Medical Records Evidence Review

JH - page-referenced extraction schedule

Prepared from the 6-page NHS Lanarkshire Neuropsychology correspondence supplied for review

Important review note: This file contains referral and administrative correspondence only. It does not contain a neuropsychological assessment, clinical formulation, care-history narrative or abuse disclosure. General crisis-service information printed on the waiting-list form is not treated as evidence that the patient experienced suicidal thoughts or self-harm.

Executive findings

• No evidence of placement in care, a named institution, foster placement, residential school, assessment centre, looked-after status or supervision requirement was identified.

• The strongest relevant evidence is that Neurology referred the patient to NHS Lanarkshire Neuropsychology for assessment in February 2026.

• The referral did not progress: the patient did not respond to the opt-in letter and was discharged from the Neuropsychology team on 6 March 2026.

• No diagnosis, abuse history, self-harm history, substance use, physical injury, neglect, safeguarding action or causal link to childhood trauma is recorded in these six pages.

Detailed extraction schedule

PDF page	Internal page	Date	Document / clinician	Category	Exact evidence / faithful summary	Care setting / perpetrator	Impact / treatment / follow-up	Link & evidential value
1	1 of 6	05-Feb-2026	NHS Lanarkshire Neuropsychology Service letter	Psychiatric / neuropsychological care	Neurology Registrar Dr Valentina Fenech referred the patient to the Neuropsychology Service for an assessment appointment. The letter asks whether he wishes to be placed on the waiting list and requires contact within 14 days.	No care setting or perpetrator recorded.	Proposed specialist assessment; service may telephone to clarify needs.	Direct evidence of referral and intended specialist assessment. No abuse or care-placement link recorded.
2	2 of 6	Associated with 05-Feb-2026 letter	Copy-recipient / correspondence page	Third-party records	Correspondence routes identify Dr S Findlay at Bruce Medical Centre and Dr Valentina Fenech, Neurology Registrar, Institute of Neurological Sciences, Queen Elizabeth University Hospital.	No care setting or perpetrator recorded.	Confirms GP, neurology and neuropsychology communication.	Supporting evidence of linked healthcare services; not evidence of abuse or placement.
3	3 of 6	Associated with Feb-2026 referral	Neuropsychology waiting-list form	Psychiatric care / administrative	Form for the patient to request placement on the Neuropsychological Service waiting list. The form is blank and does not show that it was completed or returned.	No care setting or perpetrator recorded.	Administrative step only.	Evidence of proposed assessment pathway; does not prove attendance or treatment.
3	3 of 6	Associated with Feb-2026 referral	Patient information printed on form	Neutral / crisis information	General information lists anxiety-management resources, the Calm Distress programme, NHS 24, Breathing Space and Samaritans.	Not recorded.	No patient-specific action recorded.	Neutral service information only. It must not be presented as evidence of suicidal thoughts, self-harm or crisis.
5	5 of 6	06-Mar-2026	Letter from Dr Andrew Wood, Consultant Clinical Psychologist / Clinical Lead for Neuropsychology	Psychiatric care / non-attendance / discharge	The service records that no response was received to the opt-in letter. The patient was therefore discharged from the Neuropsychology team.	No care setting or perpetrator recorded.	Referral closed without assessment or treatment.	Direct evidence of administrative discharge. The reason for non-response is not stated and should not be inferred.
6	6 of 6	Associated with 06-Mar-2026 letter	Correspondence-recipient page	Third-party records / address	The discharge correspondence identifies Dr S Findlay at Bruce Medical Centre and the patient at a private Bellshill address.	Private home address; no care establishment.	GP informed of discharge.	Confirms contemporary address and correspondence route only; not placement evidence.

Category findings not identified in the verified entries

No clear entry was identified describing placement in care, physical abuse, sexual abuse, emotional abuse, neglect, a contemporaneous disclosure, self-harm, suicidal ideation, substance or alcohol use, childhood trauma, a named institution or perpetrator, safeguarding action, police involvement, mental-health medication, counselling or therapy received, or a physical condition linked to childhood abuse. The absence of such wording in this limited correspondence is not proof that no such history exists.

Recommended evidential use

The most useful pages are PDF page 1, which proves referral to Neuropsychology, and PDF page 5, which proves that the referral was closed without assessment because no opt-in response was received. Pages 2 and 6 confirm the GP and specialist correspondence routes. These documents should be used as limited treatment-pathway evidence only and should not be relied upon as proof of care placement or abuse.