑ d dimer - rule out PE/VTE	
	3) distal parasthetia / cramps	
	Plan) CTPA	
	monitor peak flow	
	oral steroids	
	nebs PRN / reduce O2	
	ABX	
	refer to Smoking cessation ☐	
	avoid NSAID	
	atypical screen ☐	
	outpatient PFTs	
0500	Slept well overnight. Sats 97%	
	on air. No complaints voiced	
1000	Screaming with non specific	
	symptoms and restless in bed	

193443

Date & Time		Signature, Print Name & Designation
Cont.	Initially denied pain, then complained of back pain offered analgesia and refused saying "Im not taking any more tablets" Observations stable, became sob given salbutamol neb, patient then settled	
11.35	Am WR S/B Dr McGrane - Amox for 1 week Hcg test Daltaparin CTPA	
11.45.	Urine sample given by patient. Tested at ward level + glucose. ++ blood -ve pregnancy	D. Burns (STD/N)
13[20]	All care as planned. Patient independent with self care needs. Mobile independently to toilet. Obs stable as charted, meds given as per kardex. Patient continues to be in pain intermittently, prescribed tramadol which seemed to alleviate it. Eating & drinking well. Currently attending CT. For transfer to Ward 1.	D. Burns (STD/N).
1345	Attended for CTPA. Given 50mg of tramadol for pain with good effect. Handover given to ward 1	
16/6/14 1600	Received from ward 20. Introduced to staff, orientated to ward, buzzer given. Transfered independently.	E Taylor/E. Taylor (5)

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - NURSING

1701806541
HUGHES F
Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

Date & Time		Signature, Print Name & Designation
6/6/14 1830	Settled since transfered. Eating and drinking well. Mobile outside against advice to smoke. Pre and post inhaler/nebuliser peak flows to be done. Complaining of lung pain. Routine analgesia given with some effect. States she is needing a walking aid as in so much pain. I explained physio won't be back until Monday.	E. Taylor/E. Taylor (5)
0450	Has Slept Very well overnight easily to settle to Sleep all Medication given vital Signs stable as charted No complaints voiced Self releving pressure areas.	Gillian MCLUCAS (5)
7/6/14 11:40	Slept periodically this morning. Small amount of diet and fluids taken. Continues to complain of flank pain. Medications administered as prescribed, however co-codamol omitted as had been given prior to day staff starting, mobilising around the ward independently. Vital signs Stable.	E. Hammond (5)
15:20	Seen by SHO on ward round this morning planned discharge home. Medications received on ward. Given to Lisa along with D/C letter. Written removed.	

193443

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 5/6/16

Attach Addressograph
1701806541 F
HUGHES 17/01/1980
Lisa, R
8 Carham Crescent
Glasgow, Lanarkshire G52 2HN

NHS Greater Glasgow and Clyde

Ward: 20

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr (6r)

1. Signed Smeaton Name Smeaton Designation Snuse
2. Signed AKraun Name AKROWN Designation AN
3. Signed ..... Name ..... Designation .....

Individual patient needs: Red mat required: Y / N Bed rails: Y / N
'Must do's' for me. Ask the patient if there is anything they want specifically done today:
.....

USE FOLLOWING CODE:
O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Times	15 30	22 00	06 00	10 00															
	1.	Pain: assess and address If in pain inform registered nurse Y / N or N/A		N	N	N	Y															
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)		I	I	I	I															
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		INT	INT	I	INT															
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)		I	I	I	I															
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B		/	/	/	/															
		Chair Assist to walk, stand or tilt (W /ST/ T)		/	/	/	/															
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		I	I	I	I															
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)		N	N	N	N															
		Encourage the patient to drink? Y / N / N/A		Y	Y	–	Y															
		Food, snack or supplement taken? Y / N / N/A		Y	Y	–	Y															
	6.	ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		Y	Y	Y	Y															
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S		N	Y	Y	Y															
	8.	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A		N/A	N	N	Y															
			Nurse Initials	SM	JM	JM	SB															

Attach Addressograph label Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & handling aids:	
Other:	

Active Care variant sheet - Care Number

1. Pain
2. A / B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Date	Time	Number	Variation	Signed

CEDAR CODE 102083

MIS 258902

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 6/6/14

Attach Addressograph
1701806541
HUGHES
Lisa, R
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN
F
17/01/1980

Ward: 1

NHS Greater Glasgow and Clyde

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr (6r)

1. Signed ..... Name ..... Designation .....
2. Signed ..... Name ..... Designation .....
3. Signed ..... Name ..... Designation .....

Individual patient needs: Red mat required: Y / N Bed rails: Y / N
'Must do's' for me. Ask the patient if there is anything they want specifically done today:
.....

USE FOLLOWING CODE:
O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Times	16 00	22 00																			
	1.	Pain: assess and address If in pain inform registered nurse Y / N or N/A		Y	N																			
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)		I	I																			
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		INT	INT																			
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)		I	I																			
		Bed- Right side (30° tilt) – R Left Side (30° tilt) – L Back– B		—	—																			
		Chair Assist to walk, stand or tilt (W /ST/ T)		W	—																			
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		I	I																			
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)		N	N																			
		Encourage the patient to drink? Y / N / N/A		Y	N																			
		Food, snack or supplement taken? Y / N / N/A		Y	N																			
	6.	ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		Y	S																			
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S		Y	S																			
	8.	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A		~~NA~~	N																			
			Nurse Initials	EJ	J																			

Attach Addressograph label Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & handling aids:	
Other:	

Active Care variant sheet - Care Number

1. Pain
2. A / B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Date	Time	Number	Variation	Signed

NHS Greater Glasgow and Clyde

Active Care Checklist

Date: 7/6/14

Attach Addresso
1701806541
HUGHES
Lisa, R F
8 Carham Crescent 17/01/1980
Glasgow, Lanarkshire
G52 2HN
Ward:

NHS Greater Glasgow and Clyde

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr (6r)

1. Signed ..... Name GMCCANN Designation S/N
2. Signed ..... Name ..... Designation .....
3. Signed ..... Name ..... Designation .....

Individual patient needs: Red mat required: Y / N Bed rails: Y / N
'Must do's' for me. Ask the patient if there is anything they want specifically done today:
.....

USE FOLLOWING CODE:
O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Times	06 00	10 00	16 00																
	1.	Pain: assess and address If in pain inform registered nurse Y / N or N/A		N	N	N																
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)		I	I	I																
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		INT	INT	INT																
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)		I	I	I																
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B		/	/	/																
		Chair Assist to walk, stand or tilt (W /ST/ T)		/	/	/																
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		I	I	I																
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)		N	N	N																
		Encourage the patient to drink? Y / N / N/A		N	Y	Y																
		Food, snack or supplement taken? Y / N / N/A		N	Y	Y																
	6.	ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		S	Y	Y																
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S		S	Y	Y																
	8.	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A		NA	NA	NA																
			Nurse Initials		GM	GM																

Attach Addressograph label Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & handling aids:	
Other:	

Active Care variant sheet - Care Number

1. Pain
2. A / B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Date	Time	Number	Variation	Signed

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

1701806541
HUGHES F
Lisa, R 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

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 individuals condition and repeat regularly according to local protocol

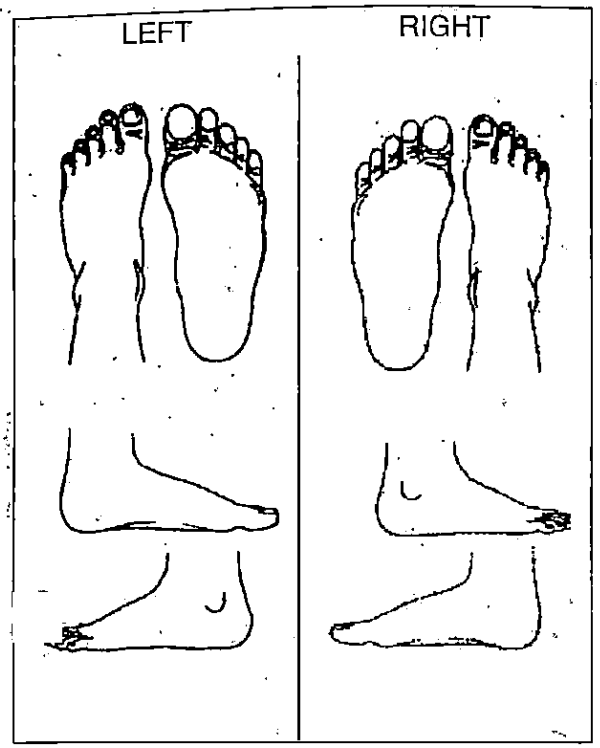
Sex									
Male	1								
Female	2	2	2						
Age									
14 -49	1	1	1						
50 -64	2								
65 - 74	3								
75 - 80	4								
81+	5								
Build/Weight for Height (BMI=weight in Kg/height in m²)									
Average - BMI 20-24.9	0	0	0						
Above average - BMI 25-29.9	1								
Obese - BMI > 30	2								
Below average - BMI < 20	3								
Continence									
Complete/catheterised	0	0	0						
Incontinent urine	1								
Incontinent faeces	2								
Doubly incontinent (urine & faeces)	3								
Skin Type - Visual Risks Area									
Healthy	0	0	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	0	0						
Restless/fidgety	1								
Apathetic (sedated/depressed/reluctant to move)	2								
Restricted (restricted by sever 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	1	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 *Max 4*	4								
Total Score		4	4						
Date		5/6	6/6						
initials		SM	ET						
Time			1830						

83826

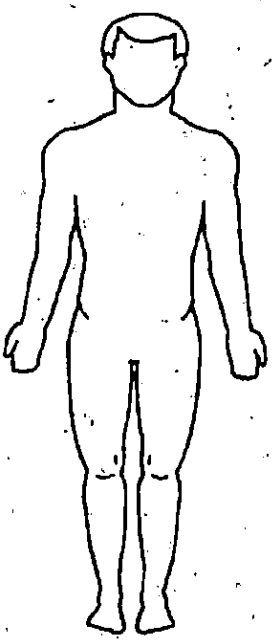
Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

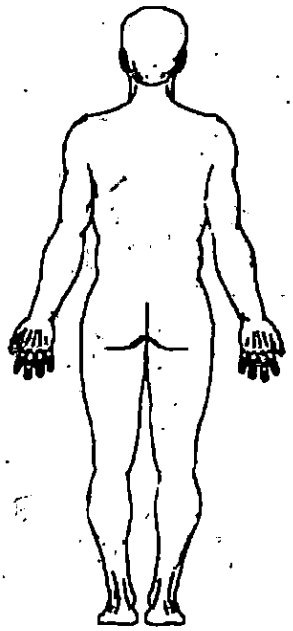
Indicate by circling and numbering all pressure damage on diagrams, then complete box below. Indicate care plan/wound assessment chart.



Anterior view



Posterior view



SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

GRADE 1 Non-blanchable erythema 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	NUMBER OF ULCER(S)	LOCATION OF ULCER(S)	GRADE OF ULCER(S)	LOCATION OF ULCER(S)

Pressure Ulcers may deteriorate from Grade 1 to Grade 4, but can not be reversed and should be documented as a healing grade of pressure ulcer, eg healing grade 4.

Acute Services Division

Hospital / Department

NHS
Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: 1701806541 HUGHES Lisa, R F 17/01/1980
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

Ward: .....

CHI number: .....

..Unit/Hospital number .....

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission to each ward.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Risk assessment and care plan reviewed monthly.

Referral Criteria for Hospital Falls Prevention Co-ordinator

1. Cannard score of 18+.
2. Second or subsequent fall
3. Significant Injury caused by a fall. (Significant Injury defined as any fracture, significant bruising or laceration to head or body.)

The patient should be referred with any of the above criteria.

General Safety Precautions

- Ensure patient has buzzer to hand
- Check patient has the manual dexterity and cognitive ability to operate buzzer
- Place personal items within easy reach
- Keep the bed in lowest position possible (use low bed if available)
- DO NOT leave patients with cognitive impairment unattended on commodes, in toilets, baths and showers.
- Patients with poor mobility, who are known not to ask for assistance, should not be left unattended on commodes, toilets, baths and showers.
- If noted that mobility / transfers are unsafe refer to physio / OT for assessment
- If patient wears glasses, ensure they are clean
- Ensure patient's footwear is adequate
- Lock wheels on all wheelchairs, beds, commodes and trolleys when in use
- Provide adequate lighting at night
- Request medication review if appropriate
- Clean up spills immediately
- Orientate patient to the ward environment

Cannard Falls Risk Assessment

(Must be completed within 24 hours of admission to each ward)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 6/6/14 Ward: 1	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				2						
Age	13-59 0	60-70 1	71-80 2	81+ 1		0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		1						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound/ wheel-chair 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		5						
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		As Below						
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves				NURSE SIGNATURE		ET						

Please see back page for glossary of terms relating to the assessment above.

Falls Assessment Care Plan

Please tick all applicable nursing interventions

	NURSING INTERVENTIONS	Date: 6/6 Ward: 1	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
Action code:								
1	Falls prevention and general safety precautions discussed with patient and family.	✓						
2	Move to more observable area of ward to optimise supervision.							
3	Advise patient they may experience dizziness when they mobilise initially.							
4	Requires assistance with mobilisation.							
5	Observe trip hazard due to invasive lines, drains and catheters.							
6	Do not leave the patient unattended when using commode, toilet, in shower or the bathroom area.							
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
8	Monitor lying and standing / sitting BP and pulse.							
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.							
10	Commence continence assessment, follow Local Guidelines.							
11	Refer to Occupational Therapist.							
12	Select suitable seating (refer to policy).							
13	Non slip mat on chair /floor following advice from therapists.							
14	Refer to Physiotherapist.							
15	Review Transfer techniques.							
16	Request medication review.							
17	Bed/chair monitor in use.							
18	Falls map in use for seven days for patient who has second or subsequent falls.							
19	Bed rails/bumpers to be used (refer to policy).							
20	Patient requires low bed / mattress on the floor (refer to policy.)							
21	Patient requires one to one nursing care.							
22	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).							
23	Other interventions. Buzzer	✓						

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment page above.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camcolit or Priadel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevrin), antidepressants, Diazepam, Lorazepam and Amitriptyline.

CARDIOVASCULAR SYSTEM MEDICATION all antihypertensive medication and inotropes including Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilofruse.

SEDATIVES / ANALGESIA AT NIGHT include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane) Morphine PCA, Fentanyl, Tramadol and Oxcycontin.

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid).

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

SBAR Handover Sheet

Patient name: Liza Hughes 34 CHI: _____

S — SITUATION

Date of admission	__/__/__
Date of transfer	16/5/14
Nurse signature	
Nurse giving handover	
Ward	23
Time	1345

Admitting complaint: asthmatic / SOB

Primary diagnosis: dry cough / Chest Pain Pleuritic A/E

Consultant:

Relatives informed of transfer? Yes ☐ No ☐

If No, why not?

B — BACKGROUND

Relevant past medical history: asthma ✓

Social circumstances: Smoke

Allergies

Mobility / Safety requirements: Indep Mob

Infection Control Risk Management

Known infection control risk? Yes ☐ No ☒

If yes, give details:

Type of isolation required:

CRA Samples / Swabs sent? (MRSA) Yes ☐ No ☐

Date sent __/__/__

Swab result

A — ASSESSMENT

Patient oriented	Yes ☐	No ☐
IV cannula in-situ	Yes ☐	No ☐
IV medication	Yes ☐	No ☐
IV fluids	Yes ☐	No ☐
NG	Yes ☐	No ☐
Urinary catheter	Yes ☐	No ☐
NEWS		
02 therapy	2L / cannula pt not using	

Insertion date: __/__/__
Insertion Time _____

Insertion date: __/__/__

Resuscitation status

Skin condition

Waterlow score

Nutritional requirements

Diet: Normal / Special / NBM / PEG / NG

MUST score		
Refer to Dietician	Yes ☐	No ☐
Referral date	__/__/__	
CANNARD	Yes ☐	No ☐
Alcohol Mgt Plan	Yes ☐	No ☐
AMT 4 Complete	Yes ☐	No ☐
Oxygen prescribed	Yes ☐	No ☐

Transfer Checklist

Medical notes	☐
Nursing notes	☐
Drug Kardex	☐
Patients Own medication	☐
Medication with patient	☐
NEWS chart	☐
Care plan	☐
Property / Valuables	☐

R — RECOMMEND

Referrals (specify)	Plan of care / Medical orders / Investigations	EDD: __/__/__
	Duplex ✓	
	CTPA ✓ D Dimer raised	
	Amoxil 1 week	
	M. Hanrahan	

WARD 20 CAREPLAN

CONSULTANT: Blyth

ADMISSON DATE: 5/6/14

COMPLETED BY: SMcLellan

1701806541
HUGHES F
Lisa, R 17/01/1980 BEL
8 Carham Crescent
Glasgow, Lanarkshire
G52 2HN

RECORDING VITAL SIGNS

	1hrly	4hrly
B.P	☐	☑
Temperature	☐	☑
Pulse	☐	☑
Lying/standing B.P	☐	☐
Sats	☐	☑
Neurological obs	☐	☐
C.V.P	☐	☐
Telemetry	☐	

FLUID BALANCE

Fluid balance ☐ Fluid restriction _____ mls/24hrs

2/8

I.V INFUSION	Stat	1hrly	2hrly	4hrly	6hrly	8hrly
Crystaloids	☐	☐	☐	☐	☐	☐
Blood products	☐	☐	☐	☐	☐	☐

Urine volumes ☐ Free drainage ☐

BLADDER/BOWEL CARE

Toilet facilities to be offered: supra pubic/ catheter at bedside ☐ independent ☑

MEDICATIONS

O2 Therapy	24%	28%	35%	40%	60%	Trauma mask
	☑	☐	☐	☐	☐	☐

Humidified ☐

Nasal Cannula ☑

Nebulised therapy ☐

Peak flows ☐

HYGIENE

Bed bath ☐ assisted wash ☐ independent ☑

Mouth care ☐ eye care ☐ catheter care ☐

INFUSION PUMPS

Infusion pumps in use Yes ☐ No ☑ See additional chart

PRESSURE PREVENTION

Therapeutic mattress required ☐ ordered ☐

Positional changes required _____ hrly

Lifting aid recommended specify_____

MOBILITY

Bed rest ☐ Bed rest awaiting Tnl ☐ Tnl Result

Mobile with Supervision ☐ Independent ☑

Cot sides required ☐

DIETARY NEEDS

Fasting ☐ Fluids only ☐ Normal diet ☑

Special diet ☐ specify_____

Nasogastric/gastrostomy feeding ☐ intermittent/continuous

DIABETIC CARE

	Sliding scale	Pre-meals	Daily
B M Stix	☐	☐	☐
Diabetic urinalysis	☐		

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name: HUGHES, Lisa, R Unit number: 1701806541 F CHI number: 17/01/1980 8 Carham Crescent Glasgow, Lanarkshire G52 2HN	Ward: Discharge destination: **Estimated Discharge Date** (1) / / **Estimated Discharge Date** (2) / / Final date of discharge : / /

Checklist	Yes	N/A	Initials	Comments
Patient informed				
Relative/carer informed				
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)				
Ambulance-1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Discharge prescription completed				
Compliance aids e.g. Dossette Box (involve pharmacist)				
Medication received				
Medication explained to patient and/or relative/carer				
Own medication returned to patient				
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)				
Informed of discharge				
Social work/ Other agencies/Home help				
Physiotherapist				
Occupational Therapist				
Dietician				
Speech and Language Therapist				
Clinical Nurse specialist e.g. Care Home Liaison				
Liaison/ District Nurse/Practice Nurse				
Other discharge items				
Access arrangements (e.g. keys, door entry)				
Patients clothing available for day of discharge				
Valuables e.g. cashier				
Intravenous cannula removed				
Equipment ordered (inc. walking aids) in place for discharge				
Part 2 Discharge letter - Required				
- Completed				
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow				
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge:				
Nurse's signature:	Designation:			Date: / /

MEDICINE **PRESCRIPTION FORM** Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date _____ Name (Print) _____

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

Print & Sign _____

PATIENT DETAILS

Hospital Number:	Height:
DOB:	Weight:
Date of Admission: ___/___/___	Surface area:
Consultant Name:	Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
5/6/14	PREDNISOLONE	40mg	PO	20:30	[signature]	LE	2015
6/6/14	TRAMADOL	50mg	PO	11:45	[signature]	SM	11:50

	DATE →	6	7																					
	MONTH →	6	6																					

	RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N	
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N	
SIGNATURE OF ASSESSOR	
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N	

Parenteral Drugs : Regular Prescription

																								Patient's Own Medicine
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☑	A DRUG DALTEPARIN																							For Use Y/N
DOSE 10 000 units	ROUTE S/C	DATE 5/5/14	STOPPED DATE:																					Qty:
PRESCRIBER (PRINT & SIGN)			INITIALS:																					Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																								Assessed by:
																								Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	B DRUG																							For Use Y/N
DOSE	ROUTE	DATE	STOPPED DATE:																					Qty:
PRESCRIBER (PRINT & SIGN)			INITIALS:																					Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																								Assessed by:
																								Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	C DRUG																							For Use Y/N
DOSE	ROUTE	DATE	STOPPED DATE:																					Qty:
PRESCRIBER (PRINT & SIGN)			INITIALS:																					Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																								Assessed by:
																								Ordered from Pharm.

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

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine
For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG
DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

E DRUG
DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

F DRUG
DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

G DRUG
DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Oral and Other Drugs: Regular Prescription

| | | |

Oral and Other Drugs: Regular Prescription

DATE → 5 6 7
MONTH → 6 6 6

M — BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☑

DRUG: CLEXANE MOONLITE
DOSE: 200 milligrams | ROUTE: | DATE: 5/6/14 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Other time	0700-0900	1200-1400	1600-1800	2200-2400	Other time
	X	B	(13)	(13)	13

Patient's Own Medicine: For Use Y/N; Qty:; Date:; Assessed by:; Ordered from Pharm.

N — BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☑

DRUG: AMOXICILLIN
DOSE: 500 mg | ROUTE: PO | DATE: 5/6/14 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: 1/52

Other time	0700-0900	1200-1400	1600-1800	2200-2400	Other time
	✓	✓ RH	✓ ET	✓ CM	1 2 3 4 5 6 7

Patient's Own Medicine: For Use Y/N; Qty:; Date:; Assessed by:; Ordered from Pharm.

P — BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☑

DRUG: CO-CODAMOL 30/500
DOSE: 2 TABS | ROUTE: PO | DATE: 6/6/14 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

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

Patient's Own Medicine: For Use Y/N; Qty:; Date:; Assessed by:; Ordered from Pharm.

R — BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG:
DOSE: | ROUTE: | DATE: | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

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

Patient's Own Medicine: For Use Y/N; Qty:; Date:; Assessed by:; Ordered from Pharm.

Oral and Other Drugs: Regular Prescription

| | | |

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

GG DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

HH DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

JJ DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

KK DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

All Routes: As Required Prescriptions

Patient's Own Medicine

| | | |

BEFORE ADMISSION ☐	RR	DRUG	STOPPED DATE: INITIALS:	DATE		Patient's Own Medicine For Use Y/N
NEW DOSE ☐	DOSE	ROUTE / INDICATION		TIME		Qty:
	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:	DOSE		Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			GIVEN BY		Assessed by: / Ordered from Pharm.
BEFORE ADMISSION ☐	SS	DRUG	STOPPED DATE: INITIALS:	DATE		For Use Y/N
NEW DOSE ☐	DOSE	ROUTE / INDICATION		TIME		Qty:
	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:	DOSE		Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			GIVEN BY		Assessed by: / Ordered from Pharm.
BEFORE ADMISSION ☐	TT	DRUG	STOPPED DATE: INITIALS:	DATE		For Use Y/N
NEW DOSE ☐	DOSE	ROUTE / INDICATION		TIME		Qty:
	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:	DOSE		Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			GIVEN BY		Assessed by: / Ordered from Pharm.
BEFORE ADMISSION ☐	VV	DRUG	STOPPED DATE: INITIALS:	DATE		For Use Y/N
NEW DOSE ☐	DOSE	ROUTE / INDICATION		TIME		Qty:
	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:	DOSE		Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			GIVEN BY		Assessed by: / Ordered from Pharm.

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



1701806541 17/01/1980

Name HUGHES Lisa Rosemary

CHI No

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

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Print & Sign your full name clearly against each prescription entry.
4. Time should be recorded in 24hr format e.g. 0600, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

Milligram = mg Gram = g
Millilitre = ml Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010

Hughes Lisa Rosemary CHI: 1701806541

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100
Date of Completion: 07/06/2014

Dr. AA Finney
Drs Semple finney and datta
Cardonald Medical Centre
1831 Paisley Road West
Glasgow
G52 3SS

Dear Dr AA Finney,

Name	CHI	DoB	Address
sa Rosemary Hughes	1701806541	17/01/1980	8 Carham Crescent Glasgow G52 2HN

imitted	Type	Discharged	Destination
05/06/2014 14:54	In Patient	07/06/2014	Private Residence - no additional detail added

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Brian Kennon	SGH Ward 1 - General Medicine	0141 201 1631

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

nical Comments: The above patient was admitted on5/6/14 with increased SOB, wheeze and cough. There was a history of nocturnal cough and some anterior chest pain. On examination chest was clear with good air entry and no wheeze audible. CXR and ECG were unremarkable. D-dimer was negative. Inflammatory markers were elevated. Dalteparin was started before CTPA showed no evidence of PTE. It also demonstrated a recent fracture of the posterolateral left 7th rib which is likely the source of chest pain on inspiration. She was started on antibiotics which should be continued for a further 5 days. We have started a step 2 inhaler (clenil modulite 200mcg). She is now fit for discharge with analgesia. We will arrange for an outpatient DEXA and isotope bone scan to be performed since there is no history of trauma to the ribs. We have sent blood for vitamin D and calcium levels today. Many thanks. Kind regards,

Dr Finn Begbie
FY1 Medicine

Treatments: None recorded.

Follow-up arranged: none

Planned Outpatient Investigations: DEXA, bone isotope scan

Final Discharge letter to follow: yes

Medication Info:

Allergies: No Allergy

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Amoxicillin Capsules	Oral	500	mg	THREE Times a Day	5 Days	disp
Citalopram Tablets	Oral	20	mg	ONCE a Day	Indefinite	POD
Clenil Modulite Inhaler (Beclometasone) 200micrograms/ puff	Inhaled	1	puff(s)	TWICE a day	Indefinite	disp
Co-codamol 30/500 Tablets	Oral	2	tablet(s)	FOUR Times a Day	2 Weeks	disp[
Diazepam Tablet	Oral	5	mg	THREE Times a Day	Indefinite	POD
Levothyroxine Tablets	Oral	200	micrograms	ONCE a Day	Indefinite	POD
Olanzapine Tablets	Oral	10	mg	At Night	Indefinite	POD
Salbutamol 200micrograms/metered dose Dry Powder Breath Actuated Inhaler	Inhaled	2	dose(s)	As Required	Indefinite	POD

New Medication Started: CLENIL MODULITE, CO-CODAMOL AND AMOXICILLIN

M cation Comment: No other changes to regular medicines

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Finn Begbie
Doctor

Prescription Review

Medications Reviewed by Pharmacist: Dominique Sweeney, Pharmacist
Dispensed Medications Checked by Pharmacy: Dominique Sweeney, Pharmacist
Nurse discharging patient: Anne Robertson, Nurse

South Glasgow University Hospitals NHS Trust

NHS

Obstetrics/Gynaecology/Paediatrics

SG00953485
LISA ROSEMARY HUGHES
8 CARHAM CRES
GLASGOW 17/01/1980
G52 2HN CHI 1701806541

CLINICAL/COUNSELLING NOTES FOR FEMALE STERIL

DATE: 9/3/11

AGE: 31yr	PARITY: 8 ↗ 8 x SVD	LMP: ??	BMI: (N)

REASONS FOR WANTING STERILISATION: = on Depo ~2yrs

CURRENT CONTRACEPTIVE METHOD: PREVIOUS CONTRACEPTION:

ALTERNATIVE CONTRACEPTION DISCUSSED:	DISCUSSED	INTERESTED
Vasectomy – *failure rate 1/2000, can be done under local anaesthetic, complications less*	☑	☐ → urology/FPC
Mirena - *>99% effective, lasts for 5 years, periods less heavy, may cause initial menstrual upset*	☑	☐ → FPC
Implanon - *>99% effective, lasts for 3 years, local anaesthetic, initial menstrual upset, weight gain*	☑	☐ → FPC
po-provera – *('The Jag') >99% effective, lasts for 12 weeks, periods may be irregular or stop, weight gain*	☑	☐ → GP/FPC
IUCD - *99% effective, lasts 3 to 10 years depending on type, periods may be heavier & more painful*	☑	☐ → GP/FPC
Oral contraception (COCP/POP) – *COCP >99% effective, periods less heavy; POP 99% effective; compliance issues*	☑	☐ → GP/FPC

FEMALE STERILISATION ⊗ LIF pain - constant. Pelvic u/s (N) / Cx smear ? Bowels (N)

	DISCUSSED	ACTION
GENERAL ANAESTHETIC, Procedure usually undertaken Laparoscopically with clips or rings as day surgery	☑	
LAPAROTOMY may be required if surgical complications are encountered	☑	
IRREVERSIBLE – difficult to reverse and NHS may not fund reversal	☑	
FAILURE RATE 1/200; if subsequent pregnancy, risk of ECTOPIC is approx. 5%	☑	
SURGICAL RISKS greater in high risk women (BMI, abdominal scars, medical disorders)	☑	*High risk* →
CONTINUE current contraception until after the procedure	☑	
PERIODS will be unchanged (unless on hormonal method pre-op, or an IUCD is removed)	☑	

PMH: Epilepsy Depression
⊗ viral cord nodules ✱
IH/ lycaine lipidips (NKDA)

MEDICAL/SURGICAL HISTORY: as above	DRUG HISTORY: as above. ALLERGIES:
EXAMINATION: ABDOMINAL ✓	VAGINAL CERVICAL SMEAR NEEDED: YES / NO

PREVIOUS ABDOMINAL SURGERY

CONSENT FORM SIGNED		LEAFLET GIVEN		

COMMENTS/PLAN:

SIGNATURE:	Print Name & Grade:

SOUTHERN GENERAL HOSPITAL
HAEMATOLOGY

Apply Reports from bottom upwards as numbered

Align top edge of report to next line above

REMOVE PROTECTIVE STRIP FROM HERE → 10

REMOVE PROTECTIVE STRIP FROM HERE → 9

REMOVE PROTECTIVE STRIP FROM HERE → 8

REMOVE PROTECTIVE STRIP FROM HERE → 7

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REMOVE PROTECTIVE STRIP FROM HERE → 4

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REMOVE PROTECTIVE STRIP FROM HERE → 2

MOUNT SO THAT FREE EDGES OF REPORTS ARE NO FURTHER TO THE RIGHT THAN THIS LINE

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
PERCY	LISA	F	17.01.80	ZC9612393

DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS
R.PARK.	Ward 20 SOUTHERN GENERAL

REPORT

FBC REPORT

No Unit Number supplied. Computer number allocated.

Done 17/6

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY
17-JUN-96	X10⁹/L	16.3	1.28	0.44	0.01	0.04	Dr.A.Alvi

DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
17-Jun-96	57804	18.0	429	4.50	134	0.398	88	29.7	

SGH 286

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

COU

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HUGHES	LISA ROSEMARY	F	SG00953485	17.01.80
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
N :.McKiernan	Acc / Emergency SGH			1701806541

Haemoglobin	131	g/l	(115-165)	White Blood Count	5.8	$x10^9$/l	(4.0-11.0)
Red Cell Count	4.30	$x10^{12}$/l	(3.80-5.80)	Neutrophils	2.7	$x10^9$/l	(2.0-7.5)
Haematocrit	0.393	l/l	(0.330-0.470)	Lymphocytes	2.4	$x10^9$/l	(1.5-4.0)
MCV	91.4	fl	(78.0-99.0)	Monocytes	0.5	$x10^9$/l	(0.2-0.8)
MCH	30.5	pg	(27.0-32.0)	Eosinophils	0.3	$x10^9$/l	(0.0-0.4)
Platelets	329	$x10^9$/l	(150-400)	Basophils	0.0	$x10^9$/l	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H.11.3089974.V	Blood	25.04.11 01:30	25.04.11 01:58	25.04.11 09:54		FBC

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HUGHES	LISA ROSEMARY	F	SG00953485	17.01.80
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
Dr.Kevin.Blyth	Ward 20 SGH			1701806541

Haemoglobin	123	g/l	(115-165)	White Blood Count	7.4	x10⁹/l	(4.0-11.0)
Red Cell Count	4.05	x10¹²/l	(3.80-5.80)	Neutrophils	4.6	x10⁹/l	(2.0-7.5)
Haematocrit	0.374	l/l	(0.330-0.470)	Lymphocytes	2.0	x10⁹/l	(1.5-4.0)
MCV	92.3	fl	(78.0-99.0)	Monocytes	0.6	x10⁹/l	(0.2-0.8)
MCH	30.4	pg	(27.0-32.0)	Eosinophils	0.3	x10⁹/l	(0.0-0.4)
Platelets	310	x10⁹/l	(150-400)	Basophils	0.0	x10⁹/l	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H,11.3090031.7	Blood	25.04.11 07:35	25.04.11 08:49	25.04.11 09:02		FBC

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HUGHES	LISA ROSEMARY	F	SG00953485	17.01.80
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
Mr.C.McKiernan	Acc / Emergency SGH			1701806541

Prothrombin Time	H 13	secs	(9-12)	
PT Ratio	1.1		(0.8-1.1)	
APTT	31	secs	(25-37)	
APTT Ratio	1.0		(0.8-1.2)	
Fibrinogen	3.2	g/l	(2.0-4.1)	

CS : APTTr Therapeutic Range for I.V Heparin (1.9 - 2.6)

CS 3/5

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H,11.3089975.R	Blood	25.04.11 01:30	25.04.11 01:58	25.04.11 10:00	SGRE	CS

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP No.
HUGHES	LISA	F	17.01.80	SG00953485

DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS	
Miss L Clark	Ward 62 SGH	Run : 8062

REPORT

FBC REPORT

Insufficient patient identification on sample ,unable to process
Addressograph label on sample.

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
09-Jun-09	X10⁹/L						Kirstie Dubojski		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
9-Jun-09	3126535				NA				

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
HUGHES	LISA	F	17.01.80	SG00953485

DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS	
Miss.L.Clark	Ear,Nose,Throat OPD, SGH	Run : 2975

REPORT

Copy sent 23/9/08

Fcc 23.9.08 & copy pdf YC

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
11-Sep-08	X10⁹/L	6.0	1.95	0.76	0.22	0.01	SCOTT WRIGHT		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
11-Sep-08	3195527	8.9	271	3.78	113	0.335	89	29.9	

SOUTHERN GENERAL HOSPITAL

BIOCHEMISTRY DEPARTMENT

C

BIOCHEMISTRY DEPARTMENT SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde C

Name	HUGHES LISA ROSEMARY	CHI Number	1701806541	Location	Ward 20 SGH
Unit No.	SG00953485	Lab Number	R,11.1137122.H	Consultant	Mr.C.McKiernan
D.O.B.	17.01.80 Sex F	Received	25.04.11 at 02:03	Prov. Diagnosis	

PARACETAMOL / SALICYLATE

Ref Range / Units		mg/L	mg/L				
Date	Time	Paracetamol	Salicylate				
25.04.11	01:30	4	<50				

A result of <3 mg/L indicates no paracetamol detected.
A result of <50 mg/L indicates no salicylate detected.

CPA
Accredited Medical Laboratory
Reference No: 2923

Report authorised by Computer validation

Run No: 97 Issued 26.04.11 at 09:13 Specimen type: Blood

SELF-ADHESIVE MOUN

A

SGH 281C

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde C

Name HUGHES LISA
Unit No. SG00953485
D.O.B. 17.01.80 Sex F

CHI Number 1701806541
Lab Number R,08.1287740.K
Received 11.09.08 at 11:41

Location Ear,Nose,Throat OPD, SGH
Consultant Miss.L.Clark
Prov. Diagnosis THYROID LUMP, PREGNANT

THYROID FUNCTION

Ref Range / Units		(0.35–5.00) mU/L	(9.0–21.0) pmol/L	(3.5–6.5) IU/L	(0.9–2.5) nmol/L	(0–6) IU/L	(0–15) U/L
Date	Time	TSH	Free T4	Free T3	Total T3	ATPO	TRAB
22.05.08	11:00	0.27	13.1		1.3		
24.07.08	10:10	0.09	10.9			568	
21.08.08	12:00	0.38	12.1		1.6		
11.09.08	11:00	0.59	10.4				

THY: NOTE: Amended Free T4 Ref Range 9.0 to 21.0 pmol/L from 01/11/07.
Result(s) indicates patient euthyroid

Copy to GP
23/9/08

UKAS Accredited Medical Laboratory Reference No: 2923

Report authorised by Computer validation
Run No: 850 Issued 11.09.08 at 13:23

BIOCHEMISTRY DEPARTMENT

SOUTHERN GENERAL HOSPITAL GLASGOW | C

Name HUGHES LISA | Sex F | D.O.B. 17.01.80 | Hospital Ear,Nose,Throat OPD, SG | Ward

Address 5 MOSSVIEW QUADRANT FLAT 2/2 | Consultant Miss.L.Clark | Reg. Number SG00953485

Received 24.07.08 10:52

Prov. Diagnosis THYROID LUMP | Lab. Number R;08.1233227.J

THYROGLOBULIN / THYROGLOBULIN Ab

Reference Range Units		up to 55 ug/L	up to 40 IU/mL				
Date	Time	TGL	TGL Ab				
24.07.08	10:10	87	25				

COMMENT Modestly raised thyroglobulin
Analysis carried out at Biochemistry Dept, North Glasgow.

fue GL 29/8/08

Report authorised by Computer validation

Reference ranges may vary with age and sex. Quoted ranges are for guidance only. Date 22.08.08 Time 16:24

Report Run No. 121

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde C

Name	HUGHES LISA	CHI Number	1701806541	Location	Ear,Nose,Throat OPD, SGH
Unit No.	SG00953485	Lab Number	R,08.1264491.K	Consultant	Miss.L.Clark
D.O.B.	17.01.80 Sex F	Received	21.08.08 at 13:50	Prov. Diagnosis	/

THYROID FUNCTION

Ref Range / Units		(0.35–5.00) mU/L	(9.0–21.0) pmol/L	(3.5–6.5) IU/L	(0.9–2.5) nmol/L	(0–6) IU/L	(0–15) U/L
Date	Time	TSH	Free T4	Free T3	Total T3	ATPO	TRAB
22.05.08	11:00	0.27	13.1		1.3		
24.07.08	10:10	0.09	10.9			568	
21.08.08	12:00	0.38	12.1		1.6		

THY: NOTE: Amended Free T4 Ref Range 9.0 to 21.0 pmol/L from 01/11/07.

Rec JC 29/8/08

CPA Accredited Medical Laboratory Reference No: 2923

Report authorised by Donald MacDonald

Run No: 508 Issued 21.08.08 at 16:10

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde C

Name HUGHES LISA	CHI Number 1701806541	Location	Ear,Nose,Throat OPD, SGH
Unit No. SG00953485	Lab Number R,08.1233227.J	Consultant	Miss.L.Clark
D.O.B. 17.01.80 Sex F	Received 24.07.08 at 10:52	Prov. Diagnosis	THYROID LUMP

CALCITONIN

Ref Range / Units		(<15) ng/L
Date	Time	Calcitonin
24.07.08	10:10	<14

Accredited Medical Laboratory Reference No: 2923

Report authorised by Graeme Chalmers

Run No: 178 Issued 04.08.08 at 12:01

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde C

Name	HUGHES LISA	*CHI Number*	1701806541	*Location*	Ear,Nose,Throat OPD, SGH
Unit No.	SG00953485	*Lab Number*	R,08.1233227.J	*Consultant*	Miss.L.Clark
D.O.B.	17.01.80 *Sex* F	*Received*	24.07.08 *at* 10:52	*Prov. Diagnosis*	THYROID LUMP

THYROID FUNCTION

Ref Range / *Units*		*(0.35–5.00) mU/L*	*(9.0–21.0) pmol/L*	*(3.5–6.5) IU/L*	*(0.9–2.5) nmol/L*	*(0–6) IU/L*	*(0–15) U/L*
Date	*Time*	**TSH**	**Free T4**	**Free T3**	**Total T3**	**ATPO**	**TRAB**
22.05.08	11:00	0.27	13.1		1.3		
24.07.08	10:10	0.09	10.9				

THY: NOTE: Amended Free T4 Ref Range 9.0 to 21.0 pmol/L from 01/11/07.

file 25/7/08
UC

Accredited Medical Laboratory
Reference No: 2923

No F/U PP

Report authorised by Dr.Scott Blackwell

Run No: 982 Issued 24.07.08 at 13:47

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde C

Name	HUGHES LISA	CHI Number	1701806541	Location	Ear,Nose,Throat OPD, SGH
Unit No.	SG00953485	Lab Number	R,08.1233227.J	Consultent	Miss.L.Clark
D.O.B.	17.01.80 Sex F	Received	24.07.08 at 10:52	Prov. Diagnosis	THYROID LUMP

THYROID FUNCTION

Ref Range / Units		(0.35–5.00) mU/L	(9.0–21.0) pmol/L	(3.5–6.5) IU/L	(0.9–2.5) nmol/L	(0–6) IU/L	(0–15) U/L
Date	Time	TSH	Free T4	Free T3	Total T3	ATPO	TRAB
22.05.08	11:00	0.27	13.1		1.3		
24.07.08	10:10					568	

ATPOAB: Raised ATPO antibodies. Patient at increased risk of developing overt thyroid disease.

CPA Accredited Medical Laboratory Reference No: 2923

Report authorised by Neil Squires

Run No: 980 Issued 24.07.08 at 12:37

RUN 6727

BIOCHEMISTRY DEPARTMENT

SOUTHERN GENERAL HOSPITAL NHS TRUST
GLASGOW

C

Name PERCY LISA Sex F D.O.B. 17.01.80 Hospital SGH Ward 20

Address NS Consultant Dr R.Park Reg. Number ZC9612393

Received DATE: 16.06.96 TIME: 2225

Prov. Diagnosis Unconscious Lab. Number R,96.0058234.Q

Paracetamol/Salicylate

Reference Range Units	umol/l	mmol/l				
Date Time	Paracet	Salicyl				
16.06.96 2200	UD	UD				

COMMENT

Undetected paracetamol means below assay detection limit ie <200umol/l

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

Issued: 17.06.96 10:13 AM

SOUTHERN GENERAL HOSPITAL

BIOCHEMISTRY DEPARTMENT

A

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	REMOVE THIS STRIP & AFFIX REPORT - TOP EDGE TO LINE ABOVE	7

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BIOCHEMISTRY DEPARTMENT SOUTH GLASGOW (0141) 201 1681 NHS Greater Glasgow and Clyde A

Name HUGHES LISA ROSEMARY CHI Number 1701806541 Location Clinical Decisions Unit

Unit No. SG00953485 Lab Number R,11.1137496.N Consultant Dr.Kevin.Blyth

D.O.B. 17.01.80 Sex F Received 26.04.11 at 09:09 Prov. Diagnosis

Withdrawal		Na	K	Cl	HCO3	Urea	Creat	eGFR	Glucose	*	CRP	Amylase	Magnesium	Urate
		135–145	3.5–5.0	98–108	23–30	2.5–7.0	40–130				<10	<100	0.70–1.00	0.15–0.35
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
26.09.09	12:30	141	4.3	113	19	4.4	72	>60	5.3	N	6	62		
10.11.09	11:00	138	4.3	107	22	3.3	65	>60						
30.03.11	09:40	140	4.7	110	21	3.5	58	>60						
25.04.11	01:30	146	3.9	113	21	2.4	54	>60			5			
25.04.11	07:00	146	4.4	116	20	2.9	57	>60			4			
26.04.11	08:00	141	4.1	111	21	2.3	61	>60						

Withdrawal		T.Protein	Albumin	Globulins	Bilirubin	Alk. Phos.	AST	ALT	GGT	CK	Calcium	Adj Ca	Phosphate
		60–80	32–45	23–38	<20	25–110	<40	<50	<40	<170		2.10–2.60	0.70–1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
15.06.09	18:30		38			40					2.22	2.31	1.15
26.09.09	12:30	70	41	29	4	41	20	20			2.32	2.35	1.23
30.03.11	09:40	68	34	34	2	58	15	17					
25.04.11	01:30	72	37	35	5	59	19	19			2.20	2.30	1.42
25.04.11	07:00	63	33	30	9	53	18	17					
26.04.11	08:00												

* Fasting: Y = Yes, N = No

CPA Accredited Medical Laboratory Reference No: 2923

Report authorised by Computer validation

Run No: 868 Issued 26.04.11 at 10:05 Specimen type: Blood

SGH 218A A SELF-ADHESIVE MOUNT SHEET UK PATENT No. GB 2254043 B JONES & BROOKS LTD 01706 843121

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde **A**

Name	HUGHES LISA	*CHI Number*	1701806541	*Location*	Ward 62 SGH
Unit No.	SG00953485	*Lab Number*	R,09.1177152.K	*Consultant*	Miss.L.Clark
D.O.B.	17.01.80 *Sex* F	*Received*	08.06.09 *at* 21:38	*Prov. Diagnosis*	

Withdrawal		Na	K	Cl	HCO3	Urea	Creat	eGFR	Glucose	*	CRP	Amylase	Magnesium	Urate
		135–145	3.5–5.0	97–107	23–30	2.5–7.0	40–130				<10	<100	0.70–1.00	0.15–0.35
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
12.02.08	14:00										5			
15.02.08	12:30										9			
01.03.08	06:30	142	3.9	108	23	4.0	63	>60	5.4	N	4	60		
22.05.08	11:00	141	4.5	107	23	4.0	65	>60						
29.05.09	13:00	140	4.4	111	19	3.4	72	>60	5.1	N				
08.06.09	21:00													

Withdrawal		T.Protein	Albumin	Globulins	Bilirubin	Alk. Phos.	AST	ALT	GGT	CK	Calcium	Adj Ca	Phosphate
		62–82	32–45	23–38	<20	25–110	<40	<40	<40	<170		2.15–2.60	0.70–1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
01.03.08	06:30	65	32	33	8	89	14	15					
24.07.08	10:10		35			34					2.26	2.40	1.20
29.05.09	13:00	69	41	28	3	40	20	23			2.28	2.31	1.11
08.06.09	21:00		34			36					2.16	2.31	1.49

* Fasting: Y = Yes, N = No

CPA

Accredited Medical Laboratory
Reference No: 0416

Report authorised by Computer validation

Run No: 446 Issued 09.06.09 at 08:36 Specimen type: Blood

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde **A**

Name **HUGHES LISA** *CHI Number* **1701806541** *Location* **Ward 62 SGH**

Unit No. **SG00953485** *Lab Number* R,09.1177214.M *Consultant* **Miss.L.Clark**

D.O.B. **17.01.80** *Sex* **F** *Received* 09.06.09 *at* 09:00 *Prov. Diagnosis*

Withdrawal		Na	K	Cl	HCO_3	Urea	Creat	eGFR	Glucose	*	CRP	Amylase	Magnesium	Urate
		135–145	3.5–5.0	97–107	23–30	2.5–7.0	40–130				<10	<100	0.70–1.00	0.15–0.35
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
12.02.08	14:00										5			
15.02.08	12:30										9			
01.03.08	06:30	142	3.9	108	23	4.0	63	>60	5.4	N	4	60		
22.05.08	11:00	141	4.5	107	23	4.0	65	>60						
29.05.09	13:00	140	4.4	111	19	3.4	72	>60	5.1	N				
09.06.09	09:00													

Withdrawal		T.Protein	Albumin	Globulins	Bilirubin	Alk. Phos.	AST	ALT	GGT	CK	Calcium	Adj Ca	Phosphate
		62–82	32–45	23–38	<20	25–110	<40	<40	<40	<170		2.15–2.60	0.70–1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
01.03.08	06:30	65	32	33	8	89	14	15					
24.07.08	10:10		35			34					2.26	2.40	1.20
29.05.09	13:00	69	41	28	3	40	20	23			2.28	2.31	1.11
08.06.09	21:00		34			36					2.16	2.31	1.49
09.06.09	09:00		32			34					2.05	2.24	1.15

* Fasting: Y = Yes, N = No

CPA Accredited Medical Laboratory Reference No: 0416

Report authorised by Computer validation

Run No: 449 Issued 09.06.09 at 10:24 Specimen type: **Blood**

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde **A**

Name HUGHES LISA | CHI Number 1701806541 | Location Ear,Nose,Throat OPD, SGH

Unit No. SG00953485 | Lab Number R,08.1233227.J | Consultant Miss.L.Clark

D.O.B. 17.01.80 Sex F | Received 24.07.08 at 10:52 | Prov. Diagnosis THYROID LUMP

Withdrawal		Na	K	Cl	HCO_3	Urea	Creat	eGFR	Glucose	*	CRP	Amylase	Magnesium	Urate
Date	Time	135–145	3.5–5.0	97–107	23–30	2.5–7.0	40–130				<10	<100	0.70–1.00	0.15–0.35
		mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
08.02.08	17:15										9			
12.02.08	14:00										5			
15.02.08	12:30										9			
01.03.08	06:30	142	3.9	108	23	4.0	63	>60	5.4	N	4	60		
22.05.08	11:00	141	4.5	107	23	4.0	65	>60						
24.07.08	10:10													

Withdrawal		T.Protein	Albumin	Globulins	Bilirubin	Alk. Phos.	AST	ALT	GGT	CK	Calcium	Adj Ca	Phosphate
Date	Time	62–82	32–45	23–38	<20	25–110	<40	<40	<40	<170		2.15–2.60	0.70–1.40
		g/L			umol/L	U/L					mmol/L		
01.03.08	06:30	65	32	33	8	89	14	15					
24.07.08	10:10		35			34					2.26	2.40	1.20

Fue 25/7/08

* Fasting: Y = Yes, N = No

CPA Accredited Medical Laboratory Reference No: 2923

No Flap

Report authorised by Computer validation

Run No: 39 Issued 24.07.08 at 12:37

RUN 83
SGH 365

BIOCHEMISTRY DEPARTMENT

SOUTHERN GENERAL HOSPITAL NHS TRUST - GLASGOW **A**

Name PERCY LISA Sex F D.O.B. 17.01.80 Hospital SGH Ward 20

Address NS Consultant Dr R.Park Reg. Number ZC9612393

Received DATE: 17.06.96 TIME: 1008

Prov. Diagnosis Unconscious Lab. Number R,96.0058268.Z

Withdrawal		Sod. 135 - 145	Pot. 3.5 - 5.0	Chlor. 101 - 111	Tot.CO_2 23 - 30	Urea 2.5 - 7.5	Creat. 40 - 130 µmol/l	H + 36 - 43 nmol/l	Pco_2 4.6 - 6.0	Po_2 10.5 - 13.5	Bicarb. 23 - 30 mmol/l	Glucose 3.3 - 5.6 mmol/l Fasting	Pl.Osm. 275 - 295	Urine Osmol.	Bili (Paed.) µmol/l
Date	Time	mmol/l							kPa				mmol/kg		
16.06.96	22:00	131	3.7	98	23	1.9	68					6.3			
17.06.96	08:00	138	3.7	101	21	5.2	79					3.1			

Withdrawal		Calc. 2.12 - 2.62	Phos. 0.70 - 1.40	T. Prot. 62 - 82	Alb. 35 - 50	Glob. 20 - 35	Bili. 5 - 20 (µmol/l)	Alk. Phos. 70 - 350	AsT. <40	AlT <40	LDH 240 - 525	CK <170	GGT M<50 F<35
Date	Time	mmol/l		g/l			IU/l						
16.06.96	22:00												
17.06.96	08:00			74	43	31	5	146	21	13			15

COMMENT

Home 17/6

Reference ranges may vary with age and sex. Quoted ranges are for guidance only. Issued: 17.06.96 3:31 PM

Page No: 1 UPDATE COPY: REPLACES ANY PREVIOUS COPY: FILE TEMPORARILY

SOUTHERN GENERAL HOSPITAL
PATHOLOGY DEPARTMENT

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NHS Greater Glasgow and Clyde

Southern General Hospital

HUGHES, Lisa
Flat 2/2, 5 Mossview Quadrant, Glasgow, , , G52 2TU
Referrer: MISS LJ CLARK - SGH ENT OP

Diagnostic Imaging Report

DoB: **17/01/1980**
Chi No: **1701806541**
CRIS No: **606240**
Hosp No: **SG00953485**

Note please

VERIFIED Verified By: DR K OSBORNE 03/04/09 1039.
Clinical History : 2.5cms right lobe lesion in multi nodular goitre. Thyroid antibodies negative. Recent pregnancy. ? for thyroidectomy. ? left side lesion changed. ? neck nodes.

Thyroid & DC Rec 21.4.09

US Neck : Examination performed by Nicola Lyttle, Sonographer.

There are multiple nodules within the thyroid. These vary in size with the largest being approximately 2.8cms in maximum diameter in the right lobe. An attempt at comparison with the ultrasound of 29.08.08 is made but direct comparison is very difficult due to differences in operator and observer and differences in sections obtained. Overall, the largest nodule in the right lobe is thought to be similar allowing for differences in measurement technique. There are also several small cysts scattered throughout the thyroid including several within some of the nodules. Overall appearances are still in keeping with multi nodular goitre but underlying malignancy cannot be excluded given the considerable thyroid distortion and multiplicity of nodules.

ON W/L Suspended

Ref. Src: Southern General Hospital, 1345 Govan Road, Glasgow, , G51 4TF
Exams: US Neck
Exam Date: 31/03/09 Event: E-11594372

08964
JMcC/71591

NHS Greater Glasgow & Clyde
SGH 401 Cat 5290802

SGH 17

A JAYBEE SELF-ADHESIVE MOUNT SHEET UK PATENT No. GB 2254043 B JONES & BROOKS LTD Tel: 01706 843121 JB-7758

NHS Greater Glasgow and Clyde

Victoria Infirmary

HUGHES, Lisa
8 Carham Crescent; Glasgow, , , G52 2HN
Referrer: Dr Alison Winter - VIC SURGICAL OP

Diagnostic Imaging Report

DoB: **17/01/1980**
Chi No: **1701806541**
CRIS No: **606240**
Hosp No:

VERIFIED Verified By: Dr Brian Mucci 01/03/12 1258.
Clinical History : Had lump in left axilla. Bloods normal. Lump has diminished in size.

US Axilla Lt :

Neither I nor the patient can really identify the abnormality. Ultrasound is normal.

Ref. Src: Victoria Infirmary, Langside Road, Glasgow, G42 9TY
Exams: US Axilla Lt
Exam Date: 29/02/12 Event: E-26429488

08964

NHS Greater Glasgow & Clyde
Vic 619 Cat 0619619

NHS Greater Glasgow

SOUTH GLASGOW UNIVERSITY HOSPITALS DIVISION

PATHOLOGY DEPARTMENT

CPA ACCREDITED

Name:	HUGHES LISA	Hospital No:	SG00953485
Address:	5 MOSSVIEW QUADRANT	CHI No:	1701806541
	FLAT 2/2	DoB:	17.01.80
	G52 2TU	Consultant:	Miss.L.Clark
Location:	Ear,Nose,Throat OPD, SGH		

Specimen: **FNA – thyroid Right**

CLINICAL HISTORY:
Right thyroid lump.. Pregnant again but lump came up when twins 2 months old.

MACRO:
Two wet fixed slides, two air dried slides and a saline washout.

MICROSCOPY:
Microscopy shows mainly blood with some admixed colloid. There is insufficient epithelium for diagnostic purposes (Thy 1).

REPORTED
28/7/08 RBA/LF

Electronically Authorised by Dr R J Barnetson.

Reporting Pathologist:	Dr.R.Barnetson		
Consultant Pathologist:	Dr.R.Barnetson		Page 1 of 1
Date Received:	24.07.08		
Date Typed:	05.08.08	Lab No:	N,08.0002021.Q

SOUTH GLASGOW

SGH487 PATHOLOGY DEPARTMENT

Name :HUGHES Lisa	Date of Birth :17.01.80
Address :5 Mossview	CHI No :
Glasgow	Previous Name :
G52 2TU	FP Number :
Unit No.:Z0335399	

Sender :FAMILY PLANNING	G.P.:NJ. Treadgold
Address :Cardonald FPC	Pollok Health Centre

Smear taken : 14.04.03	Reason for smear : Routine Repeat
Date received : 15.04.03	Appearance of cervix: Intact
	L.M.P : 00.03.03
	Hormone Treatment : No

Clinical details: Routine

Mild dyskaryosis and viral changes are identified.

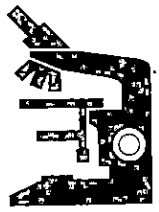
Please REFER TO COLPOSCOPY.

Dr.M.Burgoyne

Advice: REFER TO COLPOSCOPY

FEF /ABRU /MBB Date reported 29.04.03 Lab. Reference No. S,03.0007902.1

PATHOLOGY DEPARTMENT · THE VICTORIA INFIRMARY



NAME		LAB NO.
HUGHES Lisa		P,04.0003285
UNIT NO.	DOB / AGE	CONSULTANT / GP
SG00953485	17.01.80	Dr Hawthorn
ADDRESS		LOCATION
Flat 2/2 5 Mossview Quadrant Glasgow G52 2TU		Colposcopy Unit SGH

SPECIMEN

CERVICAL TISSUE

JM07/003023

CLINICAL HISTORY:

CIN 3 for treatment.

MACRO:

There are 2 pieces of cervical tissue measuring 22 x 14 x 9mm and 18 x 9 x 6mm.

MICROSCOPY:

Sections show cervical mucosa including the transformation zone. There is high grade CIN extending into the neck of endocervical glands in 9 of 10 blocks examined which focally amounts to CIN 3. The CIN appears completely excised. In addition, there is koilocytosis of the squamous epithelium in keeping with viral infection. There is no evidence of invasive malignancy.

Reported 1/6/04 RMO

RECEIVED	TYPED	REPORTED BY	SUPERVISED BY
27.05.04	02.06.04	Sarah Digby SD RMO	

TEL: 0141-201 5676 (DIRECT LINE)

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST
PATHOLOGY DEPARTMENT

SGH487

Name	:HUGHES LISA	Date of Birth	:17.01.80
Address	:5 MOSSVIEW QUADRANT	CHI No	:1701806541
	FLAT 2/2	Previous Name	:
	G52 2TU	FP Number	:
Unit No.	:SG00953485		

Sender	:Dr.P.Myint	G.P.	:Dr N J Treadgold
Address	:Colposcopy Clinic-43 OPD		Pollok Health Centre

Smear taken	: 12.05.04	Reason for smear	: Repeat of prev.non-neg.
Date received	: 13.05.04	Appearance of cervix	: NOT INDICATED
		L.M.P	: 00.03.03
		Hormone Treatment	: No

Clinical details: At colposcopy

Moderate dyskaryosis is identified.

Please repeat at follow up.

Dr.D.R.McLellan

Advice: AT COLPOSCOPY

MKD /JEA /DRM Date reported 08.06.04 Lab. Reference No. S,04.0009559.A

PATHOLOGY DEPARTMENT THE VICTORIA INFIRMARY

NAME	LAB NO.
HUGHES Linda LISA – phoned lab	P,04.0002932

UNIT NO.	DOB / AGE	CONSULTANT / GP
SG00953485	17.01.80 typing	Dr Hawthorn

ADDRESS	LOCATION
Flat 2/2 5 Mossview Quadrant email Glasgow G52 2TU	WD 43 SGH

SPECIMEN

CERVICAL BIOPSY

JMcC/963923

MACRO:
One piece 5 x 3 x 2mm.

MICROSCOPY:
Sections show CIN 3 with features of viral infection.

Reported 14/5/04 DRM

RECEIVED	TYPED	REPORTED BY	SUPERVISED BY
13.05.04	15.05.04	Dr D.R.McLellan	

TEL: 0141-201 5676 (DIRECT LINE)

X-RAY REPORTS

NHS Greater Glasgow and Clyde

Southern General Hospital

HUGHES, Lisa
Flat 2/2, 5 Mossview Quadrant, Glasgow, , , G52 2TU
Referrer: MISS LJ CLARK - SGH ENT OP

Diagnostic Imaging Report

DoB: **17/01/1980**
Chi No: **1701806541**
CRIS No: **606240**
Hosp No: **SG00953485**

VERIFIED Verified By: DR GJ MCKENZIE 03/09/08 1311.
Clinical History : Right thyroid lump. Came up after pregnancy.

US Guided aspiration thyroid : There is a multi nodular goitre. Majority of the nodules are on the right measuring up to 2.5cms in size. These are primarily iso to hypoechoic to the thyroid gland. Smaller cysts measuring 3 or 4mms in diameter are noted within the left lobe. None of the nodules have any suspicious features. The largest nodule on the right which measures 2.5cms has been FNA and specimen sent to pathology. No significant lymphadenopathy with normal salivary glands. Overall the features are most in keeping with benign multi-nodular goitre.

Copy sent - 10/9/08

Copy to GP & check she has a Stamp please

NHS Greater Glasgow & Clyde
SGH 401 Cat 5290802

Ref. Src: Southern General Hospital, 1345 Govan Road, Glasgow, , G51 4TF
Exams: US Guided aspiration thyroid
Exam Date: 29/08/08 Event: E-11194988

08964
JMcC/71591

Stick Slips on in order received commencing at the Bottom

INSTITUTE OF NEUROLOGICAL SCIENCES - Clinical Neuroradiology
Name - HUGHES, LISA DOB - 17/01/1980
Wd/Dept - IOP DR WEBB (NEUROLOGY)
CRIS No: 606240 E-2626261 Hosp No: SG00953485
Pat Type: B

CERVICAL SPINE

Reported by: Dr. EVELYN TEASDALE. Verified

History: Daily headaches and neck pain. ? cervicogenic headache.

CERVICAL SPINE :

There is abnormal straightening of the cervical lordosis consistent with spasm. There is no evidence of any bone or soft tissue abnormality to a level of T1. There is no evidence of cervical rib. The examination is normal.

Exams: CERVICAL SPINE
CRIS No: 606240 Exam Date: 17/10/2006 at 16:04

INSTITUTE OF NEUROLOGICAL SCIENCES - Clinical Neuroradiology
Name - HUGHES, LISA DOB - 17/01/1980
Wd/Dept - IOP DR WEBB (NEUROLOGY)
CRIS No: 606240 E-2626462 Hosp No: SG00953485
Pat Type: B

CT HEAD / BRAIN
Reported by: Dr.SARAH JENKINS. Verified
New sudden onset of headaches for 3 months, worse on bending. Exclude SOL.

CT HEAD / BRAIN :

The brain parenchyma and the ventricular system are within normal limits.

Exams: CT HEAD / BRAIN
CRIS No: 606240 Exam Date: 26/10/2006 at 11:22