

NHS Fife, Queen Margaret Hospital, Whitefield Road, Dunfermline KY12 0SU
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Date: 03 July 2026

Your ref: 100048

Our ref: JW/SK/SR26/1400

Enquiries to: Legal Services

Direct line: 01383 674101

Email: Fife.LegalServices@nhs.scot

MMA Legal
43-59 Princes Street
Stockport
SK1 1RY

1 of 2

* Voluminous records
Sent in 2 packages *

(Volumes 1-4 MH
Sci-store
medical Casenotes
attached hereto)

Dear Sir

Your Client: Leon James Gratton
Address: 3 Makgill Row, Cupar, Fife, KY15 5SA
Date of Birth: 17/03/1975

I refer to your letter of 29 April 2026 and as requested, I now enclose copy medical records of NHS Fife relating to your above-named client and trust that these will be of some assistance to you. Volumes 1-8 of your client's notes are enclosed. Volume 9 has not been made available to us. It is with your client's consultant as he is a current patient.

Please note that these copy records are being provided to you for your purpose only and have **not** been reviewed by the treating clinician to ascertain if they contain any information which may cause either physical or mental harm to the patient or other persons. If it is the case that your client wishes copies of their health records, they should be asked to contact Access to Health Records Department, Victoria Hospital, Kirkcaldy, Fife, KY2 5AH who will process their request.

Yours faithfully

Joanna Whitfield
Legal Services Manager



Chair: Pat Kilpatrick
Chief Executive: Carol Potter

Fife NHS Board is the common name of Fife Health Board

**MENTAL
HEALTH
CASENOTES:
VOLUME 4**

Working With Risk (1): Current Situation (RA part 1)

Name: LEON GRAYTON Date of Birth: 17 / 03 / 75 CHI/PIN No: 1703751191Address: C/O DUNINO WARD
STATHEN

Post Code: _____

Gender: MPeriod/Date of Assessment: From 06/01/12 to 1 / 1

Complete any details of identified Risk below:

Assessment (Circle relevant answer)

From Others (e.g. abuse, exploitation)

LEON VULNERABLE TO EXPLOITATION. APPEARS TO BE EASILY LED BY OTHERS. PREVIOUS ASSOCIATION WITH DRUG DEALERS SPENDING TIME IN HIS HOME

No / Unknown / Yes

To Self (e.g. suicide, self harm)

IMPULSIVE BEHAVIOUR. SIGNIFICANT HISTORY OVERDOSE ATTEMPTS
USE OF ILLICIT SUBSTANCES

No / Unknown / Yes

To Others (e.g. aggression, violence)

SIGNIFICANT HISTORY VIOLENCE TOWARDS MOTHER + STEP-FATHER - THIS IS NOT CALLED
NOTED TO BE UNFAMILIAR TOWARDS KINEMAS ON HOME VISITS) BEHAVIOUR

No / Unknown / Yes

Neglect (e.g. health, personal appearance)

MOTIVATIONAL ISSUES

No / Unknown / Yes

To Child(ren) (e.g. neglect, abuse)

No / Unknown / Yes

Physical Impairment (e.g. medical, sensory)

No / Unknown / Yes

Wandering & / or Falls

No / Unknown / Yes

Memory and Cognitive Impairment (e.g. forgetfulness)

No / Unknown / Yes

Challenges to Services (e.g. inappropriate demands, poor compliance)

MADE FALSE ALLEGATIONS - JOINING VISITS WHEN IN COMMUNITY
STANDARD ATTENDANCE AT MEET CLINIC

No / Unknown / Yes

Strengths/Positive Attributes (e.g. positive resources, agreed plans)

No / Unknown / Yes

ADMISSION FOR 6-WEEK ASSESSMENT

Name: LEON GRATTON

Mental Health Services

CHI/PIN No. 1703251191

Summary of Assessment (General Overview of situation)

Admitted Dinning for 6-week assessment, mental health
stable, some fixed beliefs but not disturbed by
them. Feels unable to return home as he is
vulnerable to exploitation from others. Leon wants
to engage with OTS and 6-week mental health program

Current behaviour appropriate, not violent or
irritabile

11/11 - noted expressing paranoid delusions concerning mother

noted on previous RAI - that 27/6/10 reported by
Barbara Barnes (child family social worker) that
Leon allegedly admitted to feeling sexually harassed
and young children when he was young - questioned
by police, no further action taken

Client involved Yes ☐ No ☒

Carer Involved Yes ☐ No ☒

Discussed with other agencies: please specify.....

Comments:.....

**If required, please continue on a continuation/evaluation sheet*

Completed By: Leet Nelson Date: 16.1.12 Time: 1530

Need For More Detailed Risk Assessment & Management:

NO ☐ **YES** ☐ If yes please go to RA part 2

Admitted as per 6-week assessment

PSYCHIATRIC CASE SUMMARY
Date: 19 March 2012

CASENOTE NO.: SF5153833A

SURNAME: Gratton

FORENAME: Leon

D.O.B.: 17.03.75 **CHI:** 1703751191

DATE OF CURRENT ADMISSION: 06.01.12

WARD: Dunino

Mr Leon Gratton is a thirty six year old man who is currently a patient in Dunino rehabilitation ward on an informal basis. He has a longstanding history of schizophrenia, drug misuse and depression. His current admission began in September 2011 when he was admitted to Ward 2 at Queen Margaret Hospital with worsening in mental state, increased substance misuse and generally becoming more chaotic. He was found to be living in squalor by the Community Outreach Team and his self-care was extremely poor. He was preoccupied with delusions and there was evidence of increased perceptual disturbance. Leon was referred to the Rehabilitation Service and was transferred to Dunino on 10 January 2012. He recently had a six-week assessment on 11 February 2012.

Personal History

Leon was born in Manchester and moved to Scotland when he was two. His parents separated when he was three years old. His childhood was uneventful up to the age of thirteen, when his mother divulged that she and her sister had been sexually abused during childhood by their father. This disclosure caused a family row, with the mother and son being ostracized from the rest of the family. She shared full details of her allegation with Leon, who subsequently became very disturbed and preoccupied with the whole issue. He spent from the age of fifteen to sixteen in children's homes and left school at fifteen with no qualifications. At that time he was abusing drugs including LSD, amphetamines and cannabis. He described from age sixteen to eighteen doing "everything I could to annoy my mother". In 1993 he took acid and following this became increasingly disturbed and paranoid, leading to his first admission at the Royal Edinburgh Hospital. He has a patchy employment record. He has had several jobs after leaving school, the longest being for four months. He moved around the country a bit, taking seasonal work. In 1996 he moved to Lanarkshire. He married his now ex-wife, Liz, a social worker who is considerably older than him. She had three children from a previous relationship and they had a son together whom he continues to see approximately once a month. The relationship with Liz lasted three to four years. He is now divorced. He also has a daughter who he is not in contact with from a more recent relationship. He is no longer with the mother, who gave up their daughter for adoption. Prior to his current admission Leon had been supported by the West Fife Community Outreach Team. He had also had Richmond Fellowship support which was withdrawn. He was in receipt of DLA and Income Support but apparently had debts of around

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£11,000. He was living alone in a council house. In terms of family psychiatric history, he has an aunt who suffers from agoraphobia.

Past Psychiatric History

At the age of seventeen Leon was referred by his GP to the Community Drugs Service with concerns about his benzodiazepine consumption. He DNA'd two appointments. In October 1992 he was re-referred. He attended on 29 October 1992 with his mother. At that time he was drug-free and it certainly did not appear to be a primary problem. It is noted that the fraught family conditions appeared to be more significant.

In March 1993, Leon was assessed at A&E after being brought by the police from a petrol station where he was shouting, swearing and disturbing the peace. He was thought to have consumed LSD, alcohol and ? Mephedrone tablets. On assessment, there was no evidence of mental illness and he was simply re-referred to the CDPS. He was later discharged from the CDPS in May 1993 due to non-attendance.

First admission – 12.09.93 to 26.01.94

Leon was admitted to the Royal Edinburgh Hospital after having been brought for assessment by his mother. His behaviour had given cause for concern over the preceding few days. He appeared frightened of people, was making odd remarks and was experiencing increased agitation. He was transferred to IPCU where he was commenced on Chlorpromazine and his mental state gradually improved. His behaviour required that he remain in IPCU for some time. His medication was changed to Trifluoperazine, he was transferred to a general ward and was discharged to Penumbra supported accommodation and referral to the Young People's Unit for follow-up. Diagnosis was acute psychotic episode.

Throughout 1994 and 1995, Leon attended the Young People's Unit in Edinburgh on a regular basis for review. He continued on Stelazine 25 mgs nocte. Towards the end of 1995 and the start of 1996 his attendance was sporadic but he appeared to remain well when taking medication and when free from psychosocial stress. The last letter from the Young People's Unit is from 10 April 1996.

Between 1996 and 1999 Leon does not appear to have had contact with the Psychiatric Services. In July 1999, while living in Lanarkshire, Leon was referred to the Psychiatric Services by his GP. He attended the outpatient clinic on 5 July 1999 with his wife at the time (Liz, who was a social worker). He presented with symptoms of a recent history of irrational fears (for example, that his wife and nine month old son may be kidnapped), paranoid ideas (people talking about him and laughing at him, calling his wife "a whore" and him "an eejit", and also "amnesiaic episodes" where he wandered the area at night and with reduced awareness of surroundings. At that time it was unclear whether he had an underlying psychotic illness or not. The opinion was that he had a profound personality disturbance from his mid-teens which had been maintained and exacerbated by a continuing over-heated relationship with his mother, though the paranoid feelings were not thought to be psychotic. The episodes of wandering were more in keeping with some kind of dissociative state. He was advised to continue on the Stelazine and further outpatient review was arranged.

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2nd admission – November 1999 to January 2001

Admission was arranged for a comprehensive ward-based assessment. Following the two and a half months inpatient stay, the diagnosis was of histrionic personality disorder and morbid jealousy state. There was little evidence to suggest a diagnosis of paranoid schizophrenia at that time. It was also mentioned that he had a fixed belief regarding his jealousy state and therefore it could also be described as a delusional disorder. He was discharged with outpatient and CPN follow-up on Olanzapine 10 mgs nocte.

In June 2001 he was assessed at Monklands A&E Department after having been brought in by his CPN following non-compliance with Olanzapine and Trazodone. He was complaining of nightmares, distressing memories of things that happened to him aged eighteen and experience of vague paranoid thoughts about former associates with whom he had previous illicit drug dealings that they may possibly be after him. At that time it was felt that he was experiencing a behavioural disturbance and lack of sleep with no evidence of psychotic disorder. His medications were recommenced. He was discharged to the previously in place outpatient and CPN follow-up.

By 2001, Leon had separated from his wife and was planning a move back to the Fife area. His care was transferred to the local sector area and a letter from the Lanarkshire consultant he stated that, although the possibility of schizophrenia had been raised, in his opinion the evidence pointed more towards gross personality dysfunction. Medications at that time were Olanzapine 10 mgs nocte and Sertraline 40 mgs daily.

By March 2002, Leon had engaged with the Fife area services and following consultant review in March 2002 it was thought his main issues were personality dysfunction with associated features. He was reviewed regularly by the Continuous Community Treatment Team.

3rd admission – 17.03.02 to 18.04.02

He was brought to his GP by the police after he had called the fire brigade thinking there was a gas leak. He had been non-compliant with his medications and had not slept for seven or eight days. He was complaining of auditory hallucinations and he presented in an agitated and confused state. He was commenced on Zuclopenthixol Decanoate depot and it was thought the form of his symptoms and pattern of his recovery remained consistent with a borderline personality disorder complicated by psychotic episodes.

He was followed up in August 2002 by a new consultant when the diagnostic impression was consistent with that of previous psychiatric assessments of personality disorder, although it was pointed out that there were features of his symptoms more consistent with a functional psychosis. Leon was placed on a Care Programme Approach and had regular review at outpatient clinics every three months. He also had weekly visits by a CPN and he was supported by Penumbra and encouraged to attend social groups, clubs and five aside football. In a letter dated February 2003 it states **"In view of his excellent response to medication, and in the context of previous diagnostic difficulties, it is looking increasingly likely that the correct diagnosis is schizophrenia rather than personality disorder"**.

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4th admission – 27.11.03 to 22.12.03

Leon was referred to the ward by the Community Outreach Team with a worsening of mood and increase in auditory hallucinations. He had also experienced suicidal thoughts and had impulsively taken a handful of Melatonin tablets to help him sleep prior to admission. He was also experiencing ideas of reference. On the ward his Clopixol depot was increased and he improved. He was discharged on Haloperidol 2 mgs qid, Zopiclone 15 mgs nocte and Zuclopenthixol Decanoate depot 250 mgs weekly. The diagnosis was schizophrenia. Follow-up continued as previous.

Throughout 2004 and 2005 he continued to be seen by the Community Outreach Team with CPA follow-up. He was referred for a neuropsychological assessment and had brief contact with a psychologist.

In October 2005 he was assessed at A&E after self-presenting with an overdose of five sleeping tablets and one Mirtazapine tablet. He described the trigger for the overdose was feeling agitated and angry. It was an impulsive act with no suicidal ideation therefore he was discharged with the regular follow-up.

In April 2006 he was assessed at Queen Margaret Hospital after the Community Outreach Team brought him in with worsening distress, paranoia, auditory hallucinations and suicidal ideation. He had taken a number of concealed overdoses recently. He was provided with additional prn antipsychotic medication and his intensive follow-up was continued.

In August 2006, at a Care Programme Approach meeting, he was noted to be engaging well with the Community Outreach Team, attending the gym regularly and engaging positively with the Occupational Therapy Department. He had seventeen hours of support per week from Richmond Fellowship. He was planning to start a drama course at college that month.

5th admission – 11.03.07 to 15.03.07

Leon was admitted to Rothes ward following an overdose of Loratadine. This was an impulsive act with no planning. He described worsening auditory hallucinations. His mood improved on the ward. He had apparently missed two doses of his depot prior to admission. It was felt that there were no new issues at that time and therefore discharge was arranged with his already in place follow-up.

In July he was reviewed at an outpatient clinic when he appeared to be psychotic, thought disordered and there were reports that he had been phoning ward 2 and the police in the middle of the night often in a threatening manner. In view of his agitation he was commenced on regular Diazepam and his depot of Flupenthixol was increased to 50 mgs weekly.

6th admission – 01.02.08 to 05.02.08

Leon had claimed to have taken an excessive amount of Co-codamol tablets. He was advised to attend A&E which he failed to do. When visited thereafter he was complaining of derogatory commanding hallucinations telling him to commit suicide. He had a disturbed sleep pattern and increased persecutory ideas. His mood was low. During his admission his depot was increased to Flupenthixol Decanoate 100 mgs weekly. He disclosed that he has experienced stressors

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including an argument with his father and concerns with an upstairs neighbour. He was discharged with increased community support.

7th admission – 25.04.08 to 29.04.08

He was referred by the Community Mental Health Team with increased suicidal ideation and had been threatening to take an overdose of Valium, Paracetamol, slimming tablets and bleach. During his admission he talked about increased social stressors. Gradually the auditory hallucinations reduced in intensity and the suicidal thoughts dissipated. He was discharged with community follow-up.

8th admission – 08.06.08 to 27.06.08

Leon was admitted following an overdose of 16 Paracetamol tablets. His father phoned an ambulance after he disclosed his actions. There was no planning. He described feeling depressed in mood and he was admitted for further assessment. He described increased ruminations regarding a charge against his father for sexually abusing him and son which had been dropped and he was also thinking about another incidence of rape in his teens. His depot was increased to 150 mgs of Flupenthixol weekly which helped with the auditory hallucinations. Following a number of passes which went well he was discharged with follow-up.

In September 2009 he attended A&E in the company of police after calling them due to hearing someone trying to break into his house. There was no evidence of deterioration in mental state and he was discharged. Later in September he presented to A&E having taken an overdose of 4 Paracetamol and 4 Simvastatin tablets. He had fleeting suicidal ideation but no ongoing plans or intent and was therefore discharged with intensive follow-up.

In October 2009 he took an impulsive overdose of mixed high energy sports tablets in response to distressing hallucinations. He was reviewed the following day at the outpatient clinic and was commenced on a trial of Citalopram 20 mgs daily.

Leon was assessed in A&E in September 2010 following an overdose of twelve x 10 mgs Diazepam tablets. He attributed this to the stress of having split up with a partner in August 2010 as she has placed their baby up for adoption. He did not continue experiencing suicidal ideation and was therefore discharged home with support and reassurance, and follow-up.

Leon was assessed at Ward 8, Queen Margaret Hospital following a mixed overdose of Citalopram, Procyclidine and street-bought Diazepam. He described feeling low in mood. He stated he had tried to contact the Samaritans, however, was unable to get hold of them. He then contacted the Emergency Services himself. He denied any thoughts of self-harm or ongoing suicidal ideation therefore he was discharged with in place follow-up. He was due to attend the clinic for his depot the following day and he was to contact the consultant for outpatient appointment as previously planned.

9th admission – 09.04.11 to 25.04.11

Leon was brought to the psychiatric ward by the Outreach Team following a deterioration in his mental state due to illicit drug abuse. He had lost a lot of weight and appeared physically unwell. He was using amphetamines and Mephedrone and was spending around £250 per fortnight on drugs. He complained of insomnia and worsening of his psychotic symptoms. Following

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admission to the ward Leon's mental state improved. He gained weight and passes went well without him abusing drugs.

10th and current admission – 08.09.11

Leon was admitted after the Community Outreach Team had concerns about his worsening mental state. Since the previous discharge in April 2011, Leon had been using amphetamines, ecstasy and cocaine on a regular basis and his lifestyle was generally more chaotic. He was not coping in his tenancy and his eating and sleeping patterns were poor. He was preoccupied with thoughts regarding "Paul Gilfillan" whom he stated was a paedophile and that he had "Madeline" who was abducted from Portugal. He described nightmares about being raped and said he spends his days "trying to find ways to keep children safe". He also was preoccupied with the delusion that his mother had only four years to live. Support workers had found him living in squalor. There was raw sewage in his garden and he had been eating from bins. Although he denied perceptual disturbance, the Community Outreach Team has witnessed him responding and he had also appeared thought-disordered. Leon was willing to accept informal admission. It was felt he would benefit from some time in rehabilitation given his diagnosis of schizophrenia and associated substance misuse with difficulty living independently in the community. A referral letter was sent in September 2011 and on 10 January 2012 he was transferred to Dunino rehabilitation ward.

Progress on Dunino

Following transfer to Dunino ward, Leon continued to voice delusional ideas and there was also evidence of perceptual disturbance. His mood was low at times and he was paranoid, occasionally making allegations against staff. Generally, however, he has settled into the ward and socializes with the other patients and staff. He continues to voice various delusions regarding "saving the children", drug dealers, Nazis. There has been evidence of auditory hallucinations and he has been observed laughing and talking to himself. He describes hearing voices which are mostly screams. He is paranoid about other patients stealing from him and can often lose track of his own conversation. On one occasion he was found in the corridor with wet floor cones in front of him which he stated was a barrier to paranoia. He manages to seek out staff. He describes feeling low in mood at times when he has thoughts about his past. He has appeared to become fixated with certain female staff members. He has also made allegations about staff, informing others that a staff nurse said he is "mad as a hatter". He also tore up letters from the DWP. He is sleeping reasonably well on the ward. He has been found smoking in his room on several occasions and has been advised against this. He often seeks one-to-one time with nursing staff. He is managing to eat well on the ward. He is able to shop independently, although has been lost trying to get back to the hospital due to the unfamiliar area. He has shown ability to cook easy meals. He manages to carry out his laundry independently but requires prompting to keep his area tidy, to budget and for self-care and self-catering. There have been no concerns about Leon while he has had time out in the community. He gets involved in ward activities and enjoys watching television with fellow patients. Leon has vocalized that he does not want to return to his house in Inverkeithing. He feels that people in the area are "after him" and he is concerned about becoming involved in the drug scene once again. A housing transfer has been applied for.

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Medical History

Leon has had quite severe eczema in childhood. In August 2002 he described what sounded like paroxysmal tachycardia. He was referred for a twenty four hour ECG with no follow-up required. In June 2007 Leon attended his GP complaining of an episode of haematospermia and also intermittent fresh rectal bleeding. The GP at the time requested an opinion of the surgeons and also the urologist as to whether further investigation would be useful. (No further letters in the file). In October 2011, Leon was seen by a consultant general surgeon for his diagnosis of bilateral auxiliary hidradenitis. He was offered excision of the affected areas or a trial of antibiotics in the first instance which he preferred. For review in three to four months time.

Investigations

In September 2011 he had an ultrasound of testes. This was based on a clinical history of a small lump in the right epididymis. Ultrasound result was of normal appearances of both testes with no focal lesion evident. The tiny 4 mm cyst in the right epididymis is exophytic. Ultrasound of axillae on 01.12.11 showed bilateral enlarged axillary nodes. It was commented these may be reactive to superficial infection but other cause could not be excluded. **Recommendation to refer to the haematologist for further assessment.** In January 2012 ECG was normal except for rate, sinus bradycardia 58 bpm. An EEG in 2004 was reported normal. Recent blood tests including U&Es and LFTs on 15.12.11 were normal apart from a slightly elevated alanine transaminase of 59. Thyroid function tests in September were normal. A full blood count on 15.12.11 was normal apart from slightly elevated WBC, RBC, neutrophils, monocytes and Eosinophils. He is now under high dose monitoring and his blood tests will be repeated.

Forensic History

In May 2002 he was charged with breach of the peace. These charges were for sending very threatening letters to Falkirk Council regarding his ex-wife social worker. In August 2002 there was also an incident where he hit his mother was arrested and charged and received a deferred sentence. In a letter in August 2004 it was noted there had been a number of incidents whereby Leon had been verbally aggressive and two where he had been physically aggressive. The focus of the physical aggression has been his mother and a verbal aggression his mother and his ex-partner.

There is also note that Leon has made some sexually inappropriate comments to some members of staff at the Fife Community Outreach Team which had been some cause for concern. There is no further documentation regarding this. In July 2007 there was further note that Leon had been phoning Haldane House excessively and at times has said sexually inappropriate and disinhibited content.

There is also a note of a history of shop-lifting, however, there is no further information regarding this.

Drug and Alcohol History

Leon has quite an extensive history of alcohol and substance misuse. He was initially referred to the Community Drug and Alcohol Services in his late teens when there was concern about his illicit benzodiazepine use. In 1993 an acute psychotic episode causing admission appeared to be precipitated by him taken LSD. Between the ages of sixteen and eighteen he described using a lot of LSD, amphetamines and cannabis. From then on there was a history of intermittent substance misuse. This appeared to worsen prior to his most recent admission when he was thought to have been using ecstasy and cocaine on a regular basis. He denied previous IV drug abuse. He smokes cigarettes.

Current Medications

Nitrazepam – 10 mgs nocte.
Citalopram – 20 mgs mane.
Omeprazole – 20 mgs daily.
Pizotifen - 1.5 mgs daily.
Trifluoperazine – 10 mgs bd.

Dr Katy Johnson
Locum Speciality Doctor in Psychiatry

19 March 2012

Name Leon Quaffor Mental Health Services

CHI/PIN No. FS158833 1703751191

Summary of Assessment (General Overview of situation)

Leon reports using amphetamines, ecstasy, cocaine on regular basis. Takes food from bins of local bakers to eat. (Intimidated by drug dealers. Has tenancy issues leaking sewage pipe. Can be over familiar with female staff hence Joint visit at home. Previous Numerous overdoses.

Recent physical altercation with a fellow patient. Leon was being verbally intimidated which resulted in said altercation. Has not been threatening to staff or other patients other than this lone incident.

Client involved Yes ☒ No ☐

Carer Involved Yes ☐ No ☒

Discussed with other agencies: please specify As

Comments: Other information obtained from previous documentation

**If required, please continue on a continuation/evaluation sheet*

Completed By: [Signature] Bryan Cliver Date: 8/9/11 Time: 1.50

Need For More Detailed Risk Assessment & Management:

NO

☐

YES

☐

If yes please go to RA part 2

Working With Risk (1): Current Situation (RA part 1)

Name: Leon Griffin Date of Birth: 17/03/75 CHI/PIN No: _____
 Address: 85 Spittalfield Road
Inverkeelung Post Code: KY11 1DZ Gender: Male
 Period/Date of Assessment: From 8/9/11 to 06/01/12

Complete any details of identified Risk below:	Assessment (Circle relevant answer)
From Others (e.g. abuse, exploitation) Leon vulnerable to exploitation. Appears to be easily led by others. Previous association with drug dealers spending time in his home. Leon appears intimidated by same.	No / Unknown / <u>Yes</u>
To Self (e.g. suicide, self harm) Impulsive behaviour, numerous overdose attempts, use of illicit substances - admitting to use large quantities of ecstasy.	No / Unknown / <u>Yes</u>
To Others (e.g. aggression, violence) Previously violent towards mother and step father. Can be overfamiliar towards females on home visits (WFCOT).	No / Unknown / <u>Yes</u>
Neglect (e.g. health, personal appearance) Reported on 8/11 had no bath for 6 weeks, Dramatic weight loss.	No / Unknown / <u>Yes</u>
To Child(ren) (e.g. neglect, abuse) On 27/6/10 Reported by Barbara Barnes (child family social worker, that Leon had allegedly admitted to feeding sexually abused around young children when he was younger 10+ years ago. Leon questioned by police no further action taken.	No / Unknown / <u>Yes</u>
Physical Impairment (e.g. medical, sensory)	No / Unknown / <u>Yes</u>
Wandering & / or Falls	No / Unknown / <u>Yes</u>
Memory and Cognitive Impairment (e.g. forgetfulness) Auditory hallucinations, command in nature. Overdose previously. Impulsive behaviour. Daily dispensing medication.	No / Unknown / <u>Yes</u>
Challenges to Services (e.g. inappropriate demands, poor compliance) Has made false accusation towards others. Can be over familiar with females. Sporadic attendance at depot clinic. Rarely attends O/P with De Cavanagh, Joint visits at home.	No / Unknown / <u>Yes</u>
Strengths/Positive Attributes (e.g. positive resources, agreed plans). Creative self published poetry, creative writing.	No / Unknown / <u>Yes</u>

Medication History

For Period From 1993 To February 2012

Name: Leon Gratton	Date of Birth: 17/03/1975 CHI 1703751191	Unit no.:
Date of admission: Ward 2 QMH September 2001 Dunino January 2012	Consultant: Dr Dasgupta	G.P.:
Ward / Address: Dunino ward	Diagnoses: Schizophrenia, depression History of substance abuse	

Current Drug Regime

- a) Regular medication
Trifluoperazine 10mg bd
Citalopram 20mg in the morning
Nitrazepam 10mg at night
Paracetamol 1g qid
Pizotifen 1.5mg at night
Omeprazole 20mg in the morning
- b) As Required Medication
Haloperidol 5mg oral up to qid
Maalox
Diclofenac 50mg bd
Soft paraffin
E45
Symptomatic relief
Bonjela

Summary (Medical / Medication)

Mr. Gratton has a long history. He was referred to young persons unit in Edinburgh aged 14 and 16 and was first admitted in 1993. The diagnosis of schizophrenia was reached relatively recently. In recent years he has self presented at A& E after overdoses. Use of cocaine ecstasy and amphetamines contributed to his most recent admission in September 2011. Sleep disturbance has been a prominent feature.

Medication	Maximum Dose Taken	Dates taken From/To	Comments
Trifluoperazine	25mg daily	1993-1996	Good response
	20mg daily	2011	Limited response
Olanzapine	15mg daily	2001-2002	
Zuclopenthixol dec	300mg 1/52	2002-2006	Some response but dose limited by EPSE
Haloperidol	10mg daily	2003-2005	In addition to depot
Flupentixol dec	150mg 1/52	2006-2011	Some response but dose limited by EPSE
Chlorpromazine	25mg bd prn	June 2010	
Sertraline	100mg daily	2001-2002	
Trazadone	300mg	2001	d/c due to concern that irregular heart

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FEB 2012

File

	nocte		rhythm may be side effect
Mirtazapine	15mg	2005-2006	Poor compliance
Citalopram	20mg	2006-2007 2009-? 2011- present	No details No details Since 2009?
Melatonin		2003	Night sedation
Zaleplon	10mg	2005	
Nitrazepam	10mg	2006-present	
Diazepam	15mg	various	

Treatment Options / Recommendations

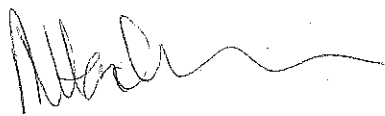
Depending on response to recent increase of trifluoperazine the dose could be further increased to 30mg daily for a full trial.

Given the history of doses being limited by EPSE an atypical antipsychotic would seem a reasonable alternative. Limited information is available on previous exposure to olanzapine and no other atypical has been tried. Compliance in the community has been a problem so risperidone with a view to Risperdal Consta is certainly an option. A full trial of olanzapine is another reasonable option.

In November 2011 the MHRA advised that citalopram should not be given with other drugs with potential to prolong QTc interval on ECG. This includes antipsychotics. Is an antidepressant still required? If so, Sertraline would seem a reasonable choice.

In the longer term Nitrazepam should be phased out.

Response to Pizotifen should be reviewed along with need for diclofenac prn.



Alyson Henderson, Senior Clinical Pharmacist 14/02/12

Drug History

Date	Medication	Comments
1993-1999	Trifluoperazine up to 25mg daily	Admitted to Royal Edinburgh for 4 months in 1993- acute psychotic episode apparently precipitated by a bad LSD trip 2-3 weeks prior to admission. Psychotic symptoms settled after a couple of weeks. Episode of paranoid ideas and visual hallucinations after stopping trifluoperazine for 2 months in 1997.
Jan 2001	Olanzapine	Discharged after being in hospital in Lanarkshire for two and a half months. Diagnosis histrionic personality disorder and morbid jealousy state.
April 2001	Olanzapine 10mg nocte Sertraline changed to trazadone which was increased to 300mg nocte	c/o chaotic sleep pattern .Hates sertraline.
June 2001	Olanzapine and trazodone recommenced	Deterioration- behavioural disturbance and lack of sleep- after 3 weeks non compliance with medication.
Sept 2001	Trazodone replaced by sertraline	c/o irregular heart rhythm; irregular pulse. ? adverse effect of trazodone.
Oct 2001	Olanzapine 10mg nocte Sertraline 100mg daily	Moved to Fife
Dec2001	Olanzapine 10mg Sertraline 50mg Diazepam 2mg	Short course of diazepam for anxiety
March 2002	Olanzapine increased to 15mg	No evidence of psychosis – borderline personality, prone to dissociative reactive states and paranoid ideation
March - April 2002	Olanzapine phased out Zuclopenthixol commenced and increased to 200mg 2/52 Sertraline 50mg daily	6 week admission to QMH ward 2. Initial presentation in agitated and confused state, c/o auditory hallucinations. Considered to be borderline personality disorder complicated by psychotic episodes
Aug 2002		Persistent nocturnal paroxysmal tachycardia and at least one episode of tachycardia with irregular pulse. 24 hour ECG requested
Dec2002	As above Zopiclone short term	Doing reasonably well
Feb 2003	Depot increased	Improvement since depot increased. "Diagnosis more likely to be functional psychosis"
May 2003	Procyclidine prn	Doing very well. C/O "shakes". Later reported that procyclidine resulted in agitation.
Aug 2003	Melatonin as night sedation	
Nov -Dec	Discharge medication	1/12 Admission to ward 2. Worsening of

2003	Zuclopenthixol dec 250mg 1/52 Haloperidol 2mg qid Zopiclone 15mg nocte	mood; poor sleep often waking up due to auditory hallucinations; poor appetite; suicidal thoughts and impulsive overdose of melatonin. Had taken cannabis in previous week. Requested increase in depot and change to night sedation. Settled after a few weeks on ward
May 2004		Reasonably well apart from sleep difficulties and hypnagogic hallucinations. For EEG
13/08/04	Haloperidol 5mg bd prn Orphenadrine 50mg tid Zuclopenthixol 250mg 1/52	Worsening in auditory hallucinations. EPSE evident. Unwilling to increase depot as feels oversedated. Much less troubled by hallucinations after haloperidol commenced.
24/08/04	Zuclopenthixol increased to 300mg 1/52 Haloperidol 5mg bd Orphenadrine 50mg tid	Agreed to increase in depot.
Oct 2004		Improvement with increase in depot. Haloperidol now only prn. Still doing well in December apart from sleep pattern.
April 2005	Mirtazapine 15mg at night	Low mood; lack of sleep; possible EPSE. Did not take mirtazapine
May 2005	Zuclopenthixol reduced to 250mg 1/52 Mirtazapine 15mg at night Zaleplon 10mg at night	Depot reduced due to EPSE. Sleep/wake cycle remains poor; team don't feel that he is particularly depressed
Oct 2005		Self presented at A&E following overdose of 5 Zaleplon and 1 mirtazapine. Said trigger was "just agitation".
Dec 2005	Trifluoperazine 2mg prn instead of haloperidol	Worsening of night time auditory hallucinations. Does not want to increase depot. Trifluoperazine worked well previously.
March 2006	Nitrazepam	Reasonably well. Sleeping better with Nitrazepam but some hangover tiredness. Main concern is tremor. He does not like procyclidine or orphenadrine. Tremor improves after taking Nitrazepam- may be exacerbated by anxiety.
April 2006	Zuclopenthixol 300mg 1/52 Nitrazepam Mirtazapine (poor compliance) Haloperidol prn supplied	Increased distress, paranoia, auditory hallucinations and suicidal ideation. Assessed at QMH and discharged.
May 2006	Depot changed to flupentixol	No psychotic symptoms but EPSE and feels zuclopenthixol no longer suiting him.
Aug 2006	Depot Reduced to fortnightly	Sleep/wake cycle poor but fewer EPSE since depot reduced
Nov 2006	Depot increased	
Dec 2006	Flupentixol dec 60mg 2/52 Citalopram 20mg daily (when started?) Nitrazepam 5mg at night	Improvement after depot increased
March 2007	Flupentixol 30mg 1/52 Ranitidine 150mg bd Nitrazepam 10mg nocte Loratadine 10mg daily prn	Self-presented at A&E after impulsive overdose of loratadine. Had missed 2 doses of depot. Discharged after a few days

	No longer on citalopram	
July 2007	Flupentixol increased to 50mg 1/52 Diazepam 5mg tid	Psychotic- thought disordered and paranoid. Improvement after increase.
01/02/08- 05/02/08	Flupentixol increased to 100mg 1/52 Nitrazepam 10mg at night Diazepam 6mg daily	4 day admission. Claimed to have taken excess co-codamol but paracetamol levels did not require treatment. C/O derogatory command hallucinations and persecutory ideas. Depot increased
25/04/08- 29/04/08	Diazepam now 5mg daily	Further admission. Had been less well over past 6-8 weeks. More anxious, hearing voices, paranoid
08/6/08- 27/06/08	Flupentixol increased to 150mg 1/52 Nitrazepam 10mg at night	Admitted following overdose of 16 paracetamol.
Aug 2008	Chlorpromazine 25mg bd prn	Hearing "screaming".
Sept 2009	Flupentixol Nitrazepam Diazepam Chlorpromazine	Assessed twice in few weeks by Psychiatric Assessment Service and discharged home.
Oct 2009	Flupentixol dec150mg 1/52 Nitrazepam 10mg nocte Citalopram 20mg daily commenced	Assessed by Psychiatric Assessment Service after overdose of high energy sport tablets Persistent, pervasive low mood, anergia and anhedonia. Hearing voices 2-3 times weekly.
Nov 2009	Flupentixol dec150mg 1/52 Nitrazepam 10mg nocte Citalopram 20mg daily Diazepam 5mg daily Trihexyphenidyl 1mg daily increase to 2mg after 1/52	Mental state largely stable- hallucinations a few times each week. Fine tremor. No akathisia, dystonia or tardive dyskinesia. Procyclidine previously no benefit and "caused hallucinations" Orphenadrine helped symptoms but gave him nightmares.
June 2010	Chlorpromazine 25mg bd prn	Very stressed somatic symptoms; hearing screams.
Sept 2010		Self- presented at A&E after overdose of 12x 10mg diazepam.
Nov 2010	Flupentixol dec Diazepam Nitrazepam Trihexyphenidyl	Assessed by Psychiatric Assessment Service after mixed overdose of citalopram, procyclidine, diazepam (street bought)
09/04/11- 25/05/11	Citalopram 20mg Nitrazepam increased from 5 to 10mg daily Trihexyphenidyl 2mg in the morning Flupentixol 150mg 1/52	Admitted for 2 weeks – taking amphetamines and mephedrone, losing weight, not sleeping. Mental state remained settled on ward and physical health improved.
Sept 2011	Flupentixol d/c Trifluoperazine commenced & increased to 5mg bd Omeprazole 20mg	Admitted due to deterioration in mental state. Using cocaine, ecstasy and amphetamines on regular basis. Last depot 26/05/11? Not keen for depot due to EPS
Nov 2011	Trifluoperazine increased to 15mg daily Pizotifen 1.5mg nocte	Feels increased trifluoperazine helped. Headache improved with pizotifen but later c/o headaches.
Jan 2012		Transferred to Dunino ward for rehab.
Feb 2012	Trifluoperazine increased to 10mg bd	

*** TX REPORT ***

TRANSMISSION OK

TX/RX NO	0296
RECIPIENT ADDRESS	901592265967
DESTINATION ID	
ST. TIME	24/08 15:28
TIME USE	00'29
PAGES SENT	3
RESULT	OK

Fax

**CONFIDENTIAL - URGENT**

To	Dr Sharon Cullinane Associate Specialist in Rheumatology	Fax	01592 265967
From	Dr Sandip Datta Locum Specialty Doctor	Date	23 August 2012
Re	Leon Gratton 1703751191	Pages	3 (including front sheet)

☐ For information☐ Please comment

The following facsimile transmission is intended only for the use of the individual or entity to which it is addressed and may contain confidential information belonging to the sender which is protected by the physician - patient privilege. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this is strictly prohibited. If you have received this transmission in error, please notify the sender by telephone to arrange for the return of the documents.

Fax



CONFIDENTIAL - URGENT

To	Dr Sharon Cullinane Associate Specialist in Rheumatology	Fax	01592 265967
From	Dr Sandip Datta Locum Specialty Doctor	Date	23 August 2012
Re	Leon Gratton 1703751191	Pages	3 (including front sheet)

☐ For information

☐ Please comment

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CHP Acting General Manager Mary Porter

**Kirkcaldy & Levenmouth CHP
Mental Health Service**

PRIVATE & CONFIDENTIAL

Dr Sharon Cullinane
Associate Specialist in Rheumatology
Department of Rheumatology
Victoria Hospital
Kirkcaldy

Medical Offices
Stratheden Hospital
CUPAR
Fife
KY15 5RR

Tel: 01334 652611
Fax: 01334 696042



Date Typed: 23 August 2012
Your Ref:
Our Ref: SD/MT/SF5153833A

Enquiries to: Margaret Thomson
Direct Line: 01334 696362
Internal ext: 56362
E-mail: m.thomson5@nhs.net

Dear Dr Cullinane

By Fax 01592 265967

**Leon Gratton, 85 Spittalfield Road, Inverkeithing, KY11 1DZ
CHI - 1703751191**

Currently care of Dunino Ward, Stratheden Hospital

I would be grateful for your opinion on the above patient. Mr Gratton is currently in inpatient on Dunino Rehabilitation Ward at Stratheden Hospital. He has a long history of schizophrenia and drug misuse and depression. His current admission began in September 2011. He was admitted to Ward 2 at queen Margaret Hospital

With respect to his medical history Leon had quite severe eczema as a child. In August 2002 he described what sounded like paroxysmal tachycardia. He was referred for a 24 hour ECG with no follow up required. He was also seen in October 2011 by a general surgeon for his bilateral axillary hidradenitis. He was offered excision of the affected areas but a trial of antibiotics in the first instance had good effect. Leon continues to complain of multiple stiffness and joint pain which has been worse in the morning for a number of months. He has been using Paracetamol regularly which relieves the pain on occasion. However he continues to ask for further analgesia but is unable to take Ibuprofen because of stomach problems.

Mr Gratton had an appointment to see yourself on the 24th of May, however there was a mix up with his hospital transport and therefore he was unable to attend.

His current medication list includes Omeprazole 20mg in the morning, Pizotifen 1.5mg at night, Rose Fraser Cream once in the morning, Clozapine 100mg once daily, Hyoscine Hydrobromide 300 mcgm twice daily, Clozapine 225 mg in the evening, Sertraline 50mg in the morning, Laxido one sachet once daily.



- ☐ Original
- ☒ Case notes
- ☐ Nursing notes
- ☐ Medical office
- ☐ Medical records

Acting CHP General Manager: Mary Porter

I would be grateful if you could send another appointment for Mr Gratton.

Please do not hesitate to contact me if you require any further information.

Kind regards.

Yours sincerely



Dr Sandip Datta
Locum Specialty Doctor

TELEPHONE MESSAGE

TO	Pritha
FROM	Mrs Gratton
Phone	077 6260 2112
DATE	18.06.12
REGARDING	Mrs Gratton telephoned asking if you would return her call. Her son Leon has been phoning her and these calls have been causing her quite some distress. Some of Leon's comments had been very personal.

18/6/12 → T/C made. Spoke to Leon's mum. She wanted to come & have a meeting with me & Leon. According to her the purpose of the meeting is about benefit & Leon's taking more responsibility about things. I advised her it might not be right time for the dealing with financial & social issues because he is needing more medical attention. She claimed that Leon's phone call is affecting her health. I tried to explain it might be because he is unwell & it would be best not to make any phone call for the time being. She appeared being emotional & angry and put the phone down.

P. Dasgupta

P. DASGUPTA
Consultant

**Kirkcaldy & Levenmouth CHP
Mental Health Service**

PRIVATE & CONFIDENTIAL

Dr S Cullinane, Associate Specialist in Rheumatology
Victoria Hospital
Hayfield Road
KIRKCALDY
KY2 5AH

BY FAX - 01592 265967

Dear Dr Cullinane

Leon Gratton, C/o Dunino Ward, Stratheden Hospital, Cupar, KY15 5RR
CHI - 1703751191

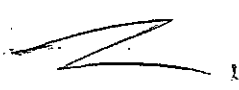
I would be grateful for your opinion on the above patient. Mr Gratton is currently a patient in Dunino rehabilitation ward at Stratheden Hospital. He has a long history of schizophrenia, drug misuse and depression. His current admission began in September 2011 when he was admitted to Ward 2 at Queen Margaret Hospital. With respect to his medical history, Leon had quite severe eczema as a child. In August 2002 he described what sounded like paroxysmal tachycardia. He was referred for a twenty four hour ECG with no follow-up required. He was also seen in October 2011 by a general surgeon for his diagnosis of bilateral axillary hidradenitis. He was offered excision of the affected areas but a trial of antibiotics in the first instance which he preferred. Leon has been complaining of multiple stiffness and joint pain which has been worse in the morning for a number of months. He has been using Paracetamol regularly which relieves the pain on occasion. He continues to ask for further analgesia but is unable to take Ibuprofen because of stomach problems.

Current Medication

Nitrazepam - 10 mgs at night.
Omeprazole 20 mgs in the morning.
Sertraline - 50 mgs in the morning.
Risperidone - 2 mgs in the morning and 3 mgs at night.

He continues to use symptomatic relief Paracetamol, although on occasion does use Ibuprofen. He complains of pain in both elbow joints as well as his knees but especially in the cervical spine. On examination, there is no swelling or redness. Physically his obs. are within normal range. I would be very grateful for your opinion on Mr Gratton. Please do not hesitate to contact me if you require any further information. Kind regards.

Yours sincerely


Dr Sandip Datta
Locum Specialty Doctor

Medical Offices
Stratheden Hospital
CUPAR
Fife
KY15 5RR

Tel: 01334 652611
Fax: 01334 696042

Date Dictated: 15 May 2012
Date Typed: 15 May 2012
Your Ref:
Our Ref: SD/MT/SF5153833A

Enquiries to: Margaret Thomson
Direct Line: 01334 696362
Internal ext: 56362
E-mail: m.thomson5@nhs.net



- ☐ Original
- ☒ Case notes
- ☐ Nursing notes
- ☐ Medical office
- ☐ Medical records

CHP General Manager: Mr George Cunningham

Victoria Hospital
Hayfield Road
Kirkcaldy
Fife
KY2 5AH

Department of Haematology
Tel: 01592 643355 Ext 29484 -
Meg Ross
<http://www.nhsfife.scot.nhs.uk>



Dr Sandeep Datta
Locum Specialty Doctor
Stratheden Hospital
CUPAR
Fife
KY15 5RR

CLINIC LETTER



CHI: 1703751191
Hospital ID: V700828K

Letter ID: 214428

Dear Dr Datta

Clinic Date: 14/05/2012

Date: 15/05/2012

Leon Gratton, C/O Dunino Ward, Stratheden Hospital, Cupar, Fife, KY15 5RR
Date of Birth: 17/03/1975

Thanks for your note about this patient who I saw in clinic today with concerns about swellings in his axillae. These haven been a problem on and off for several months usually accompanied by a crop of small boils in the axilla. Ultrasound has shown small lymph glands no more than 4mm or 5mm in diameter and a biopsy has shown reactive changes only. In addition to the axillary problems he complains of pain in most parts of her body, particularly chest and abdomen and pain in passing urine. He has no cough or sputum production. He is smoking about half an ounce of tobacco a day.

Current Medications

Nitrazepam 10mg at night, Omeprazole 20mg per day, Pizotifen 1.5mg at night, Paracetamol prn, Trifluoperazine 15mg x bd and Sertraline 50mg per day. He has recently smoked and swallowed drugs of abuse but never injected.

Allergies

Nil.

He is currently an in-patient at Stratheden for rehabilitation.

On examination, he was clearly anxious about his symptoms. He was tender in both axillae with a number of scars in the skin and some pea-sized lymph nodes, particularly on the right. There was no other peripheral lymphadenopathy and no positive findings in the chest or abdomen. He's had a recent normal full blood count and biochemistry.

SD
22/5

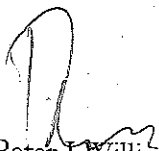
REC

13 MAY 2012

I think these must be reactive nodes from his superficial boils in the axilla and I really don't think further investigation is required here. He is clearly anxious about a number of physical symptoms but I suspect this is all part of his psychiatric state and I don't think it would be indicated or wise to pursue further investigations at this stage.

Best wishes.

Yours sincerely



Dr Peter J Williamson
Consultant Haematologist

Authorised on 16/05/2012 11:13:08 by Typist Meg Ross, on behalf of P Williamson.

(P) Dr DM Taylor, Inverkeithing Medical Centre, 5 Friary Court, Inverkeithing, Fife, KY11 1NU

*** TX REPORT ***

TRANSMISSION OK

TX/RX NO 4782
RECIPIENT ADDRESS 28055
DESTINATION ID
ST. TIME 18/04 13:25
TIME USE 02'53
PAGES SENT 5
RESULT OK



Kirkcaldy & Levenmouth CHP
Mental Health Services

Personal/Patient Information – Medical Confidential

To: Dr Williamson, Haematology Dept, VHK	Fax No:	01592 648055
From: Dr S Datta, Locum Speciality Doctor, Stratheden Hospital, Cupar	Fax No:	01334 696042
Date: 18 April 2012	No. of Pages(including this page) 5	

Subject: Referral for - LG

If you have any difficulties in reading this please telephone:
01334 696362

Ask for: **Margaret Thomson**

Please call me back to let me know you have received this fax.

- ☐ urgent
- ☐ for information
- ☐ please comment

Kirkcaldy & Levenmouth CHP
Mental Health Service

PRIVATE & CONFIDENTIAL

Dr Williamson
Haematology Department
Victoria Hospital
Hayfield Road
KIRKCALDY
KY2 5AH

Medical Offices
Stratheden Hospital
CUPAR
Fife
KY15 5RR
Tel:
Fax:

01334 652611
01334 696042



Date Dictated: 18 April 2012
Date Typed: 18 April 2012
Your Ref:
Our Ref: SD/MT/SF5153833A

Enquiries to: Margaret Thomson
Direct Line: 01334 696362
Internal ext: 56362
E-mail: m.thomson5@nhs.net

Dear Dr Williamson

Leon Gratton, C/o Dunino Ward, Stratheden Hospital, Cupar, KY15 5RR
CHI - 1703751191

I would be very grateful for your opinion on the above patient, Mr Gratton. He is currently an inpatient in Dunino rehabilitation ward at Stratheden Hospital. He has a diagnosis of schizophrenia and borderline personality disorder, and he has taken overdoses in the past.

With regard to his past medical history, he suffered from weight loss and tremors and also has a diagnosis of hidradenitis suppurativa. Late last year Mr Gratton had some superficial axillary masses which were red and tender, therefore an ultrasound scan of both axillae was conducted. The scan showed bilateral enlarged axillary nodes, cortex measuring 4 mm on the right and 4.5 mm on the left. It was concluded that this may be reactive to superficial infection and a more sinister cause could not be excluded, therefore it was suggested that a referral to Haematology may be worthwhile. However, in March of this year he was seen by the surgical team who did a biopsy which confirmed reactive changes compatible with a history of chronic infection and hidradenitis suppurativa. As can be seen from the letter enclosed it was decided that there was no further investigation planned. I would be very grateful for your advice regarding this patient.

His current medication includes:

Nitrazepam - 10 mgs at night.
Omeprazole - 20 mgs in the morning.
Pizotifen - 1.5 mgs at night.
Paracetamol - 1 gm four times a day.
Trifluoperazine liquid - 15 mgs twice a day.
Sertraline - 50 mgs once in the morning.



- ☐ Original
- ☒ Case notes
- ☐ Nursing notes
- ☐ Medical office
- ☐ Medical records

Leon Gratton - SF5153833A
CHI - 1703751191

18 April 2012

I would be very grateful for your opinion and advice regarding this patient. Please do not hesitate to contact me if you require any further information.

Kind regards.

Yours sincerely

A handwritten signature in black ink, appearing to be 'Sandip Datta', written in a cursive style.

Dr Sandip Datta
Locum Specialty Doctor

Queen Margaret Hospital
Whitefield Road
Dunfermline
Fife
KY12 0SU

Breast Services
Tel: 01383 623623 Ext 2 3701
<http://www.nhsfife.scot.nhs.uk>



Dr F Williams
Psychiatry Dept
Queen Margaret Hospital
Dunfermline

ADMINISTRATIVE LETTER



CHI: 1703751191
Hospital ID: D659366L

Letter ID: 153658

Date: 09/03/2012

Dear Dr Williams

Leon Gratton, 85 Spittalfield Road, Inverkeithing, Fife, KY11 1DZ

Date of Birth: 17/03/1975

I reviewed the result of needle aspiration of this gentleman's left axillary node which has confirmed reactive changes which is compatible with his history of chronic infection and hidradenitis suppurativa. This was discussed in our MDT meeting where it was decided no further investigation or treatment is planned.

I am therefore happy to discharge him from our clinic back to your care.

Yours sincerely

Dr H Ahmad
Staff Grade Surgeon

A handwritten signature in black ink, appearing to read 'Dr H Ahmad' with a stylized flourish.

Authorised on 09/03/2012 14:30:19 by Typist Jean Lowes, not verified by Consultant.

(P) Dr D Somerville, Inverkeithing Medical Group, 5 Friary Court, Inverkeithing, KY11 1NU

SCI Store - Patient Result Report

Report ID: E-04016690

Fife SCI Store Live

Sample Collected: 06/12/2011 14:46:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
LEON GRATTON	1703751191	17/03/1975	36	GARMANY, DAVID	INVERKEITHING MEDICAL CENTRE	CAVANAGH, P	(Q2) Ward 2 QMH

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Joseph, CAVANAGH, Paul	(F805HBCQ) QMH BREAST CLINIC	E-04016690	Radiology	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	
IMAGING	06/12/2011 14:46:00	08/12/2011 11:30:06.987	08/12/2011 11:32:09	

Report**US Axilla Both****Leon Gratton**

Clinical Information: Bilateral superficial axillary masses. Red and tender on the left. ? abscesses. Known hidradenitis suppurativa.

ULTRASOUND BOTH AXILLAE:

There are bilateral enlarged axillary nodes. Cortex measures 4 mm on the right and 4.5 mm on the left. These may be reactive to superficial infection, and the patient does mention that he probably has groin masses as well, but a more sinister cause cannot be excluded (? haematological)

CONCLUSION:

U3. Please refer to the haematologist for further assessment.

Reported by: SHARMA, Ashwini Dr

Verified by: SHARMA, Ashwini Dr

Printed By: fionnuala williams on 08/12/2011 14:14:06

Queen Margaret Hospital
Whitefield Road
Dunfermline
Fife
KY12 0SU

Breast Services
Tel: 01383 623623 Ext 2 3701
<http://www.nhsfife.scot.nhs.uk>



Dr F Williams
Psychiatry Dept
Queen Margaret Hospital
Dunfermline

ADMINISTRATIVE LETTER



CHI: 1703751191
Hospital ID: D659366L

Letter ID: 153658

Dear Dr Williams

Date: 09/03/2012

Leon Gratton, 85 Spittalfield Road, Inverkeithing, Fife, KY11 1DZ

Date of Birth: 17/03/1975

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I am therefore happy to discharge him from our clinic back to your care.

Yours sincerely

Mr H Ahmad
Staff Grade Surgeon

A handwritten signature in black ink, appearing to read 'H Ahmad', with a stylized flourish underneath.

Authorised on 09/03/2012 14:30:19 by Typist Jean Lowes, not verified by Consultant.

(P) Dr D Somerville, Inverkeithing Medical Group, 5 Friary Court, Inverkeithing, KY11 1NU

Kirkcaldy & Levenmouth CHP
Mental Health Service

PRIVATE & CONFIDENTIAL

Mr S Bennett, Consultant Surgeon
Department of General Surgery
Victoria Hospital
Hayfield Road
KIRKCALDY
KY2 5AH

Medical Offices
Stratheden Hospital
CUPAR
Fife
KY15 5RR
Tel:
Fax:

01334 652611
01334 696042



Date Dictated: 21 February 2012
Date Typed: 21 February 2012
Your Ref:
Our Ref: SD/MT/SF5153833A

Enquiries to: Margaret Thomson
Direct Line: 01334 696362
Internal ext: 56362
E-mail: m.thomson5@nhs.net

Dear Mr Bennett

Leon Gratton, 85 Spittalfield Road, Inverkeithing, KY11 1DZ
CHI - 1703751191

Thank you for your letter dated 8 February 2012. The patient named above has actually already been seen by your team had biopsies taken for axillary hidradenitis. There was some mix-up of where the original clinic letter was sent. Please do not hesitate to contact me for further information.

Kind regards.

Yours sincerely

A handwritten signature in black ink, appearing to be 'Sandip Datta', written in a cursive style.

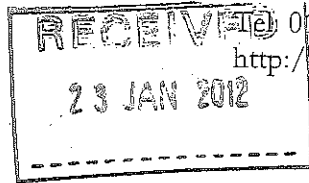
Dr Sandip Datta
Locum Specialty Doctor



- ☒ Original
- ☒ Case notes
- ☐ Nursing notes
- ☐ Medical office
- ☐ Medical records

Queen Margaret Hospital
Whitefield Road
Dunfermline
Fife
KY12 0SU

Breast Services



Tel: 01383 623623 Ext 2 3701
<http://www.nhsfife.scot.nhs.uk>



Dr F Williams
Psychiatry Dept
Queen Margaret Hospital
Dunfermline

CLINIC LETTER



CHI: 1703751191
Hospital ID: D659366L

Letter ID: 100184

Dear Dr Williams

Clinic Date: 10/01/2012

Date: 12/01/2012

Leon Gratton, 85 Spittalfield Road, Inverkeithing, Fife, KY11 1DZ

Date of Birth: 17/03/1975

Thanks for referring this gentleman to the breast clinic with bilateral axillary lumps. He has only started medication for schizophrenia and has had surgery in both arm pit and groin for possible hydradenitis suppurativa.

On examination I could not feel any lump in either breast but there were a few small lymph nodes palpable in both axillary areas but not in supraclavicular fossa.

I have explained to him that the nodes might be reactive to the infection that he has had and I have requested an ultrasound guided FNA to be done as an outpatient. We will write to you with that result.

Yours sincerely

Mr H Ahmad
Staff Grade Surgeon

Authorised on 12/01/2012 14:31:06 by Typist Jean Lowes, not verified by Consultant.

(P) Dr David Somerville, Inverkeithing Medical Group, 5 Friary Court, Inverkeithing, Fife, KY11 1NU

#12/11

7/1/12

WR Cavanagh

Still c/o headaches.
 Saw son x 2 over festive period.
 Nervous re transfer to rehab →
 A decided to view this positively

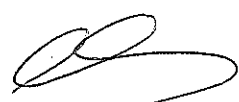
Ⓟ Stop pryzofen
 T/F to rehab on 6/1/12


 WILLIAMS
 CT1

7/1/12

09:16

Called Dennis Ward
 Made aware of OPD appt
 at QMH on 10/1/12 at
 2-30 pm


 WILLIAMS
 CT1

10.1.2012

transferred from QMH

- Δ O Schizophrenia
- Ⓣ Drug misuse
- Ⓣ Depression
- Ⓣ Borderline PD

Plan

- 1. continue medication
- 2. Review in WR on THU


 SAMUEL EASON

Nursing : for 6/52 assessment & 3/52 passed

- Received on 16.2.2012 @ 11.30 AM.
- Hears voices → requests PAN Haloperidol
- deluded about his mother
- He grew a beard + his mother was concerned that he broke the sewage pipe - Has residual psychotic symptoms.
- He is smoking in the room + gave to other patients

OT : for initial assessment this morning

Interview

- more peaceful and likes lying down as there are a lot of things going in his mind.
- Paedophile gang when he was in Edinburgh and there was a lot of homophobia and racial tension in the area.
- ~~His~~ Mother is working in this area now
- She has always been bad
- Dumfriesline is nice but there are a lot of drugs "Heroin and the rest" in the area. He used drugs but no savings now.
- Margaret McCann appears in his mind regularly.
- He was raped once and there is a lot of rape going on.
- His mother was molested by her dad. "I wanted to kill him, but he is dying of lung cancer and heart disease now"
- "There are a lot knives and guns in the area and a lot of fighting"
- used to have messages from TV and radio, but not any more - But hear a lot of screaming.
- "They put rat poison on me" Mother also did it, & she molested me when I was young
- Depot was changed because he was taking ecstasy & it
- Has pain and head aches hence Paracetamol.
- advised to attend OT sessions
- advised not to smoke on the ward

Plan

* Trifluoperazine ~~30mg~~ 10mg BD

SE

16/2/12 WR and 6 weeks review

'No body from community team

OT Nursing → Delusion existing

Evidence of responding to hallucination.

Paranoid to other people (stop 3PT)

Mood - low at time when last seen alone

Allegation against staff

Went for appt for under the arm
problem -

Gets exploited by others.

Needs prompting for budgeting,
self care and self catering
(Detail in nursing report)

② Heon came with his mother (mother)
& step dad.

Heon stated that he is doing well,
& happy to continue working here.

Mother brought in photos of his
property (absolutely cluttered)

Troubled by drug dealers.
House is still Heon's, mum has put
in an application to transfer it.

PLAN - ① Heon to continue
rehabilitation.

② ECH (he is on citalopram)
Dose of Trihexiphenazine
has been increased.

③ High dose monitoring.

NR

Nursing → Same presentation with
residual psychotic symptoms.
Engaging well in self catering
& motivators.
Using PRN Buprenorphine regularly
willing to engage.

Not much benefit from increased
dose of Trifluoperazine.

QTC interval has been increased.
Diastolic blood pressure.

Leon reviewed.

Leon drinks increased dose of Stalevo
has helped with voices - not distressed
Frequency of nightmares has been
decreased.

Feels safe here.

Feels can manage activities
despite of voices.

C/o painful joints in extremities
using brufen as required.

Abscesses are better.

PLAN - ① Continue with current
medication.

② ECG.

③ Referral to Rheumatologist.
PRN Haloperidol.

④ High dose monitoring.

P. DASARVIDA.

→ Leon asked for Lorazepam.

It has been discussed in MDT
that he responds well to 1:1
not needing PRN Haloperidol.

Verbal de-escalation would be preferred
line because of his H/O
past abuse.

J

Surname	GASTON	Unit No.	
First Names	LEON	Date seen or Admitted	
Maiden Surname		Seen at	
Address		Seen by	
		Consultant in Charge	
		Family Dr.	
		Referred by	
D. of B.	Sex M. F.	M.S.W.D.	Religion
			Occupation

13/12

MR DR DASGUPTA

Nursing staff state that Leon continues to have delusions and has a lot of psychomotoric symptoms. Leon states that "his mood" has been up and down. He states he continues to hear voices, and his mood has been in low in the morning.

① Continue on ventral 50mg.

② Continue on Trifluoperazine.

(ii) Leon would like to come gardening group with OT.


DASGUPTA

9/4/12

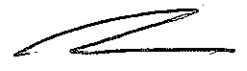
MR DR DASGUPTA

Nursing - remains delusional, sleeping for long periods through the day. Regularly seeking analgesia but not for any specific pain. Leon continues not to engage with OT. Leon feels he is overwhelmed with trifluoperazine.

patient - Leon was usually not on the ward.

① (i) Stop regular paracetamol.

(ii) Reduce trifluoperazine to 10mg BD and introduce response to long write.


DASGUPTA

8/5/12 Reviewed with Maxine

Heon reported that he is feeling better on Risperidone. Voices are less distressing & less in amount.
~~Deluded~~ - Persecutory ideas about his mum.

C/O Pain in ~~the~~ multiple joints stiff in the morning relieved by paracetamol. He is still suffering from it - unable to take Bupren because of problem in stomach.

PLAN - Refer to rheumatologist for opinion.

P. DAS GUPTA

0/5/12

UN DR DAS GUPTA

Nursing - very thought disordered, hostile, constantly requesting analgesia. Complains of multiple joint pain. Sleeping has been unable, having graphic thoughts and having nightmares.

OT - not engaging with OT. Heon is quite paranoid about his mother. Denies he is too tired to engage with OT.

Refer to rheumatology.

~~He has been sent to prison.~~

(1) Risperidone to 2mg bid + 3mg into quads because he has not felt safe.

done

4/5/12

UN DR DAS GUPTA

Nursing - States there have been delusions in mental state and expressing ↑ in psychotic symptoms.

Refer to long stay.

done

24/5/12

Reviewed

Focused on somatic problems.
(nodule under the arm to polyp in the throat).

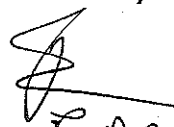
Reported feeling slightly worse on Risperidone.

Discussed about Clozapine - told me he had it before - horrible sideeffect - like a dry mouth. (?)

Agreed to give it a try if ~~there~~

Risperidone doesn't help.

Received blood result up to 2008
on SCT - stre - no evidence of
↓ WBC count.


P. DASGUPTA

31/5/12

MR DR DASGUPTA

Notes - continues to be repud and is still stressed with his mental state.

① Centre unit Tx plan.

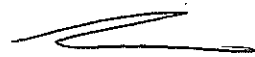
7/6/12

WORLD REVIEW DR DAS GUPTA

Heard that that sometimes he feels ok but sometimes in the morning he feels depressed.

He is happy to continue Clozapine, and all the STE have been referred to him.

- ① Continue Clozapine butch on 8/6/12
② Refer again to 2mg to.


DASGUPTA

11/6/12 Reviewed

c/o having 'rough time' during change over from Risperidone to clozapine.

Feeling dizzy when getting up.
Preoccupied with ^{debts} 'shutting down' his existing house & putting money back to his account. He wants to live either in Glenrothes, Cupar or Springfield.

PLAN: ① Sitting, standing BP - & drop of systolic BP 72 mm Hg.

Consider reducing dose of

Risperidone by 1mg.

② Referral to social work about possible bank house


P. DASARPA
consultant

4/6/12

Discuss with Mr Harbin (pharmacist) who feels it would be ok to ↓ hear rigour as his clozapine is increasing. He is currently having no SE from the clozapine.

① ↓ hepar to 1mg BP.


ams

18/6/12 Reviewed

Heard c/o feeling dizzy. ① No postural drop in BP. Pulse ranging from 110-122.

Admits ② no psychotic symptom wise feeling slightly better. ~~Not~~ He did not sleep very well last night, hasn't yet slept till now.

Agreed discussed about argument with mother on phone. Agreed following plan; -

- ① Reduce dose of Risperidone by 1mg
- ② Now If dizziness increases or vitals becomes unstable delay increasing dose of clozapine.
- ③ Escorted to town to minimize risk of to his physical health & to his mother.
- ④ Keon agreed not to make phone call to his mum for some time
- ⑤ I will speak to Keon's mum.
- ⑥ Missing at risk until reviewed further.

[Signature]
T. DASARPTA

23/6/2

Reviewed with

Nursing → seems better on clozapine
Clozapine more agitated after 5pm
& hypersalivation.

On review, Keon reported feeling better.
Tablets are working, ↓ voice
feeling brighter, no panic attack
Now I can read after noon.
is not a big bother. But finds
it difficult to keep himself awake after
the morning dose.

Happy to have tablet for
hypersalivation.

Impression - positive change on clozapine

PZAN: ① Change 8am dose of clozapine
to 1pm.

② stop Risperidone

③ Hyoscine HBr at night

④ Clozapine serum level tomorrow

J. P. Sanyal

28/6/12 Received from clinic S/N Shona.
Improved in presentation.
Psychotic symptoms improved.
He reported feeling better.
Continue with current plan

J. P. Sanyal

3/7/12

Heon tells me he has been suffering from hyperhidrosis,
which is more acute. Discuss with pharmacist Alan
Horton who has suggested to P. Knell to 700mg Bz.
Also Heon Nitroprusside has been & to F. Sanyal as he is usually
sleeping well.

J. P. Sanyal

9/7/12

ATSP re line thought

Heon states he has had a sore throat for 7/7. O/E
There is no redness or evidence of any infection. Obs within
normal range and usually appropriate.

- ①) Think to try throat lozenges
- ②) Check nose in. P/B.

J. P. Sanyal

12/7/12

MR DE DASWAPTA

Nursing - Mental state much improved, settled on the ward. No physical health concerns. Mother has been visiting.

- ① (i) Reduce nitroglycerin to 5mg route
(ii) Allow unsupervised leave to lounge x 2 weekly for 2 hrs.



16/7/12

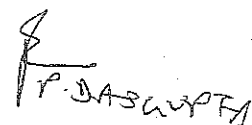
Received.

Leon c/o sore throat & loss of voice.

Vitals are normal.

Sputum & urine sample have not shown any growth.

Advised on warm-gargles & voice rest.



19/7/12

NR

Nursing → He is doing better mentally. Sometimes he is speaking normally sometimes in hoarse voice (? side role)

B.P. → 110/70. Temp 36°
F + pulse normal

Not engaging with any therapy. He wants to get clothes in community access.

Review → Budget & pleasant - still speaking
in a hoarse voice.
enjoying psychology group.

- PLAN:
- ① Reduce Nitrazapam to 2.5mg recte, to be stopped next week.
 - ② Increase clozapine by 25mg.
 - ③ Monitor hoarseness of voice - if doesn't get better or consistent - consider ENT referral.
 - ④ Community access bus inserted 4

H. DASNOVA

11/8/12

ATSP re lump in R testicle

L was asked to feel him as he has had a painful lump over the last 24 hrs which is hard in centre. It measures approx 2cm x 2cm and is attached to the skin. No redness or broken skin. Physical obs within normal range. Leon is feeling physically well.
IMP Single cyst.

① USS of testicles.


DASNOVA

23/8/12

MR DL DASNOVA

Nunig - doing well on clozapine, but putting on weight.

Liquid intake 78.
Patient - intends to find it difficult to get up in the morning.

PRESCRIPTION SHEET (USE BLOCK LETTERS)

KE-WITTEN 10-4-10

Sheet No. 10

START DATE	DISCONTINUED		REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION					PRESCRIBER'S SIGNATURE					
	Date	Signature				0800	1300	1800	2200	Other Times						
A 20/9/2009			ARIPIPRAZOLE	5mg	ORAL											
B 20/9/2009			SECTALINE	5mg	ORAL											
C 20/9/2009			CLONAZEPINE SUSPENSION	2.5mg	ORAL											
D 20/9/2009			CLONAZEPINE SUSPENSION	2.5mg	ORAL											
E 20/9/2009			CLONAZEPINE SUSPENSION	2.5mg	ORAL											
F 20/9/2009			CLONAZEPINE SUSPENSION	2.5mg	ORAL											
G 20/9/2009			CLONAZEPINE	2.5mg	ORAL											
H 20/9/2009			CLONAZEPINE	2.5mg	ORAL											
I 20/9/2009			CLONAZEPINE	2.5mg	ORAL											
J 20/9/2009			CLONAZEPINE	2.5mg	ORAL											
K																
L																
M																
N																
O																
P																
R 9/7/2009			AS REQUIRED MEDICINES													
S 10/7/2010			HALOPERIDOL	5mg	ORAL											
T 9/7/2009			LOXAPROPRONE	2mg	ORAL											
U 20/9/2011			PHENYLETHYLAMINE	5mg	ORAL											
V 20/9/2011			Symptomatic relief as per	as per												
W 24/10/2011			Paracetamol	1gml	ORAL											
X 10/1/2012			Symptomatic relief	5mg	ORAL											
Y																
Z																
START DATE	DISCONTINUED		DEPOT INJECTIONS		DOSE		FREQUENCY		PRESCRIBER'S SIGNATURE		TICK IF PRESCRIBED ON THE FOLLOWING SHEET		LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION		PRESCRIBER'S SIGNATURE	
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4																

ONCE ONLY MEDICINES AND PREMEDICATION

DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT
20/9/09	CLONAZEPINE SUSPENSION	2.5mg	ORAL	1800	P. D. WITTEN	P. D. WITTEN	1800
20/9/09	CLONAZEPINE SUSPENSION	2.5mg	ORAL	1800	P. D. WITTEN	P. D. WITTEN	1800

DETAINED PATIENT
MHA (SCOT) 2003
Please consult with Treatment Plan
(Form T2 or T3) before prescribing

PASS MEDICATION RECORD

Sheet No. 7

Marc

五

Fauvel's name

查得

Unit No. 1-5131678

[illegible][illegible]

Levitt 16/3/12

WARD DUNNO
FHB(MR) 58 MANEDEN

PASS MEDICATION RECORD

Sheet No. 7

Ward

10/21

Patient's Name L. J. CREATION

Unit No. 1703751191

[illegible][illegible]

PRESCRIPTION SHEET (USE BLOCK LETTERS)

Sheet No.

START DATE		DISCONTINUED		REGULAR MEDICINES		DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION					PREScriBER'S SIGNATURE
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START DATE	DISCONTINUED	AS REQUIRED MEDICINES		DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PREScriBER'S SIGNATURE					
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START DATE	DISCONTINUED	DEPOT INJECTIONS		DOSE	FREQUENCY	PREScriBER'S SIGNATURE	TICK IF PRESCRIBED ON THE FOLLOWING SHEET	LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION	REFERRED DATE				
Date	Signature	Date	Signature										
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ONCE ONLY MEDICINES AND PREMEDICATION													
DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PREScriBER'S SIGNATURE	GIVEN BY	GIVEN AT						
29/8/12	CLONAPINE	10mg	ORAL	2200	<i>F. U. O.</i>								
NAME OF PATIENT		LEON GRATTON		AGE	37	DATE OF BIRTH	17/7/1975	UNIT No.	1703751191				
								CONSULTANT	WARD DURING				
									FHB(MR) 58				

PASS MEDICATION RECORD

Sheet No. _____

Warc

UNION

Patient's Name

- CON CREATON

Unit No.

1703751191

SIGNATURE
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IN CHARGE

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PRESCRIPTION SHEET (USE BLOCK LETTERS)

Month 01/12

Sheet No. 1

START DATE	DISCONTINUED		REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION				PRESCRIBER'S SIGNATURE					
	Date	Signature				0800	1300	1800	2200		Other Times				
A 17/11			OMENIN 200	20mg	oral										
B 23/11			P1207FEN	1.5kg	oral										
C 3/12			SEPTALINE	50mg	oral										
D 13/12			ADH-SHARON-ETERN	1000	oral										
E 23/12			CLAZAPINE	20mg	oral										
F 23/12			CLAZAPINE	100mg	oral										
G 3/12			HYALURONIC ACID	7.5mg	oral										
H 3/12			GLUCAL HYALURONIC ACID	20mg	oral										
I 3/12			CHAMOR-SHARON	1000	oral										
J 12/12			NETR-APETAL	5mg	oral										
K 12/12															
L 12/12			NETR-APETAL	2.5mg	oral										
M 12/12			CLAZAPINE	2.25mg	oral										
N 12/12			CHAMOR-SHARON	1000	oral										
O 12/12			SEPTALINE	50mg	oral										
P 12/12			CHAMOR-SHARON	1000	oral										
Q 12/12															
R 14/12			HYALURONIC ACID	20mg	oral										
S 14/12			NETR-APETAL	5mg	oral										
T 16/12			CLAZAPINE	20mg	oral										
U 23/12			CLAZAPINE	20mg	oral										
V 23/12			CLAZAPINE	20mg	oral										
W 23/12			CLAZAPINE	20mg	oral										
X 23/12			CLAZAPINE	20mg	oral										
Y 23/12			CLAZAPINE	20mg	oral										
Z 23/12			CLAZAPINE	20mg	oral										
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START DATE	DISCONTINUED		DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT	PRESCRIBER'S SIGNATURE	TICK IF PRESCRIBED ON THE FOLLOWING SHEET	LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION	MEDICINE	REFERRED DATE
	Date	Signature											
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Unit No. 170375191

2021-70

Patient's Name: LEOA NICH / 12

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Sheet no. 4

NAME OF PATIENT	AGE	DATE OF BIRTH	UNIT No.	CONSULTANT	WARD
1222 Patient	76	17/1/75	1705276191	Dr. P. S. Gupta	FHB(MR) 58 DUNN

1703751191

7.6.12 11pm

As the school

NUMBER
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DOSES
SUPPLIED

SIGNATURE
OF NURSE
IN CHARGE

STRENGTH		STRENGTH	
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ISSUED BY

PREScription SHEET (USE BLOCK LETTERS)

Number 116114.

Sheet No. 2

START DATE	DISCONTINUED		REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION				PRESCRIBER'S SIGNATURE
	Date	Signature				0800	1300	1800	2200 Other Times	
A 8/9/11			METOPROLOL	20mg	oral					
B 8/9/11			CITALOPRAM	20mg	oral					
C 12/1/11			OMETHAZOLE	20mg	oral					
D 25/1/11			PIZOTRIPTEN	20mg	oral					
E 2/12/11			PARACETAMOL	1g	oral					
F 26/1/12			TRIFLUOPERAZINE	10mg	oral					
G 16/2/12			TRIFLUOPERAZINE	10mg	oral					
H 16/2/12			TRIFLUOPERAZINE	10mg	oral					
I 23/2/12			TRIFLUOPERAZINE	10mg	oral					
J 23/2/12			TRIFLUOPERAZINE	10mg	oral					
K 8/3/12			SERTRALINE	50mg	oral					
L 19/4/12			TRIFLUOPERAZINE	10mg	oral					
M 19/4/12			TRIFLUOPERAZINE	10mg	oral					
N 23/4/12			TRIFLUOPERAZINE	10mg	oral					
O 26/4/12			TRIFLUOPERAZINE	10mg	oral					
P										

START DATE	DISCONTINUED		AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE
	Date	Signature						
R 14/10/11			EAS					
S 14/10/11			SOFT PARACETAMOL					
T 14/10/11			DISSOLVABLE TABLETS					
U 14/10/11			HALOPERIDOL					
W 28/1/12			MARTIN					
X 27/1/12			SYNOMAL RELIEF (EXCEPT PARACETAMOL AND MARTIN)					
Y 27/2/12			BONTALA (ADULT)					
Z 5/3/12			IBUKUPEN					

START DATE	DISCONTINUED		DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE	TICK IF PRESCRIBED ON THE FOLLOWING SHEET	LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION	MEDICINE	REFERRED DATE
	Date	Signature								
1										
2										
3										
4										

ONCE ONLY MEDICINES AND PREMEDICATION									
DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT		
12/12	CITALOPRAM	20mg	oral	11.45		A. Gentry	11.45		
13/12	OMETHAZOLE	20mg	oral	11.45		A. Gentry	11.45		
13/12	PIZOTRIPTEN	1.5mg	oral	11.45		N. Gentry	11.45		
13/12	TRIFLUOPERAZINE	10mg	oral	11.45		A. Gentry	11.45		

NAME OF PATIENT	AGE	DATE OF BIRTH	UNIT No.	CONSULTANT	WARD
	74	17/12/35	1763751191	Dr. Dasgupta	FHB(MR) 58
					Ward

PASS MEDICATION RECORD

Sheet No. 2

Ward

7-70

Patient's Name

101

CONTRACT

Unit No. 1703751191

STRENGTH								SIGNATURE OF NURSE IN CHARGE
A								NUMBER OF DOSES SUPPLIED
B								
C								
D								
E								
F								
G								
H								
I								
J								
K								
L								
M								
N								
O								
P								

[illegible]

PRESCRIPTION SHEET (USE BLOCK LETTERS)

Sheet No. 2 of 2

START DATE	DISCONTINUED		REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION					PRESCRIBER'S SIGNATURE	
	Date	Signature				0800	1300	1800	2200	Other Times		
A 26/4/12			RISPERIDONE	1mg	oral							P. Dantigny
B 26/4/12			RISPERIDONE	2mg	oral							P. Dantigny
C												
D												
E												
F												
G												
H												
I												
J												
K												
L												
M												
N												
O												
P												
R 26/4/12			AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION					MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE
S 22/4/12			0.05% FRAXE OCEAN	1 APP	TOP	day 31N					93 REQUIRED	ABC
T			PARACETAMOL	g	oral	day 31N					4-6	
U												
W												
X												
Y												
Z												
START DATE	DISCONTINUED		DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE	TICK IF PRESCRIBED ON THE FOLLOWING SHEET	LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION				
Date	Date	Signature						MEDICINE	REFERRED DATE			
1												
2												
3												
4												
ONCE ONLY MEDICINES AND PREMEDICATION												
DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT					
NAME OF PATIENT	AGE	DATE OF BIRTH	UNIT No.	CONSULTANT	WARD							
				Dr. Dantigny	FHB(MR)							

PRESCRIPTION SHEET (USE BLOCK LETTERS)

Kent

141611 (Helen)

Dr. C. A. H. H. H.

Sheet No.

1 (STRENGTH)

[illegible]

MEDICINE RECORDING SHEET

KEY
 DRUG REFUSED
 PATIENT ABSENT

NAME: LEAR GRAYSON UNIT No: C70375 1191 WARD: D2W2D

(MR) 57

[illegible]

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS										OTHER TIMES						DEPOT INJECTION		AS REQUIRED				COMMENTS ON DISCREPANCIES		
	8.00	Ints	13.00	Ints	18.00	Ints	22.00	Ints	Code	Time	Ints	Code	Time	Ints	Code	Time	Ints	Code	Time	Ints	Code	Time		Ints	
3/8/12	A	C	SM	F H	MS		B H	MC																	D-Self Admin
3/8/12	A	C	SM	F H	MS		B H	MC																	D-Self Admin
3/8/12	A	C	SM	F H	MS		B H	MC																	D-Self Admin
4/8/12	A	C	SM	F H	MS		B H	MC																	D-Self Admin
5/8/12	A	C	SM	F H	MS		B H	MC																	D-Self Admin
6/8/12	A	C	SM	F H	MS		B H	MC																	D-Self Admin
7/8/12	A	C	SM	F H	MS		B H	MC																	D-Self Admin
8/8/12	A	C	SM	F H	MS		B H	MC																	D-Self Admin
9/8/12	A	C	SM	F H	MS		B H	MC																	D-Self Admin
10/8/12	A	C	SM	F H	MS		B H	MC																	D-Self Admin
11/8/12	A	C	SM	F H	MS		B H	MC																	D-Self Admin
12/8/12	A	C	SM	F H	MS		B H	MC																	D-Self Admin
13/8/12	A	C	SM	F H	MS		B H	MC																	D-Self Admin
14/8/12	A	C	SM	F H	MS		B H	MC																	D-Self Admin
15/8/12	A	C	SM	F H	MS		B H	MC																	D-Self Admin

MEDICINE RECORDING SHEET

KEY
☒ DRUG REFUSED
☒ PATIENT ABSENT

Date	REGULAR PRESCRIPTIONS										OTHER TIMES				DEPOT INJECTION				AS REQUIRED				COMMENTS ON DISCREPANCIES
	8.00		13.00		18.00		22.00		Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls		
	Intls	MC	Intls	MC	Intls	MC	Intls	MC	Intls	MC	Intls	MC	Intls	MC	Intls	MC	Intls	MC	Intls	MC			
19/1/12	A	MC	F	H	MC			B	H													D - self admin W - 10m / 5m	
20/1/12	A	MC	F	H	MC			B	H													D - self admin W - 10m / 5m	
21/1/12	A	MC	F	H	MC			B	H													D - self admin W - 10m / 5m	
22/1/12	A	MC	F	H	MC			B	H													D - self admin W - 10m / 5m	
23/1/12	A	MC	F	H	MC			B	H													D - self admin W - 10m / 5m	
24/1/12	A	MC	F	H	MC			B	H													D - self admin W - 10m / 5m	
25/1/12	A	MC	F	H	MC			B	H													D - self admin W - 10m / 5m	
26/1/12	A	MC	F	H	MC			B	H													D - self admin W - 10m / 5m	
27/1/12	A	MC	F	H	MC			B	H													D - self admin W - 10m / 5m	
28/1/12	A	MC	F	H	MC			B	H													D - self admin W - 10m / 5m	
29/1/12	A	MC	F	H	MC			B	H													D - self admin W - 10m / 5m	
30/1/12	A	MC	F	H	MC			B	H													D - self admin W - 10m / 5m	
31/1/12	A	MC	F	H	MC			B	H													D - self admin W - 10m / 5m	
1/2/12	A	MC	F	H	MC			B	H													D - self admin W - 10m / 5m	

1. Kader
2. 05.11.15
3. 07.12

KEY
A) DRUG REFUSED
B) PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS										OTHER TIMES						DEPOT INJECTION			AS REQUIRED			COMMENTS ON DISCREPANCIES
Date	8.00	Ints	13.00	Ints	18.00	Ints	22.00	Ints	Code	Time	Ints	Code	Time	Ints	Code	Time	Ints	Code	Time	Ints		
5/7/12			F H				① 6 H ① 01	01													① SELF ADMIN	
6/7/12	① 6 H ① 01	SM	F H	M			① 6 H ① 01	01													① SELF ADMIN	
7/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
8/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
9/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
10/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
11/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
12/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
13/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
14/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
15/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
16/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
17/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
18/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
19/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
20/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
21/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
22/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
23/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
24/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
25/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
26/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
27/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
28/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
29/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
30/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	
31/7/12	① 6 H ① 01	AC	F H	M			① 6 H ① 01	01													① SELF ADMIN	

KEY
 DRUG REFUSED
 PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS										OTHER TIMES				DEPOT INJECTION				AS REQUIRED				COMMENTS ON DISCREPANCIES	
	8.00		13.00		18.00		22.00		Initls		Code		Time		Initls		Code		Time		Initls			
	Initls	Code	Initls	Code	Initls	Code	Initls	Code	Initls	Code	Initls	Code	Initls	Code	Initls	Code	Initls	Code	Initls	Code	Initls	Code		
21/6/12	B D	AC	K	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	E Say Admin Z Headache
21/6/12	B D	AC	K	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	E - refused
30/6/12	B D	AC	K	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	E - Say Admin Z - Headache
1/7/12	B D	AC	K	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	E Say Admin Z Headache
2/7/12	B D	AC	K	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	E - Say Admin Z - Headache
3/7/12	B D	AC	K	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	E Say Admin Z - Headache
4/7/12	B D	AC	K	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	E Say Admin Z - Headache
5/7/12	B D	AC	K	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	E Say Admin Z - Headache

NAME: LEON GRATTON UNIT No: 170351191 WARD: Dunino

North 14/6

KEY
 (A) DRUG REFUSED
 (X) PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS											OTHER TIMES			DEPOT INJECTION			AS REQUIRED			COMMENTS ON DISCREPANCIES	
Date	8.00	Ints	13.00	Ints	18.00	Ints	22.00	Ints	Code	Time	Ints	Code	Time	Ints	Code	Time	Ints	Code	Time		Ints
14/6/12							(E) A	OS													Self admin
15/6/12	(E) A	pen					(E) A	OS													Self admin
16/6/12	(E) A	AC					(E) A	OS													Self admin
17/6/12	(E) A	AC					(E) A	OS													Self admin
18/6/12	(E) A	AC					(E) A	OS													Self admin
19/6/12	(E) A	AC					(E) A	OS													Self admin
20/6/12	(E) A	AC					(E) A	OS													Self admin
21/6/12	(E) A	AC					(E) A	OS													Self admin
22/6/12	(E) A	AC					(E) A	OS													Self admin
23/6/12	(E) A	AC					(E) A	OS													Self admin
24/6/12	(E) A	AC					(E) A	OS													Self admin
25/6/12	(E) A	AC					(E) A	OS													Self admin
26/6/12	(E) A	AC					(E) A	OS													Self admin
27/6/12	(E) A	AC					(E) A	OS													Self admin
28/6/12	(E) A	AC					(E) A	OS													Self admin
29/6/12	(E) A	AC					(E) A	OS													Self admin
30/6/12	(E) A	AC					(E) A	OS													Self admin
1/7/12	(E) A	AC					(E) A	OS													Self admin
2/7/12	(E) A	AC					(E) A	OS													Self admin
3/7/12	(E) A	AC					(E) A	OS													Self admin
4/7/12	(E) A	AC					(E) A	OS													Self admin
5/7/12	(E) A	AC					(E) A	OS													Self admin
6/7/12	(E) A	AC					(E) A	OS													Self admin
7/7/12	(E) A	AC					(E) A	OS													Self admin
8/7/12	(E) A	AC					(E) A	OS													Self admin
9/7/12	(E) A	AC					(E) A	OS													Self admin
10/7/12	(E) A	AC					(E) A	OS													Self admin
11/7/12	(E) A	AC					(E) A	OS													Self admin
12/7/12	(E) A	AC					(E) A	OS													Self admin
13/7/12	(E) A	AC					(E) A	OS													Self admin
14/7/12	(E) A	AC					(E) A	OS													Self admin
15/7/12	(E) A	AC					(E) A	OS													Self admin
16/7/12	(E) A	AC					(E) A	OS													Self admin
17/7/12	(E) A	AC					(E) A	OS													Self admin
18/7/12	(E) A	AC					(E) A	OS													Self admin
19/7/12	(E) A	AC					(E) A	OS													Self admin
20/7/12	(E) A	AC					(E) A	OS													Self admin
21/7/12	(E) A	AC					(E) A	OS													Self admin
22/7/12	(E) A	AC					(E) A	OS													Self admin
23/7/12	(E) A	AC					(E) A	OS													Self admin
24/7/12	(E) A	AC					(E) A	OS													Self admin
25/7/12	(E) A	AC					(E) A	OS													Self admin
26/7/12	(E) A	AC					(E) A	OS													Self admin
27/7/12	(E) A	AC					(E) A	OS													Self admin
28/7/12	(E) A	AC					(E) A	OS													Self admin
29/7/12	(E) A	AC					(E) A	OS													Self admin
30/7/12	(E) A	AC					(E) A	OS													Self admin
31/7/12	(E) A	AC					(E) A	OS													Self admin

NAME: LSON GRATTON UNIT No: 170351191 WARD: 1

NB - A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A
PRESCRIPTION SHEET IS CHANGED
PRESCRIPTION SHEET No. **4**

KEY
DRUG REFUSED
PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS										AS REQUIRED				COMMENTS ON DISCREPANCIES
Date	8.00		13.00		18.00		22.00		Intls	OTHER TIMES		DEPOT INJECTION		
	Code	Time	Code	Time	Code	Time	Code	Time		Code	Time	Code	Time	
9/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	12 ⁵⁵	
10/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1745	Bones' #
11/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
12/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
13/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
14/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
15/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
16/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
17/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
18/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
19/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
20/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
21/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
22/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
23/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
24/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
25/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
26/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
27/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
28/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
29/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
30/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.
31/10/12	P	8 ⁰⁰	L	13 ⁰⁰			CO	22 ⁰⁰	mc			Z	1800	L - Self admin.

NAME: **LEON C. EATON** UNIT No: **170375191** WARD: **DOMINO**

KEY
 (A) DRUG REFUSED
 (X) PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS										OTHER TIMES				DEPT INJECTION		AS REQUIRED				COMMENTS ON DISCREPANCIES	
Date	8.00	Ints	13.00	Ints	18.00	Ints	22.00	Ints	Code	Time	Ints	Code	Time	Ints	Code	Time	Ints	Code	Time		Ints
26/5/12	B	D	N				AC	MC													L Self Admin
27/5/12	B	AC	N	AC			AC	MC													L Self Admin
28/5/12	B	AC	N	AC			AC	MC													L Self Admin
29/5/12	B	D	N	AC			AC	MC													L Self Admin
30/5/12	B	AC	N	AC			AC	MC													L Self Admin
31/5/12	B	D	N	AC			AC	MC													L Self Admin
1/6/12	B	AC	N	AC			AC	MC													L Self Admin
2/6/12	B	D	N	AC			AC	MC													L Self Admin
3/6/12	B	AC	N	AC			AC	MC													L Self Admin
4/6/12	B	D	N	AC			AC	MC													L Self Admin
5/6/12	B	AC	N	AC			AC	MC													L Self Admin
6/6/12	B	D	N	AC			AC	MC													L Self Admin
7/6/12	B	AC	N	AC			AC	MC													L Self Admin
8/6/12	B	D	N	AC			AC	MC													L Self Admin

NAME: LEON CARRION UNIT No: 103751191 WARD: 202020

44- pro m...
 L- Self Admin
 P- Commence
 2- Reorder

MEDICINE RECORDING SHEET

KEY
 DRUG REFUSED
 PATIENT ABSENT

REGULAR PRESCRIPTIONS										OTHER TIMES				AS REQUIRED				COMMENTS ON DISCREPANCIES
Date	8.00	13.00	18.00	22.00	Ints	Code	Time	Ints	Code	Time	Ints	Code	Time	Ints	Code	Time	Ints	
15/12	B 155/120	AC 135/120		A 155/120														Y - severe pain Z - 1000mg par.
15/12	B 155/120	AC 135/120		A 155/120														Z - heparin Z - 1000mg par.
15/12	B 155/120	AC 135/120		A 155/120														L - 50g Admin.
16/12	B 155/120	AC 135/120		A 155/120														Y - severe pain Z - 1000mg par.
16/12	B 155/120	AC 135/120		A 155/120														Z - 1000mg par.
17/12	B 155/120	AC 135/120		A 155/120														Y - severe pain Z - 1000mg par.
18/12	B 155/120	AC 135/120		A 155/120														Y - severe pain Z - 1000mg par.
18/12	B 155/120	AC 135/120		A 155/120														Y - severe pain Z - 1000mg par.
19/12	B 155/120	AC 135/120		A 155/120														Y - severe pain Z - 1000mg par.
20/12	B 155/120	AC 135/120		A 155/120														Y - severe pain Z - 1000mg par.
21/12	B 155/120	AC 135/120		A 155/120														Y - severe pain Z - 1000mg par.
22/12	B 155/120	AC 135/120		A 155/120														Y - severe pain Z - 1000mg par.
23/12	B 155/120	AC 135/120		A 155/120														Y - severe pain Z - 1000mg par.
24/12	B 155/120	AC 135/120		A 155/120														Y - severe pain Z - 1000mg par.
25/12	B 155/120	AC 135/120		A 155/120														Y - severe pain Z - 1000mg par.

MEDICINE RECORDING SHEET

[illegible]

WARD: Domingo Lopez

(2) of (2)

KEY
 (A) DRUG REFUSED
 (X) PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS												DEPOT INJECTION	AS REQUIRED				COMMENTS ON DISCREPANCIES		
	8.00			13.00			18.00			22.00				OTHER TIMES						
	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time		Code	Time	Intls	Code			
08/01/12																				
09/01/12																				
10/01/12																				
11/01/12																				
12/01/12																				
13/01/12																				
14/01/12																				
15/01/12																				
16/01/12																				
17/01/12																				
18/01/12																				
19/01/12																				
20/01/12																				
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22/01/12																				
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24/01/12																				
25/01/12																				
26/01/12																				
27/01/12																				
28/01/12																				
29/01/12																				
30/01/12																				
31/01/12																				

KEY
(A) DRUG REFUSED
(X) PATIENT ABSENT

MEDICINE RECORDING SHEET

[illegible]

NAME: UNIT NO: WARD:

1 of 2

NB - A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A
PRESCRIPTION SHEET IS CHANGED
PRESCRIPTION SHEET No. 2

KEY
(A) DRUG REFUSED
(X) PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS										AS REQUIRED										DEPOT INJECTION		COMMENTS ON DISCREPANCIES									
Date	8.00		Intls	13.00	Intls	18.00	Intls	22.00		Intls	OTHER TIMES		Code	Time	Intls	Code	Time	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls		
	Intls	Code						Code	Time		Code	Time																		Code	Time
17/4/12	SE	LS	AC	E	QC	E	AC	AI	DI	QC																					7 jans prim.
18/4/12	SE	LS	AC	E	QC	E	AC	AI	DI	QC																					
19/4/12	SE	LS	AC	E	QC	E	AC	AI	DI	QC																					
20/4/12	SE	LS	AC	E	QC	E	AC	AI	DI	QC																					
21/4/12	SE	LS	AC	E	QC	E	AC	AI	DI	QC																					
22/4/12	SE	LS	AC	E	QC	E	AC	AI	DI	QC																					
23/4/12	SE	LS	AC	E	QC	E	AC	AI	DI	QC																					
24/4/12	SE	LS	AC	E	QC	E	AC	AI	DI	QC																					
25/4/12	SE	LS	AC	E	QC	E	AC	AI	DI	QC																					
26/4/12	SE	LS	AC	E	QC	E	AC	AI	DI	QC																					
27/4/12	SE	LS	AC	E	QC	E	AC	AI	DI	QC																					
28/4/12	SE	LS	AC	E	QC	E	AC	AI	DI	QC																					
29/4/12	SE	LS	AC	E	QC	E	AC	AI	DI	QC																					
30/4/12	SE	LS	AC	E	QC	E	AC	AI	DI	QC																					

NAME: LEAN SPATION UNIT No: 170375191 WARD: 040200 STATION: 163 P1787 (MRT) ST

KEY
 (A) DRUG REFUSED
 (X) PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS				OTHER TIMES				AS REQUIRED				COMMENTS ON DISCREPANCIES
	8.00	13.00	18.00	22.00	Code	Time	Code	Time	Code	Time	Code	Time	
12/12	C K M	E L A	E J MC	A D DOE									
13/12	C K MC	E L MC	E L MC	A D DOE									
14/12	C K MC	E L MC	E L MC	A D DOE									
15/12	C K MC	E L MC	E L MC	A D DOE									
16/12	C K MC	E L MC	E L MC	A D DOE									
17/12	C K MC	E L MC	E L MC	A D DOE									
18/12	C K MC	E L MC	E L MC	A D DOE									
19/12	C K MC	E L MC	E L MC	A D DOE									
20/12	C K MC	E L MC	E L MC	A D DOE									
21/12	C K MC	E L MC	E L MC	A D DOE									
22/12	C K MC	E L MC	E L MC	A D DOE									
23/12	C K MC	E L MC	E L MC	A D DOE									
24/12	C K MC	E L MC	E L MC	A D DOE									
25/12	C K MC	E L MC	E L MC	A D DOE									
26/12	C K MC	E L MC	E L MC	A D DOE									
27/12	C K MC	E L MC	E L MC	A D DOE									
28/12	C K MC	E L MC	E L MC	A D DOE									
29/12	C K MC	E L MC	E L MC	A D DOE									
30/12	C K MC	E L MC	E L MC	A D DOE									
31/12	C K MC	E L MC	E L MC	A D DOE									

MEDICINE RECORDING SHEET

KEY
 DRUG REFUSED
 PATIENT ABSENT

REGULAR PRESCRIPTIONS																				OTHER TIMES				DEPOT INJECTION				AS REQUIRED				COMMENTS ON DISCREPANCIES
Date	8.00		13.00		18.00		22.00		Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time												
	Intls	Code	Intls	Code	Intls	Code	Intls	Code													Intls	Code	Intls	Code	Intls	Code	Intls	Code	Intls	Code	Time	
20/3/12	C	K	E	QC	QC	QC	A	I	AC												Z 01.35 gm	G 19.14 SOLU										
21/3/12	C	K	E	QC	QC	QC	A	I	AC																							
22/3/12	C	K	E	QC	QC	QC	A	I	AC																							
23/3/12	C	K	E	QC	QC	QC	A	I	AC																							
24/3/12	C	K	E	QC	QC	QC	A	I	AC																							
25/3/12	C	K	E	QC	QC	QC	A	I	AC																							
26/3/12	C	K	E	QC	QC	QC	A	I	AC																							
27/3/12	C	K	E	QC	QC	QC	A	I	AC																							
28/3/12	C	K	E	QC	QC	QC	A	I	AC																							
29/3/12	C	K	E	QC	QC	QC	A	I	AC																							
30/3/12	C	K	E	QC	QC	QC	A	I	AC																							
31/3/12	C	K	E	QC	QC	QC	A	I	AC																							
1/4/12	C	K	E	QC	QC	QC	A	I	AC																							
2/4/12	C	K	E	QC	QC	QC	A	I	AC																							

KEY
☒ A DRUG REFUSED
☒ PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS										OTHER TIMES				DEFECT INJECTION			AS REQUIRED			COMMENTS ON DISCREPANCIES
	8.00	Ints	13.00	Ints	18.00	Ints	22.00	Ints	Code	Time	Ints	Code	Time	Ints	Code	Ints	Code	Time	Ints	Code	
6/3/12	C	AD	E	AC	E	AC	D	MC										Z 1310	61		
7/3/12	C	MC	E	AC	E	AC	D	MC										Z 2030	AC		
8/3/12	C	AC	E	AC	E	AC	D	MC										Z 9.35	AC		
9/3/12	C	AC	E	AC	E	AC	D	MC										Z 0335	AC		
10/3/12	C	AC	E	AC	E	AC	D	MC										Z 0245	MC		
11/3/12	C	AC	E	AC	E	AC	D	MC										Z 0455	MC		
12/3/12	C	AC	E	AC	E	AC	D	MC										Z 11.55	MC		
13/3/12	C	AC	E	AC	E	AC	D	MC										Z 18.50	AC		
14/3/12	C	AC	E	AC	E	AC	D	MC										Z 1430	MC		
15/3/12	C	AC	E	AC	E	AC	D	MC										Z 1635	AC		
16/3/12	C	AC	E	AC	E	AC	D	MC										Z 2230	AC		
17/3/12	C	AC	E	AC	E	AC	D	MC										Z 1710	MC		
18/3/12	C	AC	E	AC	E	AC	D	MC										Z 2200	AC		
19/3/12	C	AC	E	AC	E	AC	D	MC										Z 18.25	AC		
20/3/12	C	AC	E	AC	E	AC	D	MC										Z 1915	AC		
21/3/12	C	AC	E	AC	E	AC	D	MC										Z 11.55	AC		
22/3/12	C	AC	E	AC	E	AC	D	MC										Z 2025	MC		
23/3/12	C	AC	E	AC	E	AC	D	MC										Z 1020	AC		
24/3/12	C	AC	E	AC	E	AC	D	MC										Z 1115	AC		
25/3/12	C	AC	E	AC	E	AC	D	MC										Z 1330	AC		

MEDICINE RECORDING SHEET

KEY
☒ DRUG REFUSED
☒ PATIENT ABSENT

REGULAR PRESCRIPTIONS										OTHER TIMES				AS REQUIRED				COMMENTS ON DISCREPANCIES
Date	8.00		13.00	18.00	Initls	22.00	Initls	Code	Time	Initls	Code	Time	Initls	Code	Time	Initls		
	Code	Time															Code	
21/2/12	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC		
22/2/12	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC		
23/2/12	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC		
24/2/12	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC		
25/2/12	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC		
26/2/12	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC		
27/2/12	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC		
28/2/12	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC		
29/2/12	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC		
1/3/12	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC		
2/3/12	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC		
3/3/12	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC		
4/3/12	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC		
5/3/12	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC		

KEY
 (A) DRUG REFUSED
 (N) PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS										OTHER TIMES				DEPOT INJECTION				AS REQUIRED				COMMENTS ON DISCREPANCIES
	8.00	Ints	13.00	Ints	18.00	Ints	22.00	Ints	Code	Time	Ints	Code	Time	Ints	Code	Ints	Code	Time	Ints	Code	Time	Ints	
17/12																							
18/12																							
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29/1																							
30/1																							
31/1																							

MEDICINE RECORDING SHEET

KEY
 DRUG REFUSED
 PATIENT ABSENT

REGULAR PRESCRIPTIONS

DEPOT
INJECTION

AS REQUIRED

Index

COMMENTS ON
DISCREPANCIES[illegible]

NAME: LEON G. ZATTOR UNIT No: 170375191

WARD:

STATIONER
HOSPITAL (NR) 57

NB - A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED
PRESCRIPTION SHEET NO. 1

KEY
A DRUG REFUSED
X PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS										OTHER TIMES						INJECTION			DISCREPANCIES		
	8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls		
23/11/12	B C	mt.																				
24/11/12	B C	mt.																				
25/11/12	B C	mt.																				
26/11/12	B C	mt.																				
27/11/12	B C	mt.																				
28/11/12	B C	mt.																				
29/11/12	B C	mt.																				
30/11/12	B C	mt.																				
1/12/12	B C	mt.																				
2/12/12	B C	mt.																				
3/12/12	B C	mt.																				
4/12/12	B C	mt.																				
5/12/12	B C	mt.																				
6/12/12	B C	mt.																				
7/12/12	B C	mt.																				
8/12/12	B C	mt.																				
9/12/12	B C	mt.																				
10/12/12	B C	mt.																				
11/12/12	B C	mt.																				
12/12/12	B C	mt.																				
13/12/12	B C	mt.																				
14/12/12	B C	mt.																				
15/12/12	B C	mt.																				
16/12/12	B C	mt.																				
17/12/12	B C	mt.																				
18/12/12	B C	mt.																				
19/12/12	B C	mt.																				
20/12/12	B C	mt.																				
21/12/12	B C	mt.																				
22/12/12	B C	mt.																				
23/12/12	B C	mt.																				
24/12/12	B C	mt.																				
25/12/12	B C	mt.																				
26/12/12	B C	mt.																				
27/12/12	B C	mt.																				
28/12/12	B C	mt.																				
29/12/12	B C	mt.																				
30/12/12	B C	mt.																				
31/12/12	B C	mt.																				

NAME: 1003751191 UNIT NO: 1703751191 WARD: 1003751191 STATION: 1003751191

NB - A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A
 PRESCRIPTION SHEET IS CHANGED
 PRESCRIPTION SHEET No. 1 (S. L. A. M. C. S.)

KEY
 DRUG REFUSED
 PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS

REGULAR PRESCRIPTIONS										OTHER TIMES										DEPOT INJECTION			AS REQUIRED			PATIENT ABSENT	MEDICINE RECORD																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																		
Date	8.00	13.00	18.00	Intls	22.00	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
9/1/12	B C F	MS F	MS F	MS F	A D E F MC	MS F																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																							</

NAME: LEON GRATTION UNIT No: 17.03.75.1191 WARD: DUNING STRATHEDEN HOSPITAL (MR) 57

NB - A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED
PRESCRIPTION SHEET No.

Admitted 06/01/14
Discharged 14.15

KEY
D DRUG REFUSED
P PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS				OTHER TIMES				DEPOSIT		AS REQUIRED				COMMENTS ON DISCREPANCIES
	8.00	13.00	18.00	22.00	Code	Time	Code	Time	Code	Time	Code	Time	Code	Time	
26/12/11	B C	W	F	H							W 14.15	14.15			① No Sleep
27/12/11	B C	W	F	W							W 07.00	07.00			
28/12/11	B C	W	F	W							W 16.40	16.40			
29/12/11	B C	W	F	W							W 15.40	15.40			
30/12/11	B C	W	F	W							W 04.50	04.50			
31/12/11	B C	W	F	W							W 18.35	18.35			
1/12	B C	W	F	W							W 06.15	06.15			
2/12	B C	W	F	W							W 18.45	18.45			
3/12	B C	W	F	W							W 06.40	06.40			
4/12	B C	W	F	W							W 03.40	03.40			
5/12	B C	W	F	W							W 14.55	14.55			
6/12	B C	W	F	W							W 02.30	02.30			
7/12	B C	W	F	W							W 17.00	17.00			
8/12	B C	W	F	W							W 18.40	18.40			
9/12	B C	W	F	W							W 02.00	02.00			
10/12	B C	W	F	W							W 23.00	23.00			
11/12	B C	W	F	W							W 19.45	19.45			
12/12	B C	W	F	W							W 14.15	14.15			
13/12	B C	W	F	W							W 02.00	02.00			
14/12	B C	W	F	W							W 17.00	17.00			
15/12	B C	W	F	W							W 18.40	18.40			
16/12	B C	W	F	W							W 02.30	02.30			
17/12	B C	W	F	W							W 17.00	17.00			
18/12	B C	W	F	W							W 18.40	18.40			
19/12	B C	W	F	W							W 02.30	02.30			
20/12	B C	W	F	W							W 17.00	17.00			
21/12	B C	W	F	W							W 18.40	18.40			
22/12	B C	W	F	W							W 02.30	02.30			
23/12	B C	W	F	W							W 17.00	17.00			
24/12	B C	W	F	W							W 18.40	18.40			
25/12	B C	W	F	W							W 02.30	02.30			
26/12	B C	W	F	W							W 17.00	17.00			
27/12	B C	W	F	W							W 18.40	18.40			
28/12	B C	W	F	W							W 02.30	02.30			
29/12	B C	W	F	W							W 17.00	17.00			
30/12	B C	W	F	W							W 18.40	18.40			
31/12	B C	W	F	W							W 02.30	02.30			

NAME: LEON GANTON UNIT NO: 1703751191 WARD: TWO (MR) 57

OCCUPATIONAL THERAPY SERVICE MENTAL HEALTH



NON-STANDARDISED ASSESSMENT

Name: Leon Gratton	Ward ☒ Day Hospital ☐ Rehab ☐ Community ☐
CHI No: 1703751191	GP Name: Dr D Garmany
Address: 85 Spittalfield Road, Inverkeithing	Address: Inverkeithing Medical Centre, 5 Friary Court, Inverkeithing
Telephone: 07922 56497	Telephone: 413234
Marital Status: -	Next of Kin/Contact: -
Consultant: Dr P Cavanagh	Relationship: -
	Telephone: -

Task Description and Environment:

Leon shopped for ingredients for and made macaroni cheese from scratch in the OT kitchen.

Persons present: Leon and Susan Haynes, Occupational Therapist

Mental State/Physical:

Leon reported feeling tired as he had only slept a few hours. Motivated to attend session. Difficulty concentrating at times. Mood was reactive. Leon's over estimates his own abilities.

Self Presentation:

Dishevelled and unkempt in personal appearance.
Friendly in manner.

Medical/Physical Factors:

None encountered during session.

FACTORS IDENTIFIED FROM ASSESSMENT – INCLUDING RISK:

- Able to identify and shop for required ingredients with some assistance
- Able to sequence task independently
- After initial orientation to kitchen was able to locate items independently
- Asked for assistance when appropriate
- Easily distracted from task by conversing with therapist
- After initial prompting regarding hand washing maintained reasonable standards of hygiene
- Required prompting to restore items to original places following task
- Turned off cooker unprompted, but after a short delay whilst draining pasta

Continued

SUMMARY AND RECOMMENDATIONS:

Leon has clearly developed kitchen skills in the past. However, Leon over-estimates his current skills. At present he requires some assistance to complete ADL tasks due to deficits in processing skills.

Recommendations

Leon will benefit from continued meal-making sessions. An AMPS assessment is planned to provide baseline information and scores.

Occupational Therapist's Signature:

Susan Haynes

Date: 08/12/2011

Name: Susan Haynes

Address: OT Department (Mental Health), Phase 1, Queen Margaret Hospital
Whitefield Road, Dunfermline, KY12 0SA

Telephone: 01383 - 674153

Copies to:

GP

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OT

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Nursing

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Consultant

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CPN

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Home Care

☐

Social Worker

☐

Community OT

☐

Other:

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OCCUPATIONAL THERAPY SERVICE MENTAL HEALTH



DISCHARGE SUMMARY

Name: Leon Gratton	Ward ☒ Day Hospital ☐ Rehab ☐ Community ☐
CHI No: 1703751911	GP Name: Dr D Garmany
Address: 85 Spittalfield Road, Inverkeithing	Address: Inverkeithing Medical Centre, 5 Friary Court, Inverkeithing
Telephone: 0792 256497	Telephone: 413234
Marital Status: Unknown	Next of Kin/Contact: Lorna Gratton
Consultant: Dr P Cavanagh	Relationship: Mother
	Telephone: 07762 602112

IDENTIFIED AREA OF NEED				
Treatment Plan	Specified Assessments/Treatment	Achieved		
		Yes	No	In-part
Goal 1 To assess Leon's functional level	- Kitchen assessment - AMPS	☐	☐	☒
Goal 2 To maintain meal-making skills and interest in cooking	- Participation in 1:1 meal preparation/ shopping sessions - Meal-making group	☐	☐	☒
Goal 3		☐	☐	☐
Goal 4		☐	☐	☐
Goal 5		☐	☐	☐
Goal 6		☐	☐	☐
Goal 7	<i>all</i>	☐	☐	☐

OCCUPATIONAL THERAPY SERVICE
MENTAL HEALTH



Summary and Recommendations

Prior to transfer to rehab at Stratheden, Leon was well-motivated to engage in a kitchen assessment and breakfast preparation session.

He required minimal prompting to attend to hygiene (hand washing) and to the tasks but displayed enjoyment and pride in his achievements.

Follow-up:

- OT referral from rehab ward
- Would benefit from AMPs to establish baseline for rehab

Occupational Therapist's Signature:

B. Shaw

Date: 18.01.12

Name: Babs Shaw

Address: Adult OT Mental Health, Queen Margaret Hospital, Phase 1,
Whitefield Road, Dunfermline KY12 0SU

Telephone: 01383 674153

Copies to:

GP
OT

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☒

CPN
Home Care

☐
☐

Other: ☒
Karen Smart
(FAO Rehab OT)

Nursing
Consultant

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☒

Social Worker
Community OT

☐
☐

Dr. Crough

OCCUPATIONAL THERAPY SERVICE MENTAL HEALTH

for 6 week intake
F.A.O Mibyn

STANDARDISED ASSESSMENT

Name: Leon Gratton	Ward ☐ Day Hospital ☐ F
CHI No: 1703751911	GP Name:
Address: C/O Dunino Ward, Stratheden Hospital, Cupar, Fife, KY15 5RR.	Address:
Telephone: 01334 696227	Telephone:
Marital Status: Divorced	Next of Kin/Contact:
Consultant: Dr Dasgupta	Relationship:
Date of Assessment:	Telephone:

Location: Ceres Centre, Stratheden Hospital, Cupar, Fife, KY15 5RR.	People Present: Leon Gratton (Patient) Bill Booth (Occupational Therapist)
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ASSESSMENT NAME:

Allen Cognitive Lacing Screen – 5 (ACLS-5)

About the Assessment:

The Allen Cognitive Level (ACL) is a leather lace screening tool, designed to assist in defining patient's presenting functional abilities and difficulties - i.e. in activities of daily living (ADL). The use of the ACL does not rely on verbal responses or reading and writing skills. The score ranges from Level 6 where functioning is deemed normal; and no intervention is required, to Level 1; where the person is assessed as profoundly impaired. The Screen Score observed at the time of assessment is; as noted a screen, and therefore will require additional assessment within the appropriate settings of ADL. ADL functional scores can be provided in abilities with grooming, dressing, bathing, walking/exercising, eating, taking medication, housekeeping, preparing and obtaining food, spending money and travelling. The ACL can be used with all adult groups.

Score:

On this occasion, Leon was observed to score a 4.8 indicating:-

A need for 26% cognitive assistance – the person can live alone with daily assistance to monitor safety and check problem solving effectiveness. The person may be able to attend a regular well rehearsed community activity without assistance.

With regards to bathing and grooming, a 4.8 indicates an ability to initiate and co-ordinate bathing routine. Independent with grooming, following routines and old habits.

With regards to dressing, a 4.8 indicates an ability to initiate dressing, although may not attend to certain aspects such as cleanliness of item, general fit etc. May don items slowly. Has capacity to learn donning new items, e.g. prosthesis following a rote of sequential practise.

With regards to walking and exercising, 4.8 indicates an ability to vary routes within familiar neighbourhood to reach destinations associated with routine activities. Scans visible environment to search for a desired cue, landmark etc. to guide direction. May learn new route by rote practised over several days. Reads street signs and attempts to use this information in guiding route, but still may be unable to find way home if lost. Understands risk elements of walking on own, especially at night etc.

With regards to planning/preparing for and eating food, 4.8 indicates an inability to plan for long term food needs, going to shop repeatedly and buying for immediate use only. May however have the ability to learn how to plan for planning a well balanced diet, purchasing certain items etc. through supported practise – may follow a weekly schedule more effectively. May have ability to memorise a new sequence of actions required for preparing a new dish, following a rote of practising one stage at a time. May require assistance in following a recipe. Will clean up after with cues in line with social standards. With guided practise and support, may have ability to learn safety techniques required with cooking, managing open flames, using sharp items etc. Closely watches clock to time dishes for short periods; needs cues such as timer for longer periods.

With regards to eating, eats and attends to social conversation, and may not talk and eat at same time. Manages all utensil use.

With regards to toileting, 4.8 indicates an ability to be independent, noting all striking cues in new environment to locate a bathroom.

With regards to using adaptive equipment, 4.8 indicates an ability to recognise loss of range of motion, strength etc. and may have ability to learn use of new equipment by rote and supervised practise.

With regards to taking medication, 4.8 indicates an ability to follow prescriptions slowly. Can manage co-ordinating variables required in taking tablets, but with difficulty. Will follow verbal explanations of secondary effects to be avoided such as mixing medications etc.

With regards to housekeeping, 4.8 indicates an ability to initiate and complete a routine of housekeeping activities at the usual time of day. Learns new procedures slowly by rote.

With regards to spending money, 4.8 indicates a an ability to slowly follow a budget by rote, or learn money management recognised by others. May need assistance to adjust changes in income, expense, or usual banking procedures etc. and in managing emergencies such as stolen money or credit cards.

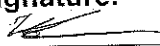
With regards to shopping, 4.8 indicates an ability to shop for routine items in familiar locations. Learns directions to new shopping areas by rote. May learn to use a shopping list, or use money saving coupons etc. from others through supervised practise. Such procedures are followed rigidly. May be able to learn safety precautions to protect against theft. When buying items, can identify price and size, however may not consider practicalities and cost.

With regards to travelling, 4.8 indicates an ability to learn a new route or travel procedure slowly by rote and supervised practise. May follow safety precautions pointed out by others, but may not anticipate potential hazards. If allowed to drive a motor vehicle, may do so slowly, or dangerously, unable to anticipate and react quickly to the movement of others.

With regards to using the telephone, 4.8 indicates an ability to learn use of new telephone, answering machine, pay phone etc. by rote. May need assistance to adjust to changes in new telephone procedures, new technologies etc.

RECOMMENDATIONS:

On the basis of this assessment, Leon would appear to demonstrate independence in many spheres of function. He would be ultimately able to maintain a tenancy in functional terms, and maintain ADL routines also. He would require background supervision and monitoring as he has a history of self-neglect and disorganisation against poor motivation when unwell. Please see complimentary non-standardised assessment.

Occupational Therapist's Signature: 		Date: 2 / 2 / 12
Name:	Bill Booth	
Address:	OT Adult Service, Ceres Centre, Stratheden Hospital, Cupar, Fife, KY15 5RR.	
Telephone:	01334 696227	

Copies to:

GP

☐

CPN

☐

Other:

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OT

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Home Care

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Nursing

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Social Worker

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Consultant

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Community OT

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OCCUPATIONAL THERAPY SERVICE MENTAL HEALTH



NON-STANDARDISED ASSESSMENT

Name: Leon Gratton	Ward ☐ Day Hospital ☐ Rehab ☐ Community ☐
CHI No: 1703751911	GP Name:
Address: C/O Dunino Ward, Stratheden Hospital, Cupar, Fife, KY15 5RR.	Address:
Telephone: 01334 696214	Telephone:
Marital Status: Divorced	Next of Kin/Contact:
Consultant: Dr Dasgupta	Relationship:
	Telephone:

Task Description and Environment:

- Shopping and errand running in Cupar town centre via private car to encompass budgeting, shopping, use of resources and road safety.
- Snack preparation/cooking in OT Kitchen at Ceres Centre to assess functional skills, safety and hygiene.

Mental State/Physical:

Leon engaged in conversation spontaneously and responded appropriately to comments and queries. He did not appear anxious or ill-at-ease at any point, despite voicing apprehension about 'bumping into' people in Cupar. He made one indirect reference to Madeleine; however, it was regarding where he could buy the book about her disappearance. Leon appeared physically fit.

Self Presentation:

Leon presented as motivated to engage in the assessment and maintained a pleasant and amenable demeanour throughout. He remained appropriate in his interactions with others; e.g., shop staff.

Medical/Physical Factors:

No significant limitations.

FACTORS IDENTIFIED FROM ASSESSMENT – INCLUDING RISK:

Leon presented as functionally able and competent as regards the above tasks; however, he omitted to wash his hands before handling raw meat and attempted to handle a hot grill pan unnecessarily without the use of; e.g., an oven glove. These omissions appeared to be due to a cavalier approach to tasks rather than a lack of awareness. Otherwise, Leon prepared a snack of bacon rolls and coffee competently and without guidance or prompting.

SUMMARY AND RECOMMENDATIONS:

Regarding this assessment, Leon presented as functionally able and competent. He followed his own routine of first visiting the Post Office, followed by a small shop and the supermarket, choosing his preferred purchases, all of his own volition. He had no difficulty orientating to unfamiliar locations and environments and was generally able to maintain safety. He would not require specific OT intervention with the above; however, he would benefit from on-ward self-catering to maintain skills. He may engage with OT for preferred activity in due course at the end of this assessment period.

Occupational Therapist's Signature:**Date:**

2 / 2 / 12

Name: Bill Booth**Address:** Adult OT Service, Ceres Centre, Stratheden Hospital, Cupar, Fife, KY15 5RR.**Telephone:** 01334 696227**Copies to:**

GP

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OT

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Nursing

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Consultant

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CPN

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Home Care

☐

Social Worker

☐

Community OT

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Other:

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OCCUPATIONAL THERAPY SERVICE MENTAL HEALTH



STANDARDISED ASSESSMENT

Name: Leon Gratton	Ward ☐ Day Hospital ☐ Rehab ☐ Community ☐
CHI No: 1703751911	GP Name:
Address: C/O Dunino Ward, Stratheden Hospital, Cupar, Fife, KY15 5RR.	Address:
Telephone: 01334 696227	Telephone:
Marital Status: Divorced	Next of Kin/Contact:
Consultant: Dr Dasgupta	Relationship:
Date of Assessment:	Telephone:

Location: Ceres Centre, Stratheden Hospital, Cupar, Fife, KY15 5RR.	People Present: Leon Gratton (Patient) Bill Booth (Occupational Therapist)
---	---

ASSESSMENT NAME:

Allen Cognitive Lacing Screen – 5 (ACLS-5)

About the Assessment:

The Allen Cognitive Level (ACL) is a leather lace screening tool, designed to assist in defining patient's presenting functional abilities and difficulties - i.e. in activities of daily living (ADL). The use of the ACL does not rely on verbal responses or reading and writing skills. The score ranges from Level 6 where functioning is deemed normal; and no intervention is required, to Level 1; where the person is assessed as profoundly impaired. The Screen Score observed at the time of assessment is; as noted a screen, and therefore will require additional assessment within the appropriate settings of ADL. ADL functional scores can be provided in abilities with grooming, dressing, bathing, walking/exercising, eating, taking medication, housekeeping, preparing and obtaining food, spending money and travelling. The ACL can be used with all adult groups.

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With regards to walking and exercising, 4.8 indicates an ability to vary routes within familiar neighbourhood to reach destinations associated with routine activities. Scans visible environment to search for a desired cue, landmark etc. to guide direction. May learn new route by rote practised over several days. Reads street signs and attempts to use this information in guiding route, but still may be unable to find way home if lost. Understands risk elements of walking on own, especially at night etc.

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With regards to eating, eats and attends to social conversation, and may not talk and eat at same time. Manages all utensil use.

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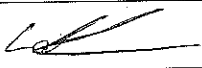
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RECOMMENDATIONS:

On the basis of this assessment, Leon would appear to demonstrate independence in many spheres of function. He would be ultimately able to maintain a tenancy in functional terms, and maintain ADL routines also. He would require background supervision and monitoring as he has a history of self-neglect and disorganisation against poor motivation when unwell. Please see complimentary non-standardised assessment.

Occupational Therapist's Signature: 		Date: 2 / 2 / 12
Name:	Bill Booth	
Address:	OT Adult Service, Ceres Centre, Stratheden Hospital, Cupar, Fife, KY15 5RR.	
Telephone:	01334 696227	

Copies to:

GP

☐

CPN

☐

Other:

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OT

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Home Care

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Nursing

☐

Social Worker

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Consultant

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Community OT

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OCCUPATIONAL THERAPY SERVICE MENTAL HEALTH



NON-STANDARDISED ASSESSMENT

Name: Leon Gratton	Ward ☐ Day Hospital ☐ Rehab ☐ Community ☐
CHI No: 1703751911	GP Name:
Address: C/O Dunino Ward, Stratheden Hospital, Cupar, Fife, KY15 5RR.	Address:
Telephone: 01334 696214	Telephone:
Marital Status: Divorced	Next of Kin/Contact:
Consultant: Dr Dasgupta	Relationship:
	Telephone:

Task Description and Environment:

- Shopping and errand running in Cupar town centre via private car to encompass budgeting, shopping, use of resources and road safety.
- Snack preparation/cooking in OT Kitchen at Ceres Centre to assess functional skills, safety and hygiene.

Mental State/Physical:

Leon engaged in conversation spontaneously and responded appropriately to comments and queries. He did not appear anxious or ill-at-ease at any point, despite voicing apprehension about 'bumping into' people in Cupar. He made one indirect reference to Madeleine; however, it was regarding where he could buy the book about her disappearance. Leon appeared physically fit.

Self Presentation:

Leon presented as motivated to engage in the assessment and maintained a pleasant and amenable demeanour throughout. He remained appropriate in his interactions with others; e.g., shop staff.

Medical/Physical Factors:

No significant limitations.

FACTORS IDENTIFIED FROM ASSESSMENT – INCLUDING RISK:

Leon presented as functionally able and competent as regards the above tasks; however, he omitted to wash his hands before handling raw meat and attempted to handle a hot grill pan unnecessarily without the use of, e.g., an oven glove. These omissions appeared to be due to a cavalier approach to tasks rather than a lack of awareness. Otherwise, Leon prepared a snack of bacon rolls and coffee competently and without guidance or prompting.

SUMMARY AND RECOMMENDATIONS:

Regarding this assessment, Leon presented as functionally able and competent. He followed his own routine of first visiting the Post Office, followed by a small shop and the supermarket, choosing his preferred purchases, all of his own volition. He had no difficulty orientating to unfamiliar locations and environments and was generally able to maintain safety. He would not require specific OT intervention with the above; however, he would benefit from on-ward self-catering to maintain skills. He may engage with OT for preferred activity in due course at the end of this assessment period.

Occupational Therapist's Signature:**Date:**

2 / 2 / 12

Name: Bill Booth**Address:** Adult OT Service, Ceres Centre, Stratheden Hospital, Cupar, Fife, KY15 5RR.**Telephone:** 01334 696227**Copies to:**

GP

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OT

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Nursing

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Consultant

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CPN

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Home Care

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Social Worker

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Community OT

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Other:

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Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]

NHS

Initial admission to Ward/Department Dunino	Community Service/Hospital: Stratheden	Admission to Hospital: Date: 06.01.12 Time: 1415
Consultant: Dr Dasgupta	Named Nurse/Case Manager: Shona Napier	Unit No/CHI No: F5153833/1703751191
		Care Programme Approach No:

Personal Information

FULL NAME: Mr / Mrs / Ms / Miss / Master Mr Leon Gratton		Where appropriate, likes to be known as: Leon	Previous or Maiden Name(s): n/a
		Date of Birth: 17.03.75 Gender: Male	Place of Birth: Manchester
Home Address: 85 Spittalfield Road verkeithing Post Code: KY11 1DZ		Current Address: c/o Dunino Ward Stratheden Hospital Cupar Post Code: KY15 5RR	Marital Status: Single Telephone No(s): 07546720244
Present/Past Occupation: Unemployed		Religion and/or Chaplaincy requirement:	Ethnic Origin: White English Sensory Impairment problem(s): None
Allergies: None known		Is English first language? Yes ☒ No ☐ Preferred Language	Is an Interpreter required? Yes ☐ No ☒ Name (relationship to client, if any)
MHA Status Informal	Review Date	Patient Informed of Status By: Date:	Clinical Risk: Yes ☒ No ☐ If yes; Specify Main Risk Since admission expressing paranoid delusions regarding mother Refer to Care Plan No: Does the Adults with Incapacity Act Apply: Yes ☐ No ☒ Is there an Identified Relapse Signature? Yes ☐ No ☐ If Yes; Refer to Care Plan No:

Main Carer/Partner/Relatives/Named Person Information etc

(1) Full Name: Mrs Leona Gratton	Home Address: Unknown – wants no details documented Post Code:	Telephone No: 07762602112 Relationship: Mother
(2) Full Name: Mr Gary Gratton	Home address 57 Orchard Brae Manchester Post Code:	Telephone No: 07762602112 Relationship: Father
Does service user agree with the sharing of information with Carer / Nearest Relative /Partner Yes ☐ No ☐	Identify person to be contacted if patient is sick, dying or in any emergency.	Where appropriate - Order of Contact

Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]

Patients Name: Leon Gratton Unit/CHI No: F5153833/1703751191

Diagnosis

Relevant Medical Condition: Schizophrenia B.P.D. Eczema Asthma	Medication Concordance:
---	--

Community Service Involvement

	Name/Address	Tel No's
LMHT/Community Team COT TEAM	Dawn Stanley c/o Haldane House	01383 432725
General Practitioner	Dr Garmany Inverkeithing Medical Practice	01383 413234
Social Worker		
Community Psychiatric Nurse		
District Nurse		
Care Programme Approach Co-ordinator		
Home Care Manager		
Chaplain		
Other	Glasgow Benefits Centre, Baird St, Glasgow, G90 8BJ	
Other involvement Richmond	Dave Chaplin	
ARK	Annie Gibbs	01592 782109

Patient Financial Information etc

	Where appropriate - Name/Address	Tel No's
Welfare Power of Attorney:		
Power of Attorney/Guardian/Curator:		
Pension Book etc held by:		
House Keys held by:		
Insurance Number:	JC 4965 64 A	
Advanced Statement held at/with	Dunino Ward with Dr Johnson 14.09.12	

Nursing Observations

Temperature 36.7	Pulse 74	Blood Pressure 136/72
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Signature of Person Completing this Form: _____

Date: 06.01.12

Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]



Initial admission to Ward/Department Dunino	Community Service/Hospital: Stratheden	Admission to Hospital: Date: 06.01.12 Time: 1415
Consultant: Dr Dasgupta	Named Nurse/Case Manager: Angela Barbieri	Unit No/CHI No: F5153833/1703751191
		Care Programme Approach No:

Personal Information

FULL NAME: Mr / Mrs / Ms / Miss / Master Mr Leon Gratton		Where appropriate, likes to be known as: Leon	Previous or Maiden Name(s): n/a
		Date of Birth: 17.03.75 Gender: Male	Place of Birth: Manchester
Home Address: 85 Spittalfield Road verkeithing Post Code: KY11 1DZ		Current Address: c/o Dunino Ward Stratheden Hospital Cupar Post Code: KY15 5RR	Marital Status: Single Telephone No(s): 07546720244
Present/Past Occupation: Unemployed		Religion and/or Chaplaincy requirement:	Ethnic Origin: White English Sensory Impairment problem(s): None
Allergies: None known		Is English first language? Yes ☒ No ☐ Preferred Language	Is an Interpreter required? Yes ☐ No ☒ Name (relationship to client, if any)
MHA Status Informal	Review Date	Patient Informed of Status By: Date:	Clinical Risk: Yes ☒ No ☐ If yes; Specify Main Risk Since admission expressing paranoid delusions regarding mother Refer to Care Plan No:
		Does the Adults with Incapacity Act Apply: Yes ☐ No ☒ Is there an Identified Relapse Signature? Yes ☐ No ☐ If Yes; Refer to Care Plan No:	

Main Carer/Partner/Relatives/Named Person Information etc

(1) Full Name: Mrs Leona Gratton	Home Address: Unknown – wants no details documented Post Code:	Telephone No: 07762602112 Relationship: Mother
(2) Full Name: Mr Gary Gratton	Home address 57 Orchard Brae Manchester Post Code:	Telephone No: 07762602112 Relationship: Father
Does service user agree with the sharing of information with Carer / Nearest Relative / Partner Yes ☐ No ☐		Identify person to be contacted if patient is sick, dying or in any emergency. Where appropriate - Order of Contact

Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]

Patients Name: Leon Gratton Unit/CHI No: F5153833/1703751191

Diagnosis

Relevant Medical Condition: Schizophrenia B.P.D. Eczema Asthma	Medication Concordance:
---	--

Community Service Involvement

	Name/Address	Tel No's
LMHT/Community Team COT TEAM	Dawn Stanley c/o Haldane House	01383 432725
General Practitioner	Dr Garmany Inverkeithing Medical Practice	01383 413234
Social Worker		
Community Psychiatric Nurse		
District Nurse		
Care Programme Approach Co-ordinator		
Home Care Manager		
Chaplain		
Other	Glasgow Benefits Centre, Baird St, Glasgow, G90 8BJ	
Other involvement Richmond	Dave Chaplin	
ARK	Annie Gibbs	01592 782109

Patient Financial Information etc

	Where appropriate - Name/Address	Tel No's
Welfare Power of Attorney:		
Power of Attorney/Guardian/Curator:		
Pension Book etc held by:		
House Keys held by:		
Insurance Number:		
Advanced Statement held at/with		

Nursing Observations

Temperature 36.7	Pulse 74	Blood Pressure 136/72
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Signature of Person Completing this Form:

Date: 06.01.12

MEDICAL – IN CONFIDENCE

ADMISSION DATA

UNIT/CASE REF NO. 117037511911

Surname <u>GRATTON</u> Forename <u>LEON</u> Title <u>MR</u> Initials <u>—</u> Previous Names <u>—</u> Marital Status <u>181</u> 1 Never Married 2 Married (includes separated) 3 Widowed 8 Other (includes divorced) 9 Not known Date of Birth <u>17/3/75</u> Address <u>95 SPITFIED ROAD</u> <u>INVERKETHING</u> Post Code <u>IK11 11 1D12</u> Have you been resident in the UK for the past 12 months? Y/N <u>Y</u> Religion <u>NONE</u> Occupation <u>UNEMPLOYED</u>	Next of Kin (relationship) <u>MOTHER</u> Name <u>MRS WONA GRATTON</u> Address <u>UNKNOWN</u> Tel No <u>0716260242</u> Named Person (relationship) <u>—</u> Name <u>—</u> Address <u>—</u> Tel No <u>—</u> Emergency Contact (relationship) <u>—</u> Name <u>—</u> Address <u>—</u> Tel No <u>—</u> G.P.'s Name <u>DR GARMARY</u> G.P.'s Address <u>INVERKETHING MOBILE</u> <u>PRACTICE</u> Tel No <u>07383 43 234</u>	ETHNIC GROUP 1A White Scottish 1B White Other 1C White Irish 1D Any other W 2A Any mixed b 3A Indian 3B Pakistani 3C Bangladeshi 3D Chinese 3E Any other As 4A Caribbean 4B African 4C Any other Bl 5A Any other Et 98 Refused/Not 99 Not Ki n PATIENT CATE 2 Paying 3 NHS 4 Overseas visi 5 Overseas visi 8 Other (includi
Admitting Ward <u>DUNINO</u> Date of Admission <u>06/01/12</u> Time <u>14¹⁰</u> CONSULTANT <u>19111</u> Specialty G1 General Psychiatry G3 Forensic Psychiatry G4 Psychiatry of Old Age G5 Learning Disability G6 Psychotherapy G2 Child & Adolescent Psychiatry G21 Child Psychiatry G22 Adolescent Psychiatry Admission precipitated by self injury/poisoning? <u>Y/N</u> Previous Psychiatric In-patient Care? Y/N <u>Y</u> If yes, state Hospital name of Previous Admission/s <u>DUNINO HOSPITAL</u>	Status on Admission <u>111</u> 1 Informal 2 Informal (respite) 3 Formal If Formal state: <u>—</u> Detention Order <u>—</u> Start: Date <u>—</u> / <u>—</u> / <u>—</u> Time <u>—</u> hours End: Date <u>—</u> / <u>—</u> / <u>—</u> Time <u>—</u> hours Emergency Admission Y/N <u>N</u> Next of Kin/Named person to be Notified Y/N <u>Y</u> Advance Statement Y/N <u>Y</u>	ADMISSION M 12 Patient admi Out-patients are at table 18 Planned trar 19 Routine adr 21 Patient dela 22 Hospital day arranging ap equipment e 31 Patient Injur 38 Other Emerg 39 Emergency The following apply 10 Routine Adm 20 Urgent admi 30 Emergency

TOP FLIMSY COPY TO BE RETAINED BY WARD
BOTTOM HARD COPY TO BE SENT TO MEDICAL RECORDS

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11B ackground ound ackground ackground ackground ded by patient	67 ADMISSION REASON 51 Diagnostic 52 Therapeutic/Clinical Crisis 53 Self inflicted injury 54 Poisoning 55 Accidental injury 56 Other injury 57 Rehabilitation 58 Other type of psychiatric admission 5A Admission after extended pass 5B Respite/Holiday care 5C Learning Disability
3 liable to pay not liable to pay spice)	3 ADMISSION REFERRAL SOURCE 1 Mental Health Out-patients 3 Direct Transfer from other Psychiatric In-patient Care (<i>if this code is used the admission transfer from code should be 4D or 4E / 5D or 5E</i>) 4 Referral from Non-Psychiatric In-patient Clinical Ward 6 Prison/Penal establishment (including Police Station) 7 Judicial (Court) 8 Local Authority/Voluntary Agency A Community Mental Health Services B Self Referral C Domiciliary Visit D GP E Community Care Order F A & E Department (not admitted to an A & E Ward) G Crisis Service
118 on same day or following day as attendance at for medical reasons because suitable resources n – type not known domestic, legal or other practical reasons) admin. or clinical reasons, e.g. riate facilities, for tests to be carried out specialist elf inflicted (Injury or Poisoning) / Admission (inc. Emergency Transfers) ssion – type not known <u>s should only be used if none of the above</u> on – no additional detail added 1, no additional detail added ission – no additional detail added	4D ADMISSION/TRANSFER FROM 11 Private Residence – living alone 12 Private Residence – living with relatives/friends 14 Private Residence – (supported) 25 Care Home 31 Holiday Accommodation 32 Student Accommodation 33 Legal Establishment, including Prison 34 No fixed abode 41 Accident & Emergency within same Health Board 43 Medical Ward within same Health Board 4B Geriatrics (except for patient on pass) within same NHS Boa 4D Psychiatric (except for patient on pass) within same NHS Brd 4E Psychiatric (patient on pass) within same NHS Board 4G Learning Disability within same NHS Board 51 Accident & Emergency from another NHS Board 53 Medical Ward from another NHS Board 5B Geriatrics (except for patient on pass) from another NHS Brd 5D Psychiatric (except for patient on pass) from another NHS Board 5E Psychiatric (patient on pass) from another NHS Board 5G Learning Disability from another Health Board <u>The following codes should only be used if none of the ave apply</u> 10 Private Residence – no additional details added 20 Place of Residence – Institution – no additional details