

**ARGYLL & BUTE CHP
Accident / Emergency Form**

INS Bul
WMB
BS

Islay
Rothesay
Dunoon
Campbeltown
Lochgilphead

Health Visitor
Name
Address 11-12

0009
2024

Surname LEITCH		Forenames ROBERT JOHN		Hospital Cowal Community	
Address 97 ARDENSLATE ROAD KINROSS DUNOON		Birth Surname LEITCH		Patient's Own Occupation CHIEF	
Postcode PA23 8NN	Telephone No. 07383443420	Date of Birth 15-8-1977	Sex MALR	Marital status Single	Religion P
Next of Kin: Name ANNETTE GOUZ		Relationship SISTER	Family Doctor: Surname CHURCH ST Surgery		Initials
Address 5 FEARANK COILLER 78 BULLOCK DUNOON		Address C11WCH ST Surgery			
Postcode PA23 7QZ		Telephone No. 01369 701104	Postcode PA23 8NN	Telephone No. 01369 702772	
Accident / Emergency: Date of Attendance 15-12-2024		Previous Attendance at this Hospital ☒ Yes / No		In / Out Patient	Year
Time of Attendance 07.50		Reason for Attendance SWOLLEN FACE			
Date of Injury or Illness 31-12-2024		Time of Injury FACIAL	Type (Code)	Source of Referral	
Road Traffic Accident Place		Details		GP _____ Self _____ Police _____ Other (Code) _____	
Home Accident Probable Cause		 1508773076 LEITCH ROBERT 15/08/1977 M 97 ARDENSLATE ROAD PA23 8NN			

To be completed by Medical Officer after seeing Patient

Dear Doctor **DR DM**,

The above named patient attended Accident and Emergency Department today

Diagnosis **(R) Sickle cell infection. Right leg sore leg**
(R) Sore of the arm - Wound by wire

X-Ray film / ECG shows **swollen and tender face. Sore on leg (R)**

Treatment Given **Day 1000 NAB (R) Sm.**
O/O 12 27.2 1000 SS -

(R) Sore on eye by eye by eye

Drugs **Penicillin** days supply of **7** has been given.

Tetanus / Prophylaxis has / has not been administered ☒ Yes ☐ No TT Course ☒ Yes ☐ No TT Booster ☒ Yes ☐ No HATI ☒ Yes ☐ No (Please tick)

Would you please arrange **11-12 DOA**

Discharge Codes: Please circle

1. Admission	3. Refer to GP	5. Died	7. Irregular Discharge
2. Discharge	4. Transfer to Other Hospital (see below)	6. Refer to CP clinic (see below)	

Ward No. (if admitted) _____ Transfer to Hospital _____ Consultant (if admitted) _____

Follow up	Not arranged	Arranged	To be arranged
-----------	--------------	----------	----------------

Clinic referred to	A&E	Hand	Fracture	Ortho	Medical	Surgical	Skin	ENT	Gyn.	Others specify
--------------------	-----	------	----------	-------	---------	----------	------	-----	------	----------------

Medical Officers Name (in block capitals) **DR DM** Signature of Medical Officer _____

Cons SR Reg SHO / JHO Clin Assist (Please circle)

GP Copy Pink - Medical records copy Yellow - Health Visitors copy Blue - Treatment card copy White

STY0441D