

MRD CHECKLIST

PARTICULARS	YES	МО
- 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	/	





Mr.RAMACHANDRAN R

64/Male/MHI202481642 05/01/2024/IPH2024000043

Dr.G. GNANAVELU





Every heart beat counts

Medway Hospitals The way to better health ADMISSION SLIP (A Unit of United Alliance Healthcare Pvt Ltd)

_
Admitting Doctor: DR UNANAVELU Speciality: Cooks Dunyy
Advised Date & Time: 5/1/24 9:49 PM
Provisional Diagnosis: April - Siemi , Rum,
Rim,
Reason for Admission: Medical Management Surgical Management
Others (please specify details)
Admission Type:
LICU CW (Specify details)
Surgery / Procedure Name (if planned):
Blood Product Requirement: No Yes (Kindly specify details of components required in space below)
Expected Duration of Stay: 3 Doub
Expected Cost of Treatment (as per Financial Counseling Form):
Paver: Self Insurance Others:
Payer: Self Insurance Others:
- Investigations - vitels monitoring
- vifelle monitoring
Any other Instructions (if any):
Doctor's Signature Name Reg. No. Date Time
91810. 5/1/24 9:49
5/1/24 4 : 49

For admission desk staff of	only:		
Room Category:	General Ward Single Room Twin Sharing Deluxe Room Suite Room Others		
Admission intimation	Receipt Details	: Admission Ti	me in HIS
Date	Time	Date	Time
5/1/24	91.49 PM	5/1/24	91.49 pm
To be filled only if Blood	OPD ER Direct requirement specified by the		No
Front offiçe Ştaff Signature	Name	Emp. No.	Date Time
plkis	IseroB King	MH10273	5)1/24 9:491
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The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



Mr.RAMACHANDRAN R

64/Male/MHI202481642 05/01/2024/IPH2024000043

Dr.G. GNANAVELU





MHI/HOSP/2022/129

ADMISSION FORM

Marital Statu	s Full Add	dress 19/4	3RD	STREET	POSTA	+L Colon	Telephone Number
Occupation	WE	SIMAM	BALAN	7 CHEN	NA -3	3	9790765247
CFRI	end)	Date of Time of		Date & Time o		Tot 4d	al No. of Days
UNIT COULD	01097	MLC	☐ Yes	No	If Yes AR N	lo. :	
1		FINA	L DIAGNO	SIS			ICD Code
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							· ,
DATE				PROCEDURES	3		ICPM Code
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1 6/1127	P	TCA TI	CAD				00-66
DATE			TYPE OF AI	NESTHESIA			·
6/1/2)	GENERA	r, , , ,	SPINAL	LOCAL	- 🗆	REGIONAL	☐ EPIDURAL
		,	DISC	HARGE STATU	IS		
Cured			•	uest			Expired < 48 hours
☐ Improve	d	☐ Agains	st Medical A nded	Advice			Expired > 48 hours
☐ Unchan	ged					□ F	Post-Operative Death
		al Bro			_	. Alem	Jost 2528
Signature	et the Consu	Itant			Sig:	nature of Med	lical Records Officer

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. A.A.A.CHAMDR.AN who is myHVSB.A.M.D....(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.

化环烷化铁铁铁铁铁铁铁铁铁铁铁铁铁 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 their 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 . சிகீச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

இதன் மூலமாக நான் நிர்வாகம், மருத்துவம், தாதியர், ஏனைய மருத்துவ ஊழியர்கள் எனக்கு / நோயாளி மருந்துகள் கொடுத்து செய்முறைகள்/அறுவை சிகீச்சை செய்யவும் அதிகாரம் வழங்குகீறேன். நான் / இதில் குறித்துள்ள நோயாளின் செலவுக்கன தொகை முழுவதும் செலுத்த இதன் மூலம் உறுதி அளிக்கிறேன்.

மேல் கூறியது போல் வேளை நான் தங்கள் மருத்துவத்திற்கான செலவுகளை கட்டத் தவறினால் என்னை நோயாளியை வேடுறாரு 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 செய்கீறேன்.

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

தேதி

எனது/உறவினர்/காப்பாளர் கையொப்பம்

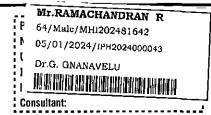
Signature of Admitting Nurse

Date 05 101/2024 Signature of the Patient / Relative / Gurdian

உறவுமுறை

Nature of Relationship







GENERAL CONSENT FOR ADMISSION

	## Representative of patient have lease tick the correct option above and below) Representative of patient have
	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 be administered necessary drugs, medications, intravenous fluids, as advised 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 as a patient as outlined in the patient handbook.
•	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 also consent and agree to the use and/or publication of my treatment details / medical record for medical, scientific or educational purposes (Teaching, research and academics) provided the pictures or the descriptive

texts accompanying them do not reveal my identity.

- 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 also consent to receive communication on treatment related information via text messages and e-mail as per the details provided at the time of registration.
- 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		RAMACHANDRAN	511/24	9.491
Surrogate/Guardian (if applicable #)	R. Deepa	DEEPA (Write name and relationship with patient)	5/1/24	9:49,
Reason for surrogate consent	Patient is unable to give consent	because:		
Witness		1+ARIS H	5)1)24	9:49
Interpreter (if applicable)				

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

	CHE
Medway Hospital The Mr.RAMACHANDRAN R 64/Male/Muses	is [®]
05/01/2024/!PH20240000	DIL / HI
Dr.G. GNANAVELU underti	was

:# 2/26,1st Main Road, United India Colony, Kodambokkam, NNAL

Chennai - 600024. Tel: 044 - 2473 4455 | Mobile No: 9962 985 985

BAKONAM: No.142-B, Sri Balasubramaniyan Nagar, Pilliyam Pettai,

Ammachathiram (Post), Thiruvidaimarudhur (Taluk), Kumbakanam - 612103,

(Taniore Dist).Ph: 0435 - 2412345 | Mob : 7397720491

E-mail: info@medwayhospitals.com | Website: www.medwayhospitals.com

IGH RISK FORM

informed that Mr./Mrs. Ramachandran-G. 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:

Dr. h. Atilais, s.

Relationship:

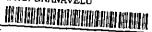
Signature: Relationship:



Mr.RAMACHANDRAN R

64/Malc/MHI202481642 05/01/2024/IPH2024000043

Dr.G. GNANAVELU





Every heart beat counts

ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

<u> </u>	ADMISSION CRITERIA FOR INTENSIVE CARE UNIT						
S. No.	PARAMETERS	MARK APPROP					
<u> </u>	Hemodynamic instability defined as	1					
	Pulse less than 40 or more than 150 beats/minute						
1 .	Systolic arterial pressure less than 80 mm Hg or 20 mm Hg below the patient's usual pressure						
ŀ, '[Mean arterial pressure less than 60 mm Hg						
	Diastolic arterial pressure more than 120 mm Hg						
	Respiratory rate more than 35 breaths/minute						
	Cardio-vascular System						
	Acute myocardial infarction						
{	Cardiogenic shock ,						
•	Complex arrhythmias requiring close monitoring and intervention						
Ì	Acute congestive heart failure with respiratory failure and / or requiring hemodynamic support						
[2 <u> </u>	Hypertensive emergencies						
	Unstable angina, particularly with dysrhythmias, hemodynamic instability, or persistent chest pain						
ļļ	Post cardiac arrest		_ _				
i l	Cardiac tamponade or constriction with hemodynamic instability						
} {	Dissecting aortic aneurysms						
	Complete heart block						
	Miscellaneous Conditions						
וגו	Septic shock with hemodynamic instability	1					
3	Hemodynamic monitoring						
	Clinical conditions requiring ICU level nursing care						
	Post procedure elective admission						
4	Post Coronary Angioplasty	, ,					
	Post Cardio-vascular Surgery						
	Following angiographic procedure						
	Complication resulting from the angiographic procedure including any significant change in pulse in the	Ì					
	affected extremity, neurologic changes, persistent bleeding, or persistent nausea and vomiting post-	<u> </u>					
5	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						
	Pulmonary System						
	Acute respiratory failure requiring ventilatory support (Invasive / Non-Invasive)						
	Pulmonary emboli with hemodynamic instability		<u> </u>				
6	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						
.]	Renal failure	ļ					
7	Oliguria or anuria for more than 12 hours	<u> </u>					
 	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								
Do	ctor	l/24	Time 9:57						
DISCHARGE CRITERIA FOR INTENSIVE CARE UNIT									
S. No.	PARAMETERS		K / AS OPRIATE						
1 2 3	Stable hemodynamic parameters Stable respiratory status (Pt. extubated with stable arterial blood gases) & airway patent Minimal oxygen requirement (not more than 3 L by pasal prongs)								

6 7 8	No sigr	Presence of distal pulses No signs of bleeding and hematoma at puncture site End of life care pathway chosen									
Do	octor	Signature	Name Dru-Akilan	Reg. No.	Date	Time					







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DISCHARGE SUMMARY

IP No.

IPH2024000043

D.O.A

: 05/01/2024

UHID

MHI202481642

D.O.P

06/01/2024

Name

Mr. RAMACHANDRAN. R

Room No.

: GN

Age / Gender

64Years / MALE

Consultant

: Dr. G. Gnanavelu. MD., DM., (cardio) FACC

D.O.D

: 08/01/2024

Chief Cardiologist

DIAGNOSIS:

CAD - ACS - STEMI-AWMI THROMBOLYSED WITH INJ. TNK – 05.01.2024 **MODERATE LV DYSFUNCTION, EF – 40%** ACUTE PULMONARY EDEMA - RESOLVED TYPE II DIABETIS MELLITUS

PROCEDURE:

- 1. CORONARY ANGIOGRAM DONE ON 06.01.2024 - SIGNIFICANT LAD DISEASE.
- 2. SUCCESSFUL PTCA + STENT TO LAD USING 2.75 X 28MM SYNERGY DES DONE ON 06.01.2024.

BRIEF HISTORY:

Mr. Ramachandran. R, 64 years old male, presented with complaints of chest pain, retrosternal compressive type for 1 hour. He came to Medway Heart Institute on 05.01.2024 for evaluation and further management.

ON EXAMINATION:

: 88bpm

BP: 120/70mmHg

SPO₂: 94% in room air

CVS : S1S2+

RS: B/L Basal crepts, ABD: Soft CNS: NFND

INVESTIGATIONS:

BLOOD(05.01.2024): Hb - 15.4gm/dl, TWBC - 11900cells / cumm, Platelet - 346000 cells/cumm, Urea – 24mg/dl, Creatinine – 0.93mg/dl, Na+ -136 mmol/L, K+ -4.67 mmol/l, Trop I – 15.5 ng/l, INR – 0.8 secs, CK - MB - 14.8 U/L, CPK - total - 55 u/l.

ECG: Sinus rhythm, HR – 63bpm, ST elevation in V1 – V6, ST depression in II, III & aVF.

SREEENING ECHO(05.01.2024): Hypokinesia of basal mid & apical. Anterior wall, anterior septum, anterior lateral of LV. Moderate LV dysfunction. EF - 40%. Mild MR. No PE. Grade I LV diastolic

1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel: 044

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94557 94557 1800 572 3003

Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

Kodambakkam Mogappair 044-2473 4455 | 044-26530011 | 044-27426829 | 04146-242000 | 044-2473 4455

Chengalpattu

Villupuram Kumbakonam

Kakinada 0884-2333367

Heart Institute 044 - 4310 8959 Institute of Pulmonology 044-2473 4451

E-mail: info@medwayhospitals.com | Website: www.medwayhospitals.com | CIN: U74900TN2011PTC083665



UHID: MHI202381642



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POST PROCEDURE INVESTIGATIONS:

BLOOD(07.01.2024): Urea- 38mg/dl, Creatinine- 1.12mg/dl, Na+ -134 mmol/L, K+ - 4.26sa mmol/l.

ECG: Sinus rhythm, HR: 97bpm, evolved AWMI changes.

ECHO(06.01.2024): S/P PTCA. All chambers normal sized. RWMA (+) - septum, apex, All apical segments, mid anterior, mid anterolateral hypokinetic. Moderate LV systolic dysfunction. EF - 40%. Grade II diastolic dysfunction. Normal RV systolic function. Aortic valve sclerosis. No AS. Trivial AR. Mild MR. Trivial TR. No PAH. Echo free space noted anterior to RV. ? Epicardial fat. No clot / vegetation / effusion. IVC normal in size and collapsing.

ECHO(08.01.2024): S/P PTCA. Mild concentric LVH. Chambers normal sized. RWMA - mid & apical septum, apex, mid & apical anterior hypokinetic. Mild LV systolic dysfunction. EF - 48%. Grade I diastolic dysfunction. Noraml RV systolic function. Increased LV filling pressure. Aortic valve sclerosis. No AS / AR. Other valves are normal. IAS / IVS intact. Minimal pericardial effusion anterior to RV. Trace effusion postero – lateral to LV .No clot / vegetation.

COURSE IN THE HOSPITAL:

Mr. Ramachandran. R, 64 years old male, admitted with above mentioned complaints. Basic investigations were done. ECG showed acute AWMI changes. ECHO showed Hypokinesia of basal mid & apical. Anterior wall, anterior septum, anterior lateral of LV. Moderate LV dysfunction. EF - 40%. He was diagnosed as ACS - AWMI, moderate LV dysfunction and thrombolysed with Inj. Tenecteplase 40mg IV stat on 05.01.2024. After obtaining consent, he underwent Coronary angiogram which revealed SIGNIFICANT LAD DISEASE followed by SUCCESSFUL PTCA + STENT TO LAD USING 2.75 X 28MM SYNERGY DES DONE ON 06.01.2024 by right radial access approach. Post procedure period was uneventful and shifted to CCU. Post procedure ECG shown no fresh ST-T changes. He was treated with IV diuretics, dual anti-platelets, statin, betablockers and other supportive measures. Patient got shifted to ward, His RFT were within normal limits and maintained with adequate fluid balance. His medications were optimized and he is being discharged in a stable clinical condition.

CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile

General condition Stable

GCS 15/15

Temp 98.6°F 110/60mmHg BP PR 96/min SPO₂ 95% in room air

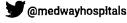
;#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel : 044 - 4310 8959

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Kodambakkam

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Kakinada

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Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

Chengalpattu Villupuram Kumbakonam Mogappair 044-2473 4455 | 044-26530011 | 044-27426829 | 04146-242000 | 044-2473 4455 | 0884-2333367 |

Heart Institute 044 - 4310 8959 Institute of Pulmonology 044-2473 4451



UHID: MHI202381642



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ADVICE MEDICATIONS:

SI.	NAME OF THE DRUGS WITH	DOSAGE	FREQ	UENCY		ROUTE	RELATION	DURATION
NO	GENERIC NAME		M	A	N		SHIP WITH FOOD	
1	TAB. ECOSPRIN (ASPIRIN)	75 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. AXCER (TICAGRELOR)	90 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. ATORVAS (ATORVASTATIN)	80 MG	0	0		ORAL	AFTER FOOD	TO CONTINUE
4	TAB. FLAVEDON MR (TRIMETAZIDINE)	35 MG	1	0	i	ORAL	AFTE FOOD	TO CONTINUE
5	TAB. NITROCONTIN (NITROGLYCERIN)	2.6 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
6	TAB. LASIX	40 MG	1/2	1/2	0	ORAL	AFTER FOOD	TO CONTINUE
8	TAB. ALDACTONE (SPIRONOLACTONE)	25 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
9	TAB. CARDACE (RAMIPRIL)	2.5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
10	TAB. CARDIVAS (CARVEDILOL)	3.125MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
11	TAB. IVABRADINE (IVABRADINE)	5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
12	SYP. CREMAFFIN	15 ML	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
13	TAB. ANXIT (ALPRAZOLAM)	0.5 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
14	SYP. SUCRAFIL	10 MG	1 .	1	1	ORAL	AFTER FOOD	TO CONTINUE
15	TAB. MONTEK LC	1 TAB	0,	0	1	ORAL	AFTER FOOD	X 1 WEEK
16	TAB. MAHACEF	200MG	1	0	1	ORAL	AFTER FOOD	X 5 DAYS

DIABETIC MEDICATIONS:

SI.	NAME OF THE DRUGS WITH	DOSAGE	FREQ	UENCY		ROUTE	RELATION	DURATION
NO	GENERIC NAME		M	A	N		SHIP WITH FOOD	
1	TAB. GLYCOMET - GP 2	2/500 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
2	TAB. SITAHENZ M	500 MG	1	0	I	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. OXRA	10MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE

#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel: 044 - 4310 8959

Villupuram

★ @MedwayHospitals

Mogappair

Kodambakkam

(i) @medwayhospitals

Chengalpattu

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Kumbakonam

@medwayhospitals

Kakinada

94557 94557 1800 572 3003

Medway Centre of Excellence (Chennai)

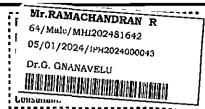
Medway Group of Hospitals

Heart Institute 044 - 4310 8959 Institute of Pulmonology 044-2473 4451

044-2473 4455 | 044-26530011 | 044-27426829 | 04146-242000 | 044-2473 4455 | 0884-2333367 | E-mail : info@medwayhospitals.com | CIN : U74900TN2011PTC083665









INPATIENT INITIAL ASSESSMENT

I	INPATIENT INITIAL ASSESSIVIENT
Ì	Date 1, 2024 Time of arrival in ward: 9!49 PM.
Ī	Allowing (if Veg. aposity details)
I	Drugs Yes No Allery & Pan -D.
I	Blood Transfusion
ĺ	Food
	Others
	Vital Signs: Temp: (°F) Pulse / HR: (beats/min) BP: 120) (mmHg) Respiration: (breaths/min) SpO ₂ : (%) Height: 11b(cms) Weight: 125 (kgs) BMI: 29 · H
	Pain: Yes No. If Yes, Score: 2 10 Pain Scale Used: Numerical Rating Scale (>12, years) CPQT (ventilator / comatose) Duration: Location:
١	Pain Character: Dull Aching Sharp Stabbing Shooting Burning Referred / Radiant Pain
ľ	CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS
	go @ sided Chest pour Sine 8:30 pm today.
	not sadishing
	not radialing
	PAST MEDICAL HISTORY (with duration of illness):
ĺ	Diabetes Mellitus: ☐ Yes ☐ No. If Yes, duration: ☐ Yes ☐ No. If Yes, duration:
l	Others:
l	
l	
	Past Surgical History:
	- M-
ľ	•

No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued due hospital stay
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
				, •	'	☐ Yes ☐ No
						☐ Yes ☐ No
	-					☐ Yes ☐ No
				_	-	☐ Yes ☐ No
			,		*:	☐ Yes ☐ No
	vil de)		FITT	, ,,	
	nal / Social History: (Tick whi	chever is a	pplicable)	, <u> </u>	•	· ,,
Lifest	nal / Social History: (Tick white)	chever is a	pplicable)	Retrail	•	
Lifest	nal / Social History: (Tick white) yle: □ Sedentary □ Active ing: □ Yes ᡌ No Alcoh	chever is a	pplicable)	Retrail	Î Drug Use: ☐ Yes ☐	
Lifest Smok Other	nal / Social History: (Tick white) yle: □ Sedentary □ Active ing: □ Yes ᡌ No Alcoh	chever is a e Occup ol: 🗌 Yes [pplicable) pation: ⊒No	Recreational	^ I Drug Use:	
Lifest Smok Other	nal / Social History: (Tick white) yle: □ Sedentary □ Active ing: □ Yes ☑ No Alcoh	chever is a e Occup ol: 🗌 Yes [pplicable) pation: ⊒No	Recreational	^ I Drug Use:	
Lifest Smok Other	nal / Social History: (Tick white) yle: Sedentary Active ing: Yes No Alcoh s: ual and Obstetric History (to	chever is a e Occup ol: Yes [be filled u	pplicable) pation: ⊒No	Recreational	^ I Drug Use:	
Lifest Smok Other	nal / Social History: (Tick white) yle: □ Sedentary □ Active ing: □ Yes ☑ No Alcoh	chever is a e Occup ol: Yes [be filled u	pplicable) pation: ⊒No	Recreational	^ I Drug Use:	
Lifest Smok Other	nal / Social History: (Tick white) yle: Sedentary Active ing: Yes No Alcoh s: ual and Obstetric History (to	chever is a e Occup ol: Yes [be filled u	pplicable) pation: ⊒No	Recreational	^ I Drug Use:	
Lifest Smok Other Menstr	nal / Social History: (Tick white) yle: Sedentary Active ing: Yes No Alcoh s: ual and Obstetric History (to	chever is a Cocup ol: Yes [be filled up	pplicable) pation: ⊒No	Recreational	^ I Drug Use:	
Lifest Smok Other Menstr	nal / Social History: (Tick white) yle: Sedentary Active ing: Yes No Alcoh s: ual and Obstetric History (to	chever is a period of the control of	pplicable) pation: No	Recreational	Î Drug Use: ☐ Yes ☐	1NO
Lifest Smok Other Menstr Menstr	nal / Social History: (Tick white yee: Sedentary Active ing: Yes No Alcohos: ual and Obstetric History (to her all Physical Examinations of the yes No Ice	chever is a period of the control of	pplicable) pation: No p for fema	Recreational	^ I Drug Use:	1NO

SYSTEMIC EXAMINATION
cvs:
Respiratory System:
BEDE D. BY Caylo
Gastrointestinal System:
Central Nervous System:
mens = 18/18.
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: E☑ Normal ☐ Anxious ☐ Depressed ☐ Others:
Nutritional Screening (ESPEN Guidelines for Nutritional Screening - NRS 2002):
Veight 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: ACS - & AW - STEMT . / Acht pul-edem
T2Dm.
Plan of Care: - Cer Admin Spir Stigh Auste Consult of Chromholyand - Theomholyand
- Ding an pui clint
- if chut Mars to

Investigations Ad	lvised:						
-	- Cath prole			(*,			
	- Cath prole - Condina +	enzy m		•			
				2 ÷ \$			
Diet Advice:	•			• ,			
☐ Nil per Oral	Clear liquid diet	☐ Normal liquid	d diet	☐ Diabetic liquid d	iet		
Semisolid diet	Soft solid diet	☐ South Indian	normal diet	North Indian nor	mal diet		
☐ Neutropenic liquid	diet Others:			<u>. </u>			
Early Discharge Plan	ning (fill in those which are a	appropriate at this	s stage):	PFE: Patient Fa	amily Education		
Special support need	led at home	∕∐Yes □ No	If Yes, PFÉ	done			
Home equipment ant	icipated	☐ Yes ☐ No	If Yes, PFE done and equipment advised				
Physiotherapy at hom	ne anticipated	☐ Yes ☐ No	If Yes, educated on physical limitations, if any				
Wound care needs a	nticipated 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	S	☐ Yes ☐ No	If Yes, educated on dietary restrictions, food drug interactions and allergies				
Continuous / ongoing	g care anticipated	☐ Yes ☐ No	If Yes, educated on various aspects of ongoing care required				
Other special educati	ion need, i.e.:	☐ Yes ☐ No	If Yes, PFE	done			
Nature of post hospit infection control, fall	al needs like patient safety, risk, etc, addressed	☐ Yes ☐ No	If Yes, spe	cific education given			
Others:							
			•				
			•				
• •	•	•					
	Signature	Name		Reg. No. Date	Time		
Resident Doctor		As hi	tristur	9,410 13,	24 22.00		
Consultant	296 A	PR-GABA	IANELU	29469 511	24 22000		
Patient Attendant	Centranoment go	Relationship (Sehi	5 (1)	14 22-00		

× . . .



Mr.RAMACHANDRAN R
64/Male/MHI202481642
05/01/2024/IPH2024000043
Dr.G. GNANAVELU



CONSENT FORM FOR CRITICAL CARE (ICU)

I, N) Y, Karm, Chandrar the Patient or Representative of patient have (please tick the correct of above and below):	tion
Read	
I have been explained in detail by the treating doctor and I understand about the condition of me / and my patient of patient's illness and I am aware of the all the possible outcomes.	my
Been explained this consent form in English / (), which I fully understand and understood the information provided about ICU Treatment	tion
I acknowledge that, I had the opportunity to discuss with the doctor about the condition of myself or my patient, treatment options, procedured to improve the patient's condition. I hereby give consent to treat the illness of myself or my patient and to do emergency procedured Endotracheal Intubation including other methods of securing airway, mechanical ventilation, central venous access, arterial lines and furnity of monitoring which are needed to improve or treat my condition.	slike

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 windcipe 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 in eeds 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
- Bleedina
- 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 procedure 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	r	Au		
Surrogate/Guardian (if applicable #)	R. Doepa	MVs.R. DEEPA (Write name and relationship with patient)	5/1/24	9:58
Reason for surrogate consent	Patient is unable to give consent because:		1	
Witness	provis wand hay 2.		5/1/24	9:58
Interpreter (if applicable)				

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				g. G. Alilu	91-810	トロン	9:58
•				-				



The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)

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



உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

		என்ற	பேயர் கெ	எண்ட பநே	யாளியா	என அல்	லது 🛭	் நோயாளியின்	பீரதிநிதி	யான		
	நான்,	இந்த	ஒ த்திசைவு	படிவத்தை	(ගෙහෙ	மற்றும்	æGD	உள்ளவற்றில்	சரியான	விருப்பத்தேர்வை	த யவுசெய்து	ழக்

செய்க)

ப வாசித்திருக்கிறேன்

🗆 சிகிச்சையளிக்கும் மருத்துவரால் எனக்கு விளக்கி சுறப்பட்டிருக்கிறது மற்றும் எனது / எனது நோயாளியின் தற்போதைய நிலைமை அல்லது எனது நோயாளியின் நோய் பாதிப்பையும் மற்றும் ஏற்பட சாத்தியமுள்ள அனைத்து விளைவுகளையும் நான் அறிந்திருக்கிறேன் மற்றும் புரிந்து கொண்டிருக்கிரேன்.

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

எனது அல்லது எனது நோயாளியீன் உடல்நிலை, சிகிச்சை விருப்பத்தேர்வுகள், நோயாளியின் நிலையை மேம்படுத்துவதற்கு தேலைப்படும் மருத்துவ சேவைகள் பற்றி மருத்துவரிடம் விவாதிக்க எனக்கு வாய்ப்பிருந்தது என்று நான் உறுதியளிக்கிறேன். எனது / எனது நோயாளியின் நோய்க்கு சிகிச்சையளிக்கவும் சுவாசப்பாதையை பாதுகாக்க / உருவாக்குவதற்கான பிற வழிமுறையை செயற்கை கவாச 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 உட்சேலுத்தல்களை வழங்குவதற்கு.
- ஒரு டெரிய அல்லது மைய சிரை / நாளத்தில் நேரடியாக இரத்தஅழுத்தத்தை அளவிடுவதற்கு. ஒரு நபருக்கு எந்தஅளவு திரவம் தேவைப்படுகிறது என்பதை தீர்மானிக்க இது உதவக்கடும்.
- 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.
- பறவெளி லைன் வழியாக வாசோபிரேசர்ஸ் ஐ வழங்குவது சிறிய இரத்த நாளங்களுக்கு சேதத்தை விளைவிக்கும் என்பதால், அதிர்ச்சியில் ஆழ்ந்துள்ள ஒரு நோயாளிக்கு வாசோபிரேசர்ஸ்களை (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 கதிட்டரைப் 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.
- இரத்தஉரைவு
- ஒழுங்கற்ற இதயத்துடிப்பு
- நுனைரயீரல் 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 செப்யப்படும்.

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:

முச்சுப் பெருங்குழலுள் குழாய் செருகுதல் (Endotracheal Intubation) என்பது, தாங்களே சுயமாக சுவாசிக்க இயலாத அல்லது நினைவிழந்துவிட்ட நபர்களுக்கு செய்யப்படும் ஒரு அவசரநிலை சிகிச்சை செயல்முறையாகும். இது, ஒரு திறந்தநிலை முச்சுப்பாதையை பராமரிக்க வகை செய்கிறது மற்றும் முச்சுத்தின்றல் நிகழாமல் தடுக்கிறது. நீங்கள் சுவாசிப்பதற்கு உதவ, உங்களது / உங்களது நோயாளியின் முச்சுக்குழலுக்குள் ஒரு நெகிழ்வுத்திறன் கொண்ட பிளாஸ்டிக் குழாய் வாய் வழியாகப் பொருத்தப்படுகிறது. முச்சுக்குழாய் என்றும் அழைக்கப்படுகின்ற இந்த மூச்சுக்குழல், ஆக்சிஐனை நுரையீரல்களுக்கு எடுத்துச்செல்லும் ஒரு குழாயாகும்.

களாசிப்பதற்கான 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 சற்றுக்டு தொடங்குகிறது ஒரு சிறிய சுற்றுப்பட்டையின் மூலம் உட்செலுத்தப்பட்ட குழாய் அதே இடத்தில் இருக்குமாறு வைக்கப்படும். மூச்சுக்குழாய், குரல்வலைக்கு சற்றுக்டு தொடங்குகிறது இற்ற மூச்சு சிறுகுழாயும், அதன்பிறுக மூச்சுக்குழாய் இரு சிறு குழல்களாக பிரிகிறது: வலது மற்றும் இடது பிரதான மூச்சு சிறுகுழாய்கள் ஒவ்கொரு சிறுகுழாயும், ஒவ்வொரு நுரையீரலோடு இணைக்கப்பட்டிருக்கிறது. இந்த மூச்சு சிறுகுழாயும், அதன்பிறுக நுரையீரலூடி இணைக்குந்து இந்த மூச்சு சிறுகுழாயும், அதன்பிறுக்குள் 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 காற்றும் உள்ளே சுவாசிக்கும்போது மூச்சுக்குழாய் சற்றே நீளமானதாக மற்றும் விரிவானதாக ஆகிறது. மூச்சை வெளியே விடும்போது அதன் முந்ததய தளர்வான நிலைக்கு அது திரும்புகிறது. மூச்சுப்பாதையில் வித்தவொரு இடமும் சேதமடைந்திருக்குமுமானல் அல்லது தடை பட்டிருக்குமானால் உங்களால் சுவாகிக்க இயலாமல் போகலாம் அல்லது கவாசிப்பதில் சிரமம் இருக்கலாம். இத்தகைக்குடுல் தான் மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல் அவசியமாக இருக்கக்கூடும். இந்த செயல்முறை உங்களது மூச்சு / காற்றுப்பாதைகைய அடைப்பின்றி திறுத்த நிலையில் வைக்கிறது. நீங்கள் சுவாசிக்கும்போது உங்களது நுரையில்குருத்து மற்றும் நுறையீருக்கிறது.

அடையத் திட்டமிடப்பட்டுள்ள பலன்கள்:

கீழ்வரும் ஏதாவதொரு காரணத்திற்காக இந்த மருத்துவ செயல்முறை உங்களுக்கு / உங்களத நோயாளிக்குத் தேவைப்படக்கடும்:

- உணர்விழப்பு மருந்து, பிற மருந்துகள் அல்லது ஆக்சிஜன் போன்றவற்றைப் பெறுவதற்காக மூச்சுப்பாதையை திறந்த நிலையில் வைப்பது.
- உங்களது / உங்களது நோயாளியீன் 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.

மேற்குறீப்பிடப்பட்ட மருத்துவ செயல்முறையின் மூலம் அனடய தீட்டமிடப்பட்டுள்ள பலன்கள், சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள், இந்த செயல்முறைக்கு கிடைக்கக்கூடிய பீற 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 உறத்தியித்துக்கொள்கிறேன், பெரும்பான்மையான நோயாளிகளுக்கு அசம்பாவிதம் இல்லாமல் அறுவைசிகிச்சை மற்றும் மீண்டு குணமடைதல் நிகழ்கின்ற நேர்வில், சில நேர்வுகளில் சிக்கல்களை ஏற்படக்கடும் என்பதையும் நான் அறிந்திருக்கிறேன். மேலே குறிப்பிடப்பட்டுள்ள இந்த மருத்துவ செயல்முறையிலும் ஏற்பட சாத்தியமுள்ள ஆழ்த்துக்கிறேன். எந்தவொரு மருத்துவ செயல்முறையிலும் ஏற்பட சாத்தியமுள்ள ஆப்ததுகள் மற்றும் சிக்கல்கள் அனைத்தையும் பட்டியலிட சாத்தியமில்லை என்பதையும் நான் புரிந்துகொள்கிறேன்.

இந்த மருத்துல் 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 மருத்துல 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

	கையொப்பம் / கட்டைவிரல் ரேகை*	பெயர்	தேதி	நேரம்
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(பொருந்துமானால் [#])		(பெயர் & நோயாளிக்கு என்ன உறவுமுறை	l	
		என்பதை எழுதவும்)		
	நோயாளியால் ஒப்புதல் வழங்க இயலவில்கை	ல; ஏனெனில்:	_	
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(பொருந்துமானால்)				

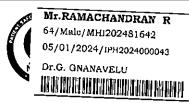
^{*}ஆண்களுக்கு வலது பெருவிரல் மற்றும் பெண்களுக்கு இடது பெருவிரல் ரேகை பதிவு | # உரிய வயது வராதவராக அல்லது ஒப்புதல் கொடுக்க இயலாதவராக நோயாளி இருந்தால் மட்டுமே.

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

	கைபொப்பம்	பெயர்	பதிவு எண்.	தேதி	நேரம்
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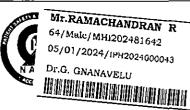


____ --;HI/IP/2022/041 **Medway** Heart Institute eart beat counts

		DOCTOR'S PROGRESS NOTES	
	DATE	NOTES	
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MHI/IP/2022/041

Medway

Heart

Institute

rt beat counts **DOCTOR'S PROGRESS NOTES** DATE **NOTES** Dr. 10 11:10 Sabapari DI C 2092 20 (·

DATE	NOTES
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MHI/IP/2022/041 Mr.RAMACHANDRAN R 64/Male/MHI202481642

05/01/2024/IPH2024000043

Dr.G. GNANAVELU

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TO BE A THE REPORT OF THE PROPERTY OF THE PROP it counts **DOCTOR'S PROGRESS NOTES** NOTES DATE Shor Go a Tem 6/1120 Beg (02mW



(A Unit of United Alliance Healthcare Pvt Ltd)

Patient Details (Affix Label here)

Mr.RAMACHANDRAN R

64/Malc/MHI202481642 05/01/2024/IPH2024000043

Dr.G. GNANAVELU

ICU PROGRESS NUTES





Every heart beat counts

Doctor's Name: ()

ICU SCORES (as Appropriate)

CLIF ACLF / AD score:

SOFA score:

MELD score: SAPS II score: AARC score:

APACHE II score:

ICU Day Background

> chut pain + hyul.

Issues last 24 hours

Ut pi + hul.

Central nervous system

Conscious / oriented / sedated with

Sedation score

GCS-EVM Pain score

Pupils Drains Cardiovascular system

HR - TIP Rhythm -

BP - رو / و صل CVP -Cardiac Medications:

Cardiac Output -

Respiratory system

Oxygen supplementation -

Saturation / PaO2-

Ventilator: Spontaneous / Controlled Last C x R -

Drains -

4102.

P/A Salt

Bowels - Y / N Loose stools / Melena

Drains

NG tube: Y/N

NGA-Day

USG CT

GIT

Nutrition & Fluids

Øral feeds / NG feeds

TPN - formula used

Supplements

Calories / Proteins achieved:

IV fluids -

24 hour Urine output

Fluid balance

Creatinine clearance

Acidosis

Lactate

RRT - SLED / IHD / CRRT

Microbiology

Invasive lines

1.

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Right

Culture reports

Antimicrobials with days

1.

2.

3.

Labs

INR

Others

Hb (5.4)

Urea U4

TC 11900

Platelets

Creatinine 9.9

Na 136 K 4.6

Bilirubin

ALT

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				_		1 1
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Mr.RAMACHANDRAN R 64/Male/MHI202481642 05/01/2024/IPH2024000043





The way to better health (A Unit of United Alliance Healthcare Pvt Ltd)



MHI/IP/2022/041



Every heart beat counts

	•
	DOCTOR'S PROGRESS NOTES
DATE	NOTES
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Mr.RAMACHANDRAN R 64/Mulc/MHI202481642 05/01/2024/IPH2024000043 Dr.G. GNANAVELU



Date:

6/1/24 ICU PROGRESS NOTES

Time:

Doctor's Name: '

ICU SCORES

CLIF ACLF / AD score:

(as Appropriate)

SOFA score:

MELD score:

SAPS II score:

AARC score:

APACHE II score:

ICU Day Background ACS

AEUME-STERMI Lysed = TNK.

Act. Nol. Edema regolal TUDA MAN.

Issues last 24 hours

HON.

Central nervous system

Conscious / oriented / sedated with

Sedation score

GCS-E V M Pain score

15/15 Pupils

Drains

Cardiovascular system

HR-90 Rhythms / Cardiac Output -

BP-150/90 CVP-

Cardiac Medications: NTC _ 3 6 4

Respiratory system

Oxygen supplementation – BAGE

Saturation / PaO2-

Last C x R -

Drains -

Ventilator: Spontaneous / Controlled Sport 93%

GIT

500

Bowels TYDN Loose stools / Melena

Drains

NG tube: Y/N

Day NGA-

Mechanical - TEDS / SCD

USG

CT

Nutrition & Fluids

Oral feeds / NG feeds

TPN - formula used

oralgeeds-

Supplements

Calories / Proteins achieved:

IV fluids -

24 hour Urine output

Fluid balance

Creatinine clearance

Acidosis

Lactate

RRT - SLED / IHD / CRRT

Microbiology

Invasive lines

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

perphellis

Culture reports

Antimicrobials with days

1.

2.

3.

Labs

Hb

TC

Urea

Creatinine

Na

K

Stress Ulcer Prophylaxis #Y/N

DVT prophylaxis (Y)N

Drugs

Drugs:

Pressure sore

Alpha bed Y /

Platelets

Bilirubin

AST

ALT

INR

Others

		<u> </u>		- X
Plan for	the day			_
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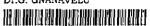




Mr.RAMACHANDRAN R

64/Malc/MHI202481642 05/01/2024/iPH2024000043

Dr.G. GNANAVELU





Every heart beat counts

ICU PROGRESS NOTES

	_	Ĭ.			Ν	
Doctor's	Name	A .	1	AP	Л.	1

	$-\upsilon$	-1		\sim
ICU SCORES	CI	LIF A	/CL	.F / AD score:

(as Appropriate) SOFA score:

MELD score: SAPS II score: AARC score: APACHE II score:

ICU Day Background

Issues last 24 hours

Central nervous system

Conscious / oriented / sedated with

GCS-E, V.M. S Pupils BLA PERC Pain score Draine

Cardiovascylar_system

HR - 10-8 Rhythm - Cardiac Output -

Cardiac Medications:

Respiratory system

Oxygen supplementation -Saturation / PaO2-

Ventilator: Spontaneous / Controlled Last C x R -

Drains -

GIT

Bowels - Y/N Loose stools / Melena

Drains

NG tube : Y / N

Day NGA-

USG

CT

Nutrition & Fluids

Oral feeds / NG feeds

Calories / Proteins achieved:

TPN - formula used

24 hour Urine output

Creatinine clearance

Supplements

Fluid balance

IV fluids -

Acidosis

Microbiology

Invasive lines

1. Mis

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

DVT prophylaxis ←Y/N

1.

2.

3.

RRT - SLED / IHD / CRRT

Labs

HЪ TC **Platelets**

Lactate

Urea

Creatinine

Na

AST

ALT

Drugs:

Mechanical - TEDS / SCD

Stress Ulcer Prophylaxis - Y/N

Drugs

Pressure sore Y/N Alpha bed Y / N

INR

Others

Bilirubin

Plan for	the day	
	- Inp on per chart.	
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Mr.RAMACHANDRAN R

64/Male/MHI202481642 05/01/2024/IPH2024000043

Dr.G. GNANAVELU





Date:

ICU PROGRESS NOTES

Time:

Doctor's Name : <

ICU SCORES

CLIF ACLF / AD score:

& Karthin

(as Appropriate) SOFA score:

MELD score: SAPS II score: AARC score:

APACHE II score:

ICU Day Background

POST PER LAS.

Issues last 24 hours

entral nervous system

Conscious / oriented / sedated with

Sedation score GCS - E V M

Pain score

15/LS_{Púpils} Drains Cardiovascular system

HR - しゃター Rhythm - 5 ~ 5_ Cardiac Output -

BP-/3060 CVP-Cardiac Medications:

Respiratory system

Oxygen supplementation -

Saturation / PaO2-

Ventilator : Spontaneous / Controlled Last C x R -

Drains -

GIT

P/A

Bowels (Y) N Loose stools / Melena

Drains

NG tube: Y/N

Day NGA-

USG CT

Nutrition & Fluids

Oral feeds / NG feeds

onlyelds.

Microbiology Invasive lines

perful lis.

TPN - formula used

Supplements

Calories / Proteins achieved a IV fluids -

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

24 hour Urine output

Fluid balance

Creatinine clearance

RRT - SLED / IHD / CRRT

Acidosis

Lactate

1.

2.

3.

Labs

Hb

Platelets

Mechanical - TEDS / SCD

Urea

Creatinine / 1/2-

Na

Bilirubin

ALT

INR

Others

DVT prophylaxis - Y/N

Drugs:

Stress Ulcer Prophylaxis 44/N

Drugs

Pressure sore Y //N

Alpha bed Y //N

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Plan for	the day					i.	• •
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MHI/IP/2022/041

Medway
Heart
Institute

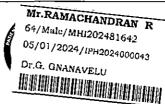
Every heart beat counts

	DOCTOR'S PROGRESS NOTES
DATE	NOTES
07/1/24	86: Dr. Graften
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S)B Dr. Molamad Abdrows	BIP PACA to CAD. Patient confortable Connius Orundel	Mars CUSS S. S. D. Started. Plan B. A. M. - Monida where - Mo Ellan der	
DATE	mdo)		









heart beat counts **DOCTOR'S PROGRESS NOTES NOTES** DATE 1/8 pr. Gnanavely team. no bresh comparte O/e = Comerous, executed - PR-96/m, ep-10/60 2702 954. RA Crh-234. · Om = 990 PL - BAC(F) - Court the serve 9124

DATE	NOTES
08.01.2024.	Screening Echo
3:10 pm	
	SIP PTCA.
	- mild concentrue WH.
	- Chambers normal sized
	- RWMA - Mid & apical septum, apex, mid & apical
	auterior hypokinetic,
	- mind ev systètie dysquenction. - Grade à diastètie dysquenction. - Normal ev systètie quention.
	- Grade i diastilie dysquención.
	Normal en systelie quindron.
	- Increased u filling pressur.
	- Aostri Value Sclerosis
	- NO ASIAR,
	- Other values are normal.
	- IAS/IVS Intact'
	- minimal pericardial effusion ardenio to Pr.
	Trace effusion postero-lateral to W
	- No clot vegetation) pleure effusion.
	1VS: 12 mm E/A: 0.79
	1VS: 12 mm E/A: 0.79 PW: 11 mm md E/E': 16.64
	Lat ElE!: 1449 .
	LVIDD: 49MM TRPG: 14 MMHS
	LVIDS: 38 mm Prsp: 24 mmHg
	EF: 46./
	EDV: 90 M
	Esr: 46 m
	EF: 48:/
	Done by: Revathy (CT, Res) MH/10098/ CARDE
	M4/100981 CARDLO







MT.RAMACHANDRAN R

RE/POST OPERATIVE ECHO

Pa

64/Malc/MHI202481642 05/01/2024/грн2024000043

Na

UH Dr.G. GNANAVELU

Date & Time	Bereening Echo Report
06/1/24	
- Sirb	- All Chambers normal sized.
-61/2,	- RWMA present: Septum, Apex, All Apical segments
· 	mid Anterior, mid Anterolateral hypotenetic
	Moderate (v Systolie dysfunction.
	Grade i Diax telie dysfunction
<u>. </u>	Normal RV Stystolic function.
	An viez Value sclerosis
	Alo AS DE TRIVIAL AR
	- Mild MR
	-Trucial to Ino PAH
	Scho freespace noted anticior to ky ? Spicordi-I fot
·	- No Not (vege tation / Effusion The normal in Size and collapsing.
	The normal in Size and collapsing.
	140.100 1.00 - 01 . 10 10 - 01
	HRI 105 bpm Tachytordin during study
	EF By sempson's method.
	EDVI- 100ml Prior: 11 con/s
	RSV. 158ml TAPSE: (7 mm
	FF: 40 + El bratis 1:12
	<u> </u>
	Crips: 38mm (sterd E/E! 12.5
	TRG+) 24mmHg None By
	Ruspi 34mmHg Ms. Lokeshwanik
	Ruspi 34mmHg Ruspi 34mmHg Ms. Loteshwant (Cardiac tech / MH10180) L 11/23 / 7.48Am
	L (1/23 / 1. 48 x x x)





Mr.RAMACHANDRAN R 64/Malc/MHI202481642

05/01/2024/IPH2024000043

Dr.G. GNANAVELU

MICROBIOLOGY SHEET

URINE ROUTINE ANALY	YSIS MICROBIOLO	GY SHEET	=_ <u>118 </u>
DATE	5/1/24	•	
COLOUR	DOLE YELLOW		
REACTION	γ		
SPECIFIC GRAVITY	1.010		
APPEARANCE	CLEOR		
ALBUMIN_			
SUGAR	•		
ACETONE			
BILE SALT			
BILE PIGMENT			
UROBILINOGEN			
PUS CELLS	2-3		
EPITHELIAL CELLS	1-2		
RBC	N//		
CASTS	NIL		
CRYSTALS	NIL		
OTHERS	NIL.		

MICROBIOLOGY-CULTURE REPORTS

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







Every heart beat counts

Mr. RAMACHANDRAN R

64/Male/MHI202481642 05/01/2024/IPH2024000043

Dr.G. GNANAVELU

THE TERM HAVE BEEN FIRST TO BEEN ALL TO BE THE TO

DIABETIC CHART

ACTUAL WE	EIGHT	L 65 69 HbA ₁ c			
PREVIOUS	DIABETIC	MEDICATIONS			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
5-1-24	21.00	228 mg/de.		ABOURT	DR. ARILAN
-1-24	6-00	383 mg/di-0.5	Tay. H. A. 15 UNIT	ARBOUL POUR	DR. OKLLAN.
6-1-04	12.00	299 mg/dl	By. HAISVAIS.	100 St	DR. Kalayii,
.1	18:20	239 mg/dl	Baj 1+. A 12U.	Winga .	DR. Koothik
T-1-24	6-00	217 mg/di.	Di 14-A 100.	1. 1001	DR AKILAN.
7/1/24	12:00	221 mg/d1	In H. A 180	D. C. 18.3	DR.KARTHICK
	18.3	U `	Without 20with	0000 (19.15)	Dr. Karthol
8/1/24	6-30	284 mald).	Inj. HABU	Sun 27.30	Dr-Salai
	12, 30	281 mg/dL	Rig. HA 60	DC 3.00	Dr. Salai
	_			120	;

INSTRUCTIONS FOR INSULIN INFUSIONS

*	Mix 40u short acting Insulin in 40 ml. of	BLOOD SUGAR mg / dl	INSULIN INFUSION
*	normal Saline (IU - 1 ml.) Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).	< 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.
*	Monitor Blood Glucose hourly (every 2nd	150-200	Adjust Infusion rate to 2u / hr.
	hourly when stable) and adjust Insulin rate according to the following Algorithm.	201-250	Adjust Infusion rate to 4u / hr.
	according to the following Augoritam.	251-300	Adjust Infusion rate to 6u / hr.
*	Target Blood Sugar 150-200 mgs.	301-350	Adjust Infusion rate to 8u / hr.
. *	To monitor K+ separately.	351-400	Adjust Infusion rate to 10u / hr.
	Urine Acetone	>400	Adjust Infusion rate to 20u / hr.







Every-heart beat counts

Mr.RAMACHANDRAN R

64/Malc/MHI202481642 05/01/2024/IPH2024000043

Na Dr.G. GNANAVELU

BLOOD GROUP

A TVE

INVESTIGATION SHEET

	_			`	200 201 1001 111	respectivate data and and the
Date	5-1-24	7-1-24	·			
HAEMATOLOGY						
Hb	15-A			İ		
P.C.V	45.1					
Platelets	346000					
TLC	119001			: -'	1	
Polymorphs	49-9					
Lymphocytes	44.47	-				
Eosinophils	1.8					
Mono / Basophils	1.3 A.2/0.2					-
E.S.R	7-7-					
BIO-CHEMISTRY						
Urea	24	88.				
Creatinine	0-9	1.12				-
Sodium	136	1311				
Potassium	4.6	2684.26				
Bicarbonate	20 V					
Chloride	98.3					
Magnesium						
Calcium					-	
Phosphorus					<u> </u>	
LFT						
T.Bilirubin				·		
D.Bilirubin				-		• .)
I.Bilirubin	_					
S.G.O.T						
S.G.P.T						
ALP						
GGT						
Total Protien						
S.Albumin						
CARDIAC ENZYMES						1
Troponin I	15.5					·
CKNAC - CPK	55			_		
CK - M.B. MASS	14.8					
LDH						
Ntpro bnp						1
						

	W 1 04					, , , , , , , , , , , , , , , , , , ,
Date	5-1-24					
COAGULATION	مارهما					-
PT / INR	0.8					
Fibrinogen TEST	10.14					
D Dimer (OA)	[2-]					
LIPID PROFILE			_			
Total Cholesterol						
Triglyceride						
H.D.L						
L.D.L						
VLDV						
THYROID FUNCTION						
T.S.H				: -		
T.3						
T.4				-	·	
SEROLORY			-			
HIV	VEREUND.					
HBsAg ,	1/100					
V.D.R.L				<u>.</u>		
COVID 19						
RT- PCR	 					
lgM			-			
lg						i i
HBA1C		·	-			
FBS/PPBS						
RBS						_
S.AMYLASE			<u> </u>			
S.LIPASE						
C.R.P			•	<u> </u>		
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Medway Hospitals

The way to better health

(A Unit of United Alliese 11 The

(A Unit of United Alliance Healthcare Oct 1-1)

Mr.RAMACHANDRAN R

64/Male/MHI202481642 05/01/2024/IPH2024000043

Dr.G. GNANAVELU

TADRY

ALLERGY



ALLEROTY => TAB. PAN -D



VITAL INFORMATION SHEET

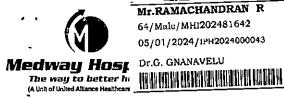
BLOOD GROUP

ON ADMISSION

Height in CM Weight in Kg.

1 1% m² ± 85 kg

Diagnosis:	40	51	A	<i>42</i>	ی ـ	.7 _E	N	ኒም	,												ا	Pro	ce	du	re	:					_												ł	<u>ተ</u>	_ [77	6		Ŋ	ገዶ	-		<u>'</u>	_	Ŗ	4	7~	1		
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Mr.RAMACHANDRAN R

64/Male/MHI202481642 05/01/2024/1PH2024000043







Every heart beat counts

EARLY WARNING SCORE MONITORING CHART

Name:					_	Age	Sex:			F	atient	Id No	:		_
NEWS key	DATE	01			<u>-</u>	$\overline{}$	_							1	DATE
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Score and monitoring	4	Every Hourly
frequency	3	Every 2 nd Hourly
	2	Every 4th Hourly







Mr.RAMACHANDRAN R Every heart beat courçs 64/Malc/MHI202481642 7/24To:7/1/20 Bed No: Curch Da 05/01/2024/IPH2024000043 **INTAKE & OUTPUT** Dr.G. GNANAVELU Ended Time : ⊣ం∪ **CHART** NPO Over at: Night Restricted Fluid (RF) SHIFT Morning **Afternoon** INTAKE **OUTPUT** Difference: **Total Output:** Total Intake: **INTAKE** (ml) **OUTPUT (ml)** Intravenous Infusion **Tube** N/G Drain **Endorsed** Time | Oral Total) Total Time Urine **Vomitus** Others R/N Sign Feeding Type of Fluid Aspirate Tube Additions Amount by







Mr.RAMACHANDRAN R 64/Male/MHI202481642 05/01/2024/IPH2024000043

dr.g. gnanavelu



ery heart beat counts

Date	Fro	m: 7/1/	24 To	D: 8(1/21	₊ Be	ed No: ८	(2)	<u> </u>				INITA	VE 9	OUT	THE
		arted Time			Ended T	ime : 🤫	-00	_				INTA			PUI
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Total	Intake:		1250 W	<u>_</u>	Fotal Outpเ	ut: 👌	200m			Differen	ce:	-10000	u _		
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Dr.G. GNANAVELU







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NPO	Starte	d at:				O Over							CHA	KK I	
SHIF	Γ	M	lorning		After	noon			Nigh	t		Resti	ricted F	luid (R	F)
INTA	KE	400 ml													
OUT	דטי	<u>500 m</u>	<u> </u>				_]							
Total I	ntake:				Total Outp	ut:				Differen	ce:				
			INTAKE	` `						OUT	PUT	(ml)			
Time	Oral	Tube		ous Infusi		िर्धित	Time	Urine	Vomitus	N/G	Drain	Others	Tiotal	R/N Sign	Endorsed
		Feeding	Type of Fluid	Additions	Amount		Tille	Office	VOITILUS	Aspirate	Tube	Ottlers	ICCER	Torr orgin	by
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Department of Dietetics



Every heart beat counts

Mr.RAMACHANDRAN R

64/Malc/MHI202481642 05/01/2024/IPH2024000043

Dr.G. GNANAVELU

110 MM 1001 OM 018 TUA HAN 1110 AN AN AN AN **NUTRITION ASSESSMENT AND CARE PLAN FORM** Diagnosis: PH -AW-STERM Deute FF-40. Height:.... Weight:.... Food allergies: Yes/ No; if yes, specify..... Kgs..بر.. Religious Beliefs: Vegetarian Non Vegetarian ☐ Eggetarian ☐ Jain Diet Prescription:.... 1600 (alous 760 SUBJECTIVE GLOBAL ASSESSMENT (ADULTS) المنك Patient's related Medical History 1) Weight Change (overall change in past 6 months) 7 □3 **D**2 П4 □ 5 No weight change/ >15% 2) Dietary intake □ 2 □ 3 □ 4 Full liquid dieta No change Hypo - calori Starvation solid diet moderate liquid diet overall decrease Adequate / Excessive Typo - calorio feeds Enteral / Sub - ontimal Inadequate Starvation Nutrition 3} Gastrointestinal mptoms Duration **□**2 □ 3 **1**4 No symptoms Nausea Vomiting / Diamboea severe anorexia moderate GI symptoms 4) Functional Capacity (Nutrition Clated functional Impairment) Duration: **3** □ 5 □ 2 Bed / chair ambulation normal actività ridden with no or little activity Co - morbidity (Disease and its relationship to nutrition requirements) 5) □ 2 **1**4 **7** 5 Пз Healthy Mild co -Very severe severe co inorbidity/ age >75 years morbidity Bì Physical examination 11 Decreased fat stores or loss of subcutaneous fat □ 2 □ 3 □ 5 Normal Mild Moderate Severe 2) Sign of muscle wasting **□** 2 □з Moderate MId Normal ٠, Severe Total Score = Sum (above 7 components Nutritional Status : Based on this patient is (7 to 14) Moderately Malnourished □(15 to 18) (19 to 35) Severely Malnourished Nutrition Intervention: ☐ Enteral ☐ Parenteral Ora! | □ No Yes Diet counselling provided:

Dietitian Signature / Name / Date / Tir Senior Dietitian

☐ Fort - night

Calorie count:

, 🔲 .Yes

Weekly

□ Daily

Frequency of re-assessment:

Sign of

☐ Monthfy

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6/1/1/20, A be year so gustonam came or to water one amounted to swater are amounted to be seen rounded as evident by seen rounded as evident by seen Rother wind to are Educated for patient and family a resociation for patient and family as resociation for patient and family as resociation for make to seem for make for make to such for the seen for the formation of the formatio			
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Every heart beat counts

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(A Unit of United Alliance Healthcare Pvt Ltd) THEOMBOLYSIS CHECK LIST Mr.RAMACHANDRAN R 64/Malc/MHI202481642 Sex: CC No.: Age: Name: 05/01/2024/IPH2024000043 Wt: Date: Diagnosis: Dr.G. GNANAVELU To: thrombolysis - From: **ELIGIBILITY CRITERIA** YES NO Clinical: Chest pain for less than 12 hours ECG: ST elevation \geq 1mm in \geq 2 limb leads ST elevation $\geq 2mm$ 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 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 NO Age more than 65 years Weight less than 70 Kg Hypertension at presentation (> 180/110 mmHg) Use of t-PA Comments:

Signature of the Doctor

I., Time ... 10.108 P18 Date : ...



Interpreter



CONSENT FOR HIV TESTING Mr.RAMACHANDRAN R 64/Malc/MHI202481642 Sex:M/F ge: Patient Name: 05/01/2024/IPH2024000043 Consultant Dr.G. GNANAVELU UHID: have been given verbal and written educational information for HIV antibody testing. 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 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 (me The patient is unable to consent because __ and I, M. Deepa (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 Doctor / Nurse / Counsellor

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Patient Representative Vitness	r doctor's designee	1	consent to this proce	edure.		
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Mr.RAMACHANDRAN R

64/Male/MHI202481642 05/01/2024/IPH2024000043

dr.g. gnanavelu



PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: _	tcs/	AW ISTEMI	T2DX	<u>) All</u>	lergi	es if any:	HB. PAN-D						
From (Area	From (Area) To (Area) Date Time Reason for Transfer / Name of Procedure												
ccu	CCU CATHLAB 6/1/24 1/39 CACT.												
Method of Transfer: ☐ On Bed ☐ On Wheelchair ☐ On Stretcher													
	ASSESSMENT OF PATIENT: General condition of Patient: Conscious Semi-conscious Un-conscious												
Language Barrier: Yes No I If Yes, specify:													
Fall Risk Cate	Fall Risk Category: ☐ Low Risk ☐ Medium Risk ☐ High Risk												
Vital Signs (to I	Vital Signs (to be documented at the time of shifting):												
Temp (°F)	RR (Ł	oreaths/min)	Pulse	e (beats/min))	SpO ₂ (%)	BP (mmHg)	Pain	Score				
97.	٤	32,	I	115		991,	177/111	%	p				
Any critical inf	Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose) Any pre-medication given:												
	Sign	ature	Nan	ne			Emp. No.	Date	Time				
Handover by	,		S.	Allwing	rov	grace.	0162	6/1/24	11.80				
Handed over to)	Q)		v.Ø	41	house	0202	6/1/24	11.30				
Procedure com	After Procedure: Procedure completed: Yes Any critical information: Vital Signs (to be documented at the time of shifting):												
Temp (°F)	RR (t	reaths/min)	Pulse	e (beats/min)		SpO ₂ (%)	BP (mmHg)	Pain	Score				
98.6'	98.6' 22 br/min 12 bt/min 100% 186(101)(106) 1/0												
☐ FLACC Scal	Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months) ☐ FIACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years) ☐ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)												
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Handed over to		MON		Nation?	794	V	2355	120 es	13.10				





CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

Mr.RAMACHANDRAN R
64/Malc/MHI202481642
05/01/2024/IPH2024000043

Age: Sex: M/F

dr.g. gnanavelu

EDURE

Ward & Bed No:

Dr ANAMEL has explained that I have the following condition:

Fat (cholesterol) and calcium can build up in the arteries like rust in old pipes. It can stop the flow of blood to the heart. This can cause angina or a heart attack. The Coronary Angiography procedure is performed to show up the amount of disease in the coronary arteries, the blood vessels that supply the heart with bleed. After an injection of local anaesthetic, a fine tube (catheter) is put into the artery in the groin/hand. The tube is carefully passed into each coronary artery in turn. A series of video pictures are taken using x-rays and an iodine containing contrast medium (x-ray dye). The contrast medium may be injected into the main pumping chamber of the heart (left ventricle). This helps us to find out whether you have any narrowing or blockage of your coronary arteries. The doctor can then tell you which treatment is best for you after carefully studying and discussing your pictures. This may be an operation such as a coronary by-pass or a procedure called an angioplasty (the arteries are widened using a small sausage shaped balloon). Sometimes, drugs alone may be a suitable option.

UHID

RISKS OF THIS PROCEDURE

The risk of coronary angiography depends on:

(i) The nature of coronary artery disease (ii) The pumping status of the heart (iii) Your age and general health These are some of the more serious risks that can happen, but are not the only risks:

Less than 1 in 10,000 (0.0001%)	(a) skin injury from radiation, causing, reddening of the skin
1 in 1000 people (0.001%)	 (b) A stroke. This can cause paralysis and long term disability (c) Heart attack. (d) A dangerous reaction to the x-ray contrast medium (dye). If this happens, you may have severe reactions such as asthma, shock and convulsions. Death in extremely rare cases about 1 in 2,50,000 to 4,00,000 injections. (e) Need for major surgery to the leg at the puncture site. (f) Need for emergency heart surgery or angioplasty. (g) A higher lifetime risk from x-ray exposure. (h) Death
1 in 100 people (0.01%)	 (I)the heart may not beat in a proper rhythm which will need urgent treatment (j) Surgical repair of the groin puncture site. This may need a longer stay in hospital. (k) Minor reaction to contrast medium such as hives. (l) Loss/impairment of kidney function due to the contrast medium
1 in 20 people (0.05%)	(m) Major bruising or swelling at the groin punture site
Most People	(n) Minor bruising

PATIENT CONSENT:
P acknowledge that Dr ANAD VELLA: has explained my medical condition and the proposed procedure. I understand the risks of the procedure, the anaesthetic including the risks that are specific to me and the likely outcomes if complications occur. The Doctor has explained other relevant treatment options their risks and my right to refuse the treatment. He has explained my prognosis and the risks of not having the procedure. I was able to ask questions and raise concerns with the doctor about my condition, the procedure and its risks, and my treatment options. My questions and converns have been discussed and answered to my satisfaction. I understand that in the unlikely event of complications, I may require a blood transfusion, an additional procedure or surgery. The doctor has explained to me that if immediate life-threatening events happen during the procedure, they will be treated accordingly. I understand that no guarantee has been made that the procedure will improve the condition On the basis of the above statements,

I REQUEST TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship	G. R. J -	G. RAMA CHANNAW.	6024	11.10
witness	Rampa	Lanya Camelle		11.10
Doctor	(A) 798	, ,	6/4/24	11.10.
Interpreter	40		011 F	



MHI/CRD/2022/026 Heart Institute Every heart beat counts

இருதய ஆன்னியோகிராம் பரிசோதனைக்கான ஒப்பம்

நோயாளியின் பெயர்:	வயது:	பாலினம்: ஆண் / பெண்
opination sident		Elistotes Courty (Idaa)
மாக்குவ அரோசகர்:	வார்டு படுக்கை எண்:	யுவைச்சுடி (UHID) :

நிலை மற்றும் செயல்முறை

பழைய இரும்புக் குழாய்களில் துருபிடிப்பதைப் போல். தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாரடைப்பினை ஒற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிரை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியரேகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு னோக்கல் அன்ஸ்தீட்டிக் (மயக்க மருந்து) வழங்கப்பட்ட பின். ஒரு சிறிய குழாயானது (கதீட்டர்) கவட்டை/கையிலுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிரை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டுள்ளன கான்ட்ராஸ்ட மீடியத்தினை (எண்ஸ்ரே டை.) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுயக்க இருதய கீழறை) இந்த கான்ட்ராஸ்ட மீடியம் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்படவும் மற்றும் அது எவ்வாறு பம்ப் செய்கிறது என்பதை மதிப்படவும் மேற்கொள்ளப்படும். இப்படங்கள் நமக்கு இதயச்சுவர்சிரை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகீட்சையை மேற்கொள்ள முடியும். இவை பை-பாஸ் அறுவை சிகீட்சையாகவும் இருக்கலாம். சில்லது ஆன்ஜியோபிளாஸ்டி (பனுரன் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகலப்படுத்துல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

கிச்சையல்முறையிலுள்ள கிடர்பாடுகள்

இதயச்சுவர் சிரை ஆன்ஜியோகீராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிரை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள சில தீவிர கிடர்பாடுகள் பின்வருமாறு. ஆகால் இவைகள் மட்டுமே முழுமையான இடர்பாடுகள் அல்ல

10.00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகிதம்)	(a) கதிர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
1000-ல் ஒருவருக்கு (0.001 சதவிகிதம்)	 (b) வலிப்பு. இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாரடைப்பு (d) எக்ஸ்-ரே காண்ட்ராஸ்ட் மீடியத்தீன் (டை) ஆபத்தான விளைவுகள் . இவை ஏற்பட்டால் உங்களுக்கு ஆஸ்துமா. அதீர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2.50.000 முதல் 4,00.000 ஊசிகளில் ஒன்று மரணத்தையும் விளைவிக்கலாம். (e) குத்தப்பட்ட இடத்தீல் பெரிய அறுவை சிகீச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரகால இதய அறுவை சிகீச்சை அல்லது ஆன்ஜியோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதீர் பாதீப்பு காரணமாக அதீக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	 (I) இதயம் சரியான முறையில் துடிக்கமாம் இருக்கலாம். அதற்கு அவசரமாக சிகீச்சை தேவைப்படும் (j) சுத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகீச்சை சரிபாடு. இதனால் மருத்துவமளையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) கான்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலுகுறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவிலான சிராய்ப்பு அல்லது வீக்கம்
பெரும்பாலான மக்களுக்கு	(n) சிறிய அளவிலான சிராய்ப்பு

நோயாளி ஒப்புதல்

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

	கையெழுத்து	பெயர்	தேதி	நேரம்
நோயாளி (பாதுகாவலா) உறவுமுறை				
சாட்சி '	*			
மருத்துவர் •	•			
மொழிபெயர்ப்பாளர்				



Patient



Mr. RAMACHANDRAN R RY ANGIOGRAM / CORONARY ANGIOPLASTY

64/Malc/MHI202481642 05/01/2024/IPH2024000043

Dr.G. GNANAVELU

Consul

Sex: M/F

Bed No: UHID

CONDITION AND PROCEDURE

Dr MNN.V.EL Vhas explained that I have the following condition:

Fat (cholesterol) and calcium can build up in the arteries like rust in old pipes. It can stop the flow of blood to the heart. This can cause angina or a heart attack. The Coronary Angiography procedure is performed to show up the amount of disease in the coronary arteries, the blood vessels that supply the heart with bleed. After an injection of local anaesthetic, a fine tube (catheter) is put into the artery in the groin/hand. The tube is carefully passed into each coronary artery in turn. A series of video pictures are taken using x-rays and an iodine containing contrast medium (x-ray dye). The contrast medium may be injected into the main pumping chamber of the heart (left ventricle). This helps us to find out whether you have any narrowing or blockage of your coronary arteries. The doctor can then tell you which treatment is best for you after carefully studying and discussing your pictures. This may be an operation such as a coronary by-pass or a procedure called an angioplasty (the arteries are widened using a small sausage shaped balloon). Sometimes, drugs alone may be a suitable option.

RISKS OF THIS PROCEDURE

The risk of coronary angiography depends on:

(i) The nature of coronary artery disease (ii) The pumping status of the heart (iii) Your age and general health These are some of the more serious risks that can happen, but are not the only risks:

Less than 1 in 10,000 (0.0001%)	(a) skin injury from radiation, causing, reddening of the skin				
1 in 1000 people (0.001%)	 (b) A stroke. This can cause paralysis and long term disability (c) Heart attack. (d) A dangerous reaction to the x-ray contrast medium (dye). If this happens, you may have severe reactions such as asthma, shock and convulsions. Death in extremely rare cases about 1 in 2,50,000 to 4,00,000 injections (e) Need for major surgery to the leg at the puncture site. (f) Need for emergency heart surgery or angioplasty. (g) A higher lifetime risk from x-ray exposure. (h) Death 				
1 in 100 people (0.01%)	 (I) the heart may not beat in a proper rhythm which will need urgent treatm (j) Surgical repair of the groin puncture site. This may need a longer stay hospital. (k) Minor reaction to contrast medium such as hives. (l) Loss/impairment of kidney function due to the contrast medium 				
1 in 20 people (0.05%)	(m) Major bruising or swelling at the groin punture site				
Most People	(n) Minor bruising				

PATIENT CONSENT:
P acknowledge that Dr Consent I understand the risks of the procedure, the anaesthetic including the risks that are specific to me and the likely outcomes if complications occur. The Doctor has explained other relevant treatment options their risks and my right to refuse the treatment. He has explained my prognosis and the risks of not having the procedure. I was able to ask questions and raise concerns with the doctor about my condition, the procedure and its risks, and my treatment options. My questions and converns have been discussed and answered to my satisfaction. I understand that in the unlikely event of complications, I may require a blood transfusion, an additional procedure or surgery. The doctor has explained to me that if immediate life-threatening events happen during the procedure, they will be treated accordingly. I understand that no guarantee has been made that the procedure will improve the condition

On the basis of the above statements.

I REQUEST TO HAVE THE PROCEDURE

	Signature	Name	Date	Time	
Patient/Guardian with relationship			, ,		
witness	ar h	Jamya (Dought	(4) 6 1/24	12.05	
Doctor		De Carcle Sebapath	6 1 24	12.05	
Interpreter	Ü		-1		



MHI/CRD/2022/026

Medway
Heart
Institute

Every heart beat counts

<u> கிருதய ஆன்தியோகிராம் பரிசோதனைக்கான ஒப்பம்</u>

நோயானியின் பெயர்:	வயது:	பாலினம்: ஆண் / பெண்
மருத்துவ ஆலோசகர்:	வாா்டு படுக்கை எண்:	யுஹெச்கூடி (UHID) :

நிலை மற்றும் செயல்முறை

பழைய இரும்புக் குழாய்களில் துருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாரடைப்பிணை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிரை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியரேகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு சேறிய கழானரி ஆஞ்சியரேகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு சேறிய கழாயானது (கதீட்டர்) கவட்டை/கையிலுள்ள தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டுள்ளன கான்ட்ராண்ட் மீடியத்தினை (எண்ஸ்ரே டை) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் மூக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுபக்க இருதய கீழறை) இந்த கான்ட்ராண்ட் மீடியும் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்ப் செய்கிறது என்பதை மதிப்படவும் மேற்கொள்ளப்படும். இப்படங்கள் நமக்கு இதயச்சுவர்சிரை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேலும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கன் படங்கன் கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகிட்சையை மேற்கொள்ள முடியும். இவை பை-பான் அறுவை சிகிட்சையாகவும் இருக்கலாம். சிலைய அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேராங்களில் மருந்துகள் மட்டுமே போதுமானதாக இக்கலாம்.

இச்சையல்முறையிலுள்ள இடர்பாடுகள்

இதயச்சுவர் சிரை ஆன்ஜியோகிராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிரை தமனி நோயின் தன்மை — (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை — (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள சில தீவிர கீடர்பாடுகள் பின்வருமாறு. ஆனால் கிவைகள் மட்டுமே முழுமையான கீடர்பாடுகள் அல்ல

10,00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகீதம்)	(a) கதீர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
1000-ல் ஒருவருக்கு (0.001 சதவிகீதம்)	(b) வலிப்பு. இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாரடைப்பு (d) எக்ஸ்-ரே காண்ட்ராஸ்ட் மீடியத்தின் (டை) ஆபத்தான விளைவுகள் . இவை ஏற்பட்டால் உங்களுக்கு ஆஸ்துமா. அதிர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2,50,000 முதல் 4,00,000 ஊசிகளில் ஒன்று மரணத்தையும் விளைவிக்கலாம். (e) சூத்தப்பட்ட இடத்தில் பெரிய அறுவை சிகீச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரகால இதய அறுவை சிகீச்சை அல்லது ஆன்லயோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதிர் பாதிப்பு காரணமாக அதிக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(I)இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகீச்சை தேவைப்படு: (j) குத்தப்பட்ட கவட்டை பகுதீயில் அறுவை சிகீச்சை சரிபாடு. இதனால் மருத்துவமளையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) கான்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலுகுறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகீதம்)	(m) குத்தப்பட்ட இடத்தீல் வெரிய அளவிலான சிராய்ப்பு அல்லது வீக்கம்
வரும்பாளை மக்களுக்கு	(n) சிறிய அளவிலான சிராப்ப்பு

நோயாளி ஒப்புதல்

சையல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

	கையெழுத்து	பெயர்	தேதி	நேரம்
நோயாளி (பாதுகாவலர்) உறவுமுறை				
சாட்சி "	•			
மருத்துவர் .	,		1	
மொழிபெயர்ப்பாளர்				







TRANSRADIAL CORONARY ANGIOGRAM REPORT

Patient Name:	Mr.RAMACHANDRAN R		ID:	MHI202481642
Age/Gender :	64 M		IPH:	IPH 2024000043
Cath No. :	3546		DOP:	06.01.2024
Done by	Assisted by	Technician	Phy	sician assistant
Dr.G.Gnanavelu	Ms. Sandhiya	Mr. Pandian		Ms. Shalini

DIAGNOSIS: AWMI; TNK LYSED; MODERATE LV DYSFUNCTION; HBP; T2DM

Access: Right Radial artery

Hardware used: 6F sheath, 5F TIG

Contrast used: CONTRAPAQUE 40 ml

Medications given: Inj Heparin 2500 IU IA + Inj NTG 100 mcg

Hemodynamic data: Aortic pressure 167/86(104) mmHg; HR 86 bpm; SpO2 99%

Selective Coronary angiogram done in multiple angulated views:

ARTERY	FINDINGS
LEFT MAIN	Normal. Bifurcates into LAD & LCx.
LAD	Type 3 vessel. Ostial LAD has plaques, Proximal LAD has 40-50% discrete stenosis, Mid LAD after major septal has 95-99% tubular stenosis, Distal LAD has non flow limiting disease, Gives 2 diagonals and many septals which have non flow limiting disease.
LCx	Nondominant. Gives 2 major OMs. Proximal & distal LCX have luminal irregularities & OMs have luminal irregularities.
RCA	Dominant. RCA appears normal. Gives PDA and PLV which appear normal.

FINDINGS: RIGHT DOMINANT SYSTEM; SIGNIFICANT LAD DISEASE

ADVICE: PTCA TO LAD

Dr. G. GNANAVELU, MD, DM

Dr. G. Gnanavelu Mo, OM (cardio), FACC Advisor & Mentor Chief Cardiologist Reg. No: 39469

#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel : 044 - 4310 8959

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Villupuram

Kumbakonam

Kakinada

Heart Institute 044 - 4310 8959 Institute of Pulmonology 044-2473 4451







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TRANSRADIAL PERCUTANEOUS CORONARY INTERVENTION REPORT

Patient name

MR. RAMACHANDRAN.R

ID

MHI202481642

Age/Gender

64 M

IP No.

IPH2024000043

Cath No.

3547

D.O.P.

6.1.2024

Done by Dr. G.Gnanavelu

Technician: Mr. Prathap

Scrub nurse: Ms. Sharmila

DIAGNOSIS: AWMI LYSED WITH TNK; MODERATE LV DYSFUNCTION; T2DM; HBP

SIGNIFICANT LAD DISEASE

APPROACH: Right radial artery

EXPOSURE TIME: 1095 sec

HARDWARE: 6F hemostatic sheath, 6 F EBU 3.0 guide

RAK: 271 mGy

DAP: 77 Gy.cm2

CONTRAST : OMNIPAQUE 200 ml

MEDICATIONS: Inj NTG 200 mcg IA; Inj. Heparin 8500 IU IA;

HEMODYNAMIC DATA: ABP 104/70 (81) PULSE 91 bpm SPO2 100%

ARTERY	LESION	GUIDE WIRE	PRE DILATATION	STENT	POST DILATATION	RESULT
PROX & MID LAD	40-50% DISCRETE ECCENTRIC PROXIMAL & 95-99% TUBULAR IN MID LAD	BMW	2 X 10 SC Balloon 10 atms	SYNERGY 2.75 X 28 11 atms 15 s	3 x 10 NC 16 atms	TIMI III FLOW

REMARKS: Uneventful procedure. Inj Nikorandil 2mg and aliquots of 50 mcg of Inj Sodium nitroprusside ACT at the end of the procedure was 303 s.

RESULT: SUCCESSFUL PTCA X LAD

Dr. G. GNANAVELU, MD, DM

Dr. G. Gnanavelu MD, DM (cardio), FACC Advisor & Mentor Chief Cardiologist Reg. No: 39469

#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel : 044 - 4310 8959

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MHI/HOSP/2022/118

Mr.RAMACHANDRAN R 64/Malc/MHI202481642 05/01/2024/IPH2024000043

"p

Dr.G. GNANAVELU

Date & Time Observations / Action Signature with 1.75 patient required Cly to (ath dab) pt consider g exerted pt vital stable pt Iv cline patient vielt go very con. ine sterile drapping done under the clocal areathering. 12:00 CHG procedure started R+ Radial for aftery approach. 12:10 Interpretation connected 12:10 Interpretation 12:10 Applied (pt procedure started for p	
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2500 TH GIVEN (OB DRG6) STr)	
12:10 > HP:72 bt/min BB:167/86 (104)mmHg	
\(\lambda \lambda \lam	
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TANHOC PICA procedure started Coso	
12.10 10 7 IN): Helputh 5000 IV gein	<u> </u>
(O/D DR.616 (S) (V)	
12 20 3 ZNI! Hepaus 1000 EV gun	<u> </u>
(OB DR.U4) (ST) - 020	
12:35 3 200 + 1R:95 BH/min BP (167/86)	
(104) mr He Spoz: 100 / VIfal stable	·
12.40 DipTCP provedue done.	1
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12.5 = pt shitted Oth das to Cle for	
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Signature Name Emp. No. Date	
endorsed by sathy solb blilly	Time

		NURSES PROGRESS	NOTES	· · · · · · · · · · · · · · · · · · ·	
Date & Time		Observations / Action		Signature with	Emp. No
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SAFE PROCEDURE CHECKLIST Adapted from WHO Safe Surgery Checklist



Every heart beat counts

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Name of the Procedure :	CAG	Location: Cath Sal	Date & Time :(64/Malc/MHI202481642 05/01/2024/IPH2024000043
Does the Procedure involve	Procedural Sedation :		Dr.G. GNANAVELU	
SIGN IN 11 2 # 5 Before Induction of Procedural S	edation	TIME OUT 150 After procedural Sedation and before procedure		SIGN OUT When Doctor indicates that the Procedure is completed
(Anaesthetist / Qualified Physicia Sedation + Nurse + Technician + Do	n administering Procedural ctor performing the procedure)	(Anaesthetist or Qualified Physic	ian administering Procedura performing the Proced	
Patient Confirmation		All team members introduce themselves by Name and R	Role	To be done for each procedure in case of multiple procedures
Identity by two identifiers	☐Yes	Identity by two identifiers	Yes	Name of the Procedure done written down
Procedure	Yes	Procedures A	LYes	Name and site of all specimens / investigations Yes NA confirms labeling and sent to lab
Side	□RÍ □LI □NA	Expected Blood loss	M	Commission and Sent to rate
Consent	€Yes	Position SUDING	☑Yea	Any recovery concerns : Yes None
Known Allergy	☐Yes ☐Nø	Consent	☐Y95	If Yes, Pls. specify:
	If yes, plaese specify	Required equipment and implants available	☐Yes ☐NA	If Yes, Pls. specify:
Difficult airway / aspiration risk	✓ Yes, equipment	Essential Imaging displayed	.□Yes □NA	0690.
/ dentures	and assistance available	Antibiotic prophylaxis within last 60 minutes	□Yes □JWA	. *
Possibility of hypothermia	☐ Yes, warmer in place	Name of the Antibiotic given		Any Equipment / instrument problem that needs to be addressed:
		Venous Thromboembolism Prophylaxis Provided	☐ Yes ☐ ₩A	If Yes, Pls. specify:
All concerned anesthesia equipment	and medication check complete	Anticipated duration briefed	☑Ýes_	
□Spo2 □MBP □Other	s pls. specify <u>FC</u>	Anticipated blood loss briefed	☑Yes □NA	
Pre OP medication taken	☐Yes IND	Adequate fluids and blood available	☐Xes ☐NA	\ _1
Described a suit mant for		Team briefed on any critical or unexpected steps	'∐Yes	Corrective action :
Required equipment for procedure available	☐ Yes ☐ WA	For procedural sedation cases Any patient specific concerns :	Yes None	
procedure diversions		Intra procedure glycernic control	☐Yes ☐MA	
	'	Any concerns about sterility	☐ Yes ☐ Norne	
Anaesthetist / Dector giving	Doctor performing the	The Purchase	Technician: Draw	Others Please Specify:
Anaesthetist / Doctor giving Procedural Sedațion	Doctor performing the Procedure :	Nurse: SN punchaum 0000	Technician: prod	Others Please Specify:
Anaesthetist / Dector giving Procedural Sedation Date:		The Purchase	Technician: Drad	Others Please Specify: Date:



Date:

Time:



SAFE PROCEDURE CHECKLIST Adapted from WHO Safe Surgery Checklist

MHI/OT/2022/086

Heart
Institute

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					MI.RAMACHANDRAN R
	Arra-	Location :CAstA_	.lall	,	64/Male/MHI202481642
Name of the Procedure :	PICPT-	Location:	<u> 1005</u>	Date & Time :_ <i>E</i>	11/2
Does the Procedure involve	Procedural Sodation :	Vos □N			Dr.G. GNANAVELU
	Frocedural Sedation .				SIGNOUT 12.40
SIGN IN 12 CO		TIME OUT 2 / d After procedural Sedation and before	e procedure		SIGN OUT 2 4/70 When Doctor indicates that the Procedure is completed
Before Induction of Procedural S (Anaesthetist / Qualified Physicia		•	•	administering Procedura	I Sedation + Nurse + Technician + Doctor
Sedation + Nurse + Technician + Do	octor performing the procedure)	(Villacouloust of	addilica i Trysician	performing the Proced	
Patient Confirmation		All team members introduce themselves	by Name and Role		To be done for each procedure in case of multiple
					procedures
Identity by two identifiers	□Yes	Identity by two identifiers		ŬYes	Name of the Procedure done written down
Procedure	☐Yes	Procedures DT	-	☐Yes/	Name and site of all specimens / investigations ☐ Yes☐ NA
Side	DKÍ □LI □NA	Side R + POWAL OUT	ON GODDOON	□Rt □Lt □NA	confirms labeling and sent to lab
		Expected Blood loss	ONB		
Consent	□Yes	Position Supply		☐ Yes	Any recovery concerns : ☐ Yes ☐ None
Known Allergy	☐Yes ☐No	Consent	_	.⊒Yes _	If Yes, Pls. specify:
	If yes, plaese specify	Required equipment and implants availa	able	☐ Yes ☐NA	
		E	· 		
Difficult airway / aspiration risk	☐No ☐ Yes, equipment and assistance available	Essential Imaging displayed	4	☐Yes ☐NA	
/ dentures		Antibiotic prophylaxis within last 60 minu	Jies	☐Yes ☐NA	Any Equipment / instrument problem that needs to be
Possibility of hypothermia	Yes, warmer in place!	Name of the Antibiotic given	Dec. date at	EV EN	addressed:
	<u> </u>	Venous Thromboembolism Prophylaxis	Provided	☐ Yes ☐ ₩A	If Yes, Pls. specify:
All concerned anesthesia equipment	6 6 7	Anticipated duration briefed		☑ Yes_	
DSpo2 DAttBP ☐ Other	s pls. specify	Anticipated blood loss briefed		Yes 🗆 NA	/ /
Pre OP medication taken	□Yes ☑No	Adequate fluids and blood available		Xes □ NA	
		Team briefed on any critical or unexpect	ted steps	□Yes	Corrective action :
Required equipment for	☐Yes ØNA	For procedural sedation cases		LIVes VINES	
procedure available		Any patient specific concerns : Intra procedure glycemic control		☐ Yes ☐ None ☐ Yes ☐ NA	
		Any concerns about sterility		☐ Yes ☐ Norie	ν
Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure :	e Nurse:S/Npun	Charan TE	echnician : poatl	Others Please Specify:

Date: 6/1/24

Date: 6

Date:

Time:







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Procedure Monitoring Sheet (Cath Lab)

Patient	Name

Mr.RAMACHANDRAN R 64/Male/MHI202481642

05/01/2024/IPH2024000043

UHID / IP:

Dr.G. GNANAVELU	

Age/Sex: 64/M

Ward Unit: ധ

Diagnosis: ACC/AM CTEM / TODA.

Consultant : _	<u> </u>		Diagr	nosis : ACS/	tm Slewi	Mean.
Pre Procedu	re Checklist (Please	tick appropriate	ly – To b	e filled by the W	ard Nurse)	
PAI	RAMETERS			YES	NO	NA
Vital signs : BP:179/11 Temp:	į į		,			
Urine voided						
Bowel preparation						
Pre-procedure medication admir	nistered					
Procedure site marked	. 1		•- ,			
Skin preparation done		,			· · ·	
NPO from 9 AM)					
Loose Tooth removed					1	
Contact lenses / Eye glasses re	moved		_	/		
Prosthesis present						
Jewellery/Nail polish removed						
Checked for Allergies (Drug / for	od) DYUG TAR	CVAQ.			<u>,</u>	, , , ,
IV line/ln-situ			_	5/		
Consent taken	· 				<u>_</u>	
Investigation reports / Documen	ts received					
Signature of Nurse :	<u> </u>			Date & Time :	6/1/24 2	. Uzes
Intra	a – Procedural Rec	ord (To be fille	by the (Cath Lab Nurse)		
Time HR / min RR /	min BP mmH	g SpC	2%	Medication	/ Remarks	Sign. of Nurse
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18:10 8hb/lmin >> hr	min 146/84/	100) 100	<u> </u>			Spron
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				Post Proc	edure Follow Up	•	be filled by the d	~ ·				
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-		•			POST PROCEI	DURE OB	_					
_	ate & Time	BP	HRR	R SpO2%	Site Evalua	ation	Extremity Status	Remarks	Sign. of Nurse			
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	Patient s		L re of th	i Recovery F ie Nurse;∕	Room Datier	ı Koom	Date & Time					
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MI.RAMACHANDRAN R 64/Male/MHI202481642

05/01/2024/IPH2024000043

Dr.G. GNANAVELU







NURSING ADMISSION ASSESSMENT (ADMIT)

Date of Admission: 5, -24, Time of Arrival: 21. 49 Mode of Admission. Walking Wheelchair Sfretcher Accompanied by Relative: Wes No If Yes, Name of the Relative: Mys. Ass. Path Relationship with Patient: Mys. Ass. Path P	1401	MORSHING ADMISSION ASSESSIVENT (ADOLT)								
Relationship with Patient:	Date of Admission: 5-1-24 Time of Arrival: 21-49 Mode of Admission: Walking Wheelchair Stretcher									
Contact No.: 4 C 4 5 5 2 4 Primary language spoken: \$\frac{1}{1} \ \ \text{English} \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Accompanied by Relative: Yes No If Yes, Name of the Relative: Mr. Despe									
Contact No.: 4 C 4 5 5 2 4 Primary language spoken: \$\frac{1}{1} \ \ \text{English} \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Relationship with Pati	ent: Wile Contact	Person's Name:	Mn. 10 00	₽9 Relationship:	140,				
Interpreter needed: Leyes No Patient status: LeyConscious Unconscious Disoriented Menstrual History: LMP:	Contact No.: 4990	9765247 Primary la	nguage spoken: 🖸	∱Tamil ∐Englis	sh 🔲 Indian 🗌 Internat	ional				
Medical History: DM / HTM / Co - Morbidity: If Yes, specify Drugs History: Antiplateiet E 04 pt / Million Anxious Withdrawn Agitated Depressed Sleeping Difficulty	Interpreter needed:	Yes No Patient status:	Conscious	Unconscious [Disoriented					
Yer the past 2 weeks, how often have out been bothered by any of the following problems? Not at Several alt Days half of the days very day ou been bothered by any of the following problems? 1	Menstrual History : L	MP: Me	nopause:		Patient Vulnerable: 🏻 Ye	s 🗌 No				
Yer the past 2 weeks, how often have out been bothered by any of the following problems? Not at Several alt Days half of the days very day ou been bothered by any of the following problems? 1	Medical History : DM	/ HTN / Co - Morbidity :	If Yes	, specify		_				
Yer the past 2 weeks, how often have out been bothered by any of the following problems? Not at Several alt Days half of the days very day ou been bothered by any of the following problems? 1	Drugs History : Antip	latelet _ 6 Depivin (18p	egify)	<u>.</u>						
Total Days half of the days every day Total problems?	Psychological Status	Psychological Status: Calm Anxious Withdrawn Agitated Depressed Sleeping Difficulty								
Day Seen bothered by any of the following problems? T. Little Interest or pleasure in doing things 1	-				-	Total				
1. Little Interest or pleasure in doing things 2. Feeling down, depressed, or hopeless 3. Scoring: A PHO-2 score ranges from 0 to 6; patients with total score of 3 or more should be further evaluated with Columbia-suicide Severity Rating Scale (C-SSRS)tool. 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: Tempol L (P) Pulse / HH: 8 (beats/min) BP: \	•	by any of the following	ali Days	nair or the c	iays every day					
2. Feeling down, depressed, or hopeless Scoring: A PPIG-2 score ranges from 0 to 6; patients with total score of 3 or more should be further evaluated with Columbia-suicide Severity Rating Scale (C-SSRS)tool. Do you have any special religious, spiritual or cultural needs to be considered?	<u></u>	easure in doing things				 				
Scoring: A PHQ-2 score ranges from 0 to 6; patients with total score of 3 or more should be further evaluated with Columbia-suicide Severity Rating Scale (C-SSRS)tool. 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 2	,			_	3	1				
Columbia-suicide Severity Rating Scale (C-SSRS)tool. 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: Tempo 1 - CPT Pulse / H7:			its with total score		uld be further evaluated v	vith				
If Yes, specify details: Socio Economic Status: Employed Retired Own Business Home-Maker Others:	Columbia-suicide Seve	erity Rating Scale (C-SSRS)	tool.	•	/					
Socio Economic Status: Employed Retired Own Business Home-Maker Others: Vital Signs: Tempa 1-2 (°F) Pulse / HR: 8 (beats/min) BP: \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			cultural needs to	be considered?	Yes ☑ No					
Vital Signs: Tempo										
Respiration: 19 (breaths/min) SpO ₂ : 17 (%) CBG: 27 g (mg/dl) Height To (cms) Weight: 185 (kgs) Allergies / Adverse Reaction: Yes No Medication Blood Transfusion Food Not known If Yes, specify: P\$ Pan - D Medication Blood Transfusion Food Not known If Yes, specify: P\$ Pan - D Medication Blood Transfusion Food Not known If Yes, specify: P\$ Pan - D Medication Blood Transfusion Food Not known If Yes, specify: P\$ Pan - D Medication Blood Transfusion Food Not known If Yes, specify: P\$ Pan - D Medication Blood Transfusion Food Not known If Yes, specify: P\$ No. If Yes, score: Old Pain Scale Used: NRS(>12 years) CPOT (ventilator / comatose) It yes No. If Yes, score: Old Pain Scale Used: NRS(>12 years) CPOT (ventilator / comatose) It yes No. If Yes, score: Old Pain Scale Used: NRS(>12 years) CPOT (ventilator / comatose) It yes No. If Yes, score: Old Pain Scale Used: NRS(>12 years) CPOT (ventilator / comatose) It yes No. Change Burning Referred / Radiant Pain It yes No. Change No. Change No. Change It yes No. Change No. Change No. Change It yes No. If Yes, mention the Name: No. Change No. Change It yes No. If Yes, mention the Name: No. Change No. Change It yes No. If Yes, mention the Name: No. Change No. Change It yes No. If Yes, mention the Name: No. Change No. Change It yes No. If Yes, mention the Name: No. Change No. Change It yes No. Change No. Change No. Change It yes No. Change No. Change No. Change It yes No. If Yes, No. Change No. Change No. Change It yes No. Change No. Change No. Change It yes No. Change No. Change No. Change It yes No. Change No. Change No. Change It yes No. Change No. Change No. Change It yes No. Change No. Change No. Change No. Change It yes No. Change No. Change No. Change No. Change It yes No. Ch										
Allergies / Adverse Reaction: Yes No Medication Blood Transfusion Food Not known Medication Medic	T.					(kaa)				
If Yes, specify: The Pown - D. Pain: Yes No. If Yes, Score: Plo Pain Scale Used: NRS(>12 years) CPOT (ventilator / comatose) Pain: Yes No. If Yes, Score: Plo Pain Scale Used: NRS(>12 years) CPOT (ventilator / comatose) Pain: Yes No. If Yes, Score: Plo Pain Scale Used: NRS(>12 years) CPOT (ventilator / comatose) Pain: Yes No. If Yes, Score: Plo Pain Scale Used: NRS(>12 years) CPOT (ventilator / comatose) Pain: Yes No. If Yes, Score: Plo Pain Scale Used: NRS(>12 years) CPOT (ventilator / comatose) Pain: Yes No. If Yes, Score: Plo Pain Scale Used: NRS(>12 years) CPOT (ventilator / comatose) Pain: Yes No Change Burning Referred / Radiant Pain Nutritional Screening: No Change Last 3 months Weight: Increased Decreased No Change Last 3 months Weight: Increased Decreased No Change Type of Patient: Pain No No Diabetic Type of Diet: No Change Time: Pain No Pain N			1 CBG. 23 8 (mg	7di) rieigit.] A	Ciris) Weight 485	(kgs)				
Pain:			Medication	n 🔲 Blood Tran	sfusion 🔲 Food 🔲 Not	known				
Location:	If Yes, specify:	<u> </u>	<u> </u>							
Location:	Pain: Yes No. If	Yes, Score: 0 [10Pain	Scale Used:	VRS(>12 years)	CPOT (ventilator / c	omatose)				
Nutritional Screening: Last 3 months Appetite:	uration:					·				
Last 3 months Appetite:	Pain Character: Du	II Aching Sharp S	Stabbing Shoot	ng Burning	Referred / Radiant Pai	n				
Last 3 months Weight:	Nutritional Screening									
Type of Patient:	* *			ange						
Dietician Informed: Yes No. If Yes, mention the Name: Mr. halfarme: Time: 100 pp Orient Patient if: Conscious Orient Patlent Attendant if: Unconscious Disoriented Room Side Rails Toilet Bell Patient Information Board Bed Controls Use of Footstool Grab Bars Durses Call Bell Television Light Controls Telephone Functional Assessment: Particular Assessment Remarks Outcome Visual Impairment Yes No Chewing Difficulty Yes No	Last 3 months Weight	: Increased Decre	ased 🔲 No Cha		Α.					
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						<u></u>				
Room Side Rails Toilet Bell Patient Information Board Bathroom Bed Controls Use of Footstool Grab Bars Durses Call Bell Television Light Controls Telephone Functional Assessment: Particular Assessment Remarks Outcome Visual Impairment Grab Bars Durses Call Bell Television Controls Telephone Hearing Impairment Grab Bars Durses Call Bell Television Controls Telephone Outcome Chewing Difficulty Grab Bars Durses Call Bell Television Controls Telephone	Dietician Informed:	Yes No. If Yes, mention	the Name: M.	halperine	Time: <u>\$3 • 6</u>	00 10m				
Use of Footstool	Orient Patient if:	Conscious	Orient Patient At	tendant if:	Jnconscious Diso	riented				
Functional Assessment: Particular Assessment Remarks Outcome Visual Impairment Yes No Hearing Impairment Yes No Chewing Difficulty Yes No	Room Side	Rails Toilet Bell	Patient Informati	on Board	Sathroom Bed	∽ Controls				
Particular Assessment Remarks Outcome Visual Impairment ☐ Yes ☑ No ☐ Hearing Impairment ☐ Yes ☑ No ☐ Chewing Difficulty ☐ Yes ☑ No ☐										
Visual Impairment ☐ Yes ☑ No Hearing Impairment ☐ Yes ☑ No Chewing Difficulty ☐ Yes ☑ No	Functional Assessme	ent:								
Hearing Impairment Yes No Chewing Difficulty Yes No	Particular	Assessment Remarks			Outcome					
Chewing Difficulty Yes No	Visual Impairment	☐ Yes ☑No								
	Hearing Impairment	☐ Yes ☑ Mo								
Walking Difficulty ☐ Yes ☑No	Chewing Difficulty	☐ Yes ☐ Mo								
	Walking Difficulty	☐ Yes ☑ No								

Daily Activity Of L	iving:	-	•					,	Section 144	
Activity	Independent			Assisted			De	Dependent :		
Bathing										
Dressing										
Eating				-		1				
Walking					\Box					
Toilet Use		$\overline{\Box}$		-	$\overline{\square}$			一		
Pressure Injury Risk Assessment: Braden Scale										
Sensory Percep		Score	Moisture		Score	Degre	e of Activity	, ¬	Score	
No Impairment		(4)	Rarely Mois	t	(4)		Frequently		4	
Slightly Limited		3	Occasionall		3		Occasional	v	3	
Very Limited		2	Very Moist	<u>-</u>	2	Chair l			2	
Completely Limit	ed	1	Constantly I	Moist	1	Bed Fa	ast		(1)	
Mobility		Score	Nutrition		Score	Friction	on & Shear		Score	
No Limitation		(4)	Excellent		4		parent prob	lem	(3)	
Slightly Limited		3	Adequate		(3)	_	tial Problem	_	2	
Very Limited	_	2	Probably in-	-Adequate	2	Proble	em Present		1	
Completely immo	obile	1	Very Poor		1					
Total Score: Lq	High Risk: 12 - 10; Severe Risk: 9 - 6 Total Score: L9									
			E FALL ASSES	SSMENT SC	ALE (Age a	bove 16	years)			
Fall Risk Assess	sment (Mo	odified Mors	e Scale):	·	<u>•</u>			·		
Variables	-				•	-	l Na	Num	neric Value	
History of falling	(immediate	e or within 6	months)				No Yes		25	
							No		0	
Secondary diagn	iosis (≥ 2 i	medical diag	nosis)				Yes		<u>(6)</u>	
Ambulatory Aid	-		·							
None / Bed Rest		ssist							1	
Crutches / Cane									15	
Furniture									30	
Intravenous Ther	any / Hens	arin Lock / Ti	ihes Insitu				No		0	
Intravendus inci	ару / Пері						Yes_			
Gait				:			1		_	
Normal / Bed Res Weak	st / Wheel	Chair	.	-					10	
Impaired	<u> </u>								20	
Mental Status Oriented to own:	stahility								6	
Overestimated or		mitations		, ,					15	
Medications			 _							
Includes PCA / o	piates, ant	ticonvulsants	, anti-hyperter	nsives, diuret	ics, hypnotic	s,	No		0	
laxatives, hypogl	ycemics, s	sedatives, im	munosuppres	ent and psyc	hotropics		Yes		(15)	
Score Interpretation	: 0-24: Low	/-risk; 25-44: N	ledium Risk; Ab	ove 45: High F		Total Sc	ore			

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 [1] 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) Epecurage 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: Remarks (please specify) Yes No 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 s					r nos. 1 to 9, and	assign a sco	re of -2 if (YES) in p				
S. No.	 -		Paran							Yes / No		Score
1	Active cancer	(on-going treatn	nent or	diag	nose	d within 6 months o	or palliative car	·e)		Yes 🖊	No	۵
2	Bedridden red	cently >3 days or	major	sur	gery w	vithin four weeks				Yes 📝	No	٥
3	Calf swelling (Assess for bo		d with	asy	mptor	matic side, measui	red at 10 cm b	pelow tibial tubercle		Yes 📝	Ńο	8
4	Collateral (no	nvaricose) super	ficial v	eins	prese	nt (Assess for both	legs)			Yes 📑	Νο	Ø
5	Entire leg swo	illen (Assess for t	ooth leg	gs)						Yes 🗌	No	0
6	Localized ten	derness along th	e deep	ven	ous sy	ystem (Assess for b	ooth legs)			Yes 🗌	No	0
7	Pitting edema	, greater in the sy	mptor	natio	c leg (/	Assess for both leg	s)			Yes 📝	No	0
8	Paralysis, par	esis, or recent pla	asterin	nmo	bilizat	tion of the lower ext	remity (Asses:	s for both legs)		Yes 📑	No	4
9	Previously do	cumented DVT (Assess	for	both le	egs)				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.											
		pretation (Pro	babil	ity (of DV	T):		-		Final Sco	re	0
lick	the score ob	tainea (✔)	√	/		_	Action Take	រា		Date		Time
Low	Risk	-2 to 0								5/1/2	<u> </u>	9:55
Mod	lerate Risk	1 to 2									\perp	
Higl	h Risk	3 to 8										
Pers	- sonal Belong	jings / Valuab	les:									
Valua	ables	Description	n	1	Vith tient	With Patient's Attendant	Name & Signature of the Patient / Patient's Attendant			t Remarks		
Dent	ures	□Upper□Lo □Both ☑N								_		
Hear	ing Aid	□Right □Lo	eft									
	Eye glasses / ☐ Yes ☑ No .											
Jewe	ellery	□ Yes □√N	, o						<u> </u>			
Othe (spec	r valuables				•							
<u> </u>		ray ECG lab	ranorti	L	taine	d with the nurse)						
ner		ray, LOG, lab		S 16	tali let		·			_		
		Sign.			Na	ıme		Emp. No.		 Date	i	ime
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Mr.RAMACHANDRAN R

64/Male/MHI202481642 05/01/2024/IPH20240000+3

Dr.G. GNANAVELU





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date:5-1	-24	Shift: Mor	ning Evening Night		•						
S	NEWS / F Ventilator Periphera Ryle's Tul	PEWS Score: — day: — al line day: Right: Le be:	POD: Central line ft: Brachial Anustrutic y: VIP Score:	days: 0/5							
В	Allergies On room	urgery: if any: 7- PBN - air / oxygen: Fm Wiff nts / New Symptoms in last s		· · · · · · · · · · · · · · · · · · ·	·	٠					
A	Vital Signs: Temp: 98-6 (°F) Pulse / HR: 86 (beats/min) Respiration: 10 (breaths/min) BP:										
R	Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: 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 g		(Mro	Dutin	0282	8-1-24	7:30					
Handover ta	ken by		S. Allwin Prongrace	0162	6/120	7.30					
Document e	endorsed	Jayr_	JAYAPAY)	0000-	6/1/24	J-8-2					

	NLNL	JRSES PROGRESS NOTES			
Date & Time		Observations / Action		Signature with I	mp. N
<u> ۲</u> ۱	NIGHT D	UTY REPORT			
21.49.	Pt admilte	d bo w, compla	int of		-
	chest pair , &	mocatting pt 28		De	
		en rod, vitals are	monito	ord	· -
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		n, conspant sed 1	• • • •	··	
		Coading dura was g			
22.00		or son thrombolys		Δ	
	I	en TNK 40 mg IV		0282	
	saministened.	, 0			
22.30	In dexame o.	6 mg Sle Stot green	g	020.	
	Dry Lasix doma	Stat gino			
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2.00	there is no	furmer igga	es		
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j')	Signature	Name	Emp. No.	Date	Tim
Document endorsed by	Jaur "	1000-00	Oon	_ \ \ 5/1/24	9-4









Every heart beat counts

	PATIE	NT CLINICAL I	HANDOVER RECOR	NUR	SES	
Date: 💪	1/24	Shift: Mor	ning Evening Night		·	
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	Catheter: ☐ Yes ☑∕No Da	ft: Brachal Anest Central line y: VIP Score: 4	days:- US		· .
B	Type of s Allergies On room	ROUND urgery: 「 if any: TAB・PAN・D air / oxygen: FM 02 5ん nts / New Symptoms in last s	4		e .:	
A	BP: 179 Others: Pain Sco Fall Risk Braden S Pressure	ns: Temp: 17.) (°F) Pulse 106 (mmHg) SpO ₂ 1 ore: 0/10 Pain Scale used Score: 50 Fall Risk Pr	/ HR:(beats/min) Respira () Height:(cms) Weight: 	ker FACES Pain Ratinsk: 14-13 High Risk: Dressing done: Yes	9-4 Ley r g Scale / NR: 12-10∐Seven	S / CPOT e Risk: 9-6
R	Referral of Pending Pending Pending Critical vo Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders:	ENo. If Yes, modified care plan date	e:		
		Signature	Name	Emp. No.	Date	Time

	Signature	Name	Emp. No	Date	Time
Handover given by		Callynmin	0161	6/124	11.21.
Handover taken by	Moh	Mohan sag.	\$362	1/1/24	13105
Document endorsed	· Neces	s- realiti	₽	6)1124	1350.

	NURSES PROGRESS NOTES		,	~,
Date & Time	Observations / Action	Sig	nature with E	np. No.
6/1/24	MORNING DUTY NOTES			
平:30	Spatient took over from night	ŧ J		-
	pt bomodynemics. Steelie No			
	Complialet Dt Rp 190/15 9	• ,		
F. Ro	Inform to or Aticles Solvect	yer.		
<u>8.00</u>	De predication arrest	ves la		
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9,00	done			
11-36_	previoled over fiver to al	J 1	$al \rightarrow$	
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Document endorsed by		Emp. No. COB4	Date 6(॥२५	Time)3'8







Patient Details (Affix Label here) Mr.RAMACHANDRAN R 64/Malc/MHJ202481642 05/01/2024/IPH2024000043 Dr.G. GNANAVELU



(A Unit of United Alliance Heat	thcare Pvt Ltd)	GNANAVELU	∫ _i Eye	ery heart bes	¢-counts
PATIE	NT CLINICAL H	HANDOVER HEVE	NUI	RSES	i
Date: 6/1/24 .	Shift: Morr	ning√☐Évening ☐Night,	4 · 3		_
SITUAT Diagnosi NEWS / Ventilato Periphers Ryle's Tu Urinary C	al line day: Right: → Let ibe: ☐ Yes ☐ Mo Day Catheter: ☐ Yes ☑ No Day	POD: ^ ~ Central lin	- ne days:		
B Type of s Allergies On room	ROUND surgery: PTCA to LAD if any: T, PAN - D air / oxygen: NPD2 14 19 nts / New Symptoms in last s	上の礼. (V fluids on	n flow: WF 30 CC	thu onfle	ow ·
BP: No.	ns: Temp: \(\frac{1}{2} \) (°F) Pulse \(\frac{1}{2} \) (mmHg) SpO ₂ : \(\frac{1}{2} \) (ore: \(\frac{1}{2} \) (D Pain Scale used a Score: \(\frac{1}{2} \) (D Fall Risk Properties)		ht: <u>& </u>	<u>Q - l4 kgl</u> M [°] ng Scale / NR : 12-10∐Sever	S / CPOT e Risk: 9-6
Referral Pending Pending Pending Critical v Changes Pending	medications: medication indent: lab reports / Investigations: value alert and its corrections is in nursing care plan: Yes follow-up orders:	No. If Yes, modified care plan d			A 90-0
Special	instructions if any:		<i>p</i> c//+ /		_
Handover given by	Signature	Name	Emp. No.	Date	Time
Handover taken by	Non	A. nutremay.	2-352	10/184	19.30
Document endorsed	No	2-Nalini		61124	20,30

	NL	JRSES PROGRESS NOTES		,	
Date & Time	(Observations / Action		Signature with E	mp. No.
6/1/24	pa Evenen	g duty Notes			
@ 13·10	>> P+ luccievo	from cath lab to	Clo.		
	Pt is Consious E	owented Pr hoamedy	ımmically	Mrs.	<u>بر</u>
	Stable & execoudo		0	23.6	
13:20	=>T-98f, P-90b	1mt 92 - 20 blmt 9 2P- 18	5 licymmun		
	SP02-981.		<u> </u>		
18.30	=> P+ 1VF 2016	the orgoing & infusion	CAYNE	رے ہے	
 	08 milher onflow	. Pt It Buachial Sy A	nestrotic	Wil	
	line puesent s	e, Patent			
13.40		given & CBG checked	ا مع		
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Mr.RAMACHANDRAN R 64/Malc/MHI202481642 05/01/2024/IPH2024000043

Dr.G. GNANAVELU





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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Date: 🔘 t	24	Shift: Morn	ing Evening Night	• • • • • • • • • • • • • • • • • • • •	-	
S	Ventilator Periphera Ryle's Tut Urinary C	S: ACS - ALD - STEM! PEWS Score: - day: - Il line day: Right: Left be: Yes No Day atheter: Yes No Day	GCS: [] POD: Central line : ATRUTTATIC, Brackhal VIP Score: (: R: Yes No. If Yes, specify organi	days:	*	
В	Allergies i On room	urgery: PTCA TO LAD	IV fluids on f	lery: 6/1/24 low: FVF NS-	gomi/hz	₹,
A	BP: (\(\psi \) Others : _ Pain Sco Fall Risk Braden S	ns: Temp 86 (°F) Pulse of Score: So Fall Risk Pro	•	#85 (kgs) BMI: 5	12-10 Sever	≶/CPOT
	RECOM	IMENDATION			· -	
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	_	medications:		,		
	Pending	medication indent:	Quea, creed, r	part 1 Kt		
H	Critical va	alue alert and its corrections:	_			
• •			No. If Yes, modified care plan dat	e:	•	
!	Pending	follow-up orders:				e11 <u>17</u>
	Special in	nstructions if any:			u.	
		Signature	Name	Emp. No.	Date	Time
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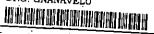
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64/Malc/MHI202481642 05/01/2024/IPH2024000043





PATIE	NT CLINICAL H	IANDOVER RECOR	D FOR NUR	SES	
Date: 7 - 2 - 24	Shift: Morn	ing Evening Night		٠ <u>.</u>	
NEWS / F Ventilator Periphera Ryle's Tu Urinary C	S:ACS - AW - STENN TO PEWS Score: day: al line day: Right: Left be: Yes	Anostral Buddaed VIP Score:	days: -		- 1°
Allergies On room	ROUND urgery: PTCA も LAD if any: T PAN - D air / oxygen: 2 ば NP nts / New Symptoms in last sl	Date of surg IV fluids on fi	1 1 1	, Dige	<u>:</u>
Others: Pain Sco Fall Risk Braden S Pressure	ore: 50 Fall Risk Pro	/ HR:	文句 (kgs) BMI: ker FACES Pain Ratin sk: 14-13	ng Scale / NR	e Risk: 9-6
Referral Pending Pending Pending Critical v Changes Pending	doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections:	No. if Yes, modified care plan date		,• <i>•</i>	·
	Signature	Name	Emp. No.	Date	Time
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Handover taken by	50)	5 Dayadharshin	0212	7/1/24	13.00
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A	Others: Pain Sco Fall Risk Braden S	ns: Tempe (F) (mmHg) S (mm	PO₂⊆1 — (%) He le used: PIPPS / Cl Risk Protocol: ☐ L : 23-19 ☐ At Risk-Mil ing (PUSH): ☐ Yes	(beats/min) Respira ghth (cms) Weight: RIES / FLACC / Wong-Bal ow Medium High / d Risk: 18-15 Moderate Ri No No NA Wound Drain	+ gdkgs) BMI:_ ker FACES Pain Ratir sk: 14-13 □ High Risk:	D 9. U Log I ig Scale / NRS 12-10⊡ Severe	S / CPO1
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64/Malc/MHI202481642 05/01/2024/IPH2024000043

Dr.G. GNANAVELU





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PATIENT CLINICAL	. HANDOVER	RECORD	FOR NURSES

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A	BP: 20 Others: Pain Sco Fall Risk Braden S	ns: Temp: $\begin{tabular}{c c c c c c c c c c c c c c c c c c c $		ht:(kgs) BMI:_ Baker FACES Pain Rati	ing Scale / NRS / CPOT :: 12-10□Severe Risk: 9-6
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Mr. RAMACO Mr.RAMACHANDRAN R 64/Malc/MHI202481642 05/01/2024/IPH2024000043 Dr.G. GNANAVELU



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Date: 🙎	1/24	Shift: U-Morr	ning Evening Night			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CAD_S\D EWS Score: 6 day: 6 I line day: Right: Lef be:	/: VIP Score:	015		
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A	Others: Pain Sco Fall Risk Braden S	ins: Temp () (°F) Pulse (mmHg) SpO	Drain	ker FACES Pain Ratin ksk: 14-13 High Risk: Dressing done: Yes	g Scale / NBS	
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ADULT NURSING CARE PLAN

Mr.RAMACHANDRAN R

64/Malc/MHI202481642 05/01/2024/IPH2024000043





Initial Date: 5 (D)	Time: (6 ! 6 D	Modified Date: Time:		
Reason for Modification:		Diagnosis: ACS-STEM1 1721	ρm,	
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	м	
Others:	requirements in accordance to his activity level and metabolic needs	necord amount or lood consumed	E	
			NP+ had pmdiet	₩ 2U0
OXYGENATION Room Air Nasal Cannula / High Flow O ₂ Mask BiPAP / CPAP Ventilator	☐ Patient will have normal O₂ saturation☐ Patient ABG levels will return to and remain within normal limits☐ No other respiratory abnormalities☐ Patient respiratory rate will remains within established limits	□ Encedrage 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 O₂ saturation and pulse rate □ If any O₂ abnormalities detected inform immediately to	M	
☐ Tracheostomy ☐ Others:	Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis	E	
		☐ Note for changes in level of consciousness	NP+ ON FM-5/14 ON Flow	DO HO
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition	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	M	
Parenteral Nutrition Others:		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	E	
		The first of the state of the s	N Pt En courage to	Pluo

	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	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment	М	
-	Utners:	Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	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)	E	
				N P+ Mobilize on	(A) (D) (D) (D) (D) (D) (D) (D) (D) (D) (D
	ELIMINATION Catheter, bedpan, urinal Nasogastric tube Blood movement	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention,	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician	М	
	☐ Urination ☐ Others:	control of bowel incontinence, and regular elimination patterns	Observe voiding accessories as foley's / silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	E	
			and follow proper protocol Check for malena / constipation / urinary retention	N Pt have @ demino	0 P 0 P 0
	SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE	☐ 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	M	
	INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased			E	
	☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			maintain Welch	0240

Patient Specific Sign & **Nursing Interventions** Evaluation Measurable Goals .Problems / Needs Initials Encourage patient to do daily bathing and oral hygiene Patient will stay clean and HYGIENE Change patient's gown daily
Encourage hand hygiene
Consider the patient's need for assistive devices Bed-Bath well-groomed Assist-Bath ☐ Patient will demonstrate lifestyle ☐ Self-Care ☐ CBD Care changes to meet self-care needs Ε (if present) Patient will recognize individual Apply moisturizing solution weakness or needs ☐ Others: Check the identity with ID band before any SAFETY Patient will have no life-threatening М Check ID Hand situations interaction with the patient ☐ IV care ☐ EJV ☐ Raise side rails Provide proper invasive line care CENTRAL LINE ☐ Keep bed locked and low at all time ☐ Side rails Ε Others: ☐ Educate care providers to be the patient Follow restrain policy (if needed) 0200 Provide clean calm and restful environment **COMFORT AND SLEEP** Patient will have comfortable sleep M Pain Control Patient will verbalize / or through Provide privacy at all time Sleep Patterns behavior about pain relief and ☐ Monitor pain scale / sleep pattern Others: adequate sleep ☐ Provide pharmacological and non-pharmacological therapy (g) OBSERVATION ☐ Patient will have normal range ☐ Monitor vital signs regularly M ☐ Vital Signs Monitor vital signs on ordered time of vital parameters Assess physically for any abnormality ☐ GCS ☐ Blood Sugar ☐ Inform doctor if there is any abnormality Monitor GCS of patient ☐ Others: Determine and treat the underlying cause of altered LOC E Regular blood sugar monitoring as per doctors order Ν PSYCHOLOGICAL / Patient will achieve spiritual need.

Patient will be able to control his Pray or encourage the patient to pray Patient will achieve spiritual needs-Use inspirational words М SPIRITUAL SUPPORT Spiritual Needs feeling toward his illness Respond to spiritual needs as they arise ☐ Beliefs / Values / Customs Patient will maintain normal ☐ Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Anxiety and Copying Pattern psychological pattern ☐ Identify Stressors ☐ Provide empathy and reassurance Others:

nt will communicate effectively / positive feedback	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's or prognosis in the patient's presence	s condition	M	· · · · · ·	
;	or prognosis in the patients presence				l
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anage on time	□ Provide proper measures of wound care		co	MMunkeatis	
:	and explain to the patient / family ☐ Check for cross matching and typing, to compatibility ☐ Practice strict asepsis while transfusing be	ensure	E		
		nt	N Mediune	givon as	A sit
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	Name	Observe and report any medication reactors provide proper measures of wound care Follow hospital polices and protocols of and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing to blood products and fluids Monitor DVT score and continue treatme as per doctors order Name Observe and report any medication reaction	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 Name Emp. ID	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 Medicare given as North Region North Reg	





ADULT NURSING CARE PLAN

Mr.RAMACHANDRAN R

64/Male/MHI202481642 05/01/2024/IPH2024000043





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Initial Date: 6	A Time: & 100	Modified Date: Time:		
Reason for Modification:		Diagnosis: ACS-SEMI, TODI	η,	
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regulár Diet	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	M Pthad Dindies	8
Others:	requirements in accordance to his activity level and metabolic needs	Theody amount of 1999 sonialined	E patient had clunch	Not
ego o o se se se se se se se se se se se se se			NPt hard of Dm diel	Coon
OXYMENATION Proom Air Nasal Cannula / High Flow O, Mask BIPAP / CPAP Ventilator	Patient will have normal O₂ saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits	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	m Pton Fm 625dit	
☐ Tracheostomy ☐ Others:	Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	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	patient spoz maintained	Noh 2352
		Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging patient with successful coughing	N DE ON Plow	d ord
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition	. Patient will have palanced fluid and electrolytes balance	Enfrance fluid intake unless restricted Check IV sites and assess if there is any complication Provide tube feedings Monitor intake and output	m Rational tood oral chole.	8
☐ Parenteral Nutrition ☐ Others:	, , ,	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	E patient taken Orals	285
			NPt had a orall	on

			·	
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
- MOBILIDY Mobile / Immobile Walk with assistance Physiotherapy	Patient will mobilize freely ratient will perform physical activity independently or within limits of disease	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment	MPA WILL Mobilize	
☐ Others:	P_tient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	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)	E Patient mabilized Pn bod	MEN.
			NPT ON Bed mobilize	0282
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement Urination	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence,	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician	M Pt Normal Chamatin	A. .
Others:	and regular elimination patterns	Observe voiding accessories as foley's / silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	E Patient climination	MAN
		and follow proper protocol Check for malena / constipation / urinary retention	N Pt (ii) dimination Pattert	020
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE	Patient will maintain normal heating 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	M Maintain Skin Sintepin.	O Jo
INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased			Maintained E Skin Pritigority	NOW 2
□ PUSH Increased □ Intermittent Assisted □ Dermatitis □ Pressure injury / blisters site care given □ Others:			Pt (a) skien Integrity	Oth
	<u> </u>	<u> </u>	<u> </u>	L.



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	Execurage 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 wive Stay Clear E patient Stay Cleaned NPt clears well Ofromed	25 PS (25)
SAFERY Peneck 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)	MID hard Cheled E Patient IN. Band (7) N D+ DO Band S EV June Checked	2337 12357
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 provided private E provided private NOT contartable DON: Hor	Most
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 patient vitale etable E patient vitale Stable. N PHOWNY VICH monitoring	Night Night
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 D+ D PSy chological Support officer.	O A

-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 or prognosis in the patient's presence	condition	M Mounto	port	1230
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 react Provide proper measures of wound care Follow hospital polices and protocols of i and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing b blood products and fluids Monitor DVT score and continue treatment as per doctors order	solation ensure	E poetant 98/101	,	Sold Now
Signature :	Name		Emp. ID		Date	Time
Endorsed by	Nuc : c	Nalin.	008	14	411184	18:00





ADULT NURSING CARE PLAN

Mr.RAMACHANDRAN R

64/Male/MHI202481642 05/01/2024/IPH2024000043





Initial Date: ヤー/ー シャ	Time: 7-00	Modified Date: Time:		
Reason for Modification:	, , <u>, , , , , , , , , , , , , , , , , </u>	Diagnosis: ACG, AW STEPOS, 71DM	n, Lysed E Dry TNK	
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 DM diet By had 10 th diet N Pt had DM diet	The state of the s
OXYGENATION Room Air Nasal Cannula / High Flow O, Mask BiPAP / CPAP Ventilator Tracheostomy Others:	Patient will have normal O₂ 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 O₂ saturation and pulse rate □ If any O₂ 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 	MPt ON ROOM OWN 8902-99.1 E patient 1'8 on Poom Air N 8,002-97%	A STA
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 Intoke well To Chart moniford No chart	Dozi Dy

ent 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 Putient will use safety measures	☐ 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	M Pt on bad mebalized	XQ_ 024
	to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	(e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	E pritient mobilized well	Pho
		,	n pt well robilized	Syl
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement Urination	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence,	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's /	M P+ (1) Oliminatió () Patteun	ST.
Others:	and regular elimination patterns	silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	Normal Elimitation	
	<i>f</i>	and follow proper protocol Check for malena / constipation / urinary retention	Normal Elemenation	ods,
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity		M P+ Naurtour (1) Skein	800
INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased			Maintain Mormal	A
☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	· · · · · · · · · · · · · · · · · · ·	~-	Skin i ptogrit y skin is restact	Shy Dole
				_



Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sig- Initials
HYGIENE Bed-Bath Assist-Bath Self-Care CBD Care (if present)	□ 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 Stay clean & woll guodand Butto'nt well groomal N Pt well groomal	A STA
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. N JD Bound @	Rote Rote
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 P+ Provide Bychological E - Constitution of the control of the	St. can
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 A VIS Chocked & Recorded Vital Signs Checoal & Peroxdod Vital Signs is Checlesd	APP AND STORES
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 Movide Rythologial Support Bythological Support NASgettelegatical Support given	A Jacks

ecifiر cims / Ne	ic eds	Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICAT Verbal Non-verbal	TION	Patient will communic with positive feedback		ely Introduce the care giver Encourage the use of call bell Obtain interpreter if needed		M B+ CONNIM	nicotion woll	X III
Sigh language	☐ Sigh language ☐ Others:			No negative speaking about the patient's condition or prognosis in the patient's presence		Chood communication N of on Crood Communication		A) 1 8
SPECIAL INTE Medication Wound care Isolation Ostomy Care Blood / Blood ptransfusion Fluid tapping DVT Managem Others:	products	To manage on time		Double check for high alert medication Observe and report any medication react Provide proper measures of wound care Follow hospital polices and protocols of i and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing b blood products and fluids Monitor DVT score and continue treatments as per doctors order	solation ensure lood or	Medical as per dr	drug chaut	\$17.2. \$4.00 \$00.00
_	Signature		Name		Emp. ID		Date	Time
Endorsed by		Paras	2. N.	lini	© 6	24	711124	18:00

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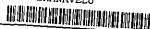




ADULT NURSING CARE PLAN

Mr.RAMACHANDRAN R 64/Malc/MHI202481642

05/01/2024/IPH2024000043





								
Initial Date: 2/1/2	4 Time: 7.00	Modified Date: Time:						
Reason for Modification:	·	Diagnosis: ACR - STAY [Diagnosis: ACC - CTAY					
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	mpt had Dy diet	HILL.				
			N					
OXYGENATION Hoom Air Nasal Cannula / High Flow O ₂ Mask BiPAP / CPAP Ventilator Tracheostomy Others:	Patient ABG levels will return to and	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 O₂ saturation and pulse rate If any O₂ abnormalities detected inform immediately to the concerned physician Place patient with proper body alignment for maximum	MPE DS ON YOUNG	Y)				
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition Parenteral Nutrition Others:	Patient will have balanced fluid and velectrolytes 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 I lo Chool monetions	MD				

ļ	Catheter, bedpan, urinal Nasogastric tube Bowel movement Urination Others:	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
- ^	MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others: ELIMINATION Catheter, bedpan, urinal	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Patient will use safety measures	☐ 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	MPt 40001 mobilizar	My
		to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	(e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	E	
				N	
	Catheter, bedpan, urinal Nasogastric tube Bowel movement	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence.	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician Observe voiding accessories as foley's /	M Normal Elimination Pattoun	H D
	Others:	and regular elimination patterns	silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol	E	
	19		Check for malena / constipation / urinary retention	N	
	Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE	Patient will maintain normal thealing 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 normal exen intact	My
	GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased	☐ Proper ☐ Follow ☐ Monito ☐ Educa	 ☐ 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 	E	
	MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:			N	-
- 1				I	

k.

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care 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	MPE 4000 hygrene	MAZ
(if present)	Patient will recognize individual weakness or needs	Apply moisturizing solution	E	
			N	
SAFETY Check ID Hand V IV care	Patient will have no life-threatening \ situations	Check the identity with ID band before any interaction with the patient Raise side rails	MID Bard Present	MR
Side rails Others:	·	□ 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)	E	
		- Pollow restrain policy (in needed)	N	
COMFORT AND SLEEP	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	м —	
☐ Sleep Patterns ☐ Others:			E	
	,		N ' /	
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar	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	M Vital Signs Charman	ND
☐ Others:		☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	E	
			N	
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Beliefs / Values / Customs	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness Patient will maintain normal	Pray or encourage the patient to pray Use inspirational words Respond to spiritual needs as they arise	М	
☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	psychològical pattern	Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	E	
			N	·

Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATION Verbal with positive feedback Non-verbal Sigh language Others:		☐ 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		MPt 40001 Communication E		MR		
SPECIAL INTE Medication Wound care Isolation Ostomy Care Blood / Blood p transfusion Fluid tapping DVT Manageme	products	To manage on time		□ Double check for high alert medication □ Observe and report any medication react □ Provide proper measures of wound care □ Follow hospital polices and protocols of it and explain to the patient / family □ Check for cross matching and typing, to compatibility □ Practice strict asepsis while transfusing belood products and fluids □ Monitor DVT score and continue treatment as per doctors order	solation ensure lood or		ion giron aschug cho	HIL OFF
	Signature		Name		Emp. ID		Date	Time
Endorsed by	\mathcal{D}_c	Dus		2. nalini	002	4	8/1/24	16.0





64/Male/MHI202481642 05/01/2024/tPH2024000043

Dr.G. GNANAVELU





Every heart beat counts

Date: 5

	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR'	Y RISK Time:	 THE PARTY
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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. Pedfast 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	ι
MOBILITY ability to change and control body position	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. Stight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	3
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		4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement	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	Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,			3
& SHEAR sl	slides down in bed or chair, requiring chair, restraints or other devices. frequent re-positioning with maximum Maintains relatively good position in chair		TOTAL SCORE	เป	
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & Emp. No. of Staff Nurse:	Axr 529
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse;	R





Datient Details (Affix I abel here)

Mr.RAMACHANDRAN R

64/Malc/MHI202481642 05/01/2024/IPH2024000043

Dr.G. GNANAVELU





Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK Time: 4. No Impairment SENSORY 1. Completely Limited 3. Slightly Limited 2. Very Limited Besponds to verbal PERCEPTION Unresponsive (does not moan, flinch,or Responds only to painful stimuli. Cannot Responds to verbal commands, but grasp) to painful stimuli, due to diminished communicate discomfort except by cannot always communicate discomfort commands. Has no sensory ability to respond meaning-fully to level of consciousness or sedation OR moaning or restlessness OR has a or the need to be turned OR had some deficit which would limit pressure-related limited ability to feel pain over most of body sensory impairment which limits the ability sensory impairment which limits ability to ability to feel or voice pain or discomfort to feel pain or discomfort over 1/2 of body feel pain or discomfort in 1 or 2 extremities discomfort 3. Occasionally Moist 1. Constantly Moist 2. Very Moist 4. Rarely Moist MOISTURE Skin is often, but not always moist. Linen Skin is occasionally moist, requiring an Skin is kept moist almost constantly by Skin is usually dry, linen only degree to which perspiration, urine etc. Dampness is must be changed at least once a shift extra linen change approximately once a requires changing at routine 3 skin is exposed detected every time patient is moved or intervals to moisture turned 1. Bedfast 2. Chairfast 3. Walks Occasionally 4. Walks Frequently Confined to bed ACTIVITY Walks occasionally during day, but for very Walks outside room at least Ability to walk severely limited or nondearee of existent. Cannot bear own weight and / or short distances, with or without twice a day and inside room physical activity must be assisted into chair or wheelchair assistance. Spends majority of each shift at least once every two hours in bed or chair during waking hours 3. Slight Limited 1. Completely Immobile 2. Very Limited 4. No Limitation MOBILITY Makes occasional slight changes in body Makes frequent through slight changes in Does not make even slight changes in body Makes major and frequent ability to change or extremity position without assistance or extremity position but unable to make body or extremity position independently changes in position without and control body frequent or significant changes assistance position independently 3. Adequate 1. Very Poor 2. Probably Inadequate 4. Excellent Rarely eats a complete meal and generally Eats over half of most meals. Eats a total of Never eats a complete meal. Rarely eats Eats most of every meal. more than any food offered. Eats 2 servings eats only about 2 of any food offered. 4 servings of protein (meat, diary Never refuses a meal. NUTRITION 2 or less of protein(meat or dairy products) per Protein intake includes only 3 servings of products) per day. Occasionally will refuse Usually eats a total of 4 or usual food day. Takes fluids poorly. Does not take a meat or diary products per day. a meal, but will usually take a supplement more servings of meat and intake pattern liquid dietary supplement OR Is NPO and / or Occasionally will take a dietary when offered OR Is on a tube feeding or diary products. Occasionally maintained on clear liquids or IV's for more TPN regimen which probably meets most eats between meals. Does supplement of nutritional needs not require supplementation than 5 days (3. No Apparent Problem 1. Problem 2. Potential Problem Moves feebly or requires minimum _Moves in bed and in chair independently and has sufficient muscle Requires moderate to maximum assistance 3 3 9 in moving. Complete lifting without sliding assistance. During a move skin probably strength to lift up completely during move. Maintains good position in bed FRICTION slides to some extent against sheets, against sheets is impossible. Frequently & SHEAR slides down in bed or chair, requiring chair, restraints or other devices. TOTAL SCORE frequent re-positioning with maximum Maintains relatively good position in chair assistance. Spasticity, contractures or or bed most of the time but occasionally Initial & Emp. No. agitation leads to almost constant friction slides down of Staff Nurse: Initial & Emp. No. Score Interpretation: Minimal Risk: 23 - 19: At Risk | Mild Risk: 18 - 15: Moderate Risk: 14 - 13: High Risk: 12 - 10: Severe Risk: 9 - 6 of Sr. Staff Nurse:





64/Malc/MHI202481642 05/01/2024/IPH2024000043

Dr.G. GNANAVELU



Every heart beat counts

Date: 국

	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Date:	└	1	24
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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	4	A
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. Parely Moist Skin is usually dry, linen only requires changing at routine intervals	4	34	4
ACTIVITY degree of physical activity	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	١.	2-1	4
MOBILITY ability to change and control body position	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		4	A
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. Aftequate Exists 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	Never refuses a meal.	3	4	4
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		y and has sufficient muscle Maintains good position in bed TOTAL SCORE Initial & Emp. No. of Staff Nurse:	3		3
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	عدد	NOR	100









BRADEN SCALE FOR PREDICTING PRESSURE Y RISK

		CALE FOR PREDICITI	NG PRESSURE II.	Time:	119	E	'n	
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	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 Molst 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			
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	Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	14			
MOBILITY ability to change and control body position	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	4			
NUTRITION usual food intake pattern	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	4			
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	C3. No Apparent Problem Moves in bed and in chair independent strength to lift up completely during move. It or chair	TOTAL SCORE Initial & Emp. No.	3			
Score	assistance. Spasticity, contractures or agitation leads to almost constant friction Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6 Initial & Emp. No. of Staff Nurse: Initial & Emp. No. of Sr. Staff Nurse:							



F-ASSESSMENT & MONITORING



Mr.RAMACHANDRAN R

64/Male/MHI202481642 05/01/2024/(PH2024000043

Dr.G. GNANAVELU



MHI/NUR/2022/052



Every heart beat counts

Senior Staff **Pain Character** Staff Initial Date & Pain Initial & Duration Interventions (dull, achy, sharp, stabbing, shooting, Location / Site & Emp. No. Time Score burning, referred / radiant pain) Emp. No. & pharmacalogical Provention 5-1-24 as per othertor is presonit prion 5 miles 21-49 & pharmocological Enternention dull poin 24.50 5mins 3Pt0 as per duchos presin prion. -) pharmawlepical intercention 23.00 dull poon 840 5 mars per dueins mercinton. phoundshipical intercention 00.00 dull pan 28/12 duton mesniphion. 9305 No rais No phi A.05 Mo pain

Pain Character Coll, any temps, stabling shooting, burning, referred / radiant pain) Pain Character Coll, any temps, stabling shooting, burning, referred / radiant pain) Pain Character Coll, any temps, stabling shooting, burning, referred / radiant pain) Pain Character Coll, any temps, stabling shooting, burning, referred / radiant pain) Pain Character Coll, any temps, stabling shooting, burning, referred / radiant pain) Pain Character Coll, any temps, stabling shooting, burning, referred / radiant pain) Pain Character Coll, any temps, stabling shooting, burning, referred / radiant pain) Pain Character Coll, any temps, stabling shooting, burning, referred / radiant pain) Pain Character Coll, any temps, stabling shooting, burning, referred / radiant pain) Pain SCALES Pain No. Pain SCALES Pain Rating Scale (2 months - 7 years) Pain Character Coll, and temps, stabling shooting, burning, shooting, burning, shooting, burning, referred / radiant pain) Pain SCALES Pain Rating Scale (2 months - 7 years - 12 years) Pain Rating Scale (3 months - 7 years) Pain Rating Scale (3 months - 7 years) Pain Rating Scale (4 months - 7 years) Pain Rating Scale (5 months - 7 years) Pain Rating Scale (6 months - 7 years) Pain Rating Scale (8 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Rating Scale (9 more than 12 years) Pain Ratin	_ (* #		
FACIAL EXPRESSION: 0 - Relaxed, Noutral, 1 - Tense, 2 - Grimacing PID ALW A four Action Act	· ·	(dull, achy,	sharp, stabbing, shooting,	Duration	Location / Site	Intoniontiono		
PAIN SCALES PIPPS (28 weeks to < 38 weeks) 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. PLACC Scale (2 months - 7 years) O: 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) PACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing	4000010		No pais	-	1	2	Det.	Jayou
PAIN SCALES PIPPS (28 weeks 10 ≤ 38 weeks) CRIES (38 weeks - 2 months) FACCS Scale (2 months - 7 years) O: 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) PAIN SCALES	\$-08 0/10	A	to pain		1		d ora ;	Joyoor
PAIN SCALES PIPPS (28 weeks to ≤ 38 weeks) CRIES (38 weeks - 2 months) CRIES (38 weeks - 2 months) FLACC Scale (2 months - 7 years) O: 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) PAIN SCALES 6 or Iess = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures >12 = Moderate to severe pain - Pharmocological intervention 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. O: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both Numerical Rating Scale (age more than 12 years) Numerical Rating Scale (age more than 12 years) Numerical Rating Scale (age more than 12 years) Numerical Rating Scale (age more than 12 years) Numerical Rating Scale (age more than 12 years) No Hurts Hurts Worat Hurts Worat More Worat None FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing	6.05 %	W	Co pais		1		Ser.	Chilocon
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) FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing 6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 12 = Mild pain - Provide comfort measures > 13 = Mild pain - Provide comfort measures > 14 + GRIES score is > 4,	7.05 0/10	. WC	o pais	<u></u>			1020	Julson
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) FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing	<u> </u>	<u> </u>			PA	IN SCALES		·.
further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher. FLACC Scale (2 months - 7 years) O: 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) O 2 4 6 8 10 No Hurts Hurts Little Bit Hurts Little More Evan More Whole Lot Worst FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing		B weeks)	7 - 12 = Mild pain - Provid	de comfort me		n ·		
(2 months - 7 years) Wong-Baker FACES Pain Rating Scale (7 years - 12 years) Wong-Baker FACES Pain Rating Scale (7 years - 12 years) O: Helaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both Numerical Rating Scale (age more than 12 years) Numerical Rating Scale (age more than 12 years) Numerical Rating Scale (age more than 12 years) Numerical Rating Scale (age more than 12 years) Numerical Rating Scale (age more than 12 years) None Mild Moderate FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing		ionths)					· ·	.,
Wong-Baker FACES Pain Rating Scale (7 years - 12 years) O 2 4 6 8 10 No Hurts Hurts Hurts Hurts Evan More Whole Lot Who	-		0: Relaxed & comfortable	e, 1-3: Mild d	iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe discomfort / pain / both		
	Pain Rating S	icale	0 2	4 Hurts Little	6 Hurts	8 10 Hurts Hurts	7 8 •	9 10
Compliance With Ventilator (or) Observation Tool (CPOT) (ventilator / comatose) (ventilator / comatose) Observation Tool (CPOT) (ven	Observation Tool	(CPOT)	BODY MOVEMENTS: 0 - COMPLIANCE WITH VEI VOCALIZATION (non-int MUSCLE TENSION: 0 - F	Absence of m NTILATION (in ubated patien Relaxed, 1 - Te	novements or normal p ntubated patients): 0 nts): 0 - Talking on no nse, Rigid, 2 - Very Te	osition, 1 - Protection, 2 - Restlessness / Agitation - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting ve mal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing nse, Rigid		-
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			Cutaneous Stimulation a Thermal Therapies (no lo	and massage: onger than 15	: E - Positioning; F - Ri to 20 minutes): G - Co	ubbing / Massage the skin Id application; H - Hot application; I - Shortwave diathermy	ling; L - Family	/ counseling
			s as per doctor's prescrip	tion.	··· <u> </u>			





F Mr.RAMACHANDRAN R

64/Male/MHI202481642

05/01/2024/IPH2024000043

Dr.G. GNANAVELU

MHI/NUR/2022/052



Every heart beat counts

1		- / IOO_OOIII_	•			_	
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.
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9:00	0/6				· · · · · · · · · · · · · · · · · · ·	8 161	Naa
10.00	%	No pain	<u></u>			A 181	Nag-
11.00	0/60	No paris	ien t	chifted	-10 Cathlab @ 11.30) oibr	NO
(F.50	0/00	No pain	•	-		Moh-	No
123:30	0/10	No pain		· ·		Noh	Non
400	0/10	No pain	-			Moh. 2852	Naa 0024
16:20	0/10	No poin	_	· ·	~	Vilya 23°a	Na.0
12.20	0/0	no pain				Wo ago	Nas





	<u>. </u>									
Date & Time	Pain Score	(dull, achy,	ain Character sharp, stabbing, shooting, referred / radiant pain)	Duration	Location / Site		Interventions		Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
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19.20	10		No pain						1990 ·	Nort.
910°, 00	0110	NO	pain	lin_	Ni		Nil		1	No24
24'. ⁰⁰	Oliv	No	pais	NI	Nil		Nil		E.	Nort
	•			<u></u>	P/	AIN SCALES		,	•	
(28 wee	PIPPS ks to <u><</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provi >12 = Moderate to sever	de comfort me		on	2			1
(38 we	CRIES eks - 2 m	onths)	The CRIES scale is used further pain assessment	i for infants >	than or = 38 week dertaken, and analg	s of gestation. A maximal sc gèsic administration is indic	ore of 10 is possible. If the Cated for a score of 6 or highe	RIES score is > 4, er.'		
	ACC Sca onths - 7 y		0: Relaxed & comfortabl	e, 1-3: Mild di	iscomfort, 4-6: Mode	erate discomfort, 7-10: Sever	re discomfort / pain / both			1
Pain	g-Baker F <i>i</i> Rating Ş ars - 12 y	cale ;	O 2 No Hurts Little Bit	4 Hurts Little More	6 Hurts Evan More	8 10 Hurts Whole Lot Worst	Numerical Rating	g Scale (age mo	7 8.	9 10
Observa	ical care f ation Tool ator / com	(CPOT)	COMPLIANCE WITH VE	Absence of m NTILATION (in Subated patien Relaxed, 1 - Te	novements or normal ntubated patients): (nts): 0 - Talking on no nse, Rigid, 2 - Very Ta	position, 1 - Protection, 2 - Re) - Tolerating Ventilator or Mov ormal tone or no sound, 1 - Sig ense, Rigid	ement , 1 - Coughing but toler	rating, 2 - Fighting v t, sobbing	entilator (or)	* * * * * * * * * * * * * * * * * * * *
	harmacol tervention		Cutaneous Stimulation a Thermal Therapies (no le	and massage: onger than 15	E - Positioning; F - R to 20 minutes): G - C	- Music; D - Physical and me lubbing / Massage the skin old application; H - Hot applic terferntial therapy Psycho-	ation; I - Shortwave diathermy		eling; L - Family	counseling
Pharmac	ological I	ntervention	s as per doctor's prescrip	otion						







MHI/NUR/2022/052

Heart Institute

Every heart beat counts

PAIN RE-ASSESSMENT & MONITORING CHART

ı			L MOOLOGIVILITI	W 141 C		OHAIII	118 188 4		_	
	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.
- 6	1124 12:00	%0	No pais	_		1				Nas
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	1.00	%	nco país	_		←			0282	Naa-
	2.00	9/10	Mo pais		~				0280	Naa.
	3.00	0/10	No país			_			028:	Nas
,	AJ 100	110	al 6 pais				•	· 	028	Nas 024
	5.∞	0) (la	No pain		<u> </u>				025	Na
	6.00	0/10	No pain.						OZR	Na.0 0026





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Date & Time	Pain Score	(dull, achy,	ain Character sharp, stabbing, shooting, , referred / radiant pain)	Duration	Location / Site		Interventions	Staff Initial & Emp. No.	Senior Staf Initial & Emp. No.
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9:00	a/0	Ŋ	o faur	_	-		<u>۔</u>	2000	port
00.00	olio	No	l any	_	~			81	Nos
					P/	AIN SCALES			
(28 week	PIPPS <s <u="" to="">< 38</s>	weeks)	6 or less = Minimal to n 7 - 12 = Mild pain - Prov >12 = Moderate to seve	ide comfort me		on			
(38 we	CRIES eks - 2 ma	onths)					core of 10 is possible. If the CRIES score	e is > 4,	
	ACC Scal		0: Relaxed & comfortab	le, 1-3: Mild d	iscomfort, 4-6: Mode	erate discomfort, 7-10: Seve	ere discomfort / pain / both		
Pain	-Baker FA Rating So ars - 12 ye	ale	O 2 No Hurts Hurts Little Bit	4 Hurts Little More	6 Hurts Even More	8 10 Hurts Whole Lot Worst	Numerical Rating Scale (a	5 6 7 8	9 10
Observa	cal care P ition Tool itor / com	(CPOT)	COMPLIANCE WITH VE	- Absence of mention (intubated patients) Relaxed, 1 - Te	novements or normal ntubated patients): nts): 0 - Talking on no nse, Rigid, 2 - Very Ti	position, 1 - Protection, 2 - R 0 - Tolerating Ventilator or Mo ormal tone or no sound, 1 - S ense, Rigid	estlessness / Agitation vement , 1 - Coughing but tolerating, 2 - F ighing, Moaning, 2 - Crying out, sobbing	ghting ventilator (or)	
	harmacolo tervention		Cutaneous Stimulation Thermal Theraples (no	and massage: longer than 15	: E - Positioning; F - F to 20 minutes): G - C		ental exercisers cation; I - Shortwave diathermy -social therapy/counselling: K - Individua	J. Connection J. Farri	









Mr.RAMACHANDRAN R

64/Malc/MHI202481642 05/01/2024/IPH2024000043

Dr.G. GNANAVELU



MHI/NUR/2022/052-



PAI	N RI	E-ASSE	ESSMENT	'& МС	NITORING	CHART	Every heart l	beat counts
	Pain Score	Pain (dull, achy, sha burning, refe	Character rp, stabbing, shooting, erred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
71, 122y	0/60	No	lain				L S LI	Need 024
oarBl	olo	No	Paur				8211	Noe
111.00	0/10	1/0	_pain_	_	-		1	Nac
18:00	pp	10	pain		~_		The state of the s	2021
22.00	0/10	No	Pæin	_	-		and so	Nac
81(12A 2-00	0/10	No	Parin	-			Auf	NCE
6-00	olio	No	Path	-			At coss	NES
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Date & Time	Pain Score	(dull, achy.	ain Charac sharp, stabbi referred / rac	ing, shooting,	Duration	Location / Site		Interven	tions				Staff Ini & Emp.	ıaı (Senior Sta Initial & Emp. No
-	ļ							d							
-												,			
1															
	,		-	-	<u> </u>	PA	AIN SCALES			-	_				-
(28 week	PIPPS (s to <u><</u> 38		7 - 12 = Mil >12 = Mod	lerate to sever	de comfort me re pain - Pharn	nocological interventi									
(38 we	CRIES eks - 2 m	onths)					s of gestation. A maximal s gesic administration is indi					core is > 4	,		
	ACC Scal		0: Relaxed	& comfortabl	e, 1-3: Mild d	iscomfort, 4-6: Mode	erate discomfort, 7-10: Sev	ere discomfo	rt / pain / l	ooth	_	_		_	
Paln	-Baker FA Rating Sc	ale		(§)				Nui	nerical I	Rating	Scale 4	e (age m	ore than	— 12 ÿ	ears) 9 10
(7 yea	ars - 12 ye	ears)	O No Hurt	2 Hurts Little Bit	4 Hurts Little More	6 Hurts Even More	8 10 Hurts Whole Lot Worst	None	Mild	_ _	<u> </u>	noderate	<u> </u>	Sever	
Observa	cal care F tion Tool tor / com	(CPOT)	BODY MOV COMPLIAN VOCALIZAT MUSCLE T	'EMENTS: 0 - ICE WITH VEI I'ION (non-int ENSION: 0 - F	Absence of m NTILATION (in tubated patien Relaxed, 1 - Te	ntubated patients): (position, 1 - Protection, 2 - F 0 - Tolerating Ventilator or Mo ormal tone or no sound, 1 - S ense, Rigid	ovement, 1 - C	oughing b				ventilator (o)	
			Distraction	A Dolovotio	n.conducive e	nvironment: B - TV: C	- Music; D - Physical and m	ontal evercise							





Mr.RAMACHANDRAN R

64/Malc/MHI202481642 05/01/2024/IPH2024000043

Dr.G. GNANAVELU





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

		5-1-24			8124			
	Time	21-49	6.00	6.00	6.00			
S. No.	PARAMETERS						_	
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0	Ø			
2	Bedridden recently >3 days or major surgery within four weeks	0	0_	0_	Ø			
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	10	0	D		_	
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	_10	Ò	0			
5	Entire leg swollen (Assess for both legs)	10	0	0	0	<u> </u>		
6	Localized tenderness along the deep venous system (Assess for both legs)	B	0	0_	0			
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	Ø	0	0			
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	D	0	0_	O			
9	Previously documented DVT (Assess for both legs)	D	۵	0	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.	0	b	O	0			
	FINAL SCORE	6	Q	0	0			
Low R	isk: -2 to 0 Moderate Risk: 1 to 2 Hlgh Risk: 3 to 8				Low			
	DVT prophylaxis started	□ Yes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	□ Yes □ No	□ Yes □ No
	Signature & Emp. No. of RN	1834/	deste	982	100 8x			
_	Signature & Emp. No. of Sr. RN	1	1/2	ros	320			



(A Unit of United Alliance Healthcare Pvt Ltd)



Mr.RAMACHANDRAN R

64/Male/MHI202481642 05/01/2024/PH2024000043

Dr.G. GNANAVELU





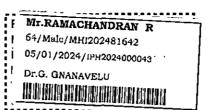
MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables		51-24	Progra	11/16	6/1/24	4/1/24	7/1/2	71124	8/1/24	
valiables ,	Time	21.49	8,00	13.30	D1:00	8:00	111.00	22.0C	8.60	
History of falling	No	6	(0)	0	6	(°0)_	سفر	10	\O	0
(immediate or within 6 months)	Yes	25	25	25	25)25	25	25	25	25
Secondary diagnosis	No	·Q	0	0	0	0	0	0	0	0
(≥ 2 medical diagnosis) ·	Yes	-(15)	(15)	$(\overline{15})$	15	(15)	15	15	15	15
Intravenous Therapy /	No	. 0	. 0	0	0	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	(20)	(20)	(20)	(20)	(20)	20-	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0		(0)	(0)	0	رو ا	70_	9	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT .		. 6	. 6		\sim	6	_ ا			
Normal / Bed Rest / Wheel Chair		(0)	6	(0)	<u>(0)</u>	(ô)	اسمور	0	\ <u>0</u>	0
Weak ·		10	10	10	10	10	10	10	10	10
Impaired	1	20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		(6)	0	(ð)	6	(°)	.8	8	\o	^ O
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives,	No	. 0	0	0	0	0	0	0	0	0
immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	Yes	(15)	(95)	(15)	(15)	(15)	15	1/5	\15~	15
Total Score		50	50	B	50	50	So	20	50	
Low Risk (0 - 24)										:
Medium Risk (25 - 44)								_	i	
High Risk (45 or above)		7	•	/	<u></u>	/ /	V	\ \	V	
Signature & Emp. No. of RN		M200/	Of 182	Han	A OF	No.	12/17	States	r Din	,
Signature & Emp. No. of Sr. RN	,	R/	/		3/1	19/25	2	75%	1825	
		: - 0	24: Low	Risk; 2	5 - 44: N	ledium	Risk; 45	or abov	/e: High	Risk

INTERVENTIONS	Date	(1)0d	1 24	ילר זי ל	11,124	-1/1/200	1/2	المكار (ما	'	t
INTERVENTIONS		5^	p	Plir	P11, 1	70	411	71111		
Tick as per the Risk Score	Time	<u> </u>	& 100	13.30	Nin	8.400	1240	25.00	5.0p	
Low Risk Interventions (0 - 24)							_	~	/	
Familiarize the patient with the immediate surround						_/_				
Remind the patient to use call beil before getting ou						,/				
Keep the two side rails in the raised position at all t	imes for	/								
all patients regardless of age			•/	·/			_ •⁄			
Keep the call bell, bedside table, water, glasses w	ithin the	/		1	/	ا مر ا		-		
patient's easy reach	_						<u> </u>	-		
Remove excess equipment or furniture to make	a clear		l . :/			_		レ	ارسا	
path	<u> </u>	<u> </u>					-		/	
Keep the patient's bed in the low position at all times	s except			V				ノレ		
during procedure				. ,	-		\sim		/	
Teach fall-prevention techniques, such as sitting	up for a	/							<u> </u>	
moment before rising from the bed	_								,	
Bed wheels should be locked			V		,		-	-		
Encourage family participation in the patient's care		 		<u> </u>			\sim	1/	<u> </u>	ļ
Ensure that floor of the bathroom is dry and not slip Review medications for potential side effects t	<u> </u>	 			/					<u> </u>
, -	nat can	/		·						,
promote falls			√		<u> </u>			/		——·`
Use safety belts during movement in wheelchair The patients are not ambulated by themselves. The		- <u>-</u> -	\ <u>`</u>							
be ambulated only with assistance	ey are to		_ /			~				
Medium risk interventions (25 - 44)										
Apply all the low risk interventions		/			/			~		
Tie yellow fall risk tag in the bed and Wheel chair / S	trotobor				-/-	_ _ _		/		
Make sure that proper transfer precautions are in		-		<u> </u>						
for heavy or debilitated patients in a bed or wheel		<i>ر</i> ا				ار				
on a toilet seat	Citali Oi	l -,		./			\ \times			
Use restraints and bed monitors as ordered by the	doctor			- <i>/</i>			. /			
Allow the patient to ambulate only with assistance	100101	-	-							
Consider peak effects of the medications that effe	cts level	1			· _				<u> </u>	
of consciousness, gait and elimination when p		/		h.				ノレ		
patient's care	,								/	
Do not leave patients unattended in diagno	ostic or									
treatment areas					′				- 	
Accompany the patient while going to bathroom		/				7				
Advice the patient to use grab bars near the toilet, I	bathtub.	 			-		-6			
and shower	,		しし					~		
Make sure the family and other visitors underst	and the									
restrictions mentioned above		1						~		
High-risk interventions (45 or above)		<u> </u>								
Apply all the low and medium risk interventions		1 -	V				ا	・ レ	<u></u> 7	ľ
Tie red fall risk tag in the bed, wheel chair and streto	her			7				レ	-	
Locate the high-risk patients in a room close to the						1				
station	1		LC/		<u> </u>		<u></u>			
Answer these patients call bells as quickly as possi	ble		1					\ \ \		
Provide a commode at bedside (if appropriate)		/		1				~		
Urinal/bedpan should be within easy reach (if appro	opriate)							\ \ \		
Encourage family members or other visitors to s	tay with	NB		MA	4/	NA				
them		<u> </u>	MA	1 ***	NA	Nr	1		/	
If appropriate, consider using protection devices	s: safety	′.	/	•/	/		1			
belts			امَّم	ļ -		-	\preceq		· _ /	
Signature & Emp. No.	of RN	BLAN		1/2/2		Maria		SK t	MA	-
Signature & Emp. No. of	Sr. RN	100 /	(S)	.9/	00		100	200		
	• • • •		/ _		1 1 2 X	1		1	TANK TO THE PARTY OF THE PARTY	
		2000°	γ	,			•		- 1	









PATIENT A Assessment To be fi	AND FA									JR	U		
Barriers to	Learning								Plan t	o A	ddr	ess	s Factors
None		/ He	aring	g lin	nitations			Е	Use	of lr	terp	rete	r
Limited Reading Abilities	Physic	al b	arrie	rs				Ш	Edu	cate	fami	ily	
Religious / Cultural Factors	Langua	age	barri	ers					Sim	ple L	.angı	uag	e
Congnitive Limitations - unable to	Low m	otiv	ation	/ d	esire to	earr	,		Writ	ten l	nstu	ctio	ns
understand and follow directions									الم				•
Completed By : Date 5-1-24 Tim	e 11-15	<u> </u>	N	lurs	e Signa	ture	:_	_	Mo	<u> </u>	/		
Learning Record					_				<u> </u>	<u>- </u>			
Need	Date	1	/isit	1	Date	\ \	/isit	2	Date	<u> </u>	/isit	3	Signature
	51.91	L	Р	0	6-1-24	L	Р	0	4/1ley	L	Р	0	
Disease				T					7,17				, Doctor
Information on									•			\square	M
Disease / Diagnostics													2181
☑ Treatment		ון	00			D	60	v		ρ	OD	v	160
Medications		ก	T	1 7		0	DC Cd	v		Q	3	1/	Doctor / Nurse
☑ Information on Safe and		4.											سرسربه
Effective use of medicines		-	~			p	ep.	\sim		?	d)	V	W 30
☐ Information on drug / drug and													
drug / food interactions									·				
☐ Discharge Medications				•									
Surgical Instructions													Nurse
Pre - Operative Instructions		1)	NΩ	V						1	g	V	
Post - Operative Instructions										'			
(Wound / Dressing Care)													
Pain Management													Nurse
Reporting of pain		Þ	@D	V					_			L	
Pain Management		4	পূ	✓	<u> </u>								一有个
Safe and effective use of medical													Doctor / Nurse
Equipment (if required)			_	<u> </u>						_		Щ	
Name of Equipment Rehabilitation Techniques													
Renabilitation Jechniques		1				1							

eed	Date	\	/isit	:1	Date	_	/isit	2	Date	1	/isit	3	Signature
		L	Р	o		L	Р	0		L	Р	0	-
lutritional Guidance								П					Dietician
Diet Instruction for patients at Nutritional risk		_		_		2	مد	\sim				, l.	Senio- a
Diet advice for home		_	_	H	-	7	⊨	Ħ	•				Nurse ^{(tlan})
Discharge Planning													
Self care													
Toilow up													
Reporting Concerns Immunizations													
Parenting education													
Others								П					
Risk Factor Reduction													
☐ Smoking Cessation				$oxedsymbol{oxedsymbol{oxedsymbol{\square}}}$		ļ				Ŀ			Doctor
Weight Control		_		Ц		L_		\square					
Exercise		<u> </u>	<u> </u>	Ц		<u> </u>	_	Ц		_	_	Щ	
Hypertension		匚	<u> </u>	Ц		L_				L			
PROCESS (P)- OD - Oral Discussion	on, D- Dem	ons	trati	ion,	W- Wri	itter					(;	Star	te Relationshi
EARNER (L) - R-Patient, M - Moth PROCESS (P)- OD - Oral Discussion OUTCOME (O) - RD - Return Demo Vritten Material given and explain	on, D- Dem	ons	trati	ion,	W- Wri	itter					(;	Sta	te Relationsh
EARNER (L) - R-Patient, M Moth PROCESS (P)- OD - Oral Discussion OUTCOME (O) - RD - Return Demo Vritten Material given and explain	on, D- Dem Instration, ed (if any)	ons V - \	trati	ion,	W- Wri	itter			1	· -			
EARNER (L) - R-Patient, M Moth PROCESS (P)- OD - Oral Discussion OUTCOME (O) - RD - Return Demo Vritten Material given and explain Reports Given :	on, D- Dem nstration, ed (if any)	ons	Verb	on,	W-Wr	itter					Per		
EARNER (L) - R-Patient, M Mother ROCESS (P)- OD - Oral Discussion DUTCOME (O) - RD - Return Demonstrate Material given and explain Reports Given : Given Pen Discharge Summary	on, D- Dem nstration, ed (if any)	ons V - \	trati	on, paliz	W- Wr	itter	tano		1				
EARNER (L) - R-Patient, M Mother ROCESS (P)- OD - Oral Discussion DUTCOME (O) - RD - Return Demonstrate Material given and explain Reports Given : Given Pen Discharge Summary	on, D- Dem nstration, ed (if any)	ons V - \	trati	Diet CT S	M-Writed Und	itter ders	tano		1				
EARNER (L) - R-Patient, M Mother ROCESS (P)- OD - Oral Discussion DUTCOME (O) - RD - Return Demonstrate Material given and explained Reports Given : Given Pen Discharge Summary	on, D- Dem nstration, ed (if any)	ons V - \	Verb	Diet CT S	Advice Scan Re	port	tano		1				
EARNER (L) - R-Patient, M Mother PROCESS (P)- OD - Oral Discussion DUTCOME (O) - RD - Return Demonstrate Material given and explained Printer Material given an	on, D- Dem nstration, ed (if any)	ons V - \	Verb	Diet CT S	Advice Scan Re Scan Fil	port	tano		1	·			
EARNER (L) - R-Patient, M Mother ROCESS (P)- OD - Oral Discussion DUTCOME (O) - RD - Return Demonstrate Material given and explained Reports Given : Given Pen Discharge Summary	on, D- Dem nstration, ed (if any)	ons V - \	Verb	Diet CT S	Advice Scan Re Scan Fil	port m Rep	tand		1				
EARNER (L) - R-Patient, M Mother PROCESS (P)- OD - Oral Discussion DUTCOME (O) - RD - Return Demonstrate Material given and explained Printer Material given an	on, D- Dem nstration, ed (if any)	ons V - \	Verb	Diet CT S	Advice Scan Re Scan Fil	port m Rep	tand		1				

•2







Mr.RAMACHANDRAN R 64/Malc/MHI202481642 05/01/2024/IPH2024000043 Dr.G. GNANAVELU



Assessment PATIENT Assessment						DUC. plines. U					JK	ש	,		
Barriers to	Lea	arning								Plan t	οА	ddr	es	s Factors	
None		Vision	/ He	arin	g lin	nitations	i			Use	of Ir	iterp	rete	:r'	
Limited Reading Abilities		Physic	al b	arrie	rs					Edu	cate	fam	ily		
Religious / Cultural Factors		Langu	age	barri	iers				Simple Language						
Congnitive Limitations - unable to		Low m	otiv	atior	ı / d	esire to	learr	1 1	Į	Writ	ten l	nstu	ctio	ns	
understand and follow directions							-								
Completed By : Date <u>@8 1124</u> Tim	1e	10.0	\circ		lurs	e Signa	ture	:_	M						
Learning Record										O#23					
Need		Date	_\	/isit	1	Date	١	/isit	2	Date	١	/isit	3	Signature	
	ļ	oslibu	L	Р	0		Ŀ	Р	0		Г	P	0		
Disease														Doctor	
Information on														ا هر	
Disease / Diagnostics	ĺ		P	OD	V									15000	
Treatment														1342	
Medications			Þ	OD	V									Doctor / Nurse	
Information on Safe and															
Effective use of medicines	İ		P	OD	y										
information on drug / drug and	Ţ		-											Na	
drug / food interactions			P	$ a \rangle$	V									652	
Discharge Medications						_									
Surgical Instructions														Nurse	
Pre - Operative Instructions														Holoton	
Post - Operative Instructions				W											
(Wound / Dressing Care)			P		ry										
Pain Management														Nurse	
Reporting of pain		i	P	ક્રિ	ン									h >c-0	
Pain Management			- 1	Ω										ma	
Safe and effective use of medical	r		۲	71/	Ť		_							Doctor / Nurse	
Equipment (if required)		1													
Name of Equipment															
Rehabilitation Techniques								· .							

Need	Date	١,	/isit	1	Date	\ \	/isit	2	Date	\ \	/isit	3	Signature	A
		┢	Р	0		L	P	0		L	Р	0		
Nutritional Guidance					-				_				Dietician	
☐ Diet Instruction for patients at Nutritional risk		b	Þη	ر ئ									Maria Min Senior Dizuta	<i>(</i> <u></u>
Diet advice for home		9	ÐΥ	ל									Nurse	
Discharge Planning														
☐ Self care										_				
☐ Follow up														
Reporting Concerns Immunizations														
☐ Parenting education						_								
☐ Others												П		
Risk Factor Reduction													_	
☐ Smoking Cessation													Doctor	
☐ Weight Control												П		· -
Exercise														1 _
Hypertension														
☐ Other Risks		-												
OUTCOME (O) - RD - Return Demonstration Material given and explained (V - \	Verb	aliz	ed Und	dera	táno	gnik 						
Reports Given :									_					
Given Pending	g 1	NΑ							Give	1	Per	ndir	ng NA	
Discharge Summary			ı	Diet	Advice				\sim	_				
ECG Report			_ (CT S	Scan Re	port	t							
Doppler Report		_	_	CT S	Scan Fil	m								
X-Ray Report				ECH	O Repo	rt		•	A_/	_				
X-Ray Film					asound		ort							
Compact Disk					Other F	-								
Name of Attendant / Patient :	any	a 80	NC 4						ure :	The state of the s		-1°	<u> </u>	









Inter Disciplinary Team Rounds (IDTR) Checklist

					-		_
Date: 5 -1 - 24	Time: ഉ	1.5	3				
Checklist	Yes	No	NA	A	ction / 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							
		lr	iter Dis	sciplinary Team Members		-	
	Signatur	e		Name	Reg. / Emp. No.	Date	Time
Doctor		$\sqrt{}$		As. h. Atielur	91810	8 124	21.58
Nursing Staff	Mar.	Ř,		<u>Douth</u>	0282	4124	21-12
Dietician		107		Maria Catherine John	Layn	BUM	_ि
Physiotherapist				Senior Dietitian	- ν ·	 `	
Patlent Care Service Staff					<u> </u>	<u> </u>	



Mr.RAMACHANDRAN R
64/Malc/MHI202481642
05/01/2024/IPH2024000043
Dr.G. GNANAVELU



IN-HOUSE TRANSFER FORM

Part	Part A (to be filled by Nurses) Date of Transfer: This Time: 12 16 Transferred from: ((), To: 100 (2006 R-ND);												
Date	e of Transfer: 구시/১)	<u></u> Time: <u>\) .</u>	Tri del	ansferred f	from:	o. To: Jid	(choof R-100:						
Diag	gnosis:		/_ 2	1 1220 6	- 2 mg	-T. W.							
	VCSIE	HWGI EMI	T2JM 1	TARE	rnis a	INK .							
Vital	l Signs: Temp: Q2 (°F	-) Pulse / HR:	<u>8p</u>	(beats/m	iin) BP: <u> </u>	(mmHg) Respi	ration:						
Part	B (to be filled by Ph)	ysicians) p	any Critic	al Investig	ations:								
2	Check for			Tran	nsferring Docto	or	Receiving Doctor						
Resp	piratory (Breath sounds)	Clear _	Crepitat	ion 🔲 R	thonchi Ot	thers:	Yes No						
Abdo	omen	Soft [Tender	D	oistended Ot	thers:	Yes No						
Hear	t Sound	Normal [Feeble	E Loud	d Others:_		Yes No						
CNS													
	or Surgical Patients applicable) Surgical Site: Healthy Soakage Others: Yes No												
-	Present Medication (for Medication Reconciliation)												
S. No.	Current Medic	ation	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay						
٦	T. Elospin	~	752	No	0-1-0	6/1/24 @ 14:00	∠ Yes □ No						
2	T. Aronuas.		807	Plo	007	6/1/24 @ 20:00	☑ Yes □ No						
	T. PLANEDO		352	do.	107.	4/1011 0 8:00	Ø Yes □ No						
	T- NIRDCON	171~	26 0	Plo.	107	71,640 8:00	□ Yes □ No						
	T. ANAIT		0.25	Pha	0007.	6/1/24@ 200	✓ Yes □ No						
	EUP-CA BONAL	FIN	Sul	Plo	007	caros Briefyld	□ Voc □ No						
	E- ALDAZIO.	NE	257	No	1-20	2018 @ pidly	☑ Yes ☐ No						
	2- CLENAN	100	8.6al	SIL	1-07	ca.8@yellf	☑ Yes □ No						
	- Amconb		52	Ple	1200.	5029 Quell F	☑ Yes ☐ No						
	T-CAPLOIN			Plo.	2-07.	7/1040000	Yes □ No						
	7. IVASRA		Sy	No	1-02,	2/1121 Q8:00	Yes □ No						
	1-KARAL	-12	2.5	4Plo	1-20-7	00.8@pdJF	-⊟ Yes □ No						
	1- Arcien		900	Plo	1-057.	7 hloy@eroo	∠ Yes ☐ No						
	SYP. SUCRA	16ATB	101	Plo	1-27	2/1/21/08:00	☐ Yes ☐ No						
	TIA	•	1.89	Ph	1, -0-1,00	,	□Yes□No						

Additional De	tails (if any):		· · · · · · · · · · · · · · · · · · ·			
i.							
Patient Condi	tion:	Stable [Sick-need urgent care	ers:			
	Sign		Name	Reg. No.	Date		Time
Transferring Doctor	1	sn_	Dr. Karthon	Z5811.	7/1	124.	12:45
Receiving Doctor	1	82	Dr. K. Anusuya	134559	211	24	12:45
Part C (to be f	illed I	oy Nurses)					
Check for			Transferring Nurse			Receivir	ng Nurse
Drains		Chest A	bdominal Others: Nil			Yes	□ No
Respiratory		Air Way Type: Oxygen Therapy	/	s:li/m	in	Yes	. □ No
NG Tube / Oral		Yes \\ No	For Feeding Gastric Suction	Fluid Restriction		Yes	☐ No
Foley's Catheter		Yes No				Yes	☐ No
Intravenous Acc	ess	Peripheral Li	ne Central Venous Line Others	:	\	Yes	☐ No
Pressure Injury		Yes No	If Yes, give details:			Yes	☐ No
Score		Fall Risk:	WELLS: NEWS / PEWS:		1	Yes	☐ No
Patient Belongin	gs	Yes No	If Yes, give details:		_	Yes	☐ No
Handover Detail	s		inistration Record explained Yes Reports handed over: Yes No			Yes	☐ No
Patient Attendar	ıt	☐Xes ☐ No	If No, give details:			Yes	☐ No
Additional De	tails (it any):					
			,				į
•							
•]
,	Sign	<u> </u>	Name	Emp. No.	Date		Time
Transferring Nurse	8	- Patro -		0211	7	1/24	12:45
Receiving Nurse	- ¥ -	Sour	Signalatha.	2200	7/11	247	50,00









	CONSU	LTANT- Dr.	Gnanava	plu. DIAGNOSIS- 4CS, FTPMI - The	י כמו			
	DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN	
X	1/24	Doctor	Luge	theomholy will lister of themboly in copled by attenden in their duringuage.		W. K. Brange	9(810	V
	6/1/24	Delor .	ME	clinical condition explained to juilly menters.		R. Deed	12399	
c	tlldop	Doutor -	MIFE.	Conform Explaned.		R-Dage	Mary 1	







Every heart beat counts

VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NA

Mr.RAMACHANDRAN R

64/Male/MHI202481642

05/01/2024/IPH2024000043

AGE / SEX:

Dr.G. GNANAVELU

IP No. / UHID No 202481642

Ward / Bed No.

w.

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29/22-08

Mr.RAMACHANDRAN R 64/Malc/MHI202481642 05/01/2024/IPH2024000043 Dr.G. GNANAVELLI

Dr.G. GNANAVELU

MHI/PHARM/2022/028



Every heart beat counts

MEDICATION ADMINISTRATION RECORD

Drug	Chart:	1	_of	_1_	_		Heig	ht (cms):	7 1700m	Weigh	t (kg): <u> </u>	<u> </u>
ŀ		KNOW	N MEDIC	CINE AL	LERGIE	S (if NC	ONE is c	onfirmed	, write NKDA ii	n box 1)		
Drug De	tails			•	Descri	otion of	Allergy		, -	Doct	or's Sign:	1
Th.					<u> </u>	Alex	7	to 5	P. Pan-D	Name	No.	Alush
										Reg.	No.	A
D	осто	R INSTRUC	TIONS				NU	RSING S	TAFF INSTRU	CTIONS		
 Write in Sign and No pre 	n BLOCK nd enter scription	me when presc (LETTERS, clea MCI registration I should be alte rmat when writin	arly and leg n no. or app red / overw	gibly ply seal	2. Nurse 3. For ne follow 4. Stand Q8hrly	in-charge w prescrip standard ard Timing : 06:00hrs,	should ve ption, follo timings gs: Q24hrly 14:00hrs, :	w the timing r: 10:00hrs, C 22:00hrs or C	f omissions art on daily basis s of doctor's preso 212hrly: 10:00hrs, 22 9:00hrs, 14:00hrs, 2 00hrs, 06:00hrs, 10:	2:00hrs or 0 21:00hrs, Q	6:00hrs, 18:00h Shrly: 05:00hrs,	ırs,
		-		Stat / C	nce O	nly / P	remed	ication	Drugs			
Date	Time]	Druģ			Dose	Route	, ,	Doctor -	 	Admińistere	-
<u> </u>						}		Sign.	Reg. No.	,Sign.	Emp. No.	Time
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Clinical Pharmacist Redway Heart Institute

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Clinical Pharmacist Medway Hearl Instigna-

Clinical Pharmacist Medway Head Institute

Clinical Pharmacist Tradway Heart Institute

Gigical Pharmacist

Clinical Pharmacist Medway Heart institute

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Date → To be filled by Nursing Staff only. Sign and time given **REGULAR PRESCRIPTIONS** To be filled in by Doctors only Time ↓ **DRUG NAME** JOMEON C 90.8 Route Frequency Dose Po 1-0-0 Start Date & Time Dr. Sign & Reg, No. / Seal azy (16 Additional Info: **DRUG NAME** 8.00 T- LAROIVAS Route Dose Frequency 3,125 707 Start Date & Time Dr. Sign & Reg. No. / Seal 6/1/24 C10.00 Stop Date & Time 20.00 io holo 4 Additional Info: **DRUG NAME** 8.00 T. INABRADINZ Clinical Pharmacist Medway Heart Institute Route ເ Frequency Dose Start Date & Time Dr. Sign & Rag. No. / Seal 20.00 Additional Info: **DRUG NAME** T. CARDACE Route Frequency Dose Clinical Pharmacist Medway Heart Institute 2.5m Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time 20 d D.00 1020 Additional Info: **DRUG NAME** 8.00 CLOPILSE Route: Dose Frequency Dr. Sign & Reg. No. / Seal Start Date & Time 6 h113/010.00 Stop Date & Time
6 [24 @ 12 50 $\mathcal{S}_{\mathcal{O}'^{\mathcal{O}}}$ Additional Info: Area In-charge Nurse Signature:

ОŁ

To be filled by Nursing Staff only. Sign and time given Date -> **REGULAR PRESCRIPTIONS** * To be filled in by Doctors only Time ↓ **DRUG NAME** T. AXCER 8.00 Route Frequency Dose 90mg Dr. Sign & Reg. No. / Seal 90.94 <u> 20,00</u> Additional Info: **DRUG NAME** Dose Route Frequency 8-00 1200 Start Date & Time Dr. Sign & Reg. No. / Seal 9 60 Stop Date & Time Additional Info: **DRUG NAME** Dose Route
Loy Plo

Dr. Sign & Reg. No. / Seal $a_{\alpha}g$ Frequency

-0-/2-0

Start Date & Time 16:00 COLPO relett M25851. Stop Date & Time Additional Info: **DRUG NAME** Dose Route Frequency Dr. Sign & Reg. No. / Seal Start Date & Time Stop Date & Time Additional Info: **DRUG NAME** Route Dose Frequency Dr. Sign & Reg. No. / Seal Start Date & Time Stop Date & Time Additional Info: Area In-charge **Nurse Signature:**

Clinical Pharmacist

Clinical Pharmacist Medway Heart Instituts

0

Clinical Pharmacist

	PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD Date Time Intravenous Volume Rate / Additive Drug Doctor Administration														
Date	Time		Volume					T				T			
————		Fluid	Volunie	Duration	Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time			
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	8.00	Om diet.	A	1206/8.					
tlilay.	8:00	DM Rot	12	25351.					
8/1/24	3'00	Diabetic diel-	k.82	13455	לא				
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NURSE IDENTIFICATION RECORD

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

		_					<u></u>	•	
Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
·	Morning					Morning			
	Evening					Evening			
5-1-24	Night	Daithi	0282	ng.		Night	,		
6/1/24	Morning	S. Allwin prengrau	0162	81.		Morning			
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8 124	Morning	F-Cathrine	0007	£.C		Morning			
8/124	Evening	B. Vanisio	0195	Q/		Evening			7 °C
	Night					Night		**	



The way to better health (A Unit of United Alliance Healthcare Pvt Ltd)

Mr.RAMACHANDRAN R

64/Mulc/MHI202481642 05/01/2024/IPH2024000043

Pat 05/01/2024/IPH202 Nai Dr.G. GNANAVELU





Every heart beat counts

MEDICATION ADMINISTRATION RECORD

Drug	g Char	:: <u> </u>	of			Heig	ht (cms):	+140	Weigh	nt (kg):	8-5
		KN	OWN MEDICINE AL	LERGIE	S (if NO	ONE is co	onfirmed,	write NKDA in	1 box 1)		
Drug Da	etails		-	Descri	ption of /	Allergy			Doct	or's Sign:	
٠		<u>-</u> -			T.	pan	ρ.		Name	139 Dr.A	559 NUSUY
D	ОСТО	R INSTE	RUCTIONS					TAFF INSTRU	CTIONS		
2. Write i 3. Sign a 4. No pre	n BLOCK nd enter escription	LETTERS MCI regist should be	orescribing drug i, clearly and legibly ration no. or apply seal e altered / overwritten writing time	2. Nurse 3. For ne follow 4. Standa Q8hrly	in-charge w prescrip standard ard Timing : 06:00hrs,	should ve otion, follow timings gs: Q24hrly 14:00hrs, 2	w the timing : 10:00hrs, Q :2:00hrs or 0	omissions art on daily basis s of doctor's preso at2hrly: 10:00hrs, 22 9:00hrs, 14:00hrs, 2 9:00hrs, 16:00hrs, 10:	2:00hrs or 0 21:00hrs, Qi	6:00hrs, 18:00h 3hrly: 05:00hrs,	rs,
	-		Stat / 0	Once O	nly / P	remed	ication	Drugs	<u> </u>		
Date	Time		Drug	•	. Dose	Route		Doctor	<u> </u>	Administered	
1 1							Sign.	Reg. No.	Sign.	Emp. No.	Time
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011/24	12.20	INJ.	<u> HEDARIN</u>	#S	1000	$\mathcal{D}V$	A	93739	000	02006	1220
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Where heart best never stops...

The way to better health (A Unit of United Aillance Healthcare Pvt Ltd)

REQUISITION FOR MEDICINE

Name of Patient :

Age / Sex :

Consultant Name:

IP No.

DOA

UHID No. :

Room No.: (, ()

S.No.	Date	Medicine Name	Qty.									
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MR Ramachandran R.
MH 201481642.

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iwayHospitals

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medwayhospitals

94457 94457 1800 572 3003

Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

Kodambakkam Mogappair Kumbakonam Chengalpattu 044-2473 4455 044-26530011 044-2473 4455 044-27426829

Heart Institute 044 - 4310 8959 Institute of Pulmopology 044-2473 4451 MH/PRINT /0123/ NRS



The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)



REQUISITION FOR MEDICINE

Name of Patient

Age / Sex

MI.RAMACHANDRAN R

64/Male/MHi202481642 05/01/2024/iPH2024000043

Consultant Name:

Dr.G. GNANAVELU

ÎP No.

DOA

UHID No.:

Room No.: CCU・

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Medway Hospitals®

The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)







Where heart beat never stops...

REQUISITION FOR MEDICINE

IP No.

•

Name of Patient :

DOA

Age / Sex

UHID No.:

Consultant Name:

Room No.:

itant Name	Hoom No. :								
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	Date	Date Medicine Name 5/1/2, T. Al Prov. 0.25 mg The himmany and the second of the sec							









Yhere heart beat never stops...

REQUISITION FOR MEDICINE

Name of Patient

Age / Sex

Mr.RAMACHANDRAN R

64/Male/MHI202481642 05/01/2024/IPH2024000043

Consultant Name

Dr.G. GNANAVELU

뉴 No. :

OA : 'HID No. :

oom No.:

S.No. Qty. Date medicine Name

Nurse Name

Pharm Bill & Name



Medway Hospitals[®]

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Where heart beat never stops...

REQUISITION FOR MEDICINE

IP No.

Name of Patient :

DOA

Age / Sex :
Consultant Name :

UHID No.:

Room No.: (CC)

COHSU	itant Name	HOOM NO. :	. C. O
S.No.	Date	Medicine Name	Qty.
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Where heart beat never stops...

REQUISITION FOR MEDICINE

(A Unit of United Alliance Healthcare Pvt Ltd)

IP No.

:

Name of Patient :

DOA

Age / Sex

UHID No.:

Consultant Name:

Room No. : ()

S.No.	Date	Medicine Name	Qty.
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٠.		nicial prongs	1
انعي		On mask	1
1/1	11.	ecc, Utads	11-
,	13	Cilvue és	18 Cei

Nurse Name

Pharm Bill & Name

DOS: - ACS/ ANSTEMP / TODM/ HYSED & INT. TNK







INTERMEDIATE CARE FLOWCHART

В

Mr.RAMACHANDRAN R

64/Male/MHI202481642

NAME 05/01/2024/IPH2024000043

Dr.G. GNANAVELU

BLOC WARMEN

UHID NO :202481642 AGE: 644

SEX: M

THEIGHT : + 1 FOCM

WEIGHT : 185Kg

B.S.A: 1.4m2

		НА	EMOD	YNAM	IICS	•		RES	P. PARAMET	TERS	INVESTIGATIONS /		
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PREVIOUS DAY - HOURS 24 VOUS

DRAINAGE

TOTAL INTAKE 1641.8101

URINE SOOM 1

TOTAL OUTPUT 2300 m)

BALANCE

659.M1

ASPS: ACS | AW. STEMPI / TODM / LYSED & INT. TAK







SEX:/

Mr.RAMACHANDRAN R INTERMEDIATE CARE FLOWCHART 64/Malc/MHI202481642

UHID NO: 901121642AGE: 644

05/01/2024/IPH2024000043 NAME: Dr.G. GNANAVELU

11 BOLLO BIRGO BOLLO BIRGO BIRGO BIRGO BIRGO BIRGO BIRGO BIRGO BIRGO BIRGO BIRGO BIRGO BIRGO BIRGO BIRGO BIRGO

BLOOD G

. HEIGHT: 170 cm

WEIGHT + 85Kg

B.S.A: 1. 4m2.

TOTAL INTAKE

TOTAL OUTPUT

BALANCE

		НА	EMOD	YNAN	lics	•		RES	P. PARAMET	rers	INVESTIGATIONS /
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA
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g 00	88	Spous	972	140 82	99	kmm	<i>++</i>	ДY	Bolci	981	Cr
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DRAINAGE

URINE

ASPS:- ACS/AW. STERTS / TOOM / HYSED & INJ. TNK







MT. RAMACHANDRAN R INTERMEDIATE CARE FLOWCHART 64/Mulc/MHJ202481642

Every heart beat counts

05/01/2024/IPH2024000043

UHID NO :2024 81642 AGE : 644

В

NAME:

Dr.G. GNANAVELU

SEX : M

BLOOD GROUP:

HEIGHT # 1 FO CM

WEIGHT: + 85Kg

B.S.A: 1, 4m2

		НА	EMOD	YNAM	ics	•		RES	P. PARAMET	ERS	INIVESTIGATIONS /			
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Q3.00	84	સુંમાજ	97-2	126 82	91	Warr	++	25	BLC	99 y.	'n			

PREVIOUS DAY - HOURS 🗁

DRAINAGE

TOTAL INTAKE 20001

URINE 1950ml

TOTAL OUTPUT 1950m/

BALANCE 1 Jom 1







Mr.RAMACHANDRAN R

64/Malc/MHI202481642

05/01/2024/IPH2024000043

Dr.G. GNANAVELU 118 MIL 1881 FEET BUR 1881 FEET BUR 1881 FEET BUR 1881 FEET BUR 1881 FEET BUR 1881 FEET BUR 1881 FEET BUR 1881 UHID NO :202481642 AGE : 644

RMEDIATE CARE FLOWCHART

SEX: M

B

BLOOD GROUP:

HEIGHT: + 170 M2

WEIGHT: + 85kg

B.S.A: / 4m²

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_		HA	EMOD	YNAN	iics	•		RES	P. PARAME	TERS	INVESTIGATIONS /
TEMP	H.R.	RHY.	ST.		R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA
ટ્રાયવ	80	sicun	agif	199	۹۱	en Strong	X	مرو	Brlen	95%	NP a lit
79,00	90	Eines.	98.4		97	Norm	44	18	Brici	96×	pron plan with
23.00	力	Anus	و.وم	2 3	107	Narm	++	14	Prola	96%	FM with 50t 02
∞.00	78	grul	41.6	1 <u>176</u> 83	ω¥	boarm	tt	18	polcl	96%	/1
1-00	12	Sinces	98.2	1 <u>56</u> <u>92</u>	แร	Warm	++	26	Brici	96%	"
2.00	76	Sinus	91.6	112	85	harm	++	дH	Bolci	96×	"
3-00	9£	Sinus	98.	156 8L	112	Karm	1+	26	Polce	9%	11
A00	94	Sinus	97.6		184.	Uar <i>i</i> m	++	એ 4	BrIK	96%	1.
5-00	ર્જક	Sinus	98.2	H6 100	118	Kam	++	22	Brici	97.	(v
6.00	94	Sung	97.4	167	1 %	Karm	++	20	Brlcc	921.	11
7:00	92.	Rines									
			_	_							
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	•						•	P!	REVIOUS DA	Y - HOUR	es
1					DR	AINAGE	: 1			TOTAL	LINTAKE

DRAINAGE URINE

TOTAL INTAKE

TOTAL OUTPUT

BALANCE

DSPS: - ACS / AN. STEMI / TODAY / SYSED T SMY. TINK







Every heart beat counts

Mr.RAMACHANDRAN R 64/Malc/MHi202481642

05/01/2024/IPH2024000043

NA Dr.G. GNANAVELU

ITERMEDIATE CARE FLOWCHART

A

UHID NO : 2024 21642 AGE : 64 4

SEX: M

SURGICAL PROCEDURE : PTCA->LAD

POSTOP DAY :D3.

FLUID REQUIREMENT: | - 2 HT | DAY

DATE	UR	INE	CI	HEST C	RAIN	AGE	TOTAL		I.V. F	LUIDS		ORAI	_/ R.T.	TOTAL	TOTAL
& TIME	Н.Т.	G.T.		AIR LEAK	H.T.	G.T.	OUTPUT				H.T.	н.т.	G.T.	TOTAL INTEKE	BALANCE
7-24												doo	goo	800	(
90.00)											loo	300	800	300
(010)	,											-	360	900	300 300
11:00	600	<i>900</i>					600					100	004	004	- 200
w.B	_	poo					600					(00)	500	500	100
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SPEC	IFIC OE	BSERVA	TIONS/	REMAR	KS	l	ļ	MEDI	CATION	I / DRUG	S				
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ASS: ACS/ AW. STEME/ TOM/ LYSED & SNJ. TAK







Mr.RAMACHANDRAN R

64/Malc/MHI202481642 05/01/2024/(PH2024000043

Dr.G. GNANAVELU

ERMEDIATE CARE FLOWCHART

UHID NO : 202481642 AGE : 644

SEX: M.

SURGICAL PROCEDURE:

POSTOP DAY: D2

FLUID REQUIREMENT:

DATE						AGE	TOTAL		1.V. F	LUIDS		ORAL	/ R.T.	TOTAL	TOTAL
& TIME	н.т.	G.T.		AIR LEAK	H.T.	G.T.	ОЙТРИТ	nis			н.т.	н.т.	G.T.	INTEKE	BALANCE
<u> 20</u> .00	_	alvo					2100	30				- (950	128/.8	- 818-2
1-00		DIC)				2100	30			岁	20	1000	1361.8	738.2
2-00		alα	>				2100	80				_	1000	1391.8	708.2
3.00	_	२१ळ					2100	30					1000	18121.8	- 618.2
4.00	-	श्रीक					2100	30				50	1090	1501.8	<u>-</u> 598·2
5.00	200	2300			_		2300	30						1531.8	100 -
6.00		2360					2300	30				570	1100	1611-8	£88.2
7.00		2300					2300.	30				_	llw	1641.8	- 658-2
			_												
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SPEC	IFIC O	BSERVA	TIONS/	REMAR	KS			MEDICATION / DRUGS							
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				_											

ASPS: - ACS/AW. STEMI / TODM / FYSED & INT. TINK







Mr.RAMACHANDRAN R

64/Malc/MHI202481642

05/01/2024/IPH2024000043

NAME:

Dr.G. GNANAVELU

SURGIC MANAGEMENT

RMEDIATE CARE FLOWCHART

UHID NO :202481642AGE :644

SEX :

POSTOP DAY: D2

FLUID REQUIREMENT: 1 -2 line 1 day

I.V. FLUIDS **URINE** ĎΑΤΕ **CHEST DRAINAGE** ORAL/ R.T. TOTAL TOTAL TOTAL & TIME INTEKE BALANCE OUTPUT H.T. н.т. | G.T. G.T. H.T. G.T. LEAK A00 400 200 200 200 800 200 400 <u> 200</u> 200 4.00 400 D00 400 200 200 *4*00 200 000 700 900 200 11.00 1300 1700 500 LAB 01130 Certh THEITAG BH1+1FD TO Cath 13.05 HOD MOD 400 800 Acon | 100 A 021 0.6 100 700 730:6 669.4 30 1400 400 <u>14.00</u> 1500 200 1600 400 761,7 838.8 1600 06 30 16.00 1600 491.8 608.2 0.6 700 1600 30 DIC. 19. w 500/2100 50 2100 30 841.8 450 1908 B.00 2100 ŚО 2100 701.8 1AB:2 BD 100 2100 2100 19,00 950 [14.8 100 2100 2100 30 20,00 950 1191.8 908.2 2100 2100 30 21-00 2100 950 1221.8 878.5 2100 30 100 BL 30 950 1251-8 348 2 23.09 2100 2/00 SPECIFIC OBSERVATIONS/REMARKS **MEDICATION / DRUGS**

Patient Recived from Cutrules LOCCU @13.06;







Mr.RAMACHANDRAN R

64/Male/MHI202481642

05/01/2024/IPH2024000043

NAME:

Dr.G. GNANAVELU

14 THE TOTAL STATE THE THE TRANSPORT OF

RMEDIATE CARE FLOWCHART

UHID NO : 201481642 AGE : 644

SEX : M

SURGICAL PROCEDURE :

POSTOP DAY: PT

FLUID REQUIREMENT: 👡

-		٠, ٧						5-1-23							
DATE &	UR	INE	CI	IEST C	RAIN	AGE	TOTAL		I.V. F	LUIDS		ORAI	_/ R.T.	TOTAL	TOTAL
TIME	Н.Т.	G.T.		AIR LEAK	H.T.	G.T.	OUTPUT				H.T.	H.T.	G.T.	INTEKE	BALANCE
5-1-24										-	-	_	_		•
21.49	-	_				<u> </u>		_		<u> </u>		 	, , , , , , , , , , , , , , , , , , ,		<u> </u>
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3.00	_	1450					1450					-	150	150	1300
fr.00	-	1450					1450					-	150	lgo	- 1300
5.00	500	1950					1950						150	150,	1800
600		1950					1950	_				50	200	200	סצדו
700	_	1950					1950				-	-	200	200	1750.
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SPEC	IFIC O	BSERVA	TIONS	REMAR	KS	l	<u> </u>	MEDICATION / DRUGS							
					r.										I