

A&E Records

E-Pacer PATIENT REPORT

Time 19:24 Date 11/07/2009

PATIENT AND INCIDENT DETAILS

Incident number ED002403923 001
 Name LISA SCOTT
 Age 20
 Date of birth 16/08/1988
 Gender Female
 Incident location 21 DELTA CRESCENT MUSSELBURGH
 Incident post code EH21 8DN
 Incident type EMG
 Call received 11/07/2009, 18:42
 Call passed 11/07/2009, 18:42
 Crew mobile 11/07/2009, 18:44

PRIMARY SURVEY

RESPONSE

AVPU Alert

AIRWAY

Airway assessment Clear

BREATHING

Breathing rate Normal

Respiratory rate 16

Pulse rate

Most peripheral pulse found

Cap refill rate

Skin colour

Skin texture

CIRCULATION

Fast

Radial

<2 secs

Normal

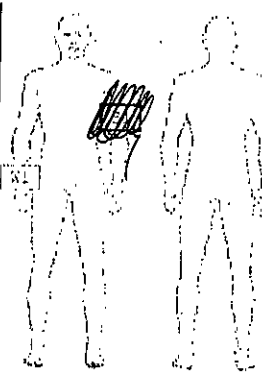
Dry

C-SPINE INJURY

Suspicion of CSI No evidence of C-spine injury

INJURIES

W1 Laceration
 W2
 W3
 W4



AMPDS

Dispatch code 25B01 Psychiatric, Serious Haemorrhage
 Final code 26A01 Sick Person, No Priority Symptom

GCS

Final GCS eye opening Spontaneous
 Final GCS verbal response Orientated
 Final GCS motor response Obeys commands

VITAL SIGNS

Time hr:min	Pulse bpm	Resp. rpm	BP mm Hg	Cap refill (secs)	%	Blood sugar mmol/l	Temp °C	SPO2 %	GCS Total	Pain score
19:05	144	16	131 / 79	<2 secs	-	5.4	-	-	15	1/4

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	Normal

AMPLE

Allergies Unknown
 Medication N/K
 Past history S/H MENTAL PROBS
 Events prior DRINKING AT HOME

PATIENT HANDOVER

On arrival at scene Seated
 Scene removal Walking
 Transportation Seated
 Care delivery at hospital Chair
 Time of handover 19:30

FINAL OBSERVATION AND COMMENTS

CONTACT
 DEF TALK S AITKEN, MARGARET
 CLOSE FRIEND, 07709195453.
 21YF DRINKING HEAVY.
 LACERATION TO RIGHT WRIST.
 BRUISING AROUND EYES, WAS
 ASSAULTED YESTERDAY.

Report ID ddf15b17-d388-47de-b8bf-a36845

Directorate of
Accident and Emergency Medicine
LOTHIAN UNIVERSITY HOSPITALS NHS TRUST



THE ROYAL INFIRMARY OF EDINBURGH
51 Little France Crescent
Edinburgh EH16 4SU
Telephone: 0131 242 1300
Fax: 0131 242 1344



A/E no. E1520880

E583223

Previous no.

UHPI no. 610094329B
CHI no. 1608881229

PATIENT INFORMATION

Surname Scott
Forenames Lisa
Address 2f Delta Crescent
Musselburgh
Midlothian
EH21 8DN
Postcode
Contact Scott, Frances
Address 12 Moredunvale Loan
Edinburgh
Midlothian EH17 7RQ
Complaint self harm
Attendances in last 12 months: 0
Date of Birth 16/08/1988
Age 20 Yrs
Sex F
neighbour
mgt Aitken
Telephone 07709195453
Telephone 620 4591
H
W
Allergies
TRIAGE
↑
School: Broughton High School

General Practitioner

Name DG Selman
Address Eskridge Medical Centre
8b Bridge Street
EH21 6AG
Telephone 0131 665 6821
Date and Time of Attendance 10/7/2009 19:35
Incident Date & Time:
Mode of Arrival Emergency Ambulance
Source of Referral 999 Emergency

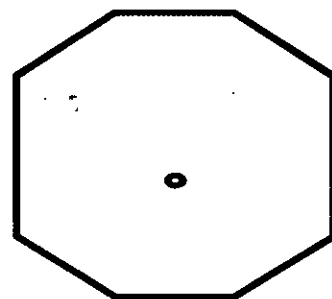
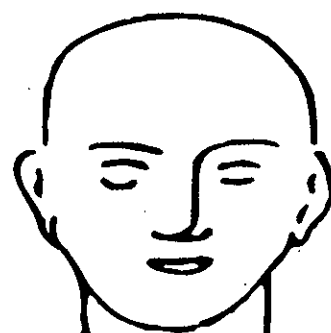
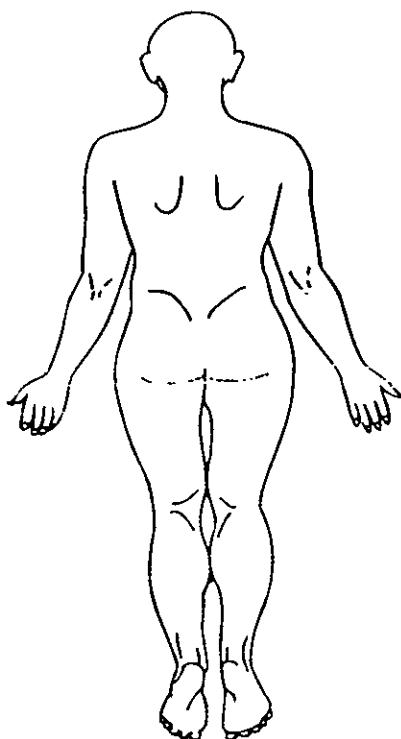
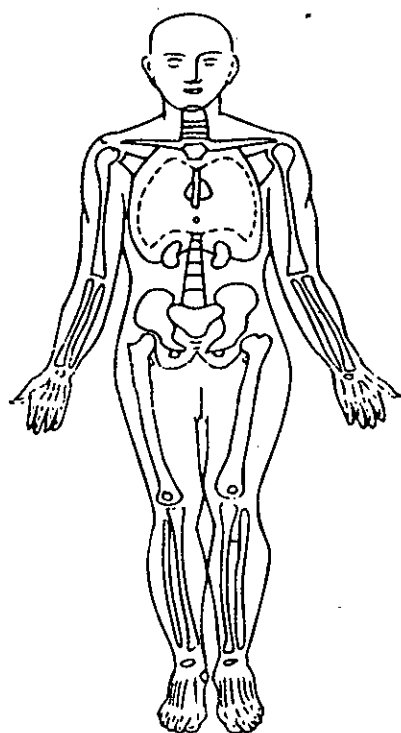
T 36.6 P 122 RR 16 BP 111/63 BM 6.2 SpO2 96% Peakflow Urinalysis Alcometer 1.56
Nursing Assessment DSH Rt arm, hearing voices telling her to harm herself.
Bruising to face, ? assault yesterday.
See previous ED notes
Psych bleed 1955
Pain Assessment Score Waterlow Score Aggravate
Pain Score Review Time Triage Score
Signature JHCC Time 1945 Print Name

Clinical Notes

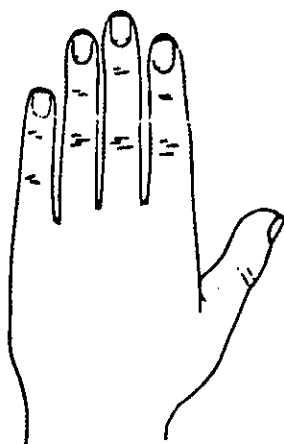
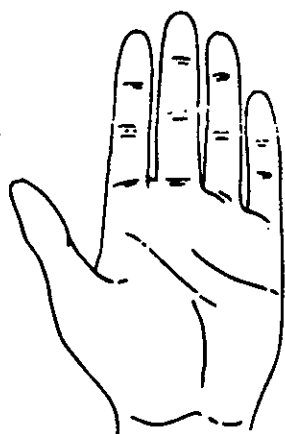
Psych review.
Asked to see. BAC 1.56 at 20³⁰. ? Responding to visual hallucination - not present at interview. Reports her 7yr old son and mother are on holiday Spain due return Thurs/Fri. Wrote suicide notes to both and states wants to die. Has plan to attend college in Sept - believes others are frightened by her and she is worthless. Reports daily alcohol intake '4litre' spirits inconsistent reports. Self Injury @ arm.
Plan Admit for psych assessment when sober. Note: Reports not reg with GP.

11/7/09 See typed note
Diagnosis
Doctor's Name (print) Signature

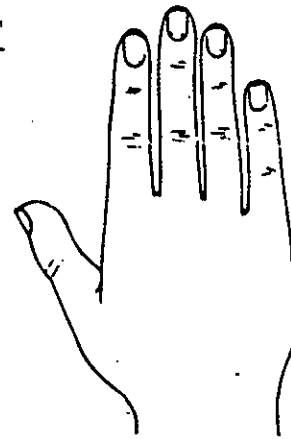
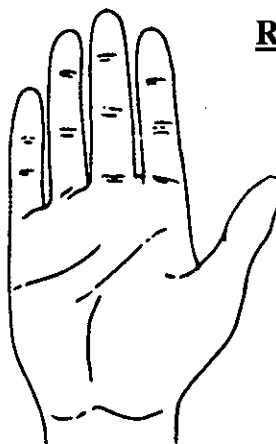
Nursing Release				Clinical Notes Continued
Instruction/Health Education	Y	N	N/A	
Medication	Y	N	N/A	
Review				
X-rays	Y	N	N/A	
Clinic	Y	N	N/A	
Notes/X-rays	Y	N	N/A	
Walking Aids	Y	N	N/A	
Transport				
Self	Y	N	N/A	
Other	Y	N	N/A	
Amb ref no.....	Y	N	N/A	
Primary Care Ref.				
Safe Home	Y	N	N/A	
Crisis Care	Y	N	N/A	
District Nurse	Y	N	N/A	
GP	Y	N	N/A	
NoK/carer aware				
Documentation Complete	Y	N		
CSW signature				
RN signature				



LEFT



RIGHT



Patient & GP Information

UHPI Number	610094329B
CHI Number	1608881229
Episode Number	04103161
Surname/Forename	Scott, Lisa
Date of Birth	16/08/1988
Sex	Female
Patient Address.	14 BREMNERS WALK Wick KW1 5HU
Registered GP	K Christen
GP Address.	Three Harbours Medical Group, Janet Street, Thurso, Caithness KW14 7AR

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Patient & GP Information

610094329B	610094329B
1608881229	1608881229
04178486	05208268
Scott, Lisa	Scott, Lisa
16/08/1988	16/08/1988
Female	Female
14 BREMNERS WALK Wick KW1 5HU	14 BREMNERS WALK Wick KW1 5HU
K Christen	K Christen
Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR	Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR

Patient & GP Information

610094329B	610094329B
1608881229	1608881229
05212270	E005290
Scott, Lisa	Scott, Lisa
16/08/1988	16/08/1988
Female	Female
14 BREMNERS WALK Wick KW1 5HU	14 BREMNERS WALK Wick KW1 5HU
K Christen	K Christen
Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR	Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR

Patient & GP Information

610094329B	610094329B
1608881229	1608881229
E094680	E1101686
Scott, Lisa	Scott, Lisa
16/08/1988	16/08/1988
Female	Female
14 BREMNERS WALK Wick KW1 5HU	14 BREMNERS WALK Wick KW1 5HU
K Christen	K Christen
Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR	Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR

Patient & GP Information

610094329B	610094329B
1608881229	1608881229
E193123	E249471
Scott, Lisa	Scott, Lisa
16/08/1988	16/08/1988
Female	Female
14 BREMNERS WALK Wick KW1 5HU	14 BREMNERS WALK Wick KW1 5HU
K Christen	K Christen
Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR	Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR

Patient & GP Information

610094329B	610094329B
1608881229	1608881229
E249773	E251101
Scott, Lisa	Scott, Lisa
16/08/1988	16/08/1988
Female	Female
14 BREMNERS WALK Wick KW1 5HU	14 BREMNERS WALK Wick KW1 5HU
K Christen	K Christen
Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR	Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR

Patient & GP Information

610094329B	610094329B
1608881229	1608881229
E252156	E267210
Scott, Lisa	Scott, Lisa
16/08/1988	16/08/1988
Female	Female
14 BREMNERS WALK Wick KW1 5HU	14 BREMNERS WALK Wick KW1 5HU
K Christen	K Christen
Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR	Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR

Patient & GP Information

610094329B	610094329B
1608881229	1608881229
E267504	E299683
Scott, Lisa	Scott, Lisa
16/08/1988	16/08/1988
Female	Female
14 BREMNERS WALK Wick KW1 5HU	14 BREMNERS WALK Wick KW1 5HU
K Christen	K Christen
Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR	Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR

Patient & GP Information

610094329B	610094329B
1608881229	1608881229
E349329	E349645
Scott, Lisa	Scott, Lisa
16/08/1988	16/08/1988
Female	Female
14 BREMNERS WALK Wick KW1 5HU	14 BREMNERS WALK Wick KW1 5HU
K Christen	K Christen
Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR	Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR

Patient & GP Information

610094329B
1608881229
E583223
Scott, Lisa
16/08/1988
Female
14 BREMNERS WALK Wick KW1 5HU
K Christen
Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR

Surname/Forename	Scott, Lisa
UHPI Number	610094329B

Episode Number	04103161
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Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Historic SJH A&E Conversion Data Episode/Ref: E1101686 Dr P Freeland 29/02/2008 17:45	A&E Doctor 1: DR P FEE,Time Seen: 22:20,Alcohol: 0,Provisonal Diagnosis: 14DH,Drug 1: Tetanus Toxoid ,Investigation 1: Nil ,Destination: ,Examination: LAC RT ARM,Primary Diagnosis: LAC RT FOREARM

Surname/Forename	Scott, Lisa	Episode Number	04103161
UHPI Number	610094329B		

Note Details	Clinical Notes
A&E Notes Episode/Ref: 04103161 Dr Roger Thompson 09/04/2004	HIST: Vomited tonight red blood at 1 p.m. Vomited several further small amounts, some dark clots in vomit. No vomiting prior to blood. No recent epistaxis, wiped blood from nose once yesterday. Denies swallowing f.b. Hasn't been feeling well since the weekend. Family all had symptoms of nausea and feeling unwell.,Sore throat - left side of neck.,Headache, going across forehead, mainly above R. eye.,Further episode of small amount - 30 ml tonight red bloody vomit in the Dept.,Bowels moved normally this a.m. No blood PR.,,PH: DSH aged 13 - childhood asthma.,SH 1 x son aged 1.,,EXAM: avoids eye contact. Doesn't look distressed.,P. 110 reg. BP 105/65. JVP NE. ,HS I + II + 0,Chest clear,Abdo. soft, slightly tender epigastrium.,BS present. PPP. No AO.,No neuro deficit detected.,,CHEST XRAY No pneumomediastinum. Lung fields clear.,PR no masses. FOB positive.,,PLAN: Routine bloods including Xmatch. ,AXR No f.b. seen ,IV fluids.,REFER MEDICS ,Hb.149 Urea 2.3 ,MEDICAL REVIEW:,15 year old female presents with probable haematemesis, can't exclude haemoptysis. ,History as above. Denies self-poisoning or harm.,PH: Previous DSH, under psychiatrist and on antidepressants with self-poisoning two months ago but no hospital review. ,Mother of one year old child. ,EXAM: Unremarkable with soft, non-tender abdo. and haemodynamically stable. ,Urinalysis ketones. HCG negative. ,Hb.149 Coag and platelets normal. ,IMP: Haematemesis ? ingestion of tablets. Rockall score 0,2. ? haemoptysis following URTI.,,PLAN: Observe overnight. Chase Paracetamol and Salicylate levels.,Repeat Hb. morning. OGD mane or possibly early out-patient. IV fluids and NBM. ,DR MARTIN/EL

Surname/Forename	Scott, Lisa
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Note Details	Clinical Notes
A&E Notes Episode/Ref: 04178486 Dr Paul John Jenkins 24/03/2005	History: 16 year old female with deliberate self harm this evening. Multiple superficial vusts to both forearm volar surfaces. Dnies taking drugs. Drank 2 glasses of wine with friend over dinner tonight. „Hearing 2nd person voice - female - that tells her she is worth nothing and should be dead. At first she denied cutting herselfm and said that this voice cut her. She further admitted that she had cut herself.,,She described the voice as an imaginary friend (and called it Lily),,She has been hearingthese vcoices since the age of 13. She has attended the YPU once last week, and saw ?Dr Gwynn,,She is tearful and says that she can't cope with voices. They are worse than ever. They subsided until a year ago, when they started getting worse agin.,,PMH: OD, DSH, Anxiety, Depression,DH: Propanolol,SH: Lives alone. Has 2 year old son. Sone currently staying with her mother, as her mother thinks she is mad. ,Was in council/secure accommodation until recently. Criminal conviction aged 12 ? why.,Smokes cigarettes,Drinks alcohol occasionally.,,OE: Both volar forearm surface - superficial incisions. No action necessary.,,Appearance: Well dressed. ,Behaviour: Tearful. Despairing,Speech: Normal voice pattern/tone/volume.,,Presence of hallucinations in 2nd and 3rd person. Also delusions of reference/persecution.,,Patient has insight into condition and wants it to stop. , ,Plan: Admit CAA6 for Psych assessment in morning.,,It is my assessment that patient is suffering mental disorder, and is a danger to herself, so she would be detainable in the event of self discharge. Patient is currently compliant with above plan of action.

Surname/Forename	Scott, Lisa
UHPI Number	610094329B

Episode Number	04103161
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Note Details	Clinical Notes
A&E Notes Episode/Ref: 05208268 Dr Fiona G McManus 05/08/2005	PC: 16 yr old female brought in by ambulance with DHS to the R arm. Intoxicated and agitated,HPC: Patient reports she had been drinking Vodka from approx. 10 a.m. this morning. She became agitated with voices she hears told her to smash the Vodka bottle and cut herself. She then proceeded to do this.,Pt has psych hx which has been apparently noted since the age of 11. She is currently receiving counselling at the REH. She reports she is not on any meds as they make her feel lousy and she discontinued them.,She c/o auditory hallucinations in the form of a voice which she knows as Lulu. Lulu generally makes derogatory remarks and sometimes tells her to harm herself which she sometimes does.Previous medications had quietened the voice down but not taken it away. She denies any visual hallucinations or any other complaints. Patient currently denies hearing the voice at this point in time. ? she reports she does not wish to hurt herself at this time. ,,Initially patient agreed to stay and discuss alternative medications with the psych team. She later decided to leave.,Patient is currently under the care of the psych at REH.,She appears calm and is denying any intent to kill herself,she is therefore not sectionable at this point in time.,Patient left the Dept against medical advice.,Note patient currently lives with her boyfriend. She has a 2/1/2 yr old son who is being cared for by her mother.

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Note Details	Clinical Notes
A&E Notes Episode/Ref: 05212270 Dr J Thomson 22/08/2005	17 year old female prpresents following alleged overdose at 12 pm. States taken 9 x nytol. Denies other medication or alcohol taken. Since feels tired, headache; lightheaded with dry mouth. Previous history of DSH. Known to YPU. No notes made, bought tablets today. ?Intent - 'wants to end this'. Found by friend whom called ambulance.,Med nil,NKDA,PMH DSH,SH Lives alone, UE, Smoker 10/day Occasional alcohol,,O/E Temp 36.8C BM 6.2,CVS HR 102 BP 128/75 HS 1+2+0,RS RR 14 98%saO2 on room air chest clear,GIT SNT No masses/LKKS BS present,CNS GCs 15 CN intact PERLA NTPRS R+L No nystagmus,,IMP OD,,REFER TOXICOLOGY

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Note Details	Clinical Notes
A&E Notes Episode/Ref: E005290 Dr Fiona G McManus 02/01/2006	17 y/o female.,,Self inflicted lacerations to volar aspect of R forearm with a broken bottle this evening.,,PMH: DSH,,OE: A&O, GCS 15, R forearm - wide gash, ~20cm in length, superficial in depth.,,LA with lignocaine and adrenaline. Irrigated with normal saline, prepped with betadine and draped. Closed with 2x 5/0 vicryl sutures and steristrips, dressed and given diftavax.,,PLAN: D/c with GP F/u for ROS in 10/7.

Surname/Forename	Scott, Lisa
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Note Details	Clinical Notes
A&E Notes Episode/Ref: E094680 Dr Koosje Van Bergen 25/12/2006	18 yo female, fell off the fence after drinking and smoking hash. No LOC, remembers the fall. Complains of a headache. No dizziness/nausea/vomiting and has a pain in her face. ,PMH: NIL,DH: NIL,NKDA,Tetanus up to date,SH: Lives with her boyfriend.,OE: Pt is alert and orientated GCS 15. PERL. Normal range of movement. ,CN intact. P/s/r normal in all four limbs. ,Swelling and abrasion of forehead. Abrasion of nose and chin. Cannot open mouth properly, but no local tenderness on maxilla or mandibular.,facial view and OPG showed no #.,PLAN: HI advice leaflet was given and pt was d/c.,,,

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Note Details	Clinical Notes
Historic RHSC A&E Conversion Data Episode/Ref: E193123 01/06/2007 04:42	Arrived with: Mother, Incident Date: 07/08/1997, Triage Nurse: Other Nurse, Consultant: TFB

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Note Details	Clinical Notes
Historic RHSC A&E Conversion Data Episode/Ref: E249471 01/06/2007 04:42	Arrived with: Mother, Referred To: A&E, Incident Date: 28/05/1999, Triage Nurse: Kate Mitchell, Consultant: TFB, Seen-By: Dr M Land, Seen-By: Surgical SHO, Seen-By: Surgical Reg, Investigation: X-Ray Pelvis, Investigation: X-Ray Hips, Investigation: X-Ray Femur, Investigation: X-Ray Foot

Surname/Forename	Scott, Lisa
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Note Details	Clinical Notes
Historic RHSC A&E Conversion Data Episode/Ref: E249773 01/06/2007 04:42	Arrived with: Mother, Referred To: A&E, Incident Date: 31/05/1999, Triage Nurse: Jane Dowie, Consultant: TFB, Seen-By: Surgical SHO

Surname/Forename	Scott, Lisa
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Episode Number	04103161
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Note Details	Clinical Notes
A&E Notes Episode/Ref: E249773 01/06/2007 06:16	calpol brufen

Surname/Forename	Scott, Lisa
UHPI Number	610094329B

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Note Details	Clinical Notes
Historic RHSC A&E Conversion Data Episode/Ref: E251101 01/06/2007 04:42	Arrived with: Mother, Incident Date: 14/06/1999, Triage Nurse: Other Nurse, Consultant: TFB, Seen-By: Dr M Land, Seen-By: Fraser Adams, Investigation: X-Ray Foot, Procedure: Plaster Cast/Backslab

Surname/Forename	Scott, Lisa
UHPI Number	610094329B

Episode Number	04103161
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Note Details	Clinical Notes
Historic RHSC A&E Conversion Data Episode/Ref: E252156 01/06/2007 04:42	Arrived with: Ambulance,Management: Treated, refer to OPD,Referred To: A&E,Incident Date: 25/06/1999,Triage Nurse: Kate Mitchell,Consultant: TFB,Seen-By: Fraser Adams,Procedure: Plaster Cast Removal,Procedure: Plaster Cast/Backslab

Surname/Forename	Scott, Lisa
UHPI Number	610094329B

Episode Number	04103161
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Note Details	Clinical Notes
Historic RHSC A&E Conversion Data Episode/Ref: E267210 01/06/2007 04:42	Arrived with: Mother,Main Injury: Fracture,Body Part: Metacarpal Bone,Management: Treated, review later A&E,Referred To: A&E,Incident Date: 12/12/1999,Triage Nurse: Fiona Todd,Consultant: TFB,Named Nurse: Fiona Todd,Seen-By: ENP A Weatherall,Seen-By: Lindsey Dixon,Investigation: X-Ray Hand,Procedure: Plaster Cast/Backslab

Surname/Forename	Scott, Lisa
UHPI Number	610094329B

Episode Number	04103161
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Note Details	Clinical Notes
Historic RHSC A&E Conversion Data Episode/Ref: E267504 01/06/2007 04:42	Arrived with: Mother,Main Injury: Inflammation/Oedema/Tenderness,Body Part: Metacarpal Bone,Management: Treated, review later A&E,Incident Date: 12/12/1999,Triage Nurse: Other Nurse,Consultant: TFB,Seen-By: Fraser Adams,Seen-By: Dr P Robertson,Procedure: Plaster Cast Removal

Surname/Forename	Scott, Lisa
UHPI Number	610094329B

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Note Details	Clinical Notes
Historic RHSC A&E Conversion Data Episode/Ref: E299683 01/06/2007 04:42	Arrived with: Other Adult,Main Injury: Haematoma/Bruising,Body Part: Tibia/ Fibula,Management: Treated, sent home,Incident Date: 13/12/2000,Triage Nurse: Caroline Mearns,Consultant: TFB,Named Nurse: Caroline Mearns,Seen-By: Dr M Craig,Investigation: X-Ray Ankle,Procedure: Double Tubigrip

Surname/Forename	Scott, Lisa
UHPI Number	610094329B

Episode Number	04103161
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Note Details	Clinical Notes
Historic RHSC A&E Conversion Data Episode/Ref: E349329 01/06/2007 04:42	Arrived with: Police,Main Injury: Haematoma/Bruising,Body Part: Tibia/ Fibula,Management: Treated, sent home,Incident Date: 18/06/2002,Triage Nurse: Other Nurse,Consultant: TFB

Surname/Forename	Scott, Lisa
UHPI Number	610094329B

Episode Number	04103161
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Note Details	Clinical Notes
Historic RHSC A&E Conversion Data Episode/Ref: E349645 01/06/2007 04:42	Arrived with: Nurse,Main Injury: Unclassified Disease,Management: Transferred (other Hosp),Referred To: A&E,Incident Date: 21/06/2002,Triage Nurse: Ali Hunt,Consultant: TFB,Named Nurse: Ali Hunt,Seen-By: Medical SHO,Seen-By: Medical Reg

Surname/Forename	Scott, Lisa
UHPI Number	610094329B

Episode Number	04103161
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Note Details	Clinical Notes
A&E Notes Episode/Ref: E583223 Dr Fiona M McCaig 12/01/2008 Louise Peden	CHI: 1608881229 „19 year old female brought in Police custody. „PC: DSH. Feels suicidal.,HPC: well known to REH. Currently under a lot of pressure recently. Last night drinking alcohol with friend and felt suicidal so made her way to the entrance of REH. On arrival she cut her R hand using a broken piece of glass. She was initially verbally and physically violent to SAS crew and therefore the Police were called to restrain her prior to transportation to ED. Denies any drug OD/illicit drugs. Tetanus up to date.,DH: nil,NKDA,SH: lives with 4 year old son. Supportive mother lives nearby. „OE: intoxicated. GCS 15. A&O. Pulse 80. „R hand - 3.5cm deep cut over mid dorsum of hand. ? abnormal extension with a lac affecting her middle finger. NVI prior to LA. Wound explored. I was suspicious of an extensor tendon injury. „Reviewed by Ortho ST1 - agrees that she may have sustained an extensor tendon injury however in view of her current state of intoxication she is difficult to assess. She was unwilling to be admitted overnight and has agreed to return to the department tomorrow for further assessment in A&E. „Wound thoroughly irrigated using saline. Suture mane as discussed with orthopaedics. Xrays showed no FB.,

Case Notes

610094329B F 16/08/1988

Scott, Lisa
2f Delta Crescent,
Musselburgh,
Midlothian,
EH21 8DN

CHI 1608881229

76048 DG Salmon

Date:

07/04/08

Form NP1

page
1/2

Referred from

☒ GP ☐ BSc ☐ OtherFirst
Clinician's
Initials

LYW

Age

19

Occupation

None

Side(s)

☒ Right ☐ Left☐ Right ☐ Left

Complaint

Tender lump, overall swelling now less.

(Doesn't have period - implantation cyst)
- but had one period 2-3 mths agoDuration (weeks)
0 if under 1 week

9

Side(s)

☐ Right ☐ Left☐ Right ☐ Left

Previous Breast Disease

☒ None

Date Diagnosed

/

Date of Previous
Mammograms

/

☐ None

Other Cancers

☒ None

Other Significant Illnesses or Operation

☒ NoneTick if
Current☐
☐
☐
☐
☐Date Diagnosed, or
Date of Operation/
/
/
/
/

Family History

Breast Cancer

☒ None☐ Unknown

Ovarian Cancer

☒ None☐ Unknown

Mother

Sister

Daughter

Aunt

Maternal Paternal

Grandmother

Maternal Paternal

Cousin

Maternal Paternal

Other

Breast Ovary

Age at Onset

1.

☐☐☐☐☐☐☐☐☐☐☐☐/
/
/

2.

☐☐☐☐☐☐☐☐☐☐☐☐

3.

☐☐☐☐☐☐☐☐☐☐☐☐Other
Cancers:Menstrual
History☒ Pre☐ Peri☐ Post☐ Unknown (HRT,
Hysterectomy, etc.)

HRT

☐ Curr☐ Prev☐ NeverTotal
Duration
to Date

/ Years

Parity

01 + 0

Pregnant

☐ Yes☒ No

Lactating

☐ Yes☒ NoCurrently On Oral
Contraception☐ Yes☒ NoImplanon
Contraception

Current Medication

☐ None☐ Steroids☐ Warfarin☐ AspirinOther
Medication:

1.

Implanon Contraception

2.

3.

4.

Drug Allergy

☐ Yes☒ NoDrug(s)
allergic to:

Tobacco Use

☒ Smoker☐ Non-smoker☐ Ex-smoker

40812

31/8/0

610094329B F 16/08/1988
Scott, Lisa
2f Delta Crescent,
Musselburgh,
Midlothian,
EH21 8DN
CHI 1608881229
76048 DC Solman

Additional Exam Findings

Ⓡ Breast (new)
Very nodular 10-12 o'clock Ⓡ Breast
where pt feels lump, but no
discrete lesion

Form
NP1

page 2/2

Right Breast

- ☐ Normal
☐ Discrete Lump
☒ Localised Nodularity
☒ Tenderness
☐ Skin Lesion
☐ Nipple Lesion
☐ Nipple Inversion
☐ Other

T4a T4b T4c T4d Tis

☐ ☐ ☐ ☐ ☐

Left Breast

- ☒ Normal
☐ Discrete Lump
☐ Localised Nodularity
☐ Tenderness
☐ Skin Lesion
☐ Nipple Lesion
☐ Nipple Inversion
☐ Other

T4a T4b T4c T4d Tis

☐ ☐ ☐ ☐ ☐

Site (1-12...)	Size (mm)	FNA Solid	Cystic drained	res. mass	Comments
☐	☐	☐	☐	☐	
☐	☐	☐	☐	☐	
☐	☐	☐	☐	☐	

Nipple Discharge: None ☒ Single ☐ Multiple ☐ Position (1-12/C) ☐ Blood (dipstick) Neg. ☐ Trace ☐ ++ ☐

Lymph Nodes: Axilla ☒ Not Palpable ☐ Benign ☐ Malignant Movable ☐ Fixed ☐ SCF ☒ Not Palpable ☐ Benign ☐ Malignant Movable ☐ Fixed ☐

Clinical Rating: ☐ E1 ☐ E2 ☐ E3 ☐ E4 ☐ E5

Site (1-12...)	Size (mm)	FNA Solid	Cystic drained	res. mass	Comments
☐	☐	☐	☐	☐	
☐	☐	☐	☐	☐	
☐	☐	☐	☐	☐	

Nipple Discharge: None ☒ Single ☐ Multiple ☐ Position (1-12/C) ☐ Blood (dipstick) Neg. ☐ Trace ☐ ++ ☐

Lymph Nodes: Axilla ☒ Not Palpable ☐ Benign ☐ Malignant Movable ☐ Fixed ☐ SCF ☒ Not Palpable ☐ Benign ☐ Malignant Movable ☐ Fixed ☐

Clinical Rating: ☐ E1 ☐ E2 ☐ E3 ☐ E4 ☐ E5

Right Results:					Tests	Left Results:				
Normal	Benign	Probably Benign	Probably Malignant	Malignant		Normal	Benign	Probably Benign	Probably Malignant	Malignant
☐ R1	☐ R2	☐ R3	☐ R4	☐ R5	Mammography	☐ R1	☐ R2	☐ R3	☐ R4	☐ R5
☒ U1	☐ U2	☐ U3	☐ U4	☐ U5	Ultrasound	☒ U1	☐ U2	☐ U3	☐ U4	☐ U5
☐ C1	☐ C2	☐ C3	☐ C4	☐ C5	FNA	☐ C1	☐ C2	☐ C3	☐ C4	☐ C5
☐ C1	☐ C2	☐ C3	☐ C4	☐ C5	Core Biopsy	☐ C1	☐ C2	☐ C3	☐ C4	☐ C5

R. Clinical Diagnosis: Right Axillary Nodularity

L. Clinical Diagnosis: Normal

Action: ☐ For Staging ☐ Operating List ☒ Follow-up ☐ Discharge ☐ Other

Notes: Discussion with Mr. Dan Young - who will review her in 6 weeks.

Consultant/
Senior Registrar LYW

Signature hyn Williams

40812 31/8/0

WESTERN GENERAL HOSPITAL

RADIOLOGY CLINICAL REPORT

PATIENT NAME:	Scott	Lisa	UHPI:	610094329B
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CHI: 1608881229

Order Items:

US Breast Rt

Clinical detailsReport

Scanning in the area marked in the right breast reveals normal fibro glandular breast tissue only.

OPINION: RIGHT = NORMAL

DC/R1

JC/CW



ADDRESS:	2f Delta Crescent	DOB:	16/08/1988
	Musselburgh	SEX:	Female
	EH21 8DN		

REFERRER:	
ADDRESS:	

Episode Consultant:	Mr U Chetty
Order Patient Location:	WGH Breast Surgery Reception Desk
Receiving Location:	WGH - Mamm

Order Items(s):	Visit No	Date of Exam	Referring Clinician
US Breast Rt	2400934	02/04/2008	Miss E Anderson

D.O.R:	02/04/2008	Reporting Radiologist:	Janet Clarke
D.O.T:	02/04/2008	Overseen by Radiologist:	
D.O.V:	02/04/2008	Verifying Radiologist:	Janet Clarke
		Typist/Secretary:	Christine Williams
		Radiologist Signature:	

Printed 02/04/2008 11:34:16

Please fill in this form as fully as possible*

This will allow us to minimise time spent on documentation and move onto your examination and any investigations (if required) as soon as possible for you.

Name LISA SCOTT Age 19 yrs

Did you see your doctor about: (Please mark form as appropriate)

A lump in the breast? If so, where?

Right ☒

Left ☐

Tenderness? If so, where?

Right ☒

Left ☐

Pain in the breast? If so, where?

Right ☒

Left ☐

Any other symptoms? No

How long have you had the problem? Few months

Have you had any previous breast problems?

Yes ☐

No ☒

If Yes, what problems and when?

Have you ever had a Mammogram?

Yes ☐

No ☒

If yes, when and where?

Any other significant illnesses or operations? No

Have any members of your family had breast cancer?

Yes ☐

No ☒

If yes please give relationship and age

Have any members of your family had ovarian cancer?

Yes ☐

No ☒

If yes please give relationship and age

Do you still have periods?

Yes ☒

No ☐

If No, have you had a hysterectomy?

Yes ☐

No ☐

How many children have you had? 1 How many pregnancies in total? 1

Please list All of your medication including HRT, aspirin, Warfarin, steroids and inhalers below:

Are you allergic to any drugs?

Yes ☐

No ☒

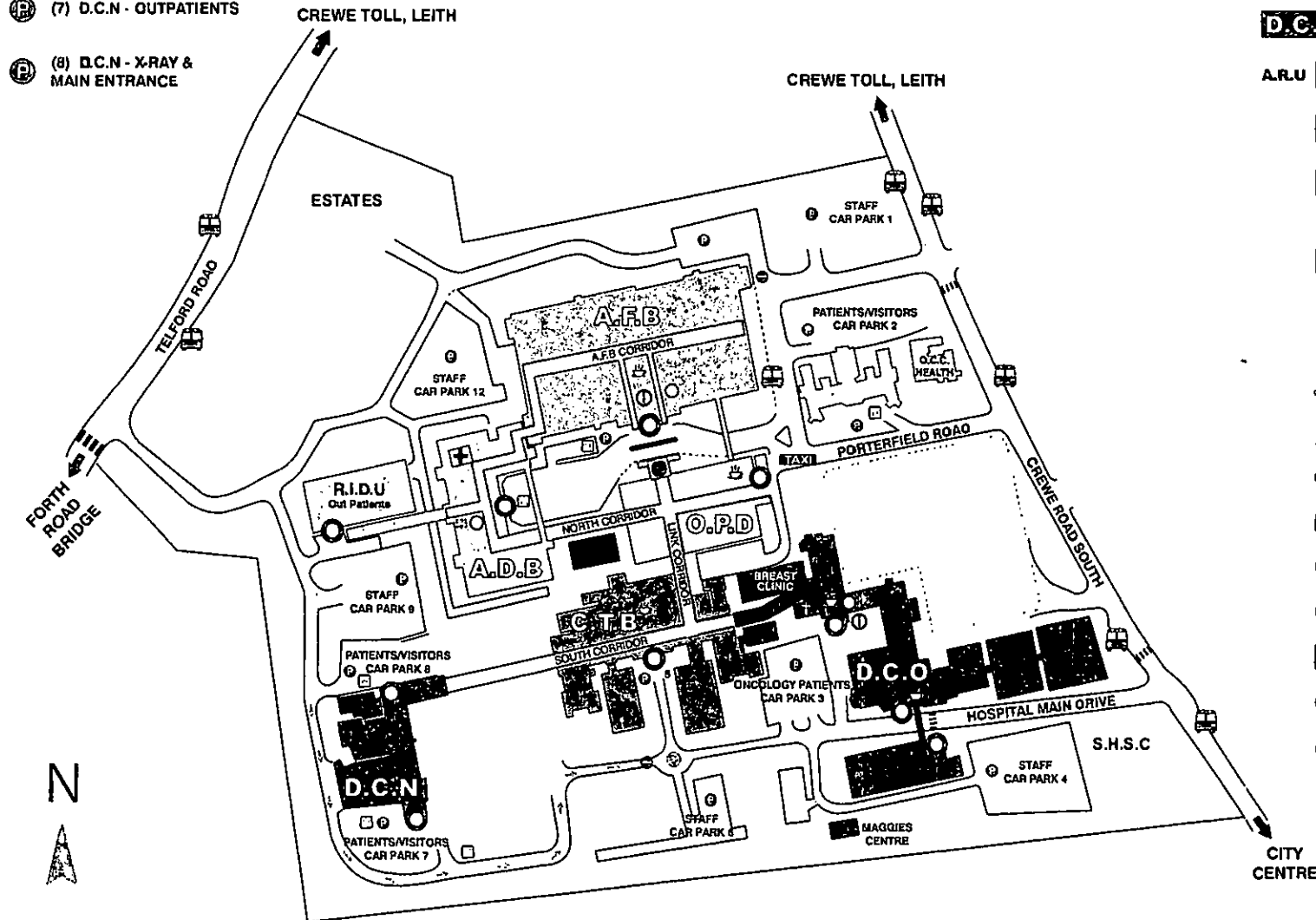
If Yes, what?

Western General Hospital

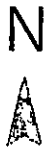


CAR PARK GUIDE FOR PATIENTS & VISITORS

- (2) OUTPATIENTS
A.F.B & A.D.B
- (3) O.C.O &
CLOCK TOWER BUILDING
- (7) D.C.N - OUTPATIENTS
- (8) D.C.N - X-RAY &
MAIN ENTRANCE



- THE ANNE FERGUSON BUILDING
WARDS 50 - 58 THEATRES, METABOLIC, UROLOGY,
DAY BED AREA & OUTPATIENT CLINICS
- THE ALEXANDER DONALD BUILDING & R.I.D.U
WARDS 20 - 27 & 41 - 43, PHYSIOTHERAPY & OCC THERAPY
- OUTPATIENT BUILDING
A.R.A.U. & X-RAY DEPARTMENT
- ONCOLOGY DEPARTMENT, EDINBURGH CANCER CENTRE
WARDS 1 - 9, OCC, BREAST CLINIC, DIALYSIS
- CLOCK TOWER BUILDING/MAIN BLOCK
WARDS 10 - 15, SOCIAL WORK
- DEPARTMENT OF CLINICAL NEUROLOGY (DCN)
WARDS 31 - 33
- ACUTE RECEIVING UNIT
MINOR INJURIES & OUT OF HOURS SERVICE
- PADEREWSKI BUILDING / ADMIN & O.C.C. HEALTH
- WTCRF
- PHARMACY
- CHAPLAINCY
- MAIN ENTRANCES
- WRVS SHOP
- CASH MACHINE
- CAFÉ
- TAXI RANK
- BUS STOP
- INFORMATION
- PARKING - STAFF/PATIENTS/VISITORS
- DISABLED PARKING
- NO ENTRY
- ROUNDABOUT
- PEDESTRIAN CROSSING



Surgical & Associated Services Division

Dr Selman
Eskbridge Medical Centre
8a Bridge Street
Musselburgh
EH21 6AG

Date 03/04/2008
Our Ref 610094329B
CHI 1608881229

Patient: Miss Lisa Scott
2f Delta Crescent
Musselburgh
EH21 8DN

UHPI: 610094329B
Date of Birth: 16/08/1988

Clinic Code: NP/WED

Attendance Date: 02/04/2008

Specialty: Edinburgh Breast Unit

Consultant: Mr U Chetty

Edinburgh Breast Unit

Mr M Dixon
Secretary : 537 1629

Mr G Neades
Secretary : 537 2647

Ms E Anderson
Secretary : 537 1614

Mr U Chetty
Secretary : 537 3273

Mr J Rainey
Secretary : 537 2468

Mr I Young
Secretary : 537 2647

Mr M Barber
Secretary : 537 1614

Dear Dr Selman,

Thank you for referring Lisa to the breast clinic for assessment of a tender lump in her right breast which she noticed about 9 weeks ago. She keeps well with no previous breast problems and no family history of breast or ovarian cancer. She has an Implanon in-situ as birth control but no other medication. On examination her right breast is larger than the left side which she says is new over the last couple of months and she does have marked nodularity from 10 - 12 o'clock in her right breast which is the area where she feels the lump but I could not feel any discrete lesions and otherwise examination of both breasts and regional nodes is satisfactory. An ultrasound scan of her right breast is reported as normal with only fibro-glandular breast tissue seen. I have discussed this with Mr Ian Young, Consultant Surgeon, who is happy for me to reassure Lisa today but he will review her in 6 weeks time.

Kind regards.

Yours sincerely,



Ms Lyn Wildridge
Clinical Nurse Specialist

Outpatient Clinic Letter

Hospital use only	Clinic	Day Date	Time	CHI 1608881229 76048	Dr. David Selman
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REFERRAL LETTER
 MEDICAL IN CONFIDENCE

REFERRAL TO	
General Surgery - Breast C1A L Breast - Non Urgent	
Western General Hospital (S116H)	
Urgency of referral	Routine
Date of referral	07-Mar-2008
Date submitted	07-Mar-2008

PATIENT DETAILS		Patient's address
Surname	Scott	2f Delta Crescent MUSSELBURGH EH21 8DN
Forename(s)	Lisa	
Title	Miss	
Sex	Female	
Date of birth	16-Aug-1988	
CHI no.	1608881229	Contact number(s) Voice : 07760 381 920

REFERRING PRACTITIONER DETAILS		Practice address
Name	Dr. David Selman	8A BRIDGE STREET MUSSELBURGH
GMC code	3054480 GP code 44032	
Practice name	ESKBRIDGE MEDICAL CENTRE (76048)	
Practice code	76048	
		Contact number(s) Voice : 0131 665 6821

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: BREAST LUMP RT SIDE

Comment: 2/12 noticed slightly tender persistent lump Rt upper outer breast
o/e 2cm mobile sl tender firm swelling
? fibroadenoma ? cyst

I'd appreciate your further assessment

Examinations and Investigations

<u>Description</u>	<u>Result</u>	<u>Date</u>
Lump - Pt younger than 30 :	true	
Main Lesion :	Right Breast	
Main Lesion :	10 o'clock position	
Main Lesion :	1-2cm size	
Other Lesion :	(BREAST NOT SPECIFIED)	
Other Lesion :	(POSITION NOT SPECIFIED)	
Other Lesion :	(SIZE NOT SPECIFIED)	
Duration :	1-2 months	
Previous Breast History :	None	
Menopausal Status :	Not Known	
Mammogram, if done - approx date and where done :	nil	
This is a protocol based referral. Has the 'Protocol Text' been completed? : Yes		

Reason for referral

Care type requested: Out Patient - New

Expected outcome: Not Specified

Past medical history

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

No recent medications recorded

Clinical warnings

Additional relevant information

Smoking status (Screening): Light smoker - 1-9 cigs/day

Alcohol status (Screening): Moderate drinker - 3-6u/day

Patient Weight in Kilograms: 0

Patient Height in Metres: 0

Patient Blood Pressure (Systolic): 0

Patient Blood Pressure (Diastolic): 0

Signature of referring doctor (or other professional) Date

Clinic Letters & Notes

Breast Services

Dr Christen
Three Harbours Medical Group
Janet Street
Thurso
Caithness
KW14 7AR

Date First Created: 03/04/2008
Date/Time Printed: 28/04/2026 09:07
Our Ref: 610094329B
CHI: 1608881229

Patient:	Miss Lisa Scott 14 BREMNERS WALK Wick KW1 5HU	UHPI:	610094329B
		Date of Birth:	16/08/1988
Specialty:	Breast Services	Consultant:	Mr U Chetty

Thank you for referring Lisa to the breast clinic for assessment of a tender lump in her right breast which she noticed about 9 weeks ago. She keeps well with no previous breast problems and no family history of breast or ovarian cancer. She has an Implanon in-situ as birth control but no other medication. On examination her right breast is larger than the left side which she says is new over the last couple of months and she does have marked nodularity from 10 - 12 o'clock in her right breast which is the area where she feels the lump but I could not feel any discrete lesions and otherwise examination of both breasts and regional nodes is satisfactory. An ultrasound scan of her right breast is reported as normal with only fibro-glandular breast tissue seen. I have discussed this with Mr Ian Young, Consultant Surgeon, who is happy for me to reassure Lisa today but he will review her in 6 weeks time.

Kind regards.

Yours sincerely,

Ms Lyn Wildridge
Clinical Nurse Specialist

Progress Notes

Patient & GP Information

UHPI Number	610094329B
CHI Number	1608881229
Episode Number	I0000307853
Surname/Forename	Scott, Lisa
Date of Birth	16/08/1988
Sex	Female
Patient Address.	14 BREMNERS WALK Wick KW1 5HU
Registered GP	K Christen
GP Address.	Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Patient & GP Information

610094329B	610094329B
1608881229	1608881229
I0000307854	I0000307855
Scott, Lisa	Scott, Lisa
16/08/1988	16/08/1988
Female	Female
14 BREMNERS WALK Wick KW1 5HU	14 BREMNERS WALK Wick KW1 5HU
K Christen	K Christen
Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR	Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR

Patient & GP Information

610094329B	610094329B
1608881229	1608881229
I0000307856	I0001415600
Scott, Lisa	Scott, Lisa
16/08/1988	16/08/1988
Female	Female
14 BREMNERS WALK Wick KW1 5HU	14 BREMNERS WALK Wick KW1 5HU
K Christen	K Christen
Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR	Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR

Patient & GP Information

610094329B
1608881229
I0002338404
Scott, Lisa
16/08/1988
Female
14 BREMNERS WALK Wick KW1 5HU
K Christen
Three Harbours Medical Group,Janet Street,Thurso,Caithness KW14 7AR

Surname/Forename	Scott, Lisa
UHPI Number	610094329B

Episode Number	I0000307853
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Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0002338404 Prof DN Bateman 27/07/2009 10:38 Christina Hood	DIAGNOSIS: DSH to wrist whilst intoxicated. „Patient detained under the Mental Health Act: NO.,,PSYCHIATRIC ASSESSMENT: This 20 year old lady was admitted CAA6 on the evening of Saturday 11th July 2009. I assessed her in my capacity as Consultant Liaison Psychiatrist on the morning of Monday 13th July 2009.,,When Lisa was 13 years old her parents separated. Her father was alcohol dependent. At around this time Lisa “went off the rails”. She was in St Catherine’s Secure Residential Unit for some time and was in contact with Adolescent Mental Health Services at the REH, (I did not have access to these notes). She became pregnant with her son, MacKay, who is now 6 years old. Her last contact with the Mental Health Services was over 4 years ago. Lisa told me that since that time she has “kept things together for my son”. On 11.07.09 MacKay left for a 1 week holiday in Spain with his grandmother. Lisa usually goes out drinking on a Friday night, but on this occasion she drank more than usual and whilst waiting for a taxi she was assaulted and her bag stolen. She managed to get a lift home and apparently scaled the outside of the building letting herself in through the third floor balcony. The following morning she woke up, felt terrible, and bought a bottle of vodka which she then drank. She wrote suicide notes to her son and mother, and then cut her wrists. A neighbour found her called an ambulance and she was brought to hospital. „At interview she regretted her actions saying that she wanted to live for her son. She also has plans to start at Jewel & Esk College in September. She reported chronic problems with poor sleep, poor motivation, poor concentration, a bulimic pattern of eating and low mood. However, she acknowledged that she is able to enjoy spending time with her son and she enjoys drinking. She usually only drinks on a Friday night, but because she does not currently have responsibility for MacKay, she is worried that she will continue to drink vodka until his return. She told me that she had seen her GP earlier this year and was prescribed Propranolol for anxiety which proved effective. I am loathe to jump to a diagnosis of depression or generalised anxiety disorder on the basis of a single interview particularly in the aftermath of a heavy drinking session and I have advised her to establish some contact with her GP. „IMPRESSION: I gained the impression that Lisa has longstanding problems with low self esteem. She is invested in her role as a mother and this guarantees a degree of self care. However, when her son is away she neglects herself and resorts to drinking at a level that equates to self harm. On this occasion she actually did self harm whilst very heavily intoxicated. „It strikes me that she is socially isolated and although she has considerable support from her mother she does not feel comfortable discussing how she feels with her mother. She told me that when she was in St Catherine’s Secure Unit, her Key Worker, Fran, was very supportive and that she would like to have someone to talk to again. I have therefore given her the contact details for Crossreach, which is an excellent Counselling Service run by the Church of Scotland that has Offices in East Lothian. I have not arranged any psychiatric follow up. „Kind regards.,,Yours sincerely,,,Dr Robby Steel,Consultant in Liaison Psychiatry,

Surname/Forename	Scott, Lisa	Episode Number	I0000307853
UHPI Number	610094329B		

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0000307853 Dr IC Stewart 22/06/2002	DIAGNOSIS: „This patient was admitted following deliberate self harm.,,No specific treatment was required and the patient was discharged.,,Patient was detained under the Mental Health Act. NO,,PSYCHIATRIC ASSESSMENT:„This 13 year old young girl was admitted to Ward 1A of the Royal Infirmary via A&E Department in the early hours of Friday 21st June 2002. On Thursday the 20th June she describes having an all right day although in her notes her Social Worker is noted as describing her behaviour that day as being erratic. She tells me that she had no particular stressors but in the evening at 10.00pm she just could not be bothered with the staff at the Young Peoples Centre and decided jointly with a friend Janet (also a resident) to leave. They had no particular plan but found themselves in Muirhouse where they met up with a cousin of Janet. They spent some time with her before being offered 4 oval shaped white tablets by an unknown male. These she took and washed them down with a bottle of Carlsberg. She vomited 1 hour later, felt dizzy and returned to the Young People Centre where she slept until Midday. She was noted to be a bit paranoid by an Educational Psychologist who saw her later that day. She appeared coherent during the remainder of the day but in the evening complained of headache, numbness in her legs and admitted taking the tablets, at which point she was taken to A&E at the Royal Hospital for Sick Children. „Lisa has been staying at Drylaw Young People Centre for around 8 weeks. She describes this as all right and a not bad place to stay. Prior to this she was staying with her mother, but in a rage she pulled a knife on her mother and younger brother and this resulted in her being placed in Social Work care. Her Key Worker at the home is Colin Baxter. She describes him as a bastard who is nippy and does my head in. Her Social Worker is called Stephen Lloyd and she harbours similar feelings towards him. She has had a Social Worker for around 3 weeks she tells me having had no involvement before this. She has no problems with any of the other residents at the Centre getting on with everybody. „I understand that on Tuesday the 18th June she was rioting in the YPC throwing things aboutetc., The police were called and Lisa found herself locking herself in her bedroom. The police were unable to gain entrance and were threatening to kick the door in at which point she smashed the jar and cut herself superficially on her wrist. It required no stitches or dressings. She subsequently opened the door to the police and was taken to see a duty psychiatrist at Rillbank Terrace. She was unsure who this was but spent over half an hour in her presence. Lisa did not think that any follow up was arranged subsequent to this. I have however subsequently spoken to someone at Drylaw YPC and I am informed that Dr Fiona McTaggart (Specialist Registrar) and Staff Nurse Jocelyn Strachan plan to see her in the next week.,,Lisa describes having thoughts of self harm since around Christmas when her mother and father split up. Prior to this she describes herself as happy, without problems. As regards her sleep she tells me that prior to moving into the YPC she had initial insomnia virtually ever night. However, now she gets this only every couple of days and will tend to take an hour to get to sleep. During this time she thinks about her life but she mentioned no particular thought which dominates this. Once asleep she wakes up quite a lot but has no difficulty getting back to sleep. She wakes spontaneously in the morning at variable times. The earliest she wakes is 9.00am with her latest being 3.00pm. She estimates that she goes to sleep around midnight. She did add that she wakes up with the slightest noise feeling frightened. She also has a recurring disturbing dream involving street violence. „With regards to her appetite she describes as does not eat. She describes how for the past 5 weeks every time I eat I start being sick. When I asked her to differentiate she felt this was more likely to be due to stress rather than physical problem. Prior to 5 weeks ago she was eating well. „As regards to her energy she describes herself as having nae energy and she never goes out and never does anything. She thinks this is very unusual for her as she thinks she has only 10% of her usual energy. She last had energy months ago. As far as concentration is concerned she can read magazines, watch television and can watch a film all the way through. She gets enjoyment from doing things with fellow residents in the home on occasion but mostly her pleasure is mainly centred around drinks and drugs. She tells me she drinks around 3 times per week. Typically this is with friends from Pilton who come to see her and they go out and drink outside on the street together. She estimates she would usually drink around a quarter bottle of vodka. As far as drugs she takes anything I can get my hands on. She does not differentiate between them as they are all the same. She is largely unsuccessful in obtaining drugs and thus does not misuse them that often. „Mental State Examination:„Lisa was a thin 13 year old with a nose stud. She sat at relative ease throughout the interview but on occasion it would appear deliberately start to hyperventilate something which she made no effort to abate despite my suggestions. She was however, on the whole co-operative and pleasant in manner. She had reasonable eye contact and a relatively defensive body language. She displayed no bizarre behaviours, movements or postures. She was not tearful but did appear on 1 occasion close to tears. This was when I suggested that she had a lot of emotional problems for someone her age which she bottles up and is dealing with essentially on her own. As far as her mood objectively she was actually rather reactive and not obviously clinically depressed. She rated her mood as being 5 out of 10. She was not thought disordered. She denied thought insertion, withdrawal, or broadcast, ideas of reference or passivity phenomena. She did describe vague persecutory ideas. She states that this is the reason why she does not go out and thinks that some people might be watching her. She was unsure who these people are saying they could be any people. She is also unsure why they may wish to watch her. As regards odd perceptual experiences she describes a couple of episodes in the past 8 weeks since she first moved into the YPC where she is in bed and sees a dark dark shadow coming out of the wall. She is unsure if she is dreaming or awake when this happens but finds it a bit creepy. She

Episode Number	10000307853
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[illegible]

Surname/Forename	Scott, Lisa
UHPI Number	610094329B

Episode Number	I0000307853
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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0000307854 Prof Neal G Uren 08/04/2004	If you need further information regarding this admission please telephone on 0131 242 21438,,DIAGNOSIS: ,,1 HAEMATEMESIS, POSSIBLY SECONDARY TO GASTRITIS,2 DELIBERATE SELF HARM AND SELF POISONING PREVIOUSLY,,HISTORY: ,,This 15 year old mother one, presented with an episode of haematemesis and a 2-3 day history of tightness when swallowing. She denied any self poisoning or deliberate self harm.,,EXAMINATION: ,,Avoiding eye contact, haemodynamically stable, slight epigastric tenderness, no obvious inflammation,,INVESTIGATIONS/ PROCEDURES: ,,Hb normal, urea normal, CXR nil focal, PR FAB positive,,CLINICAL COURSE: ,,Lisa unfortunately self discharged before being assessed by the GI reg. She was to have a non-urgent endoscopy for possible gastritis with subsequent GI bleed. If she has any further haematemesis or melaena she warrants an urgent endoscopy,,DRUGS ON DISCHARGE: Nil,,FOLLOW UP ARRANGEMENTS: No routine follow up has been arranged.,,Yours sincerely,,,,,Dr A Martin,Senior House Officer,,smcg

Surname/Forename	Scott, Lisa
UHPI Number	610094329B

Episode Number	I0000307853
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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0000307855 Dr CA Kelly 24/03/2005	DIAGNOSIS:,,No specific treatment was required and the patient was discharged.,,Patient was detained under the Mental Health Act. No.,,PSYCHIATRIC ASSESSMENT:,,I reviewed Lisa in the early hours of the morning on 24th March 2005 in A&E at the Royal Infirmary. She had presented to A&E by ambulance earlier that evening with self inflicted cuts to bilateral forearm. These did not require medical intervention. Staff at A&E were concerned about ongoing suicidality and psychotic type presentation. No beds were available for admission to the toxicology ward overnight and staff were concerned that she may not be adequately managed in A&E overnight due to her apparent agitation. I was therefore called for urgent assessment of her mental state.,,Lisa is a 16 year old girl who is known to the YPU. She attended a clinic appointment with Dr McCabe (Consultant Psychiatrist at YPU) on 21.03.05. Unfortunately no notes were available at my time of assessment and I am not clear as to her diagnosis. I understand she has been known to Psychiatric services since 2001. She has a history of repeated deliberate self harm by cutting, overdose, burn and allegedly attempted electrocution. I understand she has had no previous admissions to YPU as a result and indeed has had no previous medical attention for this. She also has a history of experience of pseudo psychotic symptoms. This is in the form of a voice (Lulu) who may be heard in either internal or external space, who is described at the other side of Lisa and who may be contradictory or derogatory in tone. She first experienced this voice when living in secure accommodation and misusing drugs and alcohol at the time.,,Lisa felt that today she just couldn't go on living with this voice anymore. The only possible trigger that she disclosed to me was that she had been visited by Ricky, an ex-partner and father of her 2 year old son Kye. He had visited unexpectedly and Lisa felt upset when he left. She immediately, seeming on impulse cut herself. This was without clear suicidal intent. She told me she had done it for something to do and that because she recognised from the past that this would sometimes leave her distressed. Immediately after cutting herself, she called her friend, Susan. Susan was unable to visit so Lisa called the Samaritans, who advised she should attend A&E.,,By the time of my assessment, Lisa was not obviously agitated or distressed, in fact, she was sleeping in her chair and I had to wake her in order to review her. She presented as a casually dressed young girl with hair dyed bright pink. She maintained reasonable eye contact and rapport. She appeared reasonably relaxed, non-irritable, and non-aggressive. She was tearful at times but at other times appropriately reactive. Her speech was normal in all modalities. Subjectively she described her mood as can't be bothered, Objectively she appeared somewhat low but reactive. She described unusual ideas about her thoughts with relation to the voice of Lulu, stating that Lulu could put thoughts into her head or perhaps remove them and that perhaps she was under the influence of Lulu. Lisa stated that her experience of this voice had subsided since being in A&E as she felt comforted by the noise around her. There was no evidence that she was acutely psychotic or responding to external stimuli. She was orientated to time, place and person.,,Lisa was somewhat contradictory in her history. She was able to recount several positives about her life at the moment, including plans to begin a course in May, which she is looking forward to. She tells me she has a good group of friends and is visited by someone at least every day. her mum lives just up the road and cares for her 2 year old son Kye. It appears that she has a reasonable relationship with her mum. It appeared that Lisa does have a degree of optimism for the future, but on questioning she continued to describe thoughts that she can't be bothered going on anymore despite this. There was no evidence that she had any active suicidal plans and, although initially she suggested to A&E Staff that her self cutting had been under the influence of the voice, she later denied this, saying she had had control over her actions. There was no evidence that her actions had been psychotically driven or that there was on going psychotic experience. ,,I discussed her case with Dr Leonie Boeing (on call Registrar in Child & Adolescent Psychiatry). We felt that although Lisa would remain at long term high risk of repeated self harm in the future, that there was no imminent risk of harm to self or others at this time. Her suicidality and psychotic like experience appear stable and long standing. Her agitation and apparent psychosis which prompted the initial referral tonight for assessment appeared to have settled. It was therefore felt that it would not be appropriate to admit Lisa to inpatient psychiatric care but that in order to discharge her we would require to put in place a plan for more immediate follow up. It was agreed that Lisa would stay in the Royal Infirmary overnight in order for plans to be formalised in the morning.,,This morning I have discussed Lisa's case with Dr McCabe (Consultant Psychiatrist) to whom she is known. Dr McCabe has agreed that it would be appropriate to discharge Lisa today and that he will review her urgently at clinic at YPU on Tuesday 29th March 2005 at 9.15am. On the basis of her assessment last night, he feels that it would not be necessary for further review of her mental state prior to discharge this morning. Dr McCabe has advised that if Lisa is struggling over the weekend, then she can contact switchboard at the Royal Edinburgh Hospital to ask to speak to the on call psychiatrist for CAMHS. Nursing staff at the Royal Infirmary will pass this information on to her. She will therefore be discharged later this morning.,,If I can provide any further information please do not hesitate to contact me. Many thanks for your help.,,Yours sincerely,,,,Dr P. Compton,SHO in Psychiatry,,cc Dr McCabe,

Surname/Forename	Scott, Lisa
UHPI Number	610094329B

Episode Number	I0000307853
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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0000307856 Prof DN Bateman 12/01/2006	Diagnosis: Ingestion of diphenhydramine,,,This woman with a known history of previous DSH and known to the Young Person s Unit and psychiatric services, was admitted following ingestion of nine tablets of diphenhydramine (Nytol) which she had bought herself. She was determined to self-discharge and was allowed to do so that night. No medical follow up has been arranged.,,Yours sincerely,,,,,,Professor D N Bateman,Consultant Physician,

Radiology Reports

XR Skull

XR Skull

Clinical details

intoxicated and self harm. also assault, this morning bilateral periorbital brusiing and swelling - need to exclude base of skull fracture.

Report

XR Skull

No skull vault fracture. No air fluid level in sphenoid sinus on lateral view.

LW

Reporting Radiologist: Dr Li Wong

Report Information

Requestor

Requesting Location (RIECAA6) AMU Bay 6

Report Identifier 5541990

Sample Date 12/07/2009 09:49:00