



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


Medway Hospitals
The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)

Mr. SELVARAJ A

56/Male/MHI202400008

02/01/2024/IPH2024000013

Dr. K. JAISHANKAR



Where heart beat never stops...

ADMISSION SLIP

 Admitting Doctor: Dr. Jaishankar Speciality: Cardiologist

 Advised Date & Time: 21/12/24 @ 12:10pm

Provisional Diagnosis:

CAD
ST/T2DM.

 Reason for Admission: ☐ Medical Management ☐ Surgical Management

☒ Others (please specify details) _____

 Admission Type: ☒ Day Care ☐ ER ☐ Ward

☐ ICU _____ (Specify details)

Surgery / Procedure Name (if planned):

CAD

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

Expected Duration of Stay:

Day Care

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

 Payer: ☐ Self ☐ Insurance ☐ Others: _____

Instructions to Nurse (if any):

→ Admit in Radial lounge.
go shift to Cath lab on call.

Any other Instructions (if any):

Doctor's Signature

Name

Reg. No.

Date

Time

(Signature)
21/12/24

Dr. Jaishankar

91810

21/12/24
12:10

For admission desk staff only:

Room Category:

☒ General Ward

☐ Single Room

☐ Twin Sharing

☐ Deluxe Room

☐ Suite Room

☐ Others _____

Admission intimation Receipt Details

Admission Time in HIS

Date

Time

Date

Time

2/1/24

12:10 PM

2/1/24

12:23 PM

Source:

☒ OPD

☐ ER

☐ Direct

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

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

Front office Staff Signature

Name

Emp. No.

Date

Time

2/1/24

S. Vignesh

0262

02/01/24

12:23 PM



ADMISSION FORM

Marital Status M	Full Address A. செல்வராஜ் No 33 சின்னாத்திடு நகரம் திருச்சி நகராட்சிப் பேரவை தெருவில் வா. செங்கப்பா பையன்	Telephone Number 9789122767
Occupation PL		
Referred from Dr. E. R.	Date of Time of Admission 21/124 12.22pm	Date & Time of Discharge 21/124 @ 18.00
	Total No. of Days 6.30	
UNIT PL	MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes AR No. :	

FINAL DIAGNOSIS		ICD Code
ATYPICAL CHEST PAIN		R01.4
TMT - POSITIVE [28/12/23]		
CAGI - MINIMAL CAD [3.2022]		I25.8
NORMAL LV FUNCTION		I50.1
SYSTEMIC HYPERTENSION		T10
TYPE II DIABETES MELLITUS		E11.9
ANEMIA - ? GI BLEED		D64.9
DATE	OPERATION / PROCEDURES	ICPM Code
21/124	CORONARY ANGIOGRAPHY DONE	88.50
DATE	TYPE OF ANESTHESIA	
21/124	<input type="checkbox"/> GENERAL <input type="checkbox"/> SPINAL <input checked="" type="checkbox"/> LOCAL <input type="checkbox"/> REGIONAL <input type="checkbox"/> EPIDURAL	
DISCHARGE STATUS		
<input checked="" type="checkbox"/> Cured <input type="checkbox"/> Discharge at Request <input type="checkbox"/> Expired < 48 hours <input type="checkbox"/> Improved <input type="checkbox"/> Against Medical Advice <input type="checkbox"/> Expired > 48 hours <input type="checkbox"/> Unchanged <input type="checkbox"/> Absconded <input type="checkbox"/> Post-Operative Death <input type="checkbox"/> Transferred to		
Signature of the Consultant, <i>[Signature]</i>		Signature of Medical Records Officer <i>S. Alen Sof</i>

AUTHORISATION FOR TREATMENT I PAYMENT

I hereby authorise the Administration, Medical and Nursing and Paramedical, Staff 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. Selvaraj..... who is my (Relationship).

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

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

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

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

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

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

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

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கப்பட்டிருக்கிறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.


செவிலியர் கையொப்பம்

Signature of Admitting Nurse

தேதி 2-01-2024

Date


எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of the Patient / Relative / Gurdian



உறவுமுறை

Nature of Relationship



GENERAL CONSENT FOR ADMISSION


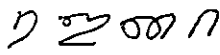



I, A. Selvaraj the ☒ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ Read

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

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

- I further declare that I have been given an opportunity to ask question(s) related to my admission, care plan and proposed hospital stay, and that such questions have been answered to my satisfaction.
- I declare that I have received and fully understood the information provided in this consent form, that I have been given an opportunity to ask questions relating to my admission, care plan and proposed hospital stay, and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my signing this form.
- I, the above-named Patient / named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.

	Signature / Thumb Impression*	Name	Date	Time
Patient		A. Selvaraj	02/1/23	12:23 PM
Surrogate/Guardian (if applicable #)		 (Write name and relationship with patient)	02/1/23	12:23 PM
Reason for surrogate consent	Patient is unable to give consent because:			
Witness			02/1/23	12:23 PM
Interpreter (if applicable)				

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



Every heart beat counts
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DAY CARE DISCHARGE SUMMARY

IP No.	IPH2024000013	D.O.A	: 02/01/2024
UHID	: MHI202400008	D.O.P	: 02/01/2024
Name	Mr. SELVARAJ. A	Room No.	: RL
Age / Gender	56Years /MALE		
Consultant	: Dr. JAISHANKAR.K MD., DM., FIAMS Director and Clinical Lead Cardiology and Electrophysiology	D.O.D	: 02/01/2024

DIAGNOSIS:

ATYPICAL CHESTPAIN
TMT – POSITIVE(28.12.2023)
CAG – MINIMAL CAD (3.2022)
NORMAL LV FUNCTION
SYSTEMIC HYPERTENSION
TYPE II DIABETES MELLITUS
ANEMIA-?GI BLEED

PROCEDURE: CORONARY ANGIOGRAM DONE ON 02.01.2024 – NORMAL EPICARDIAL CORONARIES.

BRIEF HISTORY:

Mr. Selvaraj. A, 56 years/ male, Presented with complaints of shortness of breath on exertion since 4 months. He was evaluated in ESIC hospital and treated conservatively. He was advised Coronary angiogram and referred to Medway Heart Institute on 02.01.2024 for which he has been admitted.

No H/O fever, vomiting, diarrhea.

Known case of systemic hypertension, Type II diabetes mellitus on medication.

N/K/C/O Dyslipidemia , CVA and hypothyroidism.

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

P I C C L E - NIL
HR - 81bpm
BP - 140/73mmHg
SPO₂ - 99% in room air
CVS - S1S2 (+)
RS - BAE
Abdomen - Soft
CNS - NEND

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

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PATIENT
HELPLINE
94557 94557
1800 572 3003

Medway Group of Hospitals

Kodambakkam 044-2473 4455	Mogappair 044-26530011	Chengalpattu 044-27426829	Villupuram 04146-242000	Kumbakonam 044-2473 4455	Kakinada 0884-2333367
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E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

Medway Centre of Excellence (Chennai)

Heart Institute 044 - 4310 8959	Institute of Pulmonology 044-2473 4451
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MHI/HOSP/2022/118



NAME: MR. SELVARAJ. A

UHID: MHI202400008

Every heart beat counts
(A Unit of United Alliance Healthcare Pvt Ltd)**INVESTIGATIONS:****BLOOD:** Hb- 10.5gm/dl, TWBC – 5470 cells/cumm, PLT – 175000 cells/cumm, B.Urea – 30.4mg/dl, Creatinine – 0.9mg/dl, Na+ - 137 mmol/l, K+- 4.11 mmol/l.**ECG :** sinus rhythm, HR – 66 bpm, within normal limits.**ECHO :** No RWMA, Normal LV function, EF – 70%, no PE/ clot/PHT.**COURSE IN THE HOSPITAL:**Mr. Selvaraj. A, 56 years/ male, underwent Coronary Angiogram by right radial access on 02.01.2024 which revealed **NORMAL EPICARDIAL CORONARIES**. Post procedure was uneventful. He is advised for medical management. His medications are optimized and he is being discharged in a stable clinical condition.**ADVICE MEDICATIONS:**

SL. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATIONSHIP WITH MEAL	DURATION
			M	A	N			
1.	TAB. ATORVAS (ATORVASTATIN)	10 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
2.	TAB. ENVAS (ENALAPRIL)	2.5 MG	2	0	0	ORAL	AFTER FOOD	TO CONTINUE
3.	TAB. MET – XL (METOPROLOL SUCCINATE)	25 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE

TO CONTINUE DIABETIC MEDICATIONS

DISCHARGE ADVICE	
DIET	LOW FAT, DIABETIC & SALT DIET.
PHYSICAL ACTIVITY	AVOID STRENUOUS ACTIVITY
REVIEW	REVIEW WITH CARDIOLOGIST AT ESIC HOSPITAL.

To report: If temp > 101 °F / Difficulty in breathing / chest pain / Giddiness/ palpitations.
Any other significant symptoms. In case of emergency Contact: Medway Hospitals @ 4310 8959.7.2.2024
"I understood the Content of the discharge summary."**CONSULTANT SIGNATURE**Dr. Jaishankar. K MD., DM., FIAMS
Director and Clinical Lead
Cardiology and Electrophysiology

Typed by : Ezhilarasi.

Dr. K. JAISHANKAR
Reg. No: 49448

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

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94557 94557
1800 572 3003**Medway Group of Hospitals**Kodambakkam | Mogappair | Chengalpattu | Villupuram | Kumbakonam | Kakinada
044-2473 4455 | 044-26530011 | 044-27426829 | 04146-242000 | 044-2473 4455 | 0884-2333367

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Medway Centre of Excellence (Chennai)Heart Institute | Institute of Pulmonology
044 - 4310 8959 | 044-2473 4451

MHI/HOSP/2022/118

DAY CARE INITIAL ASSESSMENT FORM

Date: 21/1/24 Time of arrival: 12.30

Part A (to be filled by Nurses)

Vital Signs: Temp: 97.2°F | Pulse / HR: 81 (beats/min) | BP: 140/73 (mmHg)
Respiration: 21 (breaths/min) | SpO₂: 99 (%) | Height: 155 (cms) | Weight: 56.1 (kgs) | BMI: 26.8 kg/m²

Any Language Barrier: ☐ Yes ☒ No If yes, please call Language Coordinator / Translator

Allergies : ☐ Yes ☒ No If Yes, specify: _____

Psychosocial Assessment:

Alcohol Intake: ☐ Yes ☒ No **Substance Abuse:** ☐ Yes ☒ No **Smoking:** ☐ Yes ☒ No

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

If Yes, specify details: _____

Pain Screening

Pain: ☐ Yes ☒ No. If Yes, Score: 0/10

Pain Scale used: ☐ PIPPS (28 weeks to < 38 weeks) ☐ CRIES (38 weeks - 2 months)

☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)

☒ Numerical Rating Scale (Age more than 12 years)

Duration: _____ Location: _____

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

Nutritional Screening:

Last 3 months Appetite ☐ Increased ☐ Decreased ☒ No Change

Last 3 months Weight ☐ Increased ☐ Decreased ☒ No Change

Fall Risk Screening for adults:

☒ No Risk

☐ Age more than 65 years

☐ History of fall in last 3 months

☐ Walks with assistance


☐ Any neurological problem

In case of 2 or more criteria met initiate detailed fall assessment and fall prevention protocol

Fall Risk Screening (for pediatrics)

☐ H/O fall in last 3 months ☐ Neurological problem (vertigo, seizure, etc) ☐ Deranged Mobility ☐ No Risk

In case of 2 or more criteria met initiate detailed fall assessment and fall prevention protocol

	Signature	Name	Emp. No.	Date	Time
Nurse		Daya, P	0151	21/1/24	12.40

DATE	NOTES
21/1/2024 2pm	<u>CAG</u> (CAG no. 3516)
	- Rt radial access
	- SF sheath
	- SF TIA → CAG done
	LMCA - (N). Bifurcates into CAD & LAD
	LAD - Type 3 vessel. LAD is (N). Giv 3 diagonals & may septal (N) D ₁ is major vessel
	LCx - Non dominant. LCx is (N). Giv 1 major OM (N)
	RCx - Dominant. RCx is (N). PDA & PCV are (N)
	<u>Imp</u> : Rt dominant / (N) epicardial coronary
	<u>Adv</u> : medical management
	hy arrow

DATE	NOTES
<u>2/1/24</u>	
<u>16:00hrs</u>	<u>8/13 Dr. Vel</u>
	- Pt reviewed
	- All new units
	<u>0/5</u> Gummies
	with study
	<u>Adv</u>
	<u>Dr. Vel</u>
<u>1/</u>	
<u>any</u>	

Every heart beat counts

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Patient Details (Affix Label here)

Name: Mr. Selvaraj. A
UHID: 20240008
DOB: 56Y Sex: male
DOA: 21/12/24
Consultant: Dr. Dishtant

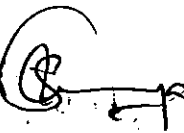

Diagnosis: CA G1 / T2DM / SHTN / TMT POSITIVE (2022) / EF-70%
Height: 155 cms Weight: 56.7 Kgs Food allergies: Yes/No, if yes, specify
Religious Beliefs: ☐ Vegetarian ☒ Non Vegetarian ☐ Eggetarian ☐ Jain
Diet Prescription: 1600 calories, Low Fat, Low Salt

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

(A) Patient's related Medical History				
1) Weight Change (overall change in past 6 months)				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
No weight change/ gain	<5%	5-10%	10-15%	>15%
2) Dietary Intake				
Duration:				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Oral	No change	Sub-optimal solid diet	Full liquid diet/ moderate overall decrease	Hypo-caloric liquid diet
Enteral / Parenteral Nutrition	Adequate / Excessive	Sub-optimal	Inadequate	Starvation
3) Gastrointestinal Symptoms Duration:				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
No symptoms	Nausea	Vomiting / moderate GI symptoms	Diarrhoea	severe anorexia
4) Functional Capacity (Nutrition related functional impairment) Duration:				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
None / Improved	Difficulty with ambulation	Difficulty with normal activity	Light activity	Bed / chair - ridden with no or little activity
5) Co-morbidity (Disease and its relationship to nutrition requirements)				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Healthy	Mild co-morbidity	Moderate co-morbidity/ age >75 years	severe co-morbidity	Very severe multiple co-morbidity
B) Physical examination				
1) Decreased fat stores or loss of subcutaneous fat				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Normal	Mild	Moderate		Severe
2) Sign of muscle wasting				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Normal	Mild	Moderate		Severe
Total Score = Sum of above 7 components				
Nutritional Status : Based on this patient is				
<input checked="" type="checkbox"/> Well Nourished (17 to 14)				
<input type="checkbox"/> Moderately Malnourished (15 to 18)				
<input type="checkbox"/> Severely Malnourished (19 to 35)				
Nutrition Intervention:				
<input checked="" type="checkbox"/> Oral <input type="checkbox"/> Enteral <input type="checkbox"/> Parenteral				
Diet counselling provided: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
Frequency of re-assessment: <input checked="" type="checkbox"/> Weekly <input type="checkbox"/> Fort-night <input type="checkbox"/> Monthly				
Enteral / Parenteral <input type="checkbox"/> Daily <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes				

Dietitian Signature / Name / Date / Time:

Dr. Dishtant 21/12/24 16:00

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
<p>02/01/24 12:00</p>	<p>756 years old gentleman came to clinic shortness of breath (4 days) was assessed to be well- nourished as evident by SGA K/CLO-TDM/CHEN patient shifted to cathlab for procedure (CAH). kept on NBM. patient received to Radial lounge. NBM over. patient tolerated liquid diabetic diet. can initiate down soft solid diet. patient oral intake good. Educated the patient & family on 1600 calories, low fat, low salt, diabetic diet on discharge.</p>	<p> 0286</p>
<p>2/1/24 16:00</p>	<p>Emphasized on small frequent meals. Diet modifications & clarifications given on discharge <u>Diet chart</u> given on discharge</p>	<p> 0286</p>

PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: CAD / STENT / T2PY Allergies if any: NIL

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
ER	CATH LAB	21.12.24	13:30	CAG

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 ☐ If Yes, specify: _____

Fall Risk Category: ☒ Low Risk ☐ Medium Risk ☐ High Risk

Vital Signs (to be documented at the time of shifting):

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
97.3	19	76	99	140/73	0/10

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

Any pre-medication given: _____

Any critical information: _____

Any specific recommendation: _____

Handover by	Signature	Name	Emp. No.	Date	Time
		Sandhya R	0159	21/12/24	1:40
Handed over to		Dr. Jayashankar	0004	22/12/24	13:40

After Procedure:

Procedure completed: ☒ Yes ☐ No | Any critical information: nil

Vital Signs (to be documented at the time of shifting):

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
97.5	16 brs/min	73 beats/min	99%	142/69	0/10

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

Handover by	Signature	Name	Emp. No.	Date	Time
		Sandhya R	0004	22/01/24	14:40
Handed over to		Dr. Jayashankar	0159	21/12/24	14:40

Mr. SELVARAJ A

56/Mulc/MHI202400008

02/01/2024/IPH2024000013

Dr. K. JAISHANKAR



CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

CONDITION AND PROCEDURE

Dr. SALAI SUNDHAR 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 blood. 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 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 puncture site
Most People	(n) Minor bruising

PATIENT CONSENT:

I acknowledge that Dr. SALAI SUNDHAR 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 have been explained that some reprocessed items might be used once its sterility and integrity is confirmed. 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 concerns 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	<u>A. Selvaraj</u>	<u>A. Selvaraj</u>	<u>2/1/24</u>	<u>12.30</u>
witness	<u>[Signature]</u>	<u>[Signature]</u>	<u>2/1/24</u>	<u>12.30</u>
Doctor	<u>[Signature]</u>	<u>Dr. Salai Sundhar</u>	<u>2/1/24</u>	<u>12.30</u>
Interpreter				

Patient Details (Affix Label here)

Name:

UHID:

DOB:

Sex:

இருதய ஆன்ஜியோகிராம் பரிசோதனைக்கான ஒப்பம்

நிலை மற்றும் செயல்முறை

பின்வரும் கருநிலையை நான் கொண்டிருப்பதாக மருத்துவர் அவர்கள் விளக்கினார்.

பழைய இருமல் குழாய்களில் துருவிடப்படுவது போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாறடைப்பினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிரை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியோகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு லோக்கல் அனஸ்தீடிக் (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கத்தீட்ர்) கவட்டை/கையிலுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிரை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின்கொண்டுள்ள காண்ட்ரான்ட் மீடியத்தினை (எண்ஸ்ரே டை) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுபக்க இருதய கீழறை) இந்த காண்ட்ரான்ட் மீடியம் உட்கொள்ளப்படலாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்பு செய்கிறது என்பதை மதிப்பிடவும் 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 சிகிச்சையை மேற்கொள்ள முடியும். இவை பை-பாஸ் அறுவை சிகிச்சையாகவும் இருக்கலாம் அல்லது ஆன்ஜியோபிளாஸ்டி (புலூன் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

இச்செயல்முறையிலுள்ள இடப்பாடுகள்

இதயச்சுவர் சிரை ஆன்ஜியோகிராஃபியிலுள்ள இடப்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிரை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள சில தீவிர இடப்பாடுகள் பின்வருமாறு. ஆனால் கீழ்க்கண்ட மட்டுமே முழுமையான இடப்பாடுகள் 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) மாறடைப்பு (d) எக்ஸ்-ரே காண்ட்ரான்ட் 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) குத்தப்பட்ட இடத்தில் பெரிய அறுவை சிகிச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரகால இதய அறுவை சிகிச்சை அல்லது ஆன்ஜியோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதிர் பாதிப்பு காரணமாக அதிக வாழ்நாள் அச்சுறுத்தல் இடப்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(I) இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகிச்சை தேவைப்படும் (j) குத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகிச்சை சரிபாடு. இதனால் மருத்துவமனையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) காண்ட்ரான்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமல் அல்லது அதன் வலுவற்றதல்
20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவினை சிராய்ப்பு அல்லது வீக்கம்
வரும்பாலான மக்களுக்கு	(n) சிறிய அளவினை சிராய்ப்பு

நோயாளி ஒப்புதல்

மருத்துவர் அவர்கள் என்னுடைய மருத்துவ நிலையையும் மற்றும் முன்மொழியப்பட்டுள்ள செயல்முறையையும் எனக்கு விளக்கினார். செயல்முறையிலுள்ள இடப்பாடுகள், மயக்க மருந்துகள் உட்பட எனக்கு குறிப்பாக ஏற்படும் இடப்பாடுகள் மற்றும் சிக்கல்கள் ஏற்பட்டால் என்னவாகும் என்பவைகளை நான் புரிந்து கொண்டள்ளேன். மருத்துவர் பிற தொடர்புள்ள சிகிச்சை விருப்பத் தேர்வுகள், அதன் இடப்பாடுகள் மற்றும் சிகிச்சை மறுப்பதற்கான என்னுடைய உரிமை ஆகியவைகளையும் எனக்கு விளக்கினார். அதன் தொற்றின்மை மற்றும் ஒருமைப்பாடு உறுதிசெய்யப்பட்டவுடன் சில மறு செயலாக்கப்பட்ட பொருட்கள் பயன்படுத்தப்படலாம் என்று எனக்கு விளக்கப்பட்டுள்ளது. அவர் என்னுடைய முன் கணரீப்புகள் மற்றும் செயல்முறையை மேற்கொள்ளாமல் இருப்பதால் ஏற்பட வாய்ப்புள்ள இடப்பாடுகள் ஆகியவைகளையும் எனக்கு விளக்கினார். என்னுடைய நிலை குறித்து என்னால் கேள்வி எழுப்ப முடிந்தது மற்றும் என்னுடைய கவலைகளை தெரிவிக்கவும், செயல்முறை மற்றும் அதன் பலன்களை தெரிவிக்கவும் மற்றும் எனது சிகிச்சை விருப்பத்தேர்வுகள் குறித்த கவலைகளையும் என்னால் தெரிவிக்க முடிந்தது. என்னுடைய கேள்விகளும் மற்றும் கவலைகளும் கலந்துகொள்கப்பட்டது மற்றும் எனக்கு திருப்திகரமான முறையில் அவற்றிற்கு பதிலளிக்கப்பட்டது. அசாதாரணமான கழுவில், எனக்கு இரத்தமேற்றதல், ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகிச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகிச்சையளிக்கப்படும் என்பதை எனக்கு விளக்கினார். இச்செயல்முறையினால் என்னுடைய நிலை மேம்படும் என்பதற்கு எத்தகைய உத்தரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டள்ளேன்.

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

	கையெழுத்து	பெயர்	தேதி	நேரம்
நோயாளி (பாதுகாவலர்) உறவுமுறை				
சாட்சி				
மருத்துவர்				
மொழிபெயர்ப்பாளர்				



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CORONARY ANGIOGRAM REPORT

PATIENT NAME : MR. SELVARAJ.A UHID : MHI202400008
 AGE/GENDER : 56 YEARS / MALE IP NO : IPH2024000013
 CONSULTANT : Dr. Jaishankar. K MD., DM., FIAMS D.O.A : 02.01.2024
 Director and Clinical Lead D.O.P : 02.01.2024
 Cardiology and Electrophysiology

CATH DATE	02.01.2024	DONE BY	DR. JAISHANKAR
CATH NO	3516	ASSISTED BY	SN. SATHYA
CATH DURATION	5 MINS	TECHNICIAN	MR. TAMIL
HEIGHT WEIGHT	155CMS 56KGS	PHYSICIAN ASSISTANT	MS. SHALINI

CLINICAL DIAGNOSIS: ATYPICAL CHESTPAIN, TMT – POSITIVE(28.12.2023), CAG – MINIMAL CAD (3.2022), NORMAL LV FUNCTION, SYSTEMIC HYPERTENSION, TYPE II DIABETES MELLITUS.

CATHETERIZATION PROCEDURE: AFTER OBTAINING INFORMED CONSENT, PATIENT WAS BROUGHT TO THE CATH LAB. UNDER SAP, PROCEDURE DONE BY USING 2% XYLOCAINE AS LOCAL ANAESTHESIA AND SELDINGER TECHNIQUE.

APPROACH : RIGHT RADIAL ARTERY
SHEATH : 5FR
CATHETER : 5FR TIG
CONTRAST MATERIAL : NON- IONIC, CONTRAPAQUE
MEDICATIONS : Inj. Heparin 2500 IU

COMMENTS:

LMCA - NORMAL. BIFURCATES INTO LAD AND LCX.

LAD - TYPE III VESSEL AND GIVES RISE TO 3 DIAGONALS AND MANY SEPTALS. DIAGONAL 2 IS MAJOR VESSEL. LAD AND BRANCHES ARE FREE OF DISEASE.

LCX - NON-DOMINANT AND GIVES RISE TO 1 MAJOR OM. LCX AND BRANCHES ARE FREE OF DISEASE.

RCA - DOMINANT AND GIVES RISE TO PDA AND PLV BRANCHES. RCA AND BRANCHES ARE FREE OF DISEASE.

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MHI/HOSP/2022/118



JCI ACCREDITED



NABH ACCREDITED



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IMPRESSION:

NORMAL EPICARDIAL CORONARIES
GOOD LV FUNCTION
RIGHT DOMINANT SYSTEM

ADVICE:

MEDICAL MANAGEMENT


CONSULTANT SIGNATURE

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

To visit at www.medwayhospitals.com

Dr. K. JAISHANKAR
Reg. No: 49448

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

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MHI/HOSP/2022/118



DATE & TIME	Observation / Action	Signature with Emp.No			
02/1/24 12:30	⇒ pt on Giot Admission 9 pt on conscious & oriented, V/S checked & recorded, no complaints ⇒ pt on NPO - Yesterday ⇒ ports preparation done ⇒ IV line inserted	for			
13:40	⇒ pt on shifted to cath lab	for			
02/1/24 13:40	<u>CATH LAB REPORTS</u> ⇒ Patient received from IC to cath lab pt is conscious and good oriented. Euvolemia present v/p. Score 0/5	for 0004			
14:00	⇒ Sterile Drapping done.				
14:05	⇒ CATH procedure Start through Right Radial artery approach under local anesthesia given.				
14:10	⇒ During procedure 4. nitor 100mg and 4. Dilator 0.25mg IV given. A/O. nitor 100mg	for 0004			
14:10	⇒ 4. Heparin 2.500 IU given.				
14:15	⇒ JVF NS 40ml/hr outflow.				
14:25	⇒ CATH procedure got over. pt is stable.				
14:30	⇒ Right Radial artery sheath removed and tight pressure bandage applied. no oozing. no tenderness	for 0004			
Document endorsed by:	Signature 	Name Sandhya	Emp. No. 0004	Date 02/1/24	Time 14:30

DATE & TIME	Observation / Action	Signature with Emp.No
14:35	→ patient shifted to RL with all documents.	
14:40	→ patient handing over to RL S/n: Ramya.	J 1004
14:45	→ pt on. Keel pad from cath cap / pt on Conscious, oriented, VLS checked & recorded, IV line patent	
	Ⓟ radial approach pressure bandage Ⓟ no complaints	
	→ pt on juice intake	
	→ pt on urine voided	
	→ pt on had lunch done	
	<u>PT DISCHARGED</u>	
18:00	→ pt on CABG- CD, Image old file pt attached given	
	→ IV line, ID band removed	
	→ pt on VLS checked & recorded	
18:00	→ pt on D/S	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Jay	JAYANAND	0002	21/1/24	18:30

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

MR. SELVARAJ
56y/M
MHI 2024 00008

MHI/OT/2022/086



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Name of the Procedure : CAL Location : ORTH LAB Date & Time : 2/1/24

PATIENT LABEL

Does the Procedure involve Procedural Sedation : ☐ Yes ☒ No

SIGN IN <u>14:00</u> Before Induction of Procedural Sedation		TIME OUT <u>14:5</u> After procedural Sedation and before procedure		SIGN OUT <u>16:20</u> When Doctor indicates that the Procedure is completed	
(Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)		(Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure)			
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 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Identity by two identifiers <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Name of the Procedure done written down <u>CAL</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Procedure <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Procedures <u>CAL</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Name and site of all specimens / investigations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	
Side <input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA		Side <u>RT</u> <input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA		confirms labeling and sent to lab	
Consent <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Position <u>Supine</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Any recovery concerns : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None If Yes, Pls. specify : <u>Observation</u>	
Known Allergy <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please specify		Consent <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Difficult airway / aspiration risk / dentures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, equipment and assistance available		Essential Imaging displayed <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA			
Possibility of hypothermia <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, warmer in place		Antibiotic prophylaxis within last 60 minutes <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		Any Equipment / instrument problem that needs to be addressed : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None If Yes, Pls. specify : <u>P</u>	
All concerned anesthesia equipment and medication check complete <input checked="" type="checkbox"/> SpO2 <input checked="" type="checkbox"/> NIBP <input checked="" type="checkbox"/> Others pls. specify <u>ECG</u>		Name of the Antibiotic given			
Pre OP medication taken <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Venous Thromboembolism Prophylaxis Provided <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA			
Required equipment for procedure available <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		Anticipated duration briefed <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Corrective action : <u>P</u>	
		Anticipated blood loss briefed <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA			
		Adequate fluids and blood available <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA			
		Team briefed on any critical or unexpected steps <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
		For procedural sedation cases			
		Any patient specific concerns : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None			
		Intra procedure glycemic control <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA			
		Any concerns about sterility <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None			

Anaesthetist / Doctor giving Procedural Sedation

Doctor performing the Procedure : Dr Selvaraj

Nurse : Shrini

Technician : Prashant

Others Please Specify :

Date :
Time :

Date : 2/1/24
Time : 14:35

Date : 2/1/24
Time : 14:35

Date : 2/1/24
Time : 14:35

Date :
Time :


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Procedure Monitoring Sheet (Cath Lab)

 Patient Name: **Mr. SELVARAJ A**
 56 / Male / MHI202400008
 UHID / IP: 02/01/2024 / IPH2024000013
 Consultant: Dr. K. JAISHANKAR

 Age / Sex: 56Y / M
 Ward Unit: 2A
 Diagnosis: CAD / STEN / TO / DN

Pre Procedure Checklist (Please tick appropriately – To be filled by the Ward Nurse)

PARAMETERS	YES	NO	NA
Vital signs : BP: 136/77 Temp: 97.3 Pulse: 79 RR: 19 SPO2: 99	<input checked="" type="checkbox"/>		
Urine voided	<input checked="" type="checkbox"/>		
Bowel preparation	<input checked="" type="checkbox"/>		
Pre-procedure medication administered	<input checked="" type="checkbox"/>		
Procedure site marked	<input checked="" type="checkbox"/>		
Skin preparation done	<input checked="" type="checkbox"/>		
NPO - Yesterday Night	<input checked="" type="checkbox"/>		
Loose Tooth removed			<input checked="" type="checkbox"/>
Contact lenses / Eye glasses removed			<input checked="" type="checkbox"/>
Prosthesis present			<input checked="" type="checkbox"/>
Jewellery/Nail polish removed			<input checked="" type="checkbox"/>
Checked for Allergies (Drug / food)			
IV line/In-situ	<input checked="" type="checkbox"/>		
Consent taken	<input checked="" type="checkbox"/>		
Investigation reports / Documents received	<input checked="" type="checkbox"/>		
Signature of Nurse: [Signature]	Date & Time: 21/12/23 @ 12.30		

Intra – Procedural Record (To be filled by the Cath Lab Nurse)

Time	HR / min	RR / min	BP mmHg	SpO2%	Medication / Remarks	Sign. of Nurse
14:05	77 beats/min	22 br/min	135/68 (98)	99%	-	[Signature]
14:15	73 beats/min	16 br/min	130/64 (93)	99%	-	[Signature]
14:25	79 beats/min	14 br/min	142/62 (104)	99%	-	[Signature]
			procedure got over			

Post Procedure Follow Up Data (to be filled by the doctor)

Time : 14:35 Route : Right Radial artery approach

Complication : Nil

BP : 135/68 mmHg, HR : 76 beats/min, RR : 22 br/min, SpO2 : 100%

Distal Pulse : felt, Puncture Site : No oozing, no hematoma

Advise:

- ◆ Shift To: Ward / ICU
- ◆ Bed rest up to 5-6 hours
- ◆ Observe puncture site for bleeding
- ◆ Watch for Pulse in Right Radial artery.
- ◆ Diet Diabetic Diet
- ◆ Inform Duty Medical Officer SOS
 - a) If patient complains of any Discomfort
 - b) If dressing is Loose or Socked with Blood
 - c) If limbs are Cold / Absent Pulse
- ◆ Remove 76 bandage dressing on 03/01/24 at 12:00 AM / PM after informing to the consultant.
- ◆ Special instruction if any:

Nil


Name & Signature of Consultant

POST PROCEDURE OBSERVATION

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse
<u>03/01/24</u> <u>14:35</u>	<u>135/70</u>	<u>77</u>	<u>22</u>	<u>99%</u>	<u>Right Radial</u> <u>artery approach</u>	<u>No oozing</u> <u>observed</u>		<u>Poooy</u>

Nurses Notes : CAT procedure got over. pt is stable. Right Radial
Radial artery Sheath removed and tight pressure bandage
applied. no oozing, no hematoma.

Condition at the end of procedure : ☒ Stable ☐ Critical

Patient shift to : ☐ Recovery Room ☐ Patient Room ☐ CCU ☐ Other RL

Name & Signature of the Nurse : Poooy
Sandhiya R

Date & Time : 03/01/24
14:40

Date: 2 / 1 / 24
Time: 8 / 15

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort		4	
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals		3	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours		4	
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance		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	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 dairy 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, dairy 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 dairy 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	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair			4	
					TOTAL SCORE	22	
					Initial & Emp. No. of Staff Nurse:		
					Initial & Emp. No. of Sr. Staff Nurse:		

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



PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
12:30	0/10	NO PAIN	—	—	—	Dr. Jaishankar	Dr. Jaishankar
13:30	0/10	NO PAIN	—	—	—	Dr. Jaishankar	Dr. Jaishankar
14:30	0/10	NO PAIN	—	—	—	Dr. Jaishankar	Dr. Jaishankar
15:30	0/10	NO PAIN	—	—	—	Dr. Jaishankar	Dr. Jaishankar
16:30	0/10	NO PAIN	—	—	—	Dr. Jaishankar	Dr. Jaishankar
17:30	0/10	NO PAIN	—	—	—	Dr. Jaishankar	Dr. Jaishankar
←		Pt on Discharged	→				



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

		Date	21/1/24						
		Time	13.00						
S. No.	PARAMETERS								
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0							
2	Bedridden recently >3 days or major surgery within four weeks	0							
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0							
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0							
5	Entire leg swollen (Assess for both legs)	0							
6	Localized tenderness along the deep venous system (Assess for both legs)	0							
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0							
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0							
9	Previously documented DVT (Assess for both legs)	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							
FINAL SCORE		0							
Low Risk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8		0							
DVT prophylaxis started		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Signature & Emp. No. of RN									
Signature & Emp. No. of Sr. RN									

2024



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



Patient Details (Affix Label here)

Name: MR. SELVAJAY A
UHID: MH/202400008
DOB: 56 Sex: MALE

MHI/NUR/2022/046



MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	21/12/24	21/12/24							
	Time	12:40	17:00							
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		20	20							
Low Risk (0 - 24)		5	✓							
Medium Risk (25 - 44)		2	—							
High Risk (45 or above)		—	—							
Signature & Emp. No. of RN		[Signature]								
Signature & Emp. No. of Sr. RN		[Signature]								

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

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

MEDWAY HOSPITALS

KODAMBAKKAM (HEART)

1, 1st Main Road, United India Colony , Kodambakkam, Chennai, Tamilnadu, India

044-2473 4455

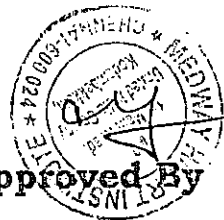
care@medwayhospitals.com

Registration No	: MHI202400008	Patient Name	: SELVARAJ A
Age	: 56	Gender	: Male
IP Number	: MMH/HM/IPH2024000013	Discharge Date	: 02/01/2024 5:11:00PM
Bill No	: MMH/HM/IPH202400006	Bill Date	: 02/01/2024 5:09:27PM
Ward Name	: RADIAL LOUNGE	Bed Name	: RL-5

NO DUE



Prepared By



Approved By



Checked By