

MRD CHECKLIST

PARTICULARS	YES	NO
- IP Number allocated to each Patient		
- Name, Age & Sex of Patient	~	
- General Admission Consent	~	
- Initial Assessment of Patient / Diagnosis	1	
- Nutritional Assessment by Consultant	1	
- Plan of care counter signed by the Consultant	√	
- Treatment Orders - Date, Time, Name & Sign.	~	
- Medication Order / Drug Chart - Date, Time, Name & Sign.	1	
- Vital Signs Chart (TPR Chart)	~	
- Intake Output Chart	,1	li .
- Drug Chart (Duly filled)	V	
- Anesthesia Consent - (8 thing) - Date, Time, Name & Sign. of both Patient & Anesthetist	1	
- Anesthesia Assessment Sheet	1	-
- Surgery Consent - (8 things) - Date, Time, Name & Sign of both Patient & Surgeon	1	
- Surgery Notes - Post Operative Plan	V	
- Pain Scoring System	V	
- Blood Transfusion if done	N	
- High Risk Procedures		
- A copy of the Discharge Summary	V	

		Mrs.S	SHANMUGAPRIYA S	-1	MHI/IPD/2022/002
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7	(2)	∖ . Ni	/2023/IPH202302475		
	E Hear		BARASU MOHANRAJ		Medway
Niedway Ho	enitals		<u> </u>		Heart
The way to bette	er health —	ΔηΜ	ISSION SL	IÞ	Institute
(A Unit of United Alliance Hea	elthcare Pvt Ltd)			W7.	ere heart best never stops
Admitting Doctor:	T.A.h.	rraso	Speciality:	_ UT	VS.
Advised Date & Time:	11/12	123 (0)	12. Dopon	•	
Provisional Diagnosis:	^-				
	Deg	(Prolocel	INM	
	151 -				
				_	
					
¹ Bason for Admission:	Medical Mar	nagement	Surgical Mar	nagement	
<u> </u>	Others (plea	se specify detai	ls)	- 	
mission Type:	☐ Day Care	ER	Ward		
		-	(Specify details)		
- / Due - strong No				<u> </u>	
Surgery / Procedure Name		1 A (1.			
	U	ABG1.			
Blood Product Requireme	nt: No	Yes (Kindly speci	fy details of componen	ts required in sp	ace below)
	<u> </u>	·		•	
Expected Duration of Stay	:	- hday	ζ.		
Expected Cost of Treatmen		I Counselina Fo	em).		
		l Gouliseling i o	<i></i>		
nyer: Self Insuranc	ce [_] Others:	· ·		 -	-
Instructions to Nurse (if an					
dideliens to Maise In all	у)	0.	in S	nu t	ovale
		Admil			
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Any other Instructions (if a	ny):				
Dr. Anbar	asu Mohanra	i.i			
3	No: 55476	บ			
/ /	. (
Dactor's Signature	Talama \ \Dr	A NID A D A CI I	I VOTIVITIEM		Trime
Doctor's Signature	Name \ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	. ANBAKASU 	Model ANDRAJ	'	Date Time 12:20
\	The	1.89 140.	30410		[[]

For admission desk s	taff only:		
Room Category:	General Ward Single Room Twin Sharing Deluxe Room Suite Room Others		
Admission intima	ation Receipt Details	Admission	Time in HIS
Date	Time	Date	Time
11/12/23	12.2000	11/12/2023	12.30
•	OPD ER Direct lood requirement specified by the and Blood Bank clearance com	1	: No
Front office Staff Signa	ture Name	Emp. No.	Date Time
A.	de l	169	4/12/23 12.30-1
	CARINA		೯೬೪೩೯



Medway Hospitals

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



MIS.SHANMUGAPRIYA S

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ





MHI/HOSP/2022/129

ADMISSION FORM

Marital Statu	us Fuli Add	iress No	· 3/3 C	HINNAMETTU	PACAYAM	Telephone Number	
M	Tī ,		8939642882				
Occupation 203		• •	1 87 - 76	- 1	. 1	٠,	
Referred from				Date & Time of Dis	=	al No. of Days	
Dr.65.6	1	11/12/20	23-12.30	17/12/25@1	250 7	days	
UNIT							
		FI	NAL DIAGNO	SIS		ICD Code	
TRIPLE	VESSEL C	ORONARY	ARTERY D.	ISPASE AC-	IN FERIOR WAL	C T25.1	
					ss IV Darwen	T24.9	
]	_			ION MODERA	·	Isol	
1 V 5YS T	TOLIC DY	FUNCTI	ON -EF.	-34 / UNICO	NTROLLED	797.2	
	T DIAR			•		E11.6	
7-1 —							
DATE				PROCEDURES		ICPM Code	
	OFF PUR	1) COR	ONARY IAI	RTERY BYFAS	S CARAFTING	,, 36.10	
[<u></u>	LIMA TO	DNA T	JUNE UM ZUM IO	12.12.2023	1 (SEQUENTIF),	
12.12.23	5VC1 10	ו אטף)01° E 01°	14,14, 4043	•	99.00	
	 	,					
DATE			TYPE OF AN	NESTHESIA			
DATE	GENERA	L [TYPE OF AN	LOCAL	☐ REGIONAL	☐ EPIDURAL	
	GENERA	L [] SPINAL		☐ REGIONAL	☐ EPIDURAL	
	GENERA	☐ Disc	SPINAL DISC charge at Requ	LOCAL HARGE STATUS		☐ EPIDURAL Expired < 48 hours	
12.12.23		☐ Disc	SPINAL DISC charge at Requirest Medical A	LOCAL HARGE STATUS			
Cured	ed ()	☐ Disc ☐ Aga ☐ Abs	SPINAL DISC charge at Requirest Medical A conded	LOCAL HARGE STATUS		Expired < 48 hours	
Cured Improve	ed ged	□ Disc □ Aga □ Abs □ Tran	DISC charge at Requirest Medical A conded asferred to	LOCAL HARGE STATUS Lest dvice		Expired < 48 hours Expired > 48 hours	

AUTHORISATION FOR TREATMENT I PAYMENT

I hereby authorise the Administration, I administer such drugs as may be nece deemed necessary and / or advisable i who is my(I	ssary and to perform such	n operation under anaesthesia or	other wise as may be
I hereby under take to settle all the bills basis. In any case, I shall pay all the du	_		d overleaf on a periodic
However, in case I fail to pay the charg me/the patient to any other hospital/ins	•	•	
I also acknowledge having been informand valuables belonging to the patient next of kin and I absolve the hospital of	or theis attendants have b	peen removed to a place of safety	•
I have read out and explained the conte	ents of the above to the Si	gnatory in his vernacular .	
சிகீச்சை, பணம் செலுத்துதல் முதலியவை	செய்ய அதிகாரம் வழங்குத		
இதன் மூலமாக நான் நிர்வாகம், மருத்துவட			
மருந்துகள் கொடுத்து செய்முறைகள்/அறு செலவுக்கன தொகை முழுவதும் செலுத்த	வை சிகீச்சை செய்யவும் அ	திகாரம் வழங்குகிறேன். நான் / இதில்	
மேல் கூறியது போல் வேளை நான் தங்க மருத்துவமனைக்கு, பிற சிகிச்சை / அறுவை அளிக்கிறேன்.			
மருத்துவமனையின் பொது சட்ட தீட்டங்கள்	ா பற்றி தெரிவிக்கீப்பட்டிருக்க	இழன்.	
நோயாளிக்கு உரிமையான எல்லா பணம், நெருங்கீய உறவினரிடம் கொடுக்கப்பட்டுவ என உறுத் செய்கிறேன்.	•		-
மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரி	ிக்கப்பட்ட பிறகுதான் கையெ	பாப்பமிட்டேன்.	
		887	7
செவிலியர் கையொ: பம்	தேதீ	√ எனது/உறவினர்/காப்பா	ளர் கையொப்பம்

Date

Signature of Admitting Nurse

e paleboon (HUSBAND)

Signature of the Patient / Relative / Gurdian

Nature of Relationship



discharge.





Mrs.SHANMUGAPRIYA S 45/Female/MHi202381078 11/12/2023/IPH202302475 Dr.ANBARASU MOHANRAJ



GENERAL CONSENT FOR ADMISSION

I, S: SHANMUGIAPRIYA the
☐ 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

- 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	88T - T	S. SHANNUGAPRIYA	11.12.23	12.30
Surrogate/Guardian (if applicable #)	Shelm	B·SELVAKUMAR (Write name and relationship with patient)	11.12.23	12.30
Reason for surrogate consent	Patient is unable to give consent i	-		
Witness			11/12/2023	12.30
Interpreter (if applicable)				

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



Mrs.SHANMUGAPRIYA S

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.Anbarasu mohanraj





ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

s. I	ADMISSION CHITCHIA FOR INTENSIVE CARE UNTI	MARK	✓ AS
No.	PARAMETERS		PRIATE
	Hemodynamic instability defined as		}
	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		
	Mean arterial pressure less than 60 mm Hg		<u> </u>
	Diastolic arterial pressure more than 120 mm Hg		
	Respiratory rate more than 35 breaths/minute		
	Onedia tenantias Stratana		
	Cardio-vascular System		
	Acute myocardial infarction		
	Cardiogenic shock		
	Complex arrhythmias requiring close monitoring and intervention		
	Acute congestive heart failure with respiratory failure and / or requiring hemodynamic support		
2	Hypertensive emergencies		-
	Unstable angina, particularly with dysrhythmias, hemodynamic instability, or persistent chest pain		<u> </u>
	Post cardiac arrest		ļ
	Cardiac tamponade or constriction with hemodynamic instability		
	Dissecting aortic aneurysms		<u> </u>
. أ	Complete heart block		-
			
	Miscellaneous Conditions		
3	Septic shock with hemodynamic instability		<u> </u>
_	Hemodynamic monitoring		
	Clinical conditions requiring ICU level nursing care		1
	Doct was a drive a location of driving and drive and dri		i
	Post procedure elective admission		1
4	Post Coronary Angioplasty		<u> </u>
	Post Cardio-vascular Surgery	1	<u> </u>
ľ	Following angiographic procedure		
	Complication resulting from the angiographic procedure including any significant change in pulse in the		į.
	affected extremity, neurologic changes, persistent bleeding, or persistent nausea and vomiting post-		
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		<u> </u>
	Acute respiratory failure requiring ventilatory support (Invasive / Non-Invasive)		
	Pulmonary emboli with hemodynamic instability		-
	Patients in an intermediate care unit (HDU / Recovery room) who are demonstrating respiratory	_	
6	deterioration		
	Need for nursing / respiratory care not available in such intermediate care units		
	Massive hemoptysis	-	
	Respiratory failure needing imminent intubation		 `
 -			
	Renal failure		J
7	Oliguria or anuria for more than 12 hours		
	Metabolic acidosis (pH < 7.1)		
	Patients requiring hemodialysis can be performed in ICU when the blood pressure is borderline		i

S. No.			1	RK ✓ AS OPRIATE		
8	Diabetic insufficie Thyroid Hyperos Other er Severe hemody Hypo or mental s Hypo or muscular	ency, or severe acidosis storm or myxedema coma v smolar state with coma and/ ndocrine problems such as hypercalcemia (Serum C mamic monitoring hypernatremia (Serum Soc tatus hypermagnesemia with he	with hemodynamic instability, alter with hemodynamic instability or hemodynamic instability or Serum Gladrenal crises with hemodynamic instablacium more than 15 mg/dl) with all sium less than 110 mEq/L or more than 1 modynamic compromise or dysrhythmics sium less than 2.0 mEq/L or more than	ucose more than 800 mg/dl bility Itered mental status, requi 55 mEq/L) with seizures, alte	ring	
Doctor		Signature	Name Or - praugu	Reg. No.	Date 12/12/14	Time

DISCHARGE CRITERIA FOR INTENSIVE CARE UNIT

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

	Signature	Name	Reg. No.	Date	Time
Doctor				1 1	10,45
		lor mouch	112-222	14/12/2	





Every heart beat counts (A Unit of United Alliance Healthcare Pvt Ltd)

: 11/12/2023 - 17:10 hour:

: 17/12/2023 - 12:50 hour:

DISCHARGE SUMMARY

IP No.

: !PH202302475

THID

: MHI202381078

Hame

: Mrs. SHANMUGAPRIYA.S

Age / Gender

: 45Years / FEMALE

Consultant

: Dr. Anbarasu Mohan Raj, MS, DNB, M.Ch (CTVS), FRCS(Glasg) Director and Clinical lead - Cardio Vascular and Thoracic Surgery

D.O.S: 12.12.2023

Room No.: 208-TS

D.O.A

D.O.D

DIAGNOSIS:

TRIPLE VESSEL CORONARY ARTERY DISEASE

ACS - INFERIOR WALL MYOCARDIAL INFARCTION - NOT THROMBOLYSED

CLASS IV DYSPNEA

WILD PULMONARY ARTERY HYPERTENSION

MODERATELY SEVERE LV SYSTOLIC DYSFUNCTION - EF: 34%

UNCONTROLLED TYPE II DIABETES MELLITUS

MURCERY:

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 4 GRAFTS: LHMA TO LAD, SVG TO DI AND OM (SEQUENTIAL), SVG TO PDA DONE ON 12.12.2023

BRIEF HISTORY:

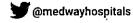
Mrs. Shanmugapriya.S, 45 years old female, a known case of Uncontrolled Type II Diabetes mellitus, Class IV dyspnea, ACS – Inferior wall myocardial infarction – not thrombolysed, Mild pulmonary artery hypertension, Triple vessel disease, Moderately severe LV systolic dysfunction, has come for CABG. Patient was apparently normal till 31.10.2023, when she developed sudden onset breathlessness which rapidly progressed to NYHA class IV. Initially, she went to Tagore Medical College and Hospital where she was diagnosed as ACS - Inferior wall myocardial infarction. She was managed conservatively and after medical stabilization she underwent Coronary angiogram on 02.11.2023 which showed Triple vessel disease. She then came to Medway Heart Institute on 29.11.2023 and advised early CABG. Patient and attenders were explained about the nature of disease, risks and prognosis of CAD and the need for revascularization. Currently, she is getting admitted for the same. No H/O Palpitations, Syncope or Swelling of Legs. No H/O CVA, CKD, BA, seizure disorder or Hypothyroidism.

93. 431 #9, 1st Main Road, United India Colony, Kodambakkam, Chennai

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@medway-hospitals



94457 94457 1800 572 3003

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Medway Centre of Excellence (Chennai)

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Mogappair 044-26530011

Kumbakonam

Chengalpattu 044-2473 4455 | 044-27426829 |

Villupuram 04146-242000

Heart Institute 044 - 4310 8959 Institute of Pulmonology 044-2473 4454

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

MHI/HOSP/2022/118





UHID: MHI202381078 | IPNO:

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ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

TEMP

98° F

HR

50bpm

BP

94/60mmHg

SPO₃

98% in room air

CVS

S1S2 (+)

RS

BAE (+)

Abdomen

Soft, non - tender

CNS

NFND

BLOOD INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	11.1	Male: 13.7 - 17.5	gms%
		Female : 11.2 - 15.7	
HAEMATOCRIT	35.9	39-52	%
TWBC	6,460	4000 - 10000	Cells/Cumm
NEUTROPHILS	58.7	40-80	%
LYMPHOCYTES	32.9	20 - 40	%
EOSINOPHILS	3.6	0 - 6	%
MONOCYTES	.11.2 '	0 - 6	%
BASOPHILS	0.6	0 - 2	%
PLATELET	1,96,000	Male: 1.5 - 3.5	Cells /cumm
	1	Female: 1.5 - 3.7	
Urea	21	14 - 40	mgs/dl
Creatinine	0.72	Male: 0.7 - 1.2	mgs/dl
	1	Female: 0.5 - 1.0	
		Child: 0.2 - 0.8	
Sodium (Na+)	139	135 - 145	mmol/I
Potassium (K+)	4.46	3.4 - 5.5` · !	mmol/I
T. Bilirubin	0.83	0.2-1.0	mg/dl
D Bilirubin	0.28	0.00 - 0.4	mg/dl
I. Bilirubin	0.55	0.4-0.6	mg/dl
S.G.O.T	15	<38	U/L
S.G.P.T	10	<41	U/L
ALP	75	Adult: 42'- 141	U/L
GGT	19	Male: 10 - 45	U/L
		Female : 5 - 32	
Total Protein	7.1	6.0 - 8.0	gm/dl
S. Albumin	3.9	3.5 - 5.0	gm/dl

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MHI/HOSP/2022/118





UHID: MHI202381078 Every heart be

(A Unit of United Alliance Healthcare Pvt Ltd)

НВА1С	11.9	Normal: Below 6.0 Good control: 6.1-7.0 Fair Control: 7.1-8.0 Unsatisfactory: 8.1-10.0 Above 10: poor control (GHB is an index of your blood Sugar control for the past (3 months)	%
T.S.H	1.52	Adult: 0.25 - 5.0 New born- 4days: 1.0-39.0 Child upto 14yrs: 1.0-9.0	UIu/ml
Т3	. 79	"Adult: 60 - 152 New born - 4 days: 96 - 730 1 - 11 Months: 102 - 243 1 - 9 yrs: 89 - 237	ug/dl
7.4	7.6	"Adult: 4.6 - 9.3 New born - 4 days: 11.0 - 21.3 1 - 11 months: 5.8 - 16.1 1 - 9 yrs: 6.3 - 13.16	ug/dl

ECG: 108bpm, sinus tachycardia, Q wave in lead III and aVF.

ECHO: EF CALCULATED BY SIMPSON'S METHOD LV EDV: 121ML, ESV: 80ML, EF: 35%, DILATED LA AND LV. OTHER CHAMBERS NORMAL IN SIZED, REGIONAL WALL MOTION ABNORMALITY PRESENT - BASAL INFERO LATERAL, BASAL ANTERO LATERAL CONTRACTING, REST OF THE SEGMENTS HYPOKINETIC, MID AND APICAL SEPTUM, APEX THINNED, MODERATE LV SYSTOLIC DYSFUNCTION, EF: 35%, NORMAL RV SYSTOLIC FUNCTION, RV TDI: 10CM/S, TAPSE: 18MM, ALL VALVES STRUCTURALLY NORMAL, IAS/IVS INTACT, AORTIC GRADIENT - MAX GRADIENT - 6MMHG, MEAN GRADIENT - 3MMHG, GRADE II DIASTOLIC DYSFUNCTION, TRIVIAL MR, TRIVIAL TR, MILD PAH, MODERATE BILATERAL PLEURAL EFFUSION, MINIMAL PERICARDIAL EFFUSION ANTERIOR TO RV AND BEHIND RA, NO CLOT/ VEGETATION. GLOBAL LONGITUDINAL STRAIN: 8.3% (NORMAL 18% TO 22%)

CXR: PA film, lung fields clear, CTR – 0.5 %, mild bilateral pleural effusion.

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Heart Institute 044 - 4310 8959 Institute of Pulmonology 044-2473 4454





UHID: MHI202381078

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COURSE IN THE HOSPITAL:

Mrs. Shanmugapriya.S, 45 years old female, was admitted with above mentioned complaints. She underwent OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 4 GRAFTS: LIMA TO LAD, SVG TO D1 AND OM (SEQUENTIAL), SVG TO PDA ON 12.12.2023. She was shifted to SICU with stable hemodynamics and nil supports. She was extubated on the same day (12/12/2023) at 20:30 hours. Drains were removed on POD1 (13/12/2023). She was shifted to ward on POD 2 (14/12/2023). Suture removal was done on POD4 (16/12/2023). Patient course in the hospital was uneventful. Her medications are optimized and she is being discharged in a stable clinical status.

POST OP INVESTIGATIONS: BLOOD:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	9.3	Male: 13.7 - 17.5	gms%
		Female: 11.2 - 15.7	
HAEMATOCRIT	25.7	39-52	%
TWBC	9310	4000 - 10000	Cells/Cumm
POLYMORPHS	63.5	40-70	%
LYMPHOCYTES	31.6	, 20 - 40	%
EOSINOPHILS	2.5	0 - 6	%
MONOCYTES	2.4	0 - 6	%
PLATELET	173000	Male: 1.5 - 3.5	Lakhs/cumm
	•	Female: 1.5 - 3.7	
Hrea	i 28	14 - 40 , (, ())	: mgs/dl
Creatinine	0.80	Male: 0.7 - 1.2	mgs/dl
	1 4	Female: 0.5 - 1.0	•
		Child: 0.2 - 0.8	
Sodium (Na+)	138	135 - 145	mmol/l
Potassium (K+)	3.80	3.4 - 5.5	mmol/l

ECG: HR – 84bpm, sinus rhythm, Poor R wave progression in anterior leads, VPC (+), Q wave in lead III and aVF.

ECHO: S/P CABG, DILATED LA AND LV, OTHER CHAMBERS NORMAL IN SIZED, REGIONAL WALL MOTION ABNORMALITY PRESENT - BASAL INFERO LATERAL, BASAL ANTERO LATERAL CONTRACTING, REST. OF THE SEGMENTS HYPOKINETIC. MID AND APICAL SEPTUM, APEX THINNED, MODERATELY LV SYSTOLIC FUNCTION – EF: 34 %, NORMAL RV SYSTOLIC FUNCTION, RV TDI: 11CM/S, TAPSE: 16MM, ALL VALVES STRUCTURALLY NORMAL, IAS / IVS INTACT, AORTIC GRADIENT - MAX GRADIENT - 8MM HG, MEAN GRADIENT -- 5 MM HG, GRADE II DIASTOLIC DYSFUNCTION, TRIVIAL MR, TRIVIAL TR, MILD PAH, MILD BILATERAL PLEURAL EFFUSION, MINIMAL PERICARDIAL EFFUSION .\NTERIOR TO RV AND BEHIND RA, NO CLOT / VEGETATION.

CXR: PA film, sternal wires seen, CTR – 0.5%, lung fields clear, BVM (+), Minimal bilateral pleural effusion.

#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel: 044 - 4310 8959 94457 94457 @MedwayHospitals in @medway-hospitals (O) @medwayhospitals @medwayhospitals 1800 572 3003 **Medway Group of Hospitals** Medway Centre of Excellence (Chennai) Kodambakkam Institute of Pulmonology Mogappair Kumbakonam Chengalpattu Villupuram **Heart Institute** 044-2473 4455 044-26530011 044-2473 4455 044-27426829 04146-242000 044 - 4310 8959 044-2473 4454 E-mail: info@medwayhospitals.com | Website: www.medwayhospitals.com | CIN: U74900TN2011PTC083665 MHI/HOSP/2022/118





Institute
UHID: MHI202381078
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CONDITION ON DISCHARGE:

HR

- 74/min

BP

106/72mmHg

SPO₂

98% in room air

ADVICE MEDICATIONS:

S1	NAME OF THE DRUGS	STRENGT	DOSAGE	FRI	QUEN			RELATIONSHI	DURATION
VO.	WITH GENERIC NAME	н	DOSAGE	M	A	N	E	P WITH MEAL	DURATION
I	TAB. CLOPITAB A (CLOPIDOGREL + ASPIRIN)	l TABLET	75MG / 75MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. ROSUVAS (ROSUVASTATIN)	1 TABLET	40MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. BETALOC (METOPROLOL)	1 TABLET	25MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB.LASILACTONE (FURSEMIDE + SPIRONOLACTONE)	l TABLET	50MG/ 20MG	1	0	0	ORAL	AFTER FOOD	X 2WEEKS
5	TAB.PARACIP (PARACETAMOL)	1 TABLET	500MG	1	0	1	ORAL	AFTER FOOD	SOS (IF PAIN OR FEVER)
6	SYP. CREMAFFIN PLUS (SODIUM PICOSULFATE+ LIQUID PARAFFIN + MILK OF MAGNESIA)	15ML		0	0	1	ORAL	AFTER FOOD	BED TIME (IF CONSTIPATI ON)
7	TAB. BEPLEX FORTE (ANTIOXIDANTS +MULTIVITAMINS+ MULTIMINERALS)	I TABLET	ı	1	0	0	ORAL	AFTER FOOD	I MONTH
8	SYP ALEX PLUS (DEXTROMETHORPHAN HYDROBROMIDE + GUAIFENESIN + PHENYLEPHRINE + CHLORPHENIRAMINE MALEATE)	10ML	-	0	0	1	ORAL	AFTER FOOD	BED TIME (1 WEEK)
9	TAB.ANXIT (ALPRAZOLAM)	1 TABLET	0.25MG	0	0	1	ORAL	AFTER FOOD	X 5 DAYS

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DIABETIC MEDICATIONS:

51.	NAME OF THE DRUGS	STRENGTH	DOSAGE	FRE	FREQUENCY		ROUTE	RELATIONSHIP	DURATION
NO	WITH GENERIC NAME			M	A	N		WITH MEAL	
1	TAB. GLIZATO M (GLICLAZIDE + METFORMIN)	I TABLET	80MG/ 500MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
2	TAB. TRAJENTA (LINAGLIPTIN)	1 TABLET	5 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
3	INJ. HUMAN MIXTARD (INSULIN ISOPHANE/ NPH (70%) + HUMAN INSULIN/ SOLUBLE INSULIN (30%)			25.º0	_	100	S/C	BEFORE FOOD	TO CONTINUE
4	TAB.FORXIGA (DAPAGLIFLOZIN)	1 TABLET	10MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE

DISCHA	RGE ADVICE
DIET	HIGH PROTEIN, LOW SALT
	LOW FAT AND DIABETIC DIET
PHYSICAL ACTIVITIES	RESTRICTED.
FLUID RESTRICTION	1800ML/DAY
	REVIEW WITH
REVIEW	DR. ANBARASU MOHANRAJ AFTER
	22/12/2023 WITH FBS, PPBS, HB,
٠.	UREA, CREATININE, SODIUM,
	POTASSIUM, CHEST X RAY

To report: If fever> 101 'F / Difficulty in breathing / Headache / Giddiness/chest pain/ Groin swelling/bleeding / discharge at operated site/ Any other significant symptoms. In case of emergency Contact: Medway Hospitals @ 044 -43108959.

Typed by: S.Hari / Kalai

CONSULTANT SIGNATURE

Dr. ANBARASU MOHANRAJ Reg. No: 55476

Dr. Anbarasu Mohan Raj, MS, DNB, M.Ch (CTVS), FRCS (Glasg) Director and Clinical lead - Cardio Vascular and Thoracic Surgery

"I understood the Content of the dischorge Summary,"

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institute of Pulmonology 044-2473 4454

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Mrs.Shanmugapriya S 45/Female/MH1202381078 11/12/2023/IPH202302475 Dr.Anbarasu mohanraj



INPATIENT INITIAL ASSESSMENT

NAME OF THE PROPERTY OF THE PR
Date: Time of arrival in ward: 12.50
Allergies (if Yes, specify details):
Drugs ☐ Yes ☐ No
Blood Transfusion
Food Yes No
Others
Vital Signs: Temps: 1 (°F) Pulse / HR: 5 (beats/min) BP: 91 6 / (mmHg) Respiration: 20 (breaths/min) SpO₂: 2 3 (%) Height: 15 (cms) Weight 6.5.11 (kgs) BMI: 2.3 (9 M)
Pain: Yes No. If Yes, Score: CONDESTINATION NO. If Yes, Score: CONDESTINAT
Pain Character: Dull Aching Sharp Stabbing Shooting Burning Referred / Radiant Pain
CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS Yoyrs old year Jensele K/c/o 72 Dm, ACS-
evolved Iwm? _ Not thrombolysed, Anemia, TVD, Anderate Ly
dysfunction, has came for CABG. Partient was apparently (D)
till 34-10.23 When she Leveloped Sudden met Shortness of
breathlessnes NY HA Class - IV. Inthally she went to Tagore medial
PAST MEDICAL HISTORY (with duration of illness): Diabetes Mellitus: Yes \(\text{No. If Yes, duration:} \) Hypertension: \(\text{Yes PNo. If Yes, duration:} \)
Others: Nkicho Bronchial Asthma) COPD/Pulmonary
tuberaulonis
Past Surgical History: Nil and Conservadrely - The Underwent Coronary Angiogramy 070 2/11/21. Which Showed
and conservatively - The Underwent Coronary
ND.
- har the check laws la protection tone.

S. O.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
,	7. Sacurise	100004	86	0-01/2	7/12/23	☐ Yes 🗹 No
	Tilde Plus	10/25m	Pb	100	11/12/23.	✓ Yes □ No
	7. Irban	Smp	Pb	Hal	11/12/23	☑ Yes □ No
ŀı	T. Chopilet	754	Ph	101	7/12/23	□Yes ØNo
•	T. Ecospisin AV	75)401	y Pb	001	7/12/23.	☐ Yes Ø No
-	7. flavedon mR	35mg	Pho	101	11/12/23.	√ Yes □ No
7	T.080 Jen XT	Hab	12/10	001	h .	Yes □ No
,.	T. Homo Chek.	Itab	16	100	'n	☐ Yes ☐ No
	T. Pantociá D	Itab	Pla	101	h	Z Yes □ No
(7)	Suj. Human Actrapid		S)c	60-60-60	ر م	✓ Yes □ No
り	ily History: Try'. Human mixtark Ni'L					
e	rsonal / Social History (Tick which	ever is ap		Tendo		
Pe Lif	N;Z	ever is ap	ation:	leacher	I Drug Use: ∐ Yes,⊠	No
Pe Lif	rsonal / Social History (Tick which estyle: Sedentary Active	ever is ap	ation:	leacher	•	No
e.if	rsonal / Social History (Tick which estyle: Sedentary Active noking: Yes No Alcohol hers:	ever is ap Occup : Yes e filled up	ation: No o for fema	Recreationa He patients):	•	No
e.if	rsonal / Social History (Tick which estyle: Sedentary Active noking: Yes No Alcohol hers:	ever is ap Occup :□ Yes □ e filled up	ation:	Recreationa He patients):	•	No
e.if	rsonal / Social History (Tick which estyle: Sedentary Active noking: Yes No Alcohol hers:	ever is ap Occup :□ Yes □ e filled up	ation:	Recreationa He patients):	•	No
Pe Lift Sn	rsonal / Social History (Tick which estyle: Sedentary Active noking: Yes No Alcohol hers:	ever is ap Occup :□ Yes □ e filled up	ation:	Recreationa He patients):	•	No
Pe. Lift Sn Ot er	rsonal / Social History (Tick which estyle: Sedentary Active noking: Yes No Alcohol hers:	ever is an Occup: Yes Defilled under the defiled and	ation:	Recreationa He patients):	•	No

SYSTEMIC EXAMINATION	
CVS:	~
S1520	
Respiratory System: BAED, no added Sounds	
BHC (b) Ma concer controls	
Gastrointestinal System:	
Søft, Ni, no organomegaly	•
Central Nervous System:	-
NO fo cal neurologient defrint	
Urinary / Reproductive / Locomotor System:	
Skin / Opthalmic / ENT	
Suspected of contagious disease: Yes No Immuno compromised status: Yes No Isolation required: Yes No, if yes, Contact Airborne Droplet	
Psychological Evaluation: Normal Anxious Depressed Others:	-
Nutritional Screening (ESPEN Guidelines for Nutritional Screening - NRS 2002):	
Weight loss within the last 3 months? ☑Yes ☐ No Is the patient severely ill? (e.g. in Intensive Therapy) ☐ Yes ☑	Νο
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: 72Dm (AD-TVD) Moderate LV/D EF-357.	
Plan of Care: Plan! CABGN GA - Monitor Ntals	
- Monitor vitalis	
- To follow dry chart	
- To follow: dry chart - To get Anasthedres Athers and - Consent - Consent	
Leg No: 55476	

Parts & Breparation.

Investigations Ad	lvised:					
		,		-	-	.v.
	Report	, enclos	ed.			
•		- :				
		·				
Diet Advice:			•			_
☐ Nil per Oral	Clear liquid diet [Normal liqui	d diet	☐ Diabetic I	iquid diet	
Semisolid diet	☐ Soft solid diet		normal diet	<u></u>	lian normal d	iet
☐ Neutropenic liquid		ou salt				
Early Discharge Plan	nning (fill in those which are a	ppropriate at thi	s stage):	PFE: Pa	tient Family E	Education
Special support need	led at home	□ Yes ☑ No	If Yes, PFE	done		
Home equipment ant	icipated	☐ Yes ☑ No	If Yes, PFE done and equipment advised			
Physiotherapy at hon	ne anticipated	☐ Yes 🗹 No	If Yes, educated on physical limitations, if any			
Wound care needs a	nticipated at home	☐ Yes ☐ Ño	If Yes, educated on signs on infection			
Pain Management		☐ Yes ☑ No	If Yes, PFE done and medication advised			
Special Dietary need	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 neèd, i.e.:	. □ Yes □ No	If Yes, PFE	If Yes, PFE done		
Nature of post hospital needs like patient safety, infection control, fall risk, etc, addressed		☐ Yes ☐ No	If Yes, specific education given			
Others:						
			<u>.</u> :	•		
			· ,			
	Signature	Name		Reg. No.	Date	Time
Resident Doctor	9000	Dr. Mohan	ed Hydron	1623.09	11/12/23	16.00
Consultant	Dr. Anbarasu Moha Reg No: 55476		ARAŠU	35478	111223	16,00
Patient Attendant	S. Lahly	Relationship	· ,	· 🚅	ו בבל מלוו	100

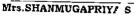
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The way to better health



45, Female/MHI2023811/8



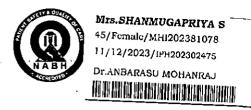




Every heart beat counts

11 12/2023/IPH20230 475 **DOCTOR'S PROGRESS NOTES** Dr ANBARASU MOH INRAJ **NOTES** 11.12.23 BB DJ-Anysuye 11.30PM) A case Of CAD-TVD parient reviewed clo chest poin on a tob Potient conscious, oriented, Agebale. CUS-5152(P) RS - BDEP vitals stable Advice POSTOD FOR CABUT TOMOGRACO oversomet mad most agu - consent parts Preparation _ Pre-modication. shift to otonicall.







	DOCTOR'S PROGRESS NOTES
DATE	NOTES
12/12/23	Mrs. shanmugapriya 454/F underwent openBX4
@16.65	Jimp yon, svy & D, S, ord (eq), wy > ppA.
	she was shifted to sice i following hemodynamics
	MR-94Bpm CVP-Jemonty
	BP-116/68 months SPO2-100x DA vantilation
	ventilation:
	Mode: VCV; Flog: 60%. peop: 5 mothy
	Supports:
	N/C
	Plan
-	Wood & estudate when fully awake
	Por P 112-216
	Do Doparase
	PA: Kartlika
,	(mH10216)
	-
	,
	<u> </u>

	
DATE	NOTES
13/12/2023	S/B Dr. Anharas u DR Rajesh IDX praveen
8:00	/10/1-/
	S/p OperBX 4 greefts
Hb -9.6	patient coscious, oriented, afebrile
Urea -21	B/2: 135/62 mm 149
(ret ~ 0.48	5/10: 94% anyoumary
	14R: 106 bjim
	I/o: 1835ml/1897ml balance-62ml.
A/3 u.	Adequak wine output on ucoth
p1+ - 7.4	Tolcrating oral feeding
1100-34.6	rempheries felt worm
110, -78.1	Supports Nill
14(0, -23.6	Drainage: 520ml.
BE-04	
HB 11.8	
Nat - 138	
K+ -4.4.	
	<u>plam</u>
RBS - 145mgloft	-> Pof/. 5 likes perday
0	-> Remove drains
	-> Chist physio & Mobil
	-) Nebulization
	-> Spircemetery
	7. HEIOPROZOL 25-mg 1-0-1
	-> T. CLIEATO MSO 1-0-1 (BF
	-> 7. TRAJENTA Sing 1-0-1 (8)
	3 TI FERMEN LONG 150-0 ()
I	Sporer - Ship to Jev B





Mrs.SHANMUGAPRIYA S 45/Female/MHI202381078 11/12/2023/IPH202302475 Dr.ANBARASU MOHANRAJ



Every heart beat counts

DOCTOR'S PROGRESS NOTES

·	DOCTOR 3 TROORESS TROTES
DATE	NOTES
14/12/2023	SB: Dr. proparase Dr. Rajest Dr. Proveen
@ 8 .20	
	sle: opens x 4 grafts.
€00412	patient comportable.
Hb - 9.8	Of conscious, oriented, Afebrile
· u - 27	·Bp-96/64 mmtg.
Cr - 0.57	.HR-112 Bpm.
Ma- 135	8P0 - 91, y. pp mon ali
k-3.89	1010 - 2506ml 2755ml; Bal 1249mL
	· c. cath removed
RRS-LbRong	de Adaquate wine output plan
	RF-1.5 lit res lday
	· Cood chest physic
	mobilize
	· Nahilization & spirometry
	Sheft to word after solfvoid
	<u> </u>

DATE	NOTES
14/12/23.	8/B. Dr. Sujith. Cono)
10:30 tm	3/PF OPCAB XUQUAR
LOOD	-bt. received in word.
170	<u></u>
Bb 1001	- pri- reviewel
Ph-lapton	18th 2014 nos silende on
V, 70	M / N A N A N A N A N A N A N A N A N A N
302	orested.
	Al Isle
	8/B-W3-5,920
	RR-RAB P
	PA-ROSA; HTND
	- Adv
	- chestply:0
	· Chentfry
	- wood warmi
,	- webel 204°0 - 4 sprovery - vitale monitory - w/4 distres or desature
	- w/I distres of desature
-	1507 155





Mrs.SHANMUGAPRIYA S 45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.Anbarasu mohanraj



_____ y heart beat counts

	DOCTOR'S PROGRESS NOTES
DATE	NOTES
14-12-23	3/B Do · Anuslug
5-30PM	Post opace to openby Agrants - patient reviewed clo: mild pain in the surgical site ote: potient conscious, oriented, Atlebnile sts: cvs -5162(P) HE: Dressing inlact ps - BAE(P) PR- Island Uitals! HR-RUDIM RR-18/min BP-110/20000000000000000000000000000000000
	- monitorité de la per chart plan auture remount on 15-12-23
-Killing	- mobilise the patrient - continue the chest physio of spixometry.

DATE	NOTES
14/12/23	SIB-Dr. Harri Vignerh (DMO)
11-30PM	DA reviewd
Jitah Stoll	Of E. On foils Pt. comer Ornhad
	SIE-LUS-S,S,D AS-BLAED (NS-NFND P14-SOft-
	- SR on 16/12/23
	- Sk on 10/12/25 - Check Physio- (spirometry) - Nebulinetion - Mobility fruit
L	<u> </u>





Mrs.SHANMUGAPRIYA S 45/Femalc/MHl202381078 11/12/2023/sph202302475 Dr.ANBARASU MOHANRAJ



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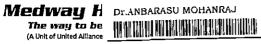
	DOCTOR'S PROGRESS NOTES .
DATE	NOTES
15 1223	S/B Do Anusuya
	5/P OPCABX HATOHS
9-00AM	. Patient reviewed.
	do: mild pain in the surgical site:
(PDD - 2)	OB: Patient conscious, wiented, Atebrile.
	6/8 : Cro-5,52(P). ME! Dressing antact
	no sodkage.
	CNS-NEND
	P/A - 607t / non-fender
	vitals: HR-86b/m RR-20/men
	BP - 110/70mmHg Sp02-98/-RA
	A UICE
	- mo nitos otals
	confinue the days as perchas
V. DO	- Plan: Suture removal on 17.12.23 - mobilite the Patient
13697	
	- Confinue Chest Physic of Spixometry

DATE	NOTES
	,
15/12/23	c/r/B-12r. An Elargo (Druo)
(N C 100 100 100 100 100 100 100 100 100 1	
10:00 / m	- pt. reviewed no yo-palpitulion.
	• •
12-93 Just	Yo-mild pour over ex sett.
30 mg	ofe: consirou, overted, afebrile
PR - 20 WW	· ·
Bo- 1017 . () 8/E:
SM-0147.	(Nos: 21 120)
	18: BAE
	P/A: 50/2.
	Adv9ce!
	- Follow up dung onland
	- monitor Vibuls
	- subme renoval on
	17/12/23,
	- mobsin pt.
- +	= 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	- consume chart johns
	Translay

.



Mrs.SHANMUGAPRIYA S 45/Female/MHl202381078 11/12/2023/IPH202302475







MHI/IP/2022/041

Heart
Institute

Every heart beat counts

	DOCTOR	'S PROGRESS NOTES	
DATE		NOTES .	
		S/R Dr. Mohamed Hydrons	
vs61m	1/23	<u> </u>	
	laum.	Post of case of OPCABX 4	refts .
		POD-18.	1,2
	·	Patient Cousins	
		Dirented	
	Vijah	Afebiuli	
	80- 18/min	CVL-2 S1S- (P)	
	RUR- 18 MARTINE	CVS-2 S1S2P) RS-2 BA EP P/A-2 SOJA, NI	
	Ru- 1821 dag	P/A-2 SS/A-2 NT	
	· 8002 -98.1		
			Adv
			- Monider vilaly - To fllow drup Chart
			- To fllow drup
	-		
		·	< mobilise the
			Patant
	- t		- Spromedy
	<u>-</u>		Chart Physis
	-		No do Patop
	· · · · · · · · · · · · · · · · · · ·	_	Investigation
	<u> </u>		- Sprishedy/ Chost Physis To do Rot op Introduction ECG, ECHO, CXRPDIDE
		<u> </u>	CXR (BYRL
			Mb se

DATE	NOTES
16.12.23	3/B DO ARUSCUJO
6.30Pm	de propor horate
	SP OP COBX 4 GOOTES
11)	Pathent devieused,
(POD - H)	CO Pain in the
	John Marian Mari
16/12/23	
TV IIV IIV	Clb Da Com To
9-069m	S/B Dr. suprh
· · ·	gro new amplant at part
vitcus: Stuh	
	0 (E pt
	lec-fecti /afes vi / PD / PEO Acw
	CW PRAD - CST - VITALI MNOM
-	- PIA: SOYERSTO BP/PTK/FOCH
-	The second secon
	0/2/10/10/18/18/18
17/12/23	3/8-Dr. Sojith.B (Dr.) 134
- a	
N,	H'reviewed. + No worklands
	ele let in Solve
ial)	Se-cus-sisiffice Period Relia
18	8/P-CUS-5, (4) PB-BAR(4), (41-10/4)
1	Adv
	- wital, non'an'
	- Follow dy dut
	- De sol.
	-(D) 16 dy 1
	7
	D(AS



Mrs.SHANMUGAPRIYA S

45/Fernale/MHl202381078 11/12/2023/IPH202302475

Dr.Anbarasu mohanraj





MH1202381078

MEDWAY HOSPITALS CARDIAC SURGICAL CHECK LIST

Name Mrs. Shanmugaporya.	Age 45/F UHID
Diagnosis Type II Drabeto mellika Linder Evolved (WM) Serology Moderate W dysfindus;	Plan CAB4. F. trosprings from fro
EURO Score / STS Score (, 13 %	PRE OP DRUGS (ACE/ARB/ANTIPLATELETS):
Diabetes Mellitus (HB1AC)	Associated Illness
Carotid Doppler	T3-19 Thyroid Enzymes T3-1-1-57
Sr. Creatinine 0.72	Any other illness of concern
Allen's Test	Myocardial viability if needed
Varicose Veins	
Pulmonologist Clearance	Nephro Clearance:
Neurology Clearance :	Dental Clearance:
Mitral Regurgitation Assessment Trival mR	
Nursing: ~	Billing Clearance:
Physiotherapy	Spirometry taught
Concerns from Surgical Team :	Spirometry taught Signature:

Mrs. Manmugaphya tulvakunar, fizyear old male, a known cane of Diabeteo melletm, Acs-Evolvad INMI - not Thromtolyped, Anemia, triple vence disease, moderate w dyspunction, has come for coise a patient was apparently normal tril. 31.10.23 when the developed Breakling difficulty which rapidly progressed to Ridden ondet Breakling difficulty which rapidly progressed to Mytha class W. Initially, the went to ragore medical college. Mytha class W. Initially, the went to ragore medical college. Anytha class W. Where the was diagnosed as INMI.

and hospital Where the was diagnosed as INMI.

The then underwent coronary anglegram on the then underwent coronary anglegram of the then came to MH ION 29/11/2023 which showed to put sense disease.

The then came to MH ION 29/11/2023 who and advised the then came to MH ION 29/11/2023 who are advised.

Tonly contin. No Opalpritation / swelling of legs fapriops.

Surran Just



CHENNAI: # 2/26, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024.

Tel: 044 - 2473 4455 | Mobile No: 9962 985 985

KUMBAKONAM: No. 142-B, Sri Balasubramaniyan Nagar, Pilliyam Pettai, Ammachathiram (Post), Thiruvidaimarudhur (Taluk), Kumbakonam - 61 2103. (Taniore Dist). Ph: 0435 - 2412345 | Mob : 7397720491

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

	— 45/Female/MH1202381078	2-OPERATIVE CHECKLIST		
Name :	11/12/2025, PH202302475 Dr.ANBARASU MOHANRAJ	Age: Gender:	UHID No. :	
Ward:		Bed No. :	B.S.	A.S.
	Clinical Diagnosis :			
	CAD -	TVD		
-	Proposed Procedure :			
	CABO	Ĵ		
		CHECKLIST		
1.	Identification Band on Hand	d Checked ?		
2.	Surgical consent Signed? a. Special Consent signed	f required. $\sqrt{\epsilon}$ 8		/
3.	Anesthetist Consultation (If	required?) Ye.g		
4.	History AND Physical Onch	art?		
	a. Heightしたら、ことつ	b. Weight 63.4 Kg/m ²		
5.	Allergic to drugs? NKD	A	<u> </u>	
6.	Surgical Preparation done	? Yeg	<u>.</u>	swort cas
7.	Nill by Mouth From5	<u> </u>		7
8.	Blood Grouping & Rh Typir	ngB+VC		7
9.	Investigation			
	☐ X-Ray ☐ ECC	G D-LAB		
10.	Blood SugarH.mg	dl. Time 17:30		7
11.	TPR Chart Pulse 82.6/M. Temp.	97°F BP 130/70 BR 206/n	2	3/
12.	Time Voided a. Retention Yes	□ -Mo	~	cashetenz
13.	Enema Yes	NO NO	1	1

14.	a. Prosthesis Removed		-
15.	Valuables and Jewellery Removed ☐ Yes ☐ No Secured ☐ Yes ☐ No	_	
16.	Pre-Operative Medication Admistered 168 a. Time 20:00 b. Nurse 281NUS	Ś	
17.	Blood Transfusion requisition Onchart 1 PCV		
18.	X-Ray No	J	
	ECG/ECHO		
	Ultra Sound	,	
	C.T. Scan		
	MRI Scan		
	TMT		
	Medication		
	11/12/23 T. PAN 40mg H8	\sim	
	T. ALPRAX 0.5 mg H8 Ju		
	0084		
	12/12/23 7. PAN 10mg 2.00	~	
	T. ALPRAK OSMQ 5-00		
	Others Obes		

Nurse Signature





Mr./Ms./Mrs ... Shanny Ga. P.R. Ya. ... _____ The Patient or Representative of patient have (Please





k correct option and below):

Read

need arises.

CONSENT FOR SURGERY

	//////////////////////////////////////
	Been explained this consent form in English, which I fully understand and understood the information
	provided about the diseaseCARANARYARTERY PISEASE /TRIPLEVESSEL DISEASE and about the
	procedure
	given below in this consent form)
1	I am now aware of the intended benefits, possible risks and complications and available alternatives to the said operation / procedure. I am also aware that results of any operation / procedure can vary from patient to patient and I declare that no guarantees have been made to me regarding success of this operation / procedure. I am aware that while majority of patients have an uneventful operation and recovery few cases may be associated with complications. I am aware of the common risks and complications associated with this operation / procedures and understand that it is not possible to list all possible risks and complications of any operation /
	procedure.
	I have been told about additional procedure that may be come necessary during the surgery which includes
	I have been told about additional procedure that may be come necessary during the surgery which includes
	I have been told about additional procedure that may be come necessary during the surgery which includes Receptorities, IASP insulting
	I have been told about additional procedure that may be come necessary during the surgery which includes Receptor 1. 148P. 1994. I also understand that sometimes a planned operation / procedure may need to be postponed or cancelled if patient's clinical condition worsens or due to any unforeseen technical reason. I am also aware that I can withdraw my consent at any point of time at my own risk and consequence by submitting the withdrawal in writing.

I am also aware of the expected course after the operation / procedure and the care to be provided and understand that sometimes admission to an Intensive Care Unit and or extension of duration of hospitalization may be required and or there may be requirement of extra medicines or treatments thereby leading to increase in the treatment expenses depending upon the body's response to the treatment / procedure.

" Anostasu Moha"

and paramedical team and that the doctor may seek consultation / assistance from relevant specialists if the

Possible risks & complications 1. Bleeding 2. Infection 3- Shake
4. Arrythmio 5. Prelonged Icu skuy 6. Mild nisk to life
- Benefits Symphon free survival
- Alternatives High righ PTCA.
• The likelihood of success of the surgery (Percentage / Other commands) 927.
Possible results of non-treatment 1. Myocordial infention

I declare that I have received and fully understand the information provided in this consent form, that I have been given an opportunity to ask questions relating to my ailment, the operation / procedure being performed, its risks, consequences, alternatives, potential complications and intended benefits and recovery 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 sign this form.

2. Heart Failure.

DETAILS	PATIENT / RELATIVES	WITNESS
Name (in BLOCK LETTER)	887 R	* S. Laken
Relationship	SELF [PATIENT)	(Monther)
Signature	80° K	'S. Lateli
Date & Time	11/12/20 @ 19-00	11/2/23 @ 19.00
Name & Signature of Doctor with Registration No.: Dr. PRANESU TEYAKUMAN		

112236.

Dr. Anbarasu Mohanraj Reg No. 55476

Doctor Seal







நேருபாளி விவரங்க	ள்:(Affix Label here)
លាការ្យ :	
UHID :	
விறந்த தேதி :	பாலினம் :

அறுவை சிகீச்சை ஒப்புதல் படிவம்

நான்பிற்கு நாயாளி குல்லது நோயாளியின் பிரதிநிதி தயவுசெய்து மேலேயும் கீழேயும் பொருத்தமானவ
தர்வு செய்யவும்
பழ்யுங்கள்
எனது / என் நோயாளியின் தற்போதைய மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளேன்.
ந்த ஒப்புதல் படிவம் ஆங்கிலத்தில் விளக்கப்பட்டுள்ளது. இந்த ஒப்புதல் படிவத்தில் கொடுக்கப்பட்ட சிகீச்சையின் செயல்பாட்டின் முழுப்பெட
சயல்முறை பற்றிய தகவல்களை நான் முழுமையாகப் புரிந்து கொண்டேன்.

- நோக்கம் கொண்ட நன்மைகள், சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்களைப் பற்றி நான் இப்போது அறிவேன். மேலும் அந்த செயல்பாடு / நடைமுறைக்கு மாற்றுகளை கீடைக்கச் செய்கீறேன். எந்தவொரு செயல்பாட்டின் / நடைமுறையின் முடிவுகளும் நோயாளியிலிருந்து நோயாளிக்கு மாறுபடும் என்பதையும் நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையின் வெற்றி குறித்து எந்த உத்தரவாதமும் எனக்கு செய்யப்படவில்லை என்று நான் அறிவிக்கீறேன். பெரும்பாலான நோயாளிகளுக்கு சீரற்ற செயல்பாடு மற்றும் மீட்பு இருக்கும்போது சில வழக்குகள் சிக்கல்களுடன் தொடர்பு படுத்தப்படலாம் என்பதை நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையுடன் தொடர்புடைய பொதுவான அபாயங்கள் மற்றும் சிக்கல்களை நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையுடன் சாத்தியமான அனைத்து அபாயங்களையும் சிக்கல்களையும் பட்டியலிட முடியாது என்பதை புரிந்து கொள்கீறேன்.
 - நோயாளியின் மருத்துவ நிலை மோசமாக இருந்தால் அல்லது எதிர்பாராத எந்தவொரு தொழில்நுட்ப காரணத்தினாலும் சில நேரங்களில் திட்டமிடப்பட்ட செயல்பாடு / நடைமுறைகளை ஒத்திவைக்க அல்லது ரத்து செய்ய வேண்டும் என்பதையும் நான் புரிந்து கொள்கிறேன். எனது சொந்த ஆபத்து மற்றும் விளைவுகளில் எந்த நேரத்திலும் எனது ஒப்புதலை நான் திரும்பப் பெறுதலை எழுத்துப்பூர்வமாக சமர்ப்பிக்குவதன் மூலம் திரும்பப் பெற முடியும்
- மருத்துவரால் தேவையான செயல்பாடு / நடைமுறையின் போது அல்லது அதற்குப் பிறகு இரத்த மற்றும் / அல்லது இரத்த தயாரிப்புகளை எனக்கு நீர்வாகம் தேவைப்படலாம் என்பதை நான் அறிவேன் ஒரு தனி ஒப்புதல் பெறப்பட வேண்டும்).
- இந்த அறுவை சிகிச்சை / நடைமுறையின் போது மருத்துவர் மற்றும் துணை மருத்துவக் குழுவால் உதவப்படுவார் என்பதையும், தேவை ஏற்பட்டால் தொடர்புடைய நிபுணர்களிடமிருந்து மருத்துவர் ஆலோசனை / உதவியை நாடுலாம் என்பதையும் நான் இப்போது அறிவேன்.

• சாத்தியமான அபாயங்கள் மற்று	ம் சிக்கல்கள்	
		
• நன்மைகள்		
• மாற்றுவழிகள் 		
• அறுவை சிகீச்சையின் வெற்றி வ	யாய்ப்பு (சதவீதம் / பிற கட்டளைகள்)	
• சிகீச்சையின்றி சாத்தியமான மு	2வுகள்	
	b வழங்கப்பட வேண்டிய கவனிப்புக்குப் பிறகு எதிர்ப	
	ப்பு அலகு மற்றும் / அல்லது மருத்துவமனையில் துகள் அல்லது சிகிச்சைகளின் தேவை இருக்கலாம். 』	
ကြေမြော (၂၀၀၀၀၍ ဝဏ္(၁၅၀၀ အကြည့်	<u> </u>	2900 (300) 2200 1000 1000 1000 2000 2000
• இந்த செயல்பாடு / நடைமுறைை	ய நடத்தும் நோக்கத்திற்காக மற்றும் பொருத்தமான	முறையில் எனது உடலில் இருந்து அகற்றக்கூடிய
எந்தவொரு தீசு அல்லது உடல் ப	குதியை அகற்ற மருத்துவமனையை நான் அங்கீகர்	க்கீறேன். இந்த ஒப்புதல் வடிவத்தில் வழங்கப்பட்ட
தகவல்களை நான் பெற்றேன் ၊	மற்றும் முமுமையாகப் புரிந்து கொண்டேன் என்ற	<u>ர</u> அறிவிக்கீறேன். எனது வியாதி, செயல்பாடு _/
நடைமுறை தொடர்பான கேள்வி	களைக் கேட்க எனக்கு வாய்ப்பு வழங்கப்பட்டது. அத	ன் அபாயங்கள், விளைவுகள், சிக்கல்கள் மற்றும்
•	றற்றும் மீட்பு மற்றும் எனது கேள்விகள் அ னைத்துப்	
2	றன்னிலையில் செருகல் மற்றும் நிறைவு செய்ய வே ்	ண்டிய அனைத்து துறைகளும் இந்த வடிவத்தில்
நிரப்பப்பட்டன என்று நான் மேலுட ————————————————————————————————————	b அறிவிக்கறேன். 	
விபரங்கள்	நோயாளி / உறவினர்	சாட்சியம்
பெயர்		
	<u>-</u>	
கையொப்பம்		
நாள் & நேரம்		
மருத்துவரின் பெயர் மற்றும் เ	பதிவு எண், கையொப்பம்:	







CONSENT FOR ANAESTHESIA SERVICES

	MUGATRIYA	\Box the patient or \Box the representative of patient have,						
(please tick the correct option abo	ove and below)							
☐ Read ☐ 1/We have been explain	ed the current clinica	al condition of me / my patient						
		h, which I fully understand and understood the information provided about						
Operation/Procedure CORONARY ARTERY BYDAGE GRAFTING								
		,, ,						
(full name of operation procedure	e given below in this o	consent form)						
expected outcome and what needed for this operation, so t It has been explained to me the	could happen if my c hat my doctor can pe hat all forms of anae:	edure and has advised me of alternative treatments and told me about the condition remains untreated. I also understand that anaesthesia services are erform the operation or procedure. sthesia involve some risks. Although rare, unexpected severe complications						
		note possibility of infection, bleeding, drug reactions, blood clots, loss of brain damage, heart attack or death.						
 I understand that these risks a they may apply to a specific ty for my procedure and that th 	pply to all forms of a pe of anaesthesia. I u e anaesthetic techni	naesthesia and that additional or specific risks have been identified below, as understand that the type(s) of anaesthesia service checked below will be used ique to be used is determined by many factors including my / my relative's						
 It has been explained to me 	that sometimes an	or's preferences, as well as my own desire. anaesthetic technique which involves the use of local anaesthesia, with or and therefore another technique may have to be used including general						
		the following may be needed as part of anaesthesia during or after surgery						
		Lumbar Puncture						
ransesophageal Dido	d & Blood product T	ransfusion						
General Anaesthesia	Expected Results	Total unconscious state that may involve placement of a tube into the windpipe to maintain airway						
Alternatives	Technique	Drug injected into the blood stream, breathed into the lungs, or given by other routes						
☐ Spinal ☐ Epidural	Risks	Sore throat, injury to vocal cords, teeth, lips, eyes; awareness during the procedure, memory dysfunction / memory loss, aspiration pneumonia, permanent organ damage, brain damage						
Others	Benefits	- Early Recovery						
	Denems ,	- Relief of Anxiety						
Spinal or Epidural Analgesia / Anaesthesia	Expected Results	Temporary decreased or loss of feeling and / or movement in the lower half of the body						
☐ With Sedation /GA ☐ Without Sedation	Technique	Drug injected through a needle / catheter placed either directly into the spinal canal or immediately outside the spinal canal						
☐ GA ☐ Others								
1	Benefits	Post-operative pain relief with epidural catheter that can be left in-situ safer under certain conditions						
Major / Minor Nerve Block	Expected Results	Temporary loss of feeling and / or movement of a specific limb or area						
✓ ☐ With Sedation / GA ☐ Without Sedation	Technique	Drug injected near nerves providing loss of sensation to the area of the operation						
Alternatives . □ ĜA	Risks .	Nerve damage, persistent pain, infection, bleeding / hematoma, toxicity due to local anaesthetic, medical necessity to convert to general anaesthesia, brain damage						
☐ IV Regional Anaesthesia ☐ Spinal/Epidural Anesathesia ☐ Others	Benefits	- Pain Free - Safer under certain conditions						

	Regional Anaesthesia	Expected Results	Temporary loss of feeling and / or movement of a limb					
☐ With Seda ☐ Without Se		Technique	Drug injected into veins of arm or leg while using a tourniquet					
Alternatives	· · · · · · · · · · · · · · · · · · ·	Risks	Infection, convulsions, persistent numbness residual pain, injury to blood vessels					
	or Nerve Block	· · · · · · · · · · · · · · · · · · ·	- Pain Free					
☐ Others		Benefits	- Safer under certain conditions					
	naesthesia care	Expected Results	Decreased anxiety and light sedation similar to normal sleep					
(with sedation		Technique	Drug injected into vein of arm		`			
Alternatives General an	unosthopia	Risks	Prolonged sedation, need for airway co	ontrol				
🖳 Spinal / Ep		D 51	Anxiety free; Early discharge					
☐ Others		Benefits				;		
	naesthesia Care	Expected Results	No changes in the system	,				
(without sedat Alternatives	tion)	Technique	None					
General an	aesthesia	Risks	Patient may have pain and anxiety					
☐ Mild Sedat ☐ Others	ion	Benefits .	Early discharge					
			, , ,					
PRENATAI	/EARLY CHILDHOOD	ANAFSTHESIA						
•			pehaviour and learning with prolong	and or repeated	d exposure to a	enoral		
			uring pregnancy and in early childho		a exposure to g	eneral		
		•	sentative, do further hereby declare		18 vears of age	eason I		
			n giving consent without any fear, thr			1		
		•			•	1		
-								
	e mentioned operation		that I have been made aware of, I giv	•	-			
carrying out the said operation / procedure on myself or my above named patient being fully aware of the nature, potential								
risks and complications, intended benefits and possible alternatives.								
	•	· · · · · · · · · · · · · · · · · · ·		,		,		
	•	· · · · · · · · · · · · · · · · · · ·		,				
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i	நோயாளி விவரங்க	ள் : (Affix Label here)
	பெயர் :	
	UHID:	
	பிறந்த தேதி:	பாலினம்:
	சேர்க்கை தேதி:	



<u>மயக்க மருந்து சேவைகளுக்கான ஒப்புதல்</u>

1. நோயாளி	அல்லது 🔲 நோ	ரயாளியின் பிரதிநிதி,
 மேலேயும் கீழேயும் சரியான விருப்பத்	_ ·) படித்தல்
என்னை / என் நோயா	ளியின் தற்போதைய	மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளோம். ஆங்கிலத்தில் இந்த ஒப்புதல் படிவம்
விளக்கப்பட்டுள்ளது. இது வழங்கப்பட்	ட தகவல்களை நான் மு	் மூமையாக புரிந்துகொண்டேன்.
செயல்பாடு/செயல்முறை		
இந்த ஒப்புதல் படிவத்தின் கீழே கொடு	க்கப்பட்ட செயல்பாட்டு ந	தடைமுறையின் முழு பெயர்
எதிர்பார்க்கப்பட்ட முடிவைப் பற்றி எ	ான்னிடம் கூறினார். எ	பங்களை விளக்கியுள்ளார் மற்றும் மாற்று சிகிச்சைகளுக்கு எனக்கு அறிவுறுத்தியுள்ளார் மற்றும் னது நிலை சிகிச்சையளிக்கப்படாவிட்டால் என்ன நடக்கும், இந்த செயல்பாட்டிற்கு மயக்க மருந்து ன். இதனால் எனது மருத்துவர் அறுவை சிகிச்சை அல்லது செயல்முறையைச் செய்ய முடியும்.
கடுமையான சிக்கல்கள் ஏற்படல	ாம். தொற்று நோய், இ	யங்களை உள்ளடக்கியதாக எனக்கு விளக்கப்பட்டுள்ளது. மயக்க மருந்துகளுடன் எதிர்பாராத இரத்தப்போக்கு, போதைப்பொருள் எதிர்வினைகள், இரத்த உறைதல், உணர்வு இழப்பு, மூட்டு போன்ற தொலைதூர சாத்தியங்களை உள்ளடக்கியிருக்கலாம்.
அடையாளம் காணப்பட்டுள்ளன விண்ணப்பிக்கலாம். கீழே சரிபார்க்	ா என்பதையும் நால் கப்பட்டமயக்க மருந்து	மருந்துகளுக்கும் பொருந்தும் என்பதையும் கூடுதல் அல்லது குறிப்பிட்ட அபாயங்கள் கீழே ர புரிந்து கொள்கீறேன். ஏனெனில் அவை ஒரு குறிப்பிட்ட வகை மயக்க மருந்துக்கு ரசேவையின் வகை குள்) எனது நடைமுறைக்கு பயன்படுத்தப்படும். மயக்க மருந்து நுட்பம் எனது ர மற்றும் எனது சொந்த விருப்பம் உள்ளிட்ட பல காரணிகளால் தீர்மானிக்கப்படுகிறது என்பதை
		படுத்துவதை உள்ளடக்கிய ஒரு மயக்க மருந்து தொழில் நுட்பத்தை, மயக்க மருந்து இல்லாமல் நந்து உட்பட பயன்படுத்த வேண்டியிருக்கும் என்று என்க்கு விளக்கப்பட்டுள்ளது.
பொது மயக்க மருந்து	எதிர்பார்க்கப்படும் முடிவுகள்	காற்றுப்பாதையை பராமரிக்க ஒரு குழாயை காற்றாலையில் அமர்த்துவதை உள்ளடக்கிய மொத்த மயக்க நிலை
மாற்று மருந்து	நும்	இரத்த ஓட்டத்தில் செலுத்தப்படும் மருந்து, நுரையீரலில் சுவாசித்து அல்லது பிற வழிகள் வழங்கப்படுகின்றன
முதுகெலும்பு இவ்விடைவெளி 	அபாயங்கள்	தொண்டைப்புண், குரல் வடங்கள், பற்கள், உதடுகள், கண்கள், செயல்முறை, நினைவக செயலிழப்பு, நினைவக இழப்பு, அபிலாஷைகள், நிரந்தர உறுப்பு சேதம், மூளை சேதம் ஆகீயவற்றின் போது விழிப்புணாவு
மற்றவை	நன்மைகள்	– ஆரம்ப மீப்பு
		_ புகுட்டத்தின் நிவாரணம்
☐ முதுகெலும்பு அல்லதுஇவ்விடைவெளி / மயக்க மருந்து	எதிர்பார்க்கப்படும் முடிவுகள்	உடலின் கீழ்பாதியில் உணர்வு அல்லது இயக்கத்தின் தற்காலிக குறைவு அல்லது இழப்பு
☐ மயக்க மருந்து / பொது மயக்க மருந்து ☐ மயக்க மருந்து இல்லாமல்	<u> ந</u> ட்பம்	ஊசி / வடிகுழாய் வழியாக செலுத்தப்டும் மருந்து நேரடியாக முதுகெலும்பில் அல்லது உடனடியாக முதுகெலும்பு கால்வாயுக்கு வெளியே வைக்கப்படுகிறது.
பாற்று மருந்து □ பொது மயக்க மருந்து	அபாயங்கள்	எலும்பு சேதம், தொடர்ச்சியான முதுகுவலி, தலைவலி, தொற்று, இரத்தப்போக்கு, இரத்தம்போதல், ஹெமடோமா, உள்ளூர் மயக்க மருந்து, நாள்பட்ட வலி, மயக்க மருந்து, மூளை சேதத்திற்கு மாற்று மருத்துவ சேவை காரணமாக நச்சுத்தன்மை
் மற்றவை	நன்மைகள்	சில நிபந்தனைகளின் கீழ் சிட்யூவில் பாதுகாப்பாக விடக்கூடிய எபிப்ரி வடிகுழாய்களுடன் செயல்பட்டு வலி நிவாரணம்
பெரிய / சிறிய நரம்புத் தொகுதி மயக்க மருந்துடன் / பொது மயக்க மருந்து	எதிர்பார்க்கப்படும் முடிவுகள்	உணர்வு மற்றும் ஒரு குறிப்பிட்ட மூட்டு அல்லது பகுதியின் தற்காலிக இழப்பு
மயக்க மருந்து இல்லாமல் மாற்று மருந்து	நுப்பம்	செயல்பாப்டின் பகுதிக்கு உணர்வு இழப்பை வழங்கும் நரம்புகளுக்கு அருகீல் மருந்து செலுத்தப்படுகிறது
பொது மயக்க மருந்து V பிராந்தீய மயக்கமருந்து	அபாயங்கள்	எலும்பு சேதம், தொடர்ச்சியான வலி, தொற்று, இரத்தப்போக்கு, ஹெமடோமா, உள்ளூர் மயக்க மருந்து,மருத்துவ சேவை காரணமாக நச்சுத்தன்மை, மயக்க மருந்து, மூளை சேதத்திற்கு மாறுதல்
முதுகெலும்பு / இவ்விடைவெளி மயக்கமருந்து மற்றவை	நன்மைகள்	– வலி இலவசம் – சில நிபந்தனைகளின் கீழ் பாதுகாப்பானவை

						<u>. </u>		
	நரம்பு மண்டலம் மயக்க மருந்து மயக்க மருந்து		2_600	ர்வு மற்றும் ஒரு குறிப்பிட்ட மூட்டு	இயக்கத்தின் தற்காலிக	இழப்பு		
_	ந்து இல்லாமல்	நுப்பம்	<u> ഉ</u> ரு டூ	ர்னிக்கேயைப் பயன்படுத்தும் பே	ாது கை அல்லது கை ந	ரம்புகளில் செலுத்	தப்படுகிறது	
	🔲 பெரிய / சிறிய நரம்பு தொகுதி		தொற்	தொற்று, வலிப்பு. தொடர்ச்சியான உணர்வின்மை, மீதமுள்ள வலி, இரத்த காயங்களு				
☐ பொதுவான ☐ மற்றவை	ர மயக்க மருந்த ு	நன்மைகள்		இலவசம் நீபந்தனைகளின் கீழ் பாதுகாப்ப	ா නෙනෙක			
கண்காணித்த ம (மயக்கத்துடன்)	 யக்க மருந்து கவனிப்பு	எதிர்பார்க்கப்படும் முடிவுகள்		ரண தூக்கத்தைப்போன்ற கவகை		வருகிறது		
மாற்றுகள்		நுப்பம்						
☐ பொதுவான ப ☐ பக்கையம்ப	மயக்க மருந்து இவ்விடைவெளி மயக்க மருந்து	அபாயங்கள்	நீண்ட	நீண்ட கால மயக்கம், காற்றுப்பாதை கட்டுப்பாடு தேவை				
மற்றவை மூற்றவை	ജ-ബംബന്ദ്വാവ നമ്പാര നധ്രിലാ		↓	ல இலவசம், ஆரம்ப கால வெளி				
	யக்க மருந்து கவனிப்பு	எதிர்பார்க்கப்படும் முடிவுகள்	, 	னியில் மாற்றங்கள் இல்லை				
மயக்கம் இல்லா மாற்றுகள்	மல்	நுப்பம்	இல்மை	 ស				
	மயக்க மருந்து	அபாயங்கள்	நோய		 க்கலாம்			
□ இலேசான ப □ மற்றவை	ാധകമഥ	நன்மைகள்	$\overline{}$					
	u. / a minumus a tariam m							
	ய / ஆரம்பகால குழந்தை	பருவ மயக்க மருந்	6 월 1					
				வினைவுகள் பொது மயக்க மருந்த ஈடும் மீண்டும் வெளிப்படுதல்] / மிதமான மயக்கம் / ச	ர்ப்ப காலத்தில் மற்	றும் ஆரம்ப	
				நீநீதி, இந்த வடிவத்தில் கைபெழு த மேற்பட்டவன் என்று இதன்மூல		போக ஒலி மற்றும்	எந்தவொரு -	
	•		-		, ,	.0a		
மேற்கூறிய எச்யல்	பாட்கிற்கு (எஸ்) / நடைமு	றை (கள்) எனக்கு வு	ஐய ம் இவ	ட்டது. நான் தானாக முன்வந்து எ	ஒவ தி ஃ படி ஜ ை வமியடு	கரை		
டாக்டர் (டாக்டர்) டி.	அல்லது டி–யில் கூறப்பட	ட செயல்பாடு / நக	യറൻയി	றமை செய்வதற்கு) அறுவை சிகிச்	சை செயல்முறையைச்	செய்வதற்கான டா	க்டர் பெயர்,	
நோயாளியிடம் மு	முமையாக அறிந்திருக்கி	றார். சாத்தியமான ச	அபாபங்	கள் மற்றும் சிக்கல்கள் மற்றும் சா	த்தியமான மாற்றுகள்			
നുങ്ങ / ദ്രോന്ക്കുനില	. கோயாளி / பெயரிடப்ப	் கோயானியின் ப	ിനക്കിക്ക്.	இந்த வடிவத்தில் கைபெழுத்திடப்	பட்ட கேகி. மன ரீகியாக	18 ஆண்டுகள் நிர	क्रिकामा धारि।वीह	
				ப்புதல் அளிக்கீறேன் என்று மேலுட			יים היים ביים.	
ļ								
	கையொப்பம் /	கட்டை விரல் பதிவு	*	பெயர்		தேதி	நேரம்	
நோயாளி								
நோயாளிகளின் பிரத்	3.6.5.6.7 () () () () () () () () () ((Portugally year Or main paint)	a a manou a un novio			
பாதுகாவலர் பொருந்தும் என்ற	тю́)			(நோயாளியுடன் பெயர் மற்றுப்	ந்றை எழுத்வுற்			
நோயாளிகளின் பிர								
சம்மதத்திற்கான காரணம்	ர நோயாளி ஒப்ப	துல் அளிக்க முடிய	ച മിல്മെ	ා ඉරිකක්බන්				
சாட்சி								
		<u> </u>						
மொழிபெயர்ப்பால் (பொருந்தீனால்)								
* நோயாளி ஒரு சிற்	 பெவராக இருந்தால் அல்எ	லது சம்மதத்தை வ <u>ෑ</u>	நங்க முடி	 யாவிட்டால் மட்டுமே ஆண்களுக்	கான வலது கை மற்றும்	பெண்களுக்கான இ	இடது கை	
	-,						_	
நான் நியமிக்கப்பட்	ட மருத்துவர், இயல்பு, சா	த்தியமான அபாயா	ங்கள் மற்	ற்றும் சிக்கல்கள், நோக்கம் கொன கு சாத்தியமான மாற்றுகள், நோ	னட நன்மைகள், எதிர்பா weed / சோயானி மிகரி	ர்க்கப்பட்ட பின் நக சிசீக்க வினக்சியல்	நடமுறைக்கு எனார் இச்ச	
				கு சாத்தயமான மாற்றுகள், நோ ாகப் புரிந்து கொண்டார் என்று நா		സ്കാരി ബലയാന്റെ	නැත්ත	
	தையொப்பட்	<u>i</u>	ர் 		பதிவு எண்	தேதி	நேரம்	
பெறப்பட்ட	0,000(10)(1001	- 611	14791		—≒=-4		ما درمو	
9ப்புதல்								
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ANAESTHESIA RECORD



(A Unit of United Alliance Healthcare Pvt Ltd)		Every heart beat counts
Mrs.SHANMUGAPRIYA S	Type of Surgery : □	Day Care ☑ Elective ☐ Emergency
45/Female/MH1202381078 11/12/2023/IPH202302475	Blood Group 1-14	Height: 165 cms Weight: 63.4 Kgs
Dr.Anbarasu mohanraj	Pre-Operative Diagn	osis:
	Proposed Surgery:	Anaesthetic Plan
ASA Grade: 🗆 I 🗆 II 🖂 III 🗆 IV 🗆 V 🗆 E	CABR.	GA.
	COMORBIDITY	Present Medication :
	☐ HT ☐ SMOI	i
SYNCOPE \	JØM □ ALCO □ ASTHMA / COPD □ GERI	i
□ CCF	 ☐ HYPO THYROID ☐ CKD.	/ NEPHROPATHY
		Anti Platelet Stopped on:
Physical Examination ;	BYSTERS EXAMINATE	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1
JAUNDICE PEDEL OEDEMA	SYSTEMC EXAMINATION	CNS: >UV
☐ CYANOSIS ☐ CAROTID BRUIT ☐ CLUBBING	RS: Um	Others: WNL
HR: NIBP:	SPO	2: 987, TEMP: 97°F
INVESTIGATION	SEROLOGY	ANGIO LAO - 80 1, -951/ LLX 951/
HB : <u>JJ.)</u> T.BILIRUBIN : <u>0,83</u> T3	M NEGATIVE	NSR, IMMI
TC : 62,60 T4	Urine:	ECG HR 95/mt
UREA : →1) D. :0, ⊃2, TSH	. 1 <u>753</u>	CXR WAL
	: <u>11,9%</u>	CAR WALL
Na+ : 139 S.ALBUMIN : 3.9 RBS	Others:	ECHO ET 35 & Mod. sw. w.dys
K+ : 4.46 PTT/INR :		Dilater LA LV-
APTT : 33.5		RHMA +
AIRWAY CAROTID D	OPPLER	MAGAL RU TAPSE 18 TOR
Mallampatti class II.		Trivial MR /TR, Mb PA14.
Mouth Opening Adequate		
Neck Movement Normal		Other Opinions:
TM Distance WWL,		
Pre OP Instruction : SAM NPO From	m: he radiagle	
Night Before Surgery: 426, Affre 15 mg	4 Ary - names 4 42 A	Blood Reservation
Pre Medication: Night Before Surgery: Day of Surgery The Alpha District Alpha	to Santo ou to ogo,	PCV : onl Platelet: FFP : CRYO:
Special Instruction :		Whole Blood:
Remarks: LSCS 2011		
Dr.	A. SAMUEL SYLVES	TER
	Reg. No: 435/0	10
Anaesthetist Name with Reg.No. :	,	Signature

Da	ate: Anaesthetist	DR.Syl	UESTER	Surgeon DR.	ANBARASU PRAVEEN	Anaesthesia Technique ☐GA ☐Regional ☐Others		
	E INDUCTION AN				D EQUIPMENTS	GENERAL ANAESTHESIA		
	se:89mt BP: 190			□NIBP □ Left		INDUCTION:		
Sen	sorium: <u>Consc</u>	Lous		₽£CG	neter End Tidal CO.	Pre O ₂ Rapid Sequence VV		
Sign	n-in Completed: 💆	ZYes □			Oxygen Sensor	☐ Inhalation - Agent used: ☐ So File Can p Mode of Ventilation: ☐ Spontaneous ☐ Controlled		
Equ	e: Shecked:	Yes/L	MSTER.	Disconnect] Temperature Probe	AIRWAY MANAGEMENT:		
Sign		Name	XX.5.53401x	Foley Catheter	Nerve Stimulator	Intubation (Gral) Nasal ETT Size: 7.5 Type: Cuffer CL Grade: 1 / W III / IV Secured at:cm		
Time				TEE	Others:	Any difficulties and accessories:		
<u> </u>	PATIENT	SAFETY	Υ	CVC Type: 2.5FR		Throat Pack: ☐ Yes ☑ No ☐ Removed		
	ition on Table: <i>S</i>			Standard Asepsis		NG / OG Tube: Tes No		
	ssure points checke		ded:□ Yes□No	☐Complications: ☐ Y		OTHER AIRWAY DEVICES:		
_	Care: ⊡Yes □No ety Belt: □Yes ⊡⊀	_		If Yes, details:	ES [2] NO	☐ Una Tracheostomy ☐ Face Mask ☐ Nasal Prongs		
	ming Blanket:			Arterial Line - Type:	200 Site Dipolia			
	d Warmer: ☐ Yes {	_		₽VC Type: 16 Gq	A3MM Site: D	Antibiotic / Dose / Time		
	Stockings: Yes			□PVC Type:	_	Injection: Cetroxian 1.59m@ 15		
	uential Compressio		mpression:	1_		Reversal of Anaesthesia		
	Yes ☑ No PROPOFOL	••		Others:		 		
N	MIDAZOLAM	3						
	FENTANYL MORPHINE	100	100	50 50	্যা ত	 		
٧	VECURONIUM	6		· ·				
SE	ETOMIDATE KETAMINE	_	 	 	+ +	 		
	KETAMINE SUXA/ROCURONIUM							
	cisatracurium/ Sevo/Isoflurané	ン	<u>ن، اس</u>	<u> </u>	1 V 7	 		
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	Time a	. 69	12,00	1500	15.60	180' 1400		
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	180	V	·					
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SIGN	Resp. ★ : ·100	<u> </u>		1 MM John				
VITAL	Operation S0							
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	40							
F	Temp X 20		++++	╉╂╂╂┼	╂╁╁┾┼	┇┊┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋┋		
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ĮΣ	onne output		``			3 Boom		
	DU .	41.1 -			-			
1	PH PCO,	4210			7-1,60			
7	PO, Na'	103.0			179,2			
	K'	440			30			
1 1	RBS LAC	74 7	7 -	+ + +	(feest)			
	BE HCO,	338	<u> </u>		2/3, Q			
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] ;	START		STOP	FLUID TRA	NFL	JSED	BLO	OD PR	ODUCTS
ANAESTHE	SIA	,	13,10		l6.40	CRYSTALOID	7	COLLOID	·	wil	
PROCEDU	RE	1	+ 25		16.35	KARILYTE 50		wil			-
СРВ		1	<u> </u>		,	n so	0			-	
AXC	•				•	-					
CUF:			MUF:								
	H	EPARI	N			PI	RES	SSURE MO	NITOR		
DOSE		TII	ME		ACT	PRE OP		. , , , , , , , , , , , , , , , , , , ,			
100 m	9	14.4	מ		505 rc	PA	/'.	RV	_	PC	WP
<u> </u>						ABP /					
	PF	ROTAI	MINE			POST OP	1				
DOSE			ME		ACT	/	/				NATE OF THE PROPERTY OF THE PR
leong		<u> 16</u>	1 00		120 see	PA /		RV	 -	PC	CWP
INOTRO	PES & II	NFUS	IONS			ABP /					ľ
DRUG	DOS	E	START		END	DRUG		DOSE	STAF	₹ Т	END
DILUTION	(RANG	BE)	TIME		TIME	DILUTION	(1	RANGE)	TIM	E	TIME
UDRADLEWALINE 4 mg/ 50cc	105/m) Kg	Int	1500-		Continued Styped.	NTG= 25000 2500b	ণ্ড	- 1/4/kg/m	t 15.	30 ×	Stopped
ADRENALINE bmg bocc	102/1	g]m	137,30		Stypedi-			, ,			
25mg 25ce		3			00						
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						TEE: NO					
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REMARKS											
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}											
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				Dr	: A. SAMUÈL	. SYLVESTE	R	_	An.		
ANAESTHE REG.NO.	:SIOLOGI	IST NA	AME:		Reg. No	: 43 570	_ S	SIGNATURE	Electric	<i>\</i>	
Market Comments							_				

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	POST OPERATIVE PL	AN	•
Transfer to: SICU	Others, specify:		<u>-</u>
ABP: 122/1 mm	Time: 16,55 / Deats/min Rhythm: Pghlw Hg CVP: 10 mmHg PAP:	mmHg	C.O : L/min
VENTILATOR SETTINGS: PR 14/mt 1, tv & FIDOZ 1.1C.	Whene control/ IONO Strong PERP Smanlfy NIL,	OTROPES:	
POST OP ORDERS:	DO ABG/Cherryong/Act. 2) Weam of enlights when	flly qual	e
MODIFIED ALDRETE'S SCO	RE (Score against each criteria)		
CRITERIA	PARAMETER	Scale	
Activity, able to move,	4 extremities	2	
voluntarily or on	2 extremities	1	
command 	No	0	Total Score : 10
	Able to breath deeply and cough freely	18/	<u></u> [
Breathing	Dyspnea, shallow or limited breathing	1	Patient fit for discharge:
	Apnea	0	⊡√YES □NO Ι
	Fully awake	\	\
Consciousnesss	Arousable on calling	1	
2 2110412 20110000	unresponsive	0	
-	+20% of pre-anaesthesia level	121	
Circulation (Plead Prossure)	+20% to 49% of pre-anaesthesia level	1	
(Blood Pressure)	+50% of pre-anaesthesia level	0	
	Maintains SPO ₂ >92% in ambient air	2	
SPO ₂	Maintains SPO ₂ > 90P% with O ₂	1	
<u>-</u>	Maintains SPO ₂ <90% with O ₂	0	j
	D. A. GALUET 614175		
	Dr. A. SAMUEL SYLVESTE	K]	,
	Reg. No: 43570		~ d 0

Anaesthetist Name & Reg.No.:





Every heart beat counts

(A Unit of United Alliance Healthcare Pvt Ltd)

PDA-1.5mm, diffuse duease

UNIT: INSTITUTE OF CARDIO VASCULAR DISEASES

	OPERATION NOTES	MIS.SHANMUGAPRIYA S
Name of Patient	Ag	TO/FCIMale/Munages
UHID No. :	Se.	Dr.ANBARASU MOULING
Pre-Operative Diagnosis : CAD-	TVD, moderately sev 24, EF-34%.	
Post-Operative Diagnosis: -do	~	
Operation Procedure opcas x	4 grafts	
	-> LAP SYY -> PDA	
	→ D. &on (Jeq.) Please tick the Closed ☑1	e type of procedure :
Operation		ature of
Commenced: 4.25	·	aesthetic : 🏖 Y P
Surgeons Dr. Anbatasu (1	praveen / PA-Sai / kartli Perfusionist .	-
Anaesthetist Dr. Sylves to	Nurse Ms 1	•
Incision Medune	e e e e e e e e e e e e e e e e e e e	
Cannulation	Arterial Ve	enous
Oxygenator	Median Sternotomy. po	vicaudiotomy. Ima:
	svy harvested, systemic hepo	vinization dure.
Total CPB Time	Heart Stabilized i myocard	
Total ACC Time Total TCA Time	•	
Findings and Relevant Details :	Distal anastomosis done. I	
ain myocaudial contraction	DISI OTO CLEAN, SVY > PDA, a	corta occluded
IMA - 1-75mm. good quality.	s particular, two summ holes or	zere made on the
good flow	aorta. progumal anastomos	sis done & 6-0 47-0
VC1 - 4mm, from left leg, good	prolene sutures protamin	ized . Hemostasis
D - 1.5mm, Healthy target - 1.5mm,	sewed Revisardium rea	
- 1.5 mm, plaques (+), diffuse	no 11 of a	
disease	two drain tubes insitu	

POST-BY PA	ASS HAEMODY	NAMICS				n.eg
RA			LA	٠.		Cardiac Output
RV			LA			CI
	SYS			SYS		
PA		MEAN	ВР		MEAN	
	DIAS			DIAS		
PA	cw					
Support:	Isoprin Dopamine Dobutrex		Adrenaline I A B P Others	WIL		
POST-OPER	RATIVE INSTRU	JCTIONS :	· ·			
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-Matrh	por: Blude	rg 3, 1	hypotensic			
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Good to	on fusion	· our				
						
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Me Pe	nest (J+) -1 ediastinal -1 ericardial 2 hers	-				
Sponge Cour	nt :					
	correct		arasu Moha g No: 55476	ınraj		
Surgeon :	200-6	Эпр _{ала}	u mohan	Ry V	left	Date: 12/12/2029







NAME:	Mrs. SHANMUGAPRIYA.S	AGE/GENDI	ER: 45Years / FEMALE
UHID NO:	MHI202381078	IP NO:	IPH202302475
DOA:	11/12/2023	DOS:	12/12/2023
SURGEON:	DR. ANBARASU MOHANRAJ	ANESTHET	IST: DR. SYLVESTER
ASSISTED	BY: DR. PRAVEEN JEYAKUMAR	PHYSICIAN	ASSOCIATE:
		MS. SAIKUM	IARI/MS. KARTHIKA
SCRUB NU	RSE: MS. SUJATHA		

DIAGNOSIS:

TRIPLE VESSEL CORONARY ARTERY DISEASE

MODERATELY SEVERE LEFT VENTRICULAR DYSFUNCTION (EF - 34%)

MILD PULMONARY ARTERY HYPERTENSION

UNCONTROLLED DIABETES MELLITUS

CLASS II - III ANGINA

SURGERY DONE:

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 4

LIMA TO LAD

SVG TO D1 AND OM (SEQUENTIAL)

SVG TO PDA

FINDINGS:

Fair myocardial contractions

Hypertrophic left ventricle

LIMA – 1.75mm, Good quality, good flow

SVG - 4mm, from left leg, Good quality

LAD - 1.8mm, Plaques (+), Distal LAD grafted

D1 - 2.0mm, diseased vessel

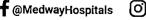
OM – 1.8mm, Plaques (+)

PDA – 2.0mm, Healthy target, proximal plaques (+)

Good distal run off in all the grafts 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel : 044 - 4310 8959

Chengalpattu

044-27426829



Mogappair

044-26530011

(O) @medwayhospitals



@medwayhospitals



Medway Group of Hospitals

Kumbakonam

044-2473 4455

Heart Institute

Institute of Pulmonology 044-2473 4454

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

Kodambakkam

044-2473 4455

Villupuram 04146-242000

044 - 4310 8959





PROCEDURE:

Median sternotomy. Pericardiotomy. LIMA and SVG harvested. Systemic heparinisation.

Heart positioned and stabilized with myocardial stabilizer for OM grafting. Arteriotomy was made and 1.5mm intracoronary shunt was inserted. The end of the saphenous vein was anastomosed to the side of the OM artery with 7-0 prolene suture. (SVG TO OM)

Heart re-positioned and stabilized with myocardial stabilizer for D1 grafting. Arteriotomy was made and 1.75mm intracoronary shunt was inserted. The side of the saphenous vein from the OM graft was anastomosed to the side of the D1 artery with 7-0 prolene suture. (SVG TO D1 (SEQUENTIAL))

Heart re-positioned and stabilized with myocardial stabilizer for LAD grafting. Arteriotomy was made and 1.5mm intracoronary shunt was inserted. The end of the Insitu LIMA was anastomosed to the side of the LAD artery with 7-0 prolene suture. (LIMA TO LAD)

Heart positioned and stabilized with myocardial stabilizer for PDA grafting. Arteriotomy was made and 1.75mm intracoronary shunt was inserted. The end of the saphenous vein was anastomosed to the side of the PDA artery with 7-0 prolene suture. (SVG TO PDA)

Aorta occluded partially. Two 4mm holes were made on the aorta with aortic punch. Proximal anastomosis of vein grafts done onto aorta with 6-0 prolene suture. Protamine administered. Hemostasis secured. Pericardium reapproximated partially. Routine chest closure done with one mediastinal and one left pleural drain tubes insitu

SUPPORTS:

She was shifted to ICU with nil support.

CONSULTANT SIGNATURE

Dr. Anbarasu Mohan Raj, MS, DNB, M.Ch (CTVS), FRCS (Glasg) Director and Clinical lead - Cardio Vascular and Thoracic Surgery

> Dr. ANBARASU MOHANRAJ Reg. No: 55476

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

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94457 94457 1800 572 3003

Medway Group of Hospitals

Medway Centre of Excellence (Chennai)







#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel : 044 - 4310 8959
Triple Vessel Coronary Atters Treeau
Moderateis Severe Lu Dystanction
Vacantable Distate Mellin
Clan 2-12 Angina
Left Subclavian Left Internal Mammary
Aorta————————————————————————————————————
Right Coronary Circumflex Obtuse Marginal Diagonal October Descending Control of the contro
Presimal Playur Fair myotarch contraction
1-11 pertrophe legt ventricle
Let Internal Marring Internal 1.12 although Sylving (Lines 7 1.12 although Sylvingh Very Graph (SVE) Conduit Name 1/2 SHALMEGIPREYA S 65/E Date of Surgery 12/12/2013 UHID. No. MHZ
Name 1 5 SHALMAGIRGYA S LISTE Date of Surgery 12/12/2013 UHID. No. MILL
Operation Performed OFF FUMP CORDURARY ARTHON SYMEI LAYFRAN SURVEYS OF CONCENSION STANDS OF CONCENSION OF THE LAND OF THE CONCENSION OF THE LAND OF THE CONCENSION OF THE CONC





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#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel: 044 - 4310 8959
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Vincentalled Distribution
Clam 2 - III Angina
Left Subclavian Left Internal Mammary
Right Coronary Circumflex Obtuse Marginal Diagonal Anterior Descending
Preximal Plaguer
Fair myocard contraction
1-11 pertropher legt - ventrèle
Let Internal Mammies Islay (Linus 7 1.12 a) the Sephsian Van brough (SVE) Conduit Name Mrs SHALMWARRIYA & Lists Date of Surgery 12/12/2013 UHID. No. MHI
Name SHALMALAGRANA S LOF Date of Surgery 12/12/2013 UHID. No. MHI
Operation Performed OFF PUMP CORDNARY ARTHY SUMEN LANFRON SUREN SU
SULTU SOA







PATIENT'S INFORMATION SHEET

NAME Mrs.SHA. Mugapriya S 45/Female/M. 1202381678	AGE / SEX	UHID NO			
11/12/2023/iPH_^2302475 Dr.ANBARASU MOHAL'N-4J	SURGEON	ANAESTHETIST			
Dr. Andorast	DR. ANBARASU	DR PRAVEEW			
DIAGNOSIS (In Capital Letters)	1. CAD -TVD				
	2. MODERATELY SEVERE LY DYS				
	EF-361.				
	3. RWMA®				
	4. TRIVIAL MR TRIVIAL TR MILD PAH				
	5. DILATED LA & LV				
	6. T2DM				
	7.				
	8.				
PRESENT PROCEDURE/ SURGERY	CHBM	, 11			
BORGBARI	\ \ \				
	ĺ .	•			
PREVIOUS PROCEDURE/ SURGERY	_				
CONTACT NO. & RELATIONSHIP	1. 8939642883 MR. SELLIA KUMAR (HU SBAND)	2.			

MEDICATION HISTORY

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	2-11-23	T.SACURICE	loomot	P60	0-0-127	
2	<i>"</i> .	T-TROEDIUS	10)25MM	Plo	1-0-0	- nee
3	_1/	T- IRPAN	คิทเท	Plo	1-0-1 -	(pnT)
4	ч	T. CLOPPLET	TOMAT	Plo	1-0-1 77	P
5	11	T-EMPRMI-AV	75 40mu	Plo	0-0-1	ارم
6	N	T PLAVEDON-MR	35MU	Plo	v-0-1	
7	N	T-OROPER XT	17703_	Plo	0-0-1	
8	h	T. HOMOCHECK	THB	Plo	(-0-0)	
9	η .	T-PANTOCZD-D	ITHB	P/6	1-0-1	Continue
10	Ŋ	EMALDE MENNEH FURE	ľ	3/2	pn-en-pn	
<i> </i>	\$ \	XXIV COMMON CUIT	TARD 3	0/70 SIC	<i>pn</i> - m - pn	
S.No	STARTED ON	CURRENT MEDICATION (After Admission)	1	Route	Frequency	STOPPED ON
1	11-12-23	T. TIDEPLUS	10/25Mh	Plo	1-0-0	
2	N	T - IRBAN	5Mb	P16	1-0-1	
3	11	T. FLAVEDON-MR	35mbj	Plo	1-0-1	
4	11	T-OROPER-XT	ITAB	Plo	0-0-1	Continue
5_	N	T-HOMO CHEK	LIAB	Pb	1-0-0	
6	η	T. PANTOCID-D	ITAB	P/0	1-0-1	
7						
8						
9			_			
10						

ANY RELEVANT INFORMATION:

Admission / OT Receival	Condition of the Patio	ent:			
Date and Time: 11\12\22	1. Stable / Unstable	2. Oriented / Disoriented			
From: Admir To: 203A	3. Conscious / Semico	5. Intubated / Extubated			
Transfer Out					
Transfer Out	Condition of the Patie	ent:			
Date and Time :	1. Stable / Unstable		2. Oriented / Disoriented		
	3. Conscious [/] / Semico	onscious / Unconscious			
From: To:	4. Febrile / A febrile		5. Intubated / Extubated		
Transfer In	Condition of the Patio	ent:			
Date and Time :	1. Stable / Unstable		2. Oriented / Disoriented		
	3. Conscious / Semico	onscious / Unconscious			
From: To:	4. Febrile / A febrile		5. Intubated / Extubated		
1) Known Case of	Year	Months	Days		
Diabetic Mellitus	124RS				
2) Known Case of Hypertension	ĺ	-			
3) Known Case of Bronchial Asthma/COPD	_				
4) Known Case Of Others			 		
, 1210 1111 0400 01 04401					
	☐ Yes	TLN ₀			
Denture	Permanent Fixatio	n			
<i>2</i>	Temporary Fixation : Present / Absent				
-					
	Yes Vo				
Allergic Reaction : Drugs/Food	If you means mention about Drug / Food Name:				
	☐ Yes	D-No	,—		
Pressure Ulcer Present	If you means mention a		4 & Site		
	II Jou mount mondon t	Sauci 1/2/3/	. a bito.		

ANY RELEVANT INFORMATION:

					Sign With Date
Peripheral Cannulation	1. Site:	1. Inserted Date and Time		1. Removed on:	
	2. Site:	2. Inserted Da	te and Time	2. Removed on :	
	3. Site:	3. Inserted Da	te and Time	3. Removed on :	
Neek Line : IJL / EJL	Site:	Inserted Date	and Time	Removed on	
Arterial Line : Right/Left	Site:	Inserted Date	and Time	Removed on	
Sheath Arterial / Venous:	Site:	Inserted Date and Time		Removed on	_
Pressure Bandage	Site:	Inserted Date and Time		Removed on	
Drain Site	1. Mediastinal: Inserted Date and Time Removed on				
	2. Pleural Right / Left: Inserted Date and Time Removed on				
Urinary Catheterization	Inserted Date and Tin	ne	Removed or	1	-
Nasal / Oral Gastric Tube	Inserted Date and Tim	ne	Removed or	1	
Intubation Date and Time	Extubation Date And	 Γime	Reintubatio	n Date And Time	
Other Information	in blo	Reserv	ation	Done	
	in blo	od b	ank	Sty	1200 M
			· · · · · · · · · · · · · · · · · · ·		





Mrs.SHANMUGAPRIYA S 45/Female/MHi202381078	TYT'S INFORMATION S	HEET
NAME 11/12/2023/IPH202302475	AGE / SEX	UHID NO
Dr.Anbarasu mohanraj		
	SURGEON	ANAESTHETIST
11°	1 :	
DR-ANBARASU	DR. ANBARAN	DR. Sylvesier
DIAGNOSIS (In Capital Letters)	1. CAD-TVD 2. DILMED LA AND 3.	LV , RUIHA PRESENT
	MODERATELY SEV 4. GRIVIAL MR, GR 5. MILD PAH	. /
	6. MOD BL PLEURA	of effusion
	8.	
PRESENT PROCEDURE/ SURGERY	CRCABX A GRAFTS LIVA -> LAD SVG1 -> D1 90 SVG1 -> PDA	M (SEQ)
PREVIOUS PROCEDURE/ SURGERY		
CONTACT NO. & RELATIONSHIP	1.8939642883 (V·c)	ا ا ا ا ا ا ا ا ا ا ا ا ا ا ا ا

N.No:- 14 553

SELF PAY

MEDICATION HISTORY

		MEDICA		IISTORI		•••
S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	111223	G. SIDE PLUS	10 05	PO	0-0-1/2	
2	81	Î.ÎRBAN	5Mg/	_RO	1-0-1	
3	pt	G. FLAVEDON MR	36Mg	90	1-0-1	
4		J. DROFER XI	1100	· '80'	0-0-1	continue
5		J. HOMOCHEK	ITAB	90	1-0-0	
6	<u>tı</u>	J. PANJOCID - D	IJAB	Po	1-0-1	
7			٦	,)
8						
9			;			
10						
	ANGIPL	Wereis Siopled	ON 8	1223		
S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	12/12/23	SYP. SUCRALFATE	lome	. 12/0	1-1-5	
2	12/12/123	SYP. SUCRALFATE HEB. LEVO HEB. SALBUTAMA	0-63	TNH.	RGHR.	
3	13/12/23	7. FRUSDMIDE	40mg	Plo	1-1-0-	
4	13/12/23	T-SARONALACATONE	32 mg	plo	1-1-0,	
5	18/12/23	T, BEPLEY VIRTE	ITAG	0 اع	1-0-0,	
6	13/12/23	T. CLOPIDOGREUT	75/75	PIO	D-1-0.	within
7	13/12/22.	T. ROSVASTATIN	Hony	PIO	0-0-6	
8	13/12/23.	T. PARACETTAMOL	600 7	P10	1-1-1.	

T. CREMAFFILM

9

10

13/12/23

0-0-1.

plo

ANY RELEVANT INFORMATION:

Admission / OT Receival	Condition of the Patie	ON VENT 2. Oriented / Disoriented			
Date and Time: 12/12/23 OF 16.65	3. Conscious / Semico				
From: DF To: SICU	4. Febrile / A febrite	, , , , ,	5. Intubated / Extubated		
Transfer Out	Condition of the Patie	ent:			
Date and Time: 14/12/28	1. Stable / Unstable		2. Oriented / Disoriented		
@ 10110	3. Conscious / Semico	onscious / Unconscious	3		
From: Specto To: 202	4. Febrile / A febrile		5. Intubated / Extubated		
Transfer In	Condition of the Patio	ent:			
Date and Time :	1. Stable / Unstable		2. Oriented / Disoriented		
	3. Conscious / Semiconscious / Unconscious				
From: To:	4. Febrile / A febrile	<u></u>	5. Intubated / Extubated		
1) Known Case of	Year	Months	Days		
Diabetic Mellitus	12 YEARS				
2) Known Case of Hypertension	-	12			
3) Known Case of Bronchial Asthma/COPD	-	-			
4) Known Case Of Others	-	7 - 1 - N - 1 + 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1			
<u> </u>	-				
	Yes	√ No			
Denture	Permanent Fixation	n .			
	Temporary Fixatio	on: Present / Absent			
	☐ Yes	No			
Allergic Reaction : Drugs/Food	If you means mention a	bout Drug / Food Nam	e :		
	☐ Yes	✓ No			
Pressure Ulcer Present	If you means mention about Grade: 1/2/3/4 & Site:				

ANY RELEVANT INFORMATION:

• • • • • • • • • • • • • • • • • • • •				Sign With Date
Peripheral Cannulation	1. Site: RT CUBITAL	1. Inserted Date and Ti		1
•	2. Site:	2. Inserted Date and Ti	, , , , , , , , , , , , , , , , , , , ,	
	3. Site:	3. Inserted Date and Ti	ime 3. Removed on:	
Neek Line: IJL/EJL	Site:	Inserted Date and Time	1 1 1	
Arterial Line : Right/Left	Site:	Inserted Date and Time		
	LT RADIAL	12/12/23 at 13.4	० । हे हिन्दर्भ हो व	2002
Sheath Arterial / Venous:	Site:	Inserted Date and Time	-	
Pressure Bandage	Site: RADIAL	Inserted Date and Time	1 1 1	
Drain Site	1. Mediastinal: Inser 十 12/12/2 2. Pleural Right / Lei	23 of 15.45	Removed on 13/12/2023W Removed on 10:00	9002
Urinary Catheterization	Inserted Date and Tim	1	ved on 2/23 @ 4.40	201
Nasal / Oral Gastric Tube	Inserted Date and Tim	ne Remov	2/23 @ 20.30	
Intubation Date and Time	Extubation Date And	BHDS 35 MIN Reintu	bation Date And Time	27
Other Information	- CAG DONE ON	1 a links lange	DRE MEDICAL COLLEG	CIEK HOSF
	- ECHOCARDIOG - ECG DONE O			Nue 027
	Į.			1 1





SAFE PROCEDURE CHECKLIST Adapted from WHO Safe Surgery Checklist

MHI/OT/2022/086 Medway Heart Institute

E Mrs.SHANMUGAPRIYA S

45/Fcmalc/MHI202381078

	0 01 a 0 m	many		45/Female/MHI202381078
Name of the December 1	604BC CFORED	Location : 0707 -07 II	Date & Time : 12	_
Name of the Procedure :	<u> </u>	Location: O/O / 120 / 243	Date & Time :_\r	- THE TENENT OF THE TENENT AND THE T
Does the Procedure involve	Procedural Sedation :	Yes No JIMA		110 447 1881 183 018 8081 1881 1881 1881 1881 1
SIGN IN 13.00 Before Induction of Procedural S	edation	TIME OUT 1 1 2 2 5 After procedural Sedation and before procedure		SIGN OUT 4 6 SO When Doctor indicates that the Procedure is completed
(Anaesthetist / Qualified Physicia Sedation + Nurse + Technician + Do	n administering Procedural	(Anaesthetist or Qualified Physician	administering Procedura performing the Proced	l Sedation + Nurse + Technician + Doctor ure
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	☑ Yes	Name of the Procedure done written down Stest OFOSED WEREST
Procedure	₽Yes	Procedures	₽TY¢s	Name and site of all specimens / investigations Yes NA-
Side	□Rt □Lt □NA	Side	□Rt □tt □NA	confirms labeling and sent to lab
	chest 4 leg	Expected Blood loss 200 - 200 MN	chest whea	
Consent	☐ Y es/	Position — SUPINE	□-Yes /	Any recovery concerns : ☐ Yes ☐ Norte
Known Allergy	☐Yes ☐NØT LINOW		□Yes)	if Yes, Pls. specify:
	If yes, plaese specify	Required equipment and implants available	☐Yeş ☐ NA	
Difficult airway / aspiration risk	☑No ☐ Yes, equipment	Essential Imaging displayed	☐Yes/☐NA	
/ dentures	and assistance available	Antibiotic prophylaxis within last 60 minutes	HYes □NA	
Possibility of hypothermia	☐ No ☐ Yes, warmer in place	Name of the Antibiotic given TWT-CEFURWING	1-210B.20	Any Equipment / instrument problem that needs to be
		Venous Thromboembolism Prophylaxis Provided	☐Yes ☐₩A7	addressed: ☐ Yes ☐ Norre> If Yes, Pls. specify:
All concerned anesthesia equipment	and medication check complete	Anticipated duration briefed	⊞Yeş	
☐8po2 ☐NIBP ☐ Other	s pls. specify	Anticipated blood loss briefed	□¥Yes/□NA	WALLEY SOUNCE IN SOUNCE STREET
Pre OP medication taken	☐Yes ☐No	Adequate fluids and blood available	☐Yes/□NA	COUNT'S ARE CORRECT
	,	Team briefed on any critical or unexpected steps	□Yes , NA-/	Corrective action :
Required equipment for	□Y9s □NA	For procedural sedation cases		
procedure available	/	Any patient specific concerns : Intra procedure glycernic control	☐ Yes ☐ None	·
		Any concerns about sterility	Yes None	_
Angesthetis Doctor divison Proceeding Secation DRASE DR. SXIVEREL DRASE DATE SELVES	Procedure Reg N	10: 55476 0081 10: 55476 Date: \2\\2\2\2\2\3\	Date: 101129	NORSE DIC-CHRISTINA:D Date: 12/12/23 608 [CTOT]
Time: Reg. No: 43570	. Inute: 1Pres	Time: 16.80 0.031 1	ime: \b \\$0_	Time: 16.50





Mts.Shanmugapriya S

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.Anbarasu Mohanraj





CONSENT FORM - PHYSIOTHERAPY

I, Mu. Shanmusa Driya the Patien above and below):	nt or e∏repre	sentative of patient have <i>(p.</i>	lease tick the correct option
Read			
1/We have been explained the current clinical condition	ofme/mvp	atient	. •
Been explained this consent form in Tourit			inderstand and understood
the information provided about Operation / procedure			
	POST	OPERATIVE	CARDIO
PULMONARY REHABILITATION	<u>√</u>		
(full name of operation / procedure given below in this conse	ent form)		
Brief description of the Operation / Procedure: DB	E's , © Rom	hest percussi Gr's, Mobi	'on, 'U'zation'
I understand the intended benefits of undergoing the proce	edure .The int	ended benefits from this pro	cedure are:
Chest Expansion. To	CORAL	nut dune	Secretion
Lunderstand that all procedures corpus actain risks. The not	ontial rieke a	od complications from this n	roondures
I understand that all procedures carry certain risks. The pot	יייי	id complications from this p	ocedure.
			<u>+</u>
Pau		···	7
	•		
I have been explained the implications of not undergoing th	is procedure	and the alternative methods	of treatment like:
			
I declare that I have received and fully understood the given an opportunity to ask questions relating to my consequences, alternatives, potential complications have been answered to my entire satisfaction and the declare that all fields (of this form) requiring insertion signing this form.	ailment, the and intende ere are no n	e operation / procedure bed benefits and recovery, nisconceptions or false he	eing performed, its risks, and that all my questions opes in my mind. I further

For the above ment Dr. Paman procedure on m	name of doctor perfe	I have been made aware of, I give my consent viorming the operation / procedure) for carrying being fully aware of the nature, potential ris	out the said oper	ration / ations,
		ve, do further hereby declare that I am above 1 onsent without any fear, threat or false misconc		on the
	Signature / Thumb Impression*	Name	Date	Time
Patient				
Surrogate/Guardian (if applicable #)	Bloke	R S റ്റ് LVAKUMAR (Write name and relationship with patient)	12/12/23	15:00
Reason for surrogate consent	Patient is unable to give consent b	pecause;		
Witness	D. Sheeby	D. Leeby Jo	12/12/23	18:00
Interpreter (if applicable)		i		
l, the undersigned procedure course,		potential risks and complications, intended be led operation / procedure, to the patient / patient		

Г

	Signature .	Ņame .	• •	Reg. No.	' Date	Time
Consent obtained by	1 Acr	Ramanathan:	ρ_'	0260	12/12/23	18.00
Procedure performed by	SPA .	Ramanathan.		0260'	12/12/23	r 6'-00



Mrs.Shanmugapriya S 45/Female/MHl202381078 11/12/2023/IPH202302475 Dr.Anbarasu Mohanraj



IN-PATIENT INITIAL ASSESSMENT FORM - PHYSIOTHERAPY

Chief Complaints:	-				
Pt developed Sudden Nytha - w.	Onset Shortness of Breath.				
MY.HA - W.	ŭ				
Occupation: Heavy Activity Moderate Activity	y Light Activity				
Past Medical / Surgical History:	Light Activity				
ECCO Dm x 12 year					
	<u> </u>				
On Observation:					
Built: Thin Fair Well Built Obese Postural Deviation	·				
Deformity: ☐ Yes ☐ No Swelling: ☐ Yes ☐ No Gait Deviation: ☐ Yes ☐ No External Appliances: ☐ Yes ☐ No					
	<u></u>				
On Palpation:	□ INSIGNIFICANT				
Tenderness: ☐ Yeş ☐ No Warmth: ☐ Yes ☐ No Muscle s	☐ INSIGNIFICANT				
Tenderness: ☐ Yes ☐ No Warmth: ☐ Yes ☐ No Muscle sp Oedema: ☐ Yes ☐ No Crepitus: ☐ Yes ☐ No Tone: ☐ Norm	☐ INSIGNIFICANT				
Tenderness: ☐ Yes ☐ No Warmth: ☐ Yes ☐ No Muscle spondedema: ☐ Yes ☐ No Crepitus: ☐ Yes ☐ No Tone: ☐ Norm	☐ INSIGNIFICANT pasm:☐Yes ☐No nal ☐Abnormal				
Tenderness: ☐ Yes ☐ No Warmth: ☐ Yes ☐ No Muscle sponded on a Green of the control of the c	☐ INSIGNIFICANT pasm:☐Yes ☐No nal ☐Abnormal ☐History of fall in last 3 months				
Tenderness: Yes No Warmth: Yes No Muscle sponded and Yes No Crepitus: Yes No Tone: Norm FALL RISK SCREENING Fall Risk Screening for Adults: Age more than 65 years Walks with assistance	☐ INSIGNIFICANT pasm: ☐ Yes ☐ No nal ☐ Abnormal ☐ History of fall in last 3 months ☐ Any neurological problem				
Tenderness: ☐ Yes ☐ No Warmth: ☐ Yes ☐ No Muscle sponded on a Green of the control of the c	☐ INSIGNIFICANT pasm: ☐ Yes ☐ No nal ☐ Abnormal ☐ History of fall in last 3 months ☐ Any neurological problem				
Tenderness: Yes No Warmth: Yes No Muscle sponded and Yes No Crepitus: Yes No Tone: Norm FALL RISK SCREENING Fall Risk Screening for Adults: Age more than 65 years Walks with assistance	☐ INSIGNIFICANT pasm: ☐ Yes ☐ No nal ☐ Abnormal ☐ History of fall in last 3 months ☐ Any neurological problem				
Tenderness: Yes No Warmth: Yes No Muscle sponded and Yes No Crepitus: Yes No Tone: Norm FALL RISK SCREENING Fall Risk Screening for Adults: Age more than 65 years Walks with assistance In case of 2 or more criteria is met, initiate detailed fall assessment.	INSIGNIFICANT pasm: Yes No nal Abnormal History of fall in last 3 months Any neurological problem nent and fall prevention protocol.				
Tenderness: Yes No Warmth: Yes No Muscle sponded and Yes No Crepitus: Yes No Tone: Norm FALL RISK SCREENING Fall Risk Screening for Adults: Age more than 65 years Walks with assistance In case of 2 or more criteria is met, initiate detailed fall assessments. Fall Risk Screening for Pediatrics:	INSIGNIFICANT pasm: Yes No nal Abnormal History of fall in last 3 months Any neurological problem nent and fall prevention protocol. seizure, etc) Deranged mobility				
Tenderness: Yes No Warmth: Yes No Muscle sponded and Yes No Crepitus: Yes No Tone: Normal Fall Risk Screening for Adults: Age more than 65 years Walks with assistance In case of 2 or more criteria is met, initiate detailed fall assessment of H/O fall in last 3 months Neurological problem (vertigo,	INSIGNIFICANT pasm: Yes No nal Abnormal History of fall in last 3 months Any neurological problem nent and fall prevention protocol. seizure, etc) Deranged mobility				
Tenderness: Yes No Warmth: Yes No Muscle sponded and Yes No Crepitus: Yes No Tone: Normal Fall Risk Screening for Adults: Age more than 65 years Walks with assistance Normal Walks with assistance In case of 2 or more criteria is met, initiate detailed fall assessment of H/O fall in last 3 months Neurological problem (vertigo, In case of 2 or more criteria is met, initiate detailed fall assessment of 2 or more criteria is met, initiate detailed fall assessment.	INSIGNIFICANT pasm: Yes No nal Abnormal History of fall in last 3 months Any neurological problem nent and fall prevention protocol. seizure, etc) Deranged mobility ment and fall prevention protocol.				
Tenderness: Yes No Warmth: Yes No Muscle sponded and Yes No Crepitus: Yes No Tone: Normal FALL RISK SCREENING Fall Risk Screening for Adults: Age more than 65 years Walks with assistance Walks with assistance In case of 2 or more criteria is met, initiate detailed fall assessment of the H/O fall in last 3 months Neurological problem (vertigo, In case of 2 or more criteria is met, initiate detailed fall assessment of 2 or more criteria is met, initiate detailed fall assessment. Respiratory Status:	INSIGNIFICANT pasm: Yes No nal Abnormal History of fall in last 3 months Any neurological problem nent and fall prevention protocol. seizure, etc) Deranged mobility ment and fall prevention protocol. Brain Injury (if applicable):				
Tenderness: Yes No Warmth: Yes No Muscle sponded on the Normal Pall Risk Screening for Adults: Age more than 65 years Walks with assistance Walks with assistance In case of 2 or more criteria is met, initiate detailed fall assessment of 2 or more cri	☐ INSIGNIFICANT Dasm:☐Yes ☐No nal ☐Abnormal ☐ History of fall in last 3 months ☐ Any neurological problem nent and fall prevention protocol. Seizure, etc) ☐ Deranged mobility ment and fall prevention protocol. ☐ Brain Injury (if applicable): ☐ Traumatic ☐ Non Traumatic				

Spine Injury: ☐ Present ☐ Absent						
AIS:ISNCSCI SCALE:						
☐ Cervical ☐ Dorsal ☐ Lumbar ☐ Sacral ☐ Coccyx						
Associated Injuries: Speech impaired: Yes No						
Voluntary Movements: ☐ Present ☐ Absent Tone Modified: ☐ Hypotonic ☐ Normal ☐ Hypertonic						
ASHWORTH SCALE:						
☐ Tightness ☐ Contracture ☐ Deformity ☐ Sensory Deficit						
Balance: ☐ Good ☐ Fair ☐ Poor │ Co-ordination: ☐ Good ☐ Fair ☐ Poor .						
Functional Activities						
Self Care: Independent Dependent Bed Mobility: Independent Dependent						
Transfers: ☐ Independent ☐ Dependent ☐ Ambulation: ☐ Independent ☐ Dependent						
FIM Score:						
Breathlessness (If applicable): Present						
Breathlessness (If applicable): Present Dyspnoea Grading Scale: NYHA - Grade IT						
Abnormal Breathing Sounds: ☐Wheezing ☐Stridor ☐ Crackles ☐ Pleural Rub ☐ Pneumothorax Click ☐ Stertor						
Abnormal Breathing Pattern:						
Pain Assessment: Pain: ☐ Yes ☐ No						
Pain Score:						
Tick whichever is applied: ☐ Numerical Rating Pain Scale ☐ Visual Analog Scale ☐ Wong-Baker Faces						
☐ Pain Scale ☐ Critical Care Pain Observation Tool ☐ FLACC						
Location: Duration: Frequency: Character:						
☐ Acute ☐ Chronic ☐ Burning ☐ Aching ☐ Radiating ☐ Numbness						
☐ Sharp ☐ Cramping ☐ Stabbing ☐ Crushing						
Aggravating Factors: Relieving Factors:						
Aggitavating ractors.						
On Evertion on Rest						
on Rest						

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=amination ((Please tick and mention ab	normal findings only):			•
☐ Range of M	lotion:				
	Mormal				
☐ Muscle Stre	ength:				
	Normal				
☐ Reflexes:	Normal				
İ	Norman				
Plantar Respo	nse: 🏿 Diminished 🔲 Brisl	k □ Clonus			
1	ninished □Brisk □Clonus				i
	minished □Brisk □Clonu		·		
Supinators: 본		onus			
Knee: Dimi	nished Brisk Clonus				
Ankle: ☐Dim	inished □Brisk □Clonus				
Sensation:					
Investigation	_	_		-	
	CAD-TUE) IT2DM MODILY	(EF - 35.).		
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Physiotherap	y Management Plan:				
	st. 1				
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-0	Chest Percumo	n`			
-	DBE'S Chest Percumo Spinometry G Arom Gr's	2.0			
-	Arom 6.5				
_	Mobilization'				
	Signature	Name	Emp. No.	Date	Time
Physiotherapist	Dar	Pamorathan. P	0260	12/12/29	18:00

	RE-ASSE	SSMENT FORM	
Date & Time	Post Intervention Pain Score:	Swarper Long Capacity Lunction Constitutions	
	Cet operatione	Cordia Pelmonory Relu	
Physiotherapist	Signature	Name AKASIA A.B	Emp. No.
. iiyo omorapist	Giral	MINASIA OID	J-~ j

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Mrs.SHANMUGAPRIYA S 45/Female/MHI202381078 11/12/2023/IPH202302475 Dr.ANBARASU MOHANRAJ

The way to better health

		PHYSIOTHERAPY TREATMENT CHART	
DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
12/12/23	20:30	8/B Raman outhan - P	
		- EF Grow Nasad Suctioning done Yielded thick Secretion - Pt Entubated and Connected to Nosal prongs (4:-02) - Pt Woise Clear & Audible - DRE'S encouraged - Chest Percussion to B/2 Chestwall - Apport G's to B/2 U 24 - Spirrometry Grá encouraged Ins: 6000 Gop: 60000	MH1 0260
13 /12/23	b. 50	SIB Ramanathan.p - DRE's encouraged Chest percussion to BIC Chestural - Arom Bo's to BIC OL 2U - Spirometry Bo's encouraged Ens: 6000 Rop: 6000	##10260





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PHYSIOTHERAPY TREATMENT CHART

MH/ PRINT / 0096 / PHY

Mis.Shanmugapriya s

45/Femalc/MHI202381078 11/12/2023/IPH202302475

Dr.Anbarasu mohanraj

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
18/12/23	9:00	S/B AWASI	O re Short
13/12/23	17.00	- DBC Emeroraged - Sproanetry 25 swowoogld Jus: booce pap: booce - dust percussion to ble Obest Wall - AROM to Ble UP fle S/3 J. VI) AYARALAWAN - DB R/ Bulomyed - clust permuton done to Ble Chust woul - Sproanety En Enlanged Jes booce Par-booce - Active en to Ble U Sle - Patract mobilisch to Chair. - Musche Release done to Meck	J. my mmc-2102
13/12/23	2) :0	SB Ramarathan p - DBE'S encouraged - Chat percurian to B1. Chai wall - AROM Ga's to B1. Us all	DARO
		- AROM Gas to BIL UL RU -Spirometry Gos encouraged Ess: 6000 Gop: 6000	#R1 mH1 0266



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PHYSIOTHERAPY TREATMENT CHART

MH/ PRINT / 0096 / PHY
Mis.Shanmugapriya s

45/Female/MHl202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
14/12	3 6:00	SB Ramanathan 1	
		- DBE'S encouraged - Chart pencueron to Ble chetrall - AROM Es's to Ble view - Spirometry Be's encouraged Ens: 600 u Exp: 6000 - Pt Chair mobilised	======================================
14/12/23	DE P	Je ARASH - prer Oucouraged - sprometry encouraged The: booce BRp: booce - cheet percusuar to ble	GB: 91000 MH10256
14/12/23	16:30	Cheet wall - AKOM to BLUILL - ST DINITHYARACIANAN - DEES Enlowinged - cheet remnifor done to Ble chotad - Spiromely end enlowinged - Jes-Gooce Mr. 600ce - Achine end to Ble uc & U - Patient no Hirel Balthe the voom	J-my mnc-2102





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PHYSIOTHERAPY TREATMENT CHART

MH/ PRINT / 0096 / PHY

Mrs.SHANMUGAPRIYA S

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
15/2/23	\$0 \$ 00	StB AKAGY - Prometry End Eurowagh - End & Source De	G E Alas
		-chet prorcueur ABLI Chest wall Arom to Ble viole - PT Mobalized	
16/12/23	41,000	- Der Ormandon Love to such from	
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MHI/IP/2022/067

CONSENT FOR BLOOD / BLOOD COMPONENTS

A Blood transfusion is life saving medical procedure, prescribed by a physician. Blood can be given 'whole' but more often a component or combination of component is transfused. Among the most common components are:

Red Cells for bleeding or low hemoglobin

Platelets for bleeding or low counts

Plasma for restoring blood volume or providing clotting factors

Cryoprecipitate for special clotting factors

The Doctor has explained the benefits that are expected from my/the patients being transfused as well as the risk are:

- I have been informed the transfusion option available, which may include banked blood (allogenic) provided by voluntary donors or self-donation (autologous). If an emergency condition exists, banked blood will be invariably be used. Self-donation is possible if time permits.
- 2. I have been informed that despite careful screening in accordance with national regulations, there are rare instances of life threatening infections such as AIDS, Hepatitis and other viruses or diseases as yet unknown. I understand that there is no practical way to eliminate all risks. I also understand that unpredictable reactions may occur which include but are not limited to, fever, rash, and shortness of breath, shock and in rare occasions, death.
- Expected benefits of the transfusion may include minimizing shock, brain and other organ damage, hastening
 recovery and limiting blood loss, however, I understand that there are no guarantees offered as to the expected
 benefits.
- 4. I have had the opportunity to ask questions about transfusions, alternate forms of treatment, risks of non-treatment, the procedures to be used, and the relative risks and hazards involved and I believe that I have sufficient knowledge to make an informed decision.
- 5. I agree/Not agree the administration of blood and/or components in the interest of proper medical care, with my signature I give consent to administering blood products for myself or for the patients. I agree this informed consent may serve for consent to give additional necessary blood products for a time certain to end with this hospitalization or for the complete course of this illness. If I have been advised that the future need for transfusion blood products is quiet likely and possibly on a recurrent basis but still related to the same illness.

Witness U. Deuton	Patients name ST S. SHANMUCORUM	
Doctor 15,30	or Guardians name	
Date 11/12/23	Guardians signature	

Informed consent not obtained because of a life threatening/emergency medical condition. I have provided the patient information sufficient to be considered informed consent and I have proceeded with ordering blood products to be administered in sufficient quantity to alter, improved or reverse a life-threatening/emergent medical condition.

Time: 15-40	Date: 11/12/2->	Doctors Signature:
(J. J.		Bubb





தேத்:



ஒப்புதல் : இரத்தம் / இரத்தத்தீன் பாகங்களை செலுத்துதல்

இரத்தம் செலுத்துதல் என்பது, மருத்துவரால் பரிந்துரைக்கப்படுகின்ற ஒர் உயிர் காக்கும் மருத்துவ செயல்முறையாகும். முழுமையான இரத்தம் அளிக்கப்படலாம் என்றாலும்,பெரும்பாலும் ஒரு பாகம் அல்லது பாகங்களின் கலவை செலுத்தப்படுகிறது. மிகப் பொதுவான பாகங்களில் கீழ்கண்டவை அடங்கும்.

சிவப்பு அணுக்கள்	இரத்தப்போக்கு அல்லது குறைந்த ஹீமோகுளோபினுக்கு
தட்ட <u>ண</u> ுக்கள்	இரத்தப்போக்கு அ ுக்கது குறைந்த எண்ணிக்கைக்கு
கருத் நீர்	இரத்த கன சிளவை மீட்டமைப்பதற்கு சில்லது உறைவு சிம்சங்களை வழங்குவதற்கு
கீரையோபிரைஸிபிடேட்	சிறப்பு உறைவு அம்சங்களுக்காக
எனக்கு /நோயாளிகளுக்கு இரத்தம் செலுத்து	ப்படுவதன் மூலம் எதிர்பார்க்கப்படும் நன்மைகள் மட்டுமின்றி இடர்களையும் மருத்துவர் விளக்கியுள்ளார்
1. இரத்தம் செலுத்துவதீல் கீடைக்கீன்ற விகு	நப்பத்தேர்வு பற்றி எனக்கு தகவளைிக்கப்பட்டுள்ளது. இதீல் தன்னார்வ தானமனிப்பவர்கள் வழங்கீயுள்ள வங்கியிலுள்ள
இரத்தம் (அலோஜெனிக்) அல்லது சுயமாக	தானமளித்தல் (ஆட்டோலோகள்) ஆகியவை அடங்கும். ஓர் அவசரநிலையில், வங்கீ இரத்தம்தான் பயன்படுத்தப்பு
வேண்டியிருக்கும். நேரம் கிடைக்கும் பட்சத்தி	ில் சு ய தானமளிப்பதற்கு வாய்ப்புள்ளது.
தேசிய விதீமுறைகளுக்கேற்ப கவன	ரத்துடன் முன்சோதனை செய்யப்பட்டிருந்தாலும், உயிருக்கு ஆபத்தை விளைவிக்கக்கூடிய தொற்றுக்கான எய்ட்ஸ்,
ஹெபடைடிஸ் மற்றும் இதர வைரஸ்கள் அக்	மலது இதுவரை அறியப்படாத நோய்கள் ஏற்பட்டுள்ள அரிதான நீகழ்வுகளும் உள்ளன. எல்லாவிதமான இடர்களையும்
நீக்குவது என்பது நடைமுறைக்கு இயலாத	ஒன்றாகும் என்பதையும் நான் புரிந்து கொள்கீறேன். கணிக்க முடியாத எதீர்விளைவுகளும் தோன்றலாம். இவை
காய்ச்சல், பொரிப்பு, மூச்சுத்திணறல், அதிர்ச்சி) மற்றும் அரிதான நிகழ்வுகளில் இறப்பு ஆகியவற்றை உள்ளடக்கி, அந்த வரம்புக்குட்படாதவையாகவும் கூட இருக்கலாம்
என்பதையும் நான் புரிந்து கொண்டேன்.	
	எதிர்பார்க்கப்படும் நன்மைகள், அதிர்ச்சி, மூளை மற்றும் இதர உறுப்புகளுக்கு ஏற்படும் சேதம் குறைக்கப்படுதல்,
	இரத்தம் இழக்கப்படுவதைக் குறைத்தல் ஆகியவற்றை உள்ளடக்கியிருக்கரைம் என்றாலும், எதிர்பார்க்கப்படும்
நன்மைகளுக்கு உத்தரவாதம் ஏதும் அளிக்க	ப்படவில்லை என்பதையும் நான் புரிந்து கொள்கிறேன்.
// / -	முறைகள். சிகீச்சை எடுக்காமல் இருப்பதிலுள்ள அபாயங்கள், பயன்படுத்தவிருக்கும் செயல்முறைகள், மற்றும் இதிலுள்ள
	ற்றிய கேள்விகள் கேட்பதற்கு எனக்கு வாய்ப்பிருந்தது. மேலும் தகவலறிந்த நிலையில் முடிவெடுப்பதற்கு ஏற்ப எனக்கு
போதிய விவரங்கள் தெரிந்திருந்தன என்று நு	
	ு . ரின் பொருட்டு, இரத்தம் மற்றும் / அல்லது அதன் பாகங்கள் செலுத்தப்படுவதற்கு நான் ஒப்புக்கொள்வதுடன். எனது
	நாயாளிகளுக்கு இரத்தப் பொருட்கள் செலுத்தப்படுத்துவதற்கு என் ஒப்புதலை அளிக்கீறேன். இதே நோய் தொடர்பாக,
	ன எதீர்காலத் தேவைக்கு வாய்ப்புள்ளது மற்றும் அது தொடர் அடிப்படையில் இருக்கலாம் என்று எனக்குத்
	ந்துவமனை சேர்ப்பின் குறிப்பிட்ட காலத்தில் முடிவடையும் வகையில் அல்லது இந்நோயின் முழுமையான
	த்தப் பொருட்கள் செலுத்தப்படுவதற்குரிய ஒப்புதலையும் இத்தகவலறிந்த ஒப்புதல் மூலம் வழங்குவதற்கு நான் ஒப்ட÷்
கொள்கிறேன்.	த்து ஏபாமுட்கள் எஷித்தாரமுள்கிற்குயார் இருந்தையும் இத்தைவகுறும் இருப்புக்க ஆக்கு ஆகும் வழியகுள்குற்கு நால் இரட
രത്തിയാട്ട്രത്.	நோயாளியின் பெயர்
em: d	நோயாளியின் கையொப்பம்
	அல்லது பாதுகாவலரின் கையொப்பம்
	பாதுகாவலரின் கையொப்பம்
-	_
(pp)	. நோயாளியுடனான உறவு
•	துவ நீலை காரணமாகத் தகவறிந்த ஒப்புதல் பெறப்படவில்லை, தகவறிந்த ஒப்புதலாகக் கருதப்படக்கூடிய அளவிற்கு
	ிக்கு வழங்கிவிட்டேன். மேலும் ஓர் உயிருக்கு ஆபத்தான / அவசரக்கால மருத்துவ நிலையை மாற்றுவதற்கு,
~ `	ற்கான போதிய அளவில் இரத்தப் பொருட்களை வழங்குவதற்கான உத்தரவை வழங்கும் நடவடிக்கையை நான்
மேற்கொண்டுள்ளேன். ் ் 🏎	
நேரம் :	
கோயானியின் பெயர் *	பதக்களின் கையெய்யம்





Mrs.Shanmugapriya S

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.Anbarasu mohanraj

11 E AN 1811 AND 1818 AND 1814 AND 181

URINE ROUTINE ANALYSIS MICROBIOLOGY SHEET

DATE	29 11 53.
COLOUR	DAJF VELLOW.
REACTION	
SPECIFIC GRAVITY	1.015.
APPEARANCE	CLEAR.
ALBUMIN	
SUGAR	(+,+)
ACETONE	
BILE SALT	
BILE PIGMENT	
UROBILINOGEN	NOPMAL.
PUS CELLS	2-4
EPITHELIAL CELLS	2-3
RBC	2-4
CASTS	Nic
CRYSTALS	NIL
OTHERS	NIC.

MICROBIOLOGY-CULTURE REPORTS

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







Everu heart heat counts Mrs.SHANMUGAPRIYA S

45/Female/MHl202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ

DIABETIC CHART

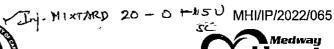
ACTUAL WE	:IGHT6	58.11 kg HbA,c	11.97. Inj. HA 60	-6U-6U	
PREVIOUS I	DIABETIC I	MEDICATIONS	Cy, Human Mi		-oqu
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
1/12/23	2.52	2H2 wd [9]	Pry. HA 60	The wa	A. Praveen.
	13:35	250 mg/d/	Inj. HA 190	19.50 8	Jeth Promeon.
		J .	Duj. Human 60		Prover.
la lights	6-36	595 mg/dl	Inferior 100/lm.	? Soly	Dar Provisa 1
		Ketone > 0.2 !	INS. Human Actropy 801 SCO 9.	00	4
	9:30	Ketone > 0.2 !	\$ 40/h	Honto 105	Dr. Answagn
	10:30	124 mgldl	Infusion Stop	184010 r	er
	 11:30_	71 mgids		Hayor	
		J			

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 Algorithm.	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.









T. FOXICA long 1-0-0 (A-F) MISSHANMUGAPRIYAS ...

DIABETIC CHART

T- CLIZATO MED 1-0-1 (BF)

T- TRAJENTA Song 1-0-1 (BF)

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.Anbarasu mohanraj

418 AN ANTAN BIRTAN

ACTUAL WI		HBA (1.14)	NO MIXIARD ATU	=0-AIU-(
PREVIOUS	DIABETIC I	MEDICATIONSINJ	MAN ACRAPID 6IU	-6 IU-6 IU.	
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
12/12/23	เรเธ	17A Mg (d)		DANG 100 FA 55	Dr. Sylvesier
, , ,	20.30	200 mg/dl	IM HUMAN ACRAPIT	J. 100 TO 3	DR-SAMEULE C. Em
	23.30	190 mg/dl	Bry. H. Adroupful	alm del	DR- SYLVECTER
13/12/03	pg. 30	150 mg/dl	erapped.	1W 70	DO -SYLVEGTE
	6.00	145 may loll	T. ULIZATO NBO	shut to	DR-SYLVESTER
	8:30	269 mg/d/	T. FLOULD (One PO	A1002	Dreveen Jestum
	12:20	292mg141	Inj. H. Adrapid.	Chan and	DR. PRAVEEN
	14:30	249 mg/dl.	Inj HiActrapid	Mean Now	DR, PRAVEEN JETAKOMAR.
13/10/23	19.15	201 mgidl.	T. Gilizato MBD T. Trojenia 5mg.	man orte. all	F
[4/12/23	Gory.	168 mg bll	INT. HUMBY MIXTARE	1080 / Col	DE. PROVEEN
	12170	ZXXX XXXII.	OTAS, T. TRAJENTA 5 mg O TAB GIVEN	623	Jayakumar.
			@ 08:00 T. Foxilla long() TAB	Quil 0222	Dr. Prarson
		INSTRUCTIONS	FOR INSULIN INFUS	ONS "	Jayakumak
-		1			

•	Mix 400 of ort acting Insulin in 40 ml. of	BLOOD SUGAR mg / dl	INSULIN INFUSION
*	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 hourly when stable) and adjust Insulin rate	150-200	Adjust Infusion rate to 2u / hr.
	according to the following Algorithm.	201-250	Adjust Infusion rate to 4u / hr.
		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.







Mrs.SHANMUGAPRIYA S

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.Anbarasu mohanraj

DIABETIC CHART

		_			
ACTUAL WE	IGHT	63-4 kg HDA,C.	11.9 /.	.TRAJENTAS	mg 1-0-1 (BF)
PREVIOUS I	DIABETIC I	MEDICATIONS TO MIXTHAD	200-0-100 s/c,	T. FOXIGA 10 mg	1-0-0 (AF)
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
14/0/3	12.50	212 my ldl		du se stat gia	DR-PRAVEEN
. _	1230	1112 mg 1 d1	Inj. Mixtand 10	1) A 608720 F	5/00
			7. OUTBUD N	80.04 60 619.8	je)
				~ a	
15/12/23	6.30	162 mg/de	TNJ. H. MIX 20U T. GUZATO M80	Artor (7.00	3 Pr. Proveen
		<u> </u>	T. TRAJENTA SMY T. FOXIMA long	Bull or a	
	18.30	199.	DNJ-H. Actropid 80	Office 10 th De	DR · Praireon
	18.30.	150 mg (d)	In Mixturd 15	ama (RIP)	10 20 30 B
			7 calibato m	D 10203	A Mag
16 0 23	6.30	100 mg/de	INJ. MIXTARD 18-00 T. TRAJENTA 5 MG	7 Sel 9-00	Dr. Prayean.
			T. 942A70 M80	J	
	12-30	101 megfoll			Delpor
		INSTRUCTIONS F	OR INSIII IN INFIIS	IONS	

*	Mix 40u short acting Insulin in 40 ml. of	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 Algorithm.	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.







DIABETIC CHART
MIXTARD 250-0-1008/L, TFOXIGH LOMG

45/Female/MH1202381078 11/12/2023/IPH202302475

Mts.SHANMUGAPRIYA S

1-0-0 (AF) Dr. ANBARASU MOHANRAJ

ACTUAL WE	IGHT	63.1KgHbA,c	11.97.	468 JPh Pheisma men Beitrin	
PREVIOUS I	DIABETIC	MEDICATIONS T. GLIZATO M	180 1-0-1 (BE), T	TRAJENTA	5MG 1-0-1 (BE
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign:	ENDORSED BY
2 12 23	8.30	182mg 1d1	T-GLIZATO MEO + TRATONTALINA	Ai 19.30	DR . PRAVEEN
			INJ. MIXTARD 150		,
17/12/23	6.30	204 mgldL	T. GLIZATO MEOU T. TRAJENDA EMG	OIL OIL	Dr. Prowon
		Ū.	THE MINTARD 2504	24 24	
		/.			
	_				
					
			}		
				<u> </u>	

INSTRUCTIONS FOR INSULIN INFUSIONS

BLOOD SUGAR

*	Mix 40u short acting Insulin in 40 ml. of	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.
	assoraning to the following vagorimini	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.







BLOOD GROUP

INVESTIGATION SHEET

Mrs.SHANMUGAPRIYA S 45/Female/MHJ202381078 11/12/2023/IPH202302475

Dr.Anbarasu mohanraj

- Br POSITIVE	INVESTIGATION SHEET	DI-ANDARASU MOHANRAJ].
Date	09 11 23.		
HAEMATOLOGY			\dashv
Hb	111.1		ŀ
P.C.V	35.9		\neg
Platelets	19 6000		
TLC	6460		
Polymorphs	58.7		
Lymphocytes	32.9		一
Eosinophils	3.6		
Mono / Basophils	4.2 0.6		
E.S.R			
BIO-CHEMISTRY			
Urea	0		
Creatinine	0.72		
Sodium	139		
Potassium	11.46		
Bicarbonate	Ž 8		
Chloride_	99.1		
Magnesium	`		
Calcium			
Phosphorus			
LFT			
T.Bilirubin	n·83		
D.Bilirubin	0.28		
	0.22		
S.G.O.T	IS		
S.G.P.T			
ALP	45		
GGT	id		
Total Protien			
S.Albumin	3.9		
CARDIAC ENZYMES		1	- 1
Troponin I			
CKNAC - CPK			
CK - M.B. MASS			
LDH			
Ntpro bnp			- 1

						
Date	Da 11 123.					
COAGULATION	_ (;- ;					
PT / INR						
Fibrinogen						
D Dimer						
LIPID PROFILE						
Total Cholesterol						
Triglyceride						
H.D.L			-			
L.D.L						
VLDV						
THYROID FUNCTION						
T.S.H	1.52					
T.3	1.3.2 -PO					
T.4	7.6				 -	
SEROLORY	**_ *				 	
HIV					 	
T II V	 	_				<u> </u>
HBsAg	1				 	
V.D.R.L	l coatie	0			 	
COVID 19	 					
RT- PCR		_			<u> </u>	
lgM			18	1	1	
lg	 					
HBA1C	11.9-1.					 -
FBS/PPBS						
RBS						
S.AMYLASE						
S.LIPASE	<u></u>		<u> </u>			
C.R.P	<u></u>					
PROCALCITONIN						
DDIMER						
S.Osmolality						
<u>URINE</u>						
Osmolality			T			
Spot - Na						
ACPTT	32.5					
					 -	
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Mrs.Shanmugapriya s

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.Anbarasu mohanraj

44 TO FEEL TO FEEL TO FEEL THE
BLOOD GROUP

INVESTIGATION SHEET

				<u> </u>	_ _
Date	29/11/23	12/12/23	13/12/03	14 12 23	16/12/23
<u>HAEMATOLOGY</u>	1 1-2	[
l_Hb_	th T	10.1	9.6	9.2	9.3
P.C.V	36.9	33.1	25.8		25.7
Platelets	196000	160000	1.57		143000
TLC	6460		10,800		9310
Polymorphs	<u> 58.7</u>		90.9		63.5
Lymphocytes	32.9		7.9		31.6
Eosinophils	3.6		0.0		2.5
Mono / Basophils	11.2 0.6		1.2/0.0		2.4 /00
E.S.R	,,,		, , , ,		
BIO-CHEMISTRY					1
Urea	01		21	<u> 24</u>	28
Creatinine	0.72		0.46	0.57	0.80
Sodium	139			135	128
Potassium	-			3.89,	3-80
Bicarbonate	4·46 28				
Chloride	99.1				
Magnesium	,	2.4	1.6		
Calcium			, ,		
Phosphorus					
LFT					
T.Bilirubin	<i>0</i>		0.75		
D.Bilirubin	0.28				
I.Bilirubin	0.55				
S.G.O.T	15				
S.G.P.T	10				
ALP	<i>ች</i> 5				
GGT	19	. .			
Total Protien	7.1				
S.Albumin	3.9		3.1		
CARDIAC ENZYMES					
Troponin I					
CKNAC - CPK			122		
CK - M.B. MASS			9.2		
LDH					
Ntpro bnp					
				·	<u> </u>

	1 . 1 1			<u> </u>		
Date	09/11/03					
<u>COAGULATION</u>	' '	, -4,	-	ı	. :	
PT/INR		1.	t , s		;	i j
Fibrinogen		Ş	**			
D Dimer , .		***	-5.4			-
LIPID PROFILE						
Total Cholesterol						-
Triglyceride	·					
H.D.L	2, 10				- •	• • •
. <u></u>			·		1 1	
L.D.L 1, 15	11	ر المنياز الم	Balang 1	* z' v		1
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THYROID FUNCTION		<u> </u>		. , ,	,	r
- T:S.H9	1.52				- 7	
Т.3	79	1	,			-
T.4 · · · · · · ·] · ·	7-6	3		- '	-	- '
SEROLORY				<u>-</u> ´	*	
-HIV						
HBsAg	NEGRIVE	1		. '	_	
V.D.R.L	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		,		;	` , '1 '
COVID 19						
RT- PCR	·				· · ·	1.
IgM	7	<u> </u>			-1	
		•	'	•	, ,	-
lg HBA1C					_	
	11.9%.					
FBS/PPBS						. , :
RBS		 			_	
S.AMYLASE		_				
S.LIPASE	_					,
C.R.P			ļ	•		
PROCALCITONIN	-	-		,		٠
DDIMER						**
S.Osmolality						
URINE				-		·
Osmolality						- 1
Spot - Na	-					
		-				
						
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Mrs.SHANMUGAPRIYA S

45/Female/MH1202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ



MHI/IP/2022/074 Heart Institute

Every heart beat counts

VITAL INFORMATION SHEET ON ADMISSIO Height in CM | Weight

BLOOD GROUP B' DOSITIVE

ON ADMISSION

Height in CM Weight in Kg.

165 CM 63.01 kg.

Diagnosis:		h.	ر)۔		ΓΛ	1	Q														Ī	² ro	cec	lur	e :																	14	<u> </u>	<u>C</u>	1	1_			6	<u>3.</u>	11	ke	7	
NO. OF DAYS		Ω					74		1													_																																
DATE		Ŋ					•																																															
HOUR	2	6 1	2	6 1	0 2	2 6	10	2	6	10 2	2	6 10	2	6 1	10 2	6	10	2	6 10	2	6	10	2 (3 10	2	6 1	0 2	2 6	10	2	6 10	0 2	6	10	2 6	10	2	6 1	0 2	6	10	2	6 10	2	6	10 2	2 6	10	2	6 1	0 2	6	10	2
40.5	F		\square	4	Ŧ	Ŧ	П	\Box	7	Ŧ	7	Ŧ	\blacksquare	\dashv	\mp		П	1	\bot	Г	П	\Box	1	Ŧ		H	Ţ	\perp	\Box	\dashv	Ŧ	Ŧ	\prod	7	T	П	\neg	4	\perp	П	\Box	Ŧ	Ŧ			4	Ŧ	П		1	F	\Box	\bot	7
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39.5	<u>"</u>		\Box		\perp	上	Ш		╛	\dagger	士	士		1	\dagger	上			†		┧		1	\pm				士	H		1			İ	士			\pm	†	\Box		\perp						Ш			土		1	士
39	۰Ę	oxdapprox	\Box	\dashv	\bot	\perp	Н	\dashv	\dashv	Τ-	7	\perp	\perp	4	Τ-	$oxed{\bot}$	Ц	\downarrow	Ŧ	$oxed{\Box}$	\Box	\dashv	\bot	\bot	$oxed{\Box}$	П	\perp	\perp	Ц	\dashv	4	\perp	Н	4	Ţ	Щ	\dashv	\bot	\perp	П	\dashv	\perp	\bot			\perp	\perp	П	\Box	4	\bot	Ц	_	\bot
38.5	╟	\vdash	$\dagger \dagger$	+	╁	士	\vdash	_	+	+	士	+	\Box	+	+	十	\vdash	_	+	╁╴	H	\dashv	╁	+	\vdash			+	Н	\dashv	\pm	+	H	\pm	+	\vdash	\exists	\pm	\pm	H	+	\pm	\pm			+	╁	Н		+	\pm	$\parallel \perp$	+	\pm
	-	Н	\square	\dashv	\bot	Ŧ	П		_	\perp	7	Ŧ	Н	-	1	$oxed{\Box}$	Н	4	4	L	\square		4	1	F	Д	Ţ	\bot	П	_	4	_[\Box	\perp	Ŧ	\square	\Box	\perp	F	\square	\dashv	\perp	F			+	\perp			7	+	Ц	4	4
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37.5	╬				1	1	П		\dashv	1	#	Ţ		ゴ	\mp	二		#	1		Ħ		#	Ţ	L	Ħ	Ţ	I	П	\dashv	7	1		\downarrow	I		\Box	1	T			#	\downarrow			#	1	\Box		#	Ţ		1	7
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Medway Hospitals

The way to better health

(A lini of linial Allicenter)

(A Unit of United Alliance Healthcare Pvt Ltd)

MIS.SHANMUGAPRIYA S

45/Female/MHI202381078 11/12/2023/PH202302475

Dr.ANBARASU MOHANRAJ







Every heart beat counts,

VITAL INFORMATION SHEET

BSA:

BLOOD GROUP' & POSITILE ON ADMISSION Height in CM Weight in Kg.

Diagnosis:		•)~[]					Sol	V J	Lν		EE	<u>: -</u>	_3	<u>6</u> `)			_					_	:	0	KF.	%)	×Α	1 0	IRF	/ k/	<u>የ</u>										(164	5 C	M			(23	4	kg	_]
NO, OF DAYS			১১				20[D		111_	P	OL		P	ot) -	IV		P	DD.	·Y	- -													_													
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39.5	•	4	+		\Box	7	\mp	F	П	+	+	F	П	7	7	F	H	7	\perp		$\overline{+}$	\dashv	Ŧ	F	П	+	\vdash	\Box	Ŧ	+	H	\Box	_	F	П	7	Ŧ	\vdash	П	\mp	\perp	\vdash	H	\dashv	\perp	\perp	H	7	\dashv	\vdash	H	\mp	\perp	F
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38.5	·		+	H	7	- -	+	Ħ		+	+	F	H	_	+	F	H	7	-	F	\dashv	7	+	ŧ	H	+	H	Ħ	‡	+	F		+	-		Ŧ	Ŧ	Ħ	\dashv	\dashv	+	╀	H	4	#	╄	Ħ	#	+	Ŧ	H	+	+	F
38°	·	\dashv	+	H	7	+	Ŧ	Ħ		+	‡	F	H	7	+	F	H	7	1			7	Ŧ	Ŧ	H	+		H	7	+	F	7	+	F	H	7	Ŧ	F	Ħ	\downarrow	+	F	H	\dashv	\downarrow	Ŧ	\Box	7	1	+	H	1	-	F
37.5	· -	\dashv	1	H	\mp	‡	\dotplus	Ħ		‡	Ŧ	F	H	#	Ŧ	F	H	#	‡		\dashv	7	‡	Ŧ	H	\downarrow	H	H	‡	Ŧ	Ħ	Ħ	Ŧ	F	H	#	Ŧ	Ħ	Ħ	\dagger	-	ŧ	H	4	\downarrow	+	Ħ	7	#	╄	H	+	+	F
37	Ë		╪	Ħ	+	1		H	•	7	1	₹		<u> </u>	Ŧ	•	-	4	Ļ		4	#	+	Ŧ		+		Ħ	‡	+	F	H	+	F		#	ļ	H		#	+	F	H	7	+	+	H	7	+	ļ	H	+	+	_
36.5	ŗ	\uparrow	‡-	H	9	7	1	Ħ	Ħ	+	+	P	H	 	1	F		7	Ŧ	Ħ		#	╪	Ŧ		$^{+}$	\Box	Ħ	Ŧ	1	F	\exists	+	F	H	‡	‡	-	H	+	\dotplus	F	H	_	7	+	H	7	Ŧ	Ŧ	H	‡	ŧ	
36	Ÿ	7	+	А	7	1	1	Ħ		+	+	-	H	_	1		Ħ	#	+		\exists	#	Ŧ	1	H	+		Ħ	‡	1	Ħ		+	-	H	#	‡	H		+	+	F	Ħ	7	7	\mp	\vdash	7	#	+		7	F	F
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DAILY WEIGHT	+									- 1	_		_		+					١,	10								+		_			\vdash		_	_						-					\dashv				_	+	
24 HRS INTAKE 24HRS OUTPUT	+		35							T	•	•	עפ		+	_	_	01					m				_		+					╁╌					-				\dashv	_			_	+				_	╁╴	
BALANCE	+ +	180	97 62	m	Ή-	21	(<u>S</u>	<u>>^</u> ⊾ o	~ !			-	_ 1		_				<u>и</u>				M.		\vdash				╁					\vdash					\vdash				\dashv	_			_	+				_	╁	
MOTION			<u>~~</u>					<u>५</u> %		1	_	-		<u> </u>		<u> </u>	(0)	OM	<i>/</i> 1		'50' %		ን!_		×				\dagger						_												_	_						



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

Mrs.Shanmugapriya S

45/Female/MH1202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ





Every heart beat counts

EARLY WARNING SCORE MONITORING CHART

Name:						Age	/Sex:			P	atient I	d No:		
NEWS key	DATE	11/12	11/2	22:00	12/12	12/12	12/12	1						DATE
1 2 3	TIME	12.5	180	22:00	2:00	600	10,00							TIME
ŦB	>25							3						>25
espirations	21-24							2						21-24
reath/ min	18-20	+	-		-	0	-							18-20
	15-17													15-17
	12-14													12-14
	9-11							1						9-11
	<8							3						<8
A+B	>96		-	-	-	0	_							>96
Po2 Scale 1	94-95							1						94-95
Oxygen Saturation (%)	92-93						1000	2						92-93
	<91							3						<91
po2 scale 2 oxygen aturation (%) use scale 2 target range is 88-92 % g: in hypercaphic	>96 on oxygen							1						>96 on oxygen
espiratory failure only	95-96 on o2							2						95-96 on o2
scale 2 under the	93-94 on O2							1						93-94 on O2
tian or qualified	>93 on air													>93 on air
	88-92													88-92
	86-87				200		1000	1		7-10-10-10-10-10-10-10-10-10-10-10-10-10-				86-87
	84-85							2						84-85
	<83%	- Marie Control	1000	Name of Street	Name of Street	-		Name of Street	CHICAGO IN	THE REAL PROPERTY.	-		COLUMN TWO IS NOT THE OWNER.	<83%
														10370
Air or Oxygen ?	A= Air	2		-	-	-0	-		MAN DE LA COLONIA DE LA COLONI	EL WEST BUILD	ACCUPATION NAMED IN			A= Air
in or oxygen r	O2litre/ min	-	-		-	-		2						A= Air O2litre/ min
	Device							2						Device Device
Blood Pressure	>220							1						>220
	201-219													201-219
	181-200							2						181-200
	161-180													161-180
	141-160													141-160
	121-140	-												121-140
	111-120	-		0	-	-								111-120
	91-100	-	-		-	-								
								1						91-100
	81-90		-			-		2						81-90
	71-80		223											71-80
	61-70		E500					3						61-70
	51-60			2000				3						51-60
	<50		1					3		Carried Co.				<50
lastolic BP	mmHg	61	63.	78	80	83	80							mmHg
	>131							3						>131
	121-130							2						121-130
/ min	111-120							2						111-120
	101-110							1						101-110
	91-100							1						91-100
	81-90													81-90
	71-80	,												71-80
	61-70													61-70
	51-60	-	-	-	-0	-0	_							51-60
	41-50						146	1						41-50
	31-40	THE REAL PROPERTY.	1000	10000	1000	1		3	1000	F 7 18 18 18 18 18 18 18 18 18 18 18 18 18	THE REAL PROPERTY.	THE RESERVE	SECTION AND PERSONS	31-40
	<30		8788		Mark the	1								<30
	Alert	-	-	-	-	-	_							Alert
onsciousness	Confusion	1	STATE OF THE PARTY.	STATE OF THE PERSON				3	1999	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	THE REAL PROPERTY.		ES 12-500	Confusion
ore for New onset of	V		1000		100									V
nfusion	Р	The state of the s	840.85		172.33			3		1				P
no score if chronic)	U	1000	A 1986		1			1						U
	>39.1 degree							2						>39.1 degree Celsius
	Celsius			1000										233.1 degree ceislus
emperature	38.1-39.0							1						38.1-39.0
egree Celsius	37.1-38.0							-						37.1-38.0
	36.1-37.0	-	~	-	~	-	_			_				36.1-37.0
	35.1-36.0	1			10000000			1						
	< 35.0	-	Name and Address of the Owner, where	SHEET STREET	-	CARLES .	COLUMN 1	-	CONTRACTOR OF		-	-		35.1-36.0
EWS Total	33.0	1	O.	A	0	5	0.		0.00	TIEL VALUE		200		< 35.0
Ionitoring Frequency		1141	CH	2 M	VA	49	AK					_		
scalation of Care Y/N		1	114	at	N	74	No			_			_	
itials by RN		0	1	d	1	h	Hay						_	
itials by Sr. RN		(NO)	0	CEC .	CV	(De	900		-				-	

Score and monitoring	4	Every Hourly	
frequency	3	Every 2 nd Hourly	
	2	Every 4th Hourly	





Mrs.SHANMUGAPRIYA S

45/Female/MH1202381078 11/12/2023/IPH202302475





ery neart beat counts

EARLY WARNING SCORE MONITORING CHART

Name: _		1.1	23.1	-		172	-	_			110	1.0	1.0112	16/1	DATE
NEWS key 1 2 3	DATE	14/21	1411	MR	12/15	124	PAL	15/12	ISM	15/12	atient	16/12	16/11/2	1011	DATE
	TIME	111.00	0,87	22.00	2-00	6.00	10-0	14.00	18.0	22-00	2.00	6-00	10.00	111.0	TIME
FB L	>25	1.1		10000				3					200	61	>25
espirations	21-24							2			~		-00		21-24
reath/ min	18-20	-	0	0	0			-					-00		18-20
	15-17														15-17 12-14
	12-14							1							9-11
	9-11	10000	-	-	-	NAME OF TAXABLE PARTY.	NAME OF TAXABLE PARTY.	2	-	DESCRIPTION OF THE PARTY OF THE	OCCUPATION.	0000000	CONTRACTOR OF THE PARTY OF THE	Name of Street	<8
A+B	>96		-	-	-	-	-	+3			-			-	>96
Po2 Scale 1	94-95					NA STORY		1		100000					94-95
Oxygen Saturation (%)	92-93							2			E 18 19 19				92-93
	<91		PERSONAL PROPERTY.	100000	10000			3							<91
Spo2 scale 2 oxygen saturation (%) use scale 2 f target range is 88-92 % g: in hypercapnic	>96 on oxygen							3							>96 on oxygen
respiratory failure only use scale 2 under the	95-96 on o2							2		Residence					95-96 on o2
direction of qualified	93-94 on O2							1							93-94 on O2
cian	>93 on air														>93 on air
	88-92														88-92
	86-87							1							86-87
	84-85							2		-		DESCRIPTION OF THE PERSON NAMED IN	-		84-85
	<83%														<83%
Air or Oxygen ?	A= Air		4	-	-	0	-	-	9 <				>	_	A= Air
	O2litre/ min						REAL PROPERTY.	2	No. of Lot						O2litre/ min
	Device														Device
C Blood Pressure	>220							3							>220
	201-219														201-219
	181-200							2							181-200
	161-180														161-180
	141-160			-											141-160
	121-140		-	-									-		121-140
	111-120	1		-	-	-	-60	1					*	-	111-120 91-100
	91-100	-	-					2							81-90
	81-90		-		NAME OF TAXABLE PARTY.			2	THE RESERVE	NO THE REAL PROPERTY.	NAME OF TAXABLE PARTY.		-	DESCRIPTION OF THE PERSON NAMED IN	71-80
	71-80 61-70							3							61-70
	51-60							3							51-60
	<50							3							<50
Diastolic BP	mmHg	14	64	40	20	Ka	C.	20	12	HD	70	70	80	82	mmHg
	>131	00	DESIGNATION OF THE PERSON OF T		30			3	No. of Lot, House, etc., in case, the lot, the l		No. Sec.		-	10000	>131
Pulse	121-130							2							121-130
ts / min	111-120							2	E CONTRACTOR						111-120
	101-110		1					1							101-110
	91-100	/		1				1	-		,-		-		91-100
	81-90	1/		-	0		-							`	81-90
	71-80			-		,									71-80
	61-70			-											61-70 51-60
	51-60 41-50							1							41-50
	31-40	- District	-	-	THE REAL PROPERTY.	SHOW		3	THE REAL PROPERTY.	THE REAL PROPERTY.					31-40
	<30							3							<30
	Alert		-	1	-	-60		-	-	_					Alert
Consciousness	Confusion		100000	10000		TO SERVICE	THE REAL PROPERTY.	3	THE RESERVE		2000	MARKET STATE	No.		Confusion
Score for New onset of	V							3							٧
confusion	P							3							Р
no score if chronic)	U		E SE	F-CITO			499	3	A 24 4 5 6	Ka akus	1	Malesta		1	U
	>39.1 degree							2							>39.1 degree Celsius
	Celsius			-		100000									204 20 0
Temperature	38.1-39.0							1							38.1-39.0
Degree Celsius	37.1-38.0		-			-0					_		-	-	37.1-38.0 36.1-37.0
	36.1-37.0 35.1-36.0	-	-	-				1	1		-				35.1-36.0
	< 35.0	-	-	100000		-	Name of Street	3			CONTRACTOR OF THE PARTY OF				< 35.0
NEWS Total	1 33.0	0.	1)	•	0	0	10	10.	7	10	10	10.	0	100	- 33.0
Monitoring Frequency		UH	1111	1.7	site	Sa	CH	444	0 1 4 3	e al la	Ath	Ath	LIK	417	
Escalation of Care Y/N	NEWSCHILL AND THE	A	71	71	11	MI	0	N	1	Tip	100	No	N	NI	
Initials by RN		(P	1	08	0	le	10	9/	M	an'	·Ai	Pri	an	2	
nitials by Sr. RN		1200	09	Ne	100	. 00	-00	400	09	10	. 09	Las	1	- 0	
	Note: Nurse	V.	V. U	1-16	P	P-SV	F-4	F-4	1.0	7.	150	F .	100	W.	

Score and monitoring	4	Every Hourly
frequency	3	Every 2 nd Hourly
	2	Every 4th Hourly



EARLY WARNING SCORE MONITORING CHART

Name: _		1	-	21	Age/Sex	:	ratient	Id No:	
NEWS key	DATE	16/1	191	14/2					DATE
1 2 3	TIME	12.0	22:00	6.00					TIME
B	>25	10	270			3			>25
spirations	21-24					2			21-24
eath/ min	18-20	-	-	0					18-20
	15-17								15-17
	12-14								12-14
	9-11					1			9-11
	<8	20000	1000	THE REAL PROPERTY.		3 3 3 3 3 3	Control States		<8
+B	>96	1	-	-					>96 94-95
PoZ Scale 1 xygen Saturation (%)	94-95					2			92-93
AARen Sardration (70)	92-93	1000000	THE REAL PROPERTY.	DESCRIPTION OF THE PERSON NAMED IN	ALC: NAME OF TAXABLE PARTY.	3	Name and Address of the Owner, where the Owner, which is the Owner, where the Owner, which is	CONTRACTOR OF THE PERSON NAMED IN	<91
po2 scale 2 oxygen	>96 on oxygen	1000				3			>96 on oxygen
aturation (%) use scale 2 target range is 88-92 % g: in hypercapnic espiratory failure only									
se scale 2 under the	95-96 on o2					2			95-96 on o2
rection of qualified	93-94 on O2					1			93-94 on O2
ian	>93 on air								>93 on air
	88-92	-							88-92
	86-87	-				2			86-87 84-85
	84-85 <83%	-	-	Sales and the last of the last	NAME OF TAXABLE PARTY.	2	No. of Concession, Name of Street, or other Designation, or other		<83%
	<0370								10370
Air or Oxygen ?	A= Air	-	-	•					A= Air
	O2litre/ min Device					2			O2litre/ min Device
lood Pressure	>220					3			>220
	201-219								201-219
	181-200					2			181-200
	161-180								161-180
	141-160								141-160
	121-140	-							121-140
	111-120	-	-	0		1			111-120
	91-100	1				1			91-100
	81-90		-			2			81-90
	71-80					3		TOTAL STREET, STREET, STREET, STREET, STREET, STREET, STREET, STREET, STREET, STREET, STREET, STREET, STREET,	71-80
	61-70 51-60					3			61-70 51-60
	<50								<50
iastolic BP	mmHg	13	20	26		-	-		mmHg
astone by	>131	1	00	0-0	and the latest designation of the latest des	NAME OF TAXABLE PARTY.	THE RESERVE AND ADDRESS.	CONTRACTOR DESCRIPTION	>131
ulse	121-130				MINISTER MANAGEMENT	2	Real Property lines in which the		121-130
s / min	111-120					2			111-120
	101-110					1			101-110
	91-100					1			91-100
	81-90	4	-R	- e					81-90
	71-80								71-80
	61-70								61-70
	51-60					-			51-60
	41-50					1			41-50
	31-40 <30	-							31-40 <30
	Alert	-	-	~		-			Alert
onsciousness	Confusion	Name of Street	STATE OF THE PARTY OF	Name and Address of the Owner, where the Owner, which is the Owner, where the Owner, which is the Owner, where the Owner, which is the Owner, which i	ALC: UNKNOWN	3	Service Service	THE REAL PROPERTY AND ADDRESS OF THE PARTY AND	Confusion
ore for New onset of	V	0000000				3			V
onfusion	P	1000				3			P
no score if chronic)	U	24 3	No. of the last	10 mg 10 mg		3		PERSONAL PROPERTY.	U
	>39.1 degree Celsius					2			>39.1 degree Celsius
emperature	38.1-39.0					1			38.1-39.0
egree Celsius	37.1-38.0								37.1-38.0
	36.1-37.0	4-	-	-0					36.1-37.0
	35.1-36.0					1			35.1-36.0
	< 35.0	1		100 E	A SECTION	3		STORY STREET	< 35.0
EWS Total		1	0	0					
Monitoring Frequency		414	10th	42					
scalation of Care Y/N		18	2	7		-			
itials by RN		14	20	10		+			
itials by Sr. RN		.01	. 45	Ja		1 1			The second second second

Score and

monitoring

frequency

4

3

2

Every Hourly

Every 2nd Hourly

Every 4th Hourly



Mrs.SHANMUGAPRIYA S 45/Female/MHl202381078 11/12/2023/IPH202302475 Dr.ANBARASU MOHANRAJ







Date	Fro	m:	12 2 To	o: 2 2 2	Be Be	ed No: 🙎	<u>)03 ·</u>					INTAI	KE 2	OUT	DIIT
24 Hr	s : St	arted Time	9: \ 7,<0	, ,	Ended T	ime : 🔽	1.0,					ши			FUI
		ed at :			NP	O Over	at:						CHA	AK I	
SHIF	Γ	N	Morning		Afterr	noon			Nigh	t		Rest	ricted F	luid (R	F)
INTAI	KE				400)			5500	w					
OUTF	2UT				<u> 450</u>	•			600						
Total I	ntake:	9	50m		Total Outpu	ut: (0,	som			Differen					
			INTAKE	<u> </u>		15		,		רטס	TPUT	(ml)	·		<u></u>
Time	Oral	Tube Feeding		Additions		iolal	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
13-30	Jan ·		.3100 01		·		18-00	250	-				250		-
15-bo							12.00						350		
16:30							16.00.						450.		
1845						,	19.30						700		
<u> </u>	RON	Վ				700	0.45	<u> चेक्तप</u>				<u> </u>	900	0088	
23:45	ison		ļ	<u> </u>	ļ.	850	4.30	150H					1050		
430	10pu	ч				950	ļ <u>'</u>								
	4P 0		ļ						TOTAL	INTAKE		950m			(A)-
_	D	<u> </u>			<u> </u>			<u> </u>	TOTAL	OUTPUT		10501			(0)
	-									ļ		<u> </u>		ļ	0005
									-	 					
					<u> </u>		<u> </u>			<u> </u>		ļ		 	



Mrs.SHANMUGAPRIYA S 45/Fernale/MHl202381078 11/12/2023/IPH202302475

dr.anbarasu mohanraj





Date	Fro	m: 14 12	2 2 To	: 15 12	্ ১৪ Be	d No: 🤈	<u>о2</u>					INITAI	/F 0	<u> </u>	DUT
24 Hr	s : Sta	arted Time	oo3F₫ ::		Ended T	ime: (71.00)				INTAI			Pul
NPO	Starte	d at :			NP	O Over a	at:			r			CHA	KKI	
SHIF	Γ	N	lorning		Afterr	ioon			Nigh	t		Rest	ricted F	luid (R	F)
INTAI	KE	3	50		375	, ,		_	34c-M	<u> </u>		1.5	Cet F	-	
OUTF			00	<u> </u>	5501	ທເ			600 M						
Total I	ntake:	<u> </u>	1100M		otal Outpu	it: 12	50m	·		Differen					
		т —	INTAKE	` 						OUT	PUT	(ml)			
Time	Oral	Tube		ous Infusio		তিগ্ৰো	Time	Urine	Vomitus	N/G	Drain		Total	R/N Sign	Endorsed
		recuirig	Type of Fluid	Additions					_	Aspirate	lube				by
07:00	<u></u>	boto	10110	2	→ ^ `	250	07/200		Up +	to	10:10	→ <u></u>	200	8#	
11.30	100					350	10.50	loo					200		
123						1100	13.00	300					600		
14.5) 1175	111-30	250.					<u>850.</u>		
1410					_	l ' '	[7]	300au					وكاأ		
16.0:	ر <u>ح</u> ک	ı				550	_ `	300 M					1450		
16.10	50					600									
16.39						700			TOTAL	INTAKE	1	1100au			
17.2s	<u>95</u>					725			TOTAL	OUTPUT	<u>~</u>	1450m		<u> </u>	<u></u>
10 -30	132n					850		· 				<u> </u>		<u> </u>	
<u> </u>	12cm	Ψ				975								<u> </u>	
4:00	18an					1100									Nces
												<u> </u>		<u> </u>	024
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MIS.SHANMUGAPRIYA S 45/Female/MH1202381078

11/12/2023/IPH202302475

Dr. ANBARASU MOHANRAJ









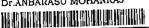
Bed No: ನಿಂಸ From: |5 | 12 | 23 To: 16/12/22 Date **INTAKE & OUTPUT** 24 Hrs: Started Time: チレップ Ended Time: 7.00 **CHART** NPO Started at : NPO Over at: SHIFT Morning Night Restricted Fluid (RF) Afternoon Abonu INTAKE RF.1.5 literelday 6cs ML 450 900 M OUTPUT 2000c 000 **Total Output:** Difference: - 200 M Total Intake: 1780 m 15 Form INTAKE (ml) **OUTPUT (ml)** Intravenous Infusion Tube N/G Drain **Endorsed** Time | Oral . iotal **Vomitus** Total' Feeding Type of Fluid Time Urine Others R/N Sign Tube Aspirate **Additions** by Amount 4.15 100 6-00 20n 100 200 400 <u>প-০০ _ দণ</u> 10-11F-200 600 10.(st 50 12-15/200 850 M 400 thills 1200 11-20 200 450 19-A5 200m 10504 12-00 50 23.40 350W 13001 12.27/00 2.15 250 W 1580n 11.00/100 はくっ 1 Hoon 2 Do 6.00 200m 1000 Co 1C-Mino 900 a 1550 av 11.00 100 ያልልል DNTAKE TOTAL 1100 Ittou OUTPUT 16.3, 100 TOTA 1200 N_{∞} 19-AS [50 1400 DR:30 150 1500 6.30 150



Mrs.SHANMUGAPRIYA S

45/Female/MH12023810 11/12/2023/IPH202302

Dr.ANBARASU MOHANRAJ









Date	Fro	m: 16 12	23 To	0: 1 12	2-3 Be	d No: 2	02		-			INITAI	VE 0		DUT	
24 Hr	s : Sta	arted Time	ne: 7-00 Ended Time: 7.00									INTA			PUI	
NPO Started at : NPO						O Over	at:					CHART				
SHIF	Γ	N	lorning		Afterr	ioon			Nigh	t		Rest	ricted F	luid (R	F)	
INTA	KE	ķ	080			ome			120	omL		P.F	1.5	litero	slday	
OUT		U	10			oml.		<u> </u>	1150	oml						
Total	ntake:	<u> </u>			otal Outpu	ıt:	T			Differen						
	_	r	INTAKE				<u></u>			OUT	PUT	(ml)	,		1	
Time	Oral	Tube		nous Infusio		Total	Time	Urine	Vomitus	N/G	Drain	Others	া তৱো	R/N Sign	Endorsed	
	-	recuirg	Type of Fluid	Additions	Amount					Aspirate	Tube				by	
750	125			<u></u>		25	R-30	250					280			
8-10						280	11.00	180					How	_		
9.15						375	13.00	250					650			
10.00	125					صهح	12.30		_				900			
11.15	50					540	19.00	<i>35</i> 0					1850			
11-30	S					600	22.00	300					1550			
12-6	B					G80	2.00	300	_				850			
12.30	125					775	5.30	200					2020			
l ⁻	100	J.		<u></u> _		375										
16.50	25					1000								_	1000 021	
17.00	1:50					150.					datal	inte	ike =	239	ome)	
19.00	900					1350						out	1 '	1	1	
	500					1850						,	rco 🔿	ĺ	Į.	
Avno		·				2250							l '			







Mis.Shanmugapriya S

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ



Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

	OT - Q	D EL 72.\'	CARY P	μ,		•
ht:	cms	D 1 ET 35-/. Weight:6-3	Food allergie	s: Yes/ No, if yes, specify	***************************************	
ious Beliefs:		Vegetarian	Non Vege	etarian	☐ Eggetarian	☐ Jain
rescription:	<i>600</i>	colous, bu	fort too	Kouk, Kigh	pustur, de	abitu; 1600 m
JECTIVE	GLOBA	AL ASSESSMENT	(ADULTS)	()	, ,	entwelted of
	(A) -	Patient's related Medical Histor				
	1)	Weight Change (overall change	` \	110-111	•	
	1-1	D1	2		□ 4	5
	1	No weight change/	<5%	5-10%	10 - 15×	>15%
` , '		gain	1	·		
2)	Dietary Intake	Ouration_1				
			□ 2 ,	D 3	□ .	" □ 5
	Oral	No change	Sub - optimal	Full liquid diet/	Hypo - caloric	Starvation
		•	splid diet	moderate overall decrease	Ilquid diet	
· -	Enteral/	Adequate/	Sub - optimal	tradequate	Typo - caloric	Starvation
	Parenteral Nutrition	Excessive			feeds	
3)	Gastrointestir	ral Symptoms Dolfation:				
	4		□ 2 ,	□ 3	□4	5
		No symptoms	Nausea	Vomiting /	Diarrhoea	Severe anoresia
	Consideration (C)	apacity (Neglition related functional impa	Land Discourse	Symptoms		<u> </u>
4)	Puncuonal Ca	1	D 2			□ s ·
	. 🖊	None /Improved	Difficulty with	Difficulty with	Light activity	Bed/chair-
,	,		* ambulation	normal activity		ridden with no or little activity
5)	Co - morbidity	(Disease and its relationship to nutrition	requirements)		•	
		□ 1 ·	□ 2	□ 3	لمستوار	_ s
		Healthy	Mild ca - morbidity	Moderate co morbidity/ age >75 years	severe co - morbidity	Very severe multiple co - morbidity
В)	Physical exam	J				 .
1)	+	stores or loss of subcutaneous fat		 		
	Vetreased (a)	stores or loss or subcutaneous rat				□ s.
	 		 		<u> </u>	
		Normal	Mild	Moderate		Severe
2)	Sign of muscle s	 	ТБ.			Пт.
	1	Normal	Mfd , ,	Moderate	□4, -	
	<u> </u>	Normai	Mkg	Moderate		. Sevele
* Total Score = St	um fabove 7 com		· · · · · · · · · · · · · · · · · · ·	ī		,
Nutritional Stat	tus : Based on this					
	Well Nourished		<i></i>	(7 to 14)	h 	
	Moderately Malnourished		,	[15 to 18]	<u>~</u>	
	-			(19 to 35)	<u> </u>	
	Severely Malno	urished				
Nutrition interv	Severely Malno	urished				
Nutrition Interv	Severely Malno	urished		☐ Enteral	☐ Parenteral	
Nutrition Interv	Severely Malno rention:			☐ Enteral	☐ Parenteral	
	Severely Malno rention; Oral Sprovided:	urtshed Yes Weekly			Parenteral Monthly	

Dietidan Signature / Name / Date / Time:

Maria Catherine Juliu (2751)

Senior Dietitian

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
11/12/11, 12/20	of years and funder come = do shoth of beneth wer arrived to be were nowshing on evident by sup.	1.
12/12/4	Educated de paturit and faming on 1600 catains, on fed, on south right public 1600 ne fluid eistwiched, dealseter dit. Expfid a man fit read i to glumin westerd Catine shipted b or for sugary (CARLI) as well as the super or MAI. Pathint wind to sure. The wind to sure. The wind to sure. The wind the sure. The wind the sure.	Mario Cotherine John You Senior Dietitian
13/12/4	Der dorfor's adim. Monorer. Portreit benated dialorter, light weer. Can initiate on dealorter, high public, soft which did. Instrated beat weer. Posteret wind to stepdom beat weer. Posteret wind to stepdom out.	Senior Dietitian Nigriz Catherine John (Pr.) Senior Dietitian



Mrs.Shanmugapriya S

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ



MHI/DIET/2022/148 Every heart beat counts

Department of Dietetics

CARE PLAN FORM - A

·	CARE PLAN FORW - A	
DATE AND TIME	DIETITIAN NOTES	SIGNATURE
4/11ley (2)00	Pateit inid b woud. Reenpfil at dit whicher patients to	Maria Catherina I
	Ocal autoli à god. Dit vodfatte ad claif cation des notated to east w	Senior Detition
رحاراتاله	Deal titale is good. Educated the patient and assistantial as too calain, come con lad, and pusher, doone flied rest. The diabetic dit on display	
	Empfid en man fril man too glan noted. Diet clarif, catier and clarf cot doe- Diet chart green on dichay.	in Ale
, 4 ,		/





MIS.SHANMUGAPRIYA S INTRAOPERATIVE NURSING RECORD

45/Femalc/MHI202381078 11/12/2023/FPH202302475 Dr.ANBARASU MOHANRAJ	Consultant: DR14M
Name of Surgery (OP CAB [CLOSED HEART] Date of Surgery: 12/18/25
Mode of Transfer to OR	☐ Bed ☐ Stretcher ☐ Other ☐
Anaesthesia Type	: Depidural Depiral LOC MAC
	GEN Regional—
Position	: Lithotomy Prone Supine Right Down Left down
	☐ Lateral ☐ Other ☐
Pressure Protection Pad	: Headrest Sand Bag Pillow Axillary roll
	Shoulder roll
	☐ Sling ☐ Boot ☐ Stirrups/Leg Holder
	L aem rest padded / Sccured R Arms tucked / padded
	□ Nil □ R □ L □ Other (Specify)
Skin preparation in OT	Ichlorhexidine Prep Providone Iodine Lodophor scrub
Electrocautery	Alcohol Prep
Tourniquet	Location
	Applied Time - Released Time -
	Applied Time
	Applied Time Released Time Applied Time Released Time
Other equipment used	•
Personal	: Surgeon DR, AM DR, PRAVEETO
	Surgeon DR.AM Assi DR. PRAVEEN Assi DR. PRAVEEN Assi DR. PRAVEEN
Type of Specimen	;
Lab	: Pathology Permanent Frozen Time sent
	Cytology Time of report
	☐ Microbiology

☐ Biochemistry

	Packing-/ Drain	s / Catheter	S									
	Туре	Size Site			Ту	pe	Size	Amo	unt	Sig	gn	
	Sussen's	28FY bette flowed						2	2 Sh			
	Enosmos	7480	mad	<u>Liastinu</u>	η				-	003		
UTT	North Cathles Sponge Court	Record	n has	l etab l	on Were	201 970	new WHC	- N 186 d	} 14F8 F	oveys ca	thetes	
	Count	Raytex Sponges	Gauze Lined	Gauze Unlined	Neuro Patties	Tonsil cotton balls	Vein Canula	Bulldog clamp	riccare	gion	Scrub Nurse Sign	
	Pre-op	wrelt (proof				Cardolt	urrell	Ur good	0031	anjatha 0125	
	Change over count	10000th	progle				thomas,	nout	usrout.	88	6125	,
	First closure	"nucon	agoly	ž	S)	,		"Legelle	40	0031 0031	2005	
	Final closure count	new C	proper				perole	remote	2015	APS FEGO	0125	
	Corrective action	et n taken										
chese	JONG V Dressing / G ast I	oth etec	ile M		reg Ineg	sing du	a with &	terile	WaLMJEQ	pallylor	epe ba	Y
	Condition of pat	ient at end o	f surger	y : 📮	Stable		Fair	☐ Crit	ical			
	Transferred to:	STCU			Patient F	Room 🗌	CCU	☐ Reco	overy Ro	om		
	Scrub Nurse Sig Name : RIN & Date & Time : N	AMPATUS	0125	-								
	•		`									

Circulating Nurse Signature & 10031 Name; SPSDWMAR 10031
Date & Time ~ 12/12/20 16.50

e)



•	Mrs.SHANMUGAPRIYA S
	45/Female/MH1202381078
	11/12/2023/IPH202302475
	Dr.ANBARASU MOHANRAJ
	110 (D) Peri i ina mamanana (ikao indepini) namena (ilay indone

PSYCHOLOGICAL WELLBEING REPORT

Date: 15/11/23

Time: 11.00am.

Unit: 20 2B

Clinical diagnosis:

Surgery/Procedure: OPCAB & Agroffs

Impression:

4

Worde perme D.

- skalm affect, riented - appetite & (''2y). - ships near, unable 16 - sleep & (ann @ hopp. - 10). - Arened savily

Employee ID: MHCOLTYPSY

Signature of the Psychologist:





Mrs.SHANMUGAPRIYA S

45/Female/MHI202381078





NUIDCING ADMICCION ACCECMENT (ADIUT)

NUNSING ADMISSION ASSESSMENT (ADULT)
Date of Admission: 11/12/23 Time of Arrival: 12.506m Mode of Admission: Walking Wheelchair Stretcher
Accompanied by Relative: Yes No If Yes, Name of the Relative:
Relationship with Patient: Contact Person's Name: MP. Selvakeman Relationship: Historial
Contact No.: 8939 642883 Primary language spoken: 「Tamil English Indian International
Interpreter needed: Yes No
Patient status: Conscious Unconscious Disoriented Patient Vulnerable: Yes No
Menstrual History: LMP: 11/9/23 Menopause: gtopeal -b[14]-3
Medical History: DMTHTN / Co - Morbility: 124 cars Yes If yes specify 7. Security to 1801 PM 1
Drugs History: Antiplatelet าญ่. H. A ๒๐(฿ฅ) (Specify) บา๋า หรางบุตร) T. ปอตุ เคเบ คือ นั้งโ
Psychological Status: Anxious Withdrawn Agitated Depressed Sleeping Difficulty
Do you have any special religious, spiritual or cultural needs to be considered? Yes No If Yes, specify details:
Socio Economic Status: Employed Retired Own Business Home-Maker Others:
Vital Signs: Temp: 98-5 (°F) Pulse / HR: 51 hlm (beats/min) BP: 94161 (mmHg)
Respiration: Apm (breaths/min) SpO ₂ : 98 (%) CBG: 242 (mg/dl) Height: 1654 (cms) Weight: 63.4 (kgs)
Allergies / Adverse Reaction: Yes No Medication Blood Transfusion Food Atot known
If Yes, specify:
Pain: Yes No. If Yes, Score: You Pain Scale Used: Wong-Baker FACES Pain Rating Scale (7-12 years) Numerical Rating Scale (>12 years) CPOT (ventilator / comatose)
Duration: Location: 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 (1 (2)
Type of Patient: Diabetic Non Diabetic Type of Diet: Non Diet Diet Diet Diet Diet Diet Diet Diet
Dietician Informed: Yes No. If Yes, mention the Name: No. 10 Catholic Time: 1250 pm
Orient Patient if: Conscious Orient Patient Attendant if: Unconscious Disoriented
Room Side Rails Toitet Bell Patient Information Board Bathroom Ged Controls
Use of Footstool Grab Bars Nurses Call Bell Television Dight Controls Telephone
Functional Assessment:
Functional Assessment: Particular Assessment Remarks Outcome
Particular Assessment Remarks Outcome
Particular Assessment Remarks Outcome Visual Impairment ☐ Yes ☐ No ☐ Outcome

Daily Activity Of L	iving:								• 1	
Activity	Activity Independent Assisted							Dependent		
Bathing	-		-							
Dressing										
Eating				 						
Walking				- -	Ħ					
Toilet Use								$\overline{}$		
Pressure Injury Ri	isk Asses	sment: Brad	en Scale			1				
Sensory Percep		Score	Moisture		Score	Dear	ee of Activi	tv.	Score	
No Impairment	11011	4/	Rarely Mois	t	4		Frequently		4	
Slightly Limited		3	Occasionall		3		Ocçasiona		3	
Very Limited		2	Very Moist	<u>*</u>	2	Chair			2	
Completely Limit	ed	1	Constantly	Moist	1	Bed F	ast		1	
Mobility		Score	Nutrition		Score	Fricti	on & Shea	r	Score	
No Limitation		A	Excellent		1-4	No ap	parent pro	blem	3	
Slightly Limited		` 3	Adequate		3	Poten	ıtial Probler	n	2	
Very Limited		2	Probably In	-Adequate	2	Probl	em Present		1	
Completely imme	obile	. 1	Very Poor		1				<u> </u>	
High Risk: 12 - 10; Severe Risk: 9 - 6 Total Score: Action needed: Yes No Pressure injury present at the time of admission: Yes No If yes, Location: Grade: Size: Relationship: Relationship: Relationship: Yes No										
MODIFIED MORSE FALL ASSESSMENT SCALE (Age above 16 years)										
Fall Risk Assess	sment (Mo	dified Mors	e Scale):				<u> </u>			
Variables					<u> </u>			Nur	neric Value	
History of falling	(immediate	e or within 6	months)				No	↓	_8'	
	<u> </u>	<u> </u>					Yes	╁	25	
Secondary diagn	iosis (≥ 2	medical diag	nosis)				No.	+	0	
							Yes	+	18	
Ambulatory Aid None / Bed Rest	/ Nurso As	eele t								
Crutches / Cane		55151	-				-	+	15	
Furniture	,								30	
_	4						No		₽	
Intravenous Ther	ару / нера	arın Lock / II 	ibės insitu				Yes		20	
Gait Normal / Bed Re	st / Wheel	Chair			_				√8 √	
Weak	-		_	<u> </u>		_			10	
Impaired									20	
Mental Status Oriented to own	stability								0	
Overestimated or		mitations						1.	15	
Medications								1		
Includes PCA / o						s,	No		0 ,	
laxatives, hypogl	ycemics, s	sedatives, im	munosuppres	ent and psyc	hotropics		Yes		18	
Score Interpretation	Score Interpretation: 0-24: Low-risk; 25-44: Medium Risk; Above 45: High Risk Total Score									

As per the score, tick the following appropriate	boxe	s:	
Low Risk Interventions (0 - 24) Familiarize the patient with the immediate surrounding: Remind the patient to use call bell before getting out of Keep the two side rails in the raised position at all times Keep the call bell, bedside table, water, glasses within to Remove excess equipment or furniture to make a clear Keep the patient's bed in the low position at all times excepted the patient's bed in the low position at all times excepted the patient's bed in the low position at all times excepted the patient's care 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 puse use safety belts during movement in wheelchair The patients are not ambulated by themselves. They are Medium risk interventions (25 - 44) Apply all the low risk interventions Tie yellow fall risk tag in the bed and Wheel chair / Stretch Make sure that proper transfer precautions are instituted 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 effection when planning patient's care Do not leave patients unattended in diagnostic or treatmy Accompany the patient while going to bathroom Advice the patient to use grab bars near the toilet, bathty Make sure the family and other visitors understand the 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 nurse 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) I frappropriate, consider using protection devices: safet	bed for all he pat path cept d a mon re to be cher ited fo tor ects ! ment a tub, ar restric ses' sta iate) in them by belts	tient'during during ment te fal e am evel areas areas ations	t's easy reach ing procedure it before rising from the bed alls inbulated only with assistance eavy or debilitated patients in a el of consciousness, gait and as shower ins mentioned above
Initial Assessment to Special Needs and Vulnera	1 1	_	
Terminally ill patients	Yes	NO	i itematika (piease specity)
Patients with intense chronic pain	1 1		-
Woman in labor or experiencing termination of pregnancy	╁╌╌╁		
Patients with emotional or psychological distress	t		<u>-</u>
Patient suspected of drug or alcohol dependency	1	\exists	
Victims of abuse and neglect	1	_	
		_	
Patients whose immune system is compromised		_	,
Patient with infections and communicable diseases	$\vdash \vdash$	_	·
Does the patient have implants			
Has tracheotomy been done		<u> </u>	1.08
Has colostomy been done	\sqcup	-	
Any other potential needs of the patient			

1	Assion a s	score of	i i ii (YE:	S) in p			ΓRISK ASSE		re of -2 if (YES) in p	aram	eter no. 1	, j
S. No.				Paran							res / No	Score
1	Active cancer	(on-goir	ng treatm	ent or	diagn	ose	d within 6 months o	or palliative car	e)			No
2	Bedridden red	cently >3	3 days or	major	surge	ery w	rithin four weeks					ν̄ο
3									Yes 🗾	No		
4	Collateral (no	nvaricos	se) superi	ficial ve	eins p	rese	nt (Assess for both	legs)			Yes 🔲	40
5	Entire leg swo	llen (Ass	sess for b	oth leg	js)						Yes 🗍 J	VO-
6	Localized ten	derness	along the	deep	veno	us sy	ystem (Assess for t	ooth legs)			Yes 🔲 I	VO _
7	Pitting edema	, greater	rin the sy	mpton	natic I	eg (Æ	Assess for both leg	s)			Yes 🗍	le-
8	Paralysis, par	esis, or r	ecent pla	ster in	nmob	ilizat	ion of the lower ext	tremity (Assess	s for both legs)		Yes 🖵 🕹	40
9	Previously do	cumente	ed DVT (A	\ssess	forbo	oth le	egs)				Yes 1	10
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.							Vo				
	Score Inter			babili	ity of	DV	T):			F	inal Sco	re o
	Action Taken					n		Date	Time			
Low	Risk	-2 t	to 0		\perp				_			
Mod	lerate Risk	1 to	to 2					_				
Hig	h Risk	3 t	to 8									
Pers	sonal Belong	gings / '	Valuabi	es:						-		·
Valua	ables	Des	scriptio	n	Wir Pati		With Patient's Attendant		Signature of the attendant		Rema	rks
Dent	ures		per□Lo th ŪMi	_		ا						Ò
Hear	ing Aid	□Rigi J2Nii	ht □Le	eft								
	glasses / act lens	J∤Yes	s □No	0					-			
Jewe	ellery	□Yes		5								
Othe (spec	r valuables cify)	·		i			-					
Rep	ort (List of X-	ray, EC	CG, lab r	eports	s reta	ined	d with the nurse)	:				
	ent / ent's Attend		sign.	_			SELVAKA.	•••	Emp. No.	1	Date War	Is w
Nur		W.	8) _	<u>-</u>		٧	SELVAKUM 11. Davit).	OLS	T	12/23	13-10,
Unit In-Charge					M. Devit	noreo'.	0005	-	12/23	161-00		





Mrs.SHANMUGAPRIYA S 45/Female/MH1202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 1/12> Shift: Morning Evening Night
SITUATION Diagnosis: CPD-TVD NEWS / PEWS Score: D Ventilator day: — Central line days: — Peripheral line day: Right: — Left: — Ryle's Tube:
BACKGROUND Type of surgery: — Date of surgery: — Allergies if any: いらかや On room air / oxygen: つりでのの が IV fluids on flow: Complaints / New Symptoms in last shift: い)し
ASSESSMENT Vital Signs: Temp f(°F) Pulse / HR: f (beats/min) Respiration: (breaths/min) BP: f (mmHg) SpO ₂ f (%) Height: (cms) Weight: (63-Jt (kgs) BMI: 2d. 3 g f f Others: Pain Score: VID Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPO Fall Risk Score: Fall Risk Protocol: Low Medium High Braden Score: Minimal Risk: 23-:9 At Risk-Mild Risk: 18-15 Moderate Risk: 14-13 High Risk: 12-10 Severe Risk: 9 Pressure Ulcer Scale for Healing (PUSH): Yes No NA Wound Dressing done: Yes No NA Current diet: Drains:
RECOMMENDATION Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: Critical value alert and its corrections: Changes in nursing care plan: Yes Dec-If Yes, modified care plan date: — Pending follow-up orders: — Special instructions if any: TOFFOLTOW DIAM CABC
Signature Name Emp. No. Date Time
Handover given by Handover taken by O DESCRIPTION OF THE PROPERTY OF THE PRO
Document endorsed Drawares. 0005 (2)(2)23 08:0

NURSES PROGRESS NOTES							
Date & Time	C	bservations / Action		Signature with Emp. No.			
17 1223	Admiso	sion Notes					
<u> </u>							
12.50	-> patient Jobs- -> patient	Conscious & orion	0				
	Perordo > Medication drug Char - Tomorrogo	1. given as pe	r				
18.30	-> patient Chelkon -> patient	handing ov	^				
	Ner8o						
							
Document endorsed by	Signature	Dhonoroeo.	Emp. No.				





Mrs.SHANMUGAPRIYA S 45/Female/MHI202381078 11/12/2023/IPH202302475 Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

Heart
Institute

Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

PATIENT CLINICAL HANDOVER RECORD FOR NURSES							
Date:	12/23	3 Shift: ☐ Morr	ning 🗋 Evening 🖵 পার্	jfit .	•		
S	NEWS / F Ventilator Periphera Ryle's Tu Urinary C	s: CAD~TVD PEWS Score: a r day: al line day: Right: Lef be: Yes ¬No Day Catheter: Yes ¬No Day	t: —	Central line days: VIP Score: 0/1- ecify organism:			
B	Type of so Allergies On room	ROUND ourgery: つ if any: ハドカみ air / oxygen: っパ Rood nts / New Symptoms in last s	MAIR I	Date of surgery: / fluids on flow:			
A	ASSESSMENT Vital Signs: Temp: 97 (°F) Pulse / HR: 80 (beats/min) Respiration: 22 (breaths/min) BP: 120 70 (mmHg) SpO ₂ : 97 (%) Height: 65 (cms) Weight: 63 4 (kgs) BMI: 22 2 4 4 7 8 7 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9						
R	RECOMMENDATION Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: Critical value alert and its corrections: Changes in nursing care plan: Yes Ne. If Yes, modified care plan date: Pending follow-up orders: Special instructions if any:						
		Signature	Name	Emp. No.	Date	Time	
Handover g	given by	94	A. ALBING	3 0088	14/2/23	7.08	
Handover t	aken by	Hart	Hannah as		<u> </u>	F:30	
Document endorsed		(000	John Mary Co	our 0005	12/12/22	OC:00	

NURSES PROGRESS NOTES						
Date & Time	Observations / Action	Signature with Emp. No.				
11/12/23	NIGHT DUTY NOTES					
19.00	Patient handover baken from the evening drites	eiles				
₹0.00	Due medications are given to the patient	9484				
22.00	indolgique are checked e recorded	Ay				
6.00	No chart is Maintaine	Sols.				
7-00	Patient handover gwin to the Majkiting derly slabb	\$ 1 80°				
<u></u>						
_						
Document endorsed by	Signature Name Emp. No.	Date Time				





MIS.SHANMUGAPRIYA S 45/Female/MHI202381078 11/12/2023/IPH202302475 Dr.ANBARASU MOHANRAJ <u>s. Publicadien bedeemde bedeemde bedeemde bedeemde bedeemde bedeemde bedeemde bedeemde bedeemde bedeemde bedeem</u>



PATIENT CLINICAL HANDOVER RECORD FOR NURSES								
Date: l2/l2/23 Shift: 山Merning □ Evening □ Night								
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	S: CAD S VI PEWS Score: O day: al line day: Right: Lef be: Yes No Day atheter: Yes No Day		days: _				
B	On room			-				
A	ASSESSMENT Vital Signs: Temp: Q& b (°F) Pulse / HR:							
RECOMMENDATION 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 given by		Har	Hannah anale	Q108-	12/20	420		
Handover taken by		Ď.	4-Daija	012	alse	H		
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NURSES PROGRESS NOTES							
Date & Time		Observations / Action		Signature with	Emp. No.		
12/12/23	Mr	PRNING DUTY NOTES					
			·				
7:30	Patient hand	ling over taken.	Jaom				
	Evening olul	y Staff in a		Hay Dios			
	hemodyname à	ling over taken . Ty Staff un a ally Stable					
<i>\$</i> ;00	Vital Signs	hecked & Record	ed	Hey	(
8:30	CBG is high	, Informed Dr.p. Stalt Treulin Inf	aveen uqion				
9:30	Iv line Secu	used, Inj. HA DINH	12	Hoy			
9:35) ~	am, Advised 201		-Hay			
	hously CBG	Checking Keto	ne oraml	· · · · · · · · · · · · · · · · · · ·			
10:00	A had Sweat Informed Informed Shif	ble & Congcious ing, CBG-71 Vitals a ting Notes	el	- Hayou	y		
	> Patient Vi	onscious & Stable hecked & Remode	d·	1 Jay -			
	> Npo from	^	,				
	> 10 Par Reserration done. > Patient hand over given to			flat			
	OT Staff	<i>O</i>					
	2	I		1 = .	1		
Document	Signature	Name	Emp. No.	Date	Time		
endorsed by	Noo	Natur	- 6076	popular	ar		

11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ





MHI/NUR/2022/048

	N'	URSES PROGRESS NOTES	;			
Date & Time		Observations / Action		Signa	ature with E	≡mp No
	CTOT R	RECEIVAL REPORT	·			
		HOSTO GOT With Blue Op File				
P		2 X-RAY: 1 ANGIO			_	
12.00	CT FILE: —			<u> </u>	•	_
	Patient Posted For Procedu	ure: UABU	·		, , ,	<u>-</u> -
	Under Anesthesia:				81	
	Allergy Status: NKDH				1002)	-
,	Known Case Of: CAD	TYD, EVO WOD INM	L TO DW			
	Past Surgical History:					-
	VITAL SIGN: TEMP: タギ	VITAL SIGN: TEMP: SEC HR: SOLDIMSPO2: 98% BP ! 130 FOMMAG				
In.8_	CTOT	SHIFTING REPORT				
12/12/28	Case Sheet Along With	To SDO) With Blue Op 1	File And			
16-20	*Surgery Safety Check Lis *Intra Operative Record	*Surgery Safety Check List *Intra Operative Record			0003T	
	*Nurses' Record * Anastrisea rewa			12	1/2/2) Lesso	
	ECG: S ECHO:					
	CT FILE: —					•
,	Patient Posted And Underv Under Anesthesia: UNA	ZWi	<u>.</u>	, 		
	Procedure: OPCABN	<u> </u>				
	Drain tube size and placem	· 	<u> </u>			
	Pacing wire placement: Present/Absent/ Site:				<u>. </u>	
	Implants:					
	Cautery burn/skin peeling/towel clip mark: Present/Absent Site:					
	VITAL SIGN: TEMP: 87°C HR: 98 LPMSPO2: 987 BP: 147/75 MM HG					
	·					·
	Notes: 0 680 Life Cal Well - PIU3 A2					
	18C8-2011			· 	· -	T
	Signature	Name	Emp. No.		Date	Time
Document endorsed by		M. SASDIWMAR	MADOO	31	12123	16.20





Mrs.Shanmugapriya s 45/Female/MHI202381078 11/12/2023/IPH202302475 Dr.Anbarasu mohanraj



	PATIENT CLINICAL HANDOVER RECORD FOR NURSES							
Date: 12	12/23	Shift: Morn	ing Evening Night	,	,			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: (AD-∫VD PEWS Score: — day: DI Il line day: Right: (White I bef be: □Yes □ No Day atheter: □Yes □ No Day	POD: DOS Central line to VIP Score:	015.	· ,			
В	Allergies i On room	ROUND urgery: OPCHBX HOTK if any: NKDA air / oxygen: ON VENTI its / New Symptoms in last s	LASOR IV fluids on f	iery: 12 12 23 iow: KABILYJE				
A	ASSESSMENT Vital Signs: Temp: 91 (°F) Pulse / HR: 90 (beats/min) Respiration: 4 (breaths/min) BP: 133/35 (mmHg) SpO ₂ :100 (%) Height: 165 (cms) Weight: 3:4 (kgs) BMI: 13:3 169 m² Others: 858: 1, 74 m² Pain Score: Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: 5 Fall Risk Protocol: Low Medium High Braden Score: Minimal Risk: 23-19 At Risk-Mild Risk: 18-15 Moderate Risk: 14-13 High Risk: 12-10 Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): Yes No NA Wound Dressing done: Yes No NA (61) Current diet: NPO Drains: Maximum High Please No NA (61)							
R	Referral of Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	No. If Yes, modified care plan date	e;				
Handover g	jiven by	Signature	Name PLORANCE'S	Emp. No.	Date Time			
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	NURSES PROGRESS NOTES			,,,,,
Date & Time	Observations / Action	Signa	ture with Er	np. No.
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16.55	has Modymont cally maintaining could ! You			
16.FM	without Nupports.	_ RNO	acistoots	
17:00	det chocked values aptidactory	, ,		
17.15	234 chocked volers offen Jackery			
	xray takan @ rovals Mormal?	RAC	glant 8 (00 =	ff
18.00	I detailers repeted the patrent and			
	explained about the condition.			
	ideaning oftended ordered by	<u> </u>		
	pr. Olylvaster.	RIN	160 100 ×4	<u> </u>
18.30	Do al drated from Modinstral and		<u> </u>	
	pleural Wite Programed to by elipsoster advised			
	to coult for this if Not drained, continue			
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19.00	I she got housed own to repet duty often		<u> </u>	
	en a hadrial grandelly maintaining andition	 		
	without Upports.	R/N/J	Bus 100 ta	<u> </u>
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~	Signature Name Emp.		Date	Time
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MIB.SHANMUGAPRIYA S 45/Female/MHI202381078 11/12/2023/IPH202302475 Dr.ANBARASU MOHANRAJ



	PAHE	NI CLINICAL F	IANDUVER REL		IUNSES			
Date: 12	12/3	Shift: Morn	ing Evening Night					
S	Ventilator Periphera Ryle's Tut Urinary C	S: CAD_TVD PEWS Score: day: D I line day: Right: WB17#\Left De: _Yes _ No Day atheter: _Yes _ No Day	POI Cen (D) VIP	S: Mep VET E D: DOS tral line days: D Score: O S	• 1 •	•		
B	Allergies i On room	ROUND irgery: OP CAB XA UTB if any: ON CDA air / oxygen: ON VENT ts / New Symptoms in last sl	ILATOR IV flu	e of surgery: 12 12 uids on flow: [AB]		į		
A	ASSESSMENT Vital Signs: Temp: 98-1(°F) Pulse / HR: 100 hint (beats/min) Respiration: 100 hint (breaths/min) BP: 100 hint (firmHg) SpO ₂ : 99/(%) Height: 16 (cms) Weight: 63-14 (kgs) BMI: 23-3 19 10 Others: 12 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: 15 Fall Risk Protocol: 15 Low Medium High Braden Score: Minimal Risk: 23-19 At Risk-Mild Risk: 18-15 Moderate Risk: 14-13 High Risk: 12-10 Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): Yes No No NA O Torins: Moderate Risk: 100 NA O Torins: Moderate Risk:							
R	Referral of Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:	·/	plan date:	<u> </u>			
		Signature	Name ,	Emp. No.	Date	Time		
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	NURSES PROGRESS NOTES	_		المحمر المرام
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	on harmody namb cally etable the g	ODE	·	
(2002-991/) BP-120 (50 MMH9, Chost			
	down tubo proport.			
20-00	Ruj. myopyoulate of sml Du	·		
	gruen. put on pelcap Fios-60/,		\	_
c	n sottongo, @ 20.30 pt got	9	W4	
	extabated and prior tobo	6	2 ⁷⁰	
<i>Ì</i>	Removed.	·		
21.00	* DRE @ pinometry was			
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	done no cognoction.		_ }	
23.00	* pt is super well.	<u> </u>		
04-00	+ OH-20 lab gampio us	a,		
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, ,	way given.			
6.00	* DRE @ spromotry uoc	NO		
	giron. , 0 6.30 HRUT way			
	Jakon no corrections.			
7-00	* pt fices @ noponto			
	handed over given b		<u> </u>	_
	morning duty Staff.	 _	<i>`</i> \\ → —	
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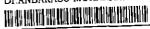




MIS.SHANMUGAPRIYA S

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ





Date: (3	112/2000	Shift: Morr	ing Evening Night					
S	Ventilator Periphera Ryle's Tul Urinary C	S: CADITVO PEWS Score: NIL day: NIL Il line day: Right: WBITELE be: Yes No Day atheter: Yes No Day	に 少2 '	days:D2.	i i			
В	Allergies On roo fs	ROUND urgery: OPUABX HUPA if any: NICDA atr Toxygen: MOL its / New Symptoms in last s	IV fluids on t	gery: 121121223	•			
A	ASSESSMENT Vital Signs: Temp: 19 of (°F) Pulse / HR: 103							
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	INAJIf Yes, modified care plan dat	e:	· ·			
		Signature	Name	Emp. No.	Date	Time		
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Handover ta		luoeng	Meena Belliam.	0286.	13/12/2			
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	NU	JRSES PROGRESS NOTES				
Date & Time		Observations / Action		Signat	ure with E	mp. No.
13/12/2028	MORNIN DO	MY PEPORT ON 15	3/12/2022			
7120-16100	'== '		<u> </u>			
7:00	Took Over t	ho patient stom a	Kemody			
ļ 		able condition rupou	//	_		
	f 1	por On Room Xiv				
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	MBP 124160 (03)	mmug, up ummug, esp	102			
	94 V. Bilateral	and entry to lunging	ao	-		
	clear X holomon	Soft Bowel sound @		20022		
,	perplan as wo	um Juliaro felipo.				
						
7:30	parrent had	mile Draly toboated	} ·	<u> </u>		
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-2:00	St. Driven	Jeyeum Adud by cont	nuo		•—	
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MTS.SHANMUGAPRIYA S 45/Female/MHJ202381078 11/12/2023/IPH202302475 Dr.ANBARASU MOHANRAJ



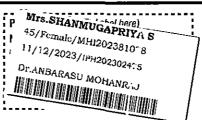


Date: \	3/12/2	另 Shift: ☐Morn	ing Evening [] Night					
S	SITUATION Diagnosis: CAP TVD Diagnosis: CAP TVD OCS: 5 15 NEWS / PEWS Score: POD: PODI Ventilator day: Central line days: P2 Peripheral line day: Right: Left: Ryle's Tube: Yes No Day: VIP Score: 0 5 Urinary Catheter: Yes No Day: Barrier nursing: Yes No MDR: Yes No. If Yes, specify organism:								
В	Allergies On room	ROUND urgery: OPCOTB × 461 if any: NUDA air / oxygen: uts / New Symptoms in last sl		Date of surge	ery: 12/12/20 ow:	23 _			
Α	ASSESSMENT Vital Signs: Temp: 640F) Pulse / HR: 45 (beats/min) Respiration: 50 (breaths/min) BP: 140 75 (mmHg) Sp0; 5 (%) Height: 165 (cms) Weight: 63 4 (kgs) BMI: 23 3 149 m ² Others: 70 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: 50 Fall Risk Protocol: 10 Low Medium 14 High Braden Score: Minimal Risk: 23-19 At Risk-Mild Risk: 18-15 Moderate Risk: 14-13 High Risk: 12-10 Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): 19 Yes No NA Nound Dressing done: 19 Yes No NA Current diet: 19 Grad Grad Grad Orains: 19 Ora								
R	RECOMMENDATION 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	jiven by	Silvoona	Meara se	hon	0296,	13/12/23	1930		
Handover t	aken by	92	AR c	<i>,</i> ,,,	250	13/12/25	LP 30		
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	NURSES PROGRESS NOTES	_			
Date & Time	Observations / Action		Signat	ure with E	mp: No.
13/11/23	patient hand over taken,				
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1400.	medication gires		mac	m9 0276	- -
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	gren .				
16/30	medicatin given,		Meen	90276	
1700	mobilized to chair.	-	neo	G 0276	~
1830.	DR. Anbalasu son-the patient.				
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19-30	patient hand over to night	Like	. <u>-</u>	<u> </u>	
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Date: 15	3/12/2	3 Shift: Morr	ing ∐Evening ∐k	light				
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CAD T V D PEWS Score: day: liline day: Right:COB Lef be: ☐ Yes ☐ No Day atheter: ☐ Yes ☐ No Day		GCS: (S/I POD: 7 Po Central line VIP Score: pecify organis	015			
В	Allergies On room	ROUND urgery: のPCA-BメルのR if any: のをりか aif Toxygen: uts / New Symptoms in last s		Date of surg	ery: (2/1423			
A	ASSESSMENT Vital Signs: Temp: 97 4°F) Pulse / HR: 106 (beats/min) Respiration: 24 (breaths/min) BP: 137/80 (mmHg) SpO ₂ : 94 (%) Height: 165 (cms) Weight: 654 (kgs) BMI: 253/59 mm Others: Pain Score: 10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS/CPOT Fall Risk Score: Fall Risk Protocol: Low Medium High Braden Score: Minimal Risk: 23-19 At Risk-Mild Risk: 18-15 Moderate Risk: 14-13 High Risk: 12-10 Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): Yes No NA Wound Dressing done: Yes No NA Current diet: Self Log Pain Rating Course Risk: 9-6							
R	Referral of Pending Pending Pending Critical von Changes	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:	<i>y</i>	care plan date	e: ^ u			
		Signature	Name		Emp. No.	Date	Time	
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	NURSES PROGRESS NOTES		5
Date & Time	Observations / Action	Signature with E	mp: No.
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	with out support and room air		
21.80.	pariet had food		
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22.30	Due redications gives as per as		
	drug charf.	W.	
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23'00	neplication and spirometry exercises	150	
	Given.		
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04-30	collected blood Sample and Sent to		
	lab for parther investigation.	1/2/	
04140	U-cash was removed Blo BR. Anha	_	
5,00	prouded osal care and sponge	both.	
6-00	Provided vebulization and spinone	lry	
	exersise.	1 200	
	Potient got mobilized to	-	
	Chair.		_
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7.80,	patient handed over to	d-	
	morning duty Staff.	ten	
	Signature Name Emp. No.	Date	Time
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Mrs.SHANMUGAPRIYA S 45/Female/MHI202381078 11/12/2023/tPH202302475 Dr.ANBARASU MOHANRA.,



	PAHE	NI CLINICAL F	IANDOVER RE	CORD F	OK NUH	12E2			
Date: אַן	1/12/23	Shift: Morn	ning Evening Nigh	t					
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	be: ☐ Yes ☑ Nó Day atheter: ☐ Yes ☑ Nó Day	Cei (: D 3 v: ViF	S: 15 (15 DD: POD - TT ntral line days: of Score: 0 (5) fy organism: he					
В	Allergies On room	ROUND urgery: のpcから メート if any: NIKOD-・ air Loxygen: ひん ドル ats / New Symptoms in last s	IV fi	te of surgery: luids on flow: N	10/10/28				
A	ASSESSMENT Vital Signs: Temp: 92 (°F) Pulse / HR: 14 (beats/min) Respiration: (breaths/min) BP: 98 62 (mmHg) SpO ₂ : 66 (%) Height: 5 (cms) Weight: 58.4 (kgs) BMI: 28.3 mc ² Others: BSD -> 1.44 m ² Pain Score: 10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale NRS CPOT Fall Risk Score: 50 Fall Risk Protocol: 10 Low Medium 14 migh Braden Score: Minimal Risk: 23-19 At Risk-Mild Risk: 18-15 Moderate Risk: 14-13 High Risk: 12-10 Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): Yes No MA Wound Dressing done: 12 min NA OT Current diet: 10 4 diet 12 min Na OT Drains: Na Charles No Main Na OT								
R	Referral of Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: mstructions if any:	. .	plan date:					
		Signature	Name	Emp	. No.	Date	Time		
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	NURS	ES PROGRESS NOTES				
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Mrs.SHANMUGAPRIYA S

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ



Date:	111/12	∫ _{2,3} Shift: ☐ Morn	ning Evening N	ight	_
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CPIO-TVIO PEWS Score: day: il line day: Right:CU DifoLeft be:	r.	GCS: S S POD: DOD ~[] Central line days: VIP Score: 0 S Decify organism:	
В	Allergies	urgery: ADUABX HGRF		Date of surgery: ユ レ ュミ	}
A	BP: 95 Others: Pain Sco Fall Risk Braden S	re: \[\int \text{D Pain Scale used} \] Score: \[\int \text{Minimal Risk: 23-19} \] Ulcer Scale for Healing (PUS)	O_(%) Height:	ms) Weight: <u>62. </u>	MI: <u>98. 310 M2</u> Rating Scale / NRS / CPOT Risk: 12-10 Severe Risk: 9-6
R	Referral of Pending Pending Pending Critical va Changes Pending	IMENDATION	\right\ \right	are plan date:	•
	 -	Signature	Name	Emp. No.	Date Time
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14/12/23	Evening	duty Notes		_	
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12:30.	& patient	taken over from	2		
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	' drug chi	art		_	
16:00	-> Nebuli	nation guen	4		
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18-3,	- patient	Vital Signs che	Cod -	13/7	
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Mrs.SHANMUGAPRIYA S Patie 45/Female/MH1202381078 Namo 11/12/2023/IPH202302475 UHID





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

DOB:

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Date: A	12/23	Shift: Morn	ing □Evening □ Nig	ht			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	SECHD - TVD PEWS Score: D day: - I line day: Right: CD Left De:	: <i>D3</i> : v	iCS: 15][5 POD: 1] Pentral line of Pentral line of Cify organis	کا د	,	:
В	On room	ROUND urgery: OPCABX 4 U1 if any: NKD H air / oxygen: ON ROOM ts / New Symptoms in last sl	vi full o	, ate of surge fluids on flo	ery: 12/12/23 Dw:		
A	ASSESSMENT Vital Signs: Temp: 91.6°F) Pulse / HR: 103 (beats/min) Respiration: 20 (breaths/min) BP: 95 64 (mmHg) SpO ₂ : 9 b (%) Height: 65 (cms) Weight: 63.1 (kgs) BMI: 23.8 kg m Others:						
R	Pending Pendin	MENDATION foctors: medications: medication indent: ab reports / Investigations: alue alert and its corrections; in nursing care plan: ☐ Yes follow-up orders: ← instructions if any:		e plan date	: -		
		Signature	Name		Emp. No.	Date	Time
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	NURSES PROGRESS NOTES					
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29.00	- Nebulizat	Pon given to the	D1	A)		
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5.30	→ Patient v	ital signs checked	ا جو			_
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6.30	> Nebulizat	for given to the	Pt			
	→ P+ 921001	med well				
7.00	> Pt MOE	ilized well				
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	mosining du	ty staffs		021		
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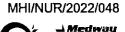




Pati Mrs.SHANMUGAPRIYA S Nan 45/Female/MH1202381078

11/12/2023/IPH202302475







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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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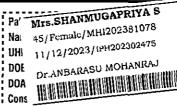
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Date: 15	- 12 2	3 Shift: ☐ Morr	ning	ght			
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В	Allergies i On room	ROUND urgery: OPCAB メ ¹ if any: 心以のら air / oxygen: しいい nts / New Symptoms in last s	om år 1	Date of surge V fluids on flo	ery: 12/12/h	1	
A	Others: Pain Sco Fall Risk Braden S	ns: Temp: Q 1-(4°F) Pulse D 6 0 (mmHg) SpO ₂ : Q ore: V 10 Pain Scale used Score: Fall Risk Pro Score: Minimal Risk: 23-19 [Ulcer Scale for Healing (PUS	5_(%) Height: <u>(6 m</u> cn : PIPPS / CRIES / FLACC otocol: □ Low□ Mediun □ At Risk-Mild Risk: 18-15□	ns) Weight: / Wong-Bak n UHigh Moderate Ris	er FACES Pain Rationsk: 14-13 High Risk:	2 3 · 3 . 20 ng Scale / NR: 12-10 □ Severe	S / CPOT e Risk: 9-6
R	Pending Pending Pending Critical va Changes Pending	imendation doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: instructions if any:	\sim	ıre plan date	:		
		Signature	Name		Emp. No.	Date	Time
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Every heart beat counts

Date:	15	12/2-2	Shift: Morr	ning Evening I	Night		
S	Ventilator Periphera Ryle's Tul Urinary C	s: (A) ((). PEWS Score day: Il line day: Doe: atheter: [Right: White Lef Yes ☑ No Day Yes ☑ No Day	/;	GCS: SI POD: SI Central line VIP Score: Specify organis	P.K	
В	Allergies i On room	urgery: (0) if any: air / oxyge	PCABX HG K1017- MON ROOM ymptoms in last s	A'r	Date of surg	ery: 12/12/2) low:-	
A	Others: Pain Sco Fall Risk Braden S	re: 10 Score: Score: Mulcer Scal	Pain Scale used Pain Risk Pro	/ HR: <u>8 o</u> (beats/ <u>6</u> (%) Height: <u>/6 5</u> (¢ :: PIPPS / CRIES / FLAC btocol: □ Low □ Medit ☐ At Risk-Mild Risk: 18-15 SH): □ Yes □ No □ NA	cms) Weight: C / Wong-Bal um	_6_5. (dkgs) BMI:_ ker FACES Pain Ratin sk: 14-13 □ High Risk: Dressing done: □ Yes	93.3kg/m ng Scale / NBS+CPOT 12-10□Severe Risk: 9-6
R	Pending Pending Pending Critical va Changes Pending	medication medication lab reports alue alert a in nursing follow-up o	ns: indent: Indent: Investigations: Ind its corrections: care plan: Yes	Ne. If Yes, modified	: care plan date		ce [‡] /k [‡] Tāmoma
Handover g	iven bv	Signatu	re	Name		Emp. No.	Date Time
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	N	JRSES PROGRESS NOTES	3		
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Patier Mrs.SHANMUGAPRIYA S

Name 45/Female/MHI202381078 UHID: 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ Consu .



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DATIENT OF INIOA

DOB:

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		INT CLINICAL	HANDOVEK	RECURI	D FOR NO	HOEO	
Date: 15	12/2	Shift: Mo	orning Evening 4	Night			_
S Di	EWS / P entilator eriphera yle's Tut rinary Ca	s: CAD → TVD EWS Score: O day: — I line day: Right: — L be: □ Yes □ No D atheter: □ Yes □ No D	eft:	GCS:(5/15 POD: [1] Central line of VIP Score: specify organis	days: —		
B	/pe of su llergies i n room	ROUND irgery:のPCAB ドム f any: NRDB air / oxygen: のN Roc ts / New Symptoms in last	M AIR	Date of surgo	ery: ルルレーラ ow:		
Pi Bi Pi	P:130 / others : _ ain Sco all Risk traden S	re: Dit b Pain Scale use Score: Minimal Risk: 23-15	17 (%) Height: 165 (ed: PIPPS / CRIES / FLAC Protocol: ☐ Low☐ Medi ☐ ☐ ATRisk-Mild Risk: 18-15 USH): ☐ Yes ☐ No ☐ NA	cms) Weight: _/ CC / Wong-Bak ium [] Hig h i [] Moderate Ris	63.4(kgs) BMI: ker FACES Pain Ra sk: 14-13 □ High Ris Dressing done: □ Y	ting Scale / NF	RS / CPOT re Risk: 9-6
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	NU	IRSES PROGRESS NOTES			
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	> patient c	onscious and orien	ded !	A.	
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20.00	> moderation	given as per	drug		
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23.00	a patient he	modynamically si	able	Q' OLZ L	
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Paliei Mrs.SHANMUGAPRIYA S
Name 45/Female/MHI202381078
UHID: 11/12/2023/IPH202302475
DDB: Dr.ANBARASU MOHANRAJ
Consuli

MHI/NUR/2022/048

Heart
Institutes

Every heart beat counts

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Date: 16	[12/23	Shift: ☐Morn	ing Evening N	Night		-	
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CAD TOD PEWS Score: day: liline day: Right: Left be: Yes No Day atheter: Yes No Day	÷ .	GCS: 16 12 POD: 48 Central line VIP Score:	A POD days:	· .	,
В	Allergies i On room	ROUND urgery: OP CAB メ HGP f if any: WODA air / oxygen: Dn でのれる ats / New Symptoms in last sl	, v	Date of surg	ery: (2 1/2-12-3) ow: —		
A	BP: (Bo Others: Pain Sco Fall Risk Braden S Pressure	n s: Temp: <u>98 (</u> °F) Pulse , 140 (mmHg) SpO ₂ : 94	(%) Height: <u>[65</u> _(c : PIPPS / CRIES / FLAC otocol:	ems) [Weight: C / Wong-Bak um	<u>らい</u> (kgs) BMI: ker FACES Pain Ratir	<u>2_3.3 keyl</u> ng Scale / NA 12-10∐Seven	8√CPOT
R	Pending Pending Pending Critical va Changes	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: mstructions if any:	→ No. If Yes, modified o	care plan date	<u>-</u>		
		Signature	Name		Emp. No.	Date .	Time
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	NURSES PROGRESS NOTES	4
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Patie Mrs.SHANMUGAPRIYA S Nam: 45/Female/MHI202381078 UHID 11/12/2023/IPH202302475 DOB:

Dr.ANBARASU MOHANRAJ Const



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

DOA:

Date: (b)	12/2>	Shift: ☐ Morr	ning 🏻 Evening 🗀 I	Night		TIOLO	
S	NEWS / F Ventilator Periphera Ryle's Tu Urinary C	s: CAD	y :	GCS: (4) (2) POD: 4 th Central line d	pop ays: ►		
В	Type of s Allergies On room	ROUND urgery: のたみBメ みり if any: んとあみ air / oxygen: か、足のか nts / New Symptoms in last s	air	Date of surge	ny: 12/12/2 ow:	3	·
A	BP: / 30 Others : Pain Sco Fall Risk Braden S Pressure	ns: Temp: <u>9·8</u> (°F) Pulse <u> ↑↑০ (</u> mmHg) SpO₂: <u>9 </u>		cms) Weight:_ CC / Wong-Bake um	63년(kgs) BMI: er FACES Pain Ra k: 14-13 □ High Ris ressing done: □ Y	ting Scale / NR	→ S/CPOT
R	Referral of Pending Pending Pending Critical volumes Pending Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders:	9	care plan date:		_	
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Handover t	aken by	Ay.	A. ALBINU) Ω	0086	16/12/23	400
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Date & Time Observations / Action Signature with Emp. No. 16.12.2) EVENINUS DUTY NOTES 17.20 Spatient has ding over taken of the partient of and constitutions. 2 Pt orderted and constitution. 2 Pt Vital are checked. 2 Pt Vital clacked and seconded. 3 Pt Vitals clacked and seconded. 14.00 = Pt Nessbuli ration given the partient. 2 Pt Mobilized well. 18.20 = S Pt No Chart Moutered. 2 Pt Leading over given to Night duty shaft.	NURSES PROGRESS NOTES					
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100 17:30 Patient bracking over tooken of the patient draw over tooken of the patient and constitution of the patient are checked. 3) Pt DD hand checked. 3) Pt DD hand checked. 4) Pt Vitale are checked. 4) Pt Vitale checked and checked. 5) Pt Vitale checked and checked. 16.00 => Pt Newbuli yation given the patient. 5) Pt Mobilized well. 18:20 => Pt DO chart Monitered. 5) Pt Annaling over given to Night duty staff.	16.12.23	EVENINU	2 TOTY NOTES			
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Pati 45/Female/MHI202381078
Nar 11/12/2023/IPH202302475
UH Dr.ANBARASU MOHANRAJ
D0 Consultant:



Date: [6	[[2]2	Shift: Morn	ning □Evening ☑₩	ight			
S	Ventilator Periphera Ryle's Tul Urinary C	s: CAD → N D PEWS Score: O day: Il line day: Right: — Left be: ☐ Yes ☑ No Day atheter: ☐ Yes ☑ No Day	l: — ″: ⊑	GCS: 15-113 POD: 4 113 Central line VIP Score:	days:	-	
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A	BP: /3 o Others : Pain Sco Fall Risk Braden S	ns: Temp: 97 (°F) Pulse 170 (mmHg) SpO ₂ :98 100 L (%) Height: 6 C (ci : PIPPS / CRIES / FLACO tocol: □ Low□ Mediu LAt-RISK-Mild Risk: 18-15 □ SH): □ Yes □ No □ NA	ns) Weight: C/Wong-Bal n ∐High] Moderate Ri	ker FACES Pain Ratin sk: 14-13 □ High Risk: Dressing done: □ Yes	A- 2 Kolm ig Scale / NRS	S / CPOT	
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Mrs.SHANMUGAPRIYA S 45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.Anbarasu mohanraj



Every heart beat counts

Date:	17/12/2	Shift: Morri	ing □Evening □Night			ļ
S	SITUAT Diagnosis NEWS / F Ventilator Periphera Ryle's Tu Urinary O	ION s: OHO TO PEWS Score: O day: day: Hight: Left be: Yes No Day Catheter: Yes No Day	GCS: l5l POD: シ Central line : VIP Score:	days:		
В	Allergies On room	ROUND urgery: OO CAり メ Groy if any: NOO お air / oxygen: のいでの M nts / New Symptoms in last sl	: IV fluids on	•		
A	BP: Ro Others: Pain Sco Fall Risk Braden S	ns: Temp: 94 (°F) Pulse on the control of the con	/ HR: Sch (beats/min) Respir (%) Height: Let (cms) Weight : PIPPS / CRIES / FLACC / Wong-Ba ptocol: Low Medium High At Risk-Mild Risk: 18-15 Moderate R SH): Yes No NA Wound	: 69.1(kgs) BMI: 5 ker FACES Pain Ratin isk: 14-13 High Risk: Dressing done: Yes	2_U-∆legf ng Scale PNR 12-10∐Sever	S / CPOT
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Handover	given by	Signature	Name Of C	Emp. No.	Date	Time
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ADULT NURSING CARE PLAN



45/Female/MH1202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ







				
Initial Date: 2	Time: 12.50.	Modified Date: Time:		
Reason for Modification:	,	Diagnosis: CAIO - TV 10		
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	Hecold amount of lood consumed	Bation had Dr diet	De
	,		IN PT NORMAL Diet	800
OXYGENATION Room Air Nasal Cannula / High Flow O, Mask BiPAP / CPAP	Patient will have normal O₂ saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rize will remains	□ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises □ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order □ Utilise pulse oximetry ocheck O₂ saturation and pulse rate	M	•
comfortable when breathing breathing pattern Evaluate skin colour, temper central venous peripheral cy	the concerned physician Place patient with proper body alignment for maximum	Foodient F&on Program Hir	Pu	
	,	Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging patient with successful coughing	N 3PO2-95%	A bobs
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	Flo Chart Monitored	
			N Ilo chart	At but

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Patient will use safety measures	☐ 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	М	
Others:	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 Patient Mobilizad	
			N PT Mobilized well	200
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel 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	M	
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 and follow proper protocol	Exformal Elimination Pattern	
		☐ Check for malena / constipation / urinary retention	N Elmination 18 9 ood	0688
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI DPI	Patient will maintain normal healing status Patient will discharge with intact skin integrity		М	
GRADES OF PRESSURE INJURY □ GRADE 1 □ GRADE 2				
GRADE 3 GRADE 4 Unstageable Deep Tissue Injury		Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further	Maintain Mormal	
☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted		skin care	E Okin integrity	一 抗
☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N Skin is - what	Sup OOK

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

Obtain interpreter if needed No negative speaking about the patient's condition Others: Signature Observed and continue treatment Observed and continue treatment Others:	Patient Specifi _Problems / Ne		Measurable Goals	<u> </u>	Nursing interventions		Evaluation		Sign & Initials
Others: Or prognosis in the patient's presence Or prognosis in the patient's presence Others: Or prognosis in the patient's presence Others:	☐ Verbal Non-verbal		Patient will communic with positive feedback	ate effectively k	☐ Encourage the use of call bell☐ Obtain interpreter if needed	condition	М		
SPECIAL INTERVENTIONS To manage on time Double check for high alert medication Double check for high alert medi	Others:				or prognosis in the patient's presence	Ondiasii	W- NA A	matipi	Auto
Wound care Siolation 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 Date Time 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 Name Emp. ID Date Time Signature Name Emp. ID Date Time	Medication	RVENTIONS	☐ To manage on time		☐ Observe and report any medication react	ion	<u> </u>	0,000	Doles
Signature Sign	☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood p	products			□ 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	solation	Medicato	n given	
Signature Name Emp. ID Date Time	☐ Fluid tapping				Practice strict asepsis while transfusing b blood products and fluids Monitor DVT score and continue treatment		os por d	rup Chart	di.
	T				as per doctors order		n are &	, 	
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ADULT NURSING CARE PLAN

Mrs.Shanmugapriya s

45/Female/MHI202381078 11/12/2023/iPH202302475

Dr.Anbarasu mohanraj





Initial Date: 12/12/	23 Time: 4.00	Modified Date: Time:		
Reason for Modification:		Diagnosis: CAD - TVD		
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 was NPO	Hay 0105
			N	
OXYGENATION Hoom Air Nasal Cannula / High Flow O ₂ Mask BiPAP / CPAP Ventilator	☐ No other respiratory abnormalities☐ Patient respiratory rate will remains	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	M pt was Stable on room our	Hay
☐ Tracheostomy ☐ Others:	within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing Within established limits 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	E		
		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	N	
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 Ilo Chaet Maintained	Hay OLDS
☐ Parenteral Nutrition ☐ Others:			E	
			N	

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 ☐ P_tient 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	
Cuters.	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	1
			N	
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 /	М	
	and regular elimination patterns	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	
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	
☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased	INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased	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	
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N .	

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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath	Patient will stay clean and well-groomed Patient will demonstrate lifestyle	Encourage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene	m pt growed well	AJens Octo
☐ Self-Care ☐ CBD Care (if present) ☐ Others:	changes to meet self-care needs Patient will recognize individual weakness or needs	Consider the patient's need for assistive devices Apply moisturizing solution	E .	,
			N	
SAFETY Check ID Hand IV care	Patient will have no life-threatening situations	Check the identity with ID band before any interaction with the patient Raise side rails	M ID band present	flory
CENTRAL LINE Side rails Others:		Provide proper invasive line care Keep bed locked and low at all time Educate care providers to be the patient	E .	
	,	Follow restrain policy (if needed)	N	,
COMFORT AND SLEEP Pain Control	Patient will have comfortable sleep Patient will verbalize / or through	☐ Provide clean calm and restful environment☐ Provide privacy at all time	М	
☐ Sleep Patterns ☐ Others:	behavior about pain relief and adequate sleep	 ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy 	E	
	'	,	N '	
OBSERVATION Vital Signs GCS Blood Sugar	Patient will have normal range of vital parameters		M Pt Vital Signs Checked	Hay
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	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness	 □ Pray or encourage the patient to pray □ Use inspirational words □ Respond to spiritual needs as they arise 	М	
☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	Patient will maintain normal psychological pattern	Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	E	
			N	

<u> </u>								
Patient Specifi Problems / Ne		Measurable Goals	-	Nursing Interventions		Evaluation		Sign & Initials
- COMMUNICAT Verbal Non-verbal		Patient will communic with positive feedbac	cate effectively k	Introduce the care giver Encourage the use of call bell Obtain interpreter if needed		M Pt-Comm	unicated well	Hory
☐ Sigh language ☐ Others:				☐ No negative speaking about the patient's or prognosis in the patient's presence	condition	E		
				_		N		
☐ Medication☐ Wound care☐ Isolation	☐ Wound care		Double check for high alert medication Observe and report any medication reaction Provide proper measures of wound care Follow hospital polices and protocols of isolation		M Due de	iugs all	Hay	
Ostomy Care Blood / Blood transfusion Fluid tapping				and explain to the patient / family Check for cross matching and typing, to ensure compatibility Practice strict asepsis while transfusing blood or		E		
Others:	Management ers:			blood products and fluids Monitor DVT score and continue treatment as per doctors order		N		
	Signature		Name		Emp. ID		Date	Time
Endorsed by		Nas		e-Nalini	ට ව න	†	12/12/83	14:00
				·				





Mts.SHANMUGAPRIYA S

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ





ADULT POST-OPERATIVE NURSING CARE PLAN

, ,				
Initial Date: 12 12 23	Time: 17.00	Modified Date: Time:		
Reason for Modification:		Diagnosis: CAD-IVID		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
PAIN ☐ Comfortable Position ☐ Pain Scale ☐ Pain Score ☐ Others:	☐ Patient will have less pain	□ Evaluate location, character, quality and severity of pain □ Administer pain medication as prescribed and as needed □ Observe for any changes in vital signs □ Maintain proper positioning of patient □ Assist or turn patient every two hours □ Assess incision area for redness, heat, induration, swelling, separation and drainage □ Non-Pharmacological therapy	M E Abusaisters androvers an NOT Order N Administers androvers and analysis N Administers and analysis	SMC SMC SMC SMC
OXYGENATION Room Air Oxygen Hood Nasal Cannula Nebulizer Ventilator Others:	Patient will have no shortness or difficulty of breathing	□ Provide well ventilated environment □ Check oxygen saturation □ Perform suctioning if needed □ Ventilator settings as per physician orders □ Monitor rate, depth of respiration □ Administer oxygen and nebulizer therapy if needed □ Encourage spriometry, deep breathing and coughing exercises □ Monitor amount, viscosity, colour and odour of sputum if present	M E SPQ -100%. ON VOILTEDOR N DIV VENTILITION SP02-901%	Asion and a significant and a
ANXIETY Increased Pulse Rate Anxious Look	Patient will cope properly with his illness and react positively to his surroundings	 □ Explain all procedures to patient or family member in simple language they understand □ Encourage and support patient while increasing anxiety level □ Help patient to cope with outcomes of surgery □ Keep patient in comfortable position in bed to enhance sleep 	M NA	· . /•
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	□ Apply Anti-Embolic stocking / SCD □ Evaluate the need for assistive devices □ Assess the safety of the environment □ Consider the need for home assistance (e.g., physical therapy, visiting nurse) □ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M E and had sent N 2mmobile	OBBA SIN DIP

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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE Oral Intravenous Enteral Nutrition Parenteral Nutrition Others:	☐ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M E Mourord To , Iv time potent monitored Ito chart N. @ drawn	Chair of a OI to
RISK OF INFECTION Prevent Infection Others:	☐ The patient will be discharged with no hospital acquired infection	Use aseptic technique in all aspect of patient care Restrict visitors and use appropriate PPE Meticulous hand washing before and after patient's care Inspect wound for signs of infection, purulent drainage or discoloration Administer antibiotics as ordered CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	M E deptic premitien followed: N Precautions tollowed	Claus COSA En Ento.
RISK OF FALL Giddiness Independent State Dependent State	The patient will have safe, free from fall hospitalization	Keep bed on low position Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed Remove clutter, keep items patient needs within reach Avoid movement out of bed after surgery for 46 hours Review patients' medication like narcotics and hypotensive agents Offer urinal or bedpan to the patient if needed	M E fall risk procedition followed: N topt block in LOW DOS ittor	an 5270
SKIN &WOUND CARE Observe REEDA Oozing Foul Smell	☐ The patient will have intact skin while staying in the hospital and on discharge	Check all drains from the operation site more frequently Provide wound care as ordered Minimize pressure Provide adequate nutritional support Report signs of poor healing or trauma to doctor	M E drain ingitu N NO 002979 in the	Cloude ODA ODA
DIET & NUTRITION NPO Soft Diet Semisolid Diet Solid Diet RT Feeds	Patient will have adequate nutrition with no nausea and vomiting	□ Encourage patient to consume prescribed diet □ Record amount of food consumed □ Provide high calories, high protein diet as prescribed □ Monitor patient's weight □ Administer supplemental vitamins and minerals as prescribed □ Administer parentral or TPN per protocol if dietary needs are not met through oral intake □ Report abdominal distention, large gastric residual volume or diarrhea to doctor	M E ON IVF toond floor	Olavis en en

Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
CARE OF CAT DRAINS, ETC.		Patient will have pater maintained catheters,	nt, properly drains etc	☐ Check the catheters, drains etc frequentl☐ Observe I/O Chart☐ Watch for any symptoms related to kinke blocked tubes☐ Maintain adequate cleaning and dressing	ed or	M E CM CBD U	nire ou fout urino	<u>e</u>
DISTURBED B	ODY IMAGE	☐ The patient will demo initial acceptance and body image		□ Note non verbal body language, negative and self talk □ Note emotional reaction (grieving, depre □ Acknowledge and accept expression of tof grief and hostility	ssion, anger)	M E		
OBSERVATIO	N	Patient will have norm of vital parameters	al range	Monitor vital signs regularly Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient		M Hanned yn	enically Mabo	2/20 T4
HEALTH EDUC Patient Family / Guard Diet Disease proces Infection contro Medication Educate about and immunosu Personal Safet Treatment Regi	ian ss ol / PPE TAC level ppressant	Patient / Family / Guar Domestic Partner / Ca others will gain adequ knowledge regarding modalities and life sty modifications	re-giver / late treatment	dian / e-giver / the Explore action, reactions and adherence about medication Provide clear, thorough, and understandable explanations regarding safety precautions. Explain to perform activities / skin care that recommended by concerned doctor Use the teach-back technique to determine the patient's understanding regarding importance of treatment Amount		bidden on Vlay. all about ndetion of	July 200 A 2 h 3570	
ANY OTHER N	EEDS					M E N		
	Signature		Name		Emp. ID		Date	Time
Endorsed by	2		S	~ 14 -	יַטטיל		13/12/2	9.W









ADULT POST-OPERATIVE NURSING CARE PLAN

ADOLI I GOI OI LIMITE ROMANIA OMILI LAR						
Initial Date: (3/12/2023	<u>දු</u> Time: 2:ග	Modified Date: — Time:	-			
Reason for Modification:		Diagnosis: CAO 17WD		-		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials		
PAIN ☐-Comfortable Position ☐-Pain Scale	☐ ,Patient will have less bain	Evaluate location, character, quality and severity of pain Administer pain medication as prescribed and as needed Observe for any changes in vital signs	M Administral medicalmia as	don		
Pain Score Others:		☐ Maintain proper positioning of patient ☐ Assist or turn patient every two hours ☐ Assess incision area for redness, heat, induration.	E Arralgeesch given	Meang		
	,	swelling, separation and drainage Non-Pharmacological therapy	N Pain Score Y10	de-		
OXYGENATION Grown Air Oxygen Hood Masal Cannula	Patient will have no shortness or difficulty of breathing	Provide well ventilated environment Check oxygen saturation Perform suctioning if needed Ventilator settings as per physician orders	M Encouraged the pathent- to perform lipromary seems	don		
☐ Nebulizer ☐ Ventilator ☐ Others:		Worthator settings as per physician orders Monitor rate, depth of respiration Administer oxygen and nebulizer therapy if needed Encourage spriometry, deep breathing and coughing exercises Monitor amount, viscosity, colour and odour of sputum if present	E on Rown ATT .	S.ingon S.ingon		
			NDNROOMAIR	B		
ANXIETY Increased Pulse Rate	Patient will cope properly with his illness and react positively to his	Explain all procedures to patient or family member in simple language they understand	м	,		
☐ Anxious Look	surroundings	 ☐ Encourage and support patient while increasing anxiety level ☐ Help patient to cope with outcomes of surgery 	E			
	1 18	Keep patient in comfortable position in bed to enhance sleep	N			
MOBILITY Mobile / Immobile Walk with assistance	Patient will mobilize freely Patient will perform physical activity independently or within	Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment	M (Fronded Rich rainfur) 00n_		
☐ Physiotherapy ☐ Others:	limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of	Consider the need for home assistance (e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis	E mohitized to chair.	125C)		
	adaptive devices to increase mobility	(e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	N patient got mobilized tochin	2_		

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE 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 (promoted Intomend Output Charr E promitored, intology and N promitored intobe sont	des de la company de la compan
BISK OF INFECTION ☐ Prevent Infection ☐ Others:	The patient will be discharged with no hospital acquired infection	Use aseptic technique in all aspect of patient care Restrict visitors and use appropriate PPE Meticulous hand washing before and after patient's care Inspect wound for signs of infection, purulent drainage or discoloration Administer antibiotics as ordered CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	M lue osephic techniques CUI cuspeut of pount call E Administres antibration	Joseph Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan
RISK OF FALL ☐ Giddiness ☐ Independent State ☐ Dependent State	☐ The patient will have safe, free from fall hospitalization		M _ E N Yeer ped on 10 m Puttion	Pos .
SKIN &WOUND CARE Observe REEDA Oozing Foul Smell	☐ The patient will have intact skin while staying in the hospital and on discharge	□ Check all drains from the operation site more frequently □ Provide wound care as ordered □ Minimize pressure □ Provide adequate nutritional support □ Report signs of poor healing or trauma to doctor	M E N DOODZing in Surgeial	
DIET & NUTRITION NPO Soft Diet Semisolid Diet Solid Diet RT Feeds	Patient will have adequate nutrition with no nausea and vomiting	☐ Encourage patient to consume prescribed diet ☐ Record amount of food consumed ☐ Provide high calories, high protein diet as prescribed ☐ Monitor patient's weight ☐ Administer supplemental vitamins and minerals ☐ as prescribed ☐ Administer parentral or TPN per protocol if dietary ☐ needs are not met through oral intake ☐ Report abdominal distention, large gastric residual ☐ volume or diarrhea to doctor		1000) Mean 6.

Patient Specific Sian & Measurable Goals **Nursing Interventions** Evaluation Problems / Needs Initials Maintin alguns dage Patient will have patent, properly CARE OF CATHETERS. Check the catheters, drains etc frequently maintained catheters, drains etc. DRAINS, ETC. Observe I/O Chart Watch for any symptoms related to kinked or blocked tubes Maintain adequate cleaning and dressing ☐ The patient will demonstrate DISTURBED BODY IMAGE ☐ Note non verbal body language, negative attitude M initial acceptance and to newly and self talk ☐ Note emotional reaction (grieving, depression, anger) body image Ε Acknowledge and accept expression of feeling of grief and hostility Patient will have normal range **OBSERVATION** ☐ Monitor vital signs regularly Jun Z ☑ Vital Signs of vital parameters Assess physically for any abnormality ∐ GCS Inform doctor if there is any abnormality intaly monitored meen ☐ Blood Sugar ☐ Monitor GCS of patient Others: (proved fleaux eduin Provide proper education regarding follow-up diet **HEALTH EDUCATION** Patient / Family / Guardian / Patient Domestic Partner / Care-giver / ☐ Insist on importance of hand hygiene 4000 Family / Guardian Explore action, reactions and adherence about medication others will gain adequate ☐ Diet Provide clear, thorough, and understandable explanations knowledge regarding treatment ☐ Disease process modalities and life style regarding safety precautions. Freath Educati ☐ Infection control / PPE modifications ☐ Explain to perform activities / skin care that recommended nand ☐ Medication by concerned doctor ഗക ☐ Educate about TAC level ☐ Use the teach-back technique to determine the patient's and immunosuppressant understanding regarding importance of treatment Personal Safety ☐ Treatment Regimen Others: **ANY OTHER NEEDS** M Ε Ν Signature Name Emp. ID Date Time 13/12/2 9·w An iu Endorsed by

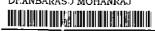




Mis.Shanmugapriya S

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.ANBARAS J MOHANRAJ





ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 14(1)	3 Time: 07!10	Modified Date: Time:		
Reason for Modification:	,	Diagnosis: CAD-TVD SF-35-4.		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
PAIN ☐ Comfortable Position ☐ Pain Scale ☐ Pain Score	Patient will have less pain	Evaluate location, character, quality and severity of pain Administer pain medication as prescribed and as needed Observe for any changes in vital signs	M Provided Conforter	
Others:	,		Compostable prestion to the p	A STORY
OXYGENATION Hoom Air Oxygen Hood Nasal Cannula Nebulizer Ventilator Others:	Patient will have no shortness or difficulty of breathing	 □ Provide well ventilated environment □ Check oxygen saturation □ Perform suctioning if needed □ Ventilator settings as per physician orders □ Monitor rate, depth of respiration □ Administer oxygen and nebulizer therapy if needed □ Encourage spriometry, deep breathing and coughing exercises □ Monitor amount, viscosity, colour and odour of sputum if present 	M On RA Spoo > 95% E Putient 1880 Poom Air N pf is on Room with	8 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
ANXIETY Increased Pulse Rate Anxious Look	Patient will cope properly with his illness and react positively to his surroundings	 □ Explain all procedures to patient or family member in simple language they understand □ Encourage and support patient while increasing anxiety level □ Help patient to cope with outcomes of surgery □ Keep patient in comfortable position in bed to enhance sleep 	M NA	813.
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	□ Patient will mobilize freely □ Patient will perform physical activity independently or within limits of disease □ Patient will use safety measures to minimize potential for injury □ Patient will demonstrate the use of adaptive devices to increase mobility	□ Apply Anti-Embolic stocking / SCD □ Evaluate the need for assistive devices □ Assess the safety of the environment □ Consider the need for home assistance (e.g., physical therapy, visiting nurse) □ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Sabety manuage followed Fatient Mobilized upt	Ai Gil

		,		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE Oral Intravenous Enteral Nutrition Parenteral 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 ☐ Measure or estimate fluid losses from all sources such	M Monitoned Ilo chait	Salm.
Others:		as diaphoresis, wound drainage, and gastric losses Monitor for possible sources of fluid loss Monitor BP for orthostatic changes	mobilized con	<i>A</i>
_			n-mobilized well	021
RISK OF INFECTION Prevent Infection Others:	The patient will be discharged with no hospital acquired infection	Use aseptic technique in all aspect of patient care Restrict visitors and use appropriate PPE Meticulous hand washing before and	M Asophe technique	37/6
		after patient's care Inspect wound for signs of infection, purulent drainage or discoloration Administer antibiotics as ordered	USe aseptic techni	A
		CVC dressing changing every 24 hours and	nuse aseptic techning to the	OLLL OLLL
RISK OF FALL ☐ Giddiness ☐ Independent State ☐ Dependent State	The patient will have safe, free from fall hospitalization	☐ Keep bed on low position ☐ Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed ☐ Remove clutter, keep items patient needs within reach	M Side raik raised	St.
:		Avoid movement out of bed after surgery for 46 hours Review patients' medication like narcotics and hypotensive agents	E	
		Offer urinal or bedpan to the patient if needed	N	
SKIN &WOUND CARE Observe REEDA Oozing	The patient will have intact skin while staying in the hospital and on discharge	Check all drains from the operation site more frequently Provide wound care as ordered	M No oosing at	# The
☐ Foul Smell	S.I. disolaries	Minimize pressure Provide adequate nutritional support Report signs of poor healing or trauma to doctor	E	a.
DIET & NUTRITION	Patient will have adequate nutrition	Encourage patient to consume prescribed diet	NNO OOZING all site	ALL ON
DIET & NUTRITION NEO Soft Diet Semisolid Diet Solid Diet RT Feeds	with no nausea and vomiting	Record amount of food consumed Provide high calories, high protein diet as prescribed Monitor patient's weight	M Potient Consumed Soft diet	Sam.
		Administer supplemental vitamins and minerals as prescribed Administer parentral or TPN per protocol if dietary	E Diabolie diet	A.
		needs are not met through oral intake Report abdominal distention, large gastric residual volume or diarrhea to doctor	" Diabetic diet	1022L

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Patient Specific Problems / Needs		Measurable Goals	Nu	ursing Interventions		Evaluation	-	Sign & Initials
CARE OF CATHETE DRAINS, ETC.	RS,	Patient will have patent, properl maintained catheters, drains etc		Check the catheters, drains etc frequently Observe I/O Chart Watch for any symptoms related to kinked blocked tubes Maintain adequate cleaning and dressing	d or	M Moritorea Emonitorea N moritorea	shout.	A Siz
DISTURBED BODY I	IMAGE	☐ The patient will demonstrate initial acceptance and to newly body image			ssion, anger)	M NA E _ N NA		
OBSERVATION ☑ Vital Signs ☑ GCS ☑ Blood Sugar □ Others:		Patient will have normal range of vital parameters		Monitor vital signs regularly Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient		M Monitors EVital Che Po N vital sign	acons acod & Lorded ns hocked	Solly Solly
HEALTH EDUCATIO Patient Family / Guardian Diet Disease process Infection control / PPI Medication Educate about TAC leand immunosuppress Personal Safety Treatment Regimen Others:	E evel	Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications		Provide proper education regarding follow Insist on importance of hand hygiene Explore action, reactions and adherence in Provide clear, thorough, and understandar egarding safety precautions. Explain to perform activities / skin care this by concerned doctor Use the teach-back technique to determinal understanding regarding importance of the same concerned doctor.	about medication able explanations at recommended ne the patient's	M Schrate Load 8hi E/100/11 0	el about	Office Andrews
ANY OTHER NEEDS	3					M E N		
Sigr	nature	Name			Emp. ID	D	ate	Time
Endorsed by	V			Duni.	000	<u>ح</u>	14/12/25	7.W





ADULT NURSING CARE PLAN

Patiept Natalla / Affine Laboratoria

Name Mrs. SHANMUGAPRIYA S

45/Fernale/MHl202381078

11/12/2023/IPH202302475

DOA: Dr.ANBARASU MOHANRAJ

Consi



	<u> </u>				
Initial Date: 15 12 2-3	Time: -&^00	Modified Date: Time:			
Reason for Modification:		Diagnosis: CAD - TVD			
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	Fatient had 104 Site NOT Wall	Jol.	
OXYGENATION Room Air Nasal Cannulà / High Flow O ₂ 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	pt et ver Mevour air patient 1801	Hon	
	comionable when breathing	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	Poom Air N SPO2-9506	St. Cook	
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 p + dones ord Here To Chart monitored N Flo chart N routased	Hospital Cook	

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 Putient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance ☐ (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis ☐ (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M pt nobilized N pt Mobilized N pt Mobilized Well	Del Attack
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement Urination Others:	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician Observe voiding accessories as foley's / silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol Check for malena / constipation / urinary retention	M D vældeng pælen Normal Blimination E Pattern Norman Elemination Pattern	For
SKIN-INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE INJURY GRADE 1 GRADE 2 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased Intermittent Assisted Dermatitis Pressure injury / blisters site care given Others:	Patient will maintain normal healing status Patient will discharge with intact skin integrity	Mynimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	Mainteun Mormal E Skih Integrity Skin is N inlast	Hose De 1008t

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYATENE Bed-Batth Assist-Bath Self-Care CBD Care (if present) Others:	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs Patient will recognize individual weakness or needs	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M pt tules self Bates Fatient well growned N pe well growned	A Constitution of the cons
SAFETY Check D 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 ID Band EJD burd present N ID Band (9)	Short Short
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+ Sleeped (eecol E N -	Bogo Zo
OBSERVATION Vital Signs GCS Blood Sugar Others:	Ratient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	M pt witals out Cheched & reason EVPtal Digno chelos experorded N vilal & igus one cheched	Hele De Septe
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 - PSY chological Support PSy chological N PSy chological Scient	t Of

Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions	<u></u>	Evaluation		Sign & Initials
COMMUNICAT Verbal Non-verbal Sigh language Others:	□ Non-verbal □ Sigh language		☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient' or prognosis in the patient's presence	m pt Veebal Communication gas Flood Communication N PT COMMUNICATION		AS TO		
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 read 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 treatments as per doctors order	isolation ensure plood or	M Dru n Modicalie as per dru N podice	e dication of Juen up chart	Jeef on
	Signature		Name		Emp. ID		Date	Time
Endorsed by		Nac	l.	Nalin	0004		15112123	16:00
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ADULT NURSING CARE PLAN

Pa MTS.SHANMUGAPRIYA S
Na 45/Female/MHI202381078
UH 11/12/2023/IPH202302475
DOI DT.ANBARASU MOHANRAJ
Con

MHI/NUR/2022/044

Medway
Heart
Institute

Every heart beat counts

Initial Date: 16 [12/23	Time: & ©	Modified Date: Time:				
Reason for Modification:		Diagnosis: CAD ~TVD				
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	M pt Normal diet	8 ou		
Others:	requirements in accordance to his activity level and metabolic needs	Theoderational of food consumed	E pt Normal diet.	8 20001		
			N PH IS ON diel	200/80		
OXYGENATION Room Air Nasal Cannula / High Flow O ₂ Mask BiPAP / CPAP	☐ 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	□ 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	Mp+ room aus	Dey-		
□ BiPAP / CPAP □ Patient reepiratory rate will remains within established limits □ Utilise □ Tracheostomy □ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing □ Place 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 pt on roomair.	Jen.			
	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		Spo - 950/6	Sobr		
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition	Patient will have balanced fluid and electrolytee-balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output	MP+ electorities pluid	Son		
Parenteral Natrition Others:	,		E pt electrogles	Sim.		
		workor or for otherstalic changes	Pt is on real	gy		

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 ☐ P_tient will use safety measures	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the eafety of the environment ☐ Consider the need for home assistance	M p+ will Mobilize fracely	\$ B
Culera.	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 Pt mobilized well.	Is.
		5 , , ,	N Pt Mobilized will	D) 8
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel 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	M P+ Climenteon peutlen	\$
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 pt elimition petteu Nond	200
		and follow proper protocol Check for malena / constipation / urinary retention	N is Good	Auf
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 pt llais tan D Stin integrity	Son
INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased	,	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 Pt Normal skin integuity.	Ser on.
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			Skin is N intact	dit.

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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath	Patient will stay clean and well-groomed Patient will demonstrate lifestyle	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene	M pa-Souff course	502
☐ Self-Care ☐ CBD Care (if present) ☐ Others:	changes to meet self-care needs Patient will recognize individual weakness or needs	☐ Consider the patient's need for assistive devices☐ Apply moisturizing solution	E pt soft come.	J
		,	N Pt Bell care	9098
SAFETY ☐ Check ID Hand ☐ IV care ☐ EJV	Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails	Mp+ IID Band	Dan
CENTRAL LINE 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 pt I/D bound	J
			N ID Band @	Potes
COMFORT AND SLEEP Pain Control	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and adequate sleep	□ Provide clear calm and restful environment □ Provide privacy at all time □ Monitor pain scale / sleep pattern □ Provide pharmacological and non-pharmacological therapy	M p4 comfortable Swap	858
☐ Sleep Patterns☐ Others:			Ept compostable	Jun
			N Pt. COMFOLATION	toll
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar	Patient will have normal range of vital parameters		M pt vital strags cheepen	Sa
Others:		Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	E Pt Vitals Signs chocked	Jen.
			N vilalegus is checked	Sop to
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness	Pray or encourage the patient to pray Use inspirational words Respond to spiritual needs as they arise	M	
☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	Patient will maintain normal psychological pattern	Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	E	
			N	

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Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATION Verbal Non-verbal Sigh language Others:		Patient will community with positive feedbac		☐ Introduce the care giver☐ Encourage the use of call bell☐ Obtain interpreter if needed		M p+ will	communicate effectively	8 cm
			No negative speaking about the patient's or prognosis in the patient's presence		s condition	1	l commeni	Jan
						N Dt we COMM	unidron	80/8
SPECIAL INTERVENTIONS Medication Wound care Isolation Ostomy Care Blood Poducts transfusion Fluid tapping DVT Management Others:			☐ Double check for high alert medication☐ Observe and report any medication reac☐ Provide proper measures of wound care☐ Follow hospital polices and protocols of		M pt Mueel	g cition gro	Do	
				and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing to		E Pl Mo given as	dication.	Dar
				blood products and fluids Monitor DVT score and continue treatm as per doctors order		N ore	alions gwan	dy od:
	Signature	j.	Name		Emp. ID		Date	Time
Endorsed by		Nac		s-Nalini	0021	+	16/12/193	13:0





ADULT NURSING CARE PLAN

Mis.Shanmugapriya s

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ





<u> </u>					
Initial Date: ノチルス	23 Time: 7.06	Modified Date: Time:			
Reason for Modification:		Diagnosis: CAP - 7VP			
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	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	M pt D aliest	De-	
	activity level and metabolic needs		N		
OXYGENATION OXYGENATION Nasal Cannula / High Flow O2 Nasal Cannula / High Flow O2 OXYGENATION	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 	M pt reom ais	Da	
☐ Tracheostomy ☐ Others:			E		
			N		
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 pt cleetingtes.	26	
☐ 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		
			N		

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 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 flooiliseiteon Film	802
- -	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	
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 pr elirentur,	De
Others:	and regular elimination patterns	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	
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 pa blein Lein	Don
INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased	Maintain adequate nutrition and hydration DE 2 DE 4 DE 4 DE 6 DE 9 DE 9 DE 9 DE 9 DE 9 DE 9 DE 9 DE 9	E		
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N	

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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE Bed-Bath Assist-Bath	☐ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene	Myp+ Self-Clene	Does
Self-Care CBD Care (if present) Others:	changes to meet self-care needs Patient will recognize individual weakness or needs	☐ Consider the patient's need for assistive devices☐ Apply moisturizing solution	E	
			N	
SAFETY Check ID Hand IV care EJV	Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails	M P+ Il D Beerd	Soy
CENTRAL LINE 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	
		,	N	
COMFORT AND SLEEP Pain Control Sleep Patterns	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and	Provide clean calm and restful environment Provide privady at all time Monitor pain scale / sleep pattern	M p4 confortable	Dan
Others:	adequate sleep	Provide pharmacological and non-pharmacological therapy	E	
·		n ! ;	N I	
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar	Patient will have normal range of vital parameters		M p.1 videl sing	Son
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 Evaluate spiritual needs	M	
☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	psychological pattern	Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	E	
			N	

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Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICAT Verbal Non-verbal	ION	Patient will communic with positive feedback	ate effectively	☐ Introduce the care giver☐ Encourage the use of call bell☐ Obtain interpreter if needed		m p+ ne	embstw	82
	☐ Sigh language			☐ No negative speaking about the patient's condition				
SPECIAL INTERVENTIONS Medication Wound care Isolation Ostomy Care Blood / Blood products transfusion Fluid tapping DVT Management			□ Double check for high alert medication □ Observe and report any medication reaction □ Provide proper measures of wound care □ Follow hospital polices and protocols of isolation		M pt most as per	icition givens	801	
				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		E		
Others:	on.			Monitor DVT score and continue treatment as per doctors order	nt	N	ļ	
	Signature	_	Name		Emp. ID		Date	Time
Endorsed by		Nua	Q-N	ralini 000		†	17/12/27	18:00
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Mr. SHANMUCAPRIYA S

45/; emale/MF;202381078 11/13/2023/;2H202302475

Dr.AN BARASU MOHANRAJ





Date: 1 12 BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK 11100 1 Time: SENSORY 1. Completely Limited 2. Very Limited 3. Slightly Limited 4. No impairment PERCEPTION Besponds to verbal Unresponsive (does not moan, flinch,or Responds only to painful stimuli. Cannot Responds to verbal commands, but grasp) to painful stimuli, due to diminished commands. Has no sensory ability to respond communicate discomfort except by cannot always communicate discomfort level of consciousness or sedation OR meaning-fully to 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 ability to feel or voice pain or sensory impairment which limits ability to discomfort to feel pain or discomfort over 1/2 of body feel pain or discomfort in 1 or 2 extremities discomfort 4: Rarely Moist 1. Constantly Moist 3. Occasionally Moist 2. Very Moist MOISTURE Skin is kept moist almost constantly by Skin is often, but not always moist, Linen Skin is occasionally moist, requiring an 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 skin is exposed detected every time patient is moved or intervals to moisture turned 1. Bedfast 4. Walks Frequently 2. Chairfast 3. Walks Occasionally Confined to bed **ACTIVITY** Ability to walk severely limited or non-Walks occasionally during day, but for very Walks outside room at least degree 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 4. No Limitation 3. Slight Limited 1. Completely immobile 2. Very Limited MOBILITY Makes major and frequent Does not make even slight changes in body Makes occasional slight changes in body Makes frequent through slight changes in 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 4 frequent or significant changes assistance position independently 4. Excellent 2. Probably Inadequate 3. Adequate 1. Very Poor Never eats a complete meal. Rarely eats Rarely eats a complete meal and generally Eats over half of most meals. Eats a total of Eats most of every meal. eats only about 2 of any food offered. more than any food offered. Eats 2 servings Never refuses a meal. 4 servings of protein (meat, diary NUTRITION 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 supplement TPN regimen which probably meets most eats between meals. Does of nutritional needs than 5 days not require supplementation 3. No Apparent Problem 1. Problem 2. Potential Problem Requires moderate to maximum assistance Moves feebly or requires minimum Moves in bed and in chair independently and has sufficient muscle 3 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** against sheets is impossible. Frequently slides to some extent against sheets, or chair & SHEAR slides down in bed or chair, requiring chair, restraints or other devices. 23 **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 ass 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:





/ Mrs.SHANMUGAPRIYA S

5/Female/MHi202381078
 1/12/2023/iPH20230247°

D :ANBARASU MOHANCAJ





(A Unit of United Al	liance Healthcare Pvt Ltd)		Tata n thirtee file beint tretter, auditamitation	_ Every ne	$\overline{}$		
	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Date:	 '\	12 €	23
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	1		
MOISTURE degree to which skin is exposed to maisture	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	Ŋ		
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	2. 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	9		
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			
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	3		
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring	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.	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3		
- William	frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	Maintains relatively good position in chair or bed most of the time but occasionally slides down	·	Initial & Emp. No. of Staff Nurse:	20 Hay	-	
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; F	digh Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	الاصح	_	





Mrs.SHANMUGAPRIYA S

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ





Date: 12 12 2312 12 BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK 1200 100 I라니 2. Very Limited SENSORY 1. Completely Limited 3. Slightly Limited 4. No Impairment -8200 PERCEPTION Unresponsive (does not moan, flinch.or Responds only to painful stimuli. Cannot Responds to verbal commands, but Responds to verbal ability to respond grasp) to painful stimuli, due to diminished communicate discomfort except by cannot always communicate discomfort commands. Has no sensory level of consciousness or sedation OR moaning or restlessness OR has a deficit which would limit meaning-fully to or the need to be turned OR had some sensory impairment which limits ability to ability to feel or voice pain or pressure-related limited ability to feel pain over most of body sensory impairment which limits the ability discomfort to feel pain or discomfort over 1/2 of body feel pain or discomfort in 1 or 2 extremities discomfort 2. Very Moist 3. Occasionally Moist 4. Rarely Moist MOISTURE Skin is kept moist almost constantly by Skin is often, but not always moist, Linen Skin is occasionally moist, requiring an 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 skin is exposed detected every time patient is moved or intervals to moisture 2 turned 1. Bedfast 3. Walks Occasionally 4. Walks Frequently 2. Chairfast Confined to bed **ACTIVITY** Ability to walk severely limited or non-Walks occasionally during day, but for very Walks outside room at least degree 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 1. Completely Immobile 2. Very Limited 3. Slight Limited 4. No Limitation MOBILITY Does not make even slight changes in body Wakes occasional slight changes in body Makes frequent through slight changes in 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 1. Very Poor 2. Probably Inadequate 3. Adequate 4. Excellent Rarely eats a complete meal and generally Eats most of every meal. Never eats a complete meal. Rarely eats Eats over half of most meals. Eats a total of 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 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 more servings of meat and a meal, but will usually take a supplement day. Takes fluids poorly. Does not take a meat or diary products per day. 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 supplement TPN regimen which probably meets most eats between meals. Does than 5 days of nutritional needs not require supplementation 2. Potential Problem 1. Problem 3. No Apparent Problem Bequires moderate to maximum assistance Moves feebly or requires minimum Moves in bed and in chair independently and has sufficient muscle 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** against sheets is impossible. Frequently slides to some extent against sheets, orchair & SHEAR slides down in bed or chair, requiring chair, restraints or other devices. TOTAL SCORE Ъ 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:





Mrs.SHANMUGAPRIYA S

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ





Date: 12/12 7 02 141 BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK Time: 1 00 111/10 SENSORY 1. Completely Limited 2. Very Limited 3. Slightly Limited 4. No Impairment PERCEPTION Unresponsive (does not moan, flinch,or Responds only to painful stimuli, Cannot Responds to verbal commands, but Responds to verbal grasp) to painful stimuli, due to diminished communicate discomfort except by cannot always communicate discomfort commands. Has no sensory ability to respond level of consciousness or sedation OR or the need to be turned OR had some deficit which would limit 2 moaning or restlessness OR has a meaning-fully to 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 pressure-related to feel pain or discomfort over 1/2 of body feel pain or discomfort in 1 or 2 extremities discomfort discomfort 1. Constantly Moist 2 Very Moist 3. Occasionally Moist 4. Rarely Moist MOISTURE Skin is kept moist almost constantly by Skin is often, but not always moist. Linen Skin is occasionally moist, requiring an Skin is usually dry, linen only degree to which must be changed at least once a shift extra linen change approximately once a requires changing at routine perspiration, urine etc. Dampness is 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** Ability to walk severely limited or non-Walks occasionally during day, but for very Walks outside room at least 9/ degree 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 1. Completely Immobile 2-Very Limited 3. Slight Limited 4. No Limitation MOBILITY Does not make even slight changes in body Makes occasional slight changes in body Makes frequent through slight changes in 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 1. Very Poor 2. Probably Inadequate 3. Adequate 4. Excellent Never eats a complete meal. Rarely eats -Marely eats a complete meal and generally Eats over half of most meals. Eats a total of Eats most of every meal. more than any food offered. Eats 2 servings eats only about 2 of any food offered. Never refuses a meal. 4 servings of protein (meat, diary NUTRITION 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 when offered OR Is on a tube feeding or liquid dietary supplement OR Is NPO and / or Occasionally will take a dietary diary products. Occasionally maintained on clear liquids or IV's for more supplement TPN regimen which probably meets most eats between meals. Does of nutritional needs than 5 days not require supplementation 2. Potential Problem 3. No Apparent Problem 1. Problem Moves feebly or requires minimum Moves in bed and in chair independently and has sufficient muscle Requires moderate to maximum assistance 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** against sheets is impossible. Frequently slides to some extent against sheets, or chair & SHEAR slides down in bed or chair, requiring chair, restraints or other devices. 12 **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:





Mrs.SHAMMUGAPRIYA S
45/Fcmalc/MHI202381078
11/12/2023/IPH202302475
Dr.ANBARASU MOHANRAJ



	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Date:	世	12- N	τ.			
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 Hesponds 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. Octasionally 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	3				
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	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		3				
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		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	meat or diary products per day. Occasionally will take a dietary	A.Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	3	3/				
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	assistance. During a move skin probably	3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. No or chair	y and has sufficient muscle flaintains good position in bed TOTAL SCORE Initial & Emp. No. of Staff Nurse:	3 19	3 19				
Score	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 Sr. Staff Nurse:									





Patie Mrs.SHANMUGAPRIYA S

Name 45/Fernale/MH1202381078

UHID 11/12/2023/IPH202302475

DOB: Dr.Anbarasu mohanraj



	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RIS	Date:	<u> </u>	12 E	72
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	deficit v	pairment nds to verbal nds. Has no sensory which would limit feel or voice pain or ort		4	2,
MOISTURE degree to which skin is exposed to moisture	1.Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals		4	4	14
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 ou twice a d at least o	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	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	1-1
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FRICTION	1.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. No Apparent Problem Moves in bed and in chair independently and has sufficient musc strength to lift up completely during move. Maintains good position in be or chair			3	_3	3
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or	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	23	23	
	agitation leads to almost constant friction	slides down			Initial & Emp. No. of Staff Nurse:	Bed	HA.	8) 01
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 Sr. Staff Nurse:								





Patient Details (Affix Label hera)
Name: MRS SHAN AMUG APRIYA
UHID: 20938 | CA 8
DOB: - | Sex: F

DOB: -- /

DOA: 11 12/23
Consultant: DR-BN/BARAS



Pate: 16 12 23

	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RIS	Date:	16 M		23 <u>~</u>	
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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 o twice a c at least o	s Frequently utside room at least ay and inside room once every two hours vaking hours	И	4	4	
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	assistance. Spasticity, contractures or agitation leads to almost constant friction	slides down	·		Initial & Emp. No. of Staff Nurse:	87	3	d ce	
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Patient Details (Affix I ahel here)

Nan Mrs.SHANMUGAPRIYA S

UHII 45/Fernalc/MHI202381078

DOB 11/12/2023/IPH202302475

DOA Dr.ANBARASU MOHANRAJ





	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISI	Date:	74 14	12 23 6 M		
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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,	or chair TOTAL SCORE Initial & Emp. No.			3			
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair			TOTAL SCORE	ವು			
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down			nitial & Emp. No. of Staff Nurse:	D.			
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 Sr. Staff Nurse:									





P-Mis.Shanmuga Priya s

45/Female/MH1202.181078 11/12/2023/IPH2023(2475

Dr.ANBARASU MOHANI AJ

MHI/NUR/2022/05



PAII	N RI	E-ASSE	SSMENT	& MC	NITORING	CHART	C TO NO ARITHM BOX DONI DIRECTOR LOT (1891) 125 (ÎARTH)	Every heart b	eat counts
Date & Time	Pain Score	Pain ((dull, achy, sharp burning, refe	Character o, stabbing, shooting, rred / radiant pain)	Duration	Location / Site	,	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
1/2fa	blio	No	bain	1	-		~	ما ال	1005
13:00		No	l Pain		-		-		(DO)
	1		Pain	_	-			Ander	(Dec)
य-०0 याच्छ	0/10	No	Pain	_	_	_		dif	(D) 000 ×
6.00	0/10	No	Pain	_		_		Diff88	CO S
[0:00	olo	No	pain)	. –	_		thy ows	Noo24
·									
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years) 9 10
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Mrs.Shanmugapriya s

45/Female/MHI202381078 11/12/2023/IPH202302475

Di.Anbarasu mohanraj

MHI/NUR/2022/052 Heart

Institute

Every heart beat counts

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.
12/12/22	0/8	CPOT ·		-	—	Noorg	Loo)
1900	0/8	By Cpos	<u> </u>	· —	-	Office of A	Wyood
\ 1-00	1/10	Dull pain	210-15 200	surgicol	nen-phormacowogical	gu 0270	Wave)
J 3-00	1/10	Dell pain	20C	Stornum	an pharmacological antonuention done	0270	lavos
13/12/03 01-00	1.	_	-		patient is slept well	0270	(000)
0.300		•		· 	pationt & clopt well	0270	Conos
05-00				p	pationt is capt wall	2/20.	Hows
07-00	Uw	Dull pain	210-15 StQC	eurghad.	uon plomacocogical entoniention done	0270.	25003
9:00	1110	Duu pain			Publicur is comportable	910	0003

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.	
Miteo	2/10		Lhy PAIN	-10/ec	Surgid	Mbr phernoyid Mongrut done	Lon	0,37	
1300	llo	DC	milian.	10800	Stelnum	Lon pharmaculogicalmanagemen	, man	Nov	
1500	110	AZI	ny pai.	Siec	Sternin	Non Phalmawlugical managenou	neorg	· 1.000	
D 6 ·	1/10.	のい	yair	>10s= .	Sternom	Non phaemaological mangement	mase ozak		
	· ·	-			P/	AIN SCALES			
(28 week	PIPPS s to <u><</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provi >12 = Moderate to sever	de comfort me		on .			
(38 we	CRIES eks - 2 mc	nths)				of gestation. A maximal score of 10 is possible. If the CRIES score is lesic administration is indicated for a score of 6 or higher.	> 4,		
	ACC Scal	_	0: Relaxed & comfortable	le, 1-3: Mild d	iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe discomfort / pain / both			
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)		ale	O 2 No Hurts Liktlo Bit	4 Hurts Little	ිලිල් 6 Hurts Even More	Numerical Rating Scale (age 8 10 Hurts Whole Lot Numerical Rating Scale (age 0 1 2 3 4 5 None Mild Moderate	6 7 8	years) 9 10	
Critical care Pain Observation Tool (CPOT) (ventilator / comatose) FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing BODY MOVEMENTS: 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation COMPLIANCE WITH VENTILATION (intubated patients): 0 - Tolerating Ventilator or Movement, 1 - Coughing but tolerating, 2 - Fighting ventilator (or) VOCALIZATION (non-intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing MUSCLE TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid									
TOTAL SCORE: 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain 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									





Pat Mrs.SHANMUGAPRIYA S

Nai 45/Female/MHI202381078

UH 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/052



PAII	N RE	E-ASSESSMENT	& MC	NITORING	CHART Cor MANUAL	/ Every heart I	beat counts
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.
13/00	1900	pull pain.	55ec	Back.	Confortable partir	14530 Jr. 20	Vavis
21,00	Yo	Dall Pain	10 Sec	840 sn um	provided confortable parition	Kor	V goos
2300					Patient - as sceping	Gros	over Land
01.00					posticifus sleeping	de la	Voas
03.00					Potient mas Sleeping	far	N DOWN
05. OC	Yio	Dull Pain	150ec	Sternum	Provided comfortale position	der.	Hos
of. oo	Yeo	Dull Pain	5 SEC	Sternum	patient got mobilized to che	v. of	A 2120)
09;00	1/10	Dul pain.	L8 Mes	Stemm	Non-phoumacolopical		0000)
1/1.00	1/10	oull pain	5-10 801		pharmalological Management	R	Nac

Date & Time	Pain Score	(dull, achy		racter bbing, shooting, radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
180	1/10	<u> </u>	<u>ust </u>	puin	10-5 <u>8</u> ec	Sternum		A.	024 Noan
22,00	1/10	D	ull_	pain	10 - Se	sternum	compositable position tother	011L	024
6.00	0/10	,	vo	pain	10-53E	et annum		AL OIL	Nua-
10.00	olio	_ h./e	n 10 a	Ú s	10.500	Hour	Compactable position to the	Boefozu	Nua
_	•	-	1			PA	IN SCALES		
(28 week	PIPPS s to <u><</u> 38	weeks)	7 - 12 =	= Minimal to no Mild pain - Provid loderate to sever	le comfort me	asures nocological intervention	n		
(38 we	CRIES eks - 2 mo	onths)					of gestation. A maximal score of 10 is possible. If the CRIES score is $>$ 4, esic administration is indicated for a score of 6 or higher.		
	ACC Scal		0: Relax	ed & comfortable	e, 1-3: Mild di	scomfort, 4-6: Mode	rate discomfort, 7-10: Severe discomfort / pain / both		
Pain	-Baker FA Rating So ars - 12 ye	cale	O No Hurt	©© 2 Hurts Little Bit	4 Hurts Little More	6 Huntan Even More V	Numerical Rating Scale (age model) 8 10 Hurts (hole Lot Worst Worst Worst Worst Worst Worst Worst Worst Worst None Mild Moderate	7 8	9 10
Observa	cal care P tion Tool tor / com	(CPOT) COMPLIANCE WITH VENTILATION (intubated patients): 0 - loterating ventilator or movement, 1 - Coughing but tolerating, 2 - Fighting ventilator (or)							
	narmacolo ervention		Cutaneo Thermal	us Stimulation a Therapies (no lo	nd massage: onger than 15	E - Positioning; F - Ri to 20 minutes): G - Co	 Music; D - Physical and mental exercisers Ibbing / Massage the skin Id application; H - Hot application; I - Shortwave diathermy erferntial therapy Psycho-social therapy/counsetling: K - Individual Counsetling: 	eling; L - Family	counseling
Pharmace	ological li	nterventior	s as per d	octor's prescrip	tion _				-





Patient Details (AGE)
Na Mrs.SHANMUGAPRIYA S

UH 45/Fernale/MH1202381078

DG| 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/952



Every heart beat counts

					_ _ _				
Date & Time	Pain Score	Pain Cha (dull, achy, sharp, sta burning, referred	abbing, shooting,	Duration	Location / Site	Interven	tions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
11/00	1/10	100111	puis	5dec	Burginal Sito	phurmulological	Langement Juio	<i>A</i>	Nac
18:00	1/10	D1111 }	puin	58ec-(Georgical Site	1 P&ychological Su	oport to the pt	D ₁	Nach
22-00	40	bull	pain	sse	owigi al	psychologica	I suppose to the	3	Naa 024
6 00	0110	NO 1	Dain		-			512°	Nac
10.0	ωlα	Nº po	uin	_	· .		<u> </u>	Soy	Nac
14.00	olio	Not	Pair	, <u> </u>		<u> </u>		Jen	Ne
16.00	o(10	No	Pair	_	<u></u>	<u> </u>		Jen on.	Nacas
20.00	olto	Mo	Pain	_)			Ay.	Naca Ozq
1410123 0,00	Ofio	No	Parin	_	_		-	25	Nove

Date & Time	Pain Score	(dull, achy,	sharp,	haracter , stabbing, shooting, ed / radiant pain)	Duration	Location / Site		Interventions	-	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.			
A-00	%	,\ 	0	Pain	_					000	Noot 02et			
820	olm		Ν£	bons	_	ħ .				&a	NO			
D.W.	Olo		No	poir			<u></u>	· · · · · · · · · · · · · · · · · · ·		Son	Nuger			
١٠	\							/ \						
					<u>, </u>	P	AIN SCALES	X	1	'	<u>' , , , , , , , , , , , , , , , , , , ,</u>			
(28 week	PIPPS (s to < 38	weeks)	7 - 1	less = Minimal to no 2 = Mild pain - Provi = Moderate to seve	de comfort me	easures nocological interventi	on				• 1			
	CRIES eks - 2 m	onths)					s of gestation. A maximal sco gesic administration is indicat			1	,			
	ACC Sca nths - 7 y		0: Re	elaxed & comfortabl	le, 1-3: Mild d	iscomfort, 4-6: Mode	erate discomfort, 7-10: Severe	discomfort / pain / both		,				
Pain	-Baker FA Rating Se ars - 12 ye	cale		O 2 No Little Bit	4 Hurts Little More	6 Hurts Evan More	8 10 Hurts Whole Lot Worst	Numerical Rating 0 1 2 3 None Mild	g Scale (age me	7 8	9 10			
Observa	cal care F ation Tool ator / com	(CPOT)	BOD COM VOC MUS	Y MOVEMENTS: 0 - IPLIANCE WITH VE ALIZATION (non-Int ICLE TENSION: 0 - 1	Absence of m NTILATION (i tubated paties Relaxed, 1 - Te	ntubated patients): (position, 1 - Protection, 2 - Resi) - Tolerating Ventilator or Move Irmal tone or no sound, 1 - Sigh Prise, Rigid	ment , 1 - Coughing but tole		entilator (or)	-			
Įni —	harmacolo tervention	is	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 s as per doctor's prescription											

`\



Mrs.SHANMUGAPRIYA S
45/Female/MHI202381078
11/12/2023/IPH202302475
Dr.ANBARASU MOHANRAJ



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

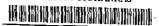
7,00		· · · · · · ·					1	
	Date	11 12 /2	12122	•				
	Time		93 00					
S. No.	PARAMETERS							-
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0					
2	Bedridden recently >3 days or major surgery within four weeks	0	O					
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	O	0					
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0					
5	Entire leg swollen (Assess for both legs)	0	0		•			
6	Localized tenderness along the deep venous system (Assess for both legs)	Ð	0					
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0					
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0					
9	Previously documented DVT (Assess for both legs)	ව	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	0					
	FINAL SCORE	0	0					
Low R	lisk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	Loes	LOW					
	DVT prophylaxis started	☐ Yes ☐ No	☐ Yes ☐ Mo	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
_	Signature & Emp. No. of RN		ALTO					
	Signature & Emp. No. of Sr. RN	(DP/	(D)					
	(000	- NOO.			_	_	



Mis.Shanmugapriya s

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ





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	12 12 2	13/2/3	14/17	12/2	316/12/2	17/12/23	
	Time		06.00	,	6,00		.6.00	_
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	O	0	0	φ	0	٥	i
2	Bedridden recently >3 days or major surgery within four weeks	41	+1	+1	41	4)	+1	
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0	۵	۵	O	
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	ව	0	0	0	0	
5	Entire leg swollen (Assess for both legs)	0	_0	Ø	b	מ	0	
6	Localized tenderness along the deep venous system (Assess for both legs)	0	9	0	0	D	0	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	o	0	0	D	Ø	0	
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	P	ь	0	D	
9	Previously documented DVT (Assess for both legs)	0	_ ව	Q	Q	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.	O	9	P	0	Ø	D	
	FINAL SCORE	41	+1	+1	41	A-1	<i>T1</i>	
Low R	lisk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	Mad.	MOT	moi)	MOD	MOD	MOD	
	DVT prophylaxis started	√ Yes □ No	Q Yes □ No	-□ Yes □ No	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
	Signature & Emp. No. of RN	ALOO PA	\$570	der	A SO	\$10	50%	
	Signature & Emp. No. of Sr. RN	2	R	N	4	Nec	100	
		كفور	722	<i>م</i>	1			



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Mrs.SHANMUGAPRIYA S 45/Fcmalc/MHI202381078 11/12/2023/IPH202302475

DT.ANBARASU MOHANRAJ





MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	11/12/2	71/12	12/18/2	,					_
variables	Time	111/00	22.00		_					
History of falling	No	0	70	9	0	0	0	0	0	0
(immediate or within 6 months)	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis	No	0	0	0	0	0	0	0	0	0
(≥ 2 medical diagnosis)	Yes	.15	115	\15	15	15	15	15	15	15
Intravenous Therapy /	No	_0_	10	00/	0	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	20	20	120	20	20	20	20	20	20
AMBULATORY AID			7 _							
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		9	, o	0	0	0	0	0	0	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		8	7 0	\0	0	0	o	0	0	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,	Yes	15	15⁄	\15	15	15	15	15	15	15
anti-hypertensives, hypoglycemics and psychotropics								!		
Total Score		30	رم ص	50						
Low Risk (0 - 24)					•					
Medium Risk (25 - 44)			<u></u>							
High Risk (45 or above)		•								
Signature & Emp. No. of RN	(1	State	Hart					-	
Signature & Emp. No. of Sr. RN		Q.L.	6 %	المحقوا						
		- 60 - :	24: Low	Risk, 25	5 - 44: N	ledium	Risk; 45	or abo	ve: High	Risk

	T	1 1			_	ı	1	T	1	
INTERVENTIONS	Date	1/12/	11/12	12/12/) }			1	-	, ,
Tick as per the Risk Score	Time	77.7			ļ —			<u> </u>		
·	Time	111.00	2200	8:00						
Low Risk Interventions (0 - 24)		. /		. /					1	
Familiarize the patient with the immediate surround			~			<u> </u>		ļ	<u> </u>	
Remind the patient to use call bell before getting or			~		<u> </u>	ļ		ļ.	<u> </u>	
Keep the two side rails in the raised position at all	times for	l ,							1	
all patients regardless of age					ļ	ļ		ļ	<u> </u>	ļļ
Keep the call bell, bedside table, water, glasses w	itnin the	 					1	1		
patient's easy reach Remove excess equipment or furniture to make	. n oloar	⊢ <u> </u>			 	 	 	 	 	
path	a Clear	<i>\</i>							i	
Keep the patient's bed in the low position at all time	s excent	 -		<u> </u>	ļ <u> </u>	 -	-	 	 	
during procedure	o croop:		レレ				!	ļ		
Teach fall-prevention techniques, such as sitting	up for a				 	1			 	
moment before rising from the bed			~						ì	
Bed wheels should be locked			<i></i>						1	
Encourage family participation in the patient's care			V					1)	
Ensure that floor of the bathroom is dry and not slip	pery								1	
Review medications for potential side effects to	that can								1	
promote falls								1	1	
Use safety belts during movement in wheelchair			~					1		
The patients are not ambulated by themselves. Th	ey are to		_							
be ambulated only with assistance				/		-	·	ļ	1	
Medium risk interventions (25 - 44)						 	-	1	 	\vdash
Apply all the low risk interventions										
Tie yellow fall risk tag in the bed and Wheel chair / S										
Make sure that proper transfer precautions are in		زا		_			· ·]		
for heavy or debilitated patients in a bed or wheel	chair or						-]	1	
on a toilet seat			,		ļ	ļ		<u> </u>	↓	igwdown
Use restraints and bed monitors as ordered by the	doctor			1/		ļ			ļ	
Allow the patient to ambulate only with assistance						ļ		 	ļ	
Consider peak effects of the medications that effe			_	•					1	
of consciousness, gait and elimination when	olanning	V								
patient's care		 				-			· ·	
Do not leave patients unattended in diagno	ostic or	-		-						
treatment areas Accompany the patient while going to bathroom		 				-		-	 	
Advice the patient to use grab bars near the toilet,	hathtub	<u> </u>	-		ļ	 		 	 	
and shower	Dallilu D ,				[١,
Make sure the family and other visitors underst	tand the	-							1	
restrictions mentioned above	and ino									
High-risk interventions (45 or above)			_			ļ				
Apply all the low and medium risk interventions	_	1		1/	<u> </u>				<i>5</i>	1
Tie red fall risk tag in the bed, wheel chair and streto	cher	1	_			1	-		1	
Locate the high-risk patients in a room close to the		<u> </u>			ļ	· · ·			1	
station					1					1
Answer these patients call bells as quickly as possi	ble									
Provide a commode at bedside (if appropriate)		<u> </u>								
Urinal/bedpan should be within easy reach (if appr	opriate)									
Encourage family members or other visitors to s	stay with									
them					ļ. <u></u>	<u> </u>	<u> </u>		<u> </u>	 _
If appropriate, consider using protection devices	s: safety		.					1		
belts				. \.	ļ	<u> </u>	<u> </u>	1	<u> </u>	igsquare
Signature & Emp. No.	of RN	[Xh	ALL	15	-	1		1	1	
Signature & Emp. No. of	Sr. RN	(PO)	CO 18	.0/		†				
Cignature & Emp. 110. 01				W. Sec		l	1	I	ــــــــــــــــــــــــــــــــــــــ	
		€		γ,	•					



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Mrs.Shanmugapriya S

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ





MHI/NUR/2022/046

MODIFIED MORSE FALL RISK ASSESSMENT CHART

				_			,			
Variables	Date	12/12/23		13/12/21	12/12	13/142	- 9/	14/12/2	314/12/2	15/12
	Time	17.00	20-00	24,00	1200	21.00	ONITO	171.00	20.00	8-01
History of falling	No	0	0	مو	®	0	<u>(6)</u>	9	0_	صمر
(immediate or within 6 months)	Yes	25	25	25	25	25 /	25	25	25	25
Secondary diagnosis	No	0	0	0	0	0	0	0	0	0
(≥ 2 medical diagnosis)	Yes	15	(15)	15	<u>(15)</u>	15	(15)	15	18	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	30
AMBULATORY AID							\sim			_
None / Bed Rest / Nurse Assist		10	(0)	•	(9)	0	(<u>6</u>)	9	20	مور
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT			0				(5)	_ /		
Normal / Bed Rest / Wheel Chair		VO	<u>(0)</u>	40	6	0	(6)	0/	78	σ
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)	8	0	0
Overestimated or forgets limitations		15	(15)	45	(15p)	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics,			•		_					_
laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants,	No	0	0	0	0	0	0	0	0	0
anti-hypertensives, hypoglycemics and psychotropics	Yes	15	15)	18	15)	15	(15)	187	15	15
Total Score		65	65	6K	50	50	50	50	80	50
Low Risk (0 - 24)										
Medium Risk (25 - 44)	,	 .	_			<u> </u>				
High Risk (45 or above)					/	1	/	-	~	17
Signature & Emp. No. of RN	(Sail Sa	***·	door	1286 1860	2/8/	4	解	ALL	Jeef
Signature & Emp. No. of Sr. RN		1/	1	A	1	1	D,	عند ا	130	معدم
		80G	24°Low	Risk; 2	5 - 44:71	/ledfum	Risk; 45	or abo	ve: High	Risk

						۲. ت	_	•		
INTERVENTIONS	Date	12/1/23	alela	12/012	13/12/2	و اما و	14/12	11/10		
Tick as per the Risk Score	Time	17.00	20-60	-	220	2 (02)	07!00	11.0		
		14160	0000	D.*		21-00	- 0 0.5	171.0	(<i>X</i>) <i>O</i> /	&
Low Risk Interventions (0 - 24)			ļ	ļ	_]	}	j
Familiarize the patient with the immediate surround		\ <u>'</u>		ļ			<u> </u>			
Remind the patient to use call bell before getting ou						,				
Keep the two side rails in the raised position at all t	imes for	/			/			'		
all patients regardless of age		<u> </u>								<u> </u>
Keep the call bell, bedside table, water, glasses w	ithin the	./		ļ						
patient's easy reach										
Remove excess equipment or furniture to make	a clear	/								
path		<u> </u>		<u> </u>						
Keep the patient's bed in the low position at all time	s 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										ĺ
Ensure that floor of the bathroom is dry and not slip	pery	/		1		~	-			
Review medications for potential side effects t	hat can				_					
promote falls		/								
Use safety belts during movement in wheelchair		/								
The patients are not ambulated by themselves. The	ev are to	<u> </u>								
be ambulated only with assistance		/			/	1				
Medium risk interventions (25 - 44)		<u> </u>		<u> </u>						
Apply all the low risk interventions					/					
Tie yellow fall risk tag in the bed and Wheel chair / S	tretcher		<u> </u>	<u> </u>						
Make sure that proper transfer precautions are in		-		 -		<u> </u>	 			
for heavy or debilitated patients in a bed or wheel				1						ĺ
on a toilet seat	Chair Oi	_		1	•	-				ĺ
Use restraints and bed monitors as ordered by the	doctor	 	ļ-		-					
	doctor	 								
Allow the patient to ambulate only with assistance	eta laval	//-	<u> </u> 					l I	 	
Consider peak effects of the medications that effe										ĺ
of consciousness, gait and elimination when p	Janning	/		ĺ	[]				[
patient's care		 		 		<u> </u>				
Do not leave patients unattended in diagno	ostic or	/								
treatment areas		-		 			-			-
Accompany the patient while going to bathroom				<u> </u>						
Advice the patient to use grab bars near the toilet,	bathtub,	/		}						ĺ
and shower		<u> </u>		<u> </u>						<u> </u>
Make sure the family and other visitors underst	tand the			ļ .	_	ا ـ ا				1
restrictions mentioned above]		Ì						
High-risk interventions (45 or abovc)		-								
Apply all the low and medium risk interventions		/_	<u> </u>				<u></u>			1
Tie red fall risk tag in the bed, wheel chair and stretc	her	/	<u> </u>						<u> </u>	
Locate the high-risk patients in a room close to the	nurses'	/		_			/	ተ 、	h.,_	
station	•	1								
Answer these patients call bells as quickly as possi	ble		~		-		W		~	
Provide a commode at bedside (if appropriate)		NP	an	NA	N K	NA	NA			
Urinal/bedpan should be within easy reach (if appro	opriate)	ND	NT)	NP.	4 m	~~	AV.	1	<u> </u>	
Encourage family members or other visitors to s	tay with					NA		. /		
them		NA	· hy	no	W Kr	1UP	NA			
If appropriate, consider using protection devices	s: safety	/					J		<u> </u>	_
belts		<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	_A+_	Ā	20-	
Signature & Emp. No.	of RN	Darla	Show of the same o	800	Jan C	23	W.C.		1	1 de
Signature & Emp. No. of	Sr. RN		<i>"/</i>	1	101	A		9/1	10	3.90
	-	VI	- 4//		/ ~	/ /\	<u> </u>	17.45	- V//	WY C
		つつフ	0 7,25	2N2>	27	رور	روس		7	•
		ס אבי	∂'	٠	0'	0	J			
		•								



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... Mis.Shanmugapriya s

Pati 45/Female/MHI202381078 Nan 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ



MODIFIED MORSE FALL RISK ASSESSMENT CHART

UHII

DOB

Variables	Date	15/12/	215/12	rolon	16/12/23	•	14/0			
	Time	11100	20.00	8.00	JA. 00	22 ∞€	80			
History of falling	No	0	~ه	_ و	-0	٥	-0	0	0	0
(immediate or within 6 months)	Yes	25	25	25	25	25	25_	25	25	25
Secondary diagnosis	No	0	0	0	0	0	0	0	0	0
(≥ 2 medical diagnosis)	Yes	15	7 15	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							1			
None / Bed Rest / Nurse Assist		0	9	0	_0_	6	0	0	0	0
Crutches / Cane / Walker		15	15	1 5	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT						-				
Normal / Bed Rest / Wheel Chair		0	10	.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_	10	-8	ے۔	رق	_8_	0	0	0
Overestimated or forgets limitations	- -	15	1 5	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	15	,15	15	15	15	15	15	15
Total Score		50	50	50	50	20	50			
Low Risk (0 - 24)			-							
Medium Risk (25 - 44)							_	-		
High Risk (45 or above)		1	7/	<u></u>	/		~			
Signature & Emp. No. of RN	-	P31-	ON THE	&a	\$	300	D8~	/		
Signature & Emp. No. of Sr. RN		عذوا	1984	رعوا	سقعا	Real	Page	_		
· · · · · · · · · · · · · · · · · · ·		0 -	ـــــــــــــــــــــــــــــــــــــ	Risk; 2	5 44 1	ledium	Risk; 45	or abo	ve: Hiat	ı Risk

INTERVENTIONS	Date	15/12	25/2/22	علعاما	क्राक	16/202	8h			= (
Tick as per the Risk Score	Time	171.0	20.00	80	14.00	22.00	&		_	
Low Risk Interventions (0 - 24)		VCI I				-			-	
Familiarize the patient with the immediate surround	linas			W		~			Ì	
Remind the patient to use call bell before getting ou		<u> </u>				~			1	
Keep the two side rails in the raised position at all t		- ` -				•	<u> </u>		<u> </u>	-
all patients regardless of age			h /			/		_		
Keep the call bell, bedside table, water, glasses w	ithin the	Ť	, /						 	
patient's easy reach										
Remove excess equipment or furniture to make	a clear		2 /						<u> </u>	
path .			_			/	,			
Keep the patient's bed in the low position at all time	s except		-				1			
during procedure							[ļ,		
Teach fall-prevention techniques, such as sitting	up for a		7 .			V				
moment before rising from the bed		·/				1				
Bed wheels should be locked			\ \		_	V				
Encourage family participation in the patient's care			\		\	/			<u> </u>	
Ensure that floor of the bathroom is dry and not slip					\	V			,	
Review medications for potential side effects t	hat can			/ '	_		/			
promote falls						<u>, , , , , , , , , , , , , , , , , , , </u>				
Use safety belts during movement in wheelchair	_		<u> </u>			~				
The patients are not ambulated by themselves. The	ey are to		_	^						
be ambulated only with assistance							"			
Medium risk interventions (25 - 44)			-	/			/			
Apply all the low risk interventions		<u></u>				<u> </u>				
Tie yellow fall risk tag in the bed and Wheel chair / S				/ ,		~			<u> </u>	
Make sure that proper transfer precautions are in					_		, ,			
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	uocior			\leftarrow					 	
Allow the patient to ambulate only with assistance Consider peak effects of the medications that effe	ote lovel						\mathcal{V}		 	ļ
of consciousness, gait and elimination when p			_ /				{			
patient's care	Jannag									
Do not leave patients unattended in diagno	ostic or								 	 -
treatment areas		\bigvee				V	1			
Accompany the patient while going to bathroom						\$			Ì	
Advice the patient to use grab bars near the toilet,	bathtub.					-				<u> </u>
and shower	,					~	′			
Make sure the family and other visitors underst	and the		_			~	11			i
restrictions mentioned above			~				//			
High-risk interventions (45 or abovc)		-			*		,			
Apply all the low and medium risk interventions										
Tie red fall risk tag in the bed, wheel chair and stretc	her					NA				
Locate the high-risk patients in a room close to the	nurses'				/	No	1/			
station		<u> </u>	/				/			ļ
Answer these patients call bells as quickly as possi	ble					MA				
Provide a commode at bedside (if appropriate)			<u> </u>			V			<u></u>	
Urinal/bedpan should be within easy reach (if appro						~			-	ļ
Encourage family members or other visitors to s	tay with			/			/			<u> </u>
If appropriets, consider using protection devices	31 00fc+:					 	1		 	
If appropriate, consider using protection devices belts	s. satety			· \		<u>ر</u>	′	<i>\</i>		
Signature & Emp. No.	of RN	S	DAY V	Dan	WOST.	Asit	94			
Signature & Emp. No. of	Sr. RN	0	1950	رمور	سوق	000	سفق			1
		 	- }-,+	بالمستورث		- 2	024			<u> </u>



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Mis.Shan. Ugapriya S 45/Female/Mr '202381078 11/12/2023/IPh 02302475

Dr.ANBARASU MOL ANRAJ



Assessment To be f	AND FA									UK	ט		
Barriers to	Learning	1	-						Plan t	o A	ddr	ess	s Factors
None	☐ Visio	n / He	arin	g lin	nitations	<u> </u>		E] Use	of la	nterp	rete	er .
Limited Reading Abilities	☐ Phys	cal b	arrie	rs					Edu	cate	fam	ily	
Religious / Cultural Factors	Lang	uage	barri	iers					Sim	ple L	.ang	uag	e
Congnitive Limitations - unable to	Low	notiv	atior	1 / de	esire to	learı	า		Writ	ten l	Instu	ıctio	ns
understand and follow directions									_p				
Completed By : Date 1 2 2 Tim	1e 2 ·	כ ⊃		lurs	e Signa	ture	·:	1	<u>\$</u>				
Learning Record													
													Signature
	11/12	L	Р	0		L	Р	0		L	Р	О	KONG
Disease	1, 1,12	十					_	П				Γ	Doctor
Information on		\top											^ ^
Disease / Diagnostics	-	b	DD D	$\lfloor \rfloor$				ļ					K D ONE
Freatment		1								\Box			
Medications			or		,								Doctor / Nurse
☐ Information on Safe and		19											
Effective use of medicines			ÞΏ	$ _{V} $		ŀ							
☐ Information on drug / drug and		N											
drug / food interactions	- 1	A	OD	V									
☐ Discharge Medications		V											
Surgical Instructions													Nurse
Pre - Operative Instructions		þ	ά¢	Ý								-	- Sir
Post - Operative Instructions		ľ							_				
(Wound / Dressing Care)	Ī												
Pain Management													Nurse
Reporting of pain													
Pain Management													
Safe and effective use of medical		Τ											Doctor / Nurse
Equipment (if required)													
Name of Equipment													mb)
Rehabilitation Techniques		1											PM MA

Need	Date	`	/isit	1	Date	\	/isit	2	Date	\	/isit	3	Signature,
		L	Р	0		L	Р	0		L	Р	0	•
Nutritional Guidance												Ma	Dietician
Diet Instruction for patients at Nutritional risk		h	à	ی		r	as as	נ	_		ļ	S	nior Sin
☐ Diet advice for home		ļ		E				Ŀ					Nurse
Discharge Planning													
Self care													
Follow up				Ш				Щ				Ш	
Reporting Concerns Immunizations													
☐ Parenting education													
Others													
Risk Factor Reduction					_								
☐ Smoking Cessation										•			Doctor
☐ Weight Control													
☐ Exercise													
☐ Hypertension													
Other Risks													
LEARNER (L) - P-Fatient, M - Mother,	F-Fathe	r, S	-Sp	ous	e Othe	r	_				(Staf	e Relationship
PROCESS (P)- OD Oral Discussion, I	D- Dem	ons	trati	on,	W- Wri	itter	ı Ma	iteri	ial				
				_									
OUTCOME (O) - RD - Return Demonst	ialion,	V - '	verb	Janz	eu yn	1612	lam	umę	4				
Written Material given and explained (if any)												
					_		_			-			
	_			متعب									
					•								
Reports Given :													
Reports Given .													
Given Pending	g M	A							Give	n	Per	ndir	ng NA
Discharge Summary /			[Diet	Advice					, 			
ECG Report		_	_ (CT S	Scan Re	port	t				-		
Doppler Report			_ (CT S	Scan Fil	m		_					
X-Ray Report			F	ECH	O Repo	rt				1			
X-Ray Film					asound		ort	•		_			
Compact Disk					Other F			•					
				3113		· · · ·							
	· 1_0	سابد	4/~	~*						ß	-X	4	-1
Name of Attendant / Patient :			-				Sig	nat	ure :				
Name of Discharge Nurse (1)	Nal						Sig	natı	ıre: ,	, (ريدل		
- 5	n ac	~TV	•				-		,	No.	921	4	
										-	•		







Mis.Shanmugapriya s

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.Anbarasu mohanraj





PATIENT AND FAMILY EDUCATION RECORD

Assessment To be filled by concerned disciplines. Use key below														
Barriers to	Le	arning								Pian t	o A	ddr	ess	Factors
None		Vision	/ He	aring	g lin	nitations	;			Use	of lı	nterp	rete	r
Limited Reading Abilities		Physic	al b	arrie	rs					Edu	cate	fam	ily	
Religious / Cultural Factors		Langu	age	barri	ers	_				Sim	pie L	ang	uag	е
Congnitive Limitations - unable to		Low m	otiv	ation	/ d	esire to	lear	1		Writ	ten	nstu	ctio	ns
understand and follow directions				,						-				
Completed By : Date 19 12 23 Tin	ne	8 20	0	N	lurs	e Signa	ture	:_	R	N OBL	KY C	201 4		
				_						,				
earning Record														
Need		Date	3 \	/isit	1	Date	Ľ	/isit	2	Date	<u>_</u>	Visit	3	Signature
		12/12/2	L	Р	0	3/20	L	Р	0	udb	, L	Р	0	
Disease					1					۲ ۱٬۰				Doctor
Information on					١,			ļ						1,80.
Disease / Diagnostics			S	Ø	V			J			p	an	\checkmark	100559 100559
☐ Treatment			51	D	✓									13,
Medications			9	02	V						2	bb	V	Doctor / Nurse
☑ Information on Safe and								<u> </u>		_	7		٠.	4.500
Effective use of medicines														Nac
☐ Information on drug / drug and														
drug / food interactions			,				•							
☐ Discharge Medications			_		1		,							
Surgical Instructions														Nurse har
☐ Pre - Operative Instructions														
Post - Operative Instructions							ر		V					
(Wound / Dressing Care)			30	D)	V						p	OD	V	
Pain Management			8	OD	V		Ś	00	٧		b	01D	$\overline{\nu}$	Nurse Mary
Reporting of pain			1			-		[]			ľ			U)APO
Pain Management		l 	1				Ω	OP	V		Þ	00	V	1
Safe and effective use of medica	ı										T			Doctor / Nurse
Equipment (if required)			S	0D	V		ک	מנט	Ľ		ρ	O))^	\bigvee	
Name of Equipment											<u>'</u>			
Rehabilitation Techniques			·		_	/	_]

Nutritional Guidance Diet Instruction for patients at Nutritional risk Diet advice for home	12/12/2	7							Date				Signature
Nutritional Guidance Diet Instruction for patients at Nutritional risk		Ľ	Р	0	18/12	L	Р	0		٦	Р	0	
Nutritional risk													Dietician
☐ Diet advice for home		9	ક્ર	2		S	97	S		5	en.	✓	Senior Division
					-	_					_	==	Nurse
Discharge Planning					_								
Self care			ſ			_							_
☐ Follow up		۷		lı			سسا	-					
Reporting Concerns Immunizations													
Parenting education			lí	П									
Others		ے	_	П				_	_				
Risk Factor Reduction					_								
☐ Smoking Cessation			_			,			~ ·,	,			Doctor
☐ Weight Control													
☐ Exercise		-				J							
Hypertension		J		ı		_		•					
Other Risks					<u> </u>	C							
OUTCOME (O) - RD - Return Demonstra Written Material given and explained (if		V - \ 	/erb	aliz	ed Und	ders		gnib	al 				
		V - \	/erb	alíz	ed Und	ders		gnik					
Written Material given and explained (if	f any)		/erb	alíz	ed Und	ders		gnik					
Written Material given and explained (if NIL Reports Given :	f any)	V-\			- -			gnik		1	Pei	ndir	ng NA
Reports Given : Given Pending Discharge Summary	f any)				Advice		tano	gnik		n	Per	ndir	ng NA
Written Material given and explained (if NIL Reports Given :	f any)			Diet CT S	Advice	eport	tano	gnik		1	Pei	ndir	ng NA
Reports Given : Given Pending Discharge Summary	f any)			Diet CT S	Advice	eport	tano	anik		1	Pei	ndir	ng NA
Reports Given : Given Pending Discharge Summary ECG Report	f any)			Diet CT S	Advice	eport	tano	gnik		1	Pei	ndir	ng NA
Reports Given : Given Penoing Discharge Summary ECG Report Doppler Report	f any)		[] () ()	Diet SCT S	Advice Scan Re	eport m	tano	gnik		1	Pei	ndir	ng NA

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Pal MIS.SHANMUGAPRIYA S

45/Female/MH1202381078 11/12/2023/IPH202302475

DO Dr.Anbarasu mohanraj DO MANAMANANAMANANANANA



PATIENT AND FAMILY EDUCATION RECORD

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UH

Assessment To be filled by concerned disciplines. Use key below														
Barriers to	Lea	arning				_				Plan t	o A	ddr	ess	s Factors
None		Vision	/ He	aring	j lin	nitations			Ш	Use	of Ir	iterp	rete	Г
Limited Reading Abilities		Physic	al b	arrie	rs				Ш	Edu	cate	fami	ily	
Religious / Cultural Factors		Langu	age	barri	ers				Ш	Sim	ple L	.angı	uag	e
Congnitive Limitations - unable to		Low m	otiv	ation	/ de	esire to	learr	1	Ш	Writ	ten l	nstu	ctio	ns
understand and follow directions										at)			
Completed By : Date Spin	ne	<u> 8.0</u>)	N	lurs	e Signa	ture	:_		10	-,			
Learning Record														
Need		Date	٦ ١	/isit	1	Date	٦ ١	/isit	2	Date	١	/isit	3	Signature
		15/14	L	Р	0	16/12/2	L	Р	0	Alor	L	Р	0	
Disease			lo.	igo.	1,		ъ	012	J	1				Doctor
Information on			Ÿ-				71							_
Disease / Diagnostics										•				,
☐ Treatment			G G	ØD.	v		Ω	σ ₂	U		5	63	0	Hollen-
Medications	Ì		r P	90	υ		0	m2	ن		၂၀	9	J.	Doctor / Nurse
Information on Safe and														
Effective use of medicines			p	୦ମ	را		D	α	U		D	DD.	V	. 0
☐ Information on drug / drug and				,										100
drug / food interactions								_ `						057
☐ Discharge Medications	_													
Surgical Instructions														Nurse
Pre - Operative Instructions									Щ					
Post - Operative Instructions														
(Wound / Dressing Care)			מ	OI.	\mathcal{L}		v	60	V		P	ьD	ט	
Pain Management			<u> </u>				١		Ц		_		Ш	Nurse
Reporting of pain			Ω.		V		D,	0	٧		P	OD '	<u> </u>	
Pain Management			$/\!$	ୀ	Υ		P	œ	7		ρ	ص م		15/14
Safe and effective use of medica	al l		V											Doctor / Nurse
Equipment (if required)									Щ	-			Щ	<u> </u>
Name of Equipment	ŀ													
Rehabilitation Techniques		-,												

Need			Date	\ \	/isit	1	Date	\ \	/isit	2	Date	١	/isit	3	Signature
				┟	Р	0		L	Р	0		L	Р	6	
Nutritional Guidance						П								П	Dietician
Diet Instruction for Nutritional risk	patients a	t		Þ	معا	2		r	٠	5		V		,	Maria Catnerine I Senie Dietis
☐ Diet advice for hom	———— ie			-	=			<u> </u>		F		4			Nurse
Discharge Planning						П				Г				П	
Self care				┢	┢					T				П	
Follow up						П									
Reporting Concerns															
Parenting education				\vdash		Н		┢	┞─	┢╴				H	
☐ Others		+		┞─	-	Н		\vdash	\vdash	\vdash			-	H	
Risk Factor Reduction				 	\vdash	H		┝	-	┝			H		<u> </u>
				┢	┢	H				H				H	Doctor
Weight Control				┢	┢	Н		\vdash	\vdash	┝			-	H	
Exercise				┝	\vdash	Н		\vdash	\vdash	┝				\vdash	
Hypertension	_			\vdash	\vdash	H	-		-	-				H	
Other Risks				┢	┢	\vdash		-	-	┝					
LEARNER (L) - P-Fa	4:4 14	M-4b 5			<u> </u>		- O4h à		<u>. </u>	<u> </u>					te Relationsh
Reports Given :															
	Given	Pending	-	NA.						_	Giver	1	Pei	ndir	ng NA
Discharge Summary			_•		_ [Diet	Advice								
ECG Report					_ (CT S	Scan Re	port	t						
Doppler Report				_			Scan Fil	_							
X-Ray Report				-	_ ,	ECH	IO Repo	ort				_			
X-Ray Film	$\overline{}$	·					asound		prt			_			
Compact Disk				/	_		Other F	-				_	_		
Name of Attendant /	Patient :	3.5	PAP	iM	Ú.	A	PRIY	A	Sig	nat	ure :		S	$\sqrt{1}$	F
Name of Discharge	Nurse	E. Call	how	<u>e</u>					Sigr	nati	ure: 💈	`•¢	ut i		
												0 <i>2</i> (0)}-		



Mrs.Shanmugapeiya S

45/Female/MH12023#1078 11/12/2023/IPH2023-)2475

Dr.Anbarasu mohanraj





Inter Disciplinary Team Rounds (IDTR) Checklist

							
Date: 11 222	Time:	19,5					
Checklist	Yes	No	NA	Ac	ction / Remarks		
MEDICAL							
Daily Consultant Visit							
Plan of care discussed							· ·
Discharge Planning							
Others if any	X						
NURSING							
Safety Precautions Ensured	. /	7					
Care of Lines and Tubes							
Infection Control Measures							
Skin Care							
Response to assistance	/						
Others if any	X						
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	1					_	
		In	ter Dis	sciplinary Team Members			
	Signatur	\sim		Name	Reg. / Emp. No.	Date	Time
Doctor	<u> </u>	DIDI	MA)	DR. ADMANYA	1347779 11	223	
Nursing Staff				1 d. Monthini	0/70	11/2	17.0
Dietician	(C	MAN	<u> </u>	Maria Catherine John	8401	11/11/2	<u>દબ</u> ્રકા
Physiotherapist		1 -1		Senior Dies 1700	0260'	12/12/2	2000
Patient Care Service Staff							



MIS.SHANMUGAPRIYA S 45/Femalc/MHI202381078 11/12/2023/IPH202302475 Dr.ANBARASU MOHANRAJ



IN-HOUSE TRANSFER FORM

								
	A (to be filled by Nu					~	hel fo	
Date	e of Transfer: 1円1기	Time: 101	tO Tr	ansferred	from:	DICU: To:	202)2 floor.	
Diag	gnosis: CMD-	TVP,						
Vital	I Signs: Temp: વૃદ્ધ (°F		lto.	(heats/n	nin\	(mmHg) Resp	iration: % b /breaths/m	
	B (to be filled by Ph	<u> </u>		al Investig		(Harring) Nespi	ination.	
	Check for				nsferring Docto		Receiving Doo	= ctor
esp	piratory (Breath sounds)	Clear	Crepital			others:		Vo.
Abdo	omen	Soft [Tender		Distended 0	thers:	Yes N	Vo.
Hear	t Sound	Normal [Feeble	e 🔲 Loud	d Others:_	<u>-</u>	Yes N	No
CNS		Consciou	ıs Or	iented	GCS Sco	ore: 15 15	Yes N	40
	Surgical Patients plicable)	Surgical Site:	Heal	thy S	oakage O	thers:	Yes 🔲	4o
		Prese	nt Medic	ation (for	Medication R	econciliation)		
S. No.	Current Medic	eation	Dose	Route	Frequency	Date & Time of last dose	To be continued duri hospital stay	ng
j	SY12 SUCKALF	-ATE	lunc	P/0	1-1-1	14/12/23@0718	☑ Yes ☐ No	
2	HEB. LEVOSA	LBUTAM	0.63 01 mg	HUAC	Q GHRLY	14/12/23@ 0918	Xes □ No	
. 3	TABI FRUSA	NIDE	ting	10	1-1-0-	14/12/23 @ 08/00		
4	TAB- SPIRONE	1 ACONE	25mg	Plo	1-1-0.	14 12/23 @ 10/00		
<u>_</u>	TAIR BEPLEX	FORTE	ITAR	PID	1-0-0	14 weles @ 08:00	☐ Yes ☐ No	
6	(T. CLOPIDOBIRE	LARPIEIR	175/75	Plo	0-1-0.	IAIODS @ INIO	, □ Yes □ No	
7	T-RUSUVMSTP	MN	407	1710	0-0-1,	18/10/09 @21:0	o	
8	T. PARAJET SYPCREMAP	Amol _	12 P	10	1-1-1.	14/12/23 @08:0	Yes□No	
9	SYPCREMAP	FIN PLUS	15,	Plo	0-0-1.	13 12 23 @ 21:0	o ∐Yes □ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	
				<u>.</u>			☐ Yes ☐ No	
	<u> </u>						Yes 🗌 No	
1 !								

Additional Det	tails (i	if any):					
			Num				
Patient Condit			Sick-need urgent care Othe				
	Sign	la	Name	Reg. No.	Date	·	Time
Transferring Doctor		F	Dr. Praven	112236	141	144.	वाःवा
Receiving Doctor	/	K-82	Dr. K. Anusuy a	134559	<i>પ્યાં</i>	423	BUT
Part C (to be f	illed l	by Nurses)					
Check for			Transferring Nurse			Receivir	ng Nurse
Drains		Chest A	Yes	∏ Nc			
Respiratory		Air Way Type: Oxygen Therapy		s: Rate:li/m	– iin a	Yes	. □ No
NG Tube / Oral		Yes No	For Feeding Gastric Suction	Fluid Restriction		Yes	☐ No
Foley's Catheter	r	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: 50	WELLS: NEWS / PEWS:			Yes	No No
Patient Belongin	ıgs	Yes No	If Yes, give details: Fceste			Yes	No]
Handover Detail	s		ninistration Record explained: Yes [c Reports handed over: Yes No	No o		Yes	□ No
Patient Attendar	nt	Yes No	If No, give details:			Yes	. □ Nǫ
Additional Det	tails (if any):					
		Mu	•				
		1					
	Sign.		Name	Emp. No.	Date		Time
Transferring Nurse		Buth		0228	 	وعادي	10110
Receiving Nurse		Pall	SociaryA.Co	00 F2	14/	12/623	10.015





Mrs.SHA IGATAYA S 45/Female/MHl202381078 11/12/2023/IPH202302475 Dr.ANBARASU MOHANRAJ



FAMILY COUNSELLING FORM

CONSU	LTANT- DR	ANBARAS	MOHAN RAY. DIAGNOSIS- CAD-JUD			
DATE	HOSPITAL	FAMILY	MEDICAL LIDDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
12/2/23	PAN OPA	B.SELVAKUM	Explained about the gonoval condition, Need of Icu Office and Medicinal Obsphorts. Viators policy explained.	ı	BRill.	112236 G
13/2/09	Rilly Bignoons.	MR. SELVA KUMAR.	Explained about general condition. Need of the Ray and medical support. Visitor Ray Policy Explainer.		Bran.	f 112236
	-					



Pharmacist



Every	heart	beat	counts

Mis.Shanmugapriya s 45/Female/MHI202381078

11/12/2023/IPH202302475

Dr.Anbarasu mohanraj

HOME MEDICATION USAGE FORM

Allergies: NKD A T2DM | CAD - TVD Diagnosis: Batch No. Medication name brought Prescribed drug name Dose Freq. Qty. & Expiry by Patient/ Attender date 60-60 B-70765 60-60 Ini. HA IN. HA wat 160 10/25 Inj. Human insulatand 40 -0 رون 40-60 Human insulatora B-80145 10 nt GITE1960A Irban 5mg 1-0-1 · Irapure 3 METOS 2309 1-0-1 To Flavedon MR To Flavedon MR 35ma 5/26 itab 2 E 166112218705 To oroler xT 0-0-1 T. orofon XT 5/24 To Homochek 23510 470 1000 1 t tal To tromo chek SIE 0953A co pan D 3 20/10 mg 1-0-1 CiPan D 3/25 Date & Time Signature Name Emp. No. 11.12.23 DR-ANUSUYA 134659 16.30 Doctor 11/12/23 Clinical 0224

This is to certify that, I take full responsibility of the quality and potency of the medications that I have brought to the hospital. Medications that I have got are stored with proper medication storage recommendation given by the manufacturer (Room temperature (below 25°C) or Fridge temperature (2°-8°C)). Any Adverse effects that is caused or effects that affects my recovery due to improper storage condition of medications that I have got from home, will be under my responsibility. I am aware that several medications that are available in Indian and International market are spurious and bogus which can cause harm to my health. I assure that Medway Hospitals or its employees will not be held responsible for any outcome/ results in the future.

	Signature/ Thumb impression	Name	Date	Time
Patient	80° N	S. SHANIMUGARIYA	॥ ।२ २०५	<u> </u>
Guardian		(Name and Relationship with the Patient)		

Reason for Guardian consent:

	Signature/ Thumb impression	Name	Date	Time
Assigned Staff				
		1. Nanteni	11/2/23	16.3

1

MHI/HOSP/2022/110



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

MIS.SHANMUGAPRIYA S

45/Female/MHI202381078 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ





Every heart beat counts

WOUND ASSESSMENT CHART

DATE	16/10/10						
SITE OF WOUND	/						
CHEST	\						
LEG L/R							
ABDOMEN							
SACRAL REGION							
_' <u>'{EEL</u>							
OTHERS					_		
SIZE OF THE WOUND							
SUPERFICIAL / DEEP IN NATURE							
PRESSURE Specify system used :		_					
RISK FACTORS Specify system used :	DM_	HTN	Age	Obesity			
WOUND TISSUE TYPE(S) PRESENT							
necrotic							
		_	_				
slough							
	0			0 0			
slough							
slough undermining granulation overgranulation							
slough undermining granulation overgranulation epithelialisation	0 0 0 0						
slough undermining granulation overgranulation epithelialisation other							
slough undermining granulation overgranulation epithelialisation other SURROUNDING SKIN TISSUE TYPE(S)							
slough undermining granulation overgranulation epithelialisation other SURROUNDING SKIN TISSUE TYPE(S) macerated							
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slough undermining granulation overgranulation epithelialisation other SURROUNDING SKIN TISSUE TYPE(S) macerated erythema oedematous cellulitis blistered							

WOUND ASSESSMENT CHART

EXUDATE AMOUNT								
none								_
evidence of some moisture								
evidence of significant flow	J						□ _	
EXUDATE								
serous								
sero - sanguinous								
Purulent								
ODOUR								
none								
some evidence of odour								
. significantly malodorous	Ø							
PAIN AT WOUND SITE	, –							
(nil) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (max)				 •				
INFECTION SUSPECTED*			,					
	◪							
SWAB SENT								
ANTIBIOTIC THERAPHY								
BLOOD GLUCOSE / URINE ANALYSÍS								
PATIENT / CARER TO DO DRESSING	무							
SIGNATURE	80% N							
*SIGNS & SYMPTOMS OF WOUND INFECT	TION:	,	<u></u>	, ,		r		, , ,
• Pytexia • excess e	xudate		, ,	ND INFECTI				1.5
● licalised pain	^		<u>.</u>	ue bleeds e:		healing is s	•	ınticipated
erythema offensive odour fragile bridge of epithelium occurs wound breakdown odour increas							10 mm	



MHI/IP/2022/116 Medway

Every heart beat counts

AGE / SEX:

(A Unit of United Alliance Healthcare Pvt Ltd)

VIP SCALE (VISUAL INFUSION PHLEBITIS)

Mis.SHANMUGAPRIYA O

45/Female/MH1202381078 PATIENT NAME:

· 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ

IP No. / UHID No

Ward / Bed No.

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT								
DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S/N EMP No.	
12/11/22	9:00	Lt	015	Patent	Hughed		Houtaos	
12/11/22								
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							 ;	
						_		







Every heart beat counts

VIP SCALE (VISUAL INFUSION PHLEBITIS) MIS.SHANMUGAPRIYA S

PATIENT NAME:

45/Female/MH1202381078

11/12/2023/IPH202302475

AGE / SEX:

Dr.ANBARASU MOHANRAJ

IP No. / UHID No

Ward / Bed No. OFKU

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

,		AIT	SCORE	O SHOOLD BE MORE	I OKLD IN L	VERT OTHER	
DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
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13/12/23	<u>න</u> ැග	FILLET LUBITUDE	015	DV UNB PHIRM		NO SUPE OF	(DO)
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reclas	# <i>J+0</i> a_	Philal .	0/5	poteent	flushon	Observation	
	20,00	COBLIBE	015	Patent	flushes	Observation	A)
	8.00	et aubi-tal	015	patous	flesho	Obsenotion	Story
15/12/2	4100	Ethetal	0/5	pitent	Lush	Observation	12
	20.00	CUBITAL	0(5	patent	flushed	observation	SILL SILL
	800	les TAC	OUT	patent	flush	Osevelion	86
16/12/23	4.00	Paterilal	ols	Patent	Hishel	observation	In.
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OPCABX 4 GRAFTS - SVG - 7PDA

SUG -> D, 40M (SEQ)



_	Mrs.SHANMUGAPRIYA S 45/Female/MHI202381078]_		М	HI/IC	U/2022/07
Name	11/12/2023/IPH202302475					Sheet No.
UHID No.	Dr.Anbarasu Mohanraj	A	ge	Sex		ŧ
Blood Grou	up Poorth & Height	· ~	Weight	BSA 2		Α

SURGICAL PROCEDURE:

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

DATE OF SURGERY: 12/12/23

POST-OP DAY: DA &

SUING	JOALFF	CCLDC	//\L.					טת	IL OI 3	OINOLIN	· 12[1	イルフ		, ,	/O1-O1 L	טעפיירי	ح	
						VENTIL	ATORS P	ARAMET	TERS	_					BLOOD	GAS		
DATE	TIME	MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	ΜV	ıτv	ETV	FiO ₂		pН	PCO ₂	PO ₂	HCO₂	SAT%	BE
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	30-00	08 japa		10		5.0					00%							
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	21.30)		_							441		01 H.K	H8.H	128.2	26.9	98.6	2.0
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·																		

PATIENT RECEIVED FROM OF AT: 16-65

OF URINE : 500HI

NEURO

Spon-4
Opens to speech-3
Opens to pain-2
Remains closed-1

VERBAL

Oriented-5
Confused/Disoriented-4
Inappropriate words-3
Sounds-2
No response-1

MOTOR

Br-Brisk

Obey commands-6 Localise pain-5 Non-localising-4 Abn.Flexion-3 Abn.Extension-2 No response/flacid-1

CAPILLARY REFILL

MOTOR ARMS/LEGS

4

S-Strong Wk-Weak O-Absent A-Anasthesia CP-Chemical paralysis

PUPILS SCALE (mm)

•	•	
1	2	3 4
	5	6
	7	8

PUPILS REACTION

Br-Brisk SI-Sluggish O-Absent

CARDIOVASCULAR

SI-Sluggish O-Absent
HEART SOUNDS S1 S2 M-Murmur
M-Murmur Rb-Rub

G-Gallop SM-Sound muffled

EDEMA

D-Dependent G-Generalised O-Absent

NECK VEINS

JVP N-Normal In-Increased

VALVE CLICK/ SHUNT NUMBER

Valve Replaced / Shunt +Present O-Absent

LIVERSIZE

E-Enlarged

N-Normal

PULMONARY

WORK OF BREATHING	SUCTION
Ab-Abdominal	ET-Endotracheal
TA-Thoraco-abdomial	N-Nasal
L-Laboured	Or-Oral

BREATH SOUNDS	SECRETION
CL-Clear Ro-Ronchi Wh-Wheezes CR-Crackles BECL-Bilat equal & clear	COLOUR CL-Clear Y-Yellow W-White Pk-Pink

SECRETIONS CHARACTER COLOUR M-Moderate Sc-Scanty Y-Yellow Th-Thin W-White Tk-Thick Pk-Pink Cs-Copious R-Red

GASTROINTESTINAL

BOWEL SOUNDS	NGT POSITION
+Present O-Absent	Air injected +Heard in Abd
	O-Absent
	GA-Gastric contents aspirated Dr-Dependent Drainage
ABDOMINAL TONE	,

ABDOMINAL TONE So-Soft F-Firm Tn-Tender Ob-Obese	GASTRIC G-Green Y-Yellow	RESIDUAL B-Bleeding C-Coffee ground
Ob-Obese D-Distented		

ORCABX 4 GRAFTS

LIHA -> LAD (SEQ)

SVG-7PDA

SVG-7PDA MTS.SHAI IMUCAPRIYA S MHI/ICU/2022/076 45/Female/MHi202381078 11/12/2023/199202302475 Name Dr.ANBARASU MOHANRAJ Heart Medway Hospitals® UHID No. Age Sex The way to better health **Blood Group** Height Weight **BSA** (A Unit of United Alliance Healthcare Pvi Ltd) Every heart beat counts

SURG	ICAL PR	ROCEDL	JRE:					DAT	TE OF SI	JRGERY	f: 15	2/12/2	23	PC	ST-OP D	DAY:			
						VENTILATORS PARAMETERS							BLOOD GAS]
DATE	TIME	MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO₂		pН	PCO ₂	PO ₂	HCO₂	SAT%	BE	
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NEURO

EYES Spon-4 Opens to speech-3 Opens to pain-2 Remains closed-1

VERBAL

Oriented-5 Confused/Disoriented-4 Inappropriate words-3 Sounds-2 No response-1

MOTOR

Br-Brisk

G-Gallop

SM-Sound muffled

SI-Sluggish

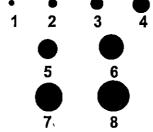
Obey commands-6 Localise pain-5 Non-localising-4 Abn.Flexion-3 Abn.Extension-2 No response/flacid-1

CAPILLARY REFILL

MOTOR ARMS/LEGS

S-Strong Wk-Weak O-Absent A-Anasthesia CP-Chemical paralysis

PUPILS SCALE (mm)



PUPILS REACTION

Br-Brisk SI-Sluggish O-Absent

CARDIOVASCULAR

-

O-Absent	C
HEART SOUNDS	N
S1 S2	J۱
M-Murmur	N
Rb-Rub	lr

D-Dependent G-Generalised O-Absent

EDEMA

NECK VEINS JVP

N-Normal Valve n-Increased Shunt +Pres

VALVE CLICK/

SHUNT NUMBER

D-Distented

LIVERSIZE

E-Enlarged

N-Normal

Valve Replaced / Shunt +Present O-Absent

PULMONARY

WORK OF BREATHING	SUCTION
Ab-Abdominal	ET-Endotracheal
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BREATH SOUNDS	SECRETIONS	CHARACTER
CL-Clear Ro-Ronchi Wh-Wheezes CR-Crackles BECL-Bilat equal & clear	COLOUR CL-Clear Y-Yellow W-White Pk-Pink	M-Moderate Sc-Scanty Th-Thin Tk-Thick Cs-Copious R-Red

GASTROINTESTINAL

BOWEL SOUNDS	NGT POSITION
+Present O-Absent	Air injected +Heard in Abd O-Absent GA-Gastric contents aspirated Dr-Dependent Drainage
ADDOMINAL TONE	·

ABDOMINAL TONE	GASTRIC	RESIDUAL
So-Soft F-Firm Tn-Tender Ob-Obese	G-Green Y-Yellow	B-Bleeding C-Coffee ground

	Ord	ABXA LIYA- SUG-	JA JA	D 40	OM (SEQ) (_		11 Name	/Female/ /12/2023	MH1202381 /IPH202302	078 475			M	Γ	022/076 et No.
ay H	ospit	als®	N A	ВН			nstitu	ıte	UHID N	.ANBARA	MOHANI	<u> </u>	Age		Sex	(2)	\mathcal{P}
					EU	ery Neor	t Deat (1		Blood Group		3 t v 6			٠ ١	_		4
CAL PR	OCEDU	RE:					DAT	TE OF S	SURGERY	12	12 23		PC	ST-OP	DAY: J	styon	
TIME			1	1	VENTIL	ATORS P	ARAMET	ERS	1 1		' '			BLOOD	GAS		
IIIVIE	MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	iτν	ETV	FiO ₂		рН	PCO ₂	PO₂	HCO₂	SAT%	BE
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NEURO

EYES Spon-4 Opens to speech-3 Opens to pain-2 Remains closed-1

VERBAL

Oriented-5 Confused/Disoriented-4 Inappropriate words-3 Sounds-2 No response-1

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1	2	3	4
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,			
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D-Distented

LIVERSIZE

E-Enlarged

N-Normal

+Heard in Abd O-Absent **GA-Gastric contents aspirated** Dr-Dependent Drainage

B-Bleeding

C-Coffee ground

NGT POSITION

Air injected

ABDOMINAL TONE GASTRIC RESIDUAL So-Soft G-Green F-Firm Y-Yellow Tn-Tender Ob-Obese

MIS.SHANMUGAPRIYA S

B +V5

Name

UHID No.

Blood Group

Sheet No.

В

45/Female/MH1202381078 11/12/2023/IPH202302475 Dr.ANBARASU MOHANRAJ

Height

Age	Sex

BSA

Weight

16500 63.4 kg 1.74m2





MHI/ICU/2022/076



	[ВЮСН	EMISTRY					VITA	L PARA	WETER	S			CARDIAC ASSIST		T DEVICE	
DATE	TIME	НЬ	Na	К	Ca SUGAR	BLOOD	TIME	ETCO,	BREATH SOUNDS	Sao,	RR/MT	NRP	TEMP°E	Abd [™] G	TIME	IABP		PACEMAKER SETTING	
				-	 	52005	111712	21002	SOUNDS	 	ļ	14101	121411	AUG G	1 11411	RATIO	DURATION	RATE	MODE
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2/12	20.30	12.9	139	3.66	1.07		<u> </u>		CC	100%	20/1	<u> </u>							
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SHE GOT FULLY DUDKE DIND MOVED ALL LINBS OF 17.20

	SHIFT	D	AY	EVE	NING	NIC	ЭНТ
	TIME			16.24	20-00	00.00	0H-D0
•	EYES			CQ_	cp	4	4
NEURO	VERBAL			Cè_	CP	5	5
ÿ	MOTOR			cP	СP	6	6_
	ARMS R/L			- cr	cp	T2	ST
	LEGS R/L			CP-	CP	87	31
PUPILS	R.SIZE/REACTIION			CP_	c p	3/82	31 _{BR}
PUF	L.SIZE/REACTION			CP	ф	31BR	3 BR
유	HEART SOUNDS			3172	2152	3152	Sisz
CARDIO-VASCULAR	VALVE CLICK			-		~	_
	CAPILLARY REFILL			Β γ_	BR	BR.	RR
RDIC	EDEMA			10_	P	Ö	0
ర	NECK VEINS			N_	N	N	N
ARY	WORK OF BREATHING			GD_	TA	T.	AT?
PULMONARY	SUCTION	_			1		
PUL	SECREATIONS			_	1		
 	BOWEL SOUNDS			+	4	+	+
STIN	ABDOMINAL TONE			_ی	3	ደ	8
INTE	N/G POSITION			<u> </u>	0	,	,
GASTRO INTESTINAL	GASTRIC RESIDUAL				_		
GAS	LIVER			N	Ν	V	N

	SHIFT	D.	AY	EVE	NING	NIGHT		
	DESCRIP.OF URINE			cl	CL	CL	CL	
G.U.	PD - FUNCTION			_	1		_	
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	PD - SITE			_	(-	-	
	COLOUR			_	{	~_	,	
	Sx WOUND-CHEST				CL	CL	CL	
	LEG			cl	CL	CL	CL	
SKN	DRESSING			ig	0	05	05	
	PRESSURE SORE-SITE			Nil	MIL	NIL	NIL	
	AREA			-	,		_	
	DRESSING CONDITION			-	1	-	1	
	POSITION CHANGE			DAH	024	DH)	D21+	
MISCELL	CHEST-PHYSIO			16/20	SPIRE	MER		
MIS	ACTIVITY			2P	CP	PE	PE	
				CVP	# B	ABP aup	1787 CDD	
	S/N NAME			Dava	070	24_	2	
	TIME			ے ۔ ۱۲	agob	00-00	04-00	
	SIGNATURE			Souds	र्मी	af B	86	







Mrs.Shanmugapriya s

45/Female/1.IH1202381078

BIVE

Blood Group

Sheet No.

В

Age Sex

Height Weight BSA





MHI/ICU/2022/076



	_	<u> </u>		BIOCH	EMISTRY					VITA	L PARA	METER:	S			CARDIAC ASSIST DEVICE			
DATE	TIME	Hb	Na	к	Ca SUGAR	BLOOD	TIME	ETCO,	BREATH SOUNDS	Sao ₂	RR/MT	N RP	TEMP°F	Abd∝mG	TIME	IABP		PACEMAKE	R SETTING
		1110	140			BLOOD		L100 ₂	SOUNDS	Oa0 ₂	I KIVIVI	I MIDI	1 - 1 - 1	ADG G	I IIVIL.	RATIO	DURATION	RATE	MODE
					(28H) 150		22.30		CL	997	aabt	ļ 	975						
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_							94.3b		cu	997	23Jul-								
13/12/03	6.30	11.8	138	44,4	1.03		05-30		CL	96/	Doblint								
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_																		<u> </u>	
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																			 -

	SHIFT	Di	AY	EVE	NING	NIC	SHT
	TIME						_
	EYES						
NEURO	VERBAL						
Ä	MOTOR						
	ARMS R/L						
	LEGS R/L						
PUPILS	R.SIZE/REACTIION						
PUF	L.SIZE/REACTION						
ĄΚ	HEART SOUNDS						
CULL	VALVE CLICK				_		
CARDIO-VASCULAR	CAPILLARY REFILL						
RDIC	EDEMA						
රී	NECK VEINS						
IARY	WORK OF BREATHING						
PULMONARY	SUCTION						
I.G	SECREATIONS						
 \ \	BOWEL SOUNDS						
STIN	ABDOMINAL TONE						
INTE	N/G POSITION						
GASTRO INTESTINAL	GASTRIC RESIDUAL						
&	LIVER		l				

(

	SHIFT	D	AY	EVE	NING	NIC	GHT
	DESCRIP.OF URINE						
G.U.	PD - FUNCTION						
	DRAINAGE						
	PD - SITE						
	COLOUR						
	Sx WOUND-CHEST						
	LEG						
SKN	DRESSING		_		-		
	PRESSURE SORE-SITE						
	AREA						
	DRESSING CONDITION						
	POSITION CHANGE						
MISCELL	CHEST-PHYSIO						
MIS	ACTIVITY						
	S/N NAME						
	TIME						
	SIGNATURE				Ī.		ı

Mrs.SHANMUGAPRIYA S

45/Female/MHI202381078

Sheet No.	Truino	11/12/2023/IPH20230 DT.ANBARASU MOHAN	2475 IRAJ	, A	ge] ;	Sex
В	Blood Grou	BAVE	Height	_	Weight	6	BSA 1. FAM







-				BIOCH	EMISTRY					VITA	L PARAM	METER	S			CARDIA	AC ASSIST	DEVICE	
DATE	TIME	НЬ	Na	к	Ca SUGAR	BLOOD	TIME	ETCO,	BREATH SOUNDS	Sao	RR/MT	NIDD	TEMPO	Abd⁵™G	TIME	IARD			R SETTING
		LID I	Na		SUGAR	BLOOD	IIIVIE		SOUNDS	3402	KIVIVII	NIDE	1 CIVIF F	AUG G	IIIVIE	RATIO	DURATION	RATE	MODE
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							16.30		CV	941.	24	32 (64	gPi),						

CRITICAL CARE FLOWCHART

	SHIFT	D	AY		NING	NIC	SHT
	TIME	200	101.V	1600			
	EYES	h	Щ	4			
NEURO	VERBAL	6	6	5			
Ä	MOTOR	<u></u>	b	6			
	ARMS R/L	945	25	کالح			
	LEGS R/L	SE	gr.	312			
PUPILS	R.SIZE/REACTIION	3/12	3hr_	3/2R			
PU	L.SIZE/REACTION	3/196	3lor	31BR			
AR	HEART SOUNDS	SISH	5132	502			
COLL	VALVE CLICK			_			
CARDIO-VASCULAR	CAPILLARY REFILL	<u> </u>	200	Ps.			
RDIC	EDEMA	0_	i o	0			
	NECK VEINS	N	~	N			
PULMONARY	WORK OF BREATHING	ત્ત	TA	TA		_	
MON	SUCTION	-				· —	
J. P.	SECREATIONS			_			
AF	BOWEL SOUNDS	4	+	+			
STIN	ABDOMINAL TONE	504 F	હેલુ-	Soft	_		
INTE	N/G POSITION		_	~			
GASTRO INTESTINAL	GASTRIC RESIDUAL			_			
GA	LIVER	<u> </u>	೧	Ŋ			

	SHIFT	D	AY	EVE	NING	NIC	SHT _
	DESCRIP.OF URINE	Ü	u	こい			
G.U.	PD - FUNCTION			_			
	DRAINAGE	,		٦			
	PD - SITE	_		-			
	COLOUR	, 		_			
	sx WOUND-CHEST	J	4	u			
	LEG	Ü	U	ساے			
SKN	DRESSING	σı	01	01			
	PRESSURE SORE-SITE	210	ارد_	NIY			
	AREA	-	_	•			
	DRESSING CONDITION	-	_	_			
	POSITION CHANGE	DIZH	Qru	Q2H			
MISCELL	CHEST-PHYSIO	NBB	NBB Spra	(WED THE B			
MIS	ACTIVITY	PE	PB	PE			
		ABP CAP	ABP	PBP			
	S/N NAME	JENEY "	Inglan	174001 62-718			
	TIME	Q.00	פונט	16/00			
	SIGNATURE	10002	20n	0286.			







	Mrs.SHANMUGAPRIYA 45/Female/MH1202381078	s ·	_				VIHI/	ICU/2022/076
Name	11/12/2023/IPH202302475 Dr.ANBARASU MOHANRAJ	i						Sheet No.
UHID No.	THE CHAIL COLOR AND THE CHAIL WAS A STATE OF THE CHAIL OF		\ \3g	е		Sex		<u> </u>
Blood Grou	BIVE	Height	- 1	Weight 63・A	(9	BSA 1 - FAM	2	С
					T			<u> </u>

	T^-	UR	INE		Cl	EST D	RAINAG	E		GAS	TRIC	LAB S	AMPLE	TOTAL	VOL	ME	INF	USIONS	
DATE	TIME	AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL	OUTPUT	AMT	Joi			
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13/12	00.3t	100	880			20		20	460				व,७	1307	ww/	900	2.0	4.0	
	01.31		-			bo		ro	470				7.0	1412	100	1000	۵.0	4.0	

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

Aci: 98 ppc of 17.00

l

GENITOURINARY (GU)

	PD		COLOUR	SURGICAL (SX) WOUN	D
URINE	FUNCTION	DRAINAGE	Pk-Pink F-Flushed P-Pale	C-Clean Oz-Oozing G-Gaping	
CL-Clear T-Turbid	Dr-Draining B-Blocked	CL-Clear BS-Blood	Cy-Cyanotic M-Mottled	Op-Open I-Infected	
Stained HC-High Coloured	SITE	50 5100d	D-Dusky J-Jaundice	I-IIIIecteu	
BS-Blood Stained HA-Haematuria	C-Clean R-Redness BD-Block discoloration		SITE	PRESSURE SORE	Г

MISCELLANEOUS

OISITION CHANGE	CHEST PHYSIO
Su-Supine RL-Right lateral LL-Left Lateral	V-Vibrator CP-Chest percussion DC-Deep breath & cough N-Nebulizer
ACTIVITY	14 Hobuiles

PE-Passive exercise Am-Ambulated

TRANSDUCER ZERO
PARAMETER
ABP-Arterial BP
RAP-Right Arterial Pressure
PAP-Pulmonary Arterial Pressure
LAP-Left Arterial Pressure

SKIN

Pk-Pink F-Flushed P-Pale Cy-Cyanotic M-Mottled D-Dusky J-Jaundice	C-Clean Oz-Oozing G-Gaping Op-Open I-Infected	B-Betadine Al-Antibiotic Irrigation
	PRESSURE SORE	

DRESSING

SITE	AREA	DRESSING / Rx
S-Sacrum Sc-Scapular Oc-Occiput	R-Redness BD-Black discoloration BL-Blister SP-Skin Peeling D-Deep	IR-Infra Red DU-Dueodem E-Eptoin dressing B-Betadine dressing EU-Eusol sitz bath ST-Sofra Tulle

CONDITION H-Healing SCo-Status quo S-Sloughing

LINES / TUBES CONDITION

O-No redness, swelling, no leak, no air R-Redness at site Sw-Swelling at site Dr-Draining D/c-Discontinued P-Positional HL-Heparin Lock B-Blocked







Mrs.SHANMUGAPRIYA S 45/Female/MHI202381078]	MHI/ICU/2022/076
Name Dr.ANBARA'SU MOHAN,(AJ		Sheet No.
UHID No	Age Sex	
Blood Group Heigni	Weight BSA	C
	17)	•

		UR	INE		CI	IEST DI	RAINAG	ÈΕ		GAS	TRIC	LAB S	AMPLE		VOLU	ME	INF	USIONS	
DATE	TIME	AMT	TOTAL	RT.PL.	LT.PL.	MED A	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT	rma .	Not	92.82 N.101	ACTEA HOLAN	
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SPECIFIC	OBSERV	ATIONS/I	PROBL	FMS

DATE	TIME

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GENITOURINARY (GU)

G	ENITOURINARY	((GU)	SKIN						
	PD		COLOUR	SURGICAL (SX) WOUND	DRESSING				
URINE	FUNCTION	DRAINAGE	Pk-Pink F-Flushed P-Pale	C-Clean Oz-Oozing G-Gaping	B-Betadine Al-Antibiotic				
CL-Clear T-Turbid	Dr-Draining B-Blocked	CL-Clear BS-Blood	Cy-Cyanotic M-Mottled	Op-Open I-Infected	Irrigation				
Stained HC-High Coloured	SITE		D-Dusky J-Jaundice						
BS-Blood Stained HA-Haematuria	C-Clean R-Redness BD-Block dis	scoloration		PRESSURE SORE					
	DD-DIOCK dis	SCOIOLAROLI	SITE S-Sacrum	AREA R-Redness	DRESSING / Rx				
	MISCELLANEO	ous	Sc-Scapular	BD-Black discoloration	lR-Infra Red DU-Dueodem				
OISITION CHANGE	С	HEST PHYSIO	Oc-Occiput	BL-Blister SP-Skin Peeling	E-Eptoin dressing B-Betadine dressing				
Su-Supine RL-Right lateral LL-Left Lateral	C	-Vibrator P-Chest percussion C-Deep breath & cough		D-Deep	EU-Eusol sitz bath ST-Sofra Tulle				
ACTIVITY	N	-Nebulizer	CONDITION						
PE-Passive exercise Am-Ambulated	P.	RANSDUCER ZERO ARAMETER BP-Arterial BP	H-Healing SCo-Status quo S-Sloughing	SCo-Status quo					
	R	AP-Right Arterial Pressure AP-Pulmonary Arterial Pressure	LINES / TUBES	CONDITION					
		AP-Left Arterial Pressure	O-No redness, swelling, no leak, no air						

O-No redness, swelling, no leak, no air R-Redness at site Sw-Swelling at site Dr-Draining D/c-Discontinued P-Positional

HL-Heparin Lock B-Blocked

MHI/ICU/2022/076











45/Female/MHI202381078 11/12/2023/IPH202302475

Sheet No. Name Dr.ANBARASU MOHANRAJ UHID No. Sex ge Weight **Blood Group** Height BSA B+165 C 63-16 1. FAM

	URINE CHEST DRAINAGE		GAS	TRIC	LAB S	AMPLE	TOTAL	7010	ME	INFUSIONS									
DATE	TIME	AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	АМТ.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT	IMI	301			
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SPECIFIC	OBSERVAT	IONS/PRO	BLEMS

DATE TIME

10:00 @ PLEUPAL XMD MBDIASTINGE DEALN REUPIED (Dr. JURIODORU)

13/12/2023

	GEN	ITOURINART (GU)								
		PD		COLOUR Pk-Pink	SURGICAL (SX) WOUND C-Clean	DRESSING B-Betadine				
	URINE	FUNCTION	DRAINAGE	F-Flushed P-Pale Cy-Cyanotic M-Mottled	Oz-Oozing	Al-Antibiotic				
-	CL-Clear T-Turbid	Dr-Draining B-Blocked	CL-Clear BS-Blood		G-Gaping Op-Open I-Infected	Irrigation				
	Stained HC-High Coloured	SITE		D-Dusky J-Jaundice						
	BS-Blood Stained HA-Haematuria	C-Clean R-Redness BD-Block discoloration	n		PRESSURE SORE					
		DIOCK DISCOMBLIO	11	SITE	AREA	DRESSING / Rx				
	м	ISCELLANEOUS		S-Sacrum Sc-Scapular	R-Redness BD-Black discoloration	IR-Infra Red DU-Dueodem				
	OISITION CHANGE	CHEST PH	IYSIO	Oc-Occiput	BL-Blister SP-Skin Peeling	E-Eptoin dressing B-Betadine dressing				
	Su-Supine RL-Right lateral LL-Left Lateral		reath & cough		D-Deep	EU-Eusol sitz bath ST-Sofra Tulle				
	ACTIVITY	N-Nebulize	er ·	CONDITION						
	PE-Passive exercise Am-Ambulated	TRANSDU PARAMET ABP-Arteri		H-Healing SCo-Status quo S-Sloughing						
		RAP-Right	Arterial Pressure onary Arterial Pressure	LINES / TUBES CONDITION						
		LAP-Left A	rterial Pressure	O-No redness, so R-Redness at site Sw-Swelling at site Dr-Draining D/c-Discontinued P-Positional	ite					

HL-Heparin Lock B-Blocked SKIN

	45/Female/MHI202381078
Vame	11/12/2023/IPH202302475
	Dr.Anbarasu mohanraj

UHID No.

Blood Group

_			SI	heet No.
Α	ge	Sex		(
_	Weight	BSA		D





MHI/ICU/2022/076



Every heart beat counts

FLUID ASSESSMENT (contd.)

INFUSIONS (contd.)

Height

BtVE

HAEMODYNAMICS ·

Bloo

od Group: B 416														
PERI	PP R/L	СО	CI	SVR										
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∞	FF				CRITIC									
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	l	INFUSIONS	(contd.)			ORAL	TOTAL	TOTAL		DVC DVI					LAP/		PP		١.,	0.5	
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LATS	nelice la	20 Ja 00 DN7	Munbus	IN FITTE	ി ബ	11 173								HRS							-

opywithit at the reliven previous day Hrs STAT DRUGS | @ 00.00 TIME

URINE:

TOTAL INTAKE:

TOTAL OUTPUT:

TOTAL BALANCE:

	DAY	EVENING	NIGHT
PATIENT CARE			
BATH			
ORAL CARE			
EYE CARE			
BACK CARE			
DRESSING/EQUIPMENT			
CHANGED	_		
WOUND			· ·
CEN.LINE			
I.V.SET			
TUBINGS	_		
HUMIDIFIER H2O			
ELECTRODES	_		
ALARMS VERIFIED			
VENT - HUMIDIFIER			
-SETTINGS			
HRT.RATE		984/m	modfint
B.P		128 4	130 60 mm
	_	HIM FIG.	
· -			

DATE	TIME	REMARKS / PLAN
1 1		
		<u> </u>

INFUSION PU	MPS						
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
Fi. juge	xoen zvs	12/12/03				R	Þ
NGTUBE	RS	12/12/03	1			12	P
IJL	₽Ĵ√_	12/12/03	1			8	P
2RI-LINE	RAD	12/12/23			ļ	3	P
PERI-LINE	RJ	12/12/03			ļ	P	P
IV EXÎN		12/12/23	t			P	p
IR DOME		12 12 23	l			7	P
MEDIA 9		12/12/03	1			7	p
PLEURAL)	15					ļ	_
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Name			(iph204.102 (iph204.102		-				She	et No.								Œ		1	MHI/IC	U/202	2/076	
UHID	No]Ā	ge	Sex			(3)·		((Y)			®	JCI ACCREDITED	NABH ACC	REDITED			L Med Lea		
Blood	Group Height Weight B+VE Height Weight				BSA	4 <i>m</i> ²	,)		he way	to bei	OSPI ter hea Healthcare P	ifth	5						nstit	ute			
	F		ASSES				11111	4 10 1		HAEN	! ^ NODYNA		ed Allibrice	noaithcera P	vi Liaj			Blo	od Gro	_	heart ら ^{せい}		:ounts	5
		_		SIONS	`.			N/G/	ORAL	TOTAL	TOTAL							LAP/		PP				Ī
DATE	TIME			_		MISC	TOTAL	AMT.	TOTAL	INTAKE	BALANCE	HR/mt	RYTHYM	ST	ABP	MAP	RAP	RAP	PERI	R/L	CO	CI	SVR	
13/12	02.30					20	6.0		ts	134	Tbb	Pa Ili	Siny	0-01	岩	79	4		Logn	++				_
	03.30					2-0	4-0		75	145D	-		g Inu	1	140	‡ 3	3		Coon	4 F_				CRITICAL CARE
	04.20			!		9.0		7 ₅	150	1629	7013	90	cim	Ø-0 <u>2</u>	132	75	4		con	++				CA
	25.20				•	2-0	4-0		150	1733	749	94	Rimla		130	72_	4		4309~	147				Ş.
	0620					3.D			150	1835	52		L, -	0.02	12]	76	Q		cean					
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STA	T DRUG	 s	<u> </u>			<u> </u>				<u></u>	 PRI	EVIOL	JS DA	\ Y _. .,/		<u> </u>	HRS		<u> </u>		<u> </u>		<u></u>]
	TIME											AINAC		X			_ INTAI	KE:						
											URI	INE :			У,	OTAL	OUTP	UT:			• .			
															-	ΓΟΤΑΙ	. BALA	NCE	:					

P.T.O.

	DAY	EVENING	NIGHT
PATIENT CARE	_		
BATH	1		
ORAL CARE			
EYE CARE			
BACK CARE	_		
DRESSING/EQUIPMENT			-
CHANGED			
WOUND		•	
CEN.LINE			
I.V.SET			
TUBINGS			
HUMIDIFIER H2O			
ELECTRODES			
ALARMS VERIFIED			
VENT - HUMIDIFIER			_
-SETTINGS			
HRT,RATE			800 pt
B.P.			30 bomby

DATE	TIME	REMARKS / PLAN

INFUSION PU	MPS	_					
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
27v	RT Day	12/12/23	2				₽
ART LINE	RAD	12/12/03	2				p
PEPI LINE	R)	12/12/03	2				P
DV EXTN		12/12/03	2				P
TR. DOME		12/12/03	2			<u> </u>	P
MEDIA 1	/				ļ		P
PLEURAL	江	12/12/13	2				P
U- MTH		12/12/02	2	<u>,</u> -			p
8-TURINO		12/12/13	2	<u> </u>	ļ	<u> </u>	P
O. TUBING		12/12/13	2			ļ	P
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	Mrs.SHANMUGAPRIYA S 45/Fernale/MHl202381078		_
Name	11/12/2023/IPH202302475 Dr.ANBARASU MOHANRAJ		Sheet No.
UHID No.		Sex	(3)
Blood Group	Height Weight	BSA	2 D







HAEMODYNAMICS

	FL	LUID ASSESS	MENT (contd.)	·			HAEN	MODYNA	MICS						Blo	od Gro	oup:	Btl		
DATE	T1845 -	INFUS	IONS (contd.)	TOTAL		ORAL	TOTAL	TOTAL	UD/mt	RYTHYM	ST	ADD	MAD	DAD	LAP/	PERI	PP	СО	CI	SVR
DATE	TIME		HIS	TOTAL	AMT.	TOTAL	INTAKE	BALANCE	HIVIII	NIMIN	31	ABP	MAP	RAP	RAP	PERI	R/L	CO	Ci	341
13/12/22	1:20		2.0	20	lpo_	100	102	. 8	lon	Shaw	9 <i>0</i> 00	132	84	6		Corn	PP			
	2:30		2-0	2 -0	lno	200	204	.49	107	Grone	B02	142	9D	٦		cition	HE			
	9:30		2,0	2.0		200	206	64	104	Cinus	וס ע	133/	87	5	(Norm.	Ac			
	10:30			•	50	250	256	र्शेष.	31	عماره	0.00					<u>llem</u>	4-+			
	Miso				160	Hav	406	314	87	StMu	D _O					(Y)(Vৰ্থ্য	11			
	12/70				100	00	506	364	88	Shu	0,01					wou	11			
	12:30				ŚŊ	500	556	. Uly	86	ر'سا	0,00	•				Way				
	14.30				100	650	656	414	92	5/200	00					Non	xx			
	15.30				100	وکہ	\$56	T464	au	King	0،02				1	Jour	++·			
	16,30				ಶು	700			96	Spin	001					بهجتيار	++			

STAT DRUGS TIME

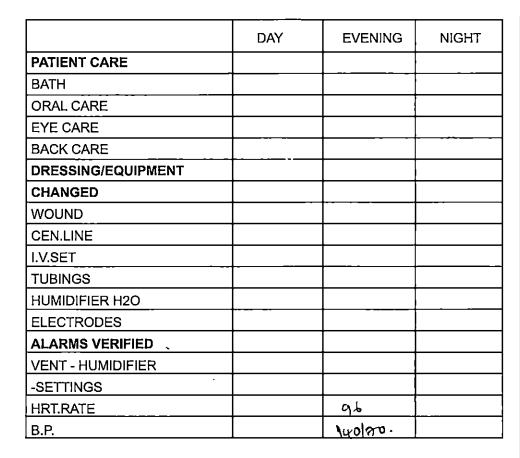
PREVIOUS DAY ... 14 1783 .. 32 HRS

DRAINAGE: 500 ML TOTAL INTAKE:

1897 ml TOTAL OUTPUT: URINE: 1390ml

TOTAL BALANCE:

P.T.O.



DATE	TIME	REMARKS / PLAN
		•

INFUSION PU	MPS						
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
Idv	Z V	12/12/08	2		P		
ART.LINE	202	12/12/03	2		P		
PERI-LINE	LUBITE	12/12/12	2		P		
DV FXTN		12/12/12	2		P	ļ	ļ
TR-DOME		12/12/23	2		<u> </u>		
MEDA					ρ		
PLEURAL	LI	12/12/13	2	_	P		
D-CATH	۲ 	12/12/13	2		P		
8-TURING	 	12/12/23	2		ρ		ļ
ON: TURIM	ļ. 	12/12/23	2		P		<u> </u>
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Йть.SHANMUGAPRIYA S 45/Female/MHI202381078 11/12/2023/IPH202302475 Dr.Anbarasu mohanraj

MHI/PHARM/2022/028 Medway

Every heart beat counts

MEDICATION ADMINISTRATION RECORD

	Drug	g Chart:	:1of	1.		Heig	ht (cms):	1659×1	Weigh	t (kg): <u>6</u> 3	<u>: ·U</u> kg
	1		KNOWN MEDICINE AL	LLERGIE	S (if NC)NE is c	onfirmed,	write NKDA ir	1 box 1)		
	Drug De	etails		Descrip	ption of A	Allergy	_		Doct	or's Sign:	
		N	IKDA		_	,			1 4	e: Dr.Ms Hydros No. 16573	
		ОСТО	R INSTRUCTIONS	<u> </u>				TAFF INSTRUC	SNOITS		
	2. Write in 3. Sign at 4. No pre	in BLOCK and enter l escription	me when prescribing drug (LETTERS, clearly and legibly MCI registration no. or apply seal a should be altered / overwritten rmat when writing time	2. Nurse 3. For ne follow 4. Standa Q8hrly:	in-charge ew prescrip standard t ard Timing :: 06:00hrs,	e should ve ption, follow timings gs: Q24hrly , 14:00hrs, 2	w the timings r: 10:00hrs, Q 22:00hrs or 09	l omissions art on daily basis s of doctor's presc alehrly: 10:00hrs, 22 9:00hrs, 14:00hrs, 2 00hrs, 06:00hrs, 10:	2:00hrs or 0 21:00hrs, Q(06:00hrs, 18:00h 6hrly: 05:00hrs,	nrs,
			Stat / (Once O	nly / P	remed	ication l	Drugs		-	
	Date	Time	Drug		Dose	Route	[Ooctor		Administered	d
	Date		5149		5000	1100.0	Sign.	Reg. No.	Sign.	Emp. No.	Time
١١،	12-23	7 PM	T · PAN		Цоти	Plo	KD	134779	*	0088	19:00
1- K	- 23	9-30p	m T. ALDRAX		טיאים מים	u Plo	KIBO	184559	刄	0088	21.30
ı	· <u>·23</u>	TET-M	T · PPm		Home	P/o	K'80	134779	d	0088	200
2.	2.23	5AM	T. ALPRAX		D. FM	n Pho	KBO	- 13UBD9	4	0088	5-00
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Clinical Pharmacist Nedway Heart Institute

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-Clinical Pharmacist Medviay Heart Institute

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Clinical Pharmacist Medway Heart Institute

REGUI	LAR PRESCRIP	TIONS I	Date →	To be	filled b	y Nurs	ing Sta	ff only.	Sign a	nd time	given
	filled in by Doctor		Time ↓	ular	R112						
DRUG NAME	T. PANTO	(D-P	#00	>	MPO						
Dose Ifab	Route	Frequency	£								
Dr. Sign & Reg. N		Start Date & Time									
		Stop Date & Time	8	19/0							
Additional Info:	-		13.00	82~	<u> </u>						
DRUG NAME											
Dose	Route	Frequency									
Dr. Sign & Reg. N	lo. / Seal	Start Date & Time									
Additional Info:		Stop Date & Time									
DRUG NAME					<u></u>						
DRUG NAIVIE											
Dose	Route	Frequency									
Dr. Sign & Reg. N	lo. / Seal	Start Date & Time									
		Stop Date & Time									
Additional Info:											
DRUG NAME	<u> </u>				,						
Dose	Route	Frequency									
Dr. Sign & Reg. N	lo. / Seal	Start Date & Time									
	<u> </u>	Stop Date & Time									
Additional Info:											
DRUG NAME											
Dose	Route	Frequency									
Dr. Sign & Reg. N	lo. / Seal	Start Date & Time									
	Stop Date & Time										_
Additional Info:											
Area In-charge Nurse Signature	rea In-charge			3	30/						

			DIET ORDERS	i (io ne hie	-301106	TO DY DOCK		,	-
Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
·12.93	2 PM	Lowest, Lowestot,	KAO	134579					
<u>12-23</u>	8 AM	mpo	KPO	1341770					
		\					····		
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		— 							
			NURSE	IDENTIFIC	CATIO	N RECOR	RD		
		(to be entered by all t	the nurses invol	ved in adn	ninister	ing medic	ations prescribed in the cha	art)	
Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning	·				Morning			
11 12 2	Evening	A. Nandkini	0170	A		Evening			
11/2/23	Night	A. ALBINUS	0088	Ø.		Night			
(Morning					Morning			

;	Morning				Morning		
11 12 23	Evening	A. Nanthini	0170	A	Evening		
11/2/23	Night	A - ALBINUS	0088	A)	Night		
	Morning				Morning		
	Evening				Evening		
	Night				Night		
	Morning				Morning		
(Evening				Evening		
3	Night				Night		
	Morning				Morning		
	Evening				Evening		
	Night				Night		



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Mrs.Shanmugaprina S

45/Female/MHI202381073 11/12/2023/IPH202302475

Dr.ANBARASU MOHANRAJ







Every heart beat counts

MEDICATION ADMINISTRATION RECORD

		MEDICATIO		, 14111 V	, , ,	,			ET "BEVAL".	<i>:</i>
Drug	Chart	of (Heig	ht (cms):	<u>165cm</u>	Weigh	(1:d1.goЯ t (kg):<u> 6</u>ዴ /	4 kg
		KNOWN MEDICINE AL	LERGIE	S (if NC	ONE is c	onfirmed	, write NKDA ii	n box 1)		
Drug De	tails		Descri	ption of A	Allergy	-		Doct	or's Sign:	
		NIKDA.		_				Name Reg.	SEYAKUN No. 11223	JUGEN BAR 86
D	ОСТО	R INSTRUCTIONS			NU	RSING S	TAFF INSTRU	CTIONS	· · -	
2. Write in 3. Sign at 4. No pre	n BLOCK nd enter scription	me when prescribing drug LETTERS, clearly and legibly MCI registration no. or apply seal should be altered / overwritten mat when writing time	2. Nurse 3. For ne follow 4. Stand Q8hrly	in-charge w prescrip standard ard Timing : 06:00hrs,	should ve otion, follo timings gs: Q24hrly 14:00hrs, i	w the timing v: 10:00hrs, C 22:00hrs or C	d omissions art on daily basis is 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	Once O	nly / P	remed	ication	Drugs			
Date	Time	Dava		Dose	Route	;	Doctor		Administered	ı,
Date	Time	Drug		Dose	noute	Sign.	Reg. No.	Sign.	Emp. No.	Time
12/12/12	Jo.00	DVJ. MYODYPULAT	E	Ls ml	- 2V	8	112216_	到面	0270	\$.00
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To be filled by Nursing Staff only. Sign and time given Date → **REGULAR PRESCRIPTIONS** To be filled in by Doctors only Time √ 330 DRUG NAME 3.16 Try . PARALETAMOL 2 Dose Route Frequency Rth Lock 19m Dr. Sign & Reg. No. / Seal Start Date & Time 19.15 Dr. PRAVEEN JEYAKUMAR 12/12/23 0 Reg. No:112236 Stop Date & Time ٠, 15/12/23 at 0.00 Additional Info: DRUG NAME 07,30 SUP. SUCRALFATE SUSPENSION Dose Route Frequency -1-1 Plo load Start Date & Time Dr. Sign & Règ. No. / Seal 13.30 10/12/22 010.00 Dr. PRAVEEN JEYAKUMAR Reg. No:112236 Stop Date & Time 9.00 19.30 Additional Info: 5.00 **DRUG NAME** 4-00 500 NEB. LEVOSAL RUTATAOL Clinical Pharmacist Medway Heart Institute Route Frequency Dose A6th body 10.00 TONH 0.63mg Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Start Date & Time 12/12/23 020.30 16-00 Reg. No:112236 Stop Date & Time Ç 33.00 Additional Info: **DRUG NAME** ይኒ00 TAR PRUSEMINE Clinical Pharmacist Medway Heart Institute Route Dose Frequency 1-1-0 Homa Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR 1600 Start Date & Time g/d/ 13/12/2023 (1) 2/100 16,00 Reg. No:112236 Stop Date & Time Additional Info: DRUG NAME 00:07 9200 TAR. SPIRANDLACTONE Dose Route Frequency Clinical Pharmacist Medway Heart Institute 1-100 <u>മിട്ട നമ</u> <u> Pío</u> Start Date & Time Dr. Sign & Reg. No. / Seal arallo sactolet Dr. PRAVEEN JEYAKUMA Reg. No:112236 Stop Date & Time VA.O 17:00 Additional Info: Area In-charge Nurse Signature: OO <ىن،

Clinical Pharmacist Medway Heart Instituto

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Clinical Pharmacist Medway Heart Institute

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To be filled by Nursing Staff only. Sign and time given Date → **REGULAR PRESCRIPTIONS** To be filled in by Doctors only ' Time 4 **DRUG NAME** Clinical Pharmacist Medway Heart Institute' Signatura ligat (S \$,00 TAB. BEPLEX. PORTE Route Dose Frequency 1-6-1 tab Plo Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMA. Start Date & Time 13/12/2023 0 3:00 O Reg. No:112236 Stop Date & Time Additional Info: **DRUG NAME** TAB. CLOPIDOGREC + ASPIRIN Route Frequency 00<u>141</u> <u> 19</u> 45/75mg 0-1-0 Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Start Date & Time - OF FRANCES JOYAKURAR 13/10/23 014:00 Ma:112238 Reg. No:112236 Stop Date & Time Additional Info: **DRUG NAME** TOB. ROSUVASTATIN Chinest Phenmedel Chronithest valued Dose Clinical Pharmacist Routé Frequency 0 ~0~1 gom g Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Start Date & Time 13/12/23 02/1:00 Ø Reg. No:112236 Stop Date & Time 21:00 Additional Info: **DRUG NAME** RIKRIS 8,00 TAB. DARACETAMOI Clinical Pharma Medway Heart Ins Dose Route Frequency 14:00 1-1-4co wa Plo Dr. Sigpra Regi Neyar Sealar Start Date & Time 12/12/23 @ 14:00 Reg. No: 112236 Stop Date & Time 0 coial Additional Info: **DRUG NAME** SUP PREMAFFIN DLUS Dose Route Frequency Clinical Pharmacist Medway Heart Institute 15 m 0-0-1 Dr. Sign-& Regi No: / Sealar Start Date & Time 13/12/22/02/:110 heg. i.u:112236 Stop Date & Time 21:00 Additional Info: Ø Area In-charge Nurse Signature:

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. METOPROLOL (BETALOC) 9:00 Dose Route Frequency Po 25mg 1-0-1 Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Start Date & Time 13/12/23 9,00 Reg. No:112236 Stop Date & Time 21:00 Additional Info: **DRUG NAME** T- PREGMIN 9:00 Route Frequency Dose 75mg P6 1-0-1 Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Start Date & Time 13/2/23 9,00 Reg. No:112236 Stop Date & Time 21-00. Additional Info: **DRUG NAME** 09/200 T: IVABRADINE Route Frequency Dose PO 1-0-1 Start Date & Time Dr. Sign & Reg. No. / Seal 21:00 14/12/23 9:00 Stop Date & Time Additional Info: DRUG NAME Dose Route Frequency Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: **DRUG NAME** Dose Route Frequency Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info:

Area In-charge Nurse Signature: Clinical Pharmacist
Medway Heart Institute

To be filled by Nursing Staff only. Sign and tim € given Date → **ANTIMICROBIALS** To be filled in by Doctors only Time ↓ **DRUG NAME** 4,60 a.50 INJ. (BFURDXIME RODIUM Dose Route Frequency a lath l 1.59m Start Date & Time Dr.:Sign & Reg. No. / Seal D1 D2 12/12/23 01 13:50 Dr. PRAVEEN JEYAKUMAR Stop Date & Time Reg. No:112238 31.50 21.50 21.50 12/27 44 22-50 Additional Info: **DRUG NAME** Route Dose Frequency Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: **DRUG NAME** Dose Route Frequency Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: **DRUG NAME** Route Frequency Dose Dr. Sign & Reg. No. / Seal Start Date & Time Stop Date & Time Additional Info: **DRUG NAME** Route Frequency Dose Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: Area In-charge **Nurse Signature:**

		Р	ARENTE	ERAL INFU	ISION P	RESCRIPTION AND ADMI	NISTRA	ATION F	RECO	RD			
Date	Time	Intravenous	Volume	Rate /		Additive Drug		_	Do	ctor	Adn	ninistratio	n
Date	Time	Fluid	volume	Duration	Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign
2 2 2 3	17.00	KABILYJE	Social	Amail ha	<u></u>			1	۶	112-236	17/20	19.80	Ι- '
		CHBILLYTE		l , l	İ	-			۶	112232	19-30	D4.30	2/
	i l	· ·		toomily		-			r	112212	00-3D	05.30	8) 029
	22:30	KABILYTE	Iooni	IDOMINI	lV	~		-	P	11225	23.30	4.00	A,
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PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD Administration, **Additive Drug Doctor** Intravenous Rate / Time Volume Date Fluid Duration Reg. No. Dose Range Start Time End Time Route Name Sign. 112236 17.30 1122-15, 17.20

340

	DIET ORDERS (to be prescribed by Doctors only)												
Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.				
12 12 22	16:55	NPO	\$	112236									
13/12/23		Liawid DIET	ę	112236	•								
	08280	SOFT DET	Ĉ.	112226									
15/12/2		Normal diel	k-81	13452)								
			1										
		,											

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	,			16 lizh	Morning	le. 18ding	6 029	Sufora
12/12/23	Evening	COMPO FLORANCE'S	DOTA	Mais.		Evening	V. Eleni Diya:	0 2:8 49	Form.
12/12/27	Night	SHEERA-D	0270	PIV-D	16/R(23)	Night	A ALBUIUS	0088	de
13/12/22	Morning	Sounday yan.k	0022	de	15/12/23	Morning	F. Cathoure	೦೨೦ಕ	F-c.
12/11/13	Evening	ARUN	2356	2	٠, ٠,	Evening	•		
13/2/2	Night	ARUN	2368	<u>*</u>		Night	ı	,	
14/12/02	Morning	Lucomp Ce	8 000	84	, 1	Morning	V	,1	<u> </u>
14/12/23	Evening	1 B. Vanishi 1 1.	0195	1 al	1.1	Evening		111 '	
H1222	Night	A- ALBINUS	BORB	10		Night			241
15/124	Morning	10. litalela	0)19	201		Morning		_	
15/12/21	C	B. Kanifort	0195	0/M		Evening			, 1
15/12/23		A. Anitha	0212	ام ي		Night			,

OPCAB XX GIRAPTS (VGI->PDA. LIMA >LAD OM (SEQ) SVGI -> DI TOM (SEQ)







MHI/ICU/2022/064

Every heart beat counts

MIS.SHANMUGAPRIYA S

45/Female/MHI202381078 11/12/2023/IPH202302475

NAME: DT.ANBARASU MOHANRAJ

DT.ANBARASU MOHANRAJ

RMEDIATE CARE FLOWCHART

A

UHID NO:

AGE:

SEX:

POSTOP DAY:

FLUID REQUIREMENT:

DATE	URINE		CHEST DRAINAGE				TOTAL	I.V. FLUIDS				ORAL/ R.T.		• .,	TOTAL	
& TIME	H.T.	G.T.		AIR LEAK	H.T.	G.T.	OUTPUT				H.T.	н.т.	G.T.	INTEKE	BALANCE	
14/12/2] m)														+	
07180												500	50	50	50	
08!30								•			low	्व।	150	150	150	
091.30	200	೨୭೦					200	_			loa	150	250	250	50	
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				_							_					
			_													
SPEC	SPECIFIC OBSERVATIONS/REMARKS								MEDICATION / DRUGS							
										`						

SX: OPCABX4GIRAFTS. SVGI > PDA.

LIMA > LAD

SVGI > DISOM

CSECIO.







Every heart beat counts

Mrs.SHANMUGAPRIYA S

45/Female/MH1202381078

11/12/2023/IPH202302475

NAME: Dr.ANBARASU MOHANRAJ

UHID NO:

AGE:

SEX:

SURGICAL FINOULDU....

POSTOP DAY:

RMEDIATE CARE FLOWCHART

FLUID REQUIREMENT: 1.54 day .

DATE	UR	INE	Cŀ	REST D	RAIN	AGE	TOTAL	I.V. FLUIDS				ORAL/ R.T.		TOTAL	TOTAL	
& TIME	н.т.	G.T.		AIR LEAK	H.T.	G.T.	OUTPUT				Н.Т.	н.т.	G.T.	INTEKE	BALANCE	
17:30	\$00	1600				20	1620 .			_			700	806	-814	
1830	120	1720				20	1740						700	8D6	934	
1913 ⁰	lo _O	1820				20	1840				<u>.</u>	100	800	906	934	
70.3D	130	1950				20	1970					150	950	1056	<u>-</u> 114	
21,30	150	2100	,			20	2120					200	ti So	1256	864	
22.30	100	2200				20	2220			KABI	A1E	(ઈઇ	(250	1356	864	
27.20		2330			 	20	2350			100	[00]	100	1350	1556	794	
00-30	100	2430				20	2450			૯૦૦	200		1350	1656	294	
1	l	2510				20	2530			(00	30°	200	1550	1956	574	
v36	10	2580				20	2600			(00)	400		1250	2056	544	
85 ⁷⁵ 0	l .	260				20	2680			(00)	\$00	_	1550	2156	524	
K-30	15	2735				20	2755					100	1650	2256	499	
5-30	R.	2735				20	2755					(00)	1750	2356	-399	
6,30		2135				20	2755							2506		
										_				· · · · · · · · · · · · · · · · · · ·		
					_											
SPEC	BECIFIC OBSERVATIONS/REMARKS Q 4.40 U-CATH REMOVED BODR. ANBARASU.								MEDICATION / DRUGS							
Q440 U-CATH REMOVED ISTUDY MASSICE																







Mts.Shanmugapriya s

45/Female/MHI202381078 11/12/2023/IPH202302475

NAME: Dr.Anbarasu mohanraj

110 AM 1831 DA 212 FIRE INCLUSION INCLUSION AND A FINIT INCLUSION AND A FINIT INCLUSION AND A FINIT INCLUSION A

BLOOD J.LUJ. .

HEIGHT: 16540

ERMEDIATE CARE FLOWCHART

В

UHID NO:

WEIGHT: 63149

AGE:

SEX:

B.S.A: 1-7m2

		НА	EMOD	YNAM	iics	,		RESI	P. PARAMET	TERS	INVESTIGATIONS /	
ТЕМР	H.R.	RHY.	ST.	B,P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA	
980	No	Sinu	0.00	92	45	همی	9 44	27/14	- d	944.	On Room Alr.	
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	[05	Stree	۵۵. 0	100	-81	loon	, 44-	28/~	tel	944	1	
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PREVIOUS DAY - HOURS 24HRS

DRAINAGE 20M

URINE 2735ml

TOTAL INTAKE 2506m 1

TOTAL OUTPUT 2755~ 1

BALANCE - 249m1







Mrs.SHANMUGAPRIYA S

RMEDIATE CARE FLOWCHART

NAME:

45/Female/MHI202381078 11/12/2023/IPH202302475

UHID NO:

AGE:

SEX:

Dr.ANBARASU MOHANRAJ

BLOOD C

165cm **HEIGHT:**

WEIGHT: 63Kg

B.S.A: |-7 m2 .

		HA	EMOD	YNAM	IICS	'	RESE	P. PARAMET	TERS	INVESTIGATIONS /	
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	INVESTIGATIONS / OTHER DATA
72·4	110	Skrið	' 'ما	1391 90	100	ween	XX	20	BL	98%	Room Air .
	los	1	0.03	1171	92	neu	+	22	RL dea	95%	Room Air.
	107	ટ(ઝપ્ટ	0.02			wan	4+	Zernst	cl	93/	
	103	Slang	0.00	13]	40	woon	4	sont	- 01	94%	
	600	<i>ج</i> ام الخ		L		ubon	++	28M	- c1	921.	
	104	SINU	0.03	2 k 18	88	work	`++	22.04	cl	961.	
	109	TACH.	0.00			الإسادي	4+	17mt	cl	924.	
_	(0)	567105	000	1246	92	wasa	++	l 8m	- 0(954	
	POJ	dung	اهره			voasm	ft	20ml	cl	96%	
	105	CINUS	0.00	121	86	108°	44	26m	બ	947	·
	106	5111/5	٥٥١			wasr	++	37 mt	cl	a17.	
	ره)	SINVS	o.ov	134	aa_	wash	4*	30mt	cl	947.	
	107	3 2005	0.09			work	+++	Bent	cl	93%	
		4 405		72	& 4	warer'	++	30mt	cl	981,	
						<u> </u>		ļļ			
					. '						

DRAINAGE URINE

PREVIOUS DAY - HOURS

TOTAL INTAKE

TOTAL OUTPUT

BALANCE

