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

NHS
Greater Glasgow and Clyde

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

Date: 13th May 2026
Your Ref:
Our Ref: LAT/ACCESS/SB
Enquiries to: Samantha Barka
Direct Line: 0141 211 0151
Email: samantha.barka2@nhs.scot

Dear Sir/Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: TRACY ROBERTS **D.O.B: 27.04.1971**

Thank you for your request received 22nd April 2026 in which you seek a copy of your client's personal information.

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

QUEEN ELIZABETH UNIVERSITY HOSPITAL
NEW VICTORIA INFIRMARY

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 CARE AMBULATORY HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

BADGERNET	☐
CAREVUE	☐
MEDICAL ILLUSTRATION	☐
METAVISION	☐
PHYSIOTHERAPY	☐
RADIOLOGY	☐
WEST MARC	☐
LABS	

SOUTH | VIC
MANUAL CASE NOTE

South Glasgow University Hospitals NHS Trust
Victoria Infirmary, Glasgow G42 9TY. Tel. 0141-201-6000

Part I Discharge Letter and Medicine Prescription Form - Confidential Ref No: 041104

Dear Doctor .....
Surg...

Patie 815245 2704716161
Addr Roberts Tracy
10/2/17 Norfolk Court F
Glasgow 1
27/04/1971
DOB: G5 9AT GP Prac:49089
Weight ..... *Fix ID label to all 4 copies.*

Ward: DSU
Ward telephone number: 65936
Consultant: Bjornsson
Named Nurse: M Martin
Admission date: ..... / ..... / 02
Discharge date: 17 / 5 / 02

Follow-up arrangements
Clinic appointment made:
Yes ☐ No ☐ To follow ☐
Clinic name .....
Date ...../ ...../ .....
Non-childproof containers required: Yes ☐ No ☐
Medicine compliance aids required: Yes ☐ No ☒
Specify: .....

Reason for admission, treatment, diagnosis

Other information

MEDICINE	Dosage form	Dose	Times for administration: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 8	pm 10	Other times	Recommended duration of treatment after discharge	New Drug ✓	New Dose ✓	Number of days supply	Dispensing Details (Pharmacy only)
VOLTAROL	SOPP	50mg		✓							✓		1 day			1	2 supps
																	H1009

Medicines discontinued	Reason (if known) e.g. side effects	Clinical Pharmacy check:
		Drug sensitivity

Doctor's name: Simon Signature: B START Date 17/5/02
Doctor's grade: ..... Pager number: .....
Number of prescription sheets at discharge: .....

Dispensed by: ..... Date: 17/5/02
Checked by: .....

WARD USE ONLY
Med. rec. on ward by: .....
Issued by: ..... Date: ...../ ...../ .....
Signature of recipient:

White copy - G.P.; Pink copy - Case Notes; Blue copy - Pharmacy; White copy - Patient.

If you have any problems after discharge, please contact the Ward or your G.P.

THE VICTORIA INFIRMARY NHS TRUST

SURNAME (Block Letters)	FIRST NAME	UNIT No.
ROBERTS	TRACY	815845

ADDR
Miss Tracy Roberts
10/2/17 Norfolk Court
Glasgow

CHANG G5 9AT

OCCUPATION
contact number
0141-429 6879

DATE OF BIRTH
27/4/71

NEXT OF KIN (Name and Address)

NAME AND ADDRESS OF OWN DOCTOR
DR BARCLAY
GORBALS H/C

CHANGE OF ADDRESS

NAME AND ADDRESS OF OWN DOCTOR

BLOOD GROUI

SENSITIVITY

UNIT CASE RECORDS

GENERAL ☐ ORTHOPAEDIC ☐
INSTITUTE ☐ PSYCHIATRIC ☐
MATERNITY ☐ CHEST ☐

INDEX OF ATTENDANCES

Every NEW out-patient attendance, and EACH in-patient admission must be noted below

DATE	CLINIC / WARD	DOCTOR	DIAGNOSIS / OPERATION	CODED	DISCH. DATE
23/11/97	WD 10	Dr Kennedy		TRACY	24/11/97
2/2/98	Gyn	Dr Bjornsson			

FORM 0163334

USE RED INK FOR NOTIFICATION OF DEATH – ALL OTHER ENTRIES IN BLACK

Continued

DATE	CLINIC / WARD	DOCTOR	DIAGNOSIS / OPERATION	CODED	DISCH. DATE

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

MEDICAL IN CONFIDENCE

THE VICTORIA INFIRMARY

ADMISSION FORM V3

CASE RECORI

Margaret Mathieson
17th May 2002

CASE RECORD NUMBER

DATE	TIME	TYPE	REASON	ADM./TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
G306H	Victoria Infirmary					V815245		

ISSION TAILS

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E.
17/05/2002 8:39	11	1 12	Dc 15th March	3 NHS	

P A T I E N T

TITLE SURNAME	FORENAME (1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
Day Surgery U 11	GYN	Dr S. BJORNSSON				

ADDRESS: Miss Roberts Tracy
10/2/17 Norfolk Court
Glasgow

POSTCODE

TELEPHONE No.

ALT./PREV. SURNAME

OCCUPATION: 31 years

DATE OF BIRTH: 27/04/1971

SEX: F

MARITAL STATUS: S

C.H.I. NUMBER

OCCUPATION (HUSBAND/FATHER)

UNEMPLOYED

HEALTH BOARD OF RESIDENCE

HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

EF. i.P.

NAME: G5 9AT
G.P. CODE

PRACTICE: 07811 726473
Greater Glasgow Heal

CONTRACT No.

FH STATUS

ADDRESS

TEL No.

POSTCODE

EG i.F

NAME

P. CODE

PRACTICE: Dr Sheila. Henderson

CONTRACT No.: 1314513

FH STATUS: 49089

ADDRESS: Gorbals Health Centr 45 Pine Place
Glasgow

TEL No.: 0141 531 8260

POSTCODE: G5 OBQ

EXT OF IN

NAME

RELATIONSHIP: Mr William Marshall
Partner

ADDRESS: S/A

DAY PHONE No.

NIGHT PHONE No.

SC.

RELIGION

VISIT REQ. BY CHAPLAIN YES/NO

PENSION BOOK No.

Unknown

N DIAGNOSIS

SPECIAL WARNINGS

IER CONDITIONS (D.G.2)

IER CONDITIONS (D.G.3)

MR04

SMR50

I. STATUS

PREVIOUS PSYCH. CARE

CONTRIBUTORY SOCIAL FACTOR

ISCHARGE SUMMARY

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
17/5/02	14 30					

HARGE TAILS

DISCH./TRANSF. TO	READY FOR DISCH.	HOSPITAL: NAME	CODE	WARD	SPECIALTY	CONSULTANT CODE
SMR04	TYPE OF CARE PROVIDED		ECT - 1st TREATMENT DATE		ECT - NUMBER OF TREATMENTS	

D I A G N O S E S

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

ND. O P E R A T I O N S

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

LOCAL USE

NATIONAL USE

THE VICTORIA INFIRMARY

CONSENT TO ANAESTHESIA, OPERATION, INVESTIGATION OR TREATMENT

315245 2704716161
Roberts Tracy
10/2/17 Norfolk Court F
Glasgow 1
27/04/1971
G5 9AT GP Prac:49089

(See Notes for Guidance of Doctors and Patients overleaf)

Patient (BLOCK CAPITALS) _____ Date 21/2/02

Unit No. _____ Proposed Procedure (BLOCK CAPITALS) LAPAROSCOPIC STERILISATION

TO BE COMPLETED BY MEDICAL OR DENTAL PRACTITIONER

I HAVE FULLY EXPLAINED: To the patient / parent / guardian / next of kin*
(*DELETE AS APPROPRIATE)

1. The procedure named on this form
2. Appropriate alternatives which are available
3. Significant side-effects which may result from the procedure

Name (BLOCK CAPITALS) BTN

SIGNATURE

TO BE COMPLETED BY THE PATIENT

You should read this form and the notes overleaf carefully. If there is anything you do not understand, ask the doctor or dentist for an explanation. If the information is correct and you understand the procedure, you should sign the form.

I AM — The patient / parent / guardian / next of kin (DELETE AS APPROPRIATE)

I UNDERSTAND — The procedure which has been explained to me by the Doctor or Dentist named on this form.

That the procedure may not be carried out by the Doctor / Dentist 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 and can be justified for medical reasons.

I AGREE — To the administration of an anaesthetic or to sedation if required.

To the procedure named on this form.

That examination for the purposes of teaching will not be undertaken without my consent (see overleaf).

Signature X T. Roberts — Patient / Parent / Guardian / Next of Kin* (*DELETE AS APPROPRIATE)

Name (BLOCK CAPITALS) _____

Address _____

_____

_____

NOTES OF GUIDANCE

1. 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, any 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 this form.

   1.1 The patient must give written consent to be examined by students during any procedure for which written consent is required. (See Below).

2. PATIENTS

   2.1 The doctor is here to help you. He or she will explain the procedure, which you are entitled to refuse. You can ask any questions and ask for more information.

   2.2 You may ask for a relative or a friend or a nurse to be present while the Doctor/Dentist explains the procedure and asks you to sign this form.

   2.3 Students need to learn how to examine patients and to see how procedure 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. It is up to you to decide whether you give your consent or not but whatever you decide, it will not affect your treatment.

---

1. I **agree / do not agree*** to the involvement of a student at the procedure named on this form.

2. I **agree / do not agree*** to examination by a student during the procedure named on this form under the supervision of the senior medical/dental officer undertaking the procedure.

Name _____ Date _____
(BLOCK CAPITALS)

Signature _____

* DELETE AS APPROPRIATE

815245 2704716161
Roberts Tracy
10/2/17 Norfolk Court F
Glasgow. 1
27/04/1971
G5 9AT GP Prac:49089

E VICTORIA INFIRMARY — OPERATION SHEET

FIRST NAMES (Block Letters)

ON PERFORMED Lap. Ster

AGE | REGISTRATION NUMBER

17/11/2

SURGEON S. Bjornsson | ASSISTANT J. Symmo | ANAESTHETIST D. Stuart

lshie clip

.OT 0108/1

rial No of Applicator 1486

rial No of Trocar/Cannula 1486

ncare Ltd
Peter's Street
ingham NG7 3EN UK.

EXP 8/2006

Umbilical inc.
Pneumo - peritoneum
5 mm Scope
Side-port (R) side.

Uterus
Tubes
Ovaries + Ligaments } Normal
Cul de Sac

1 Filshie Clip on each tube

Steinthorpi

VIC 696
FORM 0168262

THE VICTORIA INFIRMARY — ANAESTHETIC RECORD

Date: 17/5/02
Pre-operative instructions:

815245 2704716161
Roberts Tracy
10/2/17 Norfolk Court F
Glasgow 1
27/04/1971
G5 9AT GP Prac:49089

PRE-OPERATIVE ASSESSMENT DSW

Age:	Weight (kg): / Height (m):	Airway:	Dentition:

Urgency		ASA
Elective	☑	1 2
Scheduled	☐	3
Urgent	☐	4
Emergency	☐	5

Previous anaesthesia

CVS BP /

Fit.

Resp:

GIS Fasted -
Reflux -

CNS Other:

RESULTS

Na^+	Hb
K^+	WCC
Cl^-	Plats
HCO_3	CxR
Urea	ECG
Creat Gluc	

Current drugs:

Allergies:

POST-OPERATIVE INSTRUCTIONS

Operation performed:
Left Std

Routine care -
Continuous pulse oximetry
Blood pressure every 10 minutes

Oxygen:

Other medication:

Other instructions:

CVP line ____ ☐ Monitor CVP in recovery __ ☐
Nasogastric tube ____ ☐ Free drainage ____ ☐
Urinary catheter ____ ☐ Hourly urine volumes ___ ☐

Signature:

Analgesia:

I.V. Morphine as per Recovery Algorithm - *Signature:*

2 mg bolus given - *Time:*	*Signature:*	*Witness:*
2 mg bolus given - *Time:*	*Signature:*	*Witness:*
2 mg bolus given - *Time:*	*Signature:*	*Witness:*

Post-operative fluids	Volume	Rate

0163149

ANAESTHESIA

Injection site: 22 G	L/R	Hand	Arm	Foot
Injection site: ____ G	L/R	Hand	Arm	Foot
Arterial / CVP site:				
Pre-O_2	Cricoid	ETT - Size:		
Cuffed/Uncuffed		Oral/Nasal	Pack	
Grade: 1 2 3 4				
LMA Size: 3		Facemask	Airway	
Circuit -	Circle	Bain	T-piece	
Ventilation -	Controlled	Spontaneous		
Agent -	N_2O Hal Enf Iso	Sevo		
Epidural / Spinal -	Level:	Needle size:		
Drug:		Volume:		
Other Regional:				
Patient position:				

Voltaval 100mg PR

MONITORS etc

ECG		F_IO_2		CVP		Blood warmer	
NIBP		E_TAA		IABP		Warm mattress	
S_pO_2		ALL ABOVE		PA Cath		Bair Hugger	
E_TCO_2		TOF					

	Time															
Cyanokit 5g																
Drip L 20																
N2O off																
Sevo																
S_pO_2																
F_IO_2																
E_TCO_2																
E_TAA																
Fluids																
Temperature																
180																
160																
140																
120	V															
100	V															
80																
60																
40																
20																
CVP																
Blood loss																
Urine output																

Y SURGERY UNIT
PRESCRIPTION SHEET NO: 1
VALID ONLY ON THE FOLLOWING DATE: 17/5/02.

ONCE ONLY PRESCRIPTIONS

DATE	MEDICINE (BLOCK CAPITALS)	DOSE	ROUTE	TIME FOR ADMINISTRATION	PRESCRIBERS SIGNATURE (FULL)	ADMINISTERED BY	TIME GIVEN
17/5	VOLTAROL	100mg	PR	9am		MWES	10.00

AS REQUIRED PRESCRIPTIONS - OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

DATE	MEDICINE (BLOCK CAPITALS)	DOSE	ROUTE	SYMPTOM	MINIMUM INTERVAL (HRS)	MAX. 24HR DOSE	PRESCRIBERS SIGNATURE (FULL)	ADMINISTERED BY:	TIME GIVEN
17/6	Cocodamol	30/500	O	6am	6	8		SHIELDS/RGN	1155

AS REQUIRED PRESCRIPTIONS - INJECTIONS

DATE	MEDICINE (BLOCK CAPITALS)	DOSE	ROUTE	SYMPTOM	MINIMUM INTERVAL (HRS)	MAX. 24HR DOSE	PRESCRIBERS SIGNATURE (FULL)	ADMINISTERED BY:	TIME GIVEN
17/5	STEMETIL	12.5mg	IM	Pain	8	—			

DISCHARGE PRESCRIPTIONS

DATE	MEDICINE (BLOCK CAPITALS)	DOSE	ROUTE	SYMPTOM	MINIMUM INTERVAL (HRS)	NO. OF DAYS SUPPLY	PRESCRIBERS SIGNATURE (FULL)	ISSUED BY:
17/5	VOLTAROL	50mg	PR	Pain	12	1		
17/5	Cocodamol	30/500	O	Pain	6	1 pack		

IF MEDICINE DISCONTINUED BECAUSE OF ADVERSE REACTION, ENTER BELOW

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE SENSITIVITIES	1.
	2.

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
DSU	TRACY ROBERTS	27.4.71.	158 cm	75.5 Kgs	815215	BJARNASSON

815245 2704716161
Roberts Tracy
10/2/17 Norfolk Court F
Glasgow 1
27/04/1971
G5 9AT GP Prac:49089

Day Surgery Unit
Pre-operative patient Questionn[illegible]

[illegible] of patients re[illegible]ing a general anaesthetic / sedation

Have you arranged a carer for 24 hours at home?	YES ✓	NO
Do you have a cough, cold or nose trouble?	YES	NO ✓
What time did you last have something to eat?	8.00	
What time did you last have something to drink?	12.00	
If female, what was the date of your last period?	APRIL 2002	

I understand that after day surgery I must-

- **have a carer for the next 24 hours**

I understand that after day surgery I MUST NOT:-

- **drive a vehicle or ride a bicycle for a minimum of 48 hours**
- **drink any alcohol for 24 hours**
- **be alone in charge of a baby or child for a minimum of 24 hours and until fully able**
- **Operate machinery, use a cooker or kettle for 24 hours**
- **Sign any important documents for 24 hours**

Patient's signature..... T. Roberts .....

Nurse's signature..... R. Smith .....

14 40

A

Victoria Infirmary Day Surgery Unit
PATIENT CARE PLAN

Patient details

815245 2704716161
Roberts Tracy
10/2/17 Norfolk Court F
Glasgow 1
27/04/1971
G5 9AT GP Prac:49089

Telephone: 07811 726473.

Consultant: BJ MASSON

Planned Operation: LAP STER Bilateral

Proposed Date: ~~21/03/02~~ 17/5/02

Orsos number:

Person to contact: William Marshall (partner)

Telephone:

Escort: A/A.

Telephone:

Assessment details Date of assessment: 15/3/02

Height	168	BP	102/73
Weight	75.5	Pulse Rate: Regular / ~~Irregular~~	72
BMI	30.	Bloods taken	

Accepted ☑

Accepted pending result of: ☐

Rejected ☐

E.C.G. taken: Yes ☐ No ☑

E.C.G. reviewed by Dr: Date: / /

Outcome:

Signature:

Reason/s if rejected:

Additional requirements/Comments

Specify? smell of alcohol on off patient @ pre-assessment please observe for same admission

Signature

A Niven.

Ranitidine prescribed Yes ☐ No ☑

Ranitidine collected by patient, date: / /

Fasting Instructions given: Yes ☑ No ☐

Pat TC

Name: Tracy Roberts. **Unit number:** 815245.

Post-operative EDT: 4hours

Operation performed: ~~EUA~~ Laparoscopic Sterilisation

Pressure areas: Satisfactory / Other (specify): —

Follow-up: NFU.

Diathermy site: Satisfactory / Other (specify): —

Sutures: 2b dexon. None.

Packing: —

Dressings: 2xOpsite.

Signature: JMD.

Recovery Primary Recovery Nurse/s: L Campbell / A Montgomery

Time am/pm	10.01	10.11	10.21	Discharge					
BP	123/72	111/80	120/84	121/59					
Pulse rate Regular/Irregular	80	84	58 R	59					
% Sat O_2	99%	99%	99%						
Airway	Guedel	own	ONN						
O_2	5L	5L	Air						
Conscious Yes/No	No	yes	yes						
Colour	Satis	satis	Satis						
Wound	Slight.	Slight	Slight.						
PV bleeding	NIL	NIL	Nil.						
Pain score = S / 0 / 1 / 2 / 3	5	0	0						
Colour/Sensitivity/Movement									
Signature/s:	AM	AM.	[illegible]						

Transferred to Secondary Recovery Room Number: at: hours

Secondary Recovery Nurse/s:

Discharge criteria	Yes	No
Wound/operation site satisfactory	✓	
Stable vital signs	✓	
Alert and orientated	✓	
Discharge medication given	✓	
Tolerating oral fluids	✓	
Pain score satisfactory (Score=1)	✓	
Has passed urine		✓
Advice given if not passed urine	✓	
IV Cannula removed	✓	

	N/A	Yes	No
Packing/dressing removed ~~to be~~ to remain by patient			✓
Valuables returned	✓		
ANTI D given	✓		
Follow-up arranged			✓
District Nurse arranged			✓
Responsible adult escort		✓	
Letter to GP		✓	
Verbal and written post-op instructions		✓	
ECG Electrodes removed		✓	

Patient discharged by: [signature] at: 14[illegible] hours

Discharge prescription ✓

Name: Tracy Roberts Unit number: 815245

Date, time and sign all entries

17/5/02 @ 1155 Given 2 cocodamol tablets as per Kardex instructions for pain. S Arcadia

Name: Tracy Roberts Unit number: 815245

Date, time and sign all entries

Name: Tracy Roberts Unit number: 815245

Date, time and sign all entries

Name: Tracy Roberts Unit number: 27.04.71.

Date, time and sign all entries

SB/EB/815245

Email: elaine.Byrne@gvic.scot.nhs.uk

GYNAECOLOGY DEPARTMENT

TEL NO: 0141 201 5083
FAX NO: 0141 201 5094

Day Surgery: 17.05.02
Dictated: 17.05.02
Typed: 22.05.02

PRIVATE & CONFIDENTIAL

Dr S Henderson
Gorbals Health Centre
45 Pine Place
GLASGOW
G5 0BQ

Dear Dr Henderson

Tracy Roberts 10/2 17 Norfolk Court G5 9AT
DOB: 27.04.71 Unit No: 815245

Mrs Roberts was admitted to Day Surgery and had laparoscopic sterilisation carried out.

On inspection, all pelvic organs were entirely normal, and I did sterilisation using filschie clips.

No follow up was required.

Yours sincerely

Dr Stein Bjornsson
Consultant Gynaecologist

CB/SLR/815245

GYNAECOLOGY
☎ **0141 201 5375**
🖷 **0141 201 5094**

Dictated: 21.2.02
Typed: 27.2.02

Dr S Henderson
Gorbals Health Centre
45 Pine Place
Glasgow G5 0BQ

Dear Dr Henderson,

Tracy Roberts, d.o.b. 27.4.71
10/2, 17 Norfolk Court, G5 9AT

Thank you for referring this 30 year old para 3+1 whom I saw at Dr Bjornsson's Gynaecology clinic with her request for sterilisation.

As you know she delivered twins about six months ago and she feels her family is now complete. She has tried other contraceptive methods and her partner is reluctant to go for vasectomy.

I discussed the irreversibility, failure rate, laparotomy and ectopic risk of the procedure. I have arranged for her to be admitted to the Day Surgery Unit on22nd March for laparoscopic sterilisation.

I note her last smear was ten years ago, and therefore, took the opportunity to perform a cervical smear at examination at the clinic. The cervix looked healthy and there was no abnormality on examination.

Yours sincerely,

Catrina Bain
Research Fellow

A Fleming 85/44/01

Hospital use Only | Clinic Dr Bjornsson | Day Date 21/2/02 | Time 10.15 | Hospital No. 8152445 | GP112

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category: Routine ☐ Soon ☐ Urgent ☐

Hospital VICTORIA Date 27/11/01 CHI No. 2704716161

Please arrange for this patient to attend the GYNAECOLOGY clinic of Dr/Mr

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Patient's Surname ROBERTS Maiden Surname

First Names TRACY Single/Married/Widowed/Other

Address Flt 10 Blk 2 Date of Birth 27/4/71
17 NORFOLK COURT Patient's Occupation

Postal Code G5 9AT Contact telephone number

Has the patient attended hospital before? YES / NO If "YES" please state:

Name of Hospital

Year of attendance Hospital No.

If the patient's name and/or address has/have changed since then please give details:

Can patient attend at short notice? YES / NO

If YES, minimum notice required days

Name, Address and Telephone number of MEDICAL / DENTAL PRACTITIONER

Dr. S. Harjoura
GORBALS HC

Please use rubber stamp

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

This lady is para 3 + 1 – her last pregnancy was a twin pregnancy – emergency CS so she now has 4 children and wishes to be sterilised.

Thank you for seeing her for this

DATE RECEIVED 29 NOV 2001
FOR BOOKING
DATE APPT. SENT 12/12/01

Diagnosis / provisional diagnosis: 4 children – desires sterilisation

Present drug treatment and potential special hazards:

X-ray (women of childbearing age). Date of first day of L.M.P.

Relevant X-rays available from: No. (if known)

Signature

355-2104

DEPARTMENT OF GYNAECOLOGY OPD

Name: 815245 Roberts Tracy 2704716161
Address: 10/2/17 Norfolk Court Glasgow G5 9AT
Unit Number
Date of Birth: 27/04/1971 F
Civil State: 1
Occupation: GP Prac:49089
Date of First Attendance: 21/2/02
Surgeon: Dr Bjornsson

Diagnosis

Report to Dr.
Admit – Immediate / per Waiting List / Urgent/Soon/Non-Urgent
C.P. Treatment
of on

30.
Years Married
Total Pregnancies 3+1

HISTORY

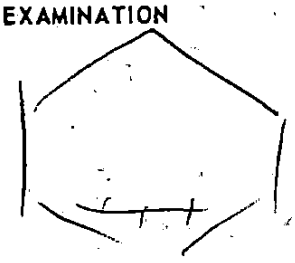
4 children:
Twins 6 months old.
1 Twin breech surgery.
Sure that family is complete
Failure rate 1:200.
Laparotomy ectopic via alternative dextrum.
SVD
SVD
(EMCLIFF TWINS)
Last mens 10 years ago.

MENARCHE / MENOPAUSE
PREVIOUS MENSTRUAL CYCLE /
PRESENT MENSTRUAL CYCLE 7/28 L.M.P. 5/52 ago

PAST HISTORY

nil.
Sth smokes 15 day, alcohol occ
DHy nil.
NKDA.
Ht 5-2" 10-½.

EXAMINATION



m/t non tender
Spec - healthy, paterlens Cx.
VE - NS AV mass.
Examined by no adnexal masses

RECOMMENDATIONS

mem -
DSV Lap ster 22/3/02

M Egan

0163739

GREATER GLASGOW COMMUNITY AND MENTAL HEALTH SERVICES NHS TRUST

Our Ref. SFW/AV/

Your Ref.

If phoning Direct dial
Ask for 211 6466

Administration Block
Leverndale Hospital
510 Crookston Road
Glasgow G53 7TU

Tel: 0141 211 6400
Fax: 0141 211 6636

26 November 1997

Dr Vernon
Consultant Physician
Ward 10
Victoria Infirmary
GLASGOW G42

815245
CODING

Dear Dr Vernon

TRACY ROBERTS (DoB 27.04.71)
54 NORFOLK COURT, GLASGOW G5 9DP

Thank you for referring this patient whom I saw in Ward 10 on 24.11.97. She had been admitted the previous day following an overdose of fifty Diazepam tablets. She had been in Leverndale Hospital the previous week after cutting her wrists but had been discharged at her own request three days before the overdose. She said that when she had been admitted to Leverndale she felt much better and that she could cope, but as soon as she got home she realised she had made the wrong decision and felt very low. She described this as being "like a black hole". She had taken the overdose because she felt there was no way out of the situation and that her partner and children would be better off without her.

She has been depressed over the last few months and is not clear as to why this has happened. She denies any specific precipitating events although she has had some arguments with her partner over recent months. She herself feels this is secondary to her depression rather than the cause of it and generally they have had a reasonable relationship over the last eight years and share in the care of their two children aged 7 and 5. The only background thing of significance is that her parents' marriage broke up and her father was physically abusive to her mother and has an alcohol problem. He is currently living in a hostel. Generally she gets good support from her mother. She seems to have had difficulties when she was at school with persistent truancy and as a teenager abused drink and was involved in glue sniffing at one point. There is no history of intravenous drug abuse and her current alcohol consumption is not excessive. She has not had previous psychiatric treatment.

When I saw her in the ward she was still somewhat drowsy following the Diazepam overdose. However she said that she still felt suicidal and that she could see no future for herself. There were some symptoms of depression and she was very negative about her ability to cope with her current situation. In view of the fact that this is the third suicide attempt in the last few months, having had a previous episode where she had contemplated throwing herself in the Clyde but was prevented by her mother, I felt that she should be re-admitted to Leverndale for further assessment and suggested that on this occasion she should remain for longer than two days. She agreed to this and arrangements were made for transfer to Ward 3 under the care of Dr Coia. However, I understand that she absconded from the ward at the Victoria Infirmary and Dr Coia has been made aware of the situation.

Yours sincerely

DR S F WHYTE
CONSULTANT PSYCHIATRIST

cc Dr D Coia, Consultant Psychiatrist, Florence Street
Dr Henderson, Gorbals Health Centre

Ref: KC/RB/815245

DIRECT LINE 0141 201 5411

Dictated 28.11.97
Typed 30.11.97

Dr S C Henderson
Gorbals Health Centre
45 Pine Place
GLASGOW G5 0BQ

Dear Dr Henderson

TRACY ROBERTS (27.04.71) 5 NORFOLK COURT GLASGOW G5 9AP

Type of admission:	Emergency
Date of admission:	23.11.97
Self-discharge:	24.11.97
Consultant:	Dr Cochran
Diagnosis:	Self-poisoning - background psychiatric disturbance

This patient was hospitalised to the Victoria Infirmary as above. She was self-poisoned with Diazepam. On the morning after admission she was drowsy, but because of history of recent care at Leverndale we decided that further psychiatric opinion was necessary. She was therefore seen 24th November. The feeling was that she had suicidal thoughts and depression, transferred to Leverndale arranged, but before this could take place the patient absconded from hospital. Contact was made with Leverndale, the Police and I believe your own Surgery.

Yours sincerely

K COCHRAN
Consultant Physician and Gastroenterologist

MEDICAL IN CONFIDENCE

THE VICTORIA INFIRMARY
NHS TRUST
ADMISSION FORM V3

CASE RECORD

YES/

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
G306H	Victoria Infirmary	V815245

DATE	TIME	TYPE	REASON	ADM./TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
23/11/1997	8:30	30	10		IP			3 NHS

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E.
WARD 10		MED	DR ~~D.VERNON~~ O CHURAN		

ISSION TAILS

PATIENT

TITLE SURNAME	FORENAME (1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
Miss Roberts	Tracy		26 years	27/04/1971	F	S

ADDRESS: 5 Norfolk Court, Glasgow
POSTCODE: G5 9AB
TELEPHONE No.: NO TEL
HEALTH BOARD OF RESIDENCE: GREATER GLASGOW HEAL
ALT./PREV. SURNAME: Roberts
OCCUPATION:
OCCUPATION (HUSBAND/FATHER):
C.H.I. NUMBER:
HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

REF. G.P.

NAME:
G.P. CODE: PRACTICE:
CONTRACT No.: FH STATUS:
ADDRESS:
TEL No.: POSTCODE:

REC G.P.

NAME: Dr S.C.Henderson
P. CODE: 1314513 PRACTICE: 49089
CONTRACT No.: FH STATUS:
ADDRESS: Gorbals Health Centr 45 Pine Place, Glasgow
TEL No.: 0141 531 8260 POSTCODE: G5 0BQ

NEXT OF KIN

NAME: Mada
RELATIONSHIP:
ADDRESS:
DAY PHONE No.:
NIGHT PHONE No.:

MISC.

RELIGION:
VISIT REQ. BY CHAPLAIN YES/NO:
PENSION BOOK No.:

Admission

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

SMR04 SMR50

PSYCH. STATUS	PREVIOUS PSYCH. CARE	CONTRIBUTORY SOCIAL FACTOR

DISCHARGE SUMMARY

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
24/11/97	Rm	21	3		A1	DrVernon
DISCH./TRANSF. TO	**READY FOR DISCH.**	**HOSPITAL: NAME**	**CODE**	**WARD**	**SPECIALTY**	**CONSULTANT CODE**
SMR04	TYPE OF CARE PROVIDED		ECT - 1st TREATMENT DATE		ECT - NUMBER OF TREATMENTS	

DISCHARGE DETAILS

DIAGNOSES

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

AND OPERATIO

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

YOU MUST USE A BALLPOINT PEN AND FULLY COMPLETE THIS FORM OR THE PRESCRIPTION WILL NOT BE DISPENSED

VICTORIA INFIRMARY NHS TRUST
Glasgow G42 9TY
Tel 0141 201 6000

IMMEDIATE DISCHARGE LETTER & MEDICINE PRESCRIPTION FORM
CONFIDENTIAL

Ref No 951627

Dear Doctor.....

Your Patient:

Fi
Na 815245
Ac ROBERTS TRACY
FLAT 232
... 200 SANDIEFIELD ROAD F
GLASGOW 27/04/71 S
... G5 0BW G.P.Prac.49089

DOB...../...../.....Unit No.....

Admitted to Ward ...10...

On 23/11/97

Consultant...Dr VERNON...Registrar.....J.H.O. .....

Discharged on 24/11/97 From Ward...10... ABSCONDED FROM WARD

Diagnosis at time of discharge

1 ...OD...
2 .....
3 .....
4 .....
5 .....

Operation/Procedures

1 .....
2 .....
3 .....

Follow Up Arrangements		
Clinic.....	Date...../...../.....	
Home Help	YES	NO
District Nurse	YES	NO
Meals/Wheels	YES	NO
Physio/OT	YES	NO
Other		

MEDICINE	Dosage Form	Dose	TIMES FOR ADMINISTRATION										Recommended duration of treatment after discharge	Pharmacy Use Only: No. of Days supply	Pharmacy Use Only: Quantity, name, Strength and Manufacturer Supplied by Pharmacy
			am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 8	pm 10	Other Times			

COMMENTS (inc. medicine sensitivity, list continuing medication not prescribed above and weight on discharge)

Patient absconded from ward but was located by police - unwilling to return. However, he was due to be transferred to Lovedale.

Doctor's Name...SHAH KASS... Signature...SHAH KASS... Date...26/11/97...
Pager no 2210

Dispensed by ..... Date .....
Checked by .....
Medication collected by (Messenger)
.....

WARD USE ONLY

Med. Rec. on Ward by .....
Issued by .....
Date Issued .....
Signature of Recipient .....

THE VICTORIA INFIRMARY NHS TRUST

ACCIDENT AND EMERGENCY DEPARTMENT 0141-201 6000

INDEX NUMBER 61490

DATE 23/11/97 TIME A.M. 6-26 P.M.

SURNAME (BLOCK LETTERS)	AGE	DATE OF BIRTH
ROBERTS	26	27 / 4 / 71
FORENAMES	**SEX**	**OCCUPATION**
TRACY	F	

ADDRESS 1/2 54 NORFOLK CRT TELEPHONE:

GENERAL PRACTITIONER Dr Henderson Gorbals Arcade.

DIAGNOSIS Drug Overdose (Valium 5g x 50-60)

INVESTIGATIONS ~~Self Poisoning~~ Bloods

X-RAYS

TREATMENT Refer Physicians Admit and IO

PLEASE PRESCRIBE

FOLLOW UP < ARRANGED / NOT ARRANGED CLINIC ON

TETANUS TOXOID / IMMUNOGLOBULIN / ALREADY IMMUNISED. PLEASE COMPLETE

SIGNED

BLOCK LETTERS C. DOBBIE

Form 0163082

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

NURSE TRIAGE

DATE 23.10.17 TIME 626 PRIORITY 1 PRIORITY 2

VITAL SIGNS (if applicable) P92

TREATMENT SIGNATURE

0700

PC Ding overdose

HPC Took 50-60 5mg valium tablets ~ 4 20pm

4-5 vodkas to drink.

vomited a few times

In house E. family

suicide note

displayed fun Lavender Ln

Tuesday

Plan (1) Refer psychiatry

admit ward

PROGRESS

SURNAME (Block Letters)	FIRST NAMES (Block Letters)	AGE	DATE OF ADMISSION
Roberts	Tracy		

DATE

23/11/97

OSCE

26 F

OD of 50-60 5mg diazepam tabs ~ 0420
+ alcohol.

Drowsy ++ : in hosp overnight.

Disch from Leverdale 5/7 ago.

O/E

Drowsy ++ but rousable. Prev. scars due to self harm on arms.

Pulse = 90/min

BP: 130/90

Chest clear

CVS ~ND

Plan - Bloods incl. drug levels
- Observe
- Psych referral

[signature]
CONSULTANT

23/11/97 OD — drowsy — Jens admitted
Well over 24 hours — note recent A/DOSE
admission — review planned by psychiatrist

[signature]

FORM 0164576

DATE

PROGRESS

SURNAME (Block Letters)	FIRST NAMES (Block Letters)	AGE	DATE OF ADMISSION

DATE

24/11/97 Psychiatric Opinion - Long F w depressive symptoms over last 2/12. No prior psychiatric hx. Married, 2 children + denies social problems. Her recent admission was in Newcastle but wanted for early discharge. Felt mood was low & she could not cope so took overdose. Was Suicidal at the time. C/O how mood feels she doesn't want to be here still experiencing depressive & suicidal thoughts. Discharged Newcastle & Referred Lewisdale for transfer. Has contacts for Community Psychiatric Nurse & Community Psychiatrist. → Ward 3/4 & will confirm arrangements tomorrow.

Con. Dep

24/11/97 2050

Informed that patient has absconded from the hospital. No Psych Hx. and for Referral to Lewisdale. DNS/Hx at Lewisdale. Advised to inform police. If patient is dangerous they will take her to Lewisdale

FORM 0164576

DATE

Otherwise patient must return to V.I. voluntarily.

Can also contact emergency GP in case of further self-harm.

D Wyatt to be informed

(CRPBRW) RG.

MEDICAL IN CONFIDENCE

THE VICTORIA INFIRMARY
NHS TRUST
ADMISSION FORM V2

CASE RECOI

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
G306H	VICTORIA INFIRMARY NHS TRUST	VIU-815245

ADMISSION DETAILS

DATE	TIME	TYPE	SOURCE	INPAT./DAYCASE	DATE ON W.L.	PATIENT CATEGORY
30/03/95	11:00	1 WLDB	1 HOME	Daycase	30/03/95	3 NHS

WARD	SPECIALTY	CONSULTANT
DAY SURGERY UNIT	GYNAECOLOGY	DR J MOWAT

PATIENT

TITLE SURNAME	FORENAME	INITIALS	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
MISS ROBERTS	TRACY		23	27/04/1971	F	

ADDRESS: FLAT 232
200 SANDIEFIELD ROAD
GLASGOW

ALT./PREV. SURNAME:

OCCUPATION:

POSTCODE: G5 0BW TELEPHONE No.: NO TEL

OCCUPATION (HUSBAND/FATHER): Greater Glasgow

REF. G.P.

NAME: HENDERSON S
G.P. CODE: 1314513 PRACTICE: 49089|1
CONTRACT No.:

ADDRESS: 45 PINE PLACE
GLASGOW
TELEPHONE No.: 429 6291 POSTCODE: G5 0BQ

NEXT OF KIN

NAME: RELATIONSHIP:
ADDRESS:
DAY PHONE No.: NIGHT PHONE No.:

AND / OR

NAME: RELATIONSHIP:
ADDRESS:
DAY PHONE No.: NIGHT PHONE No.:

MISC.

RELIGION	VISIT REQ. BY CHAPLAIN YES/NO	PENSION BOOK No.

DISCHARGE SUMMARY

DISCHARGE DETAILS

DATE	TIME	DISCH. CODE	PATIENT CATEGORY	TYPE FACILITY	SPECIALTY	CONSULTANT	CODE
30/3/95	17.10						
DISCHARGED/ TRANSFERRED TO	HOSPITAL	CODE		WARD	SPECIALTY	CONSULTANT	CODE

DIAGNOSES

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

AND OPERATIONS

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

Coded 3/4/95

LOCAL USE			NATIONAL USE	

MEDICAL IN CONFIDENCE

THE VICTORIA INFIRMARY
NHS TRUST
ADMISSION FORM V3

WAR

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
G506H	Victoria Infirmary	V015245

ADMISSION DETAILS	DATE	TIME	TYPE	REASON	ADM./TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
	23/11/1997	0750	3	30	10	I			3

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E.
WARD 10		MED	DR J.VERNON		

PATIENT

TITLE SURNAME	FORENAME (1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
Miss Roberts	Tracy		26 years	27/04/1971	F	

ADDRESS: 5 Norfolk Court, Glasgow

ALT./PREV. SURNAME: n.k.

OCCUPATION:

C.H.I. NUMBER:

POSTCODE: G5 9TE

TELEPHONE No.: NO TEL

OCCUPATION (HUSBAND/FATHER):

HEALTH BOARD OF RESIDENCE: GREATER GLASGOW HEA

HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

REF. G.P.

NAME	ADDRESS
G.P. CODE / PRACTICE	
CONTRACT No. / FH STATUS	TEL No. / POSTCODE

REF. G.P.

NAME: Dr S.C.Henderson 1314513	ADDRESS: Sorbay Health Centr 45 Pine Place Glasgo
G.P. CODE: 49085 / PRACTICE	TEL 941 331 4260
CONTRACT No. / FH STATUS	TEL No. / POSTCODE: G5 0BQ

NEXT OF KIN

NAME: Mada	ADDRESS
RELATIONSHIP	DAY PHONE No. / NIGHT PHONE No.

MISC.

RELIGION	VISIT REQ. BY CHAPLAIN YES/NO	PENSION BOOK No.

Admission

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

SMR04

SMR50

H. STATUS	PREVIOUS PSYCH. CARE	CONTRIBUTORY SOCIAL FACTOR

DISCHARGE SUMMARY

DISCHARGE DETAILS	DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
	2nd Dec	2pm	1				
	DISCH./TRANSF. TO	READY FOR DISCH.	HOSPITAL: NAME	CODE	WARD	SPECIALTY	CONSULTANT CODE
	SMR04	TYPE OF CARE PROVIDED		ECT - 1st TREATMENT DATE		ECT - NUMBER OF TREATMENTS	

DIAGNOSES

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

AND OPERATIO

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

815245
ROBERTS TRACY
FLAT 232 F
200 SANDIEFIELD ROAD S
GLASGOW 27/04/71
G5 0BW G.P.Prac.49089

ICTORIA INFIRMARY N.H.S. TRUST

OPERATION SHEET

FIRST NAMES (Block Letters)

ON PERFORMED

STOP

AGE | REGISTRATION NUMBER

SURGEON | ASSISTANT | ANAESTHETIST

30.3.95

Uterus = 11-12 wks A/V

Bulky sqt Cx

12 weeks

Cerazem given 11.50 am

⇒ Cx dilated
12mm suction curette
Syntocinon IV
Cavity checked – forceps curette

Moderate bleeding ⇒ settled

Rh Pos

Plans to see GP re: Depo Provera

Shuja

FORM 0168262

JMcC/920526

JK/EC/815245

GYNAECOLOGY DEPARTMENT
DIRECT LINE 0141 201 5376

Dictated 11.4.95
Typed 12.4.95

Dr Barclay
Govanhill Health Centre
233 Calder Street
GLASGOW G42

Dear Dr Barclay

TRACY ROBERTS, FLAT 232, 200 SANDIEFIELD ROAD, G5 - DOB 27.4.71

I would like to inform you that the above patient had termination of pregnancy at the Day Surgery Unit, Victoria Infirmary on 30 March, 1995. She was discharged later the same day.

She is planning to see you soon as she has decided to have Depo-Provera for contraception.

Yours sincerely

J KOSKOSAS
Registrar to Dr J Mowat

DAY SURGERY PATIENT CARE PLAN VICTORIA INFIRMARY NHS TRUST

ATTENDED AT OUT-PATIENT CLINIC

815245
ROBERTS TRACY
FLAT 232 F
200 SANDIEFIELD ROAD S
GLASGOW 27/04/71
G5 0BW G.P.Prac.49089

CONSULTANT
Dr Mowat

OPERATION PLANNED
EUA STOP

OPERATION DATE 30/3/95

PATIENTS PHONE NUMBER
no phone

NEXT OF KIN DETAILS
MUM Eliz Armour
170 Sandiefield Rd
House 38 ; Scotts

ESCORT DETAILS
MUM SIA.
Concierge 429 0379.

ANAESTHETIC ASSESSMENT TO BE COMPLETED BY ASSESSMENT NURSE

1	DATE ASSESSMENT COMPLETED	30/3/95
2	IS THE PATIENT UNDER 10 OR OVER 75 YEARS?	YES/(NO) 23yrs.
	HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING	
3	ANGINA, HEART TROUBLE, CHEST PAIN	YES/(NO)
4	ASTHMA, WHEEZE, BREATHLESSNESS ON WALKING	YES/(NO)
5	FITS OR CONVULSIONS, EXCEPT FEBRILE	YES/(NO)
6	DIABETES, OR A STROKE	YES/(NO)
7	HEARTBURN RELATED TO REFLUX (IF FOR CIMETIDINE COMPLETE PRO-FORMA AND PRESCRIPTION CHART AND ATTACH)	YES/(NO)
8	ANY PROBLEMS WITH PREVIOUS ANAESTHETICS	YES/(NO) 1ST GA
9	BLEEDING OR BLOOD PROBLEMS, OR ANAEMIA	YES/(NO)
10	ANY SERIOUS ILLNESS IN THE PAST	YES/(NO)
12	USING ANY DRUGS, TABLETS, MEDICATIONS (DIGOXIN, INSULIN, ORAL ANTI-DIABETIC DRUGS. MAOI PARNATE, MARPLAN, NARDIL.	YES/(NO) LIST
13	WOULD YOU BE HAPPY TO BE A DAY PATIENT	(YES)/NO
14	WILL YOU BE ABLE TO ARRANGE AN ADULT ESCORT	(YES)/NO
15	WILL YOU HAVE SOMEONE TO STAY WITH YOU OVERNIGHT, AND FOR HERNIA ETC. LOOK AFTER YOU THE NEXT DAY	(YES)/NO
16	DO YOU HAVE ACCESS TO A TELEPHONE FOR EMERGENCY	(YES)/NO
17	DO YOU LIVE WITHIN A 1 HOUR JOURNEY OF THE HOSPITAL	(YES)/NO
18	HAVE YOU ANY ALLERGIES, PLEASE LIST	YES/(NO)
19	DO YOU HAVE ANY STAIRS, TO NEGOTIATE POST OP (HERNIA, VVEIN, ARTHROSCOPY PATIENTS)	YES/NO NA

B/P 110/90	WEIGHT 58.7	HEIGHT 162	BMI 22
BLOODS TAKEN no	ACCEPTED ✓	REJECTED	NURSES SIGNATURE Shirley Thomson

ADDITIONAL REQUIREMENTS FOR PATIENT CIRCLE AND SIGN WHEN ARRANGED

AMBULANCE REQUIRED	SPECIAL DIET	NURSE SIGNATURE
COUNSELLING	OTHER SPECIFY	
INTERPRETER	COMMUNITY NURSE	DATE

PRE-OPERATIVE CHECK LIST TO BE COMPLETED BY ADMITTING AND THEATRE NURSES

CHECK LIST	ADMIT NURSE	THEATRE NURSE	COMMENTS
PRE-OPERATIVE QUESTIONNAIRE COMPLETED AND SIGNED			
FASTED FROM	2300 HRS.	23[00]	
CONSENT FORM SIGNED	YES	Yes	
CONFIRM OPERATION AND SITE	YES	Yes	
IDENTIFICATION BRACELET	YES	Yes	
HAS PASSED URINE	YES	Yes	
PRE-MEDICATION GIVEN		No	
ESCORT HOME ARRANGED	YES	Yes	
LOCKER KEY/BED NUMBER	23	23	
ANY CROWNS /CAPS	N/A	N/A	
CONFIRM KNOWN ALLERGIES AND LIST	NONE	N/A	
CONFIRM BLOOD GROUP IF TERMINATION OF PREGNANCY.	Rh+VE	O+ve	
ARTIFICIAL TEETH	NONE	REMOVED ✓	TO BE REMOVED
CONTACT LENSES	(NONE)	REMOVED ✓	TO BE REMOVED
GLASSES	(NONE)	REMOVED ✓	TO BE REMOVED
HEARING AID	(NONE)	REMOVED ✓	TO BE REMOVED
NAIL VARNISH	(NONE)	REMOVED ✓	TO BE REMOVED
JEWELLERY	NONE	REMOVED ✓	(TAPED)
OTHER ARTIFICIAL AIDS SPECIFY	(NONE)	REMOVED ✓	TO BE REMOVED
SIGNATURE OF NURSE COMPLETING	S. Carnell		DATE:-

POST-OPERATIVE INFORMATION FOR WARD/RECOVERY STAFF

OPERATION PERFORMED	STOP.
WOUND SUTURED WITH	
SUTURES REQUIRE TO BE REMOVED IN	DAYS, NUMBER OF SUTURES
SUTURES ARE DISSOLVABLE	
PATIENT DOES/(DOES NOT) REQUIRE FOLLOW-UP O/P APPOINTMENT IN	
DISTRICT NURSE DOES/DOES NOT REQUIRE TO BE ARRANGED	
PATIENT DOES/DOES NOT HAVE DRAIN/PACK TO BE REMOVED AT	
POST-OPERATIVE/DISCHARGE ANALGESIA PRESCRIBED BY ANAESTHETIST	✓
OTHER POST-OP INFORMATION SPECIFY	
ESTIMATED TIME OF DISCHARGE FROM THE WARD/DSU	1530
SIGNATURE OF NURSE COMPLETING INFORMATION	

POST-OPERATIVE RECORDINGS PRIMARY RECOVERY AREA

TIME OF RECORDINGS	1245	1255	105				
BLOOD PRESSURE	101/46	121/84	121/74				
PULSE RATE	71	63	71				
% OXYGEN SATURATION	99%	99%	96%				
AIRWAY TYPE	own	own	own				
OXYGEN	4L	4L	NIL				
UNCONSCIOUS	✓	—	—				
CONSCIOUS		✓	✓				
COLOUR SATISFACTORY	✓	✓	—				
WOUND CHECK	✓	✓	—				
PV BLEEDING	NIL	NIL	Staines				
OTHER SPECIFY							

SIGNATURE OF RECOVERY ROOM NURSE **DATE**

PERI-OPERATIVE/POST-OPERATIVE NURSING CARE UNTIL DISCHARGE

NB:- BLOOD GROUP STILL TO BE RECORDED.
PLEASE ENSURE RESULT PRIOR TO DC

1400 DISCHARGE
Blood group Rh +
Ponstan 500mg orally at 14⁰⁰ for pain relief SThomas
EOT 1530

14⁰⁰- Moderate vaginal staining noted - pad changed ST.
14²⁰- moderate vaginal staining - pad changed.
14⁴⁰ bleeding, lessening, spotting o/pad.
15²⁰- bleeding lessing small → moderate amount ST.

17¹⁰- no one came to collect Patient
therefore patient taken to ward 12A
Sitting room to wait. SThomas

DISCHARGE CRITERIA WHICH MUST BE MET PRIOR TO DISCHARGE BY NURSE FROM WARD OR DAY SURGERY UNIT

CHECK LIST	YES/~~NO~~
WOUND/OPERATION SITE SATISFACTORY	YES/~~NO~~
STABLE VITAL SIGNS.	YES/~~NO~~
ALERT AND ORIENTATED	YES/~~NO~~
SATISFACTORY ANALGESIA (Ponstan 500mg orally at 1400)	YES/~~NO~~
TOLERATING ORAL FLUIDS	YES/~~NO~~
HAS PASSED URINE	YES/~~NO~~
VENFLON REMOVED	YES/~~NO~~
RESPONSIBLE ADULT ESCORT	YES/~~NO~~
POST OPERATIVE INSTRUCTIONS GIVEN VERBAL AND WRITTEN	YES/~~NO~~
FOLLOW-UP ARRANGED	~~YES/NO~~ N/A
DISTRICT NURSE ARRANGED IF REQUIRED	~~YES/NO~~ NO
LETTER TO GP GIVEN TO PATIENT	YES/~~NO~~
DISCHARGE MEDICATION (ANALGESIA) GIVEN	YES/~~NO~~
TIME OF DISCHARGE FORM WARD/DSU AREA	YES/NO — 17¹⁰
SIGNATURE OF NURSE COMPLETING DISCHARGE	Shirley MThomas

815245
ROBERTS TRACY
FLAT 232 F
200 SANDIEFIELD ROAD S
GLASGOW 27/04/71
G5 0BW G.P.Prac.49089

DAY SURGERY UNIT

PRE-OPERATIVE PATIENT QUESTIONNAIRE

FOR THE ATTENTION OF PATIENTS RECEIVING A GENERAL ANAESTHETIC

PLEASE TICK CORRECT ANSWERS	NO/YES
Will you be on you own when you get home?	✓ /
Will this be you first operation?	/ ✓
Have you or any of your family had problems with anaethetics?	✓ /
Do you have a cough, cold or nose trouble?	✓ /
Have you had any serious illnesses in the past?	✓ /
Have you had heart disease, rheumatic fever or high blood pressure?	✓ /
Do you get swollen ankles?	✓ /
Do you smoke? - (Indicate how many per day)	/ ✓
Do you have arthritis or muscle disease?	✓ /
Do you suffer from anaemia or blood disorder?	✓ /
Have you ever had liver disease or been jaundiced?	✓ /
Do you drink more than a moderate amount of alcohol?	✓ /
Have you ever had kidney disease?	✓ /
If female, date of last period?	2,1,95

YOU ARE REMINDED THAT YOU SHOULD NOT DRIVE OR OPERATE MACHINERY FOR 24 HOURS FOLLOWING YOUR ANAESTHETIC.

PATIENT'S SIGNATURE T. Roberts

NURSE'S SIGNATURE S. Carnell.

815245
ROBERTS TRACY
FLAT 232 F
200 SANDIEFIELD ROAD S
GLASGOW 27/04/71
G5 0BW G.P.Prac.49089

VICTORIA INFIRMARY
NHS TRUST

CONSENT TO ANAESTHESIA, OPERATION, INVESTIGATION OR TREATMENT

(Notes for Guidance of Doctors and Patients overleaf)

Patient Name (BLOCK CAPITALS) Tracy Robert Date 30/3/95

Unit Number 815245 Proposed Procedure (BLOCK CAPITALS) Termination of pregnancy

TO BE COMPLETED BY MEDICAL OR DENTAL PRACTITIONER

I HAVE FULLY EXPLAINED: To the patient / parent / guardian / next of kin* (*DELETE AS APPROPRIATE)

1. The procedure named on this form
2. Appropriate alternatives which are available
3. Side-effects which may result from the procedure

Name (BLOCK CAPITALS) Dr I. KOSKOSAS

SIGNATURE

TO BE COMPLETED BY THE PATIENT

You should read this form and the notes overleaf carefully. If there is anything you do not understand, ask the doctor or dentist for an explanation. If the information is correct and you understand the procedure, you should sign the form.

I AM — The patient / parent / guardian / next of kin (DELETE AS APPROPRIATE)

I UNDERSTAND
- The procedure which has been explained to me by the Doctor or Dentist named on this form.
- That the procedure may not be carried out by the Doctor / Dentist 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 and can be justified for medical reasons.

I AGREE
- To the administration of an anaesthetic or to sedation if required.
- To the procedure named on this form.
- That examination for the purposes of teaching will not be undertaken without my consent (see overleaf).

Signature T. Roberts — Patient / Parent / Guardian / Next of Kin* (*DELETE AS APPROPRIATE)

Name (BLOCK CAPITALS)

Address

0444405 JMcC/942539

NOTES OF GUIDANCE

1. 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, any 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 this form.

   1.1 The patient must give written consent to be examined by students during any procedure for which written consent is required. (See Below).

2. PATIENTS

   2.1 The doctor is here to help you. He or she will explain the procedure, which you are entitled to refuse. You can ask any questions and ask for more information.

   2.2 You may ask for a relative or a friend or a nurse to be present while the Doctor/Dentist explains the procedure and asks you to sign this form.

   2.3 Students need to learn how to examine patients and to see how procedure are done. This important for the future of health services. you may be asked to give consent to be examined by students during the procedure. It is up to you to decide whether you give your consent or not but whatever you decide, it will not affect your treatment.

---

1. I **agree / do not agree*** to the involvement of a student at the procedure named on this form.

2. I **agree / do not agree*** to examination by a student during the procedure named on this form under the supervision of the senior medical/dental officer undertaking the procedure.

Name _____ Date _____
(BLOCK CAPITALS)

Signature _____

* DELETE AS APPROPRIATE

HOSPITAL

PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS			DOSE	ROUTE	TIMES FOR ADMINISTRATION										Prescribers Signature (Full)	DISCONTINUED	
Pharmacy Use	Date Started	MEDICINE (Block Capitals)			am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times		Date	Signed
	A																
	B																
	C																
	D																
	E																
	F																
	G																
REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED																	
	H																
	J																
	K																
	L																
	M																
	N																
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS			DIET				
DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
30/3/95		Cefuroxime	1 pcss	PR	[redacted]	[redacted]	11.50
30.3.95	TO TAKE HOME	METRONIDAZOLE 400mg tabs. Take 1 tab 3 times daily. 2 days supply	500mg	O	[redacted]	S Sharma	14.00

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE SENSITIVITIES	1.

WARD		E/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
	815245					

815245
ROBERTS TRACY F
FLAT 232 S
200 SANDIEFIELD ROAD 27/04/71
GLASGOW G.P.Prac.49089
G5 0BW

...RIA INFIRMARY N.H.S. TRUST

ANESTHESIA SHEET

	FIRST NAMES (Block Letters)	AGE	REGISTRATION No.

DATE OF OPERATION
30-3-95

ASA 1
No allergies
No Fit ~~mass~~ prosthesis
Teeth ✓ Airway ✓ Fasted ✓ 24hr restricts ✓

PREMEDICATION

TIME ADMINISTERED a.m./p.m.

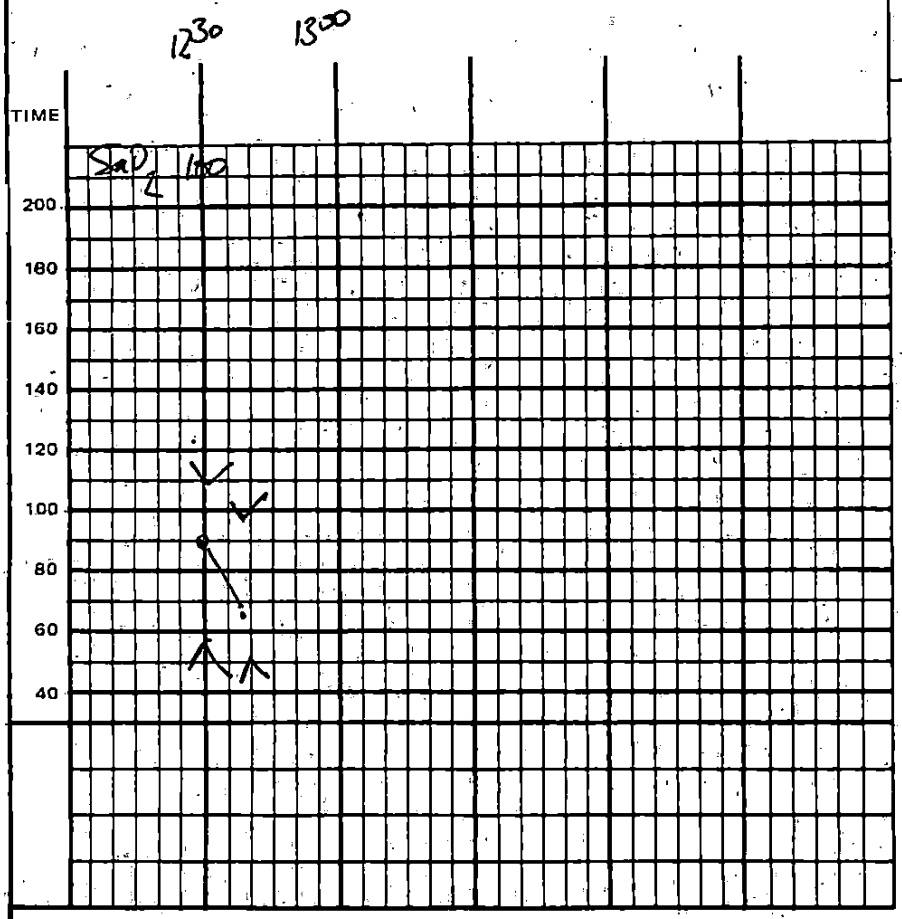
OPERATION PERFORMED
S.T.O.P

BEGAN OPERATION
ENDED

BEGAN ANAESTHESIA
ENDED

AGENTS AND TECHNIQUE EMPLOYED

- 22g venflon (L) hand
- propofol 200mg
- alfentanil 1mg
- Syntocinon 10units
- SV/hand bag O_2/N_2O/iso
- facemask



Nebcomed Monitors

HAEMOGLOBIN

BLOOD GROUP

ANAESTHETIST'S SIGNATURE

JMcC/920416 FORM 0163149

Operation performed

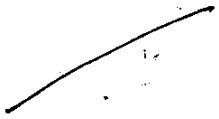
Estimated Blood Loss

Tubes

Drains

Urinary Catheter

Packing

I.V. Fluids During Operation


INSTRUCTIONS Routine post-op obs + care

Record Pulse and B.P. every 15: 30: 60: mins.

Record Central Venous Pressure every 15: 30: 60: mins

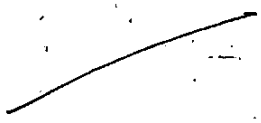
Oxygen : in recovery

ic Aspiration :

Catheter :

Medication :

Other :

Continue I.V. Fluids with	Rate
1 2 3 4 	

Signature

Time	a.m./ p.m.												
Pulse	Rate												
	Irregular												
Blood Pressure													
C al Venous Pressure													
Temperature													
Airway	Present												
	Inserted												
Oxygen													
Conscious													
Unconscious													
Colour	Satisfactory												
	Poor												
Volume Fluid Loss	Vomit												
	Aspiration												
	Urine												
	Drain												
	Wound												

Discharge to Ward : Time :

	I.V. Fluids Given	
Time	Type of Fluid	Amnt.

Time	Medication	Initial

Signature

GREATER GLASGOW HEALTH BOARD

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS																								COMMENTS ON DISCREPANCIES
DATE	6 a.m.			8 a.m.			10 a.m.			12 m.d.			2 p.m.			4 p.m.			6 p.m.			10 p.m.			12 m.n.			OTHER TIMES			
30/3/05			Initial			Initial			Initial			Initial			Initial			Initial			Initial			Initial			Initial	14.00hrs - Ranitidine 300mg orally on pain relief SThom

NAME

UNIT NUMBER

WARD

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. ✗ = PATIENT ABSENT

FORM MR1 10/90

GREATER GLASGOW HEALTH BOARD

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS																								COMMENTS ON DISCREPANCIES
DATE	6 a.m.			8 a.m.			10 a.m.			12 m.d.			2 p.m.			4 p.m.			6 p.m.			10 p.m.			12 m.n.			OTHER TIMES			
			Initial			Initial			Initial			Initial			Initial			Initial			Initial			Initial			Initial	

NAME

UNIT NUMBER

WARD

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. X = PATIENT ABSENT

JK/AB/815245

GYNAECOLOGY DEPARTMENT

DIRECT LINE 0141 201 5376

DICTATED 28/03/95
TYPED 29/03/95

Dr Barclay
Govanhill Health Centre
233 Calder Street
GLASGOW G42

Dear Dr Barclay

TRACY ROBERTS. FLAT 232, 200 SANDIEFIELD ROAD, GLASGOW G5.
DOB 27/4/71

Thank you for referring the above young girl who is requesting termination. She is a single mother on income support with 2 children, and this pregnancy was the result of unprotected intercourse. She is not sure about future contraception and mentioned sterilisation to me, but she is not sure. I note she is only 23 years old, is about 12 weeks pregnant by dates and this was confirmed by clinical examination. As our lists are fully booked until the end of April, I will try to arrange for her to have the termination on another Consultants list, so she has not been given a date today. We will arrange this as soon as possible.

Yours sincerely

J Koskosas
Registrar

THE VICTORIA INFIRMARY NHS TRUST DEPARTMENT OF HAEMATOLOGY

SURNAME	FORENAMES	SEX	HOSP. No.	D.O.B.
ROBERTS	TRACY	F	815245	27.04.71

LOCATION	CONSULTANT/G.P.	LAB No.
Day Surgery Victoria	Mowat	50330.0181

REPORT
FB REPORT

FILM NOT EXAMINED

DATE OF REPORT	Analyser Diff.	NEUTRO	LYMPH	MONO	EOS	BASO	ESR mm/hr	RETIC %	AUTHORISED BY
30-MAR-95	%	71	20	9	1	0			William McNab

DATE OF SAMPLE	W.B.C X10 9/L	PLAT X10 9/L	R.B.C. X10 12/L	Hb g/dL	Hct	M.C.V. fL	M.C.H. pg	R.D.W.
30-Mar-95	5.5	160.0	3.69	12.2	0.347	94.1	33.2	12.3

VICTORIA INFIRMARY NHS TRUST — BLOOD TRANSFUSION DEPARTMENT

SURNAME	FORENAMES	SEX	HOSP. No.	D.O.B.
ROBERTS	TRACY	F	815245	27-Apr-71

HOSPITAL	WARD	MEDICAL OFFICER
Victoria Infirmary	Day Surgery VIC	Mowat

LABORATORY NUMBER	ABO BLOOD GROUP	RHESUS BLOOD GROUP	ANTIBODY SCREEN	DIRECT COOMBS TEST
5.4652.3	O	POS	Positive	Negative

BLOOD PRODUCTS ISSUED FOR USE ON

TO BE COMPLETED BY NURSE/MEDICAL OFFICER

PRODUCT	GROUP	COMPATIBLE & PACK NOS.	SET UP BY	TIME/DATE	CHECKED BY	REACTION

"THIS BLOOD WILL BE DERESERVED" AT 9.00 a.m. ON .....

COMMENTS:
RESULTS TELEPHONED.
KNOWN ANTI-Le (a) PRESENT.

SPECIMEN RECEIVED DATE 30-Mar-95 DATE OF TEST 30-Mar-95 AUTHORISED BY C White

DEPARTMENT OF GYNAECOLOGY OPD

815245
ROBERTS TRACY
FLAT 232 F
200 SANDIEFIELD ROAD S
GLASGOW 27/04/71
G5 0BW G.P.Prac.49089

Unit Number

Date of Birth
Civil State

Occupation

Date of First Attendance Dr Mowat

Surgeon

28/3/95

Diagnosis

unwanted pregnancy

Disposal

Report to Dr. _____

Admit – Immediate
per Waiting List
Urgent/Soon/Non-Urgent.

O.P. Treatment _____

at _____ on _____

Years Married

Total Pregnancies 2+0
(normal deliveries)

HISTORY

LMP 26/1/95

- unwanted pregnancy
- single mother, on income support 12weeks
- had occasional intercourse (unprotected)
- not sure about future ~~contraception~~ contraception
- mentioned sterilisation but not sure!

MENARCHE MENOPAUSE	PREVIOUS MENSTRUAL CYCLE /	PRESENT MENSTRUAL CYCLE /	L.M.P.

PAST HISTORY

Nil of note

Drugs: nil

Allergies: none known

EXAMINATION

uterus ~ 12 weeks size

Examined by Dr ROSKOSAS

RECOMMENDATIONS

lists fully booked till 26/4
to try other consultant's lists

Dial surgery arranged For 30/3/95 P.m ~~tbc~~
or Pringle will do
For Cervagem will come 11 am

Form 0304

JMcC 914675

815245

THE KER PRACTICE

Dr L. Berlow
Dr R. Gordon
Dr Sheila Henderson
Dr E. Jane Garwood
Dr J. Travers
Dr Susan Mutch
Dr Ceri Barclay

Gorbals Health Centre
45 Pine Place
Glasgow G5 0BQ
Tel: 041–429 6291

17.3.95

Dear Doctor

re Tracy Roberts
27.4.77
200 Sandringham Rd

Thank you for seeing this lady. She is pregnant, LNMP 2.1.95 & feels she could not cope with a third child as she has recently split up from her

partner and this look like being a permanent sight. She would be interested in using the alternatives.

Thank you

Yours sincerely

KBy

Dr. Kate Barclay

IN CONFIDENCE

Certificate A

Not to be destroyed within three years of the date of the operation

ABORTION ACT 1967

Certificate to be completed in relation to an abortion under Section 1(1) of the Act

I Kathleen Mc Barcas

(name and qualifications of practitioner : in Block Capitals)

of Gorbals Health Centre

G5

(full address of practitioner)

Have/have not* seen/examined* the pregnant woman to whom this certificate relates at

Gorbals Health Centre

45 Rose Mare Glasgow

(Full address of place at which patient was seen or examined)

on 17.3.95

and I Dr. I. COSKOSAS

(Name and qualifications of practitioner : in Block Capitals)

of Flat 5, Block 1-2 Roper Place, Rutherglen

Glasgow G73

(Full address of practitioner)

*(*delete as appropriate)*

Have/~~have not~~* seen/and examined* the pregnant woman to whom this certificate relates at

Victoria Infirmary, Glasgow G42

(Full address of place at which patient was seen or examined)

on 28/3/95

We hereby certify that we are of the opinion, formed in good faith, that in the case of

Tracy Robert

(Full name of pregnant woman : in Block Capitals)

of 200 Sandiefield Road

Gorbals G5

(Usual place of residence of pregnant woman : in Block Capitals)

Tick appropriate box

- ☐ A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated.
- ☒ B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.
- ☒ C the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman. Maternal distress
- ☐ D the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman.
- ☐ E there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

This certificate of opinion is given before the commencement of treatment for the termination of pregnancy to which it refers.

Signed [signature]

Date 17.3.95

Signed [signature]

Date 28/3/95

(OVERLEAF: CERTIFICATE B - FOR USE IN CASES OF EMERGENCY)

IN CONFIDENCE

Certificate B

Not to be destroyed within three years of the date of the operation

ABORTION ACT 1967

Certificate to be completed in relation to an abortion performed in emergency under Section 1(4) of the Act

I, ...

(name and qualifications of practitioner : in Block Capitals)

of .....

.....

(full address of practitioner)

hereby certify that I *am/was of the opinion, formed in good faith, that it *is/was necessary immediately to terminate the pregnancy of

.....

(Full name of pregnant woman : in Block Capitals)

of .....

.....

(Usual place of residence of pregnant woman : in Block Capitals)

Tick appropriate box

☐ F to save the life of the pregnant woman; or

☐ G to prevent grave permanent injury to the physical or mental health of the pregnant woman.

This certificate of opinion is given:

Tick appropriate box

☐ 1 before the commencement of treatment for the termination of the pregnancy to which it relates; or, if that is not reasonably practicable, then

☐ 2 not later than 24 hours after such termination.

Signed .....

Date .....

*Delete as appropriate

(OVERLEAF: CERTIFICATE A)

Ed Rep 30m 1/92 (102496/2)

C

BIOCHEMISTRY DEPARTMENT

↑↑ REMOVE THIS STRIP & AFFIX REPORT — TOP EDGE TO LINE ABOVE ↑↑	11
↑↑ REMOVE THIS STRIP & AFFIX REPORT — TOP EDGE TO LINE ABOVE ↑↑	10
↑↑ REMOVE THIS STRIP & AFFIX REPORT — TOP EDGE TO LINE ABOVE ↑↑	9
↑↑ REMOVE THIS STRIP & AFFIX REPORT — TOP EDGE TO LINE ABOVE ↑↑	8
↑↑ REMOVE THIS STRIP & AFFIX REPORT — TOP EDGE TO LINE ABOVE ↑↑	7
↑↑ REMOVE THIS STRIP & AFFIX REPORT — TOP EDGE TO LINE ABOVE ↑↑	6
↑↑ REMOVE THIS STRIP & AFFIX REPORT — TOP EDGE TO LINE ABOVE ↑↑	5
↑↑ REMOVE THIS STRIP & AFFIX REPORT — TOP EDGE TO LINE ABOVE ↑↑	4
↑↑ REMOVE THIS STRIP & AFFIX REPORT — TOP EDGE TO LINE ABOVE ↑↑	3
↑↑ REMOVE THIS STRIP & AFFIX REPORT — TOP EDGE TO LINE ABOVE ↑↑	2

LIFT TAB AND PEEL OFF STRIP FROM THIS SIDE

APPLICATION No 9106216. JONES & BROOKS LTD. ☎ 0706 843121

817

VICTORIA INFIRMARY NHS TRUST

BIOCHEMISTRY DEPARTMENT

C

Name	Sex	Date of Birth	Regn. No.	Dr./Mr. (Consultant)
ROBERTS TRACY	F	27.04.71	Z9730910	
Hospital / Unit	**Laboratory No.**	**Date Received**	**Time**	
VIC 10	136010.R	23.11.97	1339	Depression

CHEMICAL TOXICOLOGY

Reference Range Units		mmol/L	mmol/L	hours			
Date	Time	PARACET	SALICYL	HPD			
23.11.97	1300	<0.04	<0.2				

Results with "<" indicate concentration below sensitivity of assay

Biochemist

MOUNT SHEET

OTHER

11 11
10 10
9 9
8 8
7 7
6 6
5 5
4 4
3 3

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST
PATHOLOGY DEPARTMENT

SGH487

Name :ROBERTS Tracey
Address :17 Norfolk Court
Glasgow
G5 9AT
Unit No.:815245

Date of Birth :27.04.71
CHI No :2704716161
Previous Name :
FP Number :

Sender :Dr.S.Bjornsson
Address :Gynaecology Unit Victoria

G.P.:Not Known
Not Known

Smear taken : 21.02.02
Date received : 21.02.02

Reason for smear : Routine Repeat
Appearance of cervix: Intact
L.M.P :
Hormone Treatment : No

Clinical details: Routine

NEGATIVE SMEAR.

Please repeat in 3 years.

Advice: Routine repeat

GMC / / Date reported 27.02.02 Lab. Reference No. S,02.0004256.Z

The Scottish Ambulance Service NHS Trust SAS1

Patient Transport Request Form

Ambulance Service use only
Message received date / time stamp

Day ☐☐☐ Date of journey ☐☐/☐☐/☐☐

Time of appointment/discharge ☐☐☐☐

Is a return journey required? Yes ☐ No ☐ (Tick) If yes: time ready ☐☐☐☐

Patient details:

Mr/Mrs/Miss/Ms Surname _____ First name _____

	Pick up from	Deliver to
./Street/ward or dept.		
Floors up		
Part of town/hosp.		
Town		
Postcode		

Type of case (Tick)

Outpatient	1 ☐
Day Hospital	2 ☐
Discharge	3 ☐
Admission	4 ☐
Transfer	5 ☐
Special App	6 ☐

Mobility category Tick one Box Only

Patient requires assistance from one person and can travel by car.	1 ☐
Patient requires assistance from one person and transport by Ambulance.	2 ☐
Patient requires assistance from a two person crew and transport by Ambulance.	3 ☐
Patient requires to lie down in an Ambulance.	4 ☐
Patient requires the care of a qualified ambulance crew	5 ☐

Escort Requirement (Tick)

Is a friend or relative required on Medical Grounds?	1 ☐
Will a nurse escort be provided?	2 ☐

Additional Information (include reason if Special Appointment)

_____

_____

Authorised by:

Doctor's name _____ Dept/Ward _____

Signature _____ Date _____

Hospital _____ Tel/Ext.No _____

Carried By

Ambulance service	1 ☐
ACS	2 ☐
Contractor	3 ☐
Rail	4 ☐
Air	5 ☐
Sea	6 ☐

Rec Initials ☐☐☐

Patient No ☐☐☐☐☐

Notice

Normal	1 ☐
Short	2 ☐

(JUN 95)

THE VICTORIA INFIRMARY NHS TRUST
PATIENT PROFILE

ADDRESSOGRAPH LABEL:

TRACY ROBERTS
Flat 1/2
54 Norfolk Cct

WARD: 10

RELIGION:

DATE of BIRTH: 27/4/71 AGE: 26 yrs.

OCCUPATION:

CONSULTANT: Dr COCHRAN

LIKES TO BE CALLED:

ADMISSION INFORMATION
DATE: 23.11.97. TIME: 7am

NEXT OF KIN (NAME and RELATIONSHIP):
~~Daughter~~ William Marshall

ADDRESS: Husband
As Above

TELEPHONE NO. HOME: 420 6447
WORK:

WISHES TO BE CONTACTED OVERNIGHT
IF NECESSARY: YES NO

OTHER RELEVANT CONTACT:

G.P. (NAME and HEALTH CENTRE):
Dr BARCLAY
GORBALS HEALTH CENTRE

TRANSFER INFORMATION

DATE:

REASON:

TYPE OF ADMISSION:
EMERGENCY.

REASON for ADMISSION:
self poisoning valium
50-60 tablets

CURRENT DIAGNOSIS:

INVESTIGATION/OPERATION:

OBSERVATIONS on ADMISSION
APPEARANCE on ADMISSION:

TEMP: 35° PULSE: 97 RESP:

BP: 129/90

WEIGHT: LMP:

URINALYSIS: PARITY:

KNOWN ALLERGIES:

PATIENT'S OWN DRUGS

HOW DISPOSED OF:

KNOWN/RELEVANT PAST MEDICAL HISTORY
Discharged from Leverndale 5 days ago.

OTHE

PREVIOUS HOSPITAL ADMISSION

Victoria : ☐

None : ☐

Others : ☐

Date of this admission _____

FORM 0250441

SUPPORT PRIOR TO ADMISSION

RELATIVES/VISITORS
HOME HELP
DISTRICT NURSE
MEALS ON WHEELS
DAY HOSPITAL
CLUBS
OTHER

self - caring

SOCIAL CIRCUMSTANCES

PATIENT'S PERCEPTIONS

unaware

RELATIVES PERCEPTIONS

aware.

PATIENT SPOKEN TO BY: SISTER
DOCTOR

RELATIVES SPOKEN TO BY: SISTER
DOCTOR

RELATIVES SPOKEN TO BY: CONSULTANT

(Please give names and dates)

VALUABLES

CLOTHING LISTED:
MONEY:
JEWELLERY LISTED:
ELECTRIC RAZOR:
OTHER(SPECIFY):
VALUABLES TO HOSPITAL SAFE:

valuables policy explained

RECEIPT NO.:

DENTURES: UPPER None
LOWER

HEARING AID: RIGHT EAR None.
LEFT EAR

WEARS SPECTACLES: None.
NO. OF PAIRS:

ANY PROSTHESIS:

LEFT OR RIGHT HANDED:

PERSONAL LAUNDRY

TO BE TAKEN HOME: —

WASHED BY HOSPITAL:

MARKING PROCEDURE EXPLAINED:

DAY CLOTHES REQUESTED:

ANY NEW INFORMATION FOLLOWING TRANSFER

INFORMATION GAINED FROM:
Author

INFORMATION GAINED BY (Name and Grade)

THE VICTORIA INFIRMARY NHS TRUST

PATIENT ASSESSMENT FORM

ADDRESSOGRAPH LABEL:

Tracy Roberts

DATE OF ADMISSION/TRANSFER:

ASSESSMENT OF ACTIVITIES OF LIVING.

Normally self caring.

A. MAINTAINING PERSONAL SAFETY/COMFORT:

B. COMMUNICATION:

C. BREATHING:

D. EATING AND DRINKING:

E. ELIMINATING:

F. PERSONAL HYGIENE/DRESSING:

G. CONTROLLING BODY TEMPERATURE:

FORM 0247111

H. MOBILISING:

I.WORK AND SOCIAL ACTIVITIES:

J. EXPRESSING SEXUALITY:

K. REST AND SLEEP:

L. DYING:

SACREMENT OF THE SICK:

SKIN ASSESSMENT

INSTRUCTIONS FOR USE

Identify the most appropriate description of the patient (4,3,2 or 1) under each of the headings and total score.

NORTON SCORING-

Total of 16 or below = AT RISK

A-PHYSICAL CONDITION		D-MOBILITY	
Good	4	Full	4
Fair	3	Slightly Limited	3
Poor	2	Very Limited	2
Very Poor	1	Immobile	1
B MENTAL CONDITION		**E. INCONTINENT**	
Alert	4	Not	4
Apathetic	3	Occasionally	3
Confused	2	Usually Urine	2
Stuperous	1	Double	1
C. ACTIVITY		**F. SKIN CONDITION**	
Ambulant	4	Healthy/Intact	4
Walk/Help	3	Dry/Intact	3
Chairfast	2	Red/Blanched	2
Bedfast	1	Broken	1

FRONT BACK

INFORMATION GAINED BY GRADE: DATE:

THE VICTORIA INFIRMARY NHS TRUST

NURSING NOTES

SURNAME Roberts HOSPITAL No.

FORENAME Tracy SEX

D. of B.

ADDRESS

WARD/DEPT. 10

NURSING NOTES

Date	NURSING NOTES	Signature	Grade
23/11	Emergency admission with a self poisoning of 50-60 valium tablets. Pt is very drowsy and unable to give history and daughter and not known in ward.	AHCC	D
	Plan - Bloods & drug levels		
	- Observe		
	- Psyc referral. ✓		
WR	- psych referral.	AHCC	D
pm	Now awake, is willing to talk to psychiatrists tomorrow. Is very down of mood. Forearms are covered in scars from previous suicide attempts. Observations all satisfactory	ANCCrorie	D
24/11/97	Slept all night. No complaints offered.	SMcNeil	E
am	WR - psych referral ✓	KFen	E
	SIB Dr White		
pm	Wd 3 Leverdale will have a bed tomorrow Tel 2116585		
	Ambulance booked.		
	up and mobile obs satisfactory	KFen	E
20.30	Tracy appears to have left the ward without permission. Sister with Sleep informed medical staff aware. Husband thinks Tracy left with her brother. last seen on ward 19.45hrs	KFen	C
	Partner contacted by myself who will try and find out if Tracy is with her brother. Medical staff have contacted Leverndale and have requested that police be informed. - Sister Barr has contacted police.		
	Mr Marshall (partner) has		

FORM 0164238

Date	NURSING NOTES	Signature	Grade
	telephoned ward to say Tracy is with her family and neither she or the family are keen for her to return. Medical staff informed and police informed. I have told her family that we would prefer that she was ~~to~~ in hospital but they have informed me that they would watch her at home and seek advice in morning. Dr Barr, medical staff informed and police informed.	AQuicai	E

PATIENT CARE PLAN: MOVING AND HANDLING SECTION

Patient's name:	T. Roberts	Named Nurse	A McCrorie	If patient is totally independent, tick here and go to date box.	

BODY BUILD			
Obese		Tall	
Above average	✓	Medium	—
Average	—	Short	
Below average			
Weight (if known):			

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

RISK OF FALLS			
High	✓	Low	

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

nto bath or shower.

HANDLING AID		WHICH BATH		SUPERVISION			INDEPENDENT	NO BATH OR SHOWER
Ambulift		Parker		People 1		2		✓
Dextra		Var height						
Shower chair		Standard						
		Any						

Additional Information:

ransfers (including to/from: bed; wheelchair; commode; toilet).

HOIST		MANUAL SUPPORT			INSTRUCTION	SUPERVISION	INDEPENDENT
Ambulift		People 1		2			
Dextra		Side					
Carter/Oxford		Front					
Sara		Combined					
Standaid							

Additional Information:

oiletting.

HOIST			MANUAL SUPPORT			INSTRUCTION	SUPERVISION	INDEPENDENT
People 1	2	3	People 1	2	3			
Ambulift			Side					
Dextra			Front					
Carter/Oxford			Combined					
Sara Standaid								

Additional Information:

+ commode

Walking.

NO WALKING		ASSISTANCE			INSTRUCTION	SUPERVISION	INDEPENDENT
	✓	People 1		2			
		Walking aid					

Distance Walked / Additional Information:

Move up/down bed.

HOIST		HANDLING AIDS	INSTRUCTION	SUPERVISION	INDEPENDENT
		Sliding aid (fabric)			
		Rope ladder			
		Hand blocks			

Additional Information:

Sit up over side of bed.

ROPE LADDER		SLIDING AID (FABRIC)		INSTRUCTION	SUPERVISION	INDEPENDENT
						✓

Move on/off bed pan.

HOIST		ROLL PATIENT		PATIENT BRIDGES		MONKEY POLE		NOT USED
								✓

Transfer to/from trolley (or bed etc).

SLIDING AID - RIGID (e.g. Patslide)		SLIDING AID - FABRIC (e.g. Easyslide)		INSTRUCTION	SUPERVISION	INDEPENDENT
						✓

Other instructions.

Date(s) assessed:	23/11/97				
Assessor's signature:	AMcC				
Proposed review dates:	24/11/99				
				Finishing date:	

nto bath or shower.

HANDLING AID	WHICH BATH	SUPERVISION	INDEPENDENT	NO BATH OR SHOWER
Ambulift	Parker	People 1 2	Additional Information:	
Dextra	Var height			
Shower chair	Standard			
	Any			

ransfers (including to/from: bed; wheelchair; commode; toilet).

HOIST	MANUAL SUPPORT	INSTRUCTION	SUPERVISION	INDEPENDENT
Ambulift	People 1 2	Additional Information:		
Dextra	Side			
Carter/Oxford	Front			
Sara	Combined			
Standaid				

oiletting.

HOIST	MANUAL SUPPORT	INSTRUCTION	SUPERVISION	INDEPENDENT
People 1 2 3	People 1 2 3	Additional Information:		
Ambulift	Side			
Dextra	Front			
Carter/Oxford	Combined			
Sara Standaid				

alking.

NO WALKING	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
	People 1 2	Distance Walked / Additional Information:.		
	Walking aid			

ove up/down bed.

HOIST	HANDLING AIDS	INSTRUCTION	SUPERVISION	INDEPENDENT
	Sliding aid (fabric)	Additional Information:		
	Rope ladder			
	Hand blocks			

it up over side of bed.

ROPE LADDER	SLIDING AID (FABRIC)	INSTRUCTION	SUPERVISION	INDEPENDENT

ove on/off bed pan.

HOIST	ROLL PATIENT	PATIENT BRIDGES	MONKEY POLE	NOT USED

ransfer to/from trolley (or bed etc).

SLIDING AID - RIGID (e.g. Patslide)	SLIDING AID - FABRIC (e.g. Easyslide)	INTRUCTION	SUPERVISION	INDEPENDENT

ther instructions.

Date(s) assessed:					
Assessor's signature:					
Proposed review dates:					
				Finishing date:	

THE VICTORIA INFIRMARY N.H.S. TRUST
PATIENT CARE PLAN:

NAME: Tracy Roberts WARD: 10 DATE OF ADMISSION: 23/11/97

DATE COMM. SIGNATURE	PERSONAL HYGIENE/DRESSING	DATE DISC. & SIGNATURE
23/11 AM	Bath at bedside offer oral hygiene.	
	MOBILISATION	
23/11 AM	Bedrest, can alter own position	
	EATING AND DRINKING	
23/11 AM	NBM at present.	
23/11 AM	Normal diet & fluids	
	ELIMINATION	
23/11 AM	Commode + 2 nurses	
	SPECIAL NEEDS/MAINTAIN PERSONAL SAFETY	
23/11 AM	Obs/Bgs in situ	

DATE COMM. & SIGNATURE	TECHNICAL CARE	DATE DISC. & SIGNATURE
23/11 AM	Care of venflon on Darm	
	OBSERVATIONS	
23/11 AM	BP Pulse temp	24/11/97 AM
23/11 AM	Daily BP, Pulse temp.	
	WOUND CARE/OTHER CARE	
	SPECIMENS / **INVESTIGATIONS**	
23/11 AM	MSU	

Form 0164411

THE VICTORIA INFIRMARY N.H.S. TRUST

PATIENT CARE PLAN: NAME: WARD: DATE OF ADMISSION:

DATE COMM. & SIGNATURE	PERSONAL HYGIENE/DRESSING	DATE DISC. & SIGNATURE	DATE COMM. & SIGNATURE	TECHNICAL CARE		DATE DISC. & SIGNATURE
				OBSERVATIONS		
	MOBILISATION					
				WOUND CARE/OTHER CARE		
	EATING AND DRINKING					
	ELIMINATION			SPECIMENS	INVESTIGATIONS	
	SPECIAL NEEDS/MAINTAIN PERSONAL SAFETY					

Form 0164411

THE VICTORIA INFIRMARY NHS TRUST

PRESSURE SORE RISK ASSESSMENT

Ward: 10 Diagnosis: self poisoning

Name: T. Roberts

Age: 26 Weight on admission:

Date of admission: 23/11/97 Waterlow score on admission:

Assessment should be carried out on all patients within 2-4 hours of admission and repeated 24 - 48 hours afterwards. Repeat assessment as condition changes or at weekly intervals.

WATERLOW RISK ASSESSMENT

Ring scores in the table below. Add the total.

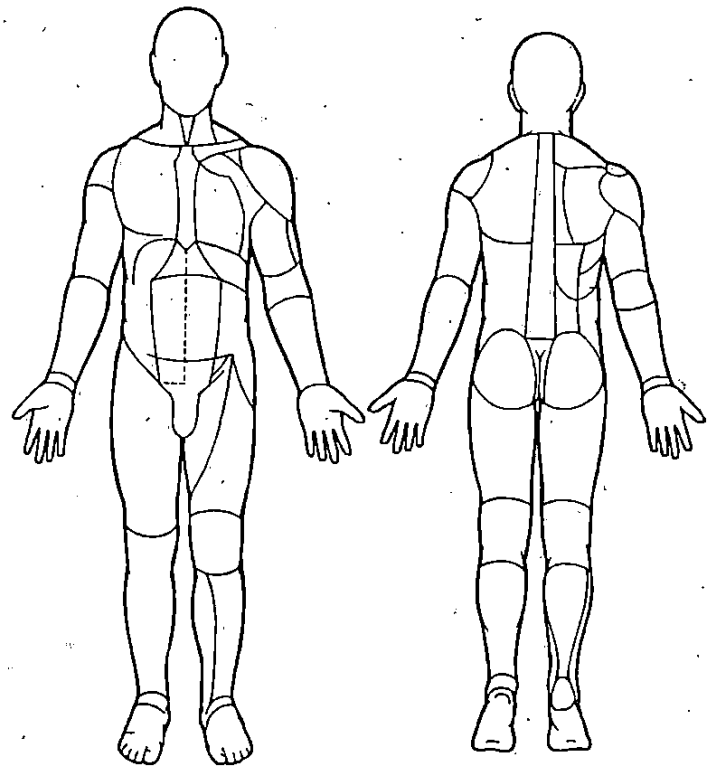
(Several scores per category may be used).

Build/weight for height		Skin type Visual risk areas		Sex / Age		SPECIAL RISKS	
Average	(0)	Healthy	(0)	Male	1	**Tissue malnutrition**	
Above average	1	Tissue paper	1	Female	(2)	e.g. Terminal cachexia	8
Obese	2	Dry	1	14-49	(1)	Cardiac failure	5
Below average	3	Oedematous	1	50-64	2	Peripheral vascular disease	5
Continence		Clammy (Temp. !)	1	65-74	3	Anaemia	2
Complete/catheterised	(0)	Discoloured	2	75-80	4	Smoking	1
Occasionaly incontinent	1	Broken/Spot	3	81+	5	**Neurological deficit**	
Catheterised/ incontinent of faeces	2	**Mobility**		**Appetite**		e.g. Diabetes, CVA, MS, par/tetraplegia, motor/sensory	4-6
Doubly incontinent	3	Fully	(0)	Average	0	**Major surgery or trauma**	
		Restless/Fidgety	1	Poor	1	Orthopaedic - below waist, spinal	5
		Apathetic	2	N.G. Tube/Fluids only	2	On table > 2 hours	5
		Restricted.	3	NBM/Anorexic	3	**Medication**	
		Inert/Traction	4			Steroids, cytotoxics, anti-inflammatory	4
		Chair/Bedbound	5				

Score 10+ : At risk.
Score 15+ : Medium/high risk.
Score 20+ : Very high risk.

Date	Score	Signature	Date	Score	Signature	Date	Score	Signature
23/11	3	ANC						

Date	Action to be taken (e.g. turning time, position, other).	Date	Equipment Matt	Cushion



GRADE OF SORE

1 Blanching hyperaemia.

2 Non-blanching hyperaemia.

3 Ulceration progresses throught to the subcutaneous tissue.

4 Lesion extends into subcutaneous fat.

5 Infective necrosis / necrotic tissue.

(Torrance 1983)

If pressure sore is grade 3-5, also complete Wound Assessment Chart

On admission, number site of sore on the above diagram and enter grade in table below. On each subsequent assessment enter grade in table bejow.
If no pressure sore is evident, enter NIL and date below.

Number	Date	Grade	Topical therapy	Initials

THE VICTORIA INFIRMARY N.H.S. TRUST

TPR CHART

Name Tracy Roberts

Address

Unit Number

Date of Birth

Sex/ Civil state

Occupation

Date 23/1 24/1 pm

Post Op Date 1 on

TEMPERATURE °C

42 41 40 39 38 37 36 35 34

PULSE

180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

RESPIRATION

No. of Stools

FORM 0164736

ELECTRONIC PATIENT RECORDS

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

Including:

BADGERNET	☐
AREVUE	☐
MEDICAL ILLUSTRATION	☐
METAVISION	☐
PHYSIOTHERAPY	☐
RADIOLOGY	☑
WEST MARC	☐
LABS	☐

Roberts Tracy CHI: 2704716161

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No
This letter supersedes previous version of 12 Nov 2015 16:49

Dr. LF Morley
Drs Treadgold duffy & morley
Pollok Health Centre
21 Cowglen Road
Glasgow
G53 6EQ

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100
Date of Completion: 12/11/2015

Dear Dr LF Morley,

Name	CHI	DoB	Address
Tracy Roberts	2704716161	27/04/1971	263 Curtis Ave Glasgow G44 4NW

Admitted	Type	Discharged	Destination
11/11/2015 22:43	In Patient	12/11/2015	

Specialty	Consultant	Ward	Telephone
Orthopaedics	Mr Nick Brownson	QEUH Ward 10D	01414522710 / 01414522711

Reason for Admission and Presenting Complaints	Admission Category
	Accidental Injury - Injury caused by an accident

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

linical Comments: Dear Doctor,
Thank you for your continuing care of this 44 year old lady in the community.
She was admitted on the 11/11 after sustaining a glass wound to her right hand.
She subsequently went on to have a right hand wound exploration and washout on the 11/11.
There were no complications during surgery and she is not well on the ward.
She is fit for discharge and FOLLOW UP?

Treatments: None recorded.

Follow-up arranged: upper limb fracture clinic next week wound review at clinic

Planned Outpatient Investigations:

Final Discharge letter to follow:

Medication Info:

Allergies:

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Dihydrocodeine Tartrate Tablets	Oral	30	mg	Every 4 - 6 Hours when required	1 Week	
Paracetamol Tablets	Oral	1000	mg	FOUR Times a Day	1 Week	

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Gabriella Samson
Doctor

Prescription Review
Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Victoria Thornthwaite, Nurse

Acute Services Division

Nursing Admission & Assessment

1. Admission

NHS Greater Glasgow and Clyde

Name: [redacted]
Addres: 2704716161
ROBERTS
Tracy
F
27/04/1971
DoB:....
CHI nur

Hospital: QEUH	Ward: 10 D
Date of admission: 11 / 11 / 15	Time: 22:30
Admitting Consultant: Beanson	Admitting Nurse: Carson
Expected date of discharge: / /	

1. Patient Details

Preferred name: Tracy	Next of Kin (NoK): ~~Mother~~ Elizabeth Armour
Age:	Relationship: Mother
Religion: Church of Scotland	NoK Address: 10 Dairsie St, muirend
Telephone: 0141 571 8540	
Dr. LF Morley Drs Treadgold duffy & morley Pollok Health Centre 21 Cowglen Road Glasgow G53 6EQ	NoK Telephone: 07733094655
	NoK Aware of admission: ☑ Yes ☐ No
	Consent for information to be given to relatives: ☑ Yes ☐ No
	Nominated family contact:
	Telephone - Day:
GP telephone: 0141 531 6860	Telephone - Evening:

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

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

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

Contact telephone number: .....

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

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

2. Presenting Complaint / Diagnosis

Lacerations to (R) hand / cut to (L) thumb

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

Tripped through glass door

3. Allergies (including food allergies)

No known allergies: ☒ Codeine

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
5	6	—	103	119/76	18	97	35.9
Urinalysis:		AMT4 Score	BM	NEWS Score	Weight Estimated / Actual	Height Estimated / Actual	BMI
		—	—	2	~~Est~~ 77kg	~~Act~~ 1.55	32

5. Current Medication

NO

Medicines reconciled on admission? ☐ Yes ☑ No

6. Relevant Past Medical History

NiL

7. Risk Assessment

MUST

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

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

   Score 0
3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
   - Score = 2
   - Not applicable: Score = 0

   Score 0

MUST Score: 0

If score 1 or more, complete full Nutrition Profile

Name: .....
Address:... 2704716161 ROBERTS F
..... Tracy 27/04/1971..
DoB: .....
CHI numb ...

8. Cognitive Impairment

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

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

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

AMT Score: ..... out of 4

Name of Doctor informed (if required)

..... Grade .....

9. MRSA Screening / CJD / Healthcare outside Scotland

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

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

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

☑ Nasal ☐ Perineum ☐ Other - Specify: Throat, Groin ☐ Patient refused

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

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

Healthcare outside Scotland

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

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

Rectal swab taken ☐ Patient refused ☐

10. Lifestyle

Smoking:

Does the patient smoke? ☑ Yes ☐ No

If 'Yes' how many per day: 18

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

Does the patient wish referral to Smoking Cessation Service?

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

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

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

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

If 'Monthly' or more then complete FAST Tool.

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

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

If 'Monthly' or more then complete FAST Tool.

11. Admission Documentation Completed By

Name (Please PRINT): SHERYL PAGE	Signature: S. Page
Designation: St/n	Date: 11/11/15

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Hospital: DEUH	Ward: 10 D
Date of Assessment: 11 / 11 / 15	Time:

Name: .....
Address: .....
.....
DoB: .....
CHI numbe

2704716161
ROBERTS F
Tracy 27/04/1971

1. Breathing and Circulation

Breathing:

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

If 'Yes' provide details:

Circulation:

- [x] No symptoms
- [ ] Known cardiac or circulatory problems

Problem identified: [ ] Yes [x] No If 'Yes' please describe

	Initial

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

English

Interpreter: Required [ ] Not required [x]

If required, provide details and arrangement made:

.....

.....

Does the patient have:

a. Speech difficulties? [ ] Yes [x] No

b. A learning disability e.g. Down's Syndrome? [ ] Yes [x] No

If 'Yes' please specify:

.....

If 'Yes' contact Liaison Learning Disability Team.

Liaison Learning Disability Team contacted: [ ] Yes [x] No

c. A learning difficulty e.g. dyslexia, dyspraxia? [ ] Yes [x] No

If 'Yes' please specify:

.....

3. Senses

Senses:

Eyesight

- [x] Normal vision
- [x] Glasses – [x] Distance [x] Reading
- [ ] Prosthesis – [ ] Left [ ] Right
- [ ] Contact lenses
- [ ] Registered blind

Hearing

- [x] Normal
- [ ] Hearing impaired
- [ ] Hearing aid – [ ] Left [ ] Right

4. Mental Status

Mental Status:

- [x] Orientated
- [ ] Confused
- [ ] Distressed
- [ ] Aggressive /Abusive
- [ ] Unconcious

Problem identified: [ ] Yes [x] No If 'Yes' please describe

	Initial

5. Hydration and Nutrition

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

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

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

Date of reassessment: / /

Name: .....
Addres: 2704716161 .....
ROBERTS F
..... Tracy 27/04/1971
DoB:... 263 Curtis Ave .....
Glasgow, Lanarkshire
CHI nu G44 4NW

5a 1. Food likes / dislikes:

Everything (likes)

5a 2. Fluid likes / dislikes:

dislikes soft drinks
Coffee - likes w/ milk

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

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

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

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

	Initial

6. Elimination

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

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

Continence assessment commenced:	Containment products in use? Please specify:
☐ Yes ☐ No ☑ Not applicable	
☑ Bowels regular ☐ Constipated ☐ Diarrhoea / loose stools	Stoma: ☐ Yes ☐ No If 'Yes' please specify and list appliances used:

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

	Initial

7. Personal Hygiene, Oral Health and Skin Assessment

Name: 2704716161 .....
Addres ROBERTS F .....
..... Tracy 27/04/1971 .....
DoB: ... .
CHI nu .....
Affix patient data label

Personal hygiene:

☑ Self-caring and independent
☐ Requires assistance

Specify assistance if required:

Oral health:

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

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

Oral Hygiene Care Bundle:

☐ Required ☑ Not required

Dentures:

☐ Not worn
☑ Upper set 9 top
☑ Lower set 4 bottom
☐ Full set
☐ Dentures with patient on admission

Skin assessment:

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

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

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

	Initial

8. Mobility

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

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

Moving and Handling Plan commenced:

☐ Yes ☐ No

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

	Initial

9. Maintaining a Safe Environment

Pain status:

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

What makes their pain better? Please provide brief details:

Bed rail assessment completed: ☐ Yes ☑ No

Bed rails required:

☐ Required ☑ Not required

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

	Initial

0. Sleep and Rest

Sleep habits:
- [x] Less than 8 hours
- [ ] Afternoon nap
- [ ] Morning nap

Sleep difficulties:
- [ ] None
- [x] Disturbed e.g. nocturia, insomnia
- [ ] Early wakening

Medication required: [ ] Yes [x] No

Nam[redacted]
Addr[redacted]
2704716161
ROBERTS F
Tracy 27/04/1971
DoB:. 263 Curtis Ave
Glesgow, Lanarkshire
CHI n G44 4NW

Problem identified: [x] Yes [ ] No If 'Yes' please describe

Insomnia

Initial SP

1. Social Circumstances

- [ ] Employed [x] Unemployed [ ] Retired
- [ ] Lives alone
- [x] Lives with Family 3 daughters
- [ ] Friend
- [ ] Dependants
- [ ] Other: [ ] Nursing Home [ ] Residential

Current Care / Support arrangements:
- [ ] Social Services [ ] Unpaid carer e.g. family, friends
- [ ] Private Carers [ ] None

If support services in place, please provide details:

Brother will look after till mother can get to house.

Problem identified: [ ] Yes [x] No If 'Yes' please describe

Initial

2. Privacy, Dignity and Sexuality

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

If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?
- [ ] Yes [x] No

If 'Yes' please provide brief details:

Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?
- [ ] Yes [x] No

If 'Yes' please provide brief details:

Ask the patient:
"Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?"
- [ ] Yes [x] No [ ] Not at this time

If 'Yes' please specify faith group:

Name: 2704716161 .....
Addr ROBERTS F.....
Tracy 27/04/1971
263 Curtis Ave
Glasgow, Lanarkshire
DoB: G44 4NW
CHI r .....
Affix patient data label

14. Anticipatory Care

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

Appropriate ☐ Not appropriate ☐

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

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

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

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

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

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

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

15. Admission Assessment Completed By

Name (Please PRINT): SHERYL PAGE

Signature: S. Page

Designation: St/n

Date: 11/11/15

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
11/11 23[30]	Pt admitted, to Cast Crom Midhand Ca Exploration + washout (R) hand. Wound during Crom A+E oozing blood, padded + bandage applied. limited movement in thumb Arm Elevated in Sling. IV fluids	

Clinical Notes continue on next page

Name: 2704716161
ROBERTS
Tracy
263 Curtis Ave
Glasgow, Lanarkshire
G44 4NW
F
27/04/1971
Addres
DoB:
CHI nu

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation
	Commenced	
15[10]	patient returned from theatre following varicose & vein repair, CSM intact, Neg 0, IV fluids running-	
16-15	Discharge letter requested.	

Writ
Nam
Add 2704716161
ROBERTS F
CHI: Tracy 27/04/1971
DOE 263 Curtis Ave
Hosp Glasgow, Lanarkshire
G44 4NW

Peripheral Vascular Cannula(PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy		
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain,redness,swelling	2	Early stage of phlebitis - Remove & resite cannula
All of the following are evident: pain,redness,hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis Remove & resite cannula Seek further advice
As above including: palpable venous cord	4	
As above including :pyrexia	5	

Insertion – Complete all sections

PVC inserted	Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *[only if inserted in ward]*
ED Theatre Ward_____	11/10/11/15	(L) arm	Pink	

Clinical Indication	IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☒	Other Please state:

Insertion Criteria (If no: please explain in comments below)	Clean field used	Hand hygiene	Skin asepsis	Dressing affixed	Non touch technique (do not re- contaminate cleaned skin)
	Yes ☐ No ☐ Unknown ☒	Yes ☐ No ☐ Unknown ☒	Yes ☐ No ☐ Unknown ☒	Yes ☒ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☒

Maintenance – To be completed daily

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date removed 12/11/15 Reason for PVC removal NOT Needed Reason PVC in greater than 72 hours_____

Date & time	PVC no.	Comments	Signature

MIS 269426
81117

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

Insertion – Complete all sections

PVC inserted ED Theatre Ward_____		Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *[only if inserted in ward]*
Clinical Indication	IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☐	Other Please state:	
Insertion Criteria (If no: please explain in comments below)	Clean field used Yes ☐ No ☐ Unknown ☐	Hand hygiene Yes ☐ No ☐ Unknown ☐	Skin asepsis Yes ☐ No ☐ Unknown ☐	Dressing affixed Yes ☐ No ☐ Unknown ☐	Non touch technique (do not re- contaminate cleaned skin) Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 2	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date & time	PVC no.	Comments	Signature

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

NHS Greater Glasgow and Clyde
Active Care Checklist

[redacted]

Date: 11/11/15

Attach Add[redacted]

2704716161
ROBERTS F
Tracy 27/04/1971
263 Curtis Ave
Glasgow, Lanarkshire
G44 4NW

Ward OD

NHS Greater Glasgow and Clyde

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

1. Signed [redacted] Name [redacted] Designation SP
2. Signed ..... Name ..... Designation .....
3. Signed ..... Name ..... Designation .....

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

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

		Times	23[redacted]	02	04																	
	1.	**Pain:** assess and address If in pain inform registered nurse Y / N or N/A	N	S	N																	
S	2.	**SKIN INSPECTION** Pressure areas checked: Y / N / I (Independent)	I	S	I																	
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)	–	S	–																	
K	3.	**KEEP MOVING:** Have you moved or walked Y / N / I (independent)	I	S	Y																	
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B	–	S	–																	
		Chair Assist to walk, stand or tilt (W /ST/ T)	–	S	–																	
I	4.	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces	I	S	I																	
N	5.	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? Y / N (consider mouth care)	N	S	Y																	
		Encourage the patient to drink? Y / N / N/A	Y	S	N																	
		Food, snack or supplement taken? Y / N / N/A	Y	S	N																	
	6.	**ENVIRONMENT: Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S	Y	S	Y																	
	7.	**INFORMATION:** Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S	Y	S	Y																	
	8.	**ESCALATION:** Escalate any issues to the Registered Nurse Y / N/A	N/A	S	N/A																	
		Nurse Initials	P	e	P																	

Attach Addressograph label Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

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

Active Care variant sheet - Care Number

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

Date	Time	Number	Variation	Signed

MIS 258902

CEDAR CODE 102083

Fluid Balance Chart

Nam [redacted] 27/04/1971
DoB: 2704716161
ROBERTS
Tracy
Chi nu

Affix patient data label

Hospital: GEUH
Ward: 10D
Date: 12/11/15

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? NHS Greater Glasgow and Clyde
Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Running Total INPUT	Output						Running Total OUTPUT	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00					500 mls				500	up to toilet							CB
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00					Ringers	1000	(TL)		1500								
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
							*Total Intake		[redacted]						*Total Output	[redacted]	

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.

Are any of the risk factors below relevant?

Acute Clinical Condition
- Increasing NEWS Score
- Decreased Urine Output
- Suspected/ Evidence of SIRS/ Sepsis

Excessive Fluid Loss
- Vomiting
- Diarrhoea
- Urine output >200mls/hr
- High output stoma

Clinical Signs of Dehydration
- Dark coloured urine
- Dry Mouth
- Abnormal Urea and Electrolytes

Functional/Cognitive ability to maintain hydration and the requirement to monitor fluid balance
- Dementia
- Muscle Weakness or Trauma.

Underlying condition with high risk of fluid electrolyte imbalance

Commenced or Prescribed IV Fluid Therapy

Commenced or Prescribed Artificial Nutrition Support e.g. Total Parenteral Nutrition, Enteral Nutrition

Routine post operative management

None are applicable or relevant → Reassess daily or if clinical condition changes

One or more are applicable or relevant → Consider commencement of Fluid balance chart*

Able to manage Oral Intake
- Ensure patient is aware of importance of taking fluids
- Identify patient preferences for oral fluids e.g. drinks only tea
- Ensure fluid balance chart is accurately completed at all times
- Use red lid water jug to identify to staff that patient requires fluid intake to be monitored

Unable to manage oral Intake sufficiently
- Ensure review of patient condition by medical staff to consider supplementary fluids e.g. IV fluids.

Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

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Pa. 2704716161
ROBERTS
Tracy
D: 263 Curtis Ave
Glasgow, Lanarkshire
C
G44 4NW
F
27/04/1971

fix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg)..... Height (cm).....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional Instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
11/11	2330	HALTMANNS	500mls	IV	5°				1/11	2334			
11/11	0A	HALTMANNS	500mls	IV	5°					0415			

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name: .....

Date of birth: .....

CHI No: .....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescribers should sign this box if the fluid/additive is no longer required.

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name	
Address	2704716161 ROBERTS Tracy F 263 Curtis Ave 27/04/1971 Glasgow, Lanarkshire
CHI No.	G44 4NW
DoB	

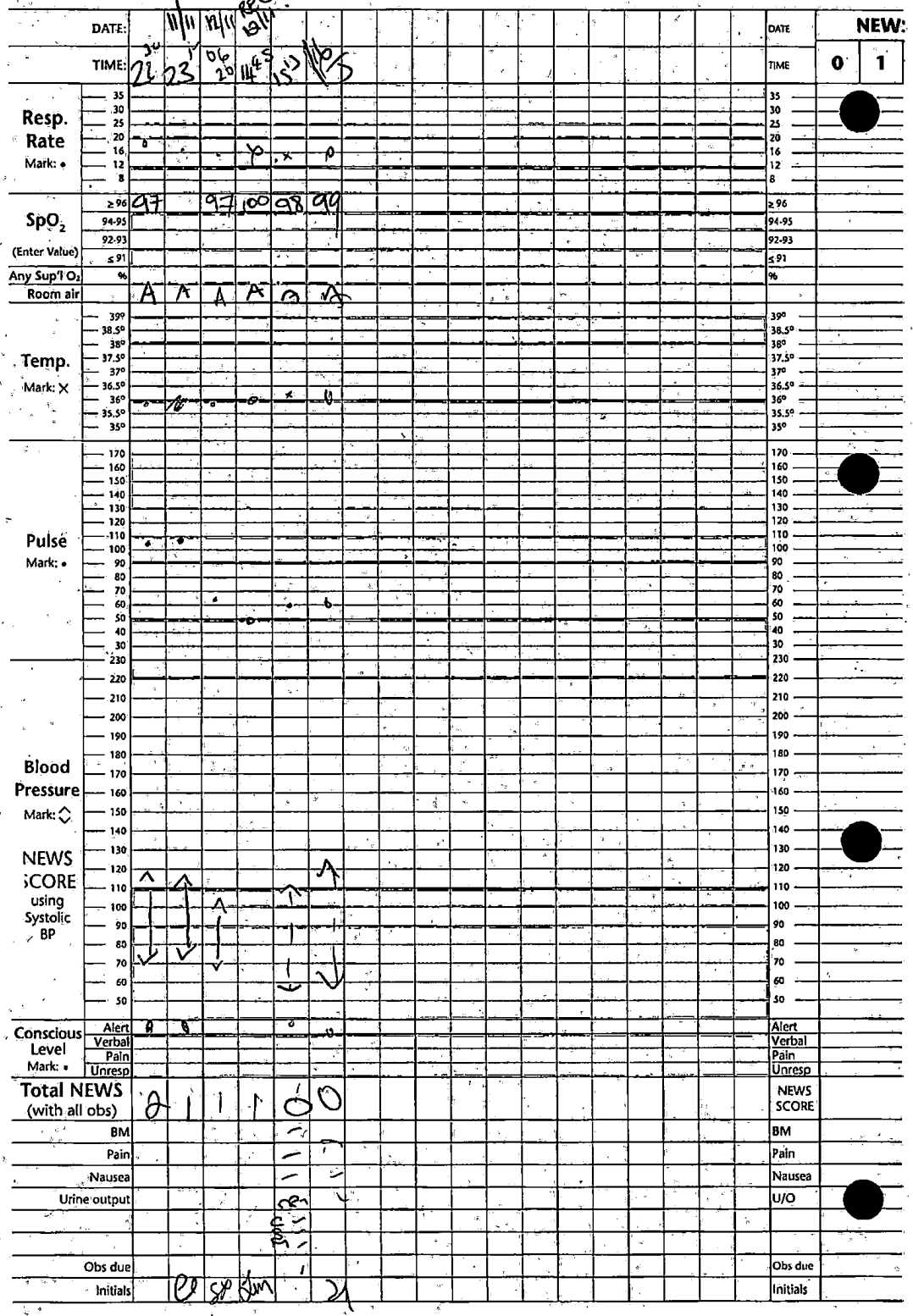
	Date	Ward
Admitted		
Transferred		
Transferred		

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

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more **or** 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE:
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Mark: •
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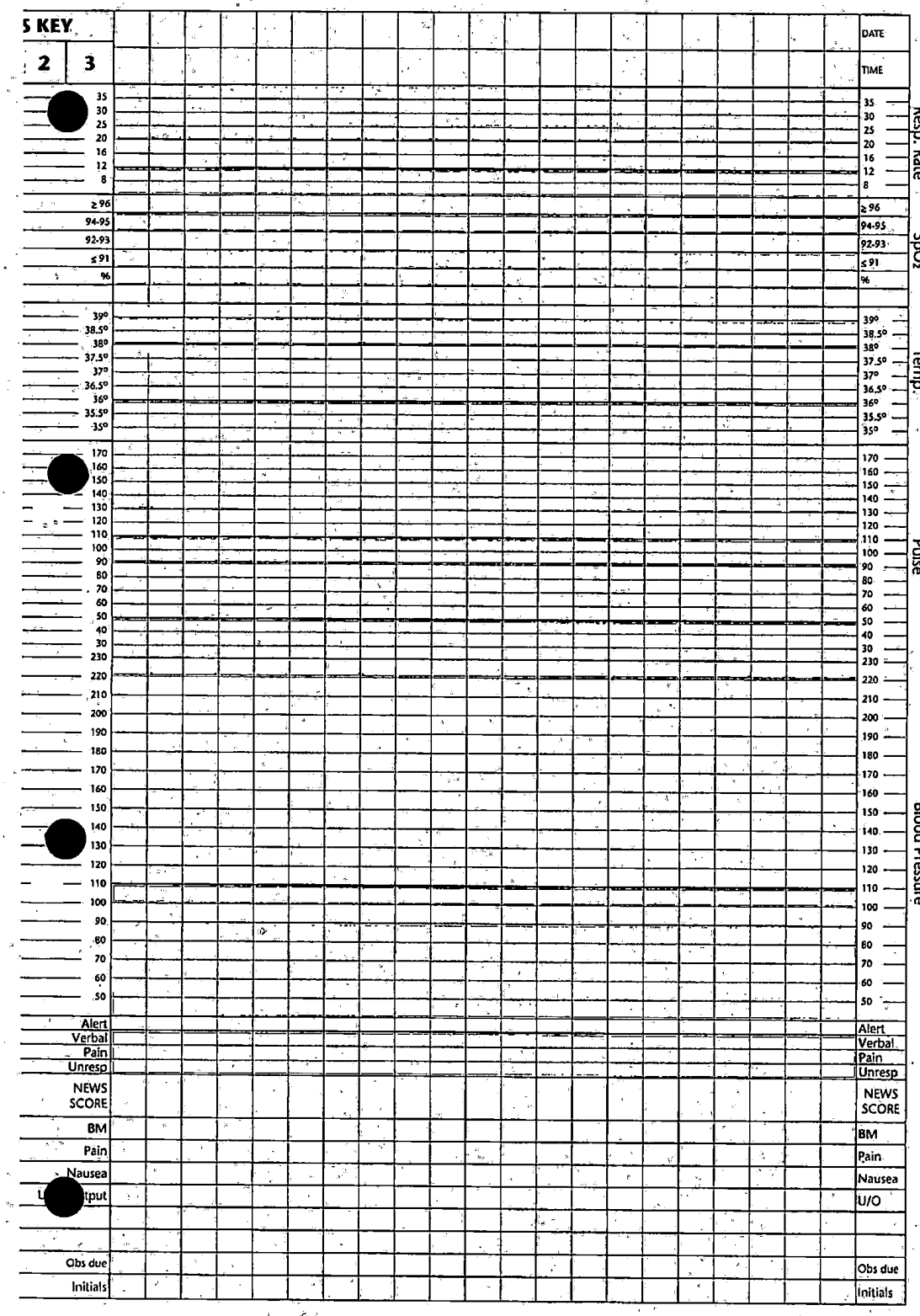
Any Sup'l O2
Room air
Temp.
Mark: X
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
DATE
TIME
NEW:
0
1
NEWS SCORE
U/O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2
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16
12
8
SpO2
≥96
94-95
92-93
≤91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

Date:																									
Time:																									
COMA SCALE	E Eyes open	Spontaneously	4																						Eyes closed by dwelling = C
		To speech	3																						
		To pain	2																						
		None	1																						
	V Best Verbal response	Orientated	5																						Endotracheal tube or tracheostomy = T
		Confused	4																						
		Inappropriate words	3																						
		Incomprehensible sounds	2																						
		None	1																						
	M Best motor response	Obeys	6																						Usually record the best arm response
		Localises	5																						
		Flexion - withdrawal	4																						
		Flexion - abnormal	3																						
		Extension to pain	2																						
		None	1																						
		TOTAL SCORE																							
PUPILS	R	Size																							+ reacts – no reaction c. eyes closed
		Reaction																							
	L	Size																							
		Reaction																							
LIMB MOVEMENT	ARMS	Normal power																							Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																							
		Severe weakness																							
		Spastic flexion																							
		Extension																							
		No response																							
	LEGS	Normal power																							
		Mild weakness																							
		Severe weakness																							
		Spastic flexion																							
		Extension																							
		No response																							

Glasgow Coma Scale

Pupil size (mm)

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Redesigned by Medical Illustration Services • 231261

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

WRITE, "

Surname 2704716161 F

Forename ROBERTS 27/04/1971

DoB Tracy

263 Curtis Ave
Glasgow, Lanarkshire
G44 4NW

Location ..

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

More than one score/category can be used: **10+= 'At Risk': 15+= 'High Risk': 20+= 'Very High Risk'**

Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

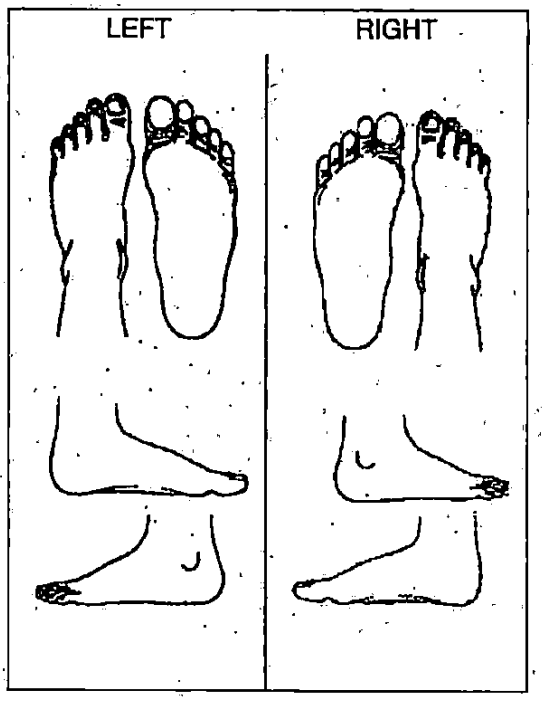
Sex										
Male	1		2							
Female	2	2								
Age										
14 -49	1	1								
50 -64	2		1							
65 - 74	3									
75 - 80	4									
81+	5									
Build/Weight for Height (BMI=weight in Kg/height in m²)										
Average - BMI 20-24.9	0									
Above average - BMI 25-29.9	1									
Obese - BMI > 30	2	2	2							
Below average - BMI < 20	3									
Continence										
Complete/catheterised	0	0								
Incontinent urine	1									
Incontinent faeces	2		/							
Doubly incontinent (urine & faeces)	3									
Skin Type - Visual Risks Area										
Healthy	0	0								
Tissue paper (thin/fragile)	1									
Dry (appears flaky)	1									
Oedematous (puffy)	1									
Clammy (moist to touch)/pyrexia	1		/							
Discoloured (bruising/mottled)	2									
Broken (established ulcer)	3									
Mobility										
Fully mobile	0	0								
Restless/fidgety	1									
Apathetic (sedated/depressed/reluctant to move)	2									
Restricted (restricted by sever pain or disease)	3									
Bedbound (unconscious/unable to change position/traction)	4		/							
Chairbound (unable to leave chair without assistance)	5									
Nutritional Element										
Unplanned weight loss in past 3-6 months										
<5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2	0								
BMI > 20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2									
Patient acutely ill or no nutritional intake > 5 days	2		/							
Special Risks - Tissue Malnutrition										
Multiple organ failure/terminal cachexia	8									
Single organ failure e.g. cardiac, renal, respiratory	5									
Peripheral vascular disease	5									
Anaemia = Hb < 8	2									
Smoking	1	1	1							
Special Risks - Neurological Deficit										
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6	0								
Special Risks - Surgery/Trauma										
On table > 6 hours	8									
Orthopaedic/below waist/spinal (up to 48 hours post op)	5	0								
On table > 2 hours (up to 48 hours post op)	5									
Special Risks - Medication										
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4	0								
Total Score		6	4							
Date		11/11	12/11							
Initials		JP								
Time		22:30								

83826

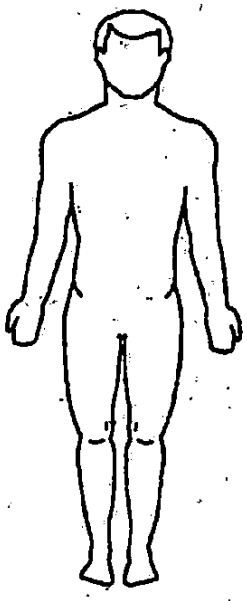
Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

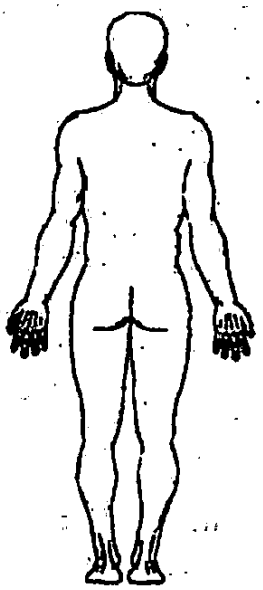
Indicate by circling and numbering all pressure damage on diagrams, then complete box below. Indicate care plan/wound assessment chart.



Anterior view



Posterior view



SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

GRADE 1 Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.

GRADE 2 Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.

GRADE 3 Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.

GRADE 4 Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

DATE	NUMBER OF ULCER(S)	LOCATION OF ULCER(S)	GRADE OF ULCER(S)	LOCATION OF ULCER(S)

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

Nutrition Profile

NHS Greater Glasgow and Clyde

Name:	Date of admission: 11 / 11 /15
Address: 2704716161 ROBERTS Tracy 263 Curtis Ave Glasgow, Lanarkshire G44 4NW	Time: 23 00
DoB: 27/04/1971 F	HOSPITAL: QEUH
CHI numb:	Ward: 10D
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 1.55 metres Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Weight: 77 kg Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

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

Is there evidence of recent weight loss?

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

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

Please state:

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

Eating likes and dislikes (including appetite):	Drinking likes and dislikes:	Patient NBM Yes ☐ No ☐ If 'Yes' why?:
Not fussy	Dislikes fizzy drinks Likes Coffee w/ milk	

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

Please specify all factors:

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

If 'Yes' please state:

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

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

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

If 'Yes' please state:

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

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

Profile completed by: Name (PRINT): Signature: Date:

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

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

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

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

Malnutrition Universal Screening Tool ('MUST')

Date	11/11/15											
Initials	S-P											
Height (see page 1) 1.55 Weight	77 kg											
Oedema or ascites present Y/N	N											
BMI (refer to chart on page 4)	32											

'MUST'

Step 1: BMI Score (refer to chart on page 4) >20 (>30 = Obese) .....0 18.5 - 20 .....1 <18.5.....2	0											
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: <5% ..... 0 5-10% ..... 1 >10% 2	0											
Step 3: Acute Disease Effect Score If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0											
Step 4: Overall Risk of Malnutrition Total:	0											

Step 5: Management Guidelines

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

Management Plan

FOR ALL PATIENTS

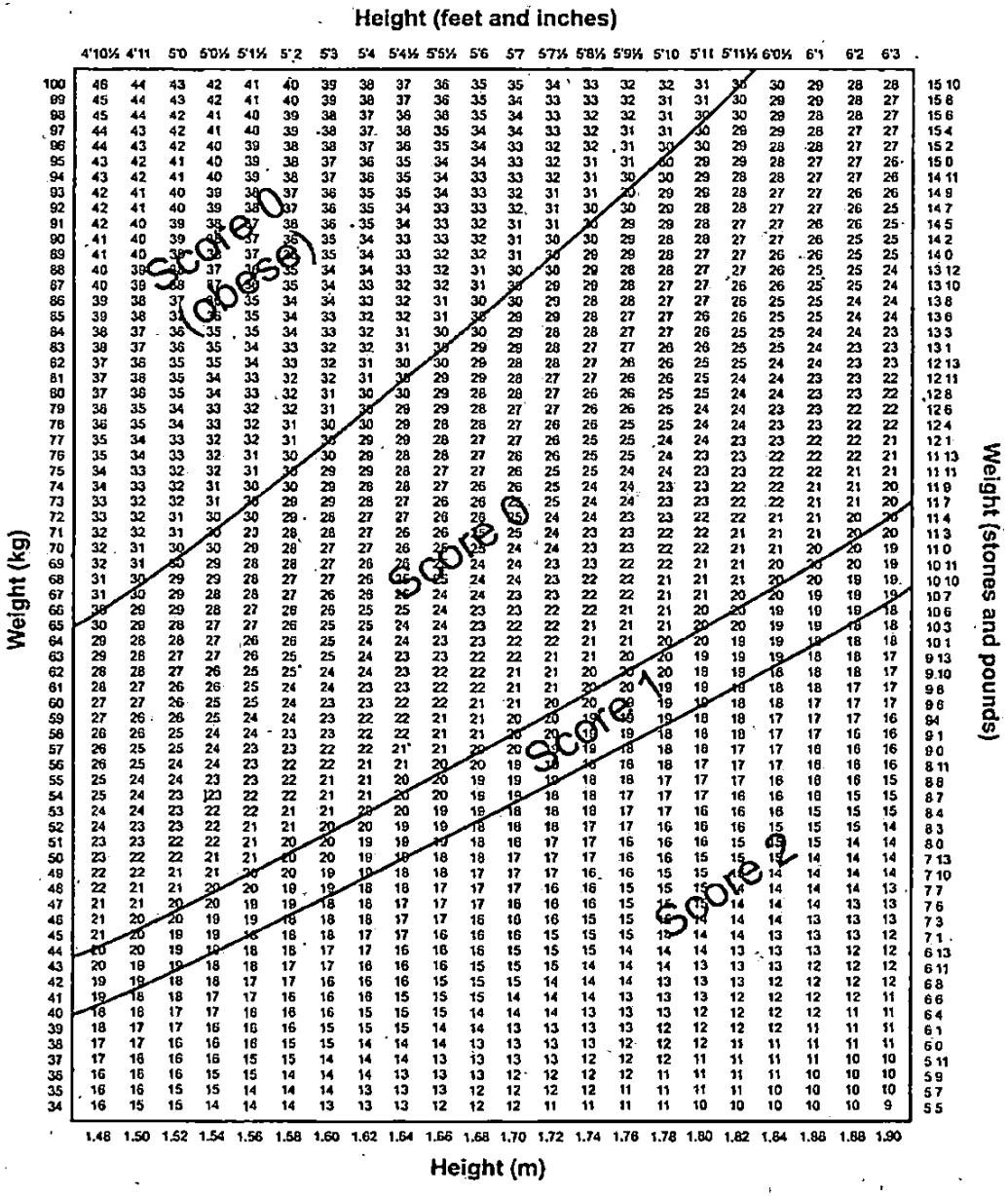
- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice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

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

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Action discussed with patient / carer	Review date	Name (PRINT) Signature/ Designation
11/11/15	0	Obtain accurate weight post-op	N	12/11/15	SHERYL S.P PAGE SL/N

Step 1 - BMI Score



Step 2 - Weight Loss Score

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

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

Medical Illustration Services • 235261
STORES ORDER CODE 41850

Acute Services Division

Hospital / Department QEUH ORTHO 10D

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: .. 2704716161
ROBERTS
Tracy
F
27/04/1971
Ward: ..... 263 Curtis Ave
Glasgow, Lanarkshire
CHI number: ..... G44 4NW .....Unit/Hospital number .....

Contents

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

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

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

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

Referral Criteria for Hospital Falls Prevention Co-ordinator

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

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

General Safety Precautions

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

Cannard Falls Risk Assessment

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

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 19/11/25	Date:	Date:	Date:	Date:	Date:	Date:
						Ward: 10D	Ward:	Ward:	Ward:	Ward:	Ward:	Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			100						
Sex	Male 1	Female 2				2						
Age	13-59 0	60-70 1	71-80 2	81+ 1		0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		0						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound/ wheel-chair 1		1000						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1000						
				TOTAL SCORE		5						
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		AS See below						
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves.				NURSE SIGNATURE								

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

Falls Assessment Care Plan

Please tick all applicable nursing interventions

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

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

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

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

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

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

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

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

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

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

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

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

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

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

2704716161
ROBERTS F
Tracy 27/04/1971
263 Curtis Ave
Glasgow, Lanarkshire
G44 4NW

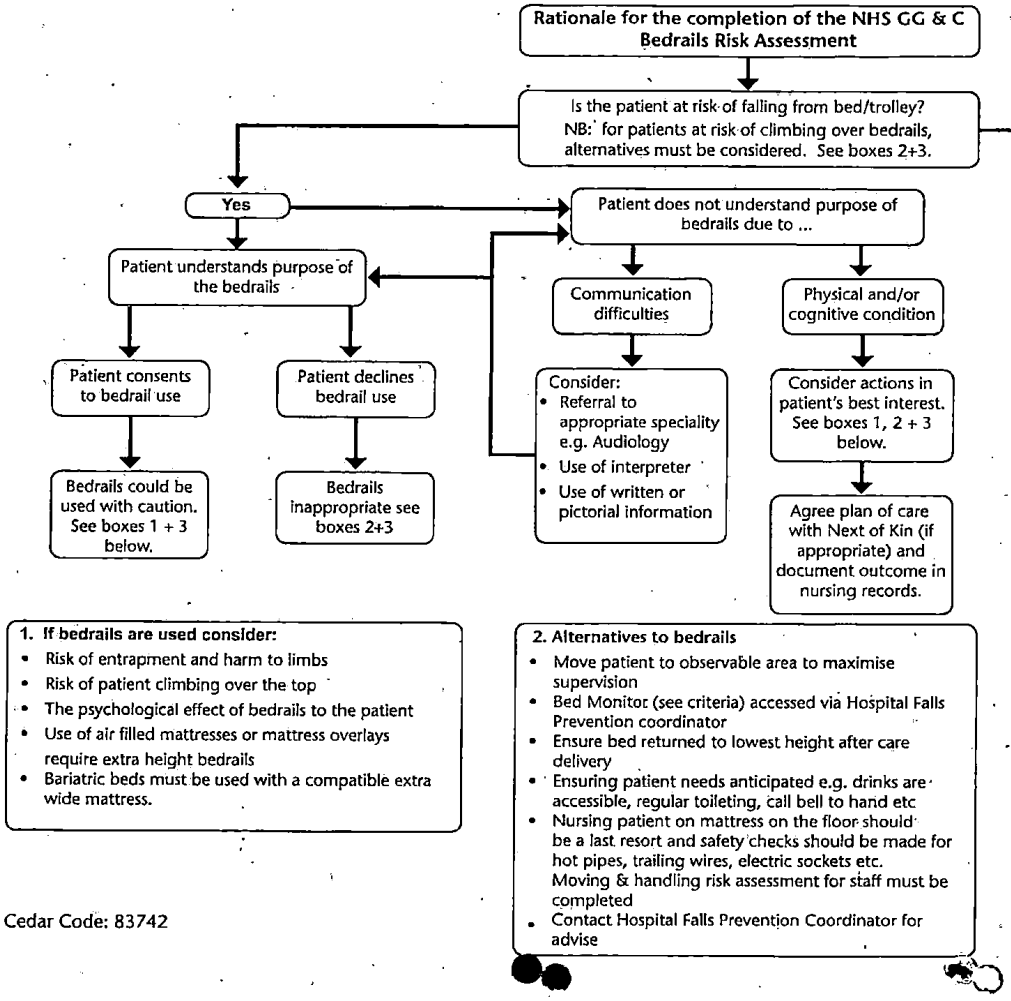
NHS Greater Glasgow and Clyde

NHSGGC&C Bedrail Risk Assessment

This Risk Assessment Tool is an aide memoir for staff. It should be used in conjunction with th Bedrails Algorithm (see reverse) and Guidelines for the Safe use of Bedrails and Falls Preventi (Adults). This document does NOT replace the need for clinical judgement.

Use algorithm on the reverse of this document when completing this Risk Assessment				DATE			DATE			DATE		
SECTION ONE	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
Is the patient at risk of climbing out of bed or trolley?		N										
Is the patient agitated or confused?		N										
Does using bedrails present a higher risk to the patient than falling out of bed?		N										
SEE ALGORITHM ON REVERSE FOR GUIDANCE												
SECTION TWO												
Has an alternative to bedrails been considered? i.e. see bedrails algorithm box 2			N/A									
Is the patient likely to roll, slip or slide from the bed?		N										
Has the patient been consulted regarding the use of bedrails?		N										
Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/ cognitive condition.			N/A									
Has the decision to use or not use bedrails been discussed with relatives / carers		N										
Has the patient / relatives been given a copy of the bedrail information leaflet		N										
IF YES, TO ANY OF SECTION 2, THEN BEDRAILS MAY BE APPROPRIATE HOWEVER, CONSIDER THE FOLLOWING POINTS												
SECTION THREE												
Is the patient small in stature?		N										
Does the patient have an unusually large or small head?		N										
When bedrail fitted is there a gap between the lower rail and mattress?		N										
Are there large spaces between the bars of bedrails		N										
Does the bedrail move away from the side of the mattress when in use?		N										
Will the bedrail fall off the bed?		N										
Will any of above create an entrapment hazard?		N										
IF YES TO SECTION 3 BEDRAILS ARE NOT APPROPRIATE												
SECTION FOUR												
The gap between the bedrail and the headboard must be less than 60mm or greater than 250mm												
Has the bedrail been fitted correctly?	Y											
Is the bedrail secure?	Y											
Is the bedrail compatible with the bed frame it will be fitted to?	Y											
Are the bedrails used in good working order?	Y											
Does the patient have access to the call buzzer at all times?	Y											
If pressure relieving overlay mattress, or air filled mattress in use, are extra height bedrails fitted?			N/A									
If Bariatric bed in use is compatible extra wide mattress fitted?			N/A									
SECTION FIVE - DECISION MAKING												
Has the decision been made to use bedrails?	N											
Date	11/11/15											
Bedrails checked by	S. Page											
Date	11/11/15											
Assessors Signature	S. Page											

Bedrails Algorithm



1. If bedrails are used consider:

- Risk of entrapment and harm to limbs
- Risk of patient climbing over the top
- The psychological effect of bedrails to the patient
- Use of air filled mattresses or mattress overlays require extra height bedrails
- Bariatric beds must be used with a compatible extra wide mattress.

2. Alternatives to bedrails

- Move patient to observable area to maximise supervision
- Bed Monitor (see criteria) accessed via Hospital Falls Prevention coordinator
- Ensure bed returned to lowest height after care delivery
- Ensuring patient needs anticipated e.g. drinks are accessible, regular toileting, call bell to hand etc
- Nursing patient on mattress on the floor should be a last resort and safety checks should be made for hot pipes, trailing wires, electric sockets etc. Moving & handling risk assessment for staff must be completed
- Contact Hospital Falls Prevention Coordinator for advise

3. Remember to document in nursing records:

- Date and time assessment made
- Patient & NOK given bedrails information leaflet
- Rationale for decision made in care plan
- Where bedrails are considered appropriate and the patient has declined their use.
- Actions taken, including discussion with Next of Kin
- Care planning and reviews

Assessment should be made:

- On admission
- If patient's condition changes
- Daily / weekly depending on the situation

Cedar Code: 83742

MIS 217816 • UPDATED SEPT 2010

2704716161
ROBERTS
Tracy
263 Curtis Ave
Glasgow, Lanarkshire
G44 4NW

F
27/04/1971

Care Plan

NHS
Greater Glasgow and Clyde

Date Commenced and Signature	1. Breathing and circulation	Date Discontinued and Signature	Date Commenced and Signature	7. Personal Hygiene, oral care and skin care	Date Discontinued and Signature
11/11/15 SP	No issues		11/11/15 SP	REQUIRES ASSITANCE	
	2, 3. Communication and senses			8. Mobility	
11/11/15 SP	No issues		11/11/15 SP	INDEPENDANT	
	4. Cognitive status			9. Maintaining a safe environment	
11/11/15 SP	No issues		11/11/15 SP	INDEPENDENT	
	Getting to Know Me / What matters to me			10. Sleep and Rest	
			11/11/15 SP	Promote restful sleep	
	5. Hydration and Nutrition			12. Privacy, dignity and sexuality	
11/11/15 S.P	No issues		11/11/15 SP	NO ISSUES	
11/11/15 SP	6. Elimination INDEPENDENT		11/11/15 SP	Negotiated care - Care discussed with patient / family (Yes) / No Patient able to participate (Yes) / No	

223591

Care Plan Guidance

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

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

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

Neurovascular Assessment Chart

NHS
Greater Glasgow and Clyde

Identification Label:

2704716161
ROBERTS F
Tracy 27/04/1971
263 Curtis Ave
Glasgow, Lanarkshire G44 4NW

Consultant:

Diagnosis/Operation/Procedure/Injury:

Area for Observation: LEFT / RIGHT (circle)

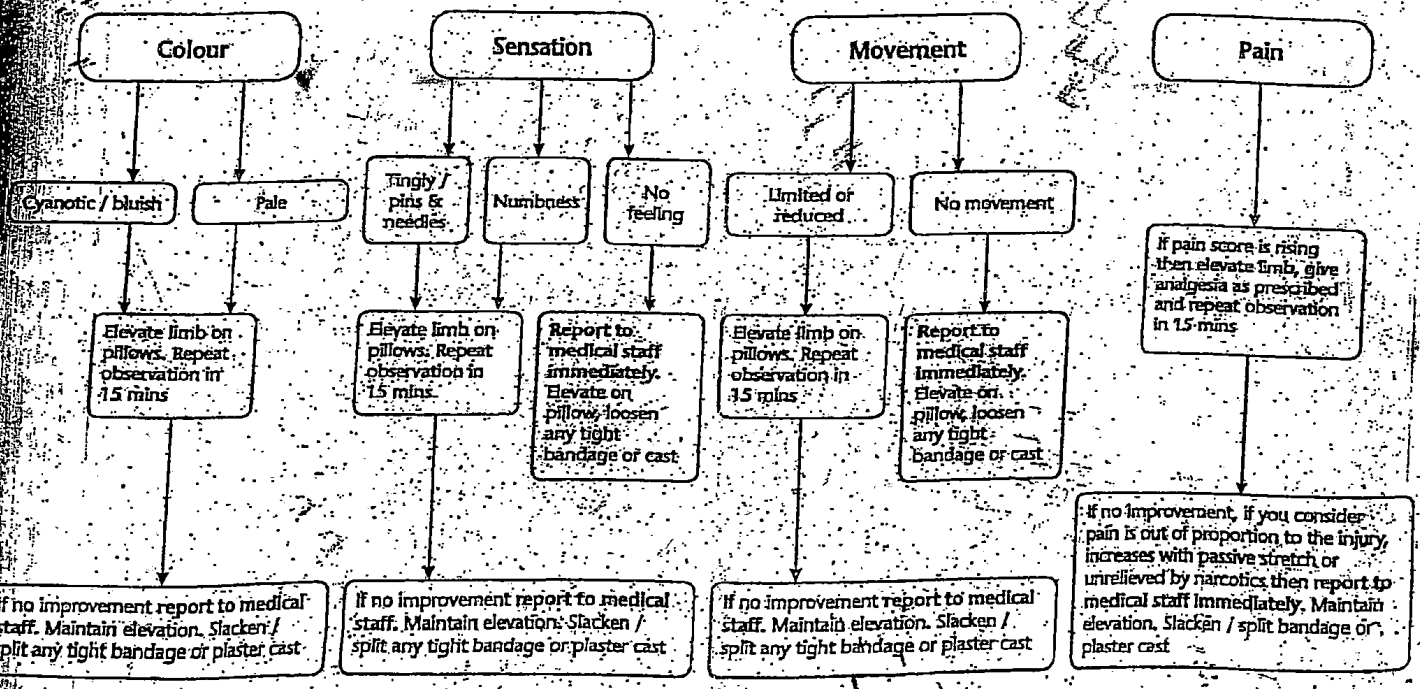
Date														
Time														
Pain Score (1-10) Ask the patient to move fingers/hand/wrist or toes/foot. If unable then you should passively stretch the digits. Ask pt to score their pain level. See flowchart overleaf.														
Colour Compare to unaffected	Normal for patient	✓												
	Cyanotic / bluish*													
	Pale*													
Sensation Ask patient how the feeling is in the affected limb. Test all fingers or toes for feeling when you touch them and ask patient again	Normal		✓											
	Tingly / pins and needles*													
	Numb*													
	No feeling *													
Movement As for pain score - ask patient to move fingers/ hand/wrist or toes/foot. Assess the movement.	Normal range of movement													
	Limited or reduced movement *		✓											
	No movement *													
Initials														

Always compare with the unaffected limb. If both limbs are affected use a separate chart for each limb.

There may be signs of abnormalities, take appropriate action, document and inform a member of the medical tea
Document all actions taken in the space below

ACTIONS:

Date / Time	Concern being reported	Who reported to	Action taken	Sign


Colour
Sensation
Movement
Pain
Cyanotic / bluish
Pale
Tingly / pins & needles
Numbness
No feeling
Limited or reduced
No movement
If pain score is rising then elevate limb, give analgesia as prescribed and repeat observation in 15 mins
Elevate limb on pillows. Repeat observation in 15 mins
Elevate limb on pillows. Repeat observation in 15 mins
Report to medical staff immediately. Elevate on pillow, loosen any tight bandage or cast
Elevate limb on pillows. Repeat observation in 15 mins
Report to medical staff immediately. Elevate on pillow, loosen any tight bandage or cast
If no improvement report to medical staff. Maintain elevation. Slacken / split any tight bandage or plaster cast
If no improvement report to medical staff. Maintain elevation. Slacken / split any tight bandage or plaster cast
If no improvement report to medical staff. Maintain elevation. Slacken / split any tight bandage or plaster cast
If no improvement, if you consider pain is out of proportion to the injury, increases with passive stretch or unrelieved by narcotics then report to medical staff immediately. Maintain elevation. Slacken / split bandage or plaster cast

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name:	Ward: 10D
Unit number: 2704716161	Discharge destination: Home
CHI number: ROBERTS Tracy F 27/04/1971 263 Curtis Ave Glasgow, Lanarkshire G44 4NW	Estimated Discharge Date (1) 12/11/15
	Estimated Discharge Date (2) / /
	Final date of discharge : / /

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓			
Relative/carer informed	✓		LS	
Others informed: Care Home		✓	LS	
Transport arranged				
Own transport (preferred option)	✓		LS	
Ambulance-1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Discharge prescription completed	✓			
Compliance aids e.g. Dossette Box (involve pharmacist)	✓			
Medication received	✓			
Medication explained to patient and/or relative/carer	✓			
Own medication returned to patient		✓	LS	
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓		
Informed of discharge				
Social work/ Other agencies/Home help				
Physiotherapist				
Occupational Therapist		✓	LS	
Dietician				
Speech and Language Therapist				
Clinical Nurse specialist e.g. Care Home Liaison				
Liaison/ District Nurse/Practice Nurse				
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓			
Patients clothing available for day of discharge	✓			
Valuables e.g. cashier	✓			
Intravenous cannula removed	✓			
Equipment ordered (inc. walking aids) in place for discharge		✓		
Part 2 Discharge letter - Required		✓	LS	
- Completed		✓		
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow	✓		LS	
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge: 1815				
Nurse's signature:	Designation: SN		Date: 12/11/15	

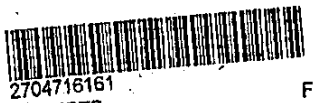
FORM NUMBER 0005752

VI MEDICAL ILLUSTRATION • DISCHARGE • 12410/14.01.08

Name: Ward: Date: 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



2704716161 F
ROBERTS 27/04/1971
Tracy
263 Curtis Ave
Glasgow, Lanarkshire G44 4NW

EVALUATION OF CARE

DATE	TIME	No.	EVALUATION AND PROGRESS OF C

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 2704716161

Queen Elizabeth University Hospital

Total Att: 10

12 Mth Att: 1

Title: MISS

ROBERTS

Tracy

DOB 27/04/1971 Age: 53y Sex: Female

263 Curtis Avenue

Glasgow
Lanarkshire
G44 4NW
07369259816

Next of kin: ARMOUR, Elizabeth
Relationship: Mother
07733094655

GP: DA Cumming
0141 531 8365

Attendance Date: 25/10/2024 Arrival Time: 23:15

Registration Time: 23:15 Date of Incident: 25/10/2024

Major Incident Desc:

Reason for Attendance: NHS24 ED direct ref BACK PAIN TODAY

Nursing Assessment

Alerts: Not Recorded Allergies: Yes Pain Score:

Triage Category: 4 Tetanus up to date/fully immunised:

Presenting Complaint: Back Pain

Observation Date: 26/10/2024 00:33 Nurse name: Nurse Emma Campbell

Temp	35.7	C
HR	88	bpm
BP	162/105	mmHg
MAP	124.00	mmHg
RR	18	bpm
SpO2	96	%
Oxygen	21	%

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: turned over in bed yesterday morning and felt excruciating pain. states unable to get out of bed. states can walk if someone helps her to stand previous trapped nerve

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
26/10/24	IBUPROFEN	400mg	PO	0035		

Date	CLINICAL NOTES
2/6/10/24	Seen by (Dr) L PAYAS FY2 Time seen 0644

53 (F)

PC- lower back pain

Woke up at 7am today with lower back pain + shooting pain down both thighs.
Pain only present on movement, if lies still, no pain.
No cauda equina symptoms / features
↳ No saddle paraesthesia, incontinence
No objective focal neurology

Has Hx of lower back pain + b/L leg pain - diagnosed with sciatica + given amytriptiline.
Today pain more severe.

No Hx of trauma / injury / fall.

PMHx
? COPD
Sciatica

Meds
Amitriptyline.
Ellipta inhaler.
Mirtazapine

Allergy- codeine.

O/E

A - Patent
B - ~~CXR~~ Chest clear

2704716181 27/04/1971
ROBERTS
Tracy

C - HS I + ~~II~~ + 0

D - GCS 15/15.

E - Abdo SNT
Nil pedal oedema
~~Hill-er~~ calves SNT

No point tenderness of spine or pelvis.
Normal ROM of hip b/L. Normal rom of spine.
Lower limbs - Normal tone, power + sensation bilaterally.

Imp - ? Nerve impingement / disc bulge / sciatica

Plan - Analgesia
- worsening advice.
- Return to GP for analgesia
- Physio self referral.

Home.
- can ? Amitriptiline to 20mg -

Plan discussed w/ ED reg Dr P Tunney

Date	CLINICAL NOTES

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

Discharge date	
Discharge time	

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

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By
26/10/24	NAPROXEN	500mg	PO	BD		LP

(4)

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

CHI: 2704716161

New Victoria Hospital

Total Att: 8

12 Mth Att: 2

Title: **MISS**

ROBERTS

Tracy

DOB **27/04/1971** Age: **50y** Sex: **Female**

263 Curtis Avenue

Glasgow
Lanarkshire
G44 4NW
0141 5718540

Next of kin: **ARMOUR, Elizabeth**
Relationship: **Mother**
07733094655

GP: **DA Cumming**
0141 531 8365

Attendance Date: **14/06/2021** Arrival Time: **10:16**

Registration Time: **10:16** Date of Incident: **13/06/2021**

Major Incident Desc:

Reason for Attendance: **right hand inj**

Affix Label

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date:

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

Nurse name:

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes:

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES	
	Seen by (Dr) MMMM ENP	Time seen 14

14/4/21

PC Wound check.

uPC Fell into mirror 5/7 ago, attended MIU, request dressing change

PMH Sciatica.

RM See ECS

ATT

Allergies CODEINE.

O/E

V-Shaped lac dorsum ® hand

~~Mildly~~ No surrounding erythema/swelling

Dry, no exudate, purulent discharge. - no infection

From NV/CSM intact

Imp: Wound check/dressing change

Plan: Wound toilet

Inadine dressing.

2704716161 27/04/1971
ROBERTS
Tracy

M.

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	T
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	14:20

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

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

Discharge Prescription Packs

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

(1)

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 2704716161

New Victoria Hospital

Total Att: 7

12 Mth Att: 1

Title: **MISS**

ROBERTS

Tracy

DOB **27/04/1971** Age: **50y** Sex: **Female**

263 Curtis Avenue

Glasgow
Lanarkshire
G44 4NW
0141 5718540

Next of kin: **ARMOUR, Elizabeth**
Relationship: **Mother**
07733094655

GP: **DA Cumming**
0141 531 8365

Attendance Date: **12/06/2021** Arrival Time: **15:43**

Registration Time: **15:43** Date of Incident: **10/06/2021**

Major Incident Desc:

Reason for Attendance: **wrist injury**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date:

Temp	35	C
HR	80.	bpm
BP	164/96	mmHg
MAP		mmHg
RR	22.	bpm
SpO2	97% RA.	%
Oxygen		%

Nurse name:

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes:

Child Assessment Questionnaire

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

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

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

2704716161 27/04/1971
ROBERTS
Tracy

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date 12/06/21. **CLINICAL NOTES**

Seen by (Dr) JIMES (ENP) Time seen 1649.

2704716161 27/04/1971
ROBERTS
Tracy

50yr old female. Unemployed.

PC, Painful (R) hand/wrist.

HPC, Intoxicated 2/7 ago - fell into glass mirror.

PMHX manic depression
sciatica

DHX HRT.
Amitryptiline.

Allergies codeine. Tetanus :- up to date.

O/E

Wound to doroum of hand as shown. Wound appears infected. Surrounding erythema. Base of wound seen.
Full ROM of wrist/hand.
Flexor/extensor tendons intact.
NV intact.
Multiple superficial scratches to hand also.
Slightly tender over distal radius/ulna.

Nonx-Ray to

INV:- X ray (R) hand/wrist:- NBI
No FB seen.

Treatment:- Flucloxacillin 1g QDS for 5/7.
Dressed with inadine & mepore.
For PN review on Mon 14/06/21.
Worsening advice given. To attend ED QEUH if any concerns.

JIMES (ENP)

PTO

Date	CLINICAL NOTES
	BP elevated. although patient very anxious. Could this be rechecked by PN please. JIMCO(ENP)

2704716161 27/04/1971
ROBERTS
Tracy

Discharge Codes (Please CIRCLE)					Discharge date	12/06/21
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		Discharge time	1740.
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.		

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

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

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By
12/06/21.	Flucloxacillin	1g	O	QDS for 5/7		JIMCO
						AD per PGDD.

may 7.

NHS GGC Hospitals, Admission Document

NHS Greater Glasgow and Clyde

Affix Label

CHI: 2704716161

Queen Elizabeth University Hospital

Total Att: 6

12 Mth Att: 0

Title: **MISS**

ROBERTS **Tracy**

DOB **27/04/1971** Age: **49y** Sex: **Female**

263 Curtis Avenue

Glasgow
Lanarkshire
G44 4NW
0141 5718540

Next of kin: **ARMOUR, Elizabeth**
Relationship: **Mother**
07733094655

GP: **DA Cumming**
0141 531 8365

Attendance Date: **14/02/2021** Arrival Time: **07:38**

Registration Time: **07:38** Date of Incident: **14/02/2021**

Major Incident Desc:

Reason for Attendance: **biba anxiety**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

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

Presenting Complaint:

Observation Date: **14/02/2021 08:03** Nurse name: **Nurse Samantha Lamont1**

Temp	35.6	C
HR	104	bpm
BP	117/86	mmHg
MAP	96.33	mmHg
RR	17	bpm
SpO2	98	%
Oxygen		%

BM	5.4	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

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

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

Nursing Notes: **"biba - states has had headache for 4/42 has been worse over past 2/52, this morning after getting out of bed felt both legs felt weak and shaking all over. states has also had increasing anxiety over the past few months and having panic attacks, not sleeping or eating well, has not been coming out of bedroom - appears very anxious in triage "**

Patient ID label

2704716161 27/04/1971
ROBERTS
Tracy

Date	Emergency Department Notes	
14/2/21	Ambulance Proforma reviewed Yes / No Seen by (Doctor) REW Pennington GPST2.	Time seen 08:55

(49) PCH Tremor, anxiety, SOB, Headache

HPCH- At 5:30am was awake at home + making cup of tea.
- Felt weak legs + arms with pressure. Rapid shallow breathing + palpitations. Felt vision get blurry + struggled to speak.
- Settled after 2 hours but feeling anxious now with slight tremor.
- Started on Citalopram 2omg OD 2 days ago but no other new meds.
- Previous issues with similar panic attacks
- No CP/Abdo pain. No new back pain.
- 4 week hx of "tight band" headache which is migratory + fluctuating.

PMHH Allergy - ~~Codeine~~
Sciatica
Anxiety / depression

DrHx H Allergy - codeine
Citralopram
Amitriptyline
Omeprazole
Fillerte-Solo
Diclofenac.

O/E H Alert, anxious ++ with tremor. No photophobia noted. GCS 15/15.
PEARL. Eye Pam (N) No Diplopia/nystagmus.

Ear ents (N) bilat
otherwise clear

L - N - to Regular

SNT.
BS present.

	RUL	LUL	RLL	LLL
Power	5/5	5/5	5/5	5/5
Sensation	N	N	N	N
Coordination	⇐⇒ Tremor noted but (N) otherwise		⇐⇒ (N) Gait slightly unsteady but (N)	

Patient ID label

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Tracy

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen
11:03	FBC (N) Cxr (N) Liver profile (N) CRP 3 U+E (N)	

Differential Diagnosis/Problem List

- Panic attack → ?Precipitated by Citalopram.
- Tension headache

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

Done/ completed	Immediate Managment Plan
	- Bloods + Ecg
	- Cxr
	- If normal → (H)
11:24 →	(N) → (H)

Signature: [signature] Designation: CPST2 Page No:

Patient ID label

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

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

Other (please specify)

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

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

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

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Social History \ Family History

Smoking History

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

Alcohol History

_____ Units/week FAST score if excess _____

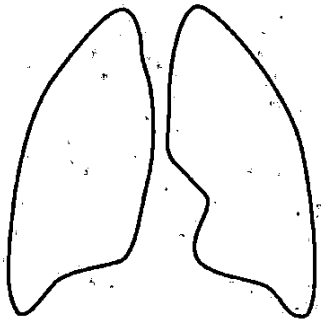
Recreational Drugs **Driving Status**

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

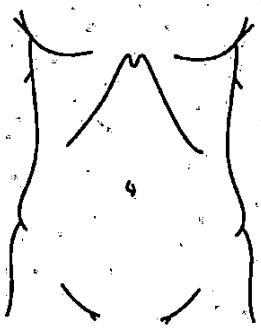
General Examination	
Temp:	RR:
Pulse:	CBG:
SpO_2:	Weight:
BP:	Urinalysis:

General Appearance:

Respiratory



Gastrointestinal System



Cardiovascular

Locomotor

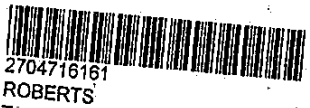
Patient ID label

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

Senior Medical review

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

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



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Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED

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

☐ Yes

☐ No

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

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

☐ Yes

☐ No

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

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

☐ No

☐ Yes

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

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

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

Patient ID label

Results

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

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Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO_2:

FiO2:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet	
Date: Time	

Patient ID label

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27/04/1971

Continuation Sheet

Date: Time	

Patient ID label

Nursing Documentation

Done/ Time	

Once only prescriptions (including tetanus prophylaxis)

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

Discharge prescription packs

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

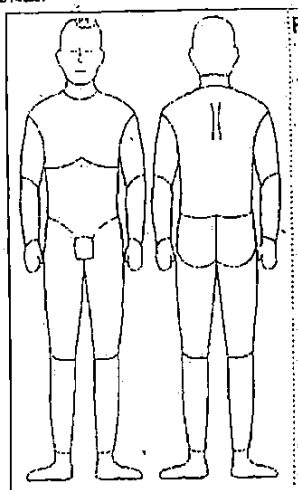
DISCHARGE CODES: Please Circle

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

Time Ready to Depart	
Discharge Time	

Ward No. (If admitted)		Transfer to Hospital	Consultant (if admitted)
Outpatient clinic specialty		Admission or specialty clinic consultant	

Clinic Referred to	AE	OP DVT		DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify



Pain

ID	Body Part	Pain Scale
P1	Head	5

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
07:15	135			97	<=2s	15	Alert								E102308X
07:09			152/128	94.6											DEFIB
07:09			152/128												DEFIB
07:07	138	26	152/128	98	<=2 Secs	15	Alert		36.8	5.8					E102308X

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
07:07	26 (3)	98 (0)		0	152 (0)	138 (3)	Alert (0)	36.8 (0)	6

Drugs

Time	Drug	Dosage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID
07:30	Paracetamol	1	g	OR				E102308X

HISTORY

AMPLE

Allergies	CODINE
Medication	AMITRIPTYLINE, ANTIDEPRESSANT CITALOPRAM, HRT
Past Medical History	SCIATICA, ANXIETY, DEPRESSION
Last Eaten	>4 Hours Ago
Events Prior	? PANIC ATTACK, HEADACHE, SHAKEY, WEAK

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MEDICAL

Stroke

Face	Negative
Arms	Negative
Speech	Negative
Time	Less than 4.5hrs or Unknown
BM Checked	Yes
Pre Alert	No

CLOSE RECORD

Treatment On Scene	Non Emergency

Patient name .. 2704716161
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Tracy 27/04/1971
Patient CHI .. 263 Curtis Avenue
Glasgow, Lanarkshire
G44 4NW

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Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature

Nursing notes - on admission

Date and Time		Name/Signature
13/2/21	Self presents - increased headache - discussion with pt in triage appears very anxious. Has been lying in bed for 4/52 not eating or drinking properly.	Olamat

Triage

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

Communication

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

Risk Assessments and Screening Tools

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

Signature:

Patient name .....

Patient C

.....

'icker

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Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

			Times											
	1	**THINK DELIRIUM**	Is the patient more confused/drowsy than normal?If yes inform registered nurse.											
	2	**PAIN: ASSESS AND ADDRESS.**	Is the patient distressed or in pain?If yes inform registered nurse.											
S	3	**SKIN INSPECTION**	Pressure areas checked?											
		R = RED **D** = Discloured **PU** - Pressure Ulcer **INT** = Intact **M**= Moisture												
K	4	**KEEP MOVING**	Has the patient moved or walked?											
		Bed **R** =Right side (30°) tilt **L** =Left side (30°) tilt **B** =Back Chair **W/ST** = Assist to walk / stand												
		ELIMINATION.	Does the patient need the toilet?											
I	5	**I** = Independent **A** - Assistance given **IC** = Incontinent (urine/faeces)												
N	6	**FOOD FLUIDS AND NUTRITIO.**	Is the patient nil by mouth?											
			Drink taken?											
			Food, snack, or supplements taken?											
			Has oral hygiene been carried out as per care plan?											
	7	**ENVIRONMENT CHECK**	Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?											
	8	**INFORMATION**	Is there anything else I can help you with? Inform the patient of the time of return											
	9	**ESCALATION**	Is there anything else I can help you with? Inform the patient of the time of return											
			Care provider											
			Role											

Ask the patient if there is anything they specifically want done today:

Patient n .....

2704716161 27/04/1971

Patient C ROBERTS .....
Tracy

or use sticker

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Nursing notes - ongoing care

Date and Time		Name/Signature

Pat
2704716161
ROBERTS F
Pat Tracy 27/04/1971
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Glasgow, Lanarkshire
G44 4NW *icker*

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4AT assessment - for delirium and cognitive impairment

		Circle Score
(1) ALERTNESS This includes patients who may be markedly drowsy (eg. dificult to rouse and/or obviously sleepy during assessment) or agitated/ hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.	Normal (alert, but not agitated, through assessment) Mild sleepiness (<10 secs) after waking, then normal Clearly abnormal	0 0 4
(2) AMT4 Age, date of birth, place (name of the hospital/building), current year.	No mistakes 1 mistake 2 or more mistakes/untestable	0 1 2
(3) ATTENTION Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.	wAchieves 7 months or more correctly Starts but scores <7 months / refuses to start Untestable (cannot start, unwell, drowsy, inattentive	0 1 2
(4) ACUTE CHANGE OR FLUCTUATING COURSE Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs.	No Yes	0 4

4 or more possible delirium + /- cognitive impairment
1-3 possible cognitive impairment
0 delirium or severe cognitive impairment unlikey (but delirium still possibe if (4) information incomplete

TOTAL

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)? circle Y or N

F	**Functional impairment**	(new or worsening) eg difficulty with self care	**Y**	**N**
R	**Resident**	in a care home	**Y**	**N**
A	**Altered mental state**	such as delirium or dementia (**4AT Assessment**)	**Y**	**N**
I	**Immobility/instability**	decline in mobility, difficulty mobilising without help, fall leading to presentation	**Y**	**N**
L	**Living at home with support**	on a daily basis (homecare, one visit or more per day)	**Y**	**N**

If YES to any of the criteria in Step 1 move to Step 2
Step 2 Would this person be better managed by another speciality team at present? circle Y or N

Clear need for other specialty input eg exacerbation of known long-term condition such as COPD	**Y**	**N**
Need for HDU/ITU (including non-invasive ventilation)	**Y**	**N**
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit	**Y**	**N**
Head injury with loss of consciousness	**Y**	**N**
Acute abdominal pain/ surgical presentation	**Y**	**N**
Upper GI Bleed	**Y**	**N**
Chest pain with suspected acute coronary syndrome	**Y**	**N**
Trauma with suspected fracture	**Y**	**N**

Are any of the criteria met?
If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.
If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

P 2704716161
P: ROBERTS Tracy F 27/04/1971

.....

.....

ticker

Hospital:	**Points to consider:** • **Use within 8 hrs of admission to care area** • **Re-assess daily and more frequently if a person's condition changes**
Ward:	

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PUDRA

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

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

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

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

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

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

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

S **Skin Inspection**	**S** **Surface**	**K** **Keep Moving**	**I** **Incontinence/ Moisture**	**N** **Nutrition**	**S** **Self Management/ Shared Care**
Check: • Pressure areas ____ hourly • Skin under medical devices ____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition ____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning ____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out ____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer **YES / NO** 2. Prevent Pressure Ulcers" leaflet given to patient/family/ carer. **YES / NO**

Patient name .....

Patient CHI 2704716161 27/04/1971 ..
ROBERTS
Tracy

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Nursing notes - discharge plannning

Date and Time		Name/Signature

Outcomes and outstanding issues

Date and Time		Name/Signature

Pause for Discharge or Transfer

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band	Y	N
Nursing Screening Tools Complete	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart NEWS completed within 1 hour of transfer/discharge	Y	N
Prescriptions and fluid charts signed	Y	N
Cannula	Y	N
Notes Complete	Y	N
Analgesia	Y	N
Belongings	Y	N
Transport	Y	N
Signature:		

Contact with relatives

Signature:

NHSGGC NEWS – National Early Warning Score

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Glasgow, Lanarkshire
G44 4NW

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

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

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

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

| | | |

NEWS 2 Key | 1 | 2 | 3

| | | |

Glasgow Coma Scale

| | | |

SWA

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital

CHI: 2704716161

Total Att: **5**

12 Mth Att: **0**

Title: **MISS**

ROBERTS **Tracy**

DOB: **27/04/1971** Age: **47y** Sex: **Female**

263 Curtis Ave

Glasgow
Lanarkshire
G44 4NW
0141 5718540

Next of kin: **ARMOUR, Elizabeth**
Relationship: **Mother**
07733094655

GP: **J Sharp**
0141 531 8365

Attendance Date: **12/04/2019** Arrival Time: **15:12**

Registration Time: **15:12** Date of Incident: **12/04/2019**

Major Incident Desc:

Reason for Attendance: **chest and back pain**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

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

Presenting Complaint: **Chest Pain**

Observation Date: **12/04/2019 15:39**

Temp	**36.3**	C
HR	**81**	bpm
BP	**146/100**	mmHg
MAP	**115.33**	mmHg
RR	**16**	bpm
SpO2	**97**	%
Oxygen		%

Nurse name: **Nurse Angela Gallagher**

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **C/O WORSENING LEFT SIDE CHEST AND BACK PAIN FOR 2/7. DENIES SPIT. STATES PAIN WORSE ON INSPIRATION AND HAS FELT SOB. PT ON HRT**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
	IBUPROFEN	400mg	PO	1730		

Date	CLINICAL NOTES
	Seen by (Dr) HAMILTON ST4 Time seen 1650

2704716161 27/04/1971
ROBERTS
Tracy

PC – Chest pain

HPC – 47y ♀

Ambulance with (L) sided chest pain

Started this last 2/7

Started sharp pain, worse on inspiration.

No associated collapse / LOC.

Started with SOB + cough associated

Started ↑ pain over (L) breast

No temp/ chills.

No calf swelling

PMH – COPD

DH – See ECS nurse

O/E – Pt looks well

Holding (L) side

A – Minimal

B – Clear
RR 16 Sats 97% RA

C – HR 81 BP 140/100 ECG – NSR

D – GCS 15/15

E – Apyrexial SNT

Temp 36.3°C

Calves SNT
(L) 37cm 35cm (R)

Date	CLINICAL NOTES
	Ins/1. ? ~~Chest pain~~ PE Pl/1. IV Access 2. Bloods – ABG ↓c TnI + D-dimer 3. ECG 4. CXR 5. (H) with Amx 5drs TID + Aci 400mg 6. wrist advice Hanna STR

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

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

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

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

NHS GGC Hospitals, Admission Document

NHS Greater Glasgow and Clyde

CHI: 2704716161

Queen Elizabeth University Hospital

Total Att: 4

12 Mth Att: 0

Title: **MISS**

ROBERTS

Tracy

DOB: **27/04/1971**

Age: **45y**

Sex: **Female**

263 Curtis Ave

Glasgow
Lanarkshire
G44 4NW
0141 5718540

Next of kin: **ARMOUR, Elizabeth**
Relationship: **Mother**
07733094655

GP: **J Sharp**
0141 531 8370

Attendance Date: **29/03/2017**

Arrival Time: **13:57**

Registration Time: **13:57**

Date of Incident: **29/03/2017**

Major Incident Desc:

Reason for Attendance: **MEDICS ?PE CDU YES**

Affix Label

Nursing Assessment

Alerts: **Not Recorded**

Allergies: **Not Recorded**

Pain Score:

Tetanus up to date/fully immunised:

Triage Category: **3**

Presenting Complaint: **Respiratory Pain - Pleuritic**

Observation Date: **29/03/2017 14:10**

Temp	**36.6**	C
HR	**87**	bpm
BP	**138/85**	mmHg
MAP	**102.67**	mmHg
RR	**18**	bpm
SpO2	**99**	%
Oxygen		%

Nurse name: **Nurse Allison Carrick**

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

Visual Acuity	
Left	
Right	
Corrected?	

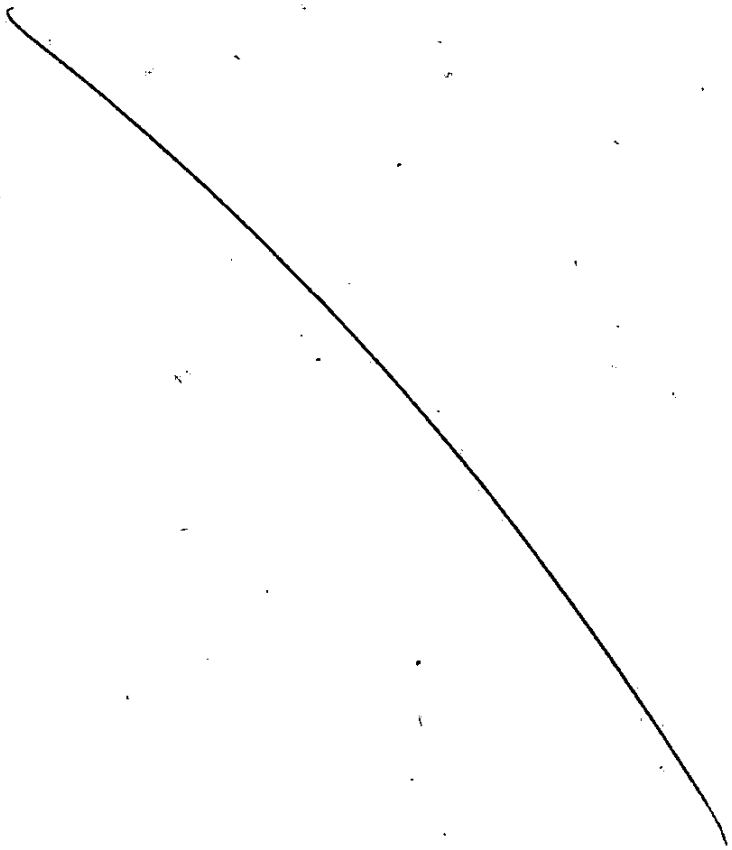
GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"MEDICS ?PE " CDU YES**

Patient ID label

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



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Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Differential Diagnosis/Problem List

NEWS ☐ 0-7

RED FLAG ☐ (Tick)

SEPSIS ☐

CURB 65 ☐

Done/ completed	Immediate Managment Plan

Signature: Designation: Page No:

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

Patient
2704716161
ROBERTS
Tracy
263 Curtis Ave
Glasgow, Lanarkshire
F
27/04/1971
G44 4NW

Seen By: JMy Print: JMy. Time Seen: 1600 Pg. No:
PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	Pleuritic chest pain.
History of presenting complaint	2/7 hisdy (R)sided pleuritic chest pain, worse on inspiration. Nil pain on palpation. No cough. Nil for a month. No Spit No haemoptysis Nil calf pain/swelling. Social pressures/stresses at present, housing issues/money-benefit issues/5 children. * took overdose diazepam/zopiclone last week, GP has started antidepressant + referred to psych.

Past Medical History / Review of portal
Nil known.

Systemic Enquiry
Nil.

Pati

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MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

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

Other (please specify)

Admission Medicines			Plan for Medicines (Dr complete)				Comments Reason for alteration
Name	Dose	Freq	Continue	Amend	Withhold	Stop	
Zopiclone	3.75g	Nocte	✓				

Allergies	List any over-the-counter or alternative medicines
NKA	
	Do medicines need further clarification ? ☐ Yes ☐ No
List collected by :	**Plan approved by :**
Designation : [illegible] Date : 2/8	Designation : Date :

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

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Social History \ Family History

Smoking History

Ex-smoker/Smoker 20 cpd 30 yrs ☐ Never smoked

Alcohol History Once per Fortnight

_____ Units/week FAST score if excess _____

Recreational Drugs NO **Driving Status** NO

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

Lives at home father, kids.
Currently really Voluntary - DEBRA.

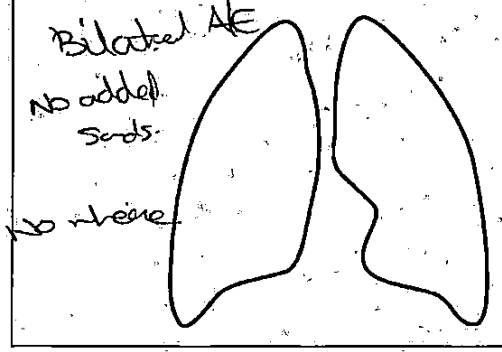
General Examination

Temp: 36.5°	RR: 16
Pulse: 85 bpm	CBG:
SpO_2: (A) 99%	Weight:
BP: 135/85	Urinalysis:

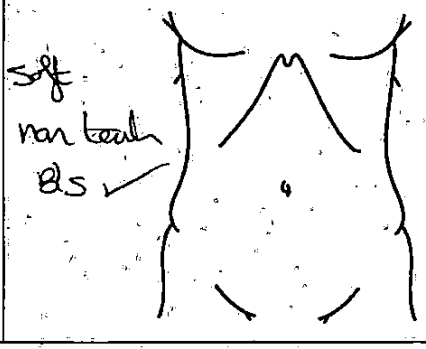
General Appearance:

pleasant lady.
Anxious, aggitated

Respiratory



Gastrointestinal System



Cardiovascular

1+11+0.
No peripheral oedema

Locomotor

NAD Acute.

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Neurological system

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

AMT 4 = age, DOB, place, year

AMT score ____ /4

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

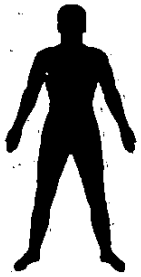
Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

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Key Results

CXR Nil Acute

ECG NSR
Nil Acute
Hx of Obsn

(Differential) diagnosis

Exclude PTE

?MSK

?Resolving viral illness

NEWS ☐
Red Flag ☐
Sepsis ☐
CURB 65 ☐

Management Plan

Bloods + DDimer.

CXR

ECG

If DDimer ↑ → CTPA

If DDimer Neg/- (H) NV follow up.

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

Signature: PRINT NAME

PRINT GRADE FY1 Page: 8 of 8

Patient ID
2704716161 F
ROBERTS 27/04/1971
Tracy
263 Curtis Ave
Glasgow, Lanarkshire G44 4NW

29/03/2017

Resuscitation Decision

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

18:20pm

If DNA CPR → Complete appropriate form

Senior Medical review

45yo F

Chest Pain + associated Pins Needles Fingers
Nil SOB
Occasional

→ Works in Charity Shop does a lot of weight lifting/dressing suit, beds, boxes etc
→ A lot of stress at home & issues
→ No other neurological symptom
Bloods

D-Dimer 80 | UE|LFT|Glucose|CRP|Troponin (N)
FBC
Coags (N)

SH:
Smoke 20/day
No recent flight
Not on OCP
No long haul flg
No personal or FH of clots
No oesophageal pain

CXR - Nil acute seen
Nil obvious pneumo seen

ECG NSR

Pt looks well & states - but relieved when told blood tests (N)

Chest Clear

Sit=II to JVP

Calves SNT

CNS Intact

Review of Systems - NAD

CNS Grossly intact
Nil focal neurology

A) Likely Musculoskeletal
P) Anxiety-related
Plan 1) Analgesia, GP FU
2) Advised if no improvement or if develops other symptoms to seek urgent medical help

→ Speak with GP

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

Dr Mahmood

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

Patie
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Glasgow, Lanarkshire
G44 4NW
F
27/04/1971

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED

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

☐ Yes

☐ No

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

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

☐ Yes

☐ No

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

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

☐ No

☐ Yes

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

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

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

Patient ID label

Results

Date Time		29/3/17							
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165	149							
WCC	4.0 - 11.0	8.5							
Plts	150 - 450	224							
MCV	80 - 100								
Neut	2.0 - 7.5								
PT	9.0 - 13.0	1.0							
APTT	27.0 - 38.0	1.1							
Fibrinogen	1.7 - 4.0								
INR	( )								
Thromb T	11-15 secs								
D-Dimer	0 - 250	80							
Na+	133 - 146	138							
K+	3.5 - 5.3	4.7							
Cl-	95 - 108	107							
HCO3-	22 - 29								
Urea	2.5 - 7.8	4.2							
Creat	40 - 130	73							
eGFR		>60							
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50	42							
AlkP	30 - 130	67							
Bil	<20	5							
ALT	<50	20							
AST	<40	18							
GGT	Male: <70 Female: <40								
ESR	Male: 1 -10 Female: 1 - 12								
CRP	<10	3							
Troponin hs I	Male: 0 - 34 Female 0 - 16	<1							
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 – 2.0								

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Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO_2:

FiO2:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet	
Date: Time	

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Tracy
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Glasgow, Lanarkshire G44 4NW

Continuation Sheet	
Date: Time	

Patient ID label

Continuation Sheet	
Date: Time	

F

2704716161
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Tracy
263 Curtis Ave
Glasgow, Lanarkshire

F
27/04/1971

G44 4NW

Continuation Sheet	
Date: Time	

Patient ID label

Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

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

Discharge prescription packs

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

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

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

Outpatient clinic specialty	Admission or specialty clinic consultant

Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

2704716161.

J.G. Dysart
Anne McNally
J. Sharp
D.A. Cumming
Fiona O'Donoghue
Ruth Macdonald
J. Saldanha

2704716161
ROBERTS F
Tracy 27/04/1971
263 Curtis Ave
Glasgow, Lanarkshire
G44 4NW

PRACTICE B
Govanhill Health Centre
233 Calder Street
Glasgow G42 7DR
Tel : 0141 531 8365
Fax: 0141 531 4431

Tracy attended today with 2/7 h/o
(R) chest wall pain worse on inspiration.
no h/o trauma. Shoulder movement ok.
no cough / unfit
O/E sats 98 on RA
non tender on palpation but sore on inspiration
chest clear
no lg swelling.
She has taken PCT and ibuprofen
? exclude PE

She also reported having taken an overdose of diazepam and zopiclone last week (didn't attend hospital). I have commenced anti depressant & referred to psych

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	
Address	2704716161 ROBERTS F Tracy 27/04/1971 263 Curtis Ave Glasgow, Lanarkshire
CHI No.	G44 4NW
DoB	

	Date	Ward
Admitted		
Transferred		
Transferred		

NEWS – NHS Early Warning Score

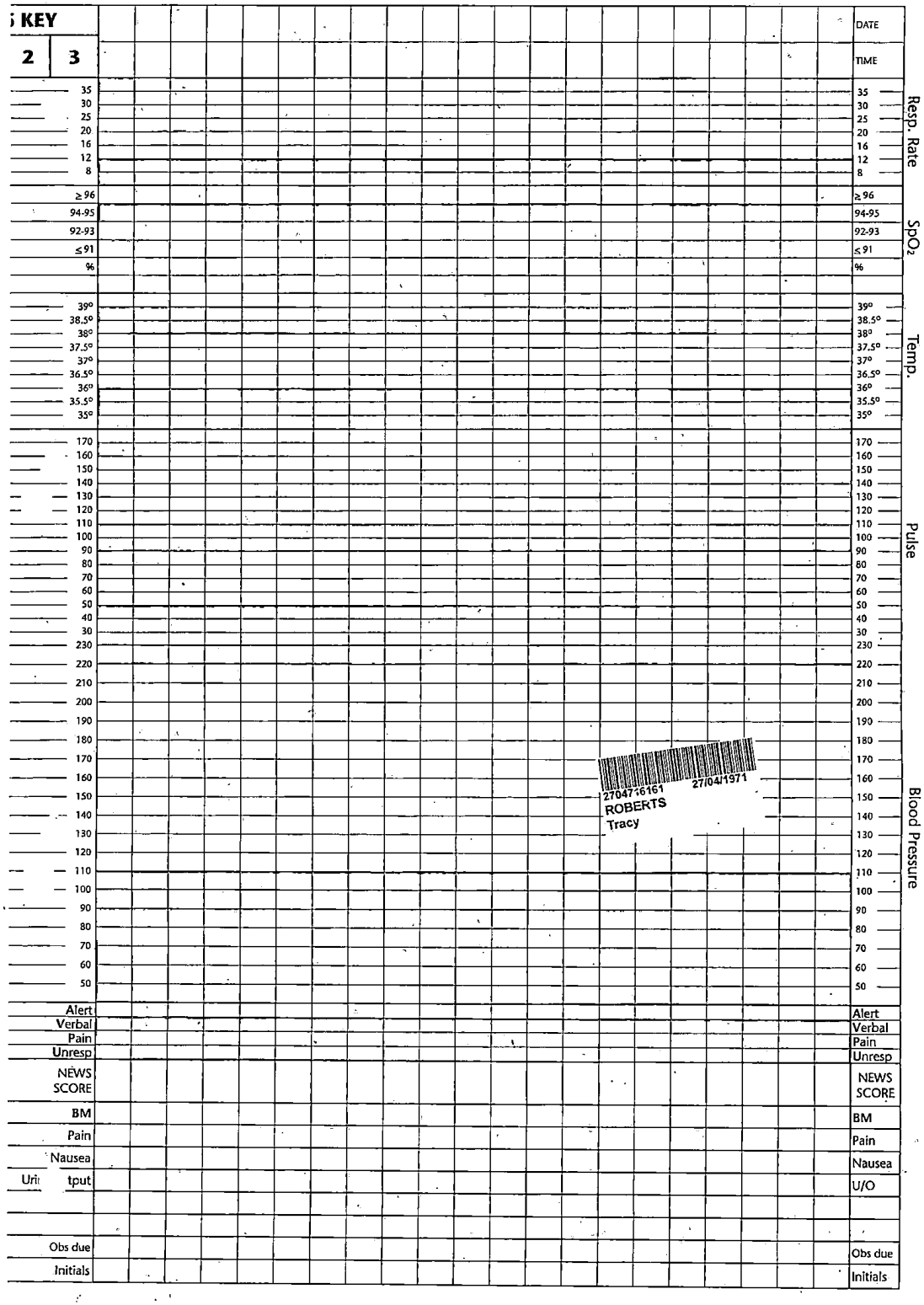
Physiological Parameter	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219	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

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more **or** 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

| | | |


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥96
94-95
92-93
≤91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials
27047161 61
27/04/1971
ROBERTS
Tracy

Glasgow Coma Scale

Pupil size (mm)

1	2	3	4	5	6	7	8
•	●						

2704716161
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Tracy
263 Curtis Ave
Glasgow, Lanarkshire
F
27/04/1971
G44 4NW

Neurological Observations

Date:																							
Time:																							
COMA SCALE	E Eyes open	Spontaneously	4																				Eyes closed by swelling = C
		To speech	3																				
		To pain	2																				
		None	1																				
	V Best Verbal response	Orientated	5																				Endotracheal tube or tracheostomy = T
		Confused	4																				
		Inappropriate words	3																				
		Incomprehensible sounds	2																				
		None	1																				
	M Best motor response	Obeys	6																				Usually record the best arm response
		Localises	5																				
		Flexion - withdrawal	4																				
		Flexion - abnormal	3																				
		Extension to pain	2																				
		None	1																				
TOTAL SCORE																							
PUPILS	R	Size																					+ reacts – no reaction c. eyes closed
		Reaction																					
	L	Size																					
		Reaction																					
LIMB MOVEMENT	ARMS	Normal power																					Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																					
		Severe weakness																					
		Spastic flexion																					
		Extension																					
		No response																					
	LEGS	Normal power																					
		Mild weakness																					
		Severe weakness																					
		Spastic flexion																					
		Extension																					
		No response																					

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Victoria Infirmary Glasgow

CHI: 2704716161

Total Att: 2

12 Mth Att: 1

Title: **MISS**

ROBERTS **Tracy**

DOB: **27/04/1971** Age: **44y** Sex: **Female**

263 Curtis Ave
5 DEVOL CRESCENT
Glasgow
Lanarkshire
G44 4NW
0141 5718540

Next of kin: **SAME?, MARGARET**
Relationship: **Mother**

GP: **LF Morley**
0141 531 6860

Attendance Date: **11/11/2015** Arrival Time: **19:02**

Registration Time: **19:02** Date of Incident: **11/11/2015**

Major Incident Desc:

Reason for Attendance: **right hand/wrist inj**

Affix Label

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date:

Temp	35.8	C
HR	70	bpm
BP	132/84	mmHg
MAP		mmHg
RR	18	bpm
SpO2	98	%
Oxygen		%

Nurse name:

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes:

97607

Child Assessment Questionnaire

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

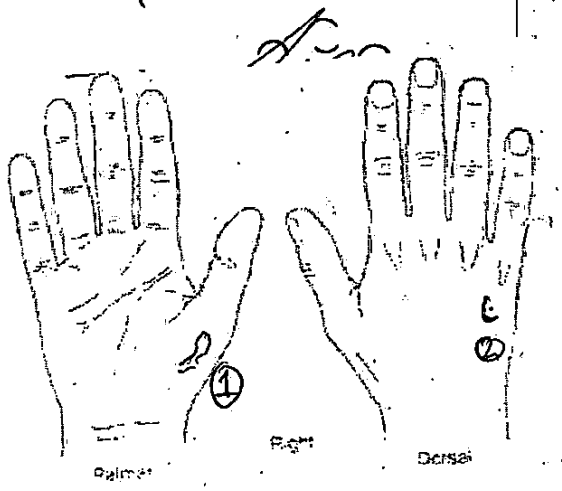
Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
11/11/15	IBUPROFEN	400mg	PO	19.20	P.GD	
11/11/15	PARACETAMOL	1 gram	PO	19.20	PGD	

Date	CLINICAL NOTES
	Seen by ~~(Dr)~~ ENP Capro Time seen 19.10
9/11/15	P.C. – Right Hand Wounds LHD
	H.P.C. – Tripped and put hand through glass door @ 18.30.
	P.M.H. – Nil D.H. – Nil N.K.D.A.
	O/E – Deep Wound at (1) Deep structures seen. Ongoing bleeding on arrival. Complaining of Numbness/altered sensation in thumb, index and middle fingers. Unable to flex or extend thumb. Possible injury to tendons.



Skin flap with Wound below at (2). Nil bleeding on arrival. Complaining of altered sensation/Numbness at Ring and Small fingers able to flex extend fingers.

Discussed with on call ortho at PCH H. ortho will kindly Review patient. Patients brother present with transport who will take patient to E.D.

R.P. Forsyth RN

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)

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

Discharge date	11/11/15
Discharge time	19.45

Ward number (if admitted):	Transfer to hospital: QEH 14	Consultant If admitted):

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

Discharge Prescription Packs

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

Designed by Medical Illustration Services ref 243836

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Mlle Foot

Affix Label

CHI: 2704716161

Victoria Infirmary Glasgow

Total Att: 1

12 Mth Att: 0

Title: **MISS**

ROBERTS **Tracy**

DOB: **27/04/1971** Age: **44y** Sex: **Female**

263 Curtis Ave
5 DEVOL CRESCENT
Glasgow
Lanarkshire
G44 4NW
0141 230 9623

Next of kin: **SAME?, MARGARET**
Relationship: **Mother**

GP: **LF Morley**
0141 531 6860

Attendance Date: **21/05/2015** Arrival Time: **13:50**

Registration Time: **13:50** Date of Incident: **07/05/2015**

Major Incident Desc:

Reason for Attendance: **/ f/b r foot**

Affix Label

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: Nurse name:

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes:

Child Assessment Questionnaire

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

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

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

2704716161 27/04/1971
ROBERTS
Tracy

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES
24/5/11	Seen by ~~(Dr)~~ [illegible] Time seen [illegible]

P.C.

- ? F.B in Night Fed for 2 weeks

Hyp in, Pulse in. Otherwise

O/E Small punctum would to Side of Face, has been using a pin to Pick away at crust, Slight discharge from it, no other Sign.

IX X-ray for F.B - not Seen

Advised to See GP if Symptoms persist

[signature]

2704716161 27/04/1971
ROBERTS
Tracy

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	04/07/11
1. Admission	2. ~~Discharge~~	3. Refer to GP	4. Transfer to other (see below)		Discharge time	
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.		

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

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

Discharge Prescription Packs

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

Designed by Medical Illustration Services ref 243836

NHS GGC Hospitals, Emergency Department

3

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital

RAH | RHSC | GRI | WIG | VI | VaMIU | Stob | WOL | SGH

CHI: 2704716161

Sex: M ☐ F ☐

SURNAME: ROBERTS

Forename: Tracy

Total Att: 3

12 Mth Att: 2

Title: MISS

Dob:

Age:

Local address:

Next of kin:

DOB: 27/04/1971 Age: 44y

Sex: Female

263 Curtis Ave

Next of kin: ARMOUR, Elizabeth

Relationship: Mother

Glasgow

Lanarkshire

07733094655

GP:

G44 4NW

GP: LF Morley

0141 5718540

0141 531 6860

Tel:

Tel:

Attendance Date: 11/11/2015 Arrival Time: 20:25

Attendance date: Arrival time: Date of Incident:

Registration Time: 20:25 Date of Incident: 11/11/2015

Registration time: Major incident description:

Major Incident Desc:

Reason for Attendance: ortho ref from vic miu

Affix Label

Nursing Assessment

Presenting complaint:

Nursing Assessment

Alerts: Not Recorded Allergies: Not Recorded Pain Score:

Tetanus up-to-date/fully immunised:

Triage cat: Triage Category: 4

Pain score: Tetanus up-to-date / fully immunised?

Allergies: Presenting Complaint:

Observations date: Observation Date: 11/11/2015 20:35

Time: Nurse name: Nurse Joanna

Hill's name:

Temp	Temperature		°C
HR	HR		bpm
BP	/ BP		mmHg
MAP	MAP		mmHg
RR			bpm
SpO2			%
Oxygen	Oxygen		%

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

Visual Acuity

Left

Right Left

Corrected?

With correction?

GCS	
Eyes	
Motor	
Verbal	
Total	

Total

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

Reaction

Nursing Notes: ref to ortho glass wound to hand

ortho aware ☑

97607

Child Assessment Questionnaire

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

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

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

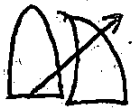
DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

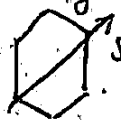
Date	CLINICAL NOTES
	Seen by (Dr) Cowell STS Time seen 1200
11/11/15	(44) LHD Not in employment. + PC: Glass wounds (R) hand HPC: Fell into glass door @ (PP) PMH: Denies any Drugs: Nil regular Allergies: codeine OE:- Sensation (light touch) intact to all digits (both sides) - FDS & FDP to all fingers intact - Unable to extend thumb (held in flexion) - Wound over radial border thumb arterial bleeding noted - Fingers & thumb ~~still~~ warm to touch => Unable to control bleeding adequately to allow exploration. (P) IV access Bloods Admit ortho Keep hand elevated Monitor CSM to thumb Xray hand ? FB Foot as protocol STS 82722

Date	CLINICAL NOTES

Pt states she feels systemically well.



HS 1+1+0.



SNT No neuro deficit

Pulse reg.

Plan for wound exploration +/- washout + tendon repair

Admit to ortho

Bloods ☑ (inc G+S).

(R) hand x-ray ☑

ECG - NSR.

GPST
N LAPRAIK

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

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

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

Discharge Prescription Packs

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

Designed by Medical Illustration Services ref 243836

2704716161
ROBERTS F
Tracy 27/04/1971

TCFF-56

MEDICINES RECONCILIATION

GH

Source of medication history (minimum 2 sources): Patient ☑ Relative/carer ☐ GP Phone call ☐ ECS ☐ GH
Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary ☐ Repeat Script ☐
Other (please specify) .....

Admission Medicines			Plan for medicines (Dr complete)				Comments
Name	Dose	Freq	Continue	Amend	Withold	Stop	Reason for alteration
NIL Regular Medicines							

Allergies

None known ☐ Codeine NKV

List collected by : CoC (GH sig)

Designation : Pharmacist Date : 18/11/15

List any Over The Counter or alternative medicines

Do medicines need further clarification Yes ☐ No ☐

Plan approved by :

Designation : Date :

Pharmacy review

Comments

Compliance aid : Yes ☐ No ☐

Community pharmacist Phone

Reviewed by : Designation : Date :

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Victoria Infirmary Glasgow

CHI: 2704716161

Total Att: 2

12 Mth Att: 1

Title: MISS

ROBERTS Tracy

DOB: 27/04/1971 Age: 44y Sex: Female

263 Curtis Ave
5 DEVOL CRESCENT
Glasgow
Lanarkshire
G44 4NW
0141 5718540

Next of kin: SAME?, MARGARET
Relationship: Mother

GP: LF Morley
0141 531 6860

Attendance Date: 11/11/2015 Arrival Time: 19:02

Registration Time: 19:02 Date of Incident: 11/11/2015

Major Incident Desc:

Reason for Attendance: right hand/wrist inj

Affix Label

Nursing Assessment

Alerts: Not Recorded Allergies: Not Recorded Pain Score:

Triage Category: Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date:

Temp	35.8	C
HR	70	bpm
BP	132/84	mmHg
MAP		mmHg
RR	18	bpm
SpO2	98	%
Oxygen		%

Nurse name:

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

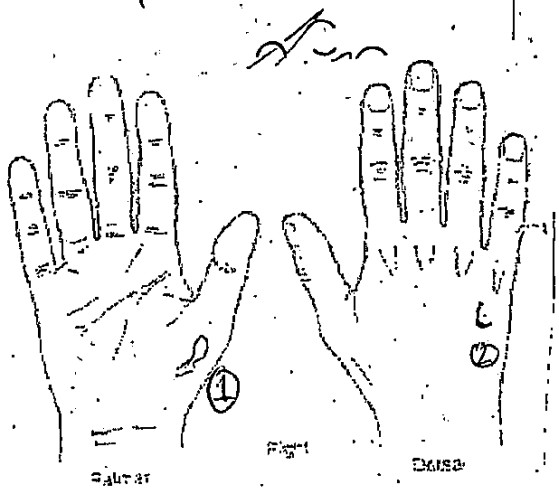
GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes:

97607

Date	CLINICAL NOTES
	Seen by (Dr) END Cons Time seen 19.10
01/11/15	P.C — Right Hand Wounds LHD
	H.P.C — Tripped and put hand through glass door @ 18.30.
	PMH — Nil DH — Nil NKDA
	O/E — Deep Wound at (1) Deep structures seen. On going bleeding on arrival. Complaining of Numbness / altered sensation in thumb, index and middle fingers. Unable to flex or extend thumb. Possible injury to tendons.



Skin flap with Wound below at (2). Next bleeding on arrival. Complaining of altered sensation / Numbness at Ring and Small fingers able to flex extend fingers

Discussed with on call ortho. at QEH & ether will kindly Review patient. Patients brother present with transport who will take patient to E.D.

Dr. Forsyth Reid

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
11/11/15	IBUPROFEN	400mg	PO	19:20	P.G.D	
11/11/15	PARACETAMOL	1 cyclus	PO	19:20	P.G.D	

ID: [redacted] 11-Nov-2015 21:1[redacted] QUEEN ELIZABETH UNIVERSITY HOSPITAL

Vent. rate	[redacted] bpm
PR interval	150 ms
QRS duration	78 ms
QT/QTc	374/415 ms
P-R-T axes	65 71 55

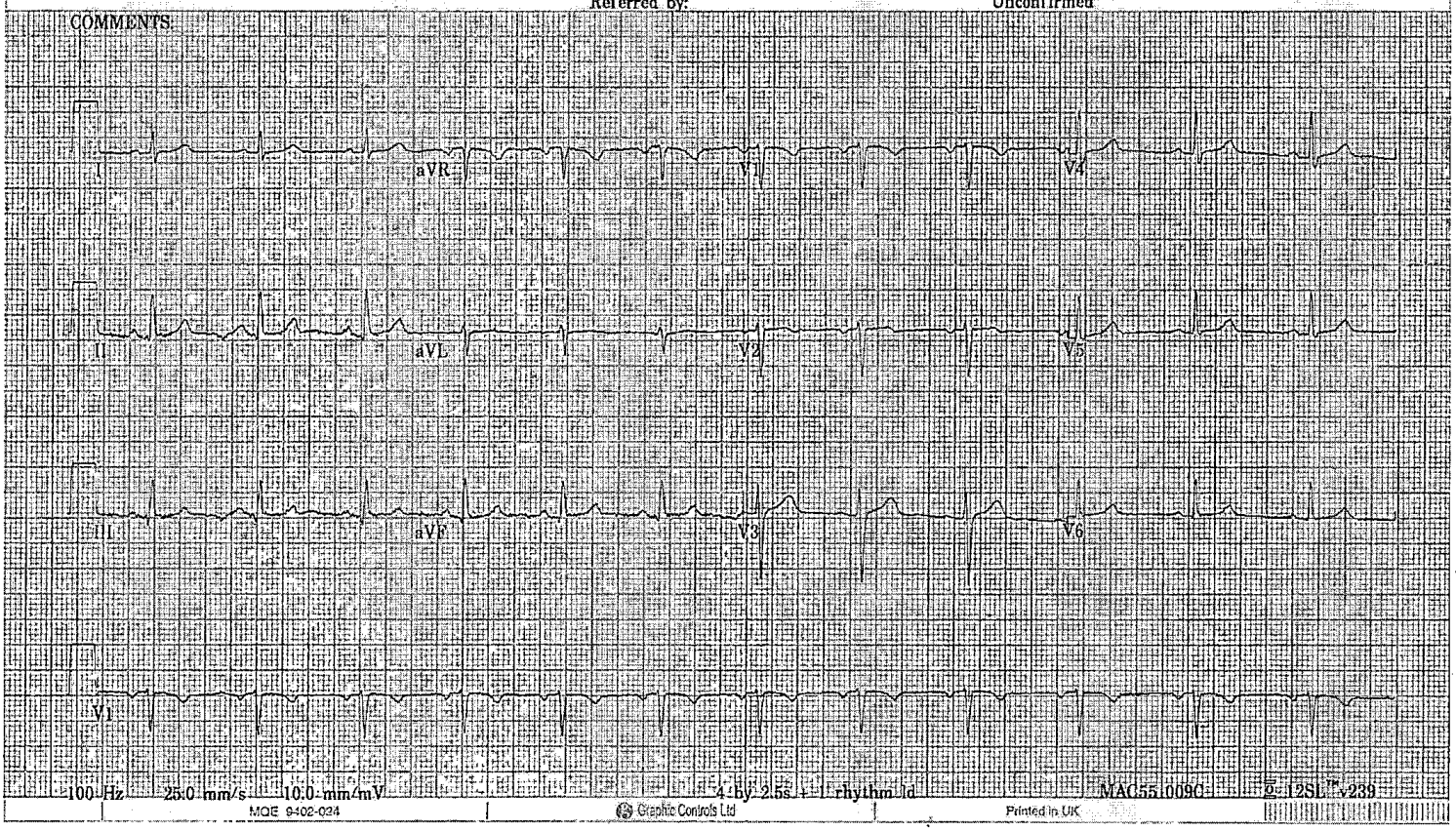
Normal sinus rhythm
Possible Left atrial enlargement
Borderline ECG

[redacted]

Technician:
Test ind:

Referred by: Unconfirmed

COMMENTS



100 Hz 25.0 mm/s 10.0 mm/mV 4 By 2.5s + rhythm Id MAC55 1009C 12SL v239

MQE 9402-034 Graphic Controls Ltd Printed in UK

Department of Orthopaedic Surgery

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Tel 0141 211 6360

MR AJR GRAY'S WARD ROUND

Date: 11/11/2015

Miss Tracy Roberts CHI: 2704716161
263 Curtis Ave Glasgow Lanarkshire G44 4NW

44 year old left handed not working otherwise reasonably fit tripped in the house and put her arm though glass door. There are lacerations on her right, one is over the dorsal radial aspect of the proximal thumb. She is unable to extend her thumb. She has another laceration on the hypothenar eminence. She has no vessel or nerve deficit and no other tendon injury apparent. The plan is for theatre today for washout and debridement.

Acute Services Division

Diagnostics Directorate

NHS
Greater Glasgow and Clyde

WEST OF SCOTLAND CENTRE FOR GENOMIC MEDICINE | Clinical Genetics | Level 2A Laboratory Medicine, Queen Elizabeth University Hospital, 1345 Govan Road Glasgow G51 4TF, www.nhsggc.org.uk/medicalgenetics

Secretaries: GeneticSecretaries@ggc.scot.nhs.uk
Reception: 0141 354 9201
Referrals: GeneticsReferrals@ggc.scot.nhs.uk

Height 160.25cm
Weight 90.39kg
BP: 148/103mmHg

West of Scotland Myotonic Dystrophy Management Clinic (WOSMDMC)

Clinic Note

Name: Tracy Roberts
Address: 263 Curtis Avenue, Glasgow, G44 4NW

Pedigree: 114345
CHI: 2704716161

Date:	11 JULY 2024
Time:	11:45
Category:	Genetics OPC, QEUH
Clinician:	Dr Bob Ballantyne (bob.ballantyne@ggc.scot.nhs.uk)

Comments:

FH type 1 myotonic dystrophy (daughter + granddaughter)

Attending for counselling and predictive testing.

Actions:

[1] Counselled
[2] Sample obtained
[3] Recommend primary care BP review

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 28/10/2024

Consultant: Dr Ali Al-Salihi

DA Cumming
Practice B
Govanhill Health Centre
233 Calder Street
Glasgow
Glasgow
G42 7DR

Dear DA Cumming

Re: **Roberts Tracy** DOB: **27/04/1971** CHI: **2704716161**
263 Curtis Avenue
Glasgow G44 4NW

Attended on: **25/10/2024 at 23:15 hrs.** Departed on: **26/10/2024 at 07:30 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
NHS24 ED direct ref BACK PAIN TODAY

Nursing Assessment:
turned over in bed yesterday morning and felt excruciating pain. states unable to get out of bed. states can walk if someone helps her to stand previous trapped nerve

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Low Back Pain		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Presented with lower back pain. Known sciatica. No signs of cauda equina, no saddle paraesthesia, incontinence or altered sensation. Normal neurological examination. Medically fit for discharge with analgesia.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Lauren Payas
Doctor

Copies to:

1. DA Cumming (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
New Victoria Hospital
Grange Road
Glasgow
Lanarkshire
G42 9LF

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 14/06/2021

Consultant: Dr Cieran McKiernan

DA Cumming
Practice B
Govanhill Health Centre
233 Calder Street
Glasgow
Glasgow
G42 7DR

Dear DA Cumming

Re: **Roberts Tracy** DOB: **27/04/1971** CHI: **2704716161**
263 Curtis Avenue
Glasgow G44 4NW

Attended on: **14/06/2021 at 10:16 hrs.** Departed on: **14/06/2021 at 14:20 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
right hand inj

Nursing Assessment:

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Attention to Surgical Dressings and Sutures		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Margaret Smyth
Nurse

Copies to:

1. DA Cumming (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
New Victoria Hospital
Grange Road
Glasgow
Lanarkshire
G42 9LF

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 12/06/2021

Consultant: Dr Malcolm Gordon

DA Cumming
Practice B
Govanhill Health Centre
233 Calder Street
Glasgow
Glasgow
G42 7DR

Dear DA Cumming

Re: **Roberts Tracy** DOB: **27/04/1971** CHI: **2704716161**
263 Curtis Avenue
Glasgow G44 4NW

Attended on: **12/06/2021 at 15:43 hrs.** Departed on: **12/06/2021 at 17:40 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
wrist injury

Nursing Assessment:

Investigations in ED:
1. XR Wrist Rt **2. XR Hand Rt**

Diagnosis:

Diagnosis	Side	Site
Open Wound of Other Parts of Wrist and Hand	**Right**	**Hand**

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None.**

Clinician Notes:

Attended MIU on 12/06 with an infected wound to dorsal aspect of right hand. Fell into a glass mirror whilst intoxicated 2/7 previously. X ray right hand/wrist:- NBI No fb seen. Cleaned and dressed with inadine and mepore. To be reviewed by PN in 2/7 please. Flucloxacillin 1g QDS for 5/7. Worsening advice given. BP elevated. Patient very anxious. Could this be reviewed by PN please.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Jacqueline Innes
Nurse

Copies to:

1. DA Cumming (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 14/02/2021

Consultant: Dr Scott Hepburn

DA Cumming
Practice B
Govanhill Health Centre
233 Calder Street
Glasgow
Glasgow
G42 7DR

Dear DA Cumming

Re: **Roberts Tracy** DOB: **27/04/1971** CHI: **2704716161**
263 Curtis Avenue
Glasgow G44 4NW

Attended on: **14/02/2021 at 07:38 hrs.** Departed on: **14/02/2021 at 11:25 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
biba anxiety

Nursing Assessment:
biba - states has had headache for 4/42 has been worse over past 2/52, this morning after getting out of bed felt both legs felt weak and shaking all over. states has also had increasing anxiety over the past few months and having panic attacks, not sleeping or eating well, has not been coming out of bedroom - appears very anxious in triage

Investigations in ED:

1. Bone Profile	**2. CRP**	**3. Urea and Electrolytes**
4. Full Blood Count	**5. Thyroid function tests**	**6. XR Chest**

Diagnosis:

Diagnosis	Side	Site
Panic Disorder [episodic Paroxysmal Anxiety]		
Tension-type Headache		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

***GP - panic attack 2 days after starting 20mg Citalopram, may benefit from alternative prescription* Tracy Roberts attended A&E having had a 2 hour episode of hyperventilation, paraesthesia, anxiety, palpitations and leg weakness with associated blurring of vision and speech difficulty without slurring. This felt similar to previous episodes of panic attacks she had experienced but more severe. Examination was unremarkable as symptoms had resolved before review in A&E other than a slight tremor and notable anxiety. Bloods and x-ray were normal. She had recently started taking 20mg Citalopram for anxiety/depression and this may be a precipitating cause of this episode, she has been advised to discuss potentially a lower dose of this drug/alternative with her GP. Additionally she has a 4 week history of tight-band tension headache that may be exacerbated by her analgesia use for her sciatica, she has been advised to trial weaning this to see if there is any benefit.**

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Ben Pilkington
Doctor

Copies to:

1. DA Cumming (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 14/04/2019

Consultant: Dr Katy McCarthy

J Sharp
Practice B
Govanhill Health Centre
233 Calder Street
Glasgow
Glasgow
G42 7DR

Dear J Sharp

Re: **Roberts Tracy** DOB: **27/04/1971** CHI: **2704716161**
263 Curtis Ave
Glasgow.G44 4NW

Attended on: **12/04/2019 at 15:12 hrs.** Departed on: **12/04/2019 at 19:11 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
chest and back pain

Nursing Assessment:
C/O WORSENING LEFT SIDE CHEST AND BACK PAIN FOR 2/7. DENIES SPIT. STATES PAIN WORSE ON INSPIRATION AND HAS FELT SOB. PT ON HRT

Investigations in ED:

1. Urea and Electrolytes	**2. Bicarbonate**	**3. LFT**
4. Lipid profile (inc. HDL)	**5. Full Blood Count**	**6. Troponin I hs**
7. XR Chest	**8. D - Dimer**	**9. Coagulation screen**

Diagnosis:

Diagnosis	Side	Site
Pleurisy / Pleuritic chest pain		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
47y admitted with sharp left sided chest pain. CXR and bloods unremarkable. Discharged with Amox 500mg TID and Pred 40mg OD 5/7. Worsening advice.

Followup :
Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Ewan Hamilton
Doctor

Copies to:
1. J Sharp (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2503 (8503)
Fax: Patient Attended
Email: QEUH Clinical Decision Unit

Date Completed: 08/04/2017

Consultant: Dr David Bell

J Sharp
Practice B
Govanhill Health Centre
233 Calder Street
Glasgow
Glasgow
G42 7DR

Dear J Sharp

Re: **Roberts Tracy** DOB: **27/04/1971** CHI: **2704716161**
263 Curtis Ave
Glasgow G44 4NW

Attended on: **29/03/2017 at 13:57 hrs.** Departed on: **29/03/2017 at 18:38 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
MEDICS ?PE CDU YES

Nursing Assessment:
MEDICS ?PE CDU YES

Investigations in ED:

1. Full Blood Count	**2. Coagulation screen**	**3. D - Dimer**
4. Urea and Electrolytes	**5. Glucose**	**6. LFT**
7. CRP	**8. Troponin I hs**	**9. XR Chest**

Diagnosis:

Diagnosis	Side	Site
Musculoskeletal chest pain (non - traumatic)		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

This lady presented with chest pain and associated pins and needles in her fingers. All her blood results where normal and she has been having a lot of stress at home, whilst doing lots of heavy lifting in work. She has been discharged home with worsening advise and advised to represent if further severe symptoms. Kind Regards

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Callum McLoughlin
Doctor

Copies to:

1. J Sharp (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Victoria Infirmary Glasgow
Langside Road
Glasgow
Lanarkshire
G42 9TY

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 11/11/2015

Consultant: Dr Jonny Gordon

LF Morley
Drs Treadgold duffy & morley
Pollok Health Centre
21 Cowglen Road
Glasgow
Glasgow
G53 6EQ

Dear LF Morley,

Re: **Roberts Tracy** DOB: **27/04/1971** CHI: **2704716161**
263 Curtis Ave
Glasgow G44 4NW

Attended on: **11/11/2015 at 19:02 hrs.** Departed on: **at hrs.**
Discharge Type: **03 - Transferred** Destination: **Transfer to other NHS healthcare provider**

Previous ED Attendance in last 12 months: **1**

Presenting complaint
right hand/wrist inj

Nursing Assessment:

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Open wound of hand		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Stumbled put right hand through glass door, deep wounds to hand, with altered sensation and ? ligamentous injury. Transferred to QEUH for ortho review

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Robert Forsyth
Nurse

Copies to:

1. LF Morley (GP)

School Address:

Chest pain, unspecified		

Procedures: None

Roberts Tracy CHI: 2704716161

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Southern General Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 201 1456
Fax: 0141 232 7588
Email:

Date Completed: 19/06/2013

Consultant: Dr Cieran McKiernan

LF Morley
Drs Treadgold duffy & morley
Pollok Health Centre
21 Cowglen Road
Glasgow
Glasgow
G53 6EQ

Dear LF Morley

Re: **Roberts Tracy** DOB: **27/04/1971** CHI: **2704716161**
FLAT 1-1
Glasgow G53 5BD

Attended on: **19/06/2013 at 03:22 hrs.** Departed on: **19/06/2013 at 04:27 hrs.**
Discharge Type: **04C Incomplete: Patient refused treatment** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
sob, chest pain

Nursing Assessment:
999 call chest tightness and hyperventilation. recent cough with green spit

Investigations in ED:

1. XR Chest	**2. Urea and Electrolytes**	**3. LFT**
4. Glucose	**5. Full Blood Count**	**6. Troponin I**
7. Bicarbonate	**8. CRP**	**9. Amylase**

VICTORIA INFIRMARY
LANGSIDE ROAD
GLASGOW G42 9TY
Accident & Emergency Dept
Phone (0141) 201 5130 Fax (0141) 636 5608

DR. SUSAN SM MUTCH
45 PINE PLACE
GLASGOW

G5 0BQ
0141 531 8246

Dear Dr. SUSAN SM MUTCH,

Your Patient
Name : TRACY ROBERTS
DOB : 27/04/1971
Address : 17 NORFOLK COURT
FLAT 1/3
GLASGOW

G5 9AT

Consultant : IAN W R ANDERSON

Account # : AE0013478/10 Unit # : SG99815245 CHI # : 270

Attended at : 1813 on 17/02/2010
Left A&E at : 1935 on 17/02/2010

Reason for Visit : EYE PAIN

Diagnosis :

Investigations :

Treatments :

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given :

Additional Notes:

Follow Up :

Yours sincerely

DR.

If you require any further information please quote this attendance number: AE00

VICTORIA INFIRMARY
LANGSIDE ROAD
GLASGOW G42 9TY
Accident & Emergency Dept
Phone (0141) 201 5130 Fax (0141) 636 5608

DR. FIONA FM HOUSTON
GORBALS HEALTH CENTRE
45 PINE PLACE
GLASGOW

G5 0BQ
0141 531 8275

Dear Dr. FIONA FM HOUSTON,

Your Patient
Name : TRACY ROBERTS
DOB : 27/04/1971
Address : 17 NORFOLK COURT
2/1
GLASGOW

G5 9AT

Consultant : DAVID RITCHIE

Account # : AE0033809/09 Unit # : SG99815245 CHI # : 270

Attended at : 0142 on 17/04/2009
Left A&E at : 0400 on 17/04/2009

Reason for Visit : HAND INJ

Diagnosis :

Investigations :

Treatments :

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given :

Additional Notes:

Follow Up :

Yours sincerely

DR.

If you require any further information please quote this attendance number: AE00

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

New Victoria Hospital
Grange Road
Glasgow
G42 9LF

Main Switchboard: 0141 201 6000
Department: Cardiology
Contact Tel: 0141 451 6130
Enquiries to: antoinette.wylie@nhs.scot
Letter Date: 31/01/2025
Reference:
Dictated Date: 30/01/2025
Transcribed Date:

Dr. DA Cumming
Practice B
Govanhill Health Centre
233 Calder Street
Glasgow
G42 7DR

Dear Dr Cumming,

Tracy Roberts; D.O.B: 27/04/1971; CHI: 2704716161
263 Curtis Avenue, Glasgow, Lanarkshire, G44 4NW

Tracy has now had her repeat Holter monitor.

The analyzed length was 21 hours 11 minutes, showing sinus rhythm throughout.

There were some non-conducted early SVEs, but no higher degree AV block. There were no entries in the patient diary.

I note that she did not attend for her planned ETT.

Yours sincerely,

Dr Simon Beggs

Post CCT Cardiology Fellow

Electronically Signed: ,

cc.

Clinical letter - GP: Discharge Letter

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100
Department: MSK Physiotherapy Qeuh
Contact Tel: 01414522935
Enquiries to:

Dr. FJ O'Donoghue
Practice B
Govanhill Health Centre
233 Calder Street
Glasgow
G42 7DR

Letter Date: 09/10/2020
Reference:
Dictated Date: 09/10/2020
Transcribed Date:

Dear Dr FJ O'Donoghue,

Tracy Roberts; D.O.B: 27/04/1971; CHI: 2704716161
263 Curtis Avenue, Glasgow, Lanarkshire, G44 4NW

This patient did not keep their first appointment with us on [08/10/2020], and did not notify us that they would not be attending.

No further appointment will be offered and they will be removed from our waiting list, unless they contact us within 24 hours.

Yours sincerely

Peter Morrison

Physiotherapist

Electronically Signed: ,

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde
New Victoria Hospital
Grange Road
Glasgow
G42 9LF
0141 201 6000

Dr. DA Cumming
Practice B
Govanhill Health Centre
233 Calder Street
Glasgow
G42 7DR

Main Switchboard:	
Department:	Cardiology
Contact Tel:	0141 451 6128
Enquiries to:	Amy.Banks2@nhs.scot
Letter Date:	23/10/2024
Reference:	SB/AB
Dictated Date:	23/10/2024
Transcribed Date:	18/11/2024

Dear Dr. DA Cumming,

Tracy Roberts; D.O.B: 27 Apr 1971; CHI: 2704716161
263 Curtis Avenue, Glasgow, Lanarkshire, G44 4NW

Attendance: Specialty - Cardiology; Clinic - VIDCCA03N-DR CORCORAN CARDIO EXTRA CLINIC
Date and Time of Appointment - 23/10/2024 11:40

Clinical Comments:
Diagnoses:
1. Long standing postural dizziness
2. Significant anxiety
3. AV Wenckebach on Holter monitor
4. Non-driver
5. Possible pre-syncope during intense laughter

Current Medications:
1. Mirtazapine
2. Incruse Ellipta inhaler

Test today:
1. 12-lead ECG
2. Transthoracic echo

Follow up:
1. ETT
2. 24 hour Holter
3. Discharge from Cardiology Clinic

I caught up with Tracy in the Cardiology Clinic. She reports dizziness for many years, always while standing. She has a clear postural prodrome.

In January of this year, she was out shopping with her family and was standing when she had onset of her usual dizziness, told them she needed to sit down, before she blacked out. She says this was for around ten seconds and there was no tongue biting, or incontinence. She quickly came to. She describes this as one of her usual episodes, but she simply couldn't control it this time.

Two weeks later whilst at home alone, she got up to go to the toilet in the early afternoon (she has insomnia and so sometimes sleeps in later in the mornings) and this time had a much shorter prodrome and couldn't protect herself before reporting that she blacked out. Again, there was no tongue biting or other sequela of "seizure". She thinks she came to quickly and still needed the toilet at that point. Again, this seemed like a typical episode simply with a shorter prodrome.

Following these episodes and your SCI Gateway referral a 72-hour tape was performed in July 2024. This demonstrated sinus rhythm with second degree AV block. Although the report mentions both Wenckebach and Mobitz 2, I do not think that this is accurate. There was certainly evidence of AV Wenckebach which looks clearly vagally mediated with sinus rate slowing before classical prolongation of the PR interval. There is 2:1 AV block which follows directly on from the AV Wenckebach episode. 2:1 AV block is not synonymous with Mobitz 2, and in this circumstance, is consistent with a vagally-mediated mechanism.

There is no evidence of higher degree AV block. It is admittedly a little less usual to have vagally-induced AV Wenckebach in the daytime, although the episodes of 2:1 AV block were at 13:21 and due to her insomnia, she often sleeps into the early afternoon. It seems feasible that she could have been asleep during this episode. No symptom diary was returned but she said she had no symptoms during the tape.

Tracy also reports different episodes of feeling very dizzy and as if her vision is "going" during episodes of intense laughter. This has happened for around two years, and she has never lost consciousness. She mentions watching cat videos on Youtube as being a precipitant. She only gets these symptoms if she laughs intensely. I am not sure what to make of this. Laughter-induced syncope as a reflex mechanism is certainly recognised, although she is not actually passing out.

Cardiovascular examination is normal. BP 134/85 mmHg, pulse 69 bpm (regular), weight 90 kg.

I have sent her for an ECG and echocardiogram today.

12 lead ECG showed sinus rhythm with normal electrical intervals.

Transthoracic echocardiogram showed mild antero-septal hypertrophy with good LV systolic function, normal RV and normal valves.

Tracy's symptoms sound like postural hypotension. We discussed pragmatic lifestyle measures including hydration, salt intake and counter pressure exercise manoeuvres. She understands all this. I hope this will make a difference. I have outlined that should she have ongoing symptoms we could consider compression stockings as a next step thereafter. I would not proceed to offer pacemaker at present.

I would like to organise an exercise tolerance to assess her conduction under stress. I hope this will be reassuring. I have also organised for her a Holter monitor one further time, since she assures me that she could induce intense laughter whilst this is on. Since we have shown transient AV block previously, it would be useful to demonstrate this is not happening while she is laughing. I am hopeful all these tests will be reassuring and if that's the case, whilst her symptoms remain clearly postural in nature, I don't think I would take this further.

Yours sincerely

Dr Simon Beggs

Post-CCT Cardiology Fellow

Electronically Signed: Dr Simon Beggs, Consultant

cc.

Clinic Letter

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
0141 201 1100

Dr. DA Cumming
Practice B
Govanhill Health Centre
233 Calder Street
Glasgow
G42 7DR

Main Switchboard:	
Department:	Cardiology
Contact Tel:	0141 451 6128
Enquiries to:	Amy.Banks2@nhs.scot
Letter Date:	16/09/2024
Reference:	KM/AB
Dictated Date:	17/09/2024
Transcribed Date:	25/09/2024

Dear Dr. DA Cumming,

Tracy Roberts; D.O.B: 27 Apr 1971; CHI: 2704716161
263 Curtis Avenue, Glasgow, Lanarkshire, G44 4NW

Attendance: Specialty - Cardiology; Clinic - SUKMCA201D-DR K MANGION CARDIO MON PM NO OVERBOOKING UNLESS AUTHORISED BY CONSULTANT OR SECRETARY
Date and Time of Appointment - 16/09/2024 14:55

Clinical Comments:
This is the second appointment Tracy Roberts did not attend for. As such she has been taken off the waiting list. If your clinical concerns persist please reassess this lady and re-request an appointment via the usual pathway.

With best wishes,

Yours sincerely

Dr Kenneth Mangion

Consultant Cardiologist

Electronically Signed: Dr Kenneth Mangion, Consultant

cc.

Tracy Roberts CHI: 2704716161

Acute Services Division
Diagnostics Directorate

WEST OF SCOTLAND CENTRE FOR GENOMIC MEDICINE | *Clinical Genetics*

Level 2A Laboratory Medicine
Queen Elizabeth University Hospital
1345 Govan Road Glasgow G51 4TF
www.nhsggc.org.uk/medicalgenetics

NHS Greater Glasgow and Clyde

West of Scotland Myotonic Dystrophy Management Clinic

Dr Mark Hamilton, Consultant, Clinical Genetics
Dr Maria Elena Farrugia, Consultant, Neurology
Dr Bob Ballantyne, Specialty Doctor, Clinical Genetics

Secretary: 0141 354 9222 (Janice)
General Enquiries: 0141 354 9200

Please quote this reference in all correspondence:

Our ref: BB/JG/114345 CHI: 2704716161

15 August 2024 (Dictated: 11/07/2024)

Ms Tracy Roberts
263 Curtis Avenue
Glasgow
G44 4NW

Dear Ms Roberts

Molecular testing excludes a diagnosis of type 1 myotonic dystrophy (you are **not** at risk of developing type 1 myotonic dystrophy)

It was a pleasure to meet with you at the genetics department at the Queen Elizabeth University Hospital on the 11th July 2024. This appointment was arranged at your request so you could attend for genetic counselling and to proceed with genetic testing for type 1 myotonic dystrophy. Your daughter and granddaughter were recently diagnosed with type 1 myotonic dystrophy and you wished to attend for testing to see if you have the myotonic dystrophy gene change or not. You advised me that you have a diagnosis of possible COPD and I understand that this has not yet been confirmed. You told me you had an appointment the day after our meeting to have a 24 hour heart monitor fitted at the New Victoria Hospital. This was to investigate some episodes of light headedness and collapse. We also spoke about a previous injury you sustained to your right hand which required some surgery to repair a tendon. You told me you have had no issues with general anaesthetics in the past. Cataracts have not been identified on any of your previous eye tests. You mentioned that on occasions you felt that your right hand can get a little stiff and painful.

We discussed the genetics of type 1 myotonic dystrophy including the autosomal dominant inheritance pattern and your own 1 in 2 (50/50) chance of having the same gene change which affects your daughter and granddaughter. We discussed that the gene change which causes myotonic dystrophy type 1 can become larger in successive generations and when this occurs it may be associated with more severe and earlier onset symptoms. We discussed that myotonic dystrophy, although predominantly known as a type of muscular dystrophy, can affect many other parts of the body including the brain, eyes, heart, lungs, bowels and skin. Adults who have type 1 myotonic dystrophy may experience increased sensitivity to general anaesthetics, opioid painkillers and sedative medications and it is recommended that affected adults carry an alert card or wear an item of jewellery which identifies that they have myotonic dystrophy and/or add an alert to their

smart phone. We also touched on some of the reproductive or family planning options which are available to affected adults including preimplantation genetic testing. Adults who are affected by type 1 myotonic dystrophy must advise the DVLA of their diagnosis. It is recommended that adults with type 1 myotonic dystrophy should attend for annual clinical reviews and to allow the recommended heart and blood test investigations to be performed.

Following our discussion you were keen to proceed with testing for type 1 myotonic dystrophy and a sample was obtained and sent to our molecular laboratory.

As you are aware from my subsequent email correspondence, the molecular testing showed that you **do not** have the myotonic dystrophy gene alteration and are **not** at risk of developing type 1 myotonic dystrophy.

Please get in touch if you have any questions.

Kind Regards,
Yours sincerely

Bob Ballantyne

Bob Ballantyne
GMC 4018250
Specialty Doctor in Clinical Genetics
Email: bob.ballantyne@ggc.scot.nhs.uk
Direct line: +44 141 354 9241
Mobile: +44 7773159881

Electronically verified by Dr Ballantyne on: 20/08/2024

Cc Dr Daniel Cumming, Practice B, Govanhill Medical Centre, 233 Calder Street, Glasgow, G42 7DR

More information on muscle conditions in Scotland is available at www.smn.scot.nhs.uk

Clinic Letter

NHS
Greater Glasgow and Clyde

New Victoria Hospital
Grange Road
Glasgow
G42 9LF
0141 201 6000

Dr. DA Cumming
Practice B
Govanhill Health Centre
233 Calder Street
Glasgow
G42 7DR

Main Switchboard:	
Department:	Cardiology
Contact Tel:	0141 451 6120
Enquiries to:	louise.kinnear@ggc.scot.nhs.uk
Letter Date:	08/08/2024
Reference:	SR/LK
Dictated Date:	08/08/2024
Transcribed Date:	14/08/2024

Dear Dr. DA Cumming,

Tracy Roberts; D.O.B: 27 Apr 1971; CHI: 2704716161
263 Curtis Avenue, Glasgow, Lanarkshire, G44 4NW

Attendance: Specialty - Cardiology; Clinic - VISRCA7-DR S RODGERS CARDIOLOGY THUR AM
Date and Time of Appointment - 08/08/2024 10:00

Clinical Comments:
Tracy did not attend her cardiology outpatient appointment today. She will be offered a further appointment.

With kind regards,

Yours sincerely

Dr Sam Rodgers

Consultant Cardiologist

Electronically Signed: Dr Samuel Rodgers, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

New Victoria Hospital
Grange Road
Glasgow
G42 9LF
0141 201 6000

Dr. J Sharp
Practice B
Govanhill Health Centre
233 Calder Street
Glasgow
G42 7DR

Main Switchboard: 0141 201 6000
Department: Obstetrics & Gynaecology
Contact Tel: 0141 347 8554
Enquiries to: annette.kirkbride@ggc.scot.nhs.uk
Letter Date: 05/06/2017
Reference: CH/AK
Dictated Date: 05/06/2017
Transcribed Date: 09/06/2017

Dear Dr. J Sharp,

Tracy Roberts; D.O.B: 27 Apr 1971; CHI: 2704716161
263 Curtis Ave, Glasgow, Lanarkshire, G44 4NW

Attendance: Specialty - Gynaecology; Clinic - VIJHGY1-DR HARDWICK GYN ONE STOP MON AM
Date and Time of Appointment - 05/06/2017 10:40

Clinical Comments:
Tracy failed to keep her appointment at the gynaecology clinic. I presume her menstrual disorder has now resolved.

Kind regards.

Yours sincerely,

C HARDWICK

CONSULTANT OBSTETRICIAN & GYNAECOLOGIST

Electronically Signed: Dr John Chris Hardwick, Consultant

cc.

Roberts Tracy CHI: 2704716161

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No
This letter supersedes previous version of 12 Nov 2015 16:49

Dr. LF Morley
Drs Treadgold duffy & morley
Pollok Health Centre
21 Cowglen Road
Glasgow
G53 6EQ

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100
Date of Completion: 12/11/2015

Dear Dr LF Morley,

Name	CHI	DoB	Address
Tracy Roberts	2704716161	27/04/1971	263 Curtis Ave Glasgow G44 4NW

Admitted	Type	Discharged	Destination
11/11/2015 22:43	In Patient	12/11/2015	

Specialty	Consultant	Ward	Telephone
Orthopaedics	Mr Nick Brownson	QEUH Ward 10D	01414522710 / 01414522711

Reason for Admission and Presenting Complaints	Admission Category
	Accidental Injury - Injury caused by an accident

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: Dear Doctor,
Thank you for your continuing care of this 44 year old lady in the community.
She was admitted on the 11/11 after sustaining a glass wound to her right hand.
She subsequently went on to have a right hand wound exploration and washout on the 11/11.
There were no complications during surgery and she is not well on the ward.
She is fit for discharge and FOLLOW UP?

Treatments: None recorded.

Follow-up arranged: upper limb fracture clinic next week wound review at clinic

Planned Outpatient Investigations: -

Final Discharge letter to follow: -

Medication Info:

Allergies:

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Dihydrocodeine Tartrate Tablets	Oral	30	mg	Every 4 - 6 Hours when required	1 Week	
Paracetamol Tablets	Oral	1000	mg	FOUR Times a Day	1 Week	

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Gabriella Samson
Doctor

Prescription Review

Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Victoria Thornthwaite, Nurse

Letter to Patient:

NHS
Greater Glasgow and Clyde

New Victoria Hospital
Grange Road
Glasgow
G42 9LF

Main Switchboard: 0141 201 6000
Department: Cardiology
Contact Tel: 0141 451 6119
Enquiries to: anouska.meldrum@ggc.scot.nhs.uk
Letter Date: 24/12/2024
Reference: DC/KS
Dictated Date: 27/11/2024
Transcribed Date: 20/12/2024

Tracy Roberts
263 Curtis Avenue
Glasgow
Lanarkshire
G44 4NW

Dear Ms Roberts,

You were recently reviewed in the New Victoria Hospital cardiology out-patient clinic by Dr Simon Beggs. Dr Beggs arranged for you to have an exercise treadmill test performed. You did not attend for this test, and it may be that you did not receive the appointment letter. If you would still like to undergo this test, then please contact me directly and I will arrange for this.

Yours sincerely

Dr David Corcoran

Consultant Cardiologist

Electronically Signed: Dr David Corcoran, Consultant

cc.

Case No 7454503 **Case Active** 25/10/2024 21:34 **Case Type** MIU Telephone / Remote Consultation

Patient Tracy Roberts **Sex** F **D.O.B** 27/04/1971 **Age** 53 years

Current Address
263 Curtis Avenue Glasgow

G44 4NW

Home Address (if currently not at home)

Current Phone: 07359 851770 **Home Phone:** **CHI:** 2704716161

Case Origin **Callers Name** Tracy **Callers Tel:**

Own Doctor

Surgery Practice B

NHS24 Received By Nicholas Kelly (Call Taker Si) () **NHS24 Triage Start** 21:35

NHS24 Triage By Nicholas Kelly (Call Taker Si) () **NHS24 Triage End** 22:33

NHS24 Reported Condition
BACK PAIN TODAY

NHS24 Outcome MIU4

NHS24 Recorded Allergies **NHS24 Recorded Medications** **NHS24 Recorded Medical History**

NHS24 Clinical Summary

Clinical summary created by: Nicholas Kelly (Call Taker Si) () [25/10/2024 22:33:38]
Reason for call: BACK PAIN TODAYConfirmed Symptom(s):
Pain in lower back and both legs

Additional details of problem(s):
Back pain started after no apparent reason
Back pain for: WOKE AT 7AM
Symptoms for less than 72 hours
Previous back pain
Back pain score of 10

Associated Features/Red Flags:
Cauda equina; Numbness, altered feeling and/or pins and needles around back passage/genitals

Symptom(s) not found:
Not pregnant
Cauda equina; No new or recent loss of bladder and/or bowel control
No current fever

Treatment/Relieving Factors:
Other treatment not required for previous episode
Previous episode required medication
Medication taken for previous episode: N/A
Medication last taken for previous pain: ? JAG FROM A&E PLUS UNKNOWN MEDS AT HOSPITAL
Medication helped previous episode
Medication did not help this episode
Medication last taken for this episode: PARA - THIS AM
ANAD - NOON ? 4PM
Medication taken for this episode: PARACETAMOL
ANADIN

Risk Factor(s):
No travel outside Europe in last 21 days or to an affected country

Case No 7454503 **Case Active** 25/10/2024 21:34 **Case Type** MIU Telephone / Remote Consultation

Call Detail(s):

25:10:2024 21:35:23 KELLYN.. WOKE TODAY TO PAIN - BACK TRACKS TO BUM AND LEGNEEDS HELP TO STAND - CANT GET UP BY SELFHAS SCIATICA - PREV HAD TO GO TO HOSPITALADV PAIN NOW WORSE THAN B4., PREV ISSUE WAS A ? TRAPPED NERVE.. CONSTANT PAIN - WORSE ON MOVEMENT., ON CALL DURING CHECK IN - PT ADV BUM NOW NUMB -.. D/W SCN NICOLA BUNCE WOKE TO BACK PAIN RADIATING TO LEGS 20 HOURS HX - NO CES CONERNS - EXPERIANCING PAIN TO BUTTOCKS ? SCIATICAPREV SIMILAR SYMPTOMS - ADV REGULAR ANALGESIA AS PER PACKET + MIU 4 FLOW HUB + WORSENING..
Outcome: Patient suitable for MIU 4Hr - Flow Hub to arrange

NHS24 Disposition

Accident & Emergency / MIU within 4 Hours

NHS24 NUrse Comments

Reported Condition **Received By** **Received**

TAS Assessment **Assessed By** **TAS Assess Start**
TAS Assess End

Consultation **Consult By** **Consult Start**
Consult End

Examination Details **Clinical Codes**

Diagnosis

Treatment

Prescriptions

Follow-up(s)

TextBox7

Detailed Print

Case Details:

Case No.	User Description
6267290	Dawn Knight (Clinical Nurse) ()

Patient's Name: Tracy Roberts
Address: 263 Curtis Avenue Glasgow

G44 4NW
Tel: 07933 542665
Call Origin
Caller Name: Tracy

Date of Birth:27/04/1971
Ethnicity:

Own Doctor:
Surgery: Practice B
Confidential: False

Tel:

Dawn Knight (Clinical
NHS 24 Assessment

Start Time:06:17 14/02/2021
End Time: 06:33 14/02/2021

HEADACHE 4 WEEKS

Clinical summary created by: Dawn Knight (Clinical Nurse) () [14/02/2021 06:35:11]
Reason for call: HEADACHE 4 WEEKS
LEGS AND ARMS FEEL SHAKY LIKE THEY ARE IN SPASM- FEELS LIKE SHE IS OUTSIDE HER BODY -NO COVID SYMPTOMS
14:02:2021 06:34:34 KNIGHTD.. SUDDEN WORSENING HEADACHE IN LAST 1 HOUR, BACK OF HEAD TO EYES, COLD, SWEATY, LIPS PALE, UNCONTROLLABLE LEGS AND ARM SHAKING, STUTTERING / STAMMERING SPEECH, CONFUSED, FEELS BALANCE IS OFF. 999 EMERGENCY RESPONSE..
Outcome: 999 contacted - For information only

Case type set to Ambulance

Start Time:06:37 14/02/2021
End Time: 06:37 14/02/2021

Detailed Print

Case Details:

Case No. **User Description**
6267290

Patient's Name: Tracy Roberts
Address: 263 Curtis Avenue Glasgow

G44 4NW
Tel: 07933 542665
Call Origin
Caller Name: Tracy

Date of Birth: 27/04/1971
Ethnicity:

Own Doctor:
Surgery: Practice B
Confidential: False

Tel:

Start Time: 06:37 14/02/2021
End Time: 06:37 14/02/2021

Priority On reception set to 999/Emergency

Special Patient Notes

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Cardiology GGC General Referral	—	**Consultant / receiving practitioner** and/or **specialty clinic**
New Victoria Hospital 55 Grange Road Glasgow G42 9LF	—	**Hospital** and **hospital address** Hospital location code. G306H Email address

Urgency of referral Routine
Date of referral 19-Jan-2024 **Date sent** 19-Jan-2024

PATIENT DETAILS

Surname	Roberts
Forename(s)	Tracy
Title	Miss
Sex	Female
Date of birth	27-Apr-1971
CHI no.	2704716161
Area of Residence	-

Patient's address

263 Curtis Avenue
Glasgow
Glasgow
G44 4NW

Contact number(s)

Voice: 571 8540
Voice: 07933 542 665

101031915559G Unique Care Pathway Number: 101031915559G

REGISTERED GP DETAILS

Name	Dr John Saldanha		
GMC code	6157070	GP code	04316
Practice name	Govanhill Health Centre (20033)		
Practice code	49041		

Practice address

233 Calder Street
Glasgow
G42 7DR

Contact number(s)

Voice: 0141 531 8365
E-mail: ggc.gp49041clinical@nhs.scot

REFERRING GP DETAILS

Name	Dr John Saldanha		
GMC code	6157070	GP code	04316
Practice name	Govanhill Health Centre (20033)		
Practice code	49041		

Practice address

233 Calder Street
Glasgow
G42 7DR

Contact number(s)

Voice: 0141 531 8365

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Syncope with two recent episodes of collapse

Comment: Dear Doctor,

This 52 year old lady suffers from anxiety. She has been experiencing episodes of light-headedness for several months. She did not really bother with it up until recently but she has now had two recent episodes of collapse with very brief loss of consciousness for no more than a few seconds. She gets light-headed four to five times per days. There are no specific triggers and episodes can occur both at rest and when she is up and about. The dizziness lasts for around five minutes and she either has to stop and hold onto something or sit down until the sensation passes.

There are no abnormal findings on cardiovascular or neurological examination. She had a CT brain scan last year which did not reveal any problems. Recent blood tests were normal. Her blood pressure was mildly elevated today but she gets white coat hypertension.

I have requested an outpatient ECG but I would be very grateful for any further help that you can offer in investigating these attacks further please.

Many thanks,

Dr John Saldanha

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Incruse Ellipta Dry Powder Inhaler 55 micrograms/dose	30	30 dose	1 Puff Daily	-	16-Nov-2021	18-Jan-2024

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Mirtazapine Tablets 15 mg	28	28 tablet	ONE TO BE TAKEN AT NIGHT	-	19-Jan-2024	19-Jan-2024
Easyhaler Salbutamol Dry Powder Inhaler 100 micrograms/actuation	200	200 dose	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	18-Jan-2024	18-Jan-2024
Nacsys Effervescent tablets 600 mg	28	28 tablet	1 DAILY	-	18-Jan-2024	18-Jan-2024
Peak Flow Meter (Standard Range) Meter	1	1 device	AS DIRECTED	-	18-Jan-2024	18-Jan-2024
Citalopram Hydrobromide Tablets 20 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	08-Jan-2024	08-Nov-2023
Amitriptyline Hydrochloride Tablets 10 mg	28	28 TABLET	ONE TO BE TAKEN IN THE EVENING	-	08-Jan-2024	19-Jan-2024
Citalopram Hydrobromide Tablets 20 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	08-Nov-2023	08-Nov-2023
Citalopram Hydrobromide Tablets 10 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	23-Oct-2023	23-Oct-2023
Citalopram Hydrobromide Tablets 10 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	17-Aug-2023	

						17-Aug-2023
Citalopram Hydrobromide Tablets 20 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	17-Aug-2023	17-Aug-2023
Salbutamol Cfc-free inhaler 100 micrograms/puff	1	1 INHALER	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	17-Aug-2023	17-Aug-2023
Amitriptyline Hydrochloride Tablets 10 mg	28	28 TABLET	ONE TO BE TAKEN IN THE EVENING	-	16-Mar-2023	23-Oct-2023

Blood Pressure

Date Recorded	Systolic	Diastolic
16-Mar-2023	142	90
10-Sep-2021	140	80
30-Aug-2019	130	80
12-Jul-2019	136	87
31-Jul-2018	135	90

Body Measurements

Date Recorded	Height	Weight	BMI
13-Jan-2016	157.48	79.35	32

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Cigarette smoker, 10 cigarettes/day:		18-Jan-2024
Current smoker:		18-Jan-2024
Current smoker:		05-Oct-2018
Current smoker:		13-Jan-2016
Teetotaller:		13-Jan-2016

Clinical warnings

Allergies

Description	Date recorded
Adverse reaction to Codeine	12-Oct-2020

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) Scottish

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

ECG
GGC Direct Access ECG

Consultant / receiving practitioner and/or **specialty clinic**

New Victoria Hospital
55 Grange Road
Glasgow
G42 9LF

Hospital and **hospital address**
Hospital location code.
G306H
Email address

Urgency of referral Routine
Date of referral 19-Jan-2024 **Date sent** 19-Jan-2024

PATIENT DETAILS

Surname	Roberts
Forename(s)	Tracy
Title	Miss
Sex	Female
Date of birth	27-Apr-1971
CHI no.	2704716161
Area of Residence	-

Patient's address

263 Curtis Avenue
Glasgow
Glasgow
G44 4NW

Contact number(s)

Voice: 571 8540
Voice: 07933 542 665

101031915527N | Unique Care Pathway Number: 101031915527N

REGISTERED GP DETAILS

Name	Dr John Saldanha		
GMC code	6157070	GP code	04316
Practice name	Govanhill Health Centre (20033)		
Practice code	49041		

Practice address

233 Calder Street
Glasgow
G42 7DR

Contact number(s)

Voice: 0141 531 8365
E-mail: ggc.gp49041clinical@nhs.scot

REFERRING GP DETAILS

Name	Dr. John Saldanha		
GMC code	6157070	GP code	04316
Practice name	Practice B (49041)		
Practice code	49041		

Practice address

Govanhill Health Centre
233 Calder Street
Glasgow
G42 7DR

Contact number(s)

Voice: 0141 531 8365

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: As per Indication for Referral

Reason for referral

Care type requested: Out Patient
Expected outcome: Not Specified

Past medical history

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Incruse Ellipta Dry Powder Inhaler 55 micrograms/dose	30	30 dose	1 Puff Daily	-	16-Nov-2021	18-Jan-2024

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Mirtazapine Tablets 15 mg	28	28 tablet	ONE TO BE TAKEN AT NIGHT	-	19-Jan-2024	19-Jan-2024
Easyhaler Salbutamol Dry Powder Inhaler 100 micrograms/actuation	200	200 dose	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	18-Jan-2024	18-Jan-2024
Nacsys Effervescent tablets 600 mg	28	28 tablet	1 DAILY	-	18-Jan-2024	18-Jan-2024
Peak Flow Meter (Standard Range) Meter	1	1 device	AS DIRECTED	-	18-Jan-2024	18-Jan-2024
Citalopram Hydrobromide Tablets 20 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	08-Jan-2024	08-Nov-2023
Amitriptyline Hydrochloride Tablets 10 mg	28	28 TABLET	ONE TO BE TAKEN IN THE EVENING	-	08-Jan-2024	19-Jan-2024
Citalopram Hydrobromide Tablets 20 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	08-Nov-2023	08-Nov-2023
Citalopram Hydrobromide Tablets 10 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	23-Oct-2023	23-Oct-2023
Citalopram Hydrobromide Tablets 10 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	17-Aug-2023	17-Aug-2023
Citalopram Hydrobromide Tablets 20 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	17-Aug-2023	17-Aug-2023
Salbutamol Cfc-free inhaler 100 micrograms/puff	1	1 INHALER	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	17-Aug-2023	17-Aug-2023
Amitriptyline Hydrochloride Tablets 10 mg	28	28 TABLET	ONE TO BE TAKEN IN THE EVENING	-	16-Mar-2023	23-Oct-2023

Blood Pressure

Date Recorded	Systolic	Diastolic
16-Mar-2023	142	90
10-Sep-2021	140	80

30-Aug-2019	130	80
12-Jul-2019	136	87
31-Jul-2018	135	90

Body Measurements

Date Recorded	Height	Weight	BMI
13-Jan-2016	157.48	79.35	32

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Cigarette smoker, 10 cigarettes/day:		18-Jan-2024
Current smoker:		18-Jan-2024
Current smoker:		05-Oct-2018
Current smoker:		13-Jan-2016
Teetotaller:		13-Jan-2016

Clinical warnings

Allergies

Description	Date recorded
Adverse reaction to Codeine	12-Oct-2020

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

Primary Reason for ECG::Syncope

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) Scottish

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments
Gynaecology - 30082019_Referral_995020

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Gynaecology - Post Menopausal Bleeding
GGC Post-Menopausal Bleeding

Consultant / receiving practitioner and/or **specialty clinic**

New Victoria Hospital
55 Grange Road
Glasgow
G42 9LF

Hospital and **hospital address**
Hospital location code.
G306H
Email address
-

Urgency of referral Urgent
Date of referral 26-Nov-2019 **Date sent** 28-Nov-2019

PATIENT DETAILS

Surname	Roberts
Forename(s)	Tracy
Title	Miss
Sex	Female
Date of birth	27-Apr-1971
CHI no.	2704716161
Area of Residence	-

Patient's address

263 Curtis Avenue
Glasgow
Glasgow
G44 4NW

Contact number(s)

Voice: 571 8540
Voice: 07933 542665

101020124666T Unique Care Pathway Number: 101020124666T

REGISTERED GP DETAILS

Name	Dr John Saldanha		
GMC code	6157070	GP code	04316
Practice name	Govanhill Health Centre (20033)		
Practice code	49041		

Practice address

233 Calder Street
Glasgow
G42 7DR

Contact number(s)

Voice: 0141 531 8365
Facsimile: 0141 531 4431

REFERRING GP DETAILS

Name	Dr. Anne McNally		
GMC code	2330370	GP code	07331
Practice name	Practice B (49041)		
Practice code	49041		

Practice address

Govanhill Health Centre
233 Calder Street
Glasgow
G42 7DR

Contact number(s)

Voice: 0141 531 8365

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: .

Comment: This lady was referred with a history of irregular bleeding on HRT.

She apparently has been having repeated episodes of prolonged PV bleeding while on Elleste Duet.

Her history is somewhat confusing and she tells me she read the information with her appointment and decided not to bother. Her last cervical smear was 2009!

She continues to have irregular bleeding and I would be grateful if she could be given a further opportunity to attend.

Yours sincerely

AMN/VA

Reason for referral

Care type requested: Out Patient
Expected outcome: Not Specified

Past medical history

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Elleste Duet 2 Mg Tablets	84	84 TABLET	ONE TO BE TAKEN EACH DAY	-	25-Nov-2019	25-Nov-2019
Elleste Duet 2 Mg Tablets	84	84 TABLET	ONE TO BE TAKEN EACH DAY	-	30-Aug-2019	30-Aug-2019

Blood Pressure

Date Recorded	Systolic	Diastolic
30-Aug-2019	130	80
12-Jul-2019	136	87
31-Jul-2018	135	90
24-May-2017	119	78

Body Measurements

Date Recorded	Height	Weight	BMI
13-Jan-2016	157.48	79.35	32

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		05-Oct-2018
Current smoker:		13-Jan-2016
Teetotaller:		13-Jan-2016

Investigations

Description/Question	Result/Comment	Date
Last smear result:	result not available	-
Last smear date:	2009-11-02	-

Clinical warnings

Additional Support Needs
No known ASN requirements

Additional relevant information
Administrative information
OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Referred By:Referring GP
Electronic Attachment Present:Yes

Social circumstances
Ethnic Origin: (White) Scottish

Gynaecology - 30082019 Referral 995020

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Gynaecology - Post Menopausal Bleeding
GGC Post-Menopausal Bleeding

Consultant / receiving practitioner and/or **specialty clinic**

New Victoria Hospital
55 Grange Road
Glasgow
G42 9LF

Hospital and **hospital address**
Hospital location code.
G306H
Email address
-

Urgency of referral Urgent
Date of referral 30-Aug-2019 **Date sent** 30-Aug-2019

PATIENT DETAILS

Surname	Roberts
Forename(s)	Tracy
Title	Miss
Sex	Female
Date of birth	27-Apr-1971
CHI no.	2704716161
Area of Residence	-

Patient's address

263 Curtis Avenue
Glasgow
Glasgow
G44 4NW

Contact number(s)

Voice: 571 8540
Voice: 0

101019486203F | Unique Care Pathway Number: 101019486203F

REGISTERED GP DETAILS

Name	Dr John Saldanha		
GMC code	6157070	GP code	04316
Practice name	Govanhill Health Centre (20033)		
Practice code	49041		

Practice address

233 Calder Street
Glasgow
G42 7DR

Contact number(s)

Voice: 0141 531 8365
Facsimile: 0141 531 4431

REFERRING GP DETAILS

Name	Amy Proctor		
GMC code	7134281	GP code	-
Practice name	Practice B (49041)		
Practice code	49041		

Practice address

Govanhill Health Centre
233 Calder Street
Glasgow
G42 7DR

Contact number(s)

Voice: 0141 531 8365

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: PV bleeding and drenching sweats

Comment: History of repeated episodes of prolonged pv bleeding lasting 10 days after being late or missing elleste duet tablet, also having drenching sweats on elleste duet - worsened when switched to taking friends tibolone. Given multiple episodes of prolonged pv bleeding with hrt - had been on for over 6 months I wonder if she needs any further investigation into post menopausal bleeding. I have arranged for her bloods to get checked due to sweats but was wondering if you had any suggestions with regards to hrt if continues to have drenching sweats on 2mg of elleste duet.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Elleste Duet 2 Mg Tablets	84	84 TABLET	ONE TO BE TAKEN EACH DAY	-	30-Aug-2019	30-Aug-2019

Blood Pressure

Date Recorded	Systolic	Diastolic
30-Aug-2019	130	80
12-Jul-2019	136	87
31-Jul-2018	135	90
24-May-2017	119	78

Body Measurements

Date Recorded	Height	Weight	BMI
13-Jan-2016	157.48	79.35	32

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		05-Oct-2018
Current smoker:		13-Jan-2016
Teetotaller:		13-Jan-2016

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) Scottish

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Gynaecology - Menstrual Disorders GGC Gynae Gen Ref	——	**Consultant / receiving practitioner** and/or **specialty clinic**
New Victoria Hospital 55 Grange Road Glasgow G42 9LF	——	**Hospital** and **hospital address** Hospital location code. G306H Email address -

Urgency of referral Routine
Date of referral 27-Mar-2017 **Date sent** 28-Mar-2017

PATIENT DETAILS

Surname	Roberts
Forename(s)	Tracy
Title	Miss
Sex	Female
Date of birth	27-Apr-1971
CHI no.	2704716161
Area of Residence	-

Patient's address

263 Curtis Avenue
Glasgow
Glasgow
G44 4NW

Contact number(s)

Voice: 571 8540
Voice: 0

101013316868E Unique Care Pathway Number: 101013316868E

REGISTERED GP DETAILS

Name	Dr John Saldanha		
GMC code	6157070	GP code	04316
Practice name	Govanhill Health Centre (20033)		
Practice code	49041		

Practice address

233 Calder Street
Glasgow
G42 7DR

Contact number(s)

Voice: 0141 531 8365
Facsimile: 0141 531 4431

REFERRING GP DETAILS

Name	Dr. John Sharp		
GMC code	2555193	GP code	03964
Practice name	Practice B (49041)		
Practice code	49041		

Practice address

Govanhill Health Centre
233 Calder Street
Glasgow
G42 7DR

Contact number(s)

Voice: 0141 531 8370

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Frequent heavy vaginal bleeding

Comment: I am grateful for any help you can offer with this 45 year old woman in our practice.

She recently joined our practice and tells me that she has been suffering over the past 4 to 5 months with very frequent vaginal bleeding, heavy and persistent.

She is para 4 + 1 which included a twin pregnancy and also suffers from what sounds like stress incontinence. I am very grateful for any help you can offer.

Many thanks.

Yours sincerely

IS/LR

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Zopiclone Tablets 3.75 mg	7	7 TABLET	ONE TO BE TAKEN AT NIGHT	-	20-Mar-2017	20-Mar-2017

Blood Pressure

No Blood Pressures Recorded

Body Measurements

Date Recorded	Height	Weight	BMI
13-Jan-2016	157.48	79.35	32

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		13-Jan-2016
Teetotaller:		13-Jan-2016

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information
Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances
Ethnic Origin: (White) Scottish

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

NHS Greater Glasgow and Clyde — Intraoperative Accountable Items Count Record

Date 12/11/15

ADDRESSOGRAPH

2704716161
ROBERTS, Tracy F
263 Curtis Ave 27/04/1971
Glasgow, Lanarkshire
G44 4NW

WARD

HOSP - QEUH

THEATRE - 13

COUNTS	Scrub Nurse(s) Print Name	Circulating Nurse(s) - Signature & Print name
PRE - OP SWAB COUNT CORRECT	SSN CARTHY	
PRE - OP INSTRUMENT COUNT CORRECT	SSN MARTHY	
FINAL SWAB COUNT CORRECT	SSN CARTHY	L. REHMAN
FINAL INSTRUMENT COUNT CORRECT	SSN CARTHY	A. REHMAN
FINAL SWAB DISPATCH COUNT CORRECT	SSN CARTHY	A. REHMAN

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 - F. Carthy

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: Debridement & washout of Rt hand laceration + TENDON REPAIR

TALLY OF EACH ITEM USED - ADD ANY ITEMS SPECIFIC TO YOUR SPECIALITY

Swabs (2x2)		Tapes					ITEMS REMAINING IN SITU (Type & Number)
Swabs (10x10)	15	Sloops/Slings					
Abdominal packs	✓	Bulldogs					
Sutures	5	Shods					
Bl[redacted]	2	Tibbs Cannula					
IV needles	4	Ports					
Syringes	2	Staple Gun Inserts					
Discard-a-pad		Spears					
Diathermy pencil		Throat packs - Anae					
Diathermy tips		Throat packs - Scrub					
Scratch pad		Retrieval Bag (Bert)					
Reels		Digital Tourniquets					
Pattles							
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

PLEASE INSERT TRACEABILITY STICKERS ON BACK OF COPY- TO STAY IN THEATRE.

Acute Services Division
Surgery and Anaesthetics

NHS
Greater Glasgow and Clyde

Na	.....
Ad 2704716161	.....
ROBERTS	F .....
.... Tracy	27/04/1971 .....
263 Curtis Ave	
Do Glasgow, Lanarkshire	.....
G44 4NW	
CH	.....

Perioperative Care Plan

Hospital: GGUH	Consultant: Beamson
Ward: 10D	Date: 19/11/15

Nursing Admission Document (NAD)

WARD STAFF – Nursing Admission Document (NAD) must accompany patient to Theatre.

THEATRE STAFF – The following information can be found in the Nursing Admission Document (NAD):

Checked by:	Reception Practitioner	Anaesthetic Practitioner
• Relevant Medical History	Yes ☐ No ☐	Yes ☐ No ☐
• Waterlow Score	Yes ☐ No ☐	Yes ☐ No ☐

THEATRE STAFF – For Baseline Observations refer to NEWS chart.

Waterlow Score – Key: 10+ = At Risk 15+ = High Risk 20+ = Very High Risk

Other information

Document any other relevant information e.g. needle phobia, request for female practitioner, interpreter arranged. Please provide 'Getting to know me' document if available.

* Codine Allergy *

Topical Local Anaesthetic applied Specify site and time applied	Yes ☐ No ☐ N/A ☐ Site 1: Time: Site 2: Time:

Patient Transport

Patient mode of transport to Theatre: Trolley ☐ Walking ☐ Chair ☐ Bed ☐

Patient assigned level of escort for transfer to Theatre (Please tick all that apply - must be a minimum of 2)

Porter ☐ Nursing Auxiliary ☐ Registered Nurse / ODP ☐ Other ☐ Please state:

Nam [redacted]
Add 2704716161
ROBERTS F
..... Tracy 27/04/1971.
DoB: 263 Curtis Ave
Glasgow, Lanarkshire
CHI G44 4NW

Ward Checklist – To be completed immediately prior to the patient being given a Pre-Med

Preoperative checks	Ward Check	Reception Check	Anaesthetic Assistant
Identity band correct (Name, DoB, CHI number, Ward)	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Case Notes / Scanner Folder (circle)	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
ECG	Yes ☑ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐
NAD document	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
NEWS chart	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Cannard pack	Yes ☑ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐
MUST Tool	Yes ☑ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐
X-Ray and Scans – Hardcopy	Yes ☐ No ☑ N/A ☐	Yes ☐ No ☑ N/A ☐	Yes ☐ No ☑ N/A ☐
Prescription Chart	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Waterlow chart	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Pressure Ulcer chart	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑
Wound Assessment chart	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑
Active Care Checklist	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Alert Sticker – specify:	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☑
PVC Care Plan in place	Yes ☑ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐
Consent / Incapacity (circle) Signed and dated	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Checked against Theatre List	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☑ No ☐
Check with Patient / Incapacity / Consent (circle)			
Procedure and site for surgery	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Correct site marked	Yes ☐ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐
Allergies/ Sensitivities and Reactions	Yes ☒ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
If 'Yes' specify:	Codine		Codeine
Fasted from – specify time (24 hr clock) N/A ☐	Food: N/N	Food: 12mn.	Food: 12mn
	Fluid: 6am	Fluid: 6am-water.	Fluid: 6a
Blood Glucose Score – if relevant	Time: Score: N/A ☑	Time: Score: N/A ☑	Time: Score: N/A ☑
Internal prosthesis in situ e.g. metalwork, pacemaker, implant etc If 'Yes' state location and type	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☑
External prosthesis removed e.g. hairpiece, false eye etc. If 'Yes' state type where stored	Yes ☐ No ☑ N/A ☐ Top + Bottom	Yes ☐ No ☑ N/A ☐	Yes ☐ No ☑ N/A ☐
Loose teeth, caps and crowns State site and type	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☑
Dentures removed If 'Yes' state where stored	Yes ☐ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☑ 2 plates	Yes ☐ No ☐ N/A ☐ Top + bottom - removed
Hearing aid(s)	R ☐ L ☐ N/A ☑	R ☐ L ☐ N/A ☑	R ☐ L ☐ N/A ☑
Hearing aid(s) removed If removed state where stored	Insitu ☐ Removed ☐	Insitu ☐ Removed ☐	Insitu ☐ Removed ☐

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Ward Checklist continued

Pre-operative checks	Ward Check	Reception Check	Anaesthetic Assistant
Spectacles/Contact lenses removed (circle) If 'Yes' state where stored	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑
Trolley/ Bed checked for head down tilt and O_2/ Accessories	Bed ☐ Trolley ☐ Operating chair ☐ Yes ☐ No ☐	Bed ☐ Trolley ☑ Operating chair ☐ Yes ☑ No ☐	Bed ☐ Trolley ☑ Operating chair ☐ Yes ☐ No ☐
Make-up/ Nail polish removed (circle)	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑
False nails in situ – Anaesthetist informed	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☑
Jewellery/Body piercing removed (circle) If 'Yes' state where stored	Yes ☑ No ☐ N/A ☐ DRAWER	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☐
Jewellery/Body piercing taped (circle) If 'Yes' state location of items on body	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑
Up-to-date Blood Results available on Clinical Portal Blood Cross Matched confirmed by labs Blood Grouped and Saved confirmed by labs	Yes ☑ No ☐ Yes ☐ No ☑ N/A ☐ Yes ☐ No ☑ N/A ☐	Comments if required:	
CJD single question asked Answer to CJD single question If answered 'Yes' or if any other questions please contact your Infection Control Team	Yes ☑ No ☐ At increased risk ☐ Not at increased risk ☑		
If CJD question has not been asked, then ask the question "Have you ever been notified that you are at an increased risk of CJD or vCJD for public health purposes?"	Yes, I have been notified ☐ No, I have not been notified ☐	Comments if required:	
Inhalers/ sprays with patient State type	Yes ☐ No ☐ N/A ☑	Type:	
Anti-embolic Prophylaxis – state type	Yes ☐ No ☐ N/A ☑	Type:	
Paper pants in situ – If 'No' specify reason:	Yes ☐ No ☐	State reason:	
Voided urine/ Catheter in situ/ Urostomy (circle)	Yes ☑ No ☐	Comment if required:	
Date of Last Menstrual Period (LMP)	Current	N/A ☐	
Is there any chance you are pregnant?	Yes ☐ No ☑ N/A ☐		
Pregnancy test carried out Pregnancy test result	Yes ☐ No ☐ N/A ☑ Postive ☐ Negative ☐		
Tampon removed	Yes ☐ N/A ☐		
MRSA swab test results	Postive ☐ Negative ☐ Results pending ☑ N/A ☐	Comments if required	
Pre-Medication given	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☑ N/A ☐
PLEASE PRINT NAME AND SIGN ONCE CHECKLIST IS COMPLETE	Ward: Time:	Reception: [signature] Time: 1115	Anaesthetic Assistant: [signature] Time: 1220

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Surgical Brief

Surgical Brief carried out:	Yes ☑ No ☐	If 'No' please specify reason:

Anaesthetics

Baseline Observations	Pulse: 63 bpm	BP: 114/78	Temp:	SpO_2: 99%	Resps:
Anaesthetic Assistant has confirmed with Anaesthetist that cross matched blood is:	Required: Yes ☐ N/A ☑	Available: Yes ☐ No ☑	Or patient has been Grouped and Saved: Yes ☐ No ☑		

Stop Before You Block — This section NOT applicable ☑

Stop Before You Block carried out:	Yes ☐ No ☐	

Anaesthetic Type – Please tick all that apply

General Anaesthetic ☑	Epidural ☐	Spinal ☐	Regional Blocks ☐	Throat spray ☐
Local Anaesthetic ☐	Site:	Drug:		mls
Sedation ☐	Drug:			mls

PVC Care Plan in place Yes ☐ No ☐ Skin Prep specify: already in situ

Skin Prepping used for Patient Monitoring / Blocks — This section NOT applicable ☐

ARTERIAL CATHETER	Yes ☐ N/A ☐	Chlorhexidine 2%/70% alcohol ☐ Chlor-a-prep solution ☐	Yes ☐ Yes ☐	Other ☐ Specify prep:
CVP CATHETER	Yes ☐ N/A ☐	Chlorhexidine 2%/70% alcohol ☐ Chlor-a-prep solution ☐	Yes ☐ Yes ☐	Other ☐ Specify prep:
SPINAL / EPIDURAL	Yes ☐ N/A ☐	Specify prep:		
REGIONAL BLOCK	Yes ☐ N/A ☐	Specify prep:		
OTHER	Yes ☐ N/A ☐	Specify prep:		

Blood Glucose Monitoring — This section NOT applicable ☑

Time								
BM Score								

Safe use of SpO_2 probe to prevent injury — This section NOT applicable ☐

SpO_2 Probe rotated hourly	Yes ☐ No ☐ N/A ☐	Initial position: left inner finger					
Time rotated							
Probe position							
Time rotated							
Probe position							

Prevention of Eye Injury — This section NOT applicable ☐

Eyes protected from injury during procedure	Yes ☑	Specify: Closed by c. micropore

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Anaesthetics continued

Maintenance of Normothermia

This section NOT applicable ☐

Actions taken to maintain the patient's temperature	Yes ☑ No ☐	Warm air blanket device – specify:	Yes ☐ No ☐ N/A ☐
		Warm Fluids	Yes ☑ No ☐ N/A ☐
		Warming Mat	Yes ☐ No ☐ N/A ☐
		Thermal Hat	Yes ☐ No ☐ N/A ☐
		IV fluid warmer	Yes ☐ No ☐ N/A ☐
		Other – specify:	Yes ☐ No ☐ N/A ☐
Temperature documented by Anaesthetist	Yes ☑	No ☐	

Record of Anaesthetic Pump Infusion Device Numbers

This section NOT applicable ☐

Comments

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Theatre

Safe Positioning

This section NOT applicable ☐

Moving aids used to move patient	Yes ☑ No ☐	Pat Slide ☑	Sliding sheet ☐	Roll board ☐
		Hover Mattress ☐	Other:	

Pressure Area Care

Pre-operative skin inspection scores (please circle)	Excoriation Level: (0) 1 2 3	Pressure Ulcer Grade: (N/A) 1 2 3 4

Area of concern identified (include area of body)	Actions taken

Position	Positioning Devices		Pressure Relieving	Arm Position	
Position 1	Head ring ☐	Lateral supports ☐	Gel pads ☐	**R Arm Position**	**L Arm Position**
Time:	Pillows ☑	Hydraulic leg supports ☐	Heel gel pads ☑	At side ☐	At side ☑
Supine ☑ Prone ☐	Straps ☐	Limb traction ☐	Full gel mattress ☐	On boards ☐	On boards ☐
Left Lateral ☐ Right lateral ☐	Wedge ☐	Side supports ☐	Gel wedge ☐	Across chest ☐	Across chest ☐
Lloyd Davis ☐ Jack-knife ☐	Sandbag ☐	Bolster ☐	Pillows ☐	Hand table ☑	Hand table ☐
Tren-delenburg ☐ Reverse Tren-delenburg ☐				Hand traction ☐	Hand traction ☐
Lower limb traction ☐ Deckchair ☐				**Secured with:**	**Secured with:**
Other ☐ Lithotomy ☐				J-board ☐	J-board ☑
				Straps ☐	Straps ☐
				Pressure care:	**Pressure care:**
				Gel/ Foam pads ☐	Gel/ Foam pads ☑
Position 2	Head ring ☐	Lateral supports ☐	Gel pads ☐	**R Arm Position**	**L Arm Position**
Time:	Pillows ☐	Hydraulic leg supports ☐	Heel gel pads ☐	At side ☐	At side ☐
Supine ☐ Prone ☐	Straps ☐	Limb traction ☐	Full gel mattress ☐	On boards ☐	On boards ☐
Left Lateral ☐ Right lateral ☐	Wedge ☐	Side supports ☐	Gel wedge ☐	Across chest ☐	Across chest ☐
Lloyd Davis ☐ Jack-knife ☐	Sandbag ☐	Bolster ☐	Pillows ☐	Hand table ☐	Hand table ☐
Tren-delenburg ☐ Reverse Tren-delenburg ☐				Hand traction ☐	Hand traction ☐
Lower limb traction ☐ Deckchair ☐				**Secured with:**	**Secured with:**
Other ☐ Lithotomy ☐				J-board ☐	J-board ☐
				Straps ☐	Straps ☐
				Pressure care:	**Pressure care:**
				Gel/ Foam pads ☐	Gel/ Foam pads ☐
Position 3	Head ring ☐	Lateral supports ☐	Gel pads ☐	**R Arm Position**	**L Arm Position**
Time:	Pillows ☐	Hydraulic leg supports ☐	Heel gel pads ☐	At side ☐	At side ☐
Supine ☐ Prone ☐	Straps ☐	Limb traction ☐	Full gel mattress ☐	On boards ☐	On boards ☐
Left Lateral ☐ Right lateral ☐	Wedge ☐	Side supports ☐	Gel wedge ☐	Across chest ☐	Across chest ☐
Lloyd Davis ☐ Jack-knife ☐	Sandbag ☐	Bolster ☐	Pillows ☐	Hand table ☐	Hand table ☐
Tren-delenburg ☐ Reverse Tren-delenburg ☐				Hand traction ☐	Hand traction ☐
Lower limb traction ☐ Deckchair ☐				**Secured with:**	**Secured with:**
Other ☐ Lithotomy ☐				J-board ☐	J-board ☐
				Straps ☐	Straps ☐
				Pressure care:	**Pressure care:**
				Gel/ Foam pads ☐	Gel/ Foam pads ☐

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Theatre continued

Electrosurgery

This section NOT applicable ☐

Monopolar: Yes ☐ N/A ☐		Bipolar: Yes ☑ N/A ☐
Site(s) of Monopolar Electrode:		
Skin site(s) assessed and meets safety criteria as per policy	Yes ☑ No ☐	If 'No' state reason:
Skin site(s) clipped	Yes ☐ N/A ☑	State site:
Electrode site(s) checked after patient repositioned and is satisfactory	Yes ☐ No ☐ N/A ☑	If 'No' state reason and action:
Post-op skin check(s) is satisfactory	Yes ☑ No ☐	If 'No' state reason and action:

Tourniquets

This section NOT applicable ☐

Tourniquet equipment applied	Yes ☑ No ☐ N/A ☐	
Padding under tourniquet	Yes ☑ No ☐ N/A ☐	
Cover over tourniquet	Yes ☑ No ☐ N/A ☐	
Post op skin check(s) is satisfactory	Yes ☑ No ☐	If 'No' state reason and action:

Site and side	Time inflated	Pressure	Time deflated	Time re-inflated	Pressure	Time deflated
(Rt) Arm	1300 hrs	250mmHg	1341			

Digit Tourniquet

This section NOT applicable ☑

Site and side applied	Time applied	Time removed

DVT Prophylaxis

This section NOT applicable ☐

Intermittent Pneumatic Compression Devices: _____ mmHg	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐
Foot Pump Devices: _____ mmHg	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐
TED Stockings	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐
Other – Specify:	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐

Theatre continues on next page

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Theatre continued

Skin Preparation

This section NOT applicable ☐

Site – specify:	Clipped	Preparation solution used	
(RT) hand & forearm	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☑	Chlorhexidine gluconate solution: ___ % ☐
		Alcohol iodine based solution ☐	Chlorhexidine acetate solution: ___ % ☐
		Aqueous iodine and sodium chloride 50/50 ☐	Other – Specify: ___ % ☐
Site – specify:	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☐	Chlorhexidine gluconate solution: ___ % ☐
		Alcohol iodine based solution ☐	Chlorhexidine acetate solution: ___ % ☐
		Aqueous iodine and sodium chloride 50/50 ☐	Other – Specify: ___ % ☐
Site – specify:	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☐	Chlorhexidine gluconate solution: ___ % ☐
		Alcohol iodine based solution ☐	Chlorhexidine acetate solution: ___ % ☐
		Aqueous iodine and sodium chloride 50/50 ☐	Other – Specify: ___ % ☐

Prevention of Compartment Syndrome

This section NOT applicable ☑

Legs in Lloyd Davis or Lithotomy position: Yes ☐ No ☐

Patient must be rested for 5 minutes every 3 hours. If this does not happen, the reason must be documented in the comments / notes section.

Time legs positioned	Position	Time legs lowered and duration	Time legs lowered and duration	Time legs lowered and duration	Time legs lowered and duration

Local Anaesthetic Infiltration to Wound

This section NOT applicable ☐

Site	Drug	Quantity
AGAINST MAXO	LEVOBUPIVACAINE	9mls

Drains

This section NOT applicable ☑

Drain	Site	Type	Size	Secured with	Dressing
1					
2					
3					
4					
5					

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Theatre continued

Wound Closure and Dressings (including Packing) This section NOT applicable ☐

Wound Closure used: Yes ☐ No ☐ N/A ☐ Wound Dressings: Yes ☑ No ☐ N/A ☐

	Site	Wound Closure	Dressings	Packing
1	RT HAND	NCW-PRIMARY	Inclive Dyne swab, WOO/E Crep	
2			BACK SLAB	
3				
4				
5				
6				
7				
8				

Urinary Catheter Inserted Pre-op ☐ This section NOT applicable ☐

	Type	Size	Anaesthetic lubricant applied / inserted	Balloon inflated with sterile water	Prepping Solution
1			mls	mls	
2			mls	mls	
3			mls	mls	

Blood Tags This section NOT applicable ☐

Blood Tags checked and dispatched appropriately: Yes ☐ No ☐ N/A ☐

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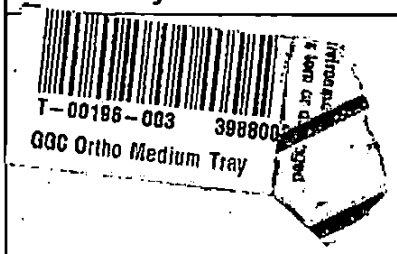
Traceability Stickers



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Operation / Procedure Performed

WASHOUT & TENDON REPAIR RIGHT HAND LACERATION

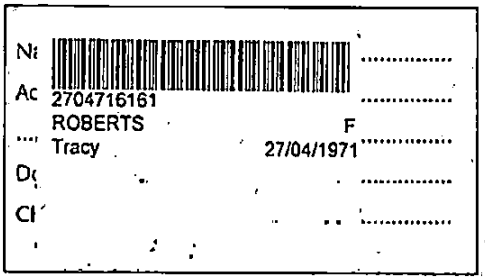
Pressure Area Care

Post-operative skin inspection scores (please circle)	Excoriation Level: 0 1 2 3	Pressure Ulcer Grade: N/A 1 2 3 4

Actions taken if required:

Notes / Comments

Note / Comment	Time	PRINT and Sign



Immediate Post-Operative Recovery

Surgical Instructions

Verbal Handover from Theatre to Recovery

Verbal Handover given by: To:

Handover should include the following

Patient	Anaesthetic	Theatre	Other
Patient's name	Anaesthetic type	Drains	
Theatre	CVP/Arterial Line	Wounds/Dressings	
Procedure	Local anaesthetic Infiltration	Urinary catheter	
Allergies	Peripheral IV	Skin inspection results	
	PVC Care Plan in place	Intra-operative events	
	Airway type	Surgical Instructions	

Recovery

This section NOT applicable ■

Safe Positioning

This section NOT applicable ☐

Moving aids used to move patient: Yes ☐ No ☐

If 'Yes' please specify (right)

Pat Slide ☐ Sliding Sheet ☐ Roll Board ☐

Hover Mattress ☐ Other ☐ Specify:

Pressure Area Care

See post operative skin inspection score from theatre on previous page

Skin inspection as required by patient but no longer than 2 hours

Time	Position	Excoriation Level	Pressure Ulcer Grade (if applicable)	Evaluation	Action

Area of concern identified (include area of body)	Actions taken

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Post-operative Observations

12/11/15 Time	1345	1400	1415	1430	1445														
Airway type	5	1	1	1															
O_2 Therapy	10	4	4	4															
SpO_2	99	100	98	98															
Resp. Rate	12	16	16	14															
CVP																			
Temp.	35.8			36.1															
Pain Score	0	0	7/4	3/															
P.O.N.V.	0	0	0																
Sedation Score		0	0																
BM Score																			
HemoCue Score																			
Hourly Urine Vol.																			
Total Urine Vol.																			
Wound Score																			
Wound Score																			
Wound Score																			
PV Staining																			
Circulation +ve/-ve	–	+ve	+ve	+ve															
Sensation +ve/-ve	–	+ve	+ve	+ve															
Movement +ve/-ve	–	+ve	+ve	+ve															
Pedal Pulse – Left																			
Pedal Pulse – Right																			
Drain 1																			
Drain 2																			
Drain 3																			
Drain 4																			
Staff initials	LM	LM	LM	LM															

Fentanyl 50mcg IV
Fentanyl 40 IV 100mg

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Time							
210							
200							
190							
180							
170							
160							
150							
140							
130							
120							
110							
100							
90							
80							
70							
60							
50							
40							
30							
Airway type							
O_2 Therapy							
SpO_2							
Resp. Rate							
CVP							
Temp.							
Pain Score							
P.O.N.V.							
Sedation Score							
BM Score							
HemoCue Score							
Hourly Urine Vol. / Total Urine Vol.	/	/	/	/	/	/	/
Wound Score							
Wound Score							
Wound Score							
PV Staining							
Circulation +ve/-ve							
Sensation +ve/-ve							
Movement +ve/-ve							
Pedal Pulse – Left							
Pedal Pulse – Right							
Drain 1							
Drain 2							
Drain 3							
Drain 4							
Staff initials							

Key to Scoring / Abbreviations

Airway Type

1	Own
2	Guedel
3	Naso-pharyngeal
4	L.M.A.
5	E.T.T.
6	Tracheostomy

Post Operative Nausea and Vomiting Assessment

0	None
1	Mild – *Not distressed; No retching/vomiting*
2	Moderate – *Troublesome; Occasional retching/vomiting*
3	Severe – *Distressing; Frequent retching/vomiting*

Sedation Score

0	Awake
S	Normal Sleep
1	Drowsy, easy to rouse – *Eyes open to speech or light shaking*
2	Sedated, difficult to rouse – *Eyes open only to vigorous shaking*
3	Unconscious, unrousable

Wound Score

0	Dry and Intact
1	Slight Staining
2	Moderate Staining
3	Saturation / Pad required

Pain Score

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

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Events

Event	Action	Outcome
Bradycardic V/C HR↓ 45-49 bpm occassionally. Dr McCluskey reviewed patient is asymptomatic so continue to observe.		

Name: .....

Address: .....

.....

DoB: .....

CHI number: .....

Affix patient data label

Events

Event	Action	Outcome

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Discharge

NEWS Score:	Time:	Local Discharge Criteria met: Yes ☐ No ☐

Verbal Handover from Recovery to Ward

Verbal Handover given by: To:

Handover should include the following

Patient	Anaesthetic	Theatre	Recovery	Other
Patient's name	Anaesthetic type	Drains	Skin Inspection results	
Theatre	CVP/Arterial Line	Wounds/Dressings	Surgical Instructions	
Procedure	Local anaesthetic Infiltration	Urinary catheter	NEWS Score	
Allergies		Intra-operative events		
	Peripheral IV			
	PVC Care Plan in place			

Blood Tags

This section NOT applicable ☐

Blood Tags checked and dispatched appropriately: Yes ☐ No ☐ N/A ☐

Name: .....

Address: .....

.....

DoB: .....

CHI number: .....

Affix patient data label

Use this page to document further patient information if required.

Mr Gray
Consultant Orthopaedic Surgeon

12/11/2015

Right Surgery to the Hand - Soft Tissue Trauma Exploration of wound and EPL tendon repair

Name: Miss Tracy Roberts
263 Curtis Ave
Glasgow
Lanarkshire

Ward: 10D

Surgeon: Alistair Gray

Hospital No: **2704716161**

D.O.B.: 27/04/1971

Assistant: Andrew Ross

Indication: **EPL Tendon (Traumatic) (Right)

Anaesthetist: Dr McKluskie

Traumatic wounds to hand following fall through glass door.

Preparation
Procedure: Primary
Tourniquet: Pneumatic tourniquet Pneumatic Pk.: 250 mm Hg Exsanguination: Elevation of the limb Magnification: None
Antibiotic Prophylaxis (SSI data): N/A Other antibiotics: Record in post-op instruction
Position: Supine with the hand on an arm board

Intra operative procedure
Other: Extension of existing scar proximally and distally
Procedure- Wound over snuffbox extended and explored. Fragment of glass removed with ease. Cleanly cut ends of EPL found. Further exploration with nothing else found to be injured. EPL repaired with 3-0 PDS Kessler suture and a 4-0 running suture around the tendon. Thorough washout and closure in layers- 2-0 for vicryl for fat and 4-0 nylon for skin. Other wounds explored and found not found to go deeper than fat. Closed with nylon following washout.
Adverse event: None

Closure
Blood loss: <100 mls Haemostasis prior to closure: Tourniquet released,No active bleeders Diathermy used: Bipolar Surgical time: 45 minutes
Wound closure: In layers Layers: Fat,Skin
Drains: No
Wound review: Yes
Elevation / Observation: Yes
Wound closure: Multiple wounds closed
Technique: Suture
Suture closure: Interrupted
Suture size: 4-0 Suture: Nylon Removal: 1 week Where / Who: At plaster room.
More than ½ hour: 50
Post-op analgesia: Local Local: LA around wound
Local: Long acting only
Long acting Local anaesthetic: 5 ml
Concentration: 0.5%
Drug: Levobupivacaine Adrenaline: No adrenaline

Post operative instructions
Patient risk: Low VTE Prophylaxis: Mechanical measures only Mechanical - Intra-op: No intra-operative mechanical measures
Mechanical - Post-op: Adequate hydration, early mobilisation
On going drug/s: Continue with existing antibiotics Select drug/s: Co-amoxiclav Co-amoxiclav: 500/125 for a total of 5 days.
Wound: Wound Location: In plaster room Timing: 5 days
Post surgery: Elevation with Bradford splint Observations: Routine

Rehabilitation
1°immobilisation: Volar slab Duration: 2 weeks
Conditions for discharge: When comfortable Discharge: Tomorrow

Addenda:

Procedure	Code Type	Code
Injury of extensor muscle and tendon of thumb at wrist and hand level	ICD 10	S66.2
Right sided operation	OPCS	Z94.2

cc:

Urea & Electrolytes View Cumulative Results

Collected	10-Jan-2024 15:12	Received	10-Jan-2024 18:14
Reported	11-Jan-2024 12:22	Order Number	B,24.0542910.P
Status	Final	Source System	Telepath
Comments	REQUESTOR**dizzy spells		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	140	133 - 146 mmol/L (mmol/L)	
Potassium	4.7	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	107	95 - 108 mmol/L (mmol/L)	
Urea	6.2	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	77	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Thyroid funct test View Cumulative Results

Collected	10-Jan-2024 15:12	Received	10-Jan-2024 18:14
Reported	11-Jan-2024 12:22	Order Number	B,24.0542910.P
Status	Final	Source System	Telepath
Comments	REQUESTOR**dizzy spells		

Test	Result	Ref. Range (Units)	Abnormality
TSH	1.34	0.35 - 5.00 mU/L (mU/L)	
Free T4	11.1	9.0 - 21.0 pmol/L (pmol/L)	
Total T3			

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	10-Jan-2024 15:12	Received	10-Jan-2024 18:14
Reported	11-Jan-2024 12:22	Order Number	B,24.0542910.P
Status	Final	Source System	Telepath
Comments	REQUESTOR**dizzy spells		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	5	<20 umol/L (umol/L)	
ALT	28	<50 U/L (U/L)	
AST	21	<40 U/L (U/L)	
Alkaline Phosphatase	92	30 - 130 U/L (U/L)	
Albumin	42	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Lipid profile View Cumulative Results

Collected	10-Jan-2024 15:12	Received	10-Jan-2024 18:14
Reported	11-Jan-2024 12:22	Order Number	B,24.0542910.P
Status	Final	Source System	Telepath
Comments	REQUESTOR**dizzy spells		

Test	Result	Ref. Range (Units)	Abnormality
Cholesterol	6.2	(mmol/L)	
Triglycerides	1.5	0.2 - 2.3 mmol/L (mmol/L)	
HDL Cholesterol	1.4	(mmol/L)	
LDL-Cholest (calc'd)	4.1	(mmol/L)	
VLDL-Chol (calc'd)	0.7	(mmol/L)	
Chol/HDL ratio	4.4		

* Abnormal ** Critically Abnormal

Glucose View Cumulative Results

Collected	10-Jan-2024 15:12	Received	10-Jan-2024 18:40
Reported	11-Jan-2024 09:27	Order Number	B,24.0544010:T
Status	Final	Source System	Telepath
Comments	Non-fasting sample REQUESTOR**dizzy spells		

Test	Result	Ref. Range (Units)	Abnormality
Glucose	4.3	3.5 - 6.0 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	10-Jan-2024 15:12	Received	10-Jan-2024 18:14
Reported	11-Jan-2024 12:22	Order Number	B,24.0542910.P
Status	Final	Source System	Telepath
Comments	REQUESTOR**dizzy spells		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	3	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Bone Profile View Cumulative Results

Collected	10-Jan-2024 15:12	Received	10-Jan-2024 18:14
Reported	11-Jan-2024 12:22	Order Number	B,24.0542910.P
Status	Final	Source System	Telepath
Comments	REQUESTOR**dizzy spells		

Test	Result	Ref. Range (Units)	Abnormality
Calcium	2.40	2.20 - 2.60 mmol/L (mmol/L)	
Calcium (adjusted)	2.42	2.20 - 2.60 mmol/L (mmol/L)	
Phosphate	1.34	0.80 - 1.50 mmol/L (mmol/L)	
Albumin	42	35 - 50 g/L (g/L)	
Alkaline Phosphatase	92	30 - 130 U/L (U/L)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	07-Jul-2021 15:38	Received	07-Jul-2021 18:46
Reported	08-Jul-2021 10:37	Order Number	B,21.1609780.N
Status	Final	Source System	Telepath
Comments	REQUESTOR**bruising		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	5	<20 umol/L (umol/L)	
ALT	15	<50 U/L (U/L)	
AST	14	<40 U/L (U/L)	
Alkaline Phosphatase	44	30 - 130 U/L (U/L)	
Albumin	40	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	14-Feb-2021 09:26	Received	14-Feb-2021 10:29
Reported	14-Feb-2021 11:27	Order Number	B,21.0645186.L
Status	Final	Source System	Telepath
Comments	REQUESTOR**Tremor, paresthesia, ?pa....		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	138	133 - 146 mmol/L (mmol/L)	
Potassium	4.4	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	107	95 - 108 mmol/L (mmol/L)	
Urea	6.0	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	70	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Thyroid funct test View Cumulative Results

Collected	14-Feb-2021 09:26	Received	14-Feb-2021 10:29
Reported	14-Feb-2021 11:27	Order Number	B,21.0645186.L
Status	Final	Source System	Telepath
Comments	REQUESTOR**Tremor, paresthesia, ?pa....		

Test	Result	Ref. Range (Units)	Abnormality
TSH	0.56	0.35 - 5.00 mU/L (mU/L)	
Free T4	11.7	9.0 - 21.0 pmol/L (pmol/L)	
Total T3			

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	14-Feb-2021 09:26	Received	14-Feb-2021 10:29
Reported	14-Feb-2021 11:27	Order Number	B,21.0645186.L
Status	Final	Source System	Telepath
Comments	REQUESTOR**Tremor, paresthesia, ?pa....		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	3	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Bone Profile View Cumulative Results

Collected	14-Feb-2021 09:26	Received	14-Feb-2021 10:29
Reported	14-Feb-2021 11:27	Order Number	B,21.0645186.L
Status	Final	Source System	Telepath
Comments	REQUESTOR**Tremor, paresthesia, ?pa....		

Test	Result	Ref. Range (Units)	Abnormality
Calcium	2.37	2.20 - 2.60 mmol/L (mmol/L)	
Calcium (adjusted)	2.31	2.20 - 2.60 mmol/L (mmol/L)	
Phosphate	0.97	0.80 - 1.50 mmol/L (mmol/L)	
Albumin	43	35 - 50 g/L (g/L)	
Alkaline Phosphatase	41	30 - 130 U/L (U/L)	

* Abnormal ** Critically Abnormal

Parathyroid Hormone View Cumulative Results

Collected	26-Jan-2021 12:34	Received	26-Jan-2021 13:42
Reported	26-Jan-2021 15:47	Order Number	B,21.0604777.T
Status	Final	Source System	Telepath
Comments	REQUESTOR**hypocalcaemia . prev ca w...		

Test	Result	Ref. Range (Units)	Abnormality
Parathyroid Hormone	5.5	1.6 - 7.5 pmol/L (pmol/L)	

* Abnormal ** Critically Abnormal

Magnesium View Cumulative Results

Collected	26-Jan-2021 12:34	Received	26-Jan-2021 13:40
Reported	26-Jan-2021 14:32	Order Number	B,21.0604788.Q
Status	Final	Source System	Telepath
Comments	REQUESTOR**hypocalcaemia . prev ca w...		

Test	Result	Ref. Range (Units)	Abnormality
Magnesium	0.81	0.70 - 1.00 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

Bone Profile View Cumulative Results

Collected	26-Jan-2021 12:34	Received	26-Jan-2021 13:40
Reported	26-Jan-2021 14:32	Order Number	B,21.0604788.Q
Status	Final	Source System	Telepath
Comments	REQUESTOR**hypocalcaemia . prev ca w...		

Test	Result	Ref. Range (Units)	Abnormality
Calcium	2.26	2.20 - 2.60 mmol/L (mmol/L)	
Calcium (adjusted)	2.26	2.20 - 2.60 mmol/L (mmol/L)	
Phosphate	1.13	0.80 - 1.50 mmol/L (mmol/L)	
Albumin	39	35 - 50 g/L (g/L)	
Alkaline Phosphatase	53	30 - 130 U/L (U/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	11-Jan-2021 10:24	Received	11-Jan-2021 13:56
Reported	11-Jan-2021 15:07	Order Number	B,21.0564781.H
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	137	133 - 146 mmol/L (mmol/L)	
Potassium	4.0	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	105	95 - 108 mmol/L (mmol/L)	
Urea	5.3	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	67	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	11-Jan-2021 10:24	Received	11-Jan-2021 13:56
Reported	11-Jan-2021 15:07	Order Number	B,21.0564781.H
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	5	<20 umol/L (umol/L)	
ALT	20	<50 U/L (U/L)	
AST	17	<40 U/L (U/L)	
Alkaline Phosphatase	43	30 - 130 U/L (U/L)	
Albumin	42	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Glucose View Cumulative Results

Collected	11-Jan-2021 10:24	Received	11-Jan-2021 13:58
Reported	11-Jan-2021 14:42	Order Number	B,21.0564798.P
Status	Final	Source System	Telepath
Comments	Non-fasting sample REQUESTOR**back pain		

Test	Result	Ref. Range (Units)	Abnormality
Glucose	4.4	3.5 - 6.0 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	11-Jan-2021 10:24	Received	11-Jan-2021 13:56
Reported	11-Jan-2021 15:07	Order Number	B21.0564781.H
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	3	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

CA125 View Cumulative Results

Collected	11-Jan-2021 10:24	Received	11-Jan-2021 13:56
Reported	11-Jan-2021 15:07	Order Number	B,21.0564781.H
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain		

Test	Result	Ref. Range (Units)	Abnormality
CA125	11	0 - 35 kU/L (kU/L)	

* Abnormal ** Critically Abnormal

Bone Profile View Cumulative Results

Collected	11-Jan-2021 10:24	Received	11-Jan-2021 13:56
Reported	11-Jan-2021 15:07	Order Number	B,21.0564781.H
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain		

Test	Result	Ref. Range (Units)	Abnormality
Calcium	2.20	2.20 - 2.60 mmol/L (mmol/L)	
Calcium (adjusted)	* **2.16**	2.20 - 2.60 mmol/L (mmol/L)	**Abnormal - low**
Phosphate	0.81	0.80 - 1.50 mmol/L (mmol/L)	
Albumin	42	35 - 50 g/L (g/L)	
Alkaline Phosphatase	43	30 - 130 U/L (U/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	17-Nov-2020 11:38	Received	17-Nov-2020 13:43
Reported	17-Nov-2020 15:17	Order Number	B,20.2099564.L
Status	Final	Source System	Telepath
Comments	REQUESTOR**Back pain		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	138	133 - 146 mmol/L (mmol/L)	
Potassium	4.3	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	106	95 - 108 mmol/L (mmol/L)	
Urea	5.7	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	69	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	17-Nov-2020 11:38	Received	17-Nov-2020 13:43
Reported	17-Nov-2020 15:17	Order Number	B,20.2099564.L
Status	Final	Source System	Telepath
Comments	REQUESTOR**Back pain		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	4	<20 umol/L (umol/L)	
ALT	16	<50 U/L (U/L)	
AST	14	<40 U/L (U/L)	
Alkaline Phosphatase	41	30 - 130 U/L (U/L)	
Albumin	41	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	17-Nov-2020 11:38	Received	17-Nov-2020 13:43
Reported	17-Nov-2020 15:17	Order Number	B,20.2099564.L
Status	Final	Source System	Telepath
Comments	REQUESTOR**Back pain		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	6	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Bone Profile View Cumulative Results

Collected	17-Nov-2020 11:38	Received	17-Nov-2020 13:43
Reported	17-Nov-2020 15:17	Order Number	B,20.2099564.L
Status	Final	Source System	Telepath
Comments	REQUESTOR**Back pain		

Test	Result	Ref. Range (Units)	Abnormality
Calcium	2.31	2.20 - 2.60 mmol/L (mmol/L)	
Calcium (adjusted)	2.28	2.20 - 2.60 mmol/L (mmol/L)	
Phosphate	1.02	0.80 - 1.50 mmol/L (mmol/L)	
Albumin	41	35 - 50 g/L (g/L)	
Alkaline Phosphatase	41	30 - 130 U/L (U/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	02-Sep-2019 11:09	Received	02-Sep-2019 14:28
Reported	02-Sep-2019 15:42	Order Number	B,19.2296249.A
Status	Final	Source System	Telepath
Comments	REQUESTOR**sweats		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	139	133 - 146 mmol/L (mmol/L)	
Potassium	4.9	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	106	95 - 108 mmol/L (mmol/L)	
Urea	7.5	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	77	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Thyroid funct test View Cumulative Results

Collected	02-Sep-2019 11:09	Received	02-Sep-2019 14:28
Reported	02-Sep-2019 15:42	Order Number	B,19.2296249.A
Status	Final	Source System	Telepath
Comments	REQUESTOR**sweats		

Test	Result	Ref. Range (Units)	Abnormality
TSH	1.45	0.35 - 5.00 mU/L (mU/L)	
Free T4	9.6	9.0 - 21.0 pmol/L (pmol/L)	
Total T3			

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	02-Sep-2019 11:09	Received	02-Sep-2019 14:28
Reported	02-Sep-2019 15:42	Order Number	B,19.2296249.A
Status	Final	Source System	Telepath
Comments	REQUESTOR**sweats		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	7	<20 umol/L (umol/L)	
ALT	17	<50 U/L (U/L)	
AST	17	<40 U/L (U/L)	
Alkaline Phosphatase	55	30 - 130 U/L (U/L)	
Albumin	41	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	02-Sep-2019 11:09	Received	02-Sep-2019 14:28
Reported	02-Sep-2019 15:42	Order Number	B,19.2296249.A
Status	Final	Source System	Telepath
Comments	REQUESTOR**sweats		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	2	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	12-Apr-2019 16:00	Received	12-Apr-2019 16:15
Reported	12-Apr-2019 17:08	Order Number	B,19.1013210.Z
Status	Final	Source System	Telepath
Comments	REQUESTOR**chest pain		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	139	133 - 146 mmol/L (mmol/L)	
Potassium	4.7	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	108	95 - 108 mmol/L (mmol/L)	
Urea	7.1	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	71	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Troponin I hs View Cumulative Results

Collected	12-Apr-2019 16:00	Received	12-Apr-2019 16:15
Reported	12-Apr-2019 16:53	Order Number	B,19.1013209.W
Status	Final	Source System	Telepath
Comments	NOTE: New Troponin-hs method. New units and diagnostic thresholds. REQUESTOR**chest pain		

Test	Result	Ref. Range (Units)	Abnormality
Troponin I hs	<1	0 - 16 ng/L (ng/L)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	12-Apr-2019 16:00	Received	12-Apr-2019 16:15
Reported	12-Apr-2019 17:08	Order Number	B,19.1013210.Z
Status	Final	Source System	Telepath
Comments	Please note change in Abbott Total Bilirubin method from 18/01/18 REQUESTOR**chest pain		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	4	<20 umol/L (umol/L)	
ALT	12	<50 U/L (U/L)	
AST	14	<40 U/L (U/L)	
Alkaline Phosphatase	57	30 - 130 U/L (U/L)	
Albumin	41	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Lipid profile View Cumulative Results

Collected	12-Apr-2019 16:00	Received	12-Apr-2019 16:15
Reported	12-Apr-2019 17:08	Order Number	B,19.1013210.Z
Status	Final	Source System	Telepath
Comments	REQUESTOR**chest pain		

Test	Result	Ref. Range (Units)	Abnormality
Cholesterol	6.0	(mmol/L)	
Triglycerides	2.3	0.2 - 2.3 mmol/L (mmol/L)	
HDL Cholesterol	1.2	(mmol/L)	
LDL-Cholest (calc'd)	3.7	(mmol/L)	
VLDL-Chol (calc'd)	1.1	(mmol/L)	
Chol/HDL ratio	5.0		

* Abnormal ** Critically Abnormal

Bicarbonate View Cumulative Results

Collected	12-Apr-2019 16:00	Received	12-Apr-2019 16:15
Reported	12-Apr-2019 17:08	Order Number	B,19.1013210.Z
Status	Final	Source System	Telepath
Comments	REQUESTOR**chest pain		

Test	Result	Ref. Range (Units)	Abnormality
Bicarbonate	*** 21**	22 - 29 mmol/L (mmol/L)	**Abnormal - low**

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	12-Apr-2018 09:17	Received	12-Apr-2018 16:38
Reported	13-Apr-2018 11:13	Order Number	B,18.1121258.G
Status	Final	Source System	Telepath
Comments	REQUESTOR**Possible menopausal flush...		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	141	133 - 146 mmol/L (mmol/L)	
Potassium	4.7	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	107	95 - 108 mmol/L (mmol/L)	
Urea	7.6	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	76	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Thyroid funct test View Cumulative Results

Collected	12-Apr-2018 09:17	Received	12-Apr-2018 16:38
Reported	13-Apr-2018 11:13	Order Number	B,18.1121258.G
Status	Final	Source System	Telepath
Comments	REQUESTOR**Possible menopausal flush...		

Test	Result	Ref. Range (Units)	Abnormality
TSH	2.21	0.35 - 5.00 mU/L (mU/L)	
Free T4	12.4	9.0 - 21.0 pmol/L (pmol/L)	
Total T3			

* Abnormal ** Critically Abnormal

Oestradiol View Cumulative Results

Collected	12-Apr-2018 09:17	Received	12-Apr-2018 16:38
Reported	13-Apr-2018 11:13	Order Number	B,18.1121258.G
Status	Final	Source System	Telepath
Comments	REQUESTOR**Possible menopausal flush...,		

Test	Result	Ref. Range (Units)	Abnormality
Oestradiol	<70	(pmol/L)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	12-Apr-2018 09:17	Received	12-Apr-2018 16:38
Reported	13-Apr-2018 11:13	Order Number	B,18.1121258.G
Status	Final	Source System	Telepath
Comments	Please note change in Abbott Total Bilirubin method from 18/01/18 REQUESTOR**Possible menopausal flush...		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	5	<20 umol/L (umol/L)	
ALT	25	<50 U/L (U/L)	
AST	22	<40 U/L (U/L)	
Alkaline Phosphatase	64	30 - 130 U/L (U/L)	
Albumin	44	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

LH View Cumulative Results

Collected	12-Apr-2018 09:17	Received	12-Apr-2018 16:38
Reported	13-Apr-2018 11:13	Order Number	B,18.1121258.G
Status	Final	Source System	Telepath
Comments	REQUESTOR**Possible menopausal flush...		

Test	Result	Ref. Range (Units)	Abnormality
LH	18.5	(U/L)	

* Abnormal ** Critically Abnormal

Glucose View Cumulative Results

Collected	12-Apr-2018 09:17	Received	12-Apr-2018 16:43
Reported	13-Apr-2018 09:18	Order Number	B,18.1121283.Q
Status	Final	Source System	Telepath
Comments	Non-fasting sample REQUESTOR**Possible menopausal flush...		

Test	Result	Ref. Range (Units)	Abnormality
Glucose	4.6	3.5 - 6.0 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

FSH View Cumulative Results

Collected	12-Apr-2018 09:17	Received	12-Apr-2018 16:38
Reported	13-Apr-2018 11:13	Order Number	B,18.1121258.G
Status	Final	Source System	Telepath
Comments	In keeping with perimenopause Hormone concentration may fluctuate widely during peri-menopause Infertility cannot be assumed during this stage and for up to 2 years post menopause (under age 50) REQUESTOR**Possible menopausal flush...		

Test	Result	Ref. Range (Units)	Abnormality
FSH	51.3	(U/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	29-Mar-2017 14:25	Received	29-Mar-2017 15:23
Reported	29-Mar-2017 16:23	Order Number	B,17.0894307.H
Status	Final	Source System	Telepath
Comments	REQUESTOR**?pe		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	138	133 - 146 mmol/L (mmol/L)	
Potassium	4.7	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	107	95 - 108 mmol/L (mmol/L)	
Urea	4.2	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	73	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Troponin I hs View Cumulative Results

Collected	29-Mar-2017 14:25	Received	29-Mar-2017 15:23
Reported	29-Mar-2017 15:58	Order Number	B,17.0894308.W
Status	Final	Source System	Telepath
Comments	NOTE: New Troponin-hs method. New units and diagnostic thresholds. REQUESTOR**?pe		

Test	Result	Ref. Range (Units)	Abnormality
Troponin I hs	<1	0 - 16 ng/L (ng/L)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	29-Mar-2017 14:25	Received	29-Mar-2017 15:23
Reported	29-Mar-2017 16:23	Order Number	B;17.0894307.H
Status	Final	Source System	Telepath
Comments	REQUESTOR**?pe		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	5	<20 umol/L (umol/L)	
ALT	20	<50 U/L (U/L)	
AST	18	<40 U/L (U/L)	
Alkaline Phosphatase	62	30 - 130 U/L (U/L)	
Albumin	42	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Glucose View Cumulative Results

Collected	29-Mar-2017 14:25	Received	29-Mar-2017 15:23
Reported	29-Mar-2017 16:23	Order Number	B,17.0894301.V
Status	Final	Source System	Telepath
Comments	Non-fasting sample REQUESTOR**?pe		

Test	Result	Ref. Range (Units)	Abnormality
Glucose	4.9	3.5 - 6.0 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	29-Mar-2017 14:25	Received	29-Mar-2017 15:23
Reported	29-Mar-2017 16:23	Order Number	B,17.0894307.H
Status	Final	Source System	Telepath
Comments	REQUESTOR**?pe		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	3	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	11-Nov-2015 23:10	Received	11-Nov-2015 23:50
Reported	12-Nov-2015 00:18	Order Number	B,15.2611826.R
Status	Final	Source System	Telepath
Comments	REQUESTOR**		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	138	133 - 146 mmol/L (mmol/L)	
Potassium	4.4	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	* **110**	95 - 108 mmol/L (mmol/L)	**Abnormal - high**
Urea	7.2	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	94	40 - 130 umol/L (umol/L)	
Estimated GFR	* **56**	>60 ml/min (ml/min)	**Abnormal - low**

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	11-Nov-2015 21:10	Received	11-Nov-2015 21:29
Reported	11-Nov-2015 22:13	Order Number	B,15.2611751.S
Status	Final	Source System	Telepath
Comments	(NA) Specimen haemolysed, result invalid. REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	135	133 - 146 mmol/L (mmol/L)	
Potassium	[a] NA		
Chloride	*** 110**	95 - 108 mmol/L (mmol/L)	**Abnormal - high**
Urea	6.6	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	77	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

[a] Haemolysed

C-reactive Protein View Cumulative Results

Collected	11-Nov-2015 21:10	Received	11-Nov-2015 21:29
Reported	11-Nov-2015 22:13	Order Number	B,15.2611751.S
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	<1	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	19-Jun-2013 03:51	Received	19-Jun-2013 04:03
Reported	19-Jun-2013 04:45	Order Number	B,13.1631690.V
Status	Final	Source System	Telepath
Comments	REQUESTOR**chest pain		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	139	133 - 146 mmol/L (mmol/L)	
Potassium	4.0	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	103	95 - 108 mmol/L (mmol/L)	
Urea	7.8	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	82	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Troponin I View Cumulative Results

Collected	19-Jun-2013 03:51	Received	19-Jun-2013 04:03
Reported	19-Jun-2013 04:45	Order Number	B,13.1631690.V
Status	Final	Source System	Telepath
Comments	Troponin negative. No evidence of recent myocyte necrosis assuming sample taken at least 12h after onset of symptoms REQUESTOR**chest pain		

Test	Result	Ref. Range (Units)	Abnormality
Troponin I	<0.04	<0.04 ug/L (ug/L)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	19-Jun-2013 03:51	Received	19-Jun-2013 04:03
Reported	19-Jun-2013 04:45	Order Number	B,13.1631690.V
Status	Final	Source System	Telepath
Comments	REQUESTOR**chest pain		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	4	0 - 20 umol/L (umol/L)	
ALT	16	0 - 50 U/L (U/L)	
AST	16	0 - 40 U/L (U/L)	
Alkaline Phosphatase	63	30 - 130 U/L (U/L)	
Albumin	42	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Glucose View Cumulative Results

Collected	19-Jun-2013 03:51	Received	19-Jun-2013 04:03
Reported	19-Jun-2013 04:30	Order Number	B,13.1631691.R
Status	Final	Source System	Telepath
Comments	Non-fasting sample REQUESTOR**chest pain		

Test	Result	Ref. Range (Units)	Abnormality
Glucose	5.3	3.5 - 6.0 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	19-Jun-2013 03:51	Received	19-Jun-2013 04:03
Reported	19-Jun-2013 04:45	Order Number	B,13.1631690.V
Status	Final	Source System	Telepath
Comments	REQUESTOR**chest pain		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	<3	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Bicarbonate View Cumulative Results

Collected	19-Jun-2013 03:51	Received	19-Jun-2013 04:03
Reported	19-Jun-2013 04:45	Order Number	B;13.1631690.V
Status	Final	Source System	Telepath
Comments	REQUESTOR**chest pain		

Test	Result	Ref. Range (Units)	Abnormality
Bicarbonate	22	22 - 29 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

Amylase View Cumulative Results

Collected	19-Jun-2013 03:51	Received	19-Jun-2013 04:03
Reported	19-Jun-2013 04:45	Order Number	B,13.1631690.V
Status	Final	Source System	Telepath
Comments	REQUESTOR**chest pain		

Test	Result	Ref. Range (Units)	Abnormality
Amylase	70	0 - 100 U/L (U/L)	

* Abnormal ** Critically Abnormal

Blood

Performed	11-Nov-2015 21:10	Received	11-Nov-2015 21:26
Reported	12-Nov-2015 00:33	Order Number	R,15.0200548.C
Status	Final	Source System	Telepath

Bloodbank Final

Sample tested at Southern General

Blood Group: O Rh(D): POS Antibody Screen: Negative

IN THE ABSENCE OF FURTHER TRANSFUSION THIS SAMPLE

WILL BE VALID FOR 14 DAYS FROM DATE/TIME COLLECTED

8290

West of Scotland Genetic Services
Laboratory Genetics
Level 2B, Laboratory Medicine
Queen Elizabeth University Hospital
1345 Govan Road, Glasgow G51 4TF

Email: geneticlabs@ggc.scot.nhs.uk Tel: 0141 354 9300

Greater Glasgow and Clyde

Head of laboratory: Paul Westwood

Molecular Genetics Report for Myotonic Dystrophy type 1

Report Number: 274360

Dr Bob Ballantyne
Clinical Genetics, Level 2A
Laboratory Medicine Building
Queen Elizabeth University Hospital Campus
1345 Govan Road
Glasgow
G51 4TF

Reported: **Shaun Prior**

Authorised: **Gillian Stevens**

Name of Patient:	**Tracy ROBERTS**			Date of Birth:	**27/04/1971**
CHI/NHS Number:	**2704716161**	Sex:	**Female**	Date of Sample:	**11/07/2024**
Hospital Number:		Sample Type:	**EDTA blood**	Date Received:	**11/07/2024**
Pedigree Number:	**114345**	Lab Number:	**4244373**	Date of Activation:	**11/07/2024**
Ref Lab Number:		Gestation:		Date of Report:	**19/07/2024**

Reason for referral: Family history of myotonic dystrophy type 1 (DM1).

Conclusion: **No evidence of a DMPK expansion detected in this patient.**

Results and interpretation:

Fluorescent flanking PCR analysis identified two DMPK alleles in the NORMAL size range of 12 (+/-1) and 13 (+/-1) CTG repeats. The characteristic ladder of CTG peaks observed in the presence of an expanded allele was NOT detected by triplet primed PCR indicating that the patient is heterozygous for 12 & 13 (CTG) repeats and does not carry any DMPK expansion.

These results exclude the possibility that this patient will develop clinical symptoms associated with myotonic dystrophy type 1.

Comments:

In order to avoid error and/or misinterpretation, transcription of the content of this report is not advised; Laboratory Genetics do not take any responsibility for the accuracy of any data/text transcribed from this report.

Technical Information:

Analysis of the CTG repeat in the 3' untranslated region of the DMPK gene using fluorescent flanking PCR and fluorescent triplet primed PCR (TP-PCR) was performed. Fluorescent flanking PCR detects CTG expansions up to ~120 repeats (Fu et al, Science 1992; 225: 1256-1258). TP-PCR of both strands using independent primer sets detects CTG expansion >50 repeats but cannot always accurately size the repeats (Warner et al, J Med Gen 1996; 33: 1022-1026). DM1 allele size ranges: Normal range = 5-35 CTG repeats. Premutation range = 36-50 CTG repeats, are not associated with symptoms but may be unstable expanding into the affected size range upon transmission. Full mutation (affected) range >50 CTG repeats. (Kamsteeg et al, Eur J Hum Genetics 2012 20:1203–1208).

Serum Ferritin View Cumulative Results

Collected	10-Jan-2024 15:12	Received	10-Jan-2024 18:14
Reported	11-Jan-2024 12:12	Order Number	B,24.0542910.P
Status	Final	Source System	Telepath
Comments	Males 15-300 (<15 iron deficiency) Females 15-200 (<15 iron deficiency) 15-50 intermediate result. Consider iron deficiency in anaemic patients, older patients and those with inflammatory disease. REQUESTOR**dizzy spells		

Test	Result	Ref. Range (Units)	Abnormality
Serum Ferritin	116	15 - 200 ug/l (ug/l)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	10-Jan-2024 15:12	Received	10-Jan-2024 18:30
Reported	10-Jan-2024 18:57	Order Number	B,24.0540560.P
Status	Final	Source System	Telepath
Comments	REQUESTOR**dizzy spells REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	8.7	4.0 - 10.0 x10^9/l (x10^9/l)	
Red Cell Count	4.34	3.80 - 5.80 x10^12/l (x10^12/l)	
Haemoglobin	144	115 - 165 g/l (g/l)	
Haematocrit	0.423	0.370 - 0.470 l/l (l/l)	
Mean Cell Volume	97.5	83.0 - 101.0 fl (fl)	
MCH	*** 33.2**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	230	150 - 410 x10^9/l (x10^9/l)	
Neutrophils	4.4	2.0 - 7.0 x10^9/l (x10^9/l)	
Lymphocytes	3.3	1.1 - 5.0 x10^9/l (x10^9/l)	
Monocytes	0.7	0.2 - 1.0 x10^9/l (x10^9/l)	
Eosinophils	0.27	0.02 - 0.50 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	07-Jul-2021 15:38	Received	07-Jul-2021 19:14
Reported	07-Jul-2021 19:47	Order Number	B,21.1612046.L
Status	Final	Source System	Telepath
Comments	REQUESTOR**bruising REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	9.8	4.0 - 10.0 x10^9/l (x10^9/l)	
Red Cell Count	4.19	3.80 - 5.80 x10^12/l (x10^12/l)	
Haemoglobin	139	115 - 165 g/l (g/l)	
Haematocrit	0.421	0.370 - 0.470 l/l (l/l)	
Mean Cell Volume	100.5	83.0 - 101.0 fl (fl)	
MCH	* **33.2**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	226	150 - 410 x10^9/l (x10^9/l)	
Neutrophils	5.8	2.0 - 7.0 x10^9/l (x10^9/l)	
Lymphocytes	3.1	1.1 - 5.0 x10^9/l (x10^9/l)	
Monocytes	0.6	0.2 - 1.0 x10^9/l (x10^9/l)	
Eosinophils	0.20	0.02 - 0.50 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	14-Feb-2021 09:26	Received	14-Feb-2021 10:38
Reported	14-Feb-2021 10:57	Order Number	B,21.0643018.V
Status	Final	Source System	Telepath
Comments	REQUESTOR**Tremor, paresthesia, ?pa.... REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	9.0	4.0 - 10.0 x10^9/l (x10^9/l)	
Red Cell Count	4.63	3.80 - 5.80 x10^12/l (x10^12/l)	
Haemoglobin	152	115 - 165 g/l (g/l)	
Haematocrit	0.445	0.370 - 0.470 l/l (l/l)	
Mean Cell Volume	96.1	83.0 - 101.0 fl (fl)	
MCH	* **32.8**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	254	150 - 410 x10^9/l (x10^9/l)	
Neutrophils	5.5	2.0 - 7.0 x10^9/l (x10^9/l)	
Lymphocytes	2.9	1.1 - 5.0 x10^9/l (x10^9/l)	
Monocytes	0.5	0.2 - 1.0 x10^9/l (x10^9/l)	
Eosinophils	0.08	0.02 - 0.50 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	11-Jan-2021 10:24	Received	11-Jan-2021 14:03
Reported	11-Jan-2021 15:07	Order Number	B,21.0564855.S
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	9.7	4.0 - 10.0 x10^9/l (x10^9/l)	
Red Cell Count	4.28	3.80 - 5.80 x10^12/l (x10^12/l)	
Haemoglobin	144	115 - 165 g/l (g/l)	
Haematocrit	0.419	0.370 - 0.470 l/l (l/l)	
Mean Cell Volume	97.9	83.0 - 101.0 fl (fl)	
MCH	*** 33.6**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	234	150 - 410 x10^9/l (x10^9/l)	
Neutrophils	4.8	2.0 - 7.0 x10^9/l (x10^9/l)	
Lymphocytes	4.1	1.1 - 5.0 x10^9/l (x10^9/l)	
Monocytes	0.6	0.2 - 1.0 x10^9/l (x10^9/l)	
Eosinophils	0.22	0.02 - 0.50 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

ESR View Cumulative Results

Collected	11-Jan-2021 10:24	Received	11-Jan-2021 14:03
Reported	11-Jan-2021 15:07	Order Number	B,21.0564855.S
Status	Final	Source System	Telepath
Comments	REQUESTOR**back pain REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
ESR	2	0 - 12 mm/hr (mm/hr)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	17-Nov-2020 11:38	Received	17-Nov-2020 13:45
Reported	17-Nov-2020 14:42	Order Number	B,20.2099567.E
Status	Final	Source System	Telepath
Comments	REQUESTOR**Back pain REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	8.7	4.0 - 10.0 x10^9/l (x10^9/l)	
Red Cell Count	4.30	3.80 - 5.80 x10^12/l (x10^12/l)	
Haemoglobin	139	115 - 165 g/l (g/l)	
Haematocrit	0.422	0.370 - 0.470 l/l (l/l)	
Mean Cell Volume	98.1	83.0 - 101.0 fl (fl)	
MCH	*** 32.3**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	233	150 - 410 x10^9/l (x10^9/l)	
Neutrophils	3.7	2.0 - 7.0 x10^9/l (x10^9/l)	
Lymphocytes	4.2	1.1 - 5.0 x10^9/l (x10^9/l)	
Monocytes	0.5	0.2 - 1.0 x10^9/l (x10^9/l)	
Eosinophils	0.28	0.02 - 0.50 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

ESR View Cumulative Results

Collected	17-Nov-2020 11:38	Received	17-Nov-2020 13:45
Reported	17-Nov-2020 14:42	Order Number	B,20.2099567.E
Status	Final	Source System	Telepath
Comments	REQUESTOR**Back pain REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
ESR	2	0 - 12 mm/hr (mm/hr)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	02-Sep-2019 11:09	Received	02-Sep-2019 14:32
Reported	03-Sep-2019 15:32	Order Number	B,19.2296248.W
Status	Final	Source System	Telepath
Comments	REQUESTOR**sweats REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	8.7	4.0 - 10.0 x10^9/l (x10^9/l)	
Red Cell Count	4.55	3.80 - 5.80 x10^12/l (x10^12/l)	
Haemoglobin	146	115 - 165 g/l (g/l)	
Haematocrit	0.448	0.370 - 0.470 l/l (l/l)	
Mean Cell Volume	98.5	83.0 - 101.0 fl (fl)	
MCH	* **32.1**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	217	150 - 410 x10^9/l (x10^9/l)	
Neutrophils	4.3	2.0 - 7.0 x10^9/l (x10^9/l)	
Lymphocytes	3.5	1.1 - 5.0 x10^9/l (x10^9/l)	
Monocytes	0.6	0.2 - 1.0 x10^9/l (x10^9/l)	
Eosinophils	0.28	0.02 - 0.50 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Blood Film View Cumulative Results

Collected	02-Sep-2019 11:09	Received	02-Sep-2019 14:32
Reported	03-Sep-2019 15:32	Order Number	B,19.2296248.W
Status	Final	Source System	Telepath

Comments
Occasional stomatocyte noted
Activated and atypical lymphocytes seen, ?viral
REQUESTOR**sweats
REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS)
REPORT**for scope on schedule. Please see the user handbook for clarification

Test	Result	Ref. Range (Units)	Abnormality
Blood Film	Yes		

* Abnormal ** Critically Abnormal

D-Dimer (IL DDHS) View Cumulative Results

Collected	12-Apr-2019 17:00	Received	12-Apr-2019 18:24
Reported	12-Apr-2019 19:03	Order Number	B,19.1011254.V
Status	Final	Source System	Telepath

Comments: The above reference range applies to patients with suspected VTE.
In other populations the reference range is 0-243 ng/mL.
REQUESTOR**pleuritic chest pain
REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS)
REPORT**for scope on schedule. Please see the user handbook for clarification

Test	Result	Ref. Range (Units)	Abnormality
D-Dimer	52	0 - 230 ng/ml (ng/ml)	

* Abnormal ** Critically Abnormal

Coagulation Screen View Cumulative Results

Collected	12-Apr-2019 17:00	Received	12-Apr-2019 18:24
Reported	12-Apr-2019 19:03	Order Number	B,19.1011254.V
Status	Final	Source System	Telepath
Comments	REQUESTOR**pleuritic chest pain REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
Prothrombin Time	12	9 - 13 s (s)	
PT Ratio	1.0		
APTT	30	27 - 38 s (s)	
APTT Ratio	0.9	0.8 - 1.2	
Thrombin time	14	11 - 15 s (s)	
TCT ratio	1.1		

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	12-Apr-2019 16:00	Received	12-Apr-2019 16:15
Reported	12-Apr-2019 16:43	Order Number	B,19.1013208.H
Status	Final	Source System	Telepath
Comments	REQUESTOR**chest pain REPORT**South Haematology Labs are an ISO:15189 accredited laboratory(UKAS) REPORT**for scope on schedule. Please see the user handbook for clarification		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	6.1	4.0 - 10.0 x10^9/l (x10^9/l)	
Red Cell Count	4.64	3.80 - 5.80 x10^12/l (x10^12/l)	
Haemoglobin	152	115 - 165 g/l (g/l)	
Haematocrit	0.446	0.370 - 0.470 l/l (l/l)	
Mean Cell Volume	96.1	83.0 - 101.0 fl (fl)	
MCH	* **32.8**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	208	150 - 410 x10^9/l (x10^9/l)	
Neutrophils	3.3	2.0 - 7.0 x10^9/l (x10^9/l)	
Lymphocytes	2.0	1.1 - 5.0 x10^9/l (x10^9/l)	
Monocytes	0.4	0.2 - 1.0 x10^9/l (x10^9/l)	
Eosinophils	0.37	0.02 - 0.50 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	12-Apr-2018 09:17	Received	12-Apr-2018 18:54
Reported	12-Apr-2018 19:13	Order Number	B,18.1121825.L
Status	Final	Source System	Telepath
Comments	REQUESTOR**Possible menopausal flush... REPORT**South Haematology Labs are an ISO: 15189 accredited laboratory(UKAS 9604) REPORT**for all tests in our schedule of scope held on the UKAS website		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	7.6	4.0 - 10.0 x10^9/l (x10^9/l)	
Red Cell Count	4.55	3.80 - 4.80 x10^12/l (x10^12/l)	
Haemoglobin	145	120 - 150 g/l (g/l)	
Haematocrit	0.446	0.360 - 0.460 l/l (l/l)	
Mean Cell Volume	98.0	83.0 - 101.0 fl (fl)	
MCH	31.9	27.0 - 32.0 pg (pg)	
Platelet Count	196	150 - 410 x10^9/l (x10^9/l)	
Neutrophils	3.0	2.0 - 7.0 x10^9/l (x10^9/l)	
Lymphocytes	* **3.8**	1.0 - 3.0 x10^9/l (x10^9/l)	**Abnormal - high**
Monocytes	0.5	0.2 - 1.0 x10^9/l (x10^9/l)	
Eosinophils	0.27	0.02 - 0.50 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	29-Mar-2017 14:25	Received	29-Mar-2017 15:21
Reported	29-Mar-2017 15:48	Order Number	B,17.0893900.S
Status	Final	Source System	Telepath
Comments	REQUESTOR**?pe		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	8.5	4.0 - 11.0 x10^9/l (x10^9/l)	
Red Cell Count	4.61	3.80 - 5.80 x10^12/l (x10^12/l)	
Haemoglobin	149	115 - 165 g/l (g/l)	
Haematocrit	0.440	0.370 - 0.470 l/l (l/l)	
Mean Cell Volume	95.4	80.0 - 100.0 fl (fl)	
MCH	* **32.3**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	224	150 - 400 x10^9/l (x10^9/l)	
Neutrophils	4.3	2.0 - 7.5 x10^9/l (x10^9/l)	
Lymphocytes	3.4	1.5 - 4.0 x10^9/l (x10^9/l)	
Monocytes	0.4	0.2 - 0.8 x10^9/l (x10^9/l)	
Eosinophils	0.32	0.00 - 0.40 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

D-Dimer (IL DDHS) View Cumulative Results

Collected	29-Mar-2017 14:25	Received	29-Mar-2017 15:21
Reported	29-Mar-2017 16:23	Order Number	B,17.0893901.Z
Status	Final	Source System	Telepath
Comments	The above reference range applies to patients with suspected VTE. In other populations the reference range is 0-243 ng/mL. REQUESTOR**?pe		

Test	Result	Ref. Range (Units)	Abnormality
D-Dimer	80	0 - 230 ng/ml (ng/ml)	

* Abnormal ** Critically Abnormal

Coagulation Screen View Cumulative Results

Collected	29-Mar-2017 14:25	Received	29-Mar-2017 15:21
Reported	29-Mar-2017 16:23	Order Number	B,17.0893901.Z
Status	Final	Source System	Telepath
Comments	REQUESTOR**?pe		

Test	Result	Ref. Range (Units)	Abnormality
Prothrombin Time	11	9 - 13 s (s)	
PT Ratio	1.0		
APTT	34	27 - 38 s (s)	
APTT Ratio	1.1	0.8 - 1.2	
Thrombin time	13	11 - 15 s (s)	
TCT ratio	0.9		

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	11-Nov-2015 21:10	Received	11-Nov-2015 21:23
Reported	11-Nov-2015 22:23	Order Number	B,15.2610792.B
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	8.3	4.0 - 11.0 x10^9/l (x10^9/l)	
Red Cell Count	4.21	3.80 - 5.80 x10^12/l (x10^12/l)	
Haemoglobin	138	115 - 165 g/l (g/l)	
Haematocrit	0.423	0.370 - 0.470 l/l (l/l)	
Mean Cell Volume	* **100.5**	80.0 - 100.0 fl (fl)	**Abnormal - high**
MCH	* **32.8**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	209	150 - 400 x10^9/l (x10^9/l)	
Neutrophils	4.4	2.0 - 7.5 x10^9/l (x10^9/l)	
Lymphocytes	3.0	1.5 - 4.0 x10^9/l (x10^9/l)	
Monocytes	0.6	0.2 - 0.8 x10^9/l (x10^9/l)	
Eosinophils	0.3	0.0 - 0.4 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	19-Jun-2013 03:51	Received	19-Jun-2013 04:01
Reported	19-Jun-2013 11:05	Order Number	B,13.1706527.F
Status	Final	Source System	Telepath
Comments	REQUESTOR**chest pain		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	10.1	4.0 - 11.0 x10^9/l (x10^9/l)	
Red Cell Count	4.37	4.00 - 5.20 x10^12/l (x10^12/l)	
Haemoglobin	135	115 - 165 g/l (g/l)	
Haematocrit	0.398	0.370 - 0.470 l/l (l/l)	
Mean Cell Volume	91.1	80.0 - 100.0 fl (fl)	
Mean Cell Hgb	31.0	26.0 - 34.0 pg (pg)	
Platelet Count	208	150 - 410 x10^9/l (x10^9/l)	
Neutrophils	3.8	1.8 - 7.7 x10^9/l (x10^9/l)	
Lymphocytes	* **5.3**	1.0 - 4.8 x10^9/l (x10^9/l)	**Abnormal - high**
Monocytes	0.5	0.2 - 1.0 x10^9/l (x10^9/l)	
Eosinophils	0.4	0.1 - 1.0 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Blood Film View Cumulative Results

Collected	19-Jun-2013 03:51	Received	19-Jun-2013 04:01
Reported	19-Jun-2013 11:05	Order Number	B,13.1706527.F
Status	Final	Source System	Telepath
Comments	Red cells show presence of some stomatocytes. Atypical lymphocytes noted. REQUESTOR**chest pain		

Test	Result	Ref. Range (Units)	Abnormality
Blood Film	Yes		

* Abnormal ** Critically Abnormal

Mid Stream Urine

Performed	17-Nov-2020 11:48	Received	17-Nov-2020 13:48
Reported	19-Nov-2020 10:07	Order Number	M,20.5196515.K
Status	Final	Source System	Telepath

Microbiology Final

Report issued by NHS GG&C Microbiology South Sector
Enquiries 0141 354 9132
** FINAL REPORT **

INVESTIGATION: Urine Culture
SPECIMEN TYPE: Mid Stream Urine

CONS/GP: Dr John Saldanha Order No:IS13528502
LOCATION: Prac B Govanhill HC 49041

RESULT: Growth of >100,000 cfu/ml

a) Escherichia coli
b)
c)
d)
e)
f)

ANTIBIOTIC	a)	b)	c)	d)	e)	f)
Amp/Amoxicillin	R					
Trimethoprim	S					
Nitrofurantoin	S					
Co-amoxiclav.	R					
Gentamicin	S					
Temocillin	R					
Tazocin	R					
Pivmecillinam	R					

Tests included in UKAS Accreditation (8078) Scope.

Senders ref. no.

Authorised by: Mark Murphy QEUH MIC
Date/Time authorised: 19.11.2020 10:03
** END OF REPORT **

Throat swab

Performed	11-Nov-2015 22:45	Received	12-Nov-2015 09:57
Reported	13-Nov-2015 09:03	Order Number	M,15.5342777.V
Status	Final	Source System	Telepath

Microbiology Final

Report issued by Microbiology,South Glasgow
* FINAL REPORT *

Specimen: Throat swab

MRSA culture MRSA NOT ISOLATED

Nose swab

Performed	11-Nov-2015 22:45	Received	12-Nov-2015 09:57
Reported	13-Nov-2015 09:03	Order Number	M,15.5342776.M
Status	Final	Source System	Telepath

Microbiology Final

Report issued by Microbiology,South Glasgow
* FINAL REPORT *

Specimen: Nose swab

MRSA culture MRSA NOT ISOLATED

Groin swab

Performed	11-Nov-2015 22:45	Received	12-Nov-2015 09:57
Reported	13-Nov-2015 09:03	Order Number	M,15.5342775.T
Status	Final	Source System	Telepath

Microbiology Final

Report issued by Microbiology,South Glasgow
* FINAL REPORT *

Specimen: Groin swab

MRSA culture MRSA NOT ISOLATED

Endometrial Biopsy (A)

Performed	30-Nov-2019 10:27	Received	02-Dec-2019 12:39
Reported	06-Dec-2019 12:07	Order Number	D,19.0090894.Z
Status	Final	Source System	Telepath

Pathology Final

NHS GREATER GLASGOW AND CLYDE
PATHOLOGY DEPARTMENT ENQUIRIES TO: 0141-354-9487 (89487)

Date collected: 30.11.2019
Date received : 02.12.2019 Date reported: 06.12.2019

Reporting Pathologist : David Millan
Consultant Pathologist: David Millan

CLINICAL HISTORY

Unscheduled bleeding on combined HRT.

PIPELLE BIOPSY OF ENDOMETRIUM
MICRO:
There are piece of proliferating endometrium and other pieces of shedding endometrium. There is no evidence of either neoplasia or hyperplasia.

Dr David Millan, Consultant

Dictated: 06/12/19
Typed: 06/12/19 LI

SARS-CoV-2 View Cumulative Results

Collected	12-Nov-2021 11:16	Received	
Reported	12-Nov-2021 11:16	Order Number	AAM72072298
Status	Final	Source System	MasterLab

Test	Result	Ref. Range (Units)	Abnormality
SARS-CoV-2	[a] SARS-CoV-2 Negative by PCR		

* Abnormal ** Critically Abnormal

[a] Sample taken at VRH and analysed in the National Lighthouse Laboratory

SARS-CoV-2 View Cumulative Results

Collected	18-Aug-2021 15:01	Received	
Reported	18-Aug-2021 15:01	Order Number	AAM67273624
Status	Final	Source System	MasterLab

Test	Result	Ref. Range (Units)	Abnormality
SARS-CoV-2	[a] SARS-CoV-2 Negative by PCR		

* Abnormal ** Critically Abnormal

[a] Sample taken at VRH and analysed in the National Lighthouse Laboratory

MEDICINE **PRESCRIPTION FORM** Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date_____ Name (Print)_____

Discharge Prescription Prepared & Reconciled YES ☐

Date_____ Name (Print)_____

Date and time this form prepared:	Sheet No	2nd Prescription in use
___/___/___ Time:_____	.....	YES☐ NO☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions:_____

Print & Sign:_____ Date:_____

COMMUNITY PHARMACY INFORMATION

Name_____ Tel No._____

Address_____

Compliance Aid Details_____

Patient consent to share discharge information Y/N

Print & Sign_____

PATIENT DETAILS

Hospital Number:	Height:
DOB:	Weight:
Date of Admission: ___/___/___	Surface area:
Consultant Name:	Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

DATE →

MONTH →

RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

A

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

B

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

C

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

H DRUG: PARACETAMOL

DOSE: 1g | ROUTE: O | DATE: 12/11/15 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

J DRUG: IBUPROFEN

DOSE: 400mg | ROUTE: O | DATE: 12/11/15 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: WITH FOOD

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

K DRUG:

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

L DRUG:

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Patient's Own Medicine
For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N.
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

All Routes: As Required Prescriptions

Patient's Own Medicine

BEFORE ADMISSION		DRUG			STOPPED	DATE																									For Use Y/N
☐	LL	PARACETAMOL				12/11	DATE	12/11																								Qty:
NEW DOSE ☐	DOSE 1 GRAM	ROUTE O	INDICATION PAIN			INITIALS:	TIME	1600																								Date:
	PRESCRIBER (PRINT & SIGN)		MAX.FREQ. 6°	DATE: 11/11			DOSE	1G																								Assessed by:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						GIVEN BY	[illegible]																								Ordered from Pharm.
BEFORE ADMISSION		DRUG			STOPPED	DATE																									For Use Y/N
☐	MM	FENTANYL.					DATE	12/11	12/10																						Qty:
NEW DOSE ☐	DOSE AS PROTOCOL	ROUTE IV	INDICATION PAIN			INITIALS:	TIME	14	10 14	30																					Date:
	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE: 12/11			DOSE	40	mcg 40	mcg																					Assessed by:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						GIVEN BY	[illegible]	[illegible]																						Ordered from Pharm.
		& RECOVERY ONLY +.																													
BEFORE ADMISSION		DRUG			STOPPED	DATE																									For Use Y/N
☐	NN	ONDANSETRON					DATE																								Qty:
NEW DOSE ☐	DOSE 4mg	ROUTE IV	INDICATION PONV			INITIALS:	TIME																								Date:
	PRESCRIBER (PRINT & SIGN)		MAX.FREQ. 8°	DATE: 12/11			DOSE																								Assessed by:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						GIVEN BY																								Ordered from Pharm.
BEFORE ADMISSION		DRUG			STOPPED	DATE																									For Use Y/N
☐	PP	CYCLIZINE					DATE																								Qty:
NEW DOSE ☐	DOSE 50mg	ROUTE SLOW IV	INDICATION PONV			INITIALS:	TIME																								Date:
	PRESCRIBER (PRINT & SIGN)		MAX.FREQ. 8°	DATE: 12/11.			DOSE																								Assessed by:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						GIVEN BY																								Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Patient's Own Medicine

| | | |

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Print & Sign your full name clearly against each prescription entry.
4. Time should be recorded in 24hr format e.g. 0600, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused
(4) Drug not available
(5) Nil by mouth/fasting
(6) Patient unavailable
(7) Patient asleep
(8) Time varied on doctor's instructions
(9) Dose withheld on doctor's instructions
(10) Nausea/vomiting
(11) Unable to swallow
(12) No intravenous access
(13) Patient Self-Administration of Medicine
(14) Other - Record in nursing notes
(15) Prescription clarification required

Cat. No. 40995 Ver 4, 09/2010

Full Blood Count View Cumulative Results

Time Collected	11-Nov-2015 21:10	Time Received	11-Nov-2015 21:23
Time Reported	11-Nov-2015 22:23	Order Number	B,15.2610792.B
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	8.3	4.0 - 11.0 x10^9/l (x10^9/l)	
Red Cell Count	4.21	3.80 - 5.80 x10^12/l (x10^12/l)	
Haemoglobin	138	115 - 165 g/l (g/l)	
Haematocrit	0.423	0.370 - 0.470 l/l (l/l)	
Mean Cell Volume	* 100.5	80.0 - 100.0 fl (fl)	+
MCH	* 32.8	27.0 - 32.0 pg (pg)	+
Platelet Count	209	150 - 400 x10^9/l (x10^9/l)	
Neutrophils	4.4	2.0 - 7.5 x10^9/l (x10^9/l)	
Lymphocytes	3.0	1.5 - 4.0 x10^9/l (x10^9/l)	
Monocytes	0.6	0.2 - 0.8 x10^9/l (x10^9/l)	
Eosinophils	0.3	0.0 - 0.4 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Not in use

Urea & Electrolytes View Cumulative Results

Time Collected	11-Nov-2015 21:10	Time Received	11-Nov-2015 21:29
Time Reported	11-Nov-2015 22:13	Order Number	B,15.2611751.S
Status	Final	Source System	Telepath
Comments	(NA) Specimen haemolysed, result invalid. REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	135	133 - 146 mmol/L (mmol/L)	
Potassium	[a] NA		
Chloride	* 110	95 - 108 mmol/L (mmol/L)	+
Urea	6.6	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	77	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Not in use

[a] Haemolysed

C-reactive Protein View Cumulative Results

Time Collected	11-Nov-2015 21:10	Time Received	11-Nov-2015 21:29
Time Reported	11-Nov-2015 22:13	Order Number	B,15.2611751.S
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	<1	0 - 10 mg/L (mg/L)	

* Abnormal ** Not in use

Patient Agreement to Investigation or Treatment
Consent Form

NHS Greater Glasgow and Clyde

Patient details (or pre-printed label)

Hospital / clinic / GP practice

Patient's surname / family

Patient's first name

2704716161 F
ROBERTS 27/04/1971
Tracy
263 Curtis Ave
Glasgow, Lanarkshire G44 4NW

Date of birth

Gender Male ☐ Female ☐

CHI number

Special requirements (e.g. other language / communication method)

Statement for practitioner
(to be filled in by practitioner with appropriate knowledge of proposed procedure)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side (write in full).

RIGHT HAND WOUND EXPLORATION WASHOUT +/- TENDON REPAIR +/- CLOSURE

Specific risks / complications
Please detail any specific risk/complications related to the procedure that were discussed.

Extended wounds
Neurovascular injury

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). I have explained who will be doing the procedure if not myself.

Signature of practitioner

Name / Designation (print) CMRA ST3

Date 11/11/15

00526

Statement to be completed by patient / parent*
(*parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- The procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- Who will be performing my procedure on the day
- 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 to the following	**Agree**	**Disagree**
to photographic images and video recordings being held in records, and made available for teaching, audit and ethically-approved research purposes, to improve the quality of patient care.	☑	☐
that surplus tissue or other biological material not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☑	☐

Patient / parent agreement to treatment

Signature [signature]	Date 11/11/15
Name (print)	

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
Signature of practitioner	Date

Pathfinder SL — Roberts, Tracy

New Victoria Hospital — Confirmed — 3 Lead Holter Report

Patient ID:	2704716161	Date of Birth: Tue 27 Apr 1971	(53 years)	Gender: Female	
Patient ID2:				Analyzed Length:	21 hr 11 min 33 sec, 0.3% artifact
Patient ID3:				Recorder No.:	00023781
National ID:				Recorded:	Mon 13/01/2025 10:18:00
Insurance Number:		Ward:		Analysis Date:	Tue 28 Jan 2025
Hospital / Practice:	New Victoria Hospital	Order:		Analysis Channels:	1,2,3 from 3 channels
Referring Physician:	Dr Corcoran	Case:		Analysis Technician:	G Docherty
Patient details at time of test		Height:		Weight:	

Beats

Normal		VE Beats		SVE Beats		Paced Beats	
Count	98,989	Count	1	Count	271	Count	0
Percent	>99%	Percent	<1%	Percent	<1%	Percent	0%
Max/Hour	5,595 on Tue 14, 00:00	Max/Hour	1 on Mon 13, 12:00	Max/Hour	75 on Mon 13, 19:00	Max/Hour	0
Average/Hour	4,671	Average/Hour	0	Average/Hour	13	Average/Hour	0

Rate Dependent Events

Heart Rates (1 min avg)		Bradycardia	0	Tachycardia	91
Max HR	123 bpm on Mon 13, 20:37	Total		Total	46 min 56 sec, 3.7%
Mean HR	78 bpm	Longest		Longest	686 beats on Tue 14, 00:53
Min HR	60 bpm on Mon 13, 15:37	Min Rate		Max Rate	133 bpm on Tue 14, 01:04
Mean HR (Day)	76 bpm (07:00:00 - 23:00:00)				
Mean HR (Night)	81 bpm (23:00:00 - 07:00:00)				

Pause 0

Ventricular Arrhythmias

VT	0, 0.0% of total beats (0 per 1000)
Longest	
Max Rate	
V-Run/AIVR	0, 0.0% of total beats (0 per 1000)
Longest	
Max Rate	
Couplet	0, 0.0% of total beats (0 per 1000)
Triplet	0, 0.0% of total beats (0 per 1000)
Single VE Events	1, 0.0% of total beats (0 per 1000)

Supraventricular Arrhythmias

SVT	0
Longest	
Max Rate	
SVE Run	0, 0.0% of total beats
Longest	
Max Rate	
SVE	194, 0.2% of total beats (1 per 1000)

Indications (reason for test) :

?AV BLOCK, Daytime Wenckebach, also presyncope whilst laughing.

Findings :

Referral Reason

Daytime Wenckebach, also presyncope whilst laughing. ? AV block

24 hr monitor
Sinus rhythm throughout recording
Episodes of Wenckebach, non-conducted SVEs and retrograde p waves noted
1 VE
Few SVEs
Max HR 123 bpm
Min HR 60 bpm
Nothing noted in patient diary

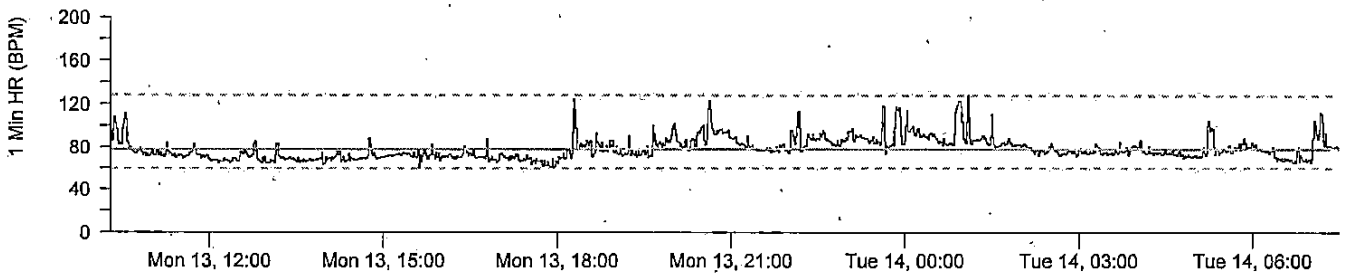
Gillian Docherty
Senior Cardiac Physiologist
NVH

Operator Signature ..... Doctor Signature .....

Signed By: Gillian Docherty (NVH) on 28/01/2025 13:48:42

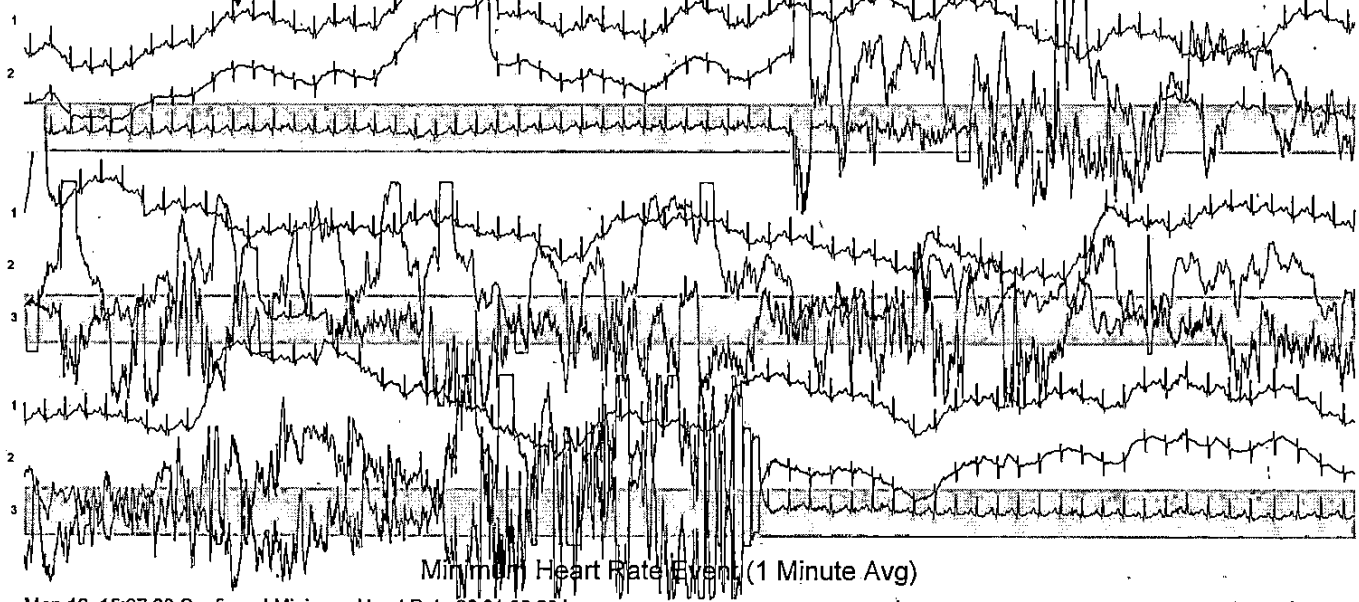
Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

Overall Heart Rate



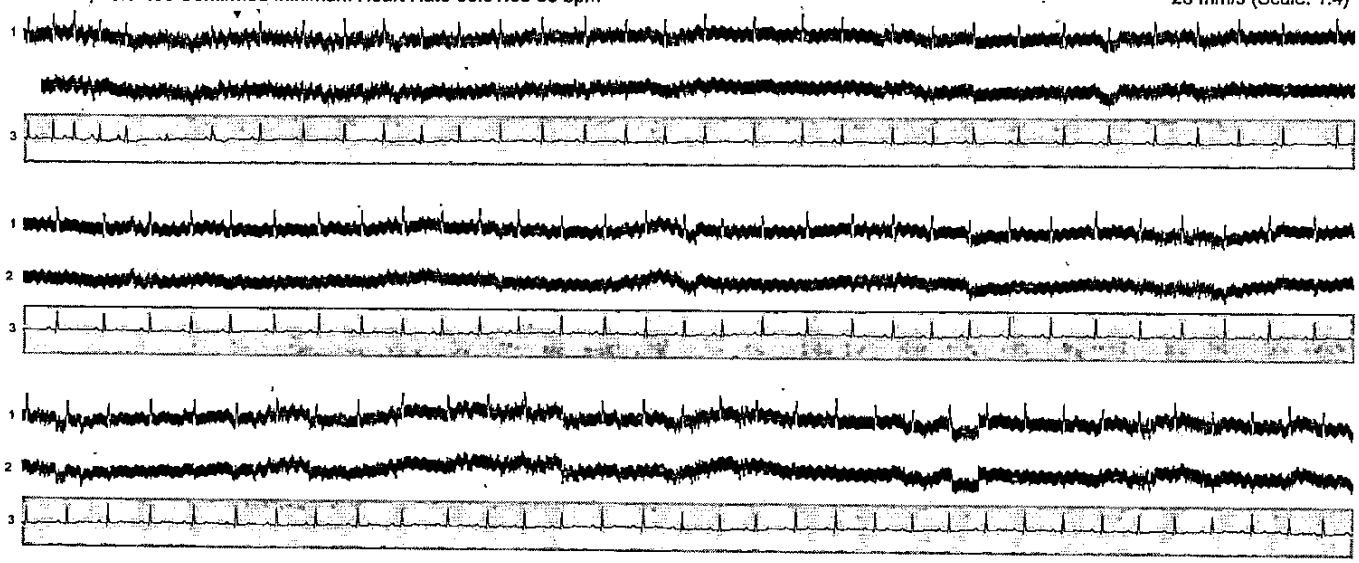
Maximum Heart Rate Event (1 Minute Avg)

Mon 13, 20:37:00 Confirmed Maximum Heart Rate 00:01:00 123 bpm — 25 mm/s (Scale: 1:4)



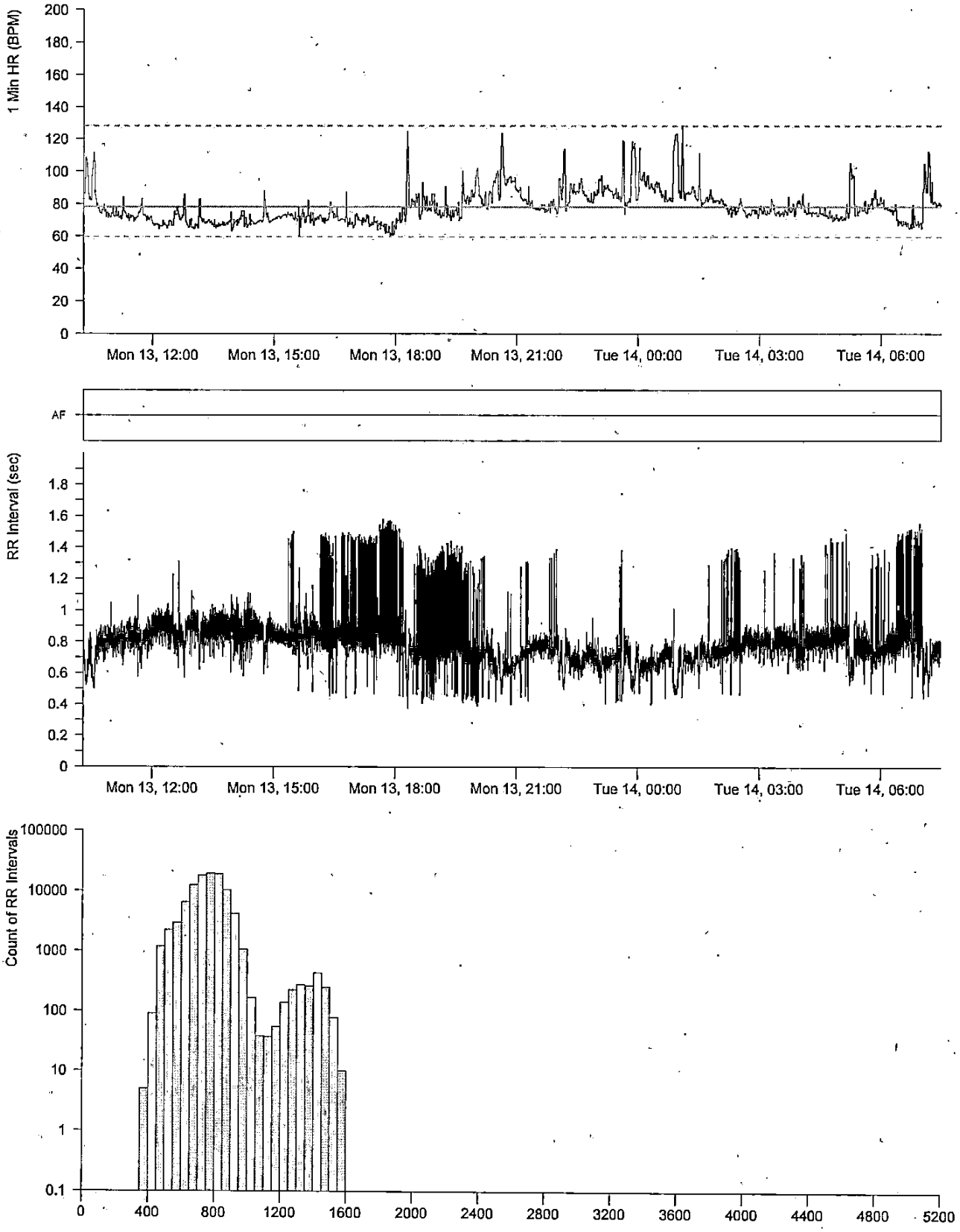
Minimum Heart Rate Event (1 Minute Avg)

Mon 13, 15:37:00 Confirmed Minimum Heart Rate 00:01:00 60 bpm — 25 mm/s (Scale: 1:4)



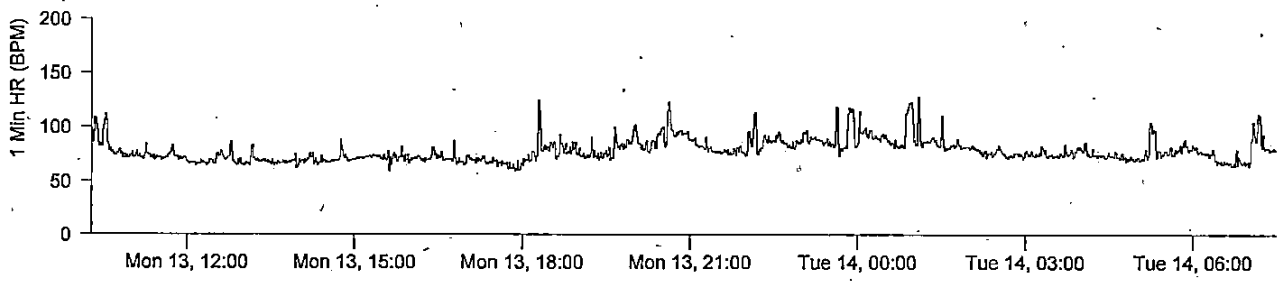
Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

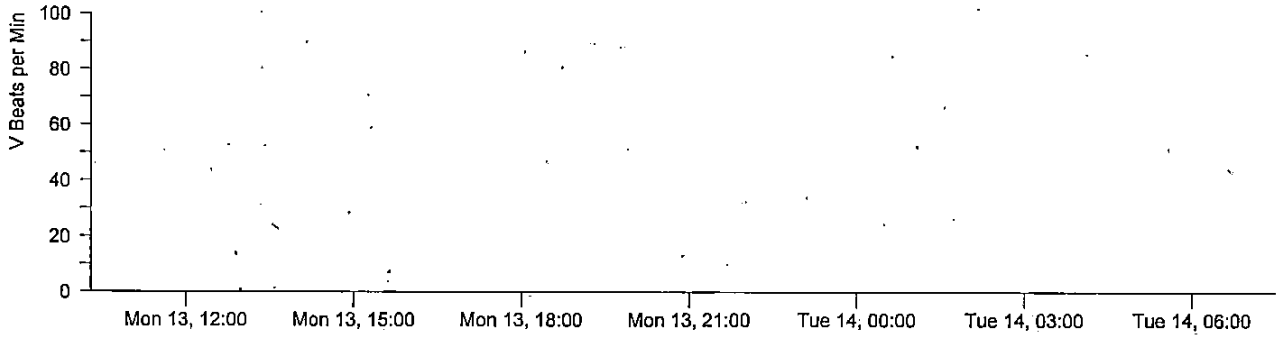
Graphs



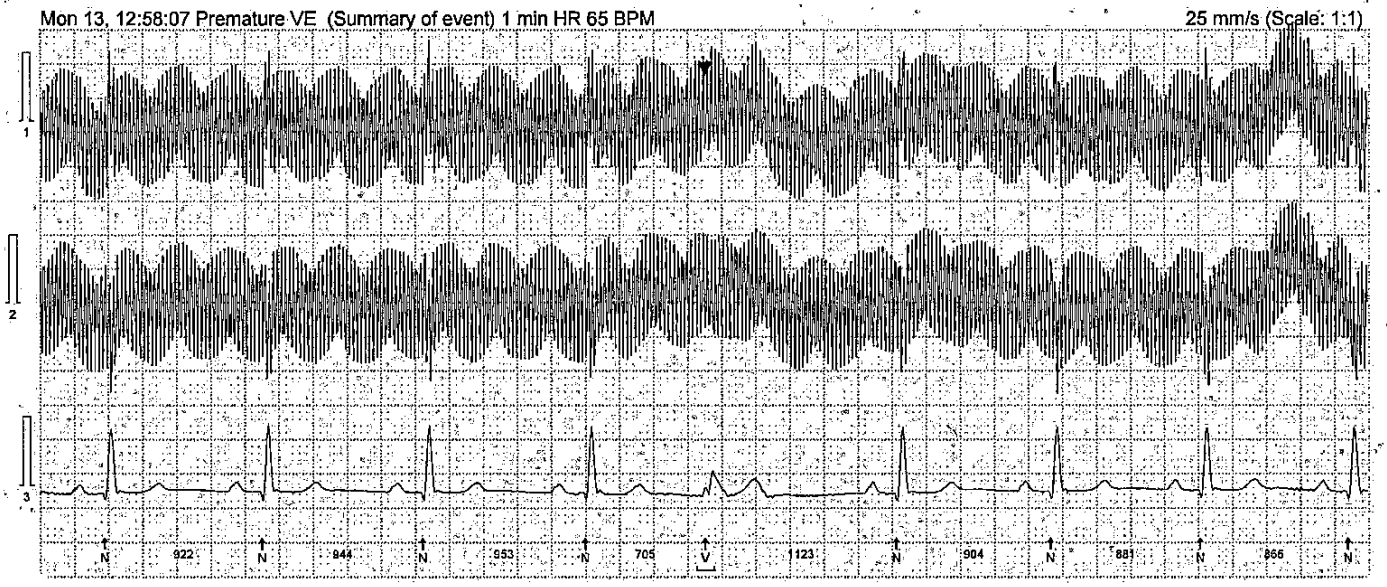
Signed By: Gillian Docherty (NVH) on 28/01/2025 13:48:42

Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

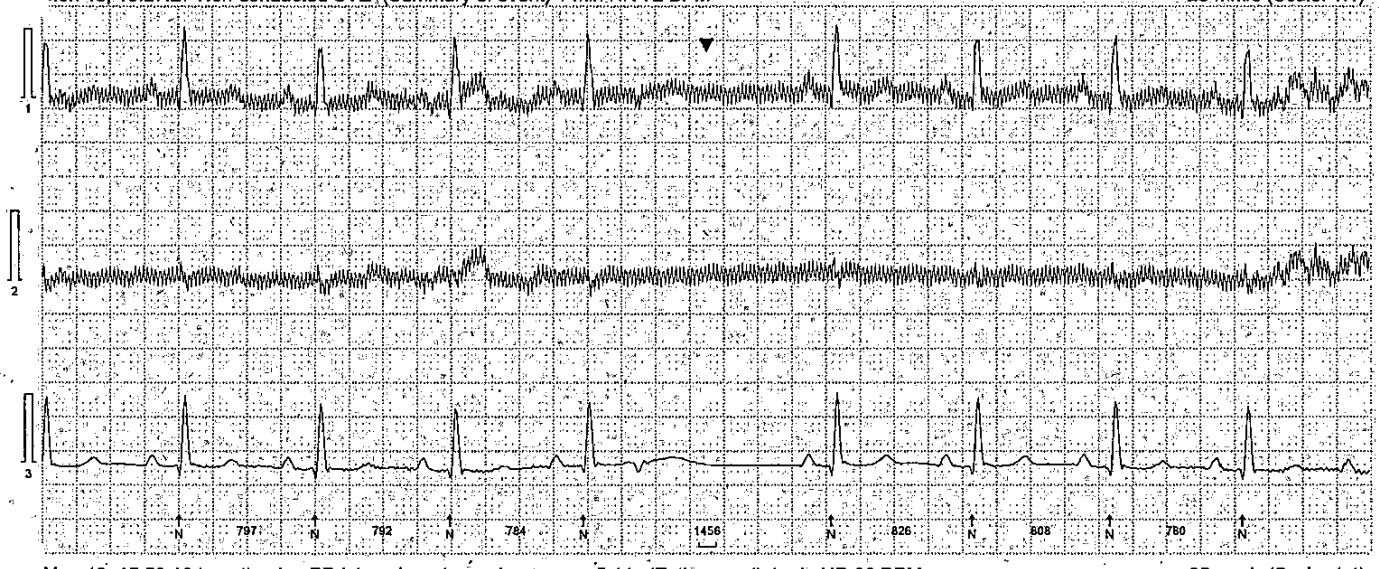




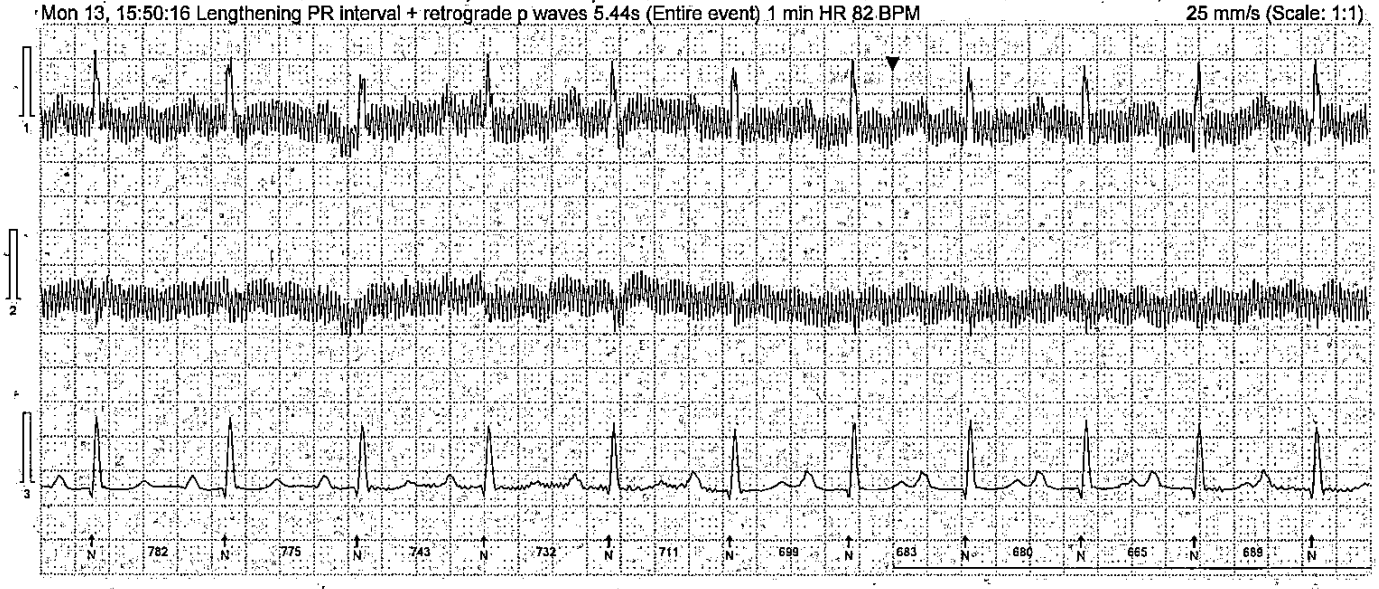
Mon 13, 12:58:07 Premature VE (Summary of event) 1 min HR 65 BPM — 25 mm/s (Scale: 1:1)



Mon 13, 15:27:27 Non-conducted SVE (Summary of event) 1 min HR 72 BPM — 25 mm/s (Scale: 1:1)



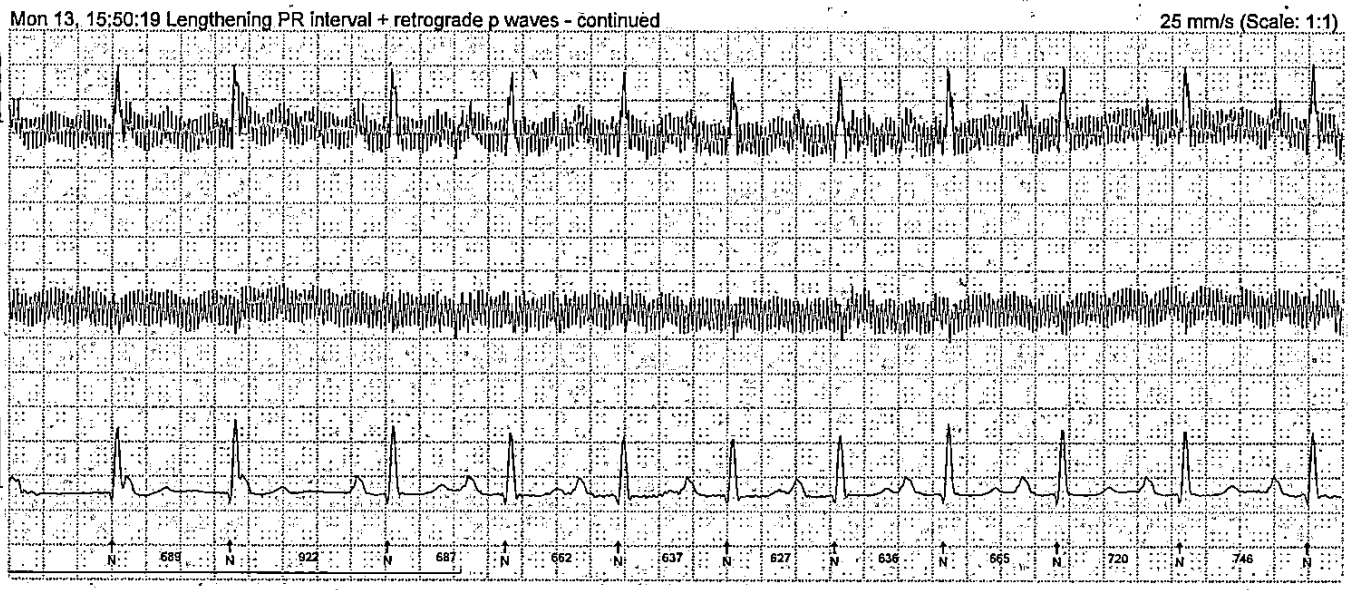
Mon 13, 15:50:16 Lengthening PR interval + retrograde p waves 5.44s (Entire event) 1 min HR 82 BPM — 25 mm/s (Scale: 1:1)



Signed By: Gillian Docherty (NVH) on 28/01/2025 13:48:42

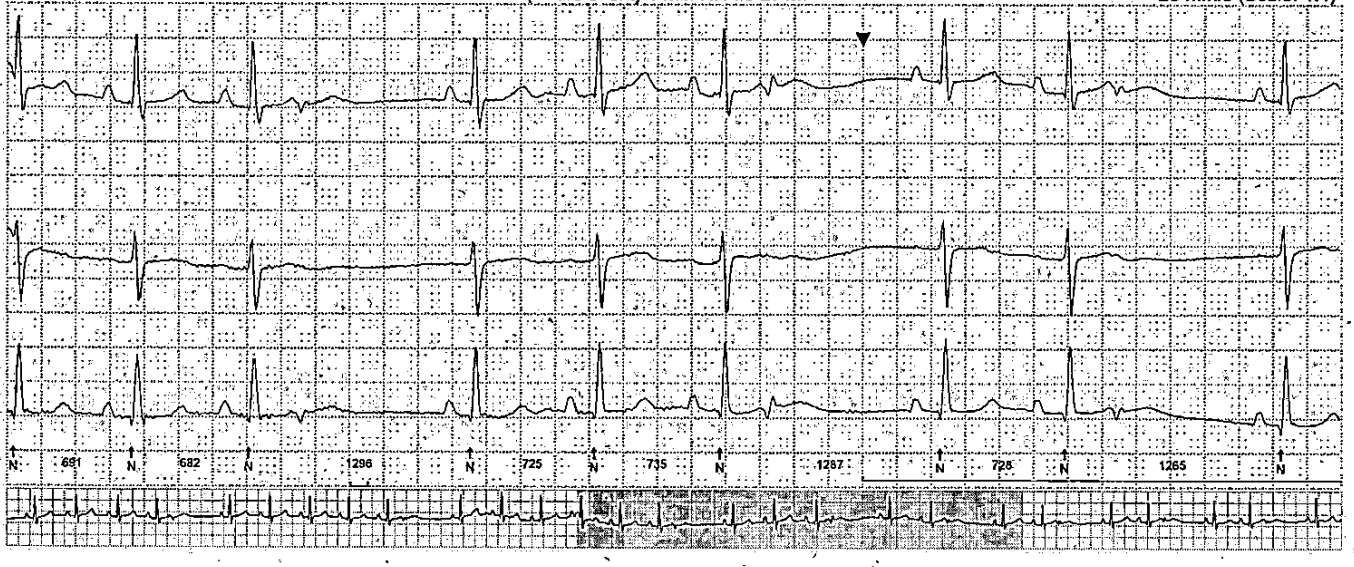
Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

Mon 13, 15:50:19 Lengthening PR interval + retrograde p waves - continued 25 mm/s (Scale: 1:1)



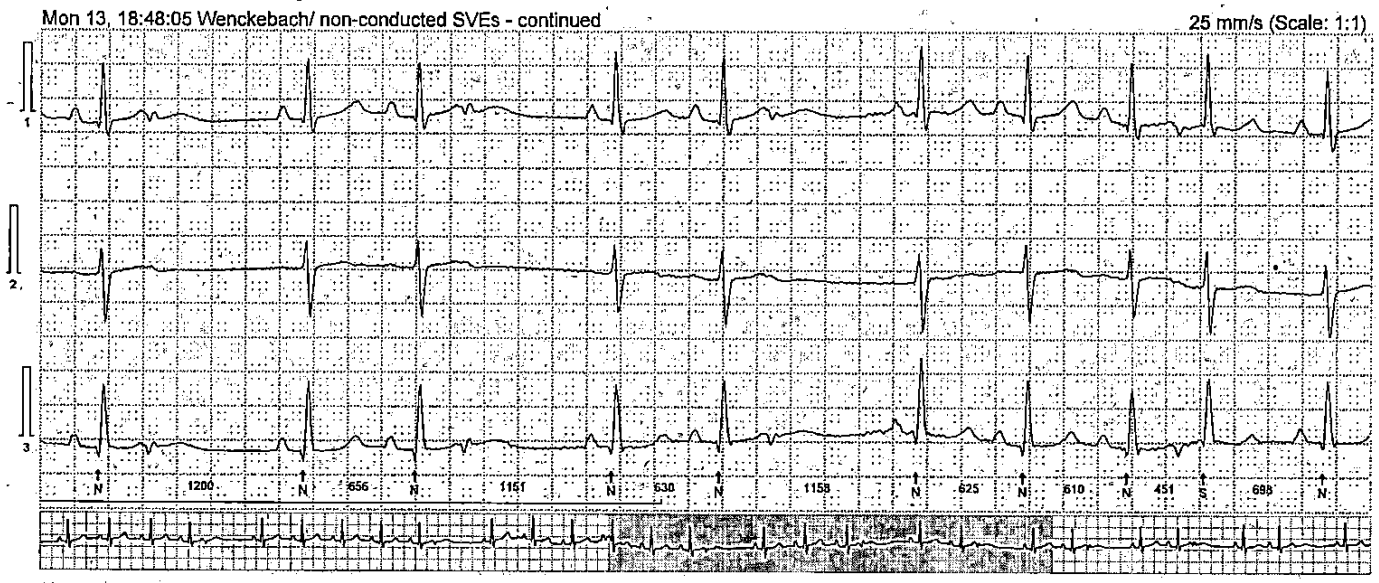
Mon 13, 17:00:14 Non-conducted SVE (Summary of event) 1 min HR 73 BPM 25 mm/s (Scale: 1:1)

Mon 13, 18:48:02 Wenckebach/ non-conducted SVEs 6.44s (Entire event) 1 min HR 76 BPM 25 mm/s (Scale: 1:1)

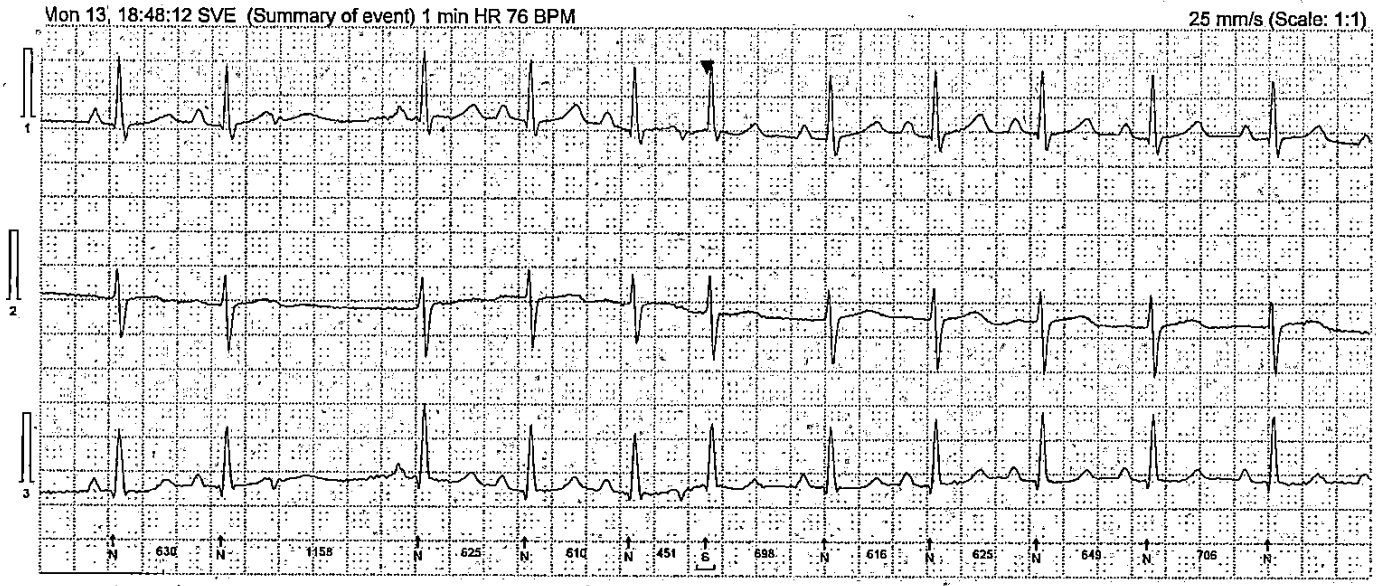


Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

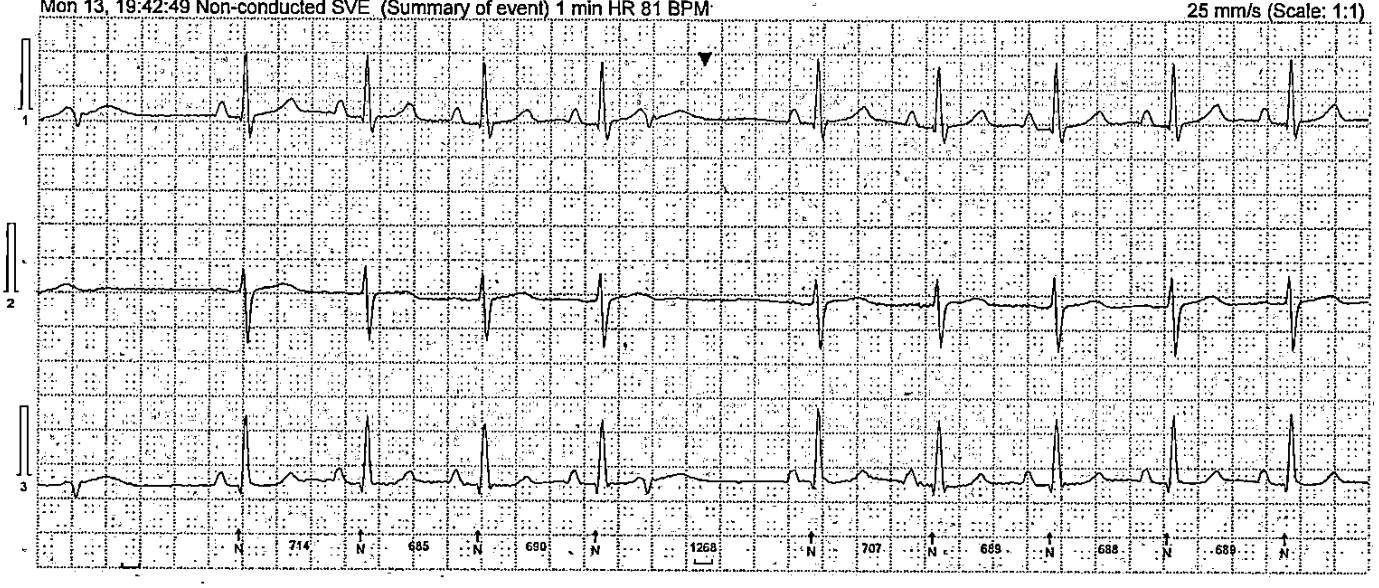
Mon 13, 18:48:05 Wenckebach/ non-conducted SVEs - continued 25 mm/s (Scale: 1:1)



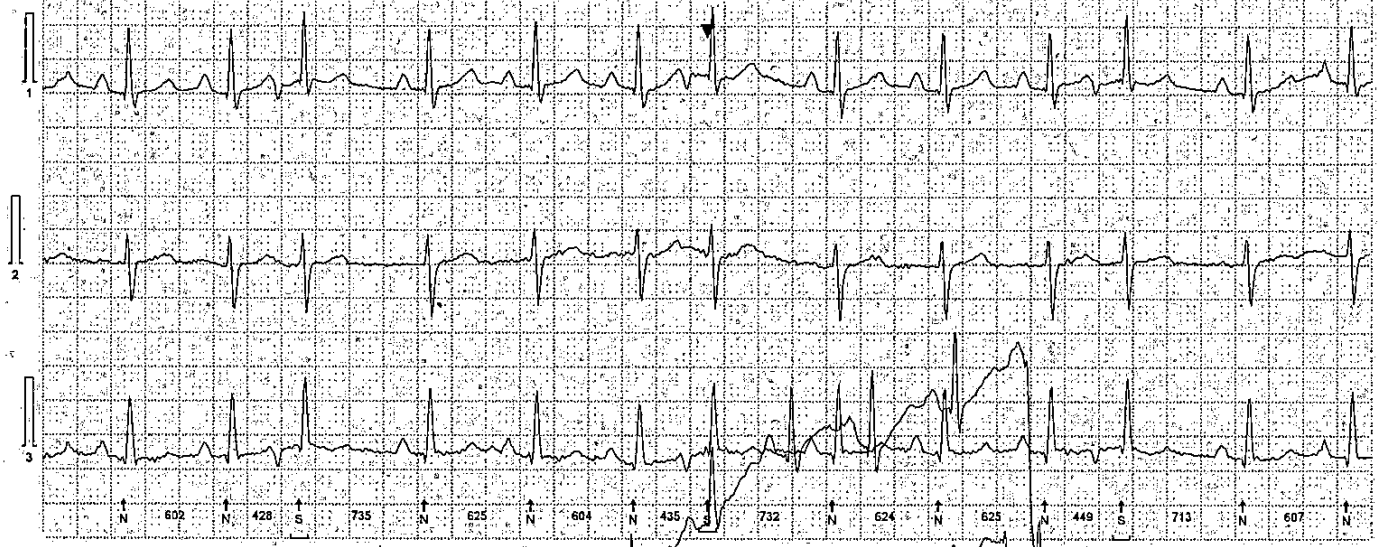
Mon 13, 18:48:12 SVE (Summary of event) 1 min HR 76 BPM 25 mm/s (Scale: 1:1)



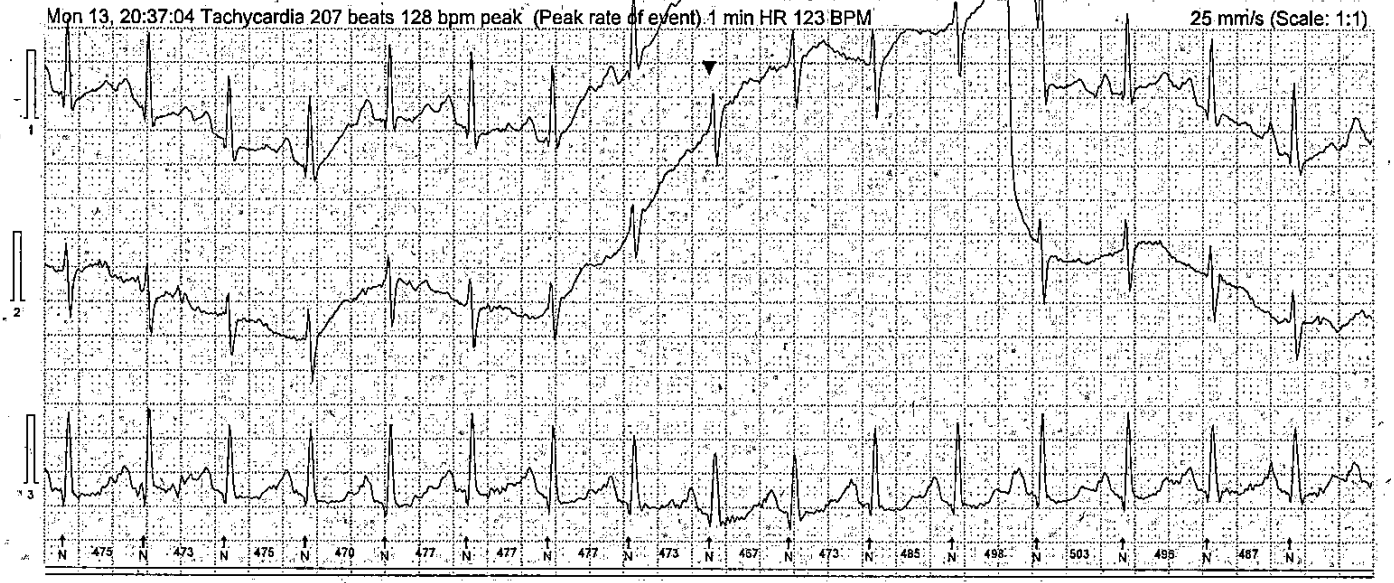
Mon 13, 19:42:49 Non-conducted SVE (Summary of event) 1 min HR 81 BPM 25 mm/s (Scale: 1:1)



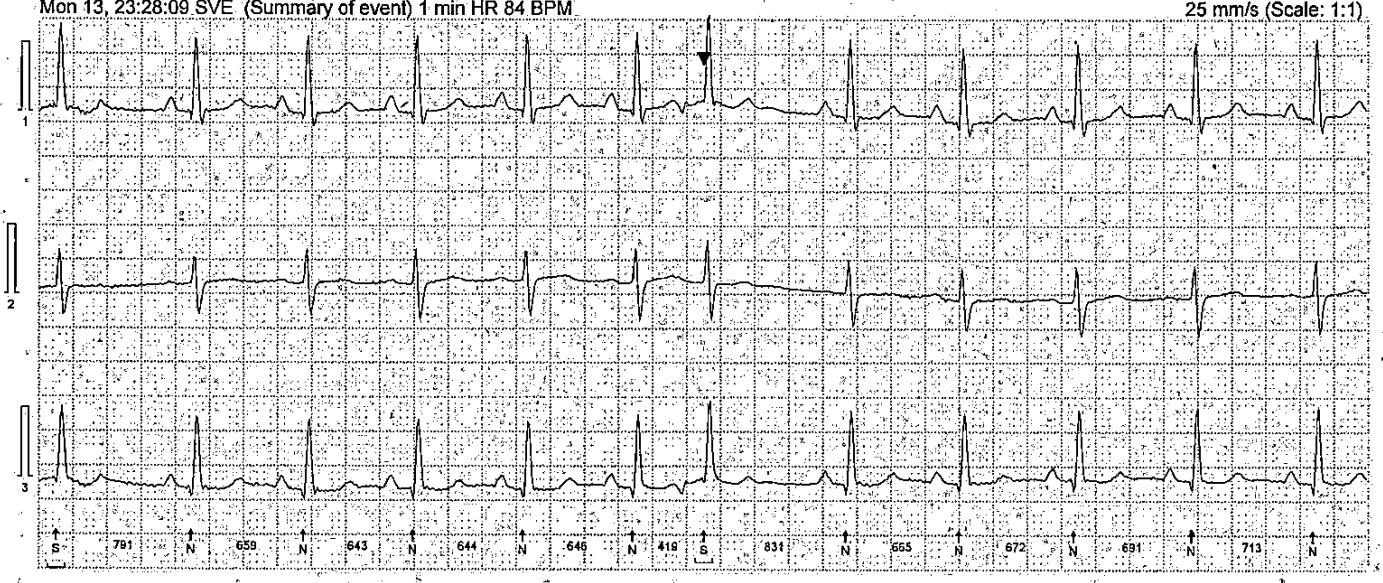
Mon 13, 19:59:16 SVE (Summary of event) 1 min HR 97 BPM
25 mm/s (Scale: 1:1)



Mon 13, 20:37:04 Tachycardia 207 beats 128 bpm peak (Peak rate of event) 1 min HR 123 BPM
25 mm/s (Scale: 1:1)

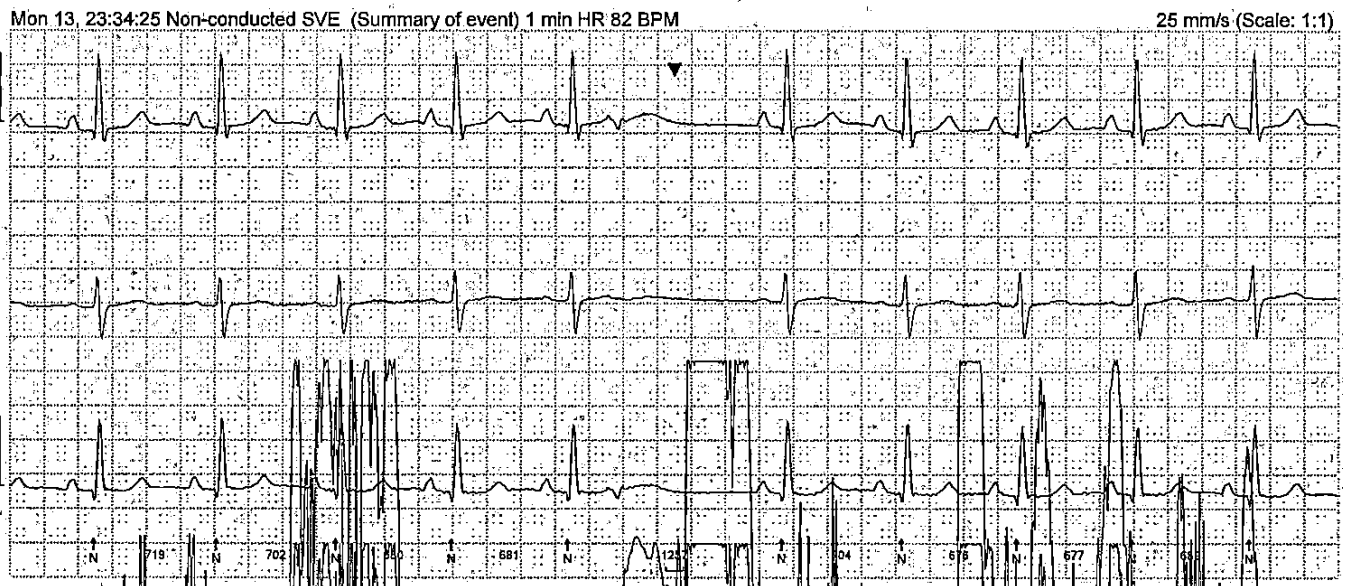


Mon 13, 23:28:09 SVE (Summary of event) 1 min HR 84 BPM
25 mm/s (Scale: 1:1)

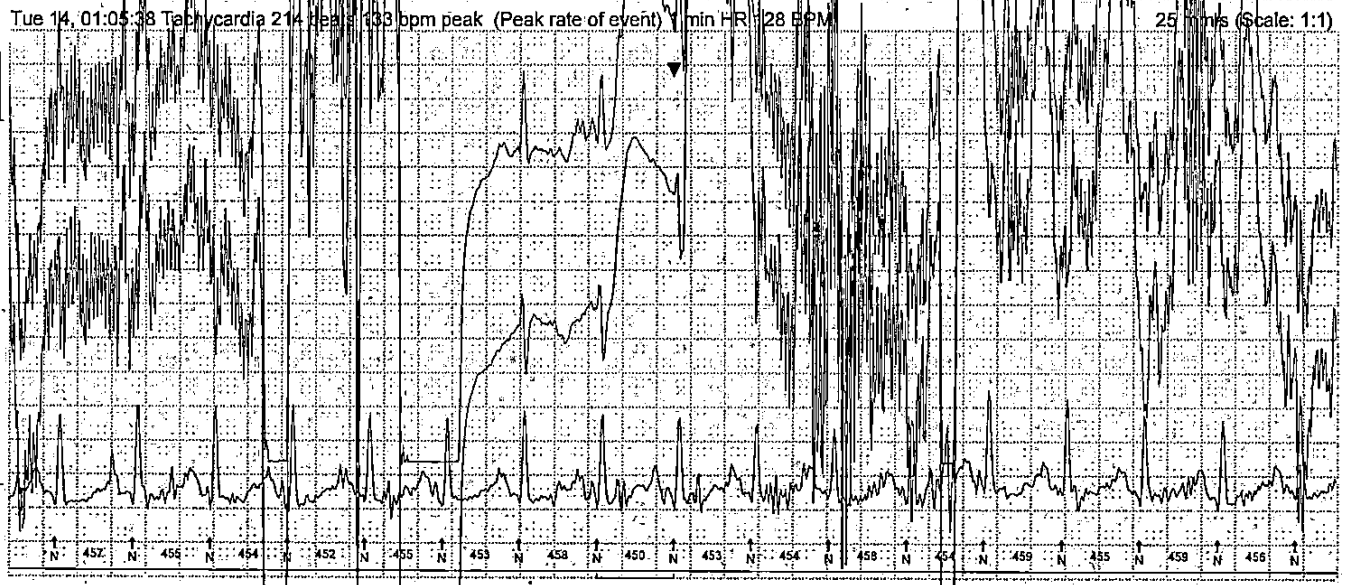


Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

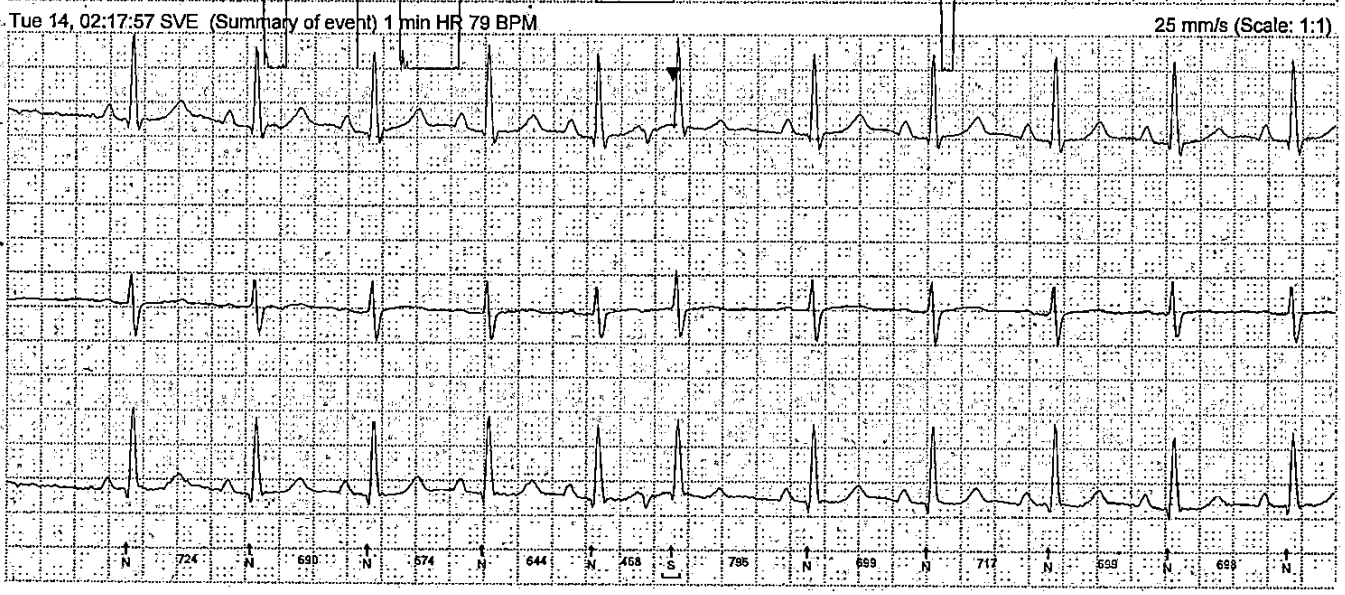
Mon 13, 23:34:25 Non-conducted SVE (Summary of event) 1 min HR 82 BPM 25 mm/s (Scale: 1:1)



Tue 14, 01:05:38 Tachycardia 214 beats 133 bpm peak (Peak rate of event) 1 min HR 128 BPM 25 mm/s (Scale: 1:1)



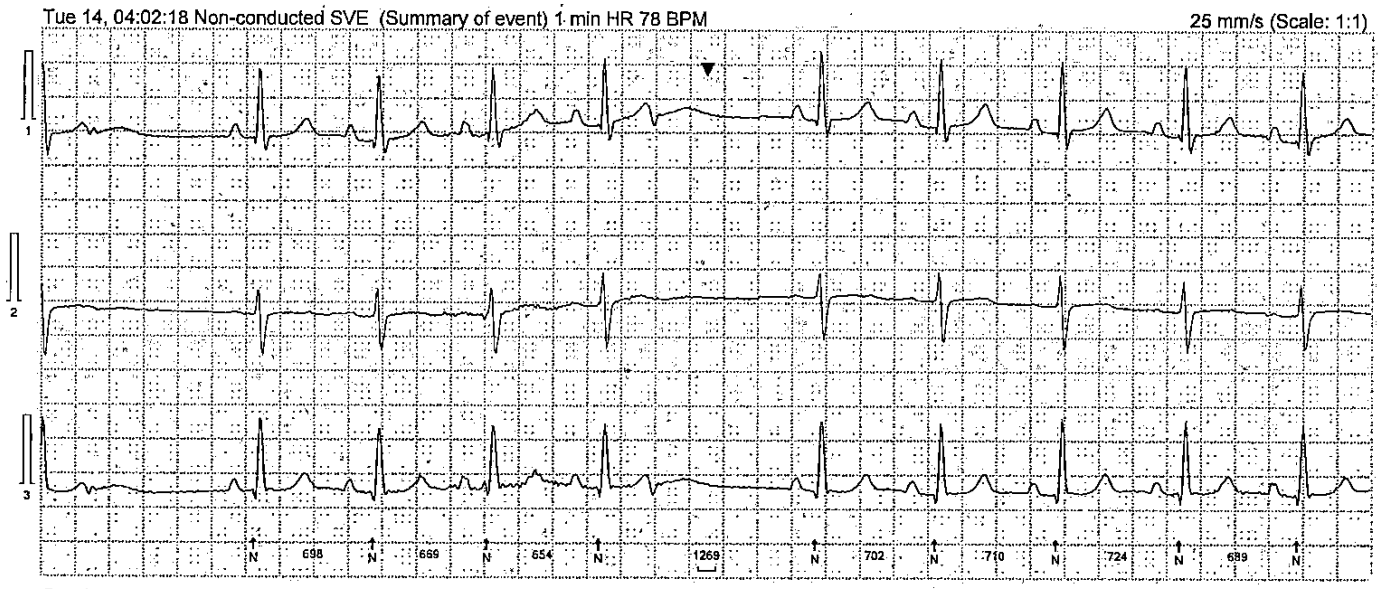
Tue 14, 02:17:57 SVE (Summary of event) 1 min HR 79 BPM 25 mm/s (Scale: 1:1)



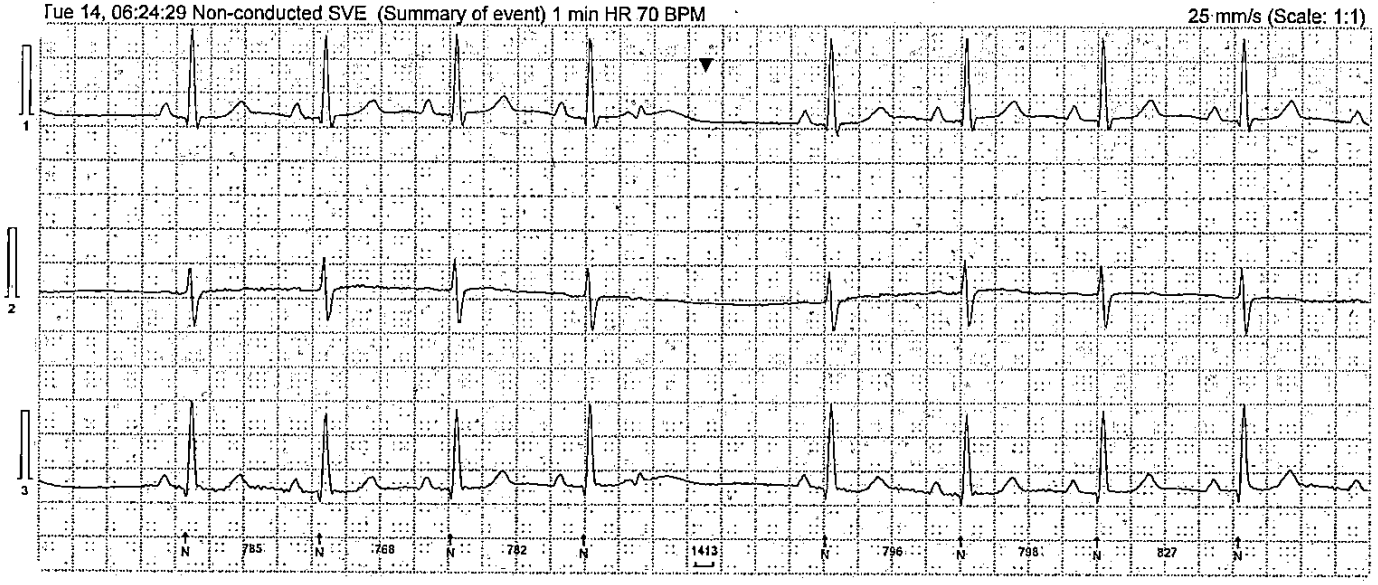
Signed By: Gillian Docherty (NVH) on 28/01/2025 13:48:42

Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

Tue 14, 04:02:18 Non-conducted SVE (Summary of event) 1 min HR 78 BPM 25 mm/s (Scale: 1:1)



Tue 14, 06:24:29 Non-conducted SVE (Summary of event) 1 min HR 70 BPM 25 mm/s (Scale: 1:1)



Signed By: Gillian Docherty (NVH) on 28/01/2025 13:48:42

Generated On Tue 28/01/2025 13:48:20

Pathfinder SL — Roberts, Tracy

Confirmed

2 Lead Holter Report

Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

National ID: Case: Recorded: Fri 12/07/2024 09:24:00
Hospital / Practice: Order: Analyzed Length: 2 day 22 hr 9 min 6 sec, 10.2% artifact
Referring Doctor: Dr Jackson Ward: Analyzed by: , Wed 09 Oct 2024

Indications (reason for test) :
RECENT SYNCOPE, ?ARRHYTHMIA

Beats

Beats	Total	Normal		Ventricular		Supraventricular		Paced	
Count	342,937	341,214	99%	16	<1%	1,707	<1%	0	0%
Max/Hour		7,341	Sat 13, 18:00	6	Sun 14, 12:00	333	Sat 13, 22:00	0	

Intervals:							
	RR Interval	Longest	2.18 s	(Sat 13, 06:12:12)	Shortest	317 ms	(Sun 14, 14:10:15)
	NN Interval	Longest	2.18 s	(Sat 13, 06:12:12)	Shortest	374 ms	(Sat 13, 18:10:01)

Heart Rates

Heart Rates (1 min avg)	Rate (bpm)	Time
Max	148	Sat 13, 17:56
Min	59	Fri 12, 13:21
Mean	90	
Mean HR (Day)	92	07:00:00 - 23:00:00
Mean HR (Night)	89	23:00:00 - 07:00:00

Rate Dependent Events

Rate Dependent Events	Count	Most Severe Rate (bpm)	Longest (beats / secs)
Pause	2	-	2.18 secs : Sat 13, 06:12
Dropped Beat	1,477	-	-
Bradycardia	2	32 : Sat 13, 06:12	5 beats : Fri 12, 13:21
Tachycardia	982	155 : Sat 13, 17:56	3433 beats : Sat 13, 19:34

Ventricular Arrhythmias

Ventricular Beats : 16 (<1%) Max/Hour : 6 (Sun 14, 12:00) Max/Minute: 4 (Sun 14, 12:35) Average/Hour : 0

Event	Event Count	V Beat Count	% V Beats	% Total Beats	Per 1000	Max Rate (bpm)	Longest (beats / cycles)
VT	0	0	0%	0%	0		
V-Run/AIVR	0	0	0%	0%	0		
IVR	0	0	0%	0%	0		
Triplet	0	0	0%	0%	0	-	-
Couplet	3	6	38%	<1%	0	-	-
Bigeminy	0	0	0%	0%	-	-	-
Trigeminy	0	0	0%	0%	-	-	-
Single VE Events	10	10	63%	<1%	0	-	-

Supraventricular Arrhythmias

Supraventricular Beats : 1,707 (<1%) Max/Hour : 333 (Sat 13, 22:00) Max/Minute: 20 (Sat 13, 21:50) Average/Hour : 24

Event	Event Count	SV Beat Count	% SV Beats	% Total Beats	Per 1000	Max Rate (bpm)	Longest (beats)
SVT	0	0	0%	0%	0		
SVE Run	0	0	0%	0%	0		
SVE Couplet	12	17	<1%	<1%	0	-	-
Single SVE Events	1694	1694	99%	<1%	4	-	-

Findings :

3 day ambulatory ECG report: poor quality recording.

Sinus rhythm / tachycardia, mean HR 90 bpm.
Pauses and dropped beats correlate with non-conducted SVE's and 2nd degree AVB Wenckebach and Mobitz II;
Bradycardia episodes correlate with short run of 2:1 conductions, longest 5 circles.
Longest R-R 2.18s @ 06:12.

16 x VE's with couplet's.
Occasional SVE's.

Min HR 59 bpm @ 13:21.
Max HR 148 bpm @ 17:56.

No symptoms reported in diary.

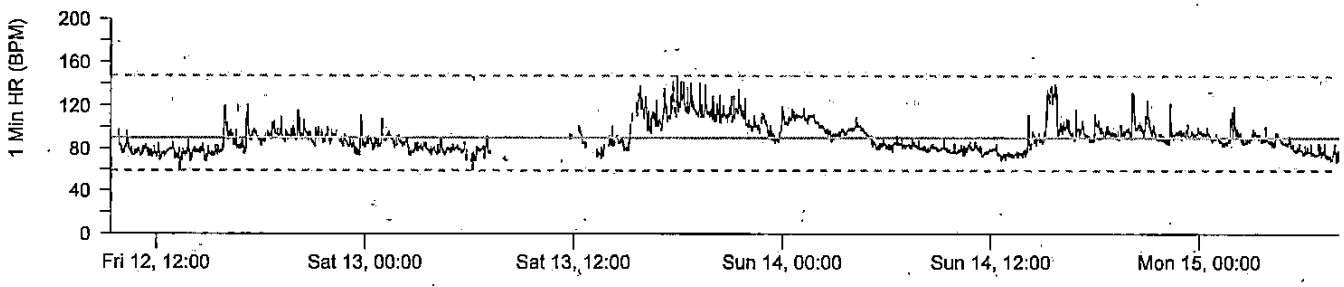
Locum CP MH.

Operator Signature ..... Doctor Signature .....

Signed By: Mingwang (Michael) Ho (WGACH) on 09/10/2024 16:17:02

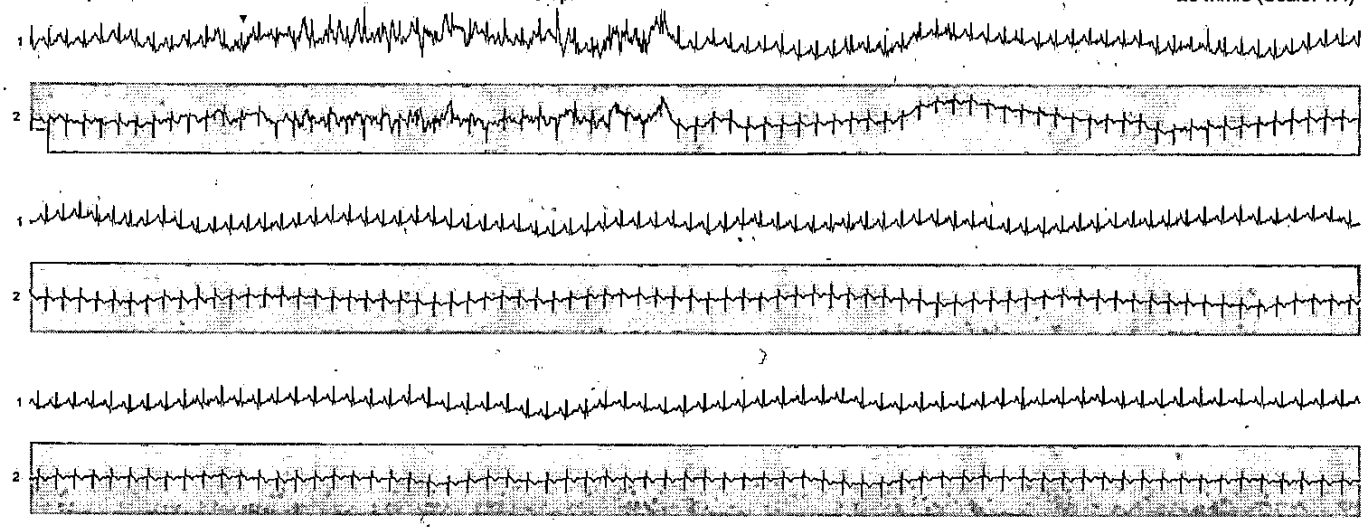
Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

Overall Heart Rate



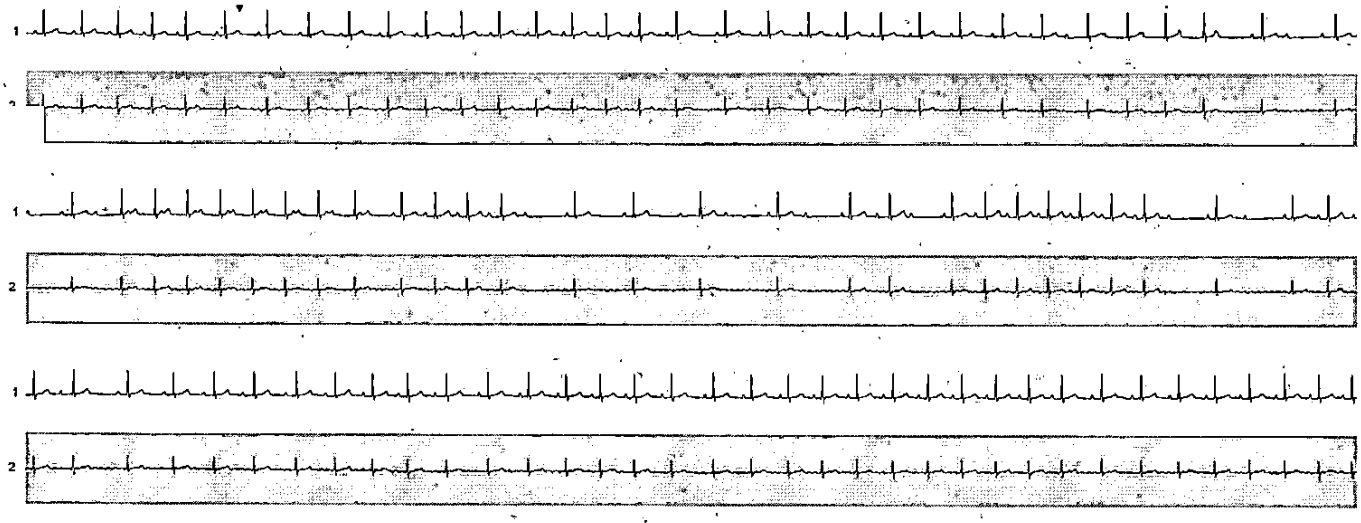
Maximum Heart Rate Event (1 Minute Avg)

Sat 13, 17:56:00 Printed Maximum Heart Rate 00:01:00 148 bpm 25 mm/s (Scale: 1:4)



Minimum Heart Rate Event (1 Minute Avg)

Fri 12, 13:21:00 Printed Minimum Heart Rate 00:01:00 59 bpm 25 mm/s (Scale: 1:4)

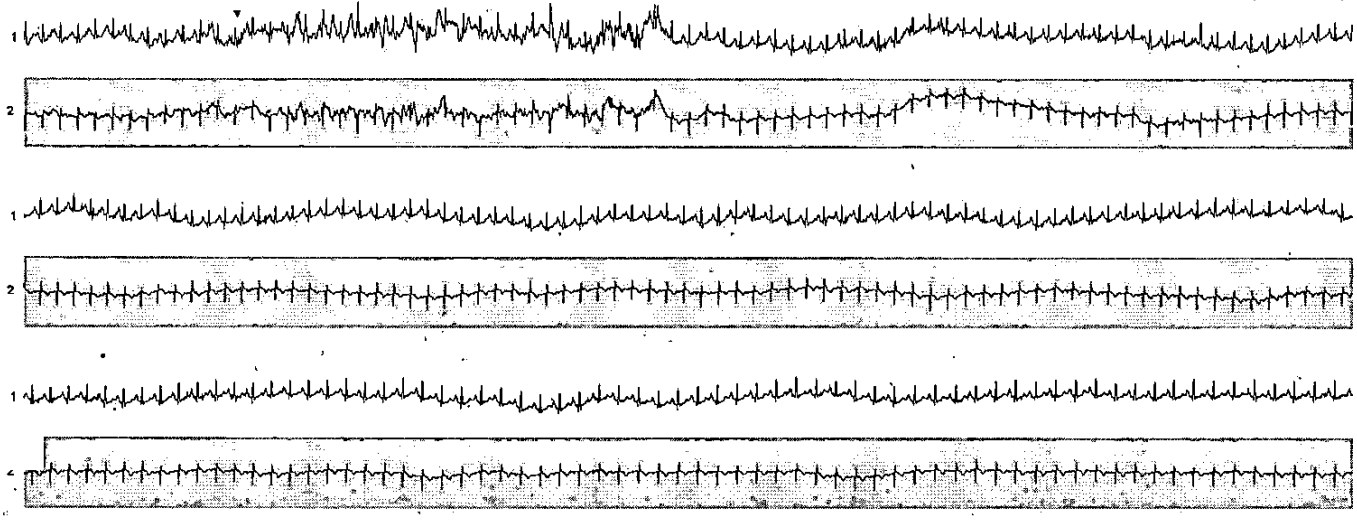


Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

Sinus Heart Rate

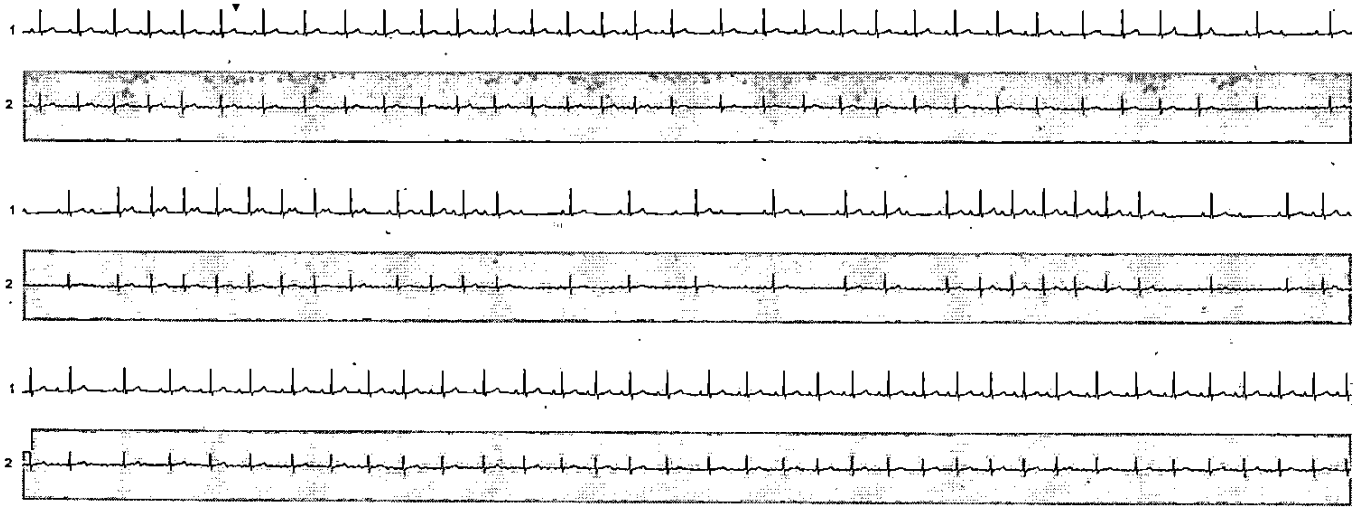
Maximum Sinus Heart Rate Event (1 Minute Avg)

Sat 13, 17:56:00 Confirmed Maximum Sinus Heart Rate 00:01:00 148 bpm 25 mm/s (Scale: 1:4)



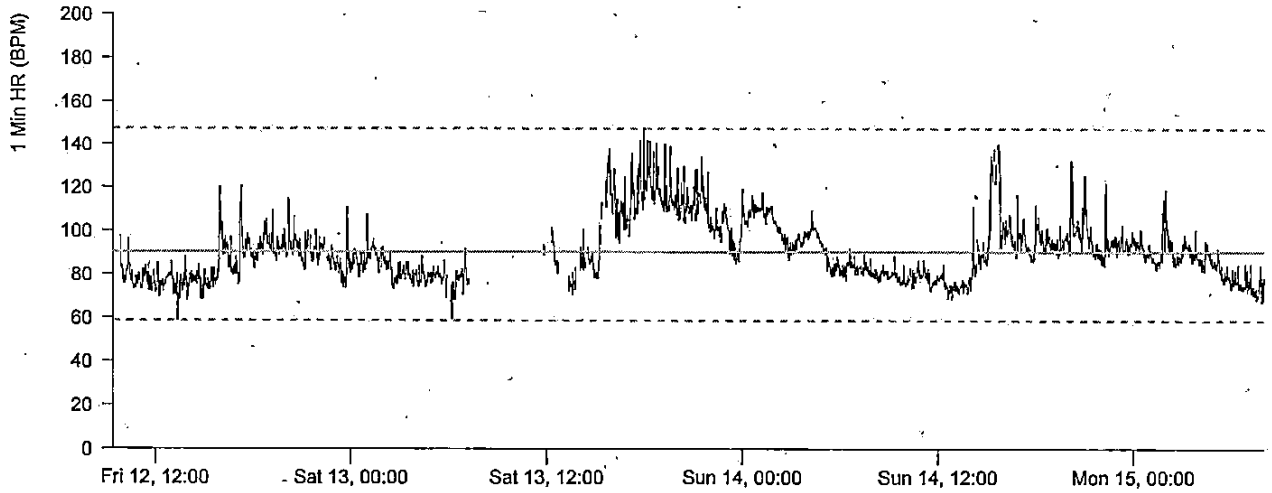
Minimum Sinus Heart Rate Event (1 Minute Avg)

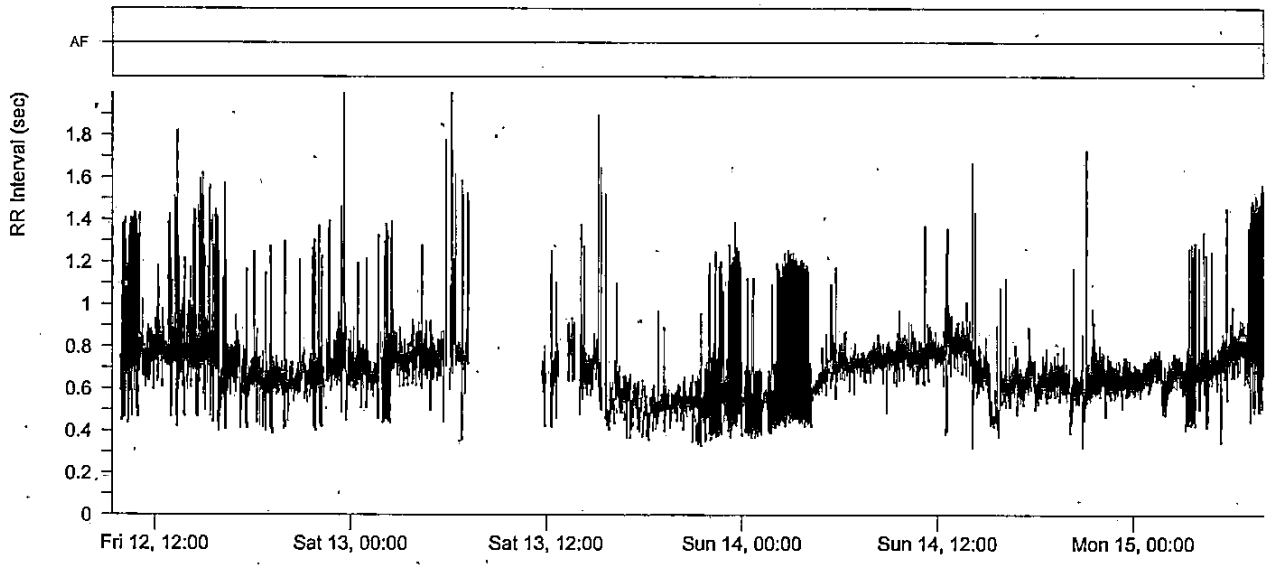
Fri 12, 13:21:00 Confirmed Minimum Sinus Heart Rate 00:01:00 59 bpm 25 mm/s (Scale: 1:4)

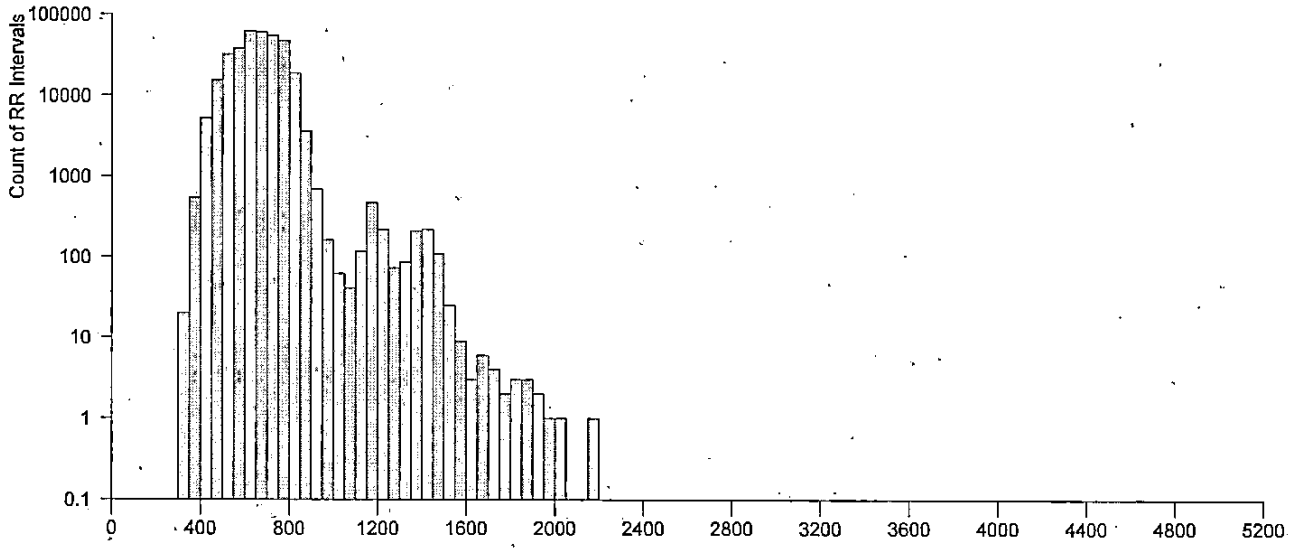


Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

Graphs

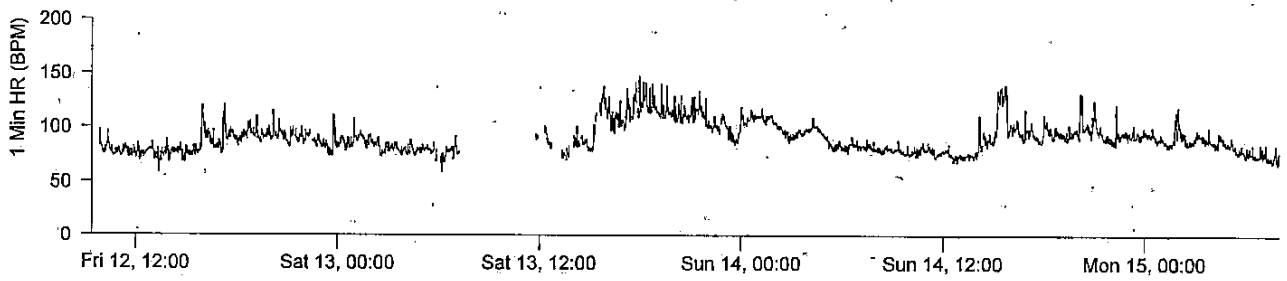


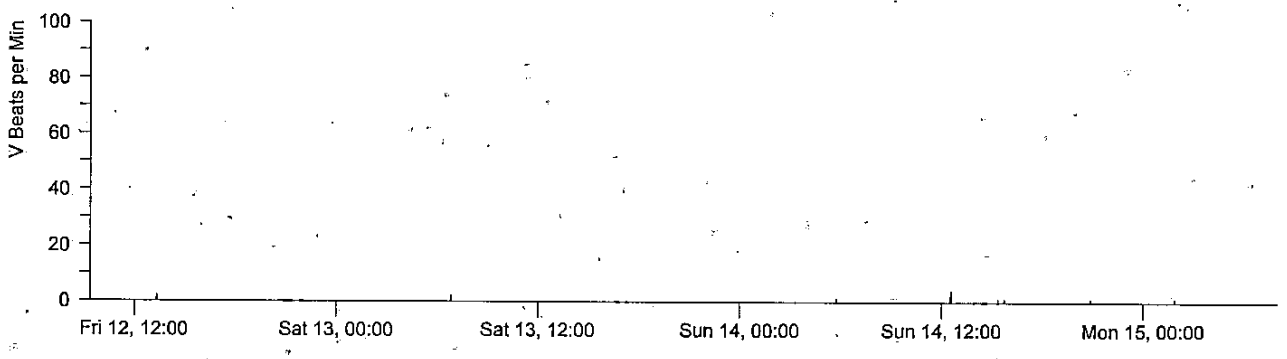




Signed By: Mingwang (Michael) Ho (WGACH) on 09/10/2024 16:17:02

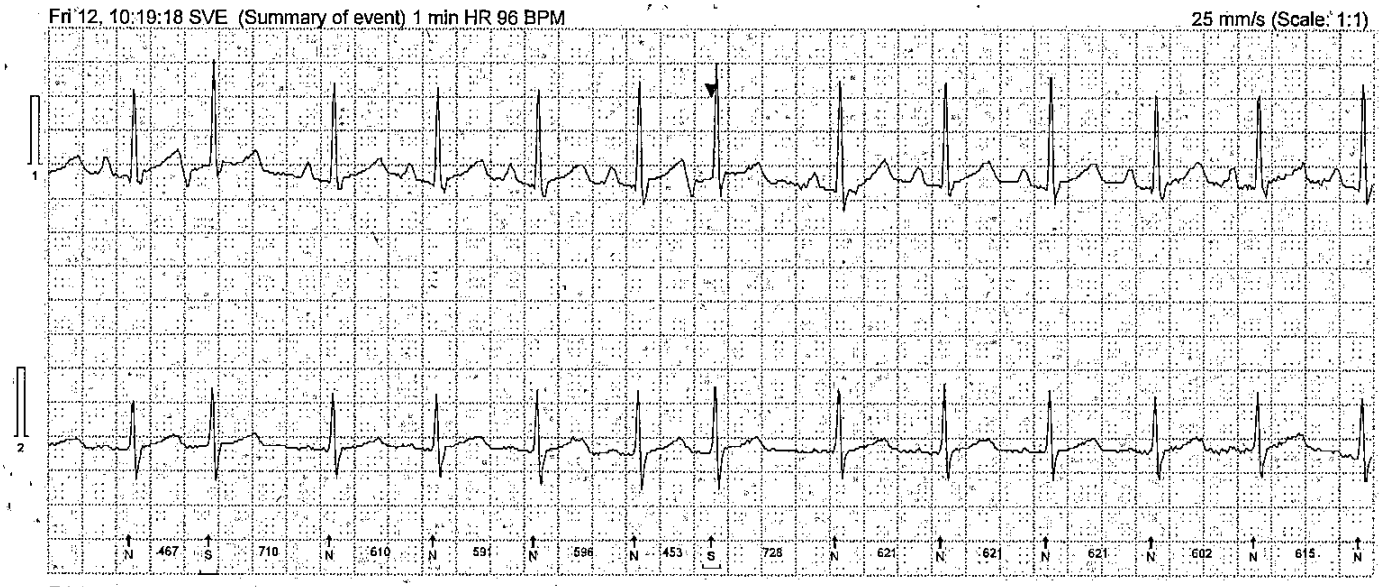
Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female



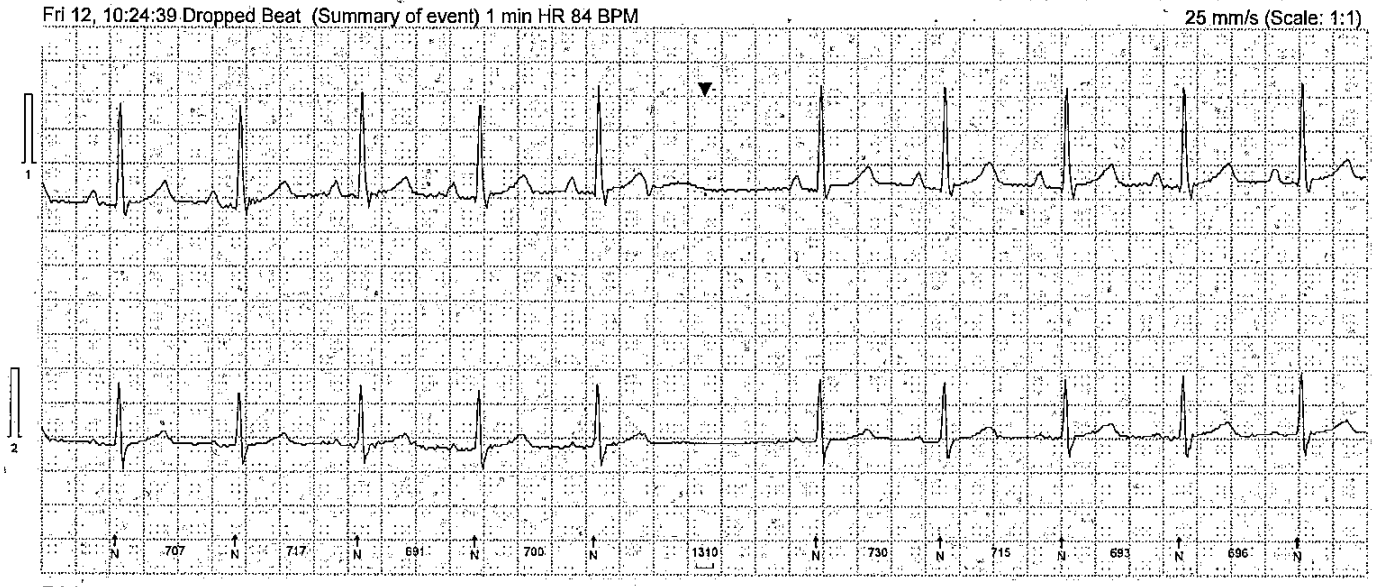


Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

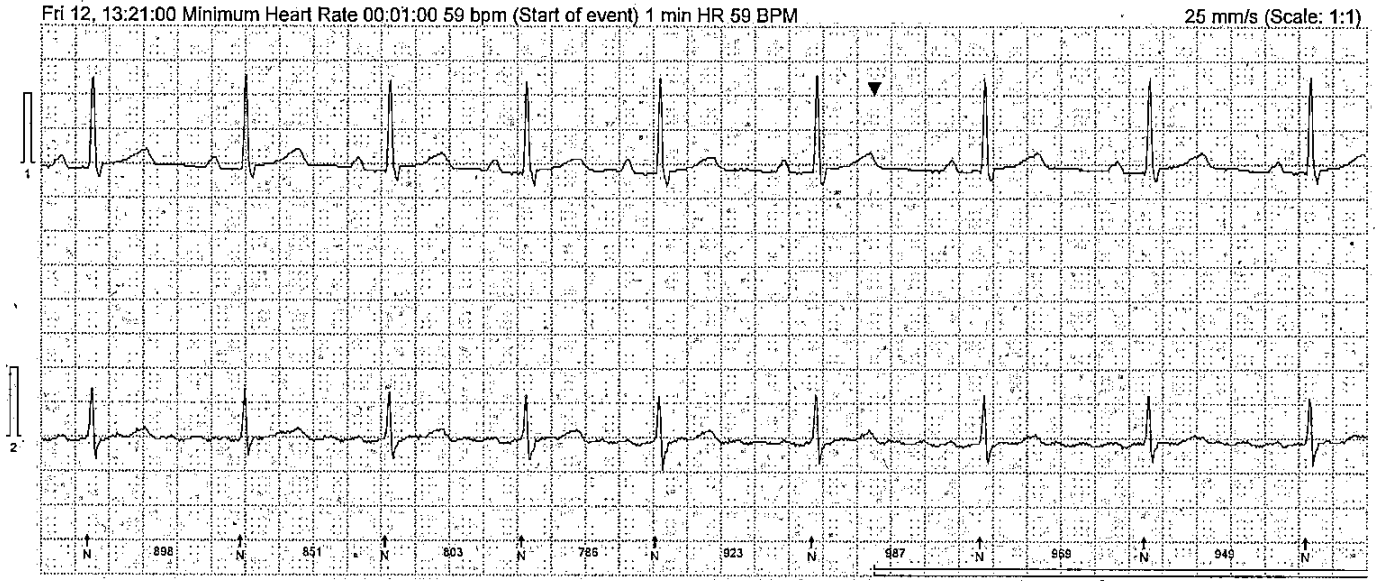
Fri 12, 10:19:18 SVE (Summary of event) 1 min HR 96 BPM 25 mm/s (Scale: 1:1)



Fri 12, 10:24:39 Dropped Beat (Summary of event) 1 min HR 84 BPM 25 mm/s (Scale: 1:1)

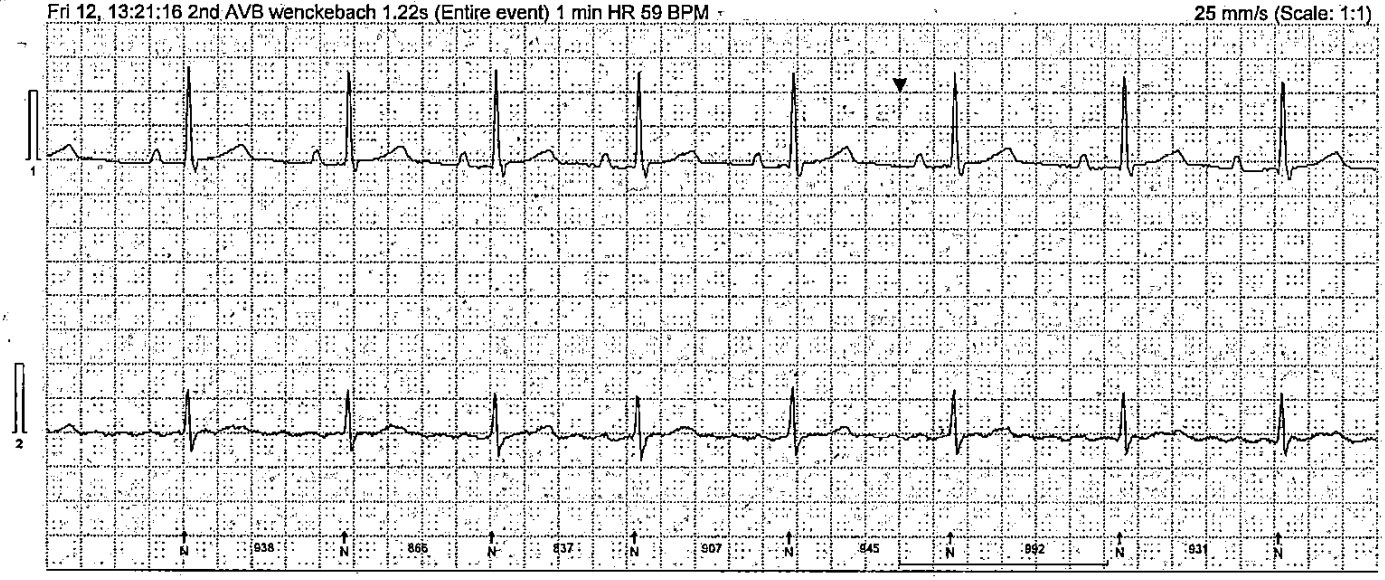


Fri 12, 13:21:00 Minimum Heart Rate 00:01:00 59 bpm (Start of event) 1 min HR 59 BPM 25 mm/s (Scale: 1:1)

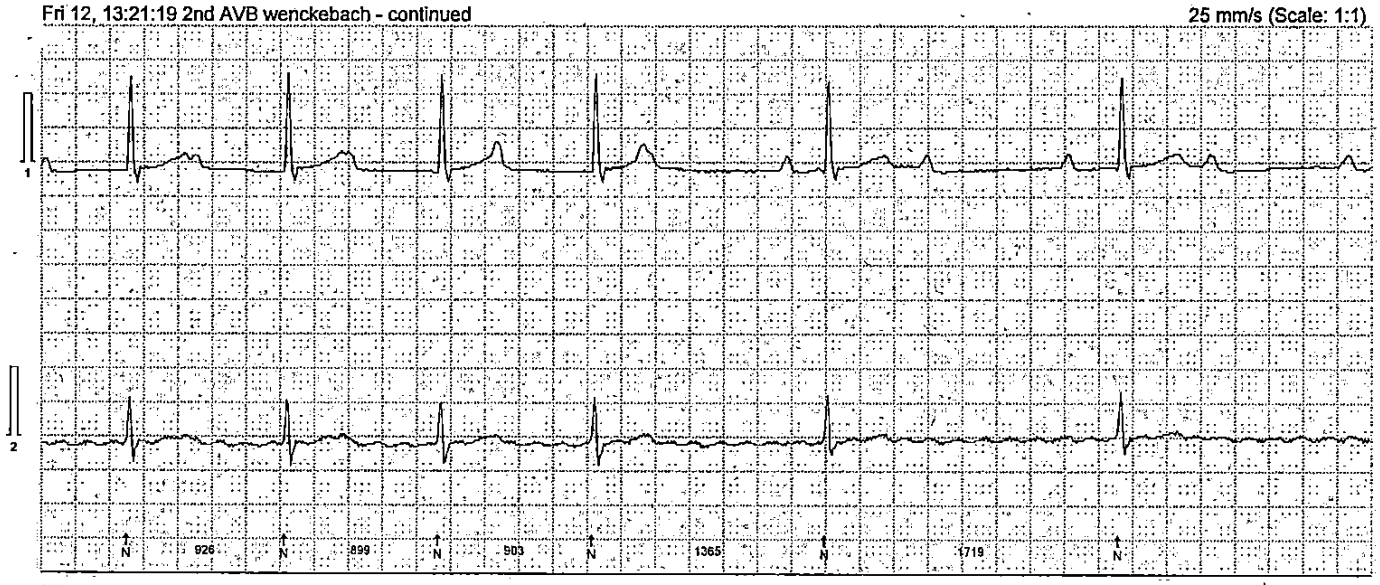


Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

Fri 12, 13:21:16 2nd AVB wenckebach 1.22s (Entire event) 1 min HR 59 BPM 25 mm/s (Scale: 1:1)

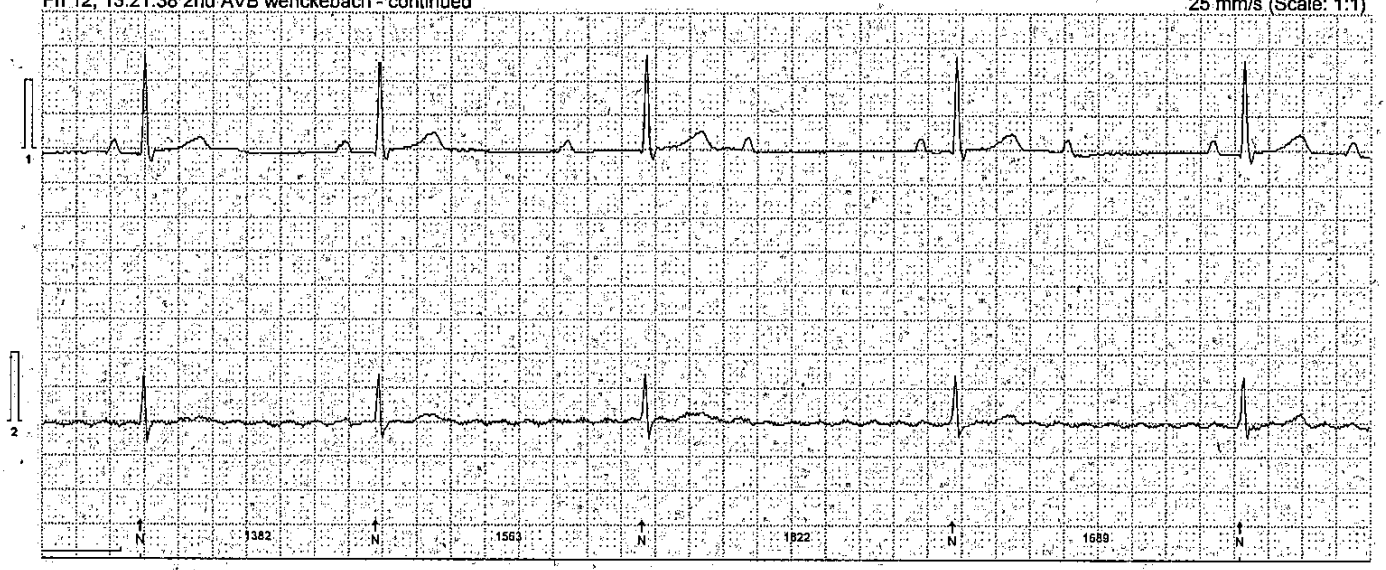


Fri 12, 13:21:19 2nd AVB wenckebach - continued 25 mm/s (Scale: 1:1)

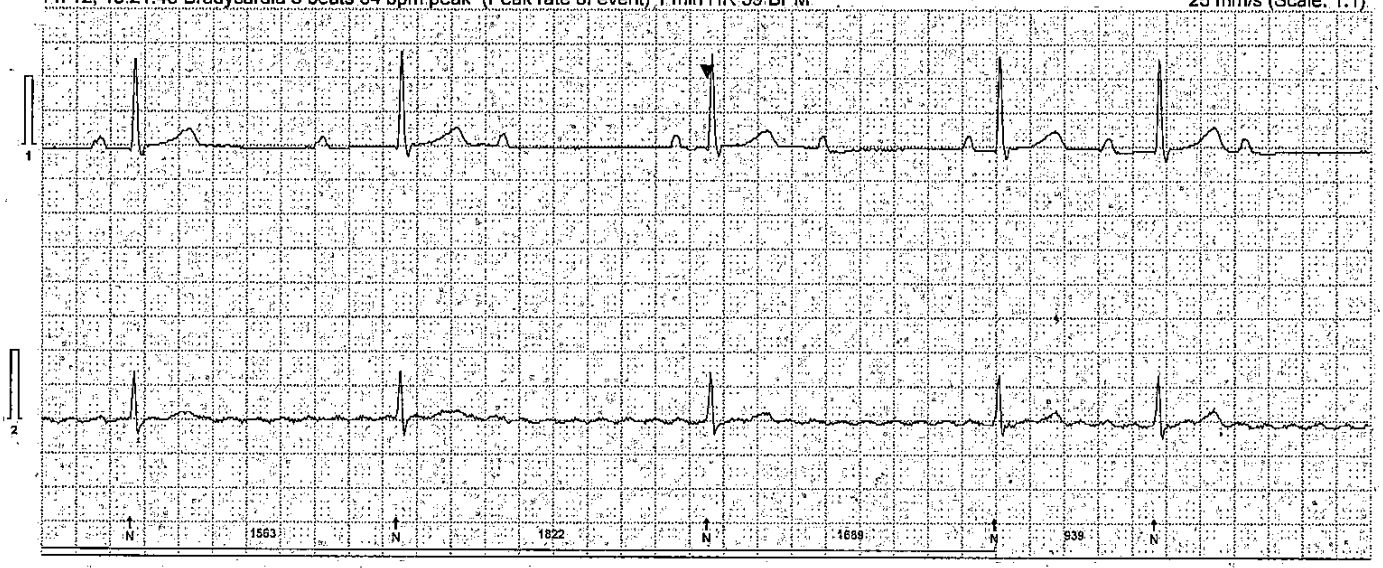


Fri 12, 13:21:35 2nd AVB wenckebach 3.26s (Entire event) 1 min HR 59 BPM 25 mm/s (Scale: 1:1)

Fri 12, 13:21:38 2nd AVB wenckebach - continued 25 mm/s (Scale: 1:1)

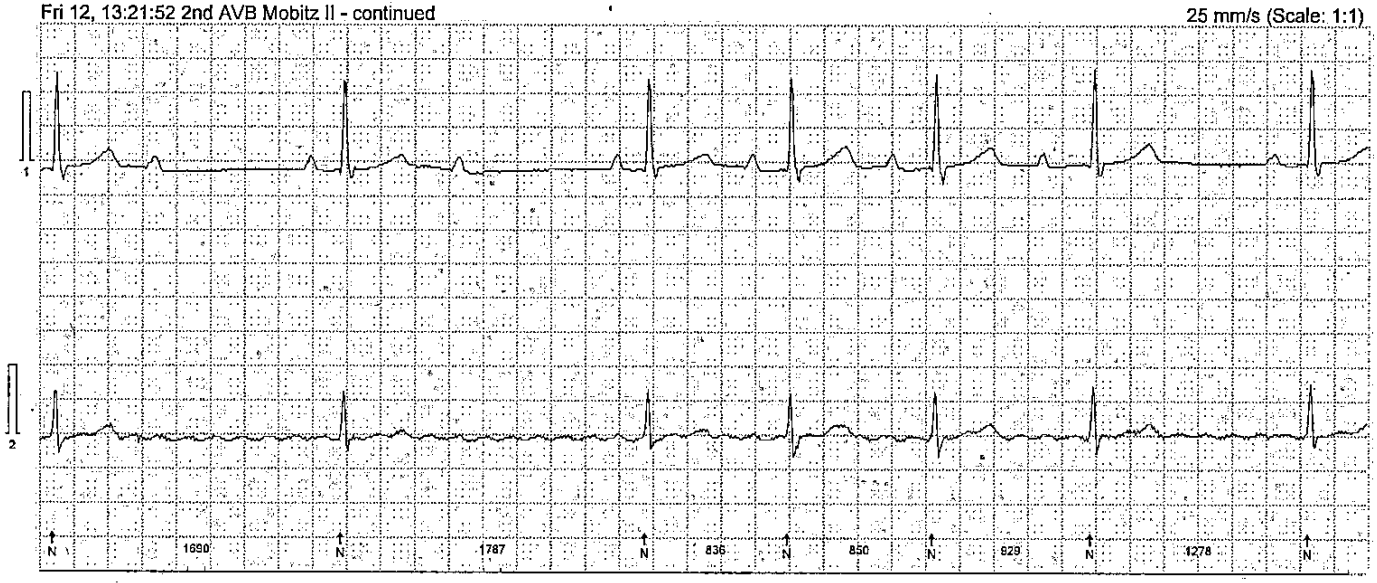


Fri 12, 13:21:43 Bradycardia 5 beats 34 bpm peak (Peak rate of event) 1 min HR 59 BPM 25 mm/s (Scale: 1:1)

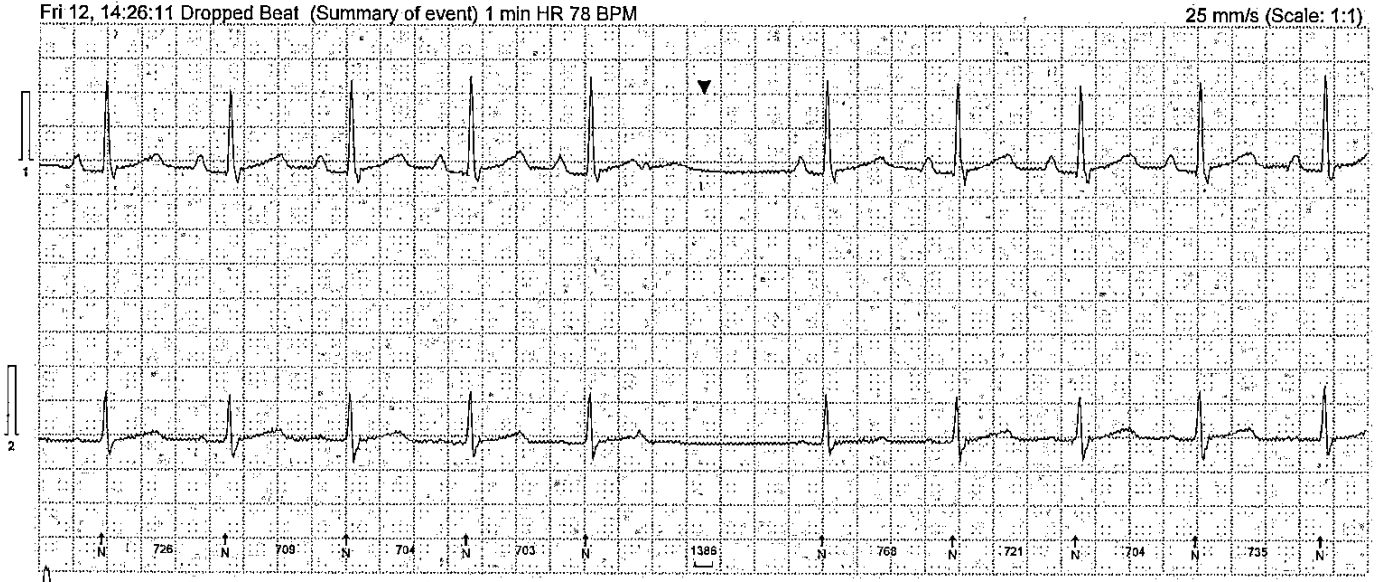


Fri 12, 13:21:49 2nd AVB Mobitz II 188ms (Entire event) 1 min HR 59 BPM 25 mm/s (Scale: 1:1)

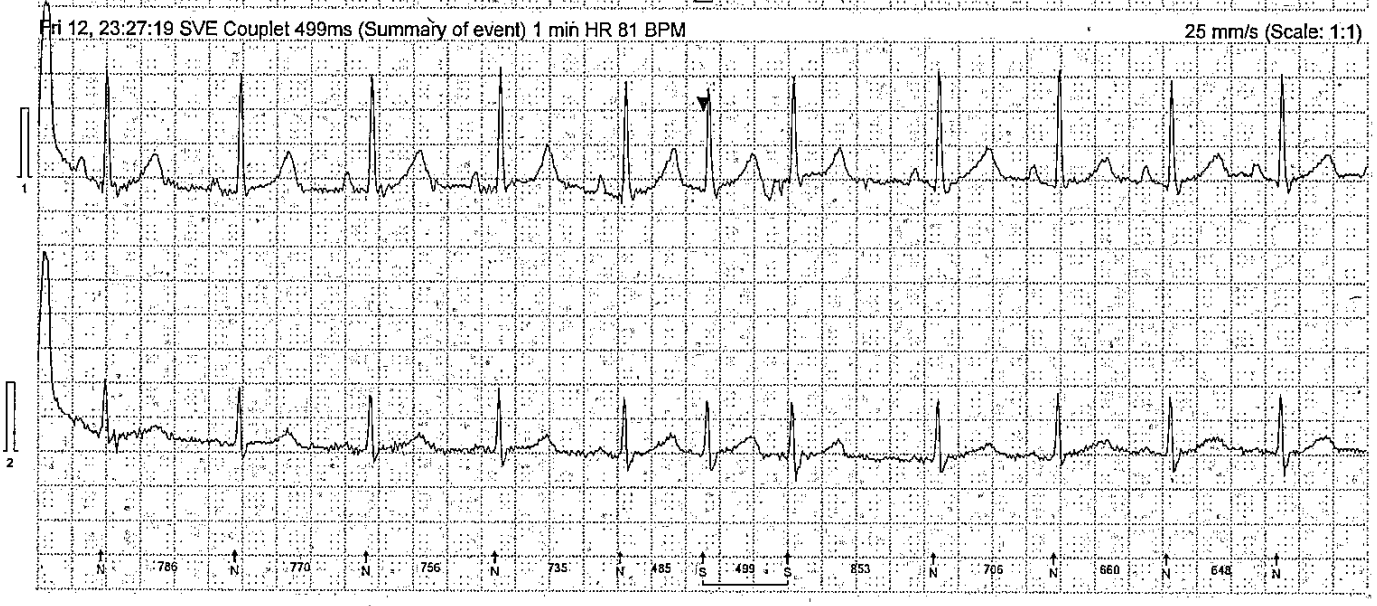
Fri 12, 13:21:52 2nd AVB Mobitz II - continued
25 mm/s (Scale: 1:1)



Fri 12, 14:26:11 Dropped Beat (Summary of event) 1 min HR 78 BPM
25 mm/s (Scale: 1:1)

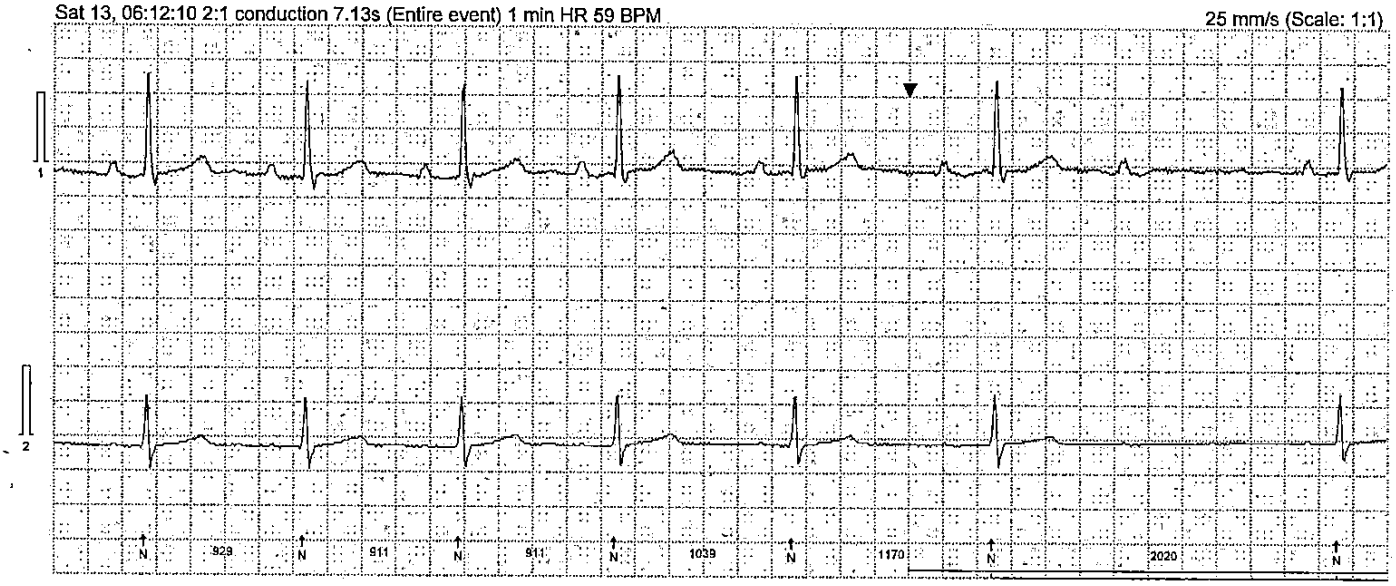


Fri 12, 23:27:19 SVE Couplet 499ms (Summary of event) 1 min HR 81 BPM
25 mm/s (Scale: 1:1)

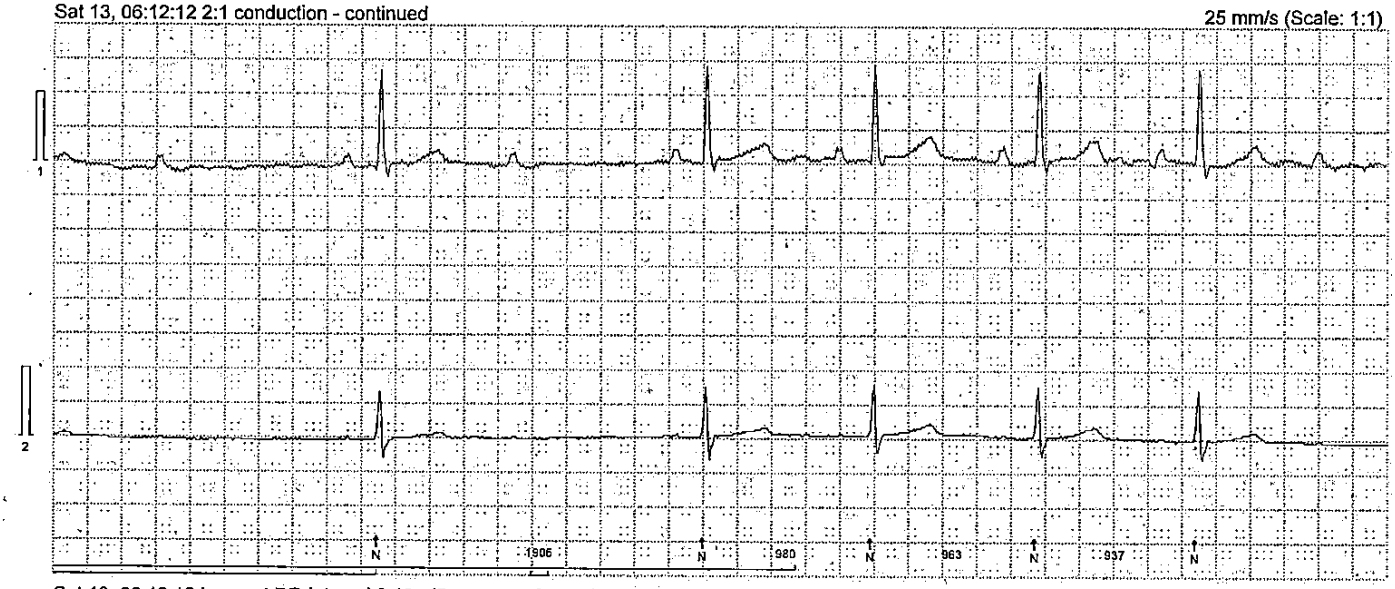


Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

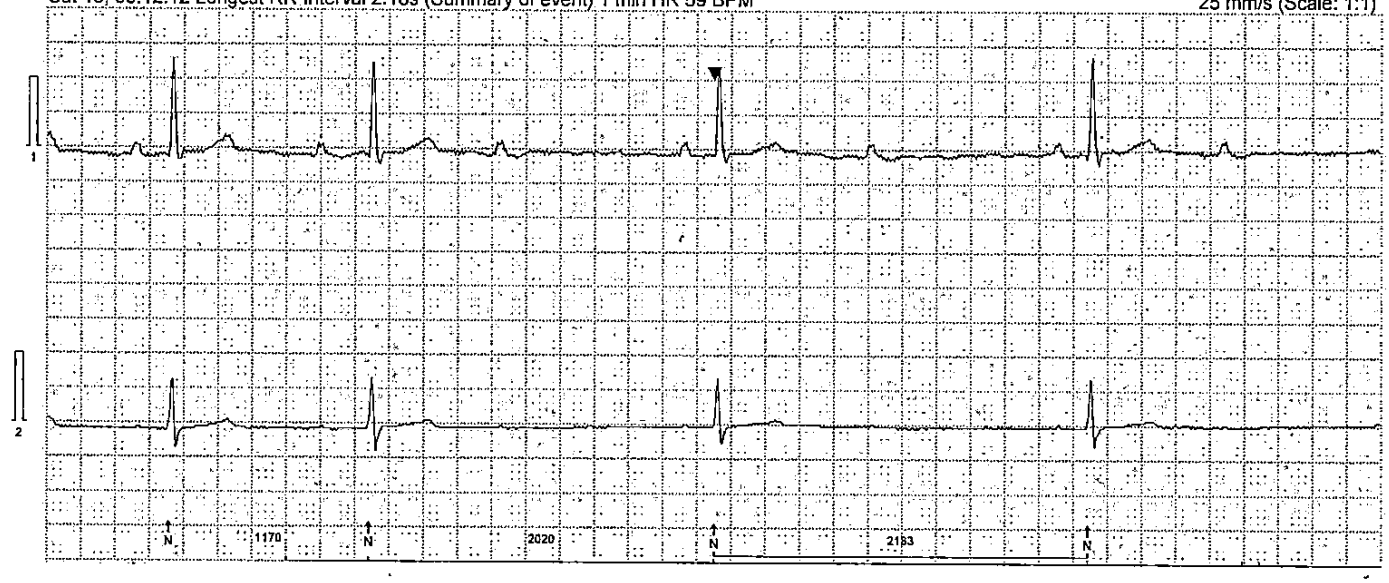
Sat 13, 06:12:10 2:1 conduction 7.13s (Entire event) 1 min HR 59 BPM 25 mm/s (Scale: 1:1)



Sat 13, 06:12:12 2:1 conduction - continued 25 mm/s (Scale: 1:1)



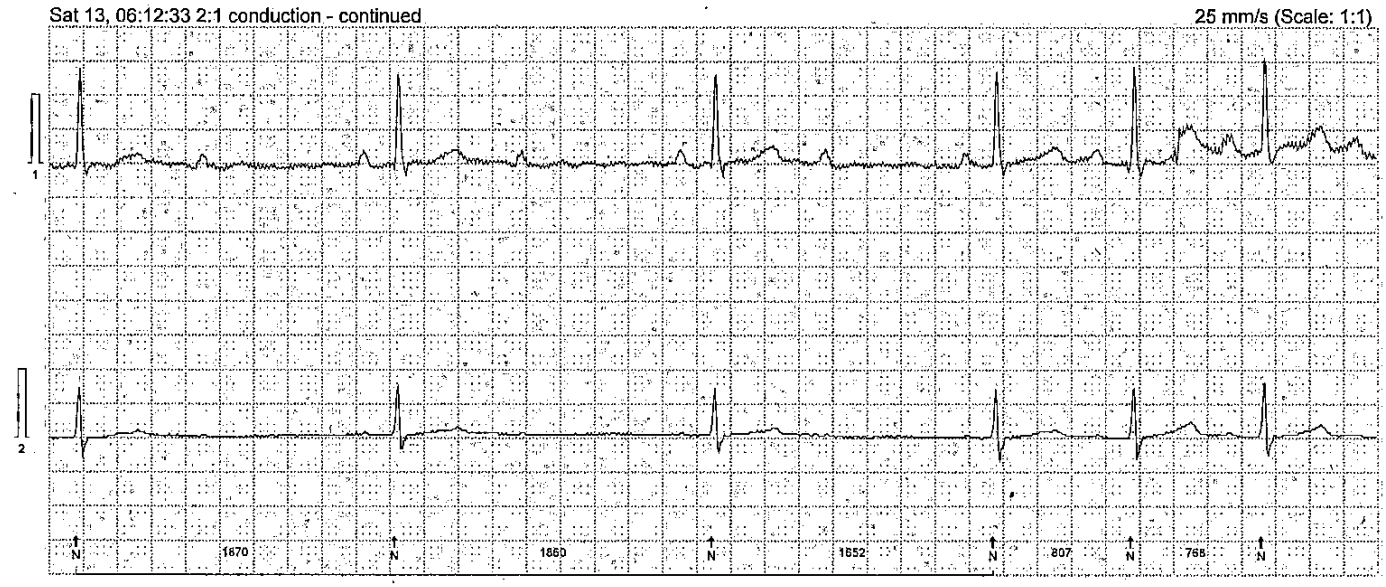
Sat 13, 06:12:12 Longest RR Interval 2.18s (Summary of event) 1 min HR 59 BPM 25 mm/s (Scale: 1:1)



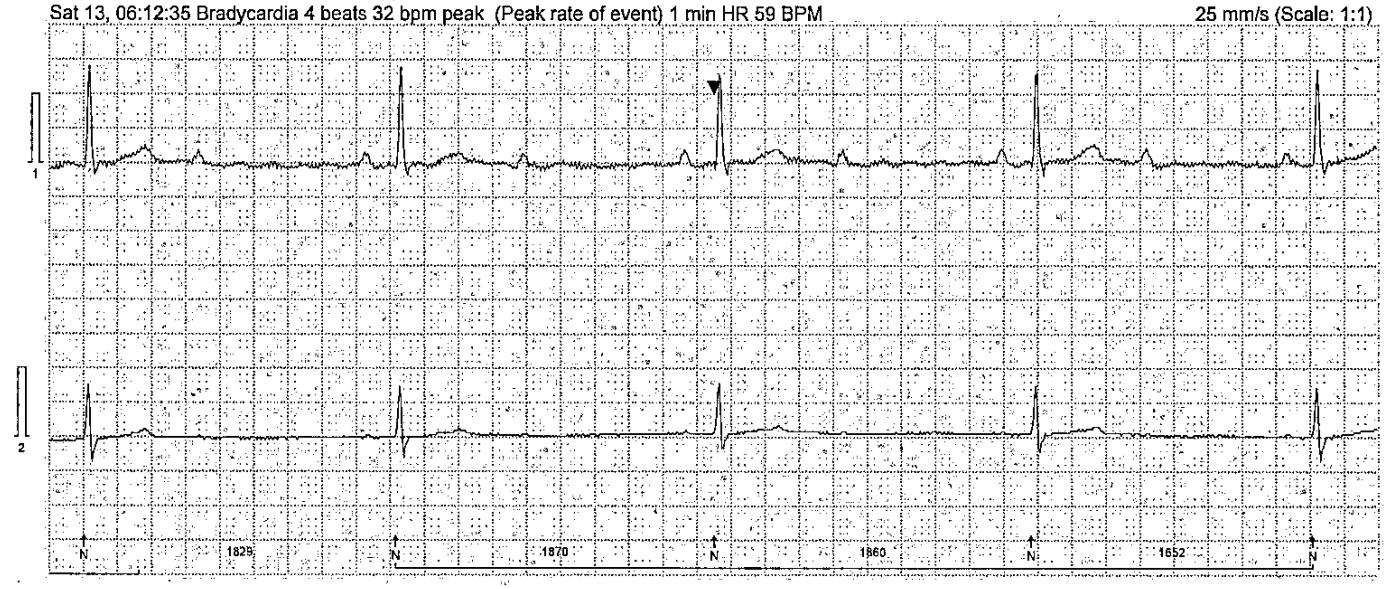
Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

Sat 13, 06:12:30 2:1 conduction 1.45s (Entire event) 1 min HR 59 BPM 25 mm/s (Scale: 1:1)

Sat 13, 06:12:33 2:1 conduction - continued 25 mm/s (Scale: 1:1)

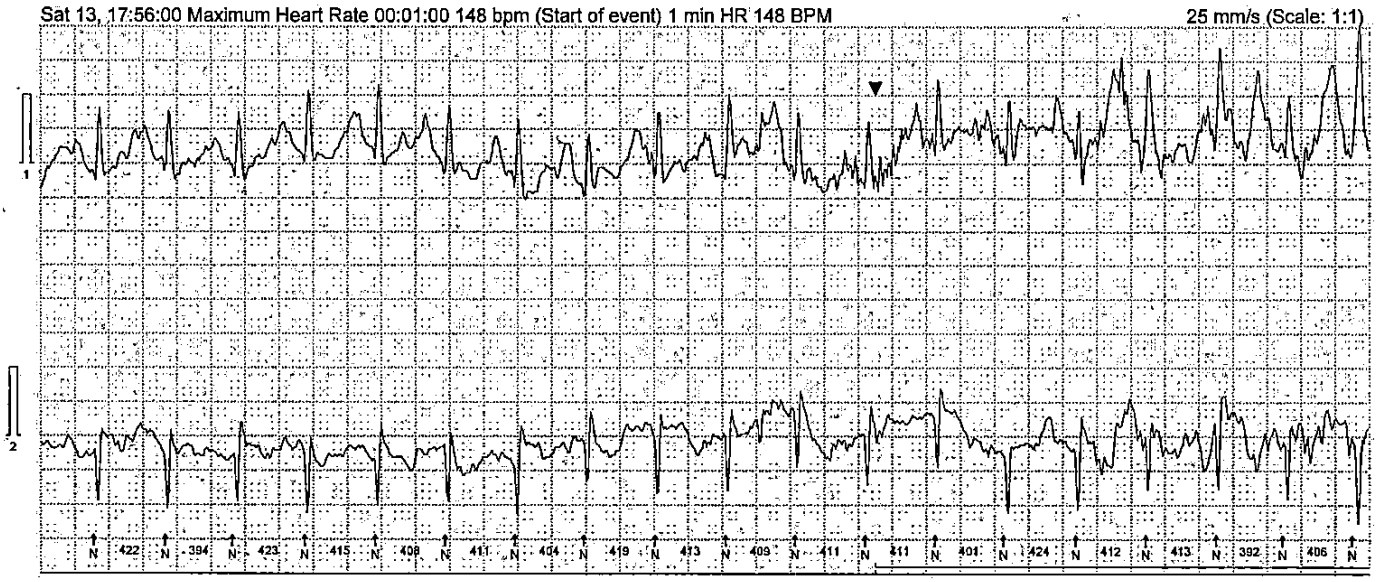


Sat 13, 06:12:35 Bradycardia 4 beats 32 bpm peak (Peak rate of event) 1 min HR 59 BPM 25 mm/s (Scale: 1:1)

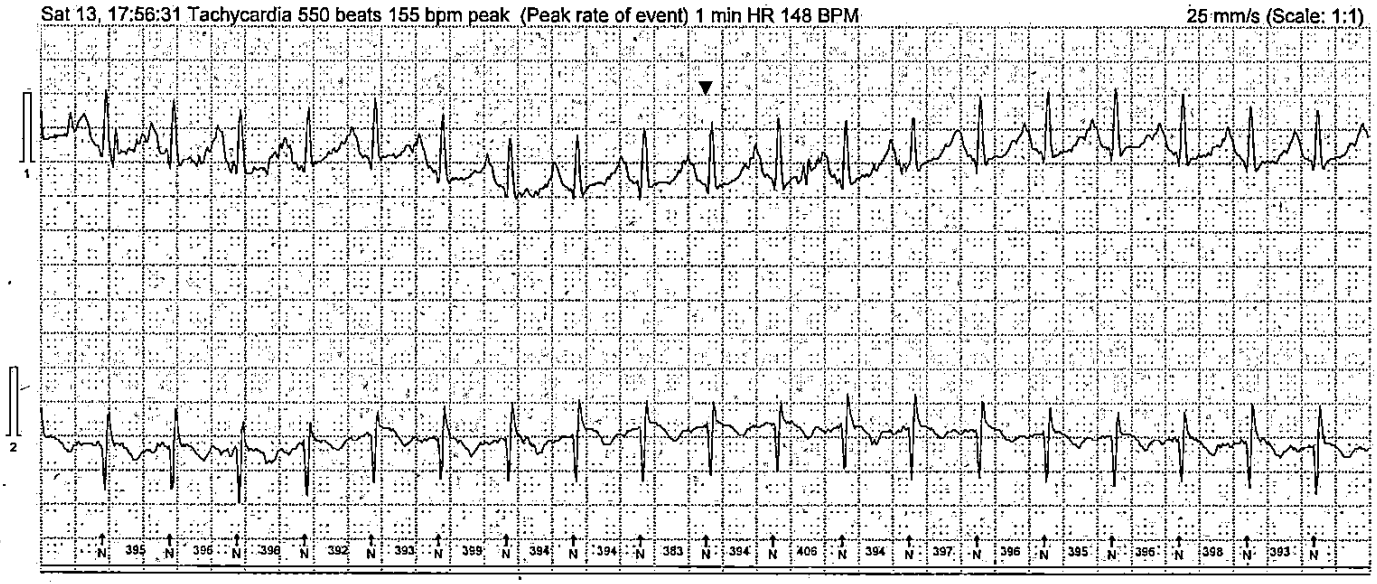


Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

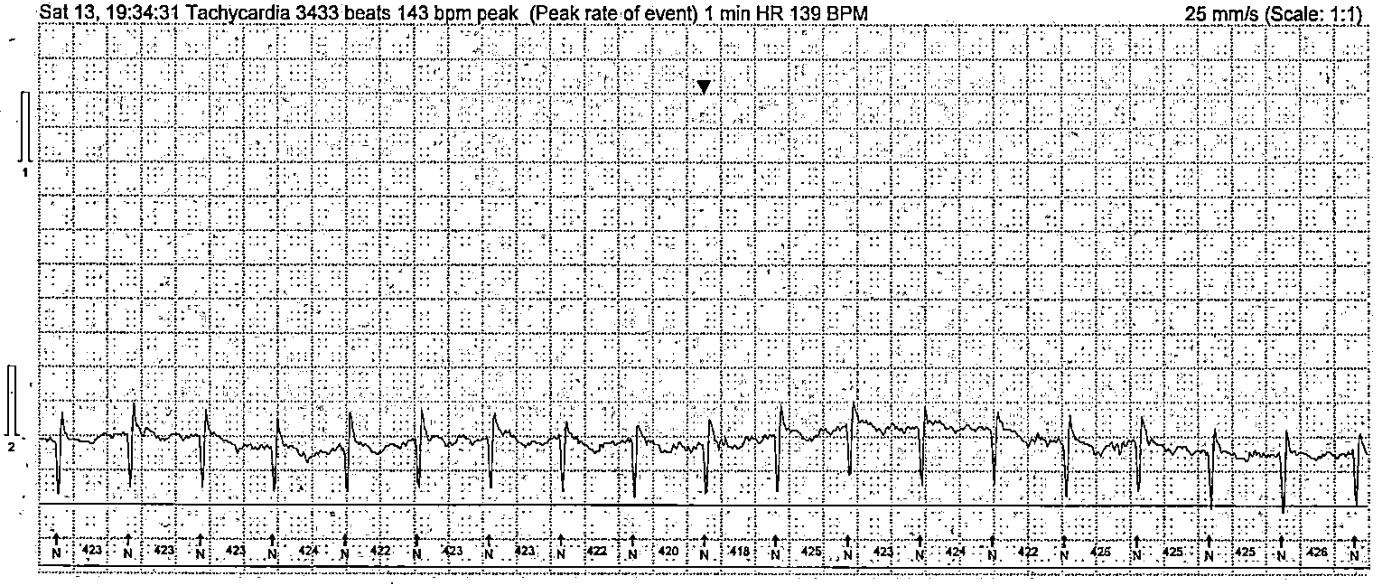
Sat 13, 17:56:00 Maximum Heart Rate 00:01:00 148 bpm (Start of event) 1 min HR 148 BPM 25 mm/s (Scale: 1:1)



Sat 13, 17:56:31 Tachycardia 550 beats 155 bpm peak (Peak rate of event) 1 min HR 148 BPM 25 mm/s (Scale: 1:1)



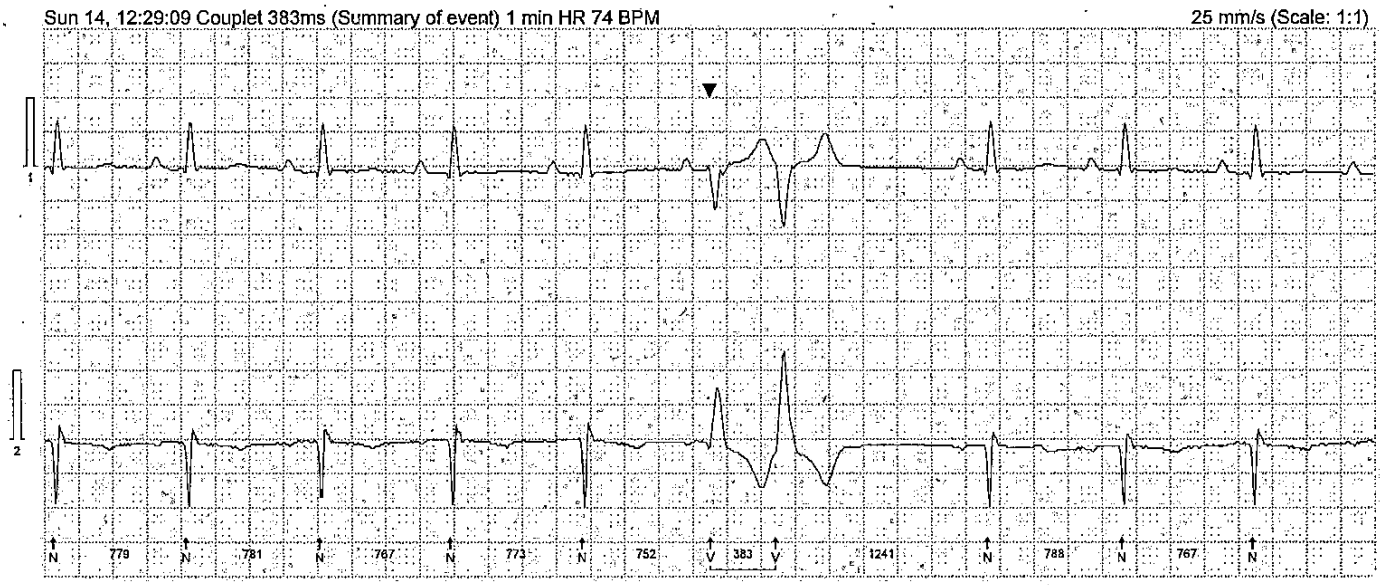
Sat 13, 19:34:31 Tachycardia 3433 beats 143 bpm peak (Peak rate of event) 1 min HR 139 BPM 25 mm/s (Scale: 1:1)



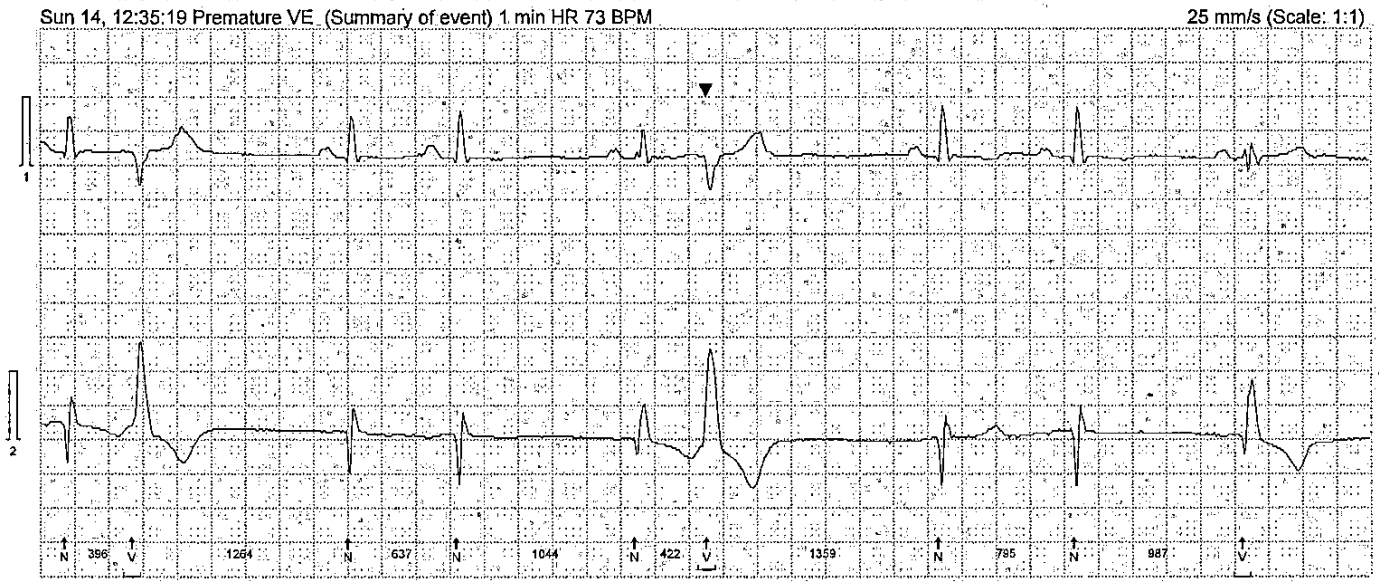
Signed By: Mingwang (Michael) Ho (WGACH) on 09/10/2024 16:17:02

Patient ID: 2704716161 Date of Birth: Tue 27 Apr 1971 (53 years) Gender: Female

Sun 14, 12:29:09 Couplet 383ms (Summary of event) 1 min HR 74 BPM 25 mm/s (Scale: 1:1)



Sun 14, 12:35:19 Premature VE (Summary of event) 1 min HR 73 BPM 25 mm/s (Scale: 1:1)



Roberts, Tracy ID:2704716161 23-OCT-2024 12:23:58 GREATER GLASGOW SITE-VACLD ROUTINE RECORD

27-APR-1971 (53 yr)
Female

Room:
Loc:601

Vent. rate	74	BPM
PR interval	176	ms
QRS duration	92	ms
QT/QTc	374/415	ms
P-R-T axes	76 87	61

Normal sinus rhythm
Normal ECG

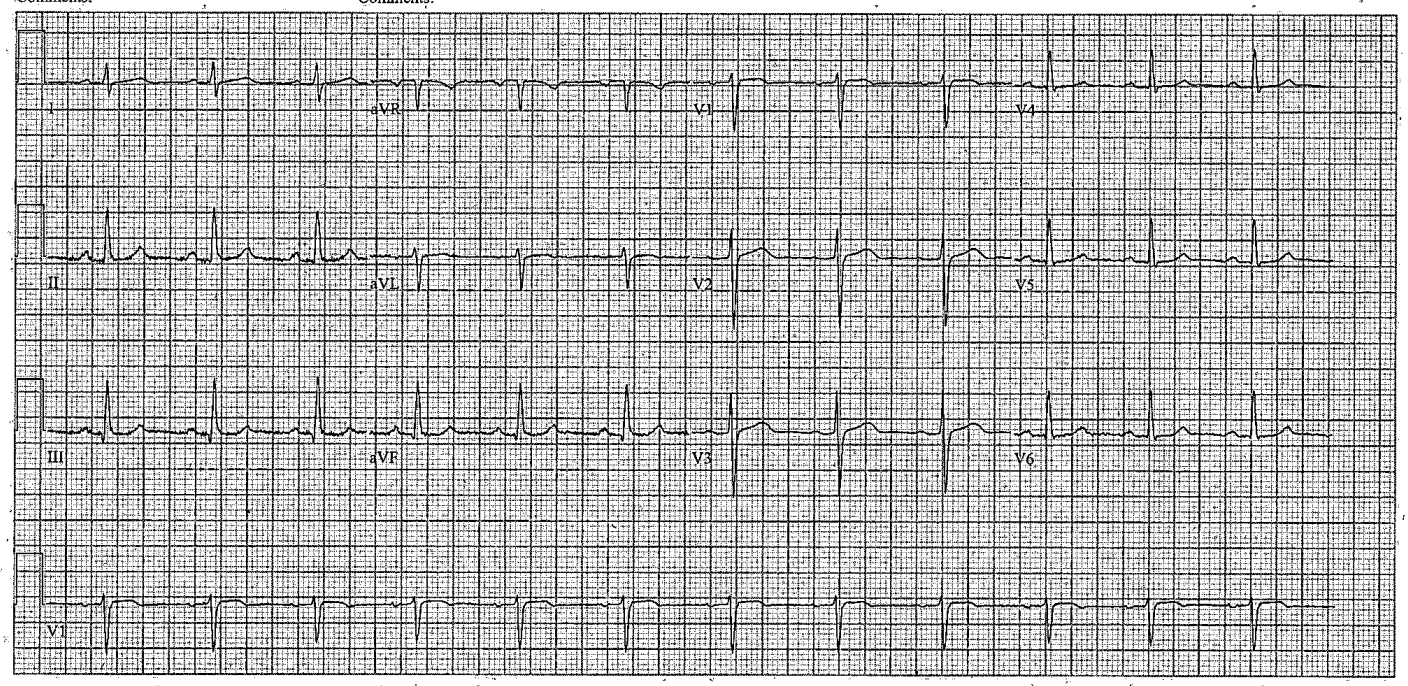
Technician: 516
Test ind:

Referred by: Dr beggs

Unconfirmed

Comments:

Comments:



25mm/s 10mm/mV 100Hz 9.0.10 12SL 243 CID: 1604

SID: 3322067 EID:13 EDT: ORDER:

Roberts, Tracy ID:2704716161 02-MAY-2024 14:08:55 GREATER GLASGOW SITE-VAGPOP ROUTINE RECORD

27-APR-1971 (53 yr)
Female

Room:
Loc:603

Vent. rate	87	BPM
PR interval	152	ms
QRS duration	90	ms
QT/QTc	358/430	ms
P-R-T axes	70 85	59

Normal sinus rhythm
Normal ECG

Confirmed by Admin 15, Sys (21015) on 07/05/2024 16:29:50

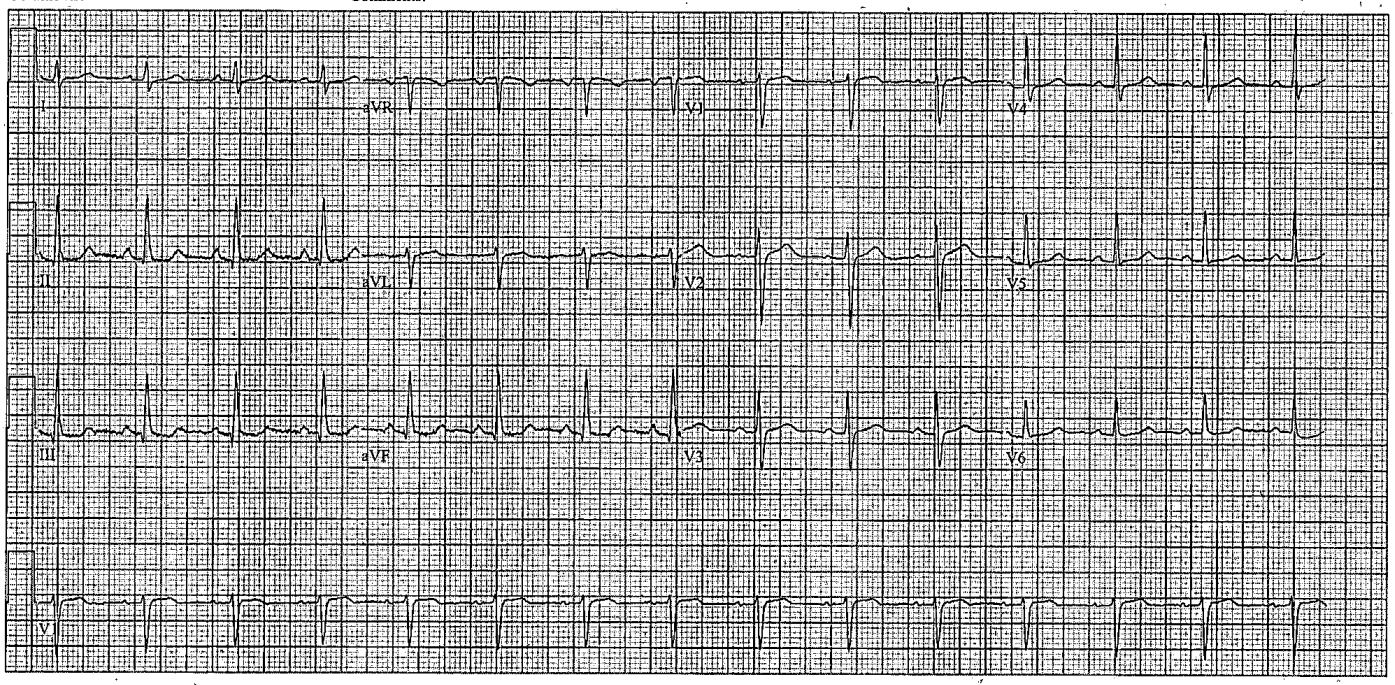
Technician: 513
Test ind:

Referred by: Dr Saldanha

CONFIRMED ECG REPORT Sys Admin 15

Comments:

Comments:



25mm/s 10mm/mV 100Hz 9.0.10 12SL 243 CID: 1604

SID: 3322067 EID:21015 EDT: 16:29 07-MAY-2024 ORDER:

Roberts, Tracy ID:2704716161 12-APR-2019 15:52:59 GREATER GLASGOW SITE-QEED ROUTINE RECORD

27-APR-1971 (47 yr)
Female

Room:
Loc:1301

Vent. rate	78	BPM	Normal sinus rhythm
PR interval	146	ms	Normal ECG
QRS duration	82	ms	
QT/QTc	372/424	ms	
P-R-T axes	71 82	50	

Technician:
Test ind:

Unconfirmed

COMMENTS:

25mm/s 10mm/mV 100Hz 9.0.4 12SL 241 CID: 27

SID: 3322067 EID: EDT: ORDER:

ROBERTS, TRACY ID:2704716161 19-JUN-2013 03:21:17 GREATER GLASGOW SITE- ROUTINE RECORD

27-APR-1971 (42 yr)
Female

Room:

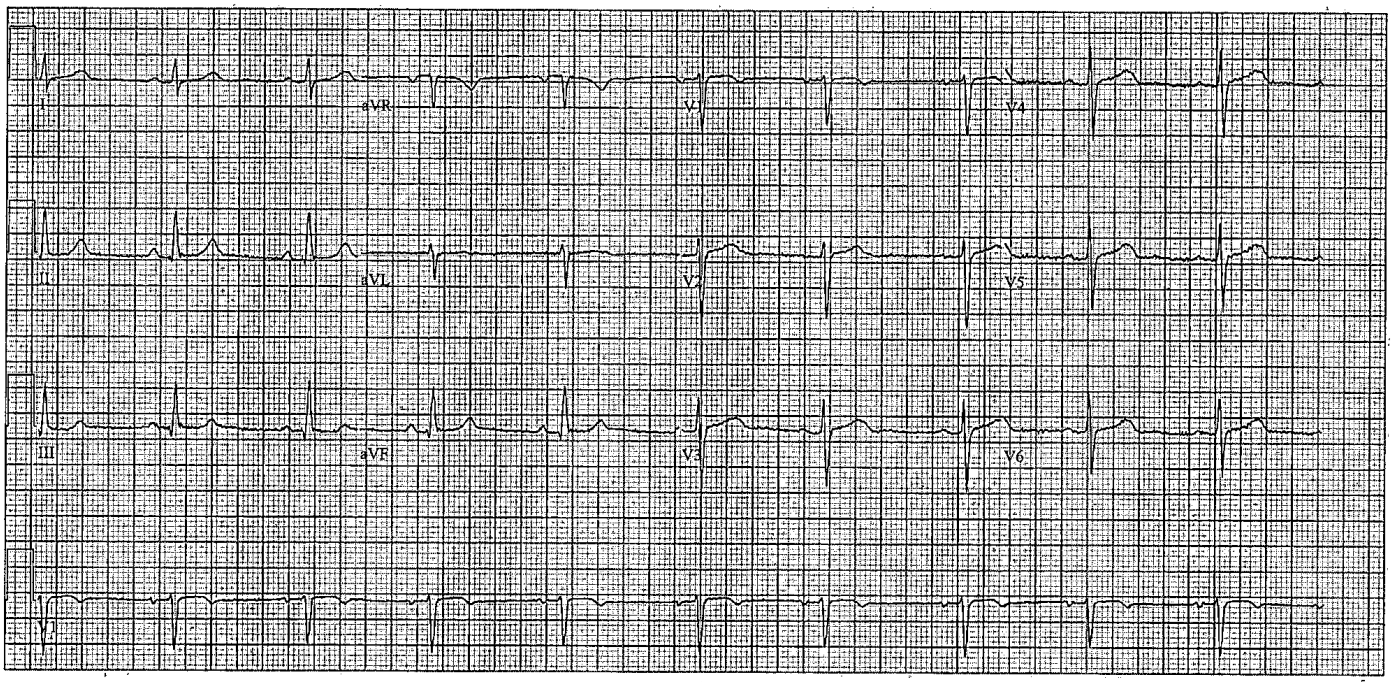
Vent. rate	59	BPM
PR interval	162	ms
QRS duration	96	ms
QT/QTc	426/421	ms
P-R-T axes	57 81	51

Sinus bradycardia

Technician:
Test ind:

Referred by:

COMMENT: UNCONFIRMED ECG REPORT Sys Admin 1



25mm/s 10mm/mV 150Hz 7.1.1 12SL 237 CID: 1

EID:21001 EDT: 09:25 09-OCT-2013 ORDER:

ROBERTS, TRACY ID: 2704716161 12-Apr-2019 15:[illegible]9 QUEEN ELIZABETH UNIVERSITY HOSPITAL

27-Apr-1971
Female

Loc: 1301

[redacted]

Technician:
Test ind:

Vent. rate		bpm
PR interval	146	ms
QRS duration	82	ms
QT/QTc	372/424	ms
P-R-T axes	71 82	50

Normal sinus rhythm
Normal ECG

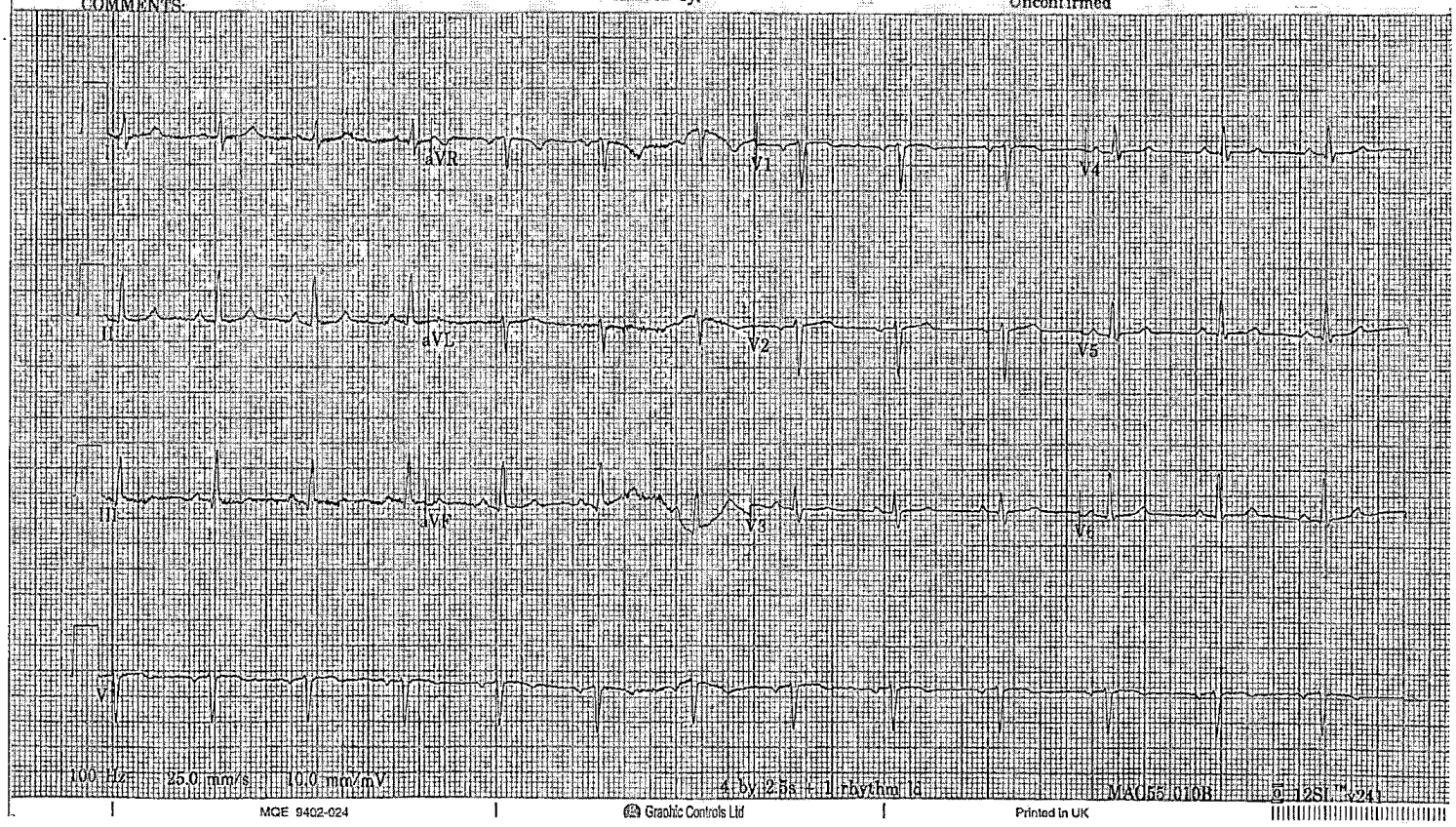
NO

2704716161 27/04/1971
ROBERTS
Tracy

COMMENTS:

Referred by:

Unconfirmed



MQE 9402-024 Graphic Controls Ltd Printed in UK

ROBERTS, TRACY ID: 29-Mar-2017 15:02:10 SOUTH GLASGOW UNIVERSITY HOSPITAL

27-Apr-1971
Female

Vent. rate	7	m
PR interval	142	ms
QRS duration	86	ms
QT/QTc	370/418	ms
P-R-T axes	86 94 58	

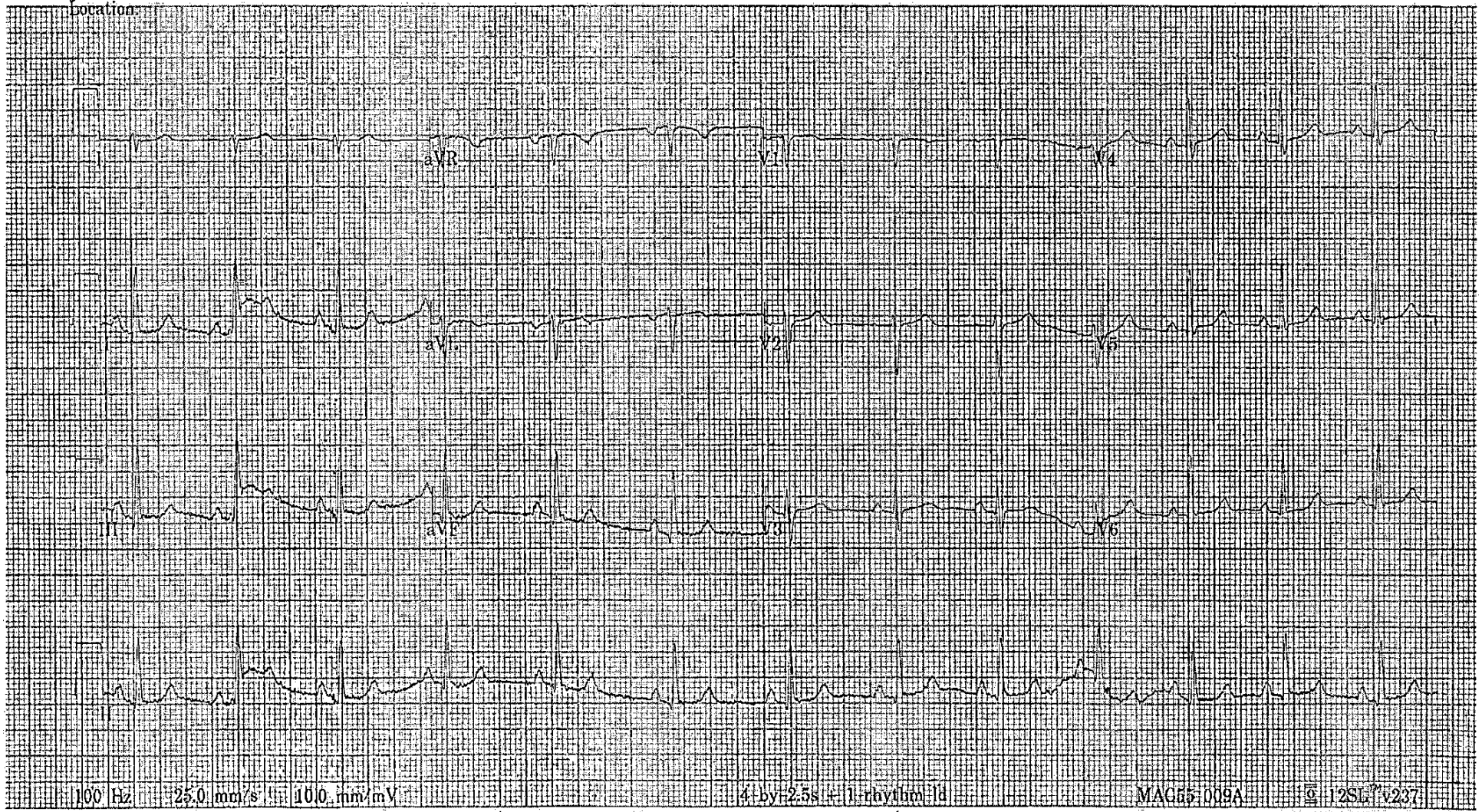
Normal sinus rhythm with sinus ar hmia
Rightward axis

2704716161 27/04/1971
ROBERTS
Tracy

Technician:

Referred by: Unconfirmed

Location:



MQE 9402-024 Graphic Controls Ltd Printed in UK

ROBERTS, TRACY ID: 29-Mar-2017 15:01:24 SOUTH GLASGOW UNIVERSITY HOSPITAL

27-Apr-1971
Female

Vent. rate	8	bpm
PR interval	144	ms
QRS duration	78	ms
QT/QTc	366/422	ms
P-R-T axes	87 97 76	

Normal sinus rhythm
Rightward axis

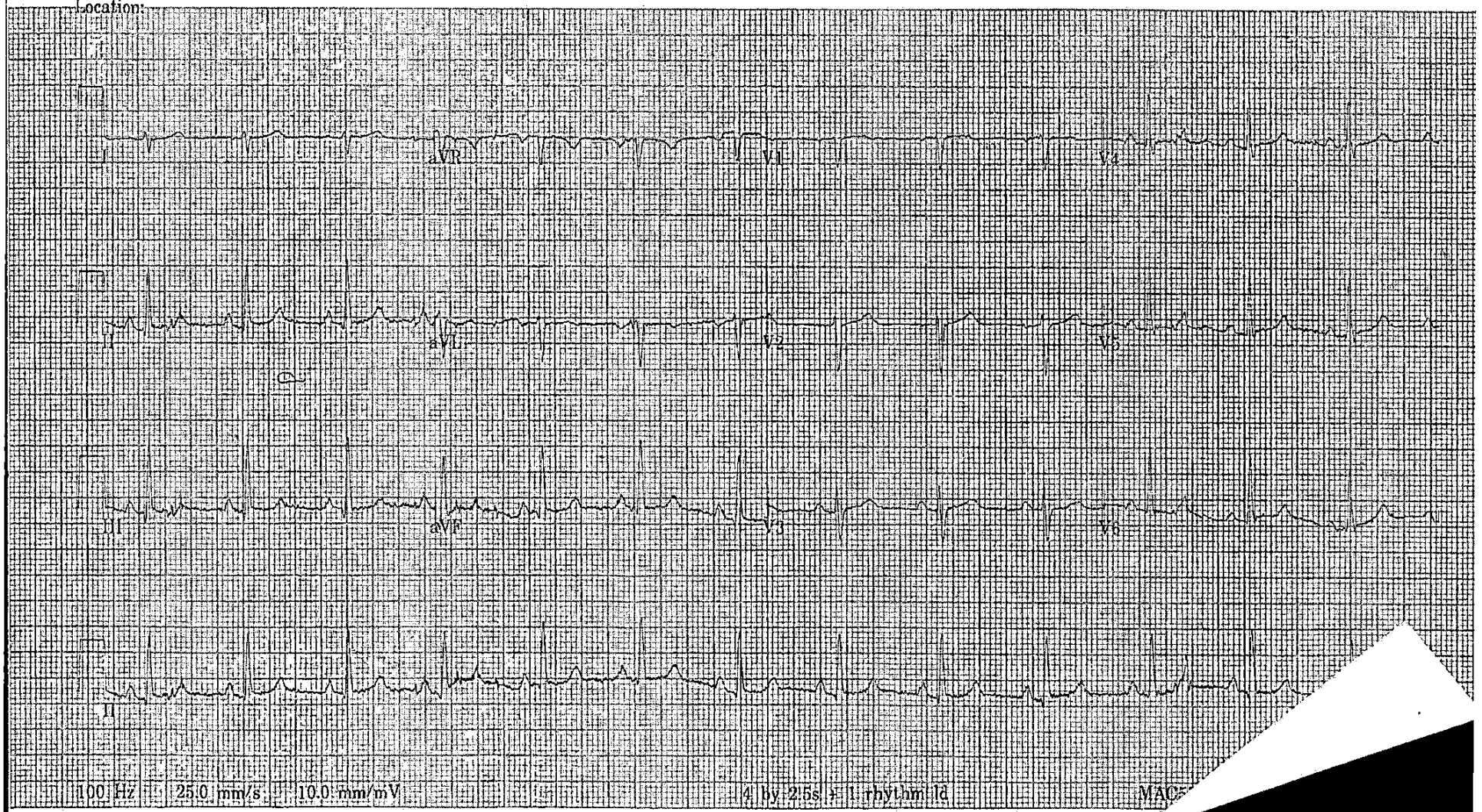
2704716161 27/04/1971
ROBERTS
Tracy

Technician:

Referred by:

Unconfirmed

Location:



MQE 9402-024 Graphic Controls Ltd Printed in UK

Victoria Infirmary Glasgow

Echocardiography Report

NHS Greater Glasgow and Clyde

Patient Name: **ROBERTS, TRACY**
Date of Birth: **27/04/1971**
Patient CHI: **2704716161**
Sex: **Female**
Referral Reasons: **SYNCOPE ?AV BLOCK**

Date of Study: **23/10/2024**
Sonographer: **Marlyn Mills**
Ref. Consultant:
Ward/Dept. **Cardiology DR S BEGGS / DR D CORCORAN CLINIC**

2D		M-Mode		Doppler	
IVSd	1.37 cm	Ao Diam	3.85 cm	MV E Vel	0.51 m/s
LVIDd	4.02 cm	LA Diam	2.88 cm	MV DecT	252.61 m s
LVIDd Index	2.39 cm/m²	LA/Ao	0.75	MV Dec Slope	2.04 m/s²
EDV(Teich)	70.87 ml	TAPSE	2.308 cm	MV A Vel	0.61 m/s
LVPWd	1.18 cm			MV E/A Ratio	0.85
LA Area	15.37 cm²			MV PHT	73.26 m s
RA Area	14.41 cm²			E/E'	7.91
Aortic Arch	1.65 cm			E' Lat	0.09 m/s
				E' Sep	0.04 m/s
				E' Average	0.07 m/s
				LVOT Vmax	0.69 m/s
				LVOT maxPG	1.93 mmHg
				AV Vmax	1.13 m/s
				AV maxPG	5.11 mmHg
				PV Vmax	0.82 m/s
				PV maxPG	2.70 mmHg

Echo Report:
ECG - Sinus
Study quality - Difficult imaging

Mild antero-septal hypertrophy.
Normal LV cavity size for BSA index.
All regions contracting well.
Est EF 60 - 65%
Normal E/E' ratio.
Normal LA and RA size.
Normal mitral valve structure with good leaflet mobility and trace MR.
Normal tri-leaflet aortic valve with good cusp separation and normal Doppler flows.
Unable to fully visualise ascending aorta and aortic arch dimensions.
Normal pulmonary valve function.
Normal tricuspid valve with no significant TR, unable to estimate a PASP
Normal RV dimensions with good systolic contraction c/w TAPSE.
Poor subcostal imaging, unable to fully visualise & assess IVC

Print Date: 23/10/2024

Conclusion:
Mild antero-septal hypertrophy
Undilated LV
Good systolic LV function
Undilated LA
No significant valvular abnormalities
Impression of normal RV dimensions & function

Reported By:

M Mills

Date **23/10/2024** **Marlyn Mills**

....
(sonographer) (physician)

CT Head

Performed	12-Apr-2023 08:49	Received	23-Apr-2023 14:27
Reported	23-Apr-2023 14:25	Order Number	G588C39466067
Status	Final	Source System	MiSys

CT Head Final
Tracy Roberts
Clinical History :
Persistent daily headache for over 4 months. Sometimes associated with nausea. ?any cerebral masses

CT Head :

Normal grey-white matter differentiation.
No evidence of acute intra-axial haemorrhage, mass, acute/chronic infarct or surface collection.
No hydrocephalus.
No significant pathology related to the paranasal sinuses and mastoids.
No significant bony lesion.

Conclusion: No acute or significant intracranial abnormality.

Dr. Sarfraz Nazir
Consultant Radiologist
GMC: 4737450
Clinicalqueries@axondiagnostics.com

Reported by: Dr Sarfraz Nazir
Verified by: Dr Sarfraz Nazir

XR Wrist Rt

Performed	12-Jun-2021 17:06	Received	14-Jun-2021 14:34
Reported	14-Jun-2021 14:32	Order Number	G306H37348517
Status	Final	Source System	MiSys

XR Wrist Rt Final
Tracy Roberts
Clinical History :

Fell through glass mirror 3/7 ago. Wound to dorsum of hand. Exclude FB. Also, tender over distal radius/ulna and over 2nd/3rd MC's. Exclude bony injury.

XR Wrist Rt :
No acute bony injury or retained radiopaque foreign body identified.
Normal bony alignment is maintained.

XR Hand Rt :
No acute bony injury identified.
Normal bony alignment is maintained.

Code N: No note: No sticky note available. Referrer's interpretation is unknown.

Images reported by Alana Stewart, trainee Reporting Radiographer.

Reported by: Alana Stewart and Kirsteen Graham
Verified by: Kirsteen Graham

XR Hand Rt

Performed	12-Jun-2021 17:06	Received	14-Jun-2021 14:34
Reported	14-Jun-2021 14:32	Order Number	G306H37348518
Status	Final	Source System	MiSys

XR Wrist Rt Final
Tracy Roberts
Clinical History :

Fell through glass mirror 3/7 ago. Wound to dorsum of hand. Exclude FB. Also, tender over distal radius/ulna and over 2nd/3rd MC's. Exclude bony injury.

XR Wrist Rt :
No acute bony injury or retained radiopaque foreign body identified.
Normal bony alignment is maintained.

XR Hand Rt :
No acute bony injury identified.
Normal bony alignment is maintained.

Code N: No note: No sticky note available. Referrer's interpretation is unknown.

Images reported by Alana Stewart, trainee Reporting Radiographer.

Reported by: Alana Stewart and Kirsteen Graham
Verified by: Kirsteen Graham

XR Chest

Performed	14-Feb-2021 10:34	Received	14-Feb-2021 16:35
Reported	14-Feb-2021 16:33	Order Number	G405H36964746
Status	Final	Source System	MiSys

XR Chest Final
Tracy Roberts
Clinical History :

Tremor, SOB, long term smoker; left basal reduced air entry ?consolidation

XR Chest :
PA projection.

Normal appearance heart and mediastinum.
No focal active pulmonary pathology.

Reported by: Dr Amit Patel
Verified by: Dr Amit Patel

XR Chest

Performed	12-Apr-2019 17:03	Received	19-Apr-2019 13:50
Reported	19-Apr-2019 13:48	Order Number	G405H34979436
Status	Final	Source System	MiSys

XR Chest Final
Tracy Roberts
Clinical History :

47y admitted with sharp left sided chest pain. Worse on inspiration and movement. States recent cough. Heavy smoker ?consolidation. ?collapse

XR Chest :
Normal cardiac and mediastinal contours. No focal active lung lesion.

Reported by: Dr Oliver Cram
Verified by: Dr Oliver Cram

XR Chest

Performed	29-Mar-2017 15:29	Received	12-Apr-2017 16:46
Reported	12-Apr-2017 16:44	Order Number	G405H32495164
Status	Final	Source System	MiSys

XR Chest Final
Tracy Roberts
Clinical History :
pleuritic chest pain, ? pe, please r/o other cause.

XR Chest :
Normal cardiac mediastinal contours.
Lungs and pleural spaces are clear.
No change from film dated 19/06/2013.

Reported by: Dr Peter Douglas (SpR)
Verified by: Dr Peter Douglas (SpR)

XR Hand Rt

Performed	11-Nov-2015 21:47	Received	12-Nov-2015 12:09
Reported	12-Nov-2015 12:07	Order Number	G405H30833846
Status	Final	Source System	MiSys

XR Hand Rt Final
Tracy Roberts
Clinical History :

laceration iwth glass, query FB

(Information via Order Comms)

XR Hand Rt :
There is an 11 mm long radio-opaque object projecting over the soft tissue of the right hand on the radial side. This could be related to the wound dressing; however, a foreign body would give a similar picture.

Code N: No note: No sticky note available. Referrer's interpretation is unknown.

Reported by: Dr Adil Mahmoud (SpR)
Verified by: Dr Adil Mahmoud (SpR)

XR Foot Rt

Performed	21-May-2015 14:53	Received	21-May-2015 15:15
Reported	21-May-2015 15:13	Order Number	G306H30278941
Status	Final	Source System	MiSys

XR Foot Rt Final
Tracy Roberts
Clinical History :
? fb in foot

XR Foot Rt :
No radiopaque foreign body is demonstrated.
Marked deformity of the third metatarsal head appears longstanding.

No clinician's report available.

Reported by: Dr Catriona Turbet (SpR)
Verified by: Dr Catriona Turbet (SpR)

XR Chest

Performed	19-Jun-2013 03:59	Received	25-Jun-2013 11:17
Reported	25-Jun-2013 10:55	Order Number	G405H28065180
Status	Final	Source System	MiSys

XR Chest Final
Tracy Roberts
Clinical History :
Chest pain, cough for 4 weeks, smokes. Respiratory infection?

XR Chest :
The lungs are clear of active disease. No consolidation is demonstrated. The mediastinal, hilar and cardiac contours are normal.

Reported by: Dr Edit Gyomber
Verified by: Dr Edit Gyomber

XR Radius & ulna Rt

Performed	17-Apr-2009 03:24	Received	20-Apr-2009 14:31
Reported	20-Apr-2009 14:10	Order Number	G306H12897443
Status	Final	Source System	MiSys

XR Hand Rt Final
Tracy Roberts
Clinical History : Punched glass, ? FB.

XR Hand Rt : No radio-opaque foreign body demonstrated.

XR Radius & ulna Rt : No radio-opaque foreign body demonstrated.

Reported by: DR G SIMPSON
Verified by: DR G SIMPSON

XR Hand Rt

Performed	17-Apr-2009 03:24	Received	20-Apr-2009 14:31
Reported	20-Apr-2009 14:10	Order Number	G306H12897442
Status	Final	Source System	MiSys

XR Hand Rt Final
Tracy Roberts
Clinical History : Punched glass, ? FB.

XR Hand Rt : No radio-opaque foreign body demonstrated.

XR Radius & ulna Rt : No radio-opaque foreign body demonstrated.

Reported by: DR G SIMPSON
Verified by: DR G SIMPSON

WEST OF SCOTLAND CENTRE FOR GENOMIC MEDICINE | Clinical Genetics
Level 2A Laboratory Medicine
Queen Elizabeth University Hospital
1345 Govan Road Glasgow G51 4TF
www.nhsggc.org.uk/medicalgenetics
NHS Greater Glasgow and Clyde

GENETIC SELF REFERRAL FORM

One of your relatives has been found to have a genetic condition called **myotonic dystrophy Type 1**. Following genetic testing a gene alteration has been identified. If you are a relative of the person who carries this gene alteration you have a chance of inheriting this which may have implications for your health or reproductive choices.

If you would like to discuss this further, then please fill in the details below and return this form to our department, and an appointment will be sent out to you.

Alternatively if you have any questions contact our reception on 0141 354 9201 and ask to speak with a genetic counsellor.

Pedigree Number	114345
Name	TRACY ROBERTS
Address	263 CURTIS AVENUE
	KINGSPARK
Post Code	G44 4NW
Date of Birth	27 04 1971
Tel Number	07359851770
GP Name	DR MCNALLY
GP Address	GOVANHILL
	HEALTH CENTER

RECEIVED 23 MAY 2024

Please tick the appropriate box:-

☑ **Please send me an appointment to discuss my family history**

☐ **I do not wish an appointment**

Signed T. ROBERTS **Dated:** 21.05.2024

Please return this form to:

Freepost RSZB-
Dr Mark Hamilton
Consultant Clinical Ge
Level 2 Clinical Genet
Queen Elizabeth Unive
1345 Govan Road
Glasgow
G51 4TF

2704716161

MH

WEST OF SCOTLAND CENTRE FOR GENOMIC MEDICINE | Clinical Genetics
Level 2A Laboratory Medicine
Queen Elizabeth University Hospital
1345 Govan Road Glasgow G51 4TF
www.nhsggc.org.uk/medicalgenetics
NHS Greater Glasgow and Clyde

RECORD OF DISCUSSIONS regarding testing and/or storage of genetic material

I have discussed genomic/genetic testing with my health professional and I understand that:

Family implications

1. The results of my test *may* have implications for other members of my family. I acknowledge that my results may sometimes be used to inform the appropriate healthcare of others. This could be done in discussion with me, or in such a way that I am not personally identified in this process.

Uncertainty

2. The results of my test *may* reveal genetic variation whose significance is not yet known. Deciding whether such variation is significant may require sharing of information about me including (inter)national comparisons with variation in others. I acknowledge that interpretation of my results may change over time as such evidence is gathered.

Unexpected information

3. The results of my test *may* reveal a chance of a disease in the future, and nothing to do with why I am having this test. This may be found by chance, while focusing on the reason for my test, and I may then need further tests to understand what this means for me. If these additional findings are to be looked for, I will be given more information about this.

DNA storage

4. Normal laboratory practice is to store the DNA extracted from my sample even after the current testing is complete. My sample might be used as a 'quality control' for other testing, for example, that of family members.

Data storage

5. Data from my test will be stored to allow for possible future interpretations.

Health records

6. Results from my test and my test report will be part of my patient health record.

Note of other specific issues discussed (*eg referral to particular research programmes, insurance*):

Possible referral to University of Glasgow Genetics Laboratory – Professor Darren Monckton

I agree to genetic/~~genomic~~ investigations: TYPE I MYOTONIC DYSTROPHY	**DATE:** 11 / 07 / 2024
Patient/~~parent~~ signature: T. ROBERTS	**Discussion undertaken by: (clinician name/signature)** Bob Ballantyne **Dr Bob Ballantyne**

Affix sticky label or fill in details

Patient Name: TRACY ROBERTS
Date of Birth 27/04/1971 CHI: 2704716161
Patient Address: 263 CURTIS AVENUE, GLASGOW, G44 4NW
Genetics ref 114345 1 COPY for notes, 1 COPY for patient to retain

Monday, 17 June 2024
AS/114345/2704716161

Acute Services Division
Diagnostics Directorate

West of Scotland Clinical Genetics Service
Level 1A Laboratory Medicine
Queen Elizabeth University Hospital Campus
1345 Govan Road, Glasgow, G51 4TF

Telephone: 0141 354 9221/9223/9264/9202

Email: Genetics.Referrals@ggc.scot.nhs.uk

NHS
Greater Glasgow and Clyde

Ms. Tracy Roberts
263 Curtis Ave
Glasgow

G44 4NW

Dear Ms. Roberts

Please quote in all correspondence: 114345

A Genetic outpatient appointment has been arranged for you with Dr Bob Ballantyne on:

Jul 11, 2024 at 11:45
Clinical Genetics
Level 1A, Laboratory Medicine Building
Queen Elizabeth University Hospital Campus
1345 Govan Road, Glasgow G51 4TF

If this appointment is not suitable or if for any reason you no longer need or are unable to keep this appointment please contact us on the above phone numbers or via email. **You can contact us by phone between the hours of 9am and 1pm Monday – Friday, excluding Public Holidays and weekends.** If our phone lines are busy, it will go straight to voicemail and we will call you back as soon as we can. Please note our phone number shows as 0141 232 4000 when we call you.

If you are contacting us by email you should include the following information:

Your name, CHI number, correspondence number, date and time of your appointment, the reason you are unable to attend and if you require a further appointment.

Our Outpatient Clinic is open between the hours of 9 am and 5 pm. If you arrive outside those hours there is a seating area on the ground floor and café facilities are available within both main hospital buildings.

If patient transport is required, it can be booked by contacting the Patient Transport Service on 0300 123 1236.

Failing to attend your appointment costs the NHS approximately £200.

Yours sincerely

Clinic Administrator

In accordance with GGC policy this letter is printed on recycled paper to save the environment

Acute Services Division

Diagnostics Directorate

WEST OF SCOTLAND CENTRE FOR GENOMIC MEDICINE | Clinical Genetics

Level 2A Laboratory Medicine
Queen Elizabeth University Hospital
1345 Govan Road Glasgow G51 4TF
www.nhsggc.org.uk/medicalgenetics

NHS Greater Glasgow and Clyde

Secretaries: GeneticSecretaries@ggc.scot.nhs.uk
Reception: 0141 354 9201
Referrals: GeneticsReferrals@ggc.scot.nhs.uk

Height 160.25cm
Weight 90.39kg
BP: 148/103mmHg

West of Scotland Myotonic Dystrophy Management Clinic (WOSMDMC)

Clinic Note

Name: Tracy Roberts
Address: 263 Curtis Avenue Glasgow G44 4NW

Pedigree: 114345
CHI: 2704716161

Date:	11 JULY 2024
Time:	11:45
Category:	Genetics opc, QEUH
Clinician:	Dr Bob Ballantyne (bob.ballantyne@ggc.scot.nhs.uk)

Comments:

FH type 1 myotonic dystrophy
(daughter + granddaughter)

Attending for counselling and predictive testing.

Actions:
[1] Counselled
[2] Sample obtained
[3] Recommend primary care BP review

Acute Services Division

Diagnostics Directorate

NHS
Greater Glasgow and Clyde

WEST OF SCOTLAND CENTRE FOR GENOMIC MEDICINE | Clinical Genetics

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Reception: 0141 354 9201
Referrals: GeneticsReferrals@ggc.scot.nhs.uk

Pre-clinic Preparation

ECG 02/05/2024 - SR, 87bpm, PR 152 ms, QRS 90 ms.

Primary care referral to Cardiology 19/04/2024
- 4 yr history of headaches and episodes of collapse with LOC
- Has ambulatory ECG at NVH tomorrow.

Dr John Saldanha
GMC 6157070
Govan Hill H/C 49041
0141 531 8365
ggc.gp49041clinicalmail.scot.nhs.uk

PMH
Possible COPD
Anxiety/low mood

c/f Headache 12/04/2023
Headaches - no abnormalities

Acute Services Division

Diagnostics Directorate

WEST OF SCOTLAND CENTRE FOR GENOMIC MEDICINE | Clinical Genetics

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Queen Elizabeth University Hospital
1345 Govan Road Glasgow G51 4TF
www.nhsggc.org.uk/medicalgenetics

NHS Greater Glasgow and Clyde

Secretaries: GeneticSecretaries@ggc.scot.nhs.uk
Reception: 0141 354 9201
Referrals: GeneticsReferrals@ggc.scot.nhs.uk

Glass injury to right hand

- surgical exploration and EPL repair

GA – no issues

Reports right hand can get stiff and painful at times

O/E No significant muscle weakness
No demonstrable myotonia

Counselled ✓
ROD signed ✓
Sample obtained

Advised result in 4-6 weeks.

Acute Services Division
Diagnostics Directorate

WEST OF SCOTLAND CENTRE FOR GENOMIC MEDICINE | *Clinical Genetics*

Level 2A Laboratory Medicine
Queen Elizabeth University Hospital
1345 Govan Road Glasgow G51 4TF
www.nhsggc.org.uk/medicalgenetics

NHS Greater Glasgow and Clyde

West of Scotland Myotonic Dystrophy Management Clinic

Dr Mark Hamilton, Consultant, Clinical Genetics
Dr Maria Elena Farrugia, Consultant, Neurology
Dr Bob Ballantyne, Specialty Doctor, Clinical Genetics

Secretary: 0141 354 9222 (Janice)
General Enquiries: 0141 354 9200

Please quote this reference in all correspondence:

Our ref: BB/JG/114345 CHI: 2704716161

15 August 2024 (Dictated: 11/07/2024)

Ms Tracy Roberts
263 Curtis Avenue
Glasgow
G44 4NW

Dear Ms Roberts

Molecular testing excludes a diagnosis of type 1 myotonic dystrophy (you are **not** at risk of developing type 1 myotonic dystrophy)

It was a pleasure to meet with you at the genetics department at the Queen Elizabeth University Hospital on the 11th July 2024. This appointment was arranged at your request so you could attend for genetic counselling and to proceed with genetic testing for type 1 myotonic dystrophy. Your daughter and granddaughter were recently diagnosed with type 1 myotonic dystrophy and you wished to attend for testing to see if you have the myotonic dystrophy gene change or not. You advised me that you have a diagnosis of possible COPD and I understand that this has not yet been confirmed. You told me you had an appointment the day after our meeting to have a 24 hour heart monitor fitted at the New Victoria Hospital. This was to investigate some episodes of light headedness and collapse. We also spoke about a previous injury you sustained to your right hand which required some surgery to repair a tendon. You told me you have had no issues with general anaesthetics in the past. Cataracts have not been identified on any of your previous eye tests. You mentioned that on occasions you felt that your right hand can get a little stiff and painful.

We discussed the genetics of type 1 myotonic dystrophy including the autosomal dominant inheritance pattern and your own 1 in 2 (50/50) chance of having the same gene change which affects your daughter and granddaughter. We discussed that the gene change which causes myotonic dystrophy type 1 can become larger in successive generations and when this occurs it may be associated with more severe and earlier onset symptoms. We discussed that myotonic dystrophy, although predominantly known as a type of muscular dystrophy, can affect many other parts of the body including the brain, eyes, heart, lungs, bowels and skin. Adults who have type 1 myotonic dystrophy may experience increased sensitivity to general anaesthetics, opioid painkillers and sedative medications and it is recommended that affected adults carry an alert card or wear an item of jewellery which identifies that they have myotonic dystrophy and/or add an alert to their smart

phone. We also touched on some of the reproductive or family planning options which are available to affected adults including preimplantation genetic testing. Adults who are affected by type 1 myotonic dystrophy must advise the DVLA of their diagnosis. It is recommended that adults with type 1 myotonic dystrophy should attend for annual clinical reviews and to allow the recommended heart and blood test investigations to be performed.

Following our discussion you were keen to proceed with testing for type 1 myotonic dystrophy and a sample was obtained and sent to our molecular laboratory.

As you are aware from my subsequent email correspondence, the molecular testing showed that you **do not** have the myotonic dystrophy gene alteration and are **not** at risk of developing type 1 myotonic dystrophy.

Please get in touch if you have any questions.

Kind Regards,
Yours sincerely

Bob Ballantyne
GMC 4018250
Specialty Doctor in Clinical Genetics
Email: bob.ballantyne@ggc.scot.nhs.uk
Direct line: +44 141 354 9241
Mobile: +44 7773159881

Electronically verified by Dr Ballantyne on: 20/08/2024

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More information on muscle conditions in Scotland is available at www.smn.scot.nhs.uk

UKAS MEDICAL 8290

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Molecular Genetics Report for Myotonic Dystrophy type 1

Report Number: 274360

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Reported: Shaun Prior

Authorised: Gillian Stevens

Name of Patient:	**Tracy ROBERTS**			Date of Birth:	**27/04/1971**
CHI/NHS Number:	**2704716161**	Sex:	**Female**	Date of Sample:	**11/07/2024**
Hospital Number:		Sample Type:	**EDTA blood**	Date Received:	**11/07/2024**
Pedigree Number:	**114345**	Lab Number:	**4244373**	Date of Activation:	**11/07/2024**
Ref Lab Number:		Gestation:		Date of Report:	**19/07/2024**

Reason for referral: Family history of myotonic dystrophy type 1 (DM1).

Conclusion: **No evidence of a DMPK expansion detected in this patient.**

Results and Interpretation:

Fluorescent flanking PCR analysis identified two DMPK alleles in the NORMAL size range of 12 (+/-1) and 13 (+/-1) CTG repeats. The characteristic ladder of CTG peaks observed in the presence of an expanded allele was NOT detected by triplet primed PCR indicating that the patient is heterozygous for 12 & 13 (CTG) repeats and does not carry any DMPK expansion.

These results exclude the possibility that this patient will develop clinical symptoms associated with myotonic dystrophy type 1.

Comments:

In order to avoid error and/or misinterpretation, transcription of the content of this report is not advised; Laboratory Genetics do not take any responsibility for the accuracy of any data/text transcribed from this report.

Technical Information:

Analysis of the CTG repeat in the 3' untranslated region of the DMPK gene using fluorescent flanking PCR and fluorescent triplet primed PCR (TP-PCR) was performed. Fluorescent flanking PCR detects CTG expansions up to ~120 repeats (Fu et al, Science 1992; 225: 1256-1258). TP-PCR of both strands using independent primer sets detects CTG expansion >50 repeats but cannot always accurately size the repeats (Warner et al, J Med Gen 1996; 33: 1022-1026). DM1 allele size ranges: Normal range = 5-35 CTG repeats. Premutation range = 36-50 CTG repeats, are not associated with symptoms but may be unstable expanding into the affected size range upon transmission. Full mutation (affected) range >50 CTG repeats. (Kamsteeg et al, Eur J Hum Genetics 2012 20:1203–1208).

TR – 2704716161 **Ped 114345**

PASS Clinical notes

29/4/24 **Other** **BB**

Self Referral Form received. See PASS/Correspondence

11/7/24 **Appointment** **BB**

Attended WOSMDMC
First appointment
Attending for counselling and predictive testing.
See clinic note in PASS/Correspondence