

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



MMA-Legal

Date: 23rd June 2026

23 Goodlass Road

Your Ref: 100929

Building B

Our Ref: LAT/ACCESS/ES

L24 9HJ

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: BRIAN MCLAUGHLIN

D.O.B: 28/01/1960

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/ GARTNAVEL
GENERAL HOSPITAL/ WESTERN INFIRMARY/ WEST
AMBULATORY CARE 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



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	☒	
<u>Including:</u>		
BADGERNET	☐	
CAREVUE	☐	
MEDICAL ILLUSTRATION	☐	
METAVISION	☐	
PHYSIOTHERAPY	☐	
RADIOLOGY	☐	
WEST MARC	☐	
LABS	☐	

Low



BRIAN
ve M
01/60



51132067E
MCLAUGHLIN
BRIAN
CHI-2801606030

WESTERN INFIRMARY GARTNAVEL GENERAL HOSPITALS

CONFIDENTIAL

Gartnavel
General
2015

A

1

**ORTHOPAEDIC DEPARTMENT
WESTERN INFIRMARY
DUMBARTON ROAD
GLASGOW
G11 6NT**

Secretary Tel: 0141 211 1853 (Ms Alison Gallacher)
Secretary Fax 0141 211 2466
Appointments Office: 0141 211 2268/2392
Email: alison.gallacher.wg@ggc.scot.nhs.uk

MR REECE'S BACK PHYSIO CLINIC - 17/06/2013

Dictated: 04/06/2013
Typed: 17/06/2013

WW/MMcC

Dr Webb
The Maryhill Red Practice
Maryhill Health Centre
41 Shawpark Street
Glasgow
G20 9DR

Dear Dr Webb

Mr Brian McLaughlin DOB 28/01/1960 ~ CHI: 2801606030 ~ Hospital Number: 2801606030
265a Broughton Road Glasgow Lanarkshire G23 5JH

Mr McLaughlin returned today for a somewhat belated review following MRI scans of the lumbar and cervical spine in October of last and also nerve conduction studies of the upper limbs in November of last year.

I see from the notes that an earlier appointment in December had been missed although Mr McLaughlin has no recollection of receiving this.

Mr McLaughlin informed me today that his lumbar spine and leg pain resolved many months ago and I have reassured him that only minor degenerative change is reported in the lumbar disc with moderate degenerative changes within the facet joint. There is no evidence of any nerve root compression therefore.

Regarding the cervical spine and left upper limb symptoms Mr McLaughlin advised me he only has subtle pain remaining at the left side of the neck. The majority of upper limb symptoms resolved at least three months ago. I have reassured him that his cervical MRI scan showed no post-operative complications or recurrent nerve root involvement. Also, his neurophysiology examination findings showed mild bilateral carpal tunnel syndrome although the Consultant Neurophysiologist was more of the impression at that stage that his left upper limb symptoms were related to the cervical spine. In any case, in view of the symptoms settling there is no indication for any further intervention or investigation. Mr McLaughlin is now to a level where he wishes to resume employment as he has been receiving benefits for a prolonged period of time now. At present he has the opportunity to apply for a post in the parks department of the local council, but he seems very sensible regarding his limitations

2

and posture awareness. I can see no reason why he cannot apply for this although any heavy manual work does raise the possibility of recurrence of symptoms which Mr McLaughlin is aware of. He will make his own decision regarding his. He has now been discharged from the orthopaedic clinic.

Yours sincerely

Wendy Wallace
Extended Scope Physiotherapy Practitioner

3

ORTHOPAEDIC DEPARTMENT
WESTERN INFIRMARY
DUMBARTON ROAD
GLASGOW
G11 6NT

Secretary Tel: 0141 211 1853 (Ms Alison Gallacher)
Secretary Fax: 0141 211 2466
Appointments Office: 0141 211 2268/2392
Email: alison.gallacher.wg@ggc.scot.nhs.uk

MR A T REECE'S SPINAL CLINIC - 22/09/2012

Dictated: 22/09/2012
Typed: 15/10/2012

FD/AG

Consultant Neurophysiology
Department of Neurophysiology
Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

Dear Doctor

Mr Brian McLaughlin DOB 28/01/1960 ~ CHI: 2801606030 ~ Hospital Number: 51132067E
265a Broughton Road Glasgow Lanarkshire G23 5JH

I would be grateful for your opinion on this gentleman with a view to performing nerve conduction studies. He had anterior cervical decompression and fusion at C5/6 and C6/7 levels carried out in March with initially good result. He has had return of his left arm pain and seems to have tightness and discomfort in a median nerve distribution of his hand. He also has very subtle wasting of the first dorsal interosseous on the left hand which does not quite tie in with his previous problems. I would therefore be grateful if you would see him for investigation of any underlying problem. I have enclosed my clinic letter for your further information.

Yours sincerely

Fraser Dean
ST7 in Orthopaedics

11/12/12 DVA Recd ED

J + L has settled

(4)

J am settled now

part 3/12. No answer.

now.

5

ORTHOPAEDIC DEPARTMENT
WESTERN INFIRMARY
DUMBARTON ROAD
GLASGOW
G11 6NT

Secretary Tel: 0141 211 1853 (Ms Alison Gallacher)
Secretary Fax: 0141 211 2466
Appointments Office: 0141 211 2268/2392
Email: alison.gallacher.wg@ggc.scot.nhs.uk

MR A T REECE'S SPINAL CLINIC - 22/09/2012

Dictated: 22/09/2012
Typed: 15/10/2012

FD/AG

Dr Alasdair Webb
The Maryhill Red Practice
Maryhill Health Centre
41 Shawpark Street
Glasgow
G20 9DR

Dear Dr Webb

Mr Brian McLaughlin DOB 28/01/1960 ~ CHI: 2801606030 ~ Hospital Number: 51132067E
265a Broughton Road Glasgow Lanarkshire G23 5JH

I reviewed this gentleman back in the clinic today. He is now almost six months following anterior cervical discectomy and fusion at the C5/6 and C6/7 level. He has been doing very well following the surgery with resolution of his left arm pain but unfortunately for the last two months this has now recurred and is quite severe. He feels pain over the clavicular area and down the antero-medial aspect of his upper arm. He also has a feeling of tightness or heaviness affecting the radial three digits of his left hand. The pain is now so severe that he finds it difficult to rest comfortably and his sleep is disturbed at night. He is also getting some lower back pain radiating to the right buttock and occasionally down to the right ankle. He feels his ankle can give way from time to time and he had previously been referred for a MRI scan of his lumbar spine but was unable to attend for the appointment and has not been reappointed.

Examining him today the scar is well healed. He has no neck pain with good range of neck movement. He had no reduced sensation in the left arm and no objective signs of weakness. There may have been some subtle wasting of the 1st dorsal interosseous muscle the left hand compared to the right hand.

This gentleman had been doing well but has now had recurrence of his symptoms. This may be due to some post-operative fibrosis around the C5 or C6 nerve root or it may be due to further impingement. I think a contrast MRI scan would be useful to further investigate this. I think it would also be useful to organise some nerve conduction studies to see if there is any peripheral entrapment or if it does appear to be coming from the nerve root. I will request these along with the repeat request for his lumbar MRI scan. We will see him back in due course with the results.

Yours sincerely

Fraser Dean
ST7 in Orthopaedics

Pat was at Mr Sharma 22/6/12
to get flap appt 2 mths. (6)

Department of Orthopaedic Surgery

MR H SHARMA

DISCHARGE LETTER

Gartnavel General Hospital
1053 Great Western Road
GLASGOW G12 0YN

Secretary Tel: 0141 211 3185
Secretary Fax: 0141 211 3189
E-mail: Alison.gallacher@ggc.scot.nhs.uk

Dictated: 30/03/2012
Typed: 27/04/2012

Ref: HS/LM

Dr Alasdair Webb
The Maryhill Red Practice
Maryhill Health Centre
41 Shawpark Street
Glasgow
G20 9DR

Dear Dr Webb

Mr Brian McLaughlin
Hospital Number: 51132067E

222 Broughton Road Glasgow Lanarkshire G23 5LP
CHI: 2801606030

Date of Admission: 29/03/2012

Date of Operation: 29/03/2012

Date of Discharge: 31/03/2012

Diagnosis: Left C6 & C7 radiculopathy from C5/C6 & C6/C7 disc osteophyte complex & disc prolapse

Operation: C5/C6 & C6/C7 anterior cervical discectomy & fusion

Mr McLaughlin underwent the above mentioned procedure without any intra operative and immediate post operative problems. His post op check x-rays were satisfactory. There were no clinical issues at the time of discharge. Mr McLaughlin was advised to wear a cervical collar for the period of 6 weeks time. He will be reviewed at my spinal clinic in 6 weeks time and advised to attend GP surgery in 10 days to 2 weeks time for removal of his clips. For any wound related problems or any neurological deterioration Mr McLaughlin was advised to contact my secretary or ward directly.

Yours sincerely

Mr Himanshu Sharma
BSC, MBBS, MS(Orth), MCh(Orth), FRCS(Tr & Orth)
Locum Orthopaedic Spinal Surgeon

DNA'D MRI 14/7

7

ORTHOPAEDIC DEPARTMENT
WESTERN INFIRMARY
DUMBARTON ROAD
GLASGOW
G11 6NT

Secretary Tel: 0141 211 1853 (Ms Alison Gallacher)
Secretary Fax: 0141 211 2466
Appointments Office: 0141 232 9499
Email: alison.gallacher.wg@ggc.scot.nhs.uk

MR H SHARMA ORTHOPAEDIC CLINIC - 22/06/2012

Typed: 04/07/2012
HS/LM

Dr Alasdair Webb
Maryhill Health Centre
41 Shawpark Street
Glasgow
G20 9DR

0141 946 2433

Dear Dr Webb

Mr Brian McLaughlin DOB 28/01/1960 ~ CHI: 2801606030 ~ Hospital Number: 51132067E
265a Broughton Road Glasgow Lanarkshire G23 5JH

Diagnosis: C5/C6 & C6/C7 anterior cervical discectomy
Management Plan: Review 9 months for cervical follow up, requested MRI scan of lumbar spine for low back pain & giving way of right ankle, review with results

Brian was reviewed at my spinal clinic today. He mentioned that his left arm pain is significantly better and he is starting to feel his left hand fingers much better now. His neck pain was better but then flared up again 4 weeks previously. He has definitely reduced his painkillers and thinks it might be the reason for giving him flare up of pain. He started noticing more of a low back pain recently and 2 episodes of giving way on his right ankle. He also mentioned that left leg feels much better now after his operation.

Examination

Examination confirmed healthy scar over the front of his neck without any sign of infection. Cervical spine movements were painful and restricted in the terminal 50% of range and restricted in the terminal 25% of the range of movement. Upper limb neurology was normal with no sign of myelopathic manifestations. There was tenderness at right lateral epicondyle with positive Mills and Cozen manoeuvre consistent with tennis elbow or lateral epicondylitis. Lumbar spine was fairly stiff. Lower limb neurology was normal.

Plan

I have requested MRI scan of his lumbar spine to rule out any disc pathology causing nerve compression giving his recurrent ankle sprains. He denies any ankle problems as such and denies any right leg pain as well. I have advised him to start doing exercise and join gym and try for weight reduction. He had cervical spine x-rays today which confirm satisfactory position of cages with ongoing fusion. I advised him to come to clinic in approximately 2 months time for review of lumbar spine MRI scan and 9 months time for review of his 2 level ACDS.

Outcome Measures

Neck Pain - 10/10 Arm Pain - 8/10

Yours sincerely

Mr Himanshu Sharma
BSC, MBBS, MS (Orth), MCh (Orth), FRCS (Tr & Orth)
Locum Orthopaedic Spinal Surgeon

8

Department of Orthopaedic Surgery

MR H SHARMA

DISCHARGE LETTER

Gartnavel General Hospital
1053 Great Western Road
GLASGOW G12 0YN

Secretary Tel: 0141 211 3185

Secretary Fax: 0141 211 3189

E-mail: Alison.gallacher@ggc.scot.nhs.uk

Dictated: 30/03/2012

Typed: 27/04/2012

Ref: HS/LM

Dr Alasdair Webb
The Maryhill Red Practice
Maryhill Health Centre
41 Shawpark Street
Glasgow
G20 9DR

Dear Dr Webb

Mr Brian McLaughlin
Hospital Number: 51132067E

222 Broughton Road Glasgow Lanarkshire G23 5LP
CHI: 2801606030

Date of Admission: 29/03/2012

Date of Operation: 29/03/2012

Date of Discharge: 31/03/2012

Diagnosis: Left C6 & C7 radiculopathy from C5/C6 & C6/C7 disc osteophyte complex & disc prolapse

Operation: C5/C6 & C6/C7 anterior cervical discectomy & fusion

Mr McLaughlin underwent the above mentioned procedure without any intra operative and immediate post operative problems. His post op check x-rays were satisfactory. There were no clinical issues at the time of discharge. Mr McLaughlin was advised to wear a cervical collar for the period of 6 weeks time. He will be reviewed at my spinal clinic in 6 weeks time and advised to attend GP surgery in 10 days to 2 weeks time for removal of his clips. For any wound related problems or any neurological deterioration Mr McLaughlin was advised to contact my secretary or ward directly.

Yours sincerely

Mr Himanshu Sharma
BSC, MBBS, MS(Orth), MCh(Orth), FRCS(Tr & Orth)
Locum Orthopaedic Spinal Surgeon

leg better
- left arm better
- neck pain (↓) p.k.
- LBP
- Annele gave us
- RT arm pain

Midline 1° Anterior Cervical Discectomy and Fusion

Name: Mr Brian McLaughlin Ward: GGH - 2a
222 Broughton Road Glasgow Lanarkshire G23 5LP Surgeon: Mr Himanshu Sharma
Hospital No: 51132067E D.O.B.: 28/01/1960 Assistant: Dr Julia Park
Indication: Cervical Radiculopathy Anaesthetist: Dr Neil Storey

Preparation

Procedure : Primary, Interbody and anterior body fusion
Disease bilateral : C5/6 and C6/7
Surgery bilateral : C5/6 and C6/7
Position : Supine, with sandbag Head ring and interscapular sandbag
Skin prep : Alcoholic Chlorhexidine
Antibiotic prophylaxis : A single antibiotic was given as prophylaxis Cefuroxime and 1.5g at induction
Discogram : Not done
Magnification : By microscope
Cord monitoring : None
Imaging : Level check

Incision and Approach

Incision : Anterior and Right sided
Approach : Single stage, anterior, transcervical

Findings

Intra-op findings : As expected from radiology
Bone stock : Normal C5/6 significant compression from disc osteophyte and C6/7 moderate compression from disc osteophyte
Spinal cord and left C6 and C7 nerve roots completely free at end of procedure
Size 5 Cage Cervical with iFactor bone graft used for both levels
Implant position checked with image intensifier and was satisfactory

Procedure

Anterior release : Performed
Disc space : Disc removed
Disc space washout : Saline
Fusion : Proceed to interbody spinal fusion
Fusion levels : C5 to C7
Instrumentation levels : C5 to C7
Fusion device : Peek and osteogenic bone graft Stand-alone interbody fusion device Cage
Final check : No abnormalities
Additional comments :

Closure

Blood loss : <200 mls.
Prior to closure : Haemostasis achieved
Surgical time : 4 hours
Drains : None
Wound closure : Single wound Continuous 2-0 Vicryl suture + Clips Remove: In 10 days by district nurse
X-ray : Imaged intra-op
Investigations : Check cervical spine xray after 24 hours post-op

Post operative instructions

VTE Risk : Low
VTE prophylaxis : Intra-op: Calf compression Post-op: Adequate hydration and Early mobilisation
Wound review : None

Rehabilitation

Bed rest : Not required
Bracing : Need bracing prior to mobilisation and Soft cervical collar for 6 weeks to be worn for 6 weeks
Mobilisation : FWB
Rehabilitation : Standard for this procedure
Discharge : When physio happy discharge 24-48 hours
Review : 6 weeks in follow up clinic

Addenda:

Procedure	Code Type	Code
Radiculopathy, cervical region	ICD 10	M54.12
Primary anterior decompression of cervical spinal cord and fusion of joint of cervical spine	OPCS	V22.1
Primary anterior excision of cervical intervertebral disc NEC	OPCS	V29.5
Unspecified primary excision of cervical intervertebral disc	OPCS	V29.9
Level of spine one	OPCS	V55.1
Primary anterior cervical discectomy +/- graft	RCS UK	N140

cc:

The Maryhill Red Practice
Maryhill Health Centre
41 Shawpark Street
Glasgow
G20 9DR

Anaesthetic Record

Name

Hospital n

CHI no.

DoB / Age

Date 29 / 3 / 12

51132067E
MCLAUGHLIN M
BRIAN 28/01/1960
222, BROUGHTON ROAD
GLASGOW
LANARKSHIRE G23 5LP
CHI-2801606030

Premedication

Procedure(s) @ cervical decomp.

Anaesthetist(s) AS / TM

Surgeon(s) HS

Supervising consultant

☒ ☐ ☒

C SAS StR

☒ ☐ ☐

Discussed ☐

Airway MP II Ltd ext.

RS

Weight (kg)

Haematology

Biochemistry

ECG

BP /

Other significant illnesses

Current therapy

Losar
Ibuprofen
Amitriptyline
Cimetidine
Pregabalin

Allergies

Gabapentin

Previous anaesthesia

ASA 1 2 3 4 5 E

Technique & associated risks discussed with patient ☐

GA ☒ . Spinal ☐ Epidural ☐ Other LA _____

Laryngoscopy grade 1

Technique details

Breathing system 

Finish

Equipment check ☐

Rapexel	200		
Albut	1		
Cefuroxime	1.5		
Harpine	6	3	
Poc	20		20
Dexameth	8		
A ⁻	0.6		
Mekaramid 0.5	x+x+x	+++	
IV fluids	(1)		

Pre-ox ☒
RSI ☐
ECG ☐
SpO₂ ☐
NIBP ☐
ETCO₂ ☐
ETAA ☐
All of the above ☒
PNS ☐

Time	15 ⁰⁰	16 ⁰⁰	15 ⁰⁰	16 ⁰⁰	17 ⁰⁰	
vents						
FiO ₂	50	50	48	46	45	47
SpO ₂	97	97	97	96	96	96
ETCO ₂	5.7	5.5	5.5	5.6	6.1	6.1
ETAA	2.4	2.3	2.3	2.5	2.7	2.7

IV fluids

Warmer

①	① R/L 500
②	② R/L 500
③	③ R/L 500
④	④
⑤	⑤
⑥	⑥
⑦	⑦
⑧	⑧
⑨	⑨

Signature _____
Name _____

12

ORTHOPAEDIC DEPARTMENT
WESTERN INFIRMARY
DUMBARTON ROAD
GLASGOW
G11 6NT

Secretary Tel: 0141 211 1853 (Ms Alison Gallacher)
Secretary Fax: 0141 211 2466
Appointments Office: 0141 232 9499
Email: alison.gallacher.wg@ggc.scot.nhs.uk

MR H SHARMA ORTHOPAEDIC CLINIC - 25/01/2012

Typed: 27/01/2012
HS/LM

Dr Alasdair Webb
The Maryhill Red Practice
Maryhill Health Centre
41 Shawpark Street
Glasgow
G20 9DR

Dear Dr Webb

Mr Brian McLaughlin DOB 28/01/1960 ~ CHI: 2801606030 ~ Hospital Number: 51132067E
222 Broughton Road Glasgow Lanarkshire G23 5LP

Mr McLaughlin returned to clinic following his MRI scan of cervical spine. MRI scan confirmed the presence of disc osteophyte complex at C5/C6 level with narrowing of exit foramen with left C6 nerve root compression.

I have discussed with Mr McLaughlin about his current symptoms. He described that his leg pain and arm both are both equally bad and this is now 7 months down the line. We both agreed to go for C5/C6 entry cervical discectomy and fusion. Mr McLaughlin understands that surgery is unlikely to fix his neck pain and trapezius muscle pain as it is from wear and tear in his neck. Surgery primarily intended to improve his left arm pain as numbness and weakness will probably persist. I have explained the serious risks with surgery including risk to life, risk of paralysis and risk of stroke, all are miniscule risks but serious. He was also told about other neurological risks like nerve root injury, injury to oesophagus, to trachea and recurrent laryngeal nerve, to vertebrae, to sympathetic nerve, subjective dysphasia and of course no improvements in the arm pain. He understands and is happy to proceed with surgery. I have put his name on the waiting list for C5/C6 anti cervical discectomy and fusion.

Special Remarks

Would need self retainers and cervical cages.

Outcome Measures

Neck Pain - 8/10 Arm Pain - 9/10 ODI - 42%

Yours sincerely

Mr Himanshu Sharma
BSc, MBBS, MS(Orth), MCh(Orth), FRCS(Tr & Orth)
Locum Orthopaedic Spinal Surgeon

Patient Details

Surname MCLAUGHLIN
Forename BRIAN
CHI 2801606030
GP Details WEBB, ALASDAIR MARYHILL HEALTH CENTRE, 41 SHAWPARK
Age STREET, GLASGOW
Hospital.CRN 51132067E, ZH01120264, ZGM1092386

13

Referral Details

Date Received 08/09/2011 08:46:44

ReferralID 7265325
Priority ROUTINE
New Priority ROUTINE

Priority History

ROUTINE 08/09/2011 12:50:37

Redirection Information

<u>Specialty</u>	<u>Hospital</u>	<u>Reason</u>	<u>Redirected Date</u>	<u>Redirected By</u>
General Surgery	Western Infirmary/Gartnavel General	Record Creation	08/09/2011 12:50	Alison Lynn
General Surgery - Colorectal	Western Infirmary/gartnavel General	not gs	08/09/2011 12:51	Alison Lynn

Tracking/Vetting Details

Cancer Code
Date Vetted 09/09/2011 09:48:03
Vetting Status Vetted
Outcome Direct OP Appointment
Vetted By Iona Drummond

Tests

Clinics

Nurse Led

Consultant

Site

Western Infirmary/gartnavel General

Instructions

HRCompleted False

Hospital use only	Clinic	Day Date	Time	Hospital No.
----------------------	--------	-------------	------	-----------------

REFERRAL LETTER

MEDICAL IN CONFIDENCE

GGC Single Stylesheet - [standard|dental|diagnostic
imaging]

GGC General Referral Protocol (Glasgow, vR13.0)

Transport required?

REFERRAL TO

General Surgery
GGC General Referral

Western Infirmary/Gartnavel General
Dumbarton Road
Glasgow
G11 6NT

Consultant / receiving practitioner
and/or specialty clinic

Hospital and hospital address

Hospital location code.

G516H

Email address.

Urgency of referral

ROUTINE

Date sent

08-Sep-2011

Date of referral

08-Sep-2011

PATIENT DETAILS

Surname McLaughlin

Forename(s) Brian

Title Mr

Sex Male

Date of birth 28-Jan-1960

CHI no. 2801606030

Area of
Residence

Patient's address

222 Broughton Road
Summerson
GLASGOW
G23 5LP

Contact number(s)

Voice: 569 5266

101002508022B

Unique Care Pathway Number: 101002508022B

REGISTERED GP DETAILS

Name Dr A Webb

GMC code 4014139 GP code 00248

Practice name Maryhill Health Centre (18866)

Practice code 43311

Practice address

41 Shawpark Street
Maryhill

Contact number(s)

Voice: 0141 531 8830 / 8831

Facsimile: 0141 531 8863

REFERRING GP DETAILS

Name Dr. Alasdair Webb

GMC code 4014139 GP code 00248

Practice name The Maryhill Red Practice (43311)

Practice code 43311

Practice address

Maryhill Health Centre
41 Shawpark Street
Glasgow

Contact number(s)

Voice: 0141 531 8830

(15)

CLINICAL INFORMATION**History of presenting complaint****Presenting complaint**

Description: Haemorrhoids

Comment: Thank you for seeing this 51yo gentleman who presents with episodes of fresh rectal bleeding. Colonoscopy last year demonstrated the presence of haemorrhoids (copy of report attached) and at his request I would appreciate your assessment with regard to treatment of them. In the meantime he has been given topical preparations.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history**Pre-existing conditions (High & medium priority - all)**

<u>Description</u>	<u>Comment</u>	<u>Date of onset</u>	<u>Date recorded</u>
Haemorrhoids		16-Dec-2010	16-Dec-2010
Irritable bowel syndrome	probable	16-Dec-2010	16-Dec-2010
Acute pancreatitis	2ndry to alcohol	31-Dec-2002	31-Dec-2002
Pulmonary embolism	Query	01-Dec-2002	01-Dec-2002
DVT - Deep vein thrombosis		01-Dec-2002	01-Dec-2002
Atypical chest pain	Associated with previous neurological symptoms	22-Aug-1997	22-Aug-1997
Obesity and other hyperalimentionation		22-Aug-1997	22-Aug-1997
Transient neurological symptoms	Particularly L arm and hand	24-Jul-1997	24-Jul-1997
Osgood-Schlatter's dis - osteochondrosis of tibial tubercle		21-Mar-1980	21-Mar-1980
Pneumonia due to staphylococcus		27-May-1960	27-May-1960

Past procedures (High and medium priority - all)

<u>Description</u>	<u>Date performed</u>	<u>Date recorded</u>
Endoscopic cholecystectomy	14-May-2003	14-May-2003
ECG:left ventricle hypertrophy	09-Jul-1997	09-Jul-1997
Excision of sebaceous cyst of head or neck	18-Oct-1996	18-Oct-1996
Emergency appendectomy	07-Jun-1971	07-Jun-1971

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)

<u>Drug name</u>	<u>Quantity</u>	<u>Formulation</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Date started</u>	<u>Date last issued</u>
Proctosedyl Suppositories	12	12 suppository	1 TO BE INSERTED TWICE DAILY	-	07-Sep-2011	07-Sep-2011
Co-Codamol 30/500 Tablets	100	100 TABLET	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)	-	07-Sep-2011	07-Sep-2011
Naproxen Tablets 500 mg	56	56 TABLET	ONE TO BE TAKEN TWICE A DAY	-	14-Jul-2011	14-Jul-2011
Co-Codamol	100	100 TABLET	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED	-	14-Jul-	14-Jul-



16

8/500 Tablets

(MAXIMUM OF 8 IN 24 HOURS)

2011

2011

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Never smoked tobacco:	Smoker\$\$ Status.clm - No Action Required	26-Jun-2003
Trivial drinker - <1u/day:	Alcohol Intake\$\$.clm - Repeat after an Interval	26-Jun-2003

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:Yes

Signature of referring doctor (or other professional) Date

17

NHS Greater Glasgow and Clyde
Endoscopy Unit, Stobhill Hospital
GASTROSCOPY REPORT

Name: **Brian McLAUGHLIN, 28/01/1960 (M)**
CHI No: **2801606030**
Case note no: **51132067E**

Address: **0/2 38 Kelvindale Place
Glasgow
Lanarkshire
G208BP**

Procedure date
16th August 2010

GP: **Dr Alasdair Webb
Maryhill Health Centre
41 Shawpark Street
Glasgow
G209DR**

Priority: **Elective**
Status: **Day patient/NHS**
Hospital: **GGH**
Ward: **(none)**
Referring Cons: **Dr Simon B Dover
(Gastroenterology)**

Consultant/Endoscopist
List consultant: **Mr David Chong**
Endoscopist No1: **Miss Joanna Gray**
Nurse: **Sister Margaret Anderson**

Indications

Clinically important comments: **FX gastric cancer.**

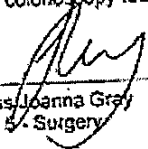
Report

The procedure was completed successfully.
Apparent mucosal junction at 40cm from the incisors.

Diagnosis

OESOPHAGUS. Normal.
STOMACH. Bile reflux, mucosa normal.
DUODENUM. Normal.

Advice/comments
For colonoscopy today.


Miss Joanna Gray
ST B Surgery

Instrument
STP PURPLE STR EG2770K A120370

Premedication
Fentanyl (IV) 50 mcg
Midazolam (IV) 3 mg

18

NHS Greater Glasgow and Clyde
Endoscopy Unit, Stobhill Hospital
COLONOSCOPY REPORT

Name: **Brian MCLAUGHLIN, 28/01/1960 (M)** Address: **0/2 38 Kelvinhall Place**
CHI No: **2801606030** Glasgow
Case note no.: **51132067E** Lanarkshire
G208BP

Procedure date
16th August 2010

GP: **Dr Alasdair Webb**
Maryhill Health Centre
41 Shawpark Street
Glasgow
G209DR

Priority: **Elective**
Status: **Day patient/NHS**
Hospital: **GGH**
Ward: **(none)**
Referring Cons: **Dr Simon B Dover**
(Gastroenterology)

Consultant/Endoscopist
List consultant: **Mr David Chong**
-Endoscopist Not: **Ewan Bell**
Nurse: **Sister Margaret Anderson**

Indications

Chronic alternating constipation/diarrhoea with overt rectal bleeding and abdominal pain.

Report

Bowel preparation with Kleanprep was satisfactory. A digital rectal examination was performed. The colonoscope was inserted via the anus to the terminal ileum. The caecum was identified positively by the ileocecal valve, the appendicular orifice, the tri-radiate caecal fold and ileal intubation. Perianal lesions: haemorrhoids (1st degree) at (c). There were no peri-operative complications.

Diagnosis

Haemorrhoids.

Follow up

Awaiting pathology results.

Advice/comments

Likely to be haemorrhoidal bleeding. These are not amenable to banding today.

Brian tells me that his altered bowel habit has improved, but the pain is still troublesome.

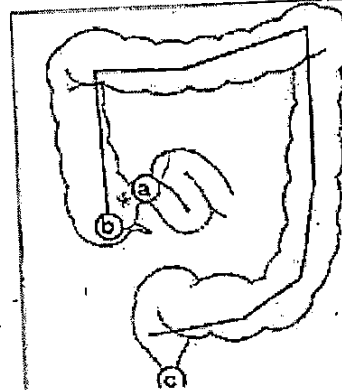
Random and TI biopsies obtained.

Clinic review with Dr Dover is already arranged.

Ewan Bell
Ewan Bell
Colorectal Nurse Specialist

Instruments
STP BLUE EC3885LK A120205
Disposable forceps

Premedication
In addition to previous procedure
Midazolam (IV) 1 mg



a: Terminal ileum
b: An area extending from the caecum to the rectum
c: Anal margin

Specimens taken
Biopsy (x2 site a and random x1 site b)

19

ORTHOPAEDIC DEPARTMENT
WESTERN INFIRMARY
DUMBARTON ROAD
GLASGOW
G11 6NT

Secretary Tel: 0141 211 1853 (Ms Alison Gallacher)
Secretary Fax: 0141 211 2466
Appointments Office: 0141 232 9499
Email: alison.gallacher.wg@ggc.scot.nhs.uk

MR H SHARMA ORTHOPAEDIC CLINIC - 01/12/2011

Typed: 05/12/2011

HS/LM

Dr Alasdair Webb
The Maryhill Red Practice
Maryhill Health Centre
41 Shawpark Street
Glasgow
G20 9DR

Dear Dr Webb

Mr Brian McLaughlin DOB 28/01/1960 ~ CHI: 2801606030 ~ Hospital Number: 51132067E
222 Broughton Road Glasgow Lanarkshire G23 5LP

Diagnosis: Neck pain, left arm pain
Management Plan: Requested MRI scan of cervical spine

Many thanks for your referral for Mr McLaughlin who is 51 and presented with a 6 month history of left arm radicular pain predominantly in the C6 distribution. He says that 2 weeks prior to onset of his left arm pain he pulled a heavy cage at Tesco where he was working as a Team Leader and this started his neck pain and left arm pain which lasted for 2 days. He also described onset of neck pain a few weeks down the line from the onset of arm pain and is primarily mechanical in nature. He has no bladder bowel dysfunction and no radicular pain in his right arm or either leg. No history of dropping objects or unsteadiness while walking. He is on Amitriptyline, Ibuprofen, Naproxen and Paracetamol plus Dihydrocodeine combination. He has been off work for the past 6 months. He also mentioned about painful per rectal bleeding for the last few months, probably twice every month and he is due to be seen at Gartnavel for his rectal bleeding soon.

Past Medical History

He is medically fit and well apart from his previous history of cholecystectomy and pancreatitis. He does not smoke and drinks only occasionally. He reported a couple of stones weight gain in the last 6 months period due to relative inactivity.

20

Examination

Examination today revealed a restriction of terminal range of neck movements associated with pain. Neurological examination of upper limbs revealed no myelopathic manifestations. There was the presence of paraesthesia in the left C6 distribution. The rest of the neurological examination was normal. Provocative test for carpal tunnel syndrome was negative bilaterally.

MRI

X-ray of cervical spine was done on 09/09/2011, this showed the presence of degenerative changes at C5/C6 level with anterior and posterior osteophytes.

Impression and Plan

The most likely cause for Mr McLaughlin's left arm pain is of neck origin. I think degenerative disc disease along with osteophyte possibly causing his left C6 neural irritation/compression. I have therefore requested MRI scan of his cervical spine and plan to review him with the results. I have mentioned to Mr McLaughlin about the natural history of radicular pain in the arm. I have reassured him that in the majority of patients that in 6 to 9 months time there is significant improvement in symptoms.

Outcome Measures

Neck Pain - 8/10 Arm Pain - 9/10 ODI - 42%

Yours sincerely

Mr Himanshu Sharma
BSC, MBBS, MS(Orth), MCh(Orth), FRCS(Tr & Orth)
Locum Orthopaedic Spinal Surgeon

21

Hospital use only	Clinic	Day Date	Time	Hospital No.
-------------------	--------	----------	------	--------------

Transport required?

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

REFERRAL TO

Trauma & Orthopaedic - Shoulder
GGC General Referral

Western Infirmary/Gartnavel General
Dumbarton Road
Glasgow
G11 6NT

Consultant / receiving practitioner
and/or specialty clinic

Hospital and hospital address

Hospital location code

G516H

Email address

Urgency of referral
Date of referral

ROUTINE
23-Sep-2011

Date sent

23-Sep-2011

PATIENT DETAILS

Surname: McLaughlin
Forename(s): Brian
Title: Mr
Sex: Male
Date of birth: 28-Jan-1960
CHI no.: 2801606030
Area of Residence:

Patient's address

222 Broughton Road
Summerson
GLASGOW
G23 5LP

Contact number(s)

Voice: 569 5266

101002574915E

Unique Care Pathway Number: 101002574915E

REGISTERED GP DETAILS

Name: Dr A Webb
GMC code: 4014139 GP code: 00248
Practice name: Maryhill Health Centre (18866)
Practice code: 43311

Practice address

41 Shawpark Street
Maryhill
G20 9DR

Contact number(s)

Voice: 0141 531 8830 / 8831
Facsimile: 0141 531 8863

REFERRING GP DETAILS

Name: Dr. Roland Leslie
GMC code: 4317801 GP code: 02861
Practice name: The Maryhill Red Practice (43311)
Practice code: 43311

Practice address

Maryhill Health Centre
41 Shawpark Street
Glasgow
G20 9DR

Contact number(s)

Voice: 0141 531 8830

(22)

- Neck pain 51/M (Uarm pain) looked up
6/12, night shift ? C6 Thru Trauma
C8

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: pain in arm

Comment: I would be grateful if you could review this 51 year old man who works doing a manual job in Tesco. He has been off work for around six weeks due to pain in his arm. X-ray of his neck has revealed significant arthritis at the C5/C6 level which corresponds to the pain that he has been having in his arm. There is osteophyte formation and loss of disc height. He has attended physiotherapy which has not made any great difference, nor has analgesia or anti-inflammatory, although we have recently added Amitriptyline to his medication.

He is off work at present and is not paid while off work and is actually concerned about his future. I would be grateful if you could review him with regard to the possibility of surgery.

45r Team leader for Tesco
pulling case = 2/8.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Painkillers

B/B ✓

ibuprofen
Naproxen

Paracetamol + DHC

- DMX

- Pancreatitis

- CB

Smoker X

Alc. Occ

Past medical history

Painful P/R bleeding

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Haemorrhoids	-	16-Dec-2010	16-Dec-2010
Irritable bowel syndrome	probable	16-Dec-2010	16-Dec-2010
Acute pancreatitis	2ndry to alcohol	31-Dec-2002	31-Dec-2002
Pulmonary embolism	Query	01-Dec-2002	01-Dec-2002
DVT - Deep vein thrombosis	-	01-Dec-2002	01-Dec-2002
Atypical chest pain	Associated with previous neurological symptoms	22-Aug-1997	22-Aug-1997
Obesity and other hyperalimentation	-	22-Aug-1997	22-Aug-1997
Transient neurological symptoms	Particularly L arm and hand	24-Jul-1997	24-Jul-1997
Osgood-Schlatter's dis - osteochondrosis of tibial tubercle	-	21-Mar-1980	21-Mar-1980
Pneumonia due to staphylococcus	-	27-May-1960	27-May-1960

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Endoscopic cholecystectomy	-	14-May-2003	14-May-2003
ECG:left ventricle hypertrophy	Query	09-Jul-1997	09-Jul-1997
Excision of sebaceous cyst of head or neck	Scalp Excised 15/1/97	18-Oct-1996	18-Oct-1996
Emergency appendectomy	-	07-Jun-1971	07-Jun-1971

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	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Amitriptyline Hydrochloride Tablets 10 mg	28	28 tablet	ONE OR TWO TABLET AT NIGHT	-	16-Sep-2011	16-Sep-2011
Proctosedyl	12	12	1 TO BE INSERTED TWICE DAILY	-	07-Sep-	07-Sep-

23

Suppositories		suppository		2011	2011
Co-Codamol 30/500 Tablets	100	100 TABLET	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)	07-Sep-2011	07-Sep-2011
Naproxen Tablets 500 mg	56	56 TABLET	ONE TO BE TAKEN TWICE A DAY	14-Jul-2011	14-Jul-2011
Co-Codamol 8/500 Tablets	100	100 TABLET	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)	14-Jul-2011	14-Jul-2011

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Never smoked tobacco:	Smoker\$\$ Status.cdm - No Action Required	26-Jun-2003
Trivial drinker - <1u/day:	Alcohol Intake\$\$ cdm - Repeat after an Interval	26-Jun-2003

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

24



Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN

Tel: 0141 278 4700 Fax: 0141 301 9736

20 Oct 2011 MRCA

BRIAN MCLAUGHLIN
222 BROUGHTON ROAD
GLASGOW
LANARKSHIRE

G23 5LP

HOSPITAL NUMBER: 51132067E
CHI NUMBER: 2801606030

According to our records you failed to attend your last appointment at **GS-GENERAL SURGERY NUR-DRUMMOND** clinic on 20 Oct 2011.

A further appointment has been arranged on 08 Dec 2011 at 09:00

If, however, this appointment is not suitable, please telephone freephone 0800 59 2087 between 08.00am and 8.00pm Monday to Friday and 08.00am to 1.00pm on a Saturday to arrange a more convenient time.

Should you neglect to inform us that this appointment is unsuitable and you fail to attend this appointment, you may be removed from the waiting list and referred back to the care of your General Practitioner – referrer who will require to re-refer you in order for you to obtain another appointment.

Yours sincerely

Appointments Supervisor

Acute Services Division

Emergency Care and Medical Services Directorate

Department of Gastroenterology

Dr Simon Dover's Gastroenterology Clinic

25



Gartnavel General Hospital
1053 Great Western Road
Glasgow G12 0YN
Switchboard: 0141 211 3000

Clinic 16/12/2010
Dictated 16/12/2010
Typed 20/12/2010
Your Ref
Our Ref JO/SON
Enquiries to 0141 211 3280 (secretary's direct line)
Fax 0141 211 1676
E-mail sandra.o'neill2@ggc.scot.nhs.uk

Dr Alasdair Webb
Maryhill Health Centre
41 Shawpark Street
G20 9DR

Dear Dr Webb

Brian McLaughlin ~ 28/01/1960 ~ CHI: 2801606030 ~ CRN: 51132067E
222 Broughton Road, Glasgow, Lanarkshire, G23 5LP

Diagnoses: 1. Probable IBS
2. Haemorrhoids

I saw this gentleman today at Dr Dover's gastroenterology clinic. He has been keeping well and feels his bowel symptoms have improved slightly. He is still moving his bowels about 3-4 times a day and is passing a large amount of formed stool at these times. He complains of occasional right iliac fossa pain.

On examination today his abdomen was soft and non-tender and there were no masses palpable. His weight is stable at 111kgs.

Since we last saw him he has had an upper GI endoscopy and colonoscopy which were normal with the exception of some haemorrhoids and biopsies from the colonoscopy confirm normal terminal ileal and colonic mucosa.

Bloods were reassuring normal in the past and he has a normal faecal elastase level. We have still to receive a sample for faecal calprotectin and I have suggested he hand in a sample for completeness sake. I haven't given him a routine appointment to return to the clinic but would be happy to see him back should the need arise.

Yours sincerely

James Orr
ST4 in Gastroenterology

Acute Services Division

Emergency Care and Medical Services Directorate

Department of Gastroenterology

Dr Simon Dover's Gastroenterology Clinic

26

Garthavel General Hospital
1053 Great Western Road
Glasgow G12 0YN
Switchboard: 0141 211 3000



Clinic 12/08/2010
Dictated 12/08/2010
Typed 12/08/2010
Your Ref
Our Ref SBD/VC
Enquiries to 0141 211 3280 (secretary's direct line)
Fax 0141 211 1676
E-mail sandra.o'Neill2@ggc.scot.nhs.uk

Dr Alasdair Webb
Maryhill Health Centre
41 Shawpark Street
G20 9DR

Dear Dr Webb

**Brian McLaughlin ~ 28/01/1960 ~ CHI: 2801606030 ~ CRN: 51132067E
222 Broughton Road, Glasgow, Lanarkshire, G23 5LP**

I saw him again today. The situation is much the same. He is getting his endoscopy here in a week or two and he is coming for colonoscopy at Stobhill next week.

His bloods including biochemistry, full blood count, thyroid function and coeliac screen were negative. Unfortunately, we haven't had any success with his faecal elastase or calprotectin. We will try again. I have arranged to see him again in a few months.

Kind regards

Yours sincerely

SIMON DOVER
Consultant Physician & Gastroenterologist

Acute Services Division

Emergency Care and Medical Services Directorate

Department of Gastroenterology

Dr Simon Dover's Gastroenterology Clinic

27

Gartnavel General Hospital
1053 Great Western Road
Glasgow G12 0YN
Switchboard: 0141 211 3000



Clinic 15/07/2010
Dictated 15/07/2010
Typed 19/07/2010
Your Ref
Our Ref NT/SON
Enquiries to 0141 211 3280 (secretary's direct line)
Fax 0141 211 1676
E-mail sandra.o'Neill2@ggc.scot.nhs.uk

Diane
Gastro scope Co-ordinator
Endoscopy Unit
GGH

Dear Diane

Brian McLaughlin ~ 28/01/1960 ~ CHI: 2801606030 ~ CRN: 51132067E
222 Broughton Road, Glasgow, Lanarkshire, G23 5LP

Can we please arrange a bi-directional endoscopic examination for this patient with a six month clear history of altered bowel habit and family history of stomach cancer.

Many thanks

Yours sincerely

12/8/10

see w/s

Nadeem Tehami
Specialist Registrar in Gastroenterology

0.001 — 24/8
lower colon
8/8/10
16/8

Acute Services Division

Emergency Care and Medical Services Directorate

Department of Gastroenterology

Dr Simon Dover's Gastroenterology Clinic

26

Gartnavel General Hospital
1053 Great Western Road
Glasgow G12 0YN
Switchboard: 0141 211 3000

NHS
Greater Glasgow
and Clyde

Clinic 15/07/2010
Dictated 15/07/2010
Typed 19/07/2010
Your Ref
Our Ref NT/SON
Enquiries to 0141 211 3280 (secretary's direct line)
Fax 0141 211 1676
E-mail sandra.o'Neill2@ggc.scot.nhs.uk

Dr Alasdair Webb
Maryhill Health Centre
41 Shawpark Street
G20 9DR

Dear Dr Webb

Brian McLaughlin ~ 28/01/1960 ~ CHI: 2801606030 ~ CRN: 51132067E
222 Broughton Road, Glasgow, Lanarkshire, G23 5LP

Many thanks for referring this pleasant 50 year old gentleman to Dr Dover's outpatient gastroenterology clinic. He gives a clear history of altered bowel habits for the last six months. Up until six months ago he was opening his bowel once a day to pass a formed stool with no other GI symptoms. For the last six months he has been opening his bowel more frequently in that he is going to the toilet 2-3 times a day passing a soft to loose stool and has noticed blood mixed in with the stool on occasions. He has also found on occasions that the stools were pale, bulkier and difficult to flush. Surprisingly over this period of time he has maintained good appetite and has gained weight. He works as a night-shift Team Leader at Tesco and does complain of opening his bowel during his night-shift. The associated generalised abdominal discomfort does get better after defaecation and he has had a stressful time both at work and at home recently, but does not think that is contributing to his symptoms.

He does have a past medical history of haemorrhoids in the past but doesn't think that haemorrhoids are causing his symptoms at present. There is a history of acute pancreatitis secondary to alcohol excess in the past and he has had a cholecystectomy.

He is not on any regular medications at present and describes what probably sounds like a penicillin allergy. He does not smoke and is not drinking alcohol to excess at present and only drinks on the weekends. His dad unfortunately died with cancer of the stomach. He denies any high-risk behaviour, contact with an ill person, history of travel abroad or use of antibiotics.

On clinical examination he did appear to have a generous BMI with a weight of 113kgs. Otherwise examination was unremarkable. I agree with your clinical impression that given a clear history of altered bowel habits in a 50 year old gentleman would need to be investigated. Going through his notes I note that he has not attended a sigmoidoscopy appointment and two outpatient clinic appointments.

Cont'd....

In the clinic today I stressed to him the importance of attending for his outpatient investigations appointment. I have arranged for him to have routine blood tests including thyroid function tests, coeliac serology, stool M C & S, faecal calprotectin, faecal elastase, an ultrasound scan of the abdomen and pelvis and an upper and lower GI endoscopy examination.

He will be reviewed in due course with the results of the above investigations.

Yours sincerely

Nadeem Tehami
Specialist Registrar in Gastroenterology

Acute Services Division

Emergency Care and Medical Services Directorate

Department of Gastroenterology

Dr Simon Dover's Gastroenterology Clinic

30

NHS
Greater Glasgow
and Clyde

Gartnavel General Hospital
1053 Great Western Road
Glasgow G12 0YN
Switchboard: 0141 211 3000

Clinic 27/05/2010
Dictated 27/05/2010
Typed 27/05/2010
Your Ref
Our Ref SBD/SON
Enquiries to 0141 211 3280 (secretary's direct line)
Fax 0141 211 1676
E-mail sandra.o'neill2@ggc.scot.nhs.uk

Dr Alasdair Webb
Maryhill Health Centre
41 Shawpark Street
G20 9DR

Dear Dr Webb

Brian McLaughlin ~ 28/01/1960 ~ CHI: 2801606030 ~ CRN: 51132067E
31 Glenfinnan Road, Glasgow, Lanarkshire, G20 8JL

This man failed to keep a further new patient appointment at today's clinic. I haven't sent him a further one. Obviously we would be happy to try again if required.

Kind regards

Yours sincerely

SIMON DOVER
Consultant Physician & Gastroenterologist


51132067E
MCLAUGHLIN
BRIAN 28/01/1960
222 BROUGHTON ROAD
GLASGOW
LANARKSHIRE G23 5LP
CHI-2801606030

Acute Services Division

Emergency Care and Medical Services Directorate

Department of Gastroenterology

Dr Simon Dover's Gastroenterology Clinic

31

Garthavel General Hospital
1053 Great Western Road
Glasgow G12 0YN
Switchboard: 0141 211 3000

NHS
Greater Glasgow
and Clyde

Clinic 17/05/2010
Dictated 17/05/2010
Typed 17/05/2010
Your Ref
Our Ref SBD/SON
Enquiries to 0141 211 3280 (secretary's direct line)
Fax 0141 211 1676
E-mail sandra.o'neill2@ggc.scot.nhs.uk

Dr Alasdair Webb
Maryhill Health Centre
41 Shawpark Street
G20 9DR

Dear Dr Webb

Brian McLaughlin ~ 28/01/1960 ~ CHI: 2801606030 ~ CRN: 51132067E
31 Glenfinnan Road, Glasgow, Lanarkshire, G20 8JL

This man failed to keep his new patient appointment at this evening's gastroenterology clinic. I haven't sent him a further one at this stage. Obviously I would be happy to try again if required.

Kind regards

Yours sincerely

SIMON DOVER
Consultant Physician & Gastroenterologist

32

S1132067E

Hospital use only	Clinic Dr Dower	Day Date	Time	Hospital No.
-------------------	--------------------	----------	------	--------------

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL-TO		Consultant / receiving practitioner and/or specialty clinic	
Gastroenterology GGC General Referral		Hospital and hospital address	
Western Infirmary/Gartnavel General Dumbarton Road Glasgow G11 6NT		Hospital location code G516H	
		Email address	
Urgency of referral	ROUTINE	Date sent	19-Feb-2010
Date of referral	18-Feb-2010		

PATIENT DETAILS

Surname	McLaughlin
Forename(s)	Brian J
Title	Mr
Sex	Male
Date of birth	28-Jan-1960
CHI no.	2801606030

Patient's address

31 Glenfinnan Rd GLASGOW G20 8JL
Contact number(s)
Voice: 946 2091

101000218024C

Unique Care Pathway Number: 101000218024C

REGISTERED GP DETAILS

Name	Dr A Webb		
GMC code	4014139	GP code	G00248
Practice name	MARYHILL HEALTH CENTRE		
Practice code	43311		

Practice address

41 Shawpark Street Glasgow G20 9DR
Contact number(s)
Voice: 0141 531 8830 Appts Facsimile: 531 8863

REFERRING GP DETAILS

Name	Dr. Alasdair Webb		
GMC code	4014139	GP code	00248
Practice name	MARYHILL HEALTH CENTRE (43311)		
Practice code	43311		

Practice address

41 SHAWPARK STREET GLASGOW
Contact number(s)
Voice: 01415318830

33

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: assessment

Comment: I would be grateful if you could see this 50 year old gentleman who gives a history of six months altered bowel habit with urgency and loose bowel motions. He also has some abdominal pain and bloating. Over that time period his weight has actually increased. Examination of the abdomen is normal today and he refused PR examination. He is under some stress at work and his symptoms appear to be related to irritable bowel.

However given his age and recent guidelines I would be grateful if he could be reviewed to exclude any other pathology.

I have checked full blood count, ESR, CRP and Anti TTG today.

Dr D Taylor
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	Modifier	Date of onset
Acute pancreatitis	2ndry to alcohol	-	31-Dec-2002
DVT - Deep vein thrombosis	-	-	01-Dec-2002
Pulmonary embolism	-	Query	01-Dec-2002
Atypical chest pain	Associated with previous neurological symptoms	-	22-Aug-1997
Obesity and other hyperalimentation	-	-	22-Aug-1997
Transient neurological symptoms	Particularly L arm and hand	-	24-Jul-1997
Finger fracture	Distal phalanx of L pinkie	Left	22-May-1985
Osgood-Schlatter's dis - osteochondrosis of tibial tubercle	-	-	21-Mar-1980
Pneumonia due to staphylococcus	-	-	27-May-1960

Past procedures (High and medium priority - all)

Description	Comment	Modifier	Date performed
Helicobacter serology negative	-	-	26-Jun-2003
Endoscopic cholecystectomy	-	-	14-May-2003
Endosc retrograde cholangiography + biopsy lesion bile duct	via cystic duct	-	29-Apr-2003
ECG:left ventricle hypertrophy	-	Query	09-Jul-1997
Excision of sebaceous cyst of head or neck	Excised 15/1/97	Scalp	18-Oct-1996
Emergency appendicectomy	-	-	07-Jun-1971

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

No current medications recorded

34

Recent medication (Any medication issued within last 90 days not shown above)
No recent medications recorded

Lifestyle Risks and Alerts / Examinations and Investigations

<u>Description/Question</u>	<u>Result/Comment</u>	<u>Date</u>
Never smoked tobacco:		26-Jun-2003
Trivial drinker - <1u/day:		26-Jun-2003

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

35

For 24/2/09
213 51132067E

Hospital use only	Clinic	Flex. siggy Prof O'Dwyer	Day Date	Time	Hospital No.
-------------------	--------	-----------------------------	----------	------	--------------

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

General Surgery - Colorectal C1B
G Colorectal Protocol

Western Infirmary/Gartnavel General

Consultant / receiving practitioner and/or specialty clinic

Hospital and hospital address

Hospital location code.

G516H

Email address

Urgency of referral Not applicable
Date of referral 15-Jan-2009

Date sent 15-Jan-2009

PATIENT DETAILS

Surname McLaughlin
Forename(s) Brian J
Title Mr
Sex Male
Date of birth 28-Jan-1960
CHI no. 2801606030

Patient's address

F0-2
38 Kelvindale Pl
GLASGOW
G20 8BP

Contact number(s)

Voice: -

REGISTERED GP DETAILS

Name Dr A Webb
GMC code 4014139 GP code G00248
Practice name MARYHILL HEALTH CENTRE
Practice code 43311

Practice address

41 Shawpark Street
Glasgow
G20 9DR

Contact number(s)

Voice: 0141 531 8830 Appts
Facsimile: 531 8863

REFERRING GP DETAILS

Name Dr. Roland Leslie
GMC code 4317801 GP code 02861
Practice name MARYHILL HEALTH CENTRE (43311)
Practice code 43311

Practice address

41 SHAWPARK STREET
GLASGOW

Contact number(s)

Voice: 01415318830

CEX 08 R

36

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

Description: pr bleeding

Comment: this chap has had rectal bleeding on defaecation for the last 6 months. he feels can be mixed in with stools and coating. he has noticed increased frequency and often needs a second visit after he is finished. nil slime pr. he has right iliac fossa discomfort. if anything he is putting on weight. given his latered bowel habita nd bleeding please appoint for investigation

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Never smoked tobacco:		26-Jun-2003
Trivial drinker - <1u/day:		26-Jun-2003

Investigations

Description/Question	Result/Comment	Date
Previous similar problems?:	No	-
Family history of colorectal cancer?:	No	-
Duration of current symptoms (weeks):	26	-
Rectal bleeding:	Yes	-
Rectal bleeding bright red:	Yes	-
Rectal bleeding dark red:	Yes	-
Rectal bleeding separate from stool:	true	-
Rectal bleeding mixed with stool:	true	-
Change in bowel habit:	Yes	-
Bowel habit - increased frequency:	true	-
Pain:	Yes	-
Abdominal pain:	Yes	-
Weight loss:	No	-
Weight loss :	No weight loss	-
Current weight:	0114	-
Abdominal Examination:	Yes	-
Abdomen tender:	true	-
Rectal Examination:	Yes	-
Rectal exam normal:	true	-
Haematology:	No	-

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
Acute pancreatitis	-	2ndry to alcohol	31-Dec-2002
Pulmonary embolism	Query	-	01-Dec-2002
DVT - Deep vein thrombosis	-	-	01-Dec-2002
Obesity and other hyperalimentation	-	-	22-Aug-1997

(37)

Atypical chest pain	-	Associated with previous neurological symptoms	22-Aug-1997
Transient neurological symptoms	-	Particularly L arm and hand	24-Jul-1997
Finger fracture	Left	Distal phalanx of L pinkie	22-May-1985
Osgood-Schlatter's dis - osteochondrosis of tibial tubercle	-	-	21-Mar-1980
Pneumonia due to staphylococcus	-	-	27-May-1960

Past procedures (High and medium priority - all)

<u>Description</u>	<u>Modifier</u>	<u>Date performed</u>
Helicobacter serology negative	-	26-Jun-2003
Endoscopic cholecystectomy	-	14-May-2003
Endosc retrograde cholangiography + biopsy lesion bile duct	-	29-Apr-2003
ECG:left ventricle hypertrophy	Query	09-Jul-1997
Excision of sebaceous cyst of head or neck	Scalp	18-Oct-1996
Emergency appendectomy	-	07-Jun-1971

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

No current medications recorded

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

No recent medications recorded

Clinical warnings**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

Mon (DMA) 38

Hospital Only Use	Clinic DIRECT ACCESS SIGMOIDOSCOPY	Day Date 145	Time 10/10/05	Hospital No 1132067E
Referral To: WESTERN INFIRMARY MR GALLOWAY SURGICAL			Registered GP Details Dr Webb Maryhill Health Centre 41 Shawpark Street Glasgow G20 9DR	
Hospital Consultant Speciality Clinic WESTERN MR GALLOWAY SURGICAL			Email address: Administrator@643311.glasgow-hb.scot.nhs.uk	
Has Patient Attended Hospital before Yes			Practice Code: 43311 GP Identifier G00248	
Name of Hospital Western			Telephone/ Fax: 531 8830/531 8863	
Hospital Number 1132067				
Year of Attendance 2002				
If patients name or address has changed since -				

Patient Details	
Surname McLaughlin Title: Mr	Patient Address: 0/2 38 Kelvindale Place
Forename: Brian Sex M	Glasgow 620
Date of Birth: 28/01/60 CHI No:	Post Code 620
	Telephone No:

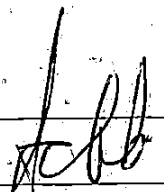
C ICAL DETAILS	Routine ☐	Soon ☐	Urgent ☐
-----------------------	----------------------------------	-------------------------------	---------------------------------

Reason For Referral -

History of presenting complaint:
I would be grateful if you could offer this 45 year old gentleman another appointment for review. He initially presented towards the end of 2003 with rectal bleeding but I understand failed to attend follow-up at your clinic. He represented in early June this year with one months history of stomach pains, again with diarrhoea and blood. Examination of his abdomen at that time was unremarkable. Full blood count, Us & Es and LFTs and amylase were all normal. At review the diarrhoea was persisting although the blood had settled. He had also developed vomiting and pain immediately after eating. Helicobacter test in July 2003 was negative. I have arranged stool culture should his diarrhoea persist and will append the result to this letter.

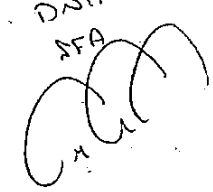
Nevertheless given his history of bloody diarrhoea, together with symptoms suggestive of gastritis I would appreciate your further assessment of his GI tract.

stool C&S negative

Past Medical History Pancreatitis 2002 DVT 2002 Appendicectomy 1971	Medication Omeprazole 20mgs (June 2005)
Other Comments:	Signature:  Date: 28 JUN 2005 16.6.05

(F) JL
 (DMA)
 R/A 18/3/04 51132067

Hospital Only Use	Clinic <u>Direct access</u> <u>flex. siggy</u>	Day Date <u>12.02.04</u>	Time <u>2.45</u>	Hospital No
<u>Referral to:</u> Hospital <u>WESTERN INFIRMARY</u> Consultant <u>MR GALLOWAY</u> Speciality Clinic <u>SURGICAL</u> Has Patient Attended Hospital before <u>Yes</u> Name of Hospital <u>Western</u> Hospital Number <u>1132067</u> Year of Attendance <u>2002</u> If patients name or address has changed since -			<u>Registered GP Details</u> Dr Leslie Maryhill Health Centre 41 Shawpark Street Glasgow G20 9DR Email address: Administrator@643311.glasgow-hb.scot.nhs.uk Practice Code: <u>43311</u> GP Identifier <u>602861</u> Telephone/ Fax: <u>531 8830/531 8863</u>	
Patient Details				
Surname <u>McLaughlin</u> Title: <u>Mr</u> Forename: <u>Brian</u> Sex <u>M</u> Date of Birth: <u>28/01/60</u> CHI No:		Patient Address: <u>2B 11 Kirkhill Place</u> Glasgow Post Code <u>620</u> Telephone No:		
CLINICAL DETAILS Routine ☐ Soon ☐ Urgent ☐				
Reason For Referral - <u>History of presenting complaint:</u> I would be grateful if you could organise an appointment for this 43 year old man. Over the last few weeks he has noticed increased bowel frequency as well as rectal bleeding. On initial questioning this sounded haemorrhoidal but Brian then told me that on occasions he felt that the blood was actually mixed in with his faeces. In view of this and the increased frequency I wondered if sigmoidoscopy or colonoscopy would be worthwhile. He is quite worried as he suffered from acute pancreatitis secondary to gallstones and a DVT in December last year. I would be grateful for your thoughts on him.				
<u>Past Medical History</u>		<u>Medication</u>		
<u>Other Comments:</u>		<u>Signature:</u> <u>Rosh</u> Date: <u>11.12.03</u>		

12.2.4
 DMA
 SFA


MARYHILL & WOODSIDE LHCC

19 DEC 2003

40

Western Infirmary, Dumbarton Rd, Glasgow, G11 6NT

DIVISION OF SURGERY

Reply to: P O'DWYER
Our Ref : Hospital No 1132067

Direct: 0141 211 2804
FAX : 0141 211 8562

2 June 2003

Dr G M Martin
Maryhill Health Centre
41 Shawpark Street
Glasgow
G20 9DR

Dear Dr Martin,

Re: BRIAN MCLAUGHLIN, D.O.B. 28/01/1960
11U LATHETON DRIVE, GLASGOW, G20 8JR

Your patient was admitted as arranged to the Western Infirmary on 26 April 2003.

MAIN DIAGNOSIS FOR EPISODE
No diagnosis reached

PAST MEDICAL HISTORY
ACUTE PANCREATITIS (577.0) Dec 02

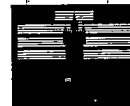
PROCEDURES PERFORMED
29/04/2003 LAPAROSCOPIC CHOLECYSTECTOMY (J18.3+Y50.8)
29/04/2003 CHOLANGIOGRAPHY VIA CYSTIC DUCT (J37.2)

OUTCOME
SATISFACTORY AT DISCHARGE

Your patient was discharged home on 6 May 2003, and has an appointment to attend my Surgical Clinic, Gartnavel General Hospital in 6 weeks.

Yours sincerely

P O'DWYER
Professor Of Surgery



Name of G.P.: _____

Your Patient: _____

Name: BRIAN MCLAUGHLIN
Address: _____
D.O.B. 28/1/60 Unit No. 1132067

Diagnosis

1 _____
2 _____
3 _____
4 _____

Consultant POD
Admitted to Ward 10E On 26/4/3
Discharged on 5/5/3 From Ward 10E
Or seen at _____ Clinic, on 1/1

Operation/Procedures

1 _____
2 _____
3 _____

Medicine	Form	Dose	TIMES FOR ADMINISTRATION										Recommended duration of treatment from date of discharge
			am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 8	pm 10	Other Times	
CIPROFLOXACIN	0	500mg	✓						✓			4 days	
FERRUS SULPHATE	0	200mg	✓			✓			✓			indef.	

OTHER TREATMENT and COMMENTS (Including details of drug sensitivities, appliances, etc.)

DR.s NAME IN BLOCK CAPITALS CHUAN SIGNATURE [Signature] DATE 5/5/3

White - GP Copy, Pink - Medical Records Copy, Blue - Pharmacy Copy

Pager No. 3142

Follow Up Arrangements

Clinic _____ Date 1/1
Home Help Yes No
District Nurse Yes No
Meals/Wheels Yes No
Paramedical (please state) _____
Other _____

Please TICK box if childproof containers are UNSUITABLE ☐

PHARMACY USE ONLY

No. of Days Supply	Quantity, Name, Strength and Manufacturer supplied by Pharmacy.
1	8x 500mg Bacter
	28 x 200mg Alpha

Dispensed by CH Checked by OK
Date 5/5/3 CP Check

Medication Collected by (Messenger)

WARD USE ONLY

Medication Rec. on Ward by _____
Issued by _____
Date Issued _____
Signature of Recipient _____

147900

CONFIDENTIAL

IMMEDIATE DISCHARGE AND MEDICINE PRESCRIPTION FORM

Name of G.P.: _____

WEST GLASGOW HOSPITALS UNIVERSITY NHS TRUST

Your Patient :

WESTERN INFIRMARY, Glasgow G11 6NT

Telephone 0141-211-2000

Name: BRIAN McLAUGHLIN

Address:

Diagnosis

1 GALLSTONES

2

3

4

1

D.O.B. 78 / 1 / 60 Unit No. 1132067

Consultant O'DNYER

Operation/Procedures

Admitted to Ward 10E On 28/6/3

1 LAPAROSCOPIC CHOLECYSTECTOMY

Discharged on 2 / 5 / 3 From Ward 10E

2

Or seen at _____ Clinic, on ____/____/____

3

[illegible]

OTHER TREATMENT and COMMENTS (Including details of drug sensitivities, appliances, etc.)

Follow Up Arrangements

Clinic _____ Date / /

Home Help	Yes	No
-----------	-----	----

District Nurse	Yes	No
-----------------------	------------	-----------

Meals/Wheels	Yes	No
--------------	-----	----

Paramedical (please state) _____

Other _____

Please TICK box if childproof containers are UNSUITABLE

PHARMACY USE ONLY

No. of Days Supply	Quantity, Name, Strength and Manufacturer supplied by Pharmacy.
7	7x7mg mps 60X50mg Zovirax
Dispensed by	Checked by
Date	CN Check

Medication Collected by (Messenger)

WARD USE ONLY

Medication Rec. on Ward by _____

Issued by

Date Issued

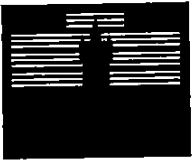
Signature of Recipient

DR.'s NAME IN BLOCK CAPITALS SHONA LWE SIGNATURE [Signature] DATE 2/5/13

White - GP Copy, Pink - Medical Records Copy, Blue - Pharmacy Copy

Pager No. 3142

DATE 2 15 13



WEST GLASGOW HOSPITALS

CLINICAL DIRECTORATE OF ANAESTHESIA THEATRES, ITU AND PAIN RELIEF SERVICES

MULTI DISCIPLINARY CARE PLAN



1132067
MCLAUGHLIN BRIAN
11U Latherton Drive M
GLASGOW 28/01/60
G20 8JR
G.P. Prac. 43311

Ward: 10E Date: 28/4/03

Consultant Prof O'Dwyer

Theatre: LSTH 4

Proposed Operation: Laparoscopic cholecystectomy

PRE-OPERATIVE VISITS

Any Relevant Visits:

CHECK LIST

Please check the following before pre-med is given:-

When did the patient last eat or drink

BM Stix?

Consent signed?

Identity band correct (Name, DoB
hospital no., ward no.)

Case notes (including current ECG
biochemistry, haematology), nursing
notes, drug Kardex, recording sheet)?

X-Rays available?

Operation site prepared - marked?

Dentures removed?

Prosthesis/Hearing aids, contact lenses removed?

Make-up, nail varnish, jewellery
(taped/removed)?

Wearing black tied cotton gown,
disposable pants?

Pacemaker?

Allergies?

Have you passed urine this morning?

Waterlow score noted

Pre-med given?

Signature *J. McQuinn* Ward

WARD

YES

TIME 12mn

RECEPTION

YES

8pm 28/4/03

COMMENT / N.A.

TIME

VALUE



Consent Laparoscopic cholecystectomy
± open procedure



NO ECG.



Time into Reception

Correct patient received and documentation
complete?

Signature *Dr. McQuinn*



0915

44

YES

N/A

☒☐

NAMED NURSE

Patient identified in anaesthetic room?

Time: 0935

Signature:

Janey Alkin

MONITORING

ECG

☒

IBP

☐

PULSE

☒

NIBP

☒

CVP

SaO₂

☒

Core Temp.

CO₂

☒

Peripheral Temp.

Laryngeal Mask

☐

Size:

ET tube

☒

Size: 9.0 secured with bandage

Throat Pack

☐

Removed?

☐

No ☐

TOL IQUET

☐

Time applied

Pressure

Time released

Site

DIATHERMY

☒

Site RIGHT THIGH

BI-POLAR

☐

Patient position on table SUPINE, both arms on boards

Positioned as per policy?

Yes

☒

Prevention of pressure sores?

☒

Prevention of heat loss

☐

Ripple mattress?

☐

Par ...?

☐

Warmed fluids?

☐

IV Cannulation

☒

Site ICG RIGHT HAND

Arterial Cannulation

☐

Site

CVP Line

☐

Site

Comment

eyes taped with micropore
full body gel mattress

METHOD OF ANAESTHESIA

General

☒

Regional ☐

Site

Local

☐

Spinal ☐

Epidural

☐

Sedation ☐

Site

EVENTS

SURGICAL POST-OP INSTRUCTIONS

46

Surgeon's Signature.....

Time Into Recovery: 10:50

RECOVERY

NAMED NURSE

	Yes	N/A
ET tube?	☐	☐
Laryngeal mask?	☐	☐
Airway?	☒	☐

removed:

removed:

removed: 11:00am (Guedel)

Patient maintaining own airway 11:00 am.

MONITORING

ECG ☒ continuous

IVP ☐

RESPIRATION ☒ 1/4 hourly

NIBP ☒ 1/4 hourly

CVP ☐

SaO₂ ☒ 1/4 hourly

PULSE ☐
Heart Rate - continuous

	Yes	N/A
X-rays Requested	☐	☒

Prevention of Pressure Sores

Comments

Waterlow score	☐	☐
----------------	--------------------------	--------------------------

Equipment?	☒	☐
------------	-------------------------------------	--------------------------

Nursing action	☐	☐
----------------	--------------------------	--------------------------

QAS Anesthetic Aid Trolley

CRITERIA TO BE MET BEFORE DISCHARGE FROM RECOVERY

Is the patient conscious and orientated to time and place?	YES ☐	☐
--	------------------------------	--------------------------

Is patient cardiovascularly stable?	YES ☐	☐
-------------------------------------	------------------------------	--------------------------

Is patient comfortable?	YES ☐	☐
-------------------------	------------------------------	--------------------------

Are drains patent and is drainage within expected limits? Are wounds free from excessive staining?	N/A ☐	☐
--	------------------------------	--------------------------

Signature: Alto

		29-4-03																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																				
Time		10:55	11:10	11:25	11:40	11:55	12:10	12:25	12:40	12:55	13:10	13:25	13:40	13:55	14:10	14:25	14:40	14:55	15:10	15:25	15:40	15:55	16:10	16:25	16:40	16:55	17:10	17:25	17:40	17:55	18:10	18:25	18:40	18:55	19:10	19:25	19:40	19:55	20:10	20:25	20:40	20:55	21:10	21:25	21:40	21:55	22:10	22:25	22:40	22:55	23:10	23:25	23:40	23:55	24:10	24:25	24:40	24:55	25:10	25:25	25:40	25:55	26:10	26:25	26:40	26:55	27:10	27:25	27:40	27:55	28:10	28:25	28:40	28:55	29:10	29:25	29:40	29:55	30:10	30:25	30:40	30:55	31:10	31:25	31:40	31:55	32:10	32:25	32:40	32:55	33:10	33:25	33:40	33:55	34:10	34:25	34:40	34:55	35:10	35:25	35:40	35:55	36:10	36:25	36:40	36:55	37:10	37:25	37:40	37:55	38:10	38:25	38:40	38:55	39:10	39:25	39:40	39:55	40:10	40:25	40:40	40:55	41:10	41:25	41:40	41:55	42:10	42:25	42:40	42:55	43:10	43:25	43:40	43:55	44:10	44:25	44:40	44:55	45:10	45:25	45:40	45:55	46:10	46:25	46:40	46:55	47:10	47:25	47:40	47:55	48:10	48:25	48:40	48:55	49:10	49:25	49:40	49:55	50:10	50:25	50:40	50:55	51:10	51:25	51:40	51:55	52:10	52:25	52:40	52:55	53:10	53:25	53:40	53:55	54:10	54:25	54:40	54:55	55:10	55:25	55:40	55:55	56:10	56:25	56:40	56:55	57:10	57:25	57:40	57:55	58:10	58:25	58:40	58:55	59:10	59:25	59:40	59:55	60:10	60:25	60:40	60:55	61:10	61:25	61:40	61:55	62:10	62:25	62:40	62:55	63:10	63:25	63:40	63:55	64:10	64:25	64:40	64:55	65:10	65:25	65:40	65:55	66:10	66:25	66:40	66:55	67:10	67:25	67:40	67:55	68:10	68:25	68:40	68:55	69:10	69:25	69:40	69:55	70:10	70:25	70:40	70:55	71:10	71:25	71:40	71:55	72:10	72:25	72:40	72:55	73:10	73:25	73:40	73:55	74:10	74:25	74:40	74:55	75:10	75:25	75:40	75:55	76:10	76:25	76:40	76:55	77:10	77:25	77:40	77:55	78:10	78:25	78:40	78:55	79:10	79:25	79:40	79:55	80:10	80:25	80:40	80:55	81:10	81:25	81:40	81:55	82:10	82:25	82:40	82:55	83:10	83:25	83:40	83:55	84:10	84:25	84:40	84:55	85:10	85:25	85:40	85:55	86:10	86:25	86:40	86:55	87:10	87:25	87:40	87:55	88:10	88:25	88:40	88:55	89:10	89:25	89:40	89:55	90:10	90:25	90:40	90:55	91:10	91:25	91:40	91:55	92:10	92:25	92:40	92:55	93:10	93:25	93:40	93:55	94:10	94:25	94:40	94:55	95:10	95:25	95:40	95:55	96:10	96:25	96:40	96:55	97:10	97:25	97:40	97:55	98:10	98:25	98:40	98:55	99:10	99:25	99:40	99:55	100:10	100:25	100:40	100:55	101:10	101:25	101:40	101:55	102:10	102:25	102:40	102:55	103:10	103:25	103:40	103:55	104:10	104:25	104:40	104:55	105:10	105:25	105:40	105:55	106:10	106:25	106:40	106:55	107:10	107:25	107:40	107:55	108:10	108:25	108:40	108:55	109:10	109:25	109:40	109:55	110:10	110:25	110:40	110:55	111:10	111:25	111:40	111:55	112:10	112:25	112:40	112:55	113:10	113:25	113:40	113:55	114:10	114:25	114:40	114:55	115:10	115:25	115:40	115:55	116:10	116:25	116:40	116:55	117:10	117:25	117:40	117:55	118:10	118:25	118:40	118:55	119:10	119:25	119:40	119:55	120:10	120:25	120:40	120:55	121:10	121:25	121:40	121:55	122:10	122:25	122:40	122:55	123:10	123:25	123:40	123:55	124:10	124:25	124:40	124:55	125:10	125:25	125:40	125:55	126:10	126:25	126:40	126:55	127:10	127:25	127:40	127:55	128:10	128:25	128:40	128:55	129:10	129:25	129:40	129:55	130:10	130:25	130:40	130:55	131:10	131:25	131:40	131:55	132:10	132:25	132:40	132:55	133:10	133:25	133:40	133:55	134:10	134:25	134:40	134:55	135:10	135:25	135:40	135:55	136:10	136:25	136:40	136:55	137:10	137:25	137:40	137:55	138:10	138:25	138:40	138:55	139:10	139:25	139:40	139:55	140:10	140:25	140:40	140:55	141:10	141:25	141:40	141:55	142:10	142:25	142:40	142:55	143:10	143:25	143:40	143:55	144:10	144:25	144:40	144:55	145:10	145:25	145:40	145:55	146:10	146:25	146:40	146:55	147:10	147:25	147:40	147:55	148:10	148:25	148:40	148:55	149:10	149:25	149:40	149:55	150:10	150:25	150:40	150:55	151:10	151:25	151:40	151:55	152:10	152:25	152:40	152:55	153:10	153:25	153:40	153:55	154:10	154:25	154:40	154:55	155:10	155:25	155:40	155:55	156:10	156:25	156:40	156:55	157:10	157:25	157:40	157:55	158:10	158:25	158:40	158:55	159:10	159:25	159:40	159:55	160:10	160:25	160:40	160:55	161:10	161:25	161:40	161:55	162:10	162:25	162:40	162:55	163:10	163:25	163:40	163:55	164:10	164:25	164:40	164:55	165:10	165:25	165:40	165:55	166:10	166:25	166:40	166:55	167:10	167:25	167:40	167:55	168:10	168:25	168:40	168:55	169:10	169:25	169:40	169:55	170:10	170:25	170:40	170:55	171:10	171:25	171:40	171:55	172:10	172:25	172:40	172:55	173:10	173:25	173:40	173:55	174:10	174:25	174:40	174:55	175:10	175:25	175:40	175:55	176:10	176:25	176:40	176:55	177:10	177:25	177:40	177:55	178:10	178:25	178:40	178:55	179:10	179:25	179:40	179:55	180:10	180:25	180:40	180:55	181:10	181:25	181:40	181:55	182:10	182:25	182:40	182:55	183:10	183:25	183:40	183:55	184:10	184:25	184:40	184:55	185:10	185:25	185:40	185:55	186:10	186:25	186:40	186:55	187:10	187:25	187:40	187:55	188:10	188:25	188:40	188:55	189:10	189:25	189:40	189:55	190:10	190:25	190:40	190:55	191:10	191:25	191:40	191:55	192:10	192:25	192:40	192:55	193:10	193:25	193:40	193:55	194:10	194:25	194:40	194:55	195:10	195:25	195:40	195:55	196:10	196:25	196:40	196:55	197:10	197:25	197:40	197:55	198:10	198:25	198:40	198:55	199:10	199:25	199:40	199:55	200:10	200:25	200:40	200:55	201:10	201:25	201:40	201:55	202:10	202:25	202:40	202:55	203:10	203:25	203:40	203:55	204:10	204:25	204:40	204:55	205:10	205:25	205:40	205:55	206:10	206:25	206:40	206:55	207:10	207:25	207:40	207:55	208:10	208:25	208:40	208:55	209:10	209:25	209:40	209:55	210:10	210:25	210:40	210:55	211:10	211:25	211:40	211:55	212:10	212:25	212:40	212:55	213:10	213:25	213:40	213:55	214:10	214:25	214:40	214:55	215:10	215:25	215:40	215:55	216:10	216:25	216:40	216:55	217:10	217:25	217:40	217:55	218:10	218:25	218:40	218:55	219:10	219:25	219:40	219:55	220:10	220:25	220:40	220:55	221:10	221:25	221:40	221:55	222:10	222:25	222:40	222:55	223:10	223:25	223:40	223:55	224:10	224:25	224:40	224:55	225:10	225:25	225:40	225:55	226:10	226:25	226:40	226:55	227:10	227:25	227:40	227:55	228:10	228:25	228:40	228:55	229:10	229:25	229:40	229:55	230:10	230:25	230:40	230:55	231:10	231:25	231:40	231:55	232:10	232:25	232:40	232:55	233:10	233:25	233:40	233:55	234:10	234:25	234:40	234:55	235:10	235:25	235:40	235:55	236:10	236:25	236:40	236:55	237:10	237:25	237:40	237:55	238:10	238:25	238:40	238:55	239:10	239:25	239:40	239:55	240:10	240:25	240:40	240:55	241:10	241:25	241:40	241:55	242:10	242:25	242:40	242:55	243:10	243:25	243:40	243:55	244:10	244:25	244:40	244:55	245:10	245:25	245:40	245:55	246:10	246:25	246:40	246:55	247:10	247:25	247:40	247:55	248:10	248:25	248:40	248:55	249:10	249:25	249:40	249:55	250:10	250:25	250:40	250:55	251:10	251:25	251:40	251:55	252:10	252:25	252:40	252:55	253:10	253:25	253:40	253:55	254:10	254:25	254:40	254:55	255:10	255:25	255:40	255:55	256:10	256:25	256:40	256:55	257:10	257:25	257:40	257:55	258:10	258:25	258:40	258:55	259:10	259:25	259:40	259:55	260:10	260:25	260:40	260:55	261:10	261:25	261:40	261:55	262:10	262:25	262:40	262:55	263:10	263:25	263:40	263:55	264:10	264:25	264:40	264:55	265:10	265:25	265:40	265:55	266:10	266:25	266:40	266:55	267:10	267:25	267:40	267:55	268:10	268:25	268:40	268:55	269:10	269:25	269:40	269:55	270:10	270:25	270:40	270:55	271:10	271:25	271:40	271:55	272:10	272:25	272:40	272:55	273:10	273:25	273:40	273:55	274:10	274:25	274:40	274:55	275:10	275:25	275:40	275:55	276:10	276:25	276:40	276:55	277:10	277:25	277:40	277:55	278:10	278:25	278:40	278:55	279:10	279:25	279:40	279:55	280:10	280:25	280:40	280:55	281:10	281:25	281:40	281:55	282:10	282:25	282:40	282:55	283:10	283:25	283:40	283:55	284:10	284:25	284:40	284:55	285:10	285:25	285:40	285:55	286:10	286:25	286:40	286:55	287:10	287:25	287:40	287:55	288:10	288:25	288:40	288:55	289:10	289:25	289:40	289:55	290:10	290:25	290:40	290:55	291:10	291:25	291:40	291:55	292:10	292:25	292:40	292:55	293:10	293:25	293:40	293:55	294:10	294:25	294:40	294:55	295:10	295:25	295:40	295:55

45

OPERATION LAP chole

ANAESTHETIC POST-OP INSTRUCTIONS

O₂ Therapy 5 L/M Upright Hours Mask

Post-operative IV Fluid Regimen:

Ø

Routine Observations:

Yes ☒

Special Instructions:

CVP ☐

Urine volumes ☐

Analgesia Prescribed

Yes ☒

N/A ☐

Does Anaesthetist wish to see patient before return to ward?

Yes ☐

N/A ☐

BLOOD LOSS IN THEATRE mls

M

Anaesthetist's Signature

WOUND CARE

- Skin Preparation ☒
- Drain ☐
- Catheter ☐
- Staples ☐
- Sutures ☒
- Packing ☐
- Dressing ☒
- Wound toilet ☒

Specify:

betadine antiseptic

3/0 mon nylon

Stenstrup

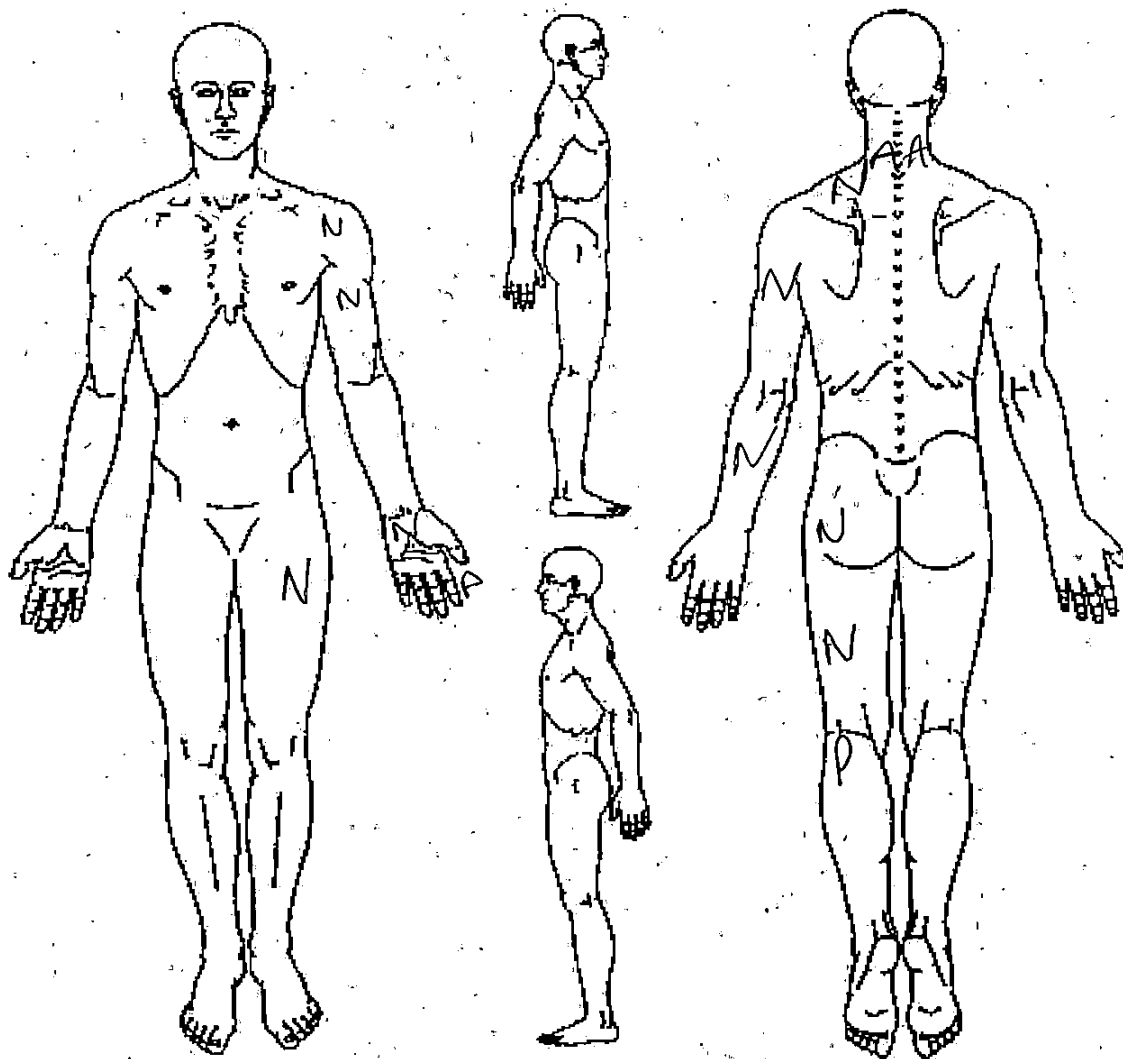
chlorhexidine asept

45

THE NECK DISABILITY INDEX QUESTIONNAIRE

NAME Brian McLaughlinDATE 20/3/12How long have you had neck pain _____ years 9 months 2 weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



A = ACHE

B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

S = STABBING

O = OTHER

OVER PLEASE ⇒

48 237

Patient Identification

Patient CRN 1132067		Provider SGC04	Hosp WIG
Surname MCLAUGHLIN		Patient's Address 110 Latherton Drive	
First Forename BRIAN			
Second Forename		GLASGOW	
Previous Surname			
Date of Birth 28 Jan 1980		Postcode G20 8JR	
Sex Male	Marital Status Single / Ne	Tel No: 948 0499	
CHI No 2801606030		Ethnic Group	
NHS No		GP Practice MARYHILL HEALTH CENTRE01415318830	
Alt CRN		GMC No: 1330386 MCMILLAN	

Episode Management

Sf are Package ID		Ward L10P*WI	Admission Date 26/04/03
Specialty/Discipline (Code + Text National) GS GENERAL SURGERY		Admission Type 11	
Significant Facility OTH OTHER HOSP WARD		Admission Reason TREAT	
Consultant Code ODWY		Admission/Transfer From 1 0	
Consultant Name O'DWYER		Admission/Transfer From - Location	
Management of Patient INPATIENT	Patient Category NATIONAL HEA	GP Referral Letter No.	
Waiting List Guarantee Exception Code	Waiting List Date 28/02/03	Waiting List Type TB	

General Clinical

Main Diagnosis - ICD 10	
Other Condition - ICD 10 - 2	
3	
4	
5	
6	

Main Operation/Procedure

	Date Main Operation	
	Clinician Responsible	
Other 2	Date (OPP2)	
	Clinician Responsible (2)	
Other 3	Date (OPP3)	
	Clinician Responsible (3)	
Other 4	Date (OPP4)	
	Clinician Responsible (4)	

Development data

Chronic Sick/Disabled ☐	Clinical Problem of Spell/Care Package	Lifestyle Risk Factors 1	2
		Outcome Measures 1	2
		Dependency/Severity Measures 1	2

**Maryhill
Health Centre**

red area

41 Shawpark Street Glasgow G20 9DR

house calls & enquiries
☎ 531 8897
appointments only
☎ 531 8830
fax
☎ 531 8863



49
? on POD list
for cholecystectomy
on warfarin → heparin

- ◆ Dr Gordon Martin MB ChB DRCOG MRCGP
- ◆ Dr Avril McMillan MB ChB DRCOG MRCGP
- ◆ Dr Susanne Russell MB ChB MRCGP DFM
- ◆ Dr Alasdair Webb BSc MB ChB MRCGP DGM
DRCOG DFFP
- ◆ Dr Roland Leslie BSc MB ChB MRCGP

27th March 2003

Professor P. O'Dwyer,
Consultant Surgeon,
Gartnavel General Hospital,
Great Western Road,
GLASGOW G12.

Dear Professor O'Dwyer,

Re: Brian McLaughlin, 11U, Latherton Drive, Glasgow G20 8JR
DOB 28.1.60. - Unit no. 616522

You have arranged for this patient to be admitted on 28.4.03. for a cholecystectomy. Following his admission in December 2002 with pancreatitis, he had a pulmonary embolism and has been on Warfarin since then. This may affect his suitability for surgery in the near future.

Yours sincerely,

Avril McMillan

DR AVRIL McMILLAN

TCI

Sat 26/4/3

to stop warfarin
on Thursday

DEPARTMENT OF SURGERY - OPERATION NOTE

Hospital Western Infirmary Hospital Number 1132067
Admission Date Operation Date 29.4.03
Patients Name Brian McLaughlin
Date of Birth 28.1.60 Age Ward L10E
Principal Surgeon Miss L Chisholm/Professor P O'Dwyer
Assistant Surgeon Mr G McKay
Anaesthetist Dr Serpell
Diagnosis Previous Gallstone Pancreatitis from previous PTE
Procedure Laparoscopic Cholecystectomy and on-table Cholangiogram

IndicationsOperation Details

Under general anaesthetic the patient was prepared and draped lying supine. Intravenous antibiotics were given by the Anaesthetist at the start of the procedure. An infra-umbilical incision was made and a 10mm blunt port inserted using an open cut-down technique. The peritoneal cavity was insufflated with carbon dioxide in the usual fashion. Two 5mm ports were inserted in the right upper quadrant in the epigastrium under direct vision. There was a lot of fat around Callot's triangle. This was dissected out carefully. The cystic duct was easily identified and clean. A small incision was made in the cystic duct and an on-table cholangiogram cannula was placed in the duct through a separate stab incision in the anterior abdominal wall. Once the cannula had been inserted it was held in place with 1, partially fired clip. An on-table cholangiogram was then carried out. There was good flow of contrast through the duct systems into the duodenum. There was no evidence of stricture nor of common bile duct stones. The peritoneal cavity was re-insufflated. The cystic duct was then ligated with clips proximally and distally before being divided. This cannula with the OTC was removed. The cystic artery was cleaned and clipped, with two clips proximally and one distally then divided. There was a little bleeding from the gallbladder end of the cystic artery and this was controlled using diathermy. The gallbladder was then dissected away from the gallbladder bed using diathermy dissection. There was a lot of oedema and evidence of previous inflammation in this area.

LC/MJS

Once the gallbladder had been dissected away the peritoneal cavity was washed out with Saline. The gallbladder was placed in a Bert bag and removed through the infra-umbilical port site. Further levage was carried out.

The infra-umbilical port site was closed using continuous 1 Vicryl. Subcuticular 3x0 Vicryl to skin. 10mls of 0.5% Bupivocaine was injected around the wound as a field block. A 5mm port site and the stab site for the on-table cholangiogram were all closed using steristrips.

Intravenous antibiotics will be continued for 24 hours.

Patient was returned to Recovery in a satisfactory condition.

Entered By

Margaret

Date

30.4.03

53

DEPARTMENT OF SURGERY - OPERATION NOTE

Hospital Western Infirmary Hospital Number 1132067
Admission Date Operation Date 29.4.03
Patients Name Brian McLaughlin
Date of Birth 28.1.60 Age Ward L10E
Principal Surgeon Miss L Chisholm/Professor P O'Dwyer
Assistant Surgeon Mr G McKay
Anaesthetist Dr Serpell
Diagnosis Previous Gallstone Pancreatitis from previous PTE
Procedure Laparoscopic Cholecystectomy and on-table
Cholangiogram

Indications

Operation Details

Under general anaesthetic the patient was prepared and draped lying supine. Intravenous antibiotics were given by the Anaesthetist at the start of the procedure. An infra-umbilical incision was made and a 10mm blunt port inserted using an open cut-down technique. The peritoneal cavity was insufflated with carbon dioxide in the usual fashion. Two 5mm ports were inserted in the right upper quadrant in the epigastrium under direct vision. There was a lot of fat around Callot's triangle. This was dissected out carefully. The cystic duct was easily identified and clean. A small incision was made in the cystic duct and an on-table cholangiogram cannula was placed in the duct through a separate stab incision in the anterior abdominal wall. Once the cannula had been inserted it was held in place with 1, partially fired clip. An on-table cholangiogram was then carried out. There was good flow of contrast through the duct systems into the duodenum. There was no evidence of stricture nor of common bile duct stones. The peritoneal cavity was re-insufflated. The cystic duct was then ligated with clips proximally and distally before being divided. This cannula with the OTC was removed. The cystic artery was cleaned and clipped, with two clips proximally and one distally then divided. There was a little bleeding from the gallbladder end of the cystic artery and this was controlled using diathermy. The gallbladder was then dissected away from the gallbladder bed using diathermy dissection. There was a lot of oedema and evidence of previous inflammation in this area.

54

2

LC/MJS

Once the gallbladder had been dissected away the peritoneal cavity was washed out with Saline. The gallbladder was placed in a Bert bag and removed through the infra-umbilical port site. Further levage was carried out.

The infra-umbilical port site was closed using continuous 1 Vicryl. Subcuticular 3x0 Vicryl to skin. 10mls of 0.5% Bupivocaine was injected around the wound as a field block. A 5mm port site and the stab site for the on-table cholangiogram were all closed using steristrips.

Intravenous antibiotics will be continued for 24 hours.

Patient was returned to Recovery in a satisfactory condition.

Entered By

Margaret

Date

30.4.03

3	RAMPLEY SPONGE HOLDERS	↑	↑
8	BACHAUS TOWEL CLIPS		
2	NO. 4 B.P. HANDLES		
1	NO. 3 B.P. HANDLE		
1	7" TOOTHED DISSECTING FORCEP		
1	7" N/T DISSECTING FORCEP		
2	5" TOOTHED DISSECTING FORCEP		
2	5" N/T DISSECTING FORCEPS		C
1	9" BICKFORDS NON TOOTHED DISSECTING FORCEP		
1	PR MAYO'S SCISSORS STRAIGHT 6 1/2"	C	
1	PR MAYO'S SCISSORS STRAIGHT 5 1/2"		O
1	PR MAYO'S SCISSORS C.O.F. 7"		
1	PR METZENBAUM SCISSORS C.O.F. 9"	O	R
1	PR MCINDOE'S SCISSORS C.O.F. 7"		
1	PR STITCH SCISSORS		R
6	KELLY HALSTED ARTERY FORCEPS C.O.F.	R	R
18	KILNER ARTERY FORCEPS C.O.F.		
4	GREY TURNER ARTERY FORCEPS STRAIGHT 7"		R
6	LARGE CURVED ARTERY FORCEPS 7"	R	R
2	KOCHER'S ARTERY FORCEPS 7"		
4	ALLIS TISSUE FORCEPS B/J 5 3/4"		C
4	BABCOCK TISSUE FORCEPS 6 1/2"	R	
4	LITTLEWOOD'S TISSUE FORCEPS		✓
2	MAYO HEGAR NEEDLE HOLDERS 7"		
1	CRILEWOOD NEEDLE HOLDER 6"	C	
2	LANGENBECK RETRACTORS 1 3/4" X 1/2"		
1	MORRIS RETRACTOR 2 3/4" X 2"		
1	SYME'S ANEURYSM NEEDLE		
1	MCDONALD'S DISSECTOR	+	
1	WILSON HEY'S INSULATED ARTERY FORCEP B/J		
1	DIATHERMY HANDLE AND LEAD		
1	DIATHERMY QUIVER		
1	MONEL KNIFE ELECTRODE		
1	PROBE 8"		
1	BALFOUR'S SELF RETAINING RETRACTOR		
2	S/STEEL GALLIPOTS	↓	↓
2	S/STEEL RECEIVERS 10"		
1	IDENTITY DISC	↓	↓

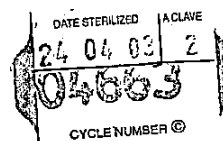
Patient Case no. ...1132067

Scrub Nurse ...G. GARDNER

Circulating Nurse ...R. R.

Set No. ...13...

Date Used 29/4/03

General Surgery
Level 5 Theatres
Western Infirmary

PLEASE FILE IN PATIENTS NOTE

56

LAPAROSCOPIC INSTRUMENTS

1	3 WAY STOPCOCK	↑	φ
1	SUCTION IRRIGATION		
1	WOLF LIGACLIP APPLICATOR		
2	DIATHERMY CABLES		
1	HOOK		
1	CYSTIC DUCT SCISSORS	C	C
1	KEYMED GRASPER & 1 INSULATION & HANDLE	O	O
1	AESCLAP GRASPER & 1 INSERT, INSULATION AND RATCHET HANDLE	R	R
1	AESCLAP SCISSORS & INSERT, INSULATION AND HANDLE	R	R
1	AESCLAP MARYLANDS & INSERT INSULATION AND HANDLE	B	B
1	WECK MARYLANDS & INSERT & INSULATION AND HANDLE	C	C
1	BLUNT HASSON	T	T
1	HASSON PORT	↓	↓
1	IDENTITY DISC	↓	↓

Patient Case no. 1132067

Scrub Nurse G. GOODWIN

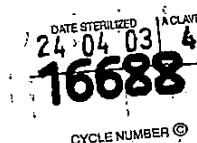
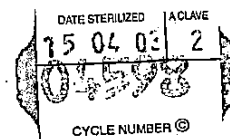
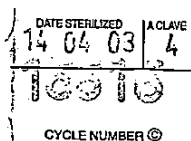
Circulating Nurse R. HALL

Set No. F

Date Used 29/4/03

General Surgery
Level 5 Theatres
Western Infirmary

PLEASE FILE IN PATIENTS NOTE



57

Level 10 Surgical Department
Western Infirmary, Dumbarton Road, Glasgow, G11 6NT

MISS JULIE C DOUGHTY'S SURGICAL CLINIC - 30/01/03

IY/SG

Direct Line: 0141 211 2122/2175
Fax No: 0141 211 8562

31 January 2003

Dr Martin
Maryhill Health Centre
41 Shawpark Street
Glasgow
G20 9DR

Dear Dr Martin

**BRIAN MCLAUGHLIN - DOB 28/01/60 - UNIT NO 1132067
11U LATHERTON DRIVE, GLASGOW**

I saw this gentleman in the Surgical Clinic for review today. As you know he as admitted as an emergency with acute pancreatitis in December. It was suspected that this may have been due to alcohol although an ultrasound scan did show evidence of gall stones. While in hospital he had a probably pulmonary embolus and is now on Warfarin. Following hjs discharge he has had an out-patient MRCP. I understand from Mr Wilson that this was normal.

Mr McLaughlin has made a reasonably good recovery from his pancreatitis and is well at present. He is due to be on Warfarin until June. I have discussed him with Mr Wilson and we will arrange for him to have a laparoscopic cholecystectomy after his 6 month course of Warfarin is completed.

Yours sincerely

IAN YOUNG
SURGICAL REGISTRAR

MRCP GLE Jan 2003 Normal
ducts

58

Western Infirmary, Dumbarton Rd, Glasgow, G11 6NT

DIVISION OF SURGERY

Reply to: JULIE DOUGHTY
Our Ref : Hospital No 1132067

Direct: 0141 211 2175
FAX : 0141 211 8562

31 December 2002

Dr G M Martin
Maryhill Health Centre
41 Shawpark Street
Glasgow
G20 9DR

Dear Dr Martin,

Re: BRIAN MCLAUGHLIN, D.O.B. 28/01/1960
11U LATHETON DRIVE, GLASGOW, G20 8JR

Your patient was admitted as an emergency to the Western Infirmary on 2 December 2002.

PRESENTING SYMPTOMS

UPPER ABDOMINAL PAIN (789.0)

MAIN DIAGNOSIS FOR EPISODE

ACUTE PANCREATITIS (577.0)

INVESTIGATIONS PERFORMED

ABDOMINAL ULTRASOUND
CT SCAN

PROCEDURES PERFORMED

NO PROCEDURE

COMPLICATIONS

NONE (V65.8)

OUTCOME

SATISFACTORY AT DISCHARGE.

ADDITIONAL COMMENTS

This gentleman was admitted with acute pancreatitis ?secondary to alcohol. He did however have gallstones on abdominal ultrasound so an out patient MRCP has been arranged. Unfortunately while on the ward he developed pleurtic chest pain and increasing shortness of breath. He has been started on six months of warfarin for suspected PTE.

Your patient was discharged home on 16 December 2002. No further appointment has been arranged in this unit, but I would be pleased to see this patient again if required.

Continued ...

Continued ...

BRIAN MCLAUGHLIN Hospital No 1132067

Yours sincerely

(59)

JULIE DOUGHTY.
Consultant Surgeon

**DIGESTIVE DISEASE DIRECTORATE
PATIENT DEPENDENCY
AUDIT FORM.**

(60)

Patient label.

Brian McLaughlin
114 Latherton Drive
GLASGOW
G20 8JR
LIN 1132067
DOB 28.01.60

Condition. Pancreatitis
Amylase > 3000
Procedure.
Procedure.
Procedure.

Please tick appropriate reason for admission.

Admitted. 1) elective. / 2) emergency. / 3) pre op resuscitation.
4) endoscopy 5) ITU/SHDU transfer. 6) interhospital transfer.
7) intrahospital transfer.

Admission date. 02/12/02.

Total number of days patient is Highly Dependant

Consultant. Mr Wilson

Dependency. (Please tick appropriate).

CVP

~~Y~~/N

O2

Y/~~N~~

O2% 35

Urinary Catheter

Y/~~N~~

10 urine volumes

PCA

~~Y~~/N

requiring regular analgesia (Morphine)

Drains / lavage

~~Y~~/N

1-20 i.v fluids

TPN / TEN

~~Y~~/N

Wound problems

~~Y~~/N

M.R.S.A.

~~Y~~/N

Mobility

independent.

Mech support. 1 nurse. > 1 nurse

Recordings

1/2hr

1hr

4hr

b.d.

Complications.

Comments. For close observation due to severity of pancreatitis.



1132067
MCLAUGHLIN BRIAN
11U Latherton Drive M
GLASGOW 28/01/60
G20 8JR
G D Drac 43311

Date 29/1/03

Premedication

TGMM 250mg 300
MORPHINE 100

Procedure(s)

LAP chole

61

Anaesthetist(s)

SERRA

Surgeon(s)

PUD

☒ ☒ ☐
C SpR ST
☐ ☐ ☐

Pre-operative assessment

Airway

MUSCULAR NOSE
EASY TO IPHY BY HAND
LONG BLADE LARYNGOSCOPE WGBD

RS

-0

CVS

PTG 12/02 SURVING
ACUTE PANCREATITIS

BP

154/95

Weight(kg)

Haematology

15.8

Biochemistry

U-6.2
Creat 95

ECG

CXR

PT 15.9

PTT 39.9

INR 1.2

MILD ACUTE
↑ ALT 49
↑ ALP 56
↑ Bil 36
Cryth Phos
HGT

Current therapy

WAPRAIN O/C 4/7/00
DALTEPARIN O/C VASODIL
CLOXING

Other significant illnesses

Allergies

Previous anaesthesia

ASA 1

2

3

4

5

E

Comments / Technique

Supine ☒ Lithotomy ☐ Prone ☐ Lateral ☐ Head up ☐ Head down ☐
 GA ☒ Spinal ☐ Epidural ☐ Other LA _____
 ETT 9.0 LMA _____ F Mask ☐ Airway ☐ DLT _____ Laryngoscopy grade II

IV site(s) PRN 16

Technique details:

Art line
 CVP/PAWP
 Ventilator
 Breathing system

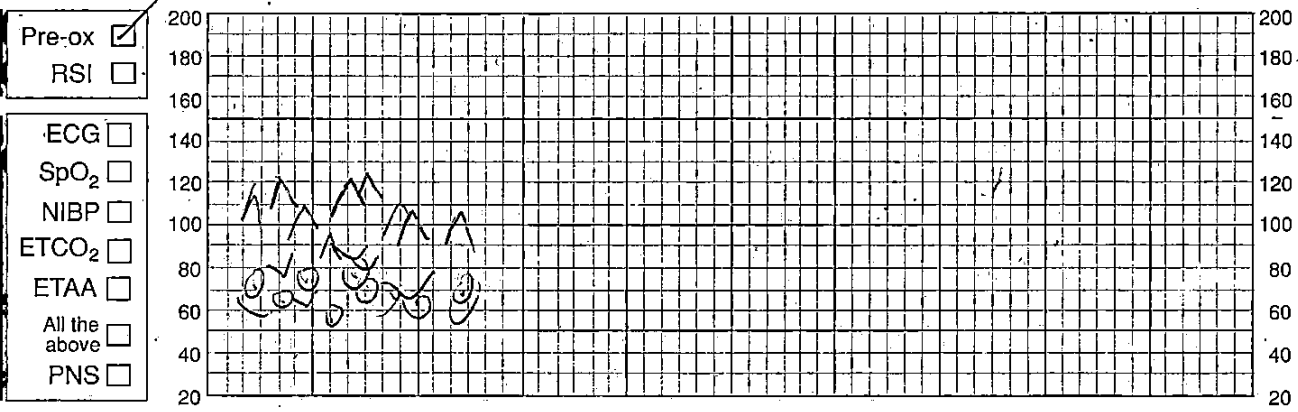
Start 09:40

Finish 10:50

Equipment check ☐

62

Propofol	200mg
VCC	100g
Fentanyl	100ug
Morphine	10
CCFentanyl	1.5g
DNB/Propofol	4mg
DNB/Propofol	4g
Neosine 25	
Glucagon 0.5g	
IV Fluids	



Time	10:00	10:30	11:00
FiO ₂	0.5	0.5	0.5
SpO ₂	96	97	94
ETCO ₂	53	61	59
ETAA	8.0	6.8	4.7

- Events**

 1. 11:00
 2. KD
 3. Ro
 - 4.
 - 5.
 - 6.
 - 7.
 - 8.
 - 9.
- IV Fluids**

 - 1.
 - 2.
 - 3.
 - 4.
 - 5.
 - 6.
 - 7.
 - 8.
 - 9.
- Warmer ☐

Anaesthetist's signature

[Signature]

(63)

**CONSENT TO ANAESTHESIA, OPERATION, INVESTIGATION
OR TREATMENT, MEDICAL PHOTOGRAPHY AND RESEARCH**1132067
BRIAN
MCLAUGHLIN
DOB 28/01/1960

DATE

26 APRIL 2003

Proposed procedure
(block capitals)LAPAROSCOPIC CHOLECYSTECTOMY
+/- OPEN PROCEDURE**NOTES ON GUIDANCE FOR CLINICIANS**

A patient has the right to grant or withhold consent prior to examination, investigation, treatment or operation. The Doctor/Dentist must give the patient sufficient information, in a way he/she can understand about the proposed procedure, significant side effects and the possible alternatives. The Doctor/Dentist 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 to a procedure at any time. The patient's consent to a procedure should be recorded on page two of this form.

Written informed consent is not required for minor procedures, however written consent should be sought for:

- i) any procedure that carries a significant risk.
- ii) any procedure to be carried out under general anaesthesia, sedation or utilising nerve blockage or regional anaesthesia beyond that provided topically or by simple infiltration.
- iii) any procedure which could be considered new, novel or experimental.
- iv) any situation where there are implications for "third parties" eg. relatives and insurance companies in relation to genetic studies or HIV testing.

For further guidance on "significant risk" see section 5 of the Trust's Policy for Consent to Anaesthesia, Operation, Investigation or Treatment.

TO BE COMPLETED BY CLINICAL PRACTITIONER

The clinician completing this form should have sufficient knowledge of the proposed investigation or treatment in order to provide the patient with the appropriate information.

I HAVE FULLY EXPLAINED: To the patient/~~parent/guardian/next of kin~~ (delete as appropriate)

1. The procedure named on this form
2. Alternatives which are available
3. Significant side effects which may result from the procedure
4. The use and implications of medical photography and video linking

Name (block capitals)

C. MCLAUGHLIN

Signature

[Signature]

Grade/Designation

SpR

TO BE COMPLETED BY THE PATIENT/PARENT/GUARDIAN/NEXT OF KIN

604

You should read this form and the notes below carefully. If there is anything you do not understand please ask the doctor for an explanation. The doctor is here to help you and he or she will explain the procedure. If for any reason you are not content with the explanation you are entitled to refuse the procedure. You can ask any questions and ask for more information. If you are happy with this, you understand the procedure and wish to proceed you should sign the form.

Increasingly in modern clinical care, photography and video pictures are used for consultation and teaching purposes. In addition, you should be aware that your operation may be observed via a video link.

You may ask for a relative or a friend or a nurse to be present while the doctor explains the procedure and asks you to sign the form.

I AM The Patient/~~Parent/Guardian/Next of Kin~~ (delete as appropriate)

I UNDERSTAND The purpose, benefits and significant risks associated with the procedure which have been explained to me by the doctor named on this form.

That the procedure may not be carried out by 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 in my best interests.

That observers may see the procedure via a link but my identity will not be broadcast. I understand Medical Photography and video pictures may subsequently be used for consultation and teaching purposes.

Students need to learn how to examine patients and see how procedures are done. This is important for the future of health services. You may be asked to give consent to be examined by students during the procedure.

Please tick the appropriate box if you agree or disagree to any of the following:

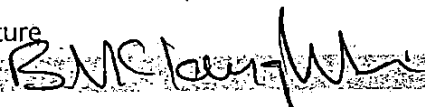
To the administration of anaesthetics or to sedation if required ☒ Agree ☐ Disagree

To the procedure named on this form ☒ Agree ☐ Disagree

To the use of medical photography and the video system ☒ N/A ☐ Agree ☐ Disagree

To examination by a student during the procedure named on this form ☒ N/A ☐ Agree ☐ Disagree

under the supervision of the senior clinician undertaking the procedure.

Signature 

Date 28/4/13

MR BRIAN MCLAUGHLIN
11U Latherton Drive
GLASGOW
G20 8JR

65

Patient Identification

Patient CRN	1132067	Provider	SGC04	Hosp	WIG
Surname	MCLAUGHLIN	Patient's Address			
First Forename	BRIAN	11U Latherton Drive			
Second Forename					
Previous Surname		GLASGOW			
Date of Birth	28 Jan 1960	Postcode G20 8JR			
Sex	Male	Marital Status	Single / Ne		
CHI No		Ethnic Group			
NHS No		GP Practice	MARYHILL HEALTH CENTRE53 1 8830		
Alt CRN		GMC No:	2836058	MCCARTNEY	

Code Management

Spell/	Package ID	Ward	L10S4WI	Admission Date	02/12/02
Speciality/Discipline (Code + Text National)				GS	GENERAL SURGERY
Significant Facility				OTH	OTHER HOSP WARD
Consultant Code				JDOU	Admission/Transfer From
Consultant Name				DOUGHTY	Admission/Transfer From - Location
Management of Patient		INPATIENT	Patient Category	NATIONAL HEA	GP Referral Letter No.
Waiting List Guarantee Exception Code			Waiting List Date		Waiting List Type

General Clinical

Main Diagnosis - ICD 10	
Other Condition - ICD 10 - 2	
4	
5	
6	

Main Operation/Procedure

Other 2		Date Main Operation	
Other 3		Clinician Responsible	
Other 4		Date (OPP2)	
		Clinician Responsible (2)	
		Date (OPP3)	
		Clinician Responsible (3)	
		Date (OPP4)	
		Clinician Responsible (4)	

Development data

Chronic Sick/Disabled	☐	Clinical Problem of Spell/Care Package		Lifestyle Risk Factors 1		2	
				Outcome Measures 1		2	
				Dependency/Severity Measures 1		2	

66

BRIAN MCLAUGHLIN

2801606030

14/11/2012 14:50

DEPARTMENT OF CLINICAL NEUROPHYSIOLOGY
SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW G51 4TF

Consultant Clinical Neurophysiologists:

Dr Cameron Mann 0141-201 2523
Dr Aline Russell 0141-201 2462
Dr Arup Mallik 0141-201 2760
Dr R Renganathan 0141-201 2480
Dr Veronica Leach 0141-201 2462

fax 0141-201-2734

EMG REPORT

Patient: BRIAN MCLAUGHLIN
CHI Number: 2801606030
Address: 265A BROUGHTON ROAD
GLASGOW
G23 5JH
Date of Birth: 28/01/1960
Notes: NCS
Referred by: Mr Reece, Consultant Spinal Surgeon
Hospital: Western Infirmary, Dumbarton Road, Glasgow, G11 6NT

Dear Mr Reece,

Opinion

This gentleman had an anterior cervical decompression in March of this year. This improved some of his symptoms but other symptoms have remained troublesome. The pain in his neck and pins in needles in his left hand improved. However he continues to have right thumb numbness and right little and ring finger numbness that is constant.

Nerve conduction studies show mild left carpal tunnel syndrome (grade 2 CTS) and very mild right carpal tunnel syndrome (grade 1 CTS). Needle EMG shows some very minor changes of chronic reinnervation in the left biceps and left deltoid but these are very subtle. There are no changes of active denervation.

Although nerve conduction studies do show evidence of mild bilateral carpal tunnel syndrome, I am not convinced that his left hand symptoms are due to carpal tunnel syndrome. Therefore I do not feel that left carpal tunnel decompression at present is likely to impact on his symptoms. I suspect his symptoms are arising more proximally from his cervical spine. EMG studies do not show any

67

BRIAN MCLAUGHLIN

2801606030

14/11/2012 14:50

significant changes of cervical radiculopathy and as you know needle EMG may not be all that sensitive. I understand he has had a repeat MRI scan of his neck which may be more helpful.

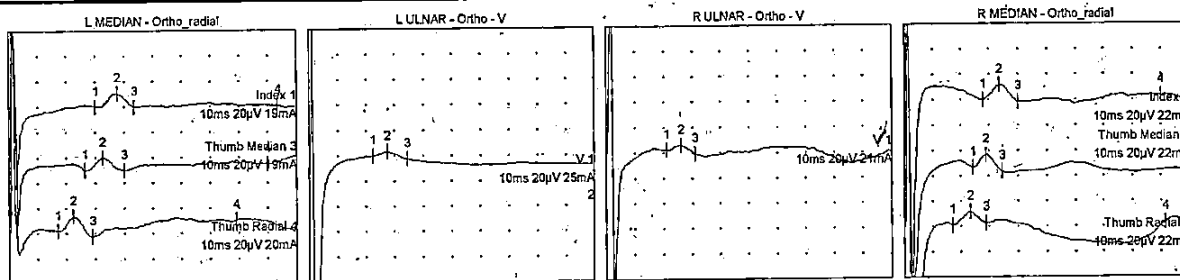
Electronically verified by Dr Mallik

Dr Arup Mallik Bsc (Hons), MBChB, FRCP

Consultant Clinical Neurophysiologist

Sensory NCS

Nerve / Sites	Lat. 2 ms	Lat. ms	Amp.1-2 μ V	Amp.2-3 μ V	Dur. ms	Area μ Vms	Vel. m/s
L MEDIAN - Ortho radial							
Index	3.75	3.00	10.7	11.0	1.35	7.1	53.3
Thumb Median	3.25	2.65	9.9	10.0	1.35	6.2	
Thumb Radial	2.25	1.70	11.9	16.2	1.20	7.6	
R MEDIAN - Ortho radial							
Index	3.35	2.80	11.6	13.3	1.20	7.7	50.0
Thumb Median	2.90	2.45	9.9	13.1	1.00	6.0	
Thumb Radial	2.35	1.70	10.8	8.9	1.20	5.5	
L ULNAR - Ortho - V							
V	2.75	2.25	3.5	6.0	1.20	2.6	
R ULNAR - Ortho - V							
V	2.60	2.10	3.6	6.9	1.00	2.9	



Motor NCS

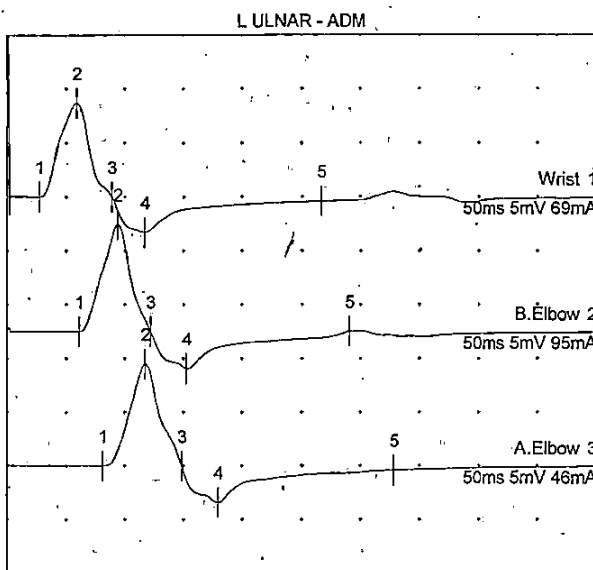
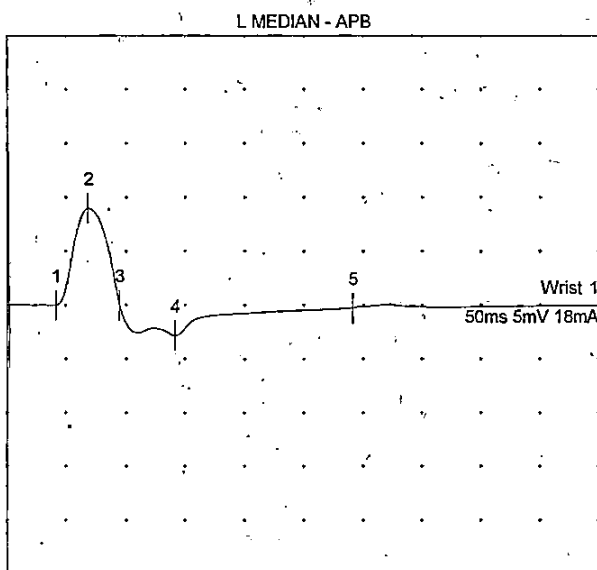
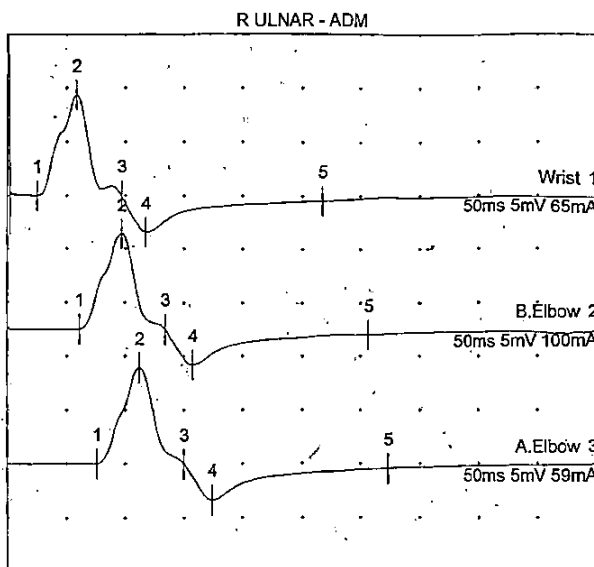
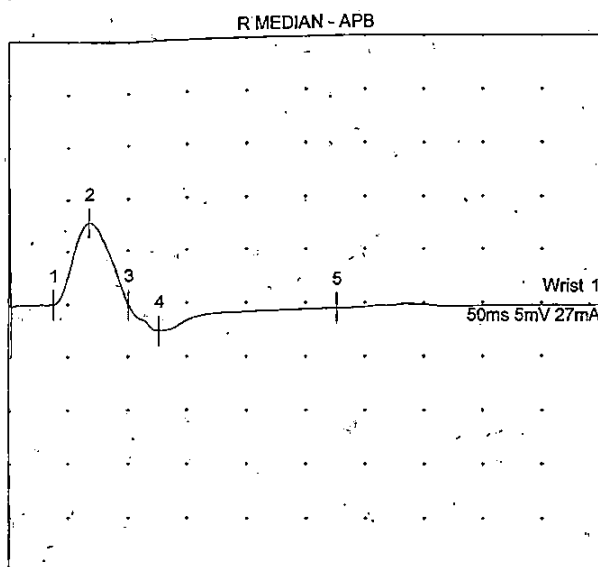
Nerve / Sites	Lat. ms	Amp.1-2 mV	Dur. ms	Area mVms	Amp.1-2 %	Dur. %	Area %	Dist. cm	Vel. m/s
R MEDIAN - APB									
Wrist	3.80	7.8	6.25	26.6	100	100	100	8	
L MEDIAN - APB									
Wrist	4.15	9.0	5.30	27.6	100	100	100	8	
R ULNAR - ADM									
Wrist	2.50	9.3	7.20	26.4	100	100	100	8	
B.Elbow	6.10	8.8	7.30	26.3	94.8	101	99.6	23	63.9
A.Elbow	7.60	8.9	7.40	27.2	95.4	103	103	11	73.3
L ULNAR - ADM									
Wrist	2.75	8.7	6.15	24.6	100	100	100	8	
B.Elbow	6.10	9.9	6.10	27.4	114	99.2	111	23	68.7
A.Elbow	8.10	9.5	6.75	27.7	109	110	113	10	50.0

68

BRIAN MCLAUGHLIN

2801606030

14/11/2012 14:50



Needle EMG

EMG Summary Table									
	Spontaneous					MUAP			Recruitment
	IA	Fib	PSW	Fasc	H.F.	Amp	Dur.	PPP	Pattern
L. BICEPS	N	None	None	None	None	N	N	1+	N
L. DELTOID	N	None	None	None	None	1+	N	N	N
L. TRICEPS	N	None	None	None	None	N	N	N	Reduced

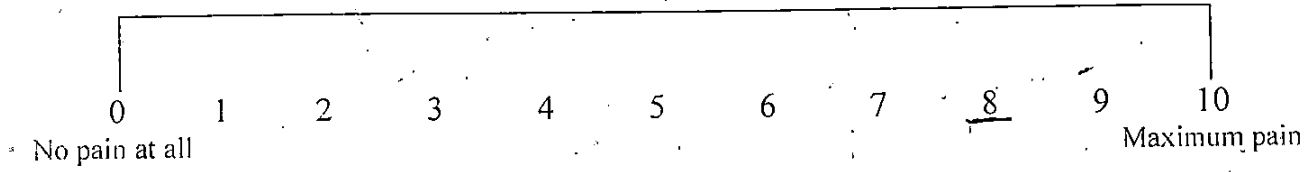
69

51132067E
MCLAUGHLIN
BRIAN
28/01/1960
222 BROUGHTON ROAD
GLASGOW
LANARKSHIRE
CHI-2801606030 G23 5LP

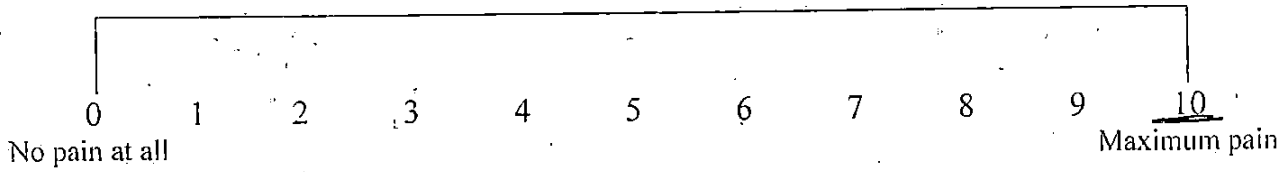
Visual Analogue Scale for Pain

[Please circle at the point that you feel best answers the question]

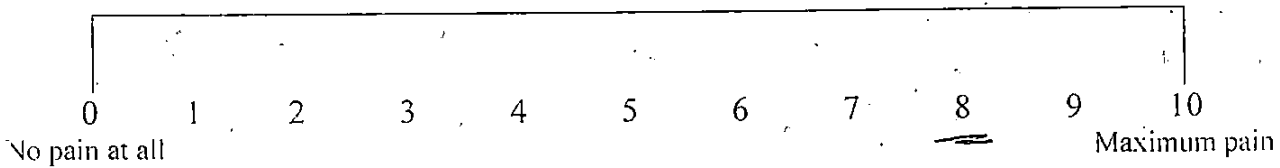
1. Please mark on the line below how much pain you have had from your **leg**, on average, over the past week.



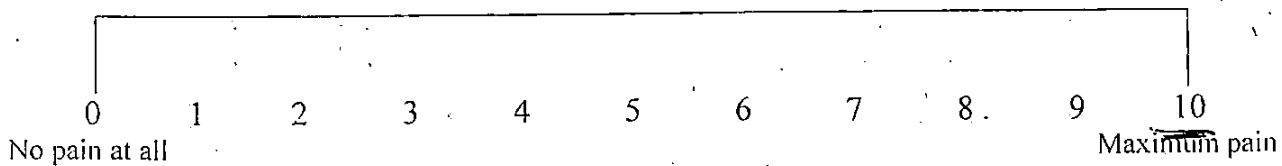
2. Please mark on the line below how much pain you have had from your **back**, on average, over the past week.



3. Please mark on the line below how much pain you have had from your **Arm**, on average, over the past week.



4. Please mark on the line below how much pain you have had from your **Neck**, on average, over the past week.



51132067E
MCLAUGHLIN M
BRIAN 28/01/1960
222 BROUGHTON ROAD
GLASGOW
LANARKSHIRE G23 5LP
CHI-2801606030

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 - Pain Intensity

- A I have no pain at the moment.
- B The pain is very mild at the moment.
- C The pain is moderate at the moment.
- D The pain is fairly severe at the moment.
- ☒ E The pain is very severe at the moment.
- F The pain is the worst imaginable at the moment.

SECTION 6 - Concentration

- A I can concentrate fully when I want to with no difficulty.
- B I can concentrate fully when I want to with slight difficulty.
- C I have a fair degree of difficulty in concentrating when I want to.
- ☒ D I have a lot of difficulty in concentrating when I want to.
- E I have a great deal of difficulty in concentrating when I want to.
- F I cannot concentrate at all.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- A I can look after myself normally without causing extra pain.
- B I can look after myself normally, but it causes extra pain.
- C It is painful to look after myself and I am slow and careful.
- D I need some help, but manage most of my personal care.
- ☒ E I need help every day in most aspects of self care.
- F I do not get dressed, I wash with difficulty and stay in bed.

SECTION 7 - Work

- A I can do as much work as I want to.
- B I can only do my usual work, but no more.
- C I can do most of my usual work, but no more.
- D I cannot do my usual work.
- E I can hardly do any work at all.
- F I cannot do any work at all.

SECTION 3 - Lifting

- A I can lift heavy weights without extra pain.
- B I can lift heavy weights, but it gives extra pain.
- C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☒ E I can lift very light weights.
- F I cannot lift or carry anything at all.

SECTION 8 - Driving

- A I can drive my car without any neck pain.
- B I can drive my car as long as I want with slight pain in my neck.
- C I can drive my car as long as I want with moderate pain in my neck.
- D I cannot drive my car as long as I want because of moderate pain in my neck.
- E I can hardly drive at all because of severe pain in my neck.
- F I cannot drive my car at all.

SECTION 4 - Reading

- A I can read as much as I want to with no pain in my neck.
- B I can read as much as I want to with slight pain in my neck.
- C I can read as much as I want to with moderate pain in my neck.
- D I cannot read as much as I want because of moderate pain in my neck.
- ☒ E I cannot read as much as I want because of severe pain in my neck.
- F I cannot read at all.

SECTION 9 - Sleeping

- A I have no trouble sleeping.
- B My sleep is slightly disturbed (less than 1 hour sleepless).
- C My sleep is mildly disturbed (1-2 hours sleepless).
- D My sleep is moderately disturbed (2-3 hours sleepless).
- ☒ E My sleep is greatly disturbed (3-5 hours sleepless).
- F My sleep is completely disturbed (5-7 hours)

SECTION 5 - Headaches

- A I have no headaches at all.
- B I have slight headaches which come infrequently.
- C I have moderate headaches which come infrequently.
- ☒ D I have moderate headaches which come frequently.
- E I have severe headaches which come frequently.
- F I have headaches almost all the time.

SECTION 10 - Recreation

- A I am able to engage in all of my recreational activities with no neck pain at all.
- B I am able to engage in all of my recreational activities with some pain in my neck.
- C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- D I am able to engage in a few of my recreational activities because of pain in my neck.
- E I can hardly do any recreational activities because of pain in my neck.
- ☒ F I cannot do any recreational activities at all.

COMMENTS:

NAME: Brian McLaughlin

DATE: 22/6/12 SCORE: _____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 - Pain Intensity A I have no pain at the moment. B The pain is very mild at the moment. C The pain is moderate at the moment. ☒ D The pain is fairly severe at the moment. E The pain is very severe at the moment. F The pain is the worst imaginable at the moment.	SECTION 6 - Concentration A I can concentrate fully when I want to with no difficulty. ☒ B I can concentrate fully when I want to with slight difficulty. C I have a fair degree of difficulty in concentrating when I want to. D I have a lot of difficulty in concentrating when I want to. E I have a great deal of difficulty in concentrating when I want to. F I cannot concentrate at all.
SECTION 2 - Personal Care (Washing, Dressing, etc.) A I can look after myself normally without causing extra pain. ☒ B I can look after myself normally, but it causes extra pain. C It is painful to look after myself and I am slow and careful. D I need some help, but manage most of my personal care. E I need help every day in most aspects of self care. F I do not get dressed, I wash with difficulty and stay in bed.	SECTION 7 - Work A I can do as much work as I want to. B I can only do my usual work, but no more. C I can do most of my usual work, but no more. D I cannot do my usual work. ☒ E I can hardly do any work at all. F I cannot do any work at all.
SECTION 3 - Lifting A I can lift heavy weights without extra pain. B I can lift heavy weights, but it gives extra pain. C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. ☒ D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. E I can lift very light weights. F I cannot lift or carry anything at all.	SECTION 8 - Driving A I can drive my car without any neck pain. B I can drive my car as long as I want with slight pain in my neck. C I can drive my car as long as I want with moderate pain in my neck. D I cannot drive my car as long as I want because of moderate pain in my neck. E I can hardly drive at all because of severe pain in my neck. F I cannot drive my car at all.
SECTION 4 - Reading A I can read as much as I want to with no pain in my neck. B I can read as much as I want to with slight pain in my neck. ☒ C I can read as much as I want to with moderate pain in my neck. D I cannot read as much as I want because of moderate pain in my neck. E I cannot read as much as I want because of severe pain in my neck. F I cannot read at all.	SECTION 9 - Sleeping A I have no trouble sleeping. B My sleep is slightly disturbed (less than 1 hour sleepless). ☒ C My sleep is mildly disturbed (1-2 hours sleepless). D My sleep is moderately disturbed (2-3 hours sleepless). E My sleep is greatly disturbed (3-5 hours sleepless). F My sleep is completely disturbed (5-7 hours)
SECTION 5 - Headaches ☒ A I have no headaches at all. B I have slight headaches which come infrequently. C I have moderate headaches which come infrequently. D I have moderate headaches which come frequently. E I have severe headaches which come frequently. F I have headaches almost all the time.	SECTION 10 - Recreation A I am able to engage in all of my recreational activities with no neck pain at all. B I am able to engage in all of my recreational activities with some pain in my neck. C I am able to engage in most, but not all of my recreational activities because of pain in my neck. ☒ D I am able to engage in a few of my recreational activities because of pain in my neck. E I can hardly do any recreational activities because of pain in my neck. F I cannot do any recreational activities at all.

COMMENTS:

NAME:

B. M. C. [Signature]

DATE: 22/6/12 SCORE:

North Glasgow Biochemistry & Immunology ** LIVE **

Patient enquiry ---- Express results

Reg Name
51132067E MCLAUGHLIN BRIAN

D.o.B. Sex Loc.
28.01.60 M GGH 2B ORTHO PR

Specimen N,12.7114377.J

Type Specimen

Collected 20.03.12 09:00 A.Diag

.....U&E.....

Sodium 137
Potassium 4.0
Chloride 107
Urea 5.6
Creat 66
eGFR >60

Quit \ Earlier req \ Later req \ ED \ LD
Back \ PHoned comment

Quit \ Earlier req \ Later req \ ED \ LD
Back \ PHoned comment

.....FBC.....
Eosins 0.15
Basos 0.02
6.28
4.97
155
0.443
89.1
31.2
350
13.2
211
3.23
2.27
0.61
Lymphs
neuts
lts
DM
CHC
CH
CV
st
c
3C
3C

51132067E MCLAUGHLIN BRIAN
Name
D.o.B. Sex Loc. 28.01.60 M 2B Orthopaedic
Specimen H,12.6548369.V
Type Blood
Collected 20.03.12 09:00 A.Diag

72

Name: MCLAUGHLIN BRIAN Sex: Male DOB:28.01.60 CHI: 2801606030
Address: 222 BROUGHTON ROAD Hosp. No. 51132067E
Source: GGH 2B Ortho Assessment Cons/GP:NOT GIVEN Coll:20.03.12
Spec: Mid stream specimen Rec:20.03.12
No: M,12.0102058.P Therapy:
Status: Authorised Date if Reported: 21.03.12

73

CLINICAL:

FINAL REPORT

MICROSCOPY: White blood cells : NIL
Red blood cells : NIL
Organisms : NIL
Squamous cells : NIL

CULTURE: No growth.

Earlier \ Later specimen - append S for same type, D for same discipline
Quit \ PHoned comment \ frame: + > ..

Earlier \ Later specimen - append S for same type, D for same discipline
Quit \ PHoned comment \ frame: + > ..

COMMENT: METHICILLIN RESISTANT STAPH.AUREUS NOT ISOLATED

FINAL REPORT

CLINICAL:

Name: MCLAUGHLIN BRIAN Sex: Male DOB:28.01.60 Coll:Not known
Address: 222 BROUGHTON ROAD Hos No:51132067E Rec:20.03.12
Source: GGH 2B Ortho Assessment Cons/GP:Mr.H.Sharma CHI:280160603
Spec: Nose
Lab No: M,12.0330604.P Therapy:
Status: Authorised Date if Reported: 21.03.12

Male

Vent. rate	81	bpm
PR interval	122	ms

Normal ECG

QPS	duration	ms
1000	1.000	1.000
2000	0.500	0.500
3000	0.333	0.333
4000	0.250	0.250
5000	0.200	0.200
6000	0.167	0.167
7000	0.143	0.143
8000	0.125	0.125
9000	0.111	0.111
10000	0.100	0.100

Q_L/Q_{1c}	404/409	ms
$-P-R-T$ axes	29	2
		5

2925

p-R-T axes 29 2 5

Technician 7112

Location: 2BPOA

Referred by

Unconfirmed

FILE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please just circle the one choice which closely describes your problem **right now**.

SECTION 1--Pain Intensity

- A. I have no pain at the moment
- B. The pain is mild at the moment.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- ☒ E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

- A. I can look after myself without causing extra pain.
- B. I can look after myself normally but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- ☒ D. I need some help, but manage most of my personal care.
- E. I need help every day in most aspects of self-care.
- F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- ☒ F. I cannot lift or carry anything at all.

SECTION 4 --Reading

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- ☒ E. I cannot read as much as I want because of severe pain in my neck.
- F. I cannot read at all.

SECTION 5--Headache

- ☒ A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come in-frequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

SECTION 6 -- Concentration

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- ☒ D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty in concentrating when I want to.
- F. I cannot concentrate at all.

SECTION 7--Work

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- ☒ F. I cannot do any work at all.

SECTION 8--Driving

- A. I can drive my car without neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive my car at all because of severe pain in my neck.
- ☒ F. I cannot drive my car at all.

SECTION 9--Sleeping

- A. I have no trouble sleeping
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- ☒ E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation

- A. I am able engage in all recreational activities with no pain in my neck at all.
- B. I am able engage in all recreational activities with some pain in my neck.
- C. I am able engage in most, but not all recreational activities because of pain in my neck.
- D. I am able engage in a few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain in my neck.
- ☒ F. I cannot do any recreational activities all all.

SIGNATURE: B. M. Plank DATE: 2/3/12

© Vernon H and Hagino C, 1991
(with permission from Fairbank J)

DISABILITY INDEX SCORE: %

THE OSWESTRY DISABILITY INDEX FOR LOW BACK PAIN

This section has been designed to give the doctor information as to how your back pain has affected your ability to manage in every-day life. Please answer every section and mark in each section only ONE statement which applies to you. We realise you may consider that two of the statements in any one section relate to you but please just tick the statement which most closely describes your problem. **[IT IS IMPORTANT TO ANSWER EACH SECTION]**

SECTION 1 - PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☒ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2-PERSONAL CARE (Washing, dressing etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☒ I can look after myself normally but it is very painful.
- ☐ It is painful to look after myself and I am slow and inept.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do get dressed; wash with difficulty; and stay in bed.

SECTION 3 - LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☒ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - WALKING

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☒ Pain prevents me walking more than a quarter of a mile.
- ☐ Pain prevents me walking more than 100 yards.
- ☐ I can only walk if I use a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favourite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☒ Pain prevents me from sitting more than half an hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

SECTION 6 - STANDING

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want, but it gives me extra pain.
- ☒ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than half an hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SECTION 7 - SLEEP

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain I have less than 6 hours sleep.
- ☒ Because of pain I have less than 4 hours sleep.
- ☐ Because of pain I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SEX LIFE

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

SECTION 9 - SOCIAL LIFE

- ☐ My social life is normal and causes me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
- ☒ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

SECTION 10 - TRAVELLING

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☒ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me travelling except to receive treatment.

51132067E
MCLAUGHLIN
BRIAN
38 KELVINDALE PLACE
FLAT 02
GLASGOW
CHI-2801606030

28/01/1960
G20 8BP

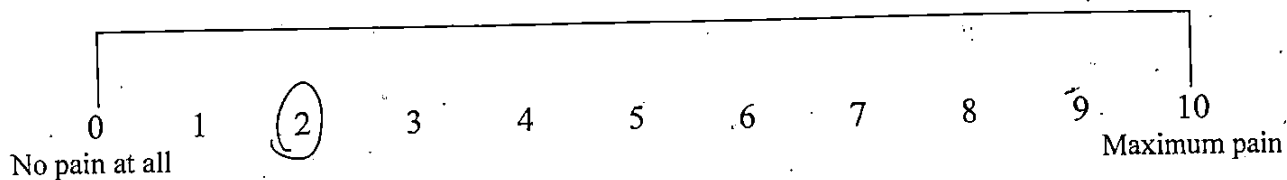
78

51132067E
MCLAUGHLIN M
BRIAN 28/01/1960
222 BROUGHTON ROAD
GLASGOW
LANARKSHIRE G23 5LP
CHI-2801606030

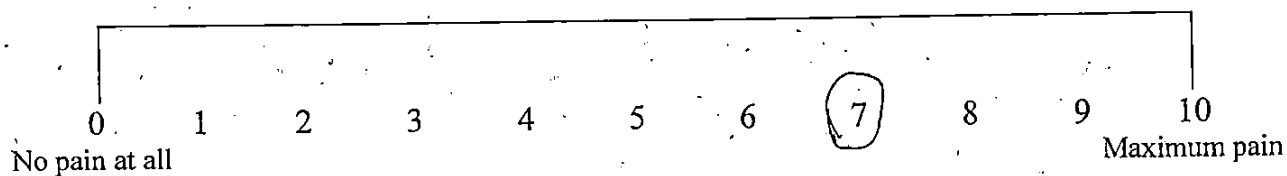
Visual Analogue Scale for Pain

[Please circle at the point that you feel best answers the question]

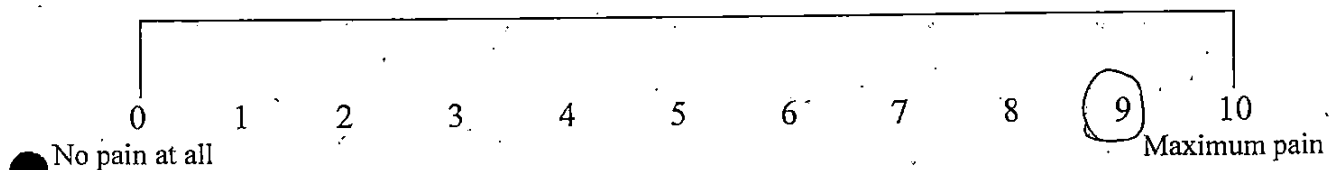
1. Please mark on the line below how much pain you have had from your **leg**, on average, over the past week.



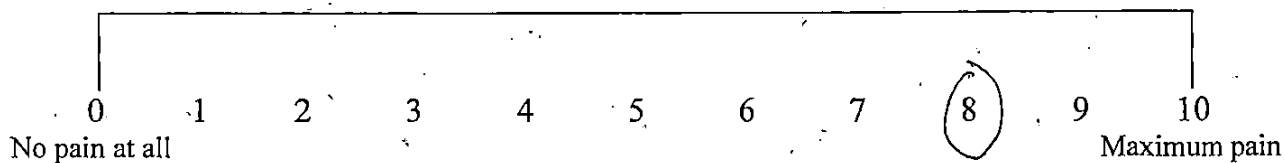
2. Please mark on the line below how much pain you have had from your **back**, on average, over the past week.



3. Please mark on the line below how much pain you have had from your **Arm**, on average, over the past week.



4. Please mark on the line below how much pain you have had from your **Neck**, on average, over the past week.



Department of Pathology
Pathology Report

79

Enquiries: 0141 211 2473

Lab No.: P,10.0016919

CHI No. 2801606030

Name: MCLAUGHLIN BRIAN

DOB/Age: 28.01.60
Post code: G20 8JR

Hosp.No (or Path.Comp.Ref.ZP): 51132067E

Consultant: DR S DOVER

Location: STOBHILL ENDOSCOPY

CC Dr Dover's Secretary, GGH

BIOPSIES OF THE TERMINAL ILEUM AND COLON.

Clinical history

going alternating bowel habit/associated abdo pain and PR bleeding. Haemorrhoids were only abnormality seen at colonoscopy.

Gross

A: BIOPSIES OF THE TERMINAL ILEUM - Two biopsies, the largest 5x3x1mm.

B: RANDOM COLONIC BIOPSIES - Multiple biopsies, the largest 3x1x1mm.

Microscopy

A: Microscopy shows normal small intestinal mucosa.

B: Microscopy shows normal large intestinal mucosa with no evidence of microscopic colitis, dysplasia or malignancy.

Sk

V Lynch
G Kohnen

u-12

File

Date collected 16.08.10
Date received 17.08.10
Date reported 19.08.10

NHS Greater Glasgow and Clyde
Endoscopy Unit, Stobhill Hospital
GASTROSCOPY REPORT

80

Name: **Brian MCLAUGHLIN, 28/01/1960 (M)**
CHI No: **2801606030**
Case note no.: **51132067E**

Address: **0/2 38 Kelvindale Place**
Glasgow
Lanarkshire
G208BP

Procedure date
16th August 2010.

GP: **Dr Alasdair Webb**
Maryhill Health Centre,
41 Shawpark Street
Glasgow
G209DR

Priority: Elective
Status: Day patient/NHS
Hospital: GGH
Ward: (none)
Referring Cons: Dr Simon B Dover
(Gastroenterology)

Indications

Clinically important comments: FHx gastric cancer.

Report

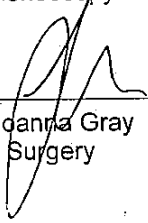
The procedure was completed successfully.
Apparent mucosal junction at 40cm from the incisors.

Diagnosis

OESOPHAGUS. Normal.
STOMACH. Bile reflux, mucosa normal.
DUODENUM. Normal.

Advice/comments

For colonoscopy today.


Miss Joanna Gray
ST 5 - Surgery

Consultant/Endoscopist

List consultant: Mr David Chong
Endoscopist No1: Miss Joanna Gray
Nurse: Sister Margaret Anderson

Instrument

STP PURPLE STR EG2770K A120370

Premedication

Fentanyl (IV) 50 mcg
Midazolam (IV) 3 mg

NHS Greater Glasgow and Clyde
Endoscopy Unit, Stobhill Hospital
COLONOSCOPY REPORT

81

Name: **Brian MCLAUGHLIN, 28/01/1960 (M)**
CHI No: **2801606030**
Case note no.: **51132067E**

Address: **0/2 38 Kelvindale Place**
Glasgow
Lanarkshire
G208BP

Procedure date
16th August 2010

GP: **Dr Alasdair Webb**
Maryhill Health Centre
41 Shawpark Street
Glasgow
G209DR

Priority: Elective
Status: Day patient/NHS
Hospital: GGH
Ward: (none)
Referring Cons: Dr Simon B Dover
(Gastroenterology)

Indications

Chronic alternating constipation/diarrhoea with overt rectal bleeding and abdominal pain.

Findings

Bowel preparation with Kleanprep was satisfactory. A digital rectal examination was performed. The colonoscope was inserted via the anus to the terminal ileum. The caecum was identified positively by the ileocecal valve, the appendicular orifice, the tri-radiate caecal fold and ileal intubation. Perianal lesions: haemorrhoids (1st degree) at (c). There were no peri-operative complications.

Diagnosis

Haemorrhoids.

Follow up

Awaiting pathology results.

Advice/comments

Likely to be haemorrhoidal bleeding. These are not amenable to banding today.

Mr MCLAUGHLIN tells me that his altered bowel habit has improved, but the pain is still troublesome.

Random and TI biopsies obtained.

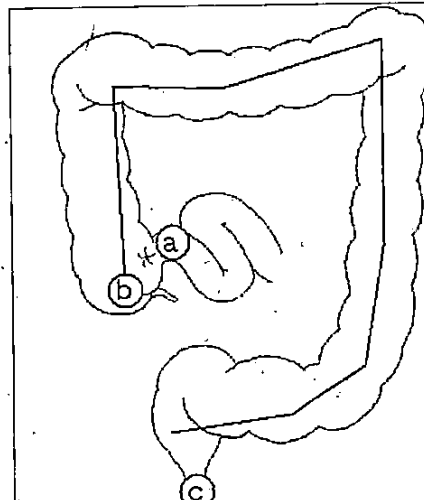
Clinic review with Dr Dover is already arranged.


Ewan Bell
Colorectal Nurse Specialist

Consultant/Endoscopist
List consultant: Mr David Chong
Endoscopist No1: Ewan Bell
Nurse: Sister Margaret Anderson

Instruments
STP BLUE EC3885LK A120205
Disposable forceps

Premedication
In addition to previous procedure
Midazolam (IV) 1 mg



a: Terminal ileum
b: An area extending from the caecum to the rectum
c: Anal margin

Specimens taken
Biopsy (x2 site a and random x1 site b)

? Endo Colon (84)



STOBHILL HOSPITAL
DAY SURGERY ENDOSCOPY

DATE 16/8/10

CONSULTANT Dr Cahill
Ewart Bell

Unit N	51132067E	
Name	MCLAUGHLIN	M
Address	BRIAN	28/01/1960
	222 BROUGHTON ROAD	
	GLASGOW	
	LANARKSHIRE	G23 5LP
DOB	CHI-2801606030	

A. ASSESSMENT

1. CURRENT MEDICATION

2. MEDICAL PROBLEMS Ruptured pancreas cholecystectomy
DT PTE post op Warfarin 7 yrs ago bronchitis as child
Appendicectomy

3. PAST HISTORY OF HEPATITIS OR JAUNDICE No ☒ Yes ☐

4. DISCHARGE ARRANGEMENTS Escort No ☐ Yes ☒ Who Son
Overnight No ☐ Yes ☒ Who Family

PATIENTS DECLARATION

I have read and understood the warnings regarding the after effects of sedation.

Patients signature

B. McLaughlin

B. PREPARATION

1. LAST ATE OR DRANK	Time	<u>Water + Klean prep am</u>	<u>1030</u>	☒
2. IDENTITY BAND				☒
3. CASENOTES/ADMISSION PACK				☒
4. DENTURE/CROWNS/CAPS/BRIDGE	<u>none</u>			☒
5. BOWEL PREPARATION (If required)	<u>Klean Prep x4</u>			☒
6. UNDERWEAR JEWELLERY REMOVED				☒
7. ALLERGIES	<u>Penicillin</u>			☒
8. BASELINE OBSERVATIONS	Pulse	<u>80</u>	Blood Pressure	<u>136/84</u>

PROBLEMS/NEEDS

Sats 95

COMMENTS

Signature

Ammonagel

ONCE ONLY PRESCRIPTIONS

Date	Time	Drug	Dose	Route	Signature	Given by	Time given
16/1/10	16:10	Midazolam	4mg	I.V.	[Signature]	[Signature]	
16/1/10	16:10	Fentanyl	50mcg	I.V.	Angus B.	[Signature]	

ENDOSCOPY

PROCEDURE Endoscopy & Colonoscopy & Biopsy

SEDATION

No ☐ Yes ☒

THROAT SPRAY

No ☒ Yes ☐ Time _____

PATIENT POSITION

Left Lateral ☒

DIATHERMY

Yes ☐ No ☒

SPECIMENS

PATH ☒ BACT ☐ CLO ☐
x2

NAMED NURSES

M. Anderson

COMMENTS

pt groggy & mild discomfort

RECOVERY

POST ENDOSCOPY OBSERVATIONS

TIME	16:35	16:45																
PULSE	70	61																
LOOD PRESSURE	131/77	117/73																
SA O2	94	95																
RESPIRATORY RATE	22	22																
OXYGEN	-	-																
SEDATION SCORE	0	0																
VENFLON	1/2	✓	OUT															
NURSES INITIALS	M	Q																

SEDATION SCORE

- A = ASLEEP
- 0 = ALERT
- 1 = RESPONDS TO VERBAL COMMAND
- 2 = RESPONDS TO PAINFUL STIMULI
- 3 = UNRESPONSIVE

MULTIDISCIPLINARY NOTES

82

Brian
McLaughlin

DATE / TIME

DISCHARGE

YES

NO

1. STABLE VITAL SIGNS
2. CANNULAE REMOVED
3. ABLE TO DRESS, SIT AND WALK UNAIDED
4. TOLERATING FOOD AND FLUIDS
5. INSTRUCTIONS GIVEN SEDATION
6. GP LETTER GIVEN BEFORE DISCHARGE
7. FOLLOW UP APPOINTMENT

☒
☒
☒
☒
☒
☒
☒

☐
☐
☐
☐
☐
☐
☐

DR DOVER'S clinic

DISCHARGE AT _____ TO home CARE

NURSE'S SIGNATURE

[Signature]

CONSENT FORM



51132067E
MCLAUGHLIN M
BRIAN 28/01/1960
222 BROUGHTON ROAD
GLASGOW
LANARKSHIRE G23 5LP
CHI-2801606030

Special requirements (e.g. other language
Communication method)

Proposed operation, investigation or other treatment.
(BLOCK CAPITALS)

COLONOSCOPY + ENDOSCOPY

I have explained the procedure named on this form to the patient in the 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 sign if cant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedure above).

An information leaflet/tape has been provided

(Title)

Signature of Practitioner

[Signature]

Name / Designation (Print)

DR BILLY / NURSE ANNE

Date 16 / 8 / 15

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*

(* parental responsibility for a minor without capacity)

83

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.

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.

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
- to the emergency administration of blood or blood products

Please sign here if you refuse to consent to the emergency administration of blood or blood products.

Signature

Date/...../.....

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 not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.

☐☐

PATIENT AGREEMENT FOR TREATMENT

Signature: X *B. M. O. A. L.*

Date 16/8/10

Name (Print):

CONFIRMATION OF CONSENT

(to be completed when patient is admitted for procedure if form signed in advance)

I confirm that I have no further questions and wish the procedure to go ahead.

Signature: X *B. M. O. A. L.* Print name:

Date 16/8/10

Endoscopy Unit
Gartnavel General Hospital
Glasgow G12 0YN
Tel: 0141 211 3101

Sigmoidoscopy Report

ID Number 51132067E
Name MCLAUGHLIN, BRIAN
Date of birth 28 Jan 1960 Sex Male
Address 11 KIRKHILL PL
2/B
GLASGOW
G20 8HZ

86

Classification

Indications

Date of procedure
10 Oct 2005 (15:53)

Endoscopist
Ms Iona Drummond

Assistant
Frances Staunton
Margaret A Tough

Medications used
No intravenous sedation.

Instrument
43 CF230L Colonoscope 2600714

Report

Following your referral letter dated 16/06/05 Mr McLaughlin was put on the list for flexible sigmoidoscopy. Unfortunately he failed to attend for this today. I assume that this is because his symptoms have resolved. If his symptoms re-occur please re-refer.

Ms Iona Drummond

North Glasgow University Hospitals NHS Trust

Department of Pathology

Pathology report

Enquiries Tel. 0141-211-2473

(87)

Lab No.: P,03.0009396

Name: MCLAUGHLIN BRIAN

DOB/Age: 28.01.60

Post code: G20 8JR

Hosp.No(orPath.Comp.Ref.ZP): 1132067

Consultant: Prof P. O'DWYER

Location: L10 Professorial Sur Unit

GALLBLADDER

History: Previous gallstone pancreatitis.

Gross: An intact gallbladder measuring 70x25x20mm. On section it contains multiple stones.

Microscopy shows features consistent with cholelithiasis.

V Geetha/C Muldoon

NB

Date collected 29.04.03
Date received 29.04.03
Date reported 06.05.03

1132067

01-May-2003

11:13:07

KIAN McLAUGHLIN

CARDIAC DEPT. WESTERN INFIRMARY
Department: L10E

Operator: CD

Rate 106
PR 142
QRSD 86
QT 328
QTc 435

--Axis--

P 35
QRS 10
T 30

Requested by:
O'DWYER

88

avR

V1

avL

V5

avF

V6

100 mm/s 1.50 mV HP 709 11:15



North Glasgow University Hospitals NHS Trust
Nuclear Medicine (Diagnosis)
Western Infirmary



89

NAME: BRIAN MC LAUGHLAN

WARD: 10 E HOSPITAL: W19

Radionuclide: ^{99m}Tc Product: MAA Activity: 80 MBq

Date of Administration 10/12/02

Nursing Instructions (To be observed until the date given below)

1. Wear disposable gloves to remove linen contaminated by spillage or incontinence.
2. Put any such linen into a labelled plastic bag, segregate it and contact the Radiation Protection Adviser who will advise on further action to be taken.
3. Should the floor or other area become contaminated, wear disposable gloves, mop up excess liquid with paper towels or tissues and wash the area. Segregate the materials used and place in a plastic bag. Cover the area temporarily with Benchote and contact the Radiation Protection Supervisor or the Radiation Protection Adviser.

4. NO 24HOUR URINE COLLECTIONS TO BE TAKEN.

Date to resume normal nursing 11/12/02

If there is any doubt about necessary precautions or procedures, advice should be sought from:

Radiation Protection Supervisor

Dr T E Hilditch (0141) 211 2000 Page No 3043

Radiation Protection Adviser

Mr A G Brennan (0141) 211 2952

Date of Printing May 2002
Date of Review May 2004

Department of Medical Illustration 001024

09-Dec-2002 09:13:11 L. MCLAUGHLIN

CARDIAC DEPT. WESTERN INFIRMARY
Department: L10E

Operator: KS

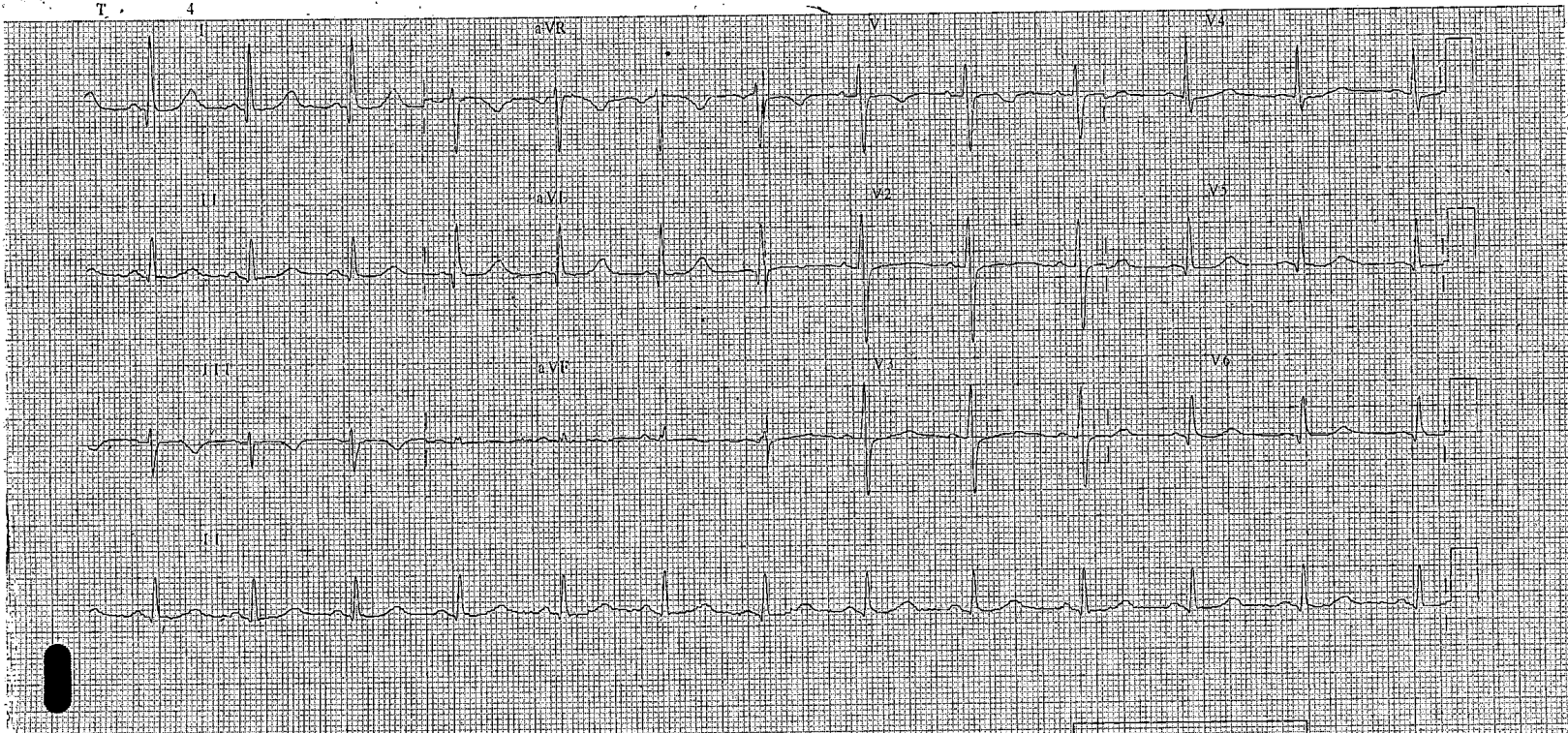
Rate 76
PR 160
QRSD 94
QT 423
QTc 476

--Axis--
P 47
QRS 9
T 4

Smith 9/12/02

Requested by:
WILSON

96



BIOCHEMISTRY REPORT

MCLAUGHLIN BRIAN A
WIG L10 PROF SURG
WG1132067 28.01.60 (92)
P O'DWYER
Lab No N.03.7393356.X
Reported 01.05.03 14:05
Collected 01.05.03 09:00
Authorised by: Auto Check

RESULTS	CONSTITUENT
138	Sodium 135-144 mmol/l
4.1	Potassium 3.5-5.1 mmol/l
102	Chloride 97-108 mmol/l
	Total CO ₂ 22-32 mmol/l
9.0 High	Urea 2.5-7.5 mmol/l *
104	Creatinine 60-110 µmol/l *
	Serum Osmolality 275-295 mmol/kg
	Urine Osmolality mmol/kg
	Calcium 2.20-2.65 mmol/l
	'Corrected' Calcium 2.16-2.53 mmol/l
	Phosphate 0.8-1.45 mmol/l
	Total Protein 60-77 g/l
	Albumin 36-50 g/l
	Bilirubin 3-18 µmol/l
	Alkaline Phosphatase 70-260 U/l *
	Gamma G.T. 5-50 U/l
	AST 10-35 U/l
	ALT 10-50 U/l
	Total CK 10-171 U/l
	CK-MB Ratio
	Glucose 2.80-6.0 mmol/l
	Urate 0.10-0.42 mmol/l *
	Amylase 0-100 U/l
	CRP <10mg/L

* Reference ranges for these assays have significant age and sex dependence.
Further information may be obtained from the
Duty Biochemist (211 - 3355/3341) MI 01/00

BIOCHEMISTRY REPORT

MCLAUGHLIN BRIAN A
WIG L10 PROF SURG
WG1132067 28.01.60 (93)
J DOUGHTY
Lab No N.02.6091080.M
Reported 12.12.02 11:05
Collected 12.12.02 09:00
Authorised by: Auto Check

RESULTS	CONSTITUENT
138	Sodium 135-144 mmol/l
4.1	Potassium 3.5-5.1 mmol/l
99	Chloride 97-108 mmol/l
	Total CO ₂ 22-32 mmol/l
3.9	Urea 2.5-7.5 mmol/l *
94	Creatinine 60-110 µmol/l *
	Serum Osmolality 275-295 mmol/kg
	Urine Osmolality mmol/kg
	Calcium 2.20-2.65 mmol/l
	'Corrected' Calcium 2.16-2.53 mmol/l
	Phosphate 0.8-1.45 mmol/l
	Total Protein 60-77 g/l
	Albumin 36-50 g/l
	Bilirubin 3-18 µmol/l
	Alkaline Phosphatase 70-260 U/l *
158 High	Gamma G.T. 5-50 U/l
42 High	AST 10-35 U/l
53 High	ALT 10-50 U/l
	Total CK 10-171 U/l
	CK-MB Ratio
	Glucose 2.80-6.0 mmol/l
	Urate 0.10-0.42 mmol/l *
	Amylase 0-100 U/l
151 High	CRP <10mg/L

* Reference ranges for these assays have significant age and sex dependence.
Further information may be obtained from the
Duty Biochemist (211 - 3355/3341) MI 01/00

BIOCHEMISTRY REPORT

MCLAUGHLIN BRIAN A
 WIG L10 PROF SURG
 WG1132067 28.01.60
 J DOUGHTY
 Lab No N.02.6091622.A
 Reported 14.12.02 11:35
 Collected 14.12.02 09:00
 Authorised by: Auto Check

RESULTS	CONSTITUENT
	Sodium
	135-144 mmol/l
	Potassium
	3.5-5.1 mmol/l
	Chloride
	97-108 mmol/l
	Total CO ₂
	22-32 mmol/l
	Urea
	2.5-7.5 mmol/l *
	Creatinine
	60-110 µmol/l *
	Serum Osmolality
	275-295 mmol/kg
	Urine Osmolality
	mmol/kg
	Calcium
	2.20-2.65 mmol/l
	'Corrected' Calcium
	2.16-2.53 mmol/l
	Phosphate
	0.8-1.45 mmol/l
	Total Protein
	60-77 g/l
44	Albumin
	36-50 g/l
14	Bilirubin
	3-18 µmol/l
210	Alkaline Phosphatase
	70-260 U/l *
134	High Gamma G.T.
	5-50 U/l
58	High AST
	10-35 U/l
62	High ALT
	10-50 U/l
	Total CK
	10-171 U/l
	CK-MB
	Ratio
	Glucose
	2.80-6.0 mmol/l
	Urate
	0.10-0.42 mmol/l *
	Amylase
	0-100 U/l
87	High CRP <10mg/L

BIOCHEMISTRY REPORT

MCLAUGHLIN BRIAN A
 WIG L10 PROF SURG
 WG1132067 28.01.60
 J DOUGHTY
 Lab No N.02.6091336.A
 Reported 13.12.02 10:35
 Collected 13.12.02 09:00
 Authorised by: Auto Check

RESULTS	CONSTITUENT
137	Sodium
	135-144 mmol/l
4.2	Potassium
	3.5-5.1 mmol/l
100	Chloride
	97-108 mmol/l
	Total CO ₂
	22-32 mmol/l
4.0	Urea
	2.5-7.5 mmol/l *
87	Creatinine
	60-110 µmol/l *
	Serum Osmolality
	275-295 mmol/kg
	Urine Osmolality
	mmol/kg
	Calcium
	2.20-2.65 mmol/l
	'Corrected' Calcium
	2.16-2.53 mmol/l
	Phosphate
	0.8-1.45 mmol/l
	Total Protein
	60-77 g/l
38	Albumin
	36-50 g/l
14	Bilirubin
	3-18 µmol/l
193	Alkaline Phosphatase
	70-260 U/l *
133	High Gamma G.T.
	5-50 U/l
49	High AST
	10-35 U/l
50	ALT
	10-50 U/l
	Total CK
	10-171 U/l
	CK-MB
	Ratio
	Glucose
	2.80-6.0 mmol/l
	Urate
	0.10-0.42 mmol/l *
	Amylase
	0-100 U/l
111	High CRP <10mg/L

* Reference ranges for these assays have significant age and sex dependence.
 Further information may be obtained from the
 Duty Biochemist (211 - 3355/3341) MI 01/00

* Reference ranges for these assays have significant age and sex dependence.
 Further information may be obtained from the
 Duty Biochemist (211 - 3355/3341) MI 01/00

BIOCHEMISTRY REPORT

MCLAUGHLIN BRIAN 96 - A
 WIG L10 PROF SURG
 WG1132067 28.01.60
 J DOUGHTY
 Lab No. N.02.7291242.X
 Reported 06.12.02 15:05
 Collected 05.12.02 09:00
 Authorized by: Jean McAllister

RESULTS		CONSTITUENT
141		Sodium 135-144 mmol/l
3.5		Potassium 3.5-5.1 mmol/l
98		Chloride 97-108 mmol/l
		Total CO ₂ 22-32 mmol/l
5.5		Urea 2.5-7.5 mmol/l *
73		Creatinine 60-110 µmol/l *
		Serum Osmolality 275-295 mmol/kg
		Urine Osmolality mmol/kg
		Calcium 2.20-2.65 mmol/l
		'Corrected' Calcium 2.16-2.53 mmol/l
		Phosphate 0.8-1.45 mmol/l
		Total Protein 60-77 g/l
38		Albumin 36-50 g/l
39	High	Bilirubin 3-18 µmol/l
193		Alkaline Phosphatase 70-260 U/l *
313	High	Gamma G.T. 5-50 U/l *
34		AST 10-35 U/l
85	High	ALT 10-50 U/l
		Total CK 10-171 U/l
		CK-MB
		Ratio
		Glucose 2.80-6.0 mmol/l
		Urate 0.10-0.42 mmol/l *
		Amylase 0-100 U/l

345 High CRP <10mg/L

* Reference ranges for these assays have significant age and sex dependence.
 Further information may be obtained from the
 Duty Biochemist (211 - 3355/3341) MI 01/00

BIOCHEMISTRY REPORT

MCLAUGHLIN
WIG L10 PROF SURG
WG1132067
J DOUGHTY
Lab No N.02.6089400.K
Reported 06.12.02 09:05
Collected 05.12.02
Authorised by: Auto Check

BRIAN

97

A

RESULTS		CONSTITUENT
134	LOW	Sodium 135-144 mmol/l
3.2	LOW	Potassium 3.5-5.1 mmol/l
97		Chloride 97-108 mmol/l
		Total CO ₂ 22-32 mmol/l
4.2		Urea 2.5-7.5 mmol/l *
77		Creatinine 60-110 µmol/l *
		Serum Osmolality 275-295 mmol/kg
		Urine Osmolality mmol/kg
		Calcium 2.20-2.65 mmol/l
		'Corrected' Calcium 2.16-2.53 mmol/l
		Phosphate 0.8-1.45 mmol/l
		Total Protein 60-77 g/l
		Albumin 36-50 g/l
		Bilirubin 3-18 µmol/l
		Alkaline Phosphatase 70-260 U/l *
		Gamma G.T. 5-50 U/l
		AST 10-35 U/l
		ALT 10-50 U/l
		Total CK 10-171 U/l
		CK-MB Ratio
		Glucose 2.80-6.0 mmol/l
		Urate 0.10-0.42 mmol/l *
		Amylase 0-100 U/l
		CRP <10mg/L

* Reference ranges for these assays have significant age and sex dependence.
Further information may be obtained from the
Duty Biochemist (211 - 3355/3341) MI 01/00

BIOCHEMISTRY REPORT

MCLAUGHLIN
WIG L10 PROF SURG
WG1132067
P O'DWYER
Lab No N.03.7394782.Y
Reported 02.05.03 13:35
Collected 02.05.03 09:00
Authorised by: Auto Check

BRIAN

A

92

RESULTS		CONSTITUENT
139		Sodium 135-144 mmol/l
3.9		Potassium 3.5-5.1 mmol/l
104		Chloride 97-108 mmol/l
		Total CO ₂ 22-32 mmol/l
4.9		Urea 2.5-7.5 mmol/l *
79		Creatinine 60-110 µmol/l *
		Serum Osmolality 275-295 mmol/kg
		Urine Osmolality mmol/kg
		Calcium 2.20-2.65 mmol/l
		'Corrected' Calcium 2.16-2.53 mmol/l
		Phosphate 0.8-1.45 mmol/l
		Total Protein 60-77 g/l
		Albumin 36-50 g/l
		Bilirubin 3-18 µmol/l
		Alkaline Phosphatase 70-260 U/l *
		Gamma G.T. 5-50 U/l
		AST 10-35 U/l
		ALT 10-50 U/l
		Total CK 10-171 U/l
		CK-MB Ratio
		Glucose 2.80-6.0 mmol/l
		Urate 0.10-0.42 mmol/l *
		Amylase 0-100 U/l
		High CRP <10mg/L

* Reference ranges for these assays have significant age and sex dependence.
Further information may be obtained from the
Duty Biochemist (211 - 3355/3341) MI 01/00

SURNAME MCLAUGHLIN		98
FORENAME BRIAN		
Hosp No 51132067E		
CHI No 2801606030		
D.O.B 28.01.60 SEX Male		
ADDRESS FLAT 4/E, 120 WYNDFORD ROAD		
CONSULTANT/GP DOVE: S DOVER		
HOSP/PRACTICE 8C OP		
WARD/TOWN GGH		
Collected 15.07.10 @	Received 15.07.10 @ 11:17	Report Issued 15.07.10 @ 13:00
Dept of Clinical Biochemistry, North Glasgow Sector, NHSGGC		
139	Sodium	135-145 mmol/L
3.9	Potassium	3.5-5.0 mmol/L
104	Chloride	98-108 mmol/L
	Bicarbonate	21-28 mmol/L
7.0	Urea	2.5-7.5 mmol/L
75	Creatinine	40-130 μ mol/L
>60	eGFR (estimated GFR)	mL/min
5.3	Plasma Glucose	3.5-5.5 mmol/L
2.4	CRP	<10 mg/L
	Amylase	<100 U/L
	Urate	μ mol/L
	Troponin I	<0.04 μ g/L
	CK	<210 U/L
* 30	Bilirubin	3-22 μ mol/L
36	AST	<40 U/L
43	ALT	<50 U/L
52	Gamma-GT	<70 μ U/L
82	Alk.Phos.	40-150 μ U/L
75	Protein	60-80 g/L
44	Albumin	32-45 g/L
31	Globulins	23-38 g/L
2.43	Calcium	mmol/L
2.41	Adjusted Calcium	2.10-2.60 mmol/L
1.11	Phosphate	0.70-1.40 μ mol/L
	Magnesium	0.70-1.00 mmol/L
	Cholesterol	target <5.0 mmol/L
	HDL Cholesterol	target >1.0 mmol/L
	Chol/HDL ratio	
	Triglycerides	target <2.3 mmol/L
	LDL Cholesterol	target <3.0 mmol/L
1.7	TSH	0.35-5.00 mU/L
15	Free T4	9-21 pmol/L
	T3	nmol/L
	IgA	0.8-4.0 g/L
	IgG	6-16 g/L
	IgM	0.5-2.0 g/L
NB Unless otherwise stated analyses carried out on serum		
Lab No. N.10:7252961 Run No. 873		
2 No letter checked		
Authorised by <i>Auto Check</i> Date Reported 15.07.10  Accredited Medical Laboratory Reference No:2335		

§Significant sex/age differences - See handbook

BIOCHEMISTRY REPORT

99

MCLAUGHLIN BRIAN
WIG L10 PROF SURG
WG1132067 28.01.60
J. DOUGHTY
Lab No N.02.7290133.Z
Reported 04.12.02 17:35
Collected 04.12.02 09:00
Authorised by: Auto Check

RESULTS		CONSTITUENT
141		Sodium 135-144 mmol/l
3.3	Low	Potassium 3.5-5.1 mmol/l
102		Chloride 97-108 mmol/l
		Total CO ₂ 22-32 mmol/l
5.8		Urea 2.5-7.5 mmol/l *
82		Creatinine 60-110 µmol/l *
		Serum Osmolality 275-295 mmol/kg
		Urine Osmolality mmol/kg
		Calcium 2.20-2.65 mmol/l
		'Corrected' Calcium 2.16-2.53 mmol/l
		Phosphate 0.8-1.45 mmol/l
		Total Protein 60-77 g/l
		Albumin 36-50 g/l
		Bilirubin 3-18 µmol/l
		Alkaline Phosphatase 70-260 U/l *
		Gamma G.T. 5-50 U/l
		AST 10-35 U/l
		ALT 10-50 U/l
		Total CK 10-171 U/l
		CK-MB Ratio
		Glucose 2.80-6.0 mmol/l
		Urate 0.10-0.42 mmol/l *
		Amylase 0-100 U/l

373 High CRP <10mg/L

* Reference ranges for these assays have significant age and sex dependence.

Further information may be obtained from the
Duty Biochemist (211 - 3355/3341)

MI 01/00

BIOCHEMISTRY REPORT

99

MCLAUGHLIN BRIAN
WIG L10 PROF SURG
WG1132067 28.01.60
J DOUGHTY
Lab No N.02.7290133.Z
Reported 04.12.02 17:35
Collected 04.12.02 09:00
Authorised by: Auto Check

RESULTS		CONSTITUENT
141		Sodium
		135-144 mmol/l
3.3	Low	Potassium
		3.5-5.1 mmol/l
102		Chloride
		97-108 mmol/l
		Total CO ₂
		22-32 mmol/l
5.8		Urea
		2.5-7.5 mmol/l *
82		Creatinine
		60-110 µmol/l *
		Serum Osmolality
		275-295 mmol/kg
		Urine Osmolality
		mmol/kg
		Calcium
		2.20-2.65 mmol/l
		'Corrected' Calcium
		2.16-2.53 mmol/l
		Phosphate
		0.8-1.45 mmol/l
		Total Protein
		60-77 g/l
		Albumin
		36-50 g/l
		Bilirubin
		3-18 µmol/l
		Alkaline Phosphatase
		70-260 U/l *
		Gamma G.T.
		5-50 U/l
		AST
		10-35 U/l
		ALT
		10-50 U/l
		Total CK
		10-171 U/l
		CK-MB
		Ratio
		Glucose
		2.80-6.0 mmol/l
		Urate
		0.10-0.42 mmol/l *
		Amylase
		0-100 U/l

373 High CRP <10mg/L

* Reference ranges for these assays have significant age and sex dependence.

Further information may be obtained from the
Duty Biochemist (211 - 3355/3341)

MI 01/00

BIOCHEMISTRY REPORT

100

MCLAUGHLIN BRIAN
WIG L10 PROF SURG
WG1132067 28.01.60
J DOUGHTY
Lab No N.02.6089193.J
Reported 04.12.02 14:05
Collected 04.12.02 09:00
Authorised by: Jean McAllister

RESULTS		CONSTITUENT
		Sodium 135-144 mmol/l
		Potassium 3.5-5.1 mmol/l
		Chloride 97-108 mmol/l
		Total CO ₂ 22-32 mmol/l
		Urea 2.5-7.5 mmol/l *
		Creatinine 60-110 µmol/l *
		Serum Osmolality 275-295 mmol/kg
		Urine Osmolality mmol/kg
		Calcium 2.20-2.65 mmol/l
		'Corrected' Calcium 2.16-2.53 mmol/l
		Phosphate 0.8-1.45 mmol/l
		Total Protein 60-77 g/l
34	Low	Albumin 36-50 g/l
44	High	Bilirubin 3-18 µmol/l
167		Alkaline Phosphatase 70-260 U/l *
421	High	Gamma G.T. 5-50 U/l
46	High	AST 10-35 U/l
121	High	ALT 10-50 U/l
		Total CK 10-171 U/l
		CK-MB Ratio
		Glucose 2.80-6.0 mmol/l
		Urate 0.10-0.42 mmol/l *
359	High	Amylase 0-100 U/l
		CRP < 10mg/L

* Reference ranges for these assays have significant age and sex dependence.
Further information may be obtained from the
Duty Biochemist (211-- 3355/3341) MI 01/00

BIOCHEMISTRY REPORT

MCLAUGHLIN
WIG L10 SURG
WG1132067
J DOUGHTY

BRIAN

A

28.01.60

Lab No N.02.7288061.R

Reported 02.12.02 12:05

Collected 02.12.02 09:00

Authorized by: A Pettigrew

RESULTS		CONSTITUENT
139		Sodium 135-144 mmol/l
4.0		Potassium 3.5-5.1 mmol/l
101		Chloride 97-108 mmol/l
		Total CO ₂ 22-32 mmol/l
5.1		Urea 2.5-7.5 mmol/l *
80		Creatinine 60-110 µmol/l *
		Serum Osmolality 275-295 mmol/kg
		Urine Osmolality mmol/kg
		Calcium 2.20-2.65 mmol/l
		'Corrected' Calcium 2.16-2.53 mmol/l
		Phosphate 0.8-1.45 mmol/l
		Total Protein 60-77 g/l
43		Albumin 36-50 g/l
65	High	Bilirubin 3-18 µmol/l
281	High	Alkaline Phosphatase 70-260 U/l *
950	High	Gamma G.T. 5-50 U/l
344	High	AST 10-35 U/l
451	High	ALT 10-50 U/l
		Total CK 10-171 U/l
		CK-MB Ratio
		Glucose 2.80-6.0 mmol/l
		Urate 0.10-0.42 mmol/l *
999	High	Amylase 0-100 U/l
19	High	CRP <10mg/L

* Reference ranges for these assays have significant age and sex dependence.

Further information may be obtained from the
Duty Biochemist (211 - 3355/3341)

MI 01/00

BIOCHEMISTRY REPORT

103

MCLAUGHLIN BRIAN A
 WIG L10 SURG
 WG1132067 28.01.60
 J DOUGHTY
 Lab No N.02.6088782.A
 Reported 03.12.02 10:35
 Collected 03.12.02 09:00
 Authorised by: Richard Spooner

RESULTS		CONSTITUENT
138		Sodium 135-144 mmol/l
3.7		Potassium 3.5-5.1 mmol/l
103		Chloride 97-108 mmol/l
		Total CO ₂ 22-32 mmol/l
6.7		Urea 2.5-7.5 mmol/l *
83		Creatinine 60-110 µmol/l *
		Serum Osmolality 275-295 mmol/kg
		Urine Osmolality mmol/kg
		Calcium 2.20-2.65 mmol/l
		'Corrected' Calcium 2.16-2.53 mmol/l
		Phosphate 0.8-1.45 mmol/l
		Total Protein 60-77 g/l
38		Albumin 36-50 g/l
51	High	Bilirubin 3-18 µmol/l
228	85	Alkaline Phosphatase 70-260 U/l *
651	High	Gamma G.T. 5-50 U/l
85	High	AST 10-35 U/l
227	High	ALT 10-50 U/l
		Total CK 10-171 U/l
		CK-MB Ratio
		Glucose 2.80-6.0 mmol/l
		Urate 0.10-0.42 mmol/l *
664	High	Amylase 0-100 U/l
275	High	CRP <10mg/L

* Reference ranges for these assays have significant age and sex dependence.
 Further information may be obtained from the
 Duty Biochemist (211 - 3355/3341) MI 01/00

BIOCHEMISTRY REPORT

MCLAUGHLIN, BRIAN *p* *A*
 WIG L10 SURG
 WG1132067 28.01.60
 J DOUGHTY
 Lab No N.02.6088467.L
 Reported 02.12.02 09:11
 Collected 02.12.02 00:16
 Authorised by: Auto Check

RESULTS		CONSTITUENT
143		Sodium 135-144 mmol/l
3.4	Low	Potassium 3.5-5.1 mmol/l
104		Chloride 97-108 mmol/l
		Total CO ₂ 22-32 mmol/l
6.1		Urea 2.5-7.5 mmol/l *
98		Creatinine 60-110 µmol/l *
		Serum Osmolality 275-295 mmol/kg
		Urine Osmolality mmol/kg
2.39		Calcium 2.20-2.65 mmol/l
2.17	Low	'Corrected' Calcium 2.16-2.53 mmol/l
		Phosphate 0.8-1.45 mmol/l
		Total Protein 60-77 g/l
51		Albumin 36-50 g/l
		Bilirubin 3-18 µmol/l
		Alkaline Phosphatase 70-260 U/l *
		Gamma G.T. 5-50 U/l
		AST 10-35 U/l
		ALT 10-50 U/l
		Total CK 10-171 U/l
		CK-MB Ratio
7.8	High	Glucose 2.80-6.0 mmol/l
		Urate 0.10-0.42 mmol/l *
3759	High	Amylase 0-100 U/l
		CRP <10mg/L

* Reference ranges for these assays have significant
 age and sex dependence.
 Further information may be obtained from the
 Duty Biochemist (211 - 3355/3341) MI 01/00

105

CLAUGHLIN BRIAN

IG L10 SURG

G1132067 28.01.60

DOUGHTY

ab No N.02.6083467.L

Reported 02.12.02 09:05

collected 02.12.02 00:16

Authorised by: Auto Check

RESULTS		CONSTITUENT
143		Sodium 135-144 mmol/l
3.4	Low	Potassium 3.5-5.1 mmol/l
104		Chloride 97-108 mmol/l
		Total CO ₂ 22-32 mmol/l
6.1		Urea 2.5-7.5 mmol/l *
98		Creatinine 60-110 µmol/l *
		Serum Osmolality 275-295 mmol/kg
		Urine Osmolality mmol/kg
2.39		Calcium 2.20-2.65 mmol/l
2.17	Low	'Corrected' Calcium 2.16-2.53 mmol/l
		Phosphate 0.8-1.45 mmol/l
		Total Protein 60-77 g/l
51		Albumin 36-50 g/l
		Bilirubin 3-18 µmol/l
		Alkaline Phosphatase 70-260 U/l *
		Gamma G.T. 5-50 U/l
		AST 10-35 U/l
		ALT 10-50 U/l
		Total CK 10-171 U/l
		CK-MB
		Ratio
7.8	High	Glucose 2.80-6.0 mmol/l
		Urate 0.10-0.42 mmol/l *
3759	High	Amylase 0-100 U/l

CRP < 10mg/L

Reference ranges for these assays have significant
and sex dependence.

Further information may be obtained from the

/ Biochemist (211 - 3355/3341)

MI 01/00

SURNAME MCLAUGHLIN	UNIT No. 51132067E	CONS/GP /: DOVE: S DOVER
FORENAME BRIAN	CHI No. 2801606030	DESTINATION 8C OP
D.O.B 28.01.60 SEX M	ADDRESS 222 BROUGHTON RD LARNARSHIRE	GGH

Investigations

Faecal Elastase NA (>200) ug/g stool

Comments

Sample from 12 August sent for analysis of faecal elastase.
?reason for duplicate request.
Analyses performed at Western General Hospital, Edinburgh.

[Handwritten signature]

Miscellaneous

Dept of Clinical Biochemistry North Glasgow Sector NHSGGC
Laboratory Number 3271851
Collected DATE 13.08.10 TIME 09:15
Received DATE 13.08.10 TIME 12:33
Report Issued DATE 16.08.10 TIME 12:00
Authorised by <i>Susan Knox</i>



Accredited Medical Laboratory
Reference No:2335

REMOVE ONE STRIP AT A TIME TO AFFIX REPORT, STARTING FROM BOTTOM LINE

BIOCHEMISTRY REPORT

GARTNAVEL GENERAL HOSPITAL E

CONSULTANT J DOUGHTY	(107) SURNAME MCLAUGHLIN	HOSPITAL WG1132067 NUMBER
HOSPITAL WIG WARD L10 SURG	FORENAME BRIAN	DATE OF BIRTH 28.01.60
DATE 02.12.02 TIME WITHDRAWN 09:00	LABORATORY NUMBER N, 02.7288061.R	SEX M

Date	AFP KU/L	CEA ug/L	CA125 KU/L	PSA ug/L	HCG IU/L	LDH U/L
02.12.02						415

JS

Authorised by Jean McAllister (GGH)
Reported time 09:51 Reported date 03.12.02



Tumour markers

RESULT CODE, ABBREVIATIONS AND REFERENCE VALUES ARE GIVEN ON THE REVERSE OF THIS REPORT

DEPARTMENT OF CLINICAL/LABORATORY HAEMATOLOGY

NHS Greater Glasgow and Clyde
Gartnavel General Hospital (0141)-301-7737
Glasgow Western Infirmary (0141)-211-2336

Surname MCLAUGHLIN	Forename BRIAN	Date of Birth 28.01.1960	Hospital Number 51132067E	CHI Number 2801606030
Patient Address GLASGOW G20 8JR	Patient Sex Male	Laboratory Number H.10.1627151.Z	Report Delivery Address Gartnavel 8C Medical	
	Consultant / GP Prof P. O'DWYER	<i>108</i> <i>Dover</i> <i>SOG 15/7</i>		

Coagulation Screen

Prothrombin Time	11.0	Seconds	(9-13)
Partial Throm Time	34.0	Seconds	(27-38)
INR	0.9		
Thrombin Clotting T	13.8	Seconds	(11.0-15.0)
PTT RATIO	1.1		

Page 1 of 1

Sample Collected 15.07.10	Received in Laboratory 15.07.10 11:00	Report Issued 15.07.10 12:57	Run No 648	Authorised By C. Little
-------------------------------------	---	--	----------------------	-----------------------------------

DEPARTMENT OF CLINICAL/LABORATORY HAEMATOLOGY

NHS Greater Glasgow and Clyde
Gartnavel General Hospital (0141)-301-7737
Glasgow Western Infirmary (0141)-211-2336

Surname MCLAUGHLIN	Forename BRIAN	Date of Birth 28.01.1960	Hospital Number 51132067E	CHI Number 2801606030
Patient Address 11U Latherton Drive GLASGOW G20 8JR		Patient Sex Male	Laboratory Number H.10.1627151.Z	Report Delivery Address Gartnavel 8C Medical
		Consultant / GP Prof P. O'DWYER		

	04.05.03	05.05.03	09.05.03	07.06.07	15.07.10	
WBC	6.46	6.26	8.33	11.50	6.41	(4.00-11.00)
RBC	3.34	3.37	4.12	5.11	4.99	(4.50-6.50)
Hb	9.9	10.1	12.2	15.8	148	(130-180)
Hct	0.295	0.300	0.365	0.448	0.448	(0.400-0.540)
MCV	88.3	89.0	88.6	87.7	89.8/	(78.0-99.0)
MCH	29.6	30.0	29.6	30.9	29.7	(27.0-32.0)
Plts	180	207	437	177	196	(150-400)
Neuts	4.08	3.54	5.09	9.50	2.85	(2.00-7.50)
Lymphs	1.53	1.66	1.96	1.07	2.67	(1.50-4.00)
Monos	0.68	0.84	1.06	0.76	0.60	(0.20-0.80)
Eos	0.12	0.17	0.21	0.15	0.26	(0.00-0.40)
ESR					8	(1-10)
GFST						
Retics						(25.0-100.0)

2

Page 1 of 1

Sample Collected 15.07.10	Received In Laboratory 15.07.10 11:00	Report Issued 15.07.10 12:57	Run No 648	Authorised By Ann McCance
-------------------------------------	---	--	----------------------	-------------------------------------

WEST GLASGOW HOSPITALS

BLOOD TRANSFUSION

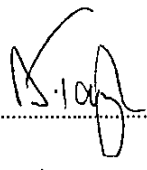
SNAME MCLAUGHLIN		FORENAMES BRIAN		HOSP. No. 1132067		D.O.B. 28-Jan-1960	
MEDICAL OFFICER TULLEY		WARD LEVEL 10 EAST		SEX M		HOSPITAL Western Infirmary	
BLOOD GROUP O		RHESUS POS		ADDRESS 114 CATHERTON DR (110)			
LABORATORY NUMBER 8.7049.1		ANTIBODY SCREEN Negative		TO BE COMPLETED BY NURSE/MEDICAL OFFICER			
EXPIRY DATE		PRODUCT CODE		DONOR GROUP		COMPATIBLE ACK No. S	
14/05		LDRA		O POS		G101 603 017 927 C	
14/05		LDRA		O POS		G101 603 031 147 C	
14/05		LDRA		O POS		G101 603 022 935 M	
14/05		LDRA		O POS		G101 603 017 929 B	
USED		PACK PUT UP BY		PATIENT ID CONFIRMED AGAINST DONOR UNIT BY		REACTION	
TIME DATE		TIME DATE		TIME DATE		TIME DATE	
17 ⁴⁵ 2/5		RTM		G. Reid (STN)			
12 ⁰⁰ 3/5		RTM		Angela S/N.			
16 ²⁰ 3/5		RTM		LHOM			
21 ⁰⁰ 3/5		ELOS		R. Kather			

THIS BLOOD WILL BE DERESERVED

AT 9.00 AM ON 04-May-03

LAB COMMENT

WARNING: THIS REPORT MUST NOT BE USED FOR PATIENT ID.
CHECK UNIT AGAINST PATIENT WRIST BAND.
MATCHED TO PLASMA NO. 6788

SPECIMEN RECEIVED DATE 02-May-03 DATE OF TEST 02-May-03 AUTHORISED BY 

WEST GLASGOW HOSPITALS

BLOOD TRANSFUSION

SURNAME McLAUGHLIN		FORENAMES BRIAN		HOSP. No. 1132067		D.O.B. 28-Jan-1960									
MEDICAL OFFICER TULLET		WARD LEVEL 10 EAST		SEX M		HOSPITAL Western Infirmary									
BLOOD GROUP O		RHESUS POS		ADDRESS 114 CATHERTON DR											
LABORATORY NUMBER 7.7049.J		ANTIBODY SCREEN Negative		TO BE COMPLETED BY NURSE/MEDICAL OFFICER											
EXPIRY DATE		PRODUCT CODE		DONOR GROUP		COMPATIBLE ACK No.S		USED		PACK PUT UP BY		PATIENT ID CONFIRMED AGAINST DONOR UNIT BY		REACTION	
14/05		LDRA		O POS		G101 603 017 927 C		15/5		P. H. G.		C. D. D. S. M.			
14/05		LDRA		O POS		G101 603 031 147 C		12/5		P. H. G.		A. M. L. S. M.			
14/05		LDRA		O POS		G101 603 022 903 M		16/5		R. T. G.		I. H. C. M.			
14/05		LDRA		O POS		G101 603 017 929 B		21/5		CROSS.		R. K. H. M.			

"THIS BLOOD WILL BE DERESERVED"

AT 9.00 AM ON 04-May-03

LAB COMMENT

WARNING: THIS REPORT MUST NOT BE USED FOR PATIENT ID.
CHECK UNIT AGAINST PATIENT WRIST BAND.
MATCHED TO PLASMA NO. 6733

SPECIMEN RECEIVED DATE 02-May-03 DATE OF TEST 02-May-03 AUTHORISED BY [Signature]

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC. OR GP NAME & ADDRESS	Prof P. O'DWYER 110 Professorial Sur Unit	SURNAME MCLAUGHLIN	FORENAME BRIAN	LABORATORY No H.30502.0960.8
	SEX M	D.O.B. AGE 28.01.60	HOSPITAL 1132067	

REPORT

	Cumulative FBC's					
	28.04.03	29.04.03	30.04.03	01.05.03	02.05.03	
WBC	6.12	11.85	11.05	8.65	6.42	(4.00-11.00)
RBC	5.26	5.18	3.99	2.70	2.49	(4.50-6.50)
Hb	15.8	15.5	12.2	8.0	6.6	(13.0-18.0)
Hct	0.463	0.452	0.352	0.238	0.193	(0.400-0.540)
MCV	87.6	87.3	88.2	88.1	88.1	(80.0-100.0)
MCH	30.0	29.9	30.6	29.6	30.1	(27.0-32.0)
Plts	189	177	227	154	131	(150-400)
Neuts	2.82	10.13	8.07	5.59	3.69	(2.00-7.50)
Lymphs	2.47	1.05	1.77	1.77	1.97	(1.50-4.00)
Monos	0.62	0.64	1.24	1.18	0.66	(0.20-0.80)
Eos	0.33	0.01	0.01	0.05	0.08	(0.04-0.40)
ESR						(2-10)
GFST						
Relies					58.6	(25.0-85.0)

02.05.03 FBC: Features suggest blood loss or haemolysis
Minimal reduction in platelets in this sample.
Suggest continue to monitor

FULL BLOOD COUNT

DATE OF REPORT 02.05.03	TIME 13:28
RUN 606	TM
DATE OF SAMPLE 02.05.03	TIME 11:33

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC. OR GP NAME & ADDRESS	Prof P. O'DWYER L10 Professorial Sur Unit	SURNAME McLAUGHLIN	FORENAME BRIAN	(112)	
		SEX M	D.O.B. AGE 28.01.60	HOSPITAL 1132067	LABORATORY NO. H 30502.0363.Y

REPORT

I.N.R.

PROTHROMBIN

16

SECONDS

(10-13)

INT. RATIO

1.3

RE

: PT NORMAL RANGE 10-13 SECS

PFIB Normal range 1.5 - 4.5 g/l

WARFARIN - RECOMMENDED THERAPEUTIC RANGES.

2.0-2.5 DVT PROPHYLAXIS.

2.0-3.0 TREATMENT DVT, PTE, / AF, MITRAL STENOSIS, ALL OTHER USE.

3.0-4.5 RECURRENT DVT/MI/MECHANICAL PROSTHETIC HEART VALVES.

Authorised by:

DATE OF REPORT 02.05.03	TIME 11:44
RUN 74	
DATE OF SAMPLE 02.05.03	TIME 11:35

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC. OR GP NAME & ADDRESS	SURNAME MCLAUGHLIN		FORENAME BRIAN	
	SEX M	D.O.B. AGE 28.01.60	HOSPITAL 1132067	LABORATORY No. H. 30501.0321.E

REPORT

I.N.R.
 PROTHROMBIN 14 SECONDS (10-13)
 INT. RATIO 1.2

INRE : PT NORMAL RANGE 10-13 SECS
 PFIB Normal range 1.5 - 4.5 g/l
 WARFARIN - RECOMMENDED THERAPEUTIC RANGES.
 2.0-2.5 DVT PROPHYLAXIS.
 2.0-3.0 TREATMENT DVT, PTE, / AF, MITRAL STENOSIS, ALL OTHER USE.
 3.0-4.5 RECURRENT DVT/MI/MECHANICAL PROSTHETIC HEART VALVES.

Authorised by:

DATE OF REPORT 01.05.03	TIME 11:00
RUN 59	
DATE OF SAMPLE 01.05.03	TIME 10:32

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC. *Prof P. O'DWYER*
 OR *L10 Professorial Sur Unit*
 GP NAME & ADDRESS

SURNAME
MCLAUGHLIN

FORENAME
BRIAN

SEX
M

D.O.B. AGE
28.01.60

HOSPITAL
1132067

LABORATORY No.
H, 30501.0790.K

REPORT

Cumulative FBC's

	26.04.03	28.04.03	29.04.03	30.04.03	01.05.03	
WBC	6.00	6.12	11.85	11.05	8.65	(4.00-11.00)
RBC	5.33	5.26	5.18	3.99	2.70	(4.50-6.50)
Hb	15.9	15.8	15.5	12.2	8.0	(13.0-18.0)
Hct	0.469	0.461	0.452	0.352	0.238	(0.400-0.540)
MCV	88.0	87.6	87.3	88.2	88.1	(80.0-100.0)
MCH	29.8	30.0	29.9	30.6	29.6	(27.0-32.0)
Plts	187	189	177	227	154	(150-400)
Neuts	2.73	2.80	10.13	3.07	5.59	(2.00-7.50)
Lymphs	2.56	2.42	1.05	1.72	1.77	(1.50-4.00)
Monos	0.50	0.67	0.64	1.24	1.18	(0.20-0.80)
Eos	0.17	0.13	0.01	0.01	0.05	(0.04-0.40)
ESR						(2-10)
GFST						
Rel.Jcs						(25.0-85.0)

FULL BLOOD COUNT

DATE OF REPORT	TIME
01.05.03	10:33
RUN	
595	DT
DATE OF SAMPLE	TIME
01.05.03	10:21

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC. *Prof. W.D. George*
OR *Outpatients Breast Clinic*
GP NAME & ADDRESS

SURNAME
MCLAUGHLAN

FORENAME
LILLIAN

115

SEX
F

D.O.B. AGE
01.10.45

HOSPITAL
729000

LABORATORY No.
H, 30430.1247.F

REPORT

Cumulative FBC's

	<i>30.01.03</i>	<i>26.02.03</i>	<i>19.03.03</i>	<i>09.04.03</i>	<i>30.04.03</i>	
<i>WBC</i>	<i>5.17</i>	<i>5.47</i>	<i>8.75</i>	<i>7.24</i>	<i>4.93</i>	<i>(4.00-11.00)</i>
<i>RBC</i>	<i>4.33</i>	<i>4.19</i>	<i>4.04</i>	<i>3.98</i>	<i>4.04</i>	<i>(3.80-5.80)</i>
<i>Hb</i>	<i>13.0</i>	<i>12.7</i>	<i>11.7</i>	<i>11.4</i>	<i>11.7</i>	<i>(11.5-16.5)</i>
<i>Hct</i>	<i>0.393</i>	<i>0.381</i>	<i>0.363</i>	<i>0.359</i>	<i>0.365</i>	<i>(0.370-0.470)</i>
<i>MCV</i>	<i>90.8</i>	<i>90.9</i>	<i>89.9</i>	<i>90.2</i>	<i>90.3</i>	<i>(80.0-100.0)</i>
<i>MCH</i>	<i>30.0</i>	<i>30.3</i>	<i>29.0</i>	<i>28.6</i>	<i>29.0</i>	<i>(27.0-32.0)</i>
<i>Plts</i>	<i>338</i>	<i>391</i>	<i>451</i>	<i>356</i>	<i>351</i>	<i>(150-400)</i>
<i>Neuts</i>	<i>2.31</i>	<i>4.11</i>	<i>6.42</i>	<i>5.17</i>	<i>2.55</i>	<i>(2.00-7.50)</i>
<i>Lymphs</i>	<i>2.04</i>	<i>1.61</i>	<i>1.53</i>	<i>1.30</i>	<i>1.26</i>	<i>(1.50-4.00)</i>
<i>Monos</i>	<i>0.51</i>	<i>0.61</i>	<i>0.65</i>	<i>0.58</i>	<i>1.00</i>	<i>(0.20-0.80)</i>
<i>Eos</i>	<i>0.26</i>	<i>0.11</i>	<i>0.12</i>	<i>0.15</i>	<i>0.10</i>	<i>(0.04-0.40)</i>
<i>ESR</i>						<i>(2-10)</i>
<i>GFST</i>						
<i>Retics</i>						<i>(25.0-85.0)</i>

FULL BLOOD COUNT.

DATE OF REPORT	TIME
<i>30.04.03</i>	<i>14:17</i>
RUN	
<i>580</i>	<i>TM</i>
DATE OF SAMPLE	TIME
<i>30.04.03</i>	<i>13:58</i>

NORTH GLASGOW UNIVERSITY HOSPITAL DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC. OR GP NAME & ADDRESS	SURNAME <i>MCLAUGHLIN</i>		FORENAME <i>BRIAN</i>	
	SEX <i>M</i>	D.O.B. AGE <i>28.01.60</i>	HOSPITAL <i>1132067</i>	LABORATORY No. <i>H. 30430.0375.A</i>

REPORT

COAGULATION SCREEN

PROTHROMBIN	12	SECONDS	(10-13)
PARTIAL THROM TIME	29	SECONDS	(26-36)
INT. RATIO	1.0		
DER FIBRINOGEN	3.55	g/l	(1.50-4.50)

Authorised by: F HIGGINS

DATE OF REPORT <i>30.04.03</i>	TIME <i>13:07</i>
RUN <i>51</i>	
DATE OF SAMPLE <i>30.04.03</i>	TIME <i>12:26</i>

REMOVE ONE STRIP AT A TIME TO AFFIX REPORT, STARTING FROM BOTTOM LINE

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC. OR GP NAME & ADDRESS	Prof P. O'DWYER L10 Professorial Sur Unit	SURNAME MCLAUGHLIN	FORENAME BRIAN	LABORATORY NO. H, 30430.0985.J
SEX	M	D.O.B. AGE	28.01.60	HOSPITAL
			1132067	

REPORT

	Cumulative FBC's					
	06.01.03	26.04.03	28.04.03	29.04.03	30.04.03	
WBC	6.46	6.00	6.12	11.85	11.05	(4.00-11.00)
RBC	4.95	5.33	5.26	5.18	3.99	(4.50-6.50)
Hb	14.7	15.9	15.8	15.5	12.2	(13.0-18.0)
Hct	0.444	0.469	0.461	0.452	0.362	(0.400-0.540)
MCV	89.7	88.0	87.6	87.3	88.2	(80.0-100.0)
MCH	29.7	29.8	30.0	29.9	30.6	(27.0-32.0)
Plts	249	187	189	177	227	(150-400)
Neuts	2.78	2.73	2.82	10.13	8.07	(2.00-7.50)
Lymphs	2.69	2.56	2.47	1.05	1.72	(1.50-4.00)
Monos	0.67	0.50	0.67	0.64	1.24	(0.20-0.80)
Eos	0.27	0.17	0.13	0.01	0.01	(0.04-0.20)
ESR						(2-10)
GFST						
Retics						(25.0-85.0)

FULL BLOOD COUNT

DATE OF REPORT	TIME
30.04.03	12:17
RUN	
578	WB
DATE OF SAMPLE	TIME
30.04.03	11:37

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DEPARTMENT OF HAEMATOLOGY

CONSULTANT PATIENT LOC.	Miss J. Doughty L10 Professorial Sur Unit	SURNAME	MCLAUGHLIN	FORENAME	BRIAN
P NAME ADDRESS		SEX	M	D.O.B. AGE	28.01.60
		HOSPITAL	1132067	LABORATORY No.	11, 21216.0614.J

REPORT

Cumulative FBC's

	12.12.02	13.12.02	14.12.02	15.12.02	16.12.02	
WBC	9.03	5.93	7.94	6.62	5.95	(4.00-11.00)
RBC	4.61	4.46	4.67	4.71	4.60	(4.50-6.50)
Hb	13.8	13.4	14.2	14.2	13.8	(13.0-18.0)
Hct	0.418	0.402	0.416	0.429	0.413	(0.400-0.540)
MCV	90.7	90.1	89.5	91.1	89.8	(80.0-100.0)
MCH	29.9	30.0	30.4	30.1	30.0	(27.0-32.0)
Plts	392	369	521	520	478	(150-400)
Neut's	6.53	3.83	4.20	3.62	3.10	(2.00-7.50)
Lymph's	1.37	1.12	2.31	2.02	1.93	(1.50-4.00)
Monos	0.05	0.69	1.07	0.65	0.67	(0.20-0.80)
Eos	0.25	0.27	0.34	0.27	0.27	(0.04-0.40)
ESR						(2-10)
GFST						
Rel's						(25.0-85.0)

FULL BLOOD COUNT

DATE OF REPORT	16.12.02	TIME	10:46
RUN	256	TM	
DATE OF SAMPLE	16.12.02	TIME	10:37

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DEPARTMENT OF HAEMATOLOGY

CONSULTANT Miss J. Doughty	SURNAME MCLAUGHLIN	FORENAME BRIAN
PATIENT LOC L10, Professorial Sur Unit	SEX M	D.O.B. AGE 28.01.60
HP NAME ADDRESS	HOSPITAL 1132067	LABORATORY No 119 13.0721.A

REPORT	Cumulative FBC's					
	09.12.02	10.12.02	11.12.02	12.12.02	13.12.02	
WBC	11.18	15.52	11.95	9.03	5.93	(4.00-11.00)
RBC	4.37	4.61	4.55	4.61	4.46	(4.50-6.50)
Hb	13.1	14.0	13.7	13.8	13.4	(13.0-18.0)
Hct	0.391	0.414	0.413	0.418	0.402	(0.400-0.540)
MCV	89.5	89.8	90.8	90.7	90.1	(80.0-100.0)
MCH	30.0	30.4	30.1	29.9	30.0	(27.0-32.0)
Plts	266	363	400	392	369	(150-400)
Neuts	8.47	12.65	9.39	6.53	3.83	(2.00-7.50)
Lymphs	1.38	1.89	1.39	1.37	1.12	(1.50-4.00)
Monos	1.10	0.75	0.85	0.85	0.69	(0.20-0.80)
Eos	0.21	0.17	0.27	0.25	0.27	(0.04-0.40)
ESR						(2-10)
GFST						
Retics						(25.0-85.0)

FULL BLOOD COUNT

DATE OF REPORT 13.12.02	TIME 10:19
RUN 213	RW
DATE OF SAMPLE 13.12.02	TIME 10:10

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DEPARTMENT OF HAEMATOLOGY

CONSULTANT PATIENT LOC. <i>Miss J. Doughty</i>	SURNAME <i>MCLAUGHLIN</i>	FORENAME <i>BRIAN</i>
SP NAME ADDRESS <i>110 Professorial Sur Unit</i>	SEX <i>M</i>	D.O.B. AGE <i>28.01.60</i>
	HOSPITAL <i>1132067</i>	LABORATORY No. <i>H, 21212.0950.S</i>

REPORT

Cumulative FBC's

	08.12.02	09.12.02	10.12.02	11.12.02	12.12.02	
WBC	12.60	11.18	15.52	11.95	9.03	(4.00-11.00)
RBC	4.60	4.37	4.61	4.55	4.61	(4.50-6.50)
Hb	13.9	13.1	14.0	13.7	13.8	(13.0-18.0)
Hct	0.414	0.391	0.414	0.413	0.418	(0.400-0.540)
MCV	90.0	89.5	89.8	90.8	90.7	(80.0-100.0)
MCH	30.2	30.0	30.4	30.1	29.9	(27.0-32.0)
Plts	252	266	363	400	392	(150-400)
NeuCs	NA	8.47	12.65	9.39	6.53	(2.00-7.50)
Lymphs	1.70	1.38	1.89	1.39	1.37	(1.50-4.00)
Monos	NA.	1.10	0.75	0.85	0.85	(0.20-0.80)
Eos	0.21	0.21	0.17	0.27	0.25	(0.04-0.40)
ESR						(2-10)
BFST						
Retic						(25.0-85.0)

08.12.02 FBC: PLEASE GIVE BRIEF CLINICAL DETAILS.

FULL BLOOD COUNT

DATE OF REPORT	TIME
12.12.02	12:17
RUN	
204	WB
DATE OF SAMPLE	TIME
12.12.02	12:03

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DEPARTMENT OF HAEMATOLOGY

CONSULTANT PATIENT LOC. <i>Miss J. Doughty</i>	SURNAME <i>MCLAUGHLIN</i>	FORENAME <i>BRIAN</i>	<i>121</i>
OR SP NAME ADDRESS <i>LEVEL 10 WARD P</i>	SEX <i>M</i>	D.O.B. AGE <i>28.01.60</i>	
			LABORATORY No. <i>H.21212.0348.A</i>

REPORT

COAGULATION SCREEN

PROTHROMBIN	11	SECONDS	(10-13)
ARTIAL THROM TIME	27	SECONDS	(26-36)
INT. RATIO	0.9		
DER FIBRINOGEN	7.56	g/l	(1.50-4.50)

Authorised by: ROBERT WYLLIE

DATE OF REPORT	TIME
12.12.02	12:46
RUN	
85	
DATE OF SAMPLE	TIME
12.12.02	11:42

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC. OR GP NAME & ADDRESS	Miss J. Doughty L10 Professorial Sur Unit	SURNAME	MCLAUGHLIN	FORENAME	BRIAN	122
SEX	M	D.O.B. AGE	28.01.60	HOSPITAL	1132067	LABORATORY NO. H, 21205.0910.N

REPORT

Cumulative FBC's

	02.12.02	02.12.02	03.12.02	04.12.02	05.12.02
WBC	12.04	11.07	17.66	12.76	11.04 (4.00-11.00)
RBC	5.30	5.57	5.26	4.73	4.53 (4.50-5.50)
Hb	16.4	17.0	16.0	14.3	13.7 (13.0-18.0)
Hct	0.469	0.498	0.474	0.428	0.409 (0.400-0.540)
MCV	88.5	89.4	90.1	90.5	90.3 (80.0-100.0)
MCH	30.9	30.5	30.4	30.2	30.2 (27.0-32.0)
Plts	187	192	170	144	178 (150-400)
Neuts	7.18	9.68	15.43	10.52	8.75 (2.00-7.50)
Lymphs	3.43	0.69	0.99	1.19	1.19 (1.50-4.00)
Monos	1.21	0.69	1.20	0.88	0.93 (0.20-0.80)
Eos	0.18	0.01	0.03	0.13	0.14 (0.04-0.40)
ESR					(2-10)
GFST					
Retics					(25.0-85.0)

02.12.02 FBC: No clinical details provided.

FULL BLOOD COUNT

DATE OF REPORT	TIME
05.12.02	12:34
RUN	
123	MS
DATE OF SAMPLE	TIME
05.12.02	11:57

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC.	Miss J. Doughty	SURNAME	MCLAUGHLIN	FORENAME	BRIAN	123			
OR GP NAME & ADDRESS	L10 Professorial Sur Unit	SEX	M	D.O.B. AGE	28.01.60	HOSPITAL	1132067	LABORATORY No.	H, 21204.0350.M

REPORT

COAGULATION SCREEN

PROTHROMBIN	13	SECONDS	(10-13)
PARTIAL THROM TIME	28	SECONDS	(26-36)
INT. RATIO	1.0		
DER FIBRINOGEN	8.54	g/l	(1.50-4.50)

Authorised by: ROBERT WYLLIE

DATE OF REPORT	TIME
04.12.02	12:49
RUN	
987	
DATE OF SAMPLE	TIME
04.12.02	11:49

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC. OR BP NAME & ADDRESS	Miss J. Doughty L10 Professorial Sur Unit	SURNAME MCLAUGHLIN	FORENAME BRIAN	124
SEX	M	D.O.B. AGE	28.01.60	HOSPITAL
			1132067	LABORATORY No.
				H121204.0952.T

REPORT

Cumulative FBC's

	02.12.02	02.12.02	03.12.02	04.12.02	
WBC	12.04	11.07	17.66	12.76	(4.00-11.00)
RBC	5.30	5.57	5.26	4.73	(4.50-5.50)
Hb	16.4	17.0	16.0	14.3	(13.0-18.0)
Hct	0.469	0.498	0.474	0.428	(0.400-0.540)
MCV	88.5	89.4	90.1	90.5	(80.0-100.0)
MCH	30.9	30.5	30.4	30.2	(27.0-32.0)
Plts	187	192	170	144	(150-400)
Neuts	7.18	9.68	15.43	10.52	(2.00-7.50)
Lymphs	3.43	0.69	0.99	1.19	(1.50-4.00)
Monos	1.21	0.69	1.20	0.88	(0.20-0.80)
Eos	0.18	0.01	0.01	0.13	(0.04-0.40)
ESR					(2-10)
GFST					
Retics					(25.0-85.0)

02.12.02 FBC: No clinical details provided.

FULL BLOOD COUNT

DATE OF REPORT	TIME
04.12.02	12:15
RUN	
94	WB
DATE OF SAMPLE	TIME
04.12.02	11:52

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC. *Miss J. Doughty*
OR *Level 10 West - Surgical*
GP NAME & ADDRESS

SURNAME
MCLAUGHLIN

FORENAME
BRIAN

125

SEX
M

D.O.B. AGE
28.01.60

HOSPITAL
1132067

LABORATORY No.
H.21203.0572.L

ORT

Cumulative FBC's

	<i>02.12.02</i>	<i>02.12.02</i>	<i>03.12.02</i>	
<i>WBC</i>	<i>12.04</i>	<i>11.07</i>	<i>17.66</i>	<i>(4.00-11.00)</i>
<i>RBC</i>	<i>5.30</i>	<i>5.57</i>	<i>5.26</i>	<i>(4.50-6.50)</i>
<i>Hb</i>	<i>16.4</i>	<i>17.0</i>	<i>16.0</i>	<i>(13.0-18.0)</i>
<i>Hct</i>	<i>0.469</i>	<i>0.498</i>	<i>0.474</i>	<i>(0.400-0.540)</i>
<i>MCV</i>	<i>88.5</i>	<i>89.4</i>	<i>90.1</i>	<i>(80.0-100.0)</i>
<i>MCH</i>	<i>30.9</i>	<i>30.5</i>	<i>30.4</i>	<i>(27.0-32.0)</i>
<i>Plts</i>	<i>187</i>	<i>192</i>	<i>170</i>	<i>(150-400)</i>
<i>Neuts</i>	<i>7.18</i>	<i>9.68</i>	<i>15.43</i>	<i>(2.00-7.50)</i>
<i>Lymphs</i>	<i>3.43</i>	<i>0.69</i>	<i>0.99</i>	<i>(1.50-4.00)</i>
<i>Monos</i>	<i>1.21</i>	<i>0.69</i>	<i>1.20</i>	<i>(0.20-0.80)</i>
<i>Eos</i>	<i>0.18</i>	<i>0.01</i>	<i>0.01</i>	<i>(0.04-0.40)</i>
<i>ESR</i>				<i>(2-10)</i>
<i>GFST</i>				
<i>Retics</i>				<i>(25.0-85.0)</i>

02.12.02 FBC: No clinical details provided.

FULL BLOOD COUNT

DATE OF REPORT	TIME
03.12.02	09:41
RUN	
69	TM
DATE OF SAMPLE	TIME
03.12.02	09:34

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC. OR GP NAME & ADDRESS	Miss J. Doughty Level 10 West - Surgical	SURNAME MCLAUGHLIN		FORENAME BRIAN	
		SEX M	D.O.B. AGE 28.01.60	HOSPITAL 1132067	LABORATORY No. R 21203.0266.D

REPORT

COAGULATION SCREEN

PROTHROMBIN	13	SECONDS	(10-13)
PARTIAL THROM TIME	28	SECONDS	(26-36)
INT. RATIO	1.0		
DER FIBRINOGEN	4.47	g/l	(1.50-4.50)

Authorised by: Robert Wyllie

DATE OF REPORT 03.12.02	TIME 09:38
RUN 965	
DATE OF SAMPLE 03.12.02	TIME 09:23

BLOOD TRANSFUSION

SPECIMEN RECEIVED DATE 02-Dec-02 DATE OF TEST 02-Dec-02 AUTHORISED BY M. Simms

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC.
OR
GP NAME & ADDRESS

Miss J. Doughty
Level 10 West - Surgical

SURNAME
MCLAUGHLIN

FORENAME
BRIAN

SEX
M

D.O.B. AGE
28.01.60

HOSPITAL
1132067

LABORATORY No.
H.21202.0563.J

PORT

Cumulative FBC's

	02.12.02	02.12.02	
WBC	12.04	11.07	(4.00-11.00)
RBC	5.30	5.57	(4.50-5.50)
Hb	16.4	17.0	(13.0-18.0)
Hct	0.469	0.498	(0.400-0.540)
MCV	88.5	89.4	(80.0-100.0)
MCH	30.9	30.5	(27.0-32.0)
Plts	187	192	(150-400)
Neuts	7.18	9.68	(2.00-7.50)
Lymphs	3.43	0.69	(1.50-4.00)
Monos	1.21	0.69	(0.20-0.80)
Eos	0.18	0.01	(0.04-0.40)
ESR			(2-10)
GFST			
Retics			(25.0-85.0)

02.12.02 FBC: No clinical details provided.

FULL BLOOD COUNT

DATE OF REPORT	TIME
02.12.02	09:36
RUN	
62	WB
DATE OF SAMPLE	TIME
02.12.02	09:16

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC. OR GP NAME & ADDRESS	SURNAME MCLAUGHLIN	FORENAME BRIAN	LABORATORY No. H, 21202.0251.N
Accident and Emergency	SEX M	D.O.B. AGE 28.01.60	HOSPITAL 1132067

REPORT

COAGULATION SCREEN

PROTHROMBIN	12	SECONDS	(10-13)
PARTIAL THROM TIME	23	SECONDS	(25-36)
INT. RATIO	1.0		
DER FIBRINOGEN	1.45	g/l	(1.50-4.50)

Authorised by: DONALD TAYLOR

DATE OF REPORT	TIME
02.12.02	00:36
RUN	
956	
DATE OF SAMPLE	TIME
02.12.02	00:26

REMOVE ONE STRIP AT A TIME TO AFFIX REPORT, STARTING FROM BOTTOM LINE

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

DEPARTMENT OF HAEMATOLOGY

CONSULTANT & PATIENT LOC. OR GP NAME & ADDRESS	SURNAME MCLAUGHLIN		FORENAME BRIAN	
	SEX M	D.O.B. AGE 28.01.60	HOSPITAL 1132067	LABORATORY No. H, 21202.0501.P

REPORT:

Cumulative FBC's
02.12.02

WBC	12.04	(4.00-11.00)
RBC	5.30	(4.50-6.50)
Hb	16.4	(13.0-18.0)
Hct	0.469	(0.400-0.540)
MCV	88.5	(80.0-100.0)
MCH	30.9	(27.0-32.0)
Plts	187	(150-400)
Neuts	7.18	(2.00-7.50)
Lymphs	3.43	(1.50-4.00)
Monos	1.21	(0.20-0.80)
Eos	0.18	(0.04-0.40)
ESR		(2-10)
GFST		
Retics		(25.0-85.0)

02.12.02 FBC: No clinical details provided.

DATE OF REPORT	TIME
02.12.02	00:29
RUN	
61	DT
DATE OF SAMPLE	TIME
02.12.02	00:26

FULL BLOOD COUNT

REMOVE ONE STRIP AT A TIME TO AFFIX REPORT, STARTING FROM BOTTOM LINE

MICROBIOLOGY DEPARTMENT

WEST GLASGOW HOSPITALS UNIVERSITY

Name: BRIAN MCLAUGHLIN
Address: 11U Latherton Drive

Sex: M
Cons: WILSON

Age: 28.01.60

Hosp: Western Infirmary
Practice Number: 6017
Ward: L10 East (Surg)

Hosp No: 1132067

Specimen: Sputum

Investigation: C & S

Taken: 12.12.02
Reported: 13.12.02

131

acid- and alcohol-fast bacilli not seen
Scanty numbers of pus cells seen

1. Heavy growth of Normal Upper Respiratory Flora

2.

3.

4.

Antibiotic Organism
1. 2. 3. 4.

G M

Microbiologists: Dr G.D. Corcoran

Sputum

Lab No: B,02.0141668.S

Western Infirmary
MCLAUGHLIN, Brian

265A, Broughton Road, Summerston, Glasgow, Lanarkshire, G23 5LP
Referrer: Dr Anthony Reece - WIG ORTHOPAEDIC CLINIC

Diagnostic Imaging Report

DoB: 28/01/1960

Chi No: 2801606030

CRIS No: 5415468

Hosp No: 51132067E

11/12/12
ESP

132

VERIFIED Verified By: Dr Nigel Raby 31/10/12 0933.

Clinical History :

Anterior cervical fusion new symptoms but decided not stated. Also lumbar pain radiating to right.

Flu apt

MRI Spine cervical :

Satisfactory appearances of the anterior spinal fusion tumour. No evidence of postoperative complications. No compromise of spinal cord or exiting nerve roots.

MRI Spine lumbar and sacral :

Normal vertebral alignment. Discs show only minor degenerative changes. The canal is capacious along its length with no compromise of the thecal sac or exiting nerve roots. There is some moderate degenerative changes within the facet joints.

Ref. Src: Western Infirmary, Dumbarton Road, Glasgow, G11 6NT

Exams: MRI Spine cervical, MRI Spine lumbar and sacral

Exam Date: 29/10/12 Event: E-26959649



Western Infirmary

MCLAUGHLIN, Brian

222 Broughton Road, Glasgow, Lanarkshire, , G23 5LP

Referrer: Dr Himanshu Sharma - WIG ORTHOPAEDIC CLINIC

Diagnostic Imaging Report

DoB: 28/01/1960

Chi No: 2801606030

CRIS No: 5415468

Hosp No: 51132067E

133

VERIFIED Verified By: Auto Reporting 28/12/11 1634

THIS PROCEDURE WAS DONE AT THE GOLDEN JUBILEE

Clinical History :

Neck pain radiating to left arm -?C5/6 disc lesion

*Mr Sharma
25/11
Mr Sharma
Glasgow Clinic*

MRI Spine cervical :

Report: Technique: Standard unenhanced cervical spine protocol.

Findings: Vertebral alignment and integrity appear normal. Disc degenerative changes are noted.

Axial images show normal appearances in the upper cervical spine.

At C4/5, there is minimal osteophytic narrowing of the left C5 nerve root exit foramen.

6/1/12

Ref. Src: Western Infirmary, Dumbarton Road, Glasgow, G11 6NT

Exams: MRI Spine cervical

Exam Date: 19/12/11 Event: E-26222512



Page 1 of 2

08966

Western Infirmary
MCLAUGHLIN, Brian

222 Broughton Road, Glasgow, Lanarkshire, G23 5LP

Referrer: Dr Himanshu Sharma - WIG ORTHOPAEDIC CLINIC

134

Diagnostic Imaging Report

DoB: 28/01/1960

Chi No: 2801606030

CRIS No: 5415468

Hosp No: 51132067E

At C5/6, there is a small broad based disc bar which indents the theca and just touches the anterior aspect of the adjacent spinal cord. No frank cord compression is seen here but there is moderate narrowing of the adjacent C6 nerve root exit foramina bilaterally, slightly more marked on the left side.

At C6/7, there is a further small broad based disc bar. This does not touch the spinal cord. There is mild narrowing of the adjacent left C7 nerve root exit foramen. No other compressive lesions are seen. Craniocervical junction region appears normal. Spinal cord itself is of normal signal.

Dictated by: Dr Jo Bhattacharya

Verified by: Dr Jo Bhattacharya

Ref. Src: Western Infirmary, Dumbarton Road, Glasgow, G11 6NT

Exams: MRI Spine cervical

Exam Date: 19/12/11 Event: E-26222512



Page 2 of 2

08966

Gartnavel General Hospital
MCLAUGHLIN, Brian

222 Broughton Road, Glasgow, , , G23 5LP

Referrer: Dr Simon Dover - GGH GASTRO-ENTEROLOGY CLINIC

Diagnostic Imaging Report

DoB: 28/01/1960

Chi No: 2801606030

CRIS No: 5415468

Hosp No: 51132067E

135

VERIFIED Verified By: Mairi Weir (Radiog) 28/07/10 1640.

Clinical History : Altered bowel habit and abdominal pain for 6 months, previous pancreatitis secondary to alcohol excess, previous cholecystectomy

SOG 12/8/10.

US Abdomen and pelvis :

Previous cholecystectomy noted.

Suboptimal examination due to body habitus.

Limited views of the liver but the liver appears to be slightly enlarged with an increased echogenicity in keeping with fatty infiltration/parenchymal change.

No focal abnormality identified. The portal vein is patent with hepatopetal flow.

The CBD could not be identified but there is no clear evidence of intra or extrahepatic biliary dilatation.

Mild splenomegaly with no focal abnormality. Both kidneys are normal in size and shape with no evidence of hydronephrosis. The pancreas not identified. The aorta is of normal calibre.

The bladder was underfilled but there is no focal abnormality identified within the pelvis.

Ref. Src: Gartnavel General Hospital, 1053 Great Western Road, Glasgow, G12 0YN

Exams: US Abdomen and pelvis

Exam Date: 27/07/10 Event: E-25064844



Page 1 of 1

08963

03034171 K

01/02/03

VB 01/02/03

X-RAY W.I.G

MCLAUGHLAN, Brian

43Y

M

PJ, ODWYER

WL10E

28/01/1960

110 LATHERTON DR, GLASGOW, G20 8JR

136

CHEST

Under inspired film. There are linear band shadows in both lower zones consistent with atelectasis. No other abnormalities are seen.

*DR MW SPROULE/AMA

16/05/03

CE

16/05/03 - CHEST

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

03033467 E

29/04/03

XR 0441962

X-RAY W.I.G

MCLAUGHLAN, Brian

43Y

M

1132067

PJ, ODWYER

WL10E

28/01/1960

110 LATHERTON DR. GLASGOW. G20 8JR

167

OPERATIVE CHOLANGIOGRAM

Contrast has been injected into the cystic duct. The common bile duct outlines normally and is not dilated. There is no evidence of stones within the CBD. Contrast refluxes into proximal pancreatic duct which is essentially unremarkable.

* A BRYDIE/RT

29/04/03

RADIOLOGY DEPARTMENT

29/04/03 - OPER CHOLANG

02097353 X

10/12/02

XR 0441962

X-RAY W.I.G

1132067

MCLAUGHLAN, Brian

42Y

M

C, WILSON

WL10E

28/01/1960

11U LATHERTON DR, G20 8JR

138

CT CHEST

Standard protocol CTPA. 150 mls of 140 mg of Iodine/ml at 4 mls/second with a 15 second delay.

The examination is considered to be suboptimal because the timing of the scan did not coincide exactly with enhancement of the pulmonary arteries. However, there is no convincing evidence of pulmonary embolism. There is subsegmental collapse at the left lung base with an associated small pleural effusion.

CONCLUSION: Indeterminate scan.

*DR A MIZZI/DR W KINCAID/MW

12/12/02

W

12/12/02 - CT CHEST

GLASGOW UNIVERSITY HOSPITALS NHS TRUST
RADIOLOGY DEPARTMENT
NOF

02096944 B .

10/12/02

XR 0441962

X-RAY W.I.G

1132067

MCLAUGHLAN, Brian

42Y

M

C, WILSON

WL10E

28/01/1960

11U LATHEERTON DR, G20 8JR

11 139

VQ SCAN 400MBqXe-133, 80MBqTc-99mMAA

There are matched ventilation perfusion defects corresponding to the chest x-ray abnormalities.

Overall indeterminate scan.

*DR G BAXTER/LCM

10/12/02

10/12/02 - VQ SCAN

02096017 K

CONTACT

AM 0441962

X-RAY W.I.G

MCLAUGHLAN, Brian

42Y

M

C, WILSON

WL10E

28/01/1960

11U LATHERTON DR, G20 8JR

140

CT ABDOMEN

Nonenhanced and enhanced helical acquisitions carried out through the abdomen and pelvis. Multiple gall stones are demonstrated within a slightly shrunken looking gall bladder. There is no evidence of biliary tree dilatation. Extensive oedematous change is demonstrated around the pancreas with extension of fluid into the left paracolic gutter. Following intravenous contrast, there does appear to be enhancement of the entire pancreas to some extent suggesting that it is viable. No other specific abnormalities are demonstrated. On balance, the appearances are thought to be those of significant pancreatitis but no convincing evidence of pancreatic necrosis.

*DR D ALCORN/MW

10/12/02

10/12/02 - CT ABDO

RADIOLOGY DEPARTMENT

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

X REPORT, STARTING FROM BOTTOM LINE

	11/05/03	XR 0441962
	06/12/02	XR 0441962

02095036 H

02/12/02

XR 0441962

X-RAY W.I.G

1132067

MCLAUGHLAN, Brian

42Y

M

C, WILSON

WL10S

28/01/1960

NK

141

US ABDOMEN

Difficult examination due to the patient's build.

Gall stones are noted within the gall bladder. The common bile duct could not be identified but there is no obvious intrahepatic biliary dilatation. The pancreas was unexaminable due to overlying bowel gas. There is no obvious cyst in the upper abdomen but a trace of free fluid is noted in the subhepatic space. The liver, spleen and kidneys appear normal.

*DR MW SPROULE/MW

03/12/02

03/12/02 - US ABDO

RADIOLOGY DEPARTMENT

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

**DEPARTMENT OF CLINICAL/LABORATORY IMMUNOLOGY**

C. REGISTERED LABORATORY

NHS Greater Glasgow and Clyde
Gartnavel General Hospital ☎(0141)-301-7752

name CLAUGHLIN	Forename BRIAN	Date of Birth 28.01.1960	Hospital Number 51132067E	CHI Number 2801606030
Patient Address FLAT 4/E, 120 WYNDFORD RO GLASGOW G20 8HB	Patient Sex Male Consultant / GP DOVE: S DOVER	Laboratory Number 1,10.0072670.V	Report Delivery Address 8C OP GGH 142	
Clinical Information				

Serum Immunoglobulins & Electrophoresis

Immunoglobulin G	12.0	(6.0-16.0)	g/L
Immunoglobulin A	2.08	(0.80-4.00)	g/L
Immunoglobulin M	0.51	(0.50-2.00)	g/L
Electrophoresis	See immunotyping result		
Paraprotein (1)	6.7		g/L
Paraprotein (2)			g/L

Specimen Comments / External Reference No :

Sample Collected 15.07.10	Received in Laboratory 15.07.10 12:02	Report Issued 03.08.10 12:31	608	Authorised By Dr Moira Thomas
------------------------------	--	---------------------------------	-----	----------------------------------



DEPARTMENT OF CLINICAL LABORATORY IMMUNOLOGY
CPA REGISTERED LABORATORY

NHS Greater Glasgow and Clyde
Gartnavel General Hospital ☎(0141)-301-7752

Su MCLAUGHLIN	Forename BRIAN	Date of Birth 28.01.1960	Hospital Number 51132067E	CHI Number 2801606030
Patient Address FLAT 4/E, 120 WYNDFORD RO GLASGOW G20 8HB	Patient Sex Male	Laboratory Number 1,10:0072670.V	Report Delivery Address 8C OP GGH	
Consultant / GP DOVE: S DOVER				
Clinical Information				

Serum free light chains (SPA Plus)

Free kappa	10.5	(3.3-19.4)	mg/L
Free lambda	6.8	(5.7-26.3)	mg/L
K/L Ratio	1.54	(0.26-1.65)	

MFREES : Please note new method.
Levels (esp very high levels) may not be directly
comparable with those obtained on the BNII (old method)
In renal impairment, K/L ratio may increase to 0.49 - 3.0
Normal levels of serum free light chains



Specimen Comments / External Reference No :

Sample Collected 15.07.10	Received in Laboratory 15.07.10 12:02	Report Issued 04.08.10 16:33	615	Authorised By Christina Ross
------------------------------	--	---------------------------------	-----	---------------------------------

**DEPARTMENT OF CLINICAL/LABORATORY IMMUNOLOGY**

REGISTERED LABORATORY

NHS Greater Glasgow and Clyde
Gartnavel General Hospital ☎(0141)-301-7752

name AUGHLIN	Forename BRIAN	Date of Birth 28.01.1960	Hospital Number 51132067E	CHI Number 2801606030
Patient Address FLAT 4/E, 120 WYNDFORD ROAD GLASGOW G20 8HB	Patient Sex Male	Laboratory Number I,10.0072670.V	Report Delivery Address 8C OP GGH <i>SDG 12/18</i> <i>144</i>	
	Consultant / GP DOVE: S DOVER			
Clinical Information				

Protein Immunotyping by Capillary

Immunotyping

IgG kappa paraprotein

Prot Itype: Small paraprotein. Please send urine for BJP.
If BJP neg & FBC, renal function, calcium normal &
no lymphadenopathy, hepatosplenomegaly, bone pain,
recurrent infection, weight loss, MGUS is likely
(monoclonal gammopathy of undetermined significance).
Suggest rpt FBC, creatinine, calcium, immunoglobulins,
serum & urine electrophoresis 3 monthly for 2 years then
annually. If any of the above abnormal, symptoms develop
or paraprotein increases, consider Haematology referral.

Specimen Comments / External Reference No:

Sample Collected
15.07.10Received in Laboratory
15.07.10 12:02Report Issued
03.08.10 12:31 608Authorised By
Dr Moira Thomas

REMOVE ONE STRIP AT A TIME

STARTING FROM BOTTOM LINE

IMMUNOLOGY

CPA DEPARTMENT OF CLINICAL/LABORATORY IMMUNOLOGY				NHS Greater Glasgow and Clyde	
CPA REGISTERED LABORATORY				Gartnavel General Hospital ☎(0141)-301-7752	
Surname MCLAUGHLIN	Forename BRIAN	Date of Birth 28.01.1960	Hospital Number 51132067E	CHI Number 2801606030	
Patient Address FLAT 4/E, 120 WYNDFORD RO GLASGOW G20 8HB	Patient Sex Male	Laboratory Number 1,10.0072670.V	Report Delivery Address 8C OP GGH		
Clinical Information			145		
Coeliac Serology (by Elia) TTG Ab (IgA) 0.4 (0.0-7.0) U/ml TTGU Ab : TTG Ab = Tissue Transglutaminase Ab Normal = <7.0, equivocal = 7.0-10.0, positive = >10.0					
Specimen Comments / External Reference No :					
Sample Collected 15.07.10	Received in Laboratory 15.07.10 12:02		Report Issued 19.07.10 16:32		554 Authorised By Auto Check

506 12/8/10

BIOCHEMISTRY REPORT

MCLAUGHLIN BRIAN A
 WIG L10 SURG
 WG1132067 28.01.60
 J DOUGHTY
 Lab No N.02.7288061.R
 Reported 02.12.02 12:05
 Collected 02.12.02 09:00
 Authorised by: A Pettigrew

RESULTS		CONSTITUENT
139		Sodium 135-144 mmol/l
4.0		Potassium 3.5-5.1 mmol/l
101		Chloride 97-108 mmol/l
		Total CO ₂ 22-32 mmol/l
5.1		Urea 2.5-7.5 mmol/l *
80		Creatinine 60-110 µmol/l *
		Serum Osmolality 275-295 mmol/kg
		Urine Osmolality mmol/kg
		Calcium 2.20-2.65 mmol/l
		'Corrected' Calcium 2.16-2.53 mmol/l
		Phosphate 0.8-1.45 mmol/l
		Total Protein 60-77 g/l
43		Albumin 36-50 g/l
65	High	Bilirubin 3-18 µmol/l
281	High	Alkaline Phosphatase 70-260 U/l *
950	High	Gamma G.T. 5-50 U/l
344	High	AST 10-35 U/l
451	High	ALT 10-50 U/l
		Total CK 10-171 U/l
		CK-MB Ratio
		Glucose 2.80-6.0 mmol/l
		Urate 0.10-0.42 mmol/l *
999	High	Amylase 0-100 U/l
19	High	CRP <10mg/L

* Reference ranges for these assays have significant
 age and sex dependence.
 Further information may be obtained from the
 Duty Biochemist (211 - 3355/3341) MI 01/00

FIX REPORT, STARTII

BIOCHEMISTRY REPORT

MCLAUGHLIN BRIAN ¹⁰⁴ _A
 WIG L10 SURG
 WG1132067 28.01.60
 J DOUGHTY
 Lab No N.02.6088467.L
 Reported 02.12.02 09:11
 Collected 02.12.02 00:16
 Authorised by: Auto Check

RESULTS		CONSTITUENT
143		Sodium 135-144 mmol/l
3.4	Low	Potassium 3.5-5.1 mmol/l
104		Chloride 97-108 mmol/l
		Total CO ₂ 22-32 mmol/l
6.1		Urea 2.5-7.5 mmol/l *
98		Creatinine 60-110 µmol/l *
		Serum Osmolality 275-295 mmol/kg
		Urine Osmolality mmol/kg
2.39		Calcium 2.20-2.65 mmol/l
2.17	Low	'Corrected' Calcium 2.16-2.53 mmol/l
		Phosphate 0.8-1.45 mmol/l
		Total Protein 60-77 g/l
51		Albumin 36-50 g/l
		Bilirubin 3-18 µmol/l
		Alkaline Phosphatase 70-260 U/l *
		Gamma G.T. 5-50 U/l
		AST 10-35 U/l
		ALT 10-50 U/l
		Total CK 10-171 U/l
		CK-MB Ratio
7.8	High	Glucose 2.80-6.0 mmol/l
		Urate 0.10-0.42 mmol/l *
3759	High	Amylase 0-100 U/l
		CRP <10mg/L

IST REPORT HERE

* Reference ranges for these assays have significant age and sex dependence.
 Further information may be obtained from the
 Duty Biochemist (211 - 3355/3341) MI 01/00

BIOCHEMISTRY REPORT

105

MCLAUGHLIN BRIAN
WIG L10 SURG
WG1132067 28.01.60
J DOUGHTY

Lab No N.02.6098467.L
Reported 02.12.02 09:05
Collected 02.12.02 00:16
Authorised by: Auto Check

RESULTS		CONSTITUENT
143		Sodium 135-144 mmol/l
3.4	Low	Potassium 3.5-5.1 mmol/l
104		Chloride 97-108 mmol/l
		Total CO ₂ 22-32 mmol/l
6.1		Urea 2.5-7.5 mmol/l *
98		Creatinine 60-110 µmol/l *
		Serum Osmolality 275-295 mmol/kg
		Urine Osmolality mmol/kg
2.39		Calcium 2.20-2.65 mmol/l
2.17	Low	'Corrected' Calcium 2.16-2.53 mmol/l
		Phosphate 0.8-1.45 mmol/l
		Total Protein 60-77 g/l
51		Albumin 36-50 g/l
		Bilirubin 3-18 µmol/l
		Alkaline Phosphatase 70-260 U/l *
		Gamma G.T. 5-50 U/l
		AST 10-35 U/l
		ALT 10-50 U/l
		Total CK 10-171 U/l
		CK-MB Ratio
7.8	High	Glucose 2.80-6.0 mmol/l
		Urate 0.10-0.42 mmol/l. *
3759	High	Amylase 0-100 U/l
		CRP <10mg/L

Reference ranges for these assays have significant
ie and sex dependence.
Further information may be obtained from the
ity Biochemist (211 - 3355/3341) MI 01/00

g/L
it

PHYSIO
THERAPY

L10E

148

NAME

HOSP. No.

ADDRESS

BRIAN McLAUGHLIN 1132067

110 LATHERTON DR AGE

G20 STR OR/LAB.

43

PHYSIOTHERAPY DEPT.

IN PATIENT

RECORD OF TREATMENT

AND PROGRESS

DATE

DETAILS OF TREATMENT AND PROGRESS

30/4/03 PC - Th 29/4/03 LAPAROSCOPIC CHOLECYSTECTOMY
HPC - A/A for bp choke. On warfarin
for prev PTE : converted heparin
Prev - ruptured pancreatitis 2/12/02
Abdominal US - gallstones
developed PTE whilst in-pt.
PMH - nil

SH - lives (+)
- mob (+)
- int + ext. stains

DH - see Rindex

30/4/03 S - Pt v nauseous + in bed,
painted in toilet AM

O - bed high (+)
- try (+) bed > ch.

Ausc - c/e ↓ (+) base c
exp. wheeze

R - AD c men hold (+) side//
C + swallowed sputum.
- try bed > ch + OTS.

DBEx -

P - ↑ mob AM

1/5/03 S - Pt improved today - RUS?
chest infection

O - On 2L O₂ via FM.

Ausc - c/e ↓ (+) m2 c added
sounds ° prod. cough

R - mob 2nd round wd c sup//
SaRaE

- AD c men hold (+) m2 // C+E

149

DATE

DETAILS OF TREATMENT AND PROGRESS

to mucoid plug spatum ↑ of
P. ↑ mob + monitor chest.

↑ Dave

5/6/3 S - Pt well

pm CoR show ↓ (R) lung sz c' fluid
? air below diaphragm from Th.

○ - Ausc: c/e mod basally
° prod cough

R - mob 3x hand wd @ sup
- TAQ ex

- DREx

P - Enc to mob (I)

↑ Dave
(SRICAT)

5/6/3 S - Pt well

○ - mob (I) in wd

Ausc: c/e good throughout
° prod cough

R - enc to ↑ mob

supported cough reinforced
P - R/v max

↑ Dave

WEST GLASGOW HOSPITALS

NAME

Hospital No.

Age

Sex

PHYS/
SURG.

Dept.
Ward

OUT PATIENT
HISTORY

146

DATE

21 JAN 2003

63.4 kg

GP referral
Hx as with h
also LFT
Several central & cysts
in 1970s & signs of
hyaline & fluid

① Same disorder in
1977 - surgical - most
recovery but with
an Kerner

② Proximal h 10/99
- mainly on scalp
+ nails

Not working

③ Hx - at times very
sore & has fluid at base
to base when very
wherry

DATE

HISTORY
(Use other side first)

147

h30

Normal HCV
New HCV test - neg
veel a cc ggt on lab
All bloods

6/82

df

20/3/3.

63.6kg

PHYSIO
THERAPY

150

1

NAME <u>Brian McLAUGHLIN</u> HOSP. No.	PHYSIOTHERAPY DEPT. IN PATIENT RECORD OF TREATMENT AND PROGRESS
ADDRESS <u>11 U LATHERTON DR. GLASGOW</u> AGE <u>42 ym.</u>	
OR/LAB. <u>28.01.60</u>	
<u>L10 S / West.</u>	

DATE	DETAILS OF TREATMENT AND PROGRESS
------	-----------------------------------

2.12.02	Referred to physio for review.
---------	--------------------------------

Summary from N/notes:
 Ac. Adm. 2.12.02 @ 01⁴⁵ $\bar{L}$ $\approx$ 24 hrs. severe abdominal pain + vomiting.
 Amylase 3759 $\rightarrow$ Δ PANCREATITIS.

PMH - Nil.

SH - Lives with family.
 Non-smoker.
 Reported breathless $\bar{L}$ moderate exercise

nb NBM : bedrest : hourly observations : $\uparrow$ BP 160/99 : SaO_2 93% on A
 T $^\circ$ 36.5
 $\rightarrow$ SL O $_2$ via FM* : 10mg IV morphine $\rightarrow$ settled : * $\uparrow$ SaO_2 98%

11⁴⁰am. Reviewed as planned.

S. "Sore" + a bit drowsy: 90 $\uparrow$ pain on attempting br. exs of any level or approach.

O. SL/min O $_2$ via FM : fairly shallow br. pattern : pt flat sup. ly :
 T $^\circ$ 36 : HR 78 bpm : BP 162/100 : SaO_2 99% @ 09⁰⁰ obs : AE fair to all areas, no obvious retained secretions or other focal findings.

A. Basic problems at present appear to be (1) PAIN ; (2) $\downarrow$ THORACIC EXCURSION + $\downarrow$ AE ; (3) BEDREST $\rightarrow$ $\uparrow$ risk of $\downarrow$ circulation/stasis/DV.
 Therefore appropriate to teach relaxed self-care Rx approach with (i) relaxed br. exs (?AD approach) + (ii) maintenance FTAQ exs.

T. (i) Advice given - currently too sore to make formal Rx practicable or appropriate : will need follow-up pm.

(ii) Advice given re. FTA exs + hip/knee movts

151

DATE	DETAILS OF TREATMENT AND PROGRESS
I.	Appears aware + understanding information.
P.	Review pm - aim to see after analgesia. <i>Gail J. Phillips</i> <i>SUPV. TO PT.</i>
30 pm.	Reviewed as planned.
S.	"Still very sore" - reports analgesia given $\approx$ 30 mins ago.
O.	Findings v. similar to am.
A.	PT appears willing to try v. gentle br. + leg X's as outlined.
T.	(i) Resp ⁿ - small volume and large volume br. exs as modified AD approach. I - managing well enough for day of admission. (ii) Rehab - gentle pelvic rocking in ckty (?? some of abdom. pain sounds like "trapped wind") and static quads. I - Holding well. 1. Patient to practice as taught re. (i) + (ii). 2. Review am to develop br. exs + rehab. regime. <i>GOP.</i>
12.02.	11 ⁰⁵ . Reviewed as planned.
S.	Reports feeling "a bit better - st. less sore".
O.	Continues on O ₂ therapy @ 8L/min: note $\uparrow$ T 38°C last night: AE fair to bases. A - generally similar to yesterday: faint restlessness.
T.	Review of AD approach br. X's with inclusion of 'medium volume breaths + SMI', and introducing FET: working in 'cycles' of 6 small vol. $\rightarrow$ 4 med. vol + SMI $\rightarrow$ 2 full vol., incl. 2-3 groups of small vol. breaths prior to 'cycles' and FET at end of groups + cycles.
R.	Working well: fair power of FET = sounds a little moist deep down - nil expectorated.
P.	Continue daily review / encouragement: progress $\rightarrow$ much shunke. <i>GOP.</i>
5/12/02.	T ^{1st} to L10 E on 3/12/02. Fully mobile. Obs stable. On air. $SpO_2 = 93-94\%$.
A.	Improved function.
P.	Review chest tomorrow. <i>M. M. Lloyd</i>
6/12/02.	(O) Nk report pt. mobile (I) about ward. (MORRISON, M. LLOYD L. (M)) Now back to bed. SpO_2 98% on 2L O ₂ via nk. Chest clear on Ausc.
(Rx)	R/v of DBEx's. Advice to cont. DBEx's + mobilising, over weekend.
(P)	R/v Monday. Stairs when able. J Forsyth
9/12/02.	S Has had "clot on line". For further scan. (FORSYTH, B. (PT)) P Await scan results. R/v tomorrow. <i>M. M. Lloyd</i>
10/12/02.	S Fine. Still has some pain lower (L) nb's at back.

PHYSIO
THERAPY
ctd

152

NAME Brian McLAUGHLIN HOSP. No.

ADDRESS

1132067

AGE

OR/LAB.

PHYSIOTHERAPY DEPT.

IN PATIENT

RECORD OF TREATMENT

AND PROGRESS

DATE

DETAILS OF TREATMENT AND PROGRESS

10/12/02

S. Using O₂ off/on

ctd.

Away for V/Q scan this am. Results awaited

R X Ray results showed consolidⁿ @ M2.

A Still unclear whether breathlessness is due to consolidⁿ or PE

R DBEx c ~ 6s insp hold, sets of 4. // able

Cough, strong dry.

Stair practice (w/o O₂). Able ↑ + ↓ 10 steps c

supervision, step-to gait.

P R/V tomorrow. Consider discontinuing if well.

11/12/02

S Not so well. Has pneumonia

Awaiting docs. round + results of scan.

Moire McLeod
(MORLEN McLEOD)
Se 11 P

O On 2L O₂ via n/c

SpO₂ = 98% this am

I CHEST: ↓ AE both bases

SPUTUM ROUGH

? Br. Br. @ M2 + base

R Br ex c 6s insp hold + ^{2x5} cough. // Nil expectⁿ c/o rib pain.

Towel supplied for supported cough. Go easier.

A Might benefit from saline nebs since has been using dry O₂ for several days.

P D/W medical staff. ✓ will write up saline nebs.

R/V tomorrow am. Sputum sample bottle c/p

Moire McLeod

12/12/02

S Has expectⁿ a little. Nebs helped. Small amt of blood

12¹⁵.

in sputum — not sure whether it came from chest or back of

nose which has been bleeding a little c n/c + O₂

SPUTUM

AWAITING R/V by RESPIRATORY PHYSICIANS

SENT
FOR C+S.

R Saline nebs, driven by air.

AD c manual holds to apices / upper Tx.

O₂ SpO₂

Some palpable crackles @ M2

on air = 91

Supported cough → 1 x mp.

P Continue c nebs + A.D. to encourage mobility.

R/V tomorrow pm

Moire McLeod

153

DATE	DETAILS OF TREATMENT AND PROGRESS
R	D/W w/staff. O ₂ left off for pt to eat lunch Advised to leave it off until n/s check obs. for SaO ₂
P	R/V pa M. McCleod
6 ³⁰ S	Feeling fine w/o O ₂ . O. On air SaO ₂ = 95%
O.	(No medical staff present) D/W medical staff. Pt to stay off O ₂ unless sats drop below 95%.
	Br. ex c in sp hold — good technique
P	R/V tomorrow. M. McCleod
12/02	(S) Pt. still feeling some chest pain. Otherwise feeling fit & well.
(O)	O ₂ therapy Staff happy w/ SaO ₂ on air. ① mobile.
	Awaiting Resp. Physician R/V TODAY.
(R)	Advice to cont DBEx's / mobility over weekend.
(P)	R/V Monday. J. Forsyth (B&T)

154

15/7/10

(50) → night shift
Team leader @ Tesco

Altered bowel habit, 6/12
once a day until 6/12 ago
↑ bowel frequency 2-3/day
loose stools

+ Blood on occasions
Haemorrhoids in the past (+)
Appetite OK Steatorrhea
wt OK

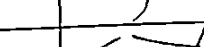
nocturnal symptoms
discomfort gets better w/ defecation
stressful time

PPHx stressful time
) Acute pancreatitis 2° to Alcohol
 DHx Presen cholecystectomy

7) NMOA: ? Penicillin allergy

PHX
→ Non-mol
Alcohol socially

PtH		age
7	tumour in stomach Dad	86v


 ① - Blood
 - Stool calprotectin
 - OGDWCA
 - USS

IN PATIENT
CONTINUATION HISTORY

1132067
MCLAUGHLIN BRIAN
11U Latherton Drive M
GLASGOW 28/01/60
G20 8JR
G.P. Prac. 43311

155

DATE

26/4/03 43yr ♂ arranged admission for laparoscopic cholecystectomy
on Tuesday 29/4/03.
on warfarin for previous PTE is requires conversion
to heparin ~~in-patient~~ pre-op: ? s/c or IV murex

Adm 2/12/03 - acute pancreatitis

Abdo USS -> gall stones

developed PTE whilst in-patient -> warfarinised.

Currently

no further attacks of pain

otherwise well.

c/o ↑ weight over past 2/12 (no ↑ intake).

↑ frequency bowel motion - 3-4 times daily

- initially loose - now formed

- normal colour.

- no urinary symptoms.

- N+V.

- appetite good.

PMH

nil

FMH

nil

DH

warfarin - 3mg mon-sat

4mg Sunday

} stopped Thurs 24/4/03.

SH

non smoker

alcohol - ~ 4 units @ weekend.

156

HISTORY (Use other side first)

SE

CNS - ° CP ° peripartum, ° oedema

Resp - ° SOB, ° pleuritic pain, ° cough, ° orthopnoea, ° PND
but productive cough in morning - brown spit

GI - as above

GU - ° dysuria

O/E

general - well, comfortable

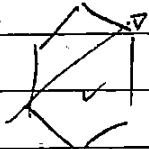
CNS - HR 96 regular

Resp  chest clear

HS I+II+0

JVP not seen

° oedema

Abdo -  soft, non tender

celiac soft

° masses

° LKKS

murphys - ve

Imp - 43y ♂ e gallstones for elective cholecystectomy. On
warfarin for previous PTE.

Plan (1) bloods FBC/UTE/coag ✓

(2) kardia ✓

(3) consent

(4) PTE dropped warfarin ✓ (last Thurs 24/4)

Lo ? for heparin infusion

? for s/c heparin

} will d/w SMO.

Jura he 1240 3142



1132067
MCLAUGHLIN BRIAN
11U Latherton Drive M
GLASGOW 28/01/60
G20 8JR
G.P. Prac. 43311

IN PATIENT
CONTINUATION HISTORY

IN-PAT
FORM 3

157

DATE

26/4/3

JHD - d/w 840

→ for dalteparin 18000 w s/c today + tomorrow.

d/w Per whether requires conversion to heparin infusion.

→ monitor INR + coag over weekend.

para he

PRHO 3142.

28/4/03

w/R Prof O'Dwyer

Switch to S/C enoxaparin ✓

PT 15 (10-13)

Na 140

aeb 48

PTT 39 (26-36)

K 3.9

Bil 36 ↑

INR 1.2

Cl 101 l.

alk Phos 195

Fib 2.52

U 6.2

SGT 67

Cr 95

AST 49 ↑

ALT 58 ↑

Hb 15.8

WCC 6.12

Plt 189

BY ——— (locum JHO).

29/04/03

THEATRE

CHISHOLM / O'DWYER / MURPHY

Lap cholecystectomy + peroperative cholangiogram.

Q. M. J. 2003

HISTORY
(Use other side first)

158

4/03 A76P R2 ↓ BP

returned from theatre post laparoscopic cholecystectomy

anaesthetic sheet notes BP sitting ~ 150/90, HR ~ 80

- last measurement BP is 110/90, HR ~ 104.

patient alert + orientated, sitting up in bed.

no complaints of - dizziness

- light headedness

minimal wound discomfort, slight nausea

has been bleeding slightly from (R) subcostal wound site

- now stopped.

all other wounds fine

O/E

general

- pale

alert + orientated

CVS - HR 104 regular

Resp -



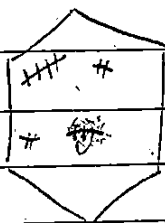
HS I + II + O

JVP ±

chest clear.

oedema

Abdo



- abdo soft, slightly tender over paraumbilical wound

o guarding

o rebound

o distension

Plan (1) bloods : FBC, U+E, Coag

(2) regular analgesia

(3) IVI - 500 saline over 1 hr then 4° until drinking

(4) check BP in 30 mins

(5) WR review in 1 hour.

area loc #3142

1:132067
MCLAUCHLIN
11th Latherton Drive
GLASGOW G20 8JR
G.P. Prac. 43311

IN PATIENT
CONTINUATION HISTORY

IN-PAT
FORM 3

159

DATE	
20/03/03	Figured 8 2/0 silk suture placed in (R) sited port site for haemostasis RWS 7 days. C. Mully suture
2/5/03	MR O'DWYER well CXR / ABG / ECG from 1/5/03 all (N) + satisfactory up + about O/E abdo soft, non tender normal sounds satisfactory obs stable. Na - 138 WCC - 6.2 K - 4.1 (Hb - 6.6) Uv - 9.0 PH - 7.3 CV - 104 Plan home when INR therapeutic / INR - 1.3 *NB Hb has dropped to 6.6* ∴ XN 4U + 7/F overnight. June he PRHO 3142. 6/5/3 - MR Muir - well - maintaining - Hb - 9.9, INR 1.2 - Imp - recovering well from lap chole - Plan - if INR therapeutic → (N) PRHO 3140

HISTORY
(Use other side first)

160

9/5/3 WR - Chisholm

- Well
- Hb 10.1, INR 1.2
- (h) today with usual regime of warfarin dose
- to come back to ward on Friday 9/5/3 for
Hb + INR check.

[Signature]

CCHUAH, #3142 JHO

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST
ACCIDENT & EMERGENCY DEPT.
WESTERN INFIRMARY
GLASGOW
G11 6NT
Tel: 0141-211-2304/2409
Fax: 0141-339-3046

CONSULTANTS: Mr W M Tullett
Mr P T Grant
Dr S Perry
NURSE MANAGER: Mr G D Wright

NHS
Greater
Glasgow

CRN: 1132067

TREATMENT COPY

Surname MCLAUGHLIN	Forename BRIAN	Age 42	Date of Birth 28/01/60	Arr Date 01/12/02	Time 23:20	AE Number 049822/02
Address 11U Latherton Drive GLASGOW		Sex Male	Religion Roman Cathol	Date of Inc 01/12/02	Time	
PC G20 8JR		Tel 946 0499	Marital Status Single /	Occupation/School	Type of Inc Other	Mode of Arrival Walking
Name Dr MCCARTNEY		Address MARYHILL HEALTH CEN 41 SHAWPARK STREET GLASGOW G20 9DR 531 8830		Referred by Selfref		
Name GRACE		Address 11 Kirkhill Place GLASGOW G20 8HZ		Complaint		
Relat MOTHER		I. No. 946 1629				

ROAD TRAFFIC ACCIDENT PLACE

DETAILS

HOME ACCIDENT PROBABLE CAUSE

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

Dear Doctor,

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

Diagnosis

X-ray film/ECG shows

Treatment given

Triage Time

23:20

Triage Category

Category 2

Initial Complaint:

Abdominal Pain

Drugs _____ days supply of _____ has been given.

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

Would you please arrange _____

DISCHARGE CODES: Please circle

1. Admission

3. Refer to G.P.

5. Died

7. Irregular Discharge

2. Discharge

4. Transfer to other hospital. (see below)

6. Refer to O.P. Clinic (see below)

8. D.O.A.

Ward No. (if admitted)

L105

Transfer to Hospital

Consultant (if admitted)

Follow-up

Not Arranged

Arranged

To be arranged

IRIS

Others (specify)

Clinic
Referred to

AE

Dressings

Hand

Fracture

Ortho

Medical

Surgical

Skin

ENT

Gyn

OHPAT

Medical Officer's Name (in BLOCK LETTERS)

Signature of Medical Officer

Cons SpR SHO3 SHO JHO Clin Assist ENP (please circle)

NURSING NOTES

SY
AC

On 10L

TIME:

PHYSICAL SIGNS

162

DISPOSITION:

1. RESUSCITATION
2. MEDICAL/SURGICAL
3. TRAUMA:
4. OTHER (SPECIFY)

ted 37.0°C

46.2 mmol/L
6.09 kPa
15.84 kPa

STATUS 37°C

15.84 kPa (10.00 - 13.33)

D

37.0 °C

TRIAGE NURSE SIGN

..... PRINT

exceeds reference range

Na⁺ 143

K⁺ 3.4

Cl 104

Ure 6.1

Creat 98

Chc 7.8

WCC 12.04

Hb 16.4

MCV 88.5

PLT 187

PT 12

PTT 23

Ca 2.39

Ca (adj) 2.17

Alb 51

#1244444 3759

NURSING DOCUMENTATION - ACCIDENT & EMERGENCY DEPARTMENT

Date 11/2/2 Time 2320 Triage Nurse OMC/erhu PC

Sudden onset ↑ abd. pain, sweating +, poor colour. Triage category 1 (2) 3 4 5

Relatives present:

Relatives informed:

ABC

INITIAL MANAGEMENT

Nurse _____

Oxygen started _____ %: Signed _____ ECG: Signed _____

Bloods: AE1 AE2 AE3 Trama OD

Other _____

Treatment _____

NEUROLOGICAL OBSERVATIONS

[illegible][illegible]

LIMB MCG ME...	ARMS	Normal power									31 Record right (R) and left (L) separately if there is a difference between the two sides Fractured limb = #
		Mild weakness									
		Severe weakness									
		Extension									
		No response									
	'EGS	Normal power									
		Mild weakness									
		Severe weakness									
		Extension									
		No response									

	1	230					40	4.
	2	220					39	
		210					38	
	3	200					37 Temp C°	
		190					36	
	4	180					35	
		170					34	
		160					33	
	5	150					32	
		140					31	
		130					30	
		120						
	6	110						
		100						
PUPIL SCALE (mm)		90						
		80						
	PULSE RATE	70						
		60						
		50						
		40						
		30						
RESPIRATORY RATE							5.	
SaO ₂								
NURSE INITIALS							6.	

INITIAL VITAL SIGNS

at: (Time) 23:35

HR: 81

BP: 168/94

RR: 30

SaO₂: 96%

Temp: 35.6

G.C.S: 15

Signed W. J. [Signature]

BLOOD GLUCOSE	Time				
	BM				
PEAK FLOW	Time				
	PF				
VISUAL ACUITY	R. eye aided/unaided				
	L. eye aided/unaided				
	pH L. eye		R. eye		

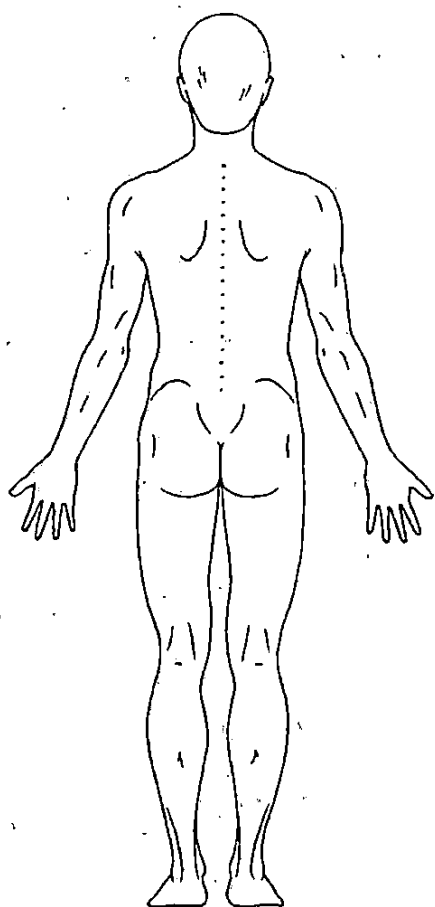
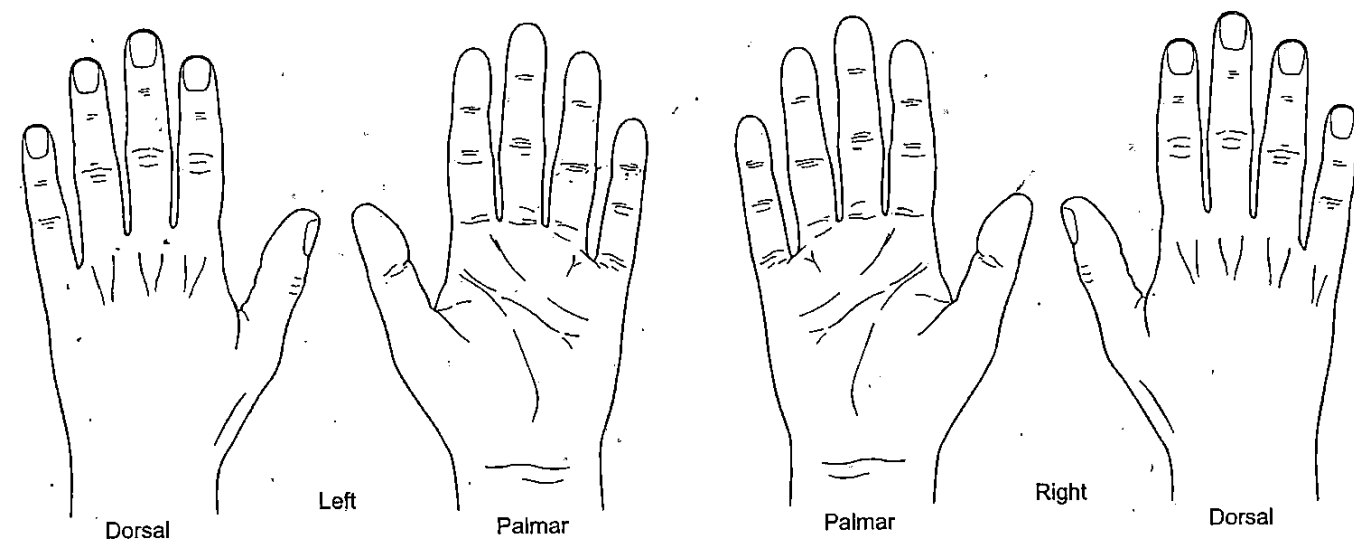
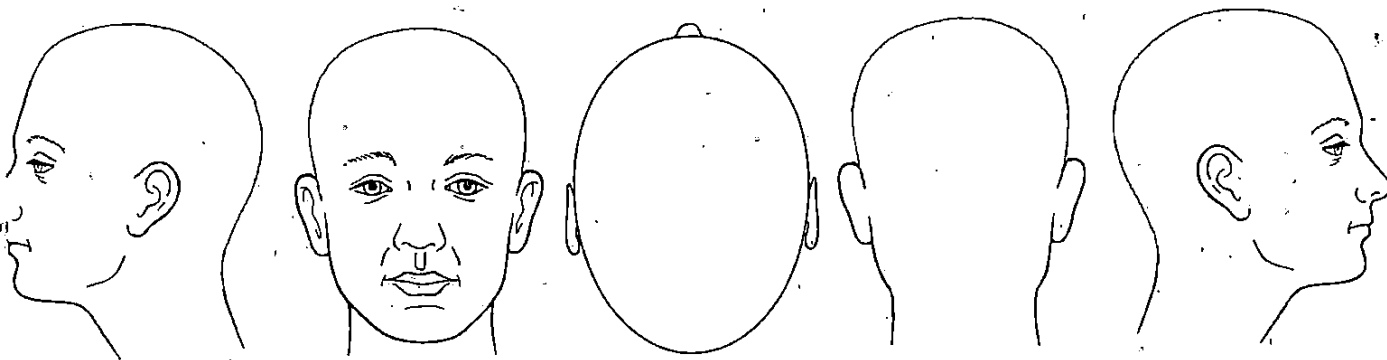
Signed: _____

URINALYSIS

Urobilinogen	Normal 3 16	33	66	131			
μmol/L	☐ ☐	☐	☐	☐			
Protein	Neg	Trace	0.30 +	1 ++	3 +++	>20 ++++	
gm/L	☐	☐	☐	☐	☐	☐	
pH	5.0	6.0	6.5	7.0	7.5	8.0	8.5
	☐	☐	☐	☐	☐	☐	☐
Blood	Neg	Non Haem	Haem Trace	Small +	Mod ++	Large +++	
	☐	☐	☐	☐	☐	☐	
Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025	1.030
	☐	☐	☐	☐	☐	☐	☐
Ketones	Neg	Trace 0.5	Small 1.5	Mod 4	Large 8	Large 16	
mmol/L	☐	☐	☐	☐	☐	☐	
Bilirubin	Neg	Small +	Mod ++	Large +++			
	☐	☐	☐	☐			
Glucose	Neg	5.5 Trace	14 +	28 ++	55 +++	111 ++++	
mmol/L	☐	☐	☐	☐	☐	☐	
Nitrites	Neg			Positive			
	☐		☐		☐		
Leucocytes	Neg	Trace	Small +	Mod ++	Large +++		
	☐	☐	☐	☐	☐		
BHCG	+ ve				- ve		

Signed: _____

Please annotate area of: Tenderness / Bruising / Swelling / Abrasions / Lacerations / Incised wounds



Left Dorsal



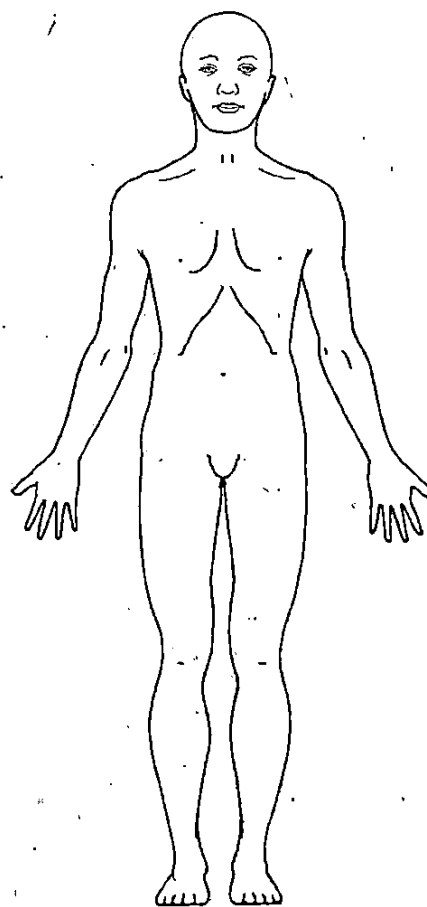
Right Dorsal



Left Plantar



Right Plantar



Signed _____

MEDICAL NOTES - HISTORY and EXAMINATION

Consultant _____

Seen by _____

LYONS

Grade: SpR SHO SHO3 JHO Clin Assist ENP

(Please circle)

At (time) 23:30

Date

1/12/02

KEY TO CLINICAL NOTES

- 1 - HISTORY OF
- 2 - ON EXAMINATION
- 3 - X-RAY FINDINGS
- 4 - TREATMENT GIVEN
- 5 - DISPOSAL
- 6 - NAME OF MEDICAL OFFICER

PE. screaming / moaning & pain
(epigastric)
started 3 pm. - sudden onset.
Previously diagnosed as peptic ulcer
as symptoms improved & emetitive
given by GP 4/5 ago
on + off.

Recurrent transient episodes over
last yr - been using Gaviscon
→ some relief.

◦ USAIDS ◦ smoking

+ alcohol (x10 pints cider 1/7 ago).

◦ PMN_x

◦ Drugs

◦ Allergies.

◦/E

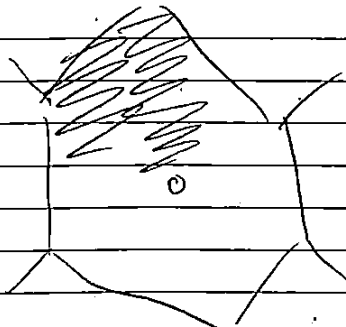
T = 36.0

P = 81

BP = 168/94

MS : 1 + 1 + 0

Reflex: clear.



Distended
not extremely tense

+++ tender
+ guarding

◦ rebound

RSS : ↓

PR : not done.

Date

Plan

165

G₂

IV Pleuro

Pleuro

IV Morphine + maxalon

IV pantoprazole

E.C.G. — nil acute

erect CXR, AXR (portable) — near quality

departmental XR's

1/2/2 ~~out~~ surgery

Thank you

for yr. ♂.

(PC): Sudden onset epigastric pain
 of severity
 Assoc: none

1 year hse of P epigastric pain

Treated by GP with H₂ antagonists

No NSAIDs

Non-smoker

Mod. alcohol; binge drinking

Ant/mt, nil else

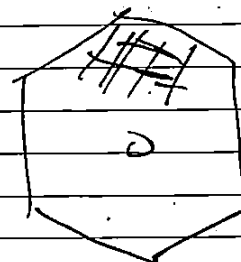
O/E: Very uncomfortable despite 20mg morphine
 also stable
 HR 98 reg
 BP 110/70

Ab: Mewheel epigastric tenderness
 Guarding ++

No lower abd

No generalised tenderness

Ref's quiet



DATE

Sample 3815

Brian McCaughlin

McGhiehan

87L02

Sample 38154 Sent

168

PATIENT SAMPLE REPORT

02 DEC 2002 10:45

SYSTEM 835 08/81

ANALYSIS DATE 02 DEC 2002

ANALYSIS TIME 12:44

Sequence 00000004

NEW FILE

Accession 00000000

NEW FILE

Source Material

01/01/00 10

Patient ID 00000000

NEW

Name

VIRAL ID

Age

Location

SYRINGE SAMPLE

000000000000

UNITS

mg/L

CPK

U/L

U/L

CPK

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

U/L

METABOLITES

10.0

10.0

10.0

10.0

10.0

10.0

10.0

10.0

10.0

10.0

10.0

10.0

10.0

10.0

ENTERE

Time

37.0

°C

F102

48.0

°C

or 1 - exceeds reference range

MEDICAL NOTES - HISTORY and EXAMINATION (cont)

Date

Amv : 3759

1.66

ECCA : Crossover (2)

COR : No free gas
NI amide

ABG : w+ 46.2
pO₂ 6.09
pO₂ 15.8L

BREATH McARTHUR
on 4L O₂

3 02 2002 14:06
physicist
new hat
new Time
operator ID

SYRINGE SAMPLE
ACT BASE 37.0

37.0

reference
35.0
37.0
39.0

37.0 °C

records reference range

2/12/02 ur: clws
- Re direct bloods
- For USS today

M. J. Jones
RMO 2170

Date

2/12/02

10:45 am.

169

Plan - changes

IV fluids and Cl
not Dec.

1 hour in 9

3176 PRN

2/12/02 Radiology - US - Abdo

Difficult exam due to patient's build.

Gallstones in GB. CBD not identified but no obvious

intrahepatic biliary dilatation

bowel unexamined due to bowel gas. No evidence of epigastric
gas but trace of fluid noted in subhepatic space.

Normal spleen, liver, kidneys.

U. Spink

RESULTS PAGE

Please record all results of investigations, time, date and sign. Append all referral letters / SAS report forms, etc to this page.

Date

2/2 blds.

170

Na 139	CRP 19	Alb 43
K 4	Hb 17	Bil 65 $\uparrow$
Cl 101	WCC 11.07	AlkP 281
Urea 5.1	Plt 192	GGT 950
creat 80	Amylase (999) $\uparrow$	AST 344
		ALT 457

3/12/02

D/W Mr. Fullerton re. ERCP.

Suggests an outpatient ERCP in 2-3/02
assuming that this episode of pancreatitis
settles OK.

Jan 12

31/12/02

WR - CHISTOLM

YOUNG

- ERCP changed to MRCP at Royal
- contacted Dr Stewart
- to sent CARD with X-rays.
- Has Not said he will do was initially
reluctant to do MRCP.

SP

Bloods	Hb 14.3	Na 141	CRP 373 $\uparrow$
	Plt 144	K 3.3	Alb 34 $\downarrow$
	WCC 12.76	Urea 5.8	Bil. - 44 $\downarrow$
	LWR 1	Creat 5.8	AlkP - 167 $\downarrow$
	PT 23		AST - 46 $\downarrow$
			ALT - 121 $\downarrow$
			GGT - 421 $\downarrow$

SPM JMD

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

Date given	Drug (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given by
1/12	MORPHINE	10mg	IV	23:45	[Signature]	[Signature]
1/12	MAXALON	10mg	IV	"	[Signature]	[Signature]
2/12	MORPHINE	10mg	IV	00:30	[Signature]	[Signature]
2/12	PAVOPRADLE		IV	00:40	[Signature]	[Signature]

(171)

PARENTERAL FLUID PRESCRIPTION SHEET

Date	FLUID	Volume	Time to run	Rate mls/hr	ADDED DRUGS	Quantity	Doctors Signature	Added by	Start time 24hr Clock	Put up by	Checked by	Serial/ Batch no
1-12-02	N. Saline	500	STAT				[Signature]		23:50	[Signature]		
2-12-02	N. Saline	500	STAT				[Signature]		00:30	[Signature]		
2-12-02	N. Saline	500	STAT				[Signature]		01:00	[Signature]		

N.B. IF USING A SYRINGE DRIVER/INFUSION PUMP PLEASE USE THE "PRESCRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE DRIVER/INFUSION PUMP"

REFUSAL TO REMAIN UNDER HOSPITAL CARE

I wish to take my discharge. I appreciate that this is against the advice and wishes of the Consultant or his or her deputy looking after me. I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising from them.

Name (print) _____ Signature _____

I confirm that I have explained to the patient the risks that might arise out of his / her decision to take his / her own discharge.

Date _____ Signature _____
(Medical Practitioner)

DISCHARGE DETAILS (NURSING)

Treatment _____

_____ Signed _____

(Please put initials in box)

Crutches ☐

Return appointment ☐

Advice Card ☐

Medication ☐

Escort to ward ☐

Relatives informed ☐

IRIS ☐

Transport ☐

Time booked _____

Discharged with _____ Admitted / transferred to _____

Time discharged _____ Signed _____

IN PATIENT
CONTINUATION HISTORY

1132067
MCLAUGHLIN BRIAN
110 Latherton Drive M
GLASGOW 28/01/60
G20 8JR
G.P. Prac. 43311

HITAL

No

AGE

DEPT
WARD

10E-

172

DATE

5/12/02: LR: Phisheim.

Pt well. Up and mobilising well.
No further abdominal pain.
Eating and drinking. I.V. fluids
opp. for CT abdomen next.

AB 13.7 Wt 134 CRP-
LCE 11.04 K+ 3.2
PLT 178 Cl- 97

Ue 4.2.

Cr 77 - 1

8/12/02.

ATSP - complaining
of chest pain.

- Pleuritic

- tender to touch

- SOB

GE - General - well
- distressed.

CVS - HR - 72 beats/min

118 - I+II + O + no
murmur

Resp - clear

Tender on LHS
Pleuritic Pain.

RR - 24.

173

HISTORY

(Use other side first)

Date

Abdo - soft - non tender.

Calfs - both soft - non swollen
- non tender

On Alexane.

Imp - ? PE.

? Chest infection

? Muscular pain

Plan - ABG's

D-dimers

CXR.

Discussed with senior.

Malgesen

Review CxR - not focal improved from 2/12/02

2L O2 via mask.

1 BAKING

3770 PR170

9/12/02 but Repeat ECG - (W) changes

S/LPn JHO.



1132067
MCLAUGHLIN BRIAN
11U Latherton Drive M
GLASGOW 28/01/60
G20 8JR
G.P. Prac. 43311

HOSPITAL

No

AGE

DEPT

WARD

10E

IN-PAT
FORM 3

IN PATIENT
CONTINUATION HISTORY

174

DATE

9/12/02 Thanks

Pb. c/o. sudden onset ^(base) ~~left~~ side pleuritic
chest pain on 7/12/02 pm.

associated c sxs.

- no fever. Staff.

- ↑ sxs + palpitations + pleuritic
chest pain on 8/12/02 pm.

- No haemoptysis / cough / sputum.

- No calf / thigh pain / swelling / tenderness.

~~NO~~ H/O FH of PE / DVT.

asthma / Asthma /

Pneumonia.

O/E: Alert. Well. RR: 20bpm.

Sweating T.T.

SATs 97% on 4L O₂.

Pulse 80bpm regular.

- has been as above ~ 3 days.

Resp: ↓ Expansion.

↓ AE.

Cervicopex @ (D) midline

[Signature]

HISTORY
(Use other side first)

175

ECG: Normal. (9-12/02 am).

CXR: New onset @ midzone
atelectasis
as reported by Dr. Rabin-Rabin.

V/Q Scan: today or tomorrow.

CTPA: Dr. Rabin suggests V/Q scan.

Plan: Rx for DVT / PE i.

Pt's Height: 110 Kg.

i.e. Neuropenia dose of Dalteparin is
18, cc units daily.

Rpt. BIs + including D-Dimer.

Plene (PRHCD).

- Lower Limbs: NAD.

Palpable Peripheral Pulses

Plene - PRHCD.

9/12/02: CT Report of Abdomen:

Gallstones in GB i Shrinkage

CRD / Biliary tree not dilated.

Occult pancreatic carcinoma i

Pancreatic / Pancreas visible.

No evidence of Necrosis. Plene (PRHCD).



HOSPITAL

No

AGE

DEPT

WARD

IN-PAT
FORM 3

1132067
MCLAUGHLIN BRIAN
110 Latherton Drive M
GLASGOW 28/01/60
G20 8JR
G.P. Prac. 43311.

IN PATIENT
CONTINUATION HISTORY

176

DATE	
10/12/62	V/Q Scan indeterminate CTPA Scan also indeterminate To get respiratory team to review tomorrow SPE JMO.
10/12/62	WR CHURCHMAN MORNING - Chest pain last night - V/Q Scan today Bloods WCC - 15.5T Wn 136 Hb - 14 K 3.9 Plt - 363 Urea 3.4 CRP - 245 uT Creat 86 WR CHURCHMAN EVENING - For Respiratory review tomorrow - Already contacted today and they help with CTPA. SPE JMO
11/12/62	NR: Chisholm. Pt. well. c/o. new onset cough, not productive of sputum. Wt = 24lbs. Still c/o. left sided pleuritic chest pain i 80% other wise no change. O/E: RR: 20 bpm. Pulse 90 bpm. Temp. 37.5 °C. BP 135/80.

HISTORY
(Use other side first)

177

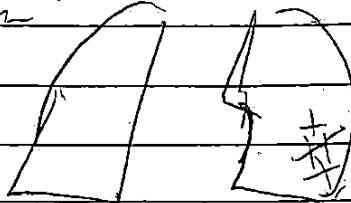
Resp: ↓ Expansion L > R. Sats 96% on Air.

↓ A/E Left lower zone.

Roll to percussion in left lower zone.

7 crackles: + "crushing" sound

scattered Q: left lower base
+ laterally.



Symp: New onset left lower lobe
Pneumonia & Atelectasis

CTPA: inconclusive

is unable to rule out PE.

Atelectasis seen.

Plan 1) Bts + R.C. U.E. ERV LAT!

2) Repeat CXR (Pneumobots)
- seniors would prefer a
Resp. review first.

3) Start Rx. for Pneumonia &
oral Augmentin + Clavibronzole.

8) Lower (PRHO)

1/12/02: Dr. G. Kellane (page 3124) SHO
in Resp. Medicine informed
regarding Mr. McLaughlin's ?PTE /
Pneumonia. These O.A. Respiratory
SRR will review memo.

8) Wong (PRHO)

HOSPITAL

IN-PAT. FORM 3

1132067
MCLAUGHLIN BRIAN
11U Latherton Drive M
GLASGOW 28/01/60
G20 8JR
G.P. Prac. 43311

No

AGE

DEPT
WARD

10E-

IN PATIENT

CONTINUATION HISTORY

178

DATE	
11/12/02:	Hb 13.7 Wt 142 ALB. 39 Uec 11.95(↓) K ⁺ 3.8 Bili 17 Plt. 400 Cl ⁻ 95 A.P. 270. W. 3.7 AST. 174 CRP. 195(↓) G. 92 AST. 40 ALT. 38
	Sheng CPR HO.
12/12/02	WR CHISMAN
	Fer. Respiratory Review today as regards shortness of breath Still Breathless mild → med exercise On Saline Nebis
	→ Contacted Dr Sward Spr Unable to see patient till tomorrow unfortunately
	Spr's MO,
12/12/02	CRP 151 ↓ INR - 0.9 Na 138 Alb 40 P.H - 7.27 K 4.1 Bili. 16 Hb - 13.8 Urea 3.4 Aphas 286 RFTS - 342 Creat 94 AST 42 WCL - 4.03 ALT 53 ↑ dLT 158 ↓ Spr

HISTORY
(Use other side first).

179

WR Chisnain

1/12/12 WIC L and CRP L
Awaiting Respiratory review today

S. M. J. K. O.

3/12/12 9/12/12 D Dimers +ve.
S. M. J. K. O.

1/12/12 Resp - thanks
42 M - Female left lower non-smoker
- Admitted - pancreatitis? Alcohol related. Amyl 3000.
~ 8-9/7 into hospital stay.
→ Pt's chest pain / SOB + SOB. No CVA symptoms
- Normally well.

6/12 - T.O Indeterminate - V/Q CTPA
CXR = No CXR available
BS - 6 (L) MZ - CT - (L) Plethorax / pleural
Crooked LMZ → D-Dimer +ve (Unhelpful).
HB - 1 P₂

Imp- In balance I think clinically this is likely to be
a PTE. A chest infection is also possible; however the notes
to patient would support a 6/12 cause of Warfarin aiming
to keep INR - 2.5-3.

→ I have advised him RE. Rather alcohol ingestion.
and notes of injury.

Assuming little or no risk of haemorrhagic conversion
of pancreatitis I would recommend anticoagulation

[Signature]
S. M. J. K. O.



1132067
MCLAUGHLIN BRIAN
110 Latherton Drive M
GLASGOW 28/01/60
G20 8JR
G.P. Prac. 43311

IN PATIENT
CONTINUATION HISTORY

IN-PAT
FORM 3

180

DATE	
14/12/12	WR VELIA Started Warfarin 10mg yesterday & if INR < 1.4 gives another 10mg Patient's pain otherwise diminished. will be on Warfarin 6 months
13/12/12	CRP 6.17 WBC - 13.7 Hb - 13.4 A/G - 3.8 R - 4.2 RHT-PLT - 369 Bil 14 Wren 4 WCC - 5.43 ALP - 143 Creat 87 ALT 64 AST 58 LGT 183
	S. Pni. DAO.
16/12/12	Na 134 Hb 11.6 A/G 2.6 R 3.7 WCC 5.28 Bil 6 Wren 3.2 PLT 373 ALP 156 Creat 70 CRP 65 ALT 72 LGT 15
	WR VELIA Contact Buckle surgery MRSA EVO Cont W Abx
	Continued Buckle surgery recommended sensitivity Ticoplanin 400mg. Given loading dose 400mg Ticoplanin & S. Pni. DAO.
	WR VELIA INR 3.3 Hb on Warfarin 3mg Back to Anti consultant clinic on Wednesday S. Pni.

1132067
MCLAUGHLIN BRIAN
11U Latherton Drive M
GLASGOW 28/01/60
G20 8JR

181

[illegible]

DEPARTMENT OF ORTHOPAEDIC SURGERY
ORTHOPAEDIC MEDICAL CLERK-IN



51132067E
MCLAUGHLIN M
BRIAN 28/01/1960
222 BROUGHTON ROAD
GLASGOW
LANARKSHIRE G23 5LP
CHI-2801606030

DATE: 20/3/12

182

ARRANGED ADMISSION FOR:

C5/C6 ANTI-CERVICAL DISCECTOMY &
FUSION.

PAST MEDICAL HISTORY:

7/12 hx leg & arm pain.
MRI C-spine → disc osteophyte complex @ C5/C6 w exit foramen
narrowing w C6 nerve root compression.

Cholecystectomy ~2003.

MI X

ANGINA X

BP X

CHOLESTEROL X

CVA X

DM X

RhF X

→ 14yrs

TB X

ASTHMA X

COPD ~~As~~ Bronchitis-obstruct

EPILEPSY X

DU X

JAUNDICE X

DVT X X

PTE ~~X~~ 1 pter PTE post

DRUG HISTORY:

Ibuprofen 200mg TDS.
Amitriptyline 10mg noct.
Pregabalin 75mg OD.
Omeprazole 20mg OD.
Remedine forte 500mg BD.

Cholecystectomy.

ALLERGIES:

Gabapentin → rash.
NKDA.

FAMILY HISTORY:

Ni fnd.

S/H: LIVES WITH: Alone.

EMPLOYMENT: Made redundant due to back pain.

ALCOHOL: Nil.

SMOKER: Non-smoker.

SYSTEMIC ENQUIRY:

Resp.

SOB X
Haemoptysis X
Wheeze X

Cough X
Fever X

Spit X
Sore Throat X

183

CVS:

OthopND X
Palpitations X

Chest Pain X
Ankle Oedema X

GI:

Dyspepsia X
Blood or Mucous PR X
Appetite X

Abdo Pain X

Bowels Regular ✓
N & V X
Weight X

GU:

Dysuria X
Frequency X

Haematuria X
Hesitancy X

Neuro:

FFF
Dysarthria X

Headaches X
Diplopia X

Numbness & Weakness
M/S NECK MOVEMENTS

ON EXAMINATION:

Blood Pressure
Anaemia X
Lymph. X

Heart Rate 70bpm
Cyanosis X
OED X

Jaundice X
Clubbing X

RESP:

Trachea Central
Percussion Resonant

Air Entry L=R, no focal
Breath Sounds Vesicular

CVS:

JVP L-R
HS 1+1+1+0
CALVES SNT.

APEX (N)
PP +

GI:

ASNT ✓
LKKS

REBOUND/GUARDING nil.
BS (N)

ROUTINE BLOODS

FBC/COAG/ESR
U&E'S/ PROFILE/GLUCOSE

NEURO: Grossly Intact
X-MATCH - UNITS
G&S

ECG

X-RAY

full
Hannah Smith SD47

NURSE TO COMPLETE

Out Patient appointment date.....

Diagnosis informed (circle) Patient Relative

Circle support services set up:

District Nurse Home Help Health Visitor

Oncology referral Hospice: day care OR home care

Discharge address if not home.....

.....

WARD USE ONLY

Medication Rec. on Ward by:

Checked against kardex:

Issued by: Date:

Signature of Recipient:

All known drug sensitivities / adverse reactions:

Gabapentin - rash.

181

PHARMACY USE ONLY

Clinical Pharmacy Check ☐	Professional Check ☒
Quantity supplied	Dispensing Details
Peds	
Peds	
Peds	
Peds	
Sol	on #11 Peds
34	Actavis
12	Organon

Dispensed by: JS Date: 30/3/11

Checked by: [Signature]

Non-childproof containers required: Yes ☐ No ☐

Medicine compliance aids required: Yes ☐ No ☐

Specify:

Medication Collected by:



51132067E
MCLAUGHLIN
BRIAN
CHI-2801606030

Test date 20-03-2012
Time 15:07
Operator _____
Test number 9382
Color Yellow
Clarity Clear

GLU Negative
*BIL 1+
KET Negative
SG ≥ 1.030
BLO Negative
pH 5.0
PRO Negative
URO 0.2 E.U./dL
*NIT Positive *
LEU Negative

105

Patient Profile

North Glasgow Hospitals



Ward:

Date:

Time:

(24hr clock)

Please print clearly in BLOCK CAPITALS

Title:

Name:

Preferred name:

Address:



51132067E
MCLAUGHLIN M
BRIAN 28/01/1960
222 BROUGHTON ROAD
GLASGOW
LANARKSHIRE G23 5LP
CHI-2801606030

Post Code:

946 2533

DOB: 01/8/26/1928 Age: 52

Hosp. No:

Occupation:

Religion:

S.O.S. ☐

date: ☐☐☐/

Interpreter required: ☐

(specify: ☐)

Lives alone ☐

1 NOK/Friend/Contact: DANIELLE MCLAUGHLIN

Address: SLA

Day: 07867430453

Night:

Relationship: DAUGHTER

2 NOK/Friend/Contact:

Address:

Day:

Night:

Relationship:

NOK informed of admission ☐

NOK informed: ☐

GP:

Address:

Dr. A WEBB
THE MARYHILL RED PRACTICE
MARYHILL HEALTH CENTRE
41 SHAWPARK STREET
GLASGOW
0141 531 8830

MEDICATION

With patient ☐

Stored & receipt given ☐

No medication required ☐

Taken home ☐

details:

PERSONAL BELONGINGS

Clothing listed ☐

Valuables listed ☐

Valuables in ward ☐

Valuables in hospital safe ☐

Consultant: MR. SHARMA

Named Nurse ①:

Admitting Nurse: Srd. B. Gilhooly

Named Nurse ②:

Relatives seen by Doctor ☐

REASON FOR ADMISSION

C5/6 + C6/7
ANTERIOR CERVICAL DISCECTOMY
+ Fusion.

Patient's perception of illness:

AWARE

Diagnosis:

Operation/Treatment:

Relevant PMH:

ACUTE PANCREATITIS '02
P.E. '02 IBS.

CHOLECYSTECTOMY. APPENDICECTOMY

OBSERVATIONS ON ADMISSION

Temperature 36 °C
Pulse 70 bpm
BP 141 / 88
Resp 98 %
Pain Score
Urinalysis
Waterlow Score
Height 1.77 m
Weight 116.8 kg
Body Mass Index 37.2
Blood sugar(if appropriate) mmols
Allergies Yes ☐ No ☒
details:

DISCHARGE PLANNING

Boarding	1st	2nd	3rd	Signature	Time	Comments/Information
Informed: ward ☐ ☐ ☐ patient ☐ ☐ ☐ relatives ☐ ☐ ☐						87
Date patient boarded: 1st: / / 2nd: / / 3rd: / /						
Internal Transfers						
Transfer destination:						
Planned transfer date: / /						
Medical consent ☐						
Arranged with receiving area ☐						
Patient informed ☐						
NOK/Contact informed ☐						
Transport: stretcher ☐						
2 hand seat chair ☐						
E t ☐						
Case notes ☐						
X-rays ☐						
Nursing notes & Drug Form ☐						
Property/Valuables listed ☐						
Catering ☐						
Dietitian ☐						
Physiotherapy ☐						
Occupational Therapist ☐						
Speech and Language Therapist ☐						
Discharge Checklist						
Planned discharge date: / /						
Medical consent ☐						
Date discussed with patient: / /						
Date discussed with NOK/Contact: / /						
Transport: own ☒ ambulance ☐						
Ambulance ordered on: / / • type: _____ • order no.: _____						
District nurse ☐ / Liaison nurse ☐						
Home help: ☐						
Social work dept. ☐						
Discharge prescription ☐						
Discharge dressings ☐						
Patient information ☐						
Valuables/Cashier ☐						
Physiotherapy ☐						
Speech and Language Therapist ☐						
Out patient appointment / /						
Other:						



Ward:

Date:

188

Case Record No.:

ACTIVITIES OF DAILY LIVING

51132067E
4CLAUGHLIN
3RIAN
222 BROUGHTON ROAD
GLASGOW
LANARKSHIRE
CHI-2801606030

M
28/01/1960
G23 5LP

STANCES/
RT

- Lives with family ☒
Lives alone ☐
Nursing home ☐
Residential care ☐
Elderly/disabled partner ☐
Family support (specify below) ☐
District Nurse (____ days/week) ☐
(cancelled ☐
Home help (____ days/week) ☐
(cancelled ☐
Other services (specify below) ☐

Stairs: Internal ☐ External ☐
Comments: _____

NUTRITION

- Normal menu (includes vegetarian) ☒
Vegan ☐ Child's menu ☐
Halal ☐ Kosher ☐
Refer to Dietician if any below ticked:
Inability to eat/swallow ☐
(refer to speech and language therapist)
Any recent weight changes ☐
Medically related nutrition
problems (e.g. diabetes) ☐
Other (specify): _____

BREATHING

1. No symptoms ☒
2. Breathless with moderate exercise ☐
3. Breathless with minimal exertion ☐
4. Breathless at rest ☐
5. Uses inhalers ☐
Comments: _____

SMOKING

- Non-smoker ☒
Smoker: _____ per day ☐
Ex-smoker ☐
Aware of hospital policy ☐

HYGIENE

- Bath ☐ Shower ☒
Requires assistance ☐ Stand up wash ☐
Skin assessment: INTACT
Other: _____

ELIMINATION

- Bowels regular ☒
Constipated ☐
Diarrhoea/Loose stools ☐
Uses aperient ☐
Has stoma:
• Colostomy ☐
• Urostomy ☐
• Ileostomy ☐
appliances used: _____

- Frequency of micturition ☐
Incontinent: urine/faeces ☐
day/night ☐
stress ☐
No urinary symptoms ☒
Comments: _____

SLEEP

- Hours/night ☐
Medication ☐
details: POOR PATTERN
DUE TO PAIN.

MENTAL STATE

- Alert/Orientated ☒
Confused: day/night ☐
Anxious/Distressed ☐
Unconscious ☐
Other (specify): _____

MEDICATION. 1BUPROFEN 600mg
 AMITRIPTYLINE 10mg
 PREGABALINE 450mg
 OMEPRAZOLE 20mg
 RIFMEDEINE FOLATE

CARE PLAN

Date Comm	Signature	6. TECHNICAL CARE	Date Disc	Signature
		IV Infusion		
		Monitor		
		Catheter		
		Oxygen Therapy		
		Nebulisers		
		IV access: ∞ IV cannulae ∞ others		
		7. WOUND CARE		
		8. SPECIMENS/INVESTIGATIONS		
		9. SLEEP		
		10. SPECIAL NEEDS		
		Assess for dysphagia (refer to speech and language therapist)		
		Source/protective isolation (refer to infection Control)		
		Blind/visually impaired		
		Deaf/hard of hearing		
		Anti-embolic stockings		
		Nurse escort when out of ward		
		11. OTHER RELEVANT INFORMATION		
		12. FAMILY/SIGNIFICANT OTHER		

Initial Care Plan seen and agreed by patient:

Signature of nurse:

Yes ☐ N/A ☐

Date: / /



432067E
GAUGHLIN
IAN
28/01/1960
2 BROUGHTON ROAD
ASGOW
NARKSHIRE G23 5LP
I-2801606030

Ward:

Date:

191

Case Record No.:

CARE PLAN EVALUATION

1. Personal Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
20/3/12			Date: 20/3/12 Ward: ZA MRSA SCREENING: A: Clinical Risk Assessment (CRA) - for patients >23 hours YES NO 1. Has the patient ever had a previous positive MRSA result? ☐ YES ☒ NO 2. Has the patient been admitted from a care home/ institutional setting or another hospital? ☐ YES ☒ NO 3. Does the patient have a wound/ulcer or invasive device which was present prior to admission? ☐ YES ☒ NO If 'Yes' to any question or if the patient is within (or admitted to) a High Impact Speciality* complete section B. ['Not known' = 'No'] *Orthopaedics / Vascular / Renal / Critical Care [please circle] B: MRSA SWABS TAKEN (✓): Other(s) THROAT ✓ Nose ☒ Perineum ☒ Patient refused ☐	
			Seen at ortho assessment clinic	
			Consent available	
			MRSA screen, MRSA	
			ECG and bloods obtained	
28/3/12	17.15	5	MRSA - see MRSA - see	
			⑤ Patient admitted to the	
			ward - OB's stable - MEWSO	
			All relevant risk assessments	
			completed, Name band	
			given and checked	
			Medication Cardex	
			Completed by FY1	
29/3/12	0600		fasting from	
			midnight for	
			theatre today	
			Changed to 2nd	
			on LST	
	1035		Pt faint and prepared	
			for theatre	
29/3/12	1945		Returned to ward following right C6	
			C6/C7 discectomy and fusion under GA	
			cauda equina sensation satisfactory, MEWSO	
			CSM intact, Patient tolerating fluids. Apprehensive	
			to eat due to position of theatre wound	
			Site at front of throat. Able to swallow	
			pain medications. Requires soft collar to	
			be fitted prior to mobilising. Query whether	

Name: Brian McCaughlin

Ward: 2A

Date: 31/3/12

Case Record No.:

193

CARE PLAN EVALUATION

1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
31/3/12	1130	(1)	patient complaining of pain in lower back. tramadol given. later complaining of pain around shoulders. will monitor pain.	SN Bewendg
	1800		patient continues to complain of pain told can go home when comfortable. Analgesia given. Reviewed by Mr Sharma who feels it is muscular pain. patient has settled overnight. Pain remains an issue but controlled with discharge medications that the patient will have at home. Fully mobile and food & fluid tolerated without any problems. A/c home today. OPA requested.	SN Bewendg
1/4/12	0430		pt. continues to complain of pain. ignored can go home when comfortable. Dressings changed, clips to feet removed. Tegaderm applied. soft collar under mobile independently. pain settled after regular dose of analgesia. pt. requested if he can go tomorrow.	DM Mclellan
	1800		settled evening.	SN Bewendg
2/4/12	6am		Settled a sleep well overnight. No complaints offered. Home today as planned.	SN Bewendg
	10 ⁰⁰	(1)	Had shower independently.	SN Bewendg
		(2)	Good dietary intake.	SN Bewendg
		(3)	Poisy urine spontaneously.	SN Bewendg
		(4)	mobility independently.	SN Bewendg
		(5)	Wound dressing changed. Clips in situ. wound re-dressed with Tegaderm.	SN Bewendg
		(6)	patient discharged to home at 0930hrs. Practice nurse letter given for clips removal.	SN Bewendg

NORTH GLASGOW HOSPITALS

CLINICAL DIRECTORATE OF ANAESTHESIA THEATRES, ITU AND PAIN RELIEF SERVICES MULTI DISCIPLINARY CARE PLAN

194



Unit No.

Name:

Address:

DoB:

51132067E
MCLAUGHLIN
BRIAN 28/01/1960
222 BROUGHTON ROAD
GLASGOW G23 5LP
LANARKSHIRE
CHI-2601606030

Ward: 2A

Date: 29/3/12

Consultant Mr SHARMA

Theatre: 4

Proposed Operation: C5/6 + C6/7
Anterior Cervical ~~Discectomy~~
+ Fusion Rm8

PRE-OPERATIVE VISITS

Any Relevant Visits:

CHECK LIST

Please check the following before pre-med is given:

When did the patient last eat or drink

WARD 2A

RECEPTION

YES

YES

COMMENT / N.A.

TIME food - 6pm
fluid - 9pm

BM Stix?

NA

TIME

VALUE

Consent signed?



Identity band correct (Name, DoB
hospital no., ward no.)



Case notes (including current ECG
biochemistry, haematology), nursing
notes, drug Kardex, recording sheet)?



X-Rays available? see PACS



Operation site prepared - marked?



Dentures removed?

None



Prosthesis/Hearing aids, contact lenses removed? None



Make-up, nail varnish, jewellery
(taped/removed)?

None



Wearing black tied cotton gown,
disposable pants?



Pacemaker?

NO



Allergies? Penicillin

~~None~~



Have you passed urine this morning?

yes



Waterlow score noted

5



Pre-med given?



Signature K Devine (STIN) / My Ward 2A

Reception:

Correct patient received and documentation
complete?



Time into Reception

Signature

[Signature]

2.00

195

Patient identified in anaesthetic room?

YES

N/A

Time: 12.20

Signature: [Signature]

NAMED NURSE

[Signature]

MONITORING

ECG ☒
NIBP ☒
SaO₂ ☒
CO₂ ☒

IBP ☐

PULSE ☒

CVP

Core Temp.

Peripheral Temp.

Laryngeal Mask

Size: P.5

ET tube

Size: [Signature]

Throat Pack

Removed?

Yes ☐

No ☐

TORNIQUET

Time applied

Pressure

Time released

Site

DIATHERMY

Site [Signature]

BI-POLAR

Patient position on table: supine

Positioned as per policy?

Prevention of pressure sores?

Prevention of heat loss

Roller mattress?

Padding?

Warmed fluids?

IV Cannulation

Arterial Cannulation

CVP Line

METHOD OF ANAESTHESIA

General

Local

Epidural

Yes

Comment

☒

☒

☒

☐

☒

☒

Site

Site

Site

Regional

Spinal

Sedation

☐

☐

☐

Site

Site

[Signature]

[Signature]

Hand 166



S6769-003

2340434

Vascular "A" Set (Level 2)

form or damaged
 returned to us
 LOT#4405821

196



L11204-001

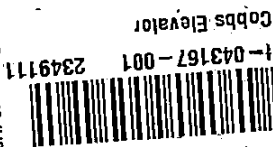
2349155

Mobi - C Cervical Disc (Load)

form or damaged
 returned to us

1266094-101

form or damaged
 returned to us



043167-001

2349111

Cobbs Elevator



S5651-001

2348503

Casper Vertebral Distraction (Meridian)



S5577-001

2254954

Anterior Cervical Set - SGH Neur



s2036-001

2347795

Micro Disc Set

form or damaged
 returned to us
 LOT#4405821



L11600-001

2349394

Titanium Black Belt Standard



s2193-006

2347914

Spinal TPS Micro Burrs Set

form or damaged
 returned to us



s2438-015

2346095

Osteotomes and Gouges



s2404-001

2287066

TPS Micro Drill / Burr Set



s2193-005

2348053

Spinal TPS Micro Burrs Set

form or damaged
 returned to us

200

00583

OPERATION

②

C4/5 Decomp

197

ANAESTHETIC POST-OP INSTRUCTIONS

O₂ Therapy

2

L/M

4%

Hours

Mask

Post-operative IV Fluid Regimen:

500ml N saline 5° x 2

Routine Observations:

Yes ☒

Special Instructions:

CVP ☐

Urine volumes ☐

CONTACT ON-CALL ANAES. IF PATIENT BECOMES
HOARSE OR DEVELOPS STRIDOR.

A-line out in recovery

Analgesia Prescribed

Yes ☒

N/A ☐

Does Anaesthetist wish to see patient
before return to ward?

Yes ☐

N/A ☒

BLOOD LOSS IN THEATRE ml

Anaesthetist's Signature

[Signature]

WOUND CARE

Skin Preparation

☒

Drain

☐

Catheter

☐

Staples

☒

Sutures

☒

Packing

☐

Dressing

☒

Wound toilet

☒

Specify:

Chlorhexidine + dme

skin closure

mepore, blue gauze
Saline

SURGICAL POST-OP INSTRUCTIONS

(198) Stg 2 CG/C7 ACDF

no intra-op problems

- Soft collar x 6/52, Chalkersay 2nd

- Home when safe

Surgeon's Signature

Time Into Recovery:

17.45

RECOVERY

NAMED NURSE

JN Cassidy

ET tube?

Yes ☒

N/A ☐

removed:

17.50

Laryngeal mask?

☐

☐

removed:

Airway?

☐

☐

removed:

MONITORING

ECG

☒

IVP

☐

RESPIRATION

☒

NIBP

☒

CVP

☐

1/4 observations

SaO₂

☒

PULSE

☒

X-rays Requested

Yes ☐

N/A ☐

Prevention of Pressure Sores

Waterlow score

☒

☐

Equipment?

☒

☐

Nursing action

☒

☐

Comments

Please observe

Waterlow increased
nursed on bed on knee
pressure relief given

CRITERIA TO BE MET BEFORE DISCHARGE FROM RECOVERY

Is the patient conscious and orientated to time and place?

☒

☐

Is patient cardiovascularly stable?

☒

☐

Is patient comfortable?

☒

☐

Are drains patent and is drainage within expected limits? Are wounds free from excessive staining?

☒

☐

Signature:

Alve Mid

EVENTS

199

- 18.45 A-line removed without incident. Clare Kidd.
- 19.00 IV paracetamol administered as per orders. Clare Kidd.
- 19.00 Patient reports pins/needles in (L) thumb & forefinger.
Clare Kidd.
- 19.10 Patient pins/needles relieved by repositioning of BP cuff. Clare Kidd.
- 19.20 500ml r/s commenced as per orders. Clare Kidd.
- 19.30 5mg Oxycodone administered as per orders.
Clare Kidd.

CONSENT FORM

201

PATIENT DETAILS (OR PRE-PRINTED LABEL)

Hospital/Clinic/GP Practice



51132067E
MCLAUGHLIN M
BRIAN 29/01/1960
222 BROUGHTON ROAD
GLASGOW
LANARKSHIRE G23 5LP
CHI-2801606030

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: H. Sharma

Job title: CONS. SPINE SURGEON

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)

C5/C6 & C6/C7 ANTERIOR
CERVICAL DISCECTOMY & FUSION
(60% IMPROVEMENT IN ARM PAIN)

- DURAL TEAR
- NERVE INJURY
- STROKE / - PARALYSIS / - DYSPHAGIA / - RESPIRATORY PROBLEMS / -
BLEEDING / HORNER'S SYNDROME / INFECTON / NON-UNION / IMPLANT
MIGRATION PROBLEMS / HOARSENESS / DISLODGE

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: H. Sharma

Name/Designation (Print) H. SHARMA / CONS. SPINE SURGEON

Date 10.1.2012

2023 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:-

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.

Agree Disagree

☐☐

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: Brian McLaughlin

Date 20/03/2012

Name (Print): Brian McLaughlin

Pre-operative marking Checklist for Surgery that can be performed on either side of the body

The operating surgeon should mark the intended site of operation prior to the patient leaving the ward area and before any pre-medication is given.

Affix label or com  Patient's name: 51132067E MCLAUGHLIN M Hospital No: BRIAN 28/01/1960 Date of Birth: 222 BROUGHTON ROAD GLASGOW LANARKSHIRE G23 5LP CHI-2801606030	Date of procedure: 29/3/12 Proposed procedure: C5/6 + C6/7 Anterior Cervical discectomy and fusion.
---	---

Check 1 - Ward

To be checked by ward staff before patient goes to theatre. left shoulder marked.

- Check the patient's identity - The mark is inspected and confirmed against the patient's supporting documentation. - Check reliable imaging will accompany the patient to theatre	Signed: K Devine (ST/N) AOH S/N Print name: KAREN DEVINE Ward: 2A Date: 29/03/12
---	---

Check 2 - Theatre/ Anaesthetic Room

To be checked by operating surgeon in the theatre department, prior to anaesthesia.

The mark is inspected and checked against the patient's supporting documentation	Signed: _____ Print name: _____
--	------------------------------------

Check 3 - Theatre Nurse

The senior theatre nurse must ensure that the surgical, anaesthetic and theatre team involved in the intended operative procedure pause prior to commencement of surgery to verbally confirm the following points:

- Presence of the correct patient - Marking of the correct site - Procedure to be performed	Signed: _____ Print name: _____
---	------------------------------------

If an error is identified during the pre-operative checks, the surgeon in charge should assess the situation, review documentation and either return the patient to the ward or note and sign a decision to proceed at risk in the box below.

Signed	Date
--------	------

Adult Peripheral Venous Cannulation (PVC) Chart

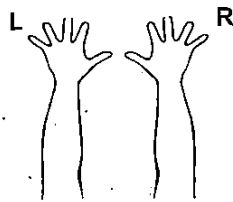
Please use 1 chart per PVC



204

PVC Insertion Information

Ensure the PVC dressing has date and time of insertion written on it. This implies that appropriate technique has been used for insertion.



Date: _____ (See IV Dressing)

Time: _____

Reason for Insertion: _____

Flushed on insertion ☐ (if known)

Other Site: _____

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 the surrounding tissue	3	Phlebitis / Thrombophlebitis Re-site Cannula & Seek Further Advice	
As above including: - palpable venous cord	4		
As above including: - pyrexia	5		

Day 1 (24 hours after insertion)

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

- Continuing clinical indication for PVC? Yes / No ☐
- VIP Score? ☐
- PVC Dressing dry & intact? Yes / No
- Was PVC dressing renewed? Yes / No / NA
- Was PVC Removed? Yes / No

Removal Reason: _____

Comments/Actions Taken: _____

Date: _____ Initials: _____

Day 2

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

- Continuing clinical indication for PVC? Yes / No ☐
- VIP Score? ☐
- PVC Dressing dry & intact? Yes / No
- Was PVC dressing renewed? Yes / No / NA
- Was PVC Removed? Yes / No

Removal Reason: _____

Comments/Actions Taken: _____

Date: _____ Initials: _____

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

Day 3

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

- Continuing clinical indication for PVC? Yes / No ☐
- VIP Score? ☐
- PVC Dressing dry & intact? Yes / No
- Was PVC dressing renewed? Yes / No / NA
- Was PVC Removed? Yes / No

Removal Reason: _____

Comments/Actions Taken: _____

Date: _____ Initials: _____

Day 4

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

- Continuing clinical indication for PVC? Yes / No ☐
- VIP Score? ☐
- PVC Dressing dry & intact? Yes / No
- Was PVC dressing renewed? Yes / No / NA
- Was PVC Removed? Yes / No

Removal Reason: _____

Comments/Actions Taken: _____

Date: _____ Initials: _____

205

GARTNAVEL WARD 2A

Cannard Falls Risk Assessment Pack

Patient name:		
Ward:	51132067E MCLAUGHLIN BRIAN 28/01/1960 222 BROUGHTON ROAD GLASGOW LANARKSHIRE G23 5LP CHI-2801606030	
CHI number:		Unit/Hospital number

Contents

1. Cannard 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.)

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

Handwritten notes:
 1. mini quiz
 2. rec - 100
 3. per - 100
 4. ben - 100
 5. at - 100
 6. mid - 100
 7. cu - 100
 8. 100 - 100
 9. 100 - 100
 10. 100 - 100

Handwritten notes:
 1. 15 min
 2. 30-40
 3. 60-120

Cannard Falls Risk Assessment

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

206

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 28/3 Ward: 2A	Date: 1/4 Ward: 2A	Date:	Date:	Date:	Date:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0	0				
Sex	Male 1	Female 2				1	1				
Age	13-59 0	60-70 1	71-80 2	81+ 1		0	0				
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0	0				
Medication type	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		0	0				
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0	0				
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound / wheel-chair 1		1	1				
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1	1				
TOTAL SCORE						3	3				
ACTION(S) TAKEN						1, 14, 23	1, 14, 23				
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	(Signature)	58				

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: 28/3 Ward: 2A	Date: 1/4 Ward: 2A	Date:	Date:	Date:	Date:
Action code:							
1	Falls prevention and general safety precautions discussed with patient and family.	1 ✓	✓				
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.	14 ✓	✓				
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. Nurse call buzzer at hand	23 ✓	✓				
Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment page above.							

207

208

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

WRITE; IMPRINT OR ATTACH LABEL

Surname

Forenames:

Dob

Location ..

1. The first group of variables is the set of variables that are used to explain the dependent variable. These variables are the independent variables in the regression model. The second group of variables is the set of variables that are used to explain the dependent variable. These variables are the independent variables in the regression model.

51132067E

MCLAUGHLIN

322 BRIGHTON ROAD

GLASGOW

LANARKSHIRE

28/01/1960

LOAD

G23 5LP

CHI-2801606030

More than one score/category can be used: 10+= 'At Risk': 15+= 'High Risk': 20+= 'Very High Risk'

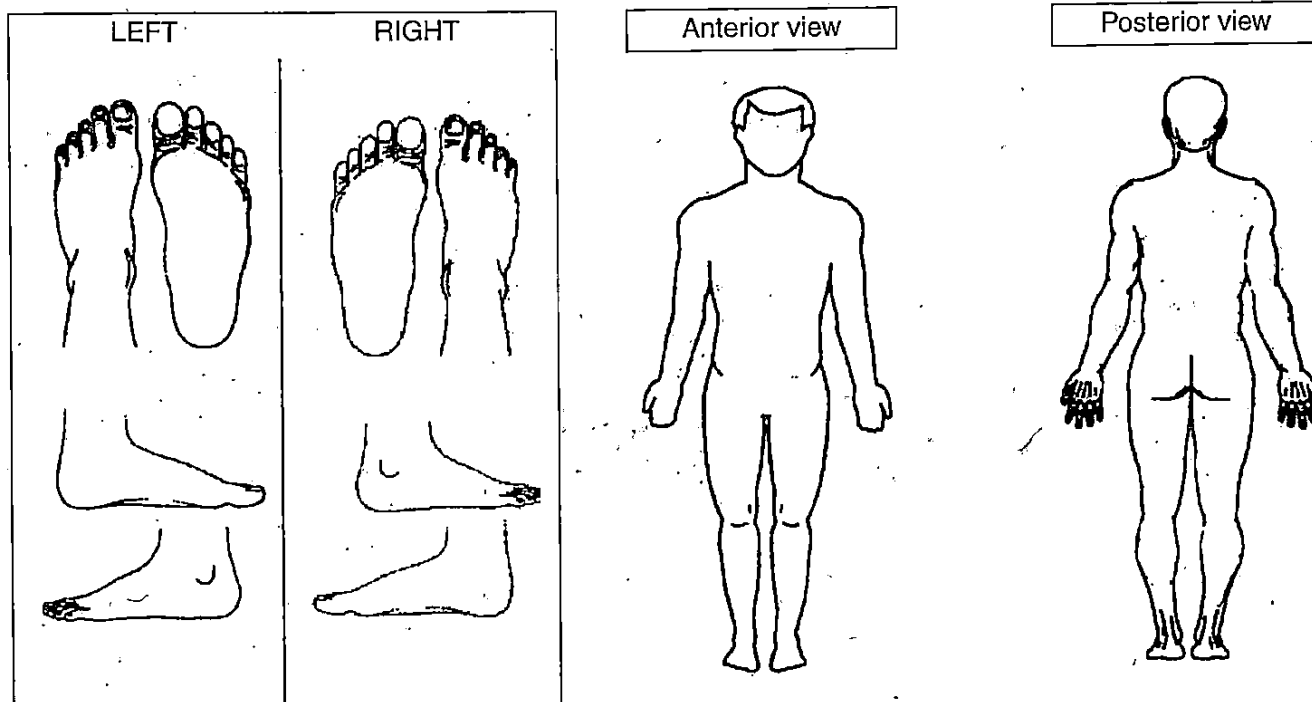
Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

[illegible]

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.



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.

Nutrition Profile

209

Name:		Date of admission: 28/3/12
Address:	 51132067E MCLAUGHLIN BRIAN 28/01/1960 M 222 BROUGHTON ROAD GLASGOW LANARKSHIRE G23 5LP CHI-2801606030	Time: 16.30 HOSPITAL: GARTNAVEL Ward: 2A
DoB:		
CHI number:		
Affix patient data label		

To be recorded within 24 hours of admission*

Height: 1.77 m Actual ☒ Patient/ carer reported ☐ Alternative measurement ☐

Weight: 116.8 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):

None

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): KARYNDREWINE(SD) Signature: K Drewine(SD) Date: 28/3/12

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

Malnutrition Universal Screening Tool ('MUST')

Date	28/3/14	(210)							
Initials	JD	08							
Height*(see page 1)	1.77 m.	Weight	116.8 kg	116.8					
Oedema or ascites present Y/N									
BMI	37.2	37.2							

'MUST'

Step 1: BMI Score (refer to chart on page 4)

>20 (>30 = Obese) 0
 18.5 - 20 1
 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 assistance is required at mealtimes (e.g. red mats, coloured napkins).
- 211

211

Referral Services

Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

Multidisciplinary Nutrition Care Plan

[illegible]

N.B. Ensure discharge plan includes most recent 'MUST' score and any necessary follow-up requirements.

212

Please Attach Patient Label CHI  Name <u>51132067E</u> MCLAUGHLIN BRIAN 28/01/1960 Address <u>222 BROUGHTON ROAD</u> GLASGOW LANARKSHIRE G23 5LP CHI-2801606030 Postcode _____	Drink / Type Wine 12% (175 ml glass) Wine 12% (750ml bottle) Beer/Lager 4.5% (440ml can/bottle) Beer/Lager 4.5% (500ml can/bottle) Spirtis 40% (25ml measure) Spirits 40% (1/4 bottle 175ml) Spirits 40% (700 ml bottle) Cider 4% (300ml glass) Cider 4% (1 litre bottle) Strong/White Cider 8% (300ml glass) Strong/White Cider 8% (1 litre bottle) Alcopops 5% (275ml bottle)	Units 2.1 Units 9.0 Units 2.0 Units 2.2 Units 1.0 Units 7.0 Units 28.0 Units 1.2 Units 4.0 Units 2.4 Units 8.0 Units 1.4 Units
--	--	---

Number of Units = ABV (%) x Volume (litres)

eg A bottle of wine (750mls) which is 12% ABV = $12 \times 0.75 = 9$ Units
 A glass of wine (200mls) which is 12% ABV = $12 \times 0.2 = 2.4$ 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 ☒ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

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

How often during the last year have you failed to do what was normally expected of you because of drinking?

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

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 ☒ Yes, on one occasion ☐ Yes, on more than one occasion ☐

Total

0

**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.

Patient Observation Chart

213

Name	 51132067E MCLAUGHLIN BRIAN 222 BROUGHTON ROAD GLASGOW LANARKSHIRE CHI-2801606030 28/01/1960 G23 5LP
Address	
Hospital No.	
DOB	

Admitted	Date _____	Ward _____
Transferred	Date _____	Ward _____
Transferred	Date _____	Ward _____

Patient Observation Chart Guidelines

Not all patients will require every part of this observation chart to be completed. Clinical judgement should be used to dictate the type and frequency of vital sign monitoring required.

The following patients are considered to be at high risk of developing a critical illness therefore it would be considered good practice to commence MEWS at the earliest opportunity.

- All emergency admissions
- Unstable patients
- Patients whose condition is causing concern
- Patients requiring frequent or increasing frequency of observations
- Patients who have stepped down from a higher level of care
- Patients with a chronic health problem
- Patients who are failing to progress
- Post-operative patients

There are also patients in whom the use of MEWS may be inappropriate:

- Day case patients
- Patients requiring no observations
- Patients who are terminally ill
- Planned discharges.

This is not an exhaustive list. Although the majority of patients may benefit from utilisation of the scoring system, a nurse's own clinical judgement dictates whether he/she feels the patient requires scoring. For guidance on the use of MEWS, refer to the Nurse in Charge.

Pain Score

Remember to check scores after pain relief.
Patient asked to report pain at rest and on movement.
0 = No pain at rest or on movement
1 = No pain at rest, slight pain on movement
2 = Intermittent pain at rest, moderate on movement
3 = Continuous pain at rest severe on movement
Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

Sedation Score

0 = Awake, alert, orientated
1 = Mild, aroused by verbal stimulus
2 = Moderate, aroused by physical stimulus
3 = Severe, no response
S = Normal sleep, easy to rouse
Score 2 or 3 requires immediate intervention

Nausea Score

0 = No nausea
1 = Mild (No treatment wanted)
2 = Moderate (Treatment required)
3 = Severe (Clinical problem persists despite treatment)
Review 1 hour after treatment. Inform doctor if additional treatment required.

29 29 29 29 30

214

**B
P** **^
v**

**a
n
d**

**P
u
l
s
e** **•**

NEWS

Score	3	2	1	0	1	2	3
Resp. Rate		≤8	9-10	11-20	21-25	26-30	≥31
Pulse		≤40	41-50	51-100	101-110	111-130	≥131
Systolic BP	≤84	85-89	90-100	101-199		>200	
GCS / AVPU	≤8	9-13	14 New agitation or confusion	15 / Alert	Voice	Pain	Unresponsive
Urine	<10mls/hr for 2 hrs	<30mls/hr for 2 hrs					
Temp. (°C)		≤35.0	35.1-35.9	36.0-37.4	37.5-38.5	≥38.6	
SpO ₂ %	≤87	88-91	92-94	95-100			

215

Abstract

Case Record:

Date of Birth:

Ward: 2A Consultant: SHARMA

1. Pain Score

2. Sedation Score

3. Nausea Score

4. See reverse for scoring details

[illegible]

1. Pain Score

REMEMBER TO CHECK SCORES AFTER PAIN RELIEF

Patient asked to report at rest and on movement.

- 0 = No pain at rest or on movement
- 1 = No pain at rest, slight pain on movement
- 2 = Intermittent pain. At rest, moderate on movement
- 3 = Continuous pain at rest, severe on movement

Review 10 mins after I/V, 1 hour after I/M or oral analgesia.

Sustained pain score of 2 or pain score of 3 requires intervention.

2. Sedation Score

- 0 = Awake, alert, oriented
- 1 = Mild, aroused by verbal stimulus
- 2 = Moderate, aroused by physical stimulus
- 3 = Severe, no response
- 5 = Normal sleep, easy to arouse

Score 2 or 3 requires intervention

3. Nausea Score

- 0 = No Nausea
- 1 = Mild (No Rx wanted)
- 2 = Moderate (Rx required)
- 3 = Severe (clinical problem persists despite Rx)

Review 1 hour after Rx. Inform doctor if additional Rx required.

Protocol of Nursing Care Monitoring Cauda Equina Syndrome

Record P = Present
 R = Reduced
 A = Absent

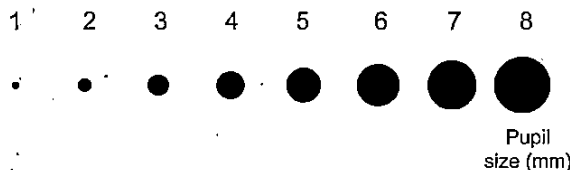
1. Assess Perianal sensation by ensuring the patient can feel the perianal region being touched.
2. Assess Bladder sensation by monitoring -
 - if the patient has passed urine
 - the nurse can palpate a possible bladder
 - if a catheter is in situ the patient can feel around the catheter area
3. Assess Bowel Control by asking the patient to contract the anal muscles (the anal wink sign) and that they can feel touch to the anus, if bowels have not moved.
4. Assess sensation to both feet and legs through touch.
5. Assess power to both feet by the patient pushing against resistance.

Report any Reduced or Absent observations to Medical Staff.

Neurological Observation Chart

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															
	M Best motor response	None	1															Usually record the best arm response
		Obeys	6															
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	
	L	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																
	LEGS	No response																
		Normal power																
		Mild weakness																
		Severe weakness																
		Extension																
	No response																	

Glasgow Coma Scale



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															
	M Best motor response	None	1															Usually record the best arm response
		Obeys	6															
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	
	L	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																
	LEGS	No response																
		Normal power																
		Mild weakness																
		Severe weakness																
		Extension																
	No response																	

Discharge Checklist

216

Patient's name:		Ward: 23	
Unit number:		Discharge destination: Home	
CHI number: 51132067E MCLAUGHLIN BRIAN CHI-2801606030		Estimated Discharge Date (1) / /	
		Estimated Discharge Date (2) / /	
		Final date of discharge: 02 / 04 / 14	
	Yes	N/A	Initials
Patient informed	☒		Ro
Relative/carer informed	☐		
Others informed: Care Home	☐		
Transport arranged			
Own transport (preferred option)	☒		Ro
Ambulance-1 man/ 2 man am/pm	☐		
Other: Flight, Air ambulance etc.	☐		
Discharge medication			
Discharge prescription completed	☒		Ro
Compliance aids e.g. Dosette Box (involve pharmacist)	☐		
Medication received	☒		Ro
Medication explained to patient and/or relative/carer	☒		Ro
Own medication returned to patient	☒		Ro
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	☒		Ro
Other discharge items			
Access arrangements (e.g. keys, door entry)	☐		
Patients clothing available for day of discharge	☐		
Valuables e.g. cash	☐		
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 6/02 Follow up Clinic	☒		Ro
If unknown at time of discharge state reason	☐		
Additional information / leaflets / factsheets	☐		
Time of Discharge: 0930			
Nurse's signature: Roxy	Designation: SN	Date: 02 / 04 / 14	

ADDRESSOGRAPH  51132067E MCLAUGHLIN BRIAN M 28/01/1960 222 BROUGHTON ROAD GLASGOW LANARKSHIRE G23 5LP CHI-2801606030		COUNTS PRE - OP SWAB COUNT CORRECT PRE - OP INSTRUMENT COUNT CORRECT FINAL SWAB COUNT CORRECT FINAL INSTRUMENT COUNT CORRECT FINAL SWAB DISPATCH COUNT CORRECT	Scrub Nurse(s) Print Name Lyon Lyon Lyon Lyon Lyon	Circulating Nurse(s) Signature & Print name S. Anderson S. Anderson S. Anderson S. Anderson S. Anderson
WARD 2B HOSP - GSH THEATRE - ME		SCRUB NURSE VERIFICATION - PLEASE SIGN ON PAGE UNDERNEATH. I have reviewed this count sheet and can verify my count(s) correct SCRUB NURSE 1- SIGNATURE - Paul Lyon SCRUB NURSE 2 SIGNATURE - To be signed by replacement scrub nurse if applicable		
HANDOVER COUNT IN EVENT OF REPLACEMENT OF SCRUB NURSE DURING PROCEDURE				
		Outgoing Scrub Nurse - Print Name	Incoming Scrub Nurse - Print Name	Circulating Nurse(s) Signature & Print name
OUTGOING COUNT To be completed for permanent and temporary replacement				
INCOMING COUNT To be completed for temporary replacement				
OPERATION 1st Anterior Cervical Discectomy and fusion C5/6				
TALLY OF EACH ITEM USED - ADD ANY ITEMS SPECIFIC TO YOUR SPECIALITY				
Swabs (2x2)	—	Tapes	—	ITEMS REMAINING IN SITU (Type & Number)
Swabs (10x10)	10	Sloops/Slings	—	
Abdominal packs	—	Bulldogs	—	
Sutures	3	Shods	—	
Blades	2	Tibbs Cannula	—	
IV needles	2	Ports	—	
Syringes	—	Staple Gun Inserts	—	
Discard-a-pad	1	Spears	—	
Diathermy pencil	1	Throat packs - Anae	—	
Diathermy tips	1	Throat packs - Scrub	—	
Scratch pad	—	Retrieval Bag (Bert)	—	
Reels	—	Digital Tourniquets	—	
Patties	—			
Pledgelets	—			
DISCREPANCY IN COUNT - ACTIONS AND OUTCOME				
COUNT IN WHICH DISCREPANCY OCCURRED				
DETAILS				
ACTIONS TAKEN AND OUTCOME (I.E. SWABS ISOLATED, SEARCH UNDERTAKEN, WOUND EXPLORED, X - RAY TAKEN) -				
SCRUB NURSES SIGNATURE IF COUNT STILL INCORRECT FOLLOWING ALL POSSIBLE ACTIONS				
SURGEONS SIGNATURE IF COUNT INCORRECT FOLLOWING ALL POSSIBLE ACTIONS				

Orthopaedic Assessment Clinic Checklist

TC
2/3

218



Name:

Address:

AD



H

51132067E

MCLAUGHLIN

BRIAN

Hospital No:

CHI-2801606030

DOB:

Booked in at

Admission desk:

Yes ☐

No ☐

Consultant

Sharma

Date

20.3.12

	YES	NO	COMMENTS	SIGNATURE
Nursing Doc. Completed	✓			
Med. Clerk-in completed	✓			
Consent signed	✓			
Pregnancy test		—		
Drug Kardex completed		—		
X-Ray available PACS				
X-ray: date sent				
ECG	✓			
Bloods sent	✓			
Blood results file - haematology	✓			
- biochemistry	✓			
Bacteriology	✓		MRSA mssu	

COMMENTS AND ACTIONS TAKEN ON ABNORMAL RESULTS	SIGNATURE
N 1 8- } -VE mssu - VE H 1.77 W 116.8 BMI 37.2	

MEDICINES RECONCILIATION			ONCE ONLY AND PREMEDICATION DRUGS							
Medicines Reconciled on Admission YES ☐			DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
Date _____ Name (Print) _____			29/3/12	DEXAMETHASONE	4mg	IV	2000	PALLEN JN		
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		Height:								
DOB:		Weight:								
	51132067E	Surface area:								
Date of	MCLAUGHLIN									
Consult	BRIAN	Ward:								
	CHI-2801606030									

		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																					
BEFORE ADMISSION ☐	NEW DOSE ☐	NEW MEDICATION ☐	A	DRUG			STOPPED													Patient's Own Medicine For Use Y/N	
				DOSE	ROUTE	DATE		DATE:													
				PRESCRIBER (PRINT & SIGN)				INITIALS:													
				ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																	
			Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time 																		
			B	DRUG			STOPPED													For Use Y/N	
				DOSE	ROUTE	DATE		DATE:													
				PRESCRIBER (PRINT & SIGN)				INITIALS:													
				ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																	
			Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time 																		
			C	DRUG			STOPPED													For Use Y/N	
				DOSE	ROUTE	DATE		DATE:													
				PRESCRIBER (PRINT & SIGN)				INITIALS:													
				ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																	
			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 →													Patient's Own Medicine	
				MONTH →														
BEFORE ADMISSION ☐	D	DRUG		DATE:	Other time													For Use Y/N
NEW DOSE ☐		DOSE	ROUTE	DATE	0700-0900													Qty:
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN)		DATE:	1200-1400													Date:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		INITIALS:	1600-1800													Assessed by:
					2200-2400													Ordered from Pharm.
				Other time														
BEFORE ADMISSION ☐	E	DRUG		DATE:	Other time													For Use Y/N
NEW DOSE ☐		DOSE	ROUTE	DATE	0700-0900													Qty:
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN)		DATE:	1200-1400													Date:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		INITIALS:	1600-1800													Assessed by:
					2200-2400													Ordered from Pharm.
				Other time														
BEFORE ADMISSION ☐	F	DRUG		DATE:	Other time													For Use Y/N
NEW DOSE ☐		DOSE	ROUTE	DATE	0700-0900													Qty:
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN)		DATE:	1200-1400													Date:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		INITIALS:	1600-1800													Assessed by:
					2200-2400													Ordered from Pharm.
				Other time														
BEFORE ADMISSION ☐	G	DRUG		DATE:	Other time													For Use Y/N
NEW DOSE ☐		DOSE	ROUTE	DATE	0700-0900													Qty:
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN)		DATE:	1200-1400													Date:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		INITIALS:	1600-1800													Assessed by:
					2200-2400													Ordered from Pharm.
				Other time														

The Proposed and its associated modified sections should be checked at each administration period to ensure that inadvertent omission, or double dating is avoided.

Oral and Other Drugs: Regular Prescription										DATE													Patient's Own Medicine
										MONTH													
BEFORE ADMISSION ☐	CC	DRUG								Other time													For Use Y/N
		DOSE		ROUTE	DATE	STOPPED DATE: INITIALS:	0700-0900													Qty:			
							1200-1400													Date:			
		PRESCRIBER (PRINT & SIGN)					1600-1800													Assessed by:			
		NEW DOSE ☐									2200-2400												
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY								Other time														
BEFORE ADMISSION ☐	DD	DRUG								Other time													For Use Y/N
		DOSE		ROUTE	DATE	STOPPED DATE: INITIALS:	0700-0900													Qty:			
							1200-1400													Date:			
		PRESCRIBER (PRINT & SIGN)					1600-1800													Assessed by:			
		NEW DOSE ☐									2200-2400												
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY								Other time														
BEFORE ADMISSION ☐	EE	DRUG								Other time													For Use Y/N
		DOSE		ROUTE	DATE	STOPPED DATE: INITIALS:	0700-0900													Qty:			
							1200-1400													Date:			
		PRESCRIBER (PRINT & SIGN)					1600-1800													Assessed by:			
		NEW DOSE ☐									2200-2400												
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY								Other time														
BEFORE ADMISSION ☐	FF	DRUG								Other time													For Use Y/N
		DOSE		ROUTE	DATE	STOPPED DATE: INITIALS:	0700-0900													Qty:			
							1200-1400													Date:			
		PRESCRIBER (PRINT & SIGN)					1600-1800													Assessed by:			
		NEW DOSE ☐									2200-2400												
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY								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													Patient's Own Medicine
				MONTH													
BEFORE ADMISSION ☐	GG	DRUG		Other time													For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	DATE	0700-0900													Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)		DATE:	1200-1400													Date:
			INITIALS:	1600-1800													Assessed by:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400													Ordered from Pharm.
				Other time													
BEFORE ADMISSION ☐	HH	DRUG		Other time													For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	DATE	0700-0900													Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)		DATE:	1200-1400													Date:
			INITIALS:	1600-1800													Assessed by:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400													Ordered from Pharm.
				Other time													
BEFORE ADMISSION ☐	JJ	DRUG		Other time													For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	DATE	0700-0900													Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)		DATE:	1200-1400													Date:
			INITIALS:	1600-1800													Assessed by:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400													Ordered from Pharm.
				Other time													
BEFORE ADMISSION ☐	KK	DRUG		Other time													For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	DATE	0700-0900													Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)		DATE:	1200-1400													Date:
			INITIALS:	1600-1800													Assessed by:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400													Ordered from Pharm.
				Other time													

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

All Routes: As Required Prescriptions

BEFORE ADMISSION ☐	LL	DRUG OXICODONE	DATE:
NEW DOSE ☐	DOSE 5mg	ROUTE o	INDICATION Pain
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) <i>[Signature]</i>		MAX.FREQ. p
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE	3/23/20	3/24/20	3/25/20	3/26/20	3/27/20	3/28/20	3/29/20	3/30/20	3/31/20	4/1/20	4/2/20	4/3/20	4/4/20	4/5/20	4/6/20	4/7/20	4/8/20	4/9/20	4/10/20	4/11/20	4/12/20	4/13/20	4/14/20	4/15/20	4/16/20	4/17/20	4/18/20	4/19/20	4/20/20	4/21/20	4/22/20	4/23/20	4/24/20	4/25/20	4/26/20	4/27/20	4/28/20	4/29/20	4/30/20	5/1/20	5/2/20	5/3/20	5/4/20	5/5/20	5/6/20	5/7/20	5/8/20	5/9/20	5/10/20	5/11/20	5/12/20	5/13/20	5/14/20	5/15/20	5/16/20	5/17/20	5/18/20	5/19/20	5/20/20	5/21/20	5/22/20	5/23/20	5/24/20	5/25/20	5/26/20	5/27/20	5/28/20	5/29/20	5/30/20	5/31/20	6/1/20	6/2/20	6/3/20	6/4/20	6/5/20	6/6/20	6/7/20	6/8/20	6/9/20	6/10/20	6/11/20	6/12/20	6/13/20	6/14/20	6/15/20	6/16/20	6/17/20	6/18/20	6/19/20	6/20/20	6/21/20	6/22/20	6/23/20	6/24/20	6/25/20	6/26/20	6/27/20	6/28/20	6/29/20	6/30/20	7/1/20	7/2/20	7/3/20	7/4/20	7/5/20	7/6/20	7/7/20	7/8/20	7/9/20	7/10/20	7/11/20	7/12/20	7/13/20	7/14/20	7/15/20	7/16/20	7/17/20	7/18/20	7/19/20	7/20/20	7/21/20	7/22/20	7/23/20	7/24/20	7/25/20	7/26/20	7/27/20	7/28/20	7/29/20	7/30/20	7/31/20	8/1/20	8/2/20	8/3/20	8/4/20	8/5/20	8/6/20	8/7/20	8/8/20	8/9/20	8/10/20	8/11/20	8/12/20	8/13/20	8/14/20	8/15/20	8/16/20	8/17/20	8/18/20	8/19/20	8/20/20	8/21/20	8/22/20	8/23/20	8/24/20	8/25/20	8/26/20	8/27/20	8/28/20	8/29/20	8/30/20	8/31/20	9/1/20	9/2/20	9/3/20	9/4/20	9/5/20	9/6/20	9/7/20	9/8/20	9/9/20	9/10/20	9/11/20	9/12/20	9/13/20	9/14/20	9/15/20	9/16/20	9/17/20	9/18/20	9/19/20	9/20/20	9/21/20	9/22/20	9/23/20	9/24/20	9/25/20	9/26/20	9/27/20	9/28/20	9/29/20	9/30/20	10/1/20	10/2/20	10/3/20	10/4/20	10/5/20	10/6/20	10/7/20	10/8/20	10/9/20	10/10/20	10/11/20	10/12/20	10/13/20	10/14/20	10/15/20	10/16/20	10/17/20	10/18/20	10/19/20	10/20/20	10/21/20	10/22/20	10/23/20	10/24/20	10/25/20	10/26/20	10/27/20	10/28/20	10/29/20	10/30/20	10/31/20	11/1/20	11/2/20	11/3/20	11/4/20	11/5/20	11/6/20	11/7/20	11/8/20	11/9/20	11/10/20	11/11/20	11/12/20	11/13/20	11/14/20	11/15/20	11/16/20	11/17/20	11/18/20	11/19/20	11/20/20	11/21/20	11/22/20	11/23/20	11/24/20	11/25/20	11/26/20	11/27/20	11/28/20	11/29/20	11/30/20	12/1/20	12/2/20	12/3/20	12/4/20	12/5/20	12/6/20	12/7/20	12/8/20	12/9/20	12/10/20	12/11/20	12/12/20	12/13/20	12/14/20	12/15/20	12/16/20	12/17/20	12/18/20	12/19/20	12/20/20	12/21/20	12/22/20	12/23/20	12/24/20	12/25/20	12/26/20	12/27/20	12/28/20	12/29/20	12/30/20	12/31/20																																																																																																																																																																																																																																																																																																																																																																																																																																									
TIME	19:30	20:00	20:30	21:00	21:30	22:00	22:30	23:00	23:30	24:00	24:30	25:00	25:30	26:00	26:30	27:00	27:30	28:00	28:30	29:00	29:30	30:00	30:30	31:00	31:30	32:00	32:30	33:00	33:30	34:00	34:30	35:00	35:30	36:00	36:30	37:00	37:30	38:00	38:30	39:00	39:30	40:00	40:30	41:00	41:30	42:00	42:30	43:00	43:30	44:00	44:30	45:00	45:30	46:00	46:30	47:00	47:30	48:00	48:30	49:00	49:30	50:00	50:30	51:00	51:30	52:00	52:30	53:00	53:30	54:00	54:30	55:00	55:30	56:00	56:30	57:00	57:30	58:00	58:30	59:00	59:30	60:00	60:30	61:00	61:30	62:00	62:30	63:00	63:30	64:00	64:30	65:00	65:30	66:00	66:30	67:00	67:30	68:00	68:30	69:00	69:30	70:00	70:30	71:00	71:30	72:00	72:30	73:00	73:30	74:00	74:30	75:00	75:30	76:00	76:30	77:00	77:30	78:00	78:30	79:00	79:30	80:00	80:30	81:00	81:30	82:00	82:30	83:00	83:30	84:00	84:30	85:00	85:30	86:00	86:30	87:00	87:30	88:00	88:30	89:00	89:30	90:00	90:30	91:00	91:30	92:00	92:30	93:00	93:30	94:00	94:30	95:00	95:30	96:00	96:30	97:00	97:30	98:00	98:30	99:00	99:30	100:00	100:30	101:00	101:30	102:00	102:30	103:00	103:30	104:00	104:30	105:00	105:30	106:00	106:30	107:00	107:30	108:00	108:30	109:00	109:30	110:00	110:30	111:00	111:30	112:00	112:30	113:00	113:30	114:00	114:30	115:00	115:30	116:00	116:30	117:00	117:30	118:00	118:30	119:00	119:30	120:00	120:30	121:00	121:30	122:00	122:30	123:00	123:30	124:00	124:30	125:00	125:30	126:00	126:30	127:00	127:30	128:00	128:30	129:00	129:30	130:00	130:30	131:00	131:30	132:00	132:30	133:00	133:30	134:00	134:30	135:00	135:30	136:00	136:30	137:00	137:30	138:00	138:30	139:00	139:30	140:00	140:30	141:00	141:30	142:00	142:30	143:00	143:30	144:00	144:30	145:00	145:30	146:00	146:30	147:00	147:30	148:00	148:30	149:00	149:30	150:00	150:30	151:00	151:30	152:00	152:30	153:00	153:30	154:00	154:30	155:00	155:30	156:00	156:30	157:00	157:30	158:00	158:30	159:00	159:30	160:00	160:30	161:00	161:30	162:00	162:30	163:00	163:30	164:00	164:30	165:00	165:30	166:00	166:30	167:00	167:30	168:00	168:30	169:00	169:30	170:00	170:30	171:00	171:30	172:00	172:30	173:00	173:30	174:00	174:30	175:00	175:30	176:00	176:30	177:00	177:30	178:00	178:30	179:00	179:30	180:00	180:30	181:00	181:30	182:00	182:30	183:00	183:30	184:00	184:30	185:00	185:30	186:00	186:30	187:00	187:30	188:00	188:30	189:00	189:30	190:00	190:30	191:00	191:30	192:00	192:30	193:00	193:30	194:00	194:30	195:00	195:30	196:00	196:30	197:00	197:30	198:00	198:30	199:00	199:30	200:00	200:30	201:00	201:30	202:00	202:30	203:00	203:30	204:00	204:30	205:00	205:30	206:00	206:30	207:00	207:30	208:00	208:30	209:00	209:30	210:00	210:30	211:00	211:30	212:00	212:30	213:00	213:30	214:00	214:30	215:00	215:30	216:00	216:30	217:00	217:30	218:00	218:30	219:00	219:30	220:00	220:30	221:00	221:30	222:00	222:30	223:00	223:30	224:00	224:30	225:00	225:30	226:00	226:30	227:00	227:30	228:00	228:30	229:00	229:30	230:00	230:30	231:00	231:30	232:00	232:30	233:00	233:30	234:00	234:30	235:00	235:30	236:00	236:30	237:00	237:30	238:00	238:30	239:00	239:30	240:00	240:30	241:00	241:30	242:00	242:30	243:00	243:30	244:00	244:30	245:00	245:30	246:00	246:30	247:00	247:30	248:00	248:30	249:00	249:30	250:00	250:30	251:00	251:30	252:00	252:30	253:00	253:30	254:00	254:30	255:00	255:30	256:00	256:30	257:00	257:30	258:00	258:30	259:00	259:30	260:00	260:30	261:00	261:30	262:00	262:30	263:00	263:30	264:00	264:30	265:00	265:30	266:00	266:30	267:00	267:30	268:00	268:30	269:00	269:30	270:00	270:30	271:00	271:30	272:00	272:30	273:00	273:30	274:00	274:30	275:00	275:30	276:00	276:30	277:00	277:30	278:00	278:30	279:00	279:30	280:00	280:30	281:00	281:30	282:00	282:30	283:00	283:30	284:00	284:30	285:00	285:30	286:00	286:30	287:00	287:30	288:00	288:30	289:00	289:30	290:00	290:30	291:00	291:30	292:00	292:30	293:00	293:30	294:00	294:30	295:00	295:30	296:00	296:30	297:00	297:30	298:00	298:30	299:00	299:30	300:00	300:30	301:00	301:30	302:00	302:30	303:00	303:30	304:00	304:30	305:00	305:30	306:00	306:30	307:00	307:30	308:00	308:30	309:00	309:30	310:00	310:30	311:00	311:30	312:00	312:30	313:00	313:30	314:00	314:30	315:00	315:30	316:00	316:30	317:00	317:30	318:00	318:30	319:00	319:30	320:00	320:30	321:00	321:30	322:00	322:30	323:00	323:30	324:00	324:30	325:00	325:30	326:00	326:30	327:00	327:30	328:00	328:30	329:00	329:30	330:00	330:30	331:00	331:30	332:00	332:30	333:00	333:30	334:00	334:30	335:00	335:30	336:00	336:30	337:00	337:30	338:00	338:30	339:00	339:30	340:00	340:30	341:00	341:30	342:00	342:30	343:00	343:30	344:00	344:30	345:00	345:30	346:00	346:30	347:00	347:30	348:00	348:30	349:00	349:30	350:00	350:30	351:00	351:30	352:00	352:30	353:00	353:30	354:00	354:30	355:00	355:30	356:00	356:30	357:00	357:30	358:00	358:30	359:00	359:30	360:00	360:30	361:00	361:30	362:00	362:30	363:00	363:30	364:00	364:30	365:00	365:30	366:00	366:30	367:00	367:30	368:00	368:30	369:00	369:30	370:00	370:30	371:00	371:30	372:00	372:30	373:00	373:30

RR DRUG				DATE:	DATE													Patient's Own Medicine
BEFORE ADMISSION	DOSE	ROUTE	INDICATION	STOPPED INITIALS:	TIME													For Use Y/N
NEW DOSE	PREScriBER (PRINT & SIGN)	MAX.FREQ.		DATE:	DOSE													Qty:
NEW MEDICATION	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			DATE:	GIVEN BY													Date:
☐																		Assessed by:
☐																		Ordered from Pharm.

SS DRUG				DATE:	DATE													For Use Y/N
BEFORE ADMISSION	DOSE	ROUTE	INDICATION	STOPPED INITIALS:	TIME													Qty:
NEW DOSE	PREScriBER (PRINT & SIGN)	MAX.FREQ.		DATE:	DOSE													Date:
NEW MEDICATION	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			DATE:	GIVEN BY													Assessed by:
☐																		Ordered from Pharm.

TT DRUG				DATE:	DATE													For Use Y/N
BEFORE ADMISSION	DOSE	ROUTE	INDICATION	STOPPED INITIALS:	TIME													Qty:
NEW DOSE	PREScriBER (PRINT & SIGN)	MAX.FREQ.		DATE:	DOSE													Date:
NEW MEDICATION	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			DATE:	GIVEN BY													Assessed by:
☐																		Ordered from Pharm.

VV DRUG				DATE:	DATE													For Use Y/N
BEFORE ADMISSION	DOSE	ROUTE	INDICATION	STOPPED INITIALS:	TIME													Qty:
NEW DOSE	PREScriBER (PRINT & SIGN)	MAX.FREQ.		DATE:	DOSE													Date:
NEW MEDICATION	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			DATE:	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 _____

CHI No _____

Drug Allergies / Sensitivities None Known ☐ Yes ☐ (provide details below)

GABAPENTIN-drach.

Notes for Users

FOR PRESCRIBERS:

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 ₂ = 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 = nasojejunosomy	PEJ = percutaneous endoscopic jejunostomy
TOP = topical	ETT = endotracheal
NEB = nebulised	INHAL = inhaled

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.

- 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

Patient Profile

224

Ward: L10SE Date: 26.4.03 Time: 13²⁰ (24hr clock)

Please print clearly in BLOCK CAPITALS

Title: _____
Name: _____
Preferred name: 1132067
Address: MCLAUGHLIN BRIAN
11U Latherton Drive M
GLASGOW 28/01/60
G20 8JR
G.P.Prac. 43311

☎: 0141 946 0499

DOB: _____ Age: 43

Hosp. No: _____

Occupation: unemployed

Religion: RC

S.O.S. ☐ date: ☐ ☐ ☐ ☐ ☐ ☐

Interpreter required: ☐

(specify: _____)

Lives alone ☐

1 NOK/Friend/Contact: Grace McLaughlin

Address: 11 Kirrihill Place

Maryhill Glasgow

☎ Day: 0141 946 1629

☎ Night: _____

Relationship: Mum

2 NOK/Friend/Contact: _____

Address: _____

☎ Day: _____

☎ Night: _____

Relationship: _____

NOK informed of admission ☒

NOK informed by: PT

GP: Dr McMillan Maryhill H/C

Address: _____

☎: _____

MEDICATION

With patient ☐

Stored & receipt given ☐

No medication required ☐

Taken home ☐

details: _____

PERSONAL BELONGINGS

Clothing listed ☐

Valuables listed ☐

Valuables in ward ☐

Valuables in hospital safe ☐

Consultant: Prof O'Dwyer

Named Nurse ①: Sr Renwick

Admitting Nurse: _____

Named Nurse ②: _____

Relatives seen by Doctor ☐

REASON FOR ADMISSION

Laparoscopic Colectomy

Patient's perception of illness: _____

Good understanding

Diagnosis: _____

Operation/Treatment: _____

Lap. chol. 29.4.03

Relevant PMH: Ruptured Pancreas

Dec 02 Pulmonary Embolism

Dec 02

OBSERVATIONS ON ADMISSION

Temperature 36.2 °C

Pulse 89 bpm

BP 154 / 95

Resp SpO2 96

Pain Score _____

Urinalysis _____

Waterlow Score _____

Height _____ m

Weight 110 kg

Body Mass Index _____

Blood sugar(if appropriate) _____ mmols

Allergies Yes ☐ No ☒

details: _____

DISCHARGE PLANNING

Boarding	1st	2nd	3rd	Signature	Time	Comments/Information
Informed:						225
ward	☐	☐	☐			
patient	☐	☐	☐			
relatives	☐	☐	☐			
Date patient boarded:						
1st:	☐	☐	☐			
2nd:	☐	☐	☐			
3rd:	☐	☐	☐			
Internal Transfers						
Transfer destination:						
Planned transfer date:						
Medical consent	☐					
Arranged with receiving area	☐					
Patient informed	☐					
NOK/Contact informed	☐					
Transport: stretcher	☐					
2 hand seat	☐					
chair	☐					
Es	☐					
Case notes	☐					
X-rays	☐					
Nursing notes & Drug Form	☐					
Property/Valuables listed	☐					
Catering	☐					
Dietitian	☐					
Physiotherapy	☐					
Occupational Therapist	☐					
Speech and Language Therapist	☐					
Discharge Checklist						
Planned discharge date:						
Medical consent	☒					
Date discussed with patient:						
Date discussed with NOK/Contact:						
Transport: own	☒					
ambulance	☐					
Ambulance ordered on:						
• type:						
• order no.:						
District nurse ☐ /Liaison nurse ☐						
Home help:	☐					
Social work dept.	☐					
Discharge prescription	☒					
Discharge dressings	☐					
Patient information	☐					
Valuables/Cashier	☐					
Physiotherapy	☐					
Speech and Language Therapist	☐					
Out patient appointment	☒					
Other:						

ACTIVITIES OF DAILY LIVING

HOME CIRCUMSTANCES/ SOCIAL SUPPORT

- Lives with family ☐
- Lives alone ☒
- Nursing home ☐
- Residential care ☐
- Elderly/disabled partner ☐
- Family support (specify below) ☐
- District Nurse (____ days/week) ☐
- (cancelled ☐)
- Home help (____ days/week) ☐
- (cancelled ☐)
- Other services (specify below) ☐

Stairs: Internal ☒ External ☒

Comments: _____

NUTRITION

- Normal menu (includes vegetarian) ☒
- Vegan ☐ Child's menu ☐
- Halal ☐ Kosher ☐
- Refer to Dietician if any below ticked:
- Inability to eat/swallow ☐
- (refer to speech and language therapist)
- Any recent weight changes ☐
- Medically related nutrition problems (e.g. diabetes) ☐
- Other (specify): _____

BREATHING

1. No symptoms ☒
2. Breathless with moderate exercise ☐
3. Breathless with minimal exertion ☐
4. Breathless at rest ☐
5. Uses inhalers ☐
- Comments: _____

SMOKING

- Non-smoker ☒
- Smoker: 226 per day ☐
- Ex-smoker ☐
- Aware of hospital policy ☐

HYGIENE

- Bath ☐ Shower ☒
- Requires assistance ☐ Stand up wash ☐
- Skin assessment: _____
- Other: _____

ELIMINATION

- Bowels regular ☒
- Constipated ☐
- Diarrhoea/Loose stools ☒
- Uses aperient ☐
- Has stoma:
- Colostomy ☐
 - Urostomy ☐
 - Ileostomy ☐
- appliances used: _____

- Frequency of micturition ☐
- Incontinent: urine/faeces ☐
- day/night ☐
- stress ☐
- No urinary symptoms ☒
- Comments: _____

SLEEP

- Hours/night 6 ☐
- Medication ☐
- details: _____

MENTAL STATE

- Alert/Orientated ☒
- Confused: day/night ☐
- Anxious/Distressed ☐
- Unconscious ☐
- Other (specify): _____

SENSES

Glasses:	distance	☐
	reading	☐
Hearing impaired:	left/right	☐
Hearing aid:	left/right	☐
Dentures:	upper	☐
	lower	☐
Communication Difficulties		☐
Other: _____		☐

MOBILITY (Pre admission)

Mobile without aid	☐
Mobile with aid	☐
(Specify type/side held: _____)	
Furniture walking	☐
Chair Bound	☐
Housebound	☐

RELATIVE PARTICIPATION

[illegible]**PROFILE COMPLETED BY:**

(Please print name in block capitals)

Signature: Lesley Stewart
Designation: Agency Nurse
Countersigned (if applicable): _____

ALCOHOL INTAKE

its/week:	nil	☐
	less than 14	☐
	14 - 21	☒
	over 21-	☐

(1 unit = 1 measure spirits/half pint beer/
lager/1 glass wine)

OTHER RELEVANT INFORMATION

[illegible]

Name: Brian McNaughton

Ward: ~~L10~~ E Date: 26.4.03

Case Record No.: 1132067

CARE PLAN

228

[illegible]

Name: Brian McLaughlin

Ward: L10

230

Date: 26.4.03

Case Record No.: 1132067

CARE PLAN EVALUATION

1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
26.4.03	12.40		Admitted today for conversion from warfarin to heparin prior to cholecystectomy (laparoscopic). Observations satisfactory. Given first dose of Dalteparin as stopped warfarin 24.4.03	L Stewart
	1900		Settled Day. No complaints	Agency Nurse
27/4/03	0545		Slept well	K McKeown
	1800		Settled day. No complaints	K Dwyer
			Independent to care	O Regan
28/4/03	0600		Slept very little due to other patient in the room snoring very loudly. Moved to another room for peace and quiet.	K Dwyer
	1545		2nd on Thromb 1st tomorrow. Warfarin stopped on Friday 18.000 BD	Lwl
	1900		11m 8am. First 12mn. Patient now on Enoxaparin 40mg BD	
29/4/03	0450	9	Settled night.	
		2	Fasted from 12 midnight. Pre-med due 8am	Seane
	12.30		patient returned to ward following laparoscopic cholecystectomy. vomited on return to ward. 4mg ondansetron given prior to return. nausea appears to have settled.	
		5.	observations satisfactory BP-154/78. Rise-96, SaO ₂ -93% on air.	
		2.	tolerating oral fluids. 4mg morphine given in recovery no complaints at present.	KCB
	1900	6	10 20pm given for nausea now drinking	
			10. disc after 2500mls	

231

EVALUATION OF CARE

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
29/4/03			bags / N/saline	
		5	BP now within normal limits	
			had ↓ 90/50	
		7	Pressure bandage to (R)	
			Laparoscopic wound owing	
			to persistent ooze	
		3	N PU	UHL
	1945		Hold warfarin tonight	
			restart tomorrow	UHL
	2315	3	Has p'ud post-op	
		7	Pressure dressing intact to wound	UHL
			IV antibiotics given as prescribed.	
			c/o pain in (L) shoulder -	
			2 observations satisfactory.	
			JHO contacted - 2 subphrenic	
			nerve pain.	
	0115		Pain ↑ c/o tramadol 100mg	
			PRN. Sats 92% on air - O2	
			therapy 2L recommenced.	
	0135		Patient found in toilet on	
			floor - was feeling light headed,	
			nauseated + hot - does not recall	
			what happened.	
			Does not appear to be hurt	
			BP 92/58, sats 92%, pulse 107.	
			Apyrexial.	
			JHO contacted, will come and review.	Stone
	0230		Seen by JHO - BP ↑ 100/60	
			Probably fainted please	
			observe.	
	0430		Vomitted	
			and wound leaking.	
			Wound redressed and	
			pressure dressing	
			reapplied.	
			Patient says he now feels	
			better.	
	0600		Care as planned	
		9	Slept for short spells	
		3	HPN post op	
		5	Cardiovascular observations	
			stable. BP	
		6	IVI continues 4° IVAB's	
		7	Wound satisfactory	UHL
	0700		Wound oozing + + +.	

Name: Brian
McLaughlin

Ward: L106

Date: 30.4.03

Case Record No.

232

CARE PLAN EVALUATION

1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
			Pressure dressing applied, coming from top (R) lap. site - please observe. BP 115/60. Pulse 90. Sats - 94% Vomitted small amount bile - feeling very nauseated. Zofran 4mg given IV SIB Mr. Young. A bit nauseated at times. IV continued till eating + drinking well. Wound had lignocaine injected into a small baking site. Settled + no further staining. BP a bit low please observe. Recommended warfarin 3mg stept for long periods. ⑦ wound satisfactory ⑤ Hypotensive last night severe. Hypotensive and tachycardic 10 bag fluid given. BP now 104/61; sats 87% on air - 4L O2 recommenced. ⑦ Slept for long periods. ⑦ wound satisfactory. ⑤ observations IVI continues 40. Please confirm with medical staff that IV abs can be discontinued BP 92/62 - advised to stay in bed. Set desaturating on air advised to keep O2 on. 1.5.03 16.05 1 independent with basic care and hygiene. 2. taking fluids, not yet tolerating diet. 3. passing urine. 4. independently mobile	VBrown. VBrown DSeagar Seane Seane

234

EVALUATION OF CARE

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
		5.	Observations satisfactory. SeO_2 - 96% on air.	
		6	IV fluids discontinued IV antibiotics given as prescribed. attended for chest X-ray and repeat ECG - ? chest infection seen by physio. no complaints offered.	K.Celt
2.5.03	6am		Care as planned	
		9	Slept well.	
		5	Observations satisfactory	
		7	Wound satisfactory	L.Brow
		1	Settled day. All care evaluated + given.	
			To remain in hospital today.	
		6	To continue on Warfarin	
		2	Fluids + diet	
		4	up mobilising for units blood 3hly overnight	OTep
	19 ¹⁵		Temp 38 blood stopped	
			2 Paracetamol given	
	19 ⁴⁵		When temp comes down it commence blood	RT
			Warfarin withheld tonight	
	23 ⁰⁰		remained pyrexial at 38°C, blood transfusion suspended until tomorrow morning.	K.D. Roberts
3/5/03	05 ⁰⁰		Slept well.	K.D. Roberts
	06 ⁰⁰		Urine cloudy - Trace protein	
			MSU obtained for CxS.	K.D. Roberts
	07 ³⁵		Temp remains at 37.8°C this am.	K.D. Roberts
	13 ⁰⁰	1	Settled day. All care evaluated + given	
		5	Temp remains 37.5.	
		4	Blood transfusion recommended for 3 units	
			Discontinue only if temp $\geq 39^\circ$	
		10	2 Paracetamol given	RTep
	22 ⁰⁰		Temp 37.5.	
	12 ⁰⁰		Temp 37.2. Blood transfusion complete	Cross

Name: Brian McLaughlin Ward:

Ward:

Date:

235

Case Record No.:

CARE PLAN EVALUATION

1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
4-5-03	06 ⁰⁰		Slept well.	
			Version remains intact.	Glass
	13 ⁰⁰	(2)	fluids + diet	
		(3)	obs stable - approxid	
		(11)	SIB Miss Chindam to commence on warfarin this evening	Heem
	18 ⁰⁰	(6)	3mg warfarin given at 6pm	
		(5)	obs stable	Heem
5/5/03	06 ⁰⁰		slept well	
			obs stable.	Glass
	13 ⁰⁰	1.	Independent shower	
		2.	fluids + diet	
		3.	obs stable.	
			SIB nr Muir - if INR stable today for discharge home later.	Robert
	14 ⁰⁰		INR note stable enough for discharge.	Robert
	19 ⁰⁰		5mg warfarin given.	Robert
6/5/03	10 ⁰⁰ - 9am	(9)	bedtime sleep well.	R. H. G.
		(11)	SIB medical staff for discharge home today on 3mg warfarin. To return on Friday to ward to have INR checked.	Heem

PRESCRIPTION FORM

Hospital Name:

PATIENT DETAILS			ONCE ONLY AND PREMEDICATION DRUGS							
			DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF DOCTOR	GIVEN BY	TIME GIVEN
1132067 MCLAUGHLIN BRIAN 11U Latherton Drive M GLASGOW 28/01/60 G20 8JR Date of Admission: 1/1/			26/4/3	DALTEPARIN	18000 IV	s/c	1pm	[Signature]	LWL	1315
igh: _____ igh: _____ face area: _____ e of writing discharge _____ prescription: 1/1			29/4/3	76mg 6PM metoclopramide	30mg	po	6PM	[Signature]	[Signature]	0810
Consultant Name: O'DWYER Ward: 10E			30/4/3	METACLOPRAMIDE	10mg	IV			GR	11.30
Date and time this form prepared: 26/4/3 Time: _____ Sheet No: _____ 2nd Prescription in use: _____ Yes or NO: _____			25/03	PARACETAMOL	1g	o	1945		GR	1945
			31/5/3	PARACETAMOL	1g	o	205		GR	1205
			3/5	paracetamol	1g	po	2200		GR	2200
DVT Risk on Admission (SIGN Guideline) High ☐ Moderate ☐ Low ☐ Assessed by: _____ Date: 1/1/										
OTHER CHARTS IN USE Insulin ☐ TPN: ☐ PCA and other infusions ☐ Enteral Nutrition: ☐ Anticoagulants: Heparin ☐ Other: ☐ Oral ☐ Topical: ☐										

836

ADMINISTRATION

DATE	26	27	28	29	30	1	2
MONTH	4	4	4	4	4	5	5

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

FOR DOCTORS USE ONLY.

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

FOR DOCTORS USE ONLY

Other time ☐

8700-0900 ☒

1200-1400 ☒

1600-1800 ☐

2200-2400 ☒

Other time ☐

FOR DOCTORS USE ONLY

Other time
<u>0700-0900</u>
<u>1200-1400</u>
1600-1800
<u>2200-2400</u>
Other time

~~_____~~ FOR DOCTORS USE ONLY

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

Parenteral Drugs: Regular Prescription				DATE	
				MONTH	
E	DRUG			Other time	
				0700-0900	
	DOSE	ROUTE	DATE	1200-1400	
	SIGNATURE OF DOCTOR			1600-1800	
				2200-2400	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time	
FOR DOCTORS USE ONLY					
F	DRUG			Other time	
				0700-0900	
	DOSE	ROUTE	DATE	1200-1400	
	SIGNATURE OF DOCTOR			1600-1800	
				2200-2400	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time	
FOR DOCTORS USE ONLY					
G	DRUG			Other time	
				0700-0900	
	DOSE	ROUTE	DATE	1200-1400	
	SIGNATURE OF DOCTOR			1600-1800	
				2200-2400	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time	
FOR DOCTORS USE ONLY					
H	DRUG			Other time	
				0700-0900	
	DOSE	ROUTE	DATE	1200-1400	
	SIGNATURE OF DOCTOR			1600-1800	
				2200-2400	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time	
FOR DOCTORS USE ONLY					

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

ADMINISTRATION

FOR DOCTORS USE ONLY					
M	DRUG				Other time
DOSE		ROUTE	DATE		0700-0900
SIGNATURE OF DOCTOR		STOPPED INITIALS:			1200-1400
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					1600-1800
					2200-2400
					Other time

[illegible]

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: INITIALS:	Other time																											
						0700-0900																											
						1200-1400																											
						1600-1800																											
						2200-2400																											
SIGNATURE OF DOCTOR					Other time																												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																																	

FOR DOCTORS USE ONLY

V	DRUG	DOSE	ROUTE	DATE	STOPPED DATE: INITIALS:	Other time																											
						0700-0900																											
						1200-1400																											
						1600-1800																											
						2200-2400																											
SIGNATURE OF DOCTOR					Other time																												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																																	

FOR DOCTORS USE ONLY

W	DRUG	DOSE	ROUTE	DATE	STOPPED DATE: INITIALS:	Other time																											
						0700-0900																											
						1200-1400																											
						1600-1800																											
						2200-2400																											
SIGNATURE OF DOCTOR					Other time																												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																																	

FOR DOCTORS USE ONLY

X	DRUG	DOSE	ROUTE	DATE	STOPPED DATE: INITIALS:	Other time																											
						0700-0900																											
						1200-1400																											
						1600-1800																											
						2200-2400																											
SIGNATURE OF DOCTOR					Other time																												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																																	

FOR DOCTORS USE ONLY

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

Oral and Other Drugs: Regular Prescriptions				DATE																								
				MONTH																								
Y	DRUG			Other time																								
	DOSE	ROUTE	DATE	0700-0900																								
	SIGNATURE OF DOCTOR			1200-1400																								
				1600-1800																								
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400																								
Other time																												
FOR DOCTORS USE ONLY																												
AA	DRUG			Other time																								
	DOSE	ROUTE	DATE	0700-0900																								
	SIGNATURE OF DOCTOR			1200-1400																								
				1600-1800																								
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400																								
Other time																												
FOR DOCTORS USE ONLY																												
BB	DRUG			Other time																								
	DOSE	ROUTE	DATE	0700-0900																								
	SIGNATURE OF DOCTOR			1200-1400																								
				1600-1800																								
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400																								
Other time																												
FOR DOCTORS USE ONLY																												
CC	DRUG			Other time																								
	DOSE	ROUTE	DATE	0700-0900																								
	SIGNATURE OF DOCTOR			1200-1400																								
				1600-1800																								
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400																								
Other time																												
FOR DOCTORS USE ONLY																												

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE

MONTH

DD

DRUG

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

DOSE

ROUTE

DATE

DATE:

SIGNATURE OF DOCTOR

INITIALS:

STOPPED

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

EE

DRUG

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

DOSE

ROUTE

DATE

DATE:

SIGNATURE OF DOCTOR

INITIALS:

STOPPED

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

FF

DRUG

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

DOSE

ROUTE

DATE

DATE:

SIGNATURE OF DOCTOR

INITIALS:

STOPPED

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

GG

DRUG

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

DOSE

ROUTE

DATE

DATE:

SIGNATURE OF DOCTOR

INITIALS:

STOPPED

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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

Oral and Other Drugs: Regular Prescriptions				DATE												
				MONTH												
HH	DRUG			Other time												
				0700-0900												
				1200-1400												
				1600-1800												
				2200-2400												
DOSE ROUTE DATE				DATE:												
SIGNATURE OF DOCTOR				INITIALS:												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time												
FOR DOCTORS USE ONLY																
JJ	DRUG			Other time												
				0700-0900												
				1200-1400												
				1600-1800												
				2200-2400												
DOSE ROUTE DATE				DATE:												
SIGNATURE OF DOCTOR				INITIALS:												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time												
FOR DOCTORS USE ONLY																
KK	DRUG			Other time												
				0700-0900												
				1200-1400												
				1600-1800												
				2200-2400												
DOSE ROUTE DATE				DATE:												
SIGNATURE OF DOCTOR				INITIALS:												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time												
FOR DOCTORS USE ONLY																
LL	DRUG			Other time												
				0700-0900												
				1200-1400												
				1600-1800												
				2200-2400												
DOSE ROUTE DATE				DATE:												
SIGNATURE OF DOCTOR				INITIALS:												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time												
FOR DOCTORS USE ONLY																

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

PATIENT'S NAME:			ADMINISTRATION											
All Routes: As Required Prescriptions														
MM	DRUG MORPHINE (1-2mg increments)	DOSE 1/2 to 2mg	ROUTE N	INDICATION PAIN	STOPPED INITIALS:	DATE:	29/4	29/4						
						TIME:	22	37						
						DOSE:	2mg	2mg						
						GIVEN BY:	GC	GC						
SIGNATURE OF DOCTOR [Signature]						DATE:	29/4							
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY														
NN	DRUG CO-CODINOL	DOSE 2 tabs	ROUTE PO	INDICATION PAIN	STOPPED INITIALS:	DATE:	29/4							
						TIME:	2300							
						DOSE:	2 tabs							
						GIVEN BY:	GC							
SIGNATURE OF DOCTOR [Signature]						DATE:	29/4							
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY														
PP	DRUG ENDORSERAL	DOSE 4mg	ROUTE IV	INDICATION PAIN	STOPPED INITIALS:	DATE:	29/4	29/4	30/4	30/4				
						TIME:	12	35	0700	0730				
						DOSE:	4mg	4mg	4mg	4mg				
						GIVEN BY:	GC	W	GC	W				
SIGNATURE OF DOCTOR [Signature]						DATE:	29/4							
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY														
RR	DRUG TRAMADOL	DOSE 50-100mg	ROUTE PO	INDICATION PAIN	STOPPED INITIALS:	DATE:	30/4	30/4	30/4	30/4	30/4	30/4	30/4	30/4
						TIME:	0125	0900	1100	2200	2300	2200	2200	2200
						DOSE:	100	100	100	100	100	100	100	100
						GIVEN BY:	GC	GC	GC	GC	GC	GC	GC	GC
SIGNATURE OF DOCTOR [Signature]						DATE:	30/4							
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.

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

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

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

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

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

Notes for Users

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

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

Signature: _____ Date: _____

[illegible]

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

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

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

5. Method of administration should be abbreviated as follows:

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

FOR NURSES:

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

Codes for Non-Administration of Drugs

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

Name	Case Record No.
BRIAN McLAUGHLIN	Age
	Sex
	Dept.
Consultant	O'DWYER
	10E

The 'added drugs' should be prescribed in the patient's main prescription sheet, cross referenced by annotating the "other prescription sheets in use" section

040

[illegible]

West Glasgow Hospital

N.B. If using a Syringe Driver/Infusion Pump Please Use The 'Prescription And Administration Sheet For Medicines Given By Syringe Driver/Infusion Pump'

Name	Case Record No.
BRYAN McHAUGHIN	Age
	Sex
	Dept.
Consultant	

PARENTERAL FLUID PRESCRIPTION SHEET

The 'added drugs' should be prescribed in the patient's main prescription sheet, cross referenced by annotating the "other prescription sheets in use" section.

2
171

Date	FLUID	Volume (mls)	Time to Run	Rate mls/hr	ADDED DRUGS	Quantity	Doctor's Signature	Added by	Start Time (24 hr clock)	Put up	Checked by	Serial/ Batch No
29/4/03	(N) SALINE	500	1°				ma le		14.45	KCL		
29/4/03	(N) SALINE	500	4°				ma le		1600	LW		
	(N) SALINE	500	4°				K. McHughin		0230	LB		
	(N) SALINE	500	4°				ma le		0730	LB		
30/4/03	5% DEXTROSE	500	12°				ma le		1030	LB		
	5% DEXTROSE	500	28°				ma le		1145	LB		
	(N) SALINE	500	4°				ma le		1400	LB		
30/4/03	0.9% SALINE	500	1°				84		2210	KZ		
30/4/03	0.9% SALINE	500	4°				84		0105	KZ		
30/4/03	5% dextrose	500	4°				84		0530	LB		
30/4/03	0.9% SALINE	500	4°				84					

West Glasgow Hospital

24 Hour Fluid Balance Chart

25/03

Name: <u>Brian McLaughlin</u>		Case Record No:		Ward: <u>UOE</u>		Date: <u>25/03</u>									
TIME HRS (Please delete 1 column)	INPUT (mls)								IN	OUTPUT (mls)					OUT
	ORAL	NASO GASTRIC TPN	BLOOD COLLOID PLASMA	IV (1) /	TYPE	IV (2)	IV (3) Drugs	Hourly Total	Cumulative Total	URINE	URINE Cumulative Total	Gastric Aspirate / Vomit	Drain 1	Hourly Total	Cumulative Total
08															
09															
10															
11															
12															
13															
14															
15															
16															
17															
18															
19															
20									270	150					
21									370	250					
22		200						200	570	200					600
23															
24								250	820						
01								100	920						
02															
03															
04															
05															
06															
07															
TOTALS															
TOTAL IN MLS									BALANCE		TOTAL OUT MLS				

West Glasgow Hospital

24 Hour Fluid Balance Chart

243

Name: Brian McLaughlin		Case Record No.:								Ward: L10E		Date: 1/5/13				
INPUT (mls)									IN	OUTPUT (mls)					OUT	
TIME HRS (Please delete 1 column)	ORAL	NASO GASTRIC TPN	BLOOD COLLOID PLASMA	IV (1) /	TYPE	IV (2)	IV (3) Drugs	Hourly Total	Cumulative Total	URINE	URINE Cumulative Total	Gastric Aspirate / Vomit	Drain 1		Hourly Total	Cumulative Total
08 24	100							100								
09 01	150							150		Pud in toilet						
10 02																
11 03									430							
12 04																
13 05	200															
14 06																
15 06									650	Pud in toilet						
16 07	200				p/cells			300	1150							
17 08									850							
18 09	200								1350	Pud in toilet						
19 10									1620							
20 11					p/cells			210	1850							
21 12	200								1050							
22 13	200							200	1250							
23 14									11							
24 15									2020							
01 16																
02 17																
03 18																
04 19																
05 20																
06 22																
07 23																
TOTALS																
TOTAL IN MLS										BALANCE				TOTAL OUT MLS		

West Glasgow Hospital

24 Hour Fluid Balance Chart

22
44

Name: BRIAN McLAUGHLIN

Case Record No:

Ward: L10E

Date: 30.4.07

		INPUT (mls)							IN	OUTPUT (mls)						OUT			
TIME HRS (Please delete 1. column)		ORAL	NASO GASTRIC TPN	BLOOD COLLOID PLASMA	IV (1) /	TYPE	IV (2)	IV (3) Drugs	Hourly Total	Cumulative Total	URINE	URINE Cumulative Total	Gastric Aspirate / Vomit	Drain 1		Hourly Total	Cumulative Total		
08	24																		
09	01																		
10	02																		
11	03				NSA	500				500									
12	04																		
13	05				Dextrose	500				1000									
14	06																		
15	06																		
16	07																		
17	08																		
18	09																		
19	10																		
20	11																		
21	12																		
22	13				NaCl				500	1500									
23	14				NaCl				500	2000	300					300	300		
24	15				NaCl	100			100	2100									
01	16																		
02	17										100					100	400		
03	18																		
04	19																		
05	20				NaCl	500			500	2600									
06	21																		
07	23																		
TOTALS																			
TOTAL IN MLS											BALANCE			TOTAL OUT MLS					

West Glasgow Hospital

24 Hour Fluid Balance Chart

245
61

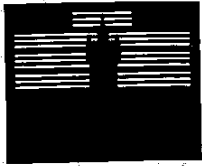
Name: Brian McLaughlin

Case Record No:

Ward: L10PSW

Date: 29/4/03

INPUT (mls)										IN	OUTPUT (mls)					OUT
TIME HRS (Please delete 1 column)	ORAL	NASO GASTRIC TFN	BLOOD COLLOID PLASMA	IV (1) /	TYPE	IV (2)	IV (3) Drugs	Hourly Total	Cumulative Total	URINE	URINE Cumulative Total	Gastric Aspirate / Vomit	Drain 1	Hourly Total	Cumulative Total	
08	24															
09	01															
10	02															
11	03															
12	04															
13	05															
14	06															
15	06															
16	07	100	commenced	Normal				500	500							
17	08	100														
18	09	100							800			400				
19	10															
20	11															
21	12															
22	13	sips							800			PU L toilet				
23	14															
24	15															
01	16															
02	17															
03	18															
04	19															
05	20															
06	22							500	1300							
07	23															
TOTALS																
TOTAL IN MLS									1300	BALANCE			TOTAL OUT MLS			400



246

West Glasgow Hospitals University NHS Trust

Warfarin Therapy

Guidelines:

1. Measure prothrombin time prior to the first dose of warfarin.
2. Usual adult loading dose -
10mg on day 1 and 10mg on day 2.
3. Dosage reduction indicated in the following conditions:
 - 1) - prolonged baseline prothrombin
 - 2) - abnormal liver function tests
 - 3) - congestive cardiac failure
 - 4) - elderly
 - 5) - less than average body weight
 - 6) - concomitant drugs which may interact with warfarin (see over)
 - 7) - parenteral feeding
4. Refer to nomogram for maintenance dose (see over).

BRIAN McLAUGHLIN

Affix addressograph label here

BLOOD GROUP:

DESIRED INR:

DATE	TIME	DOSE	INTERNATIONAL NORMALISED RATIO	PRESCRIBERS SIGNATURE	ADMINISTERED BY
30/4/03	6pm	3mg	1.0	[Signature]	AC / AS
1/5/03	6pm	6mg	1.2	[Signature]	[Signature] KGH
2/5/03	6pm	WITHOLD	Hb ↓ to 6.6	[Signature]	
4/5/3	6pm	3mg	—	[Signature]	[Signature] W. Linn
5/5/3	6pm	5mg	1.2	[Signature]	[Signature] M/M

0548856MI

NOTE: Warfarin must also be prescribed on the patient's Hospital Prescription Sheet.

Patient Observation Chart

247



Name *Brian McLaughlin*
 Address **AFFIX**
PATIENT
 Hospital No. *1132067D*
 DOB *28/11/60*

Admitted Date _____ Ward _____
 Transferred Date _____ Ward _____
 Transferred Date _____ Ward _____

Reference Scoring Chart

Modified Early Warning System Observation Score (MEWS)

Score	3	2	1	0	1	2	3
Pulse		<40	41-50	51-100	101-110	111-130	>131
Resp. Rate		<8		9-14	15-20	21-29	>30
Temp. (°C)		<35.0	35.1-36.0	36.1-38.0	38.1-38.5	>38.6	
AVPU/GCS	Unresponsive	Pain	Voice	Alert / 15	14	13-9	<8
Urine	<10mls/hr for 2 hrs	30mls/hr for 2 hrs				<300mls in 24hrs	<100mls in 24 hrs
Systolic BP	<70	71-80	81-100	101-199		>200	

If your patient scores 4 or more

If your patient score increases by 2 or more

If your patient's GCS drops by 2 points or more regardless of any other information

Or any patient causing concern to any healthcare professional

Immediately inform your relevant medical staff and contact the Critical Care Outreach Service

Glasgow Coma Scale

Eye opening

- 4 - spontaneous
- 3 - voice
- 2 - pain
- 1 - none

Verbal

- 5 - orientated
- 4 - confuse
- 3 - inappropriate word
- 2 - incomprehensible sound

Motor

- 6 - obeys commands
- 5 - localises to pain
- 4 - normal flexion
- 3 - abnormal flexion
- 2 - extension
- 1 - nil

Pain Score

Remember to check scores after pain relief.

Patient asked to report pain at rest and on movement.

- 0 = No pain at rest or on movement
- 1 = No pain at rest, slight pain on movement
- 2 = Intermittent pain at rest, moderate on movement
- 3 = Continuous pain at rest severe on movement

Sedation Score

- 0 = Awake, alert, orientated
- 1 = Mild, aroused by verbal stimulus
- 2 = Moderate, aroused by physical stimulus
- 3 = Severe, no response
- S = Normal sleep, easy to rouse

Score 2 or 3 requires immediate intervention

Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
 Sustained pain score of 2 or pain score of 3 requires intervention.

Nausea Score

- 0 = No nausea
- 1 = Mild (No treatment wanted)
- 2 = Moderate (Treatment required)
- 3 = Severe (Clinical problem persists despite treatment)

Review 1 hour after treatment. Inform doctor if additional treatment required.

HOSPITAL NO:

MEWS Scores

NEWS Scores															
Pulse			0		0	0	0		0						Pulse
Resp. Rate			0		0	0	0		0						Resp. Rate
Temp.			0		0	0	0		0						Temp.
GCS / AVPU			0		0	0	0		0						CNS
Urine Output			0		0	0	0		0						Urine
Systolic BP			0		0	0	0		0						BP
TOTAL			0		0	0	0		0						TOTAL

[illegible]

NAME:

HOSPITAL NO:

DATE														TEMP	
B P a n d P u l s e Pupil size (mm)	Time														
	1	240													40°C
		230													
	2	220													39°C
		210													
	3	200													38°C
		190													
	4	180													37°C
		170													
	5	160													36°C
		150													
	6	140													35°C
		130													
	7	120													
		110													
	8	100													
	90														
	80														
	70														
	60														
	50														
	40														
Resp. Rate															
Inspiration O ₂ %															
SpO ₂ %															
Pain Score															
Sedation Score															
Nausea Score															

MEWS Scores

[illegible][illegible]

Oxygen Devices and Flow Related Percentages

Nasal Cannula

O ₂ Flow Rate (L/min)	1	2	3	4	5	6
Approximate O ₂ concentration (%)	24	28	32	36	40	44

Hudson Face Mask

O ₂ Flow Rate (L/min)	4	6	8	12-15
Approximate O ₂ concentration (%)	40	50	55	65

Venturi Mask

Colour of Venturi Device	Blue	White	Yellow	Red	Green
O ₂ Flow Rate (L/min)	2	4	8	10	15
Approximate O ₂ concentration (%)	24	28	35	40	60

Non-rebreathe masks

An oxygen flow rate of 12-15 litres/minute will provide an oxygen percentage of approximately 95%.

These figures are intended for guidance only. Slight variations may exist between products manufactured by different companies.

Patient Observation Chart

249



Name _____
 Address _____
 1132067
 MCLAUGHLIN BRIAN
 11U Latherton Drive M
 Hospital: GLASGOW 28/01/60
 DOB: G20 8JR
 G.P. Prac. 43311

Admitted Date 26.4.03 Ward L10 E
 Transferred Date _____ Ward _____
 Transferred Date _____ Ward _____

Reference Scoring Chart

Modified Early Warning System Observation Score (MEWS)

Score	3	2	1	0	1	2	3
Pulse		<40	41-50	51-100	101-110	111-130	>131
Resp. Rate		<8		9-14	15-20	21-29	>30
Temp. (°C)		<35.0	35.1-36.0	36.1-38.0	38.1-38.5	>38.6	
AVPU/GCS	Unresponsive	Pain	Voice	Alert / 15	14	13-9	<8
Urine	<10mls/hr for 2 hrs	30mls/hr for 2 hrs				<300mls in 24hrs	<100mls in 24 hrs
Systolic BP	<70	71-80	81-100	101-199		>200	

If your patient scores 4 or more.

If your patient score increases by 2 or more

If your patient's GCS drops by 2 points or more regardless of any other information

Or any patient causing concern to any healthcare professional

Immediately inform your relevant medical staff and contact the Critical Care Outreach Service

Glasgow Coma Scale

Eye opening

- 4 - spontaneous
- 3 - voice
- 2 - pain
- 1 - none

Verbal

- 5 - orientated
- 4 - confuse
- 3 - inappropriate word
- 2 - incomprehensible sound

Motor

- 6 - obeys commands
- 5 - localises to pain
- 4 - normal flexion
- 3 - abnormal flexion
- 2 - extension
- 1 - nil

Pain Score

Remember to check scores after pain relief.

Patient asked to report pain at rest and on movement.

- 0 = No pain at rest or on movement
- 1 = No pain at rest, slight pain on movement
- 2 = Intermittent pain at rest, moderate on movement
- 3 = Continuous pain at rest severe on movement

Sedation Score

- 0 = Awake, alert, orientated
- 1 = Mild, aroused by verbal stimulus
- 2 = Moderate, aroused by physical stimulus
- 3 = Severe, no response
- S = Normal sleep, easy to rouse

Score 2 or 3 requires immediate intervention

Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
 Sustained pain score of 2 or pain score of 3 requires intervention.

Nausea Score

- 0 = No nausea
- 1 = Mild (No treatment wanted)
- 2 = Moderate (Treatment required)
- 3 = Severe (Clinical problem persists despite treatment)

Review 1 hour after treatment. Inform doctor if additional treatment required.

251

HOSPITAL NO:

[illegible]

MEWS Scores

[illegible][illegible]

Oxygen Devices and Flow Related Percentages

Nasal Cannula

O ₂ Flow Rate (L/min)	1	2	3	4	5	6
Approximate O ₂ concentration (%)	24	28	32	36	40	44

Hudson Face Mask

O ₂ Flow Rate (L/min)	4	6	8	12-15
Approximate O ₂ concentration (%)	40	50	55	65

Venturi Mask

Colour of Venturi Device	Blue	White	Yellow	Red	Green
O ₂ Flow Rate (L/min)	2	4	8	10	15
Approximate O ₂ concentration (%)	24	28	35	40	60

Non-rebreathe masks

An oxygen flow rate of 12-15 litres/minute will provide an oxygen percentage of approximately 95%.

These figures are intended for guidance only. Slight variations may exist between products manufactured by different companies.

PRESCRIPTION FORM

Hospital Name:

PATIENT DETAILS			ONCE ONLY AND PREMEDICATION DRUGS							
Name:	Height:	DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF DOCTOR	GIVEN BY	TIME GIVEN	
ROAN McLAUGHLIN		5/12/02	Gastrogaphin		0	2200		RK	2200	
Hospital Number: 1132067	Weight:	5/12/02	Gastrogaphin		0	0800		LW	0900	
DOB: 28/1/60	Surface area:	13/1/02	Wafarin	1mg	2	5pm	[Signature]	U	1800	
Date of Admission: 1/12/02	Date of writing discharge prescription: 5.12.02									
Consultant Name: Mr Wilson	Ward: LOW									
Date and time this form prepared: 1/12/02	Sheet No:	2nd Prescription in use								
Time:		Yes or NO								
DRUG SENSITIVITIES										
NKDA										
DVT Risk on Admission (SIGN Guideline)										
High ☐ Moderate ☐ Low ☐										
Assessed by:										
Date: 1/12										
OTHER CHARTS IN USE										
Insulin ☐	TPN: ☐									
PCA and other infusions ☐	Enteral Nutrition: ☐									
Anticoagulants: Heparin ☐	Oxygen Therapy: ☐									
Oral ☐	Other:									
Topical: ☐										

2010

PATIENT'S NAME:

ADMINISTRATION

Parenteral Drugs: Regular Prescription		DATE	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
		MONTH	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2
A	DRUG Cefazolin	Other time															
DOSE	ROUTE	DATE															
1000	IV	1/12/12															
SIGNATURE OF DOCTOR	INITIALS	DATE															
		1/12/12															
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time															

FOR DOCTORS USE ONLY		Other time															
B	DRUG Cefotaxime	Other time															
DOSE	ROUTE	DATE															
1g	IV	2/12															
SIGNATURE OF DOCTOR	INITIALS	DATE															
		2/12															
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time															

FOR DOCTORS USE ONLY		Other time															
C	DRUG Meropenem	Other time															
DOSE	ROUTE	DATE															
500mg	IV	2/12															
SIGNATURE OF DOCTOR	INITIALS	DATE															
		2/12															
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time															

FOR DOCTORS USE ONLY		Other time															
D	DRUG Dalteparin	Other time															
DOSE	ROUTE	DATE															
18,000	SC	2/12															
SIGNATURE OF DOCTOR	INITIALS	DATE															
		2/12															
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time															



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

Parenteral Drugs: Regular Prescription				DATE	
				MONTH	
E	DRUG			Other time	
				0700-0900	
	DOSE	ROUTE	DATE	1200-1400	
	SIGNATURE OF DOCTOR			1600-1800	
				2200-2400	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			Other time		
FOR DOCTORS USE ONLY					
F	DRUG			Other time	
				0700-0900	
	DOSE	ROUTE	DATE	1200-1400	
	SIGNATURE OF DOCTOR			1600-1800	
				2200-2400	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			Other time		
FOR DOCTORS USE ONLY					
G	DRUG			Other time	
				0700-0900	
	DOSE	ROUTE	DATE	1200-1400	
	SIGNATURE OF DOCTOR			1600-1800	
				2200-2400	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			Other time		
FOR DOCTORS USE ONLY					
H	DRUG			Other time	
				0700-0900	
	DOSE	ROUTE	DATE	1200-1400	
	SIGNATURE OF DOCTOR			1600-1800	
				2200-2400	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			Other time		
FOR DOCTORS USE ONLY					

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions		DATE	4	5	6	7	8	9	10	11	12	13	14	15	16						
		MONTH	12	12	12	12	12	12	12	12	12	12	12	12	12						
J	DRUG SANDAK	DATE 4/12/12	Other time																		
DOSE T	ROUTE PO	DATE 4/12/12	0700-0900																		
SIGNATURE OF DOCTOR SM		STOPPED DATE 4/12/12	1200-1400																		
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		INITIALS	1600-1800																		
			2200-2400																		
			Other time																		

FOR DOCTORS USE ONLY		DATE	4	5	6	7	8	9	10	11	12	13	14	15	16						
K	DRUG Kerbutide	DATE 11/12	Other time																		
DOSE 15ml	ROUTE PO	DATE 11/12	0700-0900																		
SIGNATURE OF DOCTOR DN		STOPPED DATE 11/12	1200-1400																		
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		INITIALS	1600-1800																		
			2200-2400																		
			Other time																		

FOR DOCTORS USE ONLY		DATE	4	5	6	7	8	9	10	11	12	13	14	15	16						
L	DRUG Augmentin	DATE 11/12	Other time																		
DOSE 625mg	ROUTE PO	DATE 11/12	0700-0900																		
SIGNATURE OF DOCTOR AN		STOPPED DATE 11/12	1200-1400																		
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		INITIALS	1600-1800																		
			2200-2400																		
			Other time																		

FOR DOCTORS USE ONLY		DATE	4	5	6	7	8	9	10	11	12	13	14	15	16						
M	DRUG Clarithromycin	DATE 11/12	Other time																		
DOSE 250mg	ROUTE PO	DATE 11/12	0700-0900																		
SIGNATURE OF DOCTOR AN		STOPPED DATE 11/12	1200-1400																		
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		INITIALS	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	DATE:
	SIGNATURE OF DOCTOR			STOPPED INITIALS:
				1600-1800
				2200-2400
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR DOCTORS USE ONLY

V	DRUG			
	DOSE	ROUTE	DATE	DATE:
	SIGNATURE OF DOCTOR			STOPPED INITIALS:
				1600-1800
				2200-2400
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR DOCTORS USE ONLY

W	DRUG			
	DOSE	ROUTE	DATE	DATE:
	SIGNATURE OF DOCTOR			STOPPED INITIALS:
				1600-1800
				2200-2400
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR DOCTORS USE ONLY

X	DRUG			
	DOSE	ROUTE	DATE	DATE:
	SIGNATURE OF DOCTOR			STOPPED INITIALS:
				1600-1800
				2200-2400
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR DOCTORS USE ONLY

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

Oral and Other Drugs: Regular Prescriptions				DATE																															
				MONTH																															
Y	DRUG	DOSE	ROUTE	DATE	STOPPED DATE: INITIALS:	Other time																													
						0700-0900																													
						1200-1400																													
						1600-1800																													
						2200-2400																													
SIGNATURE OF DOCTOR						Other time																													
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																																			
FOR DOCTORS USE ONLY																																			
AA	DRUG	DOSE	ROUTE	DATE	STOPPED DATE: INITIALS:	Other time																													
						0700-0900																													
						1200-1400																													
						1600-1800																													
						2200-2400																													
SIGNATURE OF DOCTOR						Other time																													
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																																			
FOR DOCTORS USE ONLY																																			
BB	DRUG	DOSE	ROUTE	DATE	STOPPED DATE: INITIALS:	Other time																													
						0700-0900																													
						1200-1400																													
						1600-1800																													
						2200-2400																													
SIGNATURE OF DOCTOR						Other time																													
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																																			
FOR DOCTORS USE ONLY																																			
CC	DRUG	DOSE	ROUTE	DATE	STOPPED DATE: INITIALS:	Other time																													
						0700-0900																													
						1200-1400																													
						1600-1800																													
						2200-2400																													
SIGNATURE OF DOCTOR						Other time																													
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																																			
FOR DOCTORS USE ONLY																																			

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DD		DRUG		DATE	
DOSE		ROUTE	DATE	MONTH	
SIGNATURE OF DOCTOR		STOPPED INITIALS:		Other time	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				0700-0900	
				1200-1400	
				1600-1800	
				2200-2400	
				Other time	

FOR DOCTORS USE ONLY

EE		DRUG		DATE	
DOSE		ROUTE	DATE	MONTH	
SIGNATURE OF DOCTOR		STOPPED INITIALS:		Other time	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				0700-0900	
				1200-1400	
				1600-1800	
				2200-2400	
				Other time	

FOR DOCTORS USE ONLY

FF		DRUG		DATE	
DOSE		ROUTE	DATE	MONTH	
SIGNATURE OF DOCTOR		STOPPED INITIALS:		Other time	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				0700-0900	
				1200-1400	
				1600-1800	
				2200-2400	
				Other time	

FOR DOCTORS USE ONLY

GG		DRUG		DATE	
DOSE		ROUTE	DATE	MONTH	
SIGNATURE OF DOCTOR		STOPPED INITIALS:		Other time	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				0700-0900	
				1200-1400	
				1600-1800	
				2200-2400	
				Other time	

FOR DOCTORS USE ONLY

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

Oral and Other Drugs: Regular Prescriptions				DATE																								
				MONTH																								
HH	DRUG			Other time																								
DOSE	ROUTE	DATE	DATE:	0700-0900																								
SIGNATURE OF DOCTOR			INITIALS:	1200-1400																								
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800																								
				2200-2400																								
				Other time																								
FOR DOCTORS USE ONLY																												
JJ	DRUG			Other time																								
DOSE	ROUTE	DATE	DATE:	0700-0900																								
SIGNATURE OF DOCTOR			INITIALS:	1200-1400																								
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800																								
				2200-2400																								
				Other time																								
FOR DOCTORS USE ONLY																												
KK	DRUG			Other time																								
DOSE	ROUTE	DATE	DATE:	0700-0900																								
SIGNATURE OF DOCTOR			INITIALS:	1200-1400																								
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800																								
				2200-2400																								
				Other time																								
FOR DOCTORS USE ONLY																												
LL	DRUG			Other time																								
DOSE	ROUTE	DATE	DATE:	0700-0900																								
SIGNATURE OF DOCTOR			INITIALS:	1200-1400																								
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800																								
				2200-2400																								
				Other time																								
FOR DOCTORS USE ONLY																												

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

All Routes: As Required Prescriptions

ADMINISTRATION

[illegible][illegible]

PP	DRUG	DATE:	DATE
	Tramadol	1/12	4/12
DOSE	ROUTE	INDICATION	TIME
100mg	Oral	Pain	12:00
SIGNATURE OF DOCTOR	MAX. FREQUENCY	DATE:	DOSE
[Signature]	4-6	4/12	100mg
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			GIVEN BY
Max 400mg/24hrs			[Signature]

[illegible]

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

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

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

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

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

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

Notes for Users

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

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

Signature: _____ Date: _____

Signature: _____ Date: _____

FOR DOCTORS:

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

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

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

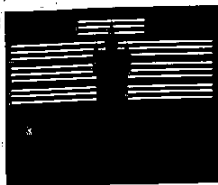
5. Method of administration should be abbreviated as follows:

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

FOR NURSES:

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

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		



Patient Profile

258

Ward: UOW Date: 2/12/12 Time: 0145 (24hr clock)

Please print clearly in BLOCK CAPITALS

Title: _____
Name: Brian McLaughlin
Preferred name: _____
Address: 114 Latherton Dr
Glasgow
Post Code: G20 8JR
Tel: 946 0499
DOB: 28.01.60 Age: 42
Hosp. No: 1132067
Occupation: _____
Religion: R/C
S.O.S. ☐ date: ☐☐☐☐☐☐
Interpreter required: ☐
(specify: _____)
Lives alone ☐

Consultant: Mr Wilson
Named Nurse @: Sr G. Kinnett
Admitting Nurse: SND MacIntyre
Named Nurse @: _____
Relatives seen by Doctor ☐

REASON FOR ADMISSION

Developed abdominal
pain since 2pm yesterday
severe in nature
Also vomiting
Patient's perception of illness: _____

1 NOK/Friend/Contact: Grace McLaughlin
Address: 11 Kirkhill Place
Glasgow
Day: 946 1629
Night: _____
Relationship: Mother
2 NOK/Friend/Contact: Lisa Tracey
Address: A/A
Day: A/A
Night: _____
Relationship: girlfriend
NOK informed of admission ☒
NOK informed by: 2nd NOK aware
GP: Dr McCarthy
Address: Mayhill H/C
41 Shawpark St
Tel: 531 8830

Diagnosis: Amylase 3759 P.E-13.12.0
GALL STONES
PANCREATITIS

Operation/Treatment: 2/12/02 - Abdo U/S
6/12/02 CT scan
10/12/02 - VQ scan
10/12/02 - CT scan

Relevant PMH: _____

NIL

MEDICATION

With patient ☐
Stored & receipt given ☐
No medication required ☒
Taken home details: ☐

PERSONAL BELONGINGS

Clothing listed ☐
Valuables listed ☐
Valuables in ward ☐
Valuables in hospital safe ☐

OBSERVATIONS ON ADMISSION

Temperature: 36.5 °C
Pulse: 90 bpm
BP: 160/99
Resp: SpO2 93% air
Pain Score: 2 on
Urinalysis: neg
Waterlow Score: 210
Height: _____ m
Weight: _____ kg
Body Mass Index: _____
Blood sugar (if appropriate): _____ mmols
Allergies: Yes ☐ No ☒
details: ? penicillin

DISCHARGE PLANNING

Boarding	1st	2nd	3rd	Signature	Time	Comments/Information
Informed:						(259)
ward	☐	☐	☐			
patient	☐	☐	☐			
relatives	☐	☐	☐			
Date patient boarded:						
1st:	☐	☐	☐			
2nd:	☐	☐	☐			
3rd:	☐	☐	☐			
Internal Transfers						
Transfer destination:						
Planned transfer date:						
☐ / ☐ / ☐						
Medical consent	☐					
Arranged with receiving area	☐					
Patient informed	☐					
NOK/Contact informed	☐					
Transport: stretcher	☐					
2 hand seat	☐					
chair	☐					
Escort	☐					
Ca notes	☐					
X-rays	☐					
Nursing notes & Drug Form	☐					
Property/Valuables listed	☐					
Catering	☐					
Dietitian	☐					
Physiotherapy	☐					
Occupational Therapist	☐					
Speech and Language Therapist	☐					
Discharge Checklist						
Planned discharge date:						
☐ / ☐ / ☐						
Medical consent	☒					
Date discussed with patient:						
☐ / ☐ / ☐						
Date discussed with NOK/Contact:						
☐ / ☐ / ☐						
Transport: own	☒					
ambulance	☐					
Ambulance ordered on:						
☐ / ☐ / ☐						
type:						
order no.:						
District nurse ☐ /Liaison nurse ☐						
Home help:	☐					
Social work dept.	☐					
Discharge prescription	☒					
Discharge dressings	☐					
Patient information	☐					
Valuables/Cashier	☐					
Physiotherapy	☐					
Speech and Language Therapist	☐					
Out patient appointment						
☐ / ☐ / ☐						
Other:						

Anti clog chmr 16-10-02-2104

Case
(260)

CARE PLAN						
Date Comm.	Signature	1.BASIC CARE AND PERSONAL HYGIENE			Date Disc.	Signature
4-12-02		Independent				
		Bed bath				
8/12/02	[Signature]	Assisted wash			4-12-02	[Signature]
		Oral hygiene				
		Pressure care				
		2.NUTRITION				
2/12/02	[Signature]	Fasting			4-12-02	[Signature]
13-12-02	[Signature]	Normal Diet				
		Special Diet / Modified Diet				
4-12-02	[Signature]	Free food - higher diet			13-12-02	[Signature]
		3.ELIMINATION				
13-12-02	[Signature]	Independent				
		Commode				
13-12-02	[Signature]	Bedpan/urinal			13-12-02	[Signature]
2/12/02	[Signature]	Urinary Catheter	Size:	Batch No:	4-12-02	[Signature]
		Type of Material:	H ₂ O in Balloon:			
		Type of Stoma Appliance:				
		4.MOBILITY				
13-12-02	[Signature]	Fully Independent/fully mobile				
4-12-02	[Signature]	Assistance x 1 13-12-02 [Signature]				
		Minimal assistance (give details)				
2/12/02	[Signature]	2 nurses			4-12-02	[Signature]
		Dependent (See movement and handling sheet - keep with patient)				
		5.OBSERVATIONS				
		Waterlow daily (if score is over 10+)				
2/12/02	[Signature]	TPR	3	1° BP TPR	4-12-02	[Signature]
		BP			4-12-02	[Signature]
		Pain Score	observe			
		Fluid Balance	accurate		13-12-02	[Signature]
4-12-02	[Signature]	4° TPR/BP				
3/12	[Signature]	Bm six daily				
6/12	[Signature]	Daily temp + pulse 4wly				
8-12-02	[Signature]	TPR + BP			8-12-02	[Signature]
19-12-02	[Signature]	Daily TPR/BP			14-12-02	[Signature]

Name: Brian McLaughlinWard: 2102Date: 2/12/2Case Record No.: 11 3 2067**ACTIVITIES OF DAILY LIVING**262**HOME CIRCUMSTANCES/
SOCIAL SUPPORT**

Lives with family ☒
Lives alone ☐
Nursing home ☐
Residential care ☐
Elderly/disabled partner ☐
Family support (specify below) ☐

District Nurse (____ days/week) ☐
(cancelled ☐)
Home help (____ days/week) ☐
(cancelled ☐)
Other services (specify below) ☐

Stairs: Internal ☐ External ☒
Comments: _____

NUTRITION

Normal menu (includes vegetarian) ☒
Vegan ☐ Child's menu ☐
Halal ☐ Kosher ☐
Refer to Dietician if any below ticked:
Inability to eat/swallow ☐
(refer to speech and language therapist)
Any recent weight changes ☐
Medically related nutrition
problems (e.g. diabetes) ☐
Other (specify): _____

BREATHING

1. No symptoms ☐
2. Breathless with moderate exercise ☒
3. Breathless with minimal exertion ☐
4. Breathless at rest ☐
5. Uses inhalers ☐
Comments: _____

SMOKING

Non-smoker ☒
Smoker: _____ per day ☐
Ex-smoker ☐
Aware of hospital policy ☐

HYGIENE

Bath ☐ Shower ☒
Requires assistance ☐ Stand up wash ☐
Skin assessment: _____
Other: _____

ELIMINATION

Bowels regular ☒
Constipated ☐
Diarrhoea/Loose stools ☐
Uses aperient ☐
Has stoma: ☐
• Colostomy ☐
• Urostomy ☐
• Ileostomy ☐
appliances used: _____

Frequency of micturition ☐
Incontinent: urine/faeces ☐
day/night ☐
stress ☐
No urinary symptoms ☒
Comments: catheterised

SLEEP

Hours/night ☐
Medication ☐
details: normally sleeps well

MENTAL STATE

Alert/Orientated ☒
Confused: day/night ☐
Anxious/Distressed ☐
Unconscious ☐
Other (specify): _____

SENSSES		
Glasses:	distance	☐
	reading	☐
Hearing impaired:	left/right	☐
Hearing aid:	left/right	☐
Dentures:	upper	☐
	lower	☐
Communication Difficulties		☐
Other:		☐

MOBILITY (Pre admission)	
Mobile without aid	☒
Mobile with aid	☐
(Specify type/side held: _____)	
Furniture walking	☐
Chair Bound	☐
Housebound	☐

RELATIVE PARTICIPATION

ALCOHOL INTAKE		
units/week:	nil	☐
	less than 14	☐
	14 - 21	☒
	over 21	☐
(1 unit = 1 measure spirits/half pint beer/ lager/1 glass wine)		

PROFILE COMPLETED BY:
(Please print name in block capitals)
DEBBIE MACINTYRE
Signature: Debbie Macintyre
Designation: SIN
Countersigned (if applicable):

[illegible]

Name: Brian Melanyn

Ward: 210W

Date: 2/12/2

Case Record No.: 1132067

264

CARE PLAN EVALUATION

1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
2/12/2	01A		Admitted with severe abdo pain. Treating as ? pancreatitis Amylase >3000 2 NBM 3 10 volumes 4 Becarect 5 Observations: ~ 1 hourly hypertensive 160/99 SpO2 93% air Pulse 99 bpm Temp 36.5	
	0245	6	IV fluids 5L O2 via mask.	Macintyre
	0500	6	10mg of IV Morphine given Appears to have settled with analgesia	Macintyre
		3	10 volumes excellent +150 ml's per hour.	
		5	Continues to be hypertensive. SpO2 98% on O2 therapy	
		6	IV fluids continued as prescribed.	Macintyre
	1715		Settled am.	
		2	Remains fasted	
		3	10 volumes remain fair	
		5	Observations stable hypertensive P 80 SpO2 99% on O2 therapy.	
		6	IV fluids continue as prescribed.	
		8	For USS abdomen this afternoon.	
	1845	11	No complaints.	H. Wilson
		8	Attended for abdo U/S this evening.	
		6	IV fluids continue as charted S/B Medical Staff this morning. Commenced on IV antibiotics.	
		3	Hourly urine volumes remain fair - urine concentrated.	

265

EVALUATION OF CARE

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
2/12/02	1845	2	Tolerating ice to suck	
		5	Observations stable. Apdynxnl.	
			O ₂ therapy continues @ 8L/min via face mask.	
			S/B Phusio.	g Kimmatt
			IM analgesic / anti emetics given as prescribed.	
3/12/02	0600		Settled overnight	
		2	Taking ice orally	
		3	Observations stable	
		3	Urine vols seen low	
		6	O ₂ therapy continues at 8L via face mask	
			IM morphine given for pain relief	
		5	T 38 at 20.30 rechecked 37.6 at 2am	
	1300	6	Wt continues as charted	BM Fall
			SIB Mr Chisholm	
		2	ALLOW oral fluids if FRCP unable to be carried out today	
		3	10 urine volumes satisfactory	
		4	Independent today	
		1	managed all self hygiene	
		5	Observations Stable	
	1330	6	IV fluids continue	Macintyre
			Transferred over from LION	
		2	Free fluids	
		3	o vols please	
		5	2hrly BP, temp + pulse + BM's please	
	1900	6	IVAB's given as prescribed	
			Seen by Mr Wilson - settled night	
		2	Free fluids	
		3	Hourly vols good	
		5	BP, temp, pulse & BM	
			Stix stable	
		6	IV & IVAB's continue	UBr
	2015	10	IM MORPHINE 10mg given	Indin
4/12/02	0130	10	IM MORPHINE 10mg given	

Name: BRIAN
W. LAUGHLIN

Ward: L10E

Date:

266

Case Record No.:

CARE PLAN EVALUATION

1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
4/12/62	0500	9	Settled night, slept long spells.	
		2	Tolerating oral fluids	
		3	10 Vols satisfactory	
		5	Stable	
			B.M. once 8-1 normal	
		6	IVI as checked IVAB given	
			Verflon resived (R) arm	h. lin
	0630	10	1st MORPHINE 10mg given /	h. lin
			Feels breathless this AM	h. lin
	1400	1	Settled morning	
		"	Reviewed by medical staff	
		2/4	Catheter may be removed	
		6	Intravenous fluids/antibiotics may be discontinued.	
		2	Tolerating oral fluids well	
		5	Observations stable	
		6	Oral analgesic as per handbook	
	1800	11/4	Few more when can be arranged	h. lin
		1	Settled afternoon	
		3	Waking more	
		2	May have short night but no disturbed, antalgic	h. lin
5/12/62	0600	9.	Slept well	
		2.	Can have fluids + diet.	
		3.	Voiding urine	
		4.	Mobile	
		5.	Obs stable Temp	
		8.	M.R.C.P. Hba	K. O'Donnell
	1500		All cares given & evaluated	
		2	Full fluids 2 C.D.	
		3	Passing fairly good vols of urine	
		4	Fully mobile	
		5	Obs stable. Sats 93-94% on air please observe	
		6.	O ₂ disc machine	
		8	C.T. scan tomorrow at 930	
			Prep drink 10m x 0800	L. N. Al
	1930	⑤	Sats 91% on air - recommended on O ₂ 2L via nasal cannula.	
			Temp 37.2°C - fan in situ.	8202

267

EVALUATION OF CARE

DATE	TIME	No	EVALUATION AND PROGRESS OF CARE	SIGNATURE
6/12/02	0600	9.	Slept well	
		2.	Fluids & diet	
		3.	Voiding good / volumes of urine	
		5.	Apyrexial 37.3°C	
		6.	GR U/L values	
		8.	for CT scan @ 9.30am	K. J. Farrell
	1300		Settled morning	
			Attended for CT scan	
			To remain in over	
			Week end	
		2	Fluids & diet	
		3	Passing urine	
		4	mobile around ward	
		5	Observations stable.	U. B. N.
	1445	6	Still Requiring O ₂ Therapy	
			oral analgesia given regularly	
		8	Attended for CT scan	
			awaiting Results	L. W. L.
	1900		Settled evening	U. B.
7/12/02	0530	9	Comfortable + Slept short periods	
		2	Fluids & diet as able	
		5	Obs Stable.	
		6	O ₂ as required.	
		11	Awaiting CT scan results.	R. K. G. K.
	1250	6	Still Requiring O ₂ PRN for	
			episodes of SOB	
		5	Temp 37.6°C	
			Regular analgesia	
			Dis plans for home as	
			yet	L. W. L.
	1440		Complaining of (L) Lower	
			back pain	
	19.15	(11)	seen by J.H. officer regarding	
			back pain, prescribed	
			Paracetamol 1M PRN for	
			further analgesia. advised	
			patient to eat little diet	L. G. M.
	2130.	5	Temp 38°C. Paracetamol 1g	
			given. Fan in situ. J.H. Officer	R. K. G. K.
8/12/02	0530	9	Fairly comfortable overnight. Slept	
			long periods.	
		2	Free fluids.	
		3	Voiding Urine.	
		5	Obs Stable. Apyrexial	
		11	Volvol 75mg 11M for pain with good	R. K. G. K.
			effect.	

Name: Bryan McLaughlin

405

268

Case Record No.:

CARE PLAN EVALUATION

1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
8/12/02			SB Murchison C/O on diet as tolerated am home tomorrow or 11- bloods are ok. Independent NO complaints	SSC
09/12/02	04:00	6.	- Oral tramadol 100mg given pm. for pain relief. - Patients completed of T pain 2° later. - JHO Imagers (3161) removed patient. - I.M. Voltadol 75mg given (20). - O2 2Lts re-commenced via nasal Cannulae due to ↑ Shortness of breath - CXR carried out in X-Ray Room. - Blood Gasses taken. 5. Obs. satisfactory. 9. Patient settled for 3-4°. Then awoke in a cold sweat. 5. Agitated. 2. Shivering at present. 9. Settled after shower. 5. Obs. am. satisfactory. Settled afternoon + evening. 2. Diet + fluids taken. 5. Observations satisfactory. 8. Medical staff querying PE - still awaiting investigation results but assumed on Diltapain anyway. No further SOB or sweating.	PNG S. K. Grew
10/12/02	0600	6	O2 Therapy via nasal prongs in use Oral analgesia to settle s/c dexmed - now changed to praxin. Settle up until this point.	ayabraye
	1525	1	Settled day. all care evaluated + given 8 Dexam for a VA scan - result now conclusive - for PE to have CT scan chest this pm	Lwil



269

EVALUATION OF CARE				
DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
11/12/02	0500	6	O ₂ therapy continues	R Fey
		2	Fluids + diet	
			Appears to have slept fairly well oral analgesic to settle.	
	1500	6	O ₂ Therapy overnight	R Fey
		1	Settled day all care evaluated + given up + about	
			To be referred to Respiratory Physicians	
			Commenced on antibiotics + R. Saline nebulisers	
			O ₂ Therapy 2 litres	
12/12/02	0600		Slept well.	
	1200	6	O ₂ 2L continues	Kross
			nebs as per Kardex.	
		1	SELF CARING	
		2	FLUIDS + DIET	
		3/4	INDEPENDENT	
		5	OBS SATS	
	1500	6	O ₂ AS REQUIRED	M. Smith
			NEBS AS PRESC WITH EFFECT	
			STILL NO SOME ABDO PAIN	
			STILL AWAITING PHYSICIANS	
		6	DISCOURAGE O ₂ IF NOT SATS	
	1900		CHEST PHYSICIANS COMING FRIDAY	R Fey
		1	Settled evening on nebulisers	
			Slept well	
3/12/02	0600		Will be seen by respiratory physicians today.	
	1130		OK in ward.	Kross
		1	(Settled) morning	
13/12/02	1415	11	Reviewed by medical staff	
		(1)	Independent with personal hygiene	
		(2)	Fluids + diet	
		(3)	passing urine	
		(4)	mobile independently	
		(5)	obs stable as charted	
		(6)	O ₂ discontinued SaO ₂ 96% on air.	
		(11)	Seen by medical + respiratory	

Name: Brian McLaughlin

Ward: L106

Date: 13.12.02

Case Record No.: 1132067

(270)

CARE PLAN EVALUATION

1. Basic Care and Hygiene	5. Observations	9. Sleep
2. Nutrition	6. Technical Care	10. Special Needs
3. Elimination	7. Wound Care	11. Other Relevant Information
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No	EVALUATION AND PROGRESS OF CARE	SIGNATURE
13.12.02			Physician, does have pulmonary embolism, patient informed to start on warfarin this evening	
14.12.02	0600		Slept well No complaints Settled morning offers no complaints	L. Henry Regent
		11	Reviewed by medical staff No changes to current management For haem when INR therapeutic	
		5	Observations stable	
		2	Tolerating food and drink -	
		4	Maintaining weight	
	1900	6	Warfarin 10mg given as prescribed	
		11	No other changes	
15/12/02	0600	9	Slept well no complaints offered	K. Bennett
	1500	1	Settled day. All care evaluated + given fully mobile. Warfarin to be given as prescribed.	R. P.
	2300		NO INR result this evening. Given 5mg warfarin as per medical staff instruction.	
16/12/02	0600		Slept well Rever INR today.	Regent
	1200	1	Settled morning	
		11	Reviewed by medical staff	
		8	INR to be checked by 72hr home later.	
		5	Observations stable	
		4	Maintaining weight	
	1800	11	Reviewed by medical staff. For discharge home this evening To have 3mg warfarin this evening, and 3 tomorrow evening To attend anti-coagulant clinic on Wednesday 18.12.02 @ 10 ¹⁵	
			Will collect prescription for warfarin 18.12.02.	



BP, TPR and Pain Assessment Chart

Name: Brian McLaughlin

271

Case Record No.:

DOB: 28/1/60

27

Ward: L10E

Consultant: CRW

1. Pain Score

2. Sedation Score

3. Nausea Score

See reverse for scoring details

Date	10/2/02	11/12/02	12/12/02	13/12/02	14/12/02
Time	07:21	11:00 20:00	7:10 14:45 18:50	10:10 18:00	11:00 15:00 18:00
Pain Score					
Sedation Score					
Nausea Score					
Nurse Initials		R		EB	EB
Temperature					
BP					
Pulse					
RESPS O ₂	97% 96%	98% 98	98% 95% 95% on on aw aw aw	16%	14% 16%
SaO ₂					96% 95% 95%
Bowels					

Warfarin Therapy

Guidelines:

1. Measure prothrombin time prior to the first dose of warfarin.
2. Usual adult loading dose -
10mg on day 1 and 10mg on day 2.
3. Dosage reduction indicated in the following conditions:
 - 1) - prolonged baseline prothrombin
 - 2) - abnormal liver function tests
 - 3) - congestive cardiac failure
 - 4) - elderly
 - 5) - less than average body weight
 - 6) - concomitant drugs which may interact with warfarin (see over)
 - 7) - parenteral feeding
4. Refer to nomogram for maintenance dose (see over).

Brian McLaughlin

Affix addressograph label here

BLOOD GROUP:

DESIRED INR:

[illegible]

0548856MI

NOTE: Warfarin must also be prescribed on the patient's Hospital Prescription Sheet.

BP, TPR and Pain Assessment Chart

Name: Brian McLaughlin

Case Record No.:

DOB: 28/1/60

Ward: 610^E Consultant: Mr Wilson

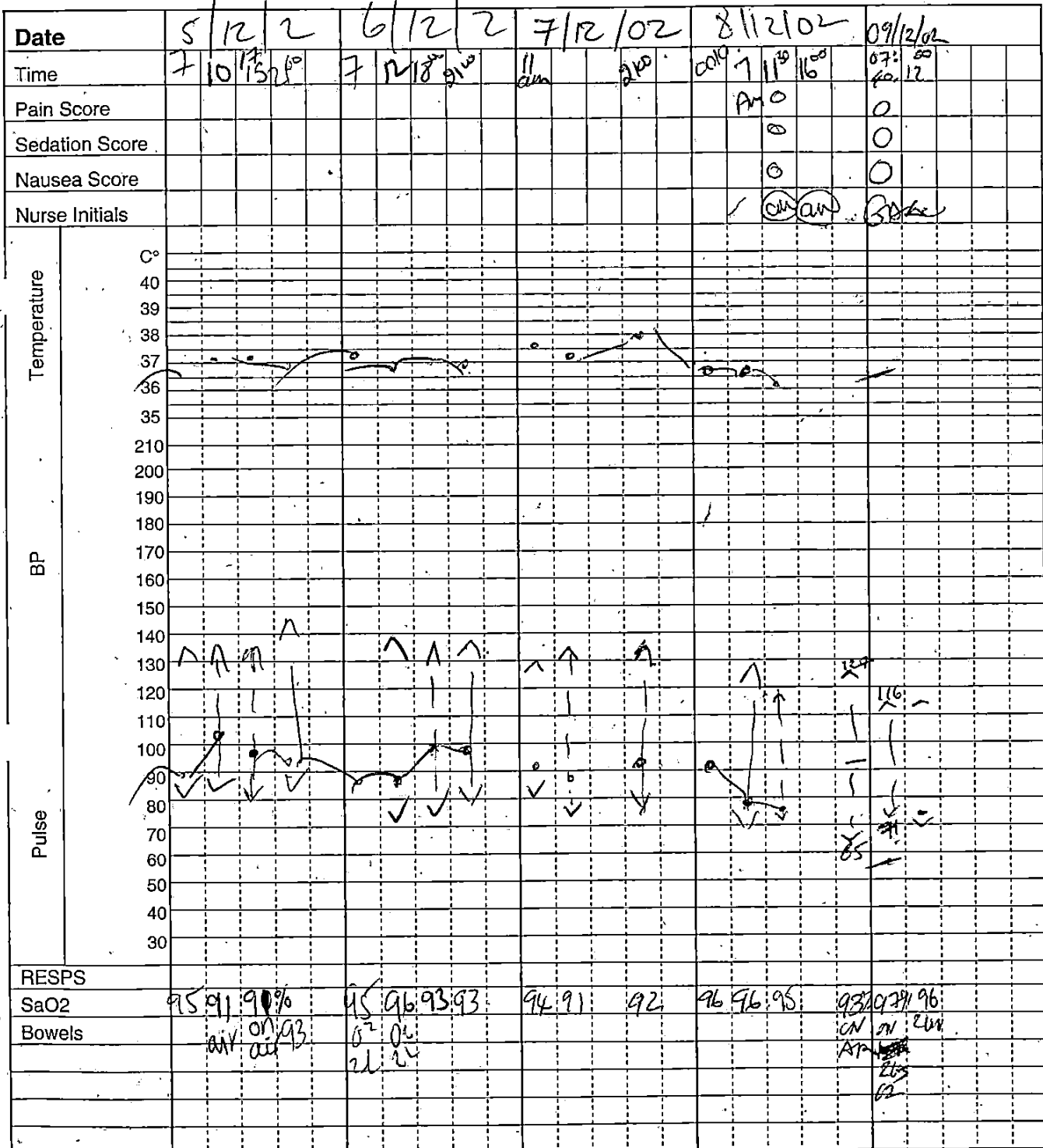
273

1. Pain Score

2.Sedation Score

3. Nausea Score

See reverse for scoring details





BP, TPR and Pain Assessment Chart

Name: *Brian McLaughlin*

Case Record No.: *1132067*

DOB: *28.01.60*

(274)

Ward: *U10W* Consultant: *Mr Wilson*

1. Pain Score

2. Sedation Score

3. Nausea Score

See reverse for scoring details

Date	2/12/2												3/12/02												4.12.02											
Time	17:00 18:00 19:00 20:00 21:00 22:00 23:00 00:00 01:00 02:00 03:00 04:00												05:00 06:00 07:00 08:00 09:00 10:00 11:00 12:00 13:00 14:00 15:00 16:00												17:00 18:00 19:00 20:00 21:00 22:00 23:00 00:00 01:00 02:00 03:00 04:00											
Pain Score	2 1 1 1 0 0 0 0 0 0 0 0												0 0 0 0 0 0 0 0 0 0 0 0												0 0 0 0 0 0 0 0 0 0 0 0											
Sedation Score	0 1 1 1 0 0 0 0 0 0 0 0												0 0 0 0 0 0 0 0 0 0 0 0												0 0 0 0 0 0 0 0 0 0 0 0											
Nausea Score	0 0 0 0 1 0 0 0 1 0 0 0												0 0 0 0 0 0 0 0 0 0 0 0												0 0 0 0 0 0 0 0 0 0 0 0											
Nurse Initials	<i>MS MS MS MS MS MS MS MS MS MS MS MS</i>												<i>MS MS MS MS MS MS MS MS MS MS MS MS</i>												<i>MS MS MS MS MS MS MS MS MS MS MS MS</i>											
Temperature																																				
BP																																				
Pulse																																				
RESPS	<i>93 92 92 92 92 92 92 92 92 92 92 92</i>																																			
SaO2	<i>97 96 99 96 95 94 93 93 93 93 93 93</i>																																			
Bowels	<i>A/R 02 02 02 02 02 02 02 02 02 02 02 02</i>																																			

NAME HOSPITAL No.

bramley h/in

AGE

PHYSICIAN DEPT. WARD

W. Wilson L100

DIABETIC CHART
and
INSULIN PRESCRIPTION
SHEET

276

Date		03/12/02				4/12/02																							
Time/Hours		03	05	08	12	18	22	03	05	08	12	18	22	07	12	17	22	07	12	17	22	07	12	17	22	07	12	17	22
Urine Sugar	2%																												
	1%																												
	1/2%																												
	1/4%																												
	0																												
Ketones																													
Blood Glucose																													
Strip/Meter Glucose		12.9				12.2				8.0				7.1				8.1											
Insulin Dose Type/Units																													
A																													
M																													
Doctor's Signature																													
Administered by																													
Checked by																													
Insulin Dose Type/Units																													
P																													
M																													
Doctor's Signature																													
Administered by																													
Checked by																													

NO DRUGS OTHER THAN INSULIN TO BE PRESCRIBED ON THIS CHART.
ON DISCHARGE. FILE WITH PRESCRIPTION SHEET.

PARENTERAL FLUID PRESCRIPTION SHEET

The 'added drugs' should be prescribed in the patient's main prescription sheet, cross referenced by annotating the "other prescription sheets in use" section

[illegible]

West Glasgow Hospitals

N.B. If using a Syringe Driver/Infusion Pump Please Use The 'Prescription And Administration Sheet For Medicines Given By Syringe Driver/Infusion Pump'

Name	Case Record No.
Age	
Sex	
Dept.	
Consultant	

McLaughlin

PARENTERAL FLUID PRESCRIPTION SHEET

The 'added drugs' should be prescribed in the patient's main prescription sheet, cross referenced by annotating the "other prescription sheets in-use" section

Date	FLUID	Volume (mls)	Time to Run	Rate mls/hr	ADDED DRUGS	Quantity	Doctor's Signature	Added by	Start Time (24 hr clock)	Put up	Checked by	Serial/ Batch No
	5% Dext	500										
	5% Dext	500	1°				<i>CM</i>		02 ³⁰	<i>Macintyre</i>		
	5% Dext	500	1°		KCl	20mmol	<i>CM</i>		03 ³⁰	<i>Macintyre</i>		
	N. Saline	500	2°				<i>CM</i>		04 ³⁰	<i>Macintyre</i>		
2/12/02	(N) Saline	500	2°				<i>Macintyre</i>		06 ³⁰	<i>Macintyre</i>		
2/12/02	5% Dext	500	2°				<i>Macintyre</i>		09 ³⁰	<i>Macintyre</i>		
2/12/02	0.9% Saline	500	2°		KCl	20mmol	<i>KB</i>		14 ⁰⁵	<i>Macintyre</i>		
2/12/02	0.9% Saline	500	2°				<i>KB</i>		17 ⁰⁰	<i>Macintyre</i>		
2/12/02	0.9% Saline	500	2°		KCl	20mmol	<i>KB</i>		18 ⁰⁰	<i>Macintyre</i>		
2/12/02	5% Dext	500	2°				<i>KB</i>		20 ³⁰	<i>Macintyre</i>		
	0.9% Saline	500	2°		KCl	20mmol	<i>KB</i>		22 ³⁰	<i>Macintyre</i>		
	(N) Saline	500	2°				<i>KB</i>		01 ⁰⁰	<i>Macintyre</i>		
	(N) Saline	500	2°						08 ⁰⁰	<i>Macintyre</i>		

Brian McLaughlin

on Air

SYRINGE SAMPLE

ACID-BASE 37°C

	Units	Reference Range
H+	nmol/L	35-45
pCO ₂	kPa	3.7-5.3
pO ₂	kPa	10-13
HCO ₃ mol	mmol/L	22-28
cIC02	mmol/L	25-30
BE(B)	mmol/L	-2 to +2

Cor: 37.0°C

H+	37.3	nmol/L
pCO ₂	5.74	kPa
pO ₂ (1)	9.83	kPa

OXYGEN STATUS 37°C

ctHb	13.0	g/dL	(12.0 - 18.0)
Hct	38	%	
pO ₂	9.83	kPa	(10.0 - 13.33)
sO ₂	95.7	%	(94.0 - 98.5)
FO ₂ Hb	94.5	%	(94.0 - 97.0)
FCOHb	0.8	%	(0.0 - 1.5)
FMethb	0.5	%	(0.0 - 1.5)
FHHb	4.2	%	(0.0 - 0.0)

ELECTROLYTES

Na+	135.0	mmol/L	(135.0 - 145.0)
K+	3.50	mmol/L	(3.50 - 5.20)
Ca ²⁺	1.20	mmol/L	(1.20 - 1.30)
Mg ²⁺	0.7	mmol/L	(0.7 - 1.0)

EN

BLOOD BANK ISSUE SLIP

PATIENT *Brian M' Laughlin*

WARD *210 East*

HOSP. No. *1132067*

GROUP *O. Pos*

BLOOD UNIT No. *G101.603 017 929-8*

MATCHED/ NAME ☒
NUMBER ☒
GROUP ☒

ISSUED

CHECKED *E. Donegan*

DATE *3.5.03*

TIME *20-20*

RETURNED

BLOOD UNIT No.

PATIENT'S NAME

No.

GROUP

TIME

DATE

DISPOSAL

51132067E

-W

BRIAN

MCLAUGHLIN



