

Grampian Health Board

RECOMMENDATIONS ON DISCHARGE

THIS FORM IS PRINTED ON N.C.R. PAPER PLEASE USE A BALL POINT PEN ON HARD SURFACE. PLEASE ENSURE THAT ALL COPIES ARE LEGIBLE.	SURNAME	Reid	UNIT NO.	968366
	FIRST NAMES	Lee Ian	SEX	
	ADDRESS	34, Newton Road Aberdeen	MARITAL STATUS	
	POST CODE		DATE OF BIRTH	10/5/92
BAR CODE		PLACE LABEL WITHIN BRACKETS		
G.P.s NAME		G.P.s ADDRESS		

Dear Dr

Your patient admitted on 21/10/92 under the care of Dr. G. Russell was discharged
from ward 6 Hospital RACH on 25/10/92

Diagnosis Main Bronchial asthma & Eryema Operation 1.....

Associated..... Operation 2.....

Date.....

COMMENTS:-

Early asthma. mis diag. review and
close follow up in Respiratory clinic

[Signature]
cos

It is recommended that the following therapy be prescribed as detailed below: A "C" in the Duration of Treatment column denotes continuing treatment unless otherwise specified in days. NB A three days supply will be dispensed unless specifically requested in this space:-

PROBLEM NUMBER	MEDICINE (BLOCK LETTERS)	TYPE OF PREPARATION	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION					OTHER TIMES	DURATION OF TREATMENT	For Completion By Pharmacist QUANTITY SUPPLIED
					8	12	2	6	10			
A	SLOPHYLLIN	cap.	800mg	O	✓						7d	
B	BRICANYL	sypr	750mg	O	✓		✓		✓		7d	
C	CANESTAN HC	OINTMENT	LA	LA	✓				✓		7d	

DRUG SENSITIVITY

Pharmacist's Initials

Doctor's Signature**

Date dispensed

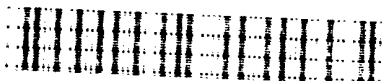
Designation

Date 25/10/92

**MEDICINES WILL NOT BE DISPENSED WITHOUT A DOCTOR'S SIGNATURE IN THIS SPACE.

A discharge letter/summary will follow.
At time of discharge this copy to be
given to patient to take/send to GP.

ROBERT ABERDEEN CHILDREN'S HOSPITAL

ABERDEEN HOSPITALS Discharge Summary Medical Wards	PATIENT'S NAME AND ADDRESS		Unit No.
			D. of B.
Consultant	Dr P Smail		
Admitted	13/9/92	Discharged	15/9/92
G.P.		Dr A K Fraser Denburn Health Centre Rosemount Viaduct ABERDEEN	

Reason for Admission

Lee was admitted with a history of wheeze accompanied by cough on the day prior to admission. He'd had a similar episode 2 months ago which had responded to a nebuliser. There is a family history of asthma.

Findings (incl. relevant investigations) on admission

On examination he did have evidence of eczema and a dry skin without any clinical evidence of rhonchi on auscultation though he was mildly dyspnoeic.

Problem/Diagnosis

Asthma.

Treatment and Outcome

He was given a nebuliser and seemed to settle on this.

It was felt that he did have some evidence of asthma and he was started on Ketotifen in a dose of 1 mg twice a day.

FILE	☒
DISCHARGE	☐
ACTION	☐
FIN TO POK	☐
Normal	☐
Make Appointment	☐
Collect Prescription	☐
Phone	☐
TELL PATIENT	☐

PLAN (itemize drugs on discharge, review arrangements and information given to parents)

No follow-up arrangements were made.

S D'COSTA
Registrar

SD'C/KAR/ 9 October 1992

Grampian Health Board

RECOMMENDATIONS ON DISCHARGE

THIS FORM IS PRINTED ON N.C.R. PAPER PLEASE USE A BALL POINT PEN ON HARD SURFACE. PLEASE ENSURE THAT ALL COPIES ARE LEGIBLE.	SURNAME	REID	968366	UNIT NO.
	FIRST NAMES	LEE		
	ADDRESS			SEX
	POST CODE	10-5-92		MARITAL STATUS
	BAR CODE	PLACE LABEL WITHIN BRACKETS		
G.P.s NAME		G.P.s ADDRESS		

Dear Dr

Your patient admitted on 13/3/92 under the care of Dr Smail was discharged
from ward 6 Hospital Racit on 15/3/92

Diagnosis Main Asthma Operation 1.....
Associated wheeze Operation 2.....

Date 15/3/92

COMMENTS:-

Nebulizers + oral steroids,
improved quickly.
On Ketotifen 1mg BD.
No Rx made

✓ Dr
Smail

It is recommended that the following therapy be prescribed as detailed below: A "C" in the Duration of Treatment column denotes continuing treatment unless otherwise specified in days. NB A three days supply will be dispensed unless specifically requested in this space:-

PROBLEM NUMBER	MEDICINE (BLOCK LETTERS)	TYPE OF PREPARATION	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION					OTHER TIMES	DURATION OF TREATMENT	For Completion By Pharmacist QUANTITY SUPPLIED
					8	12	2	6	10			
1	KETOTIFEN	Syrup	1mg	ORAL	X					X	6/32	

DRUG SENSITIVITY

Pharmacist's Initials	Doctor's Signature**
Date dispensed	Designation <u>5th</u> Date <u>15/3/92</u>

**MEDICINES WILL NOT BE DISPENSED WITHOUT A DOCTOR'S SIGNATURE IN THIS SPACE.

A discharge letter/summary will follow.
At time of discharge this copy to be
given to patient to take/send to GP.

**ABERDEEN
HOSPITALS
Discharge
Summary Medical
Wards**

PATIENT'S
NAME AND
ADDRESS

REID
MR LEE IAN
34 NEWTON ROAD

968366H

M

S

ABERDEEN
AB2 7XX

10-05-1992

Unit No.

D. of B.

Consultant: Dr A D Kindley

Referred
by

Admitted 14 July 1992

Discharged 19 July 1992

Disposal

G.P.

Dr G D MacLean
Denburn Health Centre
Rosemount Viaduct
Aberdeen

Reason for Admission

Lee, who was 9 weeks old, had a 2 day history of cough, runny nose and wheeze. His brother has eczema and asthma.

Findings (incl. relevant investigations) on admission

On examination he had a slight cough and a few expiratory rhonchi. The following cultures were obtained: catheter tips - scanty growth of coagulase negative staphylococcus, catheter tip positive for parainfluenza 3, catheter tip moderate growth of Branhamella catarrhalis isolated after prolonged incubation, CRP less than 1. Haemoglobin 11.7, platelets 416, white cell count 15.6 mainly lymphocytes.

Problem/Diagnosis

Treatment and Outcome

Parainfluenza infection

A diagnosis of bronchiolitis was made and he was observed and given pre-feed suction and Atrovent nebulisers as required.

☒	FILE	
☐	RECORDS PLEASE	
☒	ACTION TAKEN	
☐	FIX TO PINK SHEET	
TELL PATIENT	Normal	
	Make Appointment	
	Collect Prescription	
	To Phone parents	

PLAN (itemize drugs on discharge, review arrangements and information given to

No follow-up.

IAN MacDONALD
Registrar

IM.CH. 11 August 1992

cc - QMS 3 Queen's Gate Aberdeen

AKF/KS

29 July 1992

Miss Beid
34 Newton Road
ABERDEEN

Dear Miss Reid

We were sorry that you were unable to bring Lee along as arranged today for her weight check and vaccination. It is very important that she is seen for this, particularly her vaccination, and so we have made a new appointment for your at 3.20 pm next Tuesday 4/8/92, and look forward to seeing you then.

Yours sincerely

Alan K Fraser

ABERDEEN ROYAL HOSPITALS N.H.S. TRUST

RECOMMENDATIONS ON DISCHARGE

THIS FORM IS PRINTED ON N.C.R. PAPER PLEASE USE A BALL POINT PEN ON HARD SURFACE. PLEASE ENSURE THAT ALL COPIES ARE LEGIBLE.	SURNAME	REID	968366	UNIT NO.
	FIRST NAMES	LEE IAN.		
	ADDRESS	34 NEWTON ROAD ABERDEEN.		M. SEX
	POST CODE	1015192		MARITAL STATUS
	BAR CODE		PLACE LABEL WITHIN BRACKETS	
G.P.s NAME		DR G. MACLEAN		
G.P.s ADDRESS		DENBURN H.C. ABERDEEN.		

Dear Dr

Your patient admitted on 14/7/92 under the care of DR KINDEL was discharged
from ward 6 Hospital RACH on 19/7/92.

Diagnosis Main Wheeze

Operation 1.....

Associated.....

Operation 2.....

Date.....

COMMENTS:-

Settled after admission - required only one set of
inhaler x1.
Home
now.

It is recommended that the following therapy be prescribed as detailed below: A "C" in the Duration of Treatment column denotes continuing treatment unless otherwise specified in days. NB A three days supply will be dispensed unless specifically requested in this space:-

PROBLEM NUMBER	MEDICINE (BLOCK LETTERS)	TYPE OF PREPARATION	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION					OTHER TIMES	DURATION OF TREATMENT	For Completion By Pharmacist QUANTITY SUPPLIED
					8	12	2	6	10			

DRUG SENSITIVITY

Pharmacist's Initials	Doctor's Signature** <u>SAI</u>
Date dispensed	Designation <u>REE</u> Date <u>19/7/92</u>

**MEDICINES WILL NOT BE DISPENSED WITHOUT A DOCTOR'S SIGNATURE IN THIS SPACE.

A discharge letter/summary will follow.
At time of discharge this copy to be
given to patient to take/send to GP.

**ABERDEEN HOSPITALS
NEONATAL UNIT
ABERDEEN MATERNITY HOSPITAL**

CONSULTANT STAFF David J Lloyd Paul Duffty	Name:	Male Infant Reid	Date of Birth:	10.5.92
	Child of:	Nicola Reid	Date of Admission:	-
Summary Sheet (PHOTOTHERAPY ONLY)	Address:	34 Newton Road ABERDEEN	Date of Discharge to Postnatal Floors:	-
	G.P.		Home:	16.5.92
	Name:	Dr G MacLean	Baby Unit Number:	968366
	Address:	Denburn Health Centre Rosemount Viaduct ABERDEEN	Mother's Unit Number:	603756

DATA BASE

Mother: Age.....21.....years. Parity.....1+0..... Blood Group.....A pos.....Single.....

Father: Age 25 years. Blood Group Occupation Unemployed

Infant: Blood Group 0 pos

Relevant Family and Previous Obstetric History:

1989 3430 g Girl

Pregnancy: L.M.P. End July 1991 E.D.D. 5.5.92 (scan)

Antenatal Problems and Complications of Labour:

M	FILE	
E	RECORDS PLEASE	
W	ACTION TAKEN	
	FIX TO PINK SHEET	
TELL PATIENT	Normal	
	Make Appointment	
	Collect Prescription	
	To Phone	

Mode of Delivery: SVD

Gestational Age..... 40 wk. by scan..... wk. by assessment.....

Sex.....Boy

Apgar score 9 @ 1 minute, 9 @ 5 minutes

- Resuscitation: -

Birth: - Weight.....4250.....g., Head Circumference.....36.3.....cm., Length.....53.....cm.

Discharge Home: Weight.....⁴⁰⁸⁰g., Head Circumference.....cm., Length.....cm.

Investigations: Maximum Total Serum Bilirubin.....321.....micromol/l Date.....13.5.92.....

Full Blood Count, blood for haemolysins., ~~Blood culture,~~ urine culture and
urine for reducing substances all normal or negative ~~other than~~.....

	PROBLEM	MANAGEMENT	OUTCOME
1.	JAUNDICE - Phys.	PHOTOTHERAPY 13/5 (301)	Stopped 15/5 at 151
2.	Heavy for Dates	3 hrly feeds & BM checks	4 hrly feeds from 11/5
3.	> 90th centile		
4.			
5.			

DISCHARGE DATA

Immunisation Contraindicated:.....No.....

Follow-up:

Feeds on discharge Ostermilk Haemoglobin 20.2 g/dl. Date 14.5.92...

Bilirubin 120 **micromol/l.** **Date**..... 16.5.92..

Medications:

HOUSE PHYSICIAN

Dictated 2.7.92

SENIOR STAFF COMMENTS

Typed 15.7.92

Nil to add.

Yours sincerely

N. Lloyd

DAVID J LLOYD
Consultant in Perinatal Medicine

Indication(s) for Attendance at Term plus 10 months Review Clinic

Mark X in
box where
applicable

1. Perinatal asphyxia— a) to be assessed by Paediatrician ☐
b) APGAR SCORE of 5 or less at 5 minutes ☐
2. Low birth weight— a) any infant 1750 gms. or less ☐
b) light for dates infant 2250 gms. or less ☐
3. Neonatal— a) Severe cerebral irritation or convulsions (excluding hypocalcaemia) ☐
b) Symptomatic hypoglycaemia ☐
c) Respiratory difficulty requiring assisted ventilation ☐
d) Hyperbilirubinaemia (serum indirect bilirubin 340 micromols/l. or over) or any baby having an exchange transfusion ☐
e) Severe infection (including intrauterine infection) ☐
4. Miscellaneous— as defined by Paediatrician ☐

Lee Reid 10/05/1992 300/92/414

All Medical History

Address and Telephone numbers

Rossie Secure Accommodation Service Montrose DD10 9TW
Telephone - home 01674 820204

All Medical History

03/03/2009 Letter received Clinical Letter Rossie School - Consult with Dr Ledlie Rossie School - Consultation - Dr Ledlie Ms Jackie Dempster
24/02/2009 Referral letter Referral Letter Stracathro Hospital ENT Mrs Karen Dykes
20/02/2009 Letter received Clinical Letter Rossie School - Consult with Dr Ledlie Rossie School - Consultation - Dr Ledlie Miss Isla Sutherland
12/02/2009 Administration NOS MSu result mixed growth Please inform Rossie Staff if ongoing sx, repeat Dr Ruth Cranswick
12/02/2009 Asthma monitoring Dr Graham Kramer
10/02/2009 Laboratory result Result Ninewells Hospital Microbiology Ms Jackie Dempster
23/01/2009 C/O - a headache still not fully recovered from recent viral illness. Some days fine but next headache +/- vomiting. Headache today. No other features. Good appetite & drinking well. Cont paracetamol & fluids Rpt MSSU next week & see Dr Ledlie Dr Margaret Anderson
19/01/2009 Telephone encounter general aches and pains, pain in groin, congested nose. Sounds like he has a viral illness, advice re paracetamol, fluids and steam inhalation for congestion. Dr Monica Ireland
10/01/2009 Laboratory result Result Ninewells Hospital Microbiology Ms Jackie Dempster
10/01/2009 Letter received Out of Hours Out of Hours Service Ms Jackie Dempster
10/01/2009 Letter received Out of Hours Out of Hours Service Ms Jackie Dempster
09/01/2009 Urine sample sent to Lab as requested by Dr Ledlie, ?UTI Mrs Esther Smith
09/01/2009 Urinalysis - general NAD Mrs Esther Smith
06/01/2009 Letter received Clinical Letter Rossie School - Consult with Dr Ledlie Rossie School Consultation - Dr Ledlie Ms Jackie Dempster
03/01/2009 Letter received Out of Hours Out of Hours Service Miss Isla Sutherland
31/12/2008 Nausea present has had nausea and vomiting. Staff report that bug going about in Rossie. Not unwell with it. No fever. Otherwise well. Sounds viral. Treat symptomatically with Buccastem. call back sos if any concerns. Dr Suresh Arunachalam
30/12/2008 Letter received Clinical Letter Rossie School - Consult with Dr Ledlie Rossie School Consultation - Dr Ledlie Ms Jackie Dempster
18/12/2008 Asthma monitoring Dr Graham Kramer
18/11/2008 Asthma monitoring Dr Graham Kramer
03/11/2008 Hay fever - pollens - px per fax dated 031108 from Gordon Holder, Rossie. (Px to be collected). MS Dr Graham Kramer
30/10/2008 Letter received Casualty Note Links H C Minor Injuries Service Ms Jackie Dempster
30/10/2008 Letter received Casualty Note Links H C Minor Injuries Service Mrs Ann Burnett
30/10/2008 Letter received Clinical Letter NHS 24 Mrs Ann Burnett
13/10/2008 DNA hospital appointment ENT appointment, N/W on 17.09.08. No further appt sent. (see Docman 13.10.08)
13/10/2008 Letter from specialist Clinical Letter Ninewells Hospital Otolaryngology/Head Neck surgery Ms Jackie Dempster
25/09/2008 Referral letter Referral Letter Links H C Physiotherapy LETT DONE 250908(KD) Miss Isla Sutherland
25/09/2008 Letter received Clinical Letter Rossie School - Consult with Dr Ledlie Rossie School - Consultation - Dr Ledlie Miss Isla Sutherland
16/09/2008 Letter received Clinical Letter Rossie School - Consult with Dr Ledlie Rossie School Consultation - Dr Ledlie Ms Jackie Dempster
14/09/2008 Letter received Out of Hours Out of Hours Service Ms Jackie Dempster
18/06/2008 Asthma monitoring
03/06/2008 Hay fever - pollens (cetirizine) Dr Graham Kramer
21/05/2008 Letter received Clinical Letter Rossie School - Consult with Dr Ledlie Rossie School - Consultation - Dr Ledlie Mrs Susan Maddock
21/05/2008 Hay fever - pollens As per Dr Ledlie
14/05/2008 Letter received Clinical Letter Rossie School - Consult with Dr Ledlie Rossie School - Consultation - Dr Ledlie Mrs Susan Maddock
08/05/2008 Itch /dry itchy scalp. Dr Graham Kramer
30/04/2008 Letter received Clinical Letter Rossie School - Consult with Dr Ledlie Rossie School - Consultation - Dr Ledlie Mrs Susan Maddock
24/04/2008 Letter received Clinical Letter Rossie School - Consult with Dr Ledlie Mrs Ann Burnett
18/04/2008 Letter received Clinical Letter Rossie School - Consult with Dr Ledlie Mrs Ann Burnett
16/04/2008 Itch /dry itchy scalp. Px per letter dated 15/04/08 from Dr Ledlie. MS Dr Graham Kramer
27/03/2008 Notes summary on computer Dr Suresh Arunachalam
19/03/2008 Patient MRE received from FPC files now merged and with Dr Arun for summary on 24/03/08
09/03/2008 Letter received Out of Hours Out of Hours Service Mrs Aileen Coull
05/03/2008 Letter received Clinical Letter Rossie School - Consult with Dr Ledlie Mrs Susan Maddock
28/02/2008 Letter received Clinical Letter Rossie School - Consult with Dr Ledlie Mrs Ann Burnett
27/02/2008 Referral letter Referral Letter Stracathro Hospital ENT Miss Isla Sutherland
26/02/2008 Cold sore (herpetic) - px per letter from Dr Ledlie. MS Dr Graham Kramer
2005 Head injury "after falling off rope swing" Dr Suresh Arunachalam
2004 Head injury "after fall at school". No loss of consciousness Dr Suresh Arunachalam
2002 Fracture of scaphoid Dr Suresh Arunachalam
1993 Constipation NOS Has been assessed and investigated (1993 - 1999) and biopsy have ruled out Hirschsprung's disease. Behavioural issues Dr Suresh Arunachalam
10/1992 Asthma Dr Suresh Arunachalam
10/1992 Atopic dermatitis/eczema Dr Suresh Arunachalam
01/10/1992 Acute bronchiolitis Dr Suresh Arunachalam

R Encounter Report**Address and Telephone numbers**

Rossie Secure Accommodation Service Montrose DD10 9TW
Telephone - home 01674 820204

Significant Medical History

10/1992 Asthma Dr Suresh Arunachalam
10/1992 Atopic dermatitis/eczema Dr Suresh Arunachalam

Chronic Disease Register

No data recorded.
No data recorded.
No data recorded.
No data recorded.
Asthma Placed on register: 10/1992
No data recorded.
No data recorded.

Current Repeat Medication

No data recorded.

Acute and Repeat issues in last 3 months

12/02/2009 SALBUTAMOL cfc free inh 100micrograms/inhalation Supply: (1) 200 dose inhaler TWO PUFFS TO BE TAKEN WHEN REQUIRED FOR BREATHLESSNESS Dr Graham Kramer
12/02/2009 CLENIL MODULITE cfc free inh 50micrograms/actuation Supply: (1) 200 dose inhaler TWO PUFFS TWICE DAILY Dr Graham Kramer
31/12/2008 BUCCASTEM tabs 3mg Supply: (20) tablet(s) ONE TABLET(S) TWICE DAILY WHEN REQUIRED Dr Suresh Arunachalam
18/12/2008 CLENIL MODULITE cfc free inh 50micrograms/actuation Supply: (1) 200 dose inhaler TWO PUFFS TWICE DAILY Dr Graham Kramer

Allergies and Intolerances

No data recorded.
No data recorded.

Recalls - 3 months back to 1 month in future

No data recorded.

Referrals and Requests in last 3 months

No data recorded.

Tests in last 3 months

No data recorded.

Last Consultation

03/03/2009 Third Party Consultation Ms Jackie Dempster
03/03/2009 Document Image - Docman Attachment
03/03/2009 Letter received Clinical Letter Rossie School - Consult with Dr Ledlie Rossie School - Consultation - Dr Ledlie Ms Jackie Dempster

Prevention

16/09/2008 11:37.00 BP 115 / 75 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading
No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.

New Consultation Details

Date: Clinician:

Surname (Block Letters)

Rev

Forenames (Block Letters)

Lee

SUMMARY OF IMPORTANT ILLNESSES AND INVESTIGATIONS

Address

Address Russie Secure Acctmation
Northrop Services
ASIO 9TW

Date of Birth

10.CS.92

Date	
1992	Wheeze. Diagnosis of bronchiolitis
Oct '92	Asthma. Admission to hospital. Also developed atopic eczema.
Dec '92	Exacerbation of asthma (acute) - followed up @ asthma clinic RCH
1993	Constipation
1993	Acute exacerbation asthma.
1995	Further referral surgical clinic with chronic constipation. Rectal biopsy excluded Hirschsprung's disease.
1997	Bowel training.
1997	Referral to child Psychiatrist - long standing constipation + Encopresis.
14.06.98	Small laceration left forehead after head injury.
05.05.99	admission - chronic constipation.
23.03.00	leg pain (admission) - no abnormality found probably behavioural.
03.00	suspected that mother is on methadone.
2001	suspected malignant hyperpyrexia under GA
2002	Scaphoid # @ wrist
2004	head injury (after fall at school) No LOC
2005	head injury (after falling off rope swing)
2005	penicillin allergy → rash.

[illegible]

IMMUNISATIONS AND SCREENING INVESTIGATIONS	National Health Service Number 300 / 92 / 414	
	Surname (Block letters) REID	Forename (Block letters) LEE IAIN
	Address BREEOLESS CROFT DUNLUGAJ TUNRIK	
	Date of Birth 10.05.92	

IMMUNISATIONS (Insert Date and Batch Number where appropriate)

	Diphtheria	Tetanus	Pertussis	Polio	Measles	Rubella	MMR	BOG + HB
Date	←	10-5-92	→				24.8.93	19.1.93
Manufacturer & Batch No.	A2290A			APF160-01			791720	H0707
Date	←	8.9.92	→				10-6-97	9.3.93
Manufacturer & Batch No.	A2288A			APF161-08			HE48480	H1022
Date	←	6.10.92	→				PM NSD	20.4.93
Manufacturer & Batch No.	A2293A			APF161-08			Exp 7/1/97	H1060
Date	10-6-97	6-97		10/6/97		ALLERGIES & HYPERSENSITIVITIES		
Manufacturer & Batch No.	EVANS F60128 (18/97)			SP51797				
Date	22.04.98	22.04.98		22.04.98				
Manufacturer & Batch No.								
Date								
Manufacturer & Batch No.								
Date								
Manufacturer & Batch No.								

	Influenza	Hep.B.	Typhoid	Cholera	MEN C
Date					22.04.98
Manufacturer & Batch No.					
Date					
Manufacturer & Batch No.					
Date					
Manufacturer & Batch No.					
Date					
Manufacturer & Batch No.					
Date					
Manufacturer & Batch No.					
Date					
Manufacturer & Batch No.					

IMMUNOLOGICAL STATUS

	Tuberculin Test	Rubella Antibodies	HIV	Hep.B.
Date				
Result				
Date				
Result				
Date				
Result				

SCREENING INVESTIGATIONS