A&E Records

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Marriott
Winchburgh Medical Practice
Winchburgh Health Centre
Niddry Road
Winchburgh
EH52 6RX

Date: 03/04/2013

Emergency Discharge Summary

Patient	James Weir 28 Peveril Rise Livingston EH54 6NU	**CHI**	**1203893450**
		Date of Birth / Age	12/03/1989 (24 years)
		UHPI	201009798X
		A&E Attendance Number	E2442876
Attendance Date	02/04/2013		
Attendance Time	19:16		
Mode of Arrival	Emergency Ambulance		
Source of Referral	NHS 24		
Discharge Date	02/04/2013		
Discharge To	SJH Medical Assessment Unit	**Final Triage**	3 - Urgent
		Attendances in the last 12 months	1

Dear Dr Marriott

Presentation:	chest pain
Diagnosis:	None
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

24 year old male,
Previous alcohol misuse. Had a binge over the weekend. Known heartburn and reflux and awaiting UGIE next week. Past few weeks intermittant vomits ?some coffee ground vomits, and feeling constipated. Reduced oral intake and occasional vomits after food. Today ate mcdonalds then vomited a total of 5 times, 1st 2 episodes no blood, 3-5th episodes some altered blood "like coffee" with a few clots, no further vomits since. C/O epigastric/chest pain. No palpitations/SOB. No cough/fever. LBO 507 days ago, 2 week history of intermittant fresh red blood spotting when straining to pass stool, no blood mixed with the stool, painful to pass. Smoker, high caffeine and sugary food intake, eats spicy foods.
Admits to taking 10 X tramadol ?50mg tablets today due to increasing epigastric pain. No palpitations/SOB. Feeling a bit dizzy, no collapse.

PMHx/Meds/Allergies nil

Shx - precious alcohol XS >100U/week, now alcohol binges, smoker, nursing student

OE
rr15, bp 110/75, E120/80, S 105/60, HR 90, T 36.5
Chest clear HS i and II and O
Abdo soft tender with mild guarding in epigastrium, bs present, no rebound
GCS 15, pale, wwp
PR and consent - soft brown stool

CXR: clear
Bloods normal

ecg: NSR nil acute

Imp: ?bleeding DU

Plan:
after analgesia, ivf, antiemetics ongoing pain, no vomits in the dept,, still feeling mildly dizzy.
DW Med reg - will kindly admit with thanks,
Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Zoe E Smeed, Doctor

NHS Lothian

St John's Hospital at Howden
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Winchburgh Health Centre
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Date: 03/04/2013

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		Date of Birth / Age	12/03/1989 (24 years)
		UHPI	201009798X
		A&E Attendance Number	E2442876
Attendance Date	02/04/2013		
Attendance Time	19:16		
Mode of Arrival	Emergency Ambulance		
Source of Referral	NHS 24		
Discharge Date	02/04/2013		
Discharge To	SJH Medical Assessment Unit	**Final Triage**	3 - Urgent
		Attendances in the last 12 months	1

Dear Dr Marriott

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Procedures:	None
Drugs given in A&E:	None

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Chest clear HS i and II and O
Abdo soft tender with mild guarding in epigastrium, bs present, no rebound
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Imp: ?bleeding DU

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Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Zoe E Smeed, Doctor

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
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EH54 6PP

Dr Marriott
Winchburgh Medical Practice
Winchburgh Health Centre
Niddry Road
Winchburgh
EH52 6RX

Date: 10/04/2013

Emergency Discharge Summary

Patient	James Weir 28 Peveril Rise Livingston EH54 6NU	**CHI**	**1203893450**
		Date of Birth / Age	12/03/1989 (24 years)
		UHPI	201009798X
		A&E Attendance Number	E2447906
Attendance Date	09/04/2013		
Attendance Time	20:22		
Mode of Arrival	Emergency Ambulance		
Source of Referral	NHS 24		
Discharge Date	09/04/2013		
Discharge To	SJH Obs Ward	**Final Triage**	3 - Urgent
		Attendances in the last 12 months	2

Dear Dr Marriott

Presentation:	chest pain
Diagnosis:	None
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

24 yr old

coffee ground vomit
due endoscopy 10:10 tomorrow (10/4/13)

6 week hx daily coffee ground vomit, occasionally fresh, not eating much and food getting stuck in throat, able to keep down fluids. Weight loss, constipation, some fresh PR bleeding on straining, abdo pain. Recent admission - stable overnight but Hb drop from 141 to 125, urea normal.
Getting worse, today esp bad, unable to keep down fluids, vomiting several times allways coffee ground. No PU 8 hours.
Prev ETOH xs, nil for 2 weeks, smoker. No drugs.

O/E BP stable, not tachy,

abdo tender epigastrium with voluntary guardin, not peritonitic, PR no blood or stool. Chest clear, Hs pure, calves SNT.

Bloods - Hb 146, urea normal.
Rockall score zero

Plan -

IV access bloods and G+S done
IV fluids
omeprazole
for obs ward,
NBM from midnight.

This patient has been admitted to hospital and a further letter will follow.

Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Juliette Oxford, Doctor

Emergency Medicine
NHS LOTHIAN UNIVERSITY HOSPITALS DIVISION

ST. JOHN'S HOSPITAL
Howden Road West
Livingston
EH54 6PP Tel: 01506 523000

NHS Lothian

A/E no. E2475254
Previous no. E2447906

UHPI no. 201009798X
CHI no. 1203893450

PATIENT INFORMATION

Surname Weir
Forenames James Thomas
Address 28 Peveril Rise
Livingston
West Lothian
Postcode EH54 6NU

Yellow Jacket
Short hair
Black trakkies
White trainers

Date of Birth 12/03/1989
Age 24 Yrs Sex M
Telephone 01506 491184

[redacted]

Complaint suicidal

Allergies

Attendances in last 12 months: 2 School:

General Practitioner

Name
SJ Pepper
Address
Dedridge Medical Group
Dedridge Health Centre
EH54 6QQ

Telephone 01506 414586

Date and Time of Attendance
17/05/2013 16:35
Incident Date & Time: 17/05/2013
Mode of Arrival
Police

Source of Referral
Police

T	P	RR	BP	BM	SpO2	PEFR	Height	Weight	Alco
36.3	76	17	114/44	4.9	98%				0.11

Initial Assessment Pt attends stating 7yrs of feeling angry and violent. States he finds it hard to cope (what?) getting into a rage. Assaulted a colleague last week for saying. Good eye contact - good communication skills.

Signature [signature] Time 16 39. GCS 15.

Print Name Triage Cat. MAJOR 3

Urinalyis	Leuc	Nit	Blood	Protein	Glucose	Ketones	SG	PH

Clinical Notes

	Time seen	18-15
	Alcohol	/
	Investigations	/
TRIAGE	Procedures	/
	Drugs given in Dept.	/
	Diagnosis	420

Diagnosis Feeling suicidal

Name (print) SMcS Signature [signature]

Clinical Notes Continued

Once Only Prescriptions

	Drug	Dose	Route	Prescribed By	Given By	Time
A	Diazepam	5mg	Po.	[signature]	TTO · x6 tablets	
B						
C						
D						
E						

Additional Nursing Notes

PMH

Meds Omeprazole

Allergies Penicillin.

Social History

Accompanied by Police officer.

NHS Lothian

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EH54 6PP

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date: 17/05/2013

Emergency Discharge Summary

Patient	James Weir 28 Peveril Rise Livingston EH54 6NU	**CHI**	**1203893450**
		Date of Birth / Age	12/03/1989 (24 years)
		UHPI	201009798X
		A&E Attendance Number	E2475254
Attendance Date	17/05/2013		
Attendance Time	16:35		
Mode of Arrival	Police		
Source of Referral	Police		
Discharge Date	17/05/2013		
Discharge To		**Final Triage**	3 - Urgent
		Attendances in the last 12 months	3

Dear Dr Pepper

Presentation:	suicidal
Diagnosis:	feeling suicidal
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

24 year old male, bkg alcohol XS, previous ODs and depression
Brought in by police as concerns re suicidal intent.
Alleged sexual assult several years ago, reporting this to the police today. 6-7 year history of feeling angry and finding he cannot cope unless he gets in a rage. Last few days "feeling suicidal" with thoughts to kill himself. Has a knife under his bed which he has thought about using, previous self harm and ODs, nil today. Occasionally feels that the alleged abuser is touching him or tugging on his shirt. No visual/auditory hallucinations. No manic/psychotic feactures.

PMHx depression, alcohol XS, haematemesis
NKDA

OE
T 36.3, P76, RR17, BP 114/64, BM 4.9, ALC 0.11

Good eye contact, keen to talk, normal affect, normal speech pattern.

Imp:
suicidal ideations, ?underlying post traumatic stress reaction

Plan:
obs, BM and alcohometer
psych review with thanks
Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Zoe E Smeed, Doctor

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date: 18/07/2013

Emergency Discharge Summary

Patient	James Weir 28 Peveril Rise Livingston EH54 6NU	**CHI**	**1203893450**
		Date of Birth / Age	12/03/1989 (24 years)
		UHPI	201009798X
		A&E Attendance Number	E2519401
Attendance Date	18/07/2013		
Attendance Time	18:10		
Mode of Arrival	Walked		
Source of Referral	General Practitioner		
Discharge Date	18/07/2013		
Discharge To	SJH Obs Ward	**Final Triage**	3 - Urgent
		Attendances in the last 12 months	4

Dear Dr Pepper

Presentation:	suicidal
Diagnosis:	suicidal ideation
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

24 year old male, bkg:
depression, anxiety, alcohol XS, DSH, previous haematemsis

GP referral to ED - suicidal thoughts.

Low mood and feeling suicidal worse over past few days. Dad in jail, arguing with sister and recent death of mum last week. Says jumped from 15ft window today in an attempt to take his life, isolated pain to right ankle, no other injuiries.
Feels he still wants to go and kill himself. Says he is planning to cut his wrist.
Known alcohol XS, not had any alxohol today.
Recurrent visual hallucinations and feels someone is touching him since alleged sexual assult.
Not taking medication as feels it does not help him

PMHx as above
NKDA

OE
T 37.7, P98, RR14, BP 120/72, SATS 96% oA ALC 0
Chest clear HS I and II and O
Abdo SNT, BS present
GCS 15, PEARL, no bony tendenress to C/T/L/S spine tenderness, plantars downgoing, fully mobilising
FROM C spine
Pelvis/long bones NAD
Mild tenderness over right medial ligaments of foot, no tenderness to tib/fib or calcaneous, FROM ankle, nv intact, full mobilisation

Imp:
soft tissue ankle injury
suidical ideation

Plan:
refer psychiatry
soft tissue injury advice given.
Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Zoe E Smeed, Doctor

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date: 27/07/2013

Emergency Discharge Summary

Patient	James Weir 28 Peveril Rise Livingston EH54 6NU	**CHI**	**1203893450**
		Date of Birth / Age	12/03/1989 (24 years)
		UHPI	201009798X
		A&E Attendance Number	E2525164
Attendance Date	26/07/2013		
Attendance Time	22:36		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	27/07/2013		
Discharge To	SJH Obs Ward	**Final Triage**	3 - Urgent
		Attendances in the last 12 months	5

Dear Dr Pepper

Presentation:	psych/chest pain
Diagnosis:	None
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

PC: suicidal thoughts, abdo pain

HPC: Discharged from Ward 17 last week following admission with suicidal thoughts, low mood. Struggling to cope since discharge. Ongoing suicidal ideation. Ongoing abdominal pain radiating to left side of chest, feels like he has been punched in the stomach. Vomiting, 6 episodes today. C/o fresh PR blood loss each time he tries to open bowels, fresh red blood on wiping. No cough/SOB. Eating and drinking. Has consumed 2 glasses wine today. No drug use.
UGIE April 13 - moderate duodenitis with erythema, no active bleeding.

PMHx: depression, alcohole xcess, haematemesis
DHx: diazepam, thiamine
SHx:

Obs; temp 36.4, pulse 114, RR 16, BP 147/84, SpO2 97% on air, alcometer 0.8

Looks well, undistressed
HS I+II+0
Calves SNT, no oedema
Chest clear
Abdomen soft, mild epigastriv tenderness, no peritonism. BS present

PR exam performed chaperoned by SN (G.Duncan) - soft stool in rectum, no PR bleeding/melaena.
ECG: SR 100, nil acute
CXR: No free air

Plan
Bloods
Obs ward for psych review mane
Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Mhairi Doris, Doctor

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date: 28/07/2013

Emergency Discharge Summary

Patient	James Weir 28 Peveril Rise Livingston EH54 6NU	**CHI**	**1203893450**
		Date of Birth / Age	12/03/1989 (24 years)
		UHPI	201009798X
		A&E Attendance Number	E2525780
Attendance Date	27/07/2013		
Attendance Time	21:45		
Mode of Arrival	Emergency Ambulance		
Source of Referral	999 Emergency		
Discharge Date	28/07/2013		
Discharge To	SJH Medical Assessment Unit	**Final Triage**	3 - Urgent
		Attendances in the last 12 months	6

Dear Dr Pepper

Presentation:	od
Diagnosis:	OD
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

24 year old male,
bkg:
alcohol XS, gastritis (previous haematemesis), depression

DC from ward 17 this afternoon, feels he is not coping with things. Mixed OD of paracetamol 32mg, diazepam 5mg X 10 and 1/2 gm amphetamine in an attempt to kill himself, feeling regretful and said he did it as he wants help but says he is fed up of life. No chest pain/palpitations/GI symptoms. Drank 125ml wine this evening with tablets, impulsive.

PMHx as above
NKDA

oe
T 36.9, P94, RR15, BP 118/70, BM 5.9, SATS 95% OA,
Chest clear HS I and II and O
Abdo soft, tender epigastrium, no guarding/rebound, bs present
GCS 15, PEARL, T/P/R/S all normal, plantars downgoing

ECG: NSR 79 bpm QTC 413
Bloods: paracetamol 14 otherwise normal (ck awaited)

Plan:
Admit for telemetry (as per toxbase advice for amphetamines)
paracetamol levels due at 12.30
Psychiatry review mane
Note several episodes of epigastric pain over past month, previous haematemesis, nil recently, may warrent outpt UGIE after DC.
Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Zoe E Smeed, Doctor

NHS Lothian

St John's Hospital at Howden
Howden West
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West Lothian
EH54 6PP

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date: 31/07/2013

Emergency Discharge Summary

Patient	James Weir 35 Pyothall Court Broxburn EH52 6GX	**CHI**	**1203893450**
		Date of Birth / Age	12/03/1989 (24 years)
		UHPI	201009798X
		A&E Attendance Number	E2527762
Attendance Date	30/07/2013		
Attendance Time	21:31		
Mode of Arrival	Public Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	31/07/2013		
Discharge To	SJH Obs Ward	**Final Triage**	3 - Urgent
		Attendances in the last 12 months	7

Dear Dr Pepper

Presentation:	abdo pain
Diagnosis:	None
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

PMH; Depression. ADHD. ETOH XS. Haematemesis- UGIE April 13 moderate duodenitis with erythema. No active bleeding.
DH: As per ECS

HOPI:
Recent discharge from Ward 17
Apparently some one told him it was not the right ward for him which has made him upset.He has been under stress following the death of his mother and taken a recent OD.
Went home today and drank a lot of buckfast and lager and has vomited a few times.
Presents to ED for low mood and abdo pain
Reduced appetite
No malena
Denies OD

O/E
Smelling of ETOH
Comfortable at rest
Obs as noted
CVS-S1S2
Chest clear
Abdo Mild tenderness epigastric region
No guarding
No peritonism
GCS 15

Bloods normal

IMP: Alcoholic gastritis.Depression

ADMIT Obs ward for psych r/w mane

Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Amrit Ashok, Doctor

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date: 01/08/2013

Emergency Discharge Summary

Patient	James Weir 35 Pyothall Court Broxburn EH52 6GX	**CHI**	**1203893450**
		Date of Birth / Age	12/03/1989 (24 years)
		UHPI	201009798X
		A&E Attendance Number	E2528515
Attendance Date	31/07/2013		
Attendance Time	23:38		
Mode of Arrival	Emergency Ambulance		
Source of Referral	999 Emergency		
Discharge Date	01/08/2013		
Discharge To	SJH Obs Ward	**Final Triage**	3 - Urgent
		Attendances in the last 12 months	8

Dear Dr Pepper

Presentation:	psych od?
Diagnosis:	taken rolex suicidal ideation
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

24 year old male,
bkg depression, gastritis, alcohol XS
several attendances past week with ODs, suicidal intent

BIBA, with police, admits to taking Rolex tonight with alcohol at bus stop, stated to friends feeling suicidal. Vague history of possible collapse at bus stop, however GCS 15 with SAS. Says he took Rolex as he knows it kills people, and says he wants to die as he does not feel it is worth living after death of mother. Then states he has friends and family in glasgow and he doesnt want to die as it would be hard on them. Ongoing epigastric pain (normal for him) no chest pain/palpitations/SOB. Unsure if he has taken an OD today or not. No history of DSH.

PMHx as above
NKDA

OE
T 37.2, P84, RR16, BP 126/87, SATS 98% oa, ALC 1.13
Chest clear HS I and II and O
Abdo soft, generalised tenderness, no guarding/rebound , bs present
GCS 15, PEARL, T/P/R/S/C all normal, plantars downgoing

ECG: NSR 83 BPM QTC 441, 1MM STE V2, III (no chest pain)

Imp:
suicidal ideation
taken rolex

Plan:
bloods
admit obs ward for obervation
psychiatry reveiw mane
Any queries please contact A&E Reception on 01506 523011

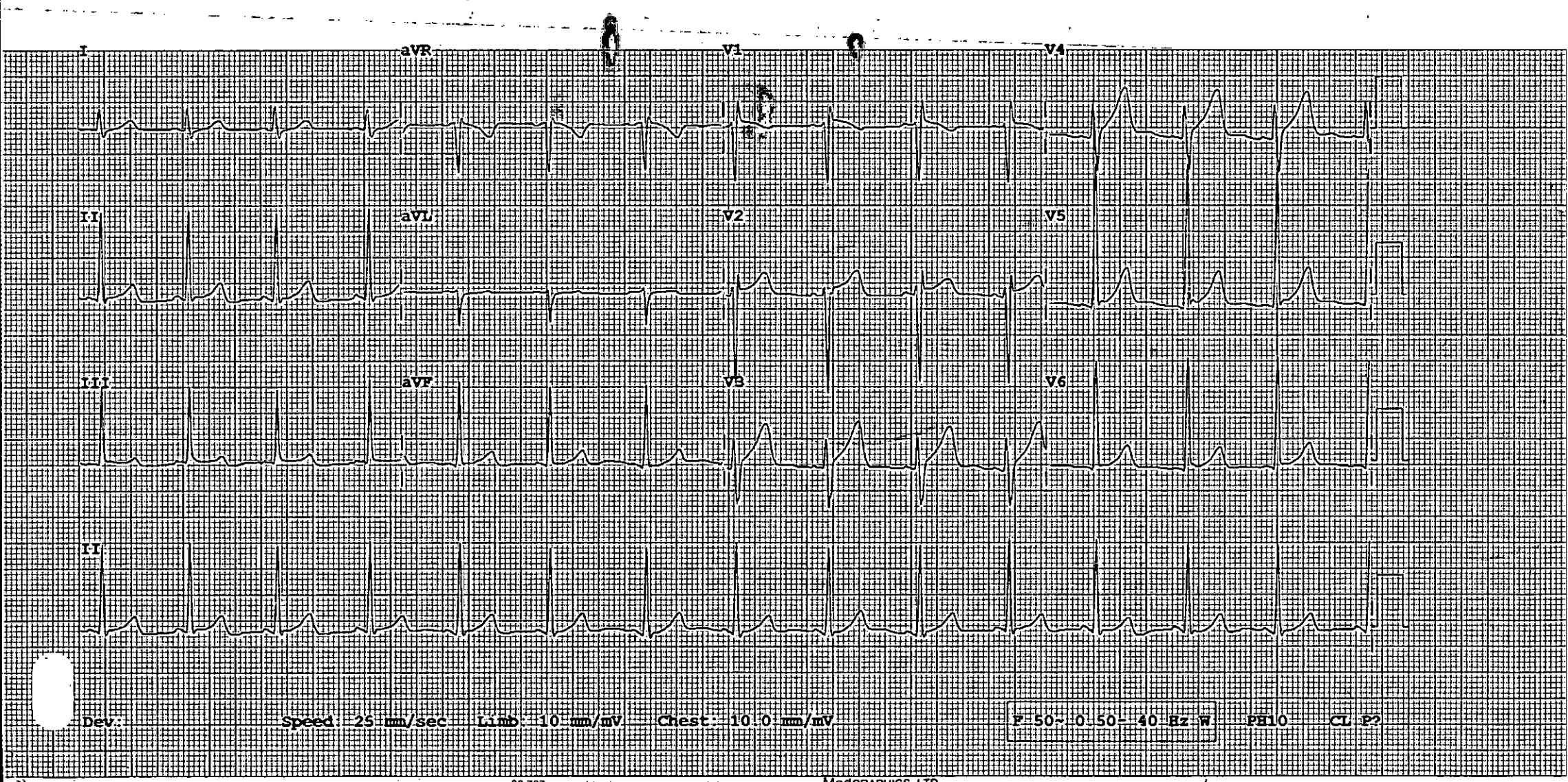
Yours Sincerely,

Dr Zoe E Smeed, Doctor

1203893450 03/08/2013 00:04:14 weir St Johns Hospital
Born 12/03/1989

Rate	86
PR	93
QRSD	89
QT	368
QTc	440
--AXIS--	
P	38
QRS	77
T	50

201009798X/E2529920 M 12/03/1989
Weir, James T
35 Pyothall Court,
Broxburn,
West Lothian,
EH52 6GX
CHI 1203893450
78260 SJ Pepper



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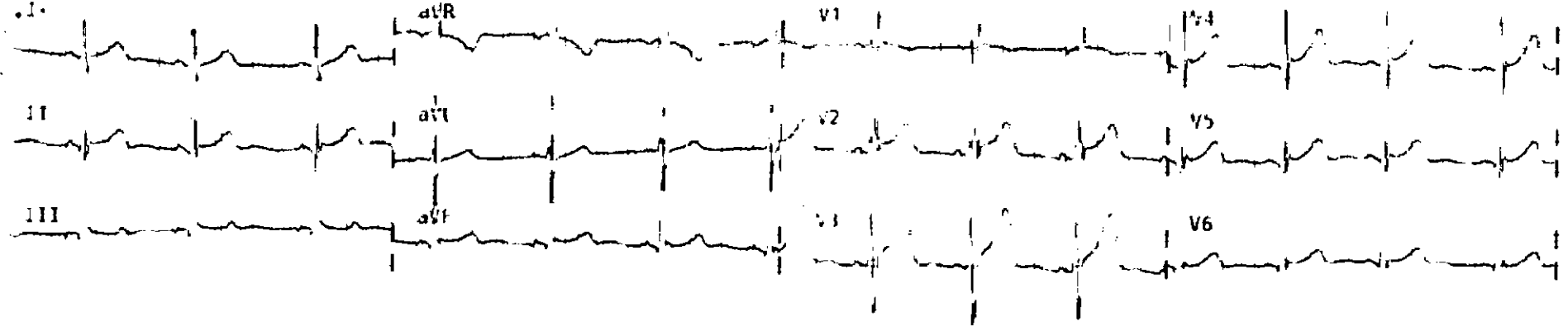


5:1

35.4

25 mm/sec Limb:10mm/mV Chest:10 mm/mV 0.05 Hz 150 Hz | PH1008 P?

Event ID :1308022258565720 ID : 07-Aug-2013 23:02:31 24 years MALE

HR	86	. Sinus rhythm	normal P axis, V-rate 50- 99
PR	95	. ST elev, probable normal early repol pattern	ST elevation, age<55
QRSD	80		
QT	349		
QTc	418		
-Axis-			
P	67		
QRS	73		
T	33		

- NORMAL ECG -

Unconfirmed diagnosis

PH100B P?

E-Pacer PATIENT REPORT

Time	23:11	Date	02/08/2013

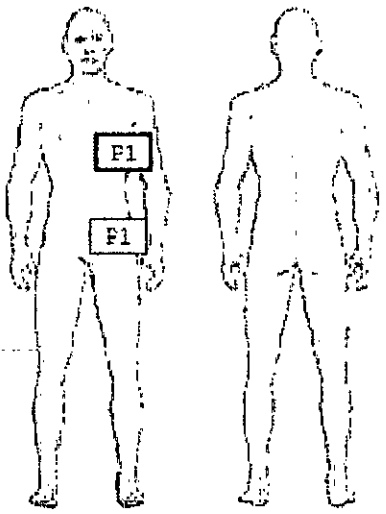
PATIENT AND INCIDENT DETAILS

Incident number	ED003705402.001
Name	JAMES WEIR
Address	35 PIATHALL BROXBURN
Age	24 year(s)
Date of birth	12/03/1989
Gender	Male
Incident location	O/S BROXBURN SWIMMING POOL 124 EAST MAIN STREET BROXBURN
Incident post code	EH52 5EQ
Incident type	EMG
Call received	02/08/2013, 22:37
Call passed	02/08/2013, 22:39
Crew mobile	02/08/2013, 22:40
Crew at scene	02/08/2013, 22:48
Crew left scene	02/08/2013, 23:03
Receiving hospital and department	STJO St. Johns Hospital Livingston

PRIMARY SURVEY

RESPONSE	
AVPU	Alert
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Normal
Respiratory rate	
CIRCULATION	
Pulse rate	Normal
Most peripheral pulse found	Radial
Cap refill rate	
Skin colour	Normal
Skin texture	Dry

INJURIES



AMPDS

Dispatch code	10D04	Clammy with Chest Pains
Final code	26A01	Sick Person, No priority symptoms, 3rd party

GCS

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

VITAL SIGNS

Time hr :	Pulse bpr	Pulse rhy	Resp. rpn	BP mm H	Cap refill	Peak flow	Blood sug	Pain scor	Temp °C	SpO2 %	GCS Tota	NEWS	RTS	ECG	Sepsis
23:00	97	-	14	141 / 95	<2 secs	-	5.1	-	35.0	98	15	4	7.6	-	2
	-	-	-	- / -	-	-	-	-	-	-	-	-	-	-	0

SEPSIS

Sepsis: Pneumonia	
Sepsis: UTI	
Sepsis: Other infection	
Sepsis: Abdo pain	
Sepsis: Diarrhoea	
Sepsis: Abdo distension	
Sepsis: Meningitis	
Sepsis: Cellulitis	
Sepsis: Septic arthritis	
Sepsis: Wound infection	
Sepsis: Infected indwelling device	
Sepsis: No signs of infection	No signs of infection

AMPLE

Allergies	
Other allergies	PENICILIN
Medication	NIL
Past history	ALCOHOL DEP.
Last eaten	
Events prior	CALLED C/O CHEST PAIN. FAMILY HISTORY OF HEART PROBS MUM DIED 3/52 FROM HEART PROBS . SISTER HAS HAD MI. C/O L SIDED CHEST PAIN AND PAIN INTO L GROIN AREA. NO OBVIOUS DISTRESS. TOLD US HE HAS HAD 2X AMOXICILIN TABS AND 2X ECIES AT AROUND 19:30. NO OTHER COMPLAINTS. NO INJURIES. 12 LEAD NSR. NO MEDS GIVEN.

Report ID	e1a34d3b-bf48-4f57-8722-4f3154bcb01c

Emergency Medicine
NHS LOTHIAN UNIVERSITY HOSPITALS DIVISION

ST. JOHN'S HOSPITAL
Howden Road West
Livingston
EH54 6PP Tel: 01506 523000

NHS Lothian

A/E no. E2529920
E2528515
Previous no.

UHPI no. 201009798X
CHI no. 1203893450

PATIENT INFORMATION

Surname Weir
Forenames James Thomas
Date of Birth 12/03/1989
Age 24 Yrs Sex M

Address 35 Pyothall Court
Broxburn
West Lothian
Postcode EH52 6GX
Telephone

[redacted]

[redacted]

Complaint abdo pain

Allergies Penicillin.

Attendances in last 12 months: 8 School:

General Practitioner

Name
SJ Pepper
Address
Dedridge Medical Group
Dedridge Health Centre
EH54 6QQ

Telephone 01506 414586

Date and Time of Attendance
02/08/2013 23:19
Incident Date & Time: 02/08/2013 22:36
Mode of Arrival
Emergency Ambulance

Source of Referral
Self Referral to A&E

T	P	RR	BP	BM	SpO2	PEFR	Height	Weight	Alco
36.9	92	14	118/77		96%				

Initial Assessment pt states took 1 amoxicillin @ 2 ets ago approx 1930 with alcohol, pt states CP & abdo pain, vomit, pt states blood in vomit

Signature [signature] Time 2345.

Print Name Triage Cat. 3

Urinalysis	Leuc	Nit	Blood	Protein	Glucose	Ketones	SG	PH

Clinical Notes

24yo ♂ PMHx

Last admission

Found called 999 as unwell yesterday. Blood + abd CP.

Abdo pain.

Started ~~about~~ new meds - unsure what they are.

? Peptic - like gastritis.

Diazepam - not taking.

Took x 2 Amoxicillin + 2x extra 'e's.

Few episodes of ~~vomiting~~ vomiting.

NAD

	Time seen	0300.
	Alcohol	
	Investigations	
	Procedures	
	Drugs given in Dept.	
	Diagnosis	

Diagnosis Gastritis

Name (print) Dawson. Signature [signature]

Clinical Notes Continued

Once Only Prescriptions

	Drug	Dose	Route	Prescribed By	Given By	Time
A						
B						
C						
D						
E						

Additional Nursing Notes

PMH

Meds

Allergies

Social History

Accompanied by

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date: 03/08/2013

Emergency Discharge Summary

Patient	James Weir 35 Pyothall Court Broxburn EH52 6GX	**CHI**	**1203893450**
		Date of Birth / Age	12/03/1989 (24 years)
		UHPI	201009798X
		A&E Attendance Number	E2529920
Attendance Date	02/08/2013		
Attendance Time	23:19		
Mode of Arrival	Emergency Ambulance		
Source of Referral	Self Referral to A&E		
Discharge Date	03/08/2013		
Discharge To	GP Care - Require Appt	**Final Triage**	3 - Urgent
		Attendances in the last 12 months	9

Dear Dr Pepper

Presentation:	abdo pain
Diagnosis:	gastritis
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

24 yo male.

Presents with on-going abdo pain, vomiting and fresh red haematemsis.
Similar to previous presentations. Has taken amoxicillin and given some Es by his friends. Also drinking.
Obs stable. Afebrile.
Abdo Soft. Chest clear.

ECG high take off.

Imp/ Abdo pain - reflux/gastritis secondary to alcohol.

Re-assured. GP F/U

Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Craig Davidson, Doctor

Emergency Medicine
NHS LOTHIAN UNIVERSITY HOSPITALS DIVISION

ST. JOHN'S HOSPITAL
Howden Road West
Livingston
EH54 6PP Tel: 01506 523000

NHS Lothian

A/E no: E2532767 AGF
E2529920
Previous no.

UHPI no. 201009798X
CHI no. 1203893450

PATIENT INFORMATION

Surname Weir
Forenames James Thomas
Date of Birth 12/03/1989
Age ~~24~~ Yrs Sex M

Address 35 Pyothall Court
Broxburn
West Lothian
Postcode EH52 6GX
Telephone

Contact Address [redacted]

Complaint Suicidal
Allergies

Attendances in last 12 months: 9
School:

General Practitioner

Name
SJ Pepper
Address
Dedridge Medical Group
Dedridge Health Centre
EH54 6QQ

Telephone 01506 414586

Date and Time of Attendance
06/08/2013 21:36
Incident Date & Time: 06/08/2013
Mode of Arrival
Police
Source of Referral
Police

T	P	RR	BP	BM	SpO	PEFR	Height	Weight	Alco
37.3	98		108/80		96%				1.52

Initial Assessment Pt attends c police - went to police station saying he felt down and suicidal. Admits to ingesting alcohol today. Police requests check over for cells. Good eye contact. Pt talkative.

Signature [illegible] Time 2150 SC815

Print Name Triage Cat. MAJOR B

Urinalyis	Leuc	Nit	Blood	Protein	Glucose	Ketones	SG	PH	

Clinical Notes

See typed on TRAK

Time seen	
Alcohol	
Investigations	
Procedures	
Drugs given in Dept.	
Diagnosis	

Diagnosis Suicidal ideation + Alcohol - Police

Name (print) [illegible] Signature [illegible]

Clinical Notes Continued

Once Only Prescriptions

	Drug	Dose	Route	Prescribed By	Given By	Time
A						
B						
C						
D						
E						

Additional Nursing Notes

PMH ADHD

Meds Concerta

Allergies Penicillin

Social History

Accompanied by Police

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date: 07/08/2013

Emergency Discharge Summary

Patient	James Weir 35 Pyothall Court Broxburn EH52 6GX	**CHI**	**1203893450**
		Date of Birth / Age	12/03/1989 (24 years)
		UHPI	201009798X
		A&E Attendance Number	E2532767
Attendance Date	06/08/2013		
Attendance Time	21:36		
Mode of Arrival	Police		
Source of Referral	Police		
Discharge Date	06/08/2013		
Discharge To	Police Care	**Final Triage**	3 - Urgent
		Attendances in the last 12 months	10

Dear Dr Pepper

Presentation:	suicidal
Diagnosis:	suicidal ideation & alcohol
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

24 yr old Male who has been in the SJH Obs ward recently for psych assessment. Continuing thoughts of suicide. In the custody of Police at the present time. Police wish check for medical fitness for cells.

No hx of head injury or drug ingestion today.

PMHx:
1.Alcoholic gastritis
2. Depression

O/E

Alocometer 1.52

Chest clear; nil added

HS pure; nil added

Abdo SNT; Nil peritonism

Nil signs of injury body wide.

BM 7.2

Police happy to take him to a place of safety in the meantime until he is assessable for psychiatry. I think this is a reasonable way forward.
Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Randal J McRoberts, Consultant

201009798X/E2535304 M 12/03/1989
Weir, James T
35 Pyothall Court,
Broxburn,
West Lothian,
EH52 6GX
CHI 1203893450
78260 SJ Pepper

Patient Sample Report

Patient

ID:	1203893450
Last Name:	**WEIR**
First Name:	**JAMES**
Gender/Age:	Male, 24 years
Birth Date:	12/03/1989
Status:	**ACCEPTED**
Analyzed:	10/08/2013 18:28:05
Sample Type:	**Venous**
Operator ID:	

Analyzer

Model:	GEM® *Premier 4000*
Area:	ERI
Name:	A&E
S/N:	11054809

Measured (37.0°C)

cH	45.2	nmol/L
pCO_2	6.0	kPa
pO_2	6.6	kPa
Na^+	142	mmol/L
K^+	3.6	mmol/L
Cl^-	incalculable	
Ca^{++}	1.04	mmol/L
Glu	7.3	mmol/L
Lac	2.6	mmol/L

CO-Oximetry

tHb	14.6	g/dL
O_2Hb	82.5	%
COHb	2.4	%
MetHb	1.9	%
HHb	13.3	%
sO_2	86.1	%

Derived

BE(B)	-1.1	mmol/L
Ca^{++}(7.4)	1.02	mmol/L
HCO_3^-(c)	24.8	mmol/L
HCO_3^-std	23.6	mmol/L
Hct(c)	44	%

Operator Entered

Temp	37.0	°C

201009798X/E2535304 M 12/03/1989
Weir, James T
35 Pyothall Court,
Broxburn,
West Lothian,
EH52 6GX
CHI 1203893450
78260 SJ Pepper

53613

atient:

ultistix® 10 SG	
est date	10-08-2013
ime	6:49PM
perator	
est number	0404
olor	Not Entered
larity	Not Entered

GLU Negative
BIL Negative
KET Negative
SG <=1.005
BLD Negative
pH 6.0
PRO Negative
UBG 3.2 umol/L
NIT Negative
LEU Negative

Patient Sample Report

Patient

ID:	1203893450
Last Name:	**WEIR**
First Name:	**JAMES**
Gender/Age:	Male, 24 years
Birth Date:	12/03/1989
Status:	**ACCEPTED**
Analyzed:	10/08/2013 20:16:32
Sample Type:	**Venous**
Operator ID:	

Analyzer

Model:	GEM® *Premier 4000*
Area:	ERI
Name:	A&E
S/N:	11054809

Measured (37.0°C)

cH	46.1	nmol/L
pCO_2	6.1	kPa
pO_2	9.7	kPa
Na^+	144	mmol/L
K^+	3.8	mmol/L
Cl^-	incalculable	
Ca^{++}	1.02	mmol/L
Glu	5.7	mmol/L
Lac	1.7	mmol/L

CO-Oximetry

tHb	13.7	g/dL
O_2Hb	92.2	%
COHb	2.4	%
MetHb	1.7	%
HHb	3.7	%
sO_2	96.1	%

Derived

BE(B)	-1.3	mmol/L
Ca^{++}(7.4)	1.00	mmol/L
HCO_3^-(c)	24.8	mmol/L
HCO_3^-std	23.8	mmol/L
Hct(c)	41	%

Operator Entered

Temp	37.0	°C

201009798X /E2535304 M
WEIR James
12-Mar-89 CHI: 120 389 3450
78260 SJ Pepper
35 Pyothall Court West Lothian
EH52 6GX

Trial version no.2

RIE ED Admission Nursing Care Plan

Admission Nurse Signature .....

Presenting History :

D+1

Date/ Time	Progress Notes	Signature
10/08/19	Observations ES charted - SEWS 1 BP 98/48. Unable to carry out glucometer as patient non-compliant.	
1730	GCS 15 - PEARL - awaits medical r/v.	

Standard Admission Orders *(Please tick when completed)*	Tick	Optional Admission Orders *(Please tick when completed)*	Tick
Undress patient into gown	✓	Connected to acuity	
Transfer to Sheet and provide blankets if required		12 Lead ECG	
Clothing bagged, labelled & stored under trolley		Nurse X-Ray	
Nameband attached		Nurse Analgesia	
Valuables listed if required and locked in ED safe		Glasgow Coma Scale	
Vital Signs recorded .		Nurse IV Venepuncture	
Pain Score recorded on Shock Chart		Nurse IV Cannulation	
Blood sugar level recorded		Weight Height	
SEWS Score recorded		Peak Flow 1. 2. 3.	
IV Cannula (if required) dated		ASU : Tested Sent	
Relatives Informed		HCG specimen	
4AT Score *On all patients over 65years, to be admitted* — Score =		E&S BP if indicated	

Discharge Orders	Y	N	NA	Discharge Orders	Y	N	NA
Advice leaflets given				Out Patient / Clinic Appointment arranged			
Own medications returned				Relatives Aware of Discharge			
New medications explained				Discharge Lounge Arranged / Checklist complete			
Clothing returned				Social Services required & contacted			
Valuables returned				SAS Transport required			
Cannula Removed				SAS Ref No			

Signature(if patient escorted) of Receiving Ward Nurse	
Name (if telephone handover) of Receiving Ward Nurse	

If a change or abnormality is noted in any of the following indicators, please document and inform relevant Care Provider

Time of Round		1745				
Initials of Care Round Leader						
Review frequency of Vital Signs & Cardiac Monitoring						
Vital signs assessment	*Please indicate frequency*	15-30min.				
Cardiac monitoring required	*Please indicate Y/ N*	Y / N	Y / N	Y / N	Y / N	Y / N
Patient Screening: Please tick appropriate box						
Mobility	Fully weight bearing	N.				
	Requires assistance and / or uses walking aid	/				
	Non Weight bearing	/				
Continence	Patient is fully Continent	N				
	Patient is incontinent with no catheter in situ	(?pt was wet on admission)				
	Patient has catheter in situ					
Nutrition	Patient appears well nourished and able to eat and drink					
	Patient is malnourished					
	Please record weight & height					
Visual Skin Inspection	Skin is intact					
	Skin is red with vulnerable areas / broken down					
	If indicated complete Waterlow Assessment & attach documentation					
Swallow Assessment If indicated perform Swallow Risk Assessment & attach documentation		Y / (N)	Y / N	Y / N	Y / N	Y / N
Falls Risk Assessment If risk identified, please perform Falls Risk Assessment & attach documentation		Y / (N)	Y / N	Y / N	Y / N	Y / N
Cognitive Impairment / Delirium / Dementia If "yes", please complete Risk Assessment Form & attach documentation		Y / (N)	Y / N	Y / N	Y / N	Y / N
Vulnerable Adult / Child Protection Issue Complete TRAK discharge for under 16yrs		Y / (N)	Y / N	Y / N	Y / N	Y / N
Nutrition / Hydration Offered / Provided : Please indicate O / P						
Please specify any Special Diet / Dietary requirements / Feeding assistance		(N)				
Drink	Offered / Provided	O / P	O / P	O / P	O / P	O / P
Snack	Offered / Provided	O / P	O / P	O / P	O / P	O / P
Catered Meal	Offered / Provided	O / P	O / P	O / P	O / P	O / P
Communication Aids:- Please tick if appropriate						
Hearing	Normal	Y				
	Impaired					
If hearing aid(s) used, please ensure in situ and turned on						
Vision	Normal					
	Impaired					
please ensure any visual aids are available to & within reach of patient						
Sign Language / Interpretation Assistance If required, please inform NIC		Y / N	Y / N	Y / N	Y / N	Y / N
Invasive Devices: please tick if in situ record appropriately in shock chart						
Arterial Line / Central Line	check position and patency	/				
Urinary Catheter	check position & free drainage					
NG tube / PEG tube / Tracheostomy	check patency					
Infusion Device	check infusion rate, site, remaining volume					
Family Communication – please tick						
Patient & Relatives made aware of any changes		N				

Police accompanying pt on admission

LHB 925

NHS Lothian
University Hospital Services
Department of Emergency Medicine

Clinical Director Dr. D.Caesar
Clinical Nurse Manager Mr. Neil Boyle
THE ROYAL INFIRMARY OF EDINBURGH
51 Little France Crescent, Edinburgh EH16 4SU
Tel: 0131 242 1300 • Fax: 0131 242 1344

NHS Lothian

A/E no. E2535304
Previous no E2532767
UHPI no. 201009798X
CHI no. 1203893450

PATIENT INFORMATION

Surname Weir
Forename James Thomas
Date of Birth 12/03/1989
Age Yrs Sex M

Address 35 Pyothall Court
Broxburn
West Lothian
Postcode EH52 6GX
Telephone

Contact Address [redacted]

Complaint D&I
Allergies

Attendances in last 12 months: 10 School:

General Practitioner

SJ Pepper
Address
Dedridge Medical Group
Dedridge Health Centre
EH54 6QQ

Telephone 01506 414586

Date and Time of Attendance
10/08/2013 17:28
Incident Date & Time: 10/08/2013
Mode of Arrival
Emergency Ambulance
Source of Referral
999 Emergency

Temp	Pulse Rate	BP	RR	Sats $O2_{/air}$	BM	PF best	Alcometer	GCS	SEWS
36	78	94/43	16	96% R/A	6.2			/15 e_v_m	

Presenting Complaint: D+I ? LOC

History of Presenting Complaint: Found by Canal. with empty bottles laying

Assessment: GCS (9)

Triaged no.: 1 2 (3) 4 7 *(circle)* Triaged to: HD / IC / exam / WR / GP *(circle)* Senior Doctor Informed? Y / N time.....

BLOODS Routine ☐ Troponin ☐ Amylase ☐ TOX ☐ Other ☐ _____ Bloods Done ☐ _____
time due..... (time of OD.....)

ECG Required ☐ Done ☐ Time.....

X-RAYS CXR ☐ Other ☐ _____

URINALYSIS Required ☐ Done ☐ HCG: + / − *(circle)* MSU Sent: Y / N

PAIN SCORE ___/10 Analgesia ☐ Time.....

Are any 2 of the following present:

1. temp >383 or <36 ☐
2. HR > 90 ☐
3. RR > 20 ☐
4. WCC > 12 or < 4 ☐
5. BM > 7 (+ not diabetic) ☐
6. age > 70 ☐
7. signs of infection ☐

>2 → **think sepsis and triage up**

FAST + / − *(circle)* Onset Time: .....
Stroke Test

Book Bed: CAA ☐ Ortho ☐ Other ☐ .....

Speciality Informed ☐ time .....

Time of Triage: 1731

Triaged by: *(sign)* [signature]

(print) [signature]

Clinical Notes

Care Providers Name:..... Signature:.....

NHS Lothian

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Dr SJ Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date: 12/08/2013

Emergency Discharge Summary

Patient	James Weir 35 Pyothall Court Broxburn West Lothian EH52 6GX	**CHI**	**1203893450**
		Date of Birth / Age	12/03/1989 (24 years)
		UHPI	201009798X
		A&E Attendance Number	E2535304
Attendance Date	10/08/2013	**Contact**	[redacted]
Attendance Time	17:28		
Mode of Arrival	Emergency Ambulance		
Source of Referral	999 Emergency		
Discharge Date	10/08/2013		
Discharge To			

Dear Dr SJ Pepper

Presentation: D&I

24 year old man

Pc:
Found unconscious by a canal

Bg:
Multiple previous overdoses
ADHD
Alcohol excess
Alcoholic gastritis

HxPc:
Found next to a canal with nearby bottle of schnapps
Rousable on arrival - sometimes aggressive
Unable to ascertain further history
Says he can't remember taking anything nor what has happened

Oe:
TT36.1, P78, BP 94/43, RR16, SpO2 96%, BM6.2
Pupils slightly dilated
GCS 9-12, rousable to sternal rub and occasionally alert
Resp clear
CVS 1+2+0
Abdo SNT
ECG sinus. Normal QTc

Imp:
Alcohol OD +/- recreational drugs +/- OD

Plan:
Pabrinex
Fluids
Bloods inc paracetamol levels
CAA 6 or home if improved in next 2 hours

VBG: Lac 2.6, H+ 45.2, BE -1.1, HCO3 24.8

20.50:

James more responsive now - telling me he has taken 4 ecstacy tablets that he got from a friend
They were green and had a frogs leg as a marker.

During the last hour of his stay here he has had several vacant episodes lasting around 1-2 minutes where he is not responsive to pain. He has had some slight jerking of his right arm just before coming around. Has been put on a monitor. Normal cardiac rhythm throughout.

Yours Sincerely,

Dr Seamus John Brayne, Doctor

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date: 13/08/2013

Emergency Discharge Summary

Patient	James Weir 35 Pyothall Court Broxburn EH52 6GX	**CHI**	**1203893450**
		Date of Birth / Age	12/03/1989 (24 years)
		UHPI	201009798X
		A&E Attendance Number	E2536915
Attendance Date	12/08/2013		
Attendance Time	20:41		
Mode of Arrival	Emergency Ambulance		
Source of Referral	Self Referral to A&E		
Discharge Date	13/08/2013		
Discharge To	SJH Medical Assessment Unit	**Final Triage**	3 - Urgent
		Attendances in the last 12 months	12

Dear Dr Pepper

Presentation:	od
Diagnosis:	None
Procedures:	None
Drugs given in A&E:	None

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info

Took 32 x 500mg paracetamol at about 7pm, took them over the hour. had a few cans of cider today. Also had 2 prescribed thiamine tabs. usually drinks 8 cans cider/day. Attends AA on sat and sunday- lost his 'buddies' numbers when he lost his fone. Mum died recently. in the army - on annual leave. Feels his problems will get better when back in the army, or back in glasgow near his family. Lives alone. Feeling nauseous with abdominal pain. Weighs 11 stone (70kg). reports he hasnt taken any other drugs. seen by psych on 8/8/13- see trak entry.

PMH/ nil
Meds- thiamine, omeprazole, diazepam, gaviscon (from ecs)
Allergies: penicillin

O/E temp 37.4, hR 81, BP 123/ 73, RR 18, sats 98%, BM 5.8
HS I+II+O reg, chest clear, abdomen SNT. Not jaundiced. smells strongly of alcohol.

Imp/ paracetamol od. 213mg/kg taken

Plan/bloods incl INR, LFTs and paracetamol level at 2300
anti-emetics. Psych review tomo

0000
Note paracetamol level 82 at 5hrs. On treatment line
Treat with NAC
Admit medicine

Any queries please contact A&E Reception on 01506 523011

Yours Sincerely,

Dr Jasmine Samuel, Doctor

In Patient Records

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Marriott
Winchburgh Medical Practice
Winchburgh Health Centre
Niddry Road
Winchburgh
EH52 6RX

Date: 11/04/2013

Inpatient Discharge Summary

Patient	James Weir 28 Peveril Rise Livingston EH54 6NU	**CHI** **Date of Birth / Age** **UHPI**	**1203893450** 12/03/1989 (24 years) 201009798X
Specialty	Accident and Emergency	**Admission Date**	09/04/2013
Ward	SJH Obs Ward		
Consultant	Mr Martin DJ McKechnie	**Discharge Date**	10/04/2013

Dear Dr Marriott

PRINCIPAL DIAGNOSIS/PROCEDURE
This gentleman was admitted to the observation ward following presentation to A+E with abdominal pain and vomitting.

He reports a history of 3-4weeks of epigastric pain and vomitting. He think this initally began following an alcohol binge and at that point stopped drinking alcohol. The pain and vomitting however has continued, with Mr Weir vomitting frequently after eating. He is a poor historian and it is not clear whether any of these vomits have contained blood or been coffee ground in appearance. His GP had started him on omperazole to little effect. On the day of admission he reported his abdominal pain was worse than previous and he reported coffee-ground vomit.

On admission his observations were stable. on exmaination he was pale but otherwise appeared well. His heart sounds were pure and his chest clear to auscultation.
His abdomen was soft but tender with voluntary gaurding in the epigastrium, however there was no evidence of peritonism. PR revealed no blood or stool.

His blood work revealed a stable Hb and normal urea.
He had been due to have an out-patient upper GI endoscopy on Friday 12th April, however as the clinical picture seemed to have progressed his endoscopy was brought forward and done on this admission. It revealed moderate duodentisis with patchy erythema but no bleeding. Urease test for H-Pylori was taken (results awaited).

Following his procedure Mr Weir was unwilling to await further senior medical review and self-discharged. He has been advised to continue with his prescribed omeprazole.
We will advise the GP of any positive H. Pylori result and Mr Weir should have eradication therapy if H. Pylori positive.

TREATMENT
As above
FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL
Nil
CHANGES TO DRUGS SINCE ADMISSION
Nil
PREVIOUS ADVERSE DRUG REACTIONS
Penicillin
SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS

GP to please consider the following...

H. Pylori results outstanding, we will advise you of the results.
Should you need further information please contact...
observation ward, St John's
Information contained in this letter has been discussed with the patient/carer.

Yours sincerely.....

Staff Signature..... PrintName.....

Designation..... Date..... Time.....

Patient/Carer Signature.....

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date: 23/04/2013

Inpatient Discharge Summary

Patient	James Weir 28 PEVERIL RISE DEDRIDGE Livingston EH54 6NU	**CHI** **Date of Birth / Age** **UHPI**	**1203893450** 12/03/1989 (24 years) 201009798X
Specialty	General Medicine	**Admission Date**	02/04/2013
Ward	SJH Medical Assessment Unit		
Consultant	Dr HR Gillett	**Discharge Date**	03/04/2013

Dear Dr Pepper

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info
Omeprazole Capsules	40 MG	ONCE DAILY	Long Term	Amount Dispensed: 26 caps
Thiamine Hcl Tablets	300 MG	In the MORNING	Long Term	Amount Dispensed: 84 tabs
Macrogol 3350 Compound	1 SACH(S)	In the MORNING	Long Term	Amount Dispensed: 1op

FINAL DISCHARGE SUMMARY

DIAGNOSIS
Vomiting
Alcohol excess

This 24-year-old man was admitted with epigastric pain and intermittent vomiting. He has been referred to the Gastroenterology Service and has an endoscopy booked for the 12th of April. He also reported severe constipation. On the day of admission he reported vomiting five times in total. The last few vomits had a few streaks of dark coloured blood. He reported not drinking for 2 weeks when he was interviewed on the ward, but in Accident & Emergency he reported having a binge of alcohol a few days earlier.

On examination his observations were normal. His cardiovascular and respiratory systems were normal. He had some tenderness in the epigastric area but no rebound or guarding.

His bloods showed a haemoglobin of 141 and MCV of 80. Otherwise his biochemistry was normal. ECG showed sinus rhythm and chest x-ray was normal.

He was commenced on a proton pump inhibitor and by the following morning was managing to take oral intake. He was therefore discharged to attend for his outpatient endoscopy on the 12th of April.

Yours sincerely

Dr H R Gillett
Consultant Gastroenterologist

Dictated 10.4.13

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date: 30/07/2013

Inpatient Discharge Summary

Patient	James Weir 35 Pyothall Court Broxburn EH52 6GX	**CHI** **Date of Birth / Age** **UHPI**	**1203893450** 12/03/1989 (24 years) 201009798X
Specialty	Accident and Emergency	**Admission Date**	27/07/2013
Ward	SJH Obs Ward		
Consultant	Mr Martin DJ McKechnie	**Discharge Date**	27/07/2013

Dear Dr Pepper

Dear Doctor,

This 24 year old gentleman was admitted to the observation ward on 26/7/13 with suicidal ideation. Mr Weir had recently been discharged from ward 17 with suicidal thoughts and low mood. Since his discharge he had been struggling to cope at home with ongoing suicidal ideation. Mr Weir had also been suffering from abdominal pain that radiated into his chest. He had associated vomiting. He also had noted some fresh PR bleeding on moving his bowels.

PMH; Depression. ADHD. ETOH XS. Haematemesis- UGIE April 13 moderate duodenitis with erythema. No active bleeding.

On admission Mr Weir was tachycardic. He had mild epigastistric pain on palpation. Abdomen was soft with bowel sounds present. Nil else to note on general examination. ECG NAD. PR exam nil to note.

Mr Weir was admitted to the observation ward for psychiatric review. The psychiatric team felt that Mr Weir would not benefit from admission on this presentation. He was discharged home with community support.

PRINCIPAL DIAGNOSIS/PROCEDURE
1. Suicidal Ideation
2. Abdominal pain.

TREATMENT
As above

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL
Nil

CHANGES TO DRUGS SINCE ADMISSION
Nil

PREVIOUS ADVERSE DRUG REACTIONS

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS
Nil

GP to please consider the following...
Nil

Should you need further information please contact...
Observation ward SJH

Information contained in this letter has been discussed with the patient/carer.

Yours sincerely.....
Dr Lily Baird
FY1

Staff Signature..... PrintName.....

Designation..... Date..... Time.....

Patient/Carer Signature.....

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date: 08/08/2013

Inpatient Discharge Summary

Patient	James Weir 35 Pyothall Court Broxburn EH52 6GX	**CHI** **Date of Birth / Age** **UHPI**	**1203893450** 12/03/1989 (24 years) 201009798X
Specialty	Accident and Emergency	**Admission Date**	01/08/2013
Ward	SJH Obs Ward		
Consultant	Dr Beth Threlfall	**Discharge Date**	01/08/2013

Dear Dr Pepper

PRINCIPAL DIAGNOSIS/PROCEDURE
1.Alcoholic gastritis
2. Depression

This 24 year old man was admitted to the Observation ward/SJH on 31/7/13 after presenting to A&E with low mood and abdominal pain. He was recently discharged from Ward 17 and apparently someone had told him that it was the wrong ward for him which made him upset. He has been under stress following the death of his mother and had taken a recent overdose. He went home that day and drank a lof of buckfast and lager. On presentation he complained of low mood and abdominal pain. He had vomited a few times. He denied any overdose.
O/E: smelt of ETOH, heart sounds normal, chest clear, abdomen mild tenderness epigastric region, no guarding, no peritonism.

TREATMENT
Bloods: NAD
He was admitted to the Observation ward for review by psychiatry. He was felt safe for discharge home with follow up with psychitary in place.

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL
Follow up made after his recent discharge from ward 17

CHANGES TO DRUGS SINCE ADMISSION
nil

PREVIOUS ADVERSE DRUG REACTIONS

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS

GP to please consider the following...

Should you need further information please contact... Obs Ward, SJH

Information contained in this letter has been discussed with the patient/carer.

Yours sincerely.....Dr. Alice E. Neffendorf

Staff Signature..... PrintName.....

Designation..... Date..... Time.....

Patient/Carer Signature.....

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date: 09/08/2013

Inpatient Discharge Summary

Patient	James Weir 35 Pyothall Court Broxburn EH52 6GX	**CHI** **Date of Birth / Age** **UHPI**	**1203893450** 12/03/1989 (24 years) 201009798X
Specialty	General Medicine	**Admission Date**	28/07/2013
Ward	Ward 9 SJH		
Consultant	Dr JD Walker	**Discharge Date**	30/07/2013

Dear Dr Pepper

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info
Thiamine Hcl Tablets	300 MG	ONCE DAILY	Long Term	Strength:100mgs Amount Dispensed:21
Omeprazole Capsules	20 MG	TWICE DAILY	Long Term	Strength:20mgs Amount Dispensed:18
Peptac Suspension	20 ML	FOUR times daily	Short Term	Amount Dispensed: 450mls
Macrogol 3350 Compound	1 SACH(S)	As Required	Short Term	Amount Dispensed: 7

Final Discharge Summary:

Dear Dr Pepper

Diagnosis:

1. Paracetamol overdose
2. Psychiatric illness

Medication on Discharge - As per Immediate Discharge Letter.

I have nothing to add to the Immediate Discharge Letter. His post-treatment liver function tests were normal.

Yours sincerely

Dr J. D. Walker
Consultant Physician

Secretary: 01506 523855

JDW/MIS

Date Dictated: 02/08/13 Date Typed: 05/08/13

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date: 30/08/2013

Inpatient Discharge Summary

Patient	James Weir 35 Pyothall Court Broxburn EH52 6GX	**CHI** **Date of Birth / Age** **UHPI**	**1203893450** 12/03/1989 (24 years) 201009798X
Specialty	General Medicine	**Admission Date**	13/08/2013
Ward	SJH Medical Assessment Unit		
Consultant	Dr Ali Harmouche	**Discharge Date**	14/08/2013

Dear Dr Pepper

FINAL DISCHARGE SUMMARY

In addition to this man's immediate discharge summary I would like to ask you to repeat his full blood count in two weeks' time and to check his haematinics as he was found to be anaemic with a haemoglobin of 121 which was stable during his stay and there was no sign of active bleeding and normal clotting. I note that his haemoglobin was 120 in July of this year and this was normalised to 140 in early August to fall back to 120 again. I note that his kidney function and liver function were completely normal. If his iron and ferritin would be low or his haemoglobin continues to be on the low side I would suggest referring him to the GI for possible upper GI endoscopy. Please do not hesitate to contact me if you need any assistance.

Yours sincerely

Dr Ali Harmouche
Acute Physician

AXH/BL
Enquiries to Beth Love (Tel:01506 523025)

Progress Notes

Patient & GP Information

UHPI Number	201009798X
CHI Number	1203893450
Episode Number	I0003174083
Surname/Forename	Weir, James
Date of Birth	3/12/89
Sex	Male
Patient Address.	31 Dumbeg Park Edinburgh EH14 3JA
Registered GP	UH Rehman
GP Address.	Alba Medical Group Glasgow,Erskine Clinic,Bargarran Centre,Erskine PA8 6BS

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Patient & GP Information

201009798X	201009798X
1203893450	1203893450
I0003178768	I0003244476
Weir, James	Weir, James
3/12/89	3/12/89
Male	Male
31 Dumbeg Park Edinburgh EH14 3JA	31 Dumbeg Park Edinburgh EH14 3JA
UH Rehman	UH Rehman
Alba Medical Group Glasgow,Erskine Clinic,Bargarran Centre,Erskine PA8 6BS	Alba Medical Group Glasgow,Erskine Clinic,Bargarran Centre,Erskine PA8 6BS

Patient & GP Information

201009798X	201009798X
1203893450	1203893450
I0003249678	I0003250034
Weir, James	Weir, James
3/12/89	3/12/89
Male	Male
31 Dumbeg Park Edinburgh EH14 3JA	31 Dumbeg Park Edinburgh EH14 3JA
UH Rehman	UH Rehman
Alba Medical Group Glasgow,Erskine Clinic,Bargarran Centre,Erskine PA8 6BS	Alba Medical Group Glasgow,Erskine Clinic,Bargarran Centre,Erskine PA8 6BS

Patient & GP Information

201009798X	201009798X
1203893450	1203893450
I0003251836	I0003252600
Weir, James	Weir, James
3/12/89	3/12/89
Male	Male
31 Dumbeg Park Edinburgh EH14 3JA	31 Dumbeg Park Edinburgh EH14 3JA
UH Rehman	UH Rehman
Alba Medical Group Glasgow,Erskine Clinic,Bargarran Centre,Erskine PA8 6BS	Alba Medical Group Glasgow,Erskine Clinic,Bargarran Centre,Erskine PA8 6BS

Patient & GP Information

201009798X	201009798X
1203893450	1203893450
I0003259061	I0003260117
Weir, James	Weir, James
3/12/89	3/12/89
Male	Male
31 Dumbeg Park Edinburgh EH14 3JA	31 Dumbeg Park Edinburgh EH14 3JA
UH Rehman	UH Rehman
Alba Medical Group Glasgow,Erskine Clinic,Bargarran Centre,Erskine PA8 6BS	Alba Medical Group Glasgow,Erskine Clinic,Bargarran Centre,Erskine PA8 6BS

Surname/Forename	Weir, James
UHPI Number	201009798X

Episode Number	I0003174083

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0003174083 Dr HR Gillett 4/3/13 10:38 Heather MacColl	PRINCIPAL DIAGNOSIS/PROCEDURE,1) haematemesis,2) constipation,,Admitted after several episodes of vomiting at home which contained small amounts of dark coloured blood and a few clots. This has been a problem for a few months now and is currently awaiting an UGIE aas arranged by the GP next week. He has a fluctuating alcohol history and had been binge drinking at the weekend. He remained stable throughout his stay in MAU with Hb of 141.,,TREATMENT,,omeprazole,,FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL,,UGIE next week,,CHANGES TO DRUGS SINCE ADMISSION,,Started omperazole, thiamine, movicol, ,PREVIOUS ADVERSE DRUG REACTIONS,,Nil,, ,GP to please consider the following..., ,Should you need further information please contact...MAU, ,Information contained in this letter has been discussed with the patient/carer.,,Yours sincerely....., ,Staff Signature..... PrintName.....MACCOLL.....,,Designation.....CT2..... Date..... 3/4/13..... Time.....1040.....,,Patient/Carer Signature....., ,This is an immediate discharge letter and a further letter may follow. ,

Surname/Forename	Weir, James
UHPI Number	201009798X

Episode Number	I0003174083

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0003174083 Dr HR Gillett 4/18/13 10:56 Elizabeth Kennedy	FINAL DISCHARGE SUMMARY,,DIAGNOSIS,Vomiting,Alcohol excess,,This 24-year-old man was admitted with epigastric pain and intermittent vomiting. He has been referred to the Gastroenterology Service and has an endoscopy booked for the 12th of April. He also reported severe constipation. On the day of admission he reported vomiting five times in total. The last few vomits had a few streaks of dark coloured blood. He reported not drinking for 2 weeks when he was interviewed on the ward, but in Accident & Emergency he reported having a binge of alcohol a few days earlier.,,On examination his observations were normal. His cardiovascular and respiratory systems were normal. He had some tenderness in the epigastric area but no rebound or guarding.,,His bloods showed a haemoglobin of 141 and MCV of 80. Otherwise his biochemistry was normal. ECG showed sinus rhythm and chest x-ray was normal.,,He was commenced on a proton pump inhibitor and by the following morning was managing to take oral intake. He was therefore discharged to attend for his outpatient endoscopy on the 12th of April.,,Yours sincerely ,,,,Dr H R Gillett,Consultant Gastroenterologist ,,Dictated 10.4.13

Surname/Forename	Weir, James
UHPI Number	201009798X

Episode Number	I0003174083

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0003178768 Mr Martin DJ McKechnie 4/10/13 09:18 Mhairi F Stewart	PRINCIPAL DIAGNOSIS/PROCEDURE,This gentleman was admitted to the observation ward following presentation to A+E with abdominal pain and vomitting.,,He reports a history of 3-4weeks of epigastric pain and vomitting. He think this initally began following an alcohol binge and at that point stopped drinking alcohol. The pain and vomitting however has continued, with Mr Weir vomitting frequently after eating. He is a poor historian and it is not clear whether any of these vomits have contained blood or been coffee ground in appearance. His GP had started him on omperazole to little effect. On the day of admission he reported his abdominal pain was worse than previous and he reported coffee-ground vomit.,,On admission his observations were stable. on exmaination he was pale but otherwise appeared well. His heart sounds were pure and his chest clear to auscultation.,His abdomen was soft but tender with voluntary gaurding in the epigastrium, however there was no evidence of peritonism. PR revealed no blood or stool.,,His blood work revealed a stable Hb and normal urea.,He had been due to have an out-patient upper GI endoscopy on Friday 12th April, however as the clinical picture seemed to have progressed his endoscopy was brought forward and done on this admission. It revealed moderate duodentisis with patchy erythema but no bleeding. Urease test for H-Pylori was taken (results awaited).,,Following his procedure Mr Weir was unwilling to await further senior medical review and self-discharged. He has been advised to continue with his prescribed omeprazole.,We will advise the GP of any positive H. Pylori result and Mr Weir should have eradication therapy if H. Pylori positive.,, ,TREATMENT, As above,FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL, Nil,CHANGES TO DRUGS SINCE ADMISSION, Nil,PREVIOUS ADVERSE DRUG REACTIONS, Penicillin,SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS, ,GP to please consider the following..., H. Pylori results outstanding, we will advise you of the results.,Should you need further information please contact..., observation ward, St John's,Information contained in this letter has been discussed with the patient/ carer.,,Yours sincerely....., ,Staff Signature..... PrintName.....,,Designation..... Date..... Time.....,,Patient/Carer Signature....., ,

Surname/Forename	Weir, James
UHPI Number	201009798X

Episode Number	I0003174083

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0003244476 Dr Prakash Shankar 7/22/13 12:05 Dr Rob M Waller	PRINCIPAL DIAGNOSIS/PROCEDURE, alcohol dependency, low mood, possible PTSD, homeless,TREATMENT, detox and stabilisation, recent bereavement [of mother],FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL, OPD5 in one week [dr shankar's team], Moving into health homeless CPN team, contact with combat stress / VFP [if able to - some confusion as he is still serving in the army but on the sick],CHANGES TO DRUGS SINCE ADMISSION, given small supply of diazepam on discharge, post-alcohol vitamins as above, not on antidepressant - might be a future optio0n,PREVIOUS ADVERSE DRUG REACTIONS, NKDA,SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS, homeless presentation,GP to please consider the following..., ,Should you need further information please contact..., ,Information contained in this letter has been discussed with the patient/carer.,,Yours sincerely....., ,Staff Signature..... PrintName.....,,Designation..... Date..... Time.....,,Patient/Carer Signature....., ,This is an immediate discharge letter and a further letter may follow. ,

Surname/Forename	Weir, James
UHPI Number	201009798X

Episode Number	I0003174083

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0003249678 Mr Martin DJ McKechnie 7/29/13 09:30 Lillian Baird	Dear Doctor,,,This 24 year old gentleman was admitted to the observation ward on 26/7/13 with suicidal ideation. Mr Weir had recently been discharged from ward 17 with suicidal thoughts and low mood. Since his discharge he had been struggling to cope at home with ongoing suicidal ideation. Mr Weir had also been suffering from abdominal pain that radiated into his chest. He had associated vomiting. He also had noted some fresh PR bleeding on moving his bowels. ,,PMH; Depression. ADHD. ETOH XS. Haematemesis- UGIE April 13 moderate duodenitis with erythema. No active bleeding. ,,On admission Mr Weir was tachycardic. He had mild epigastistric pain on palpation. Abdomen was soft with bowel sounds present. Nil else to note on general examination. ECG NAD. PR exam nil to note. ,,Mr Weir was admitted to the observation ward for psychiatric review. The psychiatric team felt that Mr Weir would not benefit from admission on this presentation. He was discharged home with community support. ,,PRINCIPAL DIAGNOSIS/PROCEDURE,1. Suicidal Ideation,2. Abdominal pain. ,,TREATMENT,As above, ,FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL,Nil, ,CHANGES TO DRUGS SINCE ADMISSION,Nil, ,PREVIOUS ADVERSE DRUG REACTIONS, ,SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS,Nil, ,GP to please consider the following...,Nil, ,Should you need further information please contact...,Observation ward SJH, ,Information contained in this letter has been discussed with the patient/carer.,,Yours sincerely.....,Dr Lily Baird,FY1, ,Staff Signature..... PrintName.....,,Designation..... Date..... Time.....,,Patient/Carer Signature.....

Surname/Forename	Weir, James
UHPI Number	201009798X

Episode Number	I0003174083

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0003250034 Dr JD Walker 7/30/13 09:21 Dr Alexandre P Eros	PRINCIPAL DIAGNOSIS/PROCEDURE,1) Paracetamol OD,,This 24 year old man presented with after taking 15g of paracetamol, ampetamine (unkown quantity) and diazepam 50mg. He was discharged from Ward 17 (psychiatry at SJH). Paracetamol level at 4 hours was 58 and he was commenced on NAC. He was also describing some abdominal pain which was in keeping with gastritis previously seen on endoscopy. ,,He was observed on the ward for a few days after completing his NAC treatment. The psychiatric team reviewed him and felt that he did not need repeat admission to their ward at the present time. He has community follow up with them as previously arranged. He was discharged on the 30/7, obs were stable and he had been mobilising around the hospital without any difficulties.,,TREATMENT as above, ,FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL psychiatry follow up as previously arranged, ,CHANGES TO DRUGS SINCE ADMISSION omperazole 20mg bd started, ,PREVIOUS ADVERSE DRUG REACTIONS, ,SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS nil, ,GP to please consider the following..., ,Should you need further information please contact...Dr Walker's team (General Medicine) at SJH, ,Information contained in this letter has been discussed with the patient/carer.,,Yours sincerely....., ,Staff Signature..... PrintName.....,,Designation..... Date..... Time.....,,Patient/Carer Signature....., ,This is an immediate discharge letter and a further letter may follow.

Surname/Forename	Weir, James
UHPI Number	201009798X

Episode Number	I0003174083

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0003250034 Dr JD Walker 8/5/13 14:35 Margaret Sinclair	Final Discharge Summary:,,Dear Dr Pepper,,Diagnosis:,,1. Paracetamol overdose,2. Psychiatric illness,,Medication on Discharge - As per Immediate Discharge Letter.,,I have nothing to add to the Immediate Discharge Letter. His post-treatment liver function tests were normal.,,Yours sincerely,,,,,,Dr J. D. Walker,Consultant Physician,,Secretary: 01506 523855,,JDW/MIS,,Date Dictated: 02/08/13 Date Typed: 05/08/13,

Surname/Forename	Weir, James
UHPI Number	201009798X

Episode Number	I0003174083

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0003252600 Dr Beth Threlfall 8/2/13 12:53 Alice E Neffendorf	PRINCIPAL DIAGNOSIS/PROCEDURE,1.Alcoholic gastritis,2. Depression,,This 24 year old man was admitted to the Observation ward/SJH on 31/7/13 after presenting to A&E with low mood and abdominal pain. He was recently discharged from Ward 17 and apparently someone had told him that it was the wrong ward for him which made him upset. He has been under stress following the death of his mother and had taken a recent overdose. He went home that day and drank a lof of buckfast and lager. On presentation he complained of low mood and abdominal pain. He had vomited a few times. He denied any overdose.,O/E: smelt of ETOH, heart sounds normal, chest clear, abdomen mild tenderness epigastric region, no guarding, no peritonism. ,,TREATMENT,Bloods: NAD,He was admitted to the Observation ward for review by psychiatry. He was felt safe for discharge home with follow up with psychitary in place. , ,FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL,Follow up made after his recent discharge from ward 17, ,CHANGES TO DRUGS SINCE ADMISSION,nil, ,PREVIOUS ADVERSE DRUG REACTIONS, ,SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS, ,GP to please consider the following..., ,Should you need further information please contact... Obs Ward, SJH, ,Information contained in this letter has been discussed with the patient/carer.,,Yours sincerely.....Dr. Alice E. Neffendorf, ,Staff Signature..... PrintName.....,,Designation..... Date..... Time.....,,Patient/Carer Signature....., ,

Surname/Forename	Weir, James
UHPI Number	201009798X

Episode Number	I0003174083

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0003259061 Prof. Michael P Eddleston 10/2/13 12:11 Susan Glass	DATE DICTATED: 27.09.13 DATE TYPED: 02.10.13 ,,This patient was found unconscious by a canal and was brought into hospital. He was rousable to sternal rub and had slightly dilated pupils at admission. He subsequently woke up and claimed to have consumed a lot of alcohol and also taken four Ecstasy tablets. ECG and blood tests were within normal limits. He was observed overnight, when he was noted to have a stable, but low, blood pressure at 94 mmHg systolic, and no other abnormalities. He was discharged the morning when fully awake.,,Yours sincerely,,,,,,Dr Veiraiah ,Consultant ,,SG,

Surname/Forename	Weir, James
UHPI Number	201009798X

Episode Number	I0003174083

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0003260117 Dr Ali Harmouche 8/14/13 11:52 Elspeth Best	PRINCIPAL DIAGNOSIS/PROCEDURE,,1. Paracetamol overdose,,This gentleman reports that he was feeling down over the recent death of his mother. He had been at the pub and had a few tablets, then went home and took 32 500mg paracetamol tablets. He now regrets this. He had some nausea and abdominal discomfort following the tablets but there was nil remarkable on examination. His paracetamol level was 82 and on the treatment line, so he was started on N acetyl cystine. He was reviewed by psychiatry, who were happy for him to be discharged.,,Thank you for his continuing care, ,TREATMENT, As above,,FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL,Nil, ,CHANGES TO DRUGS SINCE ADMISSION,Nil, ,PREVIOUS ADVERSE DRUG REACTIONS,Penicillin, ,SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS,Nil, ,GP to please consider the following..., ,Should you need further information please contact...,Dr Harmouche's team , ,Information contained in this letter has been discussed with the patient/ carer.,,Yours sincerely.....E Best (FY1 MAU)....., ,Staff Signature..... PrintName.....,,Designation..... Date..... Time.....,,Patient/Carer Signature....., ,This is an immediate discharge letter and a further letter may follow.

Surname/Forename	Weir, James
UHPI Number	201009798X

Episode Number	I0003174083

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0003260117 Dr Ali Harmouche 8/29/13 08:34 Beth Love	FINAL DISCHARGE SUMMARY,,,In addition to this man's immediate discharge summary I would like to ask you to repeat his full blood count in two weeks' time and to check his haematinics as he was found to be anaemic with a haemoglobin of 121 which was stable during his stay and there was no sign of active bleeding and normal clotting. I note that his haemoglobin was 120 in July of this year and this was normalised to 140 in early August to fall back to 120 again. I note that his kidney function and liver function were completely normal. If his iron and ferritin would be low or his haemoglobin continues to be on the low side I would suggest referring him to the GI for possible upper GI endoscopy. Please do not hesitate to contact me if you need any assistance.,,Yours sincerely,,,,,,,Dr Ali Harmouche,Acute Physician,,,AXH/BL,Enquiries to Beth Love (Tel:01506 523025),

Referrals

NHS Lothian - Referral Letter

Referral To	St John's Hospital Gastroenterology - Medical L GI - Upper
Urgency of referral	Urgent
Date of referral	14/02/2013
Date submitted	14/02/2013
UCPN	1010049068986

PATIENT DETAILS

CHI number:
Name: MR JAMES WEIR
Date of birth: 12/03/1989
Sex: Male

Contact Details

45 MILLGATE
WINCHBURGH
WEST LOTHIAN
EH52 6UA

Voice (Mobile) : 07580252195

REFERRING PRACTITIONER DETAILS

Name: Dr. Kirsten Marriott (GMC: 6071916)
Practice: Winchburgh Medical Practice (78359)
Phone: Voice : 01506 890210

Practice address

Winchburgh Health Centre
Niddry Road
Winchburgh
EH52 6RX

CLINICAL INFORMATION

Reason for Referral: Haematemesis, abdominal pains -6 months

Main Referral Text: I would be most grateful if you could see this 23 year old as soon as possible who has been suffering from abdominal pain, mainly epigastric and haematemesis over the past 6 months. He has just moved to the practice last week and I believe has been in A+E a few times with his symptoms, but apparently does not appear to have been investigated at any time. He describes worsening abdominal pain over 6 months, nausea, vomiting and at times haematemesis, and in the last couple of days has seen small amounts of fresh blood his stool. He has also lost 4 stone in weight. He does admit that in the past he has been a binge drinker, mainly buckfast, but has not been drinking for months now.

O/E obs stable. abdo-tender throughout, no guarding or rebound, bowel sounds present.

I have taken bloods off today, started a PPI and given strict instructions that if any deterioration he must present immediately, but would be most grateful for your review as soon as possible. ?ulcer ?more sinister cause.

Many thanks for your assistance.
Dr Anna Mills
Locum GP to Dr Marriott

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Omeprazole 20mg gastro-resistant capsules	capsule	2 CAPSULES TWICE A DAY		14/02/2013		14/02/2013
Ranitidine 150mg tablets	tablet	1 TABLET TWICE A DAY		12/02/2013		12/02/2013

Clinical warnings

Allergies

Description	Comment	Modifier	Start Date	Recorded Date
Adverse reaction to penicillins	Drug code for allergy: Penicillin G 12mg/vial intrathecal injection, Reaction type: Allergy, Certainty of allergy: Certain, Severity of allergy:			07/02/2013

Moderate.

Additional information

Smoking history (Encounters):Current smoker	Date recorded:7-Feb-2013
Alcohol history (Encounters):Alcohol intake within recommended sensible limits	Date recorded:7-Feb-2013
Patient Weight in Kilograms:63	
Patient Height in Metres:1.75	

Radiology Reports

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XR Chest

XR Chest

Clinical details

Report

Lungs are clear. Heart size is normal.
No consolidation or mass seen. No pleural effusion / pneumothorax noted.
No free air under diaphragm seen to suggest perforation.

Reporting Radiologist: Muhammad Rashid

Report Information

Requestor	Ashok, Dr Amrit
Requesting Location	(SJHAE) A&E, St John's Hospital
Report Identifier	14768394
Sample Date	02/04/2013 20:33:00

XR Chest

XR Chest

Clinical details

Abdo pain, hx of alcohol excess. Erect please to exclude free air
Report

CHEST

Heart and mediastinum within normal limits. Lungs clear. No free gas underneath the diaphragm.

Reported by Dr S J Glancy.

Reporting Radiologist: Dr SJ Glancy

Report Information

Requestor	Smeed, Dr Zoe E
Requesting Location	(SJHAE) A&E, St John's Hospital
Report Identifier	15655541
Sample Date	27/07/2013 01:31:00