

BOX 054



84241101651

1508773076

Robert John

Leitch

15.08.1977

Vol 1

No Paperwork



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LEITCH		ROBERT					SURNAME
SURNAME		CHRISTIAN NAMES			OCCUPATION		
National Health Service Number 532.77.145		Single Married Widowed	Date of Birth	15	8	77	(Note changes and insert year of change) 19.....
Address (1)	Name of Practitioner		Executive Council Cipher — Date				CHRISTIAN NAMES
ROSENEATH CROMWELL ST					19.....		
(2)	(2)		(2)		19.....		
(3)	(3)		(3)		Died19.....		
(4)	(4)		(4)		CAUSE OF DEATH 1. _____ 2. _____		
						Signature of Practitioner	

Form GP.5B (Scotland) — MALE

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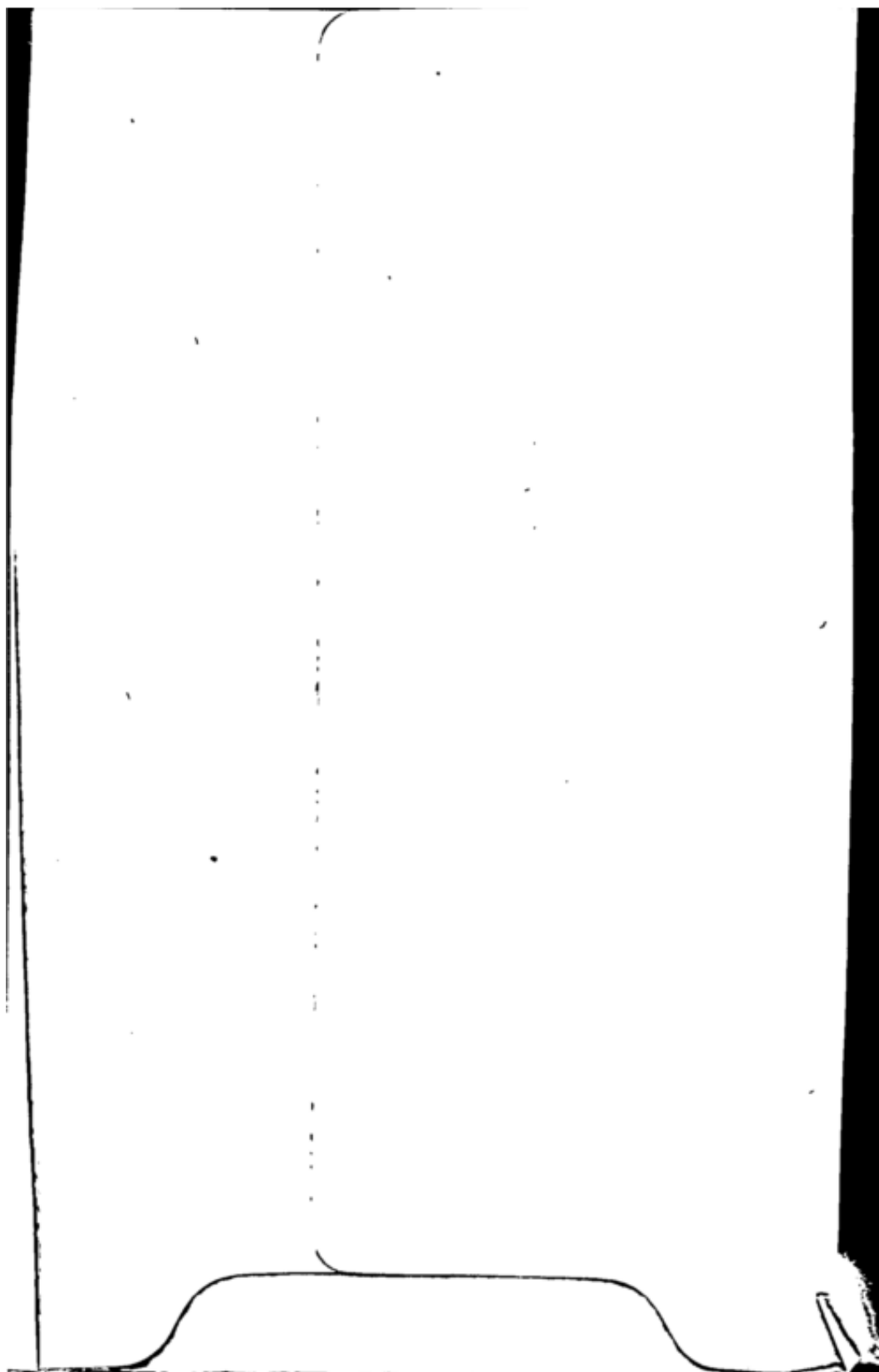


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IMMUNISATIONS AND		VACCINATIONS		
	Date	Smallpox	Date	Result
Diphtheria				
Pertussis		Tuberculin Test Method	Date	Result
Tetanus Toxoid				
Serum		B.C.G.	Date	Result
Polio				
Others		Rh. Factor	Date	Blood Group

MAJOR ALLERGIES AND NOTES OF ANY SERUM ADMINISTRATION

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MALE		SURNAME LETCH	CHRISTIAN NAMES Robert
ADDRESS 1 Pier Road - Invercarty			Date of Birth 15 08 44

DATE	C F	CLINICAL NOTES	DIAGNOSIS
29-02-00		awc	
14/3/00		new patient registration	

ARCOXIA
etoricoxib

Lamotrigine 150mg one BD

Disulfiram 200mg once daily

5 tabs.....

* In C.F. Column, which is for cases of certified incapacity only, practitioners should enter C for first certificate, and F for final certificate.

MEDICAL RECORD CARD

Form G.P. 7
(Scotland)
CODE 355-2044

Dd 8435644 120 M 7/93 25364

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[illegible]

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[illegible]

*IN C.F. COLUMN, WHICH IS FOR CASES OF CERTIFIED INCAPACITY ONLY, PRACTITIONERS SHOULD ENTER 'C' FOR FIRST CERTIFICATE, AND 'F' FOR FINAL CERTIFICATE.

MEDICAL RECORD CARD

FORM G.P. 7A (COMP)

●

[illegible]

*IN C.F. COLUMN, WHICH IS FOR CASES OF CERTIFIED INCAPACITY ONLY, PRACTITIONERS SHOULD ENTER 'C' FOR FIRST CERTIFICATE, AND 'F' FOR FINAL CERTIFICATE.

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MALE		15/8/77	
SURNAME <i>Leitch</i>		CHRISTIAN NAMES <i>Robert</i>	
ADDRESS <i>Roseneath, Branniel St</i>			
DATE	*C *F	CLINICAL NOTES	DIAGNOSIS
19.12.77		<i>Paracetamol. Per Dose</i>	<i>Brucellosis</i>
24.12.77		<i>Cheese Sp. rx. 12c</i>	
28.12.77		"	
26.1.78		<i>Siphon Peel Sp. ... 1st 1st Brucella</i>	
2.2.78		<i>Cheese</i>	
29.8.78		<i>Antibiotic</i>	<i>Brucella</i>
29.8.78		<i>Antibiotic Sp.</i>	<i>Brucellosis</i>
12.2.78		<i>Antibiotic Sp.</i>	"
25/10/82		<i>knocked down → ? part</i> <i>incurable behavioral problems</i> <i>not told by accident -</i> <i>not during a voluntary</i> <i>at night. humphys down</i> <i>at night. in value ring</i> <i>at night.</i>	
13/1/83		<i>Chronic 2/52 cough - Amoxicillin</i>	
25/2/83		<i>Says can't see board.</i> <i>Testing → OK. Rifer Optician</i>	
31/0/83		<i>Says can't see board.</i> <i>father has poor vision.</i> <i>Rifer Optician.</i>	
16/1/83		<i>Harsh cough - better now</i> <i>not OK still clear.</i>	
13/6/82		<i>Spots. Papular antecar</i>	

* In C.F. Column, which is for cases of certified incapacity only, practitioners should enter C for first certificate, and F for final certificate.

2/11/84 *Medical Record Card* FORM E.C.7 (Scotland)

(21.1.65) (D36777) Wt. P5377-59 200,000 3/65 J. & G. I. Ltd. Gp 259

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[illegible]

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APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE



1. PERSONAL DETAILS (ALL FIELDS MARKED * ARE MANDATORY AND MUST BE COMPLETED AS FULLY AS POSSIBLE)

Male* ☒ Female* ☐ Is this your first registration with a GP Practice in the UK? Yes ☐ No ☒ Will you be in the area for more than 3 months? Yes ☒ No ☐
(If 'No', please ask for form GMSTRF001)

Date of Birth* 15-8-1977 Address* 40 ARDENSAIRE CRESCENT KIRK DUNOON

Title* Mr

Surname* LEITCH

Forenames* ROBERT JOHN

Postcode* PA23 8NF

Previous Surname*

Telephone #

email address # ROBERT.LEITCH493@GMAIL.COM

Mobile # 07867 301185

The following information can be found on your current medical card:

Community Health Index (CHI) Number* NHS Number*

The following information can be found on your birth certificate:

Town of Birth* DUNOON Country of Birth* SCOTLAND

Registered district of birth (Scotland only) ARGYLL Mother's maiden name INNES

the data supplied in these fields will not be input to, or updated in, the Community Health Index (CHI), but will be held on the GP Practice's system

2. HELP US TO TRACE YOUR PREVIOUS GP HEALTH RECORDS BY PROVIDING THE FOLLOWING INFORMATION

Address in UK when you were last registered with a GP* Name and address of previous GP Practice in UK*

40 ARDENSAIRE CRESCENT KIRK DUNOON ARGYLL STRAIT SURGEON DUNOON

Postcode* PA23 8NF Postcode* PA22

If you are from abroad:

Date you first came to live in the UK* DD - - YYYY If previously resident in the UK, date of leaving* DD - - YYYY

Your most recent country of residence

If you have served in the British Armed Forces:

Enlistment date* DD - - YYYY Service Number

Are you a Reservist? Yes ☐ No ☐ If yes, please provide your address before enlisting*

Leaving date* DD - - YYYY

Is this your first registration with a GP since leaving the Armed Forces? Yes ☐ No ☐ Postcode*

3. VOLUNTARY CONSENT TO ORGAN DONATION

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick the boxes that apply. Your consent to organ donation will be shared with NHS Blood and Transplant together with the information you have provided in Section 1 including your name, gender, date of birth address and CHI number. For more information on being an organ donor or privacy, please ask for the leaflet on joining the NHS Organ Donor Register or visit www.organdonation.nhs.uk.

Any of my organs and tissue ☐ Or my

Kidneys ☒ Eyes ☐ Heart ☒ Lungs ☒ Liver ☒ Pancreas ☒ Small bowel ☒ Tissue ☒

Patient signature Date 15-1-2016

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4. HOW WE USE YOUR INFORMATION

The information you have provided will be used by the GP Practice to carry out its various functions and services including scheduling appointments, ordering tests, hospital referrals and sending correspondence.

Your information, including your name, gender, date of birth and address, will be passed to NHS National Services Scotland where it will be held on the Community Health Index (CHI). This information is used to register you with the GP Practice, transfer your medical records between GP practices in the UK, make payments to GP Practices for medical services provided, and to process and issue medical cards, medical exemption certificates and entitlement cards.

NHS National Services Scotland shares information about you within NHS Scotland to assist in the provision and improvement of NHS services and the health of the public. When we do this, we make sure that the information which identifies you as a person and your health information are separated or anonymised. Health condition and treatment information which could identify you will not be used for research purposes by the NHS unless you have consented to this.

For more information on how NHS National Services Scotland uses your personal information visit www.nhs.uk. If you have any queries or concerns about how your personal information is used by the NHS please ask for the leaflet 'Confidentiality - it's your right', visit the Health Rights Information Scotland website at www.hris.org.uk or ask your GP surgery.

NHS National Services Scotland is the common name of the Common Services Agency for the Scottish Health Service.

5. PATIENT DECLARATION

I declare that the information I have given on this form is correct and complete. I understand that, if it is not, appropriate action may be taken.

To enable NHS National Services Scotland to confirm my eligibility to lawfully register with a GP and for the purposes of prevention, detection, and investigation of crime, relevant information from this form will be disclosed to the NHS Business Services Authority, NHS National Services Scotland, the Home Office, Identity and Passport Service, HM Revenue and Customs, the General Register Office and Local Authorities.

Patient/Patient's representative signature

Date 16-1-2016

Representative's name (if applicable)

Relationship to patient (if applicable)

6. FOR PRACTICE USE

GP reference number

GP name

Practice code

Mileage (No.)

Road

Water

Footpath

Identification seen - do not take or retain photocopies

Please initial each relevant box (it is recommended that at least one form of identification is seen to positively identify the applicant)

Birth
Cert. ☐

Student
ID Card ☐

Driving
Licence ☐

Passport or
HC2 Cert. ☐

Home Office
App Reg Card ☐

Other/None
- specify

Receptionist
Initials

I accept this patient onto the practice list and declare that, to the best of my knowledge, this information is correct. I acknowledge that the details may be authenticated from appropriate records, and that payments generated from this patient registration will be subject to Payment Verification.

Authorised Practice
signature

Date 16-1-2016

7. OFFICIAL USE ONLY

Input by

Checked by

Date

DD - MM - YYYY

Practice Stamp

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Kyles Medical Centre

Date: 6-1-2016

This letter invites you as a newly registered patient to have a health check. This service involves answering some questions and a basic review with the practice nurse. This service is offered to all our newly registered patients over the age of five years.

It would be very helpful if you could complete this form before you are seen.

Surname: LEITCH	Forenames: ROBERT	Title: MR
Address: THE ROYAL AN LOCHAN HOTEL TIGHNABRUICH ARGYLL		Postcode: PA212BE
Date of birth: 15-8-77	Telephone number: 01700 811234	
Status:	Single / Married / Separated / Divorced / Widowed / Other	
Housing:	House / Maisonette / Flat / Mobile home / Other	
Occupation: CHIEF		
Emergency contact: ALAN LEITCH	Telephone number: 07479254432	

What serious illnesses have you had?			
NONE			
Do you have any medical problems at the moment?			
YES - SORE THROAT			
Are there any serious illnesses that affect members of your family (close relatives)?			
YES			
Please list any allergies you have:			
NONE			
Please list any tablets, medicines or other treatments you are taking, including those bought from a chemist: (please include strength and doses where possible) Attach an up to date repeat slip if possible			
Smoking:	Current smoker	Ex-smoker	Non-smoker
	YES		
	Number per day:	Year stopped:	
	30		
Alcohol:	Do you drink alcohol?	If yes please fill out reverse of form	
	NO		
Please describe any special diet you are on			
Height:	5'11.5"		
Weight:	19.7		

Women only:

When did you last have a cervical smear?	
When did you last have a breast examination?	

NHS Highland is routinely asking all patients to complete the following questionnaire about alcohol use. Mark your score against each question and then add your total at the bottom.

What is a unit?

1 unit = 10ml of pure alcohol, the number of units of alcohol in a drink depends on the size and strength of drink.

 1 pint of normal strength lager (4% abv) =	2.2 units of alcohol	 330ml bottle of medium strength beer (5% abv) =	1.7 units of alcohol
 250ml (large) glass of wine (12.5% abv) =	3.1 units of alcohol	 175ml (standard) glass of wine (12.5% abv) =	2.2 units of alcohol
 1 standard measure of spirit 25ml (40% abv) =	1 unit of alcohol	 750ml bottle of wine (12.5% abv) =	9.4 units of alcohol

Question 1 asks about units of alcohol, please use the information on units in the box above to give an honest and accurate answer as this will be of help to the doctor or nurse.

1. How often do you have:

	6 or more units on one occasion?	8 or more units on one occasion?	
Never 0	Less than monthly 1	Monthly 2	Weekly 3
		Daily or almost daily 4	
score 0			

2. In the last year, how often have you been unable to remember things from the night before because you had been drinking?

Never 0	Less than monthly 1	Monthly 2	Weekly 3	Daily or almost daily 4	score 0
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3. In the last year, how often have you been unable to do what was normally expected of you because you had been drinking?

Never 0	Less than monthly 1	Monthly 2	Weekly 3	Daily or almost daily 4	score 0
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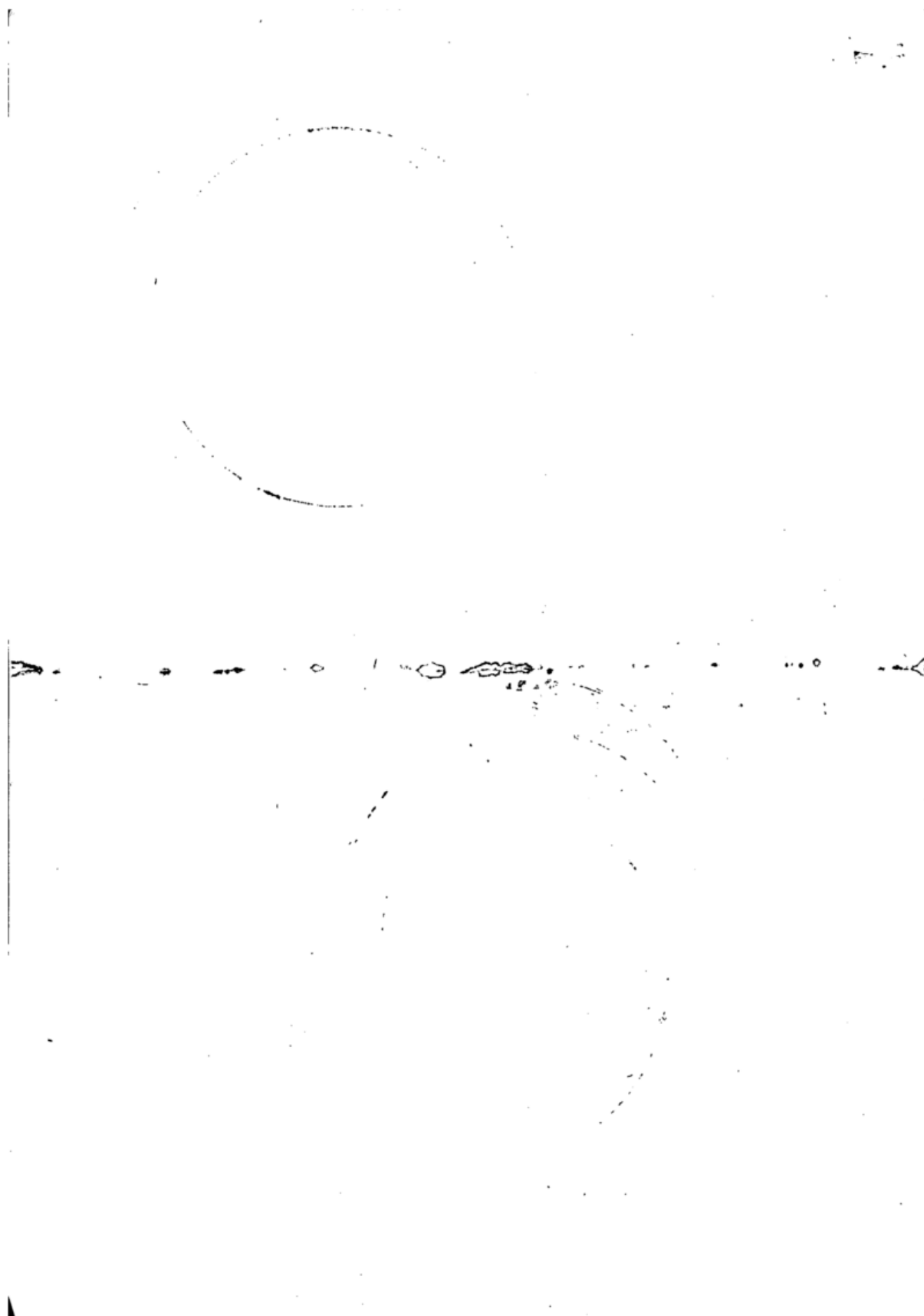
4. In the last year, has anyone suggested you should cut down your drinking?

Never 0	Yes on one occasion 2	Yes on more than one occasion 4	score 0
			total 0

Please add up your total score and write it in the box.

Thanks for your cooperation

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NHS Argyll & Clyde

Argyll and Bute Hospital
Lochgilphead
Argyll
PA31 8LD



Dr A W Thomson
246 Argyll Street
Dunoon
PA23 7HW

Date: 18th October 2005
Ref:

Telephone: 01546 602323
Fax: 01546 603350

Dear Dr Thomson

Robert Leitch – 01 Pier Road, Royal Brae, Innellan, Dunoon, Argyll PA23 7TH
Date of birth – 15th August 1977

Robert Leitch did not attend his outpatient clinic appointment at the Dunoon General Hospital on the 18th October 2005 and made no contact in this regard. I have not made another appointment to see him. Please refer him back to the clinic in future if necessary.

Yours sincerely

A handwritten signature in black ink, appearing to read "R Sandler".

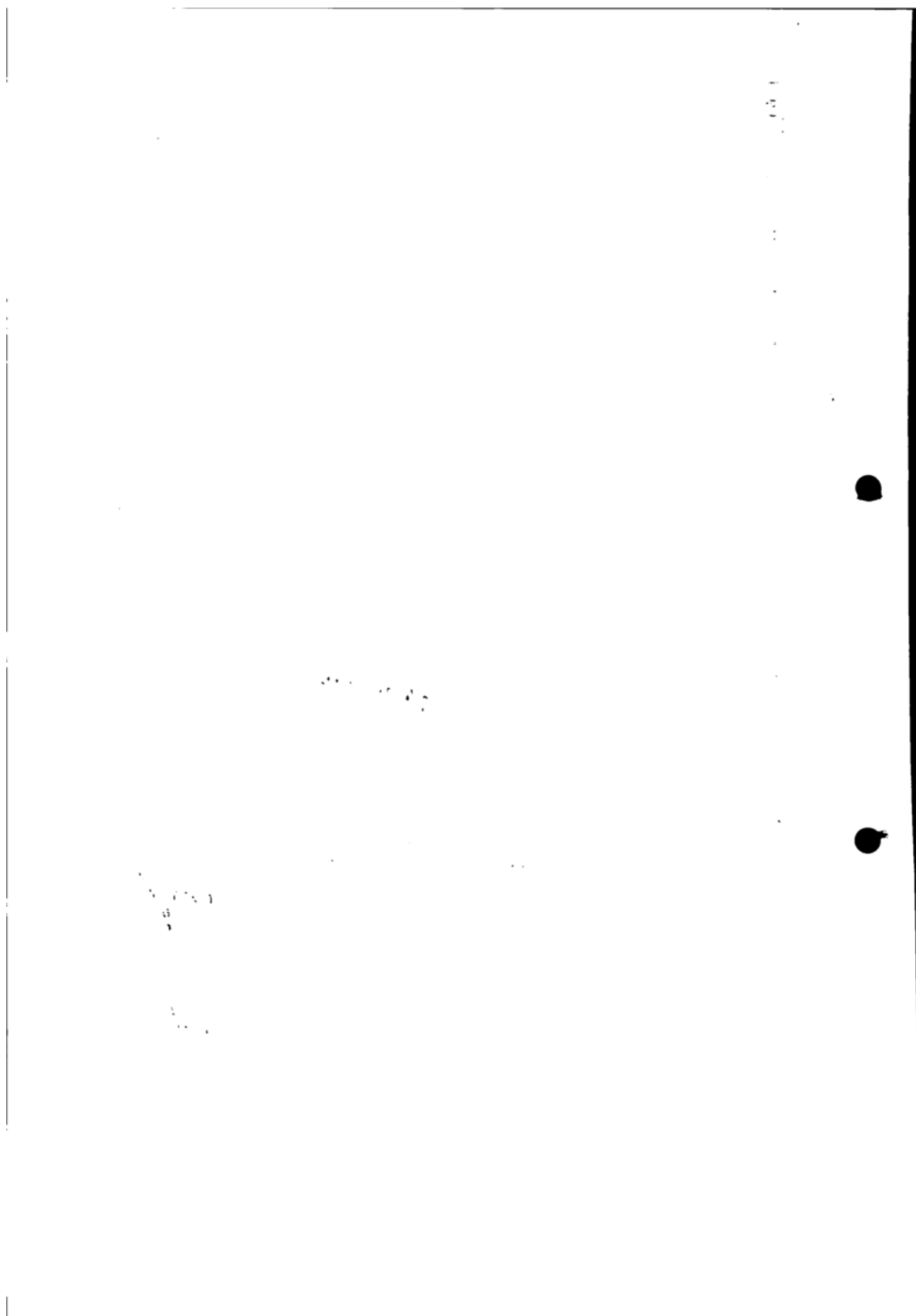
Dr Robert Sandler
Consultant Psychiatrist

24 OCT 2005

TE REC.	GP	FILE
ALL PATIENT NORMAL		
OW TO		
KE APPT		
ONTACT PATIENT		
OR PRESCRIPTION		
LEASE		
IN COMPUTER		

A handwritten signature in black ink, appearing to read "R Sandler", written over the bottom right of the form.

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Use only	clinic	Date	Time	No.	GP112		
REQUEST FOR OUT-PATIENT CONSULTATION THE INFORMATION IN THIS SECTION MUST BE COMPLETED				Appointment Category Routine ☐ Soon ☐ Urgent ☐			
AT/CC		CHI NO.		3 0 7 6			
Hospital <u>DUNOON GENERAL</u>		Date: <u>04 October 2005</u>					
Please arrange for this patient to attend the <u>PSYCHIATRIC</u> clinic of Prof/Mr/Dr <u>SANDLER</u>							
Patients Surname <u>LEITCH</u>		Maiden Surname:					
First Names: <u>ROBERT</u>		Single/Married/Widowed/Other:					
Address: <u>01 PIER ROAD ROYAL BRAE</u>		Date of Birth <u>15/08/77</u>					
<u>INNELLAN DUNOON ARGYLL</u>		Patients Occupation					
Postal code <u>PA23 7TH</u>		Contact Telephone Number: <u>01369 830 779</u>					
Has the patient attended hospital before: Yes/No if "Yes" please state:							
Name of Hospital:		Name, Address and Telephone no. of MEDICAL/DENTAL PRACTITIONER Please use rubber stamp					
Year of attendance						Hospital No:	
If the patient's name and/or address has/have changed since then please give details:							
Can patient attend at short notice? Yes/No		PRACTICE CODE NO 84256					
If Yes, minimum notice required		days					
I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:							

Dear Dr Sandler

I wonder if you would mind seeing this 28-year-old man. He apparently was accused of sexual assault approximately 2 ½ years ago and went through a torrid time in court before eventually being cleared. Following this, he seemed to get over things fairly well but over the past month or so has started getting upsetting nightmares about things once again. As a child he attended Larkfield unit for some time and found the input from them extremely helpful at that time. Following this, he had a fairly severe alcohol problem but he tells me he is now on his 1029th day of abstinence. I would value your advice on how we can help his distressing nightmares and flashback. Thank you for seeing him.

Yours sincerely,

Dr A W Thomson

NEW PATIENT MEDICAL

NAME: ROBERT LEITCH.

DOB: 15/08/77

ADDRESS: 01 PIER ROAD
ROYAL BRAE
INNEULAN

SEX: M.

PHONE NO: 830 779.

SMOKING:

☒ YES

☐ NO

CIGARETTES:
OTHER:

<1

1-9

10-19

☒ 20-39

40+

REGULAR SMOKER
WANTS TO STOP:

☒ YES
☐ YES

☐ NO
☐ NO

YEARS: 13.

BLOOD PRESSURE:

148/92.

URINALYSIS:

HEIGHT:

5ft 11in.

WEIGHT:

14st 9lb.

BMI:

ALCOHOL:

NO.

93.1 Kg

DIET:

Normal.

PHYSICAL ACTIVITY

Physical job (chef).

CURRENT MEDICATION:

Ranitidine 150mg BD.

Disulfiram 200mg. daily.

PAST MEDICAL HISTORY:

Recurrent alcoholic

FAMILY MEDICAL HISTORY:

not known.

DATE OF MEDICAL

30/5/03

DATE ON COMPUTER

03/06/03

N/P MEDICAL CLAIMED

30/5/03

ALLERGIES. none known.

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NHS IN SCOTLAND

COPY

G P R

Application to Register with a General Medical Practitioner

Please complete in block capitals and tick relevant boxes

Patient details

Surname LEITCH
Forename ROBERT JOHN
Previous Surname
Date of birth 15.08.77 Male ☒ Female ☐
I wish the child named above to be registered at the practice for Child Health Surveillance
Relationship to patient

Address
PORTSOVACHAN
HOTEL
SOUTHLOCHANE
SIDE NK DAILIMALLY
Post code
I will be in the area for more than three months ☒

Patient's / Patient's representative signature R. Leitch

Date 26.09.02

Voluntary consent to organ donation

If you wish to register on the NHS Organ Donor Register as someone whose organs can be used for transplantation purposes after your death, please tick relevant box(es) below:

Any Organ ☐ Kidneys ☒ Liver ☒ Lungs ☒ Heart ☒ Corneas ☐ Pancreas ☒
Date 26.09.02

Patient's signature R. Leitch

Please help us to trace your previous medical records by providing the following information if known

NHS No. (not National Insurance No.)

546206898

Previous address in U.K.

1 PIER ROAD, ROYAL BRAE
INVELLAN

Town DUNOON

County ARGYLL

Post code PA23 1

If returning from abroad

Date of departure from U.K.

Date of return to U.K.

Community Health Index (CHI) No.

Name and address of previous doctor in U.K.

DR KING
ARGYLL STREET SURGEON
DUNOON ARGYLL

If returning from HM Forces

Date enlisted

Service / Personnel No.

If none of the above information is known then please complete the following:

Town of birth

DUNOON

County of birth

ARGYLL

Reg. district of birth (see birth certificate)

Mother's maiden name

Doctor's agreement

Enter 'D' if supplying drugs

CHS acceptance yes ☐ no ☐

I accept this patient on my list and I claim payment in accordance with the Regulations.

Doctor's signature [Signature]

Date

26.09.02

Mileage claim road ☒ water ☐ footpath ☐

Enter date if registration examination completed

26.09.02

CHS Ref No. of GP providing service if different from below

Doctor's name

DR Singh

GP Ref. No.

3.7826

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HEALTH QUESTIONNAIRE

Surname LEITCH Forename[s] ROBERT

Sex MALE Title MR

Date of Birth 15/08/77

Address PARTSONA CHAN HOTEL Tel. No. 01866

P. CANTON CLUB 833 224

Occupation SALES MANAGER SIDE
HEAD CHIEF

What serious illnesses have you had and when?

NONE

Have you had any hospital treatment? [inpatient or outpatient]

If so - what conditions and where seen? [Hospital number or outpatients' card if available]

Please list any medications or tablets that you are currently taking: NONE

Do you have any allergies including medication allergies? NO

Is there a family history of any illness? M.S. / CANCER

Father & grand father BOTH HAD operation on spine

When did you last have a tetanus injection? 2001

Do you or have you ever smoked? If so, please give approximate dates of starting/stopping, and how many per day: yes 20 a Day 1995

Do you drink alcohol and if so how much per day/week? 14 pints

Woman only

When did you last have a cervical smear test?

Where did you have this? [GP surgery, FPA clinic, hospital clinic]

WHEN YOU ATTEND FOR YOUR PRE-REGISTRATION PLEASE BRING THIS COMPLETED FORM AND A SPECIMEN OF URINE

PRE-REGISTRATION CHECK

Name: **ROBERT LEITCH**

D.O.B. **15.08.77**

Date

26/9/02

Weight: **94** Kg.

Height: **6'0** cms **182**

B.M.I. [BMI 25-30 overweight, >30 obese]

Overweight? **10. N/A** Obese?

Exercise **moderate**

Requiring health education re. Exercise

Requiring diet education

B.P. **104/70** mm.Hg. PEFR **550** l/min, Cholesterol level Date **26/9/02**

Urinalysis **contaminated - will bring later**

Smoking: Never

No. cigarettes per day **20** Date started

Other tobacco use: Date stopped

Health education

Alcohol Use: Teetotal

Approximate units per day/per week **26 units/wk**

Health education

Family History: Brother Sister Parents Grandparents

Hypertension

CVA/Stroke

Glaucoma

Diabetes

IHD<60: **None**

IHD>60: **None**

Epilepsy

Other **Asenfen Multiple sclerosis**

History

Hospital Admissions: Clinic:

Asthma: **No**

- monitoring:

COAD/Emphysema: **No**

CHD: **No**

- Angina:

- MI:

CVA: **No**

Epilepsy: **No**

Diabetes: **No**

- Diet:

- Oral Hypoglycaemics

- Insulin

- BMI:

Mental Health

Other

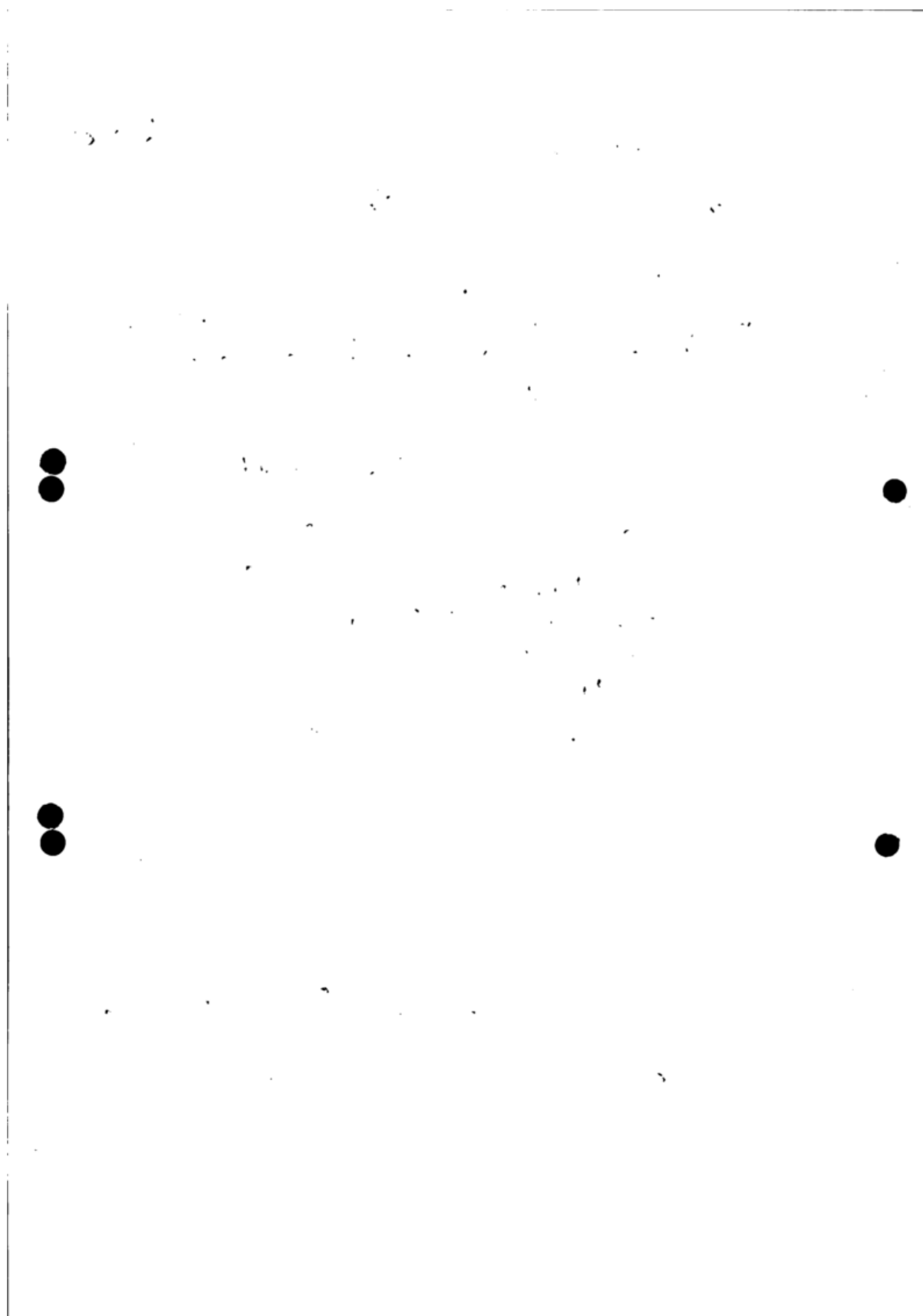
Tetanus immunisation **Last year at Helensburgh hosp**

Cervical cytology - last done Where?

Result

NAD
27/9/02

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CG

Name ROBERT
LEITCH

Address C/O DUMBUCK
..... DUMBARTON

Phone

Date of Birth

Date 21/07/97

Time phoned 14:35 (24 hour clock)

Serial Number A 017928

Patient's GP

Practice CALDER BROWN

Appt. Time

Time seen

TELEPHONE ☒ SEEN AT CENTRE ☐ VISIT ☐ NIGHT VISIT FEE ☐

HISTORY FALL HEAD & KNEE INJ

~ Fell at work bruy head at back + hurt knee
Now feels better no headache, no sickness,
Not ready to be seen
Advised could be seen if he wished

EXAMINATION

~ Advised re signs of dehydration - dizzy, sickness etc

DRUGS DISPENSED

DRUG	DOSE	AMOUNT	BATCH

PRESCRIPTION GIVEN

DRUG	DOSE	PER DAY	FOR

REVIEW: Patient to contact if needed ☒

Appointment needed on ☐

Vist needed on ☐

Admitted to ☐

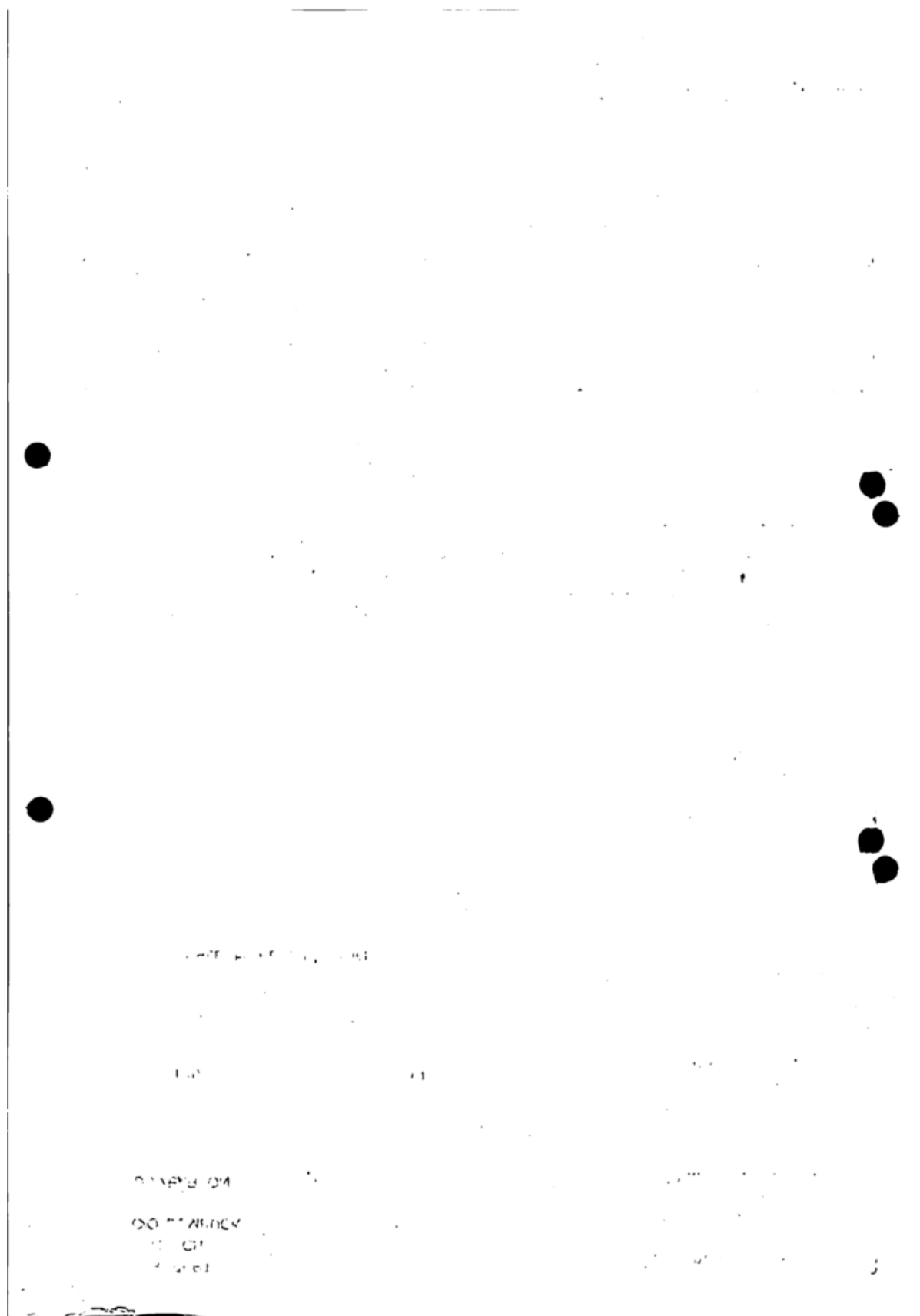
DIAGNOSIS

Wrist Bruise to hand

SEND BY FAX ☐

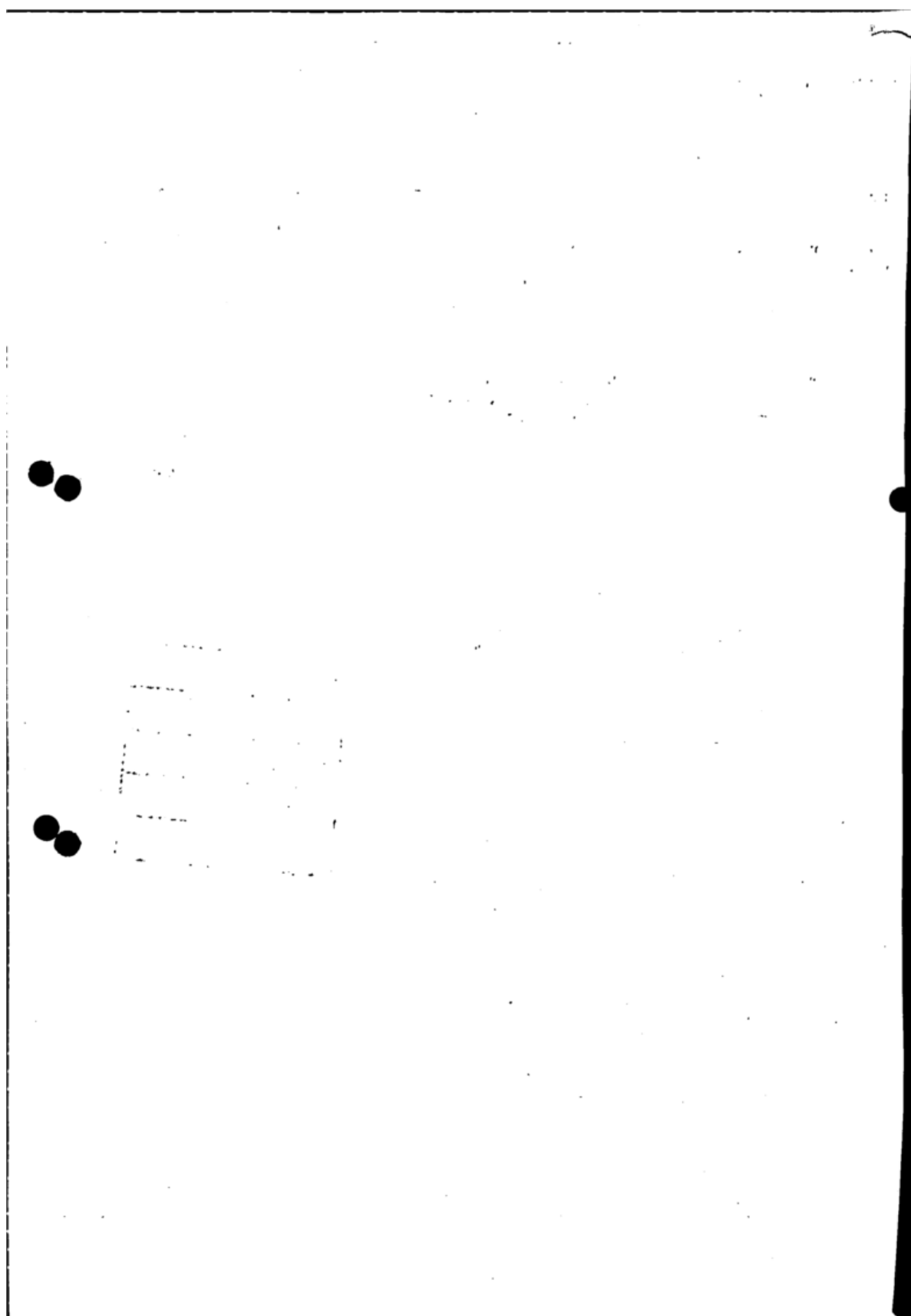
Co-Op Doctor (print) N Lynd Signature N Lynd

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LOMOND HEALTHCARE NHS TRUST ACCIDENT/EMERGENCY FORM										G.P. COPY	
ACCIDENT & EMERGENCY DEPT. MALE OF LEVEN DISTRICT GENERAL HOSPITAL ALEXANDRIA 883 OUA TEL: 01389 754121										AE No. C/	
HOSPITAL No: _____											
Surname		Forename		Age	Date of Birth	Arr Date	Time	AE Number			
LEITCH		ROBERT		19	15/08/1977	28/09/96	11:30	013532			
Address			Sex	Religion		Date of Inc		Time			
2 F DRUMFORK COURT HELENSBURGH			MALE			28/09/96		11:15			
			Marital Status	Occupation/School		Type of Inc		Mode of Arrival			
			SINGLE	CHEF		INDUSTRI		WALKING/OT			
C		Tel									
Name			Address			Referred by					
BROWN			THE MEDICAL CENTRE 12 EAST KING STREET HELENSBURGH			SELF REFERRAL					
Name			Address			Complaint					
NOT STATED						INJURY NOS					
Relat.						L ARM <i>laceration</i>					
No.											
ROAD TRAFFIC ACCIDENT PLACE					DETAILS						
HOME ACCIDENT PROBABLE CAUSE											
TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT											
Dear Doctor,											
The above-named patient attended Accident & Emergency Department today.											
Diagnosis <i>superficial laceration</i>											
X-Ray film/ECG shows _____											
Treatment given <i>steric-strip + dressing</i> <i>tetanus booster</i>											
COMPUTER _____ WHITES _____ PINKS _____ NOTES TO DR.											
Drugs _____ days supply of _____ has been given.											
Tetanus Prophylaxis has/has not been administered. TT Course _____ TT Booster _____ HATI _____ (Please Tick)											
Would you please arrange _____											
DISCHARGE CODES: Please Circle 1. Discharge Home 4. Did not wait 7. Fracture Clinic 10. Admit Ward (see below) ☒ 2. Refer to G.P. 5. Ret A/E as advised 8. Refer to O.P. Clinic (see below) 11. Trans. other Hospital (see below) 3. Irregular Discharge 6. Ret A/E as necessary 9. Social Worker 13. Died in dept. 13. Dead on arrival											
Ward No. (if admitted)			Transfer to Hospital				Consultant (if admitted)				
Follow up		Not arranged _____		Arranged _____		To be arranged _____					
Clinic Referred to	AE	Hand	Fracture	Ortho	Medical	Surgical	Skin	ENT	Gyn.	Others Specify	
Medical Officers Name (In Block Letters) <i>VIGLALIK</i>						Signature of Medical Officer <i>Ally</i>					
Cons	SR	Reg	SHO/JHO	Clin Assist	(please circle)						



CLAIM SENT TO P/C ☒ ON COMP ☒ STICKER

MEDICAL QUESTIONNAIRE

NAME Rbt Leitch D.O.B. 13/8/77

ADDRESS

HEIGHT 5' 11 1/2" WEIGHT 12 1/2 BMI 24.55 ☒

EXERCISE LEVEL tick appropriate box

Avoids even trivial exercise	1382
Enjoys light exercise	<u>1383</u>
Enjoys moderate exercise	1384
Enjoys heavy exercise	1385

ALCOHOL INTAKE

Teetotaller	1361
Trivial Drinker <1 unit per day	1362
Light drinker 1-2 units per day	<u>1363</u> at weekends.
Moderate drinker 3-6 units per day	1364
Heavy drinker 7-9 units per day	1365
Very heavy drinker >9 units per day	1366

BLOOD PRESSURE

Normal 135/85 or less	<u>2464</u>
Borderline raised 140/86 - 160/95	<u>2465</u> 120/80
Raised 161/95 - 200/100	2466
Very high 201 + / 110 +	2467

SMOKING STATUS

Never smoked tobacco	1371
Light smoker 1-9 per day	1373
Moderate smoker 10-19 per day	<u>1374</u> 12/day.
Heavy smoker 20-39 per day	1375
Very heavy smoker 40 + per day	1376
ex smoker	137F

ADVICE GIVEN

Advice on smoking	6791
Advice on diet	6799
Advice on exercise	6798
Advice on alcohol	6792
Refer to Dr because of hypertension	Z1028

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DR MITCHELSON & DR LOGAN

Date

23/1/96

Name

Robert Leitch

Address

Dunoon G87 10

☒ male ☐ female

Occupation

YTS GHEF

☒ Single ☐ married ☐ divorced

Have you had any of the following vaccinations, and if so when

Diphtheria YES / NO Polio YES / NO
Pertussis YES / NO MMR YES / NO
Typhoid YES / NO Cholera YES / NO

Tetanus ☒ YES ☐ NO
TB ☒ YES ☐ NO

2 yrs ago.

FAMILY HISTORY

Heart Disease
Stroke
Cancer

Diabetes Mellitus
Epilepsy or fits
Kidney Disease

☒ Asthma ☐ Hypertension
☐ Skin Disease ☐ Nerves

Brother - but adopted.

PAST MEDICAL HISTORY

Previous illnesses

Date

Operations

Date

Allergies : including medication none.

Date of last cervical smear

Hysterectomy YES / NO

Smoking Habits

Cigarettes

☒ YES ☐ NO

Quantity

15

Pipe

☒ YES ☐ NO

Quantity

Ex-smoker

Date of Cessation

Exercise Level

light.

alcohol Consumption

Units per week

100/week.

Height

Ft

Ins

Cm

Weight

St

Lbs

Kg

BP

Systolic

BP

Diastolic

Urine

Sugar

Protein

Blood

Visual Acuity

Right

Left

Uncorrected

Corrected

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Unsupported image format.

NHS Confidential: Personal data about a patient

Unsupported image format.

A. Butcher

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Unsupported image format.

