NHS Confidential: Personal data about a patient

FIFE HEALTH BOARD

Dunfermline & West Fife Hospital

ACCIDENT AND EMERGENCY DEPARTMENT

GP's NAME AND ADDRESS

GP Dr Burt
Woodmill St
Dunfermline

PATIENT DATA

D.O.B. 8/7/89.
Surname ~~DORRIOTT~~ DORRIOTT
Forename(s) GARY
Address 63 Bute Cres
Dunfermline
Unit No.

Date and Time of Attendance	Date and Time of Accident
14-7-90 16.50	14-7-90. 16.45

Occupation Preschool
Religion C of E
Phone No.
Consultant
Next of Kin parents
S/ADD

TYPE OF INCIDENT
R.T.A.: Work: Home: Sport: Other *(Specify)*
HOME

LOCATION	SOURCE OF REFERRAL
HOME	SELF REFERRAL

Home Phone —
Work Phone 71388.

ALLERGIES - Penicillin
OTHER - *(Specify)*
None known

ALERT

T.	P.	R.	B.P.
39.2			

INVESTIGATIONS - *(Please tick)*
Bact. Cl. Chem. Haem. Hist. Urin. E.C.G.
X-ray

CURRENT THERAPY - Insulin Steroids ATS Betablockers
OTHER - *(Specify)* Antibiotics stopped

PROVISIONAL DIAGNOSIS
FEBRILE CONVULSIONS

TREATMENT - *(Please tick)*
Dressing Bandage/Splint P.O.P. Suture
Minor Procedure -
Analgesia Antibiotics ATS

TIME FIRST SEEN BY DOCTOR

Prescription Issued:

HISTORY/CLINICAL DETAILS

1yr old
Febrile convulsion seen by GP
Fitting again when ambulance arrived ∴ brought to A+E.
Given 5mg Diazepam PR at home.
120mg Paracetamol orally - vomited - at home.
Temperature at A+E 39.2
Not fitting -
O/E Snuffly. (L) TM red. ? stiff neck.
Given 120mg Paracetamol @ 5pm.
Tepid sponged

©	JHB		JRB	AR
		18 JUL 90		

Signature .....

A. & E. I.

MS 137

PLEASE USE BALLPOINT PEN

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CHILD ADMITTED TO WARD 5, VICTORIA HOSPITAL, KIRKCALDY

Gary Dorricott
63 Bute Crescent
DUNFERMLINE

V. 359 428

D.O.B. 08.07.89

Dr Burt
Abbot House East
Maygate
DUNFERMLINE

CONSULTANT: DR MacMILLAN

ADMITTED: 14.7.90
DISCHARGED: 20.7.90

DIAGNOSIS: Febrile convulsions secondary to otitis media

HISTORY OF PRESENTING COMPLAINT: This one year old boy was admitted having had a generalised convulsion lasting 30 seconds. His father gave him rectal Diazepam but he continued to twitch all over for a further 5 minutes. He had been snuffly for the preceeding few days with a greenish nasal discharge and his mother moticed that he was feverish. He had just completed a course of Amoxil prescribed for bilateral otitis media during his recent admission to ward 5.

This was Gary's 3rd convulsion. His first one occuring 4 weeks previously and the 2nd one 3 weeks ago. He has been fully immunised against DPT, polio.

SOCIAL HISTORY: His parents are not married. His father is 26 years old and smokes. His mother is 20 years old and also smokes. Mother has a boy by her previous marriage, aged 2. They have a cat and a dog at home.

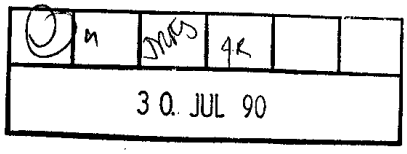
On examination, temperature was 37.5. On admission had spiked to 39.8 over the next 3 days. There was no rash and no lymphadenopathy. He had a greenish discharge from his nose, the palate was not inflammed but the left ear was reddened. Chest was clear. The rest of examination was normal.

PROGRESS & MANAGEMENT: Biochemisty and chest x ray were normal. Blood cultures and urine culture were sterile. He was started on a course of Erythromycin which was later changed to Augmentin when his temperature did not settle. He had an EEG and was started on Sodium Valporate 100 mg BD. He was discharged home to continue the course of antibiotics and with further rectal Diazepam. He will be reviewed in 6 weeks time in Dunfermline & West Fife Clinic.

Yours sincerely

M Emond
Paediatric SHO

ME/JB/25.7.90



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FIFE HEALTH BOARD

Dunfermline & West Fife Hospital

ACCIDENT AND EMERGENCY DEPARTMENT

GP's NAME AND ADDRESS

DR BURT.
MILL HILL SURG.

Date and Time of Attendance	Date and Time of Accident
14.26 18/6/90.	18/6/90

TYPE OF INCIDENT
R.T.A.: Work: Home: Sport: Other *(Specify)*

LOCATION	SOURCE OF REFERRAL

PATIENT DATA

Ref - 027084/1
D.O.B. 8/7/89. Unit No. DC361814
Surname DORRICOTT
Forename(s) GARY
Address 63 BUTE CR.
DUNE.

Occupation
Religion COFE
Phone No.
Consultant
Next of Kin PARENTS
S/A.

Home Phone →.
Work Phone

ALLERGIES - Penicillin
OTHER - *(Specify)* N/KNOWN
ALERT

CURRENT THERAPY - Insulin Steroids ATS Betablockers
OTHER - *(Specify)* NONE.

PROVISIONAL DIAGNOSIS

FEBRILE CONVULSION

TIME FIRST SEEN BY DOCTOR

T. 40-5 P. R. B.P.

INVESTIGATIONS - *(Please tick)*
Bact. Cl. Chem. Haem. Hist. Urin. E.C.G.
X-ray BM stix. 11

TREATMENT - *(Please tick)*
Dressing Bandage/Splint P.O.P. Suture
Minor Procedure -
Analgesia Antibiotics ATS

Prescription Issued:

HISTORY/CLINICAL DETAILS

999 call. - well today - was sitting drinking - fell backwards & banged head. then started fitting grandmal lasted for ~ 2-3 mins.
On arrival - pale. [illegible] not fitting
temp 40-5°C.
no rashes.
Offensive urine ++
chest clear
abdo soft non tender
fontanelle almost closed.
fundi. R: c: normal
PERL.
moves both sides of face equally
moves all 4 limbs.

20 JUN 90 [illegible] - not red, [illegible] skiffers.
SKR. not seen.
D/W. Dr Dick.
Paediatrics.
Victoria hospital

Signature .....

A. & E. I.

MS 137

PLEASE USE BALLPOINT PEN

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FIFE HEALTH BOARD

Dunfermline & West Fife Hospital

ACCIDENT AND EMERGENCY DEPARTMENT

GP's NAME AND ADDRESS
Dr. Burt,
Millhill Surgery.
D/Line.

PATIENT DATA
D.O.B. 8-7-89 Unit No.
Surname Dorrett
Forename(s) Gary
Address 63 Bute Cres.,
D/Line
Occupation Pre-school Religion
Phone No.
Consultant
Next of Kin Parents
S/A,
Home Phone
Work Phone

Date and Time of Attendance: 21-10 24-6-90
Date and Time of Accident:

TYPE OF INCIDENT
R.T.A.: Work: Home: Sport: Other *(Specify)*

LOCATION: —
SOURCE OF REFERRAL: 999.

ALLERGIES - Penicillin
OTHER - *(Specify)* M/K
ALERT

T. 40·3 P. 120 R. 26 B.P.

CURRENT THERAPY - Insulin Steroids ATS Betablockers
OTHER - *(Specify)* Anti-biotics Steroids

INVESTIGATIONS - *(Please tick)*
Bact. Cl. Chem. Haem. Hist. Urin. E.C.G.
X-ray

PROVISIONAL DIAGNOSIS
Convulsions

TREATMENT - *(Please tick)*
Dressing Bandage/Splint P.O.P. Suture
Minor Procedure -
Analgesia Antibiotics ATS

TIME FIRST SEEN BY DOCTOR

Prescription Issued:

HISTORY/CLINICAL DETAILS

off his food today - not playing as usual.
Mum says he had a febrile convulsion that lasted 2-3 minutes - was given Stesolid by mother.
O/E PMH Had 1st febrile convulsion 7/7 ago - seen at Victoria hospital - discharged 5/7 ago 2 antibiotics.

O/E drowsy.
no neck stiffness.
PERLA.
moves all limbs.
Chest - b AE + creps (R) base
CVS - reg TM.
abdo soft no tender

D/w. Victoria Hosp
→ ward 5

27. JUN '90

Signature

A. & E. I.

MS 137

PLEASE USE BALLPOINT PEN

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CHILD ADMITTED TO WARD 5, VICTORIA HOSPITAL, KIRKCALDY

Garry Dorricott V.359,428
63 Bute Crescent
DUNFERMLINE D.O.B. 08.07.89

Dr Burt
Abbot House East
DUNFERMLINE

CONSULTANT: DR A.W. BLAIR

ADMITTED:	18.06.90	RE-ADMITTED:	24.06.90
DISCHARGED:	20.06.90	DISCHARGED:	26.06.90

DIAGNOSIS: FEBRILE CONVULSION SECONDARY TO OTITIS MEDIA

HISTORY OF PRESENTING COMPLAINT: Garry was well on the afternoon of admission, although he had been slightly irritable for the past couple of days and had had coryzal symptoms. In the early afternoon he started shaking, this involved his whole body and lasted for a couple of minutes. He was unconscious and was blue around the lips and when he regained consciousness again he was drowsy and wanted to sleep. Garry is on no regular medication.

PAST MEDICAL HISTORY: Garry was born by SVD weighing 6 lb 9 oz at 35 weeks gestation at Dunfermline Maternity. He went home from hospital on an apnoea monitor because one of his older siblings had died of sudden infant death syndrome. He has had one past admission for episodes of apnoea and has had an ear infection within the last couple of months. He has had his Triple vaccine and Polio but not yet had MMR.

DEVELOPMENTAL HISTORY: He seems normal having started walking at 10 months and is beginning to speak, although his vocabulary is limited to 3 words.

FAMILY/SOCIAL HISTORY: Father is a 26 year old unemployed smoker and mother is a 20 year old housewife, also a smoker. Garry's older brother has had 2 febrile convulsions.

ON EXAMINATION: Garry had a temperature of 38, a heart rate of 130 and respiratory rate of 39 per minute. His weight was 10.1 kg and his OFC was 47.2 cm. He had some dermatitis on his cheeks, bilaterally inflammed tympanic membranes and a marked rhinorrhoea. His chest was clear and heart sounds were normal with no murmurs and his abdomen was soft and non-tender with no organomegaly and normal genitalia. Neurologically he was intact, being alert and responsive on admission.

PROGRESS AND MANAGEMENT: A lumbar puncture was performed which showed a clear, colourless fluid with no polymorphs. Urea and electrolytes, magnesium, calcium and glucose were normal and a full blood count revealed a white count of 16.2 with 62% neutrophils. A haemoglobin of 12.2 with a microcytic, hypochromic picture and in view of his bilateral otitis media, Garry was commenced on Amoxycillin 125 mg t.d.s. His temperature settled well and on the 20th he was allowed home. He was re-admitted on the 24th June with a history of one further febrile convulsion which had settled with rectal Diazepam but on this admission he settled quickly and was allowed home on the 26th. We hope Garry remains well.

04 JUL 90

Yours sincerely,

F. Dyson

Dr F. Dyson - Paediatric S.H.O. FD/ML/2.7.90

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Fife Health Board
Dunfermline Unit

Your Ref:
Our Ref: PA/ML 726/89
Enquiries to: Mrs. Marilyn Lindsay
Ext: 6216

DUNFERMLINE MATERNITY HOSPITAL,
Izatt Avenue,
Dunfermline, KY11 3BZ
Tel: 0383 737777
Fax: 0383 741056

Dr. Ray,
The Surgery,
12 Comely Park,
Dunfermline.

27th October, 1989.

Dear Dr. Ray,

Gary Dorricott, 63 Bute Crescent, Dunfermline.
Date of Birth: 8.7.89

The baby was admitted to the Victoria Hospital about three weeks ago for about three days. He had a cyanotic spell for a few minutes after his feed. He had not vomited and had an upper respiratory tract infection at that time. He, however, had an apnoea monitor which never went off. He has been on an apnoea monitor since he was one month old as his half-sibling was a cot death. He now has good head control.

On examination, he was afebrile, not pale. He weighed 6.84kgs., which was just above the 75th centile. The head circumference was 41.1 cms. His other systems were essentially normal.

His next clinic appointment is in three months' time.

Yours sincerely,

P. Adiotomre
Locum Paediatric Registrar

c.c Dr. Baijal

17. NOV 89

NOT REGISTERED

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National Health Service Number		
IMMUNISATIONS AND SCREENING INVESTIGATIONS	Surname (Block Letters): DORRICOTT	Forenames (Block Letters): GARY
	Address:	Date of Birth: 8.4.89.

IMMUNISATIONS (Insert date where appropriate)

	Diphtheria	Pertussis	Tetanus	Polio	~~Measles~~ MMR	Rubella	TAB	Smallpox
1 Hiby Jr.	15.10.89	15.10.89	15.10.89	15.10.89	C 17/10/90			
2								
3 C	16.5.90	16.5.90	16.5.90	16.5.90				
Boost	2-2-94		2-2-94	2-2-94				
Boost	3/11/03		3/11/03	3/11/03				
Boost								

Tuberculin Test					BCG.		
Result				Date	8/12/03		
Date	1/12/03						

Other Inoculations

Type							MENC
Date							25/00
Type							~~PC 12.3.97~~
Date							
Type							
Date							

SCREENING INVESTIGATIONS

Chest X-Ray (Date)	Cervical Smear (Date)	Blood Pressure		Urine			Miscellaneous		
		Date		Date	Albumen	Sugar	Date	Weight	Other (Specify)

SCREENING INVESTIGATIONS CONTINUED OVERLEAF

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CHILD ADMITTED TO WARD 5, VICTORIA HOSPITAL, KIRKCALDY

Dr Burt
Abbot House East
Maygate
DUNFERMLINE

DORRICOTT, Gary V359,428
63 Bute Crescent,
DUNFERMLINE 8.7.89

ADMITTED: 20.9.89

DISCHARGED: 22.9.89

CONSULTANT: Dr MacMillan

DIAGNOSIS: Choking episodes.

HISTORY OF PRESENT COMPLAINT:Gary was admitted to the ward having had a colour change at home, the duration of which was not clear from his mother. This has occurred at just after feeding. Mum had laid the baby down on the couch and left the room. On return she saw that his face was blue. There may also have been a colour change on the night prior to admission. Gary is normally on an apnoea monitor at home. This unfortunately has not been working for a few days. The Health visitor is arranging repair.

DRUG HISTORY: Gary is on no medication, has no drug allergies which are known.

PAST MEDICAL HISTORY: Nil of note. He had no immunisations to date.

FAMILY/SOCIAL HISTORY: Gary has a half brother who died last year due to S.I.D.S. He also has a 2 year old sibling who suffers from febrile fits.

ON EXAMINATION: On admission to the ward Gary was apyrexial with a temperature of 37.3°C. On examination of his chest, abdomen and neurological systems were normal.

INVESTIGATIONS: Chest x-ray was taken and was normal.

DRUGS AND MANGEMENT: Gary was observed in the ward for 48 hours. He had no further colour changes and remained well.

On 22.9.89 it was decided to discharge Gary home as the apnoea monitor was working at home. It was suspected that the colour change was probably due to Gary having choked on his feed.

Yours sincerely

pp

Paul Sigston
Paediatric SHO

PS/AS
27.9.89

OCT

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26. JUL

FIFE HEALTH BOARD
CHILD HEALTH SERVICE

NOTIFICATION OF APNOEA MONITOR ISSUE

WARD STAFF TO NOTIFY GP BY TELEPHONE AND TEAR-OFF SLIP

To Dr J.R. Bunt

Abbot House East

Maygate, Dunfermline

Date 20.7.89.

Name Gary Donicott

Address 63 Bute Gdns., Dunfermline

Date of Birth 08.07.89

Hospital Unit No 726/89.

Type of Monitor Issued 'DENSA' No. 30

& charger.

Tear Off

NHS Confidential: Personal data about a patient

JRFB/SP

oo

12th July, 1989

Dr. Steer,
Consultant Paediatrician,
Victoria Hospital,
Hayfield Road,
KIRKCALDY.

Dear Dr. Steer,

Gary DORRICOTT, 63 68, Bute Crescent, Dunfermline. (8·7·89)

This baby was born at 36 weeks gestation at Dunfermline Maternity Hospital by SVD to his Para 1 + 0 19 year old mother. His birth weight was 616 9oz. and he appears very well.

However, his step-brother, John Dorricott (same father) died of a cot death aged 4 months on 28:10:88.

His parents are seeking an apnoea monitor.

Yours sincerely,

J.R.F. Burt.

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Ex 58 Sept 89 Bill 89

MALE

SURNAME	CHRISTIAN NAMES
DORRICOTT	GARY

432 89 641

ADDRESS ~~63 Bute Crescent KYLE~~ 40 Trondheim Parkway

Date of Birth: 8 · 7 · 89

DATE	°C °F	CLINICAL NOTES	DIAGNOSIS
11.7.89		48 hr discharge	
		4 day check · NAD.	
		Step brother SIDS	
		– ? apnoea alarm	
		write to Steer	
7-8-90		Phenobarbitone 120mg/5ml 10ml	
		Sod. Valproate 10g/5ml 5ml bd 30ml	
25.9.90		Sod. valproate 100mg/5ml	
		ON 300mg daily – see letter	
1.11.90		Sodium valproate 100ml	
8.1.91			

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

D.J.R.F. Burt

MEDICAL RECORD CARD

Dd8102269 175M 10/87 R.P.(53791)

Form G.P. 7 (Scotland)

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National Health Service Number

Surname (Block Letters)	Forenames (Block Letters)
DORRICOTT	GARY

SUMMARY OF IMPORTANT ILLNESSES AND INVESTIGATIONS

Address

Date of Birth: 08.07.89

Joined list 25.11.91

Date	Records date from birth
	(1988 Step-brother died of S.I.D.S. age 4/12) [1221.]
1989	Apnoea alarm. [8A43.]
	Episodes coulour change with choking episodes.
1990	Febrile convulsions x 2 (secondary to O.M.). Sodium Valproate. [R0030]
Oct '90	Febrile convulsion (secondary to tonsillitis) [R0030]
Feb '91	Adenoidectomy, bilateral grommets. DNA for follow up. [74210] [73134]
Nov '91	Febrile convulsion. [R0030]
AUG '93	Epilepsy. [F25..]
Aug 93	Febrile seizure, ? erythema infectiosum. [R0030]
3/4/98	EEG - normal - no obvious sign of epilepsy [70650]
8/11/99	Attention deficit hyperactivity disorder [E0900]
23/3/99	Referral to Child Clinical Psychology Service [8H7T.]
27/9/99	Under place of safety order
25/4/99	with foster parents. [9338.]
17/11/04	# neck of 5th metacarpal. [S2...]
2006	Nil else of note. [9344.]

Form GP111G

Dd 8176435 500M 4/89 Ed(267575)