CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: COPD

Comment: smoker 10/day with persistent breathlessness and xough. emphysema on recent cxr ?copd

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Closed fracture metatarsal	-	27-Mar-2018	27-Mar-2018
Folic acid deficiency	-	03-Jul-2017	03-Jul-2017
Folic acid deficiency	-	03-Jul-2017	03-Jul-2017
Leg cramps	-	23-Jun-2017	23-Jun-2017
Alcohol dependence syndrome	-	30-Mar-2017	30-Mar-2017
Acute alcoholic hepatitis	Mild	24-Mar-2017	24-Mar-2017
Jaundice - symptom	-	21-Mar-2017	21-Mar-2017
Epilepsy NOS	-	01-Aug-2016	01-Aug-2016
Sciatica	-	16-May-2016	16-May-2016
[X]Accidental drug overdose / other poisoning	Paracetamol	14-Apr-2014	14-Apr-2014
Acute pancreatitis	-	31-May-1996	31-May-1996
Epilepsy	-	05-Dec-1993	05-Dec-1993
[X]Stabbing	-	23-Jul-1993	23-Jul-1993
Pneumothorax	Right	23-Jul-1993	23-Jul-1993
Enuresis	-	06-Oct-1980	06-Oct-1980
O/E -raised intracranial press	-	12-Dec-1979	12-Dec-1979
Fracture of metacarpal bone	-	04-Oct-1979	04-Oct-1979
Social worker involved	-	16-Feb-1979	16-Feb-1979

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Magnetic resonance imaging	of brain is normal	05-Jan-2021	05-Jan-2021
Helicobacter serology positive	-	21-Mar-2017	21-Mar-2017
[SO]Zygomatic complex of bones (Right)	Displaced	13-Jan-2016	13-Jan-2016

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Brivaracetam Tablets 50 mg	56	56 tablet	ONE TO BE TAKEN AT NIGHT	-	09-Dec-2022	10-Jan-2023
Topiramate Tablets 50 mg	56	56 TABLET	TAKE ONE DAILY	-	05-Oct-2021	13-Jan-2022
Dihydrocodeine Tablets 30 mg	112	112 TABLET	ONE TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN NECESSARY USE SPARINGLY - MONITOR FREQUENCY OF REQUESTS	-	10-Sep-2021	04-Jan-2023
Naproxen Tablets 500 mg	28	28 TABLET	ONE TO BE TAKEN TWICE A DAY	-	25-May-2021	04-Jan-2023
Thiamine Tablets 50 mg	224	224 TABLET	ONE TO BE TAKEN FOUR TIMES DAILY	-	11-Mar-2021	02-Dec-2022

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Amoxicillin Capsules 500 mg	15	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY FOR 5 DAYS	-	06-Jan-2023	06-Jan-2023
Beclometasone Aqueous nasal spray 50 micrograms/actuation	200	200 DOSE	2 PUFFS EACH NOSTRIL TWICE DAILY FOR 2 WEEKS - TO DECREASE TO ONE PUFF WHEN SYMPTOMS SETTLED	-	06-Jan-2023	06-Jan-2023
Ketoconazole Shampoo 2 %	120	120 ML	FOR TREATMENT APPLY TWICE WEEKLY FOR 2-4 WEEKS (FOR PROPHYLAXIS APPLY ONCE EVERY 1-2 WEEKS)	-	21-Dec-2022	21-Dec-2022
Otomize Spray	1	1 SPRAY	ONE SPRAY INTO AFFECTED EAR(S) THREE TIMES A DAY FOR 7 DAYS	-	21-Dec-2022	21-Dec-2022
Brivaracetam Tablets 25 mg	28	28 tablet	ONE TO BE TAKEN AT NIGHT FOR 4 WEEKS FROM 09/12/2022 THEN INCREASE DOSE TO 50MG	-	09-Dec-2022	13-Dec-2022
Ralvo Medicated Plaster 700 mg	30	30 patch	APPY TO AFFECTED AREA FOR 12 HOURS THEN HAVE 12 HOURS OFF	-	02-Dec-2022	02-Dec-2022
Ketoconazole Shampoo 2 %	120	120 ML	FOR TREATMENT APPLY TWICE WEEKLY FOR 2-4 WEEKS (FOR PROPHYLAXIS APPLY ONCE EVERY 1-2 WEEKS)	-	28-Jul-2022	28-Jul-2022

Blood Pressure

Date Recorded	Systolic	Diastolic
18-Nov-2021	136	73
14-Oct-2021	140	94
29-Jan-2021	148	45
03-Jan-2019	147	79
25-Oct-2018	124	84

Body Measurements

Date Recorded	Height	Weight	BMI
06-Jan-2023	-	59	-
14-Oct-2021	165	61	22.41
10-Sep-2018	165	63	23.14
08-Oct-1999	162	60.328	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Weight (kg):	59	-
Height (m):	165	-
BMI (Weight / Height):	22.41	-
Not interested in stopping smoking:		14-Oct-2021
Rolls own cigarettes, 1.5 oz/wk:		14-Oct-2021
Failed attempt to stop smoking:		14-Oct-2021
Current smoker:		14-Oct-2021
Not interested in stopping smoking:		10-Sep-2018

Alcohol consumption, 45 units/week:		17-Jan-2020
Alcohol consumption, 28 units/week:		10-Sep-2018
Moderate drinker - 3-6u/day:	Alcohol Intake$$.clm - Repeat after an Interval	08-Oct-1999
Aerobic exercise 0 times/week:		14-Oct-2021
Takes inadequate exercise:		14-Oct-2021
Aerobic exercise 0 times/week:		10-Sep-2018
Takes inadequate exercise:		10-Sep-2018

Investigations

Description/Question	Result/Comment	Date
Persistent Cough:	YES	-
Breathlessness:	YES	-
Known COPD:	NO	-
Known asthma:	NO	-
Previous Spirometry:	NO	-
Known current MRSA in sputum:	NO	-
Possible tubercle – if yes, do not refer till clear:	NO	-
Recent chest infection/COPD exacerbation:	YES	-
If Yes Date:	2023-01-06	-
Recent Eye surgery:	NO	-
Smoking history:	Current smoker	-

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

Short acting b-agonist:YES
Long acting b-agonist:NO
Long acting anti-cholinergic:NO
Long acting combined inhaled steroid/long acting b-agonist:NO
Inhaled steroid:NO
Oral steroid:NO
OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Referred By:Referring GP
Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) Scottish

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Neurology - Epilepsy GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
West Glasgow 1053 Great Western Road Glasgow G12 0YN	——	**Hospital** and **hospital address** Hospital location code. G516H Email address

Urgency of referral Routine
Date of referral 05-Dec-2022 **Date sent** 05-Dec-2022

PATIENT DETAILS

Surname	Hughes
Forename(s)	Scott
Title	Mr
Sex	Male
Date of birth	20-Dec-1974
CHI no.	2012746039
Area of Residence	-

Patient's address

Flat 7-6
39 Linkwood Crescent
GLASGOW
G15 7EP

Contact number(s)

Voice: 07787 255 019

101028158544B

Unique Care Pathway Number: 101028158544B

REGISTERED GP DETAILS

Name	Dr Angela Martin		
GMC code	6055734	GP code	02453
Practice name	Garscadden Burn Medical Practice		
Practice code	40436		

Practice address

Garscadden Burn Medical Practice
80-90 Kinfauns Drive
Drumchapel
Glasgow
G15 7TS

Contact number(s)

Voice: 041 211 6100
E-mail: ggc.gp40436clinical@nhs.scot

REFERRING GP DETAILS

Name	Dr. Angela Martin		
GMC code	6055734	GP code	02453
Practice name	Garscadden Burn Medical Practice (40436)		
Practice code	40436		

Practice address

Drumchapel Health Centre
80/90 Kinfauns Drive
Glasgow
G15 7TS

Contact number(s)

Voice: 0141 211 6100

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: No longer on any anti-convulsants

Comment: I wonder if Scott could be seen again for assessment. He has a diagnosis of Epilepsy but also of Alcohol Dependence. He was last seen by yourselves in 2021. At that time he was supposed to be on Topiramate. He came to see me on Friday and told me he has not taken this since February/March. He says he is still taking seizures about once per month, sometimes tonic clonic, sometimes absences. He felt he took more seizures when he was on Topiramate.
Looking back he has had Sodium Valproate, Lamotrigine, Carbamezapine, Zonisamide, Levetiracetam and they have been all been changed because he either felt they didn't work or they didn't agree with him. We have chatted about how his alcohol intake is likely contributing to his seizures and his memory issues.
I am not sure what to suggest with regards to his seizures. Many thanks for seeing him

Dr Angela Martin

Reason for referral

Care type requested: Out Patient

Expected outcome: Advise

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Closed fracture metatarsal	-	27-Mar-2018	27-Mar-2018
Folic acid deficiency	-	03-Jul-2017	03-Jul-2017
Folic acid deficiency	-	03-Jul-2017	03-Jul-2017
Leg cramps	-	23-Jun-2017	23-Jun-2017
Alcohol dependence syndrome	-	30-Mar-2017	30-Mar-2017
Acute alcoholic hepatitis	Mild	24-Mar-2017	24-Mar-2017
Jaundice - symptom	-	21-Mar-2017	21-Mar-2017
Epilepsy NOS	-	01-Aug-2016	01-Aug-2016
Sciatica	-	16-May-2016	16-May-2016
[X]Accidental drug overdose / other poisoning	Paracetamol	14-Apr-2014	14-Apr-2014
Acute pancreatitis	-	31-May-1996	31-May-1996
Epilepsy	-	05-Dec-1993	05-Dec-1993
[X]Stabbing	-	23-Jul-1993	23-Jul-1993
Pneumothorax	Right	23-Jul-1993	23-Jul-1993
Enuresis	-	06-Oct-1980	06-Oct-1980
O/E -raised intracranial press	-	12-Dec-1979	12-Dec-1979
Fracture of metacarpal bone	-	04-Oct-1979	04-Oct-1979
Social worker involved	-	16-Feb-1979	16-Feb-1979

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Magnetic resonance imaging	of brain is normal	05-Jan-2021	05-Jan-2021
Helicobacter serology positive	-	21-Mar-2017	21-Mar-2017
[SO]Zygomatic complex of bones (Right)	Displaced	13-Jan-2016	13-Jan-2016

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Topiramate Tablets 50 mg	56	56 TABLET	TAKE ONE DAILY	-	05-Oct-2021	13-Jan-2022
Dihydrocodeine Tablets 30 mg	112	112 TABLET	ONE TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN NECESSARY USE SPARINGLY - MONITOR FREQUENCY OF REQUESTS	-	10-Sep-2021	01-Dec-2022

Naproxen Tablets 500 mg	28	28 TABLET	ONE TO BE TAKEN TWICE A DAY	-	25-May-2021	01-Dec-2022
Thiamine Tablets 50 mg	224	224 TABLET	ONE TO BE TAKEN FOUR TIMES DAILY	-	11-Mar-2021	02-Dec-2022

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Ralvo Medicated Plaster 700 mg	30	30 patch	APPY TO AFFECTED AREA FOR 12 HOURS THEN HAVE 12 HOURS OFF	-	02-Dec-2022	02-Dec-2022
Ketoconazole Shampoo 2 %	120	120 ML	FOR TREATMENT APPLY TWICE WEEKLY FOR 2-4 WEEKS (FOR PROPHYLAXIS APPLY ONCE EVERY 1-2 WEEKS)	-	28-Jul-2022	28-Jul-2022

Blood Pressure

Date Recorded	Systolic	Diastolic
18-Nov-2021	136	73
14-Oct-2021	140	94
29-Jan-2021	148	45
03-Jan-2019	147	79
25-Oct-2018	124	84

Body Measurements

Date Recorded	Height	Weight	BMI
14-Oct-2021	165	61	22.41
10-Sep-2018	165	63	23.14
08-Oct-1999	162	60.328	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Not interested in stopping smoking:		14-Oct-2021
Rolls own cigarettes, 1.5 oz/wk:		14-Oct-2021
Failed attempt to stop smoking:		14-Oct-2021
Current smoker:		14-Oct-2021
Not interested in stopping smoking:		10-Sep-2018
Alcohol consumption, 45 units/week:		17-Jan-2020
Alcohol consumption, 28 units/week:		10-Sep-2018
Moderate drinker - 3-6u/day:	Alcohol Intake$$.clm - Repeat after an Interval	08-Oct-1999
Aerobic exercise 0 times/week:		14-Oct-2021
Takes inadequate exercise:		14-Oct-2021
Aerobic exercise 0 times/week:		10-Sep-2018
Takes inadequate exercise:		10-Sep-2018

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP
Electronic Attachment Present:No

Social circumstances
Ethnic Origin: (White) Scottish

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Neurology - Epilepsy GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
West Glasgow 1053 Great Western Road Glasgow G12 0YN	——	**Hospital** and **hospital address** Hospital location code. G516H Email address -

Urgency of referral Routine
Date of referral 17-Jan-2020 **Date sent** 17-Jan-2020

PATIENT DETAILS

Surname	Hughes
Forename(s)	Scott
Title	Mr
Sex	Male
Date of birth	20-Dec-1974
CHI no.	2012746039
Area of Residence	-

Patient's address

Flat 7-6
39 Linkwood Crescent
GLASGOW
G15 7EP

Contact number(s)

Voice: 07787 255 019

101020470157T Unique Care Pathway Number: 101020470157T

REGISTERED GP DETAILS

Name	Dr Angela Martin		
GMC code	6055734	GP code	02453
Practice name	Garscadden Burn Medical Practice		
Practice code	40436		

Practice address

Garscadden Burn Medical Practice
80-90 Kinfauns Drive
Drumchapel
Glasgow
G15 7TS

Contact number(s)

Voice: 041 211 6100
Facsimile: 0141 211 6104

REFERRING GP DETAILS

Name	Dr. Peter Cawston		
GMC code	4025508	GP code	07820
Practice name	Garscadden Burn Medical Practice (40436)		
Practice code	40436		

Practice address

Drumchapel Health Centre
80/90 Kinfauns Drive
Glasgow
G15 7TS

Contact number(s)

Voice: 0141 211 6100
Facsimile: 0141 211 6104

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Lost to follow up- poorly controlled refractory epilepsy

Comment: Dear colleagues this man is well known I believe to the West Glasgow epilepsy service, he has difficult to manage epilepsy and has reported intolerance to multiple AEDs listed in previous letters from the clinic. We have reviewed him recently and note that he has stopped taking Levetiracetam 1000mg BD, he reports because of side affects, and continues to have seizures 1-3 times per week, which may either be absence seizures or generalised. He continues to drink spirits at the weekend above recommended levels, but says this has significantly reduced from his previous daily drinking. I have advised him of the importance of safe drinking levels. I have restarted him on Levetiracetam 500mg twice daily, as he seems to have tolerated this in the past, emphasised the risk of SUDEP and the need to engage with the epilepsy service, issued him with a free bus pass form to help him access clinics and signposted him to Epilepsy Connections for support with the practical day to day implications of living with his condition. I would be grateful if he could be reappointed to your service. Thank you kind regards Peter Cawston

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Closed fracture metatarsal	-	27-Mar-2018	27-Mar-2018
Folic acid deficiency	-	03-Jul-2017	03-Jul-2017
Folic acid deficiency	-	03-Jul-2017	03-Jul-2017
Leg cramps	-	23-Jun-2017	23-Jun-2017
Alcohol dependence syndrome	-	30-Mar-2017	30-Mar-2017
Acute alcoholic hepatitis	Mild	24-Mar-2017	24-Mar-2017
Jaundice - symptom	-	21-Mar-2017	21-Mar-2017
Epilepsy NOS	-	01-Aug-2016	01-Aug-2016
Sciatica	-	16-May-2016	16-May-2016
[X]Accidental drug overdose / other poisoning	Paracetamol	14-Apr-2014	14-Apr-2014
Acute pancreatitis	-	31-May-1996	31-May-1996
Epilepsy	-	05-Dec-1993	05-Dec-1993
[X]Stabbing	-	23-Jul-1993	23-Jul-1993
Pneumothorax	Right	23-Jul-1993	23-Jul-1993
Enuresis	-	06-Oct-1980	06-Oct-1980
O/E -raised intracranial press	-	12-Dec-1979	12-Dec-1979
Fracture of metacarpal bone	-	04-Oct-1979	04-Oct-1979
Social worker involved	-	16-Feb-1979	16-Feb-1979

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Helicobacter serology positive	-	21-Mar-2017	21-Mar-2017
[SO]Zygomatic complex of bones (Right)	Displaced	13-Jan-2016	13-Jan-2016

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Levetiracetam Tablets 500 mg	112	112 tablet	ONE TO BE TAKEN TWICE A DAY	-	17-Jan-2020	17-Jan-2020
Folic Acid Tablets 5 mg	56	56 tablet	ONE TO BE TAKEN EACH DAY	-	23-Oct-2018	17-Jan-2020
Thiamine Hydrochloride Tablets 100 mg	168	168 tablet	1 Tab 3 times daily	-	23-Oct-2018	17-Jan-2020

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started

						Date last issued
Co-Dydramol 10/500 Tablets	30	30 tablet	ONE OR TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)	-	17-Jan-2020	17-Jan-2020
Ketoconazole Shampoo 2 %	120	120 ML	FOR TREATMENT APPLY TWICE WEEKLY FOR 2-4 WEEKS	-	14-Jan-2020	14-Jan-2020
Ketoconazole Shampoo 2 %	120	120 ML	FOR TREATMENT APPLY TWICE WEEKLY FOR 2-4 WEEKS	-	31-Oct-2019	31-Oct-2019
Co-Dydramol 10/500 Tablets	30	30 tablet	ONE OR TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)	-	31-Oct-2019	31-Oct-2019

Blood Pressure

Date Recorded	Systolic	Diastolic
03-Jan-2019	147	79
25-Oct-2018	124	84
08-Oct-2018	160	87
10-Sep-2018	165	88
18-Mar-2015	137	83

Body Measurements

Date Recorded	Height	Weight	BMI
10-Sep-2018	165	63	23.14
08-Oct-1999	162	60.328	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Not interested in stopping smoking:		10-Sep-2018
Current smoker:		10-Sep-2018
Rolls own cigarettes, 2 oz/wk:		10-Sep-2018
Current smoker:		06-Sep-2018
Light smoker - 1-9 cigs/day :	no interest in giving up .	18-Mar-2015
Alcohol consumption, 45 units/week:		17-Jan-2020
Alcohol consumption, 28 units/week:		10-Sep-2018
Moderate drinker - 3-6u/day:	Alcohol Intake$$.clm - Repeat after an Interval	08-Oct-1999
Aerobic exercise 0 times/week:		10-Sep-2018
Takes inadequate exercise:		10-Sep-2018

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) Scottish

Signature of referring doctor (or other professional)	**Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Neurology - First Seizure GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
West Glasgow/Gartnavel General Dumbarton Road Glasgow G11 6NT	——	**Hospital** and **hospital address** Hospital location code. G516H Email address -

Urgency of referral Routine
Date of referral 22-Jun-2016 **Date sent** 22-Jun-2016

PATIENT DETAILS

Surname	Hughes
Forename(s)	Scott
Title	Mr
Sex	Male
Date of birth	20-Dec-1974
CHI no.	2012746039
Area of Residence	-

Patient's address

12
Shafton Road
Glasgow
G13 2NE

Contact number(s)

Voice: 0141 463 2816
Voice: 07787255019

101011640293Y

Unique Care Pathway Number: 101011640293Y

REGISTERED GP DETAILS

Name	Dr David Taylor		
GMC code	6055912	GP code	01139
Practice name	Anniesland Medical Practice (18807)		
Practice code	40051		

Practice address

Anniesland Medical Practice
46 Munro Place
GLASGOW
G13 2UP

Contact number(s)

Voice: 0141 954 8860

REFERRING GP DETAILS

Name	Dr. David Taylor		
GMC code	6055912	GP code	01139
Practice name	Anniesland Medical Practice (40051)		
Practice code	40051		

Practice address

46 Munro Place
Glasgow
G13 2UP

Contact number(s)

Voice: 0141 954 8860

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Grand mal seizures

Comment: This patient has recently joined our practice and, unfortunately, there are no old notes available currently. He says he has a long history of epilepsy, which was secondary to brain trauma from boxing. I also note in the past he has had issues with head injuries and had a CT brain on Hogmanay last year for head injury. This showed an orbital fracture but a normal brain. He mentions that he has had epilepsy for 20 years and gets approximately six grand mal seizures a year with weekly absences. He was on a multitude of medication in the past but has not taken any for 8-10 years as he had a high tablet burden. He was drinking 4-5 pints a day and following advice, has reduced this down and is now drinking between 2-4 units per week. Last week, however, separated in time from his alcohol reduction, he had two grand mal seizures. This has given him cause for concern. I would be grateful if you could see him back in the clinic to review his case. I looked on portal for old clinical notes, however, there was none for the epilepsy clinic. He is aware that his alcohol intake needs to stay low. I would be grateful if he could be seen. With thanks.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Co-Codamol 8/500 Tablets	50	50 TABLET	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)	-	22-Jun-2016	22-Jun-2016

Blood Pressure

Date Recorded	Systolic	Diastolic
22-Jun-2016	142	90

Body Measurements

Date Recorded	Height	Weight	BMI
08-Jun-2016	162	60	22.86

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Cigarette smoker, 10 Cigarettes/day:		08-Jun-2016
Cigarette smoker, 10 Cigarettes/day:		03-Jun-2016
Alcohol units per week, 5 U/week:		22-Jun-2016
Aerobic exercise 0 times/week:		08-Jun-2016
Aerobic exercise 0 times/week:		03-Jun-2016

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information
Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Referred By:Referring GP
Electronic Attachment Present:No

Social circumstances
Ethnic Origin: (White) British

Signature of referring doctor (or other professional) **Date**

MEDICINE **PRESCRIPTION FORM**

(6)

Hospital Name: ....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☑

Date 24/3/17 Name (Print) EMMA LYDON

Discharge Prescription Prepared & Reconciled YES ☐

Date ______ Name (Print) ______

Date and time this form prepared:	Sheet No	2nd Prescription in use
__/__/__ Time: ______	....	YES ☐ NO ☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

______

with the following exceptions: ______

Print & Sign: ______ Date: ______

COMMUNITY PHARMACY INFORMATION

Name ______ Tel No. ______

Address ______

Compliance Aid Details ______

Patient consent to share discharge information Y/N

Print & Sign ______

PATIENT DETAILS

2012746039 HUGHES M Scott, S 20/12/1974 12 Shafton Road Glasgow G13 2NE	Height: Weight: Surface area: Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
24/3/17	PABRINEX 1 PAIR OF VIALS		IV	02:00	Emma Lydon	[illegible]	[illegible]

	DATE	24	25	26	27
	MONTH	3	3	3	3

RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

ARE ANTIEMBOLIC STOCKINGS ON PATIENT?
RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

A DRUG: PABRINEX

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☑

DOSE: 1 PAIR OF VIALS | ROUTE: IV | DATE: 24/3/17

PRESCRIBER (PRINT & SIGN): Emmaydon EMMA MOON

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

B DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

C DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE: 24 25 26 27
MONTH: 3 3 3 3

Patient's Own Medicine

H — DRUG: OMEPRAZOLE
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 40mg | ROUTE: ORAL | DATE: 24/3/17 | STOPPED DATE: 27/3 | INITIALS: RH
PRESCRIBER (PRINT & SIGN): Emakulan EMMA LIDDY
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
0700-0900: RC 13 JC W
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

J — DRUG: Thiamine
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☑
DOSE: 100mg | ROUTE: PO | DATE: 25/3 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
0700-0900: —
1200-1400: — RN
2200-2400: —
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

K — DRUG: LEVETIRACTAM
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 500 mg | ROUTE: ORAL | DATE: 27/3/17 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Harte
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

L — DRUG: OMEPRAZOLE
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 20 mg | ROUTE: ORAL | DATE: 27/3/17 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Harte
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

M

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

N

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

P

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

R

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

All Routes: As Required Prescriptions

Patient's Own Medicine

LL

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☑

DRUG: DIAZEPAM

DOSE: 10 - 20mg | ROUTE: ORAL | INDICATION: ALCOHOL WITHDRAWAL

PRESCRIBER (PRINT & SIGN): Emalyden Ellison | MAX.FREQ.: 4 times daily | DATE: 24/3/17

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: AS PER CMAWS

STOPPED DATE: | INITIALS:

																									For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
DATE	24/3	24/3	25/3	25/3	25/3	25/3	25/3	26/3																					
TIME	08	18[illegible]	08	14[illegible]	20	16	14	08[illegible]																					
DOSE	10mg	10mg	10mg	10mg	10mg	10mg	10mg	10mg																					
GIVEN BY	KE	NM	JC	NM	[illegible]	[illegible]	[illegible]	[illegible]																					

MM

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG:

DOSE: | ROUTE: | INDICATION:

PRESCRIBER (PRINT & SIGN): | MAX.FREQ.: | DATE:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

STOPPED DATE: | INITIALS:

																									For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
DATE																													
TIME																													
DOSE																													
GIVEN BY																													

NN

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG:

DOSE: | ROUTE: | INDICATION:

PRESCRIBER (PRINT & SIGN): | MAX.FREQ.: | DATE:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

STOPPED DATE: | INITIALS:

																									For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
DATE																													
TIME																													
DOSE																													
GIVEN BY																													

PP

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG:

DOSE: | ROUTE: | INDICATION:

PRESCRIBER (PRINT & SIGN): | MAX.FREQ.: | DATE:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

STOPPED DATE: | INITIALS:

																									For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
DATE																													
TIME																													
DOSE																													
GIVEN BY																													

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

			Patient's Own Medicine
BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐	**RR** DRUG / DOSE / ROUTE / INDICATION / PRESCRIBER (PRINT & SIGN) / MAX.FREQ. / ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	STOPPED DATE: / INITIALS: / DATE:	DATE / TIME / DOSE / GIVEN BY	For Use Y/N / Qty: / Date: / Assessed by: / Ordered from Pharm.
BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐	**SS** DRUG / DOSE / ROUTE / INDICATION / PRESCRIBER (PRINT & SIGN) / MAX.FREQ. / ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	STOPPED DATE: / INITIALS: / DATE:	DATE / TIME / DOSE / GIVEN BY	For Use Y/N / Qty: / Date: / Assessed by: / Ordered from Pharm.
BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐	**TT** DRUG / DOSE / ROUTE / INDICATION / PRESCRIBER (PRINT & SIGN) / MAX.FREQ. / ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	STOPPED DATE: / INITIALS: / DATE:	DATE / TIME / DOSE / GIVEN BY	For Use Y/N / Qty: / Date: / Assessed by: / Ordered from Pharm.
BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐	**VV** DRUG / DOSE / ROUTE / INDICATION / PRESCRIBER (PRINT & SIGN) / MAX.FREQ. / ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	STOPPED DATE: / INITIALS: / DATE:	DATE / TIME / DOSE / GIVEN BY	For Use Y/N / Qty: / Date: / Assessed by: / Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

2012746039
HUGHES M
Scott, S 20/12/1974
12 Shafton Road
Na Glasgow
G13 2NE
CI

Drug Allergies / Sensitivities None Known ☑ Yes ☐ (provide details below)

6

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Print & Sign your full name clearly against each prescription entry.

4. Time should be recorded in 24hr format e.g. 0600, 1800.

5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.

6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

7. The following metric unit abbreviations must be used –

Milligram = mg Gram = g
Millilitre = ml Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal must be written in full.

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused
(4) Drug not available
(5) Nil by mouth/fasting
(6) Patient unavailable
(7) Patient asleep
(8) Time varied on doctor's instructions
(9) Dose withheld on doctor's instructions
(10) Nausea/vomiting
(11) Unable to swallow
(12) No intravenous access
(13) Patient Self-Administration of Medicine
(14) Other - Record in nursing notes
(15) Prescription clarification required

Cat. No. 40995 Ver 4, 09/2010 GGC0029

Hughes, Scott ID:2012746039 11-MAY-2026 18:02:42 GREATER GLASGOW SITE-QEMIAU ROUTINE RECORD

20-DEC-1974 (51 yr)
Male

Room:
Loc:1302

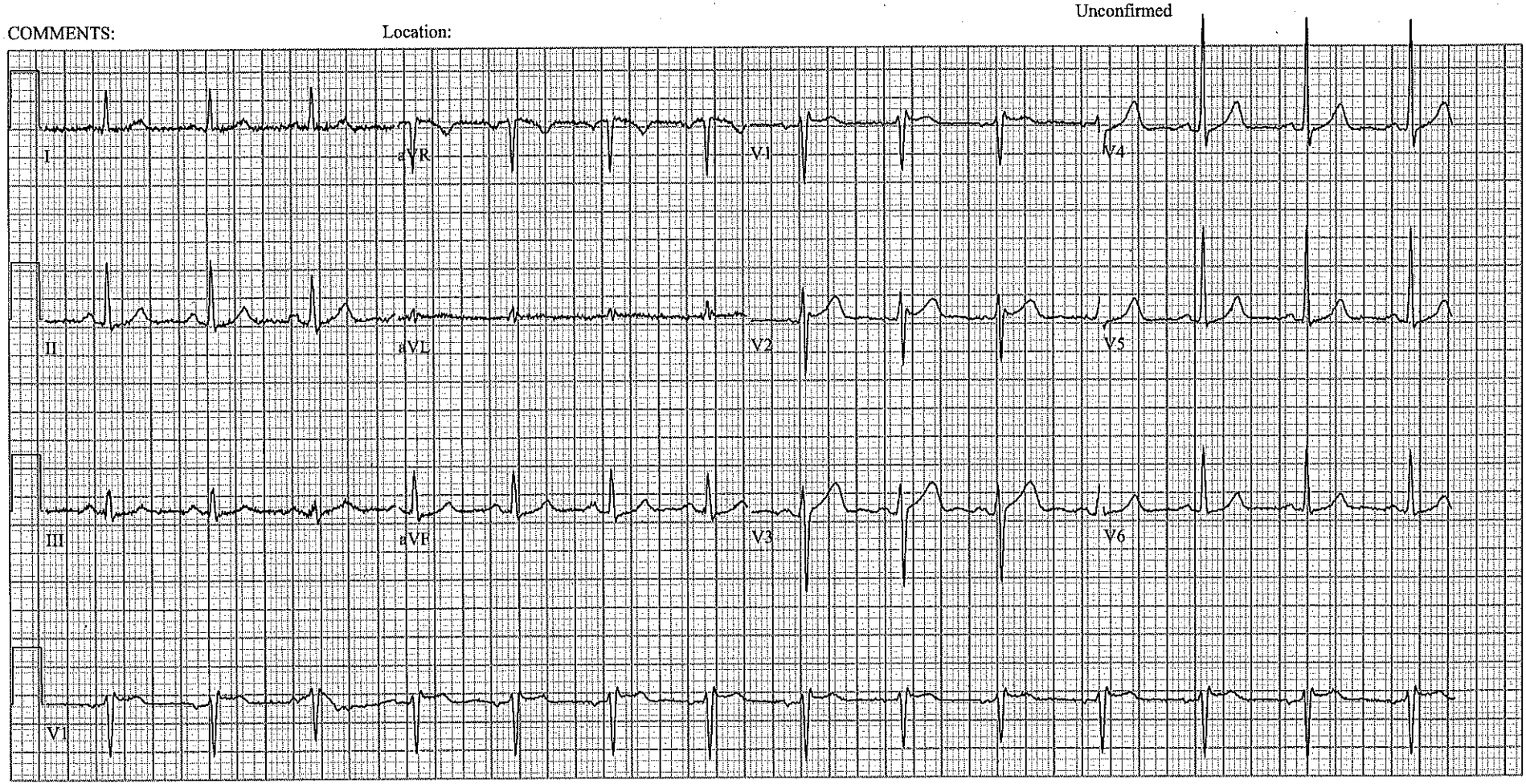
Vent. rate	84	BPM
PR interval	146	ms
QRS duration	80	ms
QT/QTc	358/423	ms
P-R-T axes	57 40	54

Normal sinus rhythm
Normal ECG
When compared with ECG of 28-FEB-2025 13:22,
No significant change was found

Technician:
Test ind:

Unconfirmed

COMMENTS: Location:



25mm/s 10mm/mV 40Hz 9.0.10 12SL 245 CID: 1055

SID: 2835086 EID:13 EDT: ORDER:

Hughes, Scott ID:2012746039 28-FEB-2025 13:22:54 GREATER GLASGOW SITE-QECDU ROUTINE RECORD

20-DEC-1974 (50 yr)
Male

Room:
Loc:1308

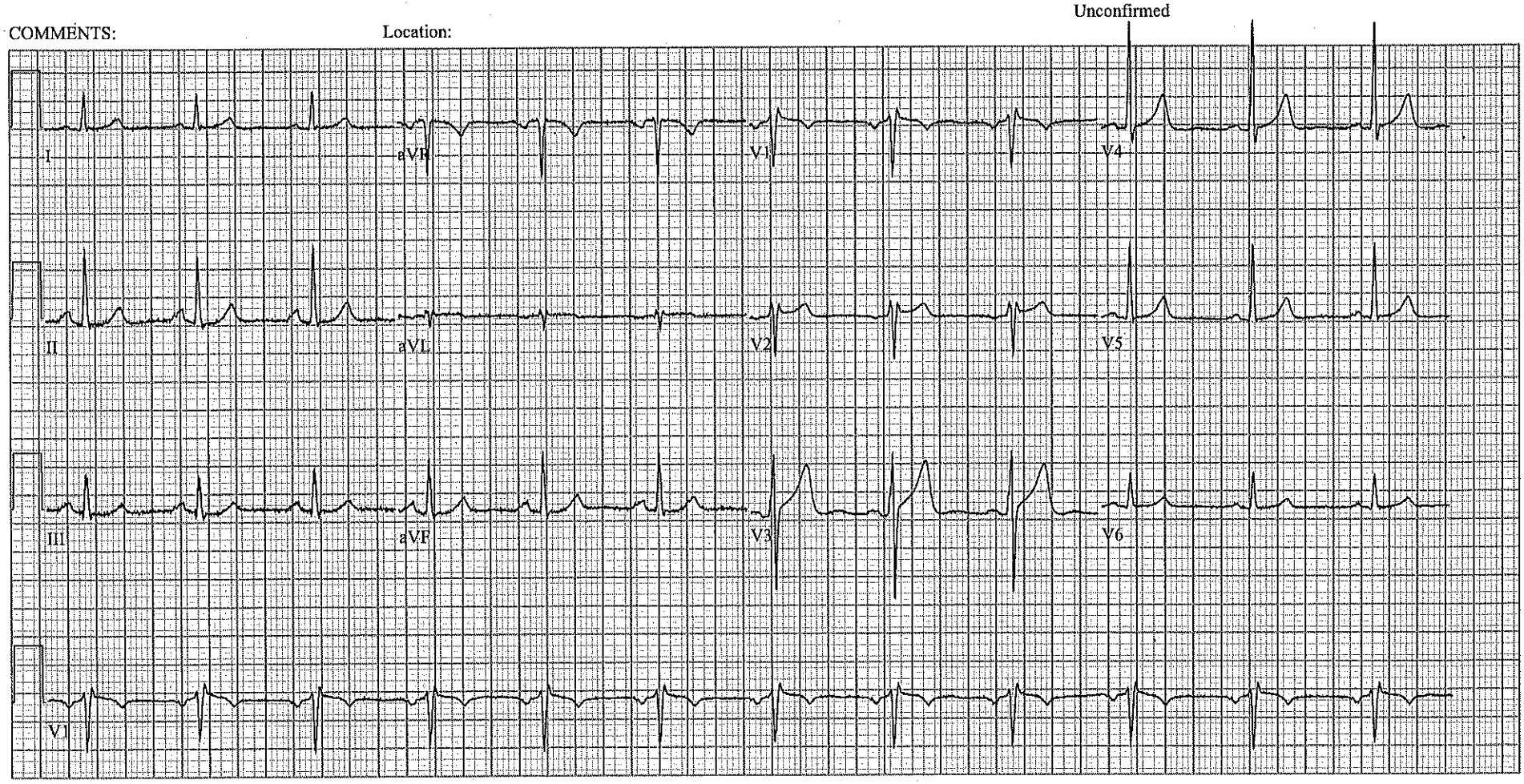
Vent. rate	72	BPM
PR interval	150	ms
QRS duration	84	ms
QT/QTc	356/389	ms
P-R-T axes	71 57	57

Normal sinus rhythm
Normal ECG

Technician:
Test ind:

COMMENTS: Location:

Unconfirmed



25mm/s 10mm/mV 150Hz 9.0.10 12SL 245 CID: 1051

SID: 2835086 EID:13 EDT: ORDER:

Hughes, Scott
Male
20/12/1974 (51 Years)

Vent. rate	84	BPM
PR interval	146	ms
QRS duration	80	ms
QT/QTc-Baz	358/423	ms
P-R-T axes	57 40 54	

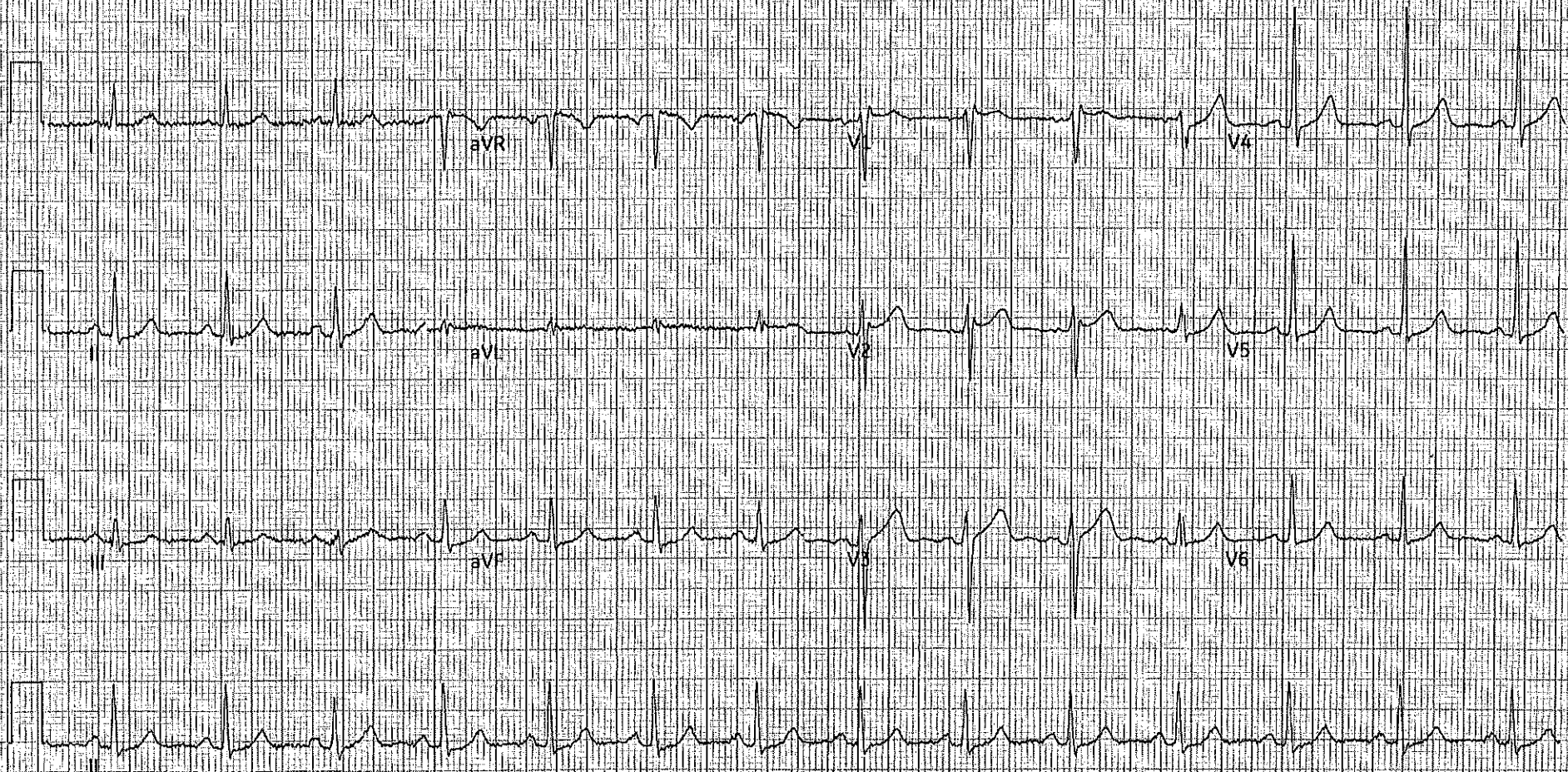
Patient ID: 2012746039
Normal sinus rhythm
Normal ECG

11/05/2026 18:02:42
Intermediate Assessment

No CP, SOB, high fever

COMMENTS:
Location:

Unconfirmed



25mm/s 10.0mm/mV 0.56-40 Hz ZPD 50 Hz MAC™ 5 1.00 SP05 12SL v24 4 by 2.5s + 1 rhythm ld

Hughes, Scott
Male
20/12/1974 (50 Years)

Location: 1308

Patient ID: 2012746039

Vent. rate	77	BPM
PR interval	150	ms
QRS duration	84	ms
QT/QTc-Baz	356/389	ms
P-R-T axes	71 57 57	

Normal sinus rhythm
Normal ECG

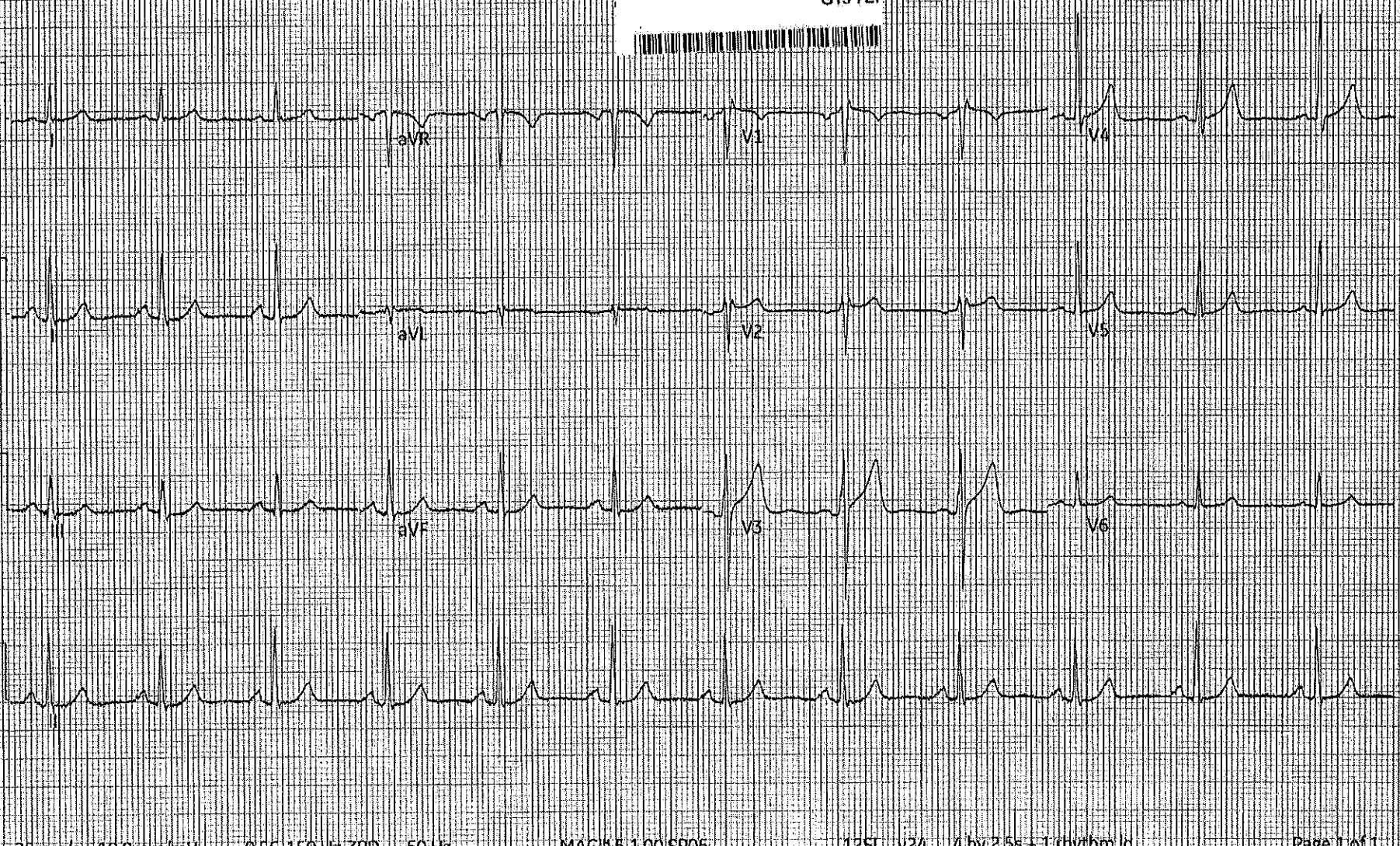
28/02/2025 13:22:54
Same Day Urgent Care Cent

2012746039
HUGHES
Scott, S
FLAT 7-6
39 LINKWOOD CRES
Glasgow, Lanarkshire
G15 7EF

N
20/12/1974

COMMENTS
Location:

Unconfirmed



25mm/s 10.0mm/mV 0.56-150 Hz ZPD 50 Hz MAC"5 1.00 SP05 12SL v24 4 by 2.5s + 1 rhythm lo Page 1 of 1

[redacted]

226 166 06

HUGHES, SCOTT ID: 2012746039 6-Nov-2019 23:31:53 QUEEN ELIZABETH UNIVERSITY HOSPITAL

20-Dec-1974
Male

Loc: 1301

[redacted]

Technician:
Test ind:

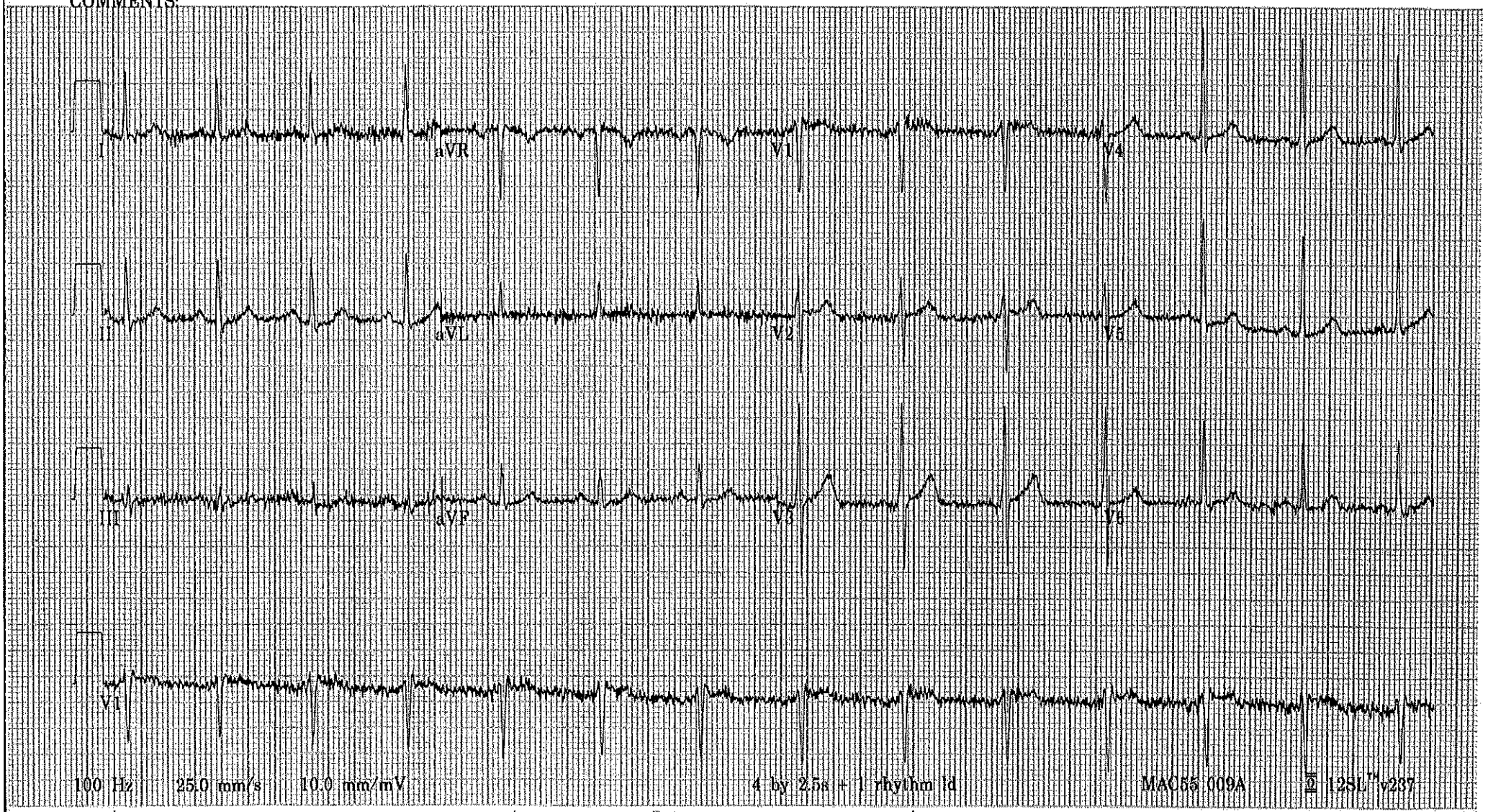
Vent. rate	82 bpm
PR interval	156 ms
QRS duration	70 ms
QT/QTc	362/422 ms
P-R-T axes	57 41 65

Normal sinus rhythm
Normal ECG

Referred by:

Unconfirmed

COMMENTS:



HUGHES, SCOTT ID: 2012746039 6-Nov-2019 23:32:10 QUEEN ELIZABETH UNIVERSITY HOSPITAL

20-Dec-1974
Male

Loc: 1301

Vent. rate	84	bpm
PR interval	118	ms
QRS duration	72	ms
QT/QTc	358/423	ms
P-R-T axes	34 34	34

Normal sinus rhythm
Normal ECG

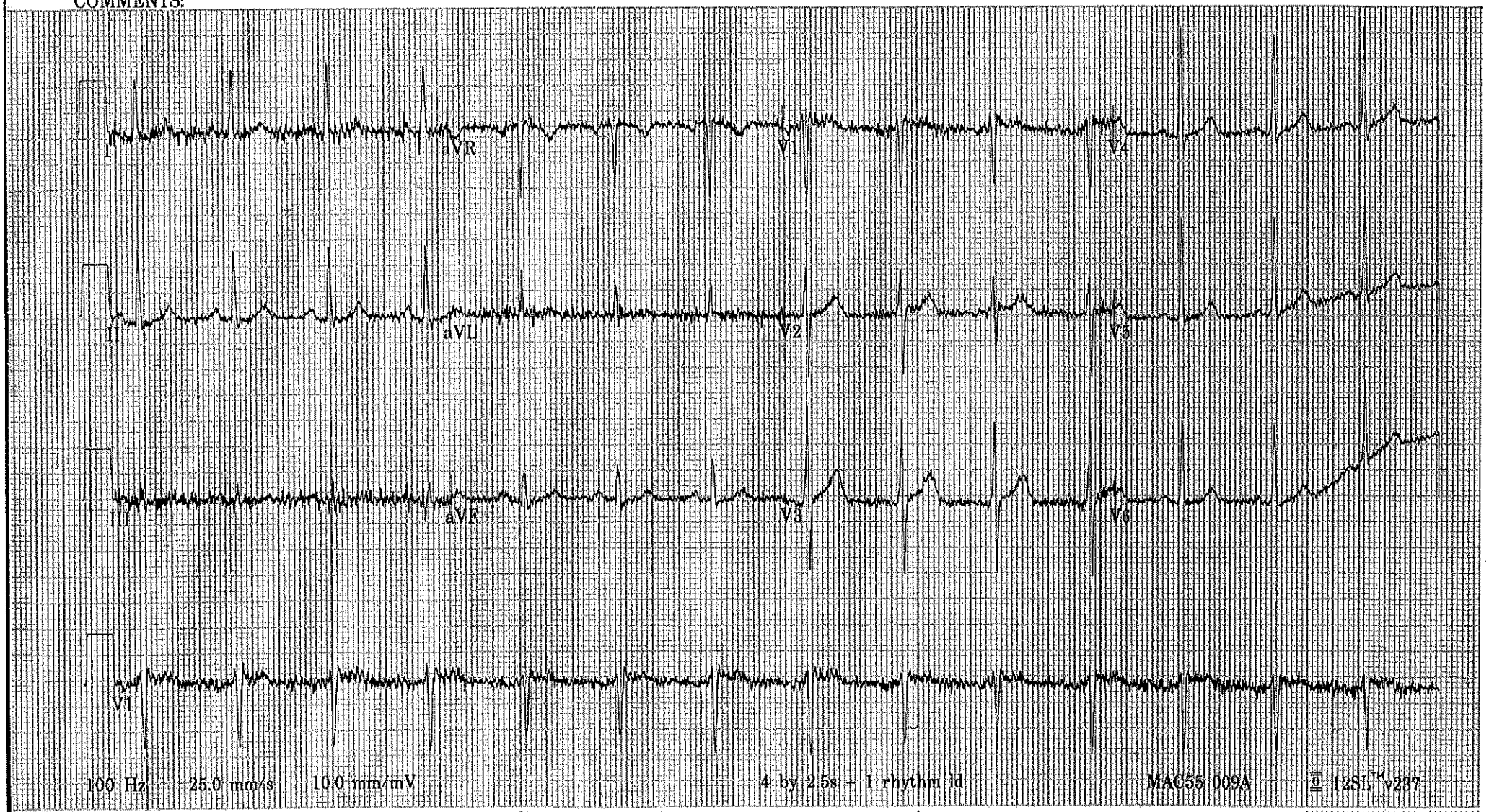
[redacted]

Technician:
Test ind:

Referred by:

Unconfirmed

COMMENTS:



HUGHES, SCOTT ID: 2012746039 23-Mar-2017 21:20:57 QUEEN ELIZABETH UNIVERSITY HOSPITAL

Vent. rate	114 bpm	Sinus tachycardia	
PR interval	132 ms	Nonspecific ST abnormality	
QRS duration	90 ms	Abnormal ECG	
QT/QTc	326/449 ms		
P-R-T axes	59 34 49		

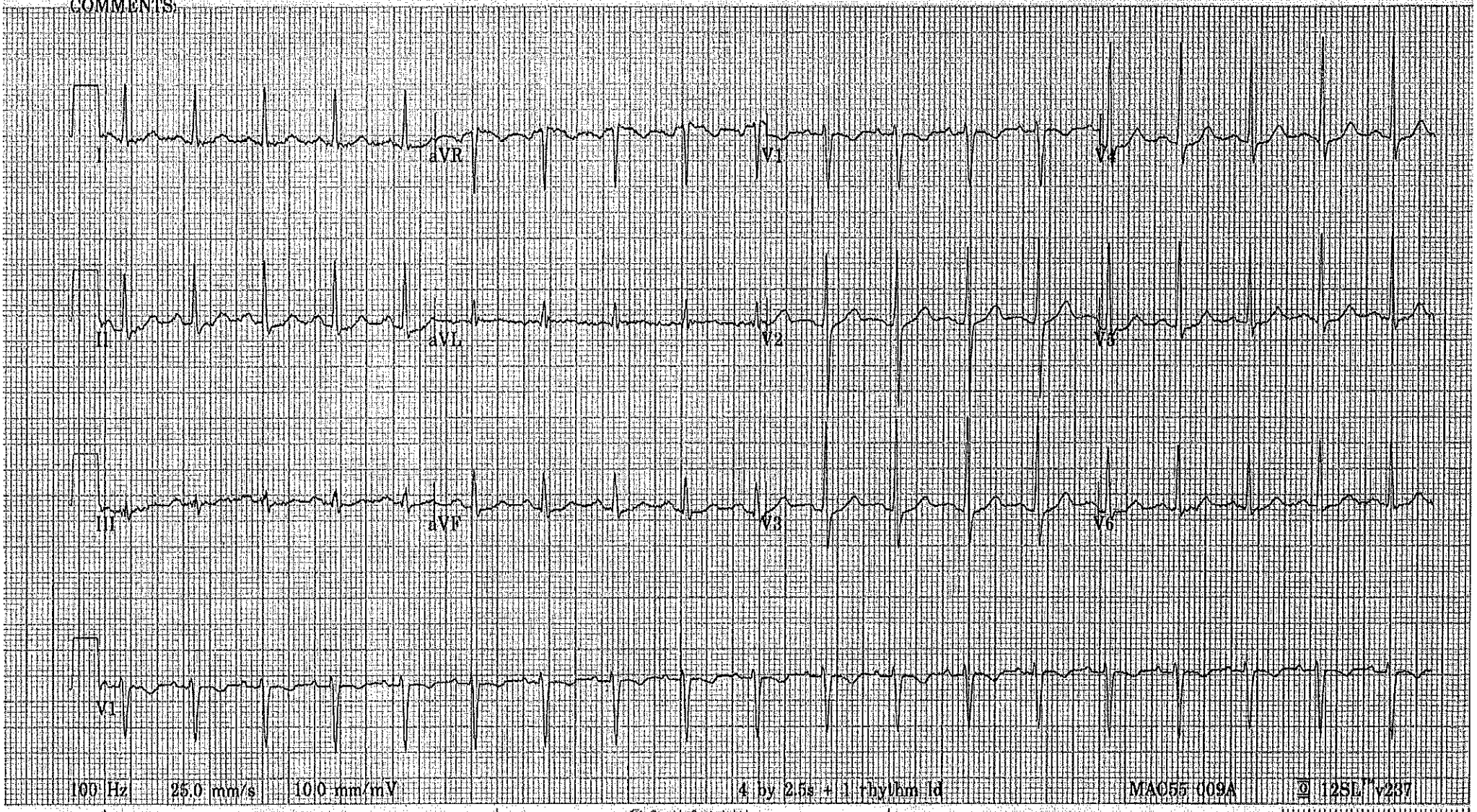
[redacted]

Technician:
Test ind:

2012746039
HUGHES M
Scott, S 20/12/1974
12 Shafton Road
Glasgow
G13 2NE

Referred by: Unconfirmed

COMMENTS:



Department of Respiratory Medicine
Gartnavel General Hospital

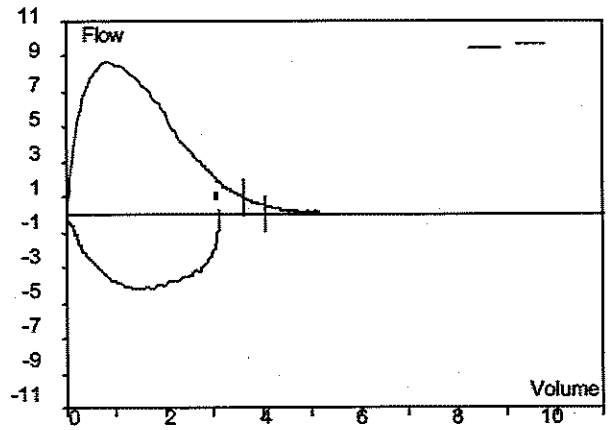
Last Name:	HUGHES	First Name:	Scott
Date Of Birth:	20/12/1974	Sex:	M
Height (cm):	162.5	Weight (Kg):	58.6
Physician:	Dr Ross	Ward:	
Pred value. :	GLI-CAUCASIAN	Physiologist :	ALEXANDRA
Identity number :	2012746039	Smoker Y/N :	Y
Exam date :	19/04/2023	Exam time :	15:33:39
Location:	Spiro Air-GGH		

Flow Volume Loop

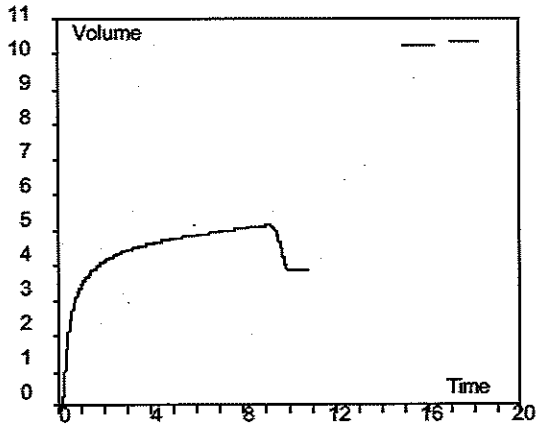
	Predicted Value	Pre Test	% Predicted	SR	Post Test	% Predicted	% Change
Product							
Time			15:33:40				
Spirometry							
FEV1(L)	3.27	**3.60**	110	0.81	—	—	—
FVC(L)	4.06	**5.13**	126	1.98	—	—	—
FEV1/FVC(%)	81	**70**	87	-1.56	—	—	—
PEF(L/S)	0.00	8.64	—	—	—	—	—
MEF75(L/S)	0.00	7.92	—	—	—	—	—
MEF50(L/S)	0.00	3.39	—	—	—	—	—
MEF25(L/S)	1.08	0.60	56	-1.23	—	—	—
PIF(L/S)	0.00	4.28	—	—	—	—	—

Bronchodilator
Dose

Flow Volume Loop



Volume/Time



Physiologist Comments

Variable technique throughout. Maximum efforts performed with best techinically acceptable effort given. Early termination on each effort.

CT Head

Performed	11-May-2026 22:12	Received	12-May-2026 09:43
Reported	12-May-2026 09:41	Order Number	G405H43524521
Status	Final	Source System	MiSys

CT Head Final
Scott Sean Hughes
Clinical History :

Complained of chest pain. Pleuritic in nature. Known COPD? pneumothorax. Also having increased seizure frequency with 2-3 times/ week. Known epilepsy. ? head injury/ ? intracranial cause of increased seizure activities.

CT Head :
Unenhanced CT head. Comparison with previous CT examinations, most recent dated 06/11/2019.

Findings: No intracranial haemorrhage or evidence of acute ischaemia. No space-occupying pathology. Normal ventricular calibre, no hydrocephalus. Partial opacification of the visualised paranasal sinuses bilaterally. Secretions within the visualised nasopharynx. Small volume fluid within the right mastoid. Intact skull.

Opinion: No acute intracranial findings.

Reported by: Dr Lars Robertson (SpR) and Dr Glen McKenzie
Verified by: Dr Glen McKenzie

CT Thorax abdomen pelvis with contrast

Performed	27-Mar-2025 15:32	Received	01-Apr-2025 08:52
Reported	01-Apr-2025 08:50	Order Number	G504H41910653
Status	Final	Source System	MiSys

CT Thorax abdomen pelvis with contrast Final
Scott Sean Hughes
Clinical History :

Suspicion of cancer but with no obvious localising features? : Yes
Do any signs, symptoms or investigations (including CXR and FBC) suggest malignancy in a specific system or alternative diagnosis? : No
Weight loss and vague left upper abdominal pain past 3/12. Weight loss >10% of body weight. No focial sympmtoms. Abdomen soft, no masses, no LN. Is there any evidence of malignancy to account for significant weight loss? Dr J Daly, GP.

CT Thorax abdomen pelvis with contrast :
Comparison made with the previous CT dated 24/01/2023.

No significant pulmonary nodule or central endobronchial lesion. Background moderate emphysema. No mediastinal, hilar or axillary lymphadenopathy. Mild to moderate coronary artery calcification.

Unchanged appearances of both kidneys with foci of calcification and several simple cysts. The remaining solid upper abdominal organs appear unremarkable. Unremarkable collapsed gallbladder and nondilated biliary tree. No gross focal oesophageal or gastric abnormality. The unprepared bowel loops appear grossly normal. No abdominal or pelvic lymphadenopathy.

No significant bony abnormality.

Impression:
No definite evidence of malignancy. GI tract malignancy is not excluded.

Mild to moderate coronary artery calcification, indicating the presence of coronary artery disease. If the patient has associated symptoms recommend management as per chest pain guidelines (e.g. NICE CG95, SIGN 151). If the patient is asymptomatic consider reviewing modifiable cardiovascular risk factors and managing as per guidelines for primary prevention (e.g. NICE CG 181).

Reported by: Dr V-Liem Soon and None
Verified by: Dr V-Liem Soon

XR Chest

Performed	28-Feb-2025 16:03	Received	01-Mar-2025 10:55
Reported	01-Mar-2025 10:53	Order Number	G405H41967029
Status	Final	Source System	MiSys

XR Chest Final
Scott Sean Hughes
Clinical History :

presents with left sided chest pain pleuritic ? PTE ? CAP

XR Chest :
PA. Previous for comparison 24/01/2023.

The cardiomediastinal contour is within normal limits.

No pneumothorax, collapse, consolidation or pleural effusion.

Reported by: Dr Kacper Dziedzic(SpR)
Verified by: Dr Kacper Dziedzic(SpR)

US Abdomen

Performed	10-Aug-2023 15:54	Received	10-Aug-2023 17:03
Reported	10-Aug-2023 17:01	Order Number	G504H39241050
Status	Final	Source System	MiSys

US Abdomen Final
Scott Sean Hughes
Clinical History :
alcohol excess. deranged lfts. hepatomeglay on scan 2017 ?cirrhosis

US Abdomen :
The liver is large in size with a mildly echobright echotexture, suggesting fatty infiltration or parenchymal changes. Normal outline. No focal abnormality identified.
Patent portal vein with hepatopetal flow.

Spleen not enlarged measuring 7.8 cm. No free fluid.

Both kidneys have good cortical thickness however the renal fat is markedly echogenic, this is consistent with recent CT report suggesting medullary sponge kidney. Bilateral simple cysts, cluster of simple cysts measuring 1.74cm is seen in the upper pole of the right kidney.
Right kidney measures 11.3 cm, left kidney measures 9.6 cm.

The gallbladder is slightly contracted, the patient reports that he has not fasted for today's scan. Within these limitations no obvious gallstones.
No intrahepatic dilatation, normal CBD.

Normal sonographic appearances of the pancreas and aorta.

Summary:
1) Liver as described above suggesting fatty infiltration or parenchymal changes.

2) Ultrasound appearances of both kidneys correlate with recent CT report of medullary sponge kidney and bilateral simple renal cysts. No gallstones.

Scan performed by Ruairidh Gilmore, trainee sonographer (RA70289).
Supervised by A. Dubojski, sonographer(RA47326).

Reported by: Ruairidh Gilmore (Trainee Sonographer) and Andrew Dubojski (Sonographer)
Verified by: Andrew Dubojski (Sonographer)

CT Thorax and abdomen with contrast

Performed	24-Jan-2023 13:18	Received	25-Jan-2023 09:56
Reported	25-Jan-2023 09:54	Order Number	G504H39242667
Status	Final	Source System	MiSys

CT Thorax and abdomen with contrast Final
Scott Sean Hughes
Clinical History :
Cough, weight loss, smoker - any lung cancer?

CT THORAX & UPPER ABDOMEN

Technique: Portal-venous phase contrast-enhanced CT scan. There are no previous CT scans for comparison.

Findings: The lungs are emphysematous with several bullae at the apices of both upper lobes. There is linear atelectasis anteriorly in the right middle lobe, which has been present on previous chest radiographs dating back to 02/07/2014.
No acute pulmonary pathology was demonstrated.
No enlarged hilar or mediastinal lymph nodes.

There is calcification of the left main stem and left anterior descending coronary arteries. The heart is not enlarged.

There is bilateral nephrocalcinosis with widespread parenchymal calcification throughout both kidneys. This was demonstrated on the previous ultrasound of 24/03/2017. Medullary sponge kidney, hyperparathyroidism and renal tubular acidosis are among the possible causes. There are also multiple simple cysts in both kidneys.

Normal appearance of liver, gallbladder, biliary tree, pancreas, spleen, and adrenals.
No gross abnormality in the imaged bowel.

Healed right-sided rib fractures. No acute skeletal abnormality.

Conclusion:
1. Emphysema. No evidence of lung cancer.
2. Coronary artery calcification.
3. Extensive nephrocalcinosis.

Reported by: Dr Iain Andrews
Verified by: Dr Iain Andrews

XR Chest

Performed	06-Jan-2023 13:00	Received	09-Jan-2023 07:08
Reported	09-Jan-2023 07:06	Order Number	G504H39220694
Status	Final	Source System	MiSys

XR Chest Final
Scott Sean Hughes
Clinical History :

persistent cough ands smoker ?lrti. exclude malignancy

XR Chest :
The heart is not enlarged. The lungs are clear of active disease. No significant focal lung lesion identified. The lungs appear relatively emphysematous and hyperinflated in keeping with the smoking history.

Reported by: Dr Sean Kelly
Verified by: Dr Sean Kelly

XR Acromioclavicular joint Rt

Performed	06-Aug-2022 19:46	Received	31-Aug-2022 18:35
Reported	07-Aug-2022 13:40	Order Number	G405H38709878
Status	Final	Source System	MiSys

XR Acromioclavicular joint Rt Final
Scott Sean Hughes
Clinical History :

isolated tenderness and swelling over ACJ ? disruption

XR Acromioclavicular joint Rt :
Normal alignment. No fracture.

Code N: No note: No sticky note available. Referrer's interpretation is unknown.

Reported by: Dr Gillian Halafihi (SpR)
Verified by: Dr Gillian Halafihi (SpR)

XR Shoulder Rt

Performed	06-Aug-2022 18:40	Received	31-Aug-2022 18:34
Reported	07-Aug-2022 11:09	Order Number	G405H38709820
Status	Final	Source System	MiSys

XR Shoulder Rt Final
Scott Sean Hughes
Clinical History :

Fall last night impact (R) shoulder. Swollen ++ tender clavicle and humeral head. ?#

XR Shoulder Rt :
No fracture identified.

Code N: No note: No sticky note available. Referrer's interpretation is unknown.

Reported by: Dr Gillian Halafihi (SpR)
Verified by: Dr Gillian Halafihi (SpR)

MRI Head

Performed	13-Dec-2020 11:12	Received	22-Dec-2020 22:59
Reported	22-Dec-2020 22:55	Order Number	G516H36738099
Status	Final	Source System	MiSys

MRI Head Final
Scott Sean Hughes

(Information via Order Comms)

Examination Dated: 13/12/2020 11:12

Title & Technique: MRI head: Axial T2, axial T2 FLAIR, sagittal T1 and SWI sequences.

Clinical Details: Seizures. Alcohol excess. Normal MRI brain scan 2017. ? Changes

Findings:

There is no intracranial mass, haemorrhage or hydrocephalus. There are non specific T2/FLAIR hyperintensities within the periventricular white matter. Basal cisterns and cortical sulci are patent.

There is a mucosal sinus cyst within the left maxillary sinus. Mucosal thickening is seen within the paranasal air sinuses.

Conclusion: No acute intracranial pathology.

4Ways Reporting Radiologist: Poe Zar Phyu - GMC 6159296 on 22/12/2020 22:55

Reported by: External Radiologist
Verified by: External Radiologist

XR Knee Lt

Performed	28-Mar-2018 02:16	Received	28-Mar-2018 13:43
Reported	28-Mar-2018 13:41	Order Number	G405H33702742
Status	Final	Source System	MiSys

XR Knee Lt Final
Scott Sean Hughes
Clinical History :

Fall down stairs. Tender proximal fibula ++ ?#

XR Knee Lt :
No acute bone or joint abnormality demonstrated.

Code N: No note: No sticky note available. Referrer's interpretation is unknown.

Examination reported by Laura Kennedy - Reporting Radiographer.

Reported by: Laura Kennedy
Verified by: Laura Kennedy

XR Foot Lt

Performed	27-Mar-2018 23:37	Received	28-Mar-2018 14:43
Reported	28-Mar-2018 14:41	Order Number	G405H33702658
Status	Final	Source System	MiSys

XR Foot Lt Final
Scott Sean Hughes
Clinical History : fallen down stairs bony tender lat mal, medial mal, 5th MT inc base. cuboid, navicular and cuneiforms. ? fracture

XR Foot Lt :
Mildly displaced fracture proximal shaft of third metatarsal.

XR Ankle Lt :
No acute bony injury demonstrated.

Code A: Agreement: No major discrepancy between the radiologist report and the referrer's 'sticky note' interpretation.

Reported by: Dr Sudipta Pal (ST4)
Verified by: Dr Sudipta Pal (ST4)

XR Ankle Lt

Performed	27-Mar-2018 23:37	Received	28-Mar-2018 14:43
Reported	28-Mar-2018 14:41	Order Number	G405H33702659
Status	Final	Source System	MiSys

XR Foot Lt Final
Scott Sean Hughes
Clinical History : fallen down stairs bony tender lat mal, medial mal, 5th MT inc base. cuboid, navicular and cuneiforms. ? fracture

XR Foot Lt :
Mildly displaced fracture proximal shaft of third metatarsal.

XR Ankle Lt :
No acute bony injury demonstrated.

Code A: Agreement: No major discrepancy between the radiologist report and the referrer's 'sticky note' interpretation.

Reported by: Dr Sudipta Pal (ST4)
Verified by: Dr Sudipta Pal (ST4)

US Abdomen

Performed	24-Mar-2017 14:50	Received	24-Mar-2017 15:51
Reported	24-Mar-2017 15:49	Order Number	G405H32476845
Status	Final	Source System	MiSys

US Abdomen Final
Scott Sean Hughes
Clinical History :

42 year old history of alcohol excess jaundiced and hepatomegaly. Ultrasound please to look for obstructive cause of deranged LFTs and masses.

US Abdomen :
Examination performed by Karen Thomson, sonographer.

There is hepatomegaly with a diffusely echogenic and attenuating parenchyma in keeping with diffuse fatty infiltration/parenchymal change. No gross pathology demonstrated.
The patient was not fasted for today's examination, no obvious gallstones identified in a non-fasted gallbladder. The biliary tree is within normal limits.
Normal appearances of the pancreas, aorta, portal vein and spleen.

Both kidneys demonstrate echogenic renal fat with the hyperechoic foci and acoustic shadowing, the appearances may be suggestive of a staghorn calculi/nephrocalcinosis. Both kidneys have mild cortical thinning with some cysts.
No abdominal free fluid present.

Reported by: Karen Thomson (Sonographer)
Verified by: Karen Thomson (Sonographer)

XR Chest

Performed	24-Mar-2017 02:19	Received	24-Mar-2017 16:26
Reported	24-Mar-2017 16:24	Order Number	G405H32476559
Status	Final	Source System	MiSys

XR Chest Final
Scott Sean Hughes
Clinical History :

42 year old man with cough for 6 weeks, non productive. Smoker. treated for a chest infection by GP. ?crackles eight base. Chest x ray please to look for consolidation.

XR Chest :
The heart is not enlarged. No consolidation seen. Old right anterior rib fractures.

Reported by: Dr Thomas Elswood (SpR) and Dr Oliver Cram
Verified by: Dr Oliver Cram

MRI Head

Performed	15-Mar-2017 08:54	Received	15-Mar-2017 15:52
Reported	15-Mar-2017 15:50	Order Number	G516H32029697
Status	Final	Source System	MiSys

MRI Head Final
Scott Sean Hughes
Clinical History : Focal seizures ? cause

MRI Head : Standard cranial protocol performed. Note made of the CT from 31/12/2015.

The brain parenchyma and ventricular system is normal, with no structural abnormality identified. No evidence of previous infarction or haemorrhage, with no extra-axial collection or space occupying lesion. Vascular flow voids are grossly normal. No artefact evident on the susceptibility-weighted imaging.

Conclusion: No structural abnormality identified to account for the clinical presentation.

Reported by: Dr Gordon Cowell
Verified by: Dr Gordon Cowell

XR Orthopantomogram Rt

Performed	31-Dec-2015 07:31	Received	31-Dec-2015 09:20
Reported	31-Dec-2015 09:18	Order Number	G405H30987164
Status	Final	Source System	MiSys

XR Facial bones Final
Scott Hughes
Clinical History :

Assaulted, tenderness around right orbit and right mandible. ?#

XR Facial bones :

Slightly rotated views. There is impression of lucency of the medial wall of the right orbit however no definite undisplaced fracture is demonstrated. I note subsequent CT brain examination which does definitely demonstrates a fracture in this region. No other acute bony injuries.

Code D: Discrepancy: There is a significant discrepancy between the radiologist report and the referrer's 'sticky note' interpretation. Senior review advised.

XR Orthopantomogram Rt :

No obvious undisplaced fracture.

Code D: Discrepancy: There is a significant discrepancy between the radiologist report and the referrer's 'sticky note' interpretation. Senior review advised.

Reported by: Dr Jon-Robert Angus
Verified by: Dr Jon-Robert Angus

XR Facial bones

Performed	31-Dec-2015 07:31	Received	31-Dec-2015 09:20
Reported	31-Dec-2015 09:18	Order Number	G405H30987163
Status	Final	Source System	MiSys

XR Facial bones Final
Scott Hughes
Clinical History :

Assaulted, tenderness around right orbit and right mandible. ?#

XR Facial bones :

Slightly rotated views. There is impression of lucency of the medial wall of the right orbit however no definite undisplaced fracture is demonstrated. I note subsequent CT brain examination which does definitely demonstrates a fracture in this region. No other acute bony injuries.

Code D: Discrepancy: There is a significant discrepancy between the radiologist report and the referrer's 'sticky note' interpretation. Senior review advised.

XR Orthopantomogram Rt :

No obvious undisplaced fracture.

Code D: Discrepancy: There is a significant discrepancy between the radiologist report and the referrer's 'sticky note' interpretation. Senior review advised.

Reported by: Dr Jon-Robert Angus
Verified by: Dr Jon-Robert Angus

XR Chest

Performed	02-Jul-2014 01:29	Received	08-Jul-2014 12:13
Reported	07-Jul-2014 15:30	Order Number	G516H29232969
Status	Final	Source System	MiSys

XR Chest Final
Scott Hughes
Clinical History :

? TIA, Chest pain + SOB Widespread wheeze +reduced air entry right base, ? pe

XR Chest :
No previous for comparison.
Normal cardiomediastinal contour. There is tenting of the right hemidiaphragm - probably due to previous inflammation. No definite active pulmonary pathology demonstrated.

Reported by: Dr Kenneth Mitchell (SpR) and Dr Oliver Cram
Verified by: Dr Kenneth Mitchell (SpR)