TAYSIDE HEALTH BOARD

HISTORY/CONTINUATION SHEET

.....UNIT/WARD/DEPT.

Ward/Clinic/ Hosp. . . . . Cons.

Surname . . . LEONARD 28 04 88 . . . . Unit No.
First Name . . . STACEY L. 0060 . . . D. of B.
Address . . . . . 9 LAMLEY TER F . . . M. State
. . . ARBROATH SI . . Sex
Occupation . . . DD11 5AD . . . MPI No. (last 4 digits)
G.P. & Address DR. A. HORNSBY
ABBEY H/CENTRE CK LETTERS
EAST ABBEY ST ARBROATH) IMPRINTER

DATE

Page .....

12/2/92 Operation : Bilateral Grommets
Surgeon Mr Hamblen
Cat Dr Bantham

Bilat Myringotomies / Rt Serous fluid / Lt Serous fluid } Bilat Sheared Grommets inserted

Have today OPD. 6/52 ABR & AUDIO

THB.(MR)3A

TAYSIDE HEALTH BOARD

..... Unit

..... Hospital

DAY SURGERY

Combined Record / Consent Form

Ward ..... Theatre .....

Surgeons .....

.....

Date | | | | | | |

Ward/Clinic/ Hosp 27

...Cons.

LEONARD 28 04 88
STACEY L. 0060
9 LAMLEY TER F
ARBROATH SI
DD11 5AD
DR. A. HORNSBY
ABBEY H/CENTRE
EAST ABBEY ST ARBROATH

Surr
Firs
Add
Occ
G.P

..... D. of B.
... M. State
..... Sex
...CHI No. (last 4 digits)

USE BLOCK LETTERS OR HAND IMPRINTER

SURGICAL CONDITION:

Operation proposed: .....

.....

Symptoms unchanged: .....

Consent Signed? Yes / No

OPERATION NOTE: .....

.....

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Post-operative Instructions: .....

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Follow-up arrangements: .....

.....

.....

.....

.....

.....

HOSPITAL: RIE

Ward / Dept.: 27

NAME OF PATIENT: STACEY LEONARD

Date of Birth: 28 04 88

Unit No. / CHI No.: 2804488

Consultant:

KNOWN DRUG SENSITIVITY OR ADVERSE REACTIONS: NIL KNOWN

CONSENT FOR *OPERATION / INVESTIGATION

I, SUSAN Leonard of .....

..... hereby consent to *the submission of my *ward .....

Stacey ~~Leonard~~ ..... to undergo the *operation / investigation of ..... gammet inserta

..... L+Rec ..... the nature and purpose of which have been fully explained

to me by *Mr. Dr. Lee .....

** I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned operation, and to the administration of general, local or other anaesthetic for any of these purposes. No assurance has been given to me that the operation will be performed by any particular practitioner.

Date 12/2/92 ..... Signed X S Leonard .....
(*Patient / Parent / Guardian)

I (PRINT NAME) ..... confirm that I have explained the nature and purpose of this operation to the *patient / parent / guardian.

Date 2/2/92 ..... Signed ..... Status 2HO
(*Medical / Dental Practitioner)

NOTES – Age of Consent

The Tayside Health Board have been advised by the Central Legal Office that anyone who has attained 16 years of age can give or withhold valid consent to operation/investigation on him/herself. Ordinarily the parent or guardian should be informed in the case of a patient who has not reached the age of 18.

* Delete as appropriate

** This clause should be deleted where the initial consent is for an investigation and not for an operation.

ANY DELETIONS / INSERTIONS OR AMENDMENTS TO THE FORM ARE TO BE MADE BEFORE THE EXPLANATION IS GIVEN AND THE FORM IS SUBMITTED FOR SIGNATURE.

MEDICAL HISTORY

Regular Medication: NO .....

..... Taken Today? Yes / No

Previous Anaesthesia No / Yes Date of most recent anaesthetic .....

Problems (including Family History) No / Yes Brother has asthma (5)

No / Yes NO epilepsy DM

Heart Attack / Angina No / Yes

Hypertension No / Yes

Breathlessness No / Yes

Exercise Tolerance good

Asthma / Bronchitis No / Yes

Cough / Sputum No / Yes

Heartburn / Regurgitation No / Yes

Other Illnesses No / Yes once a while gets bronchitis

Allergies No / Yes

Tobacco No / Yes ..... Alcohol Problems No / Yes .....

PHYSICAL EXAMINATION

Pulse Rate 100 ..... Rhythm normal ..... B.P. 104 / 60

Heart Sounds 1+11+0 ..... Teeth normal

Breath Sounds vesicular BS + occ coarse crackles

Other abdo / CVS

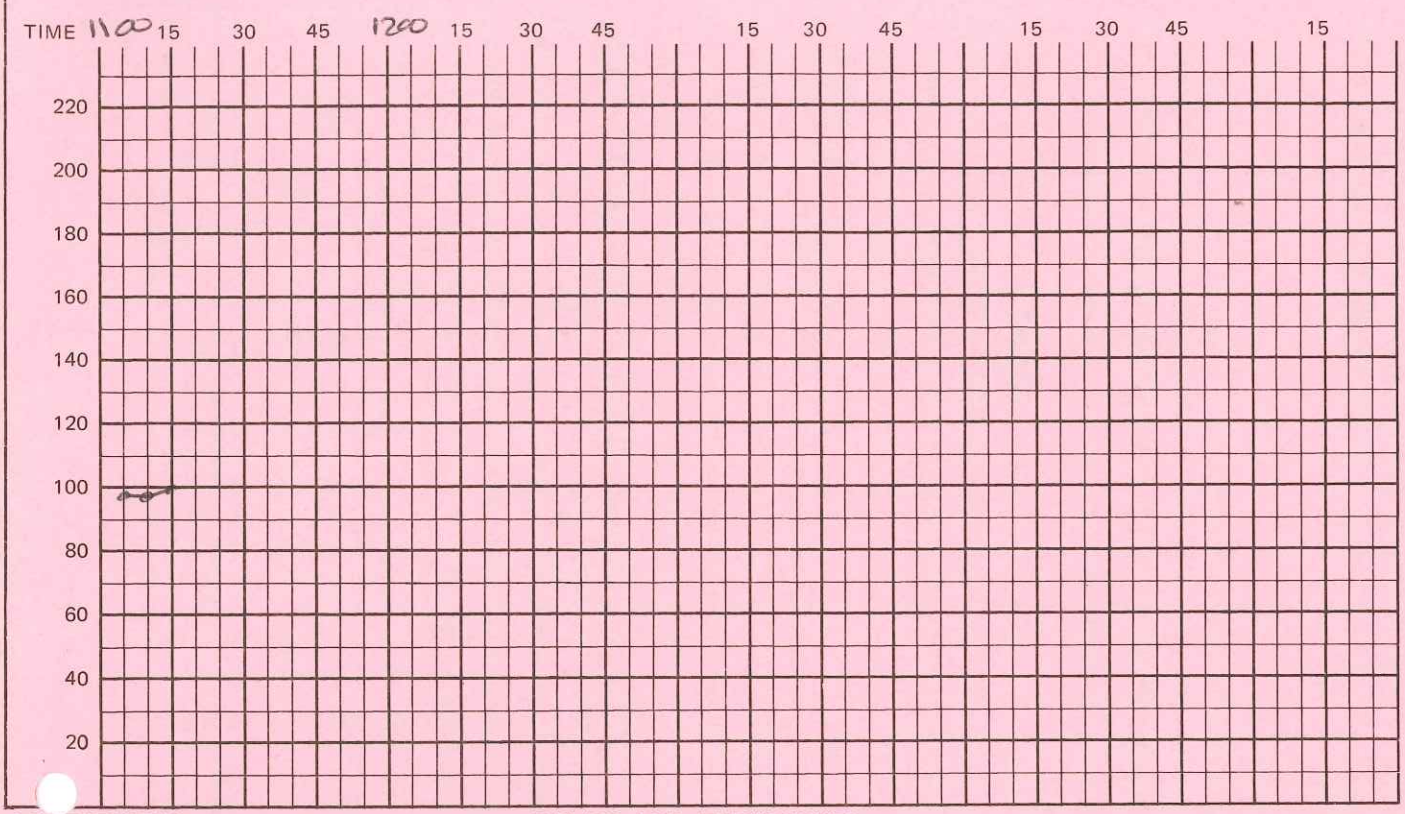
normal size normal

no organomegaly

BS ✓

Signed .....

Date 1/2/92 Status .....



...Cons.

... D. of B.

... M. State

..... Sex

...CHI No. (last 4 digits)

:K LETTERS

IMPRINTER

ANAESTHESIA DRUGS AND TECHNIQUES

Yes / No

(1).

(1) 22G vasflon DH.

Propofol 60 + 20 mg.

N_2O/O_2 1 Hal. SpO_2 - 97 %.

#2 LMA

POST-OPERATIVE INSTRUCTIONS

Maintain airway. Observe colour, airway, respiration and pulse continuously until fully awake.

O_2 4L/min paediatric Hudson mask 'til awake.

Signed: Chi A Batra

Anaesthetist

Patient's Tel. No. .....

Time Admitted 0830 hrs.

Date 12/02/92

Next of Kin Parents

Diagnosis Hearing loss and frequent Ear infections

and .....

Operation insertion of Grommets.

Address SLA

.....

..... Tel. No. .....

Weight 16.4 Kg	Dentures ~~Yes~~ / No	Spectacles ~~Yes~~ / No	Contact Lenses ~~Yes~~ / No	Hearing Aid ~~Yes~~ / No	Valuables in Safe ~~Yes~~ / No

NURSING REPORT

36.3 °C	Pulse 100	BP /	Urinalysis	Last Oral Intake 8 11/2/92	Time 8.30pm.

Recent Cold Ear infection 2wks ago, treated with antibiotics

Homegoing Arrangements

Arranged admission for insertion of grommets at theatre today under GA.
No previous anaesthetics. No past medical history.
Theatre: General Anaesthetic given by Dr Bantham See Anaesthetic Page for further detail Bilateral Myringotomys + Extrude grommet in both ears effected by Mr Hamlet Recovery uneventful
RTW 11.45 upset ++, all care as post op care plan.
Home tonight. OP arbroath 6/52, + Audio.

Signature

M Zanre.
Theatre Nurse
L A Dumpson.

Date	Medicine and (Special Instructions)	Dose	Form	Method of Administration or Site of Application	Times of Administration (24 hour clock)	Signature of Prescriber	
12/2/92	TEMAZEPAM ~~OMEG~~ LIQ	6mg	LIQ	ORAL	0900	CBeh	L A Dumpson. PRACTICAL
12/2/92	Emla Cream	1 app	both hands.	Top.	0845.	L. Gilmour Staff Nurse	LS.

Please ✓ when medicines are prescribed separately on

Fluid Prescription Sheet

Other (Specify)

Date	AGE Yrs.	Mths.	Days	Weight
	03			16.4kg

Nursing Report / Consent / Operation / Medicine Prescription
DAY CASES

HOSPITAL	Ward / Dept.	NAME OF PATIENT	Date of Birth	Unit No. / CHI No.	Consultant	KNOWN DRUG SENSITIVITY OR ADVERSE REACTIONS
NIW	27	STACEY LEONARD	280488	280488-		NIL KNOWN

E N T POST-OPERATIVE CARE PLAN

PROBLEM	GOAL	NURSING ACTION	EVALUATION
BREATHING			
a) Respiratory failure due to prolonged effects of anaesthetic.	Adequate respiration maintained within the anticipated range of measurements.	1) Position patient appropriately. 2) Observe colour of extremeties. 3) Observe rate and depth of respirations.	M Zamre
COMMUNICATION			
a) Anxiety about the outcome of surgery.	Awareness of operation completed.	1) When patient wakens from anaesthetic, explain that operation is over and remind patient of his/her surroundings. 2) Explain type of operation completed. 3) Check patients understanding of information given and equipment in use. 4) Explain nurse call system.	M Zamre

E N T POST-OPERATIVE CARE PLAN

PROBLEM	GOAL	NURSING ACTION	EVALUATION
MAINTAINING A SAFE ENVIRONMENT			
a) Haemorrhage following surgery.	Pulse and BP are within expected limits.	1) Record pulse and BP. 2) Observe for restlessness, excessive swallowing. 3) Report increase in pulse, decrease in BP, skin pallor.	MZaure.
EATING AND DRINKING			
a) Nausea and vomitting.	Free from nausea and vomitting and able to take regulated amounts of fluid.	1) Maintain oral fluid intake.	
b) Electrolyte and fluid imbalance if more major surgery.	Body fluids are in balance without signs of dehydration.	1) Maintain IV regimen. 2) Ensure function of IV line. 3) Observe IV cannula site. 4) Report swelling/ inflammation of site. 5) Change cannula site dressing. 6) Record IV fluid given.	N/A

E N T POST-OPERATIVE CARE PLAN

PROBLEM	GOAL	NURSING ACTION	EVALUATION
ELIMINATION			
a) Urine retention.	Normal micturition returns within 6 - 8 hours.	1) Offer urinal/bedpan. 2) Report any bladder discomfort. 3) If no urine passed, report to nurse in charge.	
PERSONAL CLEANSING			
a) Loss of independence in personal care.	Adequate hygiene maintained without loss of dignity.	1) Wash patient and change into own nightwear when able to sit up. 2) Clean bed linen. 3) Maintain hygiene.	
b) Pain related to surgical wound.	Pain is controlled. States pain - tolerable or not present.	1) Observe for signs of discomfort. 2) Give analgesia as prescribed. 3) Assist to maintain comfortable position.	

E N T POST-OPERATIVE CARE PLAN

PROBLEM	GOAL	NURSING ACTION	EVALUATION
SLEEPING			
a) Disturbed sleep pattern.	Sleeps for 4 hours as a minimum.	1) Check general comfort measures. 2) Provide quiet surroundings. 3) Enquire whether patient has any worries.	

post-

E N T [redacted]-OPERATIVE CARE PLAN

SPECIFIC PROBLEM	GOAL	NURSING ACTION	EVALUATION

LEONARD 28 04 88
STACEY L. 0060
9 LAMLEY TER F
ARBROATH SI
DD11 5AD
DR. A. HORNSBY
ABBEY H/CENTRE
EAST ABBEY ST ARBROATH

NINEWELLS HOSPITAL

PRE- AND POST-OPERATIVE CHECK LIST

FOR ENT THEATRE

NAME:

UNIT NO: WARD:

DATE: 27

	THEATRE CHECK / NURSING ORDERS	PLEASE SIGN
TO BE COMPLETED WARD STAFF	CHECK IDENTITY OF PATIENT WITH NAMEBAND AND NOTES	LS
	CONSENT FORM COMPLETED AND AVAILABLE	LS
	PATIENT HAS FASTED - TIME LAST ATE OR DRANK ..11/2/92 2030	
	AURAL PREPARATION - POST AURICULAR/ENDAURAL/PERMEATAL	N/A
	NASAL PREPARATION - SPRAY/PLEDGET/MOFFAT	
	OTHER PREPARATION	
	JEWELLERY HAS BEEN REMOVED AND STORED AS PER HOSPITAL POLICY	✓ LS
	MAKE-UP, NAIL VARNISH, HAIRGRIPS REMOVED	✓ LS
	REMOVE DENTURES AND OTHER PROSTHESIS, LEAVE HEARING AID IN SITU:	✓ LS
	HEARING AID YES/NO	✓ LS
	REMOVE UNDERWEAR	✓ LS
	ENSURE PATIENT'S BLADDER IS EMPTY	✓ LS
	ADMINISTER PRESCRIBED MEDICATION: TIME ..0900	✓ LS
	CASE NOTES/X-RAYS/NURSING KARDEX/PRESCRIPTION AND RECORDING SHEET ETC ACCOMPANY PATIENT	✓ LS
	ALLERGIES ..None Known	
	CHECK IDENTITY BAND WITH THEATRE REGISTER CARD AND CASE NOTES	
	REMARKS, IF ANY	LA Dumpson
TO BE COMPLETED BY THEATRE/TRR STAFF	CHECK IDENTITY OF PATIENT	
	CHECK CONSENT FORM COMPLETE	
	LAST TIME PATIENT ATE OR DRANK: TIME	
	PRESCRIBED MEDICATION GIVEN: TIME	
	CASE NOTES, X-RAYS, NURSING KARDEX. DRUG KARDEX WITH PATIENT	
	THROAT SPRAYED YES/NO	
	TYPES OF PACKS/SPLINTS ETC	11.45
TO BE COMPLETED BY WARD STAFF	Post-Operative Care	
	VITAL SIGNS 1/2 HOURLY FOR 2. HOURS	
	INTRAVENOUS THERAPY YES/NO	
	OXYGEN THERAPY FOR / HOURS	
	DIET a) NIL BY MOUTH UNTIL 1345 then	
	b) STERILE FLUIDS/FLUIDS/LIGHT DIET/IF TOLERATED	
	MOBILITY: BED REST UNTIL tonight	
	SPECIFIC CARE INSTRUCTION	

NHS Tayside

TT Morley
Brechin Medical Practice
Brechin Health Centre
Infirmary Street
Brechin
DD9 7AN

28/04/2025

Dear Colleague

Please see the following outcome from the vetting process.

Patient Name: Stacey Louise Leonard
CHI Number: 2804880060
Referral Date: 28/04/2025

Referral Source: General Practitioner

Referral Priority was: Urgent
Vetted Priority is: Urgent

ACUTE REFERRAL CENTRE URGENT
Vetted By: Ophthalmology

Please note: If the vetting outcome is Redirecting Referral then the vetted by specialty will show as the redirected to specialty and not the specialty originally referred to.

Comment (Please add comments below for the referrer as required)

Yours sincerely

Ophthalmology Department
Specialist Surgery
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Dr TT Morley
Brechin Medical Practice
Brechin Health Centre
Infirmary Street
Brechin
DD9 7AN

Date	29/04/2025
Clinic Date	28/04/2025
Your Ref	
Our Ref	SJC/LR/MPI/ **2804880060**
Enquiries to	Dr. Sze Jing Chuah
Extension	40527
Direct Line	(01382) 740527
Email	Linda.Robertson4@nhs.scot

Dear Dr Morley

Stacey Leonard, 2 Wards Road, Brechin, Angus, DD9 7AS DOB: 28/04/1988

This patient was reviewed in the Ophthalmology Department on 28.04.25.
Our findings were as follows:

Consultant: Dr D. Zeinelabedien

Diagnoses:
Left contact lens keratitis measuring 0.3mm in size off axis

Visual Acuity:
Right 6/7.5
Left 6/18

Treatment:
Hourly Exocin for 48 hours and then four times a day for one week

Outcome:
To see Opticians in two weeks to ensure resolved
Open access for Acute Referral Clinic with us lasting 3 weeks

Yours sincerely

Authorised on 30/04/2025 12:50:39 by SZE JING CHUAH.

SZE JING CHUAH
ST2 IN OPHTHALMOLOGY

The Department of Ophthalmology supports the use of generic eye drops unless a brand agent is specifically requested for a particular patient.

Ophthalmology Department
Specialist Surgery
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Dr TT Morley
Brechin Medical Practice
Brechin Health Centre
Infirmary Street
Brechin
DD9 7AN

Date	13/02/2026
Clinic Date	12/02/2026
Your Ref	
Our Ref	LH/LAB/ **2804880060**
Enquiries to	Lamia Hamidovic
Extension	40527
Direct Line	01382 740527
Email	lesleyann.brown@nhs.scot

Dear Dr Morley

Stacey Leonard, 2 Wards Road, Brechin, Angus, DD9 7AS DOB: 28/04/1988

The above patient was seen in the Ophthalmology Department on 12/02/2026.
Our findings were as follows:

Consultant: Dr. M. El-Abiary

Diagnoses:
1. Left contact lens keratitis
2. Left amblyopia

Impression:
1. Contact lens keratitis healing just with subepithelial scarring now
2. Superior temporal to the pupil about 1mm in size

Visual Acuity:
Right 6/9
Left 6/60 on pinhole 6/24

Treatment:
Stop Exocin
Start Maxidex drop taper 3 times a day for a week, twice a day for a week, once a day for a week, then stop.

Outcome:
Follow up in 3 weeks
Discharge then if all clear

Yours sincerelyAuthorised on 13/02/2026 17:28:04 by LAMIA HAMIDOVIC.

LAMIA HAMIDOVIC
ST3 IN OPHTHALMOLOGY

The Department of Ophthalmology supports the use of generic eye drops unless a brand agent is specifically requested for a particular patient.

Ophthalmology Department
Specialist Surgery
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Dr TT Morley
Brechin Medical Practice
Brechin Health Centre
Infirmary Street
Brechin
DD9 7AN

Date	06/03/2026
Clinic Date	05/03/2026
Your Ref	
Our Ref	SJC/LAB/ **2804880060**
Enquiries to	Sze Jing Chuah
Extension	40527
Direct Line	01382 740527
Email	lesleyann.brown@nhs.scot

Dear Dr Morley

Stacey Leonard, 2 Wards Road, Brechin, Angus, DD9 7AS DOB: 28/04/1988

The above patient was seen in the Ophthalmology Department on 05/03/2026.
Our findings were as follows:

Consultant: Dr. M. El-Abiary

Diagnoses:
1. Left contact lens keratitis, now settled
2. Dry eyes

Visual Acuity:
Right 6/24 to 6/9 with pinhole
Left 6/60 to 6/18 with pinhole

Management:
Worsening advice to seek advice from Optician if getting worse

Treatment:
Predsol weaning dose
Evolve HA hourly

Outcome:
Discharged

Yours sincerely

Authorised on 10/03/2026 10:05:18 by SZE JING CHUAH.

SZE JING CHUAH
ST2 IN OPHTHALMOLOGY

The Department of Ophthalmology supports the use of generic eye drops unless a brand agent is specifically requested for a particular patient.

Ophthalmology Department
Acute Services Division
NHS Tayside
Ward 25, Ninewells Hospital
DUNDEE
DD1 9SY
01382 660111
01382 632893
www.nhstayside.scot.nhs.uk

Dr R Cranswick
Annat Bank
Links Health Centre
Frank wood Way
Montrose

Date	16th March 2009 (dictated 13.03.09)
Your Ref	
Our Ref	UO/LMcG/MPI/28 04 88 0066
Enquiries to	Dr U O'Colmain
Extension	33428
Direct Line	
Email	lmcgrattan@nhs.net

Dear Dr Cranswick

STACEY ELLIS, 8 MILL PLACE, CRAIGO

Your patient attended the Ophthalmology OPD on 13.03.09
Our findings were as follows:-

Diagnoses:
Blepharitis
Contact lens wearer

Visual Acuity:
6/12 right
6/9 left

Outcome:
This lady is complaining of right worse than left ocular discomfort. She has evidence of mild infection and significant blepharitis. I have advised her regarding lid hygiene and to not wear her contact lenses. I have not arranged to see her again.

Yours sincerely

Dr U O'Colmain
Specialist Registrar

Directorate of Ophthalmology

19 Jul 95

Dr A Hornsby
Abbey Health Centre
East Abbey Street
Arbroath
DD11 1EN

Dear Dr Hornsby

Miss Stacey L LEONARD, Hospital No. 2804880060
9 Lamley Ter, Arbroath, DD115AD

Your patient underwent a day case procedure on 18/ 7/95

Consultant Dr C J MacEwen

	READ	**ICD9**
Diagnosis		
Ocular motility disorders (R & L)	F4J	378
Ocular motility disorders (R & L)	F4J	378
	READ	**OPCS4**
Procedure		
Recession med rectus eye (R & L)	72310	C321

Treatment
PREDSOL N EAR/EYE 10ml drops qid

Outcome
Follow-up 1 week Ward: OPT =default

Yours sincerely

Dr C J MacEwen
Consultant

DIRECTORATE OF OPHTHALMOLOGY

CJM/AS/MPI 28 04 88 0060

Dr. C.J. MacEwen, Wards 24/25

Mrs A. McConnachie,
Braeminzion,
Glenclova,
KIRRIEMUIR

14th June 1995

Dear Mrs McConnachie,

Stacey Leonard

You did not bring Stacey along for squint surgery on 5.6.95 as had been organised, because the appropriate consent for surgery aparently had not been obtained. I discussed this with you in the out-patient clinic and obviously it is important that consent is obtained and surgery is carried out reasonably soon in order to improve Stacey's problem. I have relisted Stacey for 18.7.95 as a day case for squint surgery, and would be grateful if you could make the appropriate arrangements to have consent arranged for that date.

Yours sincerely,

C.J. MacEwen
Consultant Ophthalmologist

c.c. Mrs Elizabeth Ross, Social Worker, Academy Lane, Arbroath

DIRECTORATE OF OPHTHALMOLOGY

CJM/AS/MPI 28 04 88 0060

Dr. C.J. MacEwen, Wards 24/25

Dr. A. Hornsby,
Abbey Health Centre,
East Abbey Street,
ARBROATH

14th June 1995

Dear Dr. Hornsby,

Stacey Leonard, 9 Lamley Terrace, Arbroath

Stacey was due for admission for squint surgery on 5.6.95. Unfortunately the day before surgery her foster parents called to indicate that this had not been cleared with the social work department and no consent had been given for surgery. She therefore was not brought along for the operation. I am not entirely clear why this had not previously been approved, as I discussed it with Mrs McConnachie in the out-patient department. I given her a new date for surgery for Tuesday the 18th of July and have written to her step mother again to ensure that she obtains consent from the appropriate authorities on this occasion.

Yours sincerely,

C.J. MacEwen
Consultant Ophthalmologist

McCONNACHIE
EYECARE

21 High Street
Brechin
DD9 6ES
01356 629293

05/02/2026

FAO On-call Ophthalmology

Stacey Leonard 2804880060

Impression LE keratitis (CLS related?)

Stacey has presented with a sore, photophobic and watery LE for 2 days. Reports no CLS wear until today as glasses broken.

Previous episode of LE CLS related ulcer managed by HES.

BE superior limbal redness RE G 1.5 LE G2.5.
LE round infiltrate/ulcer just superior temp to corneal apex, within pupil margin. Stains with NaF. Surrounding area haziness.

Discussed with on-call - px will attend today.

Yours Faithfully

Stuart McConnachie BSc Hons MSc DipTp (IP) MCOptom

HISTORY/CONTINUATION SHEET

.....UNIT/WARD/DEPT.

Ward/Clinic/
Hosp. .....

LEONARD
STACEY L.
Surname .. 9 LAMLEY TER
First Name . ARBROATH
Address DD11 5AD
-------- DR. A. HORNSBY
G.P. & Addre: ABBEY H/CENTRE
EAST ABBEY ST ARBROATH

2 8 0 4 8 8 ..... Cons.
0 0 6 0 F ☐ C.H.I. No.
ST .....
..... M. State
..... Sex
BLOCK LETTERS OR PATIENT LABEL

DATE	Page .....
5/6/95	R/L · Assessment for Squint o/p
6/6/95	Cancelled - Child in foster Care, - admission to be discussed with Social Work dept.
15/7/95	R/L - Esotropia "Worse" Squint + Convergence Acc Surgical notes:

DATE

OPHTHALMOLOGY

Ward/Clinic/
Hosp. ..... Cons.
D D M M Y Y
Surname Leonard 280425 0060 C.H.I. No.
First Name Stacey M. State
Address ..... Sex
G.P. & Address (G.P. Requests only)
USE BLOCK LETTERS OR PATIENT LABEL

Date: 280425

I.C.D.

37yrs.

Complaint: Attended for review ARC Act. Referred from optom. LE burning, red, light sensitive, CL wearer – daily, last wore 4 days ago LE.

Medications
See clinical portal.
CL use
– dailies
– no shower/swim/sleep
– ~8 hour use
– 00 source.

Past Ophthalmic History
CL's – soft, squint – had op.

Past General History
under psychiatry.

Family Ophthalmic History
Son – high risk of Glaucoma

Allergy – LATEX

R.V.A. With glasses ~~X~~ CL 6/7.5+2

L.V.A. With glasses 6/18 PH No help.

Own glasses

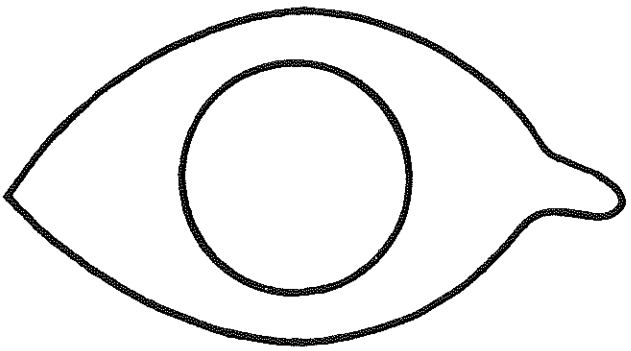
Refraction

1 – cor.

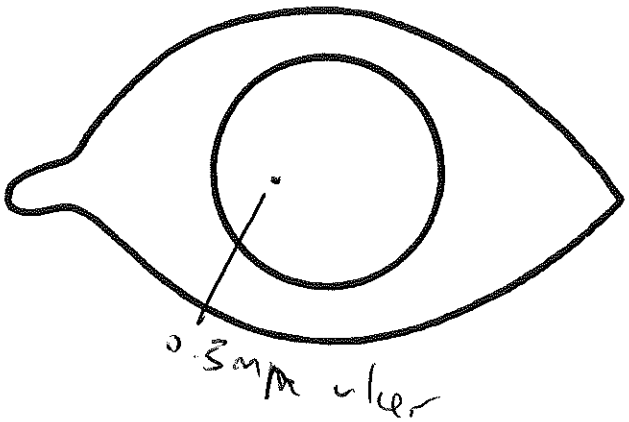
CL insitu | 6

THB(MR) 8

Right Eye



Left Eye

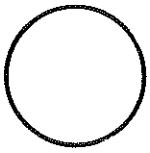


Pupil Reactions

Ocular Movements

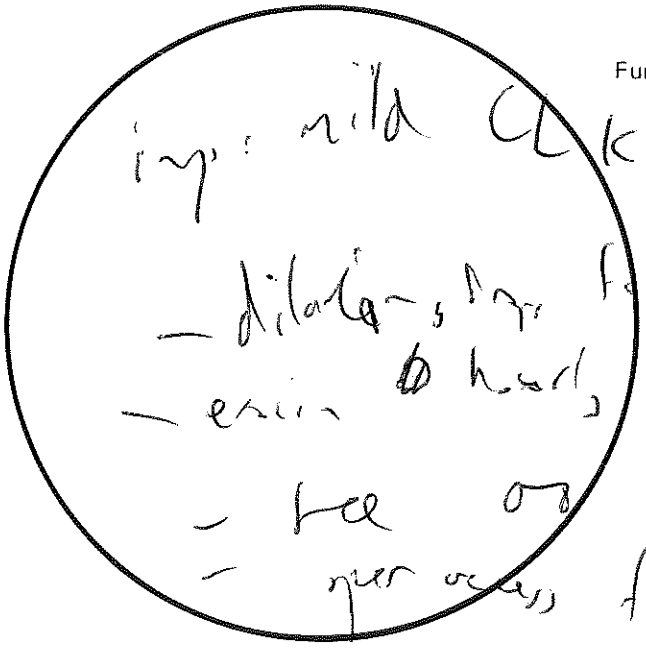
Cover Test

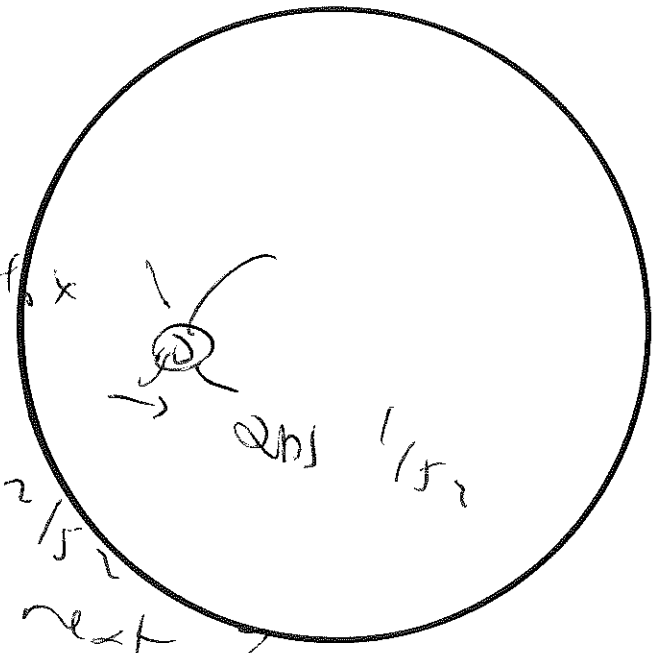
Lenses



Tensions

Fundi





OPHTHALMOLOGY

Ward/Clinic/
Hosp. ..... Cons.

Surname Leonard
First Name Stacey
Address .....
G.P. & Add

D D M M Y Y
28 04 80 60 C.H.I. No.

M. State
Sex

USE BLOCK LETTERS
OR PATIENT LABEL

Date: 05.02.26.

I.C.D.

Complaint:

Ref Referral from optom
with 2/7 history of ascre, photophobic
watery (L) eye.
Contact lens wearer (daily soft lenses).
last wore in (L) eye yesterday.
? contact lens related (L) keratitis

Past Ophthalmic History (L) lazy eye - (L) squint surgery as a child
(L) corneal ulcer April 2025.
Contact lens wearer

Past General History

Fit + well

Family Ophthalmic History

NKA allergies

R.V.A. With glasses 6/7.5 ↓ CL.

L.V.A. With glasses 6/60 UA.
6/36+1 ↓c pH

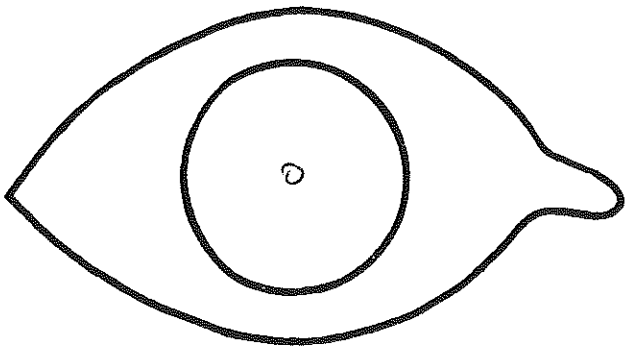
Own glasses

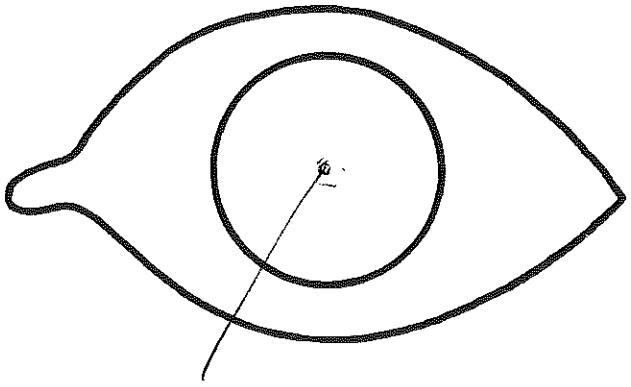
1 cure -
11.2 - 7.4

Refraction

THB(MR) 8

Right Eye DBA Ac odd cell Left Eye





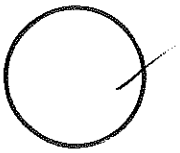
0·5×0·5mm ill-defined
no hyphyma

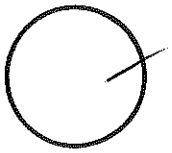
Pupil Reactions

Ocular Movements

Cover Test

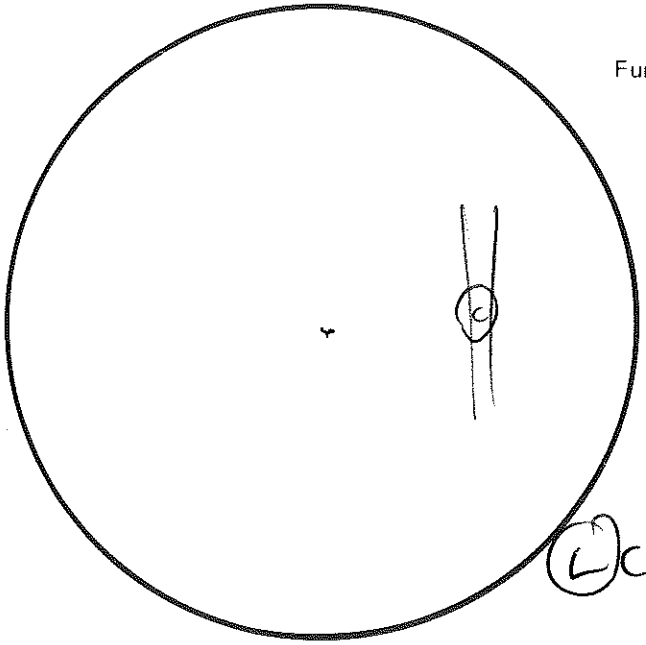
Lenses

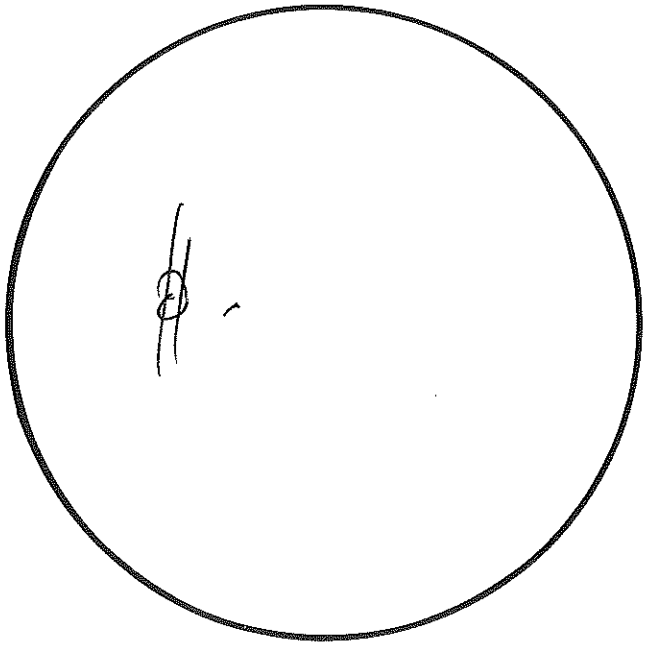




Tensions

Fundi





(L) CLK

(P) cyclo TDS
Epoch 1°
Flu Swollen

No CL 4/12

HH 073

HISTORY/CONTINUATION SHEET

.....UNIT/WARD/DEPT.

Ward/Clin
Hosp....
Surname Leonard
First Nam Stacey
Address. 2 Wards Road
Brechin
DD9 7AS
G.P. & Ac

2804880060

.....Cons.
Y
C.H.I. No.
.....M. State
..... Sex

TT Morley

USE BLOCK LETTERS OR PATIENT LABEL

DATE

Page .....

8/2/26 Attended Ward 25 for review.

Feels no change since medication given.

VA - 6/9 CL [redacted]. CF UA.

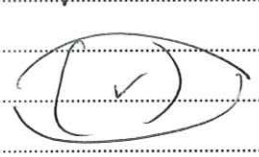
PH - 6/5 PH - 6/24.

16/5.

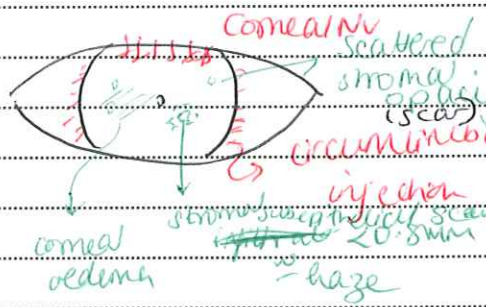
08/02/26 Dr. Tasneem Bawjee (SR)

37 F (L) CL-related Keratitis
- on Cyclo 7DS
- Hourly Exocin

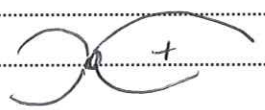
thrbbing
Feels VA worse, was initially better, but ongoing burning sensation does not resolve; ? FB sensation.
went to optician, advised to ↑ Exocin to QDS, but no improvement w symptoms.



E+L
ACD&G
CAS



No EP
No hypopyon
D✓
M✓
V✓



Imp: Resolving (L) CL Keratitis w Inflammation.

No Cetta

plan: (1) Introduce Maxidex QDS LE.
(2) Exocin QDS LE.
(3) Carbomer QDS LE.
(4) F/U [redacted] 12/02

(5) SDS advice. JM.

THB.(MR)3A

DATE

12/2/26 ARC - area 6a NWS - return, resolving
1315 (L) CLK

RVA
6/9 - 1 CL

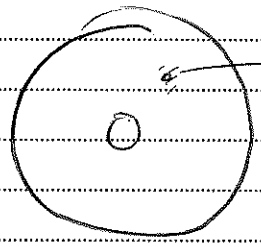
LVA
6/60 uA
6/24 ph

icare

7 10

GW.

(R) cm
(L) amblyopic



At once

(1) cm reading
(2) Stop Exam
Manifest tape 20/12, 30/12, 40/12 hm obj
Rx 3/12 → (2) if all clear

GW 2/26

HISTORY/CONTINUATION SHEET

.....UNIT/WARD/DEPT.

Ward/Clinic/Hosp..... Leonard Stacey

Surname ..... 2 Wards Road

First Name.....

Address ..... Brechin DD9 7AS

G.P. & Address (G.P. Requests on

2804880060 .Cons.

✓

.H.I. No. .....

M. State

... Sex

TT Morley ETTERS T LABEL

DATE

Page .....

5/3/26 Attended ARC for review

~~R~~RVA
CL
6/24
pH 6/9

~~LA~~

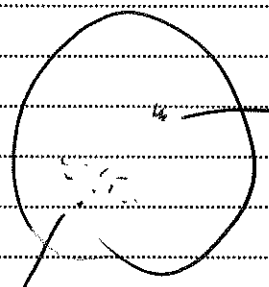
LVA
CA
6/60+1
pH 6/18

ICare
/ \
4 12

CC/Ew

5/3/26 Clinical

Still scratchy & niggly.



L/d
pain
(-ve)

Inj: settled but
~~not~~ ongoing.

dry.

① - pred 5 TDS 1/7 then OD 1/52 alt 1/52
- Quite PA
- Ale & co.

Generally

DATE	

DUNDEE TEACHING HOSPITALS
NHS TRUST

OPERATION NOTES

..... UNIT/WARD/DEPT

Ward/Clinic/
Hosp. .....

Surname ..
First Name
Address ...
.....
G.P. & Addre

LEONARD 28 04 88
STACEY L. 0060
9 LAMLEY TER F
ARBROATH SI
DD11 5AD
DR. A. HORNSBY
ABBEY H/CENTRE
EAST ABBEY ST ARBROATH

..... Cons.
C.H.I. No.
.....
..... M. State
..... Sex
.....
BLOCK LETTERS
OR PATIENT LABEL

DATE OF OPERATION	Operation Proposed	TIME BEGAN ..... AM PM TIME FINISHED..... AM PM

SURGEON'S NOTES

DMR9

CONSENT FOR OPERATION INVESTIGATION

I,.....

of, ...

hereby consent to *(undergo / (the submission of my *(child / (ward .....

..... to undergo (the operation/investigation of) .....

..... the nature and purpose of

which have been explained to me by * Dr./Mr. .....

I also consent to such further or alternative operative measures as may be found necessary durring the course of the above mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes. No assurance has been given to me that the operation will be performed by any particular practitioner.* *

Date ..... Signed .....
* (Patient/Parent/Guardian)

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian. *

Date ..... Signed .....
* Medical/Dental Practitioner

NOTE: **Age of Consent**

The Tayside Health Board have been advised by the Central Legal Office that anyone who has attained 16 years of age can give or withhold valid consent to operation/ investigation on himself/herself. Ordinarily the parent or guardian should be informed in the case of a patient who has not reached the age of 18.

* DELETE AS APPROPRIATE

** THIS CLAUSE SHOULD BE DELETED WHERE THE INITIAL CONSENT IS FOR AN INVESTIGATION AND NOT AN OPERATION

ANY DELETIONS, INSERTIONS OR AMENDMENTS TO THE FORM ARE TO BE MADE BEFORE THE EXPLANATION IS GIVEN AND THE FORM SUBMITTED FOR SIGNATURE.

Direct Referral to Eye Department- General

NHS Tayside

Patient Surname	Patient Forename	Optometrist Details
ELLIS	**Stacey**	**Graeme E Shand** **The Spectacle Company** **105 High Street** **Montrose** **DD10 8QR** **01674 678988**
DOB: **28/4/88**	CHI:	
Address: **8 Mill Place, Craigo**		
Postcode: **DD10 9LB**	Tel No:	
Ref:	Date:	

Patient history & details

Sore right eye 1 week, burning sensation comes and goes. Photophobic. No discharge. Slightly watery.
Contact lens wearer but no lenses recently.

General Health

Medications

Right — Ocular examination – External / Internal — Left

Cornea – no gross stain
Proxymetacaine does not relieve photophobia
Mild limbal injection total.
No flair, no glare anterior chamber clear.
Tarsal conj slightly inflamed.

Tonometry Time — R **15** L **15** Applanation **N**

Pupils **Normal**

Fields *Attached* ***Y / N***

Vision	Sph	Cyl	Axis	Prism	VA	PH VA	Near add	NVA	Test Date
R	+5.50	-0.50	45		6/12				
L	+6.00	-0.25	85		6/12				

Specific Additional Information: **Fundus Photo attached? Y / N**

Previous VA R 6/7.5. Spoke to Dr Faulds advised appointment this afternoon.

GP informed of referral? Y / N
(Do not send a copy of this letter – use separate GP letter for information only)

GP Name: **Annat Bank**

GP Address:

Optometrist Name: **Graeme E Shand**

Optometrist Signature:

MS Leo

OPHTHALMOLOGY

Ward/Clinic/
Hosp. ..... Cons.

D D M M Y Y
2 8 0 4 8 8 0 0 6 0 C.H.I. No.

Surname ELLIS STACEY
First Name & MILLY PLACE M. State
Address CRIEFF Sex

G.P. & Address (G.P. Requests only) USE BLOCK LETTERS OR PATIENT LABEL
Dr R Cranshick, Annat Bank, Links H/C
Frank Wood Way, Montrose

Date: 13/3/09

I.C.D.

Complaint: OPT REF

(R) eye pt woke in morning with burning sensation.
pt having more pain and headaches.
occasional CL wearer - not recently (3m)
worse when reading.

Past Ophthalmic History

previous contact lense wearer
hasn't wore contacts last month.

Past General History

Fit and well.

Family Ophthalmic History

?

	R.V.A.	L.V.A.
With glasses	Esl 6/12 Eph 6/6-3	Esl 6/9 Eph No help.
Own glasses	N5.	N5.

Refraction

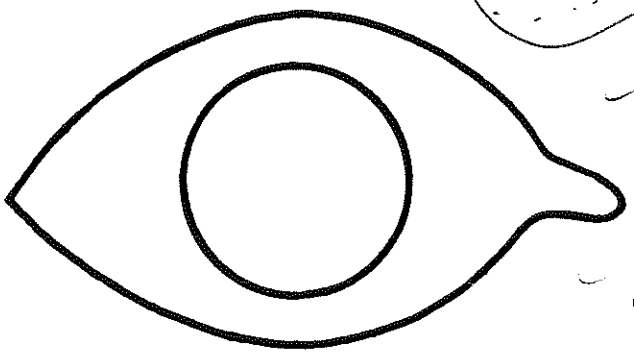
+5.50	+6.00
-0.50	-0.75

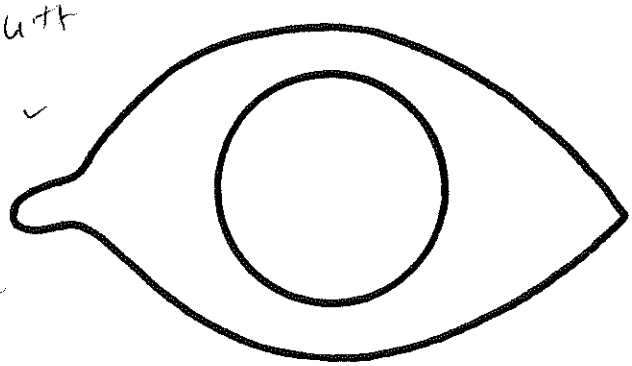
Right Eye

few follicles

+ blepharitis

- white -





Left Eye

- clear -

sl poor Teen film

- quiet -

Pupil Reactions

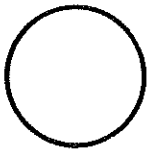
Ocular Movements

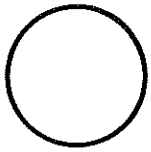
A.

Cover Test

8 9.

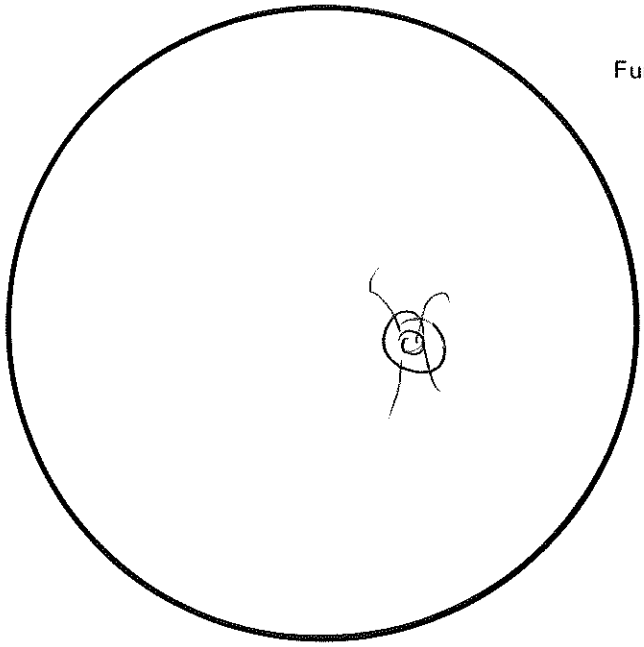
Lenses



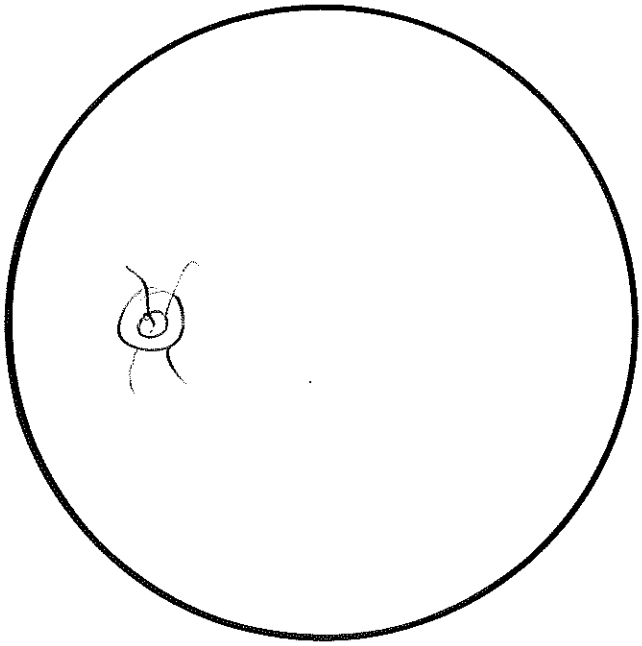


Tensions

Fundi



D ✓



I Blepharitis
Nil else seen
to CLs

P Nil hyperaem
DDO.

OPHTHALMOLOGY

Ward/Clinic/
Hosp. ..... Cons.

D D M M Y Y

ELLIS 28 04 88 0060 C.H.I. No.
STACEY L F
Surr 8 MILL LANE .....
First CRIAGO ..... M. State
Add BY MONTROSE AB30 1YS ..... Sex
DR. M ANDERSON .....
ANNAT BANK .....
G.P LINKS HEALTH CENTRE
FRANK WOOD WAY

USE BLOCK LETTERS OR PATIENT LABEL

Date: 25/10/10

I.C.D.

Complaint:

Past Ophthalmic History

Past General History

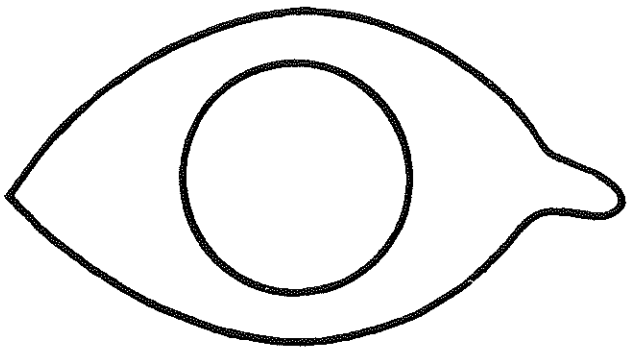
Family Ophthalmic History

R.V.A.	L.V.A.
With glasses	With glasses

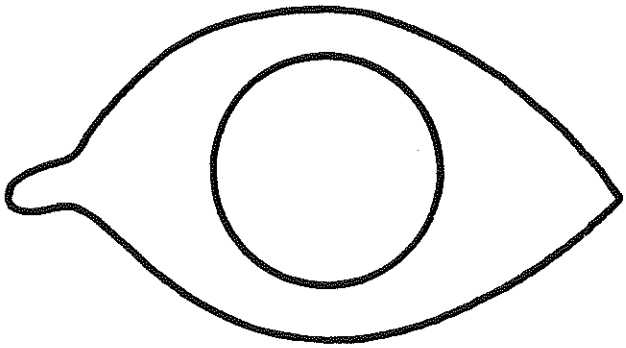
Own glasses

Refraction

Right Eye



Left Eye

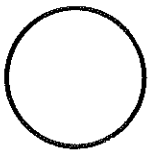


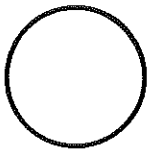
Pupil Reactions

Ocular Movements

Cover Test

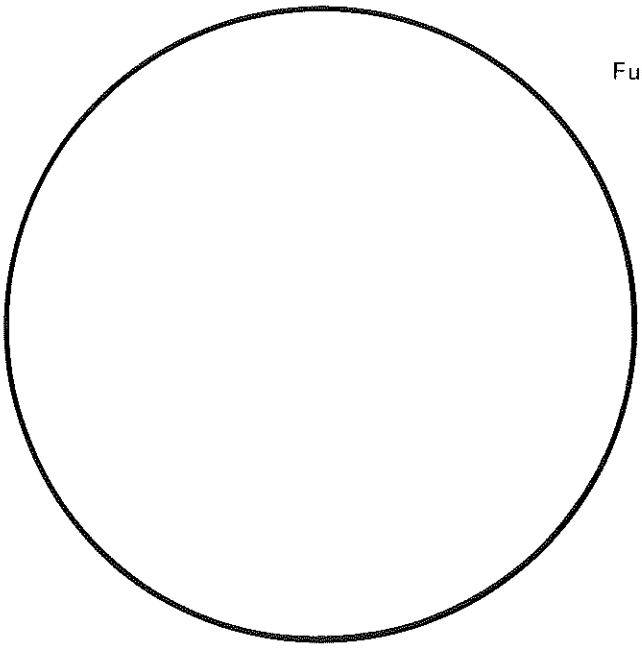
Lenses

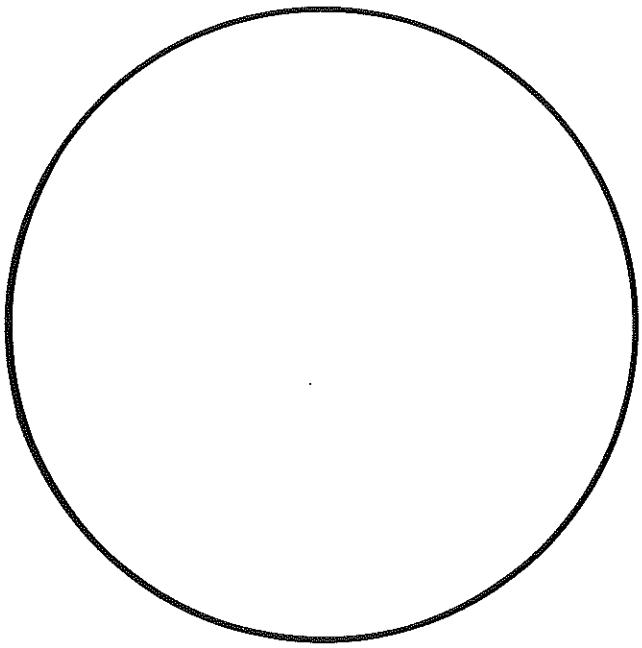




Tensions

Fundi





HISTORY/CONTINUATION SHEET

.....UNIT/WARD/DEPT.

Ward/Clinic/
Hosp

ELLIS 28 04 88 0060
STACEY L F
8 MILL LANE
CRIAGO
BY MONTROSE AB30 1YS
DR. M ANDERSON
ANNAT BANK
LINKS HEALTH CENTRE
FRANK WOOD WAY

Cons

D M M Y Y

C.H.I. No.

M. State

Sex

USE BLOCK LETTERS
OR PATIENT LABEL

DATE	Page .....

THB.(MR)3A

DATE

- 8 JUN 2023

REFERRAL FORM FOR CLINICAL GENETICS APPOINTMENT EITHER BEFORE PREGNANCY OR DURING PREGNANCY

Date Referred: 6/6/23

Discussed with Clinical Genetics: YES / (NO)

If yes, with whom: .....

Patient aware of Referral: (YES) / NO
If NO – note below who will inform her?

.....

Attach addressograph label here OR

Name Stacey Leonard
CHI 2804880060
Address 2 Wards Rd
Brechin DD9 7AS
GP Brechin

09454

Patient daytime telephone number: 07731805886

LMP/EDD: LMP 5/4/23

REASON FOR REFERRAL:

para 7/6, last son born 24/12/21 Odin, has Axonfeld-rieger syndrome.
Other children well & no concerns.
Stacey newly pregnant. Reports GP has referred to genetics, but unsure

Referring Obstetrician: Pall Agustsson/ Pauline Lynch / Other .....
(Please circle / complete)

Contact Number/Bleep Number: PP Lford 01241822537

Signed: LFORD

(Name in Block Capitals: .....)

You may contact Sheila Slater, Principal Genetic Counsellor, 01382 740481 (40481); Dr David Goudie, Consultant Clinical Geneticist, 01382 632151 (32151); or Dr Jonathan Berg, Consultant Clinical Geneticist, 01382 660111 (ext. 35716) for advice/guidance.

PLEASE ensure: **your writing is legible;**
you complete all details requested.

Please FAX this form to Clinical Genetics on 01382 496382 external / 36382 internal, together with the original referral letter from GP.

Clinical Genetics
Specialist Services
Ninewells Hospital
Dundee
DD1 9SY

Tel 01382 632035

www.nhstayside.scot.nhs.uk

PRIVATE & CONFIDENTIAL
Jillian Stewart
Midwife
Obstetrics & Gynaecology
Ninewells Hospital
Dundee
DD1 9SY

Date Typed:	28/06/2023
Date Dictated	27/06/2023
Clinic Date:	15/05/2023
Your Ref:	
Our Ref:	JB/AJ/ **2804880060**
Pedigree No:	**05454**
Enquiries to:	Clinical Genetics
Extension:	32035
Direct Line:	01382 632035
Email:	Tay.clinicalgenetics@nhs.scot

Dear Jillian

Re: Stacey Leonard, 2 Wards Road, Brechin, Angus, DD9 7AS DOB: 28/04/1988

I saw Stacey in the Genetics Clinic. You will recall that she is pregnant with an LMP of 5 April 2023. She has a son, Odin, who has Axenfeld Rieger syndrome. At the moment, we are currently seeing if we can find a genetic variant that would cause this, so we do not know if Odin has a de novo genetic variant, a familial genetic variant, or sporadic Axenfeld Rieger.

Talking to Stacey, Odin is otherwise very healthy, and does not have serious problems with his eyesight. On family history, Stacey's partner does have a squint, but has refused to see an Optician. Odin has several brothers and sisters who are all healthy and Odin is currently under investigation by Dr Catherine McWilliam in the Arbroath Clinic.

Mum seems relatively relaxed about the diagnosis in this pregnancy, and without knowing if father is affected or not, or identifying a genetic variant, it will not be possible to give a sensible recurrence risk in this pregnancy, which will be between low and 50%.

I can only suggest that care should be taken to look at cardiac and renal structures on the 20 week scan, and the baby should have their eyes reviewed shortly after delivery. I think it would be reasonable for this to be a Paediatrician check at birth, with review by Ophthalmology thereafter.

I don't feel that I have a great deal else to offer this lady during her pregnancy, so will not arrange routine follow up. I would, however, be very happy to see her again if there are further questions with which I could help.

With best wishes.

Yours sincerely,

Authorised on 28/06/2023 15:13:59 by Jonathan Berg.

Dr Jonathan Berg
Consultant in Clinical Genetics
GMC Number 3324172

(D) Dr TT Morley, Brechin Medical Practice, Brechin Health Centre, Infirmary Street, Brechin, DD9 7AN
(P) Dr Jennifer Scotland, Consultant Neonatologist, Ward 40, Ninewells Hospital, Dundee, DD1 9SY

Clinical Genetics
Specialist Services
Ninewells Hospital
Dundee
DD1 9SY

Telephone 01382 632035

www.nhstayside.scot.nhs.uk

PRIVATE & CONFIDENTIAL
Stacey Leonard
2 Wards Road
Brechin
Angus
DD9 7AS

Date Typed:	15/12/2023
Date Dictated	14/12/2023
Clinic Date:	12/12/2023
Your Ref:	
Our Ref:	JB/ER/ **2804880060**
Pedigree No:	**05454**
Enquiries to:	Clinical Genetics
Extension:	32035
Direct Line:	01382 632035
Email:	tay.clinicalgenetics@nhs.scot

Dear Mrs Leonard

We have now received the results of the genetic test we did in Odin. This was to see if we could find a cause for his eye problems.

We did not find a gene change.

From my point of view, I will just write to the paediatric doctors to suggest that they check your baby's eyes carefully after birth. I will not take any other action. This test result will also be passed to Dr Catherine McWilliam who has been seeing Odin in her clinic.

Please do not hesitate to contact me if you have any further questions at the moment.

Yours sincerely,

Authorised on 05/01/2024 11:21:53 by Jonathan Berg.

Dr Jonathan Berg
Consultant in Clinical Genetics
GMC Number 3324172

(D) Dr TT Morley, Brechin Medical Practice, Brechin Health Centre, Infirmary Street, Brechin, DD9 7AN
(P) Dr Jennifer Scotland, Consultant Neonatologist, Ward 40, Ninewells Hospital, Dundee, DD1 9SY

Jennifer
Odin has an anterior chamber eye problem, and we have now tested the different genes that could cause this but not found a genetic cause.

I think that as a precaution, Stacey Leonard's baby should be checked carefully after birth with an ophthalmology review. If this is normal, it will be very reassuring.

Ward/Clinic	Maternity	CHI	2804880060
Hospital	Arbroath Infirmary	Surname	LEONARD
Clinician	Joanne Nelson	First Name	STACEY
Date	01/06/2020	Address	2 WARDS ROAD BRECHIN DD9 7AS
		GP/Address	Brechin Medical Practice Brechin Health Centre Infirmary Street Brechin DD9 7AN

Dear Doctor,

The above patient was reviewed today; please accept this brief communication.

Provisional/Diagnosis is: MSSU tested positive for E-Coli. Postnatal Day 16.

Comment/Recommendations: Requires 7 days antibiotics. Sensitive to Trimethoprim, sensitive to amoxicillin. Please send prescription to Boots Chemist, Brechin.

Follow up by clinic required: No

Specific Monitoring Required: No

The following treatment is recommended:

	Medication	Dose	Frequency	Indication	Duration
1.	As prescribed	As prescribed	As prescribed	EColi positive on MSSU	7 days

Is any Medication to be discontinued: No

STACEY LEONARD 2 WARDS ROAD, BRECHIN, DD9 7AS *GP Practice: Brechin Medical Practice, Brechin Health Centre, Infirmary Street, Brechin, DD9 7AN*	CHI: 2804880060 Born: 28/04/1988

This letter updates/amends previous communication received in relation to this episode of care

Discharge Details

Admission	19/08/2021	**Discharge**	22/08/2021
Specialty	Obstetrics	**Consultant**	Dr Pauline Lynch (3265123)
From	Ward 38 North Ninewells Hospital	**Destination**	Home

Diagnoses

Acute abdominal pain syndrome	

Operations/Procedures

Actions Required for Primary Care

Communication to Primary Care

Dear Doctor,

Stacey Leonard was admitted to Ninewells Hospital for observation following presentation with lower abdominal cramping pains. She gave no history of ruptured membranes and was otherwise well. Observations throughout her short stay have remained normal. These cramping pains were irregular and beginning to reduce in frequency after 12 hours. CTG was reassuring.
Stacey is now fit for discharge with a diagnosis of likely irritable uterus; she will continue to be managed by her community midwife. Her low Hb was noted. As she is already taking oral folic acid and iron replacement we will arrange for a dose of IV iron replacement.

Kind regards,

Medications

Drug & Formulation	Dose	How to take	How long to take	Supply	Dispensary
Fluoxetine 20mg capsules	20mg	ONE TO BE TAKEN EVERY DAY AS ADVISED BY CMHT		Own at Home	
Quetiapine 100mg tablets	100mg	TAKE ONE AT NIGHT AS ADVISED BY CMHT		Own at Home	

Discontinued Medication

Medication Notes

Allergies

	Allergy, unspecified	07/07/2010

Deleted Allergies

Follow Up Arrangements

Final Discharge Comments

STACEY LEONARD 2 WARDS ROAD, BRECHIN, DD9 7AS *GP Practice: Brechin Medical Practice, Brechin Health Centre, Infirmary Street, Brechin, DD9 7AN*	CHI: 2804880060 Born: 28/04/1988

Pharmacy

Pharmacy Check Type: **Professional check**

Pharmacist checked prescription with limited access to information. Please contact prescriber for any queries

Copy To

Sign Off

	Name	Job Title	Date/Time
Initial Sign Off	Dr Claire McWhirter	Specialty Trainee 1	20/08/2021 12:56:42
Pharmacy Sign Off	Miss Molly Walker	Rotational Pharmacist	20/08/2021 12:59:12
Final Sign Off			

STACEY LEONARD 2 WARDS ROAD, BRECHIN, DD9 7AS *GP Practice: Brechin Medical Practice, Brechin Health Centre, Infirmary Street, Brechin, DD9 7AN*	CHI: 2804880060 Born: 28/04/1988

This letter updates/amends previous communication received in relation to this episode of care

Discharge Details

Admission	24/09/2021	**Discharge**	25/09/2021
Specialty	Obstetrics	**Consultant**	Dr Pauline Lynch (3265123)
From	Ward 38 South Ninewells Hospital	**Destination**	Home

Diagnoses

Delivery of a Live Baby	

Operations/Procedures

Spontaneous Vaginal Delivery		24/09/2021

Actions Required for Primary Care

Communication to Primary Care

Dear Doctor,

Stacey attended Ninewells hospital on 24/09/21 @39+2 in spontaneous labour. Delivered a live baby boy with EBL 200mls. Currently doing well and fit for discharge. When contraception was discussed she is considering a BTL but undecided yet and ill discuss with her GP once decided for referral, in the interim she will use barrier methods.

Kind Regards

Dr Jessie Vanderpuije
GPST2

Medications

Discontinued Medication

Medication Notes

Allergies

	Allergy, unspecified	07/07/2010

Deleted Allergies

Follow Up Arrangements

Final Discharge Comments

Pharmacy

Copy To

STACEY LEONARD 2 WARDS ROAD, BRECHIN, DD9 7AS *GP Practice: Brechin Medical Practice, Brechin Health Centre, Infirmary Street, Brechin, DD9 7AN*	CHI: 2804880060 Born: 28/04/1988

Sign Off

	Name	Job Title	Date/Time
Initial Sign Off	Dr Jessie Vanderpuije	GPST 2	25/09/2021 10:46:14
Pharmacy Sign Off			
Final Sign Off			

STACEY LEONARD 2 WARDS ROAD, BRECHIN, DD9 7AS *GP Practice: Brechin Medical Practice, Brechin Health Centre, Infirmary Street, Brechin, DD9 7AN*	CHI: 2804880060 Born: 28/04/1988

This letter updates/amends previous communication received in relation to this episode of care

Discharge Details

Admission	20/12/2023	**Discharge**	23/12/2023
Specialty	Obstetrics	**Consultant**	Dr Pauline Lynch (3265123)
From	Ward 38 North Ninewells Hospital	**Destination**	Home

Diagnoses

Spontaenous vaginal delivery	

Operations/Procedures

Actions Required for Primary Care

Communication to Primary Care

Dear Colleague,

Stacey delivered a baby boy by SVD on 22/12/23 at 17:41, following an IOL for GBS at 37+4. Details are summarised below.
Gestation 37+4
Birth weight 2700g
EBL 150ml
Complications: Nil
VTE risk: Intermediate. For 10 days of prophylactic LMWH
Contraception: Sayana press.

Thank you for the ongoing care.
Kind regards,
Ward 38

Medications

This prescription has not been reviewed by a Pharmacist

Drug & Formulation	Dose	How to take	How long to take	Supply	Dispensary
Aripiprazole 10mg tablets		1 TABLET EACH DAY AS DIRECTED BY PSYCHIATRY		Own at Home	
Dalteparin sodium 5,000units/0.2ml solution for injection pre-filled syringes	5,000 units	Take OD	10 Days	TTO	
Fluoxetine 20mg capsules		TAKE 3 CAPSULES DAILY		Own at Home	
Lamotrigine 100mg tablets		TAKE ONE A DAY AS ADVISED BY PSYCH. TOTAL OF 150MG A DAY.		Own at Home	

STACEY LEONARD 2 WARDS ROAD, BRECHIN, DD9 7AS *GP Practice: Brechin Medical Practice, Brechin Health Centre, Infirmary Street, Brechin, DD9 7AN*	CHI: 2804880060 Born: 28/04/1988

Lamotrigine 50mg tablets		TAKE ONE A DAY AS ADVISED BY PSYCH. TOTAL 150MG A DAY.		Own at Home	
Trimethoprim 200mg tablets	200mg	Take BD	Total 7 days. Last dose 26/12/23	Hospital Pharmacy	

Discontinued Medication

Medication Notes

Allergies

	Allergy, unspecified	07/07/2010

Deleted Allergies

Follow Up Arrangements

Final Discharge Comments

Pharmacy

Copy To

Sign Off

	Name	Job Title	Date/Time
Initial Sign Off	Rupali Prakash	FY1 2022	23/12/2023 10:44:18
Pharmacy Sign Off			
Final Sign Off			

Women and Child Health
Clinical Group
Acute Services
NHS Tayside
Whitehills Hospital
51 Station Road
Forfar
DD8 3DY

www.nhstayside.scot.nhs.uk

Dr RC Cranswick
Annat Bank Practice
Links Health Centre
Frank Wood Way
Montrose
DD10 8TY

Date	27/07/2016
Clinic Date	19/07/2016
Your Ref	
Our Ref	CN/RB/ **2804880060**
Enquiries to	Mrs Rosemary Bell
Extension	61206
Direct Line	01307 475206
Email	rosemarybell@nhs.net

Dear Dr Cranswick

Stacey Ellis, 17 Annat Road, Montrose, DD10 8EF DOB: 28/04/1988

Thank you for referring this twenty-eight year old para 4+0 for consideration of sterilisation.

Unfortunately NHS Tayside Protocol does not allow me to perform sterilisation in patients younger than thirty due to the high risk of regret. Stacey's main reason for wishing sterilisation is that she has finished her family and she has had trouble with other forms of contraception. She currently has a Nexplanon insitu and bleeds heavily with this. She has intermenstrual and post-coital bleeding. She is a smoker and has not had a smear in eight years. She has a low BMI. She has previously tried Depo-Provera and found that she developed a pain in her side every eight weeks. Although she has never tried the Mirena coil, she does not like the idea of a foreign body inside her uterus. Her pregnancies were essentially uncomplicated but she did have an anti-partum haemorrhage in one pregnancy and she informs me there were some concerns about her cervix at this time. I note she suffers from depression and is currently on Sertraline for this.

Stacey was understandably disappointed that I was unable to offer her sterilisation. However my concern was that her irregular bleeding may be due to an abnormality of her cervix rather than hormonal. After much persuasion she eventually allowed me to examine her cervix but she was only able to tolerate a quick look. The cervix was erythematous, probably represents an ectropion however I was not able to see whether the area was raised. There was some contact bleeding with the smear. A quick vaginal examination did not suggest any suspicious lesions.

I have suggested that she could add in the combined oral contraceptive pill for one month to see if this would upgrade her progesterone receptors and allow the Nexplanon to be more effective. She is aware that if the smear is abnormal she would need colposcopy. I have given her an Information

Leaflet on Female Sterilisation and I look forward to seeing her again when she is thirty. Her partner was present with her today but he would not consider vasectomy.

Yours sincerely

Authorised on 05/08/2016 18:16:27 by Caithlin Neill.

Dr Caithlin Neill
Consultant Obstetrician & Gynaecologist

Women and Child Health
Clinical Group
Acute Services
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

Tel: 01382 660111
Fax: 01382 632096
www.nhstayside.scot.nhs.uk

Dr RC Cranswick
Annat Bank Practice
Links Health Centre
Frank Wood Way
Montrose
DD10 8TY

Date	08/08/2016
Clinic Date	04/08/2016
Your Ref	
Our Ref	KR/JHG/ **2804880060**
Enquiries to	Mrs Jackie Gilchrist
Extension	32085
Direct Line	01382 632085
Email	jgilchrist@nhs.net

Dear Dr Cranswick

Stacey Ellis, 17 Annat Road, Montrose, DD10 8EF DOB: 28/04/1988

Clinical impression – cervical cancer (? Stage 1B)

Many thanks for referring Stacey to the colposcopy clinic today. Her smear was suggestive of high grade dyskaryosis ? invasive.

On clinical examination there is a raised lesion on the cervix measuring about 2.2 cm in its maximum dimension. I was only able to do a punch biopsy today in view of the intense vaginal pain Stacey has (long history of vaginismus). I have also organised for a CT and MRI to be carried out. I will see her back in the clinic on 15 August to give her the final diagnosis.

I have explained to her my high suspicion of cervical cancer and hopefully the scan will give us further information about staging and treatment. Stacey was accompanied by her partner today and he was part of the consultation. I have also given her details of our clinical nurse specialist in case she requires support while we are awaiting the results.

Yours sincerely

Authorised on 09/08/2016 12:29:09 by Kalpana Ragupathy.

Dr Kalpana Ragupathy
Consultant Obstetrician & Gynaecologist

Women and Child Health
Clinical Group
Acute Services
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

Tel: 01382 660111
Fax: 01382 632096
www.nhstayside.scot.nhs.uk

Dr RC Cranswick
Annat Bank Practice
Links Health Centre
Frank Wood Way
Montrose
DD10 8TY

Date	15/08/2016
Your Ref	
Our Ref	KR/JHG/ **2804880060**
Enquiries to	Mrs Jackie Gilchrist : 09/08/2016
Extension	32085
Direct Line	01382 632085
Email	jgilchrist@nhs.net

Dear Dr Cranswick

Stacey Ellis, 17 Annat Road, Montrose, DD10 8EF DOB: 28/04/1988

The biopsy taken at Stacey's last clinic visit has shown only CIN III. It might be that the sample is not representative as Stacey found the examination quite painful and I was not able to do the loop biopsy which was my initial intention. In view of this I have spoken to Stacey over the phone, have given her the diagnosis and will bring her in to theatre on 16 August to carry out the loop biopsy under general anaesthesia.

Yours sincerely

Authorised on 16/08/2016 14:01:46 by Kalpana Ragupathy.

Dr Kalpana Ragupathy
Consultant Obstetrician & Gynaecologist

Women and Child Health
Clinical Group
Acute Services
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

Tel: 01382 660111
Fax: 01382 632096
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Dr RC Cranswick
Annat Bank Practice
Links Health Centre
Frank Wood Way
Montrose
DD10 8TY

Date	17/08/2016
Theatre Date	16/08/2016
Your Ref	
Our Ref	WMcM/JHG/ **2804880060**
Enquiries to	Mrs Jackie Gilchrist
Extension	32085
Direct Line	01382 632085
Email	jgilchrist@nhs.net

Dear Dr Cranswick

Stacey Ellis, 17 Annat Road, Montrose, DD10 8EF DOB: 28/04/1988

Procedure: Loop excision of transformation zone.

Following a smear suspicious of invasive disease and a difficult examination in clinic this lady was taken to theatre today as planned for a diagnostic loop excision.

On examination she had a 1.5 cm exophytic lesion arising circumpherentially around the os. Whilst this could be a florid viral wart the appearances were certainly more inkeeping with malignancy. Clinically there was no vaginal or parametrial spread. We will liaise with the radiology department as to whether it is still appropriate to do her imaging next week and will see her once the pathology results are available.

Yours sincerely

Authorised on 25/08/2016 21:14:12 by Wendy McMullen.

Dr Wendy McMullen
Consultant in Obstetrics & Gynaecology

Women and Child Health
Clinical Group
Acute Services
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

Tel: 01382 660111
Fax: 01382 632096
www.nhstayside.scot.nhs.uk

Dr RC Cranswick
Annat Bank Practice
Links Health Centre
Frank Wood Way
Montrose
DD10 8TY

Date	30/08/2016
Your Ref	
Our Ref	KR/JHG/ **2804880060**
Enquiries to	Mrs Jackie Gilchrist : 25/08/2016
Extension	32085
Direct Line	01382 632085
Email	jgilchrist@nhs.net

Dear Dr Cranswick

Stacey Ellis, 17 Annat Road, Montrose, DD10 8EF DOB: 28/04/1988

CIN III on final histopathology.
Treatment carried out: LLETZ in August 2016.

It is quite reassuring that the final histology result was indeterminate CIN (CIN III on previous biopsy). The ectocervical margin was involved but the endocervical margin was clear. Usually for young patients like Stacey we discharge them back to yourselves for a repeat smear (test of cure) to be done in 6 months time. However Stacey has not attended for a smear test for a long time owing to severe vaginismus. I discussed the final histology with her over the phone and told her that I will bring her back to the clinic here in 6 months so that we can offer her a pudendal block if required for the smear.

Yours sincerely

Authorised on 01/09/2016 15:11:08 by Kalpana Ragupathy.

Dr Kalpana Ragupathy
Consultant Obstetrician & Gynaecologist

Women and Child Health
Clinical Group
Acute Services
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

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Dr RC Cranswick
Annat Bank Practice
Links Health Centre
Frank Wood Way
Montrose
DD10 8TY

Date	22/12/2016
Clinic Date	12/12/2016
Your Ref	
Our Ref	WMcM/JHG/ **2804880060**
Enquiries to	Mrs Jackie Gilchrist
Extension	32085
Direct Line	01382 632085
Email	jgilchrist@nhs.net

Dear Dr Cranswick

Stacey Ellis, 17 Annat Road, Montrose, DD10 8EF DOB: 28/04/1988

Diagnosis: Loop excision for CIN III August 2016. Ongoing pain and irregular bleeding. Please treat with cyclical progestogens or oral contraceptive pill.

I apologise for the delay in writing regarding this lady whose appointment was expedited to 12 December. She had a loop excision in August for a suspicious cervical lesion but the final pathology is CIN. Even before then she was getting irregular menses with pain but says this has been a lot worse since the procedure. She had recently had a 28 day bleed although this had stopped by the time she came to clinic. Ultrasound organised by Dr Ragupathy shows normal uterus and ovaries with no evidence of haematometrium.

Given her previous difficulties I thought she tolerated clinical examination remarkably well. Her cervix is scarred and tender but otherwise normal. There is no other abnormality. Thank you for taking swabs which are all normal.

I therefore think this lady has dysfunctional uterine bleeding with a tender cervix post surgical. I have advised her to take regular paracetamol and NSAIDS. To regulate her periods thanks you for prescribing either cyclical progestogens or the oral contraceptive pill which she could tricycle so she just gets a withdrawal bleed every 3 months.

She will be seen as planned for her next smear in February.

Yours sincerely

Authorised on 23/12/2016 13:43:30 by Wendy McMullen.

Dr Wendy McMullen
Consultant in Obstetrics & Gynaecology

This letter replaces all previous discharge letters that have been received relating to this patient's episode of care.

NHS Tayside

Ninewells Hospital, Dundee
Discharging Ward: 36 (Gynaecology)

IMMEDIATE DISCHARGE LETTER

Dr. RUTH CRANSWICK
ANNAT BANK PRACTICE
LINKS HEALTH CENTRE
FRANK WOOD WAY
MONTROSE
DD10 8TY

Date: 17/08/2016
Letter Version: 1.0
Enquiries to:
Telephone:
Email:

STACEY LOUISE ELLIS, CHI: 2804880060, DOB: 28/04/1988, 17 ANNAT ROAD, MONTROSE, DD10 8EF

Read Code	Diagnosis	Date	Laterality	Principal / Other
	Elective Gynae Procedure			**Principal**

Diagnosis Comments

Gynae day case. LLETZ.

Date of Admission: **15/08/2016**
Mode of Admission: **Elective**
Source of Admission: **Elective**
Admission Reason: **Elective surgical procedure**
Admission Ward: **36**
Admission Speciality: **Gynaecology**
Discharge Type: **Discharge from NHS inpatient/day case care**
Date Of Discharge: **16/08/2016**
Discharge Destination: **Not known**

Read Code	Operations, Procedures, Investigations and Complications	Date	Laterality	Principal / Other
	Elective Gynae Procedure			**Principal**

Operations, Procedures, Investigations and Complications Comments

Routine case. Post operativly had ?vasovagal attack after leaving ward. recovered well after 10minutes. Minimal cramping pain post-op.

Allergy Information

Allergy	Date Recorded	Comments
H/O: non-drug allergy	12/11/2007	Latex itchy and red

Medications

Drug	Dose	Amount To Be Taken	Frequency	Duration	Quantity	Supply	Additional Information
Fluoxetine 20mg capsules 28 capsule		1OD				Own At Home	

Medicines checked by pharmacist: Mr Iain Hewitt, 17/08/2016 11:27:17

Care Arrangements

None

Follow Up Details

Follow Up	Date	Date To Be Arranged
MRI/CT booked 18/08/2016.		
Letter will be sent out after MDT meeting.		Yes

Communication To Primary Care

Please note this is an Immediate Discharge Letter only. For further details please refer to the full discharge summary, which will follow in the post.

Dear Doctor,

Ms Stacey Ellis was admited for day case in Gynaecology for a LLETZ procedure following on from previous cervical smears producing grossly abnormal results. This was a routine case without any complications. The surgeon noted a "warty appearance and suspicious of cervical cancer". These findings have been explained in full to Ms Ellis and has taken the news well as she was already aware of the possibility.

She was also informed that she may pass a large piece of material in the coming days post-op.

Kind regards,

John Sinclair
FY1

Mr John Sinclair (Position: Doctor. Pager: _____)

Date/Time Signed Off: 17/08/2016 10:45:26

Discharge Consultant: KALPANY RAGUPATHY

Appendix

No items have been appended to this letter.

Women and Child Health
Clinical Group
Acute Services
NHS Tayside
Arbroath Royal Infirmary
Rosemount Road
Arbroath
DD11 2AT

www.nhstayside.scot.nhs.uk

Dr SM Rooney
Brechin Medical Practice
Brechin Health Centre
Infirmary Street
Brechin
DD9 7AN

Date	02/09/2019
Clinic Date	27/08/2019
Your Ref	
Our Ref	YB/MC/ **2804880060**
Enquiries to	Marianne Cowie
Extension	65021
Direct Line	01356 665021
Email	marianne.cowie@nhs.net

Dear Dr Rooney

Stacey Leonard, 2 Wards Road, Brechin, Angus, DD9 7AS DOB: 28/04/1988

The above named patient was reviewed in the gynaecology clinic in Arbroath. She is 31-years-old, para 4, who has mainly had right iliac fossa pain for more than a year. Her menstrual cycle is fairly regular but variable from being light to heavy. She has no symptoms of intermenstrual bleeding. Her smears have been regular and normal and a gynaecology laparoscopy in 2009 has been negative.

Abdominal, speculum and vaginal examination was entirely normal.

In view of the slightly raised previous CA125 I had repeated the CA125. After discussing with the patient I have made arrangements for her to have an MRI. I will aim to have a telephone consultation with the patient once I have the MRI report.

With kind regards.

Yours sincerely

Authorised on 03/09/2019 12:32:46 by Yeswanthini Bhushan.

Dr Y Bhushan
Consultant Obstetrician and Gynaecologist

L Pole
10498/1
Brechin Medical Practice
Brechin Health Centre
Infirmary Street
Brechin
Brechin
DD9 7AN

02/10/2019

Dear Colleague

Thank you for your referral. Please see the following outcome from the vetting process.
MRI features are suggestive of simple ovarian cyst. I also note that serum hcg is more than 1000 and this will be indicative of pregnancy. Can you discuss with this patient regarding pregnancy and she can be referred to EPAC for early scan. Can you also discuss and if patient wishes to continue pregnancy, advice from Obstetric team will be advisable.Though I cannot see if gadolinium/contrast was used during MRI, this will need further discussion with radiology and obstetric team if patient wishes to continue pregnancy.

ADVICE TO REFERRER

Patient Name: Stacey Louise Leonard

CHI Number: 2804880060

Referral Date: 30/09/2019

Yours sincerely

Dr Yeshi Bhushan

Women and Child Health
Clinical Group
Acute Services
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Dr P Lynch
Consultant Obstetrician & Gynaecologist
Ward 38
Ninewells Hospital
Dundee
DD1 9SY

Date	29/11/2019
Clinic Date	27/11/2019
Your Ref	
Our Ref	bp/ **2804880060**
Enquiries to	Ms Robyn Caird
Extension	40538
Direct Line	01382 740538
Email	robyn.caird@nhs.net

Dear Pauline

Stacey Leonard, 2 Wards Road, Brechin, Angus, DD9 7AS DOB: 28/04/1988

I reviewed this patient in the gynaecology clinic in Arbroath in the latter half of August 2019. She was referred in view of symptoms of right iliac fossa pain, raised Ca125 and a cystic lesion of uncertain origin in the pouch of Douglas. Her Ca125 has been between 50 – 70. I had arranged an MRI the report of which has concluded a simple, small right adnexal cyst with a mild anterior uterine adenomyosis. The uterus has arcuate configuration.

This patient is Para 4 and her last 2 pregnancies were at 37 weeks gestation. Since her deliveries she has had colposcopy and loop excision of the cervix. She is concerned about the risk of preterm labour. As suggested by yourself I had obtained input from one of the obstetric colleagues who suggested that in this scenario cervical length measurements will be undertaken at 12, 14 and 18 weeks. This patient is due to have her booking scan in Arbroath on 28 November 2019. I had a telephone consultation with her today and as there are no concerning gynaecological features at present I will discharge her. I have explained that I will write to you in regards to the patient's concerns regarding the risk of preterm labour and will leave it to your discretion if cervical length monitoring is indicated.

Yours sincerely

Authorised on 02/12/2019 11:40:51 by Yeswanthini Bhushan.

Dr Y Bhushan
Consultant Obstetrician and Gynaecologist

(D) Dr SM Rooney, Brechin Medical Practice, Brechin Health Centre, Infirmary Street, Brechin, DD9 7AN

Women and Child Health
Clinical Group
Acute Services
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

01382 423088

www.nhstayside.scot.nhs.uk

Dr TT Morley
Brechin Medical Practice
Brechin Health Centre
Infirmary Street
Brechin
DD9 7AN

Date	22/06/2022
Clinic Date	22/06/2022
Your Ref	
Our Ref	YB/RC/ **2804880060**
Enquiries to	Miss Rachel Craig
Extension	54568
Direct Line	01382 423088
Email	rachel.craig3@nhs.scot

Dear Dr Morley

Stacey Leonard, 2 Wards Road, Brechin, Angus, DD9 7AS DOB: 28/04/1988

I had a telephone consultation with the above named patient. She is a 34 year old para 6 (SVDs) who was referred with a request for a sterilisation procedure. The patient is absolutely certain of her decision and has considered all other alternative methods of contraception. She is currently on the Evorel patch. Her smear tests have been regular and up to date. Apart from a laparoscopy back in 2009, she has not had any major surgical procedures and has no major medical problems of note. Her BMI is 24.

I have explained the procedure and the risks and complications to this patient. She is aware of the prolonged waiting list within Gynae and her current surgical priority is P4 and she is aware that this wait could involve approximately 2 years. We will send out the relevant patient information leaflet by post. In the phase she is waiting for surgery, I have advised her regarding Mirena IUS which will be effective as a contraceptive as well as from a heavy periods perspective.

With regards

Yours sincerely

Authorised on 22/06/2022 15:49:19 by Yeswanthini Bhushan.

Dr Y Bhushan
Consultant Gynaecologist

NHS
Tayside

Women and Child Health
Clinical Group
Acute Services
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

Tel: 01382 660111
Fax: 01382 632096
www.nhstayside.scot.nhs.uk

Dr RC Cranswick
Annat Bank Practice
Links Health Centre
Frank Wood Way
Montrose
DD10 8TY

Date	22/12/2016
Clinic Date	12/12/2016
Your Ref	
Our Ref	WMcM/JHG/ **2804880060**
Enquiries to	Mrs Jackie Gilchrist
Extension	32085
Direct Line	01382 632085
Email	jgilchrist@nhs.net

Dear Dr Cranswick

Stacey Ellis, 17 Annat Road, Montrose, DD10 8EF DOB: 28/04/1988

Diagnosis: Loop excision for CIN III August 2016. Ongoing pain and irregular bleeding. Please treat with cyclical progestogens or oral contraceptive pill.

I apologise for the delay in writing regarding this lady whose appointment was expedited to 12 December. She had a loop excision in August for a suspicious cervical lesion but the final pathology is CIN. Even before then she was getting irregular menses with pain but says this has been a lot worse since the procedure. She had recently had a 28 day bleed although this had stopped by the time she came to clinic. Ultrasound organised by Dr Ragupathy shows normal uterus and ovaries with no evidence of haematometrium.

Given her previous difficulties I thought she tolerated clinical examination remarkably well. Her cervix is scarred and tender but otherwise normal. There is no other abnormality. Thank you for taking swabs which are all normal.

I therefore think this lady has dysfunctional uterine bleeding with a tender cervix post surgical. I have advised her to take regular paracetamol and NSAIDS. To regulate her periods thanks you for prescribing either cyclical progestogens or the oral contraceptive pill which she could tricycle so she just gets a withdrawal bleed every 3 months.

She will be seen as planned for her next smear in February.

Yours sincerely

Dr Wendy McMullen
Consultant in Obstetrics & Gynaecology

NHS
Tayside

Women and Child Health
Clinical Group
Acute Services
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

Tel: 01382 660111
Fax: 01382 632096
www.nhstayside.scot.nhs.uk

Dr RC Cranswick
Annat Bank Practice
Links Health Centre
Frank Wood Way
Montrose
DD10 8TY

Date	30/08/2016
Your Ref	
Our Ref	KR/JHG/ **2804880060**
Enquiries to	Mrs Jackie Gilchrist : 25/08/2016
Extension	32085
Direct Line	01382 632085
Email	jgilchrist@nhs.net

Dear Dr Cranswick

Stacey Ellis, 17 Annat Road, Montrose, DD10 8EF DOB: 28/04/1988

CIN III on final histopathology.
Treatment carried out: LLETZ in August 2016.

It is quite reassuring that the final histology result was indeterminate CIN (CIN III on previous biopsy). The ectocervical margin was involved but the endocervical margin was clear. Usually for young patients like Stacey we discharge them back to yourselves for a repeat smear (test of cure) to be done in 6 months time. However Stacey has not attended for a smear test for a long time owing to severe vaginismus. I discussed the final histology with her over the phone and told her that I will bring her back to the clinic here in 6 months so that we can offer her a pudendal block if required for the smear.

Yours sincerely

Dr Kalpana Ragupathy
Consultant Obstetrician & Gynaecologist

Women and Child Health
Clinical Group
Acute Services
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

Tel: 01382 660111
Fax: 01382 632096
www.nhstayside.scot.nhs.uk

Dr RC Cranswick
Annat Bank Practice
Links Health Centre
Frank Wood Way
Montrose
DD10 8TY

Date	17/08/2016
Theatre Date	16/08/2016
Your Ref	
Our Ref	WMcM/JHG/ **2804880060**
Enquiries to	Mrs Jackie Gilchrist
Extension	32085
Direct Line	01382 632085
Email	jgilchrist@nhs.net

Dear Dr Cranswick

Stacey Ellis, 17 Annat Road, Montrose, DD10 8EF DOB: 28/04/1988

Procedure: Loop excision of transformation zone.

Following a smear suspicious of invasive disease and a difficult examination in clinic this lady was taken to theatre today as planned for a diagnostic loop excision.

On examination she had a 1.5 cm exophytic lesion arising circumferentially around the os. Whilst this could be a florid viral wart the appearances were certainly more inkeeping with malignancy. Clinically there was no vaginal or parametrial spread. We will liaise with the radiology department as to whether it is still appropriate to do her imaging next week and will see her once the pathology results are available.

Yours sincerely

Dr Wendy McMullen
Consultant in Obstetrics & Gynaecology

Patient Details

CHI Number	2804880060	**Date of Birth**	28/04/1988
Current Gender	Female	**Surname**	ELLIS
1st Forename	STACEY	**2nd Forename**	LOUISE
Address 1	17 ANNAT ROAD	**Address 2**	MONTROSE
Postcode	DD10 8EF	**Registered GP Identifier**	3260678
Registered GP Name	Ruth RC Cranswick	**Registered GP Practice Identifier**	13706
Registered GP Practice Name	Annat Bank Practice		

Pathway Summary

Hospital Code	T101H	**Hospital Name**	Ninewells Hospital, Dundee
Date/Time of Admission	15/08/2016	**Admission Ward**	36
Admission Mode	Elective	**Source of Admission**	Elective
Admission Reason	Elective surgical procedure		
Admission Specialty Code	F2	**Admission Specialty Name**	Gynaecology
Discharge Specialty Code	F2	**Discharge Specialty Name**	Gynaecology
Discharge Date	16/08/2016	**Discharge Ward**	36
Discharge Consultant Identifier	6061174	**Discharge Consultant Name**	KALPANY RAGUPATHY
Discharge Type	Discharge from NHS inpatient/day case care	**Discharge Destination**	Not known

Clinical Details

Diagnosis Comment	Gynae day case. LLETZ.	**Ops / Procs / Investigations / Complications Comments**	Routine case. Post operativly had ?vasovagal attack after leaving ward. recovered well after 10minutes. Minimal cramping pain post-op.

Diagnosis / Condition Details

Read Code	Diagnosis	Diagnosis Date/Time	Laterality	Principal
	Elective Gynae Procedure			Principal

Operations / Procedures / Investigations Details

Read Code	Procedure	Procedure Date/Time	Principal	Laterality
	Elective Gynae Procedure		Principal	

Allergy Details

Read Code	Allergy	Comments	Date Recorded	Source
14M..	H/O: non-drug allergy	Latex itchy and red	12/11/2007	ECS

Medications

Medication Required	Yes		

Medications List

DMD Code	Drug	Dose	Amount To Be Taken	Frequency	Duration	Supply	Quantity	Additional Information	Source
	Fluoxetine 20mg capsules 28 capsule		1OD			Own At Home			

Care Arrangements

Care Arrangements	None		

Follow Up Details

Follow Up Date	Follow Up Date To Be Arranged	Follow Up
		MRI/CT booked 18/08/2016.
	Yes	Letter will be sent out after MDT meeting.

Letter Text

	Please note this is an Immediate Discharge Letter only. For further details please refer to the full discharge summary, which will follow in the post. Dear Doctor, Ms Stacey Ellis was admited for day case in Gynaecology for a LLETZ procedure following on from previous cervical smears producing grossly abnormal		

Communication to Primary Care	results. This was a routine case without any complications. The surgeon noted a "warty appearance and suspicious of cervical cancer". These findings have been explained in full to Ms Ellis and has taken the news well as she was already aware of the possibility. She was also informed that she may pass a large piece of material in the coming days post-op. Kind regards, John Sinclair FY1		

Correspondence

Name	Ruth Cranswick	**Address 1**	Annat Bank Practice
Address 2	Links Health Centre	**Address 3**	Frank Wood Way
Address 4	Montrose	**Postcode**	DD10 8TY
Document Sensitivity	Sensitive	**GP GMC Code**	3260678
GP Practice Code	13706		

Sign Off

Episode Status	Complete and Immediate Discharge Signed Off: Awaiting Pharmacy Sign Off		

NHS
Tayside

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Dr RC Cranswick
Annat Bank Practice
Links Health Centre
Frank Wood Way
Montrose
DD10 8TY

Date	15/08/2016
Your Ref	
Our Ref	KR/JHG/ **2804880060**
Enquiries to	Mrs Jackie Gilchrist : 09/08/2016
Extension	32085
Direct Line	01382 632085
Email	jgilchrist@nhs.net

Dear Dr Cranswick

Stacey Ellis, 17 Annat Road, Montrose, DD10 8EF DOB: 28/04/1988

The biopsy taken at Stacey's last clinic visit has shown only CIN III. It might be that the sample is not representative as Stacey found the examination quite painful and I was not able to do the loop biopsy which was my initial intention. In view of this I have spoken to Stacey over the phone, have given her the diagnosis and will bring her in to theatre on 16 August to carry out the loop biopsy under general anaesthesia.

Yours sincerely

Dr Kalpana Ragupathy
Consultant Obstetrician & Gynaecologist

NHS
Tayside

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Dr RC Cranswick
Annat Bank Practice
Links Health Centre
Frank Wood Way
Montrose
DD10 8TY

Date	08/08/2016
Clinic Date	04/08/2016
Your Ref	
Our Ref	KR/JHG/ **2804880060**
Enquiries to	Mrs Jackie Gilchrist
Extension	32085
Direct Line	01382 632085
Email	jgilchrist@nhs.net

Dear Dr Cranswick

Stacey Ellis, 17 Annat Road, Montrose, DD10 8EF DOB: 28/04/1988

Clinical impression – cervical cancer (? Stage 1B)

Many thanks for referring Stacey to the colposcopy clinic today. Her smear was suggestive of high grade dyskaryosis ? invasive.

On clinical examination there is a raised lesion on the cervix measuring about 2.2 cm in its maximum dimension. I was only able to do a punch biopsy today in view of the intense vaginal pain Stacey has (long history of vaginismus). I have also organised for a CT and MRI to be carried out. I will see her back in the clinic on 15 August to give her the final diagnosis.

I have explained to her my high suspicion of cervical cancer and hopefully the scan will give us further information about staging and treatment. Stacey was accompanied by her partner today and he was part of the consultation. I have also given her details of our clinical nurse specialist in case she requires support while we are awaiting the results.

Yours sincerely

Dr Kalpana Ragupathy
Consultant Obstetrician & Gynaecologist

The Nairn Suite
Ninewells Hospital and Medical School
Dundee
DD1 9SY
Telephone Number: 01382 660111
Fax Number: 01382 740023
www.nhstayside.scot.nhs.uk
Direct Line: 01382 632761

31st December, 2009

Dr.G.Kramer,
Annat Bank Practice,
Links H.C.,
Montrose.

Dear Dr. Kramer,

RE: Stacey Ellis, 8 Mill Place, Craigo, Montrose.
MPI: 280488 0060

Your patient attended the Early Pregnancy Counselling Clinic in Ninewells Hospital on 21/12/09 considering a termination of pregnancy. She was duly admitted to the Nairn Suite, Ninewells Hospital on 31/12/09 at 7+6 weeks gestation and underwent a Medical termination of pregnancy.

Contraception was discussed and Stacey was given Depo Provera prior to leaving the Ward. She will be attending you or Family Planning for further contraceptive advice.

A Chlamydia test was carried out and the result was negative. She is aware of this result.

She has also been tested for Rubella immunity, and will phone for the result.

Anti D was not required.

Follow up was not required.

Yours sincerely,

G.Mackie,
Staff Nurse

For N/W File

Women's & Child Health Clinical Group
Acute Services Division
Wards 37/38
Ninewells Hospital & Medical School
DUNDEE DD1 9SY
Tel Number: 01382 660111
Fax Number: 01382 632096
www.tayside.scot.nhs.uk

Date: 17th September 2009
Your Ref:
Our Ref: RY/MC
Enquiries to: Mrs Margaret Coull
Extension: 32085
Direct Line: 01382 632085
Email: margaret.coull@nhs.net

Dictated: 10/09/09
Theatre: 10/09/09

Dr M Ireland
Annat Bank Practice
Links Health Centre
MONTROSE

Dear Dr Ireland

RE: STACEY ELLIS, 8 MILL PLACE, CRAIGO, MONTROSE, DD10 9LB
MPI: 28 04 88 0060

Your patient underwent diagnostic laparoscopy under a general anaesthetic uneventfully today.

During the procedure the pelvic cavity looked entirely normal, with no evidence of endometriosis or adhesions. The left ovary had what looked like a normal follicle.

All being well she will be able to go home later on today, with no routine follow-up plans.

Yours sincerely

Dr R Youssef, Specialist Registrar to
Dr P Chien, Consultant Gynaecologist & Obstetrician

Women's & Child's Health Clinical Group
Wards 37&38
Acute Services Division
NHS Tayside
Ninewells Hospital and Medical School
DUNDEE
DD1 9SY
TEL. 01382 660111
Email www.nhstayside.scot.nhs.uk
Fax No 01382 632096
Enquiries: Mrs T Carlin, Obs & Gynae Secretary
Direct Line 01382 632089
E mail: tracycarlin@nhs.net
Ref /TC

8 October 2008
Dictated 02.10.08

Dr Anderson
Annat Bank Practice
Links Health Centre
Marine Avenue
MONTROSE

Dear Dr Anderson

STACEY ELLIS, 10 CONDOR CRESCENT, MONTROSE
MPI 2804880060

This 20 year old lady was assessed at the Gynaecology Ward on 15.09.08.

She was 14 weeks post partum and complained of a 2-3 weeks history of swelling in the left iliac fossa with a one week history of increasing pain and tenderness. She also had more recent fever and nausea.

On assessment on the ward, Stacey was afebrile. She had a tender lower abdomen on palpation. She also reported that she had no pv discharge. Her pregnancy test on the ward was also negative.

Stacey had a transvaginal ultrasound scan to rule out pelvic pathology. This showed no adnexal mass or free fluid. Both ovaries were normal in size and appearance. Stacey was informed there was no gynaecological cause to find for her pain. She did however complain that the pain was still present and that she was no longer eating because of it. She had normal bowel motions. After further discussion it was felt that it was probably a gastro-oesophageal reflux element to her pain, and she was therefore given some Lansoprazole on top of normal analgesia on discharge.

Stacey will not routinely be followed up.

Yours sincerely

Dr S Cooper
GP ST2 to Dr P W Chien

FOR PHARMACY USE

Checked by

Clinical Pharmacist

Patient Counselled

(Inits)

DISCHARGE NOTIFICATION AND PRESCRIPTION FORM

..... Hosp./Inf.

To Dr. .....

.....

.....

Ward/Clinic/ Hosp. NW11 26 ..... Cons.

D D M M Y Y

2 8 0 4 8 8 C.H.I. No.

Surname Ellis

First Name Stacey M. State

Address ..... Sex

G.P. & Address (G.P. Requests only)

USE BLOCK LETTERS OR PATIENT LABEL

THIS IS THE *ONLY / *INTERIM DISCHARGE LETTER (to be completed by Discharging Doctor).

Date Placed on Waiting List (if appropriate) .....

Date of Admission: .....

*Delete as appropriate

..... 2nd Fold .....

DISCHARGE DETAILS	DATE	SPECIALITY	CONSULTANT	DISCHARGED TO	TRANSFERRED TO: HOSPITAL	SPECIALITY	CONSULTANT
	15/9/2						

DIAGNOSIS AND OPERATIONS

PRINCIPAL DIAGNOSIS: Lt pain

PRINCIPAL OPERATION / PROCEDURES: TV ultrasound scan - no abnormality seen or free fluid both ovaries normal

OTHER CONDITIONS:

OTHER OPERATIONS / PROCEDURES:

When Medicines are to be dispensed **all** copies to be sent to Pharmacy

..... 1st Fold .....

Approx. 5 days supply is usually dispensed. Where the period is different, indicate the number of days in box provided.

MEDICINE TREATMENT ON DISCHARGE		DOSE	STOP DATE	Times of Administration (Mark ✓)												DISPENSED BY PHARMACY	
Days	NAME — State Date when Medicines should be stopped			8	10	12	14	16	18	20	22	24				Number	Brand Names (for information only)
	(Qic NURAFEN Ibuprofen 200mg	400mg															
	42 PARACETAMOL	500mg		2													

Discharge Prescriptions should normally be sent to pharmacy at least 24 hours before discharge.

TREATMENT RECOMMENDED AND ADDITIONAL INFORMATION

Urinalysis given (clear) pain

CONDITION ON DISCHARGE

COMPLETELY AMBULANT ☐ CONFINED TO HOUSE ☐ PARTIALLY BEDRIDDEN ☐ CONFINED TO BED ☐

FOLLOW-UP APPOINTMENTS

DATE	TIME	CLINIC	SPECIALITY	DELETE AS APPROPRIATE
				GIVEN/TO BE SENT
				GIVEN/TO BE SENT
				GIVEN/TO BE SENT

FOR FURTHER INFORMATION CONTACT

1. ..... Consultant

2. ..... Sen. Registrar/Registrar

3. ..... Ward/Unit Secretary Telephone ..... Ext. .....

TO PHARMACY MEDICINES REQUIRED ON WARD AT ..... (TIME) .....

Signature ..... Status .....

for ..... Consultant Date 15/9/2

Dispensed By .....

Checked By .....

Date .....

Final Distribution

WHITE - G.P.

PINK - General Office Medical Records

YELLOW - Case Records

BLUE - Pharmacy

THB(MR)26 DTH
4 Part Set

Women & Child Health Clinical Group
Wards 37/38
Acute Services Division
NHS Tayside
Level 6
Ninewells Hospital
DUNDEE
DD1 9SY
TEL. 01382 660111
Email www.nhstayside.scot.nhs.uk

Enquiries: Mrs E Goodall
Direct Line 01382 632089
Fax: 01382 632096
E mail: egoodall@tuht.scot.nhs.uk
Ref DK/EMG

25 April 2005
Dictated 20.04.05

Dr Box
The Health Centre
LAURENCEKIRK

Dear Dr Box

RE: STACEY ELLIS, 10 CONDOR CRESCENT, MONTROSE
MPI: 28 04 88 0060

Stacey was admitted to Ward 36 on 02.04.05 with a 1 week history of right iliac fossa pain. She denied any urinary or vaginal bleeding. She was approximately 10 – 11 weeks gestation according to her last menstrual period which was at the beginning of January. On examination her abdomen was soft and non tender. A scan was done which showed a thickened endometrium with no gestational sac seen. A pregnancy test was found to be positive in the ward. The impression was either early pregnancy or early ectopic pregnancy. HCG was taken at that point and she was advised to come back to have another HCG taken 8 hours later or if her pain got worse. Surprisingly the HCG result came back less than 1 and the pregnancy test was repeated again on 04.04.05 and was negative. I assume that the first pregnancy test was falsely positive and as her pain had settled she was discharged from the ward.

Yours sincerely

Dr D Koh
Registrar to Dr I D Duncan

HOSPITAL USE ONLY	CLINIC:	DAY: DATE:	TIME:	HOSPITAL NO:

OUTPATIENT REFERRAL TO: NINEWELLS HOSPITAL

FROM: DR GRAHAM KRAMER — ANNAT BANK PRACTICE, LINKS HEALTH CENTRE, MARINE AVENUE, MONTROSE, DD10 9TY
TEL: 01674 672400

PRACTICE CODE NO: 13705
REFERRAL DATE: 15 December 2009

Please arrange for this patient to attend the: NAIRN SUITE *Clinic of:*

SURNAME: ELLIS
FIRST NAME: STACEY
DATE OF BIRTH: 26.04.88 0060
ADDRESS: 8 MILL PLACE, CRAIGO, BY MONTROSE, DD10 9LB
TELEPHONE NUMBER:

Previous Hospital Attendance: YES *When:* 2009
Hospital: EATING DISORDER CLINIC, DUNDEE *Previous X-Rays* YES

Appointment – 10.30 Monday 21st December 2009

Reason – Unwanted Pregnancy

I am grateful for your involvement with Stacey. She is a 21 year old with very significant psychosocial problems. She has had a very disturbing childhood and suffers from an eating disorder. She has an 18 month old boy Declan, who has failure to thrive and requires quite extensive medical and social work input. Stacey feels that she could not cope with another pregnancy and indeed feels strongly that she never wants any more children. I have no hesitations in referring her for a termination. I enclose a completed green form.

Stacey's last period was some time in mid October. She had a negative pregnancy test on 12th November, but two weeks later has had a positive pregnancy test.

She had an implanon in until 15th October, but this was removed because of constant bleeding. She was waiting for her next period to start Microgynon.

Yours sincerely

Dr Graham Kramer
GMC No., 3205066

IN CONFIDENCE

Certificate A

Not to be destroyed within three years of the date of the operation

ABORTION ACT 1967

Certificate to be completed in relation to an abortion under Section 1(1) of the Act

I DR GRAHAM KRAMER MBChB MRCGP(UK)/MRCGP

(name and qualifications of practitioner : in Block Capitals)

of ANNAT BANK PRACTICE

LINKS HEALTH CENTRE MONTROSE DD10 8TY

(full address of practitioner)

Have/have not* seen/examined* the pregnant woman to whom this certificate relates at

ANNAT BANK PRACTICE/ LINKS HC MONTROSE

(Full address of place at which patient was seen or examined)

on 11.12.09

and I

(Name and qualifications of practitioner : in Block Capitals)

of

(Full address of practitioner)

*(*delete as appropriate)*

Have/have not* seen/and examined* the pregnant woman to whom this certificate relates at

(Full address of place at which patient was seen or examined)

on

We hereby certify that we are of the opinion, formed in good faith, that in the case of

STACEY ELLIS

(Full name of pregnant woman : in Block Capitals)

of 8 MILL PLACE, CRAIGO, BY MONTROSE DD10 9LB

(Usual place of residence of pregnant woman : in Block Capitals)

Tick appropriate box

- ☐ A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated.
- ☐ B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.
- ☑ C the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman.
- ☐ D the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman.
- ☐ E there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

This certificate of opinion is given before the commencement of treatment for the termination of pregnancy to which it refers.

Signed [signature]

Date 15/12/09

Signed

Date

(OVERLEAF: CERTIFICATE B - FOR USE IN CASES OF EMERGENCY)

NHS Tayside

NAIRN SUITE CLINIC

DATE: 21/12/09.

REFFERRAL DATE: 11/12/09 BY: GP / FP

CONS: JG NURSE: _____

ELLIS 2804880060
STACEY F
8 MILL PLACE
CRAIGO
MONTROSE DD10 9LB
DR RUTH CRANSWICK
ANNAT BANK, LINKS HEALTH CENTRE, FRAN

Age 21.

Fraser Guidelines ☐ (If under 16)

Single ✓
Single with partner
Married - Living With Partner
Divorced / Separated
Widowed

Employed / Unemployed / Student

Other _____

UK resident last 12 months YES / NO

Client contact no. Mum or Victoria.

Next of kin Mum: Susan Ellis. (Nvare)

Contact no. 01674 840628.

Emergency contact Victoria Kennedy

Contact no. 07717249383.

GP contact YES / NO

Home contact YES / NO

Results / Contact tracing ok YES / NO

OBSTETRICS / GYNAECOLOGICAL HISTORY

Total pregnancies	2.
Number of children	1
Previous T.O.P.	0
Previous miscarriage	1

Previous TOP

_____
_____
_____

Comments _____

Menstrual cycle bleeding for 3. days every 28-30. days

L.M.P. ? October.

Smear up-to-date YES / NO / NA Date due _____

Referred for booking YES / NO

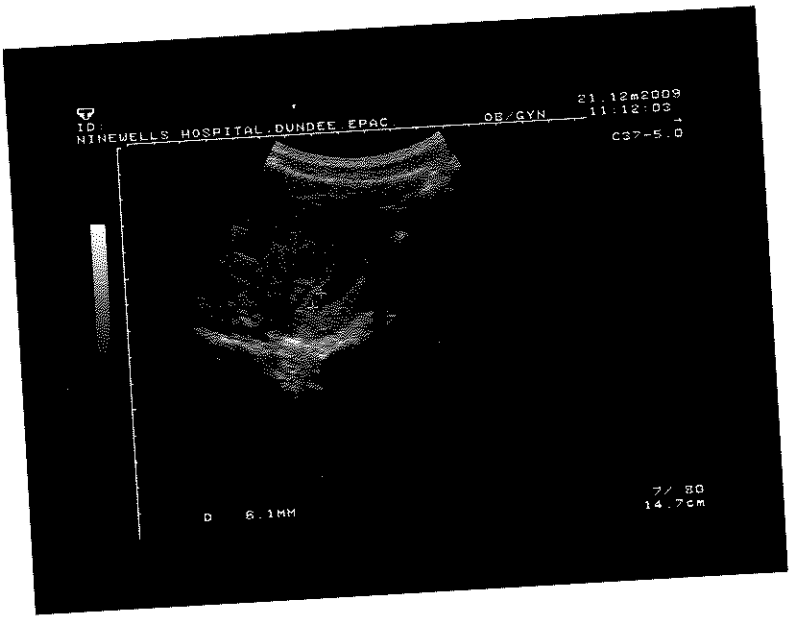
STI RISK

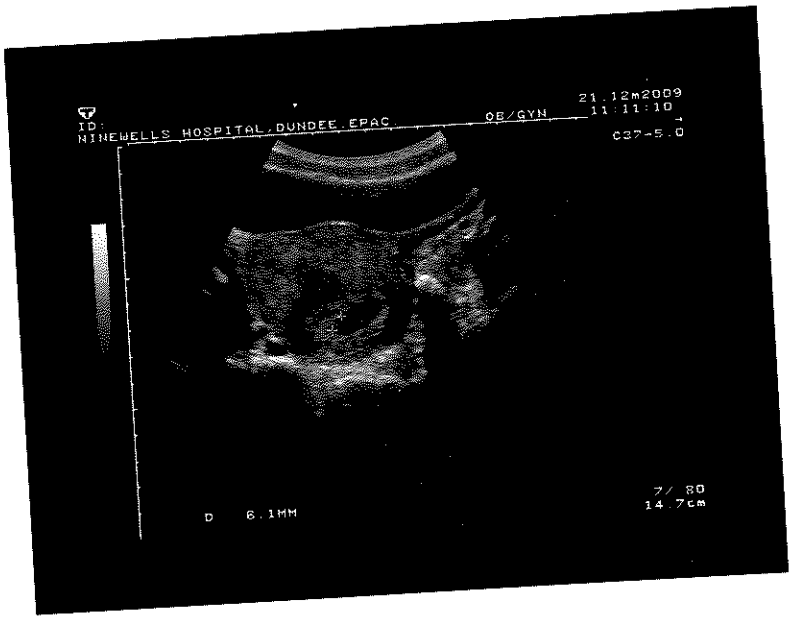
Number of sexual partners in last 6 months 2.

Has patient ever injected drugs YES / NO

Has patient ever had a partner who injected drugs YES / NO

GUM referral YES / NO / NA


ID:
NINEWELLS HOSPITAL,DUNDEE EPAC
OB/GYN
21.12m2009
11:12:03
C37-5.0
D 8.1MM
7/ 80
14.7cm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NINEWELLS HOSPITAL,DUNDEE EPAC
OB/GYN
21.12m2009
11:11:10
C37-5.0
D 8.1MM
7/ 80
14.7cm

CONTRACEPTION

Current contraception Implanon - removed Oct '09.

PCC obtained YES / (NO)

Contraceptive contraindications —
(*Please refer to BMI, Allergies, Medical history*))

Future contraception COC / POP / IUD / IUS / (DEPO) / PATCH / IMPLANON

OTHER _____ LEAFLETS GIVEN: ✓

Supplied from (WARD) / GP / FP / OWN SUPPLY

Family planning appointment made (if applicable) YES / NO Date_____ Time_____

(If in any doubt re suitable contraception please refer to FP faculty Guidelines)

Signed: Morna Forbes Date: 21/12/09.

Designation: S/M.

SCAN DATA

Yolk sac YES / NO Fetal heart YES / NO

Measurements: GEST SAC_____ mm

CRL 6.1. mm

BPD_____ mm

Gestation 6. weeks 3. days

Comments:

Single fetus

Signed: M. Forbes Date: 21/12/09

Designation: S/M

RISKS FOR PROCEDURES

Intended procedure explained	☐
Perforation of the uterus*(0.1-0.4%)	☐
Damage to the cervix*(no greater than 0.1-0.4%)	☐
Haemorrhage (1% overall. 0.88/1000 at <13 weeks and 4/1000 at 20 weeks)	☑
Transfusion (<1%)	☑
Uterine rupture (midtrimester: <0.1%)	☐
Retained products	☑
Infection (10%, reduced 50% by screening and antibiotics)	☑
Psychological sequelae (may be due to pre-existing condition)	☑
Extra procedures: *Laparoscopy/laparotomy to repair any damage (rare)	☑

Signed: M. Forbes Date: 21/12/09.

Designation: S/M.

FOR NON CONTINUING

roducts to pathology	☐
Products to cytogenetics	☐

Signed: _____ Date: _____

Designation: _____

CONSULTATION

Comments-

Definite in decision
Has 1 child already - 18mths
Old - in hospital a lot.
Unable to cope at present
w/c another pregnancy

Consent signed ☑ Blood samples taken ☑

Urine sample taken ☑ Informed escort may be required ☑

Options – MTOP / STOP / LATE MTOP / MID-TRIMESTER / MED EVAC / SURG. EVAC

Time given for questions / discussion / concerns YES / NO

Information of fetal disposal given (if requested) YES / NO

LEAFLETS GIVEN: STOP / MED / LATE MED / MID / CHLAMYDIA

Signed M. Forbes Designation S/m Date: 21/12/09.

ADMISSION FOR MEDICAL

Date of 1st visit ~~28/12/09~~ 29/12/9 Time 3pm WD41 ~~3pm - WD36~~

Date of 2nd visit ~~30/12/09~~ 31/12/9. Gestation 7+5. 7+6

1st VISIT - Date 28/12/09

Decision certain ☑ Drug Kardex signed ☑

Certificate A signed x 2 ☑

INFORMATION GIVEN:

1. Phone only if vomited within 2 hours — YES / NO
2. Advised to take Paracetamol only, for pain — YES / NO
3. Use sanitary towel only, if bleeding — YES / NO
4. Risk of miscarriage 1% - contact Wd 41/Wd 36/NHS 24 — YES / NO
5. Avoid alcohol and/or smoking for 4 days — YES / NO
6. Admission letter — YES / NO NEW ONE GIVEN
7. Decision on contraception Depo. — YES / NO

Signed _____ Designation RN

2nd VISIT - Date 30/12/09

Orientated to ward / toilet / buzzer system YES

Relative/friend Vicky. Fiance

Diet Normal

Baseline recordings T 36.4 P 81 BP 111/66

Contraception Depo.

Signed _____ Designation RN

ADMISSION FOR SURGICAL

Date_____ Gestation_____

Fasted YES / NO Time_____ Date_____

Escort YES / NO _____ Responsible adult at home for 24hrs YES / NO

Decision certain ☐ Certificate A signed x 2 ☐ Kardex signed ☐

Orientated to ward / toilet / buzzer system_____

Diet_____

Baseline recordings T_____ P_____ BP_____

Contraception_____

Signed_____ Designation_____

Time taken to theatre_____ Time returned from theatre_____

Recordings T_____ P_____ BP_____

Response - Asleep / rousable ☐ Awake /orientated ☐

Instructed not to get out of bed ☐ Buzzer given ☐

PV Loss_____

Other relevant details:

Signed_____ Designation _____

A MODIFIED POSTANAESTHETIC DISCHARGE SCORING SYSTEM (MPADSS)
The total score is 10, with patients scoring >or = 9 considered fit for discharge

Has escort home? →

Has adult at home? → NO (admit overnight)

1 Vital signs
2 = Within 20% of preoperative value
1 = 20-40% of preoperative value
0 = 40% of preoperative value

2 Ambulation
2 = Steady gait / no dizziness
1 = With assistance
0 = None / dizziness

3 Nausea / vomiting
2 = Minimal
1 = Moderate
0 = Severe

4 Pain
2 = Minimal
1 = Moderate
0 = Severe

5 Surgical bleeding
2 = Minimal
1 = Moderate
0 = Severe

Total score 10 or = 9 considered fit for discharge

Score achieved _____ Date _____ Signature _____

Signed_____ Designation _____

DISCHARGE

After care leaflet given: (YES) / NO

Discharge letter: Referring Doctor ☑ Notes ☐

Contraception Depo. — GMC

PV Loss Minimal

T_____ P_____ BP_____

Post anaesthetic score N/A

Venflon removed YES / NO / (NA)

Urine passed ☑

Chlamydia result Neg — Awaiting

GUM referral (contact tracing) YES / NO / (NA)

Partner notification letter YES / NO / (NA)

Blood group O Pos

Anti D given YES / NO / NA

Antibiotics given (YES) / N O

Rubella status Not back. Comments_____

Booking appointment cancelled YES / NO / NA

Non-continuing book YES / NO / NA

ollow up details _____

_____

Date and Time 1210 31/12/9

Signed _____ Designation RN

NHS
Tayside

NAIRN SUITE
DAY CASE CLERKING FORM

Weight _____

Height _____

BMI _____

28 04 88

2804880060

STACEY ELLIS

		PATIENT YES	PATIENT NO	FAMILY HISTORY	COMMENTS
1	Do you generally keep in good physical health?	☑	☐	☐	
2	Do you have a heart complaint?	☐	☑	☑ NO.	
	high blood pressure	☐	☐	☐	
	rheumatic fever	☐	☐	☐	
	Angina	☐	☐	☐	
	heart attacks	☐	☐	☐	
	heart surgery	☐	☐	☐	
	heart murmur	☐	☐	☐	
3	Do you have a chest problem?	☐	☑	☑ NO.	
	Bronchitis	☐	☐	☐	
	Asthma	☐	☐	☐	
	shortness of breath	☐	☐	☐	
	cough or cold now	☐	☐	☐	
4	Have you had a stroke?	☐	☑	☑ NO	
5	Have you had hepatitis?	☐	☑	☐	
6	Have you had jaundice, liver or gallbladder problems?	☐	☑	☐	
7	Have you had stomach or bowel problems	☐	☑	☐	
8	Have you had breast, ovarian or uterine cancer?	☐	☑	☐	
9	Do you have arthritis of the spine or neck?	☐	☑	☐	
10	Do you suffer from fits or fainting attacks?	☐	☑	☐	
11	Do you suffer from headaches or migraine?	☐	☑	☐	
12	Do you have anaemia, blood problems or bruise easily?	☐	☑	☐	
13	Do you have blood clots in legs or lungs?	☐	☑	☐	
14	Do you have diabetes or sugar in the urine?	☐	☑	☑ NO	

		PATIENT YES	PATIENT NO	FAMILY HISTORY	COMMENTS
15	Are you allergic to anything – e.g. medicine, food, pollen?	✓			Latex.
16	Have you had an anaesthetic or operation before?.....	✓			
17	Have you or your family had any problems after an anaesthetic?.....		✓		
18	Do you suffer from heartburn or acid reflux?.....		✓		
19	Do you smoke? If yes, how many per day?.....	✓			30/day.
20	Do you drink more than 14 units of alcohol per week?.....		✓		
21	Do you use recreational drugs?.....		✓		
22	Have you received any medicine from your doctor – e.g. tablets, injections or inhalers?.....		✓		
23	Do you have any caps, crowns, dentures or ***gold fillings*** in your teeth?.....		✓		
24	Do you attend any other hospital or specialist clinic concerning your health?.....		✓		
25	Is there any other medical problem you think the nurse should know about?.....	✓			

Signed M. Forbes Designation S/N.

Date 28/2/09

MEDICAL EXAMINATION

Blood Pressure: _____ Pulse: _____ Heart Sounds: _____

Chest: _____

Signed _____ Designation _____

Date _____

Consent for Investigation, Treatment or Operation

NHS Tayside

Patient's Surnam **28 04 88** ..... Hospital & Ward: **NW W41**

Other Names: .. **2804880060** STACEY ELLIS ..... Speciality: **GYNAE**

CHI Number: .... Consultant: **Dr. M Thomson**

(USE BLOCK LETTERS OR PATIENT LABEL)

TYPE OF INVESTIGATION, TREATMENT OR OPERATION

(USE BLOCK CAPITALS WITH NO ABBREVIATIONS)

MEDICAL TERMINATION OF PREGNANCY AND IF REQUIRED, PROCEED TO SURGICAL EVACUATION OF UTERUS.

I confirm that I have explained the **Investigation/Treatment/Operation*** as well as any alternative options, the likely benefits and the probabilities of success. I have explained the risks, serious or frequently occurring complications associated with the procedure, and detailed lifestyle changes that may be caused by, or necessitated by, the procedure. I have also acknowledged and answered concerns.
I have done this in terms that, in my judgement, have been understood.

Health Professional's Name: Myra Forbes ..... Date 21 / 12 / 09

Print Name: MYRA FORBES ..... Grade 6

PATIENT / PARENT / GUARDIAN

Please read this form very carefully. If there is anything that you do not understand, or if you would like more information, you should inform the health professional.

I agree	to what is proposed which has been explained to me by the health professional named on this form
I agree	to the administration of a general, local or other anaesthetic as deemed necessary by the anaesthetist
I understand	that students may be present and I understand that this is part of their training
I understand	that the procedure may not be carried out by the health professional who has been treating so far. The person will, however, have appropriate experience.
I understand	that any procedure in addition to the procedure, investigation or treatment described on this form will only be carried out if it is necessary and in the patients best interests and can be justified for medical reasons
I understand	that in the patient's best interests, information regarding the procedure may be stored on computer databases

Continued overleaf .....

I understand that radiological images, video recordings or photographic material may be produced as part of the procedure and that these will be stored as part of patient's medical record

I understand that body tissue which may include body fluids, organs, or parts of them, removed during the procedure may be used for diagnosis and any further treatment and then be discarded or stored

I acknowledge that the University of Dundee is very active in medical research, the sole aim of which is the benefit of patients, either directly or in the long term. Tissue and anonymous information are the most valuable resources for research

~~I do~~/ do not* agree that excess tissue stored for diagnostic purposes may also be used in medical research

~~I do~~/ do not* agree to being examined by a medical or dental student whilst under general anaesthesia

I do / ~~do not~~* acknowledge that I have received printed information regarding the procedure

I have been told about additional procedures that may become necessary during my procedure. **I have listed below any procedures that I do not wish to be carried out without further discussion**

.....

.....

Signature ..... **Patient? Yes / No**

** .....

Name STACEY ELLIS ..... **(Block Capitals)**

Date 21 / 12 / 09

Address (if not the patient) .....

.....

NOTES TO HEALTH PROFESSIONALS

** Please specify if not the patient
* Delete as appropriate
All **bold** parts should be completed

- All deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature. Any amendments made thereafter must be countersigned and dated both by the health professional and the patient.
- Patients must be allowed to decide whether they will agree to the procedure and they may refuse or withdraw consent to a procedure at any time.
- A parent or other person with parental responsibility is legally entitled to give or refuse consent to a child's treatment. However, if children aged under 16 years can satisfy the health professional that they understand sufficiently well what treatment is proposed, they may give consent for the procedure without parental consent. Furthermore, if you are not convinced enough, you can ask a parent to countersign as well.
- Adults or individuals 16 years of age or older with incapacity must not be consented on this form.

NHS
Tayside

28 04 88
2804880060
STACEY ELLIS

CONSENT FOR BLOOD/URINE TESTS AT THE TIME OF REQUESTING TERMINATION OF PREGNANCY

It has been explained to me that in order to perform a termination of pregnancy, it is necessary for me to have some investigations carried out.

Blood samples for: (please put ✓ or X into the boxes)

- **Blood group** ☑ (These are not optional)
- **Full blood count** ☑ (These are not optional)
- Rubella (german measles) ☑
- Syphilis ☑
- Hepatitis B ☑
- HIV ☑

Urine sample for Chlamydia ☑

Contact telephone number (for results): . . . . . .

Signature: P. . . SELD. . . . . Date: . . . 21/12/09 . . .

Witness: . . . M. . . Forbes . . . . . (Health Professional)

Designation: . . . . S/M . . . . . Date: . . . 21/12/09 . . .

HISTORY/CONTINUATION SHEET

41 UNIT/WARD/DEPT.

Ward/Clinic/
Hosp. Cons.
D D M M Y Y C.H.I. No.
Surname ELLIS 2804880060
First Name STACEY F M. State
Address 8 MILL PLACE Sex
CRAIGO
MONTROSE DD10 9LB
G.P. & Address (G.P. Requ DR RUTH CRANSWICK
ANNAT BANK, LINKS HEALTH CENTRE, FRAN

USE BLOCK LETTERS OR PATIENT LABEL

Page

DATE	
24/12/9 1250	Due to poor staffing levels in WD41 Stacey has agreed to move 1ST visit a admission date by a day 1ST visit now Tues 29/12/9 admission 31/12/9
29/12/9 1520	STACEY ATTENDED FOR "1ST VISIT" OF MED TOP. SEE CARE PLAN & DECS KARDEX. HOE STATES WILL COME WITH HOE ON MONDAY.
31/12/9 0845	STACEY ADMITTED FOR MED TOP SEE CARE PLAN & DECS KARDEX. STACEY IN PAIN WHEN INJECTED FIRST 2 INJ. DAILY. 1 ASKED IF SHE HAD SEEN HER G.P. RE THIS & SHE SAID SHE HAD HAD A GYNAE APPOINTMENT & THEY SAID IT WAS NOT A "GYNAE PROBLEM". SHE WAS OKAY TO CONTINUE WITH THE PROCEDURE.
1130	Pelvis passed - no bleeding noted. P Cassidy
1200	Check pad satisfactory. P.V. LSF. Minimal. Dressed. Anxious to get out for a cigarette.
1215	Discharged from the ward. See Care plan & Decs Kardex.

THB.(MR)3A

NHS TAYSIDE

PATIENTS' FUNDS AND PROPERTY PROCEDURE

PERSONAL DISCLAIMER NOTICE
LOSS OF PERSONAL EFFECTS

NHS TAYSIDE will not accept any responsibility for loss or damage to any article/personal belongings unless such articles/personal belongings (including cash) have been handed over to and accepted by NHS TAYSIDE for safe keeping and an official receipt given.

I have been given the opportunity to read the above and I do not wish to take advantage of the facilities provided.

Section A

Signed:_____ Date: _____

Hospital:_____ Ward No/Name: _____

Print Name: _____

Section B

If this form is being signed on behalf of a patient please state your relationship to the patient:

Signed:_____ Date: _____

Print Name:_____ Relationship: _____

Section C

Witness

Signature:_____

Address:_____

_____

Note for guidance to patients:

It should be understood that when a patient is absent from the ward for treatment (e.g. : x-ray, an operation etc) the safe custody of their property which has not been handed over to NHS TAYSIDE for safe keeping remains their responsibility.

Arrangements are available, whereby, such property (i.e. watches, rings etc) may be handed over to the Nursing staff for safe keeping and appropriate envelopes are available for this purpose.

NOTIFICATION OF DELIVERY OF A NON-VIABLE FETUS

(< 24 weeks gestation)

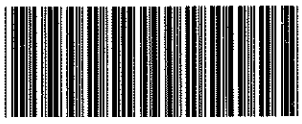
NHS Tayside

The following copies are required:

1) Top copy send to Mortuary

2) Copy 1 to be filed in Ward Office

3) Copy 2 to be included in Mother's notes



2804880060

2804880060

STACEY ELLIS

Date of *delivery/procedure _____ Time of *delivery/procedure _____

*delete as appropriate

Gestation 7+6

Post Mortem Examination:

Is fetus to be referred for post mortem / histological examination Yes / No

P.M. Authorisation form completed / Histology form completed Yes / No / Not applicable

Please tick one of the following two options:

Cremation according to NHS Tayside policy ☐

Private arrangements to be made by parent ☐
(Fetus to be collected by parent's Funeral Director)

Forms Required

NVF 1 *(this form)*

NVF 2 (Mortuary Form) not required if Private arrangements are made.

Post Mortem Authorisation form if applicable

Completed NVF Label to be placed on lid of container

Signature of Doctor/Midwife/Nurse: _____ Ward: _____

Print name in capitals: PAMELA COURTNEY STAFF NURSE Grade: _____

Date this notification completed _____

IN CONFIDENCE

Certificate A

Not to be destroyed within three years of the date of the operation

ABORTION ACT 1967

Certificate to be completed in relation to an abortion under Section 1(1) of the Act

I DR JACQUELINE GUEST MB ChB DFFP MRCOG .....

(name and qualifications of practitioner : in Block Capitals)

of NINEWELLS HOSPITAL DUNDEE .....

(full address of practitioner)

Have/have not* seen/examined* the pregnant woman to whom this certificate relates at

NINEWELLS HOSPITAL DUNDEE DD1 9SY .....

(Full address of place at which patient was seen or examined)

on .....

and I DR. PATRICK CHIEN MB ChB FRCOG MD NINEWELLS HOSPITAL DUNDEE DD1 9SY .....

(Name and qualifications of practitioner : in Block Capitals)

of NINEWELLS HOSPITAL, DUNDEE .....

(Full address of practitioner)

*(*delete as appropriate)*

Have/have not* seen/and examined* the pregnant woman to whom this certificate relates at

NINEWELLS HOSPITAL, DUNDEE .....

(Full address of place at which patient was seen or examined)

on .....

We hereby certify that we are of the opinion, formed in good faith, that in the case of

.....

(Full name of pregnant woman : in Block Capitals)

of .....

.....

(Usual place of residence of pregnant woman : in Block Capitals)

Tick appropriate box

- ☐ A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated.
- ☐ B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.
- ☑ C the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman.
- ☐ D the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman.
- ☐ E there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

This certificate of opinion is given before the commencement of treatment for the termination of pregnancy to which it refers.

Signed J Guest .....

Date 21/12/9. .....

Signed .....

Date 21/12/9 .....

(OVERLEAF: CERTIFICATE B - FOR USE IN CASES OF EMERGENCY)

IN CONFIDENCE

Certificate B

Not to be destroyed within three years of the date of the operation

ABORTION ACT 1967

Certificate to be completed in relation to an abortion performed in emergency under Section 1(4) of the Act

I, ...

(name and qualifications of practitioner : in Block Capitals)

of .....

.....

(full address of practitioner)

hereby certify that I *am/was of the opinion, formed in good faith, that it *is/was necessary immediately to terminate the pregnancy of

.....

(Full name of pregnant woman : in Block Capitals)

of .....

.....

(Usual place of residence of pregnant woman : in Block Capitals)

Tick appropriate box

☐ F to save the life of the pregnant woman; or

☐ G to prevent grave permanent injury to the physical or mental health of the pregnant woman.

This certificate of opinion is given:

Tick appropriate box

☐ 1 before the commencement of treatment for the termination of the pregnancy to which it relates; or, if that is not reasonably practicable, then

☐ 2 not later than 24 hours after such termination.

Signed .....

Date .....

*Delete as appropriate

(OVERLEAF: CERTIFICATE A)

MOUNT SHEET

Note: Remove strip to reveal gummed area.
Attach reports from bottom to top.
Please set them accurately.

JB-8267

BIOCHEMISTRY

12
11
10
9
8
7
6
5

DMR320

MICROBIOLOGY

Tayside Clinical Laboratory Services -VIROLOGY/BACTERIAL SEROLOGY- 01382 632559

Name : ELLIS, Stacey
CHI No : 2804880060
DoB : 28 Apr 1988 Sex: F
Post Code: DD10 9LB

Clinician:Dr J. GUEST
N/W Ward 41 (Nairn Suite)

MGT 6/1.

CPA Accredited 0221

ROUTINE SEROLOGY. Venous blood
Specimen Number 09V029019
Date Taken 21 Dec 2009

Rubella IgG antibody	: 25 IU/ml
Hepatitis B (HBsAg) screen	:Negative
HIV1&2 Antigen/Antibody	:Negative
Syphilis total antibody	:Negative

IP 31/12/09

RUBELLA IgG: 10 IU/ml or GREATER = Immune, BELOW 10 IU/ml = Susceptible.
SUSCEPTIBLE PATIENTS are recommended to be vaccinated taking precautions to avoid vaccination during pregnancy.
PATIENTS AT RISK OF HEPATITIS B INFECTION: please consider vaccination of such patients who are currently HBsAg negative.

Date of Report: 31 Dec 2009
N41 GUEJ1H

REPORT RECEIVED
DOCTOR'S INITIALS
DOCTOR'S INITIALS
DOCTOR'S INITIALS

HAEMATOLOGY

DMR292

Tayside Clinical Laboratory Services — Telephone 01738 473223 (PRI) 01382 632602 (NW)

Name: ELLIS Stacey Sex: F PID: 2804880060 DoB: 28 Apr 1988
Lab No: H095753797
N/W Ward 41 (Nairn Suite) Clinician: Dr J. GUEST N41 GUEJ1H

HGB	13.8	g/dL	(12.0-16.0)	WBC	13.5	H x10^9/l	(4.0-11.0)
RBC	4.66	x10^12/l	(3.8-4.8)	NE#	9.2	H x10^9/l	(2.0-7.5)
HCT	0.400		(0.37-0.47)	LY#	3.0	x10^9/l	(1.5-4.0)
MCV	85.8	fl	(80-96)	MO#	1.1	H x10^9/l	(0.2-0.8)
MCH	29.6	pg	(27-32)	EO#	0.23	x10^9/l	(0.0-0.4)
MCC	34.5	g/dl	(32-36)	BA#	0.0	x10^9/l	(0.0-0.1)
				PLT	325	x10^9/l	(150-400)

Lab.Comments:

30/12

Sample Date/Time
21 Dec 2009

Clin.Details: for top

Request Entered: 21 Dec 2009 12:34 Report Printed: 21 Dec 2009 12:57

REPORT RECEIVED

DOCTOR'S INITIALS

DOCTOR'S INITIALS

DMR320

MICROBIOLOGY

Tayside Clinical Laboratory Services -VIROLOGY/BACTERIAL SEROLOGY- 01382 632559

CPA Accredited 0221

Name : ELLIS, Stacey
CHI No : 2804880060 Clinician:Dr J. GUEST
Dob : 28 Apr 1988 Sex: F N/W Ward 41 (Nairn Suite)
Post Code: DD10 9LB Source:N/W Ward 41 (Nairn Suite)

TAYSIDE CHLAMYDIA SERVICE Chlamydia Urine
Specimen number 09V110885
Date taken 21 Dec 2009

Chlamydia trachomatis PCR : Negative

31/12

PLEASE NOTE - In infected patients who have been compliant with therapy and in whom there is no risk of reinfection, a test of cure need NOT be performed. However, if required, this should be performed a minimum of 5 weeks after initiation of therapy, to avoid false positive results.

Date of Report: 24 Dec 2009
N41 GUEJ1H

REPORT RECEIVED
LS
DOCTOR'S INITIALS

Central Vision - NHS Tayside: STACEY ELLIS: Tayside CHI - 2804880060

Report Details: Authorised | **View:** Original

Dundee and East of Scotland Blood Transfusion Service
NINEWELLS HOSPITAL DUNDEE Tel: 01382 660111 Ext.32933
ANTENATAL / SEROLOGY REPORT

Surname: ELLIS
Forename: STACEY
Address:

Cons / GP: DOCTOR IN CHARGE DR479
Ninewells Hospital

Dundee

Sex:Female
CHI: 2804880060
SNBTS Patient Ref.No. 9006421183

Ward: Ward 41
Facility Code: 0T101H\000041

Blood Group: O Rh(D) Positive
Patient Phenotype:
Irregular Antibody Screen: No Atypical Red Cell Antibodies Detected

Pre Admission Sample

Event Number: 10310004416701
Date of Sample: 21/12/2009

Date Reported: 21/12/2009
Date Received: 21/12/2009 12:30

UK PATENT No. GB 2254043 B JONES & BROOKS LTD. TEL: 01786 843121

For TRAK please

Ref to Gynae by Dr Pole 30.9.19 - Had TRI BHCG 1000 ↓ 2.10.19.

TELEPHONE INITIAL CONTACT

Date: 04.10.19 Time: 14.15

Name: Stacey Leonard. DOB: 280488 8060

07368227877 ? 23.8.19: Erratic

Parity: _____ LMP: _____ Confirmed by

Date of 1st positive pregnancy test: 3.10.19 Confirmed M/Cycle: _____

Scan this pregnancy: YES/NO comment 3+5

Referred by: Self Midwife GP Other

(Please circle)

Comment: D Pole - Brechin H/C. - Please call Neem early scan - see MLU report

Telephone Number: 01356235860 / 01356 624411

Signature: D Booth. Print Name: D BOATH.

TELEPHONE ADVICE MIDWIFE TRIAGE

Date: _____ Time: _____

Any negative pregnancy tests prior to this: YES/NO

Risk Factors		*Any Current Contraception*	
History of PID/Chlamydia		IUD/IUS	
Endometriosis		Progesterone only oral contraceptive	
Previous ectopic		Combined oral contraceptive	
Infertility		Morning after pill	
Previous abdominal surgery		Other:	
Previous sterilisation			

Assess Pain: any referred pain e.g. rectal/shoulder tip

Any pain relief taken: YES/NO

Assess bleeding :

Check pregnancy symptoms:

Advice and follow up: EPAC 9.10.19 @ 13:30

Midwife signature: Elaine Duncan SM Print name:

Emergency Gynaecology Assessment Sheet

Grey shaded areas to be completed by nursing staff. White areas to be completed by medical staff.

Date: 9.10.19 Time of arrival: 1300 GAU/Ward 36/PRI EAC NW

SURNAME: Leonard

FORENAME: Stacey

CHI No: 2804880060

ADDRESS:
2 Wards Road
Brechin
DD9 7AS

GP ADDRESS:
Brechin
+1.C.

tient's Tel No:
07368227877

Assessed by: Elena Dan

Nurse name:

Time:

Signature:

Temperature:

Pulse:

BP:

RR:

Sa 02:

Urine HCG: 3+6
3.10.19.

Urine Analysis:

ADMITTING CONSULTANT: Pavae.

Assessed by: Doctor name & designation: Time: Signature:

Presenting History: GP referral

BHCG - 1084 on 2.10.19
GP requesting scan - see MRI scan report.

Some preg symptoms
No PV bleeding

Age:

Parity: 4/

LMP: ? 23.8.19
6+5

Menstrual history:

Contraception:

Last cervical smear:

Examination

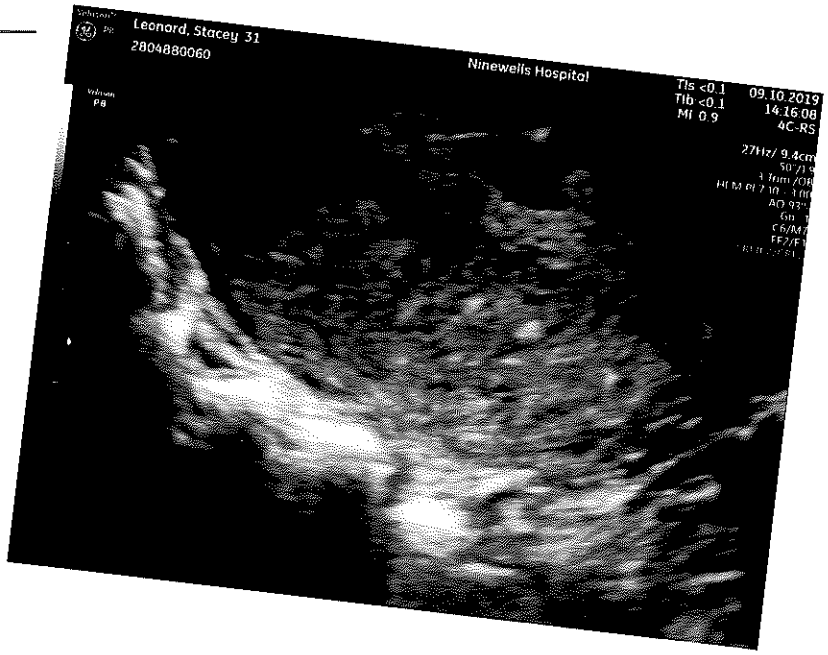
Abdominal examination

Speculum examination

vaginal examination

Systemic examination:

List all investigations performed:



Ultrasound findings: TAUSS- Appearance of gestation
~~Sac but content not clear.
Verbal consent for TVS

TVUSS 10 gestation sac 6.3mm x 10.1mm x 14.6mm
Yolk sac seen
No fetal pole seen.

For repeat scan 10 days

Elena Dean.

Elena Dean
VP
28048800

Clinical Diagnosis: Early IUP

Management plan:

EPAC 21.10.19 @ 1030.
D/w D/G Bashan re MRI report
- Dr Bashan plans to contact Stacey directly to discuss

Elena Dean
VIM.

Letter to GP dictated ☐ Admitted to ward ☐ Outpatient follow up ☐ Refer to other speciality ☐

Emergency Gynaecology Assessment Sheet

Grey shaded areas to be completed by nursing staff. White areas to be completed by medical staff.

Date: 21.10.19 Time of arrival: 1050 GAU/Ward 36/PRI EPAC NLW

SURNAME: LEONARD

FORENAME: STACEY

CHI No: 2801880080

ADDRESS:
2 WARDS RD.
BRECHIN
DD9 7AS

GP ADDRESS:
BRECHIN HIC.

Patient's Tel No:
07368227877

Assessed by: ClinicDell

Nurse name:

Time:

Signature:

Temperature:

Pulse:

BP:

RR:

Sa 02:

Urine HCG:

Urine Analysis:

ADMITTING CONSULTANT: DR 3 PANDE

Assessed by: Doctor name & designation: Time: Signature:

Presenting History:

Post pregnancy symptoms
otherwise well
For repeat scan Wednesday
Viability

Age:

Parity:
4/

LMP:
230819

Menstrual history:

Contraception:

Last cervical smear:

Examination

Abdominal examination

Speculum examination

Vaginal examination

Systemic examination:

List all investigations performed:

Ultrasound findings: TVUSS - IU gestation sac yolk sac seen
CRL 9.9mm - approx 7+1 weeks
FH activity seen

Clinical Diagnosis: Viable IUP

Management plan: F.U CM

Letter to GP dictated ☐ Admitted to ward ☐ Outpatient follow up ☐ Refer to other speciality ☐

Patient name: **Stacey Leonard**
Hospital Number: **2804880060**

Tayside Diagnostic Services

Printed by edevlin (Elaine Devlin (Non Referrer)) at 04 Oct 2019 16:07

Patient name: Stacey Leonard CHI Number: 2804880060 Sex: Female
Date of birth: 28 Apr 1988
Address: 2 Wards Road, Brechin DD9 7AS

IMPORTANT: This is a numerical summary of results for a sample (UP TO AND INCLUDING the 'Reported' date if shown in the column header). To see the complete information for a specific result you MUST look in the original report(s) or click on the test name

IMPORTANT: Results of the same name appearing under different investigations are marked with ***

Note: Results within the same report for the same test, from another investigation, have been added and highlighted to missing values.

Investigation/Test	Range	Units	Sample Collected 02 Oct 2019 09:28	14 Aug 2019 11:49	24 May 2019 09:27	11 Jan 2018 09:13	28 Apr 2017 09:33	16 Aug 2016 12:46
Bone Group								
CALCIUM	(2.10 - 2.55)	mmol/L	-	-	2.36	2.25	2.37	-
CALCIUM (CORRECTED)	(2.10 - 2.55)	mmol/L	-	-	2.37	2.27	2.36	-
Urea & Electrolytes								
SODIUM***	(133 - 146)	mmol/L	-	-	(137)	(142)	(138)	140
POTASSIUM***	(3.5 - 5.3)	mmol/L	-	-	(4.8)	(4.8)	(4.5)	3.8
UREA	(2.5 - 7.8)	mmol/L	-	-	-	-	-	4.5
CREATININE***	(44 - 80)	umol/L	-	-	(75)	(75)	(*81)	***89**
Liver Function Tests (LFT)								
ALT	(5 - 55)	U/L	-	-	LT9	9	11	-
BILIRUBINS	(0 - 21)	umol/L	-	-	8	5	8	-
ALKALINE PHOSPHATASE	(30 - 130)	U/L	-	-	48	52	54	-
ALBUMIN	(35 - 50)	g/L	-	-	39	38	40	-
Creatinine and Electrolytes								
SODIUM***	(133 - 146)	mmol/L	-	-	137	142	138	(140)
POTASSIUM***	(3.5 - 5.3)	mmol/L	-	-	4.8	4.8	4.5	(3.8)
CREATININE***	(44 - 80)	umol/L	-	-	75	75	***81**	(*89)
ZINC	(10.0 - 18.0)	umol/L	-	-	-	-	13.2	-
CA 125								
CA125	(0 - 30)	kU/L	-	***50**	***72**	24	-	-
TOTAL HCG	(0 - 5)	U/L	***1084**	-	-	-	-	-
GGT	(3 - 73)	U/L	-	-	-	-	26	-
TESTOSTERONE		nmol/L	-	-	0.7	-	-	-
LH	(0.8 - 12.0)	U/L	-	-	6.5	-	-	-
FSH	(1.1 - 9.6)	U/L	-	-	8.0	-	-	-
PHOSPHATE	(0.8 - 1.5)	mmoL/L	-	-	-	-	1.12	-
BICARBONATE	(22 - 29)	mmol/L	-	-	-	-	29	-
GLUCOSE								
GLUCOSE (preserved tube)	(3.3 - 5.8)	mmol/L	-	-	-	4.2	3.5	-
TSH	(0.4 - 4.0)	mU/L	-	-	2.47	3.82	3.56	-
Plasma Viscosity								
PV	(1.5 - 1.72)	mPa.s.	-	-	1.65	-	-	-
PROLACTIN	(0 - 600)	mU/L	-	-	138	-	-	-
CREATINE KINASE	(25 - 200)	U/L	-	-	-	-	138	-
AMYLASE	(0 - 100)	U/L	-	-	-	-	60	-
MAGNESIUM	(0.70 - 1.00)	mmoL/L	-	-	-	-	0.91	-
PROTEINS	(60 - 80)	g/L	-	-	-	-	63	-
FBC								
Hb	(120 - 160)	g/L	-	-	141	143	141	136
WBC	(4.0 - 11.0)	$x10^9$/L	-	-	6.8	7.3	7.4	***12.2**

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**

NHS Tayside Radiology Report

Printed by edevlin(Elaine Devlin (Non Referrer)) at 04 Oct 2019 16:09

Patient name:	STACEY LEONARD	**CHI Number:**	2804880060	**Sex:**	Female
Date of birth:	28 Apr 1988				
Address:	2 Wards Road, Brechin DD9 7AS				

Reported	Specialty	Location	Clinician	Status
25 Sep 2019 13:25	Radiology	NW OP GYNAE/OB CLINIC	Dr Yeswanthini BHUSHAN (Obstetrics & Gynaecology (Obstetrics & Gynaecology)	F

Radiology Examination 7308121: 25 Sep 2019 08:38

MRI Pelvis gynaecological

MRI Pelvis gynaecological

Clinical History :

31 yrs old, para 4
raised ca 125 (50-70)
pelvic pain
pelvic scan - 1.7 cm cyst in pouch of douglas with free fluid ? nature
MRI- urgent please in view of raised ca 125 and uncertain lesion in pelvis
ENTERED BY: Yeswanthini Bhushan (Medical)

BLEEP: 5478

MRI Pelvis gynaecological :
Correlation is made with previous MRI dated 18/08/16.

History of LLetz excision of CIN from CIN from the cervix noted from 2016.

The uterus is anteverted and measures 9.7 cm in the long axis. The endometrial stripe is of normal signal and uniform thickness. There is mild increase in thickness of the junctional zone in the anterior wall of the uterus up to 16 mm, suggestive of a degree of adenomyosis. No focal lesions within the myometrium.

The uterine cervix has altered anatomy due to LLetz excision but maintains zonal differentiation on T2 with no suspicious features. The uterus has arcuate configuration with a medial fundal thickness of 1.8 cm.

The ovaries are visualised in normal in size and position. Within the left ovary, there is an 11 mm cyst of intermediate T2 and high T1 and T1 fat sat signal in keeping with a small haemorrhagic cyst.

Corresponding to the findings from the ultrasound, lying posterior to the right ovary, there is an unilocular lesion measuring 2.1 cm with high T2 and long T1 and T1 fat sat signal in keeping with a small simple cyst. This cyst is closely related to the right ovary and is thought to arise from it. No concerning features.

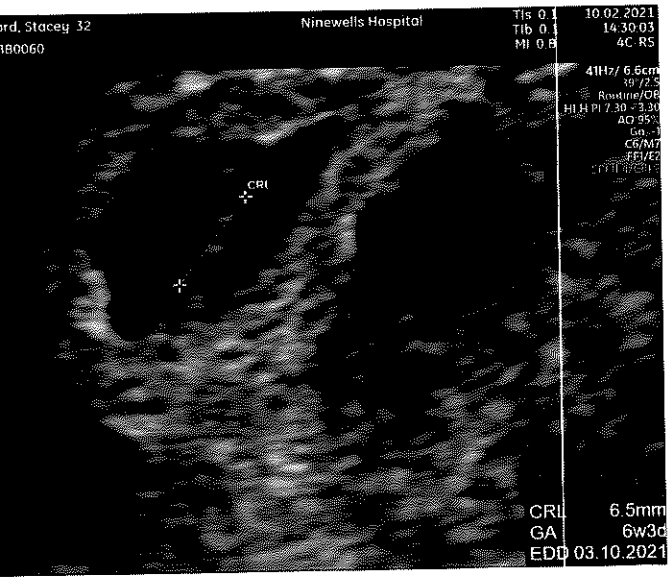
There is a trace of free fluid in the pelvis, this is considered physiological for patient age. There is no pelvic lymph adenopathy. Unremarkable appearances of the other visualised pelvic organs. No significant degenerative changes in the lumbar spine.

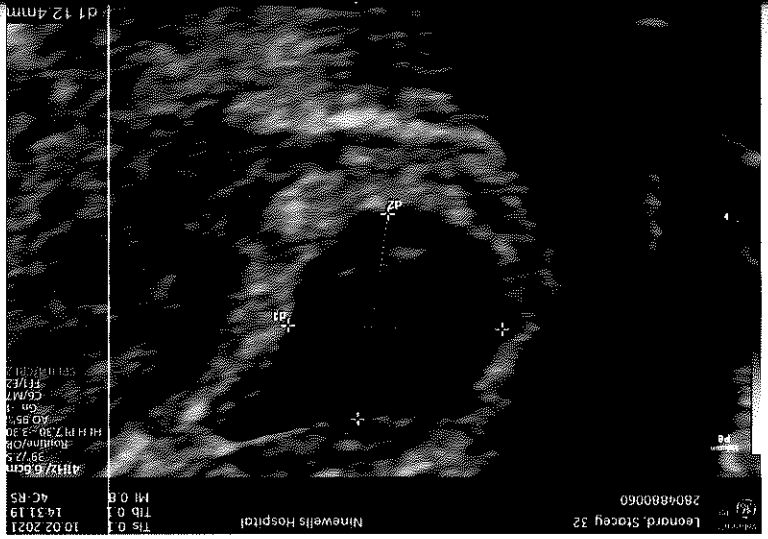
Opinion: Simple small right adnexal cyst and a mild anterior uterine adenomyosis. No other finding of note.

DR M. Szewczyk-Bieda Consultant Radiologist

DR MAGDA SZEWCZYK-BIEDA / MOND

End of report


rd, Stacey 32
180060
Ninewells Hospital
Tis 0.1
Tib 0.1
MI 0.8
10.02.2021
14:30:03
4C-RS
41Hz/ 6.6cm
Routine/OB
AO 95%
CRL
6.5mm
GA
6w3d
EDD 03.10.2021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2804880060
Ninewells Hospital
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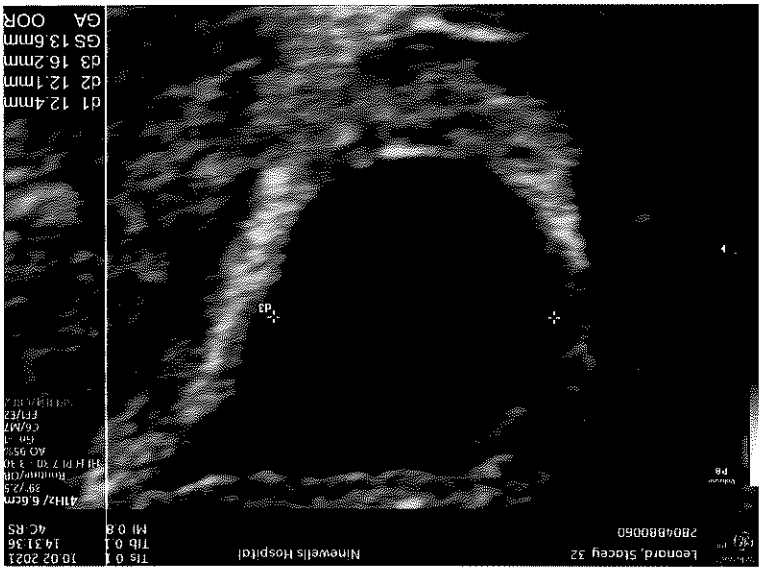
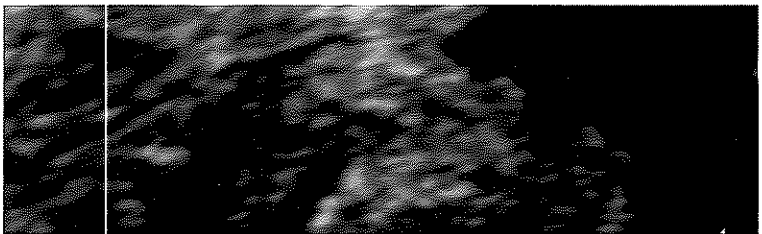
14:31:19
4C-RS


d1 12.4mm
d2 12.1mm
d3 16.2mm
GS 13.6mm
GA OOR
Leonard, Stacey 32
2804880060
Ninewells Hospital
10.02.2021
14:31:36
4C-RS

Leonard, Stacey 32
2804880060
Ninewells Hospital
10.02.2021
14:32:54
4C-RS



COVID Triage Tool for outpatients

Patient Name: Stacey Leonard CHI: 2804880060 Date: 10 ~~Jan~~ Feb 2021

If patient answers YES to any of these questions, refer to clinician in charge

	Question for patient	YES	NO
1.	Do you have any of these symptoms? • High unexplained temperature or fever • New, continuous cough • A loss or change in your sense of taste or smell Advise contact with 111/GP and postpone outpatient appointment (if possible)		✓
2.	Have you tested positive for COVID-19 within past 14 days? (or within past month for patients who are elderly (>69), immunocompromised or ex-critical care) If yes, check ICE/Clinical Portal. If urgent care is required arrange test & follow the **High Risk pathway**. Consider rescheduling appointment		✓
3.	Are you waiting for a COVID-19 test result? If yes, ascertain if treatment can be delayed until results are known. If urgent care is required follow the **Medium Risk pathway** pending results.		✓
4a	Have you travelled outside of the UK in the last 14 days? If yes, where have you travelled? Is this country on the Scottish Government's **safe** travel list? https://www.gov.uk/guidance/coronavirus-covid-19-travel-corridors If it is **not** on the safe travel list then 14 days quarantine will apply. If urgent care is required arrange test & follow the **Medium Risk pathway** pending results.		✓
4b	In the last 14 days, have you been anywhere in Tayside or the UK which has been identified as a local 'hot spot'? If yes, ascertain if treatment can be delayed & arrange test. If urgent care is required follow the **Medium Risk pathway** pending results.		✓
5.	In the past 14 days have you had contact with someone who is waiting for a test result, has tested positive for COVID-19, or has been in isolation as a suspected case? If yes, wait 14 days from start of isolation period before treatment. If urgent care is required arrange test and follow **Medium Risk pathway** pending results.		✓
6.	In the past 14 days, have you been asked to self-isolate by Health Protection or the Test and Protect Team? If yes, ascertain if treatment can be delayed until end of isolation. If urgent care required arrange test & follow the **Medium Risk pathway** pending results.		✓

If NO to ALL questions proceed with appointment and follow appropriate pathway.

Pathway:	COVID-19 Triage Tool Outpatients V8	Date:	22/10/2020
Developed by:	G Phillips, C Beecroft, B Mooka	Review Date:	As required (minimum 6 monthly)

STEVEN GRANT 07706187077

Notes for using the COVID 19 triage tool

The purpose of the COVID triage tool is to help reduce the risk of cross infection by ensuring patients with symptoms or epidemiological risk factors are placed safely and that appropriate infection control precautions are used from the start. It is based on the National Guidance COVID-19 "Guidance for the remobilisation of services within health and care settings" (August 2020):

(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/910885/COVID-19_Infection_prevention_and_control_guidance_FINAL_PDF_20082020.pdf)

It is best applied as near as possible before any planned visits to the hospitals and clinics. There are 2 versions, one for patients being admitted and one for patients attending outpatients/clinics.

A copy of the triage tool must be kept in the patient's records – it does not matter if it is paper or electronic but must be available for audit and review at any time.

For patients who visit the hospital regularly (e.g. for renal dialysis or chemotherapy), it is recommended that the full set of questions is asked **weekly**, but for in between attendances it is safe and acceptable to ask and record if there has been any change to the status.

Question 1: If YES, follow triage tool and the HIGH RISK pathway relevant to the area if admission or treatment is needed urgently. Discuss with clinician in charge if outpatient to assess

Question 2: if YES inform clinician in charge and follow the HIGH RISK pathway for the area if admission or treatment is needed urgently.

Question 3: If YES, ascertain if treatment can be delayed until results are known. If they need urgent admission or treatment, offer FRSM and single room and contact clinician in charge for further advice. Follow the MEDIUM RISK pathway for the area.

Questions 4a: if YES – click on/check the link to see if the country is on the most up to date safe travel list. If it is, the patient can follow the low risk pathway for the area if admission or treatment is needed. If it is NOT on the list then the patient must be offered a FRSM and single room until the 14 days of quarantine are over (regardless of a negative test).

Question 4b: the patient or the person asking the question may be aware of hot spots via media etc. In due course a list of 'hot spots' may be available on the dashboard. It's likely to change frequently If they answer YES to this question, and they need urgent admission or treatment, arrange testing, offer FRSM and single room and contact clinician in charge for further advice. Follow MEDIUM RISK pathway for the area

Question 5: if YES inform clinician in charge and follow the MEDIUM RISK pathway for the area if admission or treatment is needed urgently. Patient must be offered an FRSM and single room until the 14 days of quarantine are over (regardless of a negative test).

Question 6: if YES inform clinician in charge and follow the Medium risk pathway for the area if admission or treatment is needed urgently. Patient must be offered an FRSM and single room until the 14 days of self-isolation are over (regardless of a negative test).

TEAM V9.2H

DATE: 13/09/21

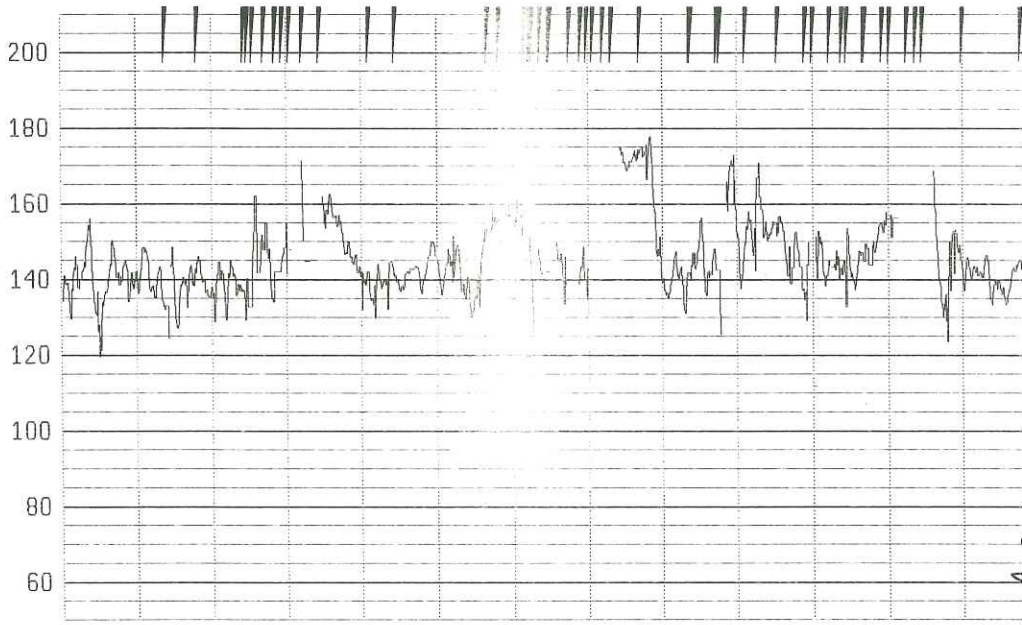
TIME: 15:04

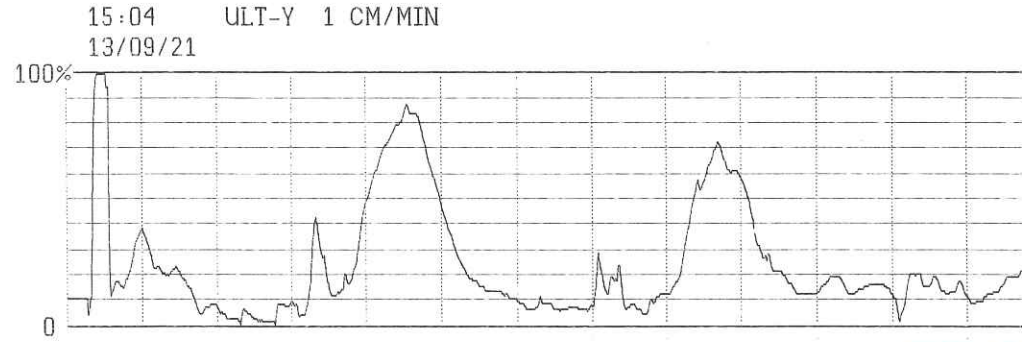
GESTATION:

Stacey Leonard.

mp 77

280488





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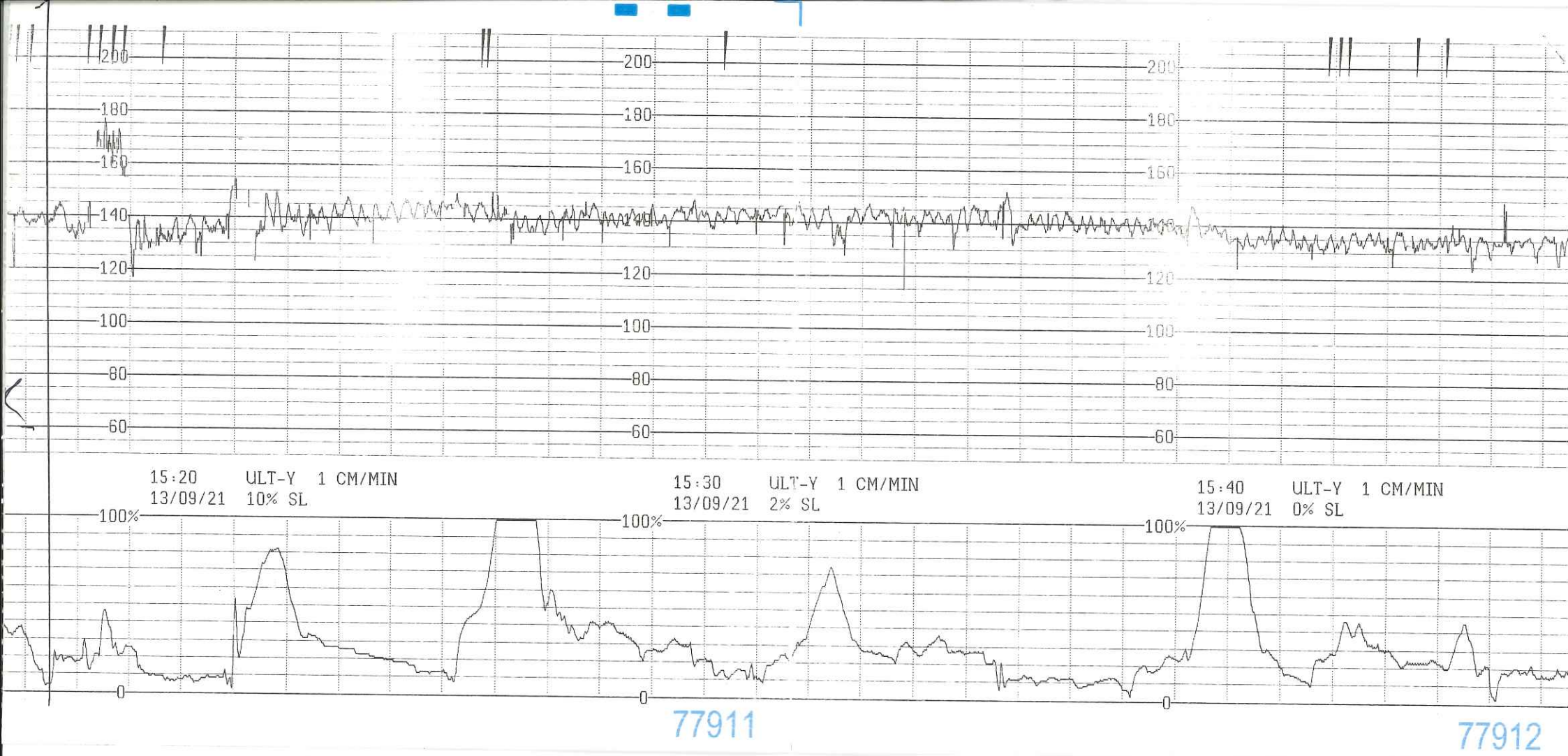
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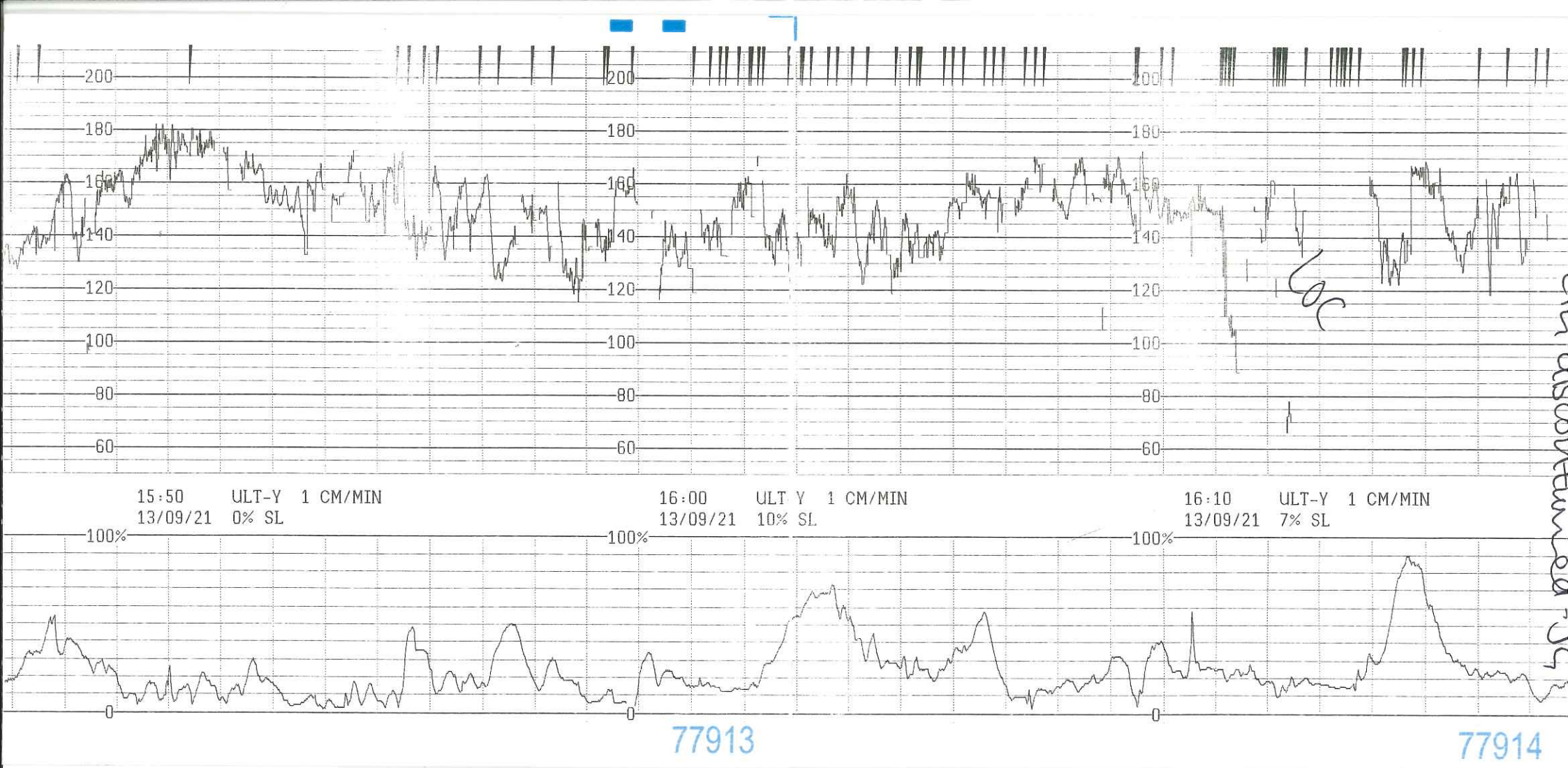
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13/09/21 10% SL
16:10 ULT-Y 1 CM/MIN
13/09/21 7% SL
77913
77914

ncounter Report

ress and Telephone numbers

6 Mill Place Craigc Montrose DD10 9LB
Mobile phone 078 920 306 01 (02/12/2007)

nificant Medical History

05/2006 Depressive disorder NEC and alcohol misuse. Referred Commit
1964 Foster care
1994 Child on protection register mother psychiatric illness, father in prison

ronic Disease Register

No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.

rrent Repeat Medication

No data recorded.

cute and Repeat issues in last 3 months

26/08/2009 METRONIDAZOLE tabs 200mg Supply: (21) tablet(s) TAKE ONE 3 TIMES/DAY Dr Graham Kramer
25/08/2009 DOXYCYCLINE (AS HYCLATE) caps 100mg Supply: (8) capsule(s) TWO NOW THEN ONE DAILY Dr Graham Kramer

llergies and Intolerances

No data recorded.
12/11/2007 Allergy Moderate H/O: non-drug allergy Latex Itchy and red Mrs Lynne Garden

ecalls - 3 months back to 1 month in future

No data recorded.

eferrals and Requests in last 3 months

27/05/2009 Refer for Gynaecological referral Action: 17/06/2009 Referred Tax: Dr Monica Ireland

ests in last 3 months

No data recorded.

ast Consultation

26/08/2009 Administration Dr Graham Kramer
26/08/2009 Right iliac fossa pain and vaginal discharge for 3 days, feels unwell. O/e mild pelvic tenderness, Inga will do HVS and chlamydia swabs, will start antibiotics.
VE has creamy discharge tender in right fornix, urinalysis ++ves but looks clear, not turbid. Preg test negative. Dr Graham Kramer
26/08/2009 METRONIDAZOLE tabs 200mg Supply: (21) tablet(s) TAKE ONE 3 TIMES/DAY Dr Graham Kramer
25/08/2009 DOXYCYCLINE (AS HYCLATE) caps 100mg Supply: (8) capsule(s) TWO NOW THEN ONE DAILY Dr Graham Kramer

Prevention

12/11/2007 11:24.00 BP 111 / 67 taken Sitting from Right Cuff: Standard recall due: O/E - blood pressure reading Mrs Lynne Garden
12/11/2007 Never smoked Never smoked tobacco Mrs Lynne Garden
12/11/2007 Life teetotaler Non drinker alcohol Mrs Lynne Garden
10/11/2008 Weight: 44 kgs BMI: 17.8 O/E - weight Dr Ruth Cranswick
12/11/2007 Height: 1.57 metres O/E - height Mrs Lynne Garden
19/12/2007 Blood grouping Blood group: O+
01/08/2008 reported 21/08/2008 Ca cervix screen normal Dr Margaret Anderson
No data recorded.

New Consultation Details

Date: Clinician:

ll Medical History

iress and Telephone numbers

6 Mill Place Craigo Montrose DD10 9LB
Mobile phone 079 926 306 01 (02/12/2007)

Medical History

26/08/2009 Telephone encounter pt worse today-feverish/vomiting and pain no better. Dw Dr Kramer -admit gynae-dw gynae Rv wd 26 -referral to be faxed Dr Locum Doctor
26/08/2009 Right iliac fossa pain and vaginal discharge for 3 days. feels unwell. O/e mild pelvic tenderness. Inga will do HVS and chlamydia swabs, will start antibiotics.
VE has creamy discharge tender in right fornix, urinalysis ++ltes but looks clear, not turbid. Preg test negative. Dr Graham Kramer
10/07/2009 Patient reviewed - no cough. Apyrexial. Chest clear. No doubt viral but i dont feel influenzal. Advice. Dr Richard Marwood
09/07/2009 Telephone encounter High fever and chest feels heavy. No cough or runny nose or sore throat Declan had feverish illnes last few days. Has taken paracetamol and ibuprofen.
eating and drinking Ok Advised rest if possible Doesn't think anyone can help her with Declan tonight. Offered appt mane Dr Ruth Cranswick
08/07/2009 Administration - 0789 383 0501 - Please call re drinks has bronchitis and not feeling very well (IAS)
18/06/2009 Letter from specialist Clinical Letter Links H C Gynaecology Ms Jackie Dempster
03/06/2009 Letter received Clinical Letter Links H C Physiotherapy Miss Isla Sutherland
27/05/2009 Dysfunctional uterine bleeding has implanon, c/o persistant vaginal bleeding for a year following birth of son, has only had 3 breaks in that time, c/o superficial dyspareunia-sore
in are where stitches were Also suprepubic pain. had USS 14/52 post partum-NAD. Requests D&C-explained this is not usually done nowadays in view of good scanning. Refer Gynae Dr
Monica Ireland
15/05/2009 DNA hospital appointment with Physio, now discharged - (See Docman 03.06.09)
07/03/2009 Contact lens wearer Dr Ruth Cranswick
12/03/2009 Tired all the time and nausea last 10 days. Says [illegible] likely. General lifestyle advice and Rv if not
improving Dr Ruth Cranswick
12/03/2009 C/O - lumber pain Since pregnancy but getting worse. No radiation No red flags. Declan 9mths and crawling. Posture very poor. Normal alignment spine and [illegible]
painkillers help so stay off them Given advice re posture and exercise sheet Ref physio Dr Ruth Cranswick
12/03/2009 Intermenstrual bleeding - irregular Has stopped. No bleeding. Dr Ruth Cranswick
19/02/2009 Did not attend - no reason Implanon removal planned Dr Margaret Anderson
06/01/2009 C/O - cough for week, productive, yellowish sputum. chest tightness. feels hot, sore throat. Her son in the hospital and was told not to visit him until she gets better.
OE afebrile, throat red, no exudate, chest clear.
Impression VIRAL chest infection.
Advised for Sx treatment but she was concerned as not seeing her son so deferred Abx given to take if no improvement by the end of tomorrow (smoker as well). Exara Contraception
precaution advised. Dr Trainee Doctor
22/12/2008 Did not attend - no reason Didn't come to appt today i phoned ward. SN reports Stacey much more involved Stayed overnight last night and did all his care today including tube
feeds and managing those well. Hoping to get him home at Xmas but possibly only for day pass. Dr Ruth Cranswick
15/12/2008 Telephone encounter Discussion with Lynda Clarshaw. Disappointed Stacey has not been back to ward since she saw her last Tues. Will see her tommorrow if Stacey goes. Ix
now limited as Stacey not there to give consent. Child protection action now looking likely
Bonnie aware of all this and will try to speak to Stacey Dr Ruth Cranswick
15/12/2008 Had a chat to patient Long chat with Stacey and friend Stacey quite tearful. Now quite entrenched in her position of not liking NWs and not wanting to go there. Hasn't been to
see Declan for 5-6 days. "They're playing games with me". Tried to explain that no-one had any incentive to do this and that everyone's aim should be to get Declan home, healthy and
feeding as soon as possible. Stacey feels let down that the admission has been much longer than initially suggested. Thinks Declan would feed Ok at home and that Declan may be taken
she would want him to go to ARI. Tried to encourage her to communicate with hospital staff but wouldn't be moved. Suggested that SW may become involved and that Declan may be taken
into care She is aware of this. Plans to go and take Declan home mane. Encouraged to at least listen to consultant who has offered to see her regularly personally. Rv with me 1/52. Happy to
me to phone consultant Dr Ruth Cranswick
11/12/2008 Telephone encounter Spoke to Dr lynda Clershaw, Paed Consultant Has taken over Declan's care this week and spoken to Stacey. Organic Ix so far neg and thinks t [illegible] ourse
feeding problems most likley. Agrees Stacey needs some continuity to build trust with hospital staff. Bonnie and i both feel she is a motivated parent but struggling for various reasons [illegible] syndr
plans to see her personally regularly. Said i felt she is not currently depressed but will continue to Rv this.Declan will be in hosp further 2 weeks at least and may need to go home with NG
tube Stacey currently reluctant to do the tube feeding. Seeing me on Mon Dr Ruth Cranswick
08/12/2008 Telephone encounter Phoned and spoke to SN Meikle. Took on board our concerns re Stacey May ask medical staff to ring me back. Dr Ruth Cranswick
06/12/2008 Emotional problem Declan been in hosp for 2 weeks Admitted after clinic appt due to poor weight gain and feeding issues. Being tube fed in hosp and Ix so far negative Stacey
struggling. Doesn't feel she can live at NWs and has been spending all her money travelling there each day. Getting very frustrated with hospital staff. Doesn't seem to be any continuity and
she feels she is being given no information. Wants Declan home. Explained the aim would be to get him home healthy. Hosp made this appt for her as felt she was depressed She, I think, is
correct I n thinking that this is a situational problem. Plans to have a rest this week and not travel to Dundee every day. I will ring the ward. Dr Ruth Cranswick
04/12/2008 Letter received Out of Hours Out of Hours Service Ms Jackie Dempster
12/11/2008 Abdominal pain saw consult on 10/11. Presenting with abdominal pain again. No change since Monday. Similar symptoms. Has moved bowels and normal. No UTI symptoms
Has implanon in situ. Anxious and worried if it could be pregnancy. Reports had UPT done 7 times which was negative and then apparently one UPT turned positive. Distraught about that
o/e alert and oriented. Mood low. Speaks in short sentences only. Difficult but did achieve rapport eventually. Afebrile. Normal colour. No neck nodes. PA - soft. No distension. No mass felt.
No acute abdominal signs. No rigidity or rebound tenderness. BS heard. Non-specific abdominal pain - I think more likely related to psychosocial stressors. Urine dipstick negative and UPT
negative. Reassurance. Long chat. Declines any further antispasmodic. Will return next week if any concerns. Dr Suresh Arunachalam
10/11/2008 Intermenstrual bleeding - irregular Reports bleeding all the time since implanon fitted immediately after Declan,s birth. Bleeding like period Also dyspareunia. Can't have sex due
to bleeding. Has boyfriend of 6 months. Wants implanon removed as wants bleeding to stop ASAP. Try adding COCP for few months RV 2 weeks and do PV then. (Prev on depo but lost
weight, tends to forget pills) Dr Ruth Cranswick
10/11/2008 Patient reviewed Eating much better. Having lunch and tea and feeling hungry all the time. Feeling generally unwell last 2 days. nausea, abd cramps, ears sore, chest sore. No
diarrhoea. O/E T 38, P- 72 reg, chest clear, ears NAD, imp viral illnes. Advised fluids and paracetamol. Calpol prescribed as can't swallow tablets. Unfortunately childminder unwell so can't
have Declan today. Dr Ruth Cranswick
27/10/2008 Did not attend - no reason Bonnie seeing her tomorrow and will report back. Dr Ruth Cranswick
20/10/2008 Patient reviewed Came with younger sister and initially much brighter and reactive. Declan not gaining weight and has Rv at NWs on Wed Manages solids but still very poor [illegible]
intake SALT are advising trial of cup. Stacey had burger today and having some "junk food" . Childminder ill so not getting night off tonight Complimented on her coping and gentley
encouraged re food See again 1 week. ? involve eating disorder team or too many professionals already. Dr Ruth Cranswick
15/10/2008 Letter received Clinical Letter Ninewells Hospital womens and childs health clinical group Miss Isla Sutherland
13/10/2008 Patient reviewed Generally very low, exhausted and tearful. Eating very little and has lost weight. Getting very little sleep as baby wakes frequently. Declan goes to childminder
for 24 hrs Mon/Tues and 3 hrs Thurs pm. Has family Support worker (Kate , visiting tomorrow). Bonnie and speech and language therapist all involved. Vulnerable young Mum although
considerable support already in place. Most urgent issue seems to be her nutrition. Unwilling to take antidepressants and denies any thoughts of self harm (other than not eating).
Encouraged to buy some pasta on way home now. See 1 week. Kate visiting mane. I will liase with RVs. RV 1 week Dr Ruth Cranswick
29/09/2008 Abdominal pain Has taken lactulose and reports pain no better but tenderness and fullness gone from LIF Still some fullness L mid abd. Not eating anything until teatime. Cha
re trying to eat earlier in day. Baby awake and playful at night, chat Back pain prob related to lifting, advice re lifting and posture and simple analgesia. see 2 weeks Seeing Bonn [illegible] mane [illegible]
Ruth Cranswick
23/09/2008 Did not attend - no reason Mrs Lynne Garden
22/09/2008 Abdominal pain Baby has been in hosp few days due to poor feeding. Staff happy no medical cause but feel Stacey needs a lot of support. Bonnie organised meeting of all
involved in her care this week.
Describes ongoing cramping abd pain esp with food. No bowel or urinary sx. Has had PV, negative swabs and USS which she was told showed no abnormality. Abd - Palpable bowel as s
is so slim. Denies constipation but I think this is most likely cause of her abd pain. Bonnie has been trying to encourage improved diet but tends to skip meals. Laxative, FBC, PV, UE, LFT T
and Rv next week Dr Ruth Cranswick
20/08/2008 Laboratory result Result Ninewells Hospital Microbiology Ms Jackie Dempster
18/09/2008 Left iliac fossa pain Went to NWs 6/7 ago Had USS and told NAD Result not available on central vision. Not admitted Advised pain not gynaecological and sent home. No bo
or urinary sx. Nausea and feeling generally unwell. Pain unchanged. LIF and also pain in midback. Finding it hard to care for baby O/E despondent, T 37.9, P 96 reg , abd tender LIF Lum
felt which I think is bowel , very slim. Urinalysis - WBCs, protein and bloda MSU sent. AB and fluids RV MDn earlier if any deterioration Dr Ruth Cranswick
15/09/2008 Discharged from hospital Discharge Letter/Summary Ninewells Hospital Unknown Ms Jackie Dempster
12/09/2008 Failed encounter NOS see query Phone engaged x2 Will try later Dr Margaret Anderson
11/09/2008 Other abnormal uterine and vaginal bleeding blood stained discharg also tender lump LIF o/e ? palpable colon, declines VE will see female doctor. On implanon, check preg
Unlikely). Will see MA on Monday Dr Graham Kramer
11/09/2008 Letter received Clinical Letter Wardgate Health Centre Medical Advisory Service Ms Jackie Dempster
26/08/2008 Letter received Admin Letter Housing Application Mrs Alison Coull

Ellis 26/04/1988 369/88/128

19/08/2008 Letter received from Medical Advisory Service, Westgate Health Centre, File and Form passed to GK boley (IAS) REPLY SENT 25.08.08
11/08/2008 Letter sent to outside agency Clinical Letter Westgate Health Centre Medical Advisory Service Miss Isla Sutherland
11/08/2008 Administration - Letter done to Dr Jane Forsyth, Medical Advisor, Westgate (IAS) Dr Ruth Cranswick
08/08/2008 Abnormal weight loss - symptom feels she is losing weight. BMI 18.2. Monitor weight weekly over next month. (May improve with elevation of mood) Dr Locum Doctor
08/08/2008 Low mood I note high EPNDS score. I think a large element may be due to circumstances - but try low dose citalopram (bottle feeding). Dr Locum Doctor
08/08/2008 Vaginal discharge symptom continues, could not tolerate clotrimazole pessary Dr Locum Doctor
08/08/2008 Backache symptom since delivery (ventouse). Locates over SI joints. Try NSAI. Dr Locum Doctor
08/08/2008 Seen by health visitor Discussed Stacey's high EPNDS and low mood with Dr Kramer and advice given by Health Visitor to make an appointment to see a GP. Mrs Bonnie Troup
07/08/2008 Seen by health visitor Repeated Edinburgh Post Natal Scale. Scored very high 21 Advised to see GP to discuss mood as she has a history of depression. To continue with weekly support visits meantime from health visitor. Mrs Bonnie Troup
04/08/2008 Laboratory result Result Ninewells Hospital Microbiology Ms Jackie Dempster
21/07/2008 Seen by health visitor Edinburgh Post-Natal Depression Scale carried out. 12 scored, discussed at length, feeling mood down at times.Advised to make use of support available, Child & Family Support team involved prior to the birth, community childminding in place and health visitor visiting weekly meantime. Referred for infant massage.Appears to be overwhelmed by the birth. Mrs Bonnie Troup
07/07/2008 Had a chat to patient HV sent along as wt dropping and no inclination to eat. no probs prior to pregnancy with eating. Note baby very poor sleeper and needs fed every 2-3 hours. little support and lots of money worries. conc al down. says mood ok, but admits to freq tearful. has contact with broomfield but feels they are not giving much support. Mum in middle of radiotherapy. I think this is all part of psychological stress. may turn into actual post natal depression. needs to be observed. Check if HV visiting more than standard and whole mood situation needs to be rev at post- natal. MJSimpson Dr Locum Doctor
13/06/2008 Fax received Clinical Letter MRI Maternity Miss Isla Sutherland
06/06/2008 Discharged from hospital Discharge Letter/Summary Ninewells Hospital Maternity Mrs Aileen Coull
02/05/2008 Anaemia during pregnancy, childbirth and the puerperium (Ferrous Sulphate) Dr Ruth Cranswick
02/05/2008 Thrush (Clotrimazole) Dr Ruth Cranswick
14/01/2008 Notes summary on computer Dr Graham Kramer
03/01/2008 Telephone encounter Concerned as 18 weeks pregnant and been in contact with child with measles (says definite diagnosis) She had MMR in June 07 so reassured. Dr Ruth Cranswick
21/12/2007 Letter received Result MRI Mally Mrs Susan Maddock
21/12/2007 Thrush on HVS 16 weeks gestation Dr Margaret Anderson
19/12/2007 Laboratory result Result Ninewells Hospital Immunology Mrs Aileen Coull
06/12/2007 Patient MRE received from FPC files now merged and with Dr Kramer for summary on 14/12/07
02/12/2007 Letter received Out of Hours Out of Hours Service Mrs Susan Maddock
13/11/2007 Letter received Admin Letter New Pt Questionnaire Mrs Susan Maddock
12/11/2007 White Scottish Mrs Lynne Gardan
08/2006 Acne vulgaris
05/2005 Depressive disorder NEC and alcohol misuse. Referred Cornhill
02/04/2005 Right iliac fossa pain admitted gynae with a false poe preg test, settled spontaneously
1997 Breast lump symptom prepubertal
1995 Eye muscle operations squint correction Dr Graham Kramer
1994 Foster care
1994 Child on protection register mother psychiatric illness, father in prison.
1992 Convergent squint left
1992 Minor head injury
1992 Burn of wrist or hand NOS right hand
1992 Insertion of grommet bilateral
1991 Recurrent acute otitis media
1989 Specific delays in development poor social circumstances

Ward 36

STACEY ELLIS

28/04/88 0060

ANNATEANK

26/08/09.

Dear Doctor,

Thank you for seeing this girl who was assessed by Dr Kramer yesterday in RIF/symptomatic tenderness + PV ~~was~~ discharge + creamy d/c + cervical tenderness. Swabs were taken (PTreg) urine (ve F) only ad doxycycline/metronidazole was prescribed. Unfortunately, Stacey phoned today + is now feverish/pain worse and ass'd vomiting. D/W Dr Kramer — requests admission.

NB Child is in protection register — SW aware + subs will look after.

Yours Sincerely

Wittingham.

T.U.H. / T.P.C.

CONTINUATION SHEET

GP. Dr Box L'Kirk, Dr Arnold.

Ward/Clinic/Hosp. MK1 ..... Cons.

D D M M Y Y
2 8 0 4 8 8 C.H.I. No.

Surname ELLIS

First Name STACEY M. State

Address 10 Candar Cres Montrose Sex

Mob: 07709077643

G.P. & Address (G.P. Requests only)

USE BLOCK LETTERS OR PATIENT LABEL

DATE		SIGNATURE
020405	?8wks gestation. H/O depression - taking cipralex	
16:00	Self-referral from home with severe (R)-sided abdominal pain, severe nausea. T=36.9°C.	
	Nil per vaginum (pv)	
	Has visited Arbroath Infirmary this morning and had urine specimen taken - normal urinalysis.	
	Phoned Gynae Ward Ninewells - to go in for medical review. (WARD 36)	JStrachan/ S/M
16:15	Stacey happy to go to NW's - friend accompanying her. Trying to contact parents re. transport to NW's. Handed over to S/M L. Macfarlane.	JStrachan S/M.
		JStrachan,

2/6/04 1600

DATE		SIGNATURE

EPAC SCAN REPORT/SUMMARY CONT.

NAME	CHI
Transabdominal: ✓	CRL (<12 weeks):
Transvaginal: Yes.	BPD (>12 weeks):
Intrauterine pregnancy confirmed: No.	Normal Adenxae:
Sac Outline - regular/irregular: No.	
Sac size: No sac seen mm	RPOC:
Fetus present:	Femur length:
Number of Fetuses	Nuchal fold thickness
Yolk sac present	Fetal movement present:
Fetal heart present:	Ultrasound code number:
PREGNANCY STATUS:	
Diagnosis	Management:
Reviewed by:	Title:
Reviewed by:	Title:
Follow up:	Next Appointment:
Booking Appointment arranged:	Cancelled by: Date cancelled:
Discharged/Transferred to:	
Comments: Scan - thickened ET. Ovaries normal No free fluid Pain has eased off now. Abdo soft, non-tender.	
Recommendations: Imp: ? early pregnancy ? ectopic pregnancy Plan - Allow home Repeat hCG 48 hrs later Adv to contact if pain gets worse.	

Ultrasound Codes:
1. Viable Intrauterine Pregnancy
2. Intrauterine Gestation Sac with Yolk Sac only
3. Non Viable Interuterine Pregnancy
4. Interuterine Gesation Sac >20mm diameter
5. POC Identified and sent to Histology
6. Empty Uterus or Small Sac
7. Small Empty Interuterine Sac
8. Post Partum/Post TOP Bleeding

Ref EPAC June '99 Signature..... Date 2/4/05

2/4/05 Total HCG <1
4/4/5 Urine test: Negative

Imp: ? very Early pregnancy → miscarriage.
D/W Dr. Gukonyi above result.

EPAC SUMMARY Tayside University Hospitals - Ninewells

NAME: STACEY ELLIS LEONARD CHI: 280488 0060

ADDRESS: 10, CONDOR CRES GP: DR ANDERSON

MONTROSE LAURENCEKIRK

Visit Date: 2.4.05	Episode No:
Consultant: DR Duncan	
Visit No:	(1) 2 3 4 5 6
New/Return:	Time In:
Booked Y/N:	Time Out:
SDR Visits HCG/Scan	Mins:
Referred from:	Referral Reason:

T. 36·8
P. 103
BP 130/72.

SG. 1.005
PH 7.
N.A.D.
BLUE X POSITIVE.

REPEATED 04.04.05.
SG. 1.005
PH. 6.5.
N.A.D.
BLUE X NEGATIVE.

Comments/History Bleeding Y/N: Pain Y/N: Other Y/N:

- c/o Rt loin + RIF pain for past 1/52
- Constant severe cramp like pain.
- c/o nausea. NO c/o urinary symptoms, fever P.V bleed/discharge.
- On cipralex for depression. started 3 wks ago.

PA: → Rt. loin + RIF slight tenderness.

LMP Date: BEGINING JAN 05 EDD: Gestation: ? 10-11 WKS

Parity: [ ] + [ ] SB/NND: [ ] EDD by Scan: Gestation by Scan:

Pregnancy Test Y/N:	Positive (Y)/N:	Smoker Y/N:
1st Positive Test (Date)		No. per day:

INVESTIGATIONS		HCG Results this Episode	
Blood Group: ✓	Group/Antibodies:		
HCG: ✓	HCG Results		
FBC: ✓	Urinalysis:		
Anti D:	Dipslide:		
Date/Time:	Result to GP:		

Vaginal Exam Y/N:	HVS:
Os Open Os Close	Endocervical Smear:
Products of Conception Y/N:	Chlamydia:
Sent to Pathology:	

Ref EPAC June '99

Signature..... Date..2/4/5

HISTORY/CONTINUATION SHEET

.....UNIT/WARD/DEPT.

Ward/Clinic/
Hosp. .....Cons

Surname ... ELLIS 28 04 88 T001
First Name . STACEY F 0060
Address .... 10 CONDOR CRESC
MONTROSE
DD10 9ED
G.P. & Addres DR. BOX
THE HEALTH CENTRE
LAURENCEKIRK
SCOTLAND

Y Y C.H.I. No.
..... M. State
..... Sex

USE BLOCK LETTERS OR PATIENT LABEL

DATE

Page .....

20/04/88 Preg test -ve
1900 HCG <1.
c/o abd pain - No bowel symptoms
- no urinary symptoms
? ? nauseated
Explained findings
Declines - analgesia / antiemetics
- admission for observations
? ? time TCT of pain worsens

Grading
Sutts

13.2.17 attended for Smear test post LETZ
for CIN III
Cervix visualised - slight PV bleeding
Smear obtained

Ssh

THB.(MR)3A

DATE

HISTORY/CONTINUATION SHEET

.....UNIT/WARD/DEPT.

Ward/Clinic/Hosp. ....

Surname Leonard

First Nam Stacey

Address .

G.P. & A

2804880060

280488

NW

Vol: 1

Cons

C.H.I. No.

M. State

Sex

USE BLOCK LETTERS OR PATIENT LABEL

Page .....

DATE	
1/8/19	31 yr nd ; P4 (NVD).
	RIF > 1 year ;
	vaginal discharge & pain > 1 year ;
	Menst Hx : fairly regular ;
	variable, light → heavy ;
	no IMB ;
	Medical Hx none ✓
	Surgery : LLETZ - CIN ;
	Smear : reg + (N) ;
	Colposcopy - Cyrae : 2009 : (N) ;
	PV : mgt ; nm tender ;
	PV bimanual exam ;
	Cx - (N) ;
	V/E Cx - (N)
	Uterus : (N)
	no mass
	no tenderness ;

THB.(MR)3A

DATE

Plan:

→ Ур CA-125

→ MRI ;

→ Терапия : нельзя - Лечение (2) препаратами

- ↓ CA-125 - ↓ 2 - по расписанию

MRI - ⊗ - ↓

Нет ↓ ОСП.

- по дезинтоксикации;

↓ выписка

(амбулат)

ℝ Encounter Report

Address and Telephone numbers

8 Mill Place Craigo Montrose DD10 9LB
Mobile phone 078 926 305 01 (02/12/2007)

Significant Medical History

05/2005 Depressive disorder NEC and alcohol misuse. Referred Cornhill
1994 Foster care
1994 Child on protection register mother psychiatric illness, father in prison.

Chronic Disease Register

No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.

Current Repeat Medication

No data recorded.

Acute and Repeat issues in last 3 months

08/08/2008 DICLOFENAC SODIUM ec tab 25mg Supply: (56) tablet(s) TAKE ONE 3 TIMES/DAY Dr Locum Doctor
08/08/2008 CITALOPRAM tabs 10mg Supply: (28) tablet(s) 1 DAILY DISP WEEKLY Dr Locum Doctor
08/08/2008 FLUCONAZOLE caps 150mg Supply: (1) capsule(s) TAKE ONE DAILY Dr Locum Doctor
01/08/2008 CLOTRIMAZOLE pessary & crm 500mg + 2% Supply: (1) pack AS DIRECTED Dr Margaret Anderson
13/06/2008 CLOTRIMAZOLE pessary 500mg Supply: (1) pessary(ies) INSERT ONE AT NIGHT Dr Margaret Anderson
13/06/2008 METRONIDAZOLE tabs 200mg Supply: (21) tablet(s) TAKE ONE 3 TIMES/DAY Dr Margaret Anderson

Allergies and Intolerances

No data recorded.
12/11/2007 Allergy Moderate H/O: non-drug allergy Latex itchy and red Mrs Lynne Garden

Recalls - 3 months back to 1 month in future

No data recorded.

Referrals and Requests in last 3 months

No data recorded.

Tests in last 3 months

No data recorded.

Last Consultation

11/09/2008 Surgery consultation Dr Graham Kramer
11/09/2008 Other abnormal uterine and vaginal bleeding blood stained discharg also tender lump LIF o/e ? palpable colon, declines VE will see female doctor. On implanon, check preg test Unlikely). Will see MA on Monday Dr Graham Kramer

Prevention

12/11/2007 11:24.00 BP 111 / 67 taken Sitting from Right Cuff: Standard recall due: O/E - blood pressure reading Mrs Lynne Garden
12/11/2007 Never smoked Never smoked tobacco Mrs Lynne Garden
12/11/2007 Life teetotaler Non drinker alcohol Mrs Lynne Garden
08/08/2008 Weight: 45 kgs BMI: 18.2 O/E - weight Dr Locum Doctor
12/11/2007 Height: 1.57 metres O/E - height Mrs Lynne Garden
19/12/2007 Blood grouping Blood group: O+
01/08/2008 Cervical cytology examination Dr Margaret Anderson
No data recorded.

New Consultation Details

Date: 12-09-08

Clinician:

Dr Margaret J. Anderson
Annat Bank Practice
Links Health Centre
Montrose DD10 8TR
Tel: 01674 673400 T13706

Thank you for seeing Stacey this evening.

HPC 14 weeks post partum
SVD - 05-06-08. Male 'Declan' Implanon post partum.
2-3 weeks - swelling (L) LF.
1wk - increasing pain & tenderness
2 days - fever & nausea

PTO

O/E T 37.7

Abdo - pain
tender ++ fluctuant swelling (L) if.

Cx - nil excitation

Utens - N. size

Adn - (R) - NAD
(L) ? tender but nil mass

Swabs done

Imp ?? P.I.D

Thank you for your help.

Mr Andelsa.

Ward 36

Ninewells

* Notes requested *

Emergency Gynaecology Assessment Sheet

Grey shaded area to be completed by nursing staff/white area to be completed by medical staff

SURNAME	Ellis
FORENAME	Stacey
CHI No.	280488 0060
ADDRESS	8 Winchard Crescent Motherwell
GP ADDRESS	Anderson Medical Centre Motherwell
PATIENT'S Tel. No.	07892630501

Date of referral	12 09 08	Time of referral	1600hrs
Date of referral	12 09 08	Time of referral	2000hrs

Assessed by nurse time	Jaclyte 2005	Signature Name Status	Jaclyte RGN
Assessed by doctor time	Dr Patongi	Signature Name Status	S.R.
Consultant	JC / AG. (on call).		

S.H.O on bleep. 5609 informed at 2015hrs.

Presenting Complaints	1. LIF + Pain 2. 3.

Clinical Findings:

Investigations:

Diagnosis	1. 2.

Suggested Management:

Drug	Dose	Times per day	Number of days	Date	Signature

Follow up			
Discharged Home ☐	Admitted Ward ☐	Outpatient Follow Up ☐	Referred to other specialty ☐
Date of discharge		Time of discharge	
Signature		Designation	

Initial Assessment:

Date: 12 09 08 Patient Name: Stacey Gillen CHI Number: 2806878060

Temperature	36.2	Pulse	81	BP 106	48
LMP	7/52 ago	Urine HCG	— ve	Urinalysis	— ve

Parity:	Menstrual History:

Presenting History:

Past Medical History	Drugs
Systemic Enquiry	Allergies

Family History:	Social History:	Contraception:

Examination:

Pelvic Examination:

Impression & Further Management

Investigations: (please circle tests performed)

Blood Tests:	FBC	U&E	Serum HCG	Group & Save
Bacteriology:	HVS	ECS	Chlamydia	MSSU
X ray:		Abdominal		Chest
Other:				

Results:

Signature: Name: Status:

Portable Ultrasound

Registrar Review

Review Date and Time:

2008/9/12 2030 14/52 ↑ pain Long 7wks ago
Irregular PVB → Implanon ↑ ago
No Pr discharge. Nausea.
H/O: LIF pain. x 3wks. Preg test (-ve)
O/E Afebrile
Pa Tender Low abd Mass LIF ?? Bowel
Plan: needs u/s - Monday
x rev
: meanwhile - Analgesics

Further Management:

TV USS - no adnexal mass / free fluid. both ovaries normal in size & appearance
patient still has pain - worse after food so not eating & losing weight
normal bowel movements
O/E - (i) ↑ R side soft
mild tenderness on deep palpation
(ii) upper epigastric pain
- reassured no gynae cause for pain. taking a lot of Ibuprofen
∴ explained acid reflux pain which seems to be causing much symptoms
plan - d/c home, after discussion with reg-on-call
- prescription for Lansoprazole + Co-codamol given.

Action			
Discharge Home ☑	Admit to Ward ☐	Outpatient Follow Up ☐	Refer to other specialty ☐
Date of discharge 15/9/08		Time of discharge	
Signature		Designation	GPST2

Hosp

Ninewells Gynae Scan Report 2008

Surname first

Name: ELLIS STACEY **Address:** **Referring Consultant**

Dob/chi: 2804880060

Date of scan : 15/09/2008 **Reason for scan:** LIF PAIN PREG TEST NEG

Scan report:

1

Abdo
Uterus mid-position, normal sized with a thin clear midline
Both ovaries normal in size and appearance
No adnexal masses or free fluid

Scanned by: SMW **Date of next appt:** 15/09/2008 **Medical Review:**

Checked by: WH **Report sent to:** WARD 36

Ref: LJN **Date report sent:** 15/09/2008

Report sent by: LJN

Notes requested 13:30 JS

Emergency Gynaecology Assessment Sheet

Grey shaded areas to be completed by nursing staff. White areas to be completed by medical staff.

SURNAME	ELLIS
FORENAME	STACEY
CHI No.	280488 0060
ADDRESS	8 Mill Place Craigo Montrose (by)
GP ADDRESS	Dr Gransuick Annatbank Health Centre
PATIENT'S Tel. No.	07892630501

Date of Referral	26.8.09	Time of Referral	1330
Date of Arrival		Time of Arrival	1540

Assessed by Nurse Time	Signature Name Status
Assessed by Doctor A Youssef Time 1710	Signature Name Status
Consultant	Dr R Allen

Presenting Complaints

1. Rt lower abd pain + Rt renal angle pain
2.
3.

Clinical Findings

T 37.1° Soft abdomen tender in RIF + Rt renal angle no rebound tenderness no masss felt PV uterus average size cervical excitation tender RIF

Investigations

UBC 11.7 CRP < 3 U LE NAD
TVS small cystic Rt adnexal structure ? tubular small amount of fluid in POD urine lepto -ve

Diagnosis

1. ? PID swabs results awaited
2.

Suggested Management

Suitable for outpatient management

Drug	Dose	Times per day	Number of days	Date	Signature
Ofloxacin tab	400mg	2	14		~ya
Metronidazole	400mg	3	14		~ya

Follow up

Discharged home ☑	Admitted Ward ☐	Outpatient Follow Up ☐	Referred to other speciality ☐
Date of discharge 26/8/09		Time of discharge	
Signature ~ya		Designation	

Initial Ass...

Date: 26/8/09 Patient Name: Stacy Ellis CHI Number: 280488 0060

Temperature	37·1	Pulse 104	104	BP	113/75
LMP	2 months ago	Urine HCG	Negative	Urinalysis	Tr Prot, ++Leuc

Parity:	Menstrual History:
1 + 0	Very irregular bleeding for several weeks at a time.

15/12 gfe

Presenting History:

Felt unwell yesterday
(R) sided abdo pain, radiating to Back
Constant pain, nausea, feels feverish
PV discharge - thick, white with blood streaks. offensive smell - past 3 days
Urinary frequency nocturia 8-9 times last night

Past Medical History	Drugs
Nil dyspareunia no investigation yet	Implanon 15/12

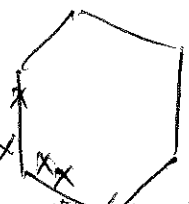
Smear OCP 12 ✓

Systemic Enquiry	Allergies
	Latex allergy

Family History:	Social History:	Contraception:
	lives with same partner long-term	Implanon - due in 2 years

Examination: T 37.1

Tender in Rt Loin Renuiquadrant + Rt renal angle no rebound tenderness no mass felt



Pelvic Examination: vulva, vagina NAD cervix could not be visualised as c/o superficial dyspareunia tender in Rt adnexal region with some cervical excitation NAD uterus

Impression & Further Management

? PID ? UTI

Swabs obtained by GP Yesterday

Investigations: (please circle tests performed)

Blood Tests:	(FBC)	(U&E) (LFT)	Serum HCG	Group & Save
Bacteriology:	HVS	ECS	Chlamydia	MSSU
X ray:		Abdominal		Chest
Other:				

Results:

Signature: Name: Status:

Portable Ultrasound

TVS AV uterus 68 x 29 x 34 mm thin endometrial line Rt thick walled longitudinal structure 41 x 20 x 24 mm seen above Rt ovary which looks normal. Lt ovary 22 x 18 x 19 mm small amount of fluid in pelvis

Registrar Review

Review Date and Time:

26/8/09 T remains 37.1

CRP < 3 UBC 11.3 Neut 7.4

P/t 308 U&E's WNAD

Suitable for outpatient Mx

Antibiotics as per policy for 14 days

See GP for follow up

Further Management:

Action			
Discharge Home ☐	Admit to Ward ☐	Outpatient Follow Up ☐	Refer to other specialty ☐
Date of discharge		Time of discharge	
Signature		Designation	

ID:
PVL-625RTC
DEPT OF OBSTETRIC ULTRASOUND NINEWELLS ENDOCAVI
26.08m2009
06:18:49PM
6.0cm→
C60-6.0
26Hz
D 22.4MM 18.0MM
6/ 76

ID:
PVL-625RTC
DEPT OF OBSTETRIC ULTRASOUND NINEWELLS ENDOCAVI
26.08m2009
06:16:15PM
6.0cm→
C60-6.0
26Hz
D 41.3MM 20.2MM
6/ 76

AMBULATORY SURGERY DOCUMENTATION

NHS Tayside

ELLIS 2804880060
STACEY F
8 MILL PLACE
CRAIGO
MONTROSE DD10 9LB
DR RUTH CRANSWICK
ANNAT BANK, LINKS HEALTH CENTRE,

Patient contact telephone number
Day 07892630501 Night .....
Mobile .....

Next of Kin
Name Susan Ellis Relationship Mum
Address Manse View
Luthermuir Ch30 1YS
Contact No 01674 860678 Mobile No .....

Please circle relevant location/type of anaesthetic planned

Location:	**Theatre**	**Procedure Room**	**Ward**
		Endoscopy	
	General anaesthetic	Local anaesthetic	Sedation

Consultant Patrick Allen

Proposed date of surgery Dropshire Lapsnapping

Anaesthetic Assessment requested

YES NO

Pre-admission Assessment Completed by:

Name Dawn McCoy

Designation SIN

Date DD/MM/YYYY 15/06/2009

Suitable for

DAY CASE ☑

DAY & STAY ☐

Not suitable for ADTC ☐

In Patient ☐

Multidisciplinary notes

Can attend at short notice YES/NO

Specify 1-2 notice

Does the patient have any particular cultural or religious needs/specify NO

Does the patient require the services of an interpreter NO

(Record arrangements made) .....

PRE ADMISSION ASSESSMENT

Please refer to the numbered guidelines and expand on positive findings in Further Notes

TEMP 1a	PULSE 1b	B.P. 1c	Resp or $Sa0_2$ 1d	HEIGHT 1e	WEIGHT 1e	B.M.I. 1e	URINALYSIS 1f
	88	117/65	98%	156 cm	45.2 kg	18.	TUE Protein TUE Leucocytes TUE Ketones

How long will it take for you to travel home? ..... hours ..45.. minutes 2

Will you be able to be escorted home by a reponsible adult (you may NOT drive)? 3 **Yes** ☑ **No** ☐

Will you have a responsible adult looking after you for 24 hours? 4 **Yes** ☑ **No** ☐

Will you have easy access to a telephone? 5 **Yes** ☑ **No** ☐

Have you suffered from . . .?	**Yes**	**No**		**Yes**	**No**
Heart attack or stroke or heart failure 6	☐	☑	Jaundice 16	☐	☑
Chest pain at rest or exercising 7	☐	☑	Indigestion/heartburn 17	☐	☑
Fainting, dizzy spells, fits or blackouts 8	☐	☑	Bowel problems 18 IBS	☑	☐
High blood pressure 9	☐	☑	Nausea/vomiting 19	☐	☑
Heart murmur 10	☐	☑	Kidney/urinary problems 20	☐	☑
Palpitations 11	☐	☑	Anaemia/blood problems 21 1yr ago	☑	☐
Ankle Oedema 12	☐	☑	Excessive bleeding/bruising 22 Period every day year	☑	☐
Breathlessness 13	☐	☑	Arthritis/neck problems 23	☐	☑
Asthma or Bronchitis 14 NOV 2008.	☑	☑	Muscle disease/weakness 24	☐	☑
Haemoptysis 15	☐	☑	Headaches 25	☐	☑

Diabetes 26 No ☑ Yes ☐ DIET/TABLETS/INSULIN? .....

WOMEN Could you be pregnant? 27 No ☑ Yes ☐ ..... Are you on the Pill/HRT? 28 No ☐ Yes ☐ Implant

Have you ever had a serious illness? 29 (state) ..NO.....

.....

Previous operations? 30 .Correction of squint.....

.....

Have you or your relatives had any anaesthetic problems? 31 ..NO.....

CURRENT MEDICATION? 32 .....

.....

ALLERGIES? 33 None ☐ Yes ☑ ..latex - itchy, skin break.....

(drugs, food, elastoplast) *state the allergen & describe what happens with exposure to it*

SMOKING? 34 No ☐ Yes 10 /day **ALCOHOL >4u/day** 35 No ☑ Yes ☐ **REC. DRUGS** 36 No ☑ Yes ☐

HAZARDS? *please indicate* **Teeth** 37 caps/crowns damaged teeth BACK dentures **Contact Lenses** 38 yes **Hearing Aid** 38 NO

Metalwork 39 ..... **Pacemaker** 40 NO

NO

Is the Patient waiting for another Op. or Specialist? [41] **No** ☑ **Yes** .....

Have you advised the Patient that he may not drink alcohol, drive or operate machinery for up to 48 hours post-op? [42] **Yes** ☑ **No** ☐

Has the relevant Information Sheet been given to the Patient? [43] **Yes** ☐ **No** ☑

Does he understand the procedure? **Yes** ☑ .....

or still have questions regarding it? [44] 0

Will mobility/eating/toileting be affected by the procedure? [45] **No** ☑ **Yes** .....

Will additional home support be required for discharge? [46] **No** ☑ **Yes** .....

Further Notes: [47]

Investigations [48] *please follow the algorithm* *THE GRADING MAY BE DEPENDENT ON THESE RESULTS BEING SATISFACTORY*

Investigation required	Date Ordered	RESULTS
ECG		
Imaging Chest X Ray		
Ultrasound		
Haematology FBC		
Other		
Biochemistry U's & E's		
Other		

Nurse Assessment: [49] Suitable for Ambulatory Surgery ☐

Suitable as a Day Case ☐

Requires Anaesthetist Assessment [50] ☐

(this document plus case-notes in the first instance)

Not suitable for Angus ADTC ☐

Must be an In-Patient ☐

Please also record assessment on Page One

Date ..... Signature/Name/Designation .....

Anaesthetist's Notes:

Date ..... Signature/Name/Designation .....

TAYSIDE UNIVERSITY HOSPITALS

Consent for Medical or Dental Investigation, Treatment or Operation

atient's Surname ..... Hospital .....

ther Names ..... Specialty .....

H Number ..... Consultant .....

OCTOR'S or DENTISTS (this part to be completed by doctor or dentist - see notes on reverse)

YPE OF OPERATION, INVESTIGATION OR TREATMENT -

confirm that I have explained the operation/investigation or treatment to the patient in terms which, in y judgement, are suited to the understanding of the patient and/or to one of the parents or guardians the patient.

octor's/Dentist's Signature ..... Date ..../..../.....

int Name ..... Grade .....

ATIENT/PARENT/GUARDIAN/REPRESENTATIVE

ease read this form and the notes overleaf very carefully:-

there is anything that you don't understand about the explanation, or if you want more information, ou should ask the doctor or dentist.

am the patient*/parent*/guardian*/representative*

agree
- to what is proposed which has been explained to me by the doctor/dentist named on this form.
- to the administration of a general, local or other anaesthetic for any of these purposes.

understand
- that the procedure may not be carried out by the doctor/dentist who has been treating me so far.

understand
- that any procedure in addition to the procedure, investigation or treatment described on this form will only be carried out if it is necessary and in my*/the patient's* best interests and can be justified for medical reasons.

understand
- that it is an essential part of diagnosis and treatment that any tissue removed as part of my operation will be submitted for pathological examination. Some of this tissue will be used to make microscope slides. This material will be stored as part of my medical record.

agree*/do not agree*
- that excess tissue stored for diagnostic purposes may also be used in medical research.

acknowledge*
- receipt of procedure specific information - title of leaflet referred to:

acknowledge
- that in my best interests, information regarding my procedure may be stored on computer data bases.

Delete as appropriate

HB14 (Revised 2001)

Continued overl

It has been explained to me that medical/dental students may be present and I understand that this is part of their training.

I do*/do not* agree to being examined by a medical student whilst under general anaesthesia.

Signature .....
PATIENT*/PARENT*/GUARDIAN*/REPRESENTATIVE*

Name ..... (BLOCK CAPITALS)

Address (if not the patient) .....

.....

Date ...../...../.....

***Delete as appropriate**

NB Any amendments to the written information completed on this form must be countersigned by both the clinician and the patient/relative/guardian/representative.

NOTES TO:-

1. DOCTORS/DENTISTS

1.1 A patient has a legal right to grant or withhold consent prior to examination, investigation, treatment or operation. Patients should be given sufficient information, in a way they can understand, about the proposed procedure and the possible alternatives. Patients must be allowed to decide whether they will agree to the procedure and that they may refuse or withdraw consent to a procedure at any time. The patient's consent to a procedure should be recorded on this form.

1.2 A parent or other person with parental responsibility is legally entitled to give or refuse consent to a child's treatment when the child is deemed incapable of understanding what is proposed.

However, if a child under 16 years old can satisfy a clinician that they understand sufficiently well what treatment is proposed they may give consent for an examination or operation without parental consent.

2. PATIENTS/RELATIVES/GUARDIANS/REPRESENTATIVES

2.1 The doctor/dentist is here to help you. He or she will explain the proposed procedure, which you are entitled to refuse. You can ask any questions and seek further information.

2.2. You may ask for a relative or a friend or a nurse to be present during the discussion.

2.3 See 1.2 above

2.4 Training health professionals is essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for teaching students or one or more members of staff under the supervision of a more senior member of staff. You may refuse to participate in such teaching sessions without this adversely affecting your care and treatment.

DAY OF SURGERY

Goal: Patient fully prepared for theatre YES ☑ NO ☐ if no, please state reason:

Tick the appropriate box for each area of care

Are the following details correct:	YES	NO	(please record if variance)
Patient details	✓		
Next of kin	✓		
GP name and address	✓		
Contact telephone numbers	✓		
Discharge address as patient address	✓		
Medical assessment (refer to page 2)	✓		
Medication		✓	
Case notes & X-rays available	✓		

Welcome to Ward ☑

Layout of ward shown ☑

Order of list explained ☑

Valuables

Retained by patient:	(Yes)	No
Taken by relatives:	Yes	(No)
Deposited in ward safe	Yes	(No)

Other please state .....

Discharge Arrangements: mum will collect

TEMP	RESP	PULSE	B.P.	Other Sats
36.4°C		86	125/57	99%

Fasted for Theatre

Record time of last

Fluid intake 9.30 am

Other intake 22⁰⁰ 9/9/09

Last Menstrual Period: 29/8/09

Pregnancy Test Result: negative

Bladder Empty Time: 11.25

Signature: RSanderson **Designation:** 5 **Date** 10/9/09

Medical Pre operative Examination:

INTRA-OPERATIVE NOTES and Theatre Checklists

To be completed by theatre staff (please circle where appropriate)

Check and confirm with patient & transfer nurse (please tick if correct)	**Ward Staff Signature**	**Theatre Staff Signature**
1. Preferred name/title STACEY	RS	✓
2. Patient identity checked against theatre list	RS	✓
3. Identity band in position and correct	RS	✓
4. Consent form correctly/accurately completed and signed		✓
5. Operation site marked	N/A	✓
6. Check for allergies & record LATEX	RS	✓
7. Check which artificial aids are present Hearing aid Contact Lenses Other (identify) ..... (Spectacles) Dentures **N/A**	RS	✓
8. Do you have any: Caps Loose Teeth (N/A) Crowns Specify	RS	✓
9. Jewellery & body piercing (removed)/taped (Oral jewellery removed) Specify	RS	✓
10. Artificial aids are present: Pacemaker Orbital Joint Other (identify)..... (N/A)	RS	✓
11. Identify & record movement restrictions (N/A) Arthritis Prosthesis Palsies Other record details.....	RS	✓
12. Removal of makeup/nail varnish	RS	✓
13. Underwear/tampon (if relevant) removed	RS	✓
14. Relevant documentation is present Notes X-rays Other	RS	✓
15. Medication Details	RS	✓

9 IPS H_2O

Moving & Handling as per policy Remained on trolley for procedure **Waterlow score** ..... **Thromboprophylaxis**	**Tourniquet** Yes/No (N/A) Time on ..... Time off ..... **Recorded by:** Name: ..... Designation:	**Diathermy** Monopolar Bipolar Pad placement (N/A) Specify ..... Pad removed Yes/No Site reaction Yes/No record details ..... **Recorded by:** HULME Name: ..... Designation: SCA

uneventful induction - eyes taped.

Patient ID and consent checked by scrub nurse

YES NO

Position during surgery: (Please circle)

Supine Lithotomy

Prone Lloyd Davis

Lateral left/right Other

Positioning Aids used: (circle if used)

Arm boards Knee posts Heel rest

Lithotomy legs Jelly pads Lloyd Davis legs

Others specify J arm boards

Comments.....

Specimens: (Please circle) NONE

Pathology Bacteriology

Cytology Other specify.....

Signature of

Ward Nurse..... Status

Theatre Nurse..... Status SCN

OPERATION PERFORMED

DIAGNOSTIC LAPAROSCOPY.

.....

Local Anaesthetic administered YES/NO

Details... 5mg chirocaine 10ml/s.

Drains ..... NONE .....

Plaster of Paris .....

SWABS/SHARPS/INSTRUMENT counts correct

First YES NO

Second YES NO

Skin closure:

Non absorbable .....

Absorbable ✓ VICRYL .....

Dressings 2 x MEPORES .....

Catheters IN AND OUT TO EMPTY BLADDER

Comments.....

.....

.....

.....

Signature of Scrub nurse S. HULME

Status SCN.

Signature of Circulating nurse C. GIBB.

Status A/N

Please attach sterilisation labels

PROBE PALPATING (NOT WOLF BULLET SHAPED END) 5MM
ID-038884 2009/08/30 N019330
NHS Tayside

CABLE FIBRE OPTIC + END SLEEVE WA03200A
ID-027288 2009/09/08 N010916
NHS Tayside

TELESCOPE CORIN 0 DEGREES 581.100 (212998)
ID-022343 2009/08/30 N006989
NHS Tayside

LAPAROSCOPY
ID - 003020 2009/09/07 NMIN418
NHS Tayside

ANAESTHESIA

GA ☐ Regional ☐ Sedation ☐

Airway

Mask

Airway

LMA Size

ETT Size

Monitoring

Pulse Ox.

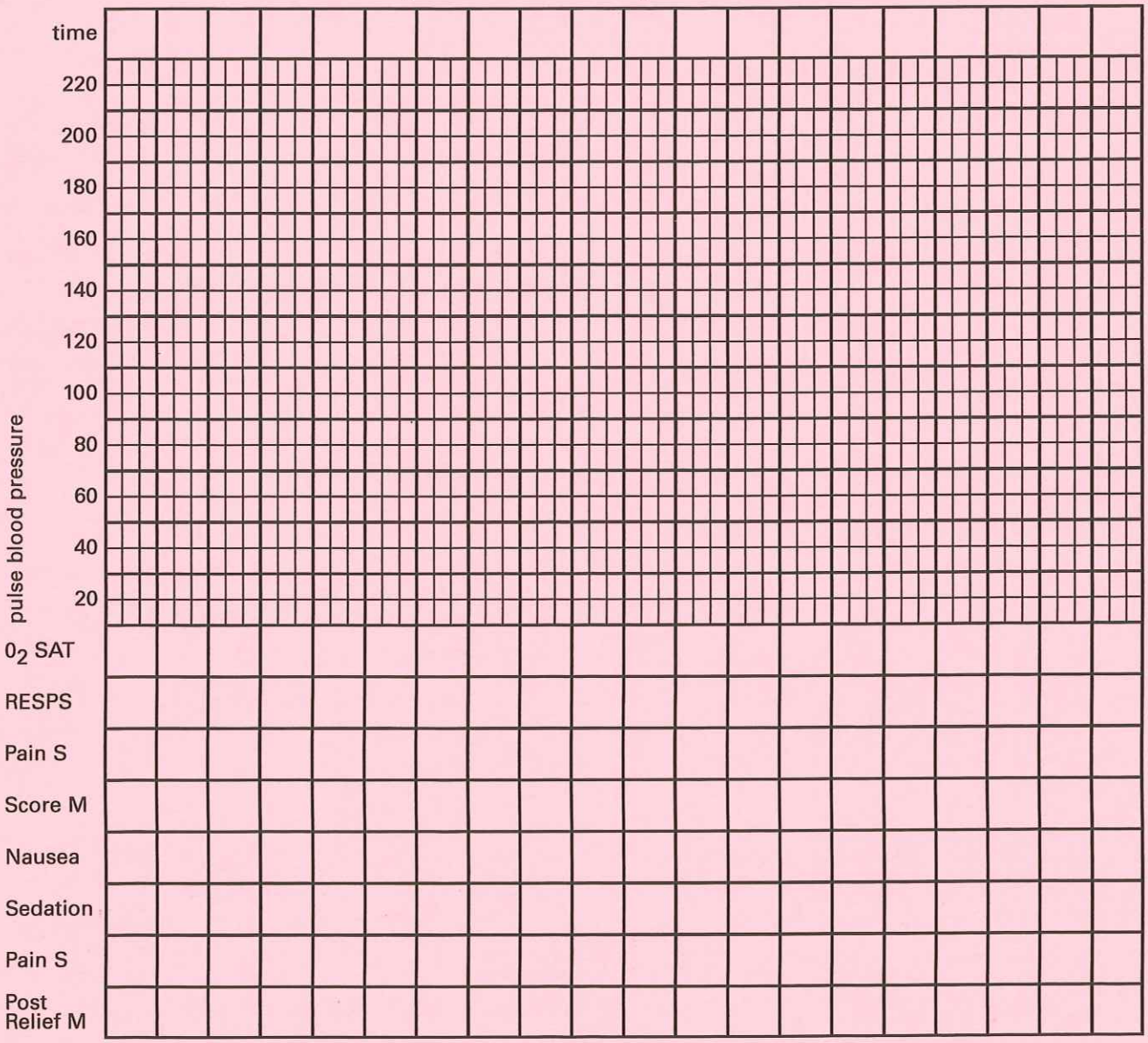
ECG

B.P.

Temp

Airway Gases ..... ANAESTHETIST

Intra-operative & Post-operative Chart



PAIN SCORE
0 No Pain
1 Mild Pain
2 Uncomfortable
3 Severe Pain

SEDATION SCORE
0 Awake
1 Drowsy
2 Asleep/rousable
3 Difficult to rouse
4 Comatose

NAUSEA SCORE
0 No nausea
1 Mild nausea
2 Nausea and/or vomiting
3 Persistant nausea and/or vomiting

NAME UNIT NUMBER MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS

Date	OTHER TIMES Time	Code	Intls	Intls	Time	Code	Intls	Intls	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400	Comments on Discrepancies
									Intls Intls	Intls Intls	Intls Intls	Intls Intls	Intls Intls	Intls Intls	Intls Intls	Intls Intls	Intls Intls	Intls Intls	

PLEASE ENTER APPROPRIATE LINE KEY FROM PRESCRIPTION SHEET: If a drug is unavailable, advise prescriber
If a drug is refused, encircle the line key letter e.g. (H)
If the patient is absent at the time of the medicine round, encircle the line key letter and cancel e.g. (E)

Sheet No. ..... Please use Ballpoint Pen and Block Letters PRESCRIPTION SHEET Date .....

Pharmacy Use	Line Key	Oral & Other Non-Parenteral Medicines – Regular Prescriptions: Date Commenced	MEDICINES and (SPECIAL INSTRUCTIONS)	DOSE	FORM	Method of Admin. or Site of Application	Times of Administration: 8	10	12	14	16	18	20	22	24			SIGNATURE	Discontinued: Date	Signature
	A																			
	B																			
	C																			
	D																			
	E																			
	F																			
	G																			
	H																			
			PARENTERAL MEDICINES																	
	I																			
	J																			
	K																			
	L																			
	M																			

Date	Oral & Other Non-Parenteral Medicines (Once Only Prescriptions)	Dose & Form	Time of Admin.	Method or Site	Signature	Given Signature	Date	Parenteral Medicines (Once Only Prescriptions)	Dose	Time of Admin.	Method or Site	Signature	Given by Signature

Please initial when medicines are prescribed seperately on one of the following:–
Record Medicines in appropriate section above, and delete boxes under times of Administration.

Fluid Prescrip. Sheet | Oral Anti-Coag. Sheet | Diabetic Prescrip. Sheet | Steroid Prescrip. Sheet | Anaesthesia Record | Other – Specify

ADMISSION DATE | AGE Yrs. Mths. Days | Weight g | UP-DATE Date | Weight g g

HOSPITAL	WARD	NAME of PATIENT	D. of B.	UNIT No. / CHI No.	CONSULTANT	KNOWN DRUG SENSITIVITY or ADVERSE REACTION

POST OPERATIVE INSTRUCTIONS

Maintain Airway ..... P, BP, RR until stable or for .....

02 ..... L/min for .....

.....

Oral fluids after .....

Other instructions .....

.....

.....

Date + Time	Multi-disciplinary progress notes	Signature Designation & Grade
10.9.09	Into recovery after G.A and	
12.45	~~bap~~ Diagnostic laparoscopy.	
	Drowsy but rousable.	
	Dressings dry and	
	intact.	
	Recordings stable.	
	Nil staining P.V.	
	O^2 at 4ltrs for 1 hour.	
	Venflon in left hand.	P. Norris.
13.45	Awake and complaining	
	of discomfort.	
	Monitors and O^2	
	discontinued	
	Recordings stable.	
	Slight staining on	
	dressings	
	Nil staining P.V.	
	Tolerating sips of water	P. Norris
15.45	- Up to ~~toilet~~ HPU'd, feeling	
	well no problems noted.	R Sandeman

Post Operative Notes Continued

Date + Time	Multi-disciplinary progress notes	Signature Designation & Grade

SURGICAL RECORD

To be completed by surgeon

DATE 10/9/2009

SURGEON Dr R Youssef

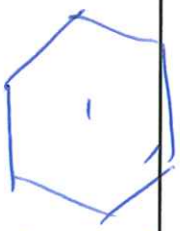
ASSISTANT Dr R Northridge
Dr P Chien (in theatre)

ANAESTHETIST Dr G Rodney

28(4880060
ELI IS STACEY

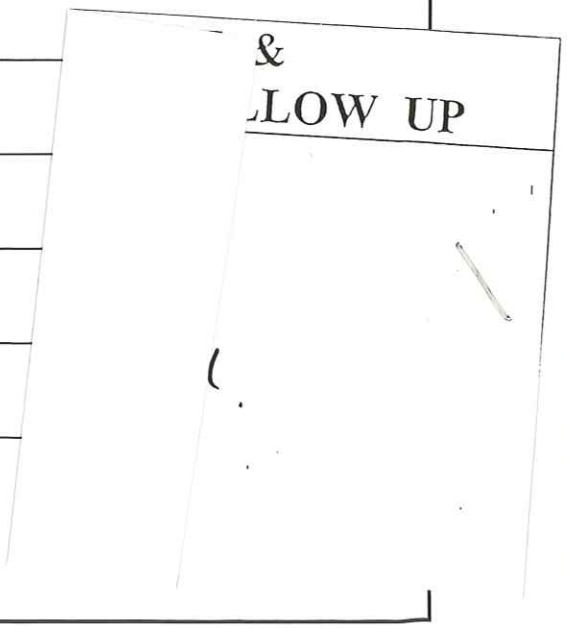
OPERATION PERFORMED Diagnostic Laparoscopy

Lloods Dorsal position
parts cleaned, draped & catheterized
Co2 pneumoperitoneum Palmer. 1st
P = 25 mm Hg
10 mm port inserted 5 mm in LIF under vision
finding Av uterus average size
normal looking tubes & ovaries
no adhesion. endometriosis
normal. liver surface
Co2 released incisions repaired
∴ Normal pelvic Anatomy



POST-OPERATIVE MANAGEMENT

SUTURES:	Vicryl Rapide
DRAIN:	–
CATHETER:	–
P.O.P.:	
OTHER:	
FOLLOW-UP:	No follow up.



DISCHARGE:
A Modified Postanaesthetic Discharge Scoring System (MPADSS)
The total score is 10, with patients scoring > or = 9 considered fit for discharge

Has escort home? ⟶

Has adult at home? ⟶

No (Admit overnight

1 Vital signs
- 2 = Within 20% of preoperative value
- 1 = 20-40% of preoperative value
- 0 = 40% of preoperative value

2 Ambulation
- 2 = Steady gait/no dizziness
- 1 = With assistance
- 0 = None/dizziness

3 Nausea/vomiting
- 2 = Minimal
- 1 = Moderate
- 0 = Severe

4 Pain
- 2 = Minimal
- 1 = Moderate
- 0 = Severe

5 Surgical bleeding
- 2 = Minimal
- 1 = Moderate
- 0 = Severe

Total score 10. > or = 9 considered fit for discharge

Score achieved
..... Date DDMMYYYY

Discharge protocol	N/A	yes	no
Medically fit for discharge	✓	✓	
Patient & carer happy to be discharged, information leaflet supplied and explanation given to patient and carer	✓	✓	
Transport available	✓	✓	
TTO's given to patient	✓	✓	
GP letter given to patient	✓	✓	
District nurse letter and appointment given			✓
Outpatient appointment given	✓		✓
Dressings supplied	✓		
Venflon removed		✓	
Valuable returned to patient	✓		
Comments:			

Multidisciplinary notes

Seen by physio: Yes ☐ N/A ☐

Equipment supplied

Patient fits the discharge criteria they may go home

Signature Fay McIntosh Date DDMMYYYY Time 1430

Print Name FAY McINTOSH Designation SSN

DISCHARGE SUMMARY

Date of admission _____

Date of discharge _____

Consultant _____

Affix patient label here

Dear Dr. **re**

PROCEDURE/OPERATION PERFORMED:
ANAESTHESIA: **General** **Sedation** **Local**
DRESSINGS:
SUTURES:
MEDICATION GIVEN ON DISCHARGE:
TTO's:
MEDICATION RECOMMENDED:
To be prescribed by the GP
FOLLOW UP ARRANGEMENTS:
ADDITIONAL INFORMATION:

Signature _____ **Designation** _____

Print Name _____

Consent for Investigation, Treatment or Operation

NHS Tayside

Patient's Surname: ..... ELLIS 2804880060 d: .....
STACEY F
8 MILL PLACE
Other Names: ..... CRAIGO .....
MONTROSE DD10 9LB
DR RUTH CRANSWICK
CHI Number: ..... ANNAT BANK, LINKS HEALTH CENTRE, ...

(USE BLOCK LETTERS OR PATIENT LABEL)

TYPE OF INVESTIGATION, TREATMENT OR OPERATION

(USE BLOCK CAPITALS WITH NO ABBREVIATIONS)

Diagnostic hysteroscopy

I confirm that I have explained the **Investigation/Treatment/Operation*** as well as any alternative options, the likely benefits and the probabilities of success. I have explained the risks, serious or frequently occurring complications associated with the procedure, and detailed lifestyle changes that may be caused by, or necessitated by, the procedure. I have also acknowledged and answered concerns.
I have done this in terms that, in my judgement, have been understood.

Health Professional's Name: Patricia Allen Date 15 / 06 / 09

Print Name: ..... Grade Consultant

PATIENT / PARENT / GUARDIAN

Please read this form very carefully. If there is anything that you do not understand, or if you would like more information, you should inform the health professional.

I agree	to what is proposed which has been explained to me by the health professional named on this form
I agree	to the administration of a general, local or other anaesthetic as deemed necessary by the anaesthetist
I understand	that students may be present and I understand that this is part of their training
I understand	that the procedure may not be carried out by the health professional who has been treating so far. The person will, however, have appropriate experience.
I understand	that any procedure in addition to the procedure, investigation or treatment described on this form will only be carried out if it is necessary and in the patients best interests and can be justified for medical reasons
I understand	that in the patient's best interests, information regarding the procedure may be stored on computer databases

Continued overleaf .....

I understand that radiological images, video recordings or photographic material may be produced as part of the procedure and that these will be stored as part of patient's medical record

I understand that body tissue which may include body fluids, organs, or parts of them, removed during the procedure may be used for diagnosis and any further treatment and then be discarded or stored

I acknowledge that the University of Dundee is very active in medical research, the sole aim of which is the benefit of patients, either directly or in the long term. Tissue and anonymous information are the most valuable resources for research

I do / ~~do not~~* agree that excess tissue stored for diagnostic purposes may also be used in medical research

I do / ~~do not~~* agree to being examined by a medical or dental student whilst under general anaesthesia

I do / do not* acknowledge that I have received printed information regarding the procedure

I have been told about additional procedures that may become necessary during my procedure. **I have listed below any procedures that I do not wish to be carried out without further discussion**

.....

.....

Signature ..... Patient? Yes / ~~No~~

** .....

Name ..... (Block Capitals)

Date ..... / ..... / ..... 10/09/09 self

Address (if not the patient) .....

.....

NOTES TO HEALTH PROFESSIONALS

** Please specify if not the patient
* Delete as appropriate
All **bold** parts should be completed

- All deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature. Any amendments made thereafter must be countersigned and dated both by the health professional and the patient.
- Patients must be allowed to decide whether they will agree to the procedure and they may refuse or withdraw consent to a procedure at any time.
- A parent or other person with parental responsibility is legally entitled to give or refuse consent to a child's treatment. However, if children aged under 16 years can satisfy the health professional that they understand sufficiently well what treatment is proposed, they may give consent for the procedure without parental consent. Furthermore, if you are not convinced enough, you can ask a parent to countersign as well.
- Adults or individuals 16 years of age or older with incapacity must not be consented on this form.

FILE IN NOTES

ANAESTHETIC RECORD
NHS Tayside

Date: 10 09 09 Ward: DSU

Theatre: DSU 1

Operation Proposed: DIAG LARAMSCOPY

Surgeon: YOUSEF / CHIEN

Ward/Hosp ..... Cons

D D M M Y Y
2 8 0 4 8 0 0 6 0 C.H.I. No

Surname: ELLIS

First Name: STACEY M. State

Address: ..... Sex

G.P. & Address

USE BLOCK LETTERS OR PATIENT LABEL

PRE OP ASSESSMENT

By: G. MOONEY Site: DSU Date: 10 09 09

ASA Grade: ASA I fit + well wt 48 kg

Airway: Mpati 1

Teeth:

Drugs: –

Allergies: –

Anaesthetic Plan / Techniques discussed: GA / LMA / SCV

POSTOPERATIVE INSTRUCTIONS

Maintain airway. Observe colour, airway, respiration and pulse continuously until fully awake.

Oxygen 4 L/min via Hudson for 1 hours

Observations: Pulse, Respiratory Rate, Blood Pressure and Pulse Oximetry

Frequency: 915 Duration: 1hr then tds

Fluid Therapy: IV:

Oral: free oral fluids

Analgesia: PARACETAMOL 1g ORAL QDS PRN +1 (1355 Pharmacy)

FENTANYL 20 → 100 mcgs IV PRN

CYCLIZINE 50mg IV PRN +1

TRAMADOL 50 mg PRN × 2 doses 5 min intervals

Recovery Actions:

1. .....
2. .....
3. .....
4. .....
5. .....
6. .....

Discharge: Home as per day case criteria | Anaesthetic Review prior to discharge | Overnight Stay/Ward

PERSONNEL:

Anaesthetist and Grade

1. MOONEY (CONS)
2.

Assistant:

Consultant:

Informed Y/N

EQUIPMENT CHECKS: Circuit, Machine and Monitor

Anaesthetic Room ☐ Theatre ☑

AIRWAY AND BREATHING SYSTEM:

Facemask	☐	SV	☐	Circuit	circle
Airway—Oral/Nasal	☐	IPPV	☑	Ventilator	Pulsevac
LMA & Size	3 ☑ Unique Intavent	Ventilation Mode: VC/PCV			
OETT/NETT	☐	VT		PEEP	
Type		frequency	12	PAW	12–14
Size		Throat Pack	☐	HME	☑
Laryngoscopy Grade					

MONITORING:

ECG	☐
NIBP	☐
SpO2	☐
ETCO2	☐
FIO2	☐
ET Agent	☐
VENT ALARM	☐
PAW	☐
MIN VOL	☐
Temp	☐

Injection Site: (LH) hand 20G IV

Patient Position & Protection: L lateral, bolsters padded

Fluid Warmer ☐ Warming blanket ☐

Anaesthetic Technique

Pre-ox
REMIFENT bolus 60 mcg
PROPOFOL 160 mg
Fentanyl 75 mcg
Dex 4 mg
ondansetron 4 mg
DYNOJECT 75 mg IV.

Events											
Time	1100			1200							
HR & Blood Pressure (210–10)											Fluids Events 1. 2. 3. 4. 5. 6.
SpO_2		99	98	100	100	100	100				SpO_2
F_IO_2		04	0.45	0	0	0	0				Pain
$ETCO_2$		5.0	6.5	3	0–1	1	0–1				Sedation
ET_{Agent} DES%		5.0	6.6	0	0	0	0				Nausea
				14	22	23	21				RESPS

Surgeon

Pre-Assessment Clinic

HOW TO USE THIS FORM

Surgical Clinic — Surgeon fills in section 1 → send form & notes to PAC → *Pre-Assess Clinic* — PAC staff complete PAC documents & section 2 on p1 → *Pre-Assess Clinic* — form scanned PDF viewable in Clinical Portal → PDF emailed to WL Sec. → *Waiting List* — Secretary Lists Patient for surgery

NHS Tayside

Use this form for **non LA** procedures

Pre-Assessment Clinic PLEASE PRINT ALL TEXT

SECTION 1 - SURGEON TO COMPLETE (Please complete all fields)

Completed by (PRINT) _____ Date: _____

Consultant: Speciality:

Procedure: (write in full)

Name
CHI ELLIS STACEY 2804880060 F
Address 17 ANNAT ROAD MONTROSE DD10 8EF
Annat Bank Practice, Links Health Cent

Urgent ☐ Estimated duration of surgery:

Consent form completed Y ☐ N ☐

Day of surgery admission? Y ☐ N ☐ Why not? Interpreter for PAC ☐ Age ☐

Expected postop LoS nights (D = Day case) **Proposed Date** (if known)
OPCS4 Code(s):

Surgical Planning Information

Minimum Grade of Surgeon Proposed Site (s) NW ☐ PRI ☐ S'CATHRO ☐ ALL SITES ☐

SECTION 2 - PAC STAFF TO COMPLETE

OUTCOME OF PRE-ASSESSMENT

Patient Telephone No: Email: Date:

List for surgery ☑ Notes review requested ☐ Not Fit ☐ Unsuitable for Stracathro/private sector/out of hours WLI ☐

Reason unsuitable for SHX/WLI

Suitable for NW ☑ PRI ☐ S'CATHRO ☐ DC ☐ DoSA ☐ In Patient ☐

Completed by (PRINT) JACOB LIU. FY1 Date Scanned

Risk Factors									
Cardiac	None								
Respiratory	None								
Diabetes	insulin ☐		drugs ☐		diet ☐				
BMI	>40 ☐		<18.5 ☐						
Allergies	☑	(see p.2)	Latex						
Warfarin	☑								
Renal	egfr <30 ☐		egfr 30-60 ☐						
CKD ☐	>75yrs ☐	Diabetes ☐	PVD ☐	Cardiac ☐					
Liver Disease ☐	Score> 2/6, refer AKI Guidelines								
VTE risk	high ☐		med ☐		low ☐				
Complex needs	☐								
Neuromuscular	☐								
Other	☐								

PAC Advice			
1	Senior anaesthetist ☐	HDU Bed ☐	ICU Bed ☐
2			
3			
4			
5			
6			
7			
8			
Admission arrangements			
Transport Required	Yes ☐		
Short Notice Availability	Yes ☐		
Dates unavailable			
Interpreter required on admission ☐	Specify		

Pre-Assessment Clinic

ALLERGIES	REACTIONS
Drugs	
Latex	Breaks Skin
Other	

ADMISSION MEDICATION

ACTION Note: Unless indicated to stop/hold, medication should be continued on TPAR/discharge

DRUG HISTORY - Source(s) of history:

Patient ☐ GP referral letter ☐ ECS database ☐
GP practice ☐ Patient's own drugs ☐ Community pharmacy ☐
Relative ☐ Nursing home prescription ☐ Other ☐

DRUGS **NOT** LISTED ON ECS

Name (Generic)	Dose	Frequency	Hold	Stop	Comments (if medication held or stopped)

Is the patient prescribed: Warfarin / Clopidogrel / Aspirin / NSAID's / Oral Contraceptive Pill? Refer to guidelines

Are you satisfied this medication history is complete and accurate? **Yes** ☐ **No** ☐

If "no" what further action is necessary (contact GP, etc)?

Reviewed by pharmacist? Name: Signature:

INVESTIGATIONS (please follow NHS Tayside guidelines when ordering)

Investigation	Date Requested	Result	Investigation	Date Requested	Result
FBC		Hb WCC Pts	ECG		
U&E's		Na K eGFR	ECHO		
G&S		Antibodies? No Yes	Spirometry		FEVI FVC FEVI / FVC PEFR
Clotting/INR		PTR APTTR	LFT's		ALT BIL
Urinalysis		Positive Specimen sent			ALP ALBUMIN
MRSA Screen as per protocol			Other		

Pre-Assessment Clinic

CARDIOVASCULAR ASSESSMENT

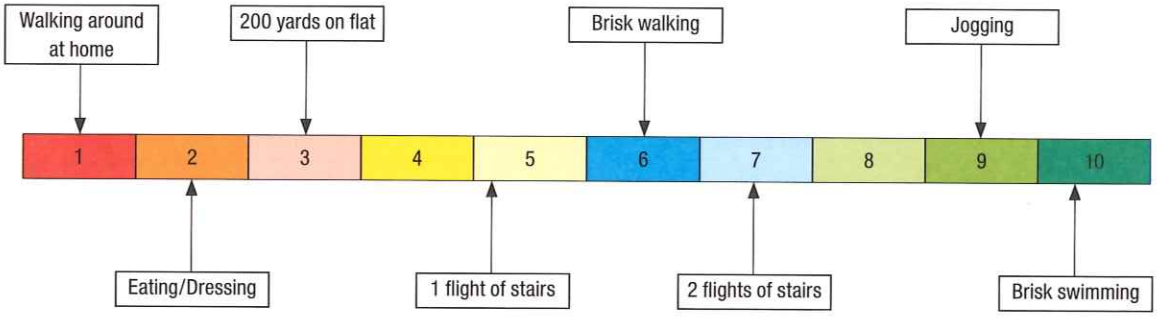
	Yes	No
1. Hypertension?	☐	☑
2. Myocardial Infarction?	☐	☑
Within the past 6 months?	☐	
3. Angina?	☐	☑
What brings on the pain?		
Vigorous exercise	☐	
Climbing 1 flight of stairs	☐	
Walking on flat 200 yards	☐	
Walking on flat < 50 yards	☐	
At rest or at night	☐	
4. Have you ever been diagnosed with Heart Failure?	☐	☑
i) do you get short of breath at rest?	☐	☐
ii) do you get SOB lying flat?	☐	☐
iii) do you ever wake at night gasping for breath?	☐	☐
5. Palpitations/atrial fibrillation?	☐	☑
6. Heart Murmur? *(See guidelines for ECHOs)*	☐	☑
Date of last Echo: *(See clinical portal)*		
7. History of Rheumatic Fever?	☐	☑
8. Cardiac Pacemaker *(See guidelines on Pre-Assessment website)*	☐	☑
(Last check <than 9 months ago)	☐	☐
Implanted cardiac defibrillator?	☐	
9. Cardiac Surgery/intervention (eg cardioversion)	☐	☑
Within the past year?	☐	
10. Coronary Stenting?	☐	☑
Within past 6 months?	☐	
Type of stent? Drug eluting/bare metal/unknown		
(Refer anti-platelet protocol and see guidelines on Clopidogrel/Aspirin. If Drug Eluting Stent must stay on Clopidogrel/Aspirin for 1yr, if bare metal stent can step down onto aspirin alone after 3 months)		
11. Peripheral Vascular Disease?	☐	☑

HEALTH IMPROVEMENT

Smoking	Since 14 years old	☑	☐
No of Cigarettes per day	20	Smoking Cessation advice/referral? ☐	
Alcohol	Women - Do you ever drink 6 or more units of alcohol on one occasion?	☐	☑
	> 14 units of alcohol per week	☐	
	Men Do you ever drink 8 or more units of alcohol on one occasion?	☐	☐
	> 21 units of alcohol per week	☐	
Recreational Drug Use *Details*		☐	☑

Pre-Assessment Clinic

FUNCTIONAL ACTIVITY GUIDE



Estimated METS Score: 10

What prevents further activity?

	Yes	No	Comments
Breathlessness			
Angina			
Arthritis or leg pain			
Other			

If the patient has a METS score of less than 5, **excluding** restriction due to arthritis or leg pain, discuss with Doctor.

RESPIRATORY ASSESSMENT

		Yes	No
12. Asthma		☐	☑
	Uses reliever once a day or more?	☐	
	Uses nebuliser/oxygen at home?	☐	
	Hospital admission in the last 3 years?	☐	
	Date:		
13. Chronic Obstructive Pulmonary Disease?		☐	☑
	Previous Hospital admission in the last 3 years?	☐	
	Previous Intensive Care admission?	☐	
	Home O_2/Home nebulisers	☐	
14. Tuberculosis?	If yes when?	☐	☑
15. Bronchiectasis?		☐	☑
16. Sleep Apnoea?		☐	☑
	Use Nocturnal CPAP (*bring machine to hospital for surgery*)	☐	
17. Other Respiratory Disease?	Details:	☐	☑

Pre-Assessment Clinic

ENDOCRINE ASSESSMENT

	Yes	No
18. Diabetes Mellitus?	☐	☑
Diet Controlled	☐	
Tablet Controlled	☐	
Insulin Controlled	☐	
HbA1c: > 75mmol/mol	☐	
>108mmol/mol	☐	

Date of last test:

(If HbA1c > 75 mmol/mol contact diabetes team. If HbA1c > 108mmol/mol, non urgent surgery should be postponed and referral to diabetic team made)

NEUROLOGICAL ASSESSMENT

	Yes	No
19. Stroke/TIA?	☐	☑
> 12 months ago	☐	
Date:		
3-12 months ago	☐	
Date:		
< 3 months ago	☐	
Date:		

Details, including residual disability:

20. Epilepsy?	☐	☑
Well controlled, last fit > 1 year ago	☐	
Last fit 3-12 months ago	☐	
Poorly controlled/fit within last 3 months	☐	
21. Other neurological disease (eg. MS, Muscular Dystrophy)?	☐	☑

Details:

22. Complex needs?	☐	☑

Details:

Pre-Assessment Clinic

OTHER

	Yes	No
23. Renal Failure?	☐	☑
Chronic Kidney Disease stage ≥4 /eGFR <30	☐	
Dialysis	☐	
24. Hepatic disease requiring treatment - *details*	☐	☑
25. Clotting disorders?	☐	☑
Easy bruising, prolonged bleeding?	☐	☑
Previous DVT/PE	☐	
Thrombophilia	☐	
Von Williebrand's Disease	☐	
Haemophilia	☐	

Further Details:

26. Gastro Oesophageal Reflux Disease?	☐	☑
Dyspepsia only	☐	
Reflux or heartburn	☐	
Known Hiatus Hernia	☐	
Proton Pump Inhibitor (PPI)	☐	☐

(If have reflux/hiatus hernia prescribe pre-op PPI according to NHST PGD)

27. Any other medical problems? *details*	☐	☑
28. Previous Surgery?	☑	☐

Dates: 6/5/15

Details: Cyst excision in leg after infection

29. Chronic pain?	☐	☑

Details:

Yes = Not Suitable for Strathcathro ☐

30. Female Patients (13-55) - any possibility of pregnancy?	☐	☑

If yes, perform pregnancy test ☐

Result positive? ☐ If yes, postpone surgery

Date of last period 14/08/16

Pre-Assessment Clinic

ANAESTHETIC

	Yes	No
31. Any personal or family history of any anaesthetic difficulty or abnormal reaction (excuding post operative nausea & vomiting)?	☐	☑
Malignant Hyperpyrexia	☐	
Difficult Intubation	☐	
Difficult Spinal or Epidural Anaesthetic	☐	☐
Other details:		
32. Any obvious airway problems? Eg. limited mouth opening, receding chin, reduced neck mobility, previous airway pathology or surgery.	☐	☑
Do you have any loose teeth, caps/crowns or dentures? *Details*	☐	☑
33. History of post op nausea and vomiting (PONV)	☐	☑

OBSERVATIONS

Pulse 64 Sats 99 % BP 108/69 > 180/110mmHg ☑ Temp 36.7°C

Height (m) 1.58 Weight (kg) 43.5kg BMI 18

(If blood pressure >160 /90 mmHg refer to GP with appropriate letter depending on reading)

Form Completed by (PRINT) Date:

MEDICAL EXAMINATION : if patient >60, any red boxes, any amber boxes Q2-17, or METS <5

CARDIOVASCULAR

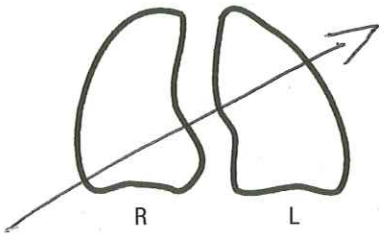
Pulse Regular ☑ Irregular ☐ - if yes do ECG

Heart sounds Normal ☑ Abnormal ☐

If abnormal please describe:

RESPIRATORY

Breath sounds Normal ☑ Abnormal ☐



Indicate site of abnormal clinical signs

■ Any Red = Notes Review

Pre-Assessment Clinic

ANAESTHETIC NOTES AND RECOMMENDATIONS

Signature: Print Name: Date:

RELEVANT SURGICAL HISTORY AND EXAMINATION

SURGICAL HISTORY AND EXAMINATION

SECTION 3 - DAY OF ADMISSION - Admitting medical/nursing team to complete

Has anything changed since Pre-Assessment: Y ☐ N ☐ Details:

Send 2nd G&S/X match to BTS as per protocol Y ☐ N ☐ N/A ☐

Pregnancy possible in females 13 - 55? Y ☐ N ☐

(if yes, test. Positive ☐ ☐ Negative)

VTE Prophylaxis Prescribed Y ☐ N ☐

Signature: Print Name: Date:

Admitting Team

NHS TAYSIDE – PATIENT FUNDS AND PROPERTY PROCEDURE
PERSONAL DISCLAIMER FORM - LOSS OF PERSONAL EFFECTS

NHS TAYSIDE STATEMENT:

*****NHS Tayside will not accept any responsibility for loss or damage to any article/personal belongings unless such article/personal belongings (including cash) have been handed over and accepted by NHS Tayside, for safe keeping and an official receipt issued****

[delete as appropriate]*

Section A TO BE COMPLETED BY NURSING STAFF

If the patient or patient's representative at the time of admission is unable or refusing to complete and sign section B below, for whatever reason, inform the patient / representative verbally that they are responsible for their own belongings and valuables and state below the reason for non completion of Section B. Sign and date this, and enter a review date in Section C:

Reason: _____

Signature of Staff Recording _____ Date _____

Signature of Staff Witness: _____ Date: _____

Section B TO BE COMPLETED BY PATIENT

I have been given the opportunity to read the above statement and *do / do not wish to take advantage of the facilities provided for safe keeping of my personal belongings.

Patient Signature*** SELW Date: 15.8.16.

Print Name: STACEY ELLIS

Hospital: NN Ward: 36

*****If signing on behalf of a patient, please enter your relationship with the patient, and your address:**

Relationship: _____

Address: _____

_____

Witness to above signature: R Burdin. C

Print Name: RACHEL BURDIN

Date: 150816.

Section C

If section A has been completed and a review is required, please enter review date (should be held every 4 weeks) noting two staff signatures required at each review :

(1) _____

Sign: _____

Sign: _____

(2) _____

Sign: _____

Sign: _____

(3) _____

Sign: _____

Sign: _____

(4) _____

Sign: _____

Sign: _____

Note: Please note that when a patient is absent from the ward for treatment (e.g. x-ray, an operation etc), the safe custody of their property which has not been handed over to NHS Tayside for safe keeping, remains the patient's responsibility. Arrangements may be available whereby property can be handed over to Nursing Staff for safe keeping during such periods. However, please note that due to storage restrictions, it is not possible to store larger items.

Discharge Plan - To be commenced on admission

(Not to be used for transfer information - use Transfer Checklist)

Planned patient discharge date: possibly 16/8/16	Actual patient discharge date: 16/8/16 ***If delay please specify reason:***
Patient informed of date 16/8/16 Initials of nurse SEL Y N N/A	Relative/carer informed of date 16/8/16 Initials of nurse Who was informed Husband Y N N/A
Patient Discharge Destination own home	

Complete referral/s to Early Supported Discharge / Enablement Team / District Nurse / AHP/NRT pharmacy referral or similar (if applicable) Please Specify:-

_____

Date Initials of nurse

Transport plan agreed and arrangements made to date and progress (if applicable) Y N N/A

Adult available to escort home if using own/public transport? Y N N/A

Date 16/8/16 Initials of nurse SEL

Does the patient have any ongoing nutritional care needs? Y N N/A Does patient currently have an infection / colonisation / history of positive culture e.g. MRSA, VRE, CDI, CPE, Norovirus, etc Y N N/A Specify..... Has this information been communicated to carers/relevant agencies? Y N N/A	Does the patient / carer understand the treatment they received? Y N N/A Healthcare / self-care / advice and information given to patient and / or carer Y N N/A **state what type(s):** Bleeding Fibro p _____ _____ Carer support referral postcard given? Y N N/A Date Initials of nurse

Medications ordered and sent to pharmacy Date NONE REQ Initials of nurse

Delivered to ward Date Initials of nurse

Dressings / catheter / equipment ordered Y N N/A

Specify: _____

Supply ordered Y N Date Initials of nurse

Patient's home is suitable for them to return to? Y N N/A

Does patient require a relative / carer to be present at home on discharge? Y N N/A

Patient has key / access to inside of their home? Y N N/A

Patient has clothing and footwear to go home in that is appropriate for the weather conditions? Y N N/A

If any issues highlighted from any of the information obtained during the admission or as part of the discharge plan, including if the patient has triggered RED or AMBER on any of the traffic lights: -

- Please describe plan and interventions required for effective and safe discharge including any conversations you have with the patient/carer on Discharge Plan Continuation sheet
- If a referral to Social Work, Enablement Team, or District Nurse are required, please complete the Social **work/District Nurse Referral Form THB(MR)565**
- For patients with a Learning Disability/Dementia consider holding a pre-discharge multidisciplinary meeting

NOTE: IF THE PATIENT DISCHARGES THEMSELVES AGAINST MEDICAL ADVICE

Complete the Discharge Plan as far as possible. Ensure the GP / relevant agencies are informed.

DAY OF DISCHARGE FINAL CHECK

Equipment/dressings etc. given to patient / carer?	Y N (N/A)
PVC removed?	(Y) N N/A
Discharge documentation completed and sent to GP / copy given to patient?	Y N (N/A)
Patient / carer given medication?	Y N (N/A)
Patient / carer given any leaflets / cards associated with medications detailing side effects and cautions?	Y N (N/A)
Valuables returned to patient? E.g. glasses / hearing aids / walking aids	Y N (N/A)
Out Patient Appointment/s Please state..... F.U to be arranged	Y N N/A
Pharmacy Smoking Support request given	

Initials of Nurse SL **Date** 15/8/16 **Time** 1800

Date/Time	DISCHARGE PLAN CONTINUATION SHEET	Initial
	(Not to be used for transfer information - Complete a Transfer SBAR in Ongoing Record of Care)	
15/8/16	Husband will collect on discharge	SL
16/8/16		
18⁰⁰ -	Discharged home as per plan.	SL

8. COMPLETE ON ADMISSION TO EACH WARD/AREA

WD36

PATIENT MEDICATION — DATE/ WARD	15/8/16			
Is the patient taking prescribed medications?	Y (N)	Y N	Y N	Y N
Patient has brought in own medicines?	Y (N)	Y N	Y N	Y N
Patient has brought in controlled drugs stored in the controlled drugs cupboard?	Y (N)	Y N	Y N	Y N
Does the patient understand what their medications are for?	Y (N)	Y N	Y N	Y N

Is the patient registered with a pharmacy? **Please state name of pharmacy & telephone number:-** NA

How does the patient usually obtain/order their medications: - include compliance aid details? (specify) NA.

ORIENTATION

Familiarised to ward environment?	(Y) N	Y N	Y N	Y N
Identity band in situ?	(Y) N	Y N	Y N	Y N
Nurse call system explained?	(Y) N	Y N	Y N	Y N
Explained where toilet/wash facilities are?	(Y) N	Y N	Y N	Y N
Explain Bed Controls to patient	(Y) N	Y N	Y N	Y N
Explained visiting/protected mealtimes/rest times?	(Y) N	Y N	Y N	Y N
Explain confidentiality of notes – does the patient wish to have access to their nursing record of care during their stay?	Y (N)	Y N	Y N	Y N

GIVE "Your Food and Drinks in Hospital" patient information leaflet ☑

If NO to any of the above , please give reason why and document in the On-going Nursing Record of Care

NA.

VALUABLES **Please circle below if applicable:-**

Dentures Top / Bottom / Full Glasses / Contact lenses Hearing aid/s Own clothing

Other (specify) Mobile phone, engagement drink.

Walking aids (specify) NA.

Patient's funds and property procedure explained and **PF1 completed**?	(Y) N	Y N	Y N	Y N
Money/property to be handed over on behalf of patient for safekeeping? **(Please refer and follow section 2.2.3 of Patient's Funds and Property procedure)**	Y (N)	Y N	Y N	Y N

6. INFECTION RISK STATUS (Please complete ALL sections for all patients within **6 hours** of admission)

If deemed "at risk" document AMBER (suspected) or RED (confirmed) on Traffic Light each shift

If there is any suspicion of, or confirmed transmissible infection please ensure appropriate patient placement, (side room where possible, practical and safe) and document in the nursing record.
Additional Infection Control Precautions (contact, droplet, airborne) as per NHS Tayside Policy.

Date and time of completion _____ **Initials** _____

CARBAPENEMASE PRODUCING ENTEROBACTERIACEAE (CPE) RISK ASSESSMENT

- **Hospitalised (as in patient including holiday dialysis) outside Scotland within the last 12 months?** Y (N)
- Transferred in from any high risk unit (ICU/HDU, Renal, Hematology, Oncology, and Infectious Diseases outside Tayside? Y (N)
- Previous known CPE colonisation / infection? Y (N)

If **YES** to any of the above questions, obtain verbal consent prior to taking swabs Consent Y N

Please tick: Stool Specimen ☐ or Rectal Swab (preferred) ☐

MRSA SCREENING RISK ASSESSMENT (NOT DAY CASE)

1. Admitted from Care Home, Sheltered Housing, Prison, Homeless Hostel or from another hospital? Y (N)
2. Admitted/transferred to:- HDU ICU Renal Vascular Orthopaedics **Please circle** Y (N)
3. Previous history of MRSA colonisation/infection? **(Check on ICE)** Y (N)
4. Any open wound/ulcer or invasive medical device present **before** admission to hospital? Y (N)

If **YES** to any of the above questions, obtain verbal consent prior to taking swabs Consent Y (N)

Swabs - please tick Nose & Perineum ☐ **(preferred option)** Nose & Throat ☐
Wound ☐ CSU ☐ Invasive Device Site ☐

If rescreened, please tick which swabs **AND** include Wound, CSU and Invasive Device Site if present

Date/Time
Nose & Perineum ☐ **(preferred option)** Nose & Throat ☐ Invasive Device Site ☐ Wound ☐ CSU ☐

Date/Time
Nose & Perineum ☐ **(preferred option)** Nose & Throat ☐ Invasive Device Site ☐ Wound ☐ CSU ☐

7. LIFESTYLE, WELLBEING AND HEALTH PROMOTION: (refer to flow charts)

Smoking
Are you a smoker / use tobacco products? (Y) N
IF YES:
Smoking policy discussed/smoking information leaflet given (Y) N
Opt into NRT In-patient Pathway? Y (N)

If No, Sign Disclaimer (THB 610 Personal Safety Risk Assessment)

Substance Use
Are you taking any 'over the counter' medications e.g. Pain killers, herbal remedies? Y (N)
Are you taking any "recreational drugs" or inhalants? Y (N)
IF YES:
Would like help and support with addiction? Y (N)

Alcohol
Do you 'regularly' drink alcohol? Y (N)
('Regularly' means drinking every day or most days of the week)

IF YES:
Would like to reduce/stop drinking? Y N

Weight / Activity Levels - BMI of >25 only
Do you undertake 30 minutes per day of physical activity? Y N
Are you comfortable with your current weight? Y N
IF NO TO BOTH:
Are you interested in receiving support to reduce your weight? Y N
Would you like help/support to increase your activity levels? Y N

Date/ Time	DISCHARGE PLAN CONTINUATION SHEET	Initials

Date/ Time	DISCHARGE PLAN CONTINUATION SHEET	Initials

DIETARY ASSESSMENT

To be completed for all patients within **24 hours** of admission

Criterion	Y	N	If YES specify below	Intervention/Considerations	
Patient has a Learning Disability		N		**Refer / contact Learning Disability Liaison on 07740 937309 Date.....**	
Patient has a Food Allergy **(Complete within 6 hours of admission)**		N		**Kitchen informed** **Relevant staff informed/included in safety brief** **Wrist allergy band in situ** **Allergies recorded in Nursing Notes and Drug Kardex** **Other, specify .....**	☐ ☐ ☐ ☐ ☐
Patient has Specific Cultural/Ethnic/Religious dietary requirements e.g. Halal/Vegetarian		N		**Kitchen informed** **Halal/Vegetarian menu offered (if appropriate)** **Other, specify .....**	☐ ☐
Patient has specific therapeutic dietary requirements e.g. Gluten Free/Renal/Diabetic		N		**Kitchen informed** **Other, specify .....**	☐
Patient **unable** to make menu choices independently		N		**Give assistance if necessary to make menu choices, taking into account likes/dislikes** **Other, specify .....**	☐
Patient has **Specific** eating and drinking likes/dislikes		N			
Patient **unable** to maintain their own hydration needs		N	**If> 60 years of age** 30 mls/kg x body weight per day **If 18-60 years of age** 35 mls/kg x body weight per day	**Calculate daily fluid goal** **.....mls/kg per day** **Offer regular fluids (8-10 drinks per day) *(or if applicable fluid restriction)***	☐

Criterion	Y	N	If YES specify below	Intervention/Considerations
Patient has cognitive impairement/Dementia/medical or psychological factors affecting nitrition		N		**If YES, please specify and follow Specific Nutritional Requirements Guidance** **Record level of risk on the traffic lights and document plan of care in the nursing record.** **If NO to any question reassess each shift and record level of risk on traffic lights**
Patient unable to take 'adequate' food and /or fluid orally/swallowing problems/poor oral health		N		
Patient requires physical assistance with eating and drinking/adapted equipment or requires nutrition/supplements		N		

Completed - Initials of nurse **Date** **Time**

Review Date	Oedema /Ascites Yes/No	Weight	Corrected Weight	B.M.I.	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	Dietetic Referral Yes/No	DATIX Yes/No	Initial
22/8/16	NO	43.5	NA	18	~~182~~	0	0	42	NO	NO	KB.

PLEASE COMPLETE WEIGHT CHART FOR LONGER STAY PATIENTS(THB(MR)566)

Date/ Time	INVESTIGATIONS/TESTS	RESULTS e.g. catheter label, urinalysis label
	wd36 HCG -ve S emens 2 initek Status® erial Number: 209242 ient: Stacey istix® 8 SG date 15-08-2016 12:34PM or umber 1632 Not Entered Not Entered tive tive ive e e ive	

ONGOING PLAN OF PATIENT CARE & EVALUATION

(Record plan of care for all **Amber/Red** problems from Traffic Light Assessment.
Document interventions/treatment, evaluation & changes to patient condition

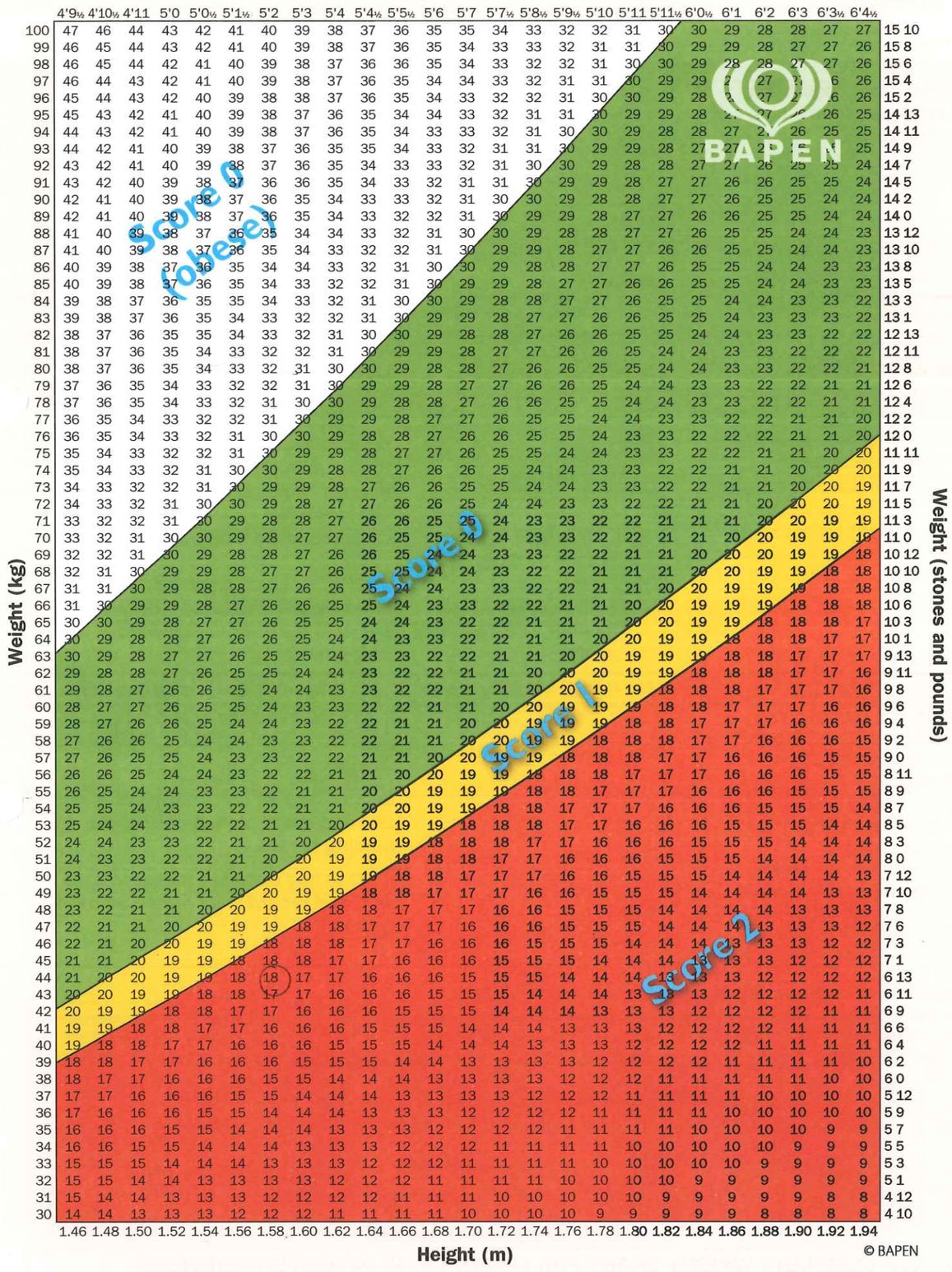
N	Nutrition	**FB**	Fluid Balance	LD	Learning Disabilities
PUP	Pressure Ulcer Prevention	**P**	Pain	PS	Personal Safety
M	Manual Handling & Mobility	**W**	Wound/Skin Integrity	PC	Psychological Care
F	Falls	**PH**	Personal Hygiene	S	Sleep
A	Airway/Breathing	**OH**	Oral Hygiene	CF	Cognitive Function
O	Observation & Monitoring	**I**	Infection Control	ACN	Additional Care Needs
E	Elimination	**C**	Communication		

Date/Time	Code	ADMISSION SBAR	Initials
		Situation (Short summary of reason for Admission)	
15/08/16	(ACN)	TCI for Th 16/08/16 - Lletz biopsy	
		Background (Recent events , circumstances, relevant medical history)	
		Assessment (Observations, risk factors, injuries)	
		Recommendation/s (Nursing plan for all Amber /Red needs) (*continue on next page if needed)*	

THB 600

Step 1 – BMI score (& BMI)

BAPEN
www.bapen.org.uk



Note : The black lines denote the exact cut off points (30,20 and 18.5 kg/m²), figures on the chart have been rounded to the nearest whole number.

THB 600

'MUST' RISK ASSESSMENT

To be completed for all patients within **24 hours** of admission

If patient **NOT** appropriate for 'MUST' Assessment specify reason:-	If patient **NOT** appropriate for Dietary Assessment specify reason:-
Review Date	**Review Date**
Review Date	**Review Date**

STEP 1

Height (m)	1.58	Stadiometer ☐ Self reported height (if reliable) ☐ Reported by carer ☐
Ulna Length (cm)		(not appropriate for Learning Disability)
Tape Measure (m)		(Learning Disability only)
Weight (kg)	43.5	Actual ☐ Self- reported ☐ Reported by carer ☐

STEP 2 **(If none, write 'nil')**

Any unplanned weight loss over the last 3–6 months) nil (kg)

Any unplanned weight gain over the last 3–6 months. nil (kg)

Are there any factors affecting weight? Yes ☐ No ☑

Amputation	Weight		(kg)	Corrected Weight		(kg)
Oedema	Wet Weight		(kg)	Corrected Weight		(kg)
Ascites	Wet Weight		(kg)	Corrected Weight		(kg)
Plaster Cast	Weight		(kg)	Corrected Weight		(kg)

BMI (kg/m²) from Ready Reckoner: 18

STEP 3

Is the patient acutely ill **and** there has been or is likely to be little or no nutritional intake for more than **5** days Y (N)

'MUST' CALCULATOR

STEP 1 BMI score (from Ready Reckoner)		STEP 2 Weight loss score (from Ready Reckoner)		STEP 3 Acute disease
BMI kg/m²	**Score**	Unplanned weight loss in past 3-6 months (this includes obese patients)		If patient is acutely ill and there has been or is likely to be little or no nutritional intake for more than 5 days
greater than 20 (>30 obese)	= 0	**%**	**Score**	**Score 2**
18.5 – 20	= 1	less than 5	= 0	**Score 0** if not applicable
Less than 18.5	= 2	5-10%	= 1	
		greater than 10	= 2	
2		0		0

STEP 4 (add step 1, 2 and 3 together to give overall risk of malnutrition 'MUST' score)

2

Score 0 Low Risk		Score 1 Medium Risk		Score 2 or more High Risk

Follow STEP 5 Management Guidelines

'MUST' is adapted and reproduced with kind permission of BAPEN (British Association for Parenteral and Enteral Nutrition).

ONGOING PLAN OF PATIENT CARE & EVALUATION

(Record plan of care for all **Amber/Red** problems from Traffic Light Assessment.
Document interventions/treatment, evaluation & changes to patient condition

Code					
N	Nutrition	FB	Fluid Balance	LD	Learning Disabilities
PUP	Pressure Ulcer Prevention	P	Pain	PS	Personal Safety
M	Manual Handling & Mobility	W	Wound/Skin Integrity	PC	Psychological Care
F	Falls	PH	Personal Hygiene	S	Sleep
A	Airway/Breathing	OH	Oral Hygiene	CF	Cognitive Function
O	Observation & Monitoring	I	Infection Control	ACN	Additional Care Needs
E	Elimination	C	Communication		

Date/Time	Code		Initials
15/8/16	N	independent with eating and drinking	
	PUP	independently relieving pressure areas	
	O	News of 0 8° hourly ~~observer~~	
		Observations	
	E	independent with toileting	
	M	independant no concerns	LCS
16/8/16 0340	N	NBM	
	ACN	Latex allergy	
	C	? 1st on theatre list today.	OR
	N	MUST = (2) due to BMI = 18.	OR
0645		Prepared for theatre, ticket complete.	OR
11:10		Patient returned from theatre following a LLETZ (biopsy), Patient alert on return.	
	(N)	Can eat and drink as able.	
	(PUP)	Pressure areas intact - Treatment Plan A.	
	(M)	Bedrest at present.	
	(O)	NEWS 2 due to low blood pressure.	
	(E)	HNPU yet.	
	(FB)	Fluid balance chart insitu	
	(P)	Patient prescribed PRN analgesia. Not	

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Date/Time	Code		Initials
cont		required as yet.	
	(W)	Maty pad insitu - slight oozing.	
	(I/PVC)	Ventflon insitu - Ⓡ hand, VIP = 0.	
	(ACN)	Patient had contact lenses on in Recovery -	
		anaesthetist aware and not concerned.	LJ
16/9/16 1150	C	Patient asked if she could leave ward	
		with husband for a coffee. Advised	
		patient to stay on ward at present as	
		not long back from theatre. Went to	
		advise FYI on ward about patient wanting	
		to go off ward and when came back to	
		bed space patient has left ward and took	
		belongings - will wait and see if patient	
		returns. FYI aware.	LS
12:15		Patient returned to ward with husband.	
		Patient drowsy, clammy and greyish	
	(O)	apperance. NEWS 5 - due to low temperature,	
		hypotensive and sats low. FYI reviewed -	
	(A)	15 litres O^2 therapy insitu, 15 minute	
		observations. Bloods taken. IV fluids	LJ
		commenced.	LJ.
1240	O	NEWS score now 2 due to temp 35.5	
		and BP 105/67. C/N 15 min obs. NEWS 4.5.	LS
13^{30}	(N)	Patient refused diet and fluids at lunch	LJ.

5. SOCIAL CIRCUMSTANCES

Dependants

Do you/ the patient provide care or support for someone, or have concerns regarding care of pets? Y (N)

IF YES, what arrangements been made for their care whilst you / the patient are in hospital?

_____

Significant other (s) Involved in Care

Do you / the patient have someone who provides unpaid care or support for you on a **daily/ weekly** basis? Y (N)

IF YES, SPECIFY Name of main Carer _____ Relationship _____

Briefly describe care given _____

Key Holder **Y N** Name _____

Home Environment

Is the patient planning to return to their usual home after they leave hospital? (Y) N

IF NO, SPECIFY _____

IF YES, are there any concerns regarding discharge i.e. poor mobility around the home , personal care, cooking, housework, shopping , laundry etc **Y N**

IF YES, and aged over 75 years AND/ OR admitted with falls, deterioration in mental state or poor mobility please complete **Functional Assessment Screening Tool** (where applicable).

OR Use **'Referral to Social Work/District Nurse Form' THB (MR)565** and document in the discharge plan

If any community service in place please table complete below

Community Services	Please circle	Specify Care	Contact Details	Days provided	Number of visits per day	Date phoned to be restarted	Initial
Home Care	Y (N)						
Nurse Specialist	Y (N)						
District Nurse	Y (N)						
Care Manager/ Social worker	Y (N)						
Meals Delivered	Y (N)						
Day care	Y (N)						
Other	Y (N)						

Phone to restart services if the patient is able to go home on existing package of care. **Complete the grey section.** Please note; services may be stopped following admission and therefore a re-referral or a new referral will be required.

2. CONSENT/CAPACITY: To be completed for all patients within **6 hours** of admission

2a. CAPACITY

Do you have any concerns regarding the patient's capacity or ability to make healthcare decisions (including Cognitive Impairment/ Delirium/ Confusion/ Diagnosed Mental Health Condition / Learning Disability)? **Y** (**N**)

IF YES SPECIFY _____

IF NO review using the Traffic Light Risk Assessment per shift/as required and complete assessment below if any changes

IF YES Please complete the **"Assessment and Intervention" section below** and review using the Traffic Light Risk Assessment per shift

2b. FORMAL CONSENT TO TREATMENT

Check Consent to Treatment Form completed for Surgery/Medical Procedure/Test **(if applicable)**, signed and in medical records ☐

Assessment and Intervention				**Date/Time**	**Initial**
"Butterfly Scheme" discussed?	**Y**	(**N**)	Consent to opt in to "Butterfly Scheme" given		
"Getting to Know Me" offered?	**Y**	(**N**)	"Getting to Know Me" completed		
Has medical staff been informed?	**Y**	(**N**)	**Inform** Consultant / medical Staff to undertake appropriate Cognitive Testing		
Has Certificate of Incapacity (Section 47) form been completed?	**Y**	(**N**)	**Notify** medical staff of the need to undertake a **capacity assessment with regard to the treatment needed**		

If the emergency / first contact has Power of Attorney (Welfare only) or Legal Guardianship they are legally entitled to full disclosure of all confidential information

3. DISCLOSURE OF INFORMATION

I/ the patient give consent for full disclosure of confidential information to first contact only i.e. diagnosis, test results etc? (**Y**) **N**

I/ the patient give consent to disclosure of general information to general enquiries from all other relative/carers/friends i.e had a good day; doing well etc? **Y** (**N**)

Is there anyone you do NOT wish us to disclose any information to? (**Y**) **N**

Full name/s & relationship Only partner to be aware.

Power of Attorney/Legal Guardianship (complete for ALL patients)

a) Welfare?	**Y**	(**N**)	If Yes is this activated: Y N Name & Contact details:
b) Financial affairs?	**Y**	(**N**)	If Yes is this activated: Y N Name & Contact details:
c) Anticipatory/ Advanced Care Plan?	**Y**	(**N**)	If Yes have you seen verification Y N

4. SELF CARE

Is there any care you/ the patient **(and/or relative/friend)** would like to be involved in whilst in hospital: for example, washing and dressing, help at mealtimes? **Y** (**N**)

IF YES, SPECIFY _____

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Date/Time	**Code**		**Initials**
16/8/16	E	Passed urine.	
18th	I	PIC reviewed.	
	ACN	SIB DR COH - operation	
		explained and any follow up	L.

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Abbreviations

This abbreviation list has been approved by NHS Tayside and is supported by NHS Tayside policy for Records and Record Keeping for Registered Nurses, Midwives and Specialist Community Public Health Nurses.

A & E	Accident and Emergency	**IM**	Intramuscular
ABX	Antibiotics	**INR**	International Ratio
BM	Blood Glucose Monitoring	**ICU**	Intensive Care Unit
BMI	Body Mass Index	**IV**	Intravenous
BP	Blood Pressure	**LA**	Local Anaesthetic
CAD	Care given as described on.....Date.....(the date and planned care must be stated on the ongoing record)	**MUST**	Malnutrition Universal Screening Tool
CCU	Coronary Care Unit	**MRSA**	Methicillin Resistant Staphylococcus Aureus
C DIFF	Clostridium Difficile	**MSSU**	Mid Stream Specimen of Urine
CHI	Community Health Index	**NIR**	No Intervention Required
CPE	Carbapenemase Producing Enterobacteriaceae	**NRT**	Nicotine Replacement Therapy
CPR	Cardio Pulmonary Resuscitation	**O2**	Oxygen
CSU	Catheter Specimen of Urine	**PAC**	Pre Assessment Clinic
CVA	Cerebral Vascular Accident (Stroke)	**PEG**	Percutaneous Endoscopic Gastronomy
CVC	Central Venous Catheter	**PICC**	Peripherally Inserted Central Catheter
DNA CPR	Do Not Attempt Cardio Pulmonary Resuscitation	**PMH**	Past Medical History
DOB	Date of Birth	**PVC**	Peripheral Vascular Catheter
DOSA	Day of Surgery Admission Unit	**SBAR**	Situation Background Assessment Recommendations
DVT	Deep Vein Thrombosis	**SEWS**	Scottish Early Warning Score
ECG	Electrocardiogram	**SPO2**	Saturation of Peripheral Oxygen
GA	General Anaesthetic	**TPAR**	Tayside Prescription Administration Record
HAN	Hospital At Night	**TTO's**	Tablets to Take Out
HDU	High Dependency Unit	**UTI**	Urinary Tract Infection
ICT	Infection Control Team		

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Multidisciplinary Record of Care
Register of all personnel writing in Core Data Set

All members of staff who are using this Core Data Set should complete this section once.

Name	Job title	Ward	Hospital	Signature	Initials	Date
Emma Paton	SN	36	NWH	EPaton	EP	15/8/16
RACHEL BURDIN	Student Nurse	36	NW	RBurdin	RB	150816
SIMON O'BOYLE	SSN	36	NW			15/8/16
Lucy Seaton	Student nurse	36	NJ		CS	15/8/16
JILLIAN REID	SN	36	NWH	J Reid	JR	16/8/16
Laura Johnston	ST/N	36	NWH	L. Johnston	LJ	16/8/16
Lisa Ballii	SN	36	NW	L. Ballii	LB	16/08/16

Admission History

Admission/Transfer/Boarding	Destination 1	Destination 2	Destination 3	Destination 4
Hospital				
Ward				
Transfer date & time				
Patient & relatives informed?				
Completed by - Initials				

Readmission History	Date	Date	Date	Date
Hospital				
Ward				
Consultant				

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All members of staff who are using this Core Data Set should complete this section once.

Name	Job title	Ward	Hospital	Signature	Initial	Date

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NHS Tayside WHO Surgical Safety Checklist (V7/10/2014)

NHS Tayside

Last Name :

First Name:

Date of Birth:

2804880060

STACEY ELLIS

NHS/CHI#:

Planned Procedure:

ASA Score: 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5 ☐

THEATRE : 21 DATE: 12/8/16

SIGN IN (to be read out loud) before induction of anaesthesia

	Yes	N/A	No
Patient confirmed identity & procedure, matched with consent form	☑		
Is surgical site/side marked		☑	☐
Any known allergies			☑
Drug prescription chart checked	☑		
Confirm anaesthetic plan/concerns (e.g. airway, blood loss)	☑		

Blood available Y ☐ N ☐ N/A ☑

Patient's pre-operative temperature 36.4 °C

Anaesthetist : Dr. Machin

Anaesthetist Signature :

SURGICAL PAUSE (to be read out loud) before start of surgical intervention, e.g. skin incision

Confirm all team members are aware of roles and responsibilities and are familiar with each other ☑

Surgeon, Anaesthetist & Registered Nurse/OPD verbally confirm :

What is the patient's name / CHI No ☑

What procedure, site and position are planned ☑

Patient allergy status confirmed? LATEX ☑

Any metal implants/stimulators Y ☐ N ☑

Plan agreed for anticipated blood loss G&S ☐ xmatch ☐ N/A ☑

Are there any specific equipment requirements or special investigations Y ☐ N ☑

Has the following been agreed and applied :

Warming measures Y ☐ N/A ☑
DVT prophylaxis Y ☑ N/A ☐
Essential imaging displayed Y ☐ N/A ☑
Diathermy setting confirmed Y ☑ N/A ☐

Is interim pause required in this case Y ☐ N ☐ N/A ☑ (if Y, see overleaf)

SURGICAL ANTIBIOTIC PROPHYLAXIS REQUIRED Y ☐ N ☑

If indicated, ensure a **single dose** of **policy compliant antibiotic** is given within 60 mins of KTS and **recorded on the front of the TPAR**. Document any deviation from policy in medical notes Y ☐ N/A ☑

Document KTS time

Name : JGRAY

To be signed by member of staff who read out checklist

SIGN OUT (to be read out loud) before any member of staff leaves the operating room

Confirm actual procedure undertaken (implant code in notes) ☑

Confirm instruments, swabs and sharps counted/correct ☑

Confirm specimens labelled correctly ☑

Blood loss confirmed to team (if >1.5l or prolonged procedure of >4 hours, refer to local abx surgical prophylaxis guideline for re-dosing instruction) ☑

Anaesthetist/Surgeon confirm post-op patient instructions

Post-operative plan for DVT prophylaxis ☑

Post-operative antibiotic plan agreed N/A ☑

Drains to be opened Y ☐ N ☐ N/A ☑

Plan for fluids/food ☑

Patient confirmed daycase/inpatient Daycase ☑ Inpatient ☐

Datix required Y ☐ N ☑

Name : JGRAY

To be signed by member of staff who read out checklist

SURGICAL SITE INFECTION

Patient body temperature maintained at ≥36° in peri-operative period Y ☑ N ☐

Record post op temp 36.8 °C

Known diabetic patient's glucose control level kept at <11mmols/l throughout the operation Y ☐ N ☐ N/A ☑

Record final glucose level mmols/l

THB (MR) 161

WHO Surgical Safety Checklist – Interim Pause

INTERIM SURGICAL PAUSE	
Patient position still correct	Yes ☐ No ☐
Diathermy correct settings	Yes ☐ No ☐
Document current blood loss	
Swabs/Instrument Count	Yes ☐ No ☐ N/A ☐
Any surgical/anaesthetic concerns	Yes ☐ No ☐

NHS

INVESTIGATIONS, TREATMENT OR OPERATION FORM

(Complete using block capitals & no abbreviations)

NHS Tayside

ELLIS STACEY 2804880060 F
17 ANNAT ROAD MONTROSE DD10 8EF
Annat Bank Practice, Links Health Cent

Patient Label can be used

Hospital/Ward: NIW
Speciality: Gynae
Consultant: Dr. Rajagopathy

Name of proposed procedure or course of treatment

Loop Biopsy of cervix

The site / side of surgery

I have explained the procedure to the patient. In particular I have explained:

Intended Benefits: To diagnose ± treat precancer / cancer

Significant Risks: Bleeding, infection, preterm labour, injury to vagina

Any extra procedures which may become necessary during the procedure:

Blood Transfusion ☑ **Other** (specify)

(The need and alternatives have been discussed with the patient)

I have also discussed what the procedure is likely to involve, the benefits and the significant risks of any available alternative (including no treatment), and any particular concerns of this patient. I have done this in terms that, in my judgement have been understood.

The following information leaflet(s) has been given

Has the patient ever been notified that they are at increased risk of CJD or vCJD for public health purposes?

No	☑	Proceed as normal
Unable to Respond	☐	Proceed as normal unless high risk tissue, e.g. Brain, Spinal Cord Posterior Eye and Quarantine instruments pending contact with infection control for further advice.
Yes	☐	Ask for further explanation. Quarantine instruments pending contact with infection control for further advice.

Clinicians Signature: Kalpana K **Date** 15/08/16

Name Printed: Dr. RAJAPATHY **Grade** Consultant

Contact Details 3290

Please Turn over for Patient Section

NHS Tayside

CONSENT FOR INVESTIGATIONS, TREATMENT OR OPERATION FORM

This page is to be completed by the patient/representative.

Please read this form carefully. If you have any further questions, do ask; we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree: To the procedure or course of treatment described on this form.

To the administration of a general, local or other anaesthetic as appropriate, following informed discussion including the benefits and significant risks with the anaesthetist.

I understand:

- That any procedure in addition to those described above will only be carried out if it is necessary to save my life or to prevent serious harm to my health.
- That you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.
- Information including digital information (radiological e.g. x-rays, CT and MRI scans, video and/or photographic material) may be stored as part of the patients medical records and may be stored on computer databases.
- Body tissue e.g. fluids, organs or parts of them may be removed during the procedure and used for diagnosis, my future treatment and then discarded or stored as considered appropriate.

Please tick ✓appropriate box if you agree to

☐ Excess body tissue not required for diagnosis or future treatment being used for medical research (the University of Dundee is very active in medical research and donations of excess body tissues are a valuable resource for research)

☐ To photographs and other digital images being used for teaching, in presentations at conferences or available on websites and in publications

(If consent is withdrawn at a later date it may not be possible to withdraw images that are already in the public domain) NB Medical staff you must complete the appropriate medical photography forms.

I have been told about additional procedures as specified which may become necessary during my treatment. I have listed below any procedures which **I do not wish to be carried out** without further discussion.

Specified Additional Procedures

Additional Procedures I do not want carried out

Patient's Signature: * SELS **Date:** 15/08/16

Print Name: MS. ELLS

Witness Signature **Date:**

(if patient unable to sign)

Print Name

Statement of Interpreter (if applicable): I have interpreted the information above to the patient to the best of my ability and in a way in which I believe the patient can understand.

Interpreters Signature: **Date:**

Name Printed:

Day of Operation

I have marked the skin at the operation site and / or confirmed consent ☐

Signature **Date**

FILE IN NOTES

TAYSIDE HOSPITALS ANAESTHETIC RECORD

Hospital: NW Ward: 36

Operation Proposed: LEFT

Consultant:

Date of Surgery: 16/8/16 Theatre:

WRITE OR ATTACH LABEL

Surname ELLIS Sex

Forename STACEY

DOB and CHI 280488 0066

PRE-OP ASSESSMENT

By: NW Site: WARD Date: 15/8/16

Elective ☐ Scheduled ☑ Urgent ☐ Emergency ☐

Weight/BMI 44kg 1m55 Pulse Blood Pressure SpO_2 on

CVS/RS:

SMOKER
METS 10
LATEX ALLERGY

Other:

Airway Assessment:

Dentition: own

Mallampati: 1

Incisor Gap: good

Jaw Protrusion: good

Neck Movement:

Aspiration Risk Y / N

Anticipated Difficulty Y / (N)

Prev Airway Hx:

FBC

U&E

Other

G&S / X-Match Y / N

Units

ECG:

Pregnant: Yes No N/A

ASA: I

PONV Score:

AKI Score:

Fasting: SOLID

LIQUID

Consent Signed & Checked ☐

Incapacity Form ☐

Drugs: NIL

Allergies: LATEX

Anaesthetic Plan / Techniques Discussed:

GA.

PREMEDICATION AND INSTRUCTIONS:

Date	Drug and Dosage	Route	Time	Signature	Given By	Time

Fast as per protocol ☐

OR

Fast solids from

Fast fluids from

Give routine medications EXCEPT: Premed Effect:

ANAESTHETIST AND GRADE

1. Assistant:

2. Consultant: Informed? Y / N

ANAESTHETIC TECHNIQUE:

INJECTION SITE: R hand dorsum 20 gauge.

DRUGS & DOSES:

Propofol 200mg.
fentanyl 50 micrograms + 25 micrograms + 25 micrograms
Lidocaine 1% 2ml

AIRWAY AND BREATHING SYSTEM:

Facemask ☐ SV ☑ Circuit ○

Airway - Oral/Nasal ☐ IPPV ☐ Machine Penlon

LMA/OETT/NETT/Trache Ventilation Mode: VCV/PCV

Type 1 gel. V_T ..... PEEP .....

Size 3. Freq ..... P_{AW} .....

Laryngoscope / Throat Pack ☐ HME ☐

Laryngoscopy Grade / Ease of Mask Ventilation: ✓easy

GEB/Stylet ☐ Ease of Intubation: NA ry.

EVENTS:

1. Induction of Anaesthetic.
2. Transfer of Patient.
3. Colposcopy + LETTS.
4. Completion of procedure.
5.
6.
7.
8.
9.
10.

Patient Position & Protection: o——/

Fluid Warmer: /

Warming Blanket: /

I.V. FLUIDS:

CL 500ml (1)

TIME	30	45	0900	15	30	45	1000	15
Events				(1) (2)	(3)		(4)	
fentanyl				50.	25		25	
								Recovery Post op 30 Adc
TEMP °C				36.4				
SpO_2				100	100	100	100	100 / 100
F_IO_2				Air	0.47	0.47	0.48	0 / 0
~~E_TCO_2~~ E_tCO_2					6.4	6.6	6.9	LMA / 0-1
Agent N_2O					0.28	0.34	0.41	0 / 0
~~CVP~~ SCV					2.1	2.1	2.2	12 / 13
~~Urine~~ Mac					1.2	1.4	1.4	
I.V. FLUIDS				(1)				

54 AIR

EQUIPMENT CHECK: Circuit, Machine & Monitor

Anaesthetic Room ☑ Theatre ☑

REGIONAL: **STOP BEFORE YOU BLOCK** ☐

BLOCK / APPROACH:

SITE / SIDE:

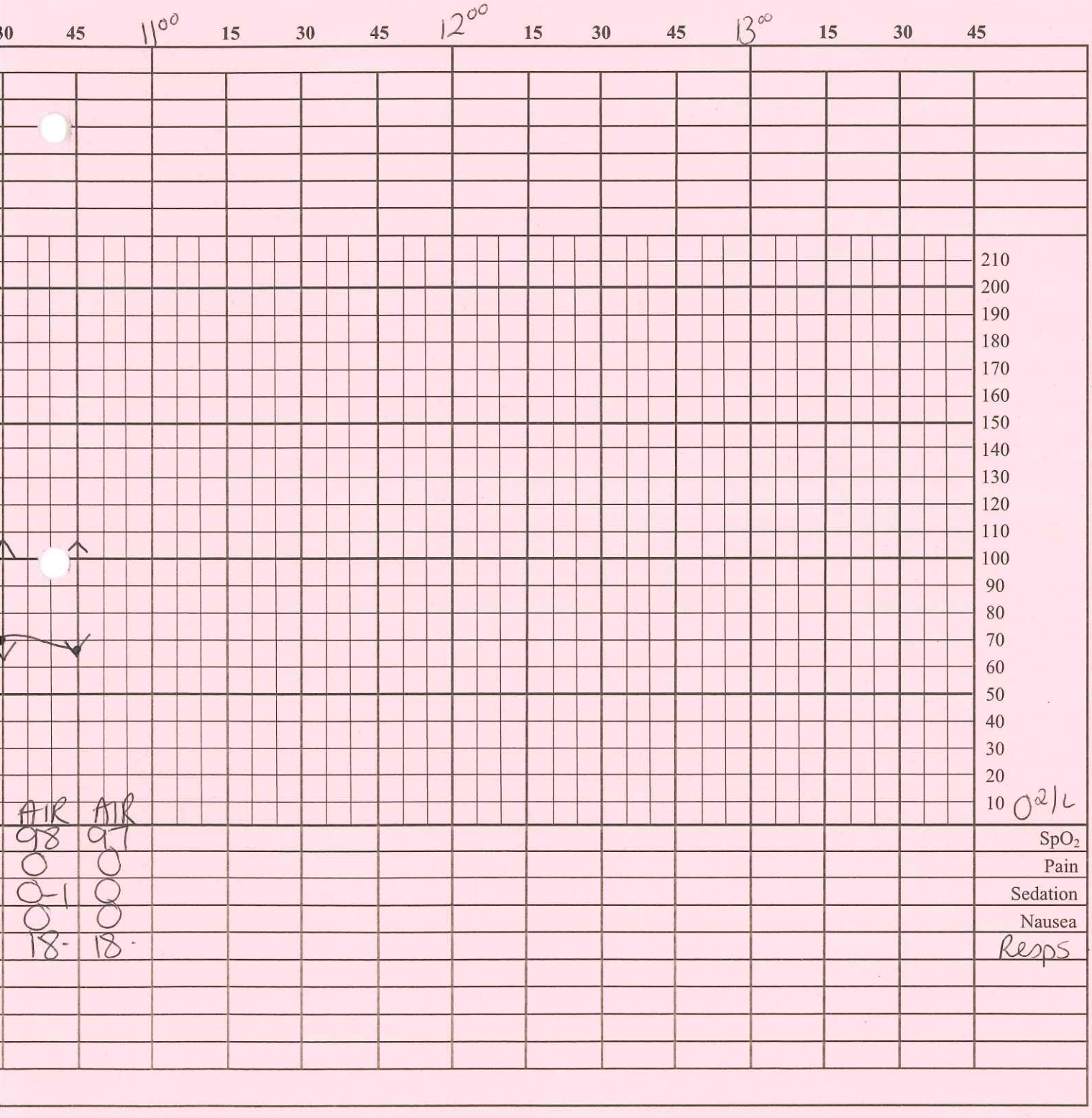
NEEDLE / CATH:

TECHNIQUE:

DRUGS:

MONITORING:

ECG	☑	PNS	☐
NIBP	☑	TEMP	☑
SpO_2	☑	URINE	☐
$ETCO_2$	☑	CO Monitor	.....
F_IO_2	☑	Depth of Anaes	.....
ET Agent	☑	ABP	.....
VENT ALARM	☑	CVP	.....
P_{AW}	☑	Other:	
MIN VOL	☑		



Operation Performed:

Operating Surgeon:

Anaesthesia: GA ☑ GA & Regional ☐ Regional Only ☐ Regional & Sedation ☐

S

Relevant Medical History: SMOKER

Allergies: LATEX None ☐

B

Anaesthetic / Surgical Difficulties: NIL None ☐

A

Fluids Given:

Total Urine Output: ..... Estimated Blood Loss: .....

Analgesia / Anti-emetics Given:

POSTOPERATIVE INSTRUCTIONS:

Oxygen 5 l/min for UNTIL AWAKE hours **OR** Aim for $SpO_2 \geq$ 94 Ward SpO_2 Monitoring ? Y / N

Observations: Pulse, Respiratory Rate, Blood Pressure and Pulse Oximetry

Frequency: Duration:

After this period observations: **as documented below** ☐ **OR** **as per EWS chart** ☐

Observations:

Invasive Monitoring and Lines:

MAY EAT & DRINK

Fluid Therapy: Fluids Prescribed? Y / N

Proposed Post-Operative Analgesia:

Post-op Thromboprophylaxis : TED ☑ LMWH ☐ RIVAROXABAN ☐ FLOWTRONS ☐ OTHER .....

Surgical Instructions:

R

RECOVERY ROOM ANALGESIA & OTHER DRUGS:

Drug Name	Maximum Dose	Increment	Route	Prescriber's Signature	Time Given/ Total Dose
FENTANYL	100 MICROGRAMS	20 MICROGRAMS	IV		
ONDANSETRON	4mg	—	IV		

DRUGS GIVEN BY RECOVERY STAFF:

1. .....
2. .....
3. .....
4. .....
5. .....
6. .....
7. .....
8. .....
9. .....
10. .....
11. .....
12. .....

RECOVERY TO WARD HANDOVER:

DISCHARGE TO:

DSU ☐

WARD ☐

HDU ☐

ITU ☐

NHS TAYSIDE

GYNAECOLOGY

OPERATION RECORD

Ward/Clinic/ Hosp. NW Gyn KR Cons.

D D M M Y Y
2 8 0 4 8 8 0 0 6 0 C.H.I. No.

Surname Ellis

First Name Stacey M. State

Address Sex

G.P. & Address (G.P. Requests only)

USE BLOCK LETTERS OR PATIENT LABEL

DATE 16/8/16

Operation(s) Performed LLETZ under GA

Time Begun

Indication(s) Smear - ? Invasion
Unable to tolerate colp examination in clinic.

hrs.

Time Finish

Diagnoses

hrs.

Type

Elective ✓

Emergency

Surgeon AGOH

Status Sr

Authorised by

Status

Assistant W McCallum

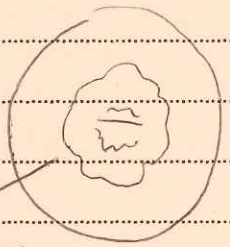
Status Cons

Scrub Nurse

Status

BLOOD LOSS	Estimated		Measured		Total	Blood Transfusion	Antibiotic	Anticoagulant
	+ mls.		= mls.		min mls.		—	—

NOTES Findings:



Exophytic appearance
Dense AW tte
? Warty appearance
but suspicious appearance
in inner aspect of TZ.

TI TZ.
SCJ visualised
Acetowhite ✓
Mosaic ✓
Punctation ✓
Atypical vessels ✓

No involvement of vagina / parametrium.

Op: C & D
Colp performed - Findings as above
LLETZ performed (1 specimen)
Rollerball diathermy after - very vascular
Haemostasis ✓

AJO

DMR 94

NOTES: Ribbon applied.

Post op: (IE) today.
Has CT/MRI in coming wk.
? Post MDT clinic after results of pathology + imaging available.

A Cook ST7
6189900

PATIENT DETAILS

Stacey
Ellis
280488 0060

GYNAECOLOGY/ONCOLOGY
M. D.T. MEETING

DISCUSSION

DATE

24/8/16

Primary report → not cancer

CT - NO LN ; some fluid POD
Cancel MRI if confirmed no cancer.

Dr. RAJUPATHY.

BENIGN
CASE

NHS TAYSIDE

NINEWELLS HOSPITAL PERIOPERATIVE CARE RECORD

Patient Name: ELLIS STACEY 2804880060 F

17 ANNAT ROAD
MONTROSE DD10 8EF

Date of birth / CHI:

Annat Bank Practice, Links Health Cent

Ward: 36

Theatre: 2/

Problem	Potential risk of wrong procedure being performed
Goal	Correct procedure performed on correct patient
Intervention	Check identity of patient with name band, theatre list and consent form Check operation site is correctly marked

Problem	Potential risk of injury during transfer from trolley to operating table
Goal	Safe transfer as per theatre policy
Intervention	Ensure trolley is in working order Ensure brakes are on trolley and operating table Ensure adequate number of staff carry out safe transfer

Problem	Potential risk of injury or pressure sore related to position on operating table
Goal	Minimise risk of injury/pressure sores during surgery
Intervention	Ensure patient is secure in following positions throughout their surgery

Supine Prone Lithotomy Loyd Davis Left Lateral Right Lateral

Position of patient's arms

Right Arm: On arm board At side Over Chest Other (specify)

Left Arm: On arm board At side Over Chest Other (specify)

Is the patient positioned on - Trolley Bed Theatre Table

Protect patient and patient's limbs using aids as per theatre policy

Propad Heel pads Head ring Gel pads Pillows

Towels Angled arm boards

Problem	Patient is unable to maintain dignity intraoperatively
Goal	Maintain patient's dignity throughout surgery
Intervention	Ensure patient is covered appropriately Do not expose patient until surgeon is ready to commence operation

STACEY ELLIS
2804880060

GYNAE
160816

Problem	Potential risk of infection
Goal	Minimise risk of infection
Intervention	Establish and record skin preparation used Ensure asepsis is maintained throughout surgery Skin prep used: TRAVASEPT
Problem	Potential for burns/skin irritation related to use of diathermy
Goal	Prevent burns/skin irritation
Intervention	Use of diathermy and application of pads as per theatre policy

Make: Valleylab ERBE Other (specify)

Placement of pad: [Left Thigh] Right Thigh Other (specify)

Mode: [Monopolar] Bi-polar

Used: [Yes] No

Generator used: [Valleylab] ERBE Other (specify)

Check skin under plate site pre and postoperatively and record observations

Preoperative skin condition: INTACT

Postoperative skin condition: ✓

Problem	Potential for shock/haemorrhage
Goal	Patient's haemodynamic state is monitored
Intervention	Maintain accurate record of blood loss from swabs and suction jars and record on nursing care summary Assist surgeon should patient be in danger of excessive blood loss Assist anaesthetist with fluid/blood replacement therapy Monitor/record urine output Assist with invasive monitoring equipment
Problem	Potential risk of foreign body retention
Goal	No foreign body retention
Intervention	All equipment used during surgery is accounted for as per NHS Tayside policy
Problem	Potential for altered urinary output
Goal	Identify patients need for a urinary catheter
Intervention	Liaise with medical staff to identify whether a urinary catheter is required

Type of catheter used:
Size:
Amount of water in balloon:

ANAESTHETIC CARE

Patient Name: STACEY ELLIS		**Ward:** 36	
Date of birth / CHI: 2804880060		**Theatre:** 2	
		Allergies: LATEX	
Anaesthetist: Dr Wilson / Dr Mealtin		**Anaesthetic Assistant:** A MOLLOY	
ECG	**Blood Pressure Cuff**	**Pulse oximeter Probe**	**Arterial Line**
Central Venous Pressure	**Capnograph**	**Temperature Probe**	**Intravenous Cannula**
Intravenous Infusion	**Blood Warmer**	**Cell Saver**	**Naso-gastric Tube**
Bair Hugger **Temperature Setting** **Low / Medium / High**	**Eye Care** **Eyes Taped / Padded** **Ointment (Specify)**	**Throat Pack** **Inserted: Yes / No** **Removed: Yes / No** **Throat Sprayed** **Yes / No**	**Urinary Catheter** **Yes** **Size Type** **No** **In Situ**
Sequential Compression Boots	**Oesophageal Doppler Monitor**	TED's	APPLIED

TYPE OF ANAESTHESIA

General Anaesthetic
Endotracheal Tube (Specify size)
Laryngeal Mask (Specify size) igel 3
Intubating Laryngeal Mask Airway (Specify size)
Proseal (Specify size)
Ventilation Spontaneous / Intermittent positive pressure ventilation

Sedation
Propofol Target Controlled Infusion
Guedel Airway
Nasopharyngeal airway (Specify size)
Face Mask
Hudson Mask
Ventimask
Nasal Cannula / Prongs

Spinal Anaesthetic
Thoracic Epidural
Lumbar Epidural
Combined Spinal/Epidural
Regional Block (Specify)
Local Infiltration
Other (specify)

ADDITIONAL INFORMATION

- IV access sited & secured in DRH
- Uneventful OA.
- Eyes taped.

SIGNATURE A. Molloy **DATE** 16/8/16

STACEY ELLIS
2804880060

Intraoperative Summary Sheet

Theatre: GYNAE 160816

Procedure Performed: LLETZ

Surgeon: DR MCMULLEN DR GOH

Specimens:

PATH X1

Drains:

N/A.

Dressings:

MATY PAD

Pack in situ ~~Yes~~ No

Local Infiltration ~~Yes~~ No

Type:

Amount:

Additional Information

I&C
D - A006405 2016/08/12 NGYN114
NHS Tayside

SPECULUM GRAVES

ID- A052011
2016/01/20 N038655
NHS Tayside

Scrub Nurse Signature: ABell.

Flooring Nurse Signature

Recovery Care Summary & Ward Handover

2804880060
STACEY ELLIS

Date: 16/08/16 Time into Recovery: 1000.

Anaesthetist: Dr Wilson Surgeon: Dr McMullen

Operation: LLETZ (Biopsy)

Anaesthetic GA ☑ LA ☐ Spinal ☐ Epidural ☐ Regional ☐ Sedation ☐ Intrathecal Opiate ☐

Theatre to Recovery Handover

Airway ETT ☐ LMA/iGel ☑ Oral Airway ☐ Nasal Airway ☐ Chin Support ☐ Self Maintaining ☐

Time Airway Removed - 1005. SpO_2 - 100%.

Conscious Level A ☐ V ☐ P ☐ U ☑ Comments: LMA insitu

O_2 Therapy 5 L/min for until fully awake Mask ☑ Nasal Cannulae ☐ Non Re-breather Mask ☐

Aim ≥94%

Monitoring Oximeter ☑ ECG ☑ NIBP ☑ Arterial BP ☐ CVP ☐ CO_2 ☐ Temperature 36.8 °C

Diabetic Yes ☐ No ☑ BM mmols GKI ☐ Sliding Scale ☐

Cannulae in Situ Peripheral ☑ Site: DRH Arterial ☒ Site: Time Removed In Situ ☐

Cannulae flushed Yes ☑ Central Line ☒ Chest x-ray required ☐ Reviewed ☐ NAD ☐

IV Infusion Yes ☐ No ☑ Flushed Yes ☐ N/A ☐ Rate: mls/hr **PCA in Situ** Yes ☐ No ☑ (see PCA chart)

Epidural in Situ can E+D. Yes ☐ No ☑ (see epidural chart) **Elastomeric Infusion** Yes ☐ No ☑ (see chart) Rate: mls/hr

Blood Loss Intraoperative: not recorded. mls Haemocue Result: N/A ☑ **Cell Salvage** Yes ☐ No ☑

Pain Score 0 ☑ 1 ☐ 2 ☐ 3 ☐ Analgesia Given ☐ Comments:

Nausea Score 0 ☑ 1 ☐ 2 ☐ 3 ☐ Antiemetic Given ☐ Comments:

Neuro Obs Yes (see chart) ☐ N/A ☑ **PPURA Scale:** see chart.

CSM Right /Left Circulation / Colour Sensation Movement Comments: NA

Dressings Dry ☑ Slight Ooze ☐ Moderate Ooze ☐ Packs in Situ: Yes ☐ No ☑

Mepilex pad. Reinforced ☐ Pressure Dressing ☐ Replaced ☐

Drains Yes ☐ No ☑ No:.... in Situ: Position: Open: Yes ☐ No ☐ To be opened at:

Catheter Yes ☐ No ☑ Hourly Volumes ☐ Irrigation ☐ Free Drainage ☐ **Nasogastric Tube** Y ☐ / N ☑

Additional Information

1015 Stacey feeling cold, extra blanket provided. Not tolerating facemask, saturating 100% on air. Pt states still has contact lenses in- anaesthetist made aware - states no concern. Stacey states no discomfort or blurred vision.

Recovery Discharge Notes and Ward Handover Summary

Conscious Level A ☑ V ☐ P ☐ U ☐ | **Maintaining Own Airway** Yes ☑ | **Patient Stable** Yes ☑

Comments: BM NA . mmols

Drains Yes ☐ No ☑ Patent ☐ Amount: mls Nature:

Dressings Mata pad dry.

Drugs Given Intraoperatively and in Recovery
See anaesthetic sheet for details

Communicated to Ward Nurse - Yes ☐

Additional Information

Pain Score 0 ☑ 1 ☐ 2 ☐ 3 ☐ Comments:

CSM Right /Left | Circulation / Colour | Sensation | Movement | Comments: NA .

Items Returned to Patient
Dentures Yes ☐ N/A ☑ | Spectacles Yes ☐ N/A ☑ | Hearing Aids Yes ☐ N/A ☑ pt states stu has contact lenses in.
Dressing Gown Yes ☑ N/A ☐ | Slippers/Shoes Yes ☑ N/A ☐ | Other

NEWS	Score : 1		Time Ready for Discharge 1045.				
	Respiration Rate	Sp02	Supplementary O2	Temperature	Pulse	Systolic BP	AVPU
3	≥25				≥131	≥220	
2	21-24			≥39.1	111-130		
1				38.1-39.0	91-110		
0	12-20	≥96	No	36.1-38.0	51-90	111-219	A
1	9-11	94-95		35.1-36.0	41-50	101-110	
2		92-93	Yes			91-100	
3	≤8	≤91		≤35.0	≤40	≤90	V, P or U

Discharge Checklist (Use in conjunction with SBAR at handover to ward nurse)

Post Op Instructions Anaesthetist ☑ Surgeon ☐ | **Epidural / PCA TPAR Prescription Checked and Recorded** Yes ☐ N/A ☑

DVT Prophylaxis Prescribed Yes ☑ 1800. No ☐ | **Post-op Antibiotics Prescribed** Yes ☐ No ☑ | **Post-op Analgesia Prescribed** Yes ☑ No ☐

Additional Information / Comments

SBAR Handover to Ward Nurse

1. Situation	2. Background
State patient details, conscious level /airway / pain / nausea.	Give summary of relevant medical history. State procedure performed and care given intraoperatively and in recovery. Provide details of postoperative instructions from anaesthetist and surgeon.
3. Assessment	**4. Recommendations**
Provide details of intravenous infusions, invasive monitoring, drains, dressings, current NEW, pain and nausea scores, CSM status, etc. State drugs given intraoperatively and in recovery with times of administration.	Confirm patient's condition is suitable for return to ward. Ask if ward nurse requires any additional information.

Recovery NEWS Score on Discharge: 1 | **Time Out of Recovery:** 1055.

Recovery Practitioner Name and Signature	Ward Practitioner Name and Signature
CARLY JEFFREY cjeffrey (SN)	LISA BALLIE L. Ballie (SN)

Ward/Clinic/ Hosp. 36 NW ..... Cons.

D D M M Y Y | C.H.I. No.

HISTORY/CONTINUATION SHEET

ELLIS STACEY 2804880060 F
17 ANNAT ROAD
MONTROSE DD10 8EF

M. State
Sex

UNIT/WARD/DE Annat Bank Practice, Links Health Cent

USE BLOCK LETTERS OR PATIENT LABEL

DATE	Page .....
16/8/16	SEEN SINCLAIR F41 No Post OP notes - LLETZ procedure Advised nurse can Eat & Drink post OP #5165
16/8/16	F41 LU Pt brought back to ward after collapsing outside NEWS: 4 BP 97/67 O2 Sats: 93% on air HR: 71 Temp 35.9°C A: Pt able to speak. B: Chest clear, RR: Not tachypnoeic - Started on 15L O2 via Trauma mask C: Started continuous BP monitoring - Given 500ml (NaCl 0.9% Stat) Sent FBC, UeEs + Blood Cultures. D: Glucose 4.1, Responding to Voice Plan: Started Sepsis Protocol - fluids, O2 + bloods SHO called #5126
16/8/16 12:40	JAMBOREE GP582 #4494 ATSP: NEWS = 5 pt left ward 30 min after return from Surgery (LLETZ) went outside for cigarette w/ partner, upon return felt faint + sweaty, Sats 93% On my arrival pt comfortable in bed, A(V)PU, Sats 100% on Air BP 106/69 - Moving all limbs, alert. - Chest clear, Abdo SNT, BM 4.1 Imp: Vasovagal P Monitor pt, fluids

THB.(MR)3A

DATE	
16/8/16 1755	Post op Explained findings - wary appearance but suspicious of 'cancer'. Pt took news well as already aware of this possibility. Explained aftercare of LUFT + CSP PIL given. Fibrillar inserted : might pass large piece of material. has MRI/CT on 18/8/16. Phone or letter c post MDT appt. ACoh ~~STG~~ ST7 6186990

HISTORY/CONTINUATION SHEET

Ward/Clinic/Hosp. .....

Surname ..... ELLIS

First Name ..... STACEY

Address ..... 8 MILL PLACE, CRAIGO, MONTROSE

ANNAT BANK, LINKS HEALTH CENTRE, FRAN

G.P. & Address (G.P. Requests onl

2804880060 F DD10 9LB

.....Cons.

C.H.I. No. .....

..... M. Stafe

..... Sex

.....UNIT/WARD/DEPT.

BLOCK LETTERS OR PATIENT LABEL

DATE

Page .....

12/12/16 SMEAR - invasive July 16. Para 4
colp 08/16 → Squamous lesion. Negation
LETZ (GA) 16/8/16.
'LARGE' Lesion
LLETZ. 19 x 20 x 20.
CIN 3 to ECC Gx.
No CGIN
Dse SMear Feb 17.

Meanwhile
very heavy bleeding + pain
Bled last Feb 17

TVS S/IL. No haematometrium
normal endom.
normal ot (small calcification)
Ovaries (n)

OE. vag hdr Gx. Scarred bt normal.
Of nil adv MOLE
no mass
no nodularity

Towards end:

Swabs by GP negative.

Adv.
Bot problems (pain/bleeding) prevented LETZ.
Now also hdr scarred Gx.

Adv add cyclical progs or OCP, cyclical
+ Regular IBUPROFEN trycte
Plus PARACETAMOL.

Rev Feb as planned.

THB.(MR)3A

Cervical Cytopathology Request Form (Complete)

Request Id	1416745013
DOB / CHI	2804880060
Name	ELLIS, STACEY LOUISE
CHI Address	17 ANNAT ROAD, MONTROSE, DD10 8EF
Correspondence	

Smear Taker ID	Loraine Stirton
Sender Location	Ninewells Colposcopy Clinic
Sender Address	Ninewells Colposcopy Clinic, Dundee, DD1 9SY
Practice Address	LINKS HEALTH CENTRE, FRANK WOOD WAY, MONTROSE, DD10 8TY

Type of Smear	**Cervical**
Appearance of Cervix	**Normal**
Current HRT	**No**
I.U.C.D.	**No**
Post Natal	**No**
Currently Immunosuppressed	**No**

Refer	**No Referral**
Observations	**No Referral**
Date Of Exam	**13 Feb 2017**
Date Sample Taken	**13 Feb 2017**
Last Menstrual Period	**03 Feb 2017**

Clinical Comments	**post lletz for cin3 for test of cure**
Signature Of Requester	**Loraine Stirton**

Cytology Result	**Negative**
Recall Advice	**Routine Recall - 3 Years**
HPV Result:	**hr-HPV Negative**
HPV Authorised Date:	**21 Feb 2017**
Infection(s)	
Cytology Report	

ELLIS, STACEY LOUISE
2804880060

show KR result please.

K.R
02/03/17

27 FEB 2017

Ninewells Gynae Scan Report 2016

Surname first

Name:	ELLIS	STACEY	Address:	
DOB/CHI	2804880060			

Date of scan :	05/12/2016	Reason for scan:	

Scan report: 1

TV USS
Normal anteverted uterus measuring 71 x 38 x 47 mm
Clear midline endometrial l echo seen
E T 2.2 mm
No evidence of haematometria, There is a small calcified area towards the fundus of uncertain significance.
Cervical length 34 mm
Left ovary measures 25 x 35 x 24 mm
vol = 10.5 ml
Right ovary measures 22 x 25 x 19 mm vol = 5.2 ml, No adnexal masses/free fluid seen

Scanned by:	SMDS (con	Date of next appt:	12/12/2016
Checked by:	CC	Report sent to:	AREA 3
Ref:	LJN	Date report sent:	06/12/2016
		Report sent by:	LJN

Medical Review:

trophon
5/12/2016 10:19 SN:24286-008
Disinfection: PASS Cycle #: 1073
Indicator: PASS ✓ FAIL ☐
Operator: C-Cha
Probe: Legacy
Notes:

NWML - R23-C28-502

THB 024SS

TAYSIDE PRESCRIPTION AND ADMINISTRATION RECORD
(3 WEEK RECORD)

NHS Tayside

DATE OF ADMISSION 13.9.21 RECORD START DATE _____

Hospital/Ward: NW MAU.	**Patient Name:** STACEY LEONARD
Consultant: PL.	**CHI Number:** 280488 0060
On admission: **Weight:** **Height:**	**Date of Birth:** 28.04.88.
	(Attach printed label here)

Name of Community Pharmacy:	**Daily/Weekly Dispensing** ☐	**TSMS** ☐
	Compliance Device ☐	
	Contacted on admission: ☐	
Telephone number:	**Contacted on discharge:** ☐	

MEDICINE ALLERGIES/SENSITIVITIES

IF NIL KNOWN TICK HERE THEN DATE & SIGN ☐ .....

MEDICINE	REACTION(S)	MEDICINE	REACTION(S)
1. LATEX		4.	
2.		5.	
3.		6.	

CONFIRMATION OF PRESCRIPTION REVIEW ON TRANSFER OF MEDICAL CARE		
Receiving Unit	Date	Authorised Prescriber (Signature)

ONCE ONLY PRESCRIPTIONS

Date	Time	Medicine	Dose	Route	Prescribed By	Time Given	Given By
13.9.21		Venofer	200mg	IV	[signature]	1510	[signature]
		Venofer	200mg	IV	R. WNE		ARitchie

WRITE OR ATTACH LABEL

ELLIS STACEY 2804880060 F

17 ANNAT ROAD MONTROSE DD10 8EF

Annat Bank Practice, Links Health Cent

PERIOPERATIVE FLUID BALANCE CHART

Date 26/8/16 Theatre 21

Ward 36 Hospital RAH

NHS Tayside

IVI No	FLUID TYPE	Amount (mls)	RATE OF FLOW PER HOUR	ROUTE	ADDITIONS	BATCH NO.	START (24HR CLOCK)	FINISH (24HR CLOCK)	PRESCRIBED BY	ADMINISTERED BY	INPUT Volume Administered	INPUT Running Total
1	Hartmanns	500	TI	IV	—		0920	TH.	Wilson	[signature]	500	500
											Total (A)	500

Oral Intake

Time	Volume	Running Total
	Total (B)	

Arterial/CVP Fluid

(Do Not include in fluid balance)

0.9% NaCl 500 mls for arterial line flush only. Prescribed by Checked by Date: Please do not include in calculation of daily fluid balance	**Start Time** **Batch No**
0.9% NaCl 500 mls for central line flush only. Prescribed by Checked by Date: Please do not include in calculation of daily fluid balance	**Start Time** **Batch No**

Other

Time	BM	Temp	Haemoglobin	
			Hemocue	Blood gas
0920		36.4		
1600		36.8		

Output

Time	Urine	Running Total
	Total (C)	

Time	Theatre Blood Loss	Vomit/NG Aspirate	DRAIN ( )	DRAIN ( )	DRAIN ( )	OTHER ( )	OTHER ( )	OUTPUT	
								Volume	Running Total
							Total (D)		

TOTAL INTAKE (A+B)	TOTAL OUTPUT (C+D)	PERIOPERATIVE BALANCE (A+B) – (C+D)
500 mls	0 mls	+500 mls

Peri-operative SKIN* Bundle Record Sheet

Date 16/8/16 Time 0925

Theatre 21

Any pre- exisitng skin conditions? Dry skin

ELLIS
STACEY 2804880060
F
17 ANNAT ROAD
MONTROSE DD10 8EF

Annat Bank Practice, Links Health Cent

Operation/ speciality
gynae

Anaesthetic type
GA

Mark each box with TICK or N/A

TIME 0925		Comments	1010	Comments		Comments		Comments
Pressure Relief (SKIN) Check Skin hrly and reposition on operating table if applicable								
Position Code (State CODE in box)	L		SF	Recovery.				
Correct pressure relieving surface (and switched on)?	✓		✓					
Heel pressure relieving device in situ?	✓		✓	Heels lowered.				
Arm / head movements?	✓		✓	Independent.				
Inspect - Skin Condition								
Pressure areas checked?	✓	Intact.	✓	see over.				
Skin is free from any wetness/incontinence?	✓		✓					
Saturation probe in correct position?	✓	(R) index	✓					
Barrier cream/spray applied?	NA		NA					
Check skin around pressure dressings if applied.	NA		NA					
Hydration/Dressings								
Intra venous fluids given if prescribed ?	N	FBC.	X					
Wound dressing applied - State type/location	NA		X					
Initials	VM		CJ	C				

CODES											
S	Supine		LL	Left Lateral 30 degree tilt	RL	Right lateral 30 degree tilt	P	Prone (front)	REP	Repositioned
L	Lithotomy		D	Deckchair	MD	Modified Deckchair	HD	Head Down	SR	Semi-recumbent
LT	Left Tilt		RT	Right Tilt	LD	Lloyd Davis	R	Recovery	TT	Theatre table

* Follow NHST Policy for the prevention and management of pressure ulcers for all sections and document care and progress in the record of ongoing care.

THB

Peri-operative SKIN™ Bundle Record Sheet

Refine risk assessment of individuals undergoing surgery by examining other factors that are likely to occur and will increase risk of pressure ulcer developing

• Length of the operation • Increased hypotensive episodes intraoperatively • Low core temperature during surgery • Reduced mobility on post operative day one

Treatment Plan D

All at risk patients receiving surgery will have a pressure-relieving device on the operating table and transfer trolleys.
All nursing staff in the **anaesthetic room, operating theatre and recovery** will ensure that they know the patient's risk status at all points of the patient's journey through theatre.
All patients identified as at risk will have their pressure areas inspected in the **anaesthetic room, in the operating room immediately after surgery has finished and in the recovery** area and where possible during the operation.
In collaboration with the anaesthetist, move the head position to prevent continued pressure on the occipital area (if patient condition allows).
All patients at risk will have measures in place to alleviate factors that cause pressure ulcers in the **anaesthetic room, operating theatre and throughout the recovery phase.**
Elevate heels completely in such a way as to distribute weight of the leg along the calf without putting all the pressure on the Achilles tendon. If possible the knee should be in slight flexion. (hyperextension of the knee may cause obstruction of the popliteal vein predisposing to deep vein thrombosis).
Position the individual in a different posture preoperatively and post operatively than the posture adopted during surgery and record this on the SKIN bundle. If a pressure ulcer develops this will be recorded.

Position of patient in anaesthetic room state:-
Length of time in anaesthetic room 20 mins / ~~hrs~~ Any significant event causing increased risk state:-

Condition of skin on **transfer to table:-** (circle) (No red areas) red area(s)- blanching red area(s) non blanching Grade 1 Grade 2 Grade 3 Grade 4
Site(s) please state:_____

Treatment plan D Active? Yes No Unable to comply state reason_____ Time 0930 Sig. A. Mallory

---

Position of patient on the theatre table state:

Length of time in theatre _____min/ hrs Any significant event causing increased risk state:-

Condition of skin **leaving theatre:-** (circle) No red areas red area(s)- blanching red area(s) non blanching Grade 1 Grade 2 Grade 3 Grade 4
Site(s) please state:_____
Treatment plan D Active? Yes No Unable to comply state reason_____ Time Sig:_____

Position of patient in recovery area semi fowler Length of time in recovery area _____min/hrs moving independently on bed.
Any significant event causing increased risk state:-

Conditon of skin in **recovery:-** (circle) No red areas (red area(s)- blanching) red area(s) non blanching Grade 1 Grade 2 Grade 3 Grade 4
Site(s) please state: markings from sheets.
Condition of skin leaving recovery (circle)
No red areas (red area(s)- blanching) red area(s) non blanching Grade1 Grade 2 Grade 3 Grade 4
Site(s) please state: As above
Treatment plan D Active? (Yes) No Unable to comply state reason_____ Time 1010 Sig Jeffrey

2804880060

STACEY ELLIS

CHI/DOB 13/8/16 Ward 36 Hospital NW

	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
(E) ELIMINATION - Urine																		
Independent and continent	19	19	4															
Long term catheter / stoma in situ and self caring																		
Short term catheter in situ (Review need daily)																		
Managed incontinence/requires prompting																		
Incontinent / new stoma																		
Moisture lesions to skin																		
Has not passed urine > 30 mls per hour																		
(E) ELIMINATION - Bowels																		
Continent - Normal bowel habit/bowels opened	19	19	4															
Stoma in situ and self caring																		
Constipated/bowels not opened																		
Managed incontinence																		
Incontinent/loose stools/new stoma																		
(P) PAIN																		
No pain	19	19	4															
Pain score 1 - 2 or on regular oral/IM analgesia																		
Pain score 3/continuous at rest or uncontrolled/IV analgesia																		
(W) WOUND/SKIN INTEGRITY																		
Skin healthy - no concerns	19	19	4															
Dry or delicate skin/Dermatological condition																		
Clean surgical wound-Wound Care Plan active																		
Open wound-Wound Care Plan active																		
(PH) PERSONAL HYGIENE																		
Independent	19	19	4															
Requires encouragement/minimal support																		
Requires active assistance to wash/bathe																		
Dependent requires full assistance																		
(OH) ORAL HYGIENE																		
Brushes teeth/dentures independently	19	19	4															
Requires assistance/observation to brush teeth/dentures (12 hourly oral care)																		
Dependent/active assistance with oral care required. (Oral assessment undertaken and 4 hourly oral care)																		
Oral trauma/acute oral complaint																		
(I) INFECTION CONTROL																		
No known risk (follow SICPS)	19	19	4															
Infection risk identified																		
Confirmed infection/colonization - (follow Transmission Based Precautions/ Consider patient placement																		

SHIFT ASSESSMENT Patient Name	CHI/DOB						Ward						Hospital					
DATE	15/8/16																	
	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
(PVC) PVC / CVC																		
No PVC/CVC	19	19	4															
PVC/CVC in situ (date/time of insertion and initials marked on dressing/dressing intact)																		
PVC/CVC requires re-insertion / phlebitis / pain at site (VIP score>than 1 or in situ for>72 hours)																		
(C) COMMUNICATION																		
No Communication barriers identified	19	19	4															
Existing communication barriers																		
New communication barriers/requires Language Interpreter/British Sign Language user																		
(LD) LEARNING DISABILITY																		
No Learning disability	19	19	4															
Learning disability identified (Contact Learning Disability Liaison Team)																		
(PS) PERSONAL SAFETY																		
Not ambulant/ambulant but clinically stable Mentally capable of making sound judgements Identity Bracelet in place - Legible/complete and correct patient details	19	19	4															
Ambulant, but clinically unstable Current smoker/Alcohol or Substance misuse (complete disclaimer on Patient Safety Risk assessment THB 610)																		
Risk of absconding/Concerns for patient safety/impaired judgment/Sedation (complete Patient Safety Risk Assessment THB610)																		
(PC) PSYCHOLOGICAL CARE/WELL BEING																		
Patient reports psychological/spiritual care needs are being met	19	19	4															
Distress or stress identified and being managed																		
Requires active psychological/spiritual care																		
Has a longstanding mental health condition that is managed																		
Patient experiencing intense emotions/distress/or behavioural issues Requiring immediate professional input																		
(S) SLEEP																		
No sleep problem identified/usual sleep pattern	19	19	4															
Altered sleep pattern/difficulty sleeping/insomnia																		
(CF) COGNITIVE FUNCTION (Think Delirium)																		
No problems identified	19	19	4															
Cognitive Impairement with controlled symptoms																		
Delirium/Acute change in cognitive function/deteriorating Dementia with significant symptoms																		
Relative/carer has Welfare Power of Attorney/Legal Guardianship																		
Active Adults with Incapacity (section 47) - review dates weekly																		
(ACN) ADDITIONAL CARE NEEDS																		
Initials of Nurse																		

SHIFT ASSESSMENT Patient Name	CHI/DOB				Ward				Hospital								
DATE	15/8/16																
COMPLETE ASSESSMENT AND RECORD CARE REQUIRED AND GIVEN FOR ANY AMBER & RED RISKS ONLY	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
(N/FB) NUTRITION AND FLUID BALANCE																		
Independent with eating and drinking needs	19																	
Requires therapeutic diet / special diet																		
Requires IV / SC fluids/On Fluid Balance Chart																		
Requires assistance or aids to eat and drink/ oral nutritional supplements																		
On texture modified diet/thickened fluids																		
Hydration Card or 3 Day Food Record Chart																		
Nausea and/or vomiting																		
Requires Enteral/Parenteral Nutrition																		
Nil by Mouth/Fasting for procedure/weight loss >than 10%			4															
(PUP) PRESSURE ULCER PREVENTION																		
No risk on PPURA Treatment plan A active	19		4															
At risk on PPURA Treatment plan B active with SKIN chart																		
Grade 1 or 2 pressure ulcer																		
At high risk Treatment plan C and SKIN chart																		
Grade 3 or 4 pressure ulcer																		
(M) MANUAL HANDLING & MOBILITY																		
Independent. No risk identified	19		4															
Independent with own mobility aids																		
Requires assistance/supervision of 1 or 2 to mobilise/new mobility aids																		
Fully Dependent Hoist required and / or assistance of > 2 to mobilise																		
(F) FALLS / BEDRAILS																		
No history of falls/No risk identified	19		4															
History of falls, At risk Falls Care Plan active																		
High risk of falls/New fall since admission Falls Care Plan Active																		
Bedrail assessment carried out Bedrails can be used																		
Bedrail assessment carried out. Bedrails can be used with caution other interventions																		
Bedrails assessment carried out **DO NOT USE BEDRAILS**																		
(A) AIRWAY / BREATHING																		
No airway/breathing problem	19		4															
Existing airway/breathing problem identified- condition optimal																		
Requires oxygen therapy																		
New problem identified/exacerbation of existing problem																		
Requires external support to assist breathing																		
(O) OBSERVATION & MONITORING																		
SEWS 0 - 1	19		4															
SEWS 2 - 3																		
Continuous Observations / cardiovascular monitoring in situ																		
SEWS 4 or more or scores 3 in two or more parameters																		
DNACPR activated																		

ANAESTHETIC/NURSING USE

Time last drink allowed [~~06~~ 06 36]

Time of last drink given by nursing staff [06 30]

Confirmed time of last food [19 00] 15/8/16.

Any specific instructions, e.g. Need EMLA, interpreter, BSL interpreter, agree light breakfast etc

[redacted]

In the event of any queries, please contact the anaesthetist on bleep no 4013 or call theatre _____

TICKET COMPLETE (for completion by Ward Staff)

I hereby confirm that the above named patient has had all necessary pre-theatre checks undertaken and is consented for theatre.

Print Name J. REID (must be registered nurse) Date 16/8/16

ACCEPTING RECEPTION NURSE

I hereby confirm that this patient ticket is accurately completed Y ☐ N ☐

PRINT NAME _____ SIGNATURE _____

DATE _____

Document any inaccuracies below : FIONA (CN)

ACCEPTING ANAESTHETIC PRACTITIONER

I hereby confirm that this patient ticket is accurately completed Y ☑ N ☐

PRINT NAME A. MOLLOY SIGNATURE _____

DATE 16/8/16

Document any inaccuracies below :

PLEASE RETAIN IN PATIENT RECORD

NHS Tayside

Patient Theatre Ticket – for patient /carer use

To make your trip to theatre as safe and effective as possible, we would be grateful if you could please fill in the following information :
(If you have any problems with this, please ask your nurse for help)

My name is STACEY My Date of Birth is 28/04/88

I would like to be called STACEY (e.g. your first name)

Do you have any concerns you would like to discuss with the theatre team?

NO.

Is there anything else we can help you with during your stay?

NO.

To make your trip to theatre safe, we need you to stop eating and drinking at the required times :

- No solid food (includes glasses of milk) for 6 hours before surgery
- You are encouraged to keep drinking either water/diluting juice/cups of tea or coffee which can contain sugar and up to 3 tablespoons of milk
- You must have one last cup of any of the above allowed drinks 2 hours before surgery

When did you last have solid food Date 15/8/16 Time 7PM.

When did you last have a drink Date 16/8/16 Time 0630AM

What did you have to drink water.

Please do not suck sweets/use chewing gum after your last drink (i.e. 2 hours before surgery)

Please write down any allergies you may have

Latex

Please tell us about any metal inside your body, e.g. artificial joints, pacemakers, nerve stimulators

(R) dermal piercing in (R) arm.

Have you taken any tablets or used inhalers or patches today YES ☐ NO ☑

If yes, please fill in the name and time you have taken it:

Have you been asked to not take any of your routine medication YES ☐ NO ☑

If yes, please fill in which medications and the date you stopped taking them

FEMALE PATIENTS – is there any risk you may be pregnant? YES ☐ NO ☑

Prior to surgery, please confirm you have removed (if applicable) :

nail varnish ☐ false nails ☐ piercings ☑

We would request that where appropriate your dentures/spectacles/hearing aids and underwear are **NOT** removed prior to going to theatre (bras should be removed please). Please remember your glasses/dressing gown/slippers

This ticket has been completed by : Patient ☐ Carer ☐ Nursing staff ☑

Please pass this ticket to your named nurse.

ATIENT THEATRE TICKET – for clinical use

WARD TEAM Patient CHI No. 2804880060

Correct name band applied	YES ☑
Consent signed and dated (including CJD box)	YES ☑
Surgical site marked	YES ☐ N/A ☑
Medical casenotes present	YES ☑
Xmatch/G&S sent	YES ☑ N/A ☐
TPAR complete with patient name, CHI, allergies, regular medication prescribed	YES ☑
Nursing records present	YES ☑
Are there any infection control issues the theatre team should be aware of?	YES ☐ NO ☑

WARD TEAM

Pregnancy test (all females aged 12-55) +ve ☐ -ve ☑
(inform anaesthetist if positive result)

If patient is on applicable medication, please complete the following :
Last fragmin injection Time 15/8/16 ↔ Date 1800hrs

Oral anticoagulants, e.g. warfarin, clopidogrel, aspirin, dipyridamole, rivaroxaban Time_____ Date N/A.

Has appropriate medication been given today, e.g. beta blocker/omeprazole, inhalers (patients inhalers/GTN spray must be taken with them to theatre)
YES ☐ NO ☐ N/A ☑

Did patient self-administer at home? YES ☐ NO ☐ N/A ☑
(if yes, see patient section)

Prescribed TEDS applied? YES ☑ N/A ☐

Is this patient high risk/or already has a pressure ulcer YES ☐ NO ☑

Pre-medication given YES ☐ NO ☐ N/A ☑

IF THIS WAS A SEDATIVE, TRANSFER TO THEATRE MUST BE ON A BED OR TROLLEY

THB 024SS

TAYSIDE PRESCRIPTION AND ADMINISTRATION RECORD
(3 WEEK RECORD)

NHS Tayside

DATE OF ADMISSION 15/8/16 RECORD START DATE _____

Hospital /Ward: NW/36

Consultant:

On admission:
Weight: 43.5kg **Height:** 1.32m.

28 04 88

2804880060

STACEY ELLIS

(Attach printed label here)

CONFIRMATION OF PRESCRIPTION REVIEW ON TRANSFER OF MEDICAL CARE		
Receiving Unit	Date	Authorised Prescriber (Signature)

MEDICINE ALLERGIES/ SENSITIVITIES

IF NIL KNOWN TICK HERE THEN DATE & SIGN ☐ .....

1. LATEX	2.	3.	4.

ONCE ONLY PRESCRIPTIONS

Date	Time	Medicine	Dose	Route	Prescribed By	Time Given	Given By

OTHER MEDICINE CHARTS IN USE			
Chart Type	Signed		Signed
1. Insulin		4. Anticoagulant	
2. Epidural/Pain relief		5. Mental Health Act	
3. Fluid		6. Other	

AS REQUIRED THERAPY

Medicine / Form		Date	16/8/A									
Paracetamol		Time	1255									
Dose & Frequency 1g 4-6°	Route oral	Dose	1g									
Signature	Start Date 16/8	Route	oral									
Indication / Notes PAIN	Pharmacy	Initials	LB									

Medicine / Form		Date										
IBUPROFEN		Time										
Dose & Frequency 400mg 6-8°	Route oral	Dose										
Signature	Start Date 16/8	Route										
Indication / Notes PAIN	Pharmacy	Initials										

Medicine / Form		Date										
Ondansetron.		Time										
Dose & Frequency 4mg 6-8°	Route IV	Dose										
Signature	Start Date 16/8	Route										
Indication / Notes N+V	Pharmacy	Initials										

Medicine / Form		Date										
		Time										
Dose & Frequency	Route	Dose										
Signature	Start Date	Route										
Indication / Notes	Pharmacy	Initials										

NOTES FOR USERS

For Prescribers:

1. Sign your name clearly against each prescription.
2. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date appropriate boxes.
3. If an existing prescription is to be modified, delete existing prescription as described and re-write new instructions in a new section.
4. Use approved names in BLOCK LETTERS and use metric doses as follows:
   Milligram = mg **Gram = g** **Millilitre = ml** **Microgram: to be written in full**
   Fractions of a milligram should be written in micro grams. A zero should be written in front of a decimal point where there is no other figure, e.g. 0.5ml **not** .5ml
5. Method of administration should be abbreviated as follows:
   Intravenous = IV **Inhalations = INH** **Intramuscular = IM** **Oral = Oral** **Topical = TOP** **Vaginal = PV**
   Subcutaneous = S Cut **Sublingual = S Ling** **Intradermal = ID** **Per rectum = PR** **Nasogastric = NG**

For Nurses:

1. The 'Regular' and 'As Required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.
2. Ensure entry is made on administration record each time drug is given. Initial in relevant date column and time row.
3. Check that all drugs prescribed at a certain time are administered.
4. If drug is not administered, enter reason in appropriate box using the coding system.

REGULAR THERAPY

| | | |

WRITE OR ATTACH

ELLIS 2804880060
STACEY F
17 ANNAT ROAD
MONTROSE DD10 8EF

Annat Bank Practice, Links Health Cent

NHS Tayside

HOSPITAL/AREA NW

WARD/AREA 36

If>**60 years** of age -30mls /kg x body weight per day

If **18-60 years** of age - 35mls/kg x body weight per day

PRESCRIPTION & FLUID BALANCE CHART

DATE: 16/8/16 TIME: _____ CURRENT WEIGHT: 43.5kg DAILY FLUID TARGET/RESTRICTION: _____ mls

(other information): _____

REASON FOR COMMENCEMENT: post operative

REASON FOR DISCONTINUATION: _____ PREFERRED DRINK: _____
(if applicable)

PRESCRIPTION CHART

TIME OF PRESCRIPTION	BAG NO.	FLUID TYPE	AMOUNT (MLS)	RATE OF FLOW PER HR	ROUTE	ADDITIONS	PRESCRIBED BY	BATCH NO.	START (24 HOUR CLOCK)	FINISH	ADMINISTERED BY
12:25	1	0.9% NaCl	500ml	STAT	IV.		[signature]	16C31T2G	1230		[signature]

NHS TAYSIDE

24 HOUR SKIN* and Care Round** Record Sheet

Ward..... 35 ..... Hospital ..NVI.....

SKIN Chart required Y N (circle)

MATTRESS TYPE- High Specification Foam ☐

Invacare Active ☐ Other state _____

Pressure Ulcer Treatment Plan A B C (circle)

28 04 88 S

2804880060

STACEY ELLIS

Agree frequency with patient **

1 / 2 / 3 / 4 hourly

(Please Circle)

Date/s ..150816..... **Mark each box with TICK or N/A or I (intervention) If Intervention given record in ongoing record of care ***

CARE ROUND

Care Round	TIME	17		14		16		18		20		22		24												
Are you comfortable? Anything you need? e.g toilet / drink or snack/ oral supplement / painkillers etc. (update nursing charts as required)		✓		✓		✓		✓		✓		✓		✓												
Nurse call system/ drink/ tissues etc within reach?		✓		✓		✓		✓		✓		✓		✓												
Is this patient more confused, agitated, sleepy or withdrawn **(THINK DELIRIUM)**		N		N		N		N		N		N		N												

Re-position frequency required ..... **hourly** **Maximum Seating Time** .....**hrs**

SKIN CHART

Pressure Relief	TIME																									
Check any powered mattress is working																										
Mobilise/ Reposition Code (State CODE in box)																										
Check **ALL** pressure areas- incude heels and toes																										
Heel protectors in place/ correct seating and cushion (if applicable)																										
Check antiembolic stockings are prescribed on the TPAR and review need **daily**																										
If antiembolic stockings prescribed check heels and toes **8 hourly**																										
Skin is free from wetness or incontinence																										
Dry skin is moistened with emollients																										
Initials		AD		LB		LK		L				CR		CR												

CODES

W	Patient Walking	L	Left lateral 30 degree tilt	R	Right lateral 30 degree tilt	P	Prone (front)	B	Back (knee section raised)
C	Sitting in chair	CP	Pressure relieved in chair	A	Asleep	BA	Angle of Bed changed	T	Toilet assistance
N/C	Patient declined	M	Mealtime	O	Off ward	S	Stand	PT/ OT	Physio/ OT

* Follow NHST Policy for the prevention and management of pressure ulcers. For Variance in any section, document care and progress in the record of ongoing care using relevant codes.

** Agree with the patient when the next care intervention is due and encourage to contact nurse beforehand if required.

NHS TAYSIDE

24 HOUR SKIN* and Care Round** Record Sheet

Ward..... 36 ..... Hospital .. N/W .....

SKIN Chart required Y N (circle)

MATTRESS TYPE- High Specification Foam ☐

Invacare Active ☐ Other state _____

Pressure Ulcer Treatment Plan A B C (circle)

PATIENT DETAILS

(Affix Label)

NAME Stacey Ellis

CHI

DOB 28048800600

Agree frequency with patient **

1 / 2 / 3 / 4 hourly

(Please Circle)

Date/s ..16/8/16.... **Mark each box with TICK or N/A or I (intervention) If Intervention given record in ongoing record of care ***

CARE ROUND

Care Round	TIME	2		4		6		8		10		12		14		16		18		20		22		24	
Are you comfortable? Anything you need? e.g toilet / drink or snack/ oral supplement / painkillers etc. (update nursing charts as required)		✓		✓				✓		0		✓		✓		✓									
Nurse call system/ drink/ tissues etc within reach?		✓		✓				✓		0		✓		✓		✓									
Is this patient more confused, agitated, sleepy or withdrawn **(THINK DELIRIUM)**		N		N				N		0		N		N		N									
Re-position frequency required ..... **hourly** **Maximum Seating Time** .....**hrs**																									
Pressure Relief	TIME																								
Check any powered mattress is working																									
Mobilise/ Reposition Code (State CODE in box)																									
Check **ALL** pressure areas- incude heels and toes																									
Heel protectors in place/ correct seating and cushion (if applicable)																									
Check antiembolic stockings are prescribed on the TPAR and review need **daily**																									
If antiembolic stockings prescribed check heels and toes **8 hourly**																									
Skin is free from wetness or incontinence																									
Dry skin is moistened with emollients																									
Initials		VK		CR				LJ		LJ		LJ		LJ		LJ									

SKIN CHART

CODES

W	Patient Walking	L	Left lateral 30 degree tilt	R	Right lateral 30 degree tilt	P	Prone (front)	B	Back (knee section raised)
C	Sitting in chair	CP	Pressure relieved in chair	A	Asleep	BA	Angle of Bed changed	T	Toilet assistance
N/C	Patient declined	M	Mealtime	O	Off ward	S	Stand	PT/ OT	Physio/ OT

* Follow NHST Policy for the prevention and management of pressure ulcers. For Variance in any section, document care and progress in the record of ongoing care using relevant codes.

** Agree with the patient when the next care intervention is due and encourage to contact nurse beforehand if required.

NEWS KEY	0	1	2	3

NAME:
DOB/CHI:

2804880060
STACEY ELLIS

WARD: 36
ADMISSION DATE: 15/8/16

NHS Tayside

| | | |

BLOOD PRESSURE

MARK AS SHOWN

120 ↕ 60

170										
160										
150										
140										
130										
120										
110	103	109	105	99	90	97	105	108	102	104
100	↕	↕	↕	↕	↕	↕	↕	↕	↕	↕
90	↕	↕	↕	↕	↕	67	67	74	67	63
80	↕	↕	↕	↕	↕					
70	↕	73	68	60	55					
60	64									
50										

CONSCIOUS LEVEL											
ANY CHANGE IN RESPONSE - COMMENCE NEURO OBS - IMMEDIATE MEDICAL REVIEW	Alert	A	A	A	A	A	A	A	A	A	A
	Verbal	V									
	Pain	P									
	Unresponsive	U									
NEWS SCORE (with all obs)			1	1	1	2	5	4	2	2	1	1
Frequency of observations H = Hourly, M = minutes, D = Daily			4'	4'	4	4°	15 min	15 MINS	15 MINS	30 mins	30 MINS	30 MINS
Escalation to medical team/HAN/ANP Y / N / E (exclusion)			N	N	N	N	Y	Y	Y	Y	Y	Y
INITIAL			LJ	LJ	LJ	LJ	LJ	LB	LB	LJ	LJ	LJ
Check patient's Urine Output			Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Consider DELIRIUM - 4AT score			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Blood Glucose			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Pain Score			0	0	0	0	1	0	0	0	0	0
Nausea Score			0	0	0	0	0	0	0	0	0	0
Sedation			0	1	0	0	2	1	1	1	1	1

If observations are expected for patient's clinical condition, please note expected parameters below

	Pulse Rate	Respiratory Rate	SpO2	BP	Temp	
Acceptable Parameters						**Doctors/NP/ANP Sign Date and time**
Discontinue Date and Sign						

DOCUMENT ALL ACTIONS, INTERVENTIONS, EXCLUSIONS AND CLINICAL RESPONSES IN THE NURSING RECORDS

CLINICAL CONCERN SHOULD ALWAYS OVERRIDE NEWS SCORE

NEWS 0	NEWS 1-4	NEWS ≥ 5 OR 3 IN ONE PARAMETER	NEWS ≥ 7
REFER TO LOCAL ACTION AND ESCALATION POLICY MIN 12 HOURLY OBSERVATIONS	MIN 4 HOURLY OBSERVATIONS INFORM REGISTERED NURSE AGREE FREQUENCY OF OBSERVATION REQUIRED RESPONSE WITHIN 60 MINUTES LOW CLINICAL RISK	MIN HOURLY OBSERVATIONS URGENT ASSESSMENT BY MEDICAL TEAM STRUCTURED RESPONSE THINK SEPSIS RESPONSE WITHIN 30 MINUTES MEDIUM CLINICAL RISK	CONTINUOUS MONITORING URGENT ASSESSMENT BY SENIOR MEDICAL TEAM STRUCTURED RESPONSE CONSIDER 2222 RESPONSE WITHIN 15 MINUTES HIGH CLINICAL RISK

REFER TO LOCAL ACTION AND ESCALATION POLICY

RECOGNISE PAIN

PAINGO **at least** once per shift

Assessment

0 No pain at rest or on movement
1 No pain at rest, slight on movement
2 Intermittent pain at rest, moderate on movement
3 Continuous pain at rest, severe on movement

If 2 or 3 repeat PAINGO to guide intervention

use ABBEY tool if patient unable to report pain

If 8 or above repeat PAINGO to guide intervention

NAUSEA AND VOMITING SCORE

(see post op nausea and vomiting guidelines)

0 No nausea and vomiting
1 Nausea only
2 Vomiting once
3 Vomiting more than once

Intervene at score 1, 2 or 3

SEDATION SCORE

0 None (patient alert)
1 Mild (occasionally drowsy, easy to rouse)
2 Moderate (frequently drowsy, easy to rouse)
3 Severe (somnolent, difficult to rouse)

Intervene at score 3

THINK - UNCONTROLLED PAIN?

THB(MR) 024SS

NHS Tayside

DATE OF ADMISSION _____
RECORD START DATE _____

TAYSIDE PRESCRIPTION AND ADMINISTRATION RECORD (SHORT STAY)

EARLY MEDICAL/INCOMPLETE MISCARRIAGE

Hospital /Ward: NINEWELLS 41	**Patien** ELLIS 2804880060 STACEY F 3 MILL PLACE CRAIGO MONTROSE DD10 9LB DR RUTH CRANSWICK ANNAT BANK, LINKS HEALTH CENTRE, FRAN
Consultant: JG.	**CHI nu**
On admission: **Weight:** **Height:**	**Date c** (Attac… printed label… here)

CONFIRMATION OF PRESCRIPTION REVIEW ON TRANSFER OF MEDICAL CARE

Receiving Unit	Date	Authorised Prescriber (Signature)

Date									
Weight									
Signature									

U13404486
134 6/12

ONCE ONLY PRESCRIPTIONS

Date	Time	Medicine	Dose	Route	Prescribed By	Time Given	Given By
29/12/09		MIFEPRISTONE	200mg	ORAL	[illegible]	1500	[signature]
30/12/09		MISOPROSTOL	800 MICROGRAM	PV	PAS	0840	[signature]
30/12/09		METRONIDAZOLE	1g	PR	PAS	0840	[signature]
30/12/09		AZITHROMYCIN	4x250mg	ORAL	PAS	TTA	[signature]
30/12/09		DICLOFENAC	100mg	PR	PAS	0840	[signature]
30/12/09		Depoprovera	150mg	IM	PAS	1210	[signature]

KNOWN MEDICINE ALLERGIES/ SENSITIVITIES (if NONE confirmed write NKA in Box 1)

1.	2.	3.	4.
Latex.			

OTHER MEDICINE CHARTS IN USE

Chart Type	Signed	Chart Type	Signed
1. Insulin		5. Anticoagulant	
2. Epidural / Pain relief		6. Mental Health Act	
3. Fluid		7. Symptomatic Relief Administration Record	
4. Anaesthetic Chart		8. Other	

AS REQUIRED THERAPY

Medicine / Form **CO-CODAMOL 30/500 TAB**		Date											
		Time											
Dose & Frequency **1-2 TAB 4-6 HOURS**	Route **ORAL**	Dose											
		Initials											
Signature PA	Start Date	Date											
		Time											
Indication / Notes **MAXIMUM 8 TAB IN 24 HOURS**	Pharmacy	Dose											
		Initials											

Medicine / Form **CYCLIMORPH INJECTION**		Date											
		Time											
Dose & Frequency **15mg 3-4 HOURS**	Route **I/M**	Dose											
		Initials											
Signature PA	Start Date	Date											
		Time											
Indication / Notes **MAX 3 DOSES IN 24 HOURS**	Pharmacy	Dose											
		Initials											

Medicine / Form **DICLOFENAC SUPP**		Date											
		Time											
Dose & Frequency **50mg EVERY 8 HOURS**	Route **PR**	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication / Notes **MAX 3 DOSES IN 24 HOURS**	Pharmacy	Dose											
		Initials											

Medicine / Form		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication/ Notes	Pharmacy	Dose											
		Initials											

Medicine / Form		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start date	Date											
		Time											
Indication / Notes	Pharmacy	Dose											
		Initials											

Medicine / Form		Date											
		Time											
Dose & Frequency	Route	Dose											
		Initials											
Signature	Start Date	Date											
		Time											
Indication / Notes	Pharmacy	Dose											
		Initials											

FOR PHARMACY USE:

Checked by

Clinical Pharmacist

Patient Counselled

(Inits)

DISCHARGE NOTIFICATION AND PRESCRIPTION FORM

..... Hosp./Inf.

To Dr. .....

.....

.....

Ward/Clinic/

Hosp. ..... Cons.

Surname .....

First Name ..... M. State

Address ..... Sex

.....

G.P. & Address (G.P. Requests

ELLIS 2804880060
STACEY F
8 MILL PLACE
CRAIGO DD10 9LB
MONTROSE
DR RUTH CRANSWICK
ANNAT BANK, LINKS HEALTH CENTRE, FRAN

C.H.I. No. .....

USE BLOCK LETTERS OR PATIENT LABEL

THIS IS THE *ONLY / *INTERIM DISCHARGE LETTER (to be completed by Discharging Doctor).

Date Placed on Waiting List ..... Date of Admission: .....
(if appropriate)
*Delete as appropriate

..... 2nd Fold .....

DISCHARGE DETAILS	DATE	SPECIALITY	CONSULTANT	DISCHARGED TO	TRANSFERRED TO: HOSPITAL	SPECIALITY	CONSULTANT
	10/9/09	Gynaecology					

When Medicines are to be dispensed **all** copies to be sent to Pharmacy

DIAGNOSIS AND OPERATIONS

PRINCIPAL DIAGNOSIS:

PRINCIPAL OPERATION / PROCEDURES: Diagnostic Laparoscopy.

OTHER CONDITIONS:

OTHER OPERATIONS / PROCEDURES:

MEDICINE TREATMENT ON DISCHARGE				Times of Administration (Mark ✓)											DISPENSED BY PHARMACY	
Days	NAME — State Date when Medicines should be stopped	DOSE	STOP DATE	8	10	12	14	16	18	20	22	24			Number	Brand Names (for information only)
5	CO-DYDRAMOL	1T 4hly													20	
5	IBUPROFEN	400mg 6hly														

.... 1st Fold .....

Approx. 5 days supply is usually dispensed. Where the period is different, indicate the number of days in box provided.

TREATMENT RECOMMENDED AND ADDITIONAL INFORMATION

No follow up

Discharge Prescriptions should normally be sent to pharmacy at least 24 hours before discharge.

CONDITION ON DISCHARGE

COMPLETELY AMBULANT ☐ CONFINED TO HOUSE ☐ PARTIALLY BEDRIDDEN ☐ CONFINED TO BED ☐

FOLLOW-UP APPOINTMENTS

DATE	TIME	CLINIC	SPECIALITY	DELETE AS APPROPRIATE
				GIVEN/TO BE SENT
				GIVEN/TO BE SENT
				GIVEN/TO BE SENT

FOR FURTHER INFORMATION CONTACT

1. ..... Consultant
2. ..... Sen. Registrar/Registrar
3. ..... Ward/Unit Secretary Telephone ..... Ext. .....

TO PHARMACY MEDICINES REQUIRED ON WARD AT ..... (TIME) .....

Signature ..... Status .....

for ..... Consultant Date 10/09/2009

Dispensed By .....
Checked By .....
Date .....

Final Distribution

WHITE - G.P.
PINK - General Office Medical Records
YELLOW - Case Records
BLUE - Pharmacy

THB(MR)26 DTH
4 Part Set

PLEASE PRESS FIRMLY WITH A F. TIPPED BALLPOINT PEN

NEONATAL RECORD (Revised 1.1.87)

Hospital of Birth (Name or Code No.)

Case Reference No. 3 0 4 0 0 0 5 0 6

Maternal Reference No. 2 1 1 6 6 3 9 3 16

Surname LEWIS 25

Infant Forenames STACY

Telephone No.

Home Address

Post Code 3 0 1 3 3 Y 39

Religion CHRIST Occupation of Mother

Father's Age 28 Occupation of Father

Family Doctor

Address

Telephone No.

MATERNAL RECORD

Age 20 Parity (Previous) Nos L B 1 S B Abor 1

Marital Status 1. Married 2. Single 8. Other 9. N/K

Health in Pregnancy (1.) Normal Abnormal

Specify

Drugs in Pregnancy Gestation

Previous Obstetric History

	Place	Gest.	Delivery	Sex	B W	Outcome
1						
2						
3						
4						

SEROLOGY

	Blood Group		Antibody		W.R./Kahn
	ABO	Rh	Type	Titre	
Mother					

Rh Genotype

Amniocentesis

Infant Blood Group

1. O Rh –ve
2. O Rh +ve
3. A Rh –ve
4. A Rh +ve
5. B Rh –ve
6. B Rh +ve
7. AB Rh –ve
8. AB Rh +ve
9. N/K

Coombs Test 1. Positive 2. Negative 9. N/K 48

Family History

LABOUR RECORD

Onset (1) Spontaneous 2. Induced 3. Nil 9. N/K

Duration 1st Stage 5 ½ hrs 2nd Stage

Marital Status 1. Married 2. No. Married 3. Not Stated 4. Not Registered 9. N/K 54

Drugs Given (1) Analgesia 2. Anaesthetic 8. Other 9. N/K

Specify

Drugs given in labour

Mode of Delivery

(1) Vertex 3. Forceps Low 6. Caesarean
2. Manipulation 4. Forceps Other 8. Other
5. Breech 5. Ventouse 9. N/K

Comments

Complication of Delivery (Specify)

Placenta Weight

Condition (1.) Normal 2. Abnormal 3. Doubtful 9. N/K

BIRTH RECORD

Specify Place (1.) Hospital 2. Home 8. Other 9. N/K 1 55

EDD 19/6/87 Sure Not Sure N/K

Gestation (by dates) 40 56

Membrane Rupture/Delivery Interval

Time Hrs. Date of Birth 2/6/87 60

Apgar Score 1 min. 8 min. (for 9 and 10 enter 9) 8 7 64

Time to First Breath (mins.) 68

Time to Established Respiration (mins.) 68

Resuscitation

(1) Mask/clear airway, funnel O2
2. Mask, IPPV (no drugs)
3. Mask, IPPV (with drugs)
4. Intubation IPPV (no drugs)
5. Intubation, IPPV (with drugs)
6. Drugs only Specify:
8. Other 9. N/K 1 70

Birth Weight (g) 3 4 5 0 71

Number of births this pregnancy and Birth Order NUMBER BIRTH ORDER 1 1 75

Sex 1 Male (2) Female 9. N/K 2 77

O.F.C. cm 33.0 78

Length Crown-heel 50.3 cm. 50.0 80

(Optional Purposes) 92 82

No. of Umbilical Vessels 3 84

Apgar Level Specific Assessment at more or more intervals (Comma code Results) 99 86

Cyanotic Type 1 Yes 2 No 9 N/K 2 88

Transferred within Hospital (Y/N) 90

Type 1 Nursery 2 Post Natal Cot 3 SCBU 8 Other 9 N/K 1st 2 2nd 0

Number of Days in SCBU 00

Normal	Abn.	Doubtful	N/K
1	2	3	9

Date 29/1/96 Signature

Exam. First

Final

Head, Face, Eyes, Ears, Nose, Mouth, Palate, Neck, Skin, Umbilicus, Heart sounds, Heart rate/rhythm, Chest, Abdomen, Spleen, Liver, Kidneys, Genitalia, Anus, Spine, Arms, Hands, Legs, Feet, Hips, Movement, Tone, Grasp, Moro, Cry (not heard (1-3))

Jaundice (bilirubin mg%: umol/l) 1. Absent 2. Mild (5.–11.9, 86.–204) or not measured 3. Moderate (12.0–19.9: 205–340) 4. Severe (20.0+: 342+) 9. N/K 115

Absent	Present	N/K
1	2	9

Any age

Infection 117
Significant Hypotonia 118
Cyanosis (Central) 119
Oedema 120
Convulsions 121
Recurrent Apnoea 122
Assisted Ventilation after 30 mins 123
Feeding Difficulty 124
Vomiting 125
Diarrhoea 126

TRANSFER BETWEEN HOSPITALS (Neonatal Only)

TRANSFER 1

Receiving Hospital Code No. 127
Case Reference No. 132
Paediatrician or G.P. 142
Date of Admission 149
Admitted to 1. Post Natal Cot 2. SCBU 8. Other 155
Number of days in SCBU 156

TRANSFER 2

Receiving Hospital Code No. 158
Case Reference No. 163
Paediatrician or G.P. 173
Date of Admission 180
Admitted to 1. Post Natal Cot 2. SCBU 8. Other 185
Number of days in SCBU 187

DISCHARGE RECORD

Feed 1. Breast 2. Bottle 3. Breast and Comp. 4. Not Applicable 8. Other 9. N/K 189

Condition 1. Normal 2. Doubtful 3. Cong. Abn. 4. Dead 5. Dead P.M. 6. Cong. Abn. & Other 8. Other 9. N/K 190

Discharge (Final)
1. Home with Mother
2. Home after Mother
3. To care of relative
4. To other ward or hospital
5. Residential or Foster care
6. Dead
8. Other
9. N/K 191

Age (Days) 3

Date of Discharge 29/1/96

Weight at Discharge 2450 192

DIAGNOSIS

RESOLUTION -V30 200

Operations (2 only) 1. 2.

PAIN ASSESSMENT CHART

Date: 10-9-09

Operation/Diagnosis: Diagnostic Laparoscopy

Ward DSU ..... Chen .....Cons

ELLIS 2804880060
STACEY F
8 MILL PLACE
CRAIGO
MONTROSE DD10 9LB
DR RUTH CRANSWICK
ANNAT BANK, LINKS HEALTH CENTRE, FRAN

Nursing Checks – Same as routine post-op
i.e. – 1 hourly/4 hourly

(Please note – The information on the back of this sheet will help you fill this section correctly)

te 10-9-09	Time	Resp Rate	Pain Score	Sed Score	Sickness Score	Analgesic/Antiemetic Intervention (Dose & Time)	Initial
1245		14	0	0-1	0		P.N
	1300	22	0	0-1	0		P.N
	1315	23	0	1	0		P.N
	1330	21	0	0	0		P.N
	1345	21	0-1	0	0	1355 1gram Paracetamol given	P.N

NURSING CHECKS

. Respirations: If respiratory rate falls below 10/minute, ensure patient has oxygen and inform resident doctor.

. Pain Score:

Score 0 = No Pain at Rest
No Pain on Movement

Score 1 = No Pain at Rest
Slight Pain on Movement

Score 2 = Intermittent Pain at Rest
Moderate Pain on Movement

Score 3 = Continuous Pain at Rest
Severe Pain on Movement

. Sedation Score:

Score 0 = None (Patient Alert)

Score 1 = Mild (Occasionally drowsy; easy to arouse)

Score 2 = Moderate (Frequently drowsy; easy to arouse)

Score 3 = Severe (Somnolent; difficult to arouse)

Score S = Sleep (Normal sleep; easy to arouse)

. Sickness Score:

Score 0 = None

Score 1 = Mild – no treatment required

Score 2 = Moderate – helped by treatment

Score 3 = Severe – despite treatment

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Tayside Diagnostic Services

Printed by cgarnes (Claire Garnes (non referrer)) at 24 Jun 2026 18:09

Patient name:	**STACEY LEONARD**	CHI Number:	**2804880060**	Sex:	**Female**
Date of birth:	**28 Apr 1988**	:			
Address:	**2 Wards Road, Brechin DD9 7AS**				

Report 1/22

Reported	Specialty	Location	Clinician
09 May 2013 08:03	Microbiology	NW WARD 37	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:36

CLINICAL DETAILS :
28+1wks PREG. ?Urinary Tract Infection. PROT, LEUCO+++.

Sample 13B279629 (Midstream Urine) Collected 07 May 2013 20:30 Received 08 May 2013 09:12

Urine Culture:

No Growth

Report 2/22

Reported	Specialty	Location	Clinician
07 May 2013 19:49	Blood Sciences	NW WARD 37	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:36

CLINICAL DETAILS :
28+1 weeks pregnant Breast abscess which burst today. ?contracting.

Sample C132173362 (Blood) Collected 07 May 2013 19:10 Received 07 May 2013 19:19

C-REACTIVE PROTEIN

C-REACTIVE PROTEIN	LT4	mg/L	0 - 10

Report 3/22

Reported	Specialty	Location	Clinician
07 May 2013 19:31	Blood Sciences	NW WARD 37	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:36

CLINICAL DETAILS :
28+1 weeks pregnant Breast abscess which burst today. ?contracting.

Sample H132173362 (EDTA) Collected 07 May 2013 19:10 Received 07 May 2013 19:19

FBC

Hb	*	**10.5**	g/dL	12.0 - 16.0
WBC	*	**14.9**	x10^9/L	4.0 - 11.0
PLT		275	x10^9/L	150 - 400
RBC	*	**3.73**	x10^12/L	3.8 - 4.8
HCT	*	**0.325**		0.37 - 0.47

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

MCV		87.2	fl	85 - 105
MCH		28.1	pg	27 - 32
MCHC		32.2	g/dL	32 - 36
NE#	*	**11.4**	x10^9/L	2.0 - 7.5
LY#		2.6	x10^9/L	1.5 - 4.0
MO#		0.6	x10^9/L	0.2 - 0.8
EO#		0.16	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

Report 4/22

Reported	Specialty	Location	Clinician
06 May 2013 09:11	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:40

```
Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)
```

Sample 10310017710310 (BLOOD) Collected 03 May 2013 11:30 Received 03 May 2013 17:07

Automated Antibody Screen

Automated Antibody Screen	Negative	

Report 5/22

Reported	Specialty	Location	Clinician
03 May 2013 18:02	Blood Sciences	MONTROSE RI ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

```
CLINICAL DETAILS :
  28 weeks gestation.
```

Sample C132167088 (Fluoride Oxalate) Collected 03 May 2013 12:24 Received 03 May 2013 17:16

GLUCOSE

GLUCOSE (preserved tube)		3.8	mmol/L	3.3 - 5.8

Report 6/22

Reported	Specialty	Location	Clinician
03 May 2013 17:38	Blood Sciences	MONTROSE RI ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

```
CLINICAL DETAILS :
  28 weeks gestation.
```

Sample H132167088 (EDTA) Collected 03 May 2013 12:24 Received 03 May 2013 17:16

FBC

Hb	*	**11.1**	g/dL	12.0 - 16.0
WBC	*	**13.0**	x10^9/L	4.0 - 11.0
PLT		248	x10^9/L	150 - 400
RBC	*	**3.70**	x10^12/L	3.8 - 4.8
HCT	*	**0.328**		0.37 - 0.47

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

MCV		88.5	fl	85 - 105
MCH		29.9	pg	27 - 32
MCHC		33.8	g/dL	32 - 36
NE#	*	**9.6**	x10^9/L	2.0 - 7.5
LY#		2.5	x10^9/L	1.5 - 4.0
MO#		0.7	x10^9/L	0.2 - 0.8
EO#		0.15	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

Report 7/22

Reported	Specialty	Location	Clinician
19 Apr 2013 09:55	Microbiology	MONTROSE RI ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

CLINICAL DETAILS :
25+ heavy discharge.

Sample 13B504128 (HIGH VAGINAL SWAB) Collected 16 Apr 2013 18:28 Received 17 Apr 2013 13:58

Genital Swabs

Trich. No Trichomonas

Culture:

Culture:

No Candida Isolated
Clue cells seen on microscopy
Consistent with Gardnerella infection

Report 8/22

Reported	Specialty	Location	Clinician
11 Apr 2013 08:04	Microbiology	MONTROSE RI ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

CLINICAL DETAILS :
24 weeks symptomatic of UTI. leucocytes++ nitrates++.

Sample 13B272710 (Midstream Urine) Collected 09 Apr 2013 11:45 Received 10 Apr 2013 09:07

Urine Culture:

No Growth

Report 9/22

Reported	Specialty	Location	Clinician
07 Feb 2013 09:24	Microbiology	MONTROSE RI ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

CLINICAL DETAILS :
symptomatic of UTI and vaginal thrush. 15 weeks pregnant.

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Sample 13B460817 (HIGH VAGINAL SWAB) Collected 04 Feb 2013 18:32 Received 05 Feb 2013 14:14

Genital Swabs

Trich. No Trichomonas

Culture:

Culture:

No Candida Isolated

Report 10/22

Reported	Specialty	Location	Clinician
06 Feb 2013 08:20	Microbiology	MONTROSE RI ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

CLINICAL DETAILS :
symptomatic of UTI and vaginal thrush. 15 weeks pregnant.

Sample 13B257327 (Midstream Urine) Collected 04 Feb 2013 18:32 Received 05 Feb 2013 13:01

Urine Culture:

No Growth

Report 11/22

Reported	Specialty	Location	Clinician
18 Jan 2013 15:52	Blood Sciences	MONTROSE RI ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

CLINICAL DETAILS :
booking sample.

LAB COMMENTS :
FOQ NOT FILLED IN CORRECTLY. PLEASE CONTACT LAB ON
EXT 32659 IF SCREENING IS REQUIRED.

Sample H131914267 (EDTA) Collected 14 Jan 2013 14:44 Received 14 Jan 2013 18:47

FBC

Hb		12.9	g/dL	12.0 - 16.0
WBC	*	**11.9**	x10^9/L	4.0 - 11.0
PLT		254	x10^9/L	150 - 400
RBC		4.15	x10^12/L	3.8 - 4.8
HCT		0.378		0.37 - 0.47
MCV		91.0	fl	85 - 105
MCH		31.0	pg	27 - 32
MCHC		34.1	g/dL	32 - 36
NE#	*	**8.5**	x10^9/L	2.0 - 7.5
LY#		2.6	x10^9/L	1.5 - 4.0
MO#		0.6	x10^9/L	0.2 - 0.8
EO#		0.20	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

HAEMOGLOBINOPATHY

HbA0	-	%	

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

HbA2	-	%
HbF	-	%
Hb Variant	-	%

Report 12/22

Reported	Specialty	Location	Clinician
16 Jan 2013 08:17	Microbiology	MONTROSE RI ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

CLINICAL DETAILS :
booking sample.

Sample 13B251808 (Midstream Urine) Collected 14 Jan 2013 14:44 Received 15 Jan 2013 08:23
Urine Culture:

No Growth

Report 13/22

Reported	Specialty	Location	Clinician
15 Jan 2013 13:00	Microbiology	MONTROSE RI ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

CLINICAL DETAILS :
booking sample.

Sample 13V000788 (Venous blood) Collected 14 Jan 2013 14:44 Received 15 Jan 2013 09:10

Hepatitis B (HBsAg) screen:		
	Hepatitis B (HBsAg) screen	Negative
HIV1&2 Antigen/Antibody:		
	HIV1&2 Antigen/Antibody	Negative
Rubella IgG:		
	Rubella IgG	DETECTED
Syphilis total antibody:		
	Syphilis total antibody	Negative

Report 14/22

Reported	Specialty	Location	Clinician
15 Jan 2013 11:35	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:39

Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)
Please send a sample at 28 to 30 weeks

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Sample 10310016493314 (BLOOD) Collected 14 Jan 2013 13:30 Received 15 Jan 2013 08:56
Automated Antibody Screen

Automated Antibody Screen		Negative

Report 15/22

Reported	Specialty	Location	Clinician
14 Jan 2013 20:16	Blood Sciences	MONTROSE RI ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

CLINICAL DETAILS :
booking sample.

Sample C131914267 (Fluoride Oxalate) Collected 14 Jan 2013 14:44 Received 14 Jan 2013 18:47
GLUCOSE

GLUCOSE (preserved tube)	*	**2.7**	mmol/L	3.3 - 5.8

Report 16/22

Reported	Specialty	Location	Clinician
06 Aug 2012 09:56	Microbiology	T13585-ANNAT HEALTH CENTRE	Dr GRAHAM A KRAMER (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 06:14

CLINICAL DETAILS :
bilateral otitis externa, both ears. discharging.

Sample 12B527068 (Right Ear Swab) Collected 02 Aug 2012 15:10 Received 03 Aug 2012 08:22
Culture:

Organism	*	**Pseudomonas aeruginosa**
Organism Growth	*	**Profuse Growth**
Gentamicin		S
Ciprofloxacin		S

No Candida Isolated
Cultures for fungi set up
If Positive, Will be Reported later

Report 17/22

Reported	Specialty	Location	Clinician
06 Aug 2012 09:56	Microbiology	T13585-ANNAT HEALTH CENTRE	Dr GRAHAM A KRAMER (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 06:14

CLINICAL DETAILS :
bilateral otitis externa, both ears. discharging.

Sample 12B527067 (Left Ear Swab) Collected 02 Aug 2012 15:10 Received 03 Aug 2012 08:22
Culture:

Organism	*	**Pseudomonas aeruginosa**
Organism Growth	*	**Profuse Growth**
Gentamicin		S
Ciprofloxacin		S

No Candida Isolated

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Report 18/22

Reported	Specialty	Location	Clinician
27 Jul 2012 12:24	Radiology	GENERAL PRACTIONER	Dr GRAHAM A KRAMER (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:10

Sample 4702933 (TYPE UNSPECIFIED) Collected 26 Jul 2012 13:39 Received 26 Jul 2012 13:39
US Pelvis transabdominal

```
Clinical History :
Right iliac fossa pain for 3 weeks, episodic and severe.
OE ( was not in pain at time of examination), thin lady, Abdomen soft, not tender, no
masses. BS normal.
ENTERED BY: Sarab Hanna (Medical)
BLEEP: 67044
US Pelvis transabdominal - Sonographer scan/Sonographer report.
The uterus, adnexae, bladder and both kidneys have been examined and no ultrasonically
detectable abnormality has been demonstrated.
 NICOLA RITCHIE / NICL
```

Report 19/22

Reported	Specialty	Location	Clinician
19 Jul 2012 08:15	Microbiology	T13585-ANNAT HEALTH CENTRE	Dr GRAHAM A KRAMER (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 06:13

```
CLINICAL DETAILS :
  RIF pain for 3 weeks. urine dip Leuco ++.
```

Sample 12B153764 (Midstream Urine) Collected 17 Jul 2012 16:00 Received 18 Jul 2012 08:46
Urine Culture:

```
No Significant Bacteriuria
```

Report 20/22

Reported	Specialty	Location	Clinician
07 Mar 2012 10:59	Microbiology	LINKS HC MINOR INJURIES UNIT - NOT GIVEN	(Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:10

```
CLINICAL DETAILS :
  2week Hx SYMPTOMS UTI. TREATED 2/52 AGO 3day COURSE OF TRIM. POSITIVE NITRATES, BLOOD, PROT, LEUCO.
```

Sample 12B130247 (Urine - Unspecified) Collected 03 Mar 2012 19:30 Received 05 Mar 2012 12:25
Urine Culture:

Organism	*	**Escherichia coli**
Organism Growth	*	**10^5 orgs/ml**
Amoxicillin		R
Trimethoprim		R
Nitrofurantoin		S
Gentamicin		R

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Temocillin	S
Pivmecillinam	S

Report 21/22

Reported	Specialty	Location	Clinician
01 Mar 2012 08:10	Microbiology	T13585-ANNAT HEALTH CENTRE	Dr GRAHAM A KRAMER (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 06:07

CLINICAL DETAILS :
Finished Trimethoprim for Presumed UTI. 5 days ago. Still has urinary Sx. urine. dip leuco +++.

Sample 12B129644 (Midstream Urine) Collected 29 Feb 2012 11:48 Received 29 Feb 2012 17:12
Urine Culture:

No Significant Bacteriuria

Report 22/22

Reported	Specialty	Location	Clinician
24 Feb 2012 08:04	Microbiology	T13585-ANNAT HEALTH CENTRE	- NOT GIVEN (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 06:07

CLINICAL DETAILS :
?Urinary Tract Infection.

Sample 12B128276 (Urine - Unspecified) Collected 22 Feb 2012 11:00 Received 23 Feb 2012 08:08
Urine Culture:

No Significant Bacteriuria

End of reports

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Tayside Diagnostic Services

Printed by cgarnes (Claire Garnes (non referrer)) at 24 Jun 2026 18:10

Patient name:	**STACEY LEONARD**	CHI Number:	**2804880060**	Sex:	**Female**
Date of birth:	**28 Apr 1988**	:			
Address:	**2 Wards Road, Brechin DD9 7AS**				

Report 1/30

Reported	Specialty	Location	Clinician
21 Jan 2015 08:42	Microbiology	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:11

CLINICAL DETAILS :
Extra details: latex
+++ leuco abdo pain back pain

Sample 15B204132 (Midstream Urine) Collected 20 Jan 2015 12:02 Received 20 Jan 2015 17:07

Urine Culture:

No Growth

Report 2/30

Reported	Specialty	Location	Clinician
20 Jan 2015 19:55	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:57

Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)

Sample 10310024398702 (BLOOD) Collected 20 Jan 2015 11:00 Received 20 Jan 2015 17:47

Automated Antibody Screen

Automated Antibody Screen	Negative		

Report 3/30

Reported	Specialty	Location	Clinician
20 Jan 2015 17:58	Blood Sciences	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:11

CLINICAL DETAILS :
29 weeks, +++ leucocytes, ++ discharge, abdo pain back pain

Sample C153583558 (Fluoride Oxalate) Collected 20 Jan 2015 11:55 Received 20 Jan 2015 16:53

GLUCOSE

GLUCOSE (preserved tube)	3.9	mmol/L	3.3 - 5.8

Report 4/30

Reported	Specialty	Location	Clinician
20 Jan 2015 17:40	Blood Sciences	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:11

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

CLINICAL DETAILS :
29 weeks, +++ leucocytes, ++ discharge, abdo pain back pain

Sample H153583558 (EDTA) Collected 20 Jan 2015 11:55 Received 20 Jan 2015 16:53

FBC

Hb	*	**111**	g/L	120 - 160
WBC	*	**12.9**	x10^9/L	4.0 - 11.0
PLT		276	x10^9/L	150 - 400
RBC		3.91	x10^12/L	3.8 - 4.8
HCT	*	**0.340**		0.37 - 0.47
MCV		86.9	fl	85 - 105
MCH		28.3	pg	27 - 32
MCHC		325	g/L	320 - 360
NE#	*	**9.5**	x10^9/L	2.0 - 7.5
LY#		2.3	x10^9/L	1.5 - 4.0
MO#		0.6	x10^9/L	0.2 - 0.8
EO#		0.24	x10^9/L	0.0 - 0.4
BA#	*	**0.2**	x10^9/L	0.0 - 0.1

Report 5/30

Reported	Specialty	Location	Clinician
24 Dec 2014 09:27	Microbiology	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:10

CLINICAL DETAILS :
green discharge pv. ++ leucocytes

Sample 14B520778 (HIGH VAGINAL SWAB) Collected 19 Dec 2014 18:23 Received 22 Dec 2014 12:38

Microscopy

-

No Trichomonas
No Clue cells seen

Culture:

Culture:

No growth of pathogenic bacteria
No Candida Isolated

Report 6/30

Reported	Specialty	Location	Clinician
22 Dec 2014 14:21	Microbiology	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:10

CLINICAL DETAILS :
Extra details: nka
green discharge pv. ++ leucocytes

Sample 14B292598 (Midstream Urine) Collected 19 Dec 2014 18:23 Received 22 Dec 2014 14:19

Urine Culture:

Urine too old on receipt.

Report 7/30

Reported	Specialty	Location	Clinician
10 Dec 2014 08:05	Microbiology	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:10

CLINICAL DETAILS :
24/40 PREGNANT

Sample 14B289228 (Midstream Urine) Collected 09 Dec 2014 00:00 Received 09 Dec 2014 13:54
Urine Culture:

No Significant Bacteriuria

Report 8/30

Reported	Specialty	Location	Clinician
21 Aug 2014 08:13	Microbiology	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:10

CLINICAL DETAILS :
Routine AN booking bloods and MSSU

Sample 14B260006 (Midstream Urine) Collected 19 Aug 2014 15:44 Received 20 Aug 2014 10:35
Urine Culture:

No Significant Bacteriuria

Report 9/30

Reported	Specialty	Location	Clinician
20 Aug 2014 13:02	Microbiology	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:10

CLINICAL DETAILS :
Routine AN booking bloods and MSSU

Sample 14V019146 (Venous blood) Collected 19 Aug 2014 15:45 Received 20 Aug 2014 09:02

Hepatitis B (HBsAg) screen:		
	Hepatitis B (HBsAg) screen	Negative
HIV1&2 Antigen/Antibody:		
	HIV1&2 Antigen/Antibody	Negative
Rubella IgG:		
	Rubella IgG	DETECTED
Syphilis total antibody:		
	Syphilis total antibody	Negative

Report 10/30

Reported	Specialty	Location	Clinician
20 Aug 2014 12:10	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:53

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

```
  Blood Group: O POSITIVE
  ABO : O
  Rh D : Positive
  Antibody Status : NAD (No Antibodies Detected)
  Please send a sample at 28 to 30 weeks
```

Sample 10310022873820 (BLOOD) Collected 19 Aug 2014 15:45 Received 19 Aug 2014 19:07

Automated Antibody Screen

Automated Antibody Screen	Negative	

Report 11/30

Reported	Specialty	Location	Clinician
19 Aug 2014 19:09	Blood Sciences	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:10

```
CLINICAL DETAILS :
  Routine AN booking bloods and MSSU
```

Sample C143244603 (Fluoride Oxalate) Collected 19 Aug 2014 15:45 Received 19 Aug 2014 18:27

GLUCOSE

GLUCOSE (preserved tube)		4.5	mmol/L	3.3 - 5.8

Report 12/30

Reported	Specialty	Location	Clinician
19 Aug 2014 18:44	Blood Sciences	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:10

```
CLINICAL DETAILS :
  Routine AN booking bloods and MSSU
```

Sample H143244603 (EDTA) Collected 19 Aug 2014 15:45 Received 19 Aug 2014 18:27

FBC

Hb		135	g/L	120 - 160
WBC	*	**14.0**	x10^9/L	4.0 - 11.0
PLT		281	x10^9/L	150 - 400
RBC		4.47	x10^12/L	3.8 - 4.8
HCT		0.397		0.37 - 0.47
MCV		88.8	fl	85 - 105
MCH		30.1	pg	27 - 32
MCHC		339	g/L	320 - 360
NE#	*	**9.1**	x10^9/L	2.0 - 7.5
LY#		4.0	x10^9/L	1.5 - 4.0
MO#		0.7	x10^9/L	0.2 - 0.8
EO#		0.19	x10^9/L	0.0 - 0.4
BA#		0.1	x10^9/L	0.0 - 0.1

Report 13/30

Reported	Specialty	Location	Clinician
15 Jul 2013 13:52	Blood Sciences	MONTROSE RI ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

```
CLINICAL DETAILS :
  raised white cell count post birth - now 3 days postnatal.
```

Sample H132325073 (EDTA) Collected 14 Jul 2013 19:26 Received 15 Jul 2013 13:04

FBC

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Hb	*	**11.0**	g/dL	12.0 - 16.0
WBC	*	**12.3**	x10^9/L	4.0 - 11.0
PLT	*	**457**	x10^9/L	150 - 400
RBC		4.47	x10^12/L	3.8 - 4.8
HCT	*	**0.356**		0.37 - 0.47
MCV	*	**79.5**	fl	85 - 105
MCH	*	**24.7**	pg	27 - 32
MCHC	*	**31.0**	g/dL	32 - 36
NE#		7.1	x10^9/L	2.0 - 7.5
LY#		3.9	x10^9/L	1.5 - 4.0
MO#		0.8	x10^9/L	0.2 - 0.8
EO#	*	**0.45**	x10^9/L	0.0 - 0.4
BA#		0.1	x10^9/L	0.0 - 0.1

Report 14/30

Reported	Specialty	Location	Clinician
15 Jul 2013 10:31	Microbiology	NW LABOUR SUITE	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:45

CLINICAL DETAILS :
para 2/0 SVD offensive smell at delivery.

Sample 13B421148 (SWAB - Exudates) Collected 11 Jul 2013 12:15 Received 11 Jul 2013 16:02

Culture:

Organism	*	**Mixed Anaerobes**
Organism Growth	*	**Profuse Growth**
Metronidazole		S

Report 15/30

Reported	Specialty	Location	Clinician
14 Jul 2013 12:47	Microbiology	NW LABOUR SUITE	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:45

CLINICAL DETAILS :
??PROM at 37+2 weeks.

Sample 13B509421 (HIGH VAGINAL SWAB) Collected 10 Jul 2013 22:42 Received 11 Jul 2013 10:21

Genital Swabs

Trich.		No Trichomonas

Culture:

Organism	*	**Mixed Anaerobes**
Organism Growth	*	**Profuse Growth**
Metronidazole		S

No Candida Isolated

Report 16/30

Reported	Specialty	Location	Clinician
13 Jul 2013 11:55	Microbiology	NW LABOUR SUITE	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:45

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

CLINICAL DETAILS :
Otitis type: Otitis externa. para 2/0 SVD offensive smell at delivery.

Sample 13B421149 (Right Ear Swab) Collected 11 Jul 2013 12:15 Received 11 Jul 2013 16:02
Culture:

No Growth
Cultures for fungi set up
If Positive, Will be Reported later

Report 17/30

Reported	Specialty	Location	Clinician
13 Jul 2013 09:11	Microbiology	MONTROSE RI ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

CLINICAL DETAILS :
37+2, +leuc, +glucose.

Sample 13B295752 (Midstream Urine) Collected 10 Jul 2013 18:15 Received 12 Jul 2013 09:51
Urine Culture:

No Growth

Report 18/30

Reported	Specialty	Location	Clinician
12 Jul 2013 14:40	Blood Sciences	NW WARD 38	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:38

CLINICAL DETAILS :
day 1 scd.

Sample H132322778 (EDTA) Collected 12 Jul 2013 11:10 Received 12 Jul 2013 11:28
FBC

Hb	*	**10.6**	g/dL	12.0 - 16.0
WBC	*	**25.0**	x10^9/L	4.0 - 11.0
PLT		375	x10^9/L	150 - 400
RBC		4.22	x10^12/L	3.8 - 4.8
HCT	*	**0.330**		0.37 - 0.47
MCV	*	**78.2**	fl	85 - 105
MCH	*	**25.1**	pg	27 - 32
MCHC		32.1	g/dL	32 - 36
NE#	*	**21.0**	x10^9/L	2.0 - 7.5
LY#		2.9	x10^9/L	1.5 - 4.0
MO#	*	**0.9**	x10^9/L	0.2 - 0.8
EO#		0.14	x10^9/L	0.0 - 0.4
BA#		0.1	x10^9/L	0.0 - 0.1

Film Report:

Film Report:	T] Blood film not examined.

Report 19/30

Reported	Specialty	Location	Clinician
12 Jul 2013 09:52	Microbiology	NW LABOUR SUITE	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:45

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

CLINICAL DETAILS :
SVD offensive smell at delivery.

Sample 13B421147 (Umbilical Swab) Collected 11 Jul 2013 12:17 Received 11 Jul 2013 16:01
Culture:

No Growth

Report 20/30

Reported	Specialty	Location	Clinician
12 Jul 2013 09:52	Microbiology	NW LABOUR SUITE	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:45

CLINICAL DETAILS :
para 2/0 SVD offensive smell at delivery.

Sample 13B421146 (SWAB - Exudates) Collected 11 Jul 2013 12:15 Received 11 Jul 2013 16:01
Culture:

No Growth

Report 21/30

Reported	Specialty	Location	Clinician
11 Jul 2013 01:21	Blood Sciences	NW LABOUR SUITE	Dr Kathleen Wendy MCMULLEN (Obstets & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:45

CLINICAL DETAILS :
For Urgent LUSCS. Previously recurrent APH.

Sample H132318786 (EDTA) Collected 10 Jul 2013 21:40 Received 11 Jul 2013 00:29
FBC

Hb	*	**9.2**	g/dL	12.0 - 16.0
WBC	*	**21.6**	x10^9/L	4.0 - 11.0
PLT		326	x10^9/L	150 - 400
RBC	*	**3.66**	x10^12/L	3.8 - 4.8
HCT	*	**0.292**		0.37 - 0.47
MCV	*	**80.0**	fl	85 - 105
MCH	*	**25.2**	pg	27 - 32
MCHC	*	**31.5**	g/dL	32 - 36
NE#	*	**17.7**	x10^9/L	2.0 - 7.5
LY#		2.7	x10^9/L	1.5 - 4.0
MO#	*	**1.1**	x10^9/L	0.2 - 0.8
EO#		0.11	x10^9/L	0.0 - 0.4
BA#		0.1	x10^9/L	0.0 - 0.1

Coagulation Screen

Prothrombin Time	11.4	secs.	9.5 - 14.0
PT Ratio:	1.0		
APTT	23.0	secs.	22.9 - 34.4
APTT Ratio	0.8		

Report 22/30

Reported	Specialty	Location	Clinician
11 Jul 2013 01:15	Blood Transfusion	New Location	New Clinician (Not Specified)

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:42

```
Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)
```

Sample 10310018466532 (BLOOD) Collected 11 Jul 2013 00:05 Received 11 Jul 2013 00:25

Automated Antibody Screen

Automated Antibody Screen	Negative	

Report 23/30

Reported	Specialty	Location	Clinician
11 Jul 2013 01:09	Blood Sciences	NW LABOUR SUITE	Dr Kathleen Wendy MCMULLEN (Obstets & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:45

```
CLINICAL DETAILS :
  For Urgent LUSCS. Previously recurrent APH.
```

Sample C132318786 (Blood) Collected 10 Jul 2013 21:40 Received 11 Jul 2013 00:29

C-REACTIVE PROTEIN					
	C-REACTIVE PROTEIN		7	mg/L	0 - 10
SODIUM					
	SODIUM		135	mmol/L	133 - 146
POTASSIUM					
	POTASSIUM		3.8	mmol/L	3.5 - 5.3
UREA					
	UREA	*	**1.8**	mmol/L	2.5 - 7.8
CREATININE					
	CREATININE		46	umol/L	44 - 80

Report 24/30

Reported	Specialty	Location	Clinician
25 Jun 2013 08:31	Microbiology	MONTROSE RI ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

```
CLINICAL DETAILS :
  34 WEEKS  LEUCICYTES +.
```

Sample 13B291361 (Midstream Urine) Collected 23 Jun 2013 12:15 Received 24 Jun 2013 17:05

Urine Culture:

```
No Growth
```

Report 25/30

Reported	Specialty	Location	Clinician
11 Jun 2013 13:21	Microbiology	NW OP ANTENATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:35

```
CLINICAL DETAILS :
  PREGNANT 33 WEEKS. 2+ LEU. TRC PRO.
```

Sample 13B287865 (Midstream Urine) Collected 10 Jun 2013 11:55 Received 10 Jun 2013 16:24

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Urine Culture:

No Growth

Report 26/30

Reported	Specialty	Location	Clinician
20 May 2013 09:37	Microbiology	NW WARD 37	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:36

CLINICAL DETAILS :
Abdo pain @ 29 weeks pregnant.

Sample 13B506024 (HIGH VAGINAL SWAB) Collected 15 May 2013 22:08 Received 16 May 2013 12:45

Genital Swabs

Trich.		No Trichomonas

Culture:

Mixed growth of organisms including		
Organism	*	**Mixed Anaerobes**
Organism Growth	*	**Profuse Growth**
Metronidazole		S

No Candida Isolated

Report 27/30

Reported	Specialty	Location	Clinician
17 May 2013 14:23	Microbiology	NW WARD 37	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:36

CLINICAL DETAILS :
Patient phone No.: 07840470020. Abdo pain @ 29 weeks pregnant.

Sample 13V108462 (Urine) Collected 15 May 2013 22:08 Received 16 May 2013 09:48

Chlamydia trachomatis DNA:

Chlamydia trachomatis DNA	Negative

N.gonorrhoeae DNA:

N.gonorrhoeae DNA	Negative

Report 28/30

Reported	Specialty	Location	Clinician
16 May 2013 00:40	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:40

Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)

Sample 10310017841205 (BLOOD) Collected 15 May 2013 22:40 Received 15 May 2013 22:41

Automated Antibody Screen

Automated Antibody Screen	Negative

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Report 29/30

Reported	Specialty	Location	Clinician
15 May 2013 22:36	Blood Sciences	NW WARD 37	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:36

CLINICAL DETAILS :
Abdo pain @ 29 weeks pregnant.

Sample H132194020 (EDTA) Collected 15 May 2013 22:08 Received 15 May 2013 22:23

FBC

Hb	*	**11.0**	g/dL	12.0 - 16.0
WBC	*	**14.2**	x10^9/L	4.0 - 11.0
PLT		299	x10^9/L	150 - 400
RBC		3.84	x10^12/L	3.8 - 4.8
HCT	*	**0.321**		0.37 - 0.47
MCV	*	**83.7**	fl	85 - 105
MCH		28.6	pg	27 - 32
MCHC		34.2	g/dL	32 - 36
NE#	*	**10.4**	x10^9/L	2.0 - 7.5
LY#		3.0	x10^9/L	1.5 - 4.0
MO#		0.7	x10^9/L	0.2 - 0.8
EO#		0.14	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

Report 30/30

Reported	Specialty	Location	Clinician
10 May 2013 09:34	Microbiology	NW LABOUR SUITE	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:43

CLINICAL DETAILS :

Sample 13B505423 (HIGH VAGINAL SWAB) Collected 07 May 2013 22:00 Received 08 May 2013 08:58

Genital Swabs

Trich.	No Trichomonas

Culture:

Culture:

No growth of pathogenic bacteria

End of reports

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Tayside Diagnostic Services

Printed by cgarnes (Claire Garnes (non referrer)) at 24 Jun 2026 18:11

Patient name:	**STACEY LEONARD**	CHI Number:	**2804880060**	Sex:	**Female**
Date of birth:	**28 Apr 1988**	:			
Address:	**2 Wards Road, Brechin DD9 7AS**				

Report 1/30

Reported	Specialty	Location	Clinician
06 Sep 2016 10:46	Radiology	NW RADIOLOGY	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:23

Sample 6201103 (TYPE UNSPECIFIED) Collected 24 Aug 2016 12:59 Received 24 Aug 2016 12:59
MDM MEETING

GYNAECOLOGY MDM MEETING 24.8.16 :
The CT of 18.8.16 was reviewed and findings are as per report. Repeat MRI is awaited.
DR AMY LESLIE / DAWS

Report 2/30

Reported	Specialty	Location	Clinician
25 Aug 2016 13:29	Histopathology	NW WARD 36 / GYNECOLOGY SUITE	Dr Kathleen Wendy MCMULLEN (Obstets & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:35

CLINICAL DETAILS :

Sample TS16019490 (Lletz Biopsy) Collected 16 Aug 2016 00:00 Received 16 Aug 2016 10:05
Report

Nature of Specimen(s)
Loop excision of cervical transformation zone.
Clinical Information Supplied
Cervical smear - ?invasion. Cervical biopsy - ?wart. Clinical appearance on colposcopy - warty appearance but suspicious of cancer. Date of LMP 2 weeks ago. Drug therapy Nexplanon in situ.
Macro Report
The specimen comprises a Lletz measuring 19x20x20mm. The mucosal surface appears warty with a slit os up to 8mm. The deep aspect is inked black. The specimen is serially sliced and all submitted in six cassettes (cut end face down).
(SADN)
Micro Report

Transformation zone:	Present.
Wart virus (HPV) infection:	Present.
Squamous epithelium:	Condyloma acuminatum in 5 out of 6 blocks. CIN 1 in 5 out of 6 blocks. CIN 2 in 3 out of 6 blocks. Indeterminate grade CIN in 1 out of 6 blocks.
Glandular epithelium:	No evidence of CGIN.
Invasion:	Absent.
Lymphovascular space invasion:	Absent.
Endocervical margin:	Clear.
Ectocervical margin:	Involved by CIN 1 and indeterminate high grade CIN.
Deep lateral/radial margin:	Clear.

Comment
This Lletz was divided into six blocks. In five of the blocks the squamous epithelium shows marked acanthosis and papillomatosis with features of a viral cytopathic effect including binucleation, dyskeratosis and suprabasal mitotic activity. The features are in keeping with a condyloma acuminatum. In multiple places there is cytonuclear atypia and maturation disorder amounting to CIN 1 and CIN 2. The lesion extends to involve the ectocervical margin in one of the end blocks (1A). This block has been turned over and shows the presence of condyloma acuminatum, CIN 1 and indeterminate high grade CIN at the superficial radial/ectocervical margin. There is no evidence of CGIN or invasive malignancy.
Summary:
Condyloma acuminatum CIN 1, CIN 2 and indeterminate high grade CIN. CIN 1 and indeterminate high grade CIN involving ectocervical margin.
Signature of Pathologist(s)
Dr N Sadiq Dr LB Jordan
MM

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Report 3/30

Reported	Specialty	Location	Clinician
21 Aug 2016 22:06	Radiology	NW OP OBS & GYNAE CLINIC	Consultant Kalpana RAGUPATHY (Obs & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:51

Sample 6171217 (TYPE UNSPECIFIED) Collected 18 Aug 2016 10:20 Received 18 Aug 2016 10:20
CT Abdomen & pelvis with contrast

```
Clinical History :
clinically - cervical cancer; Imaging to decide mode of treatment
ENTERED BY: Kalpana Ragupathy
BLEEP: 01382 660111
Date of Examination:
18 August 2016
Name of Procedure and Technique:
CT abdomen and pelvis
Findings:
Lung bases, liver, spleen, adrenal glands, pancreas and kidneys are unremarkable.
No significant sized para-aortic or pelvic lymphadenopathy.
An area of gas and heterogenous soft tissue is seen in the region of the cervix are
demonstrated which may represent the immediate postsurgical appearances following the
patient's recent LLETZ procedure.
The extent of local invasion is better assessed with MRI and I note that a repeat MRI
study has already been arranged with sufficient time for resolution of postsurgical
changes.
No sinister bone lesion
Conclusion:
No evidence of distant metastatic disease.
Local invasion is better assessed on the forthcoming MRI.
Report Date : 21 August 2016
Reporting Consultant: Dr Richard Guinness. Consultant Radiologist,
GMC: 4231600 Medica Reporting Ltd
 RICHARD GUINNESS / RGUINNESS
```

Report 4/30

Reported	Specialty	Location	Clinician
21 Aug 2016 16:21	Microbiology	NW WARD 36 / GYNECOLOGY SUITE	Consultant Kalpana RAGUPATHY (Obs & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:35

```
CLINICAL DETAILS :
post op this morning LLETZ. left ward
within hour of procedure for walk,
returned from walk, sweaty, clammy,
T35.0, Sats 92%, BP stable at 90/60
(responding 105/70 fluid chalenge)
```

Sample 16B609229 (B. Culture (Periph)) Collected 16 Aug 2016 12:40 Received 16 Aug 2016 16:05
Blood Cultures:

Anaerobic Bottle	No growth after 5 days incubation
Aerobic Bottle	No growth after 5 days incubation

Report 5/30

Reported	Specialty	Location	Clinician
18 Aug 2016 12:51	Radiology	NW OP OBS & GYNAE CLINIC	Consultant Kalpana RAGUPATHY (Obs & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:51

Sample 6171216 (TYPE UNSPECIFIED) Collected 18 Aug 2016 10:20 Received 18 Aug 2016 10:20
MRI Pelvis gynaecological

```
Clinical History :  clinically - cervical cancer; Imaging to decide mode of treatment
ENTERED BY: Kalpana Ragupathy  BLEEP: 01382 660111
MRI Pelvis gynaecological :  The patient arrived today for MRI scan, informing us that she
had LLETZ procedure performed only 2 days ago.
T2 sagittal and T1 axial sequences performed.  There is high-signal throughout the cervix
with a little gas and mixed-T2 and high-T1 signal content within endocervical canal.
These appearances are almost certainly related to the very recent LLETZ procedure.  It is
not possible for accurate local disease staging with such marked post-operative background
changes.   Therefore MRI scan terminated.
Please re-submit request for MRI to be appointed at least 3 weeks after LLETZ procedure.
I have also informed Gynae Secretary (ext 32085).
 DR YEE TING SIM / YTSIM
```

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Report 6/30

Reported	Specialty	Location	Clinician
17 Aug 2016 09:32	Blood Sciences	NW WARD 36 / GYNECOLOGY SUITE	Consultant Kalpana RAGUPATHY (Obs & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:35

CLINICAL DETAILS :
post op this morning LLETZ. left ward within hour of
procedure for walk, returned from walk, sweaty, clammy,
T35.0, Sats 92%, BP stable at 90/60 (responding 105/70 fluid
chalenge)

Sample H164871033 (EDTA) Collected 16 Aug 2016 12:46 Received 16 Aug 2016 15:15

FBC

Hb		136	g/L	120 - 160
WBC	*	**12.2**	x10^9/L	4.0 - 11.0
PLT		263	x10^9/L	150 - 400
RBC		4.46	x10^12/L	3.8 - 4.8
HCT		0.403		0.37 - 0.47
MCV		90.4	fl	85 - 105
MCH		30.5	pg	27 - 32
MCHC		338	g/L	320 - 360
NE#		5.1	x10^9/L	2.0 - 7.5
LY#	*	**6.0**	x10^9/L	1.5 - 4.0
MO#		0.7	x10^9/L	0.2 - 0.8
EO#		0.32	x10^9/L	0.0 - 0.4
BA#		0.1	x10^9/L	0.0 - 0.1

Film Report:

Film Report:
Slight leucocytosis with borderline lymphocytosis ?Reactive/inflammation/infection. Clinical details noted.

Report 7/30

Reported	Specialty	Location	Clinician
16 Aug 2016 16:58	Blood Sciences	NW WARD 36 / GYNECOLOGY SUITE	Consultant Kalpana RAGUPATHY (Obs & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:34

CLINICAL DETAILS :
post op this morning LLETZ. left ward within hour of
procedure for walk, returned from walk, sweaty, clammy,
T35.0, Sats 92%, BP stable at 90/60 (responding 105/70 fluid
chalenge)

Sample C164871033 (Blood) Collected 16 Aug 2016 12:46 Received 16 Aug 2016 15:15

Urea & Electrolytes

SODIUM	140	mmol/L	133 - 146
POTASSIUM	3.8	mmol/L	3.5 - 5.3
UREA	4.5	mmol/L	2.5 - 7.8
CREATININE	* **89**	umol/L	44 - 80

AKI

AKI	Not detected: but may not exclude AKI in all cases	.

ESTIMATED GFR

ESTIMATED GFR	GT60	mL/min

CKD Stage

CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .

Report 8/30

Reported	Specialty	Location	Clinician
15 Aug 2016 13:37	Blood Sciences	NW WARD 36 / GYNECOLOGY SUITE	- NOT GIVEN (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:35

CLINICAL DETAILS :
LAB COPY

Sample H164867499 (EDTA) Collected 15 Aug 2016 00:00 Received 15 Aug 2016 12:49

FBC

Hb	145	g/L	120 - 160

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

WBC	8.3	x10^9/L	4.0 - 11.0
PLT	249	x10^9/L	150 - 400
RBC	4.74	x10^12/L	3.8 - 4.8
HCT	0.427		0.37 - 0.47
MCV	90.0	fl	85 - 105
MCH	30.5	pg	27 - 32
MCHC	339	g/L	320 - 360
NE#	5.0	x10^9/L	2.0 - 7.5
LY#	2.6	x10^9/L	1.5 - 4.0
MO#	0.4	x10^9/L	0.2 - 0.8
EO#	0.18	x10^9/L	0.0 - 0.4
BA#	0.0	x10^9/L	0.0 - 0.1

Report 9/30

Reported	Specialty	Location	Clinician
15 Aug 2016 13:36	Blood Sciences	NW WARD 36 / GYNECOLOGY SUITE - NOT GIVEN	(Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:34

CLINICAL DETAILS :
LAB COPY

LAB COMMENTS :
SLIGHTLY HAEMOLYSED

Sample C164867499 (Blood) Collected 15 Aug 2016 00:00 Received 15 Aug 2016 12:49

Urea & Electrolytes

SODIUM	139	mmol/L	133 - 146
POTASSIUM	4.7	mmol/L	3.5 - 5.3
UREA	3.6	mmol/L	2.5 - 7.8
CREATININE	71	umol/L	44 - 80

AKI

AKI	Not detected: but may not exclude AKI in all cases	.

ESTIMATED GFR

ESTIMATED GFR	GT60	mL/min

CKD Stage

CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA	.

Report 10/30

Reported	Specialty	Location	Clinician
15 Aug 2016 13:21	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:16

Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)

Sample 10310030350621 (BLOOD) Collected 15 Aug 2016 11:30 Received 15 Aug 2016 11:47

Automated Antibody Screen

Automated Antibody Screen	Negative

Report 11/30

Reported	Specialty	Location	Clinician
08 Aug 2016 10:42	Histopathology	NW OP COLPOSCOPY CLINIC	Consultant Kalpana RAGUPATHY (Obs & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:51

CLINICAL DETAILS :

Sample TS16018611 (Cervical Biopsy) Collected 04 Aug 2016 00:00 Received 04 Aug 2016 17:28

Report

Nature of Specimen(s)
Cervical biopsy
Clinical Information Supplied
? cancer cervix (unusual appearance). Smear high grade ? invasive.

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Macro Report
Multiple fragments measuring up to 8mm in diameter.
Micro Report
These are rather superficial fragments of tissue which are covered by squamous epithelium and which have a papillomatous appearance. There are features of wart virus infection including koilocytic change, binucleate cells and single cell dyskeratosis and the features are considered to be in keeping with a viral condyloma. Superimposed upon this, however, there are dysplastic features. The changes are of varying degree ranging from CIN 1 through to CIN 3. Glandular epithelium is only represented as a few small strips lying free although these small fragments show no evidence of accompanying glandular neoplasia. There is no evidence of invasive neoplasia in the material submitted though it should be noted that subepithelial connective tissue is only represented as small cores of the papillomatous structures therefore assessment for this feature is extremely limited.
Signature of Pathologist(s)
Dr JB McCullough
MM

Report 12/30

Reported	Specialty	Location	Clinician
04 Aug 2016 18:13	Blood Sciences	NW OP OBS & GYNAE CLINIC	Consultant Kalpana RAGUPATHY (Obs & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:51

CLINICAL DETAILS :
pre imaging

Sample C164847044 (Blood) Collected 04 Aug 2016 15:07 Received 04 Aug 2016 17:27

Urea & Electrolytes			
SODIUM	140	mmol/L	133 - 146
POTASSIUM	4.4	mmol/L	3.5 - 5.3
UREA	3.9	mmol/L	2.5 - 7.8
CREATININE	71	umol/L	44 - 80
AKI			
AKI	Not detected: but may not exclude AKI in all cases	.	
ESTIMATED GFR			
ESTIMATED GFR	GT60	mL/min	
CKD Stage			
CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .		

Report 13/30

Reported	Specialty	Location	Clinician
04 Aug 2016 17:57	Blood Sciences	NW OP OBS & GYNAE CLINIC	Consultant Kalpana RAGUPATHY (Obs & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:51

CLINICAL DETAILS :
pre imaging

Sample H164847044 (EDTA) Collected 04 Aug 2016 15:07 Received 04 Aug 2016 17:27

FBC			
Hb	140	g/L	120 - 160
WBC	10.2	x10^9/L	4.0 - 11.0
PLT	267	x10^9/L	150 - 400
RBC	4.72	x10^12/L	3.8 - 4.8
HCT	0.421		0.37 - 0.47
MCV	89.1	fl	85 - 105
MCH	29.7	pg	27 - 32
MCHC	333	g/L	320 - 360
NE#	6.2	x10^9/L	2.0 - 7.5
LY#	3.2	x10^9/L	1.5 - 4.0
MO#	0.6	x10^9/L	0.2 - 0.8
EO#	0.19	x10^9/L	0.0 - 0.4
BA#	0.0	x10^9/L	0.0 - 0.1

Report 14/30

Reported	Specialty	Location	Clinician

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

14 May 2015 09:21 Histopathology NW WARD 19 Mr FARZAD ALIPOUR-TOOTOONCHI (Trauma & Ortho) (Trauma & Orthopaedics)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:20

CLINICAL DETAILS :

Sample TS15010334 (Cyst) Collected 02 May 2015 00:00 Received 04 May 2015 10:02
Report

```
Nature of Specimen(s)
?Sebaceous cyst right thigh - infected
Clinical Information Supplied
?Remnant of sebaceous cyst in abscess right post thigh.
Macro Report
Received are two fragments of fibrous tissue, the first measuring
13x6x2mm. The second is cream coloured measuring 8x4x2mm. The
larger specimen is bisected and the smaller fragment processed
intact all in one cassette. All taken.
Micro Report
Microscopy confirms the presence of elements of an epidermoid cyst
associated with a marked inflammatory reaction. There are no
concerning findings.
Signature of Pathologist(s)
Dr AT Evans
JF
```

Report 15/30

Reported	Specialty	Location	Clinician
08 May 2015 09:31	Microbiology	NW WARD 19	Mr FARZAD ALIPOUR-TOOTOONCHI (Trauma & Ortho) (Trauma & Orthopaedics)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:20

CLINICAL DETAILS :
SITE: RIGHT THIGH
INFECTED SEBACEOUS CYST WITH ABSCESS

Sample 15B402417 (SWAB - Exudates) Collected 02 May 2015 17:24 Received 02 May 2015 18:04
Culture:

Organism	*	**Mixed Anaerobes**
Organism Growth	*	**Profuse Growth**
Metronidazole		S
Organism	*	**Staphylococcus capitis**
Organism Growth	*	**Light Growth**
Penicillin		S
Flucloxacillin		S
Erythromycin		S

Report 16/30

Reported	Specialty	Location	Clinician
05 May 2015 09:42	Microbiology	NW WARD 19	Mr FARZAD ALIPOUR-TOOTOONCHI (Trauma & Ortho) (Trauma & Orthopaedics)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:20

CLINICAL DETAILS :
SITE: RIGHT THIGH
INFECTED SEBACEOUS CYST WITH ABSCESS

Sample 15B402416 (PUS) Collected 02 May 2015 17:24 Received 02 May 2015 18:04
Microscopy:

Polymorphs:		Many White Blood Cells

Culture:

Organism	*	**Mixed Anaerobes**
Organism Growth	*	**Profuse Growth**
Metronidazole		S
Organism	*	**Staphylococcus capitis**
Organism Growth	*	**Light Growth**
Penicillin		S
Flucloxacillin		S

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Erythromycin	S	

Report 17/30

Reported	Specialty	Location	Clinician
03 May 2015 09:48	Microbiology	NW WARD 19	Mr FARZAD ALIPOUR-TOOTOONCHI (Trauma & Ortho) (Trauma & Orthopaedics)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:20

CLINICAL DETAILS :
Admission screening.

Sample 15B106975 (MRSA SCREEN (N/T)) Collected 02 May 2015 10:26 Received 02 May 2015 14:55

MRSA Culture:

MRSA NOT isolated

Report 18/30

Reported	Specialty	Location	Clinician
01 May 2015 20:11	Blood Sciences	NW WARD 7 - ASRU	Mr. Arpit JARIWALA(Trauma & Orthopaedic su) (Trauma & Orthopaedics)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:49

CLINICAL DETAILS :
Abscess posterior thigh, for I&D

LAB COMMENTS :
Note rising Creatinine. Developing or established AKI
Stage 1?; Renal AKI guideline available at :
for secondary care http://tinyurl.com/AKINEW.
for primary care http://tinyurl.com/AKICHP.

Sample C153819466 (Blood) Collected 01 May 2015 19:17 Received 01 May 2015 19:30

C-REACTIVE PROTEIN				
C-REACTIVE PROTEIN		LT4	mg/L	0 - 10
AKI				
AKI	*	**AKI1**	.	
Urea & Electrolytes				
SODIUM		139	mmol/L	133 - 146
POTASSIUM		4.3	mmol/L	3.5 - 5.3
UREA		3.2	mmol/L	2.5 - 7.8
CREATININE		72	umol/L	44 - 80
ESTIMATED GFR				
ESTIMATED GFR		GT60	mL/min	
CKD Stage				
CKD Stage		IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .		

Report 19/30

Reported	Specialty	Location	Clinician
01 May 2015 19:45	Blood Sciences	NW WARD 7 - ASRU	Mr. Arpit JARIWALA(Trauma & Orthopaedic su) (Trauma & Orthopaedics)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:49

CLINICAL DETAILS :
Abscess posterior thigh, for I&D

Sample H153819466 (EDTA) Collected 01 May 2015 19:17 Received 01 May 2015 19:30

FBC				
Hb		133	g/L	120 - 160
WBC		10.7	x10^9/L	4.0 - 11.0
PLT		309	x10^9/L	150 - 400
RBC	*	**5.06**	x10^12/L	3.8 - 4.8
HCT		0.413		0.37 - 0.47
MCV	*	**81.6**	fl	85 - 105
MCH	*	**26.2**	pg	27 - 32
MCHC		321	g/L	320 - 360

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

NE#		5.6	x10^9/L	2.0 - 7.5
LY#	*	**4.4**	x10^9/L	1.5 - 4.0
MO#		0.5	x10^9/L	0.2 - 0.8
EO#		0.24	x10^9/L	0.0 - 0.4
BA#		0.1	x10^9/L	0.0 - 0.1

Report 20/30

Reported	Specialty	Location	Clinician
10 Mar 2015 15:08	Blood Sciences	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:11

CLINICAL DETAILS :
Has been on iron and folic acid for 2/52. Repeat FBC and
iron studies at Dy Lynch's request

Sample C153700300 (Blood) Collected 10 Mar 2015 10:49 Received 10 Mar 2015 13:15

FERRITIN

FERRITIN	*	**5**	ug/L	13 - 150

Report 21/30

Reported	Specialty	Location	Clinician
10 Mar 2015 14:12	Blood Sciences	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:11

CLINICAL DETAILS :
Has been on iron and folic acid for 2/52. Repeat FBC and
iron studies at Dy Lynch's request

Sample H153700300 (EDTA) Collected 10 Mar 2015 10:49 Received 10 Mar 2015 13:15

FBC

Hb	*	**106**	g/L	120 - 160
WBC	*	**14.1**	x10^9/L	4.0 - 11.0
PLT	*	**402**	x10^9/L	150 - 400
RBC		4.06	x10^12/L	3.8 - 4.8
HCT	*	**0.328**		0.37 - 0.47
MCV	*	**80.7**	fl	85 - 105
MCH	*	**26.1**	pg	27 - 32
MCHC		323	g/L	320 - 360
NE#	*	**10.3**	x10^9/L	2.0 - 7.5
LY#		2.9	x10^9/L	1.5 - 4.0
MO#		0.7	x10^9/L	0.2 - 0.8
EO#		0.16	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

B12/FOLATE

B12		273	ng/l	200 - 940
Serum Folate	*	**2.1**	ug/l	3.1 - 17.5

Report 22/30

Reported	Specialty	Location	Clinician
06 Mar 2015 18:26	Blood Sciences	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:11

CLINICAL DETAILS :
36+2 weeks pregnant - on iron

Sample H153693596 (EDTA) Collected 06 Mar 2015 13:14 Received 06 Mar 2015 16:58

FBC

Hb	*	**102**	g/L	120 - 160
WBC	*	**15.6**	x10^9/L	4.0 - 11.0
PLT		356	x10^9/L	150 - 400
RBC		3.96	x10^12/L	3.8 - 4.8
HCT	*	**0.324**		0.37 - 0.47
MCV	*	**81.7**	fl	85 - 105

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

MCH	*	**25.7**	pg	27 - 32
MCHC	*	**315**	g/L	320 - 360
NE#	*	**11.6**	x10^9/L	2.0 - 7.5
LY#		3.1	x10^9/L	1.5 - 4.0
MO#		0.7	x10^9/L	0.2 - 0.8
EO#		0.14	x10^9/L	0.0 - 0.4
BA#		0.1	x10^9/L	0.0 - 0.1

Report 23/30

Reported	Specialty	Location	Clinician
06 Mar 2015 17:58	Blood Sciences	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:11

CLINICAL DETAILS :
36+2 weeks pregnant - on iron

Sample C153693596 (Blood) Collected 06 Mar 2015 13:14 Received 06 Mar 2015 16:58

C-REACTIVE PROTEIN					
	C-REACTIVE PROTEIN		LT4	mg/L	0 - 10
URATE					
	URATE		156	umol/L	140 - 360
Urea & Electrolytes					
	SODIUM		134	mmol/L	133 - 146
	POTASSIUM		4.6	mmol/L	3.5 - 5.3
	UREA		2.5	mmol/L	2.5 - 7.8
	CREATININE		45	umol/L	44 - 80
Liver Function Tests (LFT)					
	ALT		8	U/L	5 - 55
	BILIRUBINS		10	umol/L	0 - 21
	ALKALINE PHOSPHATASE	*	**173**	U/L	30 - 130
	ALBUMIN	*	**30**	g/L	35 - 50

Report 24/30

Reported	Specialty	Location	Clinician
24 Feb 2015 08:08	Microbiology	NW OP ANTENATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:42

CLINICAL DETAILS :
Extra details: NKA
Known CKD:: No
34 weeks pregnant ++ leu no UTI symptoms

Sample 15B212929 (Midstream Urine) Collected 23 Feb 2015 10:01 Received 23 Feb 2015 11:03
Urine Culture:

No Growth

Report 25/30

Reported	Specialty	Location	Clinician
23 Feb 2015 17:14	Blood Sciences	NW OP ANTENATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:42

CLINICAL DETAILS :
hb 103

Sample H153664255 (Blood) Collected 23 Feb 2015 11:30 Received 23 Feb 2015 12:05
B12/FOLATE

B12		247	ng/l	200 - 940
Serum Folate	*	**2.1**	ug/l	3.1 - 17.5

Report 26/30

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Reported	Specialty	Location	Clinician
23 Feb 2015 14:24	Blood Sciences	NW OP ANTENATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:42

CLINICAL DETAILS :
hb 103

Sample C153664255 (Blood) Collected 23 Feb 2015 11:30 Received 23 Feb 2015 12:05

FERRITIN

FERRITIN	*	**5**	ug/L	13 - 150

Report 27/30

Reported	Specialty	Location	Clinician
17 Feb 2015 19:42	Blood Sciences	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:11

CLINICAL DETAILS :
33+6 weeks gesation FBC

Sample H153651456 (EDTA) Collected 17 Feb 2015 14:24 Received 17 Feb 2015 18:40

FBC

Hb	*	**103**	g/L	120 - 160
WBC	*	**14.8**	x10^9/L	4.0 - 11.0
PLT		375	x10^9/L	150 - 400
RBC		3.91	x10^12/L	3.8 - 4.8
HCT	*	**0.334**		0.37 - 0.47
MCV		85.3	fl	85 - 105
MCH	*	**26.4**	pg	27 - 32
MCHC	*	**310**	g/L	320 - 360
NE#	*	**10.5**	x10^9/L	2.0 - 7.5
LY#		3.2	x10^9/L	1.5 - 4.0
MO#	*	**0.9**	x10^9/L	0.2 - 0.8
EO#		0.22	x10^9/L	0.0 - 0.4
BA#		0.1	x10^9/L	0.0 - 0.1

Report 28/30

Reported	Specialty	Location	Clinician
24 Jan 2015 17:28	Microbiology	NW OP MAT DAY ASSESSMENT UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:47

CLINICAL DETAILS :
30wks preg, abdo pain

Sample 15B500979 (HIGH VAGINAL SWAB) Collected 22 Jan 2015 12:48 Received 22 Jan 2015 16:13

Microscopy

-

No Trichomonas
No Clue cells seen

Culture:

Organism	*	**Group G Streptococci**
Organism Growth	*	**Profuse Growth**
Penicillin		S
Erythromycin		S

No Candida Isolated

Report 29/30

Reported	Specialty	Location	Clinician
22 Jan 2015 15:28	Microbiology	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:11

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

CLINICAL DETAILS :
Patient phone No.: 01674959209
+++ leuco abdo pain back pain

Sample 15V101025 (Urine) Collected 20 Jan 2015 12:02 Received 20 Jan 2015 17:26

Chlamydia trachomatis DNA:

Chlamydia trachomatis DNA	Negative

N.gonorrhoeae DNA:

N.gonorrhoeae DNA	Negative

Report 30/30

Reported	Specialty	Location	Clinician
22 Jan 2015 13:24	Microbiology	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:11

CLINICAL DETAILS :
+++ leuco abdo pain back pain

Sample 15B500823 (HIGH VAGINAL SWAB) Collected 20 Jan 2015 12:02 Received 20 Jan 2015 17:18

Microscopy

-

No Trichomonas
No Clue cells seen

Culture:

Organism	*	**Group G Streptococci**
Organism Growth	*	**Light Growth**
Penicillin		S
Erythromycin		S
Doxycycline		R

No Candida Isolated

End of reports

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Tayside Diagnostic Services

Printed by cgarnes (Claire Garnes (non referrer)) at 24 Jun 2026 18:11

Patient name:	**STACEY LEONARD**	CHI Number:	**2804880060**	Sex:	**Female**
Date of birth:	**28 Apr 1988**	:			
Address:	**2 Wards Road, Brechin DD9 7AS**				

Report 1/30

Reported	Specialty	Location	Clinician
13 Nov 2019 14:52	Microbiology	LINKS HC ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

CLINICAL DETAILS :
Routine antenatal booking screen M/W
Lorna

Sample 19V023758 (Venous blood) Collected 12 Nov 2019 12:36 Received 13 Nov 2019 08:47

Hepatitis B (HBsAg) screen:

Hepatitis B (HBsAg) screen	Negative

Syphilis total antibody:

Syphilis total antibody	Negative

HIV1&2 Antigen/Antibody:

HIV1&2 Antigen/Antibody	Negative

Report 2/30

Reported	Specialty	Location	Clinician
13 Nov 2019 14:40	Microbiology	LINKS HC ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

CLINICAL DETAILS :
Symptoms of UTI?: Yes
Antibiotic Therapy: NK
Antibiotic allergies: NK
Known CKD?: No
Routine antenatal booking screen M/W
Lorna

Sample 19B263006 (Midstream Urine) Collected 12 Nov 2019 12:36 Received 12 Nov 2019 17:03

Urine Culture:

No Significant Bacteriuria

Report 3/30

Reported	Specialty	Location	Clinician
13 Nov 2019 14:23	Microbiology	LINKS HC ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

CLINICAL DETAILS :
Routine antenatal booking screen M/W
Lorna

Sample 19V023758 (Venous blood) Collected 12 Nov 2019 12:36 Received 13 Nov 2019 08:47

Syphilis total antibody:

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Syphilis total antibody	Negative

Report 4/30

Reported	Specialty	Location	Clinician
13 Nov 2019 10:46	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:34

```
Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)
Please send a sample at 28 to 30 weeks, gestation.
```

Sample 10310042937509 (BLOOD) Collected 12 Nov 2019 12:00 Received 13 Nov 2019 09:04

Automated Antibody Screen

Automated Antibody Screen	Negative

Report 5/30

Reported	Specialty	Location	Clinician
13 Nov 2019 09:41	Blood Sciences	LINKS HC ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

```
CLINICAL DETAILS :
  Routine antenatal booking screen M/W Lorna

LAB COMMENTS :
Based on FBC and Family Origin Questionnaire, no need
for Haemoglobinopathy or partner screening.
```

Sample H197482338 (EDTA) Collected 12 Nov 2019 12:36 Received 12 Nov 2019 17:20

FBC

Hb		136	g/L	120 - 160
WBC	*	**11.6**	x10^9/L	4.0 - 11.0
PLT		275	x10^9/L	150 - 400
RBC		4.30	x10^12/L	3.8 - 4.8
HCT		0.404		0.37 - 0.47
MCV		94.0	fl	85 - 105
MCH		31.7	pg	27 - 32
MCHC		338	g/L	320 - 360
NE#	*	**8.2**	x10^9/L	2.0 - 7.5
LY#		2.6	x10^9/L	1.5 - 4.0
MO#		0.5	x10^9/L	0.2 - 0.8
EO#		0.14	x10^9/L	0.0 - 0.4
BA#		0.1	x10^9/L	0.0 - 0.1

ANC BOOKING BLOODS

ANC BOOKING BLOODS	NOT REQUIRED.

Report 6/30

Reported	Specialty	Location	Clinician
04 Nov 2019 15:10	Radiology	NW OP BREAST CLINIC	Mr Douglas BROWN (Surgery) (Breast Surgery)

Filed by **wchoong** (Wen Ling Choong (medical)) at 14 Nov 2019 09:00

Sample 7384506 (TYPE UNSPECIFIED) Collected 04 Nov 2019 14:36 Received 04 Nov 2019 14:36

US Breast Lt

```
Clinical History :
31 years old left breast lump with nipple itchiness; 9 weeks pregnant; o/e P1, no lump or
```

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

nipple discharge expressed; marked the right breast 12 oclock where patient could feel lump.
ENTERED BY: Wen Ling Choong (medical)
BLEEP: 40118
US Breast Lt :
Targeted scan over left breast skin-marked area at 12 o'clock position. Normal dense glandular breast tissue. No focal suspicious lesion. U1
DR YEE TING SIM / YTSIM

Report 7/30

Reported	Specialty	Location	Clinician
02 Oct 2019 14:08	Blood Sciences	T10498-BRECHIN HEALTH CENTRE	LAURA POLE (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:27

CLINICAL DETAILS :
raised Ca125 under investigation, now unexpected positive
urine pregnancy test ?false positive

Sample C197393328 (Blood) Collected 02 Oct 2019 09:28 Received 02 Oct 2019 12:20
TOTAL HCG

TOTAL HCG	*	**1084**	U/L	0 - 5

Report 8/30

Reported	Specialty	Location	Clinician
02 Oct 2019 10:16	Microbiology	T10498-BRECHIN HEALTH CENTRE	Nigel CLUBB (nurse practitioner) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:27

CLINICAL DETAILS :
Otitis type: Otitis media
deaf in left ear, some pain, TM dull,
canal inflamed and red- ? infection

Sample 19B719823 (Left Ear Swab) Collected 30 Sep 2019 10:09 Received 30 Sep 2019 12:11
Culture:

Mixed growth of faecal organisms
No fungi isolated

Report 9/30

Reported	Specialty	Location	Clinician
25 Sep 2019 13:25	Radiology	NW OP GYNAE/OB CLINIC	Dr Yeshi BHUSHAN (Obstetrics & Gynaecology (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:00

Sample 7308121 (TYPE UNSPECIFIED) Collected 25 Sep 2019 08:38 Received 25 Sep 2019 08:38
MRI Pelvis gynaecological

Clinical History :
31 yrs old, para 4
raised ca 125 (50-70)
pelvic pain
pelvic scan - 1.7 cm cyst in pouch of douglas with free fluid ? nature
MRI- urgent please in view of raised ca 125 and uncertain lesion in pelvis
ENTERED BY: Yeswanthini Bhushan (Medical)
BLEEP: 5478
MRI Pelvis gynaecological :
Correlation is made with previous MRI dated 18/08/16.
History of LLetz excision of CIN from CIN from the cervix noted from 2016.
The uterus is anteverted and measures 9.7 cm in the long axis. The endometrial stripe is of normal signal and uniform thickness. There is mild increase in thickness of the junctional zone in the anterior wall of the uterus up to 16 mm, suggestive of a degree of adenomyosis. No focal lesions within the myometrium.
The uterine cervix has altered anatomy due to LLetz excision but maintains zonal

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

differentiation on T2 with no suspicious features. The uterus has arcuate configuration with a medial fundal thickness of 1.8 cm.
The ovaries are visualised in normal in size and position. Within the left ovary, there is an 11 mm cyst of intermediate T2 and high T1 and T1 fat sat signal in keeping with a small haemorrhagic cyst.
Corresponding to the findings from the ultrasound, lying posterior to the right ovary, there is an unilocular lesion measuring 2.1 cm with high T2 and long T1 and T1 fat sat signal in keeping with a small simple cyst. This cyst is closely related to the right ovary and is thought to arise from it. No concerning features.
There is a trace of free fluid in the pelvis, this is considered physiological for patient age. There is no pelvic lymph adenopathy. Unremarkable appearances of the other visualised pelvic organs. No significant degenerative changes in the lumbar spine.
Opinion: Simple small right adnexal cyst and a mild anterior uterine adenomyosis. No other finding of note.
DR M. Szewczyk-Bieda Consultant Radiologist
DR MAGDA SZEWCZYK-BIEDA / MOND

Report 10/30

Reported	Specialty	Location	Clinician
14 Aug 2019 17:04	Blood Sciences	T10498-BRECHIN HEALTH CENTRE	LAURA POLE (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:24

CLINICAL DETAILS :
: Postmenopausal
requested from gynae clinic

LAB COMMENTS :
** NICE GUIDANCE SUGGESTS FURTHER INVESTIGATION IF THE CA125 IS GREATER THAN 35 **

Sample C197283739 (Blood) Collected 14 Aug 2019 11:49 Received 14 Aug 2019 15:38

CA 125					
CA125	*	**50**	kU/L	0 - 30	

Report 11/30

Reported	Specialty	Location	Clinician
24 May 2019 15:34	Blood Sciences	T10498-BRECHIN HEALTH CENTRE	Dr GP LOCUM (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:19

CLINICAL DETAILS :
: Pre- or perimenopausal
LMP date: 20 May 2019
Testosterone:
On T4?: No
Pelvic pain, irregular periods, PV discharge (has had period for 4 days)

LAB COMMENTS :
** NICE GUIDANCE SUGGESTS FURTHER INVESTIGATION IF THE CA125 IS GREATER THAN 35 **

Sample C197103744 (Blood) Collected 24 May 2019 09:27 Received 24 May 2019 12:51

C-REACTIVE PROTEIN			
C-REACTIVE PROTEIN	LT4	mg/L	0 - 10
Creatinine and Electrolytes			
SODIUM	137	mmol/L	133 - 146
POTASSIUM	4.8	mmol/L	3.5 - 5.3
CREATININE	75	umol/L	44 - 80
AKI			
AKI	NOT AVAILABLE	.	
Liver Function Tests (LFT)			
ALT	LT9	U/L	5 - 55
BILIRUBINS	8	umol/L	0 - 21
ALKALINE PHOSPHATASE	48	U/L	30 - 130
ALBUMIN	39	g/L	35 - 50
Bone Group			

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

CALCIUM	2.36	mmol/L	2.10 - 2.55
CALCIUM (CORRECTED)	2.37	mmol/L	2.10 - 2.55
ESTIMATED GFR			
ESTIMATED GFR	GT60	mL/min	
CKD Stage			
CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .		
TSH			
TSH	2.47	mU/L	0.4 - 4.0
TESTOSTERONE			
TESTOSTERONE	0.7	nmol/L	

Pre-menopausal Testosterone (0.4 - 2.1 nmol/L)
Post-menopausal Testosterone (<0.24 - 1.7 nmol/L)

PROLACTIN			
PROLACTIN	138	mU/L	0 - 600
FSH			
FSH	8.0	U/L	1.1 - 9.6
LH			
LH	6.5	U/L	0.8 - 12.0
CA 125			
CA125	*** 72**	kU/L	0 - 30

Report 12/30

Reported	Specialty	Location	Clinician
24 May 2019 14:13	Blood Sciences	T10498-BRECHIN HEALTH CENTRE	Dr GP LOCUM (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:19

CLINICAL DETAILS :
: Pre- or perimenopausal
LMP date: 20 May 2019
Testosterone:
On T4?: No
Pelvic pain, irregular periods, PV discharge (has had period for 4 days)

Sample H197103744 (EDTA) Collected 24 May 2019 09:27 Received 24 May 2019 12:51

FBC

Hb	141	g/L	120 - 160
WBC	6.8	x10^9/L	4.0 - 11.0
PLT	222	x10^9/L	150 - 400
RBC	4.55	x10^12/L	3.8 - 4.8
HCT	0.417		0.37 - 0.47
MCV	91.7	fl	85 - 105
MCH	31.0	pg	27 - 32
MCHC	338	g/L	320 - 360
NE#	3.7	x10^9/L	2.0 - 7.5
LY#	2.3	x10^9/L	1.5 - 4.0
MO#	0.4	x10^9/L	0.2 - 0.8
EO#	0.33	x10^9/L	0.0 - 0.4
BA#	0.1	x10^9/L	0.0 - 0.1

Plasma Viscosity

PV	1.65	mPa.s.	1.5 - 1.72

Report 13/30

Reported	Specialty	Location	Clinician
07 May 2019 16:27	Radiology	T10498-BRECHIN HEALTH CENTRE	LAURA POLE (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:18

Sample 7188098 (TYPE UNSPECIFIED) Collected 07 May 2019 15:11 Received 07 May 2019 15:11

US Pelvis transvaginal

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

```
Clinical History :
irregular menstrual bleeding, persistent RIF pain through cycle, previous high grade CIN
treated, examination normal, preg test and urine negative, ?cyst
ENTERED BY: Laura Pole (medical)
BLEEP: 01356 624411
(Information via Order Comms)
on 01-May-2019 at 14:02)
US Pelvis transabdominal :
Both transabdominal and transvaginal scans performed with the patients verbal consent and
chaperon present.  Patient states latex sensitivity therefore latex free probe cover used.
The urinary bladder outlines smoothly.  The anteverted uterus is normal in size and shape.
 Several tiny hyperechoic foci noted adjacent to the endometrium, possibly due to previous
instrumentation. Left ovary contains a physiological corpus luteal cyst. Normal right
ovary. A 1.7 cm simple cyst with a small trace of adjacent free fluid is seen within the
pouch of Douglas, nature uncertain.
US Pelvis transvaginal :
See above report.
 VICKi SOUTAR / GOWF
```

Report 14/30

Reported	Specialty	Location	Clinician
07 May 2019 16:27	Radiology	T10498-BRECHIN HEALTH CENTRE	LAURA POLE (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:18

Sample 7182658 (TYPE UNSPECIFIED) Collected 07 May 2019 15:11 Received 07 May 2019 15:11

US Pelvis transabdominal


```
Clinical History :
irregular menstrual bleeding, persistent RIF pain through cycle, previous high grade CIN
treated, examination normal, preg test and urine negative, ?cyst
ENTERED BY: Laura Pole (medical)
BLEEP: 01356 624411
(Information via Order Comms)
on 01-May-2019 at 14:02)
US Pelvis transabdominal :
Both transabdominal and transvaginal scans performed with the patients verbal consent and
chaperon present.  Patient states latex sensitivity therefore latex free probe cover used.
The urinary bladder outlines smoothly.  The anteverted uterus is normal in size and shape.
 Several tiny hyperechoic foci noted adjacent to the endometrium, possibly due to previous
instrumentation. Left ovary contains a physiological corpus luteal cyst. Normal right
ovary. A 1.7 cm simple cyst with a small trace of adjacent free fluid is seen within the
pouch of Douglas, nature uncertain.
US Pelvis transvaginal :
See above report.
 VICKi SOUTAR / GOWF
```


Report 15/30

Reported	Specialty	Location	Clinician
01 May 2019 13:47	Radiology	T10498-BRECHIN HEALTH CENTRE	LAURA POLE (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:17

Sample 7132589 (TYPE UNSPECIFIED) Collected 01 May 2019 13:19 Received 01 May 2019 13:19

US Pelvis transabdominal

```
Clinical History :
irregular menstrual bleeding, persistent RIF pain through cycle, previous high grade CIN
treated, examination normal, preg test and urine negative, ?cyst
ENTERED BY: Laura Pole (medical)
BLEEP: 01356 624411
US Pelvis transabdominal :
Unfortunately, the patient had not followed preparation instructions. She has opted to
return at a later date with a full bladder.  We will re appoint.
 NICOLA RITCHIE / RITCHIE
```

Report 16/30

Reported	Specialty	Location	Clinician

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

18 Mar 2019 16:38 Microbiology T10498-BRECHIN HEALTH CENTRE LAURA POLE (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:15

```
CLINICAL DETAILS :
CT/NG symptoms: Discharge, Bleeding,
Pelvic pain
Patient phone No.: ref
discharge, pelvic pain
```

Sample 19V105148 (High Vaginal Swab) Collected 15 Mar 2019 09:33 Received 15 Mar 2019 15:57

C.trachomatis nucleic acid:

Chlamydia trachomatis	Negative

N.gonorrhoeae nucleic acid:

N.gonorrhoeae	Negative

Report 17/30

Reported	Specialty	Location	Clinician
17 Mar 2019 10:26	Microbiology	T10498-BRECHIN HEALTH CENTRE	LAURA POLE (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:15

```
CLINICAL DETAILS :
  discharge, pelvic pain
```

Sample 19B503690 (HIGH VAGINAL SWAB) Collected 15 Mar 2019 09:33 Received 15 Mar 2019 12:38

Microscopy

-

```
No Trichomonas
No Clue cells seen
```

Culture:

Culture:

```
No growth of pathogenic bacteria
No Candida Isolated
```

Report 18/30

Reported	Specialty	Location	Clinician
05 Sep 2018 08:57	Radiology	T10498-BRECHIN HEALTH CENTRE	Dr. Tara MORLEY (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:04

Sample 6935002 (TYPE UNSPECIFIED) Collected 04 Sep 2018 08:55 Received 04 Sep 2018 08:55

Did Not Attend

```
Clinical History :
cyclical pelvic pain and unschedualled spotting throughout the month. pain sharp RIF. ?
ovarian cyst
ENTERED BY: Tara Morley (medical)
BLEEP: 01356 624411
US Pelvis transvaginal :
Did Not Attend :
We would like to inform you that this patient failed to arrive for their Radiology
appointment.  If the patient requires a further appointment, please submit a new request.
This will be treated as a new referral.
 Auto Report / NICB
```

Report 19/30

Reported	Specialty	Location	Clinician

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

05 Sep 2018 08:57 Radiology T10498-BRECHIN HEALTH CENTRE Dr. Tara MORLEY (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:04

Sample 6909153 (TYPE UNSPECIFIED) Collected 04 Sep 2018 08:55 Received 04 Sep 2018 08:55

US Pelvis transvaginal

```
Clinical History :
cyclical pelvic pain and unschedualled spotting throughout the month. pain sharp RIF. ?
ovarian cyst
ENTERED BY: Tara Morley (medical)
BLEEP: 01356 624411
US Pelvis transvaginal :
Did Not Attend :
We would like to inform you that this patient failed to arrive for their Radiology
appointment.  If the patient requires a further appointment, please submit a new request.
This will be treated as a new referral.
 Auto Report / NICB
```

Report 20/30

Reported	Specialty	Location	Clinician
15 Aug 2018 09:20	Microbiology	T10498-BRECHIN HEALTH CENTRE	Dr. Tara MORLEY (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:03

```
CLINICAL DETAILS :
CT/NG symptoms: Bleeding
Patient phone No.: ref
cyclical pelvic pain and unschedualled
spotting throughout the month. pain
sharp RIF. ? ovarian cyst
```

Sample 18V114127 (High Vaginal Swab) Collected 10 Aug 2018 09:05 Received 10 Aug 2018 14:04

C.trachomatis nucleic acid:

Chlamydia trachomatis	Negative

N.gonorrhoeae nucleic acid:

N.gonorrhoeae	Negative

Report 21/30

Reported	Specialty	Location	Clinician
13 Aug 2018 12:06	Microbiology	T10498-BRECHIN HEALTH CENTRE	Dr. Tara MORLEY (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:03

```
CLINICAL DETAILS :
cyclical pelvic pain and unschedualled
spotting throughout the month. pain
sharp RIF. ? ovarian cyst

LAB COMMENTS :
Presence of clue cells suggestive of Bacterial
Vaginosis. Metronidazole is the recommended treatment
for confirmed Bacterial vaginosis.
```

Sample 18B511322 (HIGH VAGINAL SWAB) Collected 10 Aug 2018 09:05 Received 10 Aug 2018 13:08

Microscopy

-	*

```
No Trichomonas
Clue cells seen on microscopy
```

Culture:

Culture:

```
No growth of pathogenic bacteria
No Candida Isolated
```

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Report 22/30

Reported	Specialty	Location	Clinician
28 Jul 2018 11:24	Microbiology	T10498-BRECHIN HEALTH CENTRE	Dr GP LOCUM (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:02

CLINICAL DETAILS :
Otitis type: Otitis externa
S/B locum Dr Jefferies, ? infection, c/o
discharge

Sample 18B714862 (Left Ear Swab) Collected 25 Jul 2018 13:17 Received 25 Jul 2018 18:33

Culture:

Organism	*	**Pseudomonas aeruginosa**
Organism Growth	*	**Profuse Growth**
Gentamicin		S
Ciprofloxacin		S
Organism	*	**Group A Streptococcus**
Organism Growth	*	**Profuse Growth**
Penicillin		S
Erythromycin		S
Doxycycline		S

No fungi isolated

Report 23/30

Reported	Specialty	Location	Clinician
05 Apr 2018 09:36	Microbiology	T10498-BRECHIN HEALTH CENTRE	Dr IRENE M MAHON (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:55

CLINICAL DETAILS :
PV discharge

LAB COMMENTS :
Anaerobes are generally susceptible to Metronidazole
Presence of clue cells suggestive of Bacterial
Vaginosis. Metronidazole is the recommended treatment
for confirmed Bacterial vaginosis.

Sample 18B504671 (VAGINAL SWAB) Collected 30 Mar 2018 16:38 Received 03 Apr 2018 14:18

Microscopy

-	*	

No Trichomonas
Clue cells seen on microscopy

Culture:

Organism	*	**Mixed Anaerobes**
Organism Growth	*	**Profuse Growth**

No Candida Isolated

Report 24/30

Reported	Specialty	Location	Clinician
11 Jan 2018 13:49	Blood Sciences	T10498-BRECHIN HEALTH CENTRE	Dr GP LOCUM (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:51

CLINICAL DETAILS :

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

```
: Postmenopausal
On T4?: No
S/B Dr Taylor, abdo pain, low BMI
```

Sample C185999414 (Fluoride Oxalate) Collected 11 Jan 2018 09:13 Received 11 Jan 2018 12:22

GLUCOSE			
GLUCOSE (preserved tube)	4.2	mmol/L	3.3 - 5.8
C-REACTIVE PROTEIN			
C-REACTIVE PROTEIN	LT4	mg/L	0 - 10
Creatinine and Electrolytes			
SODIUM	142	mmol/L	133 - 146
POTASSIUM	4.8	mmol/L	3.5 - 5.3
CREATININE	75	umol/L	44 - 80
AKI			
AKI	Not detected: but may not exclude AKI in all cases	.	
Liver Function Tests (LFT)			
ALT	9	U/L	5 - 55
BILIRUBINS	5	umol/L	0 - 21
ALKALINE PHOSPHATASE	52	U/L	30 - 130
ALBUMIN	38	g/L	35 - 50
Bone Group			
CALCIUM	2.25	mmol/L	2.10 - 2.55
CALCIUM (CORRECTED)	2.27	mmol/L	2.10 - 2.55
ESTIMATED GFR			
ESTIMATED GFR	GT60	mL/min	
CKD Stage			
CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .		
TSH			
TSH	3.82	mU/L	0.4 - 4.0
CA 125			
CA125	24	kU/L	0 - 30

Report 25/30

Reported	Specialty	Location	Clinician
11 Jan 2018 12:45	Blood Sciences	T10498-BRECHIN HEALTH CENTRE	Dr GP LOCUM (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:51

```
CLINICAL DETAILS :
: Postmenopausal
On T4?: No
S/B Dr Taylor, abdo pain, low BMI
```

Sample H185999414 (EDTA) Collected 11 Jan 2018 09:13 Received 11 Jan 2018 12:22

FBC

Hb	143	g/L	120 - 160
WBC	7.3	x10^9/L	4.0 - 11.0
PLT	263	x10^9/L	150 - 400
RBC	4.62	x10^12/L	3.8 - 4.8
HCT	0.419		0.37 - 0.47
MCV	90.8	fl	85 - 105
MCH	30.9	pg	27 - 32
MCHC	340	g/L	320 - 360
NE#	3.6	x10^9/L	2.0 - 7.5
LY#	2.9	x10^9/L	1.5 - 4.0
MO#	0.5	x10^9/L	0.2 - 0.8
EO#	0.32	x10^9/L	0.0 - 0.4
BA#	0.1	x10^9/L	0.0 - 0.1

Report 26/30

Reported	Specialty	Location	Clinician

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

10 May 2017 10:23 Blood Sciences T13585-ANNAT HEALTH CENTRE Dr RUTH C CRANSWICK (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:38

CLINICAL DETAILS :
On T4?: No
eating disorder clinic

LAB COMMENTS :
PLASMA ZINC analysed by GRI

Sample C175437756 (Blood) Collected 28 Apr 2017 09:33 Received 28 Apr 2017 13:11

AMYLASE			
AMYLASE	60	U/L	0 - 100
BICARBONATE			
BICARBONATE	29	mmol/L	22 - 29
CREATINE KINASE			
CREATINE KINASE	138	U/L	25 - 200
GGT			
GGT	26	U/L	3 - 73
MAGNESIUM			
MAGNESIUM	0.91	mmoL/L	0.70 - 1.00
PHOSPHATE			
PHOSPHATE	1.12	mmoL/L	0.8 - 1.5
PROTEINS			
PROTEINS	63	g/L	60 - 80
Creatinine and Electrolytes			
SODIUM	138	mmol/L	133 - 146
POTASSIUM	4.5	mmol/L	3.5 - 5.3
CREATININE	* **81**	umol/L	44 - 80
AKI			
AKI	Not detected: but may not exclude AKI in all cases	.	
Liver Function Tests (LFT)			
ALT	11	U/L	5 - 55
BILIRUBINS	8	umol/L	0 - 21
ALKALINE PHOSPHATASE	54	U/L	30 - 130
ALBUMIN	40	g/L	35 - 50
Bone Group			
CALCIUM	2.37	mmol/L	2.10 - 2.55
CALCIUM (CORRECTED)	2.36	mmol/L	2.10 - 2.55
ESTIMATED GFR			
ESTIMATED GFR	GT60	mL/min	
CKD Stage			
CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA	.	
C-REACTIVE PROTEIN			
C-REACTIVE PROTEIN	LT4	mg/L	0 - 10
GLUCOSE			
GLUCOSE (preserved tube)	3.5	mmol/L	3.3 - 5.8
TSH			
TSH	3.56	mU/L	0.4 - 4.0
ZINC			
ZINC	13.2	umol/L	10.0 - 18.0

Report 27/30

Reported	Specialty	Location	Clinician
28 Apr 2017 13:54	Blood Sciences	T13585-ANNAT HEALTH CENTRE	Dr RUTH C CRANSWICK (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:37

CLINICAL DETAILS :
On T4?: No

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

eating disorder clinic

Sample H175437756 (EDTA) Collected 28 Apr 2017 09:33 Received 28 Apr 2017 13:11

FBC

Hb	141	g/L	120 - 160
WBC	7.4	x10^9/L	4.0 - 11.0
PLT	250	x10^9/L	150 - 400
RBC	4.72	x10^12/L	3.8 - 4.8
HCT	0.441		0.37 - 0.47
MCV	93.4	fl	85 - 105
MCH	30.0	pg	27 - 32
MCHC	321	g/L	320 - 360
NE#	3.8	x10^9/L	2.0 - 7.5
LY#	2.6	x10^9/L	1.5 - 4.0
MO#	0.6	x10^9/L	0.2 - 0.8
EO#	0.25	x10^9/L	0.0 - 0.4
BA#	0.1	x10^9/L	0.0 - 0.1

Report 28/30

Reported	Specialty	Location	Clinician
18 Nov 2016 08:56	Microbiology	T13585-ANNAT HEALTH CENTRE	Dr RUTH C CRANSWICK (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:29

CLINICAL DETAILS :
cervical pain

Sample 16B517623 (ENDOCERVICAL SWAB) Collected 15 Nov 2016 18:17 Received 16 Nov 2016 13:26

Microscopy

-

No Trichomonas
No Clue cells seen

Culture:

Culture:

No growth of pathogenic bacteria
No Candida Isolated

Report 29/30

Reported	Specialty	Location	Clinician
17 Nov 2016 15:49	Microbiology	T13585-ANNAT HEALTH CENTRE	Dr RUTH C CRANSWICK (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:29

CLINICAL DETAILS :
Patient phone No.: Not asked
cervical pain

Sample 16V119484 (Endocervical) Collected 15 Nov 2016 18:17 Received 16 Nov 2016 17:14

Chlamydia trachomatis DNA:

Chlamydia trachomatis DNA Negative

N.gonorrhoeae DNA:

N.gonorrhoeae DNA Negative

Report 30/30

Reported	Specialty	Location	Clinician

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

09 Sep 2016 09:25 Microbiology T13585-ANNAT HEALTH CENTRE Dr RUTH C CRANSWICK (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 06:25

CLINICAL DETAILS :
Discharge post LLETZ

Sample 16B513886 (HIGH VAGINAL SWAB) Collected 06 Sep 2016 18:14 Received 07 Sep 2016 13:09

Microscopy

-

No Trichomonas
No Clue cells seen

Culture:

Culture:

No growth of pathogenic bacteria
No Candida Isolated

End of reports

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Tayside Diagnostic Services

Printed by cgarnes (Claire Garnes (non referrer)) at 24 Jun 2026 18:12

Patient name:	**STACEY LEONARD**	CHI Number:	**2804880060**	Sex:	**Female**
Date of birth:	**28 Apr 1988**	:			
Address:	**2 Wards Road, Brechin DD9 7AS**				

Report 1/30

Reported	Specialty	Location	Clinician
19 Aug 2021 19:56	POC	NW Hot Lab - NOT GIVEN (Not Specified)	

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:33

CLINICAL DETAILS :

LAB COMMENTS :
** THIS IS A POINT OF CARE REPORT **

Sample POC602681U (Nose and Throat Swab) Collected 19 Aug 2021 19:32 Received 19 Aug 2021 19:32

Point of Care Respiratory		
	Point of care Influenza A	Not Detected
	Point of care Influenza B	Not Detected
SARS-CoV-2 (COVID-19) RNA		
	SARS-CoV-2 (COVID-19) RNA	Not Detected

Report 2/30

Reported	Specialty	Location	Clinician
19 Aug 2021 19:55	Blood Sciences	NW LABOUR SUITE	DR Katrine Elizabeth ORR (Obs & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:58

CLINICAL DETAILS :
Anticoagulation: No
PTL

Sample C218687533 (Blood) Collected 19 Aug 2021 17:04 Received 19 Aug 2021 18:53

C-REACTIVE PROTEIN					
	C-REACTIVE PROTEIN		LT4	mg/L	0 - 10
Urea & Electrolytes					
	SODIUM		135	mmol/L	133 - 146
	POTASSIUM		3.8	mmol/L	3.5 - 5.3
	UREA		2.7	mmol/L	2.5 - 7.8
	CREATININE		56	umol/L	44 - 80
AKI					
	AKI		NOT AVAILABLE	.	
Liver Function Tests (LFT)					
	ALT		LT9	U/L	5 - 55
	BILIRUBINS		18	umol/L	0 - 21
	ALKALINE PHOSPHATASE	*	**142**	U/L	30 - 130
	ALBUMIN	*	**29**	g/L	35 - 50

Report 3/30

Reported	Specialty	Location	Clinician

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

19 Aug 2021 19:37 Blood Sciences NW LABOUR SUITE DR Katrine Elizabeth ORR (Obs & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:58

CLINICAL DETAILS :
Anticoagulation: No
PTL

LAB COMMENTS :
Note change in reference range for APTT 21.6-30.3 sec.
Effective date 21/09/2020.
This change should not affect the APTT Ratio.

Sample H218687533 (EDTA) Collected 19 Aug 2021 17:04 Received 19 Aug 2021 18:53

FBC

Hb	*	**99**	g/L	120 - 160
WBC		11.0	x10^9/L	4.0 - 11.0
PLT		263	x10^9/L	150 - 400
RBC	*	**3.72**	x10^12/L	3.8 - 4.8
HCT	*	**0.300**		0.37 - 0.47
MCV	*	**80.7**	fl	85 - 105
MCH	*	**26.5**	pg	27 - 32
MCHC		328	g/L	320 - 360
NE#	*	**8.3**	x10^9/L	2.0 - 7.5
LY#		2.0	x10^9/L	1.5 - 4.0
MO#		0.6	x10^9/L	0.2 - 0.8
EO#		0.10	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

Coagulation Screen

Prothrombin Time	10.7	secs.	9.5 - 14.0
PT Ratio:	0.9		
APTT	22.2	secs.	21.6 - 30.3
APTT Ratio	0.9		

Report 4/30

Reported	Specialty	Location	Clinician
05 Aug 2021 13:28	Blood Sciences	ARBROATH INF MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:15

CLINICAL DETAILS :
lorna on iron

Sample H218655077 (EDTA) Collected 05 Aug 2021 08:28 Received 05 Aug 2021 13:07

FBC

Hb	*	**102**	g/L	120 - 160
WBC		9.7	x10^9/L	4.0 - 11.0
PLT		223	x10^9/L	150 - 400
RBC	*	**3.76**	x10^12/L	3.8 - 4.8
HCT	*	**0.333**		0.37 - 0.47
MCV		88.6	fl	85 - 105
MCH		27.0	pg	27 - 32
MCHC	*	**305**	g/L	320 - 360
NE#		6.8	x10^9/L	2.0 - 7.5
LY#		2.2	x10^9/L	1.5 - 4.0
MO#		0.5	x10^9/L	0.2 - 0.8

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

EO#		0.16	x10^9/L	0.0 - 0.4
BA#		0.1	x10^9/L	0.0 - 0.1

Report 5/30

Reported	Specialty	Location	Clinician
08 Jul 2021 17:12	Blood Sciences	ARBROATH INF MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:15

CLINICAL DETAILS :
pregnant, anaemic

LAB COMMENTS :
Low serum Folate - review full blood count results and clinical context. Consider cause (NB serum Folate level decreases within a few days of dietary Folate restriction and may therefore not reflect true Folate deficiency).

Sample H218599391 (Blood) Collected 08 Jul 2021 09:14 Received 08 Jul 2021 15:55

B12/FOLATE

B12		316	ng/l	200 - 940

Results may be unreliable if greater than 24hrs

Serum Folate	*	**1.5**	ug/l	3.1 - 17.5

FBC

Hb	*	**98**	g/L	120 - 160
WBC		10.0	x10^9/L	4.0 - 11.0
PLT		297	x10^9/L	150 - 400
RBC	*	**3.67**	x10^12/L	3.8 - 4.8
HCT	*	**0.312**		0.37 - 0.47
MCV	*	**84.9**	fl	85 - 105
MCH	*	**26.7**	pg	27 - 32
MCHC	*	**315**	g/L	320 - 360
NE#		6.9	x10^9/L	2.0 - 7.5
LY#		2.3	x10^9/L	1.5 - 4.0
MO#		0.5	x10^9/L	0.2 - 0.8
EO#		0.23	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

Report 6/30

Reported	Specialty	Location	Clinician
08 Jul 2021 16:57	Blood Sciences	ARBROATH INF MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:15

CLINICAL DETAILS :
pregnant, anaemic

Sample C218599391 (Blood) Collected 08 Jul 2021 09:14 Received 08 Jul 2021 15:55

FERRITIN

FERRITIN	*	**6**	ug/L	13 - 150

Report 7/30

Reported	Specialty	Location	Clinician
05 Jul 2021 14:59	Blood Sciences	LINKS HC ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:15

CLINICAL DETAILS :
28 weeks pregnant, routine. MW-Lorna

Sample H218591662 (EDTA) Collected 05 Jul 2021 11:04 Received 05 Jul 2021 14:21

FBC

Hb	*	**101**	g/L	120 - 160
WBC		8.8	x10^9/L	4.0 - 11.0
PLT		251	x10^9/L	150 - 400
RBC	*	**3.70**	x10^12/L	3.8 - 4.8
HCT	*	**0.317**		0.37 - 0.47
MCV		85.6	fl	85 - 105
MCH		27.3	pg	27 - 32
MCHC	*	**319**	g/L	320 - 360
NE#		6.0	x10^9/L	2.0 - 7.5
LY#		1.9	x10^9/L	1.5 - 4.0
MO#		0.5	x10^9/L	0.2 - 0.8
EO#		0.34	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

Report 8/30

Reported	Specialty	Location	Clinician
05 Jul 2021 14:21	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:43

Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)

Sample 10310048628713 (BLOOD) Collected 05 Jul 2021 11:00 Received 05 Jul 2021 13:12

Automated Antibody Screen

Automated Antibody Screen		Negative

Report 9/30

Reported	Specialty	Location	Clinician
23 Jun 2021 10:04	Microbiology	MONTROSE MINOR INJURY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:18

CLINICAL DETAILS :
Symptoms of UTI?: No
Test reason: Patient pregnant
Antibiotic Therapy: NK
Antibiotic allergies: nk
Known CKD?: No
24+6 WEEKS MIXED GROWTH IN PREVIOUS
SAMPLE MW LORNA

LAB COMMENTS :
THIS SAMPLE WAS GROSSLY CONTAMINATED WITH SKIN FLORA.
PLEASE ADVISE APPROPRIATE TECHNIQUE WITH CLEANING OF
AREA PRIOR TO TAKING MSSU

Sample 21B229356 (Midstream Urine) Collected 15 Jun 2021 08:54 Received 15 Jun 2021 12:46

Urine Culture:

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

AMENDED REPORT -- PLEASE DISCARD PREVIOUS

Organism	*	**Staphylococcus aureus**
Organism Growth	*	**10^4 orgs/ml**
Nitrofurantoin		S
Trimethoprim		S
Flucloxacillin		S
Cefalexin		S
Organism	*	**Escherichia coli**
Organism Growth	*	**10^3 orgs/ml**
Nitrofurantoin		S
Trimethoprim		S
Gentamicin		S
Aztreonam		S
Amoxicillin		S
Cefalexin		S

Report 10/30

Reported	Specialty	Location	Clinician
10 Jun 2021 13:15	Microbiology	LINKS HC ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:15

```
CLINICAL DETAILS :
Symptoms of UTI?: Yes
Symptoms: urinalysis prot
Antibiotic Therapy: nil
Antibiotic allergies: nil
Known CKD?: No
Lorna ?UTI
```

Sample 21B228438 (Midstream Urine) Collected 09 Jun 2021 12:30 Received 09 Jun 2021 17:01

Urine Culture:

```
Mixed Growth. Please repeat, if indicated.
```

Report 11/30

Reported	Specialty	Location	Clinician
17 Apr 2021 12:14	Microbiology	LINKS HC ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:15

```
CLINICAL DETAILS :
Site: LVS
Test reason:: symptoms of infection
lorna
```

Sample 21B504114 (VAGINAL SWAB) Collected 15 Apr 2021 10:49 Received 15 Apr 2021 13:50

Microscopy

-

```
NO Trichomonas seen
No Clue cells seen
```

Culture:

Culture:

```
No growth of pathogenic bacteria
```

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

No Candida Isolated

Report 12/30

Reported	Specialty	Location	Clinician
16 Apr 2021 09:12	Microbiology	LINKS HC ANTE-NATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:15

CLINICAL DETAILS :
Symptoms of UTI?: Yes
Antibiotic Therapy: nil
Antibiotic allergies: nil
Known CKD?: No
lorna

Sample 21B218353 (Midstream Urine) Collected 15 Apr 2021 10:49 Received 15 Apr 2021 13:54

Urine Culture:

No Significant Bacteriuria

Report 13/30

Reported	Specialty	Location	Clinician
17 Feb 2021 14:12	Microbiology	ARBROATH INF MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:15

CLINICAL DETAILS :
lorna booking

Sample 21V002035 (Venous blood) Collected 16 Feb 2021 11:01 Received 16 Feb 2021 16:53

Hepatitis B (HBsAg) screen:

Hepatitis B (HBsAg) screen	Negative

Syphilis total antibody:

Syphilis total antibody	Negative

HIV1&2 Antigen/Antibody:

HIV1&2 Antigen/Antibody	Negative

Report 14/30

Reported	Specialty	Location	Clinician
17 Feb 2021 10:04	Microbiology	ARBROATH INF MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:15

CLINICAL DETAILS :
Symptoms of UTI?: No
Test reason: Patient pregnant
Antibiotic Therapy: nil
Antibiotic allergies: nil
Known CKD?: No
lorna booking

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Sample 21B207472 (Midstream Urine) Collected 16 Feb 2021 11:01 Received 16 Feb 2021 15:31

Urine Culture:

No Significant Bacteriuria

Report 15/30

Reported	Specialty	Location	Clinician
17 Feb 2021 08:49	Blood Sciences	ARBROATH INF MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:15

CLINICAL DETAILS :
lorna booking

LAB COMMENTS :
Based on FBC and Family Origin Questionnaire, no need
for Haemoglobinopathy or partner screening.

Sample H218296495 (EDTA) Collected 16 Feb 2021 11:01 Received 16 Feb 2021 15:56

FBC

Hb	125	g/L	120 - 160
WBC	8.2	x10^9/L	4.0 - 11.0
PLT	286	x10^9/L	150 - 400
RBC	4.29	x10^12/L	3.8 - 4.8
HCT	0.382		0.37 - 0.47
MCV	89.1	fl	85 - 105
MCH	29.1	pg	27 - 32
MCHC	327	g/L	320 - 360
NE#	5.2	x10^9/L	2.0 - 7.5
LY#	2.2	x10^9/L	1.5 - 4.0
MO#	0.6	x10^9/L	0.2 - 0.8
EO#	0.23	x10^9/L	0.0 - 0.4
BA#	0.0	x10^9/L	0.0 - 0.1

ANC BOOKING BLOODS

ANC BOOKING BLOODS	NOT REQUIRED.

Report 16/30

Reported	Specialty	Location	Clinician
16 Feb 2021 17:11	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:43

Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)
Please send a sample at 28 to 30 weeks , gestation.

Sample 10310047241514 (BLOOD) Collected 16 Feb 2021 10:00 Received 16 Feb 2021 16:12

Automated Antibody Screen

Automated Antibody Screen	Negative

Report 17/30

Reported	Specialty	Location	Clinician
13 Nov 2020 09:44	Microbiology	T10498-BRECHIN HEALTH CENTRE	DR Sarab HANNA (GP) (General Practice)

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 06:44

```
CLINICAL DETAILS :
Site: HVS
Test reason:: discharge
in for smear - discharge and itch ?
thrush
```

Sample 20B513178 (VAGINAL SWAB) Collected 11 Nov 2020 12:16 Received 11 Nov 2020 15:49

Microscopy

-

```
NO Trichomonas seen
No Clue cells seen
```

Culture:

Culture:

```
No growth of pathogenic bacteria
No Candida Isolated
```

Report 18/30

Reported	Specialty	Location	Clinician
05 Oct 2020 19:46	Microbiology	RVH Staff COVID	Gillian M ELLIOTT(Dental) (Community Health Services Dental)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:28

```
CLINICAL DETAILS :
Criteria: Pre-operative - amber pathway
Symptoms: Asymptomatic
Predispositions: None
Consent given. Pre op patient
```

Sample 20V178277 (Nasal+Throat swab) Collected 04 Oct 2020 12:03 Received 05 Oct 2020 14:31

SARS-CoV-2 (COVID-19) RNA:

SARS-CoV-2 (COVID-19) RNA not detected

Report 19/30

Reported	Specialty	Location	Clinician
01 Jun 2020 09:31	Microbiology	ARBROATH INF MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

```
CLINICAL DETAILS :
Symptoms of UTI?: Yes
Antibiotic Therapy: na
Antibiotic allergies: na
Known CKD?: No
repeat fbc and crp as per medical
request
```

Sample 20B223971 (Midstream Urine) Collected 29 May 2020 11:43 Received 29 May 2020 18:01

Urine Culture:

Organism	*	**Escherichia coli**
Organism Growth	*	**10^3 orgs/ml**
Aztreonam		S
Amoxicillin		S

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Trimethoprim	S
Nitrofurantoin	S
Gentamicin	S

Report 20/30

Reported	Specialty	Location	Clinician
29 May 2020 17:16	Blood Sciences	ARBROATH INF MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

CLINICAL DETAILS :
repeat fbc and crp as per medical request

Sample H207835157 (EDTA) Collected 29 May 2020 11:44 Received 29 May 2020 15:38

FBC

Hb		136	g/L	120 - 160
WBC	*	**11.7**	x10^9/L	4.0 - 11.0
PLT		381	x10^9/L	150 - 400
RBC	*	**5.13**	x10^12/L	3.8 - 4.8
HCT		0.432		0.37 - 0.47
MCV	*	**84.3**	fl	85 - 105
MCH	*	**26.5**	pg	27 - 32
MCHC	*	**315**	g/L	320 - 360
NE#	*	**8.0**	x10^9/L	2.0 - 7.5
LY#		2.9	x10^9/L	1.5 - 4.0
MO#		0.6	x10^9/L	0.2 - 0.8
EO#		0.23	x10^9/L	0.0 - 0.4
BA#		0.1	x10^9/L	0.0 - 0.1

Report 21/30

Reported	Specialty	Location	Clinician
29 May 2020 16:14	Blood Sciences	ARBROATH INF MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

CLINICAL DETAILS :
repeat fbc and crp as per medical request

Sample C207835157 (Blood) Collected 29 May 2020 11:44 Received 29 May 2020 15:38

C-REACTIVE PROTEIN

C-REACTIVE PROTEIN	LT4	mg/L	0 - 10

Report 22/30

Reported	Specialty	Location	Clinician
27 May 2020 11:46	Microbiology	NW OP ANTENATAL CLINIC	Dr Binita PANDE (Obstets & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:00

CLINICAL DETAILS :
Antibiotic Therapy: nk
Antibiotic allergies: nk
8 PN - offensive lochia

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Sample 20B505953 (HIGH VAGINAL SWAB) Collected 24 May 2020 11:57 Received 25 May 2020 11:56

Microscopy

-

```
NO Trichomonas seen
No Clue cells seen
```

Culture:

Culture:

```
No growth of pathogenic bacteria
No Candida Isolated
```

Report 23/30

Reported	Specialty	Location	Clinician
24 May 2020 13:04	Blood Sciences	NW OP ANTENATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:00

```
CLINICAL DETAILS :
  8 PN - offensive lochia
```

Sample C207826973 (Blood) Collected 24 May 2020 11:56 Received 24 May 2020 12:25

C-REACTIVE PROTEIN			
C-REACTIVE PROTEIN	LT4	mg/L	0 - 10
Urea & Electrolytes			
SODIUM	137	mmol/L	133 - 146
POTASSIUM	5.1	mmol/L	3.5 - 5.3
UREA	5.0	mmol/L	2.5 - 7.8
CREATININE	54	umol/L	44 - 80
AKI			
AKI	Not detected: May not exclude AKI in all cases .		
Liver Function Tests (LFT)			
ALT	15	U/L	5 - 55
BILIRUBINS	6	umol/L	0 - 21
ALKALINE PHOSPHATASE	123	U/L	30 - 130
ALBUMIN	35	g/L	35 - 50

Report 24/30

Reported	Specialty	Location	Clinician
24 May 2020 12:56	Blood Sciences	NW OP ANTENATAL CLINIC	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:00

```
CLINICAL DETAILS :
  8 PN - offensive lochia
```

Sample H207826973 (EDTA) Collected 24 May 2020 11:56 Received 24 May 2020 12:25

FBC

Hb		132	g/L	120 - 160
WBC	*	**13.0**	x10^9/L	4.0 - 11.0
PLT	*	**456**	x10^9/L	150 - 400
RBC	*	**5.09**	x10^12/L	3.8 - 4.8
HCT		0.420		0.37 - 0.47
MCV	*	**82.6**	fl	85 - 105

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

MCH	*	**26.0**	pg	27 - 32
MCHC	*	**314**	g/L	320 - 360
NE#	*	**8.5**	x10^9/L	2.0 - 7.5
LY#		3.5	x10^9/L	1.5 - 4.0
MO#		0.7	x10^9/L	0.2 - 0.8
EO#		0.24	x10^9/L	0.0 - 0.4
BA#		0.1	x10^9/L	0.0 - 0.1

Report 25/30

Reported	Specialty	Location	Clinician
18 May 2020 10:14	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:39

```
Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)
```

Sample 10310044719914 (BLOOD) Collected 16 May 2020 04:30 Received 16 May 2020 07:19

Automated Antibody Screen

Automated Antibody Screen	Negative

Report 26/30

Reported	Specialty	Location	Clinician
16 May 2020 16:15	Blood Sciences	NW LABOUR SUITE	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:58

```
CLINICAL DETAILS :
  IOL on oxytocin
```

Sample C207817176 (Blood) Collected 16 May 2020 10:17 Received 16 May 2020 15:45

Urea & Electrolytes

SODIUM	141	mmol/L	133 - 146
POTASSIUM	3.9	mmol/L	3.5 - 5.3
UREA	* **2.4**	mmol/L	2.5 - 7.8
CREATININE	47	umol/L	44 - 80

AKI

AKI	Not detected: May not exclude AKI in all cases .

Report 27/30

Reported	Specialty	Location	Clinician
16 May 2020 04:55	Blood Sciences	NW LABOUR SUITE	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:58

```
CLINICAL DETAILS :
  IOL - SGA
```

Sample C207817077 (Blood) Collected 16 May 2020 02:25 Received 16 May 2020 04:21

Urea & Electrolytes

SODIUM	135	mmol/L	133 - 146

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

POTASSIUM	4.5	mmol/L	3.5 - 5.3
UREA	3.3	mmol/L	2.5 - 7.8
CREATININE	45	umol/L	44 - 80

AKI

AKI	Not detected: May not exclude AKI in all cases .

Report 28/30

Reported	Specialty	Location	Clinician
16 May 2020 04:36	Blood Sciences	NW LABOUR SUITE	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:58

CLINICAL DETAILS :
IOL - SGA

Sample H207817077 (EDTA) Collected 16 May 2020 02:25 Received 16 May 2020 04:21

FBC

Hb	*	**109**	g/L	120 - 160
WBC	*	**13.3**	x10^9/L	4.0 - 11.0
PLT		333	x10^9/L	150 - 400
RBC		4.11	x10^12/L	3.8 - 4.8
HCT	*	**0.336**		0.37 - 0.47
MCV	*	**81.7**	fl	85 - 105
MCH	*	**26.4**	pg	27 - 32
MCHC		323	g/L	320 - 360
NE#	*	**9.1**	x10^9/L	2.0 - 7.5
LY#		3.1	x10^9/L	1.5 - 4.0
MO#		0.8	x10^9/L	0.2 - 0.8
EO#		0.22	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

Report 29/30

Reported	Specialty	Location	Clinician
12 Mar 2020 10:11	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:39

Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)

Sample 10310044242434 (BLOOD) Collected 11 Mar 2020 11:30 Received 12 Mar 2020 09:02

Automated Antibody Screen

Automated Antibody Screen	Negative

Report 30/30

Reported	Specialty	Location	Clinician
11 Mar 2020 17:24	Blood Sciences	MONTROSE MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:14

CLINICAL DETAILS :

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

28wks routine - Natalie

Sample H207744771 (EDTA) Collected 11 Mar 2020 11:50 Received 11 Mar 2020 16:48

FBC

Hb	*	**110**	g/L	120 - 160
WBC	*	**12.5**	x10^9/L	4.0 - 11.0
PLT		290	x10^9/L	150 - 400
RBC		3.85	x10^12/L	3.8 - 4.8
HCT	*	**0.347**		0.37 - 0.47
MCV		90.1	fl	85 - 105
MCH		28.6	pg	27 - 32
MCHC	*	**317**	g/L	320 - 360
NE#	*	**9.4**	x10^9/L	2.0 - 7.5
LY#		2.2	x10^9/L	1.5 - 4.0
MO#		0.7	x10^9/L	0.2 - 0.8
EO#		0.21	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

End of reports

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Tayside Diagnostic Services

Printed by cgarnes (Claire Garnes (non referrer)) at 24 Jun 2026 18:12

Patient name:	**STACEY LEONARD**	CHI Number:	**2804880060**	Sex:	**Female**
Date of birth:	**28 Apr 1988**	:			
Address:	**2 Wards Road, Brechin DD9 7AS**				

Report 1/30

Reported	Specialty	Location	Clinician
18 Oct 2023 18:26	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:54

```
Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)
```

Sample 10310057215336 (BLOOD) Collected 18 Oct 2023 10:00 Received 18 Oct 2023 17:01

Automated Antibody Screen

Automated Antibody Screen	Negative

Report 2/30

Reported	Specialty	Location	Clinician
18 Oct 2023 17:32	Blood Sciences	MONTROSE MINOR INJURY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:21

```
CLINICAL DETAILS :
  28 weeks
```

Sample H231392770 (EDTA) Collected 18 Oct 2023 10:47 Received 18 Oct 2023 16:49

FBC

Hb	*	**101**	g/L	120 - 160
WBC	*	**11.5**	x10^9/L	4.0 - 11.0
PLT		329	x10^9/L	150 - 400
RBC	*	**3.74**	x10^12/L	3.8 - 4.8
HCT	*	**0.314**		0.37 - 0.47
MCV	*	**83.8**	fl	85 - 105
MCH		27.1	pg	27 - 32
MCHC		323	g/L	320 - 360
NE#	*	**9.1**	x10^9/L	2.0 - 7.5
LY#		1.8	x10^9/L	1.5 - 4.0
MO#		0.5	x10^9/L	0.2 - 0.8
EO#		0.13	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

Report 3/30

Reported	Specialty	Location	Clinician
06 Sep 2023 16:12	Blood Sciences	T10498-BRECHIN HEALTH CENTRE	Dr GP LOCUM (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 06:48

```
CLINICAL DETAILS :
  regular monitoring while in pregnancy, repeat in 1m

LAB COMMENTS :
LAMOTRIGINE performed by Birmingham City Hospital
```

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Sample C231291674 (Blood) Collected 04 Sep 2023 09:30 Received 04 Sep 2023 12:14
LAMOTRIGINE
Therapeutic range (epilepsy) 1-4
Maximum drug efficacy (Bipolar disorder) 3-14
(trough specimen taken pre dose or minimum 6 hrs
post dose)

LAMOTRIGINE	1.2	mg/L	1.0 - 4.0

Report 4/30

Reported	Specialty	Location	Clinician
22 Aug 2023 10:34	Radiology	NW OP OBS & GYNAE CLINIC	Unknown Unknown (Dental Medicine Specialties)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:16

Sample 8843923 (TYPE UNSPECIFIED) Collected 22 Aug 2023 09:58 Received 22 Aug 2023 09:58
US Anomaly

Clinical History :
20 WEEKS
Fiona Agnew
Midwife Sonographer 93I0292SReport available on Badgernet
FIONA AGNEW (Obs & Gyn) / AGNEWF

Report 5/30

Reported	Specialty	Location	Clinician
09 Aug 2023 15:28	Blood Sciences	ARBROATH INF MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:17

CLINICAL DETAILS :
16wks

LAB COMMENTS :
LAMOTRIGINE performed by Birmingham City Hospital

Sample C231218210 (Blood) Collected 02 Aug 2023 10:57 Received 02 Aug 2023 16:09
LAMOTRIGINE
Therapeutic range (epilepsy) 1-4
Maximum drug efficacy (Bipolar disorder) 3-14
(trough specimen taken pre dose or minimum 6 hrs
post dose)

LAMOTRIGINE	1.1	mg/L	1.0 - 4.0

Report 6/30

Reported	Specialty	Location	Clinician
04 Jul 2023 12:38	Radiology	ARBROATH INF OP ANTE NATAL	Unknown Unknown (Dental Medicine Specialties)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:03

Sample 8796770 (TYPE UNSPECIFIED) Collected 04 Jul 2023 08:52 Received 04 Jul 2023 08:52
US Booking

Report available on Badgernet
Fiona McInnes
Midwife Sonographer 81H0243S
FIONA MCINNES (Obs and Gyn) / MCINNESF

Report 7/30

Reported	Specialty	Location	Clinician
08 Jun 2023 16:17	Blood Sciences	ARBROATH INF MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:17

CLINICAL DETAILS :
booking

LAB COMMENTS :
LAMOTRIGINE performed by Birmingham City Hospital

Sample C231082361 (Blood) Collected 02 Jun 2023 09:58 Received 02 Jun 2023 16:10

FERRITIN

FERRITIN	*	**7**	ug/L	13 - 150

LAMOTRIGINE

Therapeutic range (epilepsy) 1-4
Maximum drug efficacy (Bipolar disorder) 3-14
(trough specimen taken pre dose or minimum 6 hrs post dose)

LAMOTRIGINE	1.3	mg/L	1.0 - 4.0

Report 8/30

Reported	Specialty	Location	Clinician
05 Jun 2023 13:49	Microbiology	ARBROATH INF MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:17

CLINICAL DETAILS :
booking

Sample 23V009823 (Venous blood) Collected 02 Jun 2023 09:58 Received 03 Jun 2023 09:02

Hepatitis B (HBsAg) screen:

Hepatitis B (HBsAg) screen	Negative

Syphilis total antibody:

Syphilis total antibody	Negative

HIV1&2 Antigen/Antibody:

HIV1&2 Antigen/Antibody	Negative

Report 9/30

Reported	Specialty	Location	Clinician
05 Jun 2023 11:37	Blood Sciences	ARBROATH INF MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:17

CLINICAL DETAILS :
booking

LAB COMMENTS :
No evidence of thalassaemia.
Not tested for haemoglobin variants as family origin questionnaire indicates both biological parents are of low risk family origins.
Testing of baby's biological father not required.

Sample H231082361 (EDTA) Collected 02 Jun 2023 09:58 Received 02 Jun 2023 16:10

FBC

Hb		121	g/L	120 - 160
WBC		7.0	x10^9/L	4.0 - 11.0
PLT		271	x10^9/L	150 - 400
RBC		4.09	x10^12/L	3.8 - 4.8
HCT	*	**0.349**		0.37 - 0.47
MCV		85.3	fl	85 - 105

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

MCH		29.6	pg	27 - 32
MCHC		347	g/L	320 - 360
NE#		5.3	x10^9/L	2.0 - 7.5
LY#	*	**1.4**	x10^9/L	1.5 - 4.0
MO#		0.3	x10^9/L	0.2 - 0.8
EO#		0.07	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

ANC BOOKING BLOODS

ANC BOOKING BLOODS	NOT REQUIRED.

Report 10/30

Reported	Specialty	Location	Clinician
03 Jun 2023 09:28	Microbiology	ARBROATH INF MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:17

```
CLINICAL DETAILS :
Symptoms of UTI?: No
Test reason: Patient pregnant
Antibiotic Therapy: nil
Antibiotic allergies: nil
Known CKD?: No
booking
```

Sample 23B229921 (Midstream Urine) Collected 02 Jun 2023 09:58 Received 02 Jun 2023 15:47

Urine Culture:

```
No Significant Bacteriuria
```

Report 11/30

Reported	Specialty	Location	Clinician
02 Jun 2023 17:26	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:54

```
Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)
Please send a sample at 28 to 30 weeks , gestation.
```

Sample 10310055761333 (BLOOD) Collected 02 Jun 2023 10:00 Received 02 Jun 2023 16:11

Automated Antibody Screen

Automated Antibody Screen	Negative

Report 12/30

Reported	Specialty	Location	Clinician
02 Jun 2023 16:47	Blood Sciences	ARBROATH INF MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:17

```
CLINICAL DETAILS :
  booking
```

Sample H231082474 (Blood) Collected 02 Jun 2023 10:14 Received 02 Jun 2023 16:02

B12/FOLATE

B12		292	ng/l	200 - 940

```
Results may be unreliable if sample older than 48h
```

Serum Folate	*	**2.6**	ug/l	3.1 - 17.5

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Report 13/30

Reported	Specialty	Location	Clinician
18 Apr 2023 11:39	Radiology	T10498-BRECHIN HEALTH CENTRE	Dr Pei Sin Ang (GP) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 06:39

Sample 8693107 (TYPE UNSPECIFIED) Collected 18 Apr 2023 11:03 Received 18 Apr 2023 11:03

Ultrasound Pelvis transvaginal

```
Clinical History :
6-7 months hx of abdo pain, irregular period and discharge. ? gynae pathology
ENTERED BY: Pei Sin Ang (medical)
BLEEP: 01356 624411
Ultrasound Pelvis transvaginal :
Scan performed with the patient's verbal consent and chaperone present. LMP 13 days.
The uterus is normal in size and shape. The myometrium has an overall heterogenous
appearance. A small trace of fluid is noted within the endometrial cavity. There is an
area of irregularity at the fundal endometrium which may represent a small submucosal
fibroid indenting or a polyp, difficult to assess.
Normal appearance of the ovaries. No adnexal mass. A small amount of pelvic free fluid is
noted.
The patient states a Gynaecological referral has been made.
Vicki Taylor, Sonographer (RA55744)
 VICKi SOUTAR / VSOUTAR
```

Report 14/30

Reported	Specialty	Location	Clinician
17 Apr 2023 15:07	Microbiology	T10498-BRECHIN HEALTH CENTRE	Dr Pei Sin Ang (GP) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 06:39

```
CLINICAL DETAILS :
CT/NG symptoms: Bleeding, Pelvic pain
6-7 months hx of abdo pain, irregular
period and discharge. ? gynae pathology
```

Sample 23V306857 (Vulval-Vaginal Swab) Collected 13 Apr 2023 15:30 Received 17 Apr 2023 09:30

C.trachomatis nucleic acid:

Chlamydia trachomatis	Negative

N.gonorrhoeae nucleic acid:

N.gonorrhoeae	Negative

Report 15/30

Reported	Specialty	Location	Clinician
16 Apr 2023 11:57	Microbiology	T10498-BRECHIN HEALTH CENTRE	Dr Pei Sin Ang (GP) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 06:39

```
CLINICAL DETAILS :
Site: LVS
Test reason:: irregular period. abdo
pain.
6-7 months hx of abdo pain, irregular
period and discharge. ? gynae pathology

LAB COMMENTS :
Thrush is a clinical diagnosis.
Please assess for signs/symptoms of candidiasis.
Swabs are of limited utility - empirical
treatment recommended if symptomatic.
```

Sample 23B504520 (VAGINAL SWAB) Collected 13 Apr 2023 15:30 Received 14 Apr 2023 12:10

Microscopy

-

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

```
NO Trichomonas seen
No Clue cells seen
```

Culture:

Organism	*	**Candida**
Organism Growth	*	**Growth**

```
No growth of pathogenic bacteria
```

Report 16/30

Reported	Specialty	Location	Clinician
11 Oct 2022 15:25	Radiology	NW ACCIDENT & EMERGENCY	Dr. Julie RONALD (A&E) (Accident & Emergency)

Filed by **jgarrett** (Justin Garrett (medical)) at 11 Oct 2022 18:44

Sample 8468745 (TYPE UNSPECIFIED) Collected 08 Oct 2022 23:17 Received 08 Oct 2022 23:17
XR Ankle Lt

```
Clinical History :
Forced inversion left ankle, tender lat mal ?#
ENTERED BY: Theodore Muth (Medical)
BLEEP: 32170
XR Ankle Lt :
No acute bony injury.
 DR SHASHANK POONIYA / SPOONIYA
```

Report 17/30

Reported	Specialty	Location	Clinician
13 Sep 2022 19:10	Blood Sciences	T10498-BRECHIN HEALTH CENTRE	Dr GP LOCUM (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 06:25

```
CLINICAL DETAILS :
Testosterone:
On T4?: No
irregualr periods
```

Sample C229505139 (Blood) Collected 13 Sep 2022 13:47 Received 13 Sep 2022 18:23

FSH			
FSH	5.7	U/L	1.1 - 9.6
TSH			
TSH	2.07	mU/L	0.4 - 4.0
LH			
LH	2.7	U/L	0.8 - 12.0
TESTOSTERONE			
TESTOSTERONE	0.6	nmol/L	

```
Pre-menopausal Testosterone (0.4 - 2.1 nmol/L)
Post-menopausal Testosterone (<0.24 - 1.7 nmol/L)
```

Creatinine and Electrolytes			
SODIUM	139	mmol/L	133 - 146
POTASSIUM	4.0	mmol/L	3.5 - 5.3
CREATININE	78	umol/L	44 - 80
AKI			
AKI	NOT AVAILABLE	.	
Liver Function Tests (LFT)			
ALT	LT9	U/L	5 - 55
BILIRUBINS	14	umol/L	0 - 21
ALKALINE PHOSPHATASE	52	U/L	30 - 130
ALBUMIN	40	g/L	35 - 50
Bone Group			
CALCIUM	2.29	mmol/L	2.10 - 2.55

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

CALCIUM (CORRECTED)	2.28	mmol/L	2.10 - 2.55

ESTIMATED GFR

ESTIMATED GFR	GT60	mL/min

eGFR should not be used to assess renal function
for any drug dosing in over 75s or extremes of BMI
and for DOAC dosing in those with an eGFR less
than 60ml/min.

CKD Stage

CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .

Report 18/30

Reported	Specialty	Location	Clinician
13 Sep 2022 18:50	Blood Sciences	T10498-BRECHIN HEALTH CENTRE	Dr GP LOCUM (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 06:25

CLINICAL DETAILS :
Testosterone:
On T4?: No
irregualr periods

Sample H229505139 (EDTA) Collected 13 Sep 2022 13:47 Received 13 Sep 2022 18:23

FBC

Hb	127	g/L	120 - 160
WBC	8.6	x10^9/L	4.0 - 11.0
PLT	306	x10^9/L	150 - 400
RBC	4.30	x10^12/L	3.8 - 4.8
HCT	0.390		0.37 - 0.47
MCV	90.7	fl	85 - 105
MCH	29.6	pg	27 - 32
MCHC	327	g/L	320 - 360
NE#	4.5	x10^9/L	2.0 - 7.5
LY#	3.2	x10^9/L	1.5 - 4.0
MO#	0.5	x10^9/L	0.2 - 0.8
EO#	0.28	x10^9/L	0.0 - 0.4
BA#	0.0	x10^9/L	0.0 - 0.1

Report 19/30

Reported	Specialty	Location	Clinician
16 Nov 2021 10:25	Histopathology	STRACATHRO OP PLASTICS	Ms Fiona J HOGG(Plastic Surgery) (Plastic Surgery)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:43

CLINICAL DETAILS :

Sample TS21018528 (Skin Excision biopsy) Collected 28 Oct 2021 00:00 Received 29 Oct 2021 13:02

Report

Nature of Specimen(s)
Excision lesion right scalp
Clinical Information Supplied
Papillomatous lesion right scalp noticed over past few months.
Cathes when brushes hair. Looks benign. No follow up pathway.
Macro Report
A possible small ellipse of skin 4x2x2mm covered by a white warty
lesion up to 9mm. Bisected and both halves taken.
Micro Report
Histological sections show hair bearing cutaneous tissue
incorporating a lobular capillary haemangioma. This focally abuts
the deep resection margin and therefore it is difficult to
guarantee excision but there are no concerning findings.
Signature of Pathologist(s)
Dr SL Edwards
JSH

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Please note that some ancillary studies performed may be out of scope of the pathology department's UKAS accreditation. Please refer to the pathology user handbook (available on staffnet) for details.

Report 20/30

Reported	Specialty	Location	Clinician
25 Sep 2021 02:17	Microbiology	NW LABOUR SUITE	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:58

CLINICAL DETAILS :
Rapid required: Y
Rapid reason: Acute admission: 4-6 hr
test is an IPC risk
IPC risk details: delivered, to be
transferred to ward
Authorised: Dr Lynch
Criteria: Admission screen
Symptoms: Asymptomatic
delivered

Sample 21V406486 (Nasal+Throat swab) Collected 25 Sep 2021 00:11 Received 25 Sep 2021 01:54

RAPID SARS-COV-2 RNA

Please refer to Point of Care Respiratory result.

Report 21/30

Reported	Specialty	Location	Clinician
25 Sep 2021 02:17	POC	NW Hot Lab - NOT GIVEN (Not Specified)	

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:38

CLINICAL DETAILS :

LAB COMMENTS :
** THIS IS A POINT OF CARE REPORT **

Sample POC609976U (Nose and Throat Swab) Collected 25 Sep 2021 01:56 Received 25 Sep 2021 01:56

Point of Care Respiratory

Point of care Influenza A	Not Detected
Point of care Influenza B	Not Detected

SARS-CoV-2 (COVID-19) RNA

SARS-CoV-2 (COVID-19) RNA	Not Detected

Report 22/30

Reported	Specialty	Location	Clinician
25 Sep 2021 02:11	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:45

Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)

Sample 10310049464930 (BLOOD) Collected 24 Sep 2021 22:15 Received 25 Sep 2021 00:53

Automated Antibody Screen

Automated Antibody Screen	Negative

Report 23/30

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Reported	Specialty	Location	Clinician
25 Sep 2021 01:39	Blood Sciences	NW LABOUR SUITE	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:58

CLINICAL DETAILS :
post delivery, antenatal anaemia

Sample H218765369 (EDTA) Collected 24 Sep 2021 23:51 Received 25 Sep 2021 01:15

FBC

Hb	*	**115**	g/L	120 - 160
WBC	*	**12.0**	x10^9/L	4.0 - 11.0
PLT		260	x10^9/L	150 - 400
RBC		4.37	x10^12/L	3.8 - 4.8
HCT	*	**0.363**		0.37 - 0.47
MCV	*	**83.0**	fl	85 - 105
MCH	*	**26.4**	pg	27 - 32
MCHC	*	**318**	g/L	320 - 360
NE#	*	**8.7**	x10^9/L	2.0 - 7.5
LY#		2.5	x10^9/L	1.5 - 4.0
MO#		0.7	x10^9/L	0.2 - 0.8
EO#		0.13	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

Report 24/30

Reported	Specialty	Location	Clinician
14 Sep 2021 14:26	Microbiology	NW OP ANTENATAL CLINIC	Dr Binita PANDE (Obstets & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:01

CLINICAL DETAILS :
Rapid required: Y
Rapid reason: Acute admission: 4-6 hr
test is an IPC risk
IPC risk details: 1.
Authorised: pl
Criteria: Admission screen
Symptoms: Asymptomatic
37+5wks For admission 2cm dilated

Sample 21V405255 (Nasal+Throat swab) Collected 13 Sep 2021 17:01 Received 13 Sep 2021 19:12

RAPID SARS-COV-2 RNA

Please refer to Point of Care Respiratory result.

Report 25/30

Reported	Specialty	Location	Clinician
13 Sep 2021 19:37	POC	NW Hot Lab - NOT GIVEN (Not Specified)	

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:38

CLINICAL DETAILS :

LAB COMMENTS :
** THIS IS A POINT OF CARE REPORT **

Sample POC607723U (Nose and Throat Swab) Collected 13 Sep 2021 19:16 Received 13 Sep 2021 19:16

Point of Care Respiratory

Point of care Influenza A	Not Detected
Point of care Influenza B	Not Detected

SARS-CoV-2 (COVID-19) RNA

SARS-CoV-2 (COVID-19) RNA	Not Detected

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Report 26/30

Reported	Specialty	Location	Clinician
01 Sep 2021 18:10	Blood Sciences	WHITEHILLS MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:36

CLINICAL DETAILS :
36 wks pregnant - On iron

Sample H218714550 (EDTA) Collected 01 Sep 2021 14:26 Received 01 Sep 2021 17:24

FBC

Hb	*	**92**	g/L	120 - 160
WBC		10.7	x10^9/L	4.0 - 11.0
PLT		296	x10^9/L	150 - 400
RBC	*	**3.71**	x10^12/L	3.8 - 4.8
HCT	*	**0.298**		0.37 - 0.47
MCV	*	**80.3**	fl	85 - 105
MCH	*	**24.8**	pg	27 - 32
MCHC	*	**310**	g/L	320 - 360
NE#	*	**7.7**	x10^9/L	2.0 - 7.5
LY#		2.2	x10^9/L	1.5 - 4.0
MO#		0.7	x10^9/L	0.2 - 0.8
EO#		0.13	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

Report 27/30

Reported	Specialty	Location	Clinician
23 Aug 2021 08:18	Microbiology	NW LABOUR SUITE	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:58

CLINICAL DETAILS :
Site: LVS
Test reason:: ?PTL 34+1
?PTL 34+1

LAB COMMENTS :
Thrush is a clinical diagnosis.
Please assess for signs/symptoms of candidiasis.
Swabs are of limited utility - empirical
treatment recommended if symptomatic.

Sample 21B509061 (VAGINAL SWAB) Collected 19 Aug 2021 18:03 Received 20 Aug 2021 08:59

Microscopy

-

NO Trichomonas seen
No Clue cells seen

Culture:

Organism	*	**Candida**
Organism Growth	*	**Growth**

No growth of pathogenic bacteria

Report 28/30

Reported	Specialty	Location	Clinician
21 Aug 2021 08:57	Microbiology	NW LABOUR SUITE	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:58

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

```
CLINICAL DETAILS :
Symptoms of UTI?: No
Test reason: Patient pregnant
Antibiotic Therapy: nil
Antibiotic allergies: nil
Known CKD?: No
?PTL 34+1
```

Sample 21B241611 (Midstream Urine) Collected 19 Aug 2021 18:24 Received 20 Aug 2021 09:05

Urine Culture:

```
No Significant Bacteriuria
```

Report 29/30

Reported	Specialty	Location	Clinician
19 Aug 2021 20:21	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:43

```
Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)
```

Sample 10310049092120 (BLOOD) Collected 19 Aug 2021 17:50 Received 19 Aug 2021 18:19

Automated Antibody Screen

Automated Antibody Screen	Negative

Report 30/30

Reported	Specialty	Location	Clinician
19 Aug 2021 19:59	Microbiology	NW LABOUR SUITE	DR Katrine Elizabeth ORR (Obs & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:58

```
CLINICAL DETAILS :
Rapid required: Y
Rapid reason: Acute admission: 4-6 hr
test is an IPC risk
IPC risk details: in labour NICU
admission likely
Authorised: Dr Ramalingham
Criteria: Admission screen
Symptoms: Asymptomatic
in labour
```

Sample 21V409727 (Nasal+Throat swab) Collected 19 Aug 2021 17:04 Received 19 Aug 2021 19:31

RAPID SARS-COV-2 RNA

	Please refer to Point of Care Respiratory result.

End of reports

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Tayside Diagnostic Services

Printed by cgarnes (Claire Garnes (non referrer)) at 24 Jun 2026 18:13

Patient name:	**STACEY LEONARD**	CHI Number:	**2804880060**	Sex:	**Female**
Date of birth:	**28 Apr 1988**	:			
Address:	**2 Wards Road, Brechin DD9 7AS**				
Report 1/30					

Reported	Specialty	Location	Clinician
29 Apr 2026 15:53	Blood Sciences	T10498-BRECHIN HEALTH CENTRE	Dr. Tara MORLEY (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 02 Jun 2026 06:01

CLINICAL DETAILS :
TATT ?cause; BS WPE on T4?: NO

Sample 26B10151124 (Blood) Collected 27 Apr 2026 08:18 Received 27 Apr 2026 12:48

CREATININE AND ELECTROLYTES				
Sodium		141	mmol/L	133 - 146
Potassium		4.3	mmol/L	3.5 - 5.3
Creatinine (Enzymatic)	*	**91**	umol/L	44 - 80
Insufficient historical creatinine data to assess AKI risk				
eGFR result (EPI)		69	mL/min/1.73m*2	
Provided acute kidney injury has been excluded - this eGFR is consistent with CKD stage G2 - mild reduction in eGFR compared to young adult				
C-REACTIVE PROTEIN				
C-reactive protein		1.2	mg/L	0 - 10
INTELLIGENT LIVER PATHWAY				
ALT		13	U/L	0 - 55
Total Bilirubin		20	umol/L	0 - 21
GGT		22	U/L	3 - 73
LFT results within iLFT reference intervals.				
BMI provided		30	kg/m*2	
WEEKLY ALCOHOL INTAKE				
Weekly alcohol intake		<15		
BONE PROFILE				
Albumin		41	g/L	35 - 50
ALP		58	U/L	30 - 130
Calcium		2.41	mmol/L	2.10 - 2.55
Adjusted Calcium		2.40	mmol/L	2.10 - 2.55
GLUCOSE (FASTING - PLASMA)				
Glucose (Fasting - Plasma)		5.1	mmol/L	3.3 - 5.8
TSH				
Thyroid stimulating hormone		2.45	mU/L	0.4 - 4.0
ANAEMIA SCREEN				
Haemoglobin		144	g/L	120 - 160
White Cell Count		8.6	10*9/L	4.0 - 11.0
Platelets		285	10*9/L	150 - 400
RBC	*	**4.82**	10*12/L	3.8 - 4.8
Haematocrit		0.438		0.37 - 0.47
MCV		90.9	fL	85 - 105
MCH		29.8	pg	27 - 32
MCHC		328	g/L	320 - 360
Neutrophils		5.8	10*9/L	2.0 - 7.5
Lymphocytes		2.0	10*9/L	1.5 - 4.0
Monocytes		0.5	10*9/L	0.2 - 0.8
Eosinophils		0.4	10*9/L	0.00 - 0.40
Basophils		0.0	10*9/L	0.0 - 0.1
TISSUE TRANSGLUTAMINASE IGA ANTIBODY				
Tissue transglutaminase IgA antibody		<0.2	U/mL	0 - 4

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

```
Important - a negative TTG result is only valid
for out ruling coeliac disease if this individual
is eating gluten containing foods twice a day, for
the previous 6 weeks.
```

Report 2/30

Reported	Specialty	Location	Clinician
12 Feb 2026 08:56	Microbiology	T10498-BRECHIN HEALTH CENTRE	- NOT GIVEN (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 06:54

```
CLINICAL DETAILS :
GenitalSwabSite: High Vaginal Swab
Seen with Susan as chaperone Note
econsult PV bleeding last 4/52 1-2 pads
per day Painful sex last 3/52  Last sex
3/7 with regular male partner No other
genital symptoms Feeling well  Obs
normal Abdo soft, mild RLQ tenderness
Small clot in cervical os Swabs taken No
other obvious pathology Urine dip +ve
blood, leukocytes and nitrites  Suggest
Empiric trimethoprim and TXA while
awaiting swab results Supportive and
worsening advice given  Happy wiht this.
NPH
```

Sample 26B501709 (VAGINAL SWAB) Collected 09 Feb 2026 17:55 Received 10 Feb 2026 12:10

Microscopy

-

```
NO Trichomonas seen
No Clue cells seen
```

Culture:

Culture:

```
No growth of pathogenic bacteria
No Candida Isolated
```

Report 3/30

Reported	Specialty	Location	Clinician
11 Feb 2026 13:42	Microbiology	T10498-BRECHIN HEALTH CENTRE	- NOT GIVEN (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 06:54

```
CLINICAL DETAILS :
CT/NG symptoms: Discharge, Bleeding,
Dysuria
Seen with Susan as chaperone Note
econsult PV bleeding last 4/52 1-2 pads
per day Painful sex last 3/52  Last sex
3/7 with regular male partner No other
genital symptoms Feeling well  Obs
normal Abdo soft, mild RLQ tenderness
Small clot in cervical os Swabs taken
No other obvious pathology Urine dip
+ve blood, leukocytes and nitrites
Suggest Empiric trimethoprim and TXA
while awaiting swab results Supportive
and worsening advice given  Happy wiht
this. NPH
```

Sample 26V303373 (Vulval-Vaginal Swab) Collected 09 Feb 2026 17:55 Received 11 Feb 2026 09:06

C.trachomatis nucleic acid:

Chlamydia trachomatis	Negative

N.gonorrhoeae nucleic acid:

N.gonorrhoeae	Negative

Report 4/30

Reported	Specialty	Location	Clinician

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

22 Apr 2025 08:56 Blood Sciences T10498-BRECHIN HEALTH CENTRE Dr. Tara MORLEY (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 06:31

CLINICAL DETAILS :
On T4?: No
chronic oral ulceration.

LAB COMMENTS :
Important - a negative TTG result is only valid for
out ruling coeliac disease if this individual is eating
gluten containing foods twice a day, for the previous 6
weeks.

Sample I252655577 (SERUM) Collected 16 Apr 2025 12:21 Received 16 Apr 2025 15:36

IgA Tissue Transglutaminase Ab

IgA Tissue Transglutaminase	<0.2	u/ml	0 - 4

Report 5/30

Reported	Specialty	Location	Clinician
16 Apr 2025 17:06	Blood Sciences	T10498-BRECHIN HEALTH CENTRE	Dr. Tara MORLEY (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 06:31

CLINICAL DETAILS :
On T4?: No
chronic oral ulceration.

Sample H252655577 (EDTA) Collected 16 Apr 2025 12:21 Received 16 Apr 2025 15:36

FBC

Hb		135	g/L	120 - 160
WBC		9.4	x10^9/L	4.0 - 11.0
PLT		261	x10^9/L	150 - 400
RBC		4.50	x10^12/L	3.8 - 4.8
HCT		0.411		0.37 - 0.47
MCV		91.2	fl	85 - 105
MCH		29.9	pg	27 - 32
MCHC		328	g/L	320 - 360
NE#		5.8	x10^9/L	2.0 - 7.5
LY#		2.7	x10^9/L	1.5 - 4.0
MO#		0.4	x10^9/L	0.2 - 0.8
EO#	*	**0.53**	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

B12/FOLATE

B12		390	ng/l	200 - 940

Results may be unreliable if sample older than 48h

Serum Folate	*	**2.7**	ug/l	3.1 - 17.5

Report 6/30

Reported	Specialty	Location	Clinician
16 Apr 2025 17:05	Blood Sciences	T10498-BRECHIN HEALTH CENTRE	Dr. Tara MORLEY (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 06:31

CLINICAL DETAILS :
On T4?: No
chronic oral ulceration.

Sample C252655577 (Blood) Collected 16 Apr 2025 12:21 Received 16 Apr 2025 15:36

Creatinine and Electrolytes

SODIUM		141	mmol/L	133 - 146
POTASSIUM		4.3	mmol/L	3.5 - 5.3
CREATININE	*	**84**	umol/L	44 - 80

AKI

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

AKI	Not detected: May not exclude AKI in all cases	.	
Liver Function Tests (LFT)			
ALT	12	U/L	5 - 55
BILIRUBINS	9	umol/L	0 - 21
ALKALINE PHOSPHATASE	64	U/L	30 - 130
ALBUMIN	37	g/L	35 - 50
ESTIMATED GFR			
ESTIMATED GFR	GT60	mL/min	

eGFR should not be used to assess renal function
for any drug dosing in over 75s or extremes of BMI
and for DOAC dosing in those with an eGFR less
than 60ml/min.

CKD Stage			
CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .		
GLUCOSE			
GLUCOSE (preserved tube)	5.5	mmol/L	3.3 - 5.8
TSH			
TSH	2.49	mU/L	0.4 - 4.0
FERRITIN			
FERRITIN	20	ug/L	13 - 150

Report 7/30

Reported	Specialty	Location	Clinician
05 Mar 2025 14:03	Blood Sciences	CARSEVIEW MULBERRY UNIT	Dr Peter D LE FEVRE (Psychiatrist) (Mental Illness)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:56

CLINICAL DETAILS :
On T4?: No
admission bloods

LAB COMMENTS :
SLIGHTLY HAEMOLYSED

Sample C252548992 (Blood) Collected 04 Mar 2025 11:05 Received 04 Mar 2025 16:39

CREATINE KINASE			
CREATINE KINASE	99	U/L	25 - 200
C-REACTIVE PROTEIN			
C-REACTIVE PROTEIN	0.7	mg/L	0.0 - 10.0
MAGNESIUM			
MAGNESIUM	0.97	mmoL/L	0.70 - 1.00
PHOSPHATE			
PHOSPHATE	0.93	mmoL/L	0.8 - 1.5
TSH			
TSH	2.48	mU/L	0.4 - 4.0
Urea & Electrolytes			
SODIUM	140	mmol/L	133 - 146
POTASSIUM	4.2	mmol/L	3.5 - 5.3
UREA	4.7	mmol/L	2.5 - 7.8
CREATININE	* **98**	umol/L	44 - 80
AKI			
AKI	Not detected: May not exclude AKI in all cases .		
Liver Function Tests (LFT)			
ALT	11	U/L	5 - 55
BILIRUBINS	16	umol/L	0 - 21
ALKALINE PHOSPHATASE	58	U/L	30 - 130
ALBUMIN	38	g/L	35 - 50
Bone Group			
CALCIUM	2.33	mmol/L	2.10 - 2.55
CALCIUM (CORRECTED)	2.35	mmol/L	2.10 - 2.55
ESTIMATED GFR			
ESTIMATED GFR	58	mL/min	

eGFR should not be used to assess renal function
for any drug dosing in over 75s or extremes of BMI

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

and for DOAC dosing in those with an eGFR less than 60ml/min.

CKD Stage

CKD Stage	3A	.	

HbA1c (IFCC)

HbA1c IFCC	38	mmol/mol	>Below 48

Report 8/30

Reported	Specialty	Location	Clinician
04 Mar 2025 17:20	Blood Sciences	CARSEVIEW MULBERRY UNIT	Dr Peter D LE FEVRE (Psychiatrist) (Mental Illness)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:56

CLINICAL DETAILS :
On T4?: No
admission bloods

Sample H252548992 (EDTA) Collected 04 Mar 2025 11:05 Received 04 Mar 2025 16:39

FBC

Hb		144	g/L	120 - 160
WBC		8.5	x10^9/L	4.0 - 11.0
PLT		298	x10^9/L	150 - 400
RBC	*	**4.90**	x10^12/L	3.8 - 4.8
HCT		0.453		0.37 - 0.47
MCV		92.4	fl	85 - 105
MCH		29.4	pg	27 - 32
MCHC	*	**318**	g/L	320 - 360
NE#		4.5	x10^9/L	2.0 - 7.5
LY#		2.8	x10^9/L	1.5 - 4.0
MO#		0.5	x10^9/L	0.2 - 0.8
EO#	*	**0.58**	x10^9/L	0.0 - 0.4
BA#		0.1	x10^9/L	0.0 - 0.1

Report 9/30

Reported	Specialty	Location	Clinician
10 Jan 2025 09:00	Microbiology	T10498-BRECHIN HEALTH CENTRE	Dr Sarah Jefferies (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 06:23

CLINICAL DETAILS :
Symptoms of UTI?: No
Test reason: OTHER REASON FOR TESTING
Test reason: Abdo pain non specific,
Antibiotic Therapy: Trimethoprim
Antibiotic allergies: NKDA
eGFR value (last 3 mths): GT60
Non specific abdo pain Leucocytes +++ on dipstick

Sample 25B200985 (Midstream Urine) Collected 07 Jan 2025 17:40 Received 09 Jan 2025 12:28

Urine Culture:

No Significant Bacteriuria

Report 10/30

Reported	Specialty	Location	Clinician
27 Nov 2024 13:19	Blood Sciences	T10498-BRECHIN HEALTH CENTRE	Susan CLARK (ANP) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 06:21

CLINICAL DETAILS :
On T4?: No
WAS SURE SHE WAS PREGNANT TEST -VE, HAS 7 KIDS FEELS THE

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

```
EXACT SAME, LIGHT HEADED, NAUSEA, tiredness period is due ,
not late as yet, baseline bloods and HCG to check
```

Sample C242326641 (Fluoride Oxalate) Collected 27 Nov 2024 08:45 Received 27 Nov 2024 12:33

FASTING GLUCOSE			
FASTING GLUCOSE	5.0	mmol/L	3.3 - 5.8
IRON			
IRON	12	umol/L	6 - 32
Creatinine and Electrolytes			
SODIUM	138	mmol/L	133 - 146
POTASSIUM	5.0	mmol/L	3.5 - 5.3
CREATININE	* **95**	umol/L	44 - 80
AKI			
AKI	Not detected: May not exclude AKI in all cases	.	
Liver Function Tests (LFT)			
ALT	11	U/L	5 - 55
BILIRUBINS	15	umol/L	0 - 21
ALKALINE PHOSPHATASE	48	U/L	30 - 130
ALBUMIN	39	g/L	35 - 50
Bone Group			
CALCIUM	2.36	mmol/L	2.10 - 2.55
CALCIUM (CORRECTED)	2.37	mmol/L	2.10 - 2.55
IRON STUDIES			
TRANSFERRIN	2.33	g/L	2.00 - 4.00
% SATN OF TRANSFERRIN	* **21**	%	22 - 55
ESTIMATED GFR			
ESTIMATED GFR	GT60	mL/min	

```
eGFR should not be used to assess renal function
for any drug dosing in over 75s or extremes of BMI
and for DOAC dosing in those with an eGFR less
than 60ml/min.
```

CKD Stage			
CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .		
FERRITIN			
FERRITIN	31	ug/L	13 - 150
TSH			
TSH	3.22	mU/L	0.4 - 4.0
C-REACTIVE PROTEIN			
C-REACTIVE PROTEIN	LT0.5	mg/L	0.0 - 10.0
TOTAL HCG			
TOTAL HCG	LT2	U/L	0 - 5

Report 11/30

Reported	Specialty	Location	Clinician
27 Nov 2024 13:04	Blood Sciences	T10498-BRECHIN HEALTH CENTRE	Susan CLARK (ANP) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 06:21

```
CLINICAL DETAILS :
On T4?: No
WAS SURE SHE WAS PREGNANT TEST -VE, HAS 7 KIDS FEELS THE
EXACT SAME, LIGHT HEADED, NAUSEA, tiredness period is due ,
not late as yet, baseline bloods and HCG to check
```

Sample H242326641 (EDTA) Collected 27 Nov 2024 08:45 Received 27 Nov 2024 12:33

FBC			
Hb	133	g/L	120 - 160
WBC	7.9	x10^9/L	4.0 - 11.0
PLT	268	x10^9/L	150 - 400
RBC	4.55	x10^12/L	3.8 - 4.8
HCT	0.413		0.37 - 0.47
MCV	90.9	fl	85 - 105
MCH	29.2	pg	27 - 32
MCHC	321	g/L	320 - 360

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

NE#		4.4	x10^9/L	2.0 - 7.5
LY#		1.8	x10^9/L	1.5 - 4.0
MO#		0.6	x10^9/L	0.2 - 0.8
EO#	*	**1.03**	x10^9/L	0.0 - 0.4
BA#		0.1	x10^9/L	0.0 - 0.1

Report 12/30

Reported	Specialty	Location	Clinician
08 Nov 2024 11:51	Microbiology	T10498-BRECHIN HEALTH CENTRE	Zoe MCCLEMENTS (ANP) (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 06:19

CLINICAL DETAILS :
Site: head
Antibiotic Therapy: nil
Antibiotic allergies: nil
scabs to head weeping ? scabies and has
head lice

Sample 24B723536 (WOUND SWAB) Collected 06 Nov 2024 13:01 Received 06 Nov 2024 15:31
Culture:

Organism	*	**Staphylococcus aureus**
Organism Growth	*	**Profuse Growth**
Flucloxacillin		S
Erythromycin		S
Doxycycline		S

Report 13/30

Reported	Specialty	Location	Clinician
11 Jun 2024 09:41	Radiology	T10498-BRECHIN HEALTH CENTRE	Dr GP LOCUM (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 06:08

Sample 9220452 (TYPE UNSPECIFIED) Collected 11 Jun 2024 09:22 Received 11 Jun 2024 09:22
Ultrasound Pelvis transvaginal

Clinical History :
PV bleed + dyspareunia since March 2024, 5 m postpartum. swabs and USS in wok up
ENTERED BY: Meaza Tewelde (Medical)BLEEP: 01738 627117
Ultrasound Pelvis transvaginal :
Verbal consent obtained, chaperone present.
Anteverted uterus. The uterus measures 89 mm in uterocervical length by 57 mm x 50 mm.
The myometrial echo pattern is very patchy and very heterogenous with venetian blind sign.
There is a particular patchy, globular bulkiness of the anterior myometrium when compared
to the posterior myometrium. Appearances may represent adenomyosis.
No gross focal pathology.
Normal appearances of both ovaries.
No adnexal mass or free fluid.
Summary: No focal pathology seen. Perhaps features to suggest adenomyosis
Shona McAuley, Clinical Specialist Sonographer RA55790
 SHONA McAULEY / SHONAM

Report 14/30

Reported	Specialty	Location	Clinician
20 May 2024 14:25	Microbiology	T10498-BRECHIN HEALTH CENTRE	Dr GP LOCUM (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 06:06

CLINICAL DETAILS :
CT/NG symptoms: Bleeding, Pelvic pain
PV bleed + dyspareunia since March
2024, 5 m postpartum. swabs and USS in
wok up

Sample 24V309540 (High Vaginal Swab) Collected 17 May 2024 12:51 Received 20 May 2024 09:47

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

C.trachomatis nucleic acid:

Chlamydia trachomatis	Negative

N.gonorrhoeae nucleic acid:

N.gonorrhoeae	Negative

Report 15/30

Reported	Specialty	Location	Clinician
19 May 2024 09:17	Microbiology	T10498-BRECHIN HEALTH CENTRE	Dr GP LOCUM (General Practice)

Filed by **sunquest** (Sunquest Administrator) at 01 Jun 2026 06:06

CLINICAL DETAILS :
Site: HVS
Test reason:: PV bleed + dyspareunia
since March 2024
PV bleed + dyspareunia since March 2024,
5 m postpartum. swabs and USS in wok up

Sample 24B505968 (VAGINAL SWAB) Collected 17 May 2024 12:50 Received 17 May 2024 16:38

Microscopy

-

NO Trichomonas seen
No Clue cells seen

Culture:

Culture:

No growth of pathogenic bacteria
No Candida Isolated

Report 16/30

Reported	Specialty	Location	Clinician
19 Feb 2024 18:05	Blood Sciences	STRACATHRO OP SURGICAL	Dr Christopher PELL (General Adult Psychiatry)) (Mental Illness)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:50

CLINICAL DETAILS :
On T4?: No
Tired all the time, cold, dry skin, sluggish thinking. 8
weeks postpartum, ?hypothyroid

LAB COMMENTS :
SLIGHTLY HAEMOLYSED

Sample C241671189 (Blood) Collected 19 Feb 2024 13:28 Received 19 Feb 2024 16:57

C-REACTIVE PROTEIN			
C-REACTIVE PROTEIN	LT0.5	mg/L	0.0 - 10.0
TSH			
TSH	3.23	mU/L	0.4 - 4.0
PROLACTIN			
PROLACTIN	128	mU/L	0 - 600
Urea & Electrolytes			
SODIUM	142	mmol/L	133 - 146
POTASSIUM	4.5	mmol/L	3.5 - 5.3
UREA	4.3	mmol/L	2.5 - 7.8
CREATININE	* **81**	umol/L	44 - 80
AKI			
AKI	Not detected: May not exclude AKI in all cases	.	
Liver Function Tests (LFT)			
ALT	20	U/L	5 - 55
BILIRUBINS	8	umol/L	0 - 21
ALKALINE PHOSPHATASE	71	U/L	30 - 130
ALBUMIN	39	g/L	35 - 50

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

ESTIMATED GFR

ESTIMATED GFR	GT60	mL/min

eGFR should not be used to assess renal function
for any drug dosing in over 75s or extremes of BMI
and for DOAC dosing in those with an eGFR less
than 60ml/min.

CKD Stage

CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .

Report 17/30

Reported	Specialty	Location	Clinician
19 Feb 2024 17:50	Blood Sciences	STRACATHRO OP SURGICAL	Dr Christopher PELL (General Adult Psychiatry)) (Mental Illness)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:50

CLINICAL DETAILS :
On T4?: No
Tired all the time, cold, dry skin, sluggish thinking. 8
weeks postpartum, ?hypothyroid

Sample H241671189 (EDTA) Collected 19 Feb 2024 13:28 Received 19 Feb 2024 16:57

FBC

Hb	138	g/L	120 - 160
WBC	7.6	x10^9/L	4.0 - 11.0
PLT	248	x10^9/L	150 - 400
RBC	4.64	x10^12/L	3.8 - 4.8
HCT	0.421		0.37 - 0.47
MCV	90.6	fl	85 - 105
MCH	29.7	pg	27 - 32
MCHC	327	g/L	320 - 360
NE#	4.3	x10^9/L	2.0 - 7.5
LY#	2.4	x10^9/L	1.5 - 4.0
MO#	0.4	x10^9/L	0.2 - 0.8
EO#	0.34	x10^9/L	0.0 - 0.4
BA#	0.0	x10^9/L	0.0 - 0.1

B12/FOLATE

B12	346	ng/l	200 - 940

Results may be unreliable if sample older than 48h

Serum Folate	5.2	ug/l	3.1 - 17.5

Report 18/30

Reported	Specialty	Location	Clinician
22 Dec 2023 16:26	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:57

Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)

Sample 10310057874405 (BLOOD) Collected 22 Dec 2023 13:15 Received 22 Dec 2023 15:23

Automated Antibody Screen

Automated Antibody Screen	Negative

Report 19/30

Reported	Specialty	Location	Clinician
22 Dec 2023 15:49	Blood Sciences	NW WARD 38	Greg CALDWELL (Obstetrics & Gynaecology) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:38

CLINICAL DETAILS :

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

induction of labour

Sample C231544450 (Blood) Collected 22 Dec 2023 13:13 Received 22 Dec 2023 15:13

Urea & Electrolytes

SODIUM	136	mmol/L	133 - 146
POTASSIUM	4.3	mmol/L	3.5 - 5.3
UREA	* **2.3**	mmol/L	2.5 - 7.8
CREATININE	55	umol/L	44 - 80

AKI

AKI	NOT AVAILABLE	.

ESTIMATED GFR

ESTIMATED GFR	GT60	mL/min

eGFR should not be used to assess renal function
for any drug dosing in over 75s or extremes of BMI
and for DOAC dosing in those with an eGFR less
than 60ml/min.

CKD Stage

CKD Stage	IF HIGH RISK, EXCLUDE CKD1/2. CHECK FOR HAEMATURIA AND PROTEINURIA .

Report 20/30

Reported	Specialty	Location	Clinician
22 Dec 2023 15:40	Blood Sciences	NW WARD 38	Greg CALDWELL (Obstetrics & Gynaecology) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 31 May 2026 05:39

CLINICAL DETAILS :
induction of labour

Sample H231544450 (EDTA) Collected 22 Dec 2023 13:13 Received 22 Dec 2023 15:13

FBC

Hb	134	g/L	120 - 160
WBC	7.9	x10^9/L	4.0 - 11.0
PLT	205	x10^9/L	150 - 400
RBC	4.51	x10^12/L	3.8 - 4.8
HCT	0.399		0.37 - 0.47
MCV	88.4	fl	85 - 105
MCH	29.8	pg	27 - 32
MCHC	337	g/L	320 - 360
NE#	5.9	x10^9/L	2.0 - 7.5
LY# *	**1.4**	x10^9/L	1.5 - 4.0
MO#	0.4	x10^9/L	0.2 - 0.8
EO#	0.06	x10^9/L	0.0 - 0.4
BA#	0.0	x10^9/L	0.0 - 0.1

Report 21/30

Reported	Specialty	Location	Clinician
22 Dec 2023 12:03	Microbiology	DUNDEE MIDWIFERY UNIT (N/W)	Greg CALDWELL (Obstetrics & Gynaecology) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:18

CLINICAL DETAILS :
Site: LVS
Test reason:: Foul smelling discharge+++
pelvic pain pregnancy 37 weeks
37 weeks foul smelling discharge
?infection

LAB COMMENTS :
Thrush is a clinical diagnosis.
Please assess for signs/symptoms of candidiasis.
Swabs are of limited utility - empirical
treatment recommended if symptomatic.

Sample 23B515767 (VAGINAL SWAB) Collected 20 Dec 2023 12:40 Received 20 Dec 2023 15:35

Microscopy

-

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

NO Trichomonas seen
No Clue cells seen

Culture:

Organism	*	**Candida**
Organism Growth	*	**Growth**

No growth of pathogenic bacteria

Report 22/30

Reported	Specialty	Location	Clinician
21 Dec 2023 11:25	Microbiology	NW OP ANTENATAL CLINIC	Dr Binita PANDE (Obstets & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:09

CLINICAL DETAILS :
Symptoms of UTI?: Yes
Symptoms: feeling of burning sensation
while urinating
Antibiotic Therapy: nk
Antibiotic allergies: nk
Known CKD?: No
feeling of burning sensation for few
days with Leu 1+ in urine

Sample 23B271371 (Midstream Urine) Collected 20 Dec 2023 11:57 Received 20 Dec 2023 15:35
Urine Culture:

No Significant Bacteriuria

Report 23/30

Reported	Specialty	Location	Clinician
20 Dec 2023 08:44	Microbiology	NW OP ANTENATAL CLINIC	Greg CALDWELL (Obstetrics & Gynaecology) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:09

CLINICAL DETAILS :
Symptoms of UTI?: No
Test reason: Patient pregnant
Antibiotic Therapy: no
Antibiotic allergies: no
Known CKD?: No
patient pregnant 37 weeks

Sample 23B270884 (Midstream Urine) Collected 18 Dec 2023 20:57 Received 19 Dec 2023 10:20
Urine Culture:

Mixed Growth. Please repeat, if indicated.

Report 24/30

Reported	Specialty	Location	Clinician
19 Dec 2023 03:01	Blood Transfusion	New Location	New Clinician (Not Specified)

Filed by **sunquest** (Sunquest Administrator) at 30 May 2026 05:57

Blood Group: O POSITIVE
ABO : O
Rh D : Positive
Antibody Status : NAD (No Antibodies Detected)

Sample 10310057831510 (BLOOD) Collected 18 Dec 2023 22:50 Received 19 Dec 2023 01:25
Automated Antibody Screen

Automated Antibody Screen	Negative

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Report 25/30

Reported	Specialty	Location	Clinician
19 Dec 2023 01:42	Blood Sciences	NW LABOUR SUITE	DR Katrine Elizabeth ORR (Obs & Gynae) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:05

CLINICAL DETAILS :
? labour

Sample H231533387 (EDTA) Collected 18 Dec 2023 22:52 Received 19 Dec 2023 01:27

FBC

Hb	129	g/L	120 - 160
WBC	8.1	x10^9/L	4.0 - 11.0
PLT	205	x10^9/L	150 - 400
RBC	4.56	x10^12/L	3.8 - 4.8
HCT	0.405		0.37 - 0.47
MCV	88.8	fl	85 - 105
MCH	28.4	pg	27 - 32
MCHC	320	g/L	320 - 360
NE#	5.5	x10^9/L	2.0 - 7.5
LY#	2.1	x10^9/L	1.5 - 4.0
MO#	0.4	x10^9/L	0.2 - 0.8
EO#	0.12	x10^9/L	0.0 - 0.4
BA#	0.0	x10^9/L	0.0 - 0.1

Report 26/30

Reported	Specialty	Location	Clinician
14 Dec 2023 14:53	Radiology	NW OP OBS & GYNAE CLINIC	Unknown Unknown (Dental Medicine Specialties)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:16

Sample 8993636 (TYPE UNSPECIFIED) Collected 14 Dec 2023 14:22 Received 14 Dec 2023 14:22

US GROWTH

Clinical History :
rgr
Fiona Agnew
Midwife Sonographer 93I0292SReport available on Badgernet
FIONA AGNEW (Obs & Gyn) / AGNEWF

Report 27/30

Reported	Specialty	Location	Clinician
08 Dec 2023 22:41	Blood Sciences	LINKS HC ANTE-NATAL CLINIC	Greg CALDWELL (Obstetrics & Gynaecology) (Obstetrics & Gynaecology)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:18

CLINICAL DETAILS :
35 weeks pregnant, glycosuria. Declines GTT. Previous low
Hb.

Sample C231511533 (Fluoride Oxalate) Collected 08 Dec 2023 12:16 Received 08 Dec 2023 16:50

GLUCOSE

GLUCOSE (preserved tube)	4.9	mmol/L	3.3 - 5.8

HbA1c (IFCC)

HbA1c IFCC	26	mmol/mol	>Below 48

Report 28/30

Reported	Specialty	Location	Clinician
08 Dec 2023 17:14	Blood Sciences	LINKS HC ANTE-NATAL CLINIC	Greg CALDWELL (Obstetrics & Gynaecology) (Obstetrics & Gynaecology)

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:18

CLINICAL DETAILS :
35 weeks pregnant, glycosuria. Declines GTT. Previous low Hb.

Sample H231511533 (EDTA) Collected 08 Dec 2023 12:16 Received 08 Dec 2023 16:50

FBC

Hb		126	g/L	120 - 160
WBC		8.9	x10^9/L	4.0 - 11.0
PLT		243	x10^9/L	150 - 400
RBC		4.40	x10^12/L	3.8 - 4.8
HCT		0.394		0.37 - 0.47
MCV		89.5	fl	85 - 105
MCH		28.5	pg	27 - 32
MCHC	*	**319**	g/L	320 - 360
NE#		7.1	x10^9/L	2.0 - 7.5
LY#	*	**1.4**	x10^9/L	1.5 - 4.0
MO#		0.3	x10^9/L	0.2 - 0.8
EO#		0.09	x10^9/L	0.0 - 0.4
BA#		0.0	x10^9/L	0.0 - 0.1

Report 29/30

Reported	Specialty	Location	Clinician
15 Nov 2023 10:36	Radiology	NW OP OBS & GYNAE CLINIC	Unknown Unknown (Dental Medicine Specialties)

Filed by **sunquest** (Sunquest Administrator) at 29 May 2026 05:16

Sample 8968406 (TYPE UNSPECIFIED) Collected 15 Nov 2023 09:58 Received 15 Nov 2023 09:58

US GROWTH

Clinical History :
GROWTH SCAN
US GROWTH :
Report available on Badgernet
Eilidh Donald
Midwife Sonographer 14I1334S
EILIDH DONALD / DONALDE

Report 30/30

Reported	Specialty	Location	Clinician
03 Nov 2023 17:31	Blood Sciences	ARBROATH INF MATERNITY UNIT	Dr Pauline LYNCH(Obs&Gynae) (Midwife Episode)

Filed by **sunquest** (Sunquest Administrator) at 28 May 2026 05:17

CLINICAL DETAILS :
30 weeks On iron, symptomatic of anaemia - mw ali

Sample H231430179 (EDTA) Collected 03 Nov 2023 12:28 Received 03 Nov 2023 17:06

FBC

Hb	*	**99**	g/L	120 - 160
WBC		10.1	x10^9/L	4.0 - 11.0
PLT		337	x10^9/L	150 - 400
RBC	*	**3.69**	x10^12/L	3.8 - 4.8
HCT	*	**0.307**		0.37 - 0.47
MCV	*	**83.1**	fl	85 - 105
MCH	*	**26.9**	pg	27 - 32
MCHC		323	g/L	320 - 360
NE#		7.3	x10^9/L	2.0 - 7.5
LY#		2.1	x10^9/L	1.5 - 4.0
MO#		0.5	x10^9/L	0.2 - 0.8
EO#		0.21	x10^9/L	0.0 - 0.4

Patient name: **STACEY LEONARD**
Hospital number: **2804880060**
:

BA#	0.0	x10^9/L	0.0 - 0.1

End of reports

CANCELLED ON April 18 2016

CANCELLATION REASON

CANCELLED ON:	18/04/2016
CANCELLED BY:	Stuart Waterston:Screening User
SCREENING REASON:	Further investigation is required before the patient is referred
REASON:	What do you think this lump might be? Cyst/lipoma/lymph node/axillary breast tissue? It would be worthwhile assessing with USS initially as this may change management. Does she have any breast history/symptoms or any suspicious skin lesions? Depending on results, referral to Stracathro General Surgey clinic may be more appropriate.

REFERRAL LETTER

MEDICAL IN CONFIDENCE

NHS Tayside

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Plastic SurgeryC9
TAY General Referral

— **Consultant / receiving practitioner** and/or **specialty clinic**

Stracathro Hospital
By Brechin
DD9 7QA

— **Hospital** and **hospital address**

Hospital unit no.
T312H

Email address
-

Date of Referral (set by referrer) 13-Apr-2016

Date referral was submitted 13-Apr-2016

Urgency of referral Routine

Armed Forces Personnel, Immediate Families & Veterans

- ☐ On active service
- ☐ Condition related to service
- ☐ Immediate family member

Impairment(s)

- ☐ Learning
- ☐ Visual
- ☐ Hearing

Miscellaneous

- ☐ Requires support of a translator

PATIENT DETAILS

Surname	ELLIS
Forename(s)	STACEY
Title	MS
Sex	Female
Date of birth	28-Apr-1988
CHI no.	2804880060

Patient's address

17 ANNAT ROAD
MONTROSE
DD10 8EF

Contact number(s)

Voice: 959209
Voice: 07938812432

REGISTERED GP DETAILS

Name	Dr Ruth Cranswick

Practice address

LINKS HEALTH CENTRE

GMC code	3260678	GP code	72001
Practice name	ANNAT BANK PRACTICE		
Practice code	13706		

MARINE AVENUE
MONTROSE

Cor

Voice: 01674-673400

REFERRING PRACTITIONER DETAILS

Name	Dr Ruth Cranswick		
GMC code	3260678	GP code	72001
Practice name	ANNAT BANK PRACTICE		
Practice code	13706		

Practice address

LINKS HEALTH CENTRE
MARINE AVENUE
MONTROSE

Cor

Voice: 01674-673400

Periods of Future Unavailability	None provided.

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: subcutaneous lump right axillae

Comment: This 27 year old slim lady has been aware of a lump of her right axillae for several months. It is not changing and is non tender. On examination there is a very superficial lump measuring approximately 2cm in diameter with the skin mobile over it. It appears benign. She would be very grateful if you would consider removing this. Thank you. Yours sincerely Dr Ruth Cranswick GMC No., 3260678

Examinations and Investigations

Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 25.	12-Apr-2016
Non drinker alcohol:	Drinking status on eventdate: Life teetotaler.	12-Nov-2007
Exercise grading:	Walking alot	12-Nov-2007

Most recent height, weight, BMI and Blood Pressure

Height:	1.59	m	Recorded Date:	None provided
Weight:	45	Kg	Recorded Date:	None provided
BMI:	17.7	Kg/m^2	Recorded Date:	None provided
Blood Pressure:	112/78	mmHg	Recorded Date:	None provided

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
[D]Lump, localized and superficial	-	-	Subcut, ref plastics.	12-Apr-2016
Depressed mood	-	New event	[TRUNCATED]Very flat. Feels like running away most days. 4 kids age 7, 4, 2 and 1. Husband supportive but works full time and aware she won't let him help with much. Long established eating habits o	15-Mar-2016
O/E - discharge from ear	-	-	[TRUNCATED]bilateral ear ache for 2 weeks, both ears discharging, clinically pussy discharge both ears left > right, tympanic membranes seem intact however reports right ear drum perforation as chil	02-Aug-2012
Anxiety with depression	-	-	[TRUNCATED]Low mood 3 months Feels not coping Anxious and feels unsafe alone in house. House cold. Sees Mhairi Still weekly. gets no time alone as Declan up till midnight. Can't keep him in room as	05-Jan-2012
Spontaneous vaginal delivery	-	-	- MRI, Male, 3160 grams, 39+5 weeks gestation. (See Docman 01.06.11)	28-May-2011
H/O: amblyopia	-	-	L eye Doesn't tolerate contact lens	19-Aug-2010
Blepharitis	-	-	Contact lens wearer	01-Apr-2009
Acne vulgaris	-	-	[MONTH AND YEAR OF EVENT 08/2006]	01-Aug-2006
Depressive disorder NEC	-	-	[MONTH AND YEAR OF EVENT 05/2005] NOTES: and alcohol misuse. Referred Cornhill.	01-May-2005
Right iliac fossa pain	-	-	admitted gynae with a false pos preg test, settled spontaneously	02-Apr-2005
Breast lump symptom	-	-	[YEAR OF EVENT 1997] NOTES: prepubertal.	01-Jan-1997
Child on protection register	-	-	[YEAR OF EVENT 1994] NOTES: mother psychiatric illness, father in prison. .	01-Jan-1994
Convergent squint	-	-	[YEAR OF EVENT 1992] NOTES: left.	01-Jan-1992
Minor head injury	-	-	[YEAR OF EVENT 1992]	01-Jan-1992
Burn of wrist or hand NOS	-	-	[YEAR OF EVENT 1992] NOTES: right hand.	01-Jan-1992
Recurrent acute otitis media	-	-	[YEAR OF EVENT 1991]	01-Jan-1991
Specific delays in development	-	-	[YEAR OF EVENT 1989] NOTES: poor social circumstances.	01-Jan-1989

Past procedures

Description	Laterality	Modifier	Date performed
Patient reviewed	-	-	12-Apr-2016
Discharged from hospital	-	-	15-Mar-2015
Advice about long acting reversible contraception	-	-	06-Mar-2013
Termination of pregnancy NEC	-	-	31-Dec-2009

Eye muscle operations	-	-	01-Jan-1995
Foster care	-	-	01-Jan-1994
Insertion of grommet	-	-	01-Jan-1992

Current and recent medication

Current repeat medication

No current repeat medications recorded

Recent acute medication (last 30 days)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration
Sertraline 50mg tablets	74050020	tablet	1 TABLET ONCE A DAY	-	12-Apr-2016	-
Sertraline 50mg tablets	74050020	tablet	1 TABLET ONCE A DAY	-	15-Mar-2016	-

Clinical warnings

Allergies

H/O: non-drug allergy	-	Reaction type: Allergy, Certainty of allergy: Likely, Severity of allergy: Moderate. NOTES: Latex itchy and red.

Additional relevant information

Administrative information

Referred By:Registered GP

Signature of referring doctor (or other professional)

Date

12/10/2021

Dear Colleague

Thank you for your referral. Please see the following outcome from the vetting process.

PLASTIC SURGERY SEE & DO CLINIC ROUTINE

Patient Name: Stacey Louise Leonard

CHI Number: 2804880060

Referral Date: 23/09/2021

Traumatised scalp papilloma

We will see to assess at a One Stop session and excise under LA if appropriate.

Yours sincerely

Ms Fiona Hogg

OPERATION NOTE **Stracathro Th MPU**

Name: Stacey Leonard

CHI: 2804880060

DATE: 28/10/2021

Surgeon: Miss L McClymont for Miss Hogg (cons)

Procedure: Excision papillomatous lesion right scalp

LA: 6mls 1% lidocaine with adrenaline

Indication:
Noticed lesion 2 months ago. Catches when brushing hair.

Findings:
Papillomatous, benign looking lesion.

Procedure:
Ticept prep
Lesion excised minimal margin – sent pathology
Bipolar haemostasis
Closed 4/0 prolene – ends left long
Opsite spray

Post op:
1. ROS at GP in 7 days
2. No follow-up pathway, patient aware will be contacted with results

Name: Miss Liusaidh McClymont
Grade: ST3
GMC: 7485695

Department Plastic Surgery – Minor Procedure Unit 2
Reconstructive Hand Surgery
Acute Services
NHS Tayside
Stracathro Hospital
Brechin
Angus
DD9 7QA

www.nhstayside.scot.nhs.uk

Dr TT Morley
Brechin Medical Practice
Brechin Health Centre
Infirmary Street
Brechin
DD9 7AN

Date	02/11/2021
Your Ref	
Our Ref	LMcC/pr/ **2804880060**
Enquiries to	Mrs Phyl Renshaw : 28/10/2021
Extension	65063
Direct Line	01356665063
Email	phyl.renshaw@nhs.scot

Dear Dr Morley

Stacey Leonard, 2 Wards Road, Brechin, Angus, DD9 7AS DOB: 28/04/1988

Diagnosis: Papillomatous lesion right scalp

Plan: Excise under local anaesthetic

I reviewed Stacey Leonard in our 1-stop plastic surgery clinic at Stracathro today. She is a 33 year old lady who noticed a papillomatous growth on her right scalp 2 months ago. It catches while she is combing her hair.

On examination, this is a well defined, soft fleshy lesion. This was excised under local anaesthetic and closed with a Prolene suture which will require removal at the GP practice in 7 days time.

I have advised her that we will send the lesion for histological assessment, but it looks benign. We will not routinely follow her up but we will be in touch with the results of the biopsy either by ‘phone or in writing.

Kind regards

Yours sincerely

Authorised on 11/11/2021 17:45:24 by Liusaidh McClymont.

Ms Liusaidh McClymont
Specialist Registrar in Plastic Surgery

NHS Tayside

Head and Neck Tumours
Cleft Lip and Palate
Laser
Congenital Anomalies
Hypospadias/Genital Abnormalities
Facial Palsy Reconstruction
Hand Surgery
Limb Trauma
Skin and Soft Tissue Tumour
Breast Reconstruction
Burns

Department Plastic Surgery
Reconstructive Hand Surgery
Acute Services
NHS Tayside
Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Stacey Leonard
2 Wards Road
Brechin
Angus
DD9 7AS

Date	07/12/2021
Date Dictated	07/12/2021
Our Ref	FJH/KN/ **2804880060**
Enquiries to	Kerry Nicoll, Medical Secretary
Extension	40054
Direct Line	01382 740054
Email	kerry.nicoll@nhs.scot

Dear Stacey Leonard

Stacey Leonard, 2 Wards Road, Brechin, Angus, DD9 7AS DOB: 28/04/1988

Procedure: Excision lesion right scalp Date: 28/10/2021

Following your recent attendance for minor surgery at Stracathro Hospital, I am now able to inform you that the lesion you had removed was a benign vascular lesion (not cancerous). As such, there is no need for you to attend for any follow up at the Plastic Surgery Clinic.

However, if you have any concerns with the wound or wish any further information about the pathology results and feel you would rather be seen by us again, please make an appointment by phoning my secretary on the number above (or writing to the above address).

A copy of this letter has been sent to your GP

Yours sincerely

Authorised on 14/12/2021 13:56:22 by F Hogg.

Ms Fiona J Hogg MBChB, MD (Hons), FRCS (Plast)
Consultant Plastic Surgeon

(D) Dr TT Morley, Brechin Medical Practice, Brechin Health Centre, Infirmary Street, Brechin, DD9 7AN

NHS
Tayside

Department Plastic Surgery – Minor Procedure Unit 2
Reconstructive Hand Surgery
Acute Services
NHS Tayside
Stracathro Hospital
Brechin
Angus
DD9 7QA

www.nhstayside.scot.nhs.uk

Dr TT Morley
Brechin Medical Practice
Brechin Health Centre
Infirmary Street
Brechin
DD9 7AN

Date	02/11/2021
Your Ref	
Our Ref	LMcC/pr/ **2804880060**
Enquiries to	Mrs Phyl Renshaw : 28/10/2021
Extension	65063
Direct Line	01356665063
Email	phyl.renshaw@nhs.scot

Dear Dr Morley

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Diagnosis: Papillomatous lesion right scalp

Plan: Excise under local anaesthetic

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On examination, this is a well defined, soft fleshy lesion. This was excised under local anaesthetic and closed with a Prolene suture which will require removal at the GP practice in 7 days time.

I have advised her that we will send the lesion for histological assessment, but it looks benign. We will not routinely follow her up but we will be in touch with the results of the biopsy either by 'phone or in writing.

Kind regards

Yours sincerely

Ms Luisaidh McClymont
Specialist Registrar in Plastic Surgery

OPERATION NOTE

Stracathro Th MPU

Name: Stacey Leonard

CHI: 2804880060

DATE: 28/10/2021

Surgeon: Miss L McClymont for Miss Hogg (cons)

Procedure: Excision papillomatous lesion right scalp

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Ticept prep
Lesion excised minimal margin – sent pathology
Bipolar haemostasis
Closed 4/0 prolene – ends left long
Opsite spray

Post op:
1. ROS at GP in 7 days
2. No follow-up pathway, patient aware will be contacted with results

Name: Miss Liusaidh McClymont
Grade: ST3
GMC: 7485695

Stacey
Leonard
2804880060

NHS
Tayside

Stracathro Regional Treatment Centre
Surgical Unit

CONFIDENTIAL

PLEASE DO NOT VIEW THESE RECORDS
UNLESS YOU HAVE THE PATIENT'S CONSENT

SURGICAL CARE DOCUMENT
LOCAL ANAESTHETIC

User Guidance Notes

The document has been developed for use for ALL patient admitted ti the surgical unit for procedures under local anaesthetic. It shall promote and demonstrate a collaborative, chronological Multidisciplinary team record of the care delivered during the patients stay.

It will be supported by other NHST assessments, observations and recording tools as required . The Senior Charge Nurse will be responsible for ensuring that all documentation will be competed in line with NHST Policy for Records and Record Keeping for Nursing and Midwifery Staff

WRITE ... 2804880060

Su Leonard
Fo Stacey
DC 2 Wards Road
Se: Brechin
DD9 7AS

TT Morley

DATE OF ADMISSION: 28/10/21
HOSPITAL: SHX
WARD MP4

LA -MINOR PROCEDURE

FIRST CONTACT	VITAL SIGNS		
Name: Steven (Partner)	PULSE	BP	TEMP
Telephone: 07706187077	71	122/80	37.0

HEALTH QUESTIONNAIRE

(Patient to complete)

Do you have?	YES (Tick)	NO (Tick)	Comments
Any allergies? Is the reaction anaphylactic?	✓		If yes please list below and make theatre aware Latex
Chest pain on minimal exertion? Used GTN spray within last week?		✓	
Any bleeding problems or have been prescribed blood thinning tablets?		✓	If yes inform consultant
Diabetes that requires you to take Insulin?		✓	Last Blood sugar:
Short of breath when walking on the flat/ or when lying down?		✓	
Any fits, falls/ fainting or dizzy spells in the last 72 hours?		✓	
Any problems with local anaesthetic in the past, including at the dentist?		✓	If yes inform consultant
Any implanted devices e.g. pacemaker or metalwork in your body (including body piercings)?	✓		If yes please list below and inform theatre Dermal piercing (P) wrist
Have any skin infection or been told you have MRSA?		✓	If yes let consultant know
NURSE CHECK : DATE AND SIGN	28/10/21		
If patient answers yes to any question/s above please escalate as required			
ANP/ CONSULTANT / THEATRE (please circle)			

NHS TAYSIDE – PATIENT FUNDS AND PROPERTY PROCEDURE

PERSONAL DISCLAIMER FORM - LOSS OF PERSONAL EFFECTS

NHS TAYSIDE STATEMENT:

*****NHS Tayside will not accept any responsibility for loss or damage to any article/personal belongings unless such article/personal belongings (including cash) have been handed over and accepted by NHS Tayside, for safe keeping and an official receipt issued**** *[* delete as appropriate]*

To be completed by Registered Nursing Staff

Section A

If the patient or patient's representative at the time of admission is unable or refusing to complete and sign section B below, for whatever reason, inform the patient / representative verbally that they are responsible for their own belongings and valuables and state below the reason for non completion of Section B. Sign and date this, and enter a review date in Section C:

Reason: _____

Signature of Staff Recording Reason: _____

Signature of Staff Witness: _____ Date: _____

Section B

I have been given the opportunity to read the above statement and ~~I~~do / do not wish to take advantage of the facilities provided for safe keeping of my personal belongings.

Patient Signature*** X Sleonard. Date: _____

Prnt Name: X STACEY LEONARD

Hospital: STH X Ward: MPU

***If signing on behalf of a patient, please enter your relationship with the patient, and your address:

Relationship: _____

Address: _____

_____

Witness to above signature: _____

Print Name: Amy Wilson

Date: 28/10/25

Section C

If section A has been completed and a review is required, please enter review date (should be held every 4 weeks) noting two staff signatures required at each review :

(1) _____

Sign: _____

Sign: _____

(2) _____

Sign: _____

Sign: _____

(3) _____

Sign: _____

Sign: _____

(4) _____

Sign: _____

Sign: _____

2804880060

Leonard
Stacey

2 Wards Road

Brechin
DD9 7AS

TT Morley

Consent for Investigation, treatment or Operation Form

(Please complete using block capitals and no abbreviations)

Name of proposed procedure or course of treatment
Site/ side of surgery EXCISION LESION SCALP

I have explained the procedure to the patient. In particular I have explained

Intended benefits: THERAPEUTIC

Significant risks: Bleeding
Pain
Infection
Scarring
Recurrence
Need for further procedure

Any extra procedures which may become necessary during the procedure:

Blood Transfusion ☐
(The need and alternatives have been discussed with the patient)

Other (specify)

I have also discussed what the procedure is likely to involve, the benefits and the significant risk of any available alternative (including no treatment) and any particular concerns of this patient. I have done this in terms that in my judgement have been understood.

The following information leaflet(s) have been given

Has the patient ever been notified that they are at increased risk of CJD or vCJD for public health purposes?

No ☑ Proceed as normal

Unable to respond ☐ Proceed as normal unless high risk tissue e.g. brain, spinal cord, posterior eye. Quarantine instruments pending contact with infection control for further advice

Yes ☐ Ask for further explanation. Quarantine instruments pending contact with infection control for further advice

Clinicians signature _____ **Date** 28/10/21
Name Printed L McClure **Grade** ST3
Contact Details _____

Consent for Investigation, treatment or Operation Form

(Please complete using block capitals and no abbreviations

Please read this form carefully. If you have any further questions, do ask; we are here to help you. You have the right to change your mind at any time, including after you have signed the form.

I agree: To the procedure or course of treatment described on this form.
To the administration of a general or, local or other anaesthetic as appropriate, following informed discussion including the benefits and significant risks with the anaesthetist.

I understand:

- That any procedure in addition to those described above will only be carried out itf it isd necessary to save my life or to prevent serious harm to my health.
- That you cannot give me a guarantee that a particular person will perform the procedure. The person will, however have appropriate experiences.
- Information including digital information (radiological e.g. X-rays, CT scans and MRI scans, video and /or photographic material) may be stored as part of the patients medical records and may be stored on computer data bases.
- Body tissues e. fluids, organs or parts of them may be removed during the procedure and used for diagnosis, my future treatment and then discarded or stored as considered appropriate.

Please tick appropriate box if you agree to

☐ Excess body tissue not required for diagnosis or future treatment being used for medical research

☐ To photographs and other digital images being used for teaching, in presentations at conferences or available on websites and in publications.

(If consent is withdrawn at a later date it may not be possible to withdraw images already in the public domain) NB medical staff – you must compete the appropriate medical photography forms.

I have been told about the additional procedures as specified which may become necessary during my treatment. I have listed below any procedures which **I do not wish to be carried out** without further discussion.

Specified additional Procedures | Additional procedures **I do not** want carried out

Patients Signature: X Sheonard. **Date:** 28/10/2021
Print Name:

Witness signature: **Date:**
(if unable to sign)
Print Name

Statement of Interpreter (if applicable) : I have interpreted the information above to the patient to the best of my ability and in a way in which I believe the patient can understand

Interpreters signature: **Date:**
Name printed:

Day of Operation
I have marked the skin at the operation site and / or confirmed consent

Signature: **Date**:

2804880060

Leonard
Stacey

2 Wards Road

Brechin
DD9 7AS

SURGICAL RECORD

SAFETY PAUSE
(To be read aloud by surgical assistant)

TT Morley

	Ward		Theatre/ MPU	
CONFIRM PATIENT NAME/CHI WITH ID BAND	Yes	No	Yes	No
CONFIRM PROCEDURE WITH PATIENT AND CONSENT	Yes	No	Yes	No
ANY ALLERGIES? Latex	Yes	No	Yes	No
ANY METALWORK / PIERCINGS /IMPLANTABLE DEVICES? Dermal Punch Piercing	Yes	No	Yes	No
CONFIRM SURGICAL SITE (IF APPLICABLE) Scalp	Left	Right	Left	Right
IS PATIENT ON ANY ANTI-COAGULANT?	Yes	No	Yes	No
CONFIRM IMAGING DIATHERMY EQUIPMENT	(Theatre only -please circle)			

Bi-polar

OPERATION NOTE

SURGEON: **ASSISTANT:**	**LOCAL ANAESTHESIA**

SKIN PREP:

PROCEDURE PERFORMED

SKIN CLOSURE:

SURGEONS SIGNATURE: **GMC Number:**

POST OPERATIVE INSTRUCTIONS

SUTURE REMOVAL:	
FOLLOW UP	
DRESSING	
MOBILTY	

SAFETY PAUSE

	Yes	No	N/A	Comment
SWABS CORRECT	✓			
INSTRUMENTS CORRECT	✓			
NEEDLES/ SHARPS CORRECT	✓			
SPECIMEN CHECKED	✓		1 x Pathology	
SCRUB NURSE	A ROSS.			
CIRCULATING NURSE	M EVANS			

TOURNIQUET TIME (IF APPLICABLE) N/A	**ON**	**OFF**	**Pressure (mmHg)**	**LEFT**	**RIGHT**	**Total Time**

STERILISATION TRACKING/ IMPLANT LABELS

MEDICINE PRESCRIPTION FORM

DATE	PRESCRITION ONCE ONLY DRUGS	DOSE	ROUTE	TIME	PRESCRIBER	GIVEN BY

MULTIDISCIPLINARY RECORD OF CARE

Date / Time		Signature
28/10/21 1545	Stacy returned following excision of lesion (R) Scalp. wound dry, no dressing. Stacey feels well, no concerns. Discharge information discussed. Removal of stitches in 7 days no follow-up required. Stacey had no concerns or questions dressed & discharged	BW/N

DISCHARGE CRITERIA

	Yes	No
Vital signs within normal limits? (IF REQUIRED)	N/A	
Wound site satisfactory? No active bleeding/ swelling	✓	
Patient Information Leaflet given?	✓	
Does the patient have their own analgesia / or able to get their own analgesia? Pain Score (1) 2 3 (please circle)	✓	
GP discharge letter given to patient?		✓
Practice Nurse /District Nurse referral?	✓	

Transport Arrangements: Pleas tick relevant box	By car with adult	✓	Public transport / Taxi		Patient to drive home *Surgeon aware*	

FIT FOR DISCHARGE (Please Tick)	Yes	No
	✓	

NURSE NAME Amy Wilson SN **DATE and TIME** 28/10/21

Tayside Pathology Laboratories
Ninewells Hospital, Dundee
☎ 01382 632548

NHS Tayside

Histopathology Report

LEONARD, Stacey **D.O.B: 28 Apr 1988** **Lab No: TS21018528**

Source: **Stracathro Plastics** **CHI No: 2804880060**
Clinician: **Miss F HOGG**
Date Received: **29 Oct 2021** **Date Reported: 15 Nov 2021**

Nature of Specimen(s)

Excision lesion right scalp

Clinical Information Supplied

Papillomatous lesion right scalp noticed over past few months. Cathes when brushes hair. Looks benign. No follow up pathway.

Macro Report

A possible small ellipse of skin 4x2x2mm covered by a white warty lesion up to 9mm. Bisected and both halves taken.

Micro Report

Histological sections show hair bearing cutaneous tissue incorporating a lobular capillary haemangioma. This focally abuts the deep resection margin and therefore it is difficult to guarantee excision but there are no concerning findings.

Signature of Pathologist(s)

Benign vascular lesion

NFN letter

Dr SL Edwards

JSH

Please note that some ancillary studies performed may be out of scope of the pathology department's UKAS accreditation. Please refer to the pathology user handbook (available on staffnet) for details.

ACKNOWLEDGEMENT OF RECEIPT	
WARD SECRETARY	DOCTOR

NINEWELLS PLASTIC SURGERY WAITING LIST SHEET

CLINIC DATE: 12/10/21

CONSULTANT: Dmy

LISTING DR: Vest

Stacey LEONARD
2804880060
DD9 7AJ

ADULT ☑ PAED ☐

MALE ☐ FEMALE ☑

CONTACT TELEPHONE (Supply 2 best)

HOME _____

OTHER _____

MOBILE 07 3682 27878

SPECIFY _____

PLANNED ABSCENCES / TIME TO AVOID _____

MIN NOTICE/SPECIAL CONSIDERATIONS _____

DIAGNOSIS: Scalp papilloma (traumatic) — SOC + D/C One Stop Spec

PROPOSED OPERATION:

SIDE: LEFT / RIGHT / BILATERAL

SURGEON REQUIRED

- SPECIFIC CONSULTANT ☐
- CONS ☐
- CONS AVAIL / SUPERVISING ☐
- ST 5 + (SR) ☐
- ST 3 - 4 (JR) ☑
- CT 1 - 2 (SHO) ☐

EST. TIME

- 30 MINS (INC BX, SIMPLE EXT ETC) ☐
- 45 MINS (EXC BX) ☑
- 75 MINS (EXC & FLAP) ☐
- 90 MINS (EXC & GRAFT) ☐
- SPECIFY TIME: _____

(IF PROCEDURE > 1 ADD 1.5x TIME)

COMPLEXITY OF CASE

- STRAIGHTFORWARD ☐ (Incision Biopsy, Excision Biopsy Limb / Trunk)
- MODERATE (Facial, Graft / Flap) ☐
- COMPLEX (All Other) ☐

LIST REQUIREMENTS

- GA ☐ BLOCK ☐
- L/A +/- Sedation ☐ L/A MAIN LIST ☐
- OPLA ☑

SPECIAL REQUIREMENTS:

- X-RAY/ C-arm (Outside Tayside) ☐
- Hoist ☐
- Other equipment (please specify) ☐
- Translator (specify language) ☐

INPATIENT ☐ DAY BEFORE ☐

DAYCASE ☐ ADMIT ON DAY ☐

PRIORITY

- P2 ☐ P3a ☐
- P3b ☑ P4 ☐

SPECIFIC DATE: _____

PT. CONSIDERATIONS:

- DIABETIC (1st on List) ☐
- INFECTION RISK (Last on List) ☐
- PACEMAKER / ICD ☐
- ALLERGY (please specify) ☐

PT. MEDICATION: TO BE STOPPED (Specify)

- WARFARIN ☐ _____
- CLOPIDOGREL ☐ _____
- ASPIRIN ☐ _____
- NOAC ☐ _____

(e.g rivaroxaban, edoxaban, apixaban)

2804880060

Leonard
Stacey

2 Wards Road

Brechin
DD9 7AS

TT Morley

For Barcode

NHS Tayside

Special Consent for Investigations, Treatment or Operation Form

COVID-19

Ward: STRACATHRO

Consultant: MISS HOGG

Specialty: PLASTIC SURGERY

I understand that I am opting for a treatment/procedure/surgery that I agree is necessary after discussion with

MISS MCCLYMONT (Clinician name)

This is for the following procedure:

EXCISION LESION SCALP (Procedure name)

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organisation (WHO). I further understand that COVID-19 is extremely infectious and is believed to spread by person-to-person contact. As a result, the Scottish Government currently recommends social distancing. I understand that social distancing is not always possible while I am receiving hospital care.

I recognise that staff within NHS Tayside are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is still a risk of becoming infected with COVID-19 by proceeding with this treatment/procedure/surgery. I hereby acknowledge the risk of becoming infected with COVID-19 through this treatment/procedure/surgery.

I understand that even if I have been tested for COVID-19 and receive a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID-19 after the test. I understand that if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/ surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalisation that may require medical therapy, Intensive Care treatment and possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. Those with pre-existing health conditions appear to be at a greater risk of significant complication from COVID-19 infection, and I have discussed my risks with my clinician.

(Document pre-existing conditions below):

.....

.....

.....

.....

In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency department or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

I further understand that my treatment/procedure/surgery may be cancelled at short notice due to unexpected changes associated with the pandemic within NHS Tayside.

I have been given the option to discuss if I can defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

Clinician's Signature: _____ **Date:** 28/10/21

Print Name: L. McLyman **Grade:** ST3

Patient's Signature: X Sleonard. **Date:** 28/10/21

Print Name: X

Witness Signature:
(if patient unable to sign) _____ **Date:** _____

Print Name: _____

Statement of Interpreter (if applicable): I have interpreted the information above to the patient to the best of my ability and in a way in which I believe the patient can understand.

Interpreters Signature: _____ **Date:** _____

Print Name: _____

NINEWELLS PLASTIC SURGERY WAITING LIST SHEET

CLINIC DATE: 12/10/21

CONSULTANT: Any Vet

LISTING DR:

Stacey LEONARD
2804880060
DD9 7AJ

ADULT ☑ PAED ☐

MALE ☐ FEMALE ☑

CONTACT TELEPHONE (Supply 2 best)

HOME _____ OTHER _____

MOBILE 07 3682 27877 SPECIFY _____

PLANNED ABSCENCES / TIME TO AVOID _____

MIN NOTICE/SPECIAL CONSIDERATIONS _____

DIAGNOSIS: Scalp pyogenic granuloma (traumatic) **PROPOSED OPERATION:** Exc + D/C One Stop Spare

SIDE: LEFT / RIGHT / BILATERAL

SURGEON REQUIRED
- SPECIFIC CONSULTANT ☐
- CONS ☐
- CONS AVAIL / SUPERVISING ☐
- ST 5 + (SR) ☐
- ST 3 - 4 (JR) ☑
- CT 1 - 2 (SHO) ☐

COMPLEXITY OF CASE
- **STRAIGHTFORWARD** (Incision Biopsy, Excision Biopsy Limb / Trunk) ☐
- **MODERATE** (Facial, Graft / Flap) ☐
- **COMPLEX** (All Other) ☐

SPECIAL REQUIREMENTS:
- X-RAY/ C-arm (Outside Tayside) ☐
- Hoist ☐
- Other equipment (please specify) ☐
- Translator (specify language) ☐

PT. CONSIDERATIONS:
- DIABETIC (1st on List) ☐
- INFECTION RISK (Last on List) ☐
- PACEMAKER / ICD ☐
- ALLERGY (please specify) ☐

EST: TIME
- 30 MINS (INC BX, SIMPLE EXT ETC) ☐
- 45 MINS (EXC BX) ☑
- 75 MINS (EXC & FLAP) ☐
- 90 MINS (EXC & GRAFT) ☐
- SPECIFY TIME: _____

(IF PROCEDURE > 1 ADD 1.5x TIME)

LIST REQUIREMENTS
- GA ☐ BLOCK ☐
- L/A +/- Sedation ☐ LA MAIN LIST ☐
- OPLA ☑

INPATIENT ☐ DAY BEFORE ☐

DAYCASE ☐ ADMIT ON DAY ☐

PRIORITY
- P2 ☐ P3a ☐
- P3b ☑ P4 ☐

SPECIFIC DATE: _____

PT. MEDICATION: **TO BE STOPPED (Specify)**
- WARFARIN ☐ _____
- CLOPIDOGREL ☐ _____
- ASPIRIN ☐ _____
- NOAC ☐ _____

(e.g rivaroxaban, edoxaban, apixaban)

Operational Unit

Surgical Directorate
Clinical Group of
Surgery&Oncology
General Surgery Department
Ninewells Hospital
Dundee
DD1 9SY
www.nhstayside.scot.nhs.uk

Private and Confidential
Ms Stacey Ellis
8 Mill Place
Craigo
Montrose
DD10 9LB

18 march 2010
Date: 18/03/2010
Dictation Date: 04/03/2010
Your Ref: (CHI:2804880060)
Our Ref: MC/DM/2804880060
Enquiries to: Ward 7 Office
Tel:(01382)660111
Ext:33890

Dear Ms Ellis,

Stacey Ellis, 280488-0060
8 Mill Place, Craigo, Montrose, DD10 9LB

Admitted 7.2.10 Discharged 8.2.10 Mr M Lavelle-Jones Ward 10 Urgent Admission
Codes 42 25 99
Follow up - none.

This young lady was admitted to Ward 10 with recurrent right lower abdominal pain. On admission she was tender in her lower abdomen with a white cell count of 12 and CRP less than 3. In the past she had a diagnostic laparoscopy in October 2000, had three courses of antibiotics for suspected pelvic inflammatory disease. Her urinalysis was leukocyte positive and nitrate negative. She was treated in the line of UTI and was commenced on Trimethoprim.

Her symptoms settled down quite quickly and she was discharged home on the following day. She also had a high vaginal swab done which did not show any evidence of candida or any trichomona's.

We have not arranged for any follow up however we would be happy to see her if there is any concern.

Yours sincerely

M Chowdhary LAT to
Mr M Lavelle-Jones Consultant Surgeon

Copy to:

Dr RuthC Cranswick
Annat Bank
Links Health Centre
Frank Wood Way
Montrose
DD10 8TY

Operational Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
Dundee, DD1 9SY
www.nhstayside.scot.nhs.uk

Dr RuthC Cranswick
Annat Bank
Links Health Centre
Frank Wood Way
Montrose
DD10 8TY

22 september 2010
Clinic 20/09/2010 Date:
22/09/2010
Dictation Date: 20/09/2010
Your Ref: (CHI:2804880060)
Our Ref: MMR/JEB/2804880060
Enquiries to: Breast Team Office
Extension: 33885
Direct Line : (01382) 633885

Dear Dr Cranswick,

Stacey Ellis, 280488-0060
8 Mill Place, Craigo, Montrose, DD10 9LB

This lady has a seven weeks history of bilateral breast pain and Stacey herself does not check her breasts. She is a heavy smoker and is under the impression that she has a latex allergy but has never had this formally checked by my Dermatology colleagues. A maternal aunt and maternal grandmother have developed breast cancer at the age of 26 and maybe in her fifties respectively, however, it seems that her mother is aged 41 and has not been affected by the condition.

Apart from referred tenderness during examination no palpable abnormalities have been detected from either side of her breasts. Breast imaging was not required but I suspect her symptoms have a combination of both hormonal local changes and maybe early stages of duct ectasia. I gave her an information leaflet on the management of breast pain and duct ectasia for background reading and hopefully the suggestions made should see an improvement of her symptoms. She was agreeable to be seen at the Family History Clinic to be formally assessed with regards to risks for breast cancer but I would be grateful if you could discuss with Stacey the issues surrounding the possible latex allergy which is a serious condition and may need to be looked into in more detail for future advice from yourself.

Further arrangements for this clinic were not required but I would be happy to see her back in the future if she has further worries about her breasts.

Yours sincerely

M. M. Reis, MD PhD,
Associate Specialist

Copy to:

Dr. D. Goudie
Clinical Geneticist
Dept of Genetics
Ninewells Hospital

Department of Surgery
Stracathro Regional Treatment Centre
Stracathro Hospital
NHS Tayside
Stracathro Hospital
Brechin DD9 7QA
65068
01356 665101
www.nhstayside.scot.nhs.uk

Dr RC Cranswick
Annat Bank Practice
Links Health Centre
Frank Wood Way
Montrose
DD10 8TY

Date	14/09/2016
Clinic Date	24/08/2016
Your Ref	
Our Ref	WJGM/ amc/ **2804880060**
Enquiries to	Mrs A. Campbell, Surgical Secretary
Extension	65068
Direct Line	01356 665068
Email	acampbell3@nhs.net

Dear Dr Cranswick

Stacey Ellis, 17 Annat Road, Montrose, DD10 8EF DOB: 28/04/1988

You referred this gentleman to our service with a lump in her right axilla. She was sent an appointment for our one stop see and do clinic at Stracathro Hospital but unfortunately, has not attended for this.

I am not sure of the reason for her non-attendance and a further appointment has not been arranged. If she still wishes to be seen in our clinic she can contact us within 4 weeks of the date of this letter and a further routine appointment can be arranged.

Yours sincerely

Authorised on 14/09/2016 09:47:21 by Typist/Secretary Aileen Campbell, not verified by Consultant.

Mr. W.J.G. Murray
Locum Consultant General Surgeon

Stacey Ellis
17 Annat Road
Montrose
DD10 8EF

Department of Surgery
Stracathro Regional Treatment Centre
Stracathro Hospital
NHS Tayside
Stracathro Hospital
Brechin DD9 7QA
65068
01356 665101
www.nhstayside.scot.nhs.uk

Dr RC Cranswick
Annat Bank Practice
links Health Centre
Frank Wood Way
Montrose
DD10 8TY

Date	12/10/2016
Clinic Date	04/10/2016
Your Ref	
Our Ref	MOH/ amc/ **2804880060**
Enquiries to	Mrs A. Campbell, Surgical Secretary
Extension	65068
Direct Line	01356 665068
Email	acampbell3@nhs.net

Dear Dr Cranswick

Stacey Ellis, 17 Annat Road, Montrose, DD10 8EF DOB: 28/04/1988

This lady was seen in the surgical see and do local anaesthetic clinic at Stracathro Hospital today regarding a lump in her right axilla.

PROCEDURE: Under infiltration of 25 mgs of Levobupivacaine the small cyst was excised through a transverse elliptical incision. It was clearly a cyst and was discarded. The skin was sutured with subcuticular 3/0 Vicryl Rapide and Steristrips over it.

She has been advised to take Paracetamol tablets for pain relief.

HISTOLOGY: Nil.

SUTURE REMOVAL: Nil.

FOLLOW UP: No follow up arrangements have been made.

Yours sincerely

Authorised on 12/10/2016 11:56:35 by Typist/Secretary Aileen Campbell, not verified by Consultant.

M. O. Hamza FRCS Edin & Glas
Speciality Doctor

Specialist Services
Breast Care Team
NHS Tayside

Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Dr SM Rooney
Brechin Medical Practice
Brechin Health Centre
Infirmary Street
Brechin
DD9 7AN

Date	05/11/2019
Clinic Date	04/11/2019
Your Ref	
Our Ref	WLC/SD/ **2804880060**
Enquiries to	Breast Care Team
Extension	32552
Direct Line	01382 632552
Email	

Dear Dr Rooney

Stacey Leonard, 2 Wards Road, Brechin, Angus, DD9 7AS DOB: 28/04/1988

I reviewed this 31 year old lady today in the outpatient breast clinic. She presents with a four to five month history of a left breast lump associated with some nipple itchiness on the same side. She denies any skin changes. She was previously seen in 2010 in the breast clinic and was found not to have anything untoward. I note she has a family history of breast cancer affecting her maternal aunt at the age of 26 years old and maternal grandmother at the age of 50.

On examination both breasts felt normal and there is no palpable lump or axillary lymphadenopathy. Subsequent ultrasound scan to look at the left breast and the nipple area showed normal breast tissue.

I have reassured the patient and I am happy to discharge her form our care. In view of her strong family history of breast cancer I shall refer her to genetics for further assessment.

Yours sincerely

Authorised on 05/11/2019 16:26:37 by Wen Ling Choong.

Wen Ling Choong
Specialty Registrar

Specialist Services
Breast Care Team
NHS Tayside

Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Consultant Anaesthetist
Anaesthetic Pre-Assessment Clinic
Area 5A
Ninewells Hospital
Dundee
DD1 9SY

Date	06/11/2019
Clinic Date	04/11/2019
Your Ref	
Our Ref	WLC/SD/ **2804880060**
Enquiries to	Breast Care Team
Extension	32552
Direct Line	01382 632552
Email	

Dear Consultant Anaesthetist

Stacey Leonard, 2 Wards Road, Brechin, Angus, DD9 7AS DOB: 28/04/1988

I reviewed this 31 year old lady in the symptomatic breast clinic today. I have noted that she had a strong family history of breast cancer and was previously referred to genetics but patient said that she has not seen anyone from genetics. She mentioned that her paternal and maternal grandmother was affected by breast cancer at an early age, 26 years old and 50 years old respectively.

We would be very grateful if you could see her in the genetics clinic for further assessment.

Yours sincerely

Authorised on 11/11/2019 08:54:00 by Wen Ling Choong.

Wen Ling Choong
Specialty Registrar

(P) Consultant Clinical Geneticist, Clinical Genetics, Level 6, Ninewells Hospital, Dundee, DD1 9SY

M/R

NHS Tayside

Specialist Services
Breast Care Team
NHS Tayside

Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Consultant Anaesthetist
Anaesthetic Pre-Assessment Clinic
Area 5A
Ninewells Hospital
Dundee
DD1 9SY

Date	06/11/2019
Clinic Date	04/11/2019
Your Ref	
Our Ref	WLC/SD/ **2804880060**
Enquiries to	Breast Care Team
Extension	32552
Direct Line	01382 632552
Email	

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Authorised on 11/11/2019 08:54:00 by Wen Ling Choong.

Wen Ling Choong
Specialty Registrar

(P) Consultant Clinical Geneticist, Clinical Genetics, Level 6, Ninewells Hospital, Dundee, DD1 9SY

DCB 4/11

NHS
Tayside

Specialist Services
Breast Care Team
NHS Tayside

Ninewells Hospital
Dundee
DD1 9SY

www.nhstayside.scot.nhs.uk

Dr SM Rooney
Brechin Medical Practice
Brechin Health Centre
Infirmary Street
Brechin
DD9 7AN

Date	05/11/2019
Clinic Date	04/11/2019
Your Ref	
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Yours sincerely

Authorised on 05/11/2019 16:26:37 by Wen Ling Choong.

Wen Ling Choong
Specialty Registrar

Clinical Genetics, Human Genetics Unit
Clinical Group of Surgery & Oncology
Ninewells Hospital
Dundee
DD1 9SY
Telephone No (01382) 632035
Fax No (01382) 496382

Dr Marta Reis
Associate Specialist
General Surgery Department
Ninewells Hospital
Dundee
DD1 9SY

Date Typed	13/12/10	Printed/sent 14/12/10
Date Dictated	29/11/10	
Date of Clinic		
Your Ref		
Our Ref	NE/KC/2804880060	
Pedigree No	05454	
Enquiries to	Miss Natalie Ellery	
Extension	32035	
Direct Line	(01382) 632035	
Email	natalie.ellery@nhs.net	

Dear Dr Reis

RE: STACEY ELIS, DOB: 28/04/88, 8 MILL PLACE, CRAIGO, MONTROSE, DD10 9LB

Thank you for referring the above patient to our department. Unfortunately, she has failed to respond to our requests for further information about her family history, and to offers of an appointment. We would be happy to see her in the future if you or her GP wish to re-refer her.

Yours sincerely

Natalie Ellery
Genetic Counsellor

c.c. Registry File
Case Notes
Dr Cranswick, Annat Bank Practice, Links Health Centre, Frank Wood Way, Montrose, DD10 8TY

Headquarters
King's Cross, Clepington Road, Dundee DD3 8EA

Chairperson, Mr Sandy Watson, OBE
Chief Executive, Professor Tony Wells

Delivery Unit

Surgical Directorate
General Surgery Department
Ninewells Hospital
Dundee, DD1 9SY
www.nhstayside.scot.nhs.uk

Dr RuthC Cranswick
Annat Bank
Links Health Centre
Frank Wood Way
Montrose
DD10 8TY

22 September 2010
Clinic 20/09/2010 Date: 22/09/2010
Dictation Date: 20/09/2010
Your Ref: (CHI:2804880060)
Our Ref: MMR/JEB/2804880060
Enquiries To: Breast Team Office
Extension: 33885
Direct Line : (01382) 633885

Dear Dr Cranswick,

Stacey Ellis, 280488-0060
8 Mill Place, Craigo, Montrose, DD10 9LB

This lady has a seven weeks history of bilateral breast pain and Stacey herself does not check her breasts. She is a heavy smoker and is under the impression that she has a latex allergy but has never had this formally checked by my Dermatology colleagues. A maternal aunt and maternal grandmother have developed breast cancer at the age of 26 and maybe in her fifties respectively, however, it seems that her mother is aged 41 and has not been affected by the condition.

Apart from referred tenderness during examination no palpable abnormalities have been detected from either side of her breasts. Breast imaging was not required but I suspect her symptoms have a combination of both hormonal local changes and maybe early stages of duct ectasia. I gave her an information leaflet on the management of breast pain and duct ectasia for background reading and hopefully the suggestions made should see an improvement of her symptoms. She was agreeable to be seen at the Family History Clinic to be formally assessed with regards to risks for breast cancer but I would be grateful if you could discuss with Stacey the issues surrounding the possible latex allergy which is a serious condition and may need to be looked into in more detail for future advice from yourself.

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Yours sincerely

M. M. Reis, MD PhD,
Associate Specialist

Delivery Unit

Surgical Directorate
Clinical Group of Surgery&Oncology
General Surgery Department
Ninewells Hospital
Dundee
DD1 9SY
www.nhstayside.scot.nhs.uk

Private and Confidential
Ms Stacey Ellis
8 Mill Place
Craigo
Montrose
DD10 9LB

18 March 2010
Date: 18/03/2010
Dictation Date: 04/03/2010
Your Ref: (CHI:2804880060)
Our Ref: MC/DM/2804880060
Enquiries To: Ward 7 Office
Tel:(01382)660111
Ext:33890

Dear Ms Ellis,

Stacey Ellis, 280488-0060
8 Mill Place, Craigo, Montrose, DD10 9LB

Admitted 7.2.10 Discharged 8.2.10 Mr M Lavelle-Jones Ward 10 Urgent Admission
Codes 42 25 99
Follow up - none.

This young lady was admitted to Ward 10 with recurrent right lower abdominal pain. On admission she was tender in her lower abdomen with a white cell count of 12 and CRP less than 3. In the past she had a diagnostic laparoscopy in October 2000, had three courses of antibiotics for suspected pelvic inflammatory disease. Her urinalysis was leukocyte positive and nitrate negative. She was treated in the line of UTI and was commenced on Trimethoprim.

Her symptoms settled down quite quickly and she was discharged home on the following day. She also had a high vaginal swab done which did not show any evidence of candida or any trichomona's.

We have not arranged for any follow up however we would be happy to see her if there is any concern.

Yours sincerely

M Chowdhary LAT to
Mr M Lavelle-Jones Consultant Surgeon

Copy to:

Dr RuthC Cranswick
Annat Bank
Links Health Centre
Frank Wood Way
Montrose
DD10 8TY

Screening Notes

Ambulance required	Yes
Redirected between specialties	No
Redirected between locations	No
Clinic booking recommendation	Yes
Cancelled	No

BOOKING DETAILS

CLINIC:	Breast Clinic		
DATE:	17/08/2010	SCREENED BY:	Douglas Brown:Screening User
SPECIALTY:	T101H_C1101		
ORIGINAL URGENCY:	Routine	LATEST URGENCY:	Routine
INSTRUCTIONS:	late clinic slot		
SUGGESTED CLINICIAN:	None selected		
CLINICAL INSTRUCTIONS:	None entered		

REFERRAL LETTER

MEDICAL IN CONFIDENCE

NHS Tayside

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

General Surgery - Breast C1A
TAY General Referral

— **Consultant / receiving practitioner** and/or **specialty clinic**

Ninewells Hospital
Dundee
DD1 9SY

— **Hospital** and **hospital address**

Hospital unit no.: T101H

Email address: -

Date of Referral (set by referrer) 16-Aug-2010

Date referral was submitted 16-Aug-2010

☐ If patient is an armed forces veteran please tick this box

Urgency of referral Routine

PATIENT DETAILS

Surname	ELLIS
Forename(s)	STACEY
Title	MS
Sex	Female
Date of birth	28-Apr-1988
CHI no.	2804880060

Patient's address

8 MILL PLACE
CRAIGO
MONTROSE
DD10 9LB

Contact number(s)

Voice: sandrastephenhasno

REGISTERED GP DETAILS

Name	Dr RC Cranswick		
GMC code	3260678	GP code	72001
Practice name	ANNAT BANK PRACTICE		
Practice code	13706		

Practice address

LINKS HEALTH CENTRE
MARINE AVENUE
MONTROSE

Contact number(s)

Voice: 01674-673400

REFERRING PRACTITIONER DETAILS

Name	Dr M Ireland		
GMC code	2848837	GP code	76007
Practice name	ANNAT BANK PRACTICE		
Practice code	13706		

Practice address

LINKS HEALTH CENTRE
MARINE AVENUE
MONTROSE

Contact number(s)

Voice: 01674-673400

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Breast Pain

Comment: This 22 year old lady complains of bilateral breast pain for 5 weeks. The pain has not varied with her period. O/E-She is tender in the upper outer quadrants of both breast which feel uneven and lumpy but no distinct lump was felt. She has a pigmented papilloma in her left axilla which has a smooth lump underneath (She is being referred to dermatologist about this). I would be grateful for your assessment.

Examinations and Investigations

Cigarette smoker:	Smoking status on date of event: Smoker.	05-Aug-2010
Non drinker alcohol:	Drinking status on eventdate: Life teetotaler.	12-Nov-2007
Exercise grading:	Walking alot	12-Nov-2007

Most recent height, weight, BMI and Blood Pressure

Height:	1.59	m	Recorded Date: None provided
Weight:	44.5	Kg	Recorded Date: None provided
BMI:	17.6	Kg/m^2	Recorded Date: None provided
Blood Pressure:	126/75	mmHg	Recorded Date: None provided

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
Blepharitis	-	-	Contact lens wearer	01-Apr-2009
Acne vulgaris	-	-	[MONTH AND YEAR OF EVENT 08/2006]	01-Aug-2006
Depressive disorder NEC	-	-	[MONTH AND YEAR OF EVENT 05/2005] NOTES: and alcohol misuse. Referred Cornhill.	01-May-2005
Right iliac fossa pain	-	-	admitted gynae with a false pos preg test, settled spontaneously	02-Apr-2005
Breast lump symptom	-	-	[YEAR OF EVENT 1997] NOTES: prepubertal.	01-Jan-1997
Convergent squint	-	-	[YEAR OF EVENT 1992] NOTES: left.	01-Jan-1992
Minor head injury	-	-	[YEAR OF EVENT 1992]	01-Jan-1992
Burn of wrist or hand NOS	-	-	[YEAR OF EVENT 1992] NOTES: right hand.	01-Jan-1992
Recurrent acute otitis media	-	-	[YEAR OF EVENT 1991]	01-Jan-1991
Specific delays in development	-	-	[YEAR OF EVENT 1989] NOTES: poor social circumstances.	01-Jan-1989

Past procedures

Description	Laterality	Modifier	Date performed
Termination of pregnancy NEC	-	-	31-Dec-2009
Eye muscle operations	-	-	01-Jan-1995
Foster care	-	-	01-Jan-1994
Insertion of grommet	-	-	01-Jan-1992

Current and recent medication

Current repeat medication

No current repeat medications recorded

Recent acute medication (last 30 days)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration
AZITHROMYCIN tabs 500mg	05476003	tablet(s)	TAKE TWO TABLETS AS A SINGLE DOSE	-	11-Aug-2010	-
TRIMETHOPRIM tabs 200mg	05148002	tablet(s)	TAKE ONE TWICE DAILY	-	03-Aug-2010	-
LAXIDO ORANGE oral pwdr	16111001	sachet(s) orange	1-3 SACHETS PER DAY FOR CONST[more]	-	22-Jul-2010	-

Clinical warnings

Allergies

H/O: non-drug allergy - Reaction type: Allergy, Certainty of allergy: Likely, Severity of allergy: Moderate. NOTES: Latex itchy and red.

Additional relevant information

Administrative information

Referred By:Registered GP

Signature of referring doctor (or other professional) **Date**

Surgical Admission Document

NHS Tayside

(Patient label if available)

First Name: Stacey

Family Name: ELLIS.

CHI: 2804880060

Address:

WARD: 10 Consultant: Lavelle Jones

Date: 07/02/2010.

Day: Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☑

Time of arrival:

Resps	17	bpm
O_2 Sats	100	%
Fi O_2	air	%
Temp	37.3	°C
BP	113/66	lying
(BP		Standing)
Pulse	89	bpm

A ☐ V ☐ P ☐ U ☐

SEWS Total: (SEWS≥4, Inform SpR)

Surgical Clerking F1 ☐ F2 ☐ SpR ☑

Name of doctor (please print): P. REENNIE.

Bleep 4338

Time of assessment: 0305.

21 ♀

PC: RIF Pain

HPC:

Allam Sudden onset 3 hrs RLQ pain 8/10 sharp, constant
- radiates to back, gradually getting worse upto 9/10
- ? vomiting or retching episodes
- Nausea, NO vomiting. Appetite ok (Normally poor appetite)
- Bowels working ok last moved yesterday - formed NAD
- passing urine ok. No dysuria. called NHS 24 - Brought by Ambulance
- husband with pain in RLQ today also.
- feeling very poorly - ambulance crew - helped
- Given morphine by
- Has had ongoing PV discharge since Oct. - white, thick, sticky daily
- Not sexually active currently.

PMH

	Yes	No	Details:
MI	☐	☑	LMP - Dec. before depoprovera injection
Angina	☐	☑	
↑BP	☐	☑	
↑Lipids	☐	☑	
COPD / Asthma	☐	☑	
Stroke/TIA	☐	☑	
Diabetes	☐	☑	
Epilepsy	☐	☑	
Cardiac Failure	☐	☑	
Jaundice / Hepatitis	☐	☑	
Peptic Ulcer Disease	☐	☑	
PE / DVT	☐	☑	

Previous Operations:
- No prev. appendicectomy
- Laparoscopy - Oct 2009 ? PID. on 3x A/Bs.

Anaesthetic History:
No probs.

Family History:

Other PMH:
- 6 weeks ago - blood in urine investigated by GP.
1 x child Normal delivery.

Drug History

Source(s) of history: Patient ☐ GP practice ☐ Relative ☐ GP referral letter ☐ Patient's Own Drugs ☐ Nursing home prescription ☐ Prescribing database ☐ Community pharmacy ☐ Other:

If the patient is taking
Aspirin, Clopidogrel(*Plavix*®), Dipyridamole (*Persantin*®) or **Warfarin**
then contact senior medical staff for advice regarding continuation of therapy.
If unavailable then **WITHOLD** therapy until senior review

Nil regular

ADMISSION MEDICATION			ACTION		Note: Unless indicated to stop / hold, medication should be continued on TPAR / discharge.
Name (Generic)	Dose	Frequency	Hold	Stop	Comments (if medication held or stopped)
Depoprovera					Next due 25th March.

Adverse reactions / Allergies

No Known Drug Allergies ☐ OR

Drug / Substance:	Reaction:	Drug / Substance:	Reaction:
Latex	itchy rash		

Are you satisfied this medication history is complete and accurate? Yes ☐ No ☐

If "no", what further action is necessary (contact GP, etc)?

Reviewed by pharmacist? Name: Signature:

Social History

Occupation..... Mother

Housing: Lives alone? Yes ☐ No ☑ Own ☐ Shelt. ☐ RH ☐ NH ☐

Smoking: Never ☐ Ex ☐ (stopped..... years) Current 15 /day

Alcohol ☐ units/week 6 units/month.

Social Care: Home Help ☐ District Nurse ☐ Meals on wheels ☐

Denies illicit drug use

Other social issues:
Lives with son (20 Months old).

Systemic Enquiry

CARDIOVASCULAR

Chest Pain / Dyspnoea / PND / Cough / Ankle Swelling / Intermittent Claudication

Details:

RESPIRATORY

Cough / Sputum / Haemoptysis / Wheeze / Weight Loss / Sweats

Details:

GASTROINTESTINAL

Appetite: ok

Bowel Habit: every 2 days.

Weight Loss: No

Jaundice:

Abdominal pain / Dysphagia / Heartburn / Indigestion / Haematemesis / Nausea / Vomiting / Diarrhoea / Constipation / PR bleed / PR mucous / Tenesmus

Details:

GENITO-URINARY

Loin pain / Suprapubic pain / Dysuria / Haematuria / Frequency / Urgency / Hesitancy / Incontinence / Dribbling.

Details:

CENTRAL NERVOUS SYSTEM

Dizziness / Headaches / Blackouts / Seizures / Numbness / Weakness / Visual Disturbances

Details: ongoing headache occipital over frequent week. otherwise tolerating comes and goes. relieved by pain well some photophobia. occurs on left side. No visual symptoms. No neuro signs

Examination

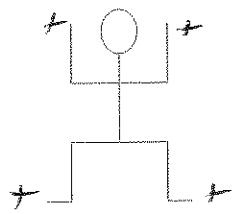
General: J° A° C° C° O° L°.

Urinalysis N.Nitrite -ve
Protein -ve.
Blood ++.
Leukocyte +
glucose -ve.

MSQ ...../10

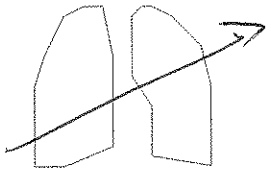
GCS: M.....E.....V.....= 15 /15

C.V.S
Pulses



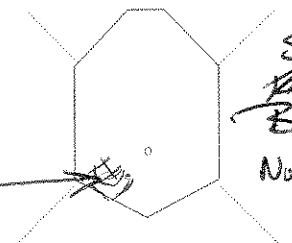
Heart Sounds S1 1+ S2 + 0 -
Murmurs N.A.
JVP
Ankle Oedema N.A. Cap refill < 2sec.
Peripheral Circulation

Respiratory



Trachea central.
Breath sounds vesicular.
Added Sounds
Percussion note resonant.

Abdomen



Soft : (Yes) No
Masses: Yes (No)
BS Present
PR - No external lesions
- empty rectum
- No Blood on glove.

Soft BS present No guarding tender

No inguinal masses or hernia.

(if PR not performed,specify WHY)

Clinical Impression

- ? Cause.
- ? appendicitis
- ? gynae cause.

Plan

- NBM.
- IV fluids, Bloods, CXR, Abdo x ray
- Analgesia.
- urinalysis / BHCG.
- Abdo USS

Clerking complete. Signed: _____ (Note: name and bleep number must appear at the front of the clerking)

Results

(Note: It is important to document times when results are recorded and to initial in the box provided)

	Initials:	Time:
ECG_1		
AXR		
CXR		
Ultrasound		
CT		
Other Investigations		

Biochemistry

Initials: | Time:

Initial results received | |

		PREVIOUS SAMPLES		
	Date	7/2/9		
	Time			
	Na	142		
	K	4.3		
	Urea	3.3		
	Creat	71		
	ALT	9		
	Bil	9		
	Alk Ph	62		
	Alb	44		
	C. Ca	2.25		
	Mg			
	PO4			
	Amylase	57		
	CRP	<3		
	CK			
	Gluc			

Haematology

Initials: | Time:

Initial results received | |

		PREVIOUS SAMPLES		
	Date			
	Time			
	Hb			
	MCV			
	WCC			
	Neut			
	Lymph			
	Plat			
	INR			
	APTTr			

ABG

Initials				
Time				
FIO_2				
pH				
PCO_2				
PO_2				
Bicarb				
BE				
Sats				
Hb				

Other Bloods: | Time:

Urinalysis

BHCG - negative.

Senior Review ☐ / Consultant Ward Round ☐ **Name:** Consultant ☐ SpR ☐ FY2 ☐

Date / / 20 Time

Advice regarding the continuation and / or restarting of **Anti-platelet / Anti-coagulation** therapy fully documented in the **DRUG HISTORY section** when appropriate ☐ (Tick Box)

08/02/2010
06:35 hrs.

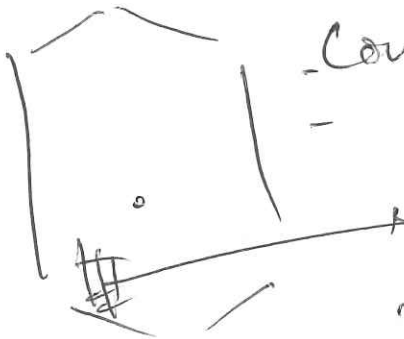
R/v by Surgical Reg (M. Chowdhary).

- Abdominal pain - 1/7
- sudden onset Right lower abdominal pain radiating to the back, constant in nature
- associated with nausea
- Bowels - regular
- denies urinary symptoms.
- not associated ± rigors/chills.
- LMP → Dec 09', on Depot Injection.

PMHx → Laparoscopy Oct 09', had 3 courses of antibiotics. ? PID,
- has been having ongoing PV discharge since october, whitish thick discharge.

O/E - apyrexial
- pulse 86/min
BP - 113/66
Temp 37.3°C

P/A



- Cough sign - negative.
-
- tender lower abdomen
no rebound.
no renal angle tenderness.

AXR
CXR
Other

Bloods
CRP <3 Hb 12.5
Amylase 57 WCC 12.1

Urine: Blood 3+
leucocyte +
Nitrite -ve

Imp ? Ureteric colic
? PID.

Plan (1) Analgesia
(2) USS abdomen/Pelvis.
(3)

Resus. Status: Normal ☐ **Not for 2222** ☐
(If not for 2222, document fully and complete form)

DVT prophylaxis: None at present ☐ TEDS ☐ LMWH ☐

Signature

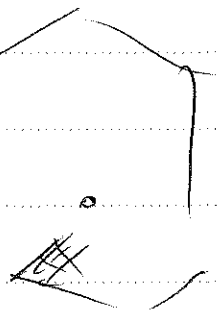
Name M. CHOWDHARY Bleep 5086

Date & Time

NOK MR MCJ

8/2/10 History noted.
apy-exid
obs - stable.

P/A



Plan
- USS abdomen & Pelvis
- High vaginal swab.

5886

8/2/10 Mr MCJ;
Pain settled.
Eat & drink & observe.

8/2/10 MR
15[00] Patient not at bed.
Will attempt to see/ again later.

S. McMichael
ST7

NHS TAYSIDE – PATIENT FUNDS AND PROPERTY PROCEDURE
PERSONAL DISCLAIMER FORM - LOSS OF PERSONAL EFFECTS

NHS TAYSIDE STATEMENT:

*****NHS Tayside will not accept any responsibility for loss or damage to any article/personal belongings unless such article/personal belongings (including cash) have been handed over and accepted by NHS Tayside, for safe keeping and an official receipt issued****

[delete as appropriate]*

Section A TO BE COMPLETED BY NURSING STAFF

If the patient or patient's representative at the time of admission is unable or refusing to complete and sign section B below, for whatever reason, inform the patient / representative verbally that they are responsible for their own belongings and valuables and state below the reason for non completion of Section B. Sign and date this, and enter a review date in Section C:

Reason: _____

Signature of Staff Recording _____ Date _____

Signature of Staff Witness: _____ Date: _____

Section B TO BE COMPLETED BY PATIENT

I have been given the opportunity to read the above statement and *do / do not wish to take advantage of the facilities provided for safe keeping of my personal belongings.

Patient Signature*** Stacey Ellis Date: 2·5·15

Print Name: Stacey Ellis

Hospital: Ninewells Ward: 19

*****If signing on behalf of a patient, please enter your relationship with the patient, and your address:**

Relationship: _____

Address: _____

_____

Witness to above signature: _____

Print Name: _____

Date: _____

Section C

If section A has been completed and a review is required, please enter review date (should be held every 4 weeks) noting two staff signatures required at each review :

(1) _____

Sign: _____

Sign: _____

(2) _____

Sign: _____

Sign: _____

(3) _____

Sign: _____

Sign: _____

(4) _____

Sign: _____

Sign: _____

Note: Please note that when a patient is absent from the ward for treatment (e.g. x-ray, an operation etc), the safe custody of their property which has not been handed over to NHS Tayside for safe keeping, remains the patient's responsibility. Arrangements may be available whereby property can be handed over to Nursing Staff for safe keeping during such periods. However, please note that due to storage restrictions, it is not possible to store larger items.

Discharge Plan - To be commenced on admission

(Not to be used for transfer information - use Transfer Checklist)

Planned patient discharge date:	Actual patient discharge date: ***If delay please specify reason:***
Patient informed of date **Y N N/A** Date Initials of nurse	Relative/carer informed of date **Y N N/A** Who was informed Date Initials of nurse

Patient Discharge Destination

Complete referral/s to Early Supported Discharge / Enablement Team / District Nurse / AHP/NRT pharmacy referral or similar (if applicable) Please Specify:-

_____

Date Initials of nurse

Transport plan agreed and arrangements made to date and progress (if applicable) **Y N N/A**

Adult available to escort home if using own/public transport? **Y N N/A**

Date Initials of nurse

Does the patient have any ongoing nutritional care needs? **Y N N/A** Does patient currently have an infection / colonisation / history of positive culture e.g. MRSA, VRE, CDI, CPE, Norovirus, etc **Y N N/A** Specify..... Has this information been communicated to carers/relevant agencies? **Y N N/A**	Does the patient / carer understand the treatment they received? **Y N N/A** Healthcare / self-care / advice and information given to patient and / or carer **Y N N/A** **state what type(s):** _____ _____ Carer support referral postcard given? **Y N N/A** Date Initials of nurse

Medications ordered and sent to pharmacy Date Initials of nurse

Delivered to ward Date Initials of nurse

Dressings / catheter / equipment ordered **Y N N/A**

Specify: _____

Supply ordered **Y N** Date Initials of nurse

Patient's home is suitable for them to return to? Y N N/A

Does patient require a relative / carer to be present at home on discharge? Y N N/A

Patient has key / access to inside of their home? Y N N/A

Patient has clothing and footwear to go home in that is appropriate for the weather conditions? Y N N/A

If any issues highlighted from any of the information obtained during the admission or as part of the discharge plan, including if the patient has triggered RED or AMBER on any of the traffic lights: -

- Please describe plan and interventions required for effective and safe discharge including any conversations you have with the patient/carer on Discharge Plan Continuation sheet
- If a referral to Social Work, Enablement Team, or District Nurse are required, please complete the Social **work/District Nurse Referral Form THB(MR)565**
- For patients with a Learning Disability/Dementia consider holding a pre-discharge multidisciplinary meeting

NOTE: IF THE PATIENT DISCHARGES THEMSELVES AGAINST MEDICAL ADVICE

Complete the Discharge Plan as far as possible. Ensure the GP / relevant agencies are informed.

DAY OF DISCHARGE FINAL CHECK

Equipment/dressings etc. given to patient / carer?	Y N N/A
PVC removed?	(Y) N N/A
Discharge documentation completed and sent to GP / copy given to patient?	Y N N/A
Patient / carer given medication?	(Y) N N/A
Patient / carer given any leaflets / cards associated with medications detailing side effects and cautions?	Y N N/A
Valuables returned to patient? E.g. glasses / hearing aids / walking aids	(Y) N N/A
Out Patient Appointment/s Please state... N/A required	Y (N) N/A
Pharmacy Smoking Support request given	
Initials of Nurse [signature] **Date** **Time**	

Date/Time	DISCHARGE PLAN CONTINUATION SHEET	Initial
	(Not to be used for transfer information - Complete a Transfer SBAR in Ongoing Record of Care)	

8. COMPLETE ON ADMISSION TO EACH WARD/AREA

PATIENT MEDICATION	**DATE/ WARD**	2/5/15			
Is the patient taking prescribed medications?		(Y) N	Y N	Y N	Y N
Patient has brought in own medicines?		Y (N)	Y N	Y N	Y N
Patient has brought in controlled drugs stored in the controlled drugs cupboard?		Y (N)	Y N	Y N	Y N
Does the patient understand what their medications are for?		(Y) N	Y N	Y N	Y N

Is the patient registered with a pharmacy? **Please state name of pharmacy & telephone number:-** STEEPLE PHARMACY - MONTROSE -

How does the patient usually obtain/order their medications: - include compliance aid details?
(specify) _____

ORIENTATION

Familiarised to ward environment?	(Y) N	Y N	Y N	Y N
Identity band in situ?	(Y) N	Y N	Y N	Y N
Nurse call system explained?	(Y) N	Y N	Y N	Y N
Explained where toilet/wash facilities are?	(Y) N	Y N	Y N	Y N
Explain Bed Controls to patient	(Y) N	Y N	Y N	Y N
Explained visiting/protected mealtimes/rest times?	(Y) N	Y N	Y N	Y N
Explain confidentiality of notes – does the patient wish to have access to their nursing record of care during their stay?	(Y) N	Y N	Y N	Y N

GIVE "Your Food and Drinks in Hospital" patient information leaflet ☐

If NO to any of the above , please give reason why and document in the On-going Nursing Record of Care
_____

VALUABLES **Please circle below if applicable:-** N/A

Dentures Top / Bottom / Full Glasses / Contact lenses Hearing aid/s Own clothing

Other (specify) _____

Walking aids (specify) _____

Patient's funds and property procedure explained and **PF1 completed**?	(Y) N	Y N	Y N	Y N
Money/property to be handed over on behalf of patient for safekeeping? **(Please refer and follow section 2.2.3 of Patient's Funds and Property procedure)**	Y (N)	Y N	Y N	Y N

6. INFECTION RISK STATUS (Please complete ALL sections for all patients within **6 hours** of admission)

If deemed "at risk" document AMBER (suspected) or RED (confirmed) on Traffic Light each shift

If there is any suspicion of, or confirmed transmissible infection please ensure appropriate patient placement, (side room where possible, practical and safe) and document in the nursing record.
Additional Infection Control Precautions (contact, droplet, airborne) as per NHS Tayside Policy.

Date and time of completion _____ **Initials** _____

CARBAPENEMASE PRODUCING ENTEROBACTERIACEAE (CPE) RISK ASSESSMENT

- **Hospitalised (as in patient including holiday dialysis) outside Scotland within the last 12 months?** Y (N)
- Transferred in from any high risk unit (ICU/HDU, Renal, Hematology, Oncology, and Infectious Diseases outside Tayside? Y (N)
- Previous known CPE colonisation / infection? Y (N)

If **YES** to any of the above questions, obtain verbal consent prior to taking swabs Consent Y N

Please tick: Stool Specimen ☐ or Rectal Swab (preferred) ☐

MRSA SCREENING RISK ASSESSMENT (NOT DAY CASE)

1. Admitted from Care Home, Sheltered Housing, Prison, Homeless Hostel or from another hospital? Y (N)
2. Admitted/transferred to:- HDU ICU Renal Vascular (Orthopaedics) **Please circle** (Y) N
3. Previous history of MRSA colonisation/infection? **(Check on ICE)** Y (N)
4. Any open wound/ulcer or invasive medical device present **before** admission to hospital? Y (N)

If **YES** to any of the above questions, obtain verbal consent prior to taking swabs Consent Y N

Swabs - please tick Nose & Perineum ☐ **(preferred option)** Nose & Throat ☑
Wound ☐ CSU ☐ Invasive Device Site ☐

If rescreened, please tick which swabs **AND** include Wound, CSU and Invasive Device Site if present

Date/Time
Nose & Perineum ☐ **(preferred option)** Nose & Throat ☐ Invasive Device Site ☐ Wound ☐ CSU ☐

Date/Time
Nose & Perineum ☐ **(preferred option)** Nose & Throat ☐ Invasive Device Site ☐ Wound ☐ CSU ☐

7. LIFESTYLE, WELLBEING AND HEALTH PROMOTION: (refer to flow charts)

Smoking
Are you a smoker / use tobacco products? (Y) N
IF YES:
Smoking policy discussed/smoking information leaflet given (Y) N
Opt into NRT In-patient Pathway? Y (N)

If No, Sign Disclaimer (THB 610 Personal Safety Risk Assessment)

Alcohol
Do you 'regularly' drink alcohol? Y (N)
('Regularly' means drinking every day or most days of the week)

IF YES:
Would like to reduce/stop drinking? Y N

Substance Use
Are you taking any 'over the counter' medications e.g. Pain killers, herbal remedies? Y (N)
Are you taking any "recreational drugs" or inhalants? Y (N)
IF YES:
Would like help and support with addiction? Y N

Weight / Activity Levels - BMI of >25 only
Do you undertake 30 minutes per day of physical activity? (Y) N
Are you comfortable with your current weight? (Y) N
IF NO TO BOTH:
Are you interested in receiving support to reduce your weight? Y (N)
Would you like help/support to increase your activity levels? Y (N)

Date/ Time	DISCHARGE PLAN CONTINUATION SHEET	Initials
3/5/15	Spoke to Dad - about change of Wishaw ad and flow Seeing Specialist Vic	

Date/ Time	DISCHARGE PLAN CONTINUATION SHEET	Initials

DIETARY ASSESSMENT

To be completed for all patients within **24 hours** of admission

Criterion	Y	N	If YES specify below	Intervention/Considerations	
Patient has a Learning Disability		✓		**Refer / contact Learning Disability Liaison on 07740 937309 Date.....**	
Patient has a Food Allergy **(Complete within 6 hours of admission)**		✓		**Kitchen informed** **Relevant staff informed/included in safety brief** **Wrist allergy band in situ** **Allergies recorded in Nursing Notes and Drug Kardex** **Other, specify .....**	☐ ☐ ☐ ☐ ☐
Patient has Specific Cultural/Ethnic/Religious dietary requirements e.g. Halal/Vegetarian		✓		**Kitchen informed** **Halal/Vegetarian menu offered (if appropriate)** **Other, specify .....**	☐ ☐
Patient has specific therapeutic dietary requirements e.g. Gluten Free/Renal/Diabetic		✓		**Kitchen informed** **Other, specify .....**	☐
Patient **unable** to make menu choices independently Patient has **Specific** eating and drinking likes/dislikes		✓		**Give assistance if necessary to make menu choices, taking into account likes/dislikes** **Other, specify .....**	☐
Patient **unable** to maintain their own hydration needs		✓	**If> 60 years of age** 30 mls/kg x body weight per day **If 18-60 years of age** 35 mls/kg x body weight per day	**Calculate daily fluid goal** **.....mls/kg per day** **Offer regular fluids (8-10 drinks per day)** ***(or if applicable fluid restriction)***	☐

Criterion	Y	N	If YES specify below	Intervention/Considerations
Patient has cognitive impairement/Dementia/medical or psychological factors affecting nitrition		✓		**If YES, please specify and follow Specific Nutritional Requirements Guidance** **Record level of risk on the traffic lights and document plan of care in the nursing record.** **If NO to any question reassess each shift and record level of risk on traffic lights**
Patient unable to take 'adequate' food and /or fluid orally/swallowing problems/poor oral health		✓		
Patient requires physical assistance with eating and drinking/adapted equipment or requires nutrition/supplements		✓		

Completed - Initials of nurse **Date** **Time**

Review Date	Oedema /Ascites Yes/No	Weight	Corrected Weight	B.M.I.	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	Dietetic Referral Yes/No	DATIX Yes/No	Initial

PLEASE COMPLETE WEIGHT CHART FOR LONGER STAY PATIENTS(THB(MR)566)

Date/ Time	INVESTIGATIONS/TESTS	RESULTS e.g. catheter label, urinalysis label
2/5/15 10.00	MRSA ✓	

SHIFT ASSESSMENT DATE			2/5/15			3/5/15											
COMPLETE ASSESSMENT AND RECORD CARE REQUIRED AND GIVEN FOR ANY AMBER & RED RISKS ONLY	PAC	DOSA	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
(N) NUTRITION																	
'MUS'T' 0 or Independent No risk identified																	
'MUST' 1 or requires assistance/encouragement/oral supplements																	
'MUST' 2 or more / dependent/NBM/Enteral/Parenteral nutrition/swallowing problems/ on 3 day Food Record Chart			10														
(PUP) PRESSURE ULCER PREVENTION																	
No risk using PPURA or Waterlow, <10 and/or No ulcer			10														
Waterlow >10 and at risk of Grade 1 or 2 pressure ulcer																	
Waterlow >10 at risk, Grade 3 or 4 pressure ulcer Cannot /will not reposition on three alternating areas																	
(M) MANUAL HANDLING & MOBILITY																	
Independent. No risk identified			10														
Requires supervision or assistance walking aids/ additional equipment																	
Dependent New problem																	
(F) FALLS																	
No history of falls No risk identified			10														
History of falls Risk factor identified/ New fall since admission																	
(A) AIRWAY/BREATHING																	
No airway/breathing problem No risk identified			10														
Existing airway/breathing problem identified – condition optimal																	
New problem identified/ exacerbation of existing problem																	
(O) OBSERVATION & MONITORING																	
SEWS 0 – 1			10														
SEWS 2 – 3																	
SEWS 4 or more or scores 3 in two or more parameters New risk/Nurse Concern. Continuous Observations/ cardiovascular monitoring in situ																	
(E) ELIMINATION																	
Independent No risk identified			10														
Requires supervision/assistance Problems with input/output or catheter / bowels/stoma																	
Dependent / incontinent of urine/faeces/new stoma/new bowel/bladder problem																	
(FB) FLUID BALANCE/HYDRATION																	
Independent No risk identified			10														
Requires Fluid balance monitoring /assistance or encouragement to drink.																	
Active Fluid Management New problem identified																	
(P) PAIN																	
No pain or score 0 – 1			10														
Pain score 2 – 3 or on regular analgesia																	
Pain Score 3 continuous at rest																	
(W) WOUND/SKIN INTEGRITY																	
Skin healthy - No risk identified			10														
Skin fragile/ dermatological condition/dry skin Clean surgical wound																	
Open wound/skin damage/excoriation, or extravasation of IV medication/ wound requiring active management																	

Step 1 – BMI score (& BMI)

BAPEN
www.bapen.org.uk

Height (feet and inches)

Weight (kg)	4'9½	4'10½	4'11	5'0	5'0½	5'1½	5'2	5'3	5'4	5'4½	5'5½	5'6	5'7	5'7½	5'8½	5'9½	5'10	5'11	5'11½	6'0½	6'1	6'2	6'3	6'3½	6'4½	Weight (stones and pounds)
100	47	46	44	43	42	41	40	39	38	37	36	35	35	34	33	32	32	31	30	30	29	28	28	27	27	15 10
99	46	45	44	43	42	41	40	39	38	37	36	35	34	33	33	32	31	31	30	29	29	28	27	27	26	15 8
98	46	45	44	42	41	40	39	38	37	36	36	35	34	33	32	32	31	30	30	29	28	28	27	27	26	15 6
97	46	44	43	42	41	40	39	38	37	36	35	34	34	33	33	32	31	31	30	29	29	28	27	27	26	15 4
96	45	44	43	42	40	39	38	38	37	36	35	34	33	32	32	31	30	30	29	28	28	27	27	26	26	15 2
95	45	43	42	41	40	39	38	37	36	35	34	34	33	32	31	31	30	29	29	28	28	27	27	26	25	14 13
94	44	43	42	41	40	39	38	37	36	35	34	33	33	32	31	30	30	29	28	28	27	27	26	25	25	14 11
93	44	42	41	40	39	38	37	36	35	35	34	33	32	31	31	30	29	29	28	27	27	26	25	25	24	14 9
92	43	42	41	40	39	38	37	36	35	34	33	33	32	31	30	30	29	28	28	27	27	26	25	25	24	14 7
91	43	42	40	39	38	37	36	36	35	34	33	32	31	31	30	29	29	28	27	27	26	26	25	25	24	14 5
90	42	41	40	39	38	37	36	35	34	33	33	32	31	30	30	29	28	28	27	27	26	25	25	24	24	14 2
89	42	41	40	39	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	25	24	24	14 0
88	41	40	39	38	37	36	35	34	34	33	32	31	30	30	29	28	28	27	27	26	25	25	24	24	23	13 12
87	41	40	39	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	25	24	24	23	13 10
86	40	39	38	37	36	35	34	34	33	32	31	30	30	29	28	28	27	27	26	25	25	24	24	23	23	13 8
85	40	39	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	25	24	24	23	23	13 5
84	39	38	37	36	35	35	34	33	32	31	30	30	29	28	28	27	27	26	25	25	24	24	23	23	22	13 3
83	39	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	25	24	23	23	23	22	13 1
82	38	37	36	35	35	34	33	32	31	30	30	29	28	28	27	26	26	25	25	24	24	23	23	22	22	12 13
81	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	24	24	23	23	22	22	22	12 11
80	38	37	36	35	34	33	32	31	30	30	29	28	28	27	26	26	25	25	24	24	23	23	22	22	21	12 8
79	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	24	24	23	23	22	22	21	21	12 6
78	37	36	35	34	33	32	31	30	30	29	28	28	27	26	26	25	25	24	24	23	23	22	22	21	21	12 4
77	36	35	34	33	32	32	31	30	29	29	28	27	27	26	25	25	24	24	23	23	22	22	21	21	20	12 2
76	36	35	34	33	32	31	30	30	29	28	28	27	26	26	25	25	24	23	23	22	22	22	21	21	20	12 0
75	35	34	33	32	32	31	30	29	29	28	27	27	26	25	25	24	24	23	23	22	22	21	21	20	20	11 11
74	35	34	33	32	31	30	30	29	28	28	27	26	26	25	24	24	23	23	22	22	21	21	20	20	20	11 9
73	34	33	32	32	31	30	29	29	28	27	26	26	25	25	24	24	23	23	22	22	21	21	20	20	19	11 7
72	34	33	32	31	30	30	29	28	27	27	26	26	25	24	24	23	23	22	22	21	21	20	20	20	19	11 5
71	33	32	32	31	30	29	28	28	27	26	26	25	25	24	23	23	22	22	21	21	21	20	20	19	19	11 3
70	33	32	31	30	30	29	28	27	27	26	25	25	24	24	23	23	22	22	21	21	20	20	19	19	19	11 0
69	32	32	31	30	29	28	28	27	26	26	25	24	24	23	23	22	22	21	21	20	20	20	19	19	18	10 12
68	32	31	30	29	29	28	27	27	26	25	25	24	24	23	22	22	21	21	21	20	20	19	19	18	18	10 10
67	31	31	30	29	28	28	27	26	26	25	24	24	23	23	22	22	21	21	20	20	19	19	19	18	18	10 8
66	31	30	29	29	28	27	26	26	25	25	24	23	23	22	22	21	21	20	20	19	19	19	18	18	18	10 6
65	30	30	29	28	27	27	26	25	25	24	24	23	22	22	21	21	21	20	20	19	19	18	18	18	17	10 3
64	30	29	28	28	27	26	26	25	24	24	23	23	22	22	21	21	20	20	19	19	18	18	18	17	17	10 1
63	30	29	28	27	27	26	25	25	24	23	23	22	22	21	21	20	20	20	19	19	18	18	17	17	17	9 13
62	29	28	28	27	26	25	25	24	24	23	22	22	21	21	20	20	20	19	19	18	18	18	17	17	16	9 11
61	29	28	27	26	26	25	24	24	23	23	22	22	21	21	20	20	19	19	18	18	18	17	17	17	16	9 8
60	28	27	27	26	25	25	24	23	23	22	22	21	21	20	20	19	19	19	18	18	17	17	17	16	16	9 6
59	28	27	26	26	25	24	24	23	22	22	21	21	20	20	19	19	19	18	18	17	17	17	16	16	16	9 4
58	27	26	26	25	24	24	23	23	22	22	21	21	20	20	19	19	18	18	18	17	17	16	16	16	15	9 2
57	27	26	25	25	24	23	23	22	22	21	21	20	20	19	19	18	18	18	17	17	16	16	16	15	15	9 0
56	26	26	25	24	24	23	22	22	21	21	20	20	19	19	18	18	18	17	17	17	16	16	16	15	15	8 11
55	26	25	24	24	23	23	22	21	21	20	20	19	19	19	18	18	17	17	17	16	16	16	15	15	15	8 9
54	25	25	24	23	23	22	22	21	21	20	20	19	19	18	18	17	17	17	16	16	16	15	15	15	14	8 7
53	25	24	24	23	22	22	21	21	20	20	19	19	18	18	18	17	17	16	16	16	15	15	15	14	14	8 5
52	24	24	23	23	22	21	21	20	20	19	19	18	18	18	17	17	16	16	16	15	15	15	14	14	14	8 3
51	24	23	23	22	22	21	20	20	19	19	19	18	18	17	17	16	16	16	15	15	15	14	14	14	14	8 0
50	23	23	22	22	21	21	20	20	19	19	18	18	17	17	17	16	16	15	15	15	14	14	14	14	13	7 12
49	23	22	22	21	21	20	20	19	19	18	18	17	17	17	16	16	15	15	15	14	14	14	14	13	13	7 10
48	23	22	21	21	20	20	19	19	18	18	17	17	17	16	16	16	15	15	15	14	14	14	13	13	13	7 8
47	22	21	21	20	20	19	19	18	18	17	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	7 6
46	22	21	20	20	19	19	18	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	7 3
45	21	21	20	19	19	18	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	7 1
44	21	20	20	19	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	12	6 13
43	20	20	19	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	12	11	6 11
42	20	19	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	12	11	11	6 9
41	19	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	12	11	11	11	6 6
40	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	12	11	11	11	11	6 4
39	18	18	17	17	16	16	16	15	15	15	14	14	13	13	13	13	12	12	12	12	11	11	11	11	10	6 2
38	18	17	17	16	16	16	15	15	14	14	14	13	13	13	13	12	12	12	11	11	11	11	11	10	10	6 0
37	17	17	16	16	16	15	15	14	14	14	13	13	13	13	12	12	12	11	11	11	11	10	10	10	10	5 12
36	17	16	16	16	15	15	14	14	14	13	13	13	12	12	12	12	11	11	11	11	10	10	10	10	10	5 9
35	16	16	16	15	15	14	14	14	13	13	13	12	12	12	12	11	11	11	11	10	10	10	10	9	9	5 7
34	16	16	15	15	14	14	14	13	13	13	12	12	12	11	11	11	11	10	10	10	10	10	9	9	9	5 5
33	15	15	15	14	14	14	13	13	13	12	12	12	11	11	11	11	10	10	10	10	10	9	9	9	9	5 3
32	15	15	14	14	13	13	13	13	12	12	12	11	11	11	11	10	10	10	10	9	9	9	9	9	9	5 1
31	15	14	14	13	13	13	12	12	12	12	11	11	11	10	10	10	10	10	9	9	9	9	9	8	8	4 12
30	14	14	13	13	13	12	12	12	11	11	11	11	10	10	10	10	9	9	9	9	9	8	8	8	8	4 10

Score 0 (obese)

Score 1

Score 2

Score 3

1.46 1.48 1.50 1.52 1.54 1.56 1.58 1.60 1.62 1.64 1.66 1.68 1.70 1.72 1.74 1.76 1.78 1.80 1.82 1.84 1.86 1.88 1.90 1.92 1.94

Height (m)

© BAPEN

Note : The black lines denote the exact cut off points (30,20 and 18.5 kg/m²), figures on the chart have been rounded to the nearest whole number.

'MUST' RISK ASSESSMENT

To be completed for all patients within **24 hours** of admission

If patient **NOT** appropriate for 'MUST' Assessment specify reason:-	If patient **NOT** appropriate for Dietary Assessment specify reason:-
Review Date	**Review Date**
Review Date	**Review Date**

STEP 1

Height (m)	159cm	Stadiometer ☐ Self reported height (if reliable) ☐ Reported by carer ☐
Ulna Length (cm)		(not appropriate for Learning Disability)
Tape Measure (m)		(Learning Disability only)
Weight (kg)	45.40	Actual ☑ Self- reported ☐ Reported by carer ☐

STEP 2 **(If none, write 'nil')**

Any unplanned weight loss over the last 3–6 months) No. **(kg)**

Any unplanned weight gain over the last 3–6 months. **(kg)**

Are there any factors affecting weight? **Yes** ☐ **No** ☑

Amputation	Weight		(kg)	Corrected Weight		(kg)
Oedema	Wet Weight		(kg)	Corrected Weight		(kg)
Ascites	Wet Weight		(kg)	Corrected Weight		(kg)
Plaster Cast	Weight		(kg)	Corrected Weight		(kg)

BMI (kg/m²) from Ready Reckoner 18.

STEP 3

Is the patient acutely ill **and** there has been or is likely to be little or no nutritional intake for more than **5** days **Y** **N**

'MUST' CALCULATOR

STEP 1 BMI score (from Ready Reckoner)		STEP 2 Weight loss score (from Ready Reckoner)		STEP 3 Acute disease
BMI kg/m²	**Score**	Unplanned weight loss in past 3-6 months (this includes obese patients) **%**	**Score**	If patient is acutely ill and there has been or is likely to be little or no nutritional intake for more than 5 days
greater than 20 (>30 obese)	= 0	less than 5	= 0	**Score 2**
18.5 – 20	= 1	5-10%	= 1	**Score 0** if not applicable
Less than 18.5	= 2	greater than 10	= 2	

2 + ☐ + ☐

STEP 4 (add step 1, 2 and 3 together to give overall risk of malnutrition 'MUST' score)

2

Score 0 Low Risk		Score 1 Medium Risk		Score 2 or more High Risk

Follow STEP 5 Management Guidelines

'MUST' is adapted and reproduced with kind permission of BAPEN (British Association for Parenteral and Enteral Nutrition).

RECORD CARE REQUIRED AND GIVEN FOR ANY AMBER & RED RISKS	PAC	DOSA	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
			21	15	18												
(PH) PERSONAL HYGIENE																	
Independent			10														
Requires supervision/assistance and /or encouragement																	
Dependent																	
(OH) ORAL HYGIENE																	
Independent - brushes teeth/dentures by self			10														
Requires assistance/observation to brush teeth/ dentures																	
Dependent/active assistance with oral care required / Oral trauma/ acute oral complaint																	
(I) INFECTION CONTROL																	
No known risk (follow HAI)																	
Infection risk identified any Invasive Device PVC/CVC/PICC			10														
Confirmed infection																	
(C) COMMUNICATION																	
No Communication barriers identified			10														
Existing communication barriers/ requires interpreter																	
New communication barriers Relative / Carer has Welfare Power of Attorney/ Legal Guardianship																	
(LD) LEARNING DISABILITY																	
No learning disability			10														
Learning disability identified (Contact Learning Disability Liaison Team)																	
(PS) PERSONAL SAFETY																	
Not ambulant/ Ambulant but clinically stable Mentally capable of making sound judgments Legible Identity Bracelet in place			10														
Ambulant, but clinically unstable Current smoker/ Alcohol or Substance misuse Risk of absconding/ Concerns for patient safety/Impaired judgment/ Sedation **Use of Bedrails** **DNACPR activated**																	
(PC) PSYCHOLOGICAL CARE																	
Psychological care needs met / no challenging behaviour identified			10														
Concerns requiring psychological/spiritual care / or has a longstanding mental health condition that is managed.																	
Patient experiencing intense emotions/ distress OR physical or self-injurious behaviour/ aggressive towards others. Requiring immediate professional input																	
(S) SLEEP																	
No sleep problem identified			10														
Altered sleep pattern/ difficulty sleeping/ insomnia																	
(CF) COGNITIVE FUNCTION (Think Delirium)																	
No problems identified			10														
Cognitive Impairment with controlled symptoms																	
Acute change in Cognitive Function, Delirium or deteriorating dementia with significant symptoms (Contact dementia/psychiatric liaison team/ communicate with previous care setting if appropriate/ medical staff)																	
(ACN) ADDITIONAL CARE NEEDS																	
			10														
INITIALS OF NURSE			PC														

ONGOING PLAN OF PATIENT CARE & EVALUATION
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E	Elimination	**C**	Communication		

Date/Time	Code	ADMISSION SBAR	Initials
2/5/15.		**Situation** (Short summary of reason for Admission)	
10.10.	ACN.	Admitted from home for I+D of thigh	
		abscess (left).	PCb
	Adm.	Notes in Clover House have been requested.	PCb
		Background (Recent events , circumstances, relevant medical history)	
		—	
		Current smoker.	
		Assessment (Observations, risk factors, injuries)	
	O	SEWS-0.	
	I	MRSA screened ✓.	
	M	Independently mobile.	
	PUP	Grade 0 all areas.	PCb
		Recommendation/s (Nursing plan for all Amber /Red needs) (*continue on next page if needed*)	
	N	Fasting for surgery.	
	I	On oral Abx, started 2 days ago.	
	N	BMI -18. MUST-2.	PCb

5. SOCIAL CIRCUMSTANCES

Dependants

Do you/ the patient provide care or support for someone, or have concerns regarding care of pets? (Y) N

IF YES, what arrangements been made for their care whilst you / the patient are in hospital?
KIDS WITH PARTNER.

Significant other (s) Involved in Care

Do you / the patient have someone who provides unpaid care or support for you on a **daily/ weekly** basis? Y (N)

IF YES, SPECIFY Name of main Carer _____ Relationship _____

Briefly describe care given _____

Key Holder **Y N** Name _____

Home Environment

Is the patient planning to return to their usual home after they leave hospital? **Y N**

IF NO, SPECIFY _____

IF YES, are there any concerns regarding discharge i.e. poor mobility around the home , personal care, cooking, housework, shopping , laundry etc **Y N**

IF YES, and aged over 75 years AND/ OR admitted with falls, deterioration in mental state or poor mobility please complete **Functional Assessment Screening Tool** (where applicable).

OR Use **'Referral to Social Work/District Nurse Form' THB (MR)565** and document in the discharge plan

If any community service in place please table complete below

Community Services	Please circle	Specify Care	Contact Details	Days provided	Number of visits per day	Date phoned to be restarted	Initial
Home Care	**Y N**						
Nurse Specialist	**Y N**						
District Nurse	**Y N**						
Care Manager/ Social worker	**Y N**						
Meals Delivered	**Y N**						
Day care	**Y N**						
Other	**Y N**						

Phone to restart services if the patient is able to go home on existing package of care. **Complete the grey section.** Please note; services may be stopped following admission and therefore a re-referral or a new referral will be required.

2. CONSENT/CAPACITY: To be completed for all patients within **6 hours** of admission

2a. CAPACITY

Do you have any concerns regarding the patient's capacity or ability to make healthcare decisions (including Cognitive Impairment/ Delirium/ Confusion/ Diagnosed Mental Health Condition / Learning Disability)? **Y N**

IF YES SPECIFY _____

IF NO review using the Traffic Light Risk Assessment per shift/as required and complete assessment below if any changes

IF YES Please complete the **"Assessment and Intervention" section below** and review using the Traffic Light Risk Assessment per shift

2b. FORMAL CONSENT TO TREATMENT

Check Consent to Treatment Form completed for Surgery/Medical Procedure/Test **(if applicable)**, signed and in medical records ☐

Assessment and Intervention				Date/Time	Initial
"Butterfly Scheme" discussed?	Y	N	Consent to opt in to "Butterfly Scheme" given		
"Getting to Know Me" offered?	Y	N	"Getting to Know Me" completed		
Has medical staff been informed?	Y	N	**Inform** Consultant / medical Staff to undertake appropriate Cognitive Testing		
Has Certificate of Incapacity (Section 47) form been completed?	Y	N	**Notify** medical staff of the need to undertake a **capacity assessment with regard to the treatment needed**		

If the emergency / first contact has Power of Attorney (Welfare only) or Legal Guardianship they are legally entitled to full disclosure of all confidential information

3. DISCLOSURE OF INFORMATION

I/ the patient give consent for full disclosure of confidential information to first contact only i.e. diagnosis, test results etc? (Y) N

I/ the patient give consent to disclosure of general information to general enquiries from all other relative/carers/friends i.e had a good day; doing well etc? (Y) N

Is there anyone you do NOT wish us to disclose any information to? Y (N)

Full name/s & relationship _____

Power of Attorney/Legal Guardianship (complete for ALL patients)

a) Welfare?	Y	N	If Yes is this activated: Y N Name & Contact details:
b) Financial affairs?	Y	N	If Yes is this activated: Y N Name & Contact details:
c) Anticipatory/ Advanced Care Plan?	Y	N	If Yes have you seen verification Y N

4. SELF CARE

Is there any care you/ the patient **(and/or relative/friend)** would like to be involved in whilst in hospital: for example, washing and dressing, help at mealtimes? Y (N)

IF YES, SPECIFY _____

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Date/Time	Code		Initials
2/5/15	N	Must 2.	
	PUP	Plan B grade independently.	
		Relieves	
	M	Independent	
	W	Pico dressing in situ	
	O	Sews o.	
	I	PVC in situ for 2/7 antibiotics	
	Adm	Pico to remain in place for 48h. then normal dressing	
	E	Has passed urine.	
2/5/15	acm.	Pt advised to be seen by F/u on Ward Rev Discharge re and Antibiotics. Stacey states she has been poorly since 20.30hrs. I went to the Ward Ward Sister & Doctor regarding oral Abx & discharge / Stacey has 4 children at Home & is desperate to get Home. is now 6/7 on 4 hours. Oral Abx Flux 500mg tds dispensed Oral Abx TTO obtained & written 25/26 n/wells Discharge Script written by Dr & Counter Signed by Ward Partner. Pt advised to take Stacey Home. PVC Removed & dressed. Oral Abx TTOs given & explained. Stacey told to visit GP & Friends regarding dressing reductions / Also informed of any problems to contact NHS 24HR. Stacey has said she will but is adamant she will attend to go Home	

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Date/Time	Code		Initials
2/5/15		Will spend a day in Ward tomorrow if stay required to district Nurse letter or not. If so will find out when a GP is ready.	
3/5/15		Stay in ward GP ready & wait to have check up & return home.	

THB 600

1. GENERIC PATIENT DETAILS

Hospital NINEWELLS Ward ASR07 Consultant VUJOVIC

Date of Admission 010515 Time 14-15 Expected Date of Discharge _____

"Coming in to and Leaving Hospital Explained" patient information leaflet given ☐

Patient details (affix label)

ELLIS
STACEY
17 ANNAT ROAD
MONTROSE

DD10 8EF

2804880060
Female

GP Details (affix label)

GP Name _____
Address _____

Postcode _____
Telephone Number _____

Allergies (Record on TPAR)

Possibility of pregnancy? Y N

LMP (If applicable) _____

If address different on admission, please state:

Home Telephone Number 01674 959 209

Mobile Telephone Number _____

Preferred Name STACEY Title MISS Age 27 Marital Status SINGLE

Ethnic Origin _____ First Language ENGLISH Other: _____ Interpreter Required Y (N)

Do you/the patient use other methods of communication? Y (N)

Sign Language ☐ Braille ☐ Makaton ☐ Talking Mat ☐ Other: _____

Date/Time Interpreter Contacted _____ Staff Initials _____

Religion _____

Do you have any religious/spiritual needs whilst in hospital? Y (N)

Please specify _____

You/the patient may have worries/concerns whilst in hospital. Would you like the opportunity to talk through these worries/concerns with a member of the Spiritual Care Team? Y (N)

Date/Time Spiritual Care Team Contacted _____ Staff Initials _____

Emergency / First Contact/s

1st. Contact STEVEN GRANT
Relationship PARTNER.
Address 17 ANNAT ROAD
MONTROSE DD10 8EF
Telephone Number 01674 959 209.

2nd Contact HEATHER GRANT
Relationship PARTNERS MOTHER.
Address 22B YORK TERRACE
MONTROSE
Telephone Number 01674 672421

Is Emergency / First contact aware of admission: (Y) N

If No Date & time notified of admission _____

THB 600

Abbreviations

This abbreviation list has been approved by NHS Tayside and is supported by NHS Tayside policy for Records and Record Keeping for Registered Nurses, Midwives and Specialist Community Public Health Nurses.

A & E	Accident and Emergency	**IM**	Intramuscular
ABX	Antibiotics	**INR**	International Ratio
BM	Blood Glucose Monitoring	**ICU**	Intensive Care Unit
BMI	Body Mass Index	**IV**	Intravenous
BP	Blood Pressure	**LA**	Local Anaesthetic
CAD	Care given as described on.....Date.....(the date and planned care must be stated on the ongoing record)	**MUST**	Malnutrition Universal Screening Tool
CCU	Coronary Care Unit	**MRSA**	Methicillin Resistant Staphylococcus Aureus
C DIFF	Clostridium Difficile	**MSSU**	Mid Stream Specimen of Urine
CHI	Community Health Index	**NIR**	No Intervention Required
CPE	Carbapenemase Producing Enterobacteriaceae	**NRT**	Nicotine Replacement Therapy
CPR	Cardio Pulmonary Resuscitation	**O2**	Oxygen
CSU	Catheter Specimen of Urine	**PAC**	Pre Assessment Clinic
CVA	Cerebral Vascular Accident (Stroke)	**PEG**	Percutaneous Endoscopic Gastronomy
CVC	Central Venous Catheter	**PICC**	Peripherally Inserted Central Catheter
DNA CPR	Do Not Attempt Cardio Pulmonary Resuscitation	**PMH**	Past Medical History
DOB	Date of Birth	**PVC**	Peripheral Vascular Catheter
DOSA	Day of Surgery Admission Unit	**SBAR**	Situation Background Assessment Recommendations
DVT	Deep Vein Thrombosis	**SEWS**	Scottish Early Warning Score
ECG	Electrocardiogram	**SPO2**	Saturation of Peripheral Oxygen
GA	General Anaesthetic	**TPAR**	Tayside Prescription Administration Record
HAN	Hospital At Night	**TTO's**	Tablets to Take Out
HDU	High Dependency Unit	**UTI**	Urinary Tract Infection
ICT	Infection Control Team		

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Multidisciplinary Record of Care
Register of all personnel writing in Core Data Set

All members of staff who are using this Core Data Set should complete this section once.

Name	Job title	Ward	Hospital	Signature	Initials	Date

Admission History

Admission/Transfer/Boarding	Destination 1	Destination 2	Destination 3	Destination 4
Hospital				
Ward				
Transfer date & time				
Patient & relatives informed?				
Completed by - Initials				

Readmission History	Date	Date	Date	Date
Hospital				
Ward				
Consultant				

Multidisciplinary Record of Care
Register of all personnel writing in Core Data Set

All members of staff who are using this Core Data Set should complete this section once.

Name	Job title	Ward	Hospital	Signature	Initial	Date
RANKING KEITH	SN	19	NIW	RK	RK	2/3/15
LAUREN. J. MCEWEN	EN	19	n/wells	LM	LM	3/3/15

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E	Elimination	**C**	Communication		

Date/Time	Code		Initials

UNSCHEDULED CARE HISTORY TAKING

Date 070210	**Time** 0030		
Name STACEY ELLIS	**m/f** F	**d.o.b.** 28.10.88	0060
PC;	abdo pain		
HOPC;	onset of (R) sided abdo pain 11am 060210 pain constant + worsening. feels hot, nauseated + lethargic since yest pm		
PMHx;	laparoscopy 1x ?PID OCT 2009 – 3 x ABx.		
DRUG Hx;	nil		
ALLERGY Hx	NKDA		
SOCIAL Hx;	lives ic 19mth old son		
FAMILY Hx;	family in Montrose		
O/E;	P 120 RR BP 126/68 BM TEMP 37.8°c		
Looks unwell + clammy feels nauseated + hot. pain score 9/10 ○vomit ○diarrhoea PV discharge today + bld stained. LMP – N/K – gets contraceptive injection – Depovera. ↳ BO – BO yest. – normal ○urinary Sx BS heard. abdo – guarding over (R) IF / LQ. Tender on percussion pain on cough. Nil palliates. Constant stabbing pain getting worse			
IMP/DDX;	?? appendicitis / ??gynae		
Management Risk Stratification	DIW Nod 10 – will kindly see + assess thanks. d/w re pain management – OK for paramedic assessed		
OPTIONS DISCUSSED	Emergency transfer		

↓ Morphine IV ~~0.1mg/kg~~ SC

Morphine Sulphate 2mg @ 0100hrs ← + further 3mg @ 5mins + titrate – pain 7/10 @ 5mg

Metoclopramide 10mg/2ml @ 0100hrs

ℝ Housecall/Summary Sheet

Patient Details

Stacey Ellis 28/04/1988 Female NHS: 369/88/128 CHI: 2804880060
17 Annat Road Montrose DD10 8EF
Mobile phone 07840470020
No data recorded.
No data recorded.

Priority 1 & 2 Past Medical History

05/01/2012 Anxiety with depression Low mood 3 months Feels not coping Anxious and feels unsafe alone in house. House cold. Sees Mhairi Still weekly. gets no time alone as Declan up till midnight. Can't keep him in room as all 3 of them sleep together Stacey feels the kids are safe if with her. Sleep worse than usual and diet even worse than usual. Discussed difficulties Start mirtazapine Rv 2-3 weeks. Discuss Mirena contraception with MA (Thinks she needs to have smear prior to appt but this could be done at same time) Dr Ruth Cranswick
28/05/2011 Spontaneous vaginal delivery - MRI, Male, 3160 grams, 39+5 weeks gestation. (See Docman 01.06.11)
19/08/2010 H/O: amblyopia L eye Doesn't tolerate contact lens Dr Ruth Cranswick
31/12/2009 Termination of pregnancy NEC - admitted to Nairn Suite on 31.12.09 at 7+6 weeks gestation and underwent a medical termination of pregnancy. (See Docman 07.01.10) Dr Ruth Cranswick
05/2005 Depressive disorder NEC and alcohol misuse. Referred Cornhill
1994 Foster care
1994 Child on protection register mother psychiatric illness, father in prison.

Repeat Medication

No data recorded.

Last 10 Clinical Consultations Recorded On Computer

01/05/2015 Surgery consultation Dr Margaret Anderson
01/05/2015 Patient reviewed increasing pain L thigh abscess despite recent ABx.. C/O sore throat but otherwise systemically well
Apyrexial, P 86 SR,
O/E as before large red fluctuant swelling proximal 1/3 post. left thigh
Refer surgical ?need open drainage Dr Margaret Anderson
30/04/2015 Surgery consultation Dr Margaret Anderson
30/04/2015 Advice about long acting reversible contraception Advice keen on nexplanon. Advice. tel 1st day period to discuss appointment & Px. To remain abstinent from day 1 cycle Dr Margaret Anderson
30/04/2015 Abscess NOS abscess L thigh. Noted inflammed area approx 3weeks . 3-4 days increasing pain & swelling & feeling unwell.
O/E T 36
Abscess L posterior thigh- approx 3-4 cm diam fluctuant & tender. Punctum centrally. Start ABx and hot compresses, baths R SOS Dr Margaret Anderson
30/04/2015 Flucloxacillin 250mg capsules Supply: (56) capsule 2 CAPSULE FOUR TIMES A DAY Dr Margaret Anderson
30/04/2015 Postnatal exam. - maternal 15./03/15 SVD 37 +4 weeks
Female 'Ailsa'
contraception discussed at 6 weeks Seen by: Dr Margaret Anderson Clinician: Dr Margaret Anderson
18/03/2015 Third Party Consultation Miss Isla Sutherland
15/03/2015 Document Image Docman Attachment
15/03/2015 Discharged from hospital Discharge Letter/Summary MRI Maternity Miss Isla Sutherland
17/03/2015 Third Party Consultation Miss Isla Sutherland
16/03/2015 Document Image Docman Attachment
16/03/2015 Laboratory result eNCCRS Exclusion Notification Cytology Reason: Pregnant Miss Isla Sutherland
13/03/2015 Administration Mrs Wendy Young - No Data Recorded
09/03/2015 Administration Mrs Wendy Young - No Data Recorded
06/03/2015 Administration Dr Richard Marwood
06/03/2015 Sytron oral solution (Forum Health Products Ltd) Supply: (500) ml 5ML THREE TIMES DAILY Dr Richard Marwood
27/02/2015 Third Party Consultation Mrs Wendy Ellis
24/02/2015 Document Image Docman Attachment
24/02/2015 Administration Prescription Request MRI Maternity Mrs Wendy Ellis
28/01/2015 Surgery consultation Dr Suresh Arunachalam
28/01/2015 Telephone encounter Midwives inform she has group B Streptococci from HVS and needs Amoxicillin. Script done. Spoke to Stacey and informs me that she has not initiated Nitrofurantoin as did not have UTI. However, she will take Amoxicillin. Dr Suresh Arunachalam
28/01/2015 Amoxicillin 500mg capsules Supply: (21) capsule 1 CAPSULE THREE TIMES A DAY Dr Suresh Arunachalam
28/01/2015 Administration Miss Sarah Garden
28/01/2015 Telephone encounter Midwife from Montrose Infirmary called. Has been started on antibiotic for group G strep on high vaginal swab. Wrong antibiotics, can you please have a look at journal and issue alternative? Tel: 623401 Miss Sarah Garden

Acute Medication prescibed in last 4 weeks

30/04/2015 Flucloxacillin 250mg capsules Supply: (56) capsule 2 CAPSULE FOUR TIMES A DAY Dr Margaret Anderson

Recent Investigations

No data recorded.

Basic Health Data

10/02/2014 10:11.00 BP 112 / 78 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading Dr Ruth Cranswick
16/06/2014 Weight: 44.6 kgs BMI: 17.6 O/E - weight Dr Graham Kramer
15/10/2009 Height: 1.59 metres O/E - height Mrs Esther Smith
09/08/2013 Smoker Heavy smoker - 20-39 cigs/day Dr Muhammad Zafar
12/11/2007 Life teetotaler Non drinker alcohol Mrs Lynne Garden
12/11/2007 Diet - patient initiated Eating habits: Type of diet: Healthy diet without the vegetables Mrs Lynne Garden
12/11/2007 Exercise grading Walking alot Mrs Lynne Garden

Family History

12/11/2007 Family history of Doesn,t know any of family history Mrs Lynne Garden

Allergies Recorded On Computer

No data recorded.
12/11/2007 Allergy Moderate H/O: non-drug allergy Latex itchy and red Mrs Lynne Garden

Last 3 Docman Attachments

16/03/2015 Document Image Docman Attachment
15/03/2015 Document Image Docman Attachment
24/02/2015 Document Image Docman Attachment

01/05/2015 Patient reviewed increasing pain L thigh abscess despite recent ABx..
C/O sore throat but otherwise systemically well
Apyrexial, P 86 SR,
O/E as before large red fluctuant swelling proximal 1/3 post. left thigh
Refer surgical ?need open drainage Dr Margaret Anderson

Dear Dr

Thank you for seeing Stacey

PMH + meds see above.

For info - 6 weeks postnatal.

HPC - see highlighted Rx pages 1 & 2.

Yours

M Anderson

Dr Margaret J. Anderson
Annat Bank Practice
Links Health Centre
Montrose DD10 8TR
Tel: 01674 673400 T13706

ELLIS
STACEY
17 ANNAT ROAD
MONTROSE

DD10 8EF

2804880060
Female

NHS TAYSIDE
PERIPHERAL VASCULAR CATHETER (PVC) INSERTION AND MAINTENANCE BUNDLE

NHS Tayside

PVC INSERTION BUNDLE (MUST BE COMPLETED BY THE PERSON INSERTING PVC)

State reason for insertion - (circle as appropriate)

IV Fluids **IV Drugs** **Suspected Haemorrhage** **Diagnostic Test** **Other** _____

BUNDLE ELEMENTS	Please tick below on completion of elements
Decontaminate hands: either hand wash or alcohol gel if hands visibly clean.	
Apply 2% chlorhexidine in 70% alcohol to 5cm radius with friction to ensure good clean	
No contamination of needle and sterile area of the skin with hands	
A sterile transparent, semipermeable dressing Dated and Timed at point of insertion	

Size/Colour of PVC :	Site of Insertion :	Date of insertion	No. of attempts to successfully insert PVC:
	DLH	2/5/15	1

Signature :	Grade of staff who inserted PVC:	Print Name :

PVC MAINTENANCE BUNDLE (TO BE COMPLETED BY NURSING STAFF)

	24 hours	48 hours	72 hours
Medical staff/Registered Nurse have reviewed the need for PVC	(Please circle reason) **IV Fluid** **IV antibiotic** **For other reason** **If no to all above** ☐Remove	(Please circle reason) **IV Fluid** **IV antibiotic** **For other reason** **If no to all above** ☐Remove	(Please circle reason) **IV Fluid** **IV antibiotic** **For other reason** **If no to all above** ☐Remove
PVC dressing intact	Y ☐ Continue / N ☐ Renew dressing	Y ☐ Continue / N ☐ Renew dressing	Y ☐ Continue / N ☐ Renew dressing
Is inflammation and/or extravasation present?	Yes ☐ Remove No ☐ Continue	Yes ☐ Remove No ☐ Continue	Yes ☐ Remove No ☐ Continue
Hand hygiene before & after all PVC procedures	Yes ☐ Continue No ☐ Consider removal	Yes ☐ Continue No ☐ Consider removal	Yes ☐ Continue No ☐ Consider removal
An antiseptic containing 70% alcohol is always used to clean the hub when it is accessed.	Yes ☐ Continue No ☐ Consider removal	Yes ☐ Continue No ☐ Consider removal	Yes ☐ Continue No ☐ Consider removal
Date and Sign	3/5/15 Removed (...)	.....	.....

IF PVC REMOVED STATE REASON WHY	for Discharge Home + and Abx c/
IF PVC IN PLACE FOR >72 HOURS REASON WHY	
DATE/TIME OF REMOVAL. REMOVED BY	**SIGN**.....

THIS RECORD IS DOUBLE-SIDED – PLEASE TURN OVER

PLEASE NOTE - A NEW RECORD IS REQUIRED FOR EACH PVC INSERTED

TAYSIDE UNIVERSITY HOSPITALS
NHS TRUST

OPERATION NOTES

Ortho 2 ..... UNIT/WARD/DEPT

Ward/Clinic/Hosp. NW ward 9 ..... Mr Alipour ..... Cons.

D D M M Y Y
2 8 0 4 8 8 0 0 6 0 ..... C.H.I. No.

Surname Ellis

First Name Stacey ..... M. State

Address ..... F ..... Sex

G.P. & Address (G.P. Requests only)

USE BLOCK LETTERS OR PATIENT LABEL

DATE OF OPERATION	Operation Proposed	TIME BEGAN ..... AM PM
2/8/15	I+D infected sebaceous cyst posterior left thigh	TIME FINISHED ..... AM PM

SURGEON'S NOTES

Cons: Alipour
Surg: Reidy

Anaes: Dr Wallace
Cat.
Less: N.I

Indication: Sml abscess below gluteal fold
Position: Lateral
Prep: Chlorhexidine

2cm transverse incision
1ml pus - Sent for MS + CTS
Remnants of captured Seb cyst identified and dissected out
- Sent for pathology
Copious lavage
Pico dressing

Post op
Home later if comfortable
7 days Flucloxacillin
- 1g QDS
No ortho RIV
Review in community with district nurse for
Pico ⇒ traditional dressing

Consultant 3669

DMR9

CONSENT FOR OPERATION INVESTIGATION

I, ...

of, ...

hereby consent to * (undergo / (the submission of my * (child / (ward .....

.....to undergo (the operation/investigation of).....

.....the nature and purpose of

which have been explained to me by * Dr/Mr/Mrs/Ms .....

I also consent to such further alternative operative measures as may be found necessary during the course of the above mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes. No assurance has been given to me that the operation will be performed by any particular practitioner.**

Date: ..... Signed: .....
* (Patient/Parent/Guardian)

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian. *

Date: ..... Signed: .....
* Medical/Dental Practitioner

NOTE: **Age of Consent**
The Tayside Health Board have been advised by the Central Legal Office that anyone who has attained 16 years of age can give or withhold valid consent to operation/investigation on himself/herself. Ordinarily the parent or guardian should be informed in the case of a patient who has not reached the age of 18.

* DELETE AS APPROPRIATE
** THE CLAUSE SHOULD BE DELETED WHERE THE INITIAL CONSENT IS FOR AN INVESTIGATION AND NOT AN OPERATION

ANY DELETIONS, INSERTIONS OR AMENDMENTS TO THE FORM ARE TO BE MADE BEFORE THE EXPLANATION IS GIVEN AND THE FORM SUBMITTED FOR SIGNATURE.

Peri-operative SKIN* Bundle Record Sheet

Refine risk assessment of individuals undergoing surgery by examining other factors that are likely to occur and will increase risk of pressure ulcer developing

• Length of the operation • Increased hypotensive episodes intraoperatively • Low core temperature during surgery • Reduced mobility on post operative day one

Treatment Plan D

All at risk patients receiving surgery will have a pressure-relieving device on the operating table and transfer trolleys.
All nursing staff in the anaesthetic room, operating theatre and recovery will ensure that they know the patient's risk status at all points of the patient's journey through theatre.
All patients identified as at risk will have their pressure areas inspected in the anaesthetic room, in the operating room immediately after surgery has finished and in the recovery area and where possible during the operation.
In collaboration with the anaesthetist, move the head position to prevent continued pressure on the occipital area (if patient condition allows).
All patients at risk will have measures in place to alleviate factors that cause pressure ulcers in the anaesthetic room, operating theatre and throughout the recovery phase.
Elevate heels completely in such a way as to distribute weight of the leg along the calf without putting all the pressure on the Achilles tendon. If possible the knee should be in slight flexion. (hyperextension of the knee may cause obstruction of the popliteal vein predisposing to deep vein thrombosis).
Position the individual in a different posture preoperatively and post operatively than the posture adopted during surgery and record this on the SKIN bundle. If a pressure ulcer develops this will be recorded.

Position of patient in anaesthetic room state:- Supine
Length of time in anaesthetic room 15 (mins) / hrs Any significant event causing increased risk state:-

Condition of skin on transfer to table:- (circle) (No red areas) red area(s)- blanching red area(s) non blanching Grade 1 Grade 2 Grade 3 Grade 4
Site(s) please state:

Treatment plan D Active? (Yes) No Unable to comply state reason: Time 17 15 Sig. [signature]

Position of patient on the theatre table state: left lateral 90 Abdominal & lumbar supports
Length of time in theatre 20 (min) / hrs Any significant event causing increased risk state:-

Condition of skin leaving theatre:- (circle) No red areas (red area(s)- blanching) red area(s) non blanching Grade 1 Grade 2 Grade 3 Grade 4
Site(s) please state: RIGHT HIP
Treatment plan D Active? Yes No Unable to comply state reason Time 1745 Sig. [signature]

Position of patient in recovery area Semi-fowler Length of time in recovery area 1 hr min/hrs
Any significant event causing increased risk state:-

Conditon of skin in recovery:- (circle) (No red areas) red area(s)- blanching red area(s) non blanching Grade 1 Grade 2 Grade 3 Grade 4
Site(s) please state:
Condition of skin leaving recovery (circle)
(No red areas) red area(s)- blanching red area(s) non blanching Grade1 Grade 2 Grade 3 Grade 4
Site(s) please state:
Treatment plan D Active? (Yes) No Unable to comply state reason Time 1800 Sig. [signature] CN

Peri-operative SKIN* Bundle Record Sheet

Date 2.5.15 Time 17.15

Theatre 2

Any pre- exisitng skin conditions? NO

ELLIS
STACEY
17 ANNAT ROAD
MONTROSE

DD10 8EF

2804880060
Female

Operation/ speciality
Ortho

Anaesthetic type
GA

Mark each box with TICK or N/A

TIME		Comments		Comments		Comments		Comments
Pressure Relief (SKIN) Check Skin 2 hrly and reposition on operating table if applicable								
Position Code (State CODE in box)	RL	back + abdo supports	S		SR			
Correct pressure relieving surface (and switched on)?	✓	gel pad between legs	✓	BED	YES			
Heel pressure relieving device in situ?	✓		✓	BED	YES	Moving feet/legs		
Arm / head movements?	✓	pillow under head	✓		YES	Independently		
Inspect Skin Condition								
Pressure areas checked?	✓		✓	(R) HIP RED & BLANCHING	YES			
Skin is free from any wetness/incontinence?	✓		✓		YES			
Saturation probe in correct position?	✓	(R) index finger	✓		YES			
Barrier cream/spray applied?	N/A		N/A		N/A			
Check skin around pressure dressings if applied.	N/A		N/A		N/A			
Hydration/ Dressings								
Intra venous fluids given if prescribed ?	X		X		N/A	- OA fluids		
Wound dressing applied - State type/location	N/A		✓	PICO ~~RIGHT~~ LEFT THIGH	YES	PICO (L) THIGH		
Initials	AR		G		THB			

CODES											
S	Supine	LL	Left Lateral 30 degree tilt	RL	Right lateral 30 degree tilt	P	Prone (front)	REP	Repositioned
L	Lithotomy	D	Deckchair	MD	Medified Deckchair	HD	Head Down	SR	Semi-recumbent
LT	Left Tilt	RT	Right Tilt	LD	Lloyd Davis	R	Recovery	TT	Theatre table

* Follow NHST Policy for the prevention and management of pressure ulcers for all sections and document care and progress in the record of ongoing care.

Recovery Care Summary & Ward Handover

Date: 02.05.15 Time into Recovery: 1145

Patient Name: STACEY ELLIS

CHI: Patient ID Label 280488 0060

Anaesthetist: Dr Wallace Surgeon: Mr Reidy.

Operation: I&D infected sebaceous cyst - posterior left thigh.

Anaesthetic GA ☑ LA ☐ Spinal ☐ Epidural ☐ Regional ☐ Sedation ☐ Intrathecal Opiate ☐

Theatre to Recovery Handover

Airway ETT ☐ LMA/iGel ☐ Oral Airway ☐ Nasal Airway ☐ Chin Support ☐ Self Maintaining ☑

Time Airway Removed - SpO_2 -

Conscious Level A ☑ V ☐ P ☐ U ☐ Comments:

O_2 Therapy 5 L/min ~~for~~ until fully awake. Mask ☑ Nasal Cannulae ☐ Non Re-breather Mask ☐

Monitoring Oximeter ☑ ECG ☑ NIBP ☑ Arterial BP ☐ CVP ☐ CO_2 ☐ Temperature 36.6°C

Diabetic Yes ☐ No ☑ BM mmols GKI ☐ Sliding Scale ☐

Cannulae in Situ Peripheral ☑ x1 Site: Rt H. Arterial ☐ Site: Time Removed In Situ ☐

Central Line ☐ Chest x-ray required ☐ Reviewed ☐ NAD ☐

Neuro Obs Yes (see chart) ☐ N/A ☑ **PPURA Scale:** See chart

Dressings Dry ☐ Slight Ooze ☑ Moderate Ooze ☐ Packs in Situ: Yes ☐ No ☑

Reinforced ☐ Pressure Dressing ☐ Replaced ☐

Blood Loss Intraoperative: Nil recorded mls Haemocue Result: N/A ☐ **Cell Salvage** Yes ☐ No ☑

Drains Yes ☐ No ☑ No:.... in Situ: Position: Open: Yes ☐ No ☐ To be opened at:

Catheter Yes ☐ No ☑ Hourly Volumes ☐ Irrigation ☐ Free Drainage ☐ **Nasogastric Tube** Y ☐ / N ☑

Pain Score 0 ☐ 1 ☐ 2 ☐ 3 ☑ Analgesia Given ☑ Comments: IV Ketamine - 100mg.

Nausea Score 0 ☑ 1 ☐ 2 ☐ 3 ☐ Antiemetic Given ☐ Comments:

IV Infusion Yes ☐ No ☑ Rate: mls/hr **PCA in Situ** Yes ☐ No ☑ (see PCA chart)

Epidural in Situ Yes ☐ No ☑ (see epidural chart) **Elastomeric Infusion** Yes ☐ No ☑ (see chart) Rate: mls/hr

CSM Right / Left Circulation / Colour Sensation Movement Comments: N/A

Additional Information

Pico Dressing in Situ (Rt H).
Tolerated drink of water

Recovery Discharge Notes and Ward Handover Summary

Conscious Level A ☑ V ☐ P ☐ U ☐ | **Maintaining Own Airway** Yes ☑ | **Patient Stable** Yes ☑

Comments: —

BM mmols

Drains Yes ☐ No ☑ Patent ☐ Amount: mls Nature:

Dressings Small area of staining. Pico dressing on

Drugs Given Intraoperatively and in Recovery
See anaesthetic sheet for details

Communicated to Ward Nurse - Yes ☐

Additional Information
IV fentanyl bolus given – Total = fentanyl 100mcg IV.
Paracetamol 1g p.o – 1830
Ibuprofen 400mg p.o. 1830.

Pain Score 0 ☐ 1 ☑ 2 ☐ 3 ☐ Comments:

CSM Right / Left | Circulation / Colour | Sensation | Movement | Comments: N/A coloured lenses ☑

Items Returned to Patient Dentures Yes ☐ N/A ☑ Spectacles Yes ☐ N/A ☑ Hearing Aids Yes ☐ N/A ☑

SEWS	Score: Respiration Rate	SpO2	Temperature	Pulse	Systolic BP
3	36+			130+	
2	31-35		38.5+	110-130	200+
1	21-30		38.0-38.5	100-110	
0	9-20	94+	36.0-37.9	50-100	100-200
1		90-93	35.5-35.9	40-50	80-100
2		85-89	35.0-35.4	30-40	
3	≤8	↓85	↓35.0	↓30	↓80

Time Ready For Discharge: 1900.

Discharge Checklist (Use in conjunction with SBAR at handover to ward nurse)

Post Op Instructions Anaesthetist ☑ Surgeon ☑ | **Epidural / PCA TPAR Prescription Checked and Recorded** Yes ☐ N/A ☑

DVT Prophylaxis Prescribed Yes ☐ No ☑ | **Post-op Antibiotics Prescribed** Yes ☐ No ☑ | **Post-op Analgesia Prescribed** Yes ☑ No ☐

Additional Information / Comments

SBAR Handover to Ward Nurse

1. Situation	2. Background
State patient details, conscious level /airway / pain / nausea.	Give summary of relevant medical history. State procedure performed and care given intraoperatively and in recovery. Provide details of postoperative instructions from anaesthetist and surgeon.
3. Assessment	**4. Recommendations**
Provide details of intravenous infusions, invasive monitoring, drains, dressings, current SEW, pain and nausea scores, CSM status, etc. State drugs given intraoperatively and in recovery with times of administration.	Confirm patient's condition is suitable for return to ward. Ask if ward nurse requires any additional information.

Recovery SEWS Score on Discharge: | **Time Out of Recovery:**

Recovery Practitioner Name and Signature	Ward Practitioner Name and Signature
Aileen Sheahan / [illegible] CNM	[signature]

NHS Tayside

Consent for Investigations, Treatment or Operation Form

(Please complete using block capitals & no abbreviations)

NHS Tayside

Patient's Surname	Ellis	**Hospital/Ward**	19 ANU
Other Names	Stacey	**Speciality**	T+O
CHI Number	2504880060	**Consultant**	M. Pau

Patient Label can be used

Name of proposed procedure or course of treatment

Incision + drainage Abscess L/S + posterior thigh.

The site / side of surgery

I have explained the procedure to the patient. In particular I have explained:

Intended Benefits: Pain relief, infection control.

Significant Risks:

Any extra procedures which may become necessary during the procedure:

Blood Transfusion ☐ **Other** (specify)

(The need and alternatives have been discussed with the patient)

I have also discussed what the procedure is likely to involve, the benefits and the significant risks of any available alternative (including no treatment), and any particular concerns of this patient. I have done this in terms that, in my judgement have been understood.

The following information leaflet(s) has been given

Has the patient ever been notified that they are at increased risk of CJD or vCJD for public health purposes?

No	☐	Proceed as normal
Unable to Respond	☐	Proceed as normal unless high risk tissue, e.g. Brain, Spinal Cord Posterior Eye and Quarantine instruments pending contact with infection control for further advice.
Yes	☐	Ask for further explanation. Quarantine instruments pending contact with infection control for further advice.

Clinicians Signature:	F. Ullyart	**Date**	02/05/15
Name Printed:	F. McPaul	**Grade**	Consultant
Contact Details			

Please Turn over for Patient Section

NHS Tayside

CONSENT FOR INVESTIGATIONS, TREATMENT OR OPERATION FORM

This page is to be completed by the patient/representative.

Please read this form carefully. If you have any further questions, do ask; we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree: To the procedure or course of treatment described on this form.

To the administration of a general, local or other anaesthetic as appropriate, following informed discussion including the benefits and significant risks with the anaesthetist.

I understand:

- That any procedure in addition to those described above will only be carried out if it is necessary to save my life or to prevent serious harm to my health.
- That you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.
- Information including digital information (radiological e.g. x-rays, CT and MRI scans, video and/or photographic material) may be stored as part of the patients medical records and may be stored on computer databases.
- Body tissue e.g. fluids, organs or parts of them may be removed during the procedure and used for diagnosis, my future treatment and then discarded or stored as considered appropriate.

Please tick ✓appropriate box if you agree to

☐ Excess body tissue not required for diagnosis or future treatment being used for medical research (the University of Dundee is very active in medical research and donations of excess body tissues are a valuable resource for research)

☐ To photographs and other digital images being used for teaching, in presentations at conferences or available on websites and in publications

(If consent is withdrawn at a later date it may not be possible to withdraw images that are already in the public domain) NB Medical staff you must complete the appropriate medical photography forms.

I have been told about additional procedures as specified which may become necessary during my treatment. I have listed below any procedures which **I do not wish to be carried out** without further discussion.

Specified Additional Procedures

Additional Procedures I do not want carried out

Patient's Signature: X Sean **Date:**

Print Name: Stacey Ellis. 02/05/15

Witness Signature **Date:**

(if patient unable to sign)

Print Name

Statement of Interpreter (if applicable): I have interpreted the information above to the patient to the best of my ability and in a way in which I believe the patient can understand.

Interpreters Signature: **Date:**

Name Printed:

Day of Operation

I have marked the skin at the operation site and / or confirmed consent ☐

Signature **Date**

NHS TAYSIDE

NINEWELLS HOSPITAL PERIOPERATIVE CARE RECORD

Patient Name: ELLIS STACEY

Date of birth / CHI: 2804880060 Female

17 ANNAT ROAD
MONTROSE
DD10 8EF

Ward: 19

Theatre: 2

* LATEX CONTACT ALLERGY *

Problem	Potential risk of wrong procedure being performed
Goal	Correct procedure performed on correct patient ✓
Intervention	Check identity of patient with name band, theatre list and consent form Check operation site is correctly marked

Problem	Potential risk of injury during transfer from trolley to operating table
Goal	Safe transfer as per theatre policy ✓
Intervention	Ensure trolley is in working order Ensure brakes are on trolley and operating table Ensure adequate number of staff carry out safe transfer

Problem	Potential risk of injury or pressure sore related to position on operating table
Goal	Minimise risk of injury/pressure sores during surgery
Intervention	Ensure patient is secure in following positions throughout their surgery

Supine Prone Lithotomy Loyd Davis Left Lateral (Right Lateral)

Position of patient's arms

Right Arm: On arm board (At side) Over Chest Other (specify)

Left Arm: On arm board (At side) Over Chest Other (specify)

Is the patient positioned on - Trolley Bed (Theatre Table)

Protect patient and patient's limbs using aids as per theatre policy

Propad Heel pads Head ring (Gel pads) (Pillows)

Towels Angled arm boards X1

Problem	Patient is unable to maintain dignity intraoperatively ✓ SN CM-thW
Goal	Maintain patient's dignity throughout surgery
Intervention	Ensure patient is covered appropriately Do not expose patient until surgeon is ready to commence operation

Problem	Potential risk of infection
Goal	Minimise risk of infection
Intervention	Establish and record skin preparation used Ensure asepsis is maintained throughout surgery Skin prep used: Chloraprep
Problem	Potential for burns/skin irritation related to use of diathermy
Goal	Prevent burns/skin irritation
Intervention	Use of diathermy and application of pads as per theatre policy Make: Valleylab ERBE Other (specify) Placement of pad: Left Thigh Right Thigh Other (specify) Mode: Monopolar (Bi-polar) Used: (Yes) No Generator used: ~~Valleylab~~ ERBE Other (specify) Check skin under plate site pre and postoperatively and record observations Preoperative skin condition: Postoperative skin condition:
Problem	Potential for shock/haemorrhage
Goal	Patient's haemodynamic state is monitored
Intervention	Maintain accurate record of blood loss from swabs and suction jars and record on nursing care summary Assist surgeon should patient be in danger of excessive blood loss Assist anaesthetist with fluid/blood replacement therapy Monitor/record urine output Assist with invasive monitoring equipment
Problem	Potential risk of foreign body retention
Goal	No foreign body retention
Intervention	All equipment used during surgery is accounted for as per NHS Tayside policy
Problem	Potential for altered urinary output
Goal	Identify patients need for a urinary catheter
Intervention	Liaise with medical staff to identify whether a urinary catheter is required Type of catheter used: Size: Amount of water in balloon:

ANAESTHETIC CARE

Patient Name:	ELLIS STACEY 17 ANNAT ROAD MONTROSE DD10 8EF	**Ward:**	19
Date of birth / CHI:	**2804880060** Female	**Theatre:**	2
		Allergies:	LATEX

Anaesthetist: DR. C. Wallace	**Anaesthetic Assistant:** C MUTCH A. ROBERTSON.

ECG ✓	**Blood Pressure Cuff** ✓	**Pulse oximeter Probe** ✓	**Arterial Line** N/A
Central Venous Pressure	**Capnograph** ✓	**Temperature Probe** 36.5°C	**Intravenous Cannula**
Intravenous Infusion N/A	**Blood Warmer** N/A	**Cell Saver**	**Naso-gastric Tube**
Bair Hugger **Temperature Setting** **Low / Medium / High**	**Eye Care** **Eyes Taped / Padded** **Ointment (Specify)**	**Throat Pack** **Inserted: Yes / No** **Removed: Yes / No** **Throat Sprayed** **Yes / No**	**Urinary Catheter** Yes **Size** **Type** No **In Situ**
Sequential Compression Boots N/A	**Oesophageal Doppler Monitor** N/A		

TYPE OF ANAESTHESIA

General Anaesthetic ✓
Endotracheal Tube (Specify size)
Laryngeal Mask (Specify size) ✓ 3
Intubating Laryngeal Mask Airway (Specify size)
Proseal (Specify size)
Ventilation Spontaneous / Intermittent positive pressure ventilation

Sedation
Propofol Target Controlled Infusion
Guedel Airway
Nasopharyngeal airway (Specify size)
Face Mask
Hudson Mask
Ventimask
Nasal Cannula / Prongs

Spinal Anaesthetic
Thoracic Epidural
Lumbar Epidural
Combined Spinal/Epidural
Regional Block (Specify)
Local Infiltration
Other (specify)

ADDITIONAL INFORMATION

Uneventful Induction to GA.
Eyes Taped, Safe Transfer to Theatre
Right lateral, Limbs protected.

SIGNATURE C Mutch **DATE** 2-5-15

Intraoperative Summary Sheet

Theatre: 2

Procedure Performed: HD Abscess left Posterior thigh

Surgeon: Mr Reidy

Specimens: 1 x Histo
2 x Bact.

Drains:

Dressings: Pico dressing

Pack in situ Yes (No)

Local Infiltration Yes (No)

Type:

Amount:

Additional Information

Scrub Nurse Signature:

Flooring Nurse Signature: N Stewart 2/9/15

NHS Tayside WHO Surgical Safety Checklist (V7/10/2014)

NHS Tayside

Last Name :	ELLIS
First Name:	STACEY.
Date of Birth:	280488
NHS/CHI#:	0060
Planned Procedure:	I&D Thigh Abscess
ASA Score	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
THEATRE : 2	DATE: 02.05.15

SIGN IN (to be read out loud) before induction of anaesthesia

	Yes
Patient confirmed identity & procedure, matched with consent form	☐
Is surgical site/side marked Left Thigh N/A ☐	☐
Any known allergies LATEX. No ☐	☐
Drug prescription chart checked	☐
Confirm anaesthetic plan/concerns (e.g. airway, blood loss)	☐

Blood available Y ☐ N ☐ N/A ☐

Patient's pre-operative temperature 36.5 °C

Anaesthetist : DR. J. Bannister.

Anaesthetist Signature :

SURGICAL PAUSE (to be read out loud) before start of surgical intervention, e.g. skin incision

Confirm all team members are aware of roles and responsibilities and are familiar with each other ☐

Surgeon, Anaesthetist & Registered Nurse/OPD verbally confirm :

What is the patient's name / CHI No ☐

What procedure, site and position are planned ☐

Patient allergy status confirmed? ☐

Any metal implants/stimulators Y ☐ N ☐

(Taped) Piercing Right forearm

Plan agreed for anticipated blood loss G&S ☐ xmatch ☐ N/A ☐

Are there any specific equipment requirements or special investigations Y ☐ N ☐

Has the following been agreed and applied :

Warming measures	Y ☐	N/A ☐
DVT prophylaxis	Y ☐	N/A ☐ Mobilise
Essential imaging displayed	Y ☐	N/A ☐
Diathermy setting confirmed	Y ☐	N/A ☐ Bipolar 10

Is interim pause required in this case Y ☐ N ☐ N/A ☐ (if Y, see overleaf)

SURGICAL ANTIBIOTIC PROPHYLAXIS REQUIRED Y ☐ N ☐

If indicated, ensure a **single dose** of **policy compliant antibiotic** is given within 60 mins of KTS and **recorded on the front of the TPAR.** Document any deviation from policy in medical notes Y ☐ N/A ☐

Document KTS time

Name : C Mulcahy

To be signed by member of staff who read out checklist

SN C Mulcahy.

SIGN OUT (to be read out loud) before any member of staff leaves the operating room

Confirm actual procedure undertaken (implant code in notes) I+D Abscess Left Thigh ☑

Confirm instruments, swabs and sharps counted/correct ☑

Confirm specimens labelled correctly ☑

Blood loss confirmed to team (if >1.5l or prolonged procedure of >4 hours, refer to local abx surgical prophylaxis guideline for re-dosing instruction) N/A ☑

Anaesthetist/Surgeon confirm post-op patient instructions

Post-operative plan for DVT prophylaxis N/A ☑

Post-operative antibiotic plan agreed ☑

Drains to be opened opened Y ☐ N ☐ N/A ☑

Plan for fluids/food on scrip. ☑

Patient confirmed daycase/inpatient Daycase ☐ Inpatient ☑

Datix required Y ☐ N ☑

Name : L

To be signed by member of staff who read out checklist

SURGICAL SITE INFECTION

Patient body temperature maintained at ≥36° in peri-operative period Y ☐ N ☐

Record post op temp °C

Known diabetic patient's glucose control level kept at <11mmols/l throughout the operation Y ☐ N ☐ N/A ☐

Record final glucose level mmols/l

WHO Surgical Safety Checklist – Interim Pause

INTERIM SURGICAL PAUSE	
Patient position still correct	Yes ☐ No ☐
Diathermy correct settings	Yes ☐ No ☐
Document current blood loss	
Swabs/Instrument Count	Yes ☐ No ☐ N/A ☐
Any surgical/anaesthetic concerns	Yes ☐ No ☐

FILE IN NOTES

TAYSIDE HOSPITALS ANAESTHETIC RECORD

Hospital: NW Ward: 2

Operation Proposed: I&D Thigh abscess r

Consultant: Alipaz

Date of Surgery: 2/5/15 Theatre:

WRITE OR ATTACH LABEL

ELLIS
STACEY
17 ANNAT ROAD
MONTROSE

DD10 8EF

2804880060
Female

PRE-OP ASSESSMENT

By: JB Site: Date: 2/5/15

Elective ☐ Scheduled ☐ Urgent ☐ Emergency ☐

T 36.8

Weight/BMI Pulse 80 Blood Pressure 167/75 SpO_2 97% on RA

CVS/RS: Ltd well

Other: 6/52 post partum
OGOR
Not breastfeeding

Airway Assessment:

Dentition: N

Mallampati:

Incisor Gap:

Jaw Protrusion:

Neck Movement:

Aspiration Risk Y / N

Anticipated Difficulty Y / N

Prev Airway Hx:

FBC **U&E** **Other**

G&S / X-Match Y / N

Units

ECG:

Pregnant: Yes No N/A

ASA: **PONV Score:** **AKI Score:** **Fasting:** SOLID ..... LIQUID .....

Consent Signed & Checked ☐

Incapacity Form ☐

Drugs:

Allergies: LATEX contact (1).

Anaesthetic Plan / Techniques Discussed:

GA ± LMA

PREMEDICATION AND INSTRUCTIONS:

Date	Drug and Dosage	Route	Time	Signature	Given By	Time

Fast as per protocol ☐

OR

Fast solids from .....

Fast fluids from .....

Give routine medications EXCEPT: ..... Premed Effect: .....

ANAESTHETIST AND GRADE

1. Wallace CAm Assistant:

2. Consultant: Informed? Y / N

ANAESTHETIC TECHNIQUE:

INJECTION SITE: DRH

DRUGS & DOSES:

Pre O2
fentanyl 75 mcg
propofol 160 mg
O2/N2O/sevo

AIRWAY AND BREATHING SYSTEM:

Facemask	☐	SV	☑	Circuit	.....
Airway - Oral/Nasal	☐	IPPV	☐	Machine	.....
LMA/OETT/NETT/Trache		Ventilation Mode:	VCV/PCV		
Type	Cuffed	V_T	.....	PEEP	.....
Size	#3	Freq	.....	P_{AW}	.....
Laryngoscope	.....	Throat Pack	☐	HME	☐
Laryngoscopy Grade	.....	Ease of Mask Ventilation:			
GEB/Stylet	☐	Ease of Intubation:			

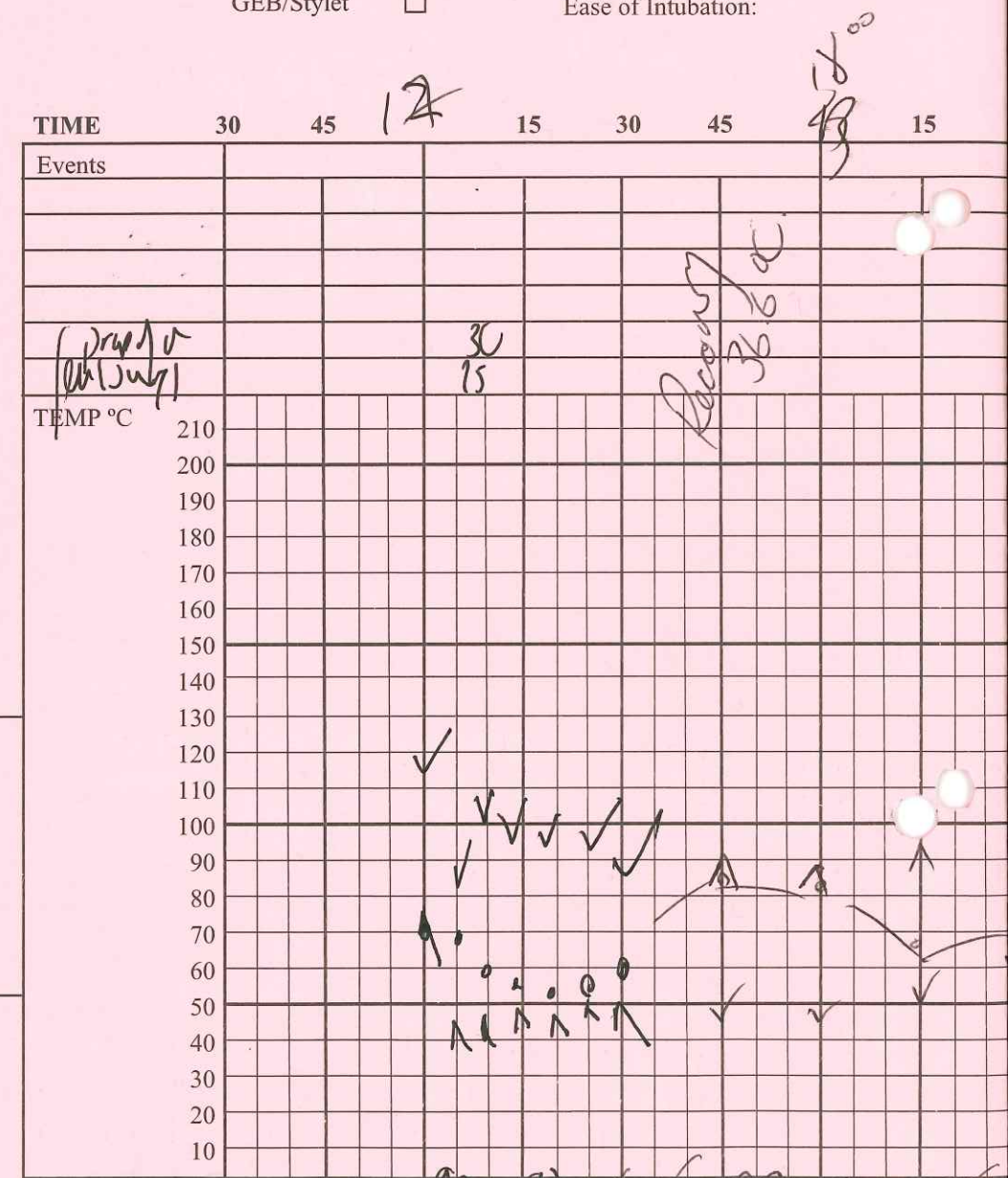
EVENTS:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Patient Position & Protection:
R lat
IPP
Fluid Warmer: Taker
Warming Blanket:

I.V. FLUIDS:

TIME	30	45	12	15	30	45	1	15
Events								
TEMP °C								
SpO_2			97	97	98	99	96	98
F_IO_2			0.5	0.4	3	3	2	1-2
E_TCO_2			6.0	7.2	0	0	0	1
Agent			2.6	2.1	0	0	0	0
CVP					11	12	12	13
Urine								
I.V. FLUIDS								



EQUIPMENT CHECK: Circuit, Machine & Monitor

Anaesthetic Room ☐ Theatre ☐

REGIONAL: **STOP BEFORE YOU BLOCK** ☐

BLOCK / APPROACH:

SITE / SIDE:

NEEDLE / CATH:

TECHNIQUE:

DRUGS:

MONITORING:

ECG	☐	PNS	☐
NIBP	☐	TEMP	☐
SpO_2	☐	URINE	☐
$ETCO_2$	☐	CO Monitor	.....
F_IO_2	☐	Depth of Anaes	.....
ET Agent	☐	ABP	.....
VENT ALARM	☐	CVP	.....
P_{AW}	☐	Other:	
MIN VOL	☐		

30 45 1900 15 30 45 15 30 45 15 30 45

210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
20
10

94	94	SpO_2
0-1	0-1	Pain
0-1	0-1	Sedation
0	0	Nausea
12	B.	Rupt

Operation Performed: Operating Surgeon:

Anaesthesia: GA ☐ GA & Regional ☐ Regional Only ☐ Regional & Sedation ☐

S

Relevant Medical History: Allergies: None ☐

B

Anaesthetic / Surgical Difficulties: None ☐

A

Fluids Given:

Total Urine Output: ..... Estimated Blood Loss: .....

Analgesia / Anti-emetics Given:

POSTOPERATIVE INSTRUCTIONS:

Oxygen l/min for hours **OR** Aim for $SpO_2 \geq$ Ward SpO_2 Monitoring ? Y / N

Observations: Pulse, Respiratory Rate, Blood Pressure and Pulse Oximetry

Frequency: 5-15min Duration: recovery

After this period observations: **as documented below** ☐ **OR** **as per EWS chart** ☑

Observations:

Invasive Monitoring and Lines:

Fluid Therapy: IVI 4D Fluids Prescribed? Y / N

Proposed Post-Operative Analgesia:

Post-op Thromboprophylaxis : TED ☐ LMWH ☐ RIVAROXABAN ☐ FLOWTRONS ☐ OTHER .....

Surgical Instructions:

R

RECOVERY ROOM ANALGESIA & OTHER DRUGS:

Drug Name	Maximum Dose	Increment	Route	Prescriber's Signature	Time Given/ Total Dose
fentanyl	100microg	10microg	IV		1715 DEBORAH SON
ondansetron	4mg		IV		

DRUGS GIVEN BY RECOVERY STAFF:

1. fentanyl 10micrograms IVe 1850 AS
2. fentanyl 10 micrograms IVe 1755 AS
3. fentanyl 10 micrograms IVe 1805 AS
4. fentanyl 10 micrograms IVe 1805 AS
5. fentanyl 10 micrograms IV 1810 AS
6. fentanyl 10 micrograms IV 1815 AS

7. fentanyl 10 micrograms IV e 1820
8. fentanyl 10 micrograms IV e 1825
9. Paracetamol 1g } 1830 AS
10. Ibuprofen 400mg }
11. fentanyl 10 micrograms IV e 1845
12. fentanyl 10 micrograms IV e 1850.

RECOVERY TO WARD HANDOVER:

TOTAL = 100mcg IV fentanyl

DISCHARGE TO:

DSU ☐
WARD ☐
HDU ☐
ITU ☐

PLEASE RETAIN THIS SHEET IN PATIENT RECORDS ON DISCHARGE

Patient Name: Stacey Ellis

CHI No: 2804880060

Date of Admission: 02/5/15

Admitting Consultant: ALIPOUR

Operating Consultant:

Date of Transfer of Patient Care:

Further Consultant: (if appropriate):

Date of Transfer of Patient Care:

ALLERGIES

YES / NO

NIL KNOWN

PLEASE SEE KARDEX

THB 024SS

TAYSIDE PRESCRIPTION AND ADMINISTRATION RECORD
(3 WEEK RECORD)

NHS Tayside

DATE OF ADMISSION 010515 RECORD START DATE _____

Hospital /Ward: NN ASRU 7

Consultant: Vuseuic

On admission:
Weight: **Height:**

ELLIS
STACEY
17 ANNAT ROAD
MONTROSE

DD10 8EF

2804880060
Female

CONFIRMATION OF PRESCRIPTION REVIEW ON TRANSFER OF MEDICAL CARE

Receiving Unit	Date	Authorised Prescriber (Signature)

MEDICINE ALLERGIES/ SENSITIVITIES

IF NIL KNOWN TICK HERE THEN DATE & SIGN ☐ .....

1. LATEX.	2.	3.	4.

ONCE ONLY PRESCRIPTIONS

Date	Time	Medicine	Dose	Route	Prescribed By	Time Given	Given By
2.5.15	2230	FLUCLOXACILLIN	1GQDS	ORAL	TTO	22.30	
2.5.15	2200	PENICILLIN V	500mg QDS	ORAL	TTO	22.00	

OTHER MEDICINE CHARTS IN USE

Chart Type	Signed		Signed
1. Insulin		4. Anticoagulant	
2. Epidural/Pain relief		5. Mental Health Act	
3. Fluid		6. Other	

REGULAR THERAPY

Date: 2/5/15

Time: 6 | 8 | 12 | 14 | 18 | 22

OXYGEN

Target O_2 Saturation

88 – 92% 94 – 98%

Continuous / PRN

Signature: [signature] RB

Start Date: 2/5/15

THROMBOPROPHYLAXIS

Dalteparin S Cut injection

TEDS

None

Dose

2500units 5000units

Signature

Start Date

Medicine / Form

Dose

Route

Signature

Start Date

Further Information

Medicine / Form

Dose

Route

Signature

Start Date

Further Information

Medicine / Form

Dose

Route

Signature

Start Date

Further Information

DRUG DOSAGE CALCULATIONS

AS REQUIRED THERAPY

Medicine / Form		Date	02.5.15									
Paracetamol		Time	1830									
Dose & Frequency	Route	Dose	1g									
1g 6°	PO											
Signature	Start Date	Route	P.O.									
	2/5/13											
Indication / Notes	Pharmacy	Initials	AS CW									
Pn												

Medicine / Form		Date	02.05.15									
Ibuprofen		Time	1830									
Dose & Frequency	Route	Dose	400mg									
400mg 6°	PO											
Signature	Start Date	Route	P.O									
	2/5/13											
Indication / Notes	Pharmacy	Initials	AS CW									

Medicine / Form		Date										
		Time										
Dose & Frequency	Route	Dose										
Signature	Start Date	Route										
Indication / Notes	Pharmacy	Initials										

Medicine / Form		Date										
		Time										
Dose & Frequency	Route	Dose										
Signature	Start Date	Route										
Indication / Notes	Pharmacy	Initials										

Medicine / Form		Date										
		Time										
Dose & Frequency	Route	Dose										
Signature	Start Date	Route										
Indication / Notes	Pharmacy	Initials										

Medicine / Form		Date										
		Time										
Dose & Frequency	Route	Dose										
Signature	Start Date	Route										
Indication / Notes	Pharmacy	Initials										

Patient Name	CHI	Date Of Birth	Age
STACEY ELLIS	2804880060	28/04/1988	27

Source of Information

Patient		Relative / Carer		Patient's Own Drugs		GP Letter		GP Practice	
Care home / MAR Chart		Previous Discharge Letter		Repeat Prescription Slip		Community Pharmacy		Other (Please State)	

Allergy Description	Date Recorded	Comments
H/O: non-drug allergy	12-Nov-2007	Latex itchy and red

Acute Medication (within 30 days)

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Continue	Withhold	Stop	Comments
GP practice	Flucloxacillin 250mg capsules	56 capsule	2 CAPSULE FOUR TIMES A DAY			30-Apr-2015				

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Continue	Withhold	Stop	Comments

Patient Name	CHI	Date Of Birth	Age
STACEY ELLIS	2804880060	28/04/1988	27

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Continue	Withhold	Stop	Comments

Compliance Device	Name and telephone number for community pharmacy

Completed by	Designation	Grade	Date	Time	Contact Number

Reviewed by	Designation	Grade	Date	Time	Contact Number

ELLIS **2804880060**
STACEY Female
17 ANNAT ROAD
MONTROSE

DD10 8EF

ELLIS **2804880060**

Hospital Ninewells

Ward 19

NHS Tayside

MANUAL HANDLING AND MOBILITY ASSESSMENT CHART

(To be completed within 24 hours of admission)

Patient Fully Independant without Aids/Assistance Y (N) **(If yes - no further action required)**

Relevant Medical History/Underlying Condition e.g. Confusion/Surgery .....

Weight: .....kg Consider safe working load of equipment

Comprehension: (sight, hearing, speech) ..... Attachments (infusions, catheter, drains) .....

	CODES	CODES	CODES	CODES	CODES	CODES	CODES
Sit>>Lie							
Lying>>Sitting							
Sit>>Stand							
Stand>>Sit							
Walking							
Bathing							
Moving up the bed							
Turning/proning							
Lateral Transfers							
Floor to Bed							
Comments							
Date							
Time							
Initials							

A Risk Assessment should be carried out prior to any Manual Handling Manoeuvre. All changes or comments should be clearly documented in the Nursing Record of On-Going Care & Multidisciplinary Notes. Please indicate 'YES' if (any) in the Comments box.

Enter Mobility and Equipment Codes

Mobility Codes

I = Independent
VP = Verbal prompting
S = Supervision
D = Dependant
BR = Bedrest
NWB = Non weight bearing
PWB = Partial weight bearing
FWB = Full weight bearing
A1 = Assistance x 1 staff
A2 = Assistance x 2 staff
A3 = Assistance x 3 staff
A4 = Assistance x 4 staff

Aids/Equipment Codes

H = Full Body Hoist
ST= Stand Aid
GS= 1/2 Glide Sheet
WS= Walking Stick
WS1=One Stick
WS2=Two Sticks
EC = Elbow Crutch
AC = Axillary Crutch
GC = Gutter Crutch
WZF = Wheeled Zimmer Frame
ZF = Zimmer Frame
TWW = Three Wheeled Walker
4WW = Four Wheeled Walker
RZ = Rollator Wheeled Zimmer
WC = Wheelchair
PAT = Patslide

ELLIS
STACEY
17 ANNAT ROAD
MONTROSE

DD10 8EF

Female

HOSPITAL/AREA Ninewells

WARD/AREA 19

NHS Tayside

ELLIS **2804880060**

Preliminary Pressure Ulcer Risk Assessment (PPURA)

The following 4 questions must be completed with ALL patients within 6 hours of admission or for community staff, on the day of admission to the service
Re-assessment required if patient condition changes including the day of major surgery

(please write Yes/No below)

1	Requires assistance and or aids to **regularly** relieve **any** pressure area (includes heels/head etc.) Cannot or will not move independently. OR on an operating table for > 2hrs?	No						
2	Incontinent - urine or faeces in contact with the skin?	No						
3	BMI <18.5 or > 40 / patient appears malnourished?	No						
4	Pressure Ulcer Grade 1- 4	No						
Date		2/5/15						
Time		10.00						
Initial		PK						

If **Yes** to any question raise the PUP treatment plan and carry out a full assessment within **6 hours** of admission (or day of admission to the DN service). **Theatre staff to complete Treatment Plan D**
If No to any question re-assess each shift, or if a change in clinical condition then record on traffic lights and implement **Treatment plan A**

DATE & TIME	Pressure ulcer on admission Y N Source of Ulcer_____ (home other ward/hospital)	Initiate PUP Treatment plan B or C and raise a wound care plan for grade 2 and above pressure ulcers Treatment plan _____ **(A B C)** Date_____

EPUAP PRESSURE ULCER CLASSIFICATION (2009)

GRADE	VISUAL DESCRIPTION
1	Intact skin with non-blanchable redness of a localised area over a bony prominence. Apply light finger pressure to the site, remove finger, and score 1 if: Non-blanchable erythema of intact skin. Discoloration of the skin, pain, firm, soft, warmer, cooler, oedema, hardness as compared to the adjacent skin may also be used as indicators, particularly in individuals with darker skin.
2	Partial thickness loss of the Dermis presenting as a shallow open ulcer with red pink wound bed, without slough or bruising. May also present as an intact or open/ruptured serum-filled blister. The ulcer is superficial and presents clinically as an abrasion or blister. It is not to be confused with skin tears, burns, incontinence dermatitis, moisture and excoriation.
3	Full thickness tissue loss subcutaneous fat may be visible but not bone muscle or tendon Slough may be present but does not obscure the depth of tissue loss. May include tunnelling and undermining
4	Full thickness tissue loss with exposed muscle, bone and tendon. Slough or Eschar may be present and may completely obscure the wound bed.

Sub categorise

- Unstageable/unclassified full thickness unknown- Full thickness tissue loss but until the slough or Eschar are removed the full extent cannot be determined
- Suspected deep tissue Injury-depth unknown – Purple or maroon area intact skin or blood filled blister – might be painful 'boggy' to touch. Evolution may expose deeper layers, or a thin Eschar may form over the surface

PRESSURE ULCER RECORD

Date/Time	Ulcer Location	EPUAP Grade	Record on AIM any stage 2 if developed in your area, also if the pressure ulcer was present on admission from another area and no record in the notes **state incident reference** number(S) and date	Initials

NHS
Quality Improvement Scotland

Adapted Waterlow Pressure Area Risk Assessment Chart

10+= 'At Risk': 15+ = 'High Risk': 20+ = 'Very High Risk'

Complete assessment on admission if PPURA shows at Risk. Repeat Waterlow weekly or if there is a change in individual's condition.

More than one score/category can be used:

Male	1							
Female	2	2	2					
Age								
14 – 49	1	1	1					
50 – 64	2							
65 – 74	3							
75 – 80	4							
81+	5							
Build/Weight for Height (BMI=weight in Kg/height in m2)								
Average – BMI 20-24.9	0							
Above average – BMI 25-29.9	1							
Obese – BMI > 30	2							
Below average – BMI < 20	3	3	3					
Continence								
Complete/catheterised	0	0	0					
Incontinent urine	1							
Incontinent faeces	2							
Do incontinent (urine & faeces)	3							
Skin Type – Visual Risks Area								
Healthy	0	0	0					
Tissue paper (thin/fragile)	1							
Dry (appears flaky)	1							
Oedematous (puffy)	1							
Clammy (moist to touch)/pyrexia	1							
Discoloured (bruising/mottled)	2							
Broken (established ulcer)	3							
Mobility								
Fully mobile	0	0	0					
Restless/fidgety	1							
Apathetic (sedated/depressed/reluctant to move)	2							
Restricted (restricted by severe pain or disease)	3							
Bedbound (unconscious/unable to change position/traction)	4							
Chair bound (unable to leave chair without assistance)	5							
Nutritional Element								
Unplanned weight loss in past 3-6 months		0	0					
< 5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2							
BMI >20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2							
Patient acutely ill or no nutritional intake > 5 days	2							
Special Risks – Tissue Malnutrition								
Multiple organ failure/terminal cachexia	8							
Single organ failure e.g. cardiac, renal, respiratory	5							
Peripheral vascular disease	5							
Anaemia = Hb < 8	2							
Smoking	1							
Special Risks – Neurological Deficit								
Diabetes/ MS/ CVA/ motor/ sensory/ paraplegia Max 6	4-6	0						
Special Risks – Surgery/Trauma								
On table > 6 hours	8							
Orthopaedic/ below waist/spinal (up to 48 hours post op)	5		5					
On table > 2 hours (up to 48 hours post op)	5		5					
Special Risks – Medication								
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4							
Total Score		6	16					
Date		21/5/15	21/5/15					
Time		10.00	21:00					
Initials		AV	NR					

Ensure plan of care is implemented / reviewed for all identified areas of concern.

Pressure Ulcer Prevention Treatment Plan Guide

The use of clinical judgement is paramount when deciding on pressure ulcer prevention.
Ensure each planned intervention is recorded on the record of ongoing care

Community staff will advise patients and carers of all pressure ulcer prevention strategies as below with the aid of the NHST pressure ulcer prevention patient/carer advice leaflet. The SKIN bundle can also be used by the patient/carer(s) as a guide if they so wish. If patients prefer not to utilise the advice given, document the advice given and the patient/carer choices in the nursing records

No risk (PPURA) and / or Waterlow <10
No evidence of current pressure damage
No history of pressure ulcers
Patient mobile

At Risk Waterlow >10 and or
No pressure ulcer or Grade 1 or 2 pressure ulcer and or
Patient able to be re-positioned

High Risk - Waterlow >10 and or
Grade 3 or 4 pressure ulcer and or
Patient unable to or will not re-position

TREATMENT PLAN A

- No special mattress intervention required
- Patient encouraged to check their own skin, if appropriate and with education from registered nurse
- Patient will independently change position, if appropriate and with education from registered nurse
- Re-assess PPURA risk factors on each shift, if Yes to the PPURA carry out a Waterlow and continue weekly or if there are changes in the patient's general condition, skin condition or treatment
- Re-assess skin if there are changes in the patient's general condition, skin condition, theatre, medication or recovery

TREATMENT PLAN B

- Profiling bed (not in community) with high specification mattress Do not elevate the bed head more than 30 degrees for long periods
- Show patients how to relieve their own pressure areas and actively mobilise where possible.
- The re-positioning interval, either 2/3/4 hrly will be determined by the condition of the skin on inspection. If applicable, re position with alternating 30 degree lateral tilt. Bony prominences are kept from direct contact with one another
- Skin inspection particularly heels and sacral areas are carried out at specified times or with each repositioning. Chart and document condition of skin/ulcer on re-positioning and the interval times using the **SKIN** bundle
- Keep bed linen loose, lie on the mattress and not the bed covers

Heels:
Friction and shear damage is minimised
Consider elevating heels off the bed with pillows or heel elevators, use film dressing or moisturisers to prevent friction, refer to NHST heel guidelines

Seating:

- Limit the time seated to no more than 2 hours at any one time. Patients with pressure ulcers and at high risk should be actively mobilised.
- Ensure maximum contact with the chair and the patient's back and head are fully supported. The buttocks, knees and feet are supported fully at angles of 90 degrees.
- Pressure relieving foam cushion will be used for grade 1 and 2 ulcers and ensure the patients are sitting at the correct angle and fully supported at the feet, thighs, buttocks back and head

Seek advice on specialist seating if required and necessary

Care plan to be implemented within 72 hrs of admission to the DN service

TREATMENT PLAN C

- Profiling bed with a dynamic mattress document type of mattress on the intervention sheet. When possible, do not elevate the bed head more than 30 degrees for long periods
- Show patients how to relieve their own pressure areas where possible. Actively mobilse when possible
- The re-positioning interval, either 2/3/4 hrly will be determined by the condition of the skin on inspection. If applicable, re position with alternating 30 degree lateral tilt. Bony prominences are kept from direct contact with one another
- Skin inspection particularly heels and sacral areas are carried out at specified times or with each repositioning. Chart and document condition of skin/ulcer on re-positioning and the interval times using the **SKIN** bundle
- Keep bed linen loose, lie on the mattress and not the bed covers

Heels:
Friction and shear damage is minimised
Consider elevating heels off the bed with pillows or heel elevators, use film dressing or moisturisers to prevent friction, refer to NHST heel guidelines

Seating:

- Patients with grade 3 / 4 ulcer on the sacral area will be discouraged from sitting in a chair and the profiling chair function of the bed utilised when possible. The body should have maximum contact with the chair and the patient's back and head are fully supported. The buttocks, knees and feet are supported fully at angles of 90 degrees.

Seek advice on specialist seating if required and necessary

Care plan to be implemented within 24hrs of admission to the DN service

For all at risk patients consider the following:-

Nutrition and hydration
Strive to ensure adequate nutrition and hydration compatible with the patient's condition.
Nutritional protein supplements to be given when ulcer healing is the goal

Skin. Wetness on the skin is a key factor in pressure ulcer development particularly from incontinence, this must be cleaned immediately with a skin cleanser **not** soap and water and the cause addressed. Where the source of wetness cannot be controlled the use of moisture absorbing continence aids must be used. Document excoriation using NHSQIS Excoriation Tool and NHS Tayside continence guidelines
For dry skin a non-perfumed moisturiser may be applied sparingly at least twice daily. Avoid rubbing and massaging

Pain
Pain control is important to enable patients to move themselves or to be moved more easily thus increasing compliance with pressure relieving turning regimes. Pain from area known to be at risk of pressure ulcer development must be inspected immediately and re-assessed.

THEATRE TREATMENT PLAN D
On the theatre table for more than 2 hours

Refine risk assessment of individuals undergoing surgery by examining other factors that are likely to occur and will increase risk of pressure ulcer developing

- Length of the operation
- Increased hypotensive episodes intraoperatively
- Low core temperature during surgery
- Reduced mobility on post operative day one

All at risk patients receiving surgery will have a pressure-relieving device on the operating table and transfer trolleys

All nursing staff in reception theatre and recovery will ensure that they know the patient's risk status at all points of the patient's journey through theatre

All patients identified as at risk will have their pressure areas inspected prior to theatre and in the recovery area and where possible during the operation

In collaboration with the anaesthetist, move the head position to prevent continued pressure on the occipital area (if patient condition allows)

All patients at risk will have measures in place to alleviate factors that cause pressure ulcers in reception, theatre and throughout the recovery phase

Elevate heels completely in such a way as to distribute weight of the leg along the calf without putting all the pressure on the Achilles tendon. If possible the knee should be in slight flexion. (hyperextension of the knee may cause obstruction of the popliteal vein predisposing to deep vein thrombosis)

Position the individual in a different posture preoperatively and post operatively than the posture adopted during surgery and record this on the **SKIN** bundle If a pressure ulcer develops this will be recorded

The recovery nurse will discuss the patients' skin integrity with the ward nurse receiving the patient

Position of patient in **anaesthetic room** state:-

Length of time in anaesthetic room _____mins / hrs Any significant event causing increased risk state:-

Condition of skin **on transfer to table**:- please circle - No red areas - red area(s)- blanching - red area(s) non blanching = grade1 - Grade 2, 3, 4 Site(s) please state:_____
Treatment plan D Active? Yes No Unable to comply state reason_____

Time Sig._____

Position of patient **on the theatre table** state:

Length of time in theatre _____min/ hrs Any significant event causing increased risk state:-

Condition of skin leaving theatre:- please circle No red areas, red area(s)- blanching, red area(s) non blanching grade1 Grade 2, 3, 4 Site(s) please state:_____

Treatment plan D Active? Yes No Unable to comply state reason_____

Time Sig._____

Position of patient **in recovery** area_____ length of time in recovery area _____min/hrs
Any significant event causing increased risk state:-

Condition of skin **in recovery (circle)**
No red areas, red area(s)- blanching, red area(s) non blanching grade1 Grade 2, 3, 4
Site(s) please state:_____
Condition of skin **leaving recovery (circle)**
No red areas, red area(s)- blanching, red area(s) non blanching grade1 Grade 2, 3, 4
Site(s) please state:_____

Treatment plan D Active? Yes No Unable to comply state reason_____

Time Sig._____

Surgical Admission Document

NHS Tayside

ELLIS
STACEY
17 ANNAT ROAD
MONTROSE
DD10 8EF

2804880060
Female

CHI 2804880060

WARD: ASRU7 Consultant: JUJOUIC

Date 01 / 05 / 2015

Day: Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☑ Sat ☐ Sun ☐

Time of arrival: 14 - 20

SEWS		SIRS Criteria	✓/✗
Resp Rate	14	Resps >20/min	✗
O2 Sats	100		
FiO2	AIR		
Temp	36.1	Temp >38/<36	✗
Pulse	87	Pulse >90/min	✗
BP	115/73		
AVPU	A		
		WCC >12/<4	
SEWS Total (if WCC ≥ 4; refer to SPR)	0	Blood glucose >7.8 (in absence of diabetes)	
		Altered mental status, e.g. Confusion	

If 2 or more SIRS criteria are met, this patient has systemic inflammatory response syndrome.
If there is a confirmed/suspected source, please start SEPSIS 6 bundle

Surgical Clerking F1 ☐ F2 ☐ SpR ☐ ANP ☐

Name of doctor / ANP (please print) : .....

Bleep

Time of assessment

PC:

HPC:

Abscess on thigh and tender over femur
- inflammation only related to abscess
(NO sign rec. fasc)
Referred ortho at 14.20 - accepted.
contacted again at ~1600
contacted again at 1830.

PMH	Yes	No	Details:
MI	☐	☐	
Angina	☐	☐	
↑BP	☐	☐	
↑Lipids	☐	☐	
COPD / Asthma	☐	☐	
Stroke/TIA	☐	☐	
Diabetes	☐	☐	
Epilepsy	☐	☐	
Cardiac Failure	☐	☐	
Jaundice / Hepatitis	☐	☐	
Peptic Ulcer Disease	☐	☐	
PE / DVT	☐	☐	

Previous Operations: PARKINSON STS surg

Anaesthetic History:

Family History:

Other PMH:

Medicines Reconciliation

Please Indicate the source(s) of Medication history:
At least 2 sources, one being the patient if appropriate, are required

- ☐ Patient
- ☐ Patient's own medications
- ☐ Relative / carer
- ☐ ECS (check date of last issue)
- ☐ Drug chart from another hospital
- ☐ GP practice (verbal)
- ☐ EDD (within last month)
- ☐ Nursing home prescription
- ☐ Other (please specify)
- ☐ GP referral letter
- ☐ GP prescriptions

If the patient is taking
Aspirin, Clopidogrel(*Plavix*®), Dipyridamole (*Persantin*®), Warfarin, Rivaroxaban, Apixaban or Dabigatran
then contact senior medical staff for advice regarding continuation of therapy.
If unavailable then **WITHOLD** therapy until senior review within 24 hours

ADMISSION MEDICATION			ACTION		Note: Unless indicated to stop / hold, medication should be continued on TPAR / discharge.
Name (Generic)	Dose	Frequency	Hold	Stop	Comments (if medication held or stopped)
FLUCLOXACILLIN	500mg	4xday			acute 30/4/15.

Adverse reactions / Allergies

No Known Drug Allergies ☐ OR

Drug / Substance:	Reaction:	Drug / Substance:	Reaction:
LATEX.			

Are you satisfied this medication history is complete and accurate? Yes ☐ No ☐

If "no", what further action is necessary (contact GP, etc)?

Medicines Reconciliation verified by? Name: Signature:

Social History

Occupation.....

Housing: Lives alone? Yes ☐ No ☐ Own ☐ Shelt. ☐ RH ☐ NH ☐

Smoking: Never ☐ Ex ☐ (stopped..... years) Current ☐ /day

Alcohol ☐ units/week

Social Care: Home Help ☐ District Nurse ☐ Meals on wheels ☐

Other social issues:

VTE Risk Assessment for SURGICAL Patients

PRESCRIBE graduated elastic compression stockings on the TPAR unless any of the following contraindications

Please tick as appropriate	
Massive leg oedema	
Pulmonary oedema	
Major leg deformity	
Peripheral vascular disease	
Peripheral neuropathy	
Dermatitis	
Ulcers on leg or heel	
Active Gout	
Patients on noradrenalin	
Other (please indicate)	
No contraindications	

Reduced mobility +/- Admission > 48 hours

- ALL other admissions → Complete BOTH VTE and BLEEDING Risk assessments below
- Urology Admission → WITHOLD Dalteparin until a senior review within 24 hours → SIGN Below

No change in mobility and patient likely to be discharged within 48 hours

- No VTE Risk: Circle "Non" on TPAR and sign TPAR → SIGN Below

VTE Risk Assessment

VTE Risk Factors	Initial Assessment (Please tick)
Acute surgical admission with inflammatory or intradominal condition	
Age > 60	
BMI > 30	
Active Cancer or Cancer Treatment	
Previous history or first degree relative with a history of VTE	
Use of hormone replacement therapy	
Use of estrogen containing contraceptive therapy	
Dehydration	
Significant medical problems (eg heart disease, COPD)	
Reduced Mobility	

Bleeding Risk Assessment

Bleeding Risk Factors	Initial Assessment (Please tick)
Active Bleeding	
Active liver disease	
Current use of anticoagulants (Warfarin, rivaroxaban, Dabigatran, etc)	
Uncontrolled hypertension (>230/120)	
Thrombocytopenia < 75 (based on current bloods)	
Untreated inherited bleeding disorders	
Acute stroke	
Epidural or spinal anaesthetic within next 12 hrs OR past 4 hrs	
Planned procedures with high bleeding risk (discuss with senior)	

Based on the above assessment, choose one of the following actions and SIGN below

- No Bleeding Risk Factors present → PRESCRIBE DALTEPARIN ON TPAR and SIGN TPAR
  - Only one risk factor → Prescribe Dalteparin 2500 units → SIGN Below
  - More than one risk factor → Prescribe Dalteparin 5000 units → SIGN Below
- Not all bleeding Risk Factors can be excluded at point of assessment. → DO NOT PRESCRIBE DALTEPARIN YET → RE-ASSESS within 24 hours of admission → SIGN Below
- 1 or more Bleeding Risk Factor(s) present → DO NOT PRESCRIBE DALTEPARIN YET → DISCUSS WITH SENIOR within 24 hours → SIGN Below

CARDIOVASCULAR

Chest Pain / Dyspnoea / PND / Cough / Ankle Swelling / Intermittent Claudication

Details:

RESPIRATORY

Cough / Sputum / Haemoptysis / Wheeze / Weight Loss / Sweats

Details:

GASTROINTESTINAL

Appetite: Bowel Habit:

Weight Loss: Jaundice:

Abdominal pain / Dysphagia / Heartburn / Indigestion / Haematemesis / Nausea . Vomiting / Diarrhoea / Constipation / PR bleed / PR mucous / Tenesmus

Details:

GENITO-URINARY

.oin pain / Suprapubic pain / Dysuria / Haematuria / Frequency / Urgency / Hesitancy / Incontinence / Dripping

Details:

Gynaecological History: (if applicable)
Any Gynae symptoms?

Please circle as appropriate

LMP	< 2 weeks	> 2 weeks	
Contraception	NIL	OCP	Other
Pregnant	YES	NO	Unknown

CENTRAL NERVOUS SYSTEM

Dizziness / Headaches / Blackouts / Seizures / Numbness / W

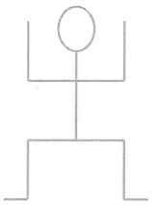
Details:

Examination

General:

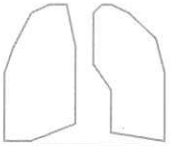
4AT tool (circle score in each section on right and total score)		Circl
Alertness: this includes patients who are markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient if asleep, attempt to wake. Ask patient to state name and address to assist rating.	Normal (fully alert, but not agitated, throughout assessment)	0
	Mild sleepiness for <10 secs after waking then normal	0
	Clearly abnormal	4
AMT4 (age, D.O.B, place (hospital), current year)	No mistakes	0
	1 mistake	1
	≥2 mistakes/untestable	2
Attention: Ask the patient: "please tell me the months of the year in backwards order, starting at December."	Achieves 7 months or more correctly	0
	Starts but scores <7 months/refuses to start	1
	Untestable (cannot start because unwell, drowsy, inattentive)	2
Acute change or fluctuating course: Evidence of significant change or fluctuation in alertness, cognition, other mental function (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24 hours.	No	0
	Yes	4
SCORE 4 OR MORE THIS IS POSSIBLE DELIRIUM +/- COGNITIVE IMPAIRMENT	**Total**	

C.V.S
Pulses



Heart Sounds
Murmurs
JVP
Ankle Oedema
Peripheral Circulation

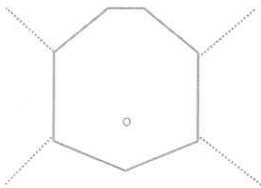
Respiratory



Trachea Added Sounds

Breath sounds Percussion note

Abdomen



Soft : Yes / No
Masses: Yes / No
BS
PR
(if PR not performed, specify WHY)

Clinical Impression

Plan

Clerking complete. Signed:_____ (Note: name and bleep number must appear at the front of the clerking)

Results

(Note: It is important to document times when results are recorded and to initial in the box provided)

	Initials	Time
ECG		
AXR		
CXR		
Ultrasound		
CT		
Other Investigations		

Biochemistry

Initial results received — Initials: ____ Time: ____

	Date	Time	Na	K	Urea	Creat	ALT	Bil	Alk Ph	Alb	C. Ca	Mg	PO4	Amylase	CRP	CK	Gluc
PREVIOUS SAMPLES																	

Haematology

Initial results received — Initials: ____ Time: ____

	Date	Time	Hb	MCV	WCC	Neut	Lymph	Plat	INR	APTTr
PREVIOUS SAMPLES										

ABG

Initials				
Time				
PiO_2				
pH				
PCO_2				
PO_2				
Bicarb				
BE				
Sats				
Hb				

Other Bloods		Time

Urinalysis

Beta-HCG Test +ve / -ve

Date & Time

020515 27 ♀; 6 weeks post partum.
09:10 ? Insect bite posterior left thigh at gluteal fold 3/52 ago.
Now Abscess, + pain.
? Allergic to Latex.
Generally fit & well. No regular medication.
Clinically → red, pointing abscess ± ulceration on gluteal fold left thigh
Plan - Admit
- swab up for theatre
- Consented for I+D abscess left thigh.
- Marked

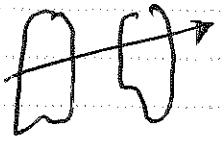
(T-Allergies
At Post, 4888
contact)

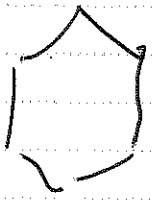
02/05/15 FYI Bannon
0920 Posterior thigh abscess following insect bite.
°Fever °rigors °SOB °Chest pain °Rash ~~Back~~
- Now settled, no vomiting
PMH Nil
6 weeks post partum - no complications
PSurgical Hx - Nil.
Allergies - Latex - skin breakdown
Medications - Nil regular
SH - lives w/ partner
- Smoker
- No EtOH

Date & Time

O/E: Alert, looks well
Pulse regular
CRT < 2 s

HS 1+11+0





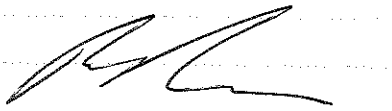
Bloods 1/5/15

CRP < 4

Hb 133
WCC 10.7

Na 139
K 4.3

① Reader ✓



Please write down any allergies you may have

Latex

Please tell us about any metal inside your body, e.g. artificial joints, pacemakers, nerve stimulators

Right forearm has under skin piercing.

Have you taken any tablets or used inhalers or patches today YES ☐ NO ☑

If yes, please fill in the name and time you have taken it:

Have you been asked to not take any of your routine medication YES ☐ NO ☑

If yes, please fill in which medications and the date you stopped taking them

FEMALE PATIENTS – is there any risk you may be pregnant? YES ☐ NO ☑

Prior to surgery, please confirm you have removed (if applicable) :

nail varnish ☐ false nails ☐ piercings ☑

We would request that where appropriate your dentures/spectacles/hearing aids and underwear are **NOT** removed prior to going to theatre (bras should be removed please). Please remember your glasses/dressing gown/slippers

This ticket has been completed by : Patient ☑ Carer ☐ Nursing staff ☐

Please pass this ticket to your named nurse.

PATIENT THEATRE TICKET – for clinical use

WARD TEAM Patient CHI No. 2804880060.

Correct name band applied	YES ☑
Consent signed and dated (including CJD box)	YES ☑
Surgical site marked	YES ☑ N/A ☐
Medical casenotes present	YES ☐
Xmatch/G&S sent	YES ☑ N/A ☐
TPAR complete with patient name, CHI, allergies, regular medication prescribed	YES ☑
Nursing records present	YES ☑
Are there any infection control issues the theatre team should be aware of? Strep B. from HVS (28/01/15)	YES ☑ NO ☒

WARD TEAM

Pregnancy test (all females aged 12-55) +ve ☐ -ve ☑
(inform anaesthetist if positive result)

If patient is on applicable medication, please complete the following :
Last fragmin injection Time_____ Date_____

Oral anticoagulants, e.g. warfarin, clopidogrel, aspirin, dipyridamole, rivaroxaban Time_____ Date_____

Has appropriate medication been given today, e.g. beta blocker/omeprazole, inhalers (patients inhalers/GTN spray must be taken with them to theatre)
YES ☐ NO ☐ N/A ☑

Did patient self-administer at home? YES ☐ NO ☐ N/A ☑
(if yes, see patient section)

Prescribed TEDS applied? YES ☐ N/A ☑

Is this patient high risk/or already has a pressure ulcer YES ☐ NO ☑

Pre-medication given YES ☐ NO ☑ N/A ☐

IF THIS WAS A SEDATIVE, TRANSFER TO THEATRE MUST BE ON A BED OR TROLLEY

ANAESTHETIC/NURSING USE

Time last drink allowed

Time of last drink given by nursing staff

Confirmed time of last food

Any specific instructions, e.g. Need EMLA, interpreter, BSL interpreter, agree light breakfast etc

In the event of any queries, please contact the anaesthetist on bleep no_____
or call theatre_____

TICKET COMPLETE (for completion by Ward Staff)

I hereby confirm that the above named patient has had all necessary pre-theatre checks undertaken and is consented for theatre.

Print Name P Keith Date 02/05/15
(must be registered nurse)

ACCEPTING RECEPTION NURSE

I hereby confirm that this patient ticket is accurately completed Y ☐ N ☑

PRINT NAME_____SIGNATURE_____

DATE_____

Document any inaccuracies below :

CONTACT LENSES IN SITU – NO MEDICAL NOTES.

ACCEPTING ANAESTHETIC PRACTITIONER

I hereby confirm that this patient ticket is accurately completed Y ☐ N ☐

PRINT NAME_____SIGNATURE_____

DATE_____

Document any inaccuracies below :

PLEASE RETAIN IN PATIENT RECORD

NHS Tayside

Patient Theatre Ticket – for patient /carer use

To make your trip to theatre as safe and effective as possible, we would be grateful if you could please fill in the following information :
(If you have any problems with this, please ask your nurse for help)

My name is Stacey Ellis My Date of Birth is 28·04·88

I would like to be called Stacey. (e.g. your first name)

Do you have any concerns you would like to discuss with the theatre team?

No

Is there anything else we can help you with during your stay?

No

To make your trip to theatre safe, we need you to stop eating and drinking at the required times :

- No solid food (includes glasses of milk) for 6 hours before surgery
- You are encouraged to keep drinking either water/diluting juice/cups of tea or coffee which can contain sugar and up to 3 tablespoons of milk
- You must have one last cup of any of the above allowed drinks 2 hours before surgery

When did you last have solid food Date 1·5·15 Time 8:30pm

When did you last have a drink Date 1·5·15 Time 11pm

What did you have to drink Cup of tea.

Please do not suck sweets/use chewing gum after your last drink (i.e. 2 hours before surgery)

THB(MR)162

ELLIS
STACEY
17 ANNAT ROAD
MONTROSE

2804880060
Female

DD10 8EF

NHS Tayside

SEWS KEY	0	1	2	3

NAME:

DOB/CHI:

WARD: ABRU 7

ADMISSION DATE: 01 05 15

DATE	01 05 15	2/5/15					3/5
TIME	14-20	18-30	10--	19 20	22 23	22	24

RESPIRATORY RATE (Write Respirations)

36 +							
31 - 35							
21 - 30							
9 - 20	14	14	16	17	18	18	17
≤ 8							

Complete only **ONE** SpO2 section based on target saturations. Ensure oxygen is prescribed on TPAR

SpO2 - Target Saturations 94-98% ☐

94 +	100	98	97	96	96	97	98
90 - 93							
85 - 89							
< 85							

SpO2 - Target Saturations 88-92% ☐

88 +							
84 - 87							
80 - 83							
< 80							

AIR / OXYGEN CODE (e.g. V)	AIR	AIR	A	A	A	A	A
% inspired O2 or L/MIN (e.g. 60%)							

EXAMPLE

OXYGEN CODES

- **A** Room Air
- **NC** Nasal Cannula 1 - 6 L/min
- **SM** Simple Mask 5 - 10 L/min
- **V** Venturi 24% (Blue) 28% (White) 35% (Yellow) 40% (Red) 60% (Green)
- **RM** Reservoir Mask 15 L/min
- **NB** Nebuliser

TEMPERATURE

record & join with a ●

Write Actual Temperature

39°							
38°							
37°							
36°	36.1	36.5	36.6	36.9	36.7	36.5	36
35°							
34°							

EXAMPLE ● 36.5

PULSE RATE

record & join with a ●

170							
160							
150							
140							
130							
120							
110							
100							
90	87			93	90	99	
80							
70							
60							
50							
40							
30							
210							

EXAMPLE ● 90

SEWS SCORE uses Systolic BP

BLOOD PRESSURE

record as shown

120 ↕ 60

200							
190							
180							
170							
160							
150							
140							
130							
120	115						
110					111		
100	120	100	107	104		104	107
90							
80							
70	73		75	66	68	64	
60		59					59
50							

EXAMPLE ↕ 120 / 60

NEURO RESPONSE

Any change in neuro response - commence neuro obs - immediate medical review

Alert	A	A	A	A	A	A	A
Verbal	V						
Pain	P						
Unresponsive	U						

SEWS SCORE (with all obs)	0	0	0	0	0	0	0
Frequency of observations H = Hourly, M = Minutes, D = Daily (e.g. 1H)	4°	4°	4°	P	2°	4	4
Escalation to medical team/HAN/ANP Y / N / E (exclusion) (e.g. E)	N	N	N	N	N	N	.
Document Pain Score (0 - 3)	2	2	1	1	1	0	0
Blood Glucose (mmol/L)	/	/	-	N/A	N/A	/	.
Catheterised patients, > 90 mls/3 hrs Y / N If No - contact medical staff immediately	/	/	-	N/A	N/A	/	.
Non catheterised patients, Passed urine in 8 hours? Y / N If No - contact medical staff if concerns	Y	Y	Y	not PoD	PU	PU	.
INITIAL	DG	DG	PK	NE	NE	.	.

PAIN ASSESSMENT

SCORE 0 = No Pain
SCORE 1 = No Pain at Rest, Slight Pain on Movement
SCORE 2 = Intermittent Pain at Rest, Moderate Pain on Movement
SCORE 3 = Continuous Pain at Rest

For Acute, Chronic & Palliative Pain - See local NHS Tayside Guidelines

Refer to Acute Kidney Injury (AKI) guidelines on staffnet

DOCUMENT ALL ACTIONS, INTERVENTIONS, EXCLUSIONS AND CLINICAL RESPONSES IN THE NURSING RECORDS

SEWS SCORE OF 0	SEWS SCORE OF 1	SEWS SCORE OF 2-3	SEWS SCORE ≥4, OR SCORE OF 3 IN ONE PARAMETER
MINIMUM 8 HOURLY OBSERVATIONS	REGISTERED NURSE TO DETERMINE FREQUENCY OF OBSERVATIONS MINIMUM 4 HOURLY OBSERVATIONS	INFORM THE NURSE IN CHARGE INCREASE FREQUENCY TO HOURLY OBSERVATIONS	URGENT ESCALATION 15 MIN OBSERVATIONS UNTIL REVIEW

SEWS ≥4: THINK SEPSIS

If 2 or more of the following:
- Temperature >38 or <36
- Altered Mental State
- Respiratory Rate >20 breaths / minute
- Known/suspected neutropenia
- Pulse Rate >90 beats per minute
- White cell <4 or >12 AND clinical suspicion of infection commence

"Sepsis 6 Bundle" within 1 hour

REFER TO LOCAL ACTION AND ESCALATION TOOL

THB(MR)103

BREAST CLINIC INITIAL INVESTIGATION FORM

NHS Tayside

PERSONAL DETAILS

Name & Address
ELLIS
STACEY
8 MILL PLACE
CRAIGO
MONTROSE
2804880060
F
DD10 9LB
ANNAT BANK, LINKS HEALTH CENTRE, FRAN

CHI

Referring Hospital:

Ninewells ☑ PRI ☐ Well Woman ☐ Screening ☐

Consultant ..... Seen by .....

Referring GP/Clinician ..... Ireland

Screening Patient: YES/NO Date of Referral 16 / 8 / 10

Date of Last Breast Screen ..... / ..... / ..... Date of Clinic 20 / 9 / 10

COMPLAINTS

	RIGHT	LEFT	OTHER
Duration:	Bil breast pain 7 weeks (22)		
Cyclical:			
Other Features:	Doesn't checks breasts		

PREVIOUS DISEASE

Previous Breast Disease? YES (NO)

Diagnosis .....

Previous Breast Clinic Patient: YES / (NO) Date ..... / ..... / .....

Previous Open Breast Surgery

NO	☐
RIGHT	☐
LEFT	☐
BOTH	☐
MULTIPLE	☐

Previous Breast Aspiration

NO	☐
RIGHT	☐
LEFT	☐
BOTH	☐
MULTIPLE	☐

PAST MEDICAL HISTORY

Other Cancer YES / NO Site: .....

Illnesses (YES) / NO What: depression

.....

Current Medications YES / (NO)

What: .....

.....

Drug Allergies (YES) / NO What latex ?!!

Smoker / ~~Ex Smoker~~ (YES) / NO 20 day.

→ never had it checked.

FAMILY HISTORY

Family History of Breast Cancer (YES) / NO

(1 unaffected)

If YES,

	Age at onset		Age at onset
MOTHER	☐	MATERNAL AUNT	✓ 26
SISTER 1	☐	MATERNAL GRAN	✓ ?
SISTER 2	☐	PATERNAL AUNT	☐
OTHER ✦	☐	PATERNAL GRAN	☐

✦ Specify

.....

MENSTRUAL HISTORY

Menopausal Status: irregular.

Pre-Menopausal*	✓	Pregnant	☐
Post-Menopausal*	☐	Oral Contraceptive Pill	☐
Peri-Menopasal*	☐	Hormone Replacement Therapy	☐

SURGERY

Hysterectomy YES / NO Why .....

Bilateral Oopherectomy YES / NO

Unilateral Oopherectomy YES / NO

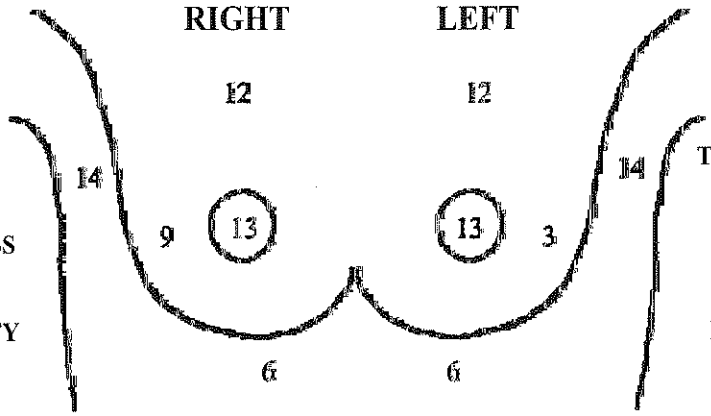
Other Operations (YES) / NO What eye OP grommet termination

* for definitions, see page 4

BREAST CLINIC INITIAL INVESTIGATION FORM

NHS Tayside

NORMAL	PAGETS		RIGHT	LEFT		NORMAL	PAGETS
DISCRETE LUMP	SINUS		12	12		DISCRETE LUMP	SINUS
THICKENING	SKIN NODULE		14			THICKENING	SKIN NODULE
NIPPLE INVERSION	TENDERNESS		9	13	13	3	NIPPLE INVERSION	TENDERNESS
NIPPLE DISCHARGE	GENERAL NODULARITY						NIPPLE DISCHARGE	GENERAL NODULARITY
OTHER			6	6			OTHER	



Axillary Nodes	**Nipple Discharge** YES / NO	**Axillary Nodes**	**Nipple Discharge** YES / NO
Not palpable ☑	Colour	Not palpable ☑	Colour
Palpable ☐	.....	Palpable ☐	.....
Fixed ☐	Single ☐	Fixed ☐	Single ☐
Supraclavicular Nodes	Multiple ☐	**Supraclavicular Nodes**	Multiple ☐
Not palpable ☑	Blood (Stick Testing) POS / NEG	Not palpable ☑	Blood (Stick Testing) POS / NEG
Palpable ☐		Palpable ☐	

FNA

#	SIZE	SITE	VOLUME/FEATURES
1			
2			

CYTOLOGY*

C1 ☐ C2 ☐ C3 ☐ C4 ☐ C5 ☐

REPORT:

MAMMOGRAMS*

NORMAL ☐ BENIGN ☐ MALIGNANT ☐

R1 ☐ R2 ☐ R3 ☐ R4 ☐ R5 ☐

N1 ☐ P1 ☐ P2 ☐ PDY ☐ DY ☐

REPORT:

ULTRASOUND

U1 ☐ U2 ☐ U3 ☐ U4 ☐ U5 ☐ U6 ☐

REPORT:

FNA

#	SIZE	SITE	VOLUME/FEATURES
1			
2			

CYTOLOGY*

C1 ☐ C2 ☐ C3 ☐ C4 ☐ C5 ☐

REPORT:

MAMMOGRAMS*

NORMAL ☐ BENIGN ☐ MALIGNANT ☐

R1 ☐ R2 ☐ R3 ☐ R4 ☐ R5 ☐

N1 ☐ P1 ☐ P2 ☐ PDY ☐ DY ☐

REPORT:

ULTRASOUND

U1 ☐ U2 ☐ U3 ☐ U4 ☐ U5 ☐ U6 ☐

REPORT:

** for definitions, see page 4*

BREAST CLINIC INITIAL INVESTIGATION FORM

NHS Tayside

RIGHT	LEFT
FINAL DIAGNOSIS **IF CANCER CLINICAL:** T* ☐ N* ☐ M* ☐ (Enter number/letter of code in appropriate box) benign ?duct ectasia	**FINAL DIAGNOSIS** **IF CANCER CLINICAL:** T* ☐ N* ☐ M* ☐ (Enter number/letter of code in appropriate box) benign ?duct ectasia

DATE OF DEFINITIVE DIAGNOSIS / /

SIGNATURE: .....

CONSULTANT WITH WHOM PATIENT DISCUSSED D Lee

ACTION:		**STAGING:**	**REQUESTED**	**RESULTS OBTAINED**	**WAITING LIST:** YES/NO
DISCHARGE	✓	FBC	☐	☐	**PROCEDURE:**
REVIEW	☐	PVISC	☐	☐	DATE: / /
FURTHER RADIOLOGY	☐	LFTs	☐	☐	DATE GIVEN YES/NO
STAGING	☐	CXR	☐	☐	FOLLOW-UP YES/NO
SURGERY	☐	USS LIVER*	☐	☐	WHEN
PATIENT REFUSED TREATMENT	☐	BONE SCAN* **(Only if T3/T4 or N2)*	☐	☐	DISCHARGE YES/NO COPY LETTER TO ONCOLOGY YES/NO

DISCUSSED AT CPC YES / NO

ELIGIBLE FOR TRIAL YES / NO **WHICH:**

SIGNATURE: ..... **DATE:** .....

NOTES

breast pain
duct ectasia > leaflet given
refer to FH clinic

** for definitions, see page 4*

BREAST CLINIC INITIAL INVESTIGATION FORM

NHS Tayside

DEFINITIONS

MENOPAUSAL STATUS

Definition:
Menopausal status is the term used to indicate whether a woman is menstruating at the end of reproductive life.
Notes:
This term categorises women into three main groups:

1. **For women with an intact uterus and at least one ovary**
   - *post-menopausal* - last menstrual period was more than 12 months before initial surgery
   - *peri-menopausal* - women experiencing menopausal symptoms (hot flushes, night sweats and genito-urinary symptoms) whose last menstruation was less than a year ago
   - *pre-menopausal* - last menstrual period was less than 12 months before initial surgery or who are on continuous oral contraception.
2. **For women who have had a hysterectomy**
   - *post-menopausal* - aged 50 years or over
   - *peri-menopausal* - women experiencing menopausal symptoms (hot flushes, night sweats and genito-urinary symptoms) whose last menstruation was less than a year ago
   - *pre-menopausal* - aged under 50
3. **For women who have had a bilateral oophorectomy**
   - *post-menopausal* - any age group
   - *peri-menopausal* - not applicable
   - *pre-menopausal* - not applicable

TUMOUR (CLINICAL)

Definition:
This is defined as the size of the tumour determined by physical examination and imaging techniques (clinical and not pathological) and is coded according to the official TNM Classification (TNM Classification of Malignant Tumours, Fourth Edition, 2nd Revision 1992).

Code	Description
TX	Tumour cannot be assessed
T0	No evidence of primary tumour
Tis	Carcinoma in situ
T1	Tumour 2cm or less
T2	Tumour more than 2cm but less than 5cm
T3	Tumour more than 5cm
T4	Tumour of any size with direct extension to chest wall or skin

---

NODAL (CLINICAL)

Definition:
This is defined as the size and position of nodes in the axilla detected by physical examination and imaging techniques.

Code	Description
NX	Regional lymph nodes cannot be assessed (previously removed)
N0	No regional lymph node metastasis
N1	Metastasis to movable ipsilateral axillary node(s)
N2	Metastasis to ipsilateral axillary node(s) fixed to one another or to other structures
N3	Metastasis to ipsilateral internal mammary lymph node(s)

METASTASES (CLINICAL)

Definition:
Using clinical, imaging and biochemical methods to determine if the disease has spread outwith the breast and axilla.

Code	Description
MX	Presence of distant metastasis cannot be assessed
M0	No distant metastasis
M1	Distant metastasis (includes metastasis to supraclavicular lymph nodes)

CYTOLOGY

Code	Description
C5	Malignant
C4	Suspicious of malignancy
C3	Atypia, probably benign/equivocal
C2	Benign/Negative
C1	Insufficient

MAMMOGRAMS

Code	Description
R5	Malignant
R4	Probably malignant
R3	Indeterminate
R2	Benign
R1	Normal

ULTRASOUND

Code	Description
U1	Normal diffuse benign
U2	Single cyst
U3	Solid benign
U4	Suspicious
U5	Malignant
U6	Multiple cysts

BREAST TYPE

Code	Description
N1, P1, P2	good visualisation; no masses/calcs/stromal deformities/architectural distortions
PDY, DY	Dense; can't rule out masses, therefore Ultrasound may be required

---

DATE OF (GP) REFERRAL

Definition:
Date of GP referral is the date on which a referral is made by a GP to a secondary healthcare service for symptoms suggestive of breast cancer.
Notes:
This is the date on the referral letter, fax message, telephone call or e-mail and may be the same date as the date on which the referral is received or earlier.
If referral for investigation of breast cancer is not directly from general practice (ie. referral from screening, incidental finding by another hospital clinician), then the date of GP referral is inapplicable.

Breast Clinic Ninewells Hospital Dundee

(Thank you for completing this form. Please bring it with you to the Breast Clinic. It will be filed on your notes)

Name..Stacey Ellis..... Date.....
Age..22.....Height..5ft 1... Weight...45Kg.....
Occupation...Housewife..... Bra size...34.....inches
Phone number..07892630501..... Cup size.....A/B/C/D

Have you had previous trouble with your breasts? Yes (No)

If so what ? .....

Did you need an operation? Yes No

Has anyone in your family had breast disease? (Yes) No

If so who? ..my gran and auntie.....

Are your periods regular? Yes (No)

When did the last one start ..26..day..08..month..10..year

Have your periods stopped? Yes (No)

Are you pregnant ? Yes (No)

How many live births have you had? 0 (1) 2 3 4 5 6

How many miscarriages? 0 1 (2) 3 4 5 6 1 Termination.

Are you taking any drugs or pills? Yes (No)

If so what ?.....

Are you taking the contraceptive pill Yes (No)

Are you taking hormone replacement therapy? Yes (No)

Have you ever taken hormone replacement therapy? Yes (No)

Have you had any problems with the womb or ovaries? (Yes) No

Have you had any operations? Yes (No)

Do you suffer from any other illnesses? Yes (No)

If so please list here.....

New Patient Breast Clinic Sheet

Please complete all applicable fields. Scoring systems are specified on page 4.

2804880060

Name	Leonard Stacey	**Hospital**	**Ninewells**	✓		
DoB			**PRI**			
Address	2 Wards Road	**Seen by**	WEN			
CHI	Brechin DD9 7AS	**Date of referral**	DD 9	MM 7	YYYY 2019	
	SM Rooney	**Date of clinic**	DD 04	MM 11	YYYY 2019	

Clinical history (from patient)

31yrs

Left breast lump 4-5 months
Associated left nipple itchy
No skin changes.

Previous history of breast problems

Previous breast disease/surgery	Previously seen in 2010 in breast clinic	
Previous breast imaging	**Screening Programme**	
	Symptomatic/FH	3yr ML.

Reproductive and hormone history

Pre-menopausal	✓	**Pregnant**	✓9wks	**Parity**	4+0	**Mirena coil**	X
Peri-menopausal		**Lactating**	X	**OCP**			
Post-menopausal		**LMP**	X	**HRT**	X		

General medical history

Operations			
Conditions	Anorexia nervosa, anxiety, emotionally unstable PD		
Current medications	Olanzapine Prazosin Sertraline.	**Anticoag yes**	
		Anticoag no	
Allergies			
Smoker	Smoker → heavy		

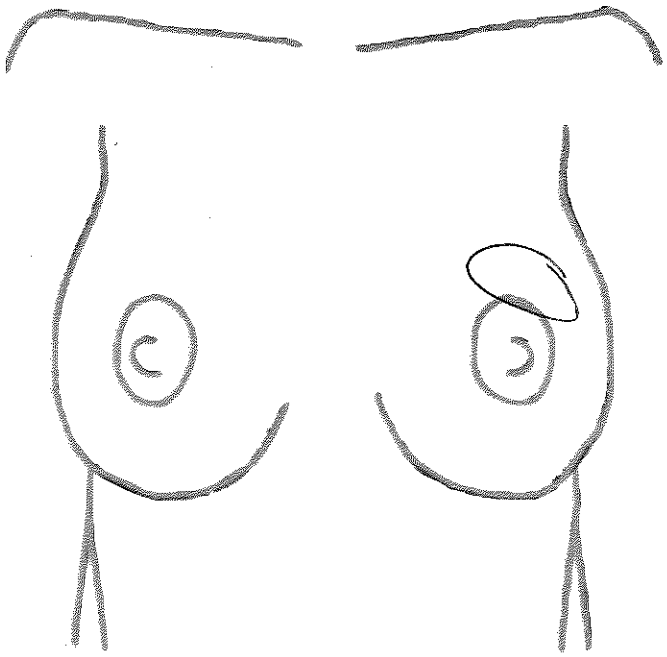
Family history of cancer

	Age at onset, site		Age at onset, site
Mother		**Maternal aunt**	✓ 26 yrs old Breast Ca
Sister 1		**Maternal gran**	✓ 50s yrs old Breast Ca
Sister 2		**Paternal aunt**	
Other		**Paternal gran**	

New Patient Breast Clinic Sheet

Clinical Examination

Right	
P1	✓
P2	
P3	
P4	
P5	
Description	
Size	



Left	
P1	✓
P2	
P3	
P4	
P5	
Description	
Size	

Comments

Right	Left
	No palpable lump No axillary LN

Investigations Requested

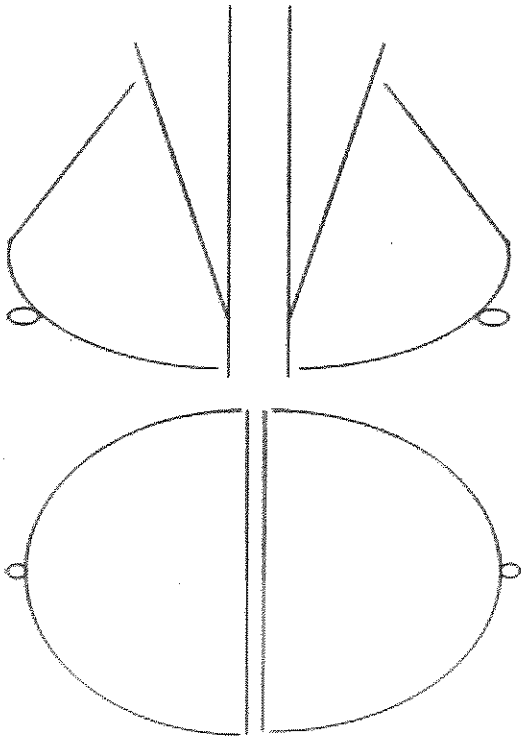
	Right	Left
Mammography		
Ultrasound		✓
Cytology		
Core Biopsy		
Vacuum Biopsy		

Signed		Date	4/11/19

New Patient Breast Clinic Sheet

Mammography

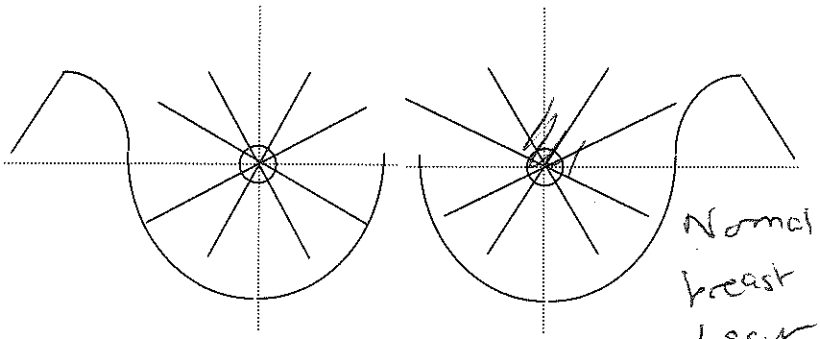
Right		Left	
M1		M1	
M2		M2	
M3		M3	
M4		M4	
M5		M5	
Description		Description	
Size		Size	



BIRADS density	1		2		3		4	

Ultrasound

Right		Left	
U1		U1	✓
U2		U2	
U3		U3	
U4		U4	
U5		U5	
Description		Description	
Size		Size	
Ax US		Ax US	



Overall imaging opinion/recommendations

Right	Left

Biopsy or other interventions performed

Right	Left

Signed	T. T. S.M	Date	4/11/19

New Patient Breast Clinic Sheet

Action						
Discharge	✓					
Review in clinic *Specify interval*						
Further imaging *Specify modalities*						
Discuss at MDT						
Staging						
Surgery						
Patient declined treatment						
Clinical TNM	**T**		**N**		**M**	

Further comments

D/W Mr D Brown for Genetics referral

Signed		**Date**	4/11/19

Physical examination score
P1 normal
P2 benign (including benign masses)
P3 indeterminate
P4 suspicious
P4 malignant

If radiology not concerning please discharge. ☐

Mammography score
M1 Normal
M2 benign abnormality e.g. well defined mass
M3 indeterminate
M4 suspicious
M5 malignant

Mammographic density
BIRADS 1 almost completely fatty
BIRADS 2 scattered fibro-glandular densities
BIRADS 3 heterogeneously dense
BIRADS 4 extremely dense

Ultrasound score
U1 normal
U2 benign (including cysts and typical fibroadenomas)
U3 indeterminate
U4 suspicious
U5 malignant

Breast Clinic Ninewells Hospital Dundee

(Thank you for completing this form. Please bring it with you to the Breast Clinic. It will be filed on your notes)

Name..STACEY LEONARD..... Date.....
Age...31.....Height...156cm Weight...44.4kg.....
Occupation.....HOUSEWIFE..... Bra size.....inches
Phone number..07368227877..... Cup size.....A/B/C/D

Have you had previous trouble with your breasts? Yes No

If so what ? .....

Did you need an operation? Yes No

Has anyone in your family had breast disease? (Yes) No

If so who? .....Aunt.....

Are your periods regular? Yes No

When did the last one start .....day.....month.....year

Have your periods stopped? Yes No

Are you pregnant ? (Yes) No

How many live births have you had? 0 1 2 3 (4) 5 6

How many miscarriages? 0 1 2 3 4 5 6

Are you taking any drugs or pills? Yes (No)

If so what ?.....

Are you taking the contraceptive pill Yes No

Are you taking hormone replacement therapy? Yes No

Have you ever taken hormone replacement therapy? Yes No

Have you had any problems with the womb or ovaries? (Yes) No

Have you had any operations? (Yes) No

Do you suffer from any other illnesses? Yes No

If so please list here.....BPD.....

THB(MR) 024SS

NHS Tayside

DATE OF ADMISSION 7/2/10.
RECORD START DATE

TAYSIDE PRESCRIPTION AND ADMINISTRATION RECORD (SHORT STAY)

Hospital /Ward: Ward 10	**Patient Name:** Stacey ELLIS.
Consultant: Lucille Jones	**CHI number:** 2804880060
On admission: **Weight:** **Height:**	**Date of Birth:** 280488.
	(Attach printed label here)

CONFIRMATION OF PRESCRIPTION REVIEW ON TRANSFER OF MEDICAL CARE

Receiving Unit	Date	Authorised Prescriber (Signature)

Date										
Weight										
Signature										

ONCE ONLY PRESCRIPTIONS

Date	Time	Medicine	Dose	Route	Prescribed By	Time Given	Given By
7/2/10		PARACETAMOL	1g	IV	[signature]	0545	JM KT.
7/2/10		TRAMADOL	50mg	IV	[signature]	0555	JM KT
9/2/10	13/4	TRIMETOPHRIM	200mg	ORAL	[signature]	1330	[signature]

KNOWN MEDICINE ALLERGIES/ SENSITIVITIES (if NONE confirmed write NKA in Box 1)

1.	2.	3.	4.
Latex.			

OTHER MEDICINE CHARTS IN USE

Chart Type	Signed	Chart Type	Signed
1. Insulin		5. Anticoagulant	
2. Epidural / Pain relief		6. Mental Health Act	
3. Fluid		7. Symptomatic Relief Administration Record	
4. Anaesthetic Chart		8. Other	

REGULAR THERAPY

Date → 7/2/10 | 8/2/10 | 9/2/10

Time ↓

Medicine / Form	Dose	Route	Signature	Start Date	Pharmacy	Time	7/2/10	8/2/10	9/2/10
PARACETAMOL	~~500mg~~ 1g	IV/oral	OR	7/2/10	5	6			
						8	✓	✓	✓
						12	✓	✓	✓
						14			
						18	✓ PN		
						22	✓		
FRAMADOL	50mg	IV/oral	OR	7/2/10	5	6			
						8	✓	✓	✓
						12	✓	✓	✓
						14			
						18	✓ PN		
						22	✓		
FRAXIPARIN	2,500 units	S/C	OR	7/2/10	5	6			
						8			
						12			
						14			
						18	✓ PN		
						22	~~✓~~		
TEDS	1 pair	topical	OR	7/2/10	Ward Pharm	6			
						8			✓
						12	✓		
						14			
						18			
						22			
TRIMETOPHRIM	200mg	ORAL		9/2/10	5	6			
						8		(6)	
						12			
						14			
						18			
						22			

CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINES

If a dose is not administered, initial and enter the appropriate code in the box with a circle drawn round it:

1. Patient refused
2. Patient unavailable
3. Medicine out of stock
4. Instructions not clear / legal
5. Nil by mouth.
6. Once only / prn given
7. Dose withheld – Prescriber's instructions
8. Self administered by patient
9. Nausea/vomiting
10. Unable to swallow
11. No intravenous access
12. Anaesthetist requested omission
13. Other .....
14. Other .....
15. Other .....

General Comments

AS REQUIRED THERAPY

Medicine / Form: CYCLIZINE.		Date										
		Time										
Dose & Frequency: 50mg Max 8 Max 24hrs	Route: IV/oral	Dose										
		Initials										
Signature: JR	Start Date: Est 7/2/10	Date										
		Time										
Indication / Notes: Nausea	Pharmacy: S	Dose										
		Initials										

Medicine / Form: TRAMADOL		Date	7.2.10									
		Time	1050									
Dose & Frequency: 50mg Max 4 gms. Max 6	Route: IV/oral	Dose	50mg									
		Initials	IW/MN									
Signature: JR.	Start Date: 7/2/10	Date										
		Time										
Indication / Notes: Pain -	Pharmacy: S	Dose										
		Initials										

Medicine / Form		Date										
		Time										
Dose & Frequency	Route	Dose										
		Initials										
Signature	Start Date	Date										
		Time										
Indication / Notes	Pharmacy	Dose										
		Initials										

Medicine / Form		Date										
		Time										
Dose & Frequency	Route	Dose										
		Initials										
Signature	Start Date	Date										
		Time										
Indication/ Notes	Pharmacy	Dose										
		Initials										

Medicine / Form		Date										
		Time										
Dose & Frequency	Route	Dose										
		Initials										
Signature	Start date	Date										
		Time										
Indication / Notes	Pharmacy	Dose										
		Initials										

Medicine / Form		Date										
		Time										
Dose & Frequency	Route	Dose										
		Initials										
Signature	Start Date	Date										
		Time										
Indication / Notes	Pharmacy	Dose										
		Initials										

Simple Discharge Plan

Patients Name: Stelley Ellis		CHI: 28·04·88 0060	Ward 10
Expected date of discharge	**Actual Date of discharge**	**Date patient informed**	**Date carer/family inform (state who)**
Discharge Destination:	Home ☐	Nursing Home ☐	Residential Care ☐ Other:

	Y	N	Comments/Variance	Date	Initial
Referral to Early Supported Discharge Scheme?	☐	☑	Contact name: Tel:		
Discharge Arrangements	**Y**	**N**	**Comments/Variance**	**Date**	**Initial**
Destination suitable for patient to return to (consider physical access, permanency of address, potential homelessness, health/social care needs)	☑	☐			
Patient has access to house keys	☑	☐			
Patient has suitable clothing for discharge	☑	☐			
Transport arrangements	**Y**	**N**	**Comments/Variance**	**Date**	**Initial**
	☑	☐			
Family	☑	☐			
Taxi	☐	☐			
Voluntary Driver	☐	☐			
1-man ambulance	☐	☐			
2-man ambulance	☐	☐			
Date and time ordered	☐	☐			
Date and time of patient being collected	☐	☐			
Health care treatments/education	**Y**	**N**	**Comments/Variance**	**Date**	**Initial**
Equipment supplies requested for patient prior to discharge	☐	☑			
Please state:					
Patient education /training needs addressed	☐	☑			
Please state:					
Carer education /training needs addressed	☐	☑			
Please state:					
Post discharge advice provided	☑	☐			
Driving/Exercise/Returning to work etc.					
AS PER GP INSTRUCTIONS					
Hospital medical certificate provided	☐	☑			
Valuables returned if applicable	☐	☐	N/A		

9/2/16

Venflon/lines removed if applicable	☑	☐			
Appropriate persons informed of infection control status (Please state)	☐	☐	N/A		
Discharge Medicines	**Y**	**N**	**Comments/Variance**	**Date**	**Initial**
Own medicines destroyed	☐	☐	N/A		
Own medicines returned to patient	☐	☐	N/A		
Discharge medication ordered	☑	☐			
Discharge medication provided	☑	☐			
Medication aids ordered	☐	☑			
Medication aids provided	☐	☑			
Patient demonstrates ability to manage own medicines	☑	☐			
Carer demonstrates ability to manage patients medicines if appropriate	☑	☐			
Multidisciplinary referrals					
Physiotherapist	☐	☑			
Occupation therapist	☐	☑			
Specialist nurse (Please state)	☐	☑			
Other (Please state)	☐	☑			
Discharge/Transfer Summaries	**Y**	**N**	**Comments/Variance**	**Date**	**Initial**
GP	☑	☐			
Practice Nurse/District Nurse	☐	☑	SEE GP LETTER		
Patient/Carer	☐	☑			
Other (Please state)	☐	☑			
Follow-Up Arrangements	**Y**	**N**	**Comments/Variance**	**Date**	**Initial**
OPD	☐	☑			
Other	☐	☑			
Discharge Completed	☑	☐			

Current Community Care Provision	Name	Contact Details	Days Provided							Date	Initial
			M	T	W	T	F	S	S		
Home Care											
Meals											
District Nurse											
Care Manager											
Day Hospital											
Crossroads											
Day Care											
Relative/Friend											
Other											
Other											

Patient requiring new or review of existing community services - complete fields below and send with core data set to relevant agency

Referrers Name	Relationship to Patient	Referral date	Contact details
Lives Alone ❑ Y ❑ N	Stairs Inside ❑ Y ❑ N	Stairs Outside ❑ Y ❑ N	Employment Status

If needs regarding any of the following are identified please tick if applicable

	Yes	No		Yes	No
Lives alone			Personal care		
Stairs inside			Finances		
Stairs outside			Feeding		
Lack of support network			Household tasks		
Accommodation unsuitable			Communication		
Cooking			Social function/contacts		
Continence			Medication		
Mental health			Physical health		
Diet			Mobility		
Vulnerability/risk (eg. domestic abuse)			Is the person being referred aware of the referral		
Is the main carer aware of the referral			Does the main carer have separate needs		

Description of Current Problem

Carer Involvement		Y	N	Comments/Variance		Date	Initial
Is the patient a main carer?		☑	☐	Has a baby boy 20 months old		07.02.10	JM
Dependant Name	Address			Relationship	Arrangements made for dependant		
Arrangements made for care of ~~pets~~: son. Sister Alisha looking after patient's child.						07.02.10	JM.

Significant Other Involvement in Care and Treatment	Y	N	Comments/Variance	Date	Initial
Has the patient a main carer?	☐	☐			
Describe care provided by main carer:					

Main Carer Name	Address	Gender	Date of Birth	Relationship	Keyholder		
					☐ Yes ☐ No		
Has the patient other carers?	☐ Y ☐ N						
Describe care provided by other carers:							

Other carer name	Address	Gender	Date of Birth	Relationship	Keyholder		
					☐ Yes ☐ No		
					☐ Yes ☐ No		

Who would you like to be involved in providing aspects of your care whilst in hospital?

Aspect of Care	Name of Individual	Individual agrees to take part		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

Investigations / Tests / Procedures / Surgery	Date	Result
MRSA	07.02.10	
URINALYSIS HCG -ve.	07.2.10	

Bayer

N-MULTISTIX* SG REPORT

Name STACEY ELLIS Date 07.02.10

Ward 10 Patient No.

TESTS — Please tick appropriate box for each test

TESTS							
NITRITE 60 seconds	NEG. ☑					POSITIVE (any degree of pink colour) ☐	☐
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	6.0 ☐	6.5 ☑	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	Leucocytes NEG. ☐	SMALL + ☑	MODERATE ++ ☐	LARGE +++ ☐			
GLUCOSE 30 seconds	NEG. ☑	mmol/L 5.5 TRACE ☐	14 + ☐	28 ++ ☐	56 +++ ☐	≥111 ++++ ☐	

Abdo Xray	07 0210	

Multi-Disciplinary Notes

Date	Time		Initial
07.02.10	0300	Admitted to the ward this morning complaining of right sided abdo pain getting worse. The crew from ambulance said patient had morphine which made him vomit. Settle her settle. Awaiting for ~~chest~~ abdo ~~Xray~~ Xray. Urinalysis positive, send away for c+s. Screened for MRSA JM.	
	0605	Had ~~an~~ abdo Xray ^? results, awaiting urine sample to test for HCG test. Tramadol ci paracetamol administered. Care as planned.	JM.
	11[00]	Reviewed on ward round by MJ. HCG -ve. Await US scan. High vaginal swabs to be taken. ½ dose paracetamol as weighs 46kg. Remains NBM, IVI in situ. For dietician referral following 3 days food-charts. Tests in situ. Sats 0.	KM
	13[30]	BM ↓ 3.6 mmols – 10% Dextrose IVI insitu	
	15[30]	BM 6.5 mmols.	
	19[00]	IVI fluids discontinued. Now allowed fluid + diet	
7/2/10	21[50]	For transfer to Ward 11 – Drake awake BM 3.8 at 20.50 hr BM now 6.7	KM
08/02/10	0500	Settled Night no complaints	US
	1300	Care as planned awaiting US review.	

Disclosure of Information: who does the patient want to receive information regards their health care?

Individuals			Level of information sharing		Mode of information sharing			
	Y	N	General eg. stable	Specific eg. test results	Face to face	Telephone	Appointment	Other
Police	☐	☑	✓	✓	✓	✓	✓	✓
Press Office	☐	☑	✓	✓	✓	✓	✓	✓
Other health care/social/housing providers	☐	☑	✓	✓	✓	✓	✓	✓
Significant others name & contact no.								
	☐	☐						
	☐	☐						
	☐	☐						

Do you want your health care records to be stored at the foot of your bed (if No, records should be stored at nursing desk) ☐ Yes ☐ No

Date and Initial

Patient Medications	Y	N	Comments/Variance	Date	Initial
Patient brought own medicines into hospital	☐	☑	Not on any medication.	07.02.10	JM.
Patient consents to using own prescription medicines in hospital	☐	☐			
Patient own prescription medicines have been assessed for suitability for use in hospital	☐	☐			
Patient consents to destroying own prescription medicines which are unfit to use/no longer prescribed	☐	☐			
Patients own medicines sent home	☐	☐			
Patient manages own medicines at home	☐	☐			
If no arrangements:					
Patient uses compliance aids at home	☐	☐	Name of Pharmacy: Tel:		

Patients preferred level of Involvement in Care and Treatment	Level of Involvement				
Aspect of Care	**Informed**	**Consulted with**	**Active participant**	**Date**	**Initial**

Significant Other Contact Details

First Contact Name	Second Contact Name
Alisha Page	
Relationship	Relationship
Sister	
Address	Address
34 High Street Montrose DD10 8AL	
Telephone Numbers (check call bar)	Telephone Numbers (check call bar)
0789 263 0501	

Date	Initial	Date	Initial
07.02.10	JM		

	Date	Initial
Who should be contacted in an emergency or overnight? Alisha.		
Will they contact significant others? ☑ Yes ☐ No	07.02.10	JM.
If not to be contacted at night, alternative arrangements:		
If not contacting all significant others, alternative arrangements:		

	Y	N	Comments/Variance		
Significant other present on admission	☐	☐	Name & Relationship to patient		
If no to above, note date and time significant other notified of patients admission					

Name	Relationship	Date Notified	Time Notified	Date	Initial

Consent/Capacity Issues	Y	N	**Comments/Variance**
Patient has capacity to understand and consent to treatment/ care/disclosure of information	☑	☐	Medical Staff Informed Yes ☑ No ☐
If no to above state reason			
Patient unconscious	☐	☐	
Medically verified incapacity	☐	☐	
Appointed welfare guardian	☐	☐	Contact details:
Legal authority to consent to medical treatment	☐	☐	Verification
Legal authority for finance affairs	☐	☐	Verification
Independent Advocate	☐	☐	Contact details:
Living will / advance directives	☐	☐	Verification
Date & Initial:			

Multi-Disciplinary Notes

Date	Time		Initial
8/2/10	21^{00}	Not informed of any changes to interventions by medical staff.	Rw
09/02/10	0530	Stacey reported some nocturia @ bed time, bed pan & foil bowl provided for sample, not managed to obtain as yet. No complaints of pain or nausea, Stacey informed myself that the Dr she seen, ? who, had said she may be for diagnostic lap today (09.02.10). No information was relayed to nursing staff, but fasted from mid night just in case.	CW
	14^{30}	S/B medical staff - commenced on Trimethoprim for a UTI - MSSU to lab. For HVS - to attend practice nurse. Due to her son being admitted to hospital she has been discharged and is to go to her GP for referral if feels unwell.	Rw

Multi-Disciplinary Notes

Date	Time		Initial

Abbreviations

#	Fracture
AF	Atrial Fibrillation
AXR	Abdominal X-ray
BM	Blood Glucose Monitoring
BO	Bowels Open
BP	Blood Pressure
C&S	Culture and Sensitivity
C Diff	Clostridium Difficile
CAT/CT	Computerised Axial Tomography
COPD	Chronic Obstructive Pulmonary Disease
CPR	Cardio Pulmonary Resuscitation
CCU	Coronary Care Unit
CSU	Catheter Specimen of Urine
CVP	Central Venous Pressure
CXR	Chest X-ray
DNS	District Nursing Service
DOB	Date of Birth
DVT	Deep Vein Thrombosis
ECG	Electrocardiogram
Echo	Echocardiogram
EEG	Electroencephalogram
ERCP	Endoscopic Retrograde Cholangio Pancreatography
FBC	Full Blood Count
GCS	Glasgow Coma Scale
GP	General Practitioner
Hb	Haemoglobin
HNPU	Has not passed urine
IDDM	Insulin Dependant Diabetes Mellitus
IHD	Ischaemic Heart Disease
IM	Intra Muscular
INR	International Ration
ITU	Intensive Therapy Unit
IV	Intravenous
IVI	Intravenous Infusion
MDT	Multidisciplinary Team
MEWS	Modified Early Warning Score
MI	Myocardial Infarction
mmHg	Millimetres of Mercury
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphylococcus Aureus
MSSU	Mid Stream Specimen of Urine
N/A	Non applicable
N/G	Naso Gastric
NBM	Nil by Mouth
NH	Nursing Home
NIDDM	Non Insulin Dependant Diabetes Mellitus
NOK	Next of Kin
NW	Ninewells
OGD	Oesophageal Gastric Duodonoscopy
OPA	Out Patient Appointment
OT	Occupational Therapist
P	Pulse
PCA	Patient Controlled Analgesia
PE	Pulmonary Embolus
PEG	Percutaneous Endoscopic Gastrostomy
PMH	Past Medical History
POP	Plaster of Paris
PRHO	Pre Registration House Officer
PRI	Perth Royal Infirmary
Physio	Physiotherapist
PU	Passed Urine
PVD	Peripheral Vascular Disease
R	Respiration
RTA	Road Traffic Accident
SB	Seen by
SC	Subcutaneous
SALT	Speech and Language Therapist
SEWS	Scottish Early Warning Score
SHO	Senior House Officer
SHX	Stracathro Hospital
SPO2	Saturation Pulse Oximetry
SPR	Specialist Registrar
SW	Social Worker
T	Temperature
TEDS	Thrombo Embolic Deterrent Stockings
TIA	Transient Ischaemic Attack
TPN	Total Parenteral Nutrition
TPR	Temperature, Pulse, Blood Pressure
U's & E's	Urea and Electrolyte
USS	Ultrasound Scan
UTI	Urinary Tract Infection
VQ	Ventilation Quotient

Multi-Disciplinary Notes

Date	Time		Initial

Multi-Disciplinary Notes			
Date	Time		Initial

NHS TAYSIDE

PATIENTS' FUNDS AND PROPERTY PROCEDURE

PERSONAL DISCLAIMER NOTICE
LOSS OF PERSONAL EFFECTS

NHS TAYSIDE will not accept any responsibility for loss or damage to any article/personal belongings unless such articles/personal belongings (including cash) have been handed over to and accepted by NHS TAYSIDE for safe keeping and an official receipt given.

I have been given the opportunity to read the above and I do not wish to take advantage of the facilities provided.

Section A

Signed: SEID Date: 07.02.10

Hospital: Ninewells. Ward No/Name: 10

Print Name: STACEY ELLIS

Section B

If this form is being signed on behalf of a patient please state your relationship to the patient:

Signed: _____ Date: _____

Print Name: _____ Relationship: _____

Section C

Witness

Signature: Manenji S/N.

Address: _____

_____

Note for guidance to patients:

It should be understood that when a patient is absent from the ward for treatment (e.g. : x-ray, an operation etc) the safe custody of their property which has not been handed over to NHS TAYSIDE for safe keeping remains their responsibility.

Arrangements are available, whereby, such property (i.e. watches, rings etc) may be handed over to the Nursing staff for safe keeping and appropriate envelopes are available for this purpose.

Name	Stacey Ellis
DOB/CHI	28.04.88 · 0060
Ward	10
Hospital	Ninewells ·

Peripheral Vascular Catheter (PVC) Bundle

NHS Tayside

1. Check the PVCs in situ are still required
2. Removing PVCs where there is extravasation or inflammation
3. Check PVC dressings are intact
4. Consider removal of PVCs in situ longer than 72 hours
5. Perform hand hygiene before and after PVC procedures (ask the patient to confirm this)

NB ensure there are no contraindications for insertion i.e. renal fistula, post breast surgery

CATHETER NO:		State reason for PVC insertion:	IV fluids and pain relief ·					
INSERTION DATE:	07·02·10	Date:	07·02·10	8/2/10				
INSERTED BY (DEPT)	Ambulance Crew ·	PVC still in use	☑ Y Continue ☐ N remove	☐ Y Continue ☐ N remove	☐ Y Continue ☐ N remove	☐ Y Continue ☐ N remove	☐ Y Continue ☐ N remove	☐ Y Continue ☐ N remove
INSERTION SITE:	(R) Hand ·	PVC dressing intact	☑ Y continue ☐ N Renew dressing	☐ Y continue ☐ N Renew dressing	☐ Y continue ☐ N Renew dressing	☐ Y continue ☐ N Renew dressing	☐ Y continue ☐ N Renew dressing	☐ Y continue ☐ N Renew dressing
DRESSING DATED:		Absence of inflammation and or extra-vasation	☑ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter
SIZE/COLOUR:	Pink ·	PVC been inserted for <72 hours	☑ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter
DATE DUE FOR REMOVAL:	10·02·10	Hand hygiene before & after all PVC procedures	☑ Y continue ☐ N Request removal	☐ Y continue ☐ N Request removal	☐ Y continue ☐ N Request removal	☐ Y continue ☐ N Request removal	☐ Y continue ☐ N Request removal	☐ Y continue ☐ N Request removal
INITIAL	JM ·	What was done (circle)	PVC left insitu / PVC removed	☐ PVC left insitu / PVC removed	PVC left insitu / PVC removed	PVC left insitu / PVC removed	PVC left insitu / PVC removed	PVC left insitu / PVC removed
		Initial & Time	JM 0600 ·	(AM)				

IF CATHETER IN PLACE FOR MORE THAN 72 HOURS, STATE REASON WHY:

CATHETER NO:		State reason for PVC insertion:						
INSERTION DATE:		Date:						
INSERTED BY (DEPT)		PVC still in use	☐ Y Continue ☐ N remove	☐ Y Continue ☐ N remove	☐ Y Continue ☐ N remove	☐ Y Continue ☐ N remove	☐ Y Continue ☐ N remove	☐ Y Continue ☐ N remove
INSERTION SITE:		PVC dressing intact	☐ Y continue ☐ N Renew dressing	☐ Y continue ☐ N Renew dressing	☐ Y continue ☐ N Renew dressing	☐ Y continue ☐ N Renew dressing	☐ Y continue ☐ N Renew dressing	☐ Y continue ☐ N Renew dressing
DRESSING DATED:		Absence of inflammation and or extra-vasation	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter
SIZE/COLOUR:		PVC been inserted for <72 hours	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter	☐ Y continue ☐ N Remove catheter
DATE DUE FOR REMOVAL:		Hand hygiene before & after all PVC procedures	☐ Y continue ☐ N Request removal	☐ Y continue ☐ N Request removal	☐ Y continue ☐ N Request removal	☐ Y continue ☐ N Request removal	☐ Y continue ☐ N Request removal	☐ Y continue ☐ N Request removal
INITIAL		What was done (circle)	PVC left insitu / PVC removed	PVC left insitu / PVC removed	PVC left insitu / PVC removed	PVC left insitu / PVC removed	PVC left insitu / PVC removed	PVC left insitu / PVC removed
		Initial & Time						

IF CATHETER IN PLACE FOR MORE THAN 72 HOURS, STATE REASON WHY:

CATHETER NO:		State reason for PVC insertion:									
INSERTION DATE:		Date:									
INSERTED BY (DEPT)		PVC still in use	☐ Y Continue	☐ N remove	☐ Y Continue	☐ N remove	☐ Y Continue	☐ N remove	☐ Y Continue	☐ N remove	☐ Y Continue	☐ N remove
INSERTION SITE:		PVC dressing intact	☐ Y continue	☐ N Renew dressing	☐ Y continue	☐ N Renew dressing	☐ Y continue	☐ N Renew dressing	☐ Y continue	☐ N Renew dressing	☐ Y continue	☐ N Renew dressing
DRESSING DATED:		Absence of inflammation and or extra-vasation	☐ Y continue	☐ N Remove catheter	☐ Y continue	☐ N Remove catheter	☐ Y continue	☐ N Remove catheter	☐ Y continue	☐ N Remove catheter	☐ Y continue	☐ N Remove catheter
SIZE/COLOUR:		PVC been inserted for <72 hours	☐ Y continue	☐ N Remove catheter	☐ Y continue	☐ N Remove catheter	☐ Y continue	☐ N Remove catheter	☐ Y continue	☐ N Remove catheter	☐ Y continue	☐ N Remove catheter
DATE DUE FOR REMOVAL:		Hand hygiene before & after all PVC procedures	☐ Y continue	☐ N Request removal	☐ Y continue	☐ N Request removal	☐ Y continue	☐ N Request removal	☐ Y continue	☐ N Request removal	☐ Y continue	☐ N Request removal
INITIAL		What was done (circle)	PVC left insitu	PVC removed	PVC left insitu	PVC removed	PVC left insitu	PVC removed	PVC left insitu	PVC removed	PVC left insitu	PVC removed
		Initial & Time										

IF CATHETER IN PLACE FOR MORE THAN 72 HOURS, STATE REASON WHY:

CATHETER NO:		State reason for PVC insertion:									
INSERTION DATE:		Date:									
INSERTED BY (DEPT)		PVC still in use	☐ Y Continue	☐ N remove	☐ Y Continue	☐ N remove	☐ Y Continue	☐ N remove	☐ Y Continue	☐ N remove	☐ Y Continue	☐ N remove
INSERTION SITE:		PVC dressing intact	☐ Y continue	☐ N Renew dressing	☐ Y continue	☐ N Renew dressing	☐ Y continue	☐ N Renew dressing	☐ Y continue	☐ N Renew dressing	☐ Y continue	☐ N Renew dressing
DRESSING DATED:		Absence of inflammation and or extra-vasation	☐ Y continue	☐ N Remove catheter	☐ Y continue	☐ N Remove catheter	☐ Y continue	☐ N Remove catheter	☐ Y continue	☐ N Remove catheter	☐ Y continue	☐ N Remove catheter
SIZE/COLOUR:		PVC been inserted for <72 hours	☐ Y continue	☐ N Remove catheter	☐ Y continue	☐ N Remove catheter	☐ Y continue	☐ N Remove catheter	☐ Y continue	☐ N Remove catheter	☐ Y continue	☐ N Remove catheter
DATE DUE FOR REMOVAL:		Hand hygiene before & after all PVC procedures	☐ Y continue	☐ N Request removal	☐ Y continue	☐ N Request removal	☐ Y continue	☐ N Request removal	☐ Y continue	☐ N Request removal	☐ Y continue	☐ N Request removal
INITIAL		What was done (circle)	PVC left insitu	PVC removed	PVC left insitu	PVC removed	PVC left insitu	PVC removed	PVC left insitu	PVC removed	PVC left insitu	PVC removed
		Initial & Time										

IF CATHETER IN PLACE FOR MORE THAN 72 HOURS, STATE REASON WHY:

Stacey Ellis 2804880060 (10)

Multi-Disciplinary Notes

Time		Date	Initial
1100	VI in situ.	7/2/10	cm
	8/2/10 RC remains in situ at present		AP

Time	Multi-Disciplinary Notes	Date	Initial

RECORD OF CARE GIVEN

Name: Stacey Ellis	CHI: 280488 0000	Ward: 10

Treatment Plan Number:

Date	7/2/10			8/2/10														
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials	[illegible]			[illegible]		[illegible]												
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		

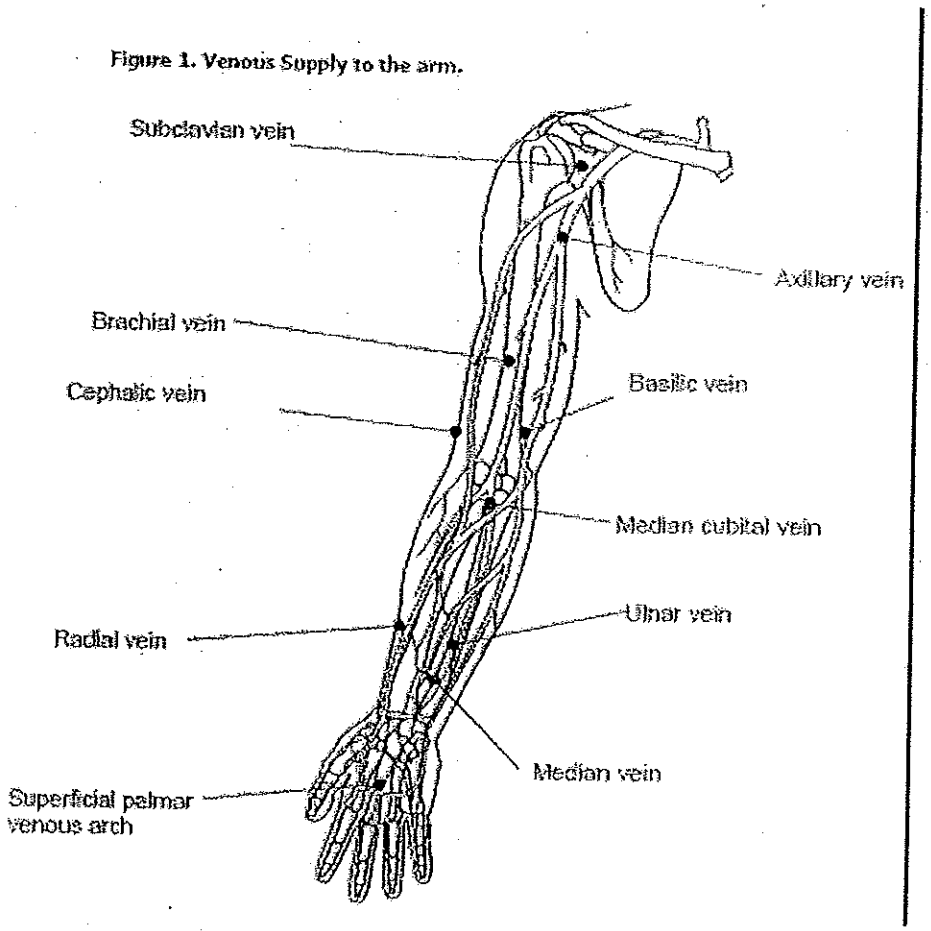
RECORD OF CARE GIVEN

Name	CHI:	Ward:
Treatment Plan Number:		

Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		

Arm Venous System

Figure 1. Venous Supply to the arm.



Peripheral Venous Canulla Sizes and Uses

Colour	Gauge	Approximate flow rate (ml/min)	Clinical Aplication
Brown	14	340	Resuscitation, rapid transfusion of blood or fluids
Grey	16	220	Rapid infusion of blood or fluids
Green	18	110	Blood transfusion, fluid maintenance 2-3 litres per day, I.V contrast using a pump injector
Pink	20	60	Maintenance fluid of 2-3 litres per day, I.V contrast administration and hand injection
Blue	22	40	Cildren, adults with small veins, chemotherapy, long-term medication, administration of Nutriflex Peri
Yellow	24	20	Paediatrics, neonates, chemotherapy

Multidisciplinary Acute Record Of Care: Assessment Reviews

Patients Surname: Ellis	Patients Forename: Stacey	CHI: 28.04.88 0060

NC | No Change | NP | New problem | P | Progress | D | Deterioration | R | Resolved

Assessment	Date & Initial	Date & Initial	Date & Initial	Date & Initial	Date & Initial	Date & Initial	Date & Initial	Date & Initial
1. Airway/Breathing	07.02.10	8/2/10						
Changes to assessment: Code	N.P							
2. Circulation								
Changes to assessment: Code	N.P							
3. Neurological/ Consciousness								
Changes to assessment: Code	NP							
4. Monitoring								
Changes to assessment: Code	NP							
5. Pain								
Changes to assessment: Code	NP	N/C						
6. Fluid Balance								
Changes to assessment: Code	NP	N/C						
7. Communication								
Changes to assessment: Code	NP							
8. Chronic Disease/ Impaired Activity								
Changes to assessment: Code	NA							
9. Infection Control Risk								
Changes to assessment: Code	NA	N/C						
10. Nutritional Assessment								
Changes to assessment: Code	NP	N/C						
11. Alcohol Withdrawal Risk Assessment								
Changes to assessment: Code	NP							
12. Falls Risk/Fall During Hospital Stay								
Changes to assessment: Code	NP							
13. Pressure Area Risk assessment								
Changes to assessment: Code	NP	N/C						
14. Wound Assessment								
Changes to assessment: Code	NP	/						
15. Manual Handling & Mobility Assessment								
Changes to assessment: Code	NP	N/C						

Patients Surname:	Patients Forename						CHI	
16. Personal hygiene assessment	090210	8/2/10						
Changes to assessment: Code	NP							
17. Oral hygiene risk assessment								
Changes to assessment: Code	NP							
Elimination								
18. Bladder Assessment Information								
Changes to assessment: Code	NP							
19. Bowel Assessment Information								
Changes to assessment: Code	NP							
20. Sleep assessment								
Changes to assessment: Code	NP							
21. Spiritual Care Assessment								
Changes to assessment: Code	NP							
22. Religious/Cultural assessment								
Changes to assessment: Code	NP							
23. Psychological Assessment								
Changes to assessment: Code	NP							
24. Learning disability assessment								
Changes to assessment: Code	NP							
25. Discharge assessment								
Changes to assessment: Code	NP	N/C						
26. Integrated care pathways								
Changes to assessment: Code	NP							
27. Use of bedrails								
Changes to assessment: Code	NP							
28. Medication								
Changes to assessment: Code	NP							
29. Patient requires orientation to clinical area (All patients admitted to hospital)								
Changes to assessment: Code	NP							

Name Stacey Ellis	CHI: Ward: 28.04.88. 0060	nd 10	
10A MUST and Nutritional assessment (to be completed within 24 hours of admission)			
Data gathered from: Patient ☑ Other ☐ Specify			
Malnutrition Universal Screening Tool (MUST) adapted from BAPEN	**Measures and Scores**	**Initial**	**Date**
Height Method height recorded • Stadiometer • Self-reported height (if reliable and realistic) • Ulna Length	1 m 58 cm ☐ ☑ ☐	JM	07
Weight Actual Weight recorded Are there any factors affecting weight e.g. ascites, oedema or an amputation. **Please specify:** Patients usual weight	46 Kg 46 Kg	JM	07
BMI score recorded	18 Kg/m2	JM	02
STEP ONE BMI >20 (>30 obese) Score = 0 BMI 18.5-20 Score = (1) BMI < 18.5 Score = 2		JM	02
STEP TWO **Unplanned weight loss past 3-6 months** Patient has < 5% weight loss Score = (0) Patient has 5-10% weight loss Score = 1 Patient has >10% weight loss Score = 2		JM	10
STEP THREE Patient is acutely ill and there has been or is likely to be no nutritional intake for>5 days Yes: Score = 2 No: Score = (0)		JM	
STEP FOUR **TOTAL SCORE:** 1		JM	

STEP FIVE **Malnutrition Management Guidelines**	**Interventions**	**Initial**	**Date**
Total MUST score = 0 Yes ☐ Patient is at **low** risk	☐ Repeat screening and record result weekly Document review date on MUST screening score chart ☐ Other: specify		
Total MUST score 1or >1 Yes ☑ Patient is at **medium/ high** risk	☑ Food chart completed for 3 days - once eating ☑ Encourage nutritious meals using a little and often approach ☑ Offer snacks from ward provisions ☑ Offer one standard Build up sachet daily or 3 additional glasses of full fat milk daily (or 1 smoothie and 2 glasses milk) ☑ Document review date and progress in MDT notes ☑ **Review 3 days of food charts to assess intake** **(If intake over 3 days = less than ½ meals, build-up /milk and snacks: refer to Dietician)** ☐ Repeat MUST screening weekly	JM	07 02 10
Immediate dietician referral Yes ☐ Date Referred: Date Seen:	☐ Enteral Feeding ☐ Parenteral Nutrition ☐ Therapeutic Diets- newly diagnosed ☐ Swallowing Problems ☐ Currently receive nutritional support at home		

NHS Tayside Acute Division Malnutrition Universal Screening Tool ('MUST')
And Dietetic Referral Guidelines

STEP 1
BMI score

BMI kg/m²
Score

>20 (>30 Obese)	= 0
18.5 – 20	= 1
< 18.5	= 2

+

STEP 2
Weight loss score

Unplanned weight loss in past 3-6 months (this includes obese patients)

%	Score
<5	= 0
5 – 10	= 1
>10	= 2

+

STEP 3
Nutritional Intake Score

If there has been or is likely to be no nutritional intake for > 5 days.

Score 2

If unable to obtain height and weight, refer to MUST pack for alternative measurements and use of subjective criteria

STEP 4
Overall risk of malnutrition

Add Scores together to calculate overall risk of malnutrition
Score 0: Low risk Score 1: Medium Risk Score 2 or more: High Risk

STEP 5
Management guidelines

0
Low Risk
Routine clinical care

Repeat screening weekly

Medium / High Risk Score
(Including obese patients)

- Encourage with meals* (*using a little and often approach*) and
- Complete food record charts for 3 days and
- Offer snacks from ward provisions
- Offer *one build-up sachet daily or 3 additional glasses of full fat milk (or 1 smoothie and 2 milk)*

Immediate Dietician Referral

- Enteral Feeding e.g. NG/PEG
- Parenteral Nutrition
- Therapeutic Diets e.g. medically diagnosed food intolerance, renal
- Swallowing problems i.e. oesophageal structures / stents, dysphagia
- Currently receiving nutritional support at home

If after 3 days ½ or more of meals and snacks taken, stop food chart, continue to

- Encourage with meals (*using a little and often approach*)
- Offer snacks from ward provisions (*biscuits/toast*)
- Offer *build-up/milk (as above)*

If after 3 days less than ½ meals, *offered build-up or milk* and snacks taken

Repeat Screening Weekly

- If further weight loss is reported or there is no improvement in patient's clinical condition

Refer to Dietitian for further assessment
(please refer to priorities attached)

- Repeat screening weekly
- Continue to encourage with meals, snacks and build-up/milk

Dietetic Department
Telephone:
Bleep:

Adapted from work originally produced by dietitians working in Oxfordshire

STACEY ELLIS 2804188 CCGG (10)

Malnutrition Universal Screening Tool (M.U.S.T) Screening Scores

Document date for review following screening

DATE FOR REVIEW	WEIGHT	B.M.I	STEP 1 SCORE	STEP 2 SCORE	STEP 3 SCORE	STEP 4 TOTAL SCORE	DIETETIC REFERRAL YES/NO	Initial	Date
14.2.10									

Assessment information: 10A Nutritional assessment (to be completed within 24 hours of admission)					
	Y	N	Comments/Variance	Initial	Date
Able to make menu choices independently?	☑	☐		JM	
Any specific religious/cultural/ethnic dietary requirements	☐	☑		JM	
Any food allergies?	☐	☑		JM	
Any specific eating and drinking dislikes?	☐	☑	If Yes: Can identify/choose independently Yes☐ No ☐ If No: Specify dislikes:	JM	
Does the patient take a special diet?	☐	☑	Reason for special diet (please specify):	JM	
Able to take diet and fluid orally and independently?	☐	☑	If No: Will need support to eat and drink ☐ New problem ☐ Old problem ☐ Need for S.A.L.T referral ☐ Patient nauseated ☐	JM	
Patient needs/uses specific equipment to help them with eating or drinking?	☐	☑	New problem ☐ Old problem ☐ Own equipment being brought in: Yes ☐ No ☐ Need for OT referral Yes☐ No ☐	JM	
Patient has specific social/environmental mealtime requirements	☐	☑	Specify:	JM	
Patient is currently receiving nutritional support at home?	☐	☑	Enteral: ☐NG ☐PEG ☐ PEJ Parenteral: ☐Central ☐ Peripheral	JM	
Patient is currently receiving dietary supplements at home	☐	☑	Type:	JM	
Patient needs Dietetic advice/ support (see assessment and referral guidelines)	☐	☑	Reason for referral:	JM	
Patient has dental problem influencing dietary intake	☐	☑	Need for dental referral ☐	JM	

Initial Treatment Plan	Y	N	Interventions /Outcomes	Initial	Date
Give assistance to make menu choices, taking into account particular likes/dislikes	☐	☐	☐ Verbal prompting ☐ Assistance		
Diet kitchen informed of patient's special (therapeutic) dietary requirements?	☐	☐			
Diet kitchen informed of religious/cultural/ethnic dietary requirements	☐	☐			
Arrangements made to ensure patient does not receive foods which they are allergic to	☐	☐	Allergies recorded: ☐ In nursing assessment ☐ On the front of medical notes ☐ On drug kardex ☐ Patient wrist allergy band in situ ☐ All relevant staff informed		
Patient has specific equipment to help them with eating or drinking?	☐	☐	Details: ☐ Own equipment being brought in ☐ Refer to O.T Date referred:		
Give support to eat and drink	☐	☐	Details: ☐ Needs food cut up ☐ Needs fed ☐ Needs help to sit in chair/sit up in bed to eat food ☐ Refer to S.A.L.T Date referred: ☐ Refer to Dentist Date referred: ☐ Initiate nausea treatment/management plan ☐ Other: specify		
Arrangements have been made to meet the specific social/environmental mealtime requirements	☐	☐	Details:		
Patient needs dietetic advice support	☐	☐	☐ Referral completed Await 3-days food charts		
Patient's food supplement requirements:			**Type** **Details:**		
Oral supplements	☐	☐			
NG feeds	☐	☐			
PEG feeds	☐	☐			
PEJ feeds	☐	☐			
Central	☐	☐			
Peripheral	☐	☐			

Nutrition Treatment Plan Reviews

Name	CHI		Ward	
Dates				
Nutrition Treatment Plan	Interventions/ Outcomes	Interventions /Outcomes	Interventions/ Outcomes	Interventions //Outcomes
Give assistance with menu choices taking into account likes/dislikes	Yes ☐ No ☐ ☐ Verbal prompting ☐ Assistance	Yes ☐ No ☐ ☐ Verbal prompting ☐ Assistance	Yes ☐ No ☐ ☐ Verbal prompting ☐ Assistance	Yes ☐ No ☐ ☐ Verbal prompting ☐ Assistance
Specific religious /cultural/ethnic dietary requirements	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Diet kitchen informed of religious/cultural/ethnic dietary requirements	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Arrangements made to ensure patient does not receive foods which they are allergic to	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Diet kitchen informed of patient's special (therapeutic) dietary requirements?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Patient needs nursing support to eat and drink. Detail:	Yes ☐ No ☐ ☐ Needs food cut up ☐ Needs fed ☐ Needs help to sit in chair/sit up in bed to eat food ☐ Refer to S.A.L.T Date referred: ☐ Refer to Dentist Date referred: ☐ Initiate nausea treatment/management plan ☐ Other: specify	Yes ☐ No ☐ ☐ Needs food cut up ☐ Needs fed ☐ Needs help to sit in chair/sit up in bed to eat food ☐ Refer to S.A.L.T Date referred: ☐ Refer to Dentist Date referred: ☐ Initiate nausea treatment/management plan ☐ Other: specify	Yes ☐ No ☐ ☐ Needs food cut up ☐ Needs fed ☐ Needs help to sit in chair/sit up in bed to eat food ☐ Refer to S.A.L.T Date referred: ☐ Refer to Dentist Date referred: ☐ Initiate nausea treatment/management plan ☐ Other: specify	Yes ☐ No ☐ ☐ Needs food cut up ☐ Needs fed ☐ Needs help to sit in chair/sit up in bed to eat food ☐ Refer to S.A.L.T Date referred: ☐ Refer to Dentist Date referred: ☐ Initiate nausea treatment/management plan ☐ Other: specify

Nutrition Treatment Plan	Interventions/ Outcomes	Interventions /Outcomes	Interventions/ Outcomes	Interventions //Outcomes
Patient has specific equipment to help them with eating or drinking?	Yes ☐ No ☐ Own equipment being brought in: Yes ☐ No ☐ ☐ Refer to O.T Date referred:	Yes ☐ No ☐ Own equipment being brought in: Yes ☐ No ☐ ☐ Refer to O.T Date referred:	Yes ☐ No ☐ Own equipment being brought in: Yes ☐ No ☐ ☐ Refer to O.T Date referred:	Yes ☐ No ☐ Own equipment being brought in: Yes ☐ No ☐ ☐ Refer to O.T Date referred:
Arrangements have been made to meet the specific social/environmental mealtime requirements	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Oral supplements	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Artificial feeding requirements	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Malnutrition risk management: Patients who are at medium/high risk	Patient tolerating 1/2 or more than all meals, milkshakes and snacks Yes ☐ No ☐ (if no, refer to dietician)	Patient tolerating 1/2 or more than all meals, milkshakes and snacks Yes ☐ No ☐	Patient tolerating 1/2 or more than all meals, milkshakes and snacks Yes ☐ No ☐	Patient tolerating 1/2 or more than all meals, milkshakes and snacks Yes ☐ No ☐
Referred to Dietitian	Date: Seen:	Date: Seen:	Date: Seen:	Date: Seen:
Other:				
Initials				
Date				

Record of Care Given

Name S. TACEY CALLS	CHI: Ward: 280488 00600 (10)																	
Treatment Plan Number:																		
Date	7.2.10			8/2/10														
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials	KW	W	W	AS		AW												
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
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Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
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Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		
Date																		
Care given	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Initials																		

Multi-Disciplinary Notes

Time	Date		Initial
0440	07.02.10	Patient has a MUST score of 1, fasting at the moment, to remain nil by mouth just now, would require to be on fluid chart once on fluids and diet.	JM.
1100	7/2/10	Remains NBM. IVI in situ.	KM
1800	7/2/10	IVI Dextrose in progress as NBM	
1900	7/2/10	IV fluids ↓. Nas allowed fluid diet	
0530	09/2/10	fasted from midnight ?? theatre.	

NHS
Quality Improvement Scotland

WRITE, IMPRINT OR ATTACH LABEL

Surname Ellis CHI No 0060
Forenames Stacey Sex Female
DoB 28.04.88
Location Ward 10

Adapted Waterlow Pressure Area Risk Assessment Chart

More than one score/category can be used:

10+= 'At Risk': 15+ = 'High Risk': 20+ = 'Very High Risk'

Complete assessment on admission/1st visit and repeat weekly or if there is a change in individual's condition.

Time of admission 0215

		07.02							
Sex									
Male	1								
Female	2	2							
Age									
14 – 49	1	1							
50 – 64	2								
65 – 74	3								
75 – 80	4								
81+	5								
Build/Weight for Height (BMI=weight in Kg/height in m²)									
Average – BMI 20-24.9	0								
Above average – BMI 25-29.9	1								
ese – BMI > 30	2								
elow average – BMI < 20	3	3							
Continence									
Complete/catheterised	0	0							
Incontinent urine	1								
Incontinent faeces	2								
Doubly incontinent (urine & faeces)	3								
Skin Type – Visual Risks Area									
Healthy	0	0							
Tissue paper (thin/fragile)	1								
Dry (appears flaky)	1								
Oedematous (puffy)	1								
Clammy (moist to touch)/pyrexia	1								
Discoloured (bruising/mottled)	2								
Broken (established ulcer)	3								
Mobility									
Fully mobile	0	0							
Restless/fidgety	1								
Apathetic (sedated/depressed/reluctant to move)	2								
Restricted (restricted by severe pain or disease)	3								
Bedbound (unconscious/unable to change position/traction)	4								
air bound (unable to leave chair without assistance)	5								
utritional Element									
Unplanned weight loss in past 3-6 months									
< 5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2	0							
BMI >20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2								
Patient acutely ill or no nutritional intake > 5 days	2								
Special Risks – Tissue Malnutrition									
Multiple organ failure/terminal cachexia	8	0							
Single organ failure e.g. cardiac, renal, respiratory	5								
Peripheral vascular disease	5								
Anaemia = Hb < 8	2								
Smoking	1								
Special Risks – Neurological Deficit									
Diabetes/ MS/ CVA/ motor/ sensory/ paraplegia *Max 6*	4-6	0							
Special Risks – Surgery/Trauma									
On table > 6 hours	8	0							
Orthopaedic/ below waist/spinal (up to 48 hours post op)	5								
On table > 2 hours (up to 48 hours post op)	5								
Special Risks – Medication									
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4	0							
Total Score		6							
Date		07.02							
Initials		JM							
Time		0215							

Ensure plan of care is implemented / reviewed for all identified areas of concern.

EPUAP PRESSURE ULCER CLASSIFICATION

GRADE	VISUAL DESCRIPTION
1	Apply light finger pressure to the site, remove finger, and score 1 if: Non-blanchable erythema of intact skin. Discoloration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly in individuals with darker skin.
2	Partial thickness skin loss or damage involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.
3	Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.
4	Extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures with or without full thickness skin loss.

INITIAL ASSESSMENT (TO BE PERFORMED WITHIN 6 HOURS OF ADMISSION)

DATE & TIME	Evidence of skin pressure damage on admission (Grade 1 & above)	Treatment plan initiated	Initials
4.2.10 11:00	(NO) YES – Grade = Consider photo / tracing of ulcer	NO (YES)	[illegible]

PRESSURE ULCER RECORD

Date/Time	Ulcer Location	EPUAP Grade	Recorded on AIM (Grade 2 & above) incident reference number_____	Initials

* Grade 2 ulcers and above with broken skin should have separate Wound Assessment / Treatment Plans. All Grade 2 ulcers and above must be recorded as a Clinical Incident *

Pressure Ulcer Prevention Treatment Plans

The use of clinical judgement is paramount when deciding on pressure ulcer prevention. The following triggers should be used when considering nursing interventions

Pressure ulcer risk assessment performed using recognised tool (Waterlow NATVNS) and skin assessment performed using EPUAP pressure ulcer classification system within 6 hours from the beginning of the episode of care

Waterlow <10 No evidence of current pressure damage No history of pressure ulcers Patient mobile	Waterlow >10 Grade 1 or 2 pressure ulcer Patient mobile	Waterlow >10 Grade 3 or 4 pressure ulcer Patient unable to be re-positioned
Patient not at risk of pressure ulcer	Patient at risk of pressure ulcer and/or further damage	[illegible]
TREATMENT PLAN A • No special mattress intervention required • Patient encouraged to check their own skin, if appropriate and with education from registered nurse • Patient will independently change position, if appropriate and with education from registered nurse • Re-assess risk factors on each shift and re-assess Waterlow weekly or if there are changes in the patient's general condition, skin condition or treatment • Re-assess skin if there are changes in the patients general condition, skin condition, theatre, medication or [illegible]covery	**TREATMENT PLAN B** • Profiling bed with high specification foam mattress e.g. Softform 26st, Softform Premier 39st • Patient actively mobilised when possible • Patient provided with information leaflet on pressure area care and ulcer prevention • Patients who can re-position themselves where possible will be shown measures to relieve pressure whilst in bed or seated under the supervision and advice of nursing/AHP staff and utilising these methods each hour • Patient to stand mobilise or re-position regularly when sitting in chair • Wheelchair users encouraged to use a mirror to inspect areas that they find difficult to see • Patients who have their own pre-determined and effective routine will have their knowledge and routine documented and continued • Document re-positioning frequency on nursing intervention sheet • Inspect skin condition when re-positioning and carrying out general care and document changes • Document type of skin cleansers and moisturisers on the intervention sheet • Re-assess risk factors each shift and document changes to the waterlow score on intervention sheet • Document type of bed and mattress on the nursing intervention sheet	**TREATMENT PLAN C** • Profiling bed with alternating pressure (AP), continuous low pressure (CLP) or Softform premier/active mattress • Patient actively mobilised when possible • Patient/carers given information leaflet on pressure area care and ulcer prevention in bed and when seated • Patients who can re-position themselves where possible will be shown measures to relieve pressure whilst in bed or seated under the supervision and advice of nursing/AHP staff and utilising these methods each hour • Patients with grade 3 / 4 ulcer on the sacral area will be discouraged from sitting in a chair for prolonged periods, and the profiling chair function of the bed utilised when possible instead • Document re-positioning frequency on nursing intervention sheet • Inspect skin condition when re-positioning and carrying out general care and document changes • Re-assess risk factors each shift and document changes to the waterlow score on intervention sheet • Document type of skin cleansers and moisturisers on the intervention sheet • Document type of bed and mattress on the nursing intervention sheet

STACEY ELLIS 280488 CCDC (10)

Ongoing Nursing Interventions Please record progress notes on the nursing progress record

- Identify treatment plan in use, A,B,C,
- Waterlow score
- re-assessment and re-positioning schedules
- Type of mattress in situ
- Evaluate interventions, using EPUAP classification when describing pressure ulcers

Date Time	Interventions	Initial	Discontinued Date/initial
07.02.10 05.00	Treatment Plan A implemented.	JM	
7.2.10 11.00	Waterlow 6.		
	Independently mobile		
	Soft - foam mattress		
		JM	

Progress

Pressure Ulcer progress continued

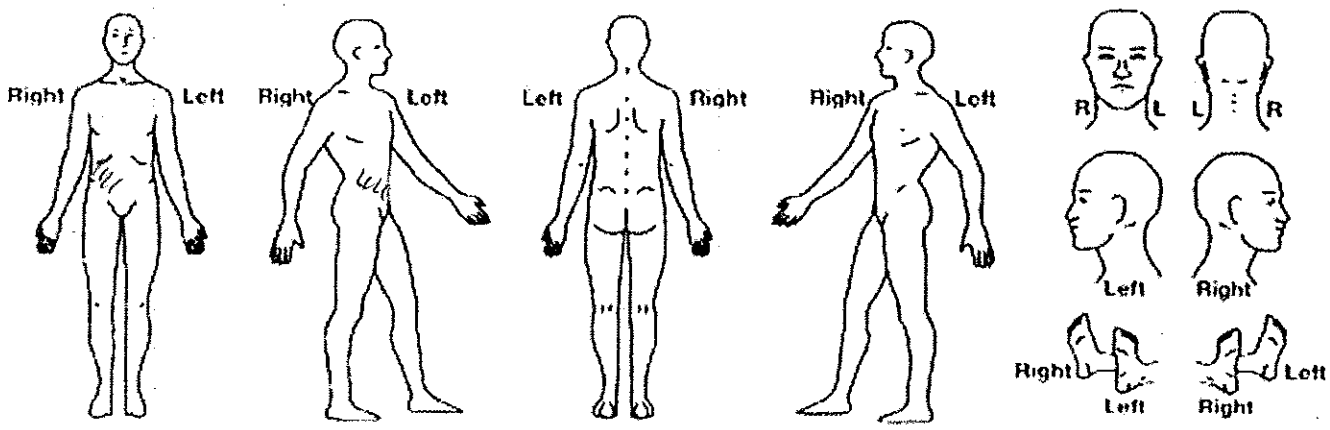
NAME:	CHI:	WARD:
Ellis Stacey	28 04 88 0060	10

Holistic Assessment : 5 Pain Management Date completed:-

To be carried out at pre-assessment clinic, on or soon after admission and repeat when pain is problematic.

Relevant Medical History	Underlying condition / Reason for admission
	RS. Abdominal pain

Pain Assessment	Y	N	Comments/Variance
Can/ does the patient report pain?	✓		If YES, Commence pain assessment chart. If unable to report pain see Pain Management Guidelines. If NO, continue assessment form top of page 2.
Location. Can the patient locate the Pain?	✓		Please mark the location(s)



	Y	N	
Is the pain referred to other parts of the body?	✓		If yes, decribe. round to back.
Description. Ask the patient to describe the pain in their own words.			e.g. burning, shooting, tingling, throbbing etc. sharp
nset / duration How long has the patient had this pain? Is the pain constant/ intermittant?			Has the pain changed in the last 24 hours. Document interventions that may account for an increase in pain e.g dressing changes, physiotherapy, changes to analgesia. 24 hours constant.
Influencing factors Does anything make the pain better?			e.g heat, cold, analgesia, positioning, TENS. analgesia
Does anything make the pain worse?			e.g coughing, movement, certain positions. no.
What impact does the pain have on activities of daily living?			Is the patient achieving their expected goals?
Is this a chronic pain problem?			If Yes, consider chronic pain referral

Assess	Comments/Variance
Any allergies/ side effects from analgesia?	Which pain killer? What effect did it have.

Current and previous analgesia (2)	Analgesia prior to admission				Current Analgesia			
Has the patient been taking analgesia prior to admission? Contact Acute Pain Team if known substance abuse	Drug	Dose	Route	Freq	Drug	Dose	Route	Freq

Treatment Plan	Nursing Intervention		
	Yes	No	
Pain assessment chart commenced Analgesia prescribed regularly Ensure analgesia has not been withheld Has the analgesic ladder been followed Consider pre-emptive anti-emetic, laxative			
Assessment completed by: Sign	Initial	Date	Reason for assessment – please circle **Pre- admission** **on admission** **Problem**

Treatment Plan	Initial	Date
Treatment Plan Review		
Treatment Plan Review		
Treatment Plan Review		

Stacey Ellis 230488 0060 (10)

PAIN MANAGEMENT CARE PLAN MULTIDISCIPLINARY NOTES.

DATE	TIME	COMMENTS	INITIAL
7.2.10	11[00]	Tramadol 50mg IV given on request.	KEH
	15[00]	Pain free at present	CO
8/2/10	AM	Continues on regular analgesia	[illegible]

NHS Tayside

PAIN ASSESSMENT CHART

PAIN MANAGEMENT BUNDLE

*P*AIN?
*A*SSESSMENT
*I*NTERVENTION
*N*OW EVALUATE
*G*OALS
*O*VERVIEW

Ward 10 Mr. Jones Cons

Surname Ellis 0060 Unit No

First Name Stacey 28.04.88 D of B

Address female Sex

MPI No

NURSING OBSERVATIONS

With routine observations of vital signs, before and after administration of breakthrough analgesia / ant-emetics and linked to activities

Pain Score
0 = No Pain at Rest or on Movement
1 = No Pain at Rest, Slight Pain on Movement
2 = Intermittent Pain at Rest
Moderate Pain on Movement
3 = Continuous Pain at Rest
Severe Pain on Movement

Sedation Score
0 = None (Patient Alert)
1 = Mild (Occasionally drowsy, easy to arouse)
2 = Moderate (Frequently drowsy, easy to arouse)
3 = Severe (Somnolent; difficult to arouse)

Nausea & Vomiting Score
0 = No nausea or vomiting
1 = Nausea only
2 = Vomited once
3 = Vomited more than once

ACTIVITY GOALS - Discuss and set with Patient

To remain pain free.

Are activity goals being achieved? YES ☐ NO ☐ *If No due to pain, review analgesia plan*

DAILY REVIEW BY MEDICAL STAFF

Review previous 24 hours. Discuss with the patient.

Are current levels of pain relief / side effects acceptable to the patient? .....

Is patient achieving daily activity goals? .....

How many doses of breakthrough analgesia were administered in the past 24 hours? .....

.....

Are any changes required to analgesia plan? .....

.....

REVIEWED BY:

Sign: ..... Print: ..... Date: .....

Date: .....

EARLY

Time	Pain	Nausea	Sed	Resp	Intervention

Patient Comments re analgesia/tolerance

EVALUATION - eg. 1 hour later

Time	Pain	Nausea	Sed	Resp	Comment	Initial

Nursing Comments re analgesia/activity goals

LATE

Time	Pain	Nausea	Sed	Resp	Intervention

Patient Comments

EVALUATION

Time	Pain	Nausea	Sed	Resp	Comment	Initial

Nursing Comments

NIGHT

Time	Pain	Nausea	Sed	Resp	Intervention

Patient Comments

EVALUATION

Time	Pain	Nausea	Sed	Resp	Comment	Initial

Nursing Comments

Patient Dependency Scores

Name:- Ellis Stacey DOB/CHI:- 28.04.88 0060

	Date: 7.2.10			Date: 8/2/10			Date:			Date:			Date:			Date:			Date:			Date:		
Time	0700	1300	2000	0700	1300	2000	0700	1300	2000	0700	1300	2000	0700	1300	2000	0700	1300	2000	0700	1300	2000	0700	1300	2000
Personal Care	A	A	A		A																			
Feeding	C	C	B		B																			
Mobility	A	A	A		A																			
Nursing Attention	C	B	B		B																			
Involuntary Drainage	—																							
Major intervention	C																							
Special ling																								
No of 'A's	2	2	2		2																			
No of 'B's		1	2		2																			
No of 'C's	3	1																						
Dependency Score	3	2	2		2																			

Kw

Dependency 1 = Four 'A' scores
Dependency 2 = 'A' and 'B' scores and not more than one 'C' score
Dependency 3 = Two or Three 'C' scores
Dependency 4 = Four or more 'C' scores
Dependency 5 = Specialling

Patient Dependency Classification

Acute Surgical Admissions Unit Ward 9, Ninewells Hospital,
Record categories for each component to determine Dependency Score on chart overleaf. Update three times per day at the end of each shift (0700- 1300-2000)

PERSONAL; CARE COMPONENT

A = Independent no supervision required
B = Requires some assistance
May require supervision or assistance due to physical or mental disability.
May be restricted due to appliances.
C = Fully dependant for bathing.

FEEDING COMPONENT

A = Patient can feed him or herself
B = Partial help required
May need help to position or cut up food.
Opportunity used to give teaching on diet.
C = Complete help required or Nil by Mouth
Includes patients requiring Enteral / Parenteral Nutrition.

MOBILITY COMPONENT

A = Up and about or fully independent in a wheelchair
Also patients who have learned to manage tubes or appliances.
B = Bedrest / Up with assistance.
C = Completely dependant for positioning, support and mobility.
Requires two hourly turning / positioning.
Restless / confused patient who is in danger of falling out of bed.

NURSING ATTENTION

A = 3 or 4 times per shift.
For routine observations, medications, psychological support.
B = Every 2 – 4 hours.
May include special procedures, tests.
C = Hourly / constant.
Acutely ill or Post-op patient requiring constant observation.
May also include support of distressed relatives.

ADDITIONAL DETERMINERS (Include if Indicated only)

C = INVOLUNTARY DRAINAGE
Includes incontinence, persistent vomiting, haemorrhaging
Uncontrolled ostomy or fistula drainage.
C = MAJOR INTERVENTION
Admission procedure
Preparation for surgery / procedures
Escort away for more than 4 hours
Requires more than normal psychological support.
C = SPECIALLING
Requires the constant presence of a nurse.

Adapted from (1) Criteria for Care – Ball & Goldstone, Newcastle Polytechnic 1984
(2) Hospital Systems Study Group – Jackson & McKague 1979

DAILY IV FLUID PRESCRIPTION AND FLUID BALANCE CHART

Date 070210

For Incompatibilities and Rate of Flow — See Overleaf

Ward/Clinic/Hosp. Wherrelly Lucille Jones Cons.

D D M M Y Y C.H.I. No. 280488 0060

Surname ELLIS

First Name Stacey M. State

Address Sex

G.P. & Address (G.P. Requests only)

USE BLOCK LETTERS OR PATIENT LABEL

Bottle No.	FLUID TYPE	FLUID Amount ml.	Rate of Flow per hour ml/hr	Batch No.	ADDITIONS (Sign here if Drugs added subsequently)	Use 24hr Clock Start	Use 24hr Clock Finish	Prescribed by (Doctors Signature) / Administered by (Signature)
	Nacl 0.9%	500ml	4°	09K19T5B			1330.	JM
	Nacl 0.9%	500ml	4°	[illegible]		[illegible]		
102	5% DEXTROSE	500	4°	09L04E1T [illegible]		1400		
	5% DEXTROSE	500	4°					

THIS CHART MAY BE DESTROYED ON DISCHARGE OF PATIENT PROVIDED NO RECORDINGS ARE MADE ABOVE THIS LINE

24hr clock Time	INTAKE in ml. I.V.	INTAKE in ml. ORAL	OUTPUT in ml. Urine	Vomit	Aspirate	Fistulae	Drain	Stool	COMMENTS
			PO'd x2.						
8			5ca						
10									
12									
14	500.								BM 3.6mmol
16									BM 6.5 mmol
18									
20									
			Dud						BM 3.8
22									BM 6.7
24									
TOTALS									

SPECIAL INSTRUCTIONS:

I.V. Total ..... Oral Total ..... } Total Intake .....

Balance ..... Total Output .....

Known Drug Sensitivity — or Adverse Reaction

1. 2.

THB (MR) 29 Rev.8/92

INCOMPATIBILITIES OF DRUGS

Precautions –

Do NOT *add Drugs to the following*

AMINO ACID SOLUTIONS
LIPID EMULSIONS
MANNITOL SOLUTIONS – *check solution has not crystallised*
WHOLE BLOOD OR BLOOD PRODUCTS

RATE OF FLOW (for 500ml)
PLEASE CONSULT OUTER COVER OF THE IV SET

POTASSIUM CHLORIDE

A standard solution of 0.3% Potassium Chloride in 5% Dextrose solution or 0.9% Sodium Chloride solution containing 40 millimoles of K^+ *per litre is available. Normally not more than* **80 millimoles K^+ (6 grams Potassium Chloride)** *should be infused in 24 hours.*

CONSULT THE PHARMACY DEPARTMENT *about the addition of drugs to infusion solution. Remember to* **ensure good mixing** *fter adding drugs to an infusion solution. Following the addition of a drug to an infusion fluid remember to affix a* **"Drug Additive" Label** *to the container.*
Infuse solution as soon as possible after the addition of drug(s).

ANTIBIOTICS – PREFERABLY AVOID ADMINISTRATION BY INTRAVENOUS INFUSION
To achieve Therapeutic Levels – ADMINISTER BY BOLUS INJECTION

ON OCCASIONS OF NECESSITY REFER TO TABLE BELOW OR SEEK ADDITIONAL INFORMATION

CEPHALORIDINE	TETRACYCLINES, ERYTHROMYCIN *incompatible*
ERYTHROMYCIN LACTOBIONATE	*Should only be added to IV Fluids after reconstitution with water for injection* (See package insert for full details) NO *other drugs to be added to infusion*
GENTAMICIN	**Do not add to Infusion Fluids.** *Give as a bolus injection*
HEPARIN	*Add* **preferably** *to* SODIUM CHLORIDE 0.9% *Solution* ANTIBIOTICS, HYDROCORTISONE *incompatible*
HYDROCORTISONES *e.g. Sodium Phosphate* *Sodium Succinate preparations*	ANTIBIOTICS, HEPARIN *incompatible*
PENICILLINS *e.g. Ampicillin* *Benzylpenicillin*	*Add* **only** *to* **Sodium Chloride 0.9%** *Prepare immediately before administration.* **Infuse within 4 hours. Do not mix with other drugs.**
TETRACYCLINES	NO *other drugs to be added to infusion.* *Do* NOT *add to solutions containing* **Calcium.**

Staff should use SBAR in all communications relating to clinical matters.

Definition
- **S ituation**
- **B ackground**
- **A ssessment**
- **R ecommendations**

Early Warning Score 4 or more or new red risk
or **concern with a patients condition**

▼

Inform Nurse in Charge Immediately
Establish Urgency of Clinical Situation
Initiate Treatment/Intervention

▼

Nurse in Charge unable to initiate Treatment/Intervention

▼

Determine level of clinician required
Contact Clinician/ HAN Practitioner
State the appropriate response time
based on urgency of clinical situation

▼

Clinician/HAN Practitioner unable to provide
Review/Treatment within required response time
or Patient Deteriorating

▼

Early Warning Score 6 or more
or rapidly deteriorating patient

▼

Call appropriate Registrar for immediate review

▼

Patient re-assessed and
treatment initiated

NO →

Registrar unable to
attend immediately
or SEWS increases by 2 or more

▼

Patients clinical condition/score improves

NO →

Call appropriate Consultant.
Consider ICU
referral/review of treatment plan

▼

Continue treatment and
SEWS scoring as required

Pain Assessment & Management Guidelines

Pain Score:

score 0 = No Pain at Rest
No Pain on Movement

score 1 = No Pain at Rest
Slight Pain on Movement

score 2 = Intermittent Pain at Rest
Moderate Pain on Movement

score 3 = Continuous Pain at Rest

Nausea Score (0-3):

0 = No nausea or vomiting
1 = Nausea only
2 = Vomiting once
3 = Vomiting more than once

For Acute and Chronic Pain
For pain score of 2 or more, implement pain assessment chart and complete Assessment Information 5: Pain Management. Refer to Pain Management Guideline/Mini-guidelines.

For Cancer Related Pain
For pain score of 2 or more, refer to Palliative Guidelines

THBMR-149

NHS Tayside

SBAR Record

Date	Time	Situation / Background	Recommendation / Action	Initials

Management Plan / Local Exclusions

Date	Management of SEWS Observations	Signed

SEWS KEY 0 | 1 | 2 | 3

SEWS 0 - 1 : Routine Observation:- state frequency:
2 - 3 : Inform Nurse in Charge and hourly observation
4 or new red risk : See flow chart overleaf and monitor patient

NAME: Stacey Elkins

D.O.B.: 28.04.88 006

WARD:

ADMISSION DATE:

DATE:		07/02				31/10				9/12	
TIME:		0215	0635	1045	1830	2/1 2½		1430	2204	0746	
RESP. RATE	36+										36+
	31 - 35										31 - 35
	21-30										21-30
	9 - 20	17	17	16	17	16	16	16	17	16	9 - 20
	≤ 8										≤ 8
SpO_2	93+	100	98	98	96	97	97	96	98	97	93+
	90 - 92										90 - 92
	85 - 89										85 - 89
	< 85										< 85
Inspired O_2%	%	A	A	A	A	A	A.	A	Air	Air	%
TEMP	39°										39°
	38°						38.4				38°
	37°	03		03	37.3	37.6	37.4		37.4	37.1	37°
			oral								
	36°										36°
	35°										35°
	34°										34°
SEWS SCORE uses Systolic BP	210										210
	200										200
	190										190
	180										180
	170										170
	160										160
	150										150
	140										140
	130										130
BLOOD PRESSURE	120	113		115		99	111	114			120
	110		105		104				101	104	110
	100										100
	90										90
	80										80
	70	66	60	63	61	71		76	55	55	70
	60										60
	50						57				50
HEART RATE	> 170										> 170
	160										160
	150										150
	140										140
	130										130
	120										120
	110										110
	100										100
	90	89		84		90		86	83	85	90
	80		77		72		70				80
	70										70
	60										60
	50										50
	40										40
	30										30
NEURO RESPONSE	Alert	A	A	A	A	A	A	A	A	A	Alert
	Verbal										Verbal
	Pain										Pain
	Unresp										Unresp
UO < 30mls/hr (3hrs+)											UO < 30
SEWS SCORE (with all obs)		0	0	0	0	1		1		0	SEWS
BG					3.6	3.8	6.4				BG
PAIN (guidance for scoring and management overleaf)	3										3
	2							1		✓	2
	1	1	1	1	1	1	0		0		1
	0										0
NAUSEA SCORE (0-3)		1	0	0	0	0	0	1	0	0	NAUSEA SCORE
Initial		SM	SM	[illegible]		[illegible]		[illegible]		[illegible]	Initial