

MRD CHECKLIST

	PARTICULARS	YES	NO
-	IP Number allocated to each Patient	5	
-	Name, Age & Sex of Patient	5	
_	General Admission Consent		_
-	Initial Assessment of Patient / Diagnosis	<i>✓</i>	
-	Nutritional Assessment by Consultant	<i>S</i>	
-	Plan of care counter signed by the Consultant	<u> </u>	
-	Treatment Orders - Date, Time, Name & Sign.	5	
-	Medication Order / Drug Chart - Date, Time, Name & Sign.		
-	Vital Signs Chart (TPR Chart)		
-	Intake Output Chart	<u> </u>	<u> </u>
-	Drug Chart (Duly filled)	<u>~</u>	
-	Anesthesia Consent - (8 thing) - Date, Time, Name & Sign. of both Patient & Anesthetist	5	
	Anesthesia Assessment Sheet	1	
_	Surgery Consent - (8 things) - Date, Time, Name & Sign of both Patient & Surgeon	\sim	
-	Surgery Notes - Post Operative Plan	5	
-	Pain Scoring System		
-	Blood Transfusion if done		-
-	High Risk Procedures		
-	A copy of the Discharge Summary	\(





Patient Details (Affix Label here) Ne Mr. VENKATACHALAM P

Uh 63/Male/MHI202381271 DO 27/12/2023/IPH2023002615

DO Dr.ANBARASU MOHANRAJ



MHI/IPD/2022/002

every heart beat counts

58476

27/423

Medway Hospitals

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)	MISSION SLIF	•	
Admitting Doctor: 1. The ral U	Speciality:	CA VS	
Advised Date & Time: 27 23 (Cu)12wpm.		
Provisional Diagnosis:	7		
CAD-TVD/	T2 DM /HTN/	old CNA	
Reason for Admission:	Surgical Mana	gement	
Others (please specify	details)		
Admission Type: Day Care E	R Ward	-	
icn	(Specify details)		
Surgery / Procedure Name (if planned):			-
	ABY.		
Blood Product Requirement: No Yes (Kindly	specify details of components	required in space below)	
			·
Expected Duration of Stay:	Lays		
Expected Cost of Treatment (as per Financial Counseling	ng Form):	THE STATE	
Payer: Self Insurance Others:		7 2 3 4 3	
Instructions to Nurse (if any):	.,	1_ 1\	el.
Ad	nit in	o vali is	- 4
Any other Instructions (if any):			
· · ·			
^			
\bigcap			
Doctor's Signatures u Mor Name	Reg. No.	Date	Time

Dr. ANBARASUAMOHANRAJ

For admission desk staff of	only:		. 1
	General Ward Single Room Twin Sharing Deluxe Room Suite Room Others		
Admission intimation	Receipt Details	Admission Ti	me in HIS
Date	Time	Date	Time
27/12/23	12.00m	27 12 23	12:19PM
To be filled only if Blood	OPD ER Direct requirement specified by the		
Front office Staff Signature	Name Soundwife	Emp. No.	Date Time 12:197 7.
		AHOI Lug	

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Patient D Mr. VENKATACHALAM P

63/Male/MHI202381271 Name: UHID:

27/12/2023/IPH2023002615 DOB: Dr.ANBARASU MOHANRAJ



MHI/HOSP/2022/129

ADMISSION FORM

Marital Status			. LAKEHMI NAGAR,		Telephone Number
Occupation	— 1 .	anthen, Chena	•		805614254
Referred from	a paraku				tal No. of Days
	thoraic c	MLC Yes	No If Yes AR	No. :	
		FINAL DIAGN	NOSIS		ICD Code
TRIPL	e VESSEL	- CORONARY AR	TTERY DISEASE, (EFT MAIN	125.1
D19	seAse, e	SPFORT ANG	INA, POSITIVE TO	· T	20.81 R94.3
ADE	QUATE	W SYSTOLIC	FUNCTION -Et:	547.	150.1
Type	I DIF	ABETES MELLI	TOS, SYSTEMIC	HYPERTEN	•
CHRON	vic OBI	STRUCTIVE	PULMONARY DIS	:eAse ,	JA4.9
OLD	(EREBRE	o VASWLARZ	ACCIDENT - PE	BRUARY	
DATE		OPERATION	/ PROCEDURES		ICPM Code
28/12/22	OPF CIRA		ONARY ARTERY 4 GRAFTS	BYPASS	36.14
DATE		TYPE OF	ANESTHESIA		
26/12/3/3	☐ GENERAL	- · □ SPINAL	LOCAL] REGIONAL	☐ EPIDURAL
			SCHARGE STATUS		
☐ Cured		☐ Discharge at Re	equest •		Expired < 48 hours
☐ Improved	Į.	☐ Against Medica	l Advice		Expired > 48 hours
☐ Unchang		☐ Absconded☐ Transferred to			Post-Operative Death
Dr. A	n parasu M Ray No: 55 of the Consult	lohanraj tant	Sig	nature of Med	dical Records Officer

AUTHORISATION FOR TREATMENT I PAYMENT

			J.
administer such drugs as may be necess	ary and to perform	such operat	dical, Staf f of the Hospital Investigate treat and ition under anaesthesia or other wise as may be my illness / patient with the start of the light
I hereby under take to settle all the bills for basis. In any case, I shall pay all the dues	•	_	ed to me/the patient named overleaf on a periodic n the hospital.
	•	•	above, I hereby authorise the hospital to transfer semed fit and proper by the hospital authorities.
	theis attendants h	ave been ren	ilations of the Hospital and that all cash, jewellery noved to a place of safety / handed over to the any loss.
I have read out and explained the conten		•	in his vernacular .
சிகீச்சை, பணம் செலுத்துதல் முதலியவை வ	சய்ய அதிகாரம் வழா	ங்குதல்	
		யப்பட்ட சோதன	ர்கள் எனக்கு /நோயாளி மனகளை செய்து மருந்துகளை கொடுக்கவும். மயக்க
மருந்துகள் கொடுத்து செய்முறைகள்/அறுண செலவுக்கன தொகை முமுவதும் செலுத்த இ		•	வழங்குகீறேன். நான் / இதீல் குறித்துள்ள நோயாளின்
, -	_, _, _,		கட்டத் தவறினால் என்னை நோயாளியை வேறொரு லை எனது உறவினர்கள் மூலமாக பெற நான் அதிகாரம்
மருத்துவமனையின் பொது சட்ட திட்டங்கள் ப	பற்றி தெரிவிக்கீப்பப்	டிருக்கிறேன்.	
-	•	_	வும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்லு நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை
மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக <u>்</u>	கப்பட்ட பிறகுதான் ச	തകധ്വെസ്വശില്	டேன்.
Vefte			OR D
செவிலியர் கையொ'பம்	தேதி	1	எனது/உறவினர்/காப்பாளர் கையொப்பம்
Signature of Admitting Nurse	Date 2	7/12/2	எனது/உறவினர்/காப்பாளர் கையொப்பம் - 🤊 Signature of the Patient / Relative / Gurdian

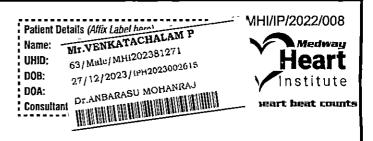
உறவுமுறை

Nature of Relationship









GENERAL CONSENT FOR ADMISSION

I, MP. Verlandschalam — the Patient or Representative of patient have (please tick the correct option above and below)
(please tick the correct option above and below)
☐ Read
Been explained this consent form in English, which I fully understand.
I give my full consent and authorization for admission and treatment at this hospital. The proposed treatment plan has been explained to me.
 I consent and authorize the hospital, treating doctors, nursing, technical and paramedical staff to provide relevant care and to conduct diagnostic as deemed necessary by the treating doctor/team.
 I also consent to use of assistants such as resident doctors, other doctors, nurses, and other healthcare workers by the hospital and treating doctor/ team.
 I consent for clinical consultation, admission, disclosure of information required for clinical management (under confidence), routine medical examination (physical examination, palpation, percussion, auscultation), routine lab and imaging investigations, general nursing care, diet and physiotherapy assessment and counselling.
 I have been explained about the proposed care plan, expected result(s), possible outcome(s) and expected cost of treatment/ hospital stay.
 I understand that the hospital will take due care of me / my patient but, that there is always a possibility of an unexpected complication(s) which may necessitate longer stay and / or use of intensive care services. In such cases, procedure different from those contemplated and other intervention(s) may sometimes be needed.
 I declare that, I have and will inform the doctor of my medical history including previous illnesses, allergies, drug reaction(s), surgical procedure, relevant medical family history and all other facts relevant to my treatment. I shall not hold the hospital/ doctor responsible for any consequences which may arise due to non-disclosure of relevant information on my part.
I declare that I have been explained about my rights and responsibilities.

- I have been made aware of the rules and regulations of the hospital including those related to security and I promise to abide by them.
- I understand that in case of some unexpected event occurring during the course of my stay I may be suggested a transfer to another hospital / healthcare organization, as considered appropriate by my treating doctor.
- I understand that, drugs, consumables and devices will be charged on an 'as actual' basis as per the hospital tariff. I have been informed and I understand that there can be usage of certain reprocessed items during the course of the treatment. I also understand that only full strips of medicines shall be issued and returned. I declare that I take full responsibility of settling the bill before leaving the hospital premises at the time of discharge.

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

	Signature / Thumb Impression*	Name		Pate	•	Time
Patient	Vulatchelan.	VENKATACHALAM P	27	12/	23	12:50
Surrogate/Guardian (if applicable #)		Mpresh V (Son) (Write name and relationship with patient)	27	B	/2:	12:6
Reason for surrogate consent	Patient is unable to give consent l	because:		1	1	·
Witness	bono	MEGNAKSHI V	27	/12	23	12:19
Interpreter (if applicable)	-					

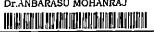
^{*} Right Hand for Males & Left Hand for Females | # Only if Patient is a minor or unable to give consent



Mr.VENKATACHALAM P

63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.Anbarasu mohanraj





	ADMISSION CRITERIA FOR INTENSIVE CARE UNIT		
S. No.	PARAMETERS	MARK APPRO	
	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		
١,	Mean arterial pressure less than 60 mm Hg		
i	Diastolic arterial pressure more than 120 mm Hg	· .	
	Respiratory rate more than 35 breaths/minute		
	Cardio-vascular System		
	Acute myocardial infarction		
	Cardiogenic shock		
	Complex arrhythmias requiring close monitoring and intervention		
	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		
	Post cardiac arrest -		
Į	Cardiac tamponade or constriction with hemodynamic instability		
	Dissecting aortic aneurysms		
į	Complete heart block		
	Miscellaneous Conditions		
3	Septic shock with hemodynamic instability		L
٠ ا	Hemodynamic monitoring		
	Clinical conditions requiring ICU level nursing care		
	Post procedure elective admission		
4	Post Coronary Angioplasty		
	Post Cardio-vascular Surgery		
	Following angiographic procedure		
	Complication resulting from the angiographic procedure including any significant change in pulse in the 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		
Į	Acute respiratory failure requiring ventilatory support (Invasive / Non-Invasive)		
ĺ	Pulmonary emboli with hemodynamic instability		
6	Patients in an intermediate care unit (HDU / Recovery room) who are demonstrating respiratory deterioration		
ļ	Need for nursing / respiratory care not available in such intermediate care units		ļ
ļ	Massive hemoptysis		<u> </u>
	Respiratory failure needing imminent intubation		
	Renal failure		I
٠,, ا	Oliguria or anuria for more than 12 hours		
7	Metabolic acidosis (pH <7.1)		
, J	Patients requiring hemodialysis can be performed in ICU when the blood pressure is borderline		

S. No.			RK ✓ AS OPRIATE			
8	Diabeti insuffice Thyroic Hyperc Other e Severe hemod Hypo o mental Hypo o muscu	iency, or severe acidosis I storm or myxedema coma v ismolar state with coma and/ indocrine problems such as hypercalcemia (Serum C ynamic monitoring r hypernatremia (Serum Soc status r hypermagnesemia with he	with hemodynamic instability, altered with hemodynamic instability for hemodynamic instability or Serum Gluadrenal crises with hemodynamic instability alcium more than 15 mg/dl) with altered with hemodynamic instability alcium more than 15 mg/dl) with altered with the modynamic compromise or dysrhythmia: ssium less than 2.0 mEq/L or more than 6	cose more than 800 mg/dl lity ered mental status, requi 55 mEq/L) with seizures, alte	iring ered	
Do	Signature Name Reg. No.					Time
		8-	Dr-prave	er 112216	28/12/2	18.3

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	. 7
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	y
7	No signs of bleeding and hematoma at puncture site	
8	End of life care pathway chosen	

	Signature	Name	Reg. No.	Date	Time
Doctor		_		, ,	
	8	Dr. museer	172216	30/12/23	10.00





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



DISCHARGE SUMMARY

IP No.

: IPH2023002615

D.O.A

: 27/12/2023

UHID

: MHI202381271

D.O.D

: 02/01/2024

Name

: Mr. VENKATACHALAM.P

Room No.: 105

Age / Gender : 63Years / MALE

Consultant

: Dr. Anbarasu Mohan Raj, MS, DNB, M.Ch (CTVS), FRCS (Glasg)

Director and Clinical lead - Cardio Vascular and Thoracic Surgery

D.O.S: 28.12.2023

DIAGNOSIS:

TRIPLE VESSEL CORONARY ARTERY DISEASE

LEFT MAIN DISEASE

EFFORT ANGINA

POSITIVE TMT

ADEQUATE LV SYSTOLIC FUNCTION – EF: 54%

TYPE II DIABETES MELLITUS

SYSTEMIC HYPERTENSION

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

OLD CEREBRO VASCULAR ACCIDENT – FEBRUARY 2023

SURGERY:

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 4 GRAFTS: LIMA TO LAD, SVG TO OM, PDA TO PLV (SEQUENTIAL) DONE ON 28.12.2023

BRIEF HISTORY:

Mr. Venkatachalam.P, 63 years old male, a known case of Type II diabetes mellitus, Systemic hypertension, Chronic obstructive pulmonary artery disease, Old Cerebro vascular accident - February 2023, Effort angina, Positive TMT, Left main disease + Triple vessel disease, Good LV systolic function, has come for CABG. Patient was apparently normal till 1 month ago when he developed breathlessness on exertion which progressed to NYHA class III. Initially, he went to nearby clinic where his TMT was positive for inducible ischemia. He was advised Coronary Angiogram. He went to Rela Hospital and underwent Coronary Angiogram which showed Left main disease + Triple vessel disease. He then came to Medway Heart Institute on 13.12.2023 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, he is getting admitted for the same. No H/O Chest pain, Palpitations, Syncope or Swelling of Legs. No H/O CKD or Hypothyroidism.

#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel: 044 - 4310 8959 MedwayHospitals (C) @medwayhospitals in @medway-hospitals @medwayhospitals

Medway Centre of Excellence (Chennai)

94457 94457 1800 572 3003

Kodambakkam 044-2473 4455

Mogappair

Kumbakonam 044-26530011 | 044-2473 4455 |

Medway Group of Hospitals

Chengalpattu 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





NAME: Mr. VENKATACHALAM.P

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

TEMP

97.2° F

HR

74bpm

BP

140/70mmHg

SPO₂

96% in room air

CVS

S1S2(+)

RS

BAE (+)

Abdomen

Soft, BS (+)

CNS

Moves all 4 limbs, Bilateral – pupil reacting to light (+).

UHID: MHI202381271

BLOOD INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	12.6	Male: 13.7 - 17.5	gms%
		Female: 11.2 - 15.7	
HAEMATOCRIT	37.3	39-52	%
TWBC	8900	4000 - 10000	Cells/Cumm
NEUTROPHILS	74.4	40-70	%
LYMPHOCYTES	20.1	20 - 40	%
EOSINOPHILS	1.2	0 - 6	%
MONOCYTES	3.8	0 - 6	%
BASOPHILS	0.5	0 - 2	%
PLATELET	275000	Male: 1.5 - 3.5	Cells/Cumm
		Female: 1.5 - 3.7	_
Urea	25	14 - 40	mgs/dl
Creatinine	0.81	Male: 0.7 - 1.2	mgs/dl
	,	Female: 0.5 - 1.0	
		Child: 0.2 - 0.8	
Sodium (Na+)	134	135 - 145	mmol/l
Potassium (K+)	5.50	3.4 - 5.5	mmol/l
T. Bilirubin	0.38	0.2-1.0	mg/dl
D. Bilirubin	0.17	0.00 – 0.4	mg/dl
I. Bilirubin	0.21	0.4-0.6	mg/dl
S.G.O.T	14	<38	U/L
S.G.P.T	12	<41	U/L
ALP	82	Adult: 42 - 141	U/L
GGT	13	Male : 10 - 45	U/L
		Female: 5 - 32	
Total Protein	6.5	6.0 - 8.0	gm/dl
S. Albumin	4.5	3.5 - 5.0	gm/dl

B	#9, 1st Main Road	l, United India Colony, Ko	dambakkam, Chen	nai - 600024:	Tel: 044 - 4310 8959

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Medway Group of Hospitals Kodambakkam

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MHI/HOSP/2022/118





(A Unit of United Alliance Healthcare Pvt Ltd) IPNO: IPH2023002615

NAME: Mr. VENKATACHALAM.P

UHID: MHI202381271

PROTHROMBIN TIME	10.3	Normal: 0.9 - 1.5 INR Therapeutic Level Myocardial Infarction: 2.0 - 3.0 Deep Vein Thrombosis: 2.0 - 3.0 Pulmonary Embolism: 2.0 - 3.0 Artificial Cardiac Value: 3.0 -4.5	
INR	0.8	Recur.Systmic Embolism: 3.0 - 4.5 INR	
НВА1С	6.4	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	1.74	Adult: 0.25 - 5.0 New born-4days: 1.0-39.0 Child upto 14yrs: 1.0-9.0	ulU/ml
Т3	73	"Adult: 60 - 152 New born - 4 days: 96 - 730 1 - 11 Months: 102 - 243 1 - 9 yrs: 89 - 237	ug/dl
T4	10.1	"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: HR – 70bpm, sinus rhythm, RBBB.

ECHO: ALL CHAMBERS NORMAL SIZED, REGIONAL WALL MOTION ABNORMALITY PRESENT – BASAL INFERO SEPTUM HYPOKINETIC, ADEQUATE LV SYSTOLIC FUNCTION – EF: 54%, AORTIC GRADIENT – MAX GRADIENT – 3 MM HG, MEAN GRADIENT – 2 MM HG, GRADE I DIASTOLIC DYSFUNCTION, NORMAL RV SYSTOLIC FUNCTION, RV TDI: 11CM/S, TAPSE: 18MM, IAS / IVS INTACT, AORTIC VALVE SCLEROSIS, TRIVIAL AR, NO AS, OTHER VALVES ARE STRUCTURALLY NORMAL, TRIVIAL MR, TRIVIAL TR, NO PAH, IVC NORMAL IN SIZE AND COLLAPSING, NO CLOT / VEGETATION / EFFUSION.

CAROTID DOPPLER: SOFT PLAQUE NOTED IN BOTH CCA, CALCIFIC PLAQUE NOTED IN LEFT CAROTID BULB EXTENDING TO LEFT ICA ORIGIN, LEFT ICA ORIGIN SHOWS 50 % DIMENSIONAL STENOSIS, LEFT CAROTID BULB SHOWS 33 %, DIMENSIONAL STENOSIS, NORMAL BILATERAL VERTEBRAL DOPPLER STUDY.

<u>CAROTID AND VERTEBRAL ARTERIES DOPPLER</u>: BILATERAL INCREASED INTIMA MEDIAL THICKNESS IN COMMON CAROTID ARTERIES, NO SIGNIFICANT STENOSIS OR OCCLUSION SEEN IN CAROTID AND VERTEBRAL ARTERIES ON BOTH SIDES.

#9, 1st Main F		dia Colony, Kod medwayhospitals			_	Tel : 044 - 4310 8959 @medwayhospitals	94457 94457 1800 572 3003
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Kodambakkam 044-2473 4455	Mogappair 044-26530011	Kumbakonam 044-2473 4455	Chengalpattu 044-27426829	Villupuram 04146-24200	•	Heart Institute 044 - 4310 8959	Institute of Pulmonology 044-2473 4454
E-mail: info@med	lwayhospitals.com	Website : www.me	dwayhospitals.com	CIN : U74900TN	1201	1PTC083665	MHI/HOSP/2022/118





(A Unit of United Alliance Healthcare Pvt Ltd) IPNO: IPH2023002615

NAME: Mr. VENKATACHALAM.P

UHID: MHI202381271

MRI – BRAIN: ACUTE INFARCT MEASURING ~ 10 X 5 MM RIGHT THALAMUS, NO EVIDENCE OF HEMORRHAGE / MIDLINE SHIFT NOTED, MILD AGE RELATED ATROPHY CHANGES, MILD PERIVENTRICULAR SMALL VESSEL ISCHEMIC CHANGES, CHRONIC INFARCT SEEN IN HEAD OF RIGHT CAUDATE NUCLEUS.

CXR: PA film, lung fields clear.

COURSE IN THE HOSPITAL:

Mr. Venkatachalam.P, 63 years old male, was admitted with above mentioned complaints. He underwent OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 4 GRAFTS: LIMA TO LAD, SVG TO OM, PDA TO PLV (SEQUENTIAL) ON 28.12.2023. He was shifted to SICU with stable hemodynamics and nil supports. He was extubated on the next day (29/12/2023) at 8.45 am. Drains were removed on POD1 (29/12/2023). He was shifted to ward on POD 2 (30/12/2023). Suture removal was done on POD5 (02/01/2024). Patient course in the hospital was uneventful. His medications are optimized and he is being discharged in a stable clinical status.

CONDITION ON DISCHARGE:

HR

94/min

BP

150/70mmHg

SPO₂

94% in room air

POST OP INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	8.2	Male: 13.7 - 17.5	gms%
	<u> </u>	Female: 11.2 - 15.7	
HAEMATOCRIT	24.3	39-52	%
TWBC	9810	4000 - 10000	Cells/Cumm
NEUTROPHILS	82.5	40-70	%
LYMPHOCYTES	13.0	20 - 40	%
EOSINOPHILS	0.4	0 - 6	%
MONOCYTES	4.0	0 - 6	%
BASOPHILS	0.1	0 - 2	%
PLATELET	183000	Male: 1.5 - 3.5	Cells /cumm
		Female: 1.5 - 3.7	
Urea	19	14 - 40	mgs/dl
Creatinine	0.76	Male: 0.7 - 1.2	mgs/dl
		Female: 0.5 - 1.0	
		Child: 0.2 - 0.8	
Sodium (Na+)	128	135 - 145	mmol/l
Potassium (K+)	4.09	3.4 - 5.5	mmol/l

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UHID: MHI202381271

NAME: Mr. VENKATACHALAM.P

ECG: HR – 70bpm, sinus rhythm, RBBB.

ECHO: S/P CABG, CONCENTRIC LVH, ALL CHAMBERS NORMAL IN SIZED, REGIONAL WALL MOTION ABNORMALITY PRESENT - BASAL INFERO SEPTUM HYPOKINETIC, ADEQUATE LV SYSTOLIC FUNCTION, EF: 55%, NORMAL RV SYSTOLIC FUNCTION, TAPSE: 16MM, AORTIC VALVE SCLEROSIS, OTHER VALVE STRUCTURALLY NORMAL, IAS/IVS INTACT, IVC NORMAL IN SIZE AND COLLAPSING, AORTIC GRADIENT - MAX GRADIENT - 3MMHG, MEAN GRADIENT - 2MMHG, GRADE II DIASTOLIC DYSFUNCTION, TRIVIAL AR, NO AS, OTHER VALVES ARE STRUCTURALLY NORMAL, TRIVIAL MR, TRIVIAL TR, NO PAH, MODERATE LEFT, MILD RIGHT PLEURAL EFFUSION, NO CLOT/ VEGETATION/ PERICARDIAL EFFUSION.

CXR: PA film, sternal wires seen, lung fields clear, no effusion.

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Villupuram 04146-242000

Heart Institute 044 - 4310 8959





NAME: Mr. VENKATACHALAM.P

UHID: MHI202381271

Every heart beat counts (A Unit of United Alliance Healthcare Pvt Ltd) IPNO: IPH2023002615

ADVICE MEDICATIONS:

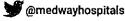
Sl	NAME OF THE DRUGS	-		FRE	OUEN			RELATIONSHI		
NO.	WITH GENERIC NAME	STRENGTH	DOSAGE	M	A	N	ROUTE	P WITH MEAL	DURATION	
1	TAB. CLOPITAB A (CLOPIDOGREL + ASPIRIN)	1 TABLET	75MG / 75MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE	
2	TAB. ROSUVAS (ROSUVASTATIN)	1 TABLET	40MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE	
_ 3	TAB. BETALOC (METOPROLOL)	1 TABLET	50MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE	
4	TAB.LASILACTONE (FURSEMIDE + SPIRONOLACTONE)	1 TABLET	50MG/ 20MG	1/2	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	CAP. RAZO D (DOMPERIDONE + RABEPRAZOLE)	1 CAPSULE	20MG 30MG	1	0	1	ORAL	30 MINUTES BEFORE FOOD	X I WEEK	
7	TAB. LIVOGEN (FOLIC ACID + FERROUS FUMARATE)	1 TABLET	1500MCG + 152MG	1	0	0	ORAL	AFTER FOOD	X 30 DAYS	
8	SYP. CREMAFFIN PLUS (SODIUM PICOSULFATE+ LIQUID PARAFFIN + MILK OF MAGNESIA)	15ML		0	0	1	ORAL	AFTER FOOD	BED TIME (IF CONSTIPATI ON)	
9	TAB. BEPLEX FORTE (ANTIOXIDANTS +MULTIVITAMINS+ MULTIMINERALS)	1 TABLET		1	0	0	ORAL	AFTER FOOD	1 MONTH	
10	SYP ALEX PLUS (DEXTROMETHORPH AN HYDROBROMIDE + GUAIFENESIN + PHENYLEPHRINE + CHLORPHENIRAMIN E MALEATE)	10ML		0	0	1	ORAL	AFTER FOOD	BED TIME (1 WEEK)	
11	TAB.ANXIT (ALPRAZOLAM)	1 TABLET	0.5MG	0	0	1	ORAL	AFTER FOOD	X 5 DAYS	

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Villupuram 04146-242000

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

MHI/HOSP/2022/118

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





UHID: MHI202381271

DIABETIC MEDICATIONS:

NAME: Mr. VENKATACHALAM.P

Sl.	NAME OF THE DRUGS	STRENGTH	DOSAGE	FREQUENCY			ROUTE	RELATIONSHIP	DURATION
NO	WITH GENERIC NAME	SIRENGIN	DOSAGE	M	A	N	KOUTE	WITH MEAL	DURATION
1	TAB, METFORMIN	1 TABLET	500MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. DIAMICRON XR MEX (GLICLAZIDE + METFORMIN)	1 TABLET	60MG/ 500MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. VOLIBO – R (REPAGLINIDE + VOGLIBOSE)	1 TABLET	0.3 MG/ 1.0MG	1	1	0	ORAL	AFTER FOOD	TO CONTINUE

DISCHARGE ADVICE					
DIET	HIGH PROTEIN, LOW SALT				
	LOW FAT AND DIABETIC DIET				
PHYSICAL ACTIVITIES	RESTRICTED.				
FLUID RESTRICTION	NIL				
-	REVIEW WITH				
REVIEW	DR. ANBARASUMOHANRAJ AFTER				
	09/01/2024 WITH FBS, PPBS, HB, 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: Kalai

CONSULTANT SIGNATURE

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 discharge summary."

Dr. ANBARASU MONANCAL HE TY, mangeris) Director & Clinical Lead Cardio Vascular and Thoracic Surgery Medway Heart Institute, Chennai-24 Reg No: 55476

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Mr.VENKATACHALAM P 63/Male/MHI202381271

63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.Anbarasu mohanraj





INPATIENT INITIAL ASSESSMENT

Date: 27 12 23 Time of arrival in ward: 13.00.
Allergies (if Yes, specify details):
Drugs Yes No
Blood Transfusion
Food
Others
Vital Signs: Temp: 14-2(°F) Pulse / HR: 14 m (beats/min) BP: 140/70 (mmHg) Respiration: 20 m/breaths/min) SpO ₂ : 9b (%) Height: 16 (cms) Weight: b((kgs) BMI: 21-b (29 m²)
Pain: Yes No. If Yes, Score: 0 10 Pain Scale Used: Numerical Rating Scale (>12 years) CPOT (ventilator / comatose) Duration: Location:
Pain Character: Dull Aching Sharp Stabbing Shooting Burning Referred / Radiant Pain
CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS
- Pt. came to 01210 with Wo-SOR, NWHA III
anounceted i chest pours, ten days back.
- H/o- CAG-done, shows TVD, advised for
CARG, PE. gobs admitted here for futher margames
PAST MEDICAL HISTORY (with duration of illness)
Diabetes Mellitus: ✓ Yes ☐ No. If Yes, duration: ☐ Yes ☐ No. If Yes, duration: ☐ Yes ☐ No. If Yes, duration: ☐ Yes ☐ No.
Others: H/o-Tzpm on R. H/o-EATH on Rx.
H/0- CAG dom, (27/12/28). NIKINO-typothyroidin /
Past Surgical History: (20/03/23)
Past Surgical History: (20/03/23)
No oy pregion rigical history.

Pre	esent Medication (for Medication R	econcilia	ation):			· · · · · ·
S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during: hospital stay
1.	T- PROLOMET	503	Plo	1-0-0	27/12/23	⊠Yes □ No
2.	T. PROLOMET C. POZA GOLD 20		pe la	00-1	23/12/23	☐ Yes ☐ No
ع.	T. IMDUR 30	30	P/0	1-000	27/10/23.	Yes □ No
	• •					☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
					,	☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
				_		☐ Yes ☐ No
Lif	rsonal / Social History (<i>Tick which</i> lestyle: ☑ Sedentary ☑ Active noking: ☑ Yes ☑ No Alcohol		ation:		ıl Drug Use: ∐ Yes ∐ I	
	hers:	<u>, </u>		<u> </u>		,
Mer	nstrual and Obstetric History (to b	e filled u	o for fema	le patients):		*
	· · ·	•			· .	<u>.</u>
	eneral Physical Examination		_			
1			es ∐-No ¹ _		Clubbing: Yes	∐ No
Ed	ema: □ Yes □ No Lym	phaden	opathy: []Yes ∏No		

•

SYSTEMIC EXAMINATION
cvs: s cvs: s cvs:
Respiratory System: 21: BAE T
Gastrointestinal System:
Central Nervous System: CM1: Moves all (4) links
Contral Nervous System: CMs: vwoves all (4) limbs B/L-pupil really to light a
Urinary / Reproductive / Locomotor System:
- Normal.
Skin / Opthalmic / ENT
Suspected of contagious disease: Yes No Immuno compromised status: Yes No Isolation required: Yes No, if yes, Contact Airborne Droplet
Psychological Evaluation: Normal Anxious Depressed Others:
Nutritional Screening (ESPEN Guidelines for Nutritional Screening - NRS 2002):
Weight loss within the last 3 months? ☐ Yes ☐ No Is the patient severely ill? (e.g. in Intensive Therapy) ☐ Yes ☐ No
Reduced dietary intake in the last week? ☐ Yes ☐ No Is the BMI < 20.5? ☐ Yes ☐ No
Interpretation: Yes: If the answer is "YES" to any 2 questions, the patient is at nutritional risk No: If the answer is "NO" to all questions, the patient is at Normal and not at risk
Provisional Diagnosis:
Triple Youel diceann (SHIM (TIPM.
Plan of Care:
CARG. Ar GA

	<u> </u>					1 20	
Investigations Ad	vised:						
	Republs er	reloved				, , , , ,	
Diet Advice:							
☐ Nil per Oral	Clear liquid diet	Normal liquid	d diet	☐ Diabetic	liquid diet		
Semisolid diet	☐ Soft solid diet	South Indian	normal diet	☐ North Inc	lian normal c	liet	
□ Neutropenic liquid	diet [] Others:					_	
Early Discharge Plan	ning (fill in those which are a	appropriate at this	s stage):	PFE: Pa	tient Family I	Education	
Special support need	led at home	☐ Yes ☑ No	If Yes, PFI	E done			
Home equipment ant	icipated	☐ Yes ☑ No	If Yes, PFE done and equipment advised				
Physiotherapy at hon	ne anticipated	□Yes☑Ño	If Yes, educated on physical limitations, if any				
Wound care needs a	nticipated at home	□Yes,☑No	If Yes, educated on signs on infection				
Pain Management		☐ Yes ☑ No	If Yes, PFE done and medication advised				
Special Dietary needs	6	□ 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	on need, i.e.:	□ Yes □ No	If Yes, PFE done				
Nature of post hospit infection control, fall r	al needs like patient safety, isk, etc, addressed	☐ Yes ☐ No	If Yes, specific education given				
Others:							
		/					
	Signature	 Name		Reg. No.	Date	Time	
Resident Doctor	101 ADED		redlyfin	N 16538J	27/12	1400	
Consultant	DR. ANDA	/p	55976	Q8/12/23	08:00		
Patient Attendant	100ha	Relationship Wid	e . V	_	24/12/23	13.00	

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DOCTOR'S PROGRESS NOTES

	DOCTOR 3 PROGRESS NOTES
DATE	NOTEȘ _.
77/12/2	S/B Dr. Mohamed Hydros
A	
John.	CAD-TVD/T2Dm/HTN
1	Plan: CABG VGA
	- homoron -
	Patient Consiens
	ariented.
	Vitals Stable
	Slable
	CUS-2 St St D
	Plans 80/t, NT
,	Plas 80/t, NT
, :	
	Atr
	-Manidor udal
	- Po fllow dung
	Chart
·	- NRo from
	Kam
	- Consent Obtaines - Parts & Prepotation
	- Parts & Prenatality
<u> </u>	Do
	(herro))

DATE	NOTES
	
28/15/2023	Prot. Venkara chalam 034 110 (Inderwen)
@ 18.80	opens x 4 grafts.
<u>-</u>	the was Shifted to sien & following homodynamics
	HR - 72 Bpm
<u> </u>	Bp -152/46 mm Hg
	CNP - 11 MMHg
·	Spo ₂ - 100 %
	vontilator;
	mode: Vev pla: 60% peep: 5 months
	suppoints:
	NIL
<u> </u>	plan'
	continue ventilation cover night)
	· ·
	pA. Kanteika Shef. (PIHIO216
	Do Anharase
	DA. Kartlika
	(P1H1026
	, \
	<u> </u>
<u></u>	

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DOCTOR'S PROGRESS NOTES

	DOCTOR'S PROGRESS NOTES
DATE	NOTES
29/12/2023	8/B: Dr. Anhaeasee /pro Rayesh / pro pravoon
@8.00	
	SIP: opene x 4 grafts.
PODITI	patient on ventilation: mode-ps/cpap
ND - 6.1	O[6 / cons-cious, Oriented, Adebrile
u - 23	BP-176/60 mmHg
cr - 0.9	HR-Ino BPM
ra - 139	·spo loov- on ventilator
K-3.51	In - 1595 ml/ 1420 ml; Bal (+) 175 ml
	on ucath
RB - 144 mg	_
<u>BBY</u>	· periphenies want
	Supports: all
Plos - 32-7	Intal drain: 290ml
po 221.0	<u>plan</u>
H100 - 22.8	· RF - 2,2 litres [day
38 - WO.1	· Good chest physic
	· Extubation
	· Remove drains & antexy lene
	mobilize
· · · · · · · · · · · · · · · · · · ·	· Nebulization & spirometry
	T- RASUVASTATIN 40mg 0-0-1
	7. HETOPROLO1 25mg 1-0-1
	Restant Offer
	· Krep han here boday.

,	
DATE	NOTES
30/12/2013	S/B DR Anharoso IDR Rajesh IDR Pravcem
3012	DOD-11
	SIP OPCIABX LIGIUITS.
Hb - 9.0	Dutront coscious, orrented i afebrile.
vorg - 290	Bp: 118/70 mm 144
C100 6-74	HR: 94 6pm
Nat - 129	5/70: 94% Ontoom air.
1ct - 4.19	I/o: 2918me / 2640ml. balance +278ml.
	Self varded
R135 -155 mg/dl	Tolerating oral feeding
0	Theriphones felt warm
	Eujipails Nill
	· · · · · · · · · · · · · · · · · · ·
	• •
	· · · · · · · · · · · · · · · · · · ·
.*	· · · · · · · · · · · · · · · · · · ·
-	
-	- RF 2-2 litra / day
	- chast Physic + Spramality
	· Hobilere
-	Nebulsie
	Rinare lones
	· Suff to wood.
	Carrier -
	1223









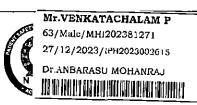
DOCTOR'S PROGRESS NOTES

DATE	NOTES
30/12/23	118 - Dr. Sis Elango (Dino)
	- 12t- received in ward.
10:300m	1200-11 -112-012 CAB X4 Gorafts
	10 11/2 - T2 Day 104 5 1
PP-101 mis	
80-120/40m	9 DIE: convau, oventod, afebrile.
80-1-1	yor pain over Ex eilE.
PE-20 (nin	
SPU2-1007) -c/e;
	WC: 5, 620
_	121 : BAED
	P/4: 50/h
,	
	Advice:
	-RF 2-24= day.
	- Check phys to + opinonel
	- To mobiline the pt.
	- Followy, dy cloub
	Ely.
-	17000
	·

DATE	NOTES
30.12.23	5/B Do- Anusuya
2.30pm	3/p openbx 3gouts
(22)	potient devieus
- 40g	ols patient conscious, oriented
1000 J	DIE CUS-5152 (P)
150.1	B - BAEP)
	CNS—NEAD
	P/n - 609to, non-tender.
	46: Dressing intact
	no 860 kage
	vitals: HR -80b/M
	BP - 130 / 80mm Hg RR - 18 min
	8/2-98/-RA
-	Advice -
	- monetos vitals
	- confinue the days as for chara-
8.0	- W/F feverspikes destruktion dehydration,
K, M	
(3470)	









DOCTOR'S PROGRESS NOTES				
DATE	NOTES			
30/12/23	S/B Dr. Mohamed Gydnom			
John	Post OP case of CAISG x3 grafts PDD-2 Patent Gurun Orniented Afebrile			
	Po.D-2.			
Patent Course				
	Dr. h <0			
	who ha			
	Vitala CVS-> GS2D.			
	Marie Cres Siszer. Non BAEB. Plans St. NI			
	P/A-> 8/t, NT			
	<u>.</u>			
	Dan			
	Monster vibels No Beland dup			
	_10 Bland onf			
	- Mobiline the Rahant - Mebalinadón Guran			
	·			
	Cum			
	(Dellie)			
	·			

	DATE	NOTES
	31.12-22	3 B Dr. Anusuya
	2019	
/	1.1	P OPCABX 3900+B
		Patient reviewel.
	007-3	00' fever with chills
	YV	8) nausea
X		0/5! Patient conscious, mented Attebrile.
		SE. CVS-6,620
		RS - BAED
		CNS - NEND
		P/n - 607t, non-tender
		1/8. Does in intact
		Vitals! HR - 82b/m
		BP - 110/80mm Hg
		RR - 18 min
	1	SP02 - 98/RA
		Advig
	· .	- monitor vi-tall
	Who have	- Confinue the days as peachast - mobilise the patient.
	K 1900	- mobilise to patient.
	100	- confinue the phast physio & spisometry
		<u> </u>
		,
		<u> </u>







Mr.VENKATACHALAM P 63/Malc/MHI202381271

63/Malc/MHI202381271 27/12/2023/IPH2023002615

Dr.Anbarasu mohanraj

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DOCTOR'S PROGRESS NOTES				
DATE	NOTES			
011/24	S/B DO. ANWAYO			
10.00	S/D OD CAB			
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	patient reviewed.			
	CD, AGNOX			
PO.D-A				
	9/E' CM3-5162P			
- Alable	Rs-BAED			
VHOW SOM	HE! Doessing Cotact			
	no boalcage.			
	Advice			
	Continue the same			
	plan: SR. on tombosow			
1000	- mobilise the patient			
TO LOCAL	CONTINUE Chest Physio 8/			
	sprometry.			
	' '			

DATE	NOTES
	SB Dr. Wohemed yours
1/1/24	
-(111	
John	Post OP case of OPCAB X 3 grafts
	PoD- 4.
	Rattent Consieur
	Pattent consieurs anenteel
	Ofebrile.
	CUS -> S, SZ. P
	(05-201220)
	Stable: P/A > 8/t, NT
	P/A Soft, NT
	Dow
	- Mondor Wall
	a ell a
,	Change
	-10 12 RAMP
	Immeration !!
	- To Lo Person Investigation S C 4, S C HO CX R I Phonomore Phonomore
	1 PAn
	Plan (Da Jones)
	46.600
	(6000)
٤	
 -	

MMC - POC - 2102



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

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

	Mr. VENKATACHALAM P PRE-OPERATIVE CHECKLIST		•
Name	63/Male/MHI202381271 27/12/2023/IPH2023002615 Age: Gender: UHID	No.: <u>2</u> @5	1381271
Ward	Dr.Anbarasu mohanraj Bed No.: 1011-19	B.S.	A.S.
	Clinical Diagnosis:	V	
	Proposed Procedure:		
_	CHECKLIST		
1.	Identification Band on Hand Checked?		
2.	Surgical consent Signed? a. Special Consent signed if required.	/	
3.	Anesthetist Consultation (If required?)		
4.	History AND Physical Onchart? a. Height	\	
5.	Allergic to drugs? KIOA		
6.	Surgical Preparation done?		appersion
7	Nill by Mouth From5::00		
8.	Blood Grouping & Rh Typing D DOSITIVE	<i>'</i>	
9.	Investigation X - Ray		
10.	Blood Sugar=23 mald) Time: (9.30	~	
11.	TPR Chart Pulse ## Temp 966 BP 1110 % RR 20		·/
12.	Time Voided a. Retention ☐ Yes √☐ No		cast follows
.13.	∴ Enema □ Yes □ No		

14.	a. Prosthesis Removed		
15.	Valuables and Jewellery Removed ☐ Yes ☐ No Secured ☐ Yes ☐ No		
16.	Pre-Operative Medication Admistered	V	
17.	Blood Transfusion requisition Onchart	V	
18.	X-Ray 1 CAG poport No (1) Gurotid topplar	RiDont-Si	:
	ECG/ECHO 1 Screening Colo Paport S(1)	~	
	Ultra Sound 150 Report 10 apples Study >0	D ~	/
	C.T. Scan		
	MRI Scan	~	
	TMT		
	Medication		
	27 12 23		
	T. PANLHOMG ? GIVEN		
	TALPRAX D'SMG AT 21.00 PA	~	/
	28 12 23		
	T. PAN HOMO 7		,
	Others		
	T. ALDRAX O.SMG JAT 21.00 PRITO	~	

Nurse Signature







MEDWAY HOSPITALS CARDIAC SURGICAL CHECK LIST

Name Mr. Venkatachelom-H	Age 63/H UHID MHT202381241
Diagnosis Effort angina / Positive TNIT/ Ct. Main + TVD:/ Good	Plan CABG.
Serology Nega Vive	
EURO Score / STS Score 0.82	7. Roswa gold shoped on 23/12/23 PRE OP DRUGS (ACE/ARB/ANTIPLATELETS):
Diabetes Melitus (HBTAC)	C/C/o Acuta CVA - 20/03/2023. Associated Illness 72pm x syn.
H. ICA - 50%. Ct. carolid Carotid Doppler 6ulb . 23%.	Thyroid Enzymes 73 73 (0.1
Sr. Creatinine 0 82 ユルル・ロ・8	Any other illness of concern -
Allen's Test	Myocardial viability if needed
Varicose Veins	
Pulmonologist Clearance —	Nephro Clearance:
Neurology Clearance: Cleaned for	Dental Clearance:
Eugery. Mitral Regurgitation Assessment Trivial M	IR NO PAH
Nursing: ∿	Billing Clearance:
Physiotherapy	Spirometry taught
. ⇒Concerns from Surgical Team :	

PA Planoj

CXR: PA film, Lung fields clear.

Har. Venkatachalam. P 62/H a K/clo 720H,
Old CNA - Fèle 2023, Effort ampina, TVP, Good CN has come for CABG. \$4. was apparently normal titl
I month ago when he dweloped existin ones breakfeired on exertion which progressed to NYHA Classici- II. Initially, he went to nearly clinic cohere his TMT was positive for inducible is chimio. He was admind CAG. He went to Rela and underwant cog which showed TVD. He Hen come to Medway Heart Intotats and was advised CARG

and the way of the problem of the contract of







(A Unit of United Alliance Healthcare Did Lad MI.VENKATACHALAM P 63/Male/MHI202381271 27/12/2023/IPH2023002615 Dr.ANBARASU MOHANRAJ THE REPORT OF THE PERSON OF TH

CONSENT FOR SURGERY

1. Mr./ Ms./Mrs У£рждтд Сна⊾д.с
tick correct option and below):
Read
I/We have been explained the current clinical condition of me/my patient
Been explained this consent form in English, which I fully understand and understood the information
provided about the disease .CARONARYARTERYDISEASE / JRIPLE. VIESSEL DISEASE, and about the
procedure
 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 Resplanation:
 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 aware that I may require administration of blood and I or blood products during or after the operation I procedure as found necessary by the doctor (for which a separate consent shall be obtained).
- I am now also aware that during the course of this operation /procedure the doctor will be assisted by medical and paramedical team and that the doctor may seek consultation / assistance from relevant specialists if the need arises.
- 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.

Possible risks & complications 1, 12	deeding 2. Infecti	in 2. Shake	
_ 2. Anythmia_ 5.	Prolonged 1ew stray	6. Hild resk to life	
Benefits Symplom for	Survival		
- Alternatives High risk Pr	CA.		
The likelihood of success of the surgery	(Percentage / Other commands)	96 y.	
Possible results of non-treatment	1. Hyocardial Infaction	n,	
	2. Heart Failur.		

• 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.

DETAILS	PATIENT / RELATIVES	WITNESS	
Name (in BLOCK LETTER)	VEMIKATACHALAM	Meenakshi. V	
Relationship	Coll	Wife	
Signature	Vilaldule.	Moona	
Date & Time	27/12/23 @ 18:00	27/12/23 @ 18:00	
Name & Signature of Doctor with Registration No.: Dr. PRAVEEN JEYAKUMAR			
		M 2236.	

Dr. Anbarasu Mohanraj Reg No: 55476

Doctor Seal







நோயானி விவரங்க	ள்:(Affix Label here)
សរាការ្	
UHID :	:
பிறந்த தேதி :	பாலினம் :

தோவு செய்யவும்

அறுவை சிகீச்சை ஒப்புதல் படிவம்

	படியுங்கள்
	எனது / என் நோயாளியின் தற்போதைய மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளேன்.
SIP.	த ஒப்புதல் படிவம் ஆங்கிலத்தில் விளக்கப்பட்டுள்ளது. இந்த ஒப்புதல் படிவத்தில் கொடுக்கப்பட்ட சிகீச்சையின் செயல்பாட்டின் முழுப்பெயர்
теш	ல்முறை பற்றிய தகவல்களை நான் முழுமையாகப் புரிந்து கொண்டேன்.
•	நோக்கம் கொண்ட நன்மைகள், சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்களைப் பற்றி நான் இப்போது அறிவேன். மேலும் அந்த
	செயல்பாடு / நடைமுறைக்கு மாற்றுகளை கிடைக்கச் செய்கிறேன். எந்தவொரு செயல்பாட்டின் / நடைமுறையின் முடிவுகளும்
	நோயாளியிலிருந்து நோயாளிக்கு மாறுபடும் என்பதையும் நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையின் வெற்றி குறித்து எந்த
	உத்தரவாதமும் எனக்கு செய்யப்படவில்லை என்று நான் அறிவிக்கிறேன். 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 அணைத்து 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 கொள்கீறேன். எனது சொந்த ஆபத்து மற்றும் விளைவுகளில் எந்த நேரத்திலும் எனது ஒப்புதலை நான் திரும்பப் பெறுதலை எழுத்துப்பூர்வமாக சமர்ப்பிக்குவதன் மூலம் திரும்பப் பெற முடியும்
- மருத்துவ**ரால்** 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 மற்றும் எ	சிக்கல்கள் 	
		<u> </u>
• நன்மைகள்		
• மாற்றுவழிகள்		
• அறுவை சிகீச்சையின் வெற்றி வா	ய்ப்பு (சதவீதம் /பிற கட்டளைகள்) 	
•	புகள்	
• செயல்பாடு / நடைமுறை மற்றும் (வழங்கப்பட வேண்டிய கவனிப்புக்குப் பிறகு எதிர்.	பார்க்கப்படும் போக்கையும் நான் அறிவேன். சில
•	பு அலகு மற்றும் / அல்லது மருத்துவமனையில்	
மற்றும் / அல்லது கூடுதல் மருந்து	கள் அல்லது சிகீச்சைகளின் தேவை இருக்கலாம். $ar{\mu}$	இதன் மூலம் உடல் சிகீச்சையில் அதீகாிக்கும்.
• இந்த செயல்பாடு / நடைமுறையை	நடத்தும் நோக்கத்திற்காக மற்றும் பொருத்தமான	முறையில் எனது உடலில் இருந்து அகற்றக்கூடிய
எந்தவொரு தீசு அல்லது உடல் பகு	தியை அகற்ற மருத்துவமனையை நான் அங்கீகரி	ிக்கீறேன். இந்த ஒப்புதல் வடிவத்தில் வழங்கப்பட்ட
தகவல்களை நான் பெற்றேன் மற்	ற்றும் முழுமையாகப் புரிந்து கொண்டேன் என்ற	று அறிவிக்கிறேன். எனது வியாதி, செயல்பாடு
•	றளக் கேட்க எனக்கு வாய்ப்பு வழங்கப்பட்டது. அத	. •
•	றும் மீட்பு மற்றும் எனது கேள்விகள் அனைத்தும் எனிலையில் செருகல் மற்றும் நிறைவு செய்ய வே	
நிரப்பப்பட்டன என்று நான் மேலும் எ		ண்டிய அணைத்து அமைகளும் இந்த வடிவத்தல்
விபரங்கள்	நோயாளி / உறவினர்	சாட்சியம்
பெயர்		·
உறவுமுறை		
கையொப்பம்		
நாள் & நேரம்	·	
மருத்துவரின் பெயர் மற்றும் பத்	தவு எண், கையொப்பம்: 	









CONSENT FOR ANAESTHESIA SERVICES

I, VEWKATA (please tick the correct option abo	CHALAM, P	The patient or A the representative of patient have,									
☐ Read ☐ I /We have been explain ☐ Been explained this co	ed the current clinica nsent form in Englisl	al condition of me/my patient h, which I fully understand and understood the information provided about									
Operation/Procedure CORONARY ARTERY RYPASS GRAFTING.											
(full name of operation / procedure	e given below in this c	consent form)									
expected outcome and what needed for this operation, so t	 My surgeon has explained the risks of the procedure and has advised me of alternative treatments and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anaesthesia services are needed for this operation, so that my doctor can perform the operation or procedure. 										
with anaesthesia can occur sensation, loss of limb function	and include the ren n, paralysis, stroke, b	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.									
they may apply to a specific ty for my procedure and that th	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 or's preferences, as well as my own desire.									
 It has been explained to me 	that sometimes an a	anaesthetic technique which involves the use of local anaesthesia, with or and therefore another technique may have to be used including general									
It has been may be needed e	-	the following may be needed as part of anaesthesia during or after surgery Lumbar Puncture 🏻 ಚಾರ್ಡಿಂstomy									
		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									
	Deficition	- 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 Alternatives	Technique	Drug injected through a needle / catheter placed either directly into the spinal canal or immediately outside the spinal canal									
☐ GA	Risks	Nerve damage, persistent back pain, headache, infection, convulsions, bleeding / hematoma, toxicity due to local anaesthetic, chronic pain, medical necessity to convert to general anaesthesia, brain damage									
	Benefits	Post-operative pain relief with epidural catheter that can be left in-situ safer under certain conditions									
Major / Minor Nerve Block With Sedation / GA	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 □ GA	Risks	Nerve damage, persistent pain, infection, bleeding / hematoma, toxicity due to local anaesthètic, medical necessity to convert to general anaesthesia, brain damage									
☐ IV Regional Anaesthesia ☐ Spinal/Epidural Anesathesia ☐ Others	Benefits	- Pain Free - Safer under certain conditions									

☐ Intravenous Regional Anaesthesia☐ With Sedation / GA		Expected Results	Temporary loss of feeling and / or movement of a limb						
	Without Sedation		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					
	☐ Major/Minor N ☐ GA	erve Block		- Pain Free					
	Others		Benefits	- Safer under certain conditions			ŀ		
П	Monitored Anaes	thesia care	Expected Results	Decreased anxiety and light sec	dation similar to norma	al sleep			
	(with sedation)		Technique	Drug injected into vein of arm	·				
	Alternatives General anaest	hesia	Risks	Prolonged sedation, need for a	rway control		-		
	Spinal / Epidura		Benefits	Anxiety free; Early discharge		 .			
_	Monitored Anaes	thesia Care	Expected Results	No changes in the system	•		_		
	(without sedation)		Technique	None					
	Alternatives General anaest	hesia	Risks	 					
	☐ Mild Sedation		<u> </u>	Patient may have pain and anxi					
<u> </u>	Others		Benefits	Early discharge					
	DDEMATAL /PA	DIVOUII DUOO!	ANAFETHERIA						
l	•		ANAESTHESIA	h ala			I annual		
				behaviour and learning with p turing pregnancy and in early o		ea exposure to g	enerai •		
			-	esentative, do further hereby d		ve 18 vears of age	as on		
				m giving consent without any fe			, 0,,		
			•			·			
				that I have been made aware o		·=			
		-		elf or my above named pati	ent being fully awar	e of the nature, po	itential		
	risks and complications, intended benefits and possible alternatives.								
	risks and compli	cations, intended	benonto ana possit	no alternatives.					
	risks and compli	cations, intended l	Deficite di la possi.	no anomaliveo.			ľ		
	·		·		vo that I am also sit d	0	4h -		
	I, the above nam	ed Patient / name	d patient's represei	ntative, do further hereby decla			on the		
	I, the above nam	ed Patient / name	d patient's represei				on the		
	I, the above nam	ed Patient / namedis form, mentally s	d patient's represer cound and am givin humb Impression	ntative, do further hereby decla g consent without any fear, thre			on the		
Pa	I, the above nam	ed Patient / namedis form, mentally s	d patient's represer cound and am givin humb Impression	ntative, do further hereby decla g consent without any fear, thre n* Name	eat or false misconc	eption. Date			
Pa	I, the above nam date of signing th	ed Patient / namedis form, mentally s	d patient's represel ound and am givin	ntative, do further hereby declar g consent without any fear, three n* Name	eat or false miscond	eption.			
Su	I, the above nam date of signing th tient rrogate/Guardia	ed Patient / name is form, mentally s Signature / T	d patient's represei sound and am givin humb Impression	ntative, do further hereby decla g consent without any fear, thre n* Name	eat or false miscond	eption. Date	Time		
Su	I, the above nam date of signing th	ed Patient / name is form, mentally s Signature / T	d patient's represei sound and am givin humb Impression	ntative, do further hereby declar g consent without any fear, three n* Name	LULAUAM, Vife)	eption. Date	Time		
Su (if a	I, the above nam date of signing the tient rrogate/Guardia	ed Patient / namedis form, mentally s	d patient's represei sound and am givin humb Impression	ntative, do further hereby declar g consent without any fear, three name and relation	LULAUAM, Vife)	Date	Time		
Su (if a	I, the above nam date of signing the tient rrogate/Guardia applicable #) ason for	ed Patient / namedis form, mentally s	d patient's represei sound and am givin	ntative, do further hereby declar g consent without any fear, three name and relation	LULAUAM, Vife)	Date	Time		
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நோயாளி விஷாங்கள் : (Affix Label here)								
பெயர் :								
UHID:								
பிறந்த தேதி:	பாலினம்:							
சேர்க்கை தேதி:								
மருத்துவர்:								



மயக்க மருந்து சேவைகளுக்கான ஒப்புதல்

1 நோயாளி மேலேயும் சீழேயும் சரியான விருப்பத்	ν Ц .	ரயாளியின் பிரதீநிதி,) படித்தல்								
என்னை / என் நோயாளியின் தற்போதைய மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளோம். ஆங்கிலத்தில் இந்த ஒப்புதல் படிவம் விளக்கப்பட்டுள்ளது. இது வழங்கப்பட்ட தகவல்களை நான் முழுமையாக புரிந்துகொண்டேன்.										
செயல்பாடு/செயல்முறை										
		 								
இந்த ஒப்புதல் படிவத்தின் கீழே கொடு	க்கப்பட்ட செயல்பாட்டு ந	டுடைமுறையின் முழு பெயரி								
எதீர்பார்க்கப்பட்ட முடிவைப் பற்றி எ	எனது அறுவை சிகீச்சை நிபுணர் நடைமுறையின் அபாயங்களை விளக்கியுள்ளார் மற்றும் மாற்று சிகீச்சைகளுக்கு எனக்கு அறிவுறுத்தியுள்ளார் மற்றும் எதிர்பார்க்கப்பட்ட முடிவைப் பற்றி என்னிடம் கூறினார். எனது நிலை சிகீச்சையளிக்கப்படாவிட்டால் என்ன நடக்கும், இந்த செயல்பாட்டிற்கு மயக்க மருந்து சேவைகள் தேவை என்பதையும் நான் புரிந்து கொள்கீறேன். இதனால் எனது மருத்துவர் அறுவை சிகீச்சை அல்லது செயல்முறையைச் செய்ய முடியும்.									
கடுமையான சிக்கல்கள் ஏற்படல	ாம். தொற்று நோய், இ	யங்களை உள்ளடக்கியதாக எனக்கு விளக்கப்பட்டுள்ளது. மயக்க மருந்துகளுடன் எதிர்பாராத நூத்தப்போக்கு, போதைப்பொருள் எதிர்வினைகள், இரத்த உறைதல், உணர்வு இழப்பு, மூட்டு போன்ற தொலைதூர சாத்தியங்களை உள்ளடக்கியிருக்கலாம்.								
அடையாளம் காணப்பட்டுள்ளன விண்ணப்பிக்கலாம். கீழே சரிபார்ச்	இந்த ஃபாயங்களை அனைத்து வகையான மயக்க மருந்துகளுக்கும் பொருந்தும் என்பதையும் கூடுதல் அல்லது குறிப்பிட்ட அபாயங்கள் கீழே அடையாளம் காணப்பட்டுள்ளன என்பதையும் நான் புரிந்து கொள்கிறேன். ஏனெனில் அவை ஒரு குறிப்பிட்ட வகை மயக்க மருந்துக்கு விண்ணப்பிக்கலாம். கீழே சரிபார்க்கப்பட்ட மயக்க மருந்து சேவையின் வகை (கள்) எனது நடைமுறைக்கு பயன்படுத்தப்படும். மயக்க மருந்து நுட்பம் எனது உறவினர் உடல்நிலை, எனது மருத்துவரின் விருப்பங்கள் மற்றும் எனது சொந்த விருப்பம் உள்ளிட்ட பல காரணிகளால் தீர்மானிக்கப்படுகிறது என்பதை நான் புரிந்து கொள்கிறேன்.									
•	, –	படுத்துவதை உள்ளடக்கிய ஒரு மயக்க மருந்து தொழில் நுட்பத்தை, மயக்க மருந்து இல்லாமல் நந்து உட்பட பயன்படுத்த வேண்டியிருக்கும் என்று எனக்கு விளக்கப்பட்டுள்ளது.								
ြ பொது மயக்க மருந்து	எதிர்பார்க்கப்படும் முடிவுகள்	காற்றுப்பாதைைய பராமரிக்க ஒரு குழாயை காற்றாலையில் அமர்த்துவதை உள்ளடக்கிய மொத்த மயக்க நிலை								
மாற்று மருந்து	நுட்பம்	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 விழிப்புணர்வு								
🗌 மற்றவை	நன்மைகள்	– ஆரம்ப மீட்பு – பதட்டத்தீன் நிவாரணம்								
முதுகெலும்பு அல்லது இவ்விடைவெளி / மயக்க மருந்து	எதிர்பார்க்கப்படும் முழவுகள்	உடலின் கீழ்பாதியில் உணர்வு அல்லது இயக்கத்தின் தற்காலிக குறைவு அல்லது இழப்பு								
☐ மயக்க மருந்து / பொது மயக்க மருந்து ☐ மயக்க மருந்து இல்லாமல்	நுட்பம்	ஊசி / வடிகுழாய் வழியாக செலுத்தப்டும் மருந்து நேரடியாக முதுகெலும்பில் அல்லது உடனடியாக முதுகெலும்பு கால்வாயுக்கு வெளியே வைக்கப்படுகிறது.								
் மாக்க மருந்து நாற்று 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								
	நன்மைகள்	சில நிபந்தனைகளின் கீழ் சிப்யூவில் 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	شينينة	செயல்பாட்டின் பகுதீக்கு உணர்வு இழப்பை வழங்கும் நரம்புகளுக்கு அருகீல் மருந்து செலுத்தப்படுகிறது								
] பொது மயக்க மருந்து] IV பிராந்திய மயக்கமருந்து	<i>ஆ</i> பாயங்கள் 	எலும்பு சேதம், தொடர்ச்சியான வலி, தொற்று. இரத்தப்போக்கு, ஹெமபோமா, உள்ளூர் மயக்க மருந்து,மருத்துவ சேவை காரணமாக நச்சுத்தன்மை, மயக்க மருந்து, மூனை சேதத்திற்கு மாறுதல்								
] முது6ிகலும்பு / இவ்விடைவெளி மயக்கமருந்து] மற்றவை	நன்மைகள்	– வலி இலவசம் – சில நிபந்தனைகளின் கீழ் பாதுகாப்பானவை								

🔲 நரம்பு மண்டலம் மயக்க மருந்து		எதிர்பார்க்கப்படும்	உண	ர்வு மற்றும் ஒரு குறிப்பிட்ட மூட்டு	இயக்கத்தீன் தற்காலி	க இழப்பு	´ •
மயக்க மருந்து மயக்க மருந்து இல்லாமல்		முடிவுகள் நுட்பம்	வரு டு	 ர்னிக்கேயைப் பயன்படுத்தும் பே	ന്ദ്യ തക அல்லது തക	நரம்புகளில் செலுச்	
மாற்றுகள் பி பெரிய / சிறிய நரம்பு தொகுதி		அபாயங்கள்		று, வலிப்பு, தொடர்ச்சியான உண		<u> </u>	
	🗌 பொதுவான மயக்க மருந்து		<u> </u>) இலவசம்			
🔲 மற்றவை	நன்மைகள்	† 	நிபந்தனைகளின் கீழ் பாதுகாப்ப	urതെ തഖ 			
(மயக்கத்துடன்)	யக்க மருந்து கவனிப்பு	எதிர்பார்க்கப்படும் முடிவுகள்	சானா	ரண தூக்கத்தைப்போன்ற கவடை ————————————————————————————————————		து வருகிறது	
மாற்றுகள் 🔲 பொதுவான ப	യുള്ള വര്ഷ്ട്ര	நுப்பம்	கையி	ன் நரம்பில் மருந்து செலுத்தப்ப(9கிறது ————————————————————————————————————		
-	இவ்விடைவெளி மயக்க மருந்த	அ பாயங்கள்	நீண்ட	கால மயக்கம், காற்றுப்பாதை கட		_	
🔲 மற்றவை		நன்மைகள்		ல இலவசம், ஆரம்ப கால வெளி	யேற்றம்		
் முயக்கம் இல்லா	லயக்க மருந்து கவனிப்பு எமல்)	முழ்வுகள் எதிர்பார்க்கப்படும்	கணி	னியில் மாற்றங்கள் இல்லை			
மாற்றுகள் 🏻 பொதுவான	INUIÁA INATÁAI	நுப்பம்	இல்ன				
🔲 இலேசான ப		அபாயங்கள்	நோய	ாளிக்கு வலி மற்றும் கவலை இரு	க்கலாம்		
🔲 மற்றவை	<u> </u>	நன்மைகள்	ஆரம்	ப வெளியேற்றம்		<u> </u>	<u> </u>
பிறப்புக்கு முந்தை	தய / ஆரம்பகால குழந்தை	பருவ மயக்க மருந்	து				ļ
பருவத்தீல் ச ★ நான் / மேற்	ஆழமான மயக்கத்துடன் நீ கூறிய நோயாளி / பெயா	ண்ட அல்லது மீண் ரெப்பட்ட நோயாளிய	டும் மீன் பின் பிர	விளைவுகள் பொது மயக்க மருந் _? ஈடும் மீண்டும் வெளிப்படுதல் திநிதி, இந்த வடிவத்தில் கையெழு	த்திபப்பட்ட தேதி, மன ர		
பயமும் இல்	லாமல் ஒப்புதல் அளிக்கிரே	றன் என்று நான் 18	வயதுக்	கு மேற்பட்டவன் என்று இதன்மூல	ம் அறிவிக்கீறேன்.		
மேற்கூறிய செயல்	ம்பாட்டிற்கு (எஸ்) / நடைமு	றை (கள்) எனக்கு வெ	தரிந்துவ	ிட்டது. நான் தானாக முன்வந்து எ	ானது ஒப்புதலை வழங்	குகீறேன்	
! பாக்டர் (ராக்டர்) மு.	ക്ക്യാട്ര ശച്ചിക ക്കസ്സ	'ட செயல்பாடு / நக	ioi diDebo	றயை செய்வதற்கு அறுவை சிகிச	ബോക് കൊല്ലാം	ச் செய்வகற்கான ப	க்ர் பெரர்
				கள் மற்றும் சிக்கல்கள் மற்றும் சா		o 010 (2019))) (31100) (21	IOSEII OILIGIII,
				இந்த வடிவத்தீல் கைபெழுத்தீடட் ப்புதல் அளிக்கீறேன் என்று மேலு			ரம்பிய நான்
வந்தவையரு பயமு	ന, அக்கரித்தல் அல்லவி	அள்பான அணிந்தா	ாண்டு ஒர	புத்தை அளகைகின் வனிர நேறி	ம் இத்தையில் அப்புள்ள	ടെയ്യാരു.	
	கையொப்பம் /	கட்டை விரல் பதிவு *		பெயர்		தேதி	நேரம்
நோயாளி							
நோயாளிகளின் பி <u>ரச்</u> பாதுகாவலா் (பொருந்தும் என்றா			(நோயாளியுடன் பெயர் மற்றும் உறவை எழுதவும்)			_	
நோயாளிகளின் பிற சம்மதத்திற்கான	·\$\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	தல் அளிக்க முடிய	ബിல്ഞ	 ചെയ്യുന്നു			J
காரணம்							
சாட்சி							
மொழிபெயாப்பா (பொகுந்தினால்)							
* நோயாளி ஒரு சிறி	 பியவராக இருந்தால் அல்		ரங்க மும	ப யாவிட்டால் மட்டுமே ஆண்களுக்	ച കான ഖலക്വ തെക ഥന്നൻ	ந் பெண்களுக்கான	
	-7.					_	
				றும் சிக்கல்கள், நோக்கம் கொன			
	THEFT INTO THE PROPERTY WAS	் ஈசுயபையடு/ ந்டை		கு சாத்தியமான மாற்றுகள், நோ		தந்தக்கு விளக்கியும்	
ஆவணக்கில் விவரி		ள அவர் /அவள் கம	முமைய	ாகப் புரிந்து கொண்டார் என்று நா	ത് നുഥപ്രക്കേത്.		ர்ளார். இந்த
<u>ஆ</u> வணத்தில் விவரி	க்கப்பட்டுள்ள தகவல்க ை	ள அவர்/அவள் மு	முமைய	ாகப் புரிந்து கொண்டார் என்று நா 	ன நமபுகறேன.		ர்ளார். இந்த
ஆவணத்தீல் விவரி 				ாகப் புரிந்து கொண்டார் என்று நா 	ன நமபுக்றேன். பதிவு எண்	தேதீ	ர்னார். இந்த நேரம்
பெறப்பட்ட	க்கப்பட்டுள்ள தகவல்கடை			ாகப் புரிந்து கொண்டார் என்று நா	, , , , I	··	1
	க்கப்பட்டுள்ள தகவல்கடை			ாகப் புரிந்து கொண்டார் என்று நா	, , , , I	··	
பெறப்பட்ட	க்கப்பட்டுள்ள தகவல்கடை			ாகப் புரிந்து கொண்டார் என்று நா	, , , , I	··	

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ANAESTHESIA RECORD



(A Unit of United Alliance Hearthcare PY Ltd)		Every heart beat counts
Mr.VENKATACHALAM P 63/Male/MHi202381271	Type of Surgery : □	Day Care_☐ Elective ☐ Emergency
27/12/2023/IPH2023002615	Blood Group : 0-1 ve	Height: 168 cms Weight: 6 1/KgsA 10
dt.anbarasu mohanraj	Pre-Operative Diagr Capo , すvo , EF	nosis: 57/ 2m old CVA - Domann
	Proposed Surgery:	Anaesthetic Plan
ASA Grade: □ I □ II □ III □ IV □ '	V DE CABA	G A
History of Present Illness:	COMORBIDITY	Present Medication :
DYANGINA LJ. Man JUD., □ DYSPNOEA	☐ HT ☐ SMO	1,000,000
☐ SYNCOPE	☑ bm എം □ alco	1 0001100 1-03.09
☐ MI ☐ CCF	☐ HYPO THYROID ☐ CKD	/ NEPHROPATHY
□ OTHERS .	☐ STROKE / TIA ☐ DRU	GALLERGY Anti Platelet Stopped on :
Previous Surgery :	☐ EPILEPSY ☐	12/3/12/23 12/30/5/17/21/15/12/28
Physical Examination : ☐ JAUNDICE ☐ PEDEL OEDEMA	SYSTEMC EXAMINATI	ON Signal of the contract of t
☐ CYANOSIS ☐ CAROTID BRUIT	cvs: Sisi	CNS: Recovered CVA,
☐ CLUBBING	RS: Normal	Others: Wがり,
HR: 74/mt. NIBP: 120/10	som Hy SPC	02: 96,1 TEMP: 98,4°F.
INVESTIGATION	SEROLOGY	ANGIO D main 50% LAD 901/4
HB : <u>) ねら</u> T.BILIRUBIN : ^{0 138}	T3 :78 SEROLOGI	· · · · · · · · · · · · · · · · · · ·
1.D. : <u>8171</u>	T4 :10,1 Urine:	ECG NSR,
TC : 3; 9 60 D. 0.17	TSH : 1-74.	
CREAT: 0182) T-PROTEINS : 6,5	_ .	CXR 1111
Na+ : 138 S.ALBUMIN :415	HBA1C : 6 / 4 Others:	DE FOI
K+ : 6138 PTT/INR 013 13	RBS :	ECHO BF 55% TAPSE 1 Brown,
APTT :38 0	INR 018	Π 4 6 4 6 3 - 1
		Aosti valve solutions Prival AR/MR.
AIRWAY CAR	OTID DOPPLER, John CCA.	TO SULVIOLO PETO / 1100
Mallampatti class	is lagor in D carotid.	
Mouth Opening	To Test Wanted	21 21: 302 11:
Neck Movement 🗓 🎞 🕯	Stewary (1) constitutes	Other Opinions: MRI 20/3/25, Aunt Byant 10x5 RD Halamas:
TM Distance	33 vertison orgala chidy	NO endence of hemospe mid his EAR
Pre OP Instruction : Ni	PO From:	Mild age relation about his charge is charme
Pre Medication :	5 Am office a curp of will and 2 stress broad 40 mg	Chronic manut in been of a caudato
Night Before Surgery : Tab, Action 0,5	"B 7)-	PCV: 372 Platelet:
Day of Surgery 476, August 0,500	+ Tab. Pauton 40 m at	FFP : CRYO :
Special Instruction :	- K	Whole Blood:
Remarks: Acute CVA a0 03	23 S NEUROLOGIST OF RECOVERED fo	BINION- (B) Thatamic Syndrome To
Dr. A	. SAMUEL SYLVESTER	
Anaesthetist Name with Reg.No. :	Reg. No: 43570	Signature Durly,

Ţ	Date: Anaesthetist R. SYLVESTER					Surgeon DR ANBARASU DR PRANEGOV				Anaesthesia Technique □GA □Regional □Others		
}	PRE INDUCTION ANAESTHESIA RECORD					MONITORS AND EQUIPMENTS				GENERAL ANAESTHESIA		
ŀ		se: <u>b2</u> BP: 135				□4HBP	Left	Rig		INDUCTION:		
ľ		se. <u>a</u> br. <u>135</u> nsorium: <u>Wn</u>		и. <u>Гв [-о</u>	<u>יטנייי</u> ט	l (eter 🔃 End		Pre O, 🗌 Ra	pid Sequence 🖺	ĭv , .
				– No				oxygen Sen				Teofluram
					Disconne		Temperature		AIRWAY MAN		nedus <u>Heolitioned</u>	
	Sic	n Naw	·Name:	5-40-A	Sylvenie	_		Nerve Stimul				:8.5 Type: Cuffed
	Tim	"- VEG 1/0:	43570	2 ((1)		_		lator	CL Grade: 1 / N/	ĺl'/ Ⅳ Secured at	22 cm
┢	1.7.	PATIENT				TEE.		Others:		Any difficulties ar	nd accessories: Yes ☑ No ☐ R	
ŀ						∏¢∀C Typ	o Vicen	Site: P1	שע_	NG / OG Tube:		emovea
i	Pro	sition on Table: essure points check	ed & Pade	red: T Ve	e Who	Standard	Asepsis	USG Guid	dance	OTHER AIRW		
ı		e Care: √⊒Yes □ N		иси. <u> —</u> п	.5_110	☐ Complica	atioπs: 🔲 Ye	es 🛂 No		☐LMA Type &	Size: /	
		ety Belt: Yes 🖂				if Yes, de	tails:	560 bo -		☐ Via Tracheost	omy 🗌 Face Ma	ask Nasal Prongs
	Wa	rming Blanket: 🗆ン	es □No			Afterial L	ine - Type:	Grey ho	Rockal	Others:	,	
		id Warmer: ☐Yes				□PVC Type	20 U 300	MSite: PL 1	mut_	Antibiotic / Dos		- 0 -
		D Stockings: ☐ Yes quential Compression	-	mnroonia	n:	☐PVC Type	**************************************	Site:		Fry. Coffee	ronine 1.5	m @ 13.990 Pose @ 17.20
ļ		quentiai Compressio Yes⊡.Mo	טפט זווע פט	inhi <i>e</i> ssio	11.	Others:				Reversal of Ana	esthesia 7 124 2	HOSE @ 17.20
ŀ		PROPOFOL			1	36		<u> </u>				
1		MIDAZOLAM	3	<u> </u>								
		FENTANYL MORPHINE	- A	135_		75		75		-57	50-	
i		VECURONIUM	6	3 U)	1	
ı	SS	ETOMIDATE KETAMINE SUXA/ROCURONIUM		_		<u> </u>		 		 	_	
ı	핆	SUXA/ROCURONIUM						1			·	
Į		CISATRACURIUM/ATRACURIUM SEVO/ISOFLURANE			٠,	1		├─. ┤		 		
	ł	Air/N,O		1	<i>J</i>	LV.	·/	· /		7 0	7	
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ļ		Temp . X 20	 			+++	┞┼┼	╂┼┼╂		┠┤ ┼╂┼	+++-	┝┼┼╂┼┦
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	트	ETCO,	124	<i>#</i> 3.	9 /3	3/4	23	2.3	2/4	23 2	الا رو	-
•	MON	Urine Output				<u> </u>		500 M	<u> </u>			
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1	ABO	RBS	75 To m	1/.							34 17979	/1
}		LAC BE	4.2	7							315	
Ì		HCO,	27-9			—					DA.C	
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>	<u></u> .	5	START	STOP	FLUID TRA	ANF	USED	BLO	DD PF	RODUCTS
ANAESTHE	SIA		13.00	18.20	CRYSTALOII		COLLOID			-
PROCEDU		<u> </u>	13.50	18,15	KABILINTE OI	111		1		
СРВ		•			O:	I				_
AXC					02					<u>-</u>
CUF:			MUF:		- 94				-	
	H	EPARII	 V				SSURE MOI	VITOR		
DOSE		TIM	/E	ACT	PRE OP					
125 M	9	16.1	7	530 seu	PA		RV		PC	WP
	-				ABP		<u> </u>			
	PF	ROTAN	/INE	-	POST OP					
DOSE		TIN	ΛE	ACT						
100-W	<u>g</u>	17:	37	123 sec	PA		RV		P(CWP
INOTRO	PES & II	VEUSI	ONS		ABP					
DRUG	DOS	- 1	START	END	DRUG		DOSE	STAF	 ₹T	END
DILUTION	(RANG	E)	TIME	TIME	DILUTION	(RANGE)	TIM	=	TIME
NORADEBUA	0.02 ~		10 1-	costd.	NATROGRYCE -RIVE	.0	2-6.0-12	16.0		Stopped.
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REGIONAL	ANAES	THESIA	A IÝES)/ NO)	IABP:	<u></u>				
DETAILS:	BILES	PB	_							
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l Mies DE	XMEDE	almi's	DINE	7						
				of 0.257% ROPWAR	TEE:	-				
				of one was						
REMARKS	/ CRITIC	AL EV	ENTS							
		_								
1										
			Dr.	A. SAMUEL'S	LVESTER		SIGNATURE	~/0	ر که ا	1 /

ANAESTHESIOLOGIST NAME : REG.NO.

Reg. No: 43570

SIGNATURE

	POST OPERA	ATIVE PLAN	_	, , , , , , , , , , , , , , , , , , ,
Transfer to: SICU	Others, specify:			
	<u>ा।</u> beats/min Rhythm Hg CVP : <u>१</u> mmH	lg PAP:	_mmHg	
		IONOTROPI N/L	ES:	
2007 02 020500				
POST OP ORDERS:) DO ABB/cher xong/) Wear of outstand	n fully aware		
MODIFIED ALDRETE'S SCO	RE (Score against each criteria)			
CRITERIA	PARAMETER		Scale	
Activity, able to move, voluntarily or on command	4 extremities 2 extremities		1 0	Total Score : 10
Breathing	Able to breath deeply and cou Dyspnea, shallow or limited b	 	2 1 / 0	Patient fit for discharge:
Consciousnesss	Fully awake Arousable on calling unresponsive		1/0	
Circulation (Blood Pressure)	+20% of pre-anaesthesia level +20% to 49% of pre-anaesthes +50% of pre-anaesthesia level	sia level	1 0	
SPO ₂	Maintains SPO ₂ >92% in ambi Maintains SPO ₂ > 90P% with O Maintains SPO ₂ <90% with O ₂	O_2	1 0	
Апаesthetist Name & Reg.N	Dr. A. SAMUEL SYLV Reg. No: 4357	ESTER 1933 A	Signa	ture Jewy





OPERATION NOTES

Pre-Operative D	iagnosis :	CAD/TVD/	Good LV	function
_				

Post-Operative Diagnosis: CAD/ ovo / Good w funtion

Operation Procedure

Off Pump CABO X 4 grafts

SVG / PLB (Sequential)

D.O. Operation 2

Dr.Anbarasu mohanraj

Mr. VENKATACHALAM P 63/Malc/MHI202381271 27/12/2023/IPH2023002615

Please tick the type of procedure:

Closed 1

Open

Operation Commenced:

13. SO

Operation

Completed:

18.15

Nature of

Anaesthetic : كومسطا

Dr. Anbarosa / Dr. Proven / DA-Sai kuman.

Perfusionist

Anaesthetist

Dr-Sphrester

PM- Kerthika

Nurse Me-Sujethe.

Incision

Millie Standborry

Cannulation

Arterial

Venous

Dxygenator

Total'

CPB Time

ACC Total Time

Total **TCA** Time

Median stemstorny - Thymus disseted - Vertical

perical change - Targets asserted - Lt sva harvested 1194 howested - System hepaunisation endanispically -

LIMA divided and prepared - Mycrondium stabilised

stabiliser - such anostomosed to PDA (end boside).

PLB (side to side) and OM (side to side) segmentally -

LIMA anesternated to LAD - Pewaonte fat cleared -

Dera applied - somorony with 4mm punch - Proximal

anostemes in with 7-0 proline - Hemosteria - Protomine -

Drains placed - Steenum closed with No.6 Steel with

wound closed in Layers.

Findings and Relevant Details:

LIMA of good colubre and flow ~1.75mm

er such of good collibre ~4mm Targets?

Atherenturasi 1-10

Healthy 1.5 MO

Healthy 113

Healthy 1.75

POST-BY PA	ASS HAEMODYI	NAMICS			,	. 4 '
RA			LA		Cardiac Outpu	t j
RV			LA		CI	- , -
	svs			SYS		
PA		MEAN	ВР		MEAN	
	DIAS			DIAS		
PA	C W					
Support:	Isoprin Dopamine Dobutrex		Adrenaline. I A B P Others	Novad	10.05 Mg lkg/min	
POST-OPER	RATIVE INSTRU	CTIONS :				
To do	- ABG, A 1-Bleeding 2 Hypotensi		of strong			
Bland Am	store - N:1					
					<u>. </u>	
Me Pe Oti	est — (i) Lt Ple ediastinal — (i) ricardial hers nt: Covered	d A A				
Surgeon :	Dr. ANBARASI	י גנוסוז	RAJ		Date : .28 12. 2.	£43







Every heart beat counts

(A Unit of United Alliance Healthcare Pvt Ltd)

NAME: Mr. VENKATACHALAM.P	AGE/GENDER: 63Years / MALE
UHID NO: MHI202381271	IP NO: IPH2023002615
DOA: 27/12/2023	DOS: 28/12/2023
SURGEON: DR. ANBARASU MOHANRAJ	ANESTHETIST: DR. SYLVESTER
ASSISTED BY: DR. PRAVEEN JEYAKUMAR	PHYSICIAN ASSOCIATE:
	MS. SAIKUMARI/MS. KARTHIKA
SCRUB NURSE: MS. SUJATHA	

DIAGNOSIS:

TRIPLE VESSEL CORONARY ARTERY DISEASE

LEFT MAIN DISEASE

ADEQUATE LEFT VENTRICULAR FUNCTION (EF - 54%)

TYPE II DIABETES MELLITUS

SYSTEMIC HYPERTENSION

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (CHRONIC SMOKER)

CLASS III ANGINA

SURGERY DONE:

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

LIMA TO LAD

SVG TO OM, PLV AND PDA (SEQUENTIAL)

FINDINGS:

Good myocardial contractions

No significant scarring

Emphysematous lungs with dark pigmentation (fixed to chest)

LIMA – 1.75mm, Good quality, good flow

SVG - 4mm, Endoscopic vein harvesting from left leg to mid thigh, Good quality

LAD - 1.5mm, Plaques (+)

OM - 1.5mm, Healthy target

PDA - 1.5mm, Healthy target

PLV – 2.0mm, Healthy target

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

GOOD dista @MedwayHospitals rus off in all the graft
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Medway Centre of Excellence (Chennai)

MHI/HOSP/2022/118





PROCEDURE:

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

Heart positioned and stabilized with myocardial stabilizer for PDA grafting. Arteriotomy was made and 1.5mm 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)

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

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

Aorta occluded partially. One 4mm hole was made on the aorta with aortic punch. Proximal anastomosis of vein graft done onto aorta with 7-0 prolene suture. Protamine administered. Hemostasis secured. Pericardium reapproximated partially. Routine chest closure done with one mediastinal and one left pleural drain tubes insitu

SUPPORTS:

He was shifted to ICU with nil support.

CONSULTANT SIGNATUR

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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Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

MHI/HOSP/2022/118





Last Internal Mammer Asterny (Linux) I shealth, Constitute Copyright (SVE) (Englishing Land) Constitute Copyright (SVE) (Englishing Land) UHID. No. MIE AUGUSTI) Operation Performed OFF PUMP CORONIES ARRES BYPMS COPYRISH SIRVERS (OPERA) × 4 (Ind. TO 1A) (SVE 7577 (EDV) 1507 PROSERVED.	#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tei : 044 - 4310 8959
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Right Coronary Right Coronary Circumflex Obtuse Marginal Diagonal Anterior Descending A	(i), while Mollitus
Right Coronary Obtuse Marginal Diagonal Anterior Descending Anterior Descending Complyional scarring Com	Left Subclavian Left Internal Mammary
Emphysemators large with plant proportion (direct in the land) Left Internal Mammer Atlan, (Linux) I Health, Conductor Ver English (Sver English) Conduct Name Mr Vertura Curtain P Gym Date of Surgery 28/12/2007 UHID. No. MIC 2013-127/ Operation Performed OFF PUMP CORDNIPS ARRES BYPAS COMPANY CORDINATION (OP) 1801 FOR 1801 CORDNIA CORDINATION (OP) 1801 CORD CORDNIA CORD CORD CORD CORD CORD CORD CORD CORD	Right Coronary Obtuse Marginal Diagonal
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Name No VENUSACUACIA P GYM Date of Surgery 28/12/2017 UHID. No. MIR AUGS 127/ Operation Performed OFF PUMP CARONIES ARRES BYPAS COMPANY SURVEY OF (OP(18)) × 4 / 120 / 100 / 1	Emphysiamators have with died proported in the sent is and
Name No VENUS-ACUACIA P 67m Date of Surgery 28/12/2017 UHID. No. MIE AUGUSTIA	Lyt Internal Mammos Atlany (Linux) I Health, Condent Condent
(OPINO) x 4 / 10 / 10 / 10 / 600 7500 GODA ; 2010 Productions /	Name No VENLUTACHACIA P Gym Date of Surgery 28/11/2007 UHID. No. MIL AUIS 1127
PLU C SCOVENTA	Operation Performed OFF PUMP CARONIFFO ARREST BYPHS COMPANY SORRISH
	PLU CSGOVENTAI







PATIENT'S INFORMATION SHEET

Mr.VENKATACHALAM P		
NAMI 63/Male/MHI202381271 27/12/2023/IPH2023002615	HAYAMAGE/SEX 63 M	TCIRREG CONDINU
Dr.ANBARASU MOHANRAJ	SURGEON	ANAESTHETIST
Br. ANBARASU	Dr. ANBARASU	BY SYLVESTER.
DIAGNOSIS (In Capital Letters)	1. CAD-7VD (() r	nam)
	2. T2Dm HTN.	
	3. OLD CVA (Aci	ete infarct).
	4.	
	5.	
	6.	
· · · · · · · · · · · · · · · · · · ·	7.	
	8.	
PRESENT PROCEDURE/ SURGERY	CABGI GA	
PREVIOUS PROCEDURE/ SURGERY	-	
CONTACT NO. & - RELATIONSHIP	1. (MEENACHI):	

ţ

MEDICATION HISTORY

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	1/8/23	7 Prolomet	Som	Plo	Loo	- continue
2	h	C- Rozagold	1 cap	Pho	6	23/12
3	h	7. Imdur	Bony	Ph	too	_ continue
4	(A, D) (120 d)	₩ 1	(+ia + i -		Asia.	1.1
5		**************************************				
6						
7		. 3				
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9						
10						

S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	1/8/23.	7. Prolomet	502	Pb	too.	7
2	<u> </u>	7. ProJonet Timbur	Bory	97	too.	bontinue
3						
4			·			
5		15.	• ; · •			
6					_	
7						
8				_		
9				-		
10			,			

ANY RELEVANT INFORMATION:

Admission / OT Receival	Condition of the Patie	ent:			
Date and Time :	1. Stable / Unstable 2. Oriented / Disoriente				
Date and Time.	3. Conscious / Semico	onscious / Unconscious	•		
From: To:	4. Febrile / A febrile		5. Intubated / Extubated		
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 Patie				
Date and Time :	1. Stable / Unstable	·	2. Oriented / Disoriented		
Date and Time .	3. Conscious / Semico	onscious / Unconscious	·		
From: To:	4. Febrile / A febrile		5. Intubated / Extubated		
1) 1/	Year	Months	Days		
Known Case of Diabetic Mellitus	4425	_			
2) Known Case of Hypertension	4yss				
3) Known Case of Bronchial Asthma/COPD					
4) Known Case Of Others		_			
4) Known Case Of Others					
			<u> </u>		
	∐ Yes	No No			
Denture	Permanent Fixation				
	Temporary Fixatio	n: 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 a	•	4 & Site:		
		·			

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: Inser	ted Date and T	Removed on		
	2. Pleural Right / Left: Inserted Date and Time Removed on				
Urinary Catheterization	Inserted Date and Tim	ne	Removed or	1	
Nasal / Oral Gastric Tube	Inserted Date and Tim	ne	Removed or	· ·	
Intubation Date and Time	Extubation Date And	Γime	Reintubation Date And Time		
Other Information	27/12/23 10 pcv	Reserv	alton SlN L	done with	Qui







PATIENT'S INFORMATION SHEET

Mr.VENKATACHALAM P			
NAME 63/Male/MHI202381271 27/12/2023/IPH2023002615		AGE / SEX	UHID NO
Dr.ANBARASU MOHANRAJ		SURGEON	ANAESTHETIST
DR-ANBARACU	OR.	ANBARASU	DR. SYLVESTER
DIAGNOSIS (In Capital Letters)	 2. 3. 4. 5. 6. 7. 	CAD- TVD + REMA PRESENT ADEQUATE LV MORTIC VALVE GRIVIAL AR, L EF- 55 %	SCLEROSIS IR, JR
PRESENT PROCEDURE/	8.	PR V d COASTS	
SURGERY		ABX 4 GRAFTS A -> L'AD PDA PLB OM (Seque	ential)
PREVIOUS PROCEDURE/ SURGERY	 MRS	. Michigal	25
CONTACT NO. & RELATIONSHIP	1.893	9330785 (W/FC)	2.

N.No:- 38/178

JNOURANCE

MEDICATION HISTORY

CN	STARTED	PAST MEDICATION	Dose	Route	Frequency	STOPPED
S.No	ON	(On Admission)	Dose	Route	Trequency	ON
	07/12/03	1. PROLOMET	50vg	PO _	1-0-0 7	
2	ė1	9.IMDUR	30mg	Po_	1-0-0	lon-finue
3			0			
4				į.	٠	
5						
6				_		
7						
8		-				
9				^		
10						
	ANTIP	LATELETS SIMPLED	ON A	13 12 1/3		
S.No	STARTED ON	CURRENT MEDICATION (After Admission)		Route	Frequency	STOPPED ON
1	29/12/2023-	SUPENSION:	(OML	blo	1-1-P	
2		INEB. LE VOSAL BUTA not	0.62 mg	FNH	a GHRY.	,
3	29/12/2023	T_FRUSEMIDE	tang	وادا	1-1-0.	
4	29/12/2022	TSPIRANALAOUN	E 25 meg	ماط	1-1-0.	bontinue
5	29/12/2028	7. BEDLEX PORTE	MAB	Plo	1-0-0,	
6	29/12/2022	TCLOPIDOGREL TABPIRIN:	75 (15 Mg	Plo	0-1-0.	
7	29/12/2028	T. PARACETA-MOL	.650	Plo	1-1-1.	
		SYP. CREMAFFIN	15001	Plo	0-0-1.	
8		- Saching Total	·LHIma	D(0	0-0-1.	
9	29/12/2023	rr- Rosuversieriu	(37.9)	• •	1	
		T- ROSUVARTATING T- METOPROLOL	DE TO	11/0	tot.	

ANY RELEVANT INFORMATION:

Admission / OT	Receival	Condition of the Patie	ent:	N VENT		
Date and Time	. 28/12/23	1. Stable / Unstable	2. Oriented / Disoriented			
Date and Time	at 18.30	3. Conscious / Semico	onscious / Unconsçiou	s		
From: OJ	To: Slev	4. Febrile / A febrile	•	5. Intubated / Extubated		
Transfer Out		Condition of the Patie	ent:			
Date and Time	· 30/12/23	1. Stable / Unstable		2. Oriented / Disoriented		
	• • •	3. Conscious / Semico	ภ์กรcious / Unconsciou	s		
From: , 31w	To: 104-13	4. Febrile / A febrile	5. Intubated / Extubated			
Transfer In		Condition of the Patie	ent:			
Date and Time		1. Stable / Unstable	, 9	2. Oriented / Disoriented		
Dute and Time	•	3. Conscious / Semico	onscious / Unconsciou	s		
From:	To:	4. Febrile / A febrile		5. Intubated / Extubated		
1) Known Case		Year	Months	Days		
Diabetic Me						
2) Known Case of		A years				
Hypertensio)n					
3) Known Case		1 year		-		
Bronchial A	sthma/COPD	,				
4) Known Case	Of Others			-		
HIO CVA	[ACUTE - IN	F				
		☐ Yes	√ No			
Denture		Permanent Fixation				
		Temporary Fixation: Present / Absent				
		☐ Yes	No			
Allergic Reacti	on : Drugs/Food	If you means mention a	bout Drug / Food Nan	ne:		
	2					
,		☐ Yes ···,				
Pressure Ulcer	Present	If you means mention a	about Grade : 1 / 2 /3	/ 4 & Site:		
}			•			

ANY RELEVANT INFORMATION:

		· · · · · ·			Sign With
Peripheral Cannulation	1. Site: R1 CUBVIPL 2. Site: 3. Site:	1. Inserted Da 8 (12) 3 0 2. Inserted Da 3. Inserted Da	te and Time	1. Removed on: 2/1/2 2. Removed on: 3. Removed on:	Date Nose port
Neek Line : IJL/EJL	Site:	Inserted Date		Removed on 30/12/23 @9.00	diff.
Arterial Line : Right/Left		Inserted Date	and Time	Removed on	Janj 013.
Sheath Arterial / Venous:	Site:	Inserted Date	and Time	Removed on	
Pressure Bandage	Site:	Inserted Date	and Time	Removed on	
Drain Site	1. Mediastinal: Inser		ate and Time	Removed on Removed on OP 112-22 AT 16-30	Jamy 017.
Urinary Catheterization	Inserted Date and Tin		Removed or		71024 5726
Nasal / Oral Gastric Tube	88112123 pt 18	ረ አ ወ	Removed or	•	
Intubation Date and Time	Extubation Date And 89/12/23 AT 8	Time		n Date And Time	
Other Information	CAGI BONE ECHO DONE CAROTIO XIV	04 23 (10 DOPLE) PLAGOE N PLAGOE N ON 23 (12)	11/23 12/23 R DONE 161ED IN 23 [H	C CHEST PAIN ON 14/12/23. BOTH CCAJ 2-74 bpm]	0 L.





Time: 18-25

18-25

SAFE PROCEDURE CHECKLIST **Adapted from WHO Safe Surgery Checklist**

MHI/OT/2022/086 Medway Heart Institute

Mr.VENKATACHALAM P

63/Malc/MHI202381271 27/12/2023/IPH2023002615

Name of the Procedure :	PCABICLOSED HER	Location: CTOT-OF-I	Date & Time : 2	812123@ 27/12/2023/IPH2023002615			
Does the Procedure involve	•			LARVAHOM UZARABNA.:O			
SIGN IN 2 V3 00 Before Induction of Procedural S	edation	TIME OUT ! [3.50 After procedural Sedation and before procedure		SIGN OUT 18-25 When Doctor indicates that the Procedure is completed			
(Anaesthetist / Qualified Physicia Sedation + Nurse + Technician + Do	n administering Procedural ctor performing the procedure)	(Anaesthetist or Qualified Physician	(Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure				
Patient Confirmation	,	All team members introduce themselves by Name and Role		To be done for each procedure in case of multiple procedures			
Identity by two identifiers	⊒Yes /	Identity by two identifiers	☐ Yes ☐	Name of the Procedure done written down DPCABICADSD HERET			
Procedure	☐Yes/	Procedures	☐Yes .	Name and site of all specimens / investigations Yes NA			
Side	□Rt □Lt ZNA	Side	□Rt □Lt ☑NA	confirms labeling and sent to lab			
	chartakeg	Expected Blood loss 200 - 300M1	chest 4 leg				
Consent	U-Yes)	Position -	DYG-SUPINE	Any recovery concerns : ☐ Yes ☐ None			
Known Allergy	☐Yes ☐NO / NOW W	Consent	□Yes 7	If Yes, Pis. specify:			
	If yes, plaese specify	Required equipment and implants available	☐¥es*fj NA				
Difficult airway / aspiration risk	☐No ☐Yes, equipment	Essential Imaging displayed	☐Ye9 □NA				
/ dentures	and assistance available	Antibiotic prophylaxis within last 60 minutes	□ Y é\$2□NA				
Possibility of hypothermia	☐ No ☐ Yes, wanner in place	Name of the Antibiotic given TWI-CEPTRIXING I-SV	60 13.20	Any Equipment / instrument problem that needs to be			
	L	Venous Thromboembolism Prophylaxis Provided	☐ Yes ☐ NAS	addressed: ☐ Yes ☐ Nene If Yes, Pis. specify:			
All concerned anesthesia equipment	and medication check complete	Anticipated duration briefed	□ Y95 ₇				
ESpo2 ☐NIBP ☐Other	s pls. specify	Anticipated blood loss briefed	☐Ye9 ☐NA				
Pre OP medication taken	☐Yes ☐No	Adequate fluids and blood available	☐Yes ☐NA				
		Team briefed on any critical or unexpected steps	☐Yes /NA	Corrective action :			
Required equipment for	☑Y@s □NA	For procedural sedation cases	☐ Yes ☐ Hore	ENETRUMENTS, VANCE & STONNE			
procedure available	'	Any patient specific concerns : Intra procedure glycemic control	TYES NA	THEFOLE COUNTS YOU CONFECT			
		Any concerns about sterility	☐ Yes ☐ None				
Anaesthetist / Dector giving Procedural Secretion	Doctor performing the Procedure :	TO SOUTH TO THE PROPERTY OF TH	echnician : SATI	4000 Others Please Specify: DK WARTY 0036			
Date: 28/19/93	Date: 28/12/2	2 Date: 28/19/23 4 D	ate: 28/12/2	Date: 28/12/123			
Time: 18-25	Time: 18-25		ime: 18-25	Time: 18-25			

Time: 18.25



Mr.VENKATACHALAM P

63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.Anbarasu mohanraj



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



Every heart beat counts

CONSENT FOR BLOOD / BLOOD COMPONENTS

A Blood transferior in the	LOOD A DECOR	COMPONENTS
s of the same of t	iving medical procedure, prescribed by a	Physician Dia 1
more often a component or co	mbination of com-	COMPONENTS physician. Blood can be given 'whole' bu
- কিলোক শিক্ত	momanon of component is transfused. Ame	physician. Blood can be given 'whole' bu ong the most common components are:
- vea cens	For 11 . 12	components are;

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.

	Patients name TVEN KATACH ALAM
Witness Doctor Pulm 43570 Time 3.45	Patient signature. Vutul-, or Guardians name. Moonakshi. V
Time 13	or Guardians name Moonakshi. V
Date 20 12-12-22	Qualulans signature 1000 M/O.
ormed consent and	Kelationship to most and by the
of a life	threatening/emergency medical condition 1

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:	ъ.	_	•	mary improved of feverse a life-three	ateninį	g/emerge	int me
THE.	Date:			Doctors signature		1,-	•
					******	••••	• • • • • • • •





Every heart beat counts '

(A Unit of United Alliance Healthcare Pvt Ltd)

் ஒப்புதல்:இரத்தம் / இரத்தத்தின் பாகங்களை செலுத்துதல்

இரத்தப்	செலுத்துதல்	் என்பது	, மருத்துவரால்	பரிந்துண	ரக்கப்படுகின் _!	B est ar	யிர் காக்	தம் மருத்துவ	செயல்கு	ஹ்மாகும்.	,மேலேமாடிய,	இரத்து
அளிக்க	ப்படலாம் எவ	நாலும்.	பெரும்பாலும்	ஒரு பாகம்	அல்லது பா	क्रम्बक्या	is ക്കാതവ	செலுத்தப்படு	கிறது. மி	கப் பொதுவ	என பாகங்களி	ນໍ
கீற்க்கள	க ்கைவு அவர்	LETIO:										

சிவப்பு அணுக்கள்

இரத்தப்போக்கு அல்லது குறைந்த ஹிமோகுளோபினுக்கு

தட்ட**ஐ**ந்க்கள்

இரத்தப்போக்கு அல்லது குறைந்த எண்ணிக்கைக்கு

குருதிநர்

தேதி:

இரத்த கனஅளவை மீட்டமைப்பதற்கு அல்லது உறைவு அம்சங்களை வழங்குவதற்கு

கிரையோப்ரெஸிப்டேட்

சிறப்பு உறைவு அம்சங்களுக்காக

எனக்கு /நோயாளிகளுக்கு இரத்தம் செலுத்தப்படுவதன் மூலம் எதிர்பார்க்கப்படும் நன்மைகள் மட்டுமின்றி இடர்களையும் மருத்துவர் வீளக்கியுள்ளார்:

- இரத்தம் செலுத்துவதில் கிடைக்கின்ற விருப்பத்தேர்வு பற்றி எனக்கு தகவலவிக்கப்பட்டுள்ளது, இதில் தன்னர்வ தானமனிப்பவர்கள் வழங்கியுள்ள வங்கியிலுள்ள இரத்தம் (அலோஜெனிக்) அல்லது கயமாக தானமனித்தல் (ஆட்டோலோகஸ்) ஆகியவை அடங்கும். ஓர் அவசரநிலையில், வங்கி இரத்தம்தான் பயன்படுத்தப்பட வேண்டியிருக்கும். நேரம் கிடைக்கும் பட்சத்தில் சுய தானமனிப்பிற்கு வாய்ப்புள்ளது.
- 2. தேசிய விதிமுறைகளுக்கேற்ப கவனத்துடன் முன்சோதனை செய்யப்பட்டிருந்தாலும், உயிருக்கு ஆயத்தை விளைவிக்கக்கூடிய தொற்றுக்களான எய்டஸ், ஹெயடைடிஸ் மற்றும் இது வைரஸ்கள் அல்லது இதுவரை அறியப்படாத நோய்கள் ஏற்பட்டுள்ள அரிதான நிகழ்வுகளும் உள்ளன. எல்லாவிதமான இடர்களையும் நீக்குவது என்பது நடைமுறைக்கு இயலாத ஒன்றாகும் என்பதையும் நான் புரிந்து கொள்கிறேன். கணிக்க முடியாத எதிர்விளைவுகளும் தோன்றலாம், இவை, காய்ச்சல், பெரிப்பு, மூச்சுத்திண்றல், அதிர்ச்சி மற்றும் அரிதான நிகழ்வுகளில் இறப்பு ஆகியவற்றை உள்ளடக்கி, அந்த வரம்புக்குட்படாதனையாகவும்கூட இருக்கலாம் என்பதையும் நான் புரிந்து கொள்கிறேன்.
- 3. இரத்தம் செலுத்துவதன் மூலம் எதிர்பார்க்கப்படும் நன்மைகள், அதிர்ச்சி, முளை மற்றும் இதர உறுப்புகளுக்கு ஏற்படும் சேதம் குறைக்கப்படுதல், குணமடைதலைத் துரிதப்படுத்துதல் மற்றும் இரத்தம் இழக்கப்படுவதைக் குறைத்தல் ஆகியவற்றை உள்ளடக்கியிருக்கலாம், என்றாலும், எதிர்பார்க்கப்படும் நன்மைகளுக்கு உத்தரவாதம் ஏதும் அளிக்கப்படவில்லை என்பதையும் நான் புரிந்து கொள்கிறேன்.
- 4. இரத்தம் செலுத்துதல், மாற்று சிகிச்சை முறைகள், சிகிச்சை எடுக்காமல் இருப்பதிலுள்ள அபாயங்கள், பயன்படுத்தப்படவிருக்கும் செயல்முறைகள், மற்றும் இதிலுள்ள இடர்கள் மற்றும் அபாயங்கள் ஆகியவை பற்றிய கேள்விகள் கேட்பதற்கு எனக்கு வாய்ப்பிருந்தது, மேலும் தகவலறிந்த நிலையில் முடிவெடுப்பதற்கு ஏற்ப எனக்கு போதிய வீவரங்கள் தெரிந்திருந்தன என்று நான் நம்புகிறேன்.
- 5. முறையான மருத்துவப் பராமரிப்பின் பொருட்டு, இரத்தம் மற்றும் /அல்லது அதன் பாகங்கள் செலுத்தப்படுவதற்கு நான் ஒப்புக்கொள்வதுடன், எனது கைபொப்பத்தின் மூலம் எனக்கு அல்லது நோயாளிகளுக்கு இரத்தப் பொருட்கள் செலுத்தப்படுவதற்கு என் ஒப்புதலை அளிக்கிறேன். இதே நோய் தொடர்பக, இரத்தப் பொருட்கள் செலுத்தப்படுவதற்கான எதிர்காலத் தேவைக்கு வாய்ப்புள்ளது மற்றும் அது தொடர் அவுப்படையில் இருக்கலாம் என்று எனக்குத் தெரிவிக்கப்பட்டிருக்குமானால், இந்த மருத்துவமனை சேர்ப்பின் குறிப்பிட்ட காலத்தில் முடிவடையும் வகையில் அல்லது இந்நோயின் முமுமையான காலகட்டத்திற்கும் தேவையான கூடுதல் இரத்தப் பொருட்கள் செலுத்தப்படுவதற்குரிய ஒப்புதலையும் இத்தகவலறிந்த ஒப்புகல் மூலம் வழங்குவதற்கு நான் ஒப்புக்கொள்கிறேன்.

	நோயாவியின்	பெயர்							
சாட்சி	தோயாவியின் :	கைபோப்ப	льди.	• • • • • • • • • • • • • • • • • • • •	• • • • • • • • • • • • • • • • • • • •				
மருத்துவர்	அல்லது பாதுக	ध्यक्ता	Qutuit						
ர ந்ரம்	பாதுகாவலரின்	கைபொட்	elio	•••••					
தேதி	நோயாளியுடன	வை உறவு					• •		
உயிருக்கு ஆபத்தான/அவசரக்கால மருத்து	வ நிலை காரன	மாகத் த	கவலநிந்த ஒப்	புதல் பெர	றப்படவில்லை	. தகவலு	மிந்த ஒப்பு	தலாகக்	
கருதப்படக்கூடிய அளவிற்கு நான் போதிய .	அளவு தகவலை	் தோயாவ	ரிக்கு வழங்கில்	ிட்டேன்,	மேலும் ஓர் உ	டயிருக்கு	ஆபத்தாவ	/அவசரக்கா	ಖ
மருத்துவ நிலையை மாற்றுவதற்கு, மேம்படு	த்துவதற்கு, நேர்	மாழக்க ஆ	தக்குவதற்கான	பேதிய	அளவில் இர	த்தப் பெ	ாருட்களை	வழங்குவதற்	SEAT GOT
உத்தரனை வழங்கும் நடவடிக்கையை நகன்	மேற்கொண்டு ள்	ோன்.							
நேரம்:									
Branca confusion Consult	104	de succellair	ene Querius à						



Pat	ient	Details	(Affix	Labe	l nere)	_
Na	me:	_	Mr.V	/EN	KATA	C

UHID:

HALAM P 63/Male/MHI202381271

DOB:

27/12/2023/IPH2023002615

DOA: Consultant:

Dr.ANBARASU MOHANRAJ



Every heart beat counts

IN-PATIENT INITIAL ASSESSMEN	T FORM - PHYSIOTHERAPY				
Chief Complaints:	eath (NYMA IY)				
Chief Complaints: P7 Olo Shortness of bri assaided E	1				
austata e	Chlist Fair .				
Occupation: Heavy Activity Moderate Activity	Light Activity				
Past Medical / Surgical History:	. L. In Ottom O				
Klelo T2DM (On 1	WHERE CHIPS				
KICO TEDM (On 1) KICO SHTA (On	Rxy (ryy)				
KIHO CAG (27/12	2[23]				
KIHlo eva Cac	uto (farct)				
On Observation: Built: Thin Fair Well Built Obese Postural Deviation: Yes No Muscles Wasting: Yes No Deformity: Yes No Swelling: Yes N					
On Palpation:					
Tenderness: ☐ Yes ☐ No Warmth: ☐ Yes ☐ No Muscle sp	easm:□Yes □No				
Oedema:□Yes ☑No │ Crepitus:□Yes □No │ Tone:☑Norm	al □Abnormal ·				
FALL RISK SCREENING NILL					
Fall Risk Screening for Adults: Age more than 65 years	History of fall in last 3 months				
☐ Walks with assistance	Any neurological problem				
In case of 2 or more criteria is met, initiate detailed fall assessm	nent and fall prevention protocol.				
Fall Risk Screening for Pediatrics: NU H/O fall in last 3 months Neurological problem (vertigo, seizure, etc) Deranged mobility In case of 2 or more criteria is met, initiate detailed fall assessment and fall prevention protocol.					
Respiratory Status:	Brain Injury (if applicable): NU				
☐Room Air ☐ O₂ Support ☐Ventilatory Support ☐ BIPAP	☐ Traumatic ☐ Non Traumatic				
☐ Tracheal Mask ☐ Nasal Prongs ☐ Face Mask	·				
	☐ Mild ☐ Moderate ☐ Severe				
Intubated: Yes No	☐ Mild ☐ Moderate ☐ Severe ☐ Conscious ☐ Unconscious				

Spine Injury: Present Absent
AIS:ISNCSCI SCALE: NL
☐ Cervical ☐ Dorsal ☐ Lumbar ☐ Sacral ☐ Coccyx
Associated Injuries: Speech impaired: Yes INo
Voluntary Movements: ☐ Present ☐ Absent Tone Modified: ☐ Hypotonic ☐ Normal ☐ Hypertonic
ASHWORTH SCALE: NL
☐ 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):
Dyspnoea Grading Scale: Grade III
Abnormal Breathing Sounds: Wheezing Stridor Crackles Pleural Rub Pneumothorax Click Stertor
Abnormal Breathing Pattern: Abdombul breathing
Pain Assessment: Pain: Yes No
Pain Score: Co
Tick whichever is applied: ✓ Numerical Rating Pain Scale □ Visual Analog Scale □ Wong-Baker Faces
☐ Pain Scale ☐ Critical Care Pain Observation Tool ☐ FLACC
Location: Cheracter: Character:
Looding Way Duranon - Hequency Condition
☐ Acute ☐ Chronic ☐ Burning ☐ Aching ☐ Radiating ☐ Numbness
☐ Sharp ☐ Cramping ☐ Stabbing ☐ Crushing
Aggravating Factors: Relieving Factors:

Examination (Please tick and mention ab	normal findings only):				
☐ Range of M	lotion:				•	
	Demal					
	,					
☐ Muscle Stre	ength:					
	Nomal					
☐ Reflexes:						
	lemody					
Planter Boons	nse: ᡌ Diminished ☐ Brisl	√ ∏ Clonus				
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	Diminished □ Brisk □ Cl					
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Ankle: ☐Dimi	inished □Brisk □Clonus					
Sensation: (7)00d					
Investigation	& Findings:				•	
	TWO/ SA	tTW/ T2DM				
•	, ,	1				
Physiotherap	y Management Plan:	-				
	-DBey	f- a.v.				
- Spiranutry & Theor percussion to Ble vidle - Mobilization						
	- Che	+ posicuston 1001l	Child war			
	- A	eon to Ble vid	ll			
	- M	obilization				
			····	,		
	Signature	Name	Emp. No.	Date	Time	
Physiotherapist	G. b. Akad	ARASH GIB	0256	28/12/23	18:00	

	RE-ASSESSMENT FORM
Date & Time	
111110	Fall Risk Score:
	Pain Score: 2/10
	Sugleal 8the valu.
છેo 12/23	or .
Ç	-DBes Culomyed
f0:00	- chart Demudor douc to Ble Clark world
	- Shironely en enloyed
:	- Aetour est to Ble or & U
	- notolised to char.
	- 10 Harrowe Joseph Rom
	- 70 Ampour ADL
	-70 Improve Levy expansion & lung charace
	Post Intervention Pain Score: 2 \ \ \co
	Treatment Care & Plan:
	Post operative cordio Pulmoning Relativitate
	Signature Name Emp. No.
Physiotherapist	J.my J. WAYARACIAN 2102

į





Patient Details (Affix Label here)
Name: Mr.VENKATACHALAM P

63/Male/MHI202381271

UHID: DOB:

27/12/2023/IPH2023002615

DOA:

Dr.ANBARASU MOHANRAJ Consultant MHI/PHY/2022/050 Medway

, heart beat counts

CONSENT FORM - PHYSIOTHERAPY

I, We have been explained the current clinical condition of me/my patient Name of language) which I fully understand and understand about Operation / procedure	
POST OPERATIVE CARDIO	
PULMONARY REHABILITATION.	
(full name of operation / procedure given below in this consent form)	
Brief description of the Operation/Procedure: 1861s, Chut Percussion, Spinom Gal, Alom A's, Mobilization	dry
Gris, Aeom Gis, Mobilization	
I understand the intended benefits of undergoing the procedure. The intended benefits from this procedure are: TO Emprove Chest Granvian, To Clean out Lung Secret To Improve Thom e ADL I understand that all procedures carry certain risks. The potential risks and complications from this procedure:	120ne
Dain	
I have been explained the implications of not undergoing this procedure and the alternative methods of treatment like:	<u> </u>
Ni .	
I declare that I have received and fully understood the information provided in this consent form, that I have given an opportunity to ask questions relating to my ailment, the operation / procedure being performed, its reconsequences, alternatives, potential complications and intended benefits and recovery, and that all my ques have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I fuldeclare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of gning this form.	risks, tions irther

	्री ि (name of do ☑myself or ☐my above named its and possible alternatives		orming the operation / pro eing fully aware of the			
/ NOONS	>					
	ned Patient / named patient's rep this form, mentally sound and am					on the
	Signature / Thumb Impres	ssion*	Name	 e	Date	Time
Patient						
Surrogate/Guardi (if applicable #)	an Joona		Meenakshi Write name and relation		28/12/23	19:20
Reason for surrogate consen	Patient is unable to give c	onsent b	ecause:			
Witness	84		Sayab	ilm - S.p.	28/12/23	19:20
Interpreter (if applicable)						
* Right Hand for Mal	es & Left Hand for Females # Or	nly if Patien	t is a minor or unable to giv	re consent		
I, the undersigned doctor, have explained the nature, potential risks and complications, intended benefits, expected post-procedure course, and possible alternatives to the planned operation / procedure, to the patient / patient representative. I am confident that he / she has understood the information fully as described in this document.						
	Signature	Name	• · · , ,	Reg. No.	Date	Time
Consent obtained by	G.E. olog	AK	ASH G.B	0256	28/12/25	19:20
Procedure performed by	G. F. Stool	A	KASH-GIE.	0256	28/12/23	[9]:20
			1			
			1.		·	
			1.		·	
			· • .		·	

Signature of Patient / Patient's Relative (only if Patient is unable to sign): a

For the above mentioned operation(s) / procedure(s) that I have been made aware of, I give my consent voluntarily to





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Mr.VENKATACHALAM P 63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ

PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
28/12/3	21:00	SB Pamanathan-P - ET Oral Suctioning done Yielded Hick Specetions	MH10280
20/12/23	8:45.	Sto Romanathour. P. By loval Inogal Enclosing done Yellded . Hran white Secreption Patient extendated and	
		Connected to 02 NP. 4/104 Inh Speech voice clear sandible DBEG encounged - Chapt remoder dove to Ble Chapt wall	J. ~ J
		- Spironely la Eulonyed Jes 600ce Ber-600ce - Active les to Ble UC & le Culonyed,	





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Mr.VENKATACHALAM P

63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ

PHYSIOTHERAPY TREATMENT CHART

·

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
29/12/23	00:F1	S/B ARASH DBer euchorages	G. F. Alkor MH10256
		- Spironetry esi encouraged Ins: booce trp: booce - cheet poscusión to Ble Cheet wall	-
		- Aron to Ble UL & LL - Vibroller gluen - PT Chair Mobilised.	
29/12/23	22:00	S/B Ramanathan.P DBES encourged	
		AROM Pos to Ble vizu	MH10260
		Spirometry Gis encouraged Zw.: book Gyp: 600ch -Vibrator Given	7.,,,,
30/12/23.	Pri co	S/B Damanathan. P DBE's encouragred Chart percussion to Blichatwa	MH1 0260
		- Heom Go's to Bliazu - Voltrator Given Iprometry Go's encouraged The: 6004 Gop: 6004	





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PHYSIOTHERAPY TREATMENT CHART

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Mr.VENKATACHALAM P

63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ

100KW <u>181</u>100 WW <u>11810</u>00 WW 1180 WW 1880 WW

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
30/12/23	9:00	- Drien Encouraged - Drien Encouraged - Sprometry on Eucourage - Sprometry on Eucourage - Sprometry on Ele	Green About
30/12/23	1700	- Check positions Check positions - Check positions - Alphander positions - Mibroston govern - Mibroston govern - Clar AKASI+	C. K. Alex
31/12/23	(0too	Sts J. MAMARAGANAN Sts J. MAMARAGANAN Doe on buyed Stronely en enbuyed	
		-Actore en do Burlou	marc 2102





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Mr.VENKATACHALAM P

63/Malc/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ

PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
DAIE	1 1141		nciviARNS
31/12/25	15,00	SIB J. VIANARACANAN	
01/01/249	(10%00	- Cheef mundon done to Ble cheef wall Shoonely en cubuyed Ing-booce Br. 600ce Actue en to Ble up ple - Pt wall week SIB ARASM SIB ARASM	J. my
		- Drey europeraged - Sprometry sir europeraged - Sprometry sir europeraged - Lap; 600cc Exp; 600cc Lap; 600cc La	Girte-Alex HUTHO256
01/01/204	16:00	See AKACH Sold Chrownaged - Sprometry of Exp 60000 - Sprometry & Exp 60000 - Check poseulien to Bli Check wall - Arom to Bli viell	G.B. AROB M HTO256





MH/ PRINT / 0096 / PHY

Mr.VENKATACHALAM P

63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.Anbarasu mohanraj

		PHYSIOTHERAPY TREATMENT CHART	- 198144 4041 004 510 844 1044 4041 0041 044 1041 1441 14
DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
		- PT Stair Clemb Eucouraged - Nucl. Whratcon to Bh Cheet wall	
2/1/24.		S/B Damanathan &	
		-Chest percuerón to 13h Chest wall	JAR.
,		HEDM BUY TO BILLIAL	mH10266.
		-ARDM Box to Ble U 2 U - Spinometry Bis encouraged 8 m. 600cc Orp: 600 cc - Pt Mobilized	
		- Pt Modailized	
}			





Every heart beat counts

Mr.VENKATACHALAM P

63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ

URINE ROUTINE ANALYSIS MICROBIOLOGY SHEET

OKINE KOOTHIL ANAL	100 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
DATE	14 12 23.
COLOUR	PALE YEllow
REACTION	
SPECIFIC GRAVITY	1.010
APPEARANCE	Clear
ALBUMIN	
SUGAR	
ACETONE	
BILE SALT	
BILE PIGMENT	
UROBILINOGEN	NORMAL
PUS CELLS	3-5
EPITHELIAL CELLS	1-5
RBC	NIC
CASTS	MC 21M
CRYSTALS	6/1 C
OTHERS	NIL

MICROBIOLOGY-CULTURE REPORTS

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



DIABETIC CHART

Mr.VENKATACHALAM P

63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ

THE RECEIVED AND THE PROPERTY OF THE PROPERTY

ACTUAL WE	EIGHT	61 kg HbA,c	6:41.	<u> </u>	
PREVIOUS	DIABETIC I	MEDICATIONS			
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
27/10/23	13.00	136 rag/d/		Q Tras	DR. PRAVEC
	12.30	123 maidl	T. melyomis NPO from SAM	D 404	Dr. Privees
28/12	6.30.	112 mg 1 de	NPO fromstan	n. SR1_	DR. PRAVECE Dr. Proves BOL Norm DR. Anushya
·	10.30	83 my/de	Npa	5.9%.	DR. Anushing
			<u> </u>	<i></i>	4
					

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 míns, 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.		
		251-300	Adjust Infusion rate to 6u / hr.		
*	Target Blood Sugar 150-200 mgs.	301-350	Adjust Infusion rate to 8u / hr.		
*	To monitor K+ separately.	351-400	Adjust Infusion rate to 10u / hr.		
	Urine Acetone	>400	Adjust Infusion rate to 20u / hr.		
			(







Every heart beat counts

Mr.VENKATACHALAM P

63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ

DIABETIC CHART

ACTUAL WE	EIGHT	61 Kg HbA,c.	V XR HEX 6/500	[0-0-0]	
PREVIOUS	DIABETIC I	MEDICATIONS	-R 0.3 10 [1-	1-07:	
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
28/12/23	18.35	18A maldl	MY ACTRAPID	Olavel 00 fg of	Dr. Squastor
	శివి!ణ	221 my Idl	Ty ACTRAPID A Du lhr.	Jan dat	DR. PRAVEEN
	20:00 144	tau maldi	STOPPED INT. ACTEAPU	1	DR. PRAVEEN
29/12/23	8 ; ∞	144 my Call	TI DIAMILLIM XR MEX LOISTO GIVEN AT 11:00 TINOUESER 0:3112 Sus) Lei	DR. PRAVEEN
29/12/2	ومنط	Momalal	AT 1100 3h AT 14.00 T. VOLIBO-R 0.3110 Plo	Dant	DR. PRAVEEN
عالا	19:30	.J 180mg1dL	This Human ActedAd His Bold Cliven of 19150.	Dandold C	DR. PRAVEEN.
30 12/28	04:30	155 melall	T. DIAMILEOH XL MIEX EGISEO TI VOLIBO-ROISINO UNUEN PLO AT 8:30	Ramon 71 13-2-	DR. PRANEEN 8 JEYAKUTAI
	12.30	22 Imgldl	Inj. HA Burils	8 13-32 Dev 19-32	Dr. Praven
	1835	148 mg/bl	T- mot 40 minto		16 Mayron
21/12/23	6:30	152 mg/d2	1. Dramicron XR		J. Br. Proween
		J	1. Veli6-R	ash. Alf	
	12.30	153 mgld	T. Volibo-R	Self 13.40	V. Dogwood
		INICATORICATIONIC P	'AB 1110111 IN INICHA	المناسلا	, - .

INSTRUCTIONS FOR INSULIN INFUSIONS

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Urine Acetone	>400	Adjust Infusion rate to 20u / hr.	







| Mr.VENKATACHALAM P | 63/Male/MH1202381271 | Pal | 27/12/2023/IPH2023002615

DO

T. HEGFORMIN Soong 0-0-1

Pal 27/12/2023/IPH2023002615
Na: Dr.ANBARASU MOHANRAJ

ACTUAL WE	IGHT	Hbaic T. DIAMI MEDICATIONS T. VOLIB	BAY. CRON XR MEX	bol soome	, [[-0-0]
PREVIOUS I	DIABETIC I	MEDICATIONS T. VOLLB	0-R 0.3/1	o [i-1-	<u>o</u>
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
31/12/n	18-20	138 malde	T-mot forming	oom (A)E)	AK BOUTOO?
	6:30	In meylde _	TiDramicron on &	bony given at	e polinos
		J.	かいんしゅール のう)		
	12.30	118 mg/dl	T-wolibo	MD 1250	W/00 124669
	18.30	118 mg (dl gy mg/oll	T-MethominD	mg 20.30	Dolum
2/1/24	630	113	1. Dramicson x1	Ry Chan	(Linn
<u></u>			9 VOL/60-Rag	1200	<u> </u>
	12-30	193 myld	T. VOC 180-R. 63	04 2 14.60	There
				D)/	
<u> </u>					
		INSTRUCTIONS FO	OR INSULIN INFUS	ONS	

*	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.
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	hourly when stable) and adjust Insulin rate according to the following Algorithm.	201-250	Adjust Infusion rate to 4u / hr.
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*	To monitor K+ separately.	351-400	Adjust Infusion rate to 10u / hr.
	Urine Acetone	>400	Adjust Infusion rate to 20u / hr.
		j	l ,







Every heart beat counts

BLOOD GROUP

o positive

INVESTIGATION SHEET

MT.VENKATACHALAM P
63/Msle/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

HAEMATOLOGY Hb	Date	14/12/23	0-11-10-	n et 1			
Hb		14112123 	<u> </u>	7415177	 -		
P.C.V 37. B Platelets 275000 T.LC 8900							
Platelets		2-6			-		
TLC		97/3					
Polymorphs		275000					
Lymphocytes 20						*	
Eosinophils		74.4					
Mono / Basophils		20.					
E.S.R BIO-CHEMISTRY Urea		, , , , , , , , , , , , , , , , , , ,				-	
BIO-CHEMISTRY Urea 18		38/0.5			<u> </u>		
Urea 18				ļ			
Creatinine 0.82 0.8t Sodium 133 134 Potassium 0.28 5.50 Bicarbonate 2.4	I .						
Sodium	L	18	25				
Sodium	Creatinine	0.52	0-81	<u> </u>			
Potassium	Sodium			1.			
Bicarbonate	Potassium	6.38	· '	11.62			
Magnesium Calcium Phosphorus LFT T.Bilirubin O.38 D.Bilirubin O.21 I.Bilirubin O.21 S.G.O.T I.Y S.G.P.T ALP ALP B2 GGT Total Protien S.Albumin CARDIAC ENZYMES Troponin I CKNAC - CPK	Bicarbonate	1 24					
Magnesium Calcium Phosphorus LFT T.Bilirubin O.38 D.Bilirubin O.21 I.Bilirubin O.21 S.G.O.T I.Y S.G.P.T ALP ALP B2 GGT Total Protien S.Albumin CARDIAC ENZYMES Troponin I CKNAC - CPK	Chloride	96-8					
Phosphorus LFT T.Bilirubin D.38 D.Bilirubin O.28 I.Bilirubin O.21 S.G.O.T S.G.O.T ALP ALP B2 GGT I3 Total Protien S.Albumin CARDIAC ENZYMES Troponin I CKNAC - CPK	Magnesium						•
LFT	Calcium						
LFT	Phosphorus						
D.Bilirubin I.Bilirubin S.G.O.T S.G.O.T ALP S.G.P.T ALP S2 GGT Total Protien S.Albumin CARDIAC ENZYMES Troponin I CKNAC - CPK	LFT						
D.Bilirubin D. 17	T.Bilirubin	0.28		1			!
I.Bilirubin 0 · 2	D.Bilirubin	1					
S.G.O.T 14 S.G.P.T 12 ALP 82 GGT 13 Total Protien 8. に	I.Bilirubin	- , ,					
S.G.P.T 12 ALP 82 GGT 13 Total Protien 8.5 S.Albumin 4.5 CARDIAC ENZYMES Troponin I CKNAC - CPK		I		Ì			
ALP							
GGT 19 Total Protien 8.5 S.Albumin 4.5 CARDIAC ENZYMES Troponin I CKNAC - CPK	ALP	8-2					
Total Protien S.Albumin CARDIAC ENZYMES Troponin I CKNAC - CPK	GGT]		_	
S.Albumin CARDIAC ENZYMES Troponin I CKNAC - CPK	Total Protien						
CARDIAC ENZYMES Troponin I CKNAC - CPK		4.5					
Troponin I CKNAC - CPK							
CKNAC - CPK							
[-			
	CK - M.B. MASS			 	 		1
LDH						<u> </u>	
Ntpro bnp							

Date	14/12/23			l		
COAGULATION	10.3 110.0				-	2
PT / INR	10.3/12.0					·
Fibrinogen	1					
D Dimer						
LIPID PROFILE						
Total Cholesterol			l			
Triglyceride				_		
H.D.L			-			
L.D.L						
VLDV						
THYROID FUNCTION						
T.S.H	1.74					
T.3	117					
T.4	73					<u> </u>
SEROLORY	10./				-	
HIV	h		 			
	1	 	 			
HBsAg V.D.R.L	nogative	_				
	¥ ·					
COVID 19					_	
RT- PCR		_				
lgM						
lg						
HBA1C	6.4			_		
FBS/PPBS	,					
RBS			_			
S.AMYLASE			J			ļ
S.LIPASE		,			_	
C.R.P						
PROCALCITONIN					_	
DDIMER						
S.Osmolality						
URINE						
Osmolality						
Spot - Na						
977	28.0					
1						
	<u> </u>					
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	-	-				
						
	 					
		<u> </u>	<u></u> _		<u> </u>	<u> </u>

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63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ

BLOOD GROUP

O' POSITIVE

INVESTIGATION SHEET

-						
Date	14 12 23	29/12/23	2012123	1/1/24		_
HAEMATOLOGY	1					
Hb	12.6	10.1	9.0	8,2]	
P.C.V	37.3	೩೨,%	i - i	24.3		
Platelets	474,000	<u> अमुत्रकठ</u>		18 3000		
TLC	8900	14890		9810		
Polymorphs	74·A	94.5		82.5		
Lymphocytes	20	2.1		13.D		
Eosinophils	1.2	0.0		0.4		
Mono / Basophils	3.80.5	3,4 0,0		1.0 001		
E.S.R	3 0 0	1	1			
BIO-CHEMISTRY	17 (12 23				-,	
Urea	35	d3.	89.	19		
Creatinine		0191	0.74	0.76		
Sodium	0.81		129	138		
Potassium	5:50		1118	4:09		
Bicarbonate						
Chloride						
Magnesium		2.1			·	
Calcium			<u> </u>			
Phosphorus						
LFT						
T.Bilirubin	0.38	0.34				
D,Bilirubin	0-17			Ţ ,		
I.Bilirubin	0.51		1			
S.G.O.T	1A					
S.G.P.T	12]_		_
ALP	82					
GGT	13					
Total Protien	6.5					
S.Albumin	4.5	3, 3				
CARDIAC ENZYMES	'					
Troponin I						
CKNAC - CPK		344		<u> </u>		
CK - M.B. MASS		19.9				
LDH						
Ntpro bnp						

	_		 		
Date	14 12 23				
COAGULATION					*
PT / INR	10.3 0.8				٠٠, د
Fibrinogen	`				
D Dimer			 		
LIPID PROFILE		<u>-</u>			
Total Cholesterol					
Triglyceride					
H.D.L					
L.D.L					
V.L.D.V					,
THYROID FUNCTION				•	
T.S.H	トキ4				
T.3	73				
T.4	101				
SEROLORY					
HIV				<u> </u>	
HBsAg	MEGATIVE				
V.D.R.L					
COVID 19			,		
RT- PCR					
lgM					
lg		1			
HBA1C	6.4%) -			
FBS/PPBS	~ 1 /				
RBS					
S.AMYLASE					
S.LIPASE					
C.R.P					
PROCALCITONIN	•				
DDIMER	_				
S.Osmolality					
<u>URINE</u>					
Osmolality					•
Spot - Na					
				·	
` ,					
			}		
L			<u> </u>		

(A Unit of United Alliance Healthcare Pvt Ltd)

.. Mr.VENKATACHALAM P

F 63/Male/MHI202381271

1 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ



VITAL INFORMATION SHEET

MHI/IP/2022/074

Every heart beat counts

BLOOD GROUP ON ADMISSION Height in CM Weight in Kg. 168 cm

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NO. OF DAYS		24[_		Ðγ													_														-						_				-				-	_				
DATE	0	27	12-1:	ኒე	بر	X.	./ .! !2	פפ	2															_	-		_							-															_				
HOUR	2	27 6 10	2	6 10	2	6	10 2	6	10	2	6	10 2	2 6	10	2 6	10	2	6 10	2	6	10	2 6	10	2	6 10	2	6	10	2 6	10	2	6 10	0 2	6 1	10 :	2 6	3 10	2	6 1	0 2	2 6	10	2	6 1	0 2	6	10	2	6 10	2	6 1	0 2	2
40.5°		\blacksquare	4	\mathbb{H}	\Box	\dashv	Ŧ	Ŧ	F		\Box	\bot	F	П		П	7	\bot	\vdash	\Box	7	\bot	\square	\Box	\perp	\perp	П	7	-	F	П	7	T	\Box	4	\mp	F	П	-	\mp	\perp	\prod	\dashv	Ŧ	F	П	7	1	\bot	П	\top	Ŧ	Ŧ
40°		$^{\pm}$		口		1	⇉	1	Ħ			丰			1			\downarrow	匚	\Box	コ	#	\sharp		#	İ	Ħ	#	1	ļ	Ħ	#		Ħ	#	1	1		1	‡	‡	\Box	_	#	‡	H		1		Ħ	1	1	#
39.5°	H		+	- -		\dashv	+	╁	H	Н	\vdash	╁	+	Н	+	H	\dashv	+	╁	╁┤	十	╁	+	H	+	╁	Н	+	+	╁	Н	+	╁	${}^{\dag \dag}$	+	╁	╁	H	-	╁	╁╴	╁┤	\dashv	╁	╁	Н	+	+	╁	H	+	+	\dashv
	\vdash	\perp	\Box	\square		\dashv	Τ.	-	H		\dashv	+	F	П	1	\square	7	\bot	\vdash	\Box	4	Ŧ	H	П	\dashv	\vdash	H	7	1	\perp	П	Ŧ	\perp	\prod	\dashv	7	1	П	1	Ţ	\bot	П	\dashv	1	\vdash		4	\mp	F	\prod	#	Ţ	\exists
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38°	H	Ŧ	H	\Box		1	1	-	H			Ţ	1	H	1	\Box	1	1	L	\Box	7	1	\Box	П	7	1	П	1	ļ	T	П	1	Ļ	H	1	ļ	Ļ	П	1	Ŧ	ļ	П	4	4	Ļ		\Box	4	\downarrow	П	1	Ŧ	_
37.5°		\pm	\ddagger	\pm		\exists	\downarrow	⇇	上		⇉	⇟	$^{\pm}$		⇟	Ħ	士	\pm	╘	目		#	\perp		#	t	\Box	†	⇟	⇇	\Box	\downarrow	\dagger	\Box	\downarrow	‡	t			†	#	\exists	⇉	#	\dagger	\vdash	Ħ	1	‡		士	\pm	_
	\vdash	+	H	+	\vdash	+	+	╀	╀	_	\vdash	+	+	H	+	\dashv	\dashv	- -	╁	\dashv	\dashv	+	+	H	+	╁	H	+	+	+	\mathbb{H}	+	╁	H	+	+	╁	\vdash	+	+	╀	Н	\dashv	+	+	\vdash	H	+	+	╂┪	+	+	-
37°	H	7		\top			\bot				\Box		1	П	1	П		1		\Box		T	Τ.	П			П	1			П				\bot	1	ļ		1	T	1	П	1	1	\downarrow	\vdash	П	1	ļ	П	_	Ŧ	_
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PULSE	H	e m	7	8	7	7									•														•		<u> </u>														•								_
RESP	17-1 20	\mathbb{Z}	2	٠,	2	ھ	\perp							_[L									\perp			Ĺ				\perp															L.		\perp	_
B.P.	17-12	140	130	o Ka	122	2[7	<u> 4</u>							_					↓_							1_		\downarrow					┸					ļ									4			L		4	_
SP02	9	17	<u>Y</u>	糾	q	17	<i>-</i>							_				_	丄									\perp					L				_	<u> </u>									\perp	_				\bot	_
AILY WEIGHT	Ш	61.	Ky											_					┸					_				\bot	_				\perp					$oxed{igspace}$									_				_	4	_
HRS INTAKE	LK	00000000000000000000000000000000000000)ľľ	<i>ال</i>						_				\perp					上	_				_				_					\perp					$oxed{oxed}$									_						_
HRS OUTPUT		20.	0	$\mathcal{M}^{\mathfrak{q}}$		-													L									\perp												_					_	_							
BALANCE	$\sqcup \sqcup$	5	\mathfrak{n})C										_[L																												\perp			_		\perp	_
MOTION	\coprod	_			~			•											1					-								70						1									- 1						

(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.VENKATACHALAM P

63/Mulc/MHI202381271

27/12/2023/IPH2023002615







BSAL

Every heart beat counts

1.66m2

BLOOD GROUP	2 O POSITIVE
ON AD	MISSION
Height in CM	Weight in Kg.
168CM	61160

VITAL INFORMATION SHEET

Dr.Anbarasu mohanraj Procedure: ORABXA URAFTS Diagnosis: CAD - TVD 16F - 55%.

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Mr. VENKATACHALAM P 63/Malc/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





art beat counts

EARLY WARNING SCORE MONITORING CHART

Name:					- 1	Age/Se	x:		Patient I	d No:	
NEWS key	DATE	27/12	22/12	271	2811	201					DATE
1 2 3	TIME	13.00	120	220	600	dno					TIME
B	>25		1			100	3				>25
spirations	21-24						2				21-24
eath/ min	18-20	-	-0-	0.0		-					18-20
	15-17										15-17
	12-14										12-14
	9-11		6	1000			1				9-11
	<8	1000000	B 100 100 100 100 100 100 100 100 100 10		No.	SECTION NO.	3	TOTAL SECTION	THE ROLL OF	REST DESCRIPTION	<8
В	>96	3	-	-							>96
o2 Scale 1	94-95						1				94-95
ygen Saturation (%)	92-93						2				92-93
	<91	100000			CONTRACT OF STREET		3				<91
o2 scale 2 oxygen	>96 on oxygen						3				>96 on oxygen
uration (%) use scale 2 arget range is 88-92 % in hypercapnic piratory failure only											
e scale 2 under the	95-96 on o2						2				95-96 on o2
ection of qualified	93-94 on O2						1				93-94 on O2
nician	>93 on air										>93 on air
	88-92										88-92
	86-87						1				86-87
	84-85						2			AND DESCRIPTION OF THE PERSON NAMED IN	84-85
	<83%					BC 545 100	3	MARKET BEE	THE PLANT OF THE		<83%
r or Oxygen ?	A= Air	- 3	-	10	- 1						A= Air
	O2litre/ min						2				O2litre/ min
	Device										Device
ood Pressure	>220	100					3				>220
	201-219										201-219
	181-200		1000				2				181-200
	161-180						1				161-180
	141-160	10	-	19-	-	-+					141-160
	121-140	-	~	-							121-140
	111-120		-								111-120
	91-100	Total Control					1				91-100
	81-90						2				81-90
		Name and Address of the Owner, where	-	-	C 600 C 100		3	STATE OF THE PARTY		CARLO CARLO DE	71-80
	71-80						3		ARUS SECTION S		61-70
	61-70										51-60
	51-60		100 Car	-			3		A SECTION OF		<50
	<50	-1-	-26	-73	11	20	3		Control of the last of the las	Name and Address of the Owner, where	
stolic BP	mmHg	-10	10	78	14	20	-	-	-	-	mmHg >131
	>131		No. of Lot				3				
ise	121-130						2				121-130 111-120
ats / min	111-120						2				
	101-110			-			1				101-110
	91-100						1				91-100
	81-90		_	.							81-90
	71-80		-	1 4	-						71-80
	61-70		-	-	-	1					61-70
	51-60		-		-						51-60
	41-50						1				41-50
	31-40		100000	No.		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	3	STATE OF THE PARTY			31-40
	<30	ALCOHOLD STATE	A COLUMN	16000	PART AND	FEET S. S. S.	3	BOOK THE REAL PROPERTY.		NORTH AND ASSESSMENT OF THE PARTY OF THE PAR	<30
	Alert		-	-	-	-					Alert
nsciousness	Confusion	NEW TON	10000		(0)	200 200	3	THE PARTY NAMED IN			Confusion
ore for New onset of	V	BURBUR .	1200	Transfer of	1030, 440	A THE OWNER WHEN	3				V
nfusion	Р	1000	THE REAL PROPERTY.	\$36.9X	100 140	Water and	3	Charles III	E 10 500 700 6		P
o score if chronic)	U	BEAL ST		1000	10000		3		ALL PLANTS OF THE	THE PARTY OF THE P	U U
	>39.1 degree						2				>39.1 degree Celsius
mperature	Celsius 38.1-39.0						1				38.1-39.0
gree Celsius	37.1-38.0										37.1-38.0
	36.1-37.0					4					36.1-37.0
	35.1-36.0		-		-		1				35.1-36.0
	< 35.0	100000	PASSE.		North	Name and	3000	100 miles	SERVICE STREET	THE PARTY OF THE	< 35.0
EWS Total	1 33.0	0	0	0	0	0					
onitoring Frequency		Uth	MG	COH	C16	att					
calation of Care Y/N		211	N	1	7	-					
tials by RN		9	and	F	13	.0					
tials by Sr. RN		(100	200	200	TE	1					
		(/2)	11 (4.7)	4771	INV	- A	1			1 1	The second secon

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





63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





Every heart beat counts

EARLY WARNING SCORE MONITORING CHART

NEWS key	DATE	1112	20/12	211	21/12		310)	21117	111	111	1111	112	11/2	1 11 13	DATE
1 2 3		3911	-0	717	10000	3/12	.613	2000	, class	TOK	1	110	16.00	2000	
	TIME >25	Los	2.0	6,00	1000	40	Co	3.1	200	pa.	10.0	16.00	10.0	32.00	TIME >25
Respirations	21-24							2				No. No. of Concession,			21-24
Breath/ min	18-20	-	-	-	-		-61	-		40	- 9		40.	-	18-20
	15-17														15-17
	12-14														12-14
	9-11		-		-	Name of Street	-	1	-	-	-	E-STATE OF	Name and Address of the Owner, where		9-11
A+B	<8 >96			THE OWNER OF THE OWNER OWNER OF THE OWNER	-	-	-		_0_	-3/	-	Name and	District on Land		>96
SPo2 Scale 1	94-95		01/20/20					1		0 /		10			94-95
Oxygen Saturation (%)	92-93		100					2			1000000				92-93
	<91							3							<91
Spo2 scale 2 oxygen saturation (%) use scale 2 rget range is 88-92 % in hypercapnic respiratory failure only	>96 on oxygen							3							>96 on oxygen
use scale 2 under the	95-96 on o2							2							95-96 on o2
direction of qualified	93-94 on O2			M	-			1			-		-		93-94 on O2
clinician	>93 on air 88-92				-	0		-4.		-	_	4		- 1	~>93 on air 88-92
	86-87					7717		1							86-87
	84-85							2					-		84-85
	<83%							3							<83%
Air or Oxygen ?	A= Air	4	- 10		-	0	,	V	-		_0	٥	10		A= Air
	O2litre/ min							2			-				O2litre/ min
	Device														Device
C Blood Pressure	>220							3							>220
	201-219														201-219
	181-200		1			- 14 18		2							181-200
	161-180		-												161-180
	141-160 121-140														141-160 121-140
	111-120	9	-		-	-	1	1	- 4		-		40		111-120
	91-100							1	230						91-100
	81-90							2							81-90
	71-80	10000						3							71-80
	61-70							3							61-70
	51-60 <50							3							51-60 <50
Diastolic BP	mmHg	20	10	10	20	02	42	-12	10	20	8/2	26	On	to	mmHg
	>131	-	7	70		07	No.	3		0	1	210	80		>131
Pulse	121-130							2							121-130
Beats / min	111-120							2							111-120
	101-110							1							101-110
	91-100			_	-	_		1			,		- 10	_	91-100
	81-90 71-80	-				2		-0-	-	-		9	-		81-90 71-80
	61-70						100								61-70
	51-60														51-60
	41-50							1							41-50
	31-40							3						DATE OF SERVICE	31-40
	<30	- China Control of			LONG ST			3	1	and the last of	DECK OF S	MITA IN A			<30
Consciousness	Alert Confusion	-	_*	1		-	7	3	AND DESCRIPTION OF THE PERSON	and the last of			1	CHINA	Alert Confusion
Score for New onset of	V							3						X 1 5 C K 1 1	V
confusion	P	0.0000					No. of the last	3							P
no score if chronic)	U							3		AMONE					U
	>39.1 degree			F 13 (15)				2							>39.1 degree Celsius
	Celsius														20.4.20.0
Temperature Degree Celsius	38.1-39.0 37.1-38.0							1							38.1-39.0 37.1-38.0
Sepi se celsius	36.1-37.0		-	-	-	9	_		la	-0	_	0	-		36.1-37.0
	35.1-36.0							1							35.1-36.0
	< 35.0		0	-				3	1	^		0	THE REAL PROPERTY.	DUSS SA	< 35.0
NEWS Total		0	0	0,4	0	6	0	0	Pin	Om	0,0		, 0	0	
Monitoring Frequency		4+1	dan	(1)		400	0104	MITT	MI	an	210)	dia	Lotto	441	
Escalation of Care Y/N		8	. 20	No	DAN	SEA	Sav	130	178	EW.	N	NO	10	1	
nitials by RN nitials by Sr. RN		(A)	1	100	100	0	0	W.	de	A A	you	8	V	M	THE RESERVE OF THE PARTY OF THE
manage of all life		100	- 00	1 28	1	V	Pick	100	- set 124	· NIL	100	120.	1 90 10	1101	

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





63/Malc/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





FARLY WARNING SCORE MONITORING CHART

Name:		1.	Age/Sex:	Patient Id No:	
NEWS key	DATE	2/1/24			DATE
1 2 3	TIME	6.00			TIME
	>25	6.00	2		>25
espirations	21-24	Maria Santa Santa Santa	2	THE RESERVE OF THE PERSON NAMED IN COLUMN 1	21-24
reath/ min	18-20		2		18-20
eatily tilli	15-17				15-17
	12-14				12-14
	9-11		1		9-11
		Name and Address of the Owner, where	1		<8
	<8	THE REAL PROPERTY.			>96
+B	>96	7			
Po2 Scale 1	94-95		1		94-95
xygen Saturation (%)	92-93		2		92-93
	<91		3		<91
po2 scale 2 oxygen aturation (%) use scale 2 rget range is 88-92 % in hypercapnic	>96 on oxygen		3		>96 on oxygen
espiratory failure only	95-96 on o2		2		95-96 on o2
se scale 2 under the firection of qualified	93-94 on O2		1		93-94 on O2
inician	>93 on air				>93 on air
	88-92				88-92
	86-87		1		86-87
	84-85		2		84-85
	<83%	STATE OF THE PERSON NAMED IN	3	CONTROL OF THE PARTY OF THE PARTY OF THE PARTY.	<83%
Air or Oxygen ?	A= Air				A= Air
	O2litre/ min		2		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				111-120
	91-100		1		91-100
	81-90		2		81-90
	71-80	100000	3		71-80
					61-70
	61-70		3		
	51-60	MATERIAL DESCRIPTION OF THE PERSON NAMED IN COLUMN 1	3		51-60
	<50	CARL STACES	3		<50
iastolic BP	mmHg	-38			mmHg
	>131	Marie State State	3		>131
ulse	121-130		2		121-130
eats / min	111-120		2	STATE OF THE PERSON NAMED IN COLUMN	111-120
	101-110		1		101-110
	91-100		1		91-100
	81-90				81-90
	71-80	4			71-80
	61-70				61-70
	51-60				51-60
	41-50		1		41-50
	31-40	SECTION AND DESIGNATION OF THE PERSON.	3		31-40
	<30	THE RESIDENCE OF THE PARTY OF T	3	CARROLL CONTROL PROPERTY	<30
	Alert			15 TO 15 TO	Alert
onsciousness	Confusion	THE RESERVE NAMED IN COLUMN	3	STATE OF STREET STREET, STREET	Confusion
core for New onset of	V	STREET COLUMN	The section of the section of the section of		V
onfusion	P	CONTROL OF THE PARTY OF THE PAR	AN ATTORNAMENT OF THE PARTY OF	STREET STREET, STREET STREET, STREET	P
no score if chronic)	U	Mark of the last	THE RESERVE THE PARTY OF THE PA	THE COLUMN CONTROL OF THE PARTY	U
	>39.1 degree		2	CONTRACTOR OF THE PARTY OF THE	>39.1 degree Celsius
	Celsius Celsius		-		Post degree ceisius
emperature	38.1-39.0		1		38.1-39.0
egree Celsius	37.1-38.0		1		37.1-38.0
E. C. C. C. C. C. C. C. C. C. C. C. C. C.	36.1-37.0	1	 		36.1-37.0
	35.1-36.0		1		35.1-36.0
	< 35.0	THE RESERVE OF THE PERSON NAMED IN	1		< 35.0
IFINIC Team	< 35.0	0	3 3 3		C 55.0
IEWS Total		CUL			
Monitoring Frequency		217			
scalation of Care Y/N		48			
nitials by RN		X			
itials by Sr. RN					

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







ATACHALAM P Mr.V

63/M 4HI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ



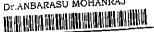


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63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr. ANBARASU MOHANRAJ









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MOTION NOT PASSED



63/Male/MHI20238127 27/12/2023/IPH2023002615









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eam	200)				1600			Mo	TON	NOTP	ASSED	+				



Mr.VENKATACHALAM P
63/Malc/MHI202381271
27/12/2023/IPH2023002C...
Dr.ANBARASU MOHANRAJ







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Mr.VENKATACHALAM P 63/Mulc/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ









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Frequency of re-assessment:

Enteral / Parenteral

Weekly

□ Daily



Department of Dietetics



Every heart beat counts

Mr.VENKATACHALAM P

63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ

NUTRITION ASSESSMENT AND CARE PLAN FORM 440 CODD Food allergies: Yes/ No, if yes, specify. Height:.... Long.....cms Religious Beliefs: **Vegetarian** Non Vegetarian Eggetarian ___ Jain Diet Prescription: 1000 (allow) dia heti. SUBJECTIVE GLOBAL ASSESSMENT (ADULTS Patient's related Medical History 1) Weight Change (overall change in past 6 months) **□**4 10 - 15 K No weight change/ <5% 5 - 10% >15% gain 21 Dietary Intak Duration **□** 4 T1 2 □ 3 Full liquid diet/ No change Sub - optimal Rypo - calorio Stanvation solid diet moderate liquid diet Adequate / Excessive Typo - caloric feeds Enteral/ Sub - optimal inadequate Stanyation Nutrition 31 GastroIntestinal Symptoms Duration **2** □4 □ 5 Diarrhoea Nausea Vomiting / severe anorexia No symptoms emolamy Functional Capacity (Nutrition related functional Impairment) Duration: 4) **0** 4 □ 3 □ 5 Red / chaic-None /Improved Difficulty with Difficulty with Light activit ridden with no or little activity Co - morbidity (Disease and its relationship to nutrition requirements) 51 <u>□</u> 5 □ 2 Healthy morbidity morbidity/age morbidity multiple co morbidity 8) Physical examination Decreased fat stores or loss of subcutaneous fat 1) **4** □ 2 □ 3 □ 5 Mild Severe Normal 2) Sign of muscle wasting 丒 _ 2 **□**3 **11**4 **□** 5 Normal MJd Moderate Severe Total Score = Sum f above 7 components Nutritional Status : Based on this patient is (/ to 14) Well Mourished Moderately Malnourished (15 to 18) [] (19 to 35) Severely Malnourished Nutrition intervention: 🗖 Enteral ☐ Parenteral □ No Diet counseiling provided:

27/12h, Dietitian Signature / Name / Date / Time Maria Catherine Jolus Senior Dietitian

Fort - night

Calorie count:

. ☐ Yes

☐ Monthly

E No

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
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**************************************	puolin, diabeter dit. Expfid es snall fut near & los gruin couled	Maria Catherina John Senior Dietitian
28/12/14 1 6:00	Patient shifted to OT for origing (ARM) and lept a MON. Patient wied to se	
	an pur donton) admin.	
29/12/u,	Mon over. Patriol benated dealists, cjil dit. Can initiate or shabile orig public, soft volid dit.	Maria Catherine John Senior Dietitian
30/12h, 14:00	Potent mind to would Recupped in	Maria Catherine John Yay Senior Dietitlan

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Mr.VENKATACHALAM P
63/Malc/MHi202381271
27/12/2023/IPH2023602615
Dr.ANBARASU MOHANRAJ



Department of Dietetics

CARE PLAN FORM - A

•	CARE PLAN FORM - A	
DATE AND TIME	DIETITIAN NOTES	SIGNATURE
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Department of Dietetics

CARE PLAN FORM - A

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Mr.VENKATACHALAM P

63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ

Dr.Anbarasu Mohanias

PSYCHOLOGICAL WELLBEING REPORT

Date: 30 [12] 23

Time: 12.30 m.

Unit: 105A

Clinical diagnosis:

CAD-ND 172 DM/HTN/OLD-CVA.

Surgery/ Procedure:

Impression:,

Smorring (:35 years) - ontronne dependamen.

- motoration I (to quit soutstance).

- calm affect, irotated by physical cfo,

oriented responsive

- sleep & appetite D.

- wistoma expensed for behavioueal

modification discursion to quit mushing,

modifications of supportive countling provided

treeds the motoration.

Employee ID: MMO278P34

Signature of the Psychologist:





INTRAOPERATIVE NURSING RECORD

Patient Details (<i>Affix Label here</i>) Name: UHID: DOB: Sex:	Mr. VENKATACHALAM P 63/Male/MHI202381271 27/12/2023/IPH2023002615 Dr. ANBARASU MOHANRAJ
Name of Surgery '> 0	PCABE CLOSED MEMENT Date of Surgery: 28/12/202
Mode of Transfer to OR	☐ Bed ☐ Stretcher ☐ Other ☐
Anaesthesia Type	: Epidural DOC 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	Chlorhexidine Prep Providone Iodine Lodophor scrub
	Alcohol Prep Others (specify)————————————————————————————————————
Electrocautery	: Monopolar Pad Loacation Bipolar
Tourniquet	Location
	☐ Applied Time → Released Time →
	Applied Time - Released Time - Released Time
•	☐ Applied Time ☐ Released Time
Other equipment used	
Personal	: Usurgeon DR. ANDARARU Wast. DR. PRAVISEN
	Surgeon DR. ANDARASU Asst. DR. PRAVERN
Type of Specimen	- / · · · · · · · · · · · · · · · ·
Lab	: Pathology Permanent Frozen Time sent
	☐ Cytology ☐ Time of report
	☐ Microbiology
	Biochemistry

	Packing / Drain	ns / Catheters											
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	Date & Time: Circulating Nur Name; Date & Time	se Signature	1800/ AMM										





63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission 39 100 Time of Arrival: 12,00 Mode of Admission: Walking Wheelchair Stretcher											
Accompanied by Relative: Yes No If Yes, Name of the Relative: Will Mentals.											
Relationship with Patient: MIFE - Contact Person's Name: Relationship: — Relationship: —											
Contact No.: 89330785 Primary language spoken: Tamil English Indian International											
Interpreter needed: Yes No											
Patient status: Conscious Unconscious Disoriented Patient Vulnerable: No											
Menstrual History: LMP: Menopause:											
Medical History: DM / HTN / Co - Morbility: Yes If yes specify											
Drugs History : Antiplatelet <u>T คิดเลนิอไD</u> (Specify) <u>9 ร 19 19</u>											
Psychological Status: Calm Anxious Withdrawn Agitated Depressed Sleeping Difficulty											
Do you have any special religious, spiritual or cultural needs to be considered? Yes No											
If Yes, specify details:											
Socio Economic Status: Employed Retired Own Business Home-Maker Others:											
Vital Signs: Temp: 17.9 (°F) Pulse / HR: 14 m. (beats/min) ВР: 140 (то (mmHg)											
Respiration: 20/m (breaths/min) SpO ₂ : 96 (%) CBG: 136 (mg/dl) Height: 168 (cms) Weight: 61 kg (kgs)											
Allergies / Adverse Reaction: Yes No Medication Blood Transfusion Food Not known											
If Yes, specify:											
Pain: Yes No. If Yes, Score: Pain Scale Used: Wong-Baker FACES Pain Rating Scale (7-12 years)											
Numerical Rating Scale (>12 years) CPOT (ventilator / comatose)											
Duration: Location:											
Pain Character: Dull Aching Sharp Stabbing Shooting Burning Referred / Radiant Pain											
Nutritional Screening:											
Last 3 months Appetite: Increased Decreased No Change											
Last 3 months Appetite: Increased Decreased No Change Last 3 months Weight: Increased Decreased No Change											
Last 3 months Appetite: Increased Decreased No Change Last 3 months Weight: Increased Decreased No Change Off Type of Patient: Diabetic Type of Diet: Diabetic Diet											
Last 3 months Appetite: Increased Decreased No Change Last 3 months Weight: Increased Decreased No Change											
Last 3 months Appetite: Increased Decreased No Change Last 3 months Weight: Increased Decreased No Change Off Type of Patient: Diabetic Type of Diet: Diabetic Diabetic											
Last 3 months Appetite: Increased Decreased No Change Last 3 months Weight: Increased Decreased No Change Off Type of Patient: Diabetic Non Diabetic Type of Diet: Diabetic Dietician Informed: Yes No. If Yes, mention the Name: No. 1 mention the											
Last 3 months Appetite: Increased Decreased No Change Last 3 months Weight: Increased Decreased No Change Off Type of Patient: Diabetic Non Diabetic Type of Diet: Diabetic Diabetic Time: 15.00. Dietician Informed: Yes No. If Yes, mention the Name: Not Cathodrom Time: 15.00. Orient Patient if: Conscious Orient Patient Attendant if: Unconscious Disoriented											
Last 3 months Appetite: Increased Decreased No Change Last 3 months Weight: Increased Decreased No Change Off Type of Patient: Diabetic Non Diabetic Type of Diet: Diabetic Diabetic Dietician Informed: Yes No. If Yes, mention the Name: Not Conscious Time: 15.00. Orient Patient if: Conscious Orient Patient Attendant if: Unconscious Disoriented Room Side Rails Toilet Bell Patient Information Board Bathroom Bed Controls											
Last 3 months Appetite: Increased Decreased No Change Last 3 months Weight: Increased Decreased No Change Of Type of Patient: Diabetic Non Diabetic Type of Diet: Dieter Dieter Dieter Dieter Dieter Dieter Dieter Dieter Dieter Dieter Dieter Dieter Diete											
Last 3 months Appetite: Increased Decreased No Change Last 3 months Weight: Increased Decreased No Change Vyes Increased Decreased No Change Vyes No. If Yes, mention the Name: Not control of the Conscious Orient Patient Attendant if: Unconscious Disoriented Room Side Rails Toilet Bell Patient Information Board Bathroom Bed Controls Use of Footstool Grab Bars Nurses Call Bell Television Light Controls Telephone Functional Assessment: Particular Assessment Remarks Outcome											
Last 3 months Appetite: Increased Decreased No Change Last 3 months Weight: Increased Decreased No Change Vyes Increased Decreased No Change Vyes No. If Yes, mention the Name: Not control of the Conscious Orient Patient Attendant if: Unconscious Disoriented Room Side Rails Toilet Bell Patient Information Board Bathroom Bed Controls Use of Footstool Grab Bars Nurses Call Bell Television Light Controls Telephone Functional Assessment: Particular Assessment Remarks Outcome											
Last 3 months Appetite: Increased Decreased No Change Last 3 months Weight: Increased Decreased No Change Color Type of Patient: Diabetic Non Diabetic Type of Diet: Diabetic Dietician Informed: Yes No. If Yes, mention the Name: No. Cathony Time: 15.00. Orient Patient if: Conscious Orient Patient Attendant if: Unconscious Disoriented Agoom Side Rails Toilet Bell Patient Information Board Bathroom Bed Controls Use of Footstool Grab Bars Nurses Call Bell Television Light Controls Telephone Functional Assessment: Particular Assessment Remarks Outcome Visual Impairment Yes No 20 yrs Roading Tributy											

Daily Activity Of L	iving:									•	
Activity	Deş	ender	nt								
Bathing											
Dressing		$\overline{\Box}$									
Eating		Ø									
Walking		<u> </u>									
Toilet Use											
Pressure Injury Ri	isk Asses	sment: Brad	en Scale								
Sensory Percep	tion	Score	Moisture		Score	Degr	ee of A	Activity	,	Score	
No Impairment		4	Rarely Mois	t	4	Walks	s Frequ	ently		29	
Slightly Limited		3	Occasionall	y Moist	3	Walks	s Occa	sionall	у	3	
Very Limited	Very Limited2Very Moist2Chair F									2	
Completely Limit	Completely Limited 1 Constantly Moist 1 Bed Fast										
Mobility	Mobility Score Nutrition Score Friction									Score-	
No Limitation		<i>9</i> ⁄	Excellent		1	-+		nt prob	lem	√3	
Slightly Limited		3	Adequate		3			<u>oblem</u>		2	
	Very Limited 2 Probably In-Adequate 2 Problem F									1	
Completely imme	obile	1	Very Poor		1						
High Risk: 12 - 10; Severe Risk: 9 - 6 Total Score: 7 Action needed: Yes No Pressure injury present at the time of admission: Yes No If yes, Location: Grade: Size: Relationship: Relationship:											
	MODIFIED MORSE FALL ASSESSMENT SCALE (Age above 16 years)										
Fall Risk Assess	sment (Mo	dified Mors	e Scale):			•					
Variables				_					Nun	neric Value	
History of falling	/immediate	e or within 6	months)			<u>-</u>		No		40	
							 }-	Yes		25	
Secondary diagn	nosis (≥ 2 i	medical diag	nosis)				-	No		0	
A b 1 - 4 A 1 - d	·							Yes	>		
Ambulatory Aid None / Bed Rest		ssist								₽	
Crutches / Cane										15	
Furniture										30	
Intravenous Ther	apv / Hepa	arin Lock / Tu	ıbes Insitu				Ĺ	No		<u> </u>	
			<u> </u>					Yes		20	
Gait Normal / Bed Re	st / Wheel	Chair								O	
Weak	517 1111001	Origin								10	
Impaired						_				20	
Mental Status			_				Î		<u> </u>		
Oriented to own										0	
Overestimated or	i iorgets iir	mitations	_	<u> </u>					•	15	
Medications Includes PCA / o	niates ant	iconvuleante	anti-hyporter	nsives diuret	ics hypnot	ics		No		0	
laxatives, hypogly							 	Yes		0 _15	
Score Interpretation	: 0-24: Low			ove 45: High I		Total S	core		•	3 5	

;

As per the score, tick the following appropriate l	boxe	es:									
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 the Remove excess equipment or furniture to make a clear Keep the patient's bed in the low position at all times except the patient's bed in the low position at all times except the patient's bed in the low position at all times except the patient's bed in the low position at all times except the patient's bed in the patient's care Recourage family participation in the patient's care Ensure that floor of the bathroom is dry and not slippen. Review medications for potential side effects that can pushed 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 wheel chair to ambulate only with assistance Consider peak effects of the medications that effection when planning patient's care Do not leave patient to ambulate only with assistance Accompany the patient while going to bathroom Advice the patient to use grab bars near the toilet, bathted 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 nurs 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) Urinal / bedpan should be within easy reach (if appropriate) If appropriate, consider using protection devices: safet	bed for al for al he pa path cept c a mo re to b cher ited fo tub, a restric ses' st iate) in then	atient' during ment ote fal oe am or he level areas and sh ctions	It's easy reach ag procedure It before rising from the bed It's easy reach ag procedure It before rising from the bed It's easy reach It's								
Initial Assessment to Special Needs and Vulnera	bilit	y of	f Patient:								
	Yes	No	Remarks (please specify)								
Terminally ill patients		$ \checkmark $									
Patients with intense chronic pain		<u>-</u>	<u> </u>								
Woman in labor or experiencing termination of pregnancy		\square									
Patients with emotional or psychological distress		-									
Patient suspected of drug or alcohol dependency											
Victims of abuse and neglect		~									
Patients whose immune system is compromised		~									
Patient with infections and communicable diseases			,								
Does the patient have implants			·								
Has tracheotomy been done		~									
Has colostomy been done											
Any other potential needs of the patient		7	-								

DVT RISK ASSESSMENT														
	Assign a s	score	of 1 if (YE	S) in p	oara	ımete	r nos. 1 to	9, and	assign a sco	re of -2 if (YES) in p	oaram	eter no. 1	10	<i>:</i>
S. No.				Parar	net	ers						Yes / No		Score
1	Active cancer	(on-g	oing treatn ————	nent or	dia	gnose	d within 6 n ————	nonths c	or palliative car	re) 		Yes 🗹	No	
2	Bedridden red	cently	>3 days or	r major	sur	gery w	rithin four w	reeks				Yes 🔽	No	
3	Calf swelling (Assess for bo			d with	asy	mptor	natic side,	measur	red at 10 cm b	pelow tibial tubercle		Yes 🔲	Νo	
4	Collateral (no	nvario	ose) super	ficial v	eins	prese	nt (Assess	for both	legs)	·		Yes 📉	No	
5	Entire leg swo	llen (A	Assess for t	ooth le	gs)						Yes No			
6	Localized tend	derne	ss along th	e deep	ver	ous s	ystem (Ass	ess for b	ooth legs)			No		
7	Pitting edema	ı, grea	iter in the sy	mptor	nati	cleg (/	Assess for I	both leg	s)		Yes No			
8	Paralysis, par	esis, c	or recent pla	aster in	nmo	bilizat	ion of the lo	ower ext	remity (Asses	s for both legs)		Yes 🔲	No	
9	Previously documented DVT (Assess for both legs)											Yes 🔲	No	
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.													
Risk Score Interpretation (Probability of DVT): Tick the score obtained (✔)										Final Sco		ore	9	
Action Taken										Date		Time		
Low Risk			-2 to 0				-							
Mod	derate Risk		1 to 2											
Higl	h Risk		3 to 8							_				
Pers	sonal Belong	gings	/ Valuab	les:										
Valua	ables	C	Description				With Pa		Name & Signature of the Patient / Patient's Attendan					
Dent	ures		Jpper□L Both ⊠N											
Hear	ing Aid	百瓦	tight □ Lo	eft						19.95				
	glasses / act lens	ΔY	∕es ⊠an Ñ	o										
Jewe	ellery	□Y	′es ℤÑ	ο										
Other valuables (specify)										_				
Rep	ort (List of X-	ray, I	ECG, lab ı	report	s re	taine	d with the	nurse)	:					
											_			
Sign. Name Emp. No.										Date	Ī	ime		
	ent's Attend	ant	Morro			14	eenak	3hi.	V 	Relationship	12/2	13	-00	
Nur	se	_ [رمول	·			B =1	ania	<u>~</u> _	0195				, 60.
Unii	In-Charge		(I)	<u> </u>			Th. 0. 16			0005	1	1/12/28	_	





Mr.VENKATACHALAM P 63/Malc/MHI202381271 27/12/2023/IPH2023002615

Dr.Anbarasu mohanraj



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date:②スト	12/23	. Shift: ☐ Morn	ing Evening I	Night ,					
S	Periphera Ryle's Tut Urinary C	s: OAD _		GCS: LS I POD: — Central line of VIP Score: of	days: —	•			
В	On room			'. Date of surg IV fluids on fl	•				
A	ASSESSMENT Vital Signs: Temp. Gr. Gr. Pulse / HR: Gr. (beats/min) Respiration: Gr. Molbreaths/min) BP: Ho Fo (mmHg) SpO2: 96 (%) Height: 68 (cms) Weight: 6] (kgs) BMI: 21 6 for Others: Pain Score: D Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NFS / CPOT Fall Risk Score: 20 Fall Risk Protocol: Low Medium High Braden Score: Minimal Risk: 23-19 At Risk-Mild Risk: 18-15 Moderate Risk: 14-13 High Risk: 12-10 Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): Yes No NA Wound Dressing done: Yes No RA Current diet: Soft Dief								
Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: Critical value alert and its corrections: Changes in nursing care plan: Yes Mo. If Yes, modified care plan date: Pending follow-up orders: Special instructions if any: Thy plan CABY									
Handover o	iven hv	Signature	Name	^ '	Emp. No.	Date	Time		
Handover given by Handover taken by		(I)	B. Vani	<u>ب.</u>	0195	多井内?	19.30 19.30		
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NURSES PROGRESS NOTES								
Date & Time		Observations / Action		Signat	ure with E	mp. No.		
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16-3	,	us are checko	J	750g	-			
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19-30		so dell mario	levil					
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Document endorsed by	(NB)	Diairararo.	0000	<u>`</u>	वसीयय	08,00		





| 63/Malc/MHI202381271 | 27/12/2023/IPH2023002615

I DI.ANBARASU MOHANRAJ



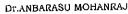
PATIENT CLINICAL HANDOVER RECORD FOR NURSES

	FAIIL	IVI CEINICAL I	MINDOVERTIES		IOLO	
Date:	7/12/27	Shift: Morr	ning Evening Might "	transfer of the second		
S	NEWS / P Ventilator Periphera Ryle's Tut Urinary C	s: CPD - LM TVD EWS Score: day: I line day: Right: - Lef be: Yes No Day atheter: Yes No Day	POD: Centra t: VIP Si	core		.) "
В	On room,	•	n Air : IV fluid	of surgery:—		
	ASSESS	MENT				
	Vital Sign	ns: Temp: (°F) Pulse	/ HR:(beats/min) F	Respiration: <u>2</u> (breat	hs/min)	
A	BP: \DS Others: Pain Sco Fall Risk Braden S	re: O (OPain Scale used Score: Minimal Risk: 23-19	Height: 18 (cms) W	veight: 6	g Scale / NE	STCPOT
	Pressure Current d	•	SH): □Yes□No□MA Wo	ound Dressing done: ∐ Yes Drains:	 □\\d\□\\\	
		Diabeti d	iet , ; ;			
	RECOM	MENDATION				
	Referral o	loctors:	· ` ` ` ` `	144 AV	`	·
	Pending	medications:	(,	and the second		
	-	medication indent:	· Y NII		•	
		lab reports / Investigations:				-
		alue alert and its corrections	_]-			
Changes in nursing care plan: Yes No. If Yes, modified care plan date: Pending follow-up orders:						
	ŭ.	nstructions if any: 10 mo	rrow Plan C	neg, Npo f	rom 5	.00
 		Signature	Name	Emp. No.	Date	Time
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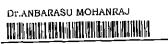
NURSES PROGRESS NOTES								
Date & Time		Observations / Action		Signat	ure with E	mp. Ņo.		
27/12/23	Night	duty Notes						
\bigcirc	()=.	-						
19.30.	& Patient ta	ken Over from	Quen	na	\square			
	duty Sta	aff Nurse		() =	جارح			
	s patient	Conécious & ori	nted					
	1 / 31 .	' · · · · · · · · · · · · · · · · · · ·	Llod &	* *				
	Perordod							
20.30	- Medicate	ion given as	per		.			
	drug Chart							
	- Tomorro	w Plan CABG	NDO					
	grom. 5.00	2 Preparative	<u> ' </u>					
	cliene, Conse	ent taken 10	NOCH C					
	Progration	done	,					
	S Today P	ottosium Correct	ìon.					
	Clone 4 k+	-5.50	·					
	-s Repeat	ct, orders DR.P	raveon	.'				
	1 ' . – 1	ormod		4		_		
23.00	-S. Patient	Sleepwell durin	1G	1 5-	<u> </u>			
	hight t	ime /						
	=> Provide	Comfortable posit	neir					
	Γ , V , M	tient	<u> </u>	1				
2.00	-> patient	pulse & salur	alion	H _F				
	Chound	· · · · · · · · · · · · · · · · · · ·		_				
		177 Monitorcol						
b.30	& Patient	77	Shoul &	-170	-			
C 0	decorded in the second	1						
7,30	-s patient Morni	handing over 4		(k)				
	Nurso	ny owy 01	<u> </u>	مزاط				
	1/11/530	<u> </u>						
	Signature	Name	Emp. No.	,	Date	Time		
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63/Male/MHI202381271

27/12/2023/IPH2023002615







MHI/NUR/2022/048

<u> </u>	N	URSES PROGRESS NOTES	<u> </u>			
Date & Time		Observations / Action	-	Signa	iture with E	mn No
		ECEIVAL REPORT		Olgino	Tare with E	-mp 140.
28/12/23		NOTO TO With Blue Op File	And Case			
12-00	ECG: \ ECHO:	X-RAY: ANGIO CI	71900 :C		<u>-</u>	<u> </u>
	CT FILE: NRD @	あくのみ りんしゅばんしゃしゃ	atterfor	<u> </u>		
	Patient Posted For Proced	ure: CABN			IL.	
, 	Under Anesthesia: WA			10	1201	
	Allergy Status: NYDP		-			
`	Known Case Of: CAB. SHYN, TUPOTT. Past Surgical History:	ON, OVA-ROLLE IN	and Land			
	VITAL SIGN: TEMP: BF_HR: 806 PNSP02: 1001. BP ',122 FAME					
	CTOT	SHIFTING REPORT				
28/10/23	Case Sheet Along With	To SOUWith Blue Op F	ile And			
18-25	*Surgery Safety Check Li *Intra Operative Record *Nurses' Record *			-	 -	_ _
	ECG: \ ECHO:	\ X-RAY: \ ANGIO CI	Models.		N.	
	CT FILE: MRD-67	TOUR BYD	UX COURSE	<u></u>	1800	
	Patient Posted And Underwent For Procedure: CABY Under Anesthesia: WA				<u> </u>	- -
	Procedure: OPCABNA (MURE TIMES THE	PINISEQ	walka	<u>'J</u>	
	Procedure: OPCABNA CATAL, LANGE LAND ON PDA PLY SEQUENTIAL TO SECUENTIAL DESCRIPTION OF PDA PLY SEQUENTIAL TO SECUENTIAL DESCRIPTION OF THE PLANTS OF THE PL					
	Pacing wire placement: Present/Absent Site:			-		
_	Implants:					
	Cautery burn/skin peeling/towel clip mark: Present/Absent Site:					
	VITAL SIGN: TEMP: 3TC HR: SALPM SPO2: VOCY BP: 126/6/1 MM of H9					
	Notes: -> CAND CONTRIGE REPORT SERON ONLY					
	present while relations the patients					
	Signature	Name	Emp. No.		Date	Time
Document endorsed by	SMPOBI	W EASTMAR	MADO	181	28/17/13C	1/8-25





63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.Anbarasu mohanraj





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: Shift: Morning Evening Night								
S	NEWS / P Ventilator Periphera Ryle's Tub Urinary Ca	EWS Score: day: I line day: Right: —	ト √ ① Left: - Day: Day: MDR: □Yes 급No. If Yes	GCS: 151 POD: Central line of VIP Score: s, specify organis	ols			
В	On room			Date of surg	,			
A	BP: 12: Others: Pain Sco Fall Risk Braden S	re: Off Pain Scale Score: Fall Risk: 2 Ulcer Scale for Healing	Pulse / HR: _ 子子(bea 2: _ 子子 (%) Height: _ } used: PIPPS / CRIES / FL ik Protocol: □ Low ☑ Me 3-19 □ At Risk-Mild Risk: 18- i (PUSH): □ Yes □ No ☑ 1	g(cms) Weight: · ACC / Wong-Bak dium □ High 15 □ Moderate Ris	ker FACES Pain Ratin	2 • b lzg ng Scale / NP7 12-10 □ Sever	S'/ CPOT	
R	Pending and Pendin	medications: medication indent: lab reports / Investigation lalue alert and its correction for the plan: follow-up orders:	tions:		:- , NPO fn	on s.e	20	
		Signature	Name		Emp. No.	Date	Time	
Handover given by		Jani	Freni mi 45	٠,	0284	28/2/22	8,00	
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Date & Time	(Observations / Action	Sign	ature with Emp. No.
	MOPMINUT	DUTY NOTES		
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	Might duby	stall.	_ Fu	<u> </u>
	=) Pt come	ions and oriental	or or	~-:
<u> </u>	=> Pt vito	als checked and)	
	Recorded.			
8.30	=> Pt de	e deuge are		
·		roday plan (ABL)		
	3 pt NPO	Jan 5:00	J.	<u> </u>
	=> provide	composhable posit	ion	. معمور
	so the pati	cert.		
9.00		to the of		
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	Signature	Name	Emp. No.	Date Time
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63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





Date: 28	12.23	Shift: Morn	ing Evening Night		,	1
S	NEWS / F Ventilator Periphera Ryle's Tut Urinary C	EWS Score: day:	VIP Score	. •		
В	On room	ROUND urgery: のCAB メ み め if any: 从似 air / oxygen: <i>VE</i> &T71よみて its / New Symptoms in last sl	Date of suit Date of suit DR	gery: 18 [[L]L]		• }
A	Others: Pain Sco Fall Risk Braden S Pressure	re: DF Fall Risk Pro		iration: 14 (breat transfer (b	ng Scale / NR 12-10 Sever	S / CPOT e Risk: 9-6
R	Pending Pending Pending Critical va	medications: medication indent: lab reports / Investigations: alue alert and its corrections	No. If Yes, modified care plan de	ute:		
Handover g	iven by	Signature	Name SURYA/CRUE · S.P	Emp. No.	Date	Time
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	NL	JRSES PROGRESS NOTES			
Date & Time	(Observations / Action	s	Signature with Er	mp̃. No.
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		TP Size a connect			
	f f	io box recpist Ral	•		
		500, Spo, 100% maint	4		
	proudene., a	reluited for 400, coas	10 ch 100		
	Soml given, a	weethe we mustigutique	him		
	fout 12 - 2.2	lang correction start	loci.		
	hy insulin 2 m	1/m on flow NTG	4 mlh	——————————————————————————————————————	
	on flow afe	Loub, warmer place	ud, BAC	à stor	9
	IFV on flow	A-fylvester advivated you	u vertolal	100	
19-00	x-sing done	·/ obsaine take @		· 	
19.10	family men	has seen the patient	<u>L</u>		
	explained police	ent constition		My.	
19-30	ha' Annal over	agree to next duty	-	- Nua.	
	staff for con	Have ventilation. I	VE		_
	on flow.				
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63/Male/MHI202381271 27/12/2023/PH2023002615

Dr.Anbarasu mohanraj



Date:	8/12/28	Shift: Morn	ing □Evening 믾서	ght				
S	NEWS / P Ventilator Peripheral Ryle's Tub Urinary Ca	: CAD - TYD EWS Score: day: D \ Iline day: Right:८७৪।TAcLeft be: ☑Yes ☐ No Day atheter: ☑Yes ☐ No Day	. Dr .Dr . Dr R: ∐Yes ∐No. If Yes, sp	GCS: CP POD: DCS Central line da VIP Score: C	210			
В	Allergies i On room	ROUND Irgery: OPCABX 4GR fany: NK air / oxygen: ON I'end ts / New Symptoms in last sl			y: 22/12/23 v: Karilyte			
A	ASSESSMENT Vital Signs: Temp: 14 (°F) Pulse / HR: 6b (beats/min) Respiration: Vev-14 (breaths/min) BP: 110 44 (68 mmHg) SpO ₂ : 100 (%) Height: 168 (cms) Weight: 61 (kgs) BMI: 21. 6 kg m² Others: 25A 1.66 m² Pain Score: D 2 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: 65 Fall Risk Protocol: Low Medium Heigh 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 Current diet: 180 Pleased Pl							
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:							
		Signafure	Name		Emp. No.	Date	Time	
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_	NL	JRSES PROGRESS NOTES				t
Date & Time		Observations / Action		Signature v	vith Em ṗ.	No.
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19.20	mirally stalle	patient in heamon	of ator	Salin	0065	
	Supporte				J00 (K	
20:10	Patron got a	wake and moned			_	
 	all the limb					
था:.00	Administered	Tuj. Paracetamof lgr				
	as 1208 corres	\$.			_	
21:30	Ructioning of	one for patient, Nebul	lization			
	gues.			Sitty	2	
22:30		er position for palien	1	Ú,		
23'·4D	Administered "	P. Ecospioin 75mg RT				
00:00	GCS assessment	done & monitored				
2100	Provided Comfort	able position for puls	<u>. </u>			
3 '-30	wearing Starled	for patient.				
H:30	Blond Sample	taken and Sent to		Sattyg Jos		
	leb.				-#cG	
5100	Be Spays ball	given for polint wi	th super			
טוי־צ	Lines care gin	en en aleptic manner	3			
5:25	U-cath case of	juen for patial.				
<u>5:</u> 20	Administered	Inj. Cofregueme 1.5gm		- 10		_
	as per orders	<u>. </u>		Saliya	168	
5.20_	kept on PS nu	, 1				
6:30	Manifound vitch	9 T(0.				
7:20	Handed over	the patient to				
	morning duty	Staff.				
 						
						
	Signature	Name	Emp. No:	Dat	te Tr	ime
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Document endorsed



Patient Mr.VENKATACHALAM P

Name: 63/Malc/MHI202381271

UHID: 27/12/2023/IPH2023002615 DOB:

DOA:

Consul



9.00

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

		_ /				0.1020	
Date: 29	12/23	Shift: Morn	ing	Night 	<u> </u>		
S	NEWS / P Ventilator Periphera Ryle's Tut Urinary C	s: CAD-TVD EWS Score: — day: D₂ I line day: Right: Ync∤a_Left be: ☑ Yes ☐ No Day atheter: ☑ Yes ☐ No Day	:: D2_ :: D2_ :: D2 R:	GCS: EH Ve POD: D(Central line d VIP Score: C	ays: D2		
В	Allergies i On room	ROUND urgery: OpcaBメ みりな fany: NKDA air/oxygen: のれいこむむ ts/New Symptoms in last s	aly		ery: 28/12/23 DW: KABUUM	E	
A	Others: Pain Sco Fall Risk Braden S	ns: Temp: 91-6F) Pulse	n (%) Height: 16 & (0 10 (%) Height: 16 & (0 10 A - 10 ms) Weight:_ CC / Wong-Bak um High Moderate Ris Wound D	<u> </u>	Al: <u> </u>	9 Risk; 9-6	
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:	☑No. If Yes, modified	care plan date	:	•	,
		Signature	Name		Emp. No.	Date	Time
Handover o		(Jount	D. PANEER		0171	29/1422	3,00
Handover t	aken bv	higana	magnagel	Nam	C276	29/12/22	19700

19 W

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	NURSES PROGRESS NOTES	
Date & Time	Observations / Action	Signature with Emp. No.
89/12/23	MORNING DUY DEPORT	
7:30		RIM PAUTER
•	of Patrial had taken over from	01H -
	night duty Staff Mad Signa are	
	harmdynamically Stable.	
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8.45	ox Pating had Extrusted, Jelland by	
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-	3mg IV Stat had guin OB	on,
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19.30	* Patrul detally handed one to the	1
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		-
	Signature Name Emp.	No. Date Time
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Mr.VENKATACHALAM P 63/Mulc/MHI202381271 27/12/2023/IPH2023002615 Dr.ANBARASU MOHANRAJ



Date: 2.9	lialaos	23 'Shift: ☐Morn	ning Evening 1	Vight .				
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	S:CAD_TVD PEWS Score: - Iday: - Mod-GC Il line day: Right! Left be: Yes No Day Interes: Yes No Day	pel P2 :: :: R: □Yes □No. If Yes, s	GCS: (57 POD: TD. Central line of VIP Score: (specify organis	days: <u>(()</u> 0(5 ·			
В	Allergies i	ROUND urgery: OPCA-P マチG if any: しんわみ air / oxygen: nts / New Symptoms in last sh			ery: 28 [12 [20] ow:12AB 124T			
A	ASSESSMENT Vital Signs: Temp: 98 1/6F) Pulse / HR: 1/2 (beats/min) Respiration: 20 (breaths/min) BP: 106 / 6 1/2 (mmHg) Sp02: 19 (%) Height: 1/68 (cms) Weight: 6 (kgs) BMI: 21 6 1/2 (k							
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		S-meena	Maena Se Suryaha	wan	0286.	30/12/25	01,30	
Handover ta	:	100 A	XURYALA Chia	repres of P	OLBL	30/4/-	07.0	
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NURSES PROGRESS NOTES							
Date & Time	Observations / Action	Signa	ture with E	mṗ. No.			
29/10/23	Patient hand over taken.	ļ					
19:00.	Healey Stable. on Roum Air.						
	off tonomper on write ucath.						
	Present.	g-M	gena os	er.			
A0 700.	Dinnergiven.	Maa	029	6			
20:30.	medication gran.	mee	naosa	် သ			
21:30.	vitale munifored.	Mee	ma 0281	6			
22.30.	Patient is on anyfortable.						
	position.	8.12	lara o	راعد			
22;30.	NEB, Spromaty given						
23:30.	Hall Deo chast munitared	1	-				
OD:30.	Patient II sleeping.						
02:30.	Patient is on conferfable			<u></u>			
	position:		<u> </u>				
04:30.	Blood sampres taken.						
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	care given,	me	لعموم	2 6			
06:00.	ritale monitored	<u> </u>					
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	assigned staff.	Soft	noena o	286			
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63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.Anbarasu mohanraj



Date: 3	>-12-2	Shift: ☑ Morn	ing Evening N	light	· .		
S	Ventilator Periphera Ryle's Tut Urinary C	S: CAD - TVD, PEWS Score: — day: — Unione day: Right: Left De: Yes No Day atheter: Yes No Day		GCS: 15/ POD: # Central line of VIP Score:	days: D3		
В	Allergies i On room	ROUND Irgery: のであるよ 4 9を f any: んん air / oxygen: のん なん ts / New Symptoms in last si	,	Date of surge	ery: 2१ (1 ८. ೬)	.	
A	Others: Pain Sco Fall Risk Braden S Pressure	ns: Temp:(°F) Pulse /	(%) Height: 168cccccccccccccccccccccccccccccccccccc	ms) Weight: C / Wong-Bak im	6 / (kgs) BMI: er FACES Pain Ratin sk: 14-13 □ High Risk: 1	21.6 kg/1 g Scale / NR	S / CPOT
R	Pending Pending Pending Pending Critical va Changes Pending	MENDATION doctors: medications: medication indent: dab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:	/ 3	care plan date		~	·
		Signature	Name	, ,	Emp. No.	Date	Time
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NURSES PROGRESS NOTES					
Date & Time	Observations / Action	Signature with Emp. No.			
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30/12/23					
7.00	Patient francoires taken from				
	the right duty Stabb Patient	PIN RAVETY			
	15 stable	ात्र.			
8:00	ord dill totude				
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8.45	DR. ANBARASO SIR ROUNDS OVER	Ay			
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2 -		1 - 1 - 1			
9.00	IJV line removed No	A.			
	ooxing vitals is stable	0480			
		<u> </u>			
9.30	ecg leads removed & cleaned	1 - 1 - 1			
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	TOTAL X-RAY - 4				
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9.35	phih and le con	n lla			
1-/35	- patiet leceived from SICU - while receiving patiet)s	Postn_			
	heardynamicaly Stable				
	- End poo				
12.30	- Patiet Lordad over to busing 50	W Solln			
	Signature Name Emp. No	A)			
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	7.00	- - -			





63/M#lc/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





Date:	Date: 30 [12 [3] Shift: Morning Devening Night						
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: (P) (V) PEWS Score: day: day: line day: Right: be: Yes No Day Satheter: Yes No Day	:	GCS: kg 1 POD: 11 Central line of VIP Score:Specify organis	days: —		
В	Allergies i On room	ROUND urgery: アイカッド た if any: メート(Anow): air / oxygen: ーハ の nts / New Symptoms in last sh	on wr	Date of surge	ery: 53/12/03 ow:		
A	ASSESSMENT Vital Signs: Temp: 96 6°F) Pulse / HR: 80 (beats/min) Respiration: 0 (breaths/min) BP: 120 80 (mmHg) SpO ₂ : 96 (%) Height 68 (cms) Weight: 61 (kgs) BMI: 20 6 (kgs)						
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 /	1	Emp. No.	Date	Time
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Handover t	aken by	(PL)	PIN Bho	reacter"	0271	30 /2/3	19.50
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NURSES PROGRESS NOTES								
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P: Mr. VENKATACHALAM P

Ni 63/Male/MHI202381271

UI 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





Date: 30 12 23 Shift: Morning Evening Night									
S	SITUATI Diagnosis NEWS / P Ventilator Periphera Ryle's Tut	EWS Score: day: I line day: Ri pe:	ght: D/3 Left ee No Day es No Day		GCS: 157 POD: 117 Central line of VIP Score: ecify organis	>15	,	, '	
В	`Allergies i On room	irgery Pi f any: M air / oxygen:	CPBX B ADP Poom nptoms in last sl	are i	Date of surg	ery: ,2 8 (2 ×	123		
A	ASSESSMENT Vital Signs: Temp: 98 - 2°F) Pulse / HR:								
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	
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20.30	Vitals O	helped Exp	concold	0281
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63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





Date: 3//2> Shift: Morning Evening Night									
S	NEWS / P Ventilator Periphera Ryle's Tul Urinary C	s: CHD TUD EWS Score: 10 day: — I line day: Right: — Left be:	•	GCS: STO POD: J Central line of VIP Score: (oly				
В	Allergies i	ROUND Jrgery: OPLABY 3 Gr fany: NODA air / oxygen: Or room ts / New Symptoms in last sl	an .	Date of surge	ery: <u>2810b</u> ow:				
A	ASSESSMENT Vital Signs: Temp: 782 °F) Pulse / HR: 74 bm (beats/min) Respiration: 20b (breaths/min) BP: 120 (8) (mmHg) SpO ₂ : 98 (%) Height: 168 (cms) Weight: 61 bm (kgs) BMI: 216 (09 m) Others: Pain Score: 9 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NR6 / CPOT Fall Risk Score: 9 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								
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:								
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NURSES PROGRESS NOTES								
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63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





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Date: 3	1/12/2	`-Shift: "☐ Morr	ning Evening N	ight .			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CAO. PEWS Score: day: ll line day: Right: Dy Left be:	: :	GCS: POD: LII Central line VIP Score	716		
B	BACKGI Type of si Allergies On room Complain	ROUND urgery: opc ff かんる if any: ゅっし (Anoc air / oxygen: った (2のc its / New Symptoms in last s	greaff on wr hitt:	Date of surg	ery: 08 (12/2 ow:	3	
A	Others:_ Pain Sco Fall Risk Braden S Pressure	ns: Temp: <u>996</u> (°F) Pulse	: PIPPS / CRIES / FLAC ctocol: □ Low□ Mediu □ At Risk-Mild Risk: 18-15[SH): □Yes □ No □ NA	C / Wong-Bal m ☑High ☐ Moderate Ri ─ Wound [ker FACES Pain Ratin sk: 14-13 ∐High Risk:	ng Scale / √RS	Э/ СРОТ
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: nstructions if any:		are plan date	÷.		
		Signature	Name .	1	Emp. No.	Date	Time
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Handover t	aken by	AB	PIN Bhas	10, the	02715	3/ 12/2	1919
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Mr.VENKATACHALAM P 63/Malc/MHI202381271 27/12/2023/IPH2023002615 Dr.ANBARASU MOHANRAJ



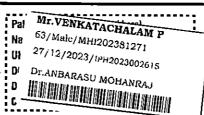
Date: 31	[2]2	3 Shift: ☐Morn	ing Evening Wight					
S	Ventilator Periphera Ryle's Tut Urinary Ca	EWS Score: day: I line day: Right: De: Yes No Day atheter: Yes No Day	VIP Score	e days: - /	·	ŧ		
В	Allergies i On room	ROUND urgery: OPCPBX f any: NNKDA air / oxygen: OP ROO ts / New Symptoms in last sh	M W IV fluids or	rgery: 28 12 n flow: —	23	,		
A	ASSESSMENT Vital Signs: Temp: R=2.4°F) Pulse / HR: R=2 (beats/min) Respiration: Poly (breaths/min) BP: D=10 + 0 (mmHg) SpO ₂ + (%) Height Respiration: Poly (kgs) BMI: Resp							
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	NIL No. If Yes, modified care plan d	ate:	,			
		Signature	Name	Emp. No.	Date	Time		
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NURSES PROGRESS NOTES									
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Date: 01/01/24 Shift: Morning Evening Night								
S	NEWS / P Ventilator Periphera Ryle's Tut	s: CAO - TVD PEWS Score: O day: I line day: Right: Left De: Yes No Day atheter: Yes No Day	:	GCS: IS POD: A de Central line of VIP Score: pecify organis	0	-		
В	Allergies i	ROUND urgery: OPCAB X 3-9 if any: NEDA air / oxygen: BA ts / New Symptoms in last sl		Date of surge	ow: —			
A	ASSESSMENT Vital Signs: Temp: 9 (°F) Pulse / HR: 8 (beats/min) Respiration: 2 (breaths/min) BP: 30 80 (mmHg) SpO ₂ : 98 (%) Height: 168 (cms) Weight: 6 (kgs) BMI: 21 - 6 kg / mm Others: Pain Score: 0 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fail Risk Score: D Fatl 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 No No No 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 No. If Yes, modified care plan date: Pending follow-up orders: Special instructions if any:								
		Signature	Name		Emp. No.	Date	Time	
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63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.Anbarasu mohanraj



Date: , (10/24	Shift: Morn	ing Evening N	light .	~	,-			
S	Ventilator Periphera Ryle's Tut Urinary C	SEWS Score: day: I line day: Right: H De: Yes No Day atheter: Yes No Day	u' u'	GCS: (") POD: (P) Central line of VIP Score Coecify organis	days: =	•			
B	BACKGROUND Type of surgery: Open & 5 quelt Allergies if any: Poof (NOS) On room air / oxyger N Room Sy.: IV fluids on flow: Complaints / New Symptoms in last shift:								
A	ASSESSMENT Vital Signs: Temp: 98 6°F) Pulse / HR: 80 (beats/min) Respiration: (breaths/min) BP: 00 10 (mmHg) SpO2 10 (%) Height: 68 (cms) Weight: 6 (kgs) BMI: 21 r 0 (44 fm) Others: Pain Score Pain Scale used: PIPPS / CRIES / FLAGC / Wong-Baker FACES Pain Rating Scale (NR\$ / 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 No NA Orains: Mild Current diet: No mul 2 10 10 10 10 10 10 10 10 10 10 10 10 10								
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:								
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Mr.VENKATACHALAM P 63/Malc/MHI202381271 27/12/2023/IPH2023002615 Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

Heart
Institute

Every heart heat counts

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Date:	1/21	Shift: ☐ Morn	ing ☐Evening ☐	Vight			• :
S	Ventilator Periphera Ryle's Tul Urinary C	s: CAD — TV D EWS Score: — day: — I line day: Right: DEY Left be:	:	GCS: S POD: 65 Central line of VIP Score: 6	lays: - ,	, ,	
В	Allergies i	ROUND urgery: OPCAB X B f any: NKDA air / oxygen: ON Pouts / New Symptoms in last st	om aug	Date of surge	ery: 28/1	2/23	
A	BP: 20 Others: Pain Sco Fall Risk Braden S Pressure	ns: Temp <u>? 6 ~ 2</u> °F) Pulse / 0 8 0 (mmHg) SpO ₂ : 9 3	#_(%) Height:(0 : PIPPS / CRIES / FLAC ptocol: Low Media] At Risk-Mild Risk: 18-15 SH):Yes NoNA	cms) Weight: CC / Wong-Bak um	(kgs) BMI	ating Scale / NR	S / CPOT
R	Referral of Pending Pending Pending Critical volume 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:	ل ا	care plan date	:	,	
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63/Malc/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





PATIENT CLINICAL HANDOVER RECORD FOR NURSES								
Date:	11/2	Shift: Morr	ing Evening N	light				
S	NEWS / F Ventilator Periphera Ryle's Tut Urinary C	s: CAD → TVD PEWS Score: — day: I line day: Right: DF Left be: ☐ Yes ☐ No Day atheter: ☐ Yes ☐ No Day	<i>r</i> :	GCS: \b\ POD: \b\ Central line do VIP Score: pecify organism	0/4			
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A	BP: 7 Others : Pain Sco Fall Risk Braden S	ns: Temp: (1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Height: A & (c	ms) Weight:_ C / Wong-Bake Im	b (kgs) BMI: er FACES Pain Rat c: 14-13 ☐ High Risl	ting Scale / NR	ST CPOT	
R	Referral of Pending Pending Pending Critical volume Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders:	. —	care plan date:	•	·		
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ADULT NURSING CARE PLAN

Mr.VENKATACHALAM P

63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





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Initial Date: タイ ルクタ	3 Time: 13.00	Modified Date: Time:		
Reason for Modification:		Diagnosis: CAJO-LM TVJO		
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 Per non done potent	O CONTRACTOR OF THE PARTY OF TH
☐ Others:	requirements in accordance to his activity level and metabolic needs	Hecord amount of food consumed	EPH on Dm Blet	O Tao
			Patient had DM die	
OXYGENATION Room Air Nasal Cannula / High Flow O ₂ Mask BiPAP / CPAP Ventilator	Patient will have normal O₂ saturation. Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains within established limits	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	м	
☐ Tracheostomy ☐ Others:	Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis	Epton Room Air	By
		□ 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	Patrint 1801 Poom Air	
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition	Patient will have balanced fluid and electrolytes balance	Enhance fluid intake unless restricted Check IV sites and assess if there is any complication Provide tube feedings Monitor intake and output	M	
Parenteral Nutrition Others:		Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses Monitor for possible sources of fluid loss Monitor BP for orthostatic changes	E Dlo Chart Maintainel	Ol Dias
	+ : : : : : : : <u> </u>		N Chart Monitor	FIEL-

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	
to minimize potential for injury Patient will describe 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 PH bould mobilized	Ontao.		
	. ,	1	Nation Mobilized well	A.
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	
☐ 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 seik wideal	Car
		and follow proper protocol Check for malena / constipation / urinary retention	n Klormal Elimination Pattern	
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI □ OPI	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	м	
GRADES OF PRESSURE INJURY. GRADE 1 * GRADE 2 GRADE 3 GRADE 4 Unstageable		☐ 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		
☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted		Educate patient and family members about further skin care	E Malnfaln (M) Skin Intrad	5100
☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			"Main tain Normal Skin integrity	
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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initíals
HYGIENE Bed-Bath Assist-Bath Self-Care CBD Care (if present) Others:	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs Patient will recognize individual weakness or needs	Encourage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene Consider the patient's need for assistive devices Apply moisturizing solution	E At well groomed	Photo Photo
SAFETY Check ID Hand IV care EJV CENTRAL LINE Side rails Others:	Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	EPH 1D sound	Onto O
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 Eprovided Eprovided Comfortable position	33 (Z
OBSERVATION ☑ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	M ritals are E chealreal Nital Digns Cheesand & Recorded	A Car
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Bellefs / Values / Customs Anxiety and Copying Pattern Identify Stressors Others:	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness Patient will maintain normal psychological pattern	Pray or encourage the patient to pray Use inspirational words Respond to spiritual needs as they arise Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	M E provided support N ROYdological Oupport	Dias Black

Patient Specific Problems / Nee		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICAT Verbal Non-verbal Sigh language Others:	ION	Patient will communic with positive feedback	cate effectively / k	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's or prognosis in the patient's presence	condition	450 L	nmunicateel	Store D.
SPECIAL INTEL Medication Wound care Isolation Ostorny Care Blood / Blood p transfusion Fluid tapping DVT Manageme	products	To manage on time		Double check for high alert medication Observe and report any medication react Provide proper measures of wound care Follow hospital polices and protocols of i and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing be blood products and fluids Monitor DVT score and continue treatme as per doctors order	solation ensure slood or	M	in given Irua Chart	
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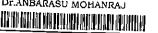


ADULT NURSING CARE PLAN

Mr.VENKATACHALAM P

63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





Initial Date: 28 223. Time: -1.00		Modified Date: Time:		
Reason for Modification:		Diagnosis: OAD- TMTVD.		
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	omiting	M P+ NPO 5.00	Ju.
Others:	requirements in accordance to his activity level and metabolic needs		E	
	·		N	
OXYGENATION Room Air Nasal Cannula / High Flow O2 Mask BiPAP / CPAP	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 O ₂ saturation and pulse rate	M Pt on Room	Sus.
☐ Tracheostomy ☐ Others:	Ventilator within established limits □ If any O₂ abnormalities detected inform immediately to □ Tracheostomy □ Patient will indicates, either verbally the concerned physician	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		M pt 2 To chart	J. W.
Parenteral Nutrition			E	
		- Solution and Grand 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 to minimize potential for injury	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)	Mpt mobilized well	Suy
	Patient will demonstrate the use of adaptive devices to increase mobility	Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	N 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 pt Normal Elimination Pattern	<u>Ju</u>
Others:	and regular elimination patterns	silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol	E	
		Check for malena / constipation / urinary retention	N	
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE INJURY	Patient will maintain normal healing status Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin Maintain adequate nutrition and hydration	M p4 raceintain nomed skin by.	134 .
GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased Intermittent Assisted		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	
☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N	

				
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation S	ign & nitials
HYGIENE Bed-Bath Assist-Bath 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 groomed T	
			"	
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 pot Da board	Bur
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	Е	
		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	M	
☐ Sleep Patterns ☐ Others:	behavior about pain relief and adequate sleep	of and Monitor pain scale / sleep pattern Provide pharmacological and non-pharmacological therapy	E	
		Tion pharmacologism morapy	N	
OBSERVATION Vital Signs GCS Blood Sugar	Patient will have normal range of vital parameters		M pf vitals are checked.	Sim.
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 	Е	
			N	

ient >bler	Specific	Measurable Goals		Nursing Interventions			Evaluation		Sign & Initials
/ Others:	UNICA bal	Patient will communic with positive feedbac		Introduce the care giver Encourage the use of call b Obtain interpreter if needed No negative speaking about or prognosis in the patient's	t the patient's o	condition	M pt Ca	ommerci costi on well	<u>Su</u>
	,						N		
I Medication Wound are Isolation Ostomy Care Blood / Blood transfusion Fluid tapping	products	To manage on time		Double check for high alert Observe and report any me Provide proper measures o Follow hospital polices and and explain to the patient / Check for cross matching a compatibility Practice strict asepsis while	dication reaction from the following the following from the following	olation	M pt de gir	ue dugs	
DVT Manager Others:	nent.			blood products and fluids Monitor DVT score and con as per doctors order	tinue treatment	t	N		
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63/Mule/MHI202381271

27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





ADULT POST-OPERATIVE NURSING CARE PLAN

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Initial Date: 28/1	2/23 Time: 7 . W	Modified Date: Time:	•		
Reason for Modification:		Diagnosis:			
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 Administered domy as not nodes Notatiting posper position.	02n	
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	E on vontibutar. E the: 99% mainluly N as needed.	Ato:	
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 E N		
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 Cavidad lafe N Provided Cafe Revisonment.	0265 0265	

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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE Oral Intravenous Enteral Nutrition Parenteral Nutrition Others:	Datient 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 hectul IV siles Nenitoned Ilo Neney hour.	02
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 jechnique during care N followed auptro precautions.	September 1
RISK OF FALL ☐ Giddiness ☐ Independent State ☐ Dependent State	The patient will have safe, free from fall hospitalization		M E Kept bed in low position N followed sick fall prevention.	On Die
SKIN &WOUND CARE Observe REEDA Oozing Foul Smell	The patient will have intact skin white 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 Checked doroins N All Lines and tubes are insite.	proton 6365
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 patient on 100 IVF on flow N NPO, on IV fluids	defination of the state of the

Patient Specific Problems / Needs		Measurable Goals		Nursing Interventions		Evaluation	Sign & Initials
CARE OF CATHETE DRAINS, ETC.	RS, /	☐ Patient will have pater maintained catheters,	nt, properly drains etc	Check the catheters, drains etc frequent Observe I/O Chart Watch for any symptoms related to kinke blocked tubes Maintain adequate cleaning and dressing	ed or	M E Martined I/o chay-	or to
DISTURBED BODY I	MAGE	☐ The patient will demo initial acceptance and body image		□ Note non verbal body language, negative and self talk □ Note emotional reaction (grieving, depreed to be a complete of grief and hostility	ssion, anger)	M ME	- Silvo
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:		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 E Nigh Nontoned vilalia Accessed for GCS.	Do to
HEALTH EDUCATION Patient Family / Guardian Diet Disease process Infection control / PPE Medication Educate about TAC leand immunosuppress Personal Safety Treatment Regimen Others:	<u>∃</u> evel	Patient / Family / Guar Domestic Partner / Ca others will gain adequ knowledge regarding modalities and life sty modifications	re-giver / ate treatment	Provide proper education regarding follo Insist on importance of hand hygiene Explore action, reactions and adherence Provide clear, thorough, and understand regarding safety precautions. Explain to perform activities / skin care the by concerned doctor Use the teach-back technique to determine understanding regarding importance of the standard properties of the standa	about medication able explanations nat recommended ine the patient's	M Eduate He E family regarding which omelition Estacolic regarding N	det ones
ANY OTHER NEEDS						M E	
						N	
Sign	nature		Name		Emp. ID	Date	Time
Endorsed by	1_		0	Kmar	ري ه ڪ	29/12/25	9.4





Patier Mr.VENKATACHALAM P

Name 63/Malc/MHI202381271

UHID: 27/12/2023/1PH2023002615

DOB: Dr.ANBARASU MOHANRAJ

DOA: UNIVERSITY OF THE PROPERTY 

ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 09/12/23	Time: \0.00	Modified Date: Time: -	
Reason for Modification:		Diagnosis: (AD _ TVD	
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation Sign & Initials
PAIN Comfortable Position Pafn 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 Paturit had devand James E Administered down of Many Of her Order N Emportable Position many
OXYGENATION Room Air Oxygen Hood Nessal 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 Patrial is an Haud Jant -priories Spor-981. E patrent on NP dy E SNUL: 981 STISL N On Roum Ato. S' men
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 Jamil E explained the range due Ly N — Tone
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 Potent is on fout of the Potential Puls of the Polision and told. N Bedislowers 87 Men. N Cocked Port Fron, 87 Men.

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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE Oral Intravenous Enteral Nutrition	☐ Pattent 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 20 Chart Mantanti	Jamy Olq.
☐ 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	e mainlaind Ilo chaet	Lyc
		Monitor BP for orthostatic changes	N Monitored Ito hast	Sugar,
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 Augustia forecombor are	Jany.
	,	after patient's care Inspect wound for signs of infection, purulent drainage or discoloration Administer antibiotics as ordered	E during case	dy
,		CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	N Aseptic technique,	Rigoes,
RISK OF FALL Giddiness Independent 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	M Fall suit Safety - presention are folly	Jan J
☐ Dependent State		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	E maintained hed an town hosition	Lyce
		Offer urinal or bedpan to the patient if needed	N rocked poether.	2750 C
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 Skin- Tutant	Jany ON:
☐ Foul Smell		☐ Minimize pressure ☐ Provide adequate nutritional support ☐ Report signs of poor healing or trauma to doctor	E downing intact N Sicir Intact.	& Wang
DIET & NUTRITION NPO Soft Diet	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	M Patrul à on out.	Day .
Solid Diet Solid Diet Solid Diet RT Feeds		 ☐ Monitor patient's weight ☐ Administer supplemental vitamins and minerals as prescribed 	E partient on and	
		□ 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	N loft Diet.	S. Man

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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 frequently ☐ Observe I/O Chart ☐ Watch for any symptoms related to kinke blocked tubes ☐ Maintain adequate cleaning and dressing	d or	M ON UBD Chart E Illo Char N 710 Char	mandamol monta monta u fored	Dy Cost
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, depredent Acknowledge and accept expression of for grief and hostility 	ssion, anger)	M NA E NA N		Daug Daug Daug
OBSERVATION Vital Signs GCS Blood Sugar Others:		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		E lital skyn	ou Steh	Downt Stranger
HEALTH EDUC Patient Semily / Guardi Diet Disease proces Infection contro Medication Educate about and immunosu Personal Safety Treatment Regi Others:	an s s l/PPE TAC level ppressant	Patient / Family / Gual Domestic Partner / Ca others will gain adequ knowledge regarding modalities and life sty modifications	re-giver / ate treatment	□ Provide proper education regarding follor □ Insist on importance of hand hygiene □ Explore action, reactions and adherence □ Provide clear, thorough, and understandaregarding safety precautions. □ Explain to perform activities / skin care the by concerned doctor □ Use the teach-back technique to determine understanding regarding importance of the second sec	about medication able explanations at recommended ne the patient's	M Patriol Knowledge	Jaund Dem Exursin and Degardy	Damy 014 Jany on.
ANY OTHER N	EEDS					M E N		
	Signature		Name		Emp. ID		Date	Time
Endorsed by	9		0	Law	0003		30/12/21	9. w





63/Male/MH1202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





ADULT POST-OPERATIVE NURSING CARE PLAN

	·			
Initial Date: 30/12/2	3 Time: 8.00	Modified Date: Time:		
Reason for Modification:	·	Diagnosis: OPLABX 4 GRAFT&		_
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
PAIN Comfortable Position Pain Scale	☐ 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 PT had Mild Pain	Stop 80
☐ Pain Score ☐ Others:			E phrouissed comport	1) le Olym
		swelling, separation and drainage Non-Pharmacological therapy	NP+ Vool Whit	150g
OXYGENATION Room Air Oxygen Hood	Patient will have no shortness or difficulty of breathing	Provide well ventilated environment Check oxygen saturation Perform suctioning if needed	M Spoz-95%	Auto
☐ Nasal Cannula ☐ Nebulizer ☐ Ventilator ☐ Others:	·	□ Ventilator settings as per physician orders □ Monitor rate, depth of respiration □ Administer oxygen and nebulizer therapy if needed □ Encourage spriometry, deep breathing and	E Spor 96-71	(San)
		coughing exercises Monitor amount, viscosity, colour and odour of sputum if present	N 8P02-987.	(P) (P)
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	M NA	
Anxious Look	surroundings	Encourage and support patient while increasing anxiety level Help patient to cope with outcomes of surgery	E	
	·	Keep patient in comfortable position in bed to enhance sleep	n MA	
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 PT Mobilized will	Auf ook
☐ 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.g., calf pain, Homan's sign, redness,	E pt mobilised	JUN!
	adaptive devices to increase mobility	localized swelling, a rise in temperature)	n pt monicioned	BAT!

<u> </u>				
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE 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 is on oral offices	A. 6080
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	E pt is chip	Sen!
		☐ Monitor BP for orthostatic changes	N Pt 20 Chout	Q 71
RISK OF INFECTION Prevent Infection Others:	☐ Æne 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 No sisk of Infortion	2000
: .		after patient's care Inspect wound for signs of infection, purulent drainage or discoloration Administer antibiotics as ordered	E	
		CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	N —	
RISK OF FALL. Giddiness Independent 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	M No sisk of	Tooler
☐ Dependent State		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	E NATI	
		Offer urinal or bedpan to the patient if needed	N WORISK OU	O F
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 PT is on wound	80000
☐ Foul Smell	, ,		E	
			N	
DIET & NUTRITION NPO Soft Diet	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	M Pt is on Normal dist	80000
☐ Semisolid Diet☐ Solid Diet☐ RT Feeds☐ RT Feeds☐ RT Feeds☐ RT Feeds	olid Diet Administer supplemental vitamins and minerals	EPT food Diot	DIM!	
	1	needs are not met through oral intake Report abdominal distention, large gastric residual volume or diarrhea to doctor	n pt nx on @	Q OPAI

Patient Specific Problems / Need		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
CARE OF CATH DRAINS, ETC.	CARE OF CATHETERS, Patient will have patent, properly maintained catheters, 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 PT is O Work E 7 (0 ch N 2 (0 (Dela Rest	
DISTURBED BO	DY IMAGE	☐ The patient will demore initial acceptance and body image		□ Note non verbal body language, negative and self talk □ Note emotional reaction (grieving, depre □ Acknowledge and accept expression of to grief and hostility	ssion, anger)	M EN		
OBSERVATION Vital Signs GCS Blood Sugar Others:	-	Patient will have norm of vital parameters	al range	Menitor vital signs regularly Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient		M vilal 8	igus is	DOST
HEALTH EDUCA ☐ Patient ☐ Family / Guardiar		Patient / Family / Guar Domestic Partner / Ca others will gain adequ	re-giver / ate	Provide proper education regarding follo Insist on importance of hand hygiene Explore action, reactions and adherence	about medication	N Vrtals & CE M Health	chereb concer education	nd to
☐ Diet ☐ Disease process ☐ Infection control / ☐ Medication ☐ Educate about T/ and immunosupp	/ PPE AC level	knowledge regarding modalities and life styl modifications		 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 		E HER AT	h selucitio	Jehn)
Personal Safety Treatment Regim Others:	ien					N Hell	Ita colu	(2)
ANY OTHER NE	EDS					М		
						E		
						N		
!	Signature		Name		Emp. ID		Date	Time
Endorsed by	0		0	La.u.	2001		30/12/25	7.00





ADULT NURSING CARE PLAN

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ



7:30 Modified Date: Initial Date: Time: Time: Reason for Modification: Diagnosis: **Patient Specific** Sign & **Nursing Interventions** Measurable Goals Evaluation Problems / Needs Initials Provide Prescribed diet on time NUTRITION Patient will have adequate nutrition ☐ Keep NPO with no nausea and vomiting ☐ Encourage patient to consume the served meal Record amount of food consumed ☐ Regular Diet Patient will consume daily nutritional Others: requirements in accordance to his activity level and metabolic needs **OXYGENATION** Patient will have normal O₄ saturation ☐ Encourage chest physio / deep breathing and ☐ Room Air . Patient ABG levels will return to and coughing exercise / Spirometry exercises roomain ☐ Nasal Cannula / High-Flow O, remain within normal limits Provide well-ventilated environment / respiratory ☐ Mask '(No other respiratory abnormalities medications / Oxygen as per doctors order ☐ BIPAP / CPAP Patient respiratory rate will remains ☐ Utilise pulse oximetry to check O₂ saturation and pulse rate Ventilator ☐ If any O₂ abnormalities detected inform immediately to within established limits the concerned physician ☐ Tracheostomy Patient will indicates, either verbally ☐ Others: or through behavior, feeling ☐ Place patient with proper body alignment for maximum comfortable when breathing breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cvanosis ■ Note for changes in level of consciousness Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging 00A patient with successful coughing **FLUID & ELECTROLYTES** ☐ Patient will have balanced fluid and Enhance-fluid intake unless restricted electry to Fluis ☐ Oral electrolytes balance Check IV sites and assess if there is any complication Provide tube feedings ☐ Intravenous Monitor intake and output ☐ Enteral Nutrition ☐ Parenteral Nutrition Measure or estimate fluid losses from all sources such ☐ Others: as diaphoresis, wound drainage, and gastric losses Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes

Patient Specific - Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sig Initi
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	☐ 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)	M p4 will mobilizely Procky	- E
	☐ Patient will demonstrate the use of adaptive devices to increase mobility	Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	E Pt mobilismed.	Wood -
			NP+ morricined	
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 ipeontinence,	□ Encourage fluid intake □ Encourage fibre diet intake □ Encourage early-ambulation □ Report any abnormalities to physician □ Observe voiding accessories as foley's /	Mp+ (1) climination perthern	En
Others:	, and regular elimination patterns	silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol	E gerther D	W.
		Check for malena / constipation / urinary retention	N pouture was I	C. C.
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	M D+ meinsteinstein Stin steites	de
INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased			E	
☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials -
HYGIENE Bed-Bath Assist-Bath Self-Care CBD Care (if present)	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs Patient will recognize individual weakness or needs	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M pt softed Est groomed med N Pt groomed	BOW BOW
SAFETY Check ID Hand IV care EJV CENTRAL LINE Side rails Others:	Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	Mp+ Ilo Band E 20 hord D N Rd power	San/ San/
COMFORT AND SLEEP Pain Control Sleep Patterns Others:	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and adequate sleep	 □ Provide clean calm and restful environment □ Provide privacy at all time □ Monitor pain scale / sleep pattern □ Provide pharmacological and non-pharmacological therapy 	M pt Compostura	
OBSERVATION Vital Signs GCS Blood Sugar Others:	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	Mpt vital sérejs E Stable N V (3 chelps of Cyrelocce	Ser_ POIN/ OXT
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Beliefs / Values / Customs Anxiety and Copying Pattern Identify Stressors Others:	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M — E	

Patient Specific Problems / Need	ls	Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATION Verbal Non-verbal Sigh language		Patient will communic with positive feedback	,	☐ Introduce the care giver☐ Encourage the use of call bell☐ Obtain interpreter if needed☐		M P+	communicate opposition	En
☐ Others:				□ No negative speaking about the patient's cond or prognosis in the patient's presence		E P	well well	Olh!
							ornumeri enticon Well	652
SPECIAL INTER Medication Wound care Isolation Ostomy Care Blood / Blood pro transfusion Fluid tapping DVT Managemen Others:	oducts	☐ To manage on time		□ Double check for high alert med □ Observe and report any medical Provide proper measures of wo □ Follow hospital polices and products and explain to the patient / famile Check for cross matching and tocompatibility □ Practice strict asepsis while transblood products and fluids □ Monitor DVT score and continual as per doctors order	tion reaction und care locols of isolation ly yping, to ensure asfusing blood or	Mpt de ay	resticitor gran pan dura en for diestion en al (por	Soin Of the
	Signature		Name		Emp. iD		Date	Time
Endorsed by		Nas		e. Nalini		0084	31/12/23	18:00

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ADULT NURSING CARE PLAN

MI.VENKATACHALAM P

63/Male/MHi202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





Modified Date: Initial Date: Time: Time: 2024 CAD-TUD Reason for Modification: Diagnosis: **Patient Specific** Sign & **Nursing Interventions** Measurable Goals **Evaluation** Problems / Needs Initials Provide Prescribed diet on time normal diet NUTRITION Patient will have adequate nutrition with no nausea and vomiting ☐ Keep NPO Encourage patient to consume the served meal Regular Diet ☐ Patient will consume daily nutritional Record amount of food consumed requirements in accordance to his Others: activity level and metabolic needs Patient will have normal O2 saturation Encourage chest physio / deep breathing and **OXYGENATION** Patient ABG levels will return to and coughing exercise / Spirometry exercises ☐/Room Air Nasal Cannula / High Flow O. remain within normal limits ☐ Provide well-ventilated environment / respiratory Mask 3 ☐ No other respiratory abnormalities☐ Patient respiratory rate will remains medications / Oxygen as per doctors order ☐ BIPAP / CPAP Utilise pulse oximetry to check O_a saturation and pulse rate within established limits If any O₂ abnormalities detected inform immediately to ☐ Ventilator ☐ Patient will indicates, either verbally the concerned physician ☐ Tracheostomy ☐ Others: or through behavior, feeling Place patient with proper body alignment for maximum comfortable when breathing 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 ☐ Enhance fluid intake unless restricted Patient will have balanced fluid and FLUID & ELECTROLYTES Oral electrolytes balance Check IV sites and assess if there is any complication ☐ Intravenous □ Provide tube feedings ☐ Enteral Nutrition ☐ Monitor intake and output Parenteral Nutrition Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses Others: ■ Monitor for possible sources of fluid loss ■ Monitor BP for orthostatic changes

	Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
	MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within/ limits of disease	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment Consider the need for home assistance	M Pt mobilized well	Polon
	☐ Others:	Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	□ Consider the need for home assistance (e.g., physical therapy, visiting nurse) □ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	E pt mostilised,	SAM
			3	N P+ mobilized well.	0271
	ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bose movement	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence.	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Reports priding appropriate to physician	M self voiding	AN n
/	✓☐ Urination ☐ Others:	and regular elimination patterns	Observe voiding accessories as foley's / silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	M self voiding E putten D	John
	• .		and follow proper protocol Check for malena / constipation / urinary retention	" Poutour good	200
۷	SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment	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	M Shin integrity	2.1
	GRADES OF PRESSURE	,	☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maistein adequate patrilian and hydratics	skin integrate	Posts
	INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased	,		E	
	☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N	

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	Patlent Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
ů.	HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet'self-care needs 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 well gesomed	Pyla i
	· · · · · · · · · · · · · · · · · · ·			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 10 bad B	Rolln
	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 SeD band	@/h/
			Follow restrain policy (if needed)	N & have	627
	. 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	M	
1	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	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality	M Vital Signs Stable	Postn
	☐ Blood Sugar ☐ Others:		☐ 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	E offel weed Stiple	SILI
				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	M Provided Psychological	loson
	☐ 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 -	
	_ c		,	N	Ç

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COMMUNICATION Patient will communicate effectively with positive feedback Introduce the care giver Encourage the use of call bell Obtain interpreter if needed Non-verbal Sigh language Others: Double check for high alert medication or prognosis in the patient's presence Prognosi
SPECIAL INTERVENTIONS Medication Medicat
Signature Name Emp. ID Date Time
Endorsed by Naly S. Nalini 0024 1/1/24 13:00

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ADULT NURSING CARE PLAN

Mr. VENKATACHALAM P
63/Malc/MHI2023S1271
27/12/2023/iPH2023002615
Dr. ANBARASU MOHANRAJ



Initial Date: 2 1 2 3	Time: 7:180	Modified Date: Time:	•	
Reason for Modification:		Diagnosis:		
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	MP+ telles (N) E N	Sol
PXYGENATION ☐ Room Air- ☐ Nasal Cannula / High Flow O₂ ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator	Patient will have normal O₂ saturation □ Patient ABG levels will return to and remain within normal limits □ No other respiratory abnormalities □ Patient respiratory rate will remains within established limits	□ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises □ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order □ Utilise pulse oximetry to check O₂ saturation and pulse rate □ If any O₂ abnormalities detected inform immediately to	M voon cei	Suf
☐ Tracheostomy ☐ Others:	Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis Note for changes in level of consciousness	E	
•		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 oral flered	Helf
☐ Parenteral Nutrition ☐ Others:			E	
			N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment	M P+ mobilized	Jaly
Others:	Ptient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	 ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature) 	E	
			N	
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 Duerding patheur	Jelo
Others:	and regular elimination patterns	silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol	E	
		☐ Check for malena / constipation / urinary retention	N	
☐¶Maintain normal skin integrity ☐ Pressure points site	Patient will discharge with intact	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces	necentained (1) .M Skin interguity	
assessment ☐ HAPI ☐ OPI GRADES OF PRESSURE INJURY	skin integrity	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	interguly	Toll
GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased		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 Sell Buth	4-7
Self-Care CBD Care (if present)	changes to meet self-care needs Patient will recognize individual weakness or needs	☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	Е	<i>Tu,</i>
Official.	WOUNTESS OF FIGURE		N	
SAFETY Check D 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 IP Boug	Josef.
CENTRAL LINE Side rails Others:		□ Ralse side rails □ 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 Pair Control	Patient will have comfortable sleep Patient will verbalize / or through	Provide clean calm and restful environment Provide privacy at all time	M pt Slooke of	Spel
☐ Sleep Patterns ☐ Others:	behavior about pain relief and adequate sleep	Monitor pain scale / sleep pattern Provide pharmacological and non-pharmacological therapy	E	
		1	N	
OBSERYATION □ √Ital Signs □ GCS □ GCS	Patien will have normal range of vital parameters	☐ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality	M Witals all	Doke
☐ Blood Sugar ☐ Others:		☐ 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	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	

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Patient Specific Sign & Nursing Interventions Measurable Goals Evaluation Problems / Needs Initials M Pt veils al Introduce the care giver
Encourage the use of call bell
Obtain interpreter if needed
No negative speaking about the patient's condition Patient will communicate effectively COMMUNICATION with positive feedback Verbal ☐ Non-verbal ☐ Sigh language or prognosis in the patient's presence Ε Others: Ν Dree needicel Double check for high alert medication
 Observe and report any medication reaction
 Provide proper measures of wound care ☐ To manage on time SPECIAL INTERVENTIONS ☐ Medication ☐ Wound care ☐ Isolation Follow hospital polices and protocols of isolation ☐ Ostomy Care and explain to the patient / family ☐ Blood / Blood products ☐ Check for cross matching and typing, to ensure E transfusion compatibility ☐ Fluid tapping Practice strict asepsis while transfusing blood or DVT Management blood products and fluids ☐ Monitor DVT score and continue treatment ☐ Others: as per doctors order Ν Signature Name Emp. ID Date Time Q. Walini 18:00 0024 2/1/24 Endorsed by





63/Male/MHI202381271 27/12/2023/iPH2023002615

Dr.ANBARASU MOHANRAJ





Every heart beat counts

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SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	
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 Molst Skin is occasionally moist, requiring an extra linen change approximately once as day		4	4	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	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	4	
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	4	4	
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. Nor chair	TOTAL SCORE Initial & Emp. No.	3 223	3	
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:		38	

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK





N 63/Male/MHJ202381271

U 27/12/2023/JPH2023002615

D Dr.ANBARASU MOHANRAJ





Every heart beat counts

	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Time	M M		23 N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4 No impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort			
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	A. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals			
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non- existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4 Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours			
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	Je		
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	A. 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	Ja		
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 independentl strength to lift up completely during move. Norchair		3		
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down		TOTAL SCORE	23	-	
Score	Interpretation: Minimal Äisk: 23 - 19; At Risk		High Risk: 12 - 10; Severe Risk: 9 - 6	of Staff Nurse: Initial & Emp. No. of Sr. Staff Nurse:	100	1	





63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





Date: 29 1 2 do 29

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR			20.00	
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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)	\
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		ì	,
ACTIVITY degree of physical activity	1 Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours		1	,
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		1	1
NUTRITION usual food intake pattern	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	1	1	
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 independentl strength to lift up completely during move. Nor chair	y and has sufficient muscle Maintains good position in bed	1	,	1
& SHEAR	slides down in bed or chair, requeiting frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down		TOTAL SCORE Initial & Emp. No. of Staff Nurse:	b for	024	Jam!
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	30	3 2005	W.





Patient I Mr. VENKATACHALAM P Name:

UHID:

63/Malc/MHI202381271

27/12/2023/IPH2023002615

DOB: Dr.ANBARASU MOHANRAJ DOA: DOA: Consult



Every heart beat counts Date: 21/2 2012

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK Time:	130	190°00
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 Presponds 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	3	3
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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	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	2	2
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		2
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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,	3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. Nor chair)	1
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down		Initial & Emp. No. of Staff Nurse:	Paul Onc	12 h
Score	Interpretation: Minimal Risk: 23 - 19; At Risk (Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	Q 31	A JOB





63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.Anbarasu mohanraj



Every heart beat counts

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	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK Time:	J 70		Ž
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FRICTION	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 independentl strength to lift up completely during move. Nor chair	y and has sufficient muscle Maintains good position in bed	3	7	3
& SHEAR	slides down in bed or chair, requiring	chair, restraints or other devices. Maintains relatively good position in chair		TOTAL SCORE	23	2	3





F Mr. VENKATACHALAM P 63/Malc/MHI202381271

| 27/12/2023/IPH2023002615

Dr.Anbarasu mohanraj





Date: 91 10 mg

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK Time;		12	223 N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	H	j.
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 Molst Skin is usually dry, linen only requires changing at routine intervals	4	H	H
ACTIVITY degree of physical activity	Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non- existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	9	4	H
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		H	4
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. Nevel 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	ų	4	4
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. Nor chair		22	3 23	3 3 9 5
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; H	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	100	100m 24	عمر معر





63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





Every heart beat counts
Date:

	BRADEN 5	CALE FOR PREDICTION	NG PRESSURE INJUR	Y HISK Time:	M	E	N
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 discomfert	4	k	R
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		H	Н
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	lı,	H	4
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4 No Limitation Makes major and frequent changes in position without assistance		H	4
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		4	Å
FRICTION	Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,			3	3	્ક
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or	chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally	·	TOTAL SCORE	23	99)	23
-	agitation leads to almost constant friction	slides down	<u></u>	Initial & Emp. No. of Staff Nurse:	Oatla	1014	
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; H	ligh Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. 4 of Sr. Staff Nurse:			190





Patient Note:
Na Nr. VENKATACHALAM P
Na 63/Malc/MH1202381271
UHI 63/Malc/MH1202381271
UHI 27/12/2023/IPH2023002615
DOA Dr.ANBARASU MOHANRAJ
Cons



Every heart beat counts

	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Date:	<u> </u>	200
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	9	
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	A-Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	
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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	A 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	2	
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	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair	3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. No or chair		3	
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & Emp. No. of Staff Nurse:	See	
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	سے پد	







63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr ANBARASU MOHANRAJ

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MHI/NUR/2022/052



PAII	N RI	E-ASSESSMENT	& МС	NITORING	CHART	γ ''' 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.
27/12	123 olio	No pain		-		Contraction	(Q)
11.00	0/10	1	_			Jal	O.
22. 0 0		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1	_	R.	Ø,
28/26	•	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	-		_		De C
6.00	0/10	No pain	_		_	A.	O J
&-00	@ (co	No pain	-			ger on	Paca.
							,

Date & Time	Pain Score	(dull, achy	ain Character sharp, stabbing, shooting, , referred / radiant pain)	Duration	Location / Site		Interventions			Staff Initial & Emp. No.	Senior Staf Initial & Emp. No.
		_									
							<i>/</i>				.,
		, ,			P/	IN SCALES					
(28 weel	PiPPS (8 to <u><</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	de comfort me		on		k.	† †	. •	1
(38 we	CRIES eks - 2 m	onths)	The CRIES scale is used further pain assessment	for infants >	than or = 38 week ndertaken, and anal	of gestation. A maximal sco esic administration is indica	re of 10 is possible. If the	e CRIES so gher. _\	core is >	4,	
	ACC Sca nths - 7 y		0: Relaxed & comfortable	e, 1-3: Mild d	Iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe	e discomfort / pain / both	1			
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)		O 2 No Hurts Little Bit	(©) 4 Hurts Little More	6 Hurts Even More	8 10 Hurts (ftole Lot Worst	Numerical Rat	 	5 (foderate	more than 12	9 10	
Observa	cal care F ition Tool ator / com	(CPOT)	COMPLIANCE WITH VEN	Absence of m NTILATION (III Ubated patler Relaxed, 1 - Te	novements or normal ntubated patlents): (nts): 0 - Talking on no nse, Rigid, 2 - Very Ta	position, 1 - Protection, 2 - Res - Tolerating Ventilator or Move mal tone or no sound, 1 - Sigl nse, Rigid	ment , 1 - Coughing but t			g ventilator (or)	
	harmacol terventior		Cutaneous Stimulation a Thermal Therapies (no lo	ind massage: onger than 15	E - Positioning; F - F to 20 minutes): G - C	- Music; D - Physical and menubbing / Massage the skin old application; H - Hot application; H - Psycho-serferntial therapy	ition; 1 - Shortwave diather		dual Cour	iii	/ counceling

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63/Malc/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/052



Every heart 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.
184%	0/8	ph ctob				44	- de
21.30	0/2			-	CPOT	det	- Voice
23.50	0/2			j	CPOT	Def.	Now?
1:20	8/3			-	CPOT	6165	Lows
3.30	0/8			_	CPOT	0167	Nov
5.30	0/8			}	CPOT	03.65	logs
29172 1-30	%		_		By Upor	Damt on.	V 000)
9,30	2/10	DUN PAIN	10015 SEA	Surthual Sate	Mon-Phanmachogist Intervents	Pany	pas
11:30	7/10	AUTY PAIN	10 SEY	STERNUM	Pharmacological Intervended of a	Jany 012	Now

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.		
13,30	1/10	Do	IL PAIN	210-15 Sey	Survival Site	Pharmacological Intrucution are	Jam .	1600		
5.30	21/10	Au	ty PAIN	८। ० ১৪.	STERMUM	Non-Pharmaelogi-1 Intrucides are flows.	Dawl 0171	A600)		
osiFl	Xo	Du	L Pain	20-15 Sto	Survial Sire	Pharmacologie Toy verter are follow,	Jam!	. Dog)		
19.30	2/10	Дц	y Paw	L10 SB	S.IESTAN	Non-Phaneir Tetretta au	Jan or:	A.,00		
	PAIN SCALES									
(28 week	PIPPS (s to <u><</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	de comfort me		on				
(38 we	CRIES eks - 2 m	onths)				s of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, gesic administration is indicated for a score of 6 or higher.				
	ACC Sca		0: Relaxed & comfortable	e, 1-3: Mild di	Iscomfort, 4-6: Mode	erate discomfort, 7-10: Severe discomfort / pain / both				
Paln	Wong-Baker FACES Pain Rating Scale (7 years - 12 years) O Notated & Comfortation (2 months - 7 years) O O O O O O O O O O O O O O O O O O O			(©©) Hurts Little More	6 Hurts	Numerical Rating Scale (age media) 8 10 Hurts Whole Lot None Numerical Rating Scale (age media) 0 1 2 3 4 5 6 Moderate	7 8	9 10		
Observa	Critical care Pain Observation Tool (CPOT) (ventilator / comatose) FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing BODY MOVEMENTS: 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation COMPLIANCE WITH VENTILATION (Intubated patients): 0 - Tolerating Ventilator or Movement, 1 - Coughing but tolerating, 2 - Fighting ventilator (or) VOCALIZATION (non-intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing MUSCLE TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid TOTAL SCORE: 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain									
Non-p In	harmacol terventlor	ogical 18	Cutaneous Stimulation a Thermal Theraples (no lo	nd massage: nger than 15	E - Positioning; F - R to 20 minutes): G - Co	- Music; D - Physical and mental exercisers ubbing / Massage the skin old application; H - Hot application; I - Shortwave diathermy erferntial therapy Psycho-social therapy/counselling: K - Individual Counse	eling; L - Family	counseling		
Pharmac	ological i	ntervention	ns as per doctor's prescrip	tion	· · · · ·					



PAIN RE-ASSESSMENT & MONITORING CHART





Mr.VENKATACHALAM P

63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ



Consultant:

MHI/NUR/2022/052



Every heart best 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.
29/12	1/10	Achy pain.	15sec	Steanum	comportable poettres.	S, Moory, S,	2000
0 <u>3</u> ;3°	110	echy pain	Losec	Shelnum.	Confortable position.	J. Moen	(Sab)
30/12	410.	Acty Pain:	issec	Otelnum,	comforfable polition giren.	J. Kroore	200
03',30	Mic	oull pain.	L Bsec.	sternum,	Centortable partion given.	J. Masy	A and
DE/30.	1/10	Dell pain	6 155ec	steurum	β''''	لتعهم. مهدن	Moos
7.30			2 15-3ec	Hernum	comportable position gwen	20089	W 5003
9,30	2/10	AUHY PAIN	210-15 Stee	Survival SITE	Pharmacological Intervadin on Ilancel	Jami.	Voos
11:30	4 /20	dall phin	oh &	Surgical 877te	provided comfortable	W an	Ncea.
165 ya			ong off	Surprised 8FTE	portion portion	SAFU SAFU	Nac

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.	
1912	el co	<u> </u>	Jo pi n	-	_		(olh)	Noon	
)) No Par				027/	Nort	
3.00	e Cro		- 64		<u></u>		002	Nor	
J. (II)	ew	\wedge	rð þein	-			12	Noo	
				_	P#	AIN SCALES		<u>Y</u>	
(28 weel	PIPPS ks to <u><</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	de comfort me		on			
(38 we	CRIES eks - 2 m	onths)				of gestation. A maximal score of 10 is possible. If the CRIES score is > 4 , jests administration is indicated for a score of 6 or higher.			
ſ	ACC Sca onths - 7 y		0: Relaxed & comfortable	e, 1-3: Mild di	iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe discomfort / pain / both		•	
Pain	Wong-Baker FACES Pain Rating Scale (7 years - 12 years) O A Hurts Little Bit			4 Hurts Little More	6 Hurts Even More	Numerical Rating Scale (age model) 8 10 Hurts Worst None Mild Moderate	7 8	9 10	
Observa	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								
	harmacol tervention		Cutaneous Stimulation a Thermal Therapies (no lo	i <mark>nd massage:</mark> onger than 15	: E - Positioning; F - R to 20 minutes): G - Ce	- Music; D - Physical and mental exercisers ubbing / Massage the skin old application; H - Hot application; I - Shortwave diathermy erferntial therapy Psycho-social therapy/counselling: K - Individual Counse	eling; L - Family	v counseling	
Pharmac	ological i	ntervention	ns as per doctor's prescrip	tion					







Pa Mr. VENKATACHALAM P

Na 63/Male/MHI202381271

UF 27/12/2023/IPH2023002615

Dr.Anbarasu mohanraj

MHI/NUR/2022/052



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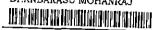
Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
20200	Ofo	No prin		•		Porni	1x10- 024
150		100 pin	_			@an!	Nac 024
هربها	910	100 per n		-	_	Jan!	Nals 024
23-00		No pour				Parl	Nac
1112A 200	e[w	No pain				Q_A	Nae,
	%	no pair	_			Q 25	Noa-
11.00	oJbo	No pin	-	-		Postn	Nas-
(3100	060	NO ping)	•	The state of the s	Naa,
9 P	of g	No puir				Jom	Nas

- •	1.	1					
Date & Time	Pain Score	(duil, achy,	Pain Character , sharp, stabbing, shooting , referred / radiant pain)	, Duration	Location / Site	Interventions Staff Infl. & Emp. I	
1100	x ola)	No pain	-	<u> </u>	025	H) Naar
3	o wo		No pour.			- 02	H poet
71124	Olvo		No pair		-	- 024	1 024
10.00	· 0/10		he pain	_	_	Jal 60	Num
	1				PA	IN SCALES	
(28 week	PIPPS (8 to <u><</u> 38	weeks)	6 or less = Minimal to r 7 - 12 = Mild pain - Pro >12 = Moderate to sev	ride comfort me		on	
(38 we	CRIES eks - 2 m	: 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 Sca nths - 7 y		0: Relaxed & comforta	ole, 1-3: Mild d	Iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe discomfort / pain / both	
Pain	-Baker F/ Rating S ars - 12 y	cale	O 2 No Hurts Hurt Little Bit	4 Hurts Little More	6 Hurts Even More	Numerical Rating Scale (age more than Numerical Rating Scale (age more than 10 1 2 3 4 5 6 7 10 1 Mild Moderate	12 years) 3 9, 10 Severe
Observa	cal care f ition Tool ator / com	(CPOT)	COMPLIANCE WITH V	- Absence of m ENTILATION (In Intubated patier Relaxed, 1 - Te	iovements or normal ; ntubated patlents): 0 nts): 0 - Talking on noi nse, Rigid, 2 - Very Te	position, 1 - Protection, 2 - Restlessness / Agitation - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting ventilator (o rmal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing nse, Rigid	
	harmacol tervention		Cutaneous Stimulation Thermal Theraples (no	and massage: longer than 15	: E - Positioning; F - Ri to 20 minutes); G - Co	- Music; D - Physical and mental exercisers ubbing / Massage the skin old application; H - Hot application; I - Shortwave diathermy erferntial therapy Psycho-social therapy/counselling: K - Individual Counseling; L - Fa	mily counseling
Pharmac	ological i	ntervention	ns as per doctor's prescr	lption			



63/Malc/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





DVT RISK ASSESSMENT

Assign a score of 1 if (VFS) in parameter nos 1 to 9 and accion a coord of -2 if (VES) in narameter no. 10

				-	(120)	m para		. 10
	Date	24/12	22/12					
	Time	13.00	4,00			•		
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	ð					
2	Bedridden recently >3 days or major surgery within four weeks	Q	0					
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	ಶ	0		,			
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0					
5	Entire leg swollen (Assess for both legs)	৩	0					
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0					
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	Ø	0					
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	Ø	0					
9	Previously documented DVT (Assess for both legs)	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.	Q	0					
_	FINAL SCORE	Ø	0	_				
Low R	isk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	hon	Low			· .	***	
	DVT prophylaxis started	□ Yes ☑ No	□ Yes □ Ne	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Signature & Emp. No. of RN	D)SUS	7				-	
<u>.</u>	Signature & Emp. No. of Sr. RN	(D)						9





63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





Every heart beat counts

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

	Data	28.122	500	061269	- 1-1-	10/10	\$11/24	0/1/0
	Time	(9.00.	29112133 6:00	19:00	301212	#-09		-1.1
S. No.	PARAMETERS				700	,, ,	<u> </u>	7
	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0	0	0	0	p
2	Bedridden recently >3 days or major surgery within four weeks	at 1	41	4	+{	41	+1	4
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0	Ø	O	0	0
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	O	b	0	0	0	0	0
5	Entire leg swollen (Assess for both legs)	0	0	0	D	D	Ø	0
6	Localized tenderness along the deep venous system (Assess for both legs)	0	b	0	0	0	10	0
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	v	0	0	Ø	0	0	\square
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	0	0	_0	<u>p</u>	0
9	Previously documented DVT (Assess for both legs)	0	0	0	0		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.	อ	0	0	O	D	0	0
	FINAL SCORE	71	41,	1	+1	+1	41	+1
Low R	isk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	MOD	Mop	Men	MOP	avol	MOD	Mid
	DVT prophylaxis started	√es □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes ☑ No	☐ Yes ☐ No	UYes UNO
	Signature & Emp. No. of RN	doth,	92 LS	Moster	Spago		18	
	Signature & Emp. No. of Sr. RN		/	•		100	المسحق	NZ



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Mr.VENKATACHALAM P

63/Male/MHI202381271 27/12/2023/IPH2023002615 Dr.ANBARASU MOHANRAJ



MODIFIED MORSE FALL RISK ASSESSMENT CHART

	Date	27/12/2) 1971 12	2 506/24	>					
Variables	Time	13.00		[]						
History of falling	No	0	0	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	15	157	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	207	20	20	20	20	20	20
AMBULATORY AID										_
None / Bed Rest / Nurse Assist		مهر ا	0	.o∽	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						į				
Normal / Bed Rest / Wheel Chair		_0_	0	-8	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		_اور	2	-8	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives,	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		20	50	<u></u>						
Low Risk (0 - 24)										
Medium Risk (25 - 44)		7								
High Risk (45 or above)		you	<u></u>	_						
Signature & Emp. No. of RN	`\.	39/60	Hala-	150%						
Signature & Emp. No. of Sr. RN		B		Non						
		0 -	24: Low	Risk; 2	5 - 44: 1	/ledium	Risk; 45	or abo	ve: High	n Risk

	Doto	2/12	1/2	1.					,	
INTERVENTIONS	Date	341.	271	28/19						
Tick as per the Risk Score	Time	13.00	20.00	B.O.						,
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surround	ings						}		<u> </u>	
Remind the patient to use call bell before getting ou			1	_						
Keep the two side rails in the raised position at all				7.						
all patients regardless of age		ľ	. با]	
Keep the call bell, bedside table, water, glasses w	ithin the			,						
patient's easy reach		L	V/							
Remove excess equipment or furniture to make	a clear			4						
path;:										
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	✓		7					[•	
moment before rising from the bed		`						İ	<u></u>	
Bed wheels should be locked		~				}				
Encourage family participation in the patient's care	 	/				İ	· ·] -	1	I
Ensure that floor of the bathroom is dry and not slip	pery			٠,٠					1	
Review medications for potential side effects to	hat can					[-
promote falls						L		-		<u> </u>
Use safety belts during movement in wheelchair	-				•	[·				,
The patients are not ambulated by themselves. Th	ey are to							-		
be ambulated only with assistance			/						_	
Medium risk interventions (25 - 44)				-	-	-		 		
Apply all the low risk interventions		\ <u>\</u>								
Tie yellow fall risk tag in the bed and Wheel chair/S	tretcher								-	
Make sure that proper transfer precautions are in	nstituted				_			-		
for heavy or debilitated patients in a bed or wheel	chair or			<u>- </u>				•		
on a toilet seat				h .	_	• ,		<u> </u>	<u> </u>	
Use restraints and bed monitors as ordered by the	doctor		<u></u>							
Allow the patient to ambulate only with assistance				\						
Consider peak effects of the medications that effe		_	<u> </u>	;				1		
of consciousness, gait and elimination when p	olanning	/	/							
patient's care									· .	
Do not leave patients unattended in diagno	ostic or			اما						
treatment areas										
Accompany the patient while going to bathroom	_			_					<u> </u>	
Advice the patient to use grab bars near the toilet,	bathtub,	_/					•	[
and shower		Ĺ,							<u> </u>	
Make sure the family and other visitors underst	and the						ľ	 	<u> </u>	
restrictions mentioned above		<i>J</i> -							1	
High-risk interventions (45 or above)										
Apply all the low and medium risk interventions		<u> </u>				· .		ļ	r -	
Tie red fall risk tag in the bed, wheel chair and streto	_						ļ <u> </u>		<u> </u>	
Locate the high-risk patients in a room close to the	nurses'	1	·. /							
station	<u> </u>		-						<u> </u>	
Answer these patients call bells as quickly as possi	pie	}		_					<u> </u>	
Provide a commode at bedside (if appropriate)	u7 = A								ļ	
Urinal/bedpan should be within easy reach (if appro		}							 	
Encourage family members or other visitors to s	tay with		. /	} _ ,	i	.				
them									<u> </u>	
If appropriate, consider using protection devices	s: sarety									
belts s		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		1				<u> </u>	 	
Signature & Emp. No.	of RN	PX60	A)Selfe	3/2	_			L		
Signature & Emp. No. of	Sr. RN	(28)	وي	رنقل	·					
			- ZZ	7		L			<u> </u>	<u>. </u>
		.63	, , J-							



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Mr.VENKATACHALAM P

63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





MHI/NUR/2022/046

MODIFIED MCRSE FALL RISK ASSESSMENT CHART

	<u> </u>	Ι,	4.	ls ı.	ا المرا	Colin	<u> </u>	72.	7 _	
Variables	Date	29.12.1	इंडीप्री	23	2012	3	30(ાર	30/12/	30/12	3)/2/
,	Time	19-00.	2)!00	8.00	134	BU:00	8.00	This	8-00	١
History of falling	No	9/	10	ø	_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	J5	15	15
Intravenous Therapy /	No	0	0	0	60	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	29	120	20	20	(20)	20^	20	20	20
AMBULATORY AID			/			A				
None / Bed Rest / Nurse Assist		9/	LO-	.0	0	6	<u></u>	9	8	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	ļ	9/	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	0	0	9/	(0)	e-	o	0/	0
Overestimated or forgets limitations		15	15-	18	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	45	,18	15	(15)	15	15⁄	15	15
Total Score		45	65	65	50	50.	50	6	50	
Low Risk (0 - 24)										
Medium Risk (25 - 44)										
High Risk (45 or above)	•	-	K	~	<u>, </u>	\(\frac{1}{4} \)		/		3
Signature & Emp. No. of RN	<u>-</u>	Hat h	- BOR	Daml OTH	Jan-	MO26.	dia.	POIN	(Ko)	1/1
Signature & Emp. No. of Sr. RN		R	1	1	X	d	A	No	Noon	
		OP6-	240 OW	Risk; 2	5 644: N	/le@ium	Risk; 45	or abo		Risk
								_		

INTERVENTIONS	Date	28.12.	02/12/23	2914	29	27/12	30/12	Shala	30/h	. 1
Tick as per the Risk Score	Time	ાવ-૭૦	21:0	8,00	13.0	3/1/00	8.00	\n/PC	<i>2</i> 8	-
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surround	lings									
Remind the patient to use call bell before getting ou	tofbed					}				
Keep the two side rails in the raised position at all t	imes for									
all patients regardless of age										
Keep the call bell, bedside table, water, glasses w	ithin the	1		1	\ 		1		1. /	Ì
patient's easy reach	01-0"	ļ. —			ļ				<u> </u>	
Remove excess equipment or furniture to make path	a clear						1			
Keep the patient's bed in the low position at all times	s except	-	-			 	1		 / 	
during procedure	ослосрі	İ					ļ	'		
Teach fall-prevention techniques, such as sitting	up for a					-	1		r/	
moment before rising from the bed	•						ĺ			
Bed wheels should be locked										
Encourage family participation in the patient's care										
Ensure that floor of the bathroom is dry and not slip									Ŭ	
Review medications for potential side effects to	hat can	•	,					/	. /	
promote falls		<u> </u>	ļ			-	ļ		\bigvee	<u> </u>
Use safety belts during movement in wheelchair			<u> </u>	-				<u> </u>	1	
The patients are not ambulated by themselves. The	ey are to	1				1				
be ambulated only with assistance Medium risk interventions (25 - 44)									1	
Apply all the low risk interventions									$\overline{}$	
Tie yellow fall risk tag in the bed and Wheel chair / St	tretcher								1/	
Make sure that proper transfer precautions are in				 		 				
for heavy or debilitated patients in a bed or wheel		1						1	V	
on a toilet seat				1						
Use restraints and bed monitors as ordered by the c	doctor								\(\sqrt{1}	
Allow the patient to ambulate only with assistance										
Consider peak effects of the medications that effects						İ	1		,	
of consciousness, gait and elimination when p	planning	ļ	İ	<u> </u>	ļ		<u> </u>			
patient's care	4:				-		-	/		
Do not leave patients unattended in diagno treatment areas	SUC OF		ļ					/	V	
Accompany the patient while going to bathroom	-	-								
Advice the patient to use grab bars near the toilet, it	bathtub							-		
and shower								/		
Make sure the family and other visitors underst	and the			-			<u> </u>	<u> </u>		
restrictions mentioned above								/		
High-risk interventions (45 or abovc)			<u> </u>			/			/	
Apply all the low and medium risk interventions		<u> </u>	~		V				$V_{/}$	
Tie red fall risk tag in the bed, wheel chair and stretc		Willer	/	V		1	~		·/_	
Locate the high-risk patients in a room close to the	nurses'	AL			l. /	1/	/		1/	,
station	hlo.		. ra.	-		<u> </u>			/-	
Answer these patients call bells as quickly as possit Provide a commode at bedside (if appropriate)	nie	NA	AA AL	NA	NA	HA	Nn		<u> </u>	ļ — —
Urinal/bedpan should be within easy reach (if appropriate)	onriate)	시	778	NA	NA	44	NA		\	
Encourage family members or other visitors to s		NA	74			NA	NA		/	<u> </u>
them	,,	MD	AM	NA	NA	120.	NA	V	$ \checkmark $	
If appropriate, consider using protection devices	s: safety		~		/	_			-	
belts			Ú	اسيا	V:	<u>L</u>	1	_ ′		
Signature & Emp. No.	of RN	1/2	VIE .	Jam.	Jan -	322	A 58	Son	(Q)(A)X	\
Signature & Emp. No. of S		<u> </u>	<u>حياري</u> ۸	104,	~ 1 1	3/6	1 000	9/	N	
Signature & Emp. 140. 013	or UN	nvz		<u> </u>			1 1/22	***	تعرمهج	
		700	ره و	727	2007	0007	0000			
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Mr.VENKATACHALAM P

63/Malc/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





MHI/NUR/2022/046

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	3/12/03	3/1/2	11/24	1/1/21	1/20	2/1/21	1 =		
	Time	14120	20.00	4.00	inpo	20- COI) A-000			
History of falling	No	ver	v	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	J 5	15	15	45	15	15	15	15	15
Intravenous Therapy /	No	JO.	0	O	0	0/	Ó	/ O	0	0
Heparin Lock / Tubes Insitu	Yes	30	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist .		10	u	9	-8	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				r /		/				
Normal / Bed Rest / Wheel Chair		0	40	0	18	9	6	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		ø	6	ø	9	\ o /	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives,	No	0_	0	0	0	0 /	0	0	0	0
immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	Yes	15	1.5	1.8	15	45	15	15	15	15
Total Score		6	9570	8	60	150	Б О			_
Low Risk (0 - 24)										
Medium Risk (25 - 44)	<u> </u>		<u> </u>					-		
High Risk (45 or above)		_	\vee		/					
Signature & Emp. No. of RN		Schl	@/sp	astr	WO F	Q (A)	pod			
Signature & Emp. No. of Sr. RN		NO	124	1900	بالورا	المعروا	124			
		0 -	24: Low	Risk; 2	5 - 44: N	ledium	Risk; 45	or abo	ve: High	ı Risk

INTERVENTIONS	Date	2/12/2	3/1/2	aleba	11/26	1/24	2)(1)2	1	, ————————————————————————————————————	
Tick as per the Risk Score	Time	24/20	2000	8-00	1 80/20	00,00	8°00		 	
Low Risk Interventions (0 - 24)		VI.	7 -			1		_		
Familiarize the patient with the immediate surround	linas	~	$\sqrt{}$		· ·	M /		1		<u> </u>
Remind the patient to use call bell before getting ou			<u> </u>	-/-					<u> </u>	
Keep the two side rails in the raised position at all t						- /-	}		 	
all patients regardless of age							//			
Keep the call bell, bedside table, water, glasses w	ithin the						- 		Ì	†
patient's easy reach			\ \ \			$ \vee\rangle$	/			
Remove excess equipment or furniture to make	a clear	 `								
path		. /				`				
Keep the patient's bed in the low position at all time	sexcept			-		1./			<u> </u>	
during procedure			$ \vee $	´		* _	_			
Teach fall-prevention techniques, such as sitting	up for a								Ì	1
moment before rising from the bed	•		$\mid \vee \mid$	ļ ·)	
Bed wheels should be locked	•		1			V/			Ì	
Encourage family participation in the patient's care			1/			1			j	
Ensure that floor of the bathroom is dry and not slip			Ň,		/	1			1	
Review medications for potential side effects t	<u> </u>		1	. /	_	7		 	1	
promote falls			` _	′ _		V /				
Use safety belts during movement in wheelchair			\	1	/	V/		<u> </u>	Ì	
The patients are not ambulated by themselves. The	ey are to		· · /	. /		1			1	
be ambulated only with assistance	•	/		_			/			
Medium risk interventions (25 - 44)		<u> </u>						ļ. —	<u> </u>	
Apply all the low risk interventions		/	\vee	//	_	 			İ	}
Tie yellow fall risk tag in the bed and Wheel chair / S	tretcher			1	-	1			 	i
Make sure that proper transfer precautions are in					V	-			 	<u> </u>
for heavy or debilitated patients in a bed or wheel			1					[<u>.</u>
on a toilet seat						' /	_			
Use restraints and bed monitors as ordered by the	doctor					V		<u> </u>		
Allow the patient to ambulate only with assistance					//	V				
Consider peak effects of the medications that effe	cts level	/			,					
of consciousness, gait and elimination when p	olanning		1/			./	l ,			
patient's care			~			🔪 🦯				
Do not leave patients unattended in diagno	ostic or		. /	/	V	,/				
treatment areas						🗸 🔎	//	,		
Accompany the patient while going to bathroom			,/			1//				
Advice the patient to use grab bars near the toilet, I	bathtub,			7		1.7				
and shower		/				🗸				
Make sure the family and other visitors underst	and the						ļ	<u> </u>		
restrictions mentioned above			\vee			$ X_{\ell} $				
High-risk interventions (45 or abovc)		 	1		1	 \	 		-	
Apply all the low and medium risk interventions		_				V				
Tie red fall risk tag in the bed, wheel chair and stretc	her	/								
Locate the high-risk patients in a room close to the	nurses'				V	1, /		/		
station		/		//		V				
Answer these patients call bells as quickly as possil	ble				V	W.				
Provide a commode at bedside (if appropriate)					/					
Urinal/bedpan should be within easy reach (if appro						1/	P /			
Encourage family members or other visitors to s	tay with		./		,	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ľ _			
them						V_				
If appropriate, consider using protection devices	: safety				· .	~	ĺ /			
belts				/					<u> </u>	
Signature & Emp. No.	of RN	(del	Wa	A) alla	Post in	W/W	K bend	<i>\</i>	(
Signature & Emp. No. of		.0/	30/		9.9	6	(1)			
	~I. 4 11 T	. a>-		14 L/	. · ·		I 69	i	ı	I







63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





PATIENT AND FAMILY EDUCATION RECORD

Assessment To be	filled	by cond	cern	ed d	iscij	olines. L	lse k	ey b	elov	N			1		
Barriers to	Le	arning								Plan t	o A	ddr	es	s Factors	
None		Vision	/ He	arin	g lin	nitations	ì] Use	of l	nterp	rete	er	'
Limited Reading Abilities		Physic	al b	arrie	rs	-] Edu	cate	fam	ily		
Religious / Cultural Factors		Langu	age	barri	ers] Sim	ple I	ang	uag	e	
Congnitive Limitations - unable to		Low m	otiv	ation	ı / de	esire to	learı	1		Writ	ten	Instu	ctio	ns	,
understand and follow directions	<u> </u>														
Completed By : Date サルンンTir	ne\	3.0	<u>0</u>	N	lurs	e Signa	ture	: _		<u></u>	190	7			
Learning Record								_			y ,				
Need		Date	1	/isit	1	Date	\	/isit	2	Date	,	Visit	3	Signature	İ
	•	2/12/	₹	Р	0	93/2	L	Р	0		L	Р	0		
Disease														Doctor	
Information on														Da	
Disease / Diagnostics		,	6	OD	\lor		P	lot						Olle Un	7
Treatment															
Medications	·		2	DD			Ď	aa	سا					Doctor / Nurse	1000
☑ Information on Safe and			V											all	
Effective use of medicines			D	00	\bigcup		Р	0)						3/00	
Information on drug / drug and												1			
drug / food interactions															
☐ Discharge Medications												<u> </u>	Ц		Mos. I
Surgical Instructions								<u>_</u>	L			<u> </u>	Ц	Nurse	100
Pre - Operative Instructions			ρ	œ	∠		P	\overline{a}	<u>٧</u>					Officer.	
Post - Operative Instructions			١												
(Wound / Dressing Care)							_						Ц		
Pain Management				_			_	<u> </u>					Ш	Nurse	
Reporting of pain			P	QQ	$ \vee $	_	P	OD	7				$oxed{\square}$	1700	
Pain Management			p	ыĎ	\checkmark		ρ	عح	Z				Ш	MOZY	
Safe and effective use of medica	li 		'											Doctor / Nurse	
Equipment (if required) Name of Equipment					\vdash		\vdash		\vdash	<u> </u>			H		
Rehabilitation Techniques														; _{(*}	سيور

Need	Date	\ \	/isit	1	Date	١,	/isit	2	Date	\	/isit	3	Signature
		L	Р	0		ı	Р	0		L	P	0	
Nutritional Guidance													Dietician
Diet Instruction for patients at Nutritional risk	_	٦	ð	S		6	<i>م</i>	J		þ	مر:	5	Senio Distribution
☐ Diet advice for home		4		Ĺ		l							Nurse
Discharge Planning													
☐ Self care													
Follow up		_				_	_					$oxed{oxed}$	
Reporting Concerns Immunizations													
☐ Parenting education													
☐ Others							Г						
Risk Factor Reduction													_
													Doctor
☐ Weight Control													_
☐ Exercise													
Hypertension					-								
☐ Other Risks					. ,							Ī	
		_		_									
Reports Given :	,												
Given Pending	<u> </u>	İΑ							Giver	1	Per	ndir	ng NA
Discharge Summary			[Diet	Advice								
ECG Report		-	_ (CT S	Scan Re	port		•					
Doppler Report	_				Scan Fil	-		•					``
X-Ray Report	_ —	$\overline{}$			O Repo			•					
X-Ray Film		1			asound		orf	•					
Compact Disk		$\overline{}$			Other F	_		•		<u> </u>			
Compact disk			/ ,	Ally	Other	cepu		_					
Name of Attendant / Patient :				_	<u>.</u>	-	Sig	nati	ure :		_		
Name of Discharge Nurse				\		;	Sigr	natu	ıre :				





63/Male/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





PATIENT AND FAMILY EDUCATION RECORD

Assessment To be	tilled	by cond	erne	ed di	scip	olines. U	se k	ey b	elov	V				
Barriers to	Le	arning						Ī		Plan t	o A	ddr	ess	s Factors
None		Vision	/ He	aring	lin	nitations			Use of Interpreter					er .
Limited Reading Abilities		Physic	al ba	arrie	rs	<u></u>				Edu	cate	fam	ily	·
Religious / Cultural Factors		Langu	age !	barri	ers				Ų	Sim	ple L	ang	uag	e
Congnitive Limitations - unable to		Low m	otiva	ation	/ de	esire to	learr	1		Writ	ten I	nstu	ctio	ns
understand and follow directions											Λ.	đ		
Completed By : Date 281213 Time 19.60 Nurse Signature :										ر مراد	K			
		_	-				•			-				
Learning Record									_		_		_	
Need		Date	\	/isit		Date	_\	/isit		Date	<u> </u>	/isit	,	Signature
		28-1213	L	Р	0	ક્યામ	L	Р	0	3012	L K	Р	0	
Disease						•						_	L	Doctor
✓ Information on			^	Ψν.	.	ļ	٥	45		·				
Disease / Diagnostics			2	0)2	Υ	<u> </u>	8	QD	À		12	වා	4	-4 %
			3	90	V		${\cal E}$	٥Đ	V		م ا	a D	y	DAY.
Medications			2	oЬ	7		S	00	Z		1/2	<u></u>	и	Doctor / Nurse
Information on Safe and											۳			
Effective use of medicines													L	Nue
☐ Information on drug / drug and				•										024
drug / food interactions				Ĺ										1
Discharge Medications											_			
Surgical Instructions											L		L	Nurse
Pre - Operative Instructions														<u>.</u>
Post - Operative Instructions		1	00	ob	V	1	'Q	æ	,			~		J.A.
(Wound / Dressing Care)			7					ľ	Y		P	T)	9	V /'
Pain Management							<u> </u>						L,	Nurse
Reporting of pain			S	<u>0</u> 0	1/		2	00	7	_	P	Ð]_	Pd	duff
☑ Pain Management			S	Ojo	V		2	сvį	√					. '
Safe and effective use of medica	al		,											Doctor / Nurse
Equipment (if required)														
Name of Equipment						,								
Rehabilitation Techniques		I –		 		Γ.,	L		ı		l		ı	

Signature:

7

Name of Discharge Nurse







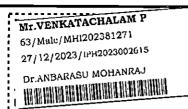




PATIENT											OR	D		
			cern	ed di	SCI	plines, U	se k	ey b			_		•	
Barriers to	Lea	arning ———								Plan t	0 A	ddr	ess	s Factors
None		Vision	/ He	aring	j lin	nitations				Use	of Ir	ıterp	rete	er
Limited Reading Abilities		Physic	al b	arrie	rs				Ų	Edu	cate	fami	ly	
Religious / Cultural Factors		Langu	age	barri	ers					Sim	ple L	ang	uag	e
Congnitive Limitations - unable to		Low m	otiva	ation	/ de	esire to	earr)		Writ	ten 1	nstu	ctic	ns
understand and follow directions														
Completed By : Date 1285 Tin	ne_	16/2)	N	lurs	e Signa	ture	:			n			
		[+4								70		-	-	
Learning Record														
Need		Date	١	/isit	1	Date	Ι, \	/isit	2	Date	١	/isit	3	Signature
		3///	L	Р	0	1112/	Ĺ,	Р	0	0/1/63	L	Р	0	
Disease		,												Doctor
☐ Information on		,												. 0
Disease / Diagnostics							1	Ì						1.60
Treatment			10	ά	٦	,	0	200	/		D	70	()	124°
Medications			20	on			0	B	\		יט	'nΦ		Doctor / Nurse
☐ Information on Safe and			7				Ű				17			G.
Effective use of medicines												<u> </u>		202
☐ Information on drug / drug and														
drug / food interactions														
☐ Discharge Medications														
Surgical Instructions														Nurse
Pre - Operative Instructions														
Post - Operative Instructions			P	4D	74	·								
(Wound / Dressing Care)			"}	•			P	Ø	\checkmark	,	Þ	00	t	p
Pain Management			R	3	ÿ		P	150	~	_	٨	മ	v	Nurse /
Reporting of pain			X	6)	\sim		p	50	V			(ע	Ů	
☐ Pain Management			Ø.			i								10172
Safe and effective use of medica	ıl													Doctor / Nurse
Equipment (if required)														
Name of Equipment														
Rehabilitation Techniques														

Need	Date	Date Visit 1 Dat		Date	Visit 2		Date	Visit 3		3	Signature		
	20/12	1	Р	0	01/1	L	Р	0	2/1	L	P	0	7
Nutritional Guidance									,				Dietician
Diet Instruction for patients at		0		7		- 8						Г	100
Nutritional risk		1	00	ν		1	00	'		P	ar.	<i>)</i> '	Senior Dines
Diet advice for home		_	-	-		}	-			P	a	7	Nurse
Discharge Planning		Г		П				П			\Box		
☐ Self care													
Follow up											_		
Reporting Concerns Immunizations													
Parenting education								Ħ				一	
Others			┢	Г				П			T	一	
Risk Factor Reduction					_			П			Г		
Smoking Cessation		Г				,	T	П	:	_	Г	П	Doctor
Weight Control								П		_	Г	П	
☐ Exercise								П					
☐ Hypertension													
Other Risks	1-7				7/	· .							
OUTCOME (O) - RD - Return Demor	nstration,			on,								Sta	
OUTCOME (O) - RD - Return Demor	nstration,			on,	W- Wri					·			
PROCESS (P) - Oral Discussion OUTCOME (O) - RD - Return Demor Written Material given and explaine Reports Given :	nstration,	V - '		on,	W- Wri						Pool		acc. NA
OUTCOME (O) - RD - Return Demor Written Material given and explaine Reports Given :	nstration,		Verb	on,	W- Wri	ders					Pe	ndir	ng NA
OUTCOME (O) - RD - Return Demor Written Material given and explaine Reports Given : Given Pence	nstration,	V - '	Verb	on, paliz	W- Wri	ders					Pei		ng NA
OUTCOME (O) - RD - Return Demor Written Material given and explaine Reports Given : Given Pence Discharge Summary ECG Report	nstration,	V - '	! !	Diet	W- Writed United	ders				·	Pe		ng NA
OUTCOME (O) - RD - Return Demor Written Material given and explaine Reports Given : Given Pence Discharge Summary ECG Report Doppler Report	nstration,	V - '		Diet	W- Writed Und	port				·	Pe		ng NA
OUTCOME (O) - RD - Return Demor Written Material given and explaine Reports Given : Given Pence Discharge Summary ECG Report Doppler Report X-Ray Report	nstration,	V - '	Verb	Diet SECH	Advice Scan Re Scan File	port m	tan			·	Pe		ng NA
OUTCOME (O) - RD - Return Demor Written Material given and explaine Reports Given : Given Pence Discharge Summary ECG Report Doppler Report X-Ray Report X-Ray Film	nstration,	V - '	Verb	Diet CT S	Advice Scan Re Scan Fili	port m Rep	tano				Pe		ng NA
OUTCOME (O) - RD - Return Demor Written Material given and explaine Reports Given : Given Pence Discharge Summary ECG Report Doppler Report X-Ray Report	nstration,	V - '	Verb	Diet CT S	Advice Scan Re Scan File	port m Rep	tano				Pe		ng NA
OUTCOME (O) - RD - Return Demor Written Material given and explaine Reports Given : Given Pence Discharge Summary ECG Report Doppler Report X-Ray Report X-Ray Film	ding	NA		Diet CT S	Advice Scan Re Scan Fili	port m Rep	tano				Pe		ng NA
OUTCOME (O) - RD - Return Demor Written Material given and explaine Reports Given : Given Pence Discharge Summary ECG Report Doppler Report X-Ray Report X-Ray Film	nstration,	NA		Diet CT S	Advice Scan Re Scan Fili	port m Rep	tano	ding	Giver		Pe		ng NA







IN-HOUSE TRANSFER FORM

Par	A (to be filled by Nu	rses)											
Dat	e of Transfer: 30(1)	23 Time: 10	<u>ි</u> Tr	ansferred	from: S	رن ، <u>رن</u>	BT FL	oor_					
Dia Co		-TVD+	LEP	r MAH	Ν,								
Vita	I Signs: Temp: (°F) Pulse / HR:	941mt	(beats/n	nin) [BP: \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	<u> ∃นมเ</u> (mmHg) Resp	iration:	18 (breaths/min)					
Pari	t B (to be filled by Phy	ysicians) /	Any Critic	al Investig	ations:		-						
	Check for			Tran	nsferring Docto	or		Receiving Doctor					
Resp	Respiratory (Breath sounds) Clear Crepitation Rhonchi Others: Yes No												
Abde	Abdomen												
Hear	Heart Sound												
CNS	CNS Conscious Oriented GCS Score: Yes No												
	For Surgical Patients (if applicable) Surgical Site: Soakage Others: Yes No												
	Present Medication (for Medication Reconciliation)												
S. No.	Current Medic		Dose	Route	Frequency	Date & Time of last dose		To be continued during hospital stay					
[SYP. SUCRALF	ATE	10mL)—(- ,	29/12/23/27:00	4	Yes □ No					
<u>ਪ</u>	NEB.LEVOCA	rl Butamo	ng	PNH	& GHECY	30/12/23 7 04:00	ار .	∕Yes ☐ No					
3	T. FRUSEMID	E·	42	1910	1-1-0.	30/12/28 PT	[⊿Yes □ No					
,	T. SPIRON ALF		250	190	1-1-0.	20/12/28 AT.	1	☐Yes ☐ No					
	T-BEPLEY A		177de	1210	1000.	30/12/129 A-5	1	Yes □ No					
6	T. CLOPIDOGIA	ELLA ELLA	71 1/1	P10	0-1-0	29/12/22 Ar	لر	√Yes □ No					
7	T. PARDCE	TAMOL	655 mg	P10	1-1-5.	30/12/23 AT		ZYes □ No					
8	- SYP. CREMPFA	FIN PWS	15,0	Plo.	0-0-1.	29/12/23 AT	1	☐Yes ☐ No					
9	T-ROSUVASTI		Hang	Plo	0-0-1	29/12/12/20:00.	<u></u>	ZYes □ No					
10	T-METO 1920L	-DL ,	32	P10	10-1.	30/12/23 At		ZYes □ No					
11	HEDDEZON LIDE	;	Ping	DNH	1-1-1-1.	3012123 8500	<u>_</u>	No					
			V I				[Yes					
-7.4	· ·						[☐ Yes ☐ No					
, ,							[☐ Yes ☐ No					
							ſ]Yes ∏No					

Additional De	tails (i	f any):					
Patient Condi	tion:	Stable [Sick-need urgent care Oth	ers:			
	Sign		Name	Reg. No.	Date		Time
Transferring Doctor		8/	DR. PRANEER	112236	341/2	423	19-00
Receiving Doctor	. /	80	Dr. K. Amesuya	134559	1	-123	10:15
Part C (to be f	illed t	y Nurses)	_ \	'		-	<u>' </u>
Check for			Transferring Nurse			Receivi	ng Nurse
Drains		Chest A	bdominal Others:	 		Yes	i ☐ No
Respiratory	!	Air Way Type: Oxygen Therapy		s:Rate:li/m	— in	Yes	No
NG Tube / Oral		Yes No	For Feeding Gastric Suction	Fluid Restriction		Yes	No 🗌
Foley's Catheter	r	Yes Mo				Yes	No No
Intravenous Acc	ess	Peripheral Li	ne Central Venous Line Others	<u> </u>		☐ Yes	. □ No
Pressure Injury		Yes Vivo	If Yes, give details:			Yes	No No
Score		Fall Risk: 50				Yes	No No
Patient Belongin	ıgs	Yes No	If Yes, give details: + HAEIL			· Yes	i ∐ No
Handover Detail	s		inistration Record explained: Ves c Reports handed over: Xes N			Yes	No
Patient Attendar Informed	nt	No No	if No, give details:			Yes	No
Additional Det	tails <i>(i</i>	if any):			ř		
			,				
							,
			•				
			•				
	Sign.		Name	Emp. No.	Date		Time
Transferring Nurse	9	**	A. ALBINUS	0088	30/1	2/23	1040
Receiving Nurse		gre-	A. ALBINUS	2~08	30)	12123	lo:15



63/Malc/MHI202381271

27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ





FAMILY COUNSELLING FORM

CONSU	LTANT- りょ	2. Anso	many DIAGNOSIS- CAD-TVD			
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
28.12.2	afaus Kla	Meonakshiv	Explained the family sugueding patient conclition, Icu rave and visitars poling	J	boera	() 2 3 () 2 3
09 112 jz,	PIN Paneemad	Mohash	Explained about the Patrul fruent Condition & would Shifting		QD	-F 1120-31

MHI/HOSP/2022/110



Patient Details (Affix Label here)	. (*	Heart
Name: Jeubata Cho:	ler	nstitute
DOB: 639 19 SEE: 0200261	Everu bear	t heat coun

WOUND ASSESSMENT CHART

DATE	2/1/23							
SITE OF WOUND					•			
CHEST								
LEG L/R								
ABDOMEN								
SACRAL REGION								
HEEL	1							ļ
OTHERS								
SIZE OF THE WOUND		l			_			
SUPERFICIAL / DEEP IN NATURE								
PRESSURE Specify system used :								
RISK FACTORS Specify system used :	DN)¿ HTN	Age	Obesity				
WOUND TISSUE TYPE(S) PRESENT								
necrotic								
slough								
undermining								
granulation								
overgranulation								
epithelialisation								
other	, 5							
SURROUNDING SKIN TISSUE TYPE(S)			_					
macerated								
erythema								
oedematous								
cellulitis blistered								
niistatad				🗆				ļ 🗆
	1		_	_,	⊢	l		i
bruising dry / scaling								

WOUND ASSESSMENT CHART

EXUDATE AMOUNT					1		
none			. ,🗆				
evidence of some moisture							
evidence of significant flow							
EXUDATE							
serous		□					
sero - sanguinous							
Purulent							
ODOUR				,			
none							
some evidence of odour							
significantly malodorous							
PAIN AT WOUND SITE							
(nil) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (max)						}	
INFECTION SUSPECTED*							
SWAB SENT							
ANTIBIOTIC THERAPHY	2/						
BLOOD GLUCOSE / URINE ANALYSIS							
PATIENT / CARER TO DO DRESSING							
SIGNATURE	John John						
*SIGNS & SYMPTOMS OF WOUND INFECT Pytexia excess a licalised pain erythema offensive	xudate	• gra	nulation tiss	ND INFECTI ue biceds e repithelium	asily •		inticipated



63/Malc/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ



buslam



Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 2 + 12/23	Time: \	<u></u>					
Checklist	Yes	No	NA	Α	ction / Remarks	•	
MEDICAL							
Daily Consultant Visit	✓						
Plan of care discussed				-			
Discharge Planning	X						
Others if any	1			<u> </u>			
NURSING							
Safety Precautions Ensured		2					
Care of Lines and Tubes		,					
Infection Control Measures							
Skin Care	V						
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			•				
		In	ter Dis	sciplinary Team Members			
	Signatur			Name	Reg. / Emp. No.	Date	Time
Doctor	Blog.	<u> </u>		Dr. Co Elarpo	179044	24/12/23	12.00
Nursing Staff	9	DOUT	-	Ba-Vani A	blar_	<u>चित्रिक</u>	13.00
Dietician	Or.	20th	<u> </u>	Sonior District	2401	20 JUL	حملظ
Physiotherapist Patient Care Service Staff	(2) / F.	Sus	<u> </u>	AKASH G.E	0256	28/12/23	19:00
Fatietit Care Service Staff						.}	





Every heart beat counts

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)

VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME:

AGE / SEX:

Mr.VENKATACHALAM P

63/Male/MHI202381271

27/12/2023/IPH2023002615

Dr.Anbarasu mohanraj

IP No. / UHID No

Ward/Bed No. 18t_Floor (104)

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

	<u> </u>		 _		1		S/N
DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	EMP No.
-1-					 		
27/12/pz		P °⊤₁	 				
	20.00	cubited	0 5	Jalent	Illusha	followol.	- The second
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	}						
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	L					<u></u>	<u> </u>







Every heart beat counts

VIP SCALE (VISUAL INFUSION PHLEBITIS)

Mr.VENKATACHALAM P PATIENT NAME:

63/Male/MHI202381271

27/12/2023/IPH2023002615

IP No. / UHID No

AGE / SEX:

Dr.ANBARASU MOHANRAJ

Ward / Bed No. (0)

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
28.15.F	<u> </u>	RIGHT CUBITAL DOCUMENTAL	_	IV LING PATENT &	JUSHER DN FROM		pytora
09/12/23	21:00 8:00 13:00	PILIT META PILIT Metanya	05	HEALTHY INE PATENT LINE PATENT	FWHED FWHO	ON DECERNATION NO SIUMS OF PHIEBID NO SIUM OF PHIEBIA	Lowlon-
	19.00 8.00	A GINT METACARA RT METACARA METACARA	0/5		FLUSHO	No signs	Si Mari Siste Sty
30/12/23	\$000	Retago	965	24 Drugod	flushed Duglied	-	Port
	DO.60	Rt noticent	015	En lingue En line good	flushed Flished		So/k/
गुरावम	8.50 Jh	notacoppl per	0/5	Putert putent	flushed flushed		Post n
	Do. 93	Retur	013	Patent,	Phylop Sleslo		Do # 1
2/1/23				Ty Qàno [emmed		-
							· ·





63/Malc/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ



MHI/PHARM/2022/028



Every heart beat counts

MEDICATION ADMINISTRATION RECORD

į								•	-					Į.
Drug	Chart:	: <u>)</u>)	of				Heig	ht (cms):	168 km	Weigh	t (kg): <u>6</u>	<u>kg</u>	
		KN	IOWN	MEDI	CINE A	LLERGIE	S (if NO	ONE is c	onfirmed,	, write NKDA ii	n box 1)		_	
Drug De	etails					Descri	ption of A	Allergy			Doct	or's Sign:	64.	L
_							•	0,				sh Ela	706	
											Nam	10.	1 1	ĺ
						ĺ								ĺ
			_	Mici)A -	}		_			Reg	No. 179	ous	1
						<u> </u>	_	·			lieg.	110. / /	- (- 1	
	ОСТО	R INST	RUCT	IONS				NU	RSING S	TAFF INSTRU	CTIONS			
1. Use ge	eneric na	me when	prescrib	oing drug	3			•	tion to avoid					
		neric name when prescribing drug BLOCK LETTERS, clearly and legibly d enter MCI registration no. or apply seal 1. Clear entires in every section to avoid offissions 2. Nurse in-charge should verify drug chart on daily basis 3. For new prescription, follow the timings of doctor's pre follow standard timings										Day 1 only, and	d then	
3. Sign at 4. No pre		_							: 10:00hrs. Q	12hrly: 10:00hrs, 22	2:00hrs or 0	18:00brs 18:00b	ırs	
5. Use 24	-				rinteri	Q8hrly	: 06:00hrs,	14:00hrs, 2	22:00hrs or 0	9:00hrs, 14:00hrs, 2	1:00hrs, Q	6hrly: 05:00hrs,		
										00hrs, 06:00hrs, 10:	00N/S, 14:0	Junts, 18:00nrs,	22:00nrs	ĺ
					Stat / (Once O	nly / P	remea	ication	Drugs				
Date	Time			Drug			Dose	Route	1	Doctor		Administere	d	
Date	711110			_				Houte	Sign.	Reg. No.	Sign.	Emp. No.	Time	
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Clinical Pharmacist Medway Heart Institute

Q Clinical Pharmacist Medway Heart Institute

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NURSE IDENTIFICATION RECORD

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

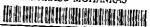
Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning	•				Morning			
27/10/1	Evening	A. Nardhini	0170	A		Evening			
28/2/2	Night ∃	A. Nandhini	0170			Night			
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63/Malc/MHI202381271 27/12/2023/IPH2023002615

Dr.Anbarasu mohanraj



MHI/PHARM/2022/028



Every heart beat counts

MEDICATION ADMINISTRATION RECORD

Orug Chart:		O!	D L	Height (cms): 102 Cms ERGIES (if NONE is confirmed, write NKD)	Weight (kg): 6 Kg
Drug Details	k.DA			Description of Allergy	Name: DA. PRAVEFIL Jeyakuman Reg. No. 111136

DOCTOR INSTRUCTIONS

- 1. Use generic name when prescribing drug
- 2. Write in BLOCK LETTERS, clearly and legibly
- 3. Sign and enter MCI registration no. or apply seal
- 4. No prescription should be altered / overwritten
- 5. Use 24-hour format when writing time

NURSING STAFF INSTRUCTIONS

- 1. Check entries in every section to avoid omissions
- 2. Nurse in-charge should verify drug chart on daily basis
- For new prescription, follow the timings of doctor's prescription on Day 1 only, and then follow standard timings
- Standard Timings: Q24hrly: 10:00hrs, Q12hrly: 10:00hrs, 22:00hrs or 06:00hrs, 18:00hrs, Q8hrly: 06:00hrs, 14:00hrs, 22:00hrs or 09:00hrs, 14:00hrs, 21:00hrs, Q6:nrly: 05:00hrs, 11:00hrs, 17:00hrs, 23:00hrs, Q4hrly: 02:00hrs, 06:00hrs, 10:00hrs, 14:00hrs, 18:00hrs, 22:00hrs

Stat / Once Only / Premedication Drugs

Date	7"	Plane	Dans	Route	Į.	Doctor	1	Administered	3	·
Date	Time	Drug	Dose	Houte	Sign.	Reg. No.	Sign.	Emp. No.	Time	
28.12.13	18-45	PALL GORALD MULTOS - ELAP	sonl	£√_	S	112236	by	ひしろし	१ ५ -५९	randowa
16.17.17	1840	14- PROTAMILE	5500	ΣV	. 4	42236	1	OLSL	18-5-3	
-21bb2	20:50	INJ. FENTANYL	50 Mics	VZ	8	112236	1	0265	ঽ७: <i>⊙</i>	8001.
28/12/38	23:4C	T. Ecospirin	15mil	RT	c/	112236	J.	D265	D3:40	
<u>विशिष्ट</u>	<u>চ.১১</u> ১	ENT METAPROLL	3mg	بتن	8	112286	Open	0171	8,55	2003.
	}	TAB. METOPPHOL	50mg	Plo	8	112236.	-Ra	0171	9.30	
29/2/23	•	•	ioma	ID	<u>&</u>	112-236	Rom	0171	9.36	2003
8111212	31673	o Ing. EMESET	HMM	' [· 1000	134779.	CDV-	6/41	13:13	
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	REGUL	AR PRESCRIP	TIONS I	Date →	To be	filled b	y Nurs	ing Sta	ff only.	Sign ar	nd time	ġiven
		filled in by Doctor		Time ¥	28/12	21/12	3/4	3/1/2	111	2/1/24	1	
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nical F Iway H	Dr. Sign & Reg. N	lo. / Seal	Start Date & Time					1				
5₹	Dr. PRAVEEN		22/2/23 of 21:00									
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rmaci I Institu	10m.	Plo	1-1-1	13:30		Je	Oab	No.	90%			
O Clinical Pharmacist Medway Heart Institute	Dr. Sign & Reg. N		Start,Date & Time		18/20	19,30	1920	77.00	10-100			
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Ø	ç Reg. No:1		Stop Date & Time			465	, yv-		1969			
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١.	Dr. PRAVEEN J		28 12/23 0 22:00	16:00	~~~	AN	8%	L OKOWA	€06.			
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. 4	Dr. PRAVEEN	JEYAKUMAR .	29 12 23 AT 10.00 Stap Date & Time	10.00			₩ %	200				
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-Clinical Pharmacist Medway Head Institute	Dr. Sign & Reg. N		Start Date & Time	1712	L	17.00	40	20-TL	لِ ا		7	
inical dway	Dr. PRAVEEN	JEYAKUMAR	Stop Date & Time	., ,		200	B	SA	V			
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	Area in charge			,	0/	2	₩.	1 / ×	gh Jh	5,4	X	
Ī	Nurse Signature	9:			\w\>	- لانور	2002	484	50,	504		

To be filled by Nursing Staff only, Sign and time given Date -REGULAR PRESCRIPTIONS To be filled in by Doctors only Time v ap 8.00 490 **DRUG NAME** 8:00 Paul 8.09 Da TAB. REPLEX FORTE Clinical Pharmacist Medway Heart Institute Route Frequency Dose 1tab Plo 100 Start Date & Time Dr. Sign & Reg. No. / Seal gradional is the 20/12/23 AT Dr. PRAVEEN JEYAKUMAR 1 Stop Date & Time Ren. No:112236 Additional Info: DRUG NAME TOB. CLODIPOUR BL ASPIRIN Dose Route Frequency למו: או 45/15ma plo 0-1-0 Dr. Sign & Reg. No. / Seal Start Date & Time 29/12/23 AT 14.00 7,747 Or. PRAVEEN JEYAKUMAR Stop Date & Time Reg. No:112236 Additional Info: **DRUG NAME** TAB - AMORVASTATIN Route Dose Frequency 0 -0 -1. HOMO elo Start Date & Time Dr. Sign & Reg. No. / Seal 09/12/23 AT 21:00 21700 TART IL 19. Dr. PRAVILIS LEAKUMAG Stop Date & Time Reg No: 112236 29/12/23 AT 80. Additional Info: **DRUG NAME** Q.O 800 9.0 8:00 TAR. PARACETAMOL GCLinical Pharmat... Medway Heart Institute Route Dose Frequency 14:00 1-1-1 <u>Lxoma</u> Dr. Sign & Reg. No. / Seal Start Date & Time Un. PRAVEEN JEYAKUMAI 29/12/23 '47 14:00 20:00 Stop Date & Time Reg. No:112230 $\cdot d$ Additional Info: **DRUG NAME** SUP CREMARFIN PLUS Dose Route Frequency Clinical Pharmacist Medway Heart Institute 0-0-1 15ml Start Date & Time Dr. Sign & Reg. No. / Seal 21:00 29/12/23 AT 200 S Dr. PRAVEEN JEY? Stop Date & Time Reg. No. 1 Ø Additional Info: W) Area In-charge V Nurse Signature: 60%

		LAR PRESCRIP		Date →		filled b	y Nursi	ng Sta	ff only.	Sign a	nd ti	viven
	To be	filled in by Doctor	s only 🔻 💮	Time ↓	00/12	200	3) [[?]	clip	3/1/5	4		
	DRUG NAME	VASTATIN						;				
Clinical Pharmacist Medway Heart Institute	Dose 40mg	Route Po	Frequency		, ,							
© Clinical Medway	Dr. Sign & Reg. No:		Start Date & Time 29/12/23 21-00 Stop Date & Time	21:00		d'e	(Pro					,
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Clinical Pharmacist Medway Heart Institute	Dr. Sign & Reg. N		Start Date & Time 29/12/13, at 9.00.	17.00	17.00 Part	8/84 (1/30)	1100	Y*\ 6 K\		ک		
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Dose 25 mg Dr. Sign & F	eg. No. / Seal	Start Date & Time 1) 1/24 9.06									
Additional la	nfo:	Stop Date & Time	-								
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Dose	Route Po	Frequency b -1-0	14.00	>	14.0			122	 		
Dr. Sign 8. F	eg. No. / Seal	Start Date & Time	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		100			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\			
Additional l	nfo:	Stop Date of Hills									
Area In-cha Nurse Sign			1	20/2 V 1/2	84	19/2	 				

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To be filled by Nursing Staff only. Sign and time given Date -> **ANTIMICROBIALS** To be filled in by Doctors only Time ↓ **DRUG NAME** 5:20 TMI CEFURDXITAL SODIUM Route Dose Frequency Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR **14.**∞ 17:20 Port. 33 at 13'.20 Reg. No:112236 Stop Date & Time 29/12/21 at 18.20. Additional Info: DRUG NAME Dose Route Frequency Dr. Sign & Reg. No. / Seal Start Date & Time 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 Dose Frequency Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: **DRUG NAME** Route Dose Frequency Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: Area In-charge W ಎಹ್ಮಿ Nurse Signature:

Clinical Pharmacist

		Intravenous		Rate /		Additive Drug			Do	ctor	Adn	ninistratio	n
Date	Time	Fluid	Volume	Duration	Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sigr
28-12	19-00	KABILYTG	500N	100ml/h	IV		_	ĺ	۶	112216	19-00	21:30	2
28/2/23	21 30	KABILYTE	500 j	100m/ har	ŢY	-			<u>s</u> _	112236	21:30	240	1
24/12/23	21.30	KABILYTE	500m)	100ml/hr	1v	, 		1	8	112236	\$ 30	7:30	1
29/12/2	33;00	KABILUTE.	500	100m2/xte	IN	-	_	(8	112236	23;00	02;40	ses Ses
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			ARENTI	ERAL INFU	ISION F	PRESCRIPTION AND ADMI	NISTR/	ATION	RECO	RD		<u></u>	· -
Date	Time	Intravenous	Volume	Rate /		Additive Drug			⊦	ctor		ninistrătio	
		Fluid		Duration	Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.
19-4L-L	18-30	21x x9-0	40ml	anlm	IV	Aly. Human ACTAMIN	AOIU		۶	112236	18.30	3.26	47
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34-17-5	18-07	0-94-43	rom	emilh	IV	July- POTABLUM QHLORIDI-	4 My		,c-	112236	1 8.45	20.45	4
29/12/23	b.30.	N3 0191	5cmj	25ml/hy	Tu	Ily POTASSIUM CHIORIDE	Somey		Ç	112231	6.30	8:30	Dout
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DIET ORDERS	(to be pr	escribed by	Dectors only)
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Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
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29/1423	9.0p	Lauro DIET	P	112246,			7		
29/10/2>	20:00	SOFT DET	8	112236					
30112123		soft diele	k.80	134555					
3/12/2	810	soft diel-	k.B	13422)				
11.24	ه؛ س	Normal diel-	4.80	134559					

NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. №o.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning				11/24	Worning	Pavi thea	00f2	Pak
27-12-23	Evening	SURYAKAW. S.P	0231	<u> </u>	1/1/24	Evening	M. Deet on	Oh	0-
عدا در ا	Night	Sathing laning	02-65	نكل	1/2/	Night	d-Nardhini	ara	A
29/4/23	Morning	D. Paverna	0174.		2/1/2-	Morning	10. Lidure	02494	192
29-12-1	Evening	RAVERIA / SURYALACA	0132/01	1 0	2(123	Evening	Parque Sursa	2733	N.
29/12/28	Night	SUGANYA-G MECMA	022 0276	Solle	ļ 	Night			
39122	Morning	D. RANEEVA	0171	Jy: .	, ,	Morning			
30/12/	Evening	M. Daile	062	8)	<u></u>	Evening			
20/12/12	Night	PIN Bharatt	0271	02		Night			
31/6/2		U-Duik	019	0_	l	Morning			3
	Evening					Evening			
31112/2	Night	REN Bhareafthi	0271			Night			

Opero x 4 CLRAFTS

LIMA -> LAD

SUCI - POA

[LB (fooguentfool)] Mr.VENKATACHALAM P MHI/ICU/2022/076 63/Malc/MHI202381271 27/12/2023/IPH2023002615 Name Sheet No. Dr.Anbarasu mohanraj Medway Hospitals® UHID No. Sex The way to better health Blood Group Weight BSA (A Unit of United Alliance Healthcare Pvt Ltd) Every heart beat counts auto Lan DATE OF SURGERY POST-OP DAY: SURGICAL PROCEDURE:

SURG	ICAL PR	CEDO	IKE:				_	DAI	IE OF SI	URGERY	<u>.</u> 98	12 0/2	,	PC	72 I-OP L		<u>り</u> り	
	7045					VENTIL	ATORS P	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
38/12/2	18.30	VLV	IA		21.0	B,0	9.0	7.1	600	495	60%		4.A3A	30'\	266-A	19.*	99.6	4.6
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									,									

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

Si-Sluggish

O-Absent

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)

•	
2	3 4
5	6
7	8

PUPILS REACTION

Br-Brisk SI-Sluggish O-Absent

CARDIOVASCULAR

D-Dependent

G-Generalised

EDEMA

•
HEART SOUNDS
S1 S2
M-Murmur
Rb-Rub
G-Gallop
SM-Sound muffled

NECK VEINS

O-Absent

JVP N-Normal In-Increased

VALVE CLICK/ SHUNT NUMBER

Valve Replaced / Shunt +Present O-Absent

PULMONARY

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

BREATH SOUNDS	
CL-Clear	(
Ro-Ronchi	1
Wh-Wheezes	•
CR-Crackles	,
BECL-Bilat	
equal & clear	•

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

GASTROINTESTINAL

BOWEL	SOUNDS
+Present	

+Present O-Absent

Air injected +Heard in Abd O-Absent GA-Gastric cont

NGT POSITION

GA-Gastric contents aspirated Dr-Dependent Drainage

ABDOMINAL TONE

So-Soft F-Firm Tn-Tender Ob-Obese D-Distented

LIVERSIZE

N-Normal E-Enlarged

GASTRIC RESIDUAL

G-Green B-Bleeding Y-Yellow C-Coffee ground

SMA -> LAD 8M4 -> LAD PLB (Leguentical) om **N**edway Medway Hospitals

The way to better health
(Aunit of United Alliance Market (A Unit of United Aillance Healthcare Pvt Ltd) Every heart beat counts

Mr.VENKATACHALAM P		М	HI/ICU/2022/076
63/Male/MHI202381271 Name 27/12/2023/IPH2023002615	,		Sheet No.
UHID No.	Age	Sex	2_
Blood Group	Weight	BSA L'AAM	Α

	SURG	SICAL PR	ROCEDU	IRE:					DA	TE OF S	URGERY	: 30 li	2/23		PC	OST-OP I	DAY: S	/		_
							VENTIL	ATORS P	ARAMET	ERS		ixo t	2100	BLOOD GAS]
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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

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)

•	•	
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 Rb-Rub G-Gallop SM-Sound muffled

EDEMA

D-Dependent G-Generalised O-Absent

NECK VEINS

JVP N-Normal In-Increased

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equal & clear

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SUCTION

N-Nasal

Or-Oral

ET-Endotracheal

CHARACTER

GASTRIC RESIDUAL

G-Green B-Bleeding Y-Yellow C-Coffee ground OpenBX & GRAFTS

LIMB -> LAD

SVG = PDB (segren Head)

Om

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Mr.VENKATACHALAM P	МН	I/ICU/2022/076
63/Male/MHI202381271 Name 27/12/2023/IPH2023002615		Sheet No.
UHID No.	Age Sex	S
Blood Group Of VE 1686	Weight BSA	Α

SUBGICAL BROCEDURE

DATE OF SUBCEDV

9-1-1-0

POOT OF PAY

SURG	ICAL PR	OCEDU	RE:					DAT	re of si	URGER\	r: 👌	3/12/0	<u>3</u>	PC	OST-ÕP I	DAY: `	<u> </u>		_
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NEURO

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

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NGT POSITION

Air injected

+Heard in Abd

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63/Male/MHI202381271

Sheet No.	Ivallie	7/12/2023/1PH2023002 T.ANBARASU MOHANR	i		
1		I HA IPULIA BIA DA WALIJUJUHA (INI		Age Sex Weight BSA	Sex
В	Blood Group	Otre	Height	_	1 ''
_				7.70	





MHI/ICU/2022/076



				ВІОСНЕ	EMISTRY					VITA	L PARA	METER	S			CARDIA	AC ASSIST	DEVICE	
DATE	TIME	Hb	Na	к	Ca SUGAR	BLOOD	TIME	ETCO,	BREATH SOUNDS		RR/MT		TEMP°F	AbdenG	TIME	IABP		PACEMAKE	R SETTING
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PATIENT FULLY AWAKE: 20:10

	SHIFT	EVE	NING	NIC	SHT	
	TIME		18.30	50:00	00:00	
	EYES		1	2	14	
NEURO	VERBAL		ET	Er	EF	
Ä	MOTOR		CP	CP	6	
	ARMS R/L		CP	CÞ	Ç î	_
	LEGS R/L		CP	CP	St	
PUPILS	R.SIZE/REACTIION		cg'	& Prog	3/20	
PU	L.SIZE/REACTION		CP.	3/120	3/3	
A A	HEART SOUNDS		5152	S152	6,52	
CUL	VALVE CLICK		_			
CARDIO-VASCULAR	CAPILLARY REFILL		By	Br	30	
RDIC	EDEMA		10	D	0	
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IARY	WORK OF BREATHING		GD	70	74	
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STIN	ABDOMINAL TONE		_ د	Seft	Siff	
INTE	N/G POSITION		INSTIC	Insilie	Tuester	
GASTRO INTESTINAL	GASTRIC RESIDUAL			cf	S	
GA.	LIVER		N	N	7	

	SHIFT	DAY	EVE	NING	NIC	∃HT
	DESCRIP.OF URINE		cl	<u>(</u>)	c)	
G.U.	PD - FUNCTION		_	,	,	
	DRAINAGE		-			
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SKN	DRESSING		6	o's	οT	
	PRESSURE SORE-SITE		Nil	MIL	NiC	
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MIS	ACTIVITY		1 cg	PP	PE 13	-
			ABO	ARP Col	1-87	
	S/N NAME		Savi)	Satis	Salya	
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	SIGNATURE		SAN!		1	*
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63/Male/MHI202381271

Sheet No.	Name	27/12/2023/IPH2023002615		_		
Sheet No.	UHID No	Dr.Anbarasu mohanraj			ge	Sex
В	Blood Gro	O+VE	1 -	·	Weight	BSA I hhm





MHI/ICU/2022/076



					BIOCHI	EMISTRY					VITA	L PARAI	METER:	3			CARDI	AC ASSIST		
	DATE	TIME	7.1.	N-	16	Ca	DI OOD	TIME		BREATH				TEMP°F	A L →Cm ←	TIRAL	IABP			R SETTING
			Hb	Na	К	Ca SUGAR	BLOOD	TIME	ETCO ₂	BREATH SOUNDS	Sao₂	RR/MT	N ₁ BP	TENFF	ADO G	TIME	RATIO	DURATION	RATE	MODE
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	SHIFT	DAY	EVENING	NIGHT
	TIME			4100
	EYES			4
NEURO	VERBAL			et
NEI	MOTOR			L
	ARMS R/L			St
	LEGS R/L			Sf
PUPILS	R.SIZE/REACTIION			3/8
PUF	L.SIZE/REACTION			2/30
AR.	HEART SOUNDS			9,52
CUL	VALVE CLICK			
CARDIO-VASCULAR	CAPILLARY REFILL	_	_	130
RDIC	EDEMA			D
ď	NECK VEINS			N
ARY	WORK OF BREATHING			FA
PULMONARY	SUCTION			ET CON
PUL	SECREATIONS			ruld
AL	BOWEL SOUNDS			7
STIN	ABDOMINAL TONE			Sigf
INTE	N/G POSITION_			Insite
GASTRO INTESTINAL	GASTRIC RESIDUAL			d
GAS	LIVER			7

·	SHIFT	D	AY	EVE	NING	NIC	GHT
	DESCRIP.OF URINE						
G.U.	PD - FUNCTION						,
	DRAINAGE						
	PD - SITE						
	COLOUR						
	Sx WOUND-CHEST			•			c)
	LEG						4
SKN	DRESSING						от
	PRESSURE SORE-SITE						Mil
	AREA						
	DRESSING CONDITION						,
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MISCELL	CHEST-PHYSIO						Neb Culi
MIS	ACTIVITY						PE
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	S/N NAME						Sating
	TIME						4,00
	SIGNATURE						

			/MHI2023812					
Sheet No.	Name		023/12H20230					
9	UHID No		RASU MOHAN		Α	ge	Sex	
В	Blood Gro	oup	AT VE	Height	M	Weight	BSA	 GMG







				ВІОСН	EMISTRY					VITA	L PARAI	METER	3			CARDI	AC ASSIST	DEVICE	
DATE	TIME	Hb	Na	к	Ca SUGAR	BLOOD	TIME	ETCO,	BREATH SOUNDS	Sao ₂	RR/MT	NRD	TEMP⁰F	Ahd™G	TIME	IABP	,		R SETTING
		110	I Va	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	SUGAR	BLOOD	I HVIL	L100 ₂	SOUNDS	3402		INIDE	I CIVIF F	ADG G	I IIVIE	RATIO	DURATION	RATE	MODE
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	SHIFT	D	AY	EVE	NING	NIC	GHT
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0	EYES	4	7	4			
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2	MOTOR	Ь	Ь	Ь			
	ARMS R/L	ST	27	ST			
	LEGS R/L	ST	ST	31			
PUPILS	R.SIZE/REACTIION	3 BR	3 Br	3 Br			
PU	L.SIZE/REACTION	3)BR	3Br	3 B₹			
AR	HEART SOUNDS	2122	2120	3132			
CUL	VALVE CLICK		-				
CARDIO-VASCULAR	CAPILLARY REFILL	BR	BR	BR			
RDIC	EDEMA	0	٥	0			
	NECK VEINS	N	8	7			
IARY	WORK OF BREATHING	TA	T4	T4			
PULMONARY	SUCTION	4	-				
<u>P</u>	SECREATIONS	V	-				
F	BOWEL SOUNDS	+	+	+			
STIN	ABDOMINAL TONE	29 1	Sqt	Soft			
INTE	N/G POSITION_	1112170					
GASTRO INTESTINAL	GASTRIC RESIDUAL		•	_			
GA	LIVER	N	N	N			

	SHIFT	D,	AY	EVE	NING	NIC	3HT
	DESCRIP.OF URINE	U	J	ئل	_		
G.U.	PD - FUNCTION	_	-	ļ		,	
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	Mr.VENKATACHALAM P 63/Malc/MHi202381271		M	HI/ICU/2022/076
Name	27/12/2023/IPH2023002615	,	-	Sheet No.
UHID No.	Dr.Anbarasu mohanraj	Age	Sex	ì
Blood Grou		Weight	BSA I 660	e C
		7	- + 9	

		UR	INE		CH	IEST DI	RAINAG	E		GAS	TRIC	LAB S	AMPLE		VOLU	ME		USIONS	5		1
DATE	TIME	AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT		1361	NORAD A 150	NIG NENE	ACJRA ADAO	_	
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SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

ACI: 164 Gle at 18.50

GENITOURINARY (GU)

Gi	-IAITOONIIVANT (GU	')		O. C.	
	PD		COLOUR Pk-Pink	SURGICAL (SX) WOUND C-Clean	DRESSING B-Betadine
URINE	FUNCTION	DRAINAGE	F-Flushed P-Pale	Oz-Oozing G-Gaping	Al-Antibiotic Irrigation
CL-Clear T-Turbid Stained	Dr-Draining B-Blocked	CL-Clear BS-Blood	Cy-Cyanotic M-Mottled D-Dusky	Op-Open I-Infected	ingation
HC-High Coloured	SITE		J-Jaundice		
BS-Blood Stained HA-Haematuria	C-Clean R-Redness			PRESSURE SORE	
1174-1 lacinatana	BD-Block discolor	ation	SITE	AREA	DRESSING / Rx
	MISCELLANEOUS		S-Sacrum Sc-Scapular Oc-Occiput	R-Redness BD-Black discoloration BL-Blister	IR-Infra Red DU-Dueodem E Entoin drosping
OISITION CHANGE	CHEST	PHYSIO	Oc-Occiput	SP-Skin Peeling	E-Eptoin dressing B-Betadine dressing
Su-Supine RL-Right lateral LL-Left Lateral		est percussion ep breath & cough		D-Deep	EU-Eusol sitz bath ST-Sofra Tulle
ACTIVITY			CONDITION		
PE-Passive exercise Am-Ambulated	PARAN ABP-A	terial BP	H-Healing SCo-Status quo S-Sloughing		
	PAP-Pt	ight Arterial Pressure ulmonary Arterial Pressure	LINES / TUBES	CONDITION	
•	LAP-L€	ft Arterial Pressure	O-No redness, s R-Redness at sit Sw-Swelling at s Dr-Draining D/c-Discontinued P-Positional HL-Heparin Lock B-Blocked	d .	

SKIN

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





l 6	Nr.VENKATACHALAM P 3/Malc/MHI202381271				MHI/ICU/2022/076
Name 2	7/12/2023/19H2023002615	ī		_	Sheet No.
UHID No.	F.ANBARASU MOHANRAJ	 	Age	Sex	2
Blood Group	OtVE	Height (68 CM	Weight 611/19	BSA I bbn	С
	_		()		

		UR	INE		CH	EST DI	RAINAG	Έ		GAS	TRIC	LAB S	AMPLE		VOL	OMÉ	INFU	SIONS		
DATE	TIME	АМТ	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT	AMI	(b)				
29/12/23	4!30	100	960			10		10	230				5.0	1190	<i>G</i> G 1	: 3æ				
_	S:30	90	0203			50		50	280			15.0		1340		1400] [
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SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

GEN	ITOURINARY (GU)		SKIN							
	PD		COLOUR	SURGICAL (SX) WOUND						
URINE	FUNCTION	DRAINAGE	Pk-Pink F-Flushed P-Pale	C-Clean Oz-Oozing G-Gaping	B-Betadine Al-Antibiotic Irrigation					
CL-Clear T-Turbid	Dr-Draining B-Blocked	CL-Clear BS-Blood	Cy-Cyanotic M-Mottled	Op-Open I-Infected	iriigation					
Stained HC-High Coloured	SITE		D-Dusky J-Jaundice							
BS-Blood Stained HA-Haematuria	C-Clean R-Redness BD-Block discoloration		SITE	PRESSURE SORE AREA	DRESSING / Rx					
MI	SCELLANEOUS		S-Sacrum Sc-Scapular	R-Redness BD-Black discoloration	IR-Infra Red DU-Dueodem					
OISITION CHANGE Su-Supine RL-Right lateral LL-Left Lateral ACTIVITY PE-Passive exercise Am-Ambulated	N-Nebulizer TRANSDUC PARAMETE ABP-Arterial RAP-Right A PAP-Pulmor	ercussion eath & cough CER ZERO	CONDITION H-Healing SCo-Status quo S-Sloughing LINES / TUBES O-No redness, sw R-Redness at site Sw-Swelling at sit Dr-Draining D/c-Discontinued P-Positional HL-Heparin Lock B-Blocked	velling, no leak, no air	E-Eptoin dressing B-Betadine dressing EU-Eusol sitz bath ST-Sofra Tulle					







Mr	VENKATACHALAM P			N	IHI/ICU/2022/076
Name 27/	Male/MHI202381271 12/2023/IPH2023002615				Sheet No.
Dr.	Anbarasu mohanraj		Age	Sex	ン
Blood Group	11.45	-: 'CM	Weight	BSA 2 1.66M	С
					-

		UR	INE	<u>_</u>	Cl	IEST DI	RAINAG	E		GAS	TRIC	LAB S	AMPLE		Volu	иЕ	INF	JSIONS]
DATE	TIME	AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT	AMI	901	KJ M5n			
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	11.30	90	<u>430</u>						PD				1.0	4190		<u> 300</u>				┨•
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	13-30	180	660			lo		w	llo				6-7	740		300				
	1430	150	810			ನಿಂ		20	130				10	810		300				:
	15,30	150	960			10		10	(HD				ho	1050	 	<u> 300</u>			 	
	16.30	150	140			R			140				3-0	taon		300_				

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME
Oglops	14.30 - LEFT RADIAL ARTERIAL WHE RETICUED OB DR. AMBARAI.
	16.30 - IET PIEURI + MEDIASTINAL PETINED OLB DI. ANBAUS.

GENITOUR	INARY	(GU)
OFMICON	71142121 1	(00)

ABP-Arterial BP

RAP-Right Arterial Pressure PAP-Pulmonary Arterial Pressure LAP-Left Arterial Pressure

	•	EMITOOMAKI (GG)				
		PD		COLOUR	SURGICAL (SX) WOUND	
	URINE	FUNCTION	DRAINAGE	Pk-Pink F-Flushed	C-Clean Oz-Oozing	B-Betadine Al-Antibiotic
	CL-Clear T-Turbid	Dr-Draining B-Blocked	CL-Clear BS-Blood	P-Pale Cy-Cyanotic M-Mottled	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	on	SITE	PRESSURE SORE	DRESSING / Rx
		MISCELLANEOUS		S-Sacrum Sc-Scapular	R-Redness BD-Black discoloration	IR-Infra Red DU-Dueodem
	OISITION CHANGE	CHEST P	HYSIO	Oc-Occiput	BL-Blister SP-Skin Peeling	E-Eptoin dressing B-Betadine dressing
Su-Supine RL-Right lateral LL-Left Lateral		DC-Deep	percussion breath & cough		D-Deep	EU-Eusol sitz bath ST-Sofra Tulle
	ACTIVITY	N-Nebuliz	er	CONDITION		
	PE-Passive exercise	TRANSDU	JCER ZERO	H-Healing		
	Am-Ambulated	PARAMET ABP-Arter		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

SKIN

Mr.VENKATACHALAM P 63/Malc/MHi202381271

3:20

	/Malc/MHI202381271 /12/2023/IPH2023002615	-			5	Sheet No.	
Dr.	Anbarasu mohanraj	. A	ge	Sex	٠,		
Blood Group	AVE		Weight	BSA 1. C.A.	2_	D	



By 10 0.00

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MHI/ICU/2022/076



Every heart beat counts

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	FI	LUID ASSESSME	NT (contd.)		•		HAE	MODYNA	MICS						Blo	od Gr	oup:	04	VE		_
		INFUSIONS	(contd.)			/ORAL	TOTAL	TOTAL	1117/4	DVTUVA		455			LAP/	DE01	PP	-00		O) (D)	
DATE	TIME		40%	TOTAL	AMT.	TOTAL	INTAKE	BALANCE		RYTHYM	'	ABP	MAP	RAP	RAP	PERI	R/L	CO	CI	SVR	
3/13	18:30		20						13	SINUS	50.07	153	94	t]		(00	FF				
l* '	19.30		a.0	8.0			Sal	127		त्र इत्य	1	部	71	4		cost	1+				CRIT
	20:30		2.0	6.0			314	61	94	ぬるな	-	A PIT	95	B		cool	4-1				CRITICAL
	शःड०		20	22.0			569	64	66	31 NVB	5.03	104	61	3)		wain	++				CARE
	22:30		2.0	20	·		671	t96	-17	SIMB	6.03	99	53	3			++				
	\$ 3:30		20	9			873	218	20	Sacus		98	53	4	_	hen	1+	1			MO
2912 23	00.30		2.0	jo Ó			Ø75	190	Qy	દુરમામ	b.02	9 4.		4		Waen	++				FLOWCHART
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	2:30		20	6.0	_		1183	218	97	SUR	6.0)	136	78	4)		warm	14				
				-				+ `			+		- ` -				_		+		

STAT DRUGS	PR	EVIOUS DAY	HRS
TIME	LATER STATE ALLER STATE STATE STATE OF THE S	AINAGE:	TOTAL INTAKE:
18-50	INT. SOMUM BICARYSOMATE JOM! IN STAT OF UR	PA. PAA VEELT !	TØTAL OUTPUT:
18-57	Mir. that		/ TOTAL BALANCE
-,-	TOTAL FORMER THE CTAT GUICAL RID DR. EVENE	TEP	O IAL DALANOL

1289

23:40 T. ECOSPIEN TSMY RT STOT GIVEN BLO DR. PRAVEEN

2.0

6.0

P.T.O.

	DAY	EVENING	NIGHT
PATIENT CARE			
ВАТН			
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		_	_
B.P.			

DATE	TIME	REMARKS / PLAN
		•
		,

4T	INFUSION PUMPS						
\neg	LINES/TUBES SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
	ET TUR- 8.6	28/12/23	1			P	P
	TTV PTV	28/12/13	1			P	P
	ART-LING DAD	28/12/23	1			P	P
	peri-Liale RT	18/12/23	1		ļ. <u> </u>	P	P
	MEDIATUALA 3M	1 1		_		P	P
	PLOURAL LT	N8/12/23	1			P	P
	TR Dome	28/12/23	ı			P	P
	IVEXIL	N8/12/23	1			P	₽
	O, Tubaly	08/12/23	1			P	P
	8.700144	NS 12 23	1			P	19
	V.708114	28/12/23	1			P	P
	U-CATH.	08 12 23	1			P	P
	MARQUET	28/12/23	ļ.,			P	₽
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Mr.VENKATACHALAM P 63/Malc/MHi202381271 MHI/ICU/2022/076 27/12/2023/IPH2023002615 Name Sheet No. Dr.ANBARASU MOHANRAJ Medway Sex UHID No. Age Weight Medway Hospitals Blood Group BSA Institute 466 D The way to better health (A Unit of United Allianco Healthcare Pvt Ltd) Every heart beat counts FLUID ASSESSMENT (contd.) **Blood Group: HAEMODYNAMICS** INFUSIONS (contd.) N/G/ORAL TOTAL TOTAL LAP/ HR/mt RYTHYM **PERI** SVR DATE ST ABP MAP RAP CO CL TIME TOTAL INTAKE BALANCE RAP R/L AMT. TOTAL MISC 170 201 83 03: 4 2,0 200 PINIS 10.02 1391 unen 쌁 CRITICAL CARE FLOWCHART 5:30 153 BAW 0.01 BA 1493 ++ 2no 108 walm 20 6:30 175 +-Water 106 20 1595 BNIS 6.62 55 2.0 **STAT DRUGS** PREVIOUS DAY HRS TIME **TOTAL INTAKE:**

DRAINAGE:

URINE:

YTOTAL OUTPUT:

TOTAL BALANCE:

	DAY	EVENING	NIGHT
PATIENT CARE			
BATH			
ORAL CARE			<u></u>
EYE CARE			
BACK CARE			
DRESSING/EQUIPMENT			
CHANGED			
WOUND			
CEN.LINE			
I.V.SET	_		
TUBINGS			
HUMIDIFIER H2O			<u>~</u>
ELECTRODES			1
ALARMS VERIFIED			
VENT - HUMIDIFIER			<u></u>
-SETTINGS			
HRT.RATE			105/mt
B.P			614/52/2

DATE	TIME	REMARKS / PLAN
DATE	I IIVIE	REIVIARRS / PLAIN
		·
		<u></u>

INFUSION PU	MPS						
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
ET TUBE		22/12/03	2_				P
VĘI	127	22/12/23	2.				P
ART LINE	1	28/12/23	2				P
peri. Lide.	12:1	28/12/23	2			ļ <u>.</u>	P
MEDIASTELLASM		28/2/23	2				P
prenue		20/12/23	2				.p
TRADOME		2-8/12/23	2				P
SV CXIL		2-3 2-3	2_	-			þ
Q TUBIHY		28 12/23	2				þ
& TUBING		28/12/23	2				P
V. TUBILLY		22/2/23	2 2 2				6
U-CATU		28/2/23	2				þ
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L			<u> </u>		L		
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Name 27/12/202	AHI202381271 23/IPH2023002615	_			SI	heet No.
UHID No.	asu mohanraj	<u> </u>	ge	Sex		9
Blood Group	0705	Height	Weight 6 Ra	BSA (·BBm²	-	D





MHI/ICU/2022/076



Every heart beat counts

FLUID AS	SSESSMENT (contd.)	U	

				1423714		7	/							*******					cvery	nearc	^	LUDITE	
	F	LUID AS	SESSME	NT (con	ıtd.)	<i>'</i>			HAE	MODYNA	MICS	i					Blo	od Gr	oup:	070	. <u></u>		_
D.475			NFUSION	S (contd.	.)			ORAL	TOTAL	TOTAL	UD/m4	RYTHYM	2	400		245	LAP/	חבטי	PP			0).(D]
DATE	TIME				H152	TOTAL	AMT.	TOTAL	INTAKE		חוייות	KIINIM	ST	ABP	MAP	RAP	RAP	PERI	R/L	CO	CI	SVR	
عالتك	7:3n				2.0	27.0	}		la 7] HR. [107-	SIM	ō.cs	168/ 163	Ŧ	M		Wooth	++-				
	8.3n				એ .લ	27-0			1254	A A A	103	Sim	0:01	161/62	පිර	H		wann	H.,				CXI ICX
	9.30		_		ಹಿಗ	2.n	SyD,		35b	66	104	SINU	0.02	153) <i>(</i> 51)	87	Ч		MICH	4F.				֡֝֝֓֓֓֓֓֓֓֓֟֝֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֡֝֡֓֓֓֡֝֡֡֓֡֡֡֡֡֡֡֓֡֓֡֡֡֡֡֡
	10,30				ನಿರ	a.n	.50	50	108	8	87	SIM	 O₁Ø١	123/84	දිදි	do		lbotm	44				227
	11:30				2.0	ു.റ	100	150	510	# &n_	&)_	SI NU_		N6/67		lo		www	14.				
<u>-</u>	la en				<u> ১.০</u>	ని-ర	aon	3 <i>5</i> 0	<u> 412</u>	+- 132	78	SIM	0، در	विक्ष निर	જે પ	9		wam	#	,			֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֡֓֓֓֡֓
	13.30				2-0	2.0	200	220	914	174	82	sulu	0.01	125	₽6	12		woon	4				
	14.30				2.0	ã∙ <u>0</u>	200	750	1116	4.	1	SIM	00	122/61	88	16		whi	#.]2
	15.30				کرن	4.0		752	1118	68	કુ	SIN	૦લ	R	R	r		wan	41-				
	16.30.					-	100	852	1018	18		Sirm					,	ubm	H				

STAT DRUGS	Ī
TIME	
TIME	

DRAINAGE: 290 m TOTAL INTAKE:

URINE: 1120m

TOTAL BALANCE: 175m

	DAY	EVENING	NIGHT
PATIENT CARE			
BATH			
ORAL CARE	V		
EYE CARE			
BACK CARE		✓	
DRESSING/EQUIPMENT			
CHANGED			
WOUND		_	
CEN.LINE			
I.V.SET			
TUBINGS			
HUMIDIFIER H2O			
ELECTRODES			
ALARMS VERIFIED			
VENT - HUMIDIFIER			
-SETTINGS			
HRT.RATE	by/m+	110/mt	<u></u>
B.P.	160 Juin	160157-1899	

DATE	TIME	REMARKS / PLAN
		<i>(</i>
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INFUSION PU	MPS						
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
VEI	弘	28/12/23	2_		P	P	
ART. LINE	245	28/12/23	2		P	P	ļ
pert-LIVE	F	a8/12/23	2_		P	P	
MODIA STEALA		28/14/23	2		P	P	
PLEURAL	П	28/14/23	2		P	P_	-
TR DOMG		28/1423	2		P	P	
TV CXTH		29/12/23	2		P	P	
O, Worky		28142	-		P	}	
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		•		<u>-</u>			1
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63/Malc/MHI202381271 27/12/2023/IPH2023002615 RMEDIATE CARE FLOWCHART

NAME:

Dr.ANBARASU MOHANRAJ

UHID NO:

AGE:

SEX:

SURGICAL PROCEDURE: OPABX HURAFTS LITTLE-71AD

POSTOP DAY : POD - W

Sur=7 PDA. PUB ISEM CM

FLUID REQUIREMENT: 2.4 Whas day

I.V. FLUIDS ORAL/ R.T. **URINE CHEST DRAINAGE** DATE TOTAL TOTAL **TOTAL TOTAL** & TIME AIR OUTPUT G.T. H.T. H.T. H.T. G.T. H.T. G.T. **LEAK** 2012/23 σF 70 70 티미 7.30 十 千0 dan 8-30 150 150 50 150 dan + 9.30100 250 320 100 320 SPECIFIC OBSERVATIONS/REMARKS **MEDICATION / DRUGS**

المستويدة







Mr.VENKATACHALAM P

63/Malc/MHI202381271 27/12/2023/IPH2023002615

UHID NO:

RMEDIATE CARE FLOWCHART

AGE:

SEX:

NAME:

Dr.ANBARASU MOHANRAJ

SURGICAL PROCEDURE: ORAB X HUMPAFTS

LITTHA - TIAD

SVIII (PDA | LEA)

POSTOP DAY : POD-T

FLUID REQUIREMENT: AH Word John

									9.							
DATE	URINE		CHEST DRAINAGE		AGE	TOTAL	LV: FLUIDS H.T.			ORAL/ R.T.		TOTAL	TOTAL			
& TIME	H.T.	G.T.		AIR LEAK	н.т.	G.T.	OUTPUT	VRBIV			н.т.	н.т.	G.T.	INTEKE	BALANCE	
911212 17130	120	\230				1210	1320					100	952	1318	₹.	
18.3.	10n_	1330				1210	1420			_		200	1152	1518	+ 98	
<i>a,</i>	200	1530				140 1	(620					100	1252	1618	-2	
<i>VD</i> 3°	120	1550	,			140	1740					50	1252	1668	-72	
21,50	150	1800				140	6P81						1252	1668	723	
99 ⁷ 30	100	1900				140	1990					100	1352	1768	-222	
9:2:30	1	205				140	2140	190			100	100.	1452	1968	172	
50;30	100	2150	•			140	2240	100			g.00	100	1552	2168	72	
01:30	150	2300			<u>-</u>	140	2390	100			300	50	1602	2318	72	
02:30	150	2450	_			140	2540	100			400	ىي	1652	2468	72	
03:30	100	2550				140	2640	100			200	sv	1702	2618	22	
04,30	R.	253				140	2640	100.			60d.	দ্র	1752	2768	128	
0[;]0		2530			<u> </u>	140	2640	100			700	ಬ	1802	2918	t 27.8	
06/3 ₉		250				140	2640.				760		1802	2918	278	
											-					
										{			<u> </u>		_ <i>]</i>	
SPEC	SPECIFIC OBSERVATIONS/REMARKS							MEDICATION / DRUGS								







63/Malc/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ

NAME: WILLIAM WILLIAM TO THE TANK THE T

RMEDIATE CARE FLOWCHART

В

UHID NO:

AGE:

SEX:

BLOOD GROUP: O POSTIVE

HEIGHT: 16 sum

WEIGHT: 61KM

B.S.A: 1.66m2

	HAEMODYNAMICS RESP. PARAMETERS									rers	INVECTIOATIONS /
TEMP	H.R.	RHY.			R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	INVESTIGATIONS / OTHER DATA
97%	106	SINM	١٥٠٥	lay H	6 5	Mooth	14	৪৩	u_	984.	ON Room air
98°F	96	SIM	0.02	12.71 171	8-6	Wash	44	೩೮	J	96 J.	ON ROOM AIR
97.57	86	SING	8.03	132/ 146	87	WARM	++	22	CL	94%	ON ROOM AIR
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				<u>.</u> .				_			
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PREVIOUS DAY - HOURS

DRAINAGE ILYO ML .
URINE JSSO ML

TOTAL INTAKE 2918 ML

TOTAL OUTPUT 2640 mL.

BALANCE + 278 ML.







63/Malc/MHI202381271 27/12/2023/IPH2023002615

Dr.ANBARASU MOHANRAJ

NAME:

RMEDIATE CARE FLOWCHART

В

UHID NO:

AGE:

SEX:

BLOOD GROUP: O POSITIVE

HEIGHT: 168um

WEIGHT: 61 Kgs

B.S.A: 1.66m2

TEMP 7AF		RHY.	ST.	B.P.	D A D						
	<i>8</i> -8	<u> </u>			R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	INVESTIGATIONS / OTHER DATA
	ļ	SIM	Oics	127/	વા	Wash	44	ðà	Ц	984.	OH Room AD
1	76	Sliv	วิต 	1331	96	Woum	++	<u>೩</u> ೮	u	9 94.	
C	79	Sirul	-0,01	14	18	won	++	20	CL	991/	on Room Ais.
1	0/8	Sicons	lao	10/4	18	Marin	14	20	CF	981.	7
	99	Q ross	6.01	106 XX			<u> </u>	20	CF	991	
	76	G!nus	D.O.	1014 64	14.	moon	get.	18	Ch	987.	poun
	qC.	ون ا	5.01	103/69	94.	Wesh	14	20	CL	984.	JE BIX.
ľ	94	S; my	0,02	10 64	78	Now	XX	0,0	CL	987	7
	95	Sinus	0,01	120	76	War	XX	18	CL	991	,
Ī	95	Cluras	501	2/2	78	Non	xx	18	CC	98%,	Room.
	96	gnes	6.01	76	96	Na	XX	18	CL	997.	0
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DRAINAGE

URINE

PREVIOUS DAY - HOURS
TOTAL INTAKE
TOTAL OUTPUT
BALANCE