Medway Hospitals ®
The way to better health

MH/ PRINT / 0075 / MRD

MRD CHECKLIST

PARTICULARS	YES	NO
- IP Number allocated to each Patient	✓	
- Name, Age & Sex of Patient	✓	
- General Admission Consent	✓	
- Initial Assessment of Patient / Diagnosis	✓	
- Nutritional Assessment by Consultant	✓	
- Plan of care counter signed by the Consultant	✓	
- Treatment Orders - Date, Time, Name & Sign.	✓	
- Medication Order / Drug Chart - Date, Time, Name & Sign.	✓	
- Vital Signs Chart (TPR Chart)	✓	
- Intake Output Chart	✓	
- Drug Chart (Duly filled)	✓	
- Anesthesia Consent - (8 thing) - Date, Time, Name & Sign. of both Patient & Anesthetist		
- Anesthesia Assessment Sheet		
- Surgery Consent - (8 things) - Date, Time, Name & Sign of both Patient & Surgeon		
- Surgery Notes - Post Operative Plan		
- Pain Scoring System	✓	
- Blood Transfusion if done		
- High Risk Procedures		
- A copy of the Discharge Summary	✓	

Medway Hospitals®
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(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

MHI/IPD/2022/002

Medway Heart Institute
Every heart beat counts

ADMISSION SLIP

Admitting Doctor: DR. JAISHANKAR. **Speciality:** Cardiology.

Advised Date & Time: 31/1/24 @ 20:57. 1:35 pm

Provisional Diagnosis:

CAD / ACS, AW - STEMI

Reason for Admission: ☑ Medical Management ☐ Surgical Management
☐ Others (please specify details) _____

Admission Type: ☐ Day Care ☐ ER ☐ Ward
☑ ICU CCU (Specify details)

Surgery / Procedure Name (if planned):

CAG.

Blood Product Requirement: ☑ No ☐ Yes *(Kindly specify details of components required in space below)*

Expected Duration of Stay: 2 - 3 days.

Expected Cost of Treatment *(as per Financial Counseling Form)*:

Payer: ☑ Self ☐ Insurance ☐ Others: _____

Instructions to Nurse (if any):

Vitals monitoring.
Inj. Lmwh 0.4ml st

Any other Instructions (if any):

Doctor's Signature	Name	Reg. No.	Date	Time
	DR. JAISHANKAR	49442	31/1/24	20:57

For admission desk staff only:

Room Category:

- ☐ General Ward
- ☐ Single Room
- ☐ Twin Sharing
- ☐ Deluxe Room
- ☐ Suite Room
- ☑ Others CCU

Admission intimation Receipt Details		Admission Time in HIS	
Date	Time	Date	Time
3/1/24	11:36 pm	3/1/24	11:36 pm

Source:

- ☐ OPD
- ☐ ER
- ☑ Direct

To be filled only if Blood requirement specified by the Doctor:

Is Blood Reservation and Blood Bank clearance completed as advised: ☐ Yes ☐ No

Front office Staff Signature	Name	Emp. No.	Date	Time
P [illegible]	Leonard [illegible]	MH10273	~~11:36 p.~~ 3/1/24	11:36 p

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Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

MHI/HOSP/2022/129

Medway Heart Institute
Where heart beat never stops...

ADMISSION FORM

Marital Status	Full Address	Telephone Number
M	SIDDIQ UZAMAN NO 603, Ayesha Mansion Apt 1st Stage	9986111077
Occupation	2nd Block HBR Layout, B-lore-43	
CA		

Referred from	Date of Time of Admission	Date & Time of Discharge	Total No. of Days
DR LAKSHMIPATHY MR MEIYAPPAN SUM	3/1/24 11.34 hr	4/1/24 18.00	18 hr 30 min.
UNIT CCU	MLC ☐ Yes ☑ No	If Yes AR No. :	

FINAL DIAGNOSIS	ICD Code
CAD – ACS – ANTERIOR WALL STEMI	I21.4
THROMBOLYSED WITH INJ. TNK 30mg on 03.01.2024	Z92.82
MODERATE LV SYSTOLIC DYSFUNCTION	I50.1

DATE	OPERATION / PROCEDURES	ICPM Code
—	—	

DATE	TYPE OF ANESTHESIA	
—	☐ GENERAL ☐ SPINAL ☐ LOCAL ☐ REGIONAL ☐ EPIDURAL	

DISCHARGE STATUS

☐ Cured	☐ Discharge at Request	☐ Expired < 48 hours
☐ Improved	☑ Against Medical Advice	☐ Expired > 48 hours
☐ Unchanged	☐ Absconded	☐ Post-Operative Death
	☐ Transferred to	

Signature of the Consultant

Signature of Medical Records Officer

S.No. : 5

AUTHORISATION FOR TREATMENT I PAYMENT

I hereby authorise the Administration, Medical and Nursing and Paramedical, Staf f of the Hospital Investigate treat and administer such drugs as may be necessary and to perform such operation under anaesthesia or other wise as may be deemed necessary and / or advisable in the diagnosis and treatment of my illness / patient..SIDDIQ USAMA who is my ..Brother..... (Relationship).

I hereby under take to settle all the bills for hospitalisation charges related to me/the patient named overleaf on a periodic basis. In any case, I shall pay all the dues before getting discharged from the hospital.

However, in case I fail to pay the charges due to the hospital as agreed above, I hereby authorise the hospital to transfer me/the patient to any other hospital/institution for further treatment as deemed fit and proper by the hospital authorities.

I also acknowledge having been informed if the General Rules and Regulations of the Hospital and that all cash, jewellery and valuables belonging to the patient or theis attendants have been removed to a place of safety / handed over to the next of kin and I absolve the hospital of any responsibility with regard to any loss.

I have read out and explained the contents of the above to the Signatory in his vernacular .

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

இதன் மூலமாக நான் நிர்வாகம், மருத்துவம், தாதியர், ஏனைய மருத்துவ ஊழியர்கள் எனக்கு / நோயாளி .....
.....க்கு தேவைப்பட்ட சோதனைகளை செய்து மருந்துகளை கொடுக்கவும். மயக்க மருந்துகள் கொடுத்து செய்முறைகள்/அறுவை சிகிச்சை செய்யவும் அதிகாரம் வழங்குகிறேன். நான் / இதில் குறித்துள்ள நோயாளின் செலவுக்கன தொகை முழுவதும் செலுத்த இதன் மூலம் உறுதி அளிக்கிறேன்.

மேல் கூறியது போல் வேளை நான் தங்கள் மருத்துவத்திற்கான செலவுகளை கட்டத் தவறினால் என்னை நோயாளியை வேறொரு மருத்துவமனைக்கு, பிற சிகிச்சை / அறுவை சிகிச்சை செய்ய இடமாற்ற ஒப்புதலை எனது உறவினர்கள் மூலமாக பெற நான் அதிகாரம் அளிக்கிறேன்.

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கிப்பட்டிருக்கிறேன்.

நோயாளிக்கு உரிமையான எல்லா பணம், நகை மதிப்பிடக்கூடி பொருட்கள் யாவும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்லு நெருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ளது. இந்த மருத்துவமனை எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை என உறுதி செய்கிறேன்.

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

செவிலியர் கையொப்பம்
Signature of Admitting Nurse

தேதி
Date 3/01/2024

எனது/உறவினர்/காப்பாளர் கையொப்பம்
Signature of the Patient / Relative / Gurdian

Brother
உறவுமுறை
Nature of Relationship

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(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

MHI/IP/2022/008

Medway Heart Institute
Every heart beat counts

GENERAL CONSENT FOR ADMISSION

I, Siddiq _____ the ☐ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ Read

☐ Been explained this consent form in English, which I fully understand.

- I give my full consent and authorization for admission and treatment at this hospital. The proposed treatment plan has been explained to me.
- I consent and authorize the hospital, treating doctors, nursing, technical and paramedical staff to provide relevant care and to conduct diagnostic as deemed necessary by the treating doctor / team.
- I also consent to use of assistants such as resident doctors, other doctors, nurses, and other healthcare workers by the hospital and treating doctor / team.
- I consent for clinical consultation, admission, disclosure of information required for clinical management (under confidence), routine medical examination (physical examination, palpation, percussion, auscultation), routine lab and imaging investigations, general nursing care, diet and physiotherapy assessment and counselling.
- I have been explained about the proposed care plan, expected result(s), possible outcome(s) and expected cost of treatment/ hospital stay.
- I understand that the hospital will take due care of me / my patient but, that there is always a possibility of an unexpected complication(s) which may necessitate longer stay and / or use of intensive care services. In such cases, procedure different from those contemplated and other intervention(s) may sometimes be needed.
- I declare that, I have and will inform the doctor of my medical history including previous illnesses, allergies, drug reaction(s), surgical procedure, relevant medical family history and all other facts relevant to my treatment. I shall not hold the hospital/ doctor responsible for any consequences which may arise due to non-disclosure of relevant information on my part.
- I declare that I have been explained about my rights and responsibilities.
- I have been made aware of the rules and regulations of the hospital including those related to security and I promise to abide by them.
- I understand that in case of some unexpected event occurring during the course of my stay I may be suggested a transfer to another hospital / healthcare organization, as considered appropriate by my treating doctor.
- I understand that, drugs, consumables and devices will be charged on an 'as actual' basis as per the hospital tariff. I have been informed and I understand that there can be usage of certain reprocessed items during the course of the treatment. I also understand that only full strips of medicines shall be issued and returned. I declare that I take full responsibility of settling the bill before leaving the hospital premises at the time of discharge.

- I further declare that I have been given an opportunity to ask question(s) related to my admission, care plan and proposed hospital stay, and that such questions have been answered to my satisfaction.

- I declare that I have received and fully understood the information provided in this consent form, that I have been given an opportunity to ask questions relating to my admission, care plan and proposed hospital stay, and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my signing this form.

- I, the above-named Patient / named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.

	Signature / Thumb Impression*	Name	Date	Time
Patient		Siddiq Usama	3/1/24	11:36 AM
Surrogate/Guardian (if applicable #)		Dawood. KS *(Write name and relationship with patient)*	3/1/24	11:36 AM
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness			3/1/24	11:36 AM
Interpreter (if applicable)				

** Right Hand for Males & Left Hand for Females | # Only if Patient is a minor or unable to give consent*

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Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

MHI/ICU/2022/114

Medway Heart Institute
Every heart beat counts

ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

S. No.	PARAMETERS	MARK ✓ AS APPROPRIATE
1	**Hemodynamic instability defined as**	
	Pulse less than 40 or more than 150 beats/minute	
	Systolic arterial pressure less than 80 mm Hg or 20 mm Hg below the patient's usual pressure	
	Mean arterial pressure less than 60 mm Hg	
	Diastolic arterial pressure more than 120 mm Hg	
	Respiratory rate more than 35 breaths/minute	
2	**Cardio-vascular System**	✓
	Acute myocardial infarction	
	Cardiogenic shock	
	Complex arrhythmias requiring close monitoring and intervention	
	Acute congestive heart failure with respiratory failure and / or requiring hemodynamic support	
	Hypertensive emergencies	
	Unstable angina, particularly with dysrhythmias, hemodynamic instability, or persistent chest pain	
	Post cardiac arrest	
	Cardiac tamponade or constriction with hemodynamic instability	
	Dissecting aortic aneurysms	
	Complete heart block	
3	**Miscellaneous Conditions**	
	Septic shock with hemodynamic instability	
	Hemodynamic monitoring	
	Clinical conditions requiring ICU level nursing care	
4	**Post procedure elective admission**	
	Post Coronary Angioplasty	
	Post Cardio-vascular Surgery	
5	**Following angiographic procedure**	
	Complication resulting from the angiographic procedure including any significant change in pulse in the affected extremity, neurologic changes, persistent bleeding, or persistent nausea and vomiting post-procedure	
	Significant findings on diagnostic angiography warranting further therapy that would necessitate inpatient admission is also a reasonable indication for admission	
	Admission at the time of the study is encouraged if problems are suspected or arise	
6	**Pulmonary System**	
	Acute respiratory failure requiring ventilatory support (Invasive / Non-Invasive)	
	Pulmonary emboli with hemodynamic instability	
	Patients in an intermediate care unit (HDU / Recovery room) who are demonstrating respiratory deterioration	
	Need for nursing / respiratory care not available in such intermediate care units	
	Massive hemoptysis	
	Respiratory failure needing imminent intubation	
7	Renal failure	
	Oliguria or anuria for more than 12 hours	
	Metabolic acidosis (pH <7.1)	
	Patients requiring hemodialysis can be performed in ICU when the blood pressure is borderline	

S. No.	PARAMETERS	MARK ✓ AS APPROPRIATE
8	**Endocrine System and Metabolism related** Diabetic ketoacidosis complicated by hemodynamic instability, altered mental status, respiratory insufficiency, or severe acidosis	
	Thyroid storm or myxedema coma with hemodynamic instability	
	Hyperosmolar state with coma and/or hemodynamic instability or Serum Glucose more than 800 mg/dl	
	Other endocrine problems such as adrenal crises with hemodynamic instability	
	Severe hypercalcemia (Serum Calcium more than 15 mg/dl) with altered mental status, requiring hemodynamic monitoring	
	Hypo or hypernatremia (Serum Sodium less than 110 mEq/L or more than 155 mEq/L) with seizures, altered mental status	
	Hypo or hypermagnesemia with hemodynamic compromise or dysrhythmias	
	Hypo or hyperkalemia (Serum Potassium less than 2.0 mEq/L or more than 6.0 mEq/L) with dysrhythmias or muscular weakness	
	Hypophosphatemia with muscular weakness	

	Signature	Name	Reg. No.	Date	Time
Doctor	✓	DR. BALAJI	1421 15.	3/1/24	11:30

DISCHARGE CRITERIA FOR INTENSIVE CARE UNIT

S. No.	PARAMETERS	MARK ✓ AS APPROPRIATE
1	Stable hemodynamic parameters	
2	Stable respiratory status (Pt. extubated with stable arterial blood gases) & airway patent	
3	Minimal oxygen requirement (not more than 3 L by nasal prongs)	
4	Intravenous Inotropic / Vasopressor support and vasodilators are no longer necessary	
5	Cardiac dysrhythmias are controlled	
6	Presence of distal pulses	
7	No signs of bleeding and hematoma at puncture site	
8	End of life care pathway chosen	

	Signature	Name	Reg. No.	Date	Time
Doctor	✓	Dr-Chaitanya	91810	4/1/24	10.00

CHENNAI :# 2/26,1st Main Road, United India Colony, Kodambakkam,
Chennai - 600024. Tel : 044 - 2473 4455 | Mobile No : 9962 985 985
KUMBAKONAM :No.142-B, Sri Balasubramaniyan Nagar, Pilliyam Pettai,
Ammachathiram (Post), Thiruvidaimarudhur (Taluk), Kumbakonam - 612103.
(Tanjore Dist).Ph: 0435 - 2412345 | Mob : 7397720491
E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com

Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

tals®
ealth

DIL / HIGH RISK FORM

I ..... was informed that Mr./Mrs.....
under the care of Dr. BALAJI ..... is seriously III.

I am aware of the seriousness of his/her illness and explained in detail by the above doctor's team member.

I am giving my consent to the above Doctor and his/her team of this Hospital to proceed with the necessary treatment like continuous monitoring, oxygen therapy, ventilator management and life saving procedures (or) surgery.

I am aware that the patient is very critical, even death may occur. I will not hold the Hospital or the doctors or any employee of this hospital responsible for any consequences happening forthwith.

I also accept the prognosis of the patient.

Witness :

1. [signature]

2.

Signature : [signature]

Relationship : Brother

DISCHARGE AGAINST MEDICAL ADVICE

IP No.	IPH2024000024	**D.O.A**	: 03/01/2024 – 23.40
UHID	MHI202481588	**D.O.D**	: 04/01/2024 – 18.00
Name	Mr. SIDDIQUZAMA	**Room No.**	: CCU
Age / Gender	42Years / MALE		
Consultant	: **Dr. JAISHANKAR.K** MD., DM., Director and Clinical Lead Cardiology and Electrophysiology		

DIAGNOSIS:

CAD – ACS – ANTERIOR WALL STEMI
THROMBOLYSED WITH INJ. TNK 30MG ON 03.01.2024
MODERATE LV SYSTOLIC DYSFUNCTION

COURSE IN THE HOSPITAL:

Mr. Siddiquazama, 42 Yrs/male , admitted last night with complaints of left side chest pain, radiating to back since 8 pm, no history of shortness of breathlessness, Palpitation. ECG was taken, which showed anterior wall STEMI. Patient condition explained to attenders & thrombolysed successfully with Inj. TNK 30mg IV after obtaining informed consent. Planned for CAG, but attenders not willing for CAG and wants to go other hospital for further management. All risk, including transport risk explained to attenders in their own language & discharged the patient against medical advice.

N/K/C/O SHTN / T2 DM / CVA / CKD.

ADVICE MEDICATIONS:

SI. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH FOOD	DURATION
			M	A	N			
1	**TAB. ECOSPRIN** (ASPRIN)	75 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	**TAB. CLOPLET** (CLOPIDOGREL)	75 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
3	**TAB. ATOVAS** (ATORVASTATIN)	80 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE

4	**TAB. LASILACTONE** (FRUSEMIDE & SPIRONOLACTONE)	20/50 MG	½	0	0	ORAL	AFTER FOOD	TO CONTINUE
5	**TAB. NITROCONTIN** (NITROGYLCERIN)	2.6 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
6	**TAB. FLAVEDON MR** (TRIMETAZIDINE)	35 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
7	**TAB. PAN** (PANTOPRAZOLE)	40 MG	1	0	0	ORAL	BEFORE FOOD	TO CONTINUE
8	**INJ. CLEXANE** (ENOXAPARIN)	60MG	1	0	1	S/C	X 3 DAYS	

CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile
General condition Stable

GCS	-	15/15			
Temp	-	98°F	BP	-	130/80mmHg
PR	-	90/min	SPO2	-	99%

CONSULTANT SIGNATURE
Dr. Jaishankar. K MD., DM., FIAMS
Director and Clinical Lead
Cardiology and Electrophysiology

Typed by:Ezhilarasi.

"I understood the Content of the discharge summary."

Dr. K. JAISHANKAR
Reg. No: 49448

MHI/HOSP/2022/135

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Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

Medway Heart Institute
Every heart beat counts

INFORMED CONSENT FOR LEAVING / DISCHARGE AGAINST MEDICAL ADVICE

1. I/We the attendants of patient Mr./Mrs./Ms./Master Mr. Siddiquzaman.
S/O W/O D/O Mr mohamed Hussain have been explained about the medical condition of self/our patient in the language which I / we Understand mohamed Hussain by Dr Akilan as mentioned below.
   a. Clinical Diagnosis : CAD / ACS / Acute STEMI / Moderate LV dysfunction
   b. Present Condition :
   c. Treatment planned / required : CAG & PCI
   d. Possible outcomes of continuing the treatment : -
   e. *Complications of not continuing the treatment* : -

2. I / We would request the concerned health professional to discharge me/our patient immediately by discontinuing the medical management / procedure.

3. I/we in my/our full senses, without any correction and unreservedly and solemnly hereby declare that I/We am/are entirely responsible for any consequences that may arise due to such a discharge against medical advice. At any point of time, now or in the future, I/we will not hold the concerned health professionals and staff of Medway Heart Institute responsible / liable for any consequences that may arise due to such a discharge against medical advice.

4. I/we also undertake the responsibility of paying all the amounts that are payable to Medway Heart Institute before leaving the hospital Premises.
5. If the patient is unable to sign, then mention the reason : -

	NAME	SIGN	DATE	TIME
Patient / Representative with Relationship	SIDDIQ	Siddiq	4/1/24	18:00
Witness	Mohamed Hussain		4/1/24	18:00
Doctor				

Discharged Against Medical Advice.

Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

DOA :- 3/1/2024, 23:40.

DOD :- 4/1/2024.

Dx :- CAD/ACS/Anterior wall STEMI.
Moderate LV Systolic dysfunction.
S/P Lysed & Inj. TNK 30mg IV last night.

Mr. Siddiquzama, 42/m, Not a known Co-Morbidity admitted last night with c/o Chest pain (L) side, radiating to back since 8pm. No H/o SOB/Palpitation.
ECG was taken, which showed Anterior wall STEMI, pt's Condition explained to attenders & Thrombolysed successfully with Inj. TNK 30mg IV after got Consent from Family Apt. Planned for CAG. But attenders Not willing for CAG and wanted to go other hospital for further Mgt.
All risks, including transport risks explained to attenders in their own language & Discharged the patient against Medical Advice.

MHI/ER/2022/113

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Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

Medway Heart Institute
Every heart beat counts

Emergency Department Consent Form

Authorization for Medical Examination / Treatment & Diagnosis

I / We Parveen (brother) the undersigned, hereby agree and give consent for the therapeutic/diagnostic treatment at **Medway Heart Institute** I / We have been clearly explained, in a language I / We understand, the need of therapeutic / diagnostic treatment for me / my dependent. I hereby voluntarily consent / Authorize to the rendering of such care, including diagnostic procedures, surgical and medical treatment and blood transfusion by Emergency Physicians, primary care-giver or their authorized designees, as may in their professional judgement be necessary to provide for the medical, surgical or emergency care.

I / We further give consent to take care of me / my dependent to arrange for routine or emergency medical care and treatment necessary to preserve my health / the health of my dependent.

- ☐ **ICU Admission**
- ☐ **Ventilator**
- ☐ **Intubation**
- ☐ **Central Line**
- ☐ **Artery Line**
- ☐ **Bladder Catheter**
- ☐ **Ryle's Tube**
- ☐ **Suturing**
- ☐ **ICD**
- ☐ **LP**
- ☐ **Radiology Imaging**
- ☐ **Bedside USG**
- ☐ ~~**IV/IA Line**~~
- ☐ **Lab Investigation (Blood Test)**
- ☐ **Others, if any:** ICU ADMISSION.

In making medical decisions on my behalf for the benefit of me / my dependent, I direct that the care-giver attempt to contact me / my attenders. However, if medical care becomes essential, I give permission to the care-giver to make decisions regarding such treatment as deemed appropriate by the Doctor, hospital or their authorized designee. In furtherance of any treatment decisions to be made by the care-giver on me / my behalf for my benefit / for the benefit of my dependent, I authorize the care-giver to obtain, review and inspect any and all information bearing upon me / my dependent's health.

I acknowledge that no guarantees have been made to me / my attenders as to the effect of such examinations or treatment on the condition of me / my dependent and that I / We are responsible for all reasonable charges in connection with the care and treatment rendered to me / my dependent during this period.

ACCIDENTAL EXPOSURE OF HEALTH CARE WORKER

I / We understand, that if any health care worker is exposed to me / my dependent's blood or other body fluid, (as optional), can test blood for disease including hepatitis, HIV and syphilis.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I / We hereby authorize and direct my insurance provider or company to make payments to **Medway Heart Institute** I also agree to settle my bills in prompt manner.

STATEMENT OF INTERPRETER (WHERE APPROPRIATE)

I / We have interpreted the information above to the person giving consent to the best of my ability and in a way which I / We believe they understand.

	Signature	Name	Date	Time
Doctor	✓	BALAJI	3/1/24	22:00
Interpreter *(if applicable)*	—	—	—	—

The information given contains nature and purpose of care and the related risk. There is opportunity to clarify any doubts regarding scope of the consent.

I / We have read this consent and agree to its scope and contents. I / We will not hold **Medway Heart Institute** Chennai or its doctors / staff responsible in the event of any untoward complications.

	Signature	Name	Relation	Date	Time
Patient					
Patient Representative	Dasaraad.	Dasaraa (.S	Brother	3/1/24	22:00
Witness	Jay	JAYAPRA)	Good	3/1/24	22:00

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Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

MHI/ER/2022/010
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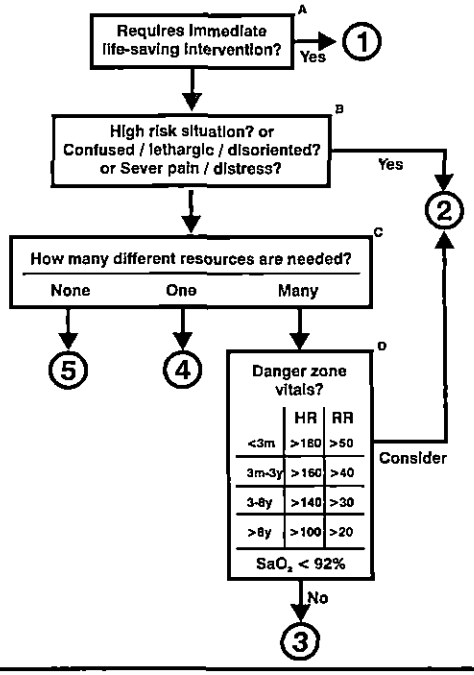
DOCTORS INITIAL ASSESSMENT - EMERGENCY

Part A *(to be filled by Nurses)* Date of Arrival: 3/1/24 Time: 20.4 ☑ Non MLC ☐ MLC no.: _____

Vital Signs: Temp: 98.2°F) Pulse / HR: 69 (beats/min) BP: 141/93 (mmHg)
Respiration: 21 (breaths/min) SpO_2: 99 (%) CBG: 109 (mg/dl)

	GLASGOW COMA SCALE (GCS)			
	Adult	Child < 4 Years	Infant	
EYE OPENING	Spontaneous	Spontaneous	Spontaneous	4
	To sound	To sound	To sound	3
	To Pressure	To Pressure	To Pressure	2
	None	None	None	1
	NonTestable (NT)	NonTestable (NT)	NonTestable (NT)	
VERBAL RSPONSE	Oriented	Oriented	Coos, Babbles	5
	Confused	Confused	Irritable cry	4
	Words	Words	Cries to Pressure	3
	Sounds	Sounds	Moans to Pressure	2
	None	None	None	1
	NonTestable (NT)	NonTestable (NT)	NonTestable (NT)	
BEST MOTOR RESPONSE	Obeys Commands	Obeys Commands	Follows Commands	6
	Localising	Localising	Localising	5
	Normal flexion	Normal flexion	Normal flexion	4
	Abnormal flexion	Abnormal flexion	Abnormal flexion	3
	Extension	Extension	Extension	2
	None	None	None	1
	NonTestable (NT)	NonTestable (NT)	NonTestable (NT)	
	Non Testable (NT) / Total Score =		/15.	



Triage Priority: ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4 ☐ Level 5

	Signature	Name	Emp. No.	Date	Time
Triage completed by		Ramya. R	0158	3/1/24	20.50

Part B *(to be filled by Doctors)*

Chief Complaints:

c/o chest pain - 9hrs - elevated enzymes.
relay to the bank.

Allergies:

Pain Score: 7/10

Pain Scale used:

☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months) ☐ FLACC Scale (2 months - 7 years)
☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years) ☐ Numerical Rating Scale (>12 years)
☐ CPOT (ventilator / comatose)

Past History:

—

Personal / Social History:

Smokes x 2 yrs

Airway: Assessment	**Management**
—	—
Breathing: Assessment	**Management**
—	—
Circulation: Assessment	**Management**
—	—
Disability: Assessment	**Management**
—	—
Exposure: Assessment	**Management**
—	—

GENERAL EXAMINATION

☐ Pallor ☐ Icterus ☐ Clubbing ☐ Cyanosis ☐ Lymp Adenopathy ☐ Dehydration

☐ Edema: ☐ Yes ☐ No If Yes, specify details: _____

Pregnancy: ☐ Yes ☐ No LMP: _____ Breast Feeding: ☐ Yes ☐ No ☐

Others: _____

SYSTEMIC EXAMINATION

Head, Neck & Face:

N

CVS:

S1 S2 ⊕

Chest:

CNS: **Right Pupil: Size:** **Left Pupil: Size:**

NAD **Reaction:** **Reaction:**

Abdomen:

soft

Extremities: **Arms: Left:** **Leg: Left:**

Right: **Right:**

MEDICATION RECONCILIATION

Drug	Dosage	Route	Frequency	Date & Time of last Dosage	To be continued	
					Yes	No
T. Aspirin	300 mg.		stat			
T. Bilhist	180 mg.		stat			
T. Atorva	80 mg.		stat			
Inj. Clexane	0.6 mg	S/C				

Communicable disease(s), if any:

Provisional Diagnosis: ACS - ANTERIOR WALL STEMI

Investigation:

CBC	☐	RP2	☐	LFT	☐	PT / INR	☐
ECG	☐	ABG	☐	UR	☐	S. Electrolyte	☐
Viral Marker	☐	Thyroid Profile	☐	2D ECHO	☐	Chest X-ray	☐
CT Brain	☐	Blood Culture	☐	Urine Culture	☐	USG	☐
Blood Grouping & Typing	☐	PAN-CT	☐	Creatinine	☐	Troponin-I	☐

Others:

Abnormality & Findings *(investigations)*:

Treatment Plan:

Obs → Admission.

Initial Assessment Completed by	Signature	Name	Reg. No.	Date	Time
		Dr. [illegible]	91810	31/1/24	23.45

Refferal

Referred to Speciality	Consultant Name	Informed Time	Seen at
Cardiology	Dr. [illegible]		

Outcome: ☑ Admission ☐ Discharge ☐ Transfer ☐ LAMA

☐ Others: _____

Transferred to: ☐ Ward: _____ ☑ ICU: _____ ☐ OT: _____ ☐ OP: _____

☐ Others: _____

	Signature	Name	Reg. No.	Date	Time
ER Physican		Dr. [illegible]	91810	31/1/24	23.45
Receiving Physican		Dr. [illegible]	91810	31/1/24	23.45

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Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

MHI/IP/2022/107

Medway Heart Institute
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INPATIENT INITIAL ASSESSMENT

Date: 3/1/24 **Time of arrival in ward:** CW @ 23.40

Allergies *(if Yes, specify details)*:

Drugs ☐ Yes ☐ No _____

Blood Transfusion ☐ Yes ☒ No _____

Food ☐ Yes ☐ No _____

Others _____

Vital Signs: Temp: 97.4 (°F) | Pulse / HR: 68 (beats/min) | BP: 190/100 (mmHg)
Respiration: 18 (breaths/min) | SpO_2: 99 (%) | Height: 151 (cms) | Weight: 60 (kgs) | BMI: 26.3 kg/m²

Pain: ☐ Yes ☐ No. If Yes, Score: _____
Pain Scale Used: ☑ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)
Duration: — Location: _____
Pain Character: ☑ Dull ☐ Aching ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Referred / Radiant Pain

CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

c/o chest pain x 8 hrs, retrosternal compressive.
radiating to the back

PAST MEDICAL HISTORY (with duration of illness):

Diabetes Mellitus: ☐ Yes ☒ No. If Yes, duration: — Hypertension: ☐ Yes ☒ No. If Yes, duration: —

Others:

—

Past Surgical History:

—

Present Medication *(for Medication Reconciliation)*:

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Family History:

NIL

Personal / Social History *(Tick whichever is applicable)*

Lifestyle: ☐ **Sedentary** ☐ **Active** **Occupation:** _____

Smoking: ☒ **Yes** ☐ **No** **Alcohol:** ☐ **Yes** ☒ **No** **Recreational Drug Use:** ☐ **Yes** ☐ **No**

Others: _____

Menstrual and Obstetric History *(to be filled up for female patients)*:

—

General Physical Examination:

Pallor: ☐ **Yes** ☒ **No** **Icterus:** ☐ **Yes** ☒ **No** **Clubbing:** ☐ **Yes** ☒ **No**

Edema: ☐ **Yes** ☒ **No** **Lymphadenopathy:** ☐ **Yes** ☒ **No**

SYSTEMIC EXAMINATION

CVS: $S_1 S_2$ (+)

Respiratory System:
BAE (+)

Gastrointestinal System:
Soft

Central Nervous System:
NFND

Urinary / Reproductive / Locomotor System: ~

Skin / Opthalmic / ENT ~

Suspected of contagious disease: ☐ Yes ☑ No Immuno compromised status: ☐ Yes ☐ No
Isolation required: ☐ Yes ☑ No, if yes, ☐ Contact ☐ Airborne ☐ Droplet

Psychological Evaluation:
☑ Normal ☐ Anxious ☐ Depressed ☐ Others: _____

Nutritional Screening *(ESPEN Guidelines for Nutritional Screening - NRS 2002)*:

Weight loss within the last 3 months? ☐ Yes ☑ No Is the patient severely ill? *(e.g. in Intensive Therapy)* ☐ Yes ☐ No

Reduced dietary intake in the last week? ☐ Yes ☑ No Is the BMI < 20.5? ☐ Yes ☐ No

Interpretation: Yes: If the answer is "YES" to any 2 questions, the patient is at nutritional risk
No: If the answer is "NO" to all questions, the patient is at Normal and not at risk

Provisional Diagnosis:
CAD / ACS /
AW - STEMI

Plan of Care:
- Admission
- Thrombolysis
- I/O & Vitals monitoring

Loading dose given before Thrombolysis

Investigations Advised:

- Cath pack
- Cardiac enzymes

Diet Advice:

☐ Nil per Oral ☐ Clear liquid diet ☐ Normal liquid diet ☐ Diabetic liquid diet

☐ Semisolid diet ☐ Soft solid diet ☐ South Indian normal diet ☐ North Indian normal diet

☐ Neutropenic liquid diet ☐ Others: _____

Early Discharge Planning *(fill in those which are appropriate at this stage)*: *PFE: Patient Family Education*

Special support needed at home	☐ **Yes** ☐ **No**	If Yes, PFE done
Home equipment anticipated	☐ **Yes** ☐ **No**	If Yes, PFE done and equipment advised
Physiotherapy at home anticipated	☐ **Yes** ☐ **No**	If Yes, educated on physical limitations, if any
Wound care needs anticipated at home	☐ **Yes** ☐ **No**	If Yes, educated on signs on infection
Pain Management	☐ **Yes** ☐ **No**	If Yes, PFE done and medication advised
Special Dietary needs	☐ **Yes** ☐ **No**	If Yes, educated on dietary restrictions, food drug interactions and allergies
Continuous / ongoing care anticipated	☐ **Yes** ☐ **No**	If Yes, educated on various aspects of ongoing care required
Other special education need, i.e.:	☐ **Yes** ☐ **No**	If Yes, PFE done
Nature of post hospital needs like patient safety, infection control, fall risk, etc, addressed	☐ **Yes** ☐ **No**	If Yes, specific education given

Others:

	Signature	Name	Reg. No.	Date	Time
Resident Doctor		DR. BALAJI	123618	3/1/24	23.50
Consultant		Dr. Sundaravadivel.	45448	3/1/24	23.50
Patient Attendant		Relationship Brother Dawood	Brother	3/1/24	23.50

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Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

MHI/ICU/2022/036

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CONSENT FORM FOR CRITICAL CARE (ICU)

I, MR. SIDDIQUZAMA the ☐ Patient or ☐ Representative of patient have *(please tick the correct option above and below):*

☐ Read

☐ I have been explained in detail by the treating doctor and I understand about the condition of me / and my patient or my patient's illness and I am aware of the all the possible outcomes.

☐ Been explained this consent form in English / TAMIL, which I fully understand and understood the information provided about **ICU Treatment**

I acknowledge that, I had the opportunity to discuss with the doctor about the condition of myself or my patient, treatment options, procedures needed to improve the patient's condition. I hereby give consent to treat the illness of myself or my patient and to do emergency procedures like Endotracheal Intubation including other methods of securing airway, mechanical ventilation, central venous access, arterial lines and further methods of monitoring which are needed to improve or treat my condition.

CENTRAL VENOUS CATHETER INSERTION

Brief description of the Procedure:

A Central venous catheter or central line is a long, soft, thin, hollow tube placed into a large vein (blood vessel). Compared to a peripheral line, central line is larger, longer and is placed into a large vein in the neck, upper chest or groin.

Intended benefits:

Common reasons for having a central line include:

- To give IV medications over a long period of time because a large vein can tolerate an IV catheter for a longer time than a small vein. Examples of such medications are antibiotics and chemotherapy.
- To rapidly deliver large amounts of fluid or blood, for example when a person is in shock.
- To give multiple drug infusions in critically ill patients
- To directly measure blood pressure in a large or central vein. This can help determine how much fluid a person needs.
- For patients who require frequent blood draws to be sent to the laboratory, the central line allows for blood to be drawn without repeatedly pricking the patient.
- To deliver nutrition directly into the blood when food or liquids cannot be given through the mouth, stomach, or intestine.
- To give vasopressors (Blood pressure increasing drugs) for a patient in shock, as giving vasopressors through peripheral line can cause injury to the small blood vessels.
- In some cases, two of the lumens on the central line can be used to perform dialysis, with one lumen used to take blood out of the vascular system and another lumen used to return the dialyzed blood to the body.

Possible risks and complications:

- Discomfort during placement: Discomfort can result from the needle stick and placement of the catheter at the time it is inserted.
- Bleeding: Bleeding can occur at the time the catheter is inserted. The bleeding is usually mild and stops by itself
- Infection: Any tube (catheter) entering the body can make it easier for bacteria from the skin to get into the bloodstream. Special care in cleaning and bandaging the skin at the catheter site can decrease the risk of infection.
- Thrombosis
- Arrythmia
- Pneumothorax (Collapsed lung): When a central venous catheter is placed in the chest area, if the needle passes through or misses the vein, the needle could pierce the lung causing the lung to collapse. If this happens, lung will be reflated by placing a tube between the ribs to remove the air that has leaked from the lung.

I have been explained the implications of not undergoing this procedure like:

- Worsening of clinical condition of the patient.
- Repeated pricking for blood samples.
- Difficulty in getting peripheral venous access.
- When high dose vasopressors are needed, ischemia to the distal part of the limb.

Alternative Forms of Treatment: Peripheral Venous Access

ENDOTRACHEAL INTUBATION

Brief description of the Procedure:
Endotracheal Intubation is often an emergency procedure that's performed on people who are unconscious or who can't breathe on their own. Endotracheal Intubation maintains an open airway and helps prevent suffocation. A flexible plastic tube is placed into your / your patient's trachea through the mouth to help you breathe. The trachea, also known as the windpipe, is a tube that carries oxygen to the lungs.
The size of the breathing tube is matched to the age and throat size. The tube is kept in place by a small cuff of air that inflates around the tube after it is inserted. The trachea begins just below the larynx, or voice box, and extends down behind the breastbone, or sternum. Trachea then divides and becomes two smaller tubes: the right and left main bronchi. Each tube connects to one of the lungs. The bronchi then continue to divide into smaller and smaller air passages within the lung. The trachea is made up of tough cartilage, muscle, and connective tissue. Its lining is composed of smooth tissue. Each time you / your patient breathes in, the windpipe gets slightly longer and wider. It returns to its relaxed size as you breathe out. You can have difficulty breathing or may not be able to breathe at all if any path along the airway is blocked or damaged. This is when Endotracheal Intubation can be necessary. Endotracheal Intubation keeps your airway open. This allows oxygen to pass freely to and from your lungs as you breathe.

Intended benefits:
The procedure might be needed for you / your patient for any of the following reasons:
- to open airways so that patient can receive anaesthesia, medication, or oxygen
- to protect your / your patient's lungs
- when patient has stopped breathing or is having difficulty breathing
- when patient needs help to breathe
- when patient has a head injury and cannot breathe on his / her own
- when patient needs to be sedated for a period of time in order to recover from a serious injury or illness

Possible risks and complications:
- Injury to teeth or dental work
- Injury to the throat or trachea
- Bleeding
- Lung complications or injury
- Aspiration (stomach contents and acids that end up in the lungs)
- Other Risks (if any): _____

Possible alternatives:
Non invasive ventilation can be helpful in a few situations. But when Endotracheal Intubation is required, there can be no alternative treatment offered.

I am now aware of the intended benefits, possible risks and complications, and available alternatives to the said procedure. I am also aware that results of any procedure can vary from patient to patient; and I declare that no guarantees have been made to me regarding success of this procedure. I am aware that while majority of patients have an uneventful prosedure and recovery, few cases may be associated with complications. I am aware of the common risks and complications associated with this procedure as listed above, and understand that it is not possible to list all possible risks and complications of any procedure.
For the above-mentioned procedures that I have been made aware of, I give my consent voluntarily to doctor for carrying out the said procedure on myself or my above-named patient being fully aware of the nature, potential risks and complications, intended benefits and possible alternatives.

I, the above-named Patient / named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.

	Signature / Thumb Impression*	Name	Date	Time
Patient				
Surrogate/Guardian (if applicable #)		Dawood (Ks Brother) *(Write name and relationship with patient)*	3/1/24	23:50
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness		Mohsin Bhai	3/1/24	23:50
Interpreter (if applicable)				

** Right Hand for Males & Left Hand for Females | # Only if Patient is a minor or unable to give consent*

I, the undersigned doctor, have explained the nature, potential risks and complications, intended benefits, expected post-procedure course, and possible alternatives to the planned procedure, to the patient / patient representative. I am confident that he / she has understood the information *fully as described in this document.*

	Signature	Name	Reg. No.	Date	Time
Doctor		DR. BILAL	122615	3/1/24	23:50

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Patient Details *(Affix Label here)*
Name:
UHID:
DOB: Sex:
DOA:
Consultant:

MHI/ICU/2022/036

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உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

_____ என்ற பெயர் கொண்ட □ நோயாளியான அல்லது □ நோயாளியின் பிரதிநிதியான _____ நான், இந்த ஒத்திசைவு படிவத்தை (மேலே மற்றும் கீழே உள்ளவற்றில் சரியான விருப்பத்தேர்வை தயவுசெய்து டிக் செய்க)

□ வாசித்திருக்கிறேன்

□ சிகிச்சையளிக்கும் மருத்துவரால் எனக்கு விளக்கி கூறப்பட்டிருக்கிறது மற்றும் எனது / எனது நோயாளியின் தற்போதைய நிலைமை அல்லது எனது நோயாளியின் நோய் பாதிப்பையும் மற்றும் ஏற்பட சாத்தியமுள்ள அனைத்து விளைவுகளையும் நான் அறிந்திருக்கிறேன் மற்றும் புரிந்து கொண்டிருக்கிறேன்.

□ நான் முழுமையாகப் புரிந்து கொள்கின்ற தமிழ் மொழியில் இந்த ஒப்புதல் படிவம் விளக்கப்பட்டிருக்கிறது மற்றும் ஐசியு சிகிச்சை பற்றி தரப்பட்ட தகவலை நான் புரிந்து கொண்டிருக்கிறேன்.

எனது அல்லது எனது நோயாளியின் உடல்நிலை, சிகிச்சை விருப்பத்தேர்வுகள், நோயாளியின் நிலையை மேம்படுத்துவதற்கு தேவைப்படும் மருத்துவ சேவைகள் பற்றி மருத்துவரிடம் விவாதிக்க எனக்கு வாய்ப்பிருந்தது என்று நான் உறுதியளிக்கிறேன். எனது / எனது நோயாளியின் நோய்க்கு சிகிச்சையளிக்கவும் சுவாசப்பாதையை பாதுகாக்க / உருவாக்குவதற்கான பிற வழிமுறையை செயற்கை சுவாச வழிமுறை, மத்திய சிரை அணுகுவசதி இதய தமனி தமனிக்குழல்கள் உட்பட மூச்சுப் பெருங்குழலுக்குள் குழாய் செருகுதல் போன்ற அவசரநிலை மருத்துவ செயல்முறைகளை செய்யவும் இதன்வழியாக நான் ஒப்புதல் அளிக்கிறேன். மேலும் எனது நிலைமைக்கு சிகிச்சையளிக்க அல்லது அதனை மேம்படுத்த தேவைப்படும் கண்காணிப்பு வழிமுறைகளை மேற்கொள்ளவும் ஒப்புதல் அளிக்கிறேன்.

மைய சிரையில் கதீட்டர் உட்செருகல்

மருத்துவ செயல்முறையின் சுருக்க விவரணை:
ஒரு மைய சிரை கதீட்டர் அல்லது மைய லைன் என்பது, ஒரு நீளமான, மென்மையான, மெல்லிய, துவாரமுள்ள குழாய் ஒரு பெரிய நாளத்திற்குள் (இரத்த நாளத்திற்குள்) செலுத்தப்படக்கூடியதாகும். மையத்திற்கு அப்பாலுள்ள புற லைனோடு ஒப்பிடுகையில், மைய லைன் என்பது பெரியது மற்றும் நீளமானது; கழுத்து, மேற்புற மார்பு அல்லது இடுப்பு கவட்டையில் உள்ள பெரிய நாளத்திற்குள் வைக்கப்படுவதற்குரியது.

அடைய திட்டமிடப்படும் பலன்கள்:
மைய லைனை பொருத்துவதற்கான பொது காரணங்களுள் கீழ்க்கண்டவை உள்ளடங்கும்:

- ஒரு சிறிய நாளத்தைவிட, ஒரு பெரிய நாளமானது நீண்ட காலஅளவிற்கு ஒரு IV கதீட்டரை தாங்கும் என்பதால், நீண்ட காலஅளவிற்கு IV மருந்துகளை வழங்குவதற்காக. ஆன்ட்டிபயாட்டிக் மருந்துகள் மற்றும் கீமோதெரபி போன்றவை இதற்கான மருந்துகளின் எடுத்துக்காட்டுகளாகும்.
- அதிக அளவிற்கு திரவம் அல்லது இரத்தத்தை அதிவேகமாக வழங்குவதற்கு; எடுத்துக்காட்டாக ஒரு நபர் அதிர்ச்சியில் ஆழ்ந்திருக்கும்போது.
- உயிருக்கு ஆபத்தான நிலையிலுள்ள நோயாளிகளுக்கு ஒன்றுக்கு மேற்பட்ட பல மருந்து உட்செலுத்தல்களை வழங்குவதற்கு.
- ஒரு பெரிய அல்லது மைய சிரை / நாளத்தில் நேரடியாக இரத்தஅழுத்தத்தை அளவிடுவதற்கு. ஒரு நபருக்கு எந்தஅளவு திரவம் தேவைப்படுகிறது என்பதை தீர்மானிக்க இது உதவக்கூடும்.
- பரிசோதனையகத்திற்கு அடிக்கடி இரத்த மாதிரிகளை அனுப்ப வேண்டிய தேவையுள்ள நோயாளிகளுக்கு திரும்பத்திரும்ப நோயாளிக்கு ஊசிகுத்தி இரத்தம் எடுப்பதற்கு பதிலாக, எளிதாக இரத்தம் எடுக்க மைய லைன் வகை செய்கிறது.
- வாய், வயிறு அல்லது குடல் வழியாக தர இயலாதபோது ஊட்டச்சத்துகளை நேரடியாக இரத்தத்திற்குள் கலக்குமாறு வழங்குவதற்கு.
- புறவெளி லைன் வழியாக வாசோபிரெசர்ஸ் - ஐ வழங்குவது சிறிய இரத்த நாளங்களுக்கு சேதத்தை விளைவிக்கும் என்பதால், அதிர்ச்சியில் ஆழ்ந்துள்ள ஒரு நோயாளிக்கு வாசோபிரெசர்ஸ்களை (இரத்த அழுத்தத்தை அதிகரிப்பதற்கான மருந்துகள்) வழங்குவதற்கு.
- சில நேர்வுகளில், டயலாலிசிஸ் செய்வதற்கு மைய லைன் மீது இரண்டு குழல்களைப் பயன்படுத்தலாம். இரத்தநாள அமைப்பிலிருந்து இரத்தத்தை எடுப்பதற்கு ஒரு குழலையும், டயலாசிஸ் செய்யப்பட்ட இரத்தத்தை உடலுக்கு திரும்ப அனுப்புவதற்கு மற்றொரு குழலையும் பயன்படுத்தலாம்.

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

- பொருத்தப்படும்போது அசௌகரியம்: ஊசியால் குத்தும்போது மற்றும் கதீட்டரைப் பொருத்தும் நேரத்தில் அதனை உட்செலுத்துகின்ற நேரத்தில் அசௌகரியம் ஏற்படக்கூடும்.
- இரத்தக்கசிவு: கதீட்டர் உட்செலுத்தப்படும் நேரத்தில் இரத்தக்கசிவு நிகழக்கூடும். இந்த இரத்தக்கசிவு வழக்கமாக மிகச்சிறிய அளவில் லேசாக இருக்கும் மற்றும் அது தானாகவே நின்றுவிடும்.
- தொற்று: உடலுக்குள் நுழைக்கப்படும் எந்தவொரு குழாயும் (கதீட்டர்), சருமத்திலிருந்து பாக்டீரியா இரத்த ஓட்டத்திற்குள் கலப்பதற்கு இதனை எளிதானதாக ஆக்கிவிடும். கதீட்டர் பொருத்தப்படும் இடத்தை தூய்மைப்படுத்துவது மற்றும் பேண்டேஜ் செய்வதில் சிறப்பு கவனம் செலுத்தப்படுவது தொற்றுக்கான இடர்வாய்ப்பைக் குறைக்கக்கூடும்.
- இரத்தஉறைவு
- ஒழுங்கற்ற இதயத்துடிப்பு
- நுரையீரல் உறைக்காற்று நோய் (நுரையீரல் துவண்டு மடிதல்): மார்பு பகுதியில் ஒரு மைய சிரைகதீட்டர் பொருத்தப்படும்போது ஊசி சிரை / நாளத்தின் வழியாக கடந்து செல்லுமானால் அல்லது அதை தவறவிடுமானால் அந்த ஊசி நுரையீரலுக்குள் ஊடுருவி, நுரையீரல் துவண்டு மடிவதை விளைவிக்கும். இது நிகழுமானால், நுரையீரலிலிருந்து வெளியே கசிந்திருக்கின்ற காற்றை அகற்றுவதற்கு விலாக்களுக்கு இடையே ஒரு குழாயை வைப்பதன் மூலம் நுரையீரல் மீண்டும் மீட்பு வீக்கம் பெறுமாறு செய்யப்படும்.

இந்த மருத்துவ செயல்முறையை மேற்கொள்ளவில்லை எனில், கீழ்க்கண்டவை போன்ற விளைவுகள் நிகழலாம் என்று எனக்கு விளக்கிக் கூறப்பட்டிருக்கின்றன:

- நோயாளியின் மருத்துவ / உடல்நிலை மோசமடைதல்.
- இரத்த மாதிரிகளுக்காக திரும்பத்திரும்ப ஊசி குத்துவது.
- புறவெளி இரத்தநாள அணுகுவசதியை பெறுவதில் சிரமம்.
- அதிக அளவிலான வாசோபிரெசஸர்ஸ் தேவைப்படும்போது உறுப்பின் தொலைதூரப் பகுதிக்கு இரத்தஓட்டத்தடை

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அணுகுவசதி

மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல்

மருத்துவ செயல்முறையின் சுருக்கமான விவரணை:
மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல் (Endotracheal Intubation) என்பது, தாங்களே சுயமாக சுவாசிக்க இயலாத அல்லது நினைவிழந்துவிட்ட நபர்களுக்கு செய்யப்படும் ஒரு அவசரநிலை சிகிச்சை செயல்முறையாகும். இது, ஒரு திறந்தநிலை மூச்சுப்பாதையை பராமரிக்க வகை செய்கிறது மற்றும் மூச்சுத்திணறல் நிகழாமல் தடுக்கிறது. நீங்கள் சுவாசிப்பதற்கு உதவ, உங்களது / உங்களது நோயாளியின் மூச்சுக்குழலுக்குள் ஒரு நெகிழ்வுத்திறன் கொண்ட பிளாஸ்டிக் குழாய் வாய் வழியாகப் பொருத்தப்படுகிறது. மூச்சுக்குழாய் என்றும் அழைக்கப்படுகின்ற இந்த மூச்சுக்குழல், ஆக்சிஜனை நுரையீரல்களுக்கு எடுத்துச்செல்லும் ஒரு குழாயாகும்.
சுவாசிப்பதற்கான இந்த குழாயின் அளவு நோயாளியின் வயது மற்றும் தொண்டை அளவிற்குப் பொருத்தமானதாக தேர்வு செய்யப்படும். உட்செலுத்தப்பட்டதற்குப் பிறகு குழாயை சுற்றி விரிவடைகின்ற காற்றின் ஒரு சிறிய சுற்றுப்பட்டையின் மூலம் உட்செலுத்தப்பட்ட குழாய் அதே இடத்தில் இருக்குமாறு வைக்கப்படும். மூச்சுக்குழாய், குரல்வலைக்கு சற்றுகீழே தொடங்குகிறது மற்றும் மார்பு எலும்பிற்கு பின்னே வரை அது நீள்கிறது. அதன்பிறகு மூச்சுக்குழாய் இரு சிறு குழல்களாக பிரிகிறது: வலது மற்றும் இடது பிரதான மூச்சு சிறுகுழாய்கள் ஒவ்வொரு சிறுகுழாயும், ஒவ்வொரு நுரையீரலோடு இணைக்கப்பட்டிருக்கிறது. இந்த மூச்சு சிறுகுழாய், அதன்பிறகு நுரையீரலுக்குள் சிறு சிறு காற்றுப் பாதைகளாக தொடர்ந்து பிரிகின்றன. மூச்சுக்குழாய் என்பது, கடினமான குருத்தெலும்பு, தசை மற்றும் இணைப்புத்திசு ஆகியவற்றால் உருவானது. இதன் அகவுறை மிருதுவான திசுக்களால் ஆனது. ஒவ்வொரு முறையும் நீங்கள் / உங்களது நோயாளி காற்றை உள்ளே சுவாசிக்கும்போது மூச்சுக்குழாய் சற்றே நீளமானதாக மற்றும் விரிவானதாக ஆகிறது. மூச்சை வெளியே விடும்போது அதன் முந்தைய தளர்வான நிலைக்கு அது திரும்புகிறது. மூச்சுப்பாதையில் எந்தவொரு இடமும் சேதமடைந்திருக்குமானால் அல்லது தடை பட்டிருக்குமானால் உங்களால் சுவாசிக்க இயலாமல் போகலாம் அல்லது சுவாசிப்பதில் சிரமம் இருக்கலாம். இத்தகைய தருணத்தில் தான் மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல் அவசியமாக இருக்கக்கூடும். இந்த செயல்முறை உங்களது மூச்சு / காற்றுப்பாதையை அடைப்பின்றி திறந்த நிலையில் வைக்கிறது. நீங்கள் சுவாசிக்கும்போது உங்களது நுரையீரலிலிருந்து மற்றும் நுரையீரலுக்கு ஆக்சிஜன் தடையின்றி, தாராளமாக சென்று வருவதை இது அனுமதிக்கிறது.

அடையத் திட்டமிடப்பட்டுள்ள பலன்கள்:
கீழ்வரும் ஏதாவதொரு காரணத்திற்காக இந்த மருத்துவ செயல்முறை உங்களுக்கு / உங்களது நோயாளிக்குத் தேவைப்படக்கூடும்:

- உணர்விழப்பு மருந்து, பிற மருந்துகள் அல்லது ஆக்சிஜன் போன்றவற்றைப் பெறுவதற்காக மூச்சுப்பாதையை திறந்த நிலையில் வைப்பது.
- உங்களது / உங்களது நோயாளியின் நுரையீரலைப் பாதுகாப்பது
  சுவாசிக்க உதவ:
- சுவாசிப்பதை நோயாளி நிறுத்திவிட்டபோது அல்லது சுவாசிப்பதில் சிரமம் இருக்கும்போது
- சுவாசிப்பதற்கு நோயாளிக்கு உதவி தேவைப்படும்போது
- நோயாளிக்கு தலைக்காயம் ஏற்பட்டிருக்கும்போது மற்றும் தானாகவே அவரால் சுவாசிக்க இயலாதபோது
- ஒரு கடுமையான காயம் அல்லது நோயிலிருந்து மீண்டு வருவதற்காக நீண்ட காலஅளவிற்கு ஒரு நோயாளி உணர்விழப்பு மருந்தின் கீழ் அல்லது மயக்க நிலையின் கீழ் வைக்கப்படுவது அவசியமாக இருக்கும்போது.

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

- பற்கள் அல்லது பற்கட்டமைப்பிற்கு காயம்
- தொண்டை அல்லது மூச்சுக்குழாயில் காயம்
- இரத்தக்கசிவு
- நுரையீரல் சிக்கல்கள் அல்லது காயம்
- உறிஞ்சி வெளியிழுத்தல் (வயிற்றிலுள்ள உணவுப்பொருட்களும், அமிலங்களும் நுரையீரல்களில் சேர்ந்திருக்கும்போது)
- பிற இடர்கள் (ஏதும் இருக்குமானால்):

சாத்தியமுள்ள மாற்று வழிமுறைகள்:
உடலுக்குள் ஊடுருவாத சுவாச ஏதுவாக்கல் முறையானது, சில சூழ்நிலைகளில் உதவிகரமாக இருக்கக்கூடும். ஆனால், மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல் அவசியப்படும்போது, வேறு மாற்று சிகிச்சை முறைகள் வழங்கப்படுவதற்கு வழியில்லை.

மேற்குறிப்பிடப்பட்ட மருத்துவ செயல்முறையின் மூலம் அடைய திட்டமிடப்பட்டுள்ள பலன்கள், சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள், இந்த செயல்முறைக்கு கிடைக்கக்கூடிய பிற மாற்று வழிமுறைகள் பற்றி இப்போது நான் அறிந்திருக்கிறேன். எந்தவொரு மருத்துவ செயல்முறையிலும் அதன் முடிவுகள் நோயாளிக்கு நோயாளி வேறுபடக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன்; மற்றும் இந்த மருத்துவ செயல்முறையின் வெற்றி குறித்து எனக்கு எந்தவித உத்தரவாதங்களும் அளிக்கப்படவில்லை என்பதையும் நான் உறுதிபட தெரிவித்துக்கொள்கிறேன். பெரும்பான்மையான நோயாளிகளுக்கு அசம்பாவிதம் இல்லாமல் அறுவைசிகிச்சை மற்றும் மீண்டு குணமடைதல் நிகழ்கின்ற நேர்வில், சில நேர்வுகளில் சிக்கல்கள் ஏற்படக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன். மேலே குறிப்பிடப்பட்டுள்ள இந்த மருத்துவ செயல்முறையோடு தொடர்புடைய பொதுவான இடர்கள் மற்றும் சிக்கல்களை நான் அறிந்திருக்கிறேன். எந்தவொரு மருத்துவ செயல்முறையிலும் ஏற்பட சாத்தியமுள்ள ஆபத்துகள் மற்றும் சிக்கல்கள் அனைத்தையும் பட்டியலிட சாத்தியமில்லை என்பதையும் நான் புரிந்துகொள்கிறேன்.
இந்த மருத்துவ செயல்முறையின் தன்மை மற்றும் சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள் மற்றும் உத்தேசிக்கப்படும் நன்மைகள் மற்றும் சாத்தியமுள்ள மாற்றுமுறைகள் பற்றி நான் அல்லது மேலே பெயர் குறிப்பிடப்பட்டுள்ள எனது நோயாளி முழுமையாக அறிந்திருக்கும் நிலையில் எனக்கு விளக்கப்பட்ட மேற்கண்ட மருத்துவ செயல்முறைக்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை நான் அளிக்கிறேன்.

மேலே பெயர் குறிப்பிடப்பட்டுள்ள நோயாளியான / நோயாளியின் பிரதிநிதியான நான், இப்படிவத்தில் கையொப்பமிடும் தேதியில் 18 ஆண்டுகள் வயதுக்கு மேற்பட்ட, சீரான நல்ல மனநலம் கொண்ட நபராக இருக்கிறேன் மற்றும் எந்தவித அச்சம், அச்சுறுத்தல் அல்லது தவறான கண்ணோட்டம் இல்லாமல் இச்செயல்முறைக்கு ஒப்புதல் அளிக்கிறேன் என்று இதன் மூலம் நான் மேலும் உறுதிமொழியளிக்கிறேன்.

	கையொப்பம் / கட்டைவிரல் ரேகை*	பெயர்	தேதி	நேரம்
நோயாளி				
பதிலாள் / பாதுகாவலர் (பொருந்துமானால் #)		(பெயர் & நோயாளிக்கு என்ன உறவுமுறை என்பதை எழுதவும்)		
பதிலாள் ஒப்புதல் வழங்குவதற்கு காரணம்	நோயாளியால் ஒப்புதல் வழங்க இயலவில்லை; ஏனெனில்:			
சாட்சி				
மொழிபெயர்ப்பாளர் (பொருந்துமானால்)				

***ஆண்களுக்கு வலது பெருவிரல் மற்றும் பெண்களுக்கு இடது பெருவிரல் ரேகை பதிவு | # உரிய வயது வராதவராக அல்லது ஒப்புதல் கொடுக்க இயலாதவராக நோயாளி இருந்தால் மட்டுமே.**

கீழே, கையொப்பமிட்டுள்ள மருத்துவராகிய நான், திட்டமிடப்பட்ட ஆபரேஷன் / நடைமுறை குறித்த தன்மை, ஏற்பட சாத்தியமுள்ள ஆபத்துகள் மற்றும் சிக்கல்கள், கிடைக்கும்என்று கருதப்படும் நன்மைகள், எதிர்பார்க்கப்படும் நடைமுறைக்குப் பின் சிகிச்சை, மற்றும் சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்றி நோயாளியிடம் / நோயாளியின் பிரதிநிதியிடம் எடுத்துக்கூறி விளக்கியுள்ளேன். மேலும் அவர், இந்த ஆவணத்தில் விவரிக்கப்பட்டபடி, தகவலை முழுமையாக புரிந்துகொண்டுள்ளார் என்பதை நான் உறுதியாக நம்புகிறேன்.

	கையொப்பம்	பெயர்	பதிவு எண்.	தேதி	நேரம்
மருத்துவர்					

Medway Hospitals®
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Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

:2/041

Medway Heart Institute
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MR. Siddiquzama 40/yrs

DOCTOR'S PROGRESS NOTES

DATE	NOTES
3/1/24 9.40 pm.	S/B: Dr. Harish Sabapathi MD DM (Cardiology)
	C/o Chest pain since 9pm, retrosternal compressive radiating to back.
	No H/o SOB
	No H/o palpitations
	No H/o dizziness or syncope
	Not a K/C/o HTN/T2DM
	No H/o CVA, Head injury,
	No H/o recent surgery
	No H/o Bleeding PR, Hematemesis
	No H/o any contraindication for Thrombolysis
Beg: Ishaemic 90/m. ST↑ V1-V6. reciprocal ST↓ in aVR. Bedd: Anterior Basal, Mid & Apical AW, AS + Apical BP: 40 y. Mod. LV Dysfunction No VSD, NOPE	O/E: Conscious CVS: S1S2 ⊕ BP: 180/90 No B/L LOE PR: 76/m. SpO2: 99% A: CAD/ACS/ AW-STEMI Mod. LV Dysfunction
	R DIL T. Aspirin 300 mg stat. T. Clopidogrel 300 mg stat T. Atorvastatin 80 mg D. Clexane 0.6 s.c Advised thrombolysis pt & attenders not willing Risk explained. pt sent - DMA
	4/3/24.

DATE	NOTES
	S/b Dr. K.R.K Sabapathi
11.30pm	pt attenders want to get admitted & thrombolyse.
	Bleeding Risk explained.
	Weight: 59kg
	℞
	(1) Inj. Tenecteplase 30mg I.V bolus given at 11.40pm.
	(2) Rpt ECG @ 1.10am.
	(3) Inj. Clexane 0.3 I.V stat
	(4) Inj. Clexane 0.6mg s.c 1-0-1.
	(5) T. Nitrocontin 2.6 1-0-1
	(6) T. Plavedol FR 35 1-0-1
	(7) T. Alprax 0.5 0-0-1
	(8)
	93725

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MHI/IP/2022/041

Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

Medway Heart Institute
y heart beat counts

4/m.

DOCTOR'S PROGRESS NOTES

DATE	NOTES
31/1/23 23:20	Mr. Siddiq-s 40/M came c chest pain since today evening.
	ECG shows ST elevation which suggests AW MI. Pt was planned to Thrombolyse with Tenplase, the thrombogenic complication can lead to blockage.
	Dawood. KS. Friend- 9986111077.

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NABH

Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

MHI/ICU/2022/040

Medway Heart Institute
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Date : 4/1/24
Time : 9.00 Am
Doctor's Name : J. madhukar

ICU PROGRESS NOTES

ICU SCORES (as Appropriate)	CLIF ACLF / AD score:	MELD score:	AARC score:
	SOFA score:	SAPS II score:	APACHE II score:

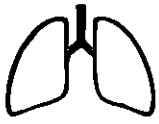
ICU Day D2
Background
AWMI - p/t Thrombolysis
ET- 40 F. (B/M/A - 6 Klinitic)
O_2 2Lt to room air

Issues last 24 hours
pow Thrombi US TTK - 30g/1.2g/m
ECG resolving
No chest pain
(Trop - 40,000)

Central nervous system
Conscious / oriented / sedated with
Sedation score
GCS - E 4 V 5 M 6
Pain score
Pupils 2+
Drains

Cardiovascular system
HR - 66/L Rhythm - Cardiac Output -
BP 113/74 CVP -
Cardiac Medications:

Respiratory system
Oxygen supplementation – Room air
Saturation / PaO2-
Ventilator : Spontaneous / Controlled



Last C x R -
Drains -

GIT
P/A Soft
Bowels – Y / N Loose stools / Melena
Drains
NG tube : Y / N Day NGA-
USG
CT

Nutrition & Fluids
Oral feeds / NG feeds normal diet.
TPN – formula used
Supplements
Calories / Proteins achieved :
IV fluids -
24 hour Urine output
Fluid balance
Creatinine clearance
Acidosis
RRT – SLED / IHD / CRRT

Microbiology
Invasive lines Peripheral lines
1. 2.
Foley's Yes / No
ET Tube / Tracheostomy tube - Y / N Day
Culture reports

Antimicrobials with days
1.
2.
3.

Labs

Hb	TC	Platelets
Urea	Creatinine	
Na	K	
Bilirubin	AST	ALT
INR		
Others		

DVT prophylaxis – Y/N
Drugs : Mechanical – TEDS / SCD

Stress Ulcer Prophylaxis – Y/N
Drugs
Pressure sore Y / N
Alpha bed Y / N

Plan for the day

Plan

=> cont on going care
=> ~~Elective CABG~~ ±
=> follow pendg reports
=> SOF solid diet
=> watch for any sign of Bleeding.
=> collect pendg reports - NT

Dr. Madhuleen
16320

Case reviewed by primary
& continue care in CCU
CABG c/m

Dr. Madhuleen
16320

Dr. T. Palaniappan
MD.,DNB.,MNAMS.,MRCP(UK)
Intensivist
Reg. No: 55530

Doctor	Signature	Name	Reg. No.	Date	Time
	Dr. Madhuleen	Dr. Madhuleen	16320	4/1/24	9.00AM

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03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

MHI/IP/2022/041

Medway Heart Institute
heart beat counts

DOCTOR'S PROGRESS NOTES

DATE	NOTES
4/1/24, 9AM	S/B: Dr. Jaishankar team.
	pt symptomatically better.
	No SOB
	No chest pain.
	Conscious
	CVS: S1S2
	BP: 110/70 mm Hg
	PR: 70/min
	RS: SAFE/A
	GIT: Relevant bowel sounds.
	Looped to prox. ileum.
	Rx
	Collect Report
	NPO from 8am after Breakfast
	Plan CAG
	If willing
	Sd/-
	Cardiologist.

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03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

URINE ROUTINE ANALYSIS

MICROBIOLOGY SHEET

DATE	4/1/24.		
COLOUR	Pale yellow		
REACTION			
SPECIFIC GRAVITY	1.010.		
APPEARANCE	Slightly Turbid.		
ALBUMIN			
SUGAR			
ACETONE			
BILE SALT			
BILE PIGMENT			
UROBILINOGEN	Normal.		
PUS CELLS	3-5.		
EPITHELIAL CELLS	1-2.		
RBC	4-6.		
CASTS	NIL.		
CRYSTALS	NIL		
OTHERS	NIL.		

MICROBIOLOGY-CULTURE REPORTS

DATE	SPECIMEN/SITE	GROWTH- 24h, 48h, ORGANISM	SENSITIVITY

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42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

OMBOLYSIS CHECK LIST

Name: Age: 42 Y Sex: M CC No.: 02

Diagnos Wt: Date: 3/1/24

Time of thrombolysis - From: To:

ELIGIBILITY CRITERIA

		YES	NO
Clinical:	Chest pain for less than12 hours	☑	☐
ECG:	ST elevation ≥ 1mm in ≥ 2 limb leads	☑	☐
	ST elevation ≥ 2mm in ≥ 2 chest leads	☐	☐

CONTRAINDICATIONS - Check list

Absolute contraindications

	YES	NO
* Any active internal bleeding	☐	☑
* *Known intra-cranial neoplasm*	☐	☑
* History of previous haemorrhagic CVA	☐	☑
* Suspected aortic dissection	☐	☑

Relative contraindications

	YES	NO
* Active peptic ulcer disease	☐	☑
* Recent internal bleed (< 2 - 4 weeks)	☐	☑
* Persistent hypertension of (> 180/110 mmHg)	☐	☑
* Previous use of streptokinase (5 days - 2 years)	☐	☑
* Pregnancy	☐	☑
* History of recent embolic or ischaemic CVA	☐	☑
* Current anticoagulation therapy (INR > 2-3)	☐	☑
* Major trauma or Surgery (< 2 - 4 weeks)	☐	☑
* Non-compressible vascular punctures	☐	☑
* History of chronic severe hypertension	☐	☐

Risk assessment of Intra-cerebral haemorrhage

	YES	NO
* Age more than 65 years	☐	☑
* Weight less than 70Kg	☑	☐
* Hypertension at presentation (> 180/110 mmHg	☑	☐
* Use of t-PA	☑	☐

Comments:

Thrombolytic used: TNK

Dose: 3amp

Signature of the Doctor

Date : 3/1/24 Time 11.40

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R HIV TESTING

Patient Name :	Mr.SIDDIQUZAMA 42/Male/MHI202481588 03/01/2024/IPH2024000024	Age : 42Y	Sex : M / F
Consultant :	Dr.K.JAISHANKAR		UHID : 202481588

- I _____ have been given verbal and written educational information for HIV antibody testinq.
- I have been informed that a sample of my blood will be drawn and tested and tested to detect HIV antibodies I have been informed of the purpose, potential uses of the test and the consequences of not having the test done
- I hereby acknowledge that I have read or have had read to me this information regarding HIV antibody testing.
- I have been given the opportunity to ask questions and all the questions have been answered to my satisfaction.
- I acknowledge that I have given consent for performance of this blood test to detect HIV antibodies. This has been explained to me in _____ language. which I can understand.

	Signature	Name	Date	Time
Patient				
Doctor / Nurse / Counsellor				
Interpreter				

CONSENT OF PATIENT REPRESENTATIVE / SURROGATE

The patient is unable to consent because _____
and I, _____ (name / relationship to the patient), therefore, consent for the patient I acknowledge that I have had an opportunity to discuss this procedure, as stated above, with the doctor or doctor's designee, and hereby consent to this procedure.

	Signature	Name	Date	Time
Patient Representative with relationship		Dawood/Ks	3/1/24	23.50
Doctor / Nurse / Counsellor		DR. BALAJI	3/1/24	23.50
Interpreter				

CONSENT OF PATIENT REPRESENTATIVE / SURROGATE

The patient is unable to consent because _____

and I, _____ (name / relationship to the patient), therefore, consent for the patient I acknowledge that I have had an opportunity to discuss this procedure, as stated above, with the doctor or doctor's designee, and hereby consent to this procedure.

	Signature	Name	Date	Time
Patient Representative				
Witness				
Doctor				
Interpreter				

MHI/IP/2022/065

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DIABETIC CHART

Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

ACTUAL WEIGHT ..... +60 kg ..... HbA_1c ..... —

PREVIOUS DIABETIC MEDICATIONS ..... —

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
4/1/24.	6.30	117 mg/dl	—		DR. BALAJI

INSTRUCTIONS FOR INSULIN INFUSIONS

* Mix 40u short acting Insulin in 40 ml. of normal Saline (IU - 1 ml.)
* Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).
* Monitor Blood Glucose hourly (every 2nd hourly when stable) and adjust Insulin rate according to the following Algorithm.
* Target Blood Sugar 150-200 mgs.
* To monitor K+ separately.

Urine Acetone

BLOOD SUGAR mg / dl	INSULIN INFUSION
< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
150-200	Adjust Infusion rate to 2u / hr.
201-250	Adjust Infusion rate to 4u / hr.
251-300	Adjust Infusion rate to 6u / hr.
301-350	Adjust Infusion rate to 8u / hr.
351-400	Adjust Infusion rate to 10u / hr.
>400	Adjust Infusion rate to 20u / hr.

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Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

BLOOD GROUP

'O' POSITIVE

INVESTIGATION SHEET

Date	4/1/24					
HAEMATOLOGY						
Hb	15.9					
P.C.V	47.0					
Platelets	260000					
TLC	18350					
Polymorphs	76.1					
Lymphocytes	19.3					
Eosinophils	0.2					
Mono / Basophils	4.3/0.1					
E.S.R						
BIO-CHEMISTRY						
Urea	25					
Creatinine	0.83					
Sodium	133					
Potassium	3.95					
Bicarbonate	23					
Chloride	94.1					
Magnesium						
Calcium						
Phosphorus						
LFT						
T.Bilirubin						
D.Bilirubin						
I.Bilirubin						
S.G.O.T						
S.G.P.T						
ALP						
GGT						
Total Protien						
S.Albumin						
CARDIAC ENZYMES						
Troponin I	740,000					
CKNAC - CPK	1454					
CK - M.B. MASS	158.4					
LDH						
Ntpro bnp						

Date	4/1/24.					
COAGULATION PT / INR	INR - 0.9. PT - 11.8					
Fibrinogen						
D Dimer						
LIPID PROFILE						
Total Cholesterol						
Triglyceride						
H.D.L						
L.D.L						
VLDV						
THYROID FUNCTION T.S.H						
T.3						
T.4						
SEROLORY						
HIV						
HBsAg						
V.D.R.L						
COVID 19						
RT- PCR						
IgM Ig						
HBA1C						
FBS/PPBS						
RBS						
S.AMYLASE						
S.LIPASE						
C.R.P						
PROCALCITONIN						
DDIMER						
S.Osmolality **URINE**						
Osmolality						
Spot - Na						

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Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

MHI/IP/2022/074

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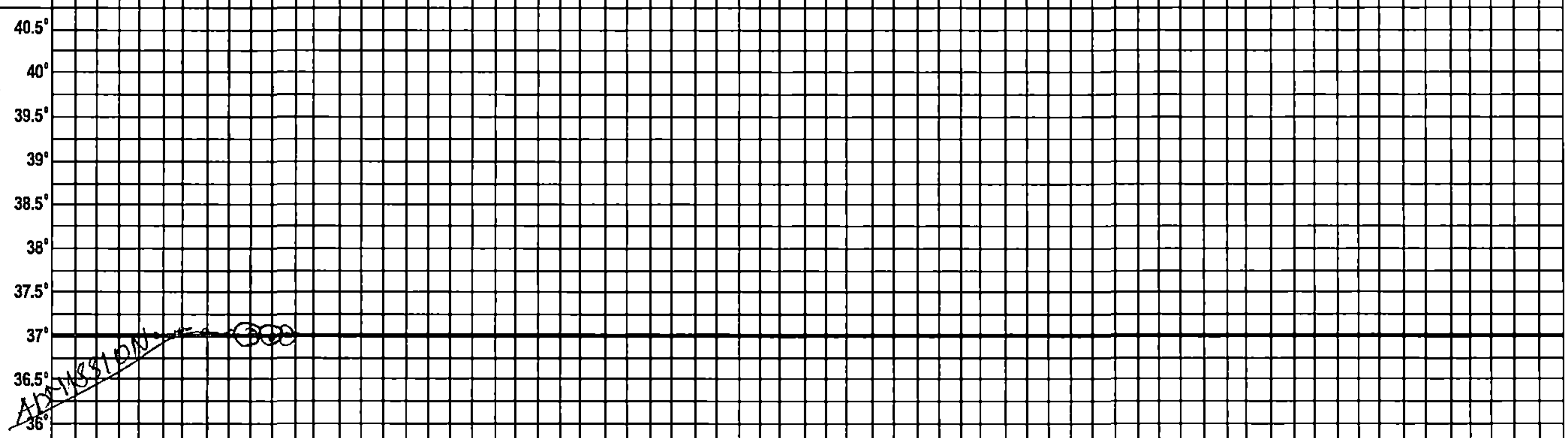
VITAL INFORMATION SHEET

BLOOD GROUP	
ON ADMISSION	
Height in CM	**Weight** in Kg.
151 cm	60 kg

Diagnosis: CAD / ACS / AW- STEMI

Procedure : -

NO. OF DAYS	1	2
DATE	3/1/24	4/1/24
HOUR	2 6 10 2 6 10	2 6 10 2 6 10



	Day 1		Day 2	
PULSE		63	90	78
RESP		20	21	20
B.P.		190/100	130/80	104/82
SPO2		99	99	99%
DAILY WEIGHT	±60kg		±60kg	
24 HRS INTAKE	150			
24HRS OUTPUT	550			
BALANCE	[illegible]00			
MOTION				

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MHI/DIET/2022/147

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Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: EF-40% | CAD | AVS | AWI-STEMI				
Height: 161 cms	Weight: 60 Kgs	Food allergies: Yes/ No, if yes, specify.....		
Religious Beliefs:	☐ Vegetarian	☐ Non Vegetarian	☐ Eggetarian	☐ Jain
Diet Prescription: 1000 Calorie, low fat, low salt, 1000ml fluid restricted diet.				

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

	(A)	Patient's related Medical History				
	1)	Weight Change (overall change in past 6 months)				
		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
		No weight change/ gain	<5%	5 - 10%	10 - 15%	>15%
2)	Dietary Intake	Duration:				
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
	Oral	No change	Sub - optimal solid diet	Full liquid diet/ moderate overall decrease	Hypo - caloric liquid diet	Starvation
	Enteral / Parenteral Nutrition	Adequate / Excessive	Sub - optimal	Inadequate	Typo - caloric feeds	Starvation
3)	Gastrointestinal Symptoms Duration:					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		No symptoms	Nausea	Vomiting / moderate GI symptoms	Diarrhoea	severe anorexia
4)	Functional Capacity (Nutrition related functional impairment) Duration:					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		None /Improved	Difficulty with ambulation	Difficulty with normal activity	Light activity	Bed / chair - ridden with no or little activity
5)	Co - morbidity (Disease and its relationship to nutrition requirements)					
		☐ 1	☐ 2	☑ 3	☐ 4	☐ 5
		Healthy	Mild co - morbidity	Moderate co - morbidity/ age >75 years	severe co - morbidity	Very severe multiple co - morbidity
B)	Physical examination					
1)	Decreased fat stores or loss of subcutaneous fat					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		Normal	Mild	Moderate		Severe
2)	Sign of muscle wasting					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		Normal	Mild	Moderate		Severe
Total Score = Sum f above 7 components						
Nutritional Status : Based on this patient is						
	Well Nourished	☑ (7 to 14)				
	Moderately Malnourished	☐ (15 to 18)				
	Severely Malnourished	☐ (19 to 35)				
Nutrition Intervention:						
	☑ Oral	☐ Enteral	☐ Parenteral			
Diet counselling provided:	☑ Yes	☐ No				
Frequency of re-assessment:	☑ Weekly	☐ Fort - night	☐ Monthly			
Enteral / Parenteral	☐ Daily	Calorie count:	☐ Yes	☑ No		

Dietitian Signature / Name / Date / Time: 4/May, 10:29p

Maria Catherine John (2401)
Senior Dietitian

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
4/1/24, 10:40	A 42year old male came to do chest pain was assumed to be well controlled as evident by SHA. Klebs AKS (CAD) Patient <u>viral</u> to CVS. Educated the patient and family on 1600 calories, Low fat, low salt, 2000 ml fluid restricted diet. Emphid on small frequent meals.	Maria Catherine Tyson Senior Dietitian
4/1/24 12:30	Educated the patient & family on 1600 calories, Low fat, Low salt, 2000 ml fluid restricted diet on <u>discharge</u>. Emphasized on small frequent meals. Diet Modifications & clarifications ~~given~~ done. <u>Diet chart</u> given on discharge	6286

MHI/ER/2022/011

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Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

...RTMENT - NURSING INITIAL ASSESSMENT

Patient Na...	Sex : M/F	UHID No. : 202481588	Trage Level Green (<120 Min) ☐ Yellow (<60 Min) ☐ Orange (<10 Min) ☐ Red (Immediate) ☐
Patient Received Date & Time : ...	...sessment done at :	Allergies : ☐ No ☐ Yes	Relatives are aware ☐ Yes ☐ No If no Reason :

Current Complaints : c/o chest pain

Emergency Contact No.: — Name & Relationship: Saaral. B.S. (Brother)

PRIMARY SURVEY

Assess Response : ☑ Responsive ☐ Unresponsive ☐ Bleeding ☐ External ☐ Internal ☐ No

Airway : ☑ Clear ☐ Noisy ☐ Obstructed ☐ Vomited	Breathing ☐ Present ☐ Absent	Pain Score : ☐ 0 = No Pain ☐ 1-3 = Mild Pain ☐ 4-6 = Moderate Pain ☐ 7-10 = Severe Pain	Temperature: ☐ = Hot ☑ = Normal ☐ = Warm ☐ = Cold
Circulation : ☑ Normal ☐ Weak ☐ Pale ☐ Flushed ☐ Cyanosed ☐ Absent			

Chest pain Assessment :
☐ Site
☐ Onset
☐ Character
☐ Time
☐ Radiates to
☐ Exacerbiting Factor
☐ Severity

SECONDARY SURVEY : Patient Past History:

PAST MEDICATION HISTORY

DRUGS	DOSE	ROUTE	FREQUENCY

Cardiac Arrest Resuscitation :
Chest Compression Started Time :
Electrical Cardioversion ☐ Yes ☐ No
If Yes : Time of First Shock .....
Joules ...../ Total No. of Shock : .....

Stroke FAST Assessment :
Facial Weakness : ☐ Yes ☑ No ☐ Unable to assess
Affected Side : ☐ Right ☐ Left
Arm Weakness: ☐ Yes ☑ No ☐ Unable to assess
Affected Side: ☐ Right ☐ Left
Speech Difficulties : ☐ Yes ☑ No ☐ Unable to assess

Types of Ventilation : ☐ Face Mask
☐ Bag Valve Mask ☐ ET / LMA Tube
☐ Others :
Time of First Assisted Ventilation :

VITAL SIGNS

Time	Temp F/C	Pulse bts/min	Res. bths/min	BP mmHg	SpO_2 %	CBG mg/dl	PUPILS Reaction to Light: Right	PUPILS Reaction to Light: Left	Conscious level: A=Alert V = Voice P = Pain U = Unresponse
20.40	97.3	63	21	191/101	99	128			☑A ☐V ☐P ☐U
21.40	98.4	64	20	100/99	99				☑A ☐V ☐P ☐U
22.00	98.3	66	24	110/30	99				☐A ☑V ☐P ☐U
									☑A ☐V ☐P ☐U

Drug Name	Time	Dose	Route
T. Clopilet	20.00	300mg	oral
T. ECOSPRIN	21.00	300	oral
T. ATORVAS	01.00	80	oral
Inj. Omesel	22.00	40mg	IV
Inj. Lasix	22.00	20mg	I.V

Procedure (Tick)

☑ IV Peripheral	☐ Defibrilation
☐ Monitor Vital signs	☐ Nebulization
☐ Bleeding Control	☐ Suture
☐ Ryles Tube	☐ Urinary Catheterization
☐ ET Insertion	☐ TPI
☐ Suction	☐ ABG / VBG
☐ Drain	☑ CBG
☐ Oxygen	☐ Central / Arterial Line Insertion
☐ LMA / BVM	☐ ECG / X-RAY / Echo

Special Instruction:

PTO

Doctor's Order :

DATE & TIME	NURSES NOTE	R/N SIGN WITH REG.NO.
2/1/24 @ 20.40	⇒ Pt on c/o Chest pain, Pt on conscious & oriented. VS checked & recorded. HR- 63 b/m, BP- 191/101 mm Hg, SpO_2 - 99%, R- 19 b/m DR. BALAJI SIR ordered to ECG, CBG done, Inj. Lasix 20mg, Inj. Emeset 4mg IV given, IV done inserted DR. KARTHICK SIR ordered to ICU admission. Pt on assed plan.	
23.30	→ Pt on shifted to ICU	

Explained that the hospital is not responsible for valuables or other personal belongings.
Relatives Name : Brother

Relatives Signature / Relationship with the patients: Dearval.

Patient Outcome : ☑ Improved ☐ Unchanged ☐ Worsened ☐ Died

Disposition : ☐ Admission ☐ Discharge ☐ Transfered / Refer to other hospital / Time ☐

Handed Over Department Discharge summary Records & Reports	Handed Over by E.R.R/N.Signature	Taken over by R/N :	Attendant signature	Date & Time
				2/1/24 @ 22.00

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Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

MHI/NUR/2022/053

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NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 3/1/24 Time of Arrival: 23.36 Mode of Admission: ☐ Walking ☐ Wheelchair ☑ Stretcher

Accompanied by Relative: ☑ Yes ☐ No If Yes, Name of the Relative: MR. DARCOD .P.S

Relationship with Patient: BROTHER Contact Person's Name: MR. DARCOD Relationship: BROTHER

Contact No.: 9986110TT Primary language spoken: ☑ Tamil ☐ English ☐ Indian ☐ International

Interpreter needed: ☐ Yes ☑ No

Patient status: ☑ Conscious ☐ Unconscious ☐ Disoriented | Patient Vulnerable: ☐ Yes ☑ No

Menstrual History : LMP : — Menopause: —

Medical History : DM / HTN / Co - Morbility : — Yes If yes specify

Drugs History : Antiplatelet — (Specify)

Psychological Status: ☑ Calm ☐ Anxious ☐ Withdrawn ☐ Agitated ☐ Depressed ☐ Sleeping Difficulty

Do you have any special religious, spiritual or cultural needs to be considered? ☐ Yes ☑ No

If Yes, specify details: —

Socio Economic Status: ☑ Employed ☐ Retired ☐ Own Business ☐ Home-Maker ☐ Others:

Vital Signs: Temp: 97.3°F) | Pulse / HR: 63 (beats/min) | BP: 140/100 (mmHg)

Respiration: 21 (breaths/min) | SpO_2: 99 (%) | CBG: 128 (mg/dl) | Height: 151 (cms) | Weight: 60 (kgs)

Allergies / Adverse Reaction: ☐ Yes ☑ No ☐ Medication ☐ Blood Transfusion ☐ Food ☐ Not known

If Yes, specify:

Pain: ☐ Yes ☑ No. If Yes, Score: 0/10 **Pain Scale Used:** ☐ Wong-Baker FACES Pain Rating Scale (7-12 years) ☐ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)

Duration: — Location: —

Pain Character: ☐ Dull ☐ Aching ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Referred / Radiant Pain

Nutritional Screening:

Last 3 months Appetite: ☐ Increased ☐ Decreased ☑ No Change

Last 3 months Weight: ☐ Increased ☐ Decreased ☑ No Change

Type of Patient: ☐ Diabetic ☑ Non Diabetic Type of Diet: NORMAL DIET

Dietician Informed: ☑ Yes ☐ No. If Yes, mention the Name: MRS. CATHERINE Time: 8.00

Orient Patient if: ☑ Conscious **Orient Patient Attendant if:** ☐ Unconscious ☐ Disoriented

☑ Room ☑ Side Rails ☑ Toilet Bell ☑ Patient Information Board ☐ Bathroom ☐ Bed Controls

☑ Use of Footstool ☑ Grab Bars ☑ Nurses Call Bell ☑ Television ☐ Light Controls ☐ Telephone

Functional Assessment:

Particular	Assessment	Remarks	Outcome
Visual Impairment	☐ Yes ☑ No		
Hearing Impairment	☐ Yes ☑ No		
Chewing Difficulty	☐ Yes ☑ No		
Walking Difficulty	☐ Yes ☑ No		

Daily Activity Of Living:

Activity	Independent	Assisted	Dependent
Bathing	☑	☐	☐
Dressing	☑	☐	☐
Eating	☑	☐	☐
Walking	☑	☐	☐
Toilet Use	☑	☐	☐

Pressure Injury Risk Assessment: Braden Scale

Sensory Perception	Score	Moisture	Score	Degree of Activity	Score
No Impairment	4	Rarely Moist	4	Walks Frequently	4
Slightly Limited	3	Occasionally Moist	3	Walks Occasionally	3
Very Limited	2	Very Moist	2	Chair Fast	2
Completely Limited	1	Constantly Moist	1	Bed Fast	1
Mobility	**Score**	**Nutrition**	**Score**	**Friction & Shear**	**Score**
No Limitation	4	Excellent	4	No apparent problem	3
Slightly Limited	3	Adequate	3	Potential Problem	2
Very Limited	2	Probably In-Adequate	2	Problem Present	1
Completely immobile	1	Very Poor	1		

Score Interpretation: *Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*

Total Score: 22 Action needed: ☐ Yes ☐ No Pressure injury present at the time of admission: ☐ Yes ☐ No

If yes, Location: _____ Grade: _____ Size: _____

Witnessed by: _____ Signature: _____ Relationship: _____

MODIFIED MORSE FALL ASSESSMENT SCALE (Age above 16 years)

Fall Risk Assessment (Modified Morse Scale):

Variables		Numeric Value
History of falling (immediate or within 6 months)	No	0
	Yes	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0
	Yes	15
Ambulatory Aid		
None / Bed Rest / Nurse Assist		0
Crutches / Cane / Walker		15
Furniture		30
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0
	Yes	20
Gait		
Normal / Bed Rest / Wheel Chair		0
Weak		10
Impaired		20
Mental Status		
Oriented to own stability		0
Overestimated or forgets limitations		15
Medications Includes PCA / opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, hypoglycemics, sedatives, immunosuppresent and psychotropics	No	0
	Yes	15
Score Interpretation: *0-24: Low-risk; 25-44: Medium Risk; Above 45: High Risk* **Total Score**	✓	0

As per the score, tick the following appropriate boxes:

Low Risk Interventions (0 - 24)

- ☑ Familiarize the patient with the immediate surroundings
- ☐ Remind the patient to use call bell before getting out of bed
- ☐ Keep the two side rails in the raised position at all times for all patients regardless of age
- ☐ Keep the call bell, bedside table, water, glasses within the patient's easy reach
- ☐ Remove excess equipment or furniture to make a clear path
- ☐ Keep the patient's bed in the low position at all times except during procedure
- ☐ Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed
- ☐ Bed wheels should be locked
- ☐ Encourage family participation in the patient's care
- ☐ Ensure that floor of the bathroom is dry and not slippery
- ☐ Review medications for potential side effects that can promote falls
- ☐ Use safety belts during movement in wheelchair
- ☐ The patients are not ambulated by themselves. They are to be ambulated only with assistance

Medium risk interventions (25 - 44)

- ☐ Apply all the low risk interventions
- ☐ Tie yellow fall risk tag in the bed and Wheel chair / Stretcher
- ☐ Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat
- ☐ Use restraints and bed monitors as ordered by the doctor
- ☐ Allow the patient to ambulate only with assistance
- ☐ Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care
- ☐ Do not leave patients unattended in diagnostic or treatment areas
- ☐ Accompany the patient while going to bathroom
- ☐ Advice the patient to use grab bars near the toilet, bathtub, and shower
- ☐ Make sure the family and other visitors understand the restrictions mentioned above

High-risk interventions (above 45)

- ☐ Apply all the low and medium risk interventions
- ☐ Tie red fall risk tag in the bed, wheel chair and stretcher
- ☐ Locate the high-risk patients in a room close to the nurses' station
- ☐ Answer these patients call bells as quickly as possible
- ☐ Provide a commode at bedside (if appropriate)
- ☐ Urinal / bedpan should be within easy reach (if appropriate)
- ☐ Encourage family members or other visitors to stay with them
- ☐ If appropriate, consider using protection devices: safety belts

Initial Assessment to Special Needs and Vulnerability of Patient:

	Yes	No	Remarks *(please specify)*
Terminally ill patients		✓	
Patients with intense chronic pain		✓	
Woman in labor or experiencing termination of pregnancy		✓	
Patients with emotional or psychological distress		✓	
Patient suspected of drug or alcohol dependency		✓	
Victims of abuse and neglect		✓	
Patients whose immune system is compromised		✓	
Patient with infections and communicable diseases		✓	
Does the patient have implants		✓	
Has tracheotomy been done		✓	
Has colostomy been done		✓	
Any other potential needs of the patient		✓	

DVT RISK ASSESSMENT

Assign a score of 1 if (YES) in parameter nos. 1 to 9, and assign a score of -2 if (YES) in parameter no. 10

S. No.	Parameters	Yes / No	Score
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	☐ Yes ☑ No	0
2	Bedridden recently >3 days or major surgery within four weeks	☐ Yes ☑ No	0
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	☐ Yes ☑ No	0
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	☐ Yes ☑ No	0
5	Entire leg swollen (Assess for both legs)	☐ Yes ☑ No	0
6	Localized tenderness along the deep venous system (Assess for both legs)	☐ Yes ☑ No	0
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	☐ Yes ☑ No	0
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	☐ Yes ☑ No	0
9	Previously documented DVT (Assess for both legs)	☐ Yes ☑ No	0
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	☐ Yes ☑ No	0

Risk Score Interpretation (Probability of DVT): **Final Score**

Tick the score obtained (✓)

		✓	Action Taken	Date	Time
Low Risk	**-2 to 0**	✓	— X —	3/1/24	23:45
Moderate Risk	**1 to 2**				
High Risk	**3 to 8**				

Personal Belongings / Valuables:

Valuables	Description	With Patient	With Patient's Attendant	Name & Signature of the Patient / Patient's Attendant	Remarks
Dentures	☐ Upper ☐ Lower ☐ Both ☑ Nil		—		
Hearing Aid	☐ Right ☐ Left ☑ Nil				
Eye glasses / Contact lens	☐ Yes ☑ No				
Jewellery	☐ Yes ☑ No				
Other valuables *(specify)*					

Report (List of X-ray, ECG, lab reports retained with the nurse): _____

	Sign.	Name	Emp. No.	Date	Time
Patient / Patient's Attendant	Dawood Js	Dawood Js	*Relationship* Brother	3/1/24	23:50
Nurse		Ramya. R	0159	3/1/24	23:50
Unit In-Charge	Jeny	[illegible]	0002	3/1/24	23:50

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NABH

Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 3/1/23 Shift: ☐ Morning ☐ Evening ☑ Night

S — SITUATION

Diagnosis: CAD-ACS / AW-STEMI
GCS: 15/15
NEWS / PEWS Score: —
POD: —
Ventilator day:
Central line days: —
Peripheral line day: Right: NEGATIVE Left: NEGATIVE
Ryle's Tube: ☐ Yes ☑ No Day: —
VIP Score: 0/5
Urinary Catheter: ☐ Yes ☑ No Day: —
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B — BACKGROUND

Type of surgery: —
Date of surgery: —
Allergies if any: NKDA
On room air / oxygen: O_2 @ 4 LPM / ONFLOW
IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 98.3°F | Pulse / HR: 69 (beats/min) | Respiration: 20 (breaths/min)
BP: 130/93 (mmHg) | SpO_2: 99 (%) | Height: 151 (cms) | Weight: 60 (kgs) | BMI: 26.3 kg/m²
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 20 **Fall Risk Protocol:** ☑ Low ☐ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: NORMAL DIET
Drains: —

R — RECOMMENDATION

Referral doctors:
Pending medications: NIL
Pending medication indent:
Pending lab reports / Investigations: Cath packs, Conolic cardyna, Blue
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date: _____
Pending follow-up orders: —
Special instructions if any: X-ray & Echo to do.

	Signature	Name	Emp. No.	Date	Time
Handover given by		Ramya. R	0150	4/1/23	7.30
Handover taken by		S Revathi	0211	4/1/23	7:30
Document endorsed		JAYAPRIYA	0077	4/1/23	7.30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
3/1/24 @ 23.46	NIGHT DUTY NOTES	
	⇒ pt on received from ER pt on Conscious & oriented, V/S checked & recorded, IV line patent, INJ 30 mg Lyset, loading T. clop 300 mg, T. Ecaspin 300 mg, T. Atoras 80 mg, Inj. clexane 0.6 mg SC pt given, pt on NO	
4/1/24 @ 00.00	complaints ⇒ pt on Dr. KARTHICK SARAVANAN sir orders pt O2 @ 4L given night dose medication given as per drug chart	
1.10	⇒ pt on comfortable sleep & Dr. KARTHICK SIR Orders FD PPI ECG done, INJ 30mg Lyed done	
4.30	⇒ Pl on Cab investigation. Cath pack/ Cardiac enzyme/ CPK, CPK-MB send.	
5.30	⇒ pt on care. Oral care & back care given	
6.00	⇒ pt on ECG, CBG done ⇒ Cath pack & cardiac enzymes @ due. ⇒ pt on NO Complaints ⇒ TC - 240,000 Cab Staff Informed to inform Dr. BALAJI Sir	
7.00	⇒ pt on handing over to morning duty staff	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Jay	JAYAPRIYA	0021	3/1/24	10.00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 4/1/24 Shift: ☑ Morning ☑ Evening ☐ Night

S — SITUATION

Diagnosis: (AD-ACS(AW-STEMI) GCS: 15/15
NEWS / PEWS Score: – POD: –
Ventilator day: – Central line days: –
Peripheral line day: Right: Netacorpal Left: Netacorpal
Ryle's Tube: ☐ Yes ☑ No Day: VIP Score: 0/5
Urinary Catheter: ☑ Yes ☐ No Day:
Barrier nursing: ☐ Yes ☐ No MDR: ☐ Yes ☐ No. If Yes, specify organism:

B — BACKGROUND

Type of surgery: – Date of surgery: –
Allergies if any: NKDA
On room air / oxygen: @ ON ROOM AIR IV fluids on flow: –
Complaints / New Symptoms in last shift: –

A — ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 71 (beats/min) | Respiration: 22 (breaths/min)
BP: 143/74 (mmHg) | SpO_2: 99 (%) | Height: 151 (cms) | Weight: 60 (kgs) | BMI: 26.3 kg/m²
Others : –
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 35 **Fall Risk Protocol:** ☐ Low ☑ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☑ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: Normal diet Drains: ✓

R — RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations: Nil
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☐ No. If Yes, modified care plan date: _____
Pending follow-up orders:
Special instructions if any:

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	S. Purnalatha	0211	4/1/24	18:00
Handover taken by	—	DC	—		
Document endorsed	[signature]	JAYAPERUMAL	0052	4/1/24	18:45

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
4/1/24	Morning Duty Note	
@7:30	⇒ Pt taken over from night duty staff. Pt is conscious & oriented. Pt haemodynamically stable & recorded.	0241
7:40	⇒ T-98°F, P-67 b/mt, R-20 b/mt, BP-148/76 (98) mmHg, SPO2 -99%.	0241
7:50	⇒ Pt on Room Air SPO2 -99%.	
7:55	⇒ Pt (R) Arm Radial & (L) Metacarpal line present & Patent.	0241
8:00	⇒ Pt Cath Pack x-ray done. report Collected.	0241
9:00	⇒ Pt had diet no other complaints.	
9:10	⇒ Pt cath pack echo done. report collected	0241
9:20	⇒ Pt medication given as per drug chart.	
10:00	⇒ Pt hourly I/o chart maintained & recorded.	0241
11:00	⇒ Pt had soup no other complaints.	
12:00	⇒ Pt hourly I/o chart maintained & recorded.	0241
13:00	⇒ Pt had diet. no other complaints.	
14:00	⇒ Pt medication given as per drug chart	0241
15:00	⇒ Pt hourly I/o chart maintained & recorded.	
17:00	⇒ Pt had TPR & no other complaints	0241
17:30	⇒ Pt attender willing LAMA. informed to Dr. Vaishanavi & advised to discharged to LAMA.	0241
18:00	⇒ Pt file Summary reports hand over to Pt attender & in line received. ⇒ A GOT LAMA.	0241

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Jay L	JAYAPRAJ	0241	4/1/24	18:00

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ADULT NURSING CARE PLAN

Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 3/1/24 **Time:** 23.50	**Modified Date:** **Time:**
Reason for Modification:	**Diagnosis:** CAD / ACS / AW-STEMI

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☑ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☐ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M E N → Pt on Diet	Roy
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O_2 ☑ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☑ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☑ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M E N → Pt on RM 4 Ltr/ onflow	Roy
FLUID & ELECTROLYTES ☑ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M E N → Pt on Chart maintained	Roy

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☑ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☑ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	**M** **E** **N** → PT on bed rest	Roy
ELIMINATION ☑ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☐ Urination ☐ Others:	☐ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☑ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	**M** **E** **N** → PT on (N) elimination pattern	Roy
SKIN INTEGRITY ☑ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI **GRADES OF PRESSURE INJURY** ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☑ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	**M** **E** **N** → PT on (N) skin integrity	Roy

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☑ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	☑ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M E N → pt on stay clean & well groomed	
SAFETY ☑ Check ID Hand ☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☑ Patient will have no life-threatening situations	☑ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M E N → pt on chair ID band (P)	
COMFORT AND SLEEP ☑ Pain Control ☐ Sleep Patterns ☐ Others:	☑ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☑ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M E N → pt on comfortable sleep	
OBSERVATION ☑ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☑ Patient will have normal range of vital parameters	☑ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M E N → pt on V/S checked & recorded	
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M E N —	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☑ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☑ Patient will communicate effectively with positive feedback	☑ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M	
			E	
			N Pt on Good Communication	Jam
SPECIAL INTERVENTIONS ☑ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☐ To manage on time	☑ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M	
			E	
			N Pt on medication given as per drug chart	Jam

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Jay	JAYARAJ	005	4/1/24	1.00

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NABH ACCREDITED

ADULT NURSING CARE PLAN

Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 4/1/24 **Time:** 8.00	**Modified Date:** **Time:**
Reason for Modification:	**Diagnosis:** CAD / ACB / AWI – STEMI

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☑ Regular Diet ☐ Others:	☐ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☑ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M Pt had normal diet E Pt had normal diet N	02/1
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M Pt on Room AIR. SpO_2 - 99.1. E Pt on Room AIR SpO_2 98.1. N	02/1
FLUID & ELECTROLYTES ☑ Oral ☑ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Pt hourly I/o chart maintained E Pt hourly I/o Chart maintained N	02/1

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☑ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☑ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Pt on bed mobilized E Pt on bed mobilized N	
ELIMINATION ☐ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☐ Urination ☐ Others:	☑ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☑ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M Pt (N) elimination Pattern E Pt (N) elimination Pattern N	
SKIN INTEGRITY ☑ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI **GRADES OF PRESSURE INJURY** ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☑ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☑ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M Pt (N) Skin maintain (N) Skin integrity E Pt maintain (N) Skin integrity N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	☐ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M Pt Clean & well groomed E Pt Clean & well groomed N	
SAFETY ☐ Check ID Hand ☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☐ Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M Pt ID band present E Pt ID band present N	
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M Pt Provide Comfortable Position E Pt Provide Comfortable Position N	
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☐ Patient will have normal range of vital parameters	☐ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M Pt VIs Checked & recorded E Pt VIs Checked & recorded N	
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M Pt Provide Psychological Support E Pt Provide Psychological Support N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☑ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☐ Patient will communicate effectively with positive feedback	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M Pt communication well E Pt communication well N	24 24
SPECIAL INTERVENTIONS ☑ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☐ To manage on time	☑ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M Pt medication given as per drug chart E Pt medication given as per drug chart N	24 24

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Jack	JAYAPRI. J	0001	4/1/24	18:50

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NABH ACCREDITED

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42/Male/MHI202481588
03/01/2024/OPH2024000024
Dr.K.JAISHANKAR

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 3	1	24
					Time:		10
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort			4
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals			3
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours			2
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance			2
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation			3
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair				3
				TOTAL SCORE			20
				Initial & Emp. No. of Staff Nurse:			
				Initial & Emp. No. of Sr. Staff Nurse:			

Score Interpretation: *Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*

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Dr.K.JAISHANKAR
Consultant.

MHI/NUR/2022/045

Medway Heart Institute
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BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 4/1/24		
					Time: 14	8	15
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain oyer most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	4	4	
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	1	
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	2	2	
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	3	3	
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	
				TOTAL SCORE	17	17	
				Initial & Emp. No. of Staff Nurse:			
				Initial & Emp. No. of Sr. Staff Nurse:			

Score Interpretation: *Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*

S.No. : 22

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MHI/NUR/2022/052

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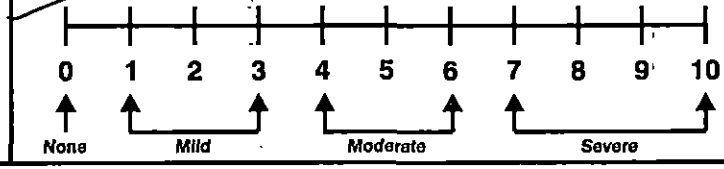
PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
3/1/24 @ 23.40	0/10	NO pain	—	—	—		
24.40	0/10	NO pain	—	—	—		
4/1/24 @ 1.40	0/10	NO pain	—	—	—		
2.40	0/10	NO pain	—	—	—		
3.40	0/10	NO pain	—	—	—		
4.40	0/10	No pain	—	—	—		
5.40	0/10	NO pain	—	—	—		
6.40	0/10	NO pain	—	—	—		
7.40	0/10	NO pain	—	—	—		

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
4/1/24 8:00	0/10	No Pain	—	—	—	021	Jaafoor
9:00	0/10	No Pain	—	—	—	021	Jaafoor
10:00	0/10	No Pain	—	—	—	021	Jaafoor
11:00	0/10	No Pain	—	—	—	021	Jaafoor

PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	**6 or less** = Minimal to no pain **7 - 12** = Mild pain - Provide comfort measures **>12** = Moderate to severe pain - Pharmocological intervention
CRIES (38 weeks - 2 months)	**The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.**
FLACC Scale (2 months - 7 years)	**0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both**
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 **Numerical Rating Scale (age more than 12 years)** 
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	**FACIAL EXPRESSION:** 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing **BODY MOVEMENTS:** 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation **COMPLIANCE WITH VENTILATION (intubated patients):** 0 - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting ventilator (or) **VOCALIZATION (non-intubated patients):** 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing **MUSCLE TENSION:** 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid **TOTAL SCORE:** 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain
Non-pharmacological Interventions	**Distraction:** A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers **Cutaneous Stimulation and massage:** E - Positioning; F - Rubbing / Massage the skin **Thermal Therapies** (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy **Transcutaneous electrical nerve stimulation** (TENS): J - Interferntial therapy | **Psycho-social therapy/counselling:** K - Individual Counseling; L - Family counseling
Pharmacological Interventions as per doctor's prescription	

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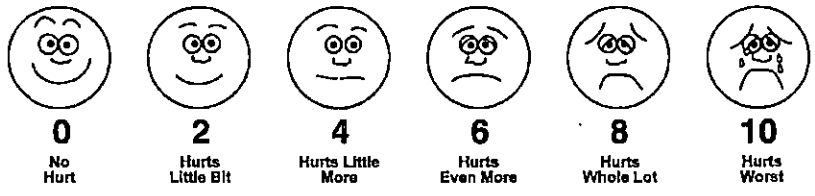
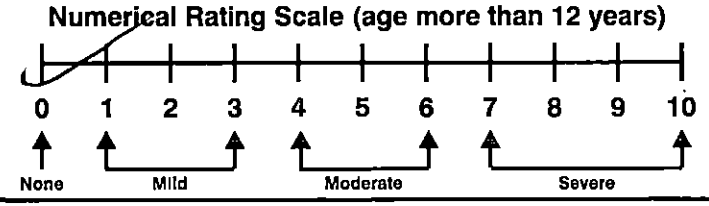
PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
4/1/24 18:00	0/10	No Pain	—	—	—	0211.	
13:00	0/10	No Pain	—	—	—	0211	
14:00	0/10	No Pain	—	—	—	0211	
15:00	0/10	No Pain	—	—	—	0211	
16:00	0/10	No Pain	—	—	—	0211	
17:00	0/10	No Pain	—	—	—	0211	
18:00	0/10	No Pain	—	—	—	0211	
		Pt GOT LAMA ON 4/1/24 @ 18:00					

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.

PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	**6 or less** = Minimal to no pain **7 - 12** = Mild pain - Provide comfort measures **>12** = Moderate to severe pain - Pharmocological intervention
CRIES (38 weeks - 2 months)	**The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.**
FLACC Scale (2 months - 7 years)	**0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both**
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	**FACIAL EXPRESSION:** 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing **BODY MOVEMENTS:** 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation **COMPLIANCE WITH VENTILATION (intubated patients):** 0 - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting ventilator (or) **VOCALIZATION (non-intubated patients):** 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing **MUSCLE TENSION:** 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid **TOTAL SCORE:** 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain
Non-pharmacological Interventions	**Distraction:** A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers **Cutaneous Stimulation and massage:** E - Positioning; F - Rubbing / Massage the skin **Thermal Therapies** (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy **Transcutaneous electrical nerve stimulation** (TENS): J - Interferntial therapy | **Psycho-social therapy/counselling:** K - Individual Counseling; L - Family counseling
Pharmacological interventions as per doctor's prescription	

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MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables										
	Date	3/1/24	4/1/24	4/1/24						
	Time	23:50	8:00	14:00						
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		00	35	35						
Low Risk (0 - 24)		✓								
Medium Risk (25 - 44)			✓	✓						
High Risk (45 or above)										
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

0 - 24: Low Risk; 25 - 44: Medium Risk; 45 or above: High Risk

INTERVENTIONS *Tick as per the Risk Score*	Date	3/1/24	4/1/24	4/1/24						
	Time	23:50	8:00	14:00						
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surroundings		✓	✓	✓						
Remind the patient to use call bell before getting out of bed		✓	✓	✓						
Keep the two side rails in the raised position at all times for all patients regardless of age		✓	✓	✓						
Keep the call bell, bedside table, water, glasses within the patient's easy reach		✓	✓	✓						
Remove excess equipment or furniture to make a clear path		✓	✓	✓						
Keep the patient's bed in the low position at all times except during procedure		✓	✓	✓						
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed		✓	✓	✓						
Bed wheels should be locked		✓	✓	✓						
Encourage family participation in the patient's care		✓	✓	✓						
Ensure that floor of the bathroom is dry and not slippery		✓	✓	✓						
Review medications for potential side effects that can promote falls		✓	✓	✓						
Use safety belts during movement in wheelchair		✓	✓	✓						
The patients are not ambulated by themselves. They are to be ambulated only with assistance		✓	✓	✓						
Medium risk interventions (25 - 44)										
Apply all the low risk interventions			✓	✓						
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher			✓	✓						
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat			✓	✓						
Use restraints and bed monitors as ordered by the doctor			✓	✓						
Allow the patient to ambulate only with assistance			✓							
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care			✓	✓						
Do not leave patients unattended in diagnostic or treatment areas			✓	✓						
Accompany the patient while going to bathroom			✓							
Advice the patient to use grab bars near the toilet, bathtub, and shower			✓	✓						
Make sure the family and other visitors understand the restrictions mentioned above			✓	✓						
High-risk interventions (45 or above)										
Apply all the low and medium risk interventions			✓							
Tie red fall risk tag in the bed, wheel chair and stretcher			✓							
Locate the high-risk patients in a room close to the nurses' station										
Answer these patients call bells as quickly as possible										
Provide a commode at bedside (if appropriate)										
Urinal/bedpan should be within easy reach (if appropriate)										
Encourage family members or other visitors to stay with them										
If appropriate, consider using protection devices: safety belts										
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

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MHI/IP/2022/055

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PATIENT AND FAMILY EDUCATION RECORD

Assessment — To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
☑ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☐ Limited Reading Abilities	☐ Physical barriers	☐ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☐ Simple Language
☐ Congnitive Limitations - unable to understand and follow directions	☐ Low motivation / desire to learn	☐ Written Instuctions

Completed By : Date 3/1/24 Time 23.30 Nurse Signature : [signature]

Learning Record

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
	3/1/24	L	P	O	4/1/24	L	P	O		L	P	O	
Disease													Doctor
☐ Information on Disease / Diagnostics													
☑ Treatment			P	D		P	D	V					
Medications			P	D		P	D	V					Doctor / Nurse
☐ Information on Safe and Effective use of medicines			P	D		P	D	V					[signature]
☐ Information on drug / drug and drug / food interactions													[signature]
☐ Discharge Medications													
Surgical Instructions													Nurse
☐ Pre - Operative Instructions													
☐ Post - Operative Instructions (Wound / Dressing Care)													
Pain Management													Nurse
☐ Reporting of pain													
☐ Pain Management													
Safe and effective use of medical Equipment (if required)													Doctor / Nurse
Name of Equipment Rehabilitation Techniques													

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance													Dietician
☑ Diet Instruction for patients at Nutritional risk		←	→			P	D	O					Maria Catherine John
☑ Diet advice for home		—	—			~~P~~	~~D~~	V					Nurse
Discharge Planning													
☐ Self care													
☐ Follow up													
☐ Reporting Concerns Immunizations													
☐ Parenting education													
☐ Others													
Risk Factor Reduction													
☐ Smoking Cessation													Doctor
☐ Weight Control													
☐ Exercise													
☐ Hypertension													
☐ *Other Risks*													

LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other_____(State Relationship)

PROCESS (P)- OD - Oral Discussion, D- Demonstration, W- Written Material

OUTCOME (O) - RD - Return Demonstration, V - Verbalized Understanding

Written Material given and explained (if any)

Reports Given :

	Given	Pending	NA		Given	Pending	NA
Discharge Summary				Diet Advice			
ECG Report				CT Scan Report			
Doppler Report				CT Scan Film			
X-Ray Report				ECHO Report			
X-Ray Film				Ultrasound Report			
Compact Disk				Any Other Report			

Name of Attendant / Patient :_____Signature :_____

Name of Discharge Nurse Signature :

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MHI/ICU/2022/056

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Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 3/1/24 **Time:** 23.50

Checklist	Yes	No	NA	Action / Remarks
MEDICAL				
Daily Consultant Visit	✓			
Plan of care discussed	✓			
Discharge Planning	✓			
Others if any				
NURSING				
Safety Precautions Ensured	✓			
Care of Lines and Tubes	✓			
Infection Control Measures	✓			
Skin Care	✓			
Response to assistance	✓			
Others if any				
DIETICIAN				
Diet Adequate	✓			
Special Request	✓			
PHYSIOTHERAPIST				
Available for Assistance for Activities of Daily Living				
Others if any				
PATIENT CARE SERVICES				
Room Cleaning satisfactory				
Room Amenities Adequate				
Billing Update available				
Non-Availability of any service				
Spiritual Needs (if yes specify)				
Others if any				

Inter Disciplinary Team Members

	Signature	Name	Reg. / Emp. No.	Date	Time
Doctor		DR. BALAJI	123615	3/1/24	23.50
Nursing Staff		JAYADEVI J	0027	3/1/24	23.50
Dietician		Maria Catherine John Senior Dietitian	2401	4/1/24	10.20
Physiotherapist					
Patient Care Service Staff					

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MHI/IP/2022/051

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FAMILY COUNSELLING FORM

CONSULTANT- DR.JAISHANKAR | DIAGNOSIS- CAD / ACB / AW - STEMI

DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
3/1/24	DOCTORS	Brothers	Pt attdr was explained about MI & Thrombi was advised & done.			
4/1/24	Doctor	Brother	Pt family briefed by primary. Observe in CCU today Elective CAG Cpnly waiting.			
			OK			

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MHI/HOSP/2022/032
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PHONE / VERBAL ORDER FORM / CRITICAL VALUE REPORTING FORM

☐ Telephone order ☐ Verbal order ☑ Critical value reporting form

Name of the Drug ☑ N/A	Dose	Route	Additional information if any

Lab / Radiology Critical result reporting *(if any)*: ☐ N/A Informed to Dr.: DR. BALAJI

CK – 1454
CK-M.B – 158.4.

Non Medication Order *(if any)*: ☑ N/A

Order Recipient Response: *Please Tick*
Write Down ☑ Yes ☐ No Read Back ☑ Yes ☐ No Confirm ☑ Yes ☐ No

Received by
Signature: S Revathy
Name: S. Revathy Date: 4/1/24.
Emp. No.: 021 Time: 7:50.

~~Ordering Physician~~ / Informing Staff
Signature:
Name: MR. BALAJI Date: 4/1/24.
Emp. No.: 2553 Time: 7:50

Action Taken *(only in Cases Of Critical Value)*:

Lysol. 2 Tab

	SIGNATURE	NAME	REG. NO.	DATE	TIME
Doctor		BALAJI	12561	4/1/24.	8:00

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NABH

Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

MHI/HOSP/2022/032

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PHONE / VERBAL ORDER FORM / CRITICAL VALUE REPORTING FORM

☐ Telephone order ☐ Verbal order ☑ Critical value reporting form

Name of the Drug ☑ N/A	Dose	Route	Additional information if any

Lab / Radiology Critical result reporting *(if any)*: ☐ N/A Informed to Dr.: BALAJI

TROP-I > 40,000

Non Medication Order *(if any)*: ☑ N/A

Order Recipient Response: *Please Tick*

Write Down ☑ Yes ☐ No Read Back ☑ Yes ☐ No Confirm ☑ Yes ☐ No

Received by

Signature:
Name: Donya Date: 4/1/24
Emp. No.: 0159 Time: 6.15

~~Ordering Physician~~ / Informing Staff

Signature:
Name: BALAJI Date: 4/1/24
Emp. No.: [illegible] Time: 6.15

Action Taken *(only in Cases Of Critical Value):*

Inj. Tab 30 mg. IV stat

	SIGNATURE	NAME	REG. NO.	DATE	TIME
Doctor		DR. BALAJI	120679.	4/1/24	6.15

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MHI/IP/2022/116

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VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAM: Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024

IP No. / UHID No: 2024 81588

AGE / SEX : Dr.K.JAISHANKAR

Ward / Bed No. CLU

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
3/1/24	23:30	(Rt) Metacarpal	0/5	patent	Flushed	Followed	Sofia
		Rt Metacarpal line removed					
4/1/24	8.00	Rt Anesthetic	0/5	Patent	Flushed	Followed.	
	14:00	Rt Anesthetic	0/5	Patent	Flushed	Followed	
		(Rt) Anesthetic line removed @ 18:00.					
4/1/24	8:00	(Lf) metacarpal	0/5	Patent	Flushed	Followed	
	4:00	(Lf) metacarpal	0/5	Patent	Flushed	Followed.	
		(Lf) metacarpal line			removed @ 18:00		

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CLINICALPATHWAYS : ST ELEVATION MI CHECKLIST

Patient Name: MR. SIDDIQUZAMA I.D. No. 2024000024

Age : 40Y Sex: M Date & Time of Arrival to ER 31/1/24 @ 20:30

Location:

Consultant: DR. K. JAISHANKAR 31/1/24

Day#: 1 Patient Complaint/ Diagnosis	Admission to Emergency/ CCU	Time	Reason	Remarks by Quality Dept.
Onset of symptoms	Patient will verbalize pain/ discomfort/ equivalents	2000	Chest pain	
Initial assessment by Doctor	History taking, patient positioning, Cardiac monitor, O2, IV access, Pain management			
Time to ECG		20:40		
Time to other Investigations	1.ECHO 2.CKMB 3.TROP-I 4.Routine lab 5.C-Xray	✓		
Time to loading dose	1.Aspirin 2.Clopidogrel 3.Statins 4.Nitrates 5.Brillianta	✓		
Time of consent for PTCA		—		
Time of transfer to Cath Lab		—		
Time of initiation of Puncture		—		
Time of Balloon inflation		—		
Time of Stenting		—		
Time of shifting out From Cath Lab		—		
Time to IV Thrombolysis		23:40		

Pre-procedure TIMI flow				
Post-procedure TIMI flow				
Teaching	Orientation to unit & routine dietary counseling, Smoking cessation, Life Style modification	✓		
Diet	Soft diet	NORMAL		
Discharge Planning/ Disposition				
Day#: 2 Patient Complaint/ Diagnosis	**CCU** 4/1/24	**Status**	**Reason**	**Remarks by Cardiology dept.**
Pain/Ischemia	Patient will be Pain free	✓		
Consults	Physical therapy, Dietary consultation	✓ ✓		
Tests	1.ECG 2.2D ECHO 3.O2saturation 4.Cardiac enzymes	✓ ✓ ✓ —		
Treatments	Sameas 1st day except for Thrombolysis/ PTCA, unless specified	— — — —		
Medicines	Same as 1st day except Thrombolysis& Primary PTCA	✓ —		
Diet	Cardiac Diet	✓		
Activity	Physical therapy Protocol	✓		
Teaching	1.Dietary teaching2.Life style 3.Modification	✓ —		
Discharge Planning/Disposition	D/C ~~DAMA~~ on 4/1/24.			

Day#: 3 Patient complaint/ Diagnosis	CCU/ward	Status	Reason	Remarks by Quality Dept.
Tests	ECG schedule as Per requirement			
Treatments	Cardiac monitoring & Transfer toward /stepdown			
Medicines	Same			
Diet	Cardiac Diet			
Activity	Physical therapy protocol			
Discharge Planning/Disposition				

SIGNATURE OF THE DOCTOR

SIGNATURE OF THE STAFF NURSE

MHI/PHARM/2022/060

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pharmacy Rotem.

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REQUISITION FOR MEDICINE

IP No. :

Name of Patient : Mr. Siddiqui Zama DOA :

Age / Sex : UHID No. :

Consultant Name : Room No. : CCU

S.No.	Date	Medicine Name	Qty.
1.	4/11/24	mouth wash	(1)
2	"	T. Atorvas 80mg	(10)
3.	"	Cantac inj.	(1)
4.	"	Pro fibal	(2)
5	"	Tab Zyl. /10ml D/S	3-1-1
6.	"	inj - Lineiz. 0.6ml	(1)
7	"		

Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/060

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CCU

REQUISITION FOR MEDICINE

IP No. : 202481588

Name of Patient :

DOA :

Age / Sex :

UHID No. :

Consultant Name :

Room No. : CCU

S.No.	Date	Medicine Name	Qty.
1.	1/1/24	T. Ecosprin 75 mg.	1 Strip
2	1/1/24	T. Clopilet 75 mg.	1 Strip
3	"	T. ATNEVA 80mg.	1 Strip
4	"	T. Pan 40 mg.	1 Strip
5	"	T. Levipil 500 mg	1 Strip

Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/060

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REQUISITION FOR MEDICINE

Name of Patient :
Age / Sex :
Consultant Name :

IP No. :
DOA :
UHID No. :
Room No. :

Sl.	Date	Medicine Name	Qty.
1		T. Clavulanic 625 mg	3
2		T. NIMESULIDE 100	1
3		T. PANTODAC-IT BBM	5
		T. ACECLOF - MR	5
5		10 ml RP	5
6		5 ml SC	5
7		ECG leads	10
8		[illegible]	1
9		[illegible]	1
		Cling Film	1
11		Gloves 20 pairs	20
12		Cuncler pad	1
13		Pulse Box	1
		Mouth wash	1

Nurse Name

Pharm Bill & Name

11:20

MHI/PHARM/2022/0[illegible]

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REQUISITION FOR MEDICINE

Name of Patient : MR. Siddiq-s
Age / Sex : 40Y/M.
Consultant Name :

IP No. :
DOA :
UHID No. :
Room No. : BR COD

S.No.	Date	Medicine Name	Qty.
1	3/1/23	Inj. TNK 30mg	1

Nurse Name

Pharm Bill & Name

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Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

MHI/PHARM/2022/028

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MEDICATION ADMINISTRATION RECORD

Drug Chart: 1 of 1 Height (cms): 151 cm Weight (kg): 60 kg

KNOWN MEDICINE ALLERGIES ***(if NONE is confirmed, write NKDA in box 1)***

Drug Details	Description of Allergy	Doctor's Sign:
—	NKDA	Name: ✓ Reg. No. 12019

DOCTOR INSTRUCTIONS	NURSING STAFF INSTRUCTIONS
1. Use generic name when prescribing drug 2. Write in BLOCK LETTERS, clearly and legibly 3. Sign and enter MCI registration no. or apply seal 4. No prescription should be altered / overwritten 5. Use 24-hour format when writing time	1. Check entries in every section to avoid omissions 2. Nurse in-charge should verify drug chart on daily basis 3. For new prescription, follow the timings of doctor's prescription on Day 1 only, and then follow standard timings 4. Standard Timings: Q24hrly: 10:00hrs, Q12hrly: 10:00hrs, 22:00hrs or 06:00hrs, 18:00hrs, Q8hrly: 06:00hrs, 14:00hrs, 22:00hrs or 09:00hrs, 14:00hrs, 21:00hrs, Q6hrly: 05:00hrs, 11:00hrs, 17:00hrs, 23:00hrs, Q4hrly: 02:00hrs, 06:00hrs, 10:00hrs, 14:00hrs, 18:00hrs, 22:00hrs

Stat / Once Only / Premedication Drugs

Date	Time	Drug	Dose	Route	Doctor		Administered		
					Sign.	Reg. No.	Sign.	Emp. No.	Time
2/1/24	11.40	INJ. TENECTEPLASE	30 mg	IV	✓	12619		0159	11.40

REGULAR PRESCRIPTIONS
To be filled in by Doctors only

Date →	To be filled by Nursing Staff only. Sign and time given						
Time ↓	31/1/24	4/1/24					

DRUG NAME INJ. CLEXANE *

Dose	Route	Frequency
0.6 mg	S/C	1-0-1

Dr. Sign & Reg. No. / Seal

Start Date & Time 31/1/24 @ 23:40

Stop Date & Time

Additional Info:

Time		
11:40	→	11:40
		00
	D1	
23:40	23:40	
	OD	
8:00	→	9:00
16:00	23:50	16:00
	24	
8:00	→	9:00
20:00	23:50	
2000	23:50	
14:00	→	14:00

Clinical Pharmacist Medway Heart Institute

DRUG NAME T. NITROCONTIN

Dose	Route	Frequency
2.6 mg	PO	OD

Dr. Sign & Reg. No. / Seal

Start Date & Time 31/1/24 @ 23:40

Stop Date & Time

Additional Info:

Clinical Pharmacist Medway Heart Institute

DRUG NAME T. FLAVEDON - MR

Dose	Route	Frequency
35mg	1-0-1	

Dr. Sign & Reg. No. / Seal

Start Date & Time 31/1/24 @ 2:340

Stop Date & Time

Additional Info:

Clinical Pharmacist Medway Heart Institute

DRUG NAME T. ALPRAX

Dose	Route	Frequency
0.5 mg	PO	HS.

Dr. Sign & Reg. No. / Seal

Start Date & Time 31/1/24 @ 9P 40

Stop Date & Time

Additional Info:

Clinical Pharmacist Medway Heart Institute

DRUG NAME T. ECOSPRIN

Dose	Route	Frequency
75mg	P/O	O — O

Dr. Sign & Reg. No. / Seal

Start Date & Time 4/1/24 @ 9:00

Stop Date & Time

Additional Info:

Clinical Pharmacist Medway Heart Institute

Area In-charge Nurse Signature:

REGULAR PRESCRIPTIONS
To be filled in by Doctors only

Date →	To be filled by Nursing Staff only. Sign and time given							
Time ↓	4/1/24							

DRUG NAME T-CLOPILET

Dose	Route	Frequency		
75mg	P/O	0 — 1 — 0	14:00	14:00 [signature]

Dr. Sign & Reg. No. / Seal: [signature] 97211

Start Date & Time: 4/1/24 @09:00

Stop Date & Time:

Additional Info:

Clinical Pharmacist Medway Heart Institute

DRUG NAME T-ATORVA

Dose	Route	Frequency		
80mg	P/O	0 — 0 — 1	20:00	

Dr. Sign & Reg. No. / Seal: [signature] 97211

Start Date & Time: 4/1/24 @ 9:00

Stop Date & Time:

Additional Info:

Clinical Pharmacist Medway Heart Institute

DRUG NAME T.PAN (Before food)

Dose	Route	Frequency		
40mg	P/O	1 — 0 — 0	7:00	8:00 [signature]

Dr. Sign & Reg. No. / Seal: [signature] 97211

Start Date & Time: 4/1/24 @9:00

Stop Date & Time:

Additional Info:

Clinical Pharmacist Medway Heart Institute

DRUG NAME T-LASILACTONE

Dose	Route	Frequency		
20/80mg	P/O	1/2 — 0 — 0	8:00	9:30 [signature]

Dr. Sign & Reg. No. / Seal: [signature] 97211

Start Date & Time: 4/1/24 @9:00

Stop Date & Time:

Additional Info:

Clinical Pharmacist Medway Heart Institute

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

Area In-charge Nurse Signature: [signature]

DIET ORDERS *(to be prescribed by Doctors only)*

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
4/1/24	12.00	NORMAL DIET		123615					
4/1/24	8:00	NORMAL DIET		105767					

NURSE IDENTIFICATION RECORD

(to be entered by all the nurses involved in administering medications prescribed in the chart)

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
	Evening					Evening			
4/1/24	Night	Daya	0159			Night			
4/1/24	Morning	S Premalatha	0211			Morning			
4/1/24	Evening	S. Premalatha	0211			Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			

MEDWAY HOSPITALS

KODAMBAKKAM (HEART)

9, 1st Main Road, United India Colony , Kodambakkam, Chennai,
Tamilnadu, India
044-2473 4455
care@medwayhospitals.com

Registration No	: MHI202481588	**Patient Name**	: SIDDIQUZAMA
Age	: 42	**Gender**	: Male
IP Number	: MMH/HM/IPH2024000024	**Discharge Date**	: 04/01/2024 4:58:00PM
Bill No	: MMH/HM/IPH202400026	**Bill Date**	: 04/01/2024 4:57:14PM
Ward Name	: CCU	**Bed Name**	: CCU-3

NO DUE

MEDWAY HEART INSTITUTE #9, 1st Main Road, United India Colony, Kodambakkam, CHENNAI-600 024

Prepared By

MEDWAY HEART INSTITUTE #9, 1st Main Road, United India Colony, Kodambakkam, CHENNAI-600 024

Approved By

MEDWAY HEART INSTITUTE #9, 1st Main Road, United India Colony, Kodambakkam, CHENNAI-600 024

Checked By

Δ SIS/- CAD (ACS / AWI- STEMI

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MHI/ICU/2022/064

Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

Medway Heart Institute
art beat counts

INTERMEDIATE CARE FLOWCHART

B

NAME : MR. SIDDIQUZAMA UHID NO : 202481588 AGE : 40 Y SEX : M

BLOOD GROUP :

HEIGHT : 151 cm WEIGHT : 60kg B.S.A : 1.91 M²

(2)

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
8:00	77	Sinus	98F	124/78	93	warm	++	21	Brld	97%	Pt on Room AIR.
9:00	76	Sinus	98F	136/94	108	warm	++	20	Brld	98%	"
10:00	74	Sinus	98F	116/66	83	warm	++	21	Brld	99%	"
11:00	73	Sinus	98F	111/65	85	warm	++	21	Brld	98%	"
12:00	86	Sinus	98F	115/79	89	warm	++	16	Brld	97%	"
13:00	95	Sinus	98F	134/81	98	warm	++	18	Brld	96%	"
14:00	76	Sinus	98F	128/82	96	warm	++	12	Brld	97%	"
15:00	73	Sinus	98F	109/61	77	warm	++	22	Brld	96%	"
16:00	76	Sinus	98F	124/78	93	warm	++	20	Brld	97%	"
17:00	74	Sinus	98F	111/65	85	warm	++	21	Brld	98%	"
18:00	75	Sinus	98F	115/79	89	warm	++	20	Brld	99%	"

PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE → 1500 ml

TOTAL OUTPUT → 550

BALANCE → -400

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MHI/ICU/2022/064

Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

Medway Heart Institute
Heart beat counts

INTERMEDIATE CARE FLOWCHART

B

NAME : MR. SIDDIQUZAMA A UHID NO : 202481588 AGE : 42Y SEX : M

BLOOD GROUP : —

HEIGHT : 151 cm WEIGHT : 60kg B.S.A : 1.9 M²

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
11.24 23 UP	91	SINUS	97.3	140/100	116	warm	++	20	Br/d	96	ON ROOM AIR
00.40	93	SINUS	97.3	110/99	106	warm	++	19	Br/d	98	O2 FM /4 L/M BY NASAL
1.40	92	SINUS	97.2	122/100	104	warm	++	01	Br/d	100	11
2.40	95	SINUS	97.3	130/82	98.	warm	++	20	Br/d	99	11
3.40	90	SINUS	98.4	135/81	99	warm	++	21	Br/d	96	11
4.40	89	SINUS	97.3	120/76	96	warm	++	19	Br/d	99	11
5.40	76	SINUS	97.3	121/73	97	warm	++	20	Br/d	96	11
6.40	68	SINUS	97.3	109/65	80	warm	++	22	Br/d	99	11
7.00	67	SINUS	98.4	124/78	93	warm	++	21	Br/d	99	11

PREVIOUS DAY - HOURS

DRAINAGE TOTAL INTAKE

URINE TOTAL OUTPUT

BALANCE

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PATIENT SAFETY & QUALITY OF CARE NABH ACCREDITED

MHI/ICU/2022/064

Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

Medway Heart Institute
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INTERMEDIATE CARE FLOWCHART

A

NAME : MR. SIDDIQUZAMA UHID NO : 202481588 AGE : 42Y SEX : M

SURGICAL PROCEDURE : –

POSTOP DAY : – FLUID REQUIREMENT : –

DATE & TIME	URINE H.T.	URINE G.T.	CHEST DRAINAGE	AIR LEAK	H.T.	G.T.	TOTAL OUTPUT	I.V. FLUIDS			H.T.	ORAL/ R.T. H.T.	G.T.	TOTAL INTEKE	TOTAL BALANCE
4/1/24 8.00	-	-					-					100	100	100	+100
9:00	-	-					-					200	300	300	+300.
10:00	-	-					-					-	300	300	+300.
11:00	-	-					-					-	300	300	+300.
12:00	600	600					600.					-	300	300	-300
13:00	-	600					600					200	500	500	-100.
14:00	-	600					600.					-	500	500	-100
15.00	-	600					600					-	500	500	-100.
16:00	800	1400					1400.					-	500	500	-900
17:00	800	1400					1400					200	750	750	-650.
18.00	-	1400					1400					-	750	750	-650

SPECIFIC OBSERVATIONS/REMARKS	MEDICATION / DRUGS

SIB :- CAD / ACS / AWI - STEMI

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NABH

Mr.SIDDIQUZAMA
42/Male/MHI202481588
03/01/2024/IPH2024000024
Dr.K.JAISHANKAR

MHI/ICU/2022/064

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INTERMEDIATE CARE FLOWCHART

A

NAME : MR. SIDDIQUZAMA UHID NO : 202481588 AGE : 42Y SEX : M

SURGICAL PROCEDURE : —

POSTOP DAY : 10 th FLUID REQUIREMENT : —

DATE & TIME	URINE		CHEST DRAINAGE				TOTAL OUTPUT	I.V. FLUIDS				ORAL/ R.T.		TOTAL INTEKE	TOTAL BALANCE
	H.T.	G.T.		AIR LEAK	H.T.	G.T.					H.T.	H.T.	G.T.		
31/1/24 23.40							—					50	50	50	+ 50
24.40							—					50	100	100	+ 100
1.40							—						100	100	+ 100
2.40							—						100	100	+ 100
3.40	550	550					550					50	150	150	— 400
4.40		550					550						150	150	— 400
5.40		550					550						150	150	— 400
6.40		550					550						150	150	— 400
7.00		550					550						150	150	— 400

SPECIFIC OBSERVATIONS/REMARKS	MEDICATION / DRUGS