

NHS Forth Valley

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Stirling
FK9 4SW



Telephone: 01324 566292
Fax:

Private and Confidential

MMA Legal
43-59 Princes Street
Stockport
SK1 1RY

Date: 20 May 2026
Your Ref: 100321
Our Ref: GDP/0021483

Enquiries to: Legal Admin Team
Extension:
Direct Line: 01324 566292

Dear Sir/Madam

Re: David Adams 07/05/1957

With reference to your recent access request please find enclosed copy health records as requested.

Please note that records held by Forth Valley Royal Hospital will include records for Falkirk Community Hospital and Stirling Health & Care Village.

If we can be of any further assistance then please do not hesitate to contact us.

Yours Sincerely

A handwritten signature in black ink, appearing to be 'EN' followed by a long horizontal stroke.

Legal Admin Team

E-mail: fv.healthrecs-legal@nhs.scot

NHS Forth Valley
Headquarters: Carseview House, Castle Business Park, Stirling, FK9 4SW

nhsforthvalley.com [/nhsforthvalley](https://www.facebook.com/nhsforthvalley)
 [@nhsforthvalley](https://twitter.com/nhsforthvalley) [@nhsforthvalley](https://www.instagram.com/nhsforthvalley)

SCI Store - Forth Valley - Patient Result Report

Report ID: PH004424N/24

Sample Collected: 05/04/2024 16:02:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
David Adams Name Changed	0705570592	07/05/1957	69	CRICHTON, ANNE-MARIE	Kinneil Medical Practice		

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Wright, Dr Fiona	(FVOMFS) Oral Maxillary Facial Surgery	PH004424N/24	Pathology	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	Status
N/A	05/04/2024 16:02:00	N/A	10/04/2024 15:15:57	Active

Report

Clinical Details

History of low grade dysplasia 2016. Smoker, moderate alcohol intake. White striated pigmented areas on right buccal and right soft palate. Quite friable on biopsy. Ellipse from right buccal punch 5mm from right soft palate ? dysplasia.

A. Right Buccal Biopsy

A mucosal ellipse 10x5x2mm with white surface. Bisected longitudinally.

Microscopy

Specimen A comprises squamous mucosa with mild squamous hyperplasia and prominent melanin pigment incontinence and melanophages in the lamina propria.

There is no evidence of an increase in melanocytes or squamous dysplasia.

The appearances are suggestive of either a post inflammatory reactive change or an oral melanotic macule. Please correlate with the clinical findings.

Summary A: Morphologic Description.

B. Right Soft Palate Biopsy

A 4mm punch biopsy to a depth of 2mm.

Microscopy

Specimen B comprises a punch biopsy of oral squamous mucosa with marked crosscutting artefact.

There is prominent hyperkeratosis and mild spongiosis. There is no evidence of dysplasia or significant inflammation.

Summary B: Keratosis.

Dr Nadja Melquiot

Last 5 users to access this result

Name	System	Location	Time
oliver.mitchell	Clinical Portal	Forth Valley Portal Server	24/03/2025 13:19:41
cara.craig	Clinical Portal	Forth Valley Portal Server	24/03/2025 08:28:28
callum.weir	Clinical Portal	Forth Valley Portal Server	17/06/2024 15:23:23
fiona.wright3	Clinical Portal	Forth Valley Portal Server	17/05/2024 12:50:43
Cancer Audit Tracker System	Cats	ICT Forth Valley	11/04/2024 09:39:42

Printed By: Jordan Rae on 12/05/2026 10:46:27

SCI Store - Forth Valley - Patient Result Report

Report ID: PH004424N/24

Sample Collected: 05/04/2024 16:02:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
David Adams Name Changed	0705570592	07/05/1957	69	CRICHTON, ANNE-MARIE	Kinneil Medical Practice		

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Wright, Dr Fiona	(FVOMFS) Oral Maxillary Facial Surgery	PH004424N/24	Pathology	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	Status
N/A	05/04/2024 16:02:00	N/A	10/04/2024 15:15:57	Active

Report**Clinical Details**

History of low grade dysplasia 2016. Smoker, moderate alcohol intake. White striated pigmented areas on right buccal and right soft palate. Quite friable on biopsy. Ellipse from right buccal punch 5mm from right soft palate ? dysplasia.

A. Right Buccal Biopsy

A mucosal ellipse 10x5x2mm with white surface. Bisected longitudinally.

Microscopy

Specimen A comprises squamous mucosa with mild squamous hyperplasia and prominent melanin pigment incontinence and melanophages in the lamina propria.

There is no evidence of an increase in melanocytes or squamous dysplasia.

The appearances are suggestive of either a post inflammatory reactive change or an oral melanotic macule. Please correlate with the clinical findings.

Summary A: Morphologic Description.

B. Right Soft Palate Biopsy

A 4mm punch biopsy to a depth of 2mm.

Microscopy

Specimen B comprises a punch biopsy of oral squamous mucosa with marked crosscutting artefact.

There is prominent hyperkeratosis and mild spongiosis. There is no evidence of dysplasia or significant inflammation.

Summary B: Keratosis.

Dr Nadja Melquiot

Last 5 users to access this result

Name	System	Location	Time
oliver.mitchell	Clinical Portal	Forth Valley Portal Server	24/03/2025 13:19:41
cara.craig	Clinical Portal	Forth Valley Portal Server	24/03/2025 08:28:28
callum.weir	Clinical Portal	Forth Valley Portal Server	17/06/2024 15:23:23
figna.wright3	Clinical Portal	Forth Valley Portal Server	17/05/2024 12:50:43
Cancer Audit Tracker System	Cats	ICT Forth Valley	11/04/2024 09:39:42

Printed By: Jordan Rae on 12/05/2026 10:46:27

SCI Store - Forth Valley - Patient Result Report

Report ID: MU811170P

Sample Collected: 18/06/2025 12:03:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
David Adams Name Changed	0705570592	07/05/1957	69	CRICHTON, ANNE-MARIE	Kinnell Medical Practice		

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Caleary, P/N Fiona	(26208_49) P/N Cheryl Cairney	MU811170P	Microbiology	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	Status
Midstream specimen of Urine	18/06/2025 12:03:00	N/A	19/06/2025 15:54:45	Active

Report**Midstream specimen of Urine****?Infection**

Red Blood Cells (u/l) :4

White Blood Cells (u/l) :0

Epithelial Cells (u/l) :0

Urine Culture

Urine microscopy indicates no culture required.

Test performed by UKAS accredited medical
Laboratory No.10825.**Normal Ranges**

Red Blood Cells 0 - 40 /u/l

White Blood Cells >400/u/l and negative culture is
considered sterile pyuria.

White Blood Cells >40 and <400/u1 with a negative culture,
consider further investigation if
clinically indicated.

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Printed By: Jordan Rae on 12/05/2026 10:48:01

SCI Store - Forth Valley - Patient Result Report

Report ID: HR636677A/06/25

Sample Collected: 18/06/2025 12:02:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
David Adams Name Changed	0705570592	07/05/1957	69	CRICHTON, ANNE-MARIE	Kinneil Medical Practice		

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Cairney, P/N Cheryl	(26208_49) P/N Cheryl Cairney	HR636677A/06/25	Routine	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	Status
Blood	18/06/2025 12:02:00	18/06/2025 19:08:00	18/06/2025 20:34:16	Active

Report

Full Blood Count

Cumulative

Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	157	130 - 170	g/L	
White Blood Count	8.4	4.0 - 10.0	10 ⁹ /L	
Platelet Count	222	150 - 410	10 ⁹ /L	
Red Blood Count	4.94	4.5 - 5.5	10 ¹² /L	
Mean Cell Volume	91.9	83.0 - 101.0	fl	
Packed Cell Volume	0.454	0.40 - 0.50		
Mean Cell Haemoglobin	31.8	27.0 - 32.0	pg	
Mean Cell Haemoglobin Conc.	346	315 - 345	g/L	A
Neutrophil Count	4.4	2.0 - 7.0	10 ⁹ /L	
Lymphocyte Count	2.9	1.0 - 3.0	10 ⁹ /L	
Monocyte Count	1.0	0.2 - 1.0	10 ⁹ /L	
Eosinophil Count	0.2	0.02 - 0.5	10 ⁹ /L	
Basophil Count	0.1	0.02 - 0.1	10 ⁹ /L	
Nucleated Red Blood Cells	0.00		10 ⁹ /L	

Hb A1c

Cumulative

Description	Value	Range	Unit	Normalcy Notes
HbA1c IFCC	38		mmol/mol	(IFCC)
Test Comments (IFCC) Target for good Diabetic Control is 48-59 mmol/mol				

Last 1 users to access this result

Name	System	Location	Time
WS Unit Test	UnitTestApp	SG033827	19/06/2025 07:00:07

Printed By: Jordan Rae on 12/05/2026 10:48:11

SCI Store - Forth Valley - Patient Result Report

Report ID: HR494439W/02/25

Sample Collected: 28/02/2025 08:24:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
David Adams Name Changed	0705570592	07/05/1957	69	CRICHTON, ANNE-MARIE	Kinnell Medical Practice		

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Webster, Dr Iain	(V60364K) Dr Iain Webster	HR494439W/02/25	Routine	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	Status
Blood	28/02/2025 08:24:00	28/02/2025 19:07:00	28/02/2025 20:55:10	Active

Report

Full Blood Count					Cumulative
Description	Value	Range	Unit	Normalcy Notes	
Haemoglobin	153	130 - 170	g/L		
White Blood Count	8.1	4.0 - 10.0	10 ⁹ /L		
Platelet Count	246	150 - 410	10 ⁹ /L		
Red Blood Count	4.71	4.5 - 5.5	10 ¹² /L		
Mean Cell Volume	92.1	83.0 - 101.0	fl		
Packed Cell Volume	0.434	0.40 - 0.50			
Mean Cell Haemoglobin	32.5	27.0 - 32.0	pg	A	
Mean Cell Haemoglobin Conc.	353	315 - 345	g/L	A	
Neutrophil Count	4.1	2.0 - 7.0	10 ⁹ /L		
Lymphocyte Count	2.8	1.0 - 3.0	10 ⁹ /L		
Monocyte Count	1.0	0.2 - 1.0	10 ⁹ /L		
Eosinophil Count	0.2	0.02 - 0.5	10 ⁹ /L		
Basophil Count	0.1	0.02 - 0.1	10 ⁹ /L		
Nucleated Red Blood Cells	0.00		10 ⁹ /L		
Hb A1c					Cumulative

Description	Value	Range	Unit	Normalcy Notes
HbA1c IFCC	37		mmol/mol	(IFCC)
Test Comments (IFCC) Target for good Diabetic Control is 48-59 mmol/mol				

Last 2 users to access this result

Name	System	Location	Time
wsmorse	wsmorse	wsmorse	03/03/2025 13:24:06
WS Unit Test	UnitTestApp	SG033827	03/03/2025 07:00:19

Printed By: Jordan Rae on 12/05/2026 10:48:21

SCI Store - Forth Valley - Patient Result Report

Report ID: HR941173R/12/24

Sample Collected: 08/12/2024 14:29:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
David Adams Name Changed	0705570592	07/05/1957	69	CRICHTON, ANNE-MARIE	Kinnell Medical Practice		

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Feltbower, Dr Stephen	(FVAE) Emergency Centre FVRH	HR941173R/12/24	Routine	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	Status
Blood	08/12/2024 14:29:00	08/12/2024 14:47:00	08/12/2024 15:11:19	Active

Report

Full Blood Count

Cumulative

Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	164	130 - 170	g/L	
White Blood Count	11.4	4.0 - 10.0	10 ⁹ /L	A
Platelet Count	361	150 - 410	10 ⁹ /L	
Red Blood Count	5.10	4.5 - 5.5	10 ¹² /L	
Mean Cell Volume	90.6	83.0 - 101.0	fl	
Packed Cell Volume	0.462	0.40 - 0.50		
Mean Cell Haemoglobin	32.2	27.0 - 32.0	pg	A
Mean Cell Haemoglobin Conc.	355	315 - 345	g/L	A
Neutrophil Count	7.8	2.0 - 7.0	10 ⁹ /L	A
Lymphocyte Count	2.5	1.0 - 3.0	10 ⁹ /L	
Monocyte Count	1.1	0.2 - 1.0	10 ⁹ /L	A
Eosinophil Count	0.0	0.02 - 0.5	10 ⁹ /L	A
Basophil Count	0.1	0.02 - 0.1	10 ⁹ /L	
Nucleated Red Blood Cells	0.00		10 ⁹ /L	

Last 3 users to access this result

<https://scistore.fv.scot.nhs.uk/StoreWeb/Restricted/Results/Result.aspx?PatientID=759564&TestReportID=29319319&SampleID=29329...> 12/05/2026

Name	System	Location	Time
wsmorse	wsmorse	wsmorse	19/12/2024 09:03:10
7509666	Clinical Portal	Forth Valley Portal Server	09/12/2024 10:21:58
7880099	Clinical Portal	Forth Valley Portal Server	08/12/2024 22:29:40

Printed By: Jordan Rae on 12/05/2026 10:48:28

SCI Store - Forth Valley - Patient Result Report

Report ID: HR611056X/03/24

Sample Collected: 25/03/2024 16:25:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
David Adams Name Changed	0705570592	07/05/1957	69	CRICHTON, ANNE-MARIE	Kinneil Medical Practice		

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Mitchell, Dr Oliver	(FVOMFS) Oral Maxillary Facial Surgery	HR611056X/03/24	Routine	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	Status
Blood	25/03/2024 16:25:00	25/03/2024 16:53:00	25/03/2024 18:08:45	Active

Report

Full Blood Count

Cumulative

Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	159	130 - 170	g/L	
White Blood Count	9.1	4.0 - 10.0	10 ⁹ /L	
Platelet Count	241	150 - 410	10 ⁹ /L	
Red Blood Count	4.83	4.5 - 5.5	10 ¹² /L	
Mean Cell Volume	89.6	83.0 - 101.0	fL	
Packed Cell Volume	0.433	0.40 - 0.50		
Mean Cell Haemoglobin	32.9	27.0 - 32.0	pg	A
Mean Cell Haemoglobin Conc.	367	315 - 345	g/L	A
Neutrophil Count	4.7	2.0 - 7.0	10 ⁹ /L	
Lymphocyte Count	3.0	1.0 - 3.0	10 ⁹ /L	
Monocyte Count	1.1	0.2 - 1.0	10 ⁹ /L	A
Eosinophil Count	0.1	0.02 - 0.5	10 ⁹ /L	
Basophil Count	0.1	0.02 - 0.1	10 ⁹ /L	
Nucleated Red Blood Cells	0.00		10 ⁹ /L	

Hb A1c

Cumulative

Description	Value	Range	Unit	Normalcy Notes
HbA1c IFCC	39		mmol/mol	(IFCC)
Test Comments (IFCC) Target for good Diabetic Control is 48-59 mmol/mol				

Last 2 users to access this result

Name	System	Location	Time
fiona.wright3	Clinical Portal	Forth Valley Portal Server	05/04/2024 14:43:35
nicola.shaw	Clinical Portal	Forth Valley Portal Server	26/03/2024 10:29:01

Printed By: Jordan Rae on 12/05/2026 10:48:36

SCI Store - Forth Valley - Patient Result Report

Report ID: HR927611V/10/23

Sample Collected: 31/10/2023 15:06:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
David Adams Name Changed	0705570592	07/05/1957	69	CRICHTON, ANNE-MARIE	Kinneil Medical Practice		

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Arogundade, Dr Folawemi	(25070_51) Dr Folawemi Arogundade	HR927611V/10/23	Routine	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	Status
Blood	31/10/2023 15:06:00	31/10/2023 19:28:00	31/10/2023 23:10:40	Active

Report

Full Blood Count

Cumulative

Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	159	130 - 170	g/L	
White Blood Count	9.2	4.0 - 10.0	10 ⁹ /L	
Platelet Count	257	150 - 410	10 ⁹ /L	
Red Blood Count	5.04	4.5 - 5.5	10 ¹² /L	
Mean Cell Volume	90.1	83.0 - 101.0	fL	
Packed Cell Volume	0.454	0.40 - 0.50		
Mean Cell Haemoglobin	31.5	27.0 - 32.0	pg	
Mean Cell Haemoglobin Conc.	350	315 - 345	g/L	A
Neutrophil Count	5.0	2.0 - 7.0	10 ⁹ /L	
Lymphocyte Count	2.9	1.0 - 3.0	10 ⁹ /L	
Monocyte Count	1.1	0.2 - 1.0	10 ⁹ /L	A
Eosinophil Count	0.2	0.02 - 0.5	10 ⁹ /L	
Basophil Count	0.1	0.02 - 0.1	10 ⁹ /L	
Nucleated Red Blood Cells	0.00		10 ⁹ /L	

Hb A1c

Cumulative

Description	Value	Range	Unit	Normalcy Notes
HbA1c IFCC	39		mmol/mol	(IFCC)
Test Comments (IFCC) Target for good Diabetic Control is 48-59 mmol/mol				

Last 1 users to access this result

Name	System	Location	Time
WS Unit Test	UnitTestApp	SG033827	01/11/2023 07:00:20

Printed By: Jordan Rae on 12/05/2026 10:48:46

SCI Store - Forth Valley - Patient Result Report

Report ID: HR812082A/03/22

Sample Collected: 25/03/2022 10:13:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
David Adams Name Changed	0705570592	07/05/1957	69	CRICHTON, ANNE-MARIE	Kinneil Medical Practice		

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Dawson, Dr Anthony	(V56201) Dr Anthony Dawson	HR812082A/03/22	Routine	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	Status
Blood	25/03/2022 10:13:00	25/03/2022 13:01:00	25/03/2022 15:50:21	Active

Report

Full Blood Count

Cumulative

Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	162	130 - 170	g/L	
White Blood Count	9.7	4.0 - 10.0	10 ⁹ /L	
Platelet Count	158	150 - 410	10 ⁹ /L	
Red Blood Count	5.31	4.5 - 5.5	10 ¹² /L	
Mean Cell Volume	89.1	83.0 - 101.0	fL	
Packed Cell Volume	0.473	0.40 - 0.50		
Mean Cell Haemoglobin	30.5	27.0 - 32.0	pg	
Mean Cell Haemoglobin Conc.	342	315 - 345	g/L	
Neutrophil Count	5.8	2.0 - 7.0	10 ⁹ /L	
Lymphocyte Count	2.7	1.0 - 3.0	10 ⁹ /L	
Monocyte Count	0.9	0.2 - 1.0	10 ⁹ /L	
Eosinophil Count	0.2	0.02 - 0.5	10 ⁹ /L	
Basophil Count	0.1	0.02 - 0.1	10 ⁹ /L	
Nucleated Red Blood Cells	0.00		10 ⁹ /L	

Hb A1c

Cumulative

Description	Value	Range	Unit	Normalcy Notes
HbA1c IFCC	37		mmol/mol	(IFCC)
Test Comments (IFCC) Target for good Diabetic Control is 48-59 mmol/mol				

Last 1 users to access this result

Name	System	Location	Time
WS Unit Test	UnitTestApp	SG033827	25/03/2022 19:00:14

Printed By: Jordan Rae on 12/05/2026 10:49:15

SCI Store - Forth Valley - Patient Result Report

Report ID: HR863606Q/01/21

Sample Collected: 14/01/2021 11:13:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
David Adams Name Changed	0705570592	07/05/1957	69	CRICHTON, ANNE-MARIE	Kinneil Medical Practice		

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Dawson, Dr Anthony	(V56201) Dr Anthony Dawson	HR863606Q/01/21	Routine	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	Status
Blood	14/01/2021 11:13:00	14/01/2021 15:08:00	14/01/2021 19:34:25	Active

Report**Full Blood Count**

Cumulative

Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	171	130 - 170	g/L	A
White Blood Count	9.8	4.0 - 10.0	10 ⁹ /L	
Platelet Count	225	150 - 410	10 ⁹ /L	
Red Blood Count	5.48	4.5 - 5.5	10 ¹² /L	
Mean Cell Volume	89.6	83.0 - 101.0	fl	
Packed Cell Volume	0.491	0.40 - 0.50		
Mean Cell Haemoglobin	31.2	27.0 - 32.0	pg	
Mean Cell Haemoglobin Conc.	348	315 - 345	g/L	A
Neutrophil Count	5.9	2.0 - 7.0	10 ⁹ /L	
Lymphocyte Count	2.7	1.0 - 3.0	10 ⁹ /L	
Monocyte Count	1.1	0.2 - 1.0	10 ⁹ /L	A
Eosinophil Count	0.1	0.02 - 0.5	10 ⁹ /L	
Basophil Count	0.1	0.02 - 0.1	10 ⁹ /L	
Nucleated Red Blood Cells	0.00		10 ⁹ /L	

ESR

Cumulative

Description	Value	Range	Unit	Normalcy Notes
Erythrocyte Sed. Rate	2	2 - 30	mm in 1st hour	

Hb A1c				Cumulative
Description	Value	Range	Unit	Normalcy Notes
HbA1c IFCC	40		mmol/mol	(IFCC)
Test Comments (IFCC) Target for good Diabetic Control is 48-59 mmol/mol				

Last 1 users to access this result			
Name	System	Location	Time
WS Unit Test	UnitTestApp	SG033827	15/01/2021 07:00:13

Printed By: Jordan Rae on 12/05/2026 10:49:23

SCI Store - Forth Valley - Patient Result Report

Report ID: HR632806V/05/20

Sample Collected: 01/05/2020 10:15:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
David Adams Name Changed	0705570592	07/05/1957	69	CRICHTON, ANNE-MARIE	Kinnell Medical Practice		

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Blackmore, Dr Michael	(5700_2) Dr Michael Blackmore	HR632806V/05/20	Routine	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	Status
Blood	01/05/2020 10:15:00	01/05/2020 12:44:00	01/05/2020 13:15:08	Active

Report

Full Blood Count				Cumulative
Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	139	130 - 170	g/L	
White Blood Count	6.4	4.0 - 10.0	10 ⁹ /L	
Platelet Count	155	150 - 410	10 ⁹ /L	
Red Blood Count	4.87	4.5 - 5.5	10 ¹² /L	
Mean Cell Volume	84.8	83.0 - 101.0	fl	
Packed Cell Volume	0.413	0.40 - 0.50		
Mean Cell Haemoglobin	28.5	27.0 - 32.0	pg	
Mean Cell Haemoglobin Conc.	337	315 - 345	g/L	
Neutrophil Count	2.9	2.0 - 7.0	10 ⁹ /L	
Lymphocyte Count	2.4	1.0 - 3.0	10 ⁹ /L	
Monocyte Count	1.0	0.2 - 1.0	10 ⁹ /L	
Eosinophil Count	0.1	0.02 - 0.5	10 ⁹ /L	
Basophil Count	0.0	0.02 - 0.1	10 ⁹ /L	A
Nucleated Red Blood Cells	0.00		10 ⁹ /L	

Last 2 users to access this result

<https://scistore.fv.scot.nhs.uk/StoreWeb/Restricted/Results/Result.aspx?PatientID=759564&TestReportID=22625647&SampleID=22629...> 12/05/2026

Name	System	Location	Time
linda.buchanan	Clinical Portal	Forth Valley Portal Server	05/06/2020 13:49:47
WS Unit Test	UnitTestApp	SG033827	01/05/2020 15:00:13

Printed By: Jordan Rae on 12/05/2026 10:49:33

SCI Store - Forth Valley - Patient Result Report

Report ID: HS431801V/03/20

Sample Collected: 10/03/2020 08:57:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
David Adams Name Changed	0705570592	07/05/1957	69	CRICHTON, ANNE-MARIE	Kinnell Medical Practice		

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Blackmore, Dr Michael	(5700_2) Dr Michael Blackmore	HS431801V/03/20	Special	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	Status
Blood	10/03/2020 08:57:00	10/03/2020 12:28:00	30/03/2020 15:10:25	Active

Report**Autoimmune Profile**

Report From Immunology NHS Greater Glasgow & Clyde

Autoimmune profile

Tissue Transglutaminase A/B === (TTG)

Test Comments

(TTG) Normal= <= 7.0, Equivocal= 7.0 -10.0 Positive = >10.0

(TTG)

(TTG) Repeat request:

(TTG) Following result is from 5/3/20 and is valid for 155 days

(TTG) TTG (IgA) 0.3 U/ml

(TTG)

Sample Comments

posted on 11/3/20

Last 2 users to access this result

Name	System	Location	Time
Iinda.buchanan	Clinical Portal	Forth Valley Portal Server	05/06/2020 13:49:49
WS Unit Test	UnitTestApp	SG033827	30/03/2020 19:00:09

Printed By: Jordan Rae on 12/05/2026 10:49:41

SCI Store - Forth Valley - Patient Result Report

Report ID: HR598262E/03/20

Sample Collected: 10/03/2020 08:57:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
David Adams Name Changed	0705570592	07/05/1957	69	CRICHTON, ANNE-MARIE	Kinnell Medical Practice		

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Blackmore, Dr Michael	(5700_2) Dr Michael Blackmore	HR598262E/03/20	Routine	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	Status
Blood	10/03/2020 08:57:00	10/03/2020 12:27:00	10/03/2020 13:15:12	Active

Report

Full Blood Count

Cumulative

Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	135	130 - 170	g/L	
White Blood Count	5.3	4.0 - 10.0	10 ⁹ /L	
Platelet Count	155	150 - 410	10 ⁹ /L	
Red Blood Count	4.83	4.5 - 5.5	10 ¹² /L	
Mean Cell Volume	85.1	83.0 - 101.0	fl	
Packed Cell Volume	0.411	0.40 - 0.50		
Mean Cell Haemoglobin	28.0	27.0 - 32.0	pg	
Mean Cell Haemoglobin Conc.	328	315 - 345	g/L	
Neutrophil Count	2.5	2.0 - 7.0	10 ⁹ /L	
Lymphocyte Count	1.9	1.0 - 3.0	10 ⁹ /L	
Monocyte Count	0.8	0.2 - 1.0	10 ⁹ /L	
Eosinophil Count	0.1	0.02 - 0.5	10 ⁹ /L	
Basophil Count	0.0	0.02 - 0.1	10 ⁹ /L	A
Nucleated Red Blood Cells	0.00		10 ⁹ /L	

Last 1 users to access this result

Name	System	Location	Time
WS Unit Test	UnitTestApp	SG033827	10/03/2020 15:00:38

Printed By: Jordan Rae on 12/05/2026 10:49:52

SCI Store - Forth Valley - Patient Result Report

Report ID: HS431570L/03/20

Sample Collected: 05/03/2020 10:06:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
David Adams Name Changed	0705570592	07/05/1957	69	CRICHTON, ANNE-MARIE	Kinneil Medical Practice		

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Blackmore, Dr Michael	(5700_2) Dr Michael Blackmore	HS431570L/03/20	Special	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	Status
Blood	05/03/2020 10:06:00	05/03/2020 12:18:00	30/03/2020 14:15:10	Active

Report

Autoimmune Profile

Report From Immunology NHS Greater Glasgow & Clyde

Autoimmune profile

Cumulative

Description	Value	Range	Unit	Normalcy Notes
Tissue Transglutaminase A/B	0.3	0.0 - 7.0	U/ml	(TTG)

Set Comments

If screening for coeliac disease, this result is only valid if the person was

eating gluten at least twice a day for previous 6 weeks.

If known to have coeliac disease, this negative result suggests adherence to gluten free diet.

Test Comments

(TTG) Normal= <= 7.0, Equivocal= 7.0 -10.0 Positive = >10.0

Sample Comments

posted 06 march

Last 2 users to access this result

Name	System	Location	Time
linda.buchanan	Clinical Portal	Forth Valley Portal Server	05/06/2020 13:49:52
WS Unit Test	UnitTestApp	SG033827	30/03/2020 15:00:12

Printed By: Jordan Rae on 12/05/2026 10:49:59

SCI Store - Forth Valley - Patient Result Report

Report ID: HR594124X/03/20

Sample Collected: 05/03/2020 10:06:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
David Adams Name Changed	0705570592	07/05/1957	69	CRICHTON, ANNE-MARIE	Kinneil Medical Practice		

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Blackmore, Dr Michael	(5700_2) Dr Michael Blackmore	HR594124X/03/20	Routine	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	Status
Blood	05/03/2020 10:06:00	05/03/2020 12:19:00	05/03/2020 13:35:09	Active

Report**Full Blood Count**

Cumulative

Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	137	130 - 170	g/L	
White Blood Count	5.1	4.0 - 10.0	10 ⁹ /L	
Platelet Count	155	150 - 410	10 ⁹ /L	
Red Blood Count	4.97	4.5 - 5.5	10 ¹² /L	
Mean Cell Volume	84.5	83.0 - 101.0	fl	
Packed Cell Volume	0.420	0.40 - 0.50		
Mean Cell Haemoglobin	27.6	27.0 - 32.0	pg	
Mean Cell Haemoglobin Conc.	326	315 - 345	g/L	
Neutrophil Count	2.3	2.0 - 7.0	10 ⁹ /L	
Lymphocyte Count	2.0	1.0 - 3.0	10 ⁹ /L	
Monocyte Count	0.7	0.2 - 1.0	10 ⁹ /L	
Eosinophil Count	0.1	0.02 - 0.5	10 ⁹ /L	
Basophil Count	0.0	0.02 - 0.1	10 ⁹ /L	A
Nucleated Red Blood Cells	0.00		10 ⁹ /L	

Hb A1c

Cumulative

Description	Value	Range	Unit	Normalcy Notes
HbA1c IFCC	39		mmol/mol	(IFCC)
Test Comments (IFCC) Target for good Diabetic Control is 48-59 mmol/mol				

Last 1 users to access this result

Name	System	Location	Time
WS Unit Test	UnitTestApp	SG033827	05/03/2020 15:00:22

Printed By: Jordan Rae on 12/05/2026 10:50:06

SCI Store - Forth Valley - Patient Result Report

Report ID: HR589993K/10/18

Sample Collected: 30/10/2018 11:28:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
David Adams Name Changed	0705570592	07/05/1957	69	CRICHTON, ANNE-MARIE	Kinneil Medical Practice		

Report Details

Report Requestor	Requestor Location	Report Identifier	Discipline	Referral Source
Jambor, Dr Adela	(60496) Dr Adela Jambor	HR589993K/10/18	Routine	N/A
Sample Type	Sample Collected	Sample Received	Processed Into Store	Status
Blood	30/10/2018 11:28:00	30/10/2018 18:39:00	30/10/2018 19:34:19	Active

Report

Full Blood Count

Cumulative

Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	158	130 - 170	g/l	
White Blood Count	9.5	4 - 10	10 ⁹ /l	
Platelet Count	214	150 - 410	10 ⁹ /l	
Red Blood Count	5.17	4.5 - 5.5	10 ¹² /l	
Mean Cell Volume	92.6	83 - 101	fl	
Packed Cell Volume	0.479	0.40 - 0.50		
Mean Cell Haemoglobin	30.6	27 - 32	pg	
Mean Cell Haemoglobin Conc.	330	315 - 345	g/l	
Neutrophil Count	4.6	2.0 - 7.0	10 ⁹ /l	
Lymphocyte Count	3.4	1.0 - 3.0	10 ⁹ /l	A
Monocyte Count	1.2	0.2 - 1.0	10 ⁹ /l	A
Eosinophil Count	0.2	0.02 - 0.5	10 ⁹ /l	
Basophil Count	0.1	0.02 - 0.1	10 ⁹ /L	
Nucleated Red Blood Cells	0.00		10 ⁹ /l	

Last 1 users to access this result

<https://scistore.fv.scot.nhs.uk/StoreWeb/Restricted/Results/Result.aspx?PatientID=759564&TestReportID=20516500&SampleID=20518...> 12/05/2026

Name	System	Location	Time
WS Unit Test	UnitTestApp	SG033827	31/10/2018 07:00:20

Printed By: Jordan Rae on 12/05/2026 10:50:12

Please tick appropriate box

CLINICAL NOTES

NURSING NOTES

PROGRESS NOTES

Consultant

Write - imprint or Attach Label

Surname

Forenames

CHI

Address

CHI NO: 0705570592

CRN:

David ADAMS

10 DOUGLAS AVENUE

07/05/1957

M

GRANGEMOUTH

FK3 0LD

Date and Time

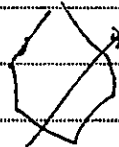
8/8/22

LIZMAN IABAR COF UROLOGY

65 y/o male

- Referred in July with chronic ^{right} sided testicular pain for 'months to a year'
- No clear onset but has been getting worse last few weeks
- States can be pain free some days, no regular pattern.
- No previous trauma.
- No LUTS passing urine well, vit haematuria.
- Had opflexuron for 3EO + prescribed Naproxen which did not help
- Pt admits to not taking analgesia regularly and only taking when pain is at absolute worst.
- US scan - 2 simple cysts on ~~right~~ right and multiloculated anovular cyst on left.
- Otherwise normal testes.
- States has scratches (left leg) which can cause itching.
- PMH / Grave's disease

O/E



Abdo exam

No palpable hernias.

Genitalia - left testicle NAD

- right - difficult to palpate epididymal cysts. Low tendr at lower pole but unable to palpate cyst. No erythema, swelling.

Please tick appropriate box

CLINICAL NOTES

☐

NURSING NOTES

☐

PROGRESS NOTES

☐

Consultant

Write - imprint or Attach Label

Surname..... Hospital No.....

Forenames..... Sex.....

CHI..... D. of B.....

Address.....

Ward / Dept.....

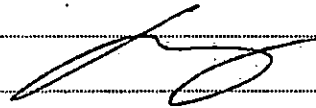
Date and Time

Imp/ Chronic scrotal pain
No gross abnormality on US testes

Plan 1. Encourage analgesia use, conservative management

2. Explained if surgically remove cysts then may have risks of operative complications, risk of ongoing/worsening pain despite intervention

3. Pt opted to continue with analgesia and take regularly. Worsening advised if ne.

 JAC CDF

VIRTUAL FRACTURE CLINIC
TRIAGE FORM

NHS
Forth Valley

David
Adams
0705570592

DATE 5.3.2017

7/3/17

DIAGNOSIS:

Left Shoulder injury - possible grade 1
AC joint sprain. No fracture

TREATMENT:

Slings while sore

OUTCOME:

VIRTUAL DISCHARGE

☒

CONSULTANT CLINIC

☐

NURSE LED CLINIC

☐

APPOINTMENT TIMESCALE

DAYS

WEEKS

CONSULTANT SIGNATURE

ju

APPOINTMENT DATE AND TIME

DISCHARGED

PATIENT CONTACTED

YES

☒

NO

☐

MESSAGE LEFT

YES

☐

NO

☒

APPOINTMENT CONFIRMED BY LETTER

☐

DISCHARGE LETTER/LEAFLET SENT

☒

AC JOINT INJURY
LETTER

NURSE'S SIGNATURE

W. MacIntyre
L. MacIntyre

TRIAGE FORM

LIST OF VIRTUAL DISCHARGE LETTERS FOR SENDING TO PATIENTS.

PLEASE TICK LETTER TO BE SENT.		
Soft Tissue Injury Hand	Child STI Hand	
Hand Fracture	Child Hand Fracture	
Soft Tissue Elbow	Child Elbow	
Ankle Fracture	Child STI	
Ankle X-Ray	Child Thumb	
Soft Tissue Injury	Child Toe	
Thumb Injury	Child Foot	
Scaphoid Injury	Child STI Forearm/Wrist	
Toe Injury	Child Humeral Fracture	
Heel Injury	Child Wrist Fracture	
Foot Injury		
Wrist Injury		
Wrist Fracture		
Humeral Fracture		
Clavicle Fracture		
Displaced Clavicle Fracture	/	
AC Joint Injury	/	

Emergency Department
Forth Valley Royal Hospital

0705570592

0705570592

A&E No.16000040714

Surname	ADAMS	Forename	DAVID	Title: MR
Address:	10 DOUGLAS AVENUE, GRANGEMOUTH, STIRLINGSHIRE	Postcode	FK3 0LD	CHI No: 0705570592
Date of Birth:	07.05.57	Telephone:	01324 874396	
Sex:	M	Age:	59 yrs	

CHI Barcode:

0705570592

GP Name:	CRAWFORD GREGOR	Postcode	FK3 8AN
Address:	33 BONESS ROAD GRANGEMOUTH	Telephone:	01324 482653

Virtual

Clinic

Next of Kin	JANICE	Postcode	FK3 0LD
Relationship:	WIFE	Telephone:	01324 874396
Address:	10 DOUGLAS AVENUE, GRANGEMOUTH, STIRLINGSHIRE		

Manual CHI Entry:

Date of Attendance: 05.03.17 16:25

Date of Incident:

Presenting Complaint: L SHOULDER INJ

Age	Tetanus Cover:
	Allergies:
P=	BP= / RR= Sat= BM=
PF=	GCS=E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

V#C Tuesday 7/3/2017
09.40hrs

Clinical Notes

Seen by:

Time:

Patient called to assess injury, do shoulder, however complaining of general chest pain and SOB requires review by medical staff
~~Monteith~~
 GP

Monteith GPST 5/3/17 17:55

PC: (L) shoulder pain

HPC Altercation with son and his friend yesterday.
 He was pushed and slipped onto wet decking
 Was drunk last night and didn't notice pain.
 Today pain has ↑ throughout the day.
 Clo pain over AC-head at shoulder.
 No numbness or tingling in hand
 Pain only in upper chest when moves shoulder.

Tender over AC joint. Hand neurovascularly intact.

PMHx Prev alcohol dependence DHx Ibuprofen
 oneprazole

O/E GCS 15/15 NEWS=0
 Painful ECG: SE nil acute
 limited ROM due to pain.
 Swelling

Says no chest pain or SOB now - only earlier when moved shoulder.

XR: likely AC joint injury.

Plan Polysling. TTD of co-Cedamol 30/500

Guidelines Used: (Already takes regular Ibuprofen)

Ref virtual # Clinic

CHI: 0705570592 07/05/1957 M
 ADAMS
 DAVID
 10 DOUGLAS AVENUE,
 STIRLINGSHIRE
 FK3 0LD

Attach continuation sheets here

Attach here onto face of pocket

Monteith
 GPST

Clinical Notes	Write - Imprint or Attach Label	
	Surname:	Hospital no:
	Forenames:	Sex:
		D of B:
	Address:	
		Ward/Dept:
Patient:		

resultant:

Write - Imprint or Attach Label

Surname:

Hospital no:

Forenames:

• Sex:

D of B:

Address:

Ward/Dept:

Orthopaedic Fracture Clinic Record

PLEASE PRINT CLEARLY. ALSO SIGN & PRINT NAME AT ALL ENTRIES

[illegible]

FVRH Operation Note

Patient Name DAVID ADAMS

CHI 0705570592

Op Date 15 Jan 2007

Patient Details

CHI	0705570592
Hospital No	F140620
Name	DAVID ADAMS
Date of Birth	07 May 1957
Sex	Male
Patient Type	Daycase
Op Type	Scheduled
Op Date	15 Jan 2007
Specialty	UROLOGY
Theatre No	FVRH 3

Staff in Attendance

Team 1	Surgeon	MR SUBODH SETH
Team 1	Supervising Surgeon	MR MICHAEL SMITH
Team 1	Anaesthetist	DR LINZI MILLAR
Team 1	O.D.P.	SN KATHRYN CARRUTHERS
Team 1	Supervising Anaesthetist	DR ANDREW WOODS
Team 1	Scrub nurse	SN SUSANNA KUHN
Team 1	Floor nurse 1	TL LESLEY MEECHAN
Team 1	Floor nurse 2	S/N TRACY MIDDLETON
Team 1	Other	NA S CUNNINGHAM

Op Notes: Side	Op Notes: Info
----------------	----------------

Procedure 1	N153B00R	EXCISION OF EPIDIDYMAL CYST - RIGHT - N153B
INCISION TRANSVERSE SCROTAL		
TUNICA VAGINALIS OPENED AND TESTIS DELIVERED , 10MLS OF STRAW COLOURED FLUID. 8 MM MUTILOCULATED CYST IN THE HEAD OF EPIDIDYMIS.		
CYST ENUCLEATED. HAEMOSTASIS WITH DIATHERMY.		
TUNICA EVERTED WITH 3/0 VICRYL.		
TESTIS REPLACED IN THE SCROTUM AND DARTOS CLOSED WITH 3/0 VICRYL CONTINUOUS. SKIN WITH RAPIDE 4/0CONT. MATTRESS.		
17 MLS OF 0.5% CHIROCAINE TO SPERMATIC CORD AND SKIN.		
SCROTAL SUPPORT APPLIED.		
POST OP		
ANALGESIA		
NO FOLLOW UP		
OPCS4 Codes:	N153	
Procedure Definitions:		

Procedure 2	N111000R	HYDROCOELE SURGERY - RIGHT - N111
An incision was made obliquely in the right scrotum and developed through the layers over the tunica vaginalis. The tunica was opened and the hydrocele drained of clear straw coloured fluid.		
The testicle looked normal.		
The sac was excised leaving a rim of tunica some 1 cm. haemostasis was secured by diathermy and a continuous interlocking suture of 3/0 Vicryl was used to run round the incised edge of the tunica.		
The testicle was replaced in the scrotum which was closed with 3/0 Vicryl to dartos and interrupted 4/0 Vicryl Rapide.		
OPCS4 Codes:	N111	
Procedure Definitions:		

Materials Used Desc	Qty	LOT1	LOT2	LOT3	LOT4	Item Code
MCDONALD DISSECTOR & TAG, MEDIPLAST 50 & 75	1	1023779				1023779
SMALL BASIC	1	1032886				1032886
NIFA0322 LARYNGEAL MASK SIZE 4	1	1036937				1036937

THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

FVRH Operation Note

Patient Name DAVID ADAMS

CHI 0705570592

Op Date 15 Jan 2007

****End of Report****

Outpatient Clinic Note

Name: **David Adams**CHI: **0705570592**

Registered GP Name:

CRICHTON, ANNE-MARIE

Registered GP Practice:

Kinneil Medical Practice

Clinic attended: Oral and Maxillofacial Surgery

Clinic (From PAS): PPC Returns

Date/Time of clinic: Mon 24 Mar 2025 13:30

Lead clinician for clinic: PPC Returns

Presenting Complaint, Investigations, Results, Diagnosis:

Pt DNAed PPC review

Bx completed 5.4.24

R b.mucosa white striated pigmented area- appearances are suggestive of either a post inflammatory reactive change or an oral melanotic macule

R soft palate white striated pigmented area- keratosis- prominent hyperkeratosis and mild spongiosis. There is no evidence of dysplasia or significant inflammation

History-

prev omfs 2019= discharged

omfs path 29/4/16 = low grade dysplasia LBM. low grade dysplasia (upper end of low grade) L soft palate

DW OM (reviewed photographs)- happy to discharge, no further appt

Letter sent

C.Weir 277487

0 Medication Recommendation(s):

No (new, stop or alter) medication recommendation(s) entered/recorded

0 Follow Up action(s):

No 'follow up' info recorded/entered

Further Info:

No 'further info' recorded/entered

Form completed by:

Callum Weir on Mon 24 March 2025 at 13:39

Form sent to:

Secondary care document management system(s), eg. EDMS

Outpatient Clinic Note

Name: **David Adams**CHI: **0705570592**

Registered GP Name:

CRICHTON, ANNE-MARIE

Registered GP Practice:

Kinnell Medical Practice

Clinic attended: Oral and Maxillofacial Surgery

Clinic (From PAS): Dr Callum Weir Week 2

Date/Time of clinic: Thu 21 Nov 2024 10:40

Lead clinician for clinic: Mr Callum Weir

Presenting Complaint, Investigations, Results, Diagnosis:

3/12 rv

Bx completed 5.4.24

R b.mucosa white striated pigmented area- appearances are suggestive of either a post inflammatory reactive change or an oral melanotic macule

R soft palate white striated pigmented area- keratosis- prominent hyperkeratosis and mild spongiosis. There is no evidence of dysplasia or significant inflammation

History-

prev omfs 2019= discharged

omfs path 29/4/16 = low grade dysplasia LBM. low grade dysplasia (upper end of low grade) L soft palate

Nil pt concerns

OE-

- scarred/rough white lesions R b.mucosa

- bilateral soft palate mixed red-white lesions, soft to touch

Smoking habit 10cigs daily, long term smoker. Pt not interested in quitting as quit once before and get ill, blames the smoking

Today- clinical photographs taken (camera ooa so used mobile)

Had previously considered discharge if well, but given clinical picture and smoking habit, to continue to be reviewed.

Plan-

1. 4/12 rv PPC returns

C.Weir 277487

0 Medication Recommendation(s):

No (new, stop or alter) medication recommendation(s) entered/recorded

0 Follow Up action(s):

No 'follow up' info recorded/entered

Further Info:

No 'further info' recorded/entered

Form completed by:

Callum Weir on Thu 21 November 2024 at 12:07

Form sent to:

Secondary care document management system(s), eg. EDMS



THIS IS A RECONSTRUCTED DOCUMENT. IT IS NOT A COPY OF THE ORIGINAL.



Outpatient Clinic Note

Name: **David Adams**CHI: **0705570592**
NHS
 Forth Valley

Registered GP Name:

CRICHTON, ANNE-MARIE

Registered GP Practice:

Kinneil Medical Practice

Clinic attended: Oral and Maxillofacial Surgery

Clinic (From PAS): PPC Returns

Date/Time of clinic: Mon 17 Jun 2024 15:10

Lead clinician for clinic: PPC Returns

Presenting Complaint, Investigations, Results, Diagnosis:

Path result rv

Bx completed 5.4.24

R b.mucosa white striated pigmented area- appearances are suggestive of either a post inflammatory reactive change or an oral melanotic macule.

R soft palate white striated pigmented area- keratosis- prominent hyperkeratosis and mild spongiosis. There is no evidence of dysplasia or significant inflammation

CO- nil issues since bx

OE-

- R b.mucosa and R soft palate has similar lesion- pigmented-white lesion. Soft to touch, no ulceration, not raised, no rolled margins

Non concerning results

Smoking habit 10cigs daily, long term smoker. Pt not interested in quitting as quit once before and get ill, blames the smoking

Plan-

3/12 f2f rv. If sound then dc

C.Weir 277487

0 Medication Recommendation(s)

No (new, stop or alter) medication recommendation(s) entered/recorded

Follow Up action(s):

No 'follow up' info recorded/entered

Further Info:

No 'further info' recorded/entered

Form completed by:

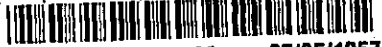
Callum Weir on Mon 17 June 2024 at 15:34

Form sent to:

Secondary care document management system(s), eg. EDMS

Minor Oral Surgery Treatment Record

Patient Label:

 CHI NO: 0705570592 CRN: David ADAMS 6 SALMON COURT SCHOOL BRAE BO'NESS EH51 9HF	07/05/1957 M
---	-------------------------------

Proposed Procedure: MOUTH BIOPSY X2
 Consultant: MR AIDAN GRAHAM
 Consultation Date: 5/4/24

Surgical Pause:

Has the patient confirmed his/her identity? ☒
 Medical history checked ☒ Allergies ☒ Up to date medication list ☒
 Antiplatelet/anticoagulants ☒ Mobility status ☒
 Consent form signed: ☒

Discharge:

Written and verbal instructions given ☒
 Haemostasis checked ☒

Sharps Count:

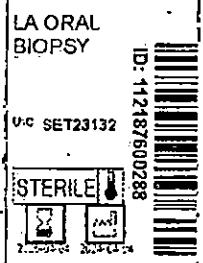
Pre - op:	Post - op:
Needle: 1	Needle: 1
Local anaesthetic: 1	Local anaesthetic: 1
Blade: 1	Blade: 1
Punch: 1	Punch: 1
Suture: 1	Suture: 1
Irrigation syringe:	Irrigation syringe:
Other:	Other:

Specimens: (please circle)

Type: Biopsy Swab Aspirate
 Number: 2
 Destination: Microbiology Pathology
 Urgency: Urgent Routine

Operator Signature/ print: _____

Nurse Signature/ print: _____



Outpatient Clinic Note

Name: **David Adams**CHI: **0705570592**

Registered GP Name:

CRICHTON, ANNE-MARIE

Registered GP Practice:

Kinnell Medical Practice

Clinic attended: Oral and Maxillofacial Surgery

Clinic (From PAS): Ms Fiona Wright Locals week 1

Date/Time of clinic: Fri 05 Apr 2024 15:30

Lead clinician for clinic: Ms Fiona Wright Locals

Presenting Complaint, Investigations, Results, Diagnosis:

RFA: Bx of right buccal, right soft palate
PPC refCO: On abx from last visit, improvement in pain LHS sub mand
Aware of prev dysplasia dx from bxExplained procedure for bx under LA incision sutures post op pain swelling bleeding bruising infection
/CG

Bloods PT 12.3, fine to proceed

TX:
3ml 2% lignocaine + 1:80k adrenaline
ellipse right buccal - quite friable on sampling - closure 4/0 VRS
5mm punch right soft palate, bipolar
HA POIG V + W

Was feeling light headed so given glucose drink, recovered well

Encouraged smoking cessation and alcohol reduction - patient states when he stopped 3 years ago, he became unwell, lost weight and had COVID

Review with results on O Mitchell clinic 4 weeks

F Wright SpDr OMFS 227393

0 Medication Recommendation(s):

No (new, stop or alter) medication recommendation(s) entered/recorded

0 Follow Up action(s):

No 'follow up' info recorded/entered

Further Info:

No 'further info' recorded/entered

Form completed by:

Fiona Wright on Fri 05 April 2024 at 16:14

Form sent to:

Secondary care document management system(s), eg. EDMS

DAVID ADAMS
6 JAZZMAN COURT
BURNES

7 1305590592

RE: MR ADAMS

PERICULUM

ADAMS 2 Day

SEND 56 TABLETS

LABEL 1x TABLETS

4x DAILY

ADAMS

1 Adalcol

1 Adalcol

25/12/4

Haematology
Falkirk FK5 4WR

TEL: 01324 567084

Forth Valley Royal Hospital

V 1 0 3 2

51020630484

Outpatient Clinic Note

Name: **David Adams**CHI: **0705570592**
NHS
 Forth Valley

Registered GP Name:

CRICHTON, ANNE-MARIE

Registered GP Practice:

Kinneil Medical Practice

Clinic attended: Oral and Maxillofacial Surgery

Clinic (From PAS): PPC Head and Neck

Date/Time of clinic: Mon 25 Mar 2024 15:00

Lead clinician for clinic: PPC Head and Neck

Presenting Complaint, Investigations, Results, Diagnosis:

New Ref re red/white patch R BM

PC
 asymp R BM - incidental finding GDP
 LLQ molar xla 1/52
 rev omfs 2019= discharged
 mfs path 29/4/16 = low grade dysplasia LBM. low grade dysplasia (upper end of low grade) L soft palate

MH F&W
 previous graves disease, no rv by hosp/GP
 NKDA
 Meds Panadol and ibuprofen PRN
 BMI 24
 MUST 0

Smoker 10 roll ups/day, hx 50 years. prev 40 roll ups/day
 Smoking cessation offered Y
 Alcohol 70cl vodka (28U) once a week
 Work retired paint decorator
 Live byself
 PS 0

++tender L neck when palpating subman region, no obvious enlargement/firmness. pain then felt to ear and temple all L
 poor OH
 fep tip tongue - pt aware -wishes to leave, dw pt options kuo or exc bx risks/bene
 R BM and R soft palate mixed white red slightly grey patches
 healing socket LLQ, mild tenderness

dysplasia R BM/R Soft palate

Dw pt findings and risks bene steps of inc bx R BM and R soft palate, VCG
 OPT today

dw Mr Mitchell, no CT at this stage

bloods today due to SH
 px chx mw and penV 7days
 green form for inc bx R BM and R soft palate

Plan
 inc bx R BM and R soft palate
 bloods taken today due to SH
 FU w Mr Mitchell, consideration of CT at this stage if continued tenderness L subman

0 Medication Recommendation(s):

No (new, stop or alter) medication recommendation(s) entered/recorded

0 Follow Up action(s):

No 'follow up' info recorded/entered

Further Info:

No 'further info' recorded/entered

Form completed by: Lucy Malcolm on Mon 25 March 2024 at 17:10

Form sent to: Secondary care document management system(s), eg. EDMS

CHI NO: 0705570592: 07/05/1957
 GRN:
 David ADAMS
 10 DOUGLAS AVENUE
 BRANDMOUTH
 FK3 0LD



ORAL AND MAXILLOFACIAL SURGERY - CONFIDENTIAL MEDICAL HISTORY

Please answer all the questions completely and truthfully. If you are not sure of any of the questions, or wish to discuss something in more detail, please inform the surgeon.

HOME PHONE NO. 0187 894444 MOBILE NO. 07736832664 OCCUPATION SCIENTIST

SMOKING STATUS:

☒ I have never smoked
☐ A smoker If yes for how long? _____ How many per day? _____
☐ An ex smoker If yes - when did you quit? _____ How long did you smoke for? _____

ALCOHOL STATUS: Do you consume alcohol?

☐ No
☒ Yes If yes - how many units on average per week? 2 (1 pint = 2 units / 1 glass wine = 2 units)

	Yes	No	Details
Are you aware of anything that you are allergic to?	☐	☒	If yes:
Do you suffer from the following;			
Any heart problems/conditions? i.e. Heart attack/high blood pressure/angina/pacemaker or replacement valve	☐	☒	If yes:
Any chest or breathing problems/conditions? i.e. asthma/bronchitis/COPD	☐	☒	If yes:
Any stomach, gut, liver or kidney problems? i.e. coeliac disease/crohn's disease/hepatitis, jaundice	☐	☒	If yes:
Any blood or bleeding problems/conditions? i.e. haemophilia	☐	☒	If yes:
HIV, Hepatitis or any other blood borne virus?	☐	☒	If yes:
Epilepsy or prone to fits/faints?	☐	☒	If yes:
Diabetes?	☐	☒	If yes:
Problem/conditions relating to your bones/joints/muscles? i.e. arthritis	☐	☒	If yes:
Pregnant or a possibility that you could be pregnant?	☐	☒	If yes, due date?
Any medical condition or problem not specified above?	☐	☒	If yes:
Have you been hospitalised in the past?	☐	☒	If yes:
Do you carry a medical warning card?	☐	☒	If yes:
Are you currently under treatment from a Doctor, Consultant or clinic?	☐	☒	If yes:
Are you taking any medications (e.g. tablets, pills, patches, inhalers, ointments, injections, oral contraceptives, recreational drugs)	☐	☒	Full list;
Doctor's name and address		Dentist's name and address	
<u>Pauchie Doctors</u>		<u>Alloa Dentist</u>	
I certify that all the information provided above is correct to the best of my knowledge.			
Signature of Patient, Parent, Carer <u>[Signature]</u>		Date: <u>24/09/2019</u>	

FORTH VALLEY ROYAL HOSPITAL

DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY

CONSENT TO CLINICAL PHOTOGRAPHY

We may like you to have some medical photographs taken and incorporated in your health records to assist staff planning and assessment of your treatment. As part of your clinical records, these photographs are bound by the same confidentiality requirements as the rest of your records.

THE REASON FOR ASKING YOU TO UNDERGO CLINICAL PHOTOGRAPHY SHOULD BE EXPLAINED TO YOU FULLY BY YOUR SURGEON.

The clinical photographs may be used for teaching doctors, nurses, health-related students and other professional NHS staff. Some may be used for publication of scientific articles.

Would you please sign below if you are agreeable to:-

- (a) use for teaching of doctors, nurses, health related students and other NHS staff.
- (b) Publication in scientific articles.

Please score out and initial either (a) or (b) if you are not happy for photographs to be used in either of these manners.

SIGNED:

FULL NAME:

DATE:

CHI NO: 0705570592 07/05/1957
CRN: 140620 M
David Adams
10 Douglas Avenue,
GRANGEMOUTH,
Stirlingshire
FK3 0LD

ORAL AND MAXILLOFACIAL SURGERY - CONFIDENTIAL MEDICAL HISTORY

Please answer all the questions completely and truthfully. If you are not sure of any of the questions, or wish to discuss something in more detail, please inform the surgeon.

HOME PHONE NO. 01324 874396 MOBILE NO. _____ OCCUPATION PAINTER

SMOKING STATUS:

☐ I have never smoked
☒ A smoker If yes for how long? 30 YRS How many per day? 20
☐ An ex smoker If yes - when did you quit? _____ How long did you smoke for? _____

ALCOHOL STATUS:

Do you consume alcohol?
☐ No
☒ Yes If yes - how many units on average per week? 12 UNITS (1 pint = 2 units / 1 glass wine = 2 units)

	Yes	No	Details
Are you aware of anything that you are allergic to?	☐	☒	If yes:
Do you suffer from the following;			
Any heart problems/conditions? <i>i.e. Heart attack/high blood pressure/angina/pacemaker or replacement valve</i>	☐	☒	If yes:
Any chest or breathing problems/conditions? <i>i.e. asthma/bronchitis/COPD</i>	☐	☒	If yes:
Any stomach, gut, liver or kidney problems? <i>i.e. coeliac disease/crohn's disease/hepatitis, jaundice</i>	☐	☒	If yes:
Any blood or bleeding problems/conditions? <i>i.e. haemophilia</i>	☐	☒	If yes:
HIV, Hepatitis or any other blood borne virus?	☐	☒	If yes:
Epilepsy or prone to fits/faints?	☐	☒	If yes:
Diabetes?	☐	☒	If yes:
Problem/conditions relating to your bones/joints/muscles? <i>i.e. arthritis</i>	☐	☒	If yes:
Pregnant or a possibility that you could be pregnant?	☐	☒	If yes, due date?
Any medical condition or problem not specified above?	☐	☒	If yes:
Have you been hospitalised in the past?	☐	☒	If yes:
Do you carry a medical warning card?	☐	☒	If yes:
Are you currently under treatment from a Doctor, Consultant or clinic?	☒	☐	If yes: <u>DERMATOLOGY</u>
Are you taking any medications (e.g. tablets, pills, patches, inhalers, ointments, injections, oral contraceptives, recreational drugs)?	☐	☒	Full list;
Doctor's name and address		Dentist's name and address	
<u>DR CRAWFORD</u>		<u>MRS MARTIN</u>	
<u>BONNESS ROAD</u>		<u>BONNESS ROAD</u>	
<u>GRANGEMOUTH</u>		<u>GRANGEMOUTH</u>	
I certify that all the information provided above is correct to the best of my knowledge.			
Signature of Patient, Parent, Carer <u>D Adams</u>		Date: <u>17/1/17</u>	

FORTH VALLEY ROYAL HOSPITAL

DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY

CONSENT TO CLINICAL PHOTOGRAPHY

We may like you to have some medical photographs taken and incorporated in your medical records to assist staff planning and assessment of your treatment. As part of your clinical records, these photographs are bound by the same confidentiality requirements as the rest of your records.

THE REASON FOR ASKING YOU TO UNDERGO CLINICAL PHOTOGRAPHY SHOULD BE EXPLAINED TO YOU FULLY BY YOUR SURGEON.

The clinical photographs may be used for teaching doctors, nurses, health-related students and other professional NHS staff. Some may be used for publication of scientific articles.

Would you please sign below if you are agreeable to:-

- (a) use for teaching of doctors, nurses, health related students and other NHS staff.
- (b) Publication in scientific articles.

Please score out and initial either (a) or (b) if you are not happy for photographs to be used in either of these manners.

SIGNED:

FULL NAME:

DATE:

Outpatient Clinic Note



GP Name: Crawford, Gregor

GP Site: Bo'ness Road Medical Practice

Patient Name: David Adams CHI: 0705570592

Presenting Complaint, Investigations, Results, Diagnosis:

Multiple incisional biopsies right soft palate and left/right buccal mucosa.

Pathology: April 2016: Left Soft palate: Low grade dysplasia. Left Retromolar region: Low Grade Dysplasia

Currently smoking 20 CPD - previously 50 CPD
alcohol - Saturdays only

OE:

Erythroplakia patches right and left soft palate - fauces

Smoking cessation/advice today.

S/B Y Shammaa - Review 4 months with Mr Thomson

The above patient attended the following Oral and Maxillofacial Surgery Outpatient Clinic:

Lead Consultant: Mr J Downie

Clinic: FVRH - MR DOWNIE ORAL & MAXILLIOFACIAL

Clinic Date: 17/01/2017 10:40

Medication Recommendation(s):

No medication recommendation(s) supplied

Follow up:

No 'Follow up' info recorded

Further info:

No 'further info' recorded

Form Completed by:

Name: Gavin Wilson at 11:08 on Tue 17 January 2017

04



Surname: Adams	Forename: David	Title: Mr
Address: 6 Salmon Court School Brae Bo'ness West Lothian	Postcode: EH51 9HF	CHI: 0705570592
Telephone: 07733 391731		
Date of Birth: 07/05/1957	Sex: Male	Age: 68 Years
GP Name: A Crichton		
Address: 26208/1 Kinneil Medical Practice Health Centre Dean Road Bo'ness EH51 0DQ	Telephone: 01506 537054	
Next of Kin		
Name: Kelly Adams		
Relationship: Daughter	Postcode:	
Address:	Telephone: 07871 559304	
Triage Information		
"CP - recent "		
"travelling 10mph on motorbike 1/7 ago, clipped by car and knocked from bike. Wearing helmet and protective clothing. Helped up and home by passer-by. Since inj has been experiencing central chest pain and L leg pain, mobilising into triage. Has not taken any analgesia, declined analgesia at triage. No LOC, no anticoags "		
Observations		
P= 84	PB= 177 / 81	RR= 16
Peak Flow=	GCS=	Sat= 97
	BM=	Temp= 36.5
	News= 0	

[illegible]

Clinical Notes

Seen by:	Time:
18:30 - went to r/v - pt. not in waiting room, not in treatment hallway's chair.	
phoned number. did not pick up.	
20:00 - Phone back again. pt picked up. stated he had left hospital. arrived today not planning on coming back.	
for morning advice given -	
for ED contact first P.R. Vignar.	
Plus - Discharge before pt reviewed	

Attach continuation sheets here

Attach here onto face of pocket

Guidelines Used:

Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



Date of Completion: 13-Mar-2026

A Crichton
Kinnell Medical Practice
Health Centre
Dean Road
Bo'ness
EH51 0DQ

GP Practice

GP Name:	A Crichton	GP GMC:	3331864
P Practice Address:		GP Practice Code:	3331864/26208
		GP Clinic Code:	26208
		GP Telephone:	

Patient Demographics

Patient Name:	ADAMS, David	Date Of Birth:	07-May-1957
Patient Address:	6 Salmon Court School Brae Bo'ness West Lothian EH51 9HF	Gender:	Male
		CHI No:	0705570592
Telephone No:	07733 391731		

Admission Details

Patient Location:	FVRH Emergency Department	Admission Date:	13-Mar-2026
Admission Care Provider:	Dr Ben Hughes	Admission Time:	16:01
Source Of Admission:	Self referral		

Presenting Complaint

fall from bike

Diagnosis

Diagnosis	Site	Laterality
ED diagnosis - Left before clinical assessment		

Discharge Details

Discharge Type:	Patient left before assessment completed	Discharge Date:	13-Mar-2026
Discharge Destination:	Private Residence - Usual place of residence	Discharge Time:	18:30
Referred To:			

Notes for GP

This patient has left prior to initial assessment

Person completing record**Authorised by**

Name: Dr Mathew Milan

Designation or role: Doctor

Specialty:

Date completed: 13-Mar-2026

Clinically completed by

Name:

Designation or role:

Specialty:

Distribution List**Recipient Name**

A Crichton

Recipient Type

GP

Recipient Organisation

Kinneil Medical Practice

Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



0705570592

Date of Completion: 18-May-2025

A Crichton
Kinnell Medical Practice
Health Centre
Dean Road
Bo'ness
EH51 0DQ

GP Practice			
P Name:	A Crichton	GP GMC:	3331664
P Practice Address:		GP Practice Code:	3331664/26208
		GP Clinic Code:	26208
		GP Telephone:	

Patient Demographics			
Patient Name:	ADAMS, David	Date Of Birth:	07-May-1957
Patient Address:	6 Salmon Court School Brae Bo'ness West Lothian EH51 9HF	Gender:	Male
		CHI No:	0705570592
Telephone No:	07733 391731		

Admission Details			
Patient Location:	FVRH Emergency Department	Admission Date:	18-May-2025
Admission Care Provider:	Dr Joanne Mitchell	Admission Time:	13:06
Source Of Admission:	Self referral		

Presenting Complaint	
dog bite to arm	

Diagnosis		
Diagnosis	Site	Laterality
ED diagnosis - Left before clinical assessment		

Discharge Details			
Discharge Type:	Patient left before being treated	Discharge Date:	18-May-2025
Discharge Destination:	Not Known	Discharge Time:	15:19
Referred To:			

Notes for GP	
Called @ 14.30 in main waiting room and minor injuries waiting room- no response.	
Called again @ 1515 in main waiting room and minor injuries waiting room- no response.	

Person completing record**Authorised by**

Name: Ms Amie Gilchrist
Designation or role: Emergency Nurse Practitioner
Specialty:
Date completed: 18-May-2025

Clinically completed by

Name:
Designation or role:
Specialty:

Distribution List

Recipient Name
A Crichton

Recipient Type
GP

Recipient Organisation
Kinneil Medical Practice

Department of Oral & Maxillofacial Surgery
Specialty Doctor: Dr Callum Weir
Tel: 01324 566360

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr K Bell
Dental Surgeon
Long & Gilmour Dental Practice
83-93 North Street
Bo'Ness
EH51 9PT

Date Dictated: 24/03/2025
Date Typed: 31/03/2025
Our Ref: CW/MA
CHI: 0705570592

Dear Dr Bell

David Adams DOB: 07-05-1957
6 Salmon Court School Brae Bo'Ness EH51 9HF

- Diagnosis:
1. Right buccal mucosa - appearance suggestive of either a post-inflammatory reactive change or oral melanotic macule
 2. Right soft palate keratosis, prominent hyperkeratosis and mild spongiosis - no evidence of dysplasia

I was expecting to see David today in the Oral and Maxillofacial Surgery Department to review him in regards to the above lesions. Unfortunately he failed to attend this appointment.

When I last saw David he continued to smoke 10 cigarettes per day.

I discussed David's case with our Consultant Surgeon and we have agreed that we no longer need to review David in regards to these as there was no evidence of dysplasia on his most recent biopsies.

I suggest David gets regularly reviewed by his Dentist for dental check-ups and, of course, he can be re-referred into the Department if he has any change of appearance.

Kind regards.

Yours sincerely

Dictated and electronically checked by:

Dr Callum Weir
Specialty Doctor in Oral and Maxillofacial Surgery

NHS Forth Valley
Headquarters: Carseview House, Castle Business Park, Stirling, FK9 4SW

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 [@nhsforthvalley](https://www.instagram.com/nhsforthvalley)

CC:

Dr A Crichton
Kinneil Medical Practice
Health Centre
Dean Road
EH51 0DQ

Department of Ageing & Health
Stroke Follow Up
Lindsay Noonan
Tel: 01324 567336

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Mr David Adams
6 Salmon Court
School Brae
Bo'Ness
West Lothian
EH51 9HF

Date Dictated: 24/12/2024
Date Typed: 27/12/2024
Our Ref: LN/LS
CHI: 0705570592

Dear Mr Adams

Stroke Follow Up

You were admitted on the 9th December 2024 spending 2 day in hospital with left sided weakness. Your MRI scan showed a right basal ganglia infarct.

It lovely to speak to you today. Unfortunately you have reported ongoing left sided weakness. I had spoken to you last week as you called in with some concerns, that your left leg was dragging, and poor grip to your left hand. You still work as a painter and decorator. You felt you memory was quite poor recently and you had left the cooker on for 2hrs and had went away out to the shops and back and you felt you weren't retaining the information as well as you used too. Due to the physical concerns your raised at the time, I discussed referring you to START which I had done on the day and they have got in contact with you today and will see you in the next couple of weeks.

You currently live alone. You have good input from one of your daughters who lives close by. You like playing the harmonica and used to go busking. You are currently a painter and decorator but feel you might have to give this up due to the stroke. You are managing your medication with no concerns, although you report only having one week of medication left. I have advised you to contact your GP for a repeat prescription. You are currently awaiting a 48hr ECG and we discussed what this is for, they are looking for an irregular heart rate. If we see this on the ECG, you may have your medication altered and someone would get in touch with you.

Today you report that your left leg is significantly more swollen than your right. I have highly advised that you see your GP today, this could just be down to swelling on your affected side of the stroke but it also could be a clot in your leg and unfortunately, I cannot diagnose this over the phone. Please see your GP as you were asked too. You were also given worsening advice of your left leg swelling today, if you notice things getting more swollen, painful, red, hot shiny leg to come into hospital to get checked out.

You are currently a smoker. You are not keen on quitting smoking. Having quite 3yrs ago and lost a huge amount of weight due to this. At this time you have you have declined Smoking Cessation input. I have advised you that smoking is one of the main causes of stroke and it is highly advised that you do quit. If you do want support with this you can get this from you GP or local pharmacy.

NHS Forth Valley
Headquarters: Carseview House, Castle Business Park, Stirling, FK9 4SW

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 [@nhsforthvalley](https://www.instagram.com/nhsforthvalley)

Currently you don't drink a huge amount of alcohol. It tends to be on a Saturday night and it would be half a bottle of Morgans. You report having a good appetite, although your portions are small that they used to be. You like to cook. You have lost a lot of weight during COVID when you had it. You feel that you are currently about 11st.

At present you are independently mobile and you are managing most of your activities of daily living, washing, dressing and cooking. You are managing to walk to Tesco and back, albeit with some difficulty due to your grip and dragging of your left leg. You have no issues with your bowel or bladder. You had reported no issues with your vision and then had also told me that you had been seeing zigzags and squares at times. I have advised you to see your Ophthalmologist. And START will check your eyesight when they visit. You are a driver and have been given advice that you cannot drive for at least 4 weeks and due to your vision will have to see a health professional before you return to driving.

Thankfully you have no issues with your swallowing or communication. You feel your mood is as it normally is. You have complained of left sided pain and feel your eyes are a little bit on the sore/tired side and that you eyes are watering a fair bit. You are sleeping well but you do tend to dose off on the chair. It seems that you are suffering from a little bit of post stroke fatigue which is quite common, but this does usually improves with time.

You have received the stroke information pack that I sent out last week which is good. This has information regarding stroke, reducing your risks and smoking. It also has out direct number, please do not hesitate to contact us should you have any questions or concerns. The pack also has some useful numbers as you were looking for help with money and I had advised you to contact Citizen's Advice or Falkirk Council.

After our discussion today, I have tried to chase up START to come in and see you a little bit earlier, just to ensure that your vision has been looked at and also check on your left leg.

No further Stroke Nurse follow up or intervention required at this time.

Yours sincerely

Dictated and electronically checked by:

**Lindsay Noonan (NHS Forth Valley)
Stroke Specialist Nurse**

CC:
Dr A Crichton
Kinneil Medical Practice
Health Centre
Dean Road
EH51 0DQ

CHI: 0705570592

DAVID ADAMS
Page 2 of 3

CHI: 0705570592

DAVID ADAMS
Page 3 of 3

THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

Immediate Discharge Letter
(Authorised)

A Crichton
Kinnell Medical Practice
Health Centre
Dean Road
Bo'ness
EH51 0DQ

General Medicine
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:

0705570592

Date of Completion: 10-Dec-2024

Patient Demographics			
Patient Name:	ADAMS, David	Date Of Birth:	07-May-1957
Patient Address:	6 Salmon Court School Brae Bo'ness West Lothian EH51 9HF	Gender:	Male
		CHI No:	0705570592
Telephone No:	01324 874396		

GP Practice			
GP Name:	A Crichton	GP GMC:	3331664
GP Practice Address:		GP Practice Code:	3331664/26208
		GP Clinic Code:	26208
		GP Telephone:	

Admission Details			
Patient Location:	General Medicine	Admission Care Provider:	Dr Daniel Beckett
Admission Date:	09-Dec-2024	Admission Time:	00:14
Admission Method:	Emergency Admission, no additional detail added	Ward:	FVRH AAU Medical Waits
Source Of Admission:	Accident and Emergency Ward - other Provider		

Discharge Details			
Discharge Specialty:	Geriatric Medicine	Discharge Care Provider:	Dr Gareth Blayney
Discharge Date:	10-Dec-2024	Ward:	FVRH Ward B21
Discharge Time:	14:50	Discharge Destination:	Private Residence - no additional detail added
Discharge Method:	Regular discharge, no additional detail added		

Clinical Summary Including History	
This 67 year old man was admitted with sudden onset left sided weakness PMH-Graves disease, left leg sciatica lives alone, independent, drives Left arm drift CN intact NIHSS 1 ECG-sinus Chest clear CTA-no sig ICA stenosis	

MRI brain-right basal ganglia infarct
Bloods-gluc 4.8, chol 4.6

-right basal ganglia infarct

Commenced on DAPT for 3 weeks and then clopidogrel 75mg only thereafter lifelong
Also started on PPI/statin

No therapy issues highlighted and can be discharged home as before with 48 hour tape as OP and driving advice given

Thank you
FSteel-NP

Safety Alerts

Nil records exist

Allergy/Intolerance

Allergy records are as recorded at time and date of printing

Nil records exist

Medications

Drug Information:

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply
------	------	-------	-----------	----------------	-----	-------------

Nil records exist

Drug Notes:

Drug	Drug Notes
------	------------

Nil records exist

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason
------	---------------------

Nil records exist

GP Communications:

Outstanding Results

Responsibility of Hospital

Nil records exist

Person completing record

Authorised by

Name: Fiona Steel
Designation or role: Nurse Specialist
Specialty:
Date completed: 10-Dec-2024

Clinically completed by

Name:
Designation or role:
Specialty:

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
A Crichton	GP	Kinneil Medical Practice

Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



0705570592

Date of Completion: 08-Dec-2024

A Crichton
Kinnell Medical Practice
Health Centre
Dean Road
Bo'ness
EH51 0DQ

GP Practice

P Name:	A Crichton	GP GMC:	3331664
P Practice Address:		GP Practice Code:	3331664/26208
		GP Clinic Code:	26208
		GP Telephone:	

Patient Demographics

Patient Name:	ADAMS, David	Date Of Birth:	07-May-1957
Patient Address:	6 Salmon Court School Brae Bo'ness West Lothian EH51 9HF	Gender:	Male
		CHI No:	0705570592
Telephone No:	01324 874396		

Admission Details

Patient Location:	FVRH Emergency Department	Admission Date:	08-Dec-2024
Admission Care Provider:	Dr Stephen Fellbower	Admission Time:	14:01
Source Of Admission:	999 Emergency Services		

Presenting Complaint

?stroke

Diagnosis

No Diagnosis Results

Discharge Details

Discharge Type:		Discharge Date:	
Discharge Destination:		Discharge Time:	
Referred To:			

Notes for GP

Person completing record

Authorised by		Clinically completed by	
Name:	Dr John Mackay	Name:	
Designation or role:	Doctor	Designation or role:	
Specialty:		Specialty:	
Date completed:	08-Dec-2024		

Distribution List**Recipient Name**
A Crichton**Recipient Type**
GP**Recipient Organisation**
Kinnell Medical Practice

Department of Oral & Maxillofacial Surgery
Specialty Doctor: Dr Callum Weir
Tel: 01324 566360

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr K Bell
Dental Surgeon
Long & Gilmour Dental Practice
83-93 North Street
Bo'Ness
EH51 9PT

Date Dictated: 21/11/2024
Date Typed: 29/11/2024
Our Ref: CW/CP
CHI: 0705570592

Dear Dr Bell

David Adams DOB: 07-05-1957
6 Salmon Court School Brae Bo'Ness EH51 9HF

- Diagnosis:
1. Right buccal mucosa appearance suggestive of either a post-inflammatory reactive change or an oral melanotic macule
 2. Right soft palate keratosis, prominent hyperkeratosis and mild spongiosis - no evidence of dysplasia

I reviewed David today in the Maxillofacial department. He continues to have no concerns from his lesions affecting his right buccal mucosa bilaterally on his soft palate.

On examination there is a roughened scarred appearance to the right buccal mucosa, though a homogenous white colour that has underlying softness. On the soft palate there are bilateral mixed red/white lesions which are soft to touch and non-ulcerated.

He continues to smoke approximately 10 cigarettes a day and is a long term smoker. He has no interest in quitting as he quit before and got ill, and he blames the lack of smoking for this.

Clinical photographs were taken today for comparison in the future.

We had previously considered discharging the patient if all is well today, but given the clinical picture and smoking habit I think it would be wise to review him once again in 4 months time. We will make a further plan from there.

Kind regards.

Yours sincerely

NHS Forth Valley
Headquarters: Carseview House, Castle Business Park, Stirling, FK9 4SW



Dictated and electronically checked by:

**Dr Callum Weir
Specialty Doctor in Oral and Maxillofacial Surgery**

**CC:
Dr A Crichton
Kinneil Medical Practice
Health Centre
Dean Road
EH51 0DQ**

Department of Oral & Maxillofacial Surgery
Specialty Doctor: Dr Callum Weir
Tel: 01324 566360

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr K Bell
Dental Surgeon
Long & Gilmour Dental Practice
83-93 North Street
Bo'Ness
EH51 9PT

Date Dictated: 17/06/2024
Date Typed: 18/06/2024
Our Ref: CW/MA
CHI: 0705570592

Dear Dr Bell

David Adams DOB: 07-05-1957
6 Salmon Court School Brae Bo'Ness EH51 9HF

Diagnosis: 1. Right buccal mucosa appearance suggestive of either a post-inflammatory reactive change or an oral melanotic macule
2. Right soft palate keratosis, prominent hyperkeratosis and mild spongiosis - no evidence of dysplasia

I saw the above patient in the Maxillofacial Department following his biopsies on the white striated pigmented lesions on his right soft palate and buccal mucosa.

He reports no issues following his biopsies.

The results are as above and non-concerning.

The lesions appear similar to how I described on his first appointment. They are soft to touch with no ulceration and no raised or rolled margins.

Given the unclear diagnosis and cause and the patient's smoking habit I plan to review the patient in 3 months' time.

We will, of course, keep you updated.

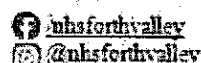
Kind regards.

Yours sincerely

Dictated and electronically checked by:

Dr Callum Weir - Specialty Doctor in Oral and Maxillofacial Surgery

NHS Forth Valley
Headquarters: Carseview House; Castle Business Park, Stirling, FK9 4SW



CC:

Dr A Crichton
Kinneil Medical Practice
Health Centre
Dean Road
EH51 0DQ

Department of Oral & Maxillofacial Surgery
Specialty Doctor: Lucy Malcolm
Tel: 01324 566360

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Ms. Katie Bell
Long & Gilmour Dental Practice
83-93 North Street
Bo'ness
EH51 9PT

Date Dictated: 25/03/2024
Date Typed: 26/03/2024
Our Ref: LM/NS
CHI: 0705570592

Dear Ms. Bell

David Adams DOB: 07-05-1957
6 Salmon Court School Brae Bo'Ness EH51 9HF

Diagnosis 1: Asymptomatic right buccal mucosa mixed white/grey/red patch
Diagnosis 2: Asymptomatic right soft palate mixed white/red/grey patch
Management: For incisional biopsy of both sites under local anaesthetic
Chlorhexidine mouthwash today. Prescribed PenV 7 days due to LLQ socket
Bloods today due to patients social history

David presented with an asymptomatic right buccal mucosa mixed red and white patch which was an incidental finding by his dentist. He reports lower left quadrant molar extracted 1 week ago and previous discharge from OMFS in 2019 following pathology on 29th April 2016 - *low grade dysplasia left buccal mucosa, low grade dysplasia upper end of low grade left soft palate.*

Medically he is fit and well. He has previous graves disease, no review by hospital or GP. He has no allergies. Medications include Panadol and Ibuprofen as required.
BMI 24. Musk 0. Performance status 0.

Socially he smokes 10 roll ups a day for the past 50 years. Previously 40 roll ups per day. Smoking cessation was provided today. Alcohol was reported of a 70cl bottle of vodka once per week (approx 28 units). He is a retired painter and decorator and lives on his own.

Clinically today David had a very tender left neck while palpating the submandibular region although there was no obvious enlargement or firmness. Pain then radiated to his left ear and temple. Oral hygiene was poor. On the right buccal mucosa, right soft palate there was a mixture of white/red and slightly grey patches. Healing socket lower left quadrant with mild tenderness noted.

Findings were discussed with regards to likely FEP tip of tongue, risks, benefits and steps of excisional biopsy or keep under observation. David wishes to keep under observation as has been present for many years.

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Headquarters: Carseview House, Castle Business Park, Stirling, FK9 4SW

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 [@nhsforthvalley](https://www.instagram.com/nhsforthvalley)

Consideration of dysplasia right buccal mucosa/right soft palate was discussed with patient and verbal consent was given to list for incisional biopsy.

Bloods were organised today due to social history prior to his biopsy and I prescribed Chlorhexidine and Pen v in order to manage the potential reactive nature of the tenderness left submandibular. After discussion with Mr Mitchell, we agreed the plan above.

We agreed at this stage for no CT to be organised but the consideration of one at his follow up review when pathology is available.

We will endeavour to keep you informed.

Kind regards

Yours sincerely

Dictated and electronically checked by:

Lucy Malcolm
Locum Specialty Doctor in Oral and Maxillofacial Surgery

CC:
Dr A Crichton
Kinneil Medical Practice
Health Centre
Dean Road
EH51 0DQ

Hospital use only	Clinic	Day Date	Time	Hospital No.
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Date Referral Submitted
(This date is fixed at hospital end):
11-Mar-2024

REFERRAL LETTER

MEDICAL IN
CONFIDENCE

?

0705570592

CHI No: 0705570592

101032428514S

Unique Care Pathway Number: 101032428514S

REFERRAL TO	
Oral and Maxillofacial SurgeryC13 FV Head and Neck Cancer	? — Consultant / receiving practitioner and/or specialty clinic
Forth Valley Cancer Services NHS Forth Valley	? — Hospital and hospital address
	Hospital location code. V001G
Urgency of Referral	
Urgent - Suspected Cancer (Head and Neck)??	
Administrative Information	
Please indicate suitability for Near Me or Telephone consult (preference Near Me):Unknown	
Patient has special requirements:No	

PATIENT DETAILS	
Surname	David
Forename(s)	Adams
Title	• Sex Male
Previous Surname	•
Date of birth	07-May-1957
CHI no.	0705570592
Patient's address	
6 Salmon Court Bo'ness EH51 9HF	
Contact number(s)	
-	

REFERRING HCP DETAILS	
Name:	Katie Bell
Organisation name:	Long & Gilmour (288) (288)
Specialty:	- (-)
Organisation address	
83-93 North Street Bo'ness EH51 9ND Voice: 01506 824231	

CLINICAL INFORMATION**History of presenting complaint / examination findings / investigation results****Presenting Complaint**

Description: Red and white patch buccal mucosa

Date Started: 11-Mar-2024

Comment: RHS buccal mucosa mixed patch with red, white and greying appearance and reticular, unclear margins. non painful, pt reports history of previous referral to hospital at FVRH and was planned for biopsy, cancer mentioned, never happened but not clear why exactly, pt says was around time of covid but not sure if this is why never got further investigation.
Previously referred by a different practice and didn't attend dentist for a number of years before attending our practice.

Examinations and Investigations

Performance Status: 0 - Fully active, able to carry on all pre-disease performance without restriction -

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Medical history**Active Repeat Therapy**

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

No current medications recorded

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

No recent medications recorded

Clinical warnings

Smoking status: Number per day: ? (not known)

Description	Comment	Date Recorded
Rolls tobacco	10/15 daily	11-Mar-2024

Alcohol status: Units per day: 9+ (very heavy drinker)

Description	Comment	Date Recorded
40 units	over 3 days	-

Exercise status: Not Known

Additional relevant information

?

Signature of referring doctor (or other professional)

Date

11-Mar-2024

Urology Department
Rizwan Iqbal
Tel: 01324 566344 / 01324 566345

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr G Crawford
Bo'Ness Road Medical Practice
33 Bo'Ness Road
Grangemouth
FK3 8AN

Date Dictated: 08/08/2022
Date Typed: 22/08/2022
Our Ref: RI/MM
CHI: 0705570592

Dear Dr G Crawford

David Adams DOB: 07-05-1957
10 Douglas Avenue Grangemouth FK3 0LD

DIAGNOSIS:
Chronic right testicular pain.

OUTCOME:
Continue conservative management and encourage regular analgesia use.

Thank you for referring Mr Adams who is a 65 year old gentleman with a long history of right sided testicular pain. He was quite vague about the time of onset but estimates this to be many months to a year. He denies any particular trigger or trauma which may have caused the pain. There was no associated lower urinary tract symptoms and he is passing urine well. His pain had improved after Ofloxacin antibiotics as well as Naproxen although the pain had got worse after he stopped taking his analgesia. He admits to not taking his analgesia regularly. He's otherwise systemically well and is only troubled by sciatica of his left leg which can cause some bother with mobility. He also has a past medical history of Grave's disease and a previous right sided inguinal hernia which was treated in the past.

An ultrasound scan was carried out which showed normal testes and 2 simple cysts on the right as well as a multiloculated avascular cyst on the left. I explained to Mr Adams that these simple cysts would unlikely be the cause of his symptoms as these are generally benign and do not pose any significant issues to the majority of patients.

On examination Mr Adams had a soft and non tender abdomen with no palpable hernias evident. His left testicle examined normally and his right testicle was tender at the lower pole but I was unable to palpate any epididymal cysts or any other masses. There was no erythema, swelling or skin breaks. Examination was limited due to the patient tensing up in anxiety.

My impression is that this gentleman has chronic scrotal pain with no gross abnormality on his ultrasound testes. I explained to him that we can continue with conservative management and I encouraged him to take his analgesia regularly and explained that if we do surgically remove the cyst there may be associated complications with this including a risk of ongoing or worsening pain despite intervention. He agreed to continue regular analgesia use going forward and if he is still experiencing significant pain despite this then a repeat ultrasound of his testes may be warranted.

Kind regards
Yours sincerely

Dictated and electronically checked by:

Rizwan Iqbal
CDF in Urology

Chair: Jamie McCosker
Chief Executive: Cathie Cowan

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CC:

Hospital use only	Clinic	Day Date	Time	Hospital No.
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Date Referral Submitted
(This date is fixed at hospital end):
01-Jul-2022

REFERRAL LETTER

MEDICAL IN
CONFIDENCE

?

0705570592

CHI No: 0705570592

101026760060V

Unique Care Pathway Number: 101026760060V

REFERRAL TO	
UrologyCB FV Urology Referral	? — Consultant / receiving practitioner and/or specialty clinic
Forth Valley Royal Hospital Stirling Road Larbert FK5 4WR	? — Hospital and hospital address Hospital location code: V217H
Urgency of Referral Urgent Urology Referral?? ?	
Administrative Information Please indicate suitability for Near Me or Telephone consult (preference Near Me): Unknown Patient has special requirements: No Employment: Occupations Ethnic Origin: (White) Scottish ?	

PATIENT DETAILS	
Surname Adams	Patient's address 10 Douglas Avenue GRANGEMOUTH FK3 0LD Contact number(s) Voice: 874395 Voice: 077 32075 848
Forename(s) David	
Title - Sex Male	
Previous Surname -	
Date of birth 07-May-1957	
CHI no. 0705570592	

REFERRING PRACTITIONER DETAILS	
Name: Dr. Anthony Dawson (GMC: 4509273)	Practice address: 33 Bo'ness Road Grangemouth FK3 8AN
Practice: Bo'ness Road Medical Practice (25332)	
Phone: Voice: 01324 482653	

CLINICAL INFORMATION**History of presenting complaint / examination findings / investigation results****Presenting Complaint**

Description: Multiloculated avascular cyst left testicle causing pain

Comment: Dear Team,

I would be grateful if you would consider seeing David who presented to me in March with a history of aching in and around his testicle. His level of ache varied, but has become more severe recently. He reports that it does vary from day to day and there is no sudden acute deterioration.

He has a past history of orchitis. Examination was difficult due significant apprehension. However, we treated it as a possible orchitis with Ofloxacin, Naproxen and Omeprazole.

Ultrasound scan was arranged which revealed normal testes, 2 simple cysts on the right, but on the left side there was a multiloculated avascular cyst.

David has got in touch today to tell me that, although his pain had eased, since he stopped the medication it appears to have got worse again and he is really struggling with the pain on some days. In light of this, I was unsure whether you would consider surgical approach for the cyst, or whether you feel further imaging may be warranted.

Thank you for your urgent advice and assessment. Please find enclosed his past medical history and drug treatment.

Yours sincerely,

Dr. Anthony Dawson

Examinations and Investigations

Murmur present: Not Recorded -
Is a 12 lead ECG: Not done -
Recent CXR: Not done -
FBC: Not Recorded -
Urea and Electrolytes: Not Recorded -
LFT: Not Recorded -
TFT: Not Recorded -
Lipid Profile: Not Recorded -
Glucose: Not Recorded -

Patient Measurements

<u>Diastolic</u>	<u>Systolic</u>	<u>Height</u>	<u>Weight</u>	<u>BMI</u>	<u>Date Recorded</u>
142	70				10-Jul-2020
144	68				18-Mar-2020
133	71				30-Oct-2018
179	79				26-Oct-2018
130	80				15-Dec-2009
		74			23-Mar-2022
		76.4			14-Jan-2021
		74.4			09-Mar-2020
167	82	29.4			30-Oct-2018

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Medical history**Pre-existing Conditions (High Priority)**

<u>Description</u>	<u>?? Laterality</u>	<u>?? Modifier</u>	<u>?? Extension</u>	<u>?? Date Started</u>	<u>??</u>
Graves' disease	?? -	?? -	?? -	?? 08-Feb-2022	
Hyperthyroidism	?? -	?? -	?? -	?? 21-Apr-2020	
Alcohol dependence syndrome	?? -	?? -	?? -	?? 01-Jun-1995	

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

<u>Drug name</u>	<u>?? Drug code</u>	<u>?? Formulation</u>	<u>?? Dosage</u>	<u>?? Frequency</u>	<u>?? Last Issued</u>	<u>??</u>
Omeprazole Capsules (Gastro-Resistant) 20 mg	?? 0103050P0AAAGAG	?? 28 capsule	?? ONE DAILY	?? -	?? -	?? -

Issued Scripts for Acutes and Inactive Repeats (In last 90 days)

No recent medications recorded

Clinical warnings

Smoking status:

Number per day: ? (not known)

<u>Description</u>	<u>Comment</u>	<u>Date Recorded</u>
Cigarette smoker, 20 Cigarettes/day	-	17-Jan-2017
Current smoker	-	23-Jan-2014
Current smoker	-	03-May-2011
Current smoker	Disease: SPICE Basic Health Values, 15 per day priority=1	23-Mar-2009
Current smoker	Disease: SPICE Basic Health Values, 20 per day priority=1	29-Jul-2006
Alcohol status:	Units per day: ? (not known)	
<u>Description</u>	<u>Comment</u>	<u>Date Recorded</u>
Alcohol intake within recommended sensible limits	Disease: SPICE Basic Health Values, "Some cans at weekend" priority=2	29-Jul-2006
Exercise status:	Not Known	
Additional relevant information		
?		

Signature of referring doctor (or other professional)	Date	01-Jul-2022
--	-------------	-------------

Department of Endocrinology & Diabetes
Endocrine Specialist Nurse: Jillian Tough
Tel: 01324 567957

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Mr David Adams
10 Douglas Avenue
Grangemouth
Stirlingshire
FK3 0LD

Date Dictated: 16/05/2022
Date Typed: 16/05/2022
Our Ref: JT/PM
CHI: 0705570592

Dear Mr Adams

Thank you for attending your GP for some recent thyroid blood tests on the 13th May. Your TSH is 0.73, this remains normal. You have been off thyroid treatment since September 2021, I will therefore discharge you from the endocrine clinic. If you experience any thyrotoxic symptoms then please do not hesitate to return to your GP to seek further blood results in the future and they will refer you back to the endocrine service as required.

Yours sincerely

Dictated and electronically checked by:

Jillian Tough
Endocrine Specialist Nurse

CC:
Dr G Crawford
Bo'Ness Road Medical Practice
33 Bo'Ness Road
Grangemouth
FK3 8AN

P.S. GP - David's thyroid bloods remain normal and has been off treatment for a significant length of time now. I would advise to recheck his TFTs in six months time and then on a yearly basis unless he has thyrotoxic symptoms in the interim. Please do not hesitate to re-refer to the service if required.



Chair: Janie McCusker
Chief Executive: Cathie Cowan

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Registered Office: Carverview House, Castle Business Park, Stirling, FK9 4SW

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THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

Department of Endocrinology & Diabetes
Endocrine Specialist Nurse: Jillian Tough
Tel: 01324 567957

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr G Crawford
Bo'Ness Road Medical Practice
33 Bo'Ness Road
Grangemouth
FK3 8AN

Date Dictated: 03/05/2022
Date Typed: 05/05/2022
Our Ref: JT/SC
CHI: 0705570592

Dear Dr G Crawford

David Adams DOB: 07-05-1957
10 Douglas Avenue Grangemouth FK3 0LD

Diagnoses:

1. Previous Graves' Disease
2. On Block and Replace & had 18 months of treatment until September 2021

Current Thyroid Medication: Nil

Blood Results 13/5/22: TSG 0.73

I was pleased to have a telephone consultation with David on 03/05/2022. He is on holiday in St Andrews. He has not had any thyroid bloods checked since October 2021 and I have spoken to him previously about getting them done. He advises that he has been having increased sweats and palpitations and increased mood swings.

His left eye is a bit more watery and he is experiencing some dryness and grittiness; I have asked him to seek an urgent review at his optician. He has also started smoking again so I advised if he could try and stop smoking that would be helpful as there is a risk of thyroid eye disease. He advises he is moving his bowels 3 to 4 times a day, which is an increase to what it was previously. He still has a tremor in his leg, and he advises he has got no obvious goitre. He advised that his original weight prior to thyrotoxicosis was 13st, he went down to 9st prior to treatment, he has put on a little bit weight over the last wee while and has gone up to 11st, which he has remained at.

He has attended for bloods and his TSH remains normal. He has been off treatment since September last year, I will therefore discharge him. He should seek review at surgery if experiences thyrotoxic symptoms. I would advise his TFTs be rechecked in 6 months and yearly unless symptomatic thyrotoxicosis. Re-refer back to endocrine service if required.



Chair: Janie McCosker
Chief Executive: Cathie Cowan

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Yours sincerely

Dictated and electronically checked by:

**Jillian Tough
Endocrine Specialist Nurse**

CC:

Department of Endocrinology & Diabetes
Endocrine Specialist Nurse: Jillian Tough
Tel: 01324 566346

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr G Crawford
Bo'Ness Road Medical Practice
33 Bo'Ness Road
Grangemouth
FK3 8AN

Date Dictated: 08/02/2022
Date Typed: 09/02/2022
Our Ref: JT/SC
CHI: 0705570592

Dear Dr G Crawford

David Adams DOB: 07-05-1957
10 Douglas Avenue Grangemouth FK3 0LD

Diagnosis: Graves Disease
(On Block and Replace for 18 months, treatment finished September 2021)
Current Thyroid Medication: Nil
Blood results: Awaited
Current Weight: 11st

I was pleased to have a telephone consultation with Mr Adams. He advised he stopped his Block and Replace treatment in September 2021. Over the last few months he has been experiencing an increase in hot flushes, he also advised he has been intermittently experiencing some chest discomfort with radiation down his arm, although he has sought no medical advice regarding this. I advised that if this occurs again he should seek urgent medical advice and in the interim he should seek a review with his GP with regards to this.

He also advised that he was seeing the Maxillofacial team regarding regular biopsies of his mouth every 3 months, but I have noticed that he was discharged in 2019 and I have advised him to seek advice if he experiences any further problems with regards to this. He advises that his legs seize up at times, but this is not new and has been over the last 2 years, he is also known to have sciatica.

He had an eye test in 2021, he has a new prescription and feels he has no other issues with his eyes, such a dry/gritty eyes, prominent eyes or any droops or swelling under his eyes.

He has also advised he has started smoking again.



Chair: Janie McCusker
Chief Executive: Cathie Cowan

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I have advised that if his bloods remain euthyroid then we will discharge him from the Endocrine clinic. If he is thyrotoxic again we will review him in 2 months. I will chase his results and we can initiate treatment if this is the case.

21/3/22 - Unfortunately no blood results available - once patient attends for thyroid blood tests he can contact my secretary on 01324 566346, and I will happily review results - I have also arranged an appointment in May to review results.

Yours sincerely

Dictated and electronically checked by:

Jillian Tough
Endocrine Specialist Nurse

CC:
Mr David Adams
10 Douglas Avenue
Grangemouth
Stirlingshire
FK3 0LD

David Adams (Contd)

Kind regards.

Yours sincerely,

(Dictated and electronically checked by Dr Linda Buchanan)

Dr Linda Buchanan
Consultant Physician

cc. Mr David Adams, 10 Douglas Avenue, Grangemouth FK3 0LD

Department of Endocrinology & Diabetes
Consultant: Dr Nick Barwell
Tel: 01324 566347

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr Gregor Crawford
Bo'ness Road Medical Practice
33 Bo'ness Road
Grangemouth
FK3 8AN

Date Dictated 19 March 2020
Date Typed 20 March 2020
Our Ref NB/NM/F140620
CHI 0705570592

Dear Dr Crawford,

David Adams 07/05/1957
10 DOUGLAS AVENUE, Grangemouth, Stirlingshire, FK3 0LD

I would be grateful if you would consider initiating carbimazole 40mg on this gentleman and then add 100mcg of thyroxine, once daily in combination therapy after 3 weeks on carbimazole alone.

He should be counselled about the risk of agranulocytosis on carbimazole. Given our current ability to see people at Outpatient clinic due to the COVID-19 pandemic, it will be some time before he can be seen but this therapy should allow him to stay adequately blocked and replaced and would reduce the need for him to have so many frequent blood tests. Hopefully this will be of help and we can tackle definitive therapy in the future.

Kind regards.

Yours sincerely,

(Dictated and electronically checked by Dr Nick Barwell)

Dr Nick Barwell
Consultant Physician



Chair: Janie McCusker
Chief Executive: Cathie Cowan

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Hospital use only	Clinic	Day Date	Time	Hospital No.
----------------------	--------	-------------	------	-----------------

Date Referral Submitted
(This date is fixed at hospital end):
19-Mar-2020

REFERRAL LETTER

MEDICAL IN
CONFIDENCE

?

0705570592

CHI No: 0705570592

101020931536R

Unique Care Pathway Number: 101020931536R

REFERRAL TO	
General Surgery C1 FV Suspected Colorectal Cancer	? — Consultant / receiving practitioner and/or specialty clinic
Forth Valley Cancer Services NHS Forth Valley	? — Hospital and hospital address
	Hospital location code: V001G
Urgency of Referral	
Urgent - Suspected Cancer (Colorectal)??	
Administrative Information	
Patient has special requirements: No	
Employment: Occupations	
Ethnic Origin: (White) Scottish	
?	

PATIENT DETAILS	
Surname	Adams
Forename(s)	David
Title	- Sex Male
Previous Surname	-
Date of birth	07-May-1957
CHI no.	0705570592
Patient's address:	
10 Douglas Avenue GRANGEMOUTH FK3 0LD	
Contact number(s)	
Voice: 874396	

REFERRING PRACTITIONER DETAILS	
Name:	Dr. Michael Blackmore (GMC: 4700555)
Practice:	Bo'hess Road Medical Practice (25332)
Phone:	Voice: 01324 482653
Practice address:	
33 Bo'hess Road Grangemouth FK3 8AN	

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: Altered bowel habit - strong FH of bowel cancer

Examinations and Investigations

Historic Details:

Dear Team,

I would be grateful if you could see Mr. Adams who presents, having been investigated for excessive weight loss. He has been found to have Hyperthyroidism. However, his T4 is only just above the normal range. He is not tachycardic, nor does he have any raised temperature.

He has noticed, pre-dating this weight loss, that he has been having intermittent abdominal pains and a change in his bowel habit to more frequent stools which are generally softer. I accept this may well be to do with his Hyperthyroidism. However, there is a very strong family history of bowel cancer, with his brother dying at aged 40 of bowel cancer.

In light of this, I wonder whether it would be prudent to arrange an urgent Colonoscopy just to make sure there is no co-morbidity, particularly as we are hanging our hat on his thyroid disease.

I am pleased to report the rest of his blood tests are reasonable, and if you feel this can be downgraded to an urgent Colonoscopy, then I accept your advice on this matter.

Thank you for seeing him. Please find enclosed his past medical history and drug treatment.

Yours sincerely,

Dr. Anthony Dawson
G.P. Locum

Has the patient had a colonic investigation in the last 2 years.:

No

Iron deficiency anaemia:

No

Is the patient Diabetic?:

No

Is the patient on Anticoagulant or Antiplatelet medication?:

No

Is the patient currently on oral iron therapy?:

No

Performance Status: 0 - Fully active, unrestricted by disease

Is this person fit for day-case colonoscopy?:

Yes

Digital Rectal Examination (DRE) findings:

DRE not performed*

Right sided abdominal mass:

No

eGFR status checked in the previous 3 months?:

Yes

Patient Measurements

Diastolic	Systolic	Height	Weight	BMI	Date Recorded
144	68				18-Mar-2020
133	71				30-Oct-2018
179	79				26-Oct-2018
130	80				15-Dec-2009
130	80				15-Dec-2009
		74.4			09-Mar-2020
167	82	29.4			30-Oct-2018

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Medical history

Pre-existing Conditions (High Priority)

Description ?? Laterality ?? Modifier ?? Extension ?? Date Started ??
Alcohol dependence syndrome ?? - ?? - ?? - ?? 01-Jun-1995

Active Repeat Therapy

Some Repeats may be Active but not Issued: In these instances, the Date Last Issued field contains the date authorised by the GP.

Drug name	?? Drug code	?? Formulation	?? Dosage	?? Frequency	?? Last Issued	??
Ibuprofen Tablets 400 mg	?? 1001010J0AAAEAE	?? 84 tablet	?? ONE TO BE TAKEN THREE TIMES A DAY	?? -	?? -	?? -

Omeprazole Capsules (Gastro-Resistant) 20 mg	?? 0103050P0AAAGAG	?? 28 capsule	?? ONE DAILY	?? -	?? -	?? -
Paracetamol Tablets 500 mg	?? 0407010H0AAAMAM	?? 200 TABS	?? 2 Tabs 4 times daily	?? -	?? -	?? -

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

<u>Drug name</u>	?? <u>Drug code</u>	?? <u>Formulation</u>	?? <u>Dosage</u>	?? <u>Frequency</u>	??
Loperamide Hydrochloride Capsules 2 mg	?? 0104020L0AAAAAA	?? 20 CAPSULE	?? TAKE TWO INITIALLY THEN ONE AFTER EACH LOOSE BOWEL MOTION. MAXIMUM 8 CAPSULES DAILY	?? -	?? - ?? 42? Days

Clinical warnings

Smoking status:	Number per day: ? (not known)	
<u>Description</u>	<u>Comment</u>	<u>Date Recorded</u>
Cigarette smoker, 20 Cigarettes/day	-	17-Jan-2017
Current smoker	-	23-Jan-2014
Current smoker	-	03-May-2011
Current smoker	Disease: SPICE Basic Health Values, 15 per day priority=1	23-Mar-2009
Current smoker	Disease: SPICE Basic Health Values, 20 per day priority=1	29-Jul-2006
Alcohol status:	Units per day: ? (not known)	
<u>Description</u>	<u>Comment</u>	<u>Date Recorded</u>
Alcohol intake within recommended sensible limits	Disease: SPICE Basic Health Values, "Some cans at weekend" priority=2	29-Jul-2006
Exercise status:	Not Known	

Additional relevant information

?

Signature of referring doctor (or other professional)	Date	19-Mar-2020
---	------	-------------

Hospital use only	Clinic	Day Date	Time	Hospital No.
----------------------	--------	-------------	------	-----------------

Date Referral Submitted
(This date is fixed at hospital end):
18-Mar-2020

REFERRAL LETTER

MEDICAL IN
CONFIDENCE

0705570592

CHI No: 0705570592

101020931353Z

Unique Care Pathway Number: 101020931353Z

REFERRAL TO	
EndocrinologyA81 FV Endocrine Clinic Referral	? Consultant / receiving practitioner and/or specialty clinic
Forth Valley Royal Hospital Stirling Road Larbert FK5 4WR	? Hospital and hospital address Hospital location code: V217H
Urgency of Referral Urgent Endocrine Clinic Referral?? ?	
Administrative Information Patient has special requirements: No Employment: Occupations Ethnic Origin: (White) Scottish ?	

PATIENT DETAILS	
Surname Adams	Patient's address 10 Douglas Avenue GRANGEMOUTH FK3 0LD Contact number(s) Voice: 874396
Forename(s) David	
Title - Sex Male	
Previous Surname -	
Date of birth 07-May-1957	
CHI no. 0705570592	

REFERRING PRACTITIONER DETAILS	
Name: Dr. Michael Blackmore (GMC: 4700555)	Practice address: 33 Bo'ness Road Grangemouth FK3 8AN
Practice: Bo'ness Road Medical Practice (25332)	
Phone: Voice: 01324 482653	

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: New diagnosis of Hyperthyroidism

Comment: Dear Team,

I would be grateful if you could see Mr. Adams who was seen regarding weight loss and, following a battery of blood tests, was found to be positive for Hyperthyroidism. TSH is running at <0.01 with a Free T4 of 26.3 and a Free T3 of 13. He has no goitre to speak of. He has been having some abdominal pains and altered bowels, and given a very strong family history of bowel cancer with his brother dying in his forties from bowel cancer, I have asked Gastroenterology if they would be willing to colonoscope him for safety.

I have arranged a Thyroid Antibody test and would be grateful if you would consider seeing him in order to manage his Hyperthyroidism. Obviously, once the results are back, if you feel this can be managed at a distance in General Practice, then of course we would be happy to assist.

Thank you for your help in this matter. Please find enclosed his past history and drug treatment.

Yours sincerely,

Dr. Anthony Dawson
G.P. Locum

Examinations and Investigations

FBC: Not Recorded -
Urea and Electrolytes: Not Recorded -
LFT: Not Recorded -
TFT: Not Recorded -
Lipid Profile: Not Recorded -
Glucose: Not Recorded -

Patient Measurements

Diastolic	Systolic	Height	Weight	BMI	Date Recorded
144	68				18-Mar-2020
133	71				30-Oct-2018
179	79				26-Oct-2018
130	80				15-Dec-2009
130	80				15-Dec-2009
		74.4			09-Mar-2020
167	82	29.4			30-Oct-2018

Reason for referral

Care type requested: Out Patient
Expected outcome: Not Specified

Medical history

Pre-existing Conditions (High Priority)

Description	?? Laterality	?? Modifier	?? Extension	?? Date Started	??
Alcohol dependence syndrome	?? -	?? -	?? -	?? 01-Jun-1995	

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

Drug name	?? Drug code	?? Formulation	?? Dosage	?? Frequency	?? Last Issued	??
Omeprazole Capsules (Gastro-Resistant) 20 mg	?? 0103050P0AAAGAG	?? 28 capsule	?? ONE DAILY	?? -	?? -	?? -
Ibuprofen Tablets 400 mg	?? 1001010J0AAAEAE	?? 84 tablet	?? ONE TO BE TAKEN THREE TIMES A DAY	?? -	?? -	?? -
Paracetamol Tablets 500 mg	?? 0407010H0AAAMAM	?? 200 TABS	?? 2 Tabs 4 times daily	?? -	?? -	?? -

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

Drug name	?? Drug code	?? Formulation	?? Dosage	?? Frequency	??
Loperamide Hydrochloride Capsules 2 mg	?? 0104020L0AAAAAA	?? 20 CAPSULE	?? TAKE TWO INITIALLY THEN ONE AFTER EACH LOOSE BOWEL MOTION. MAXIMUM 8 CAPSULES DAILY	?? -	?? - 42 Days

Clinical warnings

Smoking status	Number per day: ? (not known)	Date Recorded
Description	Comment	
Cigarette smoker, 20 Cigarettes/day	-	17-Jan-2017
Current smoker	-	23-Jan-2014

Current smoker	-	03-May-2011
Current smoker	Disease: SPICE Basic Health Values, 15 per day priority=1	23-Mar-2009
Current smoker	Disease: SPICE Basic Health Values, 20 per day priority=1	29-Jul-2006
Alcohol status:	Units per day: ? (not known)	
<u>Description</u>	<u>Comment</u>	<u>Date Recorded</u>
Alcohol Intake within recommended sensible limits	Disease: SPICE Basic Health Values, "Some cans at weekend" priority=2	29-Jul-2006
Exercise status:	Not Known	
Additional relevant information		
?		

Signature of referring doctor (or other professional)	Date	18-Mar-2020
--	-------------	-------------

Emergency Discharge Letter (Authorised)

G Crawford
Bo'ness Road Medical Practice
33 Bo'ness Road
Grangemouth
Grangemouth
FK3 8AN

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



Date of Completion: 03-Mar-2020

GP Practice			
GP Name:	G Crawford	GP GMC:	3479584
GP Practice Address:	Bo'ness Road Medical Practice	GP Practice Code:	3479584/25332
	33 Bo'ness Road	GP Clinic Code:	25332/1
	Grangemouth	GP Telephone:	01324 482653
	Grangemouth		
	FK3 8AN		

Patient Demographics			
Patient Name:	ADAMS, David	Date Of Birth:	07-May-1957
Patient Address:	10 DOUGLAS AVENUE	Gender:	Male
	Grangemouth	CHI No:	0705570592
	Stirlingshire		
	FK3 0LD		
Telephone No:	01324 874396		

Admission Details			
Patient Location:	FVRH Emergency Department	Admission Date:	03-Mar-2020
Admission Care Provider:	Dr Ainsley Heyworth	Admission Time:	11:19
Source Of Admission:	Self referral		

Presenting Complaint	
unwell	

Diagnosis		
Diagnosis	Site	Laterality
Abnormal Weight Loss		

Procedures	
No Procedure Results	

Medications	
Nil records exist	

Discharge Details			
Discharge Type:	With follow up by Primary Care team	Discharge Date:	03-Mar-2020
Discharge Destination:	Private Residence - Usual place of residence	Discharge Time:	11:58

Referred To:**Notes for GP**

Patient redirected from triage by Dr. Presented with 1.5 stone weightloss since dec. HAS been having D&V associated. No other clear symptoms in hx

CXR - formal report awaited

I have asked him to get bloods done at phleb at GP and provided a blood form. I have also arranged GP appointment for 9am next monday am

BP 128/87, Pulse 96, Spo2 100, Temp 36.4

Dr Ruth Chalmers

Person completing record

Name: Ms Ruth Chalmers

Designation or role: Doctor

Specialty:

Date completed: 03-Mar-2020

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
I Crawford	GP	Bo'ness Road Medical Practice

Department of Oral & Maxillofacial Surgery
Consultant: Mr J J Downie
Tel: 01324 566357

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr J Martin
Dental Surgeon
The Practice
72 Bo'ness Road
Grangemouth
FK3 9BL

Date Dictated 24 September 2019
Date Typed 02 October 2019
Our Ref JJD//F140620
CHI 0705570592

Dear Dr Martin

DAVID ADAMS 07/05/1957
10 DOUGLAS AVENUE, GRANGEMOUTH, STIRLINGSHIRE FK3 0LD

Diagnosis: Low grade dysplasia left buccal vestibule

I reviewed your patient back on the Oral & Maxillofacial Surgery Clinic this morning.

Happily he continues with his smoking cessation.

On examination the area of low grade dysplasia looked quiescent.

His oral hygiene was rather poor particularly in the lower left quadrant and I have encouraged him to visit your practice for some hygiene therapy.

For the time being no regular appointments have been arranged within our department, of course I would be happy to see him back if you have any future suspicion.

Thank you for your ongoing care.

Yours sincerely

(Dictated and electronically checked by Mr J J Downie)

Mr J J Downie
Consultant Oral & Maxillofacial Surgeon FDS RCS, FRCS OMFS

cc Dr Gregor Crawford
Bo'ness Road Medical Practice
33 Bo'ness Road
Grangemouth

FK3 8AN



Chairman: Alex Linkston CBE
Chief Executive: Cathie Cowan

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

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Department of Oral & Maxillofacial Surgery
Consultant: Mr J J Downie
Tel: 01324 566357

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr J Martin
Dental Surgeon
72 Bo'ness Road
Grangemouth
FK3 9BL

Date Dictated 12 March 2019
Date Typed 18 March 2019
Our Ref JJD/JC/F140620
CHI 0705570592

Dear Dr Martin

DAVID ADAMS 07/05/1957
10 DOUGLAS AVENUE, GRANGEMOUTH, STIRLINGSHIRE FK3 0LD

Diagnosis: Low grade dysplasia left buccal vestibule.

I reviewed your patient back on the oral & maxillofacial surgery clinic today. I was very happy to hear that David has stopped smoking now for six weeks.

On examination there is no progression of the dysplasia intraorally and in fact his mouth is looking healthier already following his smoking cessation.

I note he continues to attend your practice for ongoing dental treatment and is due to be provided with a partial upper denture.

I have made arrangements to review him in six months' time.

Yours sincerely

(Dictated and electronically checked by Mr J J Downie)

Mr J J Downie
Consultant Oral & Maxillofacial Surgeon FDS RCS, FRCS OMFS

cc
Dr Gregor Crawford
Bo'ness Road Medical Practice
33 Bo'ness Road
Grangemouth
FK3 8AN



**INVESTORS
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Gold
Until 2021

Chairman: Alex Linkston CBE
Chief Executive: Cathie Cowan

Forth Valley NHS Board is the common name for Forth Valley Health Board
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NHS Forth Valley Radiology Report

Patient Name:	Adams, David	Exam Date:	09/12/2024
Patient ID:	0705570592	Consultant:	BLAYNEY DR GARETH GERIATRICS
Patient Date of Birth:	07/05/1957	Report Date and Time:	09/12/2024 13:56:29
Patient Address	6 SALMON COURT SCHOOL BRAE BO'NESS EH51 9HF	Referring Dept/Location:	FV CLINICAL ASSESSMENT UNIT

Accession: V213987808701, Examination Date: 09/12/2024, Examination:
CT Angiogram Aortic Arch and Carotids:

Indication:

Clinical Details:

R TIA symptoms, recent motorbike accident 1/12 ago, recently painting house when acute onset LSW and dysarthria, CTA ? arterial dissection causing symptoms
Provisional Diagnosis : ? carotid or vertebral dissection on CTA

CT carotid angiogram:

Widely patent right common carotid artery.

Moderate calcified atherosclerosis of the right ICA origin with slight irregularity of the vessel wall but no measurable luminal narrowing.

No dissection.

Good calibre vessel within the skull base.

Minimal atherosclerosis of the left carotid bifurcation. No significant left ICA stenosis.

Dominant left vertebral artery; both vertebral arteries patent throughout the length although the V4 segment of the right vertebral is rather thready.

Normal intracranial vessels.

No new findings within the intracranial cavity.

Advanced emphysema within the imaged lung apices.

Conclusion:

Mild atherosclerosis right ICA origin but no measurable luminal stenosis.

Final Report By: Ewen Robertson Consultant Radiologist GMC 6128692 at 09/12/2024 13:56:29
Email Address: ewen.robertson@nhs.scot



NHS Forth Valley Radiology Report

Patient Name:	Adams, David	Exam Date:	09/12/2024
Patient ID:	0705570592	Consultant:	BLAYNEY DR GARETH GERIATRICS
Patient Date of Birth:	07/05/1957	Report Date and Time:	09/12/2024 17:04:18
Patient Address	6 SALMON COURT SCHOOL BRAE BO'NESS EH51 9HF	Referring Dept/Location:	FV CLINICAL ASSESSMENT UNIT

Accession: V213987957501, Examination Date: 09/12/2024, Examination:
MRI Head:

Indication:

Clinical Details :

R TIA symptoms- LSW lasting around 20 minutes with speech loss. Smoker, recent motorbike crash, residual mild LSW; MRI to confirm if evidence of ischaemic event. Note patient previously stabbed, reports no residual metal

Provisional Diagnosis :

? stroke on MRI not seen on CT

MRI brain: Comparison previous CT 08/12/2024.

Foci of diffusion restriction with high T2/FLAIR signal in the right putamen and body of caudate nucleus, in keeping with acute lacunar infarcts of the right basal ganglia.

Microvascular disease changes within the pons.

Normal configuration of the sulci and ventricles. Normal midline structures.

Normal major flow voids.

Normal craniocervical junction.

Left maxillary mucosal thickening.

Normal skull vault signal and extracranial soft tissue structures.

Opinion

Acute lacunar infarcts of the right basal ganglia.

Preliminary Report By: Jason Yang Speciality Registrar GMC 7711669 at 09/12/2024 16:53:44.

Final Report By: Ewen Robertson Consultant Radiologist GMC 6128692 at 09/12/2024 17:04:18

Email Address: ewen.robertson@nhs.scot.



NHS Forth Valley Radiology Report

Patient Name:	Adams, David	Exam Date:	08/12/2024
Patient ID:	0705570592	Consultant:	CORRIERI DR S EMERGENCY MED
Patient Date of Birth:	07/05/1957	Report Date and Time:	08/12/2024 17:04:47
Patient Address:	6 SALMON COURT SCHOOL BRAE BO'NESS EH51 9HF	Referring Dept/Location:	FV EMERGENCY DEPT

Accession: V213987709801, Examination Date: 08/12/2024, Examination:
CT Head:

Indication:

Clinical Details :

left weakness new and speech disturb

Provisional Diagnosis :

?cva ?thrombolysis

Findings:

Unenhanced CT head. No prior for reference.

No acute territorial infarct, space-occupying lesion or intracranial haemorrhage. No dense vessel identified.

Unremarkable appearance of the basal cisterns and ventricles with no CT evidence of altered intracranial pressure.

No acute fracture. Left maxillary mucosal sinus thickening.

Impression:

No acute intracranial abnormality identified.

Final Report By: Ryan Grech Consultant Radiologist GMC 7614448 at 08/12/2024 17:04:47 Email
Address: ryan.grech2@nhs.scot.



NHS Forth Valley Radiology Report

Patient Name:	Adams, David	Exam Date:	25/03/2024
Patient ID:	0705570592	Consultant:	MITCHELL DR O CONS OMFS
Patient Date of Birth:	07/05/1957	Report Date and Time:	26/03/2024 09:01:18
Patient Address:	6 SALMON COURT SCHOOL BRAE BO'NESS EH51 9HF	Referring Dept/Location:	ORAL SURGERY OPD

Accession: V213922255501, Examination Date: 25/03/2024, Examination:
XR Orthopantomogram:

Indication:

Clinical Details :

full opt please, tender LLQ intra oral ?retained root

Provisional Diagnosis :

?retained root LLQ

Bleep - 1143

Findings:

Dental images as requested.

Final Report By: Michelle Davidson Radiology Secretary at 26/03/2024 09:01:18 Email Address:
michelle.davidson@nhs.scot.



NHS Forth Valley Radiology Report

Patient Name:	Adams, David	Exam Date:	06/04/2022
Patient ID:	0705570592	Consultant:	GP REQUESTOR
Patient Date of Birth:	07/05/1957	Report Date and Time:	06/04/2022 12:54:35
Patient Address	10 DOUGLAS AVENUE GRANGEMOUTH STIRLINGSHIRE FK3 0LD	Referring Dept/Location:	DAWSON, DR A, GP BO'NESS ROAD MEDICAL PRACTICE

Accession: V203713575101, Examination Date: 06/04/2022, Examination:
US Testes:

Indication:

Clinical Details :

2/12 pain right testicle, varyign intensity, nil acute sudden, phx orchitis, exam today sl limtie dby tender
?epuiddymal cyst, with hydrocoele, and testis rel small, ?normal some apprehension.

Provisional Diagnosis :

?sol

Findings:

Chaperone: Sandra Brown.

I note history of previous scrotal ultrasound report from 2003, no available PACS images from this time. Left testicular cyst noted at that time however the patient states this was surgically removed.

Right testicular volume 18 ml. Left testicular volume 15 ml.

Both testes are normal in size and appearance being smooth in outline with a normal homogenous texture and comparable flow on colour Doppler examination. No focal intratesticular lesions evident.

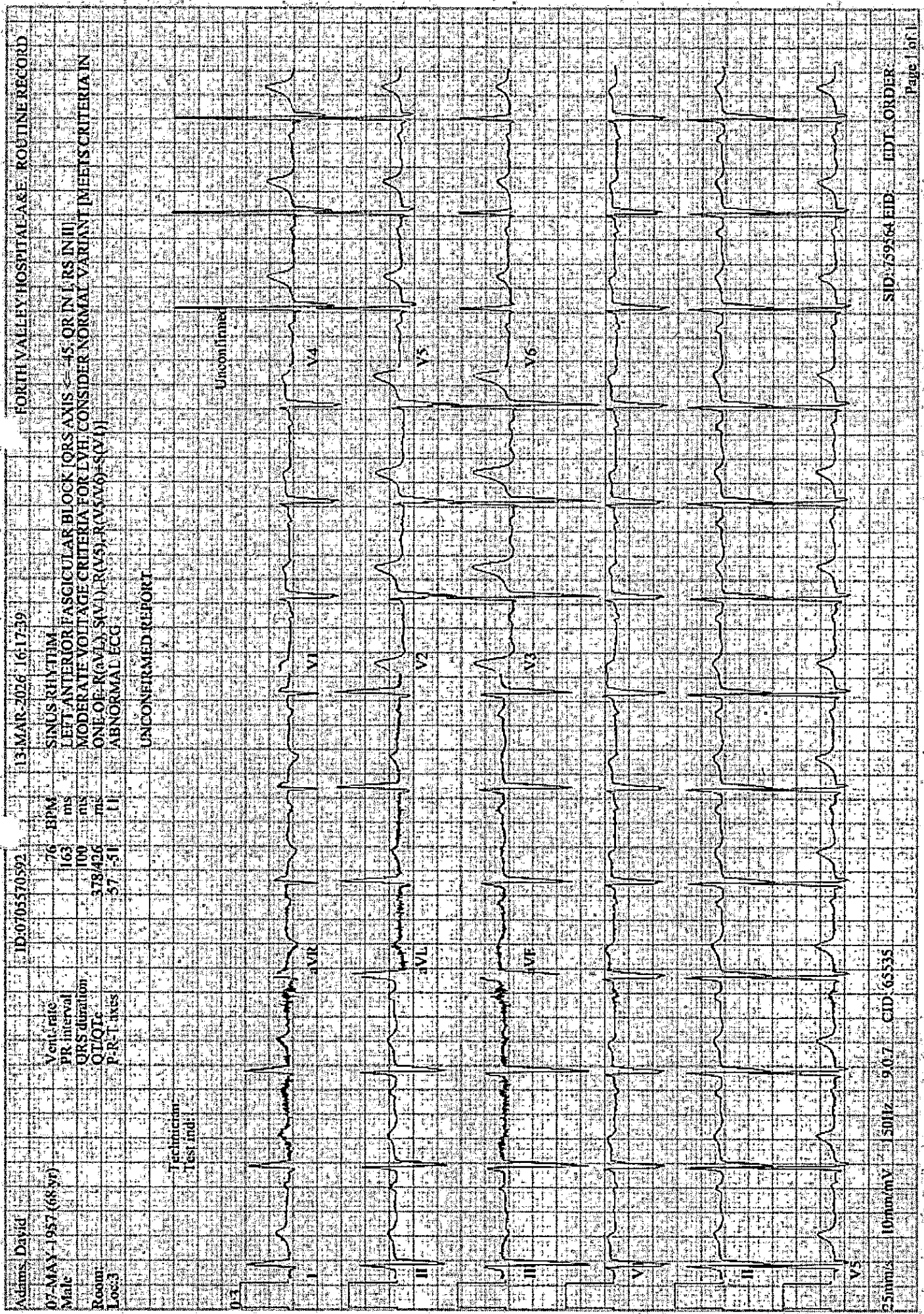
Two simple cysts within the right epididymal head measuring 2.3 mm and 4 mm in diameter.

8.8 x 10.4 x 8.5 mm multiloculated avascular cyst within the left epididymal head.

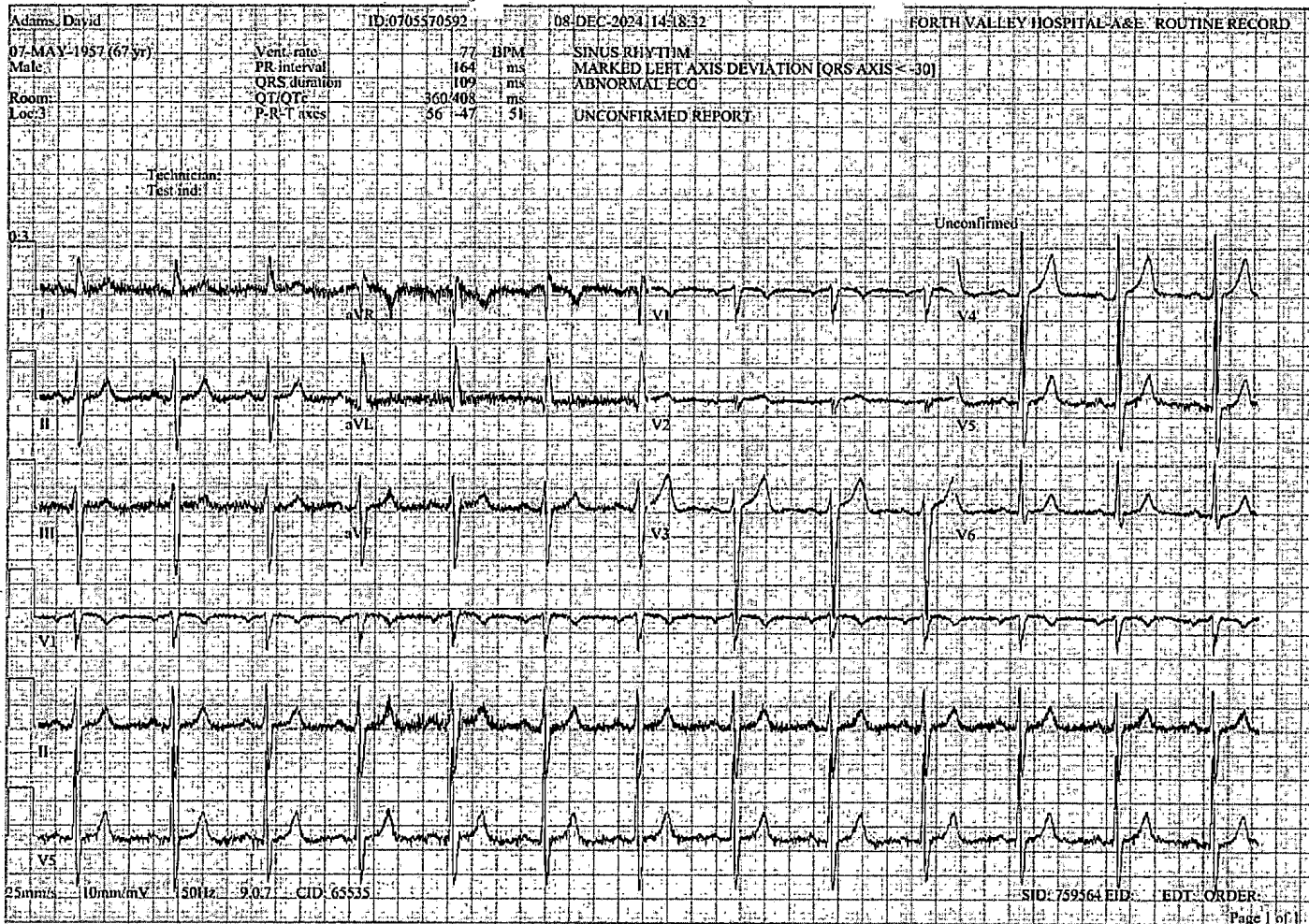
No evidence of any hydrocele. No varicocele demonstrated.

SUMMARY: No testicular pathology. Simple right epididymal cysts. Multiloculated left epididymal head cyst. No hydrocele or varicocele demonstrated.

Final Report By: Linda Bain Sonographer HCPC RA25071 at 06/04/2022 12:54:35 .



THIS IS A RECONSTRUCTED DOCUMENT DERIVED FROM ECG



THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

**FV Continuation Note -
Stroke START**



Patient Name: ADAMS, David (Mr)

CHI Number: 0705570592

Date / Time of note recorded in MORSE:

11/03/2025 08:48:06

Date / Time of contact:

11/03/2025 08:30:00

Note

Email sent to pt's GP, see below:

Evelyn Moore (NHS Forth Valley)

FV Kinneil clinical

Dear Dr,

Regarding: David Adams CHI:0705570592
6 Salmon Court
Bo'ness

I have been seeing Mr Adams in the community. He had a stroke in December 24, which has impacted his cognition & left side weakness. Left sided weakness is improving, with mostly spontaneous recovery and Mr Adams can use his left upper limb quite well in function.

With regards to his cognition there remains some ongoing difficulties particularly with memory & concentration. An Addenbrookes Cognitive Screening (ACE3) was carried out on the 4/3/25 which he scored overall 71/100.

Subscores: attention 11/18, memory 16/26, fluency 6/14, language 22/26, visuospatial 16/16.

It is worth noting that Mr Adams explained that he left education at a young age & feels his reading, writing & numerical skills are not great but he can get by. Some of the questions related to reading & writing he scored poorer on. However, the ACE3 demonstrated impairments in his short term memory, concentration & fluency. He agreed to sharing of these results with yourself.

Mr Adams did not wish further input around cognitive process training & I have provided him with some memory strategy advice however, his use of these strategies is mixed. He has difficulty remembering appointments for example I believe he has missed several medical appointments in the past. His engagement during our input has been variable.

Mr Adams is now discharged from our service, as no further rehab needs were indicated. He has the contact details for single point of referral should he need to self refer in the future.

I hope you find this information useful,
Please feel free to contact me to discuss anything,

Kind Regards,

Evelyn

Evelyn Moore
Occupational Therapist
Stroke Transition and Rehabilitation Team (START)
My working hours are: Mon - Fri 8am- 4pm
Contact details: 01324 673671

Recorded by: Evelyn Moore

Contact Number:

Designation: Occupational Therapist

Date / Time of note recorded in MORSE:

10/03/2025 12:15:00

Date / Time of contact:

10/03/2025 11:30:00

Note

Telephone call review carried out as per previous OT plan, to feedback results from ACE3 cognitive screening & to discuss with pt plan moving forward & if needs/ wishes further rehab input.

Spoke to pt, he is currently in St Andrews on holiday staying in his caravan. He is unsure how long he plans to stay there. His brother drove him there. Pt Apologised for missed visit with Physio on Friday when asked - he appeared to have forgotten about the appointment, says it must have not been on his calendar.

OT feedback results from ACE3 cognitive screen and discussed what this means how this may impact pt in terms of function. Pt in agreement his short term memory & concentration has been affected by the stroke. OT discussed again some strategies to help support these difficulties. Pt not keen for cognitive rehab input & from OT's perspective pt very unlikely to engage with same given how pt presenting during time with START. Pt consented to OT sharing results from ACE3 with his GP.

Discussion with pt moving forwards and rehab plan / need for further input. Difficult conversation & pt required support with this. Pt not coming up with any areas of concern or any specific area he would like rehab input with.

Agreed to discharge from START.

P. Send out discharge letter to pt & include details for SPR contact number for pt to self refer to rehab services in the future if feels needs input.

Email GP with update & outcome of ACE3 cognitive screen results.

Liaise with Physio.

DC from OT

Recorded by: Evelyn Moore

Contact Number:

Designation: Occupational Therapist

Date / Time of note recorded in MORSE:

07/03/2025 17:31:00

Date / Time of contact:

07/03/2025 13:10:00

Note

Attempted to review patient as per pre-arranged appointment. Arrived at patient's address, no answer at front door of building despite multiple attempts. Unable to access building to knock at flat door. Attempted to contact patient multiple times, no answer on mobile, ringing continuously with no voicemail. Patient had mentioned to OT (as per note below) he may be travelling to ST Andrews.

Will attempt patient again next week. Liaise with OT re plan.

Recorded by:	Kaylie Dyson	Contact Number:	
Designation:	Physiotherapist		

Date / Time of note recorded in MORSE: 05/03/2025 09:05:00

Date / Time of contact: 05/03/2025 08:40:00

Note

MDT discussion:
David Adams
Who involved:
OT/PT
Re-state goals
Walk to the local tesco
Progress towards goals: (Half way through?/ goals discussion/ family meeting?)
Cog screen mid 70s/100. Pt does not wish to engage in cognitive rehab. Memory strategies provided. OT will do t/c review in due course.
PT review end of week but if no engagement will likely be discharged.
Onward referral made? Exit plans?
Likely not – will provide SPR number.
EDD:
07/03/25
Outcome measures
Up to date

Recorded by:	Kathryn Scott	Contact Number:	
Designation:	Occupational Therapist		

Date / Time of note recorded in MORSE: 04/03/2025 11:31:00

Date / Time of contact: 04/03/2025 09:40:00

Note

S. Visit as planned. Pt reports feeling well today. Pt shared details of recent home visit by GP. Pt said he is awaiting blood results and is being re-referred to Cardiology for a heart monitor. Pt said that he feels his ankle pain is improving but hasn't attempted the walk to Tesco recently. Asked pt if he has been doing ex prog set by Physio of walking laps along corridor daily - pt said he hadn't been doing this but will try start this.
Pt reports he is managing all personal care and meal prep activities. Using L UL/ hand well in function now.
Pt shared that he plans to give up drinking alcohol as he does not think it is good for him. Pt declined to elaborate any further on this when asked by OT.
O. Following discussion and with encouragement pt agreed to carrying out an ACE3 cognitive screen today with OT.
Sat in kitchen at table. Pt focussed well on task. Asked pt re his age at leaving full time education - as per question on ACE3. Pt spent some time explaining to OT that he spent his childhood in various care homes which he called "boys homes" from a very young age. He said he did not attend school often. Pt shared that he feels he is not good at reading or writing but can get by.
ACE 3 cognitive screen completed.
(Scored on return to the office :
score= 71/100

Attention 11/18, memory 16/26, fluency 6/14, language 22/26, visuospatial 16/16.)

Initial feedback from score given to pt whilst on visit- OT explained will score fully when back at the office and will feedback to pt more formally. Pt aware his short term memory is affected. Pt also lost marks on the numeracy section which reflects attention. Pt did not attempt this question due to feeling he was "no good at maths".

Pt also struggled with the 1st part of the fluency section- naming as many words starting with the letter "P" however, scored better on 2nd part "name as many animals as possible".

Attempted to discuss future rehab plan however, pt remains to have difficulty staying on this topic but also at times does appear quite unbothered. He says he is managing day to day tasks but admits his memory isn't so good. Pt is utilising memory strategies eg, writing things down, & using a calendar however, not always consistent with checking this. OT offered some more input/ suggestions again around memory strategies however, pt not engaging with this.

Also offered some cognitive process training to which he declined.

Towards end of session pt explained that he plans to return to his caravan in St Andrews again possibly in next few days. He says he is not sure how long he plans to stay there, might be a few days might be a few weeks.

I suggested I call him in next few days 1) to feedback full results from ACE3 & 2) to determine if he wishes any further rehab / OT input going forwards.

A.

Pt appears to have some level of cognitive impairment which is demonstrated again with ACE3 cognitive screen carried out today. Pt appears to have combination of lack of insight +/- unbothered re this. Remains to have difficulty engaging fully with rehab & START input. Does not appear to take on board memory strategy advice at times.

Limited active engagement from pt.

P. Call pt in next few days to ascertain if he wants further input / if rehab needs can be identified.

I will ask pt if I can share results from ACE3 cognitive screen with his GP.

Liaise with MDT

Recorded by:

Evelyn Moore

Contact Number:

Designation:

Occupational Therapist

Date / Time of note recorded in MORSE:

28/02/2025 12:56:00

Date / Time of contact:

28/02/2025 09:10:00

Note

S/ Consented to pre-arranged home visit. Patient shares he had a home visit from the GP and now awaits bloods as well as further cardiology review. Patient shares he has been out with his daughter to Falkirk and tried walking further distances but struggled with pain in his ankle and fatigue. He states whenever he tries to walk further distances he then spends two days recovering. He also shares he does not take pain relief other than 'a joint' on the weekends.

Discussed future for rehab, patient having difficulty remaining on this topic and requiring support to explore options. Patient clearly stating he would like to be able to walk to local Tesco and back without difficulty. However, patient declined outdoor mobility practice today. Explained PT role for assisting patient to reach goal but highlighted the importance of consistent engagement with exercise/therapy in order to achieve goals. Advised patient to think about future rehab and will revisit this topic during next session.

O/ With encouragement, patient agreed to indoor mobility practice with stick. Completed 6x lengths of hallway slow and steady pace. Hallway is approximately 30 metres and calculated that patient would have to walk 32 lengths of hallway in order to travel same distance as Tesco. Patient provided with walking plan for gradual build up of lengths over next week and will review next

session. Plan written for patient for memory prompt.

A/ Patient having difficulty engaging with conversation regarding future of rehab today. Planned daily exercise for week and review for adherence. Patient likely would benefit from onwards referral but limited with active engagement at present. Further discussion surrounding future input required.

P/ Liaise with OT, review in 1/52

Recorded by:

Kaylie Dyson

Contact Number:

Designation:

Physiotherapist

Date / Time of note recorded in MORSE:

27/02/2025 14:03:00

Date / Time of contact:

27/02/2025 13:00:00

Note

Telephone call to pt on background of pt cancelling earlier visit with OT this week, Pt reports that he cancelled visit to go into the town with his daughter. Pt reported that the GP, Dr Webster was currently in attendance at the house to see him. Asked pt if still wanted to see Physio tomorrow as per previously arranged - pt accepting of same and for OT to join.

P. Review pt 28/2/25

Recorded by:

Evelyn Moore

Contact Number:

Designation:

Occupational Therapist

Date / Time of note recorded in MORSE:

26/02/2025 15:30:00

Date / Time of contact:

26/02/2025 08:00:00

Note

Email sent to GP as per plan:

Outlook

D Adams CHI: 0705570592

From Kaylie Dyson (NHS Forth Valley) <kaylie.dyson@nhs.scot>

Date Wed 26/02/2025 13:38

To FV Kinneilclinical <fv.kinneilclinical@nhs.scot>

Good Morning,

I am looking for support for a patient currently under the care of the START community stroke team. Mr. Adams suffered a stroke in December 2024 and his memory has been impacted along with left sided weakness.

He has difficulty remembering appointments, despite using memory strategies. Due to this, he has missed a few appointments with yourselves as well as cardiology follow up for a 48 hour tape. During my last visit, he shared he has been experiencing left ankle pain and swelling. There was no indication of any other inflammatory signs on examination. He has also reported ? blackouts/lose of consciousness/falls but is unable to provide further details when being asked for details.

I am concerned about Mr. Adams and feel he would benefit from a medical review as he has not been reviewed since returning

home from hospital. Due to his physical limitations and cognition change, I wondered if a telephone appointment or house call would be more appropriate.

Many thanks for your help in advance,

Kaylie Dyson

Stroke Transition And Rehabilitation Team
(START)
Falkirk Community Hospital
01324 673671

Recorded by:	Kaylie Dyson	Contact Number:	
Designation:	Physiotherapist		

Date / Time of note recorded in MORSE: 25/02/2025 11:51:00

Date / Time of contact: 25/02/2025 11:00:00

Note

TC received from pt today wishing to cancel today's visit with OT, my colleague Robyn Smith took the call and passed message on. Pt declined to speak to OT or rearrange at the time of phonecall.

P.

Contact pt in few days to re-arrange / determine if wishes further input

Recorded by:	Evelyn Moore	Contact Number:	
Designation:	Occupational Therapist		

Date / Time of note recorded in MORSE: 25/02/2025 11:38:00

Date / Time of contact: 24/02/2025 09:30:00

Note

Telephone call to pt to arrange further OT input following message from K Dyson re pt consenting to cognitive screen.

Spoke to pt: Pt reports feeling well today, busy prepping potatoes for dinner tonight. He said he enjoyed his time away at the motorhome but is considering selling it. Pt reports his left ankle remains quite sore & is limiting his ability to manage out of the house. Says he is managing to mobilise around the house ok.

Re-visited discussion around pt's cognition & OT explained benefits of carrying out cognitive screen. pt appeared receptive now to cognitive screen, therefore OT visit arranged for 25/2/25 to carry out ACE3.

P. OT Visit 25/2/25 to carry out cognitive screen.

Recorded by:	Evelyn Moore	Contact Number:	
Designation:	Occupational Therapist		

Date / Time of note recorded in MORSE:

21/02/2025 15:37:00

Date / Time of contact:

21/02/2025 13:45:00

Note

S. Consented to pre-arranged home visit. Patient shares he and his brother drove up to caravan and spent two weeks together at the caravan. His brother then drove them back as well. He reports he continues to have difficulty with his memory, he has left his cooker on again and burnt his pots. He also reports he 'wakes up on the couch then on the floor' but when asked if he is falling or losing consciousness, the patient was unable to provide clarification. He also reports he has not attended any of his medical appointments as he keeps forgetting these and he is forgetting to take his medication at times.

He states he has been trying to mobilise to local shops and has managed to nearby places but struggling to walk to Tesco and requires a taxi to return. He states this made him tired for a few days afterwards and his left ankle swells up and is sore.

Discussed ongoing memory concerns and explained the benefits of assessing this to aid in supporting him. David consented to cognitive screening and happy to explore this.

Also attempted to make a GP appointment with patient on the phone, but the practice receptionist advised face to face appointment available 6th March but home/telephone calls required further triage. Tried to explain limitations of patient to attend but receptionist unable to assist. Further email to GP likely required due to response received.

O/ Patient mobilising unaided around flat with steady and safe gait. Navigating furniture and doorways appropriately. Mild associated reaction in left UL present.

Using left hand in function at times to don/doff socks and slippers when showing PT ankles. Left ankle mildly swollen, no redness or heat. Tender to touch general over ankle and calf.

Left grip 4+/5, dexterity to all finger tips with thumb, hand now reaching to top of head, full range pronation/supination.

A/ Patient memory continues to be a concern due to ?falls, leaving cooker on, etc. Progress today as patient consenting to cognitive screening and for PT to email GP practice. Patient likely needs house visit or telephone call from GP as struggling to remember to attend appointments.

P/ Liaise with OT re cognitive screen. Email GP. Review in 1/52 once back from AL.

Recorded by:

Kaylie Dyson

Contact Number:

Designation:

Physiotherapist

Date / Time of note recorded in MORSE:

20/02/2025 15:29:00

Date / Time of contact:

20/02/2025 13:00:00

Note

Telephone call to pt as previous plan.

Spoke to pt: he says he enjoyed his break away to his motorhome up in Leuchars. Pt shared that he missed his appointment with Cardiology this week, forgot to check his calendar. Is trying to reschedule this.

Pt shared that he walked to Tesco yesterday but struggled and had to get a taxi back- says his leg is swollen today. Offered Physio & OT visit tomorrow to review pt which he accepted.

P. visit arranged for 21/2/25 with E Moore OT and K Dyson Physiotherapist

Recorded by:	Evelyn Moore	Contact Number:	
Designation:	Occupational Therapist		

Date / Time of note recorded in MORSE: 13/02/2025 15:11:00

Date / Time of contact: 13/02/2025 10:00:00

Note

note in error

Recorded by:	Evelyn Moore	Contact Number:	
Designation:	Occupational Therapist		

Date / Time of note recorded in MORSE: 05/02/2025 09:08:00

Date / Time of contact: 04/02/2025 09:15:00

Note

Patient contacted the START team late on 3/2/25. Messaged passed to the writer this morning. Patient has advised he will not be available for appointment this morning due to being away at caravan in St Andrews. Patient happy for telephone call after 19th February 2025 to arrange further appointment.

P/ Contact week beginning 18/02/25 to arrange further appointment

Recorded by:	Kaylie Dyson	Contact Number:	
Designation:	Physiotherapist		

Date / Time of note recorded in MORSE: 05/02/2025 09:12:00

Date / Time of contact: 05/02/2025 09:05:00

Note

David Adams
MDT discussion:
Spontaneous recovery, not really self managing, cog issues.
Not fully engaging, also had recent berevment
Who involved:
PT/OT
Re-state goals
Progress towards goals: (Half way through?/ goals discussion/ family meeting?)
Improve limb function
Onward referral made? Exit plans?
To be discussed
EDD:
11/2/24
Outcome measures

Done

Recorded by: Rebecca Cameron

Contact Number:

Designation: Speech and Language Therapist

Date / Time of note recorded in MORSE:

29/01/2025 09:12:00

Date / Time of contact:

29/01/2025 09:00:00

Note

David Adams

MDT discussion:

Spontaneous recovery, not really self managing, cog issues.

Not fully engaging, also had recent berevement

Who involved:

PT/OT

Re-state goals

Progress towards goals: (Half way through?/ goals discussion/ family meeting?)

Improve limb function

Onward referral made? Exit plans?

To be discussed

EDD:

11/2/24

Outcome measures

Done

Recorded by: Simone White

Contact Number:

Designation: Therapy Assistant Practitioner

Date / Time of note recorded in MORSE:

27/01/2025 16:18:00

Date / Time of contact:

27/01/2025 10:45:00

Note

S/ Consented to joint pre-arranged home visit with E Moore (OT). Details of session outlined in E Moore's note 27/01/25. Details true to session. Patient advised he has not been completing physio suggested exercises but did go for a walk independently around block in front of his building. He advised he did not have difficulty with this distance. He reports he has not attempted to walk to Tesco again since previous visit. Agreeable to practicing this during next visit with support of therapy staff as required.

O/ Mobilising unaided around home environment appropriately, increased natural arm swing and incorporation of left side. Balance maintained while moving dishes in and out of the oven, using right UL.

Power in left UL: grip 4/5, wrist extension 4/5, triceps 4/5, biceps 4/5. FROM abd/add all fingers. Thumb extension 1/2 range against gravity. Dexterity: thumb to all fingers except ~1 cm off tip of 5th digit.

A/ Patient requires encouragement from therapy staff to engage in rehab and does not appear to share concerns about level of function. No consent gained from patient to speak with daughter (as per details in E Moore note).

P/ Assess outdoor mobility next planned visit 4/2/25.

Recorded by:

Kaylie Dyson

Contact Number:

Designation:

Physiotherapist

Date / Time of note recorded in MORSE:

27/01/2025 15:23:00

Date / Time of contact:

27/01/2025 11:00:00

Note

S. Joint visit carried out OT & K Dyson Physio. Pt consented to input.

Pt shared that he has been busy this morning prepping banana loaf & a beef stew. Just about to put into the oven to cook.

Pt admitted to not doing any of the UL activities/ex's prescribed. But did share that he has been using / including affected UL more with everyday tasks. Feels there has been some improvement in UL movement. Feels he has recovered from recent fall and pain in UL from last week appears better.

Pt shared he has 2 funerals to attend this week, tues & wed. Also has upcoming app with Cardiology for 24hr monitor - mid Feb.

O.

Pt answered the door to therapists, independently mobile. Pt directed therapists into the kitchen to show what he has been making. Pt rhymed off ingredients he used to make banana loaf. Observed pt placing banana loaf and beef stew into the oven.

Pt looking at his calendar which he has been using to input important information, appointments.

Continues to utilise writing in notepad to support memory.

Pt still a bit distractible today during conversation but less than when seen last week.

Observed pt making cup of tea - encouraged pt to use affected UL to stir tea with teaspoon. Pt then went to place hand over hand, OT said that pt did not need to do that & would be able to stir cup with L UL. Pt then joked with therapists that he was just doing that "to annoy you".

Pt was not sure if he had already taken today's prescribed meds - checked dosette box and no taken yet - pt says he will take later once he has ate something.

Observed improved activity and movement in L UL. Forearm pronation / supination improving, wrist ext/ flex improving, digit tapping, finger adduction/ abduction. Pt repeatedly saying that his hand shakes a lot whilst doing ex's and focussed on this. Re-assured pt that this is due to muscles having to work harder due to weakness and encouraged pt to persevere because the more he uses the UL/hand & carries out ex's the easier it should become over time.

Conversation with pt re how he is coping, cognitive concerns and support from daughter. Therapists asked on several occasions if he would consent to therapists contacting his daughter to discuss concerns eg, recent fall, cognition, check if daughter has concerns. Pt did not consent to therapists contacting his daughter, was firm in this response.

Reminding to check cake in oven - due to conversation with therapists likely distracted by this.

Pt noted cake to be cooked perfectly. Oven left on as pt continuing to cook Beef Stew. Suggested pt set a timer to remind him when cooking finished, pt declined this. Therapists offered several times to show pt how to set timer on phone however, firmly declined this. OT suggested sticky note placed on cooker wall to remind pt to switch cooker off - pt declined this. Says he ensure

he turns cooker off at the wall now.

Medications: Suggested pt place dosette box somewhere handy as a visual reminder, currently kept on corner of worktop. Suggested next to kettle as pt drinks regular cups of tea and would serve as visual prompt - pt declined this suggestion. Also suggested pt may wish to stick little note on back of bedroom or kitchen door to remind to take medication - again pt declined this suggestion.

Pt stated that "I am set in my ways".

A:

Appeared brighter and less distracted today than last weeks visit. Mood better.

Improvements in UL function, some spontaneous recovery. Encouraged pt to carry out ex's prescribed but not sure if will do these. Not fully engaged with rehab. Pt appears quite unbothered about his condition & therapists concerns.

Did not consent to therapists contacting his daughter, would have been helpful to establish baseline & concerns.

P:

Return visit planned for 4/1/25

Pt agreed to outdoor mobility px to Tesco to collect some shopping.

Continue discussions around cognitive concerns/ coping strategies.

Recorded by:

Evelyn Moore

Contact Number:

Designation:

Occupational Therapist

Date / Time of note recorded in MORSE:

24/01/2025 10:57:00

Date / Time of contact:

24/01/2025 10:50:00

Note

Telephone call to patient

S/Consented to discussion. Patient advised went out this morning to buy milk and returned safely home from corner shop nearby. He shares he has not reschedule his GP appointment but will do this Monday. Patient accepting of joint visit by E Moore (OT) and PT for Monday 27/01/25. Patient also states not feel well but unable to elaborate as to why he feels this way and has daughters support if required.

P/ Review in 3/7, joint review. Gain consent for discussion with daughter.

Recorded by:

Kaylie Dyson

Contact Number:

Designation:

Physiotherapist

Date / Time of note recorded in MORSE:

23/01/2025 07:49:00

Date / Time of contact:

22/01/2025 09:12:00

Note

MDT discussion:

Who involved:

Kaylie and Evelyn

Re-state goals

To improve upper limb. Can be difficult to set goals due to his distractability.
 Progress towards goals: (Half way through?/ goals discussion/ family meeting?)
 Cognitive difficulties: insight? Trying to deflect conversations around cognition at times: forgetting things eg GP appointment and left cooker on twice. Daughter trying to help. Distractable. ?Difficulty processing.
 Can be negative but has some good movement in upper limb.
 Need baseline cognition from daughter if patient consents..
 Lots of things going on: found nephew RIP
 Has been complaining of vision: has watery eye: needs to re-schedule GP appointment re this.
 To discuss re/with Psychology for a plan
 Onward referral made? Exit plans?
 Half way through: TBC
 EDD:
 11th Feb
 Outcome measures done

Recorded by:	Juliet Molteno	Contact Number:	
Designation:	Physiotherapist		

Date / Time of note recorded in MORSE: 21/01/2025 11:58:00
 Date / Time of contact: 21/01/2025 09:10:00

Note

S/ Consented to home visit. Patient shares he not feeling well, he reports his wrist and left arm have been sore but unsure of cause. He reports he woke up on the floor in his bedroom on friday and thinks he must have fallen at this point but can't remember details. He advised he had a drink on saturday but not friday and doesn't feel this has impacted his fall. He denies red flags of worsening symptoms vision, power, sensation or balance. He reported he has left the stove on again and burn his pasta, he was able to recall he has done this twice now. He advised he put on the stove and walked away, forgetting he had done so.

O/ Answered door unaided, mobilising through home with slow reciprocal gait, reduced step length on left, maintaining balance and navigating door ways and furniture safely.

Sensation and proprioception intact throughout UL and LL. Power testing unchanged from assessment on 16/01/25.

Left wrist swollen and mild bruising over dorsal aspect. Tender on palpation over soft tissue. No obvious deformity and patient not in pain when palpating bony prominence. Pain increased with passive wrist extension, when active hand shaking slightly and sore. No other bruising visible upper arm or trunk. Some discomfort with light palpation of left and right ribs. No obvious bony deformities.

sit to stand practice at kitchen table: prompting to engage left LL, hands clasped and increased midline stand with encouragement. Set up facing table and written description for independent practice.

Patient asking if his memory and weakness would improve or if this is his new normal.

A/ Patient story conflicting with previous discussion with E Moore yesterday regarding fall/events of weekend. Patient wrist appears to be soft tissue injury, but will monitor this for worsening. Patient continuing to struggle with memory and risk associated with this as now left stove on twice. Showing some insight to memory as asking questions about recovery today.

P/ Liaise with OT for joint visit. Request consent from patient to speak to daughter for further information/insight.

Recorded by: Kaylie Dyson

Contact Number:

Designation: Physiotherapist

Date / Time of note recorded in MORSE:

20/01/2025 14:23:00

Date / Time of contact:

20/01/2025 09:30:00

Note

S.

Visit as planned. Pt consented to input. Pt shared that he is not feeling too well today but unspecific re symptoms.

Had a fall on Saturday night in his bedroom, unsure cause for fall but fell onto affected side. Pt co of some pain and ache in L UL, shoulder & wrist area. Pt also shared that he had a few alcoholic drinks on fri and sat evening but denies this attributed to fall. Pt also shared that his "head is all over the place" at the moment - recent death of nephew, found by pt at his home. Ongoing investigations into cause of death. Pt shared that he forgot about GP appointment he was supposed to attend - wrote it down on piece of paper but just forgot.

O. Pt answered the door to OT, independently mobile.

Observed pt's (L) UL: some mild swelling around the wrist. Pt co of ache / pain when moving wrist, arm and shoulder although feels is slightly better than yesterday.

Advised pt to seek assistance from Minor Injuries, call NHS 24 if symptoms persist or is concerned.

Spent some time in discussion with pt today & emotional support / reassurance.

Attempted to discuss pt's cognition however, changing topic or distracted from questions.

A.

Pt quite distracted and upset today. Frustrated due to recent fall & emotionally affected by recent death of family member. Not appropriate for rehab input today.

Cognitive concerns but pt ? deflecting from difficulties.

P.

Liaise with MDT.

Contact pt towards end of week & plan future input.

? discuss option of NeuroPsych input and refer if pt agreeable

Recorded by: Evelyn Moore

Contact Number:

Designation: Occupational Therapist

Date / Time of note recorded in MORSE:

17/01/2025 08:36:00

Date / Time of contact:

16/01/2025 13:00:00

Note

S/ Consented to home visit this afternoon. Patient welcomed PT into home and shared he had missed his GP appointment this morning as he had forgotten. Patient avoiding answering questions about memory and cognition when attempting to explore this topic by switching conversation. Patient reports he has been walking to local Tesco but unable to carry groceries and becoming tired, taking taxi back to flat. He also spoke of getting back on his scooter, stating 'I think I could tie my left hand onto the bike'.

PT strongly advised this would not be appropriate and he should not do this, outlining the safety concerns surrounding the statement. Patient accepting of this.

O/ Patient mobilising independently to answer door.

Mobility unaided, short reciprocal steps, antalgic gait pattern on left, associated reaction of left UL, steady while navigating doorframes and furniture.

L shoulder: small sublux present and tenderness on palpation of anterior deltoid and pecs. Patient guarding UL, difficult to assess for tone/spasticity. Reduced supination passively: tightness and painful at end range (1/2 range).
Delayed shoulder elevation vs right, 4-/5 resisted, 4-/5 biceps/triceps, 3/5 wrist flexion.

L LL: power 4/5 hip flexion, 4-/5 knee ext, 4-/5 knee flexion, 3/5 dorsiflexion. Encouragement+ as patient stating his left leg was 'useless'. Visual demonstration and verbal explanation to follow some instructions during testing.

Mobility practice: mobilised with self purchased stick up and down hallway with supervision. Reciprocal gait, antalgic to left, consistent foot clearance and steady throughout. Holding stick in the air at times, minimal weight bearing through stick.

Discussed goals: patient becoming distracted during conversation and difficult to establish specific goals. Patient advised not keen to return to working. Agreed that mobility practice important for getting to and from Tesco as well as strengthening his leg for this.

A/ Patient presenting with left sided weakness. Difficult to assess as patient becoming distracted and walking around home and showing PT cat/food supply/decor/bathroom. Mobility safe within home environment but struggling with distance.

P/ Liaise with OT regarding cognition/memory/processing. Continue PT assessment and commence exercises and mobility practice. Further discussion with patient regarding goals.

Recorded by:

Kaylie Dyson

Contact Number:

Designation:

Physiotherapist

Date / Time of note recorded in MORSE:

15/01/2025 09:21:00

Date / Time of contact:

15/01/2025 09:00:00

Note

MDT discussion:
David Adams

Who involved:
Evelyn, Kaylie to pick up

Re-state goals
Improve L UL function and improve outdoor mobility

Progress towards goals: (Half way through?/ goals discussion/ family meeting?)
L sided weakness, improving picture
Difficult with engagement of exercises, does not give impress practice of exercises out with therapy input. Tends to be quite negative towards ability level.
Potential cognitive impairments, patient not keen for assessment of this, avoidance behaviour.

Onward referral made? Exit plans?
Early days, to be determined.

EDD:
11/02/25

Outcome measures
completed

Recorded by: Kaylie Dyson

Contact Number:

Designation: Physiotherapist

Date / Time of note recorded in MORSE:

14/01/2025 13:55:00

Date / Time of contact:

14/01/2025 10:00:00

Note

S. Visit as planned. Pt consented to input. Pt reports feeling well today. Shared that he has adopted a cat. Reports he attended Citizens Advice for benefits check & may be entitled to some disability allowance, but unsure because he already receives a pension. They are sending out application forms & pt said he will ask his daughter to help fill these in. Pt shared that he has some difficulty reading & writing & that this was difficult prior to stroke but that he is able to get by. Asked pt if reading & writing any worse since stroke to which he denied.

UL wise - pt vague re how much activity / ex's he has been doing. Pt reporting feeling his (L) UL is "useless".

Pt reports continues to manage all basic ADLs, personal care and meal prep.

Pt shared that he has a GP app this week for a health check.

O.

Pt independently mobile within the house. Conversational with OT.

Cognition: Pt still writing everything down as reminders. Asked pt re his cognition again, not too concerned. Politely declined cognitive screening when offered. OT discussed some memory strategies again.

(L) UL Rx: whilst seated at kitchen table.

-gentle warm up

-shoulder shrugs - some difficulty activating L shoulder.

-elbow ext/flex hand to chin

-forearm pronation & supination

-wrist ext / flex : wrist extension appears to be improving.

-digit tapping & mirroring with unaffected hand. More activity in 3-5th digits, thumb & index finger reduced.

-px picking up sweets from tub - able to achieve some pincer style grip but weak.

-reach & grasp, stacking cones.

Lots of encouragement required.

At times during UL ex's pt reporting some pain in (L) LL.

Pt did not appear fully engaged in ex's at times, & also a tendency to stop ex & respond with "I can't do that" & "this arm doesn't work". Advised pt that there is good level of activity in UL but that what is required is lots & lots of reps. Neuroplasticity explained to pt.

Did not have time to review sensation.

A.

Appears to have good rehab potential & pt says wants UL to improve however, this is hindered by low engagement at times during UL ex's & avoidance / negative thoughts.

Discussed / reinforced again today the importance of repetitive task px & including affected UL in function.

P.

Return visit planned for 20/1/25

UL rehab

Awaits Physio input

Recorded by:

Evelyn Moore

Contact Number:

Designation:

Occupational Therapist

Date / Time of note recorded in MORSE:

08/01/2025 09:13:00

Date / Time of contact:

08/01/2025 09:00:00

Note

MDT discussion:

-Stroke nurses referred raised concerns re swelling in LL

Seen by OT no swelling evident, he has LSW inc shoulder, ? cog issues

Who involved:

-E.P

Re-state goals N/a

Progress towards goals: (Half way through?/ goals discussion/ family meeting?)

-Goals inc UL/LL-strengthening

Onward referral made? Exit plans?

-N/a

EDD:

-11/02/2025

Outcome measures

-To be done

Recorded by:

Simone White

Contact Number:

Designation:

Therapy Assistant Practitioner

Date / Time of note recorded in MORSE:

06/01/2025 15:45:00

Date / Time of contact:

06/01/2025 13:30:00

Note

S. Visit as planned. Pt consented to input. Pt reports some intermittent pain in L forearm just below the wrist.

Denies any falls or injury to this area. Feels his L leg is getting stronger but frustrated as had to utilise a taxi back from Tesco the other day as opposed to walk which he usually does. Pt reports he is trying to use L UL where possible & include with tasks as advised. Stating his focus is on improving UL function.

Pt mentioned he has had a "watery" eye the past few days - denies any changes to vision. Advised pt to seek GP or Optician advice re same.

Pt asked OT if he was going "senile". Reports concerns over his memory.

O.

Pt answered the door to OT. Appeared very conversational in mood. At times going a little off topic or appeared ? distracted. AT

times distracted by mobile phone use.

OT questioned pt re changes with his cognition. Difficult for pt to articulate what this is but has been forgetting things, however, now writing things down in notepad and using a calendar. OT discussed with pt how stroke can affect cognition and attempted to discuss some memory strategies pt could utilise. Pt tended to drift off topic. OT offered pt a cognitive screening & explained the benefits of this however, pt appeared not keen on this. Suggested pt could consider this option.

UL Rx:

whilst sat at the kitchen table.

Observed pt's affected hand, no swelling, even colour. Fingernails very thick & discoloured on both hands.

-gentle warm up ex's

-basic shoulder ex's - lifting arms up in front to 90 degrees, out to side at shoulder height. Attempted L hand flat on wall and reaching up however, pt found this difficult.

-digit tapping

-forearm pronation / supination.

-wrist ext / flexion.

Provided with medium/soft thera-putty & OT explained & demonstrated basic ex's :

rolling, pinching, pressing each digit into putty. Pt found these quite challenging, may benefit from Softer putty (OT can bring next time). Again, a little distracted during activity.

A.

Pt wishing to focus on improving his UL function & appears to have good potential with this however, pt appears quite distracted during therapy session, & ?cognitive difficulty impacting engagement at times.

P.

Return visit next week.

Awaiting Physio input.

Recorded by:

Evelyn Moore

Contact Number:

Designation:

Occupational Therapist

Date / Time of note recorded in MORSE:

31/12/2024 15:24:00

Date / Time of contact:

31/12/2024 10:30:00

Note

TC to pt this morning as requested by J Molteno Team Lead. OT visit arranged for today.

S. Initial START TEAM / OT Ax commenced.

Introduced self & OT role. Pt consented to input.

See Initial Ax form attached to files on Morse for details

P.

Return OT visit planned for 6/1/25

UL rehab, review cognition, Needs Physio Ax

Recorded by:

Evelyn Moore

Contact Number:

Designation:

Occupational Therapist

Date / Time of note recorded in MORSE:

27/12/2024 08:46:00

Date / Time of contact:

27/12/2024 08:45:00

Note

Attempted tel calls to patient: landline was answered by someone telling me David does not live there any more.

A couple of attempted calls on his mobile produced no answer after many rings.

Therefore plan for a visit this morning not possible to arrange.

Recorded by:

Juliet Molteno

Contact Number:

Designation:

Physiotherapist

Date / Time of note recorded in MORSE:

24/12/2024 12:51:00

Date / Time of contact:

24/12/2024 11:00:00

Note

tel call from Lindsay Noonan, stroke nurse: she is worried about patient: very difficult to get a clear history from him over the phone: possible significant upper limb, vision and memory problems and he is "driving" (?) some kind of bike (motorbike? Pushbike?)

He describes zig zags he is seeing (need for visual screen)

He describes a swollen hemi leg which is more swollen after a walk and on lying down he says.

Amy has strongly urged him to please seek medical attention but he is apparently a little blasé about this.

Amy asking please can we prioritise and let her know how he is.

Recorded by:

Juliet Molteno

Contact Number:

Designation:

Physiotherapist

Date / Time of note recorded in MORSE:

24/12/2024 11:41:00

Date / Time of contact:

24/12/2024 11:00:00

Note

Tel call to patient as we received referral 18th December via stroke nurse. Patient discharged 10th December with "no therapy need highlighted" but patient has what sound like some significant deficits: unable to walk when he was discharged he said: now barely making it to Tesco's: he feels his left leg is very tired. He has left his cooker on: knew he had done it: no harm done and he is doing the cooking himself. He lives in a flat in a big building that used to be a care home: there is a lift to his floor.

He has a daughter who comes down most days.

He has made 2 dentists appointments and forgotten to go to both of them.

He keeps dropping things: cups fall out of his hand.

His foot is dragging when he walks and he describes having good days and bad days.

He is aware we cannot get out to him until after New Year but he has our phone number and knows to ring us if we have not got to him before 7th.

I will fill in IR1 re this lack of referral to our team.

Recorded by:

Juliet Molteno

Contact Number:

Designation:

Physiotherapist

Medication Administration Profile

Patient: Adams, David
Hospital No: 0705570592 National No: 070 557 0592
Date of Birth: 7-May-1957
Allergies: ***No known drug allergies***

Weight: kg
Height: cm
Body Surface: m²

Date of Report: 12-May-2026 at 10:57 Page 1 of 1
Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Sensitivities:

Admitted On: 13-Mar-2026
Discharged On: 13-Mar-2026

Episode History:

Consultant: DR BEN HUGHES from 13-Mar-2026 16:01 to 13-Mar-2026 20:21

Transfer History:

Admitted to Ward: ED (FVRH) on 13-Mar-2026 at 16:01

There are no active medications for this patient.

Medication Administration Profile

Patient: Adams, David
Hospital No: 0705570592 National No: 070 557 0592
Date of Birth: 7-May-1957
Allergies: ***No known drug allergies***

Weight: kg
Height: cm
Body Surface: m²

Date of Report: 12-May-2026 at 10:57 Page 1 of 2
Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 9-Dec-2024
Discharged On: 10-Dec-2024

Sensitivities:

Episode History:
Consultant: DR ANTHONY BYRNE from 9-Dec-2024 01:48 to 9-Dec-2024 07:17
Consultant: DR HOLLY METCALFE from 9-Dec-2024 07:18 to 9-Dec-2024 08:24
Consultant: DR DANIEL BECKETT from 9-Dec-2024 08:25 to 10-Dec-2024 07:29
Consultant: DR GARETH BLAYNEY from 10-Dec-2024 07:30 to 10-Dec-2024 14:51
Transfer History:
Admitted to Ward: CAU (FVRH) on 9-Dec-2024 at 01:47
Transferred to Ward: B21 on 9-Dec-2024 at 16:37

Key: ! - denotes unverified order at the time of charting or administration. * - denotes charting was overridden. ? - denotes witnessable administration not witnessed. [@@] - denotes patient was/is on Short Term Leave. [†] - Order Notes exist % - Para Dose (see Pg C) <MOD> - Order Modified <DIS> - Order Discontinued <STOPPED> - Order Stopped <RES> - Order Resumed <SUS> - Order Suspended <TASK> - Order Suspended (task non-completion) AG - Recommended Action							
DRUG DOSE, ROUTE & FREQUENCY/INTERVAL/RATE VERIFIER	9-Dec-2024 Monday	10-Dec-2024 Tuesday					
ASPIRIN 75 mg Dispersible Tablets 75 mg Oral 1X08 DR LOUISE BARNARD Start Date/Time 9-Dec-2024 08:00 Stop Date/Time: 29-Dec-2024 08:01	! 08:32 AHER	! 09:13 AGRA8					
Modify Reason: Planned reduction							
CLOPIDOGREL 75 mg Tablets 75 mg Oral 1X08 DR LOUISE BARNARD Start Date/Time 9-Dec-2024 08:00	! 08:31 AHER	! 09:14 AGRA8					
ATORVASTATIN 80 mg Tablets 80 mg Oral 1X22 DR LOUISE BARNARD Start Date/Time 9-Dec-2024 22:00	! 20:37 NCAS						

Date of Report: 12-May-2026 at 10:57~ Page 2 of 2

Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 9-Dec-2024
Discharged On: 10-Dec-2024

[illegible]

Clinic

Day/Date

Time

Hosp. No.

F140620

Appointment Category

Routine (✓)

Soon ()

Urgent ()

Hospital : F.D.R.I.

Clinic : Urology

Patient's Surname : Adams

First Name : David

Address : 28 Ure Court

Grangemouth

Post Code : FK3 9DS

Tel. No. : 079 1996 0676

Has patient attended before : Not known-new patient

Name of Hospital :

Year/Unit No. :

Previous Address :

Date : 24 September 2011

Consultant : Mr. Hehir

D.O.B. : 7.5.57

Dr. L.J.W. Cruickshank

33 Bo'ness Road

Grangemouth

FK3 8AN

25332 - Tel. No. 01324 482653

COPY

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 Mr. Hehir,

This man has just joined our list. He gives a two year history of pain in his right testicle associated with a swelling at his inferior epididymis. He also complains of pain on ejaculation and that his testicle sometimes seems to swell in size although I did not detect a hydrocele today.

I would be grateful for your advice regarding management of his testicular pain.

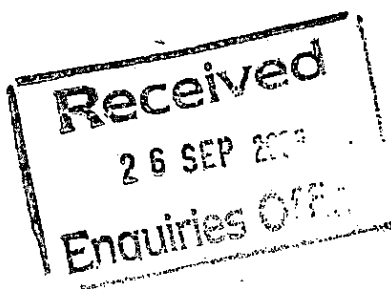
He is not currently on any medications.

Yours sincerely,

L.J.W. Cruickshank

L.J.W. Cruickshank

JPD
appt made 20/11 @
MH Thursam. 9.40.



o/r

COPY

DEPARTMENT OF UROLOGY
Consultant – Mr. Hehir

SS/CC

20th NOVEMBER, 2003.

Unit No. F. 140620

Dr. L. Cruickshank,
33 Bo'ness Road,
GRANGEMOUTH. FK3 8AN

Dear Dr. Cruickshank,

David ADAMS, (d.o.b. 7.5.57), 28 Ure Court, Grangemouth

Thank you for referring David to Mr. Hehir's clinic where I saw him on his behalf. David has a two year history of pain in his right testicle. His pain is episodic, worse on ejaculation. He has also felt a lump in his right hemiscrotum. His past medical history includes appendicectomy 17 years ago and a left hernia repair around five years ago. He has also got a sore back for which you have advised an x-ray of his lumbo sacral spine.

His abdominal examination was unremarkable. Examination of his left testicle was normal. On the right side the head of the epididymis was prominent.

I have requested an ultrasound scan of the scrotum and he will be reviewed in this clinic following that. Investigations have been commenced regarding his back pain.

Yours sincerely,

MR. SUBODH SETH,
STAFF GRADE IN SURGERY AND UROLOGY.

BO'NESS ROAD MEDICAL PRACTICE

DR. I.B. MURDOCH
DR. L.J.W. CRUICKSHANK
DR. G. CRAWFORD
DR. J.M. BARCLAY
DR. L. MUNRO
DR. N.J. HOWLAND



Tel: 01324 482653
Fax: 01324 666119

GC/AS

23rd December 2003

Mr Subodh Seth
Staff Grade in Surgery and Urology
Falkirk & District Royal Infirmary
Major's Loan
Falkirk

Dear Mr Seth,

David Adams, 28 Ure Court, Grangemouth
D.o.b. 07.05.57
Unit No: F140620

You saw Mr Adams, who is a 46 year old painter and decorator, in the Clinic and arranged an ultrasound scan as he was having pain in his right testicle. The ultrasound scan which I enclose shows he has a small epididymal cyst on the right side and he also has a loculated cyst on the left although he doesn't have any symptoms on that side.

I now have his case records and I enclose a copy of a letter from Bradford Hospitals from Mr. Flannigan, Consultant Urologist who had seen him previously with the same problem.

Kind regards.

Dr. G. Crawford

*Notes please
JLW*

clinics now planned

*Rei
6/1/04*

COPY

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X-RAY DEPARTMENT - FALKIRK & DISTRICT R I

ADAMS, DAVID
07/05/1957

28 URE COURT
GRANGEMOUTH
FK3 9DS

HEHIR M MR
FALKIRK UROLOGY CL
RFN: 03/68076

US TESTICLES/SCROTUM

Right testis:
The right testis was normal in texture and size measuring 2.4 x 4.0 x 2.7 cm and had a volume of 13.6 cc. A cystic area measuring 8 x 6 mm was present in the head of the right epididymis. The tail of the right epididymis was normal in appearance.

Left testis:
The left testis was normal in texture and size measuring 2.0 x 4.1 x 2.3 cm and had a volume of 10 cc. A loculated cystic area measuring, in total, 3.1 x 1.8 cm was present towards the lower pole of the left testis.
J Bennie
Supt. Radiographer

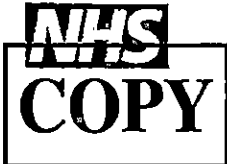
*Copy of
JMB*

*= 1/F
20/11 - mho NL*

26/11/2003 BENNIE JAN/AP Reported: 26/11/2003 03FU-7600 PAS: 140620

Bradford Hospitals

NHS Trust



Mr Flannigan's Secretary

Tel: 01274-364281

Our ref: GMF/CMB HOSP NO 472187 Bradford Royal Infirmary
NHS NO 498 076 6641

Duckworth Lane
Bradford
BD9 6RJ

Fax: 01274-366944

Telephone: 01274 542200

Text phone for the deaf: 01274 382555

www.bradfordhospitals.nhs.uk

**UROLOGY UNIT
WESTCLIFFE OUTREACH CLINIC**

16 July 2002

Typed 29 July 2002

Dr J G Craig
Westcliffe Medical Centre
(93)

2002

Dear Gavin

**DAVID ADAMS 7 5 57
13 ALEXANDRA ROAD SHIPLEY BD18 3ER**

Thank you for referring this patient who has pain in the right testicle but, in fact, I think that is the least of his problems. He complains of considerable amounts of back problems and he himself says he has got sciatica. I think it could well be that he has got a problem with his back that is causing pain in a variety of places including the testicle and, while the swelling in the testicle just seems to be a slight swelling in the upper pole of the right epididymis and I could quite easily do an epididymectomy, I fear that this might be inappropriate surgery as this may not be the source of the pain and indeed he could still end up having pain afterwards.

I would be grateful, therefore, if you would reconsider this gentleman's symptoms and, in fact, offer him management through whichever pathway for back problems you currently use. If this was left up to me I would probably arrange for him to go the Pain Clinic to have him assessed there but I will leave this matter in your hands and I would be happy to see him in the future should the need arise.

Yours sincerely

**G M FLANNIGAN
CONSULTANT UROLOGIST**



COPY

MH/TG/F140620

9 April 2004

Dr Crawford
33 Bo'ness Road
GRANGEMOUTH FK3 8AN

Dear Dr Crawford,

David Adams (7.5.57) 28 Ure Ct., Grangemouth

Mr Adams was due for review today but he did not attend. As you know there were some cystic swellings in the epididymes on both sides – more prominent it seems on the left. If he would like to come back for further I would happily see him at your request. For the moment I have arranged no further appointments.

Yours sincerely,

M Hehir
Consultant Urologist
(dictated by Mr Hehir but not signed)

COPY

MH/TG/F140620

19 August 2004

Typed 24 August 2004

Dr. Crawford
33 Bo'ness Road
GRANGEMOUTH FK3 8AN

Dear Dr Crawford,

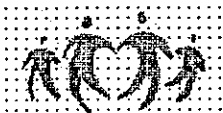
David Adams (7.5.57) 28 Ure Ct., Grangemouth

Mr Adams has failed once again to attend my clinic. You will be aware of the scrotal ultrasound report, sent to you last year, which did not appear to show anything too serious going on – a couple of small epididymal cysts, the testis were normal.

In the circumstances, I have not arranged anything further.

Yours sincerely,

M Hehir
Consultant Urologist
(dictated by Mr Hehir but not signed)



Carron Medical Centre

Ronades Rd., Bainsford, Falkirk FK2 7TA

Tel 01324 619940 Fax 01324 61994

E-mail manager@carronmedicalcentre.com

www.carronmedicalcentre.com

COPY

GM/JL

10/2/05

11am

30th September 2004

Mr Hehir,
Consultant Urologist,
Falkirk Royal Infirmary,
Majors Loan,
Falkirk.

Dear Mr Hehir,

RE: DAVID ADAMS, 23 DUNVEGAN DRIVE, LANGLEES. DOB: 07/05/57. **FK27UG**
FORMALLY 28 URE COURT, GRANGEMOUTH.

I am writing to you about this man who has been lost to follow-up, probably because he moved from Grangemouth to Langlees.

He still has problems with the cysts in his epidermis, which are painful at times and he has asked to be reviewed again. I wonder if you would be good enough to send him an appointment.

Yours sincerely,

Dr G Muircroft,
GP.

13 OCT 2004

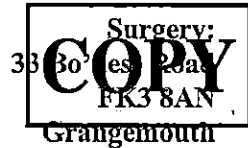
10 OCT 2004

Enquiries

0/4

BO'NESS ROAD MEDICAL PRACTICE

DR. I.B. MURDOCH
DR. L.J.W. CRUICKSHANK
DR. G. CRAWFORD
DR. J.M. BARCLAY
DR. L. MUNRO
DR. N.J. HOWLAND



Tel. 01324 482653
Fax. 01324 666119

GC/AS

6th May 2004

17/6

9.50

Mr M Hehir
Consultant Urologist
Falkirk & District Royal Infirmary
Major's Loan
Falkirk.

Dear Mr Hehir,

David Adams, 28 Ure Court, Grangemouth FK3 9DS
D.o.b 07.05.57 6592
Unit No: F.140620 ✓

Mr Adams apologises for missing his appointment on 9th April. On that day he was down at the Surgery seeing us with sciatica and his Urology appointment dates had been changed and he got them mixed up.

I would be grateful if you would send for him again.

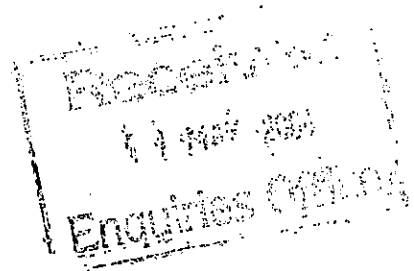
Kind regards.

Dr. G Crawford

ORD sent

Soan

✓



ok

COPY

DEPARTMENT OF UROLOGY

Tel: 01324 616026

Ref: MH/MSM/F140620

Dictated: 30.12.04

Typed: 13.01.05

Dr G Crawford
33 Bo'ness Road
Grangemouth
FK3 8AN

Dear Dr Crawford,

DAVID ADAMS (07.05.57) 28 URE COURT, GRANGEMOUTH

Thanks for writing about this man he has not yet managed to attend despite a number of appointments being arranged and at this stage I did not arrange anything further.

With kind regards.

Yours sincerely

M Hehir
Consultant Urologist
Dictated but not signed

COPY

DEPARTMENT OF UROLOGY

Tel: 01324 616026

Ref MH/MSM/F140620

Dictated: 10.02.05

Typed: 25.02.05

Dr G Muircroft
Ronades Road
Bainsford
Falkirk
FK2 7TA

Dear Dr Muircroft,

DAVID ADAMS (07.05.57) 23 DUNVEGAN DRIVE, LANGLEES

Mr Adams was due a follow up clinic appointment but did not attend. For the moment no further appointments have been arranged.

With kind regards.

Yours sincerely

M Hehir
Consultant Urologist
Dictated but not signed

16/10/06
1.30pm**COPY**

Hospital use only	Clinic	Day Date	Time	Hospital No.
-------------------	--------	----------	------	--------------

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TOUrology CB
FV Urology Referral

Falkirk and District Royal Infirmary

Consultant / receiving practitioner
and/or specialty clinic

Hospital and hospital address

Hospital location code.

Email address

Urgency of referral

Routine Urology
Referral**PATIENT DETAILS**

Surname

Adams

Forename(s)

David

Title

-

Sex

Male

Date of birth

07-May-1957

CHI no.

0705570592

Patient's address10 Douglas Avenue
GRANGEMOUTH
FK3 0LD

Contact number(s)

Voice: 874396

REFERRING PRACTITIONER DETAILS

Name

Dr NJ Howland

GMC code

3325403

GP code

60810

Practice name

Bo ness Road Medical Practice

Practice code

25332

Practice address33 Bo ness Road
Grangemouth
FK3 8AN

Contact number(s)

Voice: 01324 482653

Facsimile: 01324 666119

Revised 01/08/06 FOR
Any Consultant
NHS
28/8

RECEIVED
23 AUG 2006
UROLOGY OPD

Received
21 AUG 2006
Enquiries Office

d/s

COPY

12/9/2024

Incident Number: CR011600622

Living Arrangement Sheltered Accommodation

Patient Mobility Fully Mobile

Patient Communication No Help Required

Patient Clinical Risk Factors Smoker

Patient Environmental Risk None Identified

MEDICAL

Stroke

Face Positive

Arms Positive

Speech Positive

Time Less than 4.5hrs or Unknown

BM Checked Yes

Pre-Alert

Yes

CLOSE RECORD

Treatment On Scene Emergency

Conveyance

Transport To Hospital Emergency driving

Pre-Alert

Yes

INCIDENT LOG

Time Call Received 13:12

Allocated

13:19

Mobile

13:21

INCIDENT LOG

Time Call Received	13:12	Allocated	13:19	Mobile	13:21
First Resource On Scene		Crew On Scene	13:28	Crew Left Scene	13:42
Crew At Hosp	13:59	Receiving Hospital	FORTH VALLEY ROYAL HOSPITAL		Clear Time
Crew ID	Crew Grade			Driver	
E9888707	Paramedic			YES	
E9882421	Ambulance Technician			NO	
P122109S	Student Paramedic (BSc Placement)			NO	

COPY

03



COPY

Presenting complaint: ?stroke

Surname: Adams	Forename: David	Title: Mr
Address 6 Salmon Court School Brae Bo'ness West Lothian	Postcode: EH51 9HF	CHI: 0705570592
Telephone: 01324 874396		
Date of Birth: 07/05/1957	Sex: Male	Age: 67 Years
GP Name: A Crichton		
Address: 26208/1 Kinneil Medical Practice Health Centre Dean Road Bo'ness EH51 0DQ	Telephone: 01506 537054	
Next of Kin		
Name: Janice Adams	<i>Separated 1 yr '12 ago</i>	<i>Kelly Adams</i>
Relationship: Wife	Postcode: FK3 0LD	<i>Daughter</i>
Address: 10 DOUGLAS AVENUE Grangemouth Stirlingshire	Telephone: 01324 874396	<i>07871 55 9304</i>
Triage Information		
"stroke stand by "		
Obersvations		
P=	PB= /	RR=
Peak Flow=	GCS=	Sat=
		BM=
		Temp=
		News=

Emergency Department / Pre-Hospital Drugs			Allergies			
Date	Drug	Dose	Route	Signature	Given by	Time
12/29	Codeine	30mg	oral	[Signature]	OB	17:00
12/29	Codeine	30mg	oral	[Signature]	OB	17:00

COPY

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TroponinInitials.....	Blood Gases	Fast
Time of Trop	Arterial/venous (circle) Time taken	Free fluid identified: Yes/No (circle)
D-dimer	FiO2 pH	AAA
Urine dipstick	pCO2	Aorta clearly seen
Leucs	PO2	Yes/No (circle)
Nitrite	BE	Measured diameter.....
Protein	Lactate	
Blood		Protetanus
Ketones	Urine Pregnancy Test	Immune/Not immune (circle)
Glucose	HCG positive/negative (circle)	

Yes / No

Date.....

Date:

8/12/24

Time:

1400

CHI NO: 0705570592

07/05/1957

CRN:

M

David ADAMS
6 SALMON COURT
SCHOOL BRAE
BO'NESS
EH51 9HF

Named Nurse:

Patients preferred name:

NATANIE

DAVE (67)

COPY

S Situation	Brief history of complaint & pre-hospital treatment: L sided weakness @ 1230. started speech. 3/5 of unwell / flu symptoms full recovery 1345. Belfast Details & NOK checked: (Y) N Relative/Carer: Informed? (Y) N and present? Y/N (Y) Kelly - Daughter	
B Back-ground	MI ☐ CVA ☐ Anticoagulated: Y/N Asthma ☐ COPD ☐ Vulnerable adult: Y/N (see SAS PRF) Angina ☐ HTN ☐ Time Critical Medication: Y/N (if Yes give details) Epilepsy ☐ Diabetes T1/T2 Past Medical History: SCIATICA Allergies: NKDA L LEG WEAKNESS from motorbike accident Smoker Social Background:	
A Assessment	ECG ☒ NEWS <u>0</u> Bloods ☒ BM <u>6.9</u> PVC ☒ GCS/AVPU <u>15</u> Urinalysis ☐ Ketones <u>---</u> HCG ☐ Pain: <u>0/3</u> Analgesia ☐ Care and Comfort Chart Commenced: Y/N How often to be done: <u>NO</u> SENATION PASS ☒ CTB ☒ @ 1700 Mobility: <u>NO</u> Name Band ☒ Signature: <u>N. J.</u>	
R Recommendations	Impression: <u>TIAS.</u> Nurse Escort Required: Y/N Outstanding Treatments: <u>Monitor</u> Referred Specialty: Medics ☒ Ortho ☐ Surgeons ☐ ENT ☐ Gynae ☐ Other <u>---</u> Recommendation Falls Care Bundle required Yes / No Falls alert added to Trakca ☐ NEWS: <u>0</u> Signature: <u>lg</u>	

Nursing Notes

Was an IR1 completed for this patient? Y./N

If yes, IR1 number: _____

PATIENT LABEL

COPY

All care provided and changes to care must be documented below:

17⁰⁰ 8/12/24

- pt round at CT scan symptoms
- resolving. DOW
DOW

17¹⁵ - slurred speech, facial droop

onset again. Dr McKay
interviewed. Invalon reassessed DOW
(pamper) given food + DOW
drink

17²⁰ - symptoms resolved at 1720

DOW
DOW

Stroke Unit Admission Checklist

CHI NO: 0705570592 07/05/1957
CRN: M
David ADAMS
6 SALMON COURT
SCHOOL BRAE
BO'NESS
EH51 9HF

COPY

Admission to Stroke Unit Date: 09 / 12 / 2024 Time: 17 : 00 (hh:mm)

☐ Ensure that patient admitted to ward on TrakCare

☐ **ENSURE STROKE BUNDLE STICKER IN NOTES**
USE ADDITIONAL PROTOCOLS FOR THROMBOLYSIS PATIENTS

☐ **Welcome to the Ward** Complete as soon as possible following arrival on ward

- ☒ Update whiteboard (behind the bed) with preferred name, nurse, and consultant
- ☐ Check patient name band
- ☐ Confirm and record next of kin details and contact telephone numbers
- ☐ Confirm General Practitioner details
- ☐ Check if there is a Power of Attorney
- ☐ Document initial conversation on the blue "Family Dialogue" sheet

☐ **Swallow Screening Assessment** As soon as possible following arrival on ward

- ☒ Check if recorded on the bundle sticker
- ☐ If not done, perform swallow screening now
- ☐ If there has been a change in patient's condition, repeat the swallow screening

☐ **Hydration** As soon as possible following arrival on ward

- ☒ If swallow test passed, ensure a jug of water and tumbler are on the bedside table
- ☐ If patient is "nil by mouth" ensure IV fluids are prescribed, in place and running correctly (or an alternative) if appropriate for the situation

Hydration assessed - Date: ___ / ___ / 20___ Time: ___ : ___ (hh:mm)

☐ **Mouth Care** Within 4 hours of arrival on ward

- ☒ Mouth care checked and oral care plan to be completed

Assessment completed - Date: ___ / ___ / 20___ Time: ___ : ___ (hh:mm)

☐ **Fundamental Observations** As soon as possible following arrival on ward

- ☒ Check temperature, pulse, blood pressure, respiratory rate, oxygen saturations, level of consciousness, and blood glucose – record Early Warning Score
- ☐ Check lying and standing blood pressure

BP Lying _____ Standing / Sitting _____

☒ **Brain Imaging**

Within 12 hours of hospital arrival

CT brain is usually the first scan. Check that brain scan has been –

- ☒ Requested
- ☒ Performed
- ☒ Reported
- ☒ Doctors aware of result and have acted upon result

Tick all that are appropriate

COPY

☒ **Antiplatelet therapy**

Within 4 hours of brain imaging

Unless there is a contraindication to antiplatelet drugs (aspirin, clopidogrel), this should be started after brain imaging has excluded haemorrhage or tumour.

- ☒ Ensure that a STAT dose has been given
- ☒ Ensure that ongoing treatment has also been prescribed

If these have not been done then ask the doctor to prescribe the appropriate drug.

☒ **Intermittent Pneumatic Compression (IPC) Sleeves**

Within 4 hours of arrival on ward

- ☒ Apply IPC sleeves to patient unless patient independently mobile or contraindicated
- ☒ IPC sleeves should be prescribed on HePMA but this is not essential prior to them being used. Ask a doctor to prescribe at the next convenient opportunity.

☒ **NIH Stroke Scale**

Within 4 hours of arrival on ward

- ☒ Perform the NIH Stroke Scale examination

Total Score = 1

☒ **ECG**

Within 4 hours of arrival on ward

- ☒ Check that a 12-lead ECG has been done. If not, do one when able.

☒ **Cardiac Monitoring**

Within 4 hours of arrival on ward

- ☒ Apply TELEMETRY to the patient if indicated

☒ **Blood Tests**

Within 4 hours of arrival on ward

- ☒ Check that routine blood tests have been done (including glucose and cholesterol) and that results have been recorded and abnormalities acted upon

☒ **Skin and Pressure Injury Assessment**

As soon as possible following arrival on ward

- ☒ Skin and pressure areas to be checked and documented
- ☒ Complete Braden Score and action as appropriate

☒ **Nutrition Assessment**

Within 6 hours of arrival on ward

- ☒ Weigh patient (unless not possible due to severity of illness)
- ☒ Complete MUST score and action as appropriate

☐ **Falls Risk Assessment & Mobility Care Plan**

As soon as possible following arrival on ward

- ☒ Complete Falls Trigger Tool for assessment.
☐ Update behind-the-bed white board with mobility

COPY

☐ **Indwelling Devices**

As soon as possible following arrival on ward

- ☒ Check for indwelling devices such as venous cannula and urinary catheter
☐ Ensure that care bundles are in place for each device
☐ Move patient to a side room if indicated by Infection Control protocols for devices

☐ **Referral to Allied Health Professional Colleagues**

Within 12 hours of arrival on ward

Refer to AHP colleagues appropriate for the patient's needs

- ☐ Physiotherapy
☐ Occupational Therapy
☐ Speech & Language Therapy
☐ Dietician
☐ Specialist Nurses (such as Diabetes, Tissue Viability, Palliative Care)

☐ **AWI (Adults With Incapacity) Section 47**

Within 12 hours of arrival on ward

- ☒ Is an AWI Section 47 form needed e.g. patient unconscious, significant aphasia, delirium or dementia? If so notify a doctor to complete.
☐ Initiate AWI sticker in notes and ensure complete
☐ If unsure of POA call 01324 678300

☐ **Further Investigations**

Within 12 hours of arrival on ward

- ☒ Check whether further investigations documented in the notes have been requested, such as chest x-ray (CXR), carotid ultrasound, MRI brain or CT angiogram. Some of these tests may be appropriate to check at the next consultant ward round

☐ **Complete remaining assessments in the Care Plan Booklet**

Within 24 hours of arrival on ward

☐ **Does patient have any valuables e.g Jewellery? Phone? Please document each item in unified notes**

Planning for discharge begins soon after admission.

☐ **Initiate discharge planning checklist straight away**

NIH Stroke Scale - Serial Recordings		Admission To HASU	Day 0	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Date		9/12								
Time		1700								
1a. Level of Consciousness	0 = Alert; keenly responsive 1 = Not alert; but rousable by minor stimulation 2 = Not alert; requires repeated stimulation to attend 3 = Unresponsive; reflex movements only	0								
1b. LOC Questions Ask patient the month and their age	0 = Answers both questions correctly 1 = Answers one question correctly 2 = Answers neither question correctly	0								
1c. LOC Commands Open & close eyes and grip & release with non-paretic hand	0 = Performs both tasks correctly 1 = Performs one task correctly 2 = Performs neither task correctly	0								
2. Best Gaze Horizontal eye movements only	0 = Normal 1 = Partial gaze palsy 2 = Forced Deviation not overcome by oculoccephalic manoeuvre	0								
3. Visual Fields	0 = Normal 1 = Partial Hemianopia 2 = Complete Hemianopia 3 = Bilateral Hemianopia (blind including cortical blindness)	0								
4. Facial Palsy	0 = Normal 1 = Minor paralysis (flattened nasolabial fold, asymmetry on smiling) 2 = Partial paralysis (total or near total paralysis of lower face) 3 = Complete paralysis of one or both sides (absence of facial movement in the upper and lower face)	1								
5. Motor Function - Arm	0 = Normal; limb holds 90 (or 45) degrees for 10 seconds without drift 1 = Drift; limb holds 90 (or 45) degrees but drifts down before full 10 seconds but does not hit bed or other support 2 = Some effort against gravity 3 = No effort against gravity; limb falls 4 = No movement UN - Untestable; joint fused or amputated	R	0							
		L	0							
6. Motor Function - Leg	0 = Normal; leg holds 30 degree position for 5 seconds 1 = Drift; leg falls by end of 5 second period but does not hit bed 2 = Some effort against gravity 3 = No effort against gravity; limb falls 4 = No movement UN - Untestable; joint fused or amputated	R	0							
		L	0							
7. Limb Ataxia Finger/nose & heel/shin both sides. Ataxia disproportionate to weakness only	0 = No ataxia or paralysed/comatose/does not understand 1 = Present in one limb 2 = Present in two limbs UN = Untestable only if amputation or joint fusion	0								
8. Sensory	0 = Normal; no sensory loss 1 = Mild to moderate sensory loss; aware of touch 2 = Severe to total sensory loss	0								
9. Best Language	0 = No aphasia 1 = Mild to moderate aphasia; loss of fluency or comprehension 2 = Severe aphasia; fragmented communication 3 = Mute, global aphasia; no useable speech or auditory comprehension	0								
10. Dysarthria	0 = Normal 1 = Mild to moderate dysarthria; slurring of words, at worst can be understood with some difficulty 2 = Severe dysarthria unintelligible or unable to speak (out of proportion to aphasia) UN = Untestable due to intubation or other physical barrier	0								
11. Extinction & Inattention	0 = No abnormality 1 = Inattention or extinction to bilateral simultaneous stimulation in one sensory modality 2 = Profound hemi-inattention to more than one modality	0								
Total Score		1								
Assessors Initials		[Signature]								

STROKE BUNDLE SWALLOW SCREEN

Complete this bundle for all people with suspected stroke or TIA

COPY

(all people with suspected stroke or confirmed ischaemic stroke or intracerebral haemorrhage)

Should be checked as soon as possible and within 4 hours of arrival

Patient Label (use when available):

Name: 
CHI NO: 0705570592 07/05/1957
CRN: M
David ADAMS
8 SALMON COURT
SCHOOL BREE
BO'NESS
EH51 9HF

AUDIT
CLOCK
START

DATE of ARRIVAL in hospital

8 / 12 / 24

TIME of ARRIVAL in hospital

14:00h

Use information from EDIS or TrakCare

ENSURE THAT BOTH TIME AND DATE ARE ENTERED

IF THERE IS NO TIME, THERE IS NO AUDIT TRAIL, AND THIS SECTION WILL FAIL

Date of test

8 / 12 / 24

Screening test PASS

14:00 h



Observe first meal for problems
Refer to SLT if concerns

Screening test FAIL

hh : mm h

Too Drowsy to test

hh : mm h

Too Agitated to test

hh : mm h

Unconscious

hh : mm h



Make "Nifty Mouth" and
ensure IV fluids for hydration
where appropriate

FILL IN A TIME OR IT DOESN'T COUNT

Remember the other elements of the Stroke Bundle

BRAIN IMAGING

Should be done as soon as possible after hospital arrival
See guidelines to determine if EMERGENCY, URGENT or "NON-URGENT"

ASPIRIN

If no haemorrhage or stroke mimic on imaging and no other contra-indication,
prescribe & administer ASPIRIN 300mg stat and regular ASPIRIN 300mg daily
("Ischaemic Stroke" HePMA protocol)

STROKE UNIT

Refer to Stroke Service ☎ 67691 or Pager 1751

Refer to the **ACUTE STROKE GUIDELINE** in the Clinical Guidelines section of the intranet

COPY

Useful Numbers

Emergency Team	2222
Trauma	
Paediatrics	
Neonatal	
Obstetric	
Stroke – Thrombolysis	67691
Stroke – Nurse	Page – 1751
Anaesthetics	67688
ICU	67687
Orthopaedics	67686
Surgical	67685
Paediatrics	67692
Medical Registrar	67681
Obstetrics	#1188

COPY

Issues Delaying Treatment

Additional Notes

Record any issues that lead to delay of treatment (e.g. waiting for INR result, difficulty contacting "decision maker", delays in image review on PACS or any other difficulties in the process of delivery of treatment. If a decision is made "not to treat" please record the time that decision was made and the reason why.

Location of initial assessment

Triage Category

1 / 2 / 3

Staff Present

ED Consultant

ED Specialty Doctor

ED ST3 or higher

ED ST1 or 2

ED GRST

ED FY2

ED Nurse

Stroke Consultant

ED Locum (any grade)

Swallow Test Done

☐

Standby Details	Date:	Name: Davie Adams	DOB: 7/5/57
	M/F: M	Condition:	Age: 67
	Time: 12:30	? CVA	COPY
	COVID-19 Y/N	Stroke []	Info Only? []

Fast +ve
Acid sided droop
Slurred Speech.

Major Haemorrhage / Trauma / Stroke / Paeds / Neonate / Obstetric



Senior Doctor Aware? (WiFi 67682) [1]

g loss: Remain on Ambulance Trolley for 30 seconds

ie Age	
Time (Onset/ Incident)	12 ³⁰
Mechanism / Medical Complaint	① <i>fall</i> weakness. <i>Flu 3/52</i> <i>Resolved after 45 mins.</i>
Injuries / Information on Medical Complaint	
Signs / Symptoms	RR SpO2 HR BP GCS/AVPU Sugar Temp
Treatment / Trends	

Transfer and Clarify:

Allergies:

Medication:

Background:

Other:

CHI NO: 0705570592 07/05/1957
CRN: M
David ADAMS
6 SALMON COURT
SCHOOL BRAE
BO'NESS
EH51 9HF

Date: 8/12/24 Actual time: 1405 Current Location (e.g., TL1-7, TL8-14, Xray WR) R2 Introduce yourself to patient (Tick) ☒		What time(s) should your patient take this medication? 1405 Does your patient have this medication with them? Yes Does your patient need help with this? Yes Ensure that the medical and nursing staff are aware and work together to ensure the patient receives their time-critical medication in ED. Document omissions overleaf.		FILL THIS PART IN FULL VISIT.
ASK your patient to CHECK history for the following: 1. Seizures, 2. Insulin, 3. Parkinson's drugs, 4. current antibiotics, 5. regular steroids, 6. regular strong opioids, 7. anticoagulation, 8. Confirmed not on any. Write the corresponding number in the box.		DO NOT LEAVE THIS SECTION BLANK.		
Current pain score 0-3. 2 Analgesia offered? (Y/N) Y Analgesia accepted or declined? (A/D) D Update Patient - Plan of care/who oversees care. - Approximate waiting time		INDEPENDENT		
Assess Food, fluid and nutritional needs. - NBM - Nil by Mouth MCP - Mouth Care Provided - QA - Offered and Accepted QD - Offered and Declined - Specify diet / fluids e.g., 'tea and toast', 'sandwich and juice', 'hot meal'.		COMPLETE STROKE BUNDLE IF SUSPECTED CVA		
Assess your patient's skin - Write details of check on reverse of this checklist. - PC - Pura Complete BG - Braden Complete - CC - Check complete DR - Declined Review INCLUDE DETAILS ON REVERSE		VERSION 1.0		
Elimination: - ATT - assisted to toilet PCC - Pad check/change. - DC - declined check IND - Independent - OTH - other (elaborate overleaf) INCLUDE DETAILS ON REVERSE		Ensure that patient has access to nurse call bell or has alternative means of contacting staff. Initial when complete.		
Initial and Role (e.g., AW/ Flex) AW		When deciding how regularly to visit your patient please consider the following. Care rounding is not 'one size fits all'.		
Consider the following - Does the patient have capacity? Yes		Does the patient communicate independently? Yes		
Can the patient manage their own ADLs? Yes		Does the patient have their medication with them? Yes		
DATE: 8/12/24		TIME: 1405		

This is version 7 of C+C – your feedback is valued to keep this document meaningful and user friendly.

Please **complete at least the 1st column** for all patients in your care.

Do not score through
the document as decisions for
care rounding can change.

Do not copy previous entries, but instead document what you have done.

Time-critical drug section must be completed in full. If you notice that it has not been completed in full, please rectify this.

Further information should be added on the back of this page.

How regularly you perform care rounding should be based on the individual.²

Please write the time of each visit in the box at the top of the column.

Complete ALL SECTIONS top-to-bottom when filling out this checklist. Make sure to label all pages. Date, time and sign all entries.

Forth Valley Royal Hospital Emergency Department Care and Comfort Rounding Checklist (ADULTS)

Addressograph

COPY

VERIFIED

Complete ALL SECTIONS top-to-bottom when filling out this checklist. Make sure to label all paperwork. Date, time and sign all entries.

Medical Receiving Unit Care Rounding										 Name: CHI NO: 0705570592 07/06/1967 CRN: David ADAMS DOB: 6 SALMON COURT SCHOOL BRAE Hospital: BO'NESS EH61 9HF	
Care Rounding Frequency	1 2 3 4 hourly Circle as appropriate Review frequency if clinical condition requires										
Date	09.12.20										
Time of Round	08.00	12.00									
Clinical Area (CAU chairs)	CHAIR	CHAIR									
Fit to Sit criteria Risk Level											
Low Risk	☒ YES ☐ NO										
Medium Risk escalate to NIC	☐ YES ☐ NO										
High Risk escalate to NIC	☐ YES ☐ NO										
Vital Signs Recording											
NEWS Score and Vital Signs Frequency recorded	signature NS NS										
Is Escalation required? (if YES escalate to NIC)	☐ YES ☒ NO	☐ YES ☒ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	
Pain Management (refer to doctor if analgesia is required)											
Pain Assessed No Action required	☒ YES ☐ NO	☒ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	
Pain Assessed Action required and Analgesia been provided	☐ YES ☒ NO	☐ YES ☒ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	
Medication											
Is the patient due any routine/essential medication? (eg. Insulin, Parkinson's, epilepsy medications)	☒ YES ☐ NO										
Has these medications been prescribed? If not ask medical for them to be prescribed	☐ YES ☒ NO										
Refreshments											
Drink	☒ YES ☐ NO	☒ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	
Snack	☒ YES ☐ NO	☒ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	
Has their own food	☐ YES ☒ NO	☐ YES ☒ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	

COPY

[Redacted]

Patient and family feedback highlights consistently that they want to be kept informed of their progress of care and waiting times.

In order to meet these needs please complete the section below

- On admission the patient is informed about potential wait time to be seen by a doctor by nursing staff YES ☐

By Whom _____

- During the patients wait discuss below :

1.Communication re Plan of Care

Discuss with the patient current plan of care
for eg plan for admission/await tests/medications/bed

Time of update _____ by whom

Record of Communication

Time of update _____ by whom

Record of Communication

COPY

Vulnerable Person/or adults with a cognitive impairment

Escalate to Nurse in Charge and 1 family member can stay with the patient during their assessment to be seen

Patients placed in CAU chaired area

In 
 CHI NO: 0705570592 07/05/1957
 GRN:
 David ADAMS
 6 SALMON COURT
 SCHOOL BRAE
 BO'NESS
 EH51 9HF

Purpose of Risk Assessment

This risk assessment has been developed to support decision making around patient placement within the Clinical assessment Unit. It is applicable to patients

- a. On arrival to CAU
- b. Patients already assessed and been in a bed and expected to go home (consider RACU)
- c. Patients awaiting Consultant review

There is a risk attached to any patient moving into the CAU chaired area hence there is not a 'No Risk' category.

The tool below will assist to categorise patients into low, medium, or high risk to allow for improved communication and shared language between the CAU nursing team, patient flow team and duty manager when discussing department safety.

Low risk patients should be considered for placement in chairs before medium or high risk patients. Decisions made regarding suitability of individual patients maybe made by a senior clinician.

'Potential-to-Sit' Criteria: Patients must meet **both** criteria to be considered for placement in a chaired area.

- ☐ Able to mobilise comfortably around the ward area without nursing/medical assistance
- ☐ Patient's NEWS is less than 5 (and less than 3 in any one category)

Criteria	Tick if applicable
Patient has ongoing chest pain or acute/new changes in ECG	HIGH
Patient requires telemetry or constant monitoring	HIGH
Patient in the 'very urgent' triage category, including DKA	HIGH
Patient has a confirmed or suspected communicable disease/infection that requires Transmission Based Precautions eg CDI/CPE	HIGH
Patient has active diarrhoea and/or vomiting	HIGH
Patient has ongoing pain management issues requiring boluses of opiates	HIGH
Patient requires continuous Intravenous Fluids	MEDIUM
Patient is confused or agitated requiring enhanced observations	MEDIUM
Patients been in hospital for more than 24hrs (include ED length of stay)	MEDIUM
Patient is wearing hospital gown/ nightwear or equivalent	MEDIUM
None of above criteria	LOW

Risk level	Mobility/ NEWS criteria not met	High risk	Medium Risk	Low Risk
------------	---------------------------------	-----------	-------------	----------

Patients placed in CAU chaired area

Insert Addressograph label

COPY

FVRH DISCHARGE PLAN Acute Stroke **COPY**

Unit

Affix addressograph		 CHI NO: 0705570592 07/05/1957 CRN: M David ADAMS 6 SALMON COURT SCHOOL BRAE BO'NESS EH51 9HF
Nurse responsible for patient	Planned discharge date	

Criteria	date	please circle	signature
Patient involved in dx planning	10/12	☒ Yes /not applicable	ael
☒ Rels/carers involved in dx planning	10/12	Yes /not applicable Phoned NOK 2 daughter aware from pr	ael
Special preparation for discharge arranged—specify i.e Catheter for discharge.	10/12	Yes /not applicable	ael
Venflon removed	10/12	Yes/ not applicable	ael
Provide written information to patient/rels/carers	10/12	☒ Yes /not applicable driving advice stroke	ael
Stroke Folder	10/12	Yes /Not applicable	
TRANSPORT: method for discharge	10/12	☒ Yes /not applicable partner	ael
Referral to community based services arranged – specify i.e SALT, ReAch	10/12	Yes /not applicable	ael
Package of Care Retarded		Yes / Not Applicable	
Doctors dx letter completed DOES PT REQUIRE COMPLIANCE AID DNACPR TO GO HOME WITH PATIENT	10/12	☒ Yes /not applicable ☒ Yes No YES/NO	ael
Discharge Prescription checked by 2 nursing staff		Yes /not applicable	
Outdoor clothing available for discharge	10/12	Yes /not applicable go own	ael

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Forth Valley Royal Hospital Assessment Document



Date of arrival 8/12/24 Time of arrival 2355

Source of referral: GP ☒ (ED) Other

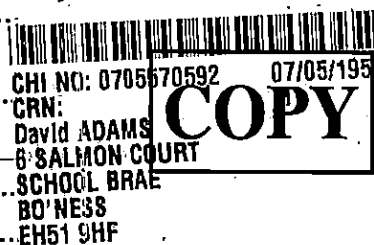
GP practice: Kinnaird Medical

CHI

Name.....

Address.....

Tel



Consent for ECS

Yes

No

BM

NEWS score

NOK 1 Name.....

Relationship.....

Address.....

Tel.....

NOK 2.....

Relationship.....

Address.....
07704443846

S

Presenting complaint

STROKE

B

Background

A

NEWS 5 or more or other clinical concern

Yes

No

T° 38°C or more within 14 days of chemotherapy (possible neutropenic sepsis)

Yes

No

Referred with potassium more than 6.4mmol/L or less than 2.8mmol/L

Yes

No

Referred with diabetic ketoacidosis

Yes

No

Reduced GCS

Yes

No

New limb weakness, speech disturbance or numbness for less than 4.5 hours

Yes

No

Abdominal pain: Does referral or patient give history of aortic aneurysm?

Yes

No

Abdominal symptom in female under 55 with possibility of pregnancy

Yes

No

NEWS 2-4

Yes

No

New oxygen requirement (not on home oxygen)

Yes

No

Chest pain at time of triage: Obtain ECG, Clinician to review/ sign within 10 minutes

Yes

No

New limb weakness, speech disturbance or numbness for 4.5 hours or longer

Yes

No

Requires assistance of 1 or more to mobilise

Yes

No

Able to mobilise independently or using own aids/appliances

Yes

No

R

Very urgent

Urgent

Non-urgent

Ambulant

Actions

Amylase

Cannula

U&E/ LFT/ CRP/ FBC/Glucose

Calcium

ECG- to be signed within 10mins

Cultures

Group and save

Troponin - 0 hours / 12 hours

Additional triage comments

Allergies and alerts

NADA

Name

Signature

Date

Time

NB KERRY

NB KERRY

8/12/24

2358

Assessment

Practitioners Name <u>Muhammed</u>	Date <u>02/12/24</u>	Patient details COPY
Grade <u>GPST</u>	Time commenced <u>22:00</u>	
GMC/ NMC	Location <u>ED</u>	

Presenting Complaint:

was at girlfriend's home when suddenly started feeling headache, dizzy, couldn't speak, speech was slurred, developed bilateral focal numbness and droop. (C) arm very weak and went spastic and left leg weak and numb. All went on for 20 minutes and resolved. Girlfriend witnessed it and called ambulance.

Systemic Enquiry:

NO other concerns.

Height:

Weight:

BMI:

Usual level of activity (please circle)

Bedbound	Dependent for personal care	Requires minimal assistance with ADLs	Slowed. Assistance with heavier household tasks	"Slowed-up" but not requiring assistance	No exercise beyond walking.	Occasional exercise	Regular exercise
----------	-----------------------------	---------------------------------------	---	--	-----------------------------	---------------------	------------------

Past medical, surgical and anaesthetic history

MI	
Angina	
Hypertension	
COPD	
Stroke /TIA	
Diabetes	
Implement diabetes bundle	

Graves disease.

Social History

Smoking: Never Ex smoker (since 31/1/15)

Current: occasional /day Pack years

Alcohol: Units / week

Occupation

Driving license yes/ no

Lives With alone

Support/ Carers

PACKAGE OF CARE YES / **NO** (please circle)

IF YES CARE PROVIDER

NUMBER OF TIMES PER DAY 1/ 2/ 3/ 4 (please circle)

Family History

Travel History

Part 11 of 11

☐ Other

☐ Electronic patient record
ECS (issued in last 6 months?)
IDL (within last month?)

☐ Nursing home prescription☐ Community pharmacy

Reaction/ Side effect

1414

Dose

Frequency

Withhold

Stop

Comment

[illegible][illegible]

Yes ☐ No ☐

Time:

Time:

Examination

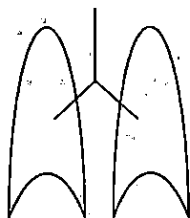
Diabetic patients → foot examination and diabetes bundle
GI Bleeding → PR examination
Age > 65 or confusion → AMT
If cognition or alertness impaired → consider delirium

Patient Details

Cardiovascular

S1 + S2 to

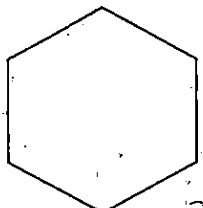
Respiratory



good air entry

COPY

Abdominal



Soft + NI

Bowel sounds:



AMT (If < 4/4, complete AMT10)

1. Age
2. DOB
3. Year
4. Location

4/4

Ask patient to remember address: "42 West Street"

5. Time to nearest hour
6. Current monarch
7. Date Of WW2
8. Count 20 → 1
9. Identify 2 people
10. Recall address

/10

Neurological (remember speech, visual assessment, balance, gait)

Cranial nerves:

	R arm			L arm			R leg			L leg		
Tone	2			2			2			2		
Power	5/5			5/5			5/5			5/5		
Sensation	intact			intact			intact			intact		
Coordination												
Reflexes	B	T	S	B	T	S	K	A	Plantar	K	A	Plantar

Other

Hb 164

Uris = 2

Uoe 11.4

U&Es = 2

CRP = 6

Miles score not documented at presentation

Interpretation of results

ECG

Sinus Rhythm

Urine HCG

Urinalysis

	Neg	Trace	+	++	+++	++++
Leucocytes						
Nitrites						
Glucose						
Ketones						
Blood						
Protein						

CXR

Other imaging

Additional comments

Department of Endocrinology & Diabetes
Consultant: Dr Linda Buchanan
Tel: 01324 566346 / 566347

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr G Crawford
Bo'Ness Road Medical Practice
33 Bo'Ness Road
Grangemouth
FK3 8AN

Date Dictated: 22/09/2021
Date Typed: 06/10/2021
Our Ref: LMB/AE
CHI: 0705570592

Dear Dr G Crawford

David Adams DOB: 07-05-1957
10 Douglas Avenue Grangemouth FK3 0LD

Mr. Adams has had repeat bloods done with his thyroid antibodies. His TSH receptor antibody is less than one. He has now had eighteen months of treatment. I would stop his Carbimazole and Levothyroxine at the stage and would suggest repeating his thyroid bloods in six weeks initially then three months after that and three monthly until he comes back to see me in the clinic.

Kind regards,

Yours sincerely

Dictated and electronically checked by:

Dr Linda Buchanan
Consultant Physician

CC:
Mr David Adams
10 Douglas Avenue
Grangemouth
Stirlingshire
FK3 0LD

Chair: Janie McCusker
Chief Executive: Cathie Cowan

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Department of Endocrinology & Diabetes

Consultant: Dr Linda Buchanan

Tel: 01324 566346

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr G Crawford
Bo'Ness Road Medical Practice
33 Bo'Ness Road
Grangemouth
FK3 8AN

Date Dictated: 03/08/2021
Date Typed: 17/08/2021
Our Ref: LMB/PM
CHI: 0705570592

Dear Dr G Crawford

David Adams DOB: 07-05-1957
10 Douglas Avenue Grangemouth FK3 0LD

Diagnosis:

Graves disease with positive thyroid antibody

Current treatment:

Carbimazole 40mg daily/ Levothyroxine 100mcg daily

I had a telephone consultation with Mr Adams today, his wife was present as well. He is feeling well on his current treatment, his last TSH was 0.79 in June. He will be due bloods in early September and I have put TFTs and a TRAB on ordercomms, it is important he has both tests done as this will determine whether or not we can stop his treatment in September or whether we need to consider him for definitive treatment in the form of radioiodine. I will keep an eye out for his results.

Kind regards.

Yours sincerely

Dictated and electronically checked by:

Dr Linda Buchanan
Consultant Physician

CC:

Mr David Adams
10 Douglas Avenue
Grangemouth

Chair: Janie McCusker
Chief Executive: Cathie Cowan

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Until 2021**

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Stirlingshire
FK3 0LD

Department of Endocrinology & Diabetes
Consultant: Dr Linda Buchanan
Tel: 01324 567373

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr G Crawford
Bo'Ness Road Medical Practice
33 Bo'Ness Road
Grangemouth
FK3 8AN

Date Dictated: 22/12/2020
Date Typed: 5/1/2021
Our Ref: LMB/JH
CHI: 0705570592

Dear Dr G Crawford

David Adams DOB: 07-05-1957
10 Douglas Avenue Grangemouth FK3 0LD

Diagnosis:

1. Graves' disease - currently on block and replace treatment with Carbimazole 40 mg daily and Levothyroxine 100 µg daily.

I had a telephone consultation with Mr Adams today. It is difficult to know exactly what is going on with him. Last time when I spoke to him I thought he seemed very muddled and to be honest I felt the same today. He is very focused on the amount of weight he has lost which is around 3 stone. He said he stopped smoking at the same time as his thyroid became an issue and his weight has not gone back up. He feels weak and lethargic and feels his legs are also weak and he can't walk to the shop and back as he did before.

I don't think any of this is currently related to his thyroid as his thyroid function has been back to normal since around July of this year. I don't know if there is something else going on but I have suggested he discusses it with someone in the Practice if he has concerns about his weight and other symptoms. From my point of view he needs an appointment for me again in 6 months and I would be grateful if his blood could be repeated in 3 months. He will have his thyroid block and replace medication for 18 months in total.

Kind regards.

Yours sincerely

Dictated and electronically checked by:

Dr Linda Buchanan
Consultant Physician

CC:/



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Chief Executive: Cathie Cowan

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THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

CC:

Mr David Adams
10 Douglas Avenue
Grangemouth
Stirlingshire
FK3 0LD

Department of Endocrinology & Diabetes
Consultant: Dr Linda Buchanan
Tel: 01324 567373

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr Gregor Crawford
Bo'ness Road Medical Practice
33 Bo'ness Road
Grangemouth
FK3 8AN

Date Dictated 05 August 2020
Date Typed 10 August 2020
Our Ref LB//F140620
CHI 0705570592

Dear Dr Crawford

David Adams 07/05/1957
10 DOUGLAS AVENUE Grangemouth Stirlingshire FK3 0LD

I can see Mr Adams has had repeat bloods done. His TRAb is positive in keeping with Graves' disease. His thyroid function tests are improving and I think he should now be changed on to a full block and replace regimen which is Carbimazole 40mg daily and Levothyroxine 100mcg daily. He will continue on this until the end of his 18 months of treatment. He would benefit from having his thyroid function tests checked at 3 monthly intervals. If you have any concerns about his current medication or his results then please don't hesitate to get in touch. Kind regards.

Yours sincerely

(Dictated and electronically checked by Dr Linda Buchanan)

Dr Linda Buchanan
Consultant Physician

cc. Mr David Adams, 10 Douglas Avenue, Grangemouth FK3 0LD



Chair: Janie McCusker
Chief Executive: Cathie Cowan

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Department of Endocrinology & Diabetes
Consultant: Dr Linda Buchanan
Tel: 01324 567373

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr Gregor Crawford
Bo'ness Road Medical Practice
33 Bo'ness Road
Grangemouth
FK3 8AN

Date Dictated 28 July 2020
Date Typed 07 August 2020
Our Ref LB/LynB/F140620
CHI 0705570592

Dear Dr Crawford

David Adams 07/05/1957
10 DOUGLAS AVENUE Grangemouth Stirlingshire FK3 0LD

Telephone Consultation:
Diagnosis:

1. Hyperthyroidism secondary to Graves' disease

Treatment: Current treatment should be Carbimazole 40mg daily and Levothyroxine 50mcg daily.

Plan: Repeat TFTs in 6 weeks time and decide if dose needs titrated.

I spoke to Mr Adams today and it was initially quite confusing as he was complaining of a lot of symptoms with spasms in his hands and legs like cramps. I can see that his calcium has been checked recently and his kidney function and this is normal. His thyroid function I thought looked normal for him being on a block and replace.

After a bit of conversation it turns out he has not been taking the Levothyroxine he has only been taking the Carbimazole. I have therefore asked him to add in 50mcg of Levothyroxine which he has in the house and that it is important that he takes both medications for the full course of 18 months. Over time we may need to adjust his dose. I would be grateful if he could have his bloods repeated again in 6 weeks.

If you have any questions about his medication dose then please let me know. I am going to give him another virtual appointment for me in 4 months. Kind regards.

Yours sincerely

(Dictated and electronically checked by Dr Linda Buchanan)

Dr Linda Buchanan
Consultant Physician

cc. Mr David Adams, 10 Douglas Avenue, Grangemouth FK3 0LD



Chair: Janie McCusker
Chief Executive: Cathie Cowan

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Department of Endocrinology & Diabetes
Consultant: Dr Linda Buchanan
Tel: 01324 566346

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr Gregor Crawford
Bo'ness Road Medical Practice
33 Bo'ness Road
Grangemouth
FK3 8AN

Date Dictated 05 June 2020
Date Typed 09 June 2020
Our Ref LB/LynB/F140620
CHI 0705570592

Dear Dr Crawford

David Adams 07/05/1957
10 DOUGLAS AVENUE Grangemouth Stirlingshire FK3 0LD

I can see Mr Adams had his thyroid function tests checked again on 25 May and they are now coming under control with his Carbimazole 40mg daily. I would suggest adding in Thyroxine 50mcg at this stage. It would be helpful to repeat his bloods again in about 6 weeks time to allow us to titrate the Thyroxine if required. He hasn't had his TRAb done which I have put on Order Comms. I would be grateful if this could be done when he next has his bloods done. Please e-mail me to let me know the results if you want advice regarding his next bloods. Kind regards.

Yours sincerely

(Dictated and electronically checked by Dr Linda Buchanan)

Dr Linda Buchanan
Consultant Physician

cc. Mr David Adams, 10 Douglas Avenue, Grangemouth FK3 0LD



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Department of Endocrinology & Diabetes
Consultant: Dr Linda Buchanan
Tel: 01324 567373

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr Gregor Crawford
Bo'ness Road Medical Practice
33 Bo'ness Road
Grangemouth
FK3 8AN

Date Dictated 21 April 2020
Date Typed 23 April 2020
Our Ref LB/LynB/F140620
CHI 0705570592

Dear Dr Crawford

David Adams 07/05/1957
10 Douglas Avenue Grangemouth Stirlingshire FK3 0LD

Telephone Consultation:

Diagnosis:

1. Hyperthyroidism

Current medication from today: Carbimazole 40mg alone.

Plan: Repeat TFTs in 4 weeks and then add in Levothyroxine 100mcg daily.

I spoke to Mr Adams by telephone today and he is feeling dreadful. He has lost a significant amount of weight, he feels very weak and lethargic and has also had loose stools. Unfortunately when he started his Carbimazole 40mg he also started the Levothyroxine at the same time and not surprisingly he has got progressively worse as he will be very thyrotoxic at the moment with that combination. He has no family history of thyroid disease. He has had no problems with his eyes. He is a non smoker.

He seemed very muddled by the whole thing. I made sure I discussed side effects of Carbimazole with him as well. I then asked if I could speak to his wife which he was happy to allow me to do to make sure she understood about the tablets. The plan going forward is that he will take Carbimazole 40mg on its own for 1 month, then attend the surgery for repeat bloods. Once you see the repeat bloods if his Free T4 is less than 12 please add in the 100mcg of Levothyroxine at that stage. The plan at the moment during the Covid situation is that we are treating patients with a block and replace. This may be for 18 months. WE are unlikely to have the option of radio-iodine treatment for some time. I have put some thyroid function tests and a TRAb on to Order Comms for him to have in 4 weeks time. If there are any problems with these being done in the surgery please let me know.

I will also ask my secretary to put in leaflets about hyperthyroidism and radioiodine treatment with his letter. If you are concerned at all about his bloods then please let me know.

Chair: Janie McCusker
Chief Executive: Cathie Cowan

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CLINICAL INFORMATION**History of presenting complaint / examination findings / investigation results****Presenting complaint**

Description: Epididymal cyst

Comment: Dear Doctor

I would be grateful this gentleman who has had intermittent swelling of his right testicle. He finds that there are no precipitating factors that cause it to swell. It just seems to come up randomly and then disappears.

He has previously been referred about this but has not been seen but I wonder if this is because he changed address.

Today he had what appeared to be an epididymal cyst. There was no pain on palpation, no erythema around the scrotum and I could find no regular hard masses on the testicle and no lymphadenopathy. However I would be grateful if you could see him and advise on further management.

Thanking you in advance for your help.

Yours sincerely,

Dr N Howland

Comment's on Examinations and Investigations**Examinations and Investigations**

Height(m):	0	-
Weight (kg):	0	-
Blood Pressure-Systolic:	0	-
Blood Pressure-Diastolic:	0	-
Murmur present:	Not Recorded	-
Is a 12 lead ECG:	Not done	-
Recent CXR:	Not done	-
FBC:	Not Recorded	-
Urea and Electrolytes:	Not Recorded	-
LFT:	Not Recorded	-
TFT:	Not Recorded	-
Lipid Profile:	Not Recorded	-
Glucose:	Not Recorded	-
Smoking Advice Recorded:	Not Recorded	-

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history**Pre-existing conditions**

<u>Description</u>	<u>Laterality</u>	<u>Modifier</u>	<u>Extension</u>	<u>Date of onset</u>
Pat. GP7B/GP8B card from HB	-	-	-	01-Aug-2006
Current smoker	-	-	20 per day	29-Jul-2006
Patient reg. form sent to HB	-	-	-	29-Jul-2006

Current medication

No current medications recorded

Recent medication**COPY**

No recent medications recorded

Clinical warnings**Lifestyle risks**

Exercise status: Not Known

Smoking status

Number per day
- (current smoker)

Alcohol consumption

Units per day
? (not known)

COPY**Additional relevant information****Administrative information**

Patient will accept any doctor:Not Recorded

Patient will accept any site:Not Recorded

Patient will accept cancellation or short notice appointment:Not Recorded

Patient has disability or requires wheelchair access:Not Recorded

Signature of referring doctor (or other professional) Date

COPY

Department of Urology

Consultant: Mr Michael F Smith
E-mail: michael.smith@fvah.scot.nhs.uk
Secretary: Susan Anderson
E-mail: susan.anderson@fvah.scot.nhs.uk
Tel. No: 01324-624000 Ext 5962
Fax. No: 01324-616164

MFS/SA/F140620

CHI 0705570592

Date dictated: 16th October 2006
Date typed: 25th October 2006

Dr N J Howland
Bo'ness Road Medical Practice
33 Bo'ness Road
Granemouth
FK3 8AN

Dear Dr Howland

DAVID ADAMS (07.05.57) 10 DOUGLAS AVENUE, GRANGEMOUTH

According to our records Mr Adams was seen on 20th November 2003 by Mr Seth at Mr Hehir's clinic and subsequently failed to attend at least 3 times.

There is a small swelling related to the upper pole of the right epididymis. This is almost certainly related to the epididymal cyst which was only 8 x 6mm identified on the ultrasound scan of November 2003. It may have increased a little in size since then. It is however quite different and I do not think in any way is related to the intermittent swelling of the scrotum which Mr Adams reported today. He felt it had always been there and it sometimes could be very painful. I suspect he has an intermittent hydrocele and I do not think he is going to be happy until the hydrocele sac is removed. We could also remove the epididymal cyst at the same procedure which could be done as a day patient, assuming he attends as he did describe himself as somewhat of a nomadic painter and decorator.

Yours sincerely

M F SMITH
Consultant Urologist

W/L

COPY

Department of Urology

Consultant: Mr Michael F Smith
E-mail: michael.smith@fvah.scot.nhs.uk
Secretary: Susan Anderson
E-mail: susan.anderson@fvah.scot.nhs.uk
Tel. No: 01324-624000 Ext 5962
Fax. No: 01324-616164

MFS/SS/SA/F140620

CHI 0705570592

Date dictated: 15th January 2007

Date typed: 16th January 2007

Dr N Howland
Surgery
33 Bo'ness Road
Grangemouth
FK3 8AN

Dear Dr Howland

THEATRE LETTER

DAVID ADAMS (07.05.57) 10 DOUGLAS AVENUE, GRANGEMOUTH

**Diagnosis: Right epididymal cyst
Right hydrocele**
**Procedure: Excision of epididymal cyst
Eversion of right hydrocele**

**Code: N153B
Code: N111**

These 2 procedures were carried out uneventfully. The hydrocele was small with approximately 10mls fluid around the testicle. The epididymal cyst was multi-loculated, 8mm in the head. All sutures are absorbable. Mr Adams does not require any further urological follow-up unless there are any problems.

Yours sincerely

MR SUBODH SETH
Staff Grade in Urology/General Surgery

F 1140620

COPY

Hospital use only	Clinic	Day Date	Time	Hospital No.
-------------------------	--------	-------------	------	-----------------

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Anaesthetics C3
FV Pain Clinic Referral

Falkirk and District Royal Infirmary

— **Consultant / receiving practitioner
and/or specialty clinic**

— **Hospital and hospital address**

Hospital location code.

Email address

Urgency of referral

Routine Pain Clinic
Referral

PATIENT DETAILS

Surname Adams
Forename(s) David
Title -
Sex Male
Date of birth 07-May-1957
CHI no. 0705570592

Patient's address

10 Douglas Avenue
GRANGEMOUTH
FK3 0LD ✓

Contact number(s)

Voice: 874396

REFERRING PRACTITIONER DETAILS

Name Dr IB MURDOCH
GMC code 2343370 GP code 55719
Practice name Bo ness Road Medical Practice
Practice code 25332

Practice address

33 Bo ness Road
Grangemouth
FK3 8AN

Contact number(s)

Voice: 01324 482653
Facsimile: 01324 666119

M

CLINICAL INFORMATION**History of presenting complaint / examination findings / investigation results****Presenting complaint**

Description: Back Pain Clinic

Comment: I wonder if you would see this gentleman. He joined us recently having been a patient here some time ago, but his problem is of back pain. He has pain in the low back radiating down his right leg to the foot.

Looking back at his notes I see he has been troubled with this at intervals over the last few years. This obviously affects his work as a painter and decorator.

I wonder if he would benefit from any further investigations of his back and would be grateful for your opinion. Thank you.

COPY**Comment's on Examinations and Investigations****Examinations and Investigations**

Height(m): 0 -
 Weight (kg): 0 -
 Blood Pressure-Systolic: 0 -
 Blood Pressure-Diastolic: 0 -
 Murmur present: Not Recorded -
 Is a 12 lead ECG: Not done -
 Recent CXR: Not done -
 FBC: Not Recorded -
 Urea and Electrolytes: Not Recorded -
 LFT: Not Recorded -
 TFT: Not Recorded -
 Lipid Profile: Not Recorded -
 Glucose: Not Recorded -
 Smoking Advice Recorded: Not Recorded -

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history**Pre-existing conditions**

Description	Laterality	Modifier	Extension	Date of onset
Hospital Unit No	-	-	F.140620	12-Sep-2006
Current smoker	-	-	20 per day	29-Jul-2006
Alcohol dependence syndrome	-	-	-	01-Jun-1995

Current medication

No current medications recorded

Recent medication

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration
Paracetamol	04.07.01.0	TABS 500MG	2 Tabs	4 times daily	13-Nov-2006	-
Ibuprofen	10.01.01.0	TABS 400MG	1 Tab	3 times daily	13-Nov-2006	-

Clinical warnings**Lifestyle risks**

Exercise status: Not Known

Smoking status

Alcohol consumption

Number per day - (current smoker)

Units per day ? (not known)

Additional relevant information

Administrative information

Patient will accept any doctor:Not Recorded

Patient will accept any site:Not Recorded

Patient will accept cancellation or short notice appointment:Not Recorded

Patient has disability or requires wheelchair access:Not Recorded

COPY

Signature of referring doctor (or other professional) **Date**

Falkirk & District Royal Infirmary
Major's Loan
Falkirk
FK1 5QE
Telephone: 01324 624000

COPY

**Department of Anaesthetics
& Pain Management**

Dr A Semple, Consultant Anaesthetist
Dr J Wood, Staff Grade Anaesthetist
Secretary 01324 624000 Ext 5571
Pain Management Suite 01324 624000 Ext 5861

JMW/MMC/FZ140620
CHI: 0705570592

Dictated: 20th March 2007
Typed: 20th March 2007

Dr I B Murdoch
Bo'ness Road Medical Practice
33 Bo'ness Road
Grangemouth
FK3 8AN

Dear Dr Murdoch

David Adams, 10 Douglas Avenue, Grangemouth, FK3 0LD
Date of Birth 07.05.1957

Further to your referral of this gentleman to the pain relief clinic he was sent an appointment for this morning. He has however failed to attend this. We have not routinely re-appointed him but should it have been an oversight and you still wish him to be seen I would be grateful if you could let us know.

Yours sincerely

Joanne M Wood
Staff Grade Anaesthetist

F14062

Bo'ness Road Dental Practice

Bo'ness Road Dental
Practice
COPY
72 Bo'ness Road
Grangemouth FK5 9BL
Phone: 01324 482292
Fax: 01324 485902

20 March 2008

ORAL
JMKM
TUES 22/4/08
10.30

Oral Surgery Dept
Falkirk & Distr Royal Infirmary
Majors Loan
Falkirk

RECEIVED 03 APR 2008

Dear Sir/Madam,

ANSWERED 03 APR 2008

I would be grateful if you could arrange to see David.

Patient Details

Name: Mr David Adams
Address: 10 Douglas Ave
Grangemouth
Stirlingshire

Phone - Home/Work: 01324 874396

D.O.B: 07/05/57

Medical History: smoker

At Davids recent examination I noticed a white patch about 5mm in diameter in the left buccal sulcus and also an area of redness speckled with white down his soft palate also on the left. I would be grateful if you could examine and advise.

Thank you for your help.

Praven
31/3/08
Soon answers next

Regards

Mrs J T Martin
Dental Surgeon

RECEIVED
1 APR 2008

6

Department of Oral & Maxillofacial Surgery

Consultant: Mr J J Downie

Tel: 01324 616052

Fax: 01324 678573

Falkirk & District Royal Infirmary

Major's Loan

Falkirk

FK1 5QE

COPY

Ref: JJD/AJT/F140620

CHI: 0705570592

Clinic Date: 6-May-2008

Date: 09 May 2008

Dr J Martin
Dental Surgeon
72 Bo'ness Rd
Grangemouth

Dear Dr Martin

DAVID ADAMS 07/05/1957

10 DOUGLAS AVE GRANGEMOUTH FK3 0LD

This patient has now failed two appointments to review a white patch that he has in his mouth. No further appointments have been made, but please re-refer should the patient contact you.

Yours sincerely

Fiona Raven

Locum Staff Grade in Oral & Maxillofacial Surgery for

Mr J J Downie

Consultant Oral & Maxillofacial Surgeon FDS RCS, FRCS OMFS

Cc to Dr Ian Murdoch, 33 Bo'ness Road, Grangemouth, FK3 8AN

Bo'ness Road Dental Practice

Mr Mc Manners.
Thurs 19/2/09
10-10

Tues 24/2/09.
10-50

F140620

Bo'ness Road Dental
Practice
COPY
72 Bo'ness Road
Grangemouth FK3 9BL
Phone: 01324 482292
Fax: 01324 485902

8 January 2009

Oral Surgery Dept
Falkirk & Distr Royal Infirmary
Majors Loan
Falkirk

Dear Sir/Madam,

I would be grateful if you could arrange to see David.

Patient Details

Name: Mr David Adams
Address: 10 Douglas Ave
Grangemouth
Stirlingshire

Phone - Home/Work: 01324 874396

D.O.B: 07/05/57

Medical History: SMOKER

I referred this gentleman to you in March 2008 regarding a white patch in the left cheek area and also an area of white with speckled red in the soft palate area on the upper right area. He did not attend due to family bereavement and I also have not seen him since. He attended today in pain to have a tooth extracted and on examination these areas are still present. The buccal sulcus patches are probably frictional but I am more concerned about the area in the palate. I would be grateful if you could rearrange another appointment to examine these areas. I have stressed to the patient the importance of attending.

Thank you for your help.

Regards

[Signature]

sent to Mr

[Signature]

22/1
RECEIVED

26 JAN 2009

Mrs J T Martin
Dental Surgeon

COPY

Department of Oral & Maxillofacial Surgery

Consultant: Mr J McManners

Tel: 01324 616419

Fax: 01324 678573

Falkirk & District Royal Infirmary

Major's Loan

Falkirk

FK1 5QE

COPY

Ref: JMCM/SS/F140620

CHI: 0705570592

Clinic Date: 05 March 2009

Date: 09 March 2009

Mrs J T Martin
Dental Surgeon
72 Bo'ness Road
GRANGEMOUTH
FK3 9BL

Dear Mrs Martin

DAVID ADAMS 07/05/1957
10 DOUGLAS AVE GRANGEMOUTH FK3 0LD

Thanks for referring this patient regarding the white patches on the left soft palate and buccal mucosa. The patient was previously unaware of this until noticed by yourself.

Socially he drinks about 15 units of alcohol at the weekends. He smokes 10 cigarettes a day and has done so for the past 10 years.

On examination extra-orally there is nil of note. Intra-orally I can see the white patches on the left soft palate and buccal mucosa at the retromolar region. The patient has a heavily restored dentition with amalgams at the molar area. The dorsal surface of the tongue is covered with tobacco. The floor of the mouth is fine.

I have advised Mr Adams to stop smoking and given him some oral hygiene instruction.

We will do a punch biopsy of the left soft palate/buccal mucosa under local anaesthesia and will keep you informed of his progress.

Yours sincerely

Yasir Shammaa

Locum Staff Grade in Oral & Maxillofacial Surgery

C.C - Dr Ian Murdoch, 33 Bo'ness Road, Grangemouth, FK3 8AN

Department of Oral & Maxillofacial Surgery

Consultant: Mr J McManners

Tel: 01324 616419

Fax: 01324 678573

Falkirk & District Royal Infirmary

Major's Loan

Falkirk

FK1 5QE

COPY

Ref: YS/MMF/FZ140620

CHI: 0705570592

Clinic Date: 12 January 2010

Date: 22 January 2010

Mrs J T Martin
Dental Surgeon
72 Bo'ness Road
Grangemouth
FK3 9BL

Dear Mrs Martin

DAVID ADAMS 07/05/1957

10 DOUGLAS AVENUE GRANGEMOUTH FK3 0LD

This patient failed to attend his appointment for the clinic. We plan to discharge him back to your care and if there are any further problems please don't hesitate to contact us.

Yours sincerely

Mr Y Shammaa

Staff Grade Oral & Maxillofacial Surgeon

c.c. Dr G Crawford, Bo'ness Road Medical Practice, 33 Bo'ness Road, Grangemouth, FK3 8AN

F140620

Hospital
use
only

Clinic

Day
Date

Time

Hospital
No
COPY

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TOGeneral SurgeryC1
FV Minor Ops referral— **Consultant / receiving practitioner
and/or specialty clinic**Falkirk and District Royal Infirmary
Majors Loan
Falkirk
FK1 5QE— **Hospital and hospital address**

Hospital location code

V102H

Email address

Urgency of referral

Routine - Minor
Ops Referral**PATIENT DETAILS**

Surname

Adams

Forename(s)

David

Title

-

Sex

Male

Date of birth

07-May-1957

CHI no.

0705570592

Patient's address10 Douglas Avenue
GRANGEMOUTH
FK3 0LD

Contact number(s)

Voice: 874396

REFERRING PRACTITIONER DETAILS

Name

Dr Jane Marshall

GMC code

4295709

GP code

V

Practice name

Bo ness Road Medical Practice

Practice code

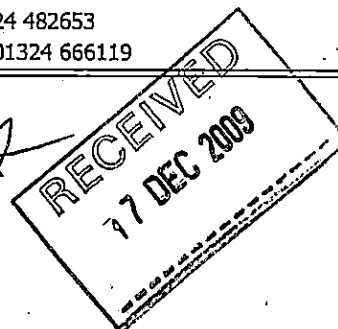
25332

Practice address33 Bo ness Road
Grangemouth
FK3 8AN

Contact number(s)

Voice: 01324 482653

Facsimile: 01324 666119



FTA

CLINICAL INFORMATION**History of presenting complaint / examination findings / investigation results****Presenting complaint**

Description: benign looking skin lesion on forehead.

Comment: Dear Doctor

COPY

I would be grateful if you could see this 52 year old painter who states that he had a small, flat, brown mole on the right side of his forehead until last year which he accidentally shaved off when cutting his hair.

A few months later in the same site a raised flesh coloured lesion appeared which has steadily grown over the last few months. He has to wear a hat at his work and the skin lesion is itchy after wearing it and when he scratches it, it often bleeds.

On examination he had a 8 mm diameter flesh coloured lesion, slightly raised with no ulceration.

I suspect that this is benign but due to the fact that it is giving him symptoms, and he repeatedly cuts it when shaving his hair, he has requested excision.

He states that a scar on his forehead does not bother him as he has numerous other scars already on his scalp.

Thank you for seeing him.

Yours sincerely,

Dr J Marshall

Comment's on Examinations and Investigations**Examinations and Investigations**

Height(m): 0 -
 Weight (kg): 0 -
 Blood Pressure-Systolic: 130 -
 Blood Pressure-Diastolic: 80 -
 Murmur present: Not Recorded -
 Is a 12 lead ECG: Not done -
 Recent CXR: Not done -
 FBC: Not Recorded -
 Urea and Electrolytes: Not Recorded -
 LFT: Not Recorded --
 TFT: Not Recorded -
 Lipid Profile: Not Recorded -
 Glucose: Not Recorded -

Investigations

Smoking Advice Recorded: Not Recorded -

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history**Pre-existing conditions**

Description	Laterality	Modifier	Extension	Date of onset
Hospital Unit No	-	-	F.140620	12-Sep-2006
Alcohol dependence syndrome	-	-	-	01-Jun-1995

Past procedures

Description	Laterality	Modifier	Date performed
-------------	------------	----------	----------------

Smoking cessation advice

15-Dec-2009

COPY**Current medication**

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration
Paracetamol	04.07.01.0	TABS 500MG	2 Tabs	4 times daily	17-Mar-2009	
Ibuprofen	10.01.01.0	TABS 400MG	1 Tab	3 times daily	17-Mar-2009	

Recent medication

No recent medications recorded

Clinical warnings**Lifestyle risks**

Exercise status: Not Known

Smoking status

Alcohol consumption

Number per day
- (current smoker)Units per day
? (not known)**Additional relevant information****Administrative information**

Patient will accept any doctor:Not Recorded

Patient will accept any site:Not Recorded

Patient will accept cancellation or short notice appointment:Not Recorded

Patient has disability or requires wheelchair access:Not Recorded

Signature of referring doctor (or other professional) Date

COPY

Department of Oral & Maxillofacial Surgery

Consultant: Mr J McManners

Tel: 01324 566357 / 01324 566353

Fax:

Forth Valley Royal Hospital

Stirling Road

Larbert

FK5 4WR

COPY

Ref: JMCM/EM/NS/F140620

CHI: 0705570592

Clinic Date: 23 October 2012

Date: 24 October 2012

Ms Jean Martin
Dental Surgeon
The Practice
72 Bo'ness Road
Grangemouth
FK3 9BL

Dear Ms Martin

David Adams 07/05/1957

10 Douglas Avenue, GRANGEMOUTH, Stirlingshire FK3 0LD

Thank you for kind referral of Mr Adams regarding the red and white patches on his soft palate and buccal mucosa. He does not report any pain or problems associated with these areas and is unsure how long they have been present. As you note he was previously referred about the same lesions in 2008.

Medically he is fit and well. He doesn't take any medications or have any allergies. He is a smoker of about 10 cigarettes per day and drinks approximately 30-35 units of alcohol per week. He is married and lives with his wife. He works as a painter and decorator.

On examination there is no TMJ problems, no lymphadenopathy and no facial asymmetry. There are white patches on the left and right buccal mucosa, adjacent to the lower posterior teeth and they are more pronounced on the left hand side. There were also red and white speckled patches bilaterally on the soft palate of approximately 5-10mm in size. These are more pronounced on the right hand side. The patient was seen by Dr Shammaa, Associate Specialist, our differential diagnosis is lichenoid reaction as Mr Adams has a heavily restored dentition. We discussed the situation with Mr Adams and agreed that a biopsy of the areas would be sensible at this stage. We have therefore arranged an appointment for this for Friday 26th October 2012.

We have also discussed with Mr Adams the risk factors associated with smoking and advised him to attend his GP for advice on smoking cessation. We shall endeavour to keep you informed of progress.

Yours sincerely

Emily Mackie

LDFT in Oral & Maxillofacial Surgery

Copy to:

Dr Gregor Crawford
Bo'ness Road Medical Practice
33 Bo'ness Road
Grangemouth
FK3 8AN

COPY

F140620

Hospital use only	Clinic	Day Date	Time	COPY
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Date Referral Submitted
15-Aug-2012

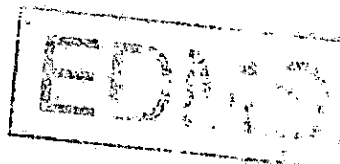
REFERRAL LETTER
MEDICAL IN CONFIDENCE

REFERRAL TO	
Oral Surgery FDRID3VA FV Oral Surgery Department	— Consultant / receiving practitioner and/or specialty clinic
FV Dental NHS Forth Valley	— Hospital and hospital address
	Hospital unit no. V006G
	Email address -
Urgency of referral Routine	

PATIENT DETAILS		Patient's address
Surname	Adams	10 Douglas Avenue Grangemouth FK3 0LD
Forename(s)	David	
Title	-	
Sex	Male	
Date of birth	07-May-1957	
CHI no.	0705570592	Contact number(s) Voice: 01324874396

REFERRING HCP DETAILS		Organisation address
Name	Jean Martin	The Practice 72 Bo'ness Road Grangemouth FK3 9BL, Tel 01324 482292
Practice Name	-	
Phone Number	-	

*routine
18/8/12*



CLINICAL INFORMATION**History of presenting complaint / examination findings / investigation results****Presenting complaint**

Description: Other oral mucosal lesions

Examinations and Investigations

If other oral mucosal lesions: Other mucosal abnormality

Additional free-text Information: I would be grateful if you could arrange an appointment for this patient for assessment and advice. He is an irregular attender with poor oral hygiene but he has a genuine phobia of needles. At a recent appointment I noticed 2 red patches with white areas on his left and right posterior soft palate. There are also white areas in the buccal sulcus on the right side. These areas have been present for some time and he was first referred in 2008 but did not attend. He then was referred back in 2009 and was examined but did not return for his biopsy. He is a smoker but says that he is trying to cut back.

Interpreter Required?: No

Relevant Medical History or Medication: Smoker

Has the patient previously attended the department to which they are being referred?: Yes

Has the patient previously attended a Forth Valley hospital (Falkirk or Stirling)?: Yes

COPY

Signature of referring dentist (or other professional) Date

Department of Oral & Maxillofacial Surgery

Consultant: Mr J McManners

Tel: 01324 566357 / 01324 566353

Fax:

Forth Valley Royal Hospital

Stirling Road

Larbert

FK5 4WR

COPY

Ref: JMCM/EM/NS/F140620

CHI: 0705570592

Clinic Date: 26 October 2012

Date: 30 October 2012

Ms Jean Martin
Dental Surgeon
The Practice
72 Bo'ness Road
Grangemouth
FK3 9BL

Dear Ms Martin

David Adams 07/05/1957

10 Douglas Avenue, GRANGEMOUTH, Stirlingshire FK3 0LD

Further to our previous correspondence Mr Adams attended today for a biopsy under local anaesthesia which he was anxious about but coped well with.

We will review Mr Adams in 3 weeks with his pathology results and shall endeavour to keep you informed of progress.

Yours sincerely

Emily Mackie

LDFT in Oral & Maxillofacial Surgery

Copy to:

Dr Gregor Crawford
Bo'ness Road Medical Practice
33 Bo'ness Road
Grangemouth
FK3 8AN

COPY

Department of Oral & Maxillofacial Surgery

Consultant: Mr J J Downie

Tel: 01324 566358

Fax:

Forth Valley Royal Hospital

Stirling Road

Larbert

FK5 4WR

COPY

Ref: JJD/LD/MSA/F140620

CHI: 0705570592

Clinic Date: 13 November 2012

Date: 16 November 2012

**Dr J Martin
Dental Surgeon
The Practice
72 Bo'ness Road
Grangemouth
FK3 9BL**

Dear Dr Martin

David Adams 07/05/1957

10 Douglas Avenue, GRANGEMOUTH, Stirlingshire FK3 0LD

Problem: Red and white patches on soft palate and left buccal mucosa
Procedure: Incisional biopsy of left buccal mucosa and right soft palate under local anaesthetic
Diagnoses: Buccal mucosa keratosis with no evidence of dysplasia and soft palate lichenoid reaction

The above patient attended the Oral and Maxillofacial Surgery Department Out-Patient Clinic today to discuss the results of the histology report as noted above.

Mr Adams is still currently unsymptomatic from these lesions:

We have discharged the patient from the clinic today and have advised regular review with yourself. We have also recommended that he attend his General Medical Practitioner with regards to smoking cessation advice.

Should you have any further queries, please do not hesitate to contact us.

Yours sincerely

LISA DURNING

LDFT in Oral and Maxillofacial Surgery

Copy to: Dr G Crawford, Bo'ness Road Medical Practice, 33 Bo'ness Road, Grangemouth, FK3 8AN

COPY

140620

Hospital
use only

Clinic

Day
Date

Time

COPY
Hospital
No.

Date Referral Submitted
(This date is fixed at hospital end):
25-May-2015

REFERRAL LETTER
MEDICAL IN CONFIDENCE

0705570592

CHI No: 0705570592

1010093012670

Unique Care Pathway Number: 1010093012670

REFERRAL TO

Oral and Maxillofacial Surgery C13
FV Oral Surgery (Den)

— **Consultant / receiving practitioner**
and/or **specialty clinic**

Forth Valley Royal Hospital
Stirling Road
Larbert FK5 4WR

— **Hospital and hospital address**

Hospital location code.

V217H

Urgency of Referral**Routine Oral Surgery Referral****Administrative Information**

Patient has special requirements: Patient has NO special requirements

Armed Forces Veteran: No

Current Armed Forces personnel or dependent: No

PATIENT DETAILS**Surname**

ADAMS

Forename(s)

DAVID

Title

-

Sex

Male

Previous Surname

-

Date of birth

07-May-1957

CHI no.

0705570592

Patient's address

10 DOUGLAS AVENUE
GRANGEMOUTH
FK3 0LD

Contact number(s)

Voice: 01324 874396

REFERRING HCP DETAILS**Name:**

Jean Martin

Organisation
name:

-

Location Code:

-

Organisation address

The Practice
72 Bo'ness Road
Grangemouth
FK3 9BL, Tel 01324 482292

20 MAY 2015

LOH

Post
27/5/15

COPY

CLINICAL INFORMATION**History of presenting complaint / examination findings / investigation results****Presenting Complaint**

Description: Other oral mucosal lesions

Examinations and Investigations

If other oral mucosal lesions:

Long-term mucosal pigmented lesion

Additional free-text Information:

I would be grateful if you could see David and advise. He was in today for a routine exam and I noticed white patches in both buccal areas and on his soft palate on the left and right. He was seen in October 2012 with similar lesions and the pathology showed keratosis and lichenoid. I haven't seen him since then so I am uncertain if there has been a change. The buccal lesions are slightly pigmented. He is a smoker but says he has started using a e cigarette.

Has the patient previously attended the department to which they are being referred?:

Yes

Has the patient previously attended a Forth Valley hospital (Falkirk or Stirling)?:

Yes

Reason for referral

Care type requested: Dental

Expected outcome: Dental

Medical history**Active Repeat Therapy**

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

No current medications recorded

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

No recent medications recorded

Clinical warnings**Additional relevant information**

Signature of referring doctor (or other professional)

Date

25-May-2015

COPY

COPY

Department of Oral & Maxillofacial Surgery

Consultant: Mr Ewen Thomson

Tel: 01324 566364

Fax:

Forth Valley Royal Hospital

Stirling Road

Larbert

FK5 4WR

COPY

Ref: ET/IH/DB/F140620

CHI: 0705570592

Clinic Date: 19 August 2015

Date: 19 August 2015

Mr D Adams
10 Douglas Avenue
GRANGEMOUTH
FK3 0LD

Dear Mr Adams

David Adams 07/05/1957

10 Douglas Avenue, GRANGEMOUTH, Stirlingshire FK3 0LD

I note that you failed to attend your Oral and Maxillofacial Surgery Out-Patient Clinic consultation appointment today.

If you still wish to be seen please telephone the number above to make a further appointment as soon as possible.

If we do not hear from you we will presume that you no longer wish to be seen and you will be discharged back to your Dentist.

Yours sincerely

Mr Ian Holland

Consultant Oral & Maxillofacial Surgeon

cc Dr J Martin
Dental Surgeon
The Practice
72 Bo'ness Road
Grangemouth
FK3 9BL

Hospital
use only

Clinic

Day
Date

Time

COPY
Hospital
No.

Date Referral Submitted
(This date is fixed at hospital end):
25-May-2015

REFERRAL LETTER

MEDICAL IN
CONFIDENCE

0705570592

CHI No: 0705570592

1010093012670

Unique Care Pathway Number: 1010093012670

REFERRAL TO	
Oral and Maxillofacial Surgery C13 FV Oral Surgery (Den)	? Consultant / receiving practitioner and/or specialty clinic
Forth Valley Royal Hospital Stirling Road Larbert FK5 4WR	? Hospital and hospital address Hospital location code: V217H
Urgency of Referral Routine Oral Surgery Referral?? ?	
Administrative Information Patient has special requirements: Patient has NO special requirements Armed Forces Veteran: No Current Armed Forces personnel or dependent: No	

PATIENT DETAILS	
Surname: ADAMS	Patient's address 10 DOUGLAS AVENUE GRANGEMOUTH FK3 0LD
Forename(s): DAVID	
Title: Mr Sex: Male	
Previous Surname: 	
Date of birth: 07-May-1957	
CHI no: 0705570592	Contact number(s) Voice: 01324 874396

REFERRING HCP DETAILS	
Name: Jean Martin	Organisation address The Practice 72 Bo'ness Road Grangemouth FK3 9BL, Tel 01324 482292
Organisation name: 	
Location Code: 	

COPY

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: Other oral mucosal lesions

Examinations and Investigations

If other oral mucosal lesions: Long-term mucosal pigmented lesion

Additional free-text Information: I would be grateful if you could see David and advise. He was in today for a routine exam and I noticed white patches in both buccal areas and on his soft palate on the left and right. He was seen in October 2012 with similar lesions and the pathology showed keratosis and lichenoid. I haven't seen him since then so I am uncertain if there has been a change. The buccal lesions are slightly pigmented. He is a smoker but says he has started using a e cigarette.

Has the patient previously attended the department to which they are being referred?: Yes

Has the patient previously attended a Forth Valley hospital (Falkirk or Stirling)?: Yes

Reason for referral

Care type requested: Dental

Expected outcome: Dental

Medical history

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

No current medications recorded

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

No recent medications recorded

Clinical warnings

Additional relevant information
?

Signature of referring doctor (or other professional)

Date

25-May-2015

Department of Oral & Maxillofacial Surgery

Consultant: Mr Ewen Thomson

Tel: 01324 566364

Fax:

Forth Valley Royal Hospital

Stirling Road

Larbert

FK5 4WR

COPY

Ref: ET/MD/DB/F140620 CHI: 0705570592

Clinic Date: 30 November 2015

Date: 01 December 2015

Dr J Martin
Dental Surgeon
The Practice
72 Bo'ness Road
Grangemouth
FK3 9BL

Dear Dr Martin

David Adams 07/05/1957

10 Douglas Avenue, GRANGEMOUTH, Stirlingshire FK3 0LD

Many thanks for your referral of the above patient who was seen today in the Oral & Maxillofacial Surgery Clinic. Mr Adams has been seen a couple of times before in the unit with oral mucosal changes thought secondary to smoking. The more recent changes seem to be pigmentation which has developed on the right buccal mucosa and there is also a relatively suspicious area of erythro leukoplakia on the left side of the soft palate.

I had a discussion today with David about smoking cessation and I think he really hasn't taken on board the message of stopping smoking. I have said to him that as there have been further changes here that we should treat this as significant and further biopsy the most clinically abnormal areas. He was initially reticent about this given his fear of needles and local anaesthetic and he has requested that we give him a little bit of time to prepare for this.

I have therefore arranged for him to have biopsy of his right buccal mucosa and left soft palate under local anaesthetic within six weeks which I think is a good balance between some degree of urgency and the time he requests to get used to the idea of this.

We will be in touch once we have done this.

Yours sincerely

Mr Mark Devlin

Consultant in Oral & Maxillofacial Surgery

cc Dr Gregor Crawford
Bo'ness Road Medical Practice
33 Bo'ness Road
Grangemouth FK3 8AN

Department of Oral & Maxillofacial Surgery

Associate Specialist: Jane Shearer

Tel: 01324 566364

Fax:

Forth Valley Royal Hospital

Stirling Road

Larbert

FK5 4WR

COPY

Ref: JS/JC/F140620

CHI: 0705570592

Clinic Date: 26 January 2016

Date: 26 January 2016

Dr J Martin

Dental Surgeon

72 Bo'ness Road

GRANGEMOUTH

FK3 9BL

Dear Dr Martin

David Adams 07/05/1957

10 Douglas Avenue, GRANGEMOUTH, Stirlingshire FK3 0LD

This patient was reviewed in the clinic today with the results of his recent biopsy. The biopsy of the soft palate shows that there is at least low grade dysplasia in this area, the area biopsied in the right buccal mucosa shows inflammation only with no dysplasia.

I have reiterated to him the need to stop smoking and the significant risks that this dysplasia will develop into something more sinister if he does not take action now. I have arranged a review and I will be glad to keep you informed of his progress.

Yours sincerely

Jane Shearer

Associate Specialist in Oral & Maxillofacial Surgery

c.c.

Dr Gregor Crawford

Bo'ness Road Medical Practice

33 Bo'ness Road

Grangemouth

FK3 8AN

Department of Oral & Maxillofacial Surgery

Consultant: Mr Ewen Thomson

Tel: 01324 566364

Fax:

Forth Valley Royal Hospital

Stirling Road

Larbert

FK5 4WR

COPY

Ref: ET/PS/MSA/F140620

CHI: 0705570592

Clinic Date: 17 May 2016

Date: 23 May 2016

**Dr J Martin
Dental Surgeon
The Practice
72 Bo'ness Road
Grangemouth
FK3 9BL**

Dear Dr Martin

David Adams 07/05/1957

10 Douglas Avenue, GRANGEMOUTH, Stirlingshire FK3 0LD

Further to previous correspondence this patient attended today for discussion of his histopathology report. Three lesions were removed at his last appointment, two of which have come back as low grade dysplasia and one as a mucocele.

I discussed with the patient and his partner the report results and warned that there is the potential for further neoplastic change.

We are to review the patient on a three monthly basis and we have referred him to the Smoking Cessation Service here at Forth Valley Royal Hospital.

We have further re-iterated the need for smoking cessation and the patient is willing to try.

We will endeavour to keep you informed of his progress, but if you have any queries in the meantime please do not hesitate to get in touch.

Kind regards:

Yours sincerely

PATRICK STEED

LDFT in Oral and Maxillofacial Surgery

Copy to: Dr G Crawford, Bo'ness Road Medical Practice, 33 Bo'ness Road, Grangemouth, FK3 8AN

Department of Oral & Maxillofacial Surgery
Consultant: Mr Ewen Thomson
Tel: 01324 566364
Fax:

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

COPY

Ref: ET/DB/F140620
CHI: 0705570592

Clinic Date: 23 August 2016
Date: 24 August 2016

Dr Gregor Crawford
Bo'ness Road Medical Practice
33 Bo'ness Road
Grangemouth
FK3 8AN

Dear Dr Crawford

David Adams 07/05/1957
10 Douglas Avenue, GRANGEMOUTH, Stirlingshire FK3 0LD

Mr Adams has now failed on two occasions for follow up regarding his oral lesions. I am therefore sending no further appointments but would be more than happy to see him in the future if you or he have any concerns.

Yours sincerely

Mr Ewen Thomson
Consultant Oral & Maxillofacial Surgeon
cc Dr J Martin
Dental Surgeon
The Practice
72 Bo'ness Road
Grangemouth
FK3 9BL

Date Received: Tue 01/11/16

CHI: 0705570592

Hospital Number: 140620

COPY

Permanent Flags

- ☐ DGENERAL - GENERAL CLINIC
☐ PLC - PLC CLINIC
☐ PAEDS - PAEDIATRIC CLINIC
☐ DERMNS - NURSE LED CLINIC
☐ BIOPSY - BIOPSY CLINIC

Hospital use only	Clinic	Day Date	Time	Hospital No.
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Date Referral Submitted
(date is fixed at hospital end):
Nov-2016

REFERRAL LETTER

MEDICAL IN
CONFIDENCE

0705570592

CHI No: 0705570592

1010124220950

Unique Care Pathway Number: 1010124220950

REFERRAL TO

Dermatology A7
FV Suspicious Skin Lesion

Forth Valley Cancer Services
NHS Forth Valley

Consultant / receiving practitioner and/or
specialty clinic

Hospital and hospital address

Hospital location code

V001G

Urgency of Referral

**Urgent - Suspected Cancer (Suspicious
Skin Lesion)**

Administrative Information

Patient has special requirements: No

Employment: Occupations

Ethnic Origin: (White) Scottish

PATIENT DETAILS

Surname

Adams

Forename(s)

David

Title

-

Sex

Male

Previous Surname

-

Date of birth

07-May-1957

CHI no.

0705570592

Patient's address

10 Douglas Avenue
GRANGEMOUTH
FK3 0LD

Contact number(s)

Voice: 874396

REFERRING PRACTITIONER DETAILS

Name: Dr. Ian Murdoch (GMC: 2343370)

Practice: Bo'ness Road Medical Practice (25332)

Phone: Voice: 01324 482653

Practice address:

33 Bo'ness Road
Grangemouth
FK3 8AN

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: Possible skin cancer - type unclear

Examinations and Investigations

Is it appropriate for this patient to be telephoned for phototriage? Yes

Performance Status: No numerical value

Location of lesion(s) on body: 1 - scalp; 2 - L side of forehead

Size of lesion(s) (mm): 1 - 6mm diameter; 2 - 5 mm diameter

Skin lesion(s) description: This 59 year old gentleman attended today with concerns regarding two skin lesions.

One is on his scalp and the other is on the left side of his forehead. He describes both of these skin lesions as being non-healing spots, however, he does tend to pick at both of them. There have been no associated bleeding or itch. He reports the lesion on his scalp being there for approximately 4 months.

On examination, there is a 6mm diameter, ill-defined and crusted lesion on his scalp. On the side of his forehead, there is a 5 mm diameter partially rolled-edged and fissured papule with a scabbed edge to it.

Mr Adams, also describes male patterned baldness. He has smoked in the past and has had various biopsies in his mouth completed by the Max Fax team.

Given this background, he is quite concerned given a cancerous cause for these scalp. The one on the scalp I wondered if it was a patch of actinic keratosis. Otherwise, on the forehead, I wondered if it was a BCC. Given his background and concerns, I'd be grateful for your further opinion.

Yours Sincerely,

Dr Robert Wilson (GP Fellow)

Likelihood of Cancer: Not Recorded

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Medical history

Pre-existing Conditions (High Priority)

Description	Laterality	Modifier	Extension	Date Started
Alcohol dependence syndrome	-	-	-	01-Jun-1995

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

Drug name	Drug code	Formulation	Dosage	Frequency	Last Issued
Ibuprofen Tablets 400 mg	10010100AAAEAE	84 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	-
Eprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	28 capsule	ONE DAILY	-	-
Paracetamol Tablets 500 mg	0407010H0AAAMAM	200 TABS	2 Tabs 4 times daily	-	-

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

No recent medications recorded.

Clinical warnings

Smoking status:

Number per day: 7 (not known)

Description

Comment

Date Recorded

Current smoker

23-Jan-2014

Current smoker

03-May-2011

Current smoker

Disease: SPICE Basic Health Values, 15 per day priority=1

23-Mar-2009

Current smoker

Disease: SPICE Basic Health Values, 20 per day priority=1

29-Jul-2006

Alcohol status:

Units per day: 7 (not known)

Description

Comment

Date Recorded

Alcohol intake within recommended sensible limits

Disease: SPICE Basic Health Values, "Some cans at weekend" priority=2

29-Jul-2006

Exercise status:

Not Known

Additional relevant information

COPY

Signature of referring doctor (or other professional)

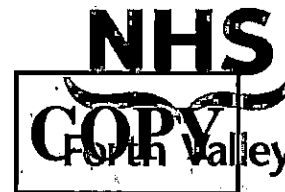
Date

01-Nov-2016

COPY

Dermatology Department
Nurse Specialist: Catherine Fraser
Tel: 01786 454504

Stirling Community Hospital
Livilands
Stirling
FK8 2AU



Dr Gregor Crawford
Bo'ness Road Medical Practice
33 Bo'ness Road
Grangemouth
FK3 8AN

Date Dictated 30 December 2016
Date Typed 10 January 2017

Our Ref CF/sp/F140620 (nn)
CHI 0705570592

Dear Dr Crawford

David Adams 07/05/1957
10 Douglas Avenue, GRANGEMOUTH, Stirlingshire FK3 0LD

Thank you for referring the above-named gentleman to phototriage, for assessment of 2 lesions (one on the scalp and one on the left side of his forehead). He attended the phototriage clinic on 29th November 2016, where the lesions were diagnosed as actinic keratoses. A treatment was arranged in clinic with liquid nitrogen cryotherapy and this was tolerated well.

A review has been arranged in 6 weeks.

With kind regards

Yours sincerely

(Dictated and electronically checked by Catherine Fraser)

Catherine Fraser
Advanced Nurse Practitioner



INVESTORS
IN PEOPLE | Silver

Chairman: Alex Linkston CBE
Chief Executive: Jane Grant

*Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW*

www.nhsforthvalley.com [Facebook.com/nhsforthvalley](https://www.facebook.com/nhsforthvalley) [@nhsforthvalley](https://twitter.com/nhsforthvalley)

Dr M. W. Loch
 Bolness Road Medical Practice
 Grangemouth

A7B Stamp

NHS
 Forth Valley

15/12/16

COPY



CHI NO: 0706570592 07/05/1957
 CRN: 140620 M
 David Adams
 10 Douglas Avenue,
 GRANGEMOUTH,
 Stirlingshire
 FK3 0LD

Referral Date:	1/11/16
Appointment Date:	2/11/16

Site of Lesion	X2 - Scalp L Side forehead	
Size of Lesion	7mm	
Duration	3mm 2w months	
Further Information/Other Lesions		
Photograph to be taken	☐ Yes ☒ No	Patient has given consent for Photograph Signature Required

Triage Diagnosis	Acute Damage
Triaged By:	Breida Sill
Outcome of Clinic	☐ Patient Re-assured and Discharged
	☐ Photograph taken for 2 nd opinion
	☒ Patient to have Follow Up appointment
Further Information	Two are treated ① left temple ② vertex treated well for LN2 to 2 weeks rev in 6/12

Photo review	
--------------	--

Clinic/histological diagnosis (if available)	
--	--

**Department of Orthopaedic Surgery
Virtual Fracture Clinic**

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Ref: IMcL/LF/SMcC/F140620
CHI: 0705570592

Clinic Date: 07 March 2017
Date Typed: 08 March 2017

DAVID ADAMS
10 DOUGLAS AVENUE,
GRANGEMOUTH,
STIRLINGSIRE
FK3 0LD

Dear David Adams



DIAGNOSIS: LEFT SHOULDER INJURY – POSSIBLE GRADE 1 AC JOINT SPRAIN (NO FRACTURE)

Your recent Emergency Department attendance has been reviewed and the above diagnosis made.

Acromioclavicular injury or shoulder separation is not an injury to the main shoulder joint itself. It is an injury to the top of the shoulder where the collar bone meets the shoulder blade. This causes a tear in the tissue that connects to the bone. This can make the bone end stick up. Most people recover from this injury without surgery within 2 to 12 weeks with pain killers, sling and then exercises. The sling is to be kept for 2 to 3 weeks from injury and can be removed after this time.

Once the sling has been removed pendular exercises can start (see overleaf) and active exercises after that as pain allows.

You may need to take regular pain killers for a few days. Your symptoms should normally ease off any time between 6 to 12 weeks after the injury.

If you have any concerns regarding the injury, numbness in the fingers, cold fingers or muscle weakness in your arm, please contact the Trauma Clinic Co-ordinator via the hospital switchboard 01324 566000 and ask for page number 1088.

Yours sincerely

NHS Forth Valley Orthopaedic Trauma Service

CC Dr Gregor Crawford
Bo'ness Road Medical Practice
33 Bo'ness Road
Grangemouth
FK3 8AN



Chairman: Alex Linkston CBE
Chief Executive: Jane Grant

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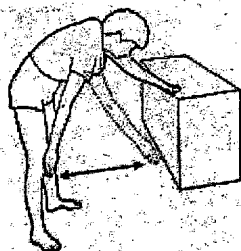
www.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalley

Following injury to your shoulder it may be necessary to rest your arm for short periods e.g. in a sling. However, it is important that your shoulder should not be allowed to 'stiffen'.

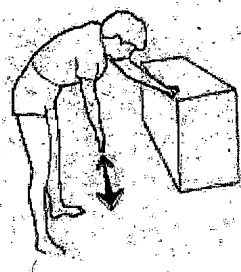
The following exercises should help with regaining normal movements of your shoulder as quickly as possible.

Stand beside a firm support e.g. a table or kitchen work surface and lean onto it with your unaffected arm. Stoop forward as far as possible, letting your affected arm hang loosely down from your body. Swing your arm gently in the following directions:

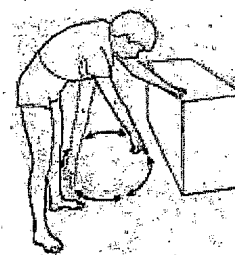
a) Forwards and backwards



b) Side to side



c) In circles, clockwise then anti-clockwise



Further advice:

- Check that your elbow bends and straightens fully and also that your wrist and hand move fully. These can become stiff if your arm is not being used normally.
- To start with you should not try to lift heavy objects. It is best to gradually increase the weight you lift when advised by your physiotherapist.
- Remember when dressing it is much easier to put your affected arm into the sleeve first.

COPY

Department of Oral & Maxillofacial Surgery

Consultant: Mr Jeff Downie

Tel: 01324 566357 / 01324 566353

Fax:

Forth Valley Royal Hospital

Stirling Road

Larbert

FK5 4WR

COPY

Ref: JJD/SD/AJT/F140620

CHI: 0705570592

Clinic Date: 27 April 2016

Date: 28 April 2016

Dr Gregor Crawford

Bo'ness Road Medical Practice

33 Bo'ness Road

Grangemouth

FK3 8AN

Dear Dr Crawford

David Adams 07/05/1957

10 Douglas Avenue, GRANGEMOUTH, Stirlingshire FK3 0LD

I reviewed Mr David Adams today in the oral and maxillofacial surgery clinic on behalf of Mr Downie, consultant. He attended along-side his wife. He reports he is still smoking about 20 roll-ups per day and drinks about 25 units of alcohol per week.

On examination, there was evident erythro-leukoplakia bilaterally on the border of the hard and soft palate and also a raised white elastic consistency lesion on the left posterior buccal mucosa. The neck examination was unremarkable.

Due to his high risk habits, I am concerned about these lesions and I have referred him for some urgent biopsies. I have also enrolled him in the smoking cessation programme. I will review him back in the clinic and will keep you informed of his progress.

Kind regards

Yours sincerely

Stergios Doumas

Clinical Fellow in Oral & Maxillofacial Surgery

Cc to Dr J Martin

Dental Surgeon

72 Bo'ness Road

Grangemouth FK3 9BL

COPY

Immediate Discharge Letter (Authorised)

COPY

General Medicine

Stirling Road

Larbert

Larbert

Stirlingshire

FK5 4WR

Dept. Contact Details:

CHI Barcode:



0705570592

Date of Completion: 10-Dec-2024

A Crichton
Kinneil Medical Practice
Health Centre
Dean Road
Bo'ness
EH51 0DQ

Patient Demographics

Patient Name:	ADAMS, David	Date Of Birth:	07-May-1957
Patient Address:	6 Salmon Court School Brae Bo'ness West Lothian EH51 9HF	Gender:	Male
		CHI No:	0705570592
Telephone No:	01324 874396		

GP Practice

GP Name:	A Crichton	GP GMC:	3331664
GP Practice Address:		GP Practice Code:	3331664/26208
		GP Clinic Code:	26208
		GP Telephone:	

Admission Details

Patient Location:	General Medicine	Admission Care Provider:	Dr Daniel Beckett
Admission Date:	09-Dec-2024	Admission Time:	00:14
Admission Method:	Emergency Admission, no additional detail added	Ward:	FVRH AAU Medical Waits
Source Of Admission:	Accident and Emergency Ward - other Provider		

Discharge Details

Discharge Specialty:	Geriatric Medicine	Discharge Care Provider:	Dr Gareth Blayney
Discharge Date:	10-Dec-2024	Ward:	FVRH Ward B21
Discharge Time:	14:50	Discharge Destination:	Private Residence - no additional detail added
Discharge Method:	Regular discharge, no additional detail added		

Clinical Summary including History

This 67 year old man was admitted with sudden onset left sided weakness
PMH-Graves disease, left leg sciatica
lives alone, independent, drives

Left arm drift
CN intact
NIHSS 1

ECG-sinus
Chest clear
CTA-no sig ICA stenosis

MRI brain-right basal ganglia infarct
Bloods-gluc 4.8, chol 4.6

-right basal ganglia infarct

Commenced on DAPT for 3 weeks and then clopidogrel 75mg only thereafter lifelong
Also started on PPI/statin

No therapy issues highlighted and can be discharged home as before with 48 hour tape as OP and driving advice given

Thank you
FSteel-NP

COPY**Safety Alerts**

Nil records exist

Allergy/Intolerance -

Allergy records are as recorded at time and date of printing
Nil records exist

Medications:-**Drug Information:**

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply
------	------	-------	-----------	----------------	-----	-------------

Nil records exist

Drug Notes:

Drug	Drug Notes
------	------------

Nil records exist

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason
------	---------------------

Nil records exist

GP Communications:**Outstanding Results -****Responsibility of Hospital**

Nil records exist

Person completing record**Authorised by**

Name: Fiona Steel
Designation or role: Nurse Specialist
Specialty:
Date completed: 10-Dec-2024

Clinically completed by

Name:
Designation or role:
Specialty:

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
A Crichton	GP	Kinnell Medical Practice

Patient Information

DAVIE ADAMS

Age/Gender: 67Y Old Male

Address: 6 SALMON COURT SCHOOL BRAE
BONESS, EH51 9HF

DOB: 07/05/1957

CHI:

Ethnicity:

Date:

08/12/2024

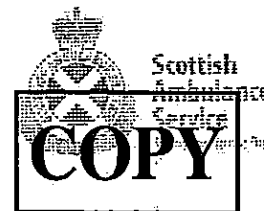
Incident Number:

CR011600622

Incident Type:

EMG

Incident Location:

6 SALMON COURT
SCHOOL BRAE BONESS,
EH51 9HF

Presenting Complaint

?CVA

Additional Comments

999 call regarding generalised weakness of the left face, arm and leg. hpcx... Pt was doing work outside when at approx 1230 he lost his balance and his speech became incomprehensible. Pt has been unwell with the flu for the past three weeks. pmhx... Sciatica, prev motorbike accident causing nerve damage left leg. O/A... Pt was sat on the couch, with an obvious left sided facial droop. Pt was unable to squeeze with his left hand and unable to keep left arm raised. J/E... Pt obs were within normal parameters, FAST+ve on speech and arm. Pt felt nausea but no vomiting. No visual changes, no LOC. No pain. Pt was transferred on blue lights and a pre-alert into resus. Enroute speech and weakness resolved, pt however reported 2 episodes of numbness on left side of face Nok Daughter Kelly 07871559304 With .
ient - 1329. At hospital 1359. Handover 1407.

PATIENT ASSESSMENT

ACVPU	Alert	<C>	No
A	Clear		
B	Breathing Adequately	Yes /	Respiratory Rate 16
	Oxygen Given	No	SPO2 98
C	Pulse Rate	BP	Cap Refill
	99	152/66	<=2 Secs
	Rhythm	Arm	ECG Rhythm
	Reg	Left	Sinus Rhythm
		Central/Peripheral	ECG
		Peripheral	12 Lead
D	GCS	Eyes	Voice
	15	Spontaneously (4)	Orientated (5)
			Motor
			Obeys Commands (6)
			PEARL
			Yes

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
13:53	98	16	134/82	98		15									P122109S
13:42	99	16	152/66	98	<=2 Secs	15	Alert		36.6	6.8	Sinus Rhythm	3	3		P122109S

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
13:42	16 (0)	98 (0)		0	152 (0)	99 (1)	Alert (0)	36.6 (0)	1

HISTORY

AMPLE

Allergies	None
Last Eaten	>4 Hours Ago
Events Prior	PAINTING IN THE GARDEN

Social History

Lives alone	Don't Know	Patient Occupation	Retired
Patients General Appearance Normal			

Treat as Stroke

COPY

Management plan

- ① ECG ✓
- ② Bloods → Add cholesterol ✓
- ③ CT H → nil acute
→ Discussed with
Edinburgh → not for
thrombolysis
- ④ Aspirin and Clopidogrel (200mg)
Que in ED
→ Continue Aspirin & clopidogrel (75mg)
- ⑤ Carotid Doppler →
will be fit for surgery
- ⑥ Add Atorvastatin 80mg
- ⑦ Stroke vlv

Additional investigations required (e.g. cultures) Please initial and date when sent

Venous thromboembolism (VTE) risk assessment

Medical patient expected to be mobilising as normal within 2 days

Proceed to VTE risk actions

Medical patient with reduced mobility for ≥2 days OR Surgical patient

Assess thrombosis and bleeding risk factors

Thrombosis risk factors. ANY thrombosis risk factor(s) should prompt VTE prophylaxis measures unless contraindicated → Assess bleeding risk.

- | | |
|---|--|
| ☐ Mobility reduced for >2 days
☐ Age >60
☐ Dehydration
☐ Obesity BMI >30 kg/m ²
☐ Significant medical comorbidity (e.g. cardiac, respiratory, endocrine, inflammatory, infectious conditions)
☐ Active cancer or cancer treatment
☐ Thrombophilia
☐ Personal history or first degree relative with history of VTE
☐ Use of hormone replacement therapy or oestrogen containing contraceptive
☐ Pregnancy or <6/52 post-partum | ☐ Acute surgical admission with inflammatory or intra-abdominal condition
☐ Surgery with significant reduction in mobility
☐ Critical care admission
☐ Knee or hip replacement
☐ Hip fracture
☐ Total anaesthetic+ surgical time >90mins
☐ Pelvic or lower-limb surgery with anaesthetic+ surgical time >60mins
☐ Varicose veins with phlebitis |
|---|--|

Bleeding risk factors. Consider whether sufficient to preclude pharmacological prophylaxis

- | |
|--|
| ☐ Active bleeding
☐ Acquired bleeding disorder (e.g. acute liver failure)
☐ Current use of therapeutic anticoagulation (e.g. warfarin, rivaroxaban, dabigatran)
☐ Acute stroke
☐ Thrombocytopenia (<75x10 ⁹ /L)
☐ Uncontrolled hypertension (>230/120mmHg)
☐ Untreated inherited bleeding disorder
☐ Neurosurgery, spinal surgery or eye surgery
☐ Other procedure with high bleeding risk
☐ Lumbar puncture, epidural or spinal anaesthesia expected within the next 12 hours
☐ Lumbar puncture, epidural or spinal anaesthesia within the previous 4 hours |
|--|

VTE risk actions

Information provided
Provide if admission is anticipated
Yes/ No

LMWH
Yes/ No/
Contraindicated

Antiembolism stockings
Consider if thrombosis risk factors present and bleeding risk factors preclude LMWH
Contraindicated in peripheral neuropathy, PVD, ulceration, cellulitis, gross oedema
Yes/ No/ Contraindicated

Name

Signature

Date

Time complete

COPY

9/12/24. 1643 #821.

Skynny Car

(67) Graves Disease

(L) by sickness

Sudden onset 2 sided weakness.

Arm and leg.

Has been slowly improving.

(L) arm still weak but much improved.

(L) arm drift

Speech intact

Carotid runs (L)

ACROSS = ?

No visual field deficit

ECG

Sin rhythm

CXR/Imaging

NA. - @ basal right infect

CTA - No significant stenosis

Results

Consultant Ward Round

CHI NO: 0705570592 07/05/1957
 CRN: M
 David ADAMS
 6 SALMON COURT
 SCHOOL BRAE
 BO'NESS
 EH51 9HF

COPY

Diagnoses and significant comorbidities

Plan

② basal glycine
 instest

- ① Diet antipilekals for 21/17
- ② Atorvastatin 80g
- ③ PT/OT inst
- ④ Smily coach

Checklist

Estimated LoS. <24h 24-48h >48h

Medicine reconciliation

Transfer of Care to: B21

VTE assessment

Outstanding criteria for ward transfer/discharge (delete as appropriate):

S_pO₂ target prescribed

Fasting

Yes / No

Name

Signature

Date

Time

BEAVER

[Signature]

9/12/24

17:00

Resuscitation/ Escalation of care/ Anticipatory Care Planning / Advance Directives

Documentation of Discussion with Patient or Family

Treatment options that may help and patient would wish considered (and in what circumstances):-

Treatment options that may not help or patient would not wish:-

Discussed with patient/family: Y /N/Unable

Documentation (circle all that apply): DNACPR ReSPECT AWI

Name

Signature

Date

Time

Date and Time **Daily MDT and Nursing update**

Consent (care planning)	Yes	☐
Name band	Yes	☐
NOK details obtained	Yes	☐
Vital Signs	Yes	☐
Own medication	Yes	☐ No ☐
Dentures	Yes	☐ No ☐
Glasses	Yes	☐ No ☐
Hearing aids	Yes	☐ No ☐

COPY

09/12/24 0600 Patient admitted via Ed
23500 EUS 2

GCS 15/15
alert and orientated
independently mobile
patient eating and drinking independently
no new complaints

- J. Wang

09.12.24 Care taken over at 07.30

09.00 EUS AS Charted

Alert and Orientated

Food and Drink provided.

medication given AS per hepma

mobliser 100.

New concerns to Note

St/N N SAYLE

9/12/24

Gallagher STS Stalk

(67) TIA sx

LSW? loss of speech → lasted ~ 20 min
2x distinct episodes of facial paresthesia

smaller present

HA-59
Teg-35-1-2
BR-139/65
5/02-95
New-01
RA-19

Phth. (C) leg. scurfs; Grains during

LP @ Upt-0 220-5 chl-4-6
dlc-4-8 Lcc-11-9 H-6-11-9

Social ex. smoky, darts socially
ecgt

CTB-MAD

Also handled of metabolic 1/2 egg, 50mm LSW / 11mm
had be going fruit down

-Dumb episode yesterday in middle out, slurred speech, fadus LSW
No galpitation

Just speech improved - had cell carrying in dark speech effort by this
gt-wild LSW, slurred, 115 @ speed @ no good drop
DART → continue

→ MCI LSW

→ 1st yr. guess from should guess CTA
→ 48 leg in OP

Need PTA

During address given
Gallagher
#1082

Date and Time Daily MDT and Nursing update

COPY

09/12/24 Transferred to B21. NEWS stable. GCS 15/15

1830 Confirmed stroke. R) Basal Ganglia Involvement.

(I) mob and i ADL's.

Continent. Unsure when BOLAST.

Skin intact.

Signed smoking form against advice.

Careplan complete.

Telemetry ☒

—EM92ans/jk.

10/12/24 Settled night.

0430 Average sleep noted

(I) mobile. Continent.

pt's friend shared word ask for update - not listed NOK - handheld phone given for pt to update (I).

pt states wife not NOK! Separated 1 1/2 years ago asked for her to be removed from record. New NOK details added ~~friend~~ girlfriend Suzanne pt not able to tell me her surname. Daughter Kelly NOK also.

pt settled + slept well.

/ry NEASSON-SIN

Date and Time	Daily MDT and Nursing update	COPY
10/12/24 07 ¹⁵ ★	CTA - No sig ICA stenosis MU - R basal ganglia infarct Wheel	
10/12/24 10:05 ■	SALT: Seen for screen - reports speech can be variable in intelligibility. Fully intelligible in conversation. Briefly discussed strategies for dysarthria. No further input required. ANNA FAUHAET AFJ (SLT)	
11 ³⁰	<u>Stroke Nurse</u> introduced self/role. Happy for FLO call in 2/12. Smoke - declined smoke cessation. Bike - aware/agreed/signed to not to drive for 1/12. Stroke Pack Given ✓ McDonald	
11/12/24	MDT → Going home today	

Daily MDT and Nursing update

12

Please tick appropriate box

CLINICAL NOTES ☐

NURSING NOTES ☐

PROGRESS NOTES ☐

Consultant

Surname

Forename

CHI

Address



CHI NO: 0705570592

CRN:

David ADAMS

6 SALMON COURT

SCHOOL BRAE

BO'NESS

EH51 9HF

07/05/1957

M

COPY

Ward / Dept

Date and Time

Gillian McElloch MSc

10/12/24

16:13

67M A/w Sudden onset (L) weakness arm/leg.

MHA
Graves
Strabismus

MRI → (L) Basal ganglia infarct

CFA no stenosis

→ DAPT for 21 days

Reports slight weakness in (L).

Speaking fluently.

Driving advice given by Dr. Gallagher.

OP tape requested.

Telemetry - L → No A.F.

Will check if can come off Telemetry
if SU MFFA.

→ Can come off Telemetry

→ (FI)

A127L

Please tick appropriate box

CLINICAL NOTES

NURSING NOTES

PROGRESS NOTES

☐
☐
☐

Write - imprint or Attach Label

Surname..... Hospital No.....

Forenames..... Sex.....

CHI..... D. of B.....

Address.....

COPY

Consultant

Ward / Dept.....

Date and Time

12:00

PT settled morning, alert

10/12/24

IND with ABLS

IND with diet and fluids

IND with own pressure relief.

PT on and off ward throughout morning -
went to canteen.

chatty, very pleasant.

continent, IND.

dlc planned.

NOK aware of partner & daughter aware.

dlc letter ☐

hepma letter ☐

transport ☒ - partner coming 13:00

HIO'S ☐

daughter present in ward at time of
report. aware of dlc and PT aware
included in dlc planning.

SIN Amy Graham
AG.

Please tick appropriate box

CLINICAL NOTES

☐

NURSING NOTES

☐

PROGRESS NOTES

☒

Consultant

Sur



Fore

CHI NO: 0705570592

07/05/1957

CHI

David ADAMS
6 SALMON COURT
SCHOOL BRAE
BO'NESS
EH51 9HF

Add

COPY

ward / Dept.

Date and Time

Physio

11/12/24
8.45

Written in retrospect of 10/12/24 at
~8.45, seen & V. MacGowan PTA
on ward for initial Ax.

S) Consent ✓

Hx noted

Has lift in block of flats but x8
steps in partner's house x2 reils

O) Mobilising (I) on ward - safe +
steady

A + B Flight of stairs (I) c rail (R)
both directions, - nil concerns

Returned to ward

All 4 limbs moving functionally
Sensation grossly intact but sl
altered (L) UL

Rx: advised re sensory re-ed +
functional use (L) UL

A) At baseline, nil PT or OT needs

P) D/C PT

SARAH DUNCAN BSPT

CHI:0705570592
CRN:F140620 07/05/1957
ADAMS DAVID
10 DOUGLAS AVE,
GRANGEMOUTH
FK3 0LD

M

NHS
Forth Valley

OFACIAL SURGERY - CONFIDENTIAL MEDICAL HISTORY

COPY

Please answer all the questions completely and truthfully. If you are not sure of any of the questions, or wish to discuss something in more detail, please inform the surgeon.

Home phone no. 01324 874396 Mobile no. Occupation PAINTER & DECORATOR

SMOKING STATUS:

☐ I have never smoked
☒ A smoker If yes for how long? 25 YRS How many per day? 20
☐ An ex smoker If yes - when did you quit? How long did you smoke for?

ALCOHOL STATUS:

☐ No Do you consume alcohol?
☒ Yes If yes - how many units on average per week? 16 (1 pint = 2 units / 1 glass wine = 2 units)

	Yes	No	Details
Are you aware of anything that you are allergic to?	☐	☒	If yes:
Any heart problems/conditions? i.e. Heart attack/high blood pressure/angina/pacemaker or replacement valve	☐	☒	If yes:
Any chest or breathing problems/conditions? i.e. asthma/bronchitis/COPD	☐	☒	If yes:
Any stomach, gut, liver or kidney problems? i.e. coeliac disease/crohn's disease/hepatitis, jaundice	☐	☒	If yes:
Any blood or bleeding problems/conditions? i.e. haemophilia	☐	☒	If yes:
HIV, Hepatitis or any other blood borne virus?	☐	☒	
Epilepsy or prone to fits/faints?	☐	☒	
Diabetes?	☐	☒	
Problem/conditions relating to your bones/joints/muscles? i.e. arthritis	☐	☒	If yes:
Pregnant or a possibility that you could be pregnant?	☐	☒	
Ever hospitalised in the past?	☐	☒	If yes:
Do you carry a medical warning card?	☐	☒	
Any medical condition or problem not specified above?	☐	☒	If yes:
Are you currently under treatment from a Doctor, Consultant or clinic?	☐	☒	If yes:
Are you taking any medications (e.g. tablets, pills, patches, inhalers, ointments, injections, oral contraceptives, recreational drugs)	☐	☒	If yes:
Doctor's name and address	Dentist's name and address		
DR CRAWFORD	MRS MARTIN		
BONESS ROAD	THE PRACTICE		
GRANGEMOUTH	BONESS ROAD		
	GRANGEMOUTH		
I certify that all the information provided above is correct to the best of my knowledge.			
Signature of Patient, Parent, Carer			Date: 30/11/15

10570
COPY

DEMOGRAPHICS/PATIENT ID LABEL

Patient Name



Patient Address

CHI:0705570592
CRN:F140620 07/05/1957
ADAMS DAVID
10 DOUGLAS AVE,
GRANGEMOUTH
FK3 0LD

M

CHI No

Responsible Consultant

MR TUNSON

Consulting Clinician

Date of Consultation

30

New Patient ☐

Mode of referral

GP ☐
GDP ☒
A&E ☐
Other ☐
Other hospital ☐

COPY

CLINICAL DETAILS

Presenting complaint

On-going Oral Mucosal lesions
- Buccal Mucosa
- Palate

History of presenting complaint

Continues to smoke

Past Medical History

Current Medication

Allergies

Yes ☐No ☐

If yes state

SOCIAL HISTORY

Alcohol Yes ☒ No ☐ If yes-how many units 16

Smoking, Never smoked ☐
Current smoker ☒
Ex smoker ☐

How long 30 How many 10
How long 20 How many 20

COPY

Home circumstances _____ Occupation _____ Retired ☐

EXAMINATION

Extra Oral Examination done Yes ☒ No ☐ Not Relevant ☐

If yes - findings

NAD

Intra Oral Examination done

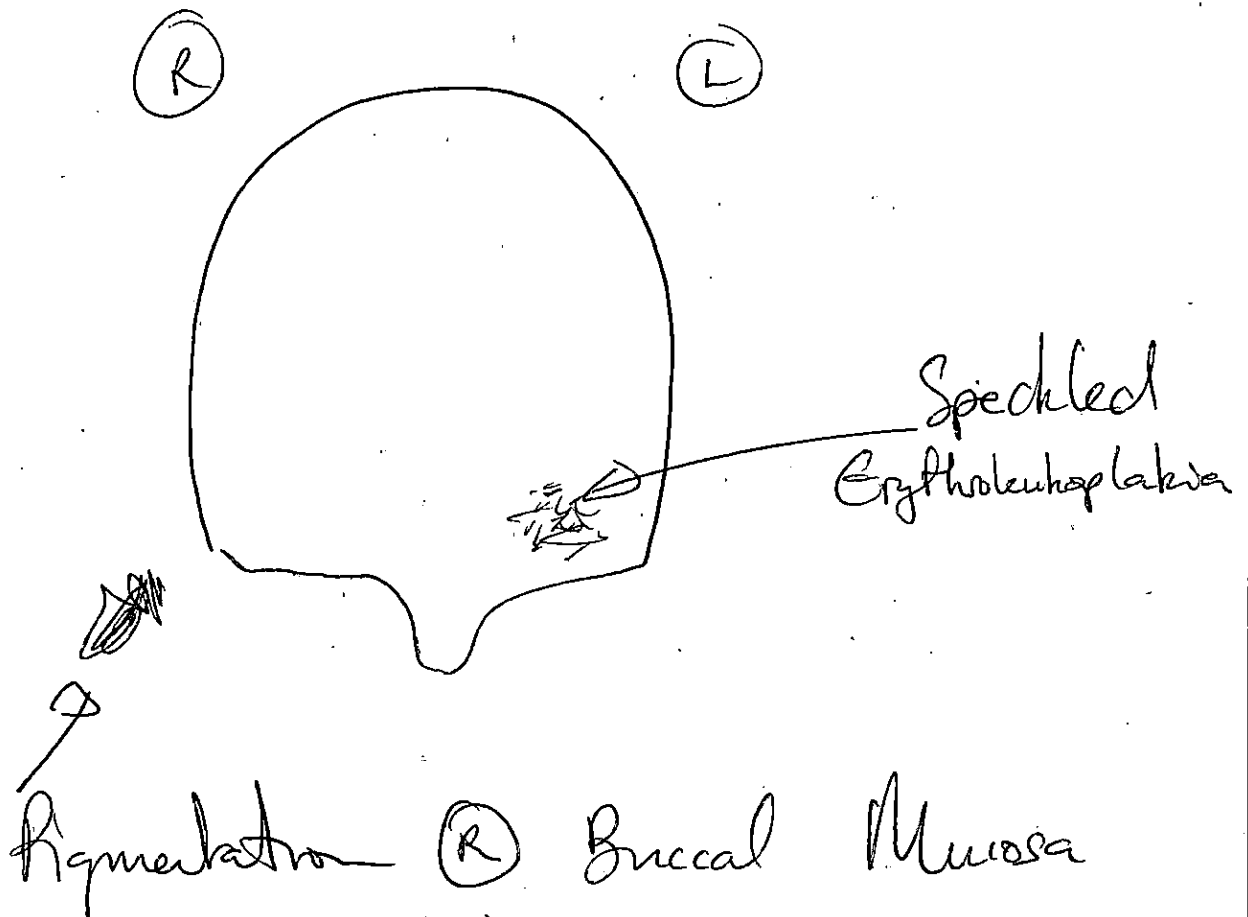
Yes [✓]

No []

Not Relevant []

If yes - findings

COPY



N.B. Multiple other lesions but these
are the most suspicious !!

INVESTIGATIONS

Requested

X Ray ☐

Biopsy ☐

Bloods ☐

Swab ☐

CT ☐

MRI ☐

U/S ☐

Other ☐

If other - Please state _____

Supporting Clinician Yes ☐

No ☐

If yes - given by _____

COPY

Differential Diagnosis

? Dysplasia (? See ~~not~~ not much likely).

Treatment Plan Yes ☒ No ☐

If Yes or No - State

L.A. Biopsy, with 6/52

N.B. Patient requests some "time" to prepare for L.A.

INFORMATION GIVEN

Information given to patient

Verbal ☐

Written ☐

Both ☐

Warnings

CLINIC OUTCOME

Outpatient Follow Up ☐

Discharged ☐

Referred elsewhere ☐

If yes state _____

For GA List ☐

For LA List ☒

Consent

Yes ☐

No ☐

Waiting List Card Done

Yes ☐

No ☐

Examining Doctor Signature

U. Dave

Date 30 / 11 / 15

Grade:

Consultant ☒

Ass Specialist ☐

SPR ☐

Staff Grade ☐

SHO ☐

GPT ☐

Other ☐

CLINICAL NOTES

Consultant

1

Write - imprint or Attach Label



Spital No.

CHI:0705570592

CRN:F140620 07/05/1957

ADAMS DAVID

10 DOUGLAS AVE,
GRANGEMOUTH
FK3 0LD

M
#B
COPY

Date

30/12/15

RFA: Bx ① soft palate erythrocytosis + Bx ②
BM pigmentation

It c/o - nil, anxious re procedure today

MM - no changes

Verbal consent gained for 2x Bx (1x ① BM
1x ② soft palate)

2x 2% fast histamine Spec (1:80000 adrenaline) as if/15
(Coop good)

1x 4mm punch Bx ② BM pigmented area → 2x 4/0 Vicryl sutures placed
1x 4mm punch Bx ① Soft palate erythrocytosis → 2x 4/0 " " "

HAPOLG written & verbally

Letter next visit with results

C/v 3/52 with results, reiterated smoking cessation

Mason
(AZ OMFS)

26/1/16

Path

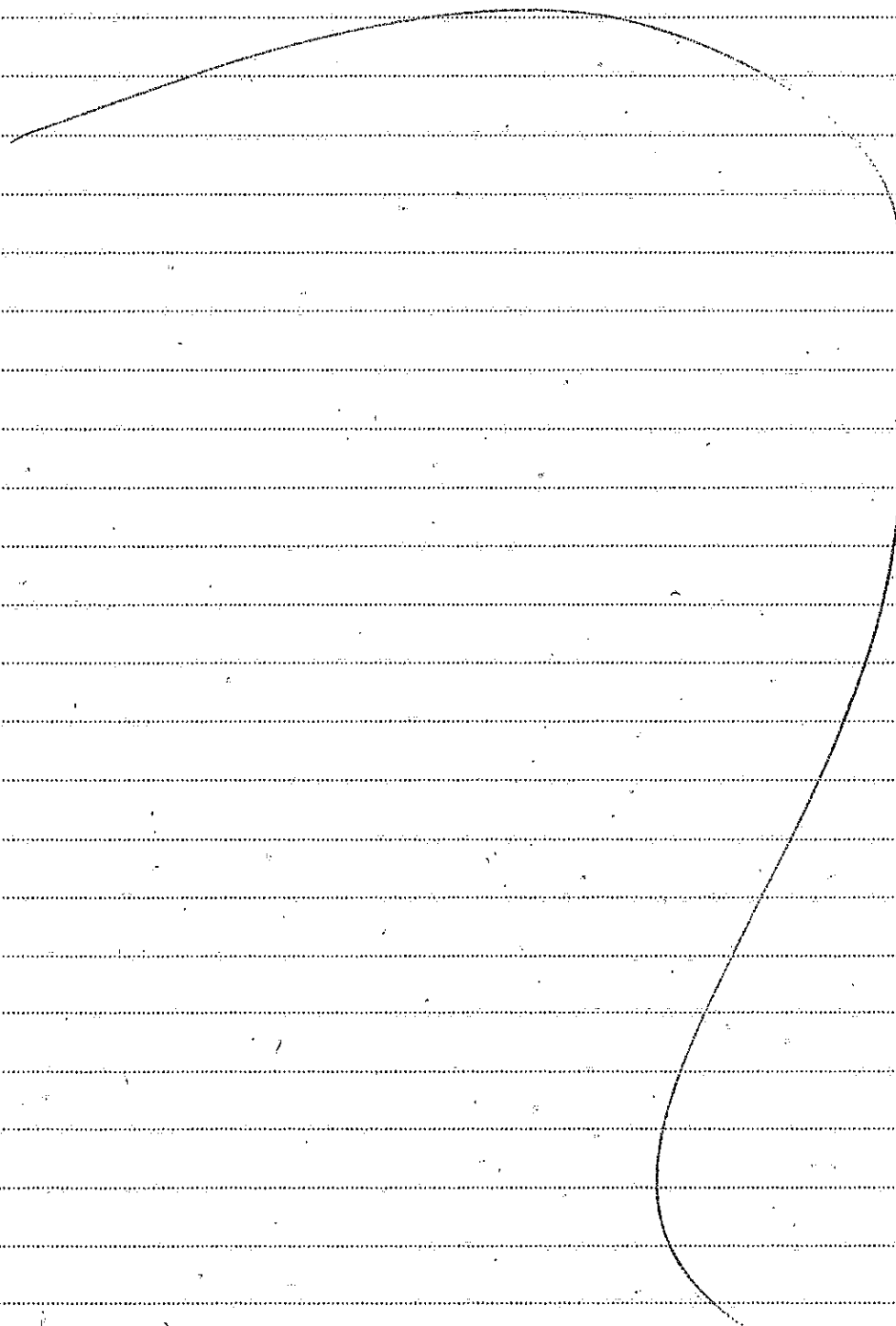
cheek - inflammation
palate - dysplasia

Reiterated need to stop smoking
ask of exhalation
laser

little inflammation
red/white
all 3/12 10mm

Date

COPY



CLINICAL NOTES

Write - imprint or Attach Label

CHI 0705570592

pital No.

CRN:F140620 07/05/1957

ADAMS DAVID
10 DOUGLAS AVE,
GRANGEMOUTH

COPY

FK3 OLD

Consultant

MR DAVIE

Date

27/04/16

LA ORAL
BIOPSY

UNC ST00908

STERILE

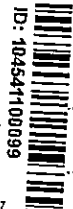


ID: 104540000246

4" BI POLAR
DISSECTOR 1 OF
2 MATCHING
KEY50217726

UNC KEY50882
408

STERILE



ID: 104541100099

23.0896

Date

COPY

CH 300

CH 300

ORAL & MAXILLO FACIAL SURGERY

CONFIDENTIAL



CHI: 0705570592
GRN: FZ 140620 07/05/1957
ADAMS DAVID M
10 DOUGLAS AVE
GRANGEMOUTH
FK3 0LD

CONDITIONS CAN AFFECT SURGICAL TREATMENT

COPY

TEL NO :- 01324 874396

OCCUPATION:- PAINTER

EXPECTANT MOTHER YES NO

	YES	NO	DETAILS
1. Do you feel generally healthy?	☒	☐	
2. Have you had rheumatic fever?	☐	☒	
3. Have you had Hepatitis or Jaundice?	☐	☒	
4. Do you have any heart complaints, such as heart attack, high blood pressure, angina, heart-murmur, or a placement heart valve?	☐	☒	
5. Do you suffer from bronchitis, asthma or other chest condition?	☐	☒	
6. Do you have Arthritis?	☐	☒	
7. (a) Are you receiving any tablets, creams, ointments from your doctor?	☐	☒	
(b) Are you taking or have you taken steroids in the last two years?	☐	☒	
8. Are you allergic to any medicines, foods or materials?	☐	☒	
9. Are you epileptic or prone to fainting attacks?	☐	☒	
10. Have you ever bled excessively following a cut or tooth extraction?	☐	☒	
11. Have you been hospitalised? If 'Yes', what for and when?	☐	☒	
12. Has the Blood Transfusion Unit ever refused your blood?	☐	☒	
13. Are you attending any other hospital clinics or specialists?	☐	☒	

Doctor's Name and Address

DR CRAWFORD
BONESS ROAD
GRANGEMOUTH
Tel:- 01324 482653

Dentist's Name and Address

MRS MARTIN
BONESS ROAD
GRANGEMOUTH
Tel:-

If you are not sure of any of the questions or if your medical circumstances change, please inform the Surgeon.

certify that the above information is correct.

DATE: 5/3/09 SIGNATURE: D. Adams

RELATIONSHIP TO PATIENT

RX 1166

COPY

CHI: 0705570592
GRN: FZ 140620 07/05/1957
ADAMS DAVID M
10 DOUGLAS AVE
GRANGEMOUTH
FK3 0LD

COPY

DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY

CONSENT TO CLINICAL PHOTOGRAPHY

We may like you to have some medical photographs taken and incorporated in your medical records to assist staff planning and assessment of your treatment. As part of your clinical records these photographs are bound by the same confidentiality requirements as the rest of your records.

THE REASON FOR ASKING YOU TO UNDERGO CLINICAL PHOTOGRAPHY SHOULD BE EXPLAINED TO YOU FULLY BY YOUR CONSULTANT.

The clinical photographs will be used for teaching doctors, nurses, health-related students and other professional NHS staff. Some may be used for publication of scientific articles.

Would you please sign below if you are agreeable to:-

- (a) use for teaching of doctors, nurses, health related students and other NHS staff.
- (b) publication in scientific articles.

Please score out and initial either (a) or (b) if you are not happy for photographs to be used in either of these manners.

SIGNED: *D. Adams*

FULL NAME: *DAVID ADAMS*

DATE: *5/3/09*

COPY

DEMOGRAPHICS/PATIENT ID LABEL

Patient Name

Patient Name _____



Patient Address

CHI: 0705570592
CRN: FZ 140620 07/05/1957
ADAMS DAVID M
10 DOUGLAS AVE.
GRANGEMOUTH
FK3 0LD

Consulting Clinician

Date of Consultation

New Patient ☐

CHI No

Mode of referral

GP

GDP

A&E

Other

Other hospital

COPY

CLINICAL DETAILS

Presenting complaint

enting complaint FA 4150
24/02/09 Reappt please. 
7-56

white patches

History of presenting complaint

At unaware about it, GDDP noticed white patches (L) BM + soft palate. Asymptomatic. No idea for how long he have it.

Past Medical History

Fit + well.

Current Medication

N.B.

Allergies

Yes

No

If yes state

SOCIAL HISTORY

Alcohol Yes ☒ No ☐

If yes-how many units 15 units / weekends

Smoking Never smoked ☐

Current smoker ☒

How long 10 y/s

How many 10 C/PD

Ex smoker ☐

How long _____

How many _____

Home circumstances married live w/ wife

Occupation Decorator

Retired ☐

COPY

EXAMINATION

Extra Oral Examination done

Yes ☒

No ☐

Not Relevant ☐

If yes - findings

Nile

COPY

✓ White patches on LHS
soft palate + buccal mucosa at
the retromolar region.

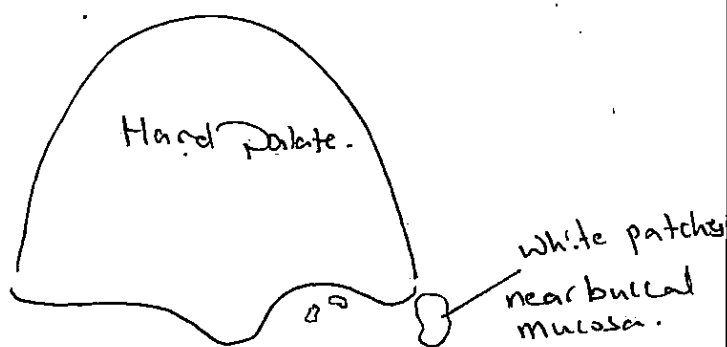
✓ Asymptomatic.

- pt have heavily restored teeth
= Amalgam + metal.

✓ Tongue dorsal surface cover
by tobacco.

✓ FOM Fine.

✓ OH modurated.



INVESTIGATIONS

Requested X Ray ☐ Biopsy ☐ Bloods ☐ Swab ☐ CT ☐ MRI ☐ U/S ☐Other ☐ If other - Please state _____Supporting Clinician Yes ☐ No ☐ If yes - given by _____**COPY**

Differential Diagnosis

? Lichenoid reaction, LP

? SCC

Treatment Plan Yes [] No []

If Yes or No - State

1) Advice to stop smoking.

2) OMI given.

3) Punch Bx (L) soft palate / buccal mucosa
↓ LA

INFORMATION GIVEN

Information given to patient Verbal [] Written [] Both []

Warnings

CLINIC OUTCOME

Outpatient Follow Up ☐ Discharged ☐ Referred elsewhere ☐ If yes state _____For GA List ☐ For LA List ☒Consent Yes ☐ No ☐Waiting List Card Done Yes ☐ No ☐

Examining Doctor Signature _____

Date 05/03/09

Grade: Consultant ☐ Ass Specialist ☐ SPR ☐ Staff Grade ☒ SHO ☐ GPT ☐ Other ☐

CLINICAL NOTES

S
F
A

CHI: 0705570592
CRN: FZ 140620 07/05/1957
ADAMS DAVID M
10 DOUGLAS AVE
GRANGEMOUTH
FK3 OLD

abel
tal No.

COPY
Ward / Dept.

Consultant

Date

13/05/09 ~~Attended for punch Bx~~
~~No change mH~~
~~No change med~~ error
~~NISA~~

13-5-9 pt FTA for punch bx.
Resppoint

QWF
microscopic
(cno)

12/01/10 FTA discharged.

7 shampoon
8th grade

Date

COPY

F140620

Hospital use only	Clinic	Day	Time	Hospital No.
	J m m	Tues	3-20	COPY
		Date	5/1/10	

REFERRAL LETTER

MEDICAL IN CONFIDENCE

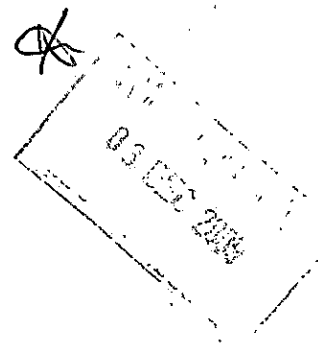
REFERRAL TO	
Oral Surgery FDRI D3VA FV Oral Surgery Department	— Consultant / receiving practitioner and/or specialty clinic
FV Dental NHS Forth Valley	— Hospital and hospital address
	Hospital unit no. V006G
	Email address
Urgency of referral	Routine

PATIENT DETAILS		Patient's address
Surname	Adams	10 Douglas Avenue
Forename(s)	David	Grangemouth
Title	-	FK3 0LD
Sex	Male	
Date of birth	07-May-1957	Contact number(s)
CHI no.	-	Voice: 01324 874396

REFERRING HCP DETAILS		Organisation address
Name	Jean Martin	The Practice
Practice Name	-	72 Bo'ness Road
Phone Number	-	Grangemouth
		FK3 9BL, Tel 01324 482292

next 4/12

7/12



CLINICAL INFORMATION**History of presenting complaint / examination findings / investigation results****Presenting complaint**

Description: Other oral mucosal lesions

Examinations and Investigations

If other oral mucosal lesions:

Other mucosal abnormality

Additional free-text Information:

Mr Adam was seen in FDRI oral surgery department in March 2009 regarding a red and white areas upper left soft palate and buccal mucosa in the retromolar area. He was due to have a biopsy done but this has never been carried out. He says he was never given an appointment but he is terrified of needles and I suspect this is why he has never had this done. He attended as an emergency patient for an extraction as he had not completed other treatment. The areas seemed unchanged from a year ago. He is still smoking. I would be grateful if you could organise another appointment for a biopsy.

Interpreter Required?: No

Relevant Medical

History or Medication: smoker

Has the patient

previously attended

the department to

which they are being

referred?:

Yes

Has the patient

previously attended a

Forth Valley hospital

(Falkirk or Stirling)?:

Yes

COPY

Signature of referring dentist (or other professional) Date

ORAL & MAXILLO FACIAL SURGERY

CONFIDENTIAL

CERTAIN MEDICAL CONDITIONS CAN AFFECT SURGICAL TREATMENT

COPY



CHI:0705570592
CRN:F140620 07/05/1957
ADAMS DAVID
10 DOUGLAS AVE,
GRANGEMOUTH

TEL NO: * 01324 874396

OCCUPATION: PAINTER

EXPECTANT MOTHER YES

NO

FK3 OLD

1. Do you feel generally healthy?
2. Have you had rheumatic fever?
3. Have you had Hepatitis or Jaundice?
4. Do you have any heart complaints, such as heart attack, high blood pressure, angina, heart-murmur, or a placement heart valve?
5. Do you suffer from bronchitis, asthma or other chest condition?
6. Do you have Arthritis?
7. (a) Are you receiving any tablets, creams, ointments from your doctor?
(b) Are you taking or have you taken steroids in the last two years?
8. Are you allergic to any medicines, foods or materials?
9. Are you epileptic or prone to fainting attacks?
10. Have you ever bled excessively following a cut or tooth extraction?
11. Have you been hospitalised? If 'Yes', what for and when?
12. Has the Blood Transfusion Unit ever refused your blood?
13. Are you attending any other hospital clinics or specialists?

YES NO

DETAILS

☒ ☐

☐ ☒

☐ ☒

☐ ☒

☐ ☒

☐ ☒

☐ ☒

☐ ☒

☐ ☒

☐ ☒

☐ ☒

☐ ☐

☐ ☒

☐ ☒

Doctor's Name and Address

DR CRAWFORD

BONESS ROAD

GRANGEMOUTH

Dentist's Name and Address

THE PRACTICE

BONESS ROAD MRS MARTIN

GRANGEMOUTH

Tel: 01324 482653

Tel:

If you are not sure of any of the questions or if your medical circumstances change, please inform the Surgeon.

certify that the above information is correct.

DATE: 23/10/12

SIGNATURE

D Adams

RELATIONSHIP TO PATIENT

RX 1166

COPY

DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY

CONSENT TO CLINICAL PHOTOGRAPHY

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Would you please sign below if you are agreeable to:-

- (a) use for teaching of doctors, nurses, health related students and other NHS staff.
- (b) publication in scientific articles.

Please score out and initial either (a) or (b) if you are not happy for photographs to be used in either of these manners.

SIGNED:

FULL NAME:

DATE:

23 / 10 / 12

INVESTIGATIONS

Requested X Ray ☐ Biopsy ☒ Bloods ☐ Swab ☐ CT ☐ MRI ☐ U/S ☐
 Other ☐ If other - Please state _____
 Supporting Clinician Yes ☒ No ☐ If yes - given by Y. Sharma

COPY

Differential Diagnosis

Lichenoid Reaction?
 Keatosis?
 SCC?

Treatment Plan Yes ☒ No ☐

If Yes or No - State

Incisional biopsy (R) Soft palate.
 (L) buccal mucosa.
 - Photos. at biopsy.
 - Pt. to consider smoking cessation.

INFORMATION GIVEN

Information given to patient Verbal ☒ Written ☐ Both ☐

Warnings

biopsy.

CLINIC OUTCOME

Outpatient Follow Up ☐ Discharged ☐ Referred elsewhere ☐ If yes state _____

For GA List ☐ For LA List ☒

Consent Yes ☐ No ☐

Waiting List Card Done Yes ☒ No ☐

Examining Doctor Signature E. Moh Date 23/10/12

Grade: Consultant ☐ Ass Specialist ☐ SPR ☐ Staff Grade ☐ SHO ☐ GPT ☒ Other ☐

COPY

- white patches L + R buccal mucosa adjacent to lower posterior teeth.
 - more pronounced (L)
- Asymptomatic.
- heavily restored dentition.
- white + red speckled patches bilaterally on Soft palate 0.5-1 cm.
 - more pronounced (R)

SOCIAL HISTORY

Alcohol

Yes ☒

No ☐

If yes-how many units

30-35 units / week

Smoking

Never smoked ☐

Current smoker ☒

Ex smoker ☐

How long

30 yrs

How many

10

How long

How many

COPY

Home circumstances

Married + living w/ wife.

Occupation

Decorator

Retired ☐

EXAMINATION

Extra Oral Examination done

Yes ☒

No ☐

Not Relevant ☐

If yes - findings

TMJ - NAD

Lymph - NAD

Asym - NAD

MAXILLOFACIAL - OUT PATIENT CLINIC

DEMOGRAPHICS/PATIENT ID LABEL

Patient Name	_____	Responsible Consultant	<u>J. [unclear]</u>
Patient Address	 CHI: 0705570592 CRN: F140620 07/05/1957 ADAMS DAVID 10 DOUGLAS AVE, GRANGEMOUTH	Consulting Clinician	_____
CHI No	FK3 OLD	Date of Consultation	<u>23</u> / <u>10</u> / <u>12</u>
		New Patient	☐
		Mode of referral	GP ☐ GDP ☒ A&E ☐ Other ☐ Other hospital ☐

COPY

CLINICAL DETAILS

Presenting complaint

I identified by dentist.
no prob for patient, no pain, dis comfort

History of presenting complaint

at least 3 yrs.

Past Medical History

F+W

Current Medication

Allergies

Yes ☐

No ☒

If yes state _____

CLINICAL NOTES

W CH10705570592
 Surname CRN: F140620 07/05/1957
 Forenames ADAMS DAVID M
 Address 10 DOUGLAS AVE, GRANGEMOUTH
 FK3 0LD
COPY
 Ward / Dept.

Consultant

Date

26/10/12 Corsydol mouthwash BN 6322LE0304
 Exp 07/2014

LA ORAL BIOPSY

ID 1010718
 LOT 00322
 User Code
 2486003

C/o - N.I.C. pt v. anxious.
 PMH - no change
 2.2 ml lignospan given 2% lidocaine
 1 in 80,000 adrenaline as inf.

BI POLAR LEAD &
 FORCEP, MEDIPLAST
 130
 ID 1024807
 LOT 00080
 User Code
 3588006

① buccal mucosa punch biopsy taken
 Sutured with 3.0 vicryl.

STERILE

② Soft palate biopsy taken, haem achieved
 with diathermy.

haem achieved
 POIG v.w.

Review 3/52

E. Macle
 MACLE (L.D.F.T.)

13.11.12 Results filed

RFA: pathology results.

Pt c/o nil since last visit.

Histology report: Part ① - Buccal mucosa keratosis.

Part ② Soft palate ulcerated reaction.

Pt informed of results.

of lesions well healed, small area of ulceration ② soft
 palate.

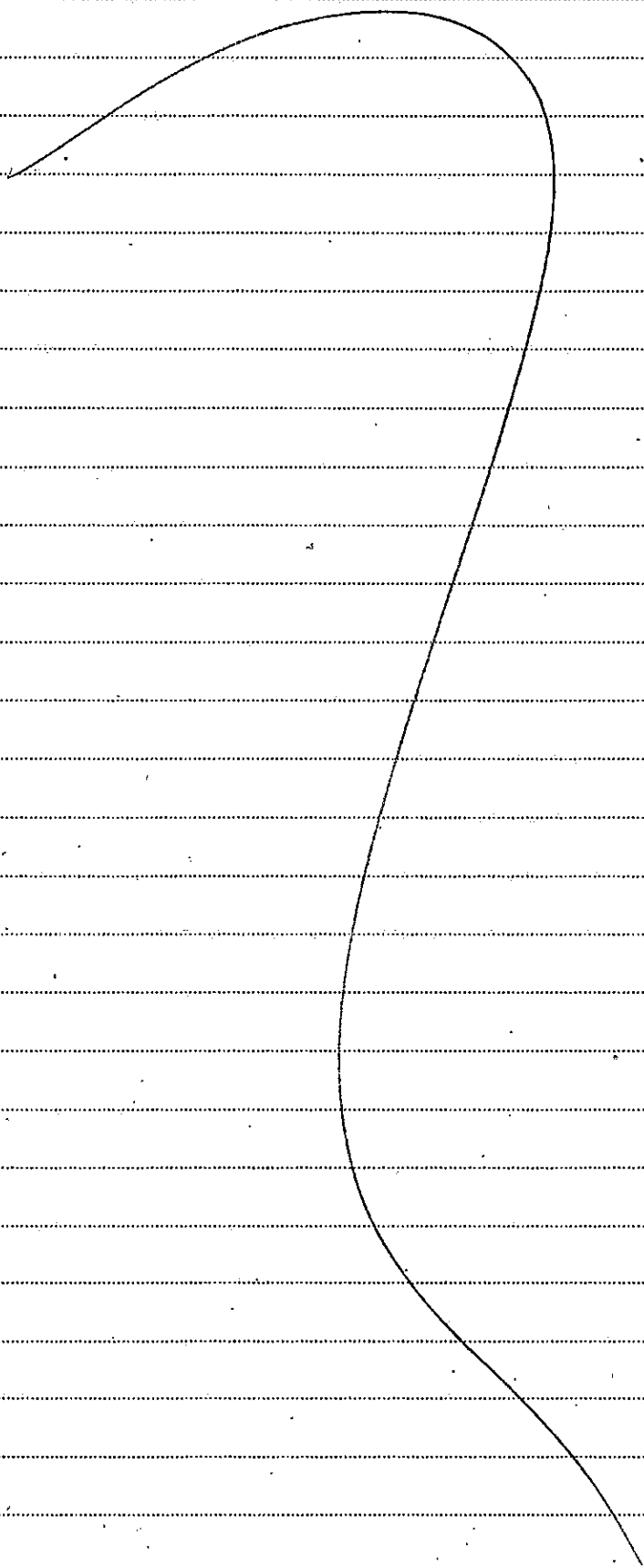
Pt happy to be discharged - GDP to regularly review.

STM 069

Letting (Duenina Lof) RX78

Date

COPY



CLINICAL NOTES

Surname

Forename



CRN: F140620 07/05/1957

Address

ADAMS DAVID
10 Douglas Avenue
GRANGEMOUTH
Stirlingshire
FK3 0LD

M

COPY

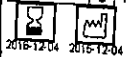
Consultant

Date 30/12/15

A ORAL
BIOPSY

HC 2486006

STERILE



26/01/16 Pathology report filed in notes, A/N T. Lyon

Attended in wife

Still sinking 20 roll up

Gut = 25 up w

6/6

Erythro leukoplakia Bilateral border hard with
palateRaised white patchy lesion (L) posterior buccal
mucosa
neck

Plan: - bx from 3 sites as above

- Sinking cessation Programme excellent

- R/L results

S. Douglas

CLINICAL NOTES

Surname
Forenames
Address
.....
.....



CHI 0705570592
CRN: F140620 07/05/1957
ADAMS DAVID
10 Douglas Avenue
GRANGEMOUTH,
Stirlingshire
FK3 0LD

M

COPY
Ward / Dept.

Consultant MR THOMSON

Date

17/05/16 Histology report filed in notes. 7 Lyon

17/05/16 Histology report discussion. *Low grade dysplasia*

Abir Khan
Norges Cl. D/w patient and partner report results. Worried of risk of smoking and potential for further neoplastic change. Patient is happy to be placed on smoking cessation referrals. To be reviewed 3/12.

Date

COPY

VIRTUAL FRACTURE CLINIC
TRIAGE FORM

NHS

Forth Valley

COPY

David
Adams
0705570592

F140620

DATE 5.3.2017

7/3/17

DIAGNOSIS:

Left Shoulder injury - grade 1
AC joint sprain. No fracture

TREATMENT:

Slings while sore

OUTCOME:

VIRTUAL DISCHARGE



CONSULTANT CLINIC



NURSE LED CLINIC



APPOINTMENT TIMESCALE

DAYS

WEEKS

CONSULTANT SIGNATURE.....

ju

EDMS

APPOINTMENT DATE AND TIME DISCHARGED

PATIENT CONTACTED

YES



NO



MESSAGE LEFT

YES



NO



APPOINTMENT CONFIRMED BY LETTER



DISCHARGE LETTER/LEAFLET SENT



AC JOINT INJURY
LETTER

NURSE'S SIGNATURE.....

W. S. N.
L. FAICHNIE

TRIAGE FORM

LIST OF VIRTUAL DISCHARGE LETTERS FOR SENDING TO PATIENTS.

COPY

PLEASE TICK LETTER TO BE SENT.

Soft Tissue Injury Hand		Child STI Hand	
Hand Fracture		Child Hand Fracture	
Soft Tissue Elbow		Child Elbow	
Ankle Fracture		Child STI	
Ankle X-Ray		Child Thumb	
Soft Tissue Injury		Child Toe	
Thumb Injury		Child Foot	
Scaphoid Injury		Child STI Forearm/Wrist	
Toe Injury		Child Humeral Fracture	
Heel Injury		Child Wrist Fracture	
Foot Injury			
Wrist Injury			
Wrist Fracture			
Humeral Fracture			
Clavicle Fracture			
Displaced Clavicle Fracture	✓		
AC Joint Injury	✓		

Emergency Department
Forth Valley Royal Hospital

0705570592

0705570592

A&E No. 16000040714

COPY

Surname	ADAMS	Forename	DAVID	Title:	MR
Address:	10 DOUGLAS AVENUE, GRANGEMOUTH, STIRLINGSHIRE	Postcode	FK3 0LD	CHI No:	0705570592
Date of Birth:	07.05.57	Telephone:	01324 874396	Sex:	M
				Age:	59 yrs

CHI Barcode:

0705570592

GP Name:	CRAWFORD GREGOR	Postcode	FK3 8AN
Address:	33 BONESS ROAD GRANGEMOUTH	Telephone:	01324 482653

virtual

clinic

Next of Kin	JANICE	Postcode	FK3 0LD
Relationship:	WIFE	Telephone:	01324 874396
Address:	10 DOUGLAS AVENUE, GRANGEMOUTH, STIRLINGSHIRE		

Manual CHI Entry:

Date of Attendance: 05.03.17 16:25

Date of Incident:

Presenting Complaint: L SHOULDER INJ

Age	Tetanus Cover:
	Allergies:
P=	BP= /
RR=	Sat=
BM=	
PF=	GCS=E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

V#C Tuesday 7/3/2017
09.40hrs

COPY

Clinical Notes

Seen by:

Time:

COPY

CHI: 0705570592 07/05/1957 M
ADAMS
DAVID
10 DOUGLAS AVENUE,
STIFLINGSHIRE
FK3 9LD



Attach here onto face of pocket

Attach continuation sheets here

Patient called to assess injury, do shoulder, however complaining of general chest pain and SOB. Requires review by medical staff

mem
EAR

Monteith GPST 5/3/17 17:55

PC: (L) shoulder pain

HPC

Altercation with son and his friend yesterday.

He was pushed and slipped onto wet decking

Was drunk last night and didn't notice pain.

Today pain has ↑ throughout the day. Clo pain over AC-head at shoulder.

No numbness or tingling in hand

Pain only in upper chest when moves shoulder.

Tender over AC joint. Hand neurovascularly intact.

PMHx Prev alcohol dependence

DHx Ibuprofen
omeprazole

O/E GCS 15/15

NEWS=0

Painful

ECG: SR nil acute

limited ROM due to pain

Swelling

Says no chest pain or SOB now - only earlier when moved shoulder

XR: likely AC joint injury

Monteith
GPST

Plan Polysling. TTD of co-Codamol 30/500

Guidelines Used:

(Already takes regular Ibuprofen)

Ref virtual # Clinic

COPY

CLINICAL NOTES

Write - Imprint or Attach Label	
Surname:	Hospital no.:
Forenames:	Sex:

DAVID ADAMS of B.

Address: 0705570896

Consultant:

Ward/Dept:

COPY

Orthopaedic Fracture Clinic Record

PLEASE PRINT CLEARLY. ALSO SIGN + PRINT NAME AT ALL ENTRIES

[illegible]

INITIAL NOTES

Write - Imprint or Attach Label

Suriname:

Hospital no:

Forenames:

Sex:

D ỏ ỏ B:

Address:

Ward/Dept:

COPY

sulfant:

Orthopaedic Fracture Clinic Record

PLEASE PRINT CLEARLY. ALSO SIGN & PRINT NAME AT ALL ENTRIES

[illegible]

CLINICAL NOTES

07/05/1957
DAVID ADAMS
28 URE COURT
GRANGEMOUTH

Hospital No.

F14062

COPY

M/NK
9DS

Consultant

Date

20
11
03

Bayer
Diagnostics

MULTISTIX* SG REPORT

Name David Adams Date 20/11/03Ward UOPD Patient No. F140620

TESTS Please tick appropriate box for each test

UROBILINOGEN 60 seconds	3 ☐	Normal 16 ☐	mmol/l 33 ☐	84 ☐	131 ☐		
PROTEIN 60 seconds	NEG. ☐	g/L TRACE ☐	0.30 + ☐	1 ++ ☐	3 +++ ☐	≥ 20 ++++ ☐	
pH 60 seconds	5.0 ☐	6.0 ☐	6.5 ☐	7.0 ☐	7.5 ☐	8.0 ☐	8.5 ☐
BLOOD 60 seconds	NEG. ☐	NON HAEMOLYZED TRACE ☐	HAEMOLYZED TRACE ☐	SMALL + ☐	MODERATE ++ ☐	LARGE +++ ☐	
SPECIFIC GRAVITY 45 seconds	1.000 ☐	1.005 ☐	1.010 ☐	1.015 ☐	1.020 ☐	1.025 ☐	1.030 ☐
KETONE 40 seconds	NEG. ☐	mmol/L TRACE 0.5 ☐	SMALL 1.5 ☐	MODERATE 4 ☐	8 ☐	LARGE 16 ☐	
BILIRUBIN 30 seconds	NEG. ☐	SMALL + ☐	MODERATE ++ ☐	LARGE +++ ☐			
GLUCOSE 30 seconds	NEG. ☐	mmol/L TRACE 5.5 ☐	14 + ☐	28 ++ ☐	55 +++ ☐	≥ 111 ++++ ☐	

*Trademark of Bayer Corporation, USA.

X804003 mpl

Pain @ testicle X 2 yrs

coms & gas

17/9/03 m.t. left test

18/2/05 Dna letter to GP

Date



CHI: 0705570592
 CRN: FZ 140620
 ADAMS DAVID
 10 DOUGLAS AVE
 GRANGEMOUTH
 FK3 0LD

COPY

16-10-06

Bayer
 Diagnostics

MULTISTIX* 8 SG REPORT

Name DAVID ADAMS Date 16-10-06
 Ward 60 PD Patient No. _____

TESTS

Please tick appropriate box for each test

LEUCOCYTES 1-2 minutes	NEG. ☒	TRACE ☐	SMALL + ☐	MODERATE ++ ☐	LARGE +++ ☐		
NITRITE 60 seconds	NEG. ☒	POSITIVE (any degree of pink colour) ☐ ☐					
PROTEIN 60 seconds	NEG. ☒	TRACE ☐	0.30 + ☐	1 ++ ☐	3 +++ ☐	≥ 20 ++++ ☐	
pH 60 seconds	5.0 ☒	6.0 ☐	6.5 ☐	7.0 ☐	7.5 ☐	8.0 ☐	8.5 ☐
BLOOD 60 seconds	NEG. ☒	NON HAEMOLYZED TRACE ☐	HAEMOLYZED TRACE ☐	SMALL + ☐	MODERATE ++ ☐	LARGE +++ ☐	
SPECIFIC GRAVITY 45 seconds	1.000 ☐	1.005 ☐	1.010 ☒	1.015 ☐	1.020 ☐	1.025 ☐	1.030 ☐
KETONE 40 seconds	NEG. ☒	mmol/L TRACE 0.5 ☐	SMALL 1.5 ☐	MODERATE 4 ☐	LARGE 8 ☐	16 ☐	
GLUCOSE 30 seconds	NEG. ☒	mmol/L TRACE 5.5 ☐	14 + ☐	28 ++ ☐	55 +++ ☐	≥ 111 ++++ ☐	

*Trademark of Bayer Corporation., USA.

X600270 mpl

CLINICAL NOTES

Write - imprint or Attach Label

S
F



tal No.

CHI: 0705570592

CRN: FZ 140620 07/05/1957

B.

ADAMS DAVID
10 DOUGLAS AVE
GRANGEMOUTH
FK3 0LD

COPY

Consultant

M^r M.O. SMITH

Date

16/10/06

Years of a lump on the right testicle.
He feels it has been there the whole time but
getting larger & smaller.
Can be painful.
Numb at times.

Feb - marathon runner - heart 2 yrs ago.
No Rx
No Allergies.

OK. Normal left testicle
Proximal right upper pole epididymis
2 intermittent hydroceles.

WL Exam right hydroceles seen
right epididymal cyst

"Remedial" mass above pubis area - penile deviation

Testes in girlfriend.

[Signature]

COPY

2

FALKIRK & DISTRICT ROYAL INFIRMARY
CONSENT TO ANAESTHESIA, OPERATION,
INVESTIGATION OR TREATMENT

COPY

CHI: 0705570592
SRN: FZ 140620 07/05/1957
(ADAMS DAVID M
10 DOUGLAS AVE
BRANGEMOUTH
URFK3 OLD

Proposed
Procedure:

EXCISION RIGHT ORAL
POLY CYSTIC DYSPLASIA
AND RIGHT HYDROCELE
SAC

TO BE COMPLETED BY MEDICAL OR DENTAL PRACTITIONER

I HAVE FULLY EXPLAINED:

To the patient/parent/guardian/next of kin*

(*Delete as appropriate)

1. The procedure named on this form
2. Appropriate alternatives which are available
3. Relevant risks associated with the procedure

Name
(Block Capitals)

M^r M. F. SMITH

SIGNATURE

Michael Smith

Date

16/10/06

TO BE COMPLETED BY THE PATIENT

You should read this form carefully. If there is anything you do not understand ask the doctor or dentist for an explanation.
If the information is correct and you understand the procedure, you should sign the form.

I AM

The patient/parent/guardian/next of kin (delete as appropriate)

I UNDERSTAND

The procedure which has been explained to me by the doctor
or dentist named on this form.

That the procedure may or may not be carried out by the doctor/
dentist who has been treating me so far.

That any procedure in addition to that named on this form
will only be carried out if it is necessary and in my best
interests and can be justified for medical reasons.

That examination for the purposes of teaching may be
undertaken during the procedure.

I AGREE

To the administration of an anaesthetic or to sedation if
required.

To the procedure named on this form.

SIGNATURE

David Adams

Patient/Parent/Guardian/

Next of Kin

(*Delete as appropriate)

NAME

(Block Capitals)

DAVID ADAMS

Date

16/10/06

COPY

Falkirk and District Royal Infirmary**Patient Details****COPY**

Hospital Number **F140620**
 Patient Name **ADAMS DAVID**
 Date of Birth **07/05/1957**
 Sex **M**
 Category Type
 Patient Type **Day Case**
 Operation Type **Scheduled**
 Date of Operation **15/01/2007**
 Theatre **Ur/Gen/Or 3**
 Confirmed By **SSETH**

Staff In Attendance - Team 1

Anaesthetist	DR LINZI MILLAR	
Floor nurse 1	SR LESLEY MEECHAN	
Floor nurse 2	S/N TRACY MIDDLETON	
O.D.P.	SN KATHRYN CARRUTHERS	
Other	NA S CUNNINGHAM	
Scrub nurse	SN SUSANNA KUHN	
Supervising Anaesthetist	DR ANDREW WOODS	Other
Supervising Surgeon	MR MICHAEL SMITH	In Theatre
Surgeon	MR SUBODH SETH	

Materials Used

<u>Item Code</u>	<u>Item Description</u>	<u>Qty</u>	<u>LOT1</u>	<u>LOT2</u>	<u>LOT3</u>	<u>LOT4</u>
1023779	MCDONALD DISSECTOR & TAG	1	1023779			
	MEDIPLAST 50 & 75					
1032886	SMALL BASIC	1	1032886			
1036937	NIFA0322 LARYNGEAL MASK SIZE 4	1	1036937			

Operation Notes

Side: **Op Notes**

Procedures

N153B00R **EXCISION OF EPIDIDYMAL CYST - RIGHT - N153B**
INCISION TRANSVERSE SCROTAL

TUNICA VAGINALIS OPENED AND TESTIS DELIVERED, 10MLS OF STRAW COLOURED FLUID, 8 MM MUTILOCULATED CYST IN THE HEAD OF EPIDIDYMIS.

CYST ENUCLEATED. HAEMOSTASIS WITH DIATHERMY.

TUNICA EVERTED WITH 3/0 VICRYL.

TESTIS REPLACED IN THE SCROTUM AND DARTOS CLOSED WITH 3/0 VICRYL CONTINUOUS. SKIN WITH RAPIDE 4/0CONT. MATTRESS.

17 MLS OF 0.5% CHIROCAINE TO SPERMATIC CORD AND SKIN.

SCROTAL SUPPORT APPLIED.

POST OP

ANALGESIA

NO FOLLOW UP

Alternate Codes **N153**

COPY

FALKIRK & DISTRICT ROYAL INFIRMARY - THEATRE CARE PLAN



CHI: 0705570592
CRN: FZ 140620 07/05/1957
ADAMS DAVID M
10 DOUGLAS AVE
GRANGEMOUTH
FK3 0LD

AC NO.

PROCEDURE:

Excision of right
epididymal cyst
+ excision of right
hydrocoele

CONSULTANT

Mr M.F. Smith

TH. No.:

COPY

ELECT/EMER

SURGEON: Mr Seth

DATE:

15.1.07.

NURSE IN CHARGE

SK MEECHAN

Procedure Start: 09-53

Exit Theatre Time: 10-15

Blood Loss: —

Urine Output: —

Position: Supine

Positioned By: Theatre 3 Staff

ANAESTHETICS TICK

GA	☒
Spinal	☐
Epidural	☐
Sedation	☐
Block	☐
L.A.	☒
Amount	17mls

Time: Chirocaine 0.5% 17mls

LOTIONS TICK BOX

Chlorhexidine	Pink	☐	Red	☐	Clear 1 : 2000	☒	1 : 5000	☐
Betadine	Alcoholic	☐	Antiseptic	☒	Aqueous Iodine	☐		
Tisept	☐	Unisept	☐	Saline	☐			
Other : Please state								

Diathermy Pad	☒	Position: Right thigh	Site Check	☒	Comments: OK
Flowtron Boots	☐	Spenko Mattress	Bair Hugger	☐	Fluid Warmer
Tourniquet	☐	Applied by (initial)	Time		Comments:

Type	Size	Position	No.
Drain(s)			
Ureteric Stents			
Catheter		Balloon Amt.	
Catheterised by	Name		
Naso Gastric	Yes/No		

Specimens : Yes/No
Number:
Results sent to:

Sutures : Tick Box

Ethilon	☐	Silk	☐	Staples	☐
Prolene	☐	PDS	☐	Monocryl	☐
Vicryl	☐	Vicryl Rapide	☒		

Dressings : Tick Box

Mepore	☐	Airstrip	☐
Steristrips	☐	Opsite Dressing/Spray	☐
Blue Gauze	☒	Mefix	☐
Pop	☐	Back Slab	☐
Bradford Sling	☐	Tubgauze	☐
Wool or Crepe	☐	Kling	☐
Pad or Pants	☒	Other: Scrotal Support	☐

Follow Up Instructions

Sutures Out-	☐	Seen before Home	☐
Dressing Change-	☐	Return to Clinic	☐

Nursing Comments:

Tracking Info:

SMALL BASIL

ID 1032886

LOT 00062

User Code

ST00186

STERILE

MC DONALD

DISSECTOR & TAG,

MEDIPLAST 50 & 75

ID 1023779

LOT 00021

User Code

4200001

STERILE

LARYNGEAL MASK

SIZE 4

ID 1036937

LOT 00011

User Code

SN04239

STERILE

1. Scrub Person -

2. Scrub Person -

Signature of person/s completing care plan

Initial Count Circ. Person -

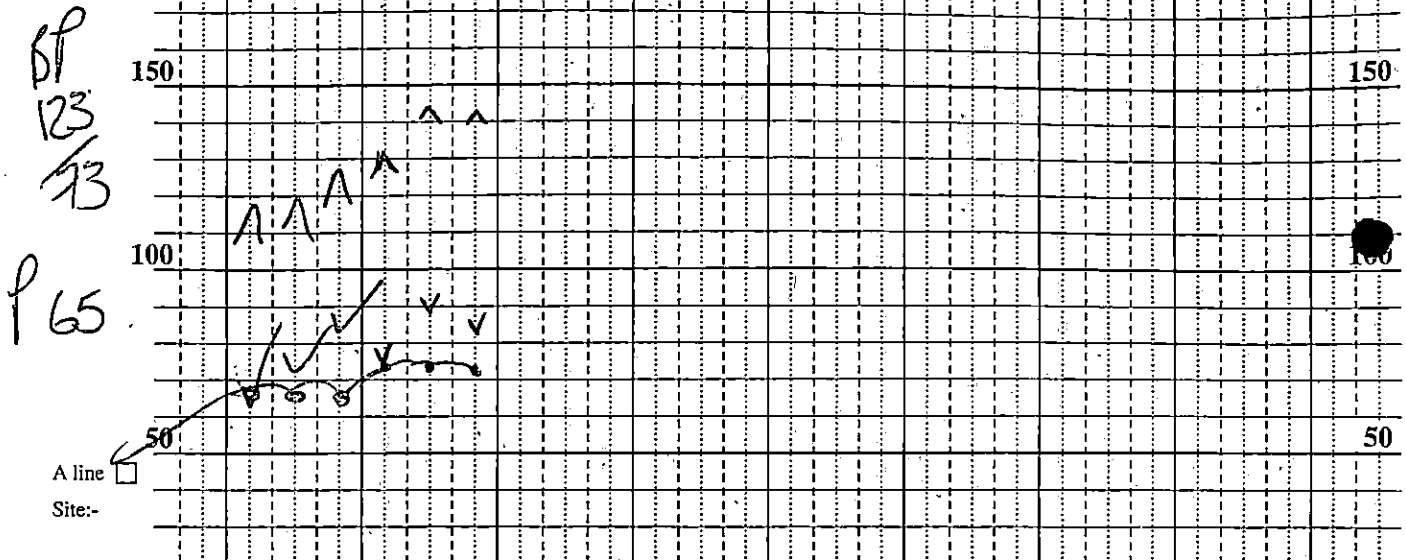
Final Count Circ. Person -

Signature: T. Middleton

Date 15/01/07	Ward OSU	Surname	Sex
Procedure and side Exc r epidymal cyst + hydrocele sac Surgeon Mv Smith		First name	 COPY CHI: 0706670592 CRN: FZ 140620 07/05/1987 ADAMS DAVID M 10 DOUGLAS AVE BRANQMOUTH FK3 0LD
		Unit No. / CHI No.	
		Date of Birth	

CHECKLIST ITEMS	WARD	HANDOVER	CHECKS	BASELINE WARD CHECKS & DATA
Verbal Name Check	✓	✓	✓	Pre-assessment Document
ID Band Checked	✓	✓	✓	Present and Checked ☐
Pre-assess/clerking completed	✓	✓	✓	Any Changes?
Pregnant Yes / No	N/A	N/A	✓	Temp 35.6° Weight (kg) 75kg
Allergies (see baseline checks Yes / No)	No	No	✓	P 65 BP 123/73
Consent / Incapacity completed	✓	✓	✓	RR SaO2 98%
Operation confirmed with patient	✓	✓	✓	BM (Sugar)
Consent form corresponds to list	✓	✓	✓	Allergies
Operation site marked clearly	✓	✓	✓	☒ No ☐ Yes NO LATEX ALLERGY
Nursing notes	✓	✓	✓	☐ Own Teeth ☐ Dentures
Case Notes (SRI, FDRI, Beatson)	✓	✓	✓	☒ ANALG
Drug Kardex	✓	✓	✓	Hb Na
X-Rays (including angiōs etc)		N/A	✓	WCC K
XMatch / G&S form (Y or N/App)	N/A	N/A	✓	Platelet U
Confirm all results available	N/A	N/A	✓	Clotting Cr
Addressograph labels	✓	✓	✓	G and S X-Match
Bone bank consent	N/A	N/A	✓	
Fasted for solids / milk from (time)	PA 14/1/07	1900	✓	
Fasted for clear fluids from (time)	BLACK TEA 6.45 AM	0645	✓	
Bladder emptied (time or No)	✓	0830	✓	
Jewellery removed / taped	N/A	None	✓	
Body piercings taped etc	N/A	None	✓	
Nail varnish / makeup removed	N/A	N/A	✓	
Contact lenses removed	N/A	None	✓	
Prosthesis (* or No)	No	None	✓	
Orthopaedic implants (* or No)	No	None	✓	
Pacemaker (Yes or No)	No	None	✓	
Hearing aid (Yes or No)	No	None	✓	
Able to move by self on trolley	YES	YES	✓	
Ward sign and designation	S/N SMITH			Thromboprophylaxis ☒ None ☐ GECS ☐ Aspirin ☐ Calf compression ☐ Clexane
Handover 1 sign and designation	S/N SMITH			
Handover 2 sign and designation	S/N SMITH			
Comments				Items to Theatre No. of Pillows <u>1</u> Cot Sides _____ Bradford Sling _____ Charnley Wedge _____

Recovery Nurse **VITAEONS**

[illegible][illegible]

Discharge to (ward) PSU

Criteria Met ☒ Time 1:00am

Signed U. Parsons

M = Morphine mg
F = Fentanyl mcg
T = Tramadol mg

Nursing notes ☒ Op notes ☒
Case notes ☒ X-Rays ☐

Post-operative instructions

Analgesia

Recovery

IV Morphine up to mg

IV Fentanyl up to 100 µg

Anti-emetic

- ☒ Cyclizine 50mg IV
☐ Granisetron 1mg IV
☐ Prochlorperazine 12.5mg IM

COPY

Analgesia

Ward

☒ Regular oral analgesia as prescribed

Oxygen - in recovery follow protocol thereafter

..... L/Min via nasal cannula

..... L/Min via facemask

IV Fluids

☐ as charted

☐ Cap off

☐ Oral

Other Care

☒ Routine

please

Investigations required

☐ Recovery

☐ Ward

FBC
U&E
ABG
CXR
ECG

Signed

we

ANAESTHETIC ASSESSMENT Date

Age

BP

ASA

NCEPOD EI ☐

Urg ☐

Sch ☐

Em ☐

PRE-OPERATIVE INSTRUCTIONS

- ☐ Give usual medication
☐ EMLA or ametop topical
☐ Fast as per Trust guidelines
☐ Free clear fluid until
☐ Additional results required before theatre

PRE-MEDICATION

Prescribed by:

Given by:

COPY

CO-MORBIDITIES

lit + well.

DRUGS

in

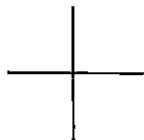
NKOA

NSAIDs OK.

Allergies	☒ No	☐ Yes
Previous GA	☒ No	☒ Yes
Problems?	☒ No	☐ Yes
FH GA problems	☒ No	☐ Yes
Reflux/full stomach	☒ No	☐ Yes
Airway difficulty	☐ No	☐ Yes

MP2
ann teeth.

Teeth



Verbal consent and explanation ☐

Explained:

☐ GA

☐ RA

☐ Risks

☐ Day Care

Na
K
U
Cr

Hb
WCC
Platelets

Clotting

G and S
X-match

Signed / Name

[Signature]

☐ nominal

Anaesthetist

کمالیہ

Procedure

excision hydrocele of epididymal cyst

COPY

☒ Anaesthetist has verified patient name, id band, procedure and side

☒ Anaesthetist has checked machine and equipment

20 g cannula. DEM

Local anaesthetic (LA) ☐ block

☐ spinal

☐ epidural

☒ infiltration

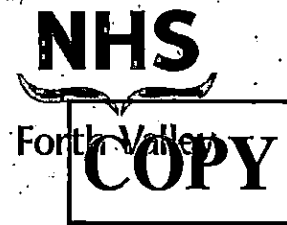
0.5% levobupivacaine 15ml

[illegible]

COPY

[illegible]

B21



NHS Forth Valley Radiology Report

Patient Name:	Adams, David	Exam Date:	08/12/2024
Patient ID:	0705570592	Consultant:	CORRIERI DR S EMERGENCY MED
Patient Date of Birth:	07/05/1957	Report Date and Time:	08/12/2024 17:04:47
Patient Address	6 SALMON COURT SCHOOL BRAE BO'NESS EH51 9HF	Referring Dept/Location:	FV EMERGENCY DEPT

CACU

Accession: V213987709801, Examination Date: 08/12/2024, Examination: CT Head:

Indication:

Clinical Details :

left weakness new and speech disturb

Provisional Diagnosis :

?cva ?thrombolysis

Findings:

Unenhanced CT head. No prior for reference.

No acute territorial infarct, space-occupying lesion or intracranial haemorrhage. No dense vessel identified.

Unremarkable appearance of the basal cisterns and ventricles with no CT evidence of altered intracranial pressure.

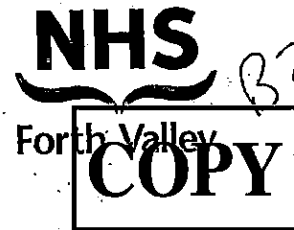
No acute fracture. Left maxillary mucosal sinus thickening.

Impression:

No acute intracranial abnormality identified.

Final Report By: Ryan Grech Consultant Radiologist GMC 7614448 at 08/12/2024 17:04:47 Email Address: ryan.grech2@nhs.scot.

COPY



NHS Forth Valley Radiology Report

Patient Name:	Adams, David	Exam Date:	09/12/2024
Patient ID:	0705570592	Consultant:	BLAYNEY DR GARETH GERIATRICS
Patient Date of Birth:	07/05/1957	Report Date and Time:	09/12/2024 17:04:18
Patient Address	6 SALMON COURT SCHOOL BRAE BO'NESS EH51 9HF	Referring Dept/Location:	FV CLINICAL ASSESSMENT UNIT

Accession: V213987957501, Examination Date: 09/12/2024, Examination:
MRI Head:

Indication:

Clinical Details :

R TIA symptoms- LSW lasting around 20 minutes with speech loss. Smoker, recent motorbike crash, residual mild LSW; MRI to confirm if evidence of ischaemic event. Note patient previously stabbed, reports no residual metal

Provisional Diagnosis :

? stroke on MRI not seen on CT

MRI brain: Comparison previous CT 08/12/2024.

Foci of diffusion restriction with high T2/FLAIR signal in the right putamen and body of caudate nucleus, in keeping with acute lacunar infarcts of the right basal ganglia.

Microvascular disease changes within the pons.

Normal configuration of the sulci and ventricles. Normal midline structures.

Normal major flow voids.

Normal craniocervical junction.

Left maxillary mucosal thickening.

Normal skull vault signal and extracranial soft tissue structures.

Opinion

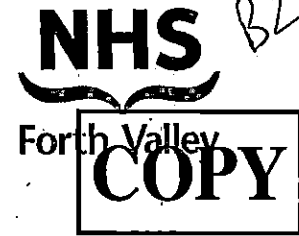
Acute lacunar infarcts of the right basal ganglia.

Preliminary Report By: Jason Yang Speciality Registrar GMC 7711669 at 09/12/2024 16:53:44.

Final Report By: Ewen Robertson Consultant Radiologist GMC 6128692 at 09/12/2024 17:04:18

Email Address: ewen.robertson@nhs.scot.

COPY



NHS Forth Valley Radiology Report

Patient Name:	Adams, David	Exam Date:	09/12/2024
Patient ID:	0705570592	Consultant:	BLAYNEY DR GARETH GERIATRICS
Patient Date of Birth:	07/05/1957	Report Date and Time:	09/12/2024 13:56:29
Patient Address	6 SALMON COURT SCHOOL BRAE BO'NESS EH51 9HF	Referring Dept/Location:	FV CLINICAL ASSESSMENT UNIT

Accession: V213987808701, Examination Date: 09/12/2024, Examination:
CT Angiogram Aortic Arch and Carotids:

Indication:

Clinical Details :

R TIA symptoms, recent motorbike accident 1/12 ago, recently painting house when acute onset LSW and dysarthria. CTA ? arterial dissection causing symptoms
Provisional Diagnosis : ? carotid or vertebral dissection on CTA

CT carotid angiogram:

Widely patent right common carotid artery.

Moderate calcified atherosclerosis of the right ICA origin with slight irregularity of the vessel wall but no measurable luminal narrowing.

No dissection.

Good calibre vessel within the skull base.

Minimal atherosclerosis of the left carotid bifurcation. No significant left ICA stenosis.

Dominant left vertebral artery; both vertebral arteries patent throughout the length although the V4 segment of the right vertebral is rather thready.

Normal intracranial vessels.

No new findings within the intracranial cavity.

Advanced emphysema within the imaged lung apices.

Conclusion:

Mild atherosclerosis right ICA origin but no measurable luminal stenosis.

Final Report By: Ewen Robertson Consultant Radiologist GMC 6128692 at 09/12/2024 13:56:29.
Email Address: ewen.robertson@nhs.scot

COPY

Mission: 20241208133925 Tim 26
Mission start: 08.12.2024 13:39 UTC+00:00

Patient ID:
Date of birth (Age):
Sex:
Height:
HR: 92 /min
CO2: 458
SpO2: 98 %
PI: 2.3 %

Case No.:
Weight:
NIBP: 152 / 86 (109) ? mmHg
RR: /min
PR: 93 /min

Device: 0002330
Radio:
Medical team:
Call back phone: 07917050816
ECG filter: 0.05 - 40 Hz
Mains filter: 50 Hz

ECG FILE INTERACTIVE - INTERPRETABILITY MAY BE AFFECTED

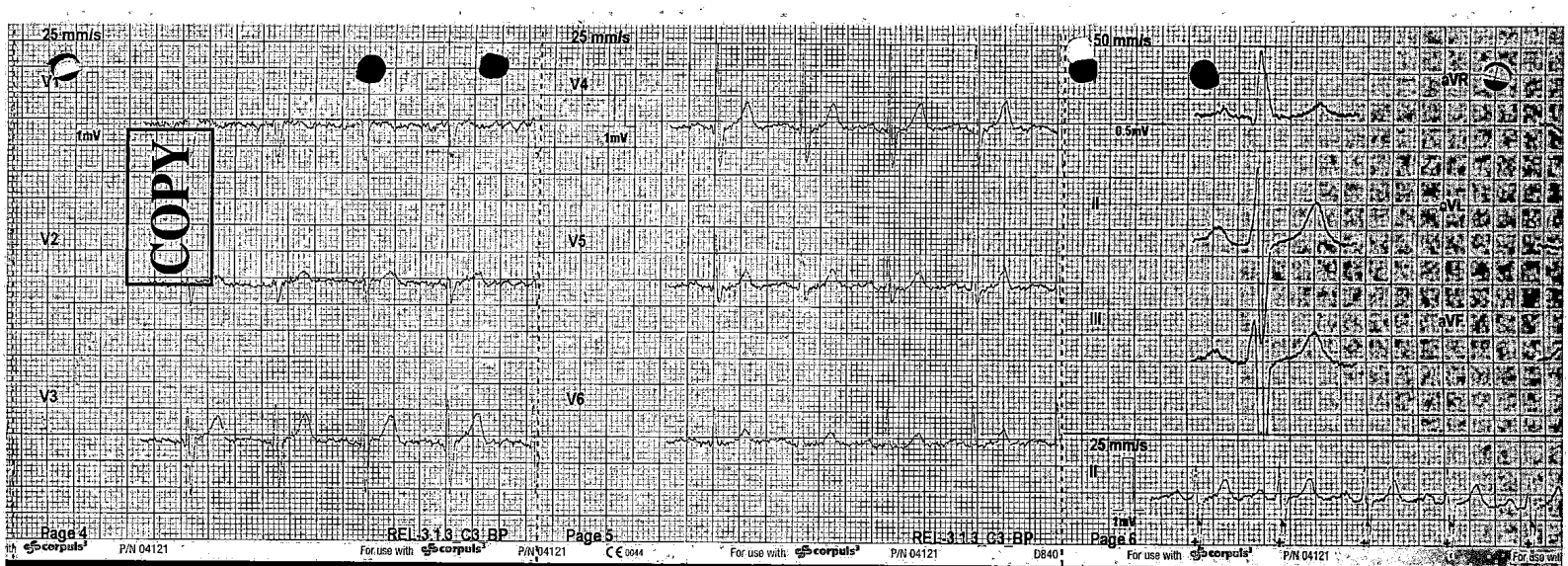
II

III

aVR

aVL

aVF



COPY

aVR

V1

V4

HR 92 /min PR 162 ms

QRS 102 ms QT 352 ms QTc 436 ms

V2

V5

SPECIFIC FINDINGS

noise 51 μ V high check ECG repeat

RMS 48 25 49 50 50 52 51

LI leads RS RS RS RS RS

CI leads R+S QRS RSRS QRS

0 in V2

broad S 30 1 1 1 1 1

QT dispersion 17 ms Max

QT dispersion 17 ms Max

remarks

checked by doctor

aVF

V3

V6

COPY

V4

V5

V6

P 92 ms PR 62 ms QRS 108 ms QT 352 ms QTc 436 ms QT 112 ms Left axis deviation

SPECIFIC FINDINGS

noise 51 μ V high

check ECG repeat recording

RMS: 48 26 49 50 50 37 51 51

LT leads: QR RS RS QR RS

CH leads: R+S QRS RSRS QRS RSRS QRS

QT in V2

broad S in V1

QT dispersion Std 17 ms Max 24 ms from 8/8 leads

QT dispersion Std 17 ms Max 22 ms from 6/6 CH leads

remarks: HES EKG 18.24.05 b

checked by doctor

END OF PRINT OUT

Last: Adams
First: David
ID: 0705570592
DOB: 07-May-1957
Age: 67yr
Comment:
Tech:
Ref Phys

Sex: Male

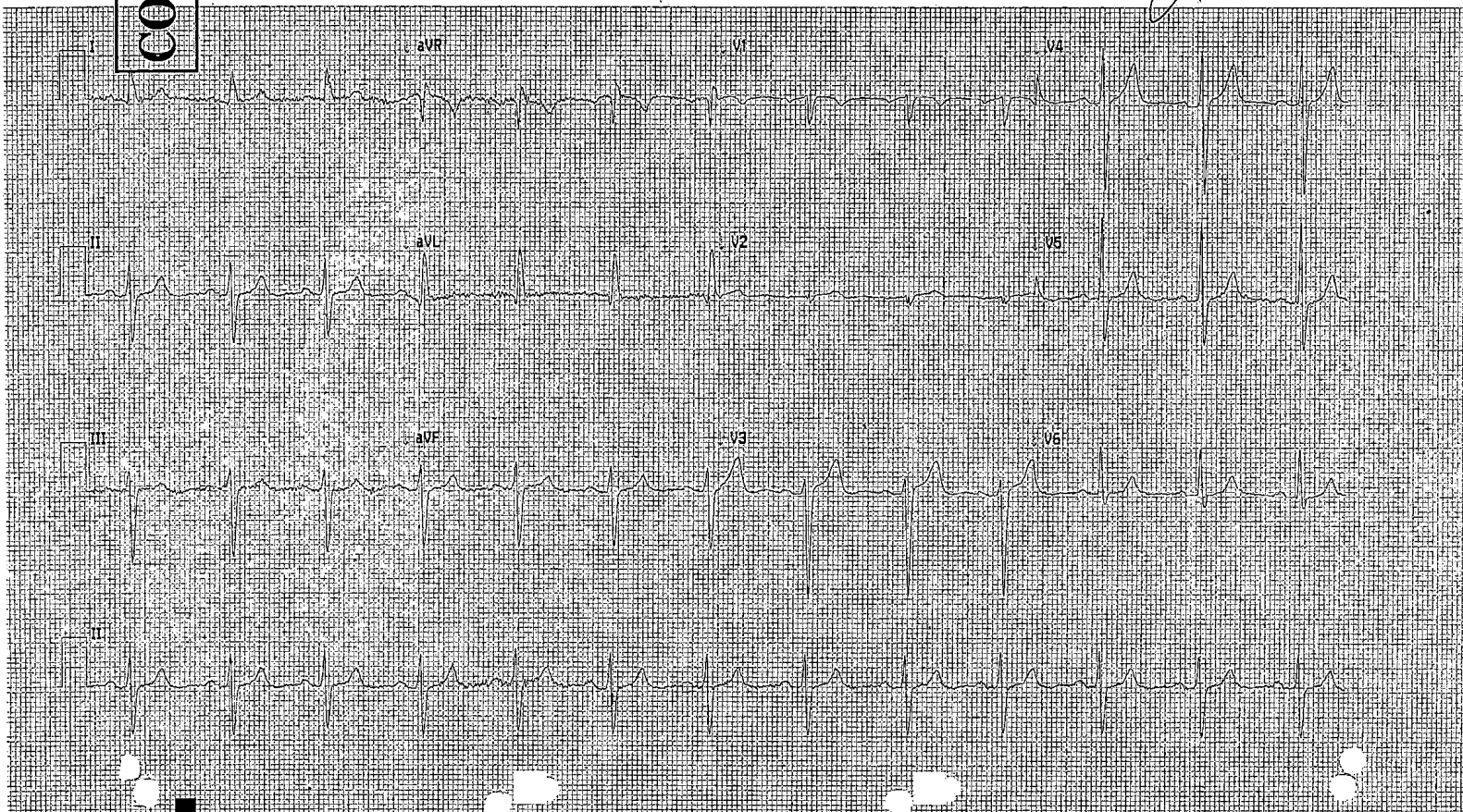
08-Dec-2024 14:18:32

Heart rate 77 BPM
PR int 164 ms
QRS dur 109 ms
QT/QTc 360/392 ms
P-R-T axes 56 -47 51

SINUS RHYTHM
MARKED LEFT AXIS DEVIATION [QRS AXIS < -30]
ABNORMAL ECG

UNCONFIRMED REPORT

COPY



Name: ADAMS, DAVID
Address: 10 DOUGLAS AVENUE
GRANGEMOUTH

DoB: 07/05/1957
Clinician: Dr Jeff Downie
Source: Oral Maxillary Facial Surgery
Forth Valley Royal Hospital

CHI No:

COPY
705570532

Date taken: 29/04/2016
Time taken: 15:45

Date rec: 30/04/2016
Time Rec: 10:35

Date Auth: 10/05/2016
Time Auth: 11:48

Clinical Details

Widespread field change over all oral mucosa.

A. White patch left retromolar region overlying mucocoele. ?Leukoplakia, ?frictional keratosis.

B. Lump left retromolar area. Burst on excision. Clear fluid extruding. ?Mucocoele.

C. Erythroleukoplakia left fauces/soft palate. Previous biopsy shows at least low grade dysplasia. Heavy smoker.

A. White Patch Left Buccal Mucosa - Incisional

Received is a 4 mm punch biopsy of mucosa to a depth of 2 mm.

Microscopy

Histological sections show a superficial biopsy of oral stratified squamous mucosa with a small portion of salivary tissue to the base. Centrally the squamous mucosa has a compact overlying layer of orthokeratin with some focal parakeratin. There is an appreciable change within the mucosa in this area with some disorganisation of basal keratinocytes seen in associated with cytonuclear atypia, scattered suprabasal mitotic activity and some possible early dyskeratotic keratinocytes. There is associated spongiosis within mucosa which suggests there may be some reactive changes, however, on balance, given the minimal degree of associated inflammation the features at this site are felt to just amount to low grade dysplastic change. There is no evidence of high grade dysplasia or invasive malignancy.

Summary: Low Grade Dysplasia.

B. ?Mucocoele Left Retromolar Area

Received is an irregular pale portion of tissue measuring 8 x 4 x 4 mm.

Microscopy

Histological sections show a portion of minor salivary gland tissue with surrounding fibrovascular connective tissue and an area of reactive granulation tissue in keeping with changes related to an extravasation mucocoele. There is no evidence of malignancy.

Summary: Extravasation Mucocoele.

COPY

C. Incisional Biopsy Left Soft Palate - Fauces

Received is a 4 mm punch biopsy of mucosa to a depth of 3 mm.

Microscopy

Histological sections show a biopsy of oral stratified squamous lined mucosa. There is some associated minor salivary tissue to the deep aspect. The squamous mucosa shows overlying compact ortho and parakeratin. Underlying this the squamous mucosa is associated with basal disorganisation with up to moderate cytonuclear atypia and areas of brisk suprabasal mitotic activity. In addition dyskeratotic keratinocytes are also seen. The changes at this site are robustly dysplastic, more striking than those within biopsy A, however felt to fall just short of high grade dysplasia (as in the previous biopsy). The appearances are therefore best regarded as low grade dysplastic change, at the upper end of low grade. There is no evidence of invasive malignancy.

Summary: Low Grade Dysplasia (Upper End of Low Grade).

This case has been reviewed in association with Dr. Mark Brown who agrees with this interpretation.

Reported By: Dr Gordon Reid

Authorised By: Dr Gordon Reid

NHS FORTH VALLEY
DEPARTMENT OF PATHOLOGY

Lab No: PH039344Q/15

appd 26/01

140620
date

Name: ADAMS, DAVID
Address: 10 DOUGLAS AVENUE
GRANGEMOUTH

CHI No:

70557432
COPY

Date taken: 30/12/2015

Time taken: 15:45

DoB: 07/05/1957
Clinician: Mr Downie
Source: Oral Maxillary Facial Surgery
Forth Valley Royal Hospital

Date rec: 31/12/2015

Time Rec: 10:21

Date Auth: 08/01/2016

Time Auth: 18:01

Clinical Details

Pigmented portion right buccal mucosa ? dysplasia. Erythroplakia left soft palate ? dysplasia.

Two Incisional Biopsies

A. Right Buccal Mucosa

A 2 mm. punch biopsy.

Microscopy

Microscopy shows a portion of oral mucosa. It is slightly cross cut. Within the subepithelial connective tissue there is some vascular ectasia and haemosiderophages are noted which may well have given rise to the clinically pigmented appearance. The surfacing epithelium is essentially unremarkable and there is no convincing evidence of dysplasia identified.

Summary: Inflammation Within the Subepithelial Connective Tissue and Haemosiderophages. No Dysplasia.

B. Biopsy Left Soft Palate

A 2 mm. punch biopsy.

Microscopy

Microscopy again shows oral mucosa. There is a mild vascular ectasia and inflammation in the subepithelial connective tissue. The squamous epithelium demonstrates robust evidence of dysplasia. This dysplasia is a little difficult to grade, however, it is regarded as at least low grade. One area in particular, at the edge, is encroaching upon higher grade change. There is no unequivocal evidence of invasive malignancy identified.

Summary: At Least Low Grade Dysplasia. See Text.

Reported By: Dr Mark Brown
Authorised By: Dr Mark Brown

DEPARTMENT OF HISTOPATHOLOGY
AREA LABORATORY SERVICE
STIRLING ROYAL INFIRMARY NHS TRUST
BIOPSY REPORT

13/11/12
F. 45620
COPY
Lab No. PH015063C/12

Name: ADAMS, DAVID
Address: 10 DOUGLAS AVENUE
GRANGEMOUTH

DoB: 07/05/1957
PAS No: 0705570592
Clinician: Mr. J. McManners
Source: Oral Maxillary Facial Surgery Forth Valley Royal Hospital
Date Rec: 27/10/2012 Date Issued:
01/11/2012

Clinical Details

1. white patches bilateral buccal mucosa, asymptomatic, adjacent to amalgum restorations.
2. bilateral speckled red and white patches on posterior soft palate.

A. Buccal Mucosa - Left Posterior

A shallow piece of mucosa 5x3x1mm.

Microscopy

Histological sections show abnormal keratinisation and acanthotic epithelium with some mild chronic inflammation. There is no significant lichenoid component and no evidence of dysplasia.

B. Soft Palate - Right Posterior

A fragment of mucosa 3x2x1mm.

Microscopy

Histological sections show abnormal keratinisation and a patchy lichenoid reaction with colloid bodies.

Summary: Part A - Buccal Mucosa Keratosis. Part B - Soft Palate Lichenoid Reaction.

Pathologists:

Dr Torquil MacLeod
Dr Catherine Humphreys

Name: ADAMS, DAVID

PH015063C/12

COPY

Clinical Details

1. white patches bilateral buccal mucosa, asymptomatic, adjacent to amalgum restorations.
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A. Buccal Mucosa – Left Posterior

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B. Soft Palate – Right Posterior

A fragment of mucosa 3x2x1mm.

Microscopy

Histological sections show abnormal keratinisation and a patchy lichenoid reaction with colloid bodies.

Summary: Part A – Buccal Mucosa Keratosis. Part B – Soft Palate Lichenoid Reaction.

Reported By: Dr Torquil MacLeod
Authorised By: Dr Torquil MacLeod

Dr Catherine Humphreys

MOUNT SHEET

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X-RAY DEPARTMENT - FALKIRK & DISTRICT R I

ADAMS, DAVID
07/05/1957

28 URE COURT
GRANGEMOUTH
FK3 9DS

HEHIR M MR
FALKIRK UROLOGY CL
RFN: 03/68076

US TESTICLES/SCROTUM

Right testis:

The right testis was normal in texture and size measuring 2.4 x 4.0 x 2.7 cm and had a volume of 1.3 6 cc. A cystic area measuring 8 x 5 mm was present in the head of the right epididymis. The tail of the right epididymis was normal in appearance.

Left testis:

The left testis was normal in texture and size measuring 2.0 x 4.1 x 2.3 cm and had a volume of 10 cc. A loculated cystic area measuring, in total, 3.1 x 1.8 cm was present towards the lower pole of the left testis.

J Bennie
Supt. Radiographer

*Copy of
JMB*

*10 F
20/11 - mho nil*

26/11/2003 BENNIE JAN/AP Reported: 26/11/2003 03FU-7600 PAS: 140620

Forth Valley Acute Hospitals NHS Trust
Elective Preoperative Assessment (Adults)

Fill out **every bold** item

Surgeon MF Smith

Diagnosis Epididymal Cyst @

Planned Procedure Exc Epid Cyst.

CHI Number:

Name:

Address:

CHI: 0705570592

CRN: FZ 140620 12/03/1957

ADAMS DAVID

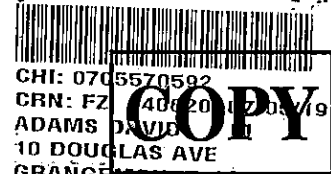
10 DOUGLAS AVE

Hospital:

GRANGEMOUTH

FK3 0LD

Date of birth:



Age 49ys **Occupation** Painter + Dec. **Patient's tel. no.** 874396

Date of Operation 15/1/07. (am) pm

Transport available: Y. **Carer Available:** Y.

Date of Assessment 8/1/07. **Date of Admission**

Medications (list drugs being taken (generic name not trade name), include dose, time taken and frequency)

None

Allergies

(Describe what happened)

None Known

Smoking — Roll ups — 20 day.

Alcohol — Weekends

Previous Surgery / Anaesthesia (list previous surgery and anaesthesia with dates and note any problems)

No

Yes

(document)

Appendicectomy Age 29ys.
Hernia Op Aged 29ys.

Any Problems (surgical or anaesthetic)

No

Yes

(document)

Family History of Anaesthetic Problems?

No

Yes

(document)

Medical History

Exercise Tolerance	Distance walked without stopping: <i>Long</i> Limited by: <i>Unlimited</i>	COPY
Shortness of Breath	☒ No ☐ Yes	
Hypertension (High BP)	☒ No ☐ Yes	
Ischaemic Heart Disease	☒ No ☐ Yes	
Valvular Heart Disease/ Murmurs Cardiac Failure	☒ No ☐ Yes	
Cerebrovascular Disease	☒ No ☐ Yes	
Peripheral Vascular Disease	☒ No ☐ Yes	
Diabetes Mellitus	☒ No ☐ Yes	
Asthma	☒ No ☐ Yes	
COAD	☒ No ☐ Yes	
Peptic Ulcer	☒ No ☐ Yes	
Hiatus Hernia / Gastro-Oesophageal Reflux	☒ No ☐ Yes	
Renal Disease or Urology Probs	☒ No ☐ Yes <i>Epididymal Cyst</i>	
Blood Clots / DVT/ PE	☒ No ☐ Yes	
Arthritis	☒ No ☐ Yes	
Epilepsy	☒ No ☐ Yes	
Other Conditions or Medical problems? Past or present	<i>Sciatica</i>	

Observations and Investigations

Weight (kg) 78

Height (m) 1.71

BMI 26

P 7.2

T 36.3

BP 150/79

1° Care BP

SaO₂ (air) 99%

RR

CHI Number:

Name:

Address:

Hospital Number

Date of birth

Able to lie flat ☒ yes ☐ no**COPY****Medical Examination / Comments****Cardiovascular System****Respiratory System**

Abdomen

Neurology

Date

Name (PRINT)

DVT Risk Factors (circle)previous DVT / PE ☒ no ☐ yes
malignancy ☒ no ☐ yes
puerperium ☒ no ☐ yestype of surgery: ☒ no ☐ yeshigh dose oestrogen ☒ no ☐ yes
thrombophilia ☒ no ☐ yes
polycythaemia ☒ no ☐ yesheart failure ☒ no ☐ yes
severe infection ☒ no ☐ yes
obesity (BMI>30) ☒ no ☐ yes**What Thromboprophylaxis Required ?** (all patients to be well hydrated and mobilised asap)

(tick at least one box according to trust guidelines)

none ☐ GECS ☐ intraop calf ☐ enoxaparin ☐ aspirin ☐ central neuraxial ☐ not sure ☐
compression (clexane) block planned

If no sure - how resolved

ASA grade 1 2 3 4 5Any Problems: ☒ No ☐ Yes (document)To discuss with anaesthetist ☒ No ☐ YesTo discuss with surgeon ☒ No ☐ Yes

Plan:

* NEEOLE PHOBIC *

Date

8/1/07

Name (PRINT)

Jmcs.

Investigations and Results

Date Test Done Enter results OR tick the "not requested in accordance with preassessment guidelines" box.
If there is no change in clinical condition / therapy results within 3 months acceptable.

Hb	WCC	Platelets	☐ not requested
Na⁺	K⁺	Ur	Cr
			☐ not requested

Blood Glucose (state whether random or fasting)	HbA1c	☒ not requested
---	--------------	---

☐ ECG attached	☒ not requested	☐ CXR attached	☒ not requested
--	---	--	---

☐ GP & save	X-match	units	☒ G&S and X match not requested
---	----------------	--------------	---

INR (PT)	APTT	☒ not requested
-----------------	-------------	---

Urinalysis	☐ not requested	MSSU	☒ not requested
-------------------	--	-------------	---

Others: ABGs, LFTs, Cardiac Echo, Pulmonary Function Tests, Exercise Test - ECG or stairs climbed (arrange as indicated)
--

Readmission/Pre-Theatre Check: **Date:**

T	P	BP	SaO₂ (air)	RR	BM
Any changes in health since pre-op assessment?		No Yes (document)			
Are you pregnant?		No Yes	LMP	Test	
Teeth		R ——— L	dentures:	in out	
Last Oral Intake		What ?	When ? (time)		

Document Thromboprophylaxis

(tick at least one box according to trust guidelines)

☐ none
 ☐ GECS
 ☐ intraop calf compression
 ☐ enoxaparin (clexane)
 ☐ aspirin
 ☐ central neuraxial block planned
 ☐ not sure

If not sure - how resolved

OK to proceed **No** **Yes**

Name (PRINT)

Nursing / Social Assessment

Named Nurse

Final Diagnosis / Treatment



COPY

CHI: 0705570592
CRN: FZ 140620 07/05/1957
ADAMS DAVID M
10 DOUGLAS AVE
GRANGEMOUTH
FK3 0LD

Prefers to be addressed as:

Occupation: *Painter + Dec.*

Religion *C of S.*

Marital Status *Engaged.*

Next of Kin Name <i>Janine Walker.</i> Address <i>SLA</i> Relationship <i>Partner</i> Tel. Day Tel. Night <i>Same.</i>	Name Address Relationship Tel. Day Tel. Night
---	---

Home Circumstances:

Communication <i>Good.</i> Bowel <i>Normal</i>	Diet <i>Normal.</i> Bladder <i>Normal.</i>
---	---

GP <i>DR CRICKSHANK</i> Practice <i>Boness Rd.</i> Phone Number	Transport Req. for Admission / Discharge ? Yes : Ambulance Ref No:..... No:..... <i>Family</i> will collect
---	---

Valuables advised <i>(Y) N</i>	Clothing advised <i>(Y) N</i>
--------------------------------	-------------------------------

Admitted By	Date
-------------	------

COPY

Day Case / Ambulatory Care Discharge Criteria

Cannula Removed	☒ Y	☐ N
Post op vital signs stable (P, BP and O2 sats), as per care plan (2).	☒ Y	☐ N
Alert and orientated, as per care plan (1).	☒ Y	☐ N
Able to sit and walk unaided.	☒ Y	☐ N
Has had something to eat and drink, as per care plan (5).	☒ Y	☐ N
Has minimal nausea and is not being sick, as per care plan (5).	☒ Y	☐ N
Operation site checked, as per care plan (4).	☒ Y	☐ N
Has passed urine, as per care plan (6).	☒ Y	☐ N
Pain well controlled, as per care plan (3).	☒ Y	☐ N
Take home medication (and verbal and written instructions) given.	☒ Y	☐ N
Own Medication at Home?	☐ Y	☒ N
Anti-D given.	☐ Y	☒ N
Outpatient clinic appointment.	☐ Y	☒ N
Going home form.	☐ Y	☒ N
District Nurse contacted.	☐ Y	☒ N
Collected by responsible adult – will be present for 24 hrs.	☒ Y	☐ N

Comments

1 PM pt met discharge criteria. MCL

Signed

J McLaughlin

Time

1 PM

ACUTE HOSPITAL ASSESSMENT & CARE PLAN BOOKLET

COPY

Affix addressograph here

CHI NO: 0705570592
CRN: 07/05/1957
M
David ADAMS
8 SALMON COURT
SCHOOL BRAE
BO'NESS
EH51 9HF

Date of admission: 9/12/04
Time of admission: AM
Ward admitted to: BU
Date/Time of transfer:
Ward transferred to:
Date/Time of transfer:
Ward transferred to:
Booklet number: ①

Assessment	Initial assessment to be completed within:	Admitting Area Initials	Transfer Area Initials
CPE (1 st ward only)	On admission		N/A
Hydration Assessment	4 hours		BM
BRADEN/Skin Assessment	6 – 8 hours		BM
Falls Trigger Tool/Care Plan	6 hours		BM
Bed Rails Assessment	6 hours		BM
4AT	24 hours		BM
Personal Hygiene and Continence	24 hours		BM
Oral Care Assessment and Care Plan	24 hours		BM
MUST Screening and Care Plan	24 hours		BM
Patient Handling and Mobility Chart	24 hours		BM
Bowel Function assessment and Care Plan	24 hours		BM

Daily assessments

1. Hydration
2. Skin assessment
3. Personal hygiene & continence
4. Bowel function

Assessments must be carried out by the required time **on admission or transfer.**

Apart from daily assessment, all other assessments will be reviewed weekly

If patients conditions changes, assessments must be stepped up to appropriate level of monitoring immediately

Patient/Carer consented to or participated in care plan process:

Staff Initials.....

Communication Assessment

No concerns ☒

New expressive difficulties (inability to name 3 objects clearly or slurred speech evident) ☐

New receptive difficulties (not understanding or following commands i.e. close eyes, make fist) ☐

Pre-existing. (Not new to this admission) ☐ (Document details in progress notes).

Check for any communication support materials being used at home, please document in the unified progress notes.

The information within this document is confidential and may only be viewed and shared with the permission of the named patient.

our signature
and is a true
COPY

[illegible]

Infection Prevention and Control Risk Assessment

COPY

All patients admitted must have a Clinical risk assessment (CRA) for Carbapenemase-Producing *Enterobacteriaceae* (CPE) and Methicillin Resistant *Staphylococcus aureus* (MRSA). This is a mandatory requirement.

CPE Clinical Risk Assessment (No patients are excluded from CPE screening).		Response
Has the patient had any previous history of CPE (check clinical portal)	YES	NO
Has the patient been transferred directly from another hospital out with NHSFV	YES	NO
Has the patient a history of admission to a hospital out with Forth Valley in the last 12 months (including dialysis patients)	YES	NO
Has the patient been in close contact with a person colonised or infected with CPE	YES	NO

A **YES** response to **ANY** of the above questions suggests the patient has an increased risk of CPE and the following actions must be taken:

- Isolated the patient in a single side room, STOP sign on door, contact precautions (PPE)
- The patient is given an information leaflet and consent is obtained for swabbing;
- CPE screen: Rectal swab taken by a registered nurse or stool specimen and, if present, a wound swab. A urine specimen is required if a urinary catheter is present;
- A rectal swab **must not** be used for children under 16 years. A stool specimen should be sent.

MRSA Clinical Risk Assessment (Exclusions from MRSA screening include: Day case patients and admissions to paediatric, obstetric and mental health specialities)		Response
1	Has the patient a history of MRSA, (check clinical portal)	YES NO
2	Has the patient been admitted from anywhere other than their own home, e.g. care home, hostel, prison, or transferred from another hospital.	YES NO
3	Does the patient have any wounds or indwelling medical devices (e.g. PEG, Hickman line, urinary catheter)	YES NO
4	Will the patient be admitted / transferred to ITU, B23 or B31	YES NO

A **YES** response to questions 1- 3 indicates an increased risk of MRSA colonisation. The following actions must be taken:

- The patient is isolated in a single side room, STOP sign on door, contact precautions initiated;
- The patient is given an MRSA screening leaflet and consent obtained for swabbing;
- MRSA screen: swab nose, perineum and if present, wounds and insertion sites of invasive devices. A urine specimen is required if a catheter is present.

Note: this is the minimal screen required and additional swabs can be sent if clinically indicated.

A **YES** response to question 4 confirms admission to a high risk specialty and the following actions must be taken:

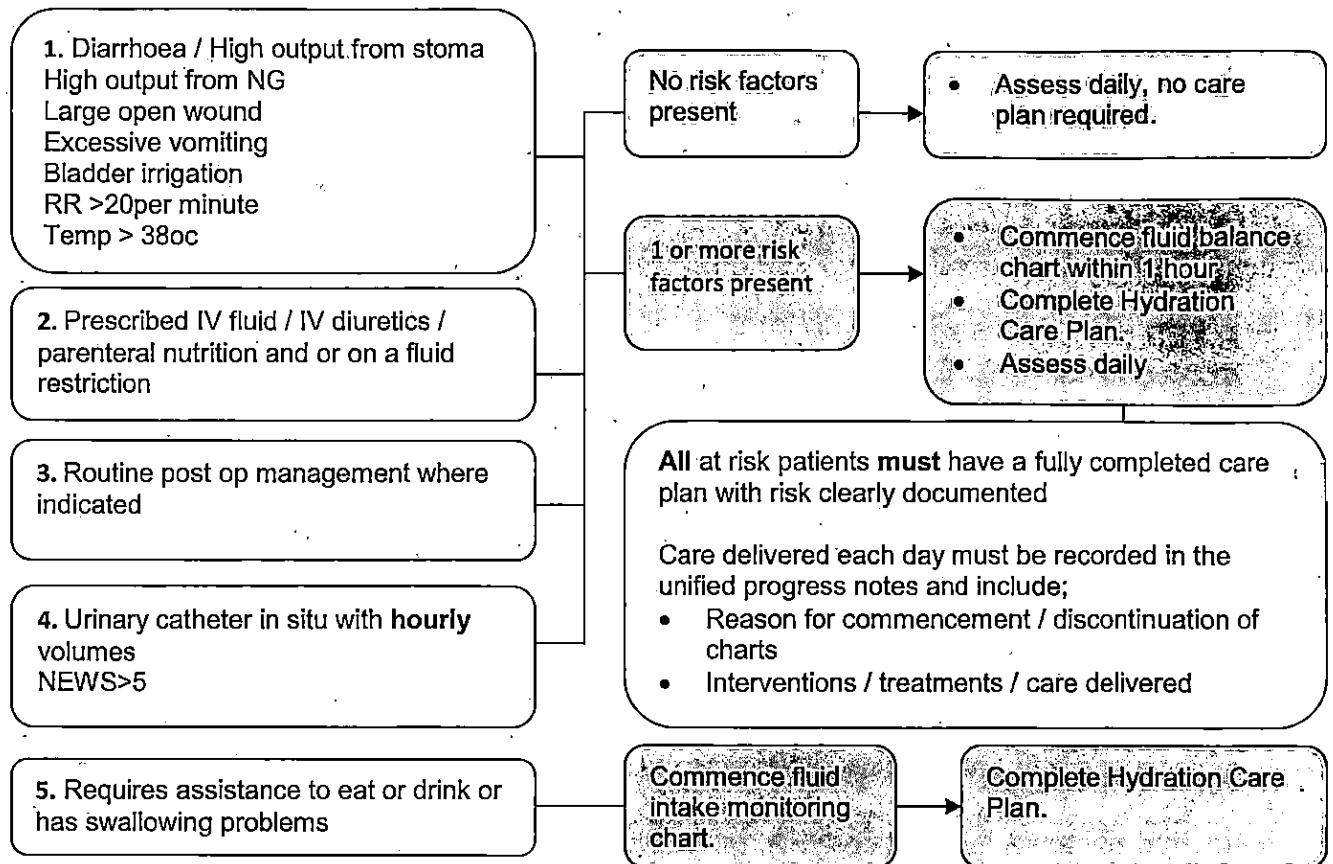
- The patient is given an MRSA screening leaflet and consent obtained for swabbing;
- MRSA screen: swab nose, perineum and if present, wounds and insertion sites of invasive devices. A urine specimen is required if a catheter is present.

Sign	Date 09/11/24	Swabs sent: Yes / No/NA
------	---------------	-------------------------

Daily Hydration Risk Assessment

Risk assessment should be carried out within 4 hrs of admission and daily thereafter

COPY



Daily Assessment

Care plan to be completed for all patients assessed as 'at risk'

Risk Assessment Week 1	Date/ Time	Date	Date	Date	Date	Date	Date
	09/12/24 1700	10/1/2					
Number of Risks present	0	0					
Fluid Balance or monitoring indicated Y= Yes N= No	N	N					
Care Plan commenced/reviewed Y=Yes N=No	Y	N					
Initials of assessor	EM	EM					

BRADEN RISK ASSESSMENT CHART

Individuals with a total score of 16 or less are considered at risk: 15-16 = low risk, 12-14 = moderate risk, 11 or less = high risk.

Undertake and document risk assessment within 6-8 hours of admission to every ward or department. Reassess if there is a change in individual's condition and repeat regularly according to local protocol or risk score.

1 .Complete skin care plan with BRADEN score included and commence a care and comfort round chart.

2. Consider contributing factors, frailty, diabetes, end of life care.

[illegible]

Skin Assessment and Care Plan

Daily Skin Care Assessment

COPY

Date/
Time

Independent, no concerns, assess daily,
review if condition changes or a concern
is raised.

Requires supervision/assistance,
visually check skin daily or more often if
at risk. Update care plan if there is a
change in condition.

Dependent, will require skin review at every patient interaction (min 2 hourly) and record findings in nursing notes

Date/
Time

Independent, no concerns, assess daily, review if condition changes or a concern is raised.

Requires supervision/assistance, visually check skin daily or more often if at risk. Update care plan if there is a change in condition.

Dependent, will require skin review at every patient interaction (min 2 hourly) and record findings in nursing notes

Care Needs

Potential nursing actions

(Please include all that apply in the care plan below)

- | | |
|--|--|
| <ul style="list-style-type: none"> • Assess daily above • Review care plan and update only when a change is evident. • Document all care given in unified progress notes. | <ul style="list-style-type: none"> • Discuss and plan care to include current patient skin condition and skin care regimen. Include any lotions or prescribed emollients. • Assess BRADEN and document current risk as well as any equipment currently in use. • Document level of assistance required to care for skin. • Ensure care and comfort chart is commenced. • Where a wound is present or skin is not intact please include information on the wound/skin tear and ensure a wound chart is commenced. • Provide an information leaflet to patients/carers |
|--|--|

Date/Time

Initial plan of care

Sign

9/12/24
1700

(I). No skin concussions. Braden 13.



Falls Risk Assessment

The following 3 questions must be completed with **ALL** patients, within 6 hours of admission.

Re-assessment required if patient falls or condition changes.

(Please document Yes/No below)

COPY

1	History of falls prior to admission? (if yes, complete falls history & falls prevention action plan)	N					
2	Falls(s) since admission? (if yes, complete falls prevention action plan)	N					
3	Additional falls risk factors for this patient? E.g. Patient tries to walk alone but unsteady/unsafe, learning disabilities, parkinson's, Stroke, cognitive impairment, acute confusional state, continence issues, visual impairment, medication (night sedation), surgery, seizures/epilepsy, fear of falling etc. (if yes, complete falls prevention action plan) Please state: (walks alone but unsafe, cognitive impairment).....	Y					
Date		9/12/24					
Time		1700					
Initial		EM					

Falls History: (to be completed within 6 hours of admission)

Falls history assessment: (Date & time of last fall prior to admission)

Estimated date and time of the last fall? Date Time of Day.....

First fall? Yes ☐ No ☐ Recurrent falls? Yes ☐ No ☐ Number of falls within the last year?

Any warning immediately prior to any falls? Yes ☐ No ☐

Palpitation ☐ Dizziness ☐ Alcohol ☐ Loss of Consciousness ☐
 Slip/Trip ☐ Environmental hazards ☐ Associated movement ☐

Explanation about fall/previous falls :(where, when, why) Activity at time of fall? (Please describe)
(consider if fall/injury could be non accidental)

Any injury sustained or previous fracture? Yes ☐ No ☐ (if yes, please describe)

Any pain related to fall? Yes ☐ No ☐ (if yes, please describe)

Any anxiety regarding further falls/confidence affected? Yes ☐ No ☐ (If yes please describe)

Comments/other information/highlight areas of concern:

Data collected from: Patient ☐ Relative ☐ Carer ☐ Other:

Initials of Nurse: EM

Date/Time: 09/12/24 1700

Falls Prevention Action Plan

The following nursing interventions may address some of the falls risk factors. They are however NOT exhaustive and staff should use their clinical reasoning/professional judgement when determining falls risk interventions.

COPY

Please state all actions taken from the list of interventions below.

Interventions:	Care Plan 1: On Admission
Environmental: Nurse in most appropriate place on ward for their needs e.g. easily observable area, near toilet etc. Area hazard free, personal belongings within easy reach Call system working/within reach at all times Adequate lighting at all times particularly overnight. Check infusion stands, facilitate mobility. Use of sound/movement monitors (if available) Select suitable seating (appropriate height, comfort) Consider one-way glide sheet for chair Frequently re-orientate confused patients.	Hazard free.
on/Hearing Ensure correct glasses worn/within easy reach and clean. Determine if patient can recognize objects from the end of the bed - if concerns, refer to medical staff for visual acuity assessment Consider hearing implications, hearing aid working etc.	Nil.
and Standing Blood Pressure: Check and record. If deficit exists, inform medical staff and continue to check twice daily for at least 72 hours. Advise patient on slow movement from sitting/lying to standing.	BWS.
ity: Follow mobility risk assessment/care plan. Consider referral to Physiotherapy and/or OT patient requires walking aid is it within easy reach?	1/NO.
ation: Request Medical staff or Pharmaceutical review.	Hepoma: Dual Antiplatelet.
um (Acute Confusional State) Complete 4AT risk assessment Treat causes of delirium, refer to delirium guidelines	4AT -VE.
ing: Assess continence. If urine frequency, ward test urine. on routine/frequent toileting. Consider a commode for night time toileting. Consider full continence assessment and refer to continence service if indicated.	1/NO.
ed bedrails: At optimum height and brakes applied. Assess the need for bedrails Low bed assessment and follow pathway	Not req.
or/Clothing Encourage patient to wear shoes not slippers. Check footwear for secure fit, non-slip sole. Ask relatives to supply safer alternatives. Toe nails are in good condition, include plan of care in personal care plan (Refer to podiatry if infected or neglected) Suitability and appropriateness of clothing e.g. length	Appropriate.
Are Medical staff, Physiotherapist, OT, Social Worker etc, are aware of this falls risk, frequency and nature Educate patient/relatives in safe practice. Discuss with patient/relative re specific interventions. Leaflet "How to reduce falls in hospital". Patient on care rounds/safety brief	MDT.
Falls Risk Management Interventions for Patient:	
/Nurse/Date & Time:	BM 09/12/24 1700

Bedrails Assessment

COPY

Bedrails NOT to be used
Code:

- A. Risk of climbing over and falling from a greater height.
- B. Patient is independent.
- C. Risk of entrapment in bedrails outweighs risk of falling
- D. Do not use with a high/low bed
- E. Patient with capacity and oriented but refuses bedrails

Bedrails CAN be used
Code:

- F. Patient with capacity and is alert and oriented and requests bedrails.
- G. Risk of injury from falling from the bed outweighs the risks of not using bed rails.
- H. Patient is unconscious.

Assessment to be completed on admission within 6 hours. Review weekly or following a fall and in response to a change in patient condition.

Date and Time	Codes	Bed rail in use	Initials
09/12/24 1700	B	YES/NO	EBM
		YES/NO	
		YES/NO	
		YES/NO	
		YES/NO	
		YES/NO	
		YES/NO	
		YES/NO	

Bed rails must be used when the bed is moving (ie; transferring patient between areas)

THE 4AT TEST: Screening instrument for cognitive impairment and delirium

To be completed on ALL patients on admission/transfer to clinical area and when a change in presentation is evident

		On admission	On transfer to ward	If condition changes	
DATE			09/12/14		
TIME			1700		
1. ALERTNESS: This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or more agitated/hyperactive than normal. If asleep, attempt to wake and ask the patient to state their name and address to assist rating.	Normal (fully alert, but not agitated throughout assessment)	0	0	0	0
	Mild sleepiness for <10 seconds after waking, then normal	0	0	0	0
	Clearly abnormal (drowsy or more agitated/hyperactive than normal)	4	4	4	4
2. AMT4: Age, date of birth, place (name of hospital or building), current year	No mistakes	0	0	0	0
	1 mistake	1	1	1	1
	2 or more mistakes/untestable as unwell or too drowsy	2	2	2	2
3. ATTENTION: Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.	Achieves 7 months or more correctly	0	0	0	0
	Scores <7 months/refuses to start/unable due to cognitive impairment	1	1	1	1
	Unable to start as unwell/drowsy	2	2	2	2
4. ACUTE CHANGE OR FLUCTUATING COURSE: Evidence of significant change or fluctuation in: alertness, cognition (e.g. increased confusion) or other mental function arising over the last 2 weeks and still evident in last 24hrs	No	0	0	0	0
	Yes	4	4	4	4
4 or above: Possible delirium +/- cognitive impairment – ensure TIME bundle completed 1 – 3: Possible cognitive impairment – only rescore if condition changes 0: Delirium or cognitive impairment unlikely – rescore if condition changes	Score	Score	Score	Score	Score
		0			
If 4 or more initiate TIME bundle (only one required per episode of delirium) TIME bundle commenced?	YES NO	YES NO	YES NO	YES NO	YES NO
Initials of tester →			TH		

COPY

*MDT decided rescreening inappropriate due to clinical presentation (ensure documented in clinical notes) Sign Date.....
 (eg end of life, stroke, where fluctuation is part of normal presentation)

COPY

[illegible]

Independent with continence, no concerns, review regularly for change	✓	✓																	
Uses continence products, continue to support whilst in hospital with prescribed products. Requires supervision/assistance (detail added to care plan)																			
Dependent or new continence issue, patient requires full assessment.																			
Initials	mmmm																		

[illegible][illegible]

Patients assessed as **yellow** or **red** require a detailed care plan overleaf.
All care given each day **must** be documented in the unified progress notes.

COPY

[illegible]

Oral Health Assessment

Assess within 24 hours of admission to determine if oral care planning is required. Discuss and agree care plan with patient/carer.

COPY

Complete this section to determine condition of mouth and the frequency of mouth care required. Document in the care plan and commence '2 Hourly' oral care record for Standard 2-4.

		Date/ Time																		
Condition of mouth Check lips, oral soft tissues and teeth with a good light	Teeth/dentures clean, mucosa pink and moist	Standard Care 1	✓																	
	Mucosa/tongue pink and dry	Standard Care 2																		
	Obvious plaque/ swollen or bleeding gums or dry/crusted mouth	Standard Care 3																		
	Possible infection	Standard Care 4																		

Complete this section to determine frequency of assessment required and document in the care plan.

		Date/ Time																		
Eating ability	Able to eat normal diet	1	✓																	
	Soft diet/delayed swallow reflex	2																		
	Nil by mouth	3																		
Physical ability	Requires assistance to access oral hygiene implements	1																		
	Requires help with oral hygiene	2																		
	Patient not able to carry out any aspect of oral hygiene	3																		
Mental ability	Loss of interest/confused	1																		
	Memory impaired/confused	2																		
	Sedated	3																		
Nutritional screening (only score if patient has own teeth)	MUST low	1	✓																	
	MUST medium	2																		
	MUST high	3																		
Additional risk factors	Diabetes mellitus	1																		
	Medications *	1																		
	Smoking	1	✓																	
	Loose/damaged dentures	1																		
	Open mouth breathing	1																		
	Oxygen therapy	1																		
	Broken or loose teeth	1																		
Total score		3																		
Initials		[Signature]																		
Re-assessment risk level: Low (2-8)/Medium (9-14)=WEEKLY High (15+) = DAILY																				

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[illegible]

COPY

Initial screening

Rescreening

[illegible]

'MUST': Low Risk Nutrition Care Plan

Date/Time care plan initiated: 09/11/14 1700

COPY

Intervention	Time Frequency	Initials
Has patient been informed of current weight and plan?	Yes/No	
Discuss the results of the 'MUST' screening/care plan with the patient and family (with agreement and involve them in identifying individualised interventions)	On admission & on-going	SM
Monitor patients weight and rescreen 'MUST' risk weekly or if patient's weight has remained stable for 4 weeks – screen monthly.	On admission and weekly	SM

Please ✓ relevant box and where yes is answered, record details of individual requirement below;

Food Allergy- No ☒ Yes ☐	Religious, cultural, ethnic requirements- No ☒ Yes ☐	Initials
Details:		SM

Therapeutic diet required - No ☒ Yes ☐	Initials
Details:	SM

Assistance required with eating/drinking- No ☒ Yes ☐	Initials
Adapted cutlery/aids- No ☒ Yes ☐	
Assistance from family - No ☐ Yes ☐ (If yes please monitor fluid intake)	
Details:	SM

Specific food preferences (patients unable to make decisions on their food and fluid choices should have a detailed dietary and fluid preference recorded)	
Details:	
Is patient able to make own choices? No ☐ Yes ☒	
Yes – patient offered daily menu	
No – for patient unable to make choices has food and fluid preferences been recorded on 'my dietary information sheet' or offer and utilise 'Getting to Know Me' document No ☐ Yes ☐	

CARE PLAN REVIEW (SIGN & DATE AT EACH REVIEW)

Discuss current weight and plan with patient (initiate new care plan if risk has changed)
*Share with relative/carer where appropriate

Init/Date	Init/Date	Init/Date	Init/Date

PATIENT HANDLING ASSESSMENT – 'MOBILITY CHART'

Independent Y / N Dependent Y / N Ability prior to admission... I

This mobility chart must be completed on admission for all patients. On transfer if the patients condition has changed and thereafter should be read/reviewed daily, post fall or if patient condition changes. Document any changes in a new column.

Please refer to Manual Handling Guidelines for all manoeuvres. If your patient is 'Plus Size', please refer to the Bariatric Handling Guidelines

CODES	MC	HA/EC	MC	HA/EC	MC	HA/EC	MC	HA/EC	MC	HA/EC	MC	HA/EC
Lying to sitting	I											
Sit to stand to sit	I											
Walking	I											
Bathing / Showering / Toileting	I											
Moving up the bed	I											
Turning / Proning	I											
On / off bed pan	IVIA	—										
Lateral transfers	I											
On / off floor	A02	VI										
State make and model of hoist / stand aid	LKO											
State type and size of sling	6MALU											
Falls assessment (Y / N)	Y											
Sign / Date / Time	EM 09/12/14											

1700

MC – Mobility Codes	HA – Handling Aids	EC – Equipment Codes
IND - Independent AST - 1/2/3	H - Full body hoist BH - Bath hoist	SC - Shower chair ST - Shower trolley
SUP - Supervision BR - Bed Rest	STA - Stand aid Pt T - Patient turner (specify)	W - Wheelchair
FWB - Full weight bearing	GS - Glide sheet ES - Extension straps	C - Crutches (specify)
PWB - Partial weight bearing	HB - Hand blocks HS - Handling sling	S - Stick Z - Zimmer
NWB - Non weight bearing	PAT - Pat slide	HJ - Hover Jack HM - Hover Jack

COPY

COPY

[illegible][illegible]

Potential nursing actions
(Please include all that apply in the care plan below)

- [illegible]

Date and time this form prepared: / / Time:
 Sheet No
 2nd Prescription in use YES ☐ NO ☐

ONCE ONLY AND PREMEDICATION DRUGS

MEDICINES RECONCILIATION
 Medicines Reconciled on Admission YES ☐
 Date Name (Print)
 Discharge Prescription Prepared & Reconciled YES ☐
 Date Name (Print)

SYMPTOMATIC RELIEF POLICY DECLARATION
 I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy:
 with the following exceptions:
 Print & Sign: Date:

COMMUNITY PHARMACY INFORMATION
 Name Tel No.
 Address
 Compliance Aid Details
 Patient consent to share discharge information Y/N
 Print & Sign

PATIENT DETAILS

 CHI NO: 0705570592 07/05/1957
 CRN: M
 David ADAMS
 6 SALMON COURT
 SCHOOL BRAE
 BO'NESS
 EH51 9HF
 Height:
 Weight:
 Surface Area:
 Consultant Name:

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

DRUGS ADMINISTERED PRIOR TO HOSPITAL ARRIVAL

DATE	DRUG	DOSE	ROUTE	GIVEN BY (e.g. SAS, GP)	Time given

ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000 YES / NO EXPIRY DATE	MENTAL HEALTH (CARE & TREATMENT) (SCOTLAND) ACT 2003 FORM T2 YES / NO FORM T3 YES / NO *If yes check treatment plan details before prescribing*	HIGH DOSE ANTIPSYCHOTIC MONITORING APPLICABLE YES / NO DATE	AFFIX 
--	---	--	--

Name
 CHI No
 Ward

Drug Allergies / Sensitivities None Known ☐ Yes ☐ (provide details below)

Nurse/Midwife Administration fro... Symptomatic Relief Policy
Authorised Nurses/Midwives Only (Maximum number of doses as per policy)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed.

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of...)

		DATE →												
RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)														
IS DRUG THROMBOPROPHYLAXIS CONTRAINDICATED?		Y / N												
ARE ANTIEMBOIC STOCKINGS INDICATED?		Y / N												
SIGNATURE OF ASSESSOR														
ARE ANTIEMBOIC STOCKINGS ON PATIENT?		Y OR N												
RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N														
Parenteral Drugs : Regular Prescription			TIME ↓											
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	A	DRUG		ENOXAPARIN (Adults only)										
	DOSE Delete as appropriate		ROUTE	DATE	DATE:									Patient's Own Medicine For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.
	20 / 40mg		S/C											
	PRESCRIBER (PRINT & SIGN)		STOPPED INITIALS:											
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY														
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	B	DRUG												For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.
	DOSE		ROUTE	DATE	DATE:									
	PRESCRIBER (PRINT & SIGN)		STOPPED INITIALS:											
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY													
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	C	DRUG												For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.
	DOSE		ROUTE	DATE	DATE:									
	PRESCRIBER (PRINT & SIGN)		STOPPED INITIALS:											
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY													

COPY

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE

Parenteral Drugs: Regular Prescription						DATE TIME ↓											Patient's Own Medicine	
BEFORE ADMISSION ☐	D	DRUG				STOPPED	DATE:											For Use Y/N
		DOSE	ROUTE	DATE														
		PRESCRIBER (PRINT & SIGN)																
NEW DOSE ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															Qty:		
NEW MEDICATION ☐																Date:		
																Assessed by:		
																Ordered from Pharmacy		
BEFORE ADMISSION ☐	E	DRUG				STOPPED	DATE:											For Use Y/N
		DOSE	ROUTE	DATE														
		PRESCRIBER (PRINT & SIGN)																
NEW DOSE ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															Qty:		
NEW MEDICATION ☐																Date:		
																Assessed by:		
																Ordered from Pharmacy		
BEFORE ADMISSION ☐	F	DRUG				STOPPED	DATE:											For Use Y/N
		DOSE	ROUTE	DATE														
		PRESCRIBER (PRINT & SIGN)																
NEW DOSE ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															Qty:		
NEW MEDICATION ☐																Date:		
																Assessed by:		
																Ordered from Pharmacy		
BEFORE ADMISSION ☐	G	DRUG				STOPPED	DATE:											For Use Y/N
		DOSE	ROUTE	DATE														
		PRESCRIBER (PRINT & SIGN)																
NEW DOSE ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															Qty:		
NEW MEDICATION ☐																Date:		
																Assessed by:		
																Ordered from Pharmacy		

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Name _____

CHI No _____

Ward _____

Drug Allergies / Sensitivities None Known ☐ Yes ☐ (provide details below)

Nurse/Midwife Administration from... Symptomatic Relief Policy
Authorised Nurses/Midwives Only (Maximum number of doses as per policy)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed.

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case

[illegible]

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Patient's Own Medicine

[illegible]

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Name _____

CHI No _____

Ward _____

Drug Allergies / Sensitivities None Known ☐ Yes ☐ (provide details below)

COPY

Nurse/Midwife Administration from Symptomatic Relief Policy Authorised Nurses/Midwives Only (Maximum number of doses as per policy)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed.

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of a drug are so important as to warrant prescribing by brand name or of sustained release lithium or theophylline).

Oral and Other Drugs: Regular Prescription				DATE TIME													Patient's Own Medicine			
BEFORE ADMISSION ☐	P	DRUG																		For Use Y/N
		DOSE	ROUTE	DATE																Qty:
NEW DOSE ☐		PRESCRIBER (PRINT & SIGN)		DATE																Date:
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		STOPPED INITIALS:																Assessed by:
																				Ordered from Pharm.
BEFORE ADMISSION ☐	R	DRUG																		For Use Y/N
		DOSE	ROUTE	DATE																Qty:
NEW DOSE ☐		PRESCRIBER (PRINT & SIGN)		DATE																Date:
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		STOPPED INITIALS:																Assessed by:
																				Ordered from Pharm.
BEFORE ADMISSION ☐	S	DRUG																		For Use Y/N
		DOSE	ROUTE	DATE																Qty:
NEW DOSE ☐		PRESCRIBER (PRINT & SIGN)		DATE																Date:
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		STOPPED INITIALS:																Assessed by:
																				Ordered from Pharm.
BEFORE ADMISSION ☐	T	DRUG																		For Use Y/N
		DOSE	ROUTE	DATE																Qty:
NEW DOSE ☐		PRESCRIBER (PRINT & SIGN)		DATE																Date:
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		STOPPED INITIALS:																Assessed by:
																				Ordered from Pharm.

COPY

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Nurse/Midwife Administration from Symptomatic Relief Policy
Authorised Nurses/Midwives Only (Maximum number of doses as per policy)

Warning: Check the As Required and Regular Prescription sections to ensure that the

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case

Oral and Other Drugs: Regular Prescription						DATE TIME ↓													Patient's Own Medicine
BEFORE ADMISSION ☐	AA	DRUG				STOPPED													For Use Y/N
		DOSE	ROUTE	DATE	DATE:														Qty:
		PRESCRIBER (PRINT & SIGN)																	INITIALS:
NEW DOSE ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																	Assessed by:	
NEW MEDICATION ☐																		Ordered from Pharm.	
BEFORE ADMISSION ☐	BB	DRUG				STOPPED													For Use Y/N
		DOSE	ROUTE	DATE	DATE:														Qty:
		PRESCRIBER (PRINT & SIGN)																	INITIALS:
NEW DOSE ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																	Assessed by:	
NEW MEDICATION ☐																		Ordered from Pharm.	
BEFORE ADMISSION ☐	CC	DRUG				STOPPED													For Use Y/N
		DOSE	ROUTE	DATE	DATE:														Qty:
		PRESCRIBER (PRINT & SIGN)																	INITIALS:
NEW DOSE ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																	Assessed by:	
NEW MEDICATION ☐																		Ordered from Pharm.	
BEFORE ADMISSION ☐	DD	DRUG				STOPPED													For Use Y/N
		DOSE	ROUTE	DATE	DATE:														Qty:
		PRESCRIBER (PRINT & SIGN)																	INITIALS:
NEW DOSE ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																	Assessed by:	
NEW MEDICATION ☐																		Ordered from Pharm.	

COPY

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Non Daily Parenteral Drugs																Patient's Own Medicine		
BEFORE ADMISSION ☐	EE	DRUG				DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	For Use Y/N
NEW DOSE ☐	DOSE		ROUTE	DATE	DATE:	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)				STOPPED INITIALS:													Date:
	INSTRUCTIONS - FREQUENCY / PHARMACY																	Assessed by:
																		Ordered from Pharm:
BEFORE ADMISSION ☐	FF	DRUG				DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	For Use Y/N
NEW DOSE ☐	DOSE		ROUTE	DATE	DATE:	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)				STOPPED INITIALS:													Date:
	INSTRUCTIONS - FREQUENCY / PHARMACY																	Assessed by:
																		Ordered from Pharm:
BEFORE ADMISSION ☐	GG	DRUG				DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	For Use Y/N
NEW DOSE ☐	DOSE		ROUTE	DATE	DATE:	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)				STOPPED INITIALS:													Date:
	INSTRUCTIONS - FREQUENCY / PHARMACY																	Assessed by:
																		Ordered from Pharm:
BEFORE ADMISSION ☐	HH	DRUG				DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	DATE DUE	For Use Y/N
NEW DOSE ☐	DOSE		ROUTE	DATE	DATE:	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)				STOPPED INITIALS:													Date:
	INSTRUCTIONS - FREQUENCY / PHARMACY																	Assessed by:
																		Ordered from Pharm:

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Name _____
 CHI No _____
 Ward _____

Drug Allergies / Sensitivities None Known ☐ Yes ☐ (provide details below)

COPY

Nurse/Midwife Administration from Symptomatic Relief Policy
Authorised Nurses/Midwives Only (Maximum number of doses as per policy)

Warning: Check the As Required and Regular Prescription sections to ensure that the

(FOR PRESCRIBERS)

1. Prescribe drugs generally in circumstances where bioavailability characteristics of the drug are so important as to

All Routes: As Required Prescriptions										Patient's Own Medicine		
BEFORE ADMISSION ☐	JJ	DRUG		DATE:	DATE	TIME	DOSE	GIVEN BY	DATE:	DATE	For Use Y/N	
		DOSE	ROUTE									INDICATION
NEW DOSE ☐		PRESCRIBER (PRINT & SIGN)		MAX DOSE IN 24hrs.	DATE:						Assessed by:	
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / MAX FREQUENCY / COMMENTS / PHARMACY										Ordered from Pharm.
BEFORE ADMISSION ☐	KK	DRUG		DATE:	DATE	TIME	DOSE	GIVEN BY	DATE:	DATE	For Use Y/N	
		DOSE	ROUTE									INDICATION
NEW DOSE ☐		PRESCRIBER (PRINT & SIGN)		MAX DOSE IN 24hrs.	DATE:						Assessed by:	
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / MAX FREQUENCY / COMMENTS / PHARMACY										Ordered from Pharm.
BEFORE ADMISSION ☐	LL	DRUG		DATE:	DATE	TIME	DOSE	GIVEN BY	DATE:	DATE	For Use Y/N	
		DOSE	ROUTE									INDICATION
NEW DOSE ☐		PRESCRIBER (PRINT & SIGN)		MAX DOSE IN 24hrs.	DATE:						Assessed by:	
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / MAX FREQUENCY / COMMENTS / PHARMACY										Ordered from Pharm.
BEFORE ADMISSION ☐	MM	DRUG		DATE:	DATE	TIME	DOSE	GIVEN BY	DATE:	DATE	For Use Y/N	
		DOSE	ROUTE									INDICATION
NEW DOSE ☐		PRESCRIBER (PRINT & SIGN)		MAX DOSE IN 24hrs.	DATE:						Assessed by:	
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / MAX FREQUENCY / COMMENTS / PHARMACY										Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

COPY

COPY

Ward _____

Drug Allergies / Sensitivities None Known ☐ Yes ☐ (provide details below)

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Nurse/Midwife Administration from Symptomatic Relief Policy
Authorised Nurses/Midwives Only (Maximum number of doses as per policy)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed.

[illegible]

DRUG NOT AVAILABLE TO BE GIVEN, DOCUMENT ACTION BELOW

DATE	DRUG	DOSE	ROUTE	TIME	ACTION TAKEN	NURSE (PRINT & SIGN)

Codes for Non-Administration of Drugs

- | | | | |
|--|--|--|--|
| 1 Patient allergy/sensitivity | 5 Patient unavailable | 9 Nausea/vomiting | 13 Other - Record in nursing notes |
| 2 Patient refused | 6 Patient asleep | 10 Unable to swallow | 14 Prescription clarification required |
| 3 Drug not available (Document Action) | 7 Time varied on doctor's instructions | 11 No intravenous access | 15 Given > 30 mins later (state time) |
| 4 Nil by mouth/fasting | 8 Dose withheld on doctor's instructions | 12 Patient Self-Administration of Medicine | |

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
 2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
 3. Print & Sign your full name clearly against each prescription entry.
 4. Please document appropriate administration times using the 24 hour clock format.
 5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
 6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
 7. The following metric unit abbreviations must be used –
Milligram = mg Gram = g
Millilitre = ml Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**
- Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).
8. The route of administration can be abbreviated using the following -

O = oral	ID = intradermal
IM = intramuscular	SL = sublingual
SC = subcutaneous	PR = per rectum
NG = nasogastric	PEG = percutaneous endoscopic gastrostomy
PV = per vagina	RIG = radiologically inserted gastostomy
NJ = nasojejunostomy	PEJ = percutaneous endoscopic jejunostomy
TOP = topical	ETT = endotracheal
NEB = nebulised	INHAL = inhaled
IV = Intravenous	

Please note - Intrathecal must be written in full.

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
 2. Insert initials in the relevant date column and time row each time a drug is administered.
 3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

20

Bloods-gluc 4.8, chol 4.6

-right basal ganglia infarct

Commenced on DAPT for 3 weeks and then clopidogrel 75mg only thereafter lifelong
Also started on PPI/statin

No therapy issues highlighted and can be discharged home as before with 48 hour tape as OP and driving advice given

Thank you
FSteel-NP**Safety Alerts****Alert Category**

Acute Receiving

Acute Receiving

Alert

Seen by Middle Grade

Seen by Consultant

Allergy/Intolerance -Allergy records are as recorded at time and date of printing
Nil records exist**Medications****Drug Information:**

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply
Nil records exist						

Drug Notes:

Drug	Drug Notes
Nil records exist	

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason
Nil records exist	

GP Communications:**Outstanding Results****Responsibility of Hospital**

Nil records exist

Person completing record**Authorised by****Clinically completed by**

Name:

Designation or role:

Specialty:

Distribution List**Recipient Name**

A Crichton

Recipient Type

GP

Recipient Organisation

Kinnell Medical Practice

COPY

Immediate Discharge Letter (In Progress)

COPY

General Medicine
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



0705570592

Date of Completion: 10-Dec-2024

A Crichton
Kinnell Medical Practice
Health Centre
Dean Road
Bo'ness
EH51 0DQ

Patient Demographics

Patient Name:	ADAMS, David	Date Of Birth:	07-May-1957
Patient Address:	6 Salmon Court School Brae Bo'ness West Lothian EH51 9HF	Gender:	Male
		CHI No:	0705570592
Telephone No:	01324 874396		

GP Practice

GP Name:	A Crichton	GP GMC:	3331664
GP Practice Address:		GP Practice Code:	3331664/26208
		GP Clinic Code:	26208
		GP Telephone:	

Admission Details

Patient Location:	General Medicine	Admission Care Provider:	Dr Daniel Beckett
Admission Date:	09-Dec-2024	Admission Time:	00:14
Admission Method:	Emergency Admission, no additional detail added	Ward:	FVRH AAU Medical Waits
Source Of Admission:	Accident and Emergency Ward - other Provider		

Discharge Details

Discharge Specialty:	Geriatric Medicine	Discharge Care Provider:	Dr Gareth Blayney
Discharge Date:		Ward:	FVRH Ward B21
Discharge Time:			
Discharge Method:			

Clinical Summary including History

This 67 year old man was admitted with sudden onset left sided weakness
PMH-Graves disease, left leg sciatica
lives alone, independent, drives

Left arm drift
CN intact
NIHSS 1

ECG-sinus
Chest clear
CTA-no sig ICA stenosis
MRI brain-right basal ganglia infarct

Bloods-gluc 4.8, chol 4.6

-right basal ganglia infarct

Commenced on DAPT for 3 weeks and then clopidogrel 75mg only thereafter lifelong
Also started on PPI/statin

No therapy issues highlighted and can be discharged home as before with 48 hour tape as OP and driving advice given

Thank you
FSteel-NP**Safety Alerts****Alert Category**Acute Receiving
Acute Receiving**Alert**Seen by Middle Grade
Seen by Consultant**Allergy/Intolerance**Allergy records are as recorded at time and date of printing
Nil records exist**Medications****Drug Information:**

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply
Nil records exist						

Drug Notes:

Drug	Drug Notes
Nil records exist	

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason
Nil records exist	

GP Communications:**Outstanding Results****Responsibility of Hospital**

Nil records exist

Person completing record**Authorised by****Clinically completed by**Name:
Designation or role:
Specialty:**Distribution List**Recipient Name
A CrichtonRecipient Type
GPRecipient Organisation
Kinneil Medical Practice**COPY**

Immediate Discharge Letter (In Progress)

COPY

A Crichton
Kinneil Medical Practice
Health Centre
Dean Road
Bo'ness
EH51 0DQ

General Medicine
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



0705570592

Date of Completion: 10-Dec-2024

Patient Demographics

Patient Name:	ADAMS, David	Date Of Birth:	07-May-1957
Patient Address:	6 Salmon Court School Brae Bo'ness West Lothian EH51 9HF	Gender:	Male
		CHI No:	0705570592
Telephone No:	01324 874396		

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GP Practice Address:		GP Practice Code:	3331664/26208
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		GP Telephone:	

Admission Details

Patient Location:	General Medicine	Admission Care Provider:	Dr Daniel Beckett
Admission Date:	09-Dec-2024	Admission Time:	00:14
Admission Method:	Emergency Admission, no additional detail added	Ward:	FVRH AAU Medical Waits
Source Of Admission:	Accident and Emergency Ward - other Provider		

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Discharge Time:			
Discharge Method:			

Clinical Summary including History

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PMH-Graves disease, left leg sciatica
lives alone, independent, drives

Left arm drift
CN intact
NIHSS 1

ECG-sinus
Chest clear
CTA-no sig ICA stenosis
MRI brain-right basal ganglia infarct

Printed: 10/12/2024 @ 11:08:04

REPRINT

Forth Valley Royal Hospital, Larbert

Tel: 01324 566 000

Serial No: 4b6bd396-7ef8-489d-948d-a175d0398e06

Page 2 of 2

Consultant: DR GARETH BLAYNEY

Immediate Discharge Letter



Ward: B21

GP Details	Patient Details	Admission Details
GP Name: A Crichton & Address: Kinneil Medical Practice Health Centre Dean Road EH51 0DQ	CHI No: 0705570592 Surname: Adams Forename: David DOB: 07/05/1957 Address: 6 Salmon Court School Brae Bo'ness WESTL EH51 9HF Patient Tel: 01324 874396	Admission Date: 09/12/2024 Admission Type: Emergency Admission Presenting Complaint: stroke Planned Discharge Date: 10/12/2024 Outpatient Follow Up:



GP Communication	Discharge Comments and Follow up arrangements
	for DAPT for 3 weeks and then clopidogrel only lifelong also started on PPI/statin

MS FIONA STEEL 10/12/2024 9:21

** End of Discharge Notes **

Dispensed by:

COPY

Checked by:

Date:

Discharging Doctor: MS FIONA STEEL

Grade: Nurse Practitioner

Originally Printed : 10/12/2024 @ 09:22

Pharmacy Copy 1/2

REPRINT

Forth Valley Royal Hospital, Larbert

Tel: 01324 566 000

Serial No: 4b6bd396-7ef8-489d-948d-a175d0398e06

Page 1 of 2

Consultant: DR GARETH BLAYNEY

Immediate Discharge Letter

NHS

Forth Valley

COPY

Ward: B21

GP Details		Patient Details		Admission Details	
GP Name	A Crichton	CHI No:	0705570592	Admission Date :	09/12/2024
& Address :	Kinneil Medical Practice Health Centre Dean Road EH51 0DQ	Surname :	Adams	Admission Type :	Emergency Admission
		Forename :	David	Presenting Complaint :	stroke
		DOB :	07/05/1957		
		Address :	6 Salmon Court School Brae Bo'ness WESTL EH51 9HF	Planned Discharge Date :	10/12/2024
				Outpatient Follow Up :	
		Patient Tel :	01324 874396		



** PLEASE NOTE: DETAILED CLINICAL INFORMATION REGARDING PATIENT EPISODE TO-FOLLOW **

Patient Drug Reactions

Allergen	Reaction	Allergen	Reaction

Allergy Status not Recorded

Forth Valley Acute Hospitals - Acute Division

Medications/Discharge Summary

Medication	Route	Dose & Frequency	Days Supply or POD	GP?	V	Notes
✓ ASPIRIN 75 mg Dispersible Tablets	Oral	75 mg ONCE daily at 8am for 21 day(s)	20	No	✓GB	
Supply 19 days. ✓ Ms Gillian Ball 10/12/2024 9:49						
✓ CLOPIDOGREL 75 mg Tablets	Oral	75 mg ONCE daily at 8am	7	Yes	✓GB	
✓ ATORVASTATIN 80 mg Tablets	Oral	80 mg ONCE daily at 10pm	7	Yes	✓GB	
✓ LANSOPRAZOLE 30 mg Capsules	Oral	30 mg ONCE daily at 8am	7	Yes	✓GB	

** Last Item **

Dispensed by :

Checked by :

Date :

Discharging Doctor : MS FIONA STEEL

Grade : Nurse Practitioner

Serial Blood Results

Surname..... CHI.....
 Forename..... D of B
 Address

COPY

Date (D) & Time (T)		D	D	D	D	D	D	D
Electrolytes	Normal Values	T	T	T	T	T	T	T
Sodium	135 - 145							
Potassium	3.5 - 5							
Chloride	97 - 107							
Urea	2.5 - 8							
Creatinine	60 - 130							
eGFR	>59							
Calcium	2.15 - 2.6							
Corrected Calcium	2.15 - 2.6							
Phosphate	0.74 - 1.32							
Magnesium	0.7 - 1.0							
C-Reactive Prot	0 - 5							
Glucose	3.3 - 5.5							
Liver Function & Cardiac Enzymes	Normal Values							
AST	12 - 31							
ALT	11 - 37							
Bilirubin	0 - 17							
Total Protein	62 - 82							
Albumin	36 - 52							
Alk Phosphatase	0 - 130							
Amylase	0 - 90							
CK	23 - 175							
Troponin T	0 - 50							
LDH	195 - 415							
8 GT	7 - 43							
Haematology & Clotting Screen	Normal Values							
Hb -	Gender dep							
WCC	3.5 - 11							
Neutrophils	1.8 - 7.7							
Platelets	150 - 440							
Prothrombin Time								
PT Control								
APTT								
APTT Control								
C Fibrinogen								
INR								
Drug Levels	Normal Values							
Digoxin								
Gentamicin								
Paracetamol								
Phenytoin	10 - 20							
Theophylline	10 - 20							
Vancomycin								
β-HCG - Pregnancy Test								
Miscellaneous								
	Initial							

BU NESS
EH51 9HF

COPY

ING1897

DATE OF ADMISSION:

COPY

DATE
TIME

≥25

21-24

18-20

15-17

12-14

9-11

≤8

≥96

94-95

92-93

≤91

≥97 on O₂

95-96 on O₂

93-94 on O₂

≥93 on air

88-92

86-87

84-85

≤83%

A-Air

O₂ L/min

Device

≥220

201-219

181-200

161-180

141-160

121-140

111-120

101-110

91-100

81-90

71-80

61-70

51-60

≤50

≥131

121-130

111-120

101-110

91-100

81-90

71-80

61-70

51-60

41-50

31-40

≤30

Alert

Confusion

V

P

U

≥39.1°

38.1-39.0°

37.1-38.0°

36.1-37.0°

35.1-36.0°

≤35.0°

TOTAL

Monitoring

Escalation

Blood Sugar

Pain Score 0-3

Initials

National Early Warning Score (NEWS2)

NHS

Forth Valley

COPY

Name:



CHI NO: 0705570592 07/05/1957

DOB:

CRN:

David ADAMS

CHI No:

6 SALMON COURT

SCHOOL BRAE

Address:

BO'NESS

EH51 9HF

*** Regardless of NEWS always escalate if concerned about a patient's condition**

Total NEWS	Frequency of Monitoring	Clinical Response
0*	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations
1 - 4*	Minimum 4 - 6 hourly	- Inform registered nurse who must assess the patient - Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5 - 6* or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	- Registered nurse to urgently inform the medical team caring for the patient - Urgent assessment by a clinician with core competencies to assess acutely ill patients - Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>)
7 or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	- Registered nurse to immediately inform the medical team caring for the patient - Emergency assessment by clinical team with core competencies to assess acutely unwell patients - Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>) - Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.

Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30-60 min to check for rising CO2 or H+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency

Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)

Acute Hypercapnia (pCO2 >6 and H+ >45)

Urgent ST3 (or equivalent) review is required to optimise management.

Duty or on call consultant should be contacted if advice required.

Critical care referral and ventilatory support may be needed.

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)

N = Nasal Canulae

SM = Simple Mask

V24 = Venturi 24% V28 = Venturi 28% V35 = Venturi 35% V40 = Venturi 40% V60 = Venturi 60%

H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)

RM = Reservoir Mask

TM = Tracheostomy Mask

CP = Patient on CPAP System

NIV = Patient on NIV System

OTH = Other Device: _____ (specify which)

Pain Score

0 = no pain

1 = mild pain

2 = moderate pain

3 = severe pain

Conscious Level Chart (only as required for head injury observation)

DATE: 8/12/24			DATE:																	
TIME: 11:05:30			COPY																	
COMA SCALE	Eyes Open	Spontaneously	4																	Eyes closed by swelling = C
		To speech	3																	
		To pain	2																	
		None	1																	
	Best verbal response	Orientated	5																	Endotracheal tube or tracheostomy = T
		Confused	4																	
		Inappropriate words	3																	
		Incomprehensible sounds	2																	
		None	1																	
	Best motor response	Obey commands	6																	Usually record the best arm response
		Localise pain	5																	
		Withdraws to pain	4																	
Flexion to pain		3																		
Extension to pain		2																		
None		1																		
1 2 3 4 5 6 7 8 Pupil Scale (mm)																				
PUPILS		right	Size	3	3	4														+ reacts - no reaction c. eye closed
		left	Size	3	3	4														
LIMB MOVEMENT	ARMS	Normal power	RRR LLL																Record right (R) and left (L) separately if there is a difference between the two sides	
		Mild weakness																		
		Severe weakness																		
		Spastic flexion																		
		Extension																		
	LEGS	No response																		
		Normal power																		
		Mild weakness																		
		Severe weakness																		
		Extension																		
No response																				

Pain Assessment & Management Guidelines

Pain Score:

- 0 = No pain
- 1 = No pain at rest
Slight pain on movement
- 2 = Intermittent pain at rest
Moderate pain on movement
- 3 = Continuous pain at rest

For Acute and Chronic Pain:

For mild (1), moderate (2) or severe (3) pain refer to Pain Management Guidelines Forth Valley Formulary Appendix 27 & 28. Implement Pain Assessment Chart

For Cancer Related Pain:

For mild (1), moderate (2) or severe (3) pain score, refer Palliative Guidelines.

